The Dudley Group
NHS Foundation Trust

**Board of Directors**
**Thursday 4th October, 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**<br>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 6 September 2018 | Enclosure 1 | J Ord | To Approve | 8.30 |
| | 4.2 Action Sheet 6 September 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 | K Kelly | To Discuss | 8.50 |
| **7.** | **Emergency Department** | | | | |
| | 7.1 ED Performance and Quality Improvement Plan | Enclosure 4 | K Kelly | To note & discuss | 9.00 |
| | 7.2 Urgent Care Service Improvement Group Chairs report | Enclosure 5 | J Ord | To note | 9.20 |
| **8.** | **Safe and Caring** | | | | |
| | 8.1 Clinical Quality, Safety and Patient Experience Committee Exception Report | Enclosure 6 | D Wulff | To note assurances & discuss any actions | 9.30 |
| | 8.2 Chief Nurse Report, including safer staffing analysis | Enclosure 7 | C Love-Mecrow | To note assurances & discuss any actions | 9.40 |

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| | 8.3 Infection Control Report | Enclosure 8 | E Rees | To note assurances & discuss actions | 9.50 |
| **9.** | **Responsive and Effective** | | | | |
| | 9.1 Integrated Performance Dashboard | Enclosure 9 | K Kelly | To note assurances & discuss any actions | 10.00 |
| | 9.2 Finance and Performance Committee Exception report | Enclosure 10 | J Hodgkin | To note assurances & discuss any actions | 10.10 |
| **10.** | **Well Led** | | | | |
| | 10.1 Digital Trust Committee Report | Enclosure 11 | M Stanton/ A Becke | To note assurances & discuss any actions | 10.20 |
| | 10.2 Workforce Committee Exception Report and Workforce Strategy Update | Enclosure 12 | J Atkins | To note assurances & discuss any actions | 10.30 |
| | 10.3 Recruitment and Retention Report | Enclosure 13 | A McMenemy | To note and discuss actions | 10.40 |
| | 10.4 Board Assurance Framework and Corporate Risk Register | Enclosure 14 | G Palethorpe | To note assurances & discuss any actions | 10.50 |
| **11.** | **Any other Business** | | J Ord | | 11.00 |
| **12.** | **Date of Next Board of Directors Meeting**<br><br>8.30am 1st November, 2018<br>Clinical Education Centre | | J Ord | | 11.00 |
| **13.** | **Exclusion of the Press and Other Members of the Public**<br><br>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 | | 11.00 |

**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 6th September, 2018 at 8.30am in the Clinical Education Centre.**

**Present:**

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

**In Attendance:**

Helen Forrester, EA
Mark Stanton, Chief Information Officer
Glen Palethorpe, Director of Governance/Board Secretary
Natalie Younes, Director of Strategy and Business Development
Carol Love-Mecrow, Deputy Chief Nurse
Catherine Holland, Non Executive Director
Jo Wakeman, Deputy Chief Nurse (Item 18/096.2)
Babar Elahi, Guardian of Safe Working (Item 18/096.8)
Derek Eaves, Freedom to Speak Up Guardian (Item 18/096.9)
Paul Stonelake, Breast Screening Clinical Lead (Item 18/098.1)

**18/087 Note of Apologies and Welcome**
**8.30am**

Apologies were received from Richard Welford, Liz Abbiss, Siobhan Jordan and Mark Hopkin. The Chairman welcomed Catherine Holland, the Trust's Non Executive Director and Carol Love-Mecrow who was attending for Siobhan Jordan, to the meeting.

**18/088 Declarations of Interest**
**8.32am**

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

There were no other declarations of interest.

**18/089 Announcements**
**8.33am**

The Board noted that the latest CQC report from their visit on 28th June, 2018, in respect of the Trust's Emergency Department was being published that day.

There were no other announcements to note.

**18/090 Minutes of the previous Board meeting held on 5th July, 2018 (Enclosure 1)**
**8.34am**

The minutes were amended as follows:

Page 10, 3rd paragraph from the bottom of the page to read "Additionally, the Trust had delivered over 90% of appraisals in the 3 month appraisal window and this was as a result of a number of initiatives."

Top of page 5 to read "The Committee were informed that the Trust was looking to offer and deliver targeted training to improve Blood Transfusion training compliance rates."

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

**18/091 Action Sheet, 5th July, 2018 (Enclosure 2)**
**8.36am**

**18/091.1 Audit Committee Exception Report**

The Director of Governance informed the Board that this item had not been closed and that he would meet the Chair of the Audit Committee before the next Board to progress this matter.

**The Director of Governance to meet with the Chair of the Audit Committee.**

**18/091.2 Patient Story**

It was noted that Community Physiotherapy support is individualised and dependent on how the patient reacts to treatment in their own home. The Deputy Chief Nurse agreed to follow up the issue relating to the option of using an electronic diary and report back to the next Board.

**Deputy Chief Nurse to follow up possible use of an electronic diary for Community staff.**

Dr Wulff, Non Executive Director, highlighted that it was Organ Donation week. The Chairman confirmed that it was good to see the "lift wraps" that had been installed to support this national awareness drive.

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

**18/091 Patient Story**
**8.39am**

The Director of Governance presented the patient story. This related to a pioneering procedure for the treatment of chronic acid reflux and the Chairman confirmed that a funding request for the procedure had been placed with the CCG. The procedure had transformed the patient's life.

The Medical Director briefed the Board on work being undertaken around new clinical initiatives and the Trust's support for these.

Mr Atkins, Non Executive Director, had met with Prof. Ishaq and asked that the Board continues to offers all the support it can to have this procedure made available to all in the Black Country.

The Chairman and Board noted the positive story.

**18/092 Chief Executive's Overview Report (Enclosure 3)**
**8.54am**

The Chief Executive presented her Overview Report, given as Enclosure 3, drawing the Board's attention to the following highlights:

- MCP: On 27th July the Trust was notified that the tender application for the MCP contract, submitted on 8th May 2018 was successful. The MCP Transition Board continues to meet regularly and an interim Managing Director was recently appointed to help take the transformation of out of hospital services forward.

- HSJ Awards: The Trust is delighted to announce that it has been shortlisted for a HSJ award for a minimally invasive procedure pioneered at Russells Hall Hospital. The Trust is one of the leading centres in the world for the endoscopic treatment of Zeneker's diverticulum.

- Healthcare Heroes Awards: The individual award this month went to Sister Katie Hodgetts on ward B4 for her efforts in discharging medically fit patients and the team award was given to the Neonatal All Stars as more than 30 members of staff from the Neonatal Unit took part in a 5k run at Himley Hall to raise funds for the unit.

The Board noted the Regional news stories and the challenges faced by other local Trusts.

Mrs Becke, Non Executive Director, asked about the risk from certain syringe drivers and if they have been removed from the Trust. The Medical Director confirmed that they had been removed.

The Chairman and Board noted the report.

**18/093 ED Position Statement (Enclosure 4)**
**8.56am**

The Chief Executive presented the ED position statement given as Enclosure 4 which gave a clear narrative on the areas where the Trust needs to improve. These included triage and the assessment and management of the deteriorating patient.

The Board and the Trust's priority was to focus on improving quality within ED.

The Board were informed as to the initiatives and actions being undertaken to improve the triage process. The Trust will focus on sustaining these improvements and is working with the national Emergency Care Intensive Support Team (ECIST) to help with steps of change and their evaluation. Information on these is submitted to the CQC on a weekly basis and significant improvement had been noted within the data in these returns, although consistent performance had not yet been achieved.

Mrs Becke, Non Executive Director, asked about 'see and treat' and what this cohort of patients referred to. The Chief Operating Officer replied that these relate to minors patients who are seen, treated and discharged within 60 minutes.

Ms Holland, Non Executive Director, asked about the triage process and its application. The Chairman confirmed that audits are undertaken to show the effectiveness of triage and the Trust is also having this process externally validated. The Director of Governance confirmed that 10% of patients every day are audited which gives a good degree of confidence in the process given that low levels are error identified in the audit, recognising that a degree of error is due to over cautiously triaging patients to a higher category of need than they actually have.

Mr Hodgkin, Non Executive Director, asked if there was an issue with the number of staff trained to undertake triage. It was noted that this was a concern and training investment was continuing but the main issue is the number of patients seen in the Department requiring triage.

The Chief Operating Officer confirmed that data is analysed daily, the Trust is learning from the in-depth review of data and this is helping improve performance.

The Chief Executive confirmed that another area of focus was around managing Sepsis. All staff within the Department had been re-trained in dealing with patients with possible Sepsis. E-Sepsis had been launched the previous day and will make a massive contribution to improving the management of Sepsis within the Department. A dedicated Sepsis trolley was now available within ED. The Trust has to demonstrate compliance with the Sepsis 6 requirements and the Medical Director has been undertaking audits within ED on this.

The Board noted some challenges with the recording of urine output but E-Sepsis will contribute to the better management of the whole pathway of interventions.

The Chairman asked about the target figures for Sepsis and whether the target was set at the right level. The Chief Executive confirmed that the target is considered realistic and is aligned with that in the Trust's Performance Report.

Mr Miner, Non Executive Director, asked about the expected improvements from the implementation of E-Sepsis. The Chief Executive confirmed that the electronic system provides real time data and will be invaluable in the timely identification and treatment of Sepsis.

Dr Wulff, Non Executive Director, confirmed that the Clinical Quality, Safety, Patient Experience Committee has asked to be provided with regular assurance reports focusing across the whole Sepsis pathway.

The Chief Executive briefed the Board on the staffing review previously undertaken within the Department and that a Business Case for additional staff has been produced within the Emergency Care Department. This will provide the 16 hour daily Consultant cover from our substantive staff in the Emergency Department, once recruited. Meanwhile locum facilities were being used to ensure compliance.

The Board noted the improvements made around Safeguarding within the Department and felt confident given the data that there is good oversight of Safeguarding now in place and excellent work has been undertaken in this area. There were some matters to address for 16-18 year olds.

The Trust was "buddying" with the Royal Wolverhampton Hospital Trust so reciprocal learning could take place and support mutual improvement.

Mr Miner, stated that this had been a difficult time for the Trust but he had a sense that the Trust was now through the worst of it. The Chief Executive stated that the data was encouraging but it was hard to anticipate outcomes of inspections given the human element involved, but it was certainly encouraging to see the daily improvement. Mr Miner asked about the Emergency Department teams away day. The Chief Executive confirmed that the first event was the following day. The theme was about clinical empowerment to make improvements for our patients.

Mr Atkins, Non Executive Director, asked about any stress testing of the current systems, particularly for the Winter period. The Chief Executive stated that volumes tend to remain constant but the acuity of patients change over Winter and the Trust is looking to provide more general and elderly care beds within the organisation to manage this change.

The Chairman raised the potential of further CQC visits and the timing of these. The Board noted that the they anticipated that the Emergency Department could be reviewed again towards the end of September/early October but nothing definitive was known.

The Chairman confirmed that there will be a fortnightly Oversight and Assurance meeting with the Trust's regulators and a weekly meeting of the Trust's internal Emergency and Urgent Care Service Improvement Group to keep the focus on the pace of improvement.

The Chief Executive confirmed that the Trust is committed to make the Emergency Department the best possible performing Department that it can be.

Dr Wulff, stated that it would be helpful to look at other CQC reports to examine system problems to ensure we are in the best possible positon to move forward.

The Chairman and Board noted the report and the ongoing work underway to improve patient safety and ED leadership.

**18/094 ED Summary at a Glance (Enclosure 5)**
**9.44am**

The Chief Operating Officer presented the ED Summary at a glance report, given as Enclosure 5.

This was taken by the Board for information given the debate just held over enclosure 4.

The Board noted that targets and improvement trajectories were included in the weekly data pack and these will be built into a series of Statistical Process Charts and Run Charts that will support this high level summary. These developments will enable the Board to assess the impact of the improvement activities.

The Chairman and Board noted the report.

**18/095 Urgent Care Service Improvement Group Report (Enclosure 6)**
**9.47am**

The Chairman presented the Urgent Care Service Improvement Group Report given as Enclosure 6.

The paper was presented to provide the Board with assurance on the oversight this Group is providing over the Trust's process of improvement within Urgent Care.

Dr Wulff, Non Executive Director, commented on the thorough nature of the meeting and that improvements and changes had been made. He informed the Board that the Group was considering whether there would be benefit in moving the meeting frequency to fortnightly to allow more time to assess the tests of change being made.

The Chairman and Board noted the report.

**18/096 Safe and Caring**

**18/096.1 Clinical Quality, Safety and Patient Experience Committee Exception Report for the meeting in July and August (Enclosure 7 and 8)**
**9.50am**

Dr Wulff, Committee Chair, presented the Clinical Quality, Safety and Patient Experience Committee Exception Report from the July and August meetings given as Enclosures 7 and 8.

The Board noted the following key areas from these Committee meetings:

- The Committee had been requested by the Audit Committee to look at the extract of the Board Assurance Framework (BAF) for those items the Committee had oversight of. The Committee felt that 3 items should be referred to the executive sponsors to reconsider their current risk scores to ensure they reflected the correct current position. These adjustments will come back to the Committee next meeting.

- The Committee had investigated concerns arising from a screening programme. An overview is being taken across all screening programmes to ensure that lessons from all reviews are applied.

The Chairman informed the Board that Mr Welford, Non Executive Director, had requested in his absence, the matter of whether the Committee agenda was too wide and asked for the Executive Team to consider this.

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

**The Clinical Quality, Safety, Patient Experience Committee to consider whether the size and breadth of its agenda was appropriate.**

**18/096.2 Chief Nurse Report (Enclosure 9)**
**9.54am**

The Deputy Chief Nurse presented the Chief Nurse Report given as Enclosure 9.

The Chairman commented that the request for a revised Chief Nurse Report was to highlight key issues by exception on the front cover of the report. If the report needed to have a significant amount of detail then these should be structured in a series of appendices.

The Chief Executive confirmed that she will take these comments forward with the Nursing Team to assist in a better structured report for the next Board.

The Deputy Chief Nurse summarised the key issues for the Board.

Mr Hodgkin, Non Executive Director, stated that he would like to see further and consistent detail around nurse staffing and the model that the Trust is working towards.

The Chief Executive commented on the difficulties with recruiting and retaining band 5 nurses across the NHS and this position was well recognised nationally. The current model is to ensure that the Trust has the right establishment levels to safely staff its wards.

The Board noted that there were particular teams where there were magnified challenges given their size, for example the Corporate Sepsis Team and the demands being placed on such a small team. The Trust also recognised that there needs to be good support for new recruits especially for graduates. The Trust is seeking to expand the Corporate Professional Development Team to support the retention of new staff.

Mr Atkins, Non Executive Director, confirmed that predictions show that the Trust will lose more staff than it will recruit over the next 6 months and this will provide a further challenge to the Trust over winter.

Mr Miner, Non Executive Director, commented that he had not seen any retention initiatives described in the paper.

Mrs Wakeman, Deputy Chief Nurse, joined the meeting and confirmed that a paper was being presented to the Finance and Performance Committee on retention initiatives. The Director of HR stated that the organisation has to improve its retention of staff and plans are being developed for this including improving the exit interview process and staff engagement initiatives. The Director of HR asked that any nursing specific retention plans be aligned to the corporate plans and suggested further discussion was needed to enable this.

The Chairman stated that our overall turnover rate is lower than the national average but that any leaver poses a challenge to recruit and then retain a successor.

The Chief Executive confirmed that the Trust needs to regain grip and control around agency spend and that focusing on substantive recruitment and retention is a cost effective and patient safety imperative. The Chairman agreed that that there needs to be consideration given to also reducing the Trust's overall cost base; this would again link to the imperative to reduce agency spend.

The Chairman asked about the wards that were agency free. The Chief Executive confirmed that this will be included in the next report to the Finance and Performance Committee.

The Chairman and Board noted the report and the number of actions that need to take place as a matter of urgency around recruitment and retention and asked for an update to the October Board. Mr Hodgkin, Non Executive Director, stated that early workforce assumptions need to be built into next year's business plan.

**Revised Chief Nurse report to detail key issues by exception on the front cover.**

**Paper on nurse retention initiatives to be presented to the Finance and Performance Committee.**

**Update on recruitment and retention to be included in the Chief Nurse report for the October Board, having linked to corporate plans.**

**18/096.3 Monthly Nurse/Midwife Staffing Report (Enclosure 10)**
**10.20am**

This report was taken for information as the information had already been included in the previous agenda item, the Chief Nurse report. The Board agreed there was no further action it was required to take in respect of this report.

**18/096.4 Nurse Revalidation Report (Enclosure 11)**
**10.20am**

This report was taken for information and the Board agreed following an explanation of the revalidation process there was no action it required to take in respect of this report.

**18/096.5 Q1 Patient Experience Report (Enclosure 12)**
**10.21am**

The Head of Patient Experience presented the Quarter 1 Patient Experience Report, given as Enclosure 12.

Mr Miner, Non Executive Director, asked about the information on page 15 and if the Head of Patient Experience had identified any specific themes as to why the Trust was in the bottom 10% nationally, and what things could be done to improve patient experience. The Head of Patient Experience confirmed that improved communication with patients and their families was a pivotal area for improvement. The Board were informed that action plans are in place to address this issue.

The Chairman asked about the number of complaints outstanding and what was being done to improve in this area. Dr Wulff, Non Executive Director, commented that the Trust is only closing 8 complaints a month and at that rate it could take over a year to resolve the outstanding complaints. The Head of Patient Experience confirmed that extra staff had been appointed and were working overtime to deal with the complaints. This was both centrally, and within the respective Divisions who are the ones who respond to the complainants.

The Chairman stated that the Trust's aim was to respond to complaints within 40 days and there a large number of complaints outstanding over this period.

The Chief Executive confirmed that the Patient Experience Manager has a corporate role and the Divisions have responsibility to respond to complaints within an appropriate timeframe. The Chairman asked that the Divisions report on this to the Clinical Quality, Safety, Patient Experience Committee.

Mrs Becke, Non Executive Director, commented that if patient's issues are dealt with immediately there is good evidence that this will not turn into a complaint. The Head of Patient Experience confirmed that this process of using PALs is already in place to seek an immediate answer or help to prevent the patient or their family feeling frustrated and needing to make a complaint. The Chairman stated that Non Executive Directors can test this out on the wards during their walkrounds, enquiring whether patients and their families know how to raise concerns and if they have raised any, were they dealt with swiftly locally. Ms Holland, Non Executive Director, confirmed that the importance of helping patients and families was highlighted at Trust induction.

The Chairman asked about what themes were being drawn from compliments. The Head of Patient Experience said that a key driver for someone taking time to provide a compliment was the communication and engagement they had received.

The Chairman highlighted a recent thank you letter that had been received and how much the patient valued the engagement given to himself and his family as well as his actual care and treatment.

The Chairman reminded the Board that the Trust had received a good result for caring within the CQC report.

Mr Atkins, Non Executive Director, confirmed that he had attended the Patient Experience Group and was impressed with the number of staff attending the meeting and their commitment to improving patient experience.

The Chairman and Board noted the report and asked that a trajectory for improving complaints responses be presented to the Clinical Quality, Safety, Patient Experience Committee.

**Complaints Report to the Clinical Quality, Safety, Patient Experience Committee to include a trajectory for improving complaints responses.**

**18/096.6 Safeguarding Report (Enclosure 13)**
**10.39am**

The Deputy Chief Nurse presented the Safeguarding Report, given as Enclosure 13. The Board noted the following key issues highlighted in the report:

- The Trust was continuing to focus on processes around Paediatric safeguarding referrals. A theme from ED had been that there had been some confusion around the age cut off for children where a referral would be made, but this has now been corrected with increased awareness that this process applies up to 18 regardless of which area the patient is seen in.

- A Business Case had been prepared for an additional Learning Disability Nurse. The Chairman confirmed that this had been raised at Board previously following a petition from a parent. Mrs Becke, Non Executive Director, supported the need for an additional nurse due to increasing numbers of patients with Learning Disabilities and the Trust's desire to support these patients to have a better experience whilst in the Trust. Discussions with the CCG were proceeding to establish their agreement to commission this additional investment.

The Chairman and Board noted the report.

**18/096.7 Q1 Learning from Deaths Report (Enclosure 14)**
**10.42am**

The Medical Director presented the Q1 Learning from Deaths Report, given as Enclosure 14. The Board were pleased with the reformatted report and the change of emphasis to be more focused on learning.

Mr Atkins, Non Executive Director, asked about item 2.4 and the definition of relevant cases. The Medical Director confirmed that these relate to deaths which are initially identified with concerns around care within the initial case screening process.

The Chairman asked about level 2 reviews and whether the number of reviews outstanding had reduced. The Medical Director stated that these had not and this was a cause for concern although he was assured that the review process being applied was robust. The frequency of review meetings and access to notes had been an issue but plans are in place to reduce the backlog and this backlog is monitored. The Chairman acknowledged this but emphasised the importance of timely reviews to secure maximum shared learning.

Mr Miner, Non Executive Director, asked about mortality numbers and if they could be broken down by division. The Medical Director confirmed that they could be as the disaggregated data is reviewed and any causes for concern are reported via the Mortality Assurance Group.

In response to questions the Medical Director drew the Board's attention to the specific conditions in the paper which appeared to reflect higher levels of mortality. The focussed improvement in Sepsis mortality was noted and it was acknowledged similar work was continuing in other areas.

The Chairman and Board noted the report and asked that the next report includes detail on the delivery of a reduction in level 2 reviews outstanding and that the report include any trends seen for other conditions. The Chief Executive asked that the target for HSMR reduction is included in the report.

**Q2 Learning from Deaths Report to include detail on reduction in outstanding level 2 reviews, trends from reviews over other conditions and an overall HSMR reduction target.**

**18/096.8 Guardian of Safe Working Report (Enclosure 15)**
**10.54am**

The Guardian of Safe Working presented his Guardian's Report, given as Enclosure 15. The Board noted the following key highlights from his report:

- Engagement information and activities were highlighted within the report and further engagement with juniors was noted to have improved since the last report. There was good turnout at the last Guardian's Forum

- The Guardian attends induction sessions for Trust FY1s and is made welcome at these meetings

- There had been 5 exception reports received in this reporting period. One of the reports had been classified as an immediate safety concern but after investigation it had been confirmed that there were no immediate harm concerns for the patient or doctor and this was the de-escalated on the system. This case whilst not being of an immediate concern did show that the process for following these up worked as the matter was dealt with very promptly.

- No exception reports had taken more than 7 days to be dealt with, with the exception of one as this could not be closed as the doctor was away from the Trust. It was confirmed not be of an immediate concern.

- The Guardian confirmed that he continues to work closely with the Freedom to Speak Up Guardians and was working on a number of initiatives for Freedom to Speak Up month in September 2018.

The Guardian concluded by confirming to the Board that they can be assured that junior doctors are safely rostered at the Trust.

The Chairman and Board noted the report and thanked the Guardian for his work and ensuring matters of concern are dealt with quickly.

**18/096.9 Freedom to Speak Up Guardian Report (Enclosure 16)**
**11.02am**

The Freedom to Speak Up Guardian presented his report, given as Enclosure 16. The Board noted the following key highlights from his report:

- Freedom to Speak Up Month is taking place in September and the Trust had secured attendance by the National Freedom to Speak Up Guardian to attend the Inaugural Lecture. The Freedom to Speak up Guardian extended an invite to the Board members to attend the presentation on 11th October and asked that they confirm their attendance to either Mr Derek Eaves or Ms Barbara White so that numbers can be tracked.

- The National Guardian's office is producing case reviews locally. It is intended to provide information on the Trust's positon against these recommendations and propose actions if necessary so that the Trust can learn from these cases.

- Freedom to Speak Up Champions: There had been 11 expressions of interest to become Freedom to Speak Up Champions and the Trust was looking to link these to Patient Safety Champions.

- The report contained an updated action plan against the recommendations made in the most recent national guardian's report. The Freedom to Speak Up Guardian conformed there were no significant gaps that he needed Board support with.

The Guardian of Safe Working asked if Junior Doctors could attend the visit from the National Freedom to Speak Up Guardian as he felt this would be useful. The Freedom to Speak up Guardian confirmed that all staff were welcome to attend but again asked that should they wish to attend that they confirm their attendance to either Mr Eaves or Ms Barbara White.

The Chairman asked if all staff groups were represented by the Champions. The Board were informed that they all had an opportunity to put forward an expression of interest but that most of the interest had come from the Trust's nurses.

The Chairman and Board noted the report and the positive work undertaken by the Guardians and looked forward to the Inaugural Lecture.

**Board members attending the Inaugural Lecture to confirm their attendance with either Derek Eaves or Barbara White.**

**18/097 Responsive and Effective**

**18/097.1 Integrated Performance Report (Enclosure 17)**
**11.09am**

The Director of Operations presented the Integrated Performance Report given as Enclosure 17.

The Board noted the following key issues within the report in respect of the Trust's July performance:

- Cancer key metrics: The Trust was ahead of trajectory for Quarter 3 and on track for 62 days.

- Diagnostics (DM01): The Trust, as reported previously, will fail this target in August but there is a robust plan is in place for recovery in September and its sustainability thereafter.

- Waiting times - 18 weeks referral to treatment: The Trust continued to show strong performance across this metric and the Trust finds itself 4th in country as result of its performance. The Trust had received a visit from Lincoln, and Leicester, to look at the Trust's RTT process as both have been struggling with their early performance across this metric.

- The Emergency Access Standard - 4 hour wait to be seen: The Trust had seen signs of improvement and some recovery against its performance trajectory, but there still remained work to be done for this performance to be sustained. The Trust had seen its busiest night on record last month, with over 310 attendances; the Trust also continues to see a high number of ambulance conveyances. These two elements present key challenges for the Trust as demand shows little sign of reduction and consequently sustaining good performance was high risk.

- Staffing metrics, appraisals, training, sickness and turnover: The Board were reminded that there had been a change to the process and a focus on securing staff appraisals early in the business year, this had resulted in the achievement of the 90% appraisal rate for this year by July. The Board was also informed that the mandatory training compliance rate for the Trust is the highest it has been. The Trust is now shifting its focus to improving compliance with priority 2 and 3 training compliance. The report showed that sickness rates overall reduced in July. The Trust's turnover rate continues to reduce but the reduction has slowed last month to that seen in previous months. The Chairman asked about if this was disaggregated into professional groups for turnover and were there any outliers. The Director of HR confirmed that the professional and scientific staffing group, the admin and clerical group and the medical and dental were the highest. The Director of HR added that to aid the Board this detail will be added to the commentary in future reports along with a summary of the actions being taken.

The Chairman reminded Board members to complete their mandatory training. The Director of HR offered assistance to Board members in assessing their required training if that would be helpful.

The Chairman and Board noted the report and current performance illustrated.

**Detail on turnover by significant staff groups be included in future reports along with actions being taken.**

**18/097.2 Finance and Performance Committee Exception Report (Enclosure 18) 11.19am**

Mr Hodgkin, Committee Chair, presented the Finance and Performance Committee Exception Report, given as Enclosure 18.

The Board noted the following key issues highlighted within the report:

- The Trust is forecasting an overall financial deficit position for the year of £9.6m, this is supported by a forecast of strong CIP delivery.

- A significant element of this deficit is attributable to 5 areas where a robust budget was not able to be set at the start of the year. The Committee had asked for their next meeting that there is clarity as to the mechanisms being applied to control and be accountable for costs in these areas.

- The Committee had discussed the Trust's cash position and the processes being applied by the Finance Team who have consistently managed cash prudently to date. The Committee had confirmed the Executives' assessment that the risk in relation to the Trust's finances remains an area for ongoing focus and scrutiny.

- Gearing around the Provider Sustainability Funding across the latter quarters of the year is significant and therefore the Trust could see a material swing in its fortunes from a deficit of £9m to surplus of £9m, assuming the Trust met expectations.

- The Committee was expecting to receive a detailed report at its next meeting on the delivery of the Trust's Quarter 2 position.

The Chairman asked about rectification plans to address the divergence against the Trust's initial financial plan for a breakeven at the end of this year. The Committee Chair replied that this was part of the information the Committee had asked for at the next meeting ahead of the Board in October.

The Chairman and Board noted the report, the Trust's financial performance and the work being undertaken to develop rectification plans for discussion at the Finance and Performance Committee before their next report to the Board in October.

**Finance rectification plans to be discussed in detail at the September Finance and Performance Committee prior to presenting to Board in October.**

**18/097.3 Audit Committee Exception Report (Enclosure 19)**
**11.26am**

Mr Miner, Committee Chair, presented the Audit Committee Exception Report, given as Enclosure 19.

Mr Miner drew the Board's attention to the following key issues from the last Audit Committee meeting:

- The Internal Audit report on staffing provided a no assurance assessment on compliance with the medical staffing controls. The Committee recognised that this report was dated and at the Committee the Executives did provide information on actions taken as result of the initial draft findings. The Executives had sought (from Internal Audit) further work in this area and this was endorsed by the Committee when they approved the internal audit work plan for 2018/19.

- The Board noted the actions the Committee had asked for and the required update at a future Audit Committee.

- Mr Miner discussed the Committee's review of the BAF and the Committee's challenge back to the respective Board Sub-Committees and Executives to review a number of the risks to ensure their current scores were reflective of the Trust's current positon. Mr Miner informed the Board that he had written to Committee Chairs about these to ensure that there was no lag in Committee's review of these risks.

The Chief Executive confirmed that this had been discussed at Executive Team and the Executives were aware of the risks referred for review. The Board discussed the difference between the BAF and Corporate Risk Register. The Chair reminded the Audit Committee chair that their check and challenge of the BAF was an appropriate process and a sign of a healthy committee. Mr Miner added he agreed and this was a process the Committee had followed previously but felt the revised format of the BAF made their ability to undertake this challenge as efficiently as it had done more difficult. The Chief Executive and Chair suggested using some of the next Board workshop to revisit the BAF process and the documentation / reporting to the Committees and Board.

The Chairman and Board noted the report, the concerns raised by the Committee and that the use and maintenance of the BAF will be part of the next Board workshop in October.

**BAF to be discussed at the Board Workshop in October.**

**18/098 Well Led**

**18/098.1 Medical Appraisal/Revalidation Annual Report (Enclosure 20)**
**11.32am**

Mr Stonelake, Responsible Officer, presented the Medical Appraisal/Revalidation Annual Report given as Enclosure 20.

The Board noted the following key highlights from the report:

- It is a requirement that the Annual report is presented to the Board by the Responsible Officer. This report fulfils this responsibility as have the previous annual reports presented to the Board.

- The National revalidation process has hardly changed since it commenced in 2012.

- There are changes planned to make the process less onerous for medical staff and for the process to include more meaningful patient feedback within the appraisal.

- There was a significant increase in doctors being appraised last year which had an impact on the work of the revalidation team, but the team had coped with these demands.

- The Trust was looking into ways practical ways of improved support for the revalidation team. For example currently there is only one person in the team that is trained to use the software so actions were taking place to train a further member of staff thus building in more resilience into the team.

- The Trust had narrowly missed its expected validation rate some 6-9 months ago but had succeeded in getting back on track. 98% of all doctors last year were re-validated. There had also been an improved email reminder system used last year and the Trust was standing at a 96% completion for appraisal within 12 months.

- The Trust was actively recruiting new appraisers and putting on refresher training for current appraisers and also under taking regular checking of appraisal documentation for quality, using a simple quality scoring mechanism. Scores for appraisal documentation had been consistently high.

- A new Trust appraisal lead had been appointed.

Mrs Becke, Non Executive Director, raised mandatory training for medics, and whether this area would be included in appraisal. Mr Stonelake confirmed that the GMC recommend not including this in the appraisal so as not to burden the process but the Trust does encourage doctors to present their mandatory training record as part of their appraisal. The Chairman stated that it would be good to re-emphasise the importance of mandatory training as part of the revalidation process, especially where training of this type was necessary for a specialty.

The Medical Director commented that there is a need to improve the depth and quality of the data set produced for appraisal. The Chairman asked that the Medical Director and Responsible Officer discuss outside the meeting and consider if these mechanisms might be used to enhance the focus on undertaking mandatory training with the doctors.

The Chairman and Board noted the report and concerns expressed about completion of medic mandatory training.

**The Medical Director and Responsible Officer to look at options for improving levels of Medical Mandatory Training through the use of the appraisal/revalidation process.**

**18/098.2 EPRR Core Standards Report (Enclosure 21)**
**11.48am**

The Chief Operating Officer presented the EPRR Core Standards Report, given as Enclosure 21.

The Board noted the following key highlights from the report:

- The Trust has submitted the required capability statement to NHS England against the 88 core EPRR standards.
- The Trust's self-assessment graded the Trust as substantially compliant.
- Action plans to address further improvements in the Trust's levels of compliance were included in the report.
- External check and challenge sessions over the Trust's self-assessment are taking place the following week.

Mr Miner, Non Executive Director, reported that the Trust's EPRR policy is flagged outstanding on the audit management action plan. The Chief Operating Officer confirmed that the policy has been completed but needed to check timescales for ratification.

The Chief Executive welcomed the improvements made to resilience planning at the Trust.

The Chairman and Board noted the report and the need for the Chief Operating Officer to check the outstanding policy sign off.

**Chief Operating Officer to check why the EPRR policy is outstanding on management actions, and if it has not been ratified to ensure the policy is put forward for ratification.**

**18/099 Any Other Business**
**11:52am**

The Board noted that Pauline Philips, NHSI Lead Director for Emergency Care was visiting the Emergency Department the following week.

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

**18/100 Date of Next Meeting**
**11.52am**

The next Board meeting will be held on Thursday, 4th October, 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 6 September 2018**

| *Item No* | *Subject* | *Action* | *Responsible* | *Due Date* | *Comments* |
|---|---|---|---|---|---|
| 18/097.2 | Finance and Performance Committee | Finance rectification plans to be discussed in detail at the September Finance and Performance Committee prior to presenting to Board in October. | TJ/JH | 27/9/18<br>4/10/18 | |
| 18/029.8 | Action Sheet | Board members perspective of the 6Cs to be presented to the Board in May. | LA | 4/10/18 | Board video to be completed for the launch of the next Annual Plan to highlight the Trust vision and values for all staff groups. |
| 18/072.2<br>&<br>18/091.1 | 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 | 4/10/18 | Done. Board Assurance Framework session taking place at the October Board Workshop. |
| 18/068 &<br>18/091.2 | Patient Story | Chief Nurse/Deputy Chief Nurse to investigate Orthopaedic Physiotherapy provision with Gail Parsons.<br>Deputy Chief Nurse to follow up possible use of an electronic diary for Community staff. | SJ/CLM | 4/10/18 | Introduced diaries on ward B1 for patients to record their experiences of having joint replacement. The diary content was evaluated and this information enabled us to make changes in practice eg pain assessment self reported by patient allowed us to look at type of analgesia used and pain assessment tools. |

| | | | | | |
|---|---|---|---|---|---|
| 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 | Meeting Stonelake attending Directors on 9th October. |
| 18/096.1 | Clinical Quality, Safety, Patient Experience Committee | The Clinical Quality, Safety, Patient Experience Committee to consider whether the size and breadth of its agenda was appropriate. | DW | 4/10/18 | Done - Committee has asked the Executive Team to consider this and for it to be considered as part of the Board Development workshops. |
| 18/096.2 | Chief Nurse Report | Revised Chief Nurse Report to detail key issues by exception on the front cover.<br>Paper on nurse retention initiatives to be presented to the Finance and Performance Committee.<br>Update on recruitment and retention to be included in the Chief Nurse report for the October Board. | CLM<br>CLM<br>CLM | 4/10/18<br>27/9/18<br>4/10/18 | On Agenda<br>Done<br>On Agenda |
| 18/097.1 | Integrated Performance Report | Detail on turnover by significant staff groups to be included in future reports along with actions being taken. | AM/KK | 4/10/18 | On Agenda |
| 18/097.3 | Audit Committee Exception Report | BAF to be discussed at the Board Workshop in October. | GP | 4/10/18 | On Agenda |
| 18/098.2 | EPRR Core Standards Report | Chief Operating Officer to check why the EPRR policy is outstanding on management actions, and if it has not been ratified to ensure the policy is put forward for ratification. | KK | 4/10/18 | Strategy has been ratified, signed off and is on the hub. |
| 18/096.9 | Freedom to Speak Up Guardian Report | Board members attending the Inaugural Lecture to confirm their attendance with either Derek Eaves or Barbara White. | All | 11/10/18 | |
| 18/096.5 | Q1 Patient Experience Report | Complaints Report to the Clinical Quality, Safety, Patient Experience Committee to include a trajectory for improving complaints responses. | JF | 23/10/18 | |

| | | | | | |
|---|---|---|---|---|---|
| 18/096.7 | Q1 Learning from Deaths Report | Q2 Learning from Deaths Report to include detail on reduction in outstanding level 2 reviews, trends from reviews and other conditions and an overall HSMR reduction target. | JH | 6/12/18 | |
| 18/098.1 | Medical Appraisal/Revalidation Report | The Medical Director and Responsible Officer to look at options for improving levels of Medical Mandatory Training through the use of the appraisal/revalidation process. | JH/PS | 6/12/18 | |

Enclosure 3

The Dudley Group
NHS Foundation Trust

**Paper for submission to the Board of Directors on 4th October 2018**

| | | | |
|---|---|---|---|
| **TITLE:** | **Public Chief Executive's Report** | | |
| **AUTHOR:** | **Diane Wake, Chief Executive** | **PRESENTER** | **Karen Kelly Chief Operating Officer** |

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

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

**SUMMARY OF KEY ISSUES:**

- Visits and Events
- National Staff Survey
- Healthcare Heroes
- Free flu vaccines for staff
- Freedom to Speak Up
- New Cancer Waiting Times
- 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 – October 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

| | |
|---|---|
| 6 September | Board of Directors |
| | Council of Governors |
| 7 September | Visit from MPs |
| 12 September | Transition Board |
| 13 September | Dudley System Oversight Assurance Group |
| | Quality Summit |
| 14 September | Visit from NHSI |
| 17 September | Black Country STP Health Partnership |
| 19 September | A&E Delivery Board |
| 20 September | Healthcare Heroes Presentations |
| 21 September | Patient Safety Summit |
| 25 September | Dudley System Oversight Assurance Group |
| | Overview and Scrutiny Committee |
| 26 September | Getting it Right First Time Review |

### National Staff Survey

The National Staff Survey is open from Monday 1st October – It helps us understand what's going well and the things to improve. All staff have the opportunity to complete the survey and we are once again encouraging as many people as possible to fill it in.

We're using Clever Together to run the survey for us – this means that all responses go to them and they only provide the Trust with an anonymous report summarising responses. It ensures everything is treated in confidence.

Staff feedback is very important and will help us improve The Dudley Group. For example, last year staff told us managers and leaders needed the time and skills to support and develop their staff. We launched additional development opportunities such as the developing leaders course and recognition schemes like Healthcare Heroes.

We are again running the survey online. If you do not have easy access to a computer, please let either your manager or lead know so we can make sure equipment is made available. You can access the survey from any device that you use to access your nhs.net email account.

**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 Rachel Andrew, Head of Learning and Development**. She stood out due to developing and implementing the first Management Development Programme within the Trust. She is always very committed and excels in order to support our current and future leaders.


**The Healthcare Heroes team award** was given to the **GI Unit**. The consultant and nursing staff took into account their patient's anxiety and hearing impediment to ensure everything was clearly explained and that she understood what was happening, they are very understanding, considerate and respectful.

## Free flu vaccines for staff

Free flu vaccines for all staff will be available from 1st October 2018 across the Trust.

The vaccine is available to all staff and volunteers and we are encouraging as many people as possible to get themselves, their families and patients protected by getting the vaccine.

We kicked off with a launch day on 1st October.

We'll be posting plenty of updates on the Hub and also on social media - #flufighter

We need to get at least 75 per cent of frontline staff vaccinated – we reached that target last year, so for 2018 let's aim even higher!

## Freedom to Speak Up

We are really excited that National Guardian Dr Henrietta Hughes is hosting this year's inaugural lecture on Thursday 11th October 2018 as part of Freedom to Speak Up Month. This is part of a month of events, with members of the Freedom to Speak Up team raising awareness of speaking up and voicing concerns.

Dr Hughes will be visiting wards and departments on Thursday 11th October 2018 after hosting the inaugural lecture.

### About Dr Henrietta Hughes

"Dr Henrietta Hughes was appointed in July 2016 as the National Guardian, a key recommendation from the Francis Report. She provides leadership and support to Freedom to Speak Up Guardians across England in Arm's-Length Bodies, NHS and Independent sector organisations to ensure that speaking up becomes business as usual.

## New Cancer Waiting Times

NHS England has introduced a new process for cancer waiting times, with the aim of better holding providers to account for waiting times where a cancer and diagnosis pathway is split across two organisations, as is common. We will report in this new format from October with first quarterly performane reports published in December. Until now, 62 day performance has automatically split any breach of the deadline between the diagnosing and treating provider, regardless of when the patient was transferred between the two.

The new system will allocate breaches to the provider that has caused the delay. The two providers responsible for diagnostics and treatment will share the breach if both failed to meet the 38 day and then the 24 day limits. For measurement purposes, each trust will be allocated half a breach for each patient not treated on time.

A treating provider will take all the credit if it meets the 62 day target despite the patient being referred late. Similarly, a diagnosing provider takes all the credit if it refers a patient for treatment within 38 days but the receiving trust fails to meet its own portion of the 62 day target.
However, if there are three are more providers, the breaches or successes of the system will only be allocated to the two providers in the process who had the longest periods of contact with the patient. Similarly, a trust that has breached the entire 62 day wait by itself will not be allocated all the failure, if the treating trust fails to meet the 24 day limit.

## National NHS News

### NHS officials reject breakthrough lymphoma treatment Yescarta

New therapy which offers a lifeline to blood cancer patients who have run out of treatment options and have months to live has been rejected for widespread NHS use because it is too costly. The National Institute for Health and Care Excellence (NICE) decided against recommending the immune cell therapy for some patients with non-Hodgkin lymphoma. The Institute of Cancer Research (ICR), which carries out studies to find new treatments, has criticised the move, saying axicabtagene ciloleucel, also known as Yescarta, is a “major advance in cancer treatment” which has cured some patients who would otherwise have died.
**The Yorkshire Post (28.08.18)**

### Less than half of eligible people take up NHS Health Check

The programme was launched in England in 2009 and offers a routine check-up every five years to people aged 40 to 74, with the aim of spotting early signs of issues like type 2 diabetes, stroke, kidney disease, heart disease and dementia. The examinations are often carried out by a nurse or healthcare assistant.The investigation by Diabetes UK found 15.4 million people were eligible for an NHS Health Check between 2013 and 2018, but only 6.8 million (44%) had one. The data analysis by Diabetes UK reveals that people face a so-called postcode lottery when it comes to the NHS Health Check, with a five-fold variation between the best and worst performing councils. Walsall is the only council in England where almost all of the eligible population received a check during the five-year period at 91%.
**Nursing Times (30.08.18)**

### NHS bosses urge hospitals to use private sector in bid to tackle waiting list backlog

Hospitals should use private providers to bring down waiting lists, NHS England has said. Trusts which had not managed to bring down their waiting lists after they were told to cancel non-urgent appointments to cope with demand last winter, were told in a letter that they should start sending patients to neighbouring or private hospitals from September. While this may help to limit patient waits with colder weather approaching, it is likely to make it even harder for trusts to hit strict savings targets and therefore they could miss on bonus payments.
**The Independent (31.08.18)**

**NHS England nets 'game-changing' childhood leukaemia treatment**
A cutting-edge personalised treatment for a form of childhood leukaemia is to be made available on the NHS in the first deal of its kind in Europe. NHS England has negotiated a contract with pharmaceutical manufacturer Novartis for a therapy that reprogrammes a patient's immune system to attack cancer cells. The treatment, known as CAR-T (chimeric antigen receptor T-cell) therapy, will be available to children and young people under the age of 25 who have B cell acute lymphoblastic leukaemia. The therapy, which is specifically developed for each patient and is currently only available in Europe in clinical trials, may be available within weeks and could help around 20 children a year.
**Sky News (04.09.18)**

**All acute NHS trusts in England now using e-referrals**
NHS trusts have reached 100% uptake of NHS England's e-referral service, ahead of October 2018 deadline. All acute NHS trusts and nearly all GP practices have switched off paper referrals and are now using NHS England's e-referral service (e-RS). NHS England had set an October deadline, requiring all GP practices and acute trusts to stop using paper and implement e-RS. However, all of the 150 acute trusts in England have completed the transition ahead of schedule and 7,110 of around 7,400 GP practices in England have also moved to e-RS so far. Steve Firman, the senior responsible owner for the programme at NHS England, said e-RS "works safely and quickly". He added that it's a "fantastic achievement all 150 acute hospital trusts are now on board ahead of the 1 October deadline".
**ComputerWeekly (06.09.18)**

**CQC takes enforcement action amid safety fears at Shrewsbury trust**
The CQC has decided to take "urgent enforcement action" against a trust that was last week embroiled in controversy after more cases of poor care were allegedly identified at its maternity unit. The organisation has inspected Shrewsbury and Telford Hospital Trust over six days last week after claims were made of staff shortages. The inspectorate has now reportedly handed the trust with a notice, which gives the CQC the ability to either suspend the provider's registration or impose restrictions on it. Shrewsbury has 28 days to appeal the notice. Heidi Smoult, the CQC's deputy chief inspector of hospitals, said that the August inspection "identified concerns regarding patient safety," adding: "We have now taken urgent enforcement action against the trust to ensure that people always get the care and treatment they have every right to expect. **National Health Executive (06.09.18)**

**One in seven NHS operations 'cancelled or postponed'**
One in seven NHS operations were cancelled or postponed on the day of surgery during one week at hospitals in the UK, a seven-day study found. The Royal College of Anaesthetists said its findings provide the most comprehensive UK-wide study to date on rates and reasons for surgical cancellations, using data from 90% of NHS hospitals across England, Wales, Scotland and Northern Ireland. It said that although last-minute cancellations of surgery were running at record highs, little was known about the specific risk factors beyond seasonal fluctuations. Looking at the week of March 21 to 27 2017, the team noted that a total of 26,171 inpatient operations were scheduled to take place. Of those operations, 3,724 were cancelled or postponed on the day of surgery – giving an overall cancellation rate of one in seven operations. **The Westmorland Gazette (07.09.18)**

**Ex-special measures trust still needs to improve as poor CQC rating left unchanged**
The Queen Elizabeth Queen Mother, William Harvey and Kent & Canterbury Hospital were all rated as 'requires improvement' in the latest CQC report, meaning there have been no substantial improvements since the last inspection in 2016. The foundation trust was originally put into special measures in 2014 because of serious failures in patient safety and leadership but was removed in 2016 after inspectors identified enough improvements. Despite this, the CQC's deputy chief inspector of hospitals, Amanda Stanford, revealed that there have been some positive changes since the last investigation, with the trust now working with local stakeholders to develop a new clinical strategy that meets regional needs.
**National Health Executive (07.09.18)**

**NHS to be franchised around the globe under post-Brexit plans**
Hospitals and heath watchdogs will be encouraged to set up franchises in dozens of countries, with profits ploughed into supporting the health service. The NHS will be asked to target up to £7bn of opportunities a year over the next decade, in a bid to share expertise and increase investment in frontline services. Officials hope to turn the UK's national health service into a global brand, in the same way that the BBC gains significant income from its commercial BBC Worldwide arm.

In recent years, a handful of NHS trusts have set up franchises abroad. Specialist eye hospital Moorfields has branches in Dubai and Abu Dhabi, while South London and Maudsley NHS Foundation trust has set up mental health services in Abu Dhabi and Northumbria Healthcare NHS Foundation trust is helping to develop hospital services in China. **The Telegraph (10.09.18)**

**NHS vacancies a 'national emergency'**
One in 11 posts is vacant with the situation particularly bad among the nursing workforce. Experts described the situation as at risk of becoming a "national emergency" given the rising demands on the NHS. It comes after sustained efforts by ministers and NHS bosses to tackle the shortages, including a new pay deal and recruitment and retention campaigns. The latest figures have been published by the regulator, NHS Improvement, for the April to June period.
They showed:
- 11.8% of nurse posts were not filled - a shortage of nearly 42,000
- 9.3% of doctor posts were vacant - a shortage of 11,500
- Overall, 9.2% of all posts were not filled - a shortage of nearly 108,000

**BBC News (11.09.18)**

**NHS nursing shortages risk becoming a 'national emergency'**
The number of NHS vacancies have risen by almost 10% in the first quarter of this year and are expected to continue rising with experts warning that "widespread and growing nursing shortages now risk becoming a national emergency." NHS Improvement's quarterly performance report showed that in England there were 107,743 NHS vacancies at the end of June, up from 98,475 back in March which bucks the downward trend seen over the past year. The regulator has published the latest figures for the April to June period, showing over 40,000 nursing vacancies in total. **National Health Executive (11.09.18)**

**NHS loses 29 midwives for every 30 that it trains**
The NHS is losing 29 midwives for every 30 trained, new figures show. The research comes as latest staff vacancy levels published by the NHS prompted warnings of a "national emergency". The Royal College of Midwives (RCM) said attempts to boost staff numbers had made little difference, because so many are leaving the NHS or taking retirement. Its research shows that even though universities trained an extra 2,000 midwives in 2016/17, the total number rose by just 67, because so many workers left the service. It came as official data published by watchdog NHS Improvement shows more than 107,743 NHS vacancies in England at the end of June, with one in eight nursing posts vacant.
**The Telegraph (12.09.18)**

**NHS mental health crisis worsens as 2,000 staff quit per month**
Thousands of nurses, therapists and psychiatrists are quitting NHS mental health services, raising serious doubts about ministerial pledges to dramatically expand the workforce. Two thousand mental health staff a month are leaving their posts in the NHS in England, according to figures from the Department of Health and Social Care (DHSC). The news comes as services are already seriously understaffed and struggling to cope with a surge in patients seeking help for anxiety, depression and other disorders.

A total of 23,686 mental health staff left the NHS between June 2017 and the end of May this year, health minister Jackie Doyle-Price told Labour MP Paula Sherriff last week. That is the equivalent of one in eight of the sector's whole workforce. One in 10 mental health posts were unfilled at the end of June, Doyle-Price also told Sherriff, the shadow mental health minister. While 187,215 whole-time-equivalent staff work in the sector, the total should be 209,233.
**The Guardian (15.09.18)**

**Targeted treatment for melanoma to be free on NHS**
At present, they have to hope their cancer will not return after surgery. The drug has been shown to improve the survival of people with stage III melanoma, with a particular mutation. A skin cancer charity said making the treatment available on the NHS was "a huge step forward". Melanoma is the most aggressive type of skin cancer, with 15,400 new cases diagnosed each year in the UK. A gene mutation called BRAF is found in approximately half of cases - and around 500 of those people have stage III. This means that cancer cells have spread into skin, lymph vessels or lymph glands close to the melanoma, but they haven't spread to more distant parts of the body. The therapy, which has been approved by the health body NICE - the National Institute for Health and Care Excellence - is a combination of the drugs dabrafenib and trametinib which can be taken at home as five tablets a day.
**BBC News (17.09.18)**

**NHS sued for failure to help transgender patients with fertility**
NHS England is to be taken to court by the UK's equality watchdog for failing to offer fertility services to transgender patients. The Equality and Human Rights Commission will launch a high-profile judicial review action, a legal manoeuvre that is likely to prove controversial at a time when the NHS is struggling to balance budgets and provide core services.

Last month the Observer reported that the commission had written to NHS England putting it on notice that it needed to offer fertility services to transgender patients before they underwent treatment for gender dysphoria, a process that normally results in a loss of fertility.
**The Guardian (22.09.18)**

**Regional NHS News**

**Inquiry into deaths at NHS maternity unit widened**
Ockenden was commissioned in April 2017 by the then health secretary Jeremy Hunt to look into the deaths of 23 babies and mothers at Shrewsbury and Telford Hospital NHS Trust. The Health Service Journal website on Thursday claimed that at least 60 cases of infant and maternal deaths and babies suffering brain damage had been identified. Its report included suggestions that the scandal at the West Midlands trust may prove bigger than that at the Morecambe Bay trust in Cumbria, where one mother and 11 babies died avoidable deaths. However, the Midlands trust has rejected the HSJ's report as "factually incorrect and untrue" and criticised the publication for its "irresponsible and scaremongering" reporting.
**The Guardian (31.08.19)**

**Urgent action taken at NHS trust facing baby death inquiry**
An inquiry was commissioned in April last year by the then health secretary, Jeremy Hunt, to look into the deaths of 23 babies and mothers at Shrewsbury and Telford hospital NHS trust. Last week, NHS Improvement said the investigation, by midwife Donna Ockenden, would look into more than the 23 cases originally planned after claims that about 40 other incidents merited investigation.The NHS regulator, the Care Quality Commission (CQC), said on Thursday that it had taken action following an inspection at the end of last month. Heidi Smoult, the CQC's deputy chief inspector of hospitals, said: "An inspection of services provided by the Shrewsbury and Telford NHS trust took place over six days at the end of August 2018. That inspection identified concerns regarding patient safety. the trust to ensure that people always get the care and treatment they have every right to expect. We will provide further information when the legal process allows."
**The Guardian (06.09.18)**

**The number of complaints against Birmingham hospitals last year revealed**
New NHS data shows there were 660 new written complaints against University Hospitals Birmingham NHS Foundation Trust in 2017/18. That was down from the 680 received the previous financial year. A total of 666 complaints were resolved by the trust in 2017/18, including some from previous years. Of the complaints resolved, 64 per cent were either upheld or partially upheld. That was up from 60.5 per cent in 2016/17. At Sandwell and West Birmingham Hospitals NHS Trust, the number of new complaints fell from 874 to 776. The number that were upheld or partially upheld dropped from 73.5 per cent to 66 per cent. The data, published by NHS Digital today, showed there were a total of 14,544 written complaints against all hospital and community health services across the West Midlands region.
**Birmingham Live (07.09.18)**

**This is how much NHS property has been identified for new Birmingham houses**
More than 30 new houses could be built on three NHS sites newly identified as surplus in Walsall. New figures released this week by NHS Digital show that in 2017/18, three sites owned by Walsall Healthcare NHS Trust were newly identified as surplus to the delivery of healthcare, and which can be sold off. These are a car park and four office blocks on the Manor Hospital site, with a total market value of £1.4m. Overall, an estimated 32 new houses could be built on these sites, with plans to sell off the sites in 2018. Another NHS site, Newington Resources Centre in Marston Green belonging to the Birmingham and Solihull Mental Health NHS Trust was also newly identified as surplus. There are plans to market the site, where an estimated eight new houses could be built, in 2020, with no market value for the plot identified yet. **Birmingham Live (11.09.18)**

**Mental health chief's aim to eliminate suicide in West Midlands**
The West Midlands should be setting itself a target of zero suicides every year, according to the Combined Authority's mental health chief. Speaking ahead of next month's 'Walking out of Darkness' event to help raise awareness and to remember the victims of suicide, Sean Russell says that "every loss of life is one too many." Last year there were 477 suicides in the West Midlands, a huge rise from ten years beforehand when just 245 deaths were recorded from suicide in 2007.
As part of its five-year plan, the NHS has set itself the target of reducing the number of suicides by ten per cent each year. **Coventry Live (12.09.18)**

**New flu jab will prevent hundreds of deaths this winter, experts say**
People in Staffordshire are being encourage to sign up for a new flu jab that is expected to prevent hundreds of deaths and thousands of hospital visits this winter. The new vaccine comes as it was been revealed that 960 people were admitted to intensive care units across the Midlands and eastern England last winter due to flu. This number has almost quadrupled since the previous year, when 246 people were admitted. Nationally, the new vaccine could reduce GP consultations due to flu by 30,000, hospitalisations by more than 2,000 and prevent more than 700 deaths in England. The newly available 'adjuvanted' vaccine is expected to be much more effective than the current one by improving the body's immune response to the vaccine. **Derbyshire Live (14.09.18)**

**Cancer patients in Coventry could have to travel to Birmingham for treatment**
Cancer patients are among those in Coventry that may have to travel to Birmingham for life-saving treatment under plans to restructure NHS services. Health bosses have plans to combine hepatobiliary (HPB) services - which treat patients who have disorders of the liver, bile ducts and pancreas including cancer - at University Hospital Coventry and Warwickshire (UCHW) and University Hospital Birmingham (UHB). That could see thousands who use the service in **Coventry** having to travel to Birmingham's Queen Elizabeth Hospital for treatment. The two hospitals are more than 30 miles apart. **Coventry Live (19.09.18)**

**West Midlands NHS trusts pay out £1 million compensation over health and safety issues**

Research by law firm Nockolds Solicitors found the average payout by NHS trusts in England over the 2017/18 financial year was £158,219 – but some trusts ended up forking out more than £1 million each. The Black Country Partnership NHS Foundation Trust paid out the most in the Midlands, £572,342, followed by the West Midlands Ambulance Service with £351,431. Sandwell & West Birmingham Hospitals NHS Trust paid £176,905, while Walsall Healthcare NHS Trust paid £131,023 in compensation. Elsewhere in England, NHS trusts paying more than £1 million included North West Ambulance Service NHS Trust (£1,076,909) and Guy's and St Thomas' NHS Foundation Trust (£1,009,306). Examples of employers' liability claims include slips, trips and falls, accidents caused by defective equipment and as a result of insufficient training or supervision. **Express & Star (24.09.18)**

**Two struck by deadly bug Legionnaires' disease in Tamworth - investigation launched**

Health chiefs and environmental experts are investigating two confirmed cases of Legionnaires' Disease in Tamworth. Details have not been released of the two patients, one who remains in hospital, although both are said to be recovering. It has been revealed that Public Health England is also investigating four separate cases of Legionnaires' disease identified in the last six months, in case they are linked to a wide community cluster. Those four patients have now fully recovered. The latest cases are being investigated by Public Health England (PHE) West Midlands, the Health and Safety Executive, the NHS in Staffordshire and Tamworth Borough Council. **Birmingham Live (24.09.18)**

**Shropshire health bosses deny insufficient information provided for Future Fit consultation**

Bosses at Shropshire and Telford & Wrekin Clinical Commissioning Groups claim 'sufficient information' was provided for people to have an informed opinion. A letter was sent to the CCGs, on behalf of Labour parties across Shropshire and Montgomeryshire, saying there was a lack of information surrounding transport, finances and who will run the urgent care centres. Chairman of The Wrekin Labour Party branch, Peter Bradley, said there had been no answers provided about the effect the proposals will have on ambulance services and if there will be changes to public transport to improve access to the county's hospitals. A final report is due on October 8. **Shropshire Star (25.09.18)**

Enclosure 5

The Dudley Group
NHS Foundation Trust

**Paper for submission to the Board on 4 October 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 | |
|---|---|---|---|---|
| Urgent and Emergency Care Service Improvement Group | 4 September 2018<br>11 September 2018<br>18 September 2018 | J Ord | **yes** | **no** |
| | | | Yes | |

## Declarations of Interest Made

None

## Activity of the Group

The Group met every Tuesday in September with the exception of the 25 September as there was a System Oversight meeting on that day.

The Group reflected that with the introduction of run charts and statistical process control charts the assurance information had been further enhanced.

Within each meeting the s31 registration assurance information was received and discussed. The Group used the action tracker appended to each meetings minutes to follow through on the completion of these actions. The Group tasked executives, operational management and clinicians with actions to secure improvement

The Group continued 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 achievements.

The Group recognised that more work was still needed on sepsis and managing the deteriorating patient and the Group tasked the department to focus their improvement with the use of ECSIT and the Royal Wolverhampton NHS Trust "buddying" arrangement to make sustainable improvements.

## Decisions Made/Items Approved

That the executive produce a broader dash board which enables the s31 improvements along with wider improvements on flow to be reported.

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

The improvements within Sepsis and the management of the Deteriorating Patient.

## Items referred to the Board for decision or action

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

Enclosure 6

The Dudley Group
NHS Foundation Trust

## Paper for submission to the Board on 4 October 2018

| | | | |
|---|---|---|---|
| **TITLE:** | **25 September 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: c**overs 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 Board note that the Committee asked the Clinical Support Division to undertake two risk assessments in respect to the contract performance of a 3rd party partner and the use of temporary facilities.

The Board note that the Committee had referred to the executives the need to consider how the Trust can improve the capturing of and the sustainability of learning and changes as a result of concerns, complaints and incidents.

The Dudley Group NHS Foundation Trust

# Committee Highlights Summary to Board

| Committee | Meeting Date | Chair | Quorate | |
|---|---|---|---|---|
| Clinical Quality, Safety and Patient Experience Committee | 25 September 2018 | D Wulff | **yes** | **no** |
| | | | Yes | |

## Declarations of Interest Made

None

## Assurances received

- The Committee received a report from the Divisional Director for Surgery, Women and Children on the risk of past QA visit issues being replicated across screening programmes conducted by the Trust. The report provided assurance that any issues from past QA visits were not replicated across other programmes.
- 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 was informed a change in process that will see the Risk and Assurance Group receive SIs as they are initially reported to support the prompt dissemination of early learning across the Trust and as the investigation is complete to allow the Group to collectively support the drive for robust determination of the root cause and the development and delivery of focused action plans as a result of the investigation.
- The Committee received a summary report of key quality metrics along with the Trust Integrated Performance Report. The report highlighted that for 5 of the 8 priority areas the Trust performance had improved and gave information on the actions being taken in respect of the other 3 which were the same as those reported last month, 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 asked for more detail at the next meeting on the effectiveness of the actions being taken in respect of the 3 areas which were still not being delivered.
- 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 for the third month to 79.7%. There remains a plan to achieve 90% by the end of the year. The report also recorded the Trust's sustained position regarding MRSA screening for elective patients at 99% and for non-elective patients at 94%. The report detailed actions arising from the NHS I inspections and, with the exception of training which is in progress, all others are complete. The Committee was reminded that the Trust commences the Flu Vaccination Programme for Staff in October.

- The Committee received a report in respect of the histopathology service and the outcome of the planned case reviews and the actions being taken.
- The Committee received an update on the cervical screening QA Team visit action plan and the learning that had already taken place as a result of the delivery of a number of these actions. The delivery of the remaining actions is monitored via the Division and any at risk actions will be reported in the Divisional update to this Committee.
- 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 recognising that the Division is ahead of its trajectory for seeing overdue follow up patients but is behind its plan for seeing new patients. The Division provided an update on the work being undertaken in respect of paediatric outpatient waiting lists. The Division is slightly behind its revised trajectory for the month of August which is a deterioration against the performance in July. However the change in process has seen a significant reduction in those waiting the longest time for an appointment.
- The Medicine Division provided an update to the Committee on the last meeting and an update on the work being done within the Division to focus on learning from incidents.
- The Clinical Support Services Division provided an update to the Committee and discussed the challenges with respect to the level of imaging reporting backlog and the progress with the MRI replacement programme. The Committee asked that a risk assessment be undertaken in respect of the contract performance of one of our 3rd party suppliers and that a separate risk assessment be undertaken in respect of the use of temporary scanners.
- 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 risk of delivery of the CQC action plan has been increased given the increase for this month of actions which are behind their original implementation dates.
- The Committee received an update on the developing ED service improvement plan. Statistical Process Charts have been developed for many areas to support an understanding of the changes and their impact. The Committee was informed that a fuller dashboard will be presented to the Board at its next meeting in October
- 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 serious incidents in the month of August and a slight increase in reported incidents overall when 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 and the number of unclosed older incidents remain similar to that reported last month. A trajectory was provided in respect of the closure of older Serious Incidents. The Committee noted that there were this month 4 investigations where the action plans had not been closed in line with the initial implementation dates, two of which were outstanding last month. The Committee referred to the executives the need to consider how the Trust can improve the capturing of and the sustainability of learning and changes as a result of concerns, complaints and incidents. The Committee asked the Divisions within their routine reports to the Committee to include information on the trajectory to close the delayed incident investigations.

- The Committee received a report from the Deputy Chief Nurse in respect to the key learning from a cohort of stage 3 and 4 pressure ulcers. This information has been submitted to the CCG as part of the agreed process for accelerating the closure of these old incidents. The delivery of the associated action plan for improving pressure care will be monitored by the Quality Safety Group who through the reporting to the Committee will flag any issues with the delivery of any of these actions
- The Committee received the monthly report on patient experience information for August 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 reports from the Surgery, Women and Children's Division and the Medicine Division on their rectification plan to address old complaints. The Committee asked that whilst a trajectory of some 12 weeks was provided by the Divisions for closure of old complaints that this be reviewed to secure a swifter set of actions to close old complaints.
- 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 report also contained information on the Trust's most recent Patient Led Assessment of the Care Environment (PLACE) findings and the associated actions for improvement. The Committee were updated as to the challenges faced by the estates team to ensure that beds and trollies were being stored correctly when not in use. The Committee endorsed the suggestion that the Executive support the estates team with this issue.
- The Committee received reports from the reporting Groups covering, Medicines

Management Group, Health & Safety Group, EPPR Group and the Quality and Safety Group. The Committee approved revised terms of reference for the EPPR Group but questioned whether this should be a reporting Group to the Committee particularly in the light of the work being undertaken to review the breadth of work of the Committee.

- The Committee received the R&D report and noted the positive position the Trust was in with respect of people recruited into the studies.
- 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 30 September. Subject to final oversight director sign off these will go to the October policy group meeting. The Committee noted that there are a further 62 due for review in the next 6 months and that the number of guidelines and standard operating procedures that require review is placing 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 reviewed the Board Assurance Framework for those risks it has oversight of along with the Trust Corporate Risk Register. The Committee noted the changes made by the Executive following Committee's comments last month.

## Decisions Made/Items Approved

- The Committee approved the revised EPPR Group terms of reference.
- The Committee endorsed the closure of 12 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 requested an update on that work is being undertaken to review the breadth of work of the Committee.
- The Committee endorsed the policy group recommendation to approve changes to 6 of the Trust's policies.

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

The Committee asked for more detail at the next meeting on the effectiveness of the actions being taken in respect of the 3 quality priority areas which were still not being delivered.

The Committee asked the Divisions to include information on the trajectory to closed the delayed incident investigations in the monthly Divisional reports

The Committee asked that whilst a trajectory of some 12 weeks was provided by the Divisions for closure of old complaints that this be reviewed to secure a swifter set of actions to close old complaints.

| Items referred to the Board for decision or action |
| --- |
| That the Board note that the Committee asked the Clinical Support Division to undertake two risk assessments in respect to the contract performance of a 3rd party partner and the use of temporary facilities.<br><br>That the Board note that the Committee had referred to the executives the need to consider how the Trust can improve the capturing of and the sustainability of learning and changes as a result of concerns, complaints and incidents. |

Enclosure 7

The Dudley Group NHS Foundation Trust

**Paper for submission to the Board of Directors 4 October 2018**

| | | | |
|---|---|---|---|
| **TITLE:** | **CHIEF NURSE REPORT** | | |
| **AUTHOR:** | **Carol Love-Mecrow, Deputy Chief Nurse** | **PRESENTER** | **Carol Love-Mecrow, Deputy 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 lists and summarises the areas of responsibility of the chief nurse and the corporate nursing team **Appendix 1**. Describes the activity which supports the Trust to achieve the Corporate Objectives and to consistently deliver safe, effective, caring and responsive care.

Detailed below are the key exceptions of note that have been highlighted by the team at other forums that the Board needs to be aware of and detailed in **Appendix 2** details the actions currently being taken to address the issues highlighted.

**Appendix 3** provides this month's update on safer staffing, agency controls and recruitment and retention

## EXECUTIVE SUMMARY

### SAFER STAFFING

The community nursing day and night has been completed. The plan is that the combined paper (day and night staffing) will be presented to the Directors meeting and then to the MCP transition Board for consideration.

EAU and ED reviews although initially completed are being further considered based on planned and actual developments within the two areas. A business case has been drawn up for changes to the staffing on ward A2 due to changes in functionality of the ward.

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 (55). 54 out of 55 incidents were no harm or near miss. One incident was reported as low harm. This pertains to the Coronary Care Unit (CCU) where staffing was reported as inadequate in relation to patient's acuity and workload. To mitigate this and maintain patient safety the Clinical Nurse Specialist was asked to support the unit.

### AGENCY CONTROLS

RN agency usage has seen an increase in August 2018 with a decrease in bank RN usage. This month has seen a significant increase in bank usage of CSWs. The high usage of CSWs appears to be the main driver for the overspend which equates to £1,056,891 at month 5. Further analysis is required to understand the increasing demand for bank CSWs across the wards. The use of agency clinical support workers remains nil in line with current agency controls.

All bank and agency requests continue to be RISK 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

August 2018 reports a total of 314 nurse vacancies across the trust

Monthly recruitment events continue however work is underway to strengthen recruitment activity.

45 graduate nurses commenced on the 17th September 2018. These will show on the nursing predictor in October following their supernumerary period.

There are currently 32.36 FTE Band 5 adverts live on NHS Jobs with a further 46.91 FTE pending and will go live once approved.

**ISSUES BY EXCEPTION, CURRENTLY BEING ADDRESSED BY THE CHIEF NURSE AND THE CORPORATE TEAM**

**ALLIED HEALTHCARE PROFESSIONALS**

**Lack of opportunity and investment for career progression** - scope the feasibility of extended and non-traditional AHP roles e.g. Therapy Matrons, highlighting areas where this will benefit the delivery of safe, efficient and effective patient care

**Recruitment and retention issues** - To work in partnership with the Recruitment and Retention Lead to explore strategies to improve recruitment potential

**Concern that the banding of roles is not reflective of the knowledge required** – Undertake AHP skill mix review

**Need for improved senior AHP Leadership**- Undertake gap analysis to review current skills and skills required

**Promote and engage AHPs in Trust wide developments** – To ensure there is AHP representation at key meetings to raise the AHP profile and market AHP services (e.g. AHP Open Days, AHP page on website, screen savers, AHP Events, AHP involvement in patient and staff stories to Trust Board, etc.) To develop an AHP Strategy in line with the Trust strategic objectives and the National AHP Strategy, which clearly outlines the aims and objectives of AHPs

**Limited involvement and knowledge of Trust wide service developments -** To explore options available to ensure AHPs are considered in business cases for service improvements.

**Limited access to IT to support the development of Digital Trust** - To ensure AHPs are actively involved in the EPR process -To work in partnership with IT to identify equipment and resource needs

**PROFESSIONAL DEVELOPMENT**

**The professional development team has an increasing portfolio of work and need to ensure the team structure can deliver** - A full review of staffing across the team and the current and expected work load and program plans. Increase demand in programs to up skill support staff through level 2 to 3 to 4.

**Student placement numbers and support.** Pre-registration team to review student numbers and discuss with Wolverhampton projections. To explore other universities especially with pan document development.

**Resus/Sepsis deteriorating patient team structure and retention**. Notably the Senior Resuscitation Officer and Resuscitation Officer have both submitted their resignation in the last month. Whilst both posts have been put to advert this poses a significant risk. These risks are currently being mitigated with the use of temporary staff.

**No centralised space for team, lack of office facilities and teaching environments**. Review of space in North block alternative office space to be sourced.

**TISSUE VIABILITY**

**Breaches of the 60 day root cause analysis (RCA) target of submissions to CCG** - Group closure of all outstanding avoidable grade 3 and 4 PU RCAs after submission of thematic review with overarching action plan as agreed with the CCG

Deep dive on 10% of the outstanding PU RCAs to ensure appropriate learning are captured in the thematic review

**Recommendations from the latest NHS Improvement guidance on PU definition and measurement** - Creation of PU task and finish group to review the latest guidance and develop plan for implementation and monitoring

Reporting of the PU task and finish group to the Quality and Safety group

**QUALITY REVIEW AND IMPROVEMENT ENSURING REGULATORY COMPLIANCE**

**Failure of wards and departments to make necessary improvements following reviews and outcomes of nursing audits.**

Deliver basic introduction to QI methodology training session to lead nurses Complete Specialist Practice Coach training for Dudley Improvement Methodology (LEAN)

Set up Quality Academy to provide supportive mechanism for improvement projects and deliver Trust Wide improvements in structured and systematic way

**Lack of capacity of the Quality Review and Improvement Lead to support quality improvement projects throughout nursing end of band 6 seconded post to support the role**

To explore funding options to make seconded post substantive. If no funding can be identified within current budget; business case to go to directors for approval of additional post

In conclusion there are a variety of metrics and forums that oversee 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:** |
| | **NHSI** | **Y** | **Details** |
| | **Other** | **N** | **Details:** |

**ACTION REQUIRED OF BOARD**

| Decision | Approval | Discussion | Other |
|---|---|---|---|
| | | **X** | |

**RECOMMENDATIONS FOR THE BOARD:**
Receive this report as requested by the Board and note its content.

**Appendix 1**

**THE DUDLEY GROUP NHS FOUNDATION TRUST**
**CHIEF NURSE REPORT OCTOBER 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.

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. The situation with the quality priorities are reported quarterly to the Board.

This paper a) summarises the teams which sit within the corporate nursing structure, reporting into the chief nurse to support the professional leadership of nurses, midwives and AHP's and b) indicates any current issues with each team that need to be brought to the attention of the Board.

### Quality Priorities

These are reported quarterly to the Clinical Quality, Safety and Patient Experience Committee (CQSPE) with the next report for Quarter 2 due at its October meeting (October 23rd).

### 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. The team provides advice, support and guidance to members of staff regarding safeguarding matters and ensures relevant policies and procedures are in place to support all staff. Among other support it provides training and education for all staff to support them with their safeguarding work.

### 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.

### Allied Health Professionals

The Trust has a lead AHP who reports into the corporate nursing structure. The lead facilitates the AHP Council which meets on a six weekly basis, focusing on initiatives to raise the profile of AHPs within the Trust. Amongst other work, the Council is responsible for the recently launched AHP newsletter. An AHP strategy is in draft and currently out for comments.

### 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 co-ordinates initiatives such as the introduction of the Nursing Associate role. Specialists in Manual Handling and Medical Devices provide training and develop policies and guidelines on these issues. The Nurse Recruitment and Retention Lead coordinates nurse recruitment and retention activity. There is a Post Registration Team which provides training and development support to all registered nursing staff. The Pre-Registration team supports all nursing and allied health care students placed within the Trust and ensures that an effective mentoring

system is in place. Non-Medical Prescribing co-ordination is undertaken by the team in collaboration with pharmacy staff providing Trust authorisation for newly qualified prescribers and ongoing support and development. The Resuscitation and Sepsis team provides training covering basic and advanced life support, RADAR (Recognise Acute Deterioration, Assess and Refer) and sepsis with a focus on the recognition of the deteriorating patient and maintaining patient safety.

## 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.

## 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 Trust was part of the NHSI Falls Collaborative in 2017 and the lead nurse continues to represent Dudley at the Falls Practitioner Network.

## Quality Review and Improvement 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 method to achieve this is through the undertaking of structured Quality and Safety Reviews, based on the CQC Key Lines of Enquiry. The corporate nursing team is committed to monitoring and supporting all areas to ensure high quality patient care, and where necessary to make improvements. To compliment the Quality and Safety reviews, there are comprehensive quality nursing and midwifery audits undertaken every month. Also, quality dashboards were introduced this year with the aim that every area will display relevant local, regional and national KPI quality data in a prominent position for staff, patients and their relatives/families to view. On a monthly basis the Trust provides data to NHSI measuring the harm free care we provide to our patients. This 'Safety thermometer' audit takes place each month in all adult inpatient wards and all district nursing community localities.

## 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. The staffing paper presented to the Finance and Performance Committee is attached as Appendix 3

## 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 Health watch. 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.

## 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.

## 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.

## Patient Experience Team

Listening to patients' views is essential to providing a patient-centred health service. The department co-ordinates the Friends and Family Test (FFT) which uses a simple question on a scale ranging from extremely likely to extremely unlikely they are to recommend the service to their friends and family. The Trust takes part in the NHS Patient Survey Programme which allows patients and the public to have a real say about the quality of NHS services and how they are developed. Local surveys are undertaken together with a variety of patient feedback events.

## 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.

## 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.

**Appendix 2**

| Action not started | Action underway | Action completed and full assurance received |
|---|---|---|

**CHIEF NURSE PORTFOLIO EXCEPTIONS ACTION PLAN**

| No | Issues | Actions Required | By whom | Progress to date | Agreed Completion Date | Status (RAG) |
|---|---|---|---|---|---|---|
| | | | **AHPs** | | | |
| **1.** | **Lack of opportunity and investment for career progression.** | To scope the feasibility of extended and non-traditional AHP roles e.g. Therapy Matrons, highlighting areas where this will benefit the delivery of safe, efficient and effective patient care | **AHP Lead** | Extended roles group established and meet bi-monthly. Extended roles table developed.<br>Board level discussion required to progress this. | Mar 2019 | |
| **2.** | **Recruitment and retention issues.** | To work in partnership with the Recruitment and Retention Lead to explore strategies to improve recruitment potential. | **AHP Lead** | Recruitment and Retention Lead attended AHP Leads Meeting to discuss recruitment strategies.<br><br>AHP representative to attend recruitment event in Ireland | Mar 2019 | |
| **3.** | **Concern that the banding of roles is not reflective of the knowledge required.** | To undertake AHP skill mix review. | **Chief Nurse** | Awaiting start date.<br>Longstanding request that was raised as a concern at JNC. | | |
| **4.** | **Need for senior AHP Leadership** | To undertake gap analysis | **AHP Lead** | Report in progress. | Oct 2018 | |

| | | | | | | |
|---|---|---|---|---|---|---|
| **5.** | **Promote and engage AHPs in Trust wide developments** | To ensure there is AHP representation at key meetings | **AHP Lead** | In progress | Dec 2018 | |
| | | To raise the AHP profile and market AHP services (e.g. AHP Open Days, AHP page on website, screen savers, AHP Events, AHP involvement in patient and staff stories to Trust Board, etc.) | **AHP Lead** | AHP Hub page established<br>Patient story and staff story presented at Trust Board.<br><br>AHP day/ AHP awards/AHP Strategy Launch planned for 15th October 2018 | Oct 2018 | |
| | | To develop an AHP Strategy in line with the Trust strategic objectives and the National AHP Strategy, which clearly outlines the aims and objectives of AHPs | **AHP Lead** | Complete and approved. | Nov 2018 | |
| **6.** | **Limited involvement and knowledge of Trust wide service developments** | To explore options available to ensure AHPs are considered in business cases for service improvements. | **AHP Lead** | | March 2019 | |
| **7.** | **Limited access to IT to support the development of Digital Trust** | To ensure AHPs are actively involved in the EPR process<br>To work in partnership with IT to identify equipment and resource needs | **Interim Therapy Services Manager** | EPR Lead attended AHP Leads Meeting to discuss concerns. | Dec 2018<br><br>Dec 2018 | |
| **PROFESSIONAL DEVELOPMENT** | | | | | | |
| **8.** | **The professional development team has an increasing portfolio of work and need to ensure the team structure can deliver.** | A full review of staffing across the team and the current and expected work load and program plans.<br>Increase demand in programs to up skill support staff through level 2 to 3 to 4 | **Non-Medical Education and training Lead/Deputy Chief Nurse** | Team requested to review current workloads and projected works.<br>Band 6 secondment to support TNA for six months to be interviewed for.<br>Bank hours been used to supplement teams in pre-registration and post registration. | 31st October 2018 | |
| **9.** | **Student placement numbers and support.** | Pre-registration team to review student numbers and discuss with Wolverhampton projections. To explore other universities | **Professional Development Leads –Pre Registration** | Discussion on going with Worcester.<br>Potentially 40 Students highlighted across programmes. | December 2018 | |

| | | | | | | |
|---|---|---|---|---|---|---|
| | | especially with pan document development. | | | | |
| **10.** | **Resus/Sepsis deteriorating patient team structure, availability and reporting** | High risk for training and support with vacancies in team from November.<br>Significant consideration needed into team structure and support delivery as a deteriorating team rather than separate components.<br>Clarification of reporting requirements and who and where this needs to go. | **Non-Medical Education and Training Lead**<br><br>**Deputy Chief Nurse** | Resuscitation officer band 6 post in the process of VAR.<br><br>Band 7 JD to be reviewed and VAR<br><br>Meeting requested with Dr Hobbs | 26th September 18<br><br>October 2018 | |
| **11.** | **Team accommodation and teaching environments.** | No centralised space for team, lack of office facilities and teaching environments purposed for task. | **Non-Medical Education and Training Lead** | Original review of North Wing pending | December 2018 | |
| | | | **TISSUE VIABILITY** | | | |
| **12.** | **Breaches of the 60 day root cause analysis (RCA) target of submissions to CCG** | Group closure of all outstanding avoidable grade 3 and 4 PU RCAs after submission of thematic review with overarching action plan as agreed with the CCG<br>Deep dive on 10% of the outstanding PU RCAs to ensure appropriate learning are captured in the thematic review | **Deputy Chief Nurse &CNIO**<br><br>**Tissue Viability Lead Nurse**<br><br>**Patient Safety Manager** | Thematic Review of stage 3 and 4 Pressure Ulcer Incidents submitted to the CCG on the 14th September 2018.<br><br>Comments on the report received from CCG on the 20th September and will resubmit on the 4th October 2018 | 5th October 2018 | |
| **13.** | **Recommendations from the latest NHS Improvement guidance on PU definition and measurement** | Creation of PU task and finish group to review the latest guidance and develop plan for implementation and monitoring<br>Reporting of the PU task and finish group to the Quality and Safety group | **Deputy Chief Nurse &CNIO**<br><br>**Tissue Viability Lead Nurse** | First meeting scheduled on the 27th September 2018<br>Group TOR drafted and for approval by the Quality and Safety Group | 27th September 2018 | |

| | | | | | | |
|---|---|---|---|---|---|---|
| **14.** | **Failure of wards and departments to make necessary improvements following reviews and nursing audit outcomes** | Deliver basic introduction to QI methodology training session to lead nurses | **Quality Review and Improvement Lead** | Sessions booked for 5th October and 24th November – rooms booked.<br>Email invite to lead nurses and matrons – bookings received | 24/11/2018 | |
| | | Complete Specialist Practice Coach training for Dudley Improvement Methodology (LEAN) | **Quality Review and Improvement Lead** | Attended module 1 training session 25/09/2018 with B.G (NHSi) | 31/03/2019 | |
| | | Set up Quality Academy to provide supportive mechanism for improvement projects and deliver Trust Wide improvements in structured and systematic way. | **Quality Review and Improvement Lead** | First meeting scheduled for; 05/11 to set TOR | 05/11/2018 | |
| **15.** | **Lack of capacity of the Quality Review and Improvement Lead to support QI projects throughout nursing following end of current seconded post** | To explore funding options to make seconded post substantive. If no funding can be identified within current budget; business case to go to directors for approval of additional post. | **Quality Review and Improvement Lead** | Identified current funding for seconded post only available for 6 months (commencing July 2018)<br>Business case completed January 2018, to revise prior to presenting at directors. | 31/10/2018 | |

The Dudley Group NHS Foundation Trust

**Paper for submission to Board of Directors 4 October 2018**

| **TITLE:** | **Nursing and Midwifery Workforce Update** | | |
|---|---|---|---|
| **AUTHOR:** | Jo Wakeman, Deputy Chief Nurse | **PRESENTER:** | Carol Love-Mecrow, 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. The plan is that the combined paper (day and night staffing) will be presented to the Directors meeting and then to the MCP transition Board for consideration.
- EAU and ED reviews although initially completed are being further considered based on planned and actual developments within the two areas. A business case has been drawn up for changes to the staffing on ward A2 due to changes in functionality of the ward.
- 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**

- RN agency usage has seen an increase in August 2018 with a decrease in bank usage. This month has seen a significant increase in bank usage of CSWs. The high usage of CSWs appears to be the main driver for the overspend which equates to £1,056,891 at mth 5. Further analysis is required to understand the increasing demand for bank CSWs across the wards. 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**

- August 2018 reports a total of 314 nurse vacancies across the trust
- Monthly recruitment events continue however work is underway to strengthen recruitment activity.
- 45 graduate nurses commenced on the 17th September 2018. These will show on the nursing predictor in October following their supernumerary period.
- Predictor tools are within the paper as requested.
- There are currently 32.36 FTE Band 5 adverts live on NHS Jobs with a further 46.91 FTE pending and will go live once approved.

**IMPLICATIONS OF PAPER:**

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

| REQUIREMENTS | | | |
|---|---|---|---|
| **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 two separate reviews of community nursing (initially a report on the day situation then a second report on evenings/nights) have been seen by Executive Directors. These have now been combined into one report with the plan that it will be considered by the Transition Board of the Multispecialty Community Provider (MCP). A draft paper on AMU/FAU was 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. A review on ED was initially completed but with further developments in the department this is being reviewed. With the change in functionality of Ward A2, a business case has been drawn up for changes to the staffing template.

**Table 1**

| Area | Position |
|---|---|
| General Medical/Surgical Wards | Complete. Due to change in functionality, a business case on changes to A2 staffing has been drawn up. |
| Critical Care | Complete |
| Neonatal Unit | Complete. |
| Paediatrics (C2) | Executive Directors requested further amendments. |
| Emergency Department | Initially completed. Further discussions occurring prior to finalisation. |
| 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 August 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 third month that 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 77% (Days) and 84% (Nights) (Table 2), which sees a small decrease in days from the previous two months and 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 August 2018

equates to 28.33 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 previous reports. 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% |
| **Aug 2018** | 77% | 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 August 2018 that related to staffing. In total there were 55 incidents compared to 43 staffing incidents for July 2018. The Maternity service (Obstetrics) and Emergency Department generated more incidents than any other area. This is followed by CCU and B3 with areas that have higher vacancies.

Out of 55 incidents reported in August 2018, 54 (98%) were of no harm or near miss. One incident was reported as low harm. This pertains to CCU where staffing was reported inadequate in relation to the patients acuity and workload. Clinical Nurse Specialist was asked to support the unit.

**Table 3**

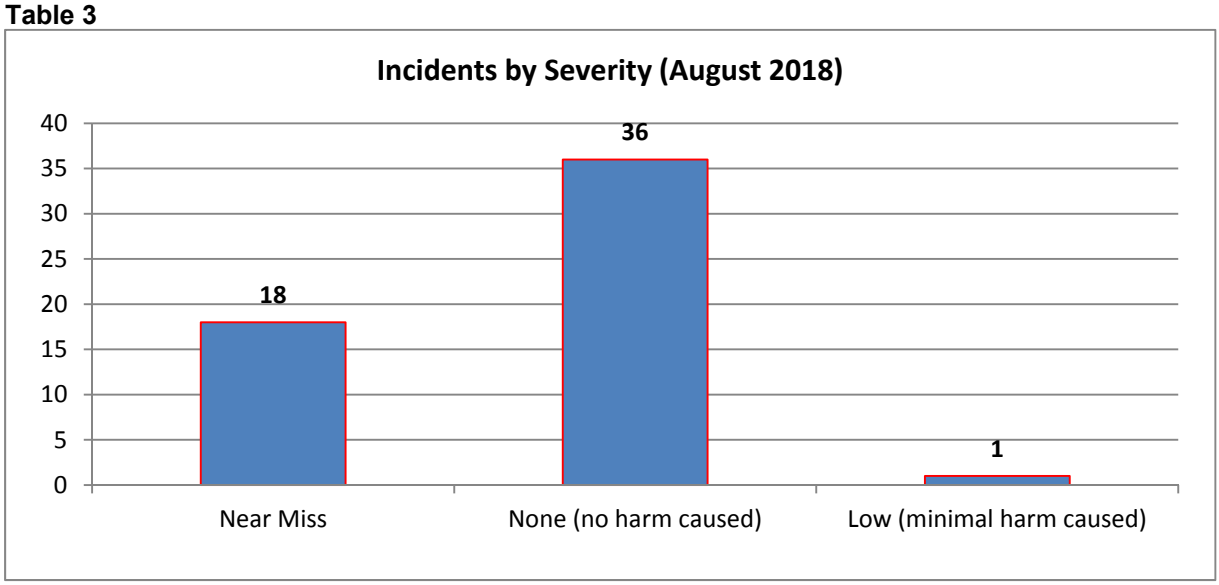
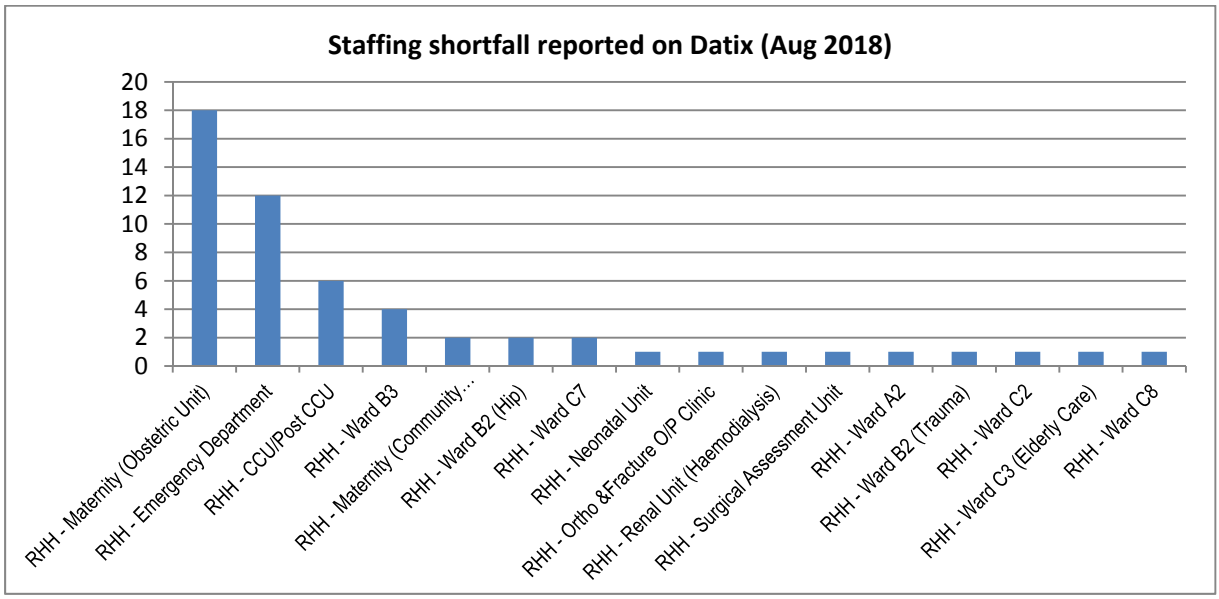



**Table 4**



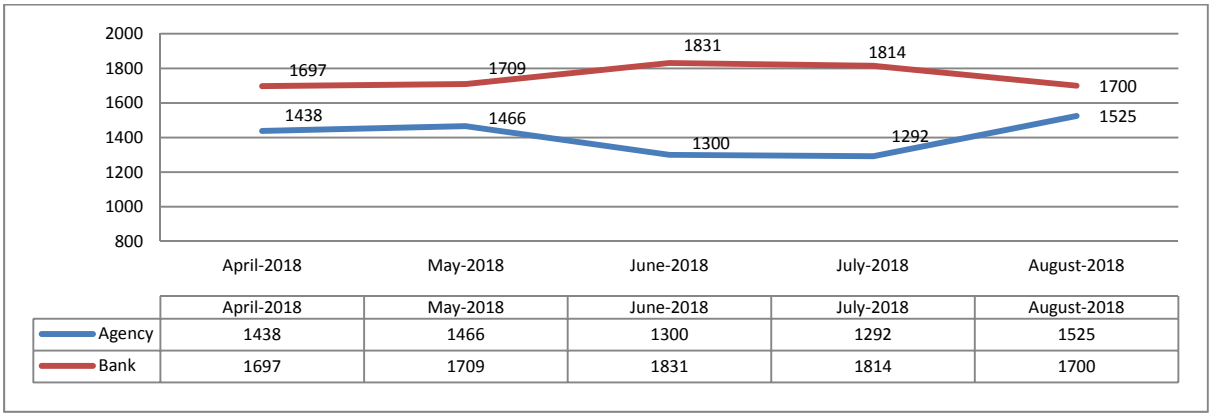

## Agency Controls

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

Table 5 shows the comparison usage of bank and agency, this month has seen a significant increase in agency usage with a reduction in bank for RNs. The month of August 2018 has seen a considerable increase in CSW bank usage. The overall budget position (app 4 &5) for the wards shows £1,762,608 underspend against RNs and a £1,056,891 deficit against bank usage for CSWs. These figures may suggest that CSWs are requested when RN shifts are not filled or there is a high number of patients requiring 1-1 supervision. Further work is required to understand the high number of CSW bank shifts required and agreed plans put in place to reduce the overall expenditure. Vacancies against RNs have reduced slightly from 323 last month to 314.11. 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 | August-2018 |
|---|---|---|---|---|---|
| Agency | 1438 | 1466 | 1300 | 1292 | 1525 |
| Bank | 1697 | 1709 | 1831 | 1814 | 1700 |

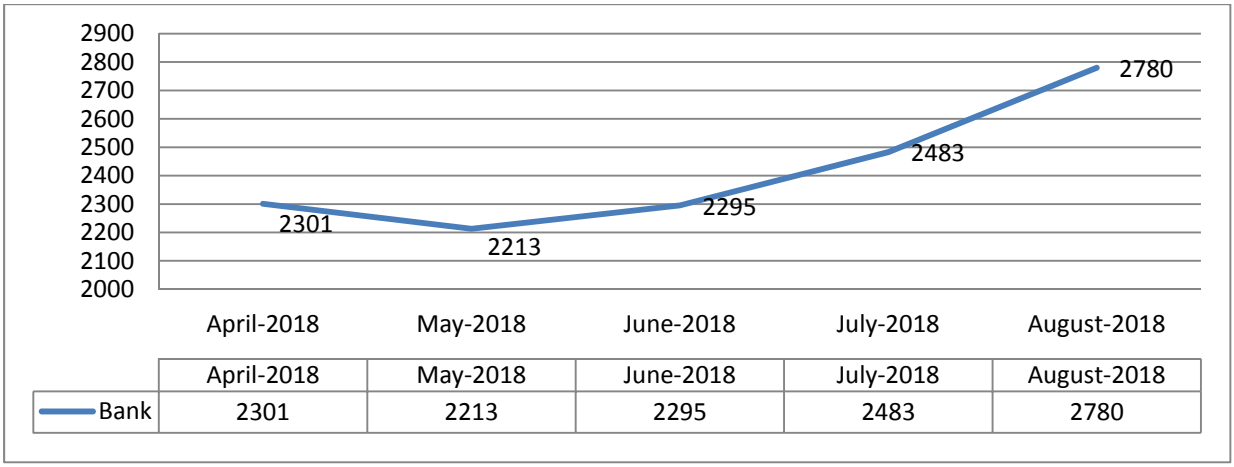
**Top 5 areas for the last two months**

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

| Ward | August-2018 |
|---|---|
| Emergency Dept Nursing Dept | 241 |
| B3 Emergency Surgery | 150 |
| A2 | 125 |
| C8 Stroke Rehab Dept | 105 |
| AMU Dept | 100 |

**CSW monthly bank usage**

**Table 6**




| | April-2018 | May-2018 | June-2018 | July-2018 | August-2018 |
|---|---|---|---|---|---|
| Bank | 2301 | 2213 | 2295 | 2483 | 2780 |

**Recruitment Update**

Monthly corporate and area specific recruitment events continue. The next corporate event is the 19th September 2018. Theatre held an open morning on the 6th September 2018 with six experienced nurses offered positions.
The following areas have local events booked:

- ED – 8th October 2018
- C5/CCU – 10th October 2018
- C7 7th November 2018
- Theatres – November 2018 date TBC
- B3 and C8 in process of organising

At the time of the report, a total of seven experienced nurses are currently going through recruitment clearances of which six are Band 5 (5.24 FTE) and one is Band 6 (0.96 FTE)
45 graduate nurses commenced on the 17th September 2018. These will show on the nursing predictor in October following their supernumerary period. The numbers have reduced from the predicted numbers due to five graduates withdrawing for personal reasons and taking a post in their training Trust and 16 having deferred to a start date of the 12th November 2018 due to failing academic work.

| Graduate Nurse Intake Sep 2018. Commenced 17/9/18 | | |
|---|---|---|
| Ward / Area | Headcount | FTE |
| A2 | 3 | 3 |
| AMU | 4 | 3.24 |
| B1 | 1 | 0.64 |
| B2 Hip | 1 | 1 |
| B2 T&O | 1 | 1 |
| B4 (A) | 1 | 0.64 |
| B4 (B) | 1 | 1 |
| B5 | 2 | 2 |
| C3 | 2 | 2 |
| C4 | 1 | 1 |
| C5 (B) | 1 | 0.64 |
| C6 | 1 | 1 |
| CCU | 6 | 5.64 |
| Community Nurses | 5 | 4.4 |
| Critical Care | 4 | 4 |
| Dermatology Out Patients | 1 | 1 |
| DSU (Ward) | 1 | 1 |
| ED | 4 | 3.64 |
| GI Unit | 2 | 1.8 |
| MHDU | 2 | 2 |
| NNU (Neonatal) | 1 | 0.96 |
| ***Total*** | ***45*** | ***41.6*** |

**Experienced Nurses completing recruitment clearances.**

| Head Count | Band | Area | Hours | Potential Start Date |
|---|---|---|---|---|
| 1 | 5 | CCU | 1 | October 2018 |

| Head Count | Band | Area | Hours | Potential Start Date |
|---|---|---|---|---|
| 2 | 5 | Critical Care | 0.64 | November 2018 |
| 1 | 5 | ED | 1 | November 2018 |

| Head Count | Band | Area | Hours | Potential Start Date |
|---|---|---|---|---|
| 1 | 6 | ED | 0.96 | December 2018 |
| 1 | 5 | NNU | 0.96 | December 2018 |
| 1 | 5 | Theatres | 1 | December 2018 |

There are currently 32.36 FTE Band 5 adverts live on NHS Jobs with a further 46.91 FTE pending and will go live once approved. The rolling advert process is being implemented and a meeting with the Matron Secretaries has been booked to ensure this process is correct and effective.

**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 | Aug | | | 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 | 277 | 210 | 253 | 211 | 191 | 177 | 227 | 207 | 76% | 83% | 93% | 91% | 1,155 | 4.02 | 4.34 | 8.37 |
| A3 | | | | | | | | | | | | | | | | |
| A4 | | | | | | | | | | | | | | | | |
| B1 | 129 | 105 | 64 | 61 | 93 | 71 | 64 | 60 | 82% | 95% | 76% | 94% | 502 | 4.10 | 2.88 | 6.99 |
| B2(H) | 158 | 117 | 221 | 173 | 126 | 93 | 206 | 195 | 74% | 78% | 74% | 94% | 880 | 2.79 | 5.01 | 7.80 |
| B2(T) | 120 | 95 | 150 | 128 | 93 | 64 | 112 | 102 | 79% | 85% | 69% | 91% | 705 | 2.71 | 3.92 | 6.63 |
| B3 | 257 | 171 | 195 | 173 | 217 | 181 | 157 | 147 | 67% | 88% | 83% | 94% | 1,005 | 4.20 | 3.81 | 8.01 |
| B4 | 250 | 186 | 250 | 235 | 186 | 144 | 188 | 182 | 74% | 94% | 77% | 97% | 1,410 | 2.74 | 3.54 | 6.29 |
| B5 | 238 | 192 | 155 | 149 | 188 | 183 | 98 | 92 | 81% | 96% | 97% | 94% | 663 | 6.64 | 4.36 | 10.99 |
| B6 | | | | | | | | | | | | | | | | |
| C1 | 243 | 160 | 296 | 273 | 186 | 156 | 239 | 226 | 66% | 92% | 84% | 95% | 1,468 | 2.59 | 4.07 | 6.66 |
| C2 | 267 | 236 | 81 | 75 | 186 | 177 | 33 | 30 | 88% | 93% | 95% | 92% | 459 | 10.53 | 2.35 | 12.88 |
| C3 | 278 | 207 | 376 | 338 | 186 | 154 | 378 | 364 | 74% | 90% | 83% | 96% | 1,559 | 2.77 | 5.40 | 8.18 |
| C4 | 157 | 144 | 62 | 63 | 123 | 105 | 66 | 78 | 92% | 101% | 85% | 118% | 656 | 4.55 | 2.57 | 7.12 |
| C5 | 240 | 154 | 260 | 283 | 186 | 155 | 190 | 194 | 64% | 109% | 83% | 102% | 1,416 | 2.62 | 4.04 | 6.66 |
| C6 | 117 | 98 | 71 | 59 | 63 | 62 | 77 | 66 | 84% | 83% | 98% | 85% | 557 | 3.45 | 2.68 | 6.13 |
| C7 | 232 | 161 | 208 | 179 | 149 | 116 | 148 | 136 | 69% | 86% | 78% | 92% | 1,088 | 2.99 | 3.48 | 6.47 |
| C8 | 338 | 203 | 270 | 217 | 279 | 180 | 260 | 249 | 60% | 80% | 65% | 96% | 1,271 | 3.61 | 4.40 | 8.02 |
| CCU_PCCU | 248 | 149 | 62 | 56 | 217 | 159 | 31 | 30 | 60% | 90% | 73% | 97% | 639 | 5.78 | 1.61 | 7.39 |
| Critical Care | 458 | 370 | 75 | 60 | 446 | 340 | | | 81% | 81% | 76% | | 320 | 26.06 | 2.27 | 28.33 |
| EAU | 271 | 190 | 315 | 285 | 247 | 227 | 309 | 272 | 70% | 90% | 92% | 88% | 1,095 | 4.57 | 6.10 | 10.67 |
| Maternity | 935 | 863 | 237 | 203 | 527 | 476 | 155 | 142 | 92% | 86% | 90% | 91% | 498 | 24.47 | 7.89 | 32.36 |
| MHDU | 155 | 120 | 35 | 31 | 155 | 119 | | | 78% | 89% | 77% | | 214 | 13.41 | 1.65 | 15.07 |
| NNU | 202 | 140 | | | 188 | 162 | | | 69% | | 86% | | 367 | 9.47 | 0.00 | 9.47 |
| **TOTAL** | **5,567** | **4,271** | **3,634** | **3,250** | **4,232** | **3,500** | **2,937** | **2,771** | **77%** | **89%** | **83%** | **94%** | **17,927** | **4.94** | **4.01** | **8.95** |

## Appendix 2 - Registered Nurse Predictor Tool- Detail New Establishments

| Med & Surg Divisions Qualified Nursing WTE | | New Establishment | | | For Info : Pressures / Temporary Staffing | | | | Targeted Recrutitment + General Recruitment 4.3% - Leavers (8%) | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Div | Team | Budget (Qual Nurses) | Contracted Staff in Post (Incl New Supernumerary) | August 18 Vacancy | Sickness | Maternity | Bank | Agency | S | O | N | D | J | F | M | A | M | J | J | A |
| Med/Int Care | Wards - Medicine | 373.92 | 242.35 | 131.57 | 15.17 | 4.67 | 28.04 | 36.33 | 1 | 13 | 0 | 5 | (1) | (1) | 1 | (1) | (1) | (1) | (1) | (1) |
| Surgery | Wards - Surgery | 242.59 | 176.76 | 65.83 | 8.73 | 7.28 | 21.55 | 25.14 | (1) | 6 | (1) | 3 | (1) | (1) | 1 | (1) | (1) | 0 | (1) | (1) |
| Med/Int Care | Specialist Areas Medicine | 40.94 | 37.52 | 3.42 | 1.76 | 1.78 | 1.74 | 0.15 | 1 | 2 | (0) | (0) | (0) | (0) | (0) | (0) | (0) | (0) | (0) | (0) |
| Surgery | Specialist Areas Surgery | 39.82 | 35.94 | 3.88 | 2.15 | 2.25 | 1.26 | 0.92 | 1 | 1 | (0) | (0) | (0) | (0) | (0) | (0) | (0) | (0) | (0) | (0) |
| Med/Int Care | ED | 85.02 | 65.20 | 19.82 | 4.04 | 3.92 | 5.89 | 19.35 | 1 | 6 | (0) | 4 | (0) | (0) | 3 | (0) | (0) | (0) | (0) | (0) |
| Surgery | Theatres | 118.78 | 86.70 | 32.08 | 1.77 | 3.19 | 12.61 | 1.92 | 0 | (1) | (1) | 1 | 1 | (0) | (0) | (0) | (0) | (0) | (0) | (0) |
| Surgery | Critical Care | 74.56 | 55.74 | 18.82 | 2.15 | 4.89 | 5.56 | 8.22 | (0) | 4 | (0) | 2 | (0) | (0) | 1 | (0) | (0) | (0) | (0) | (0) |
| Surgery | Maternity Unit | 105.12 | 101.22 | 3.90 | 4.69 | 5.00 | 5.70 | 0.00 | (1) | (1) | (1) | (1) | (0) | (0) | (0) | (0) | (0) | (0) | (0) | (0) |
| Med/Int Care | Community Nursing | 152.34 | 147.03 | 5.31 | 0.00 | 0.00 | 4.91 | 0.00 | (1) | 3 | (1) | (1) | (0) | (0) | 0 | (0) | (0) | (0) | (0) | (0) |
| Med/Int Care | All Other Med / Int Care Teams | 265.64 | 241.32 | 24.32 | 0.00 | 0.00 | 8.91 | 5.71 | (1) | 1 | (2) | (1) | (1) | (1) | 3 | (1) | (1) | (1) | (1) | (1) |
| Surgery | All Other Surgery Teams | 149.82 | 151.39 | (1.57) | 0.00 | 0.00 | 3.76 | 1.19 | (0) | 2 | (1) | (1) | (0) | (0) | 3 | (0) | (0) | (0) | (0) | (0) |
| Corp | All Corp Teams | 88.38 | 81.65 | 6.73 | 0.00 | 0.00 | 0.66 | 0.00 | (0) | (0) | (0) | (0) | (0) | (0) | (0) | (0) | (0) | (0) | (0) | (0) |
| **Total** | | **1,736.93** | **1,422.82** | **314.11** | **40.46** | **32.98** | **100.59** | **98.93** | **0** | **36** | **(7)** | **11** | **(4)** | **(4)** | **12** | **(5)** | **(4)** | **(4)** | **(4)** | **(4)** |

**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% |

**Appendix 4 -RN bank and agency usage 2018**

| CC1 Description | Cost Centre Description2 | YTD £ Budget Month 05 | YTD Variance Month 05 | Current Month Vacancy | Current Month Bank WTE | Current Month Agency Worked |
|---|---|---|---|---|---|---|
| **Medicine & Integrated Care** | Acute Med Unit (EAU) | £852,565 | (£5,434) | 2.72 | 5.42 | 5.05 |
| **Medicine & Integrated Care** | Emergency Department Nursing | £1,863,762 | £151,965 | 19.82 | 5.89 | 19.35 |
| **Medicine & Integrated Care** | Ward A2 | £765,510 | £77,567 | 17.14 | 4.07 | 1.10 |
| **Medicine & Integrated Care** | Ward AEC Flex Beds | £0 | (£15,726) | 0.00 | 0.46 | 0.00 |
| **Medicine & Integrated Care** | Ward Ambulatory Emergency Care | £234,063 | £2,024 | (0.22) | 0.99 | 0.00 |
| **Medicine & Integrated Care** | Ward B6 Med Flexi | £192,086 | £155 | 6.10 | 3.04 | 2.73 |
| **Medicine & Integrated Care** | Ward C1 | £716,458 | £142,460 | 14.75 | 2.62 | 3.92 |
| **Medicine & Integrated Care** | Ward C3 | £724,384 | £75,287 | 13.48 | 3.94 | 2.74 |
| **Medicine & Integrated Care** | Ward C4 | £501,521 | £42,045 | 3.63 | 2.08 | 0.08 |
| **Medicine & Integrated Care** | Ward C4 Onc Day OP | £259,067 | £28,632 | 3.47 | 0.07 | 1.29 |
| **Medicine & Integrated Care** | Ward C5 Area A | £343,734 | £64,689 | 9.45 | 1.22 | 3.80 |
| **Medicine & Integrated Care** | Ward C5 Area B | £344,064 | £67,015 | 8.25 | 1.67 | 1.84 |
| **Medicine & Integrated Care** | Ward C7 | £574,672 | £65,150 | 12.79 | 1.78 | 5.00 |
| **Medicine & Integrated Care** | Ward C8 | £965,750 | £247,323 | 27.19 | 3.01 | 7.12 |
| **Medicine & Integrated Care** | Ward CCU | £785,565 | £178,232 | 18.70 | 2.16 | 4.39 |
| **Medicine & Integrated Care** | Ward MHDU | £533,494 | £85,407 | 3.64 | 0.75 | 0.15 |
| **Surgery** | Ward B1 | £321,056 | £18,699 | 6.29 | 1.63 | 1.70 |
| **Surgery** | Ward B2 (H) | £458,850 | £91,158 | 10.71 | 2.43 | 1.38 |
| **Surgery** | Ward B2 (T) | £339,835 | £32,976 | 7.62 | 1.15 | 4.06 |
| **Surgery** | Ward B3 | £756,151 | £88,635 | 27.60 | 5.24 | 8.00 |
| **Surgery** | Ward B4 | £351,230 | £22,195 | 4.21 | 1.98 | 3.22 |
| **Surgery** | Ward B4b | £322,919 | £50,738 | 8.38 | 1.35 | 0.83 |
| **Surgery** | Ward B5 | £713,581 | £21,875 | 0.91 | 4.14 | 1.58 |
| **Surgery** | Ward C2 | £707,785 | (£52,148) | (2.28) | 2.00 | 2.45 |
| **Surgery** | Ward C6 | £295,215 | £8,274 | 2.39 | 1.63 | 1.92 |
| **Surgery** | I.T.U. | £1,444,526 | £13,978 | 18.82 | 5.56 | 8.22 |
| **Surgery** | Theatres | £2,137,384 | £200,018 | 32.08 | 12.61 | 1.92 |
| **Surgery** | Maternity Unit | £2,084,187 | £59,419 | 3.77 | 5.70 | 0.00 |
| **Grand Total** | | **£19,589,414** | **£1,762,608** | **281.41** | **84.59** | **93.84** |

## Appendix 5 – CSW bank usage August 2018

| CC1 Description | Cost Centre Desc | YTD £ Budget Month 05 | YTD Variance Month 05 | Current Month Vacancy | Current Month Bank WTE | Current Month Agency Worked |
|---|---|---|---|---|---|---|
| **Medicine & Integrated Care** | Acute Med Unit (EAU) | £390,446 | (£243,597) | (0.92) | 12.93 | 0.00 |
| **Medicine & Integrated Care** | Emergency Department Nursing | £349,378 | (£144,599) | (3.28) | 9.69 | 0.00 |
| **Medicine & Integrated Care** | Ward A2 | £454,002 | (£40,145) | 1.99 | 9.37 | 0.00 |
| **Medicine & Integrated Care** | Ward AEC Flex Beds | £0 | (£1,806) | 0.00 | 0.00 | 0.00 |
| **Medicine & Integrated Care** | Ward Ambulatory Emergency Care | £126,880 | (£4,591) | 1.00 | 1.01 | 0.00 |
| **Medicine & Integrated Care** | Ward B6 Med Flexi | £130,003 | (£142) | 7.33 | 7.33 | 0.20 |
| **Medicine & Integrated Care** | Ward C1 | £485,278 | (£58,799) | 4.15 | 13.62 | 0.00 |
| **Medicine & Integrated Care** | Ward C3 | £612,854 | (£202,944) | 4.76 | 22.70 | 0.00 |
| **Medicine & Integrated Care** | Ward C4 | £131,812 | (£20,755) | 0.34 | 2.74 | 0.00 |
| **Medicine & Integrated Care** | Ward C4 Onc Day OP | £71,237 | (£5,120) | 0.96 | 1.32 | 0.00 |
| **Medicine & Integrated Care** | Ward C5 Area A | £244,814 | (£25,067) | 1.30 | 3.49 | 0.00 |
| **Medicine & Integrated Care** | Ward C5 Area B | £233,628 | (£25,162) | 3.21 | 5.49 | 0.00 |
| **Medicine & Integrated Care** | Ward C7 | £311,962 | (£22,103) | 3.99 | 8.76 | 0.00 |
| **Medicine & Integrated Care** | Ward C8 | £399,984 | (£141,015) | (2.59) | 10.86 | 0.00 |
| **Medicine & Integrated Care** | Ward CCU | £106,197 | £15,639 | 1.46 | 1.27 | 0.00 |
| **Medicine & Integrated Care** | Ward MHDU | £26,887 | (£4,935) | (0.19) | 0.04 | 0.00 |
| **Surgery** | Ward B1 | £129,028 | £1,232 | 1.47 | 1.71 | 0.00 |
| **Surgery** | Ward B2 (H) | £356,188 | (£41,067) | 0.97 | 6.82 | 0.00 |
| **Surgery** | Ward B2 (T) | £231,827 | (£49,527) | (3.21) | 3.87 | 0.00 |
| **Surgery** | Ward B3 | £364,748 | £7,706 | 5.13 | 5.36 | 0.00 |
| **Surgery** | Ward B4 | £245,875 | (£14,931) | 1.74 | 3.93 | 0.00 |
| **Surgery** | Ward B4b | £223,565 | (£9,288) | 2.94 | 3.89 | 0.00 |
| **Surgery** | Ward B5 | £267,617 | (£13,934) | 2.05 | 3.99 | 0.00 |
| **Surgery** | Ward C2 | £125,472 | (£554) | 1.75 | 2.43 | 0.00 |
| **Surgery** | Ward C6 | £156,670 | (£20,984) | (0.45) | 3.50 | 0.00 |
| **Surgery** | Theatres | £590,186 | £29,296 | 5.75 | 5.19 | 0.00 |
| **Surgery** | I.T.U. | £56,963 | (£6,989) | 0.19 | 0.49 | 0.00 |
| **Surgery** | Maternity Unit | £398,236 | (£12,712) | 2.32 | 3.95 | 0.00 |
| **Grand Total** | | **£7,221,737** | **(£1,056,891)** | **44.16** | **155.75** | **0.20** |

Enclosure 8

The Dudley Group NHS Foundation Trust

**Paper for submission to the Public Board on 4th October 2018**

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

**CORPORATE OBJECTIVE:**

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

**SUMMARY OF KEY ISSUES:**

- Update of statement against the Hygiene Code for 2018/19.
- Mandatory Infection Control training – A summary of the position in relation to mandatory training is included in the report including the latest update to provide assurance for delivering compliance with the annual programme.
- Updated Trust IPC action plan.
- For 2018/19 – the C. difficile trajectory is 28 cases associated with a lapse in care. There have been 9 post 48 hr cases from 1st April to 31st August 2018.
- No post 48 hr MRSA bacteraemia cases since September 2015
- Update on progress with the work towards a reduction in E.coli bacteraemias

**IMPLICATIONS OF PAPER:**

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

**ACTION REQUIRED OF BOARD:**

| Decision | Approval | Discussion | Other |
|---|---|---|---|
| | | √ | |

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

## Introduction:

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

| Compliance Criterion | What the registered provider will need to demonstrate | RAG rating |
|---|---|---|
| 1 | Systems to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of service users and any risks that their environment and other users may post to them. | |
| **Assurance:** A risk log of all infection prevention risks identified across the Trust is maintained and updated regularly. | | |
| 2 | Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections. | As of 11th August there are 2 WTE and 1 part time HPV fogging technicians in post. Service available 6 am to 7 pm daily. |
| **Assurance:** A Cleaning Policy and associated environmental audits provide assurance that a clean and appropriate environment is maintained. The HPV business case is being implemented having recruited to the vacant posts. However a slight delay has been caused by one of the recruits withdrawing late in the process. | | |
| 3 | Ensure appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse event and antimicrobial resistance. | Antimicrobial CQUIN – the elements regarding reduction high risk antimicrobial usage has been met. |
| **Assurance:** There is an Antimicrobial Policy in place with appropriate stewardship recommendations. Audits demonstrate compliance with policy. Work towards achieving the AWARE list compliance is ongoing. | | |
| 4 | Provide suitable accurate information on infections to service users, their visitors and any person concerned with providing further support or nursing / medical care in a timely fashion. | |
| **Assurance:** Patient and visitor information is available for a variety of healthcare associated infection issues on the website. Patients identified with infections in hospital are visited and provided with information leaflets including contact information for further support. | | |
| 5 | Ensure prompt identification of people who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to other people. | MRSA elective screening 99% compliance and emergency screening 94% compliance for August. |
| **Assurance**: Patient records are flagged with information about previous healthcare associated infections. Patient admission documentation includes screening questions to identify patients at risk. | | |
| 6 | Systems to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection. | Based on an annual assessment of the position the Trust average is 79.7% for August 2018 |
| **Assurance:** Staff are provided with mandatory infection control training to ensure they are aware of their responsibilities for the prevention and control of infection. | | |
| 7 | Provide or secure adequate isolation facilities. | |
| **Assurance:** There is a policy in place to ensure that patients are isolated appropriately. 25% of the inpatient beds take the form of single ensuite rooms. | | |
| 8 | Secure adequate access to laboratory | |

| | | |
|---|---|---|
| | support as appropriate. | |
| **Assurance:** The Trust has access to a CPA/UKAS accredited Microbiology and Virology laboratory. | | |
| 9 | Have adherence to policies, designed for the individuals' care and provider organisations that will help to prevent and control infections. | Trustwide scores all green in August 2018. |
| **Assurance:** All policies, as recommended in the Hygiene Code, are in place. Audit data confirms compliance with policies and identifies areas for improvement. | | |
| 10 | Providers have a system in place to manage the occupational health needs and obligations of staff in relation to infection. | |
| **Assurance:** There is in house provision of Staff Health and Wellbeing. There are regular reports to the Infection Prevention and Control Forum detailing any issues raised within this system. | | |

**Summary of alert organism surveillance:**

**Clostridium Difficile** – The target for 2018/19 is 28 cases. The cases that count within this dataset are patients identified after 48 hrs admission with C. difficile in whom a lapse in care has been recognised using the national apportionment tool [1]. For 2018/19 there have been 9 post 48 hr cases from 1st April 2018 up to 31st August 2018.

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

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

**MSSA bacteraemia (Post 48 hrs)** – From 1st April to 31st August 2018 there have been 6 cases of post 48 hr MSSA bacteraemia reported.

**MRSA screening** – There is no external compliance target for MRSA screening. The internal target is to achieve 95% compliance with the policy. The percentage of emergency admissions screened for August 2018 is 94%. Data is available locally to the units to enable them to identify patients missing from the dataset.

The percentage of elective admissions screened for August 2018 is 99%. As above data is available locally to all units to enable them to identify patients missing from the dataset.

**E. coli bacteraemia** – For the post 48 hr cases an enhanced surveillance module, developed as part of PHE's surveillance programme, commenced in April 2017 in order to ascertain themes and trends associated with E. coli bacteraemia within the acute Trust to see where lessons may be learnt. From 1st April to 31st August 2018 there have been 5 cases of post 48 hr E. coli bacteraemia reported. There is work ongoing that is part of the national agenda for health and social care economies to reduce the number of Gram-negative bloodstream infections (BSIs) with an initial focus on Escherichia coli (E.coli). To date this has focused on the management of patients with long term urinary catheters, a group of patients who are over represented in the above dataset. Across the health economy a catheter 'passport'

has been agreed, approved at the Area Clinical Effectiveness sub committee last week and it is with the printers pending roll out.

**Klebsiella* and Pseudomonas* bacteraemias** – From 1st April to 31st August 2018 there have been 0 post 48 hr Trust identified Klebsiella bacteraemia cases and 2 post 48 hr Pseudomonas bacteraemia cases.

**Infection Control Mandatory Training** – The revised mandatory requirement is to update Infection Control training annually for clinical staff. This data is now presented from the annual programme for clinical staff. The percentage compliance as at 31.8.18 (target 90%):

| Area | Total |
|---|---|
| Corporate/Management | 82% |
| Medicine and Integrated Care | 79% |
| Surgery | 81% |
| Clinical Support | 73% |

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

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

Following these measures 79.7% of clinical staff are now trained. This is consistent with achieving the annual compliance target by year end. Next report will demonstrate training compliance against the annual programme.

**Infection Prevention and Control Group** –

From the Infection Prevention and Control Group meeting held on Thursday 27th July 2018.

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

MRSA screening continues to improve.

The cleaning scores at RHH have improved to just below 95% with further assurance that issues highlighted are resolved within 1 hour (with the exception of hard floors when they require scrubbing).

The Antimicrobial CQUIN targets in relation to high risk antibiotics are being achieved but there will be a challenge to achieving the total reduction.

**NHSi visit – 18th July 2018**

Dr D Adams, IC Lead for NHSi revisited the Trust on 18th July 2018. Dr Adams was presented with the action plan and was happy that the Trust was going in the right direction, including moving the IC mandatory training from 3 yearly to annual to

ensure staff understood IC principles and practical application of infection control. At this visit Dr Adams moved the Trust from red RAG rating to green.

**GLOSSARY OF TERMS**

**MSSA**

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

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

**MRSA**

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

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

**E Coli**

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

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

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

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

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

**Klebsiella species**

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

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

## Pseudomonas aeruginosa

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

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

## C difficile

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

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

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

## CPA/UKAS

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

## RCA

**What is RCA?**

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

## PFI

### What is PFI?

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

## CCG

### What is CCG?

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

## RAG

### What is RAG?

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

**Reference**

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

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

# ACTION PLAN FOLLOWING NHSi VISIT – 8TH NOVEMBER 2017

The Dudley Group NHS Foundation Trust

| | | | |
|---|---|---|---|
| **Manager/Lead** | Dr Elizabeth Rees, Director of Infection Prevention and Control | **Executive Lead** | Ms Siobhan Jordan, Chief Nurse |
| **Associated Staff** | Miss A Murray, Matron, Infection Prevention and Control | **Action Plan updated on** | 1st August 2018 |

| RAG status | Not started | Underway | Complete |
|---|---|---|---|

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

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

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

| Action No. | Code of Practice compliance criterions* | Recommendations | Actions Required | By Whom | Progress to date | Agreed completion date | Status (RAG) |
|---|---|---|---|---|---|---|---|
| 12 | Criterion 1, 5 and 6 | Annual Infection Prevention Training to ensure knowledge is embedded into action. | Currently on a 3 yearly cycle. Move to yearly updates with full year effect 2018/19. | Dr E Rees and Miss A Murray | Completed on 18th January for Matrons. | January 2018 | |
| | | | | | 1700 clinical staff to train; individual emails sent to request completion asap. 73.5% staff trained as of July 2018. On trajectory to achieve compliance by March 2019. | March 2019 | |
| 13 | Criterion 1 | Analytical support to be considered to provide expertise to existing IPC team. | To develop and JD, advert and PS in order to advertise this post. | Miss A Murray | JD and PS developed – awaiting banding. Complete. | January 2018 | |
| 14 | Criterion 1 | To advertise for a substantive Consultant Microbiologist | To advertise post using existing College approved JD and PS. | Dr E Rees | Currently being advertised on NHS Jobs. Advert closed. | December 2017 | |
| 15 | Criterion 1 and 5 | Catheter Care Bundles reflect national guidance but senior nursing staff seemed unaware of all available tools. | As part of the current health economy work around urinary tract infection, protocols around the management of catheters will be reviewed for each participating organisation; DGFT will review its own. | Miss A Murray and Mr B Jones | Working across healthcare economy catheter passport has been created; it will go to ACE panel for approval in March. Report back to IPCF at April meeting. Mr Jones suggested that after approval by ACE this item is included in the HCAI agenda. | April 2018 Assurance provided at April IPCG. Item closed and referred to HCAI agenda. | |

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

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

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

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

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

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

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

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

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

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

Enclosure 9

The Dudley Group
NHS Foundation Trust

**Paper for submission to the Board of Directors on 4th October 2018**

| | | | |
|---|---|---|---|
| **TITLE:** | Integrated Performance Report for Month 4 (August) 2018 | | |
| **AUTHOR:** | Andy Troth<br>Head of Informatics | **PRESENTER:** | Karen Kelly<br>Chief Operating Officer |

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

**CORPORATE OBJECTIVE:**

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

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

**ACTION REQUIRED OF BOARD:**

| **Decision** | **Approval** | **Discussion** | **Other** |
|---|---|---|---|
| | | X | |

**RECOMMENDATIONS FOR THE BOARD:**

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

# Integrated Performance Report - Board




August 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 | 2,394 | 220 | 156 | 108 | 120 | 44 | - | - | - | - | - | - | - | 648 | |
| Compliments | 6,370 | 14.50% | 21.30% | 385 | 566 | 869 | - | - | - | - | - | - | - | 2,137 | |
| Friends & Family – Community – Footfall | 3.1% | 26.0% | 35% | 4.2% | 4.1% | 3.2% | - | - | - | - | - | - | - | 3.6% | 9% |
| Friends & Family – Community – Recommended % | 96.6% | 21.7% | 34.4% | 96.6% | 95.5% | 96.2% | - | - | - | - | - | - | - | 96% | 97.7% |
| Friends & Family – ED – Footfall | 19.1% | 4.7% | 15% | 19.1% | 18.6% | 16.6% | - | - | - | - | - | - | - | 18.4% | 21.3% |
| Friends & Family – ED – Recommended % | 77.3% | 3.5% | 9.1% | 77.1% | 76.2% | 77.1% | - | - | - | - | - | - | - | 78.1% | 93.3% |
| Friends & Family – Inpatients – Footfall | 32.1% | 32.2% | 33% | 42.4% | 35.9% | 31.8% | - | - | - | - | - | - | - | 35.8% | 35.1% |
| Friends & Family – Inpatients – Not Recommended % | 1.5% | 1.8% | 2.1% | 2% | 1.8% | 2.5% | - | - | - | - | - | - | - | 1.9% | % |
| Friends & Family – Inpatients – Recommended % | 95.4% | 89.9% | 93.4% | 94.4% | 94.1% | 93.7% | - | - | - | - | - | - | - | 94.3% | 97.4% |
| Friends & Family – Maternity – Footfall | 40.3% | 96.3% | 97.4% | 37.9% | 31.8% | 25.5% | - | - | - | - | - | - | - | 36% | 34.4% |
| Friends & Family – Maternity – Not Recommended % | 0.6% | 95.6% | 98.2% | 0.4% | 0.8% | 0.6% | - | - | - | - | - | - | - | 1% | % |
| Friends & Family – Maternity – Recommended % | 97.8% | 94.6% | 97.2% | 98.1% | 98.8% | 99% | - | - | - | - | - | - | - | 98% | 97.9% |
| Friends & Family – Outpatients – Footfall | 4.3% | 89.9% | 97.7% | 5.1% | 5.8% | 5.4% | - | - | - | - | - | - | - | 5.3% | 14.4% |
| Friends & Family – Outpatients – Recommended % | 91.8% | 90.1% | 89.4% | 90.5% | 87.4% | 91.3% | - | - | - | - | - | - | - | 89.2% | 97.1% |
| HCAI – Post 48 hour MRSA | 0 | 0 | 0 | 0 | 0 | 0 | - | - | - | - | - | - | - | 0 | 0 |
| HCAI CDIFF – Due To Lapses In Care | 19 | 3 | 0 | 1 | 0 | 0 | - | - | - | - | - | - | - | 4 | 10 |
| HCAI CDIFF – Not Due To Lapses In Care | 11 | 1 | 0 | 2 | 0 | 1 | - | - | - | - | - | - | - | 4 | |
| HCAI CDIFF – Total Number Of Cases | 30 | 4 | 0 | 3 | 0 | 2 | - | - | - | - | - | - | - | 9 | |
| HCAI CDIFF – Under Review | 0 | 0 | 0 | 0 | 0 | 1 | - | - | - | - | - | - | - | 1 | |
| Incidents - Appointments, Discharge & Transfers | 1,028 | 78 | 93 | 83 | 99 | 88 | - | - | - | - | - | - | - | 441 | |
| Incidents - Blood Transfusions | 88 | 9 | 7 | 5 | 2 | 4 | - | - | - | - | - | - | - | 27 | |
| Incidents - Clinical Care (Assessment/Monitoring) | 1,375 | 149 | 149 | 131 | 161 | 140 | - | - | - | - | - | - | - | 730 | |
| Incidents - Diagnosis & Tests | 397 | 42 | 53 | 51 | 33 | 49 | - | - | - | - | - | - | - | 228 | |
| Incidents - Equipment | 290 | 29 | 33 | 51 | 33 | 23 | - | - | - | - | - | - | - | 169 | |
| Incidents - Facilities (Security, Estates, Transport, Fire etc.) | 491 | 36 | 34 | 33 | 32 | 28 | - | - | - | - | - | - | - | 163 | |
| Incidents - Falls, Injuries or Accidents | 1,442 | 106 | 89 | 109 | 94 | 111 | - | - | - | - | - | - | - | 509 | |
| Incidents - Health & Safety | 331 | 33 | 31 | 24 | 41 | 35 | - | - | - | - | - | - | - | 164 | |
| Incidents - Infection Control | 112 | 12 | 10 | 7 | 6 | 5 | - | - | - | - | - | - | - | 40 | |

NHS
The Dudley Group
NHS Foundation Trust

| Quality And Risk | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Description | LYO | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar | YTD | Target |
| Incidents - Medication | 4,160 | 412 | 285 | 445 | 312 | 417 | - | - | - | - | - | - | - | 1,871 | |
| Incidents - Obstetrics | 990 | 52 | 62 | 83 | 81 | 70 | - | - | - | - | - | - | - | 348 | |
| Incidents - Pressure Ulcer | 3,492 | 303 | 266 | 235 | 237 | 252 | - | - | - | - | - | - | - | 1,293 | |
| Incidents - Records, Communication & Information | 825 | 77 | 87 | 63 | 90 | 82 | - | - | - | - | - | - | - | 399 | |
| Incidents - Safeguarding | 866 | 86 | 120 | 105 | 154 | 101 | - | - | - | - | - | - | - | 566 | |
| Incidents - Theatres | 208 | 24 | 21 | 28 | 15 | 30 | - | - | - | - | - | - | - | 118 | |
| Incidents - Venous Thrombo Embolism (VTE) | 127 | 16 | 2 | 19 | 8 | 6 | - | - | - | - | - | - | - | 51 | |
| Incidents - Violence, Aggression & Self Harm | 734 | 52 | 66 | 48 | 67 | 49 | - | - | - | - | - | - | - | 282 | |
| Incidents - Workforce | 679 | 53 | 38 | 60 | 62 | 77 | - | - | - | - | - | - | - | 290 | |
| Maternity : Early Booking KPI: % of women who see midwife/maternity healthcare professional | 100% | 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% | 66.79% | - | - | - | - | - | - | - | 62.58% | 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% | 10.99% | - | - | - | - | - | - | - | 13.98% | 12.1% |
| Mixed Sex Sleeping Accommodation Breaches | 51 | 3 | 7 | 5 | 0 | 4 | - | - | - | - | - | - | - | 19 | 0 |
| Never Events | 3 | 0 | 0 | 0 | 0 | 0 | - | - | - | - | - | - | - | 0 | 0 |
| NQA - Matrons Audit | 92% | 91% | 95% | 94% | 92% | - | - | - | - | - | - | - | - | 93% | 94% |
| NQA - Midwifery Audit | 97% | 98% | 97% | 98% | 95% | 97% | - | - | - | - | - | - | - | 97% | 95% |
| NQA - Nutrition Audit | 94% | 94% | 96% | 93% | 93% | 94% | - | - | - | - | - | - | - | 94% | 94% |
| NQA - Paediatric Nutrition Audit | 98% | 98% | 93% | 85% | 98% | 94% | - | - | - | - | - | - | - | 95% | 95% |
| NQA - Skin Bundle | 95% | 95% | 94% | 92% | 95% | 97% | - | - | - | - | - | - | - | 95% | 94% |
| NQA - Theatres and Critical Care Environment Audit | 90% | 96% | 89% | 93% | 77% | - | - | - | - | - | - | - | - | 89% | 94% |
| NQA - Think Glucose - EAU/SAU | 77% | 90% | 100% | 100% | 100% | 100% | - | - | - | - | - | - | - | 98% | 95% |
| NQA - Think Glucose - General Wards | 94% | 96% | 95% | 98% | 95% | 93% | - | - | - | - | - | - | - | 95% | 95% |
| Nursing Care Indicators - Community Childrens | 99% | 100% | 100% | 100% | - | 100% | - | - | - | - | - | - | - | 100% | 95% |
| Nursing Care Indicators - Community Neonatal | 100% | 100% | 100% | 100% | 100% | 100% | - | - | - | - | - | - | - | 100% | 94% |
| Nursing Care Indicators - Critical Care | 98% | 100% | 98% | 100% | 98% | 98% | - | - | - | - | - | - | - | 98% | 94% |
| Nursing Care Indicators - District Nurses | 94% | 95% | 96% | 97% | 97% | 98% | - | - | - | - | - | - | - | 97% | 94% |
| Nursing Care Indicators - EAU | 90% | 96% | 90% | 94% | 86% | - | - | - | - | - | - | - | - | 91% | 95% |
| Nursing Care Indicators - ED | 88% | 95% | 88% | 91% | 92% | 88% | - | - | - | - | - | - | - | 91% | 94% |

The Dudley Group NHS Foundation Trust

| Quality And Risk | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Description | LYO | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar | YTD | Target |
| Nursing Care Indicators - General Wards | 95% | 97% | 95% | 97% | 93% | 97% | - | - | - | - | - | - | - | 96% | 94% |
| Nursing Care Indicators - Maternity | 96% | 93% | 97% | 100% | 100% | - | - | - | - | - | - | - | - | 97% | 94% |
| Nursing Care Indicators - Medicines Management | 91% | 94% | 92% | 94% | 94% | 95% | - | - | - | - | - | - | - | 94% | 94% |
| Nursing Care Indicators - Neonatal | 99% | 96% | 98% | 97% | 99% | 97% | - | - | - | - | - | - | - | 98% | 94% |
| Nursing Care Indicators - Paediatric | 95% | 96% | 94% | 99% | 86% | 91% | - | - | - | - | - | - | - | 93% | 94% |
| Nursing Care Indicators - Renal | 97% | 98% | 87% | 94% | 94% | 94% | - | - | - | - | - | - | - | 93% | 94% |
| Nursing Care Indicators - Surgical Assessment Unit | 94% | 98% | 99% | 98% | 95% | 94% | - | - | - | - | - | - | - | 97% | 94% |
| PALS Concerns | 17,507 | 1,044 | 668 | 489 | 414 | 199 | - | - | - | - | - | - | - | 2,814 | |
| Saving Lives - 1 Ventilator Associated Pneumonia (*New 18/19) | - | 100% | 100% | 100% | 100% | 100% | - | - | - | - | - | - | - | 100% | 95% |
| Saving Lives - 2a Peripheral Vascular Access Devices - Insertion (*New 18/19) | - | 99% | 100% | 100% | 99% | 100% | - | - | - | - | - | - | - | 99% | 95% |
| Saving Lives - 2b Peripheral Vascular Access Devices - Ongoing Care (*New 18/19) | - | 96% | 96% | 98% | 100% | 99% | - | - | - | - | - | - | - | 98% | 95% |
| Saving Lives - 3a Central Venous Access Devices - Insertion (*New 18/19) | - | 100% | 100% | 100% | 96% | 100% | - | - | - | - | - | - | - | 99% | 95% |
| Saving Lives - 3b Central Venous Access Devices - Ongoing Care (*New 18/19) | - | 100% | 98% | 100% | 100% | 100% | - | - | - | - | - | - | - | 99% | 95% |
| Saving Lives - 4a Surgical site infection prevention - Preoperative (*New 18/19) | - | 100% | 100% | 100% | 100% | 100% | - | - | - | - | - | - | - | 100% | 95% |
| Saving Lives - 4b Surgical site infection prevention - Intraoperative actions (*New 18/19) | - | 100% | 100% | 100% | 100% | 100% | - | - | - | - | - | - | - | 100% | 95% |
| Saving Lives - 5 Infection Prevention in Chronic Wounds (*New 18/19) | - | 100% | 100% | 100% | 100% | 100% | - | - | - | - | - | - | - | 100% | 95% |
| Saving Lives - 6a Urinary Catheter - Insertion (*New 18/19) | - | 100% | 100% | 100% | 99% | 100% | - | - | - | - | - | - | - | 99% | 95% |
| Saving Lives - 6b Urinary Catheter - Maintenance and Assessment (*New 18/19) | - | 100% | 98% | 98% | 99% | 100% | - | - | - | - | - | - | - | 99% | 95% |
| Serious Incidents - Action Plan overdue | 74 | 3 | - | - | - | - | - | - | - | - | - | - | - | 3 | |
| Serious Incidents - Appointments, Discharge & Transfers | 5 | - | - | - | 1 | - | - | - | - | - | - | - | - | 1 | |
| Serious Incidents - Clinical Care (Assessment/Monitoring) | 100 | 1 | - | 2 | 6 | 5 | - | - | - | - | - | - | - | 14 | |
| Serious Incidents - Diagnosis & Tests | 15 | - | 1 | - | 1 | 1 | - | - | - | - | - | - | - | 3 | |

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 | 105 | - | 1 | 1 | 2 | 2 | - | - | - | - | - | - | - | 6 | |
| Serious Incidents - Health & Safety | - | - | - | - | - | 1 | - | - | - | - | - | - | - | 1 | |
| Serious Incidents - Infection Control | 25 | 2 | - | - | - | - | - | - | - | - | - | - | - | 2 | |
| Serious Incidents - Medication | 10 | - | - | 1 | - | - | - | - | - | - | - | - | - | 1 | |
| Serious Incidents - Obstetrics | 15 | - | - | - | 1 | - | - | - | - | - | - | - | - | 1 | |
| Serious Incidents - Pressure Ulcer | 490 | 8 | 1 | 4 | - | - | - | - | - | - | - | - | - | 13 | |
| Serious Incidents - Safeguarding | - | - | - | - | 1 | 1 | - | - | - | - | - | - | - | 2 | |
| Serious Incidents - Venous Thrombo Embolism (VTE) | - | - | - | - | 1 | - | - | - | - | - | - | - | - | 1 | |
| Stroke Admissions : Swallowing Screen | 82.84% | 92.10% | 86.27% | 94.44% | 100% | 97.72% | - | - | - | - | - | - | - | 93.53% | 75% |
| Stroke Admissions to Thrombolysis Time | 57.69% | 42.85% | 60.00% | 50% | 50% | 42.85% | - | - | - | - | - | - | - | 48% | % |
| Stroke Patients Spending 90% of Time On Stroke Unit (VSA14) | 92.56% | 91.89% | 87.71% | 97.77% | 97.36% | 95% | - | - | - | - | - | - | - | 93.54% | 85% |
| Suspected High-risk TIA Assessed and Treated < 24hrs from presentation | 94.15% | 77.77% | 100% | 85.71% | 100.00% | 90.90% | - | - | - | - | - | - | - | 92.15% | 85% |
| Time to Procedure: Emergency Procedures (Upper GI Diagnostic endoscopic) | 66.66% | 65.3% | 57.89% | 43.33% | 53% | 40.74% | - | - | - | - | - | - | - | 52.40% | 0% |
| Time to Surgery - Elective admissions operated on within two days for all procedures | 87% | 99.77% | 99.86% | 99.95% | 99.91% | 99.94% | - | - | - | - | - | - | - | 99.88% | 0% |
| Time to Surgery : Emergency Procedures (Appendectomy) | 97% | 92.5% | 90.62% | 87.09% | 83% | 100% | - | - | - | - | - | - | - | 89.04% | 0% |
| Time to Surgery : Emergency Procedures (Femur Replacement #NOF) | 93.23% | 95.23% | 96.96% | 95% | 100% | 87.50% | - | - | - | - | - | - | - | 95.49% | 0% |
| Time to Surgery : Emergency Procedures (Reduction of fracture of bone excl. #NOF) | 91.68% | 88.57% | 91% | 88.13% | 93% | 84.84% | - | - | - | - | - | - | - | 89.66% | 0% |
| VTE Assessment Indicator (CQN01) | 93.37% | 95.10% | 94.8% | 95.47% | 95.10% | 95.44% | - | - | - | - | - | - | - | 95.18% | 95% |

The Dudley Group NHS Foundation Trust

# Performance Dashboard

| Performance | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Description | LYO | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar | YTD | Target |
| A&E - 4 Hour A&E Dept Only % (Type 1) | 78.38% | 77.09% | 76.50% | 78.66% | 76.73% | 80.59% | - | - | - | - | - | - | - | 77.87% | % |
| A&E - 4 Hour UCC Dept Only % (Type 3) | 99.38% | 99.44% | 99.46% | 99.82% | 99.43% | 99.49% | - | - | - | - | - | - | - | 99.53% | % |
| A&E - 4 Hour UCC/A&E Combined % (Type 1+3) | 86.56% | 86.29% | 85.38% | 86.93% | 85.29% | 87.64% | - | - | - | - | - | - | - | 86.27% | 95% |
| A&E - Patients who Left Without Being Seen % | 2.6% | 1.7% | 2.1% | 1.8% | 2.5% | 1.6% | - | - | - | - | - | - | - | 2% | 5% |
| A&E - Time to Initial Assessment (95th Percentile) | 9 | 4 | 8 | 9 | 7 | 4 | - | - | - | - | - | - | - | 4 | 15 |
| A&E - Time to Treatment Median Wait (Minutes) | 70 | 49 | 65 | 61 | 73 | 49 | - | - | - | - | - | - | - | 49 | 60 |
| A&E - Total Time in A&E (95th Percentile) | 731 | 593 | 587 | 504 | 524 | 463 | - | - | - | - | - | - | - | 463 | 240 |
| A&E - Unplanned Re-Attendance Rate % | 1.5% | 1.3% | 1.1% | 1.5% | 1.6% | 1.3% | - | - | - | - | - | - | - | 1.4% | 5% |
| Activity - A&E Attendances | 103,426 | 8,299 | 9,103 | 8,923 | 9,579 | 8,339 | - | - | - | - | - | - | - | 44,243 | 43,559 |
| Activity - Cancer MDT | 5,131 | 492 | 443 | 520 | 378 | 511 | - | - | - | - | - | - | - | 2,344 | 2,174 |
| Activity - Community Attendances | 376,548 | 33,662 | 36,319 | 36,299 | 35,359 | 34,748 | - | - | - | - | - | - | - | 176,387 | 166,854 |
| Activity - Critical Care Bed Days | 7,612 | 585 | 710 | 737 | 791 | 641 | - | - | - | - | - | - | - | 3,464 | 3,378 |
| Activity - Diagnostic Imaging whilst Out-Patient | 52,692 | 4,222 | 4,505 | 4,451 | 4,427 | 4,361 | - | - | - | - | - | - | - | 21,966 | 24,313 |
| Activity - Direct Access Pathology | 1,970,646 | 173,406 | 172,671 | 173,017 | 174,399 | 173,876 | - | - | - | - | - | - | - | 867,369 | 867,194 |
| Activity - Direct Access Radiology | 75,450 | 6,221 | 6,883 | 6,389 | 6,474 | 6,212 | - | - | - | - | - | - | - | 32,179 | 33,680 |
| Activity - Elective Day Case Spells | 48,682 | 4,184 | 4,366 | 4,058 | 4,269 | 4,474 | - | - | - | - | - | - | - | 21,351 | 20,846 |
| Activity - Elective Inpatients Spells | 5,828 | 433 | 464 | 451 | 478 | 502 | - | - | - | - | - | - | - | 2,328 | 2,458 |
| Activity - Emergency Inpatient Spells | 50,160 | 3,256 | 3,628 | 3,639 | 3,801 | 3,785 | - | - | - | - | - | - | - | 18,109 | 20,766 |
| Activity - Excess Bed Days | 11,066 | 707 | 823 | 922 | 836 | 221 | - | - | - | - | - | - | - | 3,509 | 6,258 |
| Activity - Maternity Pathway | 7,636 | 578 | 668 | 621 | 586 | 588 | - | - | - | - | - | - | - | 3,041 | 3,200 |
| Activity - Neo Natal Bed Days | 7,111 | 628 | 661 | 604 | 577 | 621 | - | - | - | - | - | - | - | 3,091 | 3,064 |
| Activity - Outpatient First Attendances | 146,246 | 13,055 | 14,049 | 13,954 | 15,168 | 13,571 | - | - | - | - | - | - | - | 69,797 | 65,169 |
| Activity - Outpatient Follow Up Attendances | 295,301 | 26,094 | 27,879 | 26,507 | 28,212 | 26,128 | - | - | - | - | - | - | - | 134,820 | 129,009 |
| Activity - Outpatient Procedure Attendances | 71,502 | 5,294 | 6,165 | 6,122 | 5,938 | 6,188 | - | - | - | - | - | - | - | 29,707 | 31,340 |
| Activity - Rehab Bed Days | 20,079 | 1,528 | 1,571 | 1,720 | 1,515 | 1,908 | - | - | - | - | - | - | - | 8,242 | 8,121 |
| Activity - Renal Dialysis | 52,070 | 4,233 | 4,431 | 4,225 | 4,130 | 4,371 | - | - | - | - | - | - | - | 21,390 | 21,656 |
| Ambulance Handover - 30 min – breaches (DGH view) | 4,608 | 180 | 437 | 437 | 542 | 267 | - | - | - | - | - | - | - | 1,863 | 0 |
| Ambulance Handover - 30 min – breaches (WMAS view) | 5,803 | 240 | 603 | 563 | 685 | 395 | - | - | - | - | - | - | - | 2,486 | 0 |
| Ambulance Handover - 60 min – breaches (DGH view) | 716 | 8 | 67 | 53 | 119 | 43 | - | - | - | - | - | - | - | 290 | 0 |
| Ambulance Handover - 60 min – breaches (WMAS view) | 876 | 9 | 73 | 66 | 144 | 52 | - | - | - | - | - | - | - | 344 | 0 |

The Dudley Group NHS Foundation Trust

| Performance | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Description | LYO | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar | YTD | Target |
| Cancer - 14 day - Urgent Cancer GP Referral to date first seen | 94.7% | 88.2% | 95.9% | 94.5% | 95.3% | 94.9% | - | - | - | - | - | - | - | 93.8% | 93% |
| Cancer - 14 day - Urgent GP Breast Symptom Referral to date first seen | 97.3% | 91.8% | 96.0% | 95.3% | 96.3% | 96.9% | - | - | - | - | - | - | - | 95.4% | 93% |
| Cancer - 31 day - from diagnosis to treatment for all cancers | 98.8% | 98.7% | 100.0% | 99.4% | 97.1% | 98.1% | - | - | - | - | - | - | - | 98.7% | 96% |
| Cancer - 31 Day For Second Or Subsequent Treatment - Anti Cancer Drug Treatments | 100% | 100% | 100% | 100% | 100% | 92.8% | - | - | - | - | - | - | - | 99% | 98% |
| Cancer - 31 Day For Second Or Subsequent Treatment - Surgery | 98.9% | 100% | 100% | 100% | 100% | 92.5% | - | - | - | - | - | - | - | 99% | 94% |
| Cancer - 31 Day For Subsequent Treatment From Decision To Treat | 99.4% | 100% | 100% | 100% | 100% | 92.6% | - | - | - | - | - | - | - | 99% | 96% |
| Cancer - 62 day - From Referral for Treatment following a Consultant Upgrade | 93.3% | 86.6% | 86.1% | 91.5% | 88.1% | 95% | - | - | - | - | - | - | - | 89.7% | 85% |
| Cancer - 62 day - From Referral for Treatment following national screening referral | 98.4% | 96.4% | 96.1% | 100% | 100% | 92.8% | - | - | - | - | - | - | - | 96.4% | 90% |
| Cancer - 62 day - From Urgent GP Referral to Treatment for All Cancers | 85.3% | 80.8% | 84% | 79.8% | 85.3% | 76.2% | - | - | - | - | - | - | - | 81.6% | 85% |
| Cancer: Patients on a 62 day pathway treated on or over 104 days (1: patients treated at DGFT) | 19 | 3 | 7 | 2 | 3 | - | - | - | - | - | - | - | - | 15 | |
| Cancer: Patients on a 62 day pathway treated on or over 104 days (2: patients treated at a Tertiary Centre) | 29 | 2 | 2 | 1 | 4 | - | - | - | - | - | - | - | - | 9 | |
| Cancer: Patients on a 62 day pathway treated on or over 104 days (3: combined) | 48 | 5 | 9 | 3 | 7 | - | - | - | - | - | - | - | - | 24 | |
| Maternity: Breastfeeding Data Coverage Rates | 100% | 100% | 100% | 100% | 100% | 100% | - | - | - | - | - | - | - | 100% | 0% |
| Number of Births Within the Trust | 4,435 | 351 | 384 | 363 | 356 | 385 | - | - | - | - | - | - | - | 1,839 | |
| RTT - Admitted Pathways within 18 weeks % | 87.9% | 84.6% | 87.1% | 86.6% | 88.2% | 89.3% | - | - | - | - | - | - | - | 87.2% | 90% |
| RTT - Incomplete Waits within 18 weeks % | 94% | 93.4% | 94.7% | 94.4% | 94% | 93.6% | - | - | - | - | - | - | - | 94.00% | 92% |
| RTT - Non-Admitted Pathways within 18 weeks % | 93.1% | 94.4% | 94.6% | 95.8% | 95.8% | 94.9% | - | - | - | - | - | - | - | 95% | 95% |
| Waiting Time - Diagnostic 6 Week Maximum Wait (VSA05) | 97.85% | 99.31% | 99.38% | 99.30% | 99.23% | 97.7% | - | - | - | - | - | - | - | 98.98% | 99% |

The Dudley Group NHS Foundation Trust

## Staff/HR

| Finance | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Description | LYO | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar | YTD | Target |
| Agency spend | £11,613k | £860k | £1,111k | £981k | £974k | £1,157k | - | - | - | - | - | - | - | £5,082k | k |
| Bank spend | £16,404k | £1,481k | £1,475k | £1,611k | £1,608k | £1,393k | - | - | - | - | - | - | - | £7,568k | k |
| Budgetary Performance | (£20,622)k | (£640)k | (£451)k | £646k | (£445)k | (£134)k | - | - | - | - | - | - | - | (£1,025)k | £0k |
| Capital v Forecast | 106.6% | 59.8% | 51.9% | 69% | - | - | - | - | - | - | - | - | - | 69% | 95% |
| Cash Balance | £8,617k | £13,899k | £9,420k | £9,717k | - | - | - | - | - | - | - | - | - | £9,717k | k |
| Cash v Forecast | 54.6% | 109.3% | 98.8% | 159.4% | - | - | - | - | - | - | - | - | - | 159.4% | 95% |
| Creditor Days | 16.4 | 15.5 | 15.5 | 16.7 | - | - | - | - | - | - | - | - | - | 16.7 | 15 |
| Debt Service Cover | 0.79 | 0 | 0.64 | 0.85 | - | - | - | - | - | - | - | - | - | 0.85 | 2.5 |
| Debtor Days | 7.4 | 9.4 | 10.8 | 12.8 | - | - | - | - | - | - | - | - | - | 12.8 | 15 |
| I&E (After Financing) | (£9,518)k | (£2,073)k | £179k | £116k | - | - | - | - | - | - | - | - | - | (£1,778)k | k |
| Liquidity | -7.63 | -7.78 | -8 | -8.35 | - | - | - | - | - | - | - | - | - | -8.35 | 0 |
| SLA Performance | (£3,902)k | (£419)k | (£732)k | £124k | (£71)k | £216k | - | - | - | - | - | - | - | (£882)k | £0k |

## Staff/HR Dashboard

| Staff/HR | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Description | LYO | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar | YTD | Target |
| Appraisals | 70.5% | 17.4% | 52.4% | 95.6% | 95.6% | 95.6% | - | - | - | - | - | - | - | 95.6% | 90% |
| Mandatory Training | 85.9% | 87.8% | 88.3% | 87.6% | 88.9% | 89.3% | - | - | - | - | - | - | - | 89.3% | 90% |
| RN average fill rate (DAY shifts) | 89.64% | 83.89% | 82.99% | 81.22% | 81.75% | 78.2% | - | - | - | - | - | - | - | 81.6% | 95% |
| RN average fill rate (NIGHT shifts) | 92.85% | 85.65% | 85.81% | 84.64% | 85.68% | 83.69% | - | - | - | - | - | - | - | 85.1% | 95% |
| Sickness Rate | 4.40% | 3.79% | 3.87% | 4.20% | 4.49% | 4.45% | - | - | - | - | - | - | - | 4.16% | 3.50% |
| Staff In Post (Contracted WTE) | 4,397.71 | 4,396.03 | 4,395.30 | 4,408.83 | 4,426.94 | 4,437.96 | - | - | - | - | - | - | - | 4,437.96 | |
| Turnover Rate (Rolling 12 Months) | 9.74% | 9.95% | 9.70% | 9.56% | 9.51% | 9.59% | - | - | - | - | - | - | - | 9.59% | % |
| Vacancy Rate | 6.63% | 10.87% | 11.39% | 11.30% | 11.16% | 10.89% | - | - | - | - | - | - | - | 10.89% | % |

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.

| | August | YTD |
|---|---|---|
| Total No. of cases due to lapses in care | NIL | 4 |
| Total No. of cases NOT due to lapses in care | 2 | 4 |
| No. of cases currently under review (ytd) | 1 | 1 |
| Total No. of cases ytd. | | 9 |

There were 0 post 48 hour MRSA cases reported in month. The last post 48 hours MRSA cases was in September 2015, 1095 days ago.

**Friends and Family Scores:**

FFT RAG rating rebased to reflect latest national benchmarking data and applied from 1 April 2018. The review process in future will complete in Q4 and applied in Q1 of the following year.

**Complaints:**

There continues to be a drive to clear the backlog of complaints but consideration needs to be given, that in general on a month-to-month basis, there remains a small amount of difference between the number of complaints opened and closed due to the volume of complaints received into the Trust and capacity within the complaints department and divisions. The full details are included in patient experience report.

**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. We continue to be below the national averages of falls and falls with harm.

**Pressure Ulcers**

There have been 0 avoidable grade 4 pressure ulcers reported since January 2018. There were 7 verified grade 3 pressure ulcers in August 2018, 5 Hospital acquired (3 avoidable and 2 non avoidable) and 2 Community acquired (1 avoidable and 1 non avoidable).

**Never Events**

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

**Mixed Sex Sleeping Accommodation Breaches (MSA)**

There are 5 MSA breaches in month. 1 on MHDU, 1 on SHDU and 3 in Cardiology Day Case.

**VTE Assessment On Admission: Indicator**

The target was achieved in month with provisional performance at 95.4% 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 87.65%. Whilst, the Trust only (Type 1) performance was 80.60%.

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

| | Attendances | Breaches | Performance |
|---|---|---|---|
| **A&E Dept. Type 1** | 8360 | 1622 | 80.60% |
| **UCC Type 3** | 4972 | 25 | 99.50% |

**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 72.4% (Provisional as at 17th Sept). Previous month confirmed performance was 81.6%

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

| | |
|---|---|
| No. of Patients treated on or over 104 days (DGFT) | 3 |
| No. of Patients treated on or over 104 days (Tertiary Centre) | 4 |
| No. of Patients treated on or over 104 days (Combined) | 7 |

**2WW**

The target was achieved once again in month. During this period a total of 1329 patients attended a 2ww appointment with 69 patients attending their appointments outside of the 2 week standard, achieving a performance 94.8% 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 93.6% in month against a target of 92%, a decrease in performance from 94.1% in the previous month. Urology did not meet the target in month at 89.5% up from 88.1% in previous month. Ophthalmology is at 83.9% down from 85.4% in the previous month.General Surgery at 91.4% up from 91.1%. There were no 52-week Non-admitted Waiting Time breaches in month.

**Diagnostic waits**

The diagnostic wait was below target in month with a performance of 97.7%. The number of patients waiting over 6 weeks was 161.

# Executive Summary by Exception cont.

## Key Messages

**2 Financial Performance Matters** — **Committee: F&P**

Adjusted deficit of £2.558m for April-August, representing a £0.529m adverse variance in comparison to the control total. However, underlying position is significantly worse than this linked to one-off benefits (PFI £0.790m and 17/18 income £1.074m 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 £10.149m before PSF (upside of a £6.547m deficit and downside of a £14.721m deficit). A recovery plan of the magnitude of £9.3m is thus required to improve upon the base forecast and deliver the control total.

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 October 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 89.36%. 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 decreased slightly to 4.45% from 4.49% in August 2018. Although this is a relatively positive absence rate it is still 0.24% 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 supported to return to work at the earliest possible opportunity.

**Turnover 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) | Jul-18 | Aug-18 | Actual YTD | Trend | Month Status |
|---|---|---|---|---|---|---|---|
| **Friends & Family Test - Footfall** | | | | | | | |
| Friends & Family Test - ED | 14.5% | 21.3% | 18.7% | 16.6% | 18.1% | ↓ | |
| Friends & Family Test - Inpatients | 26.0% | 35.1% | 36.0% | 31.9% | 35.0% | ↓ | |
| Friends & Family Test - Maternity | 21.7% | 34.4% | 31.9% | 25.5% | 33.8% | ↓ | |
| Friends & Family Test - Outpatients | 4.7% | 14.5% | 5.8% | 5.4% | 5.4% | ↓ | |
| Friends & Family Test - Community | 3.5% | 9.1% | 4.1% | 3.2% | 3.6% | ↓ | |
| **Friends & Family Test - Recommended** | | | | | | | |
| Friends & Family Test - ED | 89.9% | 93.4% | 76.2% | 93.4% | 78.0% | ↑ | |
| Friends & Family Test - Inpatients | 96.3% | 97.4% | 94.2% | 93.7% | 94.2% | ↓ | |
| Friends & Family Test - Maternity | 95.6% | 98.2% | 98.9% | 99.0% | 98.2% | ↑ | |
| Friends & Family Test - Outpatients | 94.6% | 97.2% | 87.4% | 91.4% | 89.7% | ↑ | |
| Friends & Family Test - Community | 96.4% | 97.7% | 95.7% | 96.4% | 96.1% | ↑ | |
| **Complaints** | | | | | | | |
| Total no. of complaints received in month | | 0 | 75 | 43 | ------ | ↓ | |
| Complaints re-opened | | | 2 | 6 | 22 | ↑ | |
| PALs Numbers | | | 301 | 271 | 1452 | ↓ | |
| Complaints open at month end | | | 216 | 203 | ------ | ↓ | |
| Compliments received | | | 566 | 438 | 2589 | ↓ | |
| **Dementia (1 month in arrears)** | | | | | | | |
| Find/Assess | | 90% | 98.3% | | 98.0% | ↑ | |
| Investigate | | 90% | 100.0% | | 100.0% | ↑ | |
| Refer | | 90% | 95.6% | | 95.8% | ↑ | |
| **Falls** | National average 6.63 per 1000 bed days | | | | | | |
| No. of Falls | | | 55 | 61 | 302 | ↑ | |
| Falls per 1000 bed days | | 6.63 | 3.27 | 3.67 | 3.57 | ↑ | |
| No. of Multiple Falls | | N/A | 7 | 8 | 33 | ↑ | |
| Falls resulting in moderate harm or above | | | 2 | 1 | 5 | ↓ | |
| Falls resulting in moderate harm or above per 1000 bed days | | 0.19 | 3.3 | 3.7 | 3.6 | ↑ | |
| **Pressure Ulcers (Grades 3 & 4)** | | | | | | | |
| Hospital Avoidable | | 0 | 0 | 3 | 5 | ↑ | |
| Hospital Non-avoidable | | 0 | 2 | 2 | 13 | ↔ | |
| Community Avoidable | | 0 | 0 | 3 | 7 | ↑ | |
| Community Non-avoidable | | 0 | 3 | 3 | 29 | ↔ | |
| **Handwash** | | | | | | | |
| Handwashing | | | 99.8% | 96.3% | 98.5% | ↓ | |

## Patients will experience safe care - Patient Safety

| | Target (Amber) | Target (Green) | Jul-18 | Aug-18 | Actual YTD | Trend | Month Status |
|---|---|---|---|---|---|---|---|
| **Mixed Sex Accommodation Breaches** | | | | | | | |
| Single Sex Breaches | | 0 | 0 | 4 | 19 | ↑ | |
| **Mortality (Quality Strategy Goal 3)** | | | | | | | |
| HSMR Rolling 12 months (**Latest data Jun 18**) | 110 | 105 | 117 | 118 | N/A | | |
| SHMI Rolling 12 months (**Latest data Mar18**) | 1.10 | 1.05 | N/A | 1.11 | N/A | | |
| HSMR Year to date (**Not available**) | | | | | N/A | | |
| **Infections** | | | | | | | |
| Cumulative C-Diff due to lapses in care | | 28 | 3 | 4 | 4 | ↑ | |
| MRSA Bacteraemia | | 0 | 0 | 0 | 0 | ↔ | |
| MSSA Bacteraemia | | 0 | 0 | 1 | 5 | ↑ | |
| E. Coli - Total hospital | | 0 | 1 | 3 | 16 | ↑ | |
| **Stroke Admissions - PROVISIONAL** | | | | | | | |
| Stroke Admissions: Swallowing Screen | | 75% | 100.0% | 97.7% | 92.6% | ↓ | |
| Stroke Patients Spending 90% of Time on Stroke Unit | | 85% | 92.7% | 95.0% | 93.1% | ↑ | |
| Suspected High Risk TIAs Assessed and Treated <24hrs | | 85% | 77.8% | 90.9% | 90.9% | ↑ | |
| **VTE - PROVISIONAL** | | | | | | | |
| VTE On Admission | | 95% | 95.1% | 95.4% | 95.3% | ↑ | |
| **Incidents** | | | | | | | |
| Total Incidents | | | 1534 | 1368 | 7086 | ↓ | |
| Recorded Medication Incidents | | | 312 | 417 | 1726 | ↑ | |
| Never Events | | | 0 | 0 | 0 | ↔ | |
| Serious Incidents | | | 13 | 10 | 45 | ↓ | |
| of which, pressure ulcers | | | 0 | 0 | 13 | ↔ | |
| **Incident Grading by Degree of Harm** | | | | | | | |
| Death | | | 3 | 2 | 6 | ↓ | |
| Severe | | | 7 | 2 | 12 | ↓ | |
| Moderate | | | 34 | 38 | 167 | ↑ | |
| Low | | | 203 | 235 | 1073 | ↑ | |
| No Harm | | | 1287 | 1091 | 5828 | ↓ | |
| Percentage of incidents causing harm | | 28% | 16.1% | 20.2% | 17.8% | ↑ | |

# Performance - "At a glance"

**Executive Lead: Karen Kelly**

The Dudley Group NHS Foundation Trust

## Performance - Key Performance Indicators

| | Target | Jul-18 | Aug-18 | Actual YTD | Trend | Month Status |
|---|---|---|---|---|---|---|
| **Cancer Reporting - TRUST (provisional)** | | | | | | |
| All Cancer 2 week waits | 93% | 94.9% | 94.8% | 93.8% | ↓ | |
| 2 week wait - Breast Symptomatic | 93% | 96.3% | 97.0% | 95.5% | ↑ | |
| 31 day diagnostic to 1st treatment | 96% | 95.3% | 97.9% | 98.7% | ↑ | |
| 31 day subsequent treatment - Surgery | 94% | 100.0% | 92.3% | 98.6% | ↓ | |
| 31 day subsequent treatment - Drugs | 94% | 100.0% | 90.9% | 99.2% | ↓ | |
| 62 day urgent GP referral to treatment | 85% | 81.6% | 72.4% | 81.1% | ↓ | |
| 62 day screening programme | 90% | 100.0% | 93.3% | 96.6% | ↓ | |
| 62 day consultant upgrades | 85% | 83.0% | 94.3% | 89.5% | ↑ | |
| **Referral to Treatment** | | | | | | |
| RTT Incomplete Pathways - % still waiting | 92% | 94.1% | 93.6% | 94.1% | ↓ | |
| RTT Admitted - % treatment within 18 weeks | 90% | 88.2% | 89.4% | 87.2% | ↑ | |
| RTT Non Admitted - % treatment within 18 weeks | 95% | 95.8% | 94.9% | 95.2% | ↓ | |
| Wait from referral to 1st OPD | 26 | 25 | 22 | 115 | ↓ | |
| Wait from Add to Waiting List to Removal | 39 | 47 | 43 | 222 | ↓ | |
| ASI List | | 2553 | 1944 | 0 | ↓ | |
| % Missing Outcomes RTT | | 0.0% | 0.1% | 0.1% | ↑ | |
| % Missing Outcomes Non-RTT | | 5.9% | 5.3% | 6.3% | ↓ | |
| **DM01** | | | | | | |
| No. of diagnostic tests waiting over 6 weeks | 0 | 56 | 161 | 355 | ↑ | |
| % of diagnostic tests waiting less than 6 weeks | 99% | 99.2% | 97.7% | 99.0% | ↓ | |
| **ED - TRUST** | | | | | | |
| Patients treated < 4 hours Type 1 (Trust ED) | 95% | 76.7% | 80.6% | 389.6% | ↑ | |
| Patients treated < 4 hours Type 1 & 3 (ED + UCC) | 95% | 85.3% | 87.6% | 86.3% | ↑ | |
| Emergency Department Attendances | N/A | 9565 | 8360 | 44241 | ↓ | |
| 12 Hours Trolley Waits | | 0 | 0 | 1 | ↔ | |
| **Ambulance to ED Handover Time - TRUST** | | | | | | |
| 30-59 minute breaches | | 542 | 267 | 1863 | ↓ | |
| 60+ minute breaches | | 119 | 43 | 290 | ↓ | |
| **Ambulance to Assessment Area Handover Time - TRUST** | | | | | | |
| 30-59 minute breaches | | 27 | 16 | 105 | ↓ | |
| 60+ minute breaches | | 2 | 4 | 18 | ↑ | |

## Performance - Key Performance Indicators cont.

| | Target | Jul-18 | Aug-18 | Actual YTD | Trend | Month Status |
|---|---|---|---|---|---|---|
| **Cancelled Operations - TRUST** | | | | | | |
| % Cancelled Operations | 1.0% | 1.5% | 2.1% | 1.7% | ↑ | |
| Cancelled operations - breaches of 28 day rule | 0 | 2 | 3 | 7 | ↑ | |
| Urgent operations - cancelled twice | 0 | 0 | 1 | 1 | ↑ | |
| **GP Discharge Letters** | | | | | | |
| GP Discharge Letters | 90% | 78.0% | 78.5% | 75.2% | ↑ | |
| **Theatre Utilisation - TRUST** | | | | | | |
| Theatre Utilisation - Day Case (RHH & Corbett) | | 77.0% | 77.6% | 76.7% | ↑ | |
| Theatre Utilisation - Main | | 88.1% | 87.5% | 88.2% | ↓ | |
| Theatre Utilisation - Trauma | | 94.9% | 96.2% | 95.8% | ↑ | |
| **GP Referrals** | | | | | | |
| GP Written Referrals - made | | 6687 | 7012 | 35809 | ↑ | |
| GP Written Referrals - seen | | 6268 | 5630 | 29152 | ↓ | |
| Other Referrals - Made | | 3763 | 3333 | 17095 | ↓ | |
| **Throughput** | | | | | | |
| Patients Discharged with a LoS >= 7 Days | | 6.6% | 6.5% | 7% | ↓ | |
| Patients Discharged with a LoS >= 14 Days | | 2.9% | 3.0% | 3% | ↑ | |
| 7 Day Readmissions | | 2.0% | 3.7% | 3% | ↑ | |
| 30 Day Readmissions - PbR | | 4% | 8% | 7% | ↑ | |
| Bed Occupancy - % | | 87% | 90% | 90% | ↑ | |
| Bed Occupancy - % Medicine & IC | | 94% | 96% | 95% | ↑ | |
| Bed Occupancy - % Surgery, W&C | | 81% | 88% | 86% | ↑ | |
| Bed Occupancy - Paediatric % | | 56% | 38% | 60% | ↓ | |
| Bed Occupancy - Orthopaedic Elective % | | 69% | 67% | 72% | ↓ | |
| Bed Occupancy - Trauma and Hip % | | 91% | 97% | 95% | ↑ | |
| Number of Patient Moves between 8pm and 8am | | 94 | 108 | 522 | ↑ | |
| Discharged by Midday | | 13% | 14% | 13% | ↑ | |
| **Outpatients** | | | | | | |
| New outpatient appointment DNA rate | 8% | 9.0% | 8.6% | 9.9% | ↓ | |
| Follow-up outpatient appointment DNA rate | 8% | 8.3% | 8.2% | 8.3% | ↓ | |
| Total outpatient appointment DNA rate | 8% | 8.5% | 8.4% | 44.4% | ↓ | |
| Clinic Utilisation | | 73.3% | 73.5% | 74.6% | ↑ | |
| **Average Length of stay (Quality Strategy Goal 3)** | | | | | | |
| Average Length of Stay - Elective | | 3.7 | 2.8 | 3.2 | ↓ | |
| Average Length of Stay - Non-Elective | 3.4 | 5.2 | 5.0 | 5.4 | ↓ | |

# 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 | 491 | 502 | 2.2% | -15 | 1,469 | 1,378 | -6.2% | -91 |
| Day Cases | 4,181 | 4,654 | 11.3% | 611 | 12,158 | 13,838 | 13.8% | 1,680 |
| Non-elective inpatients | 4,198 | 3,785 | -9.8% | -483 | 12,236 | 10,749 | -12.2% | -1,487 |
| Outpatients | 38,664 | 39,626 | 2.5% | 1,067 | 115,593 | 114,578 | -0.9% | -1,015 |
| A&E | 8,694 | 8,360 | -3.8% | 305 | 25,595 | 26,316 | 2.8% | 721 |
| **Total activity** | **56,228** | **56,927** | 1.2% | **1,485** | **167,051** | **166,859** | -0.1% | **-192** |
| | | | | | | | | |
| **CIP** | **£'000** | **£'000** | | **£'000** | **£'000** | **£'000** | | **£'000** |
| Income | 371 | 482 | 29.8% | 111 | 1,597 | 2,165 | 35.6% | 568 |
| Pay | 309 | 335 | 8.6% | 27 | 1,306 | 1,396 | 6.9% | 90 |
| Non-Pay | 421 | 416 | -1.1% | -5 | 1,444 | 2,676 | 85.4% | 1,232 |
| **Total CIP** | **1,101** | **1,233** | **12.0%** | **132** | **4,346** | **6,236** | **43.5%** | **1,890** |
| | | | | | | | | |
| **INCOME** | **£'000** | **£'000** | | **£'000** | **£'000** | **£'000** | | **£'000** |
| NHS Clinical | 27,965 | 28,233 | 1.0% | 268 | 139,631 | 138,332 | -0.9% | -1,298 |
| Other Clinical | 544 | 1,218 | 123.7% | 673 | 2,784 | 3,946 | 41.7% | 1,161 |
| STF Funding | 603 | 603 | 0.0% | 0 | 2,562 | 2,155 | -15.9% | -407 |
| Other | 1,975 | 1,873 | -5.2% | -102 | 9,685 | 9,692 | 0.1% | 8 |
| **Total income** | **31,088** | **31,926** | **2.7%** | **838** | **154,661** | **154,125** | **-0.3%** | **-536** |
| | | | | | | | | |
| **OPERATING COSTS** | **£'000** | **£'000** | | **£'000** | **£'000** | **£'000** | | **£'000** |
| Pay | -18,625 | -19,041 | 2.2% | -415 | -94,163 | -94,298 | 0.1% | -135 |
| Drugs | -2,829 | -3,044 | 7.6% | -215 | -13,987 | -14,437 | 3.2% | -450 |
| Non-Pay | -6,873 | -7,330 | 6.7% | -457 | -35,687 | -35,709 | 0.1% | -22 |
| **Total Costs** | **-28,327** | **-29,415** | **3.8%** | **-1,088** | **-143,837** | **-144,444** | **0.4%** | **-607** |

## 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** | **2,753** | **2,522** | -8.4% | **-231** | **10,781** | **9746** | -9.6% | **-1,035** |
| Depreciation | -835 | -795 | -4.8% | 40 | -4,114 | -4097 | -0.4% | 17 |
| Restructuring & Other | 0 | 0 | n/a | 0 | 0 | 0 | n/a | 0 |
| Financing Costs | -1,238 | -1,165 | -5.9% | 73 | -6,178 | -6088 | -1.5% | 90 |
| SURPLUS/(DEFICIT) | **680** | **562** | -17.4% | **-118** | **489** | **-439** | -189.8% | **-928** |
| | | | | | | | | |
| **SOFP** | **£'000** | **£'000** | | **£'000** | **£'000** | **£'000** | | **£'000** |
| Capital Spend | -1,158 | -811 | -30.0% | 347 | -4,807 | -3,283 | -31.7% | 1,524 |
| Inventory | | | | | 3,077 | 3,348 | 8.8% | 271 |
| Receivables & Prepayments | | | | | 17,692 | 20,992 | 18.7% | 3,300 |
| Payables | | | | | -29,169 | -32,210 | 10.4% | -3,041 |
| Accruals | | | | | | | n/a | 0 |
| Deferred Income | | | | | -2,534 | -3,525 | 39.1% | -991 |
| | | | | | | | | |
| **Cash & Loan Funding** | **£'000** | **£'000** | | **£'000** | **£'000** | **£'000** | | **£'000** |
| Cash | | | | | 7,708 | 7,143 | -7.3% | -565 |
| Loan Funding | | | | | | | n/a | 0 |
| | | | | | | | | |
| **KPIs** | | | | | | | | |
| EBITDA % | 9.5% | 8.7% | -0.8% | | 4.0% | 3.7% | -0.3% | |
| Deficit % | 2.3% | 1.9% | -0.4% | | 0.2% | -0.2% | -0.3% | |
| Receivable Days | | | | | 0.0 | 0.0 | n/a | |
| Payable (excluding accruals) Days | | | | | 0.0 | 0.0 | n/a | |
| Payable (including accruals) Days | | | | | 0.0 | 0.0 | n/a | |
| Use of Resource metric | | | | | 1 | 3 | | |

The Dudley Group NHS Foundation Trust

# Workforce - "At a glance"

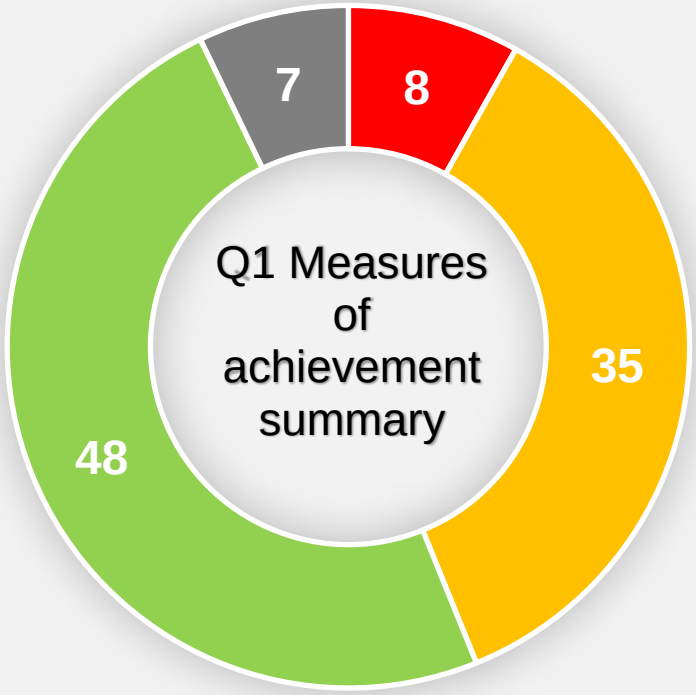
**Executive Lead: Andrew McMenemy**

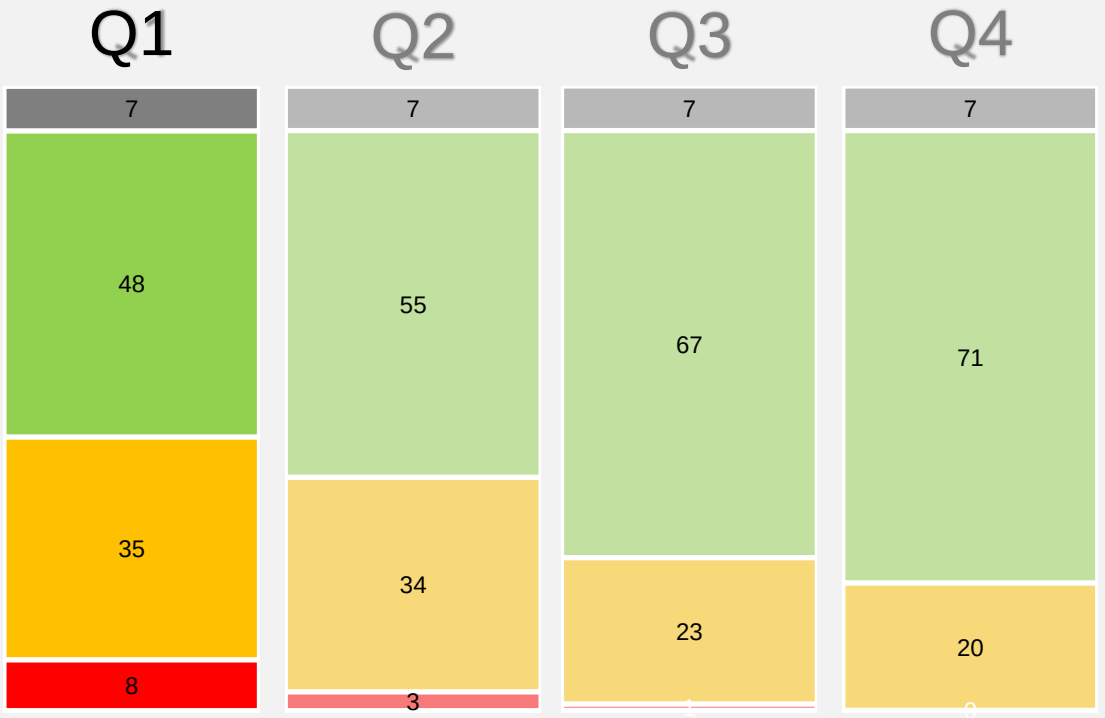
| | People | | | | | |
|---|---|---|---|---|---|---|
| | Target | | | Actual | | Month |
| | 18/19 | Jul-18 | Aug-18 | YTD | Trend | Status |
| **Workforce** | | | | | | |
| Sickness Absence Rate | 3.75% | 4.21% | 4.45% | 4.16% | ↑ | |
| Staff Turnover | 8.5% | 9.51% | 9.59% | 9.66% | ↑ | |
| Mandatory Training | 90.0% | 88.9% | 89.3% | 88.4% | ↑ | |
| Appraisal Rates - Total | 90.0% | 95.6% | 95.6% | 71.3% | ↔ | |

# OPERATIONAL PLAN PERFORMANCE

The Dudley Group NHS Foundation Trust

## Q1 2018/19




1 Deliver a great patient experience

2 Deliver safe and caring services

3 Drive service improvement, innovation & transformation

4 Be the place people choose to work

5 Make the best use of what we have

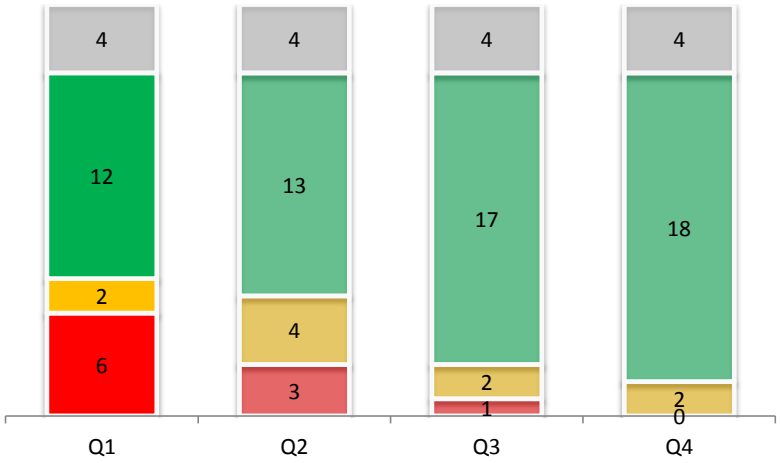
6 Deliver a viable future

The Dudley Group NHS Foundation Trust

# SO1: 2018/19

**Annual Plan Quarterly Monitoring Strategic Objective Overview: Quarter One**

## Summary of RAG Rating


## What is going well?

1. There has been an improvement in the response rate to the Family and Friends Test (FFT) in most areas with the exception of Community. Survey scores have met their targets in Maternity and Community.
2. The results of the 2017 Inpatient Survey have showed significant improvement.
3. There has been a consistent reduction in the number of Delayed Transfers of Care which are below the 3.5% of bed days and there has also been a reduction in stranded and super-stranded patients.
4. The Surgical Assessment Unit has been reconfigured for ambulatory patients and the Acute Medical Unit reconfigured for rapid assessment bays.
5. Patient access targets (99%) for diagnostics have been met (99.3%).
6. The MCP Transition Board has been established and is meeting monthly. The Board is overseeing the development and implementation of the MCP Division and pathways.

## What is going not so well?

1. The FFT survey scores for Inpatients, A&E and Outpatients require further improvement.
2. 86% of patients are admitted, transferred or discharged within 4 hours of their arrival at an A&E (target 90%). There is increased demand on Emergency Department Services and Acute Medical Admissions.
3. Transfers of care for out of area patients remain an issue but are being escalated on a daily basis.
4. 79% of patients referred for cancer are treated with 62 days (target 85%).
5. There could be slippage on MCP Programme as there are delays in annoucement of the contract. It is currently expected on 26th July 2018.

## Key Risks & Mitigation

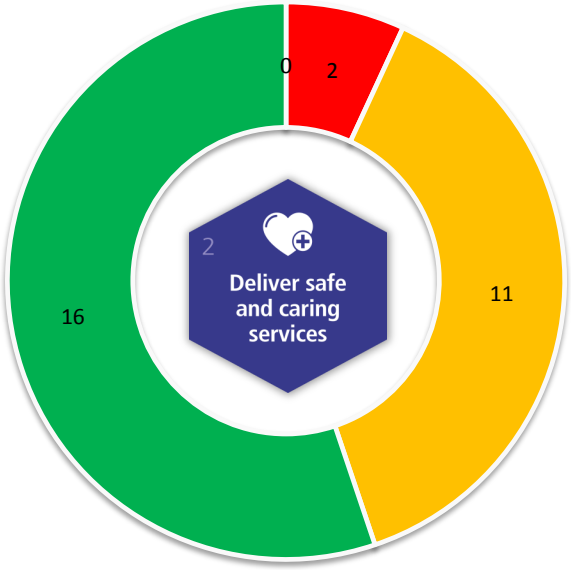
1. FFT response rates are being improved through the use of Feedback Fridays, volunteers, FFT champions and SMS messaging. Interactive voice messaging is being proposed.
2. The Patient Experience Group is focused on delivery of improved patient expereince.
3. Plans to improve waiting times in A&E are in place and are being monitored by the A&E Delivery Board.
4. Twice weekly meetings are in place to improve cancer targets. Patient tracking and escalation processes have been implemented and strengthened.
5. The Clinical Strategy Group including DGFT and Commissioners is being reinvigorated.

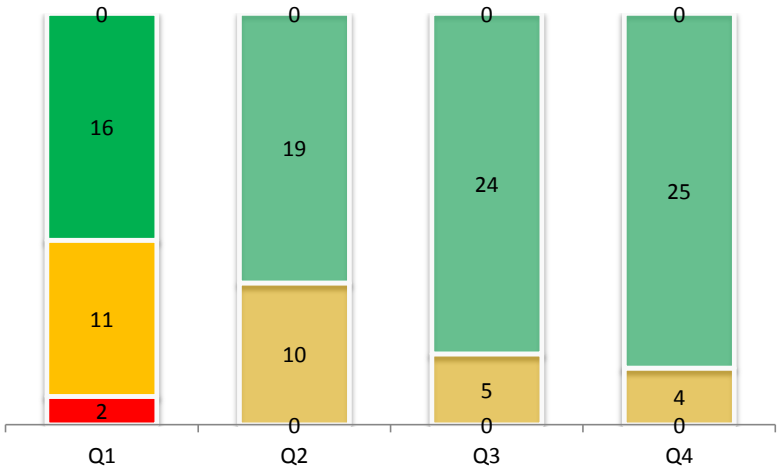
The Dudley Group NHS Foundation Trust

# SO2: 2018/19

**Annual Plan Quarterly Monitoring Strategic Objective Overview: Quarter One**

## Summary of RAG Rating




## What is going well?

1. Quality targets for Pain, community Pressure Ulcers, C. Difficile, MUST, Community and Medication and Discharge Management have been met. NEWS, PEWS and MEOWS indicators have also met their targets.
2. The implementation of the Gold Standards Framework.
3. The Trust is performing significantly better than the national average for falls (National average 6.63/1000 bed days, DGFT 3.90/1000 bed days) and falls with avoidable harm (national average 0.19 bed days, DGFT 0.06/1000 bed days).
4. Reduction in nursing vacancy rates and improvement in recruitment of contracted qualified nurses.
5. There has been an increase in the incident reporting rate. Within Quarter 1, there has been a 15% increase in incident reporting as compared to Q1 in 2017/18 .
6. The Learning from Deaths policy has been updated and multidisciplinary reviews have taken place for a high percentage of deaths.
7. 60% of Consultant job plans have been drafted and the review and agreement by Clinical Service Leads are underway.

## What is going not so well?

1. Quality targets for hospital Pressure Ulcers, nutrition, MUST hospital have not been met.
2.The reporting of Serious Incidents to commissioners within 60 days has not always occurred, predominately in respect to Pressure Ulcer care.
3. Patient notes are not always available in a timely way for multidisciplinary mortality review.
4. The CQC inspection rating for ED is inadequate.
5. 40% of Consultant job plans are to be drafted, reviewed and agreed by Clinical Service Leads.
6. The Fluid balance (target 995, Quarter 1 91%) has not been met.
7. The Sepsis target of administering IV antibiotics within one hour has not been met (Target 90%, Quarter 1 75%).

## Key Risks & Mitigation

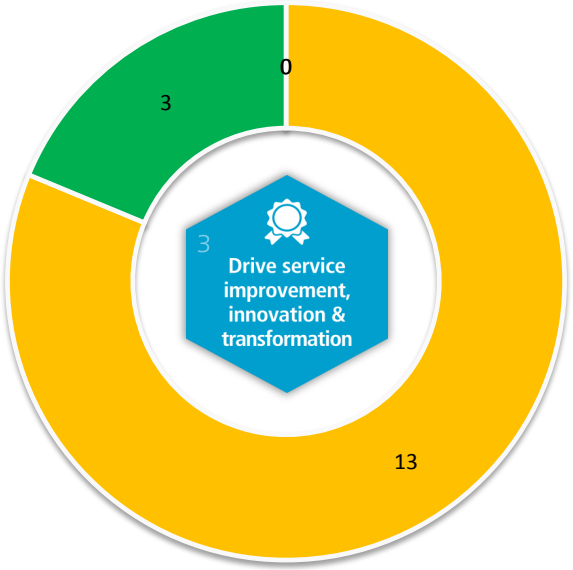
1. A trajectory is being produced by the Tissue Viability Team for their backlog of Serioius Incidents by end of September 2018. Patient Safety Advisers are supporting the reporting of serious incidents.
2. Structured Judgement Review training will be undertaken in October 2018 and an external mortatlity review is being arranged. A move to electronic patient notes will help to resolve issues with mortality reviews. The communication programme for these are being led by the Medical Director to help secure medical engagement.
3. Action plans are in place and being monitored to improve the quality targets which have not been achieved.
4. E-sepsis will be launched in August to support improvements in Sepsis screening and treatment.
5. An improvement plan is in place for ED to address the concerns raised by CQC and there is robust internal and external oversight. Internally, progress is reported to Board.
6. Four Eyes Insight are supporting the consultant job planning process.

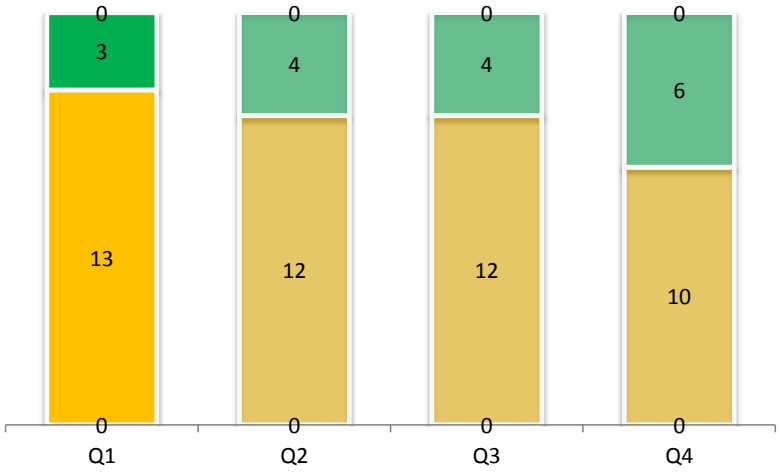
The Dudley Group NHS Foundation Trust

# SO3: 2018/19

**Annual Plan Quarterly Monitoring Strategic Objective Overview: Quarter One**

## Summary of RAG Rating




## What is going well?

1. There is positive progress on increasing access to seven day services. Imaging, Pathology and Pharmacy are available seven days a week.
2. A scheduling tool has been implemented in theatres to enhance efficiency through improved scheduling of patients.
3. A full 24/7 Interventional Radiology Service is in place for vascular and non-vascular procedures.
4. A Single Point of Access (SPA) has been developed and will be available from July to increase community and pathway referrals for admission avoidance pathways.
5. Service redesigns for Cardiology and Opthalmology are underway to improve the services offered to patients.

## What is going not so well?

1. Not all non-elective patients are seen by a consultant within 14 hours of admission and there are improvements to make in some specialties with the ongoing review of patients by consultants (Urology and Trauma).
2. Improvements in the way in which theatre lists are scheduled still need to be implemented in some specialties but a plan is in place to achieve this.
3. Pre-operative assessment processes are being reviewed to improve the quality and efficiency of clinics.
4. The recommendations from Get It Right First Time (GIRFT) Reviews of some specialties are in the process of being implemented.
5. The turnover of Pharmacy staff is impacting on progress to increase clinical Pharmacy time (target 80%, Quarter One 70%), implementatin of e-Chemo, and the implementation of pharmacy prescribers (target 70% Quarter Obne 37%).

## Key Risks & Mitigation

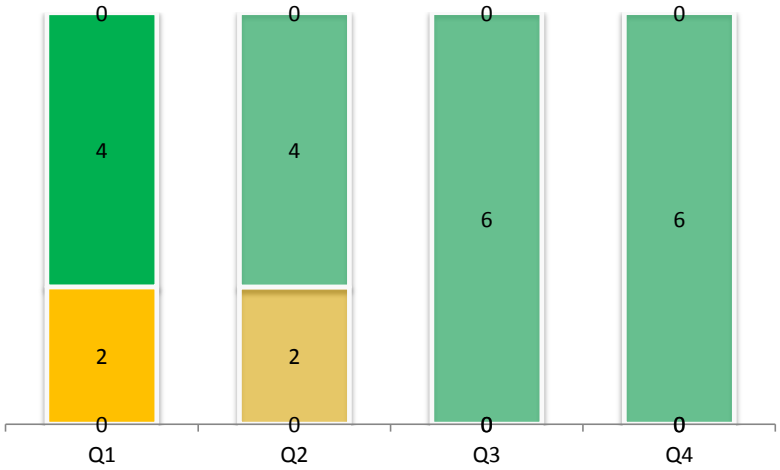
1. The SPA will improve admission avoidance, reduce ambulance conveyance for patients aged over 75 years and will receive referrals from community and primary care services.
2. A review of consultant input into non-elective pathways in Trauma and Urology will improve the number of patients seen in 14 hours by a consultant and their on going review.
3. A plan is in place to review half day theatre lists in Ophthalmology and Pain.
4. Four Eyes Insight is reviewing pre-operative assessment processes and recommending improvements identified.
5. Plans are in place to implement GIRFT review recommendations.
6. Plans are in place to fill vacancies and support retention in Pharmacy. Work is also underway to ensure the correct skill mix is in place.
7. Revised plans have been agreed with NHS England for implementation of E-Chemo.

The Dudley Group NHS Foundation Trust

# SO4: 2018/19

**Annual Plan Quarterly Monitoring Strategic Objective Overview: Quarter One**

## Summary of RAG Rating


## What is going well?

1. The staff sickness absence rate has improved from April 2018 with rates now below 4% (target 3.5%). This has risen above 4% in June but continues to demonstrate good levels of employee attenance.
2. The Trust has performed very well in engaging with staff and there is an over 95% compliance rate for staff appraisal (target 90%).
3. The compliance rate for Mandatory Training has also been very positive with the rate (88%) just under the target of 90%.
4. The staff turnover rate (10.5%) is better than the national average (11.4%).

## What is going not so well?

1. Further work is required to support staff engagement with under 40% of staff taking part in the 2017 national staff survey. The appointment of the Staff Engagement Lead alongside a plan to support and enhance employee engagement will provide positive outcomes.

## Key Risks & Mitigation

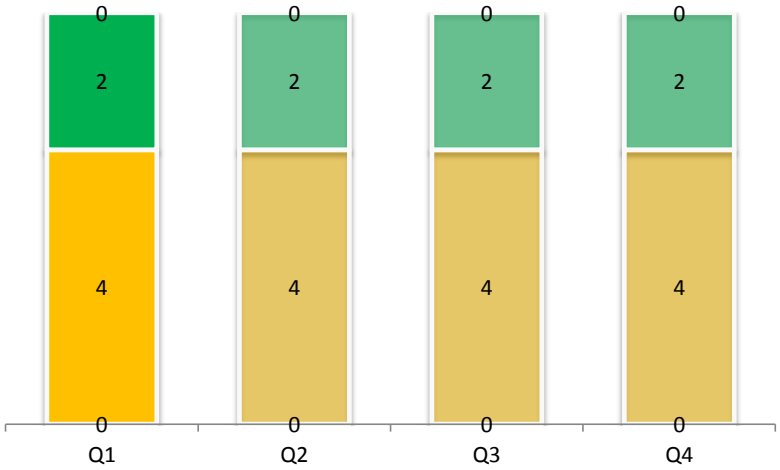
1. The risks associated to all workforce indicators is our ability to motivate and retain staff. The compliance rate for appraisals and the emphasis on listening and engaging positively with staff will support motivation and show the continued fall in turnover rate that demonstrates we are the Trust where people choose to work.
2. The Head of Communications and HR Director are exploring the use of CleverTogether as a tool to support extensive staff engagement.
3. A series of Learning into Action Events across the organisation are being planned and will be led by the Chief executive supported by other Directors.

The Dudley Group NHS Foundation Trust

# SO5: 2018/19

**Annual Plan Quarterly Monitoring Strategic Objective Overview: Quarter One**

## Summary of RAG Rating


## What is going well?

1. The Patient Safety Strategy has been drafted and will be approved following consultation.
2. The Research Strategy has been approved by Board and further refresh is underway.
3. A Medical Workforce Strategy is being developed and is on-track for March 2019.
4. Latest CIP forecast at £18.6m which is £3.2m favourable to plan.
5. The finances reported in Month 3 are in-line with plan.

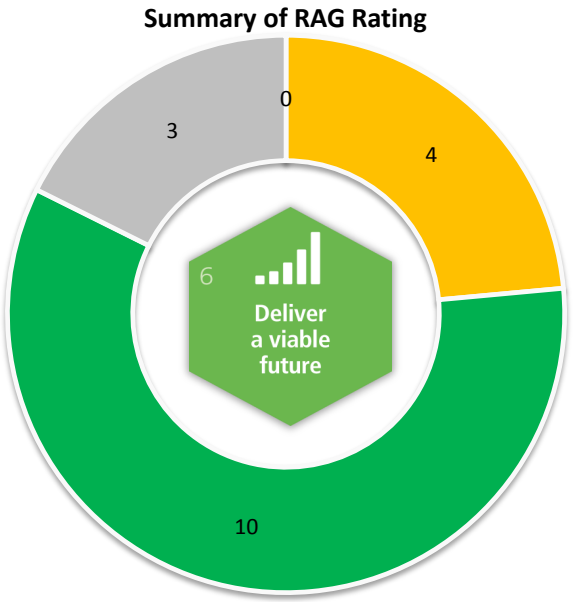
## What is going not so well?

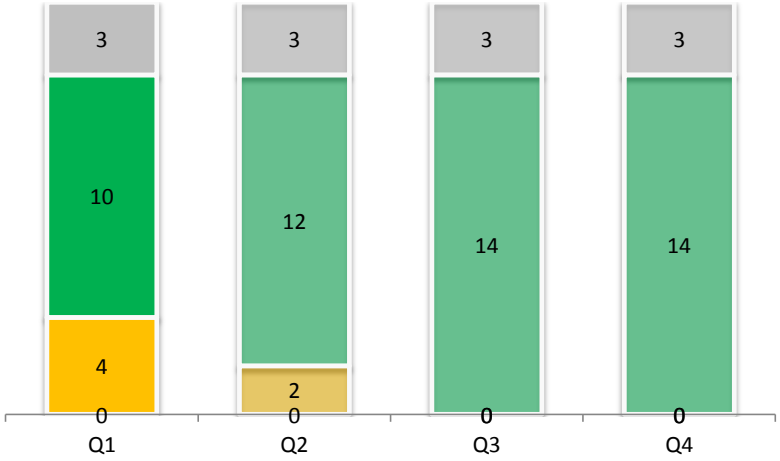
1. A number of CIP schemes are not progressing as planned and may potentially impact to the forecasted value of £18.6m.
2. The delivery of month 3 finances has depended on a number of non-recurrent adjustments.
3. Demand and capacity plans need further development in some specialties which will support a reduction in Waiting List Initiatives.

## Key Risks & Mitigation

1. Mitigating projects are being developed to further support the CIP forecast value. The progress of delivery of CIP is being reviewed by the Financial Improvement Group on a monthly basis.
2. The underlying financial position at month 3 indicates, without rectification, that the full year financial plan is at significant risk of delivery. The rectification plans are in place to mitigate this risk.
3. There are recruitment plans in place for consultants and middle grade doctors tto decrease waiting list initiatives and support demand and capacity planning.

**Annual Plan Quarterly Monitoring Strategic Objective Overview: Quarter One**




## What is going well?

1. The Eobs system has been deployed as part of the Digital Trust Programme. Launch of the eSepsis module is scheduled August 2018 and the clinical modules scheduled for 2018/19 are on track.
2. Five proof of concept sites are live for the shared patient record between GPs and the Trust. Data flow is taking place.
3. The Trust is playing a full part in the implementation of the Black Country Pathology and Procurement programmes.
4. A draft Estates Strategy is in place and requires review and approval from Directors and the Board.
5. The Black Country Pharmacy workstreams for medicine safety and optimisation have been scoped.
6. The MCP Transition Board has been established and is meeting monthly. The Board is overseeing the development and implementation of the MCP Division and pathways.
8. Nurse recruitment events have been successful with 109 appointments made which supports the ambition to reduce agency staffing. 15 nursing associates are commissioned.

## What is going not so well?

1. Funding is required for additonal GP sites for the implementation of the shared patient record which will not be potentailly available until MCP board established and contract award.
2. The achievement of recruitment key performance indicators, particularly meeting the target for shortlisting and interviewing, continue to be poor.

## Key Risks & Mitigation

1. The risk of delays in the recruitment process leads to additional temporary staffing costs. Therefore, there continues to be focus at Divisional performance reviewsmeetings to divisions having this as a priority.

Enclosure 10

The Dudley Group
NHS Foundation Trust

**Paper for submission to the Board of Directors on 4 October 2018**

| | | | |
|---|---|---|---|
| **TITLE:** | **Finance and Performance Committee Exception Report** | | |
| **AUTHOR:** | Tom Jackson<br>Director of Finance | **PRESENTER** | Jonathan Hodgkin<br>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:**<br><br>Summary report from the Finance and Performance Committee meeting held on 27 September 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** | **27 September 2018** | **Jonathan Hodgkin** | **yes** | **no** |
| | | | **Yes** | |

**Declarations of Interest Made**

**None**

**Assurances Received**

Finance and Efficiency

- Unsigned Budgets. Theatre staff supernumerary time period has been costed and approved to go to Board for approval. C2 is close to agreement. AMU medical and nursing budgets remain as outstanding issues, with progress to be brought back.
- The Year To Date position is a £2.6m deficit which is £0.6m below the Year To Date plan. The forecast position has deteriorated slightly to £10.2m deficit.
- Cash balances at the end of August amounted to £7.1m. This is £0.9m above plan and £1.6m worse than the previous month. The cash management plan agreed in August will now need to be enacted as we move through October.
- The CIP forecast is £17.1m. The Committee pressed to make sure that the additional in year efficiency initiatives, previously approved by business case, are identified separately within monthly reporting.
- The Committee sought assurance regarding the forecast position and necessary recovery plans. It was agreed to hold a special F and P to confirm forecast, recovery plans and also to review the draft presentation for the NHSI Q2 review in November.

Performance

- A and E remains busier than ever with increasing activity and this continues to challenge delivery of the 4 hour target. Challenges also remain with the delivery of Cancer 62 day targets, although the Trust remains on track to achieve Q3. RTT performance benchmarks strongly.
- Coding changes in September 2017 have been suggested to be impacting on HSMR mortality data with a detrimental effect.
- The Committee noted the excellent performance for income and RTT performance during August by the Surgical Division.

Workforce

- Nursing – A robust conversation explored the significant staff recruitment and recruitment challenges. It is accepted that further innovative options will need to be considered, with a focus on retention.
- Medical – The Committee heard how a significant proportion of spend is based on temporary staffing arrangements which has been compounded by CQC recommendations. The Acute Medical Unit is a particular area of concern as a significant proportion of medical staffing spend is on temporary staffing arrangements.

Estates and Procurement

- The PFI update was received and noted

| |
|---|
| Board Assurance Framework<br>• Amendments to the BAF were presented and confirmed by the Committee |
| **Decisions Made / Items Approved** |
| • There were no decisions made by the Committee. |
| **Actions to come back to Committee** |
| • C2 and AMU Budget updates<br>• Detailed analysis of forecasts and recovery plans plus proposed presentation to NHSI (Special F and P) |
| **Performance Issues to be referred into Executive Performance Management Process** |
| • Consultancy spend |
| **Areas of Risk to be escalated onto the Corporate or Divisional Risk Register** |
| • Nursing workforce risk score to be reviewed |
| **Items referred to the Board for decision or action** |
| • Deteriorating Income and Expenditure position<br>• Rectification plans require further work<br>• Progress on unsigned budgets is being made<br>• A & E performance behind trajectory<br>• Cancer 62 day performance on track to achieve Q3 trajectory<br>• Continued good performance against Referral to Treatment (RTT) targets<br>• DM01 target missed in August, but expected to be achieved in September |

Enclosure 11

The Dudley Group
NHS Foundation Trust

**Paper for submission to the Trust Board**
**October 2018**

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

## CORPORATE OBJECTIVE:

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

## SUMMARY OF KEY ISSUES:

The Programme Director Peter Lowe has moved to the Transformation team to Lead the Lean Project. The CIO will until March 2019 take on the direct responsibility for Programme Management.

**eObs/eSepsis**

A number of dashboard have been developed for eObs adoption continues to improve with with significant gains in adoption within ED. Activity involving the new CNIO and CCIO's is ongoing to identify the correct device for each use case.

The following devices have been deployed at ward level :-

449 Tablets
89 Workstations on Wheels(WOW's)
90 Tracking boards (Nurse stations)
75 eSepsis Workstations (Nurses stations)

eSepsis went live on Wednesday 5th September across the Trust after training adherence had reached the minimum level. Dashboard are currently under development for this module and will be on-line during October.

Later deployments of functionality will be reliant on existing PC equipment. The Trust has 2,500 PC's of which 1,100 are older than 7 years and not fit for purpose for Sunrise, windows 10 and additional malware protection could further decrease performance. Funding is available for the replacement of 750 PC's per annum (starting 18/19) for the next 3 years, priority will be given to PC's older than 7 years in clinical areas. Project planning has commenced.

**Project phases**

Additional continued support for eSepsis and eObs are utilising project resources which could cause a risk with the project completion date of 31/3/19. A workshop with Allscripts has taken place to review the specifications for each delivery :-

ePMA
Orders Management
Theatres
Maternity
Clinical documentation (includes OPD)
NEWS2 and eObs enhancements

Confidence still remains high on all deliveries with a full PID available by 30/9/18 detailing delivery of each phase.

**VTE**

Based upon advice from consultants representing the Thrombosis committee the interim deployment of VTE for October was deferred to a Q4 delivery when it can be fully embedded into the admission document. The next rollout will be NEWS2 during October which will include Neuro observations and some modifications to the eObs functionality for palliative patients.

**TOR**

It was noted that Divisional representation both clinical and operational at the Digital Trust Programme Committee remains low. The TOR and meeting dates will be reviewed when the new Chair is on board.

## IMPLICATIONS OF PAPER:

| | | | |
|---|---|---|---|
| **RISK** | **Y COR089** | | **Risk Description:** EPR programme is delayed or fails to deliver benefits |
| | **Risk Register: Y** | | **Risk Score:** 20 |
| **COMPLIANCE and/or LEGAL REQUIREMENTS** | **CQC** | **N** | **Details:** |
| | **NHSI** | **N** | **Details:** |
| | **Other** | **N** | **Details:** |

## ACTION REQUIRED OF COMMITTEE:

| Decision | Approval | Discussion | Other |
|---|---|---|---|
| | | **X** | |

## RECOMMENDATIONS FOR THE BOARD

The Board is asked to note the progress of the Digital Trust Project and assurances that delivery will still be within Board approved Timescales and budget.

Enclosure 12

The Dudley Group NHS Foundation Trust

**Paper for submission to the Board on 4th October 2018**

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

**CORPORATE OBJECTIVES**

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

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

**SUMMARY OF KEY ISSUES:**

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

**IMPLICATIONS OF PAPER:**

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

**ACTION REQUIRED OF BOARD**

| Decision | Approval | Discussion | Other |
|---|---|---|---|
| **Y** | **Y** | | **Y** |

**RECOMMENDATIONS FOR THE BOARD**

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

The Dudley Group NHS
NHS Foundation Trust

# Committee Highlights Summary to Board

| Committee | Meeting Date | Chair | Quorate | |
|---|---|---|---|---|
| Workforce & Staff Engagement Committee | 4th September 2018 | Julian Atkins | **yes** | **no** |
| | | | Yes | |

## Declarations of Interest Made

No declarations registered.

## Assurances received

**Matters Arising & Presentations**

1. The Committee received confirmation of the re-opening of the work experience programme following a review that had been taking place since June 2018.
2. A review of the Junior doctor rotation was provided with an indication of ongoing vacancies and the positive impact that MTI recruitment has had on mitigating some of the risks associated with the vacancy level. The Committee requested that this update became a regular agenda item.
3. The Committee received a presentation on the Nurse Recruitment campaign highlighting the events taking place both internally and externally. This initiated a discussion on how successful the campaign will be in order to bridge the gap of over 300 nurse vacancies. The Director of HR advised the Committee of his intention to facilitate a broader discussion in order to generate a more radical strategy to support recruitment that would sit alongside the nurse recruitment events. The Committee asked to receive a detailed report at the next meeting.
4. The Committee received a new Exit Interview Process developed and delivered by the Staff Engagement Lead. The new process was well received and the Committee asked for analysis to be produced and provided indicating themes and how these would be addressed.

**Workforce Strategy**

5. The Committee received the revised Workforce Strategy and supporting Workforce Business Plan that reflected the workforce priorities for 2018/19. The Director of HR highlighted areas of success and areas for prioritization in 2018/19.
6. The Committee received an update on the strategy for supporting the Staff Survey in 2018. The Director of HR also confirmed that the Trust would be using a new partner for the staff survey this year. It was announced that 'Clever Together' would be our new partner with greater emphasis on supporting better staff engagement and a quicker response to outcomes following receipt of feedback.

7. The standard report highlighting risks associated with the workforce was presented. The Director of Workforce highlighted the main workforce related risks associated to the Corporate Risk Register, Workforce Directorate Risk Register and the draft Board Assurance Framework. The Director of HR raised a new corporate risk associated with delays in the issuing of contracts of employment.
8. The Committee received a policy update with confirmation on policies being developed but at this time no policies were reported as being out of date.

**Workforce Education**

9. The Committee received an update from the Head of Learning & Development highlighting the success of the Leadership Development Programme that is now in its fourth cohort. She also described how the programme will be revised with workshops supporting clinical leadership as well as working towards an accredited programme.

**Workforce Performance**

10. The Workforce Key Performance Indicators were presented to the Committee with an emphasis on sickness absence, employee relations, mandatory training and turnover. In terms of mandatory training the Committee requested that further emphasis was provided for Priority Two and Three training with risks associated to non-compliance made explicit. It was agreed that Priority Two and Three compliance rates would be highlighted specifically at monthly Divisional Performance meetings in order to determine performance and associated risks as well as provide plans to improve. This matter will also be discussed with the CQSPE Committee Chair.

**Workforce Strategy**

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

## Decisions Made / Items Approved

1. To receive regular reports on Medical Workforce gaps.
2. To receive the plan to support nurse recruitment at the next meeting.
3. To have Priority Two & Three mandatory training compliance highlighted at Divisional Performance meetings with an understanding of the level of risk associated to areas of non-compliance. To also discuss this matter with the CQSPE Committee Chair.
4. To add a new risk to corporate risk register associated to delays in issuing contracts of employment.

| **Actions to come back to Committee (items the Committee is keeping an eye on)** |
| --- |
| 1. The Committee require further feedback regarding:<br>• Medical Workforce Gaps;<br>• Nurse Recruitment Plan;<br>• Mandatory Training compliance performance for Priority Two and Three. |
| **Items referred to the Board for decision or action** |
| The Committee on this occasion does not require any decision from the Board. |

Enclosure 13

The Dudley Group NHS Foundation Trust

**Paper for submission to the Board on 4th October 2018**

| | | | |
|---|---|---|---|
| **TITLE:** | **Recruitment and Retention Overview** | | |
| **AUTHOR:** | **Andrew McMenemy, Director of Workforce & OD** | **PRESENTER** | **Andrew McMenemy, Director of Workforce & OD** |

**CLINICAL STRATEGIC AIMS**

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

**CORPORATE OBJECTIVE:** **SO4: Be the place people choose to work**

**SUMMARY OF KEY ISSUES:**

The attached paper provides an overview of recruitment and retention performance alongside initiatives to support improved performance. The paper is predominantly associated with nursing recruitment as this our most significant area of risk. However, it considers medical vacancies and measures to mitigate our current and future risks.

The paper also provides insight into retention of staff which is an area of particular focus in recent months. The information provided indicates some positive performance associated to turnover alongside some of the initiatives to support improved levels of staff engagement and retention.

**IMPLICATIONS OF PAPER:**

| | | | |
|---|---|---|---|
| **RISK** | **Y** | | **Risk Description:** |
| | **Risk Register: Y** | | **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 |
|---|---|---|---|
| | Y | Y | |

**RECOMMENDATIONS FOR THE BOARD:**

The Board to consider the current performance associated to recruitment and retention and provide support for the next steps with particular emphasis on nurse recruitment. To provide approval to proceed to the development of a business case that supports the development pathways to support local nurse recruitment:

1. Nurse Degree Apprenticeship (part-time or full-time)

2. Trainee Nursing Associate route followed by Nurse Degree conversion.

## Recruitment & Retention Plan

### 1. Background and Link to the Workforce Strategy

The Trust Workforce Strategy has six Strategic Priority Areas of which one is Recruitment and Retention. This is supported by the following aim:

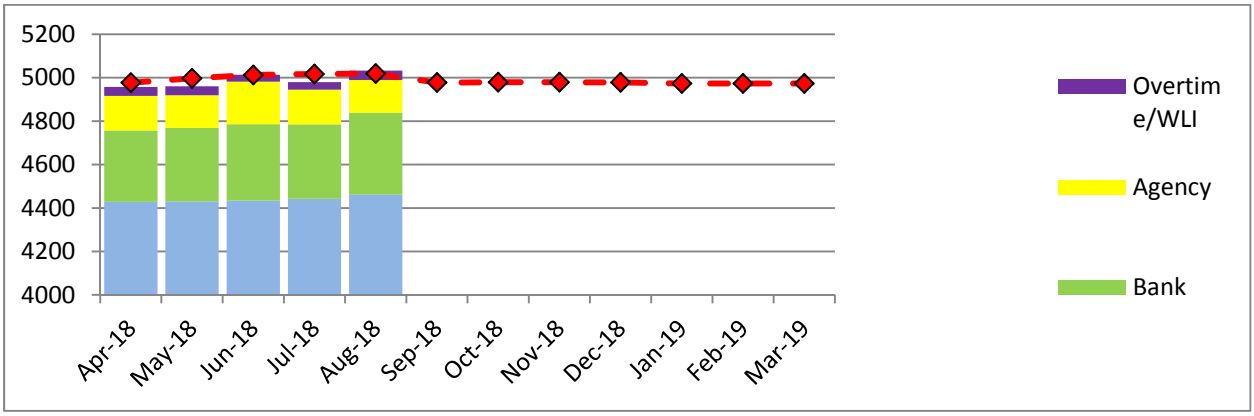
**We will have the right people in the right place within the framework of a sustainable workforce model.**

The identified Aim is also supported by three main Enablers described as:

- Strengthen the brand for the Dudley Group alongside a strategy for recruitment to high calibre candidates to the Trust.
- Develop an environment in the workplace that engages with staff effectively to support the Trust as a model employer and minimise retention.
- Support a coordinated approach to recruiting within our vacancy factor and eliminate agency use and support safer patient care.

### 2. Performance Indicators Associated to Recruitment

**Analysis of Workforce (FTE) to Funded Establishment**




| | Apr-18 | May-18 | Jun-18 | Jul-18 | Aug-18 |
|---|---|---|---|---|---|
| Funded Establishment | 4976.99 | 4997.33 | 5012.62 | 5016.93 | 5019.03 |
| Staff in Post (fte worked) | 4428.4 | 4430.63 | 4434.2 | 4442.43 | 4461.33 |
| Bank | 328.66 | 338.41 | 351.38 | 342.43 | 377.94 |
| Agency | 159.39 | 150.49 | 196.43 | 160.42 | 149.99 |
| Overtime/WLI | 40.89 | 41.18 | 31.68 | 34.55 | 43.8 |

The above table indicate an increase in the substantive workforce in the last 4 months. It continues to demonstrate a significant gap between the funded establishment and the staff in post. The gap between the funded establishment and staff in post generates the vacancy information in the Trust.

However, we are aware that a proportion of the difference between funded establishment and staff in post are within the recruitment process. The Workforce & Staff Engagement Committee has asked the finance team to work alongside the Workforce Team and Divisional Management teams to better understand posts that are being associated as vacant but where there has been no active recruitment for a considerable period of time. To provide context, in August 2018 the number of fte advertised for recruitment was 351.89 fte. This is split between the following staff groups as:

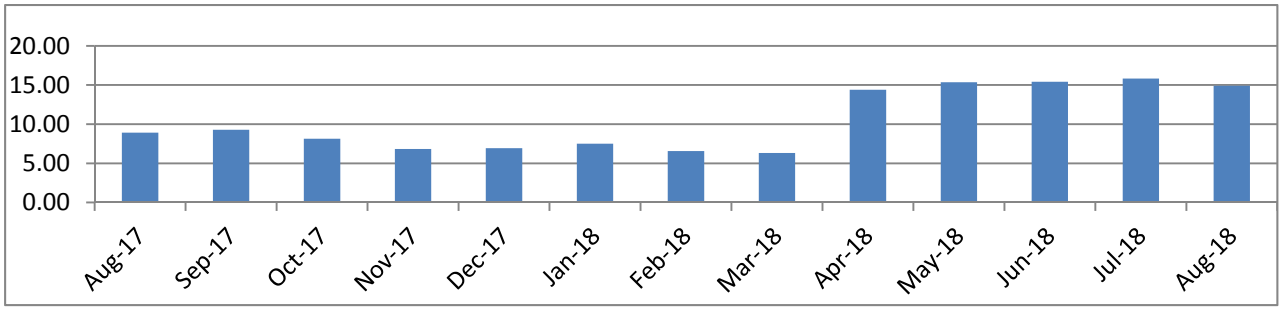
- Medical & Dental - 71 fte
- Nursing & Midwifery - 163.29 fte
- AHPs - 36.04 fte
- Admin & Clerical - 43.01 fte
- Clinical Support - 15.15 fte
- Prof, Technical & Scientists - 24.4 fte.

**Staff in Post – By Staff Group**

| Workforce by Staff Group | Aug-17 | Sep-17 | Oct-17 | Nov-17 | Dec-17 | Jan-18 | Feb-18 | Mar-18 | Apr-18 | May-18 | Jun-18 | Jul-18 | Aug-18 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Add Prof Scientific and Technic | 171.88 | 174.46 | 175.28 | 176.28 | 173.51 | 174.61 | 173.59 | 178.99 | 179.97 | 178.97 | 178.82 | 173.06 | **171.93** |
| Care Support Staff | 961.14 | 956.46 | 943.52 | 958.44 | 952.12 | 947.53 | 964.69 | 960.69 | 959.97 | 1003.43 | 978.28 | 980.78 | **986.10** |
| Administrative and Clerical | 856.10 | 854.42 | 862.55 | 860.95 | 857.26 | 860.25 | 862.24 | 871.63 | 870.98 | 878.57 | 873.34 | 884.07 | **897.60** |
| Allied Health Professionals | 288.54 | 300.54 | 296.77 | 297.87 | 297.74 | 305.21 | 306.63 | 307.85 | 303.19 | 300.13 | 298.33 | 299.22 | **300.08** |
| Healthcare Scientists | 110.47 | 110.65 | 110.89 | 114.62 | 114.62 | 114.75 | 114.75 | 111.79 | 111.01 | 110.27 | 109.27 | 109.53 | **108.53** |
| Medical and Dental | 456.80 | 465.74 | 475.21 | 475.51 | 474.86 | 477.46 | 480.36 | 479.68 | 471.61 | 469.01 | 471.05 | 466.05 | **469.91** |
| Nursing and Midwifery Registered | 1390.12 | 1404.54 | 1418.65 | 1415.84 | 1409.14 | 1430.52 | 1430.42 | 1432.01 | 1441.69 | 1441.01 | 1439.80 | 1432.33 | **1425.08** |

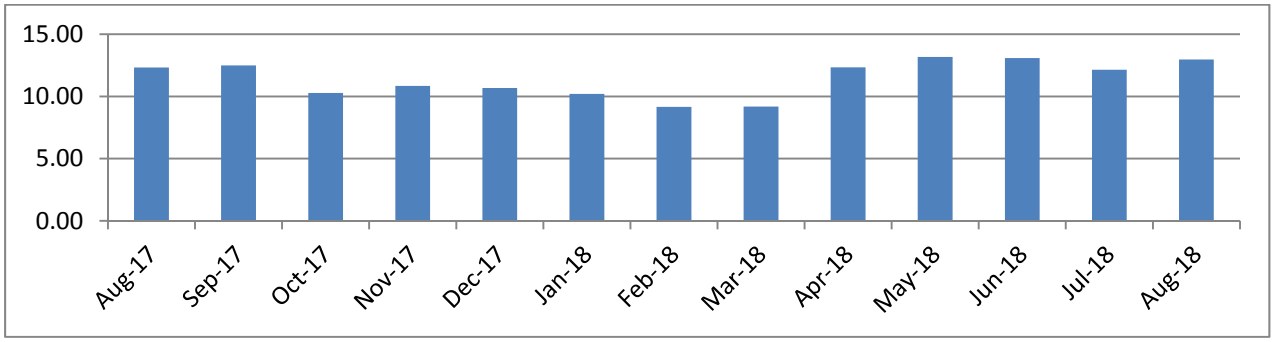
The above table demonstrates an increase in the substantive workforce across many of the staff groups. The main areas of both nursing and medical staff have seen increases over the last 12 months respectively.

**Nursing Workforce – Vacancies**




| Vacancy Rate (%) | Aug-17 | Sep-17 | Oct-17 | Nov-17 | Dec-17 | Jan-18 | Feb-18 | Mar-18 | Apr-18 | May-18 | Jun-18 | Jul-18 | Aug-18 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Monthly RN Vacancy Rate (%) | 8.92 | 9.28 | 8.14 | 6.84 | 6.94 | 7.50 | 6.57 | 6.32 | 14.39 | 15.36 | 15.41 | 15.83 | 14.91 |

**Medical Workforce - Vacancies**



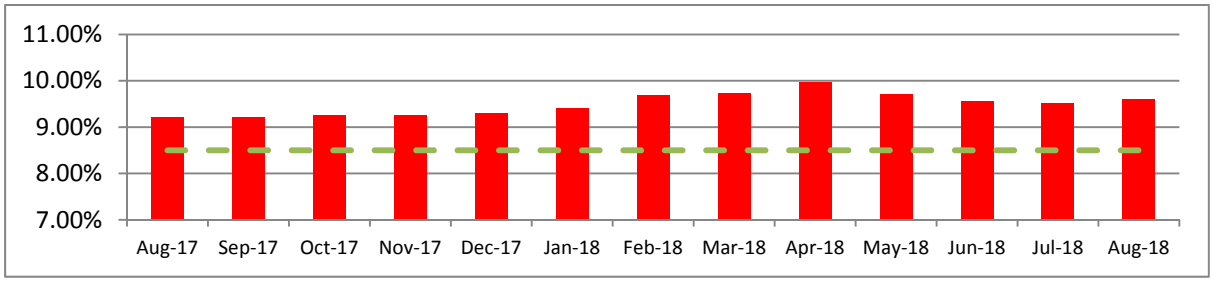

| Vacancy Rate (%) | Aug-17 | Sep-17 | Oct-17 | Nov-17 | Dec-17 | Jan-18 | Feb-18 | Mar-18 | Apr-18 | May-18 | Jun-18 | Jul-18 | Aug-18 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Monthly Medical Vacancy Rate (%) | 12.33 | 12.49 | 10.28 | 10.85 | 10.68 | 10.20 | 9.16 | 9.18 | 12.34 | 13.18 | 13.08 | 12.14 | 12.97 |

The Nurse vacancy trend demonstrates that the Trust had been working hard to reduce its vacancy rate to 6.32% in March 2018. This is against a national average vacancy rate for qualified nursing in acute Trusts of 11.8%. However, the nurse staffing review provided the requirement for additional nurse staff for the majority of ward areas and therefore the vacancy rate immediately increased to 14.39% in April 2018 and currently stands at 14.91% in August 2018.

In terms of Medical vacancies, this can fluctuate with the rotation period with August vacancy rate at 12.97%.

**Performance Indicators Associated to Retention**

The main indicator we use to determine our retention is associated to our turnover rate. We have provided a target of 8.5% (broken green line) to work towards against the national NHS average turnover rate of 11.2%. The table bellows demonstrates our turnover rate in the previous 12 months.




The information demonstrates that we had seen a continual rise in turnover from August 2017 to its peak in April 2018. However, this has declined from May 2018 until July 2018 where we have seen a fall in turnover rates. They currently sit at 9.59% for August 2018.

**Turnover by Staff Group**

| Workforce by Staff Group | Aug-17 | Sep-17 | Oct-17 | Nov-17 | Dec-17 | Jan-18 | Feb-18 | Mar-18 | Apr-18 | May-18 | Jun-18 | Jul-18 | Aug-18 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Add Prof Scientific and Technic | 12.86% | 12.28% | 12.53% | 17.81% | 12.26% | 10.68% | 12.72% | 11.89% | 13.60% | 13.44% | 12.89% | 12.96% | **11.30%** |
| Care Support Staff | 9.74% | 9.48% | 9.00% | 13.22% | 7.71% | 8.21% | 8.21% | 8.30% | 8.28% | 7.66% | 7.53% | 7.17% | **7.17%** |
| Administrative and Clerical | 9.90% | 9.79% | 9.94% | 10.30% | 10.76% | 11.34% | 11.38% | 11.54% | 12.29% | 12.37% | 12.50% | 12.65% | **13.71%** |
| Allied Health Professionals | 11.58% | 12.04% | 12.91% | 10.35% | 13.69% | 13.96% | 13.39% | 14.30% | 14.47% | 13.51% | 14.64% | 14.46% | **14.38%** |
| Healthcare Scientists | 8.34% | 10.00% | 10.76% | 11.57% | 9.48% | 9.42% | 8.55% | 9.40% | 8.86% | 9.83% | 11.88% | 15.53% | **16.62%** |
| Medical and Dental | 6.31% | 6.96% | 8.31% | 8.32% | 8.32% | 8.34% | 8.37% | 8.06% | 7.21% | 6.71% | 7.15% | 5.73% | **5.77%** |
| Nursing and Midwifery Registered | 8.22% | 8.04% | 7.91% | 7.94% | 8.60% | 8.87% | 8.89% | 8.69% | 8.94% | 8.94% | 8.00% | 7.83% | **7.75%** |

The above table demonstrates progressively improved turnover rates for Care Support Staff, Nurse & Midwifery and Medical Staff. The retention rates for the significant staff groups are well within the Trust target and also the national average for turnover rates. Therefore, contrary to concerns regarding retention rates the above statistics provide positive information regarding the three main staff groups where we have an ongoing emphasis regarding recruitment.

## 3. Action Plan to Support Enhanced Recruitment – Nursing & Medical Staff

**Nursing**

Taking consideration of the performance indicators, qualified nursing recruitment is our main priority. Taking consideration of the last 12 months, when you compare nurse new starters alongside nurse leavers we have only increased by 34.96 fte.

This conservative increase is not critical of the nurse recruitment events as these have been significantly more successful in the last 6 months. However, taking consideration of the number of vacancies and continued reliance on agency staff, the current recruitment strategy is not going to significantly reduce the vacancy rate.

The main nurse recruitment strategy is to focus on local and some national recruitment events working closely with local departments. The main actions to support this strategy that are currently in place:

- Nurse Recruitment events every month alongside bespoke events for areas of high vacancy rates.
- Rolling adverts for areas of high vacancy rates.
- To maximise the use of social media alongside NHS Jobs to attract candidates.
- To attend Nursing Job Fairs to promote Dudley as a place to work and attract prospective candidates.

The above actions are facilitated by Kerrie Walters, Nurse Recruitment Lead. This role was established 12 months ago to provide greater focus on nurse recruitment and provide specific support to nurse recruiting managers.

There are areas that have been identified that require further work to support this role and outcomes expected. These are:

- Exploring international recruitment.
- Branding locally at Trust level and/or alongside Black Country providers.
- Opportunities for rotational posts for newly qualified as well as established nurses.
- Enhancing the numbers of Band 4 Nursing Associate roles in order to create a nursing career pathway.

The final bullet point has generated significant discussion and is a strategy that is becoming increasingly popular in other acute providers. There is recognition that there is a national shortage of qualified nurses and therefore Trusts are looking towards developing their own career structure from within their own local community and workforce.

At present the Trust Care Support Worker staff are predominantly Band 2 and therefore their skills can sometimes be limited. It is recognised that there are opportunities to develop Band 3 Senior CSW roles with additional responsibilities and enhance this further with broader introduction of the Band 4 Nursing Associate role.

We are aware that we can more easily recruit to the CSW posts when advertised. In addition, the Trust have been working closely with Walsall College to develop the skills of our current and future CSW workforce.

This development prepares individuals to undertake their CSW/Nursing Associate role better but also provides the relevant preparation for those who wish to proceed to their nursing qualification.

The Trust is therefore considering what numbers of prospective Nursing Associate roles and therefore the conversion into training for qualified nursing would support a sustainable workforce plan alongside our current short term methods. The Trust has also discussed some of the barriers to potential candidates to this type of career development. The main barriers appear to be lack of understanding of what is available, the small numbers on offer at the Trust and the financial commitment required to undertake training.

It is therefore proposed that the Trust works more closely with Walsall College and Wolverhampton University to develop a career pathway that is supported by a commitment to greater numbers of Nursing Associates. In addition, that this proposal is supported by a reasonable financial package that removes some of the financial burden of training costs.

The benefits to this career model are:

- It supports local recruitment in a prospective workforce that may be less transient than other localities.
- A clear workforce plan that supports a sustainable model in 2 to 3 years.
- There can be some immediate benefits to having this enhanced workforce in place while undertaking training.
- It will support a reduction and hopeful elimination of agency expenditure in 2-3 years for nursing staff.

**Option Proposal to Support Nurse Recruitment**

There are two main development pathways:

3. **Nurse Degree Apprenticeship (part-time or full-time)**

4. **Trainee Nursing Associate route followed by Nurse Degree conversion.**

**Nurse Degree Apprenticeships Route**

Several trusts have implemented these posts with some variation on the salary being offered. The suggested training salary for Dudley is Band 3 salary for the duration of training Therefore the members of staff are employed for duration of degree. The two available options are:

- 3 Year Full time Nurse Degree – Employee paid full-time plus backfill for post (100% supernumerary)
- 4 Year Part time Nurse Degree – Employee paid full-time plus backfill for post (60% supernumerary)

The fees to support the degree programme are £27,500. This can be paid through the Apprenticeship Levy but could not be reclaimed from participants.

| | **Salary Costs** | **Backfill Costs** |
|---|---|---|
| **3 year Full time** | 100% | 100% |
| **4 year Part time** | 100% | 60% |

**Nursing Associate Route**

Current Trainee Nursing Associates are paid at Band 3 for the duration of their training. Once qualified as Nursing Associates, they are paid at Band 4 either in substantive Nursing Associate roles or until qualified as Nurses.

The member of staff trains initially as a Nursing Associate. Following completion of that qualification, undertakes a conversion course to complete the Nurse Degree Apprenticeship

**Nursing Associate Timescales**

- 3 months CSW role full time (completes the Care Certificate) – Supernumerary 100%
- 20 months Higher Apprenticeship: Nursing Associate (1 day per week study) – Supernumerary 20%

**Qualified as a Nursing Associate – Timescales**

- 19 months Registered Nurse Degree Apprenticeship (3 days per week study) - Supernumerary 60%*
- 3 months final placement full-time placement - Supernumerary 100%.

The course Fees associated with the Nurse Associate Route and toward qualified nurse are:

- Nursing Associate: £15,000
- Degree Conversion: £27,500.

This can be also paid through the Apprenticeship Levy but could not be reclaimed from participants.

| | Salary Costs | Backfill Costs |
|---|---|---|
| **3 months full time CSW Care Certificate** | 100% | 100% |
| **20 months Trainee Nursing Associate (Band 3)** | 100% | 20% |
| **19 months Qualified NA, Degree Apprentice** | 100% | 40%* |
| **3 months final placement Degree Apprentice** | 100% | 100% |

**Example 1 Degree Nurse Full Time:**

Recruit Band 3 Nurse Apprentice. They study full-time and are paid by the Trust during their training. Once qualified in 3 years, they have a substantive nurse post. During their placement they are likely to be placed at Dudley as student nurses but will remain supernumerary for the duration of the course.

There may be opportunities for them to work during non-academic study-time as a CSW and/or as bank staff around their academic studies.

**Example 2 Degree Nurse Part time**

Recruit Band 3 Nurse Apprentice. They study part-time and are paid by the Trust during their training. Once qualified in 3 years, they have a substantive nurse post. During their placement they are likely to be placed at Dudley as student nurses but will remain supernumerary for the duration of the course.

They will be working for 40% of their time and studying for 60% of their contracted hours.

There may be opportunities for them to work during non-academic study-time as a CSW and/or as bank staff around their academic studies.

**Example 3 Nursing Associate to Degree Nurse**

Recruit Band 3 Trainee Nursing Associate. They study part-time and are paid by the Trust during their training. During their training, they work part-time and study part time. They are only supernumerary for 20% of their work time. After 23 months, they qualify as a Nursing Associate. Once qualified, they are paid at Band 4 and in Nursing Associate roles.

Once qualified, they then sign up for a Nursing Degree conversion course. During the programme, they study part-time and are supernumerary for about 60% of their time until their final placement which is full-time study. This takes 22 months. Once complete they are a qualified Band 5 nurse.

There may be opportunities for them to work during non-academic study-time as a CSW and/or as bank staff around their academic studies.

**Medical Staff**

The vacancy level for medical staff is currently 12.14%. The two main areas of the medical workforce being Consultants have a vacancy rate of just over 10% while junior doctors in training posts have a vacancy rate of just over 10%. In both cases this is the lowest vacancy rate for over 12 months.

However, the vacancy rate for junior doctors in non-training posts is currently over 20% with the highest area of the Trust for vacancies being Clinical Support Services. The high vacancy rate in Clinical Support is not unexpected taking consideration of the change towards the Black Country Pathology Service from October 2018.

In terms of junior doctor posts the main areas to mitigate vacancy levels other than standard recruitment are:

- Medical Training Initiative Posts being extended across other specialities.
- Considering specialist senior nursing posts to fulfil some long standing medical vacancies.

In terms of Consultant posts the Trust has been relatively successful in appointing to this grade with the exception of Pathology posts. In the last few days the Trust has appointed two replacement Consultant Paediatrician posts and has generated a significant interest in the vacant posts for Consultants in Emergency Medicine.

There is a recognition for greater emphasis on understanding the workforce plans for medical staff by speciality and for Divisional Management teams to be addressing the solutions at the earliest possible stage. This would allow interventions to be put in place to avoid locum and agency expenditure as well as providing a sustainable solution to some of the vacancy issues.

## 4. Action Plan to Support Enhanced Retention

Taking consideration of the performance indicators, there is an emphasis on ensuring we have some turnover for our nursing staff but at the same time that is within reasonable parameters. At this time the nursing turnover at 7.83% is under our target of 8.5%. However, taking consideration of our significant level of vacancies it is even more crucial to minimise our turnover. This is particularly the case with certain high vacancy departments such as Vascular and Critical Care.

The Trust has recognised further emphasis on Staff Engagement and the drivers for turnover. Therefore the Trust have appointed a new Staff Engagement lead to facilitate and coordinate the current work to support retention and enhance this, taking consideration of her experience in the private sector.

In the short terms the Trust alongside all NHS bodies will be undertaking the National Staff Survey. Taking consideration of poor engagement previously the Trust has commissioned a new provider specifically aimed at addressing poor staff engagement. This is being supported with the new engagement and feedback forums for staff under the banner of the ‘Make it Happen’ events. This provides opportunities for staff to provide feedback directly to senior managers and ensure effective communication is being developed at all levels of the Trust.

In order to determine and better understand the reasons for staff leaving, the Trust has developed a new Exit Interview process. This was launched in September 2018 with regular feedback expected to be provided to the Workforce & Staff Engagement Committee. In addition, 'Back to the Floor' events undertaken by the Executive team alongside Board member informal walk arounds have also been reinstated.

As part of a longer term strategy to support engagement and retention the team are proposing and developing the following actions:

- Build on the successful leadership development programme.
- Have supportive career development sessions for staff to support them understand and realise their career ambitions within the Trust.
- Develop the staff support service in order to enhance the well-being of our staff. Some of this has commenced with a review of psychological support and physiotherapy services as well as published employee benefits.

## 5. Conclusion

The main focus associated to this paper is the significant level of vacancies for qualified nurses and therefore this should be the main priority. A Recruitment Summit regarding Nursing has been arranged for 12th October 2018. It is expected that the issues and initiatives highlighted in this paper will be explored further leading to immediate actions to address this issue.

The emphasis to support sustainability for nurse staffing will be further explored and commitment to the Nursing Associate route in large numbers to mitigate the future nurse vacancy issues.

There is clearly further progress to be made to support medical vacancies alongside the generation of pace around supporting some of the long standing issues. This therefore needs to be addressed directly with Speciality and Divisional leads alongside appropriate support.

Finally, improved staff engagement leading to better retention rates and more motivated and productive workforce is in everyone's best interest and particularly that of the patient. We have made a positive start in this area with further coordinated initiatives to support staff required before we can be comfortable with our staff engagement. The forthcoming Staff Survey will provide greater insight into the changes we need to facilitate to support our staff deliver better standards of care.

Enclosure 14

The Dudley Group
NHS Foundation Trust

**Paper for submission to Board**
**4 October 2018**

| | | | |
|---|---|---|---|
| **TITLE:** | **Board Assurance Framework and Corporate Risk Register** | | |
| **AUTHOR:** | Sharon Phillips – Deputy Director of Governance (Risk and Standards | **PRESENTER** | Glen Palethorpe – Director of Governance |

**CLINICAL STRATEGIC AIMS**

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

**CORPORATE OBJECTIVE:** All Objectives

The attached report includes the current BAF and a forward projection as to their risk scores for the next month.

The BAF is presented to each Board Committee at each of their meetings allowing them to consider the strength of assurance recorded against the debate and information received at that meeting. This process is to allow the Committee to engage in dialogue with the respective executive sponsor of the BAF item as to the current relative risk score. The BAF is also presented the Audit Committee at each of their meetings to allow them to consider the breadth of risk being carried by the Trust compared to the relevant target risks. The Audit Committee in their review of the BAF referred a number of areas back to the Executive Sponsors and the relevant oversight committee.

The report shows that the prediction for the current risk score in July to remain the same as that for June for objectives 1, 2 and 6 was not achieved. This was due to the increase in risk scores across 7 risks

- **BAF566** *Maintaining a high performance in national operational performance Standards in relation to Referral to Treatment times*
- **BAF 574** Compliance to the identification of all deteriorating patient Groups (e.g. Sepsis, haemorrhage, chest pain, neurosurgical emergencies)
- **BAF 577** Failure to deliver the CQC post inspection actions plans and improved the CQC inspection rating.
- **BAF694** The Trust's reputation for high quality, safe and effective care is damaged
- **BAF580** Delivery of staffing levels to ensure high quality patient care and consistent delivery (Medical, nursing, midwifery and AHP)
- **BAF564** Not achieving performance in national operational performance standards in relation to patient flow and delayed transfers for care. Capacity to meeting demand to achieve key contracts.
- **BAF 598** *EPR programme being delayed or failing to deliver the infrastructure to support new models of delivery in relation to core foundation system for digital.*

At August the Trust's BAF reflects the Trust's key risks (risk score 20), these are

- A - BAF 567 - *Maintaining high performance in national operational performance Standards in relation to Urgent Care to ensure robust triage, environment, working models and escalation and clinical pathways.* The Committee with oversight of this risk is Finance and Performance

- B - BAF 565 – *Maintaining high performance in national operational performance standards in relation to key cancer targets.* The Committee with oversight of this risk is Finance and Performance

- C - BAF 592 - *Inability to deliver the agreed financial recovery plan through 2019/2020* The

Committee with oversight of this risk is Finance and Performance.

- *D - BAF501 Ability to provide a safe, caring and effective service within the Emergency Department (inclusive of Immediate Assessment Area)* The Committee with oversight of this risk is the Clinical Quality Safety and Patient Experience Committee

- E - BAF 564 *Not achieving performance in national operational performance standards in relation to patient flow and delayed transfers for care. Capacity to meeting demand to achieve key contracts.* The Committee with oversight of this risk is Finance and Performance.

- F - BAF 574 *Compliance to the identification of all deteriorating patient Groups (e.g. Sepsis, haemorrhage, chest pain, neurosurgical emergencies)* The Committee with oversight of this risk is Clinical Quality Safety and Patient Experience Committee

- G - BAF 577 *Failure to deliver the CQC post inspection actions plans and improved the CQC inspection rating* The Committee with oversight of this risk is Clinical Quality Safety and Patient Experience Committee

- H – BAF580 *Delivery of staffing levels to ensure high quality patient care and consistent delivery (Medical, nursing, midwifery and AHP)* The Committee with oversight of this risk is Workforce Committee

- I – BAF694 The Trust's reputation for high quality, safe and effective care is damaged. The Committee with oversight of this risk is Clinical Quality Safety and Patient Experience Committee

- N - BAF 598 *EPR programme being delayed or failing to deliver the infrastructure to support new models of delivery in relation to core foundation system for digital.* The Committee with oversight of this risk is Digital Trust

The Trust's corporate risk register contains the Trust's corporate wide risks, some underpin the Trust's key BAF risks, there has been one new risk registered (COR748 *Governance arrangements from floor to board through divisional structures do not provide information on developing risks*) and one risk which has been judged to have reduced (COR638 *Failure to comply with the GDPR requirements*). This risk was reduced based on assurance provided by the Trusts Data Protection Officer.

**IMPLICATIONS OF PAPER:**

| | | | |
|---|---|---|---|
| **RISK** | | | **Risk Description:** Covers all risks |
| | **Risk Register: Y** | | **Risk Score:** Covers all risks |
| **COMPLIANCE and/or LEGAL REQUIREMENTS** | **CQC** | **Y** | **Details:** All Domains |
| | **NHSI** | **Y** | **Details:** Well led framework |
| | **Other** | **Y** | **Details:** |

**ACTION REQUIRED:**

| Decision | Approval | Discussion | Other |
|---|---|---|---|
| | | | **Y** |

**ACTIONS FOR BOARD:**

- To note the assurances provided by the respective Committee's that the current risk scores are reflective of the Trust's current position.
- To note the key risks facing the Trust

## BOARD ASSURANCE FRAMEWORK

### 1. Background

The Board Assurance Framework (BAF) is a process designed to provide evidence that the Trust is doing its reasonable best to manage the delivery of its objectives and to contain or mitigate its key risks. The BAF is also a key source of evidence that links strategic objectives to risks, controls and assurances. It is a key tool that the Board uses to demonstrate there is an effective system of internal control operating throughout the Trust.

The BAF records the key risks, assessed by the Executive team and challenged by the Board to the achievement of the Trust's stated objectives and annual goals. The BAF enables the Board to challenge whether management are effective in their management of the key risks to the delivery of the Trust's annual goals and mandated standards.

The Board sub-committees have a responsibility for the oversight of the key risks linked to their terms of reference. This allows these elements of the BAF to be considered and challenged against the debate and activity of the committee.

The Audit Committee supports the Board by seeking regular assurance over the risk management, governance and internal control process in operation to mitigate the Trust's key risks. The Audit Committee through its non-executive membership from each of the other Board Committee's seeks confirmation that each Committee is providing relevant and effective oversight of the Framework. The Audit Committee report to the Board enables to it to maintain confidence over the content and operation of the Framework.

An executive management level risk and assurance group receives both information on risks and assurance. This meets monthly and it provides the forum to assess this information against the corporate risk register, the key divisional risks and the BAF itself. This group supports and challenges the current risk score assessed by the nominated executive lead allowing a richer view of the current risk portfolio being managed by the Trust.

### 2. Summary of the Trust's risk profile against each of the Trust's objectives

| | Total number of risks | Total inherent risk score | Total value of risks at July | Predicted movement in these risks by end of month | Current value of risks at Aug | Expected movement in these risks by end of next month | Total target risk score |
|---|---|---|---|---|---|---|---|
| **Objective 1** – deliver a great patient experience | 6 | 120 | 90 | ➲ | 99 | ➲ | 66 |
| **Objective 2** – safe and caring services | 7 | 136 | 103 | ➲ | 117 | ➲ | 59 |
| **Objective 3** – drive service improvement, innovation and transformation | 3 | 60 | 43 | ➲ | 43 | ➲ | 39 |

| | Total number of risks | Total inherent risk score | Total value of risks at July | Predicted movement in these risks by end of month | Current value of risks at Aug | Expected movement in these risks by end of next month | Total target risk score |
|---|---|---|---|---|---|---|---|
| **Objective 4** – be the place people choose to work | 2 | 21 | 24 | ➲ | 24 | ➲ | 15 |
| **Objective 5** – make the best of what we have | 2 | 40 | 36 | ➲ | 36 | ➲ | 24 |
| **Objective 6** – deliver a viable future | 7 | 113 | 98 | ➲ | 102 | ➲ | 60 |

The Tracking of the BAF risks is summarised within the table at Appendix 1 and the underlying corporate risk register is summarised at Appendix 2.

## 3. Review of the BAF

The Trust's BAF is considered by each of the Board Committees supported by the work of the Executive Risk and Assurance Group which meets monthly.

**Audit Committee** – the Committee at its August meeting referred a number of risks back to their respective oversight committee and executive sponsor for review. The Audit Committee felt based on a number factors including the outcome of Internal Audit reviews, progress being made on their recommendations, other assurance providers such as the CQC as well as Trust performance as reported to the Board that the risk scores were not reflective of the current risk facing the Trust based on the assurance recorded within the BAF.

**Clinical Quality, Safety and Patient Experience Committee** – the Committee received an update on the BAF and the changes made since the Executive review following the Audit Committee's request. Specifically they received information on an increase in the following risks

- **BAF 574** Compliance to the identification of all deteriorating patient Groups (e.g. Sepsis, haemorrhage, chest pain, neurosurgical emergencies)
- **BAF 577** Failure to deliver the CQC post inspection actions plans and improved the CQC inspection rating.
- **BAF694** The Trust's reputation for high quality, safe and effective care is damaged

In respect of **BAF572** - Ability to deliver the Trust Quality Strategy priorities. risk score remained 15 (3X5) as the Quarter 1 results and planned actions to deliver these priorities were broadly on track. This risk will be reviewed again next month as the Trust's nears the reporting of Quarter 2 performance and will the assess the impact of those under delivering.

The Committee asked that the executive considered the level of regulatory compliance risk facing the Trust and report back through the next update to the BAF and Corporate Risk Register.

**Workforce Committee** the Committee received an update on the BAF and the changes made since the Executive review following the Audit Committee's request. Specifically they received information on an increase in the following risk

- **BAF580** Delivery of staffing levels to ensure high quality patient care and consistent delivery (Medical, nursing, midwifery and AHP)

**Finance and Performance Committee** the Committee received an update on the BAF and the changes made since the Executive review following the Audit Committee's request. Specifically they received information on an increase in the following risk

- **BAF564** Not achieving performance in national operational performance standards in relation to patient flow and delayed transfers for care. Capacity to meeting demand to achieve key contracts.

**Digital Trust Committee** the Committee received an update on the BAF and recommended based on the information received and debated at the Committee that the Executive the EPR risk.

- **BAF598** EPR programme being delayed or failing to deliver the infrastructure to support new models of delivery in relation to core foundation system for the digital trust.

## 4. Movements between July and August 2018

**BAF564** *Not achieving performance in national operational performance standards in relation to patient flow and delayed transfers for care. Capacity to meeting demand to achieve key contracts. The Committee with oversight of this risk is Finance and Performance*.

- The risk has increased from a current score of 16 (4X4) to 20 (5X4). Although there has been positive development with the appointment of the Deputy Director of Operations/Nursing and current performance for August 90% (type 1 and 2) there are still nurse staffing vacancies due to the ability to recruit, ED consultant vacancies and work needed in primary care to identify patients arriving to the acute trust who do not need an acute admission. In addition the risk of the ECIST focus on the flow in ED detracts from the medical model work.

**BAF566** *Maintaining a high performance in national operational performance Standards in relation to Referral to Treatment times*

- The risk has increased from a current score of 10 (2X5) to 15 (3X5) in response to a dermatology performance deteriorating due to consultant workforce challenges (reported to CQSPE).

**BAF 574** Compliance to the identification of all deteriorating patient Groups (e.g. Sepsis, haemorrhage, chest pain, neurosurgical emergencies)

- The risk has increased from 15 (3X5) to 20 (5X4). Although there has been some positive assurance from troponin and sepsis audits and a fall in sepsis mortality the Trust did receive a licence restriction from the CQC in relation to e-Obs.

**BAF 577** Failure to deliver the CQC post inspection actions plans and improved the CQC inspection rating.

- The risk has increase from 15 (3X5) to 20 (5X4). The risk score increase was in response to the 4th section 31 notice issued by the CQC following an unannounced visit in August 2018. In addition a report to CQSPE showed some ED actions overdue and gaps in section 31 compliance.

***BAF580*** Delivery of staffing levels to ensure high quality patient care and consistent delivery (Medical, nursing, midwifery and AHP)

- The risk has increase from 16 (4X4) to 20 (5X4). Although the monthly recruitment events continue and there has been harmonisation of day and night bank payment Monday to Friday the number of staff able to be recruited is low and retention of staff. Subsequently capacity continues to struggle to meet demand.

***BAF694*** The Trust's reputation for high quality, safe and effective care is damaged

- The risk has increase from 16 (4X4) to 20 (5X4). The increase in risk score was in response to negative media interest and adverse commentary on ED and relationships between staff and managers at various levels. This related to the commentary in the latest published CQC report in August 2018.

**BAF 598** EPR programme being delayed or failing to deliver the infrastructure to support new models of delivery in relation to core foundation system for digital.

- The risk has increased from 16 (4X4) to 20 (5X4). The increased score was in response to the extra demand placed on the delivery team from e-Obs and e-Sepsis roll out impacting on the ability to maintain the pace of digital transformation project.

## 5. Forecast movements for August

The Executive team are not forecasting the movement of any risks in September 2018

## 6. Top Board Assurance Risks

The risks in August with a current score of 20 are

- A - BAF 567 - *Maintaining high performance in national operational performance Standards in relation to Urgent Care to ensure robust triage, environment, working models and escalation and clinical pathways.* The Committee with oversight of this risk is Finance and Performance

- B - BAF 565 – *Maintaining high performance in national operational performance standards in relation to key cancer targets.* The Committee with oversight of this risk is Finance and Performance

- C - BAF 592 - *Inability to deliver the agreed financial recovery plan through 2019/2020* The Committee with oversight of this risk is Finance and Performance.

- *D - BAF501 Ability to provide a safe, caring and effective service within the Emergency Department (inclusive of Immediate Assessment Area) The Committee with oversight of this risk is the Clinical Quality Safety and Patient Experience Committee*

- E - BAF 564 *Not achieving performance in national operational performance standards in relation to patient flow and delayed transfers for care. Capacity to meeting demand to achieve key contracts.* The Committee with oversight of this risk is Finance and Performance.

- F - BAF 574 Compliance to the identification of all deteriorating patient Groups (e.g. Sepsis, haemorrhage, chest pain, neurosurgical emergencies)

- G - BAF 577 Failure to deliver the CQC post inspection actions plans and improved the CQC inspection rating

- *H – BAF580* Delivery of staffing levels to ensure high quality patient care and consistent delivery (Medical, nursing, midwifery and AHP)

- *I – BAF694* The Trust's reputation for high quality, safe and effective care is damaged

- N - BAF 598 *EPR programme being delayed or failing to deliver the infrastructure to support new models of delivery in relation to core foundation system for digital.* The Committee with oversight of this risk is Digital Trust

The risks in August with a current score of 16

- J - BAF 583 *Transformation and redesign of services not delivered to drive efficiency and improve key services in relation to outpatients, theatres, ophthalmology, GIRFTH, single point of access and pharmacy.* The Committee with oversight of this risk is Finance and Performance

- K - BAF 615 *Failure to deliver 2018/19 Cost Improvement Programme.* The Committee with oversight of this risk is Finance and Performance

- L - BAF 595 *Not maximising benefits through collaborative working in relation to BCA work streams in relation to investment in the Vanguard programme, implementation of revised pathways and staff engagement in the change process*. The Committee with oversight of this risk is Finance and Performance

- M - BAF 597 *Not having the right staff to deliver our clinical services currently and in the future*. The Committee with oversight of this risk is Workforce

The following table provides an overview where the top risks sit related to their current score and oversight group.

| | Likelihood | |
|---|---|---|
| **Impact score** | **4** | **5** |
| | **Likely** | **Almost certain** |
| **5 Catastrophic** | **20** E F D G H C I N | **25** |
| **4 Major** | **16** J K L M | **20** A B |

Key: Committees – arrow shows the predicted direction of travel

F & P | CQSPE | Workforce | Digital Trust

## 7. Corporate Risk Register

During the month of July there has been

- One new risk registered, COR748 *Governance arrangements from floor to board through divisional structures do not provide information on developing risks.*
- *One risk* COR638 *Failure to comply with the GDPR requirements* This risk has reduced from 9 to 6 based on assurance provided by the Trust's Data Protection Officer to the Caldicott and Information Governance Group, There remains work to be completed to achieve the target risk score of 3 with further assurance as to the Trust's position to come from Internal Audit's review of the IG toolkit in the latter part of the year.
- There have been no increases in any corporate risk.

## 8. Conclusion

The Trust has seen an increase in the risk scores of 6 significant risks following a full review of each to reflect the outcome of audit and CQC inspection reports, there is also an increase in one of the moderately rated BAF risks.

## BOARD ASSURANCE TRACKING OF RISK SCORES

| Oversight Committee | Risk Lead | Ref | Risk Title | Date entered on Risk Register | Initial Risk Score | Current Risk Score | | | | | | Trend | Target Risk Score |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | | 10/04/18 | 25/05/18 | 16/06/18 | 16/07/18 | 16/08/18 | | | |
| **Objectives: SO1 Deliver a great patient experience** | | | | | | | | | | | | | |
| **CQSPE** | **CN** | BAF568 | Risk of the level of engagement & involvement of patients, carers and the public in their care and the work of the Trust | 01/05/18 | 5X4 (20) | 3x4 (12) | 3x4 (12) | 3x4 (12) | 3x4 (12) | 3x4 (12) | | → | 2x4 (8) |
| **F & P** | COO | BAF564 | Not achieving performance in national operational performance standards in relation to patient flow and delayed transfers for care. Capacity to meeting demand to achieve key contracts. | 04/04/18 | 5X4 (20) | 5X4 (20) | 4X4 (16) | 4X4 (16) | 4X4 (16) | 4X5 (20) | | ↑ | 4X4 (16) |
| **F & P** | COO | BAF567 | Maintaining high performance in national operational performance Standards in relation to Urgent Care to ensure robust triage, environment, working models and escalation and clinical pathways | 04/04/18 | 4X5 (20) | 4X5 (20) | 4X5 (20) | 4X5 (20) | 4X5 (20) | 4X5 (20) | | → | 3X5 (9) |
| **F & P** | COO | BAF565 | Maintaining high performance in national operational performance Standards in relation to Key Cancer targets | 04/04/18 | 4X5 (20) | 3x5 (15) | 4X5 (20) | 4X5 (20) | 4X5 (20) | 4X5 (20) | | → | 3x5 (15) |
| **F & P** | COO | BAF 569 | Maintain high performance in national operational performance standards in relation to imaging for timely access to diagnostics | 04/04/18 | 5X4 (20) | 3x4 (12) | 3x4 (12) | 3x4 (12) | 3x4 (12) | 3x4 (12) | | → | 2x4 (8) |
| **F & P** | COO | BAF566 | Maintaining a high performance in national operational performance Standards in relation to Referral to Treatment times | 04/04/18 | 4X5 (20) | 2X5 (10) | 2X5 (10) | 2X5 (10) | 2X5 (10) | 3X5 (15) | | ↑ | 2X5 (10) |
| **Objectives: SO2 Safe and Caring services** | | | | | | | | | | | | | |
| **CQSPE** | CN | BAF 572 | Ability to deliver the Trust Quality Strategy priorities.. | 05/04/18 | 4X5 (20) | 4X5 (20) | 3X5 (15) | 3X5 (15) | 3X5 (15) | 3X5 (15) | | → | 2x4 (8) |
| **CQSPE** | MD | BAF 574 | Compliance to the identification of all deteriorating patient Groups(e.g. Sepsis, haemorrhage, chest pain, neurosurgical emergencies), | 13/04/18 | 4X5 (20) | 4X5 (20) | 3X5 (15) | 3X5 (15) | 3X5 (15) | 5X4 (20) | | ↑ | 2x5 (10) |
| **CQSPE** | CN | BAF 575 | Poor experience for patients and families at end of life | 02/05/18 | 4x4 (16) | 3X4 (12) | 3X4 (12) | 3X4 (12) | 3X4 (12) | 3X4 (12) | | → | 2x4 (8) |

| | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **CQSP E** | CE | BAF 577 | Failure to deliver the CQC post inspection actions plans and improved the CQC inspection rating | 02/05/18 | 4X5 (20) | 4X5 (20) | 3x5 (15) | 3x4 (12) | 3x5 (15) | 5X4 (20) | | ↑ | 2x5 (10) |
| **CQSP E** | MD | BAF 579 | Mortality reviews not robust and providing learning that is shared across the organisation to maintain the Trust within the expected SHMI/HSMR range and compliant t to 100% of hospital deaths having been reviewed | 13/04/18 | 4X5 (20) | 2X5 (10) | 2X5 (10) | 2X5 (10) | 2X5 (10) | 2X5 (10) | | → | 1x5 (5) |
| W | CN | BAF580 | Delivery of staffing levels to ensure high quality patient care and consistent delivery (Medical, nursing, midwifery and AHP) | 06/04/18 | 4X5 (20) | 4X5 (20) | 4X4 (16) | 4X4 (16) | 4X4 (16) | 5X4 (20) | | ↑ | 2x5 (10) |
| CQSP E | COO | BAF501 | Ability to provide a safe, caring and effective service within the Emergency Department (inclusive of Immediate Assessment Area) | 15/01/18 | 4X5 (20) | | | NEW | 5X4 (20) | 5X4 (20) | | → | 4x2 (8) |
| **Objectives: SO3 Drive Service improvements, innovation and transformation** | | | | | | | | | | | | | |
| **F & P** | COO | BAF582 | Access to 7 day services to deliver key standards and contribute to clinical networks | 06/04/18 | 4X5 (20) | 3X5 (15) | 3X5 (15) | 3X5 (15) | 3X5 (15) | 3X5 (15) | | → | 2x5 (10) |
| **F & P** | COO | BAF583 | Transformation and redesign of services not delivered to drive efficiency and improve key services in relation to outpatients, theatres, ophthalmology, GIRFT, single point of access and pharmacy | 10/04/18 | 5X4 (20) | 4X4 (16) | 4X4 (16) | 4X4 (16) | 4X4 (16) | 4X4 (16) | | → | 3x4 (12) |
| **F & P** | COO | BAF588 | Expansion of schemes and services outlined in the Clinical Strategy not implemented | 10/04/18 | 4X3 (12) | 4X3 (12) | 4X3 (12) | 4X3 (12) | 4X3 (12) | 4X3 (12) | | → | 3x3 (9) |
| **Objectives: SO4 Be the place people choose to work** | | | | | | | | | | | | | |
| W | DHR | BAF589 | Failure to enhance optimum levels of staff engagement can have an impact on retention and the staff motivation and experience. | 10/04/18 | 3X3 (9) | 3X3 (9) | 4X3 (12) | 4X3 (12) | 4X3 (12) | 4X3 (12) | | → | 2x3 (6) |
| W | DHR | BAF590 | Performance in sickness, mandatory training and appraisal not maximising employee capability and wellbeing. | 10/04/18 | 3X4 (12) | 3X4 (12) | 3X4 (12) | 3X4 (12) | 3X4 (12) | 3X4 (12) | | → | 3X3 (9) |
| **Objectives: SO5 Make the best use of what we have** | | | | | | | | | | | | | |
| **F & P** | DF | BAF 592 | Inability to deliver the agreed financial recovery plan through 2018/2019 | 10/04/18 | 5X4 (20) | 5X4 (20) | 5X4 (20) | 5X4 (20) | 5X4 (20) | 5X4 (20) | | → | 3x4 (12) |
| **F & P** | DSB | BAF 615 | Failure to deliver 2018/19 Cost Improvement Programme | 02/05/18 | 5X4 (20) | 4X4 (16) | 4X4 (16) | 4X4 (16) | 4X4 (16) | 4X4 (16) | | → | 3x4 (12) |
| **Objectives: SO6 Deliver a viable future** | | | | | | | | | | | | | |
| **F & P** | COO | BAF 595 | Not maximising benefits through collaborative working in relation to BCA work streams in relation to investment in the Vanguard | 06/04/18 | 5X4 (20) | 4X4 (16) | 4X4 (16) | 4X4 (16) | 4X4 (16) | 4X4 (16) | | → | 2x4 (8) |

| | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | programme, implementation of revised pathways and staff engagement in the change process. | | | | | | | | | | |
| **F & P** | DF | BAF608 | MCP bid fails | 12/04/18 | 3X3 (9) | NEW | 3X3 (9) | 3X3 (9) | 3X3 (9) | 3X3 (9) | | ➲ | 2x3 (6) |
| **F & P** | DF | BAF609 | Fail to deliver MCP contractual arrangements | 12/04/18 | 3x4 (12) | NEW | 3X3 (9) | 3X3 (9) | 3X3 (9) | 3X3 (9) | | ➲ | 2x3 (6) |
| **W** | DHR | BAF597 | Not having the right staff to deliver our clinical services currently and in the future. | 10/04/18 | 5X4 (20) | 4X4 (16) | 4X4 (16) | 4X4 (16) | 4X4 (16) | 4X4 (16) | | ➲ | 3x4 (12) |
| **DT** | CIO | BAF598 | EPR programme being delayed or failing to deliver the infrastructure to support new models of delivery in relation to core foundation system for digital trust. | 11/04/18 | 5X4 (20) | 4X4 (16) | 4X4 (16) | 4X4 (16) | 4X4 (16) | 5X4 (20) | | ➚ | 3x4 (12) |
| **DT** | CIO | BAF599 | Manage our infrastructure to support new models of delivery of a shared record between GPs and DGFT | 06/04/18 | 4X4 (16) | 4X4 (16) | 4X4 (16) | 4X4 (16) | 3X4 (12) | 3X4 (12) | | ➲ | 2x4 (8) |
| **CQSP E** | DG | BAF694 | The Trust's reputation for high quality, safe and effective care is damaged | 10/07/2018 | 4 X 4 (16) | | | NEW | 4 X 4 (16) | 5X4 (20) | | ➚ | 2x4 (8) |

**APPENDIX 2**

## CORPORATE RISK REGISTER OVERVIEW

| Oversight Committee | Risk Lead | Ref | Risk Title | Date entered on Risk Register | Initial Risk Score | Current Risk Score | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | | 10/04/18 | 10/05/18 | 10/06/18 | 10/07/18 | 16/09/18 | | Trend | Target Risk Score |
| **Objectives: SO1 Deliver a Great Patient Experience** | | | | | | | | | | | | | |
| F & P | CIO | COR111 | The risk of a cyber-threat exploiting a vulnerability that could threaten confidentiality, availability or integrity of data services required to support business operations. | 26/11/2016 | 4 X 4 (16) | 4 X 4 (16) | 4 X 4 (16) | 4 X 4 (16) | 4 X 4 (16) | 4 X 4 (16) | | ➔ | 1 X 4 (4) |
| CQSPE | COO | COR421 | Lack of paediatric medical workforce capacity to meet service demands, service standards and recommendations resulting in overdue follow up appointments | 01/11/2017 | 4 X 5 (20) | 4 X 5 20 | 4 X 5 20 | 4 X 5 20 | 4 X 5 20 | 4 X 5 20 | | ➔ | 3 X 3 (9) |
| **Objectives: SO2 Safe and Caring services** | | | | | | | | | | | | | |
| CQSPE | CN | COR576 | Not reducing the number of avoidable falls across the Trust | 02/05/2018 | 5 X 3 (15) | 3 X 3 (9) | 3 X 3 (9) | 3 X 3 (9) | 3 X 3 (9) | 3 X 3 (9) | | ➔ | 2 X 3 (6) |
| F & P | COO | COR578 | Not delivering on the agreed CQUIN requirements, negatively impacting financially, on quality delivery, patient experience and risk of harm | 17/04/2018 | 5 X 3 (15) | 3 X 3 (9) | 3 X 3 (9) | 3 X 3 (9) | 3 X 3 (9) | 3 X 3 (9) | | ➔ | 2 X 3 (6) |
| CQSPE | DG | COR573 | Deliver Trust Quality Strategy priorities to improve the delivery of incident management | 09/04/2018 | 5 X 4 (20) | 3 X 4 (12) | 3 X 4 (12) | 3 X 4 (12) | 3 X 4 (12) | 3 X 4 (12) | | ➔ | 2 X 3 (6) |
| F & P | COO | COR032 | The trust has limited service level business continuity plans in place, the plans that are currently in place do not align with ISO 22301 as requested by the EPRR Framework 2015. The overarching trust Business Continuity plan has not been updated since 2012 and reflects old practice | 17/05/2017 | 4 X 5 (20) | 3 X 5 (15) | 3 X 5 (15) | 3 X 5 (15) | 2X5 (10) | 2X5 (10) | | ➔ | 2 X 5 (10) |
| F & P | FD | COR241 | Failure of the PFI provider to maintain the building in line with statutory requirements and to ensure a resilient estate due to the capacity and capability of the sub-contractors estates function. | 04/07/2017 | 5 X 5 (25) | 4 X 5 (20) | 4 X 5 (20) | 4 X 5 (20) | 4 X 5 (20) | 4 X 5 (20) | | ➔ | 2 X 4 (8) |

| | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| CQSPE | CN | COR093 | Delays in the management of young people requiring section under the Mental Health Act (Tier 4) resulting in inappropriate use of paediatric beds and delay in receipt of specialist care of the child. | 30/11/2011 | 5 X 4 (20) | 3 X 4 (12) | 3 X 4 (12) | 3 X 4 (12) | 3 X 4 (12) | 3 X 4 (12) | | ➲ | 2 X 4 (8) |
| F & P | FD | COR104 | Failure of the PFI provider to manage the electrical infrastructure of the PFI buildings which is putting at risk the Trust's ability to deliver its clinical services. | 30/04/2017 | 4 X 4 (16) | 4 X 4 (16) | 4 X 4 (16) | 4 X 4 (16) | 2X4 (8) | 2X4 (8) | | ➲ | 1 X 4 (4) |
| CQSPE | CN | COR621 | Compliance to statutory Safeguarding processes, systems and practice | 04/05/2018 | 4 X 5 (20) | NEW | 4 X 5 (20) | 3X5 (15) | 3X5 (15) | 3X5 (15) | | ➲ | 2 X 5 (10) |
| F & P | FD | COR100 | Failure to comply with fire safety requirements of Fire Service Regulatory Reform (Fire Safety) Order 2005. The Trust has identified three areas of control where it does not have assurance | 09/05/2016 | 5 X 4 (20) | 2 X 4 (8) | 2 X 4 (8) | 2 X 4 (8) | 2 X 4 (8) | 2 X 4 (8) | | ➲ | 2 X 4 (8) |
| CQSPE | DG | COR748 | Governance arrangements from floor to board through divisional structures do not provide information on developing risks | 10/09/2018 | 5 X 4 (20) | | | | NEW | 4X4 (16) | | | 2 X 4 (8) |
| **Objectives: SO3 Drive Service improvements, innovation and transformation** | | | | | | | | | | | | | |
| F & P | DSB | COR631 | Failure to implement a Trust-wide improvement programme and methodology which means that service transformation is not owned and methodology not utilised. | 16/05/2018 | 3X3 (9) | New | 2 X 6 (6) | 2 X 6 (6) | 2 X 6 (6) | 2 X 6 (6) | | ➲ | 2 X 2 (4) |
| **Objectives: SO4 Be the place people choose to work** | | | | | | | | | | | | | |
| W | DHR | COR632 | Gaps in leadership development has led to capability issues for middle and senior managers in the trust | 16/05/2018 | 4 X 4 (16) | New | 4 X 4 (16) | 4 X 4 (16) | 4 X 4 (16) | 4 X 4 (16) | | ➲ | 2 X 3 (6) |
| **W** | DHR | COR696 | Retention of staff in the Trust based on higher than expected turnover rates is having an impact on our sustainable workforce plan and therefore causing high levels of temporary staffing costs in certain clinical areas. | 10/07/2018 | 3X4 (12) | | | NEW | 3X4 (12) | 3X4 (12) | | ➲ | 3X2 (6) |
| **Objectives: SO5 Make the best use of what we have** | | | | | | | | | | | | | |
| F & P | CIO | COR091 | In the event of one or more primary system failures, current IT Disaster Recovery (DR) is provided by a Hewlett Packard (HP) contract with Siemens Healthcare. It is estimated to take two weeks to recover the top five clinical systems, PAS, Pathology, EPR, JAC and PACS. After this other | 30/04/2016 | 5 X 4 (20) | 5 X 4 (20) | 5 X 4 (20) | 5 X 4 (20) | 2 X 4 (8) | 2 X 4 (8) | | ➲ | 1 X 4 (4) |

| | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | systems would start to be restored. For two weeks the Trust would fall back to manual and paper based activities | | | | | | | | | | |
| A | DG | COR638 | Failure to comply with the GDPR requirements | 01/04/2018 | 4x4 (16) | 3x3 ( 9) | 3x3 (9) | 3x3 (9) | 3x3 (9) | 2x3 (6) | | ⬇ | 1x3 (3) |
| W | DHR | COR119 | The Trust has committed funds of approximately £900k towards the apprenticeship levy and therefore it important that this funding is fulfilled by supporting apprenticeship appointments or relevant development within the scope of the levy in order that the Trust gets value for money based on the funding already committed | 21/06/2017 | 4 X 3 (12) | 4 X 2 (8) | 4 X 2 (8) | 4 X 2 (8) | 4 X 2 (8) | 4 X 2 (8) | | ➔ | 3 X 2 (6) |
| **Objectives: SO6 Deliver a viable future** | | | | | | | | | | | | | |
| F & P | FD | COR600 | The trust infrastructure not supporting the new models of delivery and does not align strategies to the Dudley Local & Black Country STP Estates | 02/05/2018 | 3X3 (9) | 3X3 (9) | 3X3 (9) | 3X3 (9) | 3X3 (9) | 3X3 (9) | | ➔ | 2 X 3 (6) |
| F & P | FD | COR485 | Failure to maintain liquidity in 2018-19 and beyond | 20/12/2017 | 5 X 4 (20) | 5 X 4 (20) | 5 X 4 (20) | 5 X 4 (20) | 5 X 4 (20) | 5 X 4 (20) | | ➔ | 2 X 4 (8) |
| F & P | FD | COR616 | Failure to remain financially sustainable in 2018-19 and beyond | 02/05/2018 | 5 X 4 (20) | 5 X 4 (20) | 5 X 4 (20) | 5 X 4 (20) | 5 X 4 (20) | 5 X 4 (20) | | ➔ | 4 X 4 (16) |