The Dudley Group
NHS Foundation Trust

Board of Directors
Thursday 6th September, 2018 at 8.30am
Clinical Education Centre
AGENDA

Meeting in Public Session

All matters are for discussion / decision except where noted

	Item	Enc. No.	By	Action	Time
1.	**Chairmans Welcome and Note of Apologies**		J Ord	To Note	8.30
2.	**Declarations of Interest** Standing declaration to be reviewed against agenda items.		J Ord	To Note	8.30
3.	**Announcements**		J Ord	To Note	8.30
4.	**Minutes of the previous meeting**				
	4.1 Thursday 5 July 2018	Enclosure 1	J Ord	To Approve	8.30
	4.2 Action Sheet 5 July 2018	Enclosure 2	J Ord	To Action	8.35
5.	**Patient Story**		L Abbiss	To Note & Discuss	8.40
6.	**Chief Executive's Overview Report**	Enclosure 3	D Wake	To Discuss	8.50
7.	7.1 ED Position Statement	Enclosure 4	D Wake	To note & discuss	9.00
	7.2 ED Summary at a Glance	Enclosure 5	K Kelly	To note & discuss	9.10
	7.3 Urgent Care Service Improvement Group Chairs report	Enclosure 6	J Ord	To note	9.20
8.	**Safe and Caring**				
	8.1 Clinical Quality, Safety and Patient Experience Committee Exception Report - July - August	 Enclosure 7 Enclosure 8	D Wulff	To note assurances & discuss any actions	9.30
	8.2 Chief Nurse Report	Enclosure 9	S Jordan	To note assurances & discuss any actions	9.40

	8.3 Nurse/Midwife Staffing Report	Enclosure 10	S Jordan	To note assurances & discuss any actions	9.50
	8.4 Nurse Revalidation Report	Enclosure 11	S Jordan	To note assurances	10.00
	8.5 Q1 Patient Experience Report	Enclosure 12	S Jordan	To note & discuss	10.10
	8.6 Safeguarding Report	Enclosure 13	S Jordan	To note and discuss	10.20
	8.7 Q1 Learning from Deaths Report	Enclosure 14	J Hobbs	To note assurances	10.30
	8.8 Guardian of Safe Working Report	Enclosure 15	B Elahi	To note assurances	10.40
	8.9 Freedom to Speak Up Guardian Report	Enclosure 16	D Eaves	To note assurances	10.50
9.	**Responsive and Effective**				
	9.1 Integrated Performance Dashboard	Enclosure 17	K Kelly	To note assurances & discuss any actions	11.00
	9.2 Finance and Performance Committee Exception report	Enclosure 18	J Hodgkin	To note assurances & discuss any actions	11.10
	9.3 Audit Committee Exception Report	Enclosure 19	R Miner	To note & discuss	11.20
10.	**Well Led**				
	10.1 Medical Appraisal/Revalidation Annual Report	Enclosure 20	P Stonelake	To note & discuss	11.30
	10.2 EPRR Core Standards	Enclosure 21	K Kelly	To approve	11.40
11.	**Any other Business**		J Ord		11.50
12.	**Date of Next Board of Directors Meeting** 8.30am 4th October, 2018 Clinical Education Centre		J Ord		11.50
13.	**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		11.50

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

Enclosure 1

The Dudley Group NHS
NHS Foundation Trust

Minutes of the Public Board of Directors meeting held on Thursday 5th July, 2018 at 8.30am in the Clinical Education Centre.

Present:

Jenni Ord, Chairman
Jonathan Fellows, Non Executive Director
Richard Miner, Non Executive Director
Julian Atkins, Non Executive Director
Doug Wulff, Non Executive Director
Ann Becke, Non Executive Director
Richard Welford, Non Executive Director
Diane Wake, Chief Executive
Tom Jackson, Director of Finance
Siobhan Jordan, Chief Nurse
Andrew McMenemy, Director of Human Resources
Julian Hobbs, Medical Director

In Attendance:

Helen Forrester, EA
Mark Stanton, Chief Information Officer
Glen Palethorpe, Director of Governance/Board Secretary (present from item 18/080 onwards)
Dr Mark Hopkin, Associate Non Executive Director
Natalie Younes, Director of Strategy and Business Development
Jonathan Hodgkin, Non Executive Director
Ned Hobbs, Director of Operations representing Karen Kelly Chief Operating Officer
Ruckie Kahlon, Chief Pharmacist (Item 18/082.6)
Paul Stonelake, Breast Screening Clinical Lead (Item 18/082.7)
Carol Love-Mecrow, Freedom to Speak Up Guardian (Item 18/084.4)

18/075 Note of Apologies and Welcome
8.33am

Apologies were received from Karen Kelly and Liz Abbiss. The Chairman welcomed Ned Hobbs to the meeting, who was attending for Karen Kelly.

18/076 Declarations of Interest
8.35am

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.

18/077 Announcements
8.36am

The Board noted that Mr Fellows, Non Executive Director, had been appointed as independent Chair of the Black Country STP Programme and offered congratulations. A formal commencement date had yet to be agreed.

There were no other announcements to note.

18/078 Minutes of the previous Board meeting held on 7th June, 2018 (Enclosure 1)
8.37am

Page 6 was amended to read "Mr Miner, Non Executive Director, asked for assurance around deaths in specific areas not being covered by aggregate figures."

Mr Miner said that he intended to speak to the Medical Director outside of the meeting in relation to this item to improve his understanding of the process.

Page 12 was amended to read "The Head of Internal Audit Annual Report for 2017/18 is also included in the papers".

With these amendments the minutes were agreed as a correct record of the meeting and signed by the Chairman.

Mr Miner to speak to the Medical Director in relation to assurance on deaths in specific areas not being covered by the reported aggregate figures.

18/079 Action Sheet, 7th June, 2018 (Enclosure 2)
8.41am

18/058.3 Monthly Nurse/Midwife Staffing Report

The Chief Nurse confirmed that the information presented to the Clinical Quality, Safety Patient Experience Committee and that included within the Integrated Performance Report continues to be reviewed. The aim would be to strengthen the report to Board by drawing the different information together into the staffing report to Board. An example was the inclusion now of incident data alongside staffing rates that month.

The Chief Nurse confirmed that she could further amalgamate all of the data into one report, ie a "Chief Nurse Report", with subject appendices. The Chairman asked that the new report be available from the September Board.

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

New amalgamated Chief Nurse Report to be presented to Board from September 2018.

18/080 Staff Story
8.39am

The Director of Human Resources presented the staff story which was in relation to the 'Stepping Up programme' a programme initially operating only in London that is now being run in the Black County to identify and assist those staff with leadership potential to progress through the NHS.

Dr Wulff, Non Executive Director, confirmed that it was very positive to see that individuals feel their views were taken account of in decision making within the organisation.

Mr Atkins, Non Executive Director, asked if the programme was voluntary. The Board noted that participation was voluntary and candidates were identified from the appraisal process.

Mr Miner, Non Executive Director, asked how the appraisal process would identify suitable candidates for the programme. The Director of HR confirmed that the HR Managers are looking at themes and trends from the appraisal process to identify the most appropriate training needs and to ensure relevant programmes were communicated.

The Director of Operations stressed the importance of a diverse leadership team, reporting that the division of Surgery, Women's and Children had just appointed its first female Clinical Director.

The success of the programme will be monitored through the Workforce Committee.

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

18/081 Chief Executive's Overview Report (Enclosure 3)
9.00am

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

- Staff Committed to Excellence Awards: this had been a fantastic evening which had allowed the good work of staff to be recognised. The feedback from those at the event, and those who had heard about it, was, that it was very well received. The Board added their congratulations to all winners.

- NHS 70th Anniversary: The Board were reminded that a number of celebrations were taking place throughout the NHS today, 5 July, in recognition of this being the NHS 70th Anniversary and that some of the Board members would not be at the private board later. They would be meeting staff throughout the Trust using this as a futher opportunity to thank staff for their hard work and dedication.

- Dermatology Nurse of the Year: The Board expressed their congratulations to Liz Jones who had secured this award.

- Annual Members Meeting: The Board were reminded that there would be a revised format for the meeting this year with presentations from clinical teams showcasing their services across the meeting rather than just at the end. The meeting is to take place on the 19 July.

- Fundraising: The Board were updated on the success of the Neon Dash. Feedback was that all enjoyed the event and it was well organised and thanks went to the communications team and especially the Trust's fund raiser. The Board were informed that so far the event has raised £15k

Mr Atkins confirmed that the Staff Committed to Excellence Awards was a great evening and it was a pleasure to attend.

Mr Welford, Non Executive Director, raised the issue of staff assaults and whilst this was a national story he asked what support is available to our staff in dealing with this issue. The Chief Executive stated that we ensure we have well trained and responsive security staff within the organisation to protect our staff but also that we train our staff on conflict resolution and de-escalation technique . The Chief Nurse confirmed that the Trust's reported incidences of violence against our staff are monitored at the Safeguarding Board and the organisation ensures that any staff affected get the right support.

The Chairman raised the news in relation to the Midland Metropolitan Hospital build. The Chief Executive confirmed that the situation with the previous builder will mean that it is likely a further 3 to 4 years will be added onto the building timetable .

The Chairman and Board noted the report.

18/082 Safe and Caring

18/082.1 Clinical Quality, Safety and Patient Experience Committee Exception Report (Enclosure 4)
9.08am

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:

- Report from Risk and Assurance Group: This Group continued to provide a useful source of information and assurance to the Committee. One issue the Group flagged to the Committee was the need for further work to be done on training to ensure a higher level of compliance in the use of Naso-Gastric tubes is delivered across the Trust. The Committee had asked for further updates on this area to be presented.

- Maternity: The Maternity Performance report showed positive improvements in the Trust's performance in respect of breast feeding initiation rates and reduced C-Section rates.

- Quality and Safety Group: The Group had referred to the Committee the the level of blood transfusion compliance rates across the Trust. The Committee were informed that the Trust was looking to offer and deliver targeted training to improve compliance rates.

- Complaints Annual Report: This had been reviewed and the report was endorsed by the Committee for Board approval.

- Double Reporting of Images: The Committee had received a plan to address the underlying issue of workloads that had led to an increase in the required review of images.

The Chief Nurse commented that it was a very focussed meeting and a lot of work was covered around the key areas of concern and there was Divisional engagement on the provision of solutions.

The Complaints Annual Report to be circulated to the Board to enable it approval based on the recommendation of the Committee..

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

Annual Complaints Report to be circulated to the Board.

18/082.2 Infection Prevention and Control Report (Enclosure 5)
9.15m

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

The move to annual staff training was noted to be progressing well and previous actions were delivering improved take up.

There had been concerns raised around patient data transfer. An investigation is taking place and the Board noted that problem related to IT system links. However the investigation had confirmed that the required data was submitted in full to relevant parties.

The Chairman asked about the Dr Adams visit. The Board noted that this was taking place on 16th July, 2018.

Mr Miner, Non Executive Director, asked about cleaning and the HPV programme referred to in the report. The Chief Nurse confirmed that the HPV programme relates to fogging and the process for this is being strengthened. Fogging assists in the Trust dealing with infection prevention.

The CDiff target for the Trust had reduced to 28 apportioned cases of lapses in care for 2018/19. The Board were informed there continued to be no cases of reported MRSA.

The Chairman and Board noted the report and were pleased to see the progress being made.

18/082.3 Monthly Nurse/Midwife Staffing Report (Enclosure 6)
9.20am

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

A comprehensive staffing review had been undertaken across the organisation. New staffing levels are being rolled out and the Allocate system adjusted to show these levels within the relevant rotas.

The Chief Nurse was asked by Mr Hodgkin to provide clarity to the Board around the staffing figures and new establishment and the need for figures to be consistent in all reports provided, with changes month on month highlighted and validated for accuracy.

Mr Miner, Non Executive Director, asked about the attrition rate within the Trust.

Mrs Becke, Non Executive Director, asked about agency spend. The Chief Executive confirmed that figures are down and were due in part to additional areas open within the organisation to cope with capacity pressures.

Mr Atkins, Non Executive Director, raised the table on page 9 and the actions relating to retention. He stressed that all staff should have an exit interview with a senior manager.

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.

The Chief Nurse to provide clarity around staffing figures and the new establishment.

18/082.4 Non Medical Referral Report (Enclosure 7)
9.29am

Provided on the Private Board agenda.

18/082.5 Annual Health and Safety Assurance Report (Enclosure 8)
9.36am

The Director of Operations presented the Annual Health and Safety Assurance Report, given as Enclosure 8.

The Board were reminded that this Group is Chaired by the Chief Operating Officer. The report reflects progress made in 2017/18 against the objectives of the Group and identifies plans for the Group's activities across 2018/19.

The Board noted the positive performance around hand hygiene.

Mr Miner, Non Executive Director, asked about reporting on the Risk Register in relation to any matters raised in the report. The Director of Governance/Board Secretary informed the Board that no new risks had been entered on the Corporate Risk Register in relation to the report. The Director of Governance/Board Secretary to check with the Chief Operating Officer as to risk assessments flowing from this report.

The Chairman commented that in its efforts to become a smoke free site the risk of site safety and fire in relation to smoking be considered as a further policy/presentational driver for becoming a smoke free site.

The Chairman and Board noted the report.

The Director of Governance/Board Secretary to speak to the Chief Operating Officer in relation to any items for the Risk Register.

18/082.6 Medicines Management Annual Report (Enclosure 9)
9.41am

The Chief Pharmacist presented the Medicines Management Annual Report, given as Enclosure 9. The Board noted the following key issues within the report which brings together the outcomes from all the medicines management reporting groups:

- The report identifies to the Board the systems and processes the Trust has in place to meet the CQC regulations on safe care around medicines.
- The CQC visit in December looked at Medicines Management and recognised good practice. All required actions from the visit were fulfilled quickly.
- The report provided information to the Board on the work of the Group on the availability of medicines, the management of controlled drugs, enhanced antibiotic stewardship and the work supporting patients to have appropriate and timely access to medicines.
- The report also provided information on the medicines supply chain developments. The Medicines Management Group would be monitoring this aspect of their work very closely.

The Chairman thanked the Chief Pharmacist and her team for winning the clinical support services excellence award which recognised the valuable work of the team

The Chairman asked about the vacancy situation in Pharmacy. The Chief Pharmacist confirmed that she works proactively with staff to help retain them but that there still remained pressure to maintain a full establishment.

Mrs Becke, Non Executive Director, asked about the involvement of Pharmacy in quality walkrounds. The Chief Pharmacist confirmed that noticeable improvements had occurred throughout the Trust as a result of walkrounds. She confirmed that staff had acted on medicine related matters and that pharmacy would continue to play an active role in walkrounds.

The Chief Pharmacist thanked the Chief Executive for Chairing the Medicines Management meetings as having such senior sponsorship for medicines management has improved the quality of discussion and actions taken in this area.

The Chairman and Board noted the report and progress made.

18/082.7 Breast Screening Annual Report (Enclosure 10)
10.18am

The Breast Screening Clinical Lead presented the Breast Screening Annual Report for 2017/18, given as Enclosure 10. The Board noted the following key issues:

It is a requirement of the Breast Screening Programme to present the Annual Report to the Board of each organisation the service operates within. The Screening Programme is hosted at Dudley, but is delivered from Dudley, Cannock and Wolverhampton so this report will also be presented to the Royal Wolverhampton NHS Trust.

The Breast Screening Programme Director retired during the year and Mr Stonelake was appointed to the role. A quality assurance visit was undertaken following his appointment and the visit's recommendations and action plan were included in the paper. The Board was advised that all immediate recommendations have been met and the Trust is working through the 3 month recommendations which it is on track to deliver within the agreed timescales.

The Board were informed that the main challenges to the service are cross site working and staffing. Mr Stonelake identified that work is being undertaken to unify approaches across all the sites, that weekly multidisciplinary meetings are held across the sites in support of having a consistent approach across the whole service and that the service is restructuring the Programme Office to support the Service. The Breast Team do have a number of staffing issues and a business case will be presented to commissioners for additional radiographers to support service demands. Whilst the Trust is outside the recommended interval for undertaking mammograms, a plan is in place to recover the position and this is being supported positively by the current staff delivering extra sessions.

Extra activity is being experienced due to the national breast screening incident recently highlighted in the media. The Chairman asked about the volume of activity in relation to this. Mr Stonelake confirmed that around 3,000 patients require extra mammograms. All breast referrals have to be seen within 2 weeks. Weekend and bank holiday clinics are being provided to keep up with the increasing activity. A business case will be produced in relation to increasing staff numbers within the service to deal with the demand which is likely to be sustained.

Mr Stonelake confirmed that space within the Department is also an issue in terms of being able to efficiently deal with the increasing activity levels. The Chairman confirmed that the Chief Operating Officer had established a space utilisation group and that Group should be able to support the service in having appropriate discussions regarding the space constraints.

The Board noted that cancer 2 week performance target had been delivered so far this year but May had experienced severe demand which linked to the previous discussion.

The Chairman asked that the Board's thanks and appreciation be passed to the staff within the service for their commitment given the increasing demand on the service and their efforts to meet service performance expectations. The Chairman asked the Executive Team to consider whether additional Radiographers should be recruited in advance given the projected demands on the service. The Chief Executive invited Mr Stonelake to attend Directors to make a case for the appointment of Radiographers and to provide activity data to support the assertion that more staff were needed.

Dr Wulff, Non Executive Director, asked about breast reconstruction demands. Mr Stonelake confirmed that there were no issues and the Trust has 2 plastic surgeons that undertake breast reconstruction.

The Chairman asked that the Clinical Quality, Safety, Patient Experience Committee receive a progress report on the service demands and identified actions. The Director of Operations stated that there was a need to bring together the surgical and diagnostic elements in order that demand is considered across the whole pathway.

The Chairman and Board noted the report.

Mr Stonelake to attend the Directors meetings to make a case around the appointment of additional Radiographers. The Clinical Quality, Safety, Patient Experience Committee to receive a progress report on the service demands and identified actions.

18/083 Responsive and Effective

18/083.1 Integrated Performance Report (Enclosure 11)
10.07am

The Director of Operations presented the Integrated Performance Report given as Enclosure 11.

The Board noted the following key issues with performance for May 2018:

- ED and Cancer remain a challenge. 84% achieved for the A&E 4 hour standard in May. The Department had seen a 6.6% increase on last year for ambulance arrivals. Ward B6 was open to support the medical pathway. Cancer 62 day achieved was 80.8% performance for April and 80.7% for May. The revised extract shows performance at 82.7% for June against a 79% forecast.

The Trust will fail the quarter 1 target of 85% for 62 day cancer performance. A number of actions were taking place including an independent visit to review our tracking processes. The organisation was undertaking a full review of its patient tracking list and was seeing improvements as a result of interventions. Actions are taking place to ensure that quarter 2 is delivered.

The Chief Executive confirmed that A&E performance for July stood at 95.1% to date. Mr Hodgkin, Non Executive Director, asked if this was down to a reduction in ambulance attendances. The Board noted that a reduction in ambulance attendance was not the main driver for this performance change. The Board was also informed that there was Clinical Director presence on site for the first weekend of the month. There had been 1499 breaches of the 4 hour standard in May with an improving position for June.

The Trust was ranking around 70th for national performance. Dr Hopkin asked about ambulances choosing to come to Russells Hall. The Chief Executive confirmed that datix's are raised when out of area patients are bought into ED and the Trust monitors the position closely.

The Medical Director stated that it would be good to see data from the ambulance service on conveyances as at joint meetings there seems to be differences in ambulance activity data.

The Chief Nurse confirmed that we continue to engage with patients and focus on improving the friends and family test feedback on patient experience. The Chief Nurse said that all quality metrics are improving across the Trust. The Board were reminded that patients are being surveyed in July 2018 as part of the national in patient survey and this data would be released in 2019/18 .

The Medical Director thanked the staff for the hard work put into improving VTE across the Trust. He assured the Board that the process for VTE assessment meets national guidelines.

The Chairman commented on the volatile cancer performance and asked about expectations for quarter 2. The Director of Operations confirmed that there is a risk around the backlog of patients awaiting treatment. The Chief Executive confirmed that the reporting of pathway breaches is changing and therefore is it likely that more breaches will be shared between ourselves and our tertiary partner, putting pressure on the Trust to act more timely than it does now with some of its referrals.

The Director of Operations confirmed that national comparative data will be included in the next report as this would help the Board put the Trust's performance in context.

The Board's attention was drawn to the strong performance in relation to the Trust's diagnostic and referral to treatment performance. Additionally, the Trust had delivered over 90% of appraisals in the 3 month appraisal window which was the result of the direct action taken to move the appraisal window to the first three months of the year.

Mr Hodgkin raised the growing deficit and the plans to address expenditure pressures. The Director of Finance confirmed that the vast majority of budgets had been set and agreed. Divisions have a clear view of expectations on meeting budgets.

Mr Atkins, Non Executive Director, confirmed that the achievement of the appraisal figure was good news and mandatory training was close to 90% both showing what can be achieved with focused effort. The Board noted the positive workforce metrics.

The Chairman and Board noted the report and current performance.

18/083.2 Finance and Performance Committee Exception Report (Enclosure 12)
10.39am

Mr Fellows, Committee Chair, presented the Finance and Performance Committee Exception Report, given as Enclosure 12.

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

- The Trust was £1m behind its planned position and this was due to a combination of income underperformance and agency spend which was £900k above plan.

- The Trust will not achieve all of its Provider Sustainability Funding in quarter 1 due to its ED performance but should achieve its financial performance target.

- The CIP plan is on track to deliver a £15.4m plan and the Trust continues to develop its programme to enable it to deliver its stretch target of £20m.

The Chairman and Board noted the report and financial performance and work ongoing to contain the Trust's finances within the agreed plan.

18/084 Well Led

18/084.1 Digital Trust Committee Report (Enclosure 13)
10.42am

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:

- The Programme continues to be delivered in line with the plan and within the original budget.

- E-sepis tool has been prioritised and is on schedule to go live in mid July.

- The CIO of NHS Digital had issued recommendations to NHS organisations in respect of expectations regarding cyber security.

One issue of significance for the Trust to consider is outsourcing of cyber security. As the Trust through Tera Firma act as an NHS outsourced supplied then this may result in questions from clients.

The Chief Information Officer to bring back assurance to the Board that Tera Firma is best placed to manage the Trust's cyber security requirements and the details of assurance it can provide to other NHS clients.

The Chairman and Board noted the report and progress made and that the EPR project delivery remains within budget and timescale.

The Chief Information Officer to provide assurance that Tera Firma can manage the Trust's cyber security needs.

18/084.2 Workforce Committee Exception Report (Enclosure 14)
10.47am

Mr Atkins, Committee Chair, presented the Workforce Committee Exception Report, given as Enclosure 14.

The Board noted the following key highlights:

- Changes to the work experience process have commenced to assist the Trust and those within the programme to gain more benefit for this activity.

- A presentation was made to the Committee by the newly appointed staff engagement lead on the developed plans for recruitment and retention. The Committee has asked for this report as it was seeking assurance that recruitment and retention is given sufficient focus across the Trust.

- The Committee received an update on apprenticeships and the support the Trust is giving to these.

- The Committee had discussed the positive performance around workforce KPIs and had, like the Board, noted the significant improvement in staff appraisal rates.

- The Committee approved the Terms of Reference for the Staff Experience and Engagement Group which would report into the Committee.

The Chairman asked whether the Committee were sighted on the progress being made in respect of the staff survey action plan. The Board were informed that this was reviewed in detail by the Committee and there was nothing they needed to escalate to the Board from the review at their last meeting.

The Chairman and Board noted the report and assurances provided.

18/084.3 Charitable Funds Committee Report (Enclosure 15)
10.55am

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

The report was taken for information, with the Board noting that general funds were being used in line with the Board's steer to utilise them.

The Chairman and Board noted the report.

18/084.4 Freedom to Speak Up Guardians Report (Enclosure 16)
10.56am

The Freedom to Speak Up Guardian presented her report given as Enclosure 16.

The Board noted the following key highlights:

- 15 enquiries had been received in the quarter of which only 2 related to patient concerns and none required immediate action.

- Where concerns are raised from a named individual the guardian provided assurance that there is no detriment from speaking up.

- Benchmarking data was provided in the report showing that the Trust's level of activity was within normal parameters. It was neither a low or high reporter of concerns.

- The national freedom to speak up guardian had asked that each provider complete a self assessment on their local arrangements. This response had been circulated to all Board members for comment and agreed at the last Clinical Quality, Safety, Patient Experience Committee meeting.

- A Vision and Strategy had been produced for supporting raising of concerns which documented the Trust's current processes and the support available.

- The Board were reminded that Carol Love Mecrow had stepped down from the position and Philippa Brazier from the Professional Development Team has been appointed as her replacement. Carol is providing support to Philippa whilst she becomes familiar with the role.

- As discussed at previous Board meetings the Trust is looking at the role of Freedom to Speak Up Champions to support the Guardians and given the level of interest in the recruitment to replace Carol a few natural candidates for these roles have emerged.

Dr Wulff, Non Executive Director, thanked Carol for the work undertaken in her time as Guardian.

The Chairman thanked the Chief Executive for her support to the Guardians.

The Chief Nurse said it was important to look at the professional breadth of champions so all professionals are represented but who could follow consistent process.

The Chairman and Board noted the report and thanked the Guardians for their continued work.

18/084.5 Staff Survey Action Plan (Enclosure 17)
10.49pm

The Director of Human Resources presented the Staff Survey Action Plan Report given as Enclosure 17.

The Board noted the following key highlights:

- The new staff engagement lead was having a positive impact within the organisation and is driving these improvement initiatives reporting to the Workforce Committee.

- Mr Atkins, Non Executive Director, commented that the organisation needs to get as many staff as possible to complete the survey to ensure it can secure the maximum benefit from feedback. The Board were informed that the Trust was changing the mechanisms available to staff to allow them to complete the survey in as accessible way as possible

The Chairman raised physical violence from patients as discussed earlier in the meeting. The Director of Human Resources confirmed that conflict resolution training was being provided and take up is monitored.

Mr Welford, Non Executive Director, asked about how the Trust responds to feedback from the staff survey. The Board noted that the survey closes in November and the Trust does not receive results until March so it was seeking to secure more timely feedback by extending the staff FFT questions as a gauge for the way staff are feeling.

The Director of Operations stated that the trust-wide staff engagement forum will allow the organisation to smooth out staff experience activities on a rolling basis throughout the year.

The Chairman and Board noted the report and the actions being progressed in response to staff feedback.

18/084.6 Corporate Risk Register (Enclosure 18)
11.02am

The Director of Governance/Board Secretary presented the Corporate Risk Register given as Enclosure 18.

The Board noted the report and agreed:

- The risks around and Health and Safety and Staff retention be subject to a risk assessment. The Director of Governance/Board Secretary confirmed that these risks were being considered.

- The on going work on the Board Assurance Framework be reported to the August Audit Committee.

The Director of Governance/Board Secretary asked the Board given the debate earlier in the meeting if there was a need to consider the risks regarding the breast screening service for inclusion on the Corporate Risk Register. The Board asked that this matter be considered at the Risk and Assurance Group.

The Chairman and Board noted the report.

18/085 Any Other Business
11:04am

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

18/086 Date of Next Meeting
11.05am

The next Board meeting will be held on Thursday, 6th September, 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 5 July 2018

Item No	*Subject*	*Action*	*Responsible*	*Due Date*	*Comments*
18/058.3 & 18/079	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. New amalgamated Chief Nurse Report to be presented to Board from September 2018.	SJ SJ	6/9/18 6/9/18	On Agenda
18/029.8	Action Sheet	Board members perspective of the 6Cs to be presented to the Board in May.	LA	6/9/18	To October Board
18/045.5	Nurse Revalidation Report	Further detail around numbers and quality of evidence relied upon for revalidation to be included in future reports.	SJ	6/9/18	On Agenda
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.	NY	6/9/18	The Annual Plan report was revised and the Quarter One report submitted in the new format. The format was discussed at Directors before being submitted to Board as part of the

		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	6/9/18	Integrated Performance Report in July. Action completed. Meetings with NEDs on the Strategy have taken place. Further meetings with NEDs have been arranged for 19th and 27th September for further discussion. Action complete.
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	On Agenda
18/068	Patient Story	Chief Nurse to investigate Orthopaedic Physiotherapy provision with Gail Parsons.	SJ	6/9/18	
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	Ongoing
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.	JO	6/9/18	Organ Donation lift wraps being installed. Participating in Organ Donation week – 3rd September "Go Pink" campaign. Further opportunities to be considered at the next Organ Donation Committee meeting.
		The Chief Executive to discuss the inclusion of detail around Sepsis in the Mortality Report with the Medical Director.	DW/JH	6/9/18	Done
		A report on COPD to be brought back to the Board.	JH	4/10/18	Included in the Mortality Report.
18/072.3	Research and Development Report	Board members asked to challenge Divisions on their involvement in research.	All	Ongoing	Ongoing

18/078	Minutes of the Previous Meeting	Mr Miner to speak to the Medical Director in relation to assurance on deaths in specific areas not being covered by the reported aggregate figures.	RM/JH	6/9/18	Done. Revised Mortality Report on Agenda.
18/082.1	Clinical Quality, Safety, Patient Experience Committee.	Annual Complaints Report to be circulated to the Board for approval.	SJ/HF	6/9/18	Done. Circulated and Approved.
18/082.3	Monthly Nurse/Midwife Staffing Report	The Chief Nurse to provide clarity around staffing figures and the new establishment.	SJ	6/9/18	On Agenda
18/082.5	Annual Health and Safety Assurance Report	The Director of Governance/Board Secretary to speak to the Chief Operating Officer in relation to any items for the Risk Register.	GP/KK	6/9/18	Done
18/082.7	Breast Screening Annual Report	Mr Stonelake to attend the Directors meetings to make a case around the appointment of additional Radiographers. The Clinical Quality, Safety, Patient Experience Committee to receive a progress report on the service demands and identified actions.	PS/Exec Team	4/10/18	Revised date to October to allow Business Case to be presented at Executive Team.
18/084.1	Digital Trust Committee Report	The Chief Information Officer to provide assurance that Tera Firma can manage the Trust's cyber security needs.	MS	6/9/18	TFIT has summarised its Cyber security compliance/GDPR against NHS standards and industry practice and issued to all its clients. Further benchmarks will take place once NHS Digital has published its recommendations.

Enclosure 3

The Dudley Group
NHS Foundation Trust

Paper for submission to the Board of Directors on 6th September 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
- MCP Update
- Healthcare Heroes
- Treatment Shortlisted for HSJ Award
- First of its Kind – Minimally Invasive Endoscopic Procedure
- Nominate for a Queen's Honour
- Gold Standard Service
- Organ Donation
- Charity Update
- 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 – September 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

5 July	Board of Directors
	Risk Summit
	NHS 70th Celebrations
6 July	Team Brief
9 July	Non Executive Director Interviews
	Meeting with CCG Executives
10 July	Extraordinary STP Meeting
11 July	Transition Board
12 July	Healthcare Heroes Award
13 July	MPs Meeting
17 July	ICS Development Workshop
18 July	A&E Delivery Board
	Council of Governors Briefing Session
19 July	Annual Members Meeting
23 July	ICS Development Programme
25 July	Dudley Partnership Board
1 August	Dudley System Oversight and Assurance Group
2 August	Extraordinary Council of Governors
7 August	Team Brief
8 August	Transition Board
29 August	Dudley System Oversight and Assurance Group
	Healthcare Heroes Award
30 August	Healthcare Heroes Award
31 August	Staff Engagement Event

MCP Update

On 27th July 2018 I was notified that the Trust (and partners) tender application for the MCP contract, submitted on 8th May 2018 was successful. The standstill period ended at midnight on 6th August. The notification contained a number of areas of further development that, encouragingly, aligned with the caveats that were submitted by ourselves as part of the bidding process.

The contractual form is intended to be through an innovative 'Integrated Care Provider' contract. This contract has never been used before and in August it started a period of public consultation by NHS England

The MCP Transition Board continues to meet regularly and an interim Managing Director was recently appointed to help to take the transformation of out of hospital services forward.

Healthcare Heroes

Presenting the monthly Healthcare Heroes Award is one of the highlights of my job. It's always so lovely to see the look of surprise on the faces of the recipients! The individual award this month went to Sister Katie Hodgetts on ward B4. She stood out from the crowd for discharging 20 medically fit patients, most of them before 12noon, in one day. She continuously goes the extra mile for her patients and is so friendly and approachable.

The team award was given to the Neonatal All Stars. More than 30 members of staff from the Neonatal Unit took part in a 5km run at Himley Hall Park to raise vital funds for the unit. The group was formed with all grades of staff, including consultants, matrons, staff nurses, sisters and nursery nurses. The group raised more than £1,000 alone, contributing to the astonishing £15,000 total! Both recipients this month are very worthy winners.

Treatment Shortlisted for HSJ Award

I am delighted to say that we have been shortlisted for an HSJ award for a minimally invasive procedure pioneered at Russells Hall Hospital. We are one of the leading centres in the world for endoscopic treatment for the condition Zenker's diverticulum.

Consultant Gastroenterologist Professor Sauid Ishaq introduced the procedure in 2013 and we now take nationwide referrals. Patients only have to be in hospital for the day and are able to start eating again after 24 hours.

We have been nominated for an Acute Sector Innovation award in the HSJ Awards 2018. The awards are hotly contested and this year has seen a staggering increase in entries, according to the HSJ.

Zenker's diverticulum is a rare, benign condition. In this condition, a large sac develops in the upper part of the oesophagus. The most common symptoms are difficulty in swallowing, regurgitation of food and choking during eating. Zenker's diverticulum significantly affects people's quality of life.

First of its Kind – Minimally Invasive Endoscopic Procedure

Professor Ishaq and consultant GI surgeon Mr Antonio Santos have recently completed a brand new endoscopic day case procedure, the first of its kind in the country. Gerdx is performed on patients who suffer acid reflux and where tablets fail to control the condition. It's performed without surgery. This procedure has transformed the life of Mrs Yvonne Jones who reports that the minimally invasive procedure has transformed her life and she is now cured.

With the new procedure, an endoscope is passed over the tongue and down the throat to identify the pharyngeal sac. The bridge of muscle that leads to this sac is then cut. The base of this muscle is clipped with a metal clip to prevent any perforation. Professor Ishaq will make a 25-minute presentation to the HSJ judges in London on 8th October 2018 and the winners will be announced at the awards ceremony on 21st November.

Nominate for a Queen's Honour

Our Trust is full of amazing people and we are encouraging staff to nominate a colleague for a Queen's Honour or award. Anyone is eligible, whether it's an amazing nurse, porter, doctor, cleaner, cook, physio, midwife or volunteer. The Honours system recognises people who have made achievements in public life and committed themselves to serving and helping Britain. They'll usually have made life better for other people or be outstanding at what they do.

Gold standard service

Congratulations to our Endoscopy Department which has had its accreditation as a 'gold standard' service renewed for another year. To maintain its five-year JAG (Joint Advisory Group on GI endoscopy) accreditation, the department has to pass an annual review. It has heard this month that it has met all the requirements. The accreditation is independent recognition that GI provides a first class, safe service. The review looks at all aspects of the service, from bookings and budgets to equipment, training and skills. The department has held JAG accreditation for nine years, and is A rated in a lot of the categories. The five-year renewal is due next year when it will be trying to achieve an overall A rating.

Organ Donation

We are now leading the way on organ donation in the area – and as this week is Organ Donation Week we are encouraging staff to keep up the good work. Russells Hall Hospital has now had the highest number of donors this year in the Black Country and as a thank you for our massive increase, NHS Blood and Transplant is funding two lift wraps. The lifts at the ground floor T junction will be getting a bright pink organ donation logo makeover.
The focus of Organ Donation week – Words Save Lives – is encouraging families to talk about organ donation in advance so people's wishes are known. T

Charity Update

The Baby Bereavement Suite Appeal has got off to a phenomenal start with donations to date of £35,000. Director of Workforce Andrew McMenemy is in training for the Bank of Scotland Great Scottish Half Marathon on Sunday 30 September. He has set up a Just Giving page to raise funds from the half marathon and all proceeds are for the Baby Bereavement Suite appeal. We have two more events supporting this appeal in the pipeline; a 5k timed run with the Dudley Parkrun on Saturday 20 October and the Sparkle Party on Friday 23 November at the Village Hotel.

The Trust's charity is supporting improvements to the bereavement room at the hospital by providing home comforts such as a double bed to enable parents to stay overnight.
In addition to structural improvements to the suite, such as soundproofing, the charity also aims to help staff by investing in specialist training to enable them to sensitively support bereaved parents, and their varying needs, in the best way possible. The appeal will also enable staff to provide keepsakes and photographs to enable the family to build up some precious memories.

National NHS News

NHS OUTRAGE: Union ERROR results in staff receiving HALF of the promised pay rise

NHS STAFF have responded with widespread outrage to the Royal Collage of Nursing's "miscommunication", which resulted in thousands of workers receiving hundreds of pounds less than what they were promised. However, it was discovered this week staff did not receive the uplift they expected in their first pay packets. The chief executive of the Royal College of Nursing (RCS), Janet Davies, has personally written to its members to apologise for the error. **Express (27.07.18)**

Maternity units could prevent 600 stillbirths a year if new national guidance is adopted, says NHS England
Around 600 stillbirths a year could be prevented if maternity units across the country followed national best practice, NHS England has said. The lives of more than 160 babies have been saved across 19 maternity units between 2016 to 2018. The health service said reducing smoking in pregnancy, better monitoring of a baby's growth and movement in pregnancy, and subsequently during labour, had contributed to the improved figures. The latest figures from NHS England show that of the 696,271 births in 2016 in England and Wales, 3,112 resulted in stillbirth.
The Independent (30.07.18)

NHS pays massive £3.4m on toiletries in past year alone
Doctors have given out almost 500,000 prescriptions a year for toiletries such as toothpaste, shampoo, and body wash — costing NHS England £3.4m a year. Latest figures from NHS Digital showed that a total of 470,678 prescriptions were given out last year, up by nearly 80,000 since 2007. The most popular items were branded toiletries such as Ambre Solaire after sun, Colgate toothpaste, Aveeno body wash (to which £1.64m was spent on the 195,091 prescriptions of the body wash) and Neutrogena shampoo. The total cost of supplying patients with the toiletries has skyrocketed from a mere £483,000 in 2007, Sunday Times analysis shows.
National Health Executive (30.07.18)

Younger women 'not getting enough nutrients', survey warns
Each adult in the study gave details of what they ate and drank over four consecutive days during the period from 2008 to 2014. The 20 to 29-year-old group (of both men and women) had the highest rates of potential deficiencies of potassium (24.7%), zinc (8.6%) and calcium (9.4%). Across all age groups, men were at high risk of selenium, magnesium and vitamin A deficiency (affecting 26%, 14% and 11% of men respectively), and particularly high numbers of women were at risk of iron, selenium and potassium deficiency (affecting 25%, 50% and 24%). All of these minerals and vitamins can help keep the body healthy and prevent chronic diseases. So these results are potentially concerning.
NHS Choices (31.07.18)

NHS threatened with legal action unless it offers transgender people fertility treatment
The equality watchdog has threatened the NHS with legal action if it does not offer transgender patients access to fertility services. Transitioning treatments can lead to fertility loss, and patients are often not offered the opportunity to store their eggs or sperm before beginning the process. The Equality and Human Rights Commission (EHRC) said the NHS's current policy on this matter was "outdated" and discriminated against the transgender community. On Friday EHRC took the first step towards a judicial review by writing a pre-action letter to NHS England.
The Independent (05.08.18)

NHS facing fresh cancer screening scandal as thousands may have missed appointments
Thousands of patients may have missed vital cancer screening and jabs in a fresh NHS scandal dating back up to a decade, it has emerged. Health officials are investigating concerns that adults who should have been invited for breast and bowel cancer screening were not issued with invitations, and that children missed out on crucial jabs. An urgent probe is underway with new Health Secretary Matt Hancock due to be updated on the scale of the risks on Monday. The concerns are set to be the first healthcare scandal to emerge since he took office last month in the latest cabinet reshuffle.
The Telegraph (10.08.18)

Database ballsup: NHS under pressure over fresh patient record error
NHS England confirmed The Register that it was working to establish the impact of thousands of mismatches, which saw patient records present on one database and absent from another. There are concerns that the error could mean patients have missed appointments for disease screening and vaccinations. According to the Health Service Journal, there are 120,000 discrepancies between the Personal Demographics Service (PDS) and the National Health Application and Infrastructure Services (NHAIS). The PDS is a national database of NHS patient details, recording name, address, date of birth and NHS number.
The Register (13.08.18)

NHS kept using 'danger syringes' in bid to save money, investigation claims
At least nine people died because the NHS used syringe pumps that did not meet internationally approved safety standards in a bid to save cash, it has been claimed. Thousands of lives were put at risk as Britain's health service continued to use equipment other countries had banned, an investigation by The Sunday Times reports. Experts say the number of fatalities linked to the pumps may actually be many times higher – but no record was ever made because of "institutional indifference" to elderly patients in their final days. The decision was made, at least in part, because of the financial implications of immediate replacement. Documents attached to the NPSA are reported to suggest a full recall would have cost the NHS £37.6m. **The Independent (19.08.18)**

NHS hospitals warn no-deal Brexit could hit disease control efforts
The body representing National Health Service hospitals and ambulances has written to NHS England to warn that a hard Brexit or no-deal scenario could adversely affect "the entire supply chain of pharmaceuticals" in the UK and hit "disease control." **Financial Times (21.08.18)**

Steam treatment for big prostates approved on NHS
The NHS can start offering a new steam treatment for benign prostate enlargement, says the regulator, the National Institute for Health and Care Excellence. The procedure is minimally invasive and can be done under local anaesthetic without an overnight hospital stay. It involves passing a small probe up the urethra to inject a puff of steam into the troublesome area. The steam kills off some of the enlarged tissue to ease symptoms. The dead cells are reabsorbed by the body. An enlarged prostate is common - affecting one in three men over the age of 50 - and forces the urethra (urine tube) to narrow, causing a variety of problems, including difficulty emptying the bladder. **BBC News (21.08.18)**

One in six NHS trusts do not offer caesareans on request – charity
Official guidance states that women should be offered a planned c-section "if after discussion and offer of support ... a vaginal birth is still not an acceptable option". But Birthrights found that 22 out of 147 trusts who responded to a freedom of information request did not offer maternal request caesareans (MRCs). A further 70, almost half, had policies that the charity deemed problematic or inconsistent, thereby creating a postcode lottery, Birthrights said. Almost three-quarters of NHS trusts were found not to have written guidelines clearly committing to a woman's right to have an MRC and only 39 were found to offer caesareans in line with Nice's best-practice guidance.
The Guardian (21.08.18)

Scottish NHS is stockpiling medicines for hard Brexit
Dr Catherine Calderwood said medical supplies that might be “problematic to access” after Brexit had been identified. Many drugs and much of the health equipment used in the UK are manufactured in Europe. In an interview yesterday she said the Scottish health service will be working very closely with the Department of Health to ensure there was enough medical equipment and medicines. including insulin, for people in **Scotland** even in the event of a no-deal Brexit. When asked if this meant there were plans to “stockpile” medicine and equipment ahead of Brexit, she told the BBC: “The plans that we have discussed involve ensuring that there is a supply of medicines. **The National (22.08.18)**

Avoiding late diagnosis of ovarian cancer
UCLH Cancer Collaborative has today launched the first pilot project of an NHS ovarian cancer surveillance service for women who carry a faulty BRCA gene and have chosen not to have their ovaries and fallopian tubes removed. The pilot, known as the ALDO project (Avoiding Late Diagnosis in Ovarian Cancer), aims to recruit 2,000 women aged over 35 from across England and will use Abcodia’s ROCA© Test as part of an NHS service to detect ovarian cancer amongst BRCA-carriers before they have any symptoms. The ROCA Test uses an algorithm to assess changes in the level of the blood chemical CA125, which typically rises in ovarian cancer. Participants will have the ROCA Test every four months.
University College London Hospitals (23.08.18)

Thousands died waiting for NHS funding decision
One widow told the BBC a nurse came to assess her husband the day after he died. NHS England said improvements had been made but the process could be "more efficient". Continuing healthcare (CHC) is a funding package given to people with severe health and social care needs, such as Alzheimer's or Parkinson's, but who are not in hospital. Applications should take no longer than 28 days to deal with, but clinical commissioning groups (CCGs) revealed 3,400 people died in 2017-18 while awaiting a decision on their application. The BBC obtained information from 185 out of 198 CCGs about the outcome of CHC applications received in the last financial year. **BBC News (24.08.18)**

Honey, not antibiotics, recommended for coughs
"Use honey first for a cough, new guidelines say," reports the BBC, referring to new guidelines on the best ways to treat acute short-term coughs.The guidelines from the National Institute for Health and Care Excellence (NICE) and Public Health England (PHE) have been developed after looking at the best available scientific evidence. The evidence showed that honey could be effective at reducing the symptoms of acute coughs due to upper respiratory tract infections (infections of the airways), including how often people coughed and how bad their cough was.
NHS Choices (28.08.18)

‘Breakthrough’ personalised cancer treatment rejected for NHS use
The National Institute for Health and Care Excellence (Nice) published draft guidance stating that axicabtagene ciloleucel, also known as Yescarta, is not recommended for NHS use for patients with aggressive sub-types of non-Hodgkin lymphoma. The treatment, created by Kite Pharma – a subsidiary of Gilead Sciences – is a personalised cell therapy which re-engineers a patient’s own immune cells to fight cancer. Kite Pharma said that in clinical trials, 72% of the patients responded to therapy and 51% went into complete remission. But Nice said that there is no direct data to compare it with the current standard treatment of salvage chemotherapy. It said that cost of axicabtagene ciloleucel was also too high for it to be considered a cost-effective use of NHS resources.
The Mail (28.08.18)

SNP attacked over year of missed NHS targets
The Scottish Government's benchmark for 95 per cent of A&E patients to be either admitted, transferred or discharged in four hours was last met in the week ending July 30 last year. Last night, the news urged the Scottish Liberal Democrats to call for urgent action after highlighting the failure. The party's health spokesman, Alex Cole-Hamilton MSP, accused the SNP of "mismanagement" and said more resources were needed for the NHS and social care sector. Despite this additional demand, latest figures show that more than nine-out-of-10 patients across Scotland were seen, treated and either admitted or discharged within four hours in the latest week**. The Express (29.08.18)**

Regional NHS News

New Cross Hospital trust hit with £21k fine over ambulance waits
Royal Wolverhampton NHS Trust has been penalised after almost 100 patients were forced to wait in ambulances. It is the sixth time the trust has been punished for keeping ambulances queuing outside New Cross Hospital's accident and emergency department. Hospitals are punished for the number of patients left waiting in ambulances for more than 15 minutes. The trust is fined £200 for each patient waiting between 30 minutes and an hour, with fines of £1,000 handed out for waits of more than one hour. In May, the trust was fined just £2,000 for keeping only 10 patients waiting for up to one hour. But hospital chiefs have claimed an increase in ambulance handover times was down to a rise in the number of ambulances arriving at its sites**. Express & Star (30.07.18)**

Hospital deaths: New Cross Hospital trust has worst rate in England
NHS officials estimated there should have been 2,179 deaths at the hospital or within 30 days of discharge in 2017. However, 2,654 people died – 22 per cent more than estimated, a higher percentage than any other hospital trust in England. Wolverhampton MP Emma Reynolds today called for action while Healthwatch Wolverhampton, a public body which holds the NHS to account, said the figures were 'very concerning'. Also to be identified by the NHS as having a higher than expected death rate was Sandwell and West Birmingham NHS Trust, which runs Sandwell General Hospital and City Hospital in Birmingham. It was expected to record 1,898 deaths in 2017, but instead had 2,137 – 239 more deaths (13 per cent).
Express & Star (31.07.18)

This is how many job vacancies there are at each West Midlands hospital
The Royal Wolverhampton has seen the biggest rise in the West Midlands in advertised vacancies, up 43.2% from 264.9 in April to June 2017 to 379.5 in January to March, the equivalent of 5.4 empty posts for every 100 members of staff. This includes a 41.7% increase in medical and dental posts being advertised, with 72 advertised in January to March. Vacancies at Walsall Healthcare were up 19.9% from 187.2 in April to June 2017 to 224.4 in January to March. This includes a 49% increase in nursing and midwifery posts being advertised, with 108.9 advertised in January to March. At the Royal Orthopaedic Hospital, there were eight vacancies for every 100 members of staff, with 873.5 posts being advertised in the first three months of the year. The trust has more than doubled the number of ads for medical and dental staff, up from 12 vacancies in April to June 2017 to 26.4 in January to March. **Birmingham Live (01.08.18)**

Hundreds of West Midlands children are being hospitalised - because of stabbings
Stabbings put children in the West Midlands in hospital more than 100 times last year - with the age group making up more than a quarter of stab victims. Kids aged 10 to 19 from the West Midlands metropolitan area were admitted to hospital at least 104 times in 2017/18, following an assault with a sharp object, latest NHS Digital figures reveal. This corresponds to 27 per cent of the total 393 hospitalisations for stabbing last year. In Birmingham, almost a third of hospital admissions for stabbings involved someone aged between 10 and 19, or 67 out of 216 in 2017/18, the highest proportion in the West Midlands, while there were seven out of 23 admissions in Walsall involving this age group. **Birmingham Live (13.08.18)**

Midland Met: Government-backed cash secures future of 'super' hospital
Under the agreement with Sandwell and West Birmingham NHS Trust, the Government will provide public funding for the remainder of the building work. It will be opened by 2022. Health Minister Steve Barclay said: ""By taking this bold step, we are not only giving patients in Sandwell and West Birmingham world-class NHS facilities on their doorstep but also showing our determination to build an NHS fit for the future – all whilst making sure taxpayers' money is spent in the best possible way". Construction work had begun on the hospital but halted earlier this year when the firm carrying out the work, Carillion, went into liquidation. After examining all available options, including a replacement contractor, the trust asked the Government to provide public finance for the project.
Express & Star (16.08.18)

10,000 people join stem cell register but more needed
Nationwide charity Anthony Nolan said there are now more than 112,000 potential donors from the West Midlands. A stem cell transplant could be a patient's best chance of survival if they have a condition affecting their bone marrow or blood. The annual review of the Anthony Nolan and NHS Stem Cell Registry revealed the UK stem cell register now stands at 1.4 million but young men are significantly under represented. More than 2,200 searches for a lifesaving transplant were made last year, with men making up 82 per cent of donors but only 12 per cent of men under 30 on the register. Donors from minority ethnic backgrounds make up just 14 per cent of the stem cell register, with patients from black, Asian or other minority backgrounds having just a 20 per cent chance of finding a match.
Shropshire Star (16.08.18)

Thousands of Birmingham smokers unsuccessful at quitting - these are all the benefits
More people in Birmingham are using NHS Stop Smoking Services, despite a national decline as smokers turn to vapes and e-cigarettes as a means of quitting. Some 3,868 quit attempts were made in Birmingham using the service in 2017/18 - nearly a three-fold increase on 2016/17, when 1,369 quit attempts were made. Some 42 per cent of quitters in Birmingham self-reported as having successfully stopped smoking - similar to the 43 per cent recorded last year. That's lower than the national average self-reported quit rate of 51 per cent. Across the West Midlands, the amount of people using the service stayed roughly the same, with sharp declines in Dudley, Walsall and Coventry cancelling out the rise in Birmingham. The sharp increase in people using NHS Stop Smoking Services in Birmingham runs counter to the national trend. **Birmingham Live (17.08.18)**

Brummie kids in desperate need of wheelchair forced to wait weeks
In 2017/18, 386 children across the West Midlands met county waited more than 18 weeks from referral for their new equipment to be delivered, a fifth, 20%, of those whose cases were closed during the year, according to the figures from NHS England. The proportion facing long waits was up from 15% in 2016/17. The aim is for none of these patients, who may be waiting for their first long-term wheelchair or a replacement for equipment that is no longer suitable, to wait longer than 18 weeks from referral to when they receive their new equipment. Nearly half of children in the Birmingham CrossCity CCG (46%) waited more than 18 weeks for their wheelchair in 2017/18, a total of 177 children, up from 24% the year before, while 43% of children in Birmingham South and Central faced waits of more than 18 weeks, a total of 63 children, up from 17% in 2016/17.
Birmingham Live (23.08.18)

Handlers failed to follow 999 guidelines, Telford woman's inquest told
Ambulance operators failed to follow guidelines, resulting in paramedics being diverted from attending a Telford woman found "unresponsive" at home, an inquest found. In a statement Dc Stephen Davies described how he and a colleague arrived at the property, in Grange Road, Ketley Bank, at 4.40pm to speak to Miss Bradley who was a 'potential witness' in the criminal case. They were not expected and were let in by a relative who thought she was asleep. The officers realised she was not breathing and applied chest compressions in a bid to revive her while phoning for an ambulance, which did not arrive for 30 minutes.
Shropshire Star (24.08.18)

Enclosure 4

The Dudley Group
NHS Foundation Trust

Paper for submission to the Board of Directors on 6th September 2018

TITLE:	**Quality Improvement Journey**		
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:

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.

Quality Improvement Journey

The CQC inspected five core services at Russells Hall Hospital and community adult services, including sexual health services, in December 2017. Our medicine, maternity and community services received an overall Good rating, and the CQC found examples of outstanding practice. Our overall rating remains Requires Improvement. However, our Emergency Department (ED) was rated Inadequate. We continue to work with our emergency teams and strive to improve the care we deliver which will result in an outstanding service for the people of Dudley.

We welcomed the CQC report and its findings which identified key areas for improvement. The CQC has been frustrated at the pace of change within our ED and has taken enforcement action under section 31 of the Health and Social Care Act 2008. These areas are: how we triage and assess patients; how we manage patients when their condition deteriorates; staffing and safeguarding.

We are absolutely committed to delivering the actions needed to ensure our patients are safe.

1.0 Triage and assessment

The CQC found our triage system was inconsistent and that we needed to ensure we utilised an evidence based system, triage patients within 15 minutes of arrival in line with national guidelines and standards.

In relation to this we have put in place actions to meet two objectives.

Objective 1: to achieve 95 per cent of all ambulance arrivals, adult majors and paediatric attendances being triaged within 15 minutes.

What we have done: we have:

- Increased resources to ensure patient observations are maintained during activity peeks.
- Introduced our Fit to Sit Standard Operating Procedure (SOP) criteria and monitoring process.
- We broke data down to analyse
- We can demonstrate continuous week on week improvement since 18th July 2018 with the last reported week in August being our highest to date (89.76% of patients triaged within 15 minutes).

Our next steps: to focus on sustained improvement and achievement to focus attention within adult majors and paediatrics triage. Receive further onsite support from ECIST focusing on enhanced triage (moving to rapid assessment and treatment), improving and reviewing our Fit 2 Sit pathway explaining to staff the

criteria and expectations; producing a ‘status at a glance’ dashboard within the department. We have developed a trajectory for improvement for adult majors and paediatrics.

Objective 2: undertake 100 per cent of triage assessments by Emergency Severity Index (ESI) trained staff to ensure we have the right staff with the right expertise to carry out assessments of all patients presenting to our ED using the ESI tool.

What we have done:

- use a recognised triage model, and trained sufficient nurses staff to ensure that sufficient number of staff are on duty at any given time

We undertake weekly audits of our triage process, the results of which have offered assurance that the correct skill mix and training is available in the department. We have audited the triage categories. This identifies which nurse has been assigned to the patient and has identified s few occasions where the patient has been triaged in the wrong category.

Our next steps: to increase the number of ESI trained staff available, we have met with a healthcare partner to explore the possibility of seconding / offering bank shifts to suitably experienced ambulance staff to join our bank.

2.0 Sepsis and the Deteriorating Patient

The CQC highlighted the need for us to improve our processes in the recognition and treatment of patients who may have, or who are confirmed as, having sepsis.

What we have done:

- Implemented the National Early Warning Score (NEWS). This ensures patients have an appropriate level of assessment and identify where patients require immediate intervention and assists with going monitoring of potential deterioration of their condition.
- Retrained staff in ED in the screening and management of sepsis
- Implemented electronic observations (e-Obs) along with a comprehensive dashboard enabling real-time and retrospective monitoring of adherence to observations being undertaken.
- Introduced a dedicated sepsis trolley in the department to immediately treat for patients with sepsis
- We can demonstrate our compliance of Sepsis 6 – the nationally adopted tool for monitoring screening and treatment of patients with sepsis. This enables us to share good practice within the department and share areas of learning.

- We purchased additional equipment to support us in assessing and monitoring patients' conditions.

Our next steps: to introduce eSepsis to automate the process of identifying and monitoring patients at risk for sepsis. We are undertaking reciprocal visits to share learning with colleagues at a neighbouring trust to improve staff education and process in the screening and management of sepsis. We have appointed a patient safety lead who is supporting a safety culture survey in ED to identify areas that can be developed. We are also introducing assertiveness training to enable staff to escalate concerns in a constructive way.

3.0 Staffing

The CQC identified that we need to ensure that we have the right numbers of staff in place with the right skills.

What we have done:

- We have undertaken a comprehensive staffing review in line with professional standards and best practice guidance resulting in investment.
- We have reviewed and agreed the need to increase ED consultant cover by a further five.
- Provided additional clinical support worker staff to support the waiting area.
- Increased capacity for clinical leadership and oversight in ED.
- Agreed a job plan subject to appointment of additional consultants; improved 16 hour consultant cover. On an interim basis we have in place locum cover that gives us on the whole 16 hour cover. We do have in place 14 hour cover from our substantive doctors.

Our next steps:

A new cohort of qualified nurses commence in September 2018. We have a pastoral programme for these new starters to support retention, morale and team working. We aim as a result of these new starters to have agency expenditure significantly curtailed. A neighbouring trust is supporting us with an induction programme for new nursing starters and a training programme for all staff in ED.

4.0 Safeguarding

Our aim is to ensure that all children and adults are safeguarded. We identified a concern regarding the low number of children being referred to the Paediatric Liaison Nurse (PLN) from the Emergency Department and subsequently missed Multi Agency Referral forms (MARF).

What have we done:

- We introduced electronic referral forms (to PLN) to streamline the process for the ED team.
- We sample audit 10 children daily to ensure that the appropriate referrals have been made.
- We feedback to staff when a referral is missed at time of presentation.
- We ensure that the PLNs reviews all attendances to ED to ensure that all children are appropriately referred.
- We improved content and oversight of training.

What was the impact?

- Immediate improved oversight.
- We shared with staff evidence of when children should be referred and were not.
- Reviewed and strengthened safeguarding team with the appointment of a specialist head of safeguarding
- We have recruited a dedicated PLN working within the Dudley Group safeguarding team from mid sept 2018 reporting to our head of safeguarding to be based in ED.

Our next steps:

We are working with a neighbouring hospital to review and ensure we are adopting best practice. We are reviewing our PLN form. We are also in the process of creating an electronic safeguarding screening form which will prompt and assist all ED clinicians to consider if a safeguarding referral is needed.

5.0 Other support

We have utilised, and continue to use, a number of methods and external agencies to support us on our improvement journey.

5.1 ECIST (Emergency Care Improvement Support Team) who are part of NHS improvement have been in the hospital for a number of days over the last few months. They have helped us with and continue to help with:

- Enhanced triage (moving to rapid assessment and treatment model)
- Introduction of Fit 2 Sit pathway
- Production of a “Status at a Glance” dashboard within the department

- Specialty in-reach model to ED to support “pull” function for patient flow
- Review of acute medicine pathways.

5.2 Neighbouring hospital clinical process and pathway support: we have approached a local trust whose ED was recently rated Good by the CQC to assist us with service improvement in order that we can demonstrate our achievements:

- Specifically to share sepsis guidelines and quality improvement methodology.
- Share best practice between ED consultants.
- Develop a common set of competencies.
- Undertake exchange visits.
- ED bespoke induction for new nursing starters.
- Leadership programme for Band 7 nurses

5.3 Service Improvement Director: NHSE has allocated us three day a week support. This director assists us with our assurance and governance processes offering us a ‘critical friend’ approach.

6.0 Challenges going forward

Sustaining 16 hours of consultant cover until the additional five whole time permanent workforce is recruited to is dependent on us securing locum cover.

Recruiting to vacant posts both consultants and nursing staff may be problematic. All local EDs are recruiting to the same set of staff reputationally, therefore, Dudley Group maybe at a disadvantage as a result of recent publicity.

Improving on Emergency Access Standard (seeing 95 per cent of patients within ED within a four hour target) and sustaining performance.

Move towards a continuous service improvement culture, replicating good practice and learning from mistakes and near misses.

Winter: we are about to enter the busiest time of year when attendances and ambulance activity will rise, this will put pressure on the department in terms of capacity and our ability to cope with surges in demand.

Enclosure 5

The Dudley Group
NHS Foundation Trust

Paper for submission to the Board on (date)

TITLE:	**Emergency Department Quality Improvement Dashboard**		
AUTHOR:	**Bernie Bluhm**	**PRESENTER**	**Karen Kelly**
CLINICAL STRATEGIC AIMS			
	Strengthen hospital-based care to ensure high quality hospital services provided in the most effective and efficient way.		
CORPORATE OBJECTIVE: SO1 SO2 SO3			

SUMMARY OF KEY ISSUES:

On a weekly basis the Trust is submitting a series of written reports to the CQC in response to the Section 31 notices issued in response to concerns regarding safety within the Emergency Department.
The reports provide weekly assurance on the performance against agreed standards and progress with actions identified to deliver sustainable improvements.

The reports cover performance in Triage Times, Triage Audit, Sepsis Management, Staffing numbers and skill mix, Deteriorating Patient / E-Obs and Paediatric Safeguarding.

Each report provides clear measurable outcomes / KPI's and actions associated with delivery of the outcomes.

The Emergency Department Quality Dashboard has been developed to provide a high level overview of all of the actions providing an "at a glance" view of progress and current performance and comparison with the previous week's performance.

The Dashboard is enhanced by the inclusion of trend graphs from January where data is available. Where reporting from January not possible, trend graphs will be provided from date at which reliable data was first captured.

The trend lines will provide the Board with assurance on progress and identify areas for further scrutiny and or escalation.

IMPLICATIONS OF PAPER:

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

The Dudley Group
NHS Foundation Trust

ACTION REQUIRED OF BOARD

Decision	Approval	Discussion	Other
		X	

RECOMMENDATIONS FOR THE BOARD:

To accept the Dashboard in its current form and to note that this dashboard will be further progressed to include data plotted in SPC format.

Report		Objectives	Metric	Base Date	Base Value	Target	LW 9-15 Aug	TW 16-22 Aug	TW v LW
Triage Perfor-mance	1	Ambulance, Adult Majors and Paediatric attendances will be triaged within 15 minutes	Ambulance	Jul-18	94.6%	95.0%	99.4%	96.5%	↓
			Adult Majors	Jul-18	60.0%	95.0%	62.6%	88.6%	↑
			Paediatric	Jul-18	70.0%	95.0%	85.1%	85.7%	↑
	2	Patients streamed to Adult See and Treat are seen within 60 minutes	See & Treat	Jul-18	86.5%	100.0%	89.7%	97.8%	↑
	3	Triage assessments are undertaken by an ESI trained nurse	ESI trained	Jul-18	96.0%	100.0%	100.0%	100.0%	→
Triage Audit	1	For all patients that are triaged, the ESI tool is appropriately appplied	ESI applied			100.0%	99.5%	99.1%	↓
	2	Triage assessments are undertaken by an ESI trained nurse	ESI trained			100.0%	100.0%	100.0%	→
	3	Assurance of internal audit demonstrated by independent audit	Assurance			100.0%	100.0%	100.0%	→
Sepsis	2	To ensure that our eligible patients are screened for sepsis	Screened	Jun-18	81.7%	90.0%	81.9%	83.2%	↑
	3	To ensure that patients screened positive for sepsis receive antibiotics within 60 minutes	60 mins	Jan-18	65.1%	90.0%	83.3%	78.9%	↓
Staffing	1	Registered nurses on duty will be Dudley Group staff	Dudley staff	Jan-18	69.6%	75.0%	77.0%	83.9%	↑
	2	Registered nurses have the correct skill set to support them working in their allocated areas	Correct skill			100.0%	87.5%	92.9%	↑
	3	Provision of cover hours per day by a Consultant across 7 days	16 hr / day			100.0%	100.0%	100.0%	→
E-Obs	1	No harm to patients resulting from failure to recognise a deteriorating patient	No harm			100.0%	100.0%	100.0%	→
	2	No harm to patients resulting from failure to escalate and act on deteriorating observations	No harm			100.0%	100.0%	100.0%	→
	3	Eligible patients have a recorded set of observations within 15 minutes of triage (maximum 30 minutes after arrival)	30 mins	w/e 23/5	69.2%	95.0%	70.0%	80.3%	↑
	4	Eligible patients will have each a set of observations recorded at a minimum by the time required by their early warning score trigger (unless a clinical decision is made to increase or decrease the frequency for individual patients)	30 mins	w/e 23/5	48.5%	95.0%	44.0%	53.4%	↑
			60 mins	w/e 23/5	47.8%	95.0%	66.0%	69.2%	↑
			4 hours	w/e 23/5	92.6%	95.0%	98.0%	96.4%	↓
Safe-guarding	1	Demostrate adherence to principals of safeguarding children and young people in relation to PLN referral on presentation	On present.	Jan-18	48.0%	95.0%	88.0%	90.7%	↑
	2	Demostrate adherence to principals of safeguarding children and young people in relation to PLN referral	Referred			100.0%	100.0%	100.0%	→

Enclosure 6

The Dudley Group
NHS Foundation Trust

Paper for submission to the Board on 6 September 2018

TITLE:	**Report from the Urgent and Emergency Care Service Improvement Group**		
AUTHOR:	Jenni Ord – Chair	**PRESENTER**	Jenni Ord – Chair
CLINICAL STRATEGIC AIMS			
	Strengthen hospital-based care to ensure high quality hospital services provided in the most effective and efficient way.		

CORPORATE OBJECTIVES

SO 1 – Deliver a great patient experience
SO 2 – Safe and caring services
SO 3 – Drive Service Improvement, innovation and transformation
SO 4 – Be the place people choose to work
SO 6 – Deliver a viable future

SUMMARY OF KEY ISSUES:

The attached provides a summary of the activity of the urgent and emergency care service improvement group from the end of July through August 2018. The Group brings together senior staff from across the Trust who can support with service improvement.

The Group continues to challenge its members to be more outcomes focused and increase the pace with which action is taken in the week between the meetings. The Group continues to press the Executive on the development of an outcome focused dashboard.

IMPLICATIONS OF PAPER:			
RISK	**Y**		**Risk Description:** COR 501 – risk to the delivery of a safe and effective ED service
	Risk Register: Y		**Risk Score:** 20
COMPLIANCE and/or LEGAL REQUIREMENTS	**CQC**	**Y**	**Details: Primarily links to safe, but also links to well led. s31 registration requirements.**
	NHS I	**Y**	**Details: links to good governance**
	Other	**N**	**Details:**

ACTION REQUIRED OF BOARD

Decision	Approval	Discussion	Other
			Y

RECOMMENDATIONS FOR THE BOARD

To note the Group's challenge to members to be more outcomes focused and

increase the pace with which action is taken in the week between the meetings.

To note the Group continues to press the Executive on the development of an outcome focused dashboard.

The Dudley Group NHS Foundation Trust

Committee Highlights Summary to Board

Group	Meeting Dates	Chair	Quorate	
			yes	no
Urgent and Emergency Care Service Improvement Group	31 July 2018 7 August 2018 14 August 2018 21 August 2018 28 August 2018	J Ord	Yes	

Declarations of Interest Made

None

Activity of the Group

The Group further discussed its terms of reference and the focus of its agenda which needed to be elevated from transactional process matters to that of outcome delivery and actions to resolve any matters impeding the expected improvements.

Within each meeting the s31 registration assurance information was received and discussed. The Group tasked executives, operational management and clinicians with actions to secure improvement. The Group used the action tracker appended to each meetings minutes to follow through on the completion of these actions. The Group continues to challenge members to be more outcomes focused and increase the pace with which action is taken in the week between the meetings. There is a recognition that a themed plan demonstrating delivery of the expected standards would aid pace and shared ownership of acheivements.

The Group reflected that the revised format of the assurance information now containing a data sheet and covering narrative was an improvement. This now enables the Group to understand the assurances and the impact on actions taken and planned. The Group continued to press the Executive on the development of an outcome focused dashboard both for the Emergency Department and the Board. At the meeting on the 21 August the first “at a glance” summary was provided which was a reasonable start for the wider dashboard. The wider dashboard needs to be underpinned with SPC charts that reflect the deeper understanding of performance.

The Group recognised that more work is needed on sepsis and managing the deteriorating patient in respect of both the improvement data and narrative.

Decisions Made/Items Approved

To revise the Group’s terms of reference to reflect a focus on the Trust’s delivery of patient outcome improvements and to facilitate support for solutions to issues that could affect improvement.

Actions to come back to Group (items the Group is keeping an eye on)
The revised Terms of Reference once redrafted.
Items referred to the Board for decision or action
To note the Group's challenge to members to be more outcomes focused and increase the pace with which action is taken in the week between the meetings. To note the Group continues to press the Executive on the development of an outcome focused dashboard.

Enclosure 7

The Dudley Group
NHS Foundation Trust

Paper for submission to the Board on 6 September 2018

TITLE:	**24 July 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.

There were no specific matters the Committee required to Board to take a decision on.

The Committee draws the Boards attention to the breath of discussion and oversight of clinical quality and safety risks undertaken at this meeting and that the Committee will receive quarterly information on the quality risks within the Trust's cost improvement schemes which will enhance the support the Committee provides to the Board on the review of corporate risks facing the Trust.

The Dudley Group NHS Foundation Trust

Committee Highlights Summary to Board

Committee	Meeting Date	Chair	Quorate	
Clinical Quality, Safety and Patient Experience Committee	24 July 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 two matters that were already on the list of items to come back to the Committee. These two items were the trajectory for investigating all outstanding pressure ulcer Serious Incidents by the end of September and the transfer process from the UCC to ED.
- 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 VTE over the last two months, and areas where further improvement is needed linked to both of the Trust quality priorities including nutrition. The report provided information on the outcomes of internal quality and safety reviews and highlighted that the two domains of safe and well led remain those requiring the most improvement. The issue of regular checks at a ward level on the environment and "trolley checks" are still being flagged as areas requiring attention.
- 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 now being at 68% against the annual target of 90% with a plan to achieve this by the end of the year. The Committee was updated as to the most recent visit by NHS Improvement last week which rated the Trust as "green".
- The Committee received a report in respect of the histopathology service and the work being undertaken in respect of the planned case reviews. The Committee asked that they be updated as to progress with these.
- 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 and the appointment of new consultants 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 was marginally ahead of its revised trajectory this month. The Divisional Director confirmed to the Committee that the revised process in respect of paediatric appointments had been endorsed by the patient group. The Division also provided the Committee a forecast trajectory regarding their review of Standing Operating Procedures and Guidelines which showed a significant amount of effort being applied to their review in the months of August and September.

- The Medicine & Integrated Care Division provided an update to the Committee and drew attention to the challenges within dermatology over the coming month due to sickness and planned leave. The Committee were informed that the specialty had brought clinic appointments forward to ensure that the waiting times are managed during this period and the wait times were lower this time this year when compared to the same time last year.
- The Clinical Support Services Division provided an update to the Committee and discussed the MRI replacement programme which has commenced.
- 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's attention was drawn to the actions at risk in relation to the undertaking of mandatory training within Children and Young People's services for medics and the role the new clinical director is playing in securing this action be complete by the end of August. Within Maternity the Committee's attention was again drawn to the need for the service to secure the medical staff compliance with mandatory training in one area following a review of peoples training records and as the need for the service to continue to review guidelines to ensure they remain up to date. The Committee received information in respect of the Emergency Department action plan which had been extended following the latest visit in June. The Committee asked that they receive a more detailed report from the Deteriorating Patient Group on actions to address sepsis management given the outcome of the sepsis CQUIN audits showed a reduction below the level of 100% in the previous month.
- 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 an increase in the reported incidents in the month of June 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 support the divisions to close investigations in a timely manner but the Committee was told that the central team was stretched to provide the level of support the divisions needed. 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 for this action plan a revised date had not been provided by the clinical director for urgent and emergency care.

- The Committee received a Mortality Sepsis Assurance report from the Medical Director. The report included the analysis undertaken by AQUa and the tracking of actions taken in respect of the Deteriorating Patient Strategy and that the positive outcome of the delivery of these actions reducing the Trust Sepsis mortality rate.
- The Committee received a report on progress for quarter 1 on the 2018/19 quality priorities which showed detailed the progress made and improvements from the final quarter of the previous year. The report also provided an update on the action plan developed as a result of the external audit recommendations made following their audit of the 2017/18 quality report. The Committee agreed to receive a further update on these actions at its September 2018 meeting.
- The Committee received a report in respect of compliance with the CQC guidance for the role of trusted assessor for hospital discharges. The Committee discussed the work undertaken by the Trust to provide to the care homes written expectations for both the Trust and the care homes in respect of discharges.
- The Committee received the monthly report on patient experience information for June 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 showed a significant reduction in June in the number of compliments the Trust received, the Committee was informed it was not possible yet to determine what had caused that reduction. The report continued to detail information on the changes and lessons learnt as result of a sample of complaints responded to in the month.
- 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 were informed that whilst the cleaning scores had improved there was still some local concerns over the competency of the cleaning staff which was being picked up with the provider who had brought in a cleaning expert to support their staff to recognise and deliver sound cleaning practice. The Committee discussed the process for instrument decontamination and was informed that sound processes are applied to all instruments and instruments are subject to a planned replacement programme.
- The Committee received a report on the Trust's Quality Impact Assessments undertaken across the 2018/19 CIP schemes, the process for reviewing the quality risks as projects progress and the application of a quality risk rating to each scheme. The Committee agreed that future quarterly reports should focus on changes to the quality risks within the schemes as they are delivered, with more detail on those schemes rated as carrying the highest risk.
- The Committee received reports from a number of its reporting Groups. The Internal Safeguarding Board report had no matters to refer to the Committee. The Quality and Safety Group referred to the Committee the need for improved engagement from the divisional medical staff and the divisions agreed to support this happening. The Medicines Management Group updated the Committee on

the actions being taken by the Trust in respect of antibiotic use but due to a combination of factors, including the change of antibiotics, meaning that antibiotics were administered individually, the total number of doses has increased even though the level of antibiotics used has reduced. The implication is that the specific defined target for the reduction in daily doses for 2018/19 would not be met.

- The Committee received an update on the Trust position with respect to Policies, Guidelines and Standard Operating Procedures under review. There are 6 Policies 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 48 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 corporate risk register. The Committee agreed that the risk for the MRI replacement programme should continue to be managed locally within the Support Services risk register.

Decisions Made/Items Approved

- The Committee endorsed the closure of 18 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 action plans.
- The Committee endorsed the policy group recommendation to approve changes to 8 of the Trust's policies.

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

The trajectory to eliminate the pressure ulcer serious incident investigation backlog by September 2018 be brought to the Committee for oversight.

The process for UCC and ED referrals and oversight of the pathway compliance be brought to the next meeting for information.

The update on actions taken in respect of the action plan following the external audit of the 2017/18 quality report at its meeting in September 2018.

The outcome of the case reviews in respect of histopathology be brought to the next meeting.

The report from the Deteriorating Patient Group on the actions to address sepsis management be brought to the next meeting.

Items referred to the Board for decision or action

There were no specific matters the Committee required to Board to take a decision on.

The Dudley Group
NHS Foundation Trust

The Committee draws the Boards attention to the breath of discussion and oversight of clinical quality and safety risks undertaken at this meeting and that the Committee will receive quarterly information on the quality risks within the Trust's cost improvement schemes which will enhance the support the Committee provides to the Board on the review of corporate risks facing the Trust.

Enclosure 8

The Dudley Group
NHS Foundation Trust

Paper for submission to the Board on 6 September 2018

TITLE:	**28 August 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
That the Board note the Committee review of the BAF risks BAF 501, BAF 577 and BAF 694 and that these risks have been referred back to the Executive to review their scores.

The Dudley Group NHS Foundation Trust

Committee Highlights Summary to Board

Committee	Meeting Date	Chair	Quorate	
Clinical Quality, Safety and Patient Experience Committee	28 August 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 not referred any matters to the Committee this month.
- The Committee received a summary report of key quality metrics along with the Trust Integrated Performance Report. The report highlighted that for 3 quality dashboard metrics were there remained concerns regarding failure to achieve the targets, namely MUST scoring, Medication and Nutrition. The report also identified that staff vacancies are a driver for a number of the challenges faced across the Trust. The Committee was updated on the actions being taken in respect of both recruitment and retention and the oversight of these actions being provided by the Workforce and Engagement Committee. The report also provided the Committee with an overview of the internal quality and safety review outcomes.
- 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 which has increased to 73.5% against the annual target of 90% with a plan to achieve this by the end of the year. The report also recorded an improved MRSA screening for elective patients of 98% and for non elective patients of 94%. The report also detailed that all actions arising from the NHS I inspections with the exception of training which is in progress, fare complete.
- The Committee received a report in respect of the histopathology service and the outcome of the planned case reviews and the actions being taken. An update on the cervical screening QA Team visit action in respect of independent case review was provided to the Committee.
- The Committee received the Maternity Performance Dashboard, this highlighted good performance within breastfeeding initiation rates, improved booking for women and an an increase in emergency caesarean section rates.

- The Committee received the maternity service improvement plan and discussed the progress made.
- 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 recognising that the Division is behind on seeing new patients. The Division provided an update on the work being undertaken in respect of paediatric outpatient waiting lists. The Division is marginally ahead of its revised trajectory for the month of July.
- The Clinical Support Services Division provided an update to the Committee and discussed the challenges with respect to the level of imaging reporting backlog.
- The Committee received a summary report on the progress against the agreed action plans following the CQC service inspections of Critical Care, Children and Young People, Maternity and Community Services. The report provided information on those actions which had exceeded their original implementation dates with mitigation actions to address the slippage.
- The Committee received an update on the revised ED service improvement plan, which is being reformatted around the key s31 areas along with the developing ED summary at a glance dashboard. The Committee agreed that further work was needed in respect of the sepsis pathway actions to better articulate the improvement actions. The Committee requested that the action plan be clearer on the dates the actions should be completed by.
- The Committee received the quarter 1 clinical audit report. The report highlighted that the current year programme had a significant element of work still to be commenced but that each Division had confidence that this would be delivered by the end of the year. The report highlighted the learning and changes made as a result of the reported audits.
- The Committee received the update requested at an earlier meeting in relation to Tissue Viability and progress made in respect of improving pressure area care across the Trust. The Committee was informed that the Trust will not have dealt with all older pressure ulcer incident investigations by the end of September which had been the request of Risk and Assurance in July.
- The Committee received a report on incident management. The report provided assurance on the Serious Incident process being applied and included information on the Trust position in respect of wider incidents. The Trust had seen a slight decrease in the reported incidents in the month of July and a higher number of SIs reported in July compared to the previous month. The Committee was updated on the actions being taken to support the divisions to close investigations in a timely manner but the Committee was told that the central team was stretched to provide the level of support the divisions needed. The Committee noted that there were this month 5 investigations where there action plans had not been closed in line with the initial implementation dates, one of which was outstanding last month.
- The Committee received the monthly report on patient experience information for July 2018. The report provided an update on compliments, friends and family feedback, concerns and complaints activity. The report updated the Committee on the CQC's national survey programme and the 2017 national cancer patient

experience survey. The report also updated the Committee on the number of open complaints and the actions being taken to improve the Trust response in respect of the target of 40 days. The report detailed information on the changes and lessons learnt as result of a sample of complaints responded to in the month

- 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 deterioration in cleaning audit scores and the actions being taken by the Trust and the cleaning service provider.
- The Committee received a report on Safeguarding, this included an update on the safeguarding improvement plan which incorporates the actions from the CQC inspection report. The Committee discussed the need for the divisions to accelerate their compliance with the safeguarding training and set the divisions a target to be 90% complaint by the next Committee meeting at the end of September.
- The Committee received an update on the Trust position with respect to Policies, Guidelines and Standard Operating Procedures under review. There are 3 Policies that will exceed the review dates of 31 August. Subject to final oversight director sign off these will go to the September policy group meeting. The Committee noted that there are a further 46 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 that they do track these and are working to ensure they are reviewed timely.
- The Committee received a verbal update from the Trust Clinical Safety Officer in respect of the developing e-Sepsis package.
- The Committee reviewed the Board Assurance Framework for those risks it has oversight of along with the Trust Corporate Risk Register. The Committee considered the request from the Audit Committee to seek greater assurance that the risks BAF 501 and BAF 577 and BAF 694 were correctly scored. The Committee asked that the risk scores for BAF 577 (CQC action plan delivery), BAF 694 (reputation) and BAF 564 (deteriorating patient) be reconsidered as the Committee felt the scores are too low.

Decisions Made/Items Approved

- The Committee endorsed the closure of 7 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 action plans.
- The Committee endorsed the policy group recommendation to approve changes to 1 of the Trust's policies.

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

Sepsis improvement actions to be more detailed within the ED service improvement plan. That a report on all screening programmes undertaken in the Trust be brought back to the next meeting. Adjustments to the BAF risks are brought back to this committee in the BAF report at the next meeting.
Items referred to the Board for decision or action
That the Board note the Committee review of the BAF risks BAF 501, BAF 577 and BAF 694 and that these risks have been referred back to the Executive to review their scores.

Enclosure 9

Paper for submission to the Board on (06 September 2018)

TITLE:	**THE DUDLEY GROUP NHS FOUNDATION TRUST CHIEF NURSE REPORT SEPTEMBER 2018**		
AUTHOR:	**Siobhan Jordan, Chief Nurse**	**PRESENTER**	**Siobhan Jordan Chief Nurse**

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:

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:

This paper details the roles and responsibilities of the chief nurse and the corporate nursing teams.

The report describes the activity which supports the trust to achieve both the Corporate Objectives and Quality Improvement Priorities and to consistently deliver safe, effective, caring and responsive care.

The paper also refers to the development and roll out of the quality dashboards and the variety of tools that are in place to oversee quality care such as the NHS safety thermometer.

It references the extensive staffing reviews which have taken place over the last year using a validated tool, as well as the developments within practise development to support divisions to recruit to the safe staffing levels as agreed by the Board.

The report details the successful outputs from the patient experience team as well as the significant challenges overcome by the safeguarding team. Both leads must ensure that the trust works within the regulatory framework and practise is in line with legislation.

In conclusion there are a variety of metrics and forums that over see the work of the chief nurse and her team and this detailed report attempts to illustrate this work to the board.

IMPLICATIONS OF PAPER:

RISK	**Y**	**Risk Description:** As detailed within the BAF under the chief nurse
	Risk Register: Y	**Risk Score:** As detailed within the BAF

COMPLIANCE and/or LEGAL REQUIREMENTS	**CQC**	**Y**	**Details: CQC report December 2017** **Section 31 January 2018** **Section 31 February 2018** **Section 31 June 2018**
	NHSI	**Y**	**Details** ➢ Falls Collaborative ➢ Pressure Ulcer Collaborative ➢ Infection Control Oversight ➢ ED Transformation Support
	Other	**Y**	**Details:** Coroners regulation 28 of which there are two in 2018 relating to Medicine and Emergency Care

ACTION REQUIRED OF BOARD

Decision	Approval	Discussion	Other
		X	

RECOMMENDATIONS FOR THE BOARD:

Receive this report as requested by the Board and note content.

THE DUDLEY GROUP NHS FOUNDATION TRUST
CHIEF NURSE REPORT SEPTEMBER 2018

INTRODUCTION

The chief nurse has professional responsibility for nurses, midwives and allied health professionals (AHPs) within the Trust however, does not operationally manage the majority of these staff.

The oversight and management of staff within the Trust is within the divisional management structure, which reports to the chief operating officer (COO) via the divisional directors.

There is a triumvirate arrangement where the division is led by a director of operations, chief of medicine and chief of surgery and an associate chief nurse. Within the division there is a medical structure comprising of the chief doctor, clinical directors and clinical service leads. The nursing reporting structure is lead nurses based locally who report to the matrons who in turn report to the associate chief nurse.

The chief nurse's team is comprised of senior nurses and specialists' teams who have corporate responsibilities across the Trust and this report will detail activity within each of these areas.

The Corporate team have responsibility for achieving the Trust quality priorities and formulating the Annual Quality Report.

Each year a number of quality priorities are chosen and targets are set. These priorities link directly with the Trusts vision of providing safe caring and effective services because people matter.

These are supported by our strategic objectives to:

- Deliver a great patient experience.
- Deliver safe and caring services.
- Drive improvement, innovation and transformation.
- Be the place that people choose to work.
- Make the best of what we have.
- Deliver a viable future.

The present quality priority topics are:

- Patient Experience
- Pressure Ulcers
- Infection Control
- Nutrition and Hydration
- Medications
- Discharge management (new 2018/19)
- Incident management (new 2018/19)

Specific measurable targets are chosen for each of the above topics and these are monitored throughout the year and the Board is provided with quarterly updates.

The end of year position with regards to the targets together with a wide-ranging review of other quality issues such as clinical audit, research and development, patient experience, complaints, concerns and compliments are brought together into the Annual Quality Report.

The Trust improved on all the quality priorities at the end of 2017/18 however did not fully achieve all of them. Two further Quality Priorities for 2018/19 were added; discharge management and incident management.

The position at the end of Q1 for Quality Priorities is as follows:

Patient Experience

a) Achieve monthly percentage recommended scores in Friends and Family Test (FFT) for all areas (inpatients, outpatients, maternity, Emergency Department and community) that are equal to or better than the national average

b) Achieve monthly response rates in Friends and Family Test (FFT) for all areas (inpatients, outpatients, maternity, Emergency Department and community) that are equal to or better than the national average.

c) Improve the overall year score from 2017/18 to 2018/19 for the following question used in our local real-time survey: Were you involved as much as you wanted to be in decisions about your care?

The patient experience team is supporting this priority by:

- Ensure that all areas have a champion for FFT.
- Ensure that all areas where participation is low have action plans in place.
- Roll out Friends and Family Trust survey using SMS to the whole of the Trust.
- Holding 'Feedback Fridays' every week to encourage responses to the Friends and Family Test (FFT).

April-June 2018 data for percentage recommended FFT scores

Percentage recommended FFT Scores	Apr 18	May 18**	Jun 18
Inpatient	**95**	**93.7**	**94.4**
National	96	96	96
A & E	**82**	**77.8**	**77.1**
National	87	87	87
Maternity Antenatal	**98**	**97.5**	**100**
National	97	95	96
Maternity Birth	**99**	**97.8**	**96.5**
National	97	97	97
Maternity Postnatal Ward	**98**	**95.6**	**96.5**
National	95	95	95
Maternity Postnatal Community	**98**	**100**	**100**
National	*	98	98
Community	**96**	**95.3**	**96.7**
National	96	95	95
Outpatients	**90**	**89.4**	**90.5**
National	94	94	94

**National data currently not available

April-June 2018 data for FFT response rates

Percentage response rate	Apr 18	May 18	Jun 18
Inpatient	**32.3**	**33**	**42.4**
National	24.9	25.6	25.2
A &E	**17.9**	**18**	**19.1**
National	12.9	12.4	13.0
Maternity Antenatal	**20.4**	**91.4**	**70.2**
National	**	**	**
Maternity Birth	**40**	**38**	**33.6**
National *	23.2	22	21
Maternity Postnatal Ward	**39.8**	**37.5**	**34.0**
National	**	**	**
Maternity Postnatal Community	**1.3**	**15.3**	**19.5**
National	**	**	**
Community	**2.9**	**3**	**4.2**
National *	3.3	4.0	3.7
Outpatients*	**5.7**	**5.7**	**3.4**

National *	4.9	7.0	6.8

*denotes areas where no national response rate data is published. This has been calculated internally using 12 months of NHS England raw data from February 2017 to January 2018. ** No national raw data available.

Pressure Ulcers

This priority is being supported by the Tissue Viability Team, working closely with staff has resulted in notable improvement in 2017/18 and in Quarter 1 (Q1). With no Stage 4 avoidable ulcers in either the hospital or community since January 2018 and Stage 3 avoidable ulcers in the community have reduced considerably. The Tissue Viability Team is supporting this quality priority by:

- Developing a robust education and training programs for staff.
- Delivering three educational study days to address key priority topics, pressure ulceration, lower limb ulceration and complex wound management.
- Working collaboratively with the Patient Safety Team to develop robust reporting processes to ensure data collected is accurate.
- Developing and implementing the Andersen 'Risk Assessment' Tool for the Emergency Department to ensure it is specific to the clinical area for patient assessment.
- Delivering the 'React to Risk' and '50-day pressure ulcer challenge' with an aim to reduce the incidence of avoidable stage 2, 3 and 4 pressure ulceration.
- Progressing with work on Skin Bundles following work with NHSI Pressure ulcer collaborative.

Service/Setting	**Hospital**		**Community**	
Period	2017/18*	Apr-June 18+	2017/18*	Apr-June 18+
No. of Stage 3	12	4	25	3
No. of Stage 4	3	0	11	0
Total	**15**	**4**	**36**	**3**

+ The figures for Q1 may change dependent on the outcome of the remaining RCA investigations which are awaiting review as to whether they are avoidable or unavoidable. * The figures for 2017/18 are different to those published in the annual report as further decisions on the avoidability of ulcers occurring at the very end of the financial year have been made since the publication of the report

Infection Control

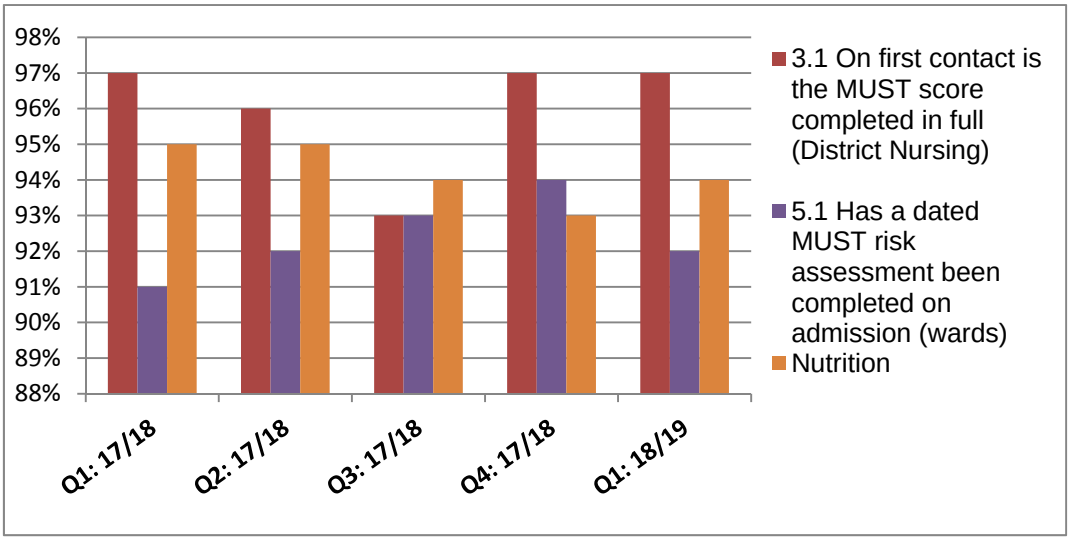
This priority is being supported by the Infection Control Team:

- Trust wide mattress audit in conjunction with Tissue Viability.
- Participate in National Infection Prevention and Control week.
- Participate in WHO campaign – Clean Your Hands Campaign.
- Review process for Gram negative surveillance.
- Review Antimicrobial prescribing and referrals from wards.
- Recruitment of Governors as 'infection control secret shoppers'.
- Review MRSA Screening Policies and data collection.
- Implement the revised mandatory training programme for Infection Prevention and Control, from three yearly to annually.
- Adopt the catheter 'passport' to improve catheter care across the health economy.
- MRSA: There have been no Trust assigned MRSA bacteraemia in this period (no Trust assigned cases since September 2015). The target is therefore being achieved **C. difficile**: There have been 7 cases of Clostridium difficile that have been identified as Trust apportioned in accordance with the Public Health England definition as of 30th June 2018. 3 cases have been identified as having lapses in care and therefore count against the Trust threshold of 28 cases. 1 case has been identified as having no lapses in care. The remaining 3 cases remain under review. The yearly target of 28 with lapses in care (i.e. 7-8 a quarter) is therefore being achieved so far this year.

Nutrition and Hydration

This priority is being supported by the following actions from the corporate team:

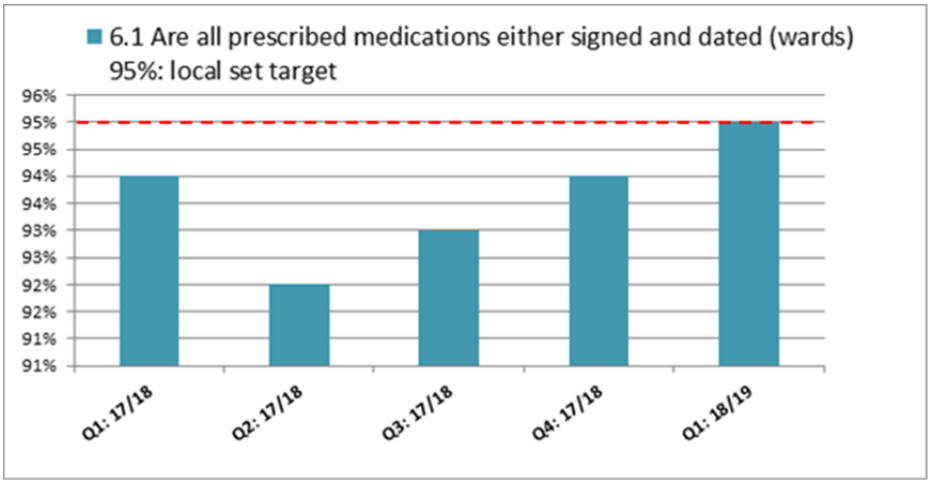
- Continue nutritional collaborative work by implementation of a more systematic approach to protected mealtimes.
- Revise protected meal time policy.
- Ensure Nutrition Group meets monthly.
- When new Electronic Patient Record is implemented MUST assessment will be mandatory.
- Review the menus available in the Trust.
- Review food supplier.
- Implement a screen saver which will stress the importance of good nutrition.
- Organise a structured training programme on MUST for all staff across the Trust.
- Escalation of the responsibility to ensure that Registered Nurses carry out MUST assessments.



Medications

This priority is being supported by the following actions from the corporate team working in collaboration with divisions & colleagues from Pharmacy:

- Collaborative work to be undertaken with the West Midland Medicines Safety Officer Group to benchmark Trusts with omitted doses. Regular audit and action plans for the region will also commence.
- Electronic EPMA system to be launched in June 2018 which will alert nursing staff to doses due, reducing the risk of omitted doses. Following implementation monitoring and audit of omitted doses will become easier.
- Red wrist band policy rewritten and agreed.
- Red wrist band policy launched Trust wide via the intranet; weekly audits commenced initially, to ensure compliance and then will revert to monthly audits once embedded to be completed by Lead nurses.
- Datix trends to be reviewed by Safer Medicines Group (SMP).



The two new Quality Priorities for 2018/19:

- Discharge management – is overseen by Karen Kelly as Chief Operating Officer (COO).
- Incident management – is overseen by Glen Palethorpe, Director of Governance.

This paper goes onto detail the teams who sit within the corporate nursing structure, reporting into the chief nurse to support the professional leadership of nurses, midwives and AHP's.

Safeguarding Adults and Children

The safeguarding team aims to ensure that all children, young people and vulnerable adults are effectively protected when using services provided by the Trust and that processes are robust for the early detection and referral processes. Working Together (2018) and The Care Act (2014) highlights that staff working within the Trust must:

- Understand risk factors and recognise children, young people and adults in need of care and support and/or safeguarding;
- Recognise the needs of parents who may need extra help in bringing up their children and know where to refer for help;
- Recognise the risks of abuse or neglect to an unborn child;
- Communicate effectively with children and young people and stay focused on the child's safety and welfare; and,
- Liaise closely with other agencies including other health professionals and share information as appropriate.

The Safeguarding Team:

- Provide advice, support and guidance to members of staff regarding safeguarding matters.
- Ensures relevant policies and procedures are in place to support all staff.
- Provide and facilitate supervision processes to staff to support areas of challenging work ensuring the focus of work remains on the safety and wellbeing of the child, young person and adult.
- Provide training and education for all staff to support them with their safeguarding work.
- Support staff in the production of statements to court or attendance at court for matters relating to safeguarding children and safeguarding adults.
- Undertake a programme of audit to provide assurance.
- Work closely with key stakeholders and other agencies to safeguard children, young people and vulnerable adults.
- The team offer support on all safeguarding concerns which may also include domestic abuse, female genital mutilation (FGM), child sexual exploitation (CSE), modern slavery/trafficking, financial abuse, fabricated or induced illness.

National/Local Review Processes

The safeguarding team are responsible for completing domestic homicide reviews, serious case reviews and safeguarding adult reviews.

Training

Currently the team provide Safeguarding Adults and Children level 1 and 2 as part of the Trust mandatory training programme. A Safeguarding Children's level 3 is also provided for staff who require this. The team also oversee the Prevent and WRAP training.

There has recently been a programme of Domestic Abuse Training delivered in the Trust and multi-agency by the CCG. Staff are also encouraged to access other multiagency training sessions in relation to safeguarding provided by the local Safeguarding Boards.

The Royal College of Nursing have produced an Adult Safeguarding Roles and Competencies for Health Care Staff - Intercollegiate document. This was only published in August 2018 and is still to be embedded into safeguarding adults training.

Although topics such as domestic abuse, FGM, CSE, modern slavery/trafficking, financial abuse, fabricated or induced illness are included in mandatory training it is recognised that more stand-alone training is required for staff.

Supervision

It is a requirement of the safeguarding team to provide safeguarding supervision to staff where children are considered to be at risk of significant harm or there are concerns regarding their welfare. Effective supervision is critical in ensuring that there is a clear focus on the child's welfare.

Supervision is provided on an individual, group or ad hoc basis. Whilst safeguarding supervision is not a requirement for professionals concerned about an adult's welfare it is provided by the Team.

MCA

Mental Capacity Act (Including DoLS) 2005 The Mental Capacity Act 2005, covering England and Wales, provides a statutory framework for people who lack capacity to make decisions for themselves, or who have capacity and want to make preparations for a time when they may lack capacity in the future.
The safeguarding team offers advice and support in regard to patients who may lack capacity or require some support to make decisions where there are safeguarding concerns.

Learning Disability

NHS England continues regional roll out of a Learning Disabilities Mortality Review (LeDeR) Programme. NHS England is committed to ensuring that people with learning disabilities receive the right care in the right settings, with the right support. This is one of their national priorities. Currently there is lack of reviewers in the Trust. The Learning Disability Liaison Nurse is the only active reviewer in Trust.

The Trust has a dedicated Learning Disability Strategy which is due for review in 2018.

Audit

There is a safeguarding audit plan to ensure alignment to the safeguarding priority and quality assurance practice. The safeguarding team are required to collate evidence for Dudley Safeguarding Boards.

The head of safeguarding has devised an Improvement Plan which addresses some key issues in relation to governance, staffing and safeguarding team processes, training and audit.

Infection Prevention and Control

The infection prevention and control team (IPCT) provides specialist advice, support and guidance for clinical teams to imbed infection control policies into clinical practice, working towards reducing hospital acquired infections, maintain a safe and clean environment for patients, visitors and staff, ensuring compliance with statutory and regulatory requirements. Moreover, ensures that infection control policies are reviewed regularly and updated based on national and local guidance to promote evidence-based practice.

Following the NHSI visit on the 18 July 2018 which focused on infection control practices within the Trust, the Trust received a green RAG rating which is a massive improvement compared to the red RAG rating received following an earlier visit this year.

As part of the healthcare associated infection partnership group a catheter passport has been developed via the local health economy. The objective of the passport is to ensure standardisation of documentation, to reduce the number of urinary tract infections across the health economy and reduce the number of E.coli bacteraemia. This also serves as a communication aid between the multidisciplinary teams involved in the patients care. The passport has now been completed and will be launched in partnership with the health economy during the months of August and September 2018.

There is a mandatory requirement to undertake surgical site surveillance of an orthopaedic category for a period of three months each year. The IPCT have undertaken surveillance of 2 categories: total hip replacements and total knee replacements. The surveillance period between January to March 2018 has now been reconciled with no surgical site infections identified for the period. A report will be available from Public Health England when all data from participating trusts has been analysed. The data for the surveillance period for April to June 2018 is currently being submitted. The National Surveillance Scheme enables hospitals to then aggregate the date and benchmark Trusts in order to improve patient outcomes.

The infection prevention & control team is trialling a “secret shopper program” through the volunteer service for the next month. The volunteer involved visits areas and observes certain aspects, e.g. clean and tidy environment, filled gel dispensers, appropriate PPE usage and hand hygiene. This will be reviewed in a months’ time and adjusted as necessary before rolling it out to other secret shoppers.

Mandatory Training Compliance Trust Figures

This data is based upon an annual cycle introduced in 2018/19 from a three yearly cycle, with a target of 90% by April 2019.

Area	Total
Corporate/Management	64%
Medicine and Integrated Care	69%
Surgery	66%
Clinical Support	72%

W.H.O International Hand Hygiene Day took place on 4 May 2018. The IPCT promoted good hand hygiene and provided education to staff, patients and visitors through display boards, posters and by attending clinical areas. Good practice was demonstrated by clinical teams by achieving 100% compliance in April, 99% in May and 100% in June and July 2018. Good practice was also noted by the team when carrying out Infection control audits within the clinical areas. The National Infection Control Week will be held between the 14 and 20 October 2018. The focus will be on the promotion of catheter passports and the recognition and the management of patients colonised or infected with multidrug resistant organisms. The Infection control team recently developed a policy for the screening and the management of multidrug resistant organisms such as Carbapenemase Resistant Enterobacteriacea (CPE) which is now available from the Hub and will be implemented in clinical practice.

The IPCT designed and implemented a robust auditing program which assessed clinical practice, environmental and equipment cleaning and estates issues. All clinical and outpatient areas were successfully audited during the first quarter of the current financial year. Assurance through a completed

action plan was received from the clinical teams after the highlighted actions were completed or in progress. This is necessary to ensure a safe environment to the patients, visitors and staff and to ensure that staff work towards reducing hospital acquired infections. The audit program is currently being reviewed to ensure as part of a Plan-Do-Study-Act cycle to ensure that it is effective Once reviewed follow up audits will be completed initially for the areas which achieved lower scores but aiming to complete all areas again by the end of the year.

The infection control team carries out surveillance on specific organisms such as Clostridium difficile (C. diff), Methicillin Resistant Staphylococcus aureus (MRSA), Methicillin Sensitive Staphylococcus aureus (MSSA), and Escherichia coli (E. coli), in line with the recommendations of Public Health England.

Allied Health Professionals

The Trust has a lead AHP who reports into the corporate nursing structure. Detailed below are some of the initiatives in 2018:

- AHP Council: The Council continues to meet on a six weekly basis, focusing on initiatives to raise the profile of AHPs within the Trust. All AHP Council activity is available to view on the AHP page on the Hub and any queries for the AHP Council may be sent to the dedicated email address (dgft.ahpcouncildudley@nhs.net).

- The AHP Council is responsible for the recently launched AHP newsletter and promotion of the AHP workforce across the Trust. The group actively seek opportunities to be involved in Trust initiatives e.g. the Easter Bunny Boat Race and the NHS 70 celebration.

- AHP Extended Roles Group**:** This group meets bi-monthly with a focus on exploring the potential and scope of AHP extended roles to improve the patient journey and patient experience.

- AHP strategy is in draft and currently out for comments.

- AHP Leads**:** Team leads and managers of Trust AHP services have a professional key role in shaping the Trust's provision of AHP care. This group meet on a monthly basis with a primary aim of leading and monitoring the standards and provision of care provided by AHPs. This group will be key in delivering the AHP strategy over the next three years.

Key Area for Development

- Development of AHP quality metrics: This is an area that requires progressing so that the Trust has a clear overview of quality performance against agreed key performance indicators.

Professional Development

The Professional Development team provide education and support to both registered and non-registered clinical staff; as well as specialist advice in their specialist areas. The team consists of the following specialists:

- **Clinical Support Staff**- This team have been instrumental in the introduction of the Nursing Associate role to the Trust since January 2017. There are currently 2 cohorts of trainee nurse associates (TNA's) continue within the Trust, 16 TNA's within the Trust. Fifteen additional TNAs have been recruited into the September cohort at Wolverhampton University and now are all placed in areas through the Trust. A Professional Development Nurse for TNA –band 6 is being recruited, to provide additional support in the clinical areas for both the TNAs and their mentors. In addition the team delivers diploma level two and three to unregistered clinical staff ensuring that there is a clear development pathway for this group of nursing staff.

- **Manual Handling Lead** - Provides training and advises on all manual handling issues, developing policies and guidelines to support all aspects of manual handling practise.

- **Medical Devices Lead** - Provides support and training on all medical devices used within the Trust supported by guidelines and policies developed by the Medical Devices Lead. Device specific training is undertaken three times per week with two-day courses delivered monthly to all new starters.

- **Nurse Recruitment and Retention Lead** – This role is a new post that came into effect in 2017 and has been recruited to substantively. Coordination of nurse recruitment and retention activity is a key responsibility of the chief nurse and since this role was developed we have recruited over 100 registered nurses via monthly recruitment events; with additional support and activity focused on areas with high vacancy levels within the divisions.

- **Post Registration Team** - The team provides training and support to all registered nursing staff. Consisting of the graduate development programme, which run biannually and comprises of face to face teaching with detailed competency completion and monthly clinical supervision sessions. Bespoke versions of this programme run as required to accommodate additional recruitment activity. In addition, this team provides a senior band five and band six development programmes, which is academically accredited at both degree and masters level with the University of Wolverhampton. Both of these programmes run twice a year.

- **Pre-Registration** - The pre-registration team supports all nursing and allied health care students placed within the trust and provide preparation of mentoring staff and ongoing development for students preparing them for substantive registered roles within the organisation. Each month there are approximately 130 nursing students being supported within the Trust by mentors that have been trained by the team. There are currently 458 mentors who receive annual updates from the Pre-Registration team on their roles and responsibilities and relevant Nursing and Midwifery Council (NMC) regulatory updates.

- **Non-Medical Prescribing** - This is also provided by the Pre-Registration Team in collaboration with pharmacy providing Trust authorisation for newly qualified prescribers and ongoing support and development.

- **Resuscitation and Sepsis** - This team provides in excess of 500 training spaces per month covering basic and advanced life support, RADAR (Recognise Acute Deterioration, Assess and Refer) and sepsis training and have focused of training around the recognition of the deteriorating patient and maintaining patient safety. In addition to training, the resus and sepsis teams are required by the Resuscitation Council to respond to and participate in cardiac arrest management and participate in the collection of data and audit of cardiac arrest. It is recommended that this data should be collected as part of the National Cardiac Arrest Audit (NCAA)

The Professional Development team collectively provide training to operational staff within the divisions to ensure that they are competent and confident to deliver safe, effective and compassionate care to patients.

The Non-Medical Education and Training (NMET) lead reports to the deputy chief nurse and oversees all of the professional development team and provides oversight on the development of registered staff within the organisation. In addition, the NMET lead also manages the distribution and appropriate utilisation of the Learning Beyond Registration (LBR) training budget (approximately £84,000 for 2018/19) ensuring the best use is made of limited educational resources and that all clinical staff have the opportunity to access continued professional development and facilitates a clear process for succession planning and continued staff development and improvement.

In addition to this the team regularly provides clinical support to staff in the divisions to support and supplement patient care and maintain patient safety at times of increased activity and capacity.

Professional Registration

All registered nurses & Midwives are required to comply with the professional standards set out by the Nursing and Midwifery Council (NMC). It is the responsibility of the chief nurse to ensure that processes are in place to ensure that all registered nurses working within the Trust adhere to these standards at all times.

Where this does not happen, it is the responsibility of the chief nurse to make referrals to the NMC, who will consider the registrants suitability to continue to practice as a registered nurse or midwife.

Nurse Revalidation

Since April 2016, revalidation of registered nurses/midwives has been required every three years and is based on staff having the required evidence as stipulated by the Nursing and Midwifery Council (NMC). This is a process that all nurses and midwives need to engage with to demonstrate that they practise safely and effectively throughout their career. The NMC Code (2015) is central to good nursing and midwifery practice and revalidation emphasises reflection on the Code and will lead to greater engagement with the standards that all registered nurses and midwives are expected to meet. If the required evidence is not produced registration will lapse.

The chief nurse has the responsibility to ensure that there are co-ordinating systems in place across the Trust that support all nurse and midwives to undergo revalidation. This includes ensuring there are awareness mechanisms and training in place so that staff are aware of their responsibilities both as registrants and confirmers.

Tissue Viability

The tissue viability team consists of seven staff which includes two clinical nurse specialists, two tissue viability sisters, a trainee nursing associate, an equipment coordinator and an administrator. The team supports the quality priority related to pressure ulcer prevention by providing advice, clinical assessment and training on wound management both in trust and in the community.

The tissue viability lead oversees risks related to tissue viability and leads on all policies and guidelines related to the service.

The team provides monthly educational updates and training to clinical staff in the community and in trust on the prevention and management of pressure ulcers as well as specialist advice and bespoke on leg ulcers and vascular conditions, pressure relieving equipment and wound formulary.

In addition, the team provides support with the completion of Root Cause Analysis (RCAs) related to pressure ulcer damage and are pivotal in the timely dissemination of the learning obtained from the completion of these RCAs. Weekly pressure ulcer RCA review meeting are held by the team with divisional staff to ascertain avoidability of pressure ulcers and facilitate discussion and learning.

Falls

The monitoring of falls is essential, as a quality key performance indicator ensuring avoidable harm is not caused to our patients. As part of our commitment to recognising this important aspect of care, a lead nurse for falls was employed in April 2017 with a focus on acute care with an aim of reducing avoidable harm due to falls.

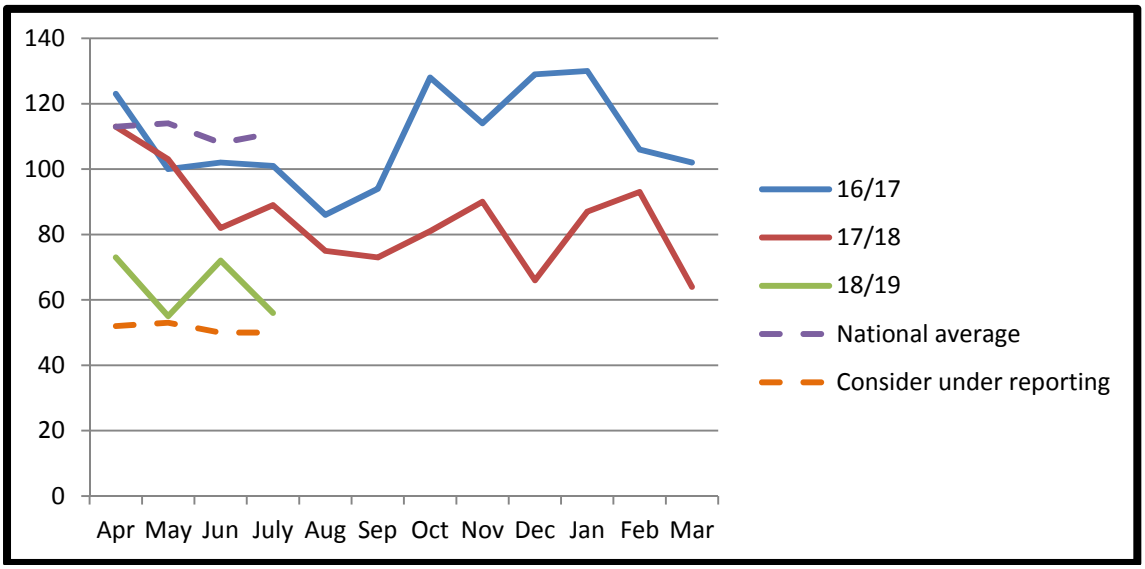
The Dudley Group was part of the NHSI Falls Collaborative in 2017 and the lead nurse continues to represent Dudley at the Falls Practitioner Network. The outcome of this collaborative included:

- Introduction of a grab bag in bathrooms as falls often occur in this area.
- ‘Call doesn’t fall’ signage.
- Introduction of 1-1 badge so that other staff did not call them for assistance.

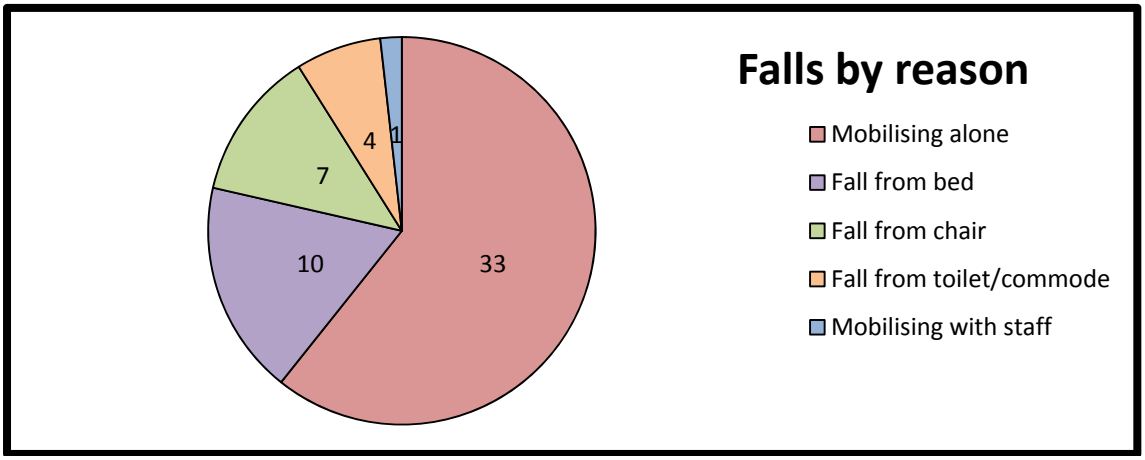
Resources / Initiatives provided 2017/18:

- New training package introduced.
- 50 ultra-low beds purchased and in place.
- Introduced a new type of bed and chair alarm across the Trust.
- Introduction of RITA – (Reminiscence interactive therapy aid).

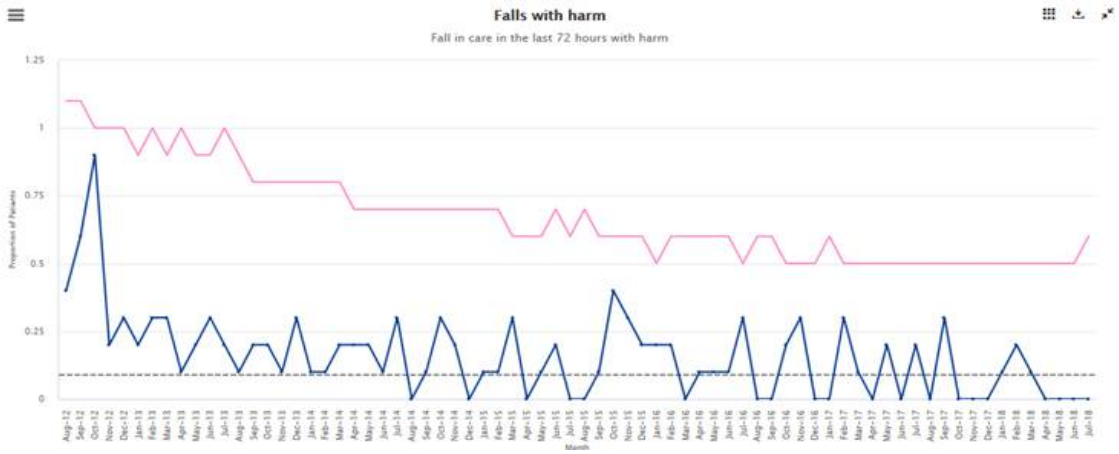
A monthly falls report is produced by the falls nurse and reported to the Quality and Safety Committee chaired by the chief nurse. Falls reported this year show a significant decrease from previous years and well below the national average when compared to similar trusts, the initiatives outlined above has contributed to the reduction in falls across the Trust.

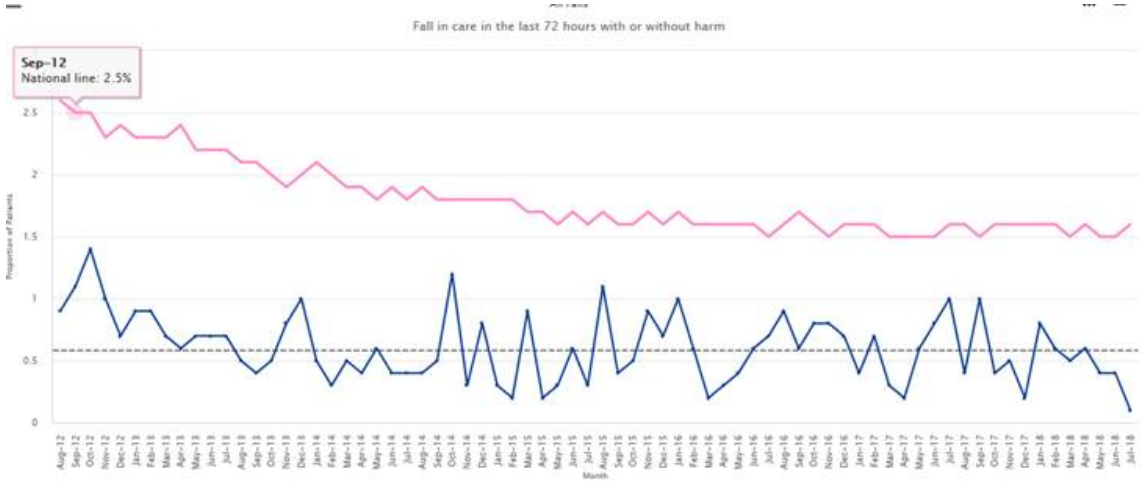


Training for frontline staff ranges from 89-100% this is believed to be a contributing factor in the low number of avoidable reported falls. Mobilisation of patients remains the highest contributory factor for falls. The graph above provides an example of reasons for falls that occurred in July 2018.



Trust inpatient falls performance is better in comparison to the national median. There were 3.27 falls incidents reported per 1,000 bed days in May 2018 which is much better position in comparison to national average of 6.63 falls per 1,000 bed days. The Trust also performs better in comparison to national median with regards to falls resulting to harm as demonstrated in the latest NHS safety Thermometer survey results (see graph below).





Quality Review and Improvement to support the Quality Priorities ensuring Regulatory Compliance

The Trust is committed to the delivery of high quality patient care and to establish a process to focus on areas highlighted for immediate action and improvement.

One such method to achieve this is through the undertaking of structured Quality and Safety Reviews which facilitate a holistic review of the clinical area and identify any areas that require improvement. The current review tool is based on the CQC Key Lines of Enquiry and includes the Quality Priorities.

Wards and departments are formally reviewed via unannounced visits by a team, led by the quality review and improvement lead, consisting of; a senior nurse or midwife, pharmacy, infection control, PALs, Trust governors, senior medics and our commissioning partners (Dudley CCG).

Through observation, review of clinical documentation and discussion with staff, the visiting team award a rating for each of the five CQC Fundamental Standards (care domains) (Safe, Effective, Caring, Responsive and Well Led). The outcome of the review is fed back verbally to the lead nurse and followed up with a full, detailed report of the findings. Actions plans are expected for domains where improvement is required (as a minimum domain that are rated as; 'Requires Improvement' (RI) or 'Inadequate'.) These action plans are monitored through the divisional governance structures and are followed up for assurance by the quality review and improvement lead.

Since April 2018 there have been 22 reviews undertaken; 12 full reviews, 8 follow up reviews, one independent matron audit in the Emergency Department and one overview visit to the Guest Outpatient Centre. The outcomes of those visits are detailed below:

	Safe	Effective	Caring	Responsive	Well Led	**Overall**
DSU Ward	**G**	**G**	**G**	**G**	**RI**	**G**
B2 Hip	Follow up review undertaken based on action plan; assurance provided for 7/13 actions. Revised action plan submitted.					
B2 Trauma	Follow up review undertaken based on action plan; assurance provided for 14/18 actions. Revised action plan submitted.					
B5	Follow up review undertaken based on action plan; assurance provided for 6/12 actions. Revised action plan submitted.					
C1	**RI**	**RI**	**RI**	**RI**	**RI**	**RI**
Critical Care	**G**	**G**	**G**	**G**	**G**	**G**
B1 (Elective Orthopaedic)	Follow up review undertaken based on action plan; 1/5 actions require further work					
B4 (General Surgery)	Follow up review undertaken based on action plan; 10/16 actions require further improvement					
C8 (Stroke)	**RI**	**RI**	**RI**	**RI**	**RI**	**RI**
Gynaecology OPD	**RI**	**NR**	**G**	**RI**	**RI**	**RI**
General OPD	**G**	**NR**	**G**	**RI**	**RI**	**RI**
T & O OPD	**RI**	**NR**	**G**	**RI**	**RI**	**RI**
A2 (Short Stay Medicine)	Follow up review undertaken based on action plan; assurance provided for 17/23 actions. Revised action plan submitted.					
C5 (Respiratory)	Follow up review undertaken based on action plan; assurance provided for 19/28 actions. Revised action plan submitted.					
Coronary Care	**RI**	**RI**	**RI**	**RI**	**RI**	**RI**
Emergency Department	Review undertaken in the form of a Matron Audit alongside Pharmacy review. Compliance results; 62%					
Imaging	**RI**	**RI**	**RI**	**RI**	**RI**	**RI**
Acute Medical Unit	**RI**	**G**	**RI**	**RI**	**RI**	**RI**
C6 (Male Urology)	Follow up review undertaken based on action plan; assurance provided for 8/17 actions. Awaiting revised action plan					
C7 (Gastro Intestinal Unit)	**RI**	**RI**	**RI**	**RI**	**RI**	**RI**
Clinical Research Unit	**RI**	**RI**	**RI**	**RI**	**RI**	**RI**
Guest Outpatient Centre	Full site visit and high level review undertaken. Overall rated as Require Improvement. Individual Department reviews to be scheduled					

The review tool is regularly updated in line with the CQC Key Lines of Enquiry, internal or external feedback and horizon scanning of CQC outcomes from other Trusts.

Quality Audits

The corporate nursing team is committed to monitoring and supporting wards and departments to ensure high quality patient care, and where necessary to make improvements. To compliment the Quality and

Safety reviews, there are comprehensive quality nursing audits undertaken every month. The audits provide assurance of the quality of care delivery for numerous aspects of the patient's journey. The quality review and improvement lead, recently supported by a seconded band 6 quality nurse, monitors submission of these audits to ensure there is oversight from every ward/department. Where compliance with audit results is poor, there is a clear escalation process, managed by the quality review and improvement lead, for wards which fail to demonstrate improvement.

The quality review and improvement lead continues to ensure oversight in each ward and department by regularly reviewing the audit tools in use to reflect changes in standards of care or key performance indicators, either locally or nationally dictated, or to support gaining assurance following learning or changes to practice following an incident or complaint. Recently new audits have been developed for maternity (community and outpatients) and GU Medicine.

Quality Dashboards

The quality dashboards were introduced and have been under development since September 2017, with the aim that every area will display relevant local, regional and national KPI quality data in a prominent position in the ward or department. The data is for staff, patients and their relatives/families. The dashboards can be produced by ward, by division or as an oversight for all areas combined.

It is expected that the divisional quality dashboards are discussed within the relevant divisional governance meetings which will then feed into divisional performance meetings, CQSPE and through to the Board. The divisions are expected to drill down into specific areas to develop improvement plans, when they are required.

The first version of the quality dashboard focused on the inpatient ward areas; A2, B1, B2 (hip), B2 (trauma), B3, B4, B5, C1, C2, C3, C4, C5, C6, C7, C8, Coronary Care Unit/Post Coronary Care Unit (CCU/PCCU), Critical Care (Surgical High Dependency Unit/Intensive Care Unit), Maternity, Medical High Dependency Unit (MHDU) and Neonates. All data discussed in this report relates to these areas only. Most lines are now populated on a monthly basis for; A2, B1, B2 (hip), B2 (trauma), B3, B4, B5, C1, C3, C4, C5, C6, C7, C8, CCU/PCCU, with the exception of Acute Kidney Injury (AKI), Consultant/Senior review and Estimated Date of Discharge (EDD) and the neonatal specific metrics. To support the population of the few remaining metrics and development of the quality dashboards for the other areas across the Trust; there has been an additional appointment to the Informatics team to support the quality review and improvement lead. This person commenced in late August 2018.

The dashboards are available to view per ward, per division and an aggregated view of all dashboards combined (see example below).

QUALITY INDICATOR (All Wards)

Patient Safety & Quality	RATINGS			2017								2018				
KPI				Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	YTD
Environmental Cleaning	<85%	85% - 95%	>=95%	94.54%	96.81%	95.62%	94.95%	94.61%	97.48%	89.03%	90.06%	93.72%	92.52%	92.58%	91.86%	93.56%
Hand-hygiene compliance (Aug 2017 onwards)				97.6%	97.6%	94.4%	99.7%	99.7%	100.0%	99.4%	99.6%	98.8%	100.0%	99.2%	99.7%	99.0%
MRSA Screening - elective												98.46%	97.46%	94.73%	98.31%	96.67%
MRSA Screening - emergency												88.04%	88.64%	90.87%	89.31%	89.17%
HCAI CDIFF – Due To Lapses In Care	>0		0	1	4	0	1	0	1	0	2	3	0	0	0	12
Saving Lives - 02b Peripheral Lines Ongoing Care	<75%	75% - 95%	>=95%	98%	98%	99%	100%	99%	98%	95%	95%	95%	94%	98%	100%	98%
Saving Lives - 06b Urinary Catheter Ongoing Care	<75%	75% - 95%	>=95%	100%	100%	100%	100%	100%	98%	99%	98%	100%	98%	99%	100%	99%
Total number of Datix incidents reported				619	568	580	554	492	567	506	511	461	502	519	570	6,449
Falls, Injuries or Accidents				75	78	91	108	82	88	90	67	67	59	70	70	943
Pressure Ulcers (Hospital Acquired) Grade 3/4	>0		0	20	8	0	0	0	24	4	12	3	0	2	0	73
Serious incidents				24	16	8	20	8	36	16	20	4	2	4	5	163
Never Events	>0		0	0	0	0	0	0	0	0	0	0	0	0	0	0
Nutrition Audit	<85%	85% - 95%	>=95%	95%	95%	95%	93%	96%	94%	93%	95%	95%	96%	93%	94%	94%
Pain Score	<85%	85% - 95%	>=95%	91%	89%	95%	93%	97%	94%	91%	89%	99%	97%	99%	94%	95%
Medicines Management Audit (Announced)	<85%	85% - 95%	>=95%							92%	89%	93%	93%	94%	93%	92%
Priorities of Care				34	43	41	29	24	41	41	32	31	37	37	32	422
Deteriorating patient trolley daily checked (1 month in arrears)	<85%	85% - 95%	>=95%	81.25%	75.00%	90.00%	100.00%	73.68%	95.23%	86.86%	100.00%	76.10%	95.45%	94.73%		88.11%

Clinical Indicators	RATINGS			2017								2018				
KPI				Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	YTD
National Early Warning System (NEWS/PEWS/MEOWS)	<85%	85% - 95%	>=95%	91%	88.3%	94.5%	93.7%	97.7%	93.7%	89%	92%	95.5%	93.2%	95.9%	88.5%	92.9%
***Newborn and Infant Physical Examination																
Fluid Balance Management Audit	<75%	75% - 93%	>=93%	91.34%	92.52%	90.88%	93.04%	93.15%	89.29%	90.57%	93.48%	89.92%	96.39%	88.34%	89.90%	91.59%
***Hearing Screening																
AKI (awaiting EPR)																
VTE Assessment Indicator (CQN01)	<95%		>=95%	95.41%	94.05%	95.47%	95.82%	94.12%	95.15%	95.99%	95.10%	96.46%	95.34%	96.54%	96.69%	95.58%
***Retinopathy of Prematurity Screening																
NQA - Skin Bundle	<85%	85% - 95%	>=95%	96%	96%	94%	96%	96%	96%	96%	95%	95%	95%	92%	95%	95%

Patient Experience	RATINGS			2017								2018				
KPI				Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	YTD
Friends & Family – Inpatients – Footfall	< 26%	26% - 35.1%	>= 35.1%	28.2%	24.9%	37.4%	36.7%	31.9%	29.9%	28.5%	32%	38.4%	34%	44.2%	38.9%	33.7%
Friends & Family – Inpatients – Recommended %	< 96.3%	96.3% - 97.4%	>=97.4%	95.7%	94.2%	92.8%	94%	93.3%	92.5%	92%	90.8%	92.4%	91.5%	93.2%	92.4%	92.9%
Friends & Family – Inpatients – Not Recommended %				1.9%	3.1%	3.5%	2.4%	3.8%	2.7%	4.2%	4.5%	3.1%	3.4%	3.1%	2.4%	3.1%
Friends & Family – Maternity – Footfall	< 26%	26% - 35.1%	>= 35.1%	58.3%	39.6%	34.6%	45.1%	23.6%	38.4%	35.9%	36.3%	30.3%	43.2%	37.9%	31.6%	38.2%
Friends & Family – Maternity – Recommended %	< 96.3%	96.3% - 97.4%	>=97.4%	97.6%	97.8%	98.6%	95%	98.4%	97.2%	97.9%	97.8%	98.1%	97.2%	98.1%	98.8%	97.6%
Friends & Family – Maternity – Not Recommended %				1%	0.8%	0.6%	0.7%	0%	0.2%	0.5%	0%	1.2%	0.9%	0.4%	0.8%	0.6%
Complaints				100	95	90	110	70	105	55	80	52	42	40	22	861
Compliments				206	333	387	301	482	487	372	310	315	428	244	395	4,258
Estimated Date Discharge (May 2018 onwards)																

Workforce & Safer Staffing	RATINGS			2017								2018				
KPI				Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	YTD
Appraisals	<80%	80% - 90%	>=90%	87.3%	87.3%	89.3%	87.9%	86.8%	85.7%	80.6%	70.9%	17%	52%	94.9%	94.9%	77.9%
Mandatory Training	<80%	80% - 90%	>=90%	84%	85.3%	86.5%	87.7%	87.5%	88.7%	86.9%	85.6%	87.1%	87.9%	86.6%	88%	86.7%

QUALITY INDICATOR (All Wards)

RN average fill rate (DAY shifts)	<95%		>=95%	86.97%	87.64%	87.88%	87.52%	87.00%	87.98%	88.54%	87.10%	82.31%	81.67%	81.04%	81.34%	85.57%
RN average fill rate (NIGHT shifts)	<85%		>=95%	90.99%	90.52%	90.21%	90.57%	89.05%	91.80%	94.68%	89.80%	84.39%	84.61%	83.55%	84.95%	88.66%
Nervecentre Contacts				4,184	4,358	4,238	4,131	4,897	4,383	3,919	3,970	4,106	4,166	3,919	3,802	49,873
Consultant/Senior review (May 2018 onwards)																
Sickness Rate	> 4%	3.5 - 4%	<= 3.5%	6.05%	5.88%	5.98%	6.71%	7.15%	7.54%	6.11%	5.57%	5.01%	4.72%	5.43%	5.55%	6.02%
***Unit Occupancy Rate																

Safety Thermometer

On a monthly basis the Trust provides data to NHSI measuring the harm free care we provide to our patients. This audit is undertaken on the same day every month across the country and includes patients in all adult inpatient wards (classic audit), all district nursing community localities (classic audit), on maternity (maternity audit) and C2 (children and young people audit).

The quality review and improvement lead monitors returns and ensure timely submission to NHSI as well as analysing the data to identify any local trends as well as monitor our national performance.

For the inpatient adult ward areas and the community localities the ‘harm free care’ is measured against pressure ulcers, falls, venous thrombro embolism, catheter insertion and catheter acquired urinary tract infection. Below is our performance (in blue) against the national average (in pink).

Quality Improvement Training and Support

The quality review and improvement lead has recently begun teaching Quality Improvement methodology to groups of staff on the graduate programme, the band 6 development programme, and the developing leaders programme to enable individuals of all bands to feel confident and able to undertake improvements in practice.

The quality review and improvement lead is working towards launching a recognition pathway for individuals/ward and departments who undertake improvements in practice and sustain them, mirroring models from Salford NHS Foundation Trust and Wrighton, Wigan and Leigh NHS Foundation Trust.

Safe Staffing

There are a number of regulatory requirements in terms of ensuring and monitoring safe staffing. The National Quality Board (NQB) set out expectations and a framework within which NHS organisations and staff should make decisions about staffing that put patients first. Putting people first remains our collective and individual responsibility and is central to the delivery of high quality care that is safe, effective, caring and responsive. This means a relentless focus on planning and delivering services in ways that both improve quality and reduce avoidable costs underpinned by the following three principles:

1. Right care: Doing the right thing, first time, in the right setting will ensure patients get the care that is right for them, avoiding unnecessary complications and longer stays in hospital and helping them recover as soon as possible.
2. Minimising avoidable harm: A relentless focus on quality, based on understanding the drivers and human factors involved in delivering high quality care, will reduce avoidable harm, prevent the unnecessary cost of treating that harm, and reduce costs associated with litigation.
3. Maximising the value of available resources: Providing high quality care to everyone and usage of resources in the most efficient way. Understanding that any waste has an opportunity cost in terms of care that could otherwise be provided.

The NQB has updated its expectation from NHS providers in 2016. The updated three NQB expectations form a ‘triangulated’ approach (‘Right Staff, Right Skills, Right Place and Time’) to staffing decisions. An approach to deciding staffing levels based on patients’ needs, acuity and risks, which is monitored from ‘ward to board’, which will enable the board to make appropriate judgements about delivering safe, sustainable and productive staffing. The Care Quality Commission (CQC) supports this triangulated approach to staffing decisions, rather than making judgements based solely on numbers or ratios of staff to patients.

In line with this national requirement, the Board receives a monthly report on the wards ‘staffing fill rates and Care Hours per Patient Day (CHPPD) in compliance to the NQB set of expectations. The staffing fill rates and CHPPD are submitted monthly via UNIFY to NHS England and published on the trust website and NHS choices. Wards planned and actual staffing is also displayed within the wards for public information as part of national requirement in promoting openness and transparency.

At least once a year, a detailed review of patient staffing need is undertaken using a validated patient acuity and dependency tool. Results of the study are discussed with the associate chief nurse, matrons and lead nurses to consider professional and clinical judgement and ward’s layout. These are further triangulated with quality metrics, vacancies, staff and patient experience before nursing and midwifery establishment is agreed. The monthly and yearly board staffing reports are all placed on the Trust website. The agreed annual staffing skill mix review is further reviewed six monthly to ensure that the correct number of staff with the right skills are in the right place and with the right cost.

Safer staffing highlights:

- Overall CHPPD remains within the nationally agreed variation of 6.3 and 16.8.
- Fill rates remained 80% and above against the planned staffing with 87% overall fill rates in July 2018.

- New establishment data introduced from July 2018 and this will be reviewed after six months
- The community nursing at night staffing review has been completed and combined with the community day review, this detailed report is with the division for presentation to the Directors
- Meetings with lead nurses/midwives and matrons continue focusing on recruitment and retention of staff to deliver the reduction in bank and agency usage.

Agency Controls

- The last four months showed a reduction in agency usage. The use of agency clinical support workers remains 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.
- Use of non-framework agency remains an Executive only authorisation

Recruitment and Retention update

- July 2018 reports a total of 323 nurse vacancies across the trust
- Monthly recruitment events continue however work is underway to strengthen recruitment activity.
- A total of 89 nurses are predicted to join the trust in the next 3 months. Figures vary slightly from the predictor tool as some of our recruits have accepted posts recently.

Percentage fill rates April –July 2018

	Qualified Day	Unqualified Day	Qualified Night	Unqualified Night
April 2018	97%	96%	98%	98%
May 2018	95%	97%	97%	97%
June 2018	81%	90%	84%	96%
July 2018	80%	89%	84%	94%

Staffing skill mix review status:

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 and draft updated. Director of Operations to 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 and draft updated.
Community Nursing (Days)	Complete, to be presented at the newly formed Transition Board of the MCP.
Community Nursing (Nights)	Complete, combined with the day review. To be presented to Executive Directors prior to MCP Transition Board.
Specialist Nurses	Presented to Executive Directors in August 2018.

Patient Experience Activities

A definition of patient experience is ‘the sum of all interactions, shaped by an organisations culture, that influence patient perceptions across the continuum of care’

The Patient Experience team provides a first line response service to patients, relatives and carers who wish to log concerns, complaints and compliments throughout the Trust. The team are the central hub within the Trust for the collation and reporting of patient feedback by the number of reporting mechanisms

in place including the Friends and Family Test, National Surveys, Real Time Surveys, NHS Choices/Opinion and Healthwatch. The chaplaincy service and the volunteer service also sit within the remit of patient experience. There is no clinical staff within the patient experience team.

Information is gathered from a range of methods of feedback, patient experience survey activity and complaints, and collated to demonstrate areas where we are performing well and areas where based on feedback, improvements are required. It is recognised that each source of data provides rich information and should not be viewed in isolation but triangulated to determine if there are patterns emerging and enabling the Trust to identify challenges and concerns that need addressing. Where areas are highlighted for improvement the service concerned with divisional oversight develop an action plan in order that issues can be addressed effectively and efficiently to ensure the Trust is continually improving. Improvements are monitored through Divisional Performance meetings as well as the Patient Experience Improvement Group. This group meet fortnightly, and is chaired by the chief nurse.

Complaints

All complaints are managed in line with the 'The Social Services and National Health Service (England) Complaints Regulations 2009'.

Complaints are received in any format (verbal, written, email, face to face) into the Trust. There is a robust triaging process in place to ensure that every complaint received is investigated in the correct manner i.e. complaint, PALS, level 2 investigation or Serious Incident. The head of patient experience oversees all complaints that are received into the Trust. Once the correct pathway has been established the complaint is logged on the Datix system and an acknowledgement letter is sent out within three working days of receipt. The complaint will then be investigated in line with the complaints and concerns policy.

As part of the complaints process a local resolution meeting (LRM) is offered to all complainants. This will either form part of the initial complaints process to enable additional information to be obtained from the complainant in relation to what they would like to investigate or, alternatively, it may form part of the final resolution process when the complainant wants to discuss the formal response they have received. These meetings take a considerable amount of time to arrange as it is very difficult to coincide all clinicians involved diaries. The Trust values the opportunity to meet with people at a LRM as we believe this provides the opportunity for people to meet and discuss their concerns direct with the service. This is the choice of the individual complainant and it is recognised that in most circumstances people prefer to pursue the formal complaints process and receive a response from the Chief Executive.

The Trust values the opportunity complaints bring to learn and share learning across the organisation to effect improvement for the benefit of our patients and staff. A complaints tracker was introduced in July 2017 to ensure monitoring and completion of complaints/actions agreed as a consequence of learning from complaints. This tracker is shared on a weekly basis with the chief executive officer, the chief operating officers, the medical director, chief nurse and the clinical and operational directors of each division/service line and clinical governance leads. We strive to demonstrate the changes that have been made as a result of the learning from complaints and to sustain the changes for long term improvement.
Some complainants do remain dissatisfied with the outcome of their complaint. In these cases the complaint is reopened and a new independent of the first investigation is undertaken. If the complainant remains dissatisfied thereafter the next step is to contact the Parliamentary Health Service Ombudsman (PHSO), Local Government Ombudsman (LGO) (the second and final stage in the complaints process).

The complaints team liaise with the PHSO, LGO and solicitors when complainants have contacted them for assistance. All information requested from PHSO and LGO including patients clinical notes are gathered and forwarded as requested to assist with their independent investigation

Complaints handling and any trends or themes identified from them are shared within the monthly and quarterly reports and overall in the annual report. A Complaints and Learning Review Group is held quarterly and it is expected that each division will present their learning and actions from complaints for that quarter.

All complainants are offered a complainant satisfaction survey at closure of their complaint. Historically there has been a low response to complainant satisfaction surveys and complainants do tend to base their response on the outcome of their complaint rather than the process in which their complaint was handled.

All complainants are offered a complainant satisfaction survey at closure of their complaint. Historically there has been a low response to complainant satisfaction surveys and complainants do tend to base their response on the outcome of their complaint rather than the process in which their complaint was handled.

PALS

The Patient Advice and Liaison Service (PALS) offers a confidential advice, support and information on health-related matters. They provide a point of contact for patients, their families and their carers. PALS liaise with individual services/departments to help resolve concerns quickly and informally to the satisfaction of the enquirer (usually within 24/48 hours). Where necessary, the PALS will help patients, relatives or carers raise a complaint and provide the necessary support through that process.

In addition to the individual learning and improvements that result from individual enquiries, the PALS analyse data to identify and share learning opportunities across the organisation through the monthly and quarterly reports.

The PALS team are appropriately based in the main reception of Russells Hall Hospital and in the Trust headquarters.

Patient Experience feedback

The Friends and Family Test (FFT) gives patients the opportunity to submit feedback to providers of NHS funded care or treatment, using a simple question which asks how likely, on a scale ranging from extremely likely to extremely unlikely; they are to recommend the service to their friends and family if they needed similar care or treatment. The FFT is intended as a service improvement tool, measuring performance continually and enabling increased responsiveness to near real time feedback. It is also a mechanism to encourage and motivate staff and reinforce good practice.

FFT cards are available throughout the Trust in all wards and departments. There is also a SMS texting system in place across the Trust. Volunteers also assist with collecting FFT in the wards and departments.

National Surveys

Listening to patients' views is essential to providing a patient-centred health service. The NHS Patient Survey Programme systematically gathers the views of patients about the care they have recently received and was established to support patients and the public to have a real say about the quality of NHS services and how they are developed. By asking organisations to carry out patient surveys in a consistent and systematic way, it is possible to build up a detailed picture across the country of patients' experiences. This approach not only allows organisations to compare their performance with others but, by repeating the same type of survey on a regular basis, progress and improvements over time can be monitored.

The Trust participates in the following national surveys:

- Adult Inpatient Survey
- Maternity Survey
- Children's and Young People's Survey
- Emergency Department Survey
- National Cancer Patient Experience Survey

The Trust is in the bottom 10% of trusts nationally based on the Overall Patient Experience Score (OPES) published in the National Adult Inpatient Survey. This was brought to the attention of the Board by the chief nurse in 2017 on her arrival to the Trust.

In June 2018 the results of the 2017 Adult Inpatient survey were published by the CQC and overall show a slightly improving picture when compared to our previous year's performance. The Trust is ranked 134 out of 148 Trusts (compared to 139 out of 149 trusts in 2016) based on the OPES. Nationally, the OPES ranged from the lowest trust score in England of 7.5 to the highest trust score in England of 9.2.

Chaplaincy

The chaplaincy service provides spiritual, religious and pastoral care to patients' visitors and staff of any faith or no faith, and they are happy to assist you during your stay. They are supported by chaplaincy volunteers as pastoral visitors and helpers at the Sunday /midweek services. The Chaplaincy Service seeks to provide for the religious needs of various faith groups. The chaplaincy has contacts with various local faith groups throughout the community and nationally.

The chaplaincy service has the experience and the qualifications to support people of various faiths and spiritual traditions. One of the main ways care is offered is through 1-to-1 sessions. These can involve someone talking about their life, beliefs, and values, and can touch on psychological and social, as well as religious or spiritual themes. The service also offers group reflective sessions, Schwartz rounds and mindfulness sessions. The chaplains undertake many non-viable foetus, baby and adult funerals. There is a dedicated prayer space within the hospital and regular services of worship are held (Russells Hall Hospital and Bushey Fields Hospital).

The team visit the wards regularly and are always ready to talk and listen to people, whether they are religious or not. The Trust employs chaplains from the Church of England, Roman Catholic, Methodist and Muslim faiths. They can also contact faith leaders of other world religions.

Volunteer Service

The volunteer service came into the remit of head of patient experience in May 2018.

Volunteers help the Trust with providing valuable additional support to enhance and complement the care and services we provide to patients. Our volunteer roles are designed to improve patient and visitor experiences. The Dudley Group NHS Foundation Trust currently engages 450 volunteers and a volunteer's coordinator. There are a further 130 volunteers going through the process to become a volunteer.

Some of the roles undertaken by volunteers are as follows:

- Supporting nursing staff on our wards to provide patients with meal time support or by providing activities and befriending services to our patients.
- Volunteers support us with collecting feedback and surveys from our patients to help the Trust learn from patient experience.
- Providing a service within the emergency department serving hot/cold drinks and meals.
- Managing the front reception desk of the hospital in times of need.

The head of patient experience and her team in conjunction with others supported by the chief nurse has led the following initiatives and continues to work to focus on improving the patients experience:

- Ongoing programme to **continually improve the physical environment and facilities for patients, their families, carers and Trust staff.** Completed projects include: a fruit and vegetable stall outside the main reception at Russells Hall Hospital which benefits both patients and staff; provision of refreshments and water fountains available in waiting areas including the emergency and in the Surgery Assessment Unit; completed the rollout of new food service trollies for inpatient areas; expanded the use of the 'follow up calls model' to T&O patients within 48 hours of discharge from hospital to assess pain management and any concerns with a wound; funding secured to install TV's at every bedside in the children's ward; installed a digital fish tank in the waiting room in C4; reviewed and replaced signage at Corbett Outpatient Centre as needed; increased the number of free parking passes for key patients groups such as those undergoing dialysis, chemotherapy and parents of neonatal patients; completed the replacement of outdated and unreliable car parking

pay machines and car park equipment at each of the Trust sites; and, review undertaken of the Guest Outpatient Centre to improve the physical environment for patients and staff including the creation of staff break way area and the installation of curtains and blinds.

- Committed to supporting the delivery of the **Dementia strategy**: the installation of dementia friendly signage and sourcing of contrasting/coloured toilet seats; introduction of RITA (reminiscence interactive therapy and activities); coloured toilet seats and toilet roll holders.

- Supported work streams within the **End of Life Strategy** with projects including: provision of enhanced mouth care; identifying an area to develop a garden for end of life patients to visit; installation of LED sky ceiling panels to help provide a relaxing and calming environment; reviewed tea and coffee provision on wards for those recently bereaved; and presently involved in the audit of guest bed provision across the Trust wards.

- Instigated many initiatives to raise awareness of the **importance of patient experience** to all levels of staff across the Trust: patient experience training has been re-introduced to the corporate induction programme along with a relaunch of visual impairment training; expanded the membership of the Patient Experience Improvement Group Improvement Group to include colleagues from all divisions and key Trust areas including HCA, podiatry, discharge co-ordinators and infection prevention and control representatives; and introduced Feedback Friday.

- **Increased patient engagement** to support an increase in the number of patient listening and engagement events; developed additional surveys for patients receiving specialist palliative care services, younger children visiting outpatients and a sick note survey. The number of pieces of feedback increased to 64,500 for 2017/18 compared to 34,500 pieces of feedback received in 2016/17.

Arts and Environment Group

This group is responsible for all of the artwork throughout the Trust. The group liaise with local artists and schools who may wish to display their work in the hospital. Some of the artwork is for sale whereby the Trust receives 10% of the sale price. The group is also responsible for all of the hospital artefacts and ensuring that they are displayed and kept safe at all times.

Clinical support for the electronic patient record and other IT developments

The chief nurse is responsible for ensuring that the introduction of digital technology will not compromise patient safety and quality of care. New technology and innovation should support staff in improving patient experience and outcomes rather than a barrier. As nursing, midwifery and AHPs are the biggest end users of digital technology, the link and collaborative work between nursing and the IT department is essential to the success of the Trust Digital Strategy. The corporate nursing team has appointed a new deputy chief curse/ chief nursing information officer who will work closely with the chief information officer (CIO) in enabling technology to support the delivery of the Trust's quality and safety agenda.

End of Life Care

The chief nurse chairs both the internal and economy wide End of Life meetings. The chief nurse played a key role in the launch, implementation and monitoring of the End of Life Strategy. The strategy and data is to inform and support the trust to focus and deliver high quality patient care.

The End of Life vison for Dudley is that:
All people with palliative and end of life care needs, irrespective of their diagnosis, together with those closest to the, are able to express their needs and wishes; and that as far as clinically appropriate and practically possible, these needs and wishes are met. We have reintroduced End of Life care as a mandatory requirement as we believe this is fundamental.

Enclosure 10

The Dudley Group NHS Foundation Trust

Paper for submission to Trust Board 6th September 2018

TITLE:	**Nursing and Midwifery Workforce Update**		
AUTHOR:	Jo Wakeman, Deputy Chief Nurse	**PRESENTER:**	Jo Wakeman, Deputy 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

- The community nursing at night staffing review has been completed and combined with the community day review, this detailed report is with the division for presentation to the Directors
- Meetings with Lead Nurses/Midwives and Matrons continue focusing on recruitment and retention of staff to deliver the reduction in bank and agency usage.
- Increased number of incidents reported in month relating to staffing (43). 43 staffing clinical incidents reported this month.

Agency Controls

- The last four months shows a reduction in agency usage. The use of agency clinical support workers remains 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

- July 2018 reports a total of 323 nurse vacancies across the trust
- Monthly recruitment events continue however work is underway to strengthen recruitment activity.
- A total of 89 nurses are predicted to join the trust in the next 3 months. Figures vary slightly from the predictor tool as some of our recruits have accepted posts recently.
- Predictor tools are within the paper as requested.

IMPLICATIONS OF PAPER:

RISK	Yes		**Risk Description:** • Nurse Recruitment – unable to recruit to vacancies 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 outlines progress against staffing reviews. The review of community nursing (during the day) has been seen by Executive Directors. With the further community nursing (evenings/nights) review now being completed the two reports have been combined for a further assessment by the Executive Directors before it is taken to the newly formed Transition Board of the Multispecialty Community Provider (MCP). A draft paper on AMU/FAU has been completed and updated and seen by the Executive Directors who have asked the Director of Operations to ensure it is consistent with the development plans for the ground floor reconfiguration.

Table 1

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 and draft updated. Director of Operations to 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 and draft updated.
Community Nursing (Days)	Complete, to be presented at the newly formed Transition Board of the MCP.
Community Nursing (Nights)	Complete and now combined into one paper with the day review. To be presented to Executive Directors prior to MCP Transition Board.
Specialist Nurses	In draft, presented to Executive Directors August 2018.

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 new establishments for July 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 rates. The totals for the Trust are also indicated. In addition, the last three columns show the actual Care Hours Per Patient Day (CHPPD). We provide this information to NHS Improvement and part of it is utilised in informing the National Model Hospital data.

This is the second month the report is based on the new establishments with the data coming from Allocate, the rostering system. As expected the fill rates for qualified staff show a reduction from previous months up to March as the planned hours for the new establishments have increased relative to the staff available. The agreed plan is to achieve 80% of the qualified staff establishments initially, moving to 85% after three months and 90% after six months. This month the overall fill rates for qualified staff are 80% (Days) and 84% (Nights) (Table 2) although not all wards are achieving the plan. A number of factors influence fill rates such as occupancy and acuity. For

example if occupancy is low it would not make financial sense to book additional temporary staff and this would reflect as a low fill rate against the original plan. Triangulation of data against staffing incidents and quality dashboard KPIs provides the oversight that safe, quality care is being delivered to our patients.

It should be noted:

- The low qualified nurse fill rate (less than 70%) in some areas e.g. Coronary Care Unit/Post Coronary Care Unit and wards C1 (Renal/Endocrinology), C5 (Respiratory), B3 (Vascular) and C8 (Stroke) reflects the challenge in recruiting staff to these areas. Further work is required for our ward clinical teams to alter planned hours on Allocate to reflect occupancy when additional staff is not required for example CHPPD within critical care for July 2018 equates to 35.23 hours per patient despite having a low fill rate this would suggest that there was adequate staffing based on occupancy.
- In reports up to May the fill rates for C2 (Children) and NNU (Neonatal Unit) were based on recognised dependency tools. Now that the data originates from Allocate and the new establishments, these wards figures need to be interpreted differently to previously. With regards to NNU, the unit has now recruited further staff and so the fill rate will improve once the new appointments commence.

Lead Nurses and Matrons continue to meet regularly with the Associate Chief Nurses to discuss staffing challenges, whilst maintaining patient safety and sustaining financial balance. Monitoring and contingency processes are in place to daily ensure that staffing does fall below an absolute minimum (which are based on the old establishments). 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.

Table 2. Percentage fill rates April 2018 to the present

	Qualified Day	Unqualified Day	Qualified Night	Unqualified Night
April 2018	97%	96%	98%	98%
May 2018	95%	97%	97%	97%
June 2018	81%	90%	84%	96%
July 2018	80%	89%	84%	94%

Care Hours per Patient Day (CHPPD)

Following the publication of the Carter Review (2016) NHS Improvement have issued new 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) (Appendix 1) remains within the nationally agreed variation of 6.3 CHPPD and 16.8 CHPPD (Carter Review, 2016).

Summary situation of staffing and potential recruitment over the next year

A summary table (Appendix 2) has been included which allows the reader to view the new budgeted establishments compared to the staff actually in post together with all operational vacancies. The use of Bank and Agency staff is also charted as are the sickness and maternity rates. All of these measures are in WTE.

This summarised chart groups staff into specific areas rather than by individual ward/units.
The predicted recruitment numbers is considered (against a forecasted 8% leaving rate).
This overview chart provides the ability to see at a glance the following:

- Vacancies compared to 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.

Clinical Incident staffing analysis

Tables 3 and 4 below detail the number of clinical incidents during July 2018 that related to staffing. In total there were 43 incidents compared to 49 staffing incidents for June 2018. The Emergency Department generated more incidents than any other area. It is of note that areas with higher vacancies such as B3 and CCU have not reported any staffing incidents; this would suggest the potential of under reporting as fill rates for RN were reported as low 60-70%. During July 2018 30 incidents were reported as no harm caused to patients as a result of staffing concerns.13 staffing incidents were recorded as near misses. The reporting of staffing issues has been shared with the Associate Chief Nurses.
Table 3

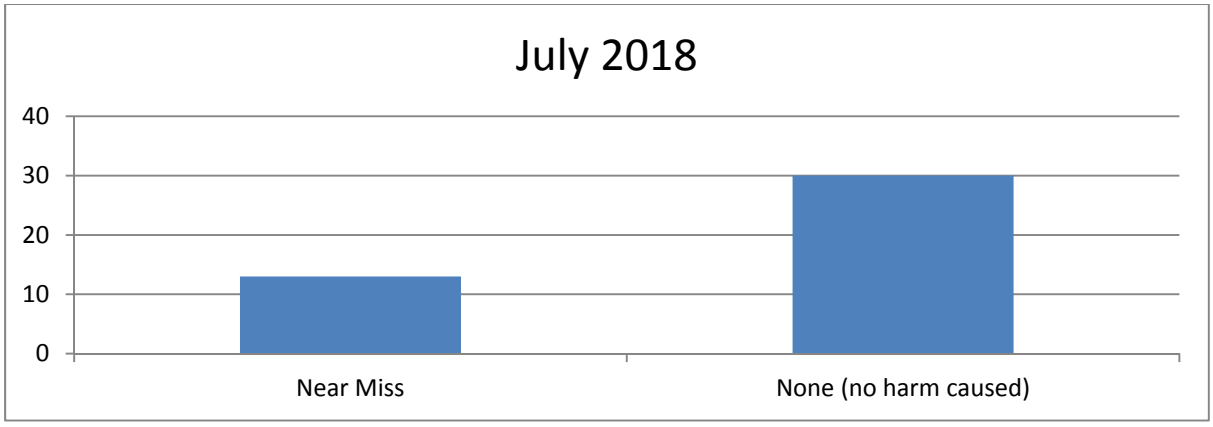
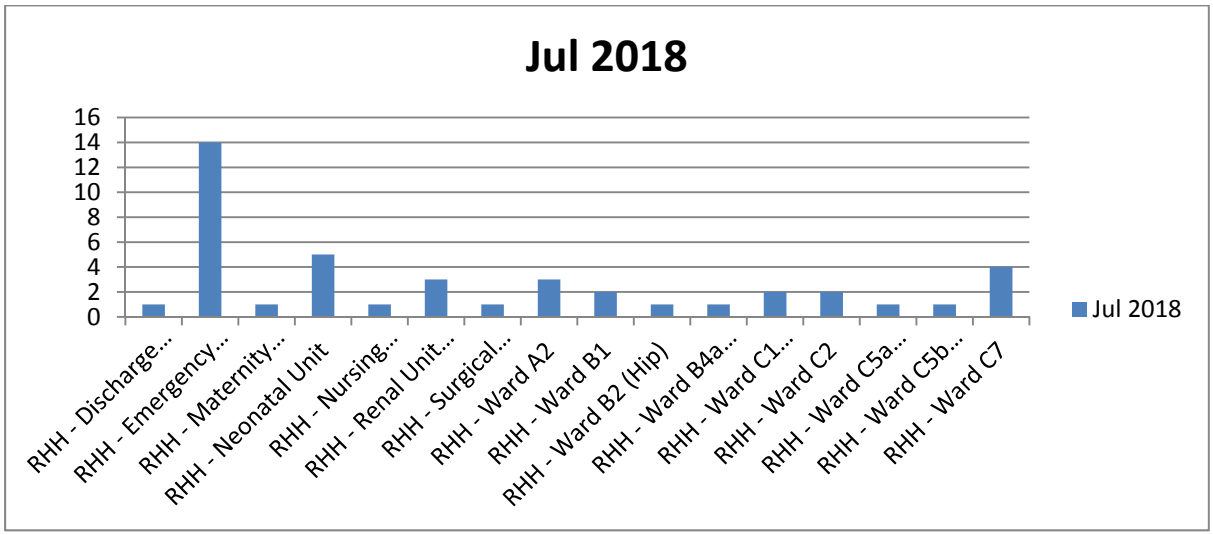


Table 4



Of the 13 incidents 10 were reported by ED, 2 by C7 and 1 by neonates. C7 was a patient reported to have had a fall, CSW allocated to confused patients. Site team unable to provide additional support.
The neonatal incident was a delay in administration of IVs via a central line as Outreach busy and staff not trained to administer.

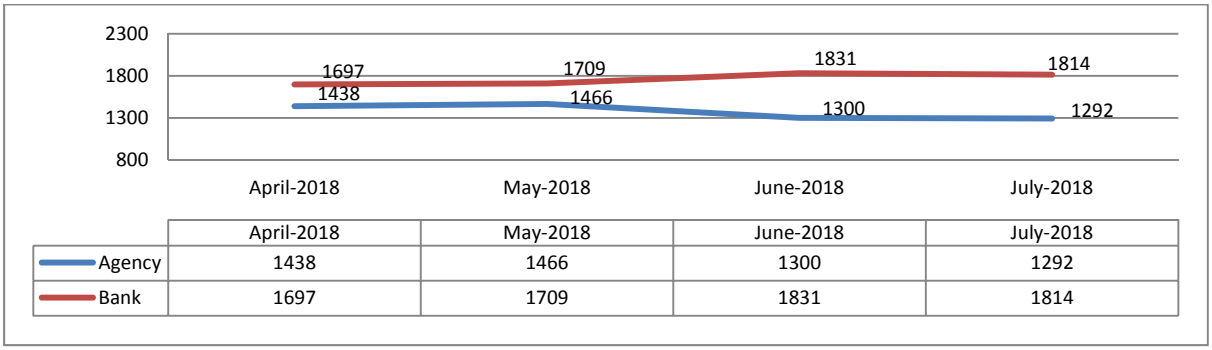
Agency Controls

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 by an Executive Director.

Table 5 shows the comparison usage of bank and agency, which has remained fairly static for June and July 2018. Agency usage has consistently been lower than bank usage since April 2018. Since June 2018 bank usage is significantly higher than agency of approximately 500 shifts per month. . This is with a vacancy situation of 323 WTE. The controls against agency usage for CSW staff have been maintained with zero shifts during this period (table 6) .

Agency and Bank RN monthly usage

Table 5



	April-2018	May-2018	June-2018	July-2018
Agency	1438	1466	1300	1292
Bank	1697	1709	1831	1814

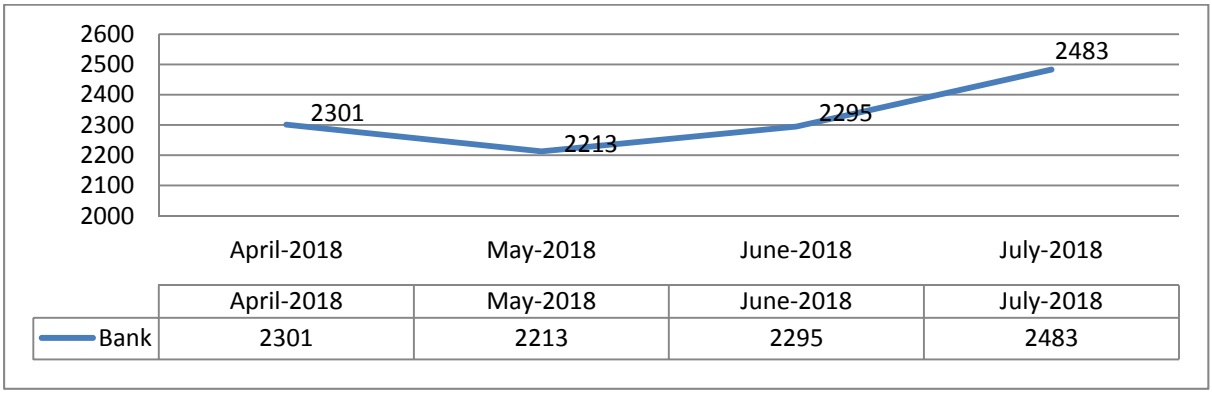
Top 5 areas for the last two months

Ward	June-2018
Emergency Dept Nursing Dept	201
B3 Emergency Surgery	145
Critical Care (ITU)	122
A2	99
AMU Dept	74

Ward	July-2018
Emergency Dept Nursing Dept	203
A2	121
B3 Emergency Surgery	112
AMU Dept	102
C8 Stroke Rehab Dept	96

CSW monthly bank usage

Table 6



	April-2018	May-2018	June-2018	July-2018
Bank	2301	2213	2295	2483

<u>Recruitment Update</u>

Monthly recruitment events continue. At the event on the 9th August 2018 five conditional offers were made for substantive posts and one offer for the neonatal bank. Area specific events are also being arranged with Theatres holding an open morning on the 6th September 2018 and C5 on the 21st of September 2018. The next general event will be held on the 19th September 2018. There is recognition that with the scale of the vacancies there needs to be greater focus on the recruitment and retention of staff at pace.

At the time of the report, a total of 15 experienced nurses are currently going through recruitment clearances of which 13 are Band 5 and two are Band 6.
69 graduate nurses are confirmed to commence 17th September at time of the report of which six are community nurses and three are paediatric nurses.

There are currently only six staff nurse adverts live on NHS Jobs totalling 40.68 WTE vacancies. These are not reflective of the Registered Nurse vacancies within the Trust. To address this, recruitment processes are being developed with the communications so all nursing vacancies within the Trust are continually advertised to optimise the recruitment activity. The recruitment and retention lead is also working with lead nurses, matrons, HR business partners and the staff engagement lead to devise specific recruitment and retention action plans specific for each area. The areas with high vacancy, bank and agency usage areas are being targeted as a priority. The concerns re divisions being proactive in the recruitment and retention of staff were raised within the divisional performance meetings as this is a key requirement to ensure we can deliver high quality patient care consistently across the organisation. The Associate Chief Nurses have been made aware of vacancies advertised versus actual vacancies.

RN Predictor Tool Current and New Establishments

The summarised version of the RN predictor tool (Appendix 2) reflects all nursing vacancies across the Trust within clinical and non-clinical roles. It enables a clearer picture of the staffing situation across each group and the whole organisation. Currently there are 323 WTE vacancies against the new establishment following the staffing review.

The Clinical Support Worker Predictor Tool

The Clinical Support Worker Predictor Tool data (Appendix 3) is attached as requested.

Appendix 1 – Percentage Fill rates by ward and CHPPD

Safer Staffing Summary	Jul			Days in Month	31											
	Day RN Day RM	Day RN Day RM	Day CSW Day MSW	Day CSW Day MSW	Night RN Night RM	Night RN Night RM	Night CSW Night MSW	Night CSW Night MSW						Actual CHPPD		
Ward	Plan	Actual	Plan	Actual	Plan	Actual	Plan	Actual	Qual Day	UnQual Day	Qual N	UnQual N	Sum 24:00 Occ	Registered	Care staff	Total
Evergreen																
A2	279	227	265	219	186	176	234	221	81%	83%	95%	94%	1,168	4.14	4.52	8.66
A3																
A4																
B1	135	99	62	45	93	66	63	43	73%	72%	71%	68%	440	4.26	2.39	6.65
B2(H)	158	108	214	176	124	88	194	176	68%	82%	71%	91%	760	3.03	5.56	8.58
B2(T)	119	99	144	123	93	66	108	103	83%	86%	71%	95%	663	2.98	4.10	7.08
B3	272	165	189	174	216	171	165	160	61%	92%	79%	97%	920	4.39	4.36	8.75
B4	247	194	255	247	186	150	197	184	78%	97%	81%	93%	1,354	2.97	3.82	6.80
B5	224	179	165	149	189	186	102	95	80%	90%	98%	93%	619	7.08	4.72	11.80
B6																
C1	247	171	279	266	186	150	199	188	69%	95%	80%	95%	1,456	2.64	3.74	6.39
C2	266	236	81	74	187	173	33	33	89%	92%	92%	100%	547	8.75	2.01	10.76
C3	225	203	372	331	187	161	376	366	91%	89%	86%	97%	1,581	2.76	5.29	8.06
C4	164	153	62	65	124	105	63	76	93%	104%	85%	121%	655	4.60	2.58	7.18
C5	236	145	262	269	186	146	190	195	62%	103%	79%	103%	1,432	2.44	3.85	6.29
C6	117	103	66	56	62	62	74	63	88%	85%	100%	85%	501	3.95	2.85	6.79
C7	243	179	187	157	149	119	151	134	74%	84%	80%	89%	1,080	3.15	3.16	6.30
C8	353	217	240	202	282	177	227	219	62%	84%	63%	96%	1,260	3.67	4.01	7.68
CCU_PCCU	237	174	62	52	217	152	33	33	74%	84%	70%	100%	636	6.15	1.60	7.76
Critical Care	430	379	86	60	419	333	1	1	88%	70%	80%	100%	257	32.51	2.73	35.23
EAU	275	219	323	297	258	241	327	299	80%	92%	93%	91%	1,168	4.73	6.12	10.86
Maternity	926	876	223	195	527	509	155	142	95%	88%	97%	92%	432	29.35	9.15	38.51
MHDU	161	132	41	39	154	116			82%	96%	75%		190	15.30	2.17	17.46
NNU	192	140			186	175			73%		94%		407	9.12	0.00	9.12
TOTAL	**5,508**	**4,399**	**3,575**	**3,197**	**4,210**	**3,522**	**2,892**	**2,731**	**80%**	**89%**	**84%**	**94%**	**17,526**	**5.14**	**4.03**	**9.17**

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	A	S	O	N	D	J	F	M	A	M	J	J
Med/Int Care	Wards - Medicine	383.33	244.49	138.84	16.34	5.31	28.13	37.59	(1)	1	18	(2)	(2)	(2)	(2)	(1)	(2)	(2)	(2)	(2)
Surgery	Wards - Surgery	248.88	180.51	68.37	10.80	10.82	16.81	25.43	(1)	(1)	10	(1)	(1)	(1)	(1)	1	(1)	(1)	(0)	(1)
Med/Int Care	Specialist Areas Medicine	41.23	38.44	2.79	2.37	2.22	1.34	0.35	(0)	(0)	2	(0)	(0)	(0)	(0)	(0)	(0)	(0)	(0)	(0)
Surgery	Specialist Areas Surgery	40.69	35.42	5.27	1.21	2.80	1.16	0.46	(0)	(0)	2	(0)	(0)	(0)	(0)	(0)	(0)	(0)	(0)	(0)
Med/Int Care	ED	85.02	63.11	21.91	5.59	4.80	6.00	14.46	1	1	9	(0)	(0)	(0)	(0)	2	(0)	(0)	(0)	(0)
Surgery	Theatres	118.84	89.84	29.00	1.54	1.99	13.37	5.88	(1)	0	2	(1)	(1)	(1)	(1)	(1)	(1)	(1)	(1)	(1)
Surgery	Critical Care	76.35	60.40	15.95	0.99	4.87	4.72	10.86	(0)	(0)	5	(0)	(0)	(0)	(0)	1	(0)	(0)	(0)	(0)
Surgery	Maternity Unit	105.40	100.72	4.68	3.59	6.77	3.27	0.00	(1)	(1)	(1)	(1)	(1)	(1)	(1)	(1)	(1)	(1)	(1)	(1)
Med/Int Care	Community Nursing	152.34	147.46	4.88	0.00	0.00	5.31	0.00	(1)	(1)	4	(1)	(1)	(1)	(1)	(0)	(1)	(1)	(1)	(1)
Med/Int Care	All Other Med / Int Care Teams	263.68	239.96	23.72	0.00	0.00	9.02	5.79	(2)	(2)	1	(2)	(2)	(2)	(2)	2	(2)	(2)	(2)	(2)
Surgery	All Other Surgery Teams	148.83	149.50	(0.67)	0.00	0.00	3.36	0.43	(1)	(1)	2	(1)	(1)	(1)	(1)	3	(1)	(1)	(1)	(1)
Corp	All Corp Teams	87.78	79.38	8.40	0.00	0.00	0.70	0.00	(1)	(1)	(1)	(1)	(1)	(1)	(1)	(1)	(1)	(0)	(0)	(0)
Total		**1,752.37**	**1,429.23**	**323.14**	**42.43**	**39.58**	**93.19**	**101.25**	**(8)**	**(5)**	**55**	**(10)**	**(10)**	**(10)**	**(10)**	**6**	**(10)**	**(10)**	**(9)**	**(9)**

Appendix 3 - CSW Predictor tool.

CSW PREDICTOR TOOL (Band 2/3)	Actual Apr-18	Actual May-18	Actual Jun-18	Predicted Jul-18	Predicted Aug-18	Predicted Sep-18	Predicted Oct-18	Predicted Nov-18	Predicted Dec-18	Predicted Jan-19	Predicted Feb-19	Predicted Mar-19
Minimum Establishment	463.86	463.86	463.86	463.86	463.86	463.86	463.86	463.86	463.86	463.86	463.86	463.86
Maximum Establishment	538.55	538.55	538.55	538.55	538.55	538.55	538.55	538.55	538.55	538.55	538.55	538.55
Staff in Post at Start of Month	**504.22**	**508.92**	**508.92**	**511.22**	**511.93**	**505.64**	**518.35**	**518.06**	**511.77**	**505.48**	**519.19**	**512.90**
Starters (predicted from active recruitment	3.00	4.00	2.00	7.00	0.00	19.00	6.00	0.00	0.00	20.00	0.00	0.00
Leavers	-3	-4	-2.7	-6.29	-6.29	-6.29	-6.29	-6.29	-6.29	-6.29	-6.29	-6.29
Other**	4.7		3									
Staff in Post at End of Month	**508.92**	**508.92**	**511.22**	**511.93**	**505.64**	**518.35**	**518.06**	**511.77**	**505.48**	**519.19**	**512.90**	**506.61**
Predicted Vacancies Minimum Establishment	-45.06	-45.06	-47.36	-48.07	-41.78	-54.49	-54.20	-47.91	-41.62	-55.33	-49.04	-42.75
Predicted Vacancy % Rate (Minimum Estab.)	-9.7%	-9.7%	-10.2%	-10.4%	-9.0%	-11.7%	-11.7%	-10.3%	-9.0%	-11.9%	-10.6%	-9.2%
Predicted Vacancies Maximum Establishment	29.63	29.63	27.33	26.62	32.91	20.20	20.49	26.78	33.07	19.36	25.65	31.94
Predicted Vacancy % Rate (Maximum Estab.)	5.5%	5.5%	5.1%	4.9%	6.1%	3.8%	3.8%	5.0%	6.1%	3.6%	4.8%	5.9%

Enclosure 11

The Dudley Group
NHS Foundation Trust

Paper for submission to the Board of Directors on 6th September 2018

TITLE:	**Nursing/Midwifery Revalidation**		
AUTHOR:	Derek Eaves Professional Lead for Quality	**PRESENTER**	Siobhan Jordan Chief Nurse

CLINICAL STRATEGIC AIMS

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

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

SUMMARY OF KEY ISSUES:

Nursing/Midwifery Revalidation was introduced in April 2016. The system at the Trust has been running smoothly since then. All staff have provided the relevant evidence with a small number having their exceptional circumstances (e.g. long term sickness) agreed by the Nursing and Midwifery Council which means they only have to undertake the full revalidation process after a further three years.

At the meeting in July when a paper on this topic was tabled, a request for further information was made by the Board. The purpose of this paper, which provides an outline of the NMC system for revalidation, is intended to cover that request for further information on the process.

IMPLICATIONS OF PAPER:

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

ACTION REQUIRED OF BOARD:

Decision	Approval	Discussion	Other
		✓	

RECOMMENDATIONS FOR THE BOARD: The Board is asked to note the NMCs system for revalidation and the latest position with revalidation at the Trust.

THE DUDLEY GROUP NHS FOUNDATION TRUST

NURSING/MIDWIFERY REVALIDATION

Revalidation is the process that allows nurses and midwives to maintain their registration with the NMC. Every year a nurse or midwife has to re-register with the NMC which entails the payment of a fee. Every third year this re-registration has to be accompanied by the nurse or midwife stating that the required evidence for revalidation has been collected and that this has been confirmed by another individual. As part of the revalidation process, all nurses and midwives need to meet a range of requirements designed to show that they are keeping up to date and actively maintaining their ability to practise safely and effectively.

Completing the revalidation process is the responsibility of nurses and midwives themselves. They are the owners of their own revalidation process.

As the NMC clearly states revalidation is not an assessment of a nurse or midwife's fitness to practise, a new way to raise fitness to practise concerns or an assessment against the requirements of their employment. There is a completely different process to be undertaken if there are concerns about a nurse's or midwife's fitness to practice. In effect, therefore, a nurse/midwife may be within the fitness to practice process but still able to revalidate.

Revalidation includes requirements which requires nurses and midwives to seek feedback from patients, service users and colleagues, consider the role of the NMC Code (reference below) in their practice by having a reflective discussion with another nurse or midwife and, importantly, seek confirmation that they have met those requirements from an appropriate person.

The specific requirements are that the nurse of midwife should have the following evidence from the previous three years:

- 450 practice hours or 900 hours if revalidating as both nurse and midwife
- 35 hours of Continuing Professional Development (CPD) with at least 20 of the 35 hours include participatory learning relevant to their practice as a nurse or midwife
- Five pieces of practice-related feedback
- Five written reflective accounts on their CPD and/or practice-related feedback and/or an event or experience in their practice and how this relates to the NMC Code. Each account must be written on the NMC reflective account form.
- Reflective discussion. A completed and signed NMC form recording that the nurse or midwife has discussed their reflective accounts with another NMC-registered nurse or midwife.

The NMC has guidelines for the nurse or midwife on choosing who will confirm the above evidence and encourages the nurse or midwife to ask their line manager to undertake the confirmation process and that this is undertaken as part of the managerial appraisal process. There is no specific rule for this and so the nurse or midwife can in fact choose other individuals to undertake the confirmation process. It can be seen from this that the Trust itself has no specific role in the confirmation process. The Trust has however encouraged nurses and NMC registered line managers to have confirmation as part of the appraisal process. Some nurses in the Trust have non-NMC registered line managers and so the Trust has provided NMC registered senior staff to undertake confirmation for these nurses. The Trust has also provided training to confirmers to ensure that they are familiar with the process.

Once confirmation has occurred, the nurse of midwife informs the NMC on line of the details of the confirmation and confirmer as part of the re-registration process. The NMC has an audit system when it may contact the registrant or confirmer for further details. The Trust is informed that the nurse has been re-registered (and hence every third year by implication that the nurse has revalidated) directly through the Electronic Staff Record (ESR) system.

In preparation for confirmation, all managers are told of all of their staff revalidation dates and informed in advance on a monthly basis by email of their staff who are due to revalidate in two months time so that they can remind those staff about the need to have their evidence confirmed and arrange the actual confirmation of evidence.

Once the confirmers have confirmed the evidence they email an internal address with the date that this is done and a Trust database is updated (a reminder system is in place when confirmers do not respond).

With regards to numbers, the following chart shows the number of confirmations that have occurred (which have resulted in revalidation) and are due to occur for the calendar year. The date allocated for revalidation is based on the month of the year that the individual first joined the register (hence the large number in September when most student courses end). As well as the monthly emails of lists of their staff that require confirmation that are sent to all Lead Nurses/Midwives and Matrons, they have been further informed about the large number in September so that they can commence those confirmations well in advance.

	Total Number of Staff revalidated following confirmation		Total Number of Staff who require confirmation
January 2018	20	July 2018	24
February 2018	30	August 2018	24
March 2018	12	September 2018	156
April 2018	8	October 2018	28
May 2018	11	November 2018	26
June 2018	10	December 2018	14

The Trust has been proactive in ensuring all registered staff are aware of their responsibilities in respect to confirmation and revalidation and has publicised this issue extensively. There is a section on the Trust intranet given over to this topic.

The Code: Professional standards of practice and behaviour for nurses and midwives,

NMC, 2015.

Enclosure 12

The Dudley Group
NHS Foundation Trust

Paper for submission to the Board of Directors on 9 September 2018

TITLE:	Patient Experience Report – Quarter 1, 2018/19		
AUTHOR:	Jill Faulkner Head of Patient Experience Helen Board, Patient & Governor Engagement Lead Lara Fullwood, Senior complaints Co-ordinator	**PRESENTER:**	Siobhan Jordan Chief Nurse
CORPORATE OBJECTIVE: SO1: Deliver a great patient experience			

SUMMARY OF KEY ISSUES:

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

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

This report covers the period April to June 2018 referred to as Quarter 1 (Q1). The aim of this report is to detail the multiple forms of patient feedback received and to evidence actions being taken to continually focus and improve the care we deliver and the experience received by both the patient and their family.

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

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

RECOMMENDATIONS FOR THE BOARD OF DIRECTORS:

To note the content of the Q1 Patient Experience report.

1. Introduction

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

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

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

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

The **Patient Experience Improvement Group (PEIG)** is held on a fortnightly basis. This meeting is well attended with representation from across the Trust. We have also extended the invitation to attend to the Non-Executive Directors.

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

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

Survey name	Last undertaken	Next survey date
Adult Inpatients Survey (National)	July 2017	July 2018
Cancer Patient Experience Survey (National)	April – June 2017	April – June 2018
Children & Young People Survey (National)	January/February 2016	January/February 2019
Community Services	Q4 2017/18	Q4 2018/19
Dementia	Using feedback from PLACE/National Audit 2017	Ongoing
Emergency Department Survey (National)	October 2016	October 2018 tbc
End of Life/VOICES	Continual	Continual
Guest Outpatient Centre Review	March 2018	Tbc
Maternity Survey (National)	February 2018	February 2019 tbc
Mini PLACE assessment activity	July 2018	September 2018
PLACE (National)	April 2018	April 2019

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

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

Within Q1 we successfully:

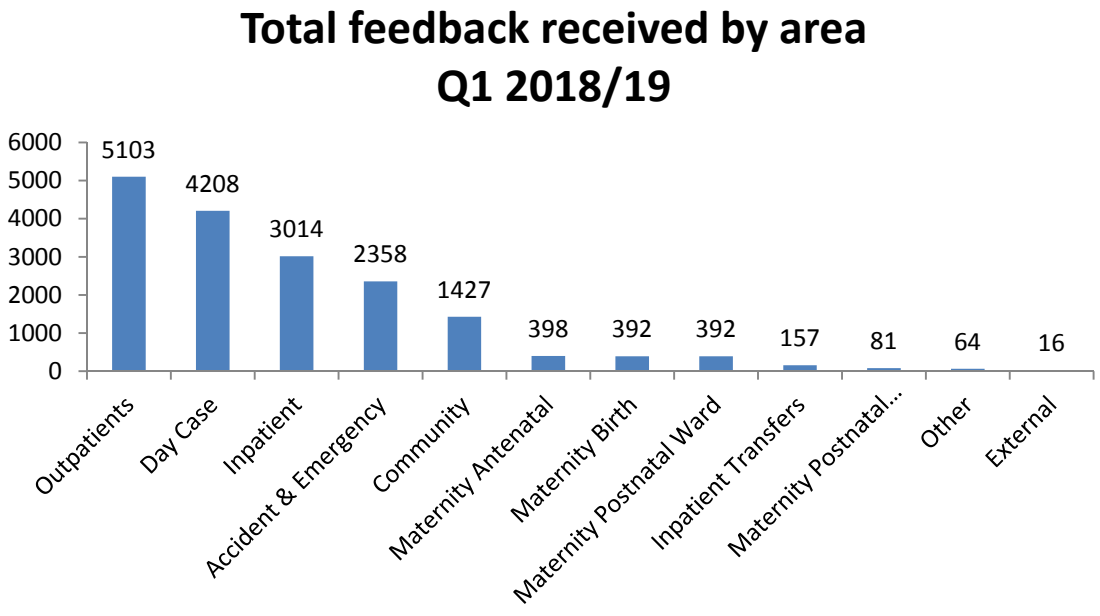
- Completed the replacement of outdated and unreliable car parking pay machines and car park equipment at each of the Trust sites. This has a significant impact on our patient experience.
- Installed LED sky ceiling panels with a cloud and sky scene in five of our wards to help provide a relaxing and calming environment
- Purchased additional new digital reminiscence therapy software R.I.T.A. and provided to areas across Russells Hall Hospital
- Developed survey for patients receiving specialist palliative care services
- Confirmed arrangements for visual impairment training for all staff attending the corporate induction
- Reviewed signage at Corbett Outpatient Centre and updated and replaced as needed
- Identified charitable funds to provide vending for hot and cold drinks in the C4 oncology day case waiting area
- Commenced rollout of new food service trollies for inpatient areas
- Expanded the attendance at the Patient Experience Improvement Group to include HCA, podiatry, discharge co-ordinators and infection prevention and control representatives
- Support the wider Trust to deliver patient experience actions

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

- Accessibility listening event

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

Patient feedback
The Trust received 17,610 pieces of feedback during Q1 in comparison to 16,550 received in the previous quarter. This included responses to the Friends and Family Test (FFT) utilising a variety of mediums such as paper, SMS, App and the web. Additionally we collate feedback through real time Surveys, NHS Choices, complaints, compliments and PALS.



2. National Survey Programme

2017 Adult Inpatient Survey results

The Trust received the initial findings of the 2017 Adult Inpatient Survey at the end of January 2018. The results of were published on the CQC website on 13 June 2018 and overall show a slightly improving picture when compared to our previous year's performance The Trusts Overall Patient Experience Score OPES) was 7.9 (Nationally, the OPES ranged from the lowest trust score in England of 7.5 to the highest trust score in England of 9.2) and ranked 134 out of 148 trusts nationally (compared to 139 out of 149 trusts in 2016).

The Dudley Group is not listed as an outlier in the 2017 Adult Inpatient Survey.

The Trust response rate is 39% compared to a national response rate of 41% which sampled 1250 patients discharged from hospital during July 2017.

This report benchmarks our performance against trusts nationally (appendix 1) and shows:

- Eight out of the 11 sections were 'about the same' as other trusts nationally.
- We were 'worse' in two sections – the hospital and ward, overall views of care and services.
- There was no score published in the 'leaving hospital' section*

The table at appendix 1 illustrates our ratings since 2014, where we have maintained 'about the same' in the majority of sections with notable exceptions of overall views of care and services in 2017. In 2016 the Trust performed worse in three of the eleven sections which includes questions about nurses, operations and procedures and leaving hospital.

The 2016 results have been used to deliver a host of improvement actions of which some will not have yet had the chance to positively impact on the survey. It is therefore anticipated that the 2018 survey (scheduled to sample 1250 patients discharged during July 2018) will reflect greater improvement in scores.

The full report can be accessed on the CQC website:
https://www.cqc.org.uk/publications/surveys/surveyspatient experience page on the Hub.

3. Friends and Family Test (FFT)

FFT gives patients the opportunity to submit feedback to providers of NHS funded care or treatment, using a simple question which asks how likely (on a scale ranging from extremely likely to extremely unlikely) they are to recommend the service to their friends and family if they needed similar care or treatment.

Improving FFT response rates across all areas remains a focus with improvements seen following the expansion of the SMS FFT survey solution to all areas. The Patient Experience team continues to work with all areas to support initiatives to improve the response rate.

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

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

RAG rating legend – response rate

Area	Below national average	Equal to or above national average	Equal to the top 20% of trusts nationally
Community	<=3.4%	>=3.5% - 9.0%	9.1% +
Emergency Department Services (ED)	<=14.1%	>=14.5-21.2%	21.3%+
Maternity - Ante Natal	<=21.6%	>=21.7% - 34.3%	34.4% +
Maternity - Births	<=21.6%	>=21.7% - 34.3%	34.4% +
Maternity - Community	<=21.6%	>=21.7% - 34.3%	34.4% +
Maternity - Wards	<=21.6%	>=21.7% - 34.3%	34.4% +
Maternity – Combined	<=21.6%	>=21.7% - 34.3%	34.4% +
Outpatients	<=4.6%	>=4.7% - 14.4%	14.5% +
Inpatients	<=25.9%	>=26% - 34.4%	35.1% +

Community Services Response rates

	2017						2018					
Ward	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
Community Nursing Services	10.7%	6.1%	3.7%	11.3%	10.8%	9.6%	7.4%	9.2%	6.9%	5.3%	4.9%	5.7%
Rehabilitation & Therapy Services	0.6%	2.7%	1.7%	3.4%	4.2%	2.8%	2.7%	3%	2.6%	2.1%	2.8%	4.5%
Specialist Services	0.3%	0.6%	0.3%	0.4%	1.2%	0.7%	0%	0.3%	0.6%	1.6%	0.3%	0.4%
Overall	**3.3%**	**3.2%**	**1.9%**	**4.9%**	**5.2%**	**4.3%**	**3.3%**	**4%**	**3.4%**	**2.9%**	**3%**	**4.2%**

ED services Response Rates

	2017						2018					
Ward	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
Acute Medical Unit						75%	69.9%	100%	100%	49.6%	45%	44.2%
Emergency Ambulatory Care												
Emergency Assessment Unit	55.4%	60.1%	63.5%	72.9%	86.2%							
Emergency Department	11.3%	12%	15.9%	24.7%	20.6%	13.5%	16.9%	16.4%	14.9%	14.4%	14.5%	15.2%
Overall	**15.3%**	**16%**	**19.6%**	**28.5%**	**24.7%**	**17%**	**21.2%**	**22.6%**	**19.5%**	**17.9%**	**18%**	**19.1%**

Maternity services Response Rates

	2017						2018					
Ward	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
Antenatal	76%	100%	96.1%	64.1%	56.6%	16.4%	47.8%	68.6%	42.7%	20.4%	91.4%	70.2%
Birth	47.5%	53.2%	27.8%	35.7%	53.9%	28.4%	39.2%	28.5%	41.2%	40%	38%	33.6%
Postnatal Community	17.1%	36.3%	21.6%	7%	7.1%	14.5%	27.8%	19.8%	9.7%	1.3%	15.3%	19.5%
Postnatal Ward	47.3%	52.4%	27%	35.1%	53.2%	28.5%	38.3%	29%	41.5%	39.8%	37.5%	34%
Overall	**48.6%**	**56.3%**	**39.6%**	**34.8%**	**45.1%**	**23.6%**	**38.4%**	**35.9%**	**36.3%**	**30.3%**	**43.2%**	**37.9%**

Outpatient services Response Rates

	2017						2018					
Ward	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
Outpatients	2.6%	4.8%	2.9%	10.9%	5.9%	3.5%	5.9%	4.4%	4.6%	4.9%	5.7%	5.1%
Overall	**2.6%**	**4.8%**	**2.9%**	**10.9%**	**5.9%**	**3.5%**	**5.9%**	**4.4%**	**4.6%**	**4.9%**	**5.7%**	**5.1%**

Inpatients services Response Rates

Ward	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
A1												
A2	15.3%	7.7%	1.5%	17.8%	4.2%	1.9%	2.2%	1.7%	2.4%	3.5%	18.7%	20.5%
A3												
A4												
B1	34.6%	51.1%	55.6%	73.5%	61.3%	50.3%	45.6%	58.4%	63.8%	41.3%	37.7%	53%
B2 Hip	36.3%	23.8%	22.8%	32%	19.1%	32.8%	38.4%	55.3%	40.7%	43.8%	36.6%	37.9%
B2 Trauma	100%	100%	74.4%	100%	100%	100%	100%	88.8%	78.5%	93.7%	76.9%	100%
B3	21.9%	21.3%	18.5%	29.4%	36.3%	27.8%	30.5%	29.1%	27%	48.1%	25.3%	52.2%
B4	37.5%	21.5%	35.4%	50.2%	39.7%	37.2%	50.7%	34.7%	35.1%	60.2%	51.2%	51.9%
B5	70.6%	19.4%	29.3%	52.7%	56.9%	54.1%	48.2%	48.2%	39.8%	38.1%	43.7%	66.3%
B6				48.4%	3.2%	33.3%	5.3%	0%	0%	10.6%	5.8%	26.1%
C1	31.2%	8.9%	22.8%	61.5%	38.7%	19.8%	21.9%	34.8%	34%	55.2%	20.8%	43.6%
C2	20.9%	30.5%	11.9%	16.3%	19.1%	26.1%	14.6%	8.4%	17.4%	16.6%	23.9%	43.3%
C3	40.2%	62.8%	58%	53.3%	40.7%	13.8%	46%	50%	38.5%	79.5%	63%	53.4%
C4	59.1%	40%	38.4%	38.8%	48%	60%	49%	56.8%	62.5%	70.3%	68.8%	55.3%
C5	48.7%	23.6%	50.3%	50.5%	54.7%	45.1%	40.8%	22.9%	19.7%	21.3%	26.8%	22.8%
C6	30.6%	32.8%	21.6%	32.9%	33.9%	25.5%	38.8%	31%	69.2%	60.5%	46.7%	61%
C7	31.7%	38.7%	27.3%	36.2%	27.3%	29.8%	34.4%	27.3%	24.2%	45.4%	19.3%	23.1%
C8	16.4%	40.9%	28.2%	21%	29.8%	13.4%	6.1%	7.5%	28.7%	30.2%	18.6%	31.1%
CCU & PCCU	27.2%	23.4%	6.2%	30.8%	26.9%	18.9%	17%	25.5%	20.4%	29.7%	25.2%	27.6%
Day Case	33.2%	34.6%	29.6%	32%	32.3%	30.2%	30.2%	38.1%	36.6%	28.9%	32.4%	41.3%
Evergreen	61.4%	41%	15.6%	4.3%								
ITU		100%	100%	100%	100%	0%	33.3%	100%	66.6%	100%	0%	0%
MHDU	50%	40%	16.6%	46.1%	42.8%	72.7%	100%	30%	33.3%	100%	66.6%	90.9%
Neonatal	61.1%	31.4%	31.5%	6.1%	100%	65%	54.9%	42.8%	41.1%	40%	55.8%	55.2%
SHDU			100%	100%	100%	0%	33.3%		100%	100%	100%	100%
Overall	34.2%	32.3%	27.8%	33.9%	33.9%	30.9%	30.1%	34.6%	34.9%	32.2%	33%	42.4%

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

The FFT percentage recommended scores for Q1 are as follows:

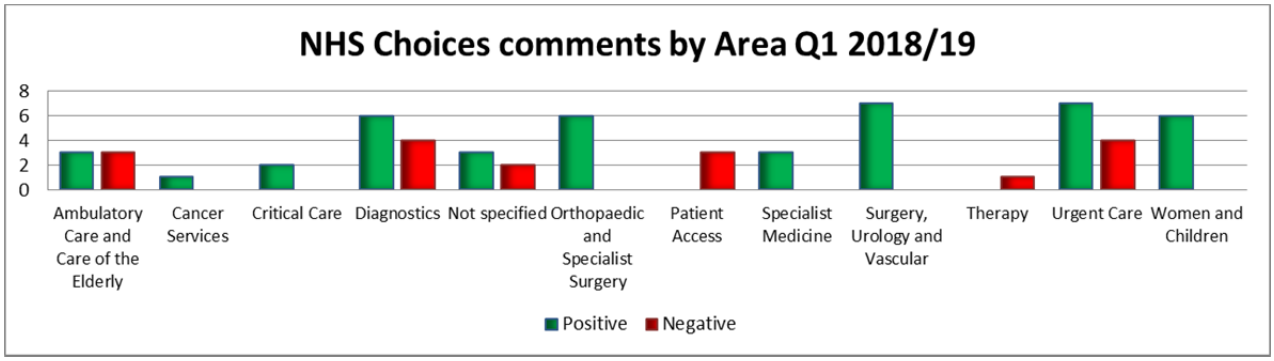
Percentage recommended FFT Scores	Apr 18	May 18	Jun 18**
Inpatient	**95**	**93.7**	**94.4**
National	96	96	**
A & E	**82**	**77.8**	**77.1**
National	87	87	**
Maternity Antenatal	**98**	**97.5**	**100**
National	97	95	**
Maternity Birth	**99**	**97.8**	**96.5**
National	97	97	**
Maternity Postnatal Ward	**98**	**95.6**	**96.5**
National	95	95	**
Maternity Postnatal Community	**98**	**100**	**100**
National	*	98	**
Community	**96**	**95.3**	**96.7**
National	96	95	**
Outpatients	**90**	**89.4**	**90.5**
National	94	94	**

**no national data available **local results. National data available mid August.*

4. NHS Choices

In Q1 61 people uploaded feedback electronically to NHS Choices or Care Opinion, (64 in Q4 2017/18). Of those 61 comments, 72% (68% in Q4 2017/18) were positive and 28% (32% in Q4 2017/18) were negative. Table 1 below details the comment received by area (where identified) for Q1.

Table 1



5. Complaints

The Trust received 122 complaints during Q1 equal to that received in Q4 17/18 (122) compared to 101 in Q3. This is a 0% increase compared to the previous quarter and a 21% increase from Q3.

Two key metrics within the complaints service is that:

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

The table below shows complaints activity and total number of complaints open as at 30 June 2018:

Complaints outstanding as of 30 June 2018	Complaints received in June 2018	Complaints Closed in June 2018	Complaints brought forward	Complaints overdue as of 30 June 2018
204	38	46	204	139

The table below details the length of time that complaints have been open (not as yet closed) as of 30 June 2018.

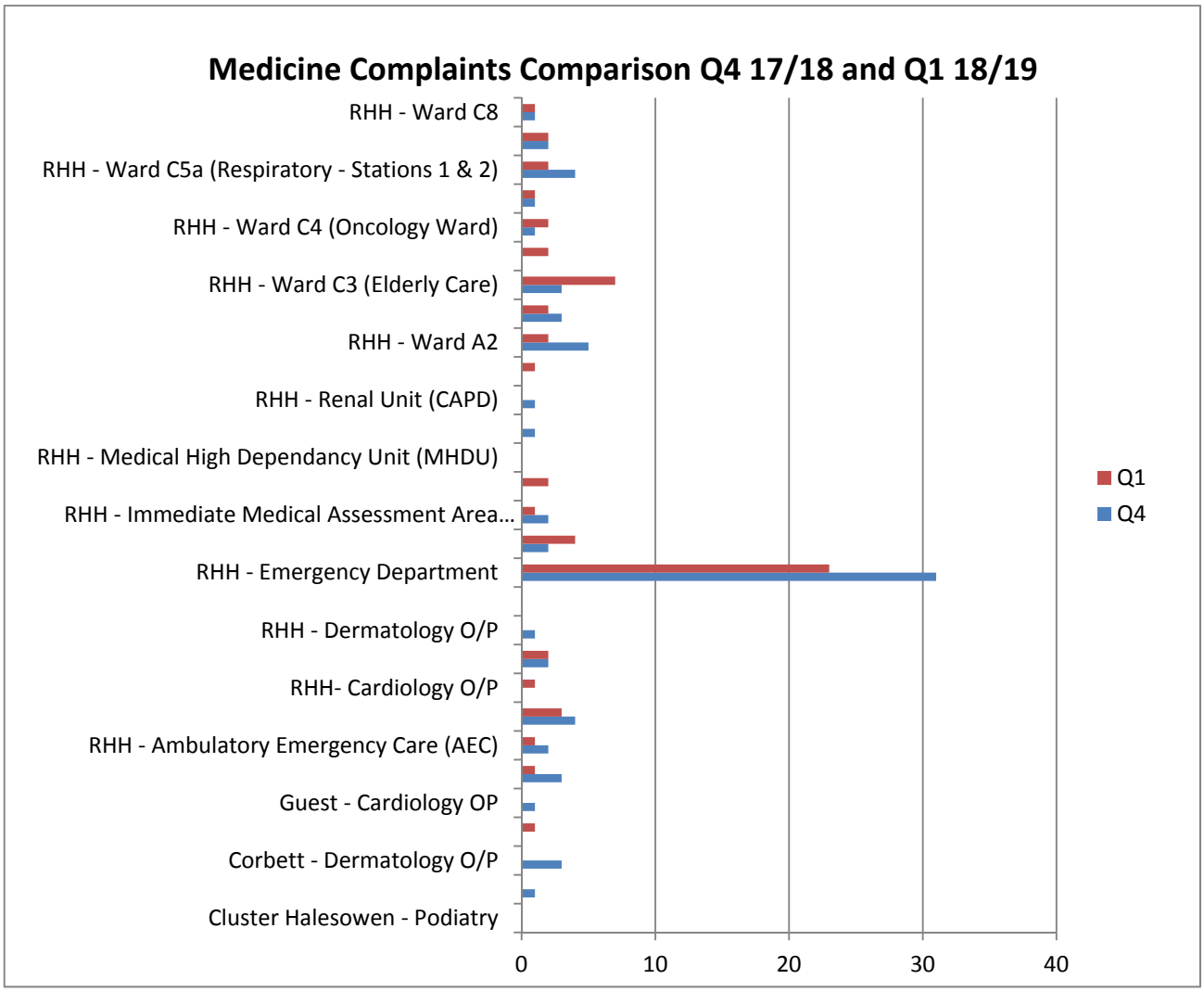
0 – 28 working days	29 – 40 working days	41 – 60 working days	61 – 100 working days	101 – 280 working days
48	17	28	36	75

The Trust had 235,891 clinical patient contacts in Q1 which equates to 0.0517% of patients/families making a complaint. The divisional performance during Q1 is as follows:

- Surgery Division received 52 complaints
- Medicine & Integrated Care Division received 63 complaints
- Clinical Support Division received 4 complaints
- Other 3 complaints (Corporate Services (including IT), Corporate Nursing Division (not wards) and External)

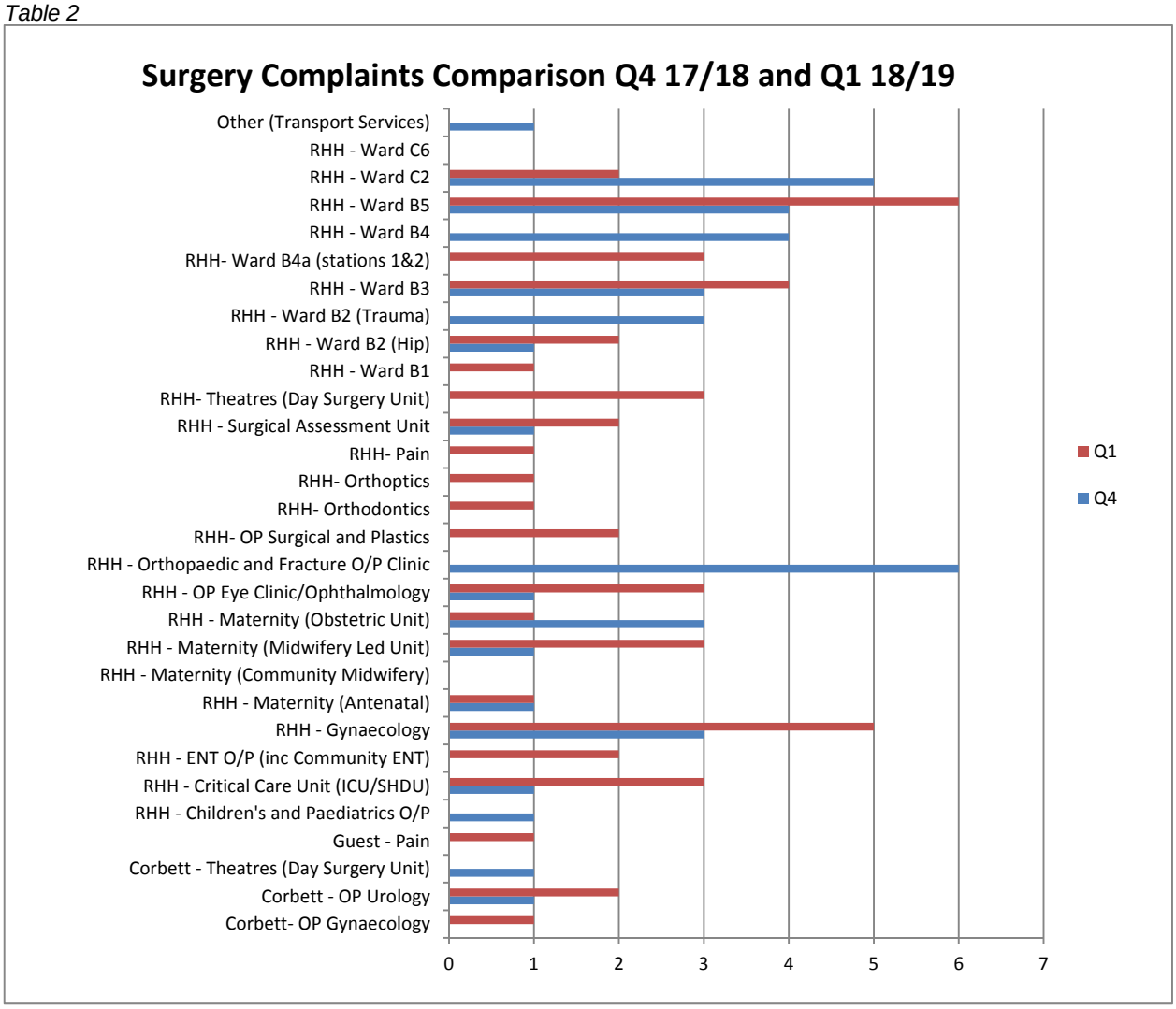
The following graphs illustrate complaints received within the division and which specific area of the Trust. They also demonstrate a comparison between Q1 and Q4 17/18.

Table 1



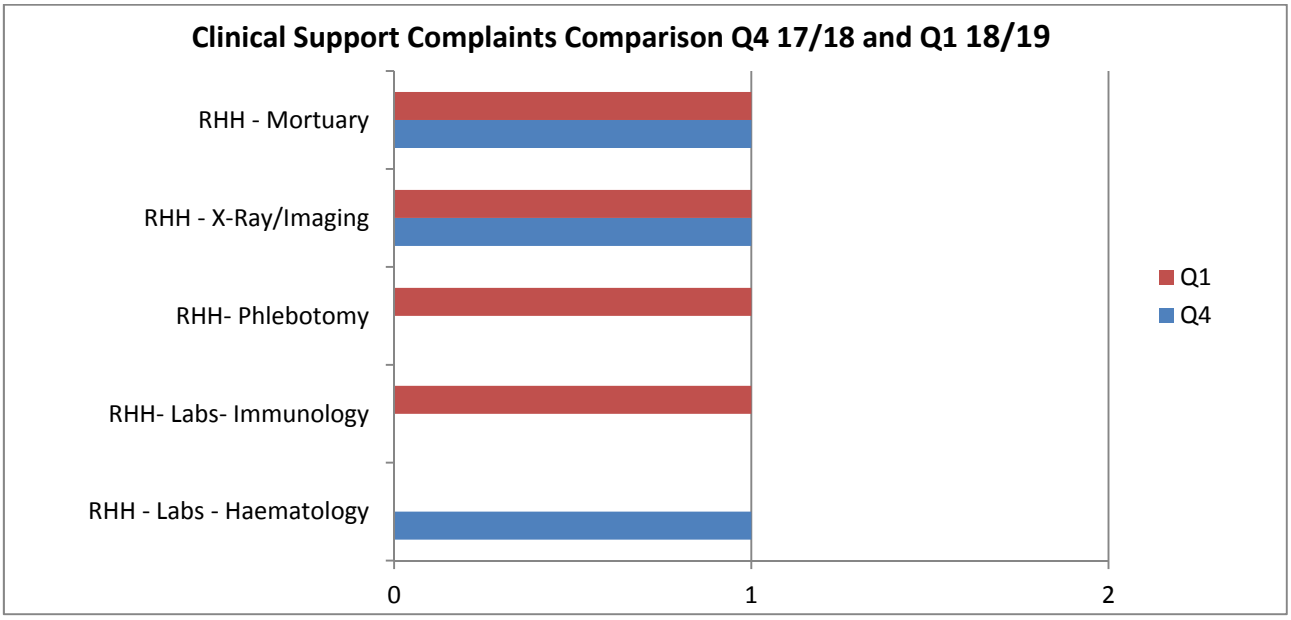
The Emergency Department has seen a decrease in complaints received. Ward C3 and GI Unit have seen an increase in complaints received. The Head of Patient Experience and the Senior Complaints Coordinator discuss complaints received on a weekly basis with Divisions.

Table 2



There has been an increase in complaints received regarding gynaecology and ward B5. Wards B2 (Hip), B3, B4a (stations 1 & 2), ophthalmology and the critical care unit have also seen an increase. The Head of Patient Experience and the Senior Complaints Coordinator discuss complaints received on a weekly basis with Divisions.

Table 3



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

There have been two complaints received relating to corporate services (RHH- PALs and RHH-security team (maternity/Trust) and one for corporate nursing division (RHH-safeguarding).

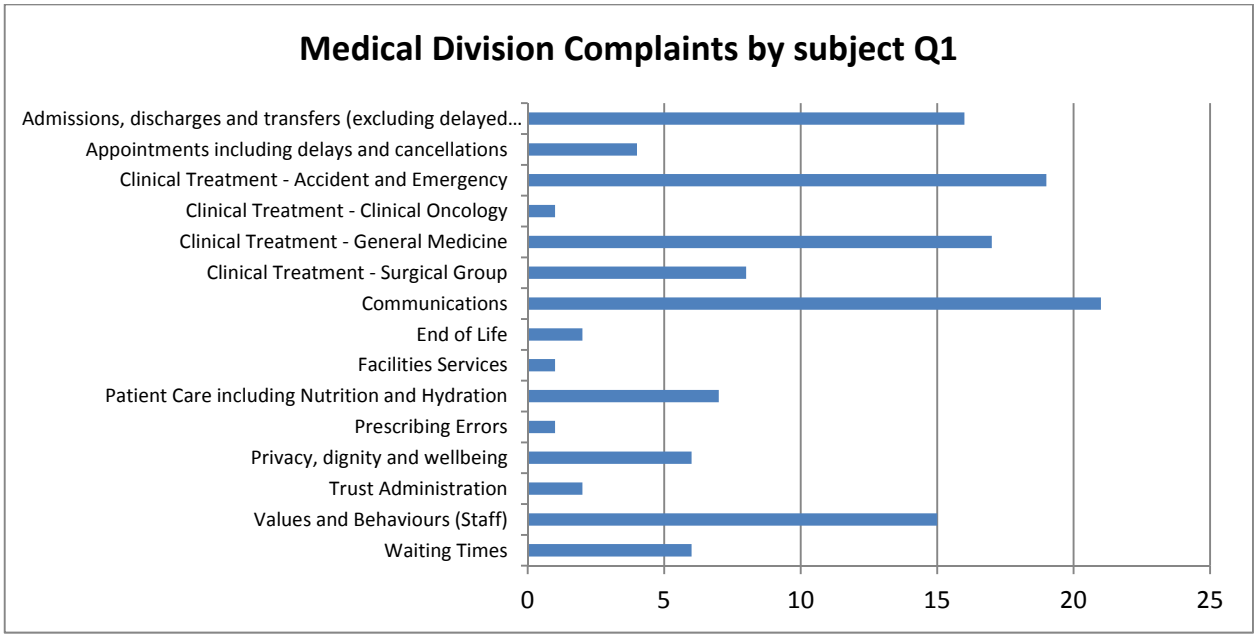
Medicine & Integrated Care Division

During Q1, a total of 63 complaints were received by the Medical & Integrated Care Division which indicates a decrease of 14.86% from Q4, 2017/18 (74) and 70.27% increase (37) for the same period last year (Q1, 2017/18). The Emergency Department has seen the most raise in complaints during Q1, 2018/19 (23) compared with Q1, 2017/18 (11).

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

Table 4, details complaints received by subject.

Table 4



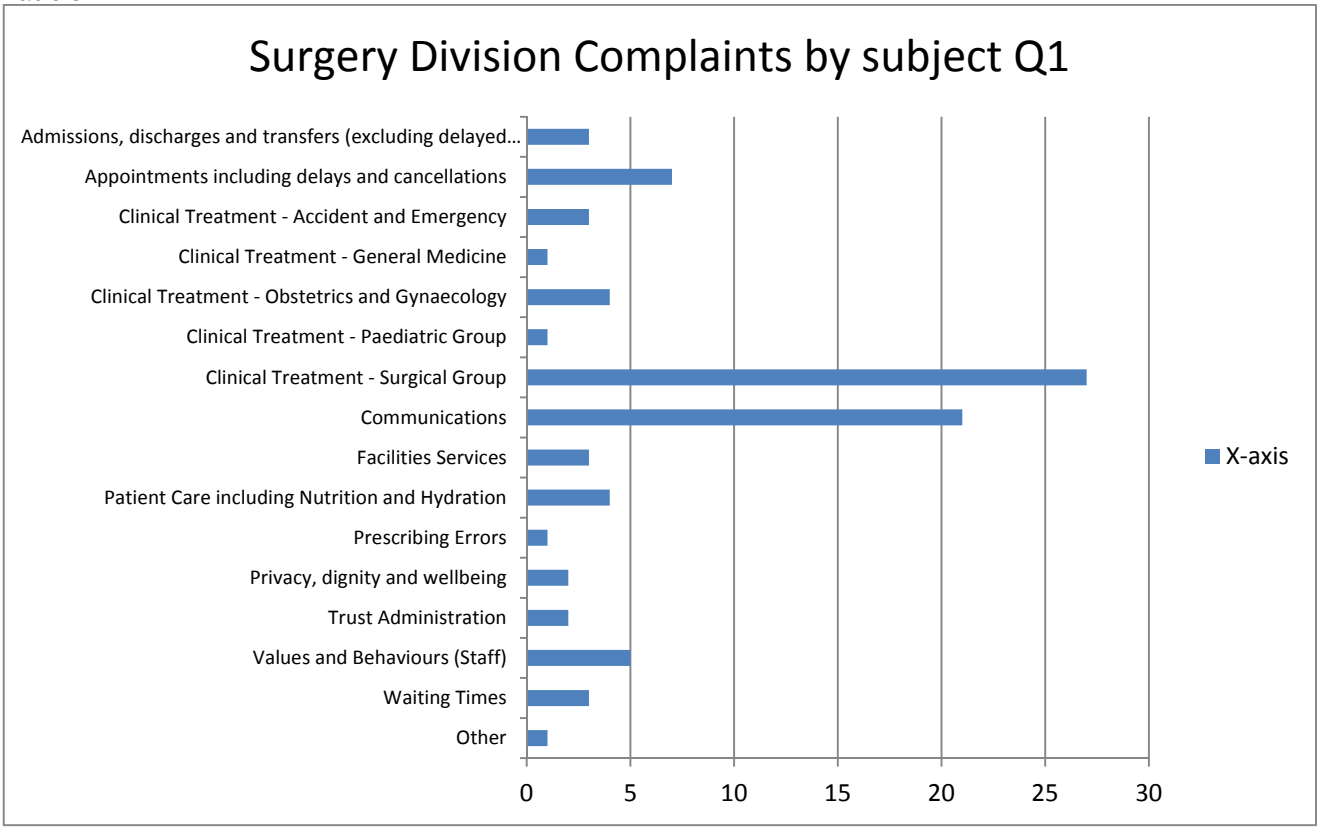
Surgery Division

During Q1, a total of 52 complaints were received by the Surgical Division which indicates an increase of 23.81% from Q4, 2017/18 (42) and 62.5% increase (32) for the same period the previous year (Q1, 2017/18). Further analysis has identified that the gynaecology department have seen an increase in complaints from Q1, 2017/18 (1) compared to Q1, 2018/19 (5) and ward B5 has increased from Q1, 2017/18 (2) compared to Q1, 2018/19 (6).

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

Table 5, details complaints received by subject.

Table 5

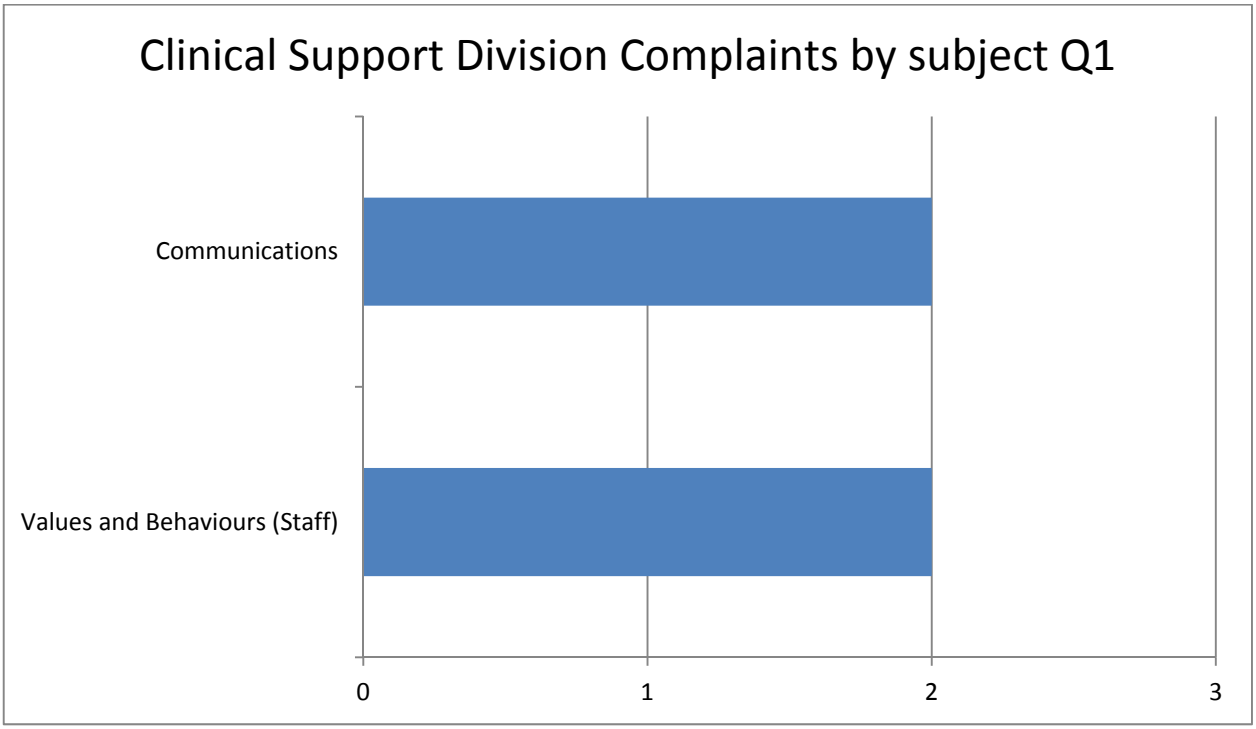


Clinical Support Division

During Q1, a total of 4 complaints were received by the Clinical Support Division which indicates a 33.3% increase from Q4, 2017/18 (3).

Table 6, details complaints received by subject.

Table 6



Complaint Themes

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

Themes Q1 18-19	
Communications	44
Clinical Treatment - Surgical Group	28
Values and Behaviours (Staff)	24
Admissions, discharges and transfers (excluding delayed discharge due to absence of package of care)	19
Clinical Treatment - Accident and Emergency	19

Reopened Complaints

During Q1, the Trust received correspondence from 14 complainants who were dissatisfied with their original complaint response from the Trust.

This included clinical discrepancies within the initial response letter and complainants stating that some of their initial concerns have not been resolved. The complaints were initially closed in Q4, 2017/18 and Q1, 2018/19. Out of the 14 reopened complaints, five have now been responded to with five requesting a local resolution meeting which are being arranged.

These related to:

- Medicine & Integrated Care Division 10
- Surgery Division 4

Complaint responses

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

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

Within the reported quarter the Trust replied to 131 complaints in total. Of the 131 responses 25 (19.08%) were closed within 40 working days.

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

Fourteen local resolution meetings (LRM) took place in Q1 which impacted on the 40 working day timescale being extended to accommodate such a meeting.

Members of Parliament

The Trust received seven new complaints from Members of Parliament (MPs) during Q1 and none remain open.

Local Government Ombudsman

The Trust received one new application from the Local Government Ombudsman (LGO) during Q1.

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

Parliamentary Health Service Ombudsman

The Trust received one new application from the Parliamentary Health Service Ombudsman (PHSO) during Q1 and none have been resolved during this quarter.

Complaints Satisfaction Surveys

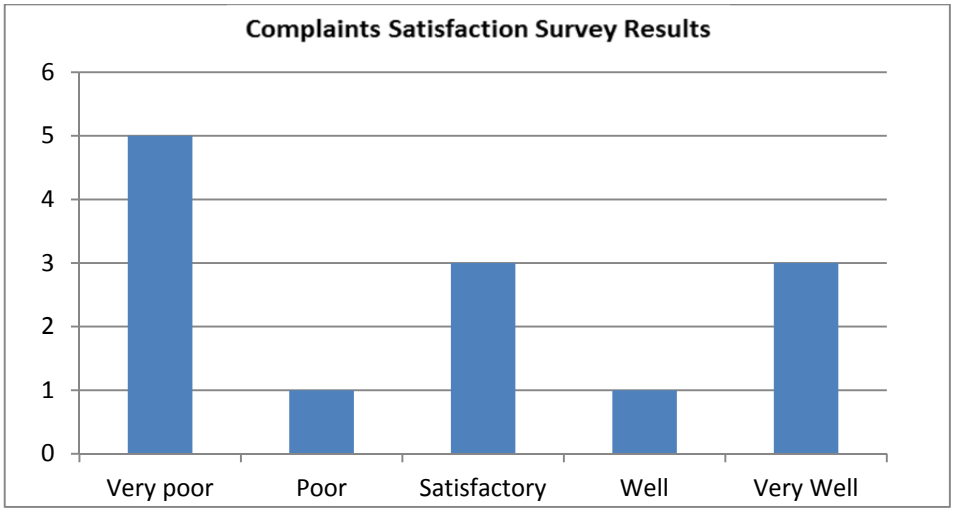
It is mandated that all Trusts participate in the complaints satisfaction survey and is part of the NHS Complaints Legislation (2009). All complainants have the opportunity to complete a complaint satisfaction survey.

Of the 131 complaints closed in Q1, 50 complaint satisfaction surveys were sent out and of those sent the Trust has received 13 completed surveys back. It has been agreed locally that surveys are sent out 6 weeks after closure to allow time for the complainant to consider the response.

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

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

Table 7



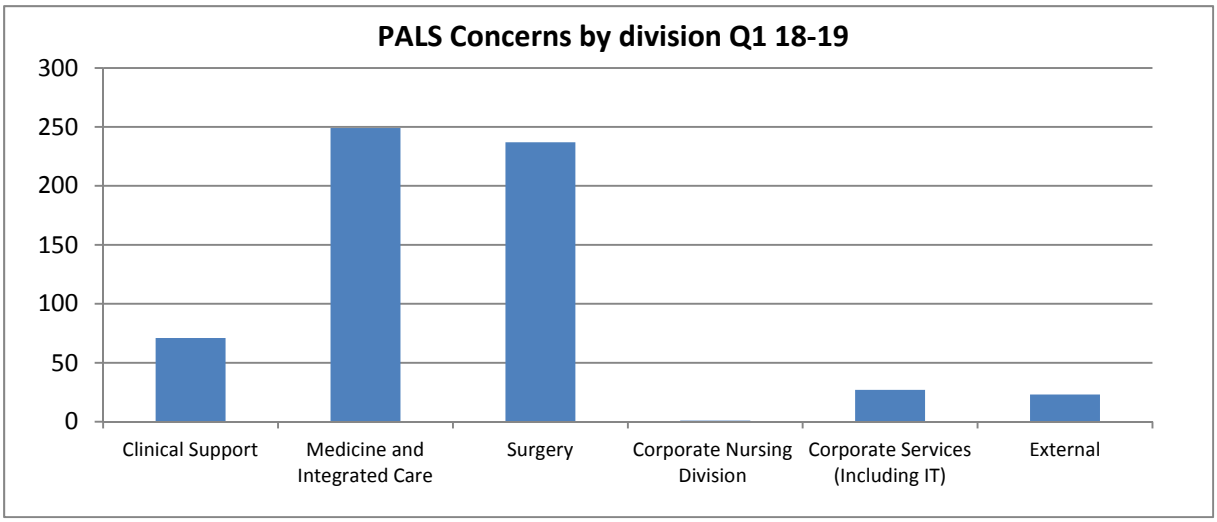
6. Compliments

The Trust continues to receive a high number of compliments equating to around 0.4% of patient activity. All compliments received by the Chief Executive and the Chief Nurse are acknowledged personally and shared with the staff involved. A total of 1,585 compliments were received in Q1 which represents a 15% decrease from Q4 (1,830), 2017/18.

7. Patient Advice Liaison Service

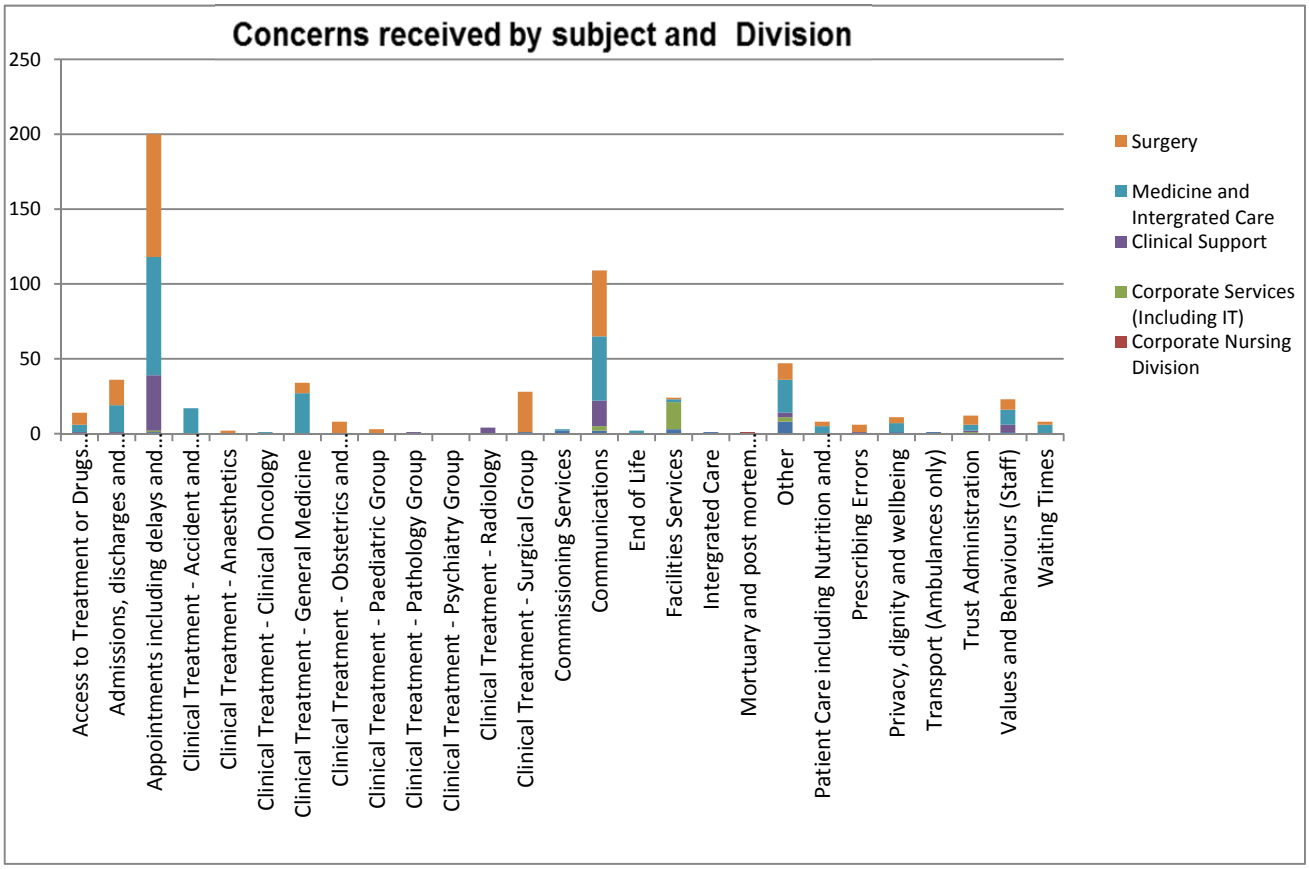
Patient Advice Liaison Service (PALS) received 608 new concerns in Q1, which is a 24.56% decrease compared to Q4 (806). *Table 1* details the breakdown by division during Q1:

Table 1



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

Table 2



The PALS team receives an average of 47 new concerns each week in addition to telephone calls received which require signposting. These concerns are escalated as appropriate (internally/externally) with the aim to seek resolution within 24 hours. However some concerns cannot be responded to within 24 hours due to annual leave, availability of information and complexity of the concerns raised (these are concerns whereby the person raising them does not wish to make a formal complaint).

Table 3 shows the time taken by PALS to respond to concerns and comments for Q1:

Table 3

1 working day	2 working days	3 working days	4 working days	5 working days	5 or more working days
290	102	47	25	21	123

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

Conclusion

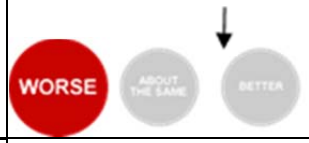
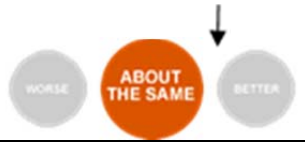
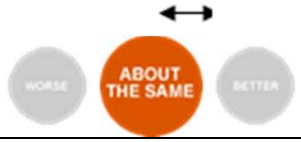
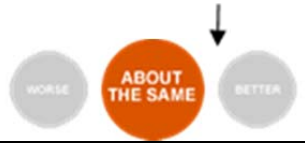
This report is intended to provide an overview of activity related to Patient Experience including national CQC surveys, Friends & Family Test, NHS Choices, patient complaints, compliments and the Patient Advice & Liaison Service (PALS).

It is important to note that nationally the Trust is rated in the bottom 10% and the Board are asked to support initiatives that will improve our patient experience.

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

Appendix 1 Adult Inpatient Survey – section scores and comparison to previous years score 2014 - 2017

Section	Rank & score 2017	Rank & score 2016	Rank & score 2015	Rank & score 2014
emergency/A&E department, answered by emergency patients only	8.2	8.1	8.3	8.2
Waiting lists and planned admissions	9.0	8.8	9.0	8.6
Waiting to get to a bed on a ward	6.7	6.6	7.3	7.3
The hospital and ward	7.5	7.7	8.2	8.0
Doctors	8.4	8.3	8.3	8.4
Nurses	7.7	7.4	8.2	8.2
Care and treatment	7.7	7.3	7.8	7.5
Operations and procedures	8.1	8.0	8.6	8.1

Leaving hospital	Not scored 	6.5 	6.9 	7.0 
Overall views of care and services	4.5 	5.1 	5.4 	5.4 
Overall experience	7.9 	7.8 	8.0 	7.8 

Enclosure 13

The Dudley Group
NHS Foundation Trust

Paper for submission to: Board of Directors on Thursday 6th September 2018

TITLE:	**Safeguarding Report**		
AUTHOR:	**Christina Rogers**	**PRESENTER**	**Siobhan Jordan**
CLINICAL STRATEGIC AIMS			
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: SO2: Safe and Caring			

SUMMARY OF KEY ISSUES:

The report provides a monthly update detailing safeguarding activity and service developments within The Dudley Group NHS Foundation Trust (DGFT), serving to provide assurance to Board members that DGFT is fulfilling its statutory responsibilities in relation to safeguarding children and adults who access services from the Trust. This front sheet presents the attached 'Safeguarding Improvement Plan' which has been updated for August 2018. Furthermore, this report presents a draft paper for consideration entitled 'Safeguarding Champions'.

Safeguarding activity across the Trust continues to intensify in volume and complexity, the Safeguarding Team remains committed to ensuring the provision of and cohesive and highly robust safeguarding service for all ages.

Key Issues

There are a number of local influences in addition to the national context which continue to drive focus and demand for the Safeguarding Agenda within DGFT these encompass:

- Continued Care Quality Commission (CQC) focus requiring daily Paediatric Liaison Service audit
- Continued growth in demand and required resource and capacity.
- Continued drive and impetus upon Safeguarding Team recruitment. Current post adverts are awaiting financial approval for key posts of safeguarding administrator and Named Midwife for Safeguarding Children.
- Continued drive and focus on radicalisation and the PREVENT agenda
- Increase in Serious Case Review (SCR), Serious Adult Review (SAR) and Domestic Homicide Review (DHR)
  - There are three SCR's awaiting publication which is expected to be the end of August 2018
  - There are three DHR's in progress and two SAR's
- Continued emphasis upon 'voice of the child' and 'making safeguarding personal', this has been further evidenced within the SCR, SAR and DHR findings.
- There is a need for continued and concerted focus upon the training compliance and safeguarding supervision

Safeguarding Children

- Children's Social Care Multi-Agency Safeguarding Hub (MASH) health enquiries have increased to 510, compared to 252 last month

- 18 child protection medicals were undertaken for the month of July 2018, this evidences a marked increase is comparison with previous monthly activity. Main category is physical abuse.
- DATIX reports and Multi-Agency Referral Form (MARF) completion to Children's Social Care in the month of July have almost doubled in volume. Main category is reported as peer on peer assault and Child Sexual Exploitation (CSE). Additionally, cumulative parenting risk factors identify substance misuse, self-harm and Domestic Abuse as main indicators.
- Paediatric liaison data collected between 13/07/18-31/07/18 indicate a marked improvement in the practice pertaining to paediatric liaison referral completion. The most common reasons for requiring paediatric liaison referrals were more than 2 attendances in a 12 month period and head injuries under 4 years
- Safeguarding supervision provision is currently under review and a scoping exercise is being undertaken to determine eligibility of staff who require group supervision.
- Safeguarding Training compliance: Level 1 and 2 remains above Trust target at 92%, however Level 3 is below Trust target at 83%. With the introduction of the revised Level 3 training package and the need for this to be accessed by all relevant staff, this is expected to be reflected within the training figures.

Safeguarding Adults

- DATIX Reports and Adult Safeguarding referrals have been steady this month, with 55 Datix's and 36 referrals being made by Trust staff. Last month indicated higher activity.
- The main categories of abuse reported appear to be, Neglect, Self-Neglect and Domestic Abuse
- Multi-Agency Risk Assessment Conferences (MARAC) for Domestic Abuse are held twice monthly. In July 51 cases were discussed between the two meetings. This presented significant work stream activity, with 51 victims, 51 perpetrators, 66 children and 2 unborn records to be researched. The Named Nurses attend MARAC and present their findings utilising analysis and understanding of risk.
- Training compliance: Level 1 and 2 is just short of Trust target at 88.6%, PREVENT is above Trust target at 91.6% and WRAP sessions are currently at 83.3% which is close to Home Office target of 85%.
- Multi-Agency Safeguarding Hub (MASH) questionnaires for health information are comparatively low to their children's counterpart with only 5 enquiries being requested for July 2018. The volume of requests has been on par with previous monthly activity.
- The Named Nurse has received five SAR scoping requests for completion in August 2018. There is potential for these to progress to SAR's.

Learning Disability

- Flagged attendance trends of Dudley residents 18 years and over show increased activity year on year – current figures show 54% increase in attendance from July 2017.
- Outpatient attendances in July have increased with a 25% increase in attendance at community clinics, however ED attendances and inpatient stays have remained stable.
- 5 patients have had more than 1 attendance to ED in July.
- 52 Patients admitted into Trust include 23 admissions of two patients into the renal

unit for Dialysis.

- 20 additional community referrals to liaison nurse for planned complex patient admissions.
- Trend identified by the learning disability liaison nurse with regards to patients who have social care funding for their placements. It is a worrying trend that funding for patients identified care and support needs have been ceased whilst they are a hospital inpatient.
- Equality and Diversity remains above Trust compliance at 91.9%

IMPLICATIONS OF PAPER:

RISK	**Y/N**		**Risk Description:**
	Risk Register: Y/N		**Risk Score:**
COMPLIANCE and/or LEGAL REQUIREMENTS	**CQC**	**Y**	**Details:** SAFE: Are patients protected from abuse and avoidable harm
	NHSI	**Y/N**	**Details:**
	Other	**Y/N**	**Details:**

ACTION REQUIRED OF BOARD:

Decision	Approval	Discussion	Other
	√	√	

RECOMMENDATIONS FOR THE BOARD/COMMITTEE:
This report outlines the work undertaken and in progress to safeguard children and adults within DGFT. Board members are requested to note the report, the improvements made during and the priority areas for implementation moving forward.

The Dudley Group NHS Foundation Trust

Safeguarding Improvement/Action Plan

Project/Improvement Area	Safeguarding	**Strategic Objective**	*Strengthen hospital-based care to ensure high quality hospital services provided in the most effective and efficient way.*
Manager/Lead	Christina Rogers Head of Safeguarding	**Executive Sponsor**	Siobhan Jordan Chief Nurse
Date Action Plan first agreed	20.03.2018	**Updated**	17.08.2018 V5

Action not started	**Action underway not yet completed**	**Action completed and assurance received**	**Action In progress**

Date action added	Actions Required	By whom	Progress to date	Date For Completion	Status (BRAG)
1. Governance					
20.03.2018	***Internal electronic flagging system review*** to include: • Review of current flags utilised pertaining to safeguarding • Review of current management and monitoring of flags (adding, amending and removing). • Administrative safeguarding support required to lead on flagging • Risk identified in respect to nil flags in place for children with high vulnerabilities, including Looked after Children (LAC), Children in Need (CIN Sec 17 CA 1989), at risk of Domestic Abuse (DA) and children at risk of child sexual exploitation (CSE) – to add to Trust Corporate Risk Register	Christina Rogers (CR) Head of Safeguarding	• CR had meeting had with current flagging lead Sharon Williams (SW) to establish current process • Escalated lack of LAC, CSE and CIN data to LAC Designated Nurse. Safeguarding Children Designated Nurse and CSC Head of Safeguarding • -Updated 03.05.2018: CR has had further meeting had with Sharon Williams on 30.04.2018 to update. -CR has reviewed administrative support to ensure reflective of the additional work stream of electronic CPP flag management, plan to provide business case for additional 0.5WTE -Go live date for electronic CPP flag management will be 01.06.2018 -CR has discussed and escalated formally to Head of Safeguarding CSC and a meeting is scheduled to discuss	Original date: 01 May 2018 Revised date: 01.06.2018- Complete for CPP and CSE flags Revised date for DA and LAC flags and process of flag review: July 2018 Delay with implementati	

			process for receiving LAC information	on of this is due to external factors outside of Trust control. Awaiting social care to go live with CP-IS which will provide data for LAC.	
20.03.2018	***External flagging system: Child Protection Information System (CP-IS)*** • SW will attend UTC to see how the system works in practice prior to the introduction across the acute trust. It was agreed that the system would be introduced within ED, Maternity and Paediatrics (OPD, PAU and C2) • CR to liaise with key Matrons to identify staff requiring system access and resultant Smart card access • SW - Issue Smartcards to identified staff • CR - Provide written guidance to support staff • Safeguarding Team - Audit the process once implemented to ensure it is embedded	Christina Rogers (CR) Head of Safeguarding Sharon Williams (SW) Information Governance Manager	• CP-IS required to be live and in use at DGFT	Original date: 1st April 2018 Revised date: 01.06.2018, further revised to 25.06.2018	
			• New action: 17.08.2018 It has been identified that there are staff in Trust who have not obtained their Smartcards to use CP-IS. CR has emailed all relevant leads to address as a matter of urgency.	24.08.2018	
			• CR has had meetings with SW, CCG Designated Nurse Sue Vincent (SV) and NHS Digital.	Meetings on: April 2018 May 2018 June 2018	
			• Action plan in place led by SV	Next review date	

				September 2018	
			• SW has applied for accelerated funding from NHS Digital	April/May 2018	
			• Updated 03.05.2018 - CR has provided SW with a list of staff whom require smartcard access - CR had meeting with SW on 30.04.2018, SW provided update in respect of staff who have received smartcard. This work is in progress. - CR has provided CP-IS guidelines to staff - CR to produce SOP to support process	June 2018	
20.03.2018	***Review of current Risk Register*** to ensure safe, effective and robust management of risks pertaining to safeguarding of children, young people and adults. • Meet with Sharon Philips (SP) to review and revise current Risk Register, ensuring any newly identified risks are added accordingly • Review previous work undertaken concerning the corporate risk register and ensure the safeguarding team has a comprehensive knowledge of risk management and responsibilities as individual practitioners.	Christina Rogers (CR) Head of Safeguarding	• Initial meeting had between CR and SP, whereby a need for review of the current Risk Register was identified • Further meeting scheduled for May 2018 between SP and CR • Review of Risk register has taken place and additional risks have been added.	Revised date: 31.05.2018 Original date: 10.04.2018	
20.03.2018	***Safeguarding reports*** • Annual Report 2017-18 – Due April 2018 • Review the structure and content of the safeguarding annual report to ensure the Board has a wide-ranging update and vigorous assurance, providing an overview on arrangements to discharge the trust's statutory responsibilities, current provision of services and the challenges ahead. Due consideration should be given to including commissioner requirements. • Quarterly Safeguarding reports	Christina Rogers (CR) Head of Safeguarding All members of the Safeguarding Team	• CR has requested information requested from Karen Anderson (KA) (Matron Paediatrics) who has commenced this work and completed a draft version • CR devised an Annual Report with supporting Safeguarding Strategy and Audit Plan	April 2018 Revised date of May 2018	
20.03.2018	***Safeguarding Declaration*** • Publish and communicate a yearly safeguarding declaration on the trust's website as evidence of the	Christina Rogers (CR) Head of		30.04.2018	

	board's commitment to safeguarding children, young people and adults.	Safeguarding			
20.03.2018	***Modern slavery Trust Statement*** • Publish and communicate a yearly Modern Slavery Statement on the trust's website as evidence of the board's commitment to safeguarding children, young people and adults.	Christina Rogers (CR) Head of Safeguarding		30.04.2018 Completion date June 2018, delay due to awaiting review from associated colleagues in HR and finance	
20.03.2018	***Review of internal and external safeguarding meetings and Trust representation*** • Continue to attend meetings and review existing ToR to support decision making • Ensure receiving all relevant communication for respective meetings • Ensure that the SCR, SAR and DHR process has a trust lead, guidance and relevant training, in order to embed the appropriate processes that enable lessons learnt to be aligned to training, development and improved practice outcomes. • Action plans should be explicitly understood and operational arrangements robust.	Christina Rogers (CR) Head of Safeguarding All team members of the Safeguarding Team	• CR has met with Liz Murphy (Chair of DSCB and DSAB Boards) to agree Trust representation at Board and Subgroup meetings • CR has commenced attendance at meetings since commencement into post • CR has reviewed meeting attendance and has ensured Trust representation of all relevant meetings • CR has enhanced information governance in this area by ensuring a robust electronic process. All associated papers for meetings are saved on the Safeguarding secure W drive and only accessible to safeguarding team.	30.04.2018 Completed May 2018	

20.03.2018	***Review of existing safeguarding policies and procedures*** • Ensure up to date and alignment with current statute and guidance • Safeguarding page on the Trust online Hub – requires urgent review	Christina Rogers (CR) Head of Safeguarding All team members of the Safeguarding Team	• CR has reviewed and commented on a selection of existing safeguarding policies • CR has identified that there is duplication of safeguarding policies in place, for example: Maternity have devised a maternity specific safeguarding children policy when there is a trust wide safeguarding children policy in place	July 2018	
			• Further policies have been identified as requiring review	October 2018	
2. Staffing and Safeguarding Team processes					
20.03.2018	***Safeguarding Team current capacity and resource*** • Review the Safeguarding Team, giving due consideration to the provision of sound strategic leadership, operational management, performance, roles and responsibilities and staffing requirements; in order to bring together the safeguarding of children, young people and adults, enabling a strong effective interface between all three. • Review current team structure to ensure fit for purpose – Risk apparent that there is no Safeguarding Team administrative support. • Recruitment processes to be commenced for vacant posts – TUPE Process (Lead Nurse for Child Deaths and Paediatric Liaison Nurse) • Commencement of new Named Nurse for Safeguarding Children on: April 2018	Christina Rogers (CR) Head of Safeguarding	• Meet with all team members • Arrange regular 1:1 meetings with team members • Produce and communicate Expression of Interest for posts subject to TUPE process (Lead Nurse for Child Deaths and Paediatric Liaison Nurse) • Siobhan Jordan (SJ) Chief Nurse has liaised with CEO of Birmingham Trust with a view to transferring across current Lead Nurse for Child Death who has expressed interest. A request has been made for interim support. • CR has liaised with BCPFT Associate Director of Safeguarding for continued support in the interim.	May 2018	
20.03.2018	***Team communication*** • Generic team email address and team contact telephone number urgently required to ensure appropriate calls and correspondence are accessed by all team members and triaged and responded to appropriately	Christina Rogers (CR) Head of Safeguarding All Safeguarding Team members IT Helpdesk support	• CR completed action	April 2018	
20.03.2018	***Safeguarding Team processes review***	Christina Rogers	• CR has commenced review of internal	June 2018	

	• Review internal processes • Ensure electronic process for all safeguarding information	(CR) Head of Safeguarding All Safeguarding Team members	team processes • Team ops meeting held fortnightly • CR has ensured all paper documentation held is reviewed to ensure robust data protection is maintained. The expectation is that all information is now stored electronically		
20.03.2018	***Safeguarding Supervision*** • Review the supervision policy and documentation to ensure all staff fully understands their roles, responsibilities, development needs and the necessary sound practice that is consistent with trust and LSCB organisational procedures. • In addition, make provision for a strong supervision process, which addresses the needs of case load holders, the named nurses and named doctor with safeguarding responsibilities. • As part of the review consider a range of reflective practice activities that could be programmed, including more opportunity for case study reflection via peer review and possible learning sets. • Ensure evaluation is undertaken to inform ongoing training programs.	Justine Morris Named Nurse for Safeguarding Children and Carol Weston Named Nurse for safeguarding children	• CR has conducted scoping of Named Doctor and Named Nurses and established current Safeguarding Supervision arrangements in place. • CR has identified gaps in amount of safeguarding supervisors in place and as such has raised this as a risk on the risk register.	June 2018	
			• CR to plan to source additional training to provide an increase in safeguarding supervisors	July 2018	
			• JM to scope staff groups who require group supervision and plan provision of this accordingly. This is in progress.	July 2018	
			• CR to provide estimate of training cost and discuss with SJ to source this	August 2018	
20.03.2018	***Ensure that the role and responsibilities of the named nurses and named doctor with safeguarding responsibilities is communicated and understood by all relevant practitioners and senior staff.*** • Review training and safeguarding supervision arrangements of key medical safeguarding staff • Revisit the appraisal system and processes to ensure all staff have clear objectives and relevant performance management for delivering the safeguarding agenda, which should be linked to the improvement plan and /or the agreed annual work programme. • Update all pertinent job descriptions and ensure the process of appraisal includes this function on a yearly basis.	Christina Rogers (CR) Head of Safeguarding All Safeguarding Team members Zala Ibrahim (Designated Doctor for Safeguarding Children) Julian Hobbs	• CR has had meetings with ZI and Dr Jain (Named Doctor) • CR has attended two Peer Review sessions held by ZI and her colleagues • CR has provided appropriate JD template for Named Doctor role • CR conducts monthly 1: 1meetings with all members of the Safeguarding Team utilising an electronic template	May 2018 Revised date: June 2018	

	• Review the sessional commitment for the Designated Doctor for children's safeguarding and Named doctor for Adults Safeguarding agree key role, responsibilities and accountabilities	(Chief Medical Officer)			
			• CR has commenced appraisals within the team – Now completed	June 2018	
			• CR has commenced ATR processes for PLN	July 2018	
			• Update: 17.08.18 – post successfully appointed to on 08.08.2018. Start date: 10.09.18	August 2018	
			• New action 17.08.2018 CR has commenced Administrator and Named Midwife	August 2018	
			• New action 17.08.18 ATR process in progress – awaiting finance approval	August 2018	
20.03.2018	***Domestic Abuse Agenda*** • Set out trust agenda for the service of Domestic Abuse, which goes beyond current engagement in MARAC; this should apply to both vulnerable children and adults. • Recent local and regional review of these services should be noted and the recommendations that emerge need to be addressed in terms of healthcare services contribution to any necessary changes. • Refer to previous action re: Flagging and align with this action	Named Nurses for adults and Children	• MARAC process reviewed by CR	May 2018	
			• Named Nurses to attend MARAC	Revised date: June 2018	
			• Electronic flagging process to be in place to flag MARAC victims and associated children • Update 17.08.2018 JM awaiting update from Informatics Team	July 2018 Revised date of: September 2018	
			• SOP and MARAC templates for collating and providing information for	July 2018	

			MARAC to be developed for use by the Named Nurses to ensure a robust, electronic process.		
3. Training					
20.03.2018	***Safeguarding Training*** • Review all current training packages • Review TNA • Review training compliance • Schedule additional Safeguarding Children level 3 Training facilitated by external provider	Christina Rogers (CR) Head of Safeguarding All Safeguarding Team members Learning and Development Team	• TNA information reviewed by CR • CR has had meeting with Rachel Andrews (L&D Lead) • CR has organised additional Safeguarding Children level 3 Training facilitated by external provider to be available to staff in high priority paediatric areas (ED, Paediatrics, Maternity, GUM and CASH).	01.04.2018	
			• New Action 17.08.2018 CW to discuss with L&D how we can identify staff who have completed new training against staff who have completed old training	September 2018	
5. Audit					
20.03.2018	***Safeguarding Team Audit work plan*** • Review recently devised Audit work-plan to ensure alignment to safeguarding priorities and quality assurance practices	Christina Rogers (CR) Head of Safeguarding	• Audit work-plan reviewed and deemed satisfactory	19.03.2018	
			• All Safeguarding Team members to commence audits as per schedule	September 2018	
20.03.2018	***Safeguarding Team external Audit*** • Complete DSCB Section 11 Audit – Due May 2018 • Collate all evidence required from Safeguarding Team members • Complete DSAB audit requested on 14.06.2018 for 31.06.2018, CR requested date to be reviewed as this is a short time frame	Christina Rogers (CR) Head of Safeguarding	• Request made by CR to safeguarding team members for evidence to support collation of DSCB Sec.11 Audit • Delay is due to DSCB processes – therefore this is an external delay and not due to DGFT • Update 17.08.2018 JM and CW are progressing with the completion of this audit in line with the expected completion date	May 2018. Date revised by DSCB – now planned for July 2018. Date now proposed by DSCB: September 2018	

			• Request made to Named Nurse for Adults to commence evidence collation for DSAB • DSAB Audit completed and returned July 2018	July 2018	

Role of the Safeguarding Champion

1. **Role**

- The Safeguarding Champion acts as a resource to staff within their area on issues relating to safeguarding children and/or adults, who will need to be signposted to appropriate services;
- To support staff within their area of responsibility to access appropriate advice when referring adults, children or families to social care and/or local authorities;
- Champions are responsible for adhering to all safeguarding policies and procedures.

2. Summary

The Safeguarding Champion's primary role will be to enhance their skills and knowledge in this subject. They will act as a conduit for information from the Internal Safeguarding Board. They will also be responsible for supporting their areas in safeguarding concerns in order to support staff in escalation or making appropriate referrals. Safeguarding Champions will also be a useful resource to the Internal Safeguarding Board to feed information that will highlight or illustrate gaps in knowledge/skills of staff members.

3. Background Experience

Each Safeguarding Champion will be expected to have a keen interest with regard to safeguarding agendas. They need to be a registered practitioner and be at least an experienced Band 5; however, it is desirable that they are a Band 6 or above. Each Champion will have to undertake all mandatory training, including Level 3 Safeguarding Children and bespoke training session twice a year provided by the Safeguarding Team, to ensure they are updated on all current issues, policies and practice.

4. Responsibilities

- To ensure safeguarding policies and procedures are in place;
- To actively promote their role and undertake a number of initiatives to champion safeguarding culture;
- To attend forums at which safeguarding practice is developed and improved;
- To provide support to the workforce in safeguarding issues;
- The Safeguarding Champion provides an essential link between practice areas across the Trust and the Internal Safeguarding Board. Supporting staff in ensuring children and adults with care and support needs are focus for consideration even when the primary intervention is with the adult;
- Each Champion is expected to have up-to-date knowledge of the Worcestershire Safeguarding Children Board, Safeguarding Adults Board and Trust procedures through their mandatory training;
- Each Champion should be aware of the Named and Designated Professionals for Safeguarding Children and Adults and know how to access them;
- To ensure up-to-date with safeguarding training and at right level and opportunity to other study related to safeguarding.
- For Safeguarding Champions to be afforded protected time to fulfil these responsibilities

5. Professional Responsibilities

- To ensure fully compliant with all training requirements to attend a minimum of four Internal Safeguarding Board meetings a year as well as taking two additional bespoke training sessions provided by the Safeguarding Team.
- To participate in any audits as required for safeguarding in order to ensure two-way communication in relation to safeguarding issues, concerns and developments and that these are communicated to the Safeguarding Team.
- To update their areas in relation to new policies, guidance or new information.
- To assist in any education/information as instructed by the Safeguarding Team.
- To keep updated and reflect on practice.

Enclosure 14

The Dudley Group
NHS Foundation Trust

Paper for submission to the Board of Directors on 6th September 2018

TITLE:	**Report on Learning from Deaths**		
AUTHOR:	**Julian Hobbs Medical Director**	**PRESENTER**	**Julian Hobbs Medical Director**

CLINICAL STRATEGIC AIMS

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

CORPORATE OBJECTIVE:
S02: Safe and Caring Service
S03: Drive service improvements, innovation and transformation

SUMMARY OF KEY ISSUES:

Following the publication of the National Guidance on Learning from Deaths (March 2017) the Trust is required to report via the Trust Board the approach and key learning from deaths occurring in the Trust. This paper covers:

- The Trust approach to Learning from Deaths and recent changes made to this process
- Summary of latest Mortality Data Set
- Learning gathered from a regional perspective
- Learning gathered at a Trust level
- Specific case learnings

IMPLICATIONS OF PAPER:

RISK	**Y/~~N~~**		**Risk Description:**
	Risk Register: Y/N		**Risk Score: (this is from the relevant risk register)**
COMPLIANCE and/or LEGAL REQUIREMENTS	**CQC**	**Y/~~N~~**	**Details: Safe, Effective, Caring, Responsive, Well-Led**
	NHSI	**~~Y~~/N**	**Details:**
	Other	**~~Y~~/N**	**Details:**

ACTION REQUIRED OF COMMITTEE

Decision	Approval	Discussion	Other
		✓	

RECOMMENDATIONS FOR THE COMMITTEE
Details further assurance required.

The Dudley Group
NHS Foundation Trust

Learning from Deaths

1.0 Introduction

Following the publication of the National Guidance on Learning from Deaths (March 2017) the Trust is required to report via the Trust Board the approach and key learning from deaths occurring in the Trust. This paper covers:

- The Trust approach to Learning from Deaths and recent changes made to this process
- Summary of latest Mortality Data Set
- Learning gathered from a regional perspective
- Learning gathered at a Trust level
- Specific case learnings

2.0 Changes to Trust Approach

In order to enhance the way in which the Trust gathers and disseminates learning from deaths occurring in the Trust, a number of process changes have occurred over the last 3 months.

2.1 Revised Policy

The Trust 'Learning from Deaths' policy was updated in July 2018. This revised policy includes the use of Structured Judgement Reviews and outlines the wider Trust approach to learning from inpatient deaths, including those patients who die in the Emergency Department.

Significant parts of the National Guidance on Learning from Deaths discuss the selection of cases for review; the Trusts position remains that all deaths should be reviewed and therefore selection of deaths to be reviewed is not part of this policy.

Further amendments to the policy included a specific section to detail reporting arrangements where mortality and the learning from deaths will be considered and revised responsibilities to include further detail regarding roles within the Trust.

The revised policy is accessible via the Trust Hub.

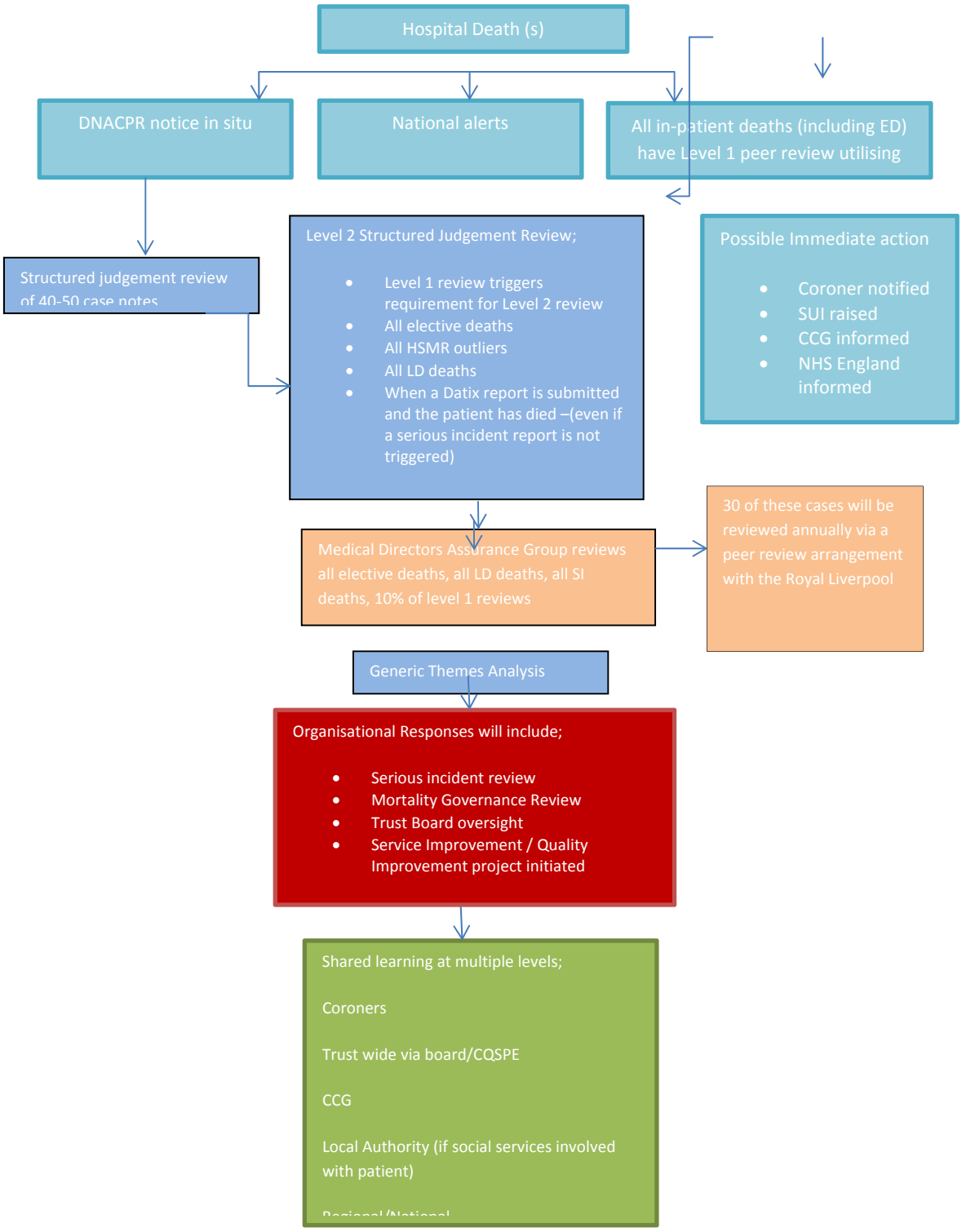
2.2 *Learning from Deaths Governance Structure*

There are a number of forums where the learnings from deaths occurring in the Trust are discussed:

- at the Mortality Surveillance Group, particularly the detail of actions around learning provided by the departmental audit leads when appropriate
- at CQSPE to provide assurance of the application of this policy and its supporting processes with a focus on the learning and changes / improvements made
- at Risk and Assurance as part of a quarterly mortality report
- at CQRM where mortality and key learning is shared with commissioning colleagues
- at the appropriate Public Board meetings in a format compliant with all statutory responsibilities.

The Trust has revised the governance arrangements in place to ensure maximum learning is captured. Key changes include the introduction of a weekly oversight meeting chaired by the Medical Director where 10% of level 1 reviews are considered and the introduction of a peer review arrangement with the Royal Liverpool and Broadgreen University Hospitals NHS Trust.

2.3 *Trust Process of Learning from Deaths (July 2018)*



2.4 *Structured Judgment Review Adoption*

The Trust is adopting the Structured Judgement Review (SJR) framework as highlighted in the governance arrangements. The SJR methodology has been validated and is endorsed by the Royal College of Physicians and uses a qualitative analysis of mortality data using a standardised, validated approach linked to quality improvement activity. The Trust has arranged for an initial cohort of reviewers to be trained in the methodology by the RCP during October 2018.

2.4 *Learning from Deaths in the Emergency Department*

Although not admitted patients, deaths in the Emergency Department are now included in the Trust wide approach to learning from deaths and will be reviewed as outlined below;

- Level 1 Daily review of deaths in the department completed by a consultant other than the responsible consultant and recorded on MTS
- Weekly review of deaths at departmental governance meeting
- Cases identified Level 2 Structured Judgement Review
- Any relevant cases reviewed at Medical Directors Assurance Group
- Identified themes discussed at departmental governance meetings
- Learning and themes will contribute to Trust Learning from Deaths report

To support this process there will be a redesign of the Trust Mortality Tracking System led by Dr Ash Singal (ED Medical Service Head) and Andy Troth (Head of Information). This review will ensure that the relevant fields are available for capturing data relating to deaths in the Emergency department and will allow for patients who arrive at hospital deceased to be identified.

3.0 How We Measure Mortality

3.1 *Data Set*

The Trust uses a range of sources to monitor mortality;

Crude Mortality: A hospital's crude mortality rate looks at the number of deaths that occur in a hospital in any given period and then compares that against the amount of people admitted for care in that hospital for the same time period. Crude Mortality identifies how a Trust's mortality rate changes over time.

SHMI: The Summary Hospital-level Mortality Indicator (SHMI) reports on mortality at trust level using a standard and transparent methodology adopted across the NHS. The SHMI is the ratio between the actual number of patients who die within 30 days following hospitalisation at the trust and the number that would be expected to die on the basis of

average England figures, given the characteristics of the patients treated there. The SHMI data usually takes longer to collect and often lags behind other data.

HSMR: The HSMR scoring system works by taking a hospital's crude mortality rate and adjusting it for a variety of factors – population size, age profile, level of poverty, range of treatments and operations provided, etc. The idea is that by taking these factors in to account for each hospital, it is possible to calculate two scores – the mortality rate that would be expected for any given hospital and its actual observed rate. It is the difference between these two rates that is important when it comes to HSMR.

The data set for SHMI is limited to a reporting period ending December 2017.

	Parameter	***Period***	***Numbers (prev. in brackets)***
Mortality	Crude mortality	Aug 2017 to Jul 2018	1815 – 4.25%* (1813 – 3.01%)
	SHMI	Jan 2017 to Dec 2017	1.03 (0.98)
	HSMR	Jun 2017 to May 2018	117 (109)

*Deaths as % of all inpatient admissions (excl. Well babies, Obstetrics, Midwifery)

The Trust has noted an increase in Crude Mortality and an increase in HSMR in the latest reporting period. This is shown graphically in the appendix. The pattern however is very similar to previous years' data despite the overall increase in absolute numbers. As indicated above, the SHMI data will lag behind these figures. There are 3 significant considerations to be made when reviewing these figures.

1. Public Health England noted an exceptional rise in Winter mortality of 20% during Jan 2018.
2. Coding changed in September 18 when a low risk cohort of ambulatory patients were excluded form the admitted cohort as part of a contract review with the CCG. This reversed a contract variation implemented 3 years ago.
3. The Trust SHIM is the lowest of neighbouring providers.

There are also several factors that influence these measures including the provision and availability of social care, palliative care and community services which can all impact on the number of patients dying in an acute setting. An external review reports in October considering these factors.

3.2 *Condition Specific Alerts (see Appendix 1)*

The Trust also receives 'Condition Specific Alerts' which identify any conditions that have had a higher than expected number of deaths in a defined period. These are useful indicators to look at and may point to specific pathways that may require improvement.

- HSMR Alert Period **April 2017-March 2018**
- CUSUM Alert Month **March 2018**

Acute renal failure, pneumonia, congestive cardiac failure, peripheral vascular disease and secondary malignancies are prominent in last report for CUSUM and HSMR. SHMI data reflects many of these conditions.

Some of these conditions have been reviewed extensively before with subsequent assurance that no major concerns have been identified. Furthermore it is increasingly recognised that coding of co-morbidities may be contributory in some values. The Trust has invested in data support to clarify some of these issues.

The action plan is detailed in appendix 1 to review the highlighted areas.

4.0 Trust Level Learning

4.1 Completion of Reviews

As at the end of August 2018 there have been 331 Level 2 reviews requested.

Of these 23 have had SJRs. There have also been 15 sepsis reviews and 20 ED SJRs completed. There have also been 2 LeDeR reviews completed prior to external review by the LeDeR Lead Investigator. An additional 300 cases are being reviewed as part of the external review. An extraordinary panel meeting is arranged for September and a more reliable way to obtain notes agreed.

4.2 Learning from Section 28 Notices

Any information is revealed as part of the Coroner's investigation or during the course of the evidence heard at the Inquest, which gives rise to "a concern that circumstances creating a risk of other deaths will occur, or will continue to exist in the future;" and if the Coroner is of the opinion that action needs to be taken, under Paragraph 7 of Schedule 5 of the Coroner and Justice Act 2009, the Coroner has a duty to issue a report to a person, organisation, local authority or government department or agency. The Coroner's Regulation 28 Report will set out the concerns and request that action should be taken.

Deteriorating Patient

Following cases which have both being dealt with as either serious incidents or coroners cases, the Trust has implemented electronic observations which provides timely and visible assessment. Dashboards report perfomance which has improved over the last 3 months. Automatic calculation of the NEWS score makes the trust compliant with national guidelines and improves reliability of score calculation allowing the Trust to audit compliance. This has allowed for more timely observations and increased focus on patients who are at risk of deterioration. We have also designed a deteriorating patient pathway which reflects much of the learning from cases which have required input from the coroner.

Sepsis mortality cases are being reviewed separately by the Sepsis team and by consultants to review the diagnosis of sepsis and to assess management. Screening rates and the implementation of Sepsis 6 continues to improve. RCA's have highlighted the need to

improve clinical recognition of sepsis including biochemical and recognition of clinical syndromes. Training in the RADAR and a range of education interventions are in place. These include the recognition and management of all aspects of sepsis. This has resulted in a change of culture improving reporting and compliance and promoting an improvement in the timeliness of therapy and a reduction in mortality from sepsis over 12 months. Sepsis SHMI has reduced from 152 to 113.

Specific Learning Points following mortality/ sepsis case reviews:

- Need for clear documentation of all results and investigations when patients admitted/ transferred to ensure appropriate prompt management and communication of escalation plans (e.g. case of necrotising fasciitis)
- Sepsis data suggests ongoing drive for compliance with sepsis 6 criteria but increasing evidence of very prompt coordinated care in ED.
- Some cases labelled as sepsis initially are actually end of life cases with expected progressive deterioration and de-escalation may need to be recognised earlier
- Dying patients presenting to ED may be more appropriately transferred out of the department more promptly to allow more privacy and dignity for patients and families
- Some patients dying within ED have been admitted within previous few weeks
    - Need for recognition of dying patients on discharge and communication of expected further deterioration
    - Appropriateness of readmission
    - Need for liaison with ambulance staff
    - Potential for need to ensure clearer planning at discharge for some cases

4.3 <u>COPD Learning</u>

The Trust is actively contributing to the national COPD audit (see Appendix 2). In summary our contribution to date has shown;

- A high frequency of spirometry (Fig 1)
- High level of timely respiratory review and use of discharge bundle (Fig 2)
- Low mortality on current data
- Higher deprivation scores than national average for patients admitted
- There is work to be progressed with regards to the prescription of smoking cessation pharmacotherapy and a consistent approach to patients receiving NIV within 3 hours of arrival when appropriate (Fig 3 - 5)

4.4 *Cardiac Arrest Learning*

The National Cardiac Arrest Audit (NCAA) is the national, clinical, comparative audit for in-hospital cardiac arrest. Our number of cardiac arrest per 1000 patients is within the national average. Our survival to discharge (alive) is 9.6% compared with the national average of 14 - 21%.

We have identified a number of areas for improvement from the most recent data set;

- Potential issues with decision making around DNACPR status and resuscitation of patients where CPR has no realistic chance of success.

- Cardiac arrest numbers out of hours during the weekends, particularly during the day are higher and this requires further analysis of the trust data.

This is being addressed by the mortality assurance group.

4.5 *Learning from Deaths and Palliative Care*

Report of the Identified gaps from national guidance and policies:

The main emerging themes identify:

1. Need for senior review and earlier identification of patients who are End of Life
2. Inappropriate hospital admissions with limited conversations with patient and family regarding preferences
3. Once patient admitted to hospital focus on active treatment rather than recognising and supporting end of life care
4. Challenge of co-ordination of care across settings

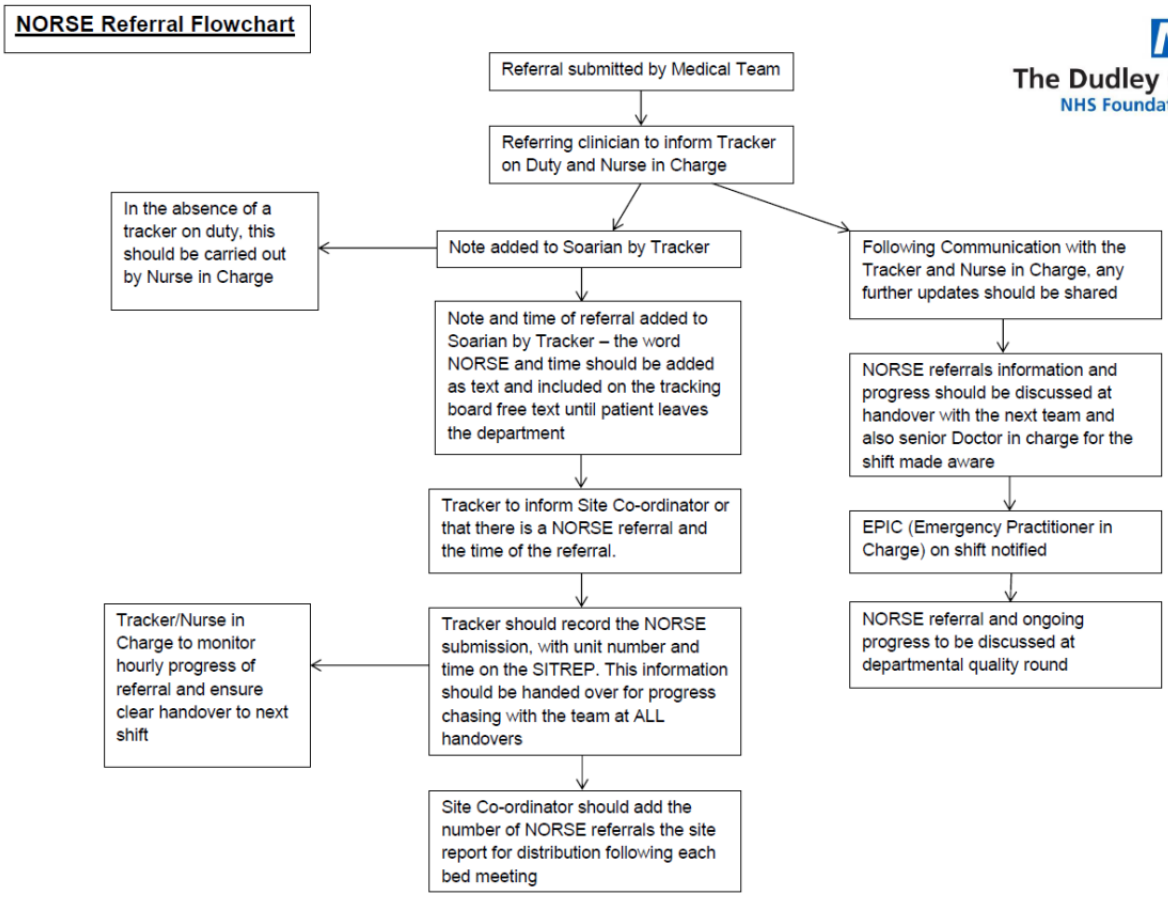
Dr Bowen and colleagues have identified the current gaps and made specific recommendations to improve gaps in both policies and staffing support and a business case is in progress.

5.0 Regional Learning

5.1 *Neurosurgical Care*

Following a previous Section 28 notice regarding delays in the neurosurgical pathway the Trust took a number of actions internally including the establishment of a fortnightly NORSE safety group chaired by the Chief of Medicine to identify and address issues in the pathway.

The group have ratified an internal process for monitoring referrals which is now in use as detailed below;



Significant delays in the pathway have been highlighted by the NORSE group. This relates to image transfer. The Trust has agreed to take part in the RISP image transfer project regionally which will resolve this issue. Patients on the pathway are highlighted on the SITREP to ensure these patients meet their milestones.

6. Urgent Care Learning

The Trust has focused heavily on developing the learning from deaths occurring in our Urgent Care pathways and has taken a series of actions to ensure learning is captured and acted upon in a timely manner.

6.1 Urgent Care Review Process

As detailed earlier in this paper, the Emergency Department have developed a revised review process of all deaths occurring in the department and are working with information colleagues to amend the Mortality Tracking system. A shared away day for emergency are colleagues for 7th September and a key objective of the session is to explore how the Trust gains assurance from across pathways of care.

Following our recent CQC visits the Trust invited Professor Mike Bewick and colleagues to undertake an independent review of mortality in the Emergency Department. This is

expected to report in September. Initial findings relate to Patients arriving in cardiac arrest or having a palliative plan and an need for an alternative care setting.

6.2 *Summary of Serious Untoward Incidents in Urgent Care 17/18*

There have been 8 SIs reported since November 2017 relating to Urgent Care with regards to the death of a patient. These have been categorised as follows;

- Failure of Treatment
- Unexpected Death
- Failure to monitor and respond to oxygen saturation
- Discharged Clinically INAPPROPRIATE/Unmanaged Complications
- Cardio Pulmonary Resuscitation
- FAILURE to MONITOR Health needs

A number of these incidents have been referred to Coroners and all have ongoing action plans associated with them.

6.3 *Action taken*

A series of actions have already been completed in the Emergency Care pathways to improve care

- Introduction of revised Triage process and audit with the support of ECIST colleagues
- Introduction of eObs and training for eSepsis
- Additional staffing support including extended Hours of consultant cover
- 7 sessions of Human factors training delivered
- Ongoing Sepsis training
- Patient safety survey complete
- Support from a range of external bodies including ECIST, NHS Improvement and the Advancing Quality Alliance
- Introduction of new tracker of tablets for medical registrars to facilitate handover to Acute Medicine
- Introduction of increased staffing in AMU and the placement of MTI doctors in the department.
- Expansion of Nerve Centre to manage acutely unwell patients out of hours and the implementation of e-Handover and a hospital at night team.

Summary

The Trust processes multiple sources of data and feedback to learn from deaths occurring in the Trust and to ensure appropriate action is taken to prevent unnecessary deaths for patients in our care. This paper outlines a number of positive steps we have taken in recent months and this learning will be cemented by the formal introduction of Structured Judgement Reviews in the October.

Appendix 1

Conditions Specific Alerts

Alert	CCS Diagnostic Group	Expected Death	Observed Death	Number of Discharges	Score
CUSUM	157-Acute and unspecified renal failure	3.08	7	41	5.24
CUSUM	122-Pneumonia (except that caused by tuberculosis or sexually transmitted disease)	34.11	47	212	3.1
CUSUM	108-Congestive heart failure; non-hypertensive	4.71	5	48	3.28
CUSUM	114-Peripheral and visceral atherosclerosis	2.82	6	57	5.63
CUSUM	42-Secondary malignancies	1.04	4	82	4.91
CUSUM	55-Fluid and electrolyte disorders	1.07	2	24	3.65
HSMR	42-Secondary malignancies	26.06	48	718	184.16

SHMI Alerts to Date

Hospital Standardised Mortality Ratio (HSMR) - Acute and unspecified renal failure	April 2017 - March 2018	153.80	
Hospital Standardised Mortality Ratio (HSMR) - Septicemia (except in labor)	April 2017 - March 2018	115.82	
Hospital Standardised Mortality Ratio (HSMR) - Liver disease; alcohol-related	April 2017 - March 2018	160.06	
Hospital Standardised Mortality Ratio (HSMR) - Other circulatory disease	April 2017 - March 2018	227.42	
Summary Hospital-Level Mortality Indicator (Monthly SHMI) - Secondary malignancies	January 2017 - December 2017	147.90	
Summary Hospital-Level Mortality Indicator (Monthly SHMI) - Other fractures	January 2017 - December 2017	177.39	
Summary Hospital-Level Mortality Indicator (Monthly SHMI) - Other diseases of kidney and ureters	January 2017 - December 2017	420.00	
Summary Hospital-Level Mortality Indicator (Monthly SHMI) - Liver disease; alcohol-related	January 2017 - December 2017	152.13	
Summary Hospital-Level Mortality Indicator (Monthly SHMI) - Septicemia (except in labor)	January 2017 - December 2017	116.29	
Summary Hospital-Level Mortality Indicator (Monthly SHMI) - Gastrointestinal hemorrhage	January 2017 - December 2017	145.12	

Condition Specific Learning

Healthcare Evaluation Data (HED) provides a useful update on the Ten Highest Condition Groups that show higher than expected numbers of deaths. The table below identifies these condition groups and details the taken and planned action to explore these findings further.

Diagnostic Group (CCS)	Number of discharges	Expected number of deaths	Observed	HSMR	Crude Mortality Rate	Obs-Exp	Known factors / actions taken	Action Planned
Pneumonia (except that caused by tuberculosis or std)	1976	266.54	305	114.43	15.44%	38	Previous arrangement for review of notes by respiratory consultant identified a number of issues with 'pneumonia' being miscoded as cause of death.	Reinstate previous review process. Monitor impact on other condition groups
Acute and Unspecified renal failure	416	39.86	64	160.55	15.38%	24		Specialty to review deaths reported in this period. Findings to presented to Mortality Surveillance Group
Congestive heart failure; non-hypertensive	625	67.17	87	129.51	13.92%	20		New lead for CCF revising pathways and reviewing NICE guidance
Acute cerebrovascular disease	578	81.41	99	121.61	17.13%	18	Independent review identified educational opportunities for the identification of stroke and SSNAP data highlights delay in access to CT scanning	Stroke specialty to review deaths reported in this period. Findings to presented to Mortality Surveillance Group
Secondary malignancies	755	22.48	36	160.13	4.77%	14	Random sample reviewed previously which identified no avoidable	Continue to monitor obs-exp deaths to identify any sharp increases.

							deaths. Some avoidable delays in discharge to home or hospice identified . Full report presented to Mortality Surveillance Group	
Liver disease; alcohol - related	177	19.33	30	155.18	16.95%	11		Gastroenterology specialty to review deaths reported in this period. Findings to presented to Mortality Surveillance Group.
Fluid and electrolyte disorders	344	15.54	26	167.27	7.56%	10		Audit of Deaths as aprt of thematic analysis
Peripheral and visceral atherosclerosis	617	28.78	39	135.51	6.32%	10		Vascular specialty to review deaths reported in this period. Findings to presented to Mortality Surveillance Group.
Skin and subcutaneous tissue infections	1172	13.37	23	171.98	1.96%	10		eSepsis to be launched Ongoing audit of screening
Septicaemia (except in labor)	1039	185.06	194	104.83	18.67%	9	Noted decrease from 27 to 9 (obs-exp) this period. Sepsis nurses reviewing cases using structured judgement review. Previous notes being reviewed by deteriorating patient group	eSepsis to be launched Ongoing audit of screening.

Appendix 2

COPD Learning

Fig 1

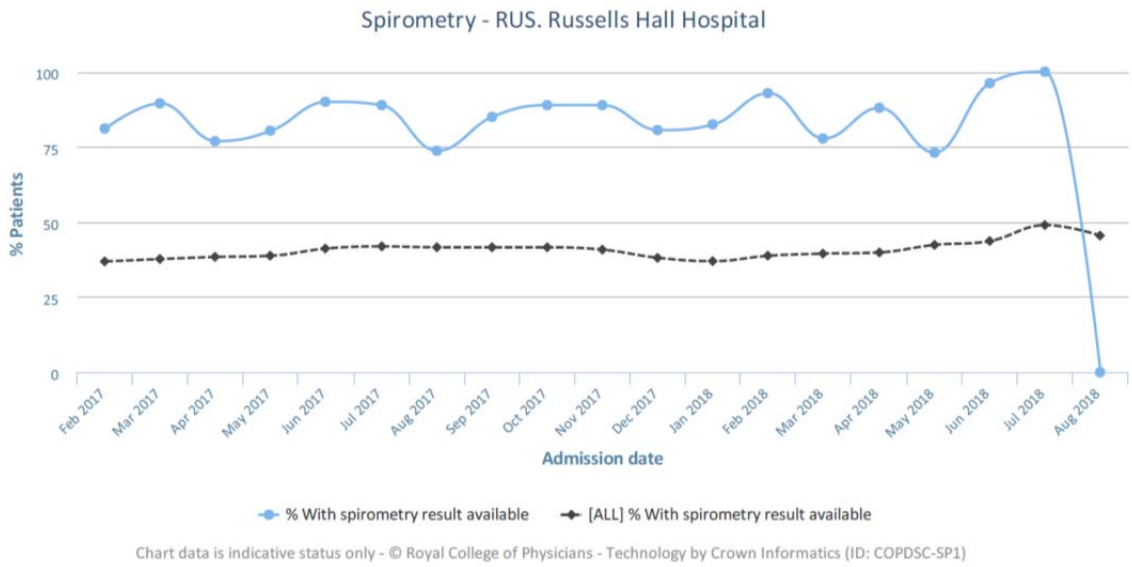


Fig 2

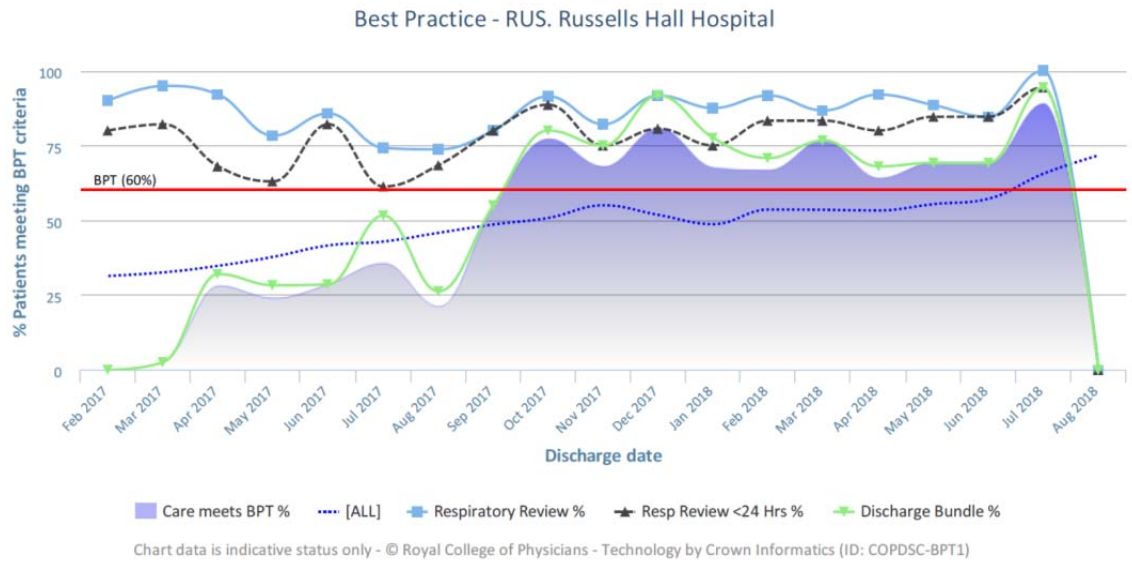


Fig 3

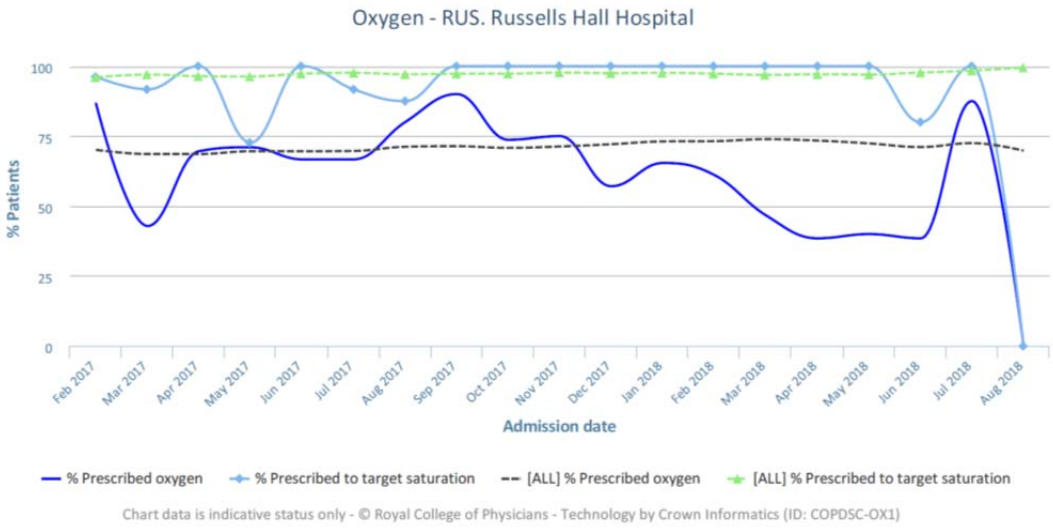

Oxygen - RUS. Russells Hall Hospital
100
75
50
25
0
% Patients
Feb 2017
Mar 2017
Apr 2017
May 2017
Jun 2017
Jul 2017
Aug 2017
Sep 2017
Oct 2017
Nov 2017
Dec 2017
Jan 2018
Feb 2018
Mar 2018
Apr 2018
May 2018
Jun 2018
Jul 2018
Aug 2018
Admission date
% Prescribed oxygen
% Prescribed to target saturation
[ALL] % Prescribed oxygen
[ALL] % Prescribed to target saturation
Chart data is indicative status only - © Royal College of Physicians - Technology by Crown Informatics (ID: COPDSC-OX1)

Fig 4

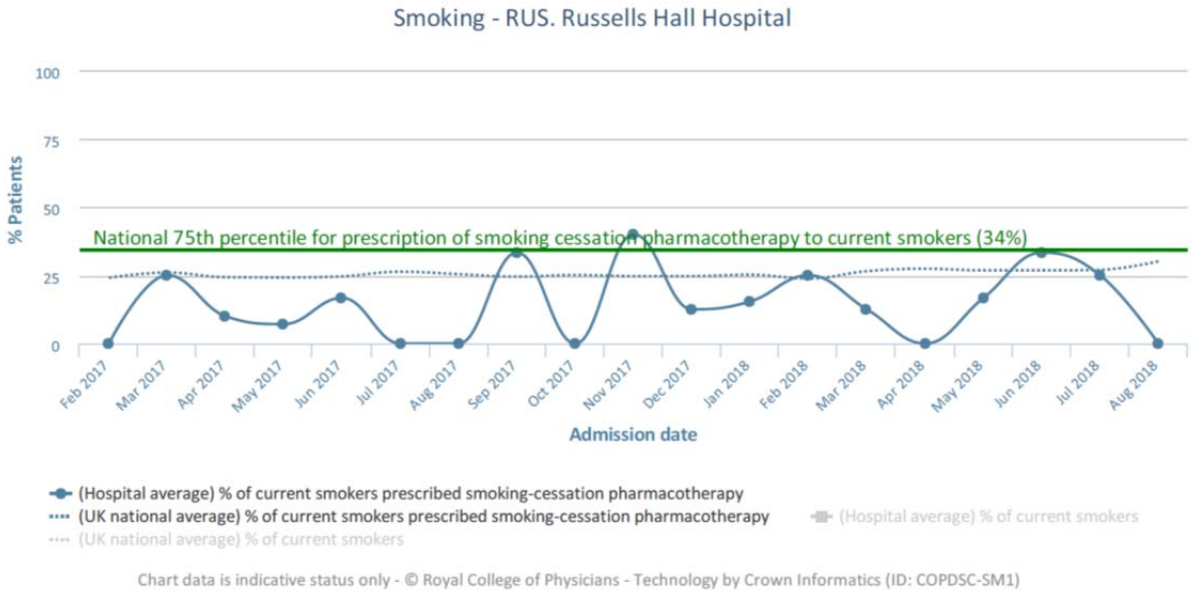

Smoking - RUS. Russells Hall Hospital
100
75
50
25
0
% Patients
National 75th percentile for prescription of smoking cessation pharmacotherapy to current smokers (34%)
Feb 2017
Mar 2017
Apr 2017
May 2017
Jun 2017
Jul 2017
Aug 2017
Sep 2017
Oct 2017
Nov 2017
Dec 2017
Jan 2018
Feb 2018
Mar 2018
Apr 2018
May 2018
Jun 2018
Jul 2018
Aug 2018
Admission date
(Hospital average) % of current smokers prescribed smoking-cessation pharmacotherapy
(UK national average) % of current smokers prescribed smoking-cessation pharmacotherapy
(Hospital average) % of current smokers
(UK national average) % of current smokers
Chart data is indicative status only - © Royal College of Physicians - Technology by Crown Informatics (ID: COPDSC-SM1)

Fig 5

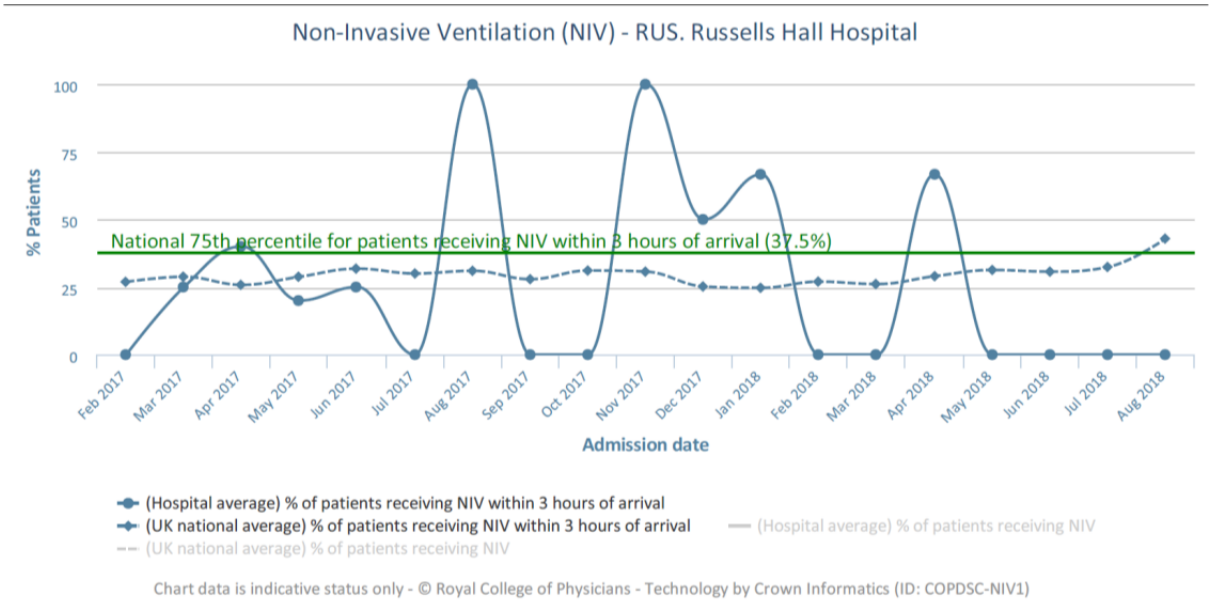
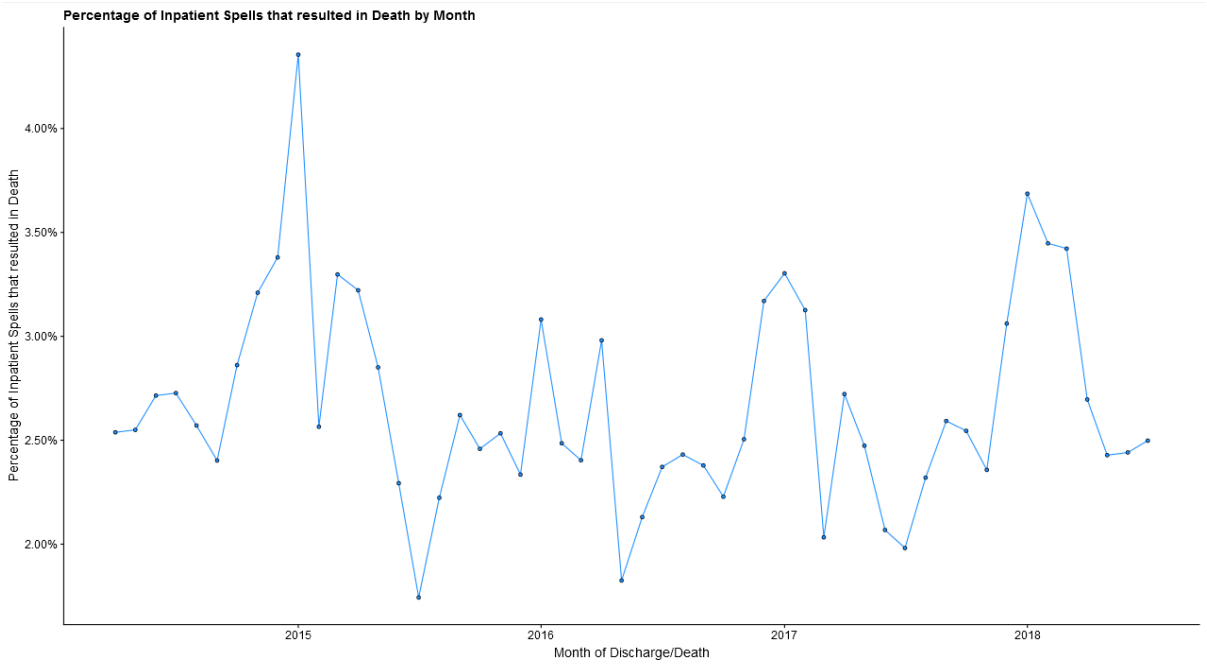


Fig. 6 Crude Mortality Data



Enclosure 15

The Dudley Group
NHS Foundation Trust

Paper for submission to the Board on the 6th September 2018

TITLE:	**Guardian of Safe Working Report**		
AUTHOR:	**Mr Babar Elahi – Guardian of Safe Working Hours**	**PRESENTER:**	**Mr Babar Elahi – Guardian of safe Working Hours**

CLINICAL STRATEGIC AIMS

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

CORPORATE OBJECTIVES:

SO2: Safe and Caring Services
SO4: Be the place people choose to work
SO5: Make the best use of what we have

The report covers the following elements:

- Guardian's quarterly report with ongoing challenges
- Progress to date

IMPLICATIONS OF PAPER:

RISK	**Y**		**Risk Description: Implementation of revised JD contract may adversely impact on rotas**
	Risk Register: Y COR102		**Risk Score: 16**
COMPLIANCE and/or LEGAL REQUIREMENTS	**CQC**	**Y**	**Details: links to safe, caring and well led domains**
	Monitor	**N**	**Details:**
	Other	**Y**	**Details: national requirement for effective guardian role**

ACTION REQUIRED OF BOARD

Decision	Approval	Discussion	Other
			Y

RECOMMENDATIONS FOR THE BOARD

The Board is asked to note the actions taken by the Trust and its appointed guardian of safe working.

The Dudley Group
NHS Foundation Trust

Guardian of Safe Working Report
September 2018

1. Purpose of Paper

To give assurance to the Trust Board that Junior Doctors in Training (JDT) are safely rostered and their working hours are compliant with the Terms and Conditions of Service for NHS Doctors and Dentists in Training (England) 2016 (TCS).

This paper provides a summary of the following areas related to JDT and the 2016 TCS:

- Challenges
- Exception reports
- Vacancies (data provided by Medical Work Force Department)

2. Background and Links to Previous Papers

The role of Guardian of Safe Working Hours (GSW) is to:

- Ensure the confidence of doctors that their concerns will be addressed
- Require improvements in working hours and work schedules for JDTs
- Provide Boards with assurance that junior medical staff are safe and able to work, identifying risks and advising Board on the required response
- Ensure the fair distribution of any financial penalty income, to the benefit of JDTs.

This is the 8th GSW report and covers the period of 22nd May 2018 to 29th August 2018. The Guardian has been working closely with colleagues from medical staffing and rostering, post graduate medical education staff, human resources and finance to establish his role in the Trust and build relationships.

3. Challenges

3.1 Engagement

Engagement with the junior doctor workforce continues to improve. The Guardian is following his strategy to engage junior doctors, which involves.

- Holding regular Guardian Junior doctor forum.
- Introduction to Guardian and his role by attending Junior Doctor Induction Day
- Attending junior doctor forum arranged by Postgraduate Clinical Tutor
- Attending junior doctors' operational forum
- Creating a dedicated Guardian email in the Trust
- Creating a webpage on the Trust HUB which carries information on Guardian role as well as how to make exception reports.
- Regular communication to junior doctors through emails
- Using Trust HUB to advertise important information to junior doctors

As part of the above mention strategy, Guardian has been engaging with junior doctors by one to one contact both formally and informally.

As mentioned in the last GSW board report, there continues to be improvement in the engagement by the Educational Supervisors (ES) and Clinical Supervisors (CS) towards exception reports.

4. Junior Doctor Induction

The Guardian has attended both inductions arranged by the Trust. First on 25th July 2018 for foundation doctors and second one for all the other junior doctors coming to the Trust on 1st August. This was part of greater strategy of engagement by the guardian with the trainees. Guardian on behalf of the Trust Board has assured all the junior doctors of their full support in creating a conducive environment for their training.

5. Guardian Forum

The last Guardian forum was held on 23rd August 2018. It was very well attended by the juniors. Doctors from different specialities and grades contributed towards a healthy discussion on various issues face by them. It was attended by representative from medical work force who tried to answer most of the queries by the junior doctors. It was agreed to hold more regular forum on shorter intervals.

6. National Speak Up month

Since October is the National Speak Up month, Guardian has been working closely with the other freedom to speak up guardians in the Trust. A leaflet has been produced jointly to create more awareness among the staff on whistleblowing, bullying and fraud prevention. As a part of National Speak Up month some of the junior doctors have volunteered to work with the Guardian office to create a poster explaining how and when to submit an exception report. The intention would be to promote a culture of openness among trainees. The poster will be placed across the Trust where junior doctors can easily access them.

7. Trust Exception Reporting Policy

As mentioned in the last report, Trust exception reporting policy is still awaiting its approval from JLNC.

7.1 Exception Reports by Department – From 22nd May to 29th August 2018 Total

Number of exceptions carried over	Number of exceptions raised	Number of exceptions closed	Number of exceptions outstanding	Specialty
None	5	3	2	T&O/ ENT SHO- 4 Surgery - 1

7.2 Exception Reports by Grade

Grade	Addressed within 48 hours	Addressed within 7 days	Addressed in longer than 7 days	Still open
ST2	2	3	0	5

7.3 **Response Time**

Within 48 hours	Within 7 days	Longer than 7 days	Still open
2	3	0	5

8. **Exception Reports and Fines**

We have received 5 exception reports by 4 doctors

- There was 1 exception report marked as "Immediate Safety Concern" which was addressed within 24 hours by the Surgical Directorate. Clinical Director, Clinical Supervisor and Director of Operation for Surgical Specialities on the request of Guardian, acted swiftly to ensure patient and doctor safety. Since the doctor who submitted the exception report is currently on leave, clinical supervisor has assured the Guardian they will address the junior's concerns upon return.
- 1 exception report has been completed with no further action agreed by the supervisor and the junior doctor but still open on the system as the doctor has left the Trust without closing the report.
- 2 exception reports submitted by 1 doctor is still open as both clinical supervisor and the junior doctor has agreed to a mutual convenient date for their meeting as both are on leave.
- 1 exception report is still open as the supervisor has requested more information after their initial meeting.

There have been no Guardian fines in the last 3 months.

9. **High Level Data**

Number of doctors/dentists in training (total): **196** (this number includes current vacancies and MTI posts)

Number of doctors/dentists in training on 2016 TCS (total): **196**

There are a total of **43** gaps (Appendix 1)

10. **Conclusion**

Guardian can give assurance to the Trust Board that Junior Doctors in Training (JDT) are safely rostered and their working hours are compliant with the Terms and Conditions of Service for NHS Doctors and Dentists in Training (England) 2016 (TCS).

11. **Recommendation**

The Board are asked to read and note this first report from the Guardian of Safe Working

Gaps as at May 2018

Speciality / Grade	FY1	FY2	ST 1-2	GPVTS	ST 3-8	Trust SHO	Trust Middle Grade	Total
Cardiology					1			1
Diabetes			1					1
Dermatology			1					1
Elderly Care					2	3	2	7
EAU		1			1			2
Gastro			1					1
ED			1		1	11		13
Renal				1	1			
General Surgery	1	1			1			3
ENT			1					1
Vascular Surgery		1						1
Haematology					2			2
T & O			1					1
Obs & Gynae								0
Paediatrics				1	1			2
Pathology								0
Radiology								0
Respiratory			2					2
Rheumatology			1					1
Stroke					1			1
Urology								0
Ophthalmology			1					1
Total	**1**	**3**	**10**	**2**	**11**	**14**	**2**	**43**

Next Steps

1. To encourage wider junior doctor engagement by the Guardian.
2. To use the Trust HUB to promote the role of Guardian in the Trust.

Enclosure 16

The Dudley Group NHS Foundation Trust

Paper for submission to the Board of Directors on 6th September 2018

TITLE:	**Speak Up (FTSU) Guardian Update**		
AUTHOR:	Derek Eaves, FTSU Guardian, Philippa Brazier, FTSU Guardian	**PRESENTER**	Derek Eaves, FTSU Guardian, Philippa Brazier, 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 Q1 of 2018/19
- Recent activities which includes: New Speak Up Guardian, Preparations for Speak Up Month in October and acceptance of National Speak Up Guardian to visit Trust on 11th October and present the Inaugural Lecture on October 11th in the CEC
- 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.

THE DUDLEY GROUP NHS FOUNDATION TRUST
Freedom to Speak Up (FTSU) Guardian September 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 the first quarter of this year and for Q2 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 includes such concerns as unfair recruitment, unfair rotas and concerns about redeployment of staff. Both of these two types of concerns cover those 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	3	8	5	2
Jul - Aug*	10	0	2	5	3	2

**To Aug 22nd (Others: Operational issues)(One concern may fall into more than one category)*

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
Jul - Aug*	10	5	1	1	1	0	2	0

**To Aug 22nd* ^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 or 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 an external review into concerns in a department about recruitment and care
- Arranged for internal investigation into behaviour of manager
- Appropriate action agreed with manager regarding concern

- Resolved a working arrangement by obtaining agreement for a staff member to change area of work
- Liaison with the Human Resources Department and resolved a sick leave issue
- Arranged meeting with senior manager and appropriate action taken.

Numbers of concerns raised at the Trust compared with other Trusts.

With regards to the full Q1 (2018/19) figures there were 15 concerns raised at the Trust. At the end of August the National Guardian Office (NGO) released the final data of the submissions from Trusts for Q1. The headlines were:

- 2,348 cases were raised to Freedom to Speak Up Guardians, ambassadors or champions.
- 731 of these cases included an element of patient safety or quality of care.
- 1,003 included elements of bullying and harassment.
- 110 related to incidents where the person speaking up may have suffered some form of detriment.
- 264 anonymous cases were received.
- 12 trusts did not report any cases through their Freedom to Speak Up Guardian.
- 223 out of 230 NHS trusts sent returns.
- Highest Trust had 112 cases (Local Trusts: 14, 12, 30 and No data received)

Recent actions and future plans

a) **New Guardian:** Philippa Brazier the new Guardian commenced in post in July and undertook the nationally based training in the same month. The appointment was announced and the Hub page was updated. New Posters have been commissioned.

b) **Self-Assessment/Vision and Values:** Following the report at the last meeting when the Board agreed both the contents of the Freedom to Speak Up self-review tool for NHS trusts and Foundation trusts and the draft FTSU Vision and Strategy an action plan has been drawn up and the Vision and strategy publicised on the Hub (see attached action plan below).

c) **Executive Lead:** Meetings with the Chief Executive continue.

d) **National Guardian Visit:** Following discussions with the Teaching Academy and Medical Education Manager an invite was made to Dr Henrietta Hughes, the National Freedom to Speak up Guardian to present the Academic Year Inaugural Lecture. This has been accepted and arranged for 11th October. Details of the lecture will be publicised shortly and arrangements will be made for Dr Hughes to meet senior staff and staff who have raised concerns and to walk round the hospital (as is the normal format when she visits Trusts).

e) **Speak up Month:** Initial discussions occurred with the Trust fraud and security specialists and staff engagement lead to arrange a joint speak up month in November. Shortly following this the National Guardian Office (NGO) announced that they were organising a national speak up month in October. It was decided to change our month to October and include the Trust patient safety lead (Dr Calthorpe). We await national branding due in week commencing 26th August. As well as the visit mentioned in d) above, the following plans are in place regarding speak up generally and on patient safety, fraud and security:

- Screensaver
- Undertake walkrounds
- Presence in Health Hub and CEC reception area
- Presence at Make it Happen event in October
- Attachment to payslips in September

- Write for the Patient Experience Bulletin
- Explore the use of Twitter/Facebook with Comms Team

f) **Champions**: In conjunction with Dr. Calthorpe an advert for FTSU Champions and Patient Safety Champions was placed on the Hub in late July with a closing date of 24th August. There has been interest from seven people. This issue will be progressed.

g) **Triangulation of data with HR**: Regular meetings with senior Human Resources staff are occurring so that general issues being raised (fully complying with confidentiality requirements) can be compared to HR cases.

h) **Attendance at staff forums:** The guardians are attending the recently formed surgical division staff forum and have been invited to recently commenced medical division forum.

i) **Demonstration of 'Speak in Confidence':** There are a number of cloudbased applications that are now available that allow staff to contact managers directly either anonymously or otherwise to raise issues and concerns. A demonstration was arranged of one which is being used by at least seven NHS Trusts such as Barts Health NHS Trust and St Helens and Knowsley Teaching Hospitals NHS Trust. Nine staff attended. Contact is now being awaited to discuss its usefulness with some pf the present users. In the meantime, the Communications Team and the Staff Engagement Lead are looking at producing a 24 hour available website for staff which may be able to take on the this function.

j) **Case Review: Derbyshire Community Health Services NHS Foundation Trust**

The NGO undertakes case reviews of the FTSU processes in Trusts when issues are raised with them by either staff or regulators. The NGO states: *'We expect all NHS trusts and foundation trusts to look at our case review reports to identify whether they can adopt the recommendations within to help improve their speaking up culture'*. Due to this when new reviews are published these will be included in these reports. The latest review was at the above Trust following staff, who had raised concerns, contacting the NGO. Twelve recommendations were made (and under each is our response):

1. The Trust should publish its new speaking up policy. The new policy should be written in a way that encourages workers to speak up and is easily understood. Unnecessary references to PIDA and malicious intention in speaking up should not be present.
   Trust speak up policy follows the national template and PIDA and malicious intention not included.
2. The Trust should take steps to ensure all existing and new workers are aware of the contents of the new freedom to speak up policy.
   Trust policy mentioned at induction and is available on the Hub both in the policy section and on Raising concerns Hub page. Reference to the Hub page is made on the staff leaflet.
3. The Trust should ensure that workers who wish to raise matters with the trust non-executive director responsible for speaking up are able to do so via routes of communication that appropriately support their confidentiality.
   Trust non-executive director direct contact details are on the Hub.
4. The Trust should ensure that, in line with its practices, it continues to value the views of its workers, including consulting staff about changes to their services where appropriate.
   This is done and the Trust has a policy in place for this.
5. Trust leaders should identify and employ a range of appropriate measures to monitor speaking up processes and culture within the trust, to ensure they are responsive to the needs of all workers and are developed in accordance with good practice.

Staff engagement Lead now in post, divisional staff forums have been commenced, FTSU Guardians have an auditing system in place using the previous FTSU Guardian.

6. The Trust should take appropriate steps to ensure that all cases of speaking up are investigated by suitably independent persons.
   This is done and examples can be provided.
7. The Trust should take all appropriate steps to ensure that responses to cases of workers speaking up, including decisions relating to the investigation of those cases, are not focused on whether or not the matters in those cases are qualifying disclosures under the Public Interest Disclosure Act.
   All concerns raised via the FTSU route are investigated on an equal consistent basis.
8. The Trust should develop a plan for embedding speaking up in the organisation. This plan should consider the use of staff inductions, team meetings, leadership training and other mechanisms to ensure that all staff have the necessary skills and knowledge to speak up well and respond to issues being raised appropriately.
   This is in place as indicated in this quarterly report to the Board.
9. The Trust should ensure that their speaking up arrangements, including the support provided by the Freedom to Speak Up Guardian, appropriately protect workers' confidentiality, and demonstrates appropriate understanding and empathy for the needs of individuals.
   This is in place and no issues on this have been raised.
10. The Trust should ensure that the Freedom to Speak Up Guardian records all instances of speaking up raised to them, not just those cases where workers state that they are raising a matter 'formally'.
    All contacts are recorded.
11. The Trust should take appropriate steps to ensure that where the grievance process is used to respond to a worker speaking up the trust's grievance policies and procedures are correctly followed, including in respect of providing an initial scoping meeting to discuss the matter the worker is speaking up about and the range of alternative processes for handling it.
    The Trust has the Speak Up Policy and all concerns raised follow that process and not the grievance process.
12. The Trust should take appropriate steps to ensure that all workers who speak up are meaningfully thanked for doing so, in accordance with trust culture, training and good practice.
    This is undertaken informally and will be done on a more formal basis immediately.

THE DUDLEY GROUP NHS FOUNDATION TRUST

Freedom to Speak Up (FTSU) Action Plan 2018

Action	Source	By Whom	By When	Progress
Draft vision and strategy to be agreed and launched with assistance from Communications Team	SA	Board Guardians	July 18	Complete
Questions on FTSU are included in walkrounds. The results will be put into quarterly reports to Board.	SA/S	Guardians	July 18	Complete
Appoint Speak Up Champions to raise awareness of the Trust's commitment to speaking up	SA/S	Guardians	Sep 18	Advert for champions placed on Hub in conjunction with Patient Safety Champions with closing date of August 24th
Undertake an LiA.	SA/S	Guardians	Mar 19	Awaiting first the development of the champions
Liaise closely with Equality and Staff Engagement Leads.	SA/S	Guardians	Jun onwards	Liaison with SE lead together with Security and Fraud leads on Speak month October
Unconscious Bias Training planned.	SA/S	E & D Lead	Mar 19	Awaiting change in Lead
A sample of cases is quality assured - To be commenced on a quarterly basis with previous Speak Up Guardian on a random number of cases	SA	Guardians	Oct 18	To commence after September
Engage with planned Staff Forums.	SA/S	Guardians	Jun 18	Attending meetings
Consider inviting National Guardian to the Trust	SA	Guardians	July 18	Invite sent. Accepted to come to Inaugural Lecture on 11th October
Positive outcomes from speaking up cases are promoted and as a result workers are more confident to speak up. Will give wider publicity to lessons learned	SA/S	Guardians	Jul 18	Placed on Hub page – need to consider how better to publicise
Working on strengthening the processes to facilitate wider learning from concerns raised with the Guardian.	SA	Medical/Nursing Directors	Mar 19	Learning is placed on Hub page and quarterly reports. Other
Locally organise and partake in the National Speak Up month in October	O	Guardians	Oct 18	Planning meeting organised for August

Source: SA= Freedom to Speak Up self-review tool for NHS trusts and foundation trusts. May 2018. S = FTSU Strategy O= Other

Enclosure 17

Paper for Submission to the Board
6 September 2018

TITLE:	Integrated Performance Report		
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 OBJECTIVES

SO1: Deliver a great patient experience
SO2: Safe and caring services
SO3: Be the place people choose to work
SO4: Make the best use of what we have
SO5: 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**:
	NHS I	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
		✓	

RECOMMENDATIONS FOR THE BOARD:

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

The Dudley Group
NHS Foundation Trust

Integrated Performance Report - Board




July 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	1,995	176	117	72	60	-	-	-	-	-	-	-	-	425	
Compliments	6,370	509	677	385	566	-	-	-	-	-	-	-	-	2,137	
Friends & Family – Community – Footfall	3.1%	2.9%	3%	4.2%	4.1%	-	-	-	-	-	-	-	-	3.6%	9%
Friends & Family – Community – Recommended %	96.6%	96.6%	95.3%	96.6%	95.5%	-	-	-	-	-	-	-	-	96%	97.7%
Friends & Family – ED – Footfall	19.1%	17.9%	18%	19.1%	18.6%	-	-	-	-	-	-	-	-	18.4%	21.3%
Friends & Family – ED – Recommended %	77.3%	81.8%	77.8%	77.1%	76.2%	-	-	-	-	-	-	-	-	78.1%	93.3%
Friends & Family – Inpatients – Footfall	32.1%	32.2%	33%	42.4%	35.9%	-	-	-	-	-	-	-	-	35.8%	35.1%
Friends & Family – Inpatients – Not Recommended %	1.5%	1.8%	2.1%	2%	1.8%	-	-	-	-	-	-	-	-	1.9%	%
Friends & Family – Inpatients – Recommended %	95.4%	94.9%	93.7%	94.4%	94.1%	-	-	-	-	-	-	-	-	94.3%	97.4%
Friends & Family – Maternity – Footfall	40.3%	30.3%	43.2%	37.9%	31.8%	-	-	-	-	-	-	-	-	36%	34.4%
Friends & Family – Maternity – Not Recommended %	0.6%	1.2%	0.9%	0.4%	0.8%	-	-	-	-	-	-	-	-	1%	%
Friends & Family – Maternity – Recommended %	97.8%	98.1%	97.2%	98.1%	98.8%	-	-	-	-	-	-	-	-	98%	97.9%
Friends & Family – Outpatients – Footfall	4.3%	4.9%	5.7%	5.1%	5.8%	-	-	-	-	-	-	-	-	5.3%	14.4%
Friends & Family – Outpatients – Recommended %	91.8%	90.1%	89.4%	90.5%	87.4%	-	-	-	-	-	-	-	-	89.2%	97.1%
HCAI – Post 48 hour MRSA	0	0	0	0	0	-	-	-	-	-	-	-	-	0	0
HCAI CDIFF – Due To Lapses In Care	19	3	0	0	0	-	-	-	-	-	-	-	-	3	8
HCAI CDIFF – Not Due To Lapses In Care	11	1	0	0	0	-	-	-	-	-	-	-	-	1	
HCAI CDIFF – Total Number Of Cases	30	4	0	3	0	-	-	-	-	-	-	-	-	7	
HCAI CDIFF – Under Review	0	0	0	3	0	-	-	-	-	-	-	-	-	3	
Incidents - Appointments, Discharge & Transfers	1,028	78	93	83	99	-	-	-	-	-	-	-	-	353	
Incidents - Blood Transfusions	88	9	7	5	2	-	-	-	-	-	-	-	-	23	
Incidents - Clinical Care (Assessment/Monitoring)	1,375	149	149	131	161	-	-	-	-	-	-	-	-	590	
Incidents - Diagnosis & Tests	397	42	53	51	33	-	-	-	-	-	-	-	-	179	
Incidents - Equipment	290	29	33	51	33	-	-	-	-	-	-	-	-	146	
Incidents - Facilities (Security, Estates, Transport, Fire etc.)	491	36	34	33	32	-	-	-	-	-	-	-	-	135	
Incidents - Falls, Injuries or Accidents	1,442	106	89	109	94	-	-	-	-	-	-	-	-	398	
Incidents - Health & Safety	331	33	31	24	41	-	-	-	-	-	-	-	-	129	
Incidents - Infection Control	112	12	10	7	6	-	-	-	-	-	-	-	-	35	

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
Medication	4,160	412	285	445	312	-	-	-	-	-	-	-	-	1,454	
Incidents - Obstetrics	990	52	62	83	81	-	-	-	-	-	-	-	-	278	
Incidents - Pressure Ulcer	3,492	303	266	235	237	-	-	-	-	-	-	-	-	1,041	
Incidents - Records, Communication & Information	825	77	87	63	90	-	-	-	-	-	-	-	-	317	
Incidents - Safeguarding	866	86	120	105	154	-	-	-	-	-	-	-	-	465	
Incidents - Theatres	208	24	21	28	15	-	-	-	-	-	-	-	-	88	
Incidents - Venous Thrombo Embolism (VTE)	127	16	2	19	8	-	-	-	-	-	-	-	-	45	
Incidents - Violence, Aggression & Self Harm	734	52	66	48	67	-	-	-	-	-	-	-	-	233	
Incidents - Workforce	679	53	38	60	62	-	-	-	-	-	-	-	-	213	
Maternity : Early Booking KPI: % of women who see midwife/maternity healthcare professional	100%	100%	100%	100%	100%	-	-	-	-	-	-	-	-	100%	100%
Maternity : Increase in breast feeding initiation rates by 2% per year	56.85%	59.22%	60.37%	56.77%	69.45%	-	-	-	-	-	-	-	-	61.45%	61%
Maternity : Smoking In Pregnancy : Reduce to a prevalence of 12.1% across the year	15.61%	14.28%	13.52%	15.77%	15.65%	-	-	-	-	-	-	-	-	14.79%	12.1%
Mixed Sex Sleeping Accommodation Breaches	51	3	7	5	0	-	-	-	-	-	-	-	-	15	0
Never Events	3	0	0	0	0	-	-	-	-	-	-	-	-	0	0
NQA - Matrons Audit	92%	91%	95%	94%	-	-	-	-	-	-	-	-	-	94%	94%
NQA - Midwifery Audit	97%	98%	97%	98%	95%	-	-	-	-	-	-	-	-	97%	94%
NQA - Nutrition Audit	94%	94%	96%	93%	93%	-	-	-	-	-	-	-	-	94%	94%
NQA - Paediatric Nutrition Audit	98%	98%	93%	85%	98%	-	-	-	-	-	-	-	-	95%	94%
NQA - Skin Bundle	95%	95%	94%	92%	95%	-	-	-	-	-	-	-	-	94%	94%
NQA - Theatres and Critical Care Environment Audit	90%	96%	89%	93%	-	-	-	-	-	-	-	-	-	93%	94%
NQA - Think Glucose - EAU/SAU	77%	90%	100%	100%	100%	-	-	-	-	-	-	-	-	97%	94%
NQA - Think Glucose - General Wards	94%	96%	95%	98%	95%	-	-	-	-	-	-	-	-	96%	95%
Nursing Care Indicators - Community Childrens	99%	100%	100%	100%	-	-	-	-	-	-	-	-	-	100%	94%
Nursing Care Indicators - Community Neonatal	100%	100%	100%	100%	100%	-	-	-	-	-	-	-	-	100%	94%
Nursing Care Indicators - Critical Care	98%	100%	98%	100%	98%	-	-	-	-	-	-	-	-	99%	95%
Nursing Care Indicators - District Nurses	94%	95%	96%	97%	97%	-	-	-	-	-	-	-	-	97%	95%
Nursing Care Indicators - EAU	90%	96%	90%	94%	86%	-	-	-	-	-	-	-	-	91%	95%
Nursing Care Indicators - ED	88%	95%	88%	91%	92%	-	-	-	-	-	-	-	-	92%	95%

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
Nursing Care Indicators - General Wards	95%	97%	95%	97%	93%	-	-	-	-	-	-	-	-	95%	94%
Nursing Care Indicators - Maternity	96%	93%	97%	100%	-	-	-	-	-	-	-	-	-	96%	94%
Nursing Care Indicators - Medicines Management	91%	94%	92%	94%	94%	-	-	-	-	-	-	-	-	93%	94%
Nursing Care Indicators - Neonatal	99%	96%	98%	97%	99%	-	-	-	-	-	-	-	-	98%	94%
Nursing Care Indicators - Paediatric	95%	96%	94%	99%	86%	-	-	-	-	-	-	-	-	94%	94%
Nursing Care Indicators - Renal	97%	98%	87%	94%	94%	-	-	-	-	-	-	-	-	93%	94%
Nursing Care Indicators - Surgical Assessment Unit	94%	98%	99%	98%	95%	-	-	-	-	-	-	-	-	97%	95%
PALS Concerns	15,006	870	501	326	207	-	-	-	-	-	-	-	-	1,904	
Saving Lives - 1 Ventilator Associated Pneumonia (*New 18/19)	-	100%	100%	100%	100%	-	-	-	-	-	-	-	-	100%	95%
Saving Lives - 2a Peripheral Vascular Access Devices - Insertion (*New 18/19)	-	99%	100%	100%	99%	-	-	-	-	-	-	-	-	99%	95%
Saving Lives - 2b Peripheral Vascular Access Devices - Ongoing Care (*New 18/19)	-	96%	96%	98%	100%	-	-	-	-	-	-	-	-	97%	95%
Saving Lives - 3a Central Venous Access Devices - Insertion (*New 18/19)	-	100%	100%	100%	96%	-	-	-	-	-	-	-	-	99%	95%
Saving Lives - 3b Central Venous Access Devices - Ongoing Care (*New 18/19)	-	100%	98%	100%	100%	-	-	-	-	-	-	-	-	99%	95%
Saving Lives - 4a Surgical site infection prevention - Preoperative (*New 18/19)	-	100%	100%	100%	100%	-	-	-	-	-	-	-	-	100%	95%
Saving Lives - 4b Surgical site infection prevention - Intraoperative actions (*New 18/19)	-	100%	100%	100%	100%	-	-	-	-	-	-	-	-	100%	95%
Saving Lives - 5 Infection Prevention in Chronic Wounds (*New 18/19)	-	100%	100%	100%	100%	-	-	-	-	-	-	-	-	100%	95%
Saving Lives - 6a Urinary Catheter - Insertion (*New 18/19)	-	100%	100%	100%	99%	-	-	-	-	-	-	-	-	99%	95%
Saving Lives - 6b Urinary Catheter - Maintenance and Assessment (*New 18/19)	-	100%	98%	98%	99%	-	-	-	-	-	-	-	-	99%	95%
Serious Incidents - Action Plan overdue	74	3	-	-	-	-	-	-	-	-	-	-	-	3	
Serious Incidents - Appointments, Discharge & Transfers	4	-	-	-	1	-	-	-	-	-	-	-	-	1	
Serious Incidents - Clinical Care (Assessment/Monitoring)	80	1	-	2	6	-	-	-	-	-	-	-	-	9	
Serious Incidents - Diagnosis & Tests	12	-	1	-	1	-	-	-	-	-	-	-	-	2	

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	84	-	1	1	2	-	-	-	-	-	-	-	-	4	
Serious Incidents - Infection Control	20	2	-	-	-	-	-	-	-	-	-	-	-	2	
Serious Incidents - Medication	8	-	-	1	-	-	-	-	-	-	-	-	-	1	
Serious Incidents - Obstetrics	12	-	-	-	1	-	-	-	-	-	-	-	-	1	
Serious Incidents - Pressure Ulcer	392	8	1	4	-	-	-	-	-	-	-	-	-	13	
Serious Incidents - Safeguarding	-	-	-	-	1	-	-	-	-	-	-	-	-	1	
Serious Incidents - Venous Thrombo Embolism (VTE)	-	-	-	-	1	-	-	-	-	-	-	-	-	1	
Stroke Admissions : Swallowing Screen	82.84%	92.10%	86.27%	94.44%	100%	-	-	-	-	-	-	-	-	92.35%	75%
Stroke Admissions to Thrombolysis Time	57.69%	42.85%	60.00%	50%	50%	-	-	-	-	-	-	-	-	50%	%
Stroke Patients Spending 90% of Time On Stroke Unit (VSA14)	92.56%	91.89%	87.71%	97.77%	92.68%	-	-	-	-	-	-	-	-	92.22%	85%
Suspected High-risk TIA Assessed and Treated < 24hrs from presentation	94.15%	77.77%	100%	85.71%	77.77%	-	-	-	-	-	-	-	-	88.09%	85%
Time to Procedure: Emergency Procedures (Upper GI Diagnostic endoscopic)	66.66%	65.3%	57.89%	43.33%	54%	-	-	-	-	-	-	-	-	54.31%	0%
Time to Surgery - Elective admissions operated on within two days for all procedures	87%	99.77%	99.86%	99.95%	99.89%	-	-	-	-	-	-	-	-	99.87%	0%
Time to Surgery : Emergency Procedures (Appendectomy)	97%	92.5%	90.62%	87.09%	84%	-	-	-	-	-	-	-	-	89.06%	0%
Time to Surgery : Emergency Procedures (Femur Replacement #NOF)	93.23%	95.23%	96.96%	95%	100%	-	-	-	-	-	-	-	-	96.59%	0%
Time to Surgery : Emergency Procedures (Reduction of fracture of bone excl. #NOF)	91.68%	88.57%	91%	88.13%	94%	-	-	-	-	-	-	-	-	90.54%	0%
VTE Assessment Indicator (CQN01)	93.37%	95.10%	94.8%	95.47%	95.11%	-	-	-	-	-	-	-	-	95.12%	95%

The Dudley Group NHS Foundation Trust

Executive Summary by Exception

Key Messages

CQSPE

HCAI

There was no C. Diff cases identified after 48hrs for the month.

	July	YTD
Total No. of cases due to lapses in care	NIL	3
Total No. of cases NOT due to lapses in care	NIL	4
No. of cases currently under review (ytd)	1	NIL
Total No. of cases ytd.	NIL	7

There were 0 post 48 hour MRSA cases reported in month. The last post 48 hours MRSA cases was in September 2015, 1064 days ago.

Friends and Family Scores:

FFT response rate improvement plan is in place.

Complaints:

The Trust is continuing to make good progress with complaints. The full details are included in patient experience paper

Falls:

We continue to work with NHSI and the National Fall Practitioner network with the aim of achieving a consistent reduction in falls, particularly falls with harm.

Pressure Ulcers

There have been 0 avoidable grade 4 pressure ulcers reported since January 2018. There were 5 verified grade 3 pressure ulcers in July 2018, 2 Hospital acquired (C1 and B2 Trauma) and 3 Community acquired, all have been determined as unavoidable.

Never Events

There were 0 never events in month, or year to date.

Mixed Sex Sleeping Accommodation Breaches (MSA)

There are 0 MSA breaches in month.

VTE Assessment On Admission: Indicator

The target was achieved in month with provisional performance at 95.1% against a target of 95%.

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 85.30%. Whilst, the Trust only (Type 1) performance was 76.73%.

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

	Attendances	Breaches	Performance
A&E Dept. Type 1	9565	2225	76.73%
UCC Type 3	5795	33	99.43%

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 81.6% (Provisional as at 17th Aug). Previous month confirmed performance was 79.9%

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

No. of Patients treated on or over 104 days (DGFT)	7
No. of Patients treated on or over 104 days (Tertiary Centre)	2
No. of Patients treated on or over 104 days (Combined)	9

2WW

The target was achieved once again in month. During this period a total of 1378 patients attended a 2ww appointment with 57 patients attending their appointments outside of the 2 week standard, achieving a performance 94.9% 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 94.1% in month against a target of 92%, a decrease in performance from 94.5% in the previous month. Urology did not meet the target in month at 88.1% down from 88.7% in previous month. Ophthalmology is at 85.4% down from 86.1% in the previous month. General Surgery at 93.1% down from 93.5%. 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 99.2%. The number of patients waiting over 6 weeks was 52.

Executive Summary by Exception cont.

Key Messages

2 Financial Performance Matters — Committee: F&P

Adjusted deficit of £2.526m for April-July, representing a £0.412m adverse variance in comparison to the control total. However, underlying position is significantly worse than this linked to one-off benefits (PFI £0.903m and 17/18 income £0.482m negated by £0.4m of 17/18 costs) plus the inclusion of £0.470m linked to "lost" emergency admissions (not yet agreed by CCG). The full year base forecast predicts a deficit of £9.606m before PSF (upside of a £5.068m deficit and downside of a £14.248m deficit). A recovery plan of the magnitude of £9m is thus required to improve upon the base forecast and deliver the control total.

The position on the Trust's liquidity ratio was -8.00 days against a planned position of -6.70 days at Month 4.

The Dudley Group NHS Foundation Trust

Executive Summary by Exception cont.

Key Messages

4 Workforce — Committee: F&P

Staff Appraisals

This includes all non-medical appraisals in the Trust. The window has now closed and we are pleased to announce a compliance rate of over 96%. This is the highest performance in this area for the Trust and puts Dudley as one of the leading Trusts in the country for staff engagement by way of the appraisal process. We are now working on collating the information from the appraisals to influence or training needs analysis. This will be presented to the Workforce Committee in September 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 overall compliance has increased to 88.92%. This is the highest compliance recorded in the Trust and therefore all efforts will continue to be made to achieve and surpass our target of 90%. There are trajectories in place for each Division with performance reviews focusing on compliance for every member of staff.

Sickness Rate

The absence rate has increased slightly to 4.43% from 4.35% in June 2018. Although this is a relatively positive absence rate it is still 0.4% above the rate at the same time last year. We have seen a rise in the number of sickness cases associated to stress and anxiety. Therefore, the strategy of managing staff has developed to provide relevant support and interventions in order that staff are fit to return to work.

Turnover & Vacancy Rate

The turnover rate has seen another drop and currently sits at 9.5%. 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 Staff Engagement lead has demonstrated a particular focus on understanding the feedback from exit interviews, listening to staff and developing strategies to support improved retention at the Trust. The initial feedback is very positive and this will be developed further as we move into the feedback for the national staff survey.

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)	Jun-18	Jul-18	Actual YTD	Trend	Month Status
Friends & Family Test - Footfall							
Friends & Family Test - ED	14.5%	21.3%	19.1%	18.7%	18.4%	↓	
Friends & Family Test - Inpatients	26.0%	35.1%	42.4%	36.0%	35.8%	↓	
Friends & Family Test - Maternity	21.7%	34.4%	37.9%	31.9%	36.1%	↓	
Friends & Family Test - Outpatients	4.7%	14.5%	5.1%	5.8%	5.4%	↑	
Friends & Family Test - Community	3.5%	9.1%	4.3%	4.1%	3.7%	↓	
Friends & Family Test - Recommended							
Friends & Family Test - ED	89.9%	93.4%	77.1%	76.2%	78.1%	↓	
Friends & Family Test - Inpatients	96.3%	97.4%	94.5%	94.2%	94.3%	↓	
Friends & Family Test - Maternity	96.0%	98.1%	98.1%	98.9%	98.0%	↑	
Friends & Family Test - Outpatients	94.6%	97.2%	90.6%	87.4%	89.3%	↓	
Friends & Family Test - Community	96.4%	97.7%	96.6%	95.7%	96.1%	↓	
Complaints							
Total no. of complaints received in month		0	38	75	197	↑	
Complaints re-opened			5	2	16	↓	
PALs Numbers			268	301	1181	↑	
Complaints open at month end			204	216	------	↑	
Compliments received			399	566	2151	↑	
Dementia (1 month in arrears)							
Find/Assess		90%	98.3%		97.9%	↑	
Investigate		90%	100.0%		100.0%	↑	
Refer		90%	90.3%		95.9%	↑	
Falls	National average 6.63 per 1000 bed days						
No. of Falls			64	55	241	↓	
Falls per 1000 bed days		6.63	3.90	3.27	3.55	↓	
No. of Multiple Falls		N/A	4	7	25	↑	
Falls resulting in moderate harm or above			1	2	4	↑	
Falls resulting in moderate harm or above per 1000 bed days		0.19	3.9	3.3	3.5	↓	
Pressure Ulcers (Grades 3 & 4)							
Hospital Avoidable		0	1	0	2	↓	
Hospital Non-avoidable		0	2	2	11	↔	
Community Avoidable		0	1	0	4	↓	
Community Non-avoidable		0	8	3	26	↓	
Handwash							
Handwashing			99.6%	99.8%	99.1%	↑	

Patients will experience safe care - Patient Safety

	Target (Amber)	Target (Green)	Jun-18	Jul-18	Actual YTD	Trend	Month Status
Mixed Sex Accommodation Breaches							
Single Sex Breaches		0	5	0	15	↓	
Mortality (Quality Strategy Goal 3)							
HSMR Rolling 12 months (**Latest data May 18**)	110	105	116	117	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	3	3	4	↔	
MRSA Bacteraemia		0	0	0	0	↔	
MSSA Bacteraemia		0	1	0	4	↓	
E. Coli - Total hospital		0	4	1	13	↓	
Stroke Admissions - PROVISIONAL							
Stroke Admissions: Swallowing Screen		75%	91.7%	100.0%	91.1%	↑	
Stroke Patients Spending 90% of Time on Stroke Unit		85%	95.6%	92.7%	92.6%	↓	
Suspected High Risk TIAs Assessed and Treated <24hrs		85%	100.0%	77.8%	90.9%	↓	
VTE - PROVISIONAL							
VTE On Admission		95%	95.6%	95.1%	95.3%	↓	
Incidents							
Total Incidents			1395	1534	5718	↑	
Recorded Medication Incidents			445	312	1309	↓	
Never Events			0	0	0	↔	
Serious Incidents			8	13	35	↑	
of which, pressure ulcers			4	0	13	↓	
Incident Grading by Degree of Harm							
Death			1	3	4	↑	
Severe			2	7	10	↑	
Moderate			57	34	129	↓	
Low			209	203	838	↓	
No Harm			1126	1287	4737	↑	
Percentage of incidents causing harm		28%	19.3%	16.1%	17.2%	↓	

Performance - "At a glance"

Executive Lead: Karen Kelly

The Dudley Group NHS Foundation Trust

Performance - Key Performance Indicators

	Target	Jun-18	Jul-18	Actual YTD	Trend	Month Status
Cancer Reporting - TRUST (provisional)						
All Cancer 2 week waits	93%	94.6%	94.9%	93.5%	↑	
2 week wait - Breast Symptomatic	93%	95.4%	93.0%	95.1%	↓	
31 day diagnostic to 1st treatment	96%	99.5%	95.3%	98.4%	↓	
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%	79.9%	81.6%	81.6%	↑	
62 day screening programme	90%	100.0%	100.0%	97.7%	↔	
62 day consultant upgrades	85%	91.5%	83.0%	87.4%	↓	
Referral to Treatment						
RTT Incomplete Pathways - % still waiting	92%	94.5%	94.1%	94.2%	↓	
RTT Admitted - % treatment within 18 weeks	90%	86.6%	88.2%	86.7%	↑	
RTT Non Admitted - % treatment within 18 weeks	95%	95.9%	95.8%	95.2%	↓	
Wait from referral to 1st OPD	26	24	25	93	↑	
Wait from Add to Waiting List to Removal	39	44	47	179	↑	
ASI List		2496	2553		↑	
% Missing Outcomes RTT		0.09%	0.02%	0.1%	↓	
% Missing Outcomes Non-RTT		9.7%	5.9%	6.6%	↓	
DM01						
No. of diagnostic tests waiting over 6 weeks	0	49	56	194	↑	
% of diagnostic tests waiting less than 6 weeks	99%	99.3%	99.2%	99.3%	↓	
ED - TRUST						
Patients treated < 4 hours Type 1 (Trust ED)	95%	78.7%	76.7%	77.2%	↓	
Patients treated < 4 hours Type 1 & 3 (ED + UCC)	95%	86.9%	85.3%	86.0%	↓	
Emergency Department Attendances	N/A	8944	9565	35881	↑	
12 Hours Trolley Waits		0	0	1	↔	
Ambulance to ED Handover Time - TRUST						
30-59 minute breaches		437	542	1596	↑	
60+ minute breaches		53	119	247	↑	
Ambulance to Assessment Area Handover Time - TRUST						
30-59 minute breaches		18	27	89	↑	
60+ minute breaches		0	2	14	↑	

Performance - Key Performance Indicators cont.

	Target	Jun-18	Jul-18	Actual YTD	Trend	Month Status
Cancelled Operations - TRUST						
% Cancelled Operations	1.0%	1.8%	1.5%	1.5%	↓	
Cancelled operations - breaches of 28 day rule	0	2	2	4	↔	
Urgent operations - cancelled twice	0	0	0	0	↔	
GP Discharge Letters						
GP Discharge Letters	90%	78.7%	78.0%	74.4%	↓	
Theatre Utilisation - TRUST						
Theatre Utilisation - Day Case (RHH & Corbett)		76.7%	77.0%	76.5%	↑	
Theatre Utilisation - Main		88.8%	88.1%	88.4%	↓	
Theatre Utilisation - Trauma		96.7%	94.9%	95.6%	↓	
GP Referrals						
GP Written Referrals - made		6993	6687	28797	↓	
GP Written Referrals - seen		5919	6268	23522	↑	
Other Referrals - Made		3508	3763	13762	↑	
Throughput						
Patients Discharged with a LoS >= 7 Days		7%	7%	7%	↔	
Patients Discharged with a LoS >= 14 Days		3%	3%	3%	↓	
7 Day Readmissions		4%	2%	3%	↓	
30 Day Readmissions - PbR		8%	4%	7%	↓	
Bed Occupancy - %		90%	87%	90%	↓	
Bed Occupancy - % Medicine & IC		94%	94%	95%	↓	
Bed Occupancy - % Surgery, W&C		87%	81%	86%	↓	
Bed Occupancy - Paediatric %		53%	56%	67%	↑	
Bed Occupancy - Orthopaedic Elective %		68%	69%	74%	↑	
Bed Occupancy - Trauma and Hip %		95%	91%	94%	↓	
Number of Patient Moves between 8pm and 8am		119	94	414	↓	
Discharged by Midday		13%	13%	13%	↑	
Outpatients						
New outpatient appointment DNA rate	8%	11.8%	9.0%	10.3%	↓	
Follow-up outpatient appointment DNA rate	8%	9.2%	8.3%	8.3%	↓	
Total outpatient appointment DNA rate	8%	10.2%	8.5%	9.9%	↓	
Clinic Utilisation		75.6%	73.3%	74.9%	↓	
Average Length of stay (Quality Strategy Goal 3)						
Average Length of Stay - Elective		2.9	3.7	3.3	↑	
Average Length of Stay - Non-Elective	3.4	5.4	5.2	5.5	↓	

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	473	458	-3.2%	-15	1,469	1,378	-6.2%	-91
Day Cases	4,148	4,759	14.7%	611	12,158	13,838	13.8%	1,680
Non-elective inpatients	4,093	3,610	-11.8%	-483	12,236	10,749	-12.2%	-1,487
Outpatients	37,969	39,036	2.8%	1,067	115,593	114,578	-0.9%	-1,015
A&E	8,639	8,944	3.5%	305	25,595	26,316	2.8%	721
Total activity	**55,322**	**56,807**	**2.7%**	**1,485**	**167,051**	**166,859**	**-0.1%**	**-192**
CIP	**£'000**	**£'000**		**£'000**	**£'000**	**£'000**		**£'000**
Income	330	630	90.9%	300	861	1,134	31.8%	274
Pay	238	265	11.5%	27	686	767	11.9%	82
Non-Pay	149	240	61.0%	91	598	1,966	228.9%	1,368
Total CIP	**717**	**1,135**	**58.3%**	**418**	**2,144**	**3,868**	**80.4%**	**1,724**
INCOME	**£'000**	**£'000**		**£'000**	**£'000**	**£'000**		**£'000**
NHS Clinical	27,362	27,677	1.2%	315	82,046	81,526	-0.6%	-520
Other Clinical	358	741	107.0%	383	964	1,338	38.8%	374
STF Funding	452	45	-90.0%	-407	1,356	949	-30.0%	-407
Other	2,066	2,247	8.7%	181	5,795	5,904	1.9%	109
Total income	**30,238**	**30,709**	**1.6%**	**471**	**90,160**	**89,717**	**-0.5%**	**-444**
OPERATING COSTS	**£'000**	**£'000**		**£'000**	**£'000**	**£'000**		**£'000**
Pay	-18,771	-18,765	0.0%	6	-55,882	-56,038	0.3%	-156
Drugs	-2,866	-2,700	-5.8%	166	-8,421	-8,498	0.9%	-77
Non-Pay	-7,088	-7,061	-0.4%	27	-21,045	-20,775	-1.3%	270
Total Costs	**-28,725**	**-28,526**	**-0.7%**	**200**	**-85,348**	**-85,311**	**0.0%**	**37**

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	**1,504**	**2,186**	45.3%	**682**	**4,785**	**4446**	-7.1%	**-339**
Depreciation	-816	-844	3.4%	-28	-2,445	-2507	2.5%	-62
Restructuring & Other	0	0	n/a	0	0	0	n/a	0
Financing Costs	-1,227	-1,215	-1.0%	12	-3,701	-3685	-0.4%	16
SURPLUS/(DEFICIT)	**-539**	**127**	-123.6%	**666**	**-1,361**	**-1746**	**28.3%**	**-385**
SOFP	**£'000**	**£'000**		**£'000**	**£'000**	**£'000**		**£'000**
Capital Spend	-809	-923	14.1%	-114	-2,939	-2,029	-31.0%	910
Inventory					3,002	3,186	6.1%	184
Receivables & Prepayments					16,608	18,938	14.0%	2,330
Payables					-22,241	-23,296	4.7%	-1,055
Accruals							n/a	0
Deferred Income					-4,656	-3,467	-25.5%	1,189
Cash & Loan Funding	**£'000**	**£'000**		**£'000**	**£'000**	**£'000**		**£'000**
Cash					6,096	9,717	59.4%	3,621
Loan Funding							n/a	0
KPIs								
EBITDA %	5.2%	7.6%	2.4%		1.8%	1.7%	-0.1%	
Deficit %	-1.9%	0.4%	2.3%		-0.5%	-0.7%	-0.2%	
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					3	3		

The Dudley Group NHS Foundation Trust

Workforce - "At a glance"

Executive Lead: Andrew McMenemy

People	Target 18/19	Target	Jun-18	Jul-18	Actual YTD	Trend	Month Status
Workforce							
Sickness Absence Rate	3.75%	3.75%	4.35%	4.21%	4.09%	↓	
Staff Turnover	8.5%	9%	9.6%	9.5%	9.7%	↓	
Mandatory Training	90.0%	90%	87.7%	88.9%	88.2%	↑	
Appraisal Rates - Total	90.0%	90.0%	95.6%	95.6%	65.3%	↔	

Enclosure 18

The Dudley Group
NHS Foundation Trust

Paper for submission to the Board of Directors on 6 September 2018

TITLE:	**Finance and Performance Committee Exception Report**		
AUTHOR:	Tom Jackson Director of Finance	**PRESENTER**	Jonathan Hodgkin Chair of Finance and Performance Committee
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 meetings held on 26 July and 30 August 2018.			

IMPLICATIONS OF PAPER:

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

ACTION REQUIRED OF BOARD

Decision	Approval	Discussion	Other
		X	X

RECOMMENDATIONS FOR THE BOARD:

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

Meeting	Meeting Date	Chair	Quorate	
Finance & Performance Committee	**26 July 2018**	**Jonathan Hodgkin**	**yes**	**no**
			Yes	

Declarations of Interest Made

None

Assurances Received

Finance and Efficiency

- The Trust recorded a deficit at Q1 of £2.7m which is in line with the original financial plan and will secure the additional £0.9m of PSF funding for the quarter
- Overspends in AMU, Theatres and an under recovery of income in Medicine are supported by non recurrent benefits, meaning the Trust has an underlying position of between £1m - £1.4m below the planned Q1 deficit position of £2.7m
- Cash remains a concern with a forecast in year shortfall based on current Treasury Management practices.
- The Committee have requested further work/analysis by the development of further I and E recovery options and enhanced cash modelling.
- A further phase of work from four eyes consultancy was discussed and approved with planned net benefits in the current financial year of £1.4m after fees. Recurrent benefit modelled to be £4.3m.

Performance

- The Committee received and debated a competitor analysis report which was felt to be informative.
- RTT Performance is in the top handful of Trusts in the country and DM01 is being delivered.
- A and E performance and 62 day cancer remains a challenge and the Committee have requested more focussed reporting of A and E.

Workforce

- All nursing safer staffing reviews have now taken place and the Committee sought assurance from more detailed analysis of retention data in the future.
- Medical agency spend was reported as above plan and noted

Estates and Procurement

- PFI Performance was noted

Board Assurance Framework

- The Committee received the report and agreed additions in relation to breast screening and A and E 4 hour targets

Decisions Made / Items Approved

- Four Eyes Business Case approved within Committee limits

Actions to come back to Committee
• Phasing of four eyes work and NHSI approval • Enhanced cashflow modelling • Enhanced ED monitoring • Inclusion of Nurse Retention figures
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 • Breast Screening
Items referred to the Board for decision or action
• None

Meeting	**Meeting Date**	**Chair**	**Quorate**	
Finance & Performance Committee	**30 August 2018**	**Jonathan Hodgkin**	**yes**	**no**
			Yes	
Declarations of Interest Made				
None				
Assurances Received				
Finance and Efficiency • The Trust recorded a £2.6m deficit to Month 4, which is £0.5m below plan. • The Committee discussed in detail the 5 unsigned budgets that account for the majority of the forecast overspend and agreed to pursue additional cost control mechanisms with some urgency. • A debate took place regarding forecasting and the transparency thereof. The Chair to discuss outside of the meeting. • The approach to cash management and modelling was described and assurance gained that based on the base case I and E forecast there was some confidence that a positive cash position can be maintained through to March 2019. Work in train to achieve this and encouraged to further push supplier terms beyond 30 days. • Detailed conversation about the development of recovery options for 2018/19. Agreed to take forward with Divisions through a brainstorm of the possible, followed by a special F and P if required • Progress with the 2018/19 CIP £20m CIP target was noted • A paper was received on the Black Country Pathology service and agreement reached that routine updates would be provided back to the Committee. Performance • Routine performance was discussed in detail. The Committee sought a rectification plan to come back to the Committee for the Emergency Access Standard. Assurance gained that the 62 day cancer target will be back on track at Quarter 3.				

Workforce

- Reports received covering nursing and medical staffing spend.

Estates and Procurement

- PFI and Procurement performance reports were received and discussed

Board Assurance Framework

- BAF564 – actions, mitigations and score to be reviewed
- BAF569 – move score to amber until assurances are received that performance is back on target
- BAF608 and BAF609 – to be updated to reflect current position with the MCP

Decisions Made / Items Approved

- The committee ratified the Business Continuity and Private Patient policy
- The Stoma care nursing sponsorship business case was approved for progress for Board approval on the basis of the recommended proposal

Actions to come back to Committee

- Progress on the unsigned budgets
- Emergency Access Standard rectification plan
- Financial recovery options and associated risks following a summit with Divisions

Performance Issues to be referred into Executive Performance Management Process

- None

Areas of Risk to be escalated onto the Corporate or Divisional Risk Register

- None

Items referred to the Board for decision or action

- Projected Deficit position
- Update on cash projections
- Good progress with the 2018/19 £20m CIP target
- ED performance remains unsatisfactory
- On track to recover 62 day cancer target at Quarter 3

Enclosure 19

The Dudley Group
NHS Foundation Trust

Paper for submission to the Board on 6 September 2018

TITLE:	**20 August 2018 Audit Committee Summary Report to the Board**		
AUTHOR:	**Richard Miner Chair of Audit Committee**	**PRESENTER**	**Richard Miner Chair of Audit Committee**

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

SUMMARY OF KEY ISSUES:

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

IMPLICATIONS OF PAPER:

RISK	**N**		**Risk Description: NA**
	Risk Register: N		**Risk Score: NA**
COMPLIANCE and/or LEGAL REQUIREMENTS	**CQC**	**Y**	**Details: links 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, the decisions taken in accordance with the Committee's terms of reference and action any items referred to the Board.

To note the issues highlighted and the impact on the Trust's Business Assurance Framework and Risk Register which the Committee considers requires further Board debate.

The Dudley Group NHS Foundation Trust

Audit Committee highlights report to Board – 6 September 2018

Meeting	Meeting Date	Chair	Quorate	
			yes	no
Audit Committee	20/8/2018	Richard Miner	x	

Declarations of Interest Made

None

Assurances Received

- Completion of the Internal Audit plan for 2017/18
- In respect of completed internal audit reports:
  Bank and agency (Phase 1)
  - Medical staff – no assurance
  - Nursing staff – partial assurance

  Safer staffing – data quality - partial assurance

  Bank and agency (Phase 2) – partial assurance

  Follow up of medium and high priority management actions (Phase 1) – little progress

  There is a follow up action plan in place against which certain assurances have now been mapped. The Internal Auditors are following this through.

- 67 out of 106 Internal Audit recommendations have been closed but 39 remain open of which 16 are overdue. These are well documented and the focus of robust follow up.
- Progress against the 2018/19 counter fraud plan
- The final 2017/18 External Audit conclusions and Audit Letter to Governors.
- Early progress against the 2018/19 Clinical Audit Plan
- The latest iteration of the Business Assurance Framework (BAF) with revised assurances, controls and direction of travel and for further consideration by the Board.
- The much better response rates (Consultants 206/234, Other medical 22/25) now being recorded against Declarations of Interest and that the outstanding returns will be followed up in 1:1 interviews.

Decisions made/Items approved

- Revisions to the 2018/19 Internal Audit Plan, following further meetings which included with the Audit and Trust Chair, including timings but which will be completed by the end of the year.
- Noted the loss report for Quarter 1 of 2018/19 and that it remains within acceptable parameters.
- Small increases in the 2017/18 final external audit fee.

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

- Any changes to the agreed dates for addressing outstanding management actions so that the Committee closely monitor the "feedback loop".
- Recommendations arising from the external audit work and process for follow up.
- External audit fee proposals for 2018/19 in the light of possible changes to the External Audit Plan.
- Follow up of review of BAF risks in the light of CQC notices and Internal Audit reports that will be referred to Committee Chairs by the Audit Chair as well as the Risk and Assurance Committee and Executive Directors to ensure that the assurances contained within it support the current risk scores.
- 7/13 management actions are not completed and need to be re-opened (some of which relate to consultant job planning).
- Ongoing assurance around safer staffing levels

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

- To alert the Board that time and availability will be required to receive a counter fraud training update
- That further work is required on the Business Assurance Framework (BAF) to demonstrate the process for highlighting and recognising risk as well as providing clarity around the BAF which the Audit Committee considers to be over complex.
- The reports received from Internal Audit which indicate a next steps/action plan/cross discipline work (and led by COO) will be required to deal with current pressures arising from nursing workforce/HR/financial control.

Enclosure 20

The Dudley Group
NHS Foundation Trust

Paper for Submission to the Board of Directors on 6th September 2018

TITLE:	**Medical Revalidation Report 2017/2018**		
AUTHOR:	**Paul Stonelake Responsible Officer**	**PRESENTER**	**Paul Stonelake Responsible Officer**

CORPORATE OBJECTIVE:
SO2: Safe and Caring Services
SO4: Be the place people choose to work

SUMMARY OF KEY ISSUES:

- Revalidation for medical staff commenced in December 2012 and is required by all doctors to be given a licence to practice every five years. In order to be revalidated doctors must engage with the appraisal process which forms the basis of a recommendation for revalidation by the Responsible Officer (RO) to the General Medical Council.
- The previous Trust Appraisal Lead resigned in Feb 2018 and was replaced in June 2018. A business case for additional band 4 support is being sought to provide cross cover support for the appraisal software database
- 352 doctors were connected to DGFT at 31/3/18 (23% rise from the 278 at 31/3/17)
- The number of revalidation recommendations required is set to increase over the next two years from 55 in 2018, 96 in 2019 and 110 in 2020.
- At 31/3/18 97.7 % complied with GMC guidelines for appraisal within 9-15 months of previous appraisal, representing improved figures from the previous year for unapproved delays in appraisal (8.9% down to 2.3%)
- All those with unapproved delays were reported to the GMC via REV6 and have now fully engaged with appraisal.
- A campaign to improve appraisal rates at 12 months (rather than 15 months) has been in place over the last few months with an improved software reminder system resulting in currently (at 23/8/18) only 4% (16/369) >12 months from last appraisal and none with unapproved delays.

IMPLICATIONS OF PAPER:

RISK	**N**		**Risk Description:**
	Risk Register: N		**Risk Score:**
COMPLIANCE and/or LEGAL REQUIREMENTS	**CQC**	**Y**	**Details: SAFE; WELL LED**
	Monitor	**Y**	**Details:**
	Other	**Y**	**Details: GMC Good Medical Practice NHS Framework for Quality Assurance for Responsible Officers**

ACTION REQUIRED OF BOARD:			
Decision	**Approval**	**Discussion**	**Other**

RECOMMENDATIONS FOR THE BOARD:

The Board is asked to note the contents of this report and to continue to satisfy its statutory duties to support the Responsible Officer in delivering Medical Appraisal and Revalidation.

REPORT BY THE RESONSIBLE OFFICER TO THE BOARD OF DIRECTORS

September 2018

1. Executive Summary

This report represents the status of medical revalidation and appraisals at The Dudley Group NHS Foundation Trust as of 31st March 2018. It represents the performance of the organisation with regards to the Framework for Quality Assurance for Medical Revalidation (FQA) and the Responsible Officer Regulations and related guidance from the General Medical Council (GMC) which forms the basis of the Annual Organisational Audit for 2017/2018 submitted to NHS England.

As of 31st March 2018 there were 352 doctors with a prescribed connection to The Dudley Group NHS Foundation Trust as a designated body. This is a significant rise (23%) over the 278 connected at 31/3/17. Most of the increase is represented by temporary / short term appointments (59 vs 30; 97% increase) and Trust grade doctors (79 vs 54; 46% increase) rather than substantive consultants (214 vs 203; 5% increase). It is noteworthy that doctors with short term or Trust grade contracts generate much more work for the Appraisal Team than the more stable consultant workforce.

The increase in workload for the Appraisal Team is also reflected in the number of projected recommendations for revalidation which is is set to increase over the next two years from 55 in 2018, 96 in 2019 and 110 in 2020. Currently the Appraisal Team consists of a Medical Trust Appraisal Lead (newly appointed June 2018 following resignation of the previous post-holder Feb 2018) and a Band 4 Medical Revalidation Support Officer. Previously responsibility for medical appraisal was also within the portfolio of a full time Directorate Manager (Band 7) but with replacement of this post with a part-time position this is not currently possible. Alternative ways of supporting the Appraisal Team are therefore being proposed including an additional Band 4 post to provide cross cover for maintaining the appraisal software database for which a business case is being developed.

The Trust has a good overall appraisal rate of 97% in relation to the GMC guidelines (which allows appraisal up to 15 months from last appraisal) but we had a significant proportion of these (20%) where the appraisal was after rather than before the 12 month recommendation which is both Trust policy and the basis of figures reported externally. A campaign begun in March 2018 to bring forward appraisal meetings, including an automated email reminder system, has resulted in 96% (353/369) of doctors being appraised within 12 months (figures as of 23/8/18).

Only 8/352 (2.3%) had unapproved delays in appraisal and notification of lack of engagement was made to the GMC using the 'REV6' notification system. All these doctors have now engaged.

A programme of appraiser training and quality assurance is in place with no current concerns regarding the quality of appraisals.

Timely recommendations to the GMC for revalidation were carried out with no missed recommendations.

2. Background

Medical Revalidation was launched in 2012 to strengthen the way that doctors are regulated, with the aim of improving the quality of care provided to patients, improving patient safety and increasing public trust and confidence in the medical system.

Provider organisations have a statutory duty to support their Responsible Officers in discharging their duties under the Responsible Officer Regulations and it is expected that provider boards will oversee compliance by:

- Monitoring the frequency and quality of medical appraisals in their organisations;
- Checking there are effective systems in place for monitoring the conduct and performance of their doctors;
- Confirming that feedback from patients is sought periodically so that their views can inform the appraisal and revalidation process for their doctors; and
- Ensuring that appropriate pre-employment background checks (including pre-engagement for Locums) are carried out to ensure that medical practitioners have qualifications and experience appropriate to the work performed.

The Board has directly, and via the Workforce and Engagement Committee, received assurance for the last 4 years from the Responsible Officer that the organisation meets the above duties and responsibilities as set out in the Regulations.

As of 1st September 2016, Mr Paul Stonelake, Consultant Surgeon, was appointed by the Board as Responsible Officer, separating the role from that of the Medical Director. The rationale for this was to remove potential for conflict of interest between the employee / employer relationship versus the appraisal requirements to receive a license to practise through revalidation. The Medical Director via the management structure is responsible for doctors being 'fit for purpose', whereas the Responsible Officer makes recommendations for revalidation to the GMC in relation to doctors being 'fit for practise'.

3. Governance

The Responsible Officer is supported by a small team Appraisal Team managed within the Medical Director's Directorate. Compliance with and support for medical appraisal is led by the Medical Trust Appraisal Lead supported with managerial support is formerly provided by a full time Band 7 Directorate Manager. Maintenance of the appraisal software system and administrative support is provided by a Band 4 Medical Revalidation Support Officer. Following resignation the Band 7 Directorate Manager the position was filled by secondment on a part-time basis with a resultant shortfall in support at this level. Proposals are being developed to strengthen the team with additional Band 4 support to provide cross cover for the Medical Revalidation Support Officer. This would mitigate against the risk of a single trained individual in the team with training in using the appraisal software system, against the background if increasing numbers of connected doctors (see section 4.1) requiring support for appraisal and the increasing numbers projected over the next two years for whom revalidation recommendations will be required: 55 in 2018, 96 in 2019 and 110 in 2020.

Assurance is provided by reporting to the Workforce and Engagement Committee bi-annually and annually to the Board.

The Appraisal Team, currently consisting of the Responsible Officer, Trust Medical Appraisal Lead and Medical Revalidation Support Officer, meet fortnightly to review

progress with appraisal, recommendations for revalidation, and discuss escalation of any issues in relation to this to the Medical Concerns Group..

The 'Medical Concerns Group', consisting of the Responsible Officer, Medical Director, Deputy Medical Director and HR Director (or HR Business Partner) meet fortnightly to discuss concerns arising from medical appraisal, complaints/adverse incidents, performance related issues, GMC communications etc. This Group functions as a senior decision making group in relation to whether to investigate further and if so under which process this should be carried out. It also reviews the outcome of any ongoing investigations and the implementation of any resultant recommendations. The output from this Group forms the basis of the Medical Director's report to the private Trust Board.

4. Medical Appraisal Performance

4.1 Appraisal and Revalidation Data

As of 31st March 2018, there were 352 doctors connected to The Dudley Group for the purpose of Medical Revalidation; 214 consultants, 79 Trust Grade doctors (Staff Grade, Associate Specialist etc) and 59 temporary or short term contract holders. The comparison with the 2017 figures is given below:

	31/3/17	31/3/18	% increase
Consultants	203	214	5%
Trust grade	54	79	46%
Temporary/Short term staff	30	59	97%
Total	287	352	23%

Rates of appraisal at 31/3/18 for the different staff groups are given below:

	Appraisals <15months (%)	Appraisals <12months rate (%)	Unapproved delays	Total
Consultants	209 (98%)	167 (78%)	5	214
Trust grade	76 (96%)	45 (57%)	3	79
Temporary/Short term staff	59 (100%)	59 (100%)		59
Total	344 (98%)	271 (77%)	8	352

These figures reflect the situation where a significant proportion of appraisals were completed just after rather than before the due date. As a consequence a concerted effort was made from around March 2018 to educate doctors regarding the standards required to meet our Trust policy which states appraisals should be completed within 56 days of the due date. All connected doctors were contacted with a reminder of the policy and an improved automated email reminder system set up such that doctors have reminders at 8, 9, 10 and 11 months from last appraisal. This includes reminding doctors of both their contractual and professional obligations to the Trust and GMC respectively.

This has resulted in an much improved situation whereby currently (August 2018) 96% of all doctors have completed their appraisals within 12 months and 100% within 15 months. There are currently no non-engaging doctors.
All 8 doctors who were reported to the GMC by the RO using the 'REV6' notification proforma have now shown evidence of engaging and completed a satisfactory appraisal.

4.2 Appraisers

There are a total of 68 Medical Appraisers within the Trust. Recruitment of new appraisers is taking place with all interested being directed to New Appraiser training courses. A refresher training session for existing appraisers was held within the Trust on 31/7/18 with around a third of the active appraisers attending. This was led by the RO and the Trust Medical Appraisal Lead with IT support from the company providing the appraisal software. Feedback was excellent and it is intended to repeat this in a few months to allow the remaining appraisers to attend.
Some appraisers have undergone enhanced mentorship training. This should allow the Trust to draw from this same pool of doctors suitable mentors for newly appointed consultants and other doctors where mentorship is required.

4.3 Quality Assurance

A review of active appraisers was undertaken in June 2018 by the incoming Medical Trust Appraisal Lead. A random sample of 20 appraisals was scored using the ASPAT recognised QA scoring system (see Trust Appraisal Policy). This exercise revealed all appraisals to be of satisfactory standard scoring >40 out of a maximum of 50 points. It is intended to repeat this exercise quarterly.

Additionally, all appraisees are required to provide feedback regarding the appraisal before the appraisal can be 'signed off'. A new reporting system has now been put in place by the software company to collate appraisal feedback and provide a report by individual appraiser which can be reviewed by the Appraisal Team and will also be automatically sent to the appraiser to use as supporting evidence in their own appraisal.

Reports on appraisal / revalidation are sent externally to NHSE usually quarterly in addition to an annual report (appendix 1). We are then notified regarding any concerns over performance compared to peers. For instance we were notified that the rates of unapproved delays in appraisal in 2016/17 at 8.9% was slightly higher than the national figure of 6%. The 2017/18 rate of 2.3% represents a significant improvement and as indicated in section 4.1 remedial action was taken successfully with all 8 of these doctors.

4.4 Access, Security and Confidentiality

Information governance guidelines, storage and access to appraisal documentation are set out in the Medical Appraisal and Revalidation Policy.

There have been no incidents with regards to security and confidentiality in the last financial year with regards to appraisal documentation.

4.5 Clinical Governance

The PreP Revalidation System for Appraisal and Revalidation ensures that the required domains for Supporting Information for Appraisal and Revalidation are completed before the appraisal can be submitted for review by an appraiser. Doctors have access to their individual complaints and incidents via the Trust Governance team and performance, mortality and morbidity data from the Informatics Team.

5. Revalidation Recommendations

The Trust has made timely recommendations to the GMC for all doctors due revalidation in 2017/18 with no missed recommendations. 16 doctors were due revalidation in that year: 13 had a recommendation to revalidate. Three had an initial recommendation to defer revalidation due to insufficient evidence but all subsequently provided the necessary appraisal evidence and had a positive recommendation to revalidate. There have been no further deferrals since 8/12/17.

6. Recommendations

The Board is asked to note the contents of this report and to continue to satisfy its statutory duties to support the Responsible Officer in delivering Medical Appraisal and Revalidation.

Appendix 1; Annual Organisational Audit 2017/8

NHS England

Annual Organisational Audit (AOA)
End of year questionnaire 2017-18

April 2017

Enclosure 21

The Dudley Group
NHS Foundation Trust

Paper for submission to the Board of Directors

TITLE:	Emergency Preparedness Resilience and Response Core Standards submission for Dudley Group NHS FT 2018-19		
AUTHOR:	Christopher Leach Emergency Planning Manager	**AUTHOR:**	Christopher Leach Emergency Planning Manager

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

SUMMARY OF KEY ISSUES:

Each year as an Acute provider Dudley Group is expected to self-assess itself against a set of EPRR Core Standards.
This looks at a number of parameters including preparedness, risk assessment and Business Continuity there is also a separate assessment pertaining to specialist response elements (Chemical, Biological, radiological and Nuclear response).
Included in this is a Deep Dive that does not count towards our overall score, this year it included Incident Control Centre preparedness.
Dudley Group grades itself as Substantially compliant against the core standards, with areas identified below that require further work to become fully compliant against the standards

- Critical incident- Plan being developed out for comment
- Pandemic influenza- Plan awaiting committee sign off
- Mass Countermeasures- Plan to be developed in line with guidance
- LRHP attendance- AEO aware and to look at further mechanisms of support to increase attendance
- BCMS scope and objectives- BC plan going through governance processes
- Decontamination capability availability 24 /7- Entered onto risk register ED to book CBRN training as soon as possible
- Staff training - decontamination- Entered onto risk register ED to book CBRN training as soon as possible

IMPLICATIONS OF PAPER:

RISK	**Y**		**Risk Description:** UC364 Local training for CBRN incident DMC622 Radiation Detection and Response for CBRN
	Risk Register: **Y**		**Risk Score:** Moderate Major
COMPLIANCE	**CQC**	**Y**	**Details** **SAFE**

and/or LEGAL REQUIREMENTS			**EFFECTIVE** **CARING** **RESPONSIVE**
	NHSI	**N**	**Details:**
	Other	**Y**	**Details:** EPRR Core Standards, EPRR Framework 2015, Civil Contingencies Act 2004 and Health and Social Care Act 2012

ACTION REQUIRED OF COMMITTEE

Decision	Approval	Discussion	Other
	Y		

RECOMMENDATIONS FOR THE COMMITTEE:
To be aware of and approve the trusts grading as substantially compliant against the core standards for 2018-19

Ref	Domain	Standard	Detail	Acute Providers	Evidence - examples listed below
1	**Governance**	**Appointed AEO**	The organisation has appointed an Accountable Emergency Officer (AEO) responsible for Emergency Preparedness Resilience and Response (EPRR). This individual should be a board level director, and have the appropriate authority, resources and budget to direct the EPRR portfolio. A non-executive board member, or suitable alternative, should be identified to support them in this role.	Y	• Name and role of appointed individual
2	**Governance**	**EPRR Policy Statement**	The organisation has an overarching EPRR policy statement. This should take into account the organisation's: • Business objectives and processes • Key suppliers and contractual arrangements • Risk assessment(s) • Functions and / or organisation, structural and staff changes. The policy should: • Have a review schedule and version control • Use unambiguous terminology • Identify those responsible for making sure the policies and arrangements are updated, distributed and regularly tested • Include references to other sources of information and supporting documentation.	Y	Evidence of an up to date EPRR policy statement that includes: • Resourcing commitment • Access to funds • Commitment to Emergency Planning, Business Continuity, Training, Exercising etc.
3	**Governance**	**EPRR board reports**	The Chief Executive Officer / Clinical Commissioning Group Accountable Officer ensures that the Accountable Emergency Officer discharges their responsibilities to provide EPRR reports to the Board / Governing Body, no less frequently than annually. These reports should be taken to a public board, and as a minimum, include an overview on: • training and exercises undertaken by the organisation • business continuity, critical incidents and major incidents • the organisation's position in relation to the NHS England EPRR assurance process.	Y	• Public Board meeting minutes • Evidence of presenting the results of the annual EPRR assurance process to the Public Board
4	**Governance**	**EPRR work programme**	The organisation has an annual EPRR work programme, informed by lessons identified from: • incidents and exercises • identified risks • outcomes from assurance processes.	Y	• Process explicitly described within the EPRR policy statement • Annual work plan
5	**Governance**	**EPRR Resource**	The Board / Governing Body is satisfied that the organisation has sufficient and appropriate resource, proportionate to its size, to ensure it can fully discharge its EPRR duties.	Y	• EPRR Policy identifies resources required to fulfill EPRR function; policy has been signed off by the organisation's Board • Assessment of role / resources • Role description of EPRR Staff • Organisation structure chart • Internal Governance process chart including EPRR group
6	**Governance**	**Continuous improvement process**	The organisation has clearly defined processes for capturing learning from incidents and exercises to inform the development of future EPRR arrangements.	Y	• Process explicitly described within the EPRR policy statement
7	**Duty to risk assess**	**Risk assessment**	The organisation has a process in place to regularly assess the risks to the population it serves. This process should consider community and national risk registers.	Y	• Evidence that EPRR risks are regularly considered and recorded • Evidence that EPRR risks are represented and recorded on the organisations corporate risk register

8	**Duty to risk assess**	**Risk Management**	The organisation has a robust method of reporting, recording, monitoring and escalating EPRR risks. Plans have been developed in collaboration with partners and service providers to ensure the whole patient pathway is considered.	Y	• EPRR risks are considered in the organisation's risk management policy • Reference to EPRR risk management in the organisation's EPRR policy document
9	**Duty to maintain plans**	**Collaborative planning**		Y	Partners consulted with as part of the planning process are demonstrable in planning arrangements
11	**Duty to maintain plans**	**Critical incident**	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to a critical incident (as per the EPRR Framework).	Y	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required
12	**Duty to maintain plans**	**Major incident**	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to a major incident (as per the EPRR Framework).	Y	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required
13	**Duty to maintain plans**	**Heatwave**	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to the impacts of heat wave on the population the organisation serves and its staff.	Y	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required
14	**Duty to maintain plans**	**Cold weather**	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to the impacts of snow and cold weather (not internal business continuity) on the population the organisation serves.	Y	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required
15	**Duty to maintain plans**	**Pandemic influenza**	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to pandemic influenza as described in the National Risk Register.	Y	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required
16	**Duty to maintain plans**	**Infectious disease**	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to an infectious disease outbreak within the organisation or the community it serves, covering a range of diseases including Viral Haemorrhagic Fever. These arrangements should be made in conjunction with Infection Control teams; including supply of adequate FFP3.	Y	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required

17	**Duty to maintain plans**	**Mass Countermeasures**	In line with current guidance and legislation, the organisation has effective arrangements in place to distribute Mass Countermeasures - including the arrangement for administration, reception and distribution, eg mass prophylaxis or mass vaccination. There may be a requirement for Specialist providers, Community Service Providers, Mental Health and Primary Care services to develop Mass Countermeasure distribution arrangements. These will be dependant on the incident, and as such requested at the time. CCGs may be required to commission new services dependant on the incident.	Y	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required
18	**Duty to maintain plans**	**Mass Casualty - surge**	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to mass casualties. For an acute receiving hospital this should incorporate arrangements to increase capacity by 10% in 6 hours and 20% in 12 hours.	Y	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required
19	**Duty to maintain plans**	**Mass Casualty - patient identification**	The organisation has arrangements to ensure a safe identification system for unidentified patients in emergency/mass casualty incident. Ideally this system should be suitable and appropriate for blood transfusion, using a non-sequential unique patient identification number and capture patient sex.	Y	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required
20	**Duty to maintain plans**	**Shelter and evacuation**	In line with current guidance and legislation, the organisation has effective arrangements in place to place to shelter and / or evacuate patients, staff and visitors. This should include arrangements to perform a whole site shelter and / or evacuation.	Y	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required
21	**Duty to maintain plans**	**Lockdown**	In line with current guidance and legislation, the organisation has effective arrangements in place safely manage site access and egress of patients, staff and visitors to and from the organisation's facilities. This may be a progressive restriction of access / egress that focuses on the 'protection' of critical areas.	Y	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required
22	**Duty to maintain plans**	**Protected individuals**	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to manage 'protected individuals'; including VIPs, high profile patients and visitors to the site.	Y	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required

23	**Duty to maintain plans**	**Excess death planning**	Organisation has contributed to and understands its role in the multiagency planning arrangements for excess deaths, including mortuary arrangements.	Y	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required
24	**Command and control**	**On call mechanism**	A resilient and dedicated EPRR on call mechanism in place 24 / 7 to receive notifications relating to business continuity incidents, critical incidents and major incidents. This should provide the facility to respond or escalate notifications to an executive level.	Y	• Process explicitly described within the EPRR policy statement • On call Standards and expectations are set out • Include 24 hour arrangements for alerting managers and other key staff.
25	**Command and control**	**Trained on call staff**	On call staff are trained and competent to perform their role, and are in a position of delegated authority on behalf on the Chief Executive Officer / Clinical Commissioning Group Accountable Officer. The identified individual: • Should be trained according to the NHS England EPRR competencies (National Occupational Standards) • Can determine whether a critical, major or business continuity incident has occurred • Has a specific process to adopt during the decision making • Is aware who should be consulted and informed during decision making • Should ensure appropriate records are maintained throughout.	Y	• Process explicitly described within the EPRR policy statement
26	**Training and exercising**	**EPRR Training**	The organisation carries out training in line with a training needs analysis to ensure staff are competent in their role; training records are kept to demonstrate this.	Y	• Process explicitly described within the EPRR policy statement • Evidence of a training needs analysis • Training records for all staff on call and those performing a role within the ICC • Training materials • Evidence of personal training and exercising portfolios for key staff
27	**Training and exercising**	**EPRR exercising and testing programme**	The organisation has an exercising and testing programme to safely test major incident, critical incident and business continuity response arrangements. Organisations should meet the following exercising and testing requirements: • a six-monthly communications test • annual table top exercise • live exercise at least once every three years • command post exercise every three years. The exercising programme must: • identify exercises relevant to local risks • meet the needs of the organisation type and stakeholders • ensure warning and informing arrangements are effective. Lessons identified must be captured, recorded and acted upon as part of continuous improvement.	Y	• Exercising Schedule • Evidence of post exercise reports and embedding learning
28	**Training and exercising**	**Strategic and tactical responder training**	Strategic and tactical responders must maintain a continuous personal development portfolio demonstrating training in accordance with the National Occupational Standards, and / or incident / exercise participation	Y	• Training records • Evidence of personal training and exercising portfolios for key staff
30	**Response**	**Incident Co-ordination Centre (ICC)**	The organisation has a preidentified an Incident Co-ordination Centre (ICC) and alternative fall-back location. Both locations should be tested and exercised to ensure they are fit for purpose, and supported with documentation for its activation and operation.	Y	• Documented processes for establishing an ICC • Maps and diagrams • A testing schedule • A training schedule • Pre identified roles and responsibilities, with action cards • Demonstration ICC location is resilient to loss of utilities, including telecommunications, and external hazards
31	**Response**	**Access to planning arrangements**	Version controlled, hard copies of all response arrangements are available to staff at all times. Staff should be aware of where they are stored; they should be easily accessible.	Y	Planning arrangements are easily accessible - both electronically and hard copies

32	**Response**	**Management of business continuity incidents**	The organisations incident response arrangements encompass the management of business continuity incidents.	Y	• Business Continuity Response plans
33	**Response**	**Loggist**	The organisation has 24 hour access to a trained loggist(s) to ensure decisions are recorded during business continuity incidents, critical incidents and major incidents.	Y	• Documented processes for accessing and utilising loggists • Training records
34	**Response**	**Situation Reports**	The organisation has processes in place for receiving, completing, authorising and submitting situation reports (SitReps) and briefings during the response to business continuity incidents, critical incidents and major incidents.	Y	• Documented processes for completing, signing off and submitting SitReps • Evidence of testing and exercising
35	**Response**	**Access to 'Clinical Guidance for Major Incidents'**	Emergency Department staff have access to the NHSE 'Clinical Guidance for Major Incidents' handbook.	Y	Guidance is available to appropriate staff either electronically or hard copies
36	**Response**	**Access to 'CBRN incident: Clinical Management and health protection'**	Clinical staff have access to the PHE 'CBRN incident: Clinical Management and health protection' guidance.	Y	Guidance is available to appropriate staff either electronically or hard copies
37	**Warning and informing**	**Communication with partners and stakeholders**	The organisation has arrangements to communicate with partners and stakeholder organisations during and after a major incident, critical incident or business continuity incident.	Y	• Have emergency communications response arrangements in place • Social Media Policy specifying advice to staff on appropriate use of personal social media accounts whilst the organisation is in incident response • Using lessons identified from previous major incidents to inform the development of future incident response communications • Having a systematic process for tracking information flows and logging information requests and being able to deal with multiple requests for information as part of normal business processes • Being able to demonstrate that publication of plans and assessments is part of a joined-up communications strategy and part of your organisation's warning and informing work
38	**Warning and informing**	**Warning and informing**	The organisation has processes for warning and informing the public and staff during major incidents, critical incidents or business continuity incidents.	Y	• Have emergency communications response arrangements in place • Be able to demonstrate consideration of target audience when publishing materials (including staff, public and other agencies) • Communicating with the public to encourage and empower the community to help themselves in an emergency in a way which compliments the response of responders • Using lessons identified from previous major incidents to inform the development of future incident response communications • Setting up protocols with the media for warning and informing
39	**Warning and informing**	**Media strategy**	The organisation has a media strategy to enable communication with the public. This includes identification of and access to a trained media spokespeople able to represent the organisation to the media at all times.	Y	• Have emergency communications response arrangements in place • Using lessons identified from previous major incidents to inform the development of future incident response communications • Setting up protocols with the media for warning and informing • Having an agreed media strategy which identifies and trains key staff in dealing with the media including nominating spokespeople and 'talking heads'
40	**Cooperation**	**LRHP attendance**	The Accountable Emergency Officer, or an appropriate director, attends (no less than 75%) of Local Health Resilience Partnership (LHRP) meetings per annum.	Y	• Minutes of meetings
41	**Cooperation**	**LRF / BRF attendance**	The organisation participates in, contributes to or is adequately represented at Local Resilience Forum (LRF) or Borough Resilience Forum (BRF), demonstrating engagement and co-operation with other responders.	Y	• Minutes of meetings • Governance agreement if the organisation is represented
42	**Cooperation**	**Mutual aid arrangements**	The organisation has agreed mutual aid arrangements in place outlining the process for requesting, co-ordinating and maintaining resource eg staff, equipment, services and supplies. These arrangements may be formal and should include the process for requesting Military Aid to Civil Authorities (MACA).	Y	• Detailed documentation on the process for requesting, receiving and managing mutual aid requests • Signed mutual aid agreements where appropriate
46	**Cooperation**	**Information sharing**	The organisation has an agreed protocol(s) for sharing appropriate information with stakeholders.	Y	• Documented and signed information sharing protocol • Evidence relevant guidance has been considered, e.g. Freedom of Information Act 2000, General Data Protection Regulation and the Civil Contingencies Act 2004 'duty to communicate with the public'.
47	**Business Continuity**	**BC policy statement**	The organisation has in place a policy statement of intent to undertake Business Continuity Management System (BCMS).	Y	Demonstrable a statement of intent outlining that they will undertake BC - Policy Statement

48	**Business Continuity**	**BCMS scope and objectives**	The organisation has established the scope and objectives of the BCMS, specifying the risk management process and how this will be documented.	Y	BCMS should detail: • Scope e.g. key products and services within the scope and exclusions from the scope • Objectives of the system • The requirement to undertake BC e.g. Statutory, Regulatory and contractual duties • Specific roles within the BCMS including responsibilities, competencies and authorities. • The risk management processes for the organisation i.e. how risk will be assessed and documented (e.g. Risk Register), the acceptable level of risk and risk review and monitoring process • Resource requirements • Communications strategy with all staff to ensure they are aware of their roles • Stakeholders
49	**Business Continuity**	**Business Impact Assessment**	The organisation annually assesses and documents the impact of disruption to its services through Business Impact Analysis(s).	Y	Documented process on how BIA will be conducted, including: • the method to be used • the frequency of review • how the information will be used to inform planning • how RA is used to support.
50	**Business Continuity**	**Data Protection and Security Toolkit**	Organisation's IT department certify that they are compliant with the Data Protection and Security Toolkit on an annual basis.	Y	Statement of compliance
51	**Business Continuity**	**Business Continuity Plans**	The organisation has established business continuity plans for the management of incidents. Detailing how it will respond, recover and manage its services during disruptions to: • people • information and data • premises • suppliers and contractors • IT and infrastructure These plans will be updated regularly (at a minimum annually), or following organisational change.	Y	• Documented evidence that as a minimum the BCP checklist is covered by the various plans of the organisation
52	**Business Continuity**	**BCMS monitoring and evaluation**	The organisation's BCMS is monitored, measured and evaluated against the Key Performance Indicators. Reports on these and the outcome of any exercises, and status of any corrective action are annually reported to the board.	Y	• EPRR policy document or stand alone Business continuity policy • Board papers
53	**Business Continuity**	**BC audit**	The organisation has a process for internal audit, and outcomes are included in the report to the board.	Y	• EPRR policy document or stand alone Business continuity policy • Board papers • Audit reports
54	**Business Continuity**	**BCMS continuous improvement process**	There is a process in place to assess and take corrective action to ensure continual improvement to the BCMS.	Y	• EPRR policy document or stand alone Business continuity policy • Board papers • Action plans
55	**Business Continuity**	**Assurance of commissioned providers / suppliers BCPs**	The organisation has in place a system to assess the business continuity plans of commissioned providers or suppliers; and are assured that these providers arrangements work with their own.	Y	• EPRR policy document or stand alone Business continuity policy • Provider/supplier assurance framework • Provider/supplier business continuity arrangements

Decontamination equipment checklist - for use by Acute providers

Ref	Equipment	Equipment model / generation / details etc	**Self assessment** Yes - have equipment No - do not have equipment
	EITHER: Inflatable mobile structure		
E1	Inflatable frame		
E1.1	Liner		
E1.2	Air inflator pump		
E1.3	Repair kit		
E1.2	Tethering equipment		
	OR: Rigid / cantilever structure		
E2	Tent shell		
	OR: Built structure		
E3	Decontamination unit or room	GRC purpose built structure	
	AND:		
E4	Lights (or way of illuminating decontamination area if dark)	Attached to external unit, Internal lighting within unit and spotlighting as part of trust exterior furniture	
E5	Shower heads	Internal to unit	
E6	Hose connectors	Internal to unit	
E7	Flooring appropriate to tent in use (with decontamination basin if needed)	Internal to unit	
E8	Waste water pump and pipe	Intergrated and maintained by estates	
E9	Waste water bladder	x2 available	
	PPE for chemical, and biological incidents		
E10	The organisation has the expected number of PRPS suits (sealed and in date) available for immediate deployment should they be required.	Full compliment of suits, expiring e/o 2018 and beginning 2019. In range of sizes, contingency being explored due to delay in PRPS programme	
E11	Providers to ensure that they hold enough (appropriately labelled) training suits in order to facilitate their local training programme	Yes 8 training suits available	
	Ancillary		
E12	A facility to provide privacy and dignity to patients	Yes, shelter provides dignity	
E13	Buckets, sponges, cloths and blue roll	buckets and soap impregnated sponges available, Blue roll available in IOR boxes	
E14	Decontamination liquid (COSHH compliant)	Soap impregnanted sponges	
E15	Entry control board (including clock)	Purpose built NHS access control board	
E16	A means to prevent contamination of the water supply	Yes Bladder is available, unit is sealed water will only exit via pump	
E17	Poly boom (if required by local Fire and Rescue Service)	N/A	
E18	Minimum of 20 x Disrobe packs or suitable equivalent (combination of sizes)	Yes in place	
E19	Minimum of 20 x re-robe packs or suitable alternative (combination of sizes - to match disrobe packs)	Yes in place	
E20	Waste bins	x2 hazardous waste bins available for CBRN response only	
	Disposable gloves	Yes within Radiological and Biological response kits, ample available in dept	
E21	Scissors - for removing patient clothes but of sufficient calibre to execute an emergency PRPS suit disrobe	Yes numerous pairs in shelter and also in Major incident cabinet	
E22	FFP3 masks	Yes available as part of Biological/Radiological response kit	
E23	Cordon tape	Within shelter, including temporary barricades	
E24	Loud Hailer	Yes x2 available in Major Incident store	
E25	Signage	Yes available	
E26	Tabbards identifying members of the decontamination team	Yes in Major Incident Store	
	Radiation		
E27	RAM GENE monitors (x 2 per Emergency Department and/or HART team)	Yes in place as part of radiological response box	
E28	Hooded paper suits	within biological response kit	
E29	Goggles	within biological response kit	
E30	Overshoes & Gloves	within biological response kit	

The Dudley Group
NHS Foundation Trust

Tel: 01384 321000

Ref: EPRR Core Standards 2018

Date: 15th August 2018

Karen Kelly
Chief Operating Officer
Dudley Group NHS FT
Russells Hall Hospital
Pensnett Road
Dudley
West Midlands
DY1 2HQ

Dear Sir/Madam

Re: EPRR Core Standards 2018

In accordance with your letter dated 2nd August 2018, please find enclosed the following documents as requested to support The Dudley Group NHS Foundation Trust Core Standard 2018 submission:

- Core Standards Submission
- Resulting work plan from self assessment (this is included in the trusts overarching workplan)
- An exercise will be undertaken in October as part of the ongoing trust exercsiign programme this will test the opening of one of the ICC's and IMT establishment
- Core Standards have been booked as part of Board of Directors meeting on the 28th August 2018 and will be followed by Public Board on the 6th September 2018

Based on this information, I can confirm that against the 2018 NHS England Core Standards The Dudley Group NHS Foundation Trust has self-assessed to be ***Substantially*** compliant.

Yours Sincerely

Karen Kelly
Chief Operating Officer (Accountable Emergency Officer)