The Dudley Group
NHS Foundation Trust

Board of Directors
Thursday 5th July, 2018 at 8.30am
Clinical Education Centre
AGENDA

Meeting in Public Session

All matters are for discussion / decision except where noted

	Item	Enc. No.	By	Action	Time
1.	**Chairmans Welcome and Note of Apologies – K Kelly**		J Ord	To Note	8.30
2.	**Declarations of Interest** Standing declaration to be reviewed against agenda items.		J Ord	To Note	8.30
3.	**Announcements**		J Ord	To Note	8.30
4.	**Minutes of the previous meeting**				
	4.1 Thursday 7 June 2018	Enclosure 1	J Ord	To Approve	8.30
	4.2 Action Sheet 7 June 2018	Enclosure 2	J Ord	To Action	8.35
5.	**Staff Story**		L Abbiss	To Note & Discuss	8.40
6.	**Chief Executive's Overview Report**	Enclosure 3	D Wake	To Discuss	8.50
7.	**Safe and Caring**				
	7.1 Clinical Quality, Safety and Patient Experience Committee Exception Report	Enclosure 4	D Wulff	To note assurances & discuss any actions	9.00
	7.2 Infection Prevention and Control Report	Enclosure 5	S Jordan	To note assurances & discuss any actions	9.10
	7.3 Nurse/Midwife Staffing Report	Enclosure 6	S Jordan	To note assurances & discuss any actions	9.20
	7.4 Nurse Revalidation Report	Enclosure 7	S Jordan	To note assurances	9.30
	7.5 Annual Health and Safety Assurance Report	Enclosure 8	N Hobbs	To note assurances	9.40
	7.6 Medicines Management Annual Report	Enclosure 9	R Kahlon	To note and discuss	9.50

	7.7 Breast Screening Annual Report	Enclosure 10	P Stonelake	To note and discuss	10.00
8.	**Responsive and Effective**				
	8.1 Integrated Performance Dashboard	Enclosure 11	N Hobbs	To note assurances & discuss any actions	10.10
	8.2 Finance and Performance Committee Exception report	Enclosure 12	J Fellows	To note assurances & discuss any actions	10.20
9.	**Well Led**				
	9.1 Digital Trust Committee Exception Report including Annual IT Strategy Report	Enclosure 13	M Stanton/ A Becke	To note assurances & discuss any actions	10.30
	9.2 Workforce Committee Exception Report	Enclosure 14	A McMenemy	To note assurances & discuss	10.40
	9.3 Charitable Funds Committee Report	Enclosure 15	J Atkins	To note assurances & discuss	10.50
	9.4 Freedom to Speak Up Guardians Report	Enclosure 16	D Eaves	To note assurances & discuss	11.00
	9.5 Staff Survey Action Plan	Enclosure 17	A McMenemy	To note & discuss	11.10
	9.6 Corporate Risk Register	Enclosure 18	G Palethorpe	To note & discuss	11.20
10.	**Any other Business**		J Ord		11.30
11.	**Date of Next Board of Directors Meeting** 8.30am 6th September, 2018 Clinical Education Centre		J Ord		11.30
12.	**Exclusion of the Press and Other Members of the Public** To resolve that representatives of the press and other members of the public be excluded from the remainder of the meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest. (Section 1 [2] Public Bodies [Admission to Meetings] Act 1960).		J Ord		11.30

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

Enclosure 1

The Dudley Group
NHS Foundation Trust

Minutes of the Public Board of Directors meeting held on Thursday 7th June, 2018 at 8.30am in the Clinical Education Centre.

Present:

Jenni Ord, Chairman
Richard Miner, Non Executive Director
Julian Atkins, Non Executive Director
Doug Wulff, Non Executive Director
Karen Kelly, Chief Operating Officer
Tom Jackson, Director of Finance
Siobhan Jordan, Chief Nurse
Ann Becke, Non Executive Director
Diane Wake, Chief Executive
Andrew McMenemy, Director of Human Resources

In Attendance:

Helen Forrester, EA
Mark Stanton, Chief Information Officer
Liz Abbiss, Head of Communications
Glen Palethorpe, Director of Governance/Board Secretary
Dr Mark Hopkin, Associate Non Executive Director
Lisa Peaty, Deputy Director of Strategy and Business Development
Paul Hudson, Clinical Director
Liz Rees, Director of Infection Prevention and Control (Item 18/070.2)
Christina Rogers, Head of Safeguarding (18/070.7)
Jeff Neilson, Director of Research and Development (Item 18/072.3)
Babar Elahi, Guardian of Safe Working (Item 18/072.4)

18/063 Note of Apologies and Welcome
8.31am

Apologies were received from Jonathan Fellows, Jonathan Hodgkin, Richard Welford, Julian Hobbs and Natalie Younes. The Chairman welcomed Paul Hudson, who was attending for Julian Hobbs, and Lisa Peaty who was attending for Natalie Younes, to the meeting.

The Chairman welcomed Andrew McMenemy who was attending the Board for the first time as a voting Director.

18/064 Declarations of Interest
8.32am

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

There were no other declarations of interest.

18/065 Announcements
8.33am

The Board noted that it was Volunteers Week and recognised their enormous contribution to the organisation and wished to pay thanks to all volunteers for their efforts in supporting both our staff and our patients

No other announcements to note.

18/066 Minutes of the previous Board meeting held on 3rd May, 2018
(Enclosure 1)
8.35am

The minutes were agreed as a correct record of the meeting and signed by the Chairman.

18/067 Action Sheet, 3rd May, 2018 (Enclosure 2)
8.37am

The actions were noted to be complete, work in progress or not yet due.

18/068 Patient Story
8.39am

The Head of Communications presented the patient story which was given by a patient who had been in the care of the Orthopaedic Team and who had had total knee replacement surgery. Her previous story had been very positive.

This was a return to this patient story so the Board could see the wider pathway. Again the story was very positive and the patient recommended the Trust to other patients for their treatment.

The Chief Nurse confirmed that the Orthopaedic Ward receives 100% feedback for the Friends and Family test.

Dr Hopkin, Non Executive Director, commented that he was assured to see the whole pathway of care being a positive story.

The Chairman asked about the patient having three Physiotherapy appointments. The Chief Nurse stated that it would be helpful to know if the patient was offered Physiotherapy in the Community and she would look at Orthopaedic Physiotherapy provision with Gail Parsons.

The Chairman and Board noted the story and positive comments made. The Chairman asked that the Board's thanks are passed on to the patient.

Chief Nurse to investigate Orthopaedic Physiotherapy provision with Gail Parsons.

Board's thanks to be passed on for patient story.

18/069 Chief Executive's Overview Report (Enclosure 3)
8.50am

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

- Dudley End of Life and Palliative Care Strategy: Successful launch event held.
- Neon Colour Dash: Taking place on 10th June, 2018. £7,000 had been raised to date.
- LEAN Programme: The Trust had been involved in the pre-launch, this was very exciting work for the organisation.

Mr Miner, Non Executive Director, asked about the impact of the LEAN programme. The Chief Operating Officer stated that it will reinvigorate staff within the organisation to look at the delivery of healthcare.

Mrs Becke, Non Executive Director, stated that it was interesting to note the number of people that do not have access to GP out of hours care.

The Chairman and Board noted the report.

18/070 Safe and Caring

18/070.1 Clinical Quality, Safety and Patient Experience Committee Exception Report (Enclosure 4)
9.00am

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

The Board noted the following key areas from the Committee meeting:

- Ophthalmology and Paediatric Waiting Times: Discussion held around how to address the backlog. Proposals were not well received by the Committee and an update is expected before the next meeting. In relation to Paediatrics the trajectory had been revised to April 2019 and Ophthalmology has taken forward the required actions to reduce the trajectory. The Chief Operating Officer also confirmed that there is further work ongoing to reduce the trajectory. The Chairman confirmed that the position and expectation was made clear to the Division at the Committee.

- ED Response to Complaints: The Committee noted the improvements in response rates.

- CQC Improvement Plans: The Committee reviewed the plans and was pleased to note the shift from red to green. The Board took assurance from this.

- Quality and Safety and Reporting Groups: Issues raised regarding oxygen compliance and attendance/frequency of meetings. The Committee will continue to monitor these issues. The Chief Executive confirmed that the Groups had met but had not reported appropriately up to the Committee and this will be corrected. The Chairman asked that the Chairs Action Logs are made available to the Committee going forward to provide better assurance.

The Board noted the infection control and Hygiene Code compliance and the request for a corporate risk assessment to be undertaken in relation to the MRI replacement programme. The Chief Executive confirmed that work is ongoing and FourEyes are working with Radiology looking at capacity and demand.

The Chairman and Board noted the report, agreed the recommendations and noted the assurances given.

Reporting Groups to the Committee to ensure that Chairs Logs are completed and provided to the Committee to provide greater assurance.

18/070.2 Infection Prevention and Control Annual Report (Enclosure 5)
9.08am

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

There were 10 elements of the Hygiene Code that the Trust is required to meet. A lot of work has been undertaken with PFI partners to improve cleaning scores. The antimicrobial agenda is a constant challenge and this was an area of constant focus for the Trust. Work is ongoing to identify patients who come into hospital with an infection. MRSA screening has been an issue and work has been undertaken on cleaning the data and the Trust is now close to target. Training has also been an area of focus for the Trust and the Trust is on trajectory to reach the target for transfer from a three year to an annual cycle.

The Chairman confirmed that the Chief Executive will meet with Dr Adams when she revisits in July.

The Chairman asked where the Infection Prevention and Contorl Annual Report is published. The Director of Infection Prevention and Control confirmed that the only requirement is to publish the report on the Trust's website and this would be complete in due course.

Dr Wulff, Non Executive Director, asked where antimicrobial stewardship is monitored. The Board noted that this is through the Medicines Management Group and a number of other fora and will be reported to the Clinical Quality, Safety, Patient Experience Committee.

Dr Wulff confirmed that the cleaning scores are also monitored by the Clinical Quality, Safety and Patient Experience Committee.

The Chairman stated that monitoring also takes place at the Board to Board meeting with Summit.

The Chairman and Board noted the report.

18/070.3 Monthly Nurse/Midwife Staffing Report (Enclosure 6)
9.17am

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

The Board noted the following key issues:

- The Trust was achieving safe staffing levels.
- The Trust is committed to recruitment and retention.
- Safe staffing to be discussed on the private agenda.
- The Trust continues to monitor the use of agency staff and Ward C4 and the Surgical Assessment Unit had volunteered to trial the non-usage of agency staff.
- The paper has been discussed in detail at the Finance and Performance Committee.
- Recruitment and retention continues to be a main focus for the Trust. 81 students will commence in the Autumn, 36 of these are from external recruitment.

Mr Miner, Non Executive Director, raised the nursing numbers detailed on page 6 and asked how long it takes to get graduate nurses to a competent level. The Chief Nurse confirmed that graduate nurses will be on a rotational programme to help build competencies across all areas. It takes 3-6 months to build competencies to an appropriate level and be counted in nursing staffing numbers.

Mr Atkins, Non Executive Director, had been to a walkround on the Surgical Assessment Unit and confirmed he was encouraged to hear the views of nursing staff on recruitment and agency staffing. Mr Atkins stated that we need to ensure that all staff that are leaving the Trust have an exit interview. The Chief Executive confirmed that work is ongoing to ensure that this happens early and monitoring is undertaken by the Workforce Committee.

The Chairman and Board noted the report and the ongoing work to ensure that the Trust maintains safe staffing levels and reduction of the use of agency staff.

18/070.4 Learning from Deaths Report (Enclosure 7)
9.29am

Dr Paul Hudson presented the Learning from Deaths Report given as Enclosure 7, for information.

The Board noted the following key issues:

- Slight increase in crude mortality and the Board noted that there had been an increase nationally. There had also been a small rise in SHMI but this was within expected rates. HSMR had also seen an increase.

- Post-operative mortality was good.

- Amber alerts had been investigated.

- There had been issues with the Sepsis pathway but numbers had fallen since the last report. The Trust will continue to monitor this area.

- The Trust was an outlier for deaths from secondary malignancy. Audits had been undertaken and it was pleasing to note that there were no deficiencies in care.

- Progress had been made on the Section 28 notices and Thrombosis Group. Work is ongoing around VTE assessments. The Chairman asked if assessments are done each time patients are moved. Dr Hudson confirmed that this is normally done on admittance.

- Deaths in patients with Learning Difficulties had recently been released and the Trust is now reviewing this area.

- The number of mortality reviewers within the Trust will be increased.

Mrs Becke, Non Executive Director, asked about Organ Donation and whether there is confidence that the Trust is not missing possible candidates for organ donation. Dr Hudson confirmed that work is ongoing in the organisation. The Chief Executive confirmed that she will pick this up with the Medical Director.

Mr Miner, Non Executive Director, asked for assurance around deaths not being covered by aggregate figures. Dr Hudson confirmed that the Board should be assured that all deaths are reviewed and the system is robust. The Chief Executive confirmed that the CQC were positive about the work the Trust undertakes on reviewing deaths.

The Chief Executive said the Trust should aspire to have an HSMR of 100 and she would also like to see more detail in the report around Sepsis.

The Chairman stated that the Trust and Community should work together to improve the whole health economy performance around mortality.

The Chief Executive asked that a report on COPD deaths be brought back to Board.

Dr Wulff, Non Executive Director, confirmed that the Clinical Quality, Safety, Patient Experience Committee also monitor mortality.

The Chairman and Board noted the report and the work undertaken around mortality.

The Chairman to pick up identifying if there are any improvements that can be made to identifying potential organ donors.

The Chief Executive to discuss the inclusion of detail around Sepsis in the Mortality Report with the Medical Director.

A report on COPD to be brought back to Board.

18/070.5 2017/18 Trust Annual Report including the Quality Accounts Report (Enclosure 8)
9.48am

The Head of Communications presented the Trust Annual Report including Quality Accounts, given as Enclosure 8, for information.

The report had been considered in detail by the Audit Committee on behalf of the Board and was for noting by the Board.

The report is laid before Parliament week commencing 25th June, 2018, and will be placed on the Trust website after this date.

The Chairman asked for confirmation that the Auditors opinion was included in the report. The Board noted that this was given on page 68.

The Board noted the following amendments to the Report:

- Page 15 The Chief Operating Officers start date to be amended.
- Page 17 The Chief Nurses start date to be amended.
- Page 20 should read Interim Medical Director.

Mr Miner, Non Executive Director, confirmed that the Audit Committee had made a number of comments around the presentation of the report. The Head of Communications confirmed that all amendments had been taken into account.

The Chairman and Board noted the report and confirmed that the Accounts and Audit reflect a very accurate position.

18/070.6 Maternity CNST Scheme (Enclosure 9)
9.54am

The Director of Governance/Board Secretary presented on the Maternity CNST Scheme, given as Enclosure 9, for information.

The Board noted the following key issues:

- The document had been discussed in detail at the Clinical Quality, Safety, Patient Experience.

- The document will be submitted to NHS resolution by the end of the month.

- The evidence relating to the self assessment is included in the Appendix.

- The document correlates with the CQC assessment of Good for maternity services.

Mr Atkins, Non Executive Director, suggested that the wording around training could be strengthened.

The Chairman and Board noted the report and agreed that there was satisfactory evidence to show compliance and achievement of the 10 maternity safety actions to the required standard. The Board asked that their thanks were passed to Dawn Lewis, Eric Watson and their teams.

18/070.7 2017/18 Annual Safeguarding Report (Enclosure 10)
9:58am

The Head of Safeguarding presented the Annual Safeguarding Report, given as Enclosure 10, for information.

The Board noted the following key issues:

- The report had been discussed in detail at the Clinical Quality, Safety, Patient Experience Committee.

- A number of actions had been delivered over the last 12 months.

- There has been a focus on training and improving the Safeguarding Team.

- The aim is to achieve outstanding practice at the Trust in respect of Safeguarding.

- A Safeguarding Strategy had been developed to support a culture of continuous improvement and best practice.

- The Audit Plan was included report to provide assurance around improvements.

Mrs Becke, Non Executive Director, thanked Christina for her work and effort on improving Safeguarding within the Trust.

Mr Miner, Non Executive Director, asked about the most effective way to report on Safeguarding to the Board. Christina confirmed that there is a robust reporting structure in place. The Clinical Quality, Safety, Patient Experience Committee will receive a quarterly report for assurance which will be presented to Board by exception.

The Chairman and Board noted the report and thanked Christina for her work.

18/071 Responsive and Effective

18/071.1 Integrated Performance Report (Enclosure 11)
10.07am

The Chief Operating Officer presented the Integrated Performance Report given as Enclosure 11.

The Board noted the following key issues:

- Performance for April.
- DM01 and RTT continues to perform well.
- Cancer 62 target is vulnerable for the quarter, work is ongoing and a paper will be presented to the Private Board.
- ED was well below the standard and trajectory. The Trust had reviewed its data and had seen a 5.7% increase in those aged 60 to 80 attending ED. These patients have multiple co-morbidities. There had been 404 breaches in the previous year and 63 breaches so far in the year to date. Rapid assessment bays have been established in AMU. This area sees in excess of 70 patients per day. The Trust had re-opened escalation Ward B6 and this had helped with flow. The majority of delayed discharges are out of area and the Trust is working with partners to address these. Work ongoing to achieve the quarterly target but this is a challenge.
- There had been a lot of emphasis on appraisals over the last few months and meetings had taken place with areas that were not compliant. The Trust was expecting to achieve 90% by the end of June.
- Mandatory training has improved.
- Sickness rates are positive at 3.9%.
- The staff in post figure was incorrect in the report and should read 4338.
- The turnover rate had continued to rise and will be an area of focus.

Dr Wulff, Non Executive Director, confirmed that the quality aspect of performance is reviewed by Clinical Quality, Safety, Patient Experience Committee.

The Chairman asked for an in depth look at performance by the Finance and Performance Committee.

Mr Atkins, Non Executive Director, raised the changes to the Surgical Assessment Unit and whether similar changes could be made elsewhere in the Trust. The Board noted that the Trust was looking at providing a chest pain arrival area.

The Chief Executive stated that specialties need to maintain expected pathways that have been put in place.

The Chief Operating Officer confirmed that Medicine are putting in place a Deteriorating Patient Pathway and this was a positive improvement for the organisation.

The Chief Executive commented on the first five dashboards and asked that targets are included.

The Chief Operating Officer confirmed that she is working with Information to provide a report that gives statistical analysis and trajectory.

The Trust is working on a bid to redesign the Emergency Department.

The Chairman and Board noted the report and current performance.

The Finance and Performance Committee to take an in-depth look at performance.

18/071.2 Finance and Performance Committee Exception Report (Enclosure 12) 10.23am

The Director of Finance presented the Finance and Performance Committee Exception Report, given as Enclosure 12.

The Board noted the following key issues:

- Performance for April 2018.
- The Committee held a planning session looking at 2018/19 and there was also a focus on budgets.
- A report had been presented on the CQUIN programme and lessons learnt.
- NHSI deep dive had been undertaken and there was assurance taken from this process although the challenge was noted.
- Month 1 key risk was around the recovery of income.

The Chairman and Board noted the report and financial performance.

18/071.3 Annual Plan Summary Report (Enclosure 13) 10.28am

The Deputy Director of Strategy and Business Development presented the Annual Plan Summary Report given as Enclosure 13.

The Board noted the following key issues:

- Amendments asked for by the Board had been implemented.

Dr Wulff, Non Executive Director asked that the percentage changes on page 11 were checked.

The Board were content with the revised format and this will now be uploaded to the Trust website.

The Chairman and Board noted the report.

Percentage changes on page 11 of the report to be verified.

18/072 Well Lead

18/072.1 Digital Trust Committee Report (Enclosure 14)
10.30am

Mrs Becke, Committee Chair and the Chief Information Officer presented the Digital Trust Committee Report given as Enclosure 14.

The Board noted the following key highlights:

- There had been successful Go Live on 17th May, 2018. The IT Team had worked tremendously hard to support the Go Live.

- The Trust is undertaking 4,000 e-obs each day.

- E-Sepsis to be rolled out on 9th July, 2018.

- Other functionality will be rolled out up to March 2019.

- The production environment had been tested and the infrastructure is now live.

The Digital Trust Committee was meeting the following Wednesday.

Mr Atkins, Non Executive Director, confirmed that some staff had suggestions for improvement and asked if the Trust was capturing this. The Chief Information Officer confirmed that all feedback is captured and acted upon.

The Chairman and Board noted the report and the position regarding go live and positive news regarding e-Sepsis.

18/072.2 Audit Committee Exception Report including Audit Committee Annual Report (Enclosure 15)
10.36am

Mr Miner, Committee Chair, presented the Audit Committee Exception Report including Audit Committee Annual Report, given as Enclosure 15.

The Board noted the following key highlights:

- Challenging Audit Committee meeting.

- There were a number of outstanding actions that required closure. VTE, oxygen prescribing, CQC and safeguarding. Reports had been closed but there were a number of outstanding issues.

- There had been a discussion around the presentation of the Accounts and Annual Report. The Annual Accounts had moved to a position where the Trust had to modify accounting policy relating to going concern. This was highlighted in accounting policies and audit report. The Trust is not an outlier for this nationally.

- VFM/use of resources received an except for position as there were some gaps in assurance.

- Undertook self assessment review with some interesting learning, particularly the review of risks from other Committees.

- The Annual Report for 2017/18 is also included in the papers and all reports contain substantial or reasonable assurance from the Trust's auditors in all areas.

- A summary of issues, attendance, training and professional development of Audit Committee members is included in the paper.

The Chief Executive stated that the use of the term Governance was misleading and reads like the Trust is not robust in its data recording procedures. The Chairman asked about the VFM decision. The Director of Finance confirmed that the Trust had pushed back strongly on this area. The Chairman stated that the Audit Opinion must be absolutely clear.

Mr Miner, Non Executive Director, stated that in relation to four hour access target, the issue related to the aggregation of scores and availability of data from the third party. The Chief Operating Officer stated that the issue was about the tracking of Malling Health data.

Mr Miner, confirmed that in relation to 18 week waits there were issues with stopping and starting of clocks.

Mr Miner confirmed that the Audit Committee were content with the report and changes made given the situation.

The Chief Executive stated that oxygen prescribing had improved at the Trust and a policy had been implemented from September and Phil Brammer was trialling this in Respiratory.

Mrs Becke, Non Executive Director, stated that we are suffering from the “Carillion effect”.

The Chairman commented that the report also uses the term losses but this was actually a failure to achieve.

The Chairman commented that the Auditors attendance at the Annual Members meeting was paramount.

Dr Wulff, Non Executive Director, raised the clarity of flow from Committee to Committee and what the expectations were. Mr Miner confirmed that this had arisen from the self assessment and it related to risk and clinical audit. The Chairman confirmed that the Board will receive updates on Clinical Quality through the Clinical Quality, Safety, Patient Experience Committee report.

The Chairman stated that there are opportunities for an Audit Committee half day workshop and asked that Mr Miner consider this as Audit Chair. Mr Miner agreed that he would discuss this with the Director of Governance/Board Secretary.

The Chairman and Board noted the report and thanked Mr Miner for his work as Audit Chair.

Mr Miner to discuss the opportunity for an Audit Committee half day workshop with the Director of Governance/Board Secretary.

18/072.3 Research and Development Report (Enclosure 16)
11.03noon

The Director of Research and Development presented the Research and Development Report given as Enclosure 16.

The Board noted the following key highlights:

- The Trust had seen success through Research in the last few months.
- Holly Johns and Mike Douglas had work published.
- A number of Studies were performing well nationally.
- There was a Strategy in place to increase the amount of research led by non medics.
- A regular research newsletter had been established.

- The Trust website and Hub were being updated to emphasise the work of Research and Development.

- Research Lunch club continues to run with good attendance.

- The Department wants to involve more specialties in research and target specialties that are not currently involved.

- Research is involved in EPR and can be used to identify patients for studies and feed research.

- Performance overall has improved and at target for overall recruitment.

- Activity Based Funding has decreased.

The Chairman raised the high level objectives and ranked 84 out of 207. The Board noted that this should say nationally.

The Director of Research and Development asked that Board members challenge Divisions on their involvement in research.

The Chairman and Board noted the report and commended the positive performance.

Board members asked to challenge Divisions on their involvement in research.

18/072.4 Guardian of Safe Working Report (Enclosure 17)
11.11pm

The Guardian of Safe Working presented his report given as Enclosure 17.

The Board noted the following key highlights:

- Report for February to May 2018.

- Engagement continues to be good.

- Next Junior Doctors Forum being held on 21st June, 2018.

- The Guardian had started to go out into the hospital to meet with doctors formally and informally.

- He was also meeting with educational and clinical supervisors.

- All contracts have now been issued.
- The Guardian will meet with the Director of Education on a monthly basis following concerns raised on the GMC website.
- Only two exceptions had been raised and these had been dealt with effectively.
- The Trust was undertaking national benchmarking for exception reporting.
- There were significant rota gaps and these will be filled by MTIs.

The Chairman confirmed that the Trust is trying to reduce locum expenditure.

The Director of HR confirmed that the schedules have gone out for the September rotation and this is much improved performance.

The Chairman and Board noted the report and thanked the Guardian for his continued work.

18/073 Any Other Business
11:21pm

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

18/074 Date of Next Meeting
12:21pm

The next Board meeting will be held on Thursday, 5th July, 2018, at 8.30am in the Clinical Education Centre.

Signed ……

Date ……

Enclosure 2

The Dudley Group NHS Foundation Trust

Action Sheet
Minutes of the Board of Directors Public Session
Held on 7 June 2018

Item No	*Subject*	*Action*	*Responsible*	*Due Date*	*Comments*
18/057.2	Infection Prevention and Control Update	The Chief Executive to have a pre-meeting and feedback meeting with Dr Adams when she next visits the Trust in July.	DW	6/9/18	Visit scheduled for 18th July.
18/058.3	Monthly Nurse/Midwife Staffing Report	Chief Nurse to reflect on how data on all aspects of quality can be brought together into an overarching Chief Nurse report. Mr Welford to meet with the Chief Nurse to further understand the staffing position.	SJ SJ/RW	5/7/18 5/7/18	Meeting being arranged.
18/054.7	Action Sheet – 12th April 2018	Utilisation and retention of staff to be presented back to the next Workforce Committee.	AM	26/6/18	Done
18/071.1	Integrated Performance Report	The Finance and Performance Committee to take an in-depth look at performance.	JF	28/6/18	Done
18/029.8	Action Sheet	Board members perspective of the 6Cs to be presented to the Board in May.	LA	6/9/18	To September Board.
18/035.2	Staff Survey Report	Staff Survey action plan to be presented to Board.	AM	6/7/18	On Agenda
18/045.5	Nurse Revalidation Report	Further detail around numbers and quality of evidence relied upon for revalidation to be included in future reports.	SJ	5/7/18	On Agenda
18/070.5	Trust Annual Report	Annual report to be amended on pages 15, 17 and 20 as discussed.	LA	25/6/18	Done

18/071.3	Annual Plan Summary Report	Percentage changes on page 11 of the report to be verified.	NY/LP	5/7/18	Percentages were provisional and have now been revised.
18/072.2	Audit Committee Exception Report	Mr Miner to discuss the opportunity for an Audit Committee half day workshop with the Director of Governance/Board Secretary.	RM/GP	5/7/18	The Director of Governance/Board Secretary to meet with the Chair of the Audit Committee after Board on 5th July to agree a programme for each of the 4 Audit Committee meetings for 2018/19.
18/059.4	Q4 Monitoring of 2017/18 Annual Plan	Trust to look at the way the report is presented and consider revising. In future workshops on the development of the Trust's strategy, the format, number of annual goals and how their effectiveness could be tested could be debated.	NY NY	6/9/18 2/8/18	Not due Not due
18/059.6	Patient Experience Quarterly Report	Report to be revised to include a timeline for achieving the 40 day complaints response rate and to stratify the key areas for improvement.	SJ	6/9/18	Not due
18/068	Patient Story	Chief Nurse to investigate Orthopaedic Physiotherapy provision with Gail Parsons. Board's thanks to be passed on for the patient story.	SJ LA	6/9/18 5/7/18	Not due Done
18/070.1	Clinical Quality, Safety, Patient Experience Committee	Reporting Groups to the Committee to ensure that Chairs Logs are completed and provided to the Committee to provide greater assurance.	SJ/GP	6/9/18	Not due
18/070.4	Learning from Deaths Report	The Chairman to pick up identifying if there are any improvements that can be made to identifying potential organ donors. The Chief Executive to discuss the inclusion of detail around Sepsis in the Mortality Report with the Medical Director.	JO DW/JH	6/9/18 6/9/18	Not due Not due

		A report on COPD to be brought back to the Board.	JH	6/9/18	Not due
18/072.3	Research and Development Report	Board members asked to challenge Divisions on their involvement in research.	All	Ongoing	

Enclosure 3

The Dudley Group
NHS Foundation Trust

Paper for submission to the Board of Directors on 5th July 2018

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

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

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

SUMMARY OF KEY ISSUES:

- Visits and Events
- Committed to Excellence Awards
- Annual Members Meeting
- Charity Update
- NHS 75th Anniversary
- Dermatology Nurse of the Year
- Gastroenterology News
- Prime Minister's Speech on NHS Funding
- National NHS News
- Regional NHS News

IMPLICATIONS OF PAPER:

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

ACTION REQUIRED OF BOARD:

Decision	Approval	Discussion	Other
		Y	Y

RECOMMENDATIONS FOR THE BOARD:

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

The Dudley Group
NHS Foundation Trust

Chief Executive's Report – Public Board – July 2018

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

Items below are not reported in any order of priority.

Visits and Events

7th June	Board of Directors
	Council of Governors
18th June	Renal Dialysis Centre Opening
	Black Country STP Health Partnership Meeting
20th June	NHSI Chief Executive's Event
25th June	Black Country ICS Development Meeting
	West Midlands Urgent and Emergency
27th June	Ophthalmology Workshop
	Transition Board

Oscars style Committed to Excellence Awards

This year's Committed to Excellence staff awards were held on the 29th June and heralded as huge success by all who attended. The awards featured many new categories the Patient Choice Award which allowed our patients and visitors to highlight the work of teams and individuals who have made a real difference to them.

I would like to formally thank our sponsors who are: Interserve, Allscripts, Four Eyes Insight, Summit Healthcare, Hill Dickinson, Geoff Hill Charitable Trust, Healthcare Staff Benefits and Zicam Security. The generosity of our sponsors allows us to hold the awards and show how much we appreciate the hard work and dedication of our staff and volunteers.

And the winners were:-

Excellence in Patient Care, Hollie Murphy, Lead Nurse, ward B2

Team Excellence, Contraception & Sexual Health (Community)

Excellence in Business Development, Digital Trust

Unsung Hero – Clinical Kate O'Connor, Simulation Lead

Unsung Hero – Non-clinical, Andrew Rigby, Head of Facilities & Property Management

Volunteer Award, Peter Bisbey, Volunteer, Emergency Department

Healthcare Hero Team Award, Ward C8 Stroke

Healthcare Hero Individual Award, Karen Lewis, Macmillan End of Life Care Facilitator

Patient Choice, C4 Georgina Unit

Outstanding Achievement Award – Team, Maternity Department

Outstanding Achievement Award – Individual, Michelle Pinto, Matron, Community Nursing

Chief Executive Award, Sara Davis, Matron, Surgery

Chairman Award, Megan Jane Fleetwood, Volunteers' Coordinator

Chief Nurse Award, Sepsis Team

Medical Director Award, GI Team – Zenkers

Chief Operating Officer Award, Site Team

Medicine & Integrated Care Award, Cardiac Assessment Team

Surgery, Women & Children Award, Becky Field

Clinical Support Services Award, Pharmacy Management Team

Corporate Services Award, Governance Team

Annual Members Meeting

The Annual Members Meeting will be on the 19th July at 5.30pm in the Clinical Education Centre, Russells Hall Hospital. Everyone is welcome to join us for a showcase of our Maternity, Community and Stroke services as well as our financial and quality accounts being presented.

Charity Update

Sunday 10th June was our Neon 5k Colour Dash at Himley Hall in Dudley. Over 250 runners participated in the Trust charity Neon Dash at Himley Hall. Thank you to all the staff and volunteers who supported the event, which was a massive success and has raised nearly £15,000 for our Neonatal Unit.

The Dudley Group
NHS Foundation Trust

Celebrate the 70th Anniversary of the NHS with a Big 7Tea Party

This year marks the 70th anniversary of the NHS and we're doing our bit to mark the occasion by joining in the Charity Big 7Tea Party. We have been capturing memories and thoughts from patients staff and visitors via a video booth in main reception. These will be shared in a screen on the 5th at the tea party from 2.30 – 4.30 across the Trust.

Dermatology Nurse of the Year

I am delighted to announce our very own staff nurse Liz Jones has been awarded Dermatology Nurse of the year from the British Dermatological Nursing Group and Psoriasis Association. She was nominated by a patient which makes the award extra special.

Gastroenterology News

Dr Sharan Shetty has been successfully elected onto the British Society of Gastroenterology, Pancreas Section Committee and I wish him all the best in this commitment.

Prime Minister's Speech on NHS Funding

On 18th June, 2018, the Prime Minister Theresa May has announced a new funding settlement for the NHS, giving the service real terms growth of more than 3% for the next five years. She has also tasked the NHS with producing a 10-year plan to improve performance, specifically on cancer and mental health care, and unpick barriers to progress.

Key announcements from the speech are attached at Appendix 1.

National NHS News

Hull NHS trust 'requires improvement' after CQC inspection
CQC inspectors have rated one of the largest trusts in England as 'requires improvement' today, citing inconsistencies in follow-up appointments and the storing of patient's records as cause for concern in the trust. The inspection of Hull and East Yorkshire NHS Trust — which runs the Hull Royal Infirmary (HRI) and Castle Hill Hospital — also found that improvements needed to be made in areas such as patient risk assessments and adhering to the "five steps to safer surgery" scheme.
10 out of 22 trusts in the region, including Bradford and York, now 'require improvement.'
National Health Executive (01.06.18)

Pill to treat ovarian cancer approved for use on NHS
Up to 850 women in England and Wales could benefit from a targeted pill that treats ovarian cancer after it was approved for use on the NHS through the Cancer Drugs Fund. Clinical trial results showed that niraparib delayed cancer growth by around six to 15.5 months more than a placebo, depending on a woman's genetic profile. Niraparib, a once-a-day pill, works by inhibiting two proteins involved in DNA repair to prevent cancer growth.
The Independent (01.05.18)

High Court backs NHS decision to stop funding homeopathy
The British Homeopathic Association (BHA) brought a legal challenge against NHS England's decision, made in November last year, to stop paying the £92,000 annual cost of homeopathic remedies. But, following a four-day hearing in London in May, Mr Justice Supperstone dismissed the BHA's case in a ruling on Tuesday. Simon Stevens, head of the NHS, welcomed the decision, describing the legal action as "costly and spurious". NHS England issued guidance in November last year that GPs should not prescribe "homeopathic treatments" as a new treatment for any patient. The guidance also stated GPs should be "supported in de-prescribing" such remedies for all patients who were receiving them at that time.
The Telegraph (05.06.18)

Hundreds going blind each year amid NHS delays, research shows
Ophthalmologists warned of a growing crisis in services affecting patients with common eye conditions such as glaucoma and age-related macular degeneration (AMD). Their research shows that more than 260 patients a year are losing their vision permanently, because they were not seen by the NHS in time.
Research by the The British Ophthalmological Surveillance Unit found up to 22 patients every month were going blind or being left partially sighted because treatment was not started in time.
The Telegraph (06.06.18)

Troubled East Sussex NHS trust out of special measures
A Sussex health trust has come out of special measures after a positive report from the health watchdog. East Sussex Healthcare NHS Trust runs Eastbourne District General Hospital and the Conquest Hospital, St Leonards. It was put in special measures in 2015, after consecutive 'inadequate' ratings by the Care Quality Commission (CQC). The trust remains in financial special measures and "must make rapid progress to strengthen its finances", NHS Improvement said.
BBC News (06.06.18)

NHS in crisis: Unexpected price hikes cost NHS £300MILLION extra in shock bill
MASSIVE unexpected price hikes for medicines cost the English NHS more than £300million extra last year, the official spending watchdog has calculated. Price tags on a range of common non-branded drugs soared to as high as 70 times the previous level, said the National Audit Office, as manufacturers stopped supply and wholesalers pushed up their profits. The NHS spent an estimated £4.3billion on generic medicines in 2016-17.
The Express (08.06.18)

Hundreds of out-of-date X-ray machines leave NHS patients at risk, claims Labour
Freedom of Information research showed that hundreds of pieces of critical machinery are being used even after they are meant to be replaced, such as:
Jeremy Hunt says people are willing to pay higher taxes amid NHS row
• 892 X-ray machines in use that were more than 10 years old, with 139 past their replacement dates, 295 ultrasound machines more than 10 years old, with 134 past their replacement dates, 46 MRI scanners more than 10 years old, with 10 past their replacement dates, 45 CT scanners more than 10 years old, also with 10 past their replacement dates,
One X-ray machine from 1984 was still in use at a hospital in Leeds, while a 1992 ultrasound machine was being used in Oxford. In South Tees an ultrasound which should have been replaced in 2001 was still being used, as well as an MRI scanner at the Royal Free in London which should have been replaced in 2007. **The Independent (11.06.18)**

The UK health tax hurting foreign nurses
Migrant workers coming to the UK from outside the European Economic Area (EEA) and their dependents have to a pay an annual fee of £200 ($268) each.
The health surcharge was introduced in 2015 to boost funding for the National Health Service (NHS) and as a way to discourage health tourism. Later this year, the annual charge is to be doubled from £200 to £400, with the discounted rate for students set to increase from £150 to £300. The union's resolution said it was "morally questionable" for foreign nurses "to pay the health surcharge, given that they pay national insurance and income taxes, as well as providing a vital service to the public".
BBC News (12.06.18)

May to unveil £20bn a year boost to NHS spending
Taxpayers are to be asked to help fund a £20bn a year injection of extra cash into the National Health Service by 2023-24 that will pay for thousands more doctors and nurses, while cutting cancer deaths and improving mental health services, Theresa May will say today. The announcement, before the NHS's 70th birthday next month, will represent the biggest funding boost since Gordon Brown imposed a one percentage point rise in National Insurance to pay for more NHS spending in his 2002 budget, in the face of Tory claims that Labour was slapping a "tax on ordinary families".
The Guardian (16.06.18)

Breast cancer patients 'denied reconstructive surgery due to NHS restrictions'
Figures revealed nearly a quarter of local NHS commissioning groups had introduced policies to restrict reconstruction services for non-clinical reasons, the Breast Cancer Now investigation found. The charity said the policies included limiting the number of surgeries women were allowed, putting a time-frame on when they could have the surgery, and also led to some women being denied operations to ensure both breasts were symmetrical. Baroness Delyth Morgan, chief executive of the charity, said it was "totally unacceptable" that any patient was being denied reconstructive surgery – or being rushed into potentially life-changing decisions.
NW Evening Mail (18.06.18)

Brexit: Will a dividend help pay for increasing the NHS budget?
The government says a combination of tax rises, economic growth and a "Brexit dividend" will help cover the costs of the increased spending in England's NHS budget. Under the plans, the NHS annual budget will increase by £20.5bn by 2023.On top of that, about £4bn will be given to the rest of the UK - although it will be up to Scotland, Wales and Northern Ireland to decide how that is spent. So is the UK government right to claim that we can expect a "dividend" by leaving the European Union?
BBC News (20.06.18)

The great NHS cover□up: opiate syringes may have killed thousands
Thousands of elderly patients may have died prematurely because of cheap, faulty syringe pumps in a scandal described as "one of the biggest cover-ups" in NHS history, The Sunday Times reveals today. A whistleblower on the government inquiry into hundreds of deaths at Gosport War Memorial Hospital, Hampshire, said decision makers on the panel had "ignored" evidence of fatalities caused by the devices because they feared a national scandal.
The Times (24.06.18)

Cheap and faulty syringe pumps linked to overdose deaths in Devon and Cornwall investigated as 'NHS's biggest cover-up' scandal
As reported by the Sunday Times , a whistleblower on the government inquiry into hundreds of deaths at Gosport War Memorial Hospital in Hampshire, believes evidence of fatalities caused by the Graseby MS 16A MS 26 syringe drivers have been swept under the carpet by NHS bosses who feared a national scandal. The devices have been linked to Dr Jane Barton, who was in charge of prescribing medicine on the Gosport wards, and may have made her more dangerous than first thought. According to the national newspaper, some of the faulty syringes may have led to the rapid infusion of dangerous doses of drugs into the bloodstream of patients, causing overdoses. Dr Barton was found responsible last week for the deaths of up to 650 people and a culture in which powerful opiates were routinely and recklessly prescribed. The Department of Health whistleblower believes the question of the pumps was “buried” after senior members of the inquiry realised its implications for the NHS even though the syringes continued to be used in hospitals up until 2013.
Cornwall Live (25.06.18)

Almost 150,000 Scottish NHS staff offered 9% pay rise
NHS staff in Scotland have been offered a pay rise worth almost a tenth of their current salary, the Scottish Government has announced today. Scottish health secretary Shona Robinson unveiled the 9% offer over three years for employees currently earning up to £80,000 as part of the highest NHS pay uplift being offered in the UK. 147,000 NHS staff who will receive the pay rise are the NHS ‘Agenda for Change’ staff, including all nurses, midwives, allied health professionals and paramedics, subject to agreements from the NHS Unions. By 2020/21, Scottish staff will be “significantly better paid” than anywhere else in the UK, according to the Scottish Government. Pay for an advanced nurse practitioner at the top of Band 7 will be over £1,500 more than their English counterpart.
National Health Executive (25.06.18)

Regional NHS News

GPs ‘not surprised’ by figures suggesting 2 in 5 intend to quit within five years
The figures, released in the government-funded GP worklife survey, found that 39 per cent of GPs said they would leave their jobs before 2022. This compares to 35 per cent in 2015, and 19 per cent in 2005. Only half of GPs in the work life survey said they were satisfied with their job. 98 per cent said patients were presenting with increasingly complex needs, and 89 per cent said they had to work very quickly.
iNews (31.05.18)

Embarrassing Bodies surgeon accused of leaving up to 130 patients incontinent or infertile with experimental treatment can keep working in NHS hospitals and WON'T face tribunal
A surgeon from Channel 4's Embarrassing Bodies has avoided a tribunal and been allowed to keep working in the NHS - despite being sued by up to 130 patients. Urologist Manu Nair, 53, allegedly left patients incontinent or infertile following surgery he carried out at four hospitals in the West Midlands. The operations in question took place at three private hospitals: Spire Parkway in Solihull, Spire Little Aston, and BMI Priory, Edgbaston, and at Heartlands NHS Hospital in Birmingham
It is understood he worked at Southport and Ormskirk Hospital NHS Trust and Maidstone and Tunbridge Wells NHS Trust.
Daily Mail (01.06.18)

New Birmingham hospital stalled by Carillion collapse loses over £100m in EU funding
Funding for the building of the Midland Metropolitan Hospital has been terminated by the European Investment Bank (EIB) following the collapse of lead contractor Carillion. The EU bank had previously pledged the cash to be put towards the hospital in Smethwick, West Midlands in 2015, but now blamed “ongoing project costs” of £5m for pulling out. Last week chief executive of Sandwell and West Birmingham NHS Trust Toby Lewis claimed that if the new hospital is not weather-proofed by winter, then ongoing costs could rise even further. Last month MPs found that the hospitals stalled by construction giant Carillion’s bankruptcy were a result of “recklessness, hubris, and greed.”
National Health Executive (07.06.18)

Over 40 Worcestershire acute beds not ready by winter
Work to put 46 beds in refurbished wards at the Worcestershire Royal got the go-ahead from the Department of Health on Monday. The approval came after an £8m business case was signed off. Worcestershire Acute Hospitals trust said the two wards of acute beds will not be ready until the end of January.

The trust remains in special measures and a third ward of 23 beds is not expected to be ready until the end of March. Board chairman Sir David Nicholson, the former head of NHS England, said: "We cannot have another winter like the last one."
BBC News (07.06.18)

Coventry's hospital second worst in whole region for leaving people waiting outside in ambulances
A shocking 141 poorly patients were left waiting in an ambulance for over an hour to access treatment at Coventry's Hospital in just one month. The disturbing figures make **University Hospital Coventry and Warwickshire** (UHCW) the second worst in the region for ambulance handover delays in March - out of 22 hospitals. Latest figures show the hospital missed the **60-minute ambulance handover target** set by the government 141 times that month as the winter crisis rumbled on. The poor performance has been blamed on increasing numbers of patients using hospital services and the pressure on the NHS.
Coventry Live (08.06.18)

Work begins on West Midlands dementia care home
Work has begun on a new 60-bed, dementia care home in Shirley, Solihull in the West Midlands. The home, which is due for completion in summer 2019, will provide a range of affordable care for those funded by the council, the NHS and people who pay for their own care. Councillor Karen Grinsell, Cabinet Member for Adult Social Care and Health, said: “As a council, our aim is to care for people suffering with dementia with dignity and respect.
Care Home Professional (11.06.18)

The staggering number of NHS staff being assaulted in West Midlands
According to responses to the NHS staff survey, 16.8% of staff at both the Dudley Group and Walsall Healthcare said they had experienced physical violence from patients, their relatives or other members of the public in 2017. This was up from 14.6% at the Dudley Group, but was down from 17.2% in 2016 at Walsall Healthcare. At both University Hospitals Birmingham and the Royal Wolverhampton, 12.9% of staff said they had been assaulted in 2017, while it was 13.4% at Heart of England. Among staff who responded, 2.4% at Walsall Healthcare said they had been assaulted more than 10 times, while it was 2.1% at Sandwell and West Birmingham. **Birmingham Live (19.06.18)**

Deaths not caused by staff errors, says mental health trust
A mental health trust which reported 13 of its patients likely died due to failings in their care has said none of the deaths were caused by staff errors. Dudley and Walsall Mental Health Partnership NHS Trust exonerated its clinicians after the deaths came to light in a Quality Account report published by the trust this week. The defence of its doctors and nurses came in a statement released after it was reported that of 37 patient deaths investigated by the trust, 13 were 'assessed as to be more likely than not to have been due to problems in the care provided to the patient'.

The trust has said between 2016 and 2018 it treated 35,000 patients and conducted 37 investigations into a total of 292 patient deaths.
Birmingham Live (22.06.18)

Vaccination warning as 80 measles cases confirmed in West Midlands this year
Young people are being encouraged to make sure they have had both doses of the MMR vaccine before going on holiday to Europe, where there are large outbreaks of the disease. Between January 1 and June 18 there have been 643 laboratory confirmed measles cases in England, including 82 in the West Midlands. The vaccine is available for free to anyone who has not received both doses as a child. It protects against measles, mumps and rubella – all of which can be very serious diseases and are highly infectious.
Shropshire Star (25.06.18)

Treasury agreed to terminate PFI on Midland hospital
The decision to end the PFI deal on the Midland Metropolitan Hospital following Carillion's collapse was made by the Treasury as well as the banks involved, Construction News has learned. It had previously been reported that the decision to scrap the PFI deal was made by the consortium of five banks – the European Investment Bank, Credit Agricole, KfW IPEX, DZ Bank and Sumitomo Mitsui – which were part-funding it. However, Construction News has learned the decision to end the deal was mutually agreed between the banks and the Treasury – which has a £100m stake in the project. A source close to the deal said the banks "had been keen" to reach an agreement to complete the hospital, but a solution could not be agreed with the Treasury. As a result, the Treasury and the banks jointly agreed to terminate the deal.
Construction News (25.06.18)

Enclosure 4

The Dudley Group
NHS Foundation Trust

Paper for submission to the Board on 5 July 2018

TITLE:	**26 June 2018 Clinical Quality, Safety and Patient Experience Committee Meeting Summary**		
AUTHOR:	Glen Palethorpe – Director of Governance	**PRESENTER**	Doug Wulff – Committee Chair

CLINICAL STRATEGIC AIMS

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

CORPORATE OBJECTIVES

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

SUMMARY OF KEY ISSUES:

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

IMPLICATIONS OF PAPER:

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

ACTION REQUIRED OF BOARD

Decision	Approval	Discussion	Other
Y			**Y**

RECOMMENDATIONS FOR THE BOARD

The Committee requests the Board note the assurances received at the meeting and the decisions made by the Committee.

The Dudley Group NHS Foundation Trust

The Committee requests that the Board note the Committee's endorsement of the complaints annual report presented for approval by the Board.

The Dudley Group NHS Foundation Trust

Committee Highlights Summary to Board

Committee	Meeting Date	Chair	Quorate	
Clinical Quality, Safety and Patient Experience Committee	26 June 2018	D Wulff	**yes**	**no**
			Yes	

Declarations of Interest Made

None

Assurances received

- The Committee received a report from the Risk and Assurance Group which provided information on the receipt and debate of information covering NPSA alerts, coroners cases including actions taken as a result of regulation 28 rulings, serious incidents including their progress and tracking of improvements. The Group had referred a number of items to the respective divisions for updates to the next meeting of the Group and drew the Committee's attention to one matter that being the results of a recent audit of NG Tube compliance. This audit showed that further work is required to sustain the level of training compliance across the Trust and the Committee asked for a further update on actions taken and the impact.
- The Committee received a summary report of key quality metrics along with the Trust Integrated Performance Report. The summary report highlighted both areas that had improved or had sustained improvement, such as falls prevention, and areas where further improvement is needed linked to both of the Trust quality priorities including nutrition and wider quality matters such as compliance with trolley checks. The report provided information on the outcomes of internal quality and safety reviews and that the current tools used for these reviews are being updated to take into account the recent CQC updated guidance on 'what does a good hospital look like'.
- The Committee received a report on Infection Prevention and Control which included a summary of the position with regard to the Hygiene Code compliance requirements for 2018/19. The report updated the latest position with regards to the infection control training for staff and the Director of Infection Prevention and Control provided assurance that the annual training commitment would be achieved. The Committee was updated as to the latest position with regards to the NHS Improvement visit action plan which showed that most actions are complete and the remaining actions are on track to be delivered by the agreed implementation date.
- The Committee received a report on the actions being taken as result of the recent Cervical Quality Assurance visit.
- The Committee reviewed the Maternity Dashboard report and noted the improved performance across a range of areas since last month's report, in particular the

improved performance in breast feeding initiation rates. The Committee was reminded of the actions now in place to review caesarian section activity and noted that for the second month there was a reduction in emergency cases.

- An update was provided on the Maternity Service Improvement Plan. The report provided assurance of progress and the continued executive oversight of the action tracking process which has and will continue to take place within the Division and the Directorate.
- The Surgery, Women and Children Division provided an update on the actions being undertaken within ophthalmology to ensure sustainably in the delivery of the service. The Division updated the Committee on actions being taken to provide further clinic slots to improve the pace of addressing the identified backlog. The Division provided an update on the work being undertaken in respect of paediatric outpatient waiting lists and that the Division remained behind its forecast trajectory for recovery of this position. The Division provided the detail requested at the last meeting in respect of the revisions to the clinic booking processes which will see a reduced length of time between patients being rebooked for any cancelled appointments.
- The Committee received reports from the Divisions of Medicine & Integrated Care, Surgery and Clinical Support Services. The divisions updated the Committee on the actions being taking to improve patient quality. The Committee were updated on the challenges in respect of imaging reporting and asked that more detail on the improvement plan be provided to the next meeting.
- The Committee received a report on the progress against the agreed action plans following the CQC service inspections of Urgent and Emergency Care, Critical Care, Children and Young People, Maternity, Medicine and Community Services. The Committee was updated as to the work to provide assurance on the actions within the improvement plan. The plans showed progress made across each of the services. The Committee was updated as to the developing outcome / performance measures in place that will enable the Executive, the Committee and Board to have oversight of the sustainability of the delivery of the actions on patient safety, quality and experience. The development of these measures was commencing within the Emergency Department and once developed would be useful for many of the other service improvement plans.
- The Committee received a report on incident management. The report provided assurance on the Serious Incident process being applied and included information on the Trust position in respect of wider incidents. The Trust had seen an increase in the reported incidents in the month of May which is in support the Trust quality priority to see the Trust become a higher reporter thus increasing the opportunities to learn. The Committee was updated on the actions being taken to close investigations in a timely manner. The Committee noted that there was only one serious incident where the action plan was not being closed in line with the initial implementation date and a revised date had been provided. The report provided confirmation on the outcome of the duty of candour compliance audit showing that this requirement was being delivered well by the divisions and clinicians.
- The Committee received a report on the Trust processes for the management of Patient Safety Alerts and the linkage with clinical audit review of actions taken in respect of key alerts received and actioned by the Trust.

- The Committee received the monthly report on patient experience information for May 2018. The report provided an update on compliments, friends and family feedback, concerns and complaints activity. The report updated the Committee on the number of open complaints and the actions being taken to improve the Trust's response performance in respect of the target of 40 days. The report contained information on the changes and lessons learnt as result of a sample of complaints responded to in the month. The Committee was informed of actions the Chief Executive had instigated following her visit to out patients and the Committee requested feedback on progress in subsequent reports from the Head of Patient Experience.
- The Committee received the 2017/18 annual complaints report and endorsed its presentation for approval at the Board in July. The Committee considered the drawing out of lessons learnt and changes made as a result of complaints was a good addition to the annual report.
- The Committee received a report on the qualitative aspects of the estates contract management processes in respect of estates and facilities. The report provided information on actions taken in respect of water safety, decontamination and cleaning. The Committee was informed of the improved cleaning audit scores.
- The Committee received the Trust 2017 Adult inpatient survey report which showed a slight improvement in the overall rating when compared to all Trusts across the Country. The Committee was informed that a detailed action plan has been developed and is to be tracked through the Patient Improvement Group which meets every week.
- The Committee received reports from a number of its reporting Groups. The Infection Prevention and Control Group issues had been reflected on the separate agenda item. The Quality and Safety Group referred to the Committee the issue of blood transfusion training compliance rates and the actions being taken to improve these and that the Group had considered and agreed the sign up to safety topics for 2018/19.
- The Committee received an update on the Trust position with respect to Polices, Guidelines and Standard Operating Procedures under review. There are 7 Polices that have exceeded review dates. The Committee was updated on the progress of ensuring that these are reviewed at the next Policy Group meeting. The Committee noted that there are a further 44 due for review in the next 6 months and that the number of guidelines and standard operating procedures that require review is putting a challenge on the divisions / clinicians to ensure these are reviewed in a timely manner. The Divisions confirmed they do track these and are working to ensure they are reviewed timely.
- The Committee reviewed the Board Assurance Framework for those risks it has oversight of along with the Trust's corporate risk register. The Committee confirmed its decision at its last meeting that the MRI replacement programme should be considered for inclusion on the corporate risk register to enable effective tracking of the risk management action plan being applied to this project.

Decisions Made/Items Approved

- The Committee endorsed that the Complaints annual report and for it to be presented to the July Board for approval.
- The Committee endorsed the closure of 10 Serious Incident action plans based on the conformation by the patient safety team that evidence supported the delivery of each action within each of the 10 action plans.

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

A further update on actions taken and their impact on improving Trust compliance with training on the use of NG Tubes be presented to next meeting.

Updates on the progress being made in respect of ophthalmology and paediatric outpatient waits. Specifically a review of the issues log being maintained to track the success of the revised booking process.

The developed performance report for the ED improvement plan be added to the next report to the Committee.

A review of the action plan to deal with the workload requirements for double reporting of images.

An update to be provided in respect of patient experience improvements within outpatients in a subsequent report from the Head of Patient Experience.

Items referred to the Board for decision or action

The Committee requests that the Board note the Committee's endorsement of the complaints annual report presented for approval by the Board.

Enclosure 5

NHS Foundation Trust

Paper for submission to the Public Board on 5th July 2018

TITLE:	Infection Prevention and Control Group Report		
AUTHOR:	Dr Elizabeth Rees Director of Infection Prevention and Control	**PRESENTER:**	Dr Elizabeth Rees Director of Infection Prevention and Control
CLINICAL STRATEGIC AIMS			
Develop integrated care provided locally to enable people to stay at home or be treated as close to home as possible.	*Strengthen hospital-based care to ensure high quality hospital services provided in the most effective and efficient way.*	*Provide specialist services to patients from the Black Country and further afield.*	

CORPORATE OBJECTIVE:

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

SUMMARY OF KEY ISSUES:

- Update of statement against the Hygiene Code for 2018/19.
- Mandatory Infection Control training - Data for May has been gathered on a 3 yearly basis during the implementation phase of the move to the annual programme and the Trust is compliant at >90%. The detail against the annual target is included in the report.
- Updated NHSi action plan.
- For 2018/19 C. difficile post 48 hr cases: the annual threshold for 2018/19 is no more than 28 cases where a lapse is care is identified (1 less than last year) – there were no cases during May 2018.
- No post 48 hr MRSA bacteraemia cases since September 2015
- Update on progress with the work towards a reduction in E.coli bacteraemias

IMPLICATIONS OF PAPER:

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

ACTION REQUIRED OF BOARD:

Decision	Approval	Discussion	Other
		√	

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

Introduction:

The summary information below demonstrates the data set required to provide assurance of compliance with the Code of Practice (The Health and Social Care Act 2008): Code of Practice on the Control of Infections and Related Guidance, July 2015). Each element has been RAG rated and will be updated monthly to ensure we can show compliance by the end of the financial year 2018/19.

Compliance Criterion	What the registered provider will need to demonstrate	RAG rating
1	Systems to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of service users and any risks that their environment and other users may post to them.	
Assurance: A risk log of all infection prevention risks identified across the Trust is maintained and updated regularly.		
2	Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections.	Cleaning scores have been improving over the last 2 months with assurance received that failings are resolved within 1 hour. However the implementation of the HPV programme has been delayed by approx.. 2 weeks due to a recruitment issue.
Assurance: A Cleaning Policy and associated environmental audits provide assurance that a clean and appropriate environment is maintained. The HPV business case is being implemented having recruited to the vacant posts. However a slight delay has been caused by one of the recruits withdrawing late in the process.		
3	Ensure appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse event and antimicrobial resistance.	Antimicrobial CQUIN for 2018/19 has several new elements including more robust review of prescribing and usage.
Assurance: There is an Antimicrobial Policy in place with appropriate stewardship recommendations. Audits demonstrate compliance with policy. Work towards achieving the AWARE list compliance is ongoing.		
4	Provide suitable accurate information on infections to service users, their visitors and any person concerned with providing further support or nursing / medical care in a timely fashion.	
Assurance: Patient and visitor information is available for a variety of healthcare associated infection issues on the website. Patients identified with infections in hospital are visited and provided with information leaflets including contact information for further support.		
5	Ensure prompt identification of people who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to other people.	MRSA elective screening 97% compliance and emergency screening 93% compliance for May.
Assurance: Patient records are flagged with information about previous healthcare associated infections. Patient admission documentation includes screening questions to identify patients at risk.		
6	Systems to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection.	Mandatory IC training has moved to an annual programme for clinical staff. Work is being undertaken to achieve compliance by March 2019.
Assurance: Staff are provided with mandatory infection control training to ensure they are aware of their responsibilities for the prevention and control of infection.		

7	Provide or secure adequate isolation facilities.	A business case for the isolation pods for critical care areas has been created and funding the for the ITU pod secured.
Assurance: There is a policy in place to ensure that patients are isolated appropriately. 25% of the inpatient beds take the form of single ensuite rooms.		
8	Secure adequate access to laboratory support as appropriate.	
Assurance: The Trust has access to a CPA/UKAS accredited Microbiology and Virology laboratory.		
9	Have adherence to policies, designed for the individuals' care and provider organisations that will help to prevent and control infections.	Trustwide scores all green in May 2018.
Assurance: All policies, as recommended in the Hygiene Code, are in place. Audit data confirms compliance with policies and identifies areas for improvement.		
10	Providers have a system in place to manage the occupational health needs and obligations of staff in relation to infection.	
Assurance: There is in house provision of Staff Health and Wellbeing. There are regular reports to the Infection Prevention and Control Forum detailing any issues raised within this system.		

Summary of alert organism surveillance:

Clostridium Difficile – The target for 2018/19 is 28 cases. The cases that count within this dataset are patients identified after 48 hrs admission with C. difficile in whom a lapse in care has been recognised using the national apportionment tool [1]. For 2018/19 there have been 0 post 48 hr cases in May.

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

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

MSSA bacteraemia (Post 48 hrs) - For May 2018, 1 case of post 48 hr MSSA bacteraemia was reported.

MRSA screening – There is no external compliance target for MRSA screening. The internal target is to achieve 95% compliance with the policy. The percentage of emergency admissions screened for May 2018 is 93%. Data is available locally to the units to enable them to identify patients missing from the dataset.

The percentage of elective admissions screened for May 2018 is 97%. As above data is available locally to all units to enable them to identify patients missing from the dataset.

E. coli bacteraemia – For the post 48 hr cases an enhanced surveillance module, developed as part of PHE's surveillance programme, commenced in April 2017 in order to ascertain themes and trends associated with E. coli bacteraemia within the acute Trust to see where lessons may be learnt. For May 2018, 5 cases of post 48

hr E. coli bacteraemia were reported. There is work ongoing that is part of the national agenda for health and social care economies to reduce the number of Gram-negative bloodstream infections (BSIs) with an initial focus on Escherichia coli (E.coli). To date this has focused on the management of patients with long term urinary catheters, a group of patients who are over represented in the above dataset. Across the health economy a catheter 'passport' has been agreed, approved at the Area Clinical Effectiveness sub committee last week and it is with the printers pending roll out.

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

Infection Control Mandatory Training – The revised mandatory requirement is to update Infection Control training annually for clinical staff. During the implementation phase, whilst moving to the annual programme, the data will continue to be presented based on the historical 3 yearly cycle. The percentage compliance as at 31.5.18 (target 90%):

Area	Total
Corporate/Management	96%
Medicine and Integrated Care	93%
Surgery	94%
Clinical Support	93%

To achieve compliance based on an annual programme at 90% of clinical staff by end of March 2019 1700 clinical staff will require training during the year. The following measures have been introduced to achieve this:

- IPCT providing additional training sessions (19 session in May).
- Individual emails being sent to the outstanding staff.
- The creation of a '1 click' access module for this training as an alternative to the traditional e learning package – making access easier and quicker for staff.

Following these measures 522 staff were trained in May. This is consistent with achieving the annual compliance target by year end. Next report will demonstrate training compliance against the annual programme.

Infection Prevention and Control Group –

From the Infection Prevention and Control Group meeting held on Thursday 23rd May 2018.

The Trust is on trajectory for achieving the Mandatory HCAI requirements for MRSA and C. difficile.

Work to improve the infection control mandatory training compliance has resulted in over 800 staff having been trained in the first 2 months of this financial year.

MRSA screening continues to improve.

The cleaning scores at RHH have improved to 94% with further assurance that issues highlighted are resolved within 1 hour (with the exception of hard floors when they require scrubbing).

The Antimicrobial CQUIN targets are being achieved during the first quarter but will be a challenge as the target increased over the year.

NHSi visit – 20th March 2018

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

GLOSSARY OF TERMS

MSSA

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

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

MRSA

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

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

E Coli

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

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

Otherwise healthy patients in the community may develop cystitis, and patients in hospital who have catheters, or tubes, placed in the urethra and bladder are also at risk. *E. coli* is

also present in the bacteria that cause intra-abdominal infections following leakage from the gut into the abdomen, as for example with a ruptured appendix or following traumatic injury to the abdomen.

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

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

Klebsiella species

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

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

Pseudomonas aeruginosa

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

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

C difficile

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

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

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

CPA/UKAS

What is CPA/UKAS?

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

RCA

What is RCA?

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

PFI

What is PFI?

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

CCG

What is CCG?

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

RAG

What is RAG?

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

Reference

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

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

ACTION PLAN FOLLOWING NHSi VISIT – 8TH NOVEMBER 2017

The Dudley Group NHS Foundation Trust

Manager/Lead	Dr Elizabeth Rees, Director of Infection Prevention and Control	**Executive Lead**	Ms Siobhan Jordan, Chief Nurse
Associated Staff	Miss A Murray, Matron, Infection Prevention and Control	**Action Plan updated on**	25th June 2018

RAG status	Not started	Underway	Complete

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

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

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

Action No.	Code of Practice compliance criterions*	Recommendations	Actions Required	By Whom	Progress to date	Agreed completion date	Status (RAG)
12	Criterion 1, 5 and 6	Annual Infection Prevention Training to ensure knowledge is embedded into action.	Currently on a 3 yearly cycle. Move to yearly updates with full year effect 2018/19.	Dr E Rees and Miss A Murray	Completed on 18th January for Matrons.	January 2018	
					1700 clinical staff to train; individual emails sent to request completion asap. First 500 trained by mid May. On trajectory to achieve compliance by March 2019.	March 2019	
13	Criterion 1	Analytical support to be considered to provide expertise to existing IPC team.	To develop and JD, advert and PS in order to advertise this post.	Miss A Murray	JD and PS developed – awaiting banding. Complete.	January 2018	
14	Criterion 1	To advertise for a substantive Consultant Microbiologist	To advertise post using existing College approved JD and PS.	Dr E Rees	Currently being advertised on NHS Jobs. Advert closed.	December 2017	
15	Criterion 1 and 5	Catheter Care Bundles reflect national guidance but senior nursing staff seemed unaware of all available tools.	As part of the current health economy work around urinary tract infection, protocols around the management of catheters will be reviewed for each participating organisation; DGFT will review its own.	Miss A Murray and Mr B Jones	Working across healthcare economy catheter passport has been created; it will go to ACE panel for approval in March. Report back to IPCF at April meeting. Mr Jones suggested that after approval by ACE this item is included in the HCAI agenda.	April 2018 Assurance provided at April IPCG. Item closed and referred to HCAI agenda.	

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

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

Action No.	Code of Practice compliance criterions*	Recommendations	Actions Required	By Whom	Progress to date	Agreed completion date	Status (RAG)
28 **Added 13.2.18**	Criterion 2	Assurance that mattresses are clean prior to use.	To add 'check date of clean' to checklist to ensure mattresses are clean prior to use and include in regular Matron audits.	Miss Murray	IPCT will provide A4 poster for wards (to be added to Medical Devices policy) on how to clean a mattress and insert a green 'I am clean' sticker.	March 2018. Policy and green sticker in use.	
29 **Added 13.2.18 20.3.18**	Criterion 2	To ensure macerators are maintained appropriate and seals are kept clean.	To check maintenance records of macerators and remind staff to clean seals. 20.3.18 – Dr Adams' visit identified ongoing issues with macerator seals on C1. To confirm as already agreed the verifications.	Mr Rigby and Mrs Pain	Last quarter's audit results are in order. Issue regarding who was responsible for cleaning. Now agreed that spillage during use would be wiped by nursing staff but daily and weekly cleans will be carried out by Interserve together with checking seals.	June 2018	

Action No.	Code of Practice compliance criterions*	Recommendations	Actions Required	By Whom	Progress to date	Agreed completion date	Status (RAG)
33 **Added 13.2.18**	Criterion 2	To replace material curtains with disposable curtains in UCC and ED.	Mrs Porter agreed to provide the IPCF with the number of curtain changes in these areas in order for the Trust to understand the cost of such a change.	Mrs Porter	UCC has disposable curtains (non trust premises). Frequency of curtain change has been agreed during the revision of the Cleaning Policy.	June 2018	
19	Criterion 2	a) Revised Cleaning Policy approaching sign off. Interserve must share implementation plan with DGFT. b) Assurance must be given to Trust that training of Interserve staff reflects needs of policy. c) Lack of confidence regarding the cleanliness of domestic trolleys.	a) Request implementation plan from Interserve for next IPCF meeting. b) To review Interserve staff's toolbox talks reflect Cleaning Policy needs. c) Interserve to share cleaning policy for domestic equipment with the Trust.	Mr A Rigby Miss A Murray Mr A Rigby	Complete	January 2018 January 2018 January 2018	
4 **Added 20.3.18**	Criterion 1 and 2	Cleaning Scores are presented to IPCF with RAG ratings in order to facilitate observance of non-compliance.	To provide cleaning scores with RAG ratings.	Mr A Rigby (for Estates Report)	20.3.18 – Dr Adams identified 2 dusty fans and tape on ANTT trays on C1 and dirty medical equipment on NNU; to ask for assurance on above at next IPCF on 22.3.18.	Completed and assured at the IPCG on 22.3.18	

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

Action No.	Code of Practice compliance criterions*	Recommendations	Actions Required	By Whom	Progress to date	Agreed completion date	Status (RAG)
Criterion 5: Ensure prompt identification of people who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to other people.							
12	Criterion 1, 5 and 6	Annual Infection Prevention Training to ensure knowledge is embedded into action.	Currently on a 3 yearly cycle. Move to yearly updates with full year effect 2018/19.	Dr E Rees and Miss A Murray	Completed on 18th January for Matrons.	January 2018	
					See above.	March 2019	
15	Criterion 1 and 5	Catheter Care Bundles reflect national guidance but senior nursing staff seemed unaware of all available tools.	As part of the current health economy work around urinary tract infection, protocols around the management of catheters will be reviewed for each participating organisation; DGFT will review its own.	Miss A Murray and Mr B Jones	Working across healthcare economy catheter passport has been created; it will go to ACE panel for approval in March. Report back to IPCF at April meeting.	April 2018 Assurance provided at April IPCG. Item closed and referred to HCAI agenda.	
23	Criterion 5	Compliance with MRSA screening target.	Provide action plans to explain how the Trust target (90%) will be achieved.	Miss Murray/Mrs Pain/Mrs Bree	The internal stretch target for MRSA screening is 90% for both emergency and elective cases. April's data shows emergency screening at 94.2% and elective screening at 96.4%.	May 2018	

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

Action No.	Code of Practice compliance criterions*	Recommendations	Actions Required	By Whom	Progress to date	Agreed completion date	Status (RAG)
32 **Added 13.2.18**	Criterion 6	Assurance to IPCF that junior medical staff undertake appropriate skills training during their time at DGFT (junior doctor witnessed carrying syringe of blood by hand).	To enquire with Post Graduate centre regarding training.	Dr Rees	Clinical skills have developed a self declaration tool to confirm that non-training grades have had appropriate training including IC elements required.	April 2018	
12	Criterion 1, 5 and 6	Annual Infection Prevention Training to ensure knowledge is embedded into action.	Currently on a 3 yearly cycle. Move to yearly updates with full year effect 2018/19.	Dr E Rees and Miss A Murray	a) Training delivered by Dr Adams on 18th January.	December 2017	
					b) See above.	March 2019	
Criterion 9: Have and adhere to policies, designed for the individual's care and provider organisations that will help to prevent and control infections.							
21	Criterion 9	MRSA Screening Policy has 'meticillin' spelled with an 'h' ie, 'methicillin'.	Amend policy.	Dr E Rees		Immediate	
22	Criterion 9	The Management of Patients and Staff with Diarrhoea policy to reflect national guidance relating to stool type.	Review policy to ensure compliance.	Dr E Rees		Immediate	
39 **Added 20.3.18**	Patient Safety Issue	To confirm the security arrangements around the storage of breast milk to ensure expressed breast milk cannot be tampered with/contaminated.	To review the arrangements for safe storage of expressed breast milk.	Mrs K Anderson	Swipe card access installed.	May 2018	
40 **Added 20.3.18**	Patient Safety Issue	To confirm the temperature and 'use by' dates applied to stored expressed breast milk to ensure that it is safe to use.	To review SOP for monitoring temperatures in the fridge and freezers used for milk storage.	Mrs K Anderson/Mrs J Pain	Milk was held within date during the audit held on 21.3.18. temp monitoring in place.	April 2018	

Action No.	Code of Practice compliance criterions*	Recommendations	Actions Required	By Whom	Progress to date	Agreed completion date	Status (RAG)
41 **Added 20.3.18**	Criterion 2	To establish a cleaning schedule for toys on the NNU and to ensure that there are no soft toys.	To remove soft toys and to review toy cleaning SOP.	Mrs K Anderson/Mrs J Pain	The soft toys present have been removed. All toys have been decontaminated according to the agreed policy and all toys have been HPV fogged.	April 2018	

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

Enclosure 6

The Dudley Group NHS Foundation Trust

Paper for submission to Board of Directors 5th July 2018

TITLE:	**Safe Staffing Nursing and Midwifery Workforce Update**		
AUTHOR:	Jo Wakeman, Deputy Chief Nurse, Derek Eaves, Professional Lead for Quality,	**PRESENTER:**	Siobhan Jordan Chief Nurse

CLINICAL STRATEGIC AIMS

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

CORPORATE OBJECTIVE:

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

SUMMARY OF KEY ISSUES:

Safer Staffing

- Note progression against staffing reviews
- Care hours per patient day (CHPPD) remains within the nationally agreed variation of 6.3 and 16.8.
- Fill rates for May 2018 greater than 95% based on old establishments.
- Introduction of new establishment data to be introduced from July 2018. Note the phased approach to achieving 95% fill rates over the next nine months.
- Twelve staffing incidents raised during May 2018 all reported as 'no harm'.
- Note change in process from manual calculation of nursing workforce to utilising Allocate to collate data. This may take a couple of months to embed as the system is reliant on staff to accurately reflect staff on duty via the Allocate system.

Agency Controls

- This month has seen an increase in agency usage based on last month. However, the data states that generally bank and agency usage is requested in line with actual vacancies.The use of agency clinical support workers remaining nil in line with current agency controls.
- All bank and agency requests continue to be assessed daily by the Associate Chief Nurses to ensure continued patient safety and financial balance. A breakdown of the main areas using agency staff is included.
- Use of non-framework agency remains an Executive only authorisation.

Recruitment and Retention update

- Recruitment events continue
- Details of all of the recruitment and retention initiatives are included in the paper.

IMPLICATIONS OF PAPER:

RISK	Yes		**Risk Description:** • Nurse Recruitment – unable to recruit to vacancies in nursing establishments to meet NICE guidance for nurse staffing ratios • Finance – Unable to remain within divisional Budget due to spend on Temporary Staff.
	Risk Register: Y		**Risk Score:** 20
COMPLIANCE and/or LEGAL REQUIREMENTS	**CQC**	Y	**Details:** Safe and effective care
	Monitor	Y	**Details:** Agency capping targets
	Other	N	**Details:**

ACTION REQUIRED OF COMMITTEE:

Decision	Approval	Discussion	Other
		√	

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

Staffing Reviews

Table 1 details the progress made against staffing reviews. The recently review of community nursing (during the day) was completed and has been shared with the CCG before it is taken to the newly formed Transition Board of the Multispecialty Community Provider (MCP). The review of nights in the community is near completion. The staffing review for the Emergency Department (ED) has been finalised. A draft paper on EAU/FAU has now been completed and is to be reviewed by the Executives.

Area	Position
General Medical/Surgical Wards	Complete
Critical Care	Complete
Neonatal Unit	Complete
Paediatrics (C2)	Executive Directors requested further amendments
Emergency Department	Complete
Acute Medical Unit	Completed, draft updated and awaiting Executive review
Outpatients Department	Completed, presented to Executive Directors and will be considered as part of the planned OPD review
Medical Day Case	Complete
Renal Unit	Complete
Frailty Assessment Unit (FAU)	Completed, draft updated and awaiting Executive review
Community Nursing (Days)	Complete, shared with the CCG and to be presented at the newly formed Transition Board of the MCP
Community Nursing (Nights)	In progress, near completion
Specialist Nurses	In draft, to be presented to Executive Directors in July 2018

Table 1

Safer Staffing

The Safer Staffing Summary (Appendix 1) shows the actual and planned hours for qualified staff and unqualified staff for both day and night shifts for each area of the Trust based on the historical establishments for May 2018 (wards that have been fully or partially closed in the month are omitted). As well as showing the actual and planned hours the report shows the fill rate. The totals for the Trust are also indicated. In addition, the last four columns show the actual Care Hours Per Patient Day (CHPPD). We provide this information to NHS Improvement which is used to inform the National Model Hospital data.

The report shows that the overall fill rates for the trust is greater than 95% during May 2018 against historic establishments with a significant reliance on temporary staff (bank and agency). A number of factors influence fill rates such as occupancy and acuity. For example if occupancy is low then it would make financial sense not to book additional temporary staff, this would reflect as a low fill rate against planned establishment. Triangulation of data against staffing incidents and quality dashboard KPIs provides the assurance that safe, quality care is being delivered to our patients.

Table 2 shows that fill rates reduced from November/December 2017 onwards with a rise from last month. It should be noted:

- On occasion, the fill rate is over 100%. This tends to occur with C2, the paediatric ward as the planned hours are derived from the dependency tool used for each shift. Each shift the planned hours are determined by the acuity of the children actually on the ward.
- Also, sometimes there are occasions when the fill rate of unqualified staff exceeds 100%. This occurs when it is recognised that there will be a reduction in qualified staff (e.g. C5 (Respiratory) and the Medical High Dependency Unity (MHDU)).
- The low fill rate in some areas e.g. Coronary Care Unit/Post Coronary Care Unit and wards C5/C6 (Urology) reflects the problems in recruiting staff to these areas.

Table 2. Percentage fill rates April 2017 to the present

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

Care Hours per Patient Day (CHPPD) (Appendix 1)

Following the publication of the Carter Review (2016), NHS Improvement has issued guidance which requires all Trusts to report Care Hours per Patient Day. From May 2016 CHPPD has become the principle measure of nursing and care support deployment. CHPPD provides a single consistent metric of nursing and healthcare support worker deployment on inpatient wards and units. Care hours per patient day (CHPPD) remains within the nationally agreed variation of 6.3 CHPPD and 16.8 CHPPD (Carter Review, 2016).

Summary situation of staffing compared to the old and new establishments and potential recruitment over the next year

A summary table (Appendix 2) has been included which allows the reader to view the historic and new budgeted establishments compared to the staff actually in post together with all operational vacancies for qualified staff. The use of Bank and Agency staff is also charted as are the sickness and maternity rates. All of these measures are in WTE. The data details that during May 2018 a total of 216.62 wte was used in bank and agency against a vacancy of 298.34 wte. In addition there is a 30.34 wte operational deficit against maternity leave. Generally the data shows that areas are booking appropriately bank and agency against vacancies.

Lead Nurses and Matrons continue to be given the opportunity to discuss staffing challenges, whilst maintaining patient safety and sustaining financial balance. Timely filling of bank shifts continues to be a challenge however the Associate Chief Nurses are reviewing this daily to avoid late requests for staff that cannot be filled.

Appendix 2 details the predicted recruitment numbers (against a forecasted 8% leaving rate).

This overview chart provides the ability to see at a glance the following:

- Vacancies compared to historic and new establishments
- Vacancies compared to Bank and Agency Usage
- Maternity rates which are fully funded
- Overall sickness rates (funding is up to 3% of establishment)
- Recruitment rates based on expected joiners from jobs offered minus an estimated 8% leaver rate per month

Please note: Some areas do not log sickness and maternity on Allocate and so these cannot be displayed for these areas.

b) Proposal to start charting fill rates against new establishments and move from paper based system to Allocate

The fill rates in this report are calculated by comparing the historical planned shifts with the actual staffing. This data originates from senior nurses manually adding into an excel spreadsheet the numbers of qualified staff and care support workers (CSWs) working each shift. Internal audits have found on more than one occasion inaccurate data input which in part is due to staff not competing the spreadsheets on a daily basis but sometimes leaving input to the end of the week or even after a longer period of time.

Now that the new higher establishments took effect after the beginning of April and significant efforts are being made to recruit up to them, the decision has been made by the Executives to commence calculating the fill rates based on these new establishments from August 1st (i.e. with July's data) .
A plan has been agreed to achieve higher fill rates in a phased approach:

- 80% fill rates in all areas July 2018
- 85% fill rates by October 2018
- 90% fill rates by April 2019

At the same time, a more accurate source of the fill rate data can also be commenced. When the fill rate data was initially started to be collected on a national basis, it was thought that it could be extracted from the Allocate system, which holds the daily rotas of all staff but this was not possible for two main reasons:

- Well-being workers who were assigned to work in different areas shift by shift dependent on need were on their own specific rota on Allocate and could not be placed on the rotas of the different wards they worked on.
- When the number of staff needed on a ward was different to that of the establishment, say, due to a surgical ward having many empty beds that day or a medical ward needing a number of extra CSWs for 1:1 care the Allocate planned numbers could not be changed.

The Allocate software has now been updated and wellbeing workers are now allocated to specific wards on a long term basis and so the source of the data for this report can now come direct from the Allocate software, which is fully accurate as it is the basis for staff pay.

The extra manual system of spreadsheets could now stop, which will be welcomed by busy nursing staff. As important, the data will also be more accurate. In this report (Appendix 3) is the chart of May's fill rates from the Allocate system which gives an indication of the rates moving forward based on the new establishments. It can be seen that the overall registered nurse/midwife fill rates for May are just over 80%, recognising this is not the case for every ward.

Staffing Incidents May 2018

The T**ables 3 and 4** below detail the number of clinical incidents during May 2018 that related to staffing. In total there were 12 incidents. The neonatal unit generated the most incidents; whilst the unit is fully recruited the staff appointed are going through the normal recruitment process. Of the 12 incidents raised they were all recorded as no harm caused to the patient. The Chief Nurse and Head of Children's Services and appropriate others have daily oversight over NNU staffing.

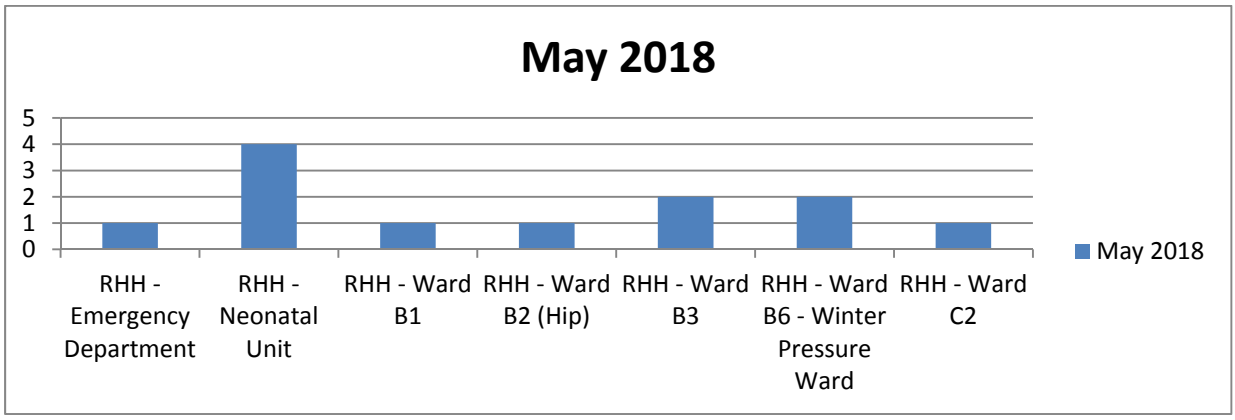


Table 3

(WRK) Inadequate Staff for Workload - ABSENCE	No Harm/near miss	2	2
(WRK) Inadequate Staff for Workload - BANK Shift unfilled	No Harm/near miss	3	3
(WRK) Inadequate Staff for Workload - RAISED Dependency	No Harm/near miss	2	2
(WRK) Inadequate Staff for Workload - SICKNESS	No Harm/near miss	1	1
(WRK) Incorrect SKILL MIX for Workload	No Harm/near miss	1	1
(WRK) Less than 2 Registered Nurses on ward per shift	No Harm/near miss	2	2
(WRK) Neonatal staffing below minimum standard for dependency levels.	No Harm/near miss	1	1
Total		12	12

Table 4

Agency Controls

All bank and agency requests continue to be risk assessed by the Associate Chief Nurses to ensure continued patient safety and financial balance supporting the overall reduction in agency use. Requests for non-framework agency can only be made in exceptional circumstances and authorised only by an Executive Director.

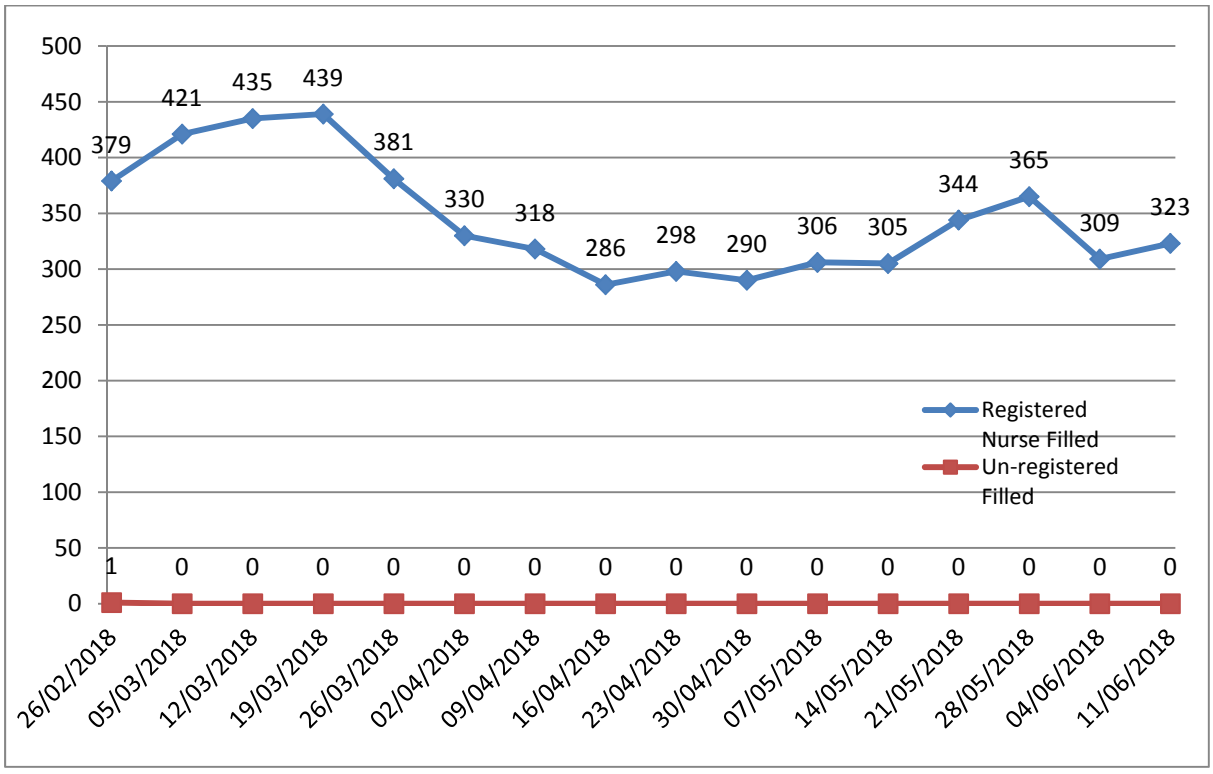
The table below shows the five main areas using agency staff over the past four weeks. ED remains the highest user of registered nurse agency staff. The timely filling of bank shifts continues to be challenging and some framework agency staff have been used to maintain patient safety across the hospital.

Top 5 Areas of Nursing Agency usage

W/C 21/5/18		W/C 28/5/18		W/C 4/6/18		W/C 11/6/18	
ED	60	ED	60	Critical Care	44	ED	60
B3	41	B3	41	ED	38	B3	39
Critical Care	40	Critical Care	40	B3	32	A2	32
A2	29	A2	29	AMU	20	Critical Care	25
C8	20	C8	20	C8	16	AMU	20

The graph below shows the overall agency usage; this month has seen an increase of 142 shifts based on the previous four week period. The use of agency clinical support workers (CSWs) remains nil in line with current agency controls. On average, 335 shifts per week have been filled . This is with a vacancy situation of 298.34 wte across all areas and bands. It should be noted that the contingency ward has remained open and this has had an impact on the increased requirement for nursing staff. The controls against agency usage for CSW staff have been maintained with zero shifts during this period.

Nurse Agency Usage Figures (Registered, unregistered and total)



Recruitment Update

The Trust has hosted a further two recruitment events in May/June, one Trust wide and one area specific (C1 - Renal/Diabetes). The total numbers of events run to date is 11 Trust wide and 2 area specific.

The event held on the 5th June saw 10 conditional offers made (1 experienced nurse, 1 experienced ODP and 8 student nurses). The current number of graduate nurses due to commence within the Trust on the September preceptorship programme is 83 wte (this includes Dudley students and externally recruited students).

The monthly Trust events have continued to prove successful however the area/ward specific events have attracted fewer numbers. This may be due to the fact that it is a single speciality. The Divisions are reviewing the time of recruitment events and considering offering opportunities out of hours.

A suggestion would be to host a Dudley Group 'jobs fair' giving individual areas a stand to showcase their speciality. If this was to go ahead, consideration would need to be given to the location and day/time. The event could be run from the Clinical Education Centre on a Saturday allowing all rooms to be used for the event. All areas would need to support the event and would be required to interview for their own areas. Due to the University term coming to an end and the summer holidays fast approaching, it seems a good time to step back from the monthly events during July and August and plan for a large scale event in September.

Dublin Jobs Fair

Consideration is to be given to attending the jobs fairs in Dublin at an approximate cost of £3,950. The jobs fair will take place in October 2018 a paper is being presented to the Executive team at the beginning of July 2018.

Overseas Trained Nurses

Work is ongoing around the possibility of supporting overseas trained nurses who hold a live pin and are currently working as clinical support workers in the UK, through the IELTS, CBT and OSCE program. The University of Wolverhampton would be able to support the Trust in running an IELTS preparation course. There are no further updates as yet regarding the numbers of current substantive and bank staff within the Trust who may fall into this category.

Exit Interviews

Unfortunately due to Government Data Protection legislation, the Trust is no longer able to use Survey Monkey. The online exit questionnaire is therefore not currently available. The recruitment and retention lead is working with the workforce information team to resolve this. There have been no requests for a face to face exit meeting this month.

Appendix 1 – CHPPD

Safer Staffing Summary	May			Days in Month	31										
	Day RN	Day RN	Day CSW	Day CSW	Night RN	Night RN	Night CSW	Night CSW		UnQual		UnQual	Sum	Actual CHPPD		
Ward	Day RM Plan	Day RM Actual	Day MSW Plan	Day MSW Actual	Night RM Plan	Night RM Actual	Night MSW Plan	Night MSW Actual	Qual Day	Day	Qual N	N	24:00 Occ	Registered	Care staff	Total
Evergreen																
A2	248	242	217	203	155	179	186	191	98%	94%	115%	103%	1,240	4.07	3.73	7.81
A3																
A4																
B1	120	116	62	62	78	74	60	60	97%	100%	94%	99%	570	3.89	2.55	6.44
B2(H)	127	117	221	218	97	96	191	181	92%	99%	99%	95%	871	2.86	5.50	8.36
B2(T)	93	96	124	124	62	67	93	93	103%	100%	108%	100%	689	2.84	3.78	6.62
B3	214	196	192	187	187	167	158	152	92%	97%	89%	96%	1,100	3.87	3.69	7.56
B4	214	206	248	239	186	157	187	183	96%	96%	84%	98%	1,423	2.98	3.56	6.54
B5	191	185	150	142	187	177	95	94	97%	95%	95%	99%	749	5.55	3.78	9.33
B6																
C1	187	172	324	319	157	143	215	211	92%	98%	91%	98%	1,457	2.54	4.37	6.90
C2	175	227	62	59	169	179	31	29	130%	95%	106%	94%	673	7.07	1.39	8.47
C3	258	234	373	370	184	159	380	372	91%	99%	86%	98%	1,539	3.06	5.79	8.85
C4	155	150	65	64	93	116	93	68	97%	98%	125%	73%	670	4.54	2.32	6.86
C5	248	185	248	258	186	168	187	188	75%	104%	90%	101%	1,439	2.94	3.67	6.61
C6	93	81	68	68	62	62	75	76	87%	100%	100%	101%	551	3.04	3.14	6.18
C7	186	175	142	135	124	122	138	138	94%	95%	98%	100%	1,090	3.26	3.01	6.27
C8	215	198	231	225	186	172	224	221	92%	97%	92%	99%	1,298	3.34	4.12	7.47
CCU_PCCU	217	178	30	32	157	152	31	28	82%	107%	97%	90%	642	6.17	1.12	7.29
Critical Care	351	353	68	66	350	350	-	-	101%	97%	100%		349	23.65	2.17	25.83
EAU	279	252	341	326	279	267	341	327	90%	96%	96%	96%	1,224	5.09	6.40	11.49
Maternity	549	557	217	197	527	524	155	143	101%	91%	99%	92%	456	22.95	8.73	31.68
MHDU	130	128	34	35	125	120	-	1	98%	103%	96%		242	12.03	1.55	13.58
NNU	190	179	-	-	187	175	-	-	94%		94%		445	9.13	0.00	9.13
TOTAL	**4,439**	**4,225**	**3,417**	**3,327**	**3,738**	**3,625**	**2,840**	**2,756**	**95%**	**97%**	**97%**	**97%**	**18,717**	**4.82**	**3.87**	**8.70**

Appendix 2 - Registered Nurse Predictor Tool- Detail New Establishments

Med & Surg Divisions Qualified Nursing WTE		New Establishment			For Info : Pressures / Temporary Staffing				Known Recruitment Minus Estimated Leavers @ 8%											
Div	Team	Budget (Qual Nurses)	Contracted Staff in Post (Incl New Supernumerary)	Vacancy	Sickness	Maternity	Bank	Agency	J	J	A	S	O	N	D	J	F	M	A	M
Med/Int Care	Wards - Medicine	383.33	252.51	130.82	15.66	4.03	35.09	40.85	1	(2)	(2)	(2)	10	(2)	5	(2)	(2)	(1)	(2)	(2)
Surgery	Wards - Surgery	290.36	212.81	77.55	7.63	10.80	20.33	22.71	3	(1)	(1)	(1)	3	(1)	7	(1)	(1)	1	(1)	(1)
Med/Int Care	Specialist Areas Medicine	225.92	194.29	31.63	1.62	1.92	1.00	5.99	(1)	(2)	(1)	(2)	11	(2)	(9)	(2)	(2)	1	(2)	(2)
Surgery	Specialist Areas Surgery	35.53	38.22	(2.69)	0.00	0.00	0.00	0.67	(1)	(1)	(1)	(1)	10	(1)	(9)	(1)	(1)	1	(1)	(1)
Med/Int Care	ED	93.84	75.91	17.93	4.34	3.47	5.27	18.07	1	(0)	1	(0)	4	(0)	(0)	(0)	(0)	1	(0)	(0)
Surgery	Theatres	167.30	145.81	21.49	0.70	0.89	13.83	13.58	0	(1)	(1)	(1)	1	(1)	(1)	(1)	(1)	(1)	(1)	(1)
Surgery	Critical Care	75.95	60.53	15.42	3.09	3.57	4.68	10.74	1	(0)	(0)	(0)	1	(0)	(0)	(0)	(0)	(0)	(0)	(0)
Surgery	Midwifery	154.54	153.34	1.20	3.19	5.66	3.20	0.00	(1)	(1)	(1)	(1)	(1)	(1)	(1)	(1)	(1)	(1)	(1)	(1)
Med/Int Care	Community Nursing	152.34	149.94	2.40			5.88	0.00	0	(1)	(1)	(1)	4	(1)	(1)	(1)	(1)	(1)	(1)	(1)
Med/Int Care	All Other Med / Int Care Teams	63.68	62.73	0.95			7.14	0.00												
Surgery	All Other Surgery Teams	63.29	61.85	1.44			7.01	0.58												
Total		**1,706.08**	**1,407.94**	**298.14**	**36.23**	**30.34**	**103.43**	**113.19**	**4**	**(9)**	**(7)**	**(9)**	**42**	**(10)**	**(9)**	**(9)**	**(9)**	**0**	**(9)**	**(9)**

APPENDIX 3- Fill rates for May 2018 against new establishment (data taken from Allocate)

Name	Day Reg Fill Rate	Night Reg Fill Rate	Day Unreg Fill Rate	Night Unreg Fill Rate
A2	89%	94%	92%	96%
AMU Dept	92%	94%	94%	95%
B1 Nursing Unit	91%	77%	104%	102%
B2 Hip	76%	83%	96%	98%
B2 Trauma	80%	72%	99%	100%
B3 Emergency Surgery	69%	79%	95%	99%
B4A Elective Surgery	83%	73%	94%	97%
B4B Elective Surgery	83%	87%	93%	97%
B5 Ward	83%	92%	90%	95%
C1 Rehab, Renal, Endocrinology	70%	79%	90%	93%
C2 - Paediatrics	91%	99%	95%	97%
C3 Older People Dept	73%	84%	83%	103%
C4 Haematology/Oncology Dept	96%	94%	102%	108%
C5A Respiratory Dept	69%	91%	104%	98%
C5B Respiratory Dept	79%	83%	98%	103%
C6 Urology and Plastic Surgery	86%	100%	81%	92%
C7 Gastro Dept	81%	78%	81%	96%
C8 Stroke Rehab Dept	67%	64%	92%	98%
Coronary Care Unit Dept	72%	71%	89%	87%
HDU Dept	85%	81%	100%	50%
Maternity MSW & Admin	-	-	88%	90%
Maternity RM	97%	98%	-	-
Neonatal Unit Dept	76%	95%	100%	100%
Critical Care (ITU)	83%	81%	73%	0%
Grand Total	**82%**	**85%**	**91%**	**97%**

Key: Red: Less than 80%

Enclosure 8

The Dudley Group NHS Foundation Trust

Paper for submission to the Trust Board July 2018

TITLE:	**Health, Safety and Fire Assurance Report**		
AUTHOR:	**Helen Watkiss, Health and Safety and Fire Manager**	**PRESENTER**	**Karen Kelly Chief Operating Officer**

CORPORATE OBJECTIVE:

SO2 and SO4

SUMMARY OF KEY ISSUES:

- Overview of actions from 2017 Annual Report
- H&S Work plan 2018/19
- Fire Work plan 2018/19
- Incident Data
- Enforcement Authority Involvement in the Trust

IMPLICATIONS OF PAPER:

RISK	**For Information only**		**Risk Description:**
	Risk Register:		**Risk Score: Low**
COMPLIANCE and/or LEGAL REQUIREMENTS	**CQC**	X	**Details:** Safe and Well Led
	Monitor		**Details:**
	Other	X	**Details:** Health and Safety Executive West Midlands Fire Service

ACTION REQUIRED OF BOARD:

Decision	Approval	Discussion	Other
	Y		**Y**

RECOMMENDATIONS FOR THE BOARD:
To **NOTE** the contents of the report
To **APPROVE** the Health and Safety Work Plan for 2018/19
To **APPROVE** the Fire Safety Work Plan for 2018/19

OVERVIEW

This report is presented to the Board to give an overview of the actions completed during 2017/18 identified in the previous year's report and the work plan for Health and Safety and Fire for 2018/19. The report also contains a brief overview of the reactive health and safety incident data and involvement from the Enforcement Authorities over the 2017/18 period.

Actions from 2017/18 Report

During 2017/18 a commitment was made to review and target the following areas within Health and Safety and Fire:-

Health and Safety Action Plan Update

- Display Screen Equipment
- Stress
- Dermatitis
- Safer Sharps
- Diathermy Fume

The progress made to date is noted below:-

Display Screen Equipment
All corporate measures have been completed and implemented including policy and arrangements for eye sight testing, workshops to offer training to give competency and confidence in completing the assessments have been scheduled throughout 2018/19.
During the period of 2017/18 no staff members attended any of the training that was available to enable the assessments to be completed at local level. There is a significant gap in the completion of DSE assessments that are required to be completed as part of the Display Screen Equipment Regulations 1992.

All Divisions have been advised that the lack of compliance with Trust policy and Regulations should be raised on their local risk registers to ensure actions are taken and monitored. This will be addressed via the Health, Safety and Fire Assurance Group now chaired by the Chief Operating Officer.

Stress
The Trust has a policy in place and training is available to support staff on completing the assessments to enable them to carry out the local area assessment confidently and competently.

Throughout the period there has been support offered to areas in order to complete the assessments and work to reduce the impact of the increased pressures on teams.

Auditing will be taking place during 2018/19 which will give a quantative level of compliance across all Divisions to highlight the areas.

Dermatitis
The Trust has moved to a full synchronized hand hygiene system with all staff having access to hand wash, hand gel and moisturiser. The three elements of the hand hygiene system working together is critical to ensure that the moisturiser is able to rehydrate the hands rather than continue to dry and lead to cracking.

Health surveillance is in place with skin surveillance checks carried out on an annual basis as an assurance that the measures in place to prevent drying / cracking of staff's hands and subsequently potentially leading to dermatitis are suitable and sufficient.

Since the implementation of the new system there have been no Datix reports raised to identify individuals that are experiencing any problems or issues.

No incidents in regards to Occupational Dermatitis have been reported to the Health and Safety Executive under the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013 (RIDDOR).

Monitoring will continue through the reports on Datix and health surveillance to continually ensure that the trend continues.

Safer Sharps
Work in this standard has not progressed to the level that should be expected. Actions outstanding from this target will be carried forward to 2018/19 and actioned as a priority.
A review of incident data was undertaken during the period which identified that the two main causes for needle stick injuries were:-

- During the delivery of care 49%
- Disposal of sharps 51%

The data identified that the disposal of sharps is the main causation of incidents. The Trust policy has been reviewed and is currently out for consultation to ensure that the measures that are determined in the standard are suitably viable for team members to adopt.

Works to be carried forward include an audit of the compliance with the bin to beside policy and ensuring that staff are fully aware of the rationale behind the bin to bedside requirement. Review of the unsafe sharps still in use in the Trust to ensure that there have not been any technological developments where a safer alternative is available for evaluation. Review of the risk assessments in place for the unsafe sharps to ensure the control measures are known and adopted by the team members.

Action	
• Audit of bin to bedside. • Communications around the findings and the reason behind the requirement to take the bin to the point of use. • Review of risk assessments and DPE group to ensure that safer sharps are in place where alternative is available.	
Assigned to:	Helen Watkiss, Health and Safety and Fire Manager
Date for completion:	30th September 2018

Diathermy fume release through treatment.
Air monitoring has been carried out within the Acute Trust in various areas as there has been concern raised which has taken priority over the original plan to review diathermy fume.
The International Agency for Cancer Research (IACR), changed the classification of Formaldehyde from a class 2 to a class 1, this changed the categorisation from probably cancer causing agent to carcinogenic.
This change has an effect on the formalin that is used within areas in the Trust as it is a product containing formaldehyde.
In the Theatres areas there are containers of the formalin stored within the sluice rooms used for preservation of specimens. The process undertaken is for the specimen to be placed into the appropriate sized container, then filled from a central dispenser, this dispenser works on a tap and as such there is a release of the product into the breathing zone.
Rooms were monitored for the presence of formaldehyde against the short term exposure limits within the EH40 guidance in accordance with the Control of Substances Hazardous to Health Regulations 2002.
The report that was returned identified that the levels within the rooms were below the levels in the guidance and no additional control measures were advised.

Air monitoring of expelled anaesthetic gases within the theatre recovery and expelled nitrous oxide gases within the Maternity delivery rooms has also been completed and no concerns or issues raised.

Currently monitoring is being carried out within the MRI suites during the paediatric clinic to determine if the engineering controls in place are sufficient to remove the levels of expelled

gases from patients. A second phase of testing was undertaken on 11th June 2018 as there are two MRI suites and confirmation of suitability of both was required.
This data will be informing the works currently planned for the MRI suites in respect to the engineering controls and air changes.
At the time of compiling this report results and any relevant recommendations are awaited.

Fire Safety Action Plan Update

A commitment was made in July 2017 to the Board for the areas below to be the main focus of work for the Fire Officer:-

- Compartmentation / change of use breaches
- Community Fire Inspections
- Community Fire Training
- Fire Evacuation Drills

The current picture is noted below:-

Compartmentation / changes of use breaches
The compartmentation gaps on C6, C7 and C8 where there had been changes to the ward layout that affected the fire compartments, fire alarm and nurse call systems. A business case was approved and works are set to be completed within the areas over the summer months. The works were agreed during September however the physical works were not started until after the period of winter pressures.

Summit Healthcare have instructed Interserve to carry out annual maintenance inspections throughout the site to ensure that the compartments throughout the Hospital are maintained in full working order and any areas where works have been required to penetrate have been suitably and appropriately repaired so as to ensure no breach of the compartment.

The Trust Fire policy states that no area should undergo a change of use without the variation process – even if there are no perceived costs to the works by the teams, this is because there may be structural works required that must be considered prior to any changes, this includes fire alarm systems, nurse call systems and other aspects such as lighting, air changes etc.
During the fire risk assessment process the drawings held by the Trust and Interserve are used as the basis of the assessments. These identify how the area should be laid out and the systems in place, if on assessment there are any rooms that have had a change of use then this will be identified at this point and escalated as a change of use without formal agreement through variation.

One assessment completed in May 18 has identified an area on B2 where there has been a local change to the layout, where 6 beds currently in B3 are being used by B2 extending the boundary of the ward past the compartment door. The concern that this raises is in relation to the fire panel zone not being aligned to the correct area, if an alarm was sounded in this bay it would sound a continuous alarm in B3 not B2 and also display the ward incorrectly on the fire panel with the fire team and fire service being deployed to the wrong location. There is also a concern in regards to the compartment wall now not being on a ward boundary as this has implications if moving patients from one zone to another. There is also a potential risk for the nurse call system to not sound in the correct area where a patient on B2 presses the call button and it sounds in B3 so could delay the staff in responding to the patient.
This is has been escalated through the appropriate channels and advised for inclusion on the risk register and a variation to be raised for the works required maintaining fire and nursing call safety.

The works to the compartments within C6, C7 and C8 are the final elements of the full site compartmentation works within the Summit Healthcare buildings at RHH. During 2018/19 the Trust owned North Block building will be surveyed for compartmentation breaches and a report issued for consideration and action.

Community Fire Inspections
The clinical and administrative areas where the Trust has occupancy in the community have not previously been subjected to fire risk assessment.

The work in the Community started in February 18 when a full fire team was in place, prior to this the assessment and training processes for the Russell's Hall Hospital took priority with the limited staffing resources that were available this is because the risk basis is greater in the Acute Trust as the more dependant and in-patient facilities are based at this site.

To date the Brierley Hill Health and Social Care Centre, Stourbridge Health and Social Care Centre and Halesowen sites have been completed. The assessments are being carried out to HTM standard for areas of high occupancy and are based on an assessment per service, this is resulting in high numbers of assessments, however this approach will enable the team to deliver the significant findings to the relevant areas for action.

The sites are being targeted on a risk basis with the highest use and occupancy being completed first.

During the fire risk assessment, the Trust fire officer is discussing the monthly fire inspection and asking for these to be carried out locally. This will enable teams to carry out a local check of the priority aspects such as fire doors closing, escape exits not being blocked and fire action notices being displayed, in-between the full fire risk assessments.
Any area of concern identified by the teams is to be highlighted to the Health and Safety and Fire Manager for resolution.

The main findings of the assessment process to date is the staff members lack of understanding on the actions to take in the event of an evacuation and the lack of fire wardens / marshals within the community buildings.
The actions to resolve these concerns will be completed through the works included within the 2018/19 Fire Action Plan detailed further in the report.

Fire Evacuation Drills
A planned evacuation was undertaken during September 2017 on a Friday evening around 9pm to test the response to the fire alarm at the fire panel and if the secondary assembly point was clearly understood.

The alarm was triggered within the main entrance and it took 10 minutes for staff to attend the secondary assembly point in North Block to receive instructions from the person in charge.
Some staff did attend the area; however within 15 minutes of the alarm activation only 10 members of staff had arrived at the assembly point to offer assistance which would have been insufficient if the Trust had been required to evacuate patients.

An unplanned evacuation took place within ED and South Block during the year, these identified concerns in respect to communication and the understanding of local evacuation procedures.

Fire training now forms part of the study days held in ED for their specific teams and covers evacuation within their area. The training includes more emphasis being placed on the purpose and use of the fire door as a barrier of safety whilst moving patients and staff from an unsafe zone to a safe zone, this is to build confidence with the staff in the physical fire structural arrangements.

Measures are being reviewed and adopted within South Block to improve the communication process for stand down of an evacuation and the safe to re-enter message, along with the requirements for sweeping areas rather than role call systems.

Works are planned through 2018/19 linking with the new EPRR lead to carry out evacuation exercises across the Trust both table top and in non-patient affected areas with a live exercise already being planned for July 2019.

Apologies are made to the Board members as the work has not progressed to the level of compliance that should be expected at this time. Work around the safer sharps review and the community fire risk assessments / inspections have not been completed, these projects will be carried into the 2018/19 and will be completed as a priority.
During the period alternative projects presented which diverted time and focus from the original targets set along with changes to the fire team personnel. Unfortunately the Fire Officer in post at the time reduced their working hours and ultimately left the Trust.
Recruitment took place and since January 2018, two part time fire officers have been recruited that cover a full working week.
This has had a significant impact upon the progress made against the targets set.

Health and Safety Work Plan 2018/19

Following the work undertaken during the year the targets set for 2018/19 are a direct result of the findings and gaps identified where additional support and guidance is required.

General Risk Assessments

There is an absolute requirement under Regulation 3 of the Management of Health and Safety at Work Regulations 1999 (as amended), for work activities and environments in which staff carry out to be risk assessed to ensure that the risks to staff's health and safety have been identified and measures adopted to reduce the risks to the lowest level reasonably practicable.

The Trust has a General Risk Assessment Templates Policy in place that identifies the legal duty and the measures in place to support teams in complying with the regulations. There is a mixture of both understanding and compliance with this policy that needs to be addressed and resolved from a Corporate and Local level.

The implementation of the general risk assessments will help support teams to understand if there are any further gaps in regards to compliance with assessments in other areas.

Action	
• Communication around the policy to raise awareness of the content. • Generic risk assessments to be completed for the common tasks / environments carried out in all areas to prevent the same work being duplicated several times over. • Training for local assessors so as specific tasks can be assessed locally.	
Assigned to:	Helen Watkiss, Health and Safety and Fire Manager
Date for completion:	September 2018 *(for generic assessments and communication, training sessions for 2018/19 already scheduled and displayed on HUB).*

Audit of compliance

The suite of Health and Safety Policies is in place and the standard set for compliance with the regulations has been agreed through the formal consultation and approval route. An audit tool can now be developed in accordance with the agreed standards and used throughout the Trust to give a detailed and comprehensive view of the levels of compliance with all aspects of H&S policy and any actions required to be undertaken.

Action	
• Audit tool and report template to be developed. • Audit schedule to be put together to ensure all areas are audited within a timely period. • Complete audits and feedback to the local areas and Divisions on compliance levels for each areas and actions required to raise compliance levels. • Action plans to be developed and monitored through the appropriate local governance meetings. • Feedback to the Health, Safety and Fire Assurance Groups on findings and progress.	
Assigned to:	Helen Watkiss, Health and Safety and Fire Manager
Date for completion:	Audit template to be developed by July 2018 First audit completed by August 2018 and reported findings at August 2018 Health, Safety and Fire Assurance Group. An audit completed every quarter and reported back to the Assurance Group at each meeting full site completion by August 2019.

Trust wide schedule of air monitoring

During 2017/18 some environmental monitoring has been completed in areas where concern has been raised or where there has been a change in legislation / guidance.
There is no formal schedule for air monitoring within the Trust, a programme is to be developed and cross referenced to the Control of Substances Hazardous to Health Regulations 2002.
The schedule will need to consider the most suitable and appropriate method of monitoring and the time frames for reviews.

Action	
• Schedule of the air monitoring needs to be developed. • Costs for monitoring and reporting to be progressed and agreed. • Review schedule and costs to be agreed and implemented within work plans.	
Assigned to:	Helen Watkiss, Health and Safety and Fire Manager
Date for completion:	May 2019

Fire Work Plan 2018/19

Standardised approach to Community Fire Safety

A consistent and agreed standard to be developed and agreed that formalises the manner in which the Trust manages and meets its duties under the Regulatory Reform Fire Safety Order 2005.

The approach will set out the way in which the Trust co-operates and co-ordinates with its landlords within the Community and how the Trust will conduct its fire risk assessments and training. The role of fire wardens and evacuation plans will also be included.

Structural fire safety measures will also be covered that will include the planned maintenance of the buildings along with the reactive repairs.
Testing and inspection data will be required to be evidenced as assurance that the buildings and its internal systems are being maintained to a reasonable standard.

Action	
Policy to be agreed with all Landlords. Regular meetings to be arranged and agenda to be agreed. Overview of risk assessments and compliance in community buildings to be given at the Health, Safety and Fire Assurance Group.	
Assigned to:	Helen Watkiss, Health and Safety and Fire Manager
Completion Date:	November 2018

Evacuation Exercises.

The Trust is required to carry out planned exercises of the fire evacuation process to ensure that all persons who are required to support or assist in an evacuation have sufficient information and training in their responsibilities.

It is not practical to carry out planned evacuation exercises in the patient areas particularly in the in-patient and theatre areas, however there are a number of areas – with pre-planning where exercises can be carried out to test the systems and procedures.

Table top exercises can be completed with teams in the in-patient areas to confirm understanding and to test that the process that are in place work for the teams and can be implemented appropriately.

Action	
• Identify areas that can undertake evacuation exercises and put together a schedule and implement. • Identify areas in which table top exercises are required and schedule in sessions with the relevant teams. • Develop a five year schedule of testing for agreement with the Senior Management Team – ensuring no disruption to patient care. • Review findings of the exercises and implement all changes that are required.	
Assigned to:	Helen Watkiss, Health and Safety and Fire Manager (Working in conjunction with C Leach EPRR Lead)
Completion Date:	Schedule in place by October 2018

North Block Review

During 2017 work was undertaken to determine that the cladding that surrounds the exterior of the Trust buildings was in accordance with the standards required.
All information was submitted to NHSI as requested and the Trust was not asked to take any further action.

Through our internal investigations some concerns in respect to the North Block building were identified namely the lack of cavity barriers installed between the internal structure and the cladding, this is a requirement in HTM and the survey will determine the implications of them not being installed. Confirmation is also sought on the compartmentation areas and where there has been any penetration through the walls this has been repaired correctly. Further surveys have been requested to look at the internal fire structure and compartmentation.

Action	
• Review the report findings of the surveys completed within North Block and implement any necessary measures.	
Assigned to:	Helen Watkiss, Health and Safety and Fire Manager

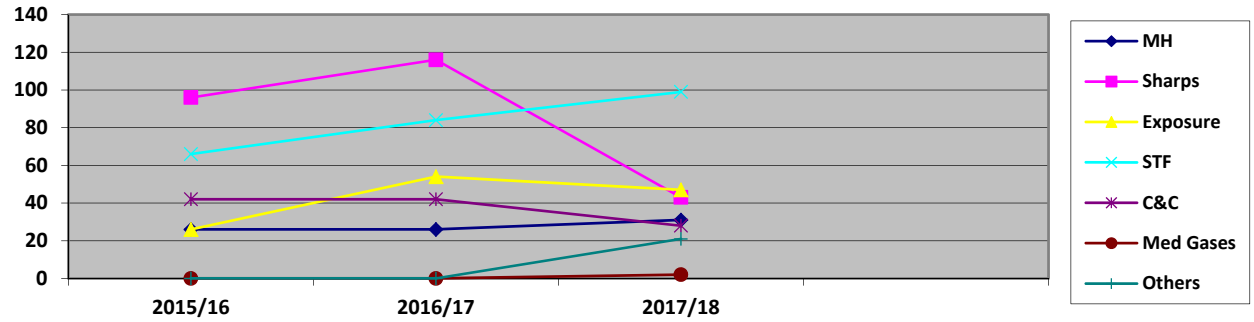
Completion Date:	July 2018

Incident Data April 17 – March 18

Health and Safety

The table gives an overview of the total number of incidents affecting staff reported during 2015/16, 2016/17 and 2017/18.

Incident Category	Incidents during 2015/16	Incidents during 2016/17	Incidents during 2017/18
Manual Handling	26	26	31
Needle sticks and Sharps	96	116	106
Exposure to hazardous substances	26	54	47
Slips, Trips and Falls	66	84	99
Collisions and Contacts	42	42	28
Medical Gases	N/A	N/A	2*
Others	0	0	21
Total number of reported incidents	**256**	**322**	**334**



The incidents reported include near misses and harm caused, of the 334 reported incidents 12 of them caused harm to staff members that required them to be reported to the Health and Safety Executive under the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013 (RIDDOR), details of these incidents are included within this report.

Action	
• Incident data reported at the Health, Safety and Fire Assurance Group and ultimately the Board Report July 2019 will include a b reakdown of harm caused from near miss to level of harm to enable comparable dats to be considered as to if the increase in incident reporting is reflective of an increase in harm being caused or awareness from near miss incidents.	
Assigned to:	Helen Watkiss, Health and Safety and Fire Manager
Completion Date:	August 2018

The figures indicate that there has been a slight increase of 4% in the total number of incidents reported across the Trust in comparison to 2016/17.

The data indicates that there has been an increase in the following two categories on comparison to the number of incidents within the catagories reported for 2016/17:-

Manual Handling **19% Increase**
Slips, Trips and Falls **18% Increase**

The highest number of slips, trips and falls were reported during December 2017 and related significantly to the periods of snow and ice experienced through the winter period, with slips on icey / frosted pathways. A number of these occurred within the Community areas where the staff were visiting patients' homes.
Another causation for the incidents are slips on wet floors, on investigation the wet floor signs are in place in the main however in some instances the domestic has moved along the floor area and not

moved the sign to the new location further down the ward corridor or main hospital streets, not alerting persons using these walk areas.

The domestic teams have been contacted in respect to ensuring that the signage is displayed in the areas where they are working and to ensure that dry mopping is carried out in accordance with their working instructions.

The Slips, Trips and Falls Policy for staff and visitors is due for review during 2018/19 which will include a review of the cleaning and gritting practices around the Trust sites.

Action	
• Review of the existing policy and arrangements in place for cleaning and gritting to ensure viable and suitable to prevent incidents.	
Assigned to:	Helen Watkiss, Health and Safety and Fire Manager
Completion Date:	October 2018

Manual handling incidents increased during this reporting year. This category includes incidents involving inanimate items along with patient handling incidents. 86% of the incidents relate to patient handling of which 75% of these occurred on the Wards within the Acute Trust. 14% of incidents related to staff members sustaining an injury whilst moving products such as fluids and patient notes boxes.

Action:	
• All manual handling datix reports to be reviewed to determine if the affected person was in date with Manual Handling training as this may be a contributory factor to the incidents. • Information to be reported at each Health, Safety and Fire Assurance Group.	
Assigned to:	Helen Watkiss, Health and Safety and Fire Manager
Completion Date:	August 2018

The data indicates that the following categories have seen a calculated reduction in the numbers reported:-

Needle sticks and sharps	**9%**
Exposure to hazardous substances	**13%**
Collisions and contacts	**33%**

Despite the reduction in comparison to last year's figures needle sticks and sharps remain the highest reported category. 106 incidents were reported over the annual period of which 88% of the incidents related directly to needle sticks. The data indicates that the incidents occur at two points during the delivery of care when using a needle stick, the first is during the point of delivery and results from patient's reaction to the sharp penetrating the skin, causing patients to jump / flinch which cause the needle to puncture the care givers fingers / hands. The second point is during disposal a number of incidents are reported where a sharp has been found / identified within the incorrect waste stream, for example placed in the domestic or clinical waste bags rather than the Sharp Smart bin system.
There has been an occasion of re-sheathing reported during this period, of which this is prohibited and should only be undertaken within the Pharmacy aseptic unit where it is considered a clean sharp as it is the re-sheathing of needle prepared for the delivery of drugs and has not been in contact with other persons bloods.

The division of the needle stick incidents is as noted below:-

Community	10%
Theatres	19%
Maternity	16%
Wards	40%
Clinical Support	15%

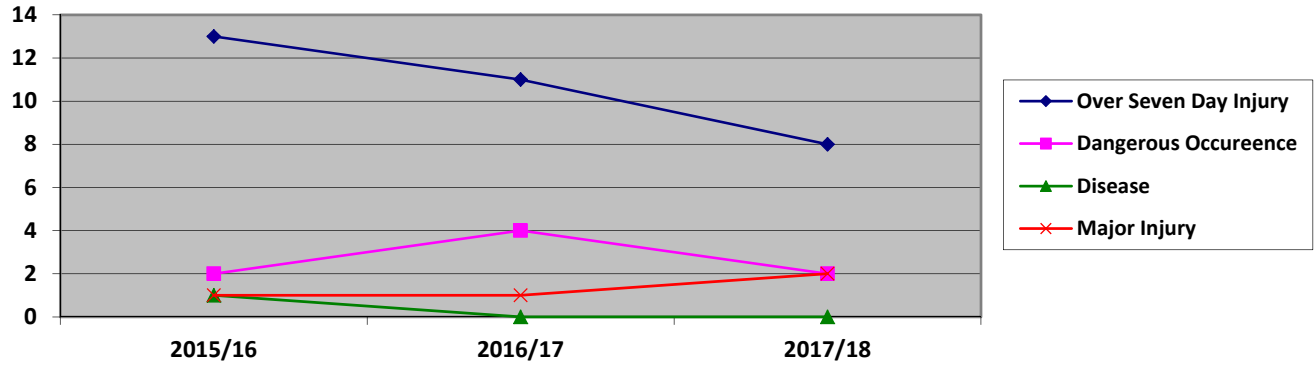
Within Maternity and Theatres the use of unsafe suture needles is sited as the causation, these needles have no safer alternative at this time and therefore the use of the unsafe sharp has to be managed.
The use of insulin prefilled syringes are a high reported causation for incidents that occur within the Community and on the Wards when staff are supporting patients using their own medications. The prefilled syringes are noted by the HSE as not being safe by design and works are underway with the Pharmaceutical industries to provide safer products.

ACTION:
• The work being implemented as part of the safer sharps focus will address the increase in

needle sticks and exposure incidents. • Review of the information, instruction and training given to staff and any refresher to ensure that the messages are current. • The interventions implemented as part of this project should instigate a reduction over the coming period.	
Assigned to:	Helen Watkiss, Health and Safety and Fire Manager
Completion Date:	September 2018

RIDDOR Data:

Incident Category	Incidents During 2015/16	Incidents during 2016/17	Incidents during 2017/18
Over seven day injury	13	11	8
Dangerous Occurrence	2	4	2
Disease	1	0	0
Major Injury	1	1	2
Total number of staff RIDDOR's	**17**	**16**	**12**
Total number of RIDDOR reports affecting patients	**17**	**20**	**4**
Total number of RIDDOR Reports	**34**	**36**	**16**



During the year 2017/18 there were 16 reports submitted to the Health and Safety Executive under the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013 (RIDDOR), affecting patients, staff and visitors. This is a significant decrease overall of 55% for all RIDDOR incidents.
There has been a 27% reduction in the number of incidents in which caused staff members to take more than seven days sickness absence or undertake restrictions to duty as a result of an injury caused by work.

Incidents reported under the remit of dangerous occurrences reduced by 50%, these are incidents in which staff members have been exposed to blood borne viruses either due to needle stick or splash incidents.

The most significant reduction in RIDDOR incidents is in relation to the incidents that affect patients and cause major harm (fractures / scalding), this section of the reporting stream has seen a reduction of 80%.

Action	
• Ensure Managers are fully aware of the incidents that need to be reported under RIDDOR and the timeframe for reporting to the HSE to ensure the Trust is in compliance with the regulations.	
Assigned to:	Helen Watkiss, Health and Safety and Fire Manager
Completion Date:	December 2018

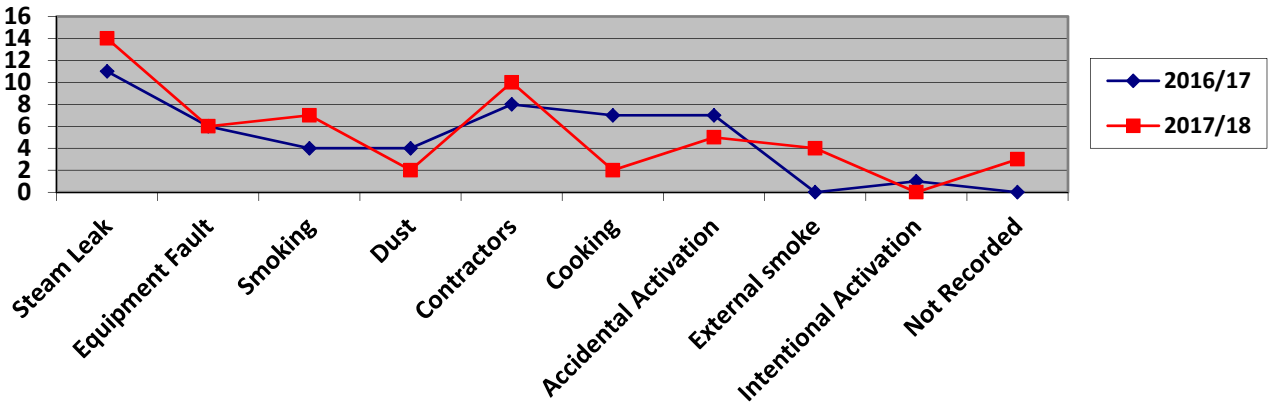
Fire Incidents

During the annual period the Trust had received 53 fire alarm activations across the Trust premises, this includes Corbett and Guest. This is an increase of 7% in comparison to the data from the last annual period.

The number of actual fires reported remains the same with 1 in both annual periods; both real fires were caused by equipment that developed a fault.

The main causation of the false activations is noted below:

Activation Type	2016/17	2017/18
Steam Leak in Plantrooms	11	14
Equipment fault / fume	6	6
Smoking	4	7
Dust	4	2
Contractor caused activation	8	10
Cooking	7	2
Visitor activated in error thinking it was door control	7	5
Smoke external to the building	0	4
Intentional Activation	1	0
Not recorded	0	3
TOTAL	**48**	**53**



The data indicates that there has been significant reductions in some of the areas which caused false activations. During this period cooking incidents such as smoke from burning bread in toasters have reduced by 71%.
Dust contamination within the detector heads that triggered the alarm to be raised has reduced by 50% in comparison to the data from 2016/17, this is due to the covers being correctly fitted over the detectors in areas where works are being carried out.
Both intentional and accidental activations have increased over the year with no intentional activations during this annual period. Accidental activations where patients / visitors have pressed the fire alarm call point in error for the switch to open the door has also decreased by 28%. The introduction of the cover points with a local alarm will have contributed to this reduction as when the plastic cover is lifted it sounds a local alarm that alerts people instantly to the error made.

Activations caused by steam leaks within the plant rooms has increased by 27%, this is in part due to life cycle paining of the pipes that has been undertaken within the plant room areas, as the pipes heat up it causes the paint to steam off which in turn activates the smoke detectors that are sited within the plant rooms.
Discussions have been held with Interserve in respect to the increase in the activations and a request for the detector heads to be changed from smoke to heat was requested. The Trust have refused this request as the heat detectors are less sensitive than the smoke detectors and as the plant rooms are areas that are not staffed and there is no early indication of any incident the Trust need to ensure that the most effective form of detection is held in this area. The painting of the pipework is completed on life cycle every 15 years, therefore it is not considered to be a persistent issue in which warrants the proposed changes.

Contractors accidentally activating the fire alarms during works has increased by 25%, this was due to incorrect isolations of zones on the fire alarm panel and also carrying out work that produced sufficient fume which activated the detectors.

The most significant increase, 75%, has been in regards to smoking on site, this has nearly doubled with 7 incidents reported this year in comparison to 4 in the previous period. This figure includes vaping of e-cigarettes of which vaping caused 43% of the activations.
Vaping incidents occurred internal and external to the site with one activation being as a result of a member of the public vaping outside the ED entrance, however the amount of visible smoke produced from the vape, as this entered the building the staff considered it a viable fire and activated the call point.
The Trust is moving to a smoke free site early 2019 therefore the incidents relating to smoking will be monitored to identify any potential increase or decrease as a result of this change.

Action –	
• Monitor the use smoking related alarm activations in accordance with the smoke free site and raise individual incidents as necessary.	
Assigned to:	Helen Watkiss, Health and Safety and Fire Manager
Completion Date:	January 2019

Enforcement Interest in the Trust.

During 2017/18 the Trust received no contact by the Health and Safety Executive as a result of any RIDDOR report that was submitted in connection with any injury to staff, patients or visitors.

The HSE contacted the Health and Safety Manager for details on the cooling towers at the Russell's Hall site, of which there are no cooling towers on the Trust premise. This was in connection to an investigation into a patient who was being treated for suspected exposure to Legionella of which the exposure was thought to have occurred in the Dudley Borough, the individual had been an in-patient at Russell's Hall. Once confirmed that there were no cooling towers on site no further follow up or action was required.

The HSE attended site for a schedule visit and inspection in December 2017 of the containment level 3 facility in the Pathology department. The visit was part of a schedule of visits being conducted by the HSE where the specialist team were visiting NHS and Private Trusts to ensure the requirements of the Legislation was being adhered to.
The Trusts visit went extremely well and no enforcement notices or letters of advice were given.

West Midlands Fire Service have contacted the Trust in respect to the number of false alarm activations in which they attended that were in connection to steam leaks within the plant rooms.

The Trust has liaised with Interserve as the plant rooms are not part of the Trust's remit to discuss planned preventative maintenance and regular inspections.

CONCLUSION

The actions noted above are for implementation over this financial year, progress will be monitored through the Health, Safety and Fire Assurance Group.

Enclosure 9

The Dudley Group
NHS Foundation Trust

Paper for submission to the Trust Board
5th July 2018

TITLE:	**Medicines Management Annual Report 2017/18**		
AUTHOR:	Ruckie Kahlon Associate Director of Medicines Optimisation and Head of Pharmacy	**PRESENTER**	Ruckie Kahlon Associate Director of Medicines Optimisation and Head of Pharmacy

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

CORPORATE OBJECTIVE: SO2: Safe and Caring Services

SUMMARY OF KEY ISSUES:
The Medicines Management Group was formed August 2017 following agreement at CQSPE Committee that a multidisciplinary forum was required to undertake detailed discussion on medicines management processes: prescribing, dispensing, supply, storage and administration, medicines optimisation, quality improvement, safety and learning from best practice. The attached report describes progress in 2017/18 with the Trust journey towards improved medicines optimisation.
It describes medicines management performance indicators, key achievements and challenges in medicines optimisation in the past year and progress with the objectives in the Medicines Optimisation strategy within the Hospital Pharmacy Transformation Plan.
Key achievements in medicines management in the past year include

- Improved patient safety, through better management and learning from incidents
- Controlled drug accountable officer and Medicines Safety Officers roles embedded
- Antimicrobial stewardship
- Supporting patient access to medicines through timely implementation of NICE technology appraisals guidance
- Improved working in multi-disciplinary teams to deliver safe and effective medicines management
- Positive medicines management feedback by CQC

IMPLICATIONS OF PAPER:

RISK	**Y/~~N~~**		**Risk Description:** Failure to provide secure medicines related practice within the Trust
	Risk Register: Y/~~N~~		**Risk Score: 15**
COMPLIANCE and/or LEGAL REQUIREMENTS	**CQC**	**Y/~~N~~**	**Details:** SAFE, WELL LEAD
	Monitor	**~~Y~~/N**	**Details:** Links to good governance
	Other	**~~Y~~/N**	**Details:**

ACTION REQUIRED OF GROUP:

Decision	Approval	Discussion	Other
		✓	

RECOMMENDATIONS FOR THE BOARD:
To note the assurances from the Medicines Management Group, the work plan to date and the plans devised to improve compliance within the Divisions

The Dudley Group NHS Foundation Trust

Medicines Management Group Annual Report 2017/18

Introduction

The Audit Commission's Report "Spoonful of Sugar" (2001) defined Medicines Management in hospitals as encompassing the entire way that medicines are selected, procured, delivered, prescribed, administered and reviewed, to optimise the contribution that medicines make to producing informed and desired outcomes of patient care. The Care Quality Commission regulatory framework 'Fundamental Standards of Quality and Care' includes medicines management within the 'Safe' domain, serving its position as a high-priority governance issue for health provider organisations. The CQC identify medicines management as representing one of the highest non-compliance areas across the healthcare providers and greater emphasis on assessing this area is emerging.

Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014 states with respect to the management of medicines:

- Providers must ensure that medicines are supplied in sufficient quantities, managed safely and administered appropriately to make sure people are safe.
- Providers must do all that is reasonably practicable to mitigate risks with regards to medicines. Medication reviews must be part of, and align with, people's care and treatment assessments, plans or pathways and should be reviewed regularly when their medication changes.
- Medicines must be administered accurately, in accordance with any prescriber instructions and at suitable times to make sure that people who use the service are not placed at risk.
- Staff responsible for the management and administration of medication must be suitably trained and competent and this should be kept under review.
- Staff must follow policies procedures about managing medicines.
- The policies and procedures should be in line with current legislation and guidance and address:
    - Supply and ordering
    - Storage, dispensing and preparation
    - Administration
    - Disposal
    - Recording.

The Care Quality Commission (CQC) expects that people who use healthcare services:

- Will have their medicines at the times they need them, and in a safe way.
- Wherever possible will have information about the medicine being prescribed made available to them or others acting on their behalf.

This is because providers who comply with the regulations will:

- Handle medicines safely, securely and appropriately.
- Ensure that medicines are prescribed and given by people safely.
- Follow published guidance about how to use medicines safely.

The MMG was established to lead on medicines related best practice within the Trust, receive assurance, risk mitigate and advise on non-compliance to standards affecting the use of medicines within the Trust. Care, Quality, Safety and Patient Experience (CQSPE) is provided monthly highlight report updates on medicines management issues, assurances, initiatives and audits discussed at the Medicines Management Group (MMG).

Medicines Management Group Aims and Objectives
MMG meets monthly with an aim of 10 meetings per year. The frequency will be reviewed after 12 months of inception. Key aims of the Group have been:

To lead on medicines risk management including:-
- Storage and handling of medicines including controlled drugs
- Interventions and clinical incident reporting
- Education and training relating to medicines
- Oversee the work of the Trust Medication Safety Officer (MSO)
- Antimicrobial stewardship
- To oversee the medicines management risk on the corporate risk register
- To oversee medicines related patient safety alerts and provides assurance to the Risk and Assurance Group.

To lead on the development and implementation of medicines policy and management in conjunction with the Drugs &Therapeutics Group including but not limited to:-
- Commissioning the development of policies and procedures
- Reviewing policies
- NICE and other relevant guidelines

To provide guidance in relation to medicines management for operational, technical and quality improvement Trust service development initiatives.

To receive and sign off:
- Subgroup annual work plans.
- The Annual Medicines Management Strategy & plan Reporting Group report compliance

Medicines Management Group Core Members
- Chair: Chief Executive Officer
- Deputy Chair: Associate Director of Medicines Optimisation-Chief Pharmacist
- Chair of the Drugs & Therapeutics Group
- Deputy Chief Pharmacist (Medication Safety Officer)
- Principal Pharmacist - Medicines Optimisation
- Medicines Governance Lead Pharmacist
- Associate Chief Nurse – Surgery, Women's and Children
- Associate Chief Nurse – Medicine and Integrated Care
- Governance Lead – Surgery, Women's and Children
- Governance Lead – Medicine and Integrated Care
- Governance Lead – Clinical Support Services
- Modern Matron Lead for Medicines Management
- Modern Matron for Community Services
- Quality Lead for Allied Health Professionals
- Senior Medics – Surgery and Medicine

Medicines Related Reporting Groups
The MMG receives updates from a number of existing clinical, technical and operational groups that discuss medicines issues within their terms of reference. The reporting groups manage their work plan largely determined by local and national initiatives, clinical incidents and safety alerts. The MMG provides a senior steer to ensure each reporting Group's work plan and audit findings are timely, assessed for safety and clinical effectiveness. Action plans are developed to drive improvements and provide Board assurance that medicines are managed safely, effectively and efficiently with DGFT.

The following groups report directly into this Group:
- Drugs and Therapeutics Group
- Safe Medicines Practices Group
- Pharmacy Medicines Use Group (Includes storage and security of medicines)

- Non-Medical Prescribing Leads
- Antibiotic Steering Group.
- Medical Gases and Piped Systems Group
- IVIG Group
- Thrombosis Group
- Chemotherapy Multi-professional Group
- Medicines Link Nurse Group

Each Group provides a highlight report or nil return (where meetings are not due within the reporting month). The highlight report provides assurances of actions taken, developments made, issues that remain pending and concerns for escalation to MMG. The cascade process ensures medicines related issues are highlighted within the multidisciplinary MMG and support continual quality improvement and learning. This is captured in a number of patient safety bulletins and Medicines Link Nurse bulletins.

Highlight report provision compliance has been relatively high and further work is planned with the Thrombosis Group and Chemotherapy multi-professional Group to improve the frequency of submission.

The Drugs and Therapeutics Group (D&T)

The Group is the longest standing medicines optimisation forum and has concentrated in formulary management, prescribing across the interfaces and ensuring compliance with medicines prescribing, administration and supply statutory functions. The Core Group consists of clinicians representing surgical and medicine specialities, chaired by the Associate Medical Director, deputy chair Consultant Rheumatologist, Chief Pharmacist, Medication Safety Officer, Principal Pharmacist Medicines Optimisation, Antimicrobial Lead Pharmacist, CCG Pharmaceutical Advisor, Matron lead for medicines and a lay member. The Group meets every two months and in 2017/18 completed the following under its terms of reference:

Formulary Decisions

During 2017/18 the Group discussed formulary addition requests, one-off treatment requests and advised on Individual Funding Requests that are then referred to the appropriate Commissioner for final decision. The Group assesses the clinical effectiveness, safety, risks, financial impact and operational viability of each request. A summary of decisions is available below. In addition the core group members represent the Trust at the Dudley Health Economy Area Clinical Effectiveness Group and the wider implication of the formulary requests in each forum are tabled accordingly.

NICE guidance, NICE technology appraisals, Specialised Services commissioning statements, early access to medicines (EAMs) and NHS England medicines commissioning decisions are also discussed by the Group to ensure managed drug entry and fully elucidate the risks and operational challenges of each drug introduced to the Trust.

Blueteq® has been fully rolled out to ensure prior approval criteria are met for CCG and NHS England commissioned medicines.

New Medicine Formulary Addition Requests

Eleven new medicines formulary addition requests were received by D&T and these were clinically, technically and financially assessed using criteria used by the Dudley Area Clinical Effectiveness Group to ensure a consistent approach on medicines optimisation.

Date of Meeting	Drug	Indication	D&T Decision
May 2017	Fulvestrant (Faslodex)	post-menopausal women with ER positive breast cancer after failure of anti-oestrogen therapy	Approved for patients intolerant to existing anti-oestrogen therapy
May	18% alcohol	To remove epithelium for corneal	Approved for ophthalmology

2017	single use drops	collagen cross linking and other reasons - Unlicensed use	use only
July 2017	Ceftolozane tazobactam	A new antimicrobial indicated for complicated intra-abdominal and urinary tract infections	Approved on restricted indication list and subject to audit reporting
July 2017	Riboflavin	To remove epithelium for corneal collagen cross linking and other reasons - Unlicensed use	Approved for ophthalmology use only
July 2017	Acetazolamide Liquid	Epilepsy	Approved for restricted paediatric use only
July 2017	DHEA-sulphate	Endocrinology assessment of adrenal insufficiency	Approved for endocrinology use only
Sept 2017	Dalbavancin	skin and soft tissue infections management via OPAT service	Rejected pending further clinical data
Nov 2017	Dymista	moderate-to-severe Seasonal Allergic Rhinitis	Referred to ACE for health economy decision
Nov 2017	Pembrolizumab	locally advanced or metastatic urothelial carcinoma in adults who have received prior platinum-containing chemotherapy – pre NICE guidance	One off use if access scheme continues funding. NICE approval now granted
Jan 2018	Mydrane	mydriatic and anaesthetic effects in patients prior to surgical intervention in cataract surgery	Approved
March 2018	Ketamine oral solution	hip pain following septic arthritis 4 years ago resulting in chronic pain that is none responsive to a range of analgesics (including strong opioids), anti-depressants and anticonvulsants	One off approval with outcome data feedback

Guideline / Policy and Procedures Reviewed

Sixteen policies, procedures and guidelines were reviewed by the Group to provide clinical and technical scrutiny. Operational, financial issues posed by the documents were highlighted to prevent problems downstream.

Date of meeting	SOP/ Guideline/ Policy	Group Decision
May 2017	Safe handling and use of FP10 prescriptions within Dudley Group NHS Foundation Trust	Approved
May 2017	Chemotherapy Electronic Prescribing and Medicines Administration (cEPMA) Business Continuity Policy	Approved
July 2017	Paediatric antibiotic therapy at home (PATH) standard operating procedure	Approved
July 2017	Drug fridge temperature monitoring on wards and departments Standard Operating Procedure	Approved
July 2017	Room (ambient) temperature monitoring within drug storage areas on wards and departments Standard Operating Procedure	Approved
July 2017	Proton pump inhibitors in adult in-patients (guideline review)	Approved
July 2017	Unlicensed medicines policy	Approved
July 2017	Transdermal patch application record	Approved
July 2017	Recognition and management of immunotherapy associated adverse events in oncology or haematology patient's guideline	Amendments requested and approved Feb 2018
July 2017	Medical Gases Policy	Approved

July 2017	Oxygen Prescribing Policy	Approved
Sept 2017	Outpatient Parenteral Antimicrobial Therapy (OPAT) guideline for adults with complicated skin or soft tissue infections including cellulitis	Amendments requested
Sept 2017	Subcutaneous Bortezomib (VELCADE®) Administration in a Primary Care setting standard Operation Procedure.	Approved
Nov 2017	Acute treatment of hypophosphatemia in adults guideline	Approved
March 2018	Artificial hydration SOP	Amendments requested
March 2018	Lignocaine infusion for acute pain guideline	Amendments requested

Responsibility for prescribing between Primary & Secondary/Tertiary Care (Gateway 07573 NHS England)

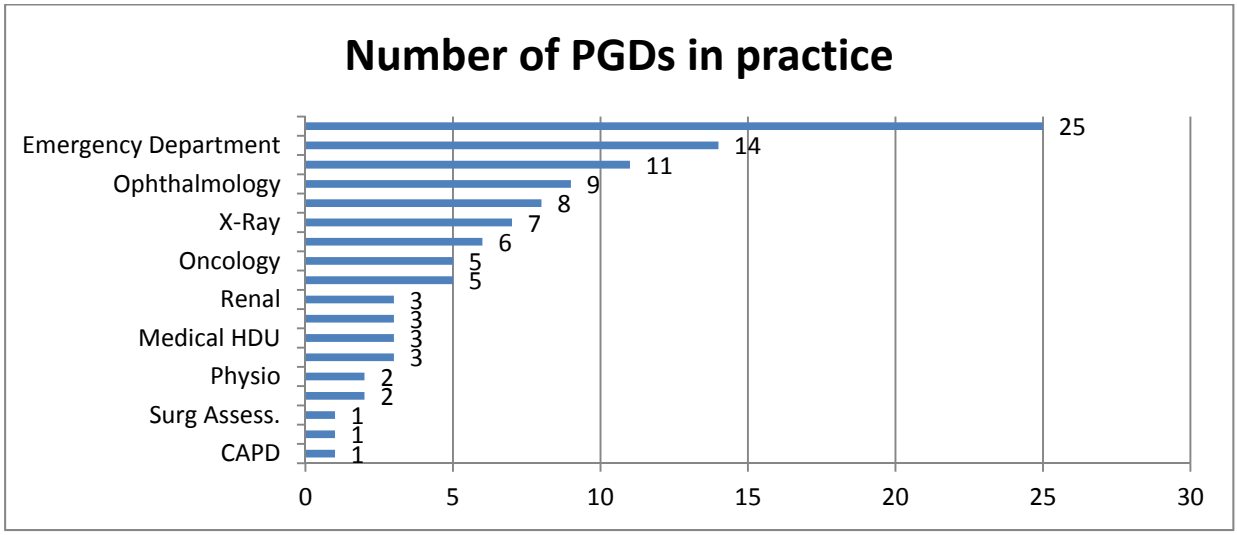
This guidance was introduced late January 2018 to address ongoing national shortfall of access to medicines supply across the interface between primary and secondary/tertiary care. The guidance aims to provide clarity on the responsibilities of all professionals involved in commissioning and prescribing medicines for:

- Supply of medicines
- In-patient and day cases
- Patients attending urgent and emergency care centres
- Out-patients
- People at risk of self-harm
- Shared care

D&T assessed the criteria outlined within the guidance and the Trust is compliant with its responsibilities.

Patient Group Directions

Patient Group Directions (PGDs) are written instructions to help with the supply or administration of medicines to patients, usually in planned circumstances. D&T review the Trust compliance with the legal standards and requirements for PGDs as contained in the Human Medicines Regulations 2012 and within the NICE Medicines Practice Guidance (MPG2). The latter has supported the Group leads to ensure good practice for developing, authorising, using and updating patient group directions. Compliance with NICE MPG2 legal standards for PGDs are being met.



New PGDs under development	Department
ProHance – Contrast Media	MRI
Metoclopramide for endoscopy nurses	GI Unit
Chloramphenicol TTO packs for plastic surgery	Max. Facial Department
Atropine for occlusion therapy for amblyopia	Orthoptists
Metvix cream (sunlight)	Dermatology

Antimicrobial Stewardship Group (ASG)
This Group reports to D&T Group and provides assurance on the compliance with standards set out by Health and Social care IPC code of practice for Antimicrobial stewardship, Department of Health "Start Smart then Focus" and NICE NG15 (2015) Antimicrobial Stewardship: systems and processes for effective antimicrobial medicines use. However ASG provides CQUIN updates to both D&T and MMG due to the quality improvement importance.

CQUIN: Reducing the impact of serious infections (Antimicrobial Resistance and Sepsis)
For 2017-18 Dudley participated in the national CQUIN: Reducing the impact of serious infections. The goal of this CQUIN was to reduce antibiotic consumption with a focus on antimicrobial stewardship and ensuring antibiotic review within 72 hours. Indiscriminate and inappropriate antibiotic prescribing has been identified as a key driver for antibiotic resistance therefore the CQUIN aimed to reduce total antibiotic usage and usage of key broad-spectrum antibiotics and ensure antibiotics are appropriately reviewed after initiation.

Part 2 c of CQUIN: **Antibiotic review between 24-72 hours of initiation in patients with sepsis who are still inpatients at 72 hours.**
Dudley achieved all four milestones for antibiotic review within 72 hours, with a final result of 91.3% (internal calculations) of antibiotic prescriptions receiving a review within 72 hours.
In order to further the excellent achievements to date, the Trust has recruited an additional sepsis nurse and antimicrobial pharmacist to support initiatives to improve sepsis and stewardship. An online sepsis database/ sepsis report has been created for Pharmacists on the Hub for identifying patients who are due for antibiotics review.

Part 2 d Antimicrobial Consumption
Part 2 d of CQUIN is further divided into 3 individual targets,
1. Reduce Total antibiotics consumption by 1%.
2. Reduce Carbepenem consumption by 2%.
3. Reduce Pip/Taz consumption by 2%.

When compared with National consumption data reported on Public Health England Fingertips, Dudley falls in the 2nd lowest percentile for total antibiotic usage (4363 Defined Daily Doses (DDDs)/1000 admissions vs. 4853 DDDs/1000 admissions for Dudley and national average, respectively). The antibiotic consumption targets and local achievements are detailed in table 1.

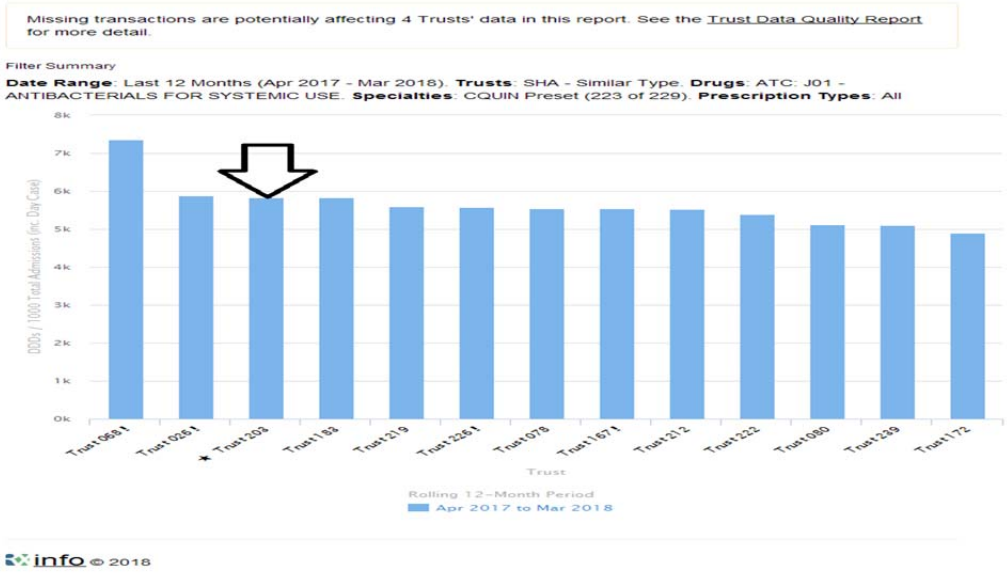
Table 1

Indicator (per 1000 admissions)	Target reduction	Reduction achieved(internal)
Total antibiotic consumption	1%	16.42%
Total carbapenem consumption	2%	-28.70%
Total piperacillin / tazobactam consumption	2%	-69.16%

Compared to similar Trusts, DGFT achieved a significant reduction in carbapenem and piperacillin / tazobactam use. However the antibiotic supply chain, significant winter pressure patient flow and changes to admission definitions undermined our ability to drive down

overall antibiotic consumption during 2017/18. Figure 1 extracted from Define benchmarking software.

Figure 1: Total antibiotic consumption (DDDs/1000 admissions) compared to similar Trusts



Interventions over past 12 months to improve Antimicrobial Stewardship at DGFT
The target was achieved with help of multiple initiatives i.e.

- Project group formed including medical director, chief pharmacist, AMS team, Sepsis leads and service improvement
- IV to oral switch stickers.
- Drs and Nurses awareness via teaching programs and internal communications.
- Collaboration with sepsis team.
- Collaboration and feedback to the Divisions.
- Executive level reporting to influence change.
- Review section on drug chart.
- Referrals to Antimicrobial Pharmacists.
- Review of OPAT use of IV antibiotics
- Complete review of antibiotic treatment guideline choices, reducing large proportion of piperacillin / tazobactam use.
- Course lengths in antibiotic guidelines rationalised
- Teaching with pharmacists to empower challenge of prescriptions
- Antimicrobial stewardship ward rounds

Updated/new Guidelines
Several new guidelines were changed in 2017-18. Many of the existing guidelines were reviewed and updated to reduce broad spectrum antibiotic usage and address global antibiotic shortages. Guidance is produced between the microbiology and pharmacy departments with input from the relevant specialties. Clinician engagement in guideline compliance is clear from the excellent rate of compliance demonstrated in the audits.

Education and Training
Mandatory training for clinicians in antimicrobial prescribing and stewardship continues to take place. All doctors new to the Trust are provided with antimicrobial training at induction. Better Training Better Care for FY1 and FY2 doctors in Antimicrobial Prescribing received excellent feedback from the participants. Additional training sessions have also been carried out through the year when guideline changes have occurred.

Pharmacists receive regular feedback on antimicrobial prescribing in their clinical areas after the snapshot audits; Pharmacist prescriber's complete online modules on antimicrobial prescribing.

Current Challenges

- Antibiotic shortages are unpredictable and require frequent guidance changes leading to prescriber confusion.
- Lack of real time tracking of antibiotic consumption, guidance compliance and improved data reporting / time management on reporting. Roll out of chosen e-PMA will support real time tracking.
- Re defined criteria of antibiotic review by NHSE (stricter than last year).
- Introduction of new target i.e. removal of piperacillin / tazobactam from 2018/19 CQUIN and introduction of AWARE antibiotics list (Access, Watch, Reserve).

Plans for 2018/2019

- Review guidelines as outlined previously.
- Close links with sepsis work streams: created "Sepsis team" (2x sepsis nurses + 2 x antimicrobial pharmacists)
- Focus on drive for IV2PO switch – septic patients flagged to sepsis nurses by ward clinical staff. Antibiotics flagged on electronic database which turns "red" on day 2 indicating the need to review and complete IV2PO decision tool. Reinforce the use of tool at Pharmacist Clinical huddles.
- Training session with all Pharmacists to highlight the changes in review criteria.
- Engage Clinicians from Medical and Surgical divisions to attend Antimicrobial Stewardship Group meetings and feedback to respective directorates.
- Regular snap shot audits to assess antimicrobial prescribing.
- Maintain antimicrobial ward rounds on Critical Care and extending to acute wards when feasible.
- Regular communication: patient safety alerts, screen savers, trust wide communications on changes in processes and guidance.
- Develop antimicrobial review page on upcoming electronic prescribing system (Sunrise) to help achieve required standards of antimicrobial review.
- To establish a suitable platform for middle grade/senior doctor training on antimicrobial prescribing.

The Safe Medicines Practice Group

Under the guidance of MMG, SMP Group re-evaluated their reporting process in Jan 2018 and commenced producing a monthly trended occurrence reports. The reports have become invaluable in providing areas of practice to undertake deep dive analysis, produce learning and assessment assurance plans. The occurrence reports are extracted within two key focus areas: prescribing interventions (near miss) undertaken by the Pharmacy team and Medicines related incidents reported by all Trust staff.

MMG monitors the incident reports working to extract learning and support with its dissemination across the Trust. Areas under review are prescribing and administration of insulin, controlled drug management and anticoagulation therapy.

Medicines Incidents Reported into Datix

The DATIX system was updated in February 2016 – Data from 16/17 (1st April 2016 until 31st March 2017) reported 3,244 medication prescribing incidents compared with 2918 from 17/18 (1st April 2017 to 31st March 2018) a decrease of 326 (10%). These are low to no harm (near miss) incidents. Key themes observed from a review of incidents have included antibiotic choice, anticoagulation dosing/ VTE prescribing, renal dose adjustment and use of laxatives. Learning feedback is in place through group teaching, medication safety bulletins and medicines management mandatory training.

Prescriber training, ward based pharmacist presence and feedback of incidents to Divisions by the Medication Safety officer have contributed to the reduction. In addition changes to the recording of prescribing incidents using the pharmacy P forms was rolled out across the Trust on 1st December 2017 following agreement at CQSPE to differentiate pharmacist advice and intervention on Datix. Only interventions are now extracted from Datix to monitor prescribing incidents and trended reports are presented to Divisional / Directorate Governance meetings to share learning from this work.

In addition the number of incidents relating to omitted medicines has declined over the second half of the year following a snapshot review of missed doses undertaken by the pharmacy team. This work supported the review of medicines stock list to ensure core and critical medicines are available on ward areas. In addition the roll out of the use of Summary Care Records (SCRs) and junior doctor training supports prescribers to accurate prescribe medicines at admission alongside the increasing use of IT systems for accessing JAC discharge letters/ clinic letters.

Pharmacy Intervention Reporting
Learning from past incidents can help to minimise the risk of future medicines related patient safety incidents and produce better outcomes for people who take medicines. [(2)]
A total of 2918 medication incidents were reported using the pharmacist note (P form), only 1 of these incidents was reported as causing low /minimal harm. All the other incidents were reported as a near miss or no harm.

Actions taken and learning from incidents
Trends from medication incidents are reviewed monthly by the Trust Medication Safety Officer (MSO) and Safe Medicines Practice (SMP) group. Level of harm, themes and learning from incidents are incorporated into the monthly occurrence report. In addition pharmacy led training education and training sessions for nurses and doctors e.g. induction is updated to reflect current issues.
Use of the Medicines Link Nurses network and the bi-monthly Link Nurse newsletter has enhanced the dissemination of learning from incidents across the Trust.

Feedback is also provided to pharmacy team via a weekly team brief and pharmacist meetings. Wider learning is disseminated to the Dudley Health Economy via the Dudley CCG Medicines Management Team.

Further work

- Introduction of a new electronic prescribing and medicines administration (EPMA) system within the Sunrise EPR launch is planned for 2018/19 and this will support prescribers in the Trust with limited decision support.
- SMP Group will closely monitor prescribing incidents over the next two quarters of 18/19 to oversee the safe implementation of EPMA as a priority for the Trust.
- Provide further support and training for doctors in Acute and Urgent Care areas to help access drug history information for newly admitted patients. Training for FY1s through Better Training Better Care is currently in place.

Security and Storage of Medicines

The Pharmacy Team undertake medicines management ward/department audits. The audit toolkit used is developed and updated regularly by the West Midlands Regional Chief Pharmacist Network to measure the compliance of medicines related activities undertaken across the Trust.
A mixture of executive led Quality and Safety and pharmacy audits have been undertaken throughout 2017/18 to follow up any areas of concern and promote good practice. Daily snapshots undertaken by Pharmacy medicines management teams provide added assurance and early escalation to the shift lead or lead nurses as deemed appropriate.

The aggregated 2017/18 visit summary of results is as follows:

Division	Average Audit Score	No. of areas 100% Compliant	No. of wards/ depts. audited
Surgery Women's &Children	85%	1	16
Medicine	89%	2	23
Clinical Support Services and Community	85%	0	25
Quality and Safety Walkarounds	83%	2	28

Key issues and actions taken:

- Huddle board medicines management information cascade process in place for quick dissemination of immediate actions.
- Authorised signatory list for medicine ordering was unavailable in some areas and this action has culminated with the preparation of two lists per year to avoid further repeat failures.
- Medicines storage in patient lockers and in treatment rooms is reminded and quality improvement noted over the 12 month period.
- Fridge temperature monitoring / escalation / resetting evidence requires further work and individual ward/ department areas are being supported to improve this deficiency.
- Fridge PAT testing process reviewed to improve Trust wide compliance.
- Remedial action plans have been provided to each lead nurse with one month to complete remedial actions. Incomplete actions after one month are then escalated to the associated Matron.

Monthly Medicines Management Nurse Led Quality Indicators

Nurse led monthly quality improvement medicines management audits have been developed in conjunction with the Chief Pharmacist, Lead Nurse for Quality Improvement and Matron lead for medicines management. The indicators cover key issues around medicines storage, security, medical gases, controlled drugs and high level prescribing issues. The audit was piloted on 3 wards initially in January 2018, refined and rolled out to 12 wards in March and complete roll out in all areas including community in May 2018.

CQC Medicines Management Findings

Following the unannounced CQC inspection December 2017 seven medicines management related recommendations were made during the inspection across the Trust. A decision was made to keep all the medication issues within one action plan rather than distribute them across into the respective core service action plans. This decision was made to enable the tracking of these actions to be made easier for the pharmacy team.

All seven actions were reviewed by the Chief Pharmacist and remedial actions undertaken. Each action has been assessed as complete, evidence has been seen to support the assessment of completion, and there are planned audits and spot checks to ensure that the actions taken provide on-going assurance.

Controlled Drugs & CD Accountable Officer Responsibility

The storage, prescribing, dispensing, supply and administration of controlled drugs (CDs) are highly regulated activities and overseen by the CD Accountable Officer for the Trust. This responsibility is maintained by the Associate Director of Medicines Optimisation- Chief Pharmacist. The DGFT ensure CDs are tightly managed in accordance with the following regulations:

- The Misuse of Drugs Act, 1971 as amended prohibits certain activities in related to 'Controlled Drugs' in particular their manufacture, supply and possession.
- The Misuse of Drugs (Safe Custody) Regulations 1973 as amended details the storage and safe custody requirements for CDs

- The Misuse of Drugs Regulations 2001 defines the classes of person who are authorised to supply and possess CDs while acting in their professional capacities and lays down conditions under which these activities may be carried out.
- The Health Act 2006 introduced the concept of the CD Accountable Officer with responsibility for the management of CDs and related governance issues in their organisation
- The Controlled Drugs (Supervision of Management and Use) Regulations 2013 were published to ensure good governance concerning the safe management and use of CDs.

Principal activities during the year
The Controlled Drugs Accountable Officer (CDAO) has provided quarterly occurrence reports to the Controlled Drug Local Intelligence Network (CDLIN) and Medicines Management Group (MMG) on incidents involving Controlled Drugs and key activities that have been completed. These have included:

- Reviewing all incidents involving CDs at the organisation to identify and mitigate current and emerging risks.
- Rationalisation of stock levels and stock lists for opioid analgesics on pre-assessment unit, Day Case Unit and Day Surgery Unit.
- Implementation of robust checking process to minimise risk of stock diversion or misappropriation across the Trust.
- Development and introduction of a Standard Operating Procedure and care plan for documenting transdermal patch application and removal
- Sharing learning with individuals involved in incidents and the wider healthcare team by incorporating key themes into education and training e.g. Foundation Programme 'Better Training Better Care' sessions, Medicines Link Nurse newsletter, Divisional Governance meetings.

Learning from incidents involving topical patches has resulted in the implementation of a SOP including a 'body map' to record patch application and removal. This has been shared with nursing staff via the Medicines Link Nurse newsletter, communications on the intranet and the medicines management update mandatory training. Post-implementation, the number of incidents involving fentanyl patches has reduced; however, a similar reduction has not been seen with buprenorphine patches because these incidents were related to the medication storage rather than administration process.

Activities to be completed in 2018/19 the CDAO will:

- Continue to provide reports to the MMG and CDLIN on controlled drug incidents to provide assurance that current and emerging risks are being identified and mitigated.
- Continue to promote good practice and good systems of care for reporting, learning, sharing, taking action and review of incidents involving CDs
- Strengthen of existing arrangements for the completion of CD audits and the subsequent actions taken and review by mandating dates for completion.
- Continue to optimise the use of ADIoS® (Abusable Drugs Investigational Software) to complement existing systems of monitoring and reporting on controlled and abusable drugs at the Trust.

Pharmacy Medicines Use Group
This Group was established within the Pharmacy department by the Chief Pharmacist to formally review and promote best practice in all matters relating to the safe and secure handling of medicines, implement and monitor progress with National Patient Safety Alerts, Medicines and Healthcare products Regulatory Agency Alerts and associated audits. The Group monitors and supports the development of policies, procedures and staff education and training materials relating to the safe and secure handling of medicines and staff compliance with training.

The main remit is to monitor risks associated with the supply of medicines including investigational medicinal products, report trends and themes from pharmacy department medication incident reports and consider requests for non-formulary or unlicensed medications pre-submission of requests to the Trust Drug and Therapeutics Group.

In addition the Group monitor information and technology issues and risk relating to the pharmacy stock management digital system – JAC and the forthcoming electronic prescribing system.

The Group has reviewed new and existing patient group directions, all unlicensed drug requests, assessed medicines shortages that will have Trust wide or high impact on business continuity, medicines related patient safety alerts and all MHRA medicines recalls.

Non-Medical Prescribing Leads

The Group provides assurance to MMG that Trust non-medical prescribers (NMPs) have completed the prescriber course, obtained prescribing qualifications, maintain competence in their chosen scope and remain in practice. The Group maintains a register of non-medical prescribers, their scope, their status and ongoing maintenance.

MMG has sought assurance that all NMPs maintain prescribing status and to enquire when this is stopped, changed or extended. In addition MMG has sought assurance of the development of a Non-Medical Prescriber Policy outlining the processes to register / maintain NMPs within DGFT.

Medical Gases & Piped Systems Group

The Group provides assurance that the appropriate policies and procedures are in place and implemented to ensure that the Medical Gas Pipeline Systems (MGPS) delegated to Summit Healthcare Ltd are designed, managed and operated in accordance with the relevant HTM-02. In addition the MGPS Group report:

- Compliance updates on the physical management of medical gas cylinders is in accordance with best practice.
- Compliance updates that appropriate procedures are in place and implemented to provide a robust, high quality, sufficient and cost effective supply of medical gases to the providers of patient care.
- Assurance that both medical and non-medical staff are adequately trained and competent, and where necessary appropriately appointed to carry out the tasks assigned to them as identified in the HTM-02 and to maintain a register of those persons.

MGPS Group has produced:

- The Trust Medical Gas Pipeline and Cylinder Systems Policy associated procedures to maintain this provision.
- Patient Safety bulletin, record sheets, educational material and disseminated Trust wide training sessions to ensure compliance with the Patient Safety Alert
- Medical Gas Pipeline System permit-to-work system and medical gas cylinder inventory management document.

The Group has overseen the implementation of the MGPS Authorising Engineer and MGPS Quality Assurance Pharmacist recommendations following planned audits and remedial works. With the support of the Local Management Security Officer medical gas cylinder storage security has been reviewed regularly to prevent the risk of cylinder theft.

In addition the Group has reviewed three NPSA alerts issued relating to safe use of oxygen in hospital and worked through each to provide MMG assurance of completion of each and monitoring compliance.

Intravenous Immunoglobulin (IVIG) Group

The Group supports Drugs and Therapeutics group to oversee the use, supply and approval of parenteral human immunoglobulin. The multidisciplinary group is chaired by a consultant haematologist and supported by a Principal Pharmacist and Lead Immunologist. The Group has ensured the risks associated with the difficult IVIG supply chain are mitigated and patient safety maintained.

In addition the Principal Pharmacist has maintained the IVIG database as outlined in the national CQUIN GE3: Medicines Optimisation Trigger 4. The database has achieved 100% compliance on reporting each of the mandated data fields.

Medicines Link Nurse Group

The Group chaired by the Medicines Governance Pharmacist supports Safe Medicines Practice Group with disseminating learning, education and training programmes following the review of medicines related clinical incident occurrence report analysis. Four Medicines Link nurse newsletters have been produced and cover the following themes of learning:

1. Use of transdermal patches
2. Prescribing and management of Valproate / Valproic Acid
3. Medication missed doses
4. Transfer and storage of medicines
5. Management of hyperglycaemia
6. Allergy status checking
7. Use of Controlled drugs
8. Discharge medication checking

Medicines Management Group Work Plan for 2018-19

- Support reporting groups with annual work plans and improve submission of highlight reports.
- Develop a medication storage quality improvement strategy
- Continue to refine medicines incident reporting trend analysis and feedback learning
- Reduction of missed medication doses in line with the Trust Quality Priorities
- Deliver medicines related audit framework
- Improve antimicrobial stewardship to reduce antibiotic consumption in line with Serious Infections CQUIN year 2.
- Support safe oxygen administration and improve prescribing compliance
- Support safe implementation of Sunrise (Allscripts) EMPA
- Roll out red allergy wrist band policy
- Develop patient safety medication bulletins to improve staff awareness on high risk medication.

References

1) MHRA Patient Safety Alert. NHS/PSA/D/2014/005. Improving medication error incident reporting and learning. 20 March 2014
2) NICE. Medicines Optimisation Guidance. March 2016. https://www.nice.org.uk/guidance/qs120 {Accessed 21.3.17}

Enclosure 10

The Dudley Group
NHS Foundation Trust

Paper for submission to the Trust Board of Directors on 5 July 2018

TITLE:	**Dudley, Wolverhampton and South Staffordshire Breast Screening Service Annual Report and QA Visit Report**		
AUTHOR:	**Rita Khan Breast Imaging Manager**	**PRESENTER**	**Mr Paul Stonelake Director of Breast Screening**

CLINICAL STRATEGIC AIMS

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

CORPORATE OBJECTIVE:

SO1: Deliver a great patient experience
SO3: Drive service improvements, innovation and transformation
SO6: Deliver a viable future

SUMMARY OF KEY ISSUES:

This report summarises the successes and challenges that the service has experienced over the past year within Dudley, Wolverhampton and South West Staffordshire Breast Screening Services. The results for the service illustrate how all specialties associated with Breast Screening have worked as a multi-disciplinary team in all aspects of screening, assessment and subsequent surgery.

The service received the final QA Visit Report on Wednesday 6 June 2018. The report makes 66 recommendations, of which there are:

- 3 immediate recommendations
- 10 one month recommendations
- 34 three month recommendations
- 17 six month recommendations
- 2 twelve month recommendations

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

RISK	**Y**		**Risk Description:**
	Risk Register: Y		**Risk Score:**
COMPLIANCE and/or LEGAL REQUIREMENTS	**CQC**	**Y**	**Details: Screening Quality Assurance Visit 29 January 2018**
	NHSI	**Y**	**Details:**
	Other	**Y**	**Details:**

The Dudley Group
NHS Foundation Trust

ACTION REQUIRED OF BOARD:

Decision	Approval	Discussion	Other
Y	Y	Y	

RECOMMENDATIONS FOR THE BOARD:

Accept and support large scale change for the Breast Screening Service.

The Dudley Group
NHS Foundation Trust

Dudley, Wolverhampton and South Staffordshire Breast Screening Service

Annual Report

2017-18

Mr Paul Stonelake
Director of Breast Screening

Contents

1. Executive Summary

This report summarises the successes and challenges that the service has experienced over the past year within Dudley, Wolverhampton and South West Staffordshire Breast Screening Services. The results for the service illustrate how all specialties associated with Breast Screening have worked as a multi-disciplinary team in all aspects of screening, assessment and subsequent surgery.

The incidence, mortality and survival rates are of a positive trend and our outcome measures in 2017/18 are a recognition of the challenges the service has had to contend in the last year.

The report also illustrates the challenges and pressures that the service will be facing in the coming year.

2. Introduction

This annual report is for the Dudley, Wolverhampton and South Staffordshire Breast Screening Service and is based on the 36,543 women invited for screening between 1st April 2016 and 31st March 2017, of which 18,561 were offered an appointment within 36 months.

Most women invited were aged between 50-70 years, however women aged between 47-49, and between 71-73 years were also invited, following the national age expansion trial.

Only data for women aged 50-70 has been included in the tables below to allow comparison with other units that have not yet undertaken the age expansion.

Of the women aged 50-70 years 35,543 that were invited, 25,531 attended screening. 1,335 of the screened women were referred for assessment and 309 cancers were diagnosed.

3. Profile and Provision of the Dudley and Wolverhampton Breast Screening Service.

The programme is delivered from the breast unit, which sits within the Radiology Department in Russells Hall Hospital, Dudley and at Cannock Chase Hospital.

Screening occurs on three mobile vans, one within the Dudley area; one in Wolverhampton area and one in the Staffordshire area; in addition to which Cannock Chase Hospital provides a routine screening service within the department. Supplementary appointments and special appointments take place in the breast units located in the Radiology departments of Russells Hall Hospital, New Cross Hospital, and Cannock Chase Hospital. Images and paperwork are transported from the vans back to the relevant Department by secure NHS Trust couriers, on an encrypted portable hard drives.

The reporting of images takes places at Russells Hall Hospital, New Cross Hospital, and Cannock Chase Hospital; dependent upon which screening location the service user was screened at. Ladies images that display any abnormalities, are recalled back to their nearest hospital for further investigations in an Assessment Clinic. A joint weekly MDT takes place on a Wednesday lunchtime between Russells Hall Hospital and New Cross Hospital using video-conferencing, where joint decisions are made regarding treatment; women then see the surgical team from the site that they were assessed at.

There is a full four-tier skill-mix structure in place including assistant practitioners and radiographers for mammography; advanced practitioners undertaking film reading, ultrasound and stereotactic biopsies and four Consultant radiographers participating in all aspects of breast work including MDTs.

The performance of the unit is monitored by the Screening Quality Assurance Service (Midlands and East) who report performance to the national screening office. Monthly and quarterly reports are measured against: uptake, round length, screen to assessment/date of first offered assessment, screen to normal result, technical recall/ repeat rate and clinical nurse specialist workload. The results are discussed at regional Quality assurance meetings, local management meetings and quarterly Programme Board meetings, which are chaired by the commissioner representation.

3.1 Screening Office Management

0.8 WTE Band 8a- Breast Imaging Manager
1.0 WTE Band 4- Office Manager
0.8 WTE Band 4- Deputy Office Manager
1.0 WTE Band 4 Data Coordinator
6.26 WTE Band 2- Clerical Officers (3.26wte posts Dudley, 3wte posts Cannock)

The administration teams in Dudley is responsible for the organisation of batches of clients for screening, printing of all screening letters, along with inviting ladies to attend the assessment clinic at Russells Hall Hospital. There are 2 direct phone lines for patients, one for Dudley office and one for Cannock office.

The data and statistics for the Programme, in liaison with the Quality Assurance Team, are provided by the Screening Offices at Russells Hall Hospital and Cannock Chase Hospital. Wolverhampton Trust also employs 1.8 wte clerical officers who load/unload images for reporting, book appointments for the assessment clinic at Wolverhampton, along with the day book for the Wolverhampton van.

The Breast Imaging Manager employed 0.8wte is also based at Russells Hall Hospital and is responsible for the management of the Programme, working across all three sites. The same administrators on both sites are also responsible for administration of the respective symptomatic services.

3.2 Radiography

The majority of screening radiographers, who work across all sites, are employed by Dudley Trust. This totals:
2.0 wte Consultant Radiographers (band 8c)
1.0 wte advanced practitioner specializing in ultrasound, biopsies and film-reading (band 8a);
1.8 wte advanced practitioner specializing in film-reading (band 7)
0.6 wte specializing in core biopsies; (band 7)
8.8 wte trained screening radiographers (band 6)
5.8 wte assistant practitioners

However, under the sub-contract to Royal Wolverhampton Trust, they also employ 2.0 wte consultant radiographer and 0.8 wte advanced practitioner responsible for the assessment clinics and film-reading at Wolverhampton.

The introduction of the recommended 4-tier system has been continued successfully, although the service is looking to introduce the 5-tier system, by introducing the role of a Band 5 Associate Practitioner, which will help address the national shortage of mammographers.

The service currently has one mammographer undertaking Advanced Practice. There are currently 4 Consultant Radiographers within the service. There is a Clinical Specialist at Russells Hall Hospital who is undertakes film-reading and biopsies.

3.3 Film-reading and Radiology

Screening images are delivered to Russells Hall Hospital, New Cross Hospital and Cannock Chase daily during the week on encrypted hard drives.

Screening images are uploaded using a DIMEX onto the local breast MICAS mini-PACS at Russells Hall Hospital and Cannock Chase Hospital; and onto the Siemens iSite PACS at New Cross. The images are then retrieved onto Securview image reviewers in dedicated film-reading rooms on all sites.

There are currently 4 film reading Consultant Radiographers and 2 film reading Advanced Practitioners across the service. All discordant decisions are made by group consensus decisions. All film-readers participate in monthly interval audit and Performs, along with attending regular MDT sessions.

There is currently no screening Radiologist in post for the Programme, and the future service model has been reviewed and will be based on Consultant Radiographers for the foreseeable future.

3.4 Pathology:

The pathology service at all respective sites provide the required pathology services for the Programme, utilising the 'Technidata' software at New Cross and the 'Masterlab' data at Russells Hall. The lead pathologist at New Cross Hospital is also the regional Quality Assurance Pathologist.

3.5 Surgery and Breast Care Nursing

Screening patients are booked into surgical clinics for the results of their malignant biopsies at the hospital they attended for assessment following joint MDT discussions. Patients with benign results are phoned by breast care nurses with the result for expediency; and offered full support on the phone along with the offer to attend an appointment with a Consultant Surgeon to discuss the result; this is also followed up with a formal written letter and supporting literature.

There are a team of 3 specialised Consultant Breast Surgeons at each site; the lead breast surgeon at Russells Hall is also the Director of Breast Screening.

The Breast Care Nursing team consists of a breast nurse consultant, a lead clinical nurse specialist and four part time Breast Care nurses.

4. Randomised AgeX Trial

The service started the randomised age expansion trial of ladies aged between 47-50 and 70-73 in 2011 and will now be continuing until at least 2020 nationally.

The service has received details of the estimated number of women affected by the national incident, they are as follows:

NHSE Region	SO Name	SO	AgeX?	Migration Complete?	70-71	72-74	75-79	Total
Midlands & East	Dudley, Wolverhampton & South West Staffordshire	MDU	Y	N	**577**	**910**	**1,387**	**2,874**

NHSE has advised the service to assume 100% uptake for women ages 70-71, and 80% uptake for women aged 72-74 and 75-79.

The service has appointed the first cohort of 577 women (aged 70-71) from week commencing 2 July 2018, and they will have screening completed by the end of July as per national requirements.

Following on from this cohort, the service will be appointing women aged 72-79 that have contacted the Public Health England Helpline, currently only 36% of this cohort have contacted the helpline.

The first Assessment Clinic that will take place for these women is scheduled for Saturday 21 July 2018 at Russells Hall Hospital and at New Cross. Assessment sessions will take place on a fortnightly basis and if we have unused appointment slots in our normal working day then then these women will be allocated these appointments.

5. Breast Screening Performance

The service has struggled with round length performance and screen to assessment for a number of years; however, during 2018/19 the service has made considerable progress in improving round length and screen to assessment, with recovery plans in place.

Dudley & Wolverhampton - consolidated 3 yr performance summary 1 April 2014 to 31 March 2017							
KPI	Standard	Activity data	Local performance				National standards
			14/15	15/16	16/17	14-17	
Screen round length	The percentage of women whose first offered appointment is within 36 months of their previous screen	Previously screened	17,904	17,923	18,167	**53,994**	
		FOA ≤36m	16,966	14,515	11,049	**42,530**	
		FOA ≤36m (%)	**94.8**	**81.0**	**60.8**	**78.8**	**Minimum ≥90% Achievable 100%**
Waiting time for results	The percentage of women who are sent their result within 2 weeks	Screened	19,996	20,547	20,054	**60,597**	
		Result ≤2 weeks	19,686	19,607	19,708	**59,001**	
		Result ≤2 weeks (%)	**98.4**	**95.4**	**98.3**	**97.4**	**Minimum ≥90% Achievable 100%**
Technical recall/ repeat	The number of repeat examinations	Screened	21,084	21,735	21,321	**64,140**	
		Tech recalls/repeats	321	343	425	**1,089**	
		Tech recalls/repeats (%)	**1.52**	**1.58**	**1.99**	**1.70**	**Minimum <3% Achievable <2%**
Waiting time for assessment	The percentage of women who attend an assessment centre within 3 weeks of attendance for the screening mammogram	Assessed	966	1,083	1,133	**3,182**	
		Assessed ≤3 weeks	873	925	1,029	**2,827**	
		Assessed ≤3 weeks (%)	**90.4**	**85.4**	**90.8**	**88.8**	**Minimum ≥90% Achievable 100%**

Achieved minimum standard and achievable standard | Achieved minimum standard but failed achievable standard | Failed both minimum standard and achievable standard

5.1 Coverage (53-70 years)

Coverage is defined as the percentage of women aged 53-70 on the index date (e.g.last day in March each year) resident in each upper tier local authority (excluding those ineligible) who have been screened in the previous 3 years. The acceptable standard is 70%. Dudley, Wolverhampton and South West Staffordshire Breast screening service managed to exceed this minimum standard at 75%.

Upper tier LA	2013/14 % Coverage	2014/15 % Coverage	2015/16 % Coverage
Dudley	75.8	76.0	75.3
Wolverhampton	70.4	71.9	71.3
Staffordshire	79.4	78.5	78.4
Midlands and East	**77.6**	**77.2**	**77.1**

5.2 Uptake (45-70 years)

The minimum standard is ≥70%, and the achievable standard is ≥ 80%. The minimum standard for overall uptake in women aged 50-70 was not met during 2016/17, nor was it met for quarter 2 of 2017/18.

Dudley, Wolverhampton & South West Staffordshire uptake activity 01/04/2014 to 30/09/2017	Prevalent screen (Table A)						Incident screen (Table C1)			Overall (KPI) Tables A-C2		
	Age 45-49			Age 50-52			Age 53-70			Age 50-70		
	Invited	Screened		Invited	Screened		Invited	Screened		Invited	Screened	
	No.	No.	Uptake %	No.	No.	Uptake %	No.	No.	Uptake %	No.	No.	Uptake %
Apr 2014 to Mar 2015	1,954	1,340	68.6	1,867	1,328	71.1	14,326	12,740	88.9	24,623	17,727	72.0
Apr 2015 to Mar 2016	1,968	1,393	70.8	1,646	1,181	71.7	13,813	12,350	89.4	24,809	18,055	72.8
Apr 2016 to Mar 2017	2,267	1,380	60.9	1,918	1,312	68.4	14,160	12,304	86.9	25,900	17,655	68.2
New KPI measures from 1 April 2017	**Prevalent screen (Table A)**						**Incident screen (Table C1)**			**Overall (KPI) Tables A-C2**		
	Age 45-49			**Age 45-52**			**Age 50-70**			**Age 50-70**		
	Invited	Screened		Invited	Screened		Invited	Screened		Invited	Screened	
	No.	No.	Uptake %	No.	No.	Uptake %	No.	No.	Uptake %	No.	No.	Uptake %
Q1 Apr to Jun 2017	650	424	65.2	1,046	687	65.7	5,451	4,515	82.8	7,625	5,365	70.4
Q2 Jul to Sep 2017	1,329	861	64.8	2,753	1,896	68.9	6,498	5,396	83.0	10,776	7,179	66.6

5.3 Round Length (50-70 years)

Round Length is defined as the number of women who are re-invited within 36 months for breast screening. In 2016/17 the service was below the minimum standard. In 2017/18 the service remained below the minimum standard. However, during quarter 2 2018 and quarter 3 2018n the service has improved performance from 41.1% to 79.3%, with a recovery plan to further improve to 99% by December 2018.

Screen round length data 01/04/2014 to 31/10/2017 (age 50-70) Weeks obtained minimum standard ≥ 90%						
Period	**Total invited**	**Total Invited within 36m of Previous Screen ≤36m**		**36m + 3 wks**	**36m + 4 wks**	**36m + 11 wks**
		No.	**%**	**%**	**%**	**%**
Apr 2014 to Mar 2015	17,904	16,966	94.8	-	-	-
Apr 2015 to Mar 2016	17,923	14,515	**81.0**	-	92.5	-
Apr 2016 to Mar 2017	18,167	11,049	**60.8**	93.0	-	-
Q1 Apr to Jun 2017	5,817	5,743	98.7	-	-	-
Q2 Jul to Sep 2017	7,397	3,063	**41.4**	-	-	91.4
October 2017	3,442	1,707	**49.6**	-	-	99.3

5.4 Time from screen to normal results (all ages)

The service exceeded the minimum standard of over 95% of women receiving their results within two weeks of their screening appointment, up to and including the second quarter of 2017/18. The NHSBSP minimum standard of 90% increased to 95% from April 2017.

In October 2017 the minimum standard was not met due to annual leave and sickness. Additionally, records were not being closed until consensus had taken place. A cross-site reporting process has now been agreed and implemented to prevent future slippage and a policy is being written to reflect this new film reading process.

Waiting times for results of screening 01/04/2014 to 31/10/2017									
Time period	≤ 2 weeks		≤ 3 weeks		≤ 4 weeks		> 4 weeks		Total
	No.	%	No.	%	No.	%	No.	%	
Apr 2014 to Mar 2015	19,686	98.4	189	99.4	58	99.7	63	100.0	19,996
Apr 2015 to Mar 2016	19,607	95.4	629	98.5	190	99.4	121	100.0	20,547
Apr 2016 to Mar 2017	19,708	98.3	147	99.0	87	99.4	112	100.0	20,054
Q1 Apr to Jun 2017	5,743	98.7	41	99.4	21	99.8	12	100.0	5,817
Q2 Jul to Sep 2017	7,860	96.3	174	98.4	96	99.6	31	100.0	8,161
October 2017	2,146	72.7	695	96.3	58	98.2	52	100.0	2,951

5.5 Time from screen to assessment (all ages)

The NHSBSP minimum standard changed from April 2017 for this KPI, ≥ 98% of women should be offered an Assessment appointment with 3 weeks of their screen. The service fell below the minimum standard of ≥ 98% of women offered an assessment appointment within 3 weeks of their screen in quarter 1 and quarter 2 of 2017/18 and in October 2017.

Time from screen to actual assessment and time from screen to DOFOaA 01/04/2014 to 31/10/2017																						
Time period	Actual assessment ≤ 3 weeks		DOFOaA assessment ≤ 3 weeks		Actual assessment ≤ 4 weeks		DOFOaA assessment ≤ 4 weeks		Actual assessment ≤ 5 weeks		DOFOaA assessment ≤ 5 weeks		Actual assessment ≤ 6 weeks		DOFOaA assessment ≤ 6 weeks		Actual assessment >6 weeks		DOFOaA assessment >6 weeks		Total assess	Total FOa assess
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%		
Apr 2014 to Mar 2015	873	90.4	967	99.4	54	96.0	5	99.9	17	97.7	1	100.0	7	98.4	0	100.0	15	100.0	0	100.0	966	973
Apr 2015 to Mar 2016	925	85.4	1,035	94.9	96	94.3	37	98.3	33	97.3	17	99.8	10	98.2	1	99.9	19	100.0	1	100.0	1,083	1,091
Apr 2016 to Mar 2017	1,029	90.8	1,120	98.3	58	95.9	10	99.2	26	98.2	6	99.7	12	99.3	2	99.9	8	100.0	1	100.0	1,133	1,139
Q1 Apr to Jun 2017	260	86.4	303	97.1	29	96.0	8	99.7	6	98.0	0	99.7	6	100.0	1	100.0	0	100.0	0	100.0	301	312
Q2 Jul to Sep 2017	178	46.2	210	51.1	116	76.4	115	79.1	56	90.9	67	95.4	16	95.1	16	99.3	19	100.0	3	100.0	385	411
October 2017	44	31.0	48	33.8	35	55.6	42	63.4	40	83.8	41	92.3	11	91.5	9	98.6	12	100.0	2	100.0	142	142

5.6 Technical Recall / Technical Repeat (all ages)

Dudley, Wolverhampton and South West Staffordshire breast screening service met the minimum standard for technical recall/repeat rate for the whole time period.

6. Quality Assurance Visit 29 January 2018

The service had a challenging Quality Assurance (QA) visit on 29 January 2018, which was carried out by PHE screening quality assurance service (SQAS). The visit aims to maintain national standards and promote continuous improvement in breast screening. This is to ensure that all eligible people have access to a consistent high quality service wherever they live.

The QA visit team identified 3 immediate concerns and a letter was sent to the Chief Executive on 30 January 2018. All three recommendations were resolved within 7 days.

The service received the final QA Visit Report on Wednesday 6 June 2018. The report makes 66 recommendations, of which there are:

- 3 immediate recommendations
- 10 one month recommendations
- 34 three month recommendations
- 17 six month recommendations
- 2 twelve month recommendations

6.1 Immediate Recommendations

As detailed at the previous Programme Board, all immediate recommendations have been completed and appropriate governance has been implemented. (See Appendix A).

6.2 One Month Recommendations

All one month recommendations have also been completed and appropriate governance has been implemented. (See Appendix B)

6.3 Three Month Recommendations

10 three month recommendations have been completed, 5 are in progress, and the remaining 19 three month recommendations area waiting to be commenced. (See Appendix C).

6.4 Six and Twelve Month Recommendations

The Programme Manager is currently reviewing these recommendations to develop the associated action plans.

Furthermore, there were thirteen high priority findings following the QA visit, these are summarised below:

1. Formalise the governance arrangements between the 2 NHS trusts to support optimal working.
2. Review and revise the management structure for the service.
3. Undertake regular and timely audits on the National Breast Screening System (NBSS).
4. Identify workforce, skills, and capacity at each site required to deliver agreed model, particularly in relation to screening office management, mammography and radiology. The service is currently running with only 52% of its recommended establishment for mammographers and have 1 radiologist in post.
5. Ensure all electronic data and images are transferred between sites on encrypted devices.
6. Ensure regular and timely reports are produced and actioned on BS Select.

7. Implement monthly failsafe.
8. Ensure the screening round plan is fit for purpose and accurate.
9. Ensure physical separation of routine recall and arbitration / recall to assessment cases at Russells Hall Hospital.
10. Outcomes of all consensus discussions to be entered onto NBSS by film readers.
11. Agree a single film reading policy and uniformly implement it across all sites.
12. Ensure that women are offered an assessment appointment in accordance with national guidance.
13. Reduce the prevalent recall to assessment rate in line with national targets.

7. Service Update at Programme Board 14 June 2018

7.1 Workforce

The QA visit highlighted the lack of resources within the service which is impacting on delivering a successful screening service. There are three key areas that have been identified as weaknesses within the service: 1. Mammography; and 2. Screening Office management and structure; 3. Programme Management.

The service is currently advertising for the following roles:

- Superintendent Radiographer 1wte, Band 8A
- Advanced Practitioner 2wte, Band 7
- Clinical Specialist – Mammography 1wte, Band 8A
- Mammographer 2.2wte, Band 6

A funding request from DGH Finance has been submitted to NHSE Commissioners. The request has not yet been approved. The commissioners have requested that the service submits a detailed business case. Following this submission the commissioners have stated that in the first instance they would like to conduct an 'open book exercise'. Until this process has been completed and funding approved, the service will not be able to complete the proposed restructure, nor recruit to any further posts due to insufficient funding. This subsequently will continue to impact upon service performance.

7.2 Round Plan

The Programme Manager has updated the current round plan and placed into a new format that is 'user friendly' for the screening office staff. The updated round plan is reflective of the round length slippage and has realistic estimated screening dates for each GP Practice based upon our current workforce establishment.

The Programme Manager has a plan to recover round length by December 2018 and has commenced work on the 'new' round plan for the service. Currently the Programme Manager is at the 'mapping stage'.

7.3 Failsafe Programme Batches

The service has appointed all women from the backlog of batches from the Failsafe Programme. All women from this cohort will have been screened by Saturday 30 June 2018.

The service has now resumed monthly failsafe batches as per NHSBSP Failsafe Programme guidelines, effective from Friday 25 May 2018.

7.4 Service Reconfiguration – Cannock Site

The ultrasound machine is due to be delivered to Cannock w/c 18 June 2018 and will be subject to Medical Physics tests before it can utilised.

The service is proposing to commence its first Assessment Clinic on Monday 2 July 2018, consisting 2-3 patients in the first instance. It is anticipated that this will be successful, hence full Assessment Clinics will then commence from Monday 9 July 2018.

7.5 High Risk Breast Screening

The service has cleared the backlog of women that were awaiting high risk surveillance.

Furthermore, there has been some confusion in regards to the referral process for high risk women. City Hospital were arranging an appointment with a Clinician first and then an MRI appointment. The service has clarified with City Hospital, that women referred from our service only require an MRI appointment. This should now alleviate the delays and reduce patient complaints.

7.6 Addressing Health Inequalities

The service currently does not have a strategy to address health inequalities and raise the uptake of the breast screening Programme, although the Programme Manager will be developing one as per QA recommendations.

However, one of our mammographer's has an interest in raising breast awareness and increasing the profile of the breast screening Programme for our residing population. She has undertaken two public breast awareness sessions, the first occasion was in conjunction with City, Sandwell and Walsall Breast Screening Service at the Pentecostal Church, Dudley; and the second occasion was with DGH Consultant Breast Care Nurse at Dudley Council House.

8. Action Plans Commencing 2018

8.1 Address QA recommendations.

8.2 Devise a robust Business Case to request additional funding from Commissioners to support:

- 8.2.1 Restructure the Programme management and administration functions of the service.
- 8.2.2 Increase clinical establishment of the service.
- 8.2.3 Recruit to additional posts throughout the Programme.

8.3 Streamline High Risk Programme - identify high-risk individuals and enter into screening programme; ensuring that all of the information required is returned for MRI Centres.

8.4 Devise Health Inequalities Strategy and work closely with other agencies to ensure that health inequalities activities takes place within target areas to encourage ladies to attend for their breast screening appointment.

9. Issues

9.1 Accommodation remains an issue for expansion of the service, with additional film-readers requiring a dedicated film reporting office and relocating the administration team to another larger office, which has currently not yet been identified.

9.2 Radiography and radiology staffing is currently an issue throughout the Programme/ nationally with poor uptake to advertisements, putting the Programme at risk. Currently the service will be focusing on recruiting trainee mammographers to rebuild workforce and introducing the 5 tier skill mix with an introduction of the Associate Practitioner's role.

9.3 Finding new screening locations to coincide with the new service round plan once complete will be challenging process.

Appendix A: Immediate Recommendations

Ref	Key Task	Reference	Timescale	Priority	Evidence Required	Update April 2018	Contact
8	Review and appropriately action the 6 cases identified as part of the pre-visit reviews as having incomplete episodes. Consideration should be given where women have experienced significant delays	NHSBSP 47	Immediate	Immediate	Confirm the action taken for of the 6 women identified.	All patients resolved and actioned appropriately.	Paul Stonelake Rita Khan
21	Fully complete the PACS pre-visit questionnaire relating to arrangements and facilities for the management of breast screening images at The Royal Wolverhampton NHS Trust	Programme Specific Operating Model for Quality Assurance of Breast Screening Programmes	Immediate	Immediate	Submission of a fully completed PACS pre-visit questionnaire.	PACS questionnaire completed.	Paul Stonelake Rita Khan
40	Cease the current practice of staff insecurely transferring patient identifiable information between sites on hospital shuttle bus service.	NHSCSP Information Security Policy	Immediate	Immediate	Confirm that this practice has ceased and provide an outline of the secure process now in place.	Practice ceased and secure Trust courier service implemented.	Paul Stonelake Rita Khan

Appendix B: One Month Recommendations

Ref	Key Task	Reference	Timescale	Priority	Evidence Required	Update April 2018	Update May 2018	Contact
23	Ensure all electronic data and images are transferred between sites on encrypted devices.	NHSCSP Information Security Policy	1 month	High	Confirm that all devices used for data and image transfer are fully encrypted	The service can confirm that all devices used to transfer patient data between sites are encrypted. This includes USB devices and Dimex's.		Rita Khan
27	Implement monthly failsafe	Service Specification number 24	1 month	High	Confirm failsafe is being undertaken monthly and that the backlog of women have been appointed appropriately.	Failsafe backlog will be cleared by the end of June 2018. Monthly failsafe to recommence on 25 May 2018.		Rita Khan
31	Ensure the screening round plan is fit for purpose and accurate	NHSBSP 47	a) 1 month b) 3 months	High	a) Confirmation that the electronic screening plan has been accurately updated to reflect when GP Practices will be invited. b) Copy of the revised round plan, including details of the recovery plan along with estimated dates for achieving 90% within 36 months standard.	a) Current screening plan has been updated to reflect when GP Practices will be invited. b) The Breast Imaging Manager has acquired agreement from the commissioners to combine this recommendation with the 6 month recommendation of 'developing a new forward screening round plan'. The new forward screening round plan (6 months) will rectify the Round Length performance for the service, as all 'previous screened dates' will be reviewed as part of this process. The new plan will also have capacity built in for population growth, the Failsafe Programme, the High Risk Programme, Second timed appointments, equipment service dates, mobile moves and slippage for equipment breakdowns. Currently none		Rita Khan

						of these are factored in the screening round plan.		
32	Ensure all women are offered a timely second timed appointment and address the current backlog.	Service Specification number 24	1 month	Standard	Details of how the backlog of second timed appointments were managed. Confirm plan in place to accommodate second timed appointments going forward.	The Programme Manager has acquired agreement from the commissioners to suspend this facet of the contract for a period of 6 months. The service will not be issuing women that have DNA'd their first appointment, a second timed appointment. Instead the lady will be issued with a 'DNA' letter and the responsibility will then be upon the lady to contact the Service to make another appointment. this will now allow the service to focus its efforts and capacity on the 'Failsafe women' and improving Round Length performance for Routine screening ladies.		Rita Khan

35	Ensure training of the Eklund Technique is completed for all mammographers	NHSBSP Screening women with Breast Implants	1 month	Standard	Confirm that all mammographers have viewed the DVD and read the guidance.	11 out of 15 mammographers have viewed the DVD. Guidance will be disseminated at the next staff meeting on Thursday 5th April 2018.	All mammographers have viewed the DVD and guidance has been disseminated to all clinical staff.	Rita Khan
41	Ensure suitable facilities for film reading at Russell's Hall Hospital	NHSBSP 55	1 month	High	Confirm the changes made and that the environment is suitable for reporting	This is in progress. Office space is being negotiated within Imaging so that suitable Film Reporting environment can be made available.	Dedicated Film Reporting environment has now been implemented.	Julie Whiles
42	Ensure physical separation of routine recall and arbitration / recall to assessment cases at Russell's Hall Hospital.	NHSBSP 55	1 month	High	Confirmation that the screening packets are separated by film readers according to required action, prior to being passed to the screening office.	A meeting had been scheduled to take place on Friday 2nd March 2018 with colleagues from Royal Wolverhampton NHS Trust, to discuss the above recommendations and agree a single way of working in regards to these specific areas. However, due to adverse weather the meeting was cancelled. The service will be rearranging this meeting, with a view to make this a regular 'meeting' that takes place on a monthly basis. Once this meeting has been rescheduled, these recommendations will be actioned. Provisional date 27th April - awaiting confirmation from all parties.	Service met with RWT colleagues on Friday 4 May 2018. A single film reading process has been agreed and policy is being drafted.	Paul Stonelake, Rita Khan
43	Outcomes of all consensus discussions to be entered onto NBSS by film readers.	Service Specification number 24	1 month	High	Confirmation that the film readers enter the consensus discussion outcome onto NBSS and that this is documented in a work instruction.	A meeting had been scheduled to take place on Friday 2nd March 2018 with colleagues from Royal Wolverhampton NHS Trust, to discuss the above recommendations and agree a single way of working in regards to these specific areas. However, due to adverse weather the meeting was cancelled. The service will be rearranging this meeting,	New Film Reading Process for reporting and Consensus agreed on Friday 4 May 2018 and implemented at all sites. Beverley Moran (RHH) will be writing the new policy for film reading.	Rita Khan

						with a view to make this a regular ‘meeting’ that takes place on a monthly basis. Once this meeting has been rescheduled, these recommendations will be actioned. Provisional date 27th April - awaiting confirmation from all parties.		

44	Agree a single film reading policy and uniformly implement all sites	NHSBSP 55	1 month	High	Copy of cross-site film reading policy and conformation from all sites that the policy is being followed. The process should include: a) physical separation of the screening packets for recall and arbitration at the time of second read b) entering the consensus opinion into NBSS by the readers at the time the decision is made c) a process and documentation for the retrieval of previous images	A meeting had been scheduled to take place on Friday 2nd March 2018 with colleagues from Royal Wolverhampton NHS Trust, to discuss the above recommendations and agree a single way of working in regards to these specific areas. However, due to adverse weather the meeting was cancelled. The service will be rearranging this meeting, with a view to make this a regular 'meeting' that takes place on a monthly basis. Once this meeting has been rescheduled, these recommendations will be actioned. Provisional date 27th April - awaiting confirmation from all parties.	New Film Reading Process for reporting and Consensus agreed on Friday 4 May 2018 and implemented at all sites. Beverley Moran (RHH) will be writing the new policy for film reading.	Rita Khan
49	Ensure that all short-term recall cases have imaging of both breasts	NHSBSP 49	1 month	Standard	Evidence of communication to all assessors and confirmation that guidance is being followed	A meeting had been scheduled to take place on Friday 2nd March 2018 with colleagues from Royal Wolverhampton NHS Trust, to discuss the above recommendations and agree a single way of working in regards to these specific areas. However, due to adverse weather the meeting was cancelled. The service will be rearranging this meeting, with a view to make this a regular 'meeting' that takes place on a monthly basis. Once this meeting has been rescheduled, these recommendations will be actioned. Provisional date 27th April - awaiting confirmation from all parties.	Imaging of both breasts for short-term recall ladies implemented at all sites.	Rita Khan

Appendix C: Three Month Recommendations

Ref	Key Task	Reference	Timescale	Priority	Evidence Required	Update April 2018	Update May 2018	Contact
1	Director of Breast Screening to present the QA Visit report at a Trust Executive Board Meeting at both Sites	NHSBSP 40	3 months	Standard	Trust Executive Board meeting minutes	Scheduled for Tuesday 26 June 2018.		Paul Stonelake
2	Appoint an imaging lead to provide professional support to the Director of Breast Screening	Service Specification number 24	3 months	Standard	Confirmation of appointment and allocated time within job plan	Imaging lead appointed - Beverley Moran. Job plan to be amended to reflect this.		Rita Khan
4	Revise the staffing structure supporting the programme management, screening office functions and mammography team to ensure all key functions are being delivered in a timely fashion at all sites	Service Specification number 24	3 months	High	Revised staffing structure with an outline of key roles and responsibilities including scope of practice for advanced practitioners.	Staffing structure has been revised. Job descriptions are awaiting 'job matching' with Dawn Wood. Funding request has also been submitted to commissioners. Commissioners would lie to meet with the Breast Screening Management team and a Trust Executive before any funding will be approved.		Rita Khan

7	Undertake regular and timely audits on NBSS	NHSBSP 47	3 months 12 months	High Standard	a) Comprehensive audit schedule to include frequencies of reports run, plus 3 months evidence of audit reports for compliance b) 12 month audit demonstrating compliance with the schedule.		a) NBSS Audit reports implemented: SASP4 for every clinic, SASP5 run 3 times per week, SASP7 run weekly, Disaster recovery run daily. B) Audit schedule being developed.	Rita Khan
10	Undertake a staffing capacity review of the whole programme across all sites	Service Specification number 24	3 months	High	Report of staffing review and future plans including: a) review of screening office staff across all sites. b) Agree a workforce plan for mammography staffing including succession planning. c) Agree a workforce plan for radiology staffing including succession planning.	Staffing structure has been revised. Job descriptions are awaiting 'job matching' with Dawn Wood.	Staffing structure has been revised. Job descriptions are awaiting 'job matching' with Dawn Wood. Funding request has also been submitted to commissioners. Commissioners would like to meet with the Breast Screening Management team and a Trust Executive before any funding will be approved. Superintendent Radiographer is currently being advertised.	Rita Khan

11	Complete the final section of the equipment handover form when a unit is accepted back into clinical use.	HSE Requirement Report PM77	3 months	Standard	Confirmation that handover forms are fully completed			
12	Ensure radiation protection supervisors are trained and appointed for all sites.	IRR17	3 months	Standard	Letters of appointment and evidence of training.			
14	Ensure all medical physics tests are undertaken.	NHSBSP 0604	3 months	Standard	Evidence that all tests required by the NHSBSP have been implemented.			Mark Rawson
15	Clarify responsibilities for managing user QC across all sites and ensure sufficient user QC radiographers are appointed.	NHSBSP guidance for breast screening mammograp-hers (replaces 63)	3 months	Standard	Organogram showing user QC responsibilities across all sites.			
16	Develop a new user QC spreadsheet template for use at all hospital sites.	NHSBSP 1303 and 63	3 months	Standard	Copy of new user QC spreadsheet template and confirmation that this is in use at all hospital sites, with old versions having been removed.			
17	Undertake user QC update training to ensure practice is aligned across all sites.	NHSBSP 63	3 months	Standard	Evidence of update training.			
18	Obtain a suitable object to undertake stereo testing at	NHSBSP 63	3 months	Standard	Confirmation of a suitable stereo test object in use.			

	Russells Hall Hospital							
19	Revise user QC work instructions to ensure that all testing complies with NHSBSP requirements	NHSBSP 63 and NHSBSP 1303	3 months	Standard	Copy of revised work instructions to reference: a) correct positioning when testing each needle in stereo mode. b) the latest signal to noise (SNR) and contrast to noise (CNR) tolerances. c) The grey level set for artefact evaluation for each mammography unit and filter, along with frequency of testing.			

20	Ensure PACS processes are optimal across all sites	Service Specification number 24	3 months	Standard	Confirmation of review completed, changes implemented and processes in place to include: a) agreed work instructions for pre-reading procedures, utilising appropriate functionality within NBSS. b) staffing support to cover all functions			
22	Agree a lead organisation and member of staff, for each piece of equipment or software used for breast screening.	Service Specification number 24	3 months	Standard	Copy of the completed agreed flowchart.			
24	Review current administrative provision and structure to provide appropriate facilities and resilient succession planning.	NHSBSP 47	3 months	Standard	Outcome of staffing review to detail administrative support at each of the 3 hospital sites including data input and audit.	Staffing structure has been revised. Job descriptions are awaiting 'job matching' with Dawn Wood. Funding request has also been submitted to commissioners. Commissioners would lie to meet with the Breast Screening Management team and a Trust Executive before any funding will be approved.	Staffing structure has been revised. Job descriptions are awaiting 'job matching' with Dawn Wood. Funding request has also been submitted to commissioners. Commissioners would like to meet with the Breast Screening Management team and a Trust Executive before any funding will be approved.	Rita Khan

25	Ensure a robust induction process is in place for all administration staff	NHSBSP 47	3 months	Standard	Copy of Skills Matrix and confirm implementation across all staff.		Currently being developed.	Rita Khan
26	Ensure regular and timely monitoring reports are produced and actioned on BS Select.	Service Specification number 24	3 months	High	Comprehensive audit schedule to include frequencies for each monitoring report plus 3 months evidence of audit reports for compliance.		Backlog of reports are being actioned and schedule being developed for actioning of reports.	Rita Khan
28	Ensure Open Episodes are actioned appropriately and timely	NHSBSP 47	3 months	Standard	Confirm the process is in place for the routine closure of episodes and for routine checks.	Open Episode's report is currently being actioned.	Open Episode Audit is complete. SASP4 implemented as part of results process, SASP5 is run 3 times per week, and SASP7 weekly for clinic reconciliation.	Rita Khan
29	Send a GP Pack to each Practice 6 weeks prior to selection of the batch	NHSBSP 47	3 months	Standard	Copy of GP Pack and confirmation it is routinely sent out to all GP Practices.			
30	Clear the backlog of high risk clients awaiting surveillance.	NHSBSP 74	3 months	Standard	Confirm all women have been appropriately actioned.	All clients have been actioned appropriately. There is no further backlog to be cleared. All new referrals are being actioned effectively in a timely manner.		Rita Khan

31	Ensure the screening round plan is fit for purpose and accurate	NHSBSP 47	a) 1 month b) 3 months	High	a) Confirmation that the electronic screening plan has been accurately updated to reflect when GP Practices will be invited. b) Copy of the revised round plan, including details of the recovery plan along with estimated dates for achieving 90% within 36 months standard.	a) Current screening plan has been updated to reflect when GP Practices will be invited. b) The Programme Manager has acquired agreement from the commissioners to combine this recommendation with the 6 month recommendation of 'developing a new forward screening round plan'. The new forward screening round plan (6 months) will rectify the Round Length performance for the service, as all 'previous screened dates' will be reviewed as part of this process. The new plan will also have capacity built in for population growth, the Failsafe Programme, the High Risk Programme, Second timed appointments, equipment service dates, mobile moves and slippage for equipment breakdowns. Currently none of these are in the screening plan.		Rita Khan
34	Complete regular image quality assessment at service level in line with NHSBSP guidance.	NHSBSP guidance for breast screening mammographers	3 months	Standard	Confirm that a schedule is in place accordance with NHSBSP guidance			

36	Risk assess lone working and develop a policy that covers all sites	Society of Radiographers - Violence and Aggression at Work (including lone working)	3 months	Standard	Confirm the risk assessment has been undertaken and provide a copy of the agreed lone working policy.			
37	Risk assess musculoskeletal disorders and develop a policy which covers all sites	NHSBSP guidance for breast screening mammographers	3 months	Standard	Confirm the risk assessment has been undertaken and provide a copy of the agreed policy.			
38	Identify a training lead to support the coordination of training within the mammographic workforce	NHSBSP guidance for breast screening mammographers	3 months	Standard	Confirmation that a training lead has been identified and that the job description is reflective of the new responsibility.	Two mammographers have attended the 'Clinical Educator in Mammography' course at Nottingham University and are mentoring the training of two new trainee mammographers.		Rita Khan
45	Ensure that women are offered an assessment appointment in accordance with NHSBSP standard	NHSBSP consolidated standards	3 months	High	Copy of the action plan to achieve at least 98% of women offered an assessment appointment within 3 weeks of their mammogram.		Workload and recall rate is currently being reviewed. Service performance for Screen to Assessment is currently 98%.	Rita Khan

47	Agree a cross-site practice for assessment	NHSBSP 49	3 months	Standard	a) a copy of the agreed assessment policy b) a policy for second review of cases discharged to routine recall at assessment and a process for recall from second review. c) confirmation that these policies have been agreed at all sites			
48	Put in place a standard process for the timely review of interval cancers and previously assessed (screen detected and interval cancers) across all sites.	NHSBSP Reporting classification and monitoring of interval cancers following previous assessment. NHS Screening Programmes Guidance in applying duty of candour and disclosing audit results	3 months	Standard	a) a cross site policy for the review of interval cancers including timeframes for reviews b) a cross site policy for the review of previously assessed interval and screen detected cancers c) confirms the process for applying duty of candour and disclosure of audit has been implemented on both sites	A meeting had been scheduled to take place on Friday 2nd March 2018 with colleagues from Royal Wolverhampton NHS Trust, to discuss the above recommendations and agree a single way of working in regards to these specific areas. However, due to adverse weather the meeting was cancelled. The service will be rearranging this meeting, with a view to make this a regular 'meeting' that takes place on a monthly basis. Once this meeting has been rescheduled, these recommendations will be actioned. Provisional date 27th April - awaiting confirmation from all parties.	For discussion at Radiology meeting scheduled for 14 June 2018.	
50	Preparation time for radiological review of images before the multidisciplinary meeting is to made	Cancer multidisciplinary team meetings - standards for	3 months	Standard	Copy of radiologist and consultant radiographer job plans with amendments			

	available within job plans	clinical radiologists RCR 2014			highlighted.			
54	Ensure all pathologists meet the continuing professional development (CPD) requirements of the NHSBSP	NHSBSP 2	3 months	Standard	Evidence of attendance			
59	Ensure adequate staffing arrangements are in place to cover periods in which the CMS is unavailable at the Royal Wolverhampton NHS Trust	NHSBSP 29	3 months	Standard	Confirmation of arrangement		Breast Care Nurses at RWT are still under resourced, no plan currently in place.	Margaret Casey
61	Ensure that the multidisciplinary team meetings held at Russell's Hall Hospital operate in line with local specification and national guidance.	The Characteristics of an Effective Multidisciplinary Team (MDT)	3 months	Standard	Confirmation that the MDT record is validated in real time and the record is immediately available to the team in clinical areas.			
64	Ensure all clinical information at Royal Wolverhampton NHS Trust is uploaded to the clinical portal in a timely manner and available in patient notes.	NHBSP 20	3 months	Standard	Confirm the process is in place and is working satisfactorily.			

Public Health England

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Diane Wake
Chief Executive
The Dudley Group NHS Foundation Trust
Russells Hall Hospital
Pensnett Road
Dudley
DY1 2HQ

6 June 2018

Dear Ms Wake,

Re: Final report on the Quality Assurance (QA) team visit to Dudley, Wolverhampton and South West Staffordshire breast screening service on 29 January 2018

Please find enclosed the Dudley, Wolverhampton and South West Staffordshire breast screening service QA visit report from the QA visit made on 29 January 2018.

The report will be circulated to all key stakeholders within the breast screening programme as per the distribution list below.

Within the next 4 weeks we will expect the breast screening service to develop an action plan to address the recommendations made within the report and to provide a response to the recommendations according to the following timescales:

- 1 month recommendations by **6 July 2018**
- 3 month recommendations by **6 September 2018**
- 6 month recommendations by **6 December 2018**
- 12 month recommendations by **6 March 2019**.

Consent to publish the executive summary of the report on the gov.uk website has been given and will be processed accordingly.

If you have any queries please contact me.

Yours sincerely,

Olive Kearins
Head of QA, Midlands & East

Encs.

cc Paul Stonelake, Director of Breast Screening
Rita Khan, Breast Imaging Services Manager

Karen Kelly, Chief Operating Officer
Julian Hobbs, Interim Medical Director
Andrew McMenemy, Director of Human Resources
Alec Wolinski, Clinical Director
Julie Whiles, Radiology Manager

David Loughton CBE, Chief Executive (The Royal Wolverhampton NHS Trust)
Gwen Nuttall, Chief Operating Officer
Jonathan Odum, Medical Clinical Director
Sanjay Vydianath, Clinical Director
Stuart Simper, Radiology Manager
Kerry Davies, Cancer Services Manager

Karen Davis, Interim Head of Commissioning, NHS England
Nicola Benge, Screening & Immunisation Lead, NHS England (West Midlands)
Joanne Wood, Screening and Immunisation Manager
Neena Venu-Gopal, Screening and Immunisation Coordinator

Visiting QA team

Public Health England

NHS

Screening Quality Assurance visit report

NHS Breast Screening Programme Dudley, Wolverhampton & South West Staffordshire

29 January 2018

Public Health England leads the NHS Screening Programmes

About Public Health England

Public Health England exists to protect and improve the nation's health and wellbeing, and reduce health inequalities. We do this through world-class science, knowledge and intelligence, advocacy, partnerships and the delivery of specialist public health services. We are an executive agency of the Department of Health, and are a distinct delivery organisation with operational autonomy to advise and support government, local authorities and the NHS in a professionally independent manner.

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About PHE Screening

Screening identifies apparently healthy people who may be at increased risk of a disease or condition, enabling earlier treatment or better informed decisions. National population screening programmes are implemented in the NHS on the advice of the UK National Screening Committee (UK NSC), which makes independent, evidence-based recommendations to ministers in the 4 UK countries. The Screening Quality Assurance Service ensures programmes are safe and effective by checking that national standards are met. PHE leads the NHS Screening Programmes and hosts the UK NSC secretariat.

www.gov.uk/phe/screening
Twitter: @PHE_Screening Blog: phescreening.blog.gov.uk
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0.01	12/03/2018	JT/EO	First draft

Review / approval

Version	Date	Requirement	Signed
01.00	06/06/2018	Approved for release	OK

Contents

Scope of this report

	Covered by this report?	If 'no', where you can find information about this part of the pathway
Underpinning functions		
Uptake and coverage	Yes	
Workforce	Yes	
IT and equipment	Yes	
Commissioning	No	Local public health commissioning team
Leadership and governance	Yes	
Pathway		
Cohort identification	Yes	
Invitation and information	Yes	
Testing	Yes	
Results and referral	Yes	
Diagnosis	Yes	
Intervention / treatment	Yes	

Executive summary

The NHS Breast Screening Programme aims to reduce mortality from breast cancer by findings signs of the disease at an early stage.

The findings in this report relate to the quality assurance visit of the Dudley, Wolverhampton & South West Staffordshire screening service held on 29 January 2018.

Quality assurance purpose and approach

Quality assurance (QA) aims to maintain national standards and promote continuous improvement in breast screening. This is to ensure all eligible people have access to a consistent high quality service wherever they live.

QA visits are carried out by the PHE screening quality assurance service (SQAS).

The evidence for this report comes from the following sources:

- routine monitoring data collected by the NHS screening programmes
- data and reports from external organisations
- evidence submitted by the provider(s), commissioner and external organisations
- information collected during pre-review visits to Dudley, Wolverhampton & South West Staffordshire breast screening service in January 2018
- information shared with the West Midlands regional SQAS as part of the visit process

Local screening service

The Dudley, Wolverhampton and South West Staffordshire breast screening service has an eligible population of around 106,200 (women aged 50-70). The service is part of the national randomised age extension trial of women aged 47 to 49 and those aged 71 to 73. The eligible population rises to just over 137,000 when including the full age extension population (women aged 47-73).

Prior to 1 April 2017, the service had been known as Dudley and Wolverhampton breast screening service. South Staffordshire breast screening service closed on 31 March 2017 and the eligible population redistributed to 3 neighbouring breast screening services. Dudley and Wolverhampton breast screening service received approximately 33% of the population and changed their name to reflect this new geographical catchment area. A number of risks were identified across the service that may be

attributable to the impact of this reorganisation. It is important that these risks are recognised and relevant mitigations implemented.

The Dudley Group NHS Foundation Trust delivers the breast screening service in collaboration with The Royal Wolverhampton NHS Trust. The service operates 3 static screening sites – Russells Hall Hospital, New Cross Hospital and Cannock Chase Hospital. There are also 3 mobile units, which rotate between 5 locations. Assessment clinics take place at both Russells Hall and New Cross Hospitals. It is planned that assessment clinics will start imminently at Cannock Chase Hospital. Each hospital trust has a radiology team, histopathologists, surgeons and breast care nurses working in breast screening. Medical physics provision for the service comes from The Royal Wolverhampton NHS Trust.

Although this is a single service the visiting team identified significant differences in the reading and assessment practice at both sites. Such a degree of difference is not acceptable in a single service and needs urgent redress. A large number of recommendations have been made regarding specific elements of clinical inconsistencies between the 2 trusts. The continued differences in practice should be considered as a significant clinical risk to the trusts as woman may have a different pathway depending on the site which is incompatible with a single service.

Findings

Immediate concerns

The QA visit team identified 3 immediate concerns. A letter was sent to the chief executive on 30 January 2018, asking that the following items were addressed within 7 days:

- review and appropriately action the 6 cases identified as part of the pre-visit reviews as having incomplete episodes. Consideration should be given to additional communication requirements where women have experienced significant delays
- cease the current practice of staff insecurely transferring patient identifiable information between sites on the hospital shuttle bus service
- fully complete the PACS pre-visit questionnaire relating to arrangements and facilities for the management of breast screening images at The Royal Wolverhampton NHS Trust

A response was received and actions have been taken to mitigate the immediate risks within the programme.

High priority

The QA visit team identified 13 high priority findings as summarised below:

- formalise the governance arrangements between the 2 NHS trusts to support optimal working
- review and revise the management structure for the service
- undertake regular and timely audits on the National Breast Screening System (NBSS)
- identify workforce, skills and capacity at each site required to deliver agreed model, particularly in relation to screening office management, mammography and radiology. The service is current running with only 52% of their recommended establishment for mammographers and have 1 radiologist in post
- ensure all electronic data and images are transferred between sites on encrypted devices
- ensure regular and timely monitoring reports are produced and actioned on BS Select
- implement monthly failsafe
- ensure the screening round plan is fit for purpose and accurate
- ensure physical separation of routine recall and arbitration / recall to assessment cases at Russells Hall Hospital
- outcomes of all consensus discussions to be entered onto NBSS by film readers
- agree a single film reading policy and uniformly implement across all sites
- ensure that women are offered an assessment appointment in accordance with national guidance
- reduce the prevalent recall to assessment rate in line with national targets

Shared learning

The QA visit team identified several areas of practice for sharing, including:

- use of rota cloud to keep the mammographic staff informed of changes
- radiography audit undertaken on blurring and presented at UKRC
- monthly notification of film reading numbers to all readers
- oncoplastic multidisciplinary team meeting (MDTM) held (Dudley)
- nursing audit undertaken of assessment clinics and telephoning of results (Dudley)
- extensive interest in oncoplastic techniques and breast reconstruction, with tertiary referrals received from other centres (Wolverhampton)

Recommendations

The following recommendations are for the provider to action unless otherwise stated.

Each recommendation number in the tables below is a hyperlink to the relevant text within the report

Governance and leadership

No.	Recommendation	Reference	Timescale	Priority	Evidence required
1	Director of breast screening to present the QA visit report at a trust executive board meeting at both sites	NHSBSP 40	3 months	Standard	Trust executive board meeting minutes
2	Appoint an imaging lead to provide professional support to the director of breast screening	Service specification number 24	3 months	Standard	Confirmation of appointment and allocated time within job plan

No.	Recommendation	Reference	Timescale	Priority	Evidence required
3	Put in place a governance process that spans both trusts to: • ensure appropriate escalation of risk and priorities and cascade of information through a network of meetings • improve the flow of service wide communication	Service specification number 24 NHSBSP No. 52	6 months	High	a) annual schedule of management and team meetings showing input from both trusts focusing on risks, incidents, performance, service updates b) minutes of a whole service annual meeting c) communication strategy outlining frequency, method and recipients
4	Revise the staffing structure supporting the programme management, screening office functions and mammography team to ensure all key functions are being delivered in a timely fashion at all sites	Service specification number 24	3 months	High	Revised staffing structure with an outline of key roles and responsibilities including scope of practice for advanced practitioners
5	Update / amend relevant local incident policy at Royal Wolverhampton NHS Trust to include reference to managing screening incidents in accordance with the current guidance	Managing Safety Incidents in NHS Screening Programmes	6 months	Standard	Policy ratified at programme board

No.	Recommendation	Reference	Timescale	Priority	Evidence required
6	Review and update the quality management system (QMS), including controlled forms	NHSBSP 47	6 months	Standard	Index of protocols demonstrating document number and version number and/or effective date
7	Undertake regular and timely audits on NBSS	NHSBSP 47	3 months 12 months	High Standard	a) Comprehensive audit schedule to include frequencies of reports run, plus 3 months evidence of audit reports for compliance b) 12 month audit demonstrating compliance with the schedule
8	Review and appropriately action the 6 cases identified as part of the pre-visit reviews as having incomplete episodes. Consideration should be given to additional communication requirements where women have experienced significant delays.	NHSBSP 47	Immediate	Immediate	Confirm the action taken for each of the 6 women identified.
9	Agree a service wide audit plan covering all parts of the programme	Service specification no. 24	6 months	Standard	Agreed audit plan/schedule

Infrastructure

No.	Recommendation	Reference	Timescale	Priority	Evidence required
10	Undertake a staffing capacity review of the whole programme across all sites	Service specification no. 24	3 months	High	Report of staffing review and future plans including: • review of screening

No.	Recommendation	Reference	Timescale	Priority	Evidence required
					office staffing across all sites • agree a workforce plan for mammography staffing including succession planning • agree a workforce plan for radiology staffing including succession planning
11	Complete the final section of the equipment handover form when a unit is accepted back into clinical use	HSE requirement Report PM77	3 months	Standard	Confirmation that handover forms are fully completed
12	Ensure radiation protection supervisors are trained and appointed for all sites	IRR17	3 months	Standard	Letters of appointment and evidence of training
13	Ensure ionising radiation regulation (IRR) and IR(ME)R documentation is aligned across all sites	IRR17 and IR(ME)R17	6 months	Standard	a) Copy of updated IRR documentation b) Copy of updated IR(ME)R documentation
14	Ensure all medical physics tests are undertaken	NHSBSP 0604	3 months	Standard	Evidence that all tests required by the NHSBSP have been implemented
15	Clarify responsibilities for managing user QC across all sites and ensure sufficient user QC radiographers are appointed	NHSBSP guidance for breast screening mammographers (replaces 63)	3 months	Standard	Organogram showing user QC responsibilities across all sites

No.	Recommendation	Reference	Timescale	Priority	Evidence required
16	Develop a new user QC spreadsheet template for use at all hospital sites	NHSBSP 1303 and 63	3 months	Standard	Copy of new user QC spreadsheet template and confirmation that this is in use at all hospital sites, with old versions having been removed
17	Undertake user QC update training to ensure practice is aligned across all sites	NHSBSP 63	3 months	Standard	Evidence of update training
18	Obtain a suitable object to undertake stereo testing at Russells Hall Hospital	NHSBSP 63	3 months	Standard	Confirmation of a suitable stereo test object in use
19	Revise user QC work instructions to ensure that all testing complies with NHSBSP requirements	NHSBSP 63 / NHSBSP 1303	3 months	Standard	Copy of revised work instructions to reference: a) correct positioning when testing each needle in stereo mode b) the latest signal to noise (SNR) and contrast to noise (CNR) tolerances c) the grey level set for artefact evaluation for each mammography unit and filter, along with frequency of testing

No.	Recommendation	Reference	Timescale	Priority	Evidence required
20	Ensure PACS processes are optimal across all sites	Service specification no. 24	3 months	Standard	Confirmation of review completed, changes implemented and processes in place to include: • agreed work instructions for pre reading procedures, utilising appropriate functionality within NBSS • staffing support to cover all required functions
21	Fully complete the PACS pre-visit questionnaire relating to arrangements and facilities for the management of breast screening images at The Royal Wolverhampton NHS Trust.	Programme Specific Operating Model for Quality Assurance of Breast Screening Programmes	Immediate	Immediate	Submission of a fully completed PACS pre-visit questionnaire.
22	Agree a lead organisation and member of staff, for each piece of equipment or software used for breast screening	Service specification no. 24	3 months	Standard	Copy of the completed, agreed flowchart
23	Ensure all electronic data and images are transferred between sites on encrypted devices	NHSCSP Information Security Policy	1 month	High	Confirm that all devices used for data and image transfer are fully encrypted

Identification of cohort

No.	Recommendation	Reference	Timescale	Priority	Evidence required
24	Review the current administrative provision and structure to provide appropriate facilities and resilient succession planning	NHSBSP 47	3 months	Standard	Outcome of staffing review to detail administrative support at each of the 3 hospital sites including data input and audit
25	Ensure a robust induction process is in place for all administration staff	NHSBSP 47	3 months	Standard	Copy of skills matrix and confirm implementation across all staff
26	Ensure regular and timely monitoring reports are produced and actioned on BS Select	Service specification no. 24	3 months	High	Comprehensive audit schedule to include frequencies for each monitoring report plus 3 months evidence of audit reports for compliance
27	Implement monthly failsafe	Service specification no. 24	1 month	High	Confirm failsafe is being undertaken monthly and that the backlog of women have been appointed appropriately
28	Ensure open episodes are actioned appropriately and timely	NHSBSP 47	3 months	Standard	Confirm the process in place for the routine closure of episodes and for routine checks
29	Send a GP pack to each practice 6 weeks prior to the selection of the batch	NHSBSP 47	3 months	Standard	Copy of GP pack and confirmation it is routinely sent out to all GP practices
30	Clear the backlog of high risk clients awaiting surveillance	NHSBSP 74	3 months	Standard	Confirm all women have been appropriately actioned

Invitation, access and uptake

No.	Recommendation	Reference	Timescale	Priority	Evidence required
31	Ensure the screening round plan is fit for purpose and accurate	NHSBSP 47	a) 1 month b) 3 months	High	a) Confirmation that the electronic screening plan has been updated to accurately reflect when GP practices will be invited b) Copy of the revised round plan, including details of the recovery plan along with estimated dates for achieving the 90% within 36 months standard
32	Ensure all women are offered a timely second timed appointment and address the current backlog	Service specification no. 24	1 month	Standard	Details of how the backlog of outstanding second timed appointments were managed. Confirm plan in place to accommodate second timed appointments going forward
33	Develop and implement a health promotion strategy	Service specification no. 24	6 months	Standard	Health promotion strategy document

The screening test – accuracy and quality

No.	Recommendation	Reference	Timescale	Priority	Evidence required
34	Complete regular image quality assessment at service level in line with NHSBSP guidance	NHSBSP guidance for breast screening mammographers	3 months	Standard	Confirm that a schedule for review is in place in accordance with NHSBSP guidance
35	Ensure training of the Eklund technique is completed for all mammographers	NHSBSP Screening women with breast implants	1 month	Standard	Confirm that all mammographers have viewed the DVD and read the guidance
36	Risk assess lone working and develop a policy which covers all sites	Society of Radiographers - Violence and Aggression at Work (including lone working)	3 months	Standard	Confirm the risk assessment has been undertaken and provide a copy of the agreed lone working policy
37	Risk assess musculoskeletal disorders and develop a policy which covers all sites	NHSBSP guidance for breast screening mammographers	3 months	Standard	Confirm the risk assessment has been undertaken and provide a copy of the agreed policy
38	Identify a training lead to support the coordination of training within the mammographic workforce	NHSBSP guidance for breast screening mammographers	3 months	Standard	Confirmation that a training lead has been identified and that the job description is reflective of the new responsibility

No.	Recommendation	Reference	Timescale	Priority	Evidence required
39	Ensure all film readers read the required 5,000 images per year with a minimum of 1,500 first reads	NHSBSP 59	6 months	Standard	An action plan to ensure adequate reading time is available. 6 monthly film reading numbers commencing in June 2018
40	Cease the current practice of staff insecurely transferring patient identifiable information between sites on the hospital shuttle bus service	NHSCSP Information Security Policy	Immediate	Immediate	Confirm that this practice has ceased and provide an outline of the secure process now in place
41	Ensure suitable facilities for film reading at Russells Hall Hospital	NHSBSP Report 71	3 months	Standard	Confirm the changes made and that the environment is suitable for reporting
42	Ensure physical separation of routine recall and arbitration / recall to assessment cases at Russells Hall Hospital	NHSBSP 55	1 month	High	Confirmation that the screening packets are separated by film readers according to required action, prior to being passed to the screening office

No.	Recommendation	Reference	Timescale	Priority	Evidence required
43	Outcomes of all consensus discussions to be entered onto NBSS by film readers	Service specification no. 24	1 month	High	Confirmation that the film readers enter the consensus discussion outcome onto NBSS and that this is documented in a work instruction
44	Agree a single film reading policy and uniformly implement across all sites	NHSBSP 55	1 month	High	Copy of cross-site film reading policy and confirmation from all sites that the policy is being followed. The process should include: a) physical separation of the screening packets for recall and arbitration at the time of second read b) entering the consensus opinion into NBSS by the

No.	Recommendation	Reference	Timescale	Priority	Evidence required
					readers at the time the decision is made c) a process and documentation for the retrieval of previous images

Referral

No.	Recommendation	Reference	Timescale	Priority	Evidence required
45	Ensure that women are offered an assessment appointment in accordance with the NHSBSP standard	NHSBSP consolidated standards	3 months	High	Copy of the action plan to achieve at least98% of women offered an assessment appointment within 3 weeks of their mammogram
46	Reduce the prevalent recall to assessment rate in line with national targets	NHSBSP consolidated standards	6 months	High	An action plan to address the high recall rate, particularly in Wolverhampton

Diagnosis

No.	Recommendation	Reference	Timescale	Priority	Evidence required
47	Agree a cross-site practice for assessment	NHSBSP49	3 months	Standard	• a copy of the agreed assessment policy • a policy for second review of cases discharged to routine recall at assessment and a process for recall from second review • conformation that these policies have been agreed at all sites

No.	Recommendation	Reference	Timescale	Priority	Evidence required
48	Put in place a standard process for the timely review of interval cancers and previously assessed cancers (screen detected and interval cancers) across all sites	NHSBSP Reporting, classification and monitoring of interval cancers and cancers following previous assessment NHS Screening Programmes Guidance on applying duty of candour and disclosing audit results	3 months	Standard	• a cross-site policy for the review of interval cancers including timeframes for reviews • a cross-site policy for the review of previously assessed interval and screen detected cancers, including timeframes for reviews • confirm the process is implemented on both sites • confirm the process for applying duty of candour and disclosure of audit has been implemented on both sites
49	Ensure that all short term recall cases have imaging of both breasts	NHSBSP 49	1 month	Standard	Evidence of communication to all assessors and confirmation that guidance is being followed

No.	Recommendation	Reference	Timescale	Priority	Evidence required
50	Preparation time for radiological review of images before the multidisciplinary meeting is to made available within job plans	Cancer multidisciplinary team meetings – standards for clinical radiologists. RCR 2014	3 months	Standard	Copy of radiologist and consultant radiographer job plans with amendments highlighted
51	Complete a review of grading distribution within the Russells Hall Hospital laboratory	RCPath guidance – An audit of breast cancer grading	6 months	Standard	Results from the completed audit, along with any agreed actions
52	Ensure the lead pathologist at Russells Hall Hospital has the additional responsibilities reflected in the job plan	NHSBSP 2	6 months	Standard	Copy of job plan
53	Ensure that pathology staffing levels in Russells Hall Hospital are sufficient	RCPath guidance Guidelines on staffing and workload for histopathology and cytopathology departments (4th edition)	6 months	Standard	Confirmation of the current shortfall
54	Ensure all pathologists meet the continuing professional development (CPD) requirements of the NHSBSP	NHSBSP 2	3 months	Standard	Evidence of attendance
55	Ensure all pathologists meet the training requirements of the NHSBSP	NHSBSP 2	12 months	Standard	Confirm that all pathologists have undertaken the relevant multidisciplinary

No.	Recommendation	Reference	Timescale	Priority	Evidence required
					breast course

Intervention and outcome

No.	Recommendation	Reference	Timescale	Priority	Evidence required
56	Provide breast care nursing support in Wolverhampton as per guidelines	NHSBSP 29	6 months	Standard	• confirm the nurses meet all women at the start of the clinic and undertake a holistic assessment • confirm that women who have a biopsy are also seen again at the end of the clinic • a copy of agreed structured holistic assessment form to be provided
57	Undertake a patient satisfaction survey regarding women's assessment experience in New Cross Hospital and Cannock Chase Hospital once clinics commence	NHSBSP 29	6 months	Standard	Copy of the audit results along with details of any agreed actions
58	Undertake an audit regarding women's satisfaction with the practice of telephoning with benign results at New Cross Hospital	NHSBSP 29	6 months	Standard	Copy of the audit results along with details of any agreed actions
59	Ensure adequate staffing arrangements are in place to cover periods in which the CNS is unavailable at The Royal Wolverhampton NHS Trust	NHSBSP 29	3 months	Standard	Confirmation of arrangement

No.	Recommendation	Reference	Timescale	Priority	Evidence required
60	Ensure adequate videoconferencing audio facilities for the multidisciplinary meeting	The Characteristics of an Effective Multidisciplinary Team (MDT)	6 months	Standard	Confirmation of the changes made
61	Ensure that the multidisciplinary team meetings held at Russells Hall Hospital operate in line with the local specification and national guidance	The Characteristics of an Effective Multidisciplinary Team (MDT) NCAT 2010	3 months	Standard	Confirmation that the MDT record is validated in real time and the record immediately available to the team in clinical areas
62	Ensure monitors utilised at both hospital sites meet the NHSBSP specification	NHSBSP 71	6 months	Standard	Confirmation that all required monitors in multidisciplinary rooms and theatres are in place at both hospital sites and meet the NHSBSP specification
63	Ensure that all women are seen within 7 days of assessment with their results	NHSBSP 20	6 months	Standard	Outcome of a 4 month audit, along with any resulting actions
64	Ensure all clinical information at Royal Wolverhampton NHS Trust is uploaded to the clinical portal in a timely manner and available in patient notes.	NHSBSP 20	3 months	Standard	Confirm the process is in place and is working satisfactorily.

Next steps

The screening service provider is responsible for developing an action plan in collaboration with the commissioners to complete the recommendations contained within this report.

SQAS will work with commissioners to monitor activity / progress in response to the recommendations made for a period of 12 months after the report is published. After this point SQAS will send a letter to the provider and the commissioners summarising the progress made and will outline any further action(s) needed.

Service provider and population served

The Dudley, Wolverhampton and South West Staffordshire breast screening service (BSS) has an eligible population of around 106,200 (women aged 50-70). The total population of the area served is around 805,000. The service is part of the national randomised age extension trial of women aged 47 to 49 and those aged 71 to 73.

Prior to 1 April 2017, the service had been known as Dudley and Wolverhampton BSS. South Staffordshire BSS closed on 31 March 2017, with the eligible population redistributed to 3 neighbouring breast screening services. Dudley and Wolverhampton BSS received approximately 33% of the population and changed their name to encompass their new geographical catchment area. Throughout this report, both Dudley and Wolverhampton and Dudley, Wolverhampton and South West Staffordshire are referred to depending on the timeframe.

The Dudley Group NHS Foundation Trust delivers the breast screening service in collaboration with The Royal Wolverhampton NHS Trust, with whom there is a sub-contract. The service operates 3 static screening sites – Russells Hall Hospital, New Cross Hospital and Cannock Chase Hospital. There are also 3 mobile units, which rotate between 5 locations. Assessment clinics take place at both Russells Hall and New Cross Hospitals. It is planned that assessment clinics will start imminently at Cannock Chase Hospital, although no known start date has been confirmed. Each hospital trust has its own radiology team, histopathologists, surgeons and breast care nurses working in breast screening. Medical physics provision for the service comes from The Royal Wolverhampton NHS Trust.

Governance and leadership

Commissioning and accountability

The NHS England (West Midlands) screening and immunisation team (SIT) has undertaken commissioning of breast screening within Dudley and Wolverhampton since 2013. Following the service reconfiguration, there is a separate contract for the screening provision for the former South Staffordshire BSS population. This separate contract is with NHS England (North Midlands). NHS England (West Midlands) act as lead commissioners.

The SIT chairs quarterly programme board meetings to oversee the quality and performance of the programme. Quality standards, key performance indicators and service risks are monitored. A representative from the finance teams at both trusts routinely attend these meetings. Clinical representation from Wolverhampton is variable. Clinical input from across the service may be beneficial at future programme board meetings.

The SIT confirmed that there is a signed contract in place between the trust and NHS England. There are no commissioning for quality and innovation's (CQUINs) specified within the contract. At the request of the SIT the service have completed a gap analysis against the 2017/18 service specification. This identified a number of gaps in service delivery which are currently under consideration and will be discussed at future programme board meetings.

The screening and symptomatic budgets are split.

An organisational chart shows that the director of breast screening (DoBS) is directly accountable to the chief executives at both trusts. The DoBS should present the visit report at an appropriate executive board meeting at each trust. (Recommendation 1)

Programme management and coordination

The management team for the service are based at Russells Hall Hospital. Following the recent retirement of the DoBS, the current director has been in post since December 2017. The job description specifies one programme activity (PA) for the director, which has been factored into his job plan although this has not yet been signed off. The breast imaging services manager is the programme manager. The current programme manager is in place on a 12 month secondment, as the substantive post holder in on maternity leave. The breast imaging service manager, reports into the radiology manager, meeting on a weekly basis.

The former DoBS was also the lead radiologist for the service. Given that the director of breast screening is not a radiologist, a lead consultant should be identified to provide specific professional support across all sites and this person should have specific time within their job plan for this function. (Recommendation 2). There are leads appointed in all other professional disciplines although the current model of this service is not to have a clinical superintendent radiographer which is currently being reviewed.
There appears to be a lack of scheduled meetings in place to support the breast screening service. The DoBS and programme manager are planning to meet on a weekly basis which given the number of challenges currently being manged should be seen as an absolute minimum. There are currently no meetings between the 2 trusts to manage the sub-contract. Neither are there any internal service meetings across the 2 trusts. The governance arrangements between the 2 trusts need to be strengthened. These are outlined in the appendix of the sub-contract and should be revisited in light of the findings of this report and the current challenges faced by the services and the lead radiologist arrangements. An agreement between the 2 trusts was drawn up in 2014 following the last QA visit, detailing the process for managing performance issues. The current management team were unaware of this agreement suggesting that it is not robustly followed. (Recommendation 3 part a).

A multidisciplinary team away day was held in December 2017. It was reported that this was not well represented by team members based at New Cross Hospital. There was a recurring theme across the professional groups of sporadic and incomplete communication between professionals based at the different trusts. The service should develop a communication strategy. There must be robust mechanisms in place to keep all staff, at all sites, informed of general breast screening issues as well as key items pertinent to their professional group. (Recommendation 3 part b & c)

The submitted pre-visit evidence stated that all members of the service had completed NHSBSP specific confidentiality training within the last 3 years. However, the new management team were not aware of this, nor where a record is retained to this effect. Unless this documentation can be located, this process should be repeated.

The last completed service annual report produced was for 2013/14. A 2016/17 report was in progress when the former DoBS retired, but has not been completed.

Following the recent reorganisation there is a planned review of the organisational structure within the service. This is much needed and should ensure that there is adequate support at an appropriate level, particularly for both the administrative and radiographic functions of the service as the current structure within these professional areas lacks clarity which is a risk for the service. (Recommendation 4).

Incidents, risk management and escalation

Both trusts have an incident management policy in place. The policy for the Dudley Group NHS Foundation Trust contains a reference to the current managing screening incidents policy. However, the submitted policy from The Royal Wolverhampton NHS Trust does not contain the relevant reference. This policy is due for review in April 2018 and an amendment to the policy was discussed and the service agreed to take this forward. (Recommendation 5). The national screening incident assessment form for reporting incidents is used to notify SQAS and the SIT as necessary. The service reports incidents in a timely manner and carry out thorough investigations which supports appropriate learning.

Any member of staff can enter a clinical incident on Datix. At Dudley the consultant radiographer and the radiology manager should receive automatic notification of clinical incidents, if recorded as the incident handlers. Incidents are taken through the directorate governance meetings within the Dudley Group. There was no working knowledge of the incident process for within The Royal Wolverhampton NHS Trust, within the service management team. Incidents are also discussed at staff meetings.

Issues are identified for inclusion on departmental risk registers as required. There was no awareness of what risks relating to screening may be included within the register held by The Royal Wolverhampton NHS Trust. There is also risk register monitoring by the commissioners at the local programme board. The most recent submission to this group was dated July 2017. It was not felt by the current management team to be the most up to date version. Current open risks include mammography and radiology staffing shortages.

Complaints are dealt with in line with relevant trust policies and are discussed confidentially with all staff involved. Compliments are shared with relevant team members.

Policies and guidelines

The service has a quality management system (QMS) covering the main screening processes. This includes annual audits when processes undergo review and are updated as appropriate. At the right result walkthrough it was noted that some of the procedure documents were yet to be updated or developed to reflect a change of practice or new practice. The administration team stated that changes to processes / workflows were not always implemented in a controlled manner. This introduces risk of error to service delivery. This is particularly pertinent given the multisite nature of the service and the recent service reorganisation. The service should update the QMS to include controlled versions of core process documentation. (Recommendation 6).

Audits

The professional and clinical advisors (PCAs) for administration and radiography together with the senior QA advisor carried out the right result walkthrough on 10 January 2018 at Russells Hall Hospital and on 24 January 2018 at New Cross Hospital. The summary report is included in Appendix B.

The administrative processes for the production of results are well organised and letters are checked and cross-checked prior to production. The service has recently outsourced the printing and posting of all invitation and routine result letters.

During the review it was noted that some of the prescribed audits were not being undertaken. The service should undertake regular and timely audits on the national breast screening computer system (NBSS) to include:

- the daily use of SASP5 (audit of outstanding results)
- weekly use of SASP7 / SAWB (audit of clinic reconciliation / whiteboard) to monitor film reading and outcomes
- monthly use of SPRCL (identification of short term recall women).

(Recommendation 7).

During the pre-visit the QA team identified 6 clients who had not completed the patient pathway in a timely manner. These women included a high risk woman transferred into the service and not actioned; a woman not invited for assessment following a short-term recall and images remaining open for a prolonged period of time without a second read. The service were requested to investigate and resolve each of these cases immediately. (Recommendation 8).

All positive cancer cases are audited to monitor the correctness of data. A different member of the team should always audit the data to improve levels of accuracy. This should be incorporated into the recommended review of administration provision and structures

The screening office carries out the annual KC62 and NHSBSP and Association of Breast Surgery (ABS) audits. The office manager is experienced in this role but will require support to ensure that there is sufficient capacity for the additional workload generated by the recent service reconfiguration. Additionally some data errors were noted at the visit in the case review session indicating that the data held on NBSS and reported into national audits is not complete and an accurate reflection of management by the 2 trusts. These points should also feed into the wider review.

Key performance indicators (KPI) are monitored monthly and quarterly in line with SQAS requirements.

The multidisciplinary team based at New Cross Hospital have an agreed annual audit plan for the multidisciplinary team. Within Russells Hall Hospital, audits are performed throughout the screening pathway, however they are managed separately within professional areas. The QA team recommend that a service wide audit plan is implemented. (Recommendation 9).

Communication and user feedback

The results of a 2017 client satisfaction survey, undertaken at multiple screening locations were submitted as part of the QA visit evidence. These results have been discussed in a staff meeting, but have not been presented to the programme board.

The service should repeat these surveys annually in line with the requirement of the service specification. This should alternate between screening locations and times of year to demonstrate differing client views.

Infrastructure

Workforce

The QA team observed staffing shortages in many areas. There are significant shortages within mammography and radiology as discussed later in this report. These shortages are recorded on the programme risk register. The former director of breast screening / lead radiologist retired in December 2017. With the remaining radiologist planning on retiring imminently from screening this leaves the service in a vulnerable position.

Staffing shortages have impacted on targets such as screening round length and have significantly impacted on the ability of the service to deliver screening effectively.

The QA team strongly recommend that a review of staffing required to support delivery across the service is conducted as a priority. (Recommendation 10).

Medical physics and equipment

The medical physics department based at New Cross Hospital provides the medical physics service for mammography, ultrasound, reporting monitors and specimen cabinets at all sites across the service. They also provide radiation protection advisor (RPA) services. They do not provide a physics service to MRI, but since the high risk service is provided centrally for the West Midlands by another service this is outside the scope of this visit.

Mean glandular dose to the standard breast and image quality are assessed for the mammography units as part of routine physics surveys. These all meet NHSBSP standards. Mammography equipment has been optimised. In particular the doses have been increased on the Siemens units at New Cross Hospital to improve image quality. Surveys of dose to women have been performed within the last 3 years as required for all mammography units. Mean glandular doses to women are below the national diagnostic reference level for mammography for all units, and are in line with other units of the same type. Physics test results for the ultrasound units, specimen cabinets and reporting monitors indicate that performance meets NHSBSP standards.

The breast screening service consults the medical physics service appropriately and is satisfied with the service it receives.

The static mammography units at all sites are part of a private finance initiative (PFI) and covered by an equipment replacement programme. The equipment on the mobile

vans is leased and will be due for replacement in 2019. NHSBSP guidelines for replacement of mammography equipment advise a 7-10 year replacement plan. There are no significant problems with any of the mammography units and few faults have occurred recently. Any faults that have occurred have been reported to the national coordinating centre for the physics of mammography (NCCPM). All reporting and acquisition workstations have adequate resolution monitors.

There are no significant problems with the ultrasound units, though the one at Cannock Chase Hospital is 7 years old and was previously in use at Russells Hall Hospital. There are specimen cabinets at each site and performance of these is satisfactory.

Equipment servicing arrangements are good and responsive to issues. Radiography staff and service engineers perform equipment handover and complete forms at service visits. However the final section of the handover form, where the radiographer accepts the equipment back into clinical use, is often not completed. (Recommendation 11).

Regarding compliance with the Ionising Radiation Regulation 2017 (IRR17), local rules are now in place for all controlled areas. The radiation protection supervisor for Russells Hall Hospital has been temporarily acting in this role at Cannock Chase Hospital too, but this is not appropriate since she does not work there. Furthermore this member of staff is leaving the trust soon. New radiation protection supervisors need to be identified, trained and appointed for Russells Hall Hospital and Cannock Chase Hospital. (Recommendation 12). Ionising Radiation Regulations (IRR17) documentation needs to be aligned across all sites. (Recommendation 13).

The employer's procedures required under the Ionising Radiation (Medical Exposure) Regulations (IR(ME)R) need review and alignment. (Recommendation 13). Currently there are separate sets of procedures for Russells Hall Hospital and New Cross Hospital. Both sets pertain to the main radiology department and are not specific to breast screening. It is recommended that the new IR(ME)R legislation coming into force in 2018 is used as an opportunity to align the employer's procedures across all sites and make them specific to breast screening. In particular, the staff groups entitled to act as the various duty holders should be revised and clarified, and justification and authorisation criteria reviewed.

Medical Physics provider

A full audit of the medical physics service was carried out on this occasion. The medical physics team at New Cross Hospital provides services to 2 breast screening services, comprising 10 mammography units and 6 ultrasound units in total. This is a small equipment base so the service has to work hard to maintain staff competency. The service achieves this by performing surveys in pairs, attending regional and national training events and making buddy visits. The current arrangements are considered

satisfactory, but if the ratio of staff to units tested changes significantly this may require review.

The medical physics service meets the requirements of the NHSBSP Quality Assurance Guidelines for Medical Physics Services (NHSBSP 33). Facilities, equipment and accommodation for medical physics are all adequate and lone working procedures are robust. Staff members are adequately trained. They undertake continuous professional development (CPD) activities and all have had an appraisal within the last year. The service participates in national data collection exercises as required. There is no formal quality management system, but test procedures and work instructions are described in the template spreadsheets used by the service. This is considered to be satisfactory.

The equipment tests performed by the physics service generally meet NHSBSP standards for mammography units, ultrasound units, specimen cabinets and reporting workstations. The only required tests not carried out are routine assessment of the TOR MAM test object on a reporting workstation; and testing the distance calliper calibration on reporting workstations at commissioning and following software upgrades. It is recommended that these tests are implemented as there are currently no physics tests that assess the entire imaging chain. (Recommendation 14). The survey reports are comprehensive and contain clear recommendations for the breast screening service.

Over 90% of the equipment surveys audited were performed within 1 month of the due date, and over 95% of reports were issued within the service's 3 week target. The surveys and reports that were late were all from a period during 2015 when there had been significant staff sickness. Since the last survey a formal mechanism has been put in place to ensure that the breast screening service takes action in response to medical physics' recommendations and reports this to the physics service.

User quality control (QC)

The same user quality control (QC) spreadsheets and work instructions are used at all sites, but the management arrangements for user QC are different at New Cross Hospital than at Russells Hall Hospital and Cannock Chase Hospital. The designated QC radiographer at Russells Hall Hospital does not oversee the user QC at New Cross Hospital, though she does read TOR MAM images there. However this radiographer is leaving soon. Arrangements need to be made for the appointment of user QC radiographers at all sites and responsibilities for managing this work clarified. (Recommendation 15).

At Russells Hall Hospital and Cannock Chase Hospital, the frequency of daily, weekly and monthly tests for mammography, ultrasound and reporting and acquisition monitors meets NHSBSP standards. Sufficient time is made available for carrying out this user QC. At New Cross Hospital the mammography testing is not always carried out at the

required frequency. Old versions of spreadsheets were found to be used on some occasions which used 20% tolerances for some tests when these should be 10%. This means that results out of tolerance may not always be flagged. (Recommendation 16).

All radiography staff members carry out the routine mammography user QC testing. At Russells Hall Hospital and Cannock Chase Hospital, most results from user QC tests for mammography, ultrasound and monitors are within tolerances. At Russells Hall Hospital where on occasion results appear to be out of tolerance, a reason or the action taken is always given on the spreadsheet. At Cannock Chase Hospital there are some challenges in ensuring staff carry out the user QC to required standards and act on any results out of tolerance. Until April 2017 Cannock Chase Hospital staff had been using different systems and paper records. At New Cross Hospital and Cannock Chase Hospital several examples were found of tests not being done, and cells and formulae being deleted. Old versions of spreadsheets should be removed. The medical physics service should develop the current version to include locking cells with formulae and protecting spreadsheets. Named individuals only should adjust the spreadsheets. At all sites, the baseline values of the filter and kilovoltage (kV) used for daily, weekly and monthly tests were not displayed on the spreadsheets though they are on paper. The values entered were not always correct. The service should amend the spreadsheet templates to include baseline values for filter and kV. Conditional formatting should be applied to flag when recorded filter and kV values are not as expected. (Recommendation 16). The user QC radiographer at Russells Hall Hospital is developing a protocol on using the spreadsheets for Cannock Chase Hospital staff. This could be useful for all sites. User QC update training is required for staff to ensure practice is aligned across all sites. (Recommendation 17).

Significant variation in TOR MAM mAs and score values were found. This is most likely due to variation in positioning. Update training could also address this issue.

Daily and monthly tests on acquisition and reporting monitors are satisfactory at all sites. Mechanical safety and function testing is usually performed at the required monthly frequency though there were a few months missing in the New Cross Hospital data.

Practical stereo testing was observed at Russells Hall Hospital. There is still no dedicated test object and a paperclip inserted between perspex blocks is used as the target. The paperclip is thicker than the 1mm tolerance however. The service should obtain a suitable stereo test object, or use a finer target than the paperclip currently in use. (Recommendation 18). For each needle type, the needle should be moved to where the user assesses is the correct position by eye. The displayed values of x, y and z should be recorded, rather than setting all to zero. The centre of the channel should be marked on test biopsy needles to facilitate consistent localisation. (Recommendation 19 part a).

Practical mammography uniformity testing was also observed. To check for artefacts a narrow window setting is required, centred around the mean grey level. On the mammography unit evaluated, the grey level specified in the work instruction was not the true mean value, meaning that the uniformity image looked too bright and artefacts present might be missed. This could be due to a change in detector dose since the baselines were established. In conjunction with medical physics, the grey levels set for artefact evaluation should be reviewed for each unit and filter to ensure they are appropriate. (Recommendation 19 part b).

User QC results recorded on the mobile vans are backed up on to the shared drive at the hospital base once a month. Paper QC records for each mobile are retained.

Work instructions for user QC tests are fit for purpose and reflect the tests carried out. However the tolerances for signal to noise (SNR) and contrast to noise (CNR) ratios are out of date and need to be reviewed to reflect the latest tolerances used in the spreadsheet. (Recommendation 19 part c).

Picture archiving and communication system (PACS)

The Dudley, Wolverhampton and South West Staffordshire BSS currently has 3 PACS suppliers:

- MIS MICAS PACS standalone breast PACS
- Siemens Healthcare (Plaza) at Russells Hall Hospital
- Philips at New Cross Hospital

Images taken at New Cross Hospital and the 1 mobile generally located within the Wolverhampton area are transferred to, and stored on, the Philips PACS. All other images transfer to MIS MICAS PACS in the first instance. Images for women requiring assessment at Russells Hall Hospital are manually transferred onto the Siemens Healthcare (Plaza) PACS prior to the assessment clinic. Images taken at Cannock Chase Hospital are manually pushed from MICAS PACS to Philips PACS in preparation for reporting.

The clinical module is not used for assessment and there are no plans to introduce it as the current system is working.

Live NBSS is not available on the mobile screening vans. Information is transferred between the screening offices and mobile screening vans via trust courier. There is a reported issue with the worklists where all screening patients are appearing on each of the worklists at all 3 sites. This increases the risk of selecting the wrong woman and should be resolved. Women who attend on the wrong day for screening get a new appointment but if capacity allows they are put on the list manually using accession number.

The imaging service have sufficient 5-megapixel work stations at all 3 hospital sites, with agreed hanging protocols. There was conflicting information provided regarding whether the monitors used in theatres at either hospital site are 2-3 megapixels as per the NHSBSP requirements. This should be ascertained and the monitors replaced if necessary. Pathology have standard trust PCs but have access to higher specification monitors via imaging. There is lack of clarity about the monitors available for the multi-disciplinary meetings depending on which room is available.

Dudley Group NHS Foundation Trust

Migration of images from the South Staffordshire breast screening service happened in June 2017 from a GE Medical PACS to the MIS MICAS PACS. There is a long term plan within the Dudley Group NHS Foundation Trust to move to a single PACS supplier. There is no named PACS lead based in Russells Hall Hospital and there is no defined role in either administration or radiography staffing to support the tasks associated with PACS. Activity associated with these additional tasks is not resourced and staff do not work to a protocol. This is a significant risk. (Recommendation 20).

NHS number is the unique identifier for screening patients on the MICAS PACS. When images are transferred to the main hospital Siemens PACS, ahead of assessment, the identifier is manually changed to the hospital number. This identifier is not consistently being changed back once the woman's episode is closed, which results in the images not displaying in MICAS PACS when they are next required. Images are having to be manually retrieved from Siemens PACS. This is a time consuming process for staff.

The PACS team offer same day response for problems and/or issues raised by the screening service. No dates are given for the duration of the support contract for MICAS PACS or Plaza PACS. There is no central coordination of the MICAS PACS error log. The screening office staff contact MIS directly with problems. Escalation to the breast services manager happens if problems remain unresolved.

Multiple checks happen to establish if women have previous screening or symptomatic images. This is staff resource intensive and is duplication of work. The service should review this practice for efficiency and usefulness.

The screening office request previous digital images from other screening centres and hospitals via the image exchange portal (IEP). The trust PACS team handle external requests for images in the absence of the admin team. Retrieval of previous images is auto fetch for screening images and manual for symptomatic images.

Checks are in place to search for unreported images. Administration staff check the client lists match with the images sent to PACS. Unresolved issues are escalated to the

office manager or deputy office manager or advice is sought from the clinical team. In preparation for reporting the administrative staff check that all required images are available. Currently this is not undertaken using the SIRV facility within NBSS, which would speed up the process and also reduce the risk of the wrong patient being selected from the list.

All relevant images are available to the clinician at assessment but require pre fetching.

Administration staff do all the preparation for the multi-disciplinary meetings in terms of making sure required images are available. Long term storage plans will be to move images to a vendor neutral archive (VNA). There are currently no plans to cull any images. The VNA solution with a universal viewer is the business continuity plan for Russells Hall Hospital.

The Royal Wolverhampton NHS Trust

At the time of the visit, the pre-visit questionnaire from New Cross Hospital was incomplete and there was no representative at the meeting on the day of the QA visit. An immediate recommendation was made at the QA visit for the PACS pre-visit questionnaire relating to the arrangements and facilities for the management of breast screening images at The Royal Wolverhampton NHS Trust to be completed. (Recommendation 21).

A separate meeting was held on the 8 February 2018 with the PACS Manager and Head of Radiology at The Royal Wolverhampton NHS Trust. It is clear that there is a lack of clarity over the roles and responsibilities of the staff working across the different sites. A flowchart should be developed to clarify the roles and organisations responsible for each piece of equipment. (Recommendation 22).

NHS number is the unique identifier for screening patients. It was reported that the PACS team are responsive when queries are raised.

Requests for previous images from external hospitals are made by the PACS office, at the request of the screening office. Retrieval of previous images is auto fetch for screening images and manual for symptomatic images. It was reported that pre fetching time on Philips PACS is slow and delays reporting.

Regular checks are made of the exceptions file, which would contain unreported images.

Not all of the memory sticks used to transfer information between the mobile vans and the static units are encrypted. This is an information governance risk and should be

rectified. Confirmation should be sought that the Dimex's used to transfer images and worklists between sites are encrypted. (Recommendation 23).

Identification of cohort

The screening administration office provision for the Dudley, Wolverhampton and South West Staffordshire breast screening service is currently split across 3 sites: Dudley – Russells Hall Hospital; Wolverhampton - New Cross Hospital and Cannock – Cannock Chase Hospital.

The accommodation generally provides a reasonable working environment and is appropriate for the number of staff at each of the sites. However this multisite situation raises significant issues for the team. These include, but are not limited to:

- provision of appropriate management cover and support to each team
- appropriate staffing cover on all sites, at all times
- appropriate workload division between sites
- difficult team communication with the inability to arrange full team meetings without significant disruption to the service
- inability to access all systems and information at all sites

A full review of the administrative provision is planned for completion by March 2018. This will need to be wide ranging and take into consideration the overall plans for the future provision of the service.

The administration team is currently staffed with an establishment of 12.1 WTE staff consisting of programme manager (1.0 WTE), screening office manager (1.0 WTE), deputy screening office manager (1.0 WTE), data manager (1.0 WTE) and clerical officers (8.1 WTE). The team is carrying a vacancy of 0.4 WTE clerical officer. The team at Russells Hall Hospital also cover symptomatic work. The staffing structure is presently under review by the service as part of the wider review.

At the visit the overall structure of the administration department was unclear. Senior team members do not have a current job description and the lines of accountability and responsibility are unclear. This was raised as a particular concern by members of the team who are confused by the current management arrangements. There needs to be a robust structure in place which clearly defines the role and responsibility for each member of staff along with identified lines of accountability. This should be shared with the team to ensure that there is a clear understanding of all management roles and responsibilities. The structure should include the roles of programme manager, screening office manager and deputy screening office manager as defined by the service specification. Appropriate plans should also exist for succession planning to reduce the reliance on individual staff members and to eliminate the risks of a single point of failure. (Recommendation 24).

The administration team members are keen to move forward with new ideas. They are embracing the challenges of their multisite working and the recent reconfiguration and have identified innovative working methods to overcome many of the issues posed. They have good overall knowledge of the national breast screening system (NBSS), breast screening select (BS Select) and the breast screening programme.

All staff except for one have had appraisals within the last 12 months. The team report that they have good access to mandatory training via trust courses and online resources. The service needs to implement a robust induction process for the new staff to ensure they feel well integrated into the overall screening service and have appropriate competencies for their role. This should be effectively documented and monitored over the 3 sites by the introduction of a skills matrix. It would be advisable for this skills matrix to be applied to all current members of staff as well. (Recommendation 25).

The administration team hold ad hoc internal staff discussions and contribute to the overall service team meetings. The service should consider a more formal monthly arrangement for administration meetings to ensure effective communication across the multiple sites.

The team have successfully implemented the change to BS Select from the national health application and infrastructure services (NHAIS) Exeter system. There are currently 2 fully trained users of the system. Training is planned for a third user. The remaining team members have read only access. This allows the efficient identification of clients and the location of previous screening images. The implementation of BS Select has had limited impact on the screening round plan as the service screens by GP practice which is fully supported by BS Select.

The information available from BS Select is used daily by the team, however, the service should address a backlog of work associated with the monitoring reports produced by the system. These include unmatched clients, open episodes, death records, date of birth changes, high risk clients moving into the area and general updates. These reports need to be actioned promptly to ensure clients are appropriately invited for screening. (Recommendation 26).

Those team members who regularly work on BS Select and / or are involved in data input or analysis would greatly benefit from a second computer screen. This additional resource would allow for more efficient working and reduces the possibility of transcription error between systems.

The administration team previously ran failsafe batches every month, however, due to time restraints and capacity issues the last failsafe was ran in July 2017 which is not in line with the service specification. The BS Select failsafe report identified 2,443 women

overdue as of 31 January 2018. The service must review this report prior to selection of a batch to identify any significant numbers of clients from a single GP practice. The service, together with the screening QA service (SQAS) and screening and immunisation team (SIT), should agree the management of any identified practices as to the ones who could be removed from the failsafe batch and included in standard GP batches. (Recommendation 27).

The team review open episodes on both BS Select and NBSS to ensure the timely transfer of information between the systems. The QA team identified open episodes more than 6 months old on BS Select and NBSS and these need to be actioned appropriately. Issues around housekeeping not being undertaken in a timely manner were identified on both BS Select and NBSS. (Recommendation 28).

A review of the ceasing protocol identified that the service is ceasing clients appropriately. The team are planning to scan all historical documentation and any new ceasing documentation onto NBSS and is retaining all in hard copy format. There is no requirement to retain the paper copies once scanned copies are available providing that a full audit is undertaken prior to their destruction.

The administration team have previously sent out a GP pack to each practice 6 weeks prior to the selection of the batch. This has however stopped due to resource and time constraints. The QA team discussed the need to reintroduce this practice as per the service specification. (Recommendation 29). GP practices receive information about the performance of the practice regarding uptake and cancers detected once all episodes are closed. The team send out GP reports on a daily basis however it was noted that this practice had ceased for a considerable amount of time previously and was reintroduced in November 2017.

The local IT department provide good support to the service. All parts of the NBSS system are routinely backed up every evening. The trust has a robust disaster recovery system.

The team are aware of the requirement for accurate and complete data. The office manager primarily undertakes this area of work. The introduction of the breast screening information system (BSIS) will in future give clinicians access to increased levels of data and comparisons against other services, and regional and national averages. The service need to consider additional resources for this role as the workload has increased significantly following the reconfiguration.

The professional and clinical advisor (PCA) for administration and clerical reviewed a random selection of screening surgical information held on NBSS during the visit. The data input was of a high standard and no areas of concern identified through this audit

although as noted previously issues were noted at the surgical case review session of the visit.

High risk women

NHS England (West Midlands) have a contract with University Hospitals Coventry and Warwickshire (UHCW) NHS Trust on behalf of the 7 West Midlands breast screening services. UHCW hold sub-contracts with 3 other hospital trusts to provide this service across the sub-region. This contract started in April 2016 for a 3 year term. The women eligible for MRI (with or without mammography) are referred by the Dudley, Wolverhampton and South West Staffordshire BSS to Sandwell & West Birmingham Hospitals NHS Trust, which is a sub-contracting site. Women requiring mammography only are managed entirely by Dudley, Wolverhampton and South West Staffordshire BSS. An MRI guided biopsy service is available at UHCW if required.

Women recalled for second look imaging have ultrasound performed by consultant radiographers or radiologists (who may or may not be MRI reporters). The team feel that they are adequately guided by the detailed reports they receive to be able to perform second look ultrasound appropriately.

An efficient and organised system is being put in place to monitor this process. The screening office manager is responsible for coordinating this process. Other staff should be trained to support this role to avoid the risk of a single point of failure and to provide continuity during periods of annual leave and sickness. The service receives high risk referrals from the West Midlands regional genetics department and these are reviewed and authorised by a consultant radiographer.

Women at high risk who are known to the service have been transferred to the high risk NBSS database. The service report that they have 85 women at present eligible for high risk surveillance within the breast screening programme. A backlog of clients has been identified. This backlog should be reviewed and addressed to prevent clients having their screening delayed. (Recommendation 30).

Invitation, access and uptake

The service met the overall national standard for uptake of 70% during 2014/15 and 2015/16. The standard was not met in 2016/17 or in quarter 2 of 2017/18. Uptake for quarter 2 of 2017/18 could increase as the service has 6 months to re-invite women. For incident women the service exceeded the achievable standard throughout the same period and for prevalent women uptake was below the minimum standard for the screening year 2016/17 and quarters 1 and 2 of 2017/18.

The administration office send out invitation letters 2 to 3 weeks prior to the appointment date as clinic capacity is limited due to reduced radiographic staffing levels within the service. Wherever possible, invitation letters should be sent out with 3 to 4 weeks notice to maximise the opportunity for clients to attend. GP reports are collated and enveloped manually and sent out by the team. This provision should be reviewed and consideration given to outsourcing the production of GP reports. This would reduce time taken in this laborious task and have postage savings in the medium term. Invitation letters should be sent out on a daily basis to ensure that the number of telephone calls generated is kept to a manageable level. The content of letters is in line with national requirements.

The accessibility of screening is acceptable but fairly limited. Appointments are available from 08:48 to 15.54. Limited weekend screening is available at one site only which could be having a negative impact on screening uptake. The service could include additional questions in the client satisfaction survey to understand client requirements for out of hours screening. This information could be used to support a review of staffing, clinic capacity and appointment availability. Clients with mobility issues can attend one of the 3 static screening units.

Only previous images for clients who have attended for screening are requested however there is variation across sites as to normal practice for calling for previous images. Analogue images are now only requested where previous images are non-digital. Previous images are also made available as requested by film readers.

NBSS client screening forms (SIF) have been recently introduced into the service and are currently being retained in clinic order in the screening office. The service intends to destroy all routine recall forms. Assessment paperwork is kept in a screening packet for all positive clients.

Round length

The service use a spreadsheet based electronic round plan to manage their screening round. This is managed by the programme manager. The service need to review and audit the round plan to ensure that it is fit for purpose and complete. The QA team identified the information contained within it was inaccurate and out of date. This could have a negative impact on the team's ability to effectively monitor round length, plan a robust recovery to address round length slippage or provide timely information to women who request when their screening will be undertaken. (Recommendation 31).

The problems identified with the round plan are also contributing to issues with the completion of screening batches. Clients who have self referred are appearing in screening batches which necessitate manual intervention within the batch completion. This practice is not recommended and batches should be managed appropriately with reference to recent Hitachi training guides.

During 2014/15 the service exceeded the 90% national standard for round length (women invited within 36 months of their last screen). During 2015 to 2016 round length declined to 81% and further declined in 2016 to 2017 to 69.7%. The most recent available figures for April to June 2017 show that 69.7% of clients were invited within 3 years of their previous screen and in July to September 2017 this declined further to 41.4%. Some clients are currently being invited up to 11 weeks after their due date. Initially this was as a result of mammography equipment failure and issues with the reporting workstations. Some round length slippage was expected as part of the service reconfiguration in April 2017 but more recently planned screening clinics are being cancelled due to mammography shortages.

The service expressed concern regarding practice mergers. In particular the affect that this has on round length and how these practices can be screened. This is a national issue which is currently under review. BS Select is able to support the screening of these practices by the use of next test due date (NTDD) or out code within the GP practice to ensure that the appropriate clients are screened at the appropriate time. However, this issue can result in a reduction in uptake and raises complaints from clients regarding suitability of screening location. This is difficult for the service to address as the issue is beyond their control.

The service makes effective use of SMART clinics. They have a reasonable clinic utilisation. They optimise appointment bookings to ensure that clients are screened in the best order to maximise round length. They run the round length sorter crystal report on every batch of appointments to ensure that clients have been booked appropriately.

The service offers all clients who fail to attend an initial invitation a second timed appointment as required by the national service specification. This has resulted in

16.4% of clients attending following receipt of this second appointment notification between April 2016 and March 2017. The service currently has a backlog of second timed appointments that are overdue for re-appointing with episodes over 6 months old. An agreement on how this should be addressed and managed should be discussed with SQAS and the SIT. (Recommendation 32).

Health promotion

The service does not currently have a defined health promotion strategy but has links with GP practices and plans to send out information to practices both before and after screening. There is no identified resource to undertake this function and this should form part of the wider staffing review. The service should identify this resource and develop a 3 year health improvement strategy, in agreement with the SIT, outlining planned activities and focused population targeting. (Recommendation 33). Greater involvement from GP practices should be encouraged. This has been found to have a positive influence on uptake. This may be particularly important if the recent reduction in uptake continues.

The screening test – accuracy and quality

Radiography

The service provided evidence of audit and monitoring processes of mammographic standards. The technical recall / technical repeat (TCTP) rate was 1.40% from July to September 2017 and 1.10% in October 2017. The rates meet the national target of less than 2%. There is a mechanism in place to identify and resolve trends in individual high TCTP rates. The service has a poster accepted for a national scientific conference United Kingdom Radiological Congress (UKRC), of a TCTP audit on image blurring.

The service use the national image quality assessment tool for image review. However, radiographic staffing shortages mean that image quality assessment is not routinely undertaken. (Recommendation 34). A review of 70 sets of images was completed and the standard was of a consistently good quality with several examples of excellent technique. Due to time constraints, the image review did not cover images from each individual mammographer in the service. Image review feedback to the consultant radiographer happened at the pre-visit and for the mammographers on the day of the QA visit.

The partial mammography rate meets the guidelines of less than 1%. Partial mammography leaflets are available at all sites where screening takes place. Training for the Eklund technique for imaging women with implants is not complete across the merged service. Some mammographers have not seen the DVD. Appropriate training must be undertaken and all staff, including assistant practitioners, should familiarise themselves with the DVD and national guidance documentation. (Recommendation 35).

The service has Hologic Dimensions x-ray equipment at Russells Hall Hospital and Cannock Chase Hospital and Siemens Inspirations at New Cross Hospital. There are 3 mobiles with 1 Hologic Dimensions and 2 Hologic Selenia's. There are fully comprehensive maintenance contracts in place for all x-ray and ultrasound equipment across all sites.

The service uses the Dudley Group NHS Foundation Trust lone working policy to cover the mobile screening vans. The service should risk assess lone working and develop a policy with specific consideration to site location and ways of working across all sites, static and mobile. (Recommendation 36).

Based on NHSBSP staffing guidance the staffing establishment required to deliver screening mammography to the population of 137,000 women (including age extension) women is 17.8 WTE. Currently the service has 9.2 WTE which represents a significant shortfall in required staffing levels. In addition to the baseline shortfall there are 3 vacant

posts, 1 maternity leave plus 2 further pending resignations. Reviewing the rotas for the period January to March 2018, the staffing shortfall means that at least 30 out of a possible 240 screening lists cannot run. It is not possible to rotate all staff through screening, assessment and symptomatic clinics, resulting in remaining staff covering screening for 80% of their working time. This is having a big impact on staff morale and could lead to an increase in musculoskeletal problems (Recommendation 37). The service has advertised on 3 separate occasions for qualified mammographers. A recent advert for a trainee mammographer has attracted several applicants and interviews are imminent. The current level of radiographic staffing puts the viability of the service into doubt and steps to address this problem are required as a matter of urgency. The radiographic workforce issues, staffing levels, roles and responsibilities should be included as part of the overall organisation review. (Recommendation 3).

All radiographic staff have or are working towards an accredited award in mammography. Staff have access to relevant NHSBSP guidance and policies through team meetings and trust intranet. Annual appraisals and mandatory training are very out of date for some staff. Support for training and mentorship for advanced roles is limited due to staffing shortages. It would be beneficial for the service to identify a training coordinator. (Recommendation 38). Written protocols for advanced practitioners were not discussed in detail although the service state they are in place. They should be part of the organisational review. Any reconfiguration of roles, responsibilities and scope of practice needs clear documentation and communicated to all staff.

Staff meetings happen quarterly. All staff can put items on the agenda. The day alters between Tuesday and Thursday and the site changes to maximise staff attendance. All staff have access to the minutes however staff at Cannock have problems with accessing the intranet and staff have raised an issue with the timeliness of the minutes being available. Staff meetings will be crucial to maintaining good and open communication as the service works through all the issues and problems associated with the organisational review and on-going merger.

Radiology

The imaging team at Russells Hall Hospital comprises 2 consultant radiographers, (one of whom has recently been appointed), a trainee consultant radiographer and 3 advanced practitioners. 2 of the latter perform film reading and 2 perform stereotactic biopsies. The previous director of screening / consultant radiologist based in Dudley retired in December 2017. At New Cross Hospital the team comprises of one consultant radiologist, 2 consultant radiographers and 3 advanced practitioners. 2 of the latter perform film reading, 1 performs ultrasound and 1 undertakes stereotactic biopsies. A further film reader is based at Cannock Chase Hospital.

One member of the imaging team has an appraisal outstanding. All film readers have participated in the PERFORMS test set. Readers are sent their film reading numbers on a monthly basis. In New Cross Hospital, third reading had previously been required to meet the national target of 5,000 reads. Since the service reconfiguration the population has increased and there are now sufficient images for this not to be required. In 2016/17 there were 3 established film readers who did not read the required minimum of 5,000 images. Reasons for this include covering clinical work, a reduction of working hours and time spent learning new clinical skills. The service should ensure that all film readers read 5,000 images, of which 1,500 should be as the first reader, in line with NHSBSP guidance. (Recommendation 39).

Reading is performed at all 3 hospital sites. Due to only 1 film reader being based at Cannock Chase Hospital currently, all paperwork needs to be transferred to New Cross Hospital for second reporting. This is currently couriered by screening office staff via the hospital shuttle bus. This is insecure and should cease immediately and alternative arrangements made. (Recommendation 40).

There are sufficient reporting workstations across the service. Readers at New Cross Hospital reported that they are often interrupted to undertake clinical duties and that their sessions are curtailed to provide cover for symptomatic clinics during annual leave. The arrangements in the reporting room at Russells Hall Hospital are sub-optimal. The room doubles as an office which is distracting for image readers. It is uncomfortably hot, and clutter under the desks makes it difficult to sit comfortably. These factors mean that reporting conditions are less than ideal. It is understood that air-conditioning is planned for the room, however it would also benefit from reconfiguration and removal of extraneous material. (Recommendation 41).

The service's single reading policy is to arbitrate single recall cases only. However, the actual reading practice differs between the hospital sites. At New Cross Hospital, for example, all concordant recall cases are discussed and the second reader reads without access ('blind') to the first reader opinion which differs from the process in Russells Hall Hospital. During group discussion at the visit, readers wondered if the latter practice could be a contributory factor in the high recall to assessment rates in Wolverhampton. In Russells Hall Hospital, cases for recall and arbitration were not separated from those for routine recall at the time of reading. This was done later in the screening office. This process poses a potential risk of errors in the recall process and is not considered to be safe practice. (Recommendation 42).

Both hospitals perform arbitration as a consensus group. The reader based in Cannock has found it difficult to attend consensus meetings recently due to clinical pressures which prevent her travelling between sites. Entering of arbitration outcomes into NBSS is not uniform across the service sites. Some outcomes are delegated to the office staff for inputting rather than being done by readers. This practice is not supported by the

NHSBSP and should stop. (Recommendation 43). The service should agree and implement a single film reading policy across all sites. In order to ensure robust right results outcomes, the reading process should include separating the packets for recall and arbitration at the time of second read. The consensus opinion should be entered into NBSS by the readers at the consensus review. Processes and documentation for retrieval of previous images when required for reading should also be included in the policy. (Recommendation 44).

2013 to 2016 film reader QA (FRQA) outcomes demonstrate that all readers had first reader positive predictive values (PPVs) higher than the mean for the Midlands and East region. 4 readers are high outliers for recall to assessment rates, but all these have high cancer detection rates. Readers have been informed of their individual FRQA outcomes and that their results are available on the newly launched Breast Screening Information System (BSIS) to which all readers have access.

Referral

Screen to assessment

The service has consistently exceeded the 95% national minimum standard of timeliness for screen to normal results up to and including quarter 2 of 2017/18. In October 2017 the minimum standard was not met due to issues with film reading capacity. The service plan to facilitate cross site reporting to address this.

The service has been unable to achieve the 90% screen to assessment attendance within 3 weeks measure for 7 of the last 11 quarters. There has been a substantial decline over time. Whilst screen to date of first offered assessment appointment has been monitored for many years, a programme standard of ≥98% was only introduced in April 2017. The service have not achieved this in the 2 quarters of 2017/18 so far. The increased workload following the service reconfiguration and limited clinic capacity have been cited as the reasons. Detailed investigation should be completed by the service so that appropriate corrective action can be taken. The service anticipate that performance will improve with the opening of the weekly Cannock Chase Hospital assessment clinic, although a date for this was not known at the visit. (Recommendation 45).

Recall to assessment rates have been increasing over the last 3 years and remain higher than the Midlands and East average. The 2 clinical teams within the service work independently and have very different recall to assessment rates. In 2016 to 2017 the team based in Russells Hall Hospital have a prevalent recall rate of 6.82% compared to 19.38% for the team based in New Cross Hospital. The service should audit the recall rates and undertaken appropriate actions to reduce recall rates in line with national standards. (Recommendation 46).

Diagnosis

Assessment clinics

Assessment cases were reviewed for each assessor at the radiology pre-visit. The service does not have an agreed assessment policy and variable practice was noted between the 2 assessment sites. This was demonstrated in differing indications for undertaking cyst aspiration, ultrasound of the axilla, and in the images taken for calcification. The clinical teams should agree a cross-site practice for assessment and record these in a service assessment policy. (Recommendation 47).

Biopsies are taken at the first assessment visit unless there is a contraindication. Advanced practitioners perform stereotactic biopsies. Vacuum assisted biopsies are available at both sites and there are plans to move to larger bore excisions in the near future.

Second review of cases discharged to routine recall from assessment is undertaken but the process differs between the hospital sites. An incident has been reported where there was a delay in recalling a patient after second review. The service should agree and implement a cross-site policy for second review of cases discharged to routine recall, including a process for recall from second review when required. (Recommendation 47).

At the pre-visit, reviews of previously assessed cancers at Russells Hall Hospital were observed as having been carried out appropriately. Assessment reviews had previously been undertaken by the previous director and had never involved the clinical team at New Cross Hospital. As a result, the team in Wolverhampton were not familiar with the paperwork or process for assessment reviews. 13 cases were outstanding at the time of the pre-visit but the PCA for radiology was only able to review a few of these due to time constraints. At a later visit the images were not available for the PCA to review. These cases were subsequently reviewed after overcoming difficulties in obtaining the necessary paperwork. The service should develop and implement a robust cross-site process for the review of previously assessed interval and screen detected cancers in line with national guidance. This should involve participation on both sites by all assessors and include individual feedback for educational purposes. (Recommendation 48).

At the pre-visit, benign surgical biopsies from 2016 to 2017 proved to be satisfactory with pathologies including phyllodes and spindle cell tumours, radial scars or papillomas. Non-operative diagnosis cases were a mixture of B3 lesions with atypia or

papillomas and some cases in which the multidisciplinary team meeting decision had been to remove the lesion rather than undertake a second line vacuum assisted biopsy.

A review of B1 to routine recall cases was also undertaken at the pre-visit. Many of these were biopsies undertaken for calcification which demonstrated calcium in the specimen x-ray and on pathology. Others were due to hamartomas or small asymmetric densities and no concerns were raised on review of these cases. Localisation wires were seen to be correctly placed in the cases reviewed.

Cases placed on short term recall were mainly due to difficulty with biopsy of calcification in difficult sites. These were noted to have occurred at the correct interval of one year but not all cases had both sides imaged. The service should ensure that all short term recall cases have imaging of both breasts in line with national guidance. (Recommendation 49).

Preparation time for the multidisciplinary team (MDT) meeting is not included in all relevant staff job plans. Some members of the team do not have time to review the cases in advance of the meeting. This should be addressed. (Recommendation 50).

Screening women who require MRI as part of their work up for treatment purposes, for example lobular cancers, have MRI performed locally at either Russells Hall or New Cross Hospitals. In Wolverhampton there are 2 MRI reporting clinicians (1 radiologist and 1 consultant radiographer). In Dudley MRI scans are sent to the City, Sandwell & Walsall service for reporting, for which there is a service level agreement.

Interval cancers are identified at multidisciplinary team (MDT) meetings when women present to the symptomatic service. No formal process for the review of interval cancers is in place in Wolverhampton. Backlogs in classifications have occurred as the team wait for instructions from the main screening office to initiate reviews. Classifications had been brought up to date by the time of the imaging pre-visit. The service should agree and implement a unified cross-site policy and process for the review and classification of interval cancers in line with published guidance. This should involve all members of the team who are involved in assessment clinics and include a feedback process to individual assessors for educational purposes. (Recommendation 48).

Interval cancer data demonstrates that the percentage of cases showing suspicious features at previous screen (category 3) was higher in the service than the Midlands and East average. At the pre-visit, the new classification method was used to review the 11 category 3 interval cancers in Dudley. 7 of these were re-classified as category 2 (possible abnormality seen on previous images). All members of the film reading team are aware of the duty of candour guidance and knew about the recently released NHSBSP toolkit.

Dudley Group NHS Foundation Trust

Assessment clinics are held in Russells Hall Hospital on Monday and Tuesday mornings with one consultant practitioner in each clinic.

The PCA for nursing carried out a pre-visit to the nursing team at Russells Hall Hospital, but an assessment clinic was not observed.

The unit at Dudley consists of a divided symptomatic and screening waiting room where patients wait for assessment and investigations. There is a wide range of written information leaflets available for women attending the clinics, but there are not many leaflets on display in the waiting room. There is an adequate counselling room available for screening women.

The team has a comprehensive assessment patient care pathway and use a structured assessment proforma to collect all the information.

The nurses cover 2 x 6 hour assessment clinics a week. As recommended in the guidelines, they meet all women at the start of the assessment, to outline the assessment pathway, identify the women's levels of anxiety, complete a short holistic assessment and take a history.

The nurse contact details are in the assessment letter, so that women can contact the team prior to appointment, but not many women are using this facility. The team can only give general information about the recall, because the notes are not at hand when women ring.

The Royal Wolverhampton NHS Trust

Assessment clinics at New Cross Hospital are held Tuesday morning and afternoon and on Wednesday morning. Clinics are run by a single clinician.

A pre-visit was carried at New Cross Hospital and an assessment clinic was observed.

The unit at Wolverhampton facilitates a symptomatic and screening waiting room where patients wait for assessment and investigations. A wide range of written leaflets is available for women attending the clinics. There is an appropriate counselling room available were women are seen before a biopsy and after assessment. The previous office space and the facilities for nurses had not been fit for purpose. This issue has now been resolved after moving to a new building. Unfortunately the office is not adjacent to the clinic.

The nurses are a motivated and established team, which is well supported in the undertaking of appropriate accredited courses. The majority of the team has gained qualifications for the advanced breast care course. The new member of staff will finish the advanced communication course in March 2018 and will commence the breast care course in 2019.

The nurses have meetings with an element of clinical supervision and can meet with the psychologist if needed.

One of the assessment clinics is due to move to Cannock Chase Hospital and one of the nurses from Wolverhampton will be covering this clinic. The plan is that the film readers room will be made suitable as a counselling room and office. It is important that the room does not appear too clinical and meet the purpose of a counselling space. It is important that the team are provided with relevant resources to ensure a comparable service.

The nurses details are in the recall to assessment letter but not many women take up the opportunity to ring for more details.

A nurse is available during the clinic and will meet women if they need investigations and after assessment.

Pathology

Dudley Group NHS Foundation Trust

3 pathologists deliver the breast histopathology service at Russells Hall Hospital, reporting biopsy and surgical specimens taken within the hospital. Only 1 pathologist is in a full time substantive post (the breast lead) who has joined recently. Oestrogen receptor (ER) immunohistochemistry is done on site. Human epidermal growth factor receptor 2 (HER2) immunohistochemistry and fluorescence in situ hybridisation (FISH) testing are done at Birmingham Heartlands Hospital, part of the Heart of England NHS Foundation Trust.

The laboratory participates in the breast pathology hormonal receptors module of the UK National External Quality Assessment Scheme (NEQAS) with overall satisfactory results for ER over the past 3 years.

The laboratory is UKAS accredited and maintained accreditation following the recent annual visit conducted in January 2018.

In terms of breast workload within the laboratory, the team reported 1,007 core biopsies and 555 surgical specimens in a 12 month period. The wide bore needle statistics (BQA) from NBSS showed 2 pathologists with low specificity, 1 of whom has now left this service. The specificity of the laboratory is 80.00% which is above the national minimum standard of >75%.

Preliminary audit data from the NHSBSP and ABS audit for 2014-17 indicates that the laboratory has a high proportion of grade 2 tumours and a low proportion of grade 3 tumours. The distribution of grading should be audited across the laboratory, in accordance with Royal College of Pathologists guidelines. (Recommendation 51). Grading of invasive carcinoma was previously well audited by the service pathologists, both of whom have now moved to another hospital.

The lead breast pathologist does not currently have the lead role recognised in his job plan. Therefore, no internal audits were submitted or discussed with the professional and clinical advisor (PCA) for pathology. This lead role needs to be recognised in the job plan and time allowed for the responsibilities including undertaking screening audits. (Recommendation 52). Multidisciplinary team (MDT) meeting preparation time is adequate and the breast lead presents all cases. Cover is provided when the lead pathologist is on leave.

This is a hard working team. There is concern over the sustainability of the service. The service overall has been chronically short staffed and does not meet the royal college of pathologists guidance on workforce. There is a 7.6 WTE pathology establishment for the whole department; of which there is only one full time substantive consultant. At the time of the visit, the breast reporting was done by the breast lead and 2 long term locum consultants. The breast pathologists also have to cover other specialties and with the current shortage this adds extra pressure. Currently there are arrangements to provide reporting cover by a pathologist from Wolverhampton for non breast reporting. Cover during annual leave, particularly of the lead pathologist, is problematic. (Recommendation 53).

Some concern was raised regarding prolonged HER2 turnaround time for some cases. The team are looking into the pathway of HER2 testing to reduce the overall turnaround time. The pathologists participate in the NHSBSP external quality assurance (EQA) scheme. Apart from the lead pathologist, participation at the QA regional training days and UK update courses is lacking. All pathologists should meet the CPD requirements of the NHSBSP. (Recommendation 54).

The PCA for pathology reviewed 900 selected slides at the pre-visit. This included screening QA service selected cases, MDT discussion cases and 5 cases from each pathologist. A trend towards suboptimal sampling was identified with 1 pathologist which may lead to inaccurate and/or missed pathological information. This has been discussed with them and the lead breast pathologist and the issue has now been

rectified. This should be closely monitored by the lead pathologist to ensure that optimal practice persists.

The Royal Wolverhampton NHS Trust

The histopathology department at New Cross Hospital is well staffed with 11 consultants and 1 specialty doctor. 4 pathologists currently report breast screening cases including 1 part time pathologist. A fifth consultant has recently joined the team and is currently double reporting. The laboratory is UKAS accredited.

Breast reporting and ER testing occur on site. During a 12 month period between August 2016 and July 2017, the laboratory reported 823. The laboratory participates in the breast pathology hormonal receptors module of the UK National External Quality Assessment Scheme (NEQAS) with overall satisfactory results for ER over the past 3 years.

HER2 testing is undertaken at Birmingham Heartlands Hospital, part of the Heart of England NHS Foundation Trust. The pathologists performed a detailed audit of the HER2 pathway, from request to receipt of results. They have recently refined their pathway to further shorten the turnaround time. Other audits performed by the pathologists included cancer dataset reporting, turnaround time and Oncotype DX® testing.

In terms of breast workload within the laboratory, the team reported 794 core biopsies and 629 surgical specimens in a 12 months period. The BQA statistics show that during 2014 to 2017, 2 pathologists have low full specificity and the average for service is 74.82% falling just below the national minimum standard of >75%. One pathologist is a high outlier for suspicious rate (13.51%) during 2013 to 2016, with the Midlands and East average being 7.57%. The data has been discussed with the pathologists.

All pathologists participate in the NHSBSP histopathology EQA scheme and CPD activities. The most recent pathologist to join the team is yet to undertake a multidisciplinary breast course. (Recommendation 55).

The breast co-lead is planning an early retirement in the next year. This together with the planned reorganisation of the pathology service between Wolverhampton, Dudley, City Hospital and Walsall will have an impact on staffing levels, degree of specialisation and reconfiguration of service at both Dudley and Wolverhampton. Both teams are aware of the challenges and opportunities and the need for future planning.

There is adequate MDT meeting preparation time. Currently 2 of the 5 breast pathologists do not attend the breast MDT meeting due to it clashing with the skin MDT meeting. They receive adequate feedback from their colleagues who attend the breast

MDT meetings and no issues were raised from either the clinical team or the pathologists.

910 slides and reports were reviewed at the pre-visit. This included screening QA service selected cases, MDT discussion cases and 5 cases from each pathologist. These met the Royal College of Pathologists minimum dataset standards.

Intervention and outcome

Support to women

Dudley Group NHS Foundation Trust

The nursing team in Russells Hall Hospital is pro-active demonstrating good team work, development within the team and spread of experience. The team is well supported in the undertaking of appropriate accredited courses. 1 nurse is on the waiting list for the breast care nurse (BCN) course. The lead nurse works at a consultant level and several nurses have undertaken a module in breast examination.

The team provide new, cancer follow up clinics, seroma drainage and nipple tattooing in the symptomatic service. The nurses have monthly meetings with the psychologist and group supervision within the team.

All patients are seen before and after assessment. A nurse informs patients about routine recall results and provides breast awareness information. Otherwise, after a biopsy, information given by the consultant is reiterated, the next stage of the pathway is explained and verbal and written post biopsy information is given.

There are team members present during the weekly multidisciplinary team (MDT) meetings to act as the patients advocate, when the results and management plan of women is discussed. The nurses make face to face appointments for all patients undergoing a biopsy. If the outcome is benign or a repeat biopsy is needed, women are telephoned with the result. There is a protocol in place for this. Telephoning women is audited on an annual basis and the results are positive.

The team support their surgical colleagues in giving cancer results and support the women at their subsequent surgical appointment.

The nursing team reflects on and reviews their own practice. There has been an audit regarding the women’s experience of the BCN in assessment clinics. 40 questionnaires were sent out and 14 responses were received. All women assessed were seen by a BCN. 71.4% found it very helpful to speak to a nurse and 85.7% left the clinic feeling not anxious. The responses and comments received were complimentary and supportive of a good experience.

The team undertake breast awareness and health promotion throughout the year formally and informally within the hospital and within the community. There is no particular focus on low uptake areas.

The Royal Wolverhampton NHS Trust

The assessment pathway in New Cross Hospital is such that the nursing team do not meet women at the start of the clinic to outline the assessment pathway, identify the woman's level of anxiety and complete a brief holistic assessment. In accordance with NHSBSP guidelines, nurses should see women at the beginning of the assessment clinic. (Recommendation 56).

The nurses see all patients during the assessment process to discuss breast health and to answer any outstanding questions. If patients need a biopsy they are seen before the investigations. Verbal and written information about the further investigations are given, the next stage of the pathway is explained and a follow up appointment with the surgeon is given. Patients are not routinely seen post biopsy, however there is always a CNS available in the clinic to see any patients that requires additional information and or support. The team should ascertain whether their patients would benefit from an opportunity to meet with a nurse after all investigations are finished. Prior to leaving the clinic contacts details for the CNS are reiterated to the patient.

There has not been an audit regarding the women's experience of assessment clinics. According to the NHSBSP guidelines this should be audited at least once every screening round. (Recommendation 57).

There is documented evidence available of the discussions with the patients. The nurse enters information onto the clinical portal but at the moment it is not a structured holistic assessment as the information collected depends on the nurse who facilitates the clinic. A structured assessment form to collect the required information would ensure consistency across the team. (Recommendation 56).

There are team members present during the weekly MDT meetings to act as the patients advocate, when the results and management plan of the women is discussed. Members of the nursing team do give benign results over the telephone and this process is supported by a protocol. The team should audit this process to find out the effectiveness of delivering benign results in this way. (Recommendation 58).

The team also support their surgical colleagues in giving cancer results and support the women at their subsequent surgical appointment.

At present, general breast awareness and health promotion is carried out for all patients after assessment. However there is no specific focus on health promotion at events and low uptake areas by the nursing team.

The team consists of full time and part time nurses. A member of the team is on long term sick leave and another will be from April 2018 for at least 3 months. The team are concerned about cover for these posts and this should be addressed by the trust. According to national guidance, staffing arrangements should be in place to cover any periods in which a nurse is unavailable. (Recommendation 59).

Multidisciplinary team

2 breast MDT meetings (MDTMs) are held at each hospital site per week, on a Wednesday and Friday. In Russells Hall Hospital, the main MDTM takes place on a Friday, with a smaller screening MDTM on a Wednesday. In New Cross Hospital, the main MDTM is held on a Wednesday at which screening cases are predominantly discussed with a smaller MDTM on a Friday.

Videoconferencing is used on a Wednesday to link the 2 meetings for a discussion of the screening patients on the list. Screening cases may be discussed on Friday at both sites independently. The minutes for these meetings are shared between the teams. Visually the videoconferencing was demonstrated to work effectively, with imaging sharing between sites available. The single desktop microphone in each room meant that the audio quality was not optimum and appeared to limit the opportunity for full discussion. (Recommendation 60). The videolink was reported to generally work well and on the rare occasion that there is a problem there is still appropriate discussion of the patient.

The discussion of cases between the 2 sites was predominately surgical in nature and the full team did not appear to be fully engaged. Radiology support is present at both sites to discuss cases. It is important that all team members recognise that in having a joint screening MDTM it is expected that they participate in discussion and challenge planned care as appropriate.

Dudley Group NHS Foundation Trust

The lead surgeon chairs the MDTM meetings. Different rooms are used for each of the weekly meetings, but with the same facilities. It was reported that the monitors do not meet the NHSBSP requirements of 2-3 megapixels. Participation by all members of the team and good interdisciplinary working was observed at both the Wednesday and Friday MDTMs.

Until recently, 1 of the surgeons had a full day operating list on a Wednesday which limited attendance at the MDTM. This surgeon has now become director of breast screening and has altered his job plan to facilitate regular MDTM attendance.

The MDT coordinator inputs the MDT discussion into Somerset during the meeting and issues minute shortly afterwards. Despite it being a QA visit recommendation in 2014, Somerset is not projected during the meeting for instant validation. It was implemented, but the practice was then abandoned. With proposed moves towards a paperless hospital, it is particularly important that this practice is reinstated. (Recommendation 61).

There is oncology at its main Friday meeting, but not at the diagnostic meeting on a Wednesday. On the rare occasion that a screening case is felt to be suitable for primary chemotherapy, this is identified by the surgeons at the Wednesday meeting and the case discussed on the Friday.

The Royal Wolverhampton NHS Trust

The lead surgeon chairs the MDTM meetings. The same room is used for both of the weekly meetings. It was reported that the monitors within this room did not meet the NHSBSP requirements of 2-3 megapixels. (Recommendation 62).

The MDT meeting rooms do not contain full workstations suitable for diagnosis. If there are any queries regarding the imaging, the case is reviewed back in the imaging department and the case discussed further at the next MDT.

The MDT coordinator documents the discussion and decision live into Somerset, which is projected for all to see. It was evident from the MDTM observations undertaken at the meeting that this is reviewed and verified in real time.

Although oncologists are expected to be present at the main Wednesday MDTM, this not always the case. Intermittent attendance can disrupt the flow of the meeting. With the loss of a key member of staff, the concern is that the situation will worsen.

Surgery

The 2 surgical units which together provide the surgical input to the breast screening service work as independent departments. The only collaboration is over the screening patient multidisciplinary team meeting (MDTM) on a Wednesday when they are video linked.

Dudley Group NHS Foundation Trust

Until recently the department in Russells Hall Hospital has had 3 consultant surgeons, 1 of whom has just left. There is an established Associate Specialist who is currently standing in as a locum consultant, but is not involved in the treatment of screening

cases. Plans are in place to make a substantive appointment. Once this occurs there will be appropriate staffing levels.

On discussion of cases flagged as potential outliers, clear explanations were provided on each occasion. There appeared to be issues with cases due to inaccuracies in data entry. The team felt that there was insufficient staff for data entry, and that they would benefit from the appointment of a data manager. (Recommendation 24). There were no concerns on review of the NHSBSP audit data and KPIs.

Results are given to patients in a timely fashion within 1 week of MDTM discussion.

Sentinel lymph node biopsy is routinely offered using the combined technique of radioisotope and blue dye.

There is a well established breast reconstructive service provided jointly with the local plastic surgeons (2 with special breast interest). 1 of the breast surgeons also offers an oncoplastic service. There is a regular oncoplastic MDT involving both breast and plastic surgeons which is to be commended. Some of the reconstructive techniques offered, in particular pedicled TRAM flaps, are rarely now performed in other units.

There is a specimen cabinet in theatre, with the breast surgeon interpreting the images in most cases. A radiologist opinion can be sought at the time if needed, and is available at the post-operative MDTM.

Impalpable lesions are localised by guide-wire. The surgeons are happy with the service that they receive from the radiologists.

Trial recruitment is adequate. The team feel that they would be able to participate more in trial recruitment if the clinical workload were less and with greater research nurse input.

The Royal Wolverhampton NHS Trust

5 consultant breast surgeons work at New Cross Hospital with an extensive oncoplastic interest evident.

On discussion of cases flagged as potential outliers, clear explanations were provided on each occasion. There appeared again to be issues with cases due to inaccuracies in data entry. The team felt that there was insufficient staff for data entry, and that they would benefit from the appointment of a data manager. (Recommendation 24). There were no concerns on review of the NHSBSP audit data and KPIs.

Result appointments for surgical clinics are given to women from assessment following biopsy, with arrangements made by the breast care nurses. It takes a long time to get an appointment arranged and this is time which could be used more efficiently. In addition the nurses are concerned that some patients have to wait up to 2 weeks to have a surgical appointment. This was not identified as an issue by the surgeons and therefore requires further investigation locally. To achieve this the service should undertake an audit of the time from assessment to results, to ensure compliance with NHSBSP guidance. (Recommendation 63). Women with benign results are phoned by a breast care nurse ahead of the planned appointment to save them travelling to the clinic.

Sentinel lymph node biopsy is routinely offered using the combined technique of radioisotope and blue dye.

The unit has an extensive interest in oncoplastic techniques and breast reconstruction, with 4 of the 5 surgeons regularly involved in this. They are happy to receive tertiary referrals from other centres for this. In terms of reconstruction, they primarily offer an implant / acellular dermal matrix (ADM) based service. For cases in which a free tissue flap is felt to be appropriate, or when a plastic surgical second opinion is desired, there is an arrangement with the plastic surgeons at University Hospitals Birmingham NHS Trust. There is an unusual arrangement in place whereby the clinical commissioning group (CCG) has contracted plastic surgical support privately, with patients being seen and treated as private patients at the BMI Priory Hospital. Free tissue flap procedures take place there at weekends. Currently only 1 of the breast surgeons has admitting rights to this hospital so is the sole operator for the oncological part of the procedure. Further surgeons are in the process of obtaining similar admitting rights.

There is a specimen cabinet in theatre, with the breast surgeon interpreting the images in most cases. A radiologist opinion can be sought at the time if needed, and is available at the post-operative MDTM. It was not confirmed whether the monitors used in theatres are 2-3 megapixels as per the NHSBSP requirements. This should be ascertained and the monitors replaced if necessary.

Impalpable lesions are localised by guide-wire. The surgeons are happy with the service that they receive from the radiologists.

New Cross is a paperless hospital, although there is a slim paper folder for on-going clinical episodes. Concerns were expressed about some of the uploading of this paperwork onto the system, for example operative notes which are not always available when patients are seen back with results. This problem should be resolved. (Recommendation 64).

The geographical location of breast services at New Cross Hospital is sub-optimal. Surgical out-patients, breast radiology and breast care nurse specialists occupy 3

different sites quite distant from each other. This is not ideal for the coordinated functioning of the unit or for the patient experience.

Trial recruitment is adequate. The team feel that they would be able to participate more in trial recruitment with greater research nurse input.

Appendix A: Data

Dudley & Wolverhampton - consolidated 3 yr performance summary 1 April 2014 to 31 March 2017							
KPI	**Standard**	**Activity data**	**Local performance**				**National standards**
			14/15	**15/16**	**16/17**	**14-17**	
Screen round length	The percentage of women whose first offered appointment is within 36 months of their previous screen	Previously screened	17,904	17,923	18,167	**53,994**	
		FOA ≤36m	16,966	14,515	11,049	**42,530**	
		FOA ≤36m (%)	**94.8**	**81.0**	**60.8**	**78.8**	**Minimum ≥90% Achievable 100%**
Waiting time for results	The percentage of women who are sent their result within 2 weeks	Screened	19,996	20,547	20,054	**60,597**	
		Result ≤2 weeks	19,686	19,607	19,708	**59,001**	
		Result ≤2 weeks (%)	**98.4**	**95.4**	**98.3**	**97.4**	**Minimum ≥90% Achievable 100%**
Technical recall/ repeat	The number of repeat examinations	Screened	21,084	21,735	21,321	**64,140**	
		Tech recalls/repeats	321	343	425	**1,089**	
		Tech recalls/repeats (%)	**1.52**	**1.58**	**1.99**	**1.70**	**Minimum <3% Achievable <2%**
Waiting time for assessment	The percentage of women who attend an assessment centre within 3 weeks of attendance for the screening mammogram	Assessed	966	1,083	1,133	**3,182**	
		Assessed ≤3 weeks	873	925	1,029	**2,827**	
		Assessed ≤3 weeks (%)	**90.4**	**85.4**	**90.8**	**88.8**	**Minimum ≥90% Achievable 100%**

Dudley & Wolverhampton - consolidated 3 yr performance summaries 1 April 2014 to 31 March 2017									
KPI	Standard		KC62 source	Activity data	Local performance				National standards
					14/15	15/16	16/17	14-17	
Uptake	The percentage of eligible women who attend for screening	Overall	Table A-C2 age 50-70	Invited	24,623	24,809	25,900	**75,332**	
				Screened	17,727	18,055	17,655	**53,437**	
				Uptake rate (%)	**72.0**	**72.8**	**68.2**	**70.9**	**Minimum ≥70% Achievable ≥80%**
Uptake	The percentage of eligible women who attend for screening	Prevalent screen	Table A age 50-52	Invited	1,867	1,646	1,918	**5,431**	**Non KPI measure of performance**
				Screened	1,328	1,181	1,312	**3,821**	
				Uptake rate (%)	**71.13**	**71.75**	**68.40**	**70.36**	
		Incident screen	Table C1 age 53-70	Invited	14,326	13,813	14,160	**42,299**	
				Screened	12,740	12,350	12,304	**37,394**	
				Uptake rate (%)	**88.93**	**89.41**	**86.89**	**88.40**	
Referral to assessment	The percentage of women referred to assessment	Prevalent screen	Table A age 50-52	Screened	1,328	1,181	1,312	**3,821**	
				Assessed	134	116	142	**392**	
				Referred to assessment Rate (%)	**10.09**	**9.82**	**10.82**	**10.26**	**Minimum <10% Achievable <7%**
		Incident screen	Table C1 age 53-70	Screened	12,740	12,350	12,304	**37,394**	
				Assessed	447	482	490	**1,419**	
				Referred to assessment Rate (%)	**3.51**	**3.90**	**3.98**	**3.79**	**Minimum <7% Achievable <5%**
Short term recall	The percentage of women placed on short term recall	Overall	Table T age 50-70	Screened	18,002	18,408	18,194	**54,604**	
				Short term recall	2	1	0	**3**	
				Short term recall rate (%)	**0.01**	**0.01**	**0.00**	**0.01**	**Minimum <0.25% Achievable <0.12%**
Invasive cancer detection	The rate of invasive cancers detected in eligible women invited and screened	Prevalent screen	Table A age 50-52	Screened	1,328	1,181	1,312	**3,821**	
				Invasive cancers	7	6	10	**23**	
				Invasive cancer detection rate (per 1,000)	**5.27**	**5.08**	**7.62**	**6.02**	**Minimum ≥3.6/1000 Achievable ≥5.1/1000**
		Incident screen	Table C1 age 53-70	Screened	12,740	12,350	12,304	**37,394**	
				Invasive cancers	106	93	85	**284**	
				Invasive cancer detection rate (per 1,000)	**8.32**	**7.53**	**6.91**	**7.59**	**Minimum ≥4.1/1000 Achievable ≥5.7/1000**
Non-invasive cancer detection	The rate of non-invasive cancers detected in eligible women invited and screened	Prevalent screen	Table A age 50-52	Screened	1,328	1,181	1,312	**3,821**	
				Non/Micro invasive cancers	3	3	4	**10**	
				Non-invasive cancer detection rate (per 1,000)	**2.26**	**2.54**	**3.05**	**2.62**	**Minimum ≥0.5/1000**
		Incident screen	Table C1 Age 53-70	Screened	12,740	12,350	12,304	**37,394**	
				Non/Micro Invasive Cancers	27	18	20	**65**	
				Non-Invasive Cancer Detection Rate (per 1,000)	**2.12**	**1.46**	**1.63**	**1.74**	**Minimum ≥0.6/1000**
SDR	Standardised detection ratio	Prevalent and Incident Screen	Table A-C1 age 50-70	Observed	121	114	111	**346**	
				Expected	66	65	66	**196.74**	
				SDR	**1.82**	**1.76**	**1.69**	**1.76**	**Minimum ≥1.0 Achievable ≥1.4**
SDR <15mm	Standardised detection ratio	Prevalent and Incident Screen	Table A-C1 age 50-70	Observed	71	59	57	**187**	**Non KPI measure of performance**
				Expected	36	36	36	**108.21**	
				SDR	**1.95**	**1.65**	**1.58**	**1.73**	
SDR	Standardised detection ratio	Prevalent screen	Table A + B age 50-70	Observed	12	11	21	**44**	
				Expected	9	8	10	**26.97**	
				SDR	**1.36**	**1.30**	**2.18**	**1.63**	
SDR <15mm	Standardised detection ratio	Prevalent screen	Table A + B age 50-70	Observed	7	4	10	**21**	
				Expected	5	5	5	**14.83**	
				SDR	**1.44**	**0.86**	**1.88**	**1.42**	
SDR	Standardised detection ratio	Incident screen	Table C1 age 50-70	Observed	109	103	90	**302**	
				Expected	58	56	56	**169.77**	
				SDR	**1.90**	**1.83**	**1.61**	**1.78**	
SDR <15mm	Standardised detection ratio	Incident screen	Table C1 age 50-70	Observed	64	55	47	**166**	
				Expected	32	31	31	**93.37**	
				SDR	**2.02**	**1.77**	**1.53**	**1.78**	
SDR	Standardised detection ratio	Prevalent Screen and Age Extension	Table A + B age 45-52	Observed	13	10	19	**42**	
				Expected	10	9	10	**29.09**	
				SDR	**1.34**	**1.06**	**1.91**	**1.44**	
SDR <15mm	Standardised detection ratio	Prevalent Screen and Age Extension	Table A + B age 45-52	Observed	10	4	9	**23**	
				Expected	5	5	5	**16.00**	
				SDR	**1.87**	**0.77**	**1.64**	**1.44**	
Small invasive cancer detection	The rate of invasive cancers <15mm detected in eligible women invited and screened	Prevalent screen	Table A age 50-52	Screened	1,328	1,181	1,312	**3,821**	
				Invasive cancers <15mm	7	3	5	**15**	
				Small invasive cancer detection rate (per 1,000)	**5.27**	**2.54**	**3.81**	**3.93**	**Minimum ≥2.0/1000 Achievable ≥2.8/1000**
		Incident screen	Table C1 age 53-70	Screened	12,740	12,350	12,304	**37,394**	
				Invasive cancers <15mm	63	51	45	**159**	
				Small invasive cancer detection rate (per 1,000)	**4.95**	**4.13**	**3.66**	**4.25**	**Minimum ≥2.3/1000 Achievable ≥3.1/1000**
Non-operative diagnosis	The percentage of women who have a non-operative diagnosis of cancer by cytology or needle histology after a maximum of two visits	Invasive cancers	Table T age 50-70	Referred for cytology/core	141	138	123	**402**	
				Invasive cancers	139	137	123	**399**	
				Invasive non-operative diagnosis rate (%)	**98.6**	**99.3**	**100.0**	**99.3**	**Minimum ≥90% Achievable ≥95%**
		Non-invasive cancers		Referred for cytology/core	40	28	37	**105**	
				Non-invasive cancers	31	20	31	**82**	
				DCIS non-operative diagnosis rate (%)	**77.5**	**71.4**	**83.8**	**78.1**	**Minimum ≥85% Achievable ≥90%**
Benign biopsy	The rate of benign biopsies	Prevalent screen	Table A age 50-52	Screened	1,328	1,181	1,312	**3,821**	
				Benign biopsies	4	4	3	**11**	
				Benign biopsy rate (per 1,000)	**3.01**	**3.39**	**2.29**	**2.88**	**Minimum <1.5/1000 Achievable <1.0/1000**
		Incident screen	Table C1 age 53-70	Screened	12,740	12,350	12,304	**37,394**	
				Benign biopsies	9	11	8	**28**	
				Benign biopsy rate (per 1,000)	**0.71**	**0.89**	**0.65**	**0.75**	**Minimum <1.0/1000 Achievable <0.75/1000**

Appendix B:

Right Results to Right Woman Walkthrough – Overall assessment 10 & 24 January 2018

The overall assessment by reviewers of the service's adherence to the right results procedures and general principles

Statement	Fully Comply	Partly Comply Comments	Do Not Comply Comments
1. There is a consistent unit-wide approach to the right results which applies to all staff, including consultant medical staff.			Varying practices observed across the multiple sites
2. All staff are involved in drawing up procedures and work instructions for those elements of the right results processes in which they are involved.	✓		
3. There is staff training about the right results processes so that each staff member understands how his or her role contributes to the overall process. For screening office staff this will be part of wider training on the NBSS system.		A robust induction process ensuring all staff have appropriate competencies for their role needs to be developed	
4. Clearly laid out controlled forms lead staff through the tally and checking process at each stage of the results process.	✓		
5. All forms and other documentation are kept up to date and reflect current practice.		Not all forms used are QMS controlled	
6. Individuals can feed changes or better ways of working into the unit-wide change control process.	✓		
7. All non-conformances are recorded and analysed by the management team so that improvements in working practice and training issues can be identified.			Not all non-conformances are captured and recorded. No clear log of non-conformances and no audit trail of actions taken.

8. Any issues of concern are highlighted to the director of breast screening without delay.			Observed not all processes being completed and gaps not being escalated

Appendix C: References

- NHSBSP 2 - Quality Assurance Guidelines for Breast Pathology Services
- NHSBSP 20 - Quality Assurance guidelines for Surgeons in Breast Cancer Screening. March 2009
- NHSBSP 29 - Interim Quality Assurance guidelines for Clinical Nurse Specialists in breast cancer screening (5th Edition). December 2012
- NHSBSP 40 – Guidelines on Quality Assurance visits. October 2000
- NHSBSP 47 - Quality Assurance Guidelines for Administration and IT in Breast Screening. September 2014
- NHSBSP 49 - Clinical Guidelines for Breast Cancer Screening Assessment. Fourth edition. November 2016
- NHSBSP 52 – Organising a Breast Screening Programme. December 2002
- NHSBSP 55 – The Right Results Guide to the Correct Processing and Issuing of Results. May 2003
- NHSBSP 59 - Quality Assurance Guidelines for Breast Cancer Screening Radiology
- NHSBSP 63 – Quality Assurance guidelines for Mammography including Radiographic Quality Control. April 2006
- NHSBSP 71 – Guidance on Image Display Equipment for use in Breast Screening. December 2010
- NHSBSP 74 – Protocols for the surveillance of women at higher risk of developing breast cancer. June 2013
- NHSBSP equipment report 1303 - Routine quality control tests for full-field digital mammography systems. Fourth edition. October 2013
- NHSBSP 0604 – Commissioning and routine testing of full field digital mammography systems
- NHSBSP consolidated standards
- NHS public health functions agreement 2017-18. Service specification no.24 Breast Screening Programme. April 2017

- The Royal College of Pathologists – Guidelines on staffing and workload for histopathology and cytopathology departments (4th edition)
- Society of Radiographers - Violence and Aggression at Work (including lone working)
- Managing Safety Incidents in NHS Screening Programmes. October 2015
- NHS Breast Screening Programme Breast screening: guidance for breast screening mammographers
- NHS Breast Screening Programme: Screening women with breast implants
- NHS Breast Screening Programme: Reporting, classification and monitoring of interval cancers and cancers following previous assessment
- NHS Screening Programmes Guidance on applying duty of candour and disclosing audit results
- The Characteristics of an Effective Multidisciplinary Team (MDT) NCAT 2010
- HSE requirement Report PM77
- Ionising Radiations Regulations (IRR) 17
- Ionising Radiation (Medical Exposure) Regulations (IR(ME)R) 17
- Programme Specific Operating Model for Quality Assurance of Breast Screening Programmes
- The Royal College of Pathologists – An audit of breast cancer grading. January 2017
- NHS Cancer Screening Programmes Information Security Policy. July 2009

Enclosure 11

The Dudley Group NHS Foundation Trust

Paper for submission to the Board of Directors on 5th July 2018

TITLE:	Integrated Performance Report for Month 1 (May) 2018		
AUTHOR:	Andy Troth Head of Informatics	**PRESENTER:**	Karen Kelly Chief Operating Officer

CLINICAL STRATEGIC AIMS

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

CORPORATE OBJECTIVE:

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

IMPLICATIONS OF PAPER:

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

ACTION REQUIRED OF BOARD:

Decision	Approval	Discussion	Other
		X	

RECOMMENDATIONS FOR THE BOARD:

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

Integrated Performance Report - Board




May 2018

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

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

The Dudley Group NHS Foundation Trust

Quality Dashboard

Quality And Risk															
Description	LYO	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	YTD	Target
Complaints	1,197	88	39	-	-	-	-	-	-	-	-	-	-	127	
Compliments	6,370	509	677	-	-	-	-	-	-	-	-	-	-	1,186	
Friends & Family – Community – Footfall	3.10%	2.90%	3%	-	-	-	-	-	-	-	-	-	-	3%	9%
Friends & Family – Community – Recommended %	96.60%	96.60%	95.30%	-	-	-	-	-	-	-	-	-	-	95.90%	97.60%
Friends & Family – ED – Footfall	19.10%	17.90%	18%	-	-	-	-	-	-	-	-	-	-	17.90%	21.30%
Friends & Family – ED – Recommended %	77.30%	81.80%	77.80%	-	-	-	-	-	-	-	-	-	-	79.70%	93.30%
Friends & Family – Inpatients – Footfall	32.10%	32.20%	33%	-	-	-	-	-	-	-	-	-	-	32.60%	35.10%
Friends & Family – Inpatients – Not Recommended %	1.50%	1.80%	2.10%	-	-	-	-	-	-	-	-	-	-	2%	%
Friends & Family – Inpatients – Recommended %	95.40%	94.90%	93.70%	-	-	-	-	-	-	-	-	-	-	94.30%	97.40%
Friends & Family – Maternity – Footfall	40.30%	30.30%	43.20%	-	-	-	-	-	-	-	-	-	-	37.20%	34.30%
Friends & Family – Maternity – Not Recommended %	0.60%	1.20%	0.90%	-	-	-	-	-	-	-	-	-	-	1%	%
Friends & Family – Maternity – Recommended %	97.80%	98.10%	97.20%	-	-	-	-	-	-	-	-	-	-	97.60%	97.80%
Friends & Family – Outpatients – Footfall	4.30%	4.90%	5.70%	-	-	-	-	-	-	-	-	-	-	5.30%	14.40%
Friends & Family – Outpatients – Recommended %	91.80%	90.10%	89.40%	-	-	-	-	-	-	-	-	-	-	89.70%	97.10%
HCAI – Post 48 hour MRSA	0	0	0	-	-	-	-	-	-	-	-	-	-	0	0
HCAI CDIFF – Due To Lapses In Care	19	0	0	-	-	-	-	-	-	-	-	-	-	0	4
HCAI CDIFF – Not Due To Lapses In Care	11	0	0	-	-	-	-	-	-	-	-	-	-	0	
HCAI CDIFF – Total Number Of Cases	30	4	0	-	-	-	-	-	-	-	-	-	-	4	
HCAI CDIFF – Under Review	0	4	0	-	-	-	-	-	-	-	-	-	-	4	
Incidents - Appointments, Discharge & Transfers	1,028	78	93	-	-	-	-	-	-	-	-	-	-	171	
Incidents - Blood Transfusions	88	9	7	-	-	-	-	-	-	-	-	-	-	16	
Incidents - Clinical Care (Assessment/Monitoring)	1,375	149	149	-	-	-	-	-	-	-	-	-	-	298	
Incidents - Diagnosis & Tests	397	42	53	-	-	-	-	-	-	-	-	-	-	95	
Incidents - Equipment	290	29	33	-	-	-	-	-	-	-	-	-	-	62	
Incidents - Facilities (Security, Estates, Transport, Fire etc.)	491	36	34	-	-	-	-	-	-	-	-	-	-	70	
Incidents - Falls, Injuries or Accidents	1,442	106	89	-	-	-	-	-	-	-	-	-	-	195	
Incidents - Health & Safety	331	33	31	-	-	-	-	-	-	-	-	-	-	64	
Incidents - Infection Control	112	12	10	-	-	-	-	-	-	-	-	-	-	22	

NHS
The Dudley Group
NHS Foundation Trust

Quality And Risk															
Description	LYO	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	YTD	Target
Incidents - Medication	4,160	412	285	-	-	-	-	-	-	-	-	-	-	697	
Incidents - Obstetrics	990	52	62	-	-	-	-	-	-	-	-	-	-	114	
Incidents - Pressure Ulcer	3,492	303	266	-	-	-	-	-	-	-	-	-	-	569	
Incidents - Records, Communication & Information	825	77	87	-	-	-	-	-	-	-	-	-	-	164	
Incidents - Safeguarding	866	86	120	-	-	-	-	-	-	-	-	-	-	206	
Incidents - Theatres	208	24	21	-	-	-	-	-	-	-	-	-	-	45	
Incidents - Venous Thrombo Embolism (VTE)	127	16	2	-	-	-	-	-	-	-	-	-	-	18	
Incidents - Violence, Aggression & Self Harm	734	52	66	-	-	-	-	-	-	-	-	-	-	118	
Incidents - Workforce	679	53	38	-	-	-	-	-	-	-	-	-	-	91	
Maternity : Early Booking KPI: % of women who see midwife/maternity healthcare professional	100%	100%	100%	-	-	-	-	-	-	-	-	-	-	100%	100%
Maternity : Increase in breast feeding initiation rates by 2% per year	56.85%	59.22%	60.37%	-	-	-	-	-	-	-	-	-	-	59.83%	61%
Maternity : Smoking In Pregnancy : Reduce to a prevalence of 12.1% across the year	15.61%	14.28%	13.52%	-	-	-	-	-	-	-	-	-	-	13.88%	12.10%
Mixed Sex Sleeping Accommodation Breaches	51	3	7	-	-	-	-	-	-	-	-	-	-	10	0
Never Events	3	0	0	-	-	-	-	-	-	-	-	-	-	0	0
NQA - Matrons Audit	92%	91%	-	-	-	-	-	-	-	-	-	-	-	91%	95%
NQA - Midwifery Audit	97%	98%	97%	-	-	-	-	-	-	-	-	-	-	98%	94%
NQA - Nutrition Audit	94%	94%	96%	-	-	-	-	-	-	-	-	-	-	95%	95%
NQA - Paediatric Nutrition Audit	98%	98%	93%	-	-	-	-	-	-	-	-	-	-	95%	95%
NQA - Skin Bundle	95%	95%	94%	-	-	-	-	-	-	-	-	-	-	95%	95%
NQA - Theatres and Critical Care Environment Audit	90%	96%	-	-	-	-	-	-	-	-	-	-	-	96%	95%
NQA - Think Glucose - EAU/SAU	77%	90%	100%	-	-	-	-	-	-	-	-	-	-	95%	95%
NQA - Think Glucose - General Wards	94%	96%	95%	-	-	-	-	-	-	-	-	-	-	96%	94%
Nursing Care Indicators - Community Childrens	99%	100%	100%	-	-	-	-	-	-	-	-	-	-	100%	95%
Nursing Care Indicators - Community Neonatal	100%	100%	100%	-	-	-	-	-	-	-	-	-	-	100%	95%
Nursing Care Indicators - Critical Care	98%	100%	98%	-	-	-	-	-	-	-	-	-	-	99%	95%
Nursing Care Indicators - District Nurses	94%	95%	96%	-	-	-	-	-	-	-	-	-	-	96%	95%
Nursing Care Indicators - EAU	90%	96%	90%	-	-	-	-	-	-	-	-	-	-	93%	95%
Nursing Care Indicators - ED	88%	95%	88%	-	-	-	-	-	-	-	-	-	-	92%	95%

NHS
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NHS Foundation Trust

Quality And Risk															
Description	LYO	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	YTD	Target
Nursing Care Indicators - General Wards	95%	97%	95%	-	-	-	-	-	-	-	-	-	-	96%	94%
Nursing Care Indicators - Maternity	96%	93%	-	-	-	-	-	-	-	-	-	-	-	93%	95%
Nursing Care Indicators - Medicines Management	91%	94%	92%	-	-	-	-	-	-	-	-	-	-	93%	95%
Nursing Care Indicators - Neonatal	99%	96%	98%	-	-	-	-	-	-	-	-	-	-	97%	95%
Nursing Care Indicators - Paediatric	95%	96%	94%	-	-	-	-	-	-	-	-	-	-	95%	94%
Nursing Care Indicators - Renal	97%	98%	87%	-	-	-	-	-	-	-	-	-	-	92%	95%
Nursing Care Indicators - Surgical Assessment Unit	94%	98%	99%	-	-	-	-	-	-	-	-	-	-	98%	95%
PALS Concerns	10,004	522	167	-	-	-	-	-	-	-	-	-	-	689	
Saving Lives - 1 Ventilator Associated Pneumonia (*New 18/19)	-	100%	100%	-	-	-	-	-	-	-	-	-	-	100%	95%
Saving Lives - 2a Peripheral Vascular Access Devices - Insertion (*New 18/19)	-	99%	100%	-	-	-	-	-	-	-	-	-	-	99%	95%
Saving Lives - 2b Peripheral Vascular Access Devices - Ongoing Care (*New 18/19)	-	96%	96%	-	-	-	-	-	-	-	-	-	-	96%	95%
Saving Lives - 3a Central Venous Access Devices - Insertion (*New 18/19)	-	100%	100%	-	-	-	-	-	-	-	-	-	-	100%	95%
Saving Lives - 3b Central Venous Access Devices - Ongoing Care (*New 18/19)	-	100%	98%	-	-	-	-	-	-	-	-	-	-	99%	95%
Saving Lives - 4a Surgical site infection prevention - Preoperative (*New 18/19)	-	100%	100%	-	-	-	-	-	-	-	-	-	-	100%	95%
Saving Lives - 4b Surgical site infection prevention - Intraoperative actions (*New 18/19)	-	100%	100%	-	-	-	-	-	-	-	-	-	-	100%	95%
Saving Lives - 5 Infection Prevention in Chronic Wounds (*New 18/19)	-	100%	100%	-	-	-	-	-	-	-	-	-	-	100%	95%
Saving Lives - 6a Urinary Catheter - Insertion (*New 18/19)	-	100%	100%	-	-	-	-	-	-	-	-	-	-	100%	95%
Saving Lives - 6b Urinary Catheter - Maintenance and Assessment (*New 18/19)	-	100%	98%	-	-	-	-	-	-	-	-	-	-	99%	95%
Saving Lives - 7a Antimicrobial Stewardship - All Care Settings (*New 18/19)	-	100%	-	-	-	-	-	-	-	-	-	-	-	100%	95%
Saving Lives - 7b Antimicrobial Stewardship - Secondary Care (*New 18/19)	-	100%	-	-	-	-	-	-	-	-	-	-	-	100%	95%
Serious Incidents - Action Plan overdue	74	3	-	-	-	-	-	-	-	-	-	-	-	3	
Serious Incidents - Clinical Care (Assessment/Monitoring)	40	1	-	-	-	-	-	-	-	-	-	-	-	1	
Serious Incidents - Diagnosis & Tests	6	-	1	-	-	-	-	-	-	-	-	-	-	1	

The Dudley Group NHS Foundation Trust

Quality And Risk															
Description	LYO	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	YTD	Target
Serious Incidents - Falls, Injuries or Accidents	42	-	1	-	-	-	-	-	-	-	-	-	-	1	
Serious Incidents - Infection Control	10	2	-	-	-	-	-	-	-	-	-	-	-	2	
Serious Incidents - Pressure Ulcer	196	8	1	-	-	-	-	-	-	-	-	-	-	9	
Stroke Admissions : Swallowing Screen	82.84%	92.10%	83.33%	-	-	-	-	-	-	-	-	-	-	86.95%	75%
Stroke Admissions to Thrombolysis Time	57.69%	42.85%	33.33%	-	-	-	-	-	-	-	-	-	-	38.46%	%
Stroke Patients Spending 90% of Time On Stroke Unit (VSA14)	92.56%	91.89%	90.56%	-	-	-	-	-	-	-	-	-	-	91.11%	85%
Suspected High-risk TIA Assessed and Treated < 24hrs from presentation	94.15%	77.77%	94.11%	-	-	-	-	-	-	-	-	-	-	88.46%	85%
Time to Procedure: Emergency Procedures (Upper GI Diagnostic endoscopic)	66.66%	65.30%	57.89%	-	-	-	-	-	-	-	-	-	-	62.06%	0%
Time to Surgery - Elective admissions operated on within two days for all procedures	86.89%	99.77%	99.86%	-	-	-	-	-	-	-	-	-	-	99.82%	0%
Time to Surgery : Emergency Procedures (Appendectomy)	97%	92.50%	90.62%	-	-	-	-	-	-	-	-	-	-	91.66%	0%
Time to Surgery : Emergency Procedures (Femur Replacement #NOF)	93.23%	95.23%	96.96%	-	-	-	-	-	-	-	-	-	-	96.29%	0%
Time to Surgery : Emergency Procedures (Reduction of fracture of bone excl. #NOF)	91.68%	88.57%	91.22%	-	-	-	-	-	-	-	-	-	-	90.21%	0%
VTE Assessment Indicator (CQN01)	93.37%	95.14%	95%	-	-	-	-	-	-	-	-	-	-	95.07%	95%

The Dudley Group NHS Foundation Trust

Performance Dashboard

Performance															
Description	LYO	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	YTD	Target
A&E - 4 Hour A&E Dept Only % (Type 1)	78.38%	77.09%	76.50%	-	-	-	-	-	-	-	-	-	-	76.78%	%
A&E - 4 Hour UCC Dept Only % (Type 3)	99.38%	99.44%	99.46%	-	-	-	-	-	-	-	-	-	-	99.45%	%
A&E - 4 Hour UCC/A&E Combined % (Type 1+3)	86.56%	86.29%	85.38%	-	-	-	-	-	-	-	-	-	-	85.83%	95%
A&E - Patients who Left Without Being Seen %	2.60%	1.70%	2.10%	-	-	-	-	-	-	-	-	-	-	1.90%	5%
A&E - Time to Initial Assessment (95th Percentile)	9	4	8	-	-	-	-	-	-	-	-	-	-	8	15
A&E - Time to Treatment Median Wait (Minutes)	70	49	65	-	-	-	-	-	-	-	-	-	-	65	60
A&E - Total Time in A&E (95th Percentile)	731	593	587	-	-	-	-	-	-	-	-	-	-	587	240
A&E - Unplanned Re-Attendance Rate %	1.50%	1.30%	1.10%	-	-	-	-	-	-	-	-	-	-	1.20%	5%
Activity - A&E Attendances	103,426	8,299	9,105	-	-	-	-	-	-	-	-	-	-	17,404	16,955
Activity - Cancer MDT	5,131	492	409	-	-	-	-	-	-	-	-	-	-	901	870
Activity - Community Attendances	376,548	32,851	33,329	-	-	-	-	-	-	-	-	-	-	66,180	67,068
Activity - Critical Care Bed Days	7,612	583	672	-	-	-	-	-	-	-	-	-	-	1,255	1,347
Activity - Diagnostic Imaging whilst Out-Patient	52,692	4,216	4,450	-	-	-	-	-	-	-	-	-	-	8,666	9,446
Activity - Direct Access Pathology	1,970,646	173,406	181,445	-	-	-	-	-	-	-	-	-	-	354,851	335,446
Activity - Direct Access Radiology	75,450	6,221	6,865	-	-	-	-	-	-	-	-	-	-	13,086	13,086
Activity - Elective Day Case Spells	48,682	4,191	4,363	-	-	-	-	-	-	-	-	-	-	8,554	8,010
Activity - Elective Inpatients Spells	5,828	447	473	-	-	-	-	-	-	-	-	-	-	920	996
Activity - Emergency Inpatient Spells	50,160	3,262	3,852	-	-	-	-	-	-	-	-	-	-	7,114	8,143
Activity - Excess Bed Days	11,066	602	206	-	-	-	-	-	-	-	-	-	-	808	2,495
Activity - Maternity Pathway	7,636	534	608	-	-	-	-	-	-	-	-	-	-	1,142	1,252
Activity - Neo Natal Bed Days	7,111	602	621	-	-	-	-	-	-	-	-	-	-	1,223	1,221
Activity - Outpatient First Attendances	146,246	13,421	13,146	-	-	-	-	-	-	-	-	-	-	26,567	26,099
Activity - Outpatient Follow Up Attendances	295,301	25,646	25,970	-	-	-	-	-	-	-	-	-	-	51,616	51,853
Activity - Outpatient Procedure Attendances	71,502	5,120	7,212	-	-	-	-	-	-	-	-	-	-	12,332	12,443
Activity - Rehab Bed Days	20,079	1,532	1,553	-	-	-	-	-	-	-	-	-	-	3,085	3,238
Activity - Renal Dialysis	52,070	4,243	4,583	-	-	-	-	-	-	-	-	-	-	8,826	8,596
Ambulance Handover - 30 min – breaches (DGH view)	4,608	180	437	-	-	-	-	-	-	-	-	-	-	617	0
Ambulance Handover - 30 min – breaches (WMAS view)	5,803	240	603	-	-	-	-	-	-	-	-	-	-	843	0
Ambulance Handover - 60 min – breaches (DGH view)	716	8	67	-	-	-	-	-	-	-	-	-	-	75	0
Ambulance Handover - 60 min – breaches (WMAS view)	876	9	73	-	-	-	-	-	-	-					

The Dudley Group NHS Foundation Trust

Performance															
Description	LYO	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	YTD	Target
Cancer - 14 day - Urgent Cancer GP Referral to date first seen	94.70%	88.20%	95.90%	-	-	-	-	-	-	-	-	-	-	92.10%	93%
Cancer - 14 day - Urgent GP Breast Symptom Referral to date first seen	97.30%	91.80%	95.60%	-	-	-	-	-	-	-	-	-	-	94.10%	93%
Cancer - 31 day - from diagnosis to treatment for all cancers	98.80%		99.30%	-	-	-	-	-	-	-	-	-	-	99.00%	96%
Cancer - 31 Day For Second Or Subsequent Treatment - Anti Cancer Drug Treatments	100%	100%	100%	-	-	-	-	-	-	-	-	-	-	100%	98%
Cancer - 31 Day For Second Or Subsequent Treatment - Surgery	98.90%	100%	100%	-	-	-	-	-	-	-	-	-	-	100%	94%
Cancer - 31 Day For Subsequent Treatment From Decision To Treat	99.40%	100%	100%	-	-	-	-	-	-	-	-	-	-	100%	96%
Cancer - 62 day - From Referral for Treatment following a Consultant Upgrade	93.30%	86.60%	83.10%	-	-	-	-	-	-	-	-	-	-	85.10%	85%
Cancer - 62 day - From Referral for Treatment following national screening referral	98.40%	96.40%	96.10%	-	-	-	-	-	-	-	-	-	-	96.20%	90%
Cancer - 62 day - From Urgent GP Referral to Treatment for All Cancers	85.30%	80.80%	80.70%	-	-	-	-	-	-	-	-	-	-	80.80%	85%
Maternity: Breastfeeding Data Coverage Rates	100%	100%	100%	-	-	-	-	-	-	-	-	-	-	100%	0%
Number of Births Within the Trust	4,435	351	384	-	-	-	-	-	-	-	-	-	-	735	
RTT - Admitted Pathways within 18 weeks %	87.90%	84.60%	87.10%	-	-	-	-	-	-	-	-	-	-	85.80%	90%
RTT - Incomplete Waits within 18 weeks %	94%	93.40%	94.70%	-	-	-	-	-	-	-	-	-	-	94.10%	92%
RTT - Non-Admitted Pathways within 18 weeks %	93.10%	94.40%	94.60%	-	-	-	-	-	-	-	-	-	-	94.50%	95%
Waiting Time - Diagnostic 6 Week Maximum Wait (VSA05)	97.85%	99.31%	99.38%	-	-	-	-	-	-	-	-	-	-	99.34%	99%

The Dudley Group NHS Foundation Trust

Finance Dashboard

Finance															
Description	LYO	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	YTD	Target
Agency spend	£11,613k	£860k	£1,111k	-	-	-	-	-	-	-	-	-	-	£1,971k	k
Bank spend	£16,404k	£1,481k	£1,475k	-	-	-	-	-	-	-	-	-	-	£2,956k	k
Budgetary Performance	(£20,622)k	(£640)k	(£1,338)k	-	-	-	-	-	-	-	-	-	-	(£1,978)k	£0k
Capital v Forecast	106.60%	59.80%	-	-	-	-	-	-	-	-	-	-	-	59.80%	95%
Cash Balance	£8,617k	£13,899k	-	-	-	-	-	-	-	-	-	-	-	£13,899k	k
Cash v Forecast	54.60%	109.30%	-	-	-	-	-	-	-	-	-	-	-	109.30%	95%
Creditor Days	16.4	15.5	-	-	-	-	-	-	-	-	-	-	-	15.5	15
Debt Service Cover	0.79	0	-	-	-	-	-	-	-	-	-	-	-	0	2.5
Debtor Days	7.4	9.4	-	-	-	-	-	-	-	-	-	-	-	9.4	15
Liquidity	-7.63	-7.78	-	-	-	-	-	-	-	-	-	-	-	-7.78	0
SLA Performance	(£3,902)k	(£567)k	(£848)k	-	-	-	-	-	-	-	-	-	-	(£1,415)k	£0k

Staff/HR Dashboard

Staff/HR															
Description	LYO	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	YTD	Target
Appraisals	70.50%	17.40%	50.90%	-	-	-	-	-	-	-	-	-	-	50.90%	89.90%
Mandatory Training	85.90%	87.80%	88.30%	-	-	-	-	-	-	-	-	-	-	88.30%	90%
RN average fill rate (DAY shifts)	89.64%	83.89%	82.99%	-	-	-	-	-	-	-	-	-	-	83.43%	95%
RN average fill rate (NIGHT shifts)	92.85%	85.65%	85.81%	-	-	-	-	-	-	-	-	-	-	85.73%	95%
Sickness Rate	4.40%	3.90%	3.99%	-	-	-	-	-	-	-	-	-	-	3.90%	3.50%
Staff In Post (Contracted WTE)	4,397.71	4,338.42	4,381.39	-	-	-	-	-	-	-	-	-	-	4,396.26	
Turnover Rate (Rolling 12 Months)	9.74%	9.95%	9.70%	-	-	-	-	-	-	-	-	-	-	9.95%	%
Vacancy Rate	6.63%	10.79%	11.21%	-	-	-	-	-	-	-	-	-	-	11.21%	%

The Dudley Group NHS Foundation Trust

Executive Summary by Exception

Key Messages

1 Performance Matters — Committee: F&P

A&E 4 hour wait

The combined Trust and UCC performance was below target in month at 85.39%. Whilst, the Trust only (Type 1) performance was 76.50%.

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

	Attendances	Breaches	Performance
A&E Dept. Type 1	9113	2141	76.50%
UCC Type 3	5753	31	99.46%

Cancer Waits

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

Cancer – 62 Day from Urgent GP Referral to Treatment performed below target for the month at 79.7% (Provisional as at 19th June). Previous month confirmed performance was 80.9%

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

No. of Patients treated on or over 104 days (DGFT)	3
No. of Patients treated on or over 104 days (Tertiary Centre)	2
No. of Patients treated on or over 104 days (Combined)	5

2WW

The target was achieved once again in month. During this period a total of 1394 patients attended a 2ww appointment with 57 patients attending their appointments outside of the 2 week standard, achieving a performance 95.9% against the 93% target.

Referral To Treatment (RTT)

The performance of the key target RTT Incomplete Waiting Time indicator remained above target, with performance of 94.7% in month against a target of 92%, an increase in performance from 93.4% in the previous month. Urology did not meet the target in month at 89.7% up from 88.2% in previous month. Ophthalmology is at 86.2% up from 83.87% in the previous month. General Surgery at 91.0% up from 90.82%. There were no 52-week Non-admitted Waiting Time breaches in month.

Diagnostic waits

The diagnostic wait target was achieved in month with a performance of 99.38%. The number of patients waiting over 6 weeks was 43.

Of the 43, MRI accounted for 32 (11 other).

The Dudley Group NHS Foundation Trust

Executive Summary by Exception cont.

Key Messages

2 Financial Performance Matters — Committee: F&P

Cumulative adjusted deficit to May of £2.769m (before PSF) which represents a £1.062m adverse variance in comparison to the control total. Main issue relates to ongoing income shortfall (non elective medical spells and community attendances). Work continues to determine how this position could be rectified. Pay costs are over plan and now include a 1% estimate for the pay award. The difference between 1% and the final agreed pay award should be fully funded. Agency costs have increased significantly from April of 17/18 and are now £0.433m above the NHSI cap. The level of vacancies are higher than estimated within the NHSI plan but consequently, the bank spend has increased. Non pay spend is on budget but this has been skewed by a sum of £1.129m that has been brought forward from the CIP. The increased costs within clinical supplies are cause for concern. The May figures assume full receipt of the Provider Sustainability Fund (PSF) for quarter 1. However, the underlying position places this in jeopardy and if left unchecked, could result in a deficit of up to £11m. There must be a change in behaviour that is not yet evident within the organisation, requiring the management of spend within budgetary limits, maximisation of income and delivery of CIP.

The position on the Trust's liquidity ratio was -8.0 days at the end of Month 2 which was only 0.05 days worse than the planned position.

Executive Summary by Exception cont.

Key Messages

CQSPE

HCAI

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

	May	YTD
Total No. of cases due to lapses in care	N/A	0
Total No. of cases NOT due to lapses in care	N/A	0
No. of cases currently under review (ytd)	4	N/A
Total No. of cases ytd.	N/A	4

There were 0 post 48 hour MRSA cases reported in month. The last post 48 hours MRSA cases was in September 2016, 977 days ago.

Friends and Family Scores

We continue to focus on engaging with our patients and their families.

Complaints: Additional staffing was put in place from the middle of May 2018 to work on the backlog of complaints (1 x wte and 2 x .2 wte). It is difficult to state what the trajectory will be as it is dependent on whether the investigation has been completed in order for the complaint response to be drafted and close the complaint. During May 2018, 55 complaints were closed (29 in April 2018) but a further 39 new complaints were received.

Falls

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

Pressure Ulcers

We continue to focus on improvement and learning in relation to Pressure Ulcers in both the community and the hospital.

Never Events

There were 0 never events in month, or year to date.

Mixed Sex Sleeping Accommodation Breaches (MSA)

There are 7 MSA breaches in month.

VTE Assessment On Admission: Indicator

The indicator achieved the target in month with provisional performance at 95.0% against a target of 95%.

Executive Summary by Exception cont.

Key Messages

4 Workforce — Committee: F&P

Staff Appraisals:

This includes all non-medical appraisals in the Trust. As a result of the new Appraisal Window running between 1st April and 30th June the current performance is under target. However, this is to be expected as the window is still open for another 5 weeks. There is a trajectory in place for ensuring performance of 90% is achieved by 30th June 2018. At the most recent performance review meetings, all Divisional Management Teams confirmed that they would achieve at least 90% compliance with this target. The areas where completed appraisals are at their lowest have been invited to meet with members of the Executive Team to understand that plans are in place to ensure their department and the Trust achieve the expected rate of compliance. The step increase between April and May compliance rates provides confidence that the Trust will reach 90% compliance by the end of June 2018.

Mandatory Training:

There have been significant efforts to improve our mandatory training rates with a particular emphasis on specific areas such as Safeguarding and Infection Control. The increased emphasis has seen a rise again between April and May with the Trust now only just over 1% away from meeting its compliance target. There are trajectories in place for each Division with performance reviews focusing on compliance for every member of staff. There was further emphasis and commitment from each Divisional Management Team that the compliance rate of 90% will be achieved by the June report.

Sickness Rate:

The Trust has seen a slight downturn in absence rates since April 2018. The report last month attributed some of this to expected seasonal trends with the expectation that this would improve further in April 2018. However we have seen a small dip in absence rates. It is encouraging to see that we continue to have moved out of the red and into amber with absence rates 3.99%. This is higher than this time last year with the challenge to sustain and improve on this performance based on the new interventions in place. The rate as it stands in May is still ahead of our projected target that we submitted to NHSI as part of our annual plan.

Turnover & Vacancy Rate:

The turnover rate has seen a drop for the first time in 7 months and currently sits at 9.7%. This is still significantly above our target of 8.5% but continues to be below the average turnover rate for acute NHS Trusts in England. The appointment of the new Staff Engagement lead will have a particular focus on understanding the feedback from exit interviews, listening to staff and developing strategies to support improved retention at the Trust. It is hoped that some of the interventions around engagement are having an impact and this is the beginning of a downward trend associated to turnover.

The Dudley Group NHS Foundation Trust

Patients will experience safe care - "At a glance"

Executive Lead: Siobhan Jordan

Patients will experience safe care - Quality & Experience

	Target (Amber)	Target (Green)	Apr-18	May-18	Actual YTD	Trend	Month Status
Friends & Family Test - Footfall							
Friends & Family Test - ED	14.5%	21.3%	17.9%	18.0%	18.0%	↑	
Friends & Family Test - Inpatients	26.0%	35.1%	32.3%	33.0%	32.6%	↑	
Friends & Family Test - Maternity	21.7%	34.4%	30.4%	43.3%	37.2%	↑	
Friends & Family Test - Outpatients	4.7%	14.5%	4.9%	5.7%	5.3%	↑	
Friends & Family Test - Community	3.5%	9.1%	2.9%	3.3%	3.1%	↑	
Friends & Family Test - Recommended							
Friends & Family Test - ED	89.9%	93.4%	81.9%	77.8%	79.8%	↓	
Friends & Family Test - Inpatients	96.3%	97.4%	95.0%	93.8%	94.3%	↓	
Friends & Family Test - Maternity	96.0%	98.1%	98.1%	97.3%	97.6%	↓	
Friends & Family Test - Outpatients	94.6%	97.2%	90.1%	89.4%	89.7%	↓	
Friends & Family Test - Community	96.4%	97.7%	96.6%	95.4%	96.0%	↓	
Complaints							
Total no. of complaints received in month		N/A	45	39	84	↓	
Complaints re-opened			5	4	9	↓	
PALs Numbers			306	306	612	↔	
Complaints open at month end			231	212	443	↓	
Compliments received			509	677	1186	↑	
Dementia (1 month in arrears)							
Find/Assess		90%	97.0%		97.0%	↑	
Investigate		90%	100.0%		100.0%	↑	
Refer		90%	100.0%		100.0%	↑	
Falls	National average 6.63 per 1000 bed days						
No. of Falls			67	55	122	↓	
Falls per 1000 bed days		6.63	3.90	3.14	3.52	↓	
No. of Multiple Falls		N/A	8	6	14	↓	
Falls resulting in moderate harm or above			1	0	1	↓	
Falls resulting in moderate harm or above per 1000 bed days		0.19	0.06	0	0.03	↓	
Pressure Ulcers (Grades 3 & 4)							
Hospital Avoidable		0	1	0	1	↓	
Hospital Non-avoidable		0	1	6	7	↑	
Community Avoidable		0	2	1	3	↓	
Community Non-avoidable		0	4	11	15	↑	
Handwash							
Handwashing			99.6%	96.6%	98.2%		

Patients will experience safe care - Patient Safety

	Target (Amber)	Target (Green)	Apr-18	May-18	Actual YTD	Trend	Month Status
Mixed Sex Accommodation Breaches							
Single Sex Breaches		0	3	7	10	↑	
Mortality (Quality Strategy Goal 3)							
HSMR Rolling 12 months (**Latest data Feb 18**)	110	105	110.0	115.5	N/A		
SHMI Rolling 12 months (**Latest data Dec17**)	1.10	1.05	N/A	N/A	N/A		
HSMR Year to date (**Not available**)					N/A		
Infections							
Cumulative C-Diff due to lapses in care		28	0	0	0	↔	
MRSA Bacteraemia		0	0	0	0	↔	
MSSA Bacteraemia		0	3	0	3	↓	
E. Coli - Total hospital		0	3	5	8	↑	
Stroke Admissions - PROVISIONAL							
Stroke Admissions: Swallowing Screen		75%	94.4%	83.3%	87.8%	↓	
Stroke Patients Spending 90% of Time on Stroke Unit		85%	91.9%	90.6%	91.1%	↓	
Suspected High Risk TIAs Assessed and Treated <24hrs		85%	90.0%	94.1%	92.6%	↑	
VTE - PROVISIONAL							
VTE On Admission		95%	95.3%	95.0%	95.1%	↓	
Incidents							
Total Incidents			1466	1457	2789	↓	
Recorded Medication Incidents			255	297	552	↑	
Never Events			0	0	0	↔	
Serious Incidents			11	3	14	↓	
of which, pressure ulcers			8	1	9	↓	
Incident Grading by Degree of Harm							
Death			0	0	0	↔	
Severe			1	0	1	↓	
Moderate			17	21	38	↑	
Low			253	173	426	↓	
No Harm			1061	1263	2324	↑	
Percentage of incidents causing harm		28%	20.3%	13.3%	16.7%	↓	

Performance - "At a glance"

Executive Lead: Karen Kelly

The Dudley Group NHS Foundation Trust

Performance - Key Performance Indicators

	Target	Apr-18	May-18	Actual YTD	Trend	Month Status
Cancer Reporting - TRUST (provisional)						
All Cancer 2 week waits	93%	88.2%	95.9%	92.2%	↑	
2 week wait - Breast Symptomatic	93%	91.9%	95.7%	94.2%	↑	
31 day diagnostic to 1st treatment	96%	98.8%	99.3%	99.1%	↑	
31 day subsequent treatment - Surgery	94%	100.0%	100.0%	100.0%	↔	
31 day subsequent treatment - Drugs	94%	100.0%	100.0%	100.0%	↔	
62 day urgent GP referral to treatment	85%	80.9%	79.7%	41.1%	↓	
62 day screening programme	90%	96.4%	95.8%	96.2%	↓	
62 day consultant upgrades	85%	86.7%	83.2%	85.1%	↓	
Referral to Treatment						
RTT Incomplete Pathways - % still waiting	92%	93.5%	94.7%	94.1%	↑	
RTT Admitted - % treatment within 18 weeks	90%	84.7%	87.1%	85.9%	↑	
RTT Non Admitted - % treatment within 18 weeks	95%	94.5%	94.7%	94.6%	↑	
Wait from referral to 1st OPD	26	22	22	44	↔	
Wait from Add to Waiting List to Removal	39	45	43	88	↓	
ASI List		2277	2595		↑	
% Missing Outcomes RTT		0.1%	0.0%	0.1%	↓	
% Missing Outcomes Non-RTT		5.3%	5.7%	5.5%	↑	
DM01						
No. of diagnostic tests waiting over 6 weeks	0	46	43	89	↓	
% of diagnostic tests waiting less than 6 weeks	99%	99.3%	99.4%	99.3%	↑	
ED - TRUST						
Patients treated < 4 hours Type 1 (Trust ED)	95%	77.1%	76.5%	76.8%	↓	
Patients treated < 4 hours Type 1 & 3 (ED + UCC)	95%	86.3%	85.4%	85.8%	↓	
Emergency Department Attendances	N/A	8259	9113	17372	↑	
12 Hours Trolley Waits	0	0	1	0	↑	
Ambulance to ED Handover Time - TRUST						
30-59 minute breaches		240	603	843	↑	
60+ minute breaches		9	67	76	↑	
Ambulance to Assessment Area Handover Time - TRUST						
30-59 minute breaches		18	27	10157	↑	
60+ minute breaches		9	7	11335	↓	

Performance - Key Performance Indicators cont.

	Target	Apr-18	May-18	Actual YTD	Trend	Month Status
Cancelled Operations - TRUST						
% Cancelled Operations	1.0%	1.0%	1.8%	1.4%	↑	
Cancelled operations - breaches of 28 day rule	0	0	0	0	↔	
Urgent operations - cancelled twice	0	0	0	0	↔	
GP Discharge Letters						
GP Discharge Letters	90%	62.2%	77.6%	70.3%	↑	
Theatre Utilisation - TRUST						
Theatre Utilisation - Day Case (RHH & Corbett)		75.8%	76.6%	76.2%	↑	
Theatre Utilisation - Main		86.7%	90.0%	88.4%	↑	
Theatre Utilisation - Trauma		93.4%	97.7%	95.5%	↑	
GP Referrals						
GP Written Referrals - made		7133	7523	15117	↑	
GP Written Referrals - seen		5812	5789	11335	↓	
Other Referrals - Made		3066	3330	6491	↑	
Throughput						
Patients Discharged with a LoS >= 7 Days		7%	7%	7%	↓	
Patients Discharged with a LoS >= 14 Days		3%	3%	3%	↓	
7 Day Readmissions		3%	4%	4%	↑	
30 Day Readmissions - PbR		7%	8%	8%	↑	
Bed Occupancy - %		92%	93%	92%	↑	
Bed Occupancy - % Medicine & IC		95%	95%	95%	↑	
Bed Occupancy - % Surgery, W&C		88%	90%	89%	↑	
Bed Occupancy - Paediatric %		82%	82%	82%	↓	
Bed Occupancy - Orthopaedic Elective %		78%	80%	79%	↑	
Bed Occupancy - Trauma and Hip # %		96%	96%	96%	↓	
Number of Patient Moves between 8pm and 8am		86	115	201	↑	
Discharged by Midday		14%	14%	14%	↑	
Outpatients						
New outpatient appointment DNA rate	8%	10.1%	10.8%	10.5%	↑	
Follow-up outpatient appointment DNA rate	8%	6.7%	10.3%	8.4%	↑	
Total outpatient appointment DNA rate	8%	7.8%	10.5%	10.0%	↑	
Clinic Utilisation		75.7%	75.0%	75.4%	↓	
Average Length of stay (Quality Strategy Goal 3)						
Average Length of Stay - Elective	0.0	2.9	3.6	3.3	↑	
Average Length of Stay - Non-Elective	3.4	5.9	5.6	5.7	↓	

Financial Performance - "At a glance"

Executive Lead: Tom Jackson

The Dudley Group NHS Foundation Trust

Performance - Financial Overview

	Month Plan	Month Actual	Variance %	Variance	Plan YTD	Actual YTD	Variance %	Variance
ACTIVITY LEVELS (PROVISIONAL)								
Elective inpatients	516	473	-8.3%	-43	996	920	-7.6%	-76
Day Cases	4,163	4,662	12.0%	499	8,010	9,079	13.3%	1,069
Non-elective inpatients	4,231	3,852	-9.0%	-379	8,143	7,139	-12.3%	-1,004
Outpatients	40,708	39,026	-4.1%	-1,682	77,624	75,542	-2.7%	-2,082
A&E	8,942	9,113	1.9%	171	16,956	17,372	2.5%	416
Total activity	**58,560**	**57,126**	**-2.4%**	**-1,434**	**111,729**	**110,052**	**-1.5%**	**-1,677**
CIP	**£'000**	**£'000**		**£'000**	**£'000**	**£'000**		**£'000**
Income	273	250	-8.5%	23	530	485	-8.6%	-45
Pay	262	246	-6.0%	16	448	498	11.3%	51
Non-Pay	243	1,502	517.3%	1,258	449	1,749	289.7%	1,300
Total CIP	**779**	**1,998**	**156.6%**	1,220	**1,427**	**2,733**	**91.5%**	**1,306**
INCOME	**£'000**	**£'000**		**£'000**	**£'000**	**£'000**		**£'000**
NHS Clinical	28,451	28,243	-0.7%	-208	54,993	54,079	-1.7%	-914
Other Clinical	128	112	-12.5%	-16	256	259	1.2%	3
STF Funding	452	452	0.0%	0	904	904	0.0%	0
Other	1,907	1,824	-4.4%	-84	3,769	3,765	-0.1%	-4
Total income	**30,939**	**30,631**	**-1.0%**	-308	**59,922**	**59,007**	**-1.5%**	**-915**
OPERATING COSTS	**£'000**	**£'000**		**£'000**	**£'000**	**£'000**		**£'000**
Pay	-18,503	-19,003	2.7%	337	-37,111	-37,273	0.4%	-161
Drugs	-2,740	-2,830	3.3%	-153	-5,555	-5,798	4.4%	-243
Non-Pay	-7,008	-6,561	-6.4%	-206	-13,956	-13,714	-1.7%	242
Total Costs	**-28,251**	**-28,394**	**0.5%**	**-143**	**-56,623**	**-56,785**	**0.3%**	**-162**

Performance - Financial Overview - TRUST LEVEL ONLY

	Month Plan	Month Actual	Variance %	Variance	Plan YTD	Actual YTD	Variance %	Variance
	£'000	**£'000**		**£'000**	**£'000**	**£'000**		**£'000**
EBITDA	**1,422**	**2,261**	59.0%	**839**	**3,281**	**2260**	-31.1%	**-1,021**
Depreciation	-784	-831	6.0%	-47	-1,629	-1663	2.1%	-34
Restructuring & Other	0	0	n/a	0	0	0	n/a	0
Financing Costs	-1,120	-1,241	10.8%	-121	-2,474	-2470	-0.2%	4
SURPLUS/(DEFICIT)	**-482**	**189**	-139.2%	**671**	**-822**	**-1873**	**127.9%**	**-1,051**
SOFP	**£'000**	**£'000**		**£'000**	**£'000**	**£'000**		**£'000**
Capital Spend	1,104	492	-55.4%	-612	2,130	1,106	-48.1%	-1,024
Inventory					3,010	3,094	2.8%	84
Receivables & Prepayments					15,836	16,081	1.5%	245
Payables					-22,371	-21,504	-3.9%	867
Accruals							n/a	0
Deferred Income					-4,656	-3,467	-25.5%	1,189
Cash & Loan Funding	**£'000**	**£'000**		**£'000**	**£'000**	**£'000**		**£'000**
Cash					9,534	9,420	-1.2%	-114
Loan Funding							n/a	0
KPIs								
EBITDA %	4.9%	7.8%	2.9%		1.2%	0.9%	-0.4%	
Deficit %	-1.7%	0.7%	2.3%		-0.3%	-0.7%	-0.4%	
Receivable Days					0.0	0.0	n/a	
Payable (excluding accruals) Days					0.0	0.0	n/a	
Payable (including accruals) Days					0.0	0.0	n/a	
Use of Resource metric					1	3		

The Dudley Group NHS Foundation Trust

Workforce - "At a glance"

Executive Lead: Andrew McMenemy

	People					
	Target			Actual		Month
	18/19	Apr-18	May-18	YTD	Trend	Status
Workforce						
Sickness Absence Rate	3.75%	3.90%	3.99%	3.95%	↑	
Staff Turnover	8.5%	9.95%	9.70%	9.83%	↓	
Mandatory Training	90.0%	87.8%	88.30%	88.1%	↑	
Appraisal Rates - Total	90.0%	17.4%	50.90%	34.2%	↑	

Enclosure 12

The Dudley Group
NHS Foundation Trust

Paper for submission to the Board of Directors on 5 July 2018

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

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

CORPORATE OBJECTIVE: S06 Plan for a viable future

SUMMARY OF KEY ISSUES:

Summary report from the Finance and Performance Committee meeting held on 28 June 2018.

IMPLICATIONS OF PAPER:

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

ACTION REQUIRED OF BOARD

Decision	Approval	Discussion	Other
		X	X

RECOMMENDATIONS FOR THE BOARD:

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

Meeting	Meeting Date	Chair	Quorate	
Finance & Performance Committee	**28 June 2018**	**Jonathan Fellows**	**yes**	**no**
			Yes	

Declarations of Interest Made

None

Assurances Received

Finance and Efficiency

- The Trust recorded a small deficit in May which represented an adverse variance against the in month plan of £0.45m. The cumulative deficit to date is £2.679m which is £1m worse than the plan. Key underperforming budget areas are income and non pay spend.
- Income is underperforming in May by £0.3m and to date by £0.9m. Main underperforming areas are emergency medical spells, outpatients and community attendances.
- Non pay spend shows a breakeven position to date, supported by a £1m CIP on the PFI unitary payment.
- Pay shows a small overspend and within this agency is spending above the plan.
- The CIP plan is on track to deliver the original plan of £15.4m with a degree of confidence that this target can be stretched to the desired £20m.
- Given the underperformance on I and E, the cash position is deteriorating.
- The system and process for submitting reference costs in 2017/18 was approved.

Performance

- Achievement of A and E and cancer 62 day is challenging and rectification plans are being worked through.
- RTT and DM01 are being delivered.

Workforce

- Reports were received in relation to nursing and medical agency spend. The Committee sought assurance regarding medical agency spend above plan and the reconciliation of funded nursing establishment figures within this and the finance reports.

Estates and Procurement

- Update reports were noted and the PFI contract continues to be monitored closely including regular Director meetings. The improvement in performance was recognised.
-

Board Assurance Framework

- The BAF was reviewed. The Committee sought assurance that current reputational risks and EPR risks are adequately reflected in the Corporate Risk Register.

Decisions Made / Items Approved

- Process and systems to produce the reference costs.
- 2 policies approved; Decontamination and Surge & Escalation

Actions to come back to Committee
• Understanding of reference costs and impact on service sustainability/profitability • Presentation on Model Hospital when updated for 2017/18 • Reconciliation of nursing funded establishment analyses • Rectification Plans
Performance Issues to be referred into Executive Performance Management Process
• None
Areas of Risk to be escalated onto the Corporate or Divisional Risk Register
To confirm on Corporate Risk Register • EPR • Retention
Items referred to the Board for decision or action
• Underperformance against the income and expenditure plan • Underachievement to date of the planned reduction in agency spend • Likelihood of failure of the Q1 internal improvement trajectory of the Emergency Access Standard and the non-receipt of the Provider Sustainability Fund element linked to this • Positive progress against the full year CIP target

Enclosure 13

The Dudley Group
NHS Foundation Trust

Paper for submission to the Trust Board
July 2018

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

CORPORATE OBJECTIVE:

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

SUMMARY OF KEY ISSUES:

- A High level Milestone plan incorporating learnings from the eObs rollout has now been developed with Allscripts to ensure delivery this financial year and to the original budget. This plan will now be agreed with the Stakeholders before it is published.
- e-Sepsis will go live mid-July 2018.
- A letter from NHS Digital following the WannaCry incident last year has been received, it makes a number of Cyber security recommendations of which the majority are complete or are already within our Cyber Security Strategy, any additional plans will be incorporated. One recommendation is for the Trust board to consider Outsourcing as an option to gain better Cyber resilience, A report potentially validated by an external 3rd party will be produced for assurance.
- A number of New Trust Suppliers who have Digital services embedded within there offering do not meet Mandatory Clinical Safety Guidelines issues by NHS Digital, a few recent examples could impact revenue. The Divisional leads will get involved in obtaining the accreditation or preparing a risk report.

IMPLICATIONS OF PAPER:

RISK	**Y COR089**		**Risk Description:** EPR programme is delayed or fails to deliver benefits
	Risk Register: Y		**Risk Score:** 16
COMPLIANCE	**CQC**	**N**	**Details:**

and/or LEGAL REQUIREMENTS	**NHSI**	**N**	**Details:**
	Other	**N**	**Details:**

ACTION REQUIRED OF COMMITTEE:

Decision	Approval	Discussion	Other
		X	

RECOMMENDATIONS FOR THE BOARD

The Board is asked to note the progress of the Digital Trust Project and assurances that delivery will still be within Board approved Timescales and budget.

The Dudley Group NHS Foundation Trust

Committee Highlights Summary to Board
July 2018

Committee	Meeting Date	Chair	Quorate	
			yes	no
Digital Trust Programme Committee	20th June 2018	Ann Becke	X	

Declarations of Interest Made

None

Assurances received

Project status – Digital Trust

Learning from the first roll out of e-Obs, which was a small subset of functionality rolled out across the estate for in-patients, the effort required to ensure that the organisation was prepared for the change and supporting the organisation through to a steady state was considerable.

In order to ensure that Sunrise deployments are acceptable from an operational perspective and each deployment can reach a steady state returning to business as usual as quickly as possible requires a change in the approach of how we deploy this functionality.

The proposed approach for the rest of the Sunrise deployment is to roll out the functionality by modules. The proposed plan also takes into consideration the areas that are impacted; therefore, no two areas are directly impacted in quick succession, allowing for departments and staff to focus on adoption from the last deployment.

A Proposed milestone plan has been drafted and will be submitted to the Stakeholders for approval and will form the new rollout plan.

Once the milestones are agreed an aggressive roll out plan will be produced in order to achieve the original timeline agreed of a full deployment of Sunrise functionality by the end of financial year 2018/19 within the original Business case budget.

E-Sepsis will be delivered Mid July and activity in each module continues so the stakeholder engagement process will not impact delivery at this stage.

The revised approach also focuses on migrating all functionality from Soarian to Sunrise by the end of November 2018.

Cyber Security

Following the WannaCry attack on the NHS in May 2017, NHS Digital have carried out a full review. The CIO of NHS Digital (Will Smart) has made a number of recommendations in a full report. Currently there is no formal request to meet these recommendations although many of these are compliant or being worked towards in our current planning.

An interim plan has been produced and a full plan will be developed and included in the next update of the Cyber Security plan.

See below recommendation 2 from the NHS Digital report which suggest outsourcing should be considered, IT should be benchmarking itself against commercial organisations with the assistance of external assurance.

- *Recommendation 2:*
  In the first quarter of 2018/2019 financial year, ***the CIO for health and social care will convene an expert panel to define and consult on a set of IT infrastructure, application and service management guidelines for organisations hosting clinical systems and patient data*** *to work toward a set of guidelines for all organisations hosting patient records and clinical data that use existing best practice standards including ISO27001.*

o ***Boards/Governing Bodies should consider whether ICT services could be more effectively provided by third party organisations*** *and should regularly assess their organisations' ICT management, cyber capability and capacity. Trusts and CCGs may therefore need to show evidence during 2018/19 that they have reviewed existing arrangements and objectively considered third-party alternatives*

DCB0160

It has been Mandatory since 2017 that all suppliers of Digital system are DCB0129 (formerly SCCI0129) Clinical safety standards complaint and the Trust is DCB0160 complaint. It is the role of the newly appointed Clinical safety Officer (CSO) to ensure this standard met or for the Trust to formally accept the risk. As part of the due diligence a number of Trust suppliers have been found not to hold the relevant compliance which in some cases is causing some impact on revenue. The Divisional leads in future will take a more active role in pursuing their suppliers for the appropriate compliance.

Decisions Made / Items Approved

- The High milestone plan was accepted in principle and needs to gain approval of the appropriate Trust Stakeholders.

Actions to come back to Committee (items Committee keeping an eye on)
• Approved project plan
Items referred to the Board for decision or action
None
Comments relating to the DTPC from the CCIO
N/A
Comments relating to the DTPC from the CNIO
N/A

Enclosure 14

The Dudley Group
NHS Foundation Trust

Paper for submission to the Board on 5th July 2018

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

CLINICAL STRATEGIC AIMS

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

CORPORATE OBJECTIVE:

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

SUMMARY OF KEY ISSUES:

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

IMPLICATIONS OF PAPER:

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

ACTION REQUIRED OF BOARD:

Decision	Approval	Discussion	Other
	Y	**Y**	

RECOMMENDATIONS FOR THE BOARD:
To note the assurances received via the Committee and the decisions taken in accordance with the Committee's terms of reference.

The Dudley Group NHS Foundation Trust

Committee Highlights Summary to Board

Committee	Meeting Date	Chair	Quorate	
Workforce & Staff Engagement Committee	26th June 2018	Julian Atkins	**yes**	**no**
			Yes	

Declarations of Interest Made

No declarations registered.

Assurances received

Matters Arising

1. The Committee received confirmation of the revised process supporting Work Experience demonstrating our commitment to working closely with local schools, colleges and universities. The Committee were provided assurance that the Trust had effective plans in place that supported a clear career structure aligned to the workforce strategy where work experience was one of the initial steps in this process.
2. Paul Stonelake, Responsible Officer reported on medical appraisals, highlighting some difficulties with compliance that would be taken forward alongside support from the Medical Director and Director of HR & OD.

Presentation on Utilisation and Retention of the Workforce

3. The Committee received a presentation from Becky Cooke, Staff Engagement lead alongside Kerrie Walters, Nurse Recruitment Lead. The presentation focused on the challenges facing the Trust to retain and recruit and discussed action plans and initiatives that will be put in place over the next 12-18 months. The actions and topic initiated significant discussion and encouragement from Committee members. Therefore Becky and Kerrie will be invited to future Committee meetings to update on outcomes from their action plans.

Workforce Strategy

4. The Committee received the revised Workforce Strategy and supporting Workforce Business Plan that reflected the workforce priorities for 2018/19. The Committee were assured of progress made against the business plan with particular recognition of the work to support leadership development which has been well received in the Trust.
5. The Committee received the action plan associated with the 2017 Staff Survey alongside the plans to enhance engagement and performance for the forthcoming survey in 2018. It was recommended by the Committee that the plans to support the previous and forthcoming staff survey should be presented to the Trust Board.
6. The Head of HR provided an update on Diversity with particular emphasis on the Workforce Disability Equality Standard which is designed to support disabled staff in the workplace.

Workforce Education

7. The Committee received an update report on the progress of our apprenticeship schemes and the initiatives being undertaken to support them. Two changes to the Apprentice Training Agreement were approved.

8. The Committee received an update on the implementation of the new Leadership Development programme. The first cohort commenced early in April 2018 with 15 members. Cohort two had 16 prospective applicants and that cohort three had over 20 expressions of interest. The feedback received from participants has been extremely positive. There are plans to track attendees to see if over the next 12 months there has been career progression and how this may have related to participation on the programme.

Workforce Performance

9. The Workforce Key Performance Indicators were presented to the Committee with an emphasis on sickness absence, employee relations, mandatory training and turnover. The performance report highlighted positive performance on absence, appraisals and some positive changes to the turnover rate. The Committee also received further analysis of Mandatory Training compliance and associated risks. There were concerns raised regarding governance arrangements regarding who determined priority one and two training as well as some concerns of clinical programmes where there were levels of non-compliance. It was recommended that this was discussed further at the weekly Executive Team meeting led by the Director of HR & OD.

Workforce Governance

10. The standard report highlighting risks associated with the workforce was presented. The Director of HR & OD highlighted the main workforce related risks associated to the Corporate Risk Register, Workforce Directorate Risk Register and the draft Board Assurance Framework. The Committee considered the workforce related risks and were satisfied with those identified and the risk score applied at this time.

11. The Committee received a policy update with confirmation on policies being developed but at this time no policies were reported as being out of date.

12. The Committee approved the Terms of Reference for the newly established Staff Experience and Engagement Group that would report their main actions and outcomes into the Workforce Committee. The main areas of remit for the group will be Recruitment & Retention, Engagement, Staff Well-Being and Diversity.

Workforce Change

13. The Committee were provided a brief update of the progress alongside the BCP with confirmation of the initiation of the consultation process as the first part of TUPE (30th April 2018). 1:1 meetings with staff are planned until the end of August 2018. In terms of the MCP it was confirmed that a recruitment process and draft job descriptions for the transition team had been developed in conjunction with our CCG partners.

The Dudley Group
NHS Foundation Trust

Decisions Made / Items Approved

1. Approval of Terms of Reference for the Staff Experience & Engagement Group.
2. Two changes to the Apprentice Training Agreement.

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

The Committee require further feedback regarding:

- Update on Leadership Programme.
- Outcomes from the Utilisation and Retention presentation.

Items referred to the Board for decision or action

The Committee recommended that the Board receive the Staff Survey Action Plan.

Enclosure 15

The Dudley Group
NHS Foundation Trust

Paper for submission to the Board of Directors
On 5 July 2018

TITLE	**Charitable Funds Committee Summary**		
AUTHOR	**Julian Atkins Non-Executive Director**	**PRESENTER**	**Julian Atkins Non-Executive Director**

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

CORPORATE OBJECTIVE:

S01 – Deliver a great patient experience
S05 – Make the best use of what we have

SUMMARY OF KEY ISSUES:

Summary of key issues discussed and approved at the Charitable Funds Committee on 31 May 2018.

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

ACTION REQUIRED OF BOARD:

Decision	Approval	Discussion	Other
			X

RECOMMENDATIONS FOR THE BOARD:

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

Meeting	Meeting Date	Chair	Quorate	
Charitable Funds Committee	31 May 2018	Julian Atkins	yes	no
			Yes	

Declarations of Interest Made

None

Assurances Received

MATTERS ARISING FROM PREVIOUS MEETING

Pennies from payroll – Mr Walker agreed to establish the process for this with payroll. Once the process is defined, Mrs Abbiss will take responsibility for the communication of the initiative to staff.

Market testing of Investment Fund Managers – Mr Walker presented a paper which explained that five companies had been approached of which three had submitted a proposal for consideration. These were documented in the paper which also considered possible bank account returns. The Committee approved the recommendation that Blackrock should continue to be used to manage the Charity's investment portfolio.

FUNDRAISING UPDATE

Mrs Phillips reported that the 2017/2018 income and expenditure year-end total was above plan by £8,689. It was noted that a large amount of income had been derived from donations.

The 2018/2019 income and expenditure plan was presented to the Committee for approval. The plan aims to achieve, as in 2017/2018, a positive variance of circa £250,000 during the year. It was reported that April showed a positive variance of over £38,000.

Mrs Phillips said that she will continue to focus on grant applications and corporate support during 2018/2019 and was strongly encouraged by the Committee to do so.

Mrs Phillips presented a three-year Funding Strategy but was asked to review this in light of benchmarking data from other Trusts. Mr Walker agreed to assist in the collection of benchmarking data.

It was reported that there had been good support from staff for the Neon Dash in June and that it was expected that circa £17,000 would be raised from the event.

The Committee were informed that the major campaign for the year would be in support of the maternity bereavement room.

It was reported that contactless donations are becoming increasingly popular and Mrs Phillips agreed to monitor this development.

FINANCE UPDATE

Mr Walker presented the 2018/19 financial position of the Charity for the period ending 30 April 2018. He reported a net profit of £38,817 and stated that overall fund balances were £2,044,158. He informed to Committee that the amount available in general funds totalled £50,600.

CHARITY FINANCIAL STATEMENTS AND ANNUAL REPORT 2017/18

Mr Walker presented the Charitable Funds financial statements and Annual Report for 2017/18 highlighting the following:

- Total income received was £458,000
- Total expenditure was £846,000
- Fund balances at year end were £2.005m
-

ANNUAL REVIEW OF COMMITTEE'S EFFECTIVENESS

It was agreed that the self-assessment review was positive and that no changes were required to the Terms of Reference.

Decisions Made / Items Approved

FUNDING REQUESTS

Three bids were approved :-

- A bid from Speech and Language Therapy to support a six month trial to improve oral care on three acute wards; £12,500
- Two non-invasive ventilators for patients requiring NIV on MHDU/C5/ED and AMU; £6,600
- Funding to assist with the installation costs of televisions in the Children's ward; £30,000 (£10,000 to come from general funds, £10,000 from the staff lottery and £10,000 from the Children's ward fund).

Actions to come back to Committee

Three-year Funding Strategy

Items referred to the Board for decision or action

None

Enclosure 16

The Dudley Group NHS Foundation Trust

Paper for submission to the Board of Directors on 5th July 2018

TITLE:	**Speak Up (FTSU) Guardian Update**		
AUTHOR:	Derek Eaves, Professional Lead for Quality/FTSU Guardian Carol Love-Mecrow Deputy Chief Nurse/FTSU Guardian	**PRESENTER**	Carol Love-Mecrow Deputy Chief Nurse/FTSU Guardian

CLINICAL STRATEGIC AIMS

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

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

SUMMARY OF KEY ISSUES:

This paper gives an update on:

- For the last quarter, numbers and types of recent concerns raised and an outline of outcomes from some of the concerns raised recently.
- Numbers of concerns raised at the Trust compared with other Trusts in Q4 of 2016/17
- Completed self-assessment and FTSU vision and strategy
- Recent activities which includes: Change in Speak Up Guardian
- Plans for the appointment of Freedom to Speak Up Champions

IMPLICATIONS OF PAPER:

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

ACTION REQUIRED OF BOARD:

Decision	Approval	Discussion	Other
✓		✓	

RECOMMENDATIONS FOR THE BOARD: To note the latest developments with Freedom to Speak Up Guardian issues. To note the contents of the self-assessment and the vision and strategy agreed by CQSPE.

THE DUDLEY GROUP NHS FOUNDATION TRUST
Freedom to Speak Up (FTSU) Guardian July 2018 update

Numbers of concerns raised at the Trust

The table below indicates the numbers and types of concerns raised with the Guardians a) each full quarter in the last financial year with an annual total and b) in this quarter up to the date stated. As previously noted, the National Guardian Office (NGO) has discussed the difficulties in categorising types of concerns being raised and those below are locally based. The majority of concerns being raised are regarding behaviour unrelated to patient care. We have divided the national category on this topic into two: a) perceived bullying and harassment and b) perceived unfair behaviour, the latter including concerns raised about unfair recruitment, unfair rotas and concerns about redeployment of staff. All of these two types of concerns have been concerns regarding colleagues, line and senior managers.

2017/18	Number	Anonymously	Patient Safety	Behaviour: Bullying/ Harassment	Behaviour: Unfair/ Inappropriate	Other
Apr-Jun	2	0	0	2	0	0
Jul-Sep	14	3	4	8	2	0
Oct-Dec	17	0	3	8	6	0
Jan-Mar	11	2	2	4	5	0
2017/18	44	5	9	22	13	0
Apr- Jun*	15	0	2	2	11	2

**To Jun 26th*
(Others: Operational issues)

The table below breaks down the types of staff who are raising the concerns and it can be seen that these come from a cross-section of staff.

2017/18	Number	Nursing	Midwife	Medical	AHP	Clinical Scientist	Administration/ Ancillary	Unknown
Apr-Jun	2	2	0	0	0	0	0	0
Jul-Sep	14	7	2	0	1	0	3	1
Oct-Dec	17	7	0	1	0	1	8^	0
Jan- Mar	11	5	2	2	0	0	2	0
2017/18	44	21	4	3	1	1	13	1
Apr- Jun*	15	9	2	2	1	0	1	0

**To Jun 28th* ^1 of these was a PFI staff member

Actions/Outcomes

The concerns being raised vary considerably in complexity and as a consequence the time and resources required to come to a conclusion do differ markedly. Some issues can be resolved quickly by the Guardian, sometimes with the assistance of the Chief Executive, in liaison with local management while others are handed over, with the agreement of the person raising the concern, to such departments as Human Resources and Complaints.

The following are some latest examples of actions/outcomes as a result of concerns raised on the following topics:

- Arranged for a person who had resigned from the Trust due to inappropriate behaviour in one area being re-employed in another department.
- Formal warning given to manager due to inappropriate behaviour
- Concern raised has now been taken by a different route for the time being

- Resolved working arrangement with the staff member so that they could return to their base area
- Handed over to the operational lead for management with the consent of the individuals raising the concerns

Numbers of concerns raised at the Trust compared with other Trusts.

With regards to the full Q4 (2017/18) figures there were 11 concerns raised at the Trust. At the beginning of May the National Guardian Office (NGO) released the final data of the submissions from Trusts for Q4. The headlines were:

- 2,114 cases were raised to Freedom to Speak Up Guardians/ambassadors/ champions.
- 642 of these cases included an element of patient safety / quality of care.
- 1,027 included elements of bullying and harassment.
- 93 related to incidents where the person speaking up may have suffered some form of detriment.
- 366 anonymous cases were received.
- 16 trusts did not receive any cases through their Freedom to Speak Up Guardian
- 222 of the 232 NHS trusts listed in the NGO directory sent returns
- Highest Trust had 87 cases (Local Trusts: 12, 17, 6 and 0)

National Guardian Office (NGO) Self-Assessment and FTSU Vision and Strategy

On the third of May the NGO asked all Trusts to complete a self-assessment tool on FTSU. A draft assessment was completed by the Chief Executive and the two Guardians and the Medical Director, Chief Nurse and Director of Human Resources were asked to complete their respective sections. All Board members were given the opportunity to contribute to it. The completed assessment is attached.

The recommendations include the need for a Speak Up vision and strategy (the present lack of which accounts for most of the non-compliance in the assessment). A vision and strategy has been drafted up and this was circulated to all of the Board for comments. This is attached and was approved at the last CQSPE meeting. This is deliberately short and to the point as it is more likely to be read and considered by staff as opposed to a long document that only a few people may read. It will be publicised in conjunction with the Communications Department. The actions within the strategy and self-assessment will be combined into an action plan which will be updated as time progresses and brought to the Board of Directors as part of this quarterly report.

Recent actions and future plans

a) Scheduled meetings with the Chief Executive continue.
b) Audit of awareness: of the latest ten Quality and Safety reviews, staff in seven knew the names of the freedom to speak up guardians and the purpose of the role.
c) Carol Love-Mecrow has decided to step down from the role to concentrate on her commitments for the Deputy Chief Nurse role. The vacancy was advertised on the Hub and four applicants were interviewed in mid-June and it is pleasing to report that Philippa Brazier has been appointed. Philippa is presently the Professional Development Lead for Support Staff and has worked at the Trust for 29 years. Prior to her present role she worked in orthopaedics as a clinical nurse.
d) Due to the high quality of the unsuccessful candidates the plan is to appoint them as the first phase of FTSU Champions. As the concept is embedded further appointments will be made to ensure the range of champions is diverse across all sections of the workforce.

National Guardian
Freedom to Speak Up

NHS
Improvement

Freedom to Speak Up self-review tool for NHS trusts and foundation trusts

May 2018

How to use this tool

Effective speaking up arrangements help to protect patients and improve the experience of NHS workers. Having a healthy speaking up culture is evidence of a well-led trust.

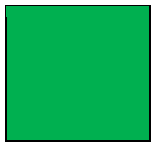
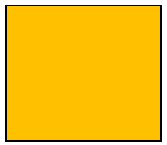
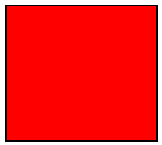
NHS Improvement and the National Guardian's Office have published a guide setting out expectations of boards in relation to Freedom to Speak Up (FTSU) to help boards create a culture that is responsive to feedback and focused on learning and continual improvement.

This self-review tool accompanying the guide will enable boards to carry out in-depth reviews of leadership and governance arrangements in relation to FTSU and identify areas to develop and improve.

The Care Quality Commission (CQC) assesses a trust's speaking up culture during inspections under key line of enquiry (KLOE) 3 as part of the well-led question. This guide is aligned with the good practice set out in the well-led framework, which contains references to speaking up in KLOE 3 and will be shared with Inspectors as part of the CQC's assessment framework for well-led.

Completing the self-review tool and developing an improvement action plan will help trusts to evidence their commitment to embedding speaking up and help oversight bodies to evaluate how healthy a trust's speaking up culture is.

Initial assessment undertaken in June 2018. Key:

Complete  **Partial**  **To be commenced** 

Self review indicator (Aligned to well-led KLOEs)	To what extent is this expectation being met?	What are the principal actions required for development?	How is the board assured it is meeting the expectation? Evidence
Our expectations			
Leaders are knowledgeable about FTSU			
Senior leaders are knowledgeable and up to date about FTSU and the executive and non-executive leads are aware of guidance from the National Guardian's Office.			Quarterly reports to Board. Trust Intranet Posters displayed
Senior leaders can readily articulate the trust's FTSU vision and key learning from issues that workers have spoken up about and regularly communicate the value of speaking up.		Draft explicit vision needs to be agreed	Quarterly reports to Board.
They can provide evidence that they have a leadership strategy and development programme that emphasises the importance of learning from issues raised by people who speak up.			New Leadership Programme starting April 2018 Leadership Forum
Senior leaders can describe the part they played in creating and launching the trust's FTSU vision and strategy.		Draft vision and strategy to be agreed and launched with assistance from Communications Team	
Leaders have a structured approach to FTSU			
There is a clear FTSU vision, translated into a robust and realistic strategy that links speaking up with patient safety, staff experience and continuous improvement.		Draft explicit vision and strategy to be agreed	
There is an up-to-date speaking up policy that reflects the minimum standards set out by NHS Improvement.			Policy in place and on Hub

The FTSU strategy has been developed using a structured approach in collaboration with a range of stakeholders (including the FTSU Guardian) and it aligns with existing guidance from the National Guardian.		Draft explicit vision and strategy to be agreed	Strategy and vision in draft form for consultation
Progress against the strategy and compliance with the policy are regularly reviewed using a range of qualitative and quantitative measures.		Draft explicit vision and strategy to be agreed.	
Leaders actively shape the speaking up culture			
All senior leaders take an interest in the trust's speaking up culture and are proactive in developing ideas and initiatives to support speaking up.			Leaders engage regularly with FTSU Guardians
They can evidence that they robustly challenge themselves to improve patient safety, and develop a culture of continuous improvement, openness and honesty.			Board and CQSPE Minutes. Responses to external assessments e.g. CQC
Senior leaders are visible, approachable and use a variety of methods to seek and act on feedback from workers.			Chief Executive Team Brief. Three types of Formal Walkrounds: Executive,Non Executive and Quality. Informal Visits
Senior leaders prioritise speaking up and work in partnership with their FTSU Guardian.			Regular meetings with Guardians
Senior leaders model speaking up by acknowledging mistakes and making improvements.			Dialogue with CQC and NHSi
The board can state with confidence that workers know how to speak up; do so with confidence and are treated fairly.		Questions on FTSU are included in walkrounds. The results will be put into quarterly reports to Board.	Posters. Evidence from: variety of types of concerns raised coming from different groups

		Appoint Speak Up Champions to raise awareness of the Trust's commitment to speaking up	
Leaders are clear about their role and responsibilities			
The trust has a named executive and a named non-executive director responsible for speaking up and both are clear about their role and responsibility.			Diane Wake Doug Wulff
They, along with the chief executive and chair, meet regularly with the FTSU Guardian and provide appropriate advice and support.			Monthly meetings
Other senior leaders support the FTSU Guardian as required			Contacts with HR Director, Head of Patient Experience
Leaders are confident that wider concerns are identified and managed			
Senior leaders have ensured that the FTSU Guardian has ready access to applicable sources of data to enable them to triangulate speaking up issues to proactively identify potential concerns.			HR HR - Staff Engagement Lead Minority
The FTSU Guardian has ready access to senior leaders and others to enable them to escalate patient safety issues rapidly, preserving confidence as appropriate.			All Directors available as are HR staff
Leaders receive assurance in a variety of forms			
Workers in all areas know, understand and support the FTSU vision, are aware of the policy and have confidence in the speaking up process.		Questions on FTSU are included in walkrounds. The results will be put into quarterly reports to Board. Undertake an LiA. Engage with planned Staff Forums.	

Steps are taken to identify and remove barriers to speaking up for those in more vulnerable groups, such as Black, Asian or minority ethnic (BAME), workers and agency workers		Undertake an LiA. Liaise closely with Equality and Staff Engagement Leads, Unconscious Bias Training planned.	Equality Co-ordinator in post. 'Stepping Up' training undertaken by 11 people. Staff Engagement walkround daily.
Speak up issues that raise immediate patient safety concerns are quickly escalated			Examples of actions taken after concerns raised
Action is taken to address evidence that workers have been victimised as a result of speaking up, regardless of seniority			Example of single concern when this occurred
Lessons learnt are shared widely both within relevant service areas and across the trust		Will give wider publicity to lessons learned	Examples on Hub
The handling of speaking up issues is routinely audited to ensure that the FTSU policy is being implemented		Questions on FTSU are included in walkrounds. The results will be put into quarterly reports to Board.	
FTSU policies and procedures are reviewed and improved using feedback from workers			Policy updated formally three yearly and as required if issues change
The board receives a report, at least every six months, from the FTSU Guardian.			Quarterly reports
Leaders engage with all relevant stakeholders			
A diverse range of workers' views are sought, heard and acted upon to shape the culture of the organisation in relation to speaking up; these are reflected in the FTSU vision and plan.		Will arrange a LiA on FTSU later in the year Guardians to attend the new Staff Forums.	

Issues raised via speaking up are part of the performance data discussed openly with commissioners, CQC and NHS Improvement.			Discussions with CQC. Quarterly reports presented to CQRM.
Discussion of FTSU matters regularly takes place in the public section of the board meetings (while respecting the confidentiality of individuals).			Quarterly reports
The trust's annual report contains high level, anonymised data relating to speaking up as well as information on actions the trust is taking to support a positive speaking up culture.			Annual Quality Report 2017/18
Reviews and audits are shared externally to support improvement elsewhere.			FTSU Guardians attend regional meetings
Senior leaders work openly and positively with regional FTSU Guardians and the National Guardian to continually improve the trust's speaking up culture		Consider inviting National Guardian to the Trust	FTSU Guardians attend regional meetings
Senior leaders encourage their FTSU Guardians to develop bilateral relationships with regulators, inspectors and other local FTSU Guardians			FTSU Guardians attend regional and national meetings Discussions with CQC
Senior leaders request external improvement support when required.			External reviews e.g. recent ED visit
Leaders are focused on learning and continual improvement			
Senior leaders use speaking up as an opportunity for learning that can be embedded in future practice to deliver better quality care and improve workers' experience.			Quarterly reports Examples of actions taken after concerns raised
Senior leaders and the FTSU Guardian engage with other trusts to identify best practice.			FTSU Guardians attend regional meetings

Executive and non-executive leads, and the FTSU Guardian, review all guidance and case review reports from the National Guardian to identify improvement possibilities.			Quarterly reports
Senior leaders regularly reflect on how they respond to feedback, learn and continually improve and encourage the same throughout the organisation.			Variety of external assessments
The executive lead responsible for FTSU reviews the FTSU strategy annually, using a range of qualitative and quantitative measures, to assess what has been achieved and what hasn't; what the barriers have been and how they can be overcome; and whether the right indicators are being used to measure success.		Draft explicit vision and strategy to be agreed	
The FTSU policy and process is reviewed annually to check they are fit for purpose and realistic; up to date; and takes account of feedback from workers who have used them.			Up to date policy
A sample of cases is quality assured to ensure: • the investigation process is of high quality; that outcomes and recommendations are reasonable and that the impact of change is being measured • workers are thanked for speaking up, are kept up to date though out the investigation and are told of the outcome • Investigations are independent, fair and objective; recommendations are designed to promote patient safety and learning; and change will be monitored		To be commenced on a quarterly basis with previous Speak Up Guardians on a random number of cases	
Positive outcomes from speaking up cases are promoted and as a result workers are more confident to speak up.		Examples placed on Hub	Quarterly reports

Individual responsibilities			
Chief executive and chair			
The chief executive is responsible for appointing the FTSU Guardian.			Oversees JD, advert, interview process and outcome
The chief executive is accountable for ensuring that FTSU arrangements meet the needs of the workers in their trust.			Monthly meetings. Is Executive Lead.
The chief executive and chair are responsible for ensuring the annual report contains information about FTSU.			Quality Account 2017/18
The chief executive and chair are responsible for ensuring the trust is engaged with both the regional Guardian network and the National Guardian's Office.			Guardians attend regional and national meetings. Quarterly data submitted.
Both the chief executive and chair are key sources of advice and support for their FTSU Guardian and meet with them regularly.			Regular meetings occur as do one-off meetings, as required.
Executive lead for FTSU			
Ensuring they are aware of latest guidance from National Guardian's Office.			All relevant documents sent by Guardians.
Overseeing the creation of the FTSU vision and strategy.			Minutes of meeting when vision and strategy agreed.
Ensuring the FTSU Guardian role has been implemented, using a fair recruitment process in accordance with the example job description and other guidance published by the National Guardian.			Oversees JD, advert, interview process and outcome

Ensuring that the FTSU Guardian has a suitable amount of ring fenced time and other resources and there is cover for planned and unplanned absence.			Ring fenced time agreed
Ensuring that a sample of speaking up cases have been quality assured.			Agreed to process outlined above
Conducting an annual review of the strategy, policy and process.			Policy updated. Key role in vision and strategy
Operationalising the learning derived from speaking up issues.			Reviews reports outlining outcomes form concerns raised
Ensuring allegations of detriment are promptly and fairly investigated and acted on.			Involved in one case that has arisen so far
Providing the board with a variety of assurance about the effectiveness of the trusts strategy, policy and process.			Quarterly reports
Non-executive lead for FTSU			
Ensuring they are aware of latest guidance from National Guardian's Office.			Relevant documents received from Guardian and accessed on-line
Holding the chief executive, executive FTSU lead and the board to account for implementing the speaking up strategy.		Challenge at Board when receiving FTSU reports	Board minutes and actions
Robustly challenge the board to reflect on whether it could do more to create a culture responsive to feedback and focused on learning and continual improvement.		Challenge at Board when receiving FTSU reports	Board minutes and actions

Role-modelling high standards of conduct around FTSU.			Challenge in Board and sub-committees
Acting as an alternative source of advice and support for the FTSU Guardian.		Meetings with FTSU and ad hoc communication as required	Notes of meetings
Overseeing speaking up concerns regarding board members.		No cases raised to either SID or Non-Executive FTSU lead	FTSU Report to Board
Human resource and organisational development directors			
Ensuring that the FTSU Guardian has the support of HR staff and appropriate access to information to enable them to triangulate intelligence from speaking up issues with other information that may be used as measures of FTSU culture or indicators of barriers to speaking up.			There are fortnightly meetings between the HR Team and one of the FTSU Guardians, which ensure that issues are triangulated with other informal and formal processes. There are good examples of coordinated support between the FTSU Guardians and the Operational HR team to resolve issues highlighted by staff with good outcomes for all parties.
Ensuring that HR culture and practice encourage and support speaking up and that learning in relation to workers' experience is disseminated across the trust.			There is a positive culture to support staff speaking up. This has been extended further with the appointment of a new Staff Engagement lead. There is a longstanding culture of openness that extends from the CEO, executive Team and through the Trust.

Ensuring that workers have the right knowledge, skills and capability to speak up and that managers listen well and respond to issues raised effectively.			In order to support better development and deal with difficult issues more appropriately the Trust has trained a number of staff from different backgrounds on meditation techniques. This ensures better listening skills and supports an open culture that promotes speaking up.
Medical director and director of nursing			
Ensuring that the FTSU Guardian has appropriate support and advice on patient safety and safeguarding issues.			Guardians appointed are experienced in recognizing patient safety issues and have no hesitation in taking immediate action and discussing issues with the two Directors. Both directors available for advice on individual cases as necessary. Chief Nurse: As part of appraisal and personal development plans
Ensuring that effective and, as appropriate, immediate action is taken when potential patient safety issues are highlighted by speaking up.		No such issues have arisen up to the present	Both available in this regard in any way that this occurs, not just through the speaking up route
Ensuring learning is operationalised within the teams and departments that they oversee.		Working on strengthening the processes to facilitate wider learning from concerns raised with the Guardian.	Performance Management reviews, Patient Safety Bulletin, Liaison with operational teams as necessary, Governance Division and Directorate meetings.

THE DUDLEY GROUP NHS FOUNDATION TRUST

FREEDOM TO SPEAK UP (FTSU) VISION AND STRATEGY

VISION

'Speak often and loudly'

- Patient safety and staff engagement are key priorities of the organisation
- The culture and management of the organisation will develop so that staff do not have concerns about patient safety and staff behaviour
- However, if concerns do arise, staff will feel comfortable about raising these immediately with their manager or through other appropriate routes
- Concerns will be dealt with and resolved quickly and effectively
- Staff raising concerns will be thanked and not experience detriment

STRATEGY

With The Trust's overall strategic objectives including: *Deliver a great patient experience*, *Deliver safe and caring services* and *Be the place choose to work*, the Trust Directors are committed to producing a culture of Speaking Up. The key elements of the Freedom to Speak Up strategy are:

- LEADERSHIP: Having effective, approachable, visible leadership
- PUBLICITY: Promoting speaking up
- LEARNING: Learning from concerns, acknowledging mistakes, making improvements and sharing those lessons
- AWARENESS: Ensuring staff are aware of and have confidence in the speaking up process
- BREAKING DOWN BARRIERS: Identifying any barriers to speaking up particularly amongst vulnerable groups

Key actions being taken:

- LEADERSHIP: Leadership development programmes and Leadership Forum. Staff not experiencing detriment when incidents take place and concerns are raised
- PUBLICITY: Publicity on FTSU – induction, posters, leaflets, the Hub and intranet webpage, take part in Staff Forums (see below)
- LEARNING: Learning taking a prominent place, evidenced in patient experience, incidents, complaints and FTSU reports
- AWARENESS: Feedback from those raising concerns, audit of staff seen on formal walkabouts, Guardians to take part in Staff Forums that are being set up. Appoint Speak Up Champions.
- BREAKING DOWN BARRIERS: Co-ordinate and liaise with Equality and Staff Engagement Leads, Undertake an LiA, Unconscious Bias Training

Enclosure 17

The Dudley Group NHS Foundation Trust

Paper for submission to the Trust Board on 5th July 2018

TITLE:	**Staff Survey Update**		
AUTHOR:	**Rachel Andrew, Head of Learning and OD**	**PRESENTER**	**Andrew McMenemy, Director of HR & OD**

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

CORPORATE OBJECTIVE:
O1: Deliver a great patient experience
O4: Be the place people choose to work

SUMMARY OF KEY ISSUES:

The report provides a summary of the engagement activity and actions to address key findings from the 2017 Staff Survey.

The paper also outlines the planned approach for delivery of the Staff Survey 2018 in order to increase the response rate to the target of 50% and achieve better outcomes.

IMPLICATIONS OF PAPER:

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

Action Required of the Trust Board

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

RECOMMENDATIONS FOR THE Workforce and Staff Engagement Committee

1. Note the key areas for action responding to the Staff Survey 2017.

2. To be assured that Workforce and Staff Engagement Committee are sufficient overview of the actions that will demonstrate improvements for the 2018 staff survey.

The Dudley Group
NHS Foundation Trust

1. Staff Survey 2017 – Key Findings, Engagement Plan and Actions

The report provides an update on engagement and actions around the staff survey results from 2017. In addition, it summarises key actions to improve participation from staff in the survey due to be launched in October 2018.

Background

The Staff Survey is undertaken between October and December each year.

Results from 2017 identified a number of key themes for action:

Bottom 5 ranking scores	
KF16 Percentage of staff working extra hours (lower score better)	Trust 75%
	National 71%
KF22 Percentage of staff experiencing physical violence from patients, relatives or the public in the last 12 months (lower score better)	Trust 16%
	National 14%
KF18 Percentage of staff attending work in the last 3 months despite feeling unwell because they felt pressure from their manager, colleagues or themselves(lower score better)	Trust 55%
	National 53%
KF2 Staff satisfaction with the quality of work and care they are able to deliver (higher score better)	Trust 3.83
	National 3.90
KF17 Percentage of staff feeling unwell due to work related stress in the last 12 months (lower score better)	Trust 41%
	National 38%

Responses from this year and previous surveys also continue to identify reward, recognition and job satisfaction as recurring themes.

Engagement & Feedback

Following publication of the national results in May 2018, a series of focus groups with the overall findings were arranged.

The focus group provided some initial insight into actions required to support improvements but does not provide sufficient engagement with staff across the Trust. This mirrors engagement in the survey this year where participation fell significantly.

Therefore, a Staff Engagement Lead was appointed in May 2018 to focus on listening to staff and working on plans to improve staff engagement. During May and June she has visited most ward/service areas, attended team meetings and other meetings such as the AHP Leads meeting, to gather feedback and explore barriers to completing the staff survey.

In addition, the Director of Workforce is attending team meetings across the Trust during June, July and August, in some instances alongside the staff side convenor. Initial feedback has identified a number of short-term issues around staff development, parking, communication, staff benefits and awareness of well-being services in addition to the themes already identified in the survey.

The Staff Engagement Lead has identified a number of areas for action including improving the ownership of managers of survey outcomes, promoting the importance of the survey as a staff voice and actions to improve confidence in the impact of the survey. These have been included in the suggested actions for the Staff Survey in 2018.

From the 2017 survey, there were a number of suggested actions to focus on embedding the themes from the survey. These are outlined in the table below, alongside actions to demonstrate activity to address the gaps.

Action Plan

Area of Focus (You Said)	**Activities that would support this (We are Committed to doing)**
A clear and well communicated trust vision with objectives that are focussed on delivering high quality care and they are endorsed by all.	Trust Vision refreshed and annual objectives distributed to managers as part of appraisal window. Messages promoted through Team Brief, the Hub and messages to managers.
Ensuring staff have clear objectives that are SMART, linked to the organisation vision and there is support in place to achieve them.	Additional training on objective setting as part of appraisal window and links made with Trust objectives. Further work linked to appraisal on development programmes being linked to objectives through the training needs analysis to be published in September 2018.
Managers and Leaders have the time and skills to support and develop their staff. Recognising effort and outcome is part of everyday work behaviour. Health and wellbeing activity is part of this pillar.	Launch of Developing Leaders programme to enhance skills of managers around managing people. Recognition schemes in place – Healthcare Heroes, Committed to Excellence, Capacity Champions. Additional work underway to promote the importance of daily recognition and praise for individuals and teams. A review of wellbeing activity is underway to ensure that services are targeted to need – and then services are promoted to staff, and managers. Additional support is being identified to prepare staff for periods of increased demand and training is being offered in human factors and resilience. By the end of quarter 2, there will be a robust process for identifying and managing stress for staff including: stress risk assessments, case conferences, flexible options to return to work, mediation, team and individual development. This will be supported by HR and REMPLOY.
Quality and safety is the bedrock of our work and all are committed to implementing this. Everyone understands why this is important. All staff are given the opportunity to learn from experience with a focus on learning from excellence.	AQUA has been commissioned to support a quality improvement approach and teams have been identified for the first cohort. This will be complimented by the Trust's approach to implementing LEAN through NHS Improvement. A Quality Academy is in development to promote quality improvement approaches and coordinate activity, share learning and provide a governance structure. Learning from excellence has now been

	added to the DATIX reporting system – additional focused promotion and engagement will be included in quality improvement work during the year. A review of incidents of physical violence needs to undertaken to identify key learning points and act upon findings. This is likely to include training and awareness in a range of areas such as communication, customer care and de-escalation.
Values and behaviour are important and are clear for all staff. This means that positive behaviour is celebrated and role modelled and teams are committed to working together – across the organisation towards the agreed goals.	This remains an area for development. Work on the Behaviour Charter is planned for Quarter 2 with a re-launch and training for individuals and teams. Some work has already been undertaken in response to complaints in teams where attitudes and behaviour have not always met the Trust standard. In addition, a session on this was delivered to the Medical Leaders Conference in May. The Leadership Forum in November will promote positive behaviour at work to senior leaders with a guest speaker from the Civility Saves Lives campaign. Existing mechanisms are continued and enhanced including Healthcare Heroes and Committed to Excellence, recognition days (Nurse Celebration day, compliments and thank you cards)

2. Preparation for the 2018 Survey

The response rate for 2017 and engagement in focus groups as above outlines the need to review our approach to participation. There are a couple of identified barriers:

- Staff concerns about anonymity of surveys;
- Time to complete surveys during busy winter period;
- Staff interest and engagement in the value of the survey.

This means we will require a different campaign to raise awareness and interest, create opportunities for staff to take part and to reinforce the way we collect data to reassure of anonymity. We have agreed a joint approach with our trade union colleagues in order to provide greater levels of reassurance to staff regarding the confidential nature of the survey.

Appendix 1 outlines the key activities and timescale for them to be undertaken. The main work for 2018 is to engage with team and service managers on their responsibility to promote the importance of the Staff Survey to their teams. Activities below reflect areas of success for the 2017 flu campaign in engaging a wider audience, sharing the commitment of staff and using a wide pool of campaign promoters to talk to staff about the survey and address any staff concerns.

The Dudley Group NHS Foundation Trust

Appendix 1	
Planned Activity 2018/19	**Timeline**
Identify department leads and provide a briefing for all before the campaign to highlight: • The importance of the survey in measuring areas of strength and areas to develop • Its role as a measurement of how staff feel about their work, their team/service and the organisation • Feedback from 2017 with 'you said, we did' for distribution • Responsibility/accountability of team leaders to achieve a minimum of 50% response rate	Feedback with departments during Quarter 2 Briefings for leads Quarter 2
Identify IT and provide a timetable of access in a range of locations including: additional equipment in ward/departments (using break rooms, nursing stations, communal areas); nominated survey points in main reception (of all Trust buildings and those with a high staff population such as Brierley Hill and Stourbridge);	Identify resource and timetable for survey points by August 2018
Have a dedicated email address and phone line for information and enquiries.	Email in place by Sept 2017
Identify staff survey champions who will support giving clear messages on staff survey – these should be clinical and non-clinical staff. Ensure champions and are visible with t-shirts/sashes and have access to resources – myth busting materials, stickers and information on clinics. Focus on 3 key messages.	Named champions to be in place by Sept 2018
Promote key messages around Staff Survey at Staff inductions and any other gathering place for staff to promote campaign. Identify videos/messages for display and agree timetable for displays at Induction/Mandatory Training, Staff Briefings, Lunchtimes, Main Canteen.	Timetable and resources to be in place by mid-Sept 2018
Develop a range of materials to increase visibility of the campaign from September onwards and during the campaign on key messages: • Why the survey is important • What has happened since 2017 • How we make sure people's information is protected Methods to include: Hub messages, screensavers, Pay Slip messages, posters, email signature strip for all leads/managers, champions, publish and promote survey drop ins and other locations on the staff intranet, bulletins and Facebook/twitter.	Activity plan to be available August 2018. Activity to be undertaken throughout the campaign
Rewards for staff – agree prize draw arrangements and prizes for individuals and teams who improve their compliance rates and the first team/teams to hit 50%. Include rewards for individuals – pens/stickers.	Rewards scheme in place by 30/9/18 Prize draw at the end of the first week; then monthly.
Review data from previous year/s on uptake for the staff groups/departments/directorates to identify 'hot spot' areas to target this year. Monitor on an on-going basis to direct activity.	End July 2018. To be reviewed weekly with targeted support.

Enclosure 18

The Dudley Group
NHS Foundation Trust

Paper for submission to Board of Directors 5 July 2018

TITLE:	**Board Assurance Framework / Corporate Risk Register**		
AUTHOR:	Sharon Phillips – Deputy Director of Governance (Risk and Standards	**PRESENTER**	Glen Palethorpe – Director of Governance

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

CORPORATE OBJECTIVE: All Objectives

The attached report includes the current scores of the BAF and Corporate Risks, both showing no change to the risk scores reported in May and a forward projection as to their score for the next month which should see a reduction of one BAF risk relating to the agreed delivery of the Trust's financial recovery plan through 2018/19 based on the assurance that will be provided through the Financial Improvement Group.

The Committees of the Board which met in June have all considered the BAF and the Corporate Risk register and none of the Committee's in their reports to the Board have identified any risks that need to be escalated to the BAF. However, the Finance and Performance and Clinical Quality, Safety and Patient Experience Committees have identified areas where the Executive have been asked to undertake corporate risk assessments, these being Workforce Retention, EPR implementation and the Trust's MRI replacement.

IMPLICATIONS OF PAPER:

RISK			**Risk Description:** Covers all risks
	Risk Register: Y		**Risk Score:** Covers all risks
COMPLIANCE and/or LEGAL REQUIREMENTS	**CQC**	**Y**	**Details:** All Domains
	NHSI	**Y**	**Details:** Well led framework
	Other	**Y**	**Details:**

ACTION REQUIRED:

Decision	Approval	Discussion	Other
X		**X**	

ACTIONS FOR BOARD:

To confirm based on the review undertaken by the Executives, the Risk and Assurance Group, the Committees and the discussions at the Board directly that the attached BAF reflects the key risks facing the Trust.

To note the projected direction of travel for the BAF risks for the next month.

To also note the recommendations made by the respective Committees in relation to the assessment of potential corporate risks.

BOARD ASSURANCE FRAMEWORK

1. Background

The Board Assurance Framework (BAF) is a process designed to provide evidence that the Trust is doing its reasonable best to manage the delivery of its objectives and to contain or mitigate its key risks. The BAF is also a key source of evidence that links strategic objectives to risks, controls and assurances. It is a key tool that the Board uses to demonstrate there is an effective system of internal control operating throughout the Trust.

The BAF records the key risks, assessed by the Executive team and challenged by the Board to the achievement of the Trust's stated objectives and annual goals. The BAF enables the Board to challenge whether management are effective in their management of the key risks to the delivery of the Trust's annual goals and mandated standards.

The Board sub-committees have a responsibility for the oversight of the key risks linked to their terms of reference. This allows these elements of the BAF to be considered and challenged against the debate and activity of the committee.

The Audit Committee supports the Board by seeking regular assurance over the risk management, governance and internal control process in operation to mitigate the Trust's key risks. The Audit Committee through its non-executive membership from each of the other Board Committee's seeks confirmation that each Committee is providing relevant and effective oversight of the Framework. The Audit Committee report to the Board enables to it to maintain confidence over the content and operation of the Framework.

An executive management level risk and assurance group receives both information on risks and assurance. This meets monthly and it provides the forum to assess this information against the corporate risk register, the key divisional risks and the BAF itself. This group supports and challenges the current risk score assessed by the nominated executive lead allowing a richer view of the current risk portfolio being managed by the Trust.

2. Summary of the Trust's risk profile against each of the Trust's objectives

	Total number of risks	Total inherent risk score	Total value of risks at May	Predicted movement in these risks by end of month	Current value of risks at June	Expected movement in these risks by end of next month	Total target risk score
Objective 1 – deliver a great patient experience	6	120	90	➲	90	➲	62
Objective 2 – safe and caring services	6	116	83	➲	83	➲	51
Objective 3 – drive service improvement, innovation and transformation	3	52	43	➲	43	➲	31
Objective 4 – be the place people	2	28	28	➲	28	➲	15

choose to work							
Objective 5 – make the best of what we have	2	40	36	➲	36	🕐	24
Objective 6 – deliver a viable future	6	97	82	➲	82	➲	52

The Tracking of the BAF risks is summarised within the table at Appendix 1 and the underlying corporate risk register is summarised at Appendix 2.

3. Review of the BAF

The Trust's BAF is considered each of the Board Committees supported by the work of the Executive Risk and Assurance Group which meets monthly.

Escalations to the Board

CQSPE – the Committee at its June meeting identified no further risks for consideration for inclusion on the Corporate Risk Register over and above the previously reported area relating to the risk implications of the MRI equipment replacement plan and this should see a change to the July CRR with the addition of this risk.

F&P – the Committee at its June referred to the Director of Human Resources the need to consider the risks relating to the retention of staff. The Director of Human Resources agreed to draw out the implications of retention within the already recorded risks and consider if there should also be a separate risk in respect of this issue. The Committee also asked the Chief Information Officer to check if the EPR implementation risk was clearly recorded within the Corporate Risk Register.

Digital Trust – the Committee at its June meeting did not identify and changes to the BAF.

Workforce – the Committee at its meeting in June did not identify and changes to the BAF.

4. Movements between May and June 2018

There were no movements in the risk levels between those recorded

5. Forecast movements for July

The Executive are forecasting movement of only one risk for June, BAF 592 Inability to deliver the agreed financial recovery plan through 2019/2020, within objective 5 make the best of what we have. The prediction is this risk will reduce from its current score of 20. This prediction is based on the work being tracked through the financial improvement group. It is not expected that the risk will meet its target score of 12 in July.

6. Top Board Assurance Risks

The risks in June with a current score of 20 are

- BAF 567 - *Maintaining high performance in national operational performance Standards in relation to Urgent Care to ensure robust triage, environment, working models and escalation and clinical pathways.* The Committee with oversight of this risk is Finance and Performance

- BAF 592 - *Inability to deliver the agreed financial recovery plan through 2019/2020* The Committee with oversight of this risk is Finance and Performance.

- BAF 565 – *Maintaining high performance in national operational performance standards in relation to key cancer targets.* The Committee with oversight of this risk is Finance and Performance

The risks in June with a current score of 16 are

- BAF 564 *Not achieving performance in national operational performance standards in relation to patient flow and delayed transfers for care. Capacity to meeting demand to achieve key contracts.* The Committee with oversight of this risk is Finance and Performance.

- BAF 580 Delivery of safer staffing levels to ensure high quality patient care and consistent delivery (Medical, nursing, midwifery and AHP). The Committee with oversight of this risk is Workforce.

- BAF 583 *Transformation and redesign of services not delivered to drive efficiency and improve key services in relation to outpatients, theatres, ophthalmology, GIRFTH, single point of access and pharmacy.* The Committee with oversight of this risk is Finance and Performance

- BAF 589 *Failure to enhance optimum levels of staff engagement can have an impact on retention and the staff motivation and experience.* the Committee with oversight of this risk is Workforce

- BAF 615 *Failure to deliver 2018/19 Cost Improvement Programme.* The Committee with oversight of this risk is Finance and Performance

- BAF 595 *Not maximising benefits through collaborative working in relation to BCA work streams in relation to investment in the Vanguard programme, implementation of revised pathways and staff engagement in the change process*. The Committee with oversight of this risk is Finance and Performance

- BAF 597 *Not having the right staff to deliver our clinical services currently and in the future*. The Committee with oversight of this risk is Workforce

- BAF 598 *EPR programme being delayed or failing to deliver the infrastructure to support new models of delivery in relation to core foundation system for digital.* The Committee with oversight of this risk is Digital Trust

- BAF 599 *Manage our infrastructure to support new models of delivery of a shared record between GPs and DGFT.* The Committee with oversight of this risk is Digital Trust

7. Conclusion

The Trust has seen no change in its BAF and Corporate Risk profile in the month of June.

BOARD ASSURANCE FRAMEWORK TRACKING OF RISK SCORES

Oversight Committee	Risk Lead	Ref	Risk Title	Date entered on Risk Register	Initial Risk Score	Current Risk Score							
						10/04/18	25/05/18	15/06/18				Trend	Target Risk Score
Objectives: SO1 Deliver a great patient experience													
CQSPE	**CN**	BAF568	Risk of the level of engagement & involvement of patients, carers and the public in their care and the work of the Trust	01/05/18	5X4 (20)	3x4 (12)	3x4 (12)	3x4 (12)				➔	2x4 (8)
F & P	COO	BAF564	Not achieving performance in national operational performance standards in relation to patient flow and delayed transfers for care. Capacity to meeting demand to achieve key contracts.	04/04/18	5X4 (20)	5X4 (20)	4X4 (16)	4X4 (16)				➔	4X4 (16)
F & P	COO	BAF567	Maintaining high performance in national operational performance Standards in relation to Urgent Care to ensure robust triage, environment, working models and escalation and clinical pathways	04/04/18	4X5 (20)	4X5 (20)	4X5 (20)	4X5 (20)				➔	3X5 (9)
F & P	COO	BAF565	Maintaining high performance in national operational performance Standards in relation to Key Cancer targets	04/04/18	4X5 (20)	3x5 (15)	3x5 (15)	3x5 (15)				➔	3x5 (15)
F & P	COO	BAF 569	Maintain high performance in national operational performance standards in relation to imaging for timely access to diagnostics	04/04/18	5X4 (20)	3x4 (12)	3x4 (12)	3x4 (12)				➔	2x4 (8)
F & P	COO	BAF566	Maintaining a high performance in national operational performance Standards in relation to Referral to Treatment times	04/04/18	4X5 (20)	2X5 (10)	2X5 (10)	2X5 (10)				➔	2X5 (10)
Objectives: SO2 Safe and Caring services													
CQSPE	CN	BAF 572	Ability to deliver the Trust Quality Strategy priorities..	05/04/18	4X5 (20)	4X5 (20)	3X5 (15)	3X5 (15)				➔	2x4 (8)
CQSPE	MD	BAF 574	Compliance to the identification of all deteriorating patient Groups(e.g. Sepsis, haemorrhage, chest pain, neurosurgical emergencies),	13/04/18	4X5 (20)	4X5 (20)	3X5 (15)	3X5 (15)				➔	2x5 (10)
CQSPE	CN	BAF 575	Poor experience for patients and families at end of life	02/05/18	4x4 (16)	3X4 (12)	3X4 (12)	3X4 (12)				➔	2x4 (8)

CQSPE	CE	BAF 577	Failure to deliver the CQC post inspection actions plans and improved the CQC inspection rating	02/05/18	4X5 (20)	4X5 (20)	3x5 (15)	3x5 (15)				➲	2x5 (10)
CQSPE	MD	BAF 579	Mortality reviews not robust and providing learning that is shared across the organisation to maintain the Trust within the expected SHMI/HSMR range and compliant to 100% of hospital deaths having been reviewed	13/04/18	4X5 (20)	2X5 (10)	2X5 (10)	2X5 (10)				➲	1x5 (5)
W	CN	BAF580	Delivery of staffing levels to ensure high quality patient care and consistent delivery (Medical, nursing, midwifery and AHP)	06/04/18	4X5 (20)	4X5 (20)	4X4 (16)	4X4 (16)				➲	2x5 (10)
Objectives: SO3 Drive Service improvements, innovation and transformation													
F & P	COO	BAF582	Access to 7 day services to deliver key standards and contribute to clinical networks	06/04/18	4X5 (20)	3X5 (15)	3X5 (15)	3X5 (15)				➲	2x5 (10)
F & P	COO	BAF583	Transformation and redesign of services not delivered to drive efficiency and improve key services in relation to outpatients, theatres, ophthalmology, GIRFTH, single point of access and pharmacy	10/04/18	5X4 (20)	4X4 (16)	4X4 (16)	4X4 (16)				➲	3x4 (12)
F & P	COO	BAF588	Expansion of schemes and services outlined in the Clinical Strategy not implemented	10/04/18	4X3 (12)	4X3 (12)	4X3 (12)	4X3 (12)				➲	3x3 (9)
Objectives: SO4 Be the place people choose to work													
W	DHR	BAF589	Failure to enhance optimum levels of staff engagement can have an impact on retention and the staff motivation and experience.	10/04/18	3X3 (9)	3X3 (9)	4x4 (16)	4x4 (16)				➲	2x3 (6)
W	DHR	BAF590	Performance in sickness, mandatory training and appraisal not maximising employee capability and wellbeing.	10/04/18	3X4 (12)	3X4 (12)	3X4 (12)	3X4 (12)				➲	3X3 (9)
Objectives: SO5 Make the best use of what we have													
F & P	DF	BAF 592	Inability to deliver the agreed financial recovery plan through 2019/2020	10/04/18	5X4 (20)	5X4 (20)	5X4 (20)	5X4 (20)				➲	3x4 (12)
F & P	DSB	BAF 615	Failure to deliver 2018/19 Cost Improvement Programme	02/05/18	5X4 (20)	4X4 (16)	4X4 (16)	4X4 (16)				➲	3x4 (12)
Objectives: SO6 Deliver a viable future													
F & P	COO	BAF 595	Not maximising benefits through collaborative working in relation to BCA work streams in relation to investment in the Vanguard programme, implementation of revised pathways and staff engagement in the change process.	06/04/18	5X4 (20)	4X4 (16)	4X4 (16)	4X4 (16)				➲	2x4 (8)

F & P	DF	BAF608	MCP bid fails	12/04/18	3X3 (9)	NEW	3X3 (9)	3X3 (9)				➲	2x3 (6)
F & P	DF	BAF609	Fail to deliver MCP contractual arrangements	12/04/18	3x4 (12)	NEW	3X3 (9)	3X3 (9)				➲	2x3 (6)
W	DHR	BAF597	Not having the right staff to deliver our clinical services currently and in the future.	10/04/18	5X4 (20)	4X4 (16)	4X4 (16)	4X4 (16)				➲	3x4 (12)
DT	CIO	BAF598	EPR programme being delayed or failing to deliver the infrastructure to support new models of delivery in relation to core foundation system for digital trust.	11/04/18	5X4 (20)	4X4 (16)	4X4 (16)	4X4 (16)				➲	3x4 (12)
DT	CIO	BAF599	Manage our infrastructure to support new models of delivery of a shared record between GPs and DGFT	06/04/18	4X4 (16)	4X4 (16)	4X4 (16)	4X4 (16)				➲	2x4 (8)

Key to Risk Rating

	Likelihood				
Impact score	**1**	**2**	**3**	**4**	**5**
	Rare	**Unlikely**	**Possible**	**Likely**	**Almost certain**
5 Catastrophic	5	10	15	20	25
4 Major	4	8	12	16	20
3 Moderate	3	6	9	12	15
2 Minor	2	4	6	8	10
1 Negligible	1	2	3	4	5

Key for Executives Leads

CE	Chief Executive
MD	Medical Director
CN	Chief Nurse
DF	Director of Finance
COO	Chief Operating officer
DSBD	Director of Strategy and Business Development
DG	Director of Governance
DHR	Director of HR
CIO	Chief Information Officer

APPENDIX 2

CORPORATE RISK REGISTER OVERVIEW

Oversight Committee	Risk Lead	Ref	Risk Title	Date entered on Risk Register	Initial Risk Score	Current Risk Score							Target Risk Score
						10/04/18	10/05/18	15/06/18				Trend	
Objectives: SO1 Deliver a Great Patient Experience													
F & P	CIO	COR111	The risk of a cyber-threat exploiting a vulnerability that could threaten confidentiality, availability or integrity of data services required to support business operations.	26/11/2016	4 X 4 (16)	4 X 4 (16)	4 X 4 (16)	4 X 4 (16)				➔	1 X 4 (4)
CQSPE	COO	COR421	Lack of paediatric medical workforce capacity to meet service demands, service standards and recommendations resulting in overdue follow up appointments	01/11/2017	4 X 5 (20)	4 X 5 20	4 X 5 20	4 X 5 20				➔	3 X 3 (9)
Objectives: SO2 Safe and Caring services													
CQSPE	CN	COR576	Not reducing the number of avoidable falls across the Trust	02/05/2018	5 X 3 (15)	3 X 3 (9)	3 X 3 (9)	3 X 3 (9)				➔	2 X 3 (6)
F & P	COO	COR578	Not delivering on the agreed CQUIN requirements, negatively impacting financially, on quality delivery, patient experience and risk of harm	17/04/2018	5 X 3 (15)	3 X 3 (9)	3 X 3 (9)	3 X 3 (9)				➔	2 X 3 (6)
CQSPE	DG	COR573	Deliver Trust Quality Strategy priorities to improve the delivery of incident management	09/04/2018	5 X 4 (20)	3 X 4 (12)	3 X 4 (12)	3 X 4 (12)				➔	2 X 3 (6)
F & P	COO	COR032	The Trust Major Incident Plan was tested (Tamarin) and found to have areas of weakness in the management of walking wounded (P3). In the event of an incident, the instructions within the new plan would require all MI patients to be streamed, triaged and treated within ED.	17/05/2017	4 X 5 (20)	3 X 5 (15)	3 X 5 (15)	3 X 5 (15)				➔	2 X 5 (10)

F & P	FD	COR241	Failure of the PFI provider to maintain the building in line with statutory requirements and to ensure a resilient estate due to the capacity and capability of the sub-contractors estates function.	04/07/2017	5 X 5 (25)	4 X 5 (20)	4 X 5 (20)	4 X 5 (20)				➔	2 X 4 (8)
CQSPE	COO	COR501	Ability to provide a safe, caring and effective service within ED at all times	08/02/2018	4 X 5 (20)	4 X 5 (20)	4 X 5 (20)	4 X 5 (20)				➔	2 X 4 (8)
CQSPE	CN	COR093	Delays in the management of young people requiring section under the Mental Health Act (Tier 4) resulting in inappropriate use of paediatric beds and delay in receipt of specialist care of the child.	30/11/2011	5 X 4 (20)	3 X 4 (12)	3 X 4 (12)	3 X 4 (12)				➔	2 X 4 (8)
F & P	FD	COR104	Failure of the PFI provider to manage the electrical infrastructure of the PFI buildings which is putting at risk the Trust's ability to deliver its clinical services.	30/04/2017	4 X 4 (16)	4 X 4 (16)	4 X 4 (16)	4 X 4 (16)				➔	1 X 4 (4)
CQSPE	CN	COR621	Compliance to statutory Safeguarding processes, systems and practice	04/05/18	4 X 5 (20)	NEW	4 X 5 (20)	4 X 5 (20)				➔	2 X 5 (10)
F & P	FD	COR100	Failure to comply with fire safety requirements of Fire Service Regulatory Reform (Fire Safety) Order 2005. The Trust has identified three areas of control where it does not have assurance	09/05/2016	5 X 4 (20)	2 X 4 (8)	2 X 4 (8)	2 X 4 (8)				➔	2 X 4 (8)
Objectives: SO3 Drive Service improvements, innovation and transformation													
F & P	DSB	COR631	Failure to implement a Trust-wide improvement programme and methodology which means that service transformation is not owned and methodology not utilised.	16/05/18	3X3 (9)	New	2 X 6 (6)	2 X 6 (6)				➔	2 X 2 (4)
Objectives: SO4 Be the place people choose to work													
W	DHR	COR632	Gaps in leadership development has led to capability issues for middle and senior managers in the trust	16/05/18	4 X 4 (16)	New	4 X 4 (16)	4 X 4 (16)				➔	2 X 3 (6)
Objectives: SO5 Make the best use of what we have													
F & P	CIO	COR091	In the event of one or more primary system failures, current IT Disaster Recovery (DR) is provided by a Hewlett Packard (HP) contract with Siemens Healthcare. It is estimated to take two weeks to recover the top five clinical systems, PAS, Pathology, EPR, JAC and PACS. After this other systems would start to be restored. For two weeks the Trust would fall back to manual and paper based activities	30/04/2016	5 X 4 (20)	5 X 4 (20)	5 X 4 (20)	5 X 4 (20)				➔	1 X 4 (4)

A	DG	COR638	Failure to comply with the GDPR requirements	01/04/2018	4x4 (16)	3x3 (9)	3x3 (9)	3x3 (9)				➔	1x3 (3)
W	DHR	COR119	The Trust has committed funds of approximately £900k towards the apprenticeship levy and therefore it important that this funding is fulfilled by supporting apprenticeship appointments or relevant development within the scope of the levy in order that the Trust gets value for money based on the funding already committed	21/06/2017	4 X 3 (12)	4 X 2 (8)	4 X 2 (8)	4 X 2 (8)				➔	3 X 2 (6)
Objectives: SO6 Deliver a viable future													
F & P	FD	COR600	The trust infrastructure not supporting the new models of delivery and does not align strategies to the Dudley Local & Black Country STP Estates	02/05/2018	3X3 (9)	3X3 (9)	3X3 (9)	3X3 (9)				➔	2 X 3 (6)
F & P	FD	COR485	Failure to maintain liquidity in 2018-19 and beyond	20/12/17	5 X 4 (20)	5 X 4 (20)	5 X 4 (20)	5 X 4 (20)				➔	2 X 4 (8)
F & P	FD	COR616	Failure to remain financially sustainable in 2018-19 and beyond	02/05/2018	5 X 4 (20)	5 X 4 (20)	5 X 4 (20)	5 X 4 (20)				➔	4 X 4 (16)