Enclosure 13

The Dudley Group NHS Foundation Trust

Paper for submission to the Board of Directors December 2018

TITLE:	**CHIEF NURSE REPORT**		
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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.*

ACTION REQUIRED OF BOARD

Decision	Approval	Discussion	Other
		x	

OVERALL ASSURANCE LEVEL

Significant Assurance	Acceptable Assurance	Partial Assurance	No Assurance
☐	☐	☒	☐
High level of confidence in delivery of existing mechanisms / objectives	General confidence in delivery of existing mechanisms / objectives	Some confidence in delivery of existing mechanisms / objectives, some areas of concern	No confidence in delivery

RECOMMENDATIONS FOR THE BOARD

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

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:

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.

Appendix 1 Provides this month's update on safer staffing, agency controls and recruitment and retention
Appendix 2 Details the actions currently being taken to address the issues within the Resuscitation team
Appendix 3 Update on safeguarding within the Trust
Appendix 4 Update on Q2 quality account performance

SAFER STAFFING

- The latest position with staffing reviews is included.
- Target fill rate for October 2018 aims for 85%. Fill rates are improving however, day shifts for qualified staff continue to be challenging (82%). There are 16 wards which reported a high occupancy >80% with low fill rates < 85% across a mixture of day and nights.
- A number of quality indicators have been included from the Model Hospital. The trust compares positively in comparison to our peers.
- An analysis of the CHPPD for all Trust wards has been undertaken using the latest peer trust and national comparator figures from the Model Hospital all areas are within the agreed variation of 6.3 to 16.8 CHPPD.
- Meetings with Lead Nurses/Midwives and Matrons continue focusing on recruitment and retention of staff to deliver the reduction in bank and agency usage.
- 38 staffing incidents reported in October 2018, all recorded as no harm or near miss.

RESUSCITATION

From the end of November the resuscitation service to the Trust will have only 0.6 wte experienced RO in post. One A band 6 will be commencing at the start of December who will be in a development role and will require significant support and cannot run national courses at this time but will be going through Advanced Life Support (ALS), European Peadiatric Advanced Life Support (EPALS) within the next six months. Lead Resuscitation Officer (RO) post advertised with one single applicant, The job description is being reviewed to consider the banding and role within the Trust and management of the deteriorating patient. However even at full staffing levels the service is still showing a deficient in numbers compared to recommended standards in practice from the Resuscitation Council UK.

Resuscitation Council Standards

- Every organisation must have at least one person, the Resuscitation Officer (RO), resuscitation lead or resuscitation services manager, who is responsible for coordinating the teaching and training of staff in resuscitation.
- This person will have additional important responsibilities (e.g. quality improvement, incident review).
- One whole-time-equivalent RO is recommended for every 750 members of clinical staff - see below for further details. Depending on the size and geographical distribution of the organisation, more than one RO may be needed to fulfill training requirements and additional responsibilities relating to resuscitation.

Appendix 2 shows a short-term action plan detailing the actions being taken to mitigate the risk that this poses for the Trust. These are:

- Provisions of mandatory resuscitation training - Band 6 to commence in development role within resuscitation team from the 2nd December, supervision and support from Non-Medical Education Lead and part time RO
- Specialist training cover - Access specialist training from independent providers (Diamond Resuscitation, HESTraining, Cannock Resuscitation services). Costing to be against vacancy in Lead RO role (£300 + vat Per DAY £250 +vat FOR HALF DAY) Cover for one day per week by Non-Medical Educational Lead
- Over booking of resuscitation training sessions - To reduce bookings in line with staff numbers. All matrons and leads to be advised staff will only be able to attend when bookings confirmed and that as this is mandatory training it should be managed within the individuals working times. Staff will not be trained at the end of night shifts.
- Sepsis support and review of team.- Band 6 sepsis practitioner to start December 2018 Review of Role and team and reporting
- 2 additional band 7 Sepsis practitioners to be recruited as soon as possible

SAFEGUARDING

- Continued Care Quality Commission (CQC) inspection focus requiring daily Paediatric Liaison Service audit
- The position in compliance with safeguarding training targets has significantly improved in this quarter, however there is a need for sustained focus in this area with exploration of learning themes and trends and the provision of safeguarding supervision
- The Trust is contributing to Safeguarding Adults Reviews (SAR), Domestic Homicide Reviews (DHR) and Serious Case Review (SCR).
- There are several risks associated within existing safeguarding work streams assessed to be moderate to high.
- Continued growth in demand and the required resource and capacity to meet this.

- Continued drive and impetus upon Safeguarding Team recruitment. Current post adverts are awaiting financial approval for key posts of safeguarding administrator and Named Midwife for Safeguarding Children.

QUALITY PRIORITIES Q2 Performance

- FFT: For recommended scores, of the 47 available results for Q1/Q2 25 have achieved the target. For response rate scores, of the 30 available results 21 have achieved the target.
- Local Patient Experience Survey: Target was not achieved in Q2 but was in Q1 so the target at the end of the year may still be met.
- For the targets based on the Quality Metrics, the following have achieved the 95% target: Pain (98%), Community MUST (98%). The Nutrition Audit just missed the target (94%) while the Hospital MUST was 89% and Medications was 92%.
- Infection Control targets: For Q2 these have been achieved.
- Pressure Ulcer targets: For Q2 with the data available so far three of the four targets have been achieved.
- Discharge management: One of three targets is being achieved.
- Incident management: Both targets are being achieved so far this year.

The Trust is taking part in all of the required national audits.

ISSUES AND ACHIEVEMENTS BY EXCEPTION, FROM THE CHIEF NURSE AND THE CORPORATE TEAM
INFECTION CONTROL

First Meticillin resistant staphylococcus aureus MRSA bacteraemia in Trust since September 2015, the gentleman was admitted on 04.10.2018 to ward C8 and had several peripheral vascular devices inserted of which he pulled out. He also required catheterisation three times due to urinary retention
He had a raised temperature on 15.10.18 and a blood culture was taken which was confirmed as MRSA positive. The microbiologist and physician managing the case believed this to be a contaminant rather than a true blood stream infection.

A root cause analysis (RCA) was undertaken utilising the national audit tool. The outcomes of the RCA were presented and discussed at a multidisciplinary meeting chaired by the Chief Executive and included representatives from the Dudley Office of Public Health and Dudley Clinical Commissioning Group .
Many areas of good practice were identified and fed back to the clinical team.

Recommendations from the RCA were:

- All patients to be screened for MRSA as per local policy. The results to be followed up by clinical staff.
- MRSA treatment to be commenced on receipt of a positive result regardless of the culture site
- A peripheral device chart (PVD) chart must be completed for each PVD. The visual infusion phlebitis (VIP) score needs to be completed during each shift and the relevant section needs to be fully completed when the PVD is removed.
- Ensure that all staff members collecting blood cultures are following local guidelines to reduce the risk of obtaining a contaminated sample.

Learning outcomes to be shared at ward level via staff meeting/huddle board and with the wider trust through divisional meetings and the infection prevention group.

PROFESSIONAL DEVELOPMENT
Student placement and support
The Health Education England's (HEE) National Education and Training Survey (NETS) successfully launched on 12 November 2018. NETS is the National Education and Training Survey that has been developed by Health Education England (HEE) in order to gain feedback about the clinical learning environment. It is the first national multi-professional survey specifically focussing on the quality of the clinical learning environment for learners who are on placement between 12 November and 14 December 2018. NETS offer learners the opportunity to provide anonymous feedback on the quality of training within their clinical placement.
Following recent feedback to the Trust and our educational partners' two placement areas had issues raised. There were C4 at Russells Hall Hospital and Day case surgery at Corbett Hospital.
The pre-registration support team along with University team have visited both areas and an action plan has been drawn up to address the concerns raised and ensure placements remain appropriate to the students' needs and support is offered to develop a work force that will want to stay with the Trust when qualified.

CHAPLAINCY
Following the departure of Lead Chaplain Mark Stobert the chaplain that was appointed has declined the offer of employment from the Trust. The post is now back out to advert and interviews will be held on 10 December 2018.

TISSUE VIABILITY

- Thirty seven (37) outstanding Pressure Ulcers (PU) SI RCAs have now been closed by Dudley CCG following Trust submission of PU thematic review.
- One category 3 PU incidents reported on STEIS in October 2018 as hospital acquired and one category 4 unavoidable reported in community services.
- No category 4 avoidable pressure ulcer reported since February 2018
- Pressure ulcer task and finish group fortnightly meeting is ongoing which includes a review of the Trust PU verification and SI notification process in line with national guidance.

QUALITY REVIEW AND IMPROVEMENT ENSURING REGULATORY COMPLIANCE
Perfect Ward App
Currently nursing staff, predominantly Matrons and Lead Nurses, undertake around 300 audits per month across the Trust measuring the quality of care delivered to all patients on a day to day basis. These audits are carried out on paper, before being inputted electronically by the Matron or Lead Nurse.

The Quality and Improvement Lead receives this 'raw data' then manually feeds it through an internally devised analysis tool, giving percentage compliance and a RAG rating. Following trend and theme analysis, the ratings are then manually inputted, by the Quality and Improvement Lead, onto an excel spread sheet and shared through the Trust Hub page.

The purpose of the purchasing the 'Perfect Ward' app, in relation to the nursing quality audits, is to eradicate almost all of the time consuming elements of the current process, allowing for Matrons and Lead Nurses to receive instant compliance scores and RAG rating and spend quality time developing and leading change and improvements and allowing the Quality and Improvement Lead time to work with the wards to facilitate their change and improvement ideas and work to replicate Trust wide for all patients. The app can reduce the time taken to complete the audit by 20 to 30 minutes per audit undertaken and provides instantaneous compliance percentages and RAG rating, and eradicating additional administration time. Reducing the time spent on data collection to approximately 150 hours per month.

Other benefits of the app are;

- Quickly identify issues across the organisation from ward to Board.
- Easily identify best and worst performing areas.
- Ensures inspection evidence is captured with clear audit trail.
- Gain assurance from being able to track performance.
- Ensure our inspection regime is comprehensive, covering all areas.
- Ensures inspection results are robust.
- Access key area information including staffing, management and location.
- Ensures consistent inspections with automated updates.
- Utilisation of newly purchased hardware for eObs and the EPR system could be used, eradicating the need for further spend to support electronic auditing
- At many hospitals already using the app (list provided appendix 1), many of the audits are carried out weekly, rather than monthly for greater oversight and assurance
- Instant notifications of poor or deteriorating compliance

The last planned training session took place on Thursday 22 November. Approximately 50 staff were trained an additional session is planned for December date to be confirmed. IT are in the process of uploading software onto the devices across all areas. The team is currently liaising with IT regarding the areas that have no devices .i.e. Theatres, Day Surgery, ITU, OPD, GUM as they do not currently do E obs in these areas. Deputy Chief Nurse, Jo Wakeman is currently reviewing preliminary questions that have been set

The plan is to commence a trial of the app commenced w/c 26th November.

QUALITY AUDITS

Medicine
Environmental cleaning:
Concerns about the standard of the cleaning on C5 have been raised with the Trust Facilities Contract Manager and Head of Property and Facilities Management. Photographs taken identified a poor standard of cleaning and actions were put in place to rectify. The Infection control team have been involved and will be present on

subsequent cleaning audits to be assured of data validity. Regular Matron and Lead Nurse spot checks are occurring at present to monitor ongoing compliance with expected standards.

MUST, Medication and Nutrition:
Overall nutrition audit compliance increased to 94% in Oct from 91% in Sept.

Additional training continues on wards with regard to malnutrition universal screening tool (MUST) scores. All wards have action plans in place to address this and are meeting with Matrons to monitor compliance. The Professional Developing Nurses from within the areas

Overall, there continues to be an improvement in compliance with medicines management. A2 have developed an action plan to address the issues identified and this will be closely monitored by the Matron.

Falls:
Of the Falls, Injuries and Accidents; there were 2 patient falls in October and both occurred on C1 – these are the first falls with harm that have occurred on this ward since February 2017. No link is identified between these two separate incidents.

Family and Friends Test:
Both response and recommended rate continue to improve across medicine.

VTE Risk Assessment:
C7 and C8 have recorded the largest deficit in compliance against actual patient numbers (12 patients for C7 and 13 patients for C8). Both areas are working to improve their compliance by identifying the specific responsibilities of staff groups from ward clerks through to medical staff and sharing this information through various staff communications. Following a recent SI relating to a venous thrombus-embolism, C8 continue to work through the actions identified in the subsequent RCA investigation.

Workforce:
Most wards have vacancies of more than 10% of their 'whole time equivalent' for registered nursing. The Division continues to actively recruit to vacant posts. C3, A2/AMU in particular but all of the medical wards are subject to a review in order to manage the establishment slightly differently that will provide further support to Registered Nurses on these wards. The Recruitment and Retention lead continues to hold Trust wide recruitment events, as well as working with the individual areas with high vacancy numbers to develop specific actions to support their recruitment drives.

Ward C7 recorded a video for the recruitment day which had over 21, 000 views, all medical wards have been asked to come up with a theme and be innovative.

A2/AMU bed configuration has been remodelled which included a staffing review, it was presented executives 6th November and approved, it is felt that this will have a positive impact on staff retention and recruitment.
There continues to be monthly meetings with HR and Lead nurses to manage sickness and absence.

<u>Surgery</u>
Environmental cleaning:
The compliance score is starting to show improvements. B3 are having issues due to ongoing bathroom work since May 2018 this is causing increased dust levels and reduced storage space. This has been escalated to Estates and provisional date for completion is January 2019. The issue has also been noted by Quality walk round by audit teams in October 2018.

Friends and Family Test:
A Matron has been identified to support improvements in patient experience. The accessibility, distribution and return of FFT cards continues to discussed at various staffing meetings to improve the response rate. Whilst the recommended rate remains short of the expected compliance, there has been a small improvement overall from 88% to 89.8%.

VTE Risk Assessment:
Senior nursing staff have ceased assessing the VTE risk on new patients due to ongoing discussions about if this is appropriate. The matter has been raised at Risk and Assurance and CQSPE meetings for a resolution.

In the meantime, Matron Sara Davis has been undertaking reviews of VTE compliance in her areas, since 26 October 2018, to assess where and why VTE is not recorded.

Date	VTE not assessed by medical staff	VTE not logged by nursing/clerical staff
26.10.18	4	17
27.10.18	3	2
28.10.18	No Data - Sunday	
29.10.18	8	7
30.10.18	8	15
31.10.18	4	16
1.11.18	All completed	14

Results are indicating that assessments not being logged are the wider issue in the Division and will be managed via the daily white board round going forward. It has further been noted that clerical staff have been logging the time of assessment as the time they enter the data onto the data base. This is incorrect. They should enter the time the doctor states on the form that assessment is completed. This practice has been addressed.

Mandatory Training:
Following discussion and challenge at the previous Division Governance meeting; discussions are underway between the division and professional development to identify how training can be offered to ensure staff attendance to ultimately improve compliance.

Workforce:
RN fill rates are affected by the investment shifts not being released to agency and not filling as per agreement with Directors.

The division continues to work closely with the Recruitment and Retention Lead. The ward areas continue to support and participate in the Trust wide recruitment events, as well as developing specific actions to support their recruitment drives.

Gaps in data:
Gaps in the data relate to data mapping issues, where wards have either merged, A2/AMU or split B4 (to B4a. B4b.), non – submission or not applicable to that ward.

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/N**	**Details**
	NHSI	**Y/N**	**Details:**
	Other	**Y/N**	**Details:**