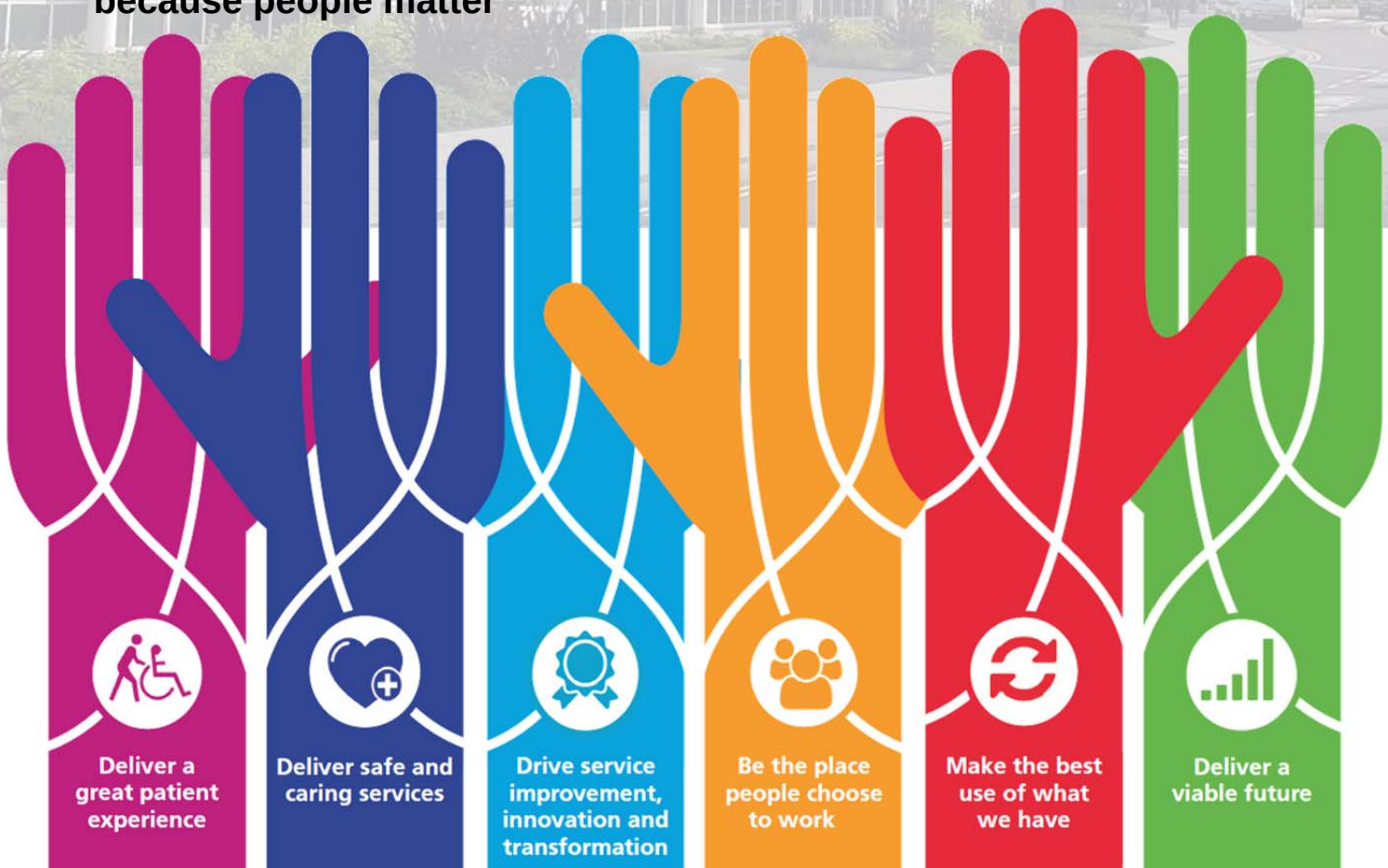
The Dudley Group
NHS Foundation Trust

Public Board of Directors Meeting

Thursday 6th December 2018
10.20am – 12.30pm

Meeting room 7 & 8,
Clinical Education Centre,
1st Floor, South Block

Our vision: Trusted to provide safe, caring and effective services because people matter



The Dudley Group
NHS Foundation Trust

BOARD MEETINGS
PUBLIC INFORMATION SHEET

The Dudley Group meets in public every month and welcomes the attendance of members of the public and staff at its Board meetings to observe the Board's decision-making process.

1. Introduction

This sheet provides some information about how Board meetings work.

Name signs for each board member are displayed on the table in front of the member to enable you to identify who is speaking at the meeting.

Some items are confidential (for example if they concern an individual or a commercial contract) – these are dealt with in part II (confidential) of the meeting.

Copies of the agenda and papers are available at the meetings, and on our website http://dudleygroup.nhs.uk/ or may be obtained in advance from:

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2. Board Members' interests

All members of the Board are required to declare if they have any interests (e.g. financial) which are relevant to the work of the trust and these are recorded in a register. If you would like to see the register, please contact the Company Secretary or visit our website.

Members are also required to state at the start of the meeting if they have an interest in any of the items under discussion. Special rules govern whether a member who has declared an interest may take part in the subsequent discussion.

3. Opportunity for questions

Members the public, should raise any questions directly to the Chair at the conclusion of the meeting.

4. Debate

The board considers each item on the agenda in turn. Each report includes a recommendation of the action the board should take. For some items there may be presentation; for others this may not be necessary. The board may not actively discuss every item – this does not mean that they have not received careful consideration; it means that nobody at the meeting considers it necessary to debate the subject. A formal vote need not be taken if there is a general consensus on a suggested course of action.

5. Minutes

A record of the items discussed and decisions taken is set out in the minutes, which the board will be asked to approve as a correct record at its next meeting.

The minutes as presented to the next meeting of the Trust Board for approval are added to the website at the same time as the papers for that meeting.

6. Key Contacts

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THE SEVEN PRINCIPLES OF PUBLIC LIFE

The Committee has set out **'Seven Principles of Public Life'** which it believes should apply to all in the public service. These are:

Selflessness
Holders of public office should act solely in terms of the public interest. They should not do so in order to gain financial or other benefits for themselves, their family or their friends.

Integrity
Holders of public office should not place themselves under any financial or other obligation to outside individuals or organisations that might seek to influence them in the performance of their official duties.

Objectivity
In carrying out public business, including making public appointments, awarding contracts, or recommending individuals for rewards and benefits, holders of public office should make choices on merit.

Accountability
Holders of public office are accountable for their decisions and actions to the public and must submit themselves to whatever scrutiny is appropriate to their office.

Openness
Holders of public office should be as open as possible about all the decisions and actions that they take. They should give reasons for their decisions and restrict information only when the wider public interest clearly demands.

Honesty
Holders of public office have a duty to declare any private interests relating to their public duties and to take steps to resolve any conflicts arising in a way that protects the public interest.

Leadership
Holders of public office should promote and support these principles by leadership and example.
This document should be read in association with the NHS Code of Conduct.

The Dudley Group NHS Foundation Trust

Board of Directors
Thursday 6th December, 2018 at 10.20am
Clinical Education Centre
AGENDA

Meeting in Public Session

All matters are for discussion / decision except where noted

	Item	Enc. No.	By	Item Related to BAF Risk	Action	Time
11.	**Chairmans Welcome and Note of Apologies**		J Ord		To Note	10.20
12.	**Declarations of Interest** Standing declaration to be reviewed against agenda items.		J Ord		To Note	10.20
13.	**Announcements**		J Ord		To Note	10.20
14.	**Minutes of the previous meeting**					
	14.1 Thursday 1 November 2018	Enclosure 9	J Ord		To Approve	10.20
	14.2 Action Sheet 1 November 2018	Enclosure 10	J Ord		To Action	10.25
15.	**Patient Story**	Video	L Abbiss		To Note & Discuss	10.30
16.	**Chief Executive's Overview Report**	Enclosure 11	D Wake		To Discuss	10.40
17.	**Safe and Caring**					
	17.1 Clinical Quality, Safety and Patient Experience Committee Exception	Enclosure 12	D Wulff		To note assurances & discuss any actions	10.50
	17.2 Chief Nurse Report including Safer Staffing	Enclosure 13	C Love-Mecrow		To note assurances & discuss any actions	11.00
18.	**Responsive and Effective**					
	18.1 Integrated Performance Dashboard	Enclosure 14	K Kelly		To note assurances & discuss any actions	11.10

	18.2 Finance and Performance Committee Exception report	Enclosure 15	J Hodgkin		To note assurances & discuss any actions	11.20
19.	**Well Led**					
	19.1 Workforce Committee Exception Report	Enclosure 16	J Atkins		To note assurances & discuss actions	11.30
	19.2 Winter – Operational Plan	Enclosure 17	K Kelly		To note	11.40
	19.3 Guardian of Safe Working Report	Enclosure 18	B Elahi		To note assurances	11.50
	19.4 Freedom to Speak Up Guardian's Report	Enclosure 19	D Eaves		To note assurances & discuss actions	12.00
	19.5 Research and Development Report	Enclosure 20	J Neilson		To note assurances & discuss actions	12.10
	19.6 Digital Trust Committee Exception Report	Enclosure 21	R Welford/ M Stanton		To note	12.20
	19.7 Audit Committee Exception Report	Enclosure 22	R Miner		To note assurances & discuss	12.30
20.	**Any other Business**		J Ord			12.40
21.	**Date of Next Board of Directors Meeting** 8.30am 10th January, 2018 Clinical Education Centre		J Ord			12.40
22.	**Exclusion of the Press and Other Members of the Public** To resolve that representatives of the press and other members of the public be excluded from the remainder of the meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest. (Section 1 [2] Public Bodies [Admission to Meetings] Act 1960).		J Ord			12.40

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

Enclosure 9

The Dudley Group NHS
NHS Foundation Trust

Minutes of the Public Board of Directors meeting held on Thursday 1st November, 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
Tom Jackson, Director of Finance
Julian Hobbs, Medical Director
Richard Welford, Non Executive Director
Jonathan Hodgkin, Non Executive Director
Diane Wake, Chief Executive

In Attendance:

Helen Forrester, EA
Mark Stanton, Chief Information Officer
Glen Palethorpe, Director of Governance/Board Secretary
Mark Hopkin, Non Executive Director
Jo Wakeman, Deputy Chief Nurse
Peter Lowe, Head of Improvement Practice
Dawn Woods, Head of HR Operations
Gilbert George, Interim Board Secretary - designate
Jo Newens, Divisional Director of Operations
Jill Faulkner, Head of Patient Experience (Item 18/125.4)

18/116 Note of Apologies and Welcome
8.30am

Apologies were received from Liz Abbiss, Andrew McMenemy, Natalie Younes and Karen Kelly and Catherine Holland. The Chairman welcomed Gilbert George, Interim Board Secretary designate, Jo Wakeman, who was attending for the Chief Nurse, Jo Newens who was attending for the Chief Operating Officer, Peter Lowe who was attending for the Director of Strategy and Business Development and Dawn Woods who was attending for the Director of HR.

18/117 Declarations of Interest
8.33am

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

There were no other declarations of interest.

18/118 Announcements
8.33am

The Chief Executive was pleased to announce that the Trust had won the Nursing Times Award for Learning Disabilities the previous evening.

There were no other announcements to note.

18/119 Minutes of the previous Board meeting held on 5th October, 2018 (Enclosure 1)
8.34am

The minutes were amended as follows:

Page 12, 5th paragraph to read "we should consider changing the approach".

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

18/120 Action Sheet, 5th October, 2018 (Enclosure 2)
8.35am

18/120.1 Clinical Quality, Safety, Patient Experience Committee

There is a need to consider the number of Committees reporting into the Clinical Quality, Safety, Patient Experience Committee. This remained under review and would form part of the Board Development session next week.

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

18/121 Staff Story
8.40am

The Head of Improvement Practice presented the staff story. The story was given by the Lead Nurse for Medical and Surgical Outpatients and focussed on the engagement of staff with new initiatives and service improvements that had taken place within the Department in the past and the difference with the new approach to transformation.

The nurse felt inspired by the new approach to service improvements and commented on the positive leadership within the organisation now and how she was hoping that staff were being empowered to make change.

The Chief Executive asked the Head of Improvement Practice about the next steps in the Trust's roll out of its improvement methodology in respect of the week long event undertaken that the lead nurse was referring to. He confirmed that quality improvement initiatives have to be sustained and this is a focus of staff ownership for the delivery of improvement. At the event teams identified inefficiencies and areas for change, small focus groups will be established to progress these into improvement plans over the next 12 months.

The Chairman asked what support was being given to staff to help them spread improvement practice. Mr Lowe replied that the Service Improvement team are helping staff facilitate the use of problem / niggle boards to drive their local focus on improvement and the design of the solutions.

Mr Miner, Non Executive Director, asked for the Head of Service Improvement's view on the combination of both service improvement and Digital Trust initiatives on the level of efficiency gains that could be achieved. Mr Lowe confirmed that it was essential to align both methodologies to maximise benefits and the Trust had a target of 10% efficiency to be achieved in the first year, with this target also being referenced by the lead nurse within her story.

Mr Atkins, Non Executive Director, commented on the positive step the use of problem boards should bring and that it was essential that staff are supported to achieve solutions.

The Director of Finance reflected on his view of the event and of the work and how positive it was to see staff engaged in the process across the five days.

Mr Welford, Non Executive Director, commented on previous barriers to change that were referred to and how this issue can be managed under this initiative. The Head of Service Improvement commented that blockers to change need to be removed, and that these blockers are not always the senior managers but the middle management tier that need support to navigate to a workable solution which may be outside their sphere of knowledge or influence. The Lead Nurse for Outpatients had joined the meeting and confirmed that her comment related to all staff being engaged in change and finding solutions.

The Chief Executive confirmed that cultural change was crucial and staff must feel empowered to make change.

The Non Executive Directors were invited to be involved in the service improvement work.

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

18/122 Chief Executive's Overview Report (Enclosure 3)
9.05am

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

- Planning Update: A number of the Executive and the Chair had been to national planning events and the report contained a brief update for information ahead of the Trust's plan being discussed further at a Board Workshop.

- Staff Survey: Only 14% completed and work will be done with Communications to try and encourage staff to complete the survey as there is a real need to secure a better response rate to support the development of a comprehensive improvement plan.

- Flu Vaccinations: The Trust was doing well compared to last year and was now at a vaccination rate of 45%. The Chief Executive said that the Trust's ambition was to surpass the 75% target.

- Bake Off: There had been many amazing cakes put forward for this event and these were judged yesterday by the Chief Executive and Medical Director.

Dr Wulff, Non Executive Director, asked about the national body parts news item and asked if the Trust uses this supplier. The Board noted that the Trust had not used HealthCare Environmental Services.

Mr Welford asked about the significant differences in the impact of CQC inspections on NHS sectors news item and whether there was any further insight on this. The Chief Executive confirmed that a number of reports had been published by the CQC within the last 6 months and these were informing our improvements.

The Chairman and Board noted the report.

18/123 ED Performance and Quality Improvement Plan (Enclosure 4)
9.15am

The Divisional Director of Operations presented the ED Performance and Quality Improvement Plan given as Enclosure 4.

The Board noted the following key highlights:

The Director of Operations described the QIP tree included in the Plan which provides a visual picture of the areas of improvement and links each workstream to a quality message. The Divisional Director said that a key element for this plan to be successful is for staff to be able to articulate where we were as a Trust, where we are now and where we want to be and the actions within this plan that will move the department forward. The format and wording of the plan and the summary diagram had been led by the service.

Mr Welford, Non Executive Director, commented that he felt there were still gaps in the plan for it to be more usable for the wider organisation. Mr Welford described the elements that would enhance the document, including a mapping of the s31 conditions, a more visible tracking of improvement linked to the end goals, citing that for some areas an upward green arrow was a small positive change and that the measure was still not at the set performance level but for others the upward green arrow took the measure above the set target.

Mr Hodgkin, Non Executive Director, commented that it is important to consider the audience for the plan. The Chief Executive confirmed that the staff have created the QIP pictorial tree and this is what they are working to every single day Mr Hodgkin stated that the Board may need to see a different set of information to give it assurance with the detail remaining with the local teams. The Chief Executive confirmed that the inclusion of the SPC charts should be helpful for the Board as they convey the improvements made in an easy to assimilate way. Mr Welford stated that he was seeking clarity within the report that all the Section 31 actions are being addressed. The Divisional Director of Operations stated that there are 3 audiences to be satisfied, the staff, the Board and the CQC and agreed that the reporting needed to be adjusted for each audience.

The Chairman stated that the area of greatest risk is managing sepsis and the deteriorating patient. She felt that the risk score on the cover sheet was not adequately describing this and that the section within the plan on risk was incomplete. The Medical Director stated that the plan was designed for staff to focus on the improvement for patients and how the Trust delivers quality care to its patients. He confirmed that the Trust is seeing significant improvement in performance around the care of deteriorating patients and this is discussed at the weekly meetings.

The Chairman referred to the quality dashboard and commented that this was a welcome addition to the report but that it needed supporting narrative and targets.

The Chairman commented on the recent running of a "Perfect Fortnight" for the Medical and Surgical Divisions and asked that the Board sees detail on the changes this is to bring in future reports and actions. The Chief Executive commented that evaluation of this will be included in the reporting of the Trust's performance against the Emergency Access Standard and this will be within the Integrated Performance Report which comes to the Board.

The Director of Operations confirmed that there is an operational plan in place that sits alongside the QIP Plan that focuses on flow and achieving the Emergency Access Standard.

The Chairman and Board noted the report and the comments in relation to the QIP tree and section 31 notices.

18/124 Urgent Care Service Improvement Group Report (Enclosure 5)
9.42am

The Chairman presented the Urgent Care Service Improvement Group Report given as Enclosure 5.

The Group discussed whether the meeting should continue to exist in its current formation and with the current Chair. It was agreed that the Group was well established and focussed on the actions that need to be undertaken. The Chairman will now attend as an observer and will no longer Chair the meeting. The new Chair will be agreed when the Chief Operating Officer returns from annual leave.

The Chief Executive asked that the draft diagram explaining the revised governance process be updated once the Chief Operating Officer returns from leave, recognising that this proposed structure removes the anomaly of the chairman chairing an operational group.

The Chairman and Board noted the report.

New Chair of the SIG to be confirmed when the Chief Operating Officer returns from annual leave.

18/125 Safe and Caring

18/125.1 Clinical Quality, Safety and Patient Experience Committee Exception Report (Enclosure 6)
9.45am

Dr Wulff, Committee Chair, presented the Clinical Quality, Safety and Patient Experience Committee Exception Report, given as Enclosure 6.

The Board were informed there were no specific matters the Committee wished to refer to the Board for action. Dr Wulff drew the Board's attention to the work of the Committee in particular in their review of the Trust's quality priority performance and the Committee's request for further information back to committee in respect of improvement actions for those areas where that targets were not being met which included Pressure Ulcer Care, Discharge Management and Friends and Family Tests.

The Chairman and Board noted the report and assurances provided.

18/125.2 Chief Nurse Report (Enclosure 7)
9.48am

The Deputy Chief Nurse presented the Chief Nurse Report given as Enclosure 7.

The Board's attention was drawn to the following key items within the report:

- The AHP Strategy was successfully launched in October.
- The Trust is working with the CCG on securing closure of the tissue viability serious incident investigations.
- The plan around the launch of the Perfect Ward app which will enhance the Trust's ability to more efficiently undertake and analyse nursing audits.
- The revised C2 ward staffing budget had been signed off by the Executive Team.
- Further information on fill rates will be provided to the November Finance and Performance Committee as agreed at that Committee.

Dr Wulff, Non Executive Director asked for assurance on the delivery of Resus staffing and training. The Deputy Chief Nurse confirmed that this training will continue to be provided.

The Deputy Chief Nurse confirmed that the Trust was undertaking mock CQC inspections in readiness for the CQC unannounced visits. Walkrounds had been well attended and front line staff were being encouraged to attend the reviews to both learn from others area but to also demystify the CQC inspection process.

Mr Miner, Non Executive Director, commented that the walkrounds were very positive and he was pleased to see the breadth of staff included in the visiting team.

Mr Welford, Non Executive Director, raised staffing levels and that the report appears to show very little improvement from the numbers reported in the last report. The Chief Executive confirmed that the Executive Directors are seeing a dashboard that RAG rates each ward for their staffing levels and that this being included in the report may provide the missing information and bridge from substantive staff through the use of bank and agency staff to the determination of safely staffed wards. It was agreed by the Deputy Chief Nurse that this will be included in the report to the November Finance and Performance Committee and will provide assurance to Non Executive Directors that the Trust has safe staffing levels.

The Chief Executive confirmed that the Trust is looking at alternative roles to fill staff vacancies and the Director of HR is arranging an evening session for AHPs looking at how they could help with this.

The Chairman and Board noted the report and the additional reporting of assurance on safe staffing that will be provided to the November Finance and Performance Committee.

Information of fill rates to be presented to the November Finance and Performance Committee.

Deputy Chief Nurse to provide assurance on Resus staffing and training.

New dashboard on ward staffing to be presented to the November Finance and Performance Committee.

18/125.3 Learning from Deaths Report (Enclosure 8)
10.15am

The Medical Director presented the Learning from Deaths Report given as Enclosure 8.

The Board's attention was drawn to the following key items within the report;

The paper included a narrative related to the impact of coding changes for ambulatory patients on mortality indicators and a trajectory for reducing the number of outstanding level 2 structured judgement reviews, this should be completed by December.

A summarised action plan relating to condition specific alerts is now included in the paper.

The Board noted the excellent work undertaken by Dr Bowen on learning from deaths relating to palliative patients.

The Medical Director updated the Board on the positive work undertaken around sepsis and the management of deteriorating patients and reminded the Board on the Trust reducing mortality rates in this area as reported previously to the Board.

Mr Miner, Non Executive Director, raised the inclusion of disaggregated data within the report and whether the report provides greater assurance as a result. Dr Wulff, Non Executive Director, confirmed that he felt that the detail did provide further assurance and confirmed that the Clinical Quality, Safety, Patient Experience Committee also receive assurance around the levels of mortality.

The Chairman welcomed the additional detail and assurance provided in the report and confirmed that Professor Bewick had been very positive about the way the Trust reviews deaths.

The Chairman and Board noted the report.

18/125.4 Patient Experience Report (Enclosure 9)
10.22am

The Head of Patient Experience presented the Patient Experience Report given as Enclosure 9.

The Board's attention was drawn to the following key items within the report;

The Trust had received over 64,000 pieces of feedback the previous year and was on target to receive over 70,000 pieces of feedback for this year.

The Trust is still working on the turnround of complaints and it was acknowledged there had been an issue with sickness and annual leave within the Complaints team in the last quarter but a full time member of staff had been appointed.

Mr Atkins, Non Executive Director, commented that the Trust was still receiving more complaints than it was closing. The Head of Patient Experience confirmed that the additional member of staff will assist with addressing this. Dr Wulff, Non Executive Director confirmed that the Clinical Quality, Safety, Patient Experience Committee looked at complaints and held the Divisions to account in relation to their delivery of complaint responses in a more timely manner. The Chief Executive confirmed that she was looking at the whole complaints process as part of her Service Improvement project using the methodology described in the staff story.

Mr Hodgkin, Non Executive Director, stated that it was important to drive down the number of complaints but more important was the taking of action about identified issues, such as attitude and communication. The Head of HR Operations confirmed that the Trust is undertaking a piece of work around staff attitude and communication to help reduce the number of complaints in this area. Mr Hodgkin asked if the Trust is tracking the outcomes from this. The Head of HR Operations confirmed that this work is in early stages but in the coming months it will be possible to demonstrate improvement and this would be reported. The Medical Director confirmed that he had witnessed examples of improvement but it was important to not only pick up outliers of poor behaviour but to improve all practice as there is room for all of us within the area of communication. Mr Welford, Non Executive Director, asked how such a wider spread improvement would be achieved. The Medical Director said this would be achieved by drawing on external support regarding quality improvement but the crucial matter is to get all staff to reflect on the point that communication fundamentally influences a patients and their family's perception of care and compassion received.

The Chairman confirmed that the Clinical Quality, Safety, Patient Experience Committee were looking at how early resolution could be improved to reduce the number of formal complaints.

The Head of Patient Experience confirmed that she personally triages all contact.

Dr Hopkin, Non Executive Director, asked that all general "whinges" are also recorded and acted upon. The Head of Patient Experience confirmed that all feedback is captured and used to improve patient experience.

The Chairman highlighted some feedback received from a patient who had collapsed and was treated in ED. The compassion and care shown by staff was noted by the Board.

The Board noted that 1534 compliments were received in Quarter 2.

The Chairman and Board noted the report.

18/126 Responsive and Effective

18/126.1 Integrated Performance Report (Enclosure 10)
10.40am

The Chief Operating Officer presented the Integrated Performance Report given as Enclosure 9 for month of September 2018.

The Board's attention was drawn to the following key items within the report:

- Cancer key metrics: the Trust is on track to deliver 62 day cancer target and on track to deliver quarter 3 performance across all the related cancer metrics.

- Diagnostics (DM01): the Trust will achieve target for October.

- ED Emergency Access Standard (EAS): The Divisional Director of Operations was optimistic that the Trust will achieve 90% performance for October. However sustaining this level of EAS performance will be a challenge. There had been improved performance in October for ambulance delays but ambulance turnaround times remains a challenge.

The Chairman asked about the Executive summary by exception and the narrative in relation to 7 treated on or over 104 days combined. The Board were informed these were total number of patients and where updated as to the 14 patients outstanding this week and that these were due to the need for tertiary intervention for which there was a delay but the patients were exercise their choice of provider and did not want to move to another less local alternative.

The Board's attention was drawn to the reported increase in sickness absence rates and the Head of HR Operations assured the Board that support is being given to the wards to improve the position.

Mr Welford, Non Executive Director, raised the Operational Plan performance included within the report and the lack of narrative on the follow up actions against areas not performing well. It was noted that cross-referencing should be provided in the report to provide assurance to the Board rather than relying on the reader to search that out from within the integrated performance report detail.

The Chairman and Board noted the report and current performance.

Cross Referencing of actions being taken in respect of poorer performance to be included in the Operational Plan detail in the Performance Report.

18/126.2 Finance and Performance Committee Exception Report (Enclosure 11)
10.49am

Mr Hodgkin, Committee Chair, presented the Finance and Performance Committee Exception Report, given as Enclosure 11.

The Board's attention was drawn to the following key items within the report:

- The Committee had reflected on the disappointing performance in the month of September as the year end forecast has further deteriorated.

- The analysis of the variance had shown this was substantially down to cost variances and less to do with income, which reinforces the importance of service improvement to control costs.

- The Trust is expecting to receive financial element of PSF for the second quarter based on the performance to month 6..

The Chairman and Board noted the report and financial performance.

18/127 Well Lead

18/127.1 Winter Plan (Enclosure 12)
10.51am

The Divisional Director of Operations presented the Winter Plan given as Enclosure 12.

The Divisional Director of Operations confirmed that the Plan had been submitted to the CCG, but no feedback had been received to date.

The Chairman stated that the key issue are the triggers for escalation to cope with demand pressure. The Divisional Director of Operations confirmed that ECIST had undertaken a PDSA cycle testing out the Trust's the triggers as part of the Perfect Fortnight process. Work is being undertaken with the ED staff around how they respond to triggers and codifying this for winter.

The Chairman stated that the Trust needs to anticipate when triggers are going to be reached and thus be reactive to the situation as it develops to stop it from escalating into a significant issue. The Divisional Director of Operations confirmed that an operational plan around how this occurs will be provided to the Board including the codified triggers for escalation.

Mr Miner, Non Executive Director, stated that the Board needs to see detailed assurance on the front cover of such a report to prevent the reader from searching it out as he had done with this report.

The Medical Director commented that the plan needs to include quality metrics around flow and crowding to make it more relevant to patient experience and that these could then provide assurance that the triggers are effective.

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Mr Welford, Non Executive Director, commented that the document shows historical data but does not show the predicted outcomes of these actions and agreed the linking to outcome metrics would allow better monitoring of the impact of applying escalation triggers.

The Chairman and Board noted the report and comments in relation to triggers, reactive actions, assurance, quality metrics and need to model the outcomes of actions. The Board asked that a revised paper be brought back having regard to the suggested enhancements just discussed.

Operational plan providing detail on trigger points and reactive actions to be provided to the Board.

18/127.2 Estates Strategy (Enclosure 13)
11.04am

The Director of Finance presented the Estates Strategy, given as Enclosure 13.

The Board noted the current Strategy has been under review for some time, therefore a short term strategy had been produced for the Dudley Health Economy of which this document was one component. The Board noted that the document reflected the changes that an MCP and a developing STP will bring to a longer term strategy.

The Strategy had been reviewed by the STP and was noted to be one of the best in the examples locally.

The Chairman and Chief Executive are meeting with the STP Independent Chair later that day and will ask for an update on the STP capital bids.

The Chief Executive commented that whilst this was short term strategy to serve a short term purpose a more succinct Trust document was required and informed the Board she had asked the Director of Finance to start working on that.

The Chairman and Board noted the report and approved the short term Strategy.

18/127.3 Black Country Integrated Care System Roadmap (Enclosure 14)
11.10am

The Chief Executive presented the Black Country Integrated Care System Roadmap given as Enclosure 14.

The Board noted the document was primarily for information, but if they had any comments to provide them to the Chief Executive in advance of the next Health Partnership meeting on 19th November, 2018.

Mr Miner, Non Executive Director, asked the Chairman to raise the outcomes framework and progress on workforce at her meeting with the STP Independent Chair.

The Head of HR Operations confirmed that she had recently attended a Local Workforce Advisory Board meeting and each of the 4 local Trusts are bringing together workforce plans for discussion at the next meeting.

18/127.4 Charitable Funds Committee Report (Enclosure 15)
11.16am

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

The Board's attention was drawn to the following key item within the report

- The main discussion at the last Committee meeting was on a proposal from The Divisional Director for Surgery and Women's and Children's Division to establish a staff health and well-being fund for his Division in response to feedback from their staff as to what would make a difference. The Committee had asked for an update on this initiative at its next meeting.

The Chairman and Board noted the report.

18/128 Any Other Business
11:17am

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

18/129 Date of Next Meeting
11.18am

The next Board meeting will be held on Thursday, 6th December, 2018, at 8.30am in the Clinical Education Centre.

Signed ……

Date ……

Enclosure 10

The Dudley Group NHS Foundation Trust

Action Sheet
Minutes of the Board of Directors Public Session
Held on 1 November 2018

Item No	*Subject*	*Action*	*Responsible*	*Due Date*	*Comments*
18/082.7 & 105.4	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. Update on Breast Screening/recruitment of additional Radiographers to the November Board.	PS/Exec Team	6/12/18	Paper presented to Exec Team on 30th October. Request for funding submitted to NHSE. Update to be provided to future Exec Team and CQSPE.
18/097.3 & 19/105.2	Audit Committee Exception Report	BAF to be discussed at the Board Workshop in October. Half day training session on the Board Assurance Framework to be arranged.	GP	11/12/18	Board update on BAF re-scheduled to 11th December.
18/113.3	Recruitment and Retention Report	Recruitment and Retention Business Case to be presented to the October Workforce Committee and December Board meeting taking account of actions outlined by the Board.	AM/JA	23/11/18 & 6/12/18	On Agenda.
18/113.4	Board Assurance Framework and Corporate Risk Register Report	Board Assurance Framework to be discussed at the November Board Workshop.	GP	8/11/18	As 18/097.3 above.
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	23/11/18	To be included in the report to the Workforce Committee.
18/124	Urgent Care Service Improvement Group	New Chair of the SIG to be confirmed when the Chief Operating Officer returns from annual leave.	KK	9/11/18	The Chief Operating Officer will take over as Chair of the Service Improvement Group.

18/125.2	Chief Nurse Report	Information on fill rates to be presented to the November Finance and Performance Committee. Deputy Chief Nurse to provide assurance on Resus staffing and training. New dashboard on ward staffing to be presented to the November Finance and Performance Committee.	CLM/JW CLM/JW CLM/JW	29/11/18 29/11/18 29/11/18	On Agenda
18/126.1	Integrated Performance Report	Cross referencing of actions being taken in respect of poorer performance to be included in the Operational Plan detail in the Performance report.	KK	29/11/18 & 6/12/18	Cross referencing will be added from the quarter 3 monitoring report onwards so that the reader can cross check between the coloured dashboards and the full plan report. The full plan report with full commentary on mitigating actions can be found in Finance and Performance Committee papers.
18/127.1	Winter Plan	Operational plan providing detail on trigger points and reactive actions to be provided to the Board.	KK	6/12/18	On Agenda

Enclosure 11

The Dudley Group
NHS Foundation Trust

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

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

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

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

OVERALL ASSURANCE LEVEL			
Significant Assurance	**Acceptable Assurance**	**Partial Assurance**	**No Assurance**
X 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

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

CORPORATE OBJECTIVE:

SO1, SO2, SO3, SO4, SO5, SO6

SUMMARY OF KEY ISSUES:

- Visits and Events
- Healthcare Heroes
- National Staff Survey
- Flu Vaccine
- Staff Health and Wellbeing
- Christmas Cheer
- Care Home Chef Support
- Baby Bereavement Suite Appeal
- National News
- Regional News

The Dudley Group
NHS Foundation Trust

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:**

Chief Executive's Report – Public Board – December 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

2nd November	Team Brief
7th November	NHSI Performance Review Meeting
8th November	Board Workshop
	Dudley System Oversight and Assurance Group
	National Radiology Day
	Extraordinary Council of Governors
14th November	Endoscopy Away Day
	Tansition Board
19th November	Winter Assurance Visit
28th November	Healthcare Heroes
30th November	Healthcare Heroes

Healthcare Heroes

Congratulations to **Melvin Wilson and Kingswinford, Amblecote and Brierley Hill zone 1 & 3 district nurses** who are this month's Healthcare Hero team winners! This award is our way of saying thank you.

KAB zone 1 & 3 district nurses have received the award for their extremely hard work. The team often stay long after their shifts have finished to ensure patients are seen and are safe regardless of the weather conditions. Rain and deep snow don't deter this hardy team! The team make remarkable effort, seeing between 12 – 20 patients a day with compassion, care and dedication. Well done!

Melvin Wilson received the award after getting letters from grateful relatives who thanked Melvin for his outstanding care, kindness and patience while their loved ones were on the Forget-me-not Unit. Another relative has praised Melvin's special talent for empathising with his patients. Melvin works with many patients who present with dementia and have challenging behaviour, but he always respects all patients and ensures their care is individualised. This attention helps his patients settle a lot better on the ward. Well done!

Don't forget to nominate your Healthcare Heroes to be in the running for next month's awards!

National Staff Survey

The National Staff Survey is open until the end of November and responses are coming in, so far 33% of staff have completed. Results will follow in the New Year and we will ensure improvements are tailored to support staff to make Dudley the best place to work.

Free Flu Vaccines for Staff

Free flu vaccines for all staff are available with peer vaccinators getting out and about across the Trust as well as many drop in sessions across all sites. We are well on our way to our target of at least 75 per cent of frontline staff being vaccinated with 55% of staff taking up the vaccine up to 29.11.2018.

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.

Staff Health and Well Being Fairs

As part of our commitment to supporting staff and making Dudley an excellent place to work we have two health and well being fairs coming up. Staff can receive a free health check and a range of beauty treatments.

The events will take place at Brierley Hill Health & Social Care Centre on Wednesday 5th December and at Russells Hall Hospital on Friday 7th December.

Christmas Cheer

Staff have been grabbing their dancing shoes and practising the high notes for our Dudley Christmas Cheer video to be launched in December. We have also held a design a Christmas card competition. The winning design will be made into cards for staff to give to patients so keep your eyes peeled for the winning designs.

Care Home Chef Support

Trust Dietitians co-ordinated two training events for care home cooks, to help them create delicious meals for people with swallowing difficulties. It is part of a move to new international standards.

The events, held at Mary Stevens Hospice and St James' Medical Practice, saw 50 cooks get to grips with the likes of desserts suitable for a pureed diet such as 'deconstructed black forest gateau' and white chocolate, strawberries and prosecco.

The session was run by specialist chef Gary Brailsford of Dining With Dignity, which provides training nationally to those who support people with dysphagia.

Lisa Truefitt, medicines management dietitian at the Trust, said: “We work closely with the care homes in our area and wanted to support their chefs with the knowledge and practical skills to prepare food and fluids for those on modified texture diets. This has important safety implications.

“At the moment we are transitioning to new international standards through the IDDSI (International Dysphagia Diet Standardisation Initiative) so this training will help get our care homes up to speed.”

Baby Bereavement Suite Appeal

We have got off to a fantastic start with our appeal and the Sparkle Party held on Friday 23rd November was a huge success raising over £1000 on the raffle and auction alone. A big thankyou to everyone who attended on the night and was so generous with their hard earned cash to support this really important appeal.

National NHS News

HEE to be made ‘accountable’ to NHS Improvement

Health Education England (HEE) will be made “accountable” to NHS Improvement, the NHS bodies have announced, alongside a number of measures that will create a “more coherent approach to workforce development.” The Department of Health and Social Care (DHSC) will be working with HEE and other partners to review the roles of the national organisations and their responsibilities as they all work to ensure “that the national workforce system is well aligned.” **National Health Executive (23.10.18)**

Two North East NHS trusts in national top 5 for cancelled children's operations in the past year

Two North East hospital trusts are in the top five nationally for the highest number of cancellations of children's operations in the past year. A record 18,647 emergency and non-emergency children's operations were cancelled last year right across the UK, figures show. County Durham and Darlington NHS Foundation Trust cancelled 5,580, while City Hospitals Sunderland NHS Foundation Trust cancelled 3,644. **ITV News (27.10.18)**

Couples being denied IVF on NHS over man's age or weight

Couples are being turned down for NHS fertility treatment in some areas of England because the man is too old or too fat, despite neither criteria forming part of national guidelines or being proven to affect the success of IVF. Ninety-one per cent of local clinical commissioning groups (CCGs) also refuse access to IVF on the NHS if one of the couple has a child from a previous relationship, a process criticised as social rationing by the campaign group Fertility Fairness. **The Guardian (29.10.18)**

Where are the most violent workplaces?
Until last year, national figures were produced on assaults on health staff - but the body responsible, NHS Protect was closed in April 2017. The Department of Health says part of a new violence reduction strategy for the NHS will involve reintroducing a system of national reporting. For now, we can look at the annual staff survey - it has a sample size of almost half a million or about 45% of NHS workers in England. According to that, 15% of NHS staff have experienced physical violence at work in the last year. The last national figures from NHS Protect we have on reported assaults on staff are from 2015-16 and suggest there was one assault per every 19 staff members.
BBC News (02.11.18)

Children's tonsils 'are being removed unnecessarily'
The claim was prompted by a new study that suggests 7 out of 8 children who have their tonsils removed (tonsillectomy) will experience no benefit. This study reviewed medical records from more than 700 general practices between 2005 and 2016 to see how many tonsillectomies were performed for children, and the reason for doing so. Overall, 2.5 children per 1,000 had a tonsillectomy each year. But only 1 in 8 of these cases met recommended criteria for the procedure. The study was carried out by researchers from the University of Birmingham. It was published in the peer-reviewed British Journal of General Practice.
NHS Choices (06.11.18)

NHS England in legal battle with American firm over medicine procurement
An American pharmaceutical company has launched a legal challenge against NHS England over a procurement process seeking suppliers for ground-breaking hepatitis C treatment. The legal proceedings were launched by the American firm Abbvie in London's Technology and Construction Court during the summer, claiming that NHS England breached its duty to treat all bidders fairly. The procurement was launched in spring in a bid to lower the cost of hepatitis C drugs which are manufactured by Abbvie, MSD Pharmaceutical, Janssen Pharmaceutica, and Gilead Sciences. Back in January, NHS England asked businesses in the pharmaceutical industry to help make the UK the first country in the world to eliminate hepatitis C through its next round of procurement. Hepatitis C leads to around 400,000 deaths a year and affects around 160,000 people in England, and NHS England says it believes it can go further with its treatment and eliminate it five years earlier than the World Health Organisation's goal of 2030. **National Health Executive (07.11.18)**

NHS postcode lottery denying thousands of diabetics blood sugar monitor used by Theresa May, investigation finds
Tens of thousands of people with type 1 diabetes are being put at increased risk of serious complications by "short-sighted" rationing of a blood sugar patch used by Theresa May, an investigation has found. The prime minister is one of 400,000 type one diabetics in the UK. She told Parliament in last month that NHS patients would be prescribed the same Freestyle Libre monitor she uses to maintain a healthy blood glucose levels. **The Independent (08.11.18)**

'Rocketing demand' sees NHS performance figures drop as winter approaches
Last month saw the lowest percentage of NHS patients seen within four hours for any October since records began as the NHS's latest performance figures do not bode well for the upcoming winter pressures. New statistics show that the NHS missed its two-week cancer target for the sixth month running, and the number of people waiting longer than the 18-week elective care target has risen by a third in the last 12 months against a backdrop of "stark" increases in admissions and waiting times across England. The performance figures released by NHS England show that there has been a 3.6% increase in A&E admissions compared to this time last year when "extremely challenging" winter conditions saw the highest figures ever recorded for the number of patients waiting in trolleys for more than four hours in A&E. **National Health Executive (08.11.18)**

NHS England has said it is "working to ensure delays are minimised" around the publication of national clinical audits amid "significant concerns" raised by royal colleges.
In a joint statement agreed on Wednesday and published on the Healthcare Quality Improvement Partnership website, NHS England said it planned to keep the process "under constant review" to ensure patients benefit from the work. The statement followed concerns raised with NHS England over clinical audit reports being delayed for months. **National Health Executive (09.11.18)**

Capita's cancer screening blunder hits 50,000 NHS patients
More than 40,000 women have not received information on cervical cancer screening after the NHS contractor Capita failed to send out letters. The problem, which occurred between January and June, affected 43,200 women who were supposed to receive an invitation or a reminder but received only one of the two, and also led to the delays of 4,508 results letters, the company said. **The Guardian (14.11.18)**

NHS England overhauling national cancer screening programmes
NHS England will overhaul cancer screening as part of the long-term plan and has called on England's first national cancer director to lead the work. Sir Mike Richards will review England's three national cancer screening programmes, NHS England said today. He is expected to report next summer. The review will examine the breast, bowel and cervical screening programmes' strengths and weaknesses, try to increase the number of eligible patients being screened, and find ways of incorporating new technology and techniques into existing programmes. The review comes three weeks after HSJ revealed the National Audit Office is investigating the four national screening programmes, consisting of the three cancer programmes now under review and the abdominal aortic aneurysm screening programme. **HSJ (15.11.18)**

Britain at risk of paralysing Russian cyber attacks against NHS and Parliament
Russian hackers are planning "hostile, disruptive and destructive" **cyber attacks** on the **NHS** and Parliaments, politicians today warned. There are said to be up to 10 small attacks every day but hackers are reportedly preparing to cripple the country's health system and national grid in the near future. **The Mirror (19.11.18)**

Dozens of NHS trusts fail key targets on waiting times for a year
Nearly one in five NHS hospital services has failed to hit any key national waiting-time targets in the past year, analysis shows. Some 29 hospital trusts and boards out of 157 had not hit a single target for 12 months running, an investigation by the BBC found. **The Independent (21.11.18)**

PHE and NHSE launch national drive to trace hepatitis C patients
Public Health England (PHE) and NHS England have launched a national exercise to identify and treat patients who have been previously diagnosed with hepatitis C. In recent years new, potentially curative treatments have been developed for hepatitis C, but tens of thousands of people who were diagnosed in the past may not have accessed them. A new report, the first of its kind, by PHE shows more than 24,500 people in England have accessed new hepatitis C treatments in the last 3 years. **Gov.UK (21.11.18)**

20-minute flu test could save NHS up to £24m a year and free up beds, manufacturer says
A test that can diagnose the flu in just 20 minutes has helped cut the numbers of needless admissions and freed up hospital beds in pilots at two NHS trusts. Hospital patients usually have to wait for their tests to be sent to a laboratory and it can take several days to get the results, often meaning they are put into unnecessary isolation, significantly affecting the management of beds. **The Independent (24.11.18)**

NHS replaces highest-spend drug with £300m cheaper alternative
The NHS is set to make a record-breaking saving after reaching deals with manufacturers on low-cost "biosimilar" versions of its most expensive drug, according to the health service's chief executive in England. The deal should save hospitals £300m, which equates to roughly three-quarters of the amount they currently spend, Simon Stevens will announce on Monday. The saving is the result of the introduction of drugs almost identical to adalimumab, which is prescribed to more than 46,000 patients to treat conditions such as rheumatoid arthritis, inflammatory bowel disease and psoriasis. Adalimumab was previously available only under the brand name Humira, but its exclusive patent recently expired, allowing the NHS to accept bids from companies who make biosimilar versions. The new drugs should be available to patients from December. In 2016-17, the NHS spent £18.2bn on medicines, an increase of more than a third since 2010-11. It says it saved more than £200m in 2017-18 by using best-value biological medicines. **The Guardian (26.11.18)**

NHS leadership pressures creating 'negative working culture' where bullying is prevalent, says official review
A review into NHS leadership has said it found a "a negative working culture" where "bullying and discrimination are prevalent and accepted." Sir Ron Kerr was commissioned by the Department of Health and Social Care to conduct the review in executive leadership within the NHS, and has today published a series of recommendations.

The review, which included evidence from NHS Providers and NHS Clinical Commissioners, recommended a number of actions which were needed to "build a modern working culture in which all staff feel supported, valued and respected for what they do and can challenge without fear." The report focused on three issues: the expectations and support available to leaders, options for reducing administrative burdens on leaders, and the scope for further aligning management expectations at an organisational and system level. One of the review's major recommendations was to use the NHS long-term plan to ensure challenged NHS organisations become "desirable" places to work, and called for a "new deal" between national bodies. **National Health Executive (28.11.18)**

Regional NHS News

Shock figures reveal one in six NHS workers were attacked at Stoke-on-Trent's biggest hospital in just one year

The NHS will adopt a 'zero tolerance' approach to violence against staff after it emerged one in six hospital workers in North Staffordshire were attacked last year. Health Secretary Matt Hancock will set out a series of measures to protect employees after a survey showed that 15.2 per cent of staff have experienced physical violence in the last 12 months, the highest in five years. Staff working at the **Royal Stoke University Hospital** or Stafford County Hospital are even more likely to be assaulted by patients, their relatives or other members of the public than the national average. Figures show that 15.8 per cent of Royal Stoke staff had been subjected to violence while carrying out their jobs in 2017.
StokeonTrentLive (01.11.18)

New Cross to take the bulk of extra patients when Telford's A&E closes overnight

Bosses at West Midlands Ambulance Service (WMAS) have started preparing for the move, which has been proposed by Shrewsbury and Telford NHS Trust (SaTH) due to staff shortages. In a report to the WMAS foundation trust board, CEO Anthony Marsh said most patients from the Princess Royal Hospital would be transferred to Wolverhampton's New Cross Hospital – a journey of 23 miles. **Express & Star (01.11.18)**

West Midlands Hospital Trust Put In Special Measures

NHS Improvement confirmed on Thursday that Shrewsbury and Telford Hospital NHS Trust has been placed into special measures following recommendations from the Care Quality Commission (CQC). Ian Dalton, chief executive of NHS Improvement, said: "While Shrewsbury and Telford Hospital NHS Trust has been working through its many challenges, it is important that the trust is able to deliver the high-quality care that patients deserve. **Heart (09.11.18)**

NHS bosses to meet over night-time Telford A&E closure plan
The planned night-time closure of Telford's A&E will need to signed off by health commissioners and NHS regulators before it can go ahead. Health bosses will meet with representatives from NHS Improvement in Birmingham tomorrow to work through the details of how an overnight closure would work, Shropshire Clinical Commissioning Group's governing body has heard. Shrewsbury and Telford Hospital NHS Trust is planning to bring in the closure of A&E at Princess Royal Hospital, between 10pm and 8am, from December 5 if additional staff cannot be found. There are currently shortages of A&E consultants, nurses and middle grade doctors. A report put before Shropshire CCG's board yesterday said the decision to close the department overnight has been supported by the West Midlands Clinical Senate. **Shropshire Star (15.11.18)**

Cancer patients not being seen quickly enough
During September almost half of patients at The Royal Wolverhampton NHS Trust waiting too long to start treatment after an urgent GP referral. The trust came last among all 131 trusts in England for its cancer waiting times, which saw 56.9 per cent of patients start treatment within the 62 days - or two months. The target is for 85 per cent of patients to be seen within 62 days, and The Royal Wolverhampton NHS Trust fell short of this by 28 per cent. Targets suggest 96 per cent of those should start treatment within a month. In September, at the trust, it was 87 per cent. Nationally, 78.2 per cent of patients urgently referred by their GP with suspected cancer started treatment within the two-month set time period. Sandwell and West Birmingham Hospitals NHS Trust at 84.5 per cent, and University Hospitals of North Midlands NHS Trust, which treats patients in Stafford and Stoke, 84.6 per cent. Walsall Healthcare NHS Trust did hit the recommended target with 86.7 per cent of patients being seen within 62 days. **Express & Star (20.11.18)**

A&E, cancer care and operations: Wolverhampton NHS trust missing three key targets
A shock report shows the Royal Wolverhampton NHS Trust, which runs the hospital, failed to meet the Government's most important targets for A&E, cancer and routine operations every month in 2017-18. NHS bosses have warned of a testing winter ahead, while politicians in the city have demanded health bosses stop piling extra pressure on New Cross Hospital's already strained resources. Only 53.3 per cent of patients were treated within the required 62 day period, compared to the national average of 78.2 per cent and an NHS target of 85 per cent. March saw the trust's best performance for cancer, when three-quarters of all patients were dealt with on time. **Express & Star (23.11.18)**

Online DNA analysis decodes the secrets to better health
An online platform is uniting medical and health experts to deliver rapid analysis of patient DNA data in a bid to reduce costs and improve lives. The company behind the platform, Rightangled, is CQC-registered and part-owned by West Midlands Academic Health Science Network, and is gaining attention in both the UK and US for its ability to combine testing of thousands of genetic markers with a specialist review of that data. **APN News (26.11.18)**

Urgent care company collapse leaves GPs just 10 days to find out-of-hours cover
A number of GP practices are being forced to urgently seek replacement out-of-hours cover after the private company providing services on their behalf gave them just 10 days' notice of ceasing operations. Primecare, which forms part of the financially struggling Allied Healthcare group, wrote last week to over 20 Birmingham GP practices for which it directly provides out-of-hours cover, informing them they would stop services by the end of the month. NHS Walsall CCG, NHS Sandwell and West Birmingham CCG, NHS Herefordshire CCG and NHS Nene CCG all hold out-of-hours and urgent care services contract with the company, while Primecare also forms part of a wider NHS 111 and out-of-hours contract covering more than a dozen West Midlands CCGs. **Pulse (26.11.18)**

Out-of-hours GP service used by 24 practices is to close in just THREE DAYS in 'absolutely disgraceful' move that will affect tens of thousands of patients
Tens of thousands of patients are set to be affected by the closure of an out-of-hours GP service in just a matter of days. Primecare will 'cease all operations' as of December, the firm said in a letter sent to organisations it provides care for in the West Midlands. Health leaders have today condemned the firm's decision to shut its services – with just 10 days' notice - as 'absolutely disgraceful'. **Daily Mail (27.11.18)**

300 new paramedics to be recruited at West Midlands Ambulance Service
By Christmas next year, 225 more student paramedics and around 90 graduate and registered paramedics will be taken on by the ambulance service, which covers the Black Country and Staffordshire as well as Shropshire, Herefordshire, Worcestershire, Warwickshire, Coventry, and Birmingham. Recruitment manager, Louise Harris, said the service's student paramedic programme has seen more than 1,000 members of staff taken on since it began. She said: “Our innovative student paramedic programme has proved hugely successful since its introduction, seeing more than 1,000 members of staff taken on through it.
Express & Star (28.11.18)

Shropshire Hospital Trust Gets Another Grilling Over Maternity Care
The Care Quality Commission (CQC) rated services at Shrewsbury and Telford Hospital NHS Trust (SaTH) as "inadequate" in findings published on Thursday. The trust runs Shropshire's two main hospitals, Telford's Princess Royal and the Royal Shrewsbury Hospital. It was placed into special measures earlier in November amid a review of more than 100 cases of alleged poor maternity care. **Heart (29.11.18)**

Enclosure 12

The Dudley Group NHS Foundation Trust

Paper for submission to the Board of Directors 6 December

TITLE:	**27 November 2018 Clinical Quality, Safety and Patient Experience Committee Meeting Summary**		
AUTHOR:	Gilbert George – Interim Director of Governance	**PRESENTER**	Julian Atkins – 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.*

ACTION REQUIRED OF BOARD

Decision	Approval	Discussion	Other (Assurance)
			Y

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

The Board should note the assurances provided by the Committee and the actions they took at the last meeting. The Board should note that there are no specific matters requiring referral to the Board from the November meeting.

CORPORATE OBJECTIVES:

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

The Dudley Group
NHS Foundation Trust

SUMMARY OF KEY ISSUES:			
The attached provides a summary of the assurances received at this meeting, the decisions taken, the tracking of actions for subsequent meetings of this Committee and the action the Committee is seeking the Board to take.			
IMPLICATIONS OF PAPER:			
RISK	**Y**		**Risk Description:** covers many risks, nut key are those related to the Trust quality priorities, deteriorating patient and patient experience
	Risk Register: Y		**Risk Score:** numerous across the BAF, CRR and divisional risk registers
COMPLIANCE and/or LEGAL REQUIREMENTS	**CQC**	**Y**	**Details:** links all domains
	NHSI	**Y**	**Details:** links to good governance
	Other	**N**	**Details:**

The Dudley Group NHS Foundation Trust

Committee Highlights Summary to Board

Committee	Meeting Date	Chair	Quorate	
Clinical Quality, Safety and Patient Experience Committee	27 November 2018	J Atkins	**yes**	**no**
			Yes	

Declarations of Interest Made

None

Assurances received

RISK AND ASSURANCE GROUP HIGHLIGHT REPORT

The Committee received a report from the Risk and Assurance Group which provided information covering NPSA alerts, Coroner's 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 of 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.

SAFREGUARDING REPORT

The Committee received a Safeguarding report covering November 2018 detailing safeguarding activity and the service. The presenter confirmed there had been an increase in safeguarding referrals and the Safeguarding Team continued to contribute to a high number of Safeguarding Adults Reviews (SAR), Domestic Homicide Reviews (DHR) and Serious Case Reviews (SCR) which was impacting upon existing resource and capacity.

The presenter reported the need to increase safeguarding supervision provision across the Trust. Staff with the training to deliver safeguarding supervision had increased from 2 to 4 but the trajectory was for 8 to enhance delivery.

In relation to recruitment the mandated role of maternity safeguarding lead had had its hours increased from part to full time and was presently out for advertisement. The safeguarding team provided assurance they had a sustained and consistent presence now across the Trust and had developed close working relationships with multiagency partners.

There was now a live safeguarding children system in the Trust, this was also live in Dudley Social care and allowed sharing of local intelligence. This was presently being embedded in the departments.

INTEGRATED QUALITY AND PERFORMANCE REPORT

The committee received the integrated quality and performance report which highlighted the following:

- There had been no C Diff cases identified after 48 hours in the month
- There had been one MRSA bacteraemia which was presently being investigated
- The Dudley group continued to perform better in comparison to national average in terms of number of falls and falls with harm. Two falls with harm were reported in October: one patient required no treatment for the injury and has since been discharged. The second patient was treated for their injury and continues to recover on the hip suite.
- A thematic review had been completed in relation to pressure ulcers and presented to Dudley CCG. One category 3 avoidable pressure ulcer was reported on STEIS in October 2018 with no category 4 since February 2018.
- There had been nine sleeping accommodation breaches in October all were reported by SHDU and were all related to capacity issues in the acute hospital.
- There had been a draft quality heat map developed for quick guidance and overview with regards to areas of concern and where resources and quality improvement will be focused.

PATIENT EXPERIENCE

The Committee received the monthly report on patient experience information for October 2018. The report provided an update on compliments, friends and family feedback, concerns and complaints activity. In summary:

- There had been a 12% decrease in compliments received in October compared to September 2018 with 14 received via NHS choices– work was being completed to relaunch the initiative of providing cards in clinical areas to encourage patients and relatives to comment on NHS choices.

MATERNITY DASHBOARD

A paper was presented in relation to the maternity dashboard; the Maternity Dashboard is a locally agreed set of metrics and performance indicators that allows a monthly snapshot of a variety of aspects of the service. It was highlighted that although there had been an increase in October in the Caesarean section (C/S) rate, it was confirmed that these had with exception of emergency cases all been the patient's decision and this had been discussed prior to procedure being undertaken. In addition a daily review of all cases was completed to identify if there are any themes; there was no known cause as to why this had increased. The group were informed that the breastfeeding initiation rates had decreased again this month. In response there had been the introduction and promotion of the 'Flow' texting service but there had been a poor uptake.

SURGERY, WOMEN AND CHILDREN'S DIVISION

The Committee received reports from the Surgery, Women and Children's Division and the Clinical Support Division. The Committee were assured from the Clinical Support Division the MRI Replacement Programme was on schedule and would be completed within one and a half days.

MEDICINES MANAGEMENT GROUP

The Committee received a report from the Medicines Management Group which highlighted a mapping exercise that was being completed in relation to drug prescribing to support the development of a robust training and development programme and set standards. The potential unknown risk of the impact of Brexit was discussed. It was noted that this could have an impact on the supply chains of some medications. The Trust was making preparations now to reduce the potential impact.

DERMATOLOGY

A paper was presented to the Committee which highlighted the impact of capacity (workforce) had on RTT. The group were assured the appointment of locums had had a positive impact on RTT and a trajectory had been developed to reduce this. It was confirmed the department had recruited a substantive consultant and had in post two locums until the end of December 2018 (this was one additional member of staff to support RTT reduction).

MORALTITY REPORT

The Mortality Report was presented to the Committee and highlighted themes that had come from the structured judgement reviews of patients who had been treated in the emergency department. These related to the provision of prompt care, the large number of patients deceased before arrival to the department or in cardiac arrest and many at end of life.
The paper summarised the current SHMI data and reports relating to the impact of a change of coding related to the high inpatient admissions rate in September 2017 and made a recommendation to the Trust and CCG as to the appropriate steps to take from a patient safety and reputation perspective.

SUMMARY OF KEY PROVIDER INFORMATION REQUEST (PIR)

The committee received a report which provided an overview of the Trust's self-assessment submitted to the CQC as part of the PIR. These were: The Trusts self-assessment against its core services and where the Trust assessment had changed since the last published ratings in March 2018 and the Trusts quality assessment against the CQC 5 Key questions.

ESTATES AND FACILITIES REPORT

The Committee received a report on the qualitative aspects of the estates contract management processes in respect of estates and facilities. The report provided information on actions taken in respect of water safety, decontamination and cleaning. The report also contained on the latest medical device compliance and actions taken within the community to improve compliance. 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.

BOARD ASSURABNCE FRAMEWORK

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 updates made by the Executive following the Committee's comments last month.

Decisions Made/Items Approved
• To ratify the removal of 17 audits from the clinical audit forward plan, based on the scrutiny provided by the Clinical Effectiveness Committee, which is chaired by the Medical Director. • To ratify the decision of the policy group to approve GI Operational Policy.
Actions to come back to Committee (items the Committee is keeping an eye on)
To complete a review of the last 12 month caesarean section rates and the actions and changes in practice that had been taken during this period.
Items referred to the Board for decision or action
None

Enclosure 13

The Dudley Group NHS Foundation Trust

Paper for submission to the Board of Directors December 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.*

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:**

Appendix 1

The Dudley Group NHS Foundation Trust

Paper for submission to the Finance and Performance Committee November 2018

TITLE:	**NURSE STAFFING**		
AUTHOR:	**Jo Wakeman Deputy Chief Nurse**	**PRESENTER:**	**Jo Wakeman 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.*	

ACTION REQUIRED OF Finance and Performance COMMITTEE			
Decision	**Approval**	**Discussion**	**Other**
		y	

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 Finance and Performance Committee

To receive the report and note the contents.
Note high vacancy levels that may adversely affect divisional budgets due to spend on temporary staffing.

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

SUMMARY OF KEY ISSUES:

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.

Agency Controls

- Agency usage has seen an increase within month, whilst bank usage has remained static. A contributing factor may have been the October half term period
- 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.
- A combination of bank and agency usage remains consistently lower than vacancies /operational deficits.
- Use of non-framework agency remains an Executive only authorisation this process has been strengthened.

Recruitment and Retention update

- 25 Experienced nurses are due to start between November and January 2019 with a further 51.88 wte post graduate nurses.
- There are currently 33 nursing adverts live on NHS Jobs totalling 199.25 WTE vacancies
- Targeted and monthly recruitment events continue.
- Predictor tools are within the paper as requested. Vacancies have reduced in month by approximately 43 wte.

IMPLICATIONS OF PAPER:

RISK	**Yes**		• **Risk Description:** ➢ Nurse Recruitment – unable to recruit to vacancies to meet NICE guidance for nurse staffing ratios ➢ Finance – Unable to remain within divisional Budget due to spend on Temporary Staff.
	Risk Register: Yes		**Risk Score: 20**
COMPLIANCE and/or LEGAL REQUIREMENTS	**CQC**	**Yes**	**Details:** ➢ Safe- Are patients protected from abuse and avoidable harm ➢ Effective- Peoples care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence ➢ Caring - Staff involve and treat people with compassion, kindness, dignity and respect ➢ Responsive - Services are organised so that they meet people's needs ➢ Well Led - The leadership, management and governance of the organisation assures the delivery of high quality person-centred care, supports learning and innovation, and promotes an open and fair culture
	NHSI	**Yes**	**Details:** Capping of agency
	Other	**Y/N**	**Details:**

Staffing Reviews

Table 1 outlines progress against staffing reviews

Area	Position
General Medical/Surgical Wards	Complete
Critical Care	Complete
Neonatal Unit	Complete.
Paediatrics (C2)	Complete.
Emergency Department	Initially completed. Awaiting a further review.
Acute Medical Unit	AMU 1 and AMU 2 (A2) review agreed by Executive Directors pending an associated paper on the required medical staffing
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) (C6)	Pending
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 (NICE, 2014)

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 that commenced in July 2018. 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 are required to provide this information to NHS Improvement and part of it is utilised in informing the National Model Hospital data.

As previously indicated, the report is based on the new establishments with the data coming from Allocate. The Executive team greed a phase plan to achieve fill rates against the new establishment from September 2018 we aim to achieve 85%. The table 2 below indicates fill rates are improving when taking a trust wide view the only area that has not achieved a fill rate of 85% for October is qualified staff on days. Appendix 1 highlights 13 wards are not achieving a fill rate of 80% with a further 10 wards not achieving a fill rate of 85% against the qualified nursing fill rates. Poor fill rates mainly occur on day shifts. An additional column has been added to appendix 1 that states the occupancy which can be a contributing factor to low fill rates. Seven of the wards with low fill rates had occupancy of less than 80%. This indicates that the other 16 wards (across a mixture of day and night shifts) reported a high occupancy with low fill rates. Triangulation of data against staffing incidents and quality dashboard KPIs provides the oversight that safe, quality care is being delivered to our patients.

Table 2 – Trust position against fill rates

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

July 2018	80%	80%	89%	84%	94%
Aug 2018	80%	77%	89%	84%	94%
Sept 2018	85%	78%	84%	83%	90%
Oct 2018	85%	82%	87%	88%	92%

Mitigation /action

- Matrons review staffing numbers; patient acuity and skill mix each shift when they mitigate any immediate shortfalls by moving staff between wards and then plan for the night and following day. If mitigation within the division is not possible discussions occur with other divisions for support. Staffing issues also occur at the capacity meetings and support is requested when required.
- Each ward and department has a bespoke recruitment and retention action plan with monthly rolling adverts on NHS jobs.
- It has been recognised that some of the Allocate templates need to be amended. For instance, on a number of days on B3 six beds were closed and so one nurse should have been taken off the planned which would have increased the fill rate. Similarly, VASCU is not always full and there is a second nurse planned on Allocate for when there are more than two patients in the unit. Action is being taken to ensure that if this occurs in the future the planned numbers will be amended.
- For CCU, the staffing required will depend on how many patients they have and so staff from the neighbouring catheter laboratory support the unit which are not reflected in the figures. This also occurs on the Stoke Unit when additional support from the stroke bleep holder and the clinical nurse specialists.
- B2Hip during day is covered by the hip fracture nurse when there is a shortfall of staff and this member of staff is not registered on the Allocate system.
- C6 had a particular problem with sickness of unqualified staff during the day this month when the Lead Nurse and Matron assisted the clinical staff.

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.

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) remain within the nationally agreed variation of 6.3 CHPPD and 16.8 CHPPD for general wards (Carter Review, 2016). At a recent NHSI meeting it was recommended that we compare our Trust CHPPD against the model Hospital data for potential cost saving opportunities. A piece of work collating and analysing the data has been undertaken this month using data from the Model Hospital (see appendix 4 for detailed breakdown). A meeting is being set up with NHSI to explore further.
Table 3 below provides an overall view of the 19 areas (excluding Maternity and ITU units due to the reasons outlined in Appendix 4) gives the following:

Table 3

Total CHPPD- HCSW	Equal	Above	Below
Number	5	8	6

Registered Nurse CHPPD	Equal	Above	Below
Number	2	6	11

Quality Indicators

The Committee raised concerns relating to the impact of staffing levels against quality. A full detailed quality report is taken to Clinical Quality and Patient Experience Committee each month. However, detailed below sows some national quality metrics when comparing DGHFT to our peers. These come from the Model Hospital (with latest data being July 2018). It can be seen that the Trust compares favourably with its peers and the national picture (the list of peer Trusts is in Appendix 4)

Table 4

Quality Indicator	Trust %	Peer Median %	National Median %
Proportion of patients on day of survey with "harm-free care"	93.3	94.9	93.9
The proportion of patients with harm from a fall in care - The proportion of patients with evidence of harm from a fall in a care setting in the last 72 hours	0	0.3	0.3
The proportion of patients being treated clinically for a new VTE.	0.2	0.2	0.4
Proportion of patients on the day of survey with one or more new pressure ulcers of grade 2 to grade 4, where the pressure ulcer developed at least 72 hours after admission to the trust.	0.5	0.8	0.6
Proportion of patients with an indwelling urethral urinary catheter also receiving treatment for a urinary tract infection (on the basis of notes, clinical judgement and patient feedback), including UTIs that developed before admission to the trust.	0.3	0.4	0.9

Summary situation of staffing and potential recruitment over the next year

Monthly corporate and local recruitment events continue and have generated the following activity:

Internal Recruitment Events

Recruitment Event	Date of Event	Number of conditional offers made

C5 & CCU local recruitment event	10th October 2018	1 adult nurse
ED local recruitment event	15th October 2018	3 paediatric nurses 1 adult nurse
Corporate recruitment event	23rd October	2 adult nurses

External Recruitment Events

Recruitment Event	Date of Event	Number of conditional offers made
Health Sector Jobs Fair Dublin	13th October 2018	11 Adult Nurses 3 Occupational Therapist 3 Physio Therapists

Ongoing recruitment events both internal and external have been arranged and continual recruitment activity is being conducted.

The next corporate recruitment event will be held on the 22nd November 2018. A advertising campaign for this event will focus on not only registered nurses working in the acute NHS setting but also any nurses wishing to return to the NHS from a non-acute setting.
The following areas have local events booked:

- C7 - 7th November 2018
- C8 - 14th November 2018
- B3 - 6th December 2018
- C1 - 13th December 2018
- ED – 9th January 2019
- Theatres and Critical Care – 16th January 2018
- AMU 1&2 – 24th January 2019

At the time of the report, a total of 25 experienced nurses are currently going through recruitment clearances.
Experienced Nurses completing recruitment clearances.

Head Count	Band	Area	Hours WTE	Potential Start Date
1	5	Theatres	1	November 2018
1	5	ED	1	November 2018
1	6	Community MS Nurse	1	November 2018
1	7	ED	0.96	November 2018
Head Count	Band	Area	Hours WTE	Potential Start Date
1	5	NNU	0.96	December 2018
1	5	Theatres (ODP)	1	December 2018
1	5	Theatres (Nurse)	1	December 2018
1	5	C3	1	December 2018
1	7	Community Care Home Practitioner	1	December 2018
1	8a	Critical Care Deputy Matron	1	December 2018
1	8a	Coronary Heart Disease Nurse - ANP	1	December 2018

Head Count	Band	Area	Hours WTE	Potential Start Date
1	5	Critical Care/ITU	1	January 2019
1	5	Day Case Theatre	1	January 2019
1	5	Theatre	1	January 2019
1	5	AMU2 ***(A2 on nursing predictor)***	1	January 2019
3	5	ED Paediatric Nurses	2.44	January 2019
2	5	GU Medicine	1.60	January 2019
2	5	C5	2	January 2019
1	6	Community	1	January 2019
2	7	ED	2	January 2019

Potential graduate nurses due to commence in November 2018 and January 2019 are as follows:

November 2018

Dudley Graduates		
Head Count	Hours WTE	Potential Start Date
3	3	12th November 2018
External Graduates		
Head Count	Hours WTE	Potential Start Date
8	8	12th November 2018

January 2019

Dudley Graduates		
Head Count	Hours WTE	Potential Start Date
31	28.60	28th January 2019
External Graduates		
Head Count	Hours WTE	Potential Start Date
16	15.28	28th January 2019

These figures are subject to change from possible withdrawals and deferrals due to not completing all academic work.

There are currently 33 nursing adverts live on NHS Jobs totalling 199.25 WTE vacancies. This has increased our recruitment activity; however the recruitment and retention lead is continually working with lead nurses, matrons, HR business partners and the staff engagement lead with the areas with high vacancies as a priority. Specific recruitment and retention action plans for these areas are being devised and reviewed every 6-8weeks.

Clinical Incident staffing analysis

Tables 5 and 6 below detail the number of clinical incidents during October 2018 that related to staffing. In total there were 38 incidents, 31 of these were recorded as no harm and 7 incidents were reported as a near miss. There were no staffing incidents reported during October that was stated as causing harm.

Table 5

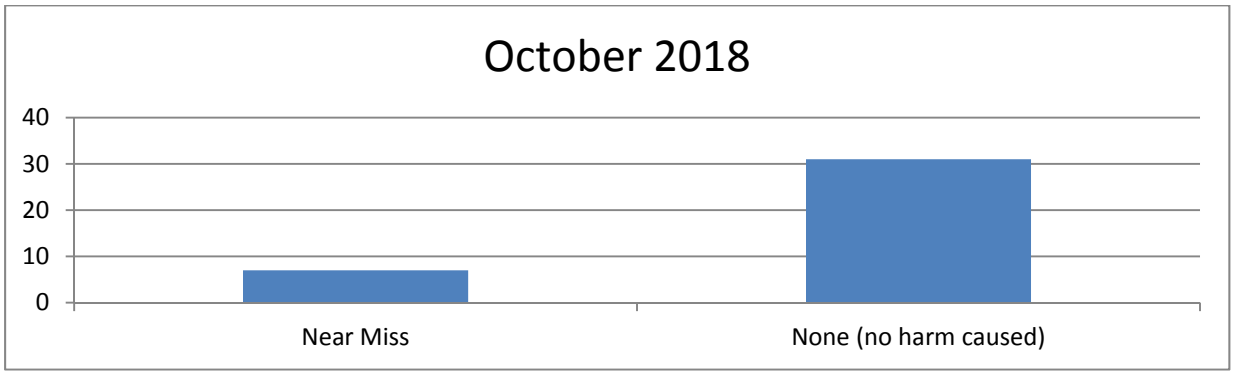
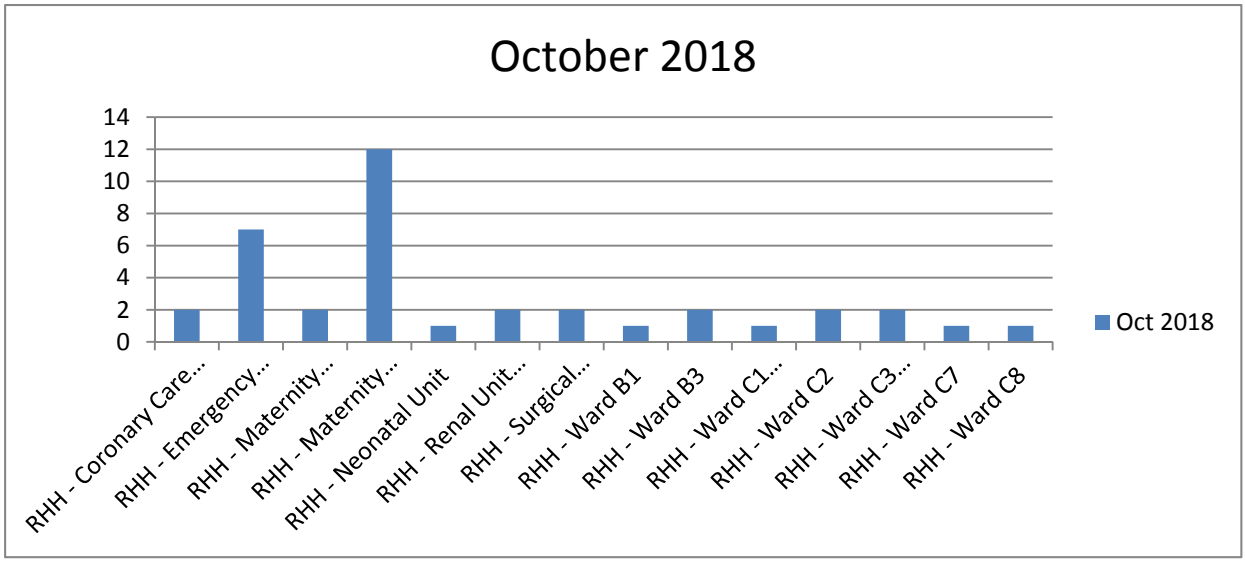


Table 6

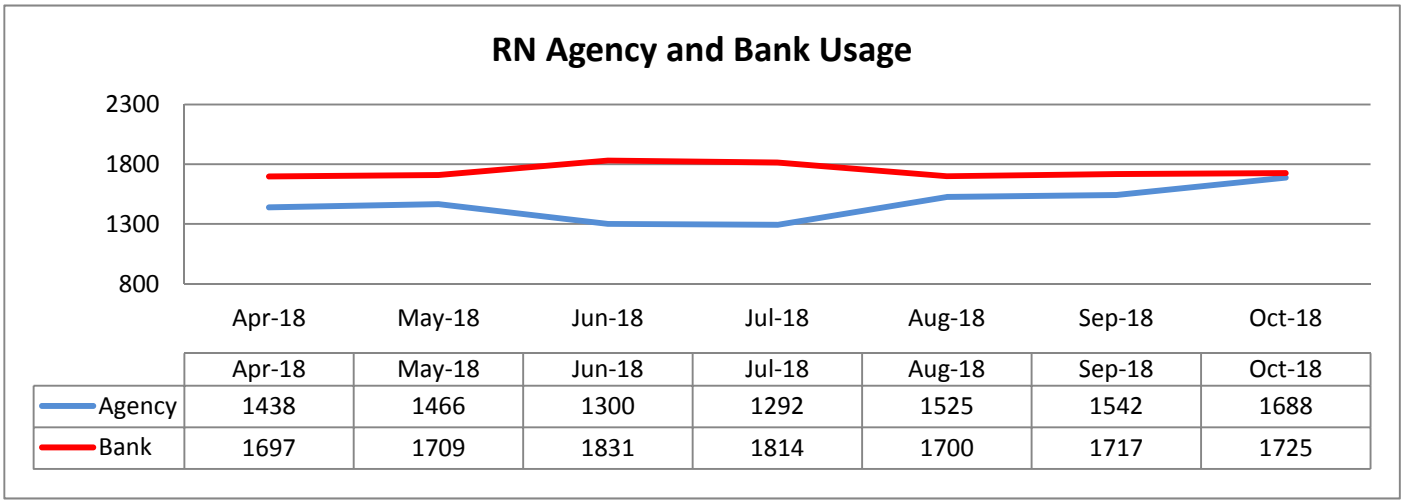


Agency Controls

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 7 shows the comparison usage of bank and agency; agency usage has seen a significant increase in month whilst bank has remained static. The increase in agency may have been seen due to October half term as the maximum allowances for annual leave would have been taken by the staff. This is with a vacancy situation of 280 WTE a reduction of 43 wte from last month. The controls against agency usage for CSW staff have been maintained with zero shifts during this period (table 8).

Agency and Bank RN monthly usage (measured in shifts)
Table 7



	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18
Agency	1438	1466	1300	1292	1525	1542	1688
Bank	1697	1709	1831	1814	1700	1717	1725

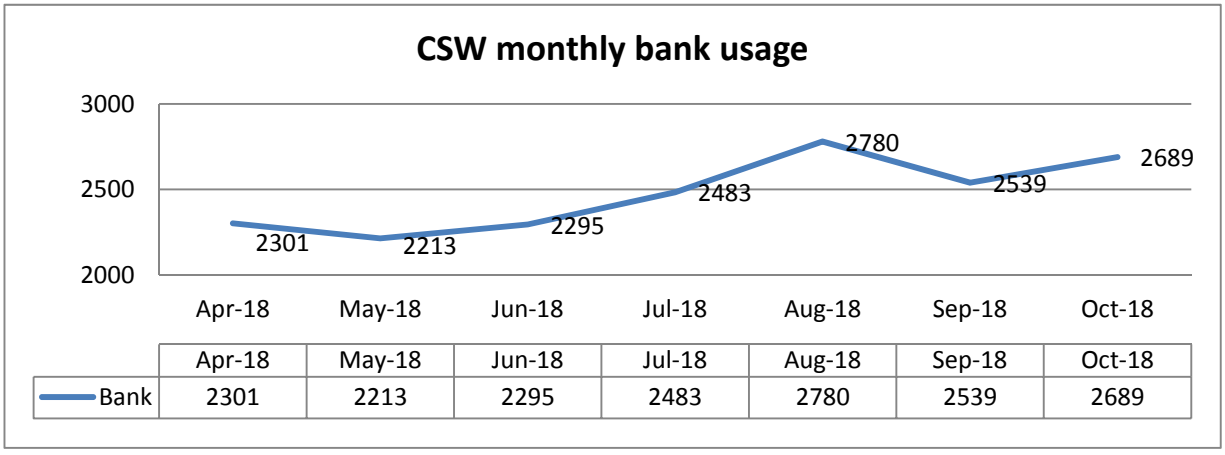
Detailed below is the top 5 areas with the highest usage of bank and agency over the last two months. (Measured in shifts)

ED remains the highest user of temporary staffing, staffing review remains incomplete.

Ward	Sep-18
Emergency Dept Nursing Dept	263
A2	151
B3 Emergency Surgery	150
Critical Care (ITU)	102
Coronary Care Unit Dept	94

Ward	Oct-18
Emergency Dept Nursing Dept	299
B3 Emergency Surgery	188
A2	154
C8 Stroke Rehab Dept	153
Critical Care (ITU)	126

CSW monthly bank usage (measured in shifts)
Table 8



	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18
Bank	2301	2213	2295	2483	2780	2539	2689

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 280 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	Oct			Days in Month	31												
	Day RN	Day RN	Day CSW	Day CSW	Night RN	Night RN	Night CSW	Night CSW					Actual CHPPD				
Ward	Plan	Actual	Plan	Actual	Plan	Actual	Plan	Actual	Qual Day	UnQual Day	Qual N	UnQual N	Sum 24:00 Occ	Average Occupancy	Registered	Care staff	Total
Evergreen																	
A2 AMU 2	278	222	245	189	186	174	219	187	80%	77%	93%	86%	1,149	88%	4.13	3.93	8.06
A3																	
A4																	
B1	122	108	66	55	90	73	64	58	88%	84%	81%	90%	533	66%	3.97	2.54	6.51
B2(H)	156	121	192	167	124	100	205	195	77%	87%	81%	95%	903	97%	2.86	4.82	7.68
B2(T)	118	102	136	113	95	62	111	100	86%	83%	65%	90%	690	93%	2.85	3.71	6.55
B3	283	200	209	188	218	181	169	149	71%	90%	83%	88%	1,043	80%	4.29	3.79	8.07
B4	253	205	258	218	186	152	202	187	81%	85%	82%	93%	1,405	94%	2.94	3.46	6.40
B5	239	200	156	129	188	177	95	87	84%	83%	94%	91%	647	87%	6.83	4.00	10.83
B6																	
C1	249	169	300	257	186	162	204	198	68%	85%	87%	97%	1,458	98%	2.73	3.74	6.47
C2	274	238	74	67	189	180	31	31	87%	89%	95%	99%	644	69%	7.60	1.61	9.21
C3	258	202	305	301	186	168	397	380	78%	99%	90%	96%	1,598	99%	2.77	5.11	7.89
C4	164	156	62	62	124	96	62	81	95%	100%	77%	130%	654	96%	4.50	2.62	7.12
C5	237	179	260	272	185	161	192	184	76%	105%	87%	96%	1,447	97%	2.82	3.78	6.60
C6	125	107	111	66	63	61	116	103	86%	59%	97%	89%	551	89%	3.56	3.69	7.25
C7	244	203	196	172	147	124	165	135	83%	88%	85%	82%	1,094	98%	3.40	3.29	6.69
C8	342	238	264	204	283	227	250	216	70%	77%	80%	86%	1,291	95%	4.33	3.90	8.22
CCU_PCCU	258	189	62	53	217	154	31	31	73%	85%	71%	100%	642	80%	6.26	1.57	7.83
Critical Care	365	370	56	57	342	349			101%	101%	102%		297	60%	28.43	2.29	30.73
EAU AMU 1	273	215	302	249	254	235	299	265	79%	83%	92%	88%	860	99%	6.27	7.17	13.44
Maternity	932	841	238	218	527	492	155	146	90%	92%	93%	94%	812	60%	15.04	5.12	20.16
MHDU	157	153	41	31	156	127			97%	75%	81%		209	67%	16.07	1.55	17.62
NNU	204	144			186	172			71%		92%		432	77%	8.44	0.00	8.44
TOTAL	**5,531**	**4,559**	**3,534**	**3,069**	**4,131**	**3,626**	**2,967**	**2,731**	**82%**	**87%**	**88%**	**92%**	**18,359**		**5.07**	**3.76**	**8.83**

Appendix 2 - Registered Nurse Predictor Tool- Detail New Establishments

2018	To end of October 2018		November 2018				December 2018				January 2019				February 2019				March 2019				
Contracted Vacancy Vs NEW ESTABLISHMENT	Adjustments to end of month	Vacs	All Recruit	Net Leave (8%)	Agency RAG	Vacs	All Recruit	Net Leave (8%)	Agency RAG	Vacs	All Recruit	Net Leave (8%)	Agency RAG	Vacs	All Recruit	Net Leave (8%)	Agency RAG	Vacs	Targeted Recruit	General Recruit (4.3%)	Net Leave (8%)	Agency RAG	Vacs
14.52	0.00	14.52	1.00	0.18		13.70	0.00	0.18		13.88	5.00	0.18		9.07	0.00	0.22		9.28	0.00	0.11	0.21		9.38
14.75	0.00	14.75	0.00	0.16		14.91	0.00	0.16		15.07	4.00	0.16		11.23	0.00	0.19		11.42	0.00	0.10	0.18		11.50
9.48	0.00	9.48	1.00	0.18		8.66	0.00	0.19		8.85	0.00	0.19		9.03	0.00	0.18		9.22	0.00	0.10	0.18		9.30
1.71	0.00	1.71	0.00	0.17		1.88	0.00	0.17		2.05	0.64	0.17		1.58	0.00	0.17		1.75	0.00	0.09	0.17		1.82
3.40	0.00	3.40	0.00	0.08		3.48	0.00	0.08		3.55	0.00	0.08		3.63	0.00	0.08		3.70	0.00	0.04	0.07		3.74
9.29	0.00	9.29	0.00	0.07		9.36	0.00	0.07		9.43	0.00	0.07		9.49	0.00	0.07		9.56	0.00	0.04	0.07		9.59
7.37	0.00	7.37	0.00	0.08		7.45	0.00	0.08		7.53	0.00	0.08		7.61	0.00	0.08		7.69	0.00	0.04	0.08		7.73
13.51	0.00	13.51	0.00	0.14		13.65	0.00	0.14		13.79	3.00	0.14		10.92	0.00	0.16		11.08	0.00	0.08	0.15		11.15
27.19	0.00	27.19	0.00	0.18		27.37	0.00	0.18		27.55	2.00	0.18		25.73	0.00	0.19		25.92	0.00	0.10	0.19		26.00
14.99	0.00	14.99	1.00	0.20		14.19	0.00	0.20		14.39	3.00	0.20		11.59	0.00	0.22		11.80	0.00	0.12	0.22		11.90
3.13	0.00	3.13	1.00	0.23		2.36	0.00	0.24		2.60	3.44	0.23		(0.61)	0.00	0.26		(0.35)	0.00	0.14	0.25		(0.23)
0.72	0.00	0.72	0.00	0.18		0.90	0.00	0.18		1.08	2.00	0.18		(0.74)	0.00	0.19		(0.55)	0.00	0.10	0.19		(0.46)
(0.86)	0.00	(0.86)	0.00	0.09		(0.77)	0.00	0.09		(0.68)	0.00	0.09		(0.58)	0.00	0.09		(0.49)	0.00	0.05	0.09		(0.45)
18.99	0.00	18.99	2.96	0.44		16.47	0.00	0.46		16.93	13.48	0.45		3.90	0.00	0.54		4.44	0.00	0.29	0.54		4.69
6.05	(0.72)	6.77	0.00	0.99		7.75	1.00	0.98		7.73	3.24	0.98		5.47	1.00	0.99		5.47	0.00	0.53	0.99		5.93
11.63	(2.76)	14.39	0.50	1.62		15.51	1.50	1.61		15.63	8.58	1.61		8.66	1.00	1.66		9.32	0.00	0.89	1.65		10.08
5.66	0.00	5.66	0.00	0.09		5.75	0.00	0.09		5.84	0.00	0.09		5.93	0.00	0.09		6.03	0.00	0.05	0.09		6.07
7.58	0.00	7.58	0.00	0.08		7.66	0.00	0.08		7.74	0.64	0.08		7.18	0.00	0.08		7.26	0.00	0.04	0.08		7.30
9.71	1.00	8.71	0.00	0.12		8.83	0.00	0.12		8.95	2.00	0.12		7.06	0.00	0.13		7.19	0.00	0.07	0.13		7.25
27.60	0.00	27.60	1.00	0.11		26.71	0.00	0.11		26.82	2.00	0.11		24.93	0.00	0.12		25.06	0.00	0.07	0.12		25.12
5.17	2.08	3.09	0.00	0.10		3.19	0.00	0.09		3.28	1.00	0.09		2.37	0.00	0.10		2.47	0.00	0.05	0.10		2.52
5.77	1.00	4.77	1.00	0.09		3.86	0.00	0.10		3.96	0.00	0.10		4.06	0.00	0.10		4.15	0.00	0.05	0.10		4.20
1.79	0.00	1.79	0.00	0.25		2.04	0.00	0.25		2.29	1.64	0.25		0.89	0.00	0.25		1.14	0.00	0.14	0.25		1.26
1.43	0.00	1.43	0.00	0.10		1.53	0.00	0.10		1.63	0.00	0.10		1.72	0.00	0.10		1.82	0.00	0.05	0.10		1.86
(1.00)	0.00	(1.00)	0.00	0.26		(0.74)	0.00	0.26		(0.48)	0.00	0.26		(0.22)	0.00	0.26		0.03	0.00	0.14	0.25		0.15
2.44	0.00	2.44	0.00	0.25		2.69	0.96	0.25		1.98	1.00	0.25		1.23	0.00	0.26		1.49	0.00	0.14	0.26		1.60
15.77	0.00	15.77	1.00	0.39		15.16	0.00	0.40		15.56	5.00	0.39		10.95	0.00	0.42		11.38	0.00	0.23	0.42		11.57
21.41	(0.69)	22.10	3.00	0.34		19.44	2.00	0.36		17.79	3.00	0.37		15.16	0.00	0.38		15.54	0.00	0.21	0.38		15.72
11.66	0.00	11.66	0.00	0.25		11.91	0.00	0.25		12.16	1.00	0.25		11.40	0.00	0.25		11.65	0.00	0.13	0.25		11.77
2.32	0.00	2.32	0.00	0.69		3.01	0.00	0.68		3.69	0.00	0.68		4.36	0.00	0.67		5.03	0.00	0.36	0.67		5.34
(0.24)	(2.76)	2.52	0.50	1.01		3.03	1.50	1.00		2.53	8.58	1.01		(5.04)	1.00	1.06		(4.98)	0.00	0.57	1.06		(4.50)
7.33	0.00	7.33	0.00	0.25		7.58	0.00	0.25		7.83	0.00	0.25		8.08	0.00	0.25		8.33	0.00	0.29	0.53		8.57
280.27	(2.85)	283.12	13.96	9.35		278.50	6.96	9.38		280.92	74.24	9.36		216.04	3.00	9.79		222.84	0.00	5.40	10.04		227.48

Qual Nurses Band 5 and Above		As At End Of...										October 2018		To end of October
Div	Team	OLD ESTABLISHMENT Qual Nurses Band 5 and Above	NEW ESTABLISHMENT Qual Nurses Band 5 and Above	Contracted Staff in Post (Incl New Supernumuary)	Starters (Actual this month)	Leavers (Actual this month)	Sickness	Maternity	Bank Worked WTE	Agency Worked WTE	Agency RAG	Contracted Vacancy Vs OLD ESTABLISHMENT	Contracted Vacancy Vs NEW ESTABLISHMENT	Adjustments to end of month
Medicine & Integrated Care	Ward A2 AMU 2	36.89	41.32	26.80	0.00	0.00	1.88	3.10	3.77	4.20		10.09	14.52	0.00
	Ward C1	31.36	39.03	24.28	0.00	0.00	1.18	0.15	2.93	3.65		7.08	14.75	0.00
	Ward C3	34.91	36.62	27.14	0.00	0.96	0.82	0.00	3.83	3.07		7.77	9.48	0.00
	Ward C4	25.61	27.15	25.44	0.00	0.00	1.71	0.00	1.34	0.00		0.17	1.71	0.00
	Ward C4 Onc Day OP	14.84	14.88	11.48	0.00	0.00	0.66	0.00	0.14	2.08		3.36	3.40	0.00
	Ward C5 Area A	15.30	19.49	10.20	0.00	0.00	0.00	0.00	1.59	3.56		5.10	9.29	0.00
	Ward C5 Area B	15.30	19.49	12.12	0.00	0.00	0.00	0.00	1.66	1.84		3.18	7.37	0.00
	Ward C7	29.60	34.26	20.75	0.00	0.00	0.88	0.00	3.46	3.70		8.85	13.51	0.00
	Ward C8	37.79	54.15	26.96	0.00	0.00	1.04	1.88	5.64	10.73		10.83	27.19	0.00
	Ward CCU	37.12	44.31	29.32	1.00	0.00	0.97	0.00	3.43	5.13		7.80	14.99	0.00
	Acute Med Unit (EAU)	37.84	37.84	34.71	0.00	0.96	0.00	0.00	4.89	6.43		3.13	3.13	0.00
	Ward MHDU	17.56	27.88	27.16	0.00	0.00	1.70	0.00	0.60	0.22		(9.60)	0.72	0.00
	Ward Ambulatory Emergency Care	13.39	13.06	13.92	0.00	0.00	0.19	0.92	0.80	0.00		(0.53)	(0.86)	0.00
	Emergency Department Nursing	63.97	85.02	66.03	0.00	0.00	3.50	3.30	5.74	23.68		(2.06)	18.99	0.00
	Community Nursing	152.45	153.94	147.89	2.40	2.80			6.23	0.00		4.56	6.05	(0.72)
	All Other Med & Int Care Teams	245.52	254.75	243.12	1.00	3.00			8.38	3.58		2.40	11.63	(2.76)
Surgery	Ward B1	18.35	19.50	13.84	0.00	0.00	0.94	0.89	1.95	1.24		4.51	5.66	0.00
	Ward B2 (T)	14.80	19.50	11.92	0.00	0.00	0.44	0.00	0.82	4.98		2.88	7.58	0.00
	Ward B2 (H)	23.08	27.55	17.84	0.00	0.00	0.89	1.69	3.54	0.50		5.24	9.71	1.00
	Ward B3	31.36	43.68	16.08	0.00	0.00	1.54	1.10	3.25	14.31		15.28	27.60	0.00
	Ward B4	15.68	19.49	14.32	0.00	0.00	1.55	0.07	2.50	0.75		1.36	5.17	2.08
	Ward B4B	15.68	19.49	13.72	0.00	0.00	1.54	0.14	1.70	0.99		1.96	5.77	1.00
	Ward B5	34.94	39.04	37.25	0.00	0.00	1.64	2.84	1.82	3.41		(2.31)	1.79	0.00
	Ward C6	16.92	16.19	14.76	0.00	0.00	1.03	0.00	1.58	2.44		2.16	1.43	0.00
	Ward C2	38.16	38.16	39.16	0.00	0.00	1.95	2.07	2.27	1.73		(1.00)	(1.00)	0.00
	Neonatal Unit	39.70	39.82	37.38	0.00	0.00	1.69	2.58	0.87	0.43		2.32	2.44	0.00
	I.T.U.	70.43	74.56	58.79	0.64	0.00	1.83	4.48	4.36	9.38		11.64	15.77	0.00
	Theatres (Excl ODP's)	66.89	72.15	50.74	0.00	0.68	0.98	2.03	6.43	2.13		16.15	21.41	(0.69)
	Day Case Theatres (Excl ODP's)	46.65	48.98	37.32	0.00	0.00	1.94	1.77	8.57	0.19		9.33	11.66	0.00
	Maternity unit	104.60	105.12	102.80	0.96	1.00	6.51	4.48	6.61	0.00		1.80	2.32	0.00
	All other Surgery Teams	154.19	150.80	151.04	0.00	1.00			4.47	0.68		3.15	(0.24)	(2.76)
Corp	All Corp Teams	75.72	88.38	81.05	0.00	0.00			1.34	-0.08		(5.33)	7.33	0.00
Total Qualified Nurses		**1576.59**	**1725.60**	**1445.33**	**6.00**	**10.40**	**39.00**	**33.49**	**106.51**	**114.95**		131.26	280.27	(2.85)

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.

CHPPD (Care Hours per Patient Day) comparative Figures of the Trust with Peer and National Medians for August 2018 (latest figures available for Peer/National Figures)

Below is a chart of all of the wards/departments in the Trust with their total, registered nurse and HCSW (Health Care Support Worker) staff CHPPDs. These are compared with the equivalent Peer and National Medians. The peer group of hospitals is provided.

A convention of symbols has been used on the chart. An = sign means that the Trust CHPPD is a value between the peer and national medians while a ↑ or ↓ symbol is used to indicate a Trust value which is either above or below the two peer and national medians.

As when comparisons of this nature were made last year, it needs to be stressed that the figures need to be interpreted with caution. For instance, the Model Hospital has only a single median figure for certain specialities which may cover quite different wards. For example, for C2, the paediatric ward and the neonatal unit one would expect these to have different comparators based on the different nature of a specialist unit compared to a general paediatric ward. There are also some obvious anomalies. For instance, for ITU, the Trust's CHPPD is just over 24 which is what you would expect for a 1:1 care area but the regional/national comparative figures are for General Surgery as there is no comparative speciality in the model hospital. This has been pointed out to the relevant staff there and it was agreed with them a number of months ago to move ITU into the Critical Care Medicine Section although they have not done this yet. Similarly, the figures for Maternity are obviously not comparing like with like. This may possibly be due to most hospitals having three separate areas, an antenatal ward, a delivery suite and a postnatal ward while the Trust had an integrated approach. In saying this, there is some useful data on the general ward comparators, although again caution in interpreting the figures is required.

Speciality/ Staffing Type			
Cardiology	**CCU**	**Peer Median**	**National Median**
Total	7.40↓	8.16	8.10
Registered	5.79↑	5.37	5.69
HCSW	1.61↓	2.38	2.43
The Trust has a lower total CHPPD but a higher registered staff figure.			
Haematology	**C4**	**Peer Median**	**National Median**
Total	7.13=	6.65	7.56
Registered	4.55=	4.08	4.78
HCSW	2.57=	2.73	2.46
This ward is within the peer and national range.			
Gastroenterology	**C7**	**Peer Median**	**National Median**
Total	6.47↑	5.56	6.13
Registered	2.99=	3.04	2.95
HCSW	3.48↑	2.58	3.03
A higher overall and HCSW CHPPD may be due to the ward having a high proportion of patients with alcohol problems that need high supervision.			

Speciality/ Staffing Type			
Critical Care Med	**HDU**	**Peer Median**	**National Median**
Total	15.00↓	23.93	27.18
Registered	13.41↓	22.68	24.90
HCSW	1.59=	1.55	2.35
There is a considerable difference between the Trust and the comparators. This may be due to the area having the four bed bay that is used for non – level 2 patients.			
Gen Medicine	**A2 (AMU2)**	**Peer Median**	**National Median**
Total	8.37↑	7.41	7.38
Registered	4.02↑	3.90	4.01
HCSW	4.34↑	3.10	3.47
Both this ward and AMU1 (below) are acute medical assessment areas and so one would expect higher staffing figures compared to general medical wards which the model hospital uses as comparators.			
Gen Medicine	**AMU1**	**Peer Median**	**National Median**
Total	10.67↑	7.41	7.38
Registered	4.57↑	3.90	4.01
HCSW	6.10↑	3.10	3.47
See comment above.			
General Surgery	**ITU**	**Peer Median**	**National Median**
Total	28.33	8.10	7.46
Registered	26.06	4.65	4.39
HCSW	2.27	2.92	3.07
See introductory comment			
General Surgery	**B3**	**Peer Median**	**National Median**
Total	8.01=	8.10	7.46
Registered	4.20↓	4.65	4.39
HCSW	3.81↑	2.92	3.07
The total CHPPD is within the comparator range but there is a lower skill mix which reflects the difficulty in recruiting qualified staff.			
General Surgery	**B4**	**Peer Median**	**National Median**
Total	6.29↓	8.10	7.46
Registered	2.74↓	4.65	4.39
HCSW	3.54↑	2.92	3.07
The total CHPPD is below the comparator range and there is a lower skill mix which reflects the difficulty in recruiting qualified staff.			
General Surgery	**B5**	**Peer Median**	**National Median**
Total	11.00↑	8.10	7.46
Registered	6.64↑	4.65	4.39
HCSW	4.36↑	2.92	3.07
All Trust CHPPDs are higher than the comparators. This may be due to this area having the specialised area of the Surgical Assessment Unit. Further analysis of this may be worthwhile.			

Speciality/ Staffing Type			
Geriatric Med	**C3**	**Peer Median**	**National Median**
Total	8.18↑	6.48	6.78

Registered	2.77↓	3.13	3.14
HCSW	5.40↑	3.37	3.80
The total CHPPD is above the comparator range but there is a lower skill mix which reflects the difficulty in recruiting qualified staff.			
Nephrology	**C1**	**Peer Median**	**National Median**
Total	6.66=	6.38	6.94
Registered	2.59↓	4.11	4.00
HCSW	4.07↑	1.58	2.68
The total CHPPD is within the comparator range but there is a lower skill mix which reflects the difficulty in recruiting qualified staff.			
Maternity	**Maternity**	**Peer Median**	**National Median**
Total	32.36	15.12	14.98
Registered	24.47	12.06	11.94
HCSW	7.89	2.86	3.50
See introductory comment			
Paediatrics	**C2**	**Peer Median**	**National Median**
Total	12.88=	12.79	13.42
Registered	10.53↓	10.78	10.95
HCSW	2.36=	1.80	2.47
C2 has similar values to the comparators except a lower registered nurse CHPPD.			
Paediatrics	**NNU**	**Peer Median**	**National Median**
Total	9.47↓	12.79	13.42
Registered	9.47↓	10.78	10.95
HCSW	0↓	1.80	2.47
All of the CHPPDs are below the comparators.			
Rehabilitation	**C8**	**Peer Median**	**National Median**
Total	8.02↑	5.95	6.91
Registered	3.61↑	2.65	3.12
HCSW	4.40↑	3.54	3.76
C8 is the Stroke Unit and has a rehabilitation section but also has the acute stroke unit and so one would expect it to have higher staffing than a pure rehabilitation ward.			
Respiratory	**C5**	**Peer Median**	**National Median**
Total	6.66↑	5.79	6.40
Registered	2.62↓	3.05	3.51
HCSW	4.04↑	2.56	2.90
The total CHPPD is above the comparator range but there is a lower skill mix which reflects the difficulty in recruiting qualified staff.			
T and O	**B1**	**Peer Median**	**National Median**
Total	6.99=	6.97	7.26
Registered	4.10↑	3.65	3.72
HCSW	2.88↓	3.19	3.39
While the total CHPPD falls with the comparator range, the registered nurse value is higher and the HCSW lower.			

Speciality/ Staffing Type			
T and O	**B2 HIP**	**Peer Median**	**National Median**
Total	7.80↑	6.97	7.26
Registered	2.79↓	3.65	3.72
HCSW	5.01↑	3.19	3.39
The total CHPPD is above the comparator range but there is a lower skill mix which reflects			

the difficulty in recruiting qualified staff. A higher total CHPPD is expected due to the specialist area caring for hip fracture patients.			
T and O	**B2 TRAUMA**	**Peer Median**	**National Median**
Total	6.63↓	6.97	7.26
Registered	2.71↓	3.65	3.72
HCSW	3.92↑	3.19	3.39
The total CHPPD is below the comparator range and there is a lower skill mix which reflects the difficulty in recruiting qualified staff.			
Urology	**C6**	**Peer Median**	**National Median**
Total	6.14↓	6.69	6.63
Registered	3.45↓	3.78	3.70
HCSW	2.68=	2.57	2.70
The total and registered nurse CHPPDs are below the comparators.			

(Custom list of peer trusts: Aintree University Hospital NHS Foundation Trust, City Hospitals Sunderland NHS Foundation Trust, Great Western Hospitals NHS Foundation Trust, Newcastle Upon Tyne Hospitals NHS Foundation Trust, Northern Lincolnshire and Goole NHS Foundation Trust, Royal Surrey County Hospital NHS Foundation Trust, Royal Wolverhampton NHS Trust, Sandwell and West Birmingham Hospitals NHS Trust, Stockport NHS Foundation Trust, Walsall Healthcare NHS Trust)

Resuscitation service cover

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 ALS, EPALS within the next six months. Lead RO post advertised with one single applicant, JD to be reviewed with assistance of deputy chief nurse and HR director to consider banding and role within the Trust and management of the deteriorating patient.
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. As detailed below:

Resuscitation Council UK 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.
- Smaller organisations must appoint a resuscitation lead who may have other roles within their working environment.
- Resuscitation Officers must possess a current Advanced Life Support (ALS) provider certificate (or equivalent) as a minimum standard; ideally ALS instructor qualification is recommended. Where appropriate, the organisation must ensure that ROs possess certified resuscitation training certificates in other specialist areas (e.g. paediatrics, the newborn, obstetrics and trauma). For example, ROs in acute settings which treat children must have EPLS/APLS provider status as a minimum. Advice about professional development of ROs can be sought from the Council for Professionals as Resuscitation Officers (CPRO).
- The RO must have access to a designated training room(s) of adequate size. The room(s) should comfortably accommodate instructors, trainees and all the training equipment required for any teaching session.
- The RO must have access to suitable electronic teaching aids and projection facilities. There must be adequate space for storing equipment. It is recommended that separate office space, with a desk, computer facilities, and filing cabinets, is available.
- The RO must have adequate administrative assistance.
- Equipment for training will vary according to local needs. Adult, paediatric and newborn manikins, airway management trainers, an ECG monitor and rhythm simulator, and at least one defibrillator dedicated for training, must be available. To ensure appropriate clinical use, equipment for training (especially defibrillators) must be the same model as that used in actual clinical practice.
- There must be a defined resuscitation budget made available for the RO to maintain, upgrade and purchase new equipment for patient use and for training. Purchasers of health care need to be made aware of this when contracts are negotiated and adequate provision made. Such financial support for resuscitation services must be taken into account during budget planning by the organisation.
- It is recommended that the RO is responsible for ensuring that there are systems in place for maintaining resuscitation equipment in good working order. This will usually mean delegation of routine checking of equipment to other members of staff.

- It is recommended that the RO is involved in data collection and audit of cardiac arrest. It is recommended that this data should be collected as part of the National Cardiac Arrest Audit (NCAA).
- In order to maintain standards and clinical credibility, it is recommended that responding to and participating in cardiac arrest management is an integral part of the RO's clinical responsibility on a week-to-week basis. ROs with a clinical role must have appropriate clinical supervision and support.
- The RO has a responsibility to maintain his/her own education in resuscitation. In order to achieve this, teaching on resuscitation courses outside the organisation is recommended. In addition, regular attendance at professional meetings must be supported with a budget for study expenses.
- ROs must not be expected to generate income to provide for their own salary.
- If the RO is expected to generate income for the organisation it should be agreed in writing with the relevant manager. Any income must be directed to improving resuscitation services.

Supporting tools

This is an example calculation to support the statement that, 'One whole-time-equivalent RO is recommended for every 750 members of clinical staff':

- 750 staff to be trained equates to 75 per month over a 10-month period. This is based on an RO working for a total of 10 out of every 12 months, allowing for annual leave, study leave, teaching elsewhere, etc.
- Each training session lasts approximately 2 hours.
- Each session has 6 attendees.
- If all 6 people attend then 12.5 sessions per month are required.
- If only 4 people attend then 18.75 sessions per month are required.
- Therefore to provide enough sessions over the year allowing for peaks and troughs about 15 sessions per month are required.
- 15 sessions per month at 2 hours each provides 30 hours of basic training.
- This is "classroom" time and does not include set up/set down time, preparation, administration etc.
- The above calculation also does not include accredited courses or other training such as ward-based scenario or other types of sessions.
- Most ROs spend at least 50% of their time involved in training activities when all the different types of training and preparation are taken into account.
- The remainder of an RO's time includes other responsibilities such as audit, governance, DNACPR, clinical commitments, attending cardiac arrest calls, planning, finance, equipment checks, etc.

These are ideal standards in practice for acute care providers, the management of the deteriorating patient is multi-faceted and the overarching support for both resuscitation and sepsis is been given by the non-medical educational lead ensuring the delivery of national courses, many of which we are required to support for our trainees and in line with peer review standards is also dependent of the availability of other instructors in the Trust.
To access specialist qualifications in resuscitation you firstly require completing the relevant course and showing outstanding contribution. The faculty then put people forward following a recognised nomination and scoring process; maintaining instructor status request 2teaching on 2 courses per year.
The crossover of services with the unwell patient, sepsis and resuscitation should be considered in any further development of the team. Leave at this present time leaves a critical shortage in cover.

THE DUDLEY GROUP NHS FOUNDATION TRUST
Resuscitation Service Provision ACTION PLAN

Source of Action Plan	Deteriorating Patient Group	**Oversight Committee**	Nursing Governance
Action plan prepared and lead by	Non-Medical Educational Lead	**Action plan signed off by**	
Date presented to Div Gov Meeting	12/11/2018	**Anticipated date for completion**	
KEY	**Completed and Assurance Received**	**Action commenced but not yet completed**	**Action Overdue not completed in agreed time scales or at significant risk of note achieving time scales**

Action Number	Recommendation / Area for Action Identified	Action Agreed	Lead	Date for Completion	Progress / Assurance	Key
1	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	W Dainty	May 2019	Induction pack already given in preparation of commencement. ALS booked for February 2019	
2	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	W Dainty	December on Going until post filled	Purchase order requested for ongoing specialist cover, discussed with R Price in finance. Contact established for bookings with Diamond Resuscitation and other providers For further discussion with deputy chief nurse.	

Action Number	Recommendation / Area for Action Identified	Action Agreed	Lead	Date for Completion	Progress / Assurance	Key
3	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.	W Dainty	December	All Dates for 2019 to be planned and released. In accordance with staff numbers on ESR with a 10% variance.	
4	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	Sian Annakin J Hobbs/C Love-Mecrow/ W Dainty	December November	Pre-employment checks underway Meeting With CEO 16.11.2018	

William Dainty
Non-Medical Education Lead

Paper for submission to: Clinical Quality, Safety and Patient Experience Committee (CQPSE) Meeting on Tuesday 23rd October 2018 at 9.00am

TITLE:	**Safeguarding Quarterly Report**		
AUTHOR:	**Christina Rogers Head of Safeguarding**	**PRESENTER**	**Christina Rogers Head of Safeguarding**
CLINICAL STRATEGIC AIMS			
Strengthen hospital-based care to ensure high quality hospital services provided in the most effective and efficient way.		*Provide specialist services to patients from the Black Country and further afield.*	
CORPORATE OBJECTIVE: SO2: Safe and Caring			

Purpose of the report:
This paper provides the Quarter 2 (Q2) report detailing safeguarding activity and service developments within The Dudley Group NHS Foundation Trust (DGFT), serving to provide assurance to respective Board members that DGFT is fulfilling its statutory responsibilities in relation to safeguarding children and adults who access services from the Trust.

Correspondingly to Q1 safeguarding activity, work stream across the Trust continue to intensify in volume and complexity, the Safeguarding Team remains committed to ensuring the provision of a cohesive and highly vigorous safeguarding service for all ages.

Summary of key Issues

- 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.

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

ACTION REQUIRED OF BOARD:

Decision	Approval	Discussion	Other
	√	√	

RECOMMENDATIONS FOR THE BOARD/COMMITTEE:
This report outlines the work undertaken and in progress to safeguard children and adults within DGFT. Board members are requested to note the report representing quarter 2 period, the improvements made during and the priority areas for implementation moving forward.

THE DUDLEY GROUP NHS FOUNDATION TRUST

REPORT TO CQPSE – Safeguarding Quarterly Report – Quarter 2 – July, August and September 2018

1 Situation

1.1 The statutory duties and Trust responsibilities for safeguarding children are set out in the Children Act 1989 and 2004 and Working Together to Safeguard Children 2018 and for safeguarding adults primarily within the Care Act 2014. Safeguarding children and adults is everyone's responsibility with ultimate accountability resting with the Chief Executive.

1.2 This report covers the period July to September 2018 and will demonstrate how the Safeguarding Team support the Trust in fulfilling its statutory obligations towards vulnerable children, young people and adults. It will also provide assurance that vulnerable children, young people and adults are effectively protected and that staff are supported when working with complex cases.

1.3 A CQC Inspection was published in July 2018, with an overall rating of Requires Improvement. This highlighted areas of good practice as well as identifying areas for improvement.

1.4 Safeguarding children and adults has a high emphasis on a competent well-established workforce; up to date policies and procedures, robust governance arrangements and sound collaborative practices. This report details how this is achieved in Dudley.

1.5 Safeguarding activity remains high in Trust. Children's Social Care Multi-Agency Safeguarding Hub (MASH) health enquiries have increased to over 500, compared to 252 in previous months. DATIX reports and Multi-Agency Referral Form (MARF) completion to Children's Social Care in the month of July and September have almost doubled in volume. Main category is reported as peer on peer assault and Child Sexual Exploitation (CSE). Additionally, cumulative parenting risk factors identify substance misuse, self-harm and Domestic Abuse as main indicators. DATIX Reports and Adult Safeguarding referrals have been comparatively steady, averaging 50 plus Datix's and 30 plus referrals being made by Trust staff. Last month indicated higher activity. The main categories of abuse reported appear to be, Neglect, Self-Neglect and Domestic Abuse. Multi-Agency Safeguarding Hub (MASH) questionnaires for health information are comparatively low to their children's counterpart with only 5 enquiries being requested for July 2018. The volume of requests has been on par with previous monthly activity.

2 The Dudley Group NHS Foundation Trust (DGFT) Safeguarding Team

Background

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

- Understand risk factors and recognise children, young people and adults in need of support and/or safeguarding

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

2.2 **The Safeguarding Team:**

- Provide advice, support and guidance to members of staff regarding safeguarding matters
- Ensures relevant policies and procedures are in place to support all staff
- Provide and facilitate supervision processes to staff to support areas of challenging work ensuring the focus of work remains on the safety and wellbeing of the child, young person and adult
- Provide training and education for all staff to support them with their safeguarding work
- Support staff in the production of statements to court or attendance at court for matters relating to safeguarding children and safeguarding adults
- Undertake a programme of audit to provide assurance
- Work closely with key stakeholders and other agencies to safeguard children

2.3 **Safeguarding Team; Current and planned recruitment**

Designation	WTE
Head of Safeguarding	1 WTE
Named Nurse Safeguarding Children	1.5 WTE
Named Midwife	0.8 WTE New post - Vacant – ATR in progress
Named Nurse Safeguarding Adults	1 WTE
Child Death Lead Nurse	1 WTE
Paediatric Liaison Nurse	1 WTE
Lead Nurse Vulnerable Adults	0.8 WTE
Administrative support	0.2 WTE
Safeguarding Administrator	1 WTE New post – Vacant – ATR in progress

For the period of Q2, the role of Paediatric Liaison Nurse was successfully appointed to in September 2018. Furthermore, the post-holder for Lead Nurse for Child Death returned from maternity leave. Further developments are planned with the recruitment of a Named Midwife and dedicated Safeguarding Administrator. This renewed drive in recruitment will support

increasing work stream demands and strengthen team collaborative endeavour. However, it is recognised that the continued high volume and complexity within safeguarding demands require regular work force review to ensure DGFT can fulfil its safeguarding obligations.

2.4 Governance

The Internal Safeguarding Board (ISB) continues on a monthly basis, attendance at recent meetings has been low. The Safeguarding Improvement plan (Appendix 1) and any other associated work plans are monitored through this meeting.

2.5 Risk Register

No new risks have been added within Q2. Existing risks have controls in place and are deemed moderate to high. High risks pertain to:

- Team resource and capacity – Lack of Named Midwife and lack of safeguarding administrator
- Safeguarding supervision arrangements – lack of trained supervisors and provision of supervision
- Compliance to statutory Safeguarding processes, systems and practice
- Compliance with MARAC (Multi-agency Risk Assessment Conference) processes
- Delay in response to Section 42 and other safeguarding enquiries

A combined Serious Incident and three Level 2 investigations have taken place within this quarter; furthermore an action plan has been devised and is included as an attachment within this report (Appendix 2).

2.6 Training

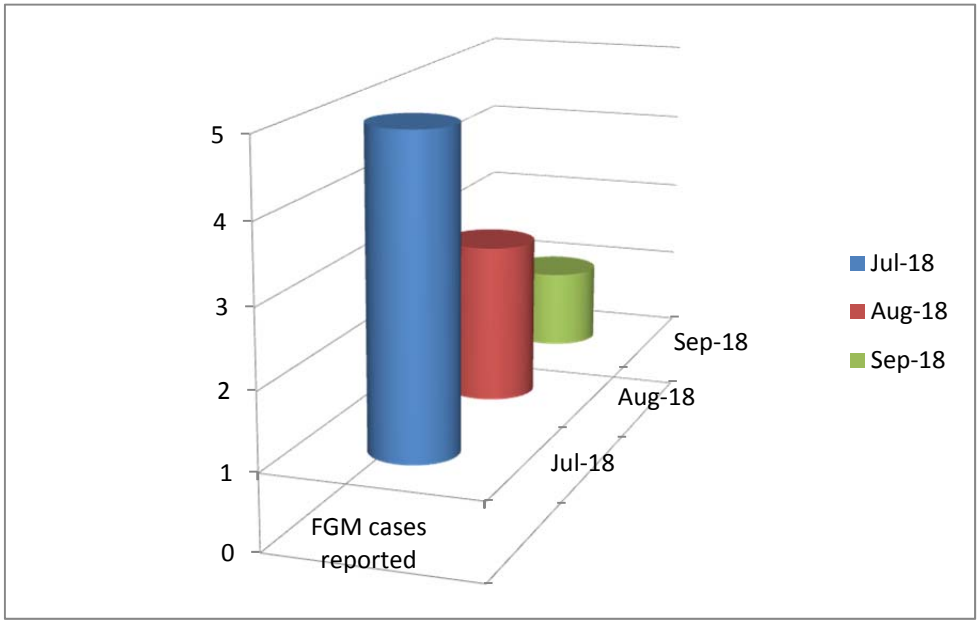
Safeguarding training and its high priority for the Trust continues. The Safeguarding Team have continued to focus upon training as a key priority for this quarter. Following a full review of training packages in the last quarter, the revised training sessions have been delivered with a renewed focus upon emphasis upon additional group work exercises and case scenario discussion, affording practitioners the opportunity to consider and develop their analytical skills and understanding of risk in relation to child sexual exploitation (CSE), trafficking, modern slavery, domestic abuse and female genital mutilation (FGM), supporting CQC recommendations. Early evaluation of training has proven positive. However, with the recent new guidelines in adult safeguarding training (RCN 2018) introduced in August 2018, further development within this area is planned in respect to provision of Level 3 safeguarding adults training in collaboration with our adult social care partners. The use of E Learning training for Level 2 Safeguarding Adults and Level 2 Safeguarding Children training accessed via E-Learning for Healthcare is being considered, as it is recognised that providing training in this way will promote ease of access to Trust staff recognising that they have competing clinical priorities and can work various unsociable hours.

Safeguarding training figures for the end of September 2018 demonstrate great improvement with almost all training meeting Trust 90% compliance as cited on page 16:

Training type and level	End September 2018
Safeguarding Children Level 1 and 2:	94%
Safeguarding Adults Level 1 and 2	87.6%
Safeguarding Children Level 3	92%
WRAP	84%
PREVENT	91.6%

2.7 Female Genital Mutilation (FGM)

The number of FGM cases reported this quarter remains low in comparison to regional and national comparatives. The Trust has an FGM lead in post and there is a dedicated Trust wide policy. FGM training is provided within mandatory Safeguarding Adults and Safeguarding Children training across all levels.



2.8 Child Sexual Exploitation (CSE)

Referrals into Dudley Children's Social Care in relation to CSE remain stable at 1-2 per week. There are 85 young people where CSE has been identified as a concern (August 2018). Currently two children have been placed out of borough and are considered to be at serious risk, 12 are deemed to be at significant risk and 71 (55 female and 16 male) are considered to be at risk. It is important to note that the figure for males may not be a true reflection as evidence suggests that males are less to disclose experiences of child sexual exploitation. Although there are no CSE specific location indicators, CSE appears to be more prevalent in Dudley Central and Halesowen townships but there is no explanation for this. A feature within these young people is missing episodes, exclusions from school and Children who are Looked After (Dudley CSE Profile August 2018). It is unclear how many referrals are made by Dudley Group in relation to known CSE as referrals are generally for single issues/vulnerabilities, e.g. alcohol/substance misuse, sexual assaults,

peer assaults, deliberate self-harm and overdose which could all be indicators of CSE.

DGFT were recently requested to participate in a multi-agency audit relating to Harmful Sexual Behaviour to facilitate an in providing an accurate reflection of services for children and young people in Dudley. The audit covered response, prevention, assessment, interventions and workforce development.

Information is now received from the Local Authority in relation to children and young people at serious and significant risk of CSE. A request has been made to allow flags on the current Oasis system to alert staff to safeguarding concerns in relation to CSE.

2.9 **Domestic Abuse**

Previously a bid had been made for an Independent Domestic Abuse Advisor (IDVA) in the Emergency Department. There has been no update received from Black Country Women's Aid and CHADD in relation to the outcome of this at this time. The bid if successful would fund a full time IDVA in the Emergency Department mirroring a similar pilot project in operation in Sandwell.

DGFT has invested in the provision of stand-alone Domestic Abuse training. The Vulnerable Adults Liaison Nurse (jointly with CHADD) has delivered 7 domestic abuse training sessions. 104 staff from high risk areas have attended training to date. High risk areas include ED, Paediatrics, Maternity and CASH/GUM. Feedback has been positive from all sessions delivered to date. A training session specifically for ED doctors is also planned at their request in October. Furthermore, staff can also complete the Domestic Violence and Aggression e-Learning modules which are available on the Learning & Development Page on the Hub. 47 staff have completed this to date. The CCG organised 6 domestic abuse training sessions which Dudley Group were invited to attend. Attendance from Trust staff was extremely low with only 18 members of staff attending the sessions.

Multi Agency Risk Assessment Conference (MARAC) MARAC is a local, multi-agency victim-focused meeting where information is shared on the highest risk cases of domestic violence and abuse between different statutory and voluntary sector agencies. The meeting is attended by the Named Nurses who attend on a rota basis. Attending the meeting requires a significant commitment from a planning and research perspective due to the number of cases heard many of whom will have accessed DGFT services. There is a robust 'Think Family' approach with, the victim, alleged perpetrator and children all being discussed. MARAC is held twice monthly. In August 45 cases were discussed between the two meetings. 45 victims, 45 perpetrators and there were 40 child records to be researched. This continues to have a significant impact in terms of commitment and work stream for the three Named Nurses who complete all lateral checks due to the lack of dedicated administrative support.

2.10 **Electronic flagging**

Developments are in progress with regards to the Trusts internal electronic flagging system. A review has taken place to ascertain current flags utilised

pertaining to safeguarding, current management and monitoring of flags (adding, amending and removing), administrative safeguarding support required to lead on flagging and risk identified in respect to nil flags in place for children and adults with high vulnerabilities, including but not limited to, Looked after Children (LAC), Children in Need (CIN Sec 17 CA 1989), at risk of Domestic Abuse (DA), vulnerable adults and children at risk of child sexual exploitation (CSE). Due to the Trust's impending system change to Sunrise, this has proved challenging to progress. Electronic flags form part of the overall assessment of a patient and can prove critical in establishing whether a safeguarding vulnerability exists.

2.11 **Child Protection - Information Sharing (CP-IS)**

CP-IS is a nationwide system that enables child protection information to be shared securely between local authorities and NHS trusts across England. The Child Protection Information System (CP-IS) has been introduced within The Trust priority paediatric areas. Guidelines and training have been provided to staff. The current challenges pertain to, embedding the practice within these areas and in achieving effective implementation of CP-IS for Dudley Children's Social Care. NHS England is aware of these challenges and has extended the date to 2018. This is currently monitored and under review via ISB.

2.12 **Allegations made against People in Position of Trust**

The Trust has made 3 Local Authority Designated Officer (LADO) referrals during the time frame of the report. Numbers for referrals are low in comparison to regional figures. Developments are planned within this area to include a dedicated Trust policy and provision of allegation training for key Trust staff with support from the (LADO) and CCG.

2.13 **Policy Development and Quality Assurance - Audits**

During Q2, the Safeguarding Team have invested great time and resource within this area as it is recognised that robust safeguarding practice is reliant upon safe and effective processes and systems being in place. Two policies have been ratified and reviewed, Child Protection Medical Examination Policy and Bruising and other injuries in immobile children. Furthermore, a collaborative Safeguarding Supervision Policy has been introduced. It is recognised that further concerted effort is required within policy development and both Safeguarding Children and Safeguarding Adults Trust policies will be revised and reported on in the next quarterly report. Additionally, there is a safeguarding Audit Plan in place stipulating the required areas to focus on in order to identify gaps in practice, areas for improvement and areas of good practice. Priority has had to be afforded to external Safeguarding Board audit works streams which have been completed within this quarter. These have been the DSAB Safeguarding Adults, the DSCB sec.11 Audit and the DSCB Multi-Agency Case File Audit (MACFA). There is a high risk in place in respect to the challenges experienced in completing these work streams in a timely manner (*High Risk-Compliance to statutory Safeguarding processes, systems and practice).*

2.14 **Serious Adult Reviews (SAR) and Domestic Homicide Reviews (DHR) – Safeguarding Adults**

There has been a high number of SAR cases for consideration this quarter, five scoping exercises were completed and sent to Dudley Safeguarding Adults Board in July 2018. A further two were completed in August 2018. Two SAR'S are in progress and a further one has been commissioned in

September 2018. There has been one external SAR commenced. In relation to DHR's, there are a total of three cases in progression, one was commissioned in August 2018 and the other two remain in progress during the time frame of this report.

2.15 Serious Case Reviews (SCR) – Safeguarding Children

Three SCR's are awaiting publication and three table top reviews are in progress. Updates will be provided in the next Quarter.

2.16 Safeguarding Supervision

Community Midwives were highlighted as a priority to receive Safeguarding Supervision and are mandated to do so (RCPCH 2014). Safeguarding Supervision is scheduled in accordance with the three-monthly requirement. The Trust has only three registered Safeguarding Supervisors in post. Scoping is being undertaken to source commissioned training, a further 6 Safeguarding Supervisors would be required to meet service need.

All Supervisors will be required to contribute to monthly data collation of all supervision sessions provided; this will be managed by The Safeguarding Team who will then input onto electronically onto the Shared Drive and relevant Spreadsheet. This will facilitate effective governance processes and ensure supervision is undertaken in a timely and robust manner. Progress will be reported in respect to this.

Further developments and improvements in this area will incorporate the identification of key staffing groups whom may require this, for example sexual health areas (CASH and GUM). The team will be undertaking a scoping exercise to identify key groups and offering group Safeguarding Supervision.

3 Quarter 3 Priorities

1. Continue to support CQC recommendations
2. Training delivery remains high priority
    - Continue to monitor and review training compliance for mandatory training ensuring 90% Trust target exceeded
    - Embed suitable provision for Level 3 Safeguarding Adult training and revise Level 1 and 2 ensuring reflective of RCN (2018) Adult Intercollegiate Document
    - Analyse learning themes and trends and develop bespoke training sessions which are receptive to learning needs
3. Review and strengthen existing policies:
    - Safeguarding Children Policy
    - Safeguarding Supervision Policy
4. Complete audits as per Audit Plan schedule
5. Commission Safeguarding Supervisor training
6. Develop Trust policy for 'Allegations made against people in positions of trust' and schedule appropriate training to embed policy into practice
7. Recruit to Named Midwife and Safeguarding Administrator Posts
8. Revise the Safeguarding Hub page- strengthening and promoting sound safeguarding practice, process and systems

9. Continue to strengthen the Trust internal flagging process and externally CP-IS
10. Reporting will be available in respect to Child Death and Paediatric Liaison roles

4 Implications

Safeguarding is covered in the following legislation and guidance

- Working Together to Safeguard Children (2018)
- Children Act 1989 and 2004
- Children and Social Work act 2017
- Intercollegiate Document - Safeguarding children & young people: roles and competencies for healthcare staff (RCPCH 2014)
- Multi-agency statutory guidance on FGM (Department for Education, Department of Health and Social Care and Home Office 2018)
- Female Genital Mutilation Act 2003, Mandatory reporting of FGM – Procedural information (Department for Education and Home Office 2016)
- PREVENT duty guidance 2015
- Counter Terrorism and Security Act 2015
- The Care Act 2014
- RCN Safeguarding Adults: Intercollegiate Document: roles and competencies for healthcare staff 2018
- Deprivation of Liberty Safeguards 2009
- Health & Social Care Act 2008
- Mental Capacity Act 2005
- Mental Health Act 1983
- CQC Fundamental Standards
- Statement on CQC's roles and responsibilities for safeguarding children and adults June 2015
- Domestic Violence, Crime and Victims Act 2004
- Domestic Abuse: How to get help (Gov. 2018)
- Domestic Abuse: A resource for health professional (DHSE 2017)
- Serious Crime Act 2015

5 Recommendation

The CQPSE committee is asked to approve the Safeguarding quarterly report Q2 2018.

The Dudley Group
NHS Foundation Trust

Paper for submission to the Clinical Quality, Safety and Patient Experience Committee on 23rd October 2018

TITLE:	**Quarter 2 2018/19 Quality Priorities Report**		
AUTHOR:	Derek Eaves Professional Lead for Quality	**PRESENTER**	Mitchell Fernandez, 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: Deliver a great patient experience, Safe and Caring Services, Be the place people choose to work, Make the best use of what we have

SUMMARY OF KEY ISSUES:

With regards to the Trust's position at the end of Quarter 2 with the quality priorities, these are the key issues:

- FFT: For recommended scores, of the 39 available results for Q1/Q2 23 have achieved the target. For response rate scores, of the 25 available results 17 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.

IMPLICATIONS OF PAPER:

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

ACTION REQUIRED OF BOARD:

Decision	Approval	Discussion	Other
		✓	

RECOMMENDATIONS FOR THE BOARD: To note the Trust's position at the end of Q2 with regards to this year's Quality priority targets.

THE DUDLEY GROUP NHS FOUNDATION TRUST
QUALITY ACCOUNT UPDATE. SECOND QUARTER 2018/19 – OCTOBER 2018

QUALITY PRIORITY 1. PATIENT EXPERIENCE TARGETS:

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

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

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

Planned Actions	Who	By When	Progress at end of September 2018
Hold 'Feedback Fridays' once a month to encourage responses to the survey	Jill Faulkner	April 2018	COMPLETE. Launched Feedback Fridays from monthly to weekly
Ensure that all areas have a Champion for FFT	Jill Faulkner	April 2018	COMPLETE. Identified FFT champions in most wards/areas and departments in the Trust
Ensure that all areas where participation is low have action plans in place	Jill Faulkner	March 2019	Continue to monitor response rates and action plans.
Roll out SMS to the rest of the Trust	Helen Board	December 2018	Explore options for the roll out to children's and maternity areas
Ensure delivery of improvements actions identified using FFT feedback to support an improved percentage recommended score.	Siobhan Jordan	March 2019	Action plans monitored via the Patient Experience Improvement Group that meets each fortnight

April-September 2018 data and commentary for percentage recommended FFT scores

Percentage recommended FFT Scores	Apr 18	May 18	Jun 18	Jul 18	Aug 18	Sep 18**
Inpatient	**95**	**93.7**	**94.4**	**94.1**	**93.7**	**93.0**
National	96	96	96	96	96	**
A & E	**82**	**77.8**	**77.1**	**76.2**	**77.1**	**75.7**
National	87	87	87	87	88	**
Maternity Antenatal	**98**	**97.5**	**100**	**98.3**	**99.1**	**94.5**
National	97	95	96	95	95	**
Maternity Birth	**99**	**97.8**	**96.5**	**100**	**98.6**	**96.8**
National	97	97	97	97	97	**
Maternity Postnatal Ward	**98**	**95.6**	**96.5**	**98.9**	**98.6**	**95.7**
National	95	95	95	95	95	**
Maternity Postnatal Community	**98**	**100**	**100**	**98.1**	**100**	**96.5**
National	*	98	98	98	98	**
Community	**96**	**95.3**	**96.7**	**95.6**	**96.2**	**93.3**
National	96	95	95	95	96	**
Outpatients	**90**	**89.4**	**90.5**	**87.4**	**91.3**	**88.9**
National	94	94	94	94	94	**

*no national data available ** National data available mid-November

For the five months where national figures are available (39 areas were published for months of April, May, June, July and August 2018) the Trust is achieving the target on 23 occasions where the score is equal to or better than the national average percentage recommended. The areas missing the target are inpatients, A&E and outpatients for all of the months and maternity birth for June.

April-September 2018 data and commentary for FFT response rates

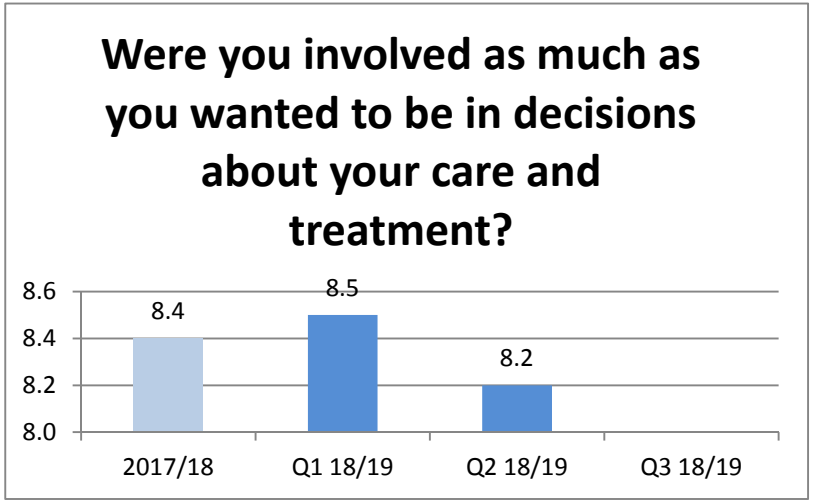
Percentage response rate	Apr 18	May 18	Jun 18	Jul 18	Aug 18	Sep 18
Inpatient	**32.3**	**33**	**42.4**	**35.9**	**31.9**	**35.0**
National	24.9	25.6	25.2	25.2	25	**
A &E	**17.9**	**18**	**19.1**	**18.6**	**16.6**	**18.2**
National	12.9	12.4	13.0	12.8	12.9	**
Maternity Antenatal	**20.4**	**91.4**	**70.2**	**52.4**	**56.8**	**28.7**
National	**	**	**	**	**	**
Maternity Birth	**40**	**38**	**33.6**	**27.4**	**19.9**	**27.4**
National *	23.2	22	21	20.87	20.3	**
Maternity Postnatal Ward	**39.8**	**37.5**	**34.0**	**27.6**	**19.7**	**27.6**
National	**	**	**	**	**	**
Maternity Postnatal Community	**1.3**	**15.3**	**19.5**	**24.1**	**15.8**	**18.8**
National	**	**	**	**	**	**
Community	**2.9**	**3**	**4.2**	**4.1**	**3.2**	**5.8**
National *	3.3	4.0	3.7	4.13	3.5	**
Outpatients*	**5.7**	**5.7**	**3.4**	**5.8**	**5.8**	**5.4**
National *	4.9	7.0	6.8	7.0	6.6	**

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

For the five months where national figures are available (25 areas were published for months of April, May, June, July and August 2018) the Trust is achieving the target on 17 occasions where the percentage response rate score is equal to or better than the national average percentage response rate. The areas missing the target are maternity birth for August 2018, community for April, May and August 2018 and outpatients for May, June, July and August 2018.

April-September 2018 data and commentary for Local Survey

The results of the local survey question 'Were you involved as much as you wanted to be in decisions about your care?' at the end of Q2 is 8.2 compared to the 2017/18 full year score of 8.4 (please see graph on the next page).



d) Ensure that in 95% or more cases, a patient's pain score is recorded at least every four hours (unless otherwise indicated in the exception box)

Planned Actions	Who	By When	Progress at end of September 2018
Study days will occur in May to ensure all staff are re-educated on the importance of pain management and its correct documentation.	Mel Rushton Acute pain team	May 2018	COMPLETE
Clarify the audit question so that it covers all documents where pain relief may be recorded.	Sara Davis/Sara Whitbread	Jun 2018	COMPLETE – NCI audit tool altered to reflect all documents, Q1 98%

April-June 2018 Data and Commentary

It can seen that for the second quarter the target is being met.

NCI question	2017/18	Quarter 1 2018/2019	Quarter 2 2018/2019
Pain score	93%	98%	98%

Board sponsor: Chief Nurse **Operational lead (FFT and Real-time survey)**: Jill Faulkner, Head of Patient Experience
Operational leads (Pain Management): Julie Pain and Jenny Bree, Associate Chief Nurses and Sara Davis, Matron

QUALITY PRIORITY 2. PRESSURE ULCERS TARGETS:

a) Ensure that there are no avoidable stage 4 hospital acquired pressure ulcers throughout the year.
b) Ensure that the number of avoidable stage 3 hospital acquired pressure ulcers in 2018/19 reduces from the number in 2017/18 by at least 10 per cent.
a) Ensure that there are no avoidable stage 4 pressure ulcers acquired on the district nurse caseload throughout the year.
b) Ensure that the number of avoidable stage 3 pressure ulcers acquired on the district nurse caseload in 2018/19 reduces from the number in 2017/18 by at least 10%.

Planned Actions	**Who**	**By When**	**Progress at end of September 2018**
Develop robust education and training programs for staff	TV Team	Oct 2018	COMPLETE. All training programs are under review. Formalizing the booking process through Learning and Development to enable better quality training data.
Plan and deliver three educational study days to address key priority topics, pressure ulceration, lower limb ulceration and complex wound management	TV Team	Mar 2019	Pressure Ulcer Study Day – completed 13th March 2018 Lower Limb Ulceration Study Day – Completed for 20th September 2018 Complex Wound Management Day - Planned for March 2019 this will support the New Formulary & Guidelines completed September 2018
Work with the Patient Safety Team to develop robust reporting processes to ensure data collected is accurate	TV Team PS Team	Aug 2018	COMPLETE. Patient Safety Support provided to work with TV on RCA process. A 'Task and Finish' group has been set up to review processes going forward. PU Datix pane is being amended to standardize reporting incorporating the NHSi June 2018 Guidance Pressure Ulcers: Revised Definition and Measurement. Meeting with CCG to agree processes going forward.
Explore the 'Risk Assessment' tool for the emergency department to ensure it is specific to the clinical area for patient assessment.	TV Team	Jul 2018	COMPLETE. Amended Anderson Tool agreed and is in use in ED since June 2018. Audit have raised some issues with the use of this Tool and currently is under review.
Deliver the 'React to Risk' and '50 day pressure ulcer challenge' with an aim to reduce the	TV Team	Jun 15th to Aug 6th	COMPLETE. The 50 day challenge campaign is completed raising awareness of preventative strategies to prevent pressure ulcers (including but not exhaustive) 'React to Risk', 'React to red', appropriate

incidence of avoidable stage2, 3 and 4 pressure ulceration.		2018	use of equipment and identifying areas where pressure damage is most likely to occur on the body. The outcome of the challenge will be delivered at the Trust 'STOP the Pressure' day on 15th November (National Day). The trust has procured 'Stop, Respond, Prevent' mirrors that fit into the staff security badge holder that will enable easier inspection of body areas in difficult situations such as heels, sacral areas. These will be disseminated during the campaign.
Deliver the International 'Stop the Pressure' campaign to the Trust.	TV Team	Nov 2018	This will take place on November 15th 2018

April –September 2018 Avoidable Pressure Ulcer Data

Hospital

Period	2017/18*	Apr-June 18+	Jul-Sept 18+	Oct-Dec 18
No. of Stage 3	12	4	5	
No. of Stage 4	3	0	0	
Total	15	4	5	

Community

Period	2017/18*	Apr- June 18+	Jul-Sept 18+	Oct-Dec 18
No. of Stage 3	25	3	3	
No. of Stage 4	11	0	0	
Total	36	3	3	

+ The figures for Q1/Q2 may change dependent on the outcome of the remaining RCA investigations which are awaiting review as to whether they are avoidable or unavoidable.
* The figures for 2017/18 are different to those published in the annual report as further decisions on the avoidability of ulcers occurring at the very end of the financial year have been made since the publication of the report.

April – September 2018 Commentary

The Trust has made a good start to the year with no Stage 4 avoidable ulcers in either the hospital or community and the Stage 3 avoidable ulcers in the community have reduced considerably meaning that three targets are on track to be achieved. With there being 12 Stage 3 avoidable ulcers in the hospital in 2017/18 the target for one quarter would be less than three and so this target is slightly underachieved.

Board sponsor: Chief Nurse **Operational lead**: Mitchell Fernandez/Carol Love-Mecrow, Deputy Chief Nurse, Julie Pain and Jenny Bree, Associate Chief Nurses and Gill Hiskett, Tissue Viability Lead Nurse.

QUALITY PRIORITY 3 INFECTION CONTROL TARGETS:

Maintain or reduce our MRSA and Clostridium difficile (C. diff) rates in line with national and local priorities. All cases will undergo a root cause analysis, the results of which will be discussed jointly by the Trust and Dudley CCG to agree on any avoidability/lapses in care.
Have 0 post 48 hour cases of MRSA bacteraemia (blood-stream infections).
Have no more than 29 post 48 hour cases of Clostridium difficile with a lapse in care identified.

Planned Actions	Who	By When	Progress at end of September 2018
Trust wide mattress audit in conjunction with Tissue Viability	Angela Murray/Timea Vig	Sept 2018	Audit complete.
Participate in National Infection Prevention and Control week	Angela Murray	Nov 2018	Week confirmed as 15th -19th October.
Participate in W.H.O campaign – Clean Your Hands Campaign	Angela Murray	May 2018	COMPLETE. Display held at main reception and link workers promoted day in wards and departments.
Review process for Gram negative surveillance	Sarah Raybould/Angela Murray	August 2018	COMPLETE .Enhanced surveillance undertaken for all post 48 hour cases.
Antimicrobial Stewardship awareness week	Syed Gilani	Dec 2018	Planned for late November.
Review Antimicrobial prescribing and referrals from wards	Syed Gilani	June 2018	COMPLETE. Getting referrals from ward Pharmacists, and snap shot audit completed.
Recruitment of Governors as 'infection control secret shoppers'	Kim Jarrett	Nov 2018	Attended Governors training to recruit volunteers. A volunteer was recruited however this individual has now left the Trust. A new volunteer is being sourced.
Review MRSA Screening Policies and data collection.	Dr EN Rees/Angela Murray	Sept 2018	COMPLETE Policies reviewed, data collection methods reviewed with ongoing monitoring of compliance.
Implement the revised mandatory training programme for Infection Control.	Dr EN Rees/Angela Murray	March 2019	Revised mandatory training programme implemented. Reports being sent to all managers on annual compliance as of June 2018.
After final ratification – to adopt the catheter 'passport' to improve catheter care across the health economy.	Kim Jarrett	Oct 2018	COMPLETE Catheter passport launched across Dudley Health Economy and in use.

April - September 2018 Data and Commentary

MRSA: There have been no Trust assigned MRSA bacteraemia in this period (in fact, there have not been any Trust assigned cases since September 2015). The target is therefore being achieved so far this year.
C. difficile: There have been 12 cases of Clostridium difficile that have been identified as Trust apportioned in accordance with the Public Health England definition as of 30th September 2018. 4 cases have been identified as having lapses in care and therefore count against the Trust threshold of 28 cases. 4 cases have been identified as having no lapses in care. The remaining 4 cases remain under review. The yearly target of 28 with lapses in care (i.e. 7-8 a quarter) is therefore being achieved so far this year.

Board sponsor: Chief Nurse **Operational leads:** Dr. E.N. Rees, Director of Infection Prevention and Control, Angela Murray, Matron, Infection Prevention and Control

QUALITY PRIORITY 4. NUTRITION/HYDRATION TARGETS:

Ensure that the overall score of the monthly nutrition and hydration audit (made up of 24 items):
a) is 95% or above in each of the first three quarters for the Trust as a whole
b) has a 'Green' rating (95% or above) in the final quarter for every ward in the hospital

At least 95% of acute patients will receive a nutritional assessment within 24 hours of admission using the nationally recognised MUST (Malnutrition Universal Screening Tool).
At least 95% of patients will receive a nutritional assessment on initial contact with the community health nursing team using the nationally recognised MUST (Malnutrition Universal Screening Tool).

Planned Actions	Who	By When	Progress at end of September 2018
Continue nutritional collaborative work by implementation of a more systematic approach to protected mealtimes	L Leddington. D Vasey Nutrition team. Lead Dietician	Ongoing	Supported mealtimes launched on C1 – has proved very successful. Phase 2 has begun on Ward C7, C3 and C4. Patients' relatives can come in to support if they want, or volunteers/mealtime companions can be used. Areas using new process report that the whole meal service takes less time with everyone helping. Ward C5 /CCU/PCCU launching protected mealtimes w/c 15/10/18. The plan is for all wards to be compliant by December 2018 when new food supplier and new menu launched.
Revise protected meal policy	L Leddington. D Vasey Nutrition team. Lead Dietician	Aug 2018	COMPLETE: Policy has been rewritten as Supported Mealtime Policy and ratified in July and on the HUB.
Ensure Nutrition Group meets on a monthly basis	L Leddington. D Vasey Nutrition team.	Ongoing	Nutrition Link Nurse meeting is monthly. Newly established Nutrition steering group meets on a 3 monthly basis and is chaired by Consultant GI Physician. Multidisciplinary approach with core attendees as Nutrition

			Team, Pharmacy, Speech and Language therapists, Dieticians.
When new Electronic Patient Record is implemented MUST assessment will be mandatory	L Leddington	Oct 2018	EPR team are aware of this requirement.
Review the menus available in the Trust	L Leddington. D Vasey Nutrition team. Interserve Catering Team	Oct 2018	COMPLETE: Task and Finish group set up to review menus. New menu choice now selected and agreed with Interserve. Tablet data has been analyzed for popularity of menu choices Scores have been reviewed before next menu change.
Review food supplier	L Leddington. D Vasey Nutrition team. Interserve Catering Team	Oct 2018	COMPLETE: Interserve and Trust Catering group has identified a preferred supplier. Group from Trust /summit and Interserve visited Apetito on 3rd October 2018 .This is the chosen new food supplier from December 2018.Group did menu food sampling. Representatives from Apetito will be visiting hospital to support and train Interserve staff in preparation for December launch. Food tasting session planned with Governors by Helen Board. Public and staff tasting session planned for November 2018 in Interserve dining room by main entrance. Questionnaire consultation taking place re Halal and Kosher meal selections. Current popular meal choices also reviewed.
Implement a screen saver which will stress the importance of good nutrition	L Leddington Nutrition Team	Sep 2018	COMPLETE: To discuss with Communications once Supported Mealtime Policy has been ratified.
Organise a structured training programme on MUST for all staff across the Trust	L Leddington Nutrition Team Lead Dietician	Ongoing	Meeting held with Lead Nurses to understand scale of issue. Negligible training around MUST had taken place across the Trust. Trust MUST training on a train the trainer basis has commenced with Band 7 staff. Training sessions now taking place to include a practical element to the training. This will be supported by making available training material, to support the trainers on the wards. Training needs to be completed prior to the roll out of electronic MUST. Lead Nurse to hold training records within their areas to prove evidence of compliance.

April-September 2018 Commentary and Data

The chart below shows that we are achieving one of the targets so far this year. Work continues as outlined in the action plan above to ensure that the targets are achieved at the end of the year.

Nutrition audit Hospital			MUST assessment Hospital			MUST assessment Community		
2017/2018	Qtr 1 2018/2019	Qtr 2 2018/2019	2017/2018	Qtr 1 2018/2019	Qtr 2 2018/2019	2017/2018	Qtr 1 2018/2019	Qtr 2 2018/2019
94%	94%	94%	93%	91%	89%	96%	97%	98%

Board sponsor: Siobhan Jordan, Chief Nurse, **Operational leads:** Jenny Bree, Associate Chief Nurse and Lesley Leddington, Matron

QUALITY PRIORITY 5. MEDICATION TARGETS:

a) Ensure that in 95% or more cases, all prescribed medications will either be: a) signed and dated as administered or b) have an omission code recorded.
b) All patients who have a known potential to have an adverse reaction or have an allergy or sensitivity to a product/medication are clearly identified by having a red identification band in place.

Planned Actions	Who	By When	Progress at end of September 2018
Collaborative work to be undertaken with the West Midland Medicines Safety Officer Group to benchmark Trusts with omitted doses. Regular audit and action plans for the region will also commence.	Jane Elvidge	May 2018	Standardised audit tool agreed and undertaken across West Midlands Trusts. Results presented at the West Midlands MSO meeting on 22nd May 2018 and the Trust Medicines Management Group on 11th July 2018 – COMPLETE. Repeat audit on Tuesday 16th October 2018 of time critical medicines across the Trust for presentation and benchmarking across the region at the WMMSO group in November. Support from the clinical audit team to support with data entry requested. Presentation at the Medicines Management Group in December 2018.
Electronic EPMA system to be launched which will alert nursing staff to doses due, reducing the risk of omitted doses. Following implementation monitoring and audit of omitted doses will become easier.	Digital Team	Mar 2019	Sunrise Electronic Prescribing and Medicines Administration (EPMA) system is being configured.

Datix trends to be reviewed by Safer Medicines Group (SMP).	Suzanne Cooper	April 2018	COMPLETE – monthly occurrence reports of all non-prescribing medication errors trended and reviewed at SMP
Red wrist band policy to be written and agreed	Sara Davis	April 2018	COMPLETE – available on Hub
Red wrist band policy to be launched Trust wide via the intranet	Sara Davis	May 2018	COMPLETE – policy ratified and available on hub
Weekly audits will commence initially by Medicines Matron to ensure compliance and then will revert to monthly audits once embedded to be completed by Lead nurses.	Sara Davis	August 2018	COMPLETE – 2 months of audit completed by Matron, audit to be completed by Lead nurses from month of October 2018

April-September 2018 Data and Commentary

Medications signed and dated or omission code recorded		
2017/2018	Qtr 1 2018/2019	Qtr 2 2018/2019
93%	95%	92%

It can be seen that this target has been met in the first quarter; however quarter 2 is at 92%. We are still awaiting the medicines management boards to be purchased for all treatment rooms to ensure that medication information is communicated to all staff and this issue in particular is standardised and emphasised across the Trust. Approval for the finance of the Boards continues to be chased. Communication continues via Medicines Link nurse meetings.
The West Midlands Medication Safety Officer (MSO) group is committed to auditing medication safety alerts and issues across the region to baseline and benchmark medicine safety. Preliminary data from the West Midlands Trusts Omitted Doses Audit was shared at the MSO meeting on 22nd May 2018. At that time The Dudley Group NHS FT had the lowest incident of patients experiencing a missed dose including time critical medicines within the Trusts who submitted data.

Board sponsor: Chief Nurse
Operational leads: Julie Pain and Jenny Bree, Associate Chief Nurse, Sara Davies, Matron and Suzanne Cooper, Governance Pharmacist

QUALITY PRIORITY 6. DISCHARGE MANAGEMENT TARGETS:

a) All patients will have an Expected Discharge Date (EDD) determined by assuming ideal recovery and assuming no unnecessary waiting.
b) Early discharge. All medical and surgical wards will discharge the following number of patients before midday: In Q1, at least one patient. In Q2 at least two patients, which will be maintained in Q3 and Q4.
c) Delays in discharge. The total number of days that patients due for discharge are delayed will reduce by the following compared to the same quarter in 2017/18: Q1 by 10%, Q2 by 15%, which will be maintained in Q3 and Q4.

Planned Actions	Who	By When	Progress at end of September 2018
Ensure that daily ward rounds occur moving to twice daily ward rounds by the end of the year	Johanne Newens Ned Hobbs	September 18	COMPLETE. Twice daily ward rounds in assessment / short stay areas in place. Board rounds also twice a day. Full 7 day service ward rounds now in place with consultant decisions making flow as optimal as possible
Ensure that daily/twice daily ward rounds are included in consultant job planning	Johanne Newens Ned Hobbs	September 18	COMPLETE. Twice daily ward rounds in assessment / short stay areas in place. Full 7 day service is in place.
Implement the 'Red 2 Green' process	Hassan Paraiso GF	September 18	COMPLETE. Deputy Director of Operations / Nursing commenced as has a reinvigorated process to ensure the right actions are affecting optimal patient flow
Reinstate 'stranded patient'/length of stay meetings	Gerard Fogarty(GF)	June 18	Re-reviewed. Looking to look at this twice weekly
Ensure that the Estimated Discharge Date is a mandatory field on the patient administration system and the Estimated Discharge Date is retained in the system	Hassan Paraiso	Oct 18	COMPLETE. Daily EDD report being run, looking to complete new proforma to better reflect a revised bed base and new patient pathways

April-September 2018 Data and Commentary

a) Expected Discharge Date (EDD)

Month	Total No. Discharges	EDD Recorded	EDD Percentage Recorded
April 2018	2136	1665	77.9%
May 2018	2137	1734	81.1%
June 2018	2082	1657	79.6%

July 2018	2203	1677	76.1%
Aug 2018	2178	1713	78.7%
Sept 2018	2050	1428	69.7%

b) Early Discharge.

	Q1		Q2			Q1		Q2	
Ward	**Days with 1 patient Discharge 7am-12am**	**Days with Discharges**	**Days with 2 patient Discharges 7am-12am**	**Days with Discharges**	**Ward**	**Days with 1 Discharge between 7am-12am**	**Days with Discharges**	**Days with 2 patient Discharges 7am-12am**	**Days with Discharges**
A2	87	91	32	92	C1	80	91	5	91
B1	86	91	8	91	C3	83	91	25	90
B2 - Trauma	77	91	3	87	C4	56	90	4	79
B2 -Hip	77	91	1	80	C5	81	91	10	91
B3	89	91	25	92	C6	81	91	27	90
B4	85	91	19	90	C7	67	91	11	87
B5	72	91	8	87	C8	83	91	9	90
B6	60	83	11	82					

In Q2 the trust is now looking to widen its discharge portfolio with a number of streams and processes to enhance better discharges. A new red to green process, 2 before 10, the golden patient, a newly adapted weekend and weekly plan, '1 small thing', a repatriation review twice weekly and targeted board rounds to ensure all delays are identified. This should improve the above figures in the coming months.

c) Delays in discharge.

Comparison of first 5 months 2017/18 with the previous year's first and second quarter*
(* September 2018 data has not yet been analysed)

Year	Reimbursable delays	Total delays	% decrease (reimbursable)	% decrease (total delays)
2017/2018 Q1	2126	3856		
2018/2019 Q1	445	1464	70%	55%
2017/2018 Q2	1463	2575		

2018/2019 Q2	293	855	80%	67%

(Reimbursable delays are related to social services responsibilities while totals also include delays due to Trust processes and relatives seeking accommodation for patients medically fit for discharge)

A considerable amount of work is being undertaken to ensure effective patient flow through the organisation. Delays in discharge have reduced dramatically since the same period last year resulting in the target being met. With regards to the other targets, more work is needed. The Trust is being assisted by an Emergency Care Intensive Support Team. The Red 2 Green process will take on a new guise to ensure it fits with the organizations strategy is also being rolled out in the coming months. Both of these initiatives, together with the EDD being a mandatory field on the patient administration system will contribute to achieving the other two targets in the future. Process mapping currently in phase 2 of 6 is realigning appropriate pathways to ensure patients are moved in a timely manner.

Board sponsor: Karen Kelly, Chief Operating Officer **Operational leads:** Gregg Marson, Trust Lead - Discharge, Gerard Fogarty - Deputy Director of Operations/ Nursing, Jo Newens, Divisional Manager, Matt Weller, Chief of Surgery, Matt Banks, Chief of Medicine and Integrated Care and Hassan Paraiso, Clinical Director of the Urgent Care Directorate

QUALITY PRIORITY 7. INCIDENT MANAGEMENT TARGETS:

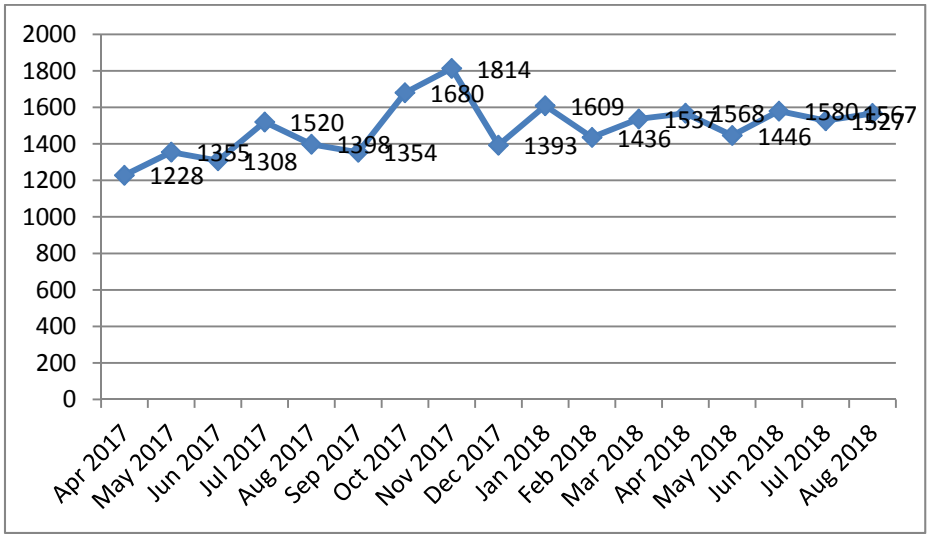
a) The Trust's reporting rate will increase every quarter, culminating in a 5% increase for the whole year and its comparative position on the reporting rate of incidents will improve every six months.
b) In 2018/19, for the full year reduce the number of Serious Incidents (non-pressure ulcers) by 5% compared to the numbers in 2017/18.

Planned Actions	Who	By When	Progress at end of September 2018
The expansion of the corporate incident management team to provide enhanced divisional support through a dedicated incident business partner.	G Palethorpe	June 2018	COMPLETE. Two more staff appointed
Enhanced reporting on learning from past incidents to encourage future reporting	N. Hobbs, J Newens, A-M. Williams, G. Palethorpe	March 2019	This remains in progress supported by enhanced central resources.
Development of the reporting of positive practice to encourage best practice	G Palethorpe	July 2018	Downgraded to IN PROGRESS. Positive reporting tool was launched within Datix, but there has been a need to suspend the Positive reporting tool within Datix due to anomalies being identified within the Datix system. The Patient Safety Lead Consultant is liaising with other Trusts to identify a system or module that can be considered for implementation within the Trust. We continue to raise the issue with Datix to see if a

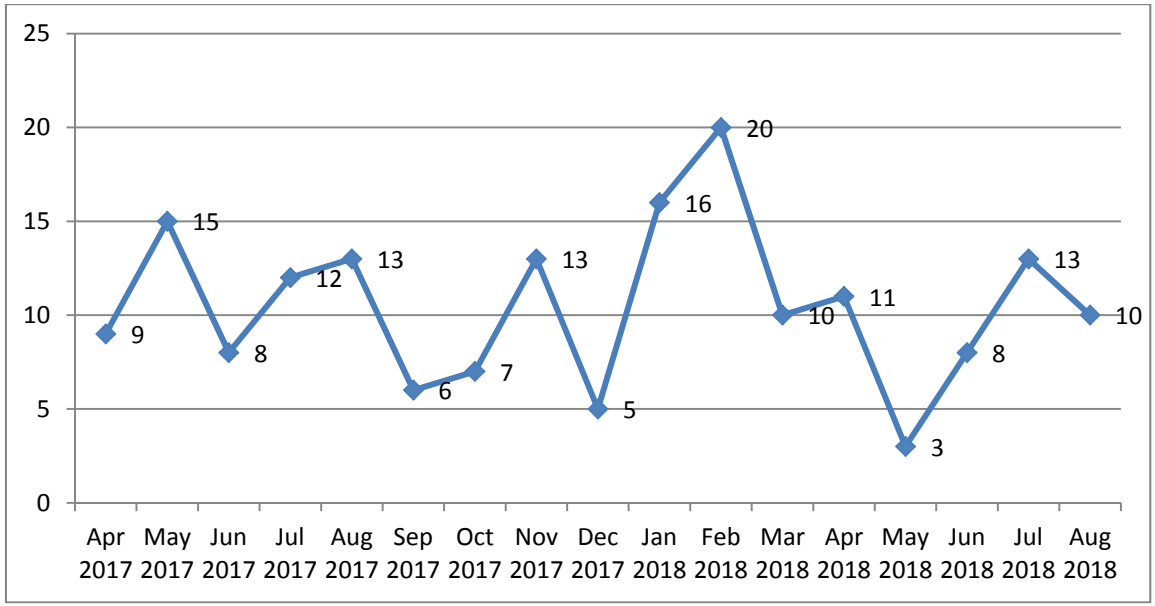
			solution can be found.

April-September 2018 Data and Commentary

With regards to the number of incidents reported (see the chart below), the Trust has seen an increase over the past 5 months (data to 31 August 2018). There has been an 11.5% increase over this period compared to same period in 2017 and this will support the achievement of Quality Priority 7, a 5% increase for the whole year.



The chart on the next page shows that for the same period in 2017/18 the serious incident numbers have decreased in the period 1st April 2018 to 31st August 2018 compared to the same period in 2017. Therefore, the target of a reduction of 5% is being achieved so far this year.



Board sponsor: Glen Palethorpe, Director of Governance **Operational leads:** Justine Edwards, Patient Safety Manager supported by the enhanced divisionally aligned incident officers.

NATIONAL CLINICAL AUDITS AND CONFIDENTIAL ENQUIRIES

There are 42 National Clinical Audits currently listed on the DH Quality Account (QA) in which the Trust is eligible to participate and accordingly the Trust is registered to participate in all of these. There are 2 new audits due to commence nationally in December:
BTS - secondary care adult asthma audit & Community Acquired Pneumonia (CAP).

Contributors to report: G. Palethorpe, H. Board, J. Faulkner, A. Murray, E. Rees, S. Davis, C. Love-Mecrow, L. Nation, J. Elvidge, D. Vasey, J. Newens, K. Kelly, D. Lynch, J. Edwards, D. Lynch. October 2018

Enclosure 14

The Dudley Group
NHS Foundation Trust

Paper for submission to the Board of Directors on 6 December 2018

TITLE:	**Integrated Performance Report for Month 6 (October) 2018**		
AUTHOR:	**Andy Troth** **Head of Informatics**	**PRESENTER**	**Karen Kelly** **Chief Operating Officer**

CLINICAL STRATEGIC AIMS
(delete the aim(s) not relevant to the paper

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

ACTION REQUIRED OF BOARD:

Decision	Approval	Discussion	Other
		Y	

OVERALL ASSURANCE LEVEL (***Please insert x in one of the boxes***)

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

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

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

SUMMARY OF KEY ISSUES:

The Dudley Group
NHS Foundation Trust

Workforce Performance

Overall the performance associated with our workforce is positive with sustained outcomes for appraisal and mandatory training as well as continued improvements with staff turnover. This is offset with a deterioration in absence rates overall. However, there are areas where absence rates are reducing such as nursing staff in the Division of Medicine.

The Workforce Committee oversees the full suite of Workforce key performance indicators and is provided a report from the senior HR team highlighting areas of priority being absence alongside vacancy management and the reduction of temporary staffing.

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 (CORO79)**
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:**

Integrated Performance Report - Board




October 2018

Created by: Informatics.
Title of report: Integrated Performance Report

Executive Lead:	**Performance**	**Chief Operating Officer, Karen Kelly**
	Finance	**Director of Finance, Tom Jackson**
	Workforce	**Director of HR, Andrew McMenemy**

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.

	October	YTD
Total No. of cases due to lapses in care	NIL	6
Total No. of cases NOT due to lapses in care	NIL	6
No. of cases currently under review (ytd)	2	
Total No. of cases (ytd)		14

There was one post 48 hour MRSA cases reported in month. The post-48 hr MRSA bacteraemia case was identified on 18th October 2018. Patient was admitted on 4th October with slurred speech and admitted to ward (C8). Treated for urosepsis - improving on antibiotics had an unwitnessed fall and had indwelling urinary catheter (full bladder). Nose and groin swabs not received in lab on first occasion when admitted. MRSA screens taken after blood culture taken; nose and groin positive. Not a previously known MRSA carrier. Contamination is being considered the most likely cause. RCA meeting held on 14th November and recommendations from the RCA will be monitored by the Infection Control Group.

Friends and Family Scores:

It is pleasing to record that actions put in place to support an improving FFT response rate across all areas have resulted in response rates that are equal to or better than the national average RAG rated amber.

Complaints:

From month to month, there is little way of knowing how many complaints may be submitted and in general there remains a small amount of difference between the number of complaints opened and closed. The picture of complaints is that it has changed very little from September to October for the total number of complaints ongoing. The focus remains on clearing the backlog of complaints with an emphasis on those that have breached and divisions are working hard to address this by using some additional resources to support the process. Communications remains the most frequently raised concern.

Falls:

We continue to work with NHSI and the National Fall Practitioner network with the aim of achieving a consistent reduction in patient falls, particularly falls with harm. We continue to perform better in comparison to national average in terms of number of falls and falls with harm.

Two falls with harm were reported in October: one patient required no treatment for the injury and has since been discharged. The second patient was treated for their injury and continues to recover on the hip suite.

In October five patients fell twice: no patient fell more than twice and no injuries were sustained in repeat incidents.

Pressure Ulcers

Thirty seven (37) outstanding Pressure Ulcers SI RCAs has now been closed by Dudley CCG following Trust submission of PU thematic review in November 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. Once finished, a report will be presented to the CQSPE committee for approval prior to implementation trust wide.

One category 3 PU incidents reported on STEIS in October 2018 as hospital acquired (ward B4). No category 4 avoidable pressure ulcer reported since February 2018. One category 4 unavoidable reported in community services in October 2018.

Never Events

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

Mixed Sex Sleeping Accommodation Breaches (MSA)

There were nine MSA breaches reported in October 2018. All incidents were reported by SHDU and were all related to capacity issues in the acute hospital.

VTE Assessment On Admission: Indicator

There is a continued decline in VTE performance since August 2018 achieving 94.5% in October which is slightly below the set 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 88.2%. Whilst, the Trust only (Type 1) performance was 80.9%.

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

	Attendances	Breaches	Performance
ED Dept Type 1	8930	1704	80.9%
UCC Type 3	5458	0	100.0%

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 83.1% (Provisional as at 14th Nov). Previous month confirmed performance was 80.5%

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

No. of Patients treated on or over 104 days (DGFT)	7
No. of Patients treated on or over 104 days (Tertiary Centre)	9
No. of Patients treated on or over 104 days (Combined)	16

2WW

The target was achieved once again in month. During this period a total of 1424 patients attended a 2ww appointment with 76 patients attending their appointments outside of the 2 week standard, achieving a performance 94.66% 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 93.3% in month against a target of 92%, an increase in performance from 93.1% in the previous month. Urology did not meet the target in month at 90.6% up from previous month. Ophthalmology is at 85.2% up from 84.8% in the previous month. General Surgery at 89.6% up from 88.8%. Also Plastic Surgery (90.5%) and Dermatology (90.5%) did not achieve the target. There were no 52-week Non-admitted Waiting Time breaches in month.

Diagnostic waits

The diagnostic wait was above target in month with a performance of 99.2%. The number of patients waiting over 6 weeks was 59.

The Dudley Group NHS Foundation Trust

Executive Summary by Exception cont.

Key Messages

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

Deficit of £3.242m for April-October, representing a £1.442m adverse variance in comparison to the control total following the consolidation of the pharmacy company and other technical changes. This position includes a pro rata benefit related to a new optimised alternative site evaluation. However, this remains at risk as the revised valuation has yet to be agreed by external auditors. In order to achieve the financial component of the PSF for Q3, the Trust needs to deliver a surplus of £1.532m over November and December which seems extremely unlikely. As such the full PSF for Q3 of £2.713m is at risk. Following an extraordinary F&P Committee in October, a recovery plan was agreed to deliver a deficit of £7.058m. However, the October performance has resulted in a deterioration of the forecast to a deficit of £9.731m before PSF. Whilst this revised forecast deficit factors in a degree of risk, it should be noted that there is still a sizeable gap of circa £2.2m regarding the estimated contract outturn with Dudley CCG. The Trust is working closely with the CCG to resolve the challenges with a view to agreeing a pragmatic settlement. However, this is likely to be constrained by CCG affordability.

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 November 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 continued at almost the same rate but has dipped slightly to 88.69%. All efforts will continue to be made to achieve and surpass our target of 90%. There are trajectories in place for each Division with performance reviews focusing on compliance for every member of staff.

Sickness Rate

The absence rate has increased to 4.96% from 4.84% in October 2018. 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. There has also been an emphasis on hot spots regarding short term recurrent absence as well as continued support to managers regarding long term absence. This has led to further awareness sessions to support managers to have the relevant skills to manage absence effectively.

Turnover Rate

The turnover rate has seen another drop and currently sits at 9.45%. This is still 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)	Sep-18	Oct-18	Actual YTD	Trend	Month Status
Friends & Family Test - Footfall							
Friends & Family Test - ED	14.5%	21.3%	18.3%	18.7%	18.2%	↑	
Friends & Family Test - Inpatients	26.0%	35.1%	35.1%	32.5%	34.7%	↓	
Friends & Family Test - Maternity	21.7%	34.4%	26.5%	32.8%	32.7%	↑	
Friends & Family Test - Outpatients	4.7%	14.5%	5.4%	5.2%	5.4%	↓	
Friends & Family Test - Community	3.5%	9.1%	5.8%	6.1%	4.3%	↑	
Friends & Family Test - Recommended							
Friends & Family Test - ED	89.9%	93.4%	75.8%	93.4%	78.0%	↑	
Friends & Family Test - Inpatients	96.3%	97.4%	93.0%	94.2%	94.1%	↑	
Friends & Family Test - Maternity	95.6%	98.2%	96.0%	99.4%	98.1%	↑	
Friends & Family Test - Outpatients	94.6%	97.2%	89.0%	90.3%	89.7%	↑	
Friends & Family Test - Community	96.4%	97.7%	93.2%	94.1%	95.1%	↑	
Complaints							
Total no. of complaints received in month			56	48	------	↓	
Complaints re-opened			5	3	30	↓	
PALs Numbers			293	295	2040	↑	
Complaints open at month end			219	210	------	↓	
Compliments received			513	452	3554	↓	
Dementia (1 month in arrears)							
Find/Assess		90%	98.7%		98.0%	↑	
Investigate		90%	100.0%		100.0%	↑	
Refer		90%	95.0%		96.3%	↑	
Falls	National average 6.63 per 1000 bed days						
No. of Falls			76	67	462	↓	
Falls per 1000 bed days		6.63	4.78	3.89	3.93	↓	
No. of Multiple Falls			5	5	43	↔	
Falls resulting in moderate harm or above			1	2	8	↑	
Falls resulting in moderate harm or above per 1000 bed days		0.19	4.8	3.9	3.9	↓	
Pressure Ulcers (Grades 3 & 4)							
Hospital Avoidable		0	0	1	6	↑	
Community Avoidable		0	0	0	7	↔	
Handwash							
Handwashing			99.6%	99.8%	98.8%	↑	

Patients will experience safe care - Patient Safety

	Target (Amber)	Target (Green)	Sep-18	Oct-18	Actual YTD	Trend	Month Status
Mixed Sex Accommodation Breaches							
Single Sex Breaches		0	7	9	35	↑	
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	6	6	4	↔	
MRSA Bacteraemia		0	0	1	1	↑	
MSSA Bacteraemia		0	1	1	10	↔	
E. Coli - Total hospital		0	2	0	18	↓	
Stroke Admissions - PROVISIONAL							
Stroke Admissions: Swallowing Screen		75%	100.0%	96.2%	94.2%	↓	
Stroke Patients Spending 90% of Time on Stroke Unit		85%	83.3%	94.4%	91.8%	↑	
Suspected High Risk TIAs Assessed and Treated <24hrs		85%	88.9%	100.0%	91.9%	↑	
VTE - PROVISIONAL							
VTE On Admission		95%	94.7%	94.5%	95.1%	↓	
Incidents							
Total Incidents			1219	1445	9750	↑	
Recorded Medication Incidents			197	594	2517	↑	
Never Events			0	0	0	↔	
Serious Incidents			4	4	53	↔	
of which, pressure ulcers			2	2	17	↔	
Incident Grading by Degree of Harm							
Death			3	1	10	↓	
Severe			3	1	16	↓	
Moderate			57	60	284	↑	
Low			154	188	1415	↑	
No Harm			1002	1195	8025	↑	
Percentage of incidents causing harm		28%	17.8%	17.3%	17.7%	↓	

Performance - "At a glance"

Executive Lead: Karen Kelly

The Dudley Group NHS Foundation Trust

Performance - Key Performance Indicators

	Target	Sep-18	Oct-18	Actual YTD	Trend	Month Status
Cancer Reporting - TRUST (provisional)						
All Cancer 2 week waits	93%	94.69%	94.66%	94.9%	↓	
2 week wait - Breast Symptomatic	93%	92.5%	96.4%	95.6%	↑	
31 day diagnostic to 1st treatment	96%	96.0%	97.7%	97.9%	↑	
31 day subsequent treatment - Surgery	94%	100.0%	96.3%	99.3%	↓	
31 day subsequent treatment - Drugs	94%	100.0%	90.0%	98.1%	↓	
62 day urgent GP referral to treatment	85%	80.5%	83.1%	81.9%	↑	
62 day screening programme	90%	100.0%	93.3%	98.2%	↓	
62 day consultant upgrades	85%	89.5%	94.2%	91.9%	↑	
Referral to Treatment						
RTT Incomplete Pathways - % still waiting	92%	93.1%	93.3%	93.7%	↑	
RTT Admitted - % treatment within 18 weeks	90%	85.8%	85.7%	87.2%	↓	
RTT Non Admitted - % treatment within 18 weeks	95%	93.9%	92.9%	94.6%	↓	
Wait from referral to 1st OPD	26	24	22	117	↓	
Wait from Add to Waiting List to Removal	39	42	42	218	↔	
ASI List		1825	1934	0	↑	
% Missing Outcomes RTT		0.1%	0.0%	0.1%	↓	
% Missing Outcomes Non-RTT		4.4%	3.8%	5.7%	↓	
DM01						
No. of diagnostic tests waiting over 6 weeks	0	96	59	421	↓	
% of diagnostic tests waiting less than 6 weeks	99%	98.7%	99.2%	98.8%	↑	
ED - TRUST						
Patients treated < 4 hours Type 1 (Trust ED)	95%	77.2%	80.9%	78.8%	↑	
Patients treated < 4 hours Type 1 & 3 (ED + UCC)	95%	85.2%	88.2%	86.6%	↑	
Emergency Department Attendances	N/A	8832	8930	44631	↑	
12 Hours Trolley Waits		0	0	0	↔	
Ambulance to ED Handover Time - TRUST						
30-59 minute breaches		441	428	2115	↓	
60+ minute breaches		120	88	423	↓	
Ambulance to Assessment Area Handover Time - TRUST						
30-59 minute breaches		9	14	84	↑	
60+ minute breaches		2	1	9	↓	

Performance - Key Performance Indicators cont.

	Target	Sep-18	Oct-18	Actual YTD	Trend	Month Status
Cancelled Operations - TRUST						
% Cancelled Operations	1.0%	1.8%	1.5%	1.7%	↓	
Cancelled operations - breaches of 28 day rule	0	0	4	11	↑	
Urgent operations - cancelled twice	0	0	0	1	↔	
GP Discharge Letters						
GP Discharge Letters	90%	81.0%	85.0%	80.3%	↑	
Theatre Utilisation - TRUST						
Theatre Utilisation - Day Case (RHH & Corbett)		77.9%	77.7%	77.4%	↓	
Theatre Utilisation - Main		84.6%	86.6%	87.2%	↑	
Theatre Utilisation - Trauma		94.8%	92.4%	95.0%	↓	
GP Referrals						
GP Written Referrals - made		6329	6462	33483	↑	
GP Written Referrals - seen		5220	6603	29634	↑	
Other Referrals - Made		3197	4052	17853	↑	
Throughput						
Patients Discharged with a LoS >= 7 Days		6.6%	6.2%	7%	↓	
Patients Discharged with a LoS >= 14 Days		3.2%	3.1%	3%	↓	
7 Day Readmissions		2.0%	1.6%	3%	↓	
30 Day Readmissions - PbR		8.0%	8.1%	8%	↑	
Bed Occupancy - %		86%	87%	88%	↑	
Bed Occupancy - % Medicine & IC		94%	94%	94%	↔	
Bed Occupancy - % Surgery, W&C		81%	81%	83%	↔	
Bed Occupancy - Paediatric %		45%	56%	49%	↑	
Bed Occupancy - Orthopaedic Elective %		69%	69%	69%	↔	
Bed Occupancy - Trauma and Hip %		91%	91%	93%	↔	
Number of Patient Moves between 8pm and 8am		109	104	534	↓	
Discharged by Midday		12.6%	13.2%	13%	↑	
Outpatients						
New outpatient appointment DNA rate	8%	9.5%	7.5%	9.0%	↓	
Follow-up outpatient appointment DNA rate	8%	5.2%	7.8%	6.4%	↑	
Total outpatient appointment DNA rate	8%	6.6%	7.7%	39.2%	↑	
Clinic Utilisation		77.7%	77.5%	77.1%	↓	
Average Length of stay (Quality Strategy Goal 3)						
Average Length of Stay - Elective	2.4	2.83	2.81	3.0	↓	
Average Length of Stay - Non-Elective	3.4	5.3	5.4	5.3	↑	

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	527	511	-3.0%	-15	1,469	1,378	-6.2%	-91
Day Cases	4,676	4,336	-7.3%	611	12,158	13,838	13.8%	1,680
Non-elective inpatients	4,074	3,931	-3.5%	-483	12,236	10,749	-12.2%	-1,487
Outpatients	41,698	45,690	9.6%	1,067	115,593	114,578	-0.9%	-1,015
A&E	9,134	8,930	-2.2%	305	25,595	26,316	2.8%	721
Total activity	**60,109**	**63,398**	**5.5%**	**1,485**	**167,051**	**166,859**	**-0.1%**	**-192**
CIP	**£'000**	**£'000**		**£'000**	**£'000**	**£'000**		**£'000**
Income	499	600	20.3%	101	2,520	3,563	41.4%	1,043
Pay	386	254	-34.2%	-132	1,968	1,975	0.3%	6
Non-Pay	514	262	-49.1%	-253	2,358	3,177	34.7%	819
Total CIP	**1,399**	**1,116**	**-20.2%**	**-283**	**6,847**	**8,715**	**27.3%**	**1,868**
INCOME	**£'000**	**£'000**		**£'000**	**£'000**	**£'000**		**£'000**
NHS Clinical	29,105	28,298	-2.8%	-807	195,376	193,104	-1.2%	-2,272
Other Clinical	544	612	12.4%	68	3,873	5,162	33.3%	1,289
STF Funding	904	633	-30.0%	-271	4,069	2,849	-30.0%	-1,220
Other	1,972	1,712	-13.2%	-260	13,739	13,390	-2.5%	-349
Total income	**32,525**	**31,254**	**-3.9%**	**-1,271**	**217,057**	**214,505**	**-1.2%**	**-2,552**
OPERATING COSTS	**£'000**	**£'000**		**£'000**	**£'000**	**£'000**		**£'000**
Pay	-17,965	-18,939	5.4%	-974	-130,952	-132,751	1.4%	-1,799
Drugs	-2,976	-3,006	1.0%	-30	-19,390	-20,224	4.3%	-834
Non-Pay	-7,554	-7,760	2.7%	-205	-49,933	-50,304	0.7%	-371
Total Costs	**-28,496**	**-29,705**	**4.2%**	**-1,209**	**-200,275**	**-203,279**	**1.5%**	**-3,004**

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	**4,023**	**1,573**	-60.9%	**-2,450**	**16,723**	**11322**	-32.3%	**-5,401**
Depreciation	-846	-552	-34.8%	294	-5,796	-3982	-31.3%	1,814
Restructuring & Other	0	0	n/a	0	0	0	n/a	0
Financing Costs	-1,238	-1,113	-10.1%	125	-8,641	-7653	-11.4%	988
SURPLUS/(DEFICIT)	**1,939**	**-92**	-104.7%	**-2,031**	**2,286**	**-313**	-113.7%	**-2,599**
SOFP	**£'000**	**£'000**		**£'000**	**£'000**	**£'000**		**£'000**
Capital Spend	-1,334	-713	-46.6%	621	-7,593	-5,525	-27.2%	2,068
Inventory					3,131	3,481	11.2%	350
Receivables & Prepayments					20,126	17,921	-11.0%	-2,205
Payables					-20,546	-23,995	16.8%	-3,449
Accruals							n/a	0
Deferred Income					-1,639	-1,784	8.8%	-145
Cash & Loan Funding	**£'000**	**£'000**		**£'000**	**£'000**	**£'000**		**£'000**
Cash					4,840	7,367	52.2%	2,527
Loan Funding							n/a	0
KPIs								
EBITDA %	13.9%	5.4%	-8.5%		6.2%	4.3%	-1.9%	
Deficit %	6.7%	-0.3%	-7.0%		0.9%	-0.1%	-1.0%	
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	

The Dudley Group NHS Foundation Trust

Workforce - "At a glance"

Executive Lead: Andrew McMenemy

	People					
	Target			Actual		Month
	18/19	Sep-18	Oct-18	YTD	Trend	Status
Workforce						
Sickness Absence Rate	3.50%	4.84%	4.96%	4.57%	↑	
Staff Turnover	8.5%	9.48%	9.45%	9.52%	↓	
Mandatory Training	90.0%	89.3%	88.6%	88.8%	↓	
Appraisal Rates - Total	90.0%	95.6%	95.6%	95.6%	↔	

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%	77.23%	80.91%	-	-	-	-	-	78.22%	%
A&E - 4 Hour UCC Dept Only % (Type 3)	99.38%	99.44%	99.46%	99.82%	99.43%	99.49%	100%	100%	-	-	-	-	-	99.65%	%
A&E - 4 Hour UCC/A&E Combined % (Type 1+3)	86.56%	86.29%	85.38%	86.93%	85.29%	87.64%	85.21%	88.15%	-	-	-	-	-	86.40%	95%
A&E - Patients who Left Without Being Seen %	2.6%	1.7%	2.1%	1.8%	2.5%	1.6%	1.7%	1.2%	-	-	-	-	-	1.8%	5%
A&E - Time to Initial Assessment (95th Percentile)	9	4	8	9	7	4	5	7	-	-	-	-	-	7	15
A&E - Time to Treatment Median Wait (Minutes)	70	49	65	61	73	49	64	55	-	-	-	-	-	55	60
A&E - Total Time in A&E (95th Percentile)	731	593	587	504	524	463	511	462	-	-	-	-	-	462	240
A&E - Unplanned Re-Attendance Rate %	1.5%	1.3%	1.1%	1.5%	1.6%	1.3%	1.3%	1%	-	-	-	-	-	1.3%	5%
Activity - A&E Attendances	103,426	8,299	9,103	8,923	9,580	8,339	8,843	8,935	-	-	-	-	-	62,022	61,495
Activity - Cancer MDT	5,131	492	443	520	378	511	508	517	-	-	-	-	-	3,369	3,044
Activity - Community Attendances	376,548	33,662	36,319	36,299	38,817	34,833	30,408	35,507	-	-	-	-	-	245,845	237,475
Activity - Critical Care Bed Days	7,612	585	710	737	791	604	690	770	-	-	-	-	-	4,887	4,724
Activity - Diagnostic Imaging whilst Out-Patient	52,692	4,222	4,505	4,451	4,434	4,445	4,151	4,672	-	-	-	-	-	30,880	34,168
Activity - Direct Access Pathology	1,970,646	173,406	172,671	173,017	174,399	173,882	165,563	189,859	-	-	-	-	-	1,222,797	1,224,107
Activity - Direct Access Radiology	75,450	6,221	6,883	6,389	6,475	6,235	5,930	6,992	-	-	-	-	-	45,125	47,333
Activity - Elective Day Case Spells	48,682	4,184	4,366	4,058	4,159	4,401	3,984	4,530	-	-	-	-	-	29,682	29,430
Activity - Elective Inpatients Spells	5,828	433	464	451	471	493	444	511	-	-	-	-	-	3,267	3,478
Activity - Emergency Inpatient Spells	50,160	3,256	3,628	3,639	3,783	3,713	3,467	3,851	-	-	-	-	-	25,337	28,768
Activity - Excess Bed Days	11,066	707	823	922	841	576	645	472	-	-	-	-	-	4,986	8,753
Activity - Maternity Pathway	7,636	578	668	621	642	652	557	565	-	-	-	-	-	4,283	4,482
Activity - Neo Natal Bed Days	7,111	628	661	604	611	643	523	621	-	-	-	-	-	4,291	4,285
Activity - Outpatient First Attendances	146,246	13,055	14,049	13,954	14,960	13,856	13,552	15,837	-	-	-	-	-	99,263	91,646
Activity - Outpatient Follow Up Attendances	295,301	26,094	27,879	26,507	28,812	27,385	26,608	29,927	-	-	-	-	-	193,212	181,506
Activity - Outpatient Procedure Attendances	71,502	5,294	6,165	6,122	6,065	5,730	5,769	5,987	-	-	-	-	-	41,132	44,166
Activity - Rehab Bed Days	20,079	1,528	1,571	1,720	1,618	1,908	1,728	1,967	-	-	-	-	-	12,040	11,359
Activity - Renal Dialysis	52,070	4,233	4,431	4,225	4,121	4,180	3,882	4,259	-	-	-	-	-	29,331	30,252
Ambulance Handover - 30 min – breaches (DGH view)	4,608	180	437	437	542	267	441	428	-	-	-	-	-	2,732	0
Ambulance Handover - 30 min – breaches (WMAS view)	5,803	240	603	563	685	395	548	554	-	-	-	-	-	3,588	0
Ambulance Handover - 60 min – breaches (DGH view)	716	8	67	53	119	43	120	88	-	-	-	-	-	498	0
Ambulance Handover - 60 min – breaches (WMAS view)	876	9	73	66	144	52	138	106	-	-	-	-	-	588	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%	95.0%	94.60%	94.6%	-	-	-	-	-	94.1%	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%	92.50%	96.3%	-	-	-	-	-	95.2%	93%
Cancer - 31 day - from diagnosis to treatment for all cancers	98.8%	98.7%	100.0%	99.4%	97.1%	98.7%	96.00%	97.2%	-	-	-	-	-	98.2%	96%
Cancer - 31 Day For Second Or Subsequent Treatment - Anti Cancer Drug Treatments	100%	100%	100%	100%	100%	100.0%	100%	90.0%	-	-	-	-	-	99%	98%
Cancer - 31 Day For Second Or Subsequent Treatment - Surgery	98.9%	100%	100%	100%	100%	100.0%	100.00%	93.5%	-	-	-	-	-	99%	94%
Cancer - 31 Day For Subsequent Treatment From Decision To Treat	99.4%	100%	100%	100%	100%	100.0%	100%	92.1%	-	-	-	-	-	99%	96%
Cancer - 62 day - From Referral for Treatment following a Consultant Upgrade	93.3%	86.6%	86.1%	91.5%	88.1%	95%	90%	94.3%	-	-	-	-	-	90.5%	85%
Cancer - 62 day - From Referral for Treatment following national screening referral	98.4%	96.4%	96.1%	100%	100%	100.0%	100%	93.3%	-	-	-	-	-	97.6%	90%
Cancer - 62 day - From Urgent GP Referral to Treatment for All Cancers	85.3%	80.8%	84%	79.8%	85.3%	79.8%	80.40%	85.1%	-	-	-	-	-	82.3%	85%
Cancer: Patients on a 62 day pathway treated on or over 104 days (1: patients treated at DGFT)	19	3	7	2	3	2	7	-	-	-	-	-	-	24	
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	5	9	-	-	-	-	-	-	23	
Cancer: Patients on a 62 day pathway treated on or over 104 days (3: combined)	48	5	9	3	7	7	16	-	-	-	-	-	-	47	
Maternity: Breastfeeding Data Coverage Rates	100%	100%	100%	100%	100%	100%	100%	100%	-	-	-	-	-	100%	0%
Number of Births Within the Trust	4,435	351	384	363	356	385	356	368	-	-	-	-	-	2,563	
RTT - Admitted Pathways within 18 weeks %	87.9%	84.6%	87.1%	86.6%	88.2%	89.3%	85.80%	85.6%	-	-	-	-	-	86.8%	90%
RTT - Incomplete Waits within 18 weeks %	94%	93.4%	94.7%	94.4%	94%	93.6%	93.10%	93.2%	-	-	-	-	-	93.80%	92%
RTT - Non-Admitted Pathways within 18 weeks %	93.1%	94.4%	94.6%	95.8%	95.8%	94.9%	93.80%	92.8%	-	-	-	-	-	94.6%	95%
Waiting Time - Diagnostic 6 Week Maximum Wait (VSA05)	97.85%	99.31%	99.38%	99.30%	99.23%	97.7%	98.69%	99.18%	-	-	-	-	-	98.97%	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	£1,172k	£1,119k	-	-	-	-	-	£7,373k	k
Bank spend	£16,404k	£1,481k	£1,475k	£1,611k	£1,608k	£1,393k	£1,883k	£1,735k	-	-	-	-	-	£11,185k	k
Budgetary Performance	(£20,622)k	(£640)k	(£451)k	£646k	(£445)k	(£134)k	(£1,833)k	£98k	-	-	-	-	-	(£2,760)k	£0k
Capital v Forecast	106.6%	59.8%	51.9%	69%	67.7%	68.3%	-	-	-	-	-	-	-	68.3%	95%
Cash Balance	£8,617k	£13,899k	£9,420k	£9,717k	£8,752k	£7,143k	-	-	-	-	-	-	-	£7,143k	k
Cash v Forecast	54.6%	109.3%	98.8%	159.4%	85.20%	92.70%	-	-	-	-	-	-	-	92.7%	95%
Creditor Days	16.4	15.5	15.5	16.7	17	15.9	-	-	-	-	-	-	-	15.9	15
Debt Service Cover	0.79	0	0.64	0.85	1.03	1.12	-	-	-	-	-	-	-	1.12	2.5
Debtor Days	7.4	9.4	10.8	12.8	14.1	14.9	-	-	-	-	-	-	-	14.9	15
I&E (After Financing)	(£9,518)k	(£2,073)k	£179k	£116k	£733k	£554k	-	-	-	-	-	-	-	(£492)k	k
Liquidity	-7.63	-7.78	-8	-8.35	-7.98	-8.06	-	-	-	-	-	-	-	-8.06	0
SLA Performance	(£3,902)k	(£417)k	(£599)k	£255k	£113k	(£275)k	(£362)k	£324k	-	-	-	-	-	(£961)k	£0k

Staff/HR Dashboard

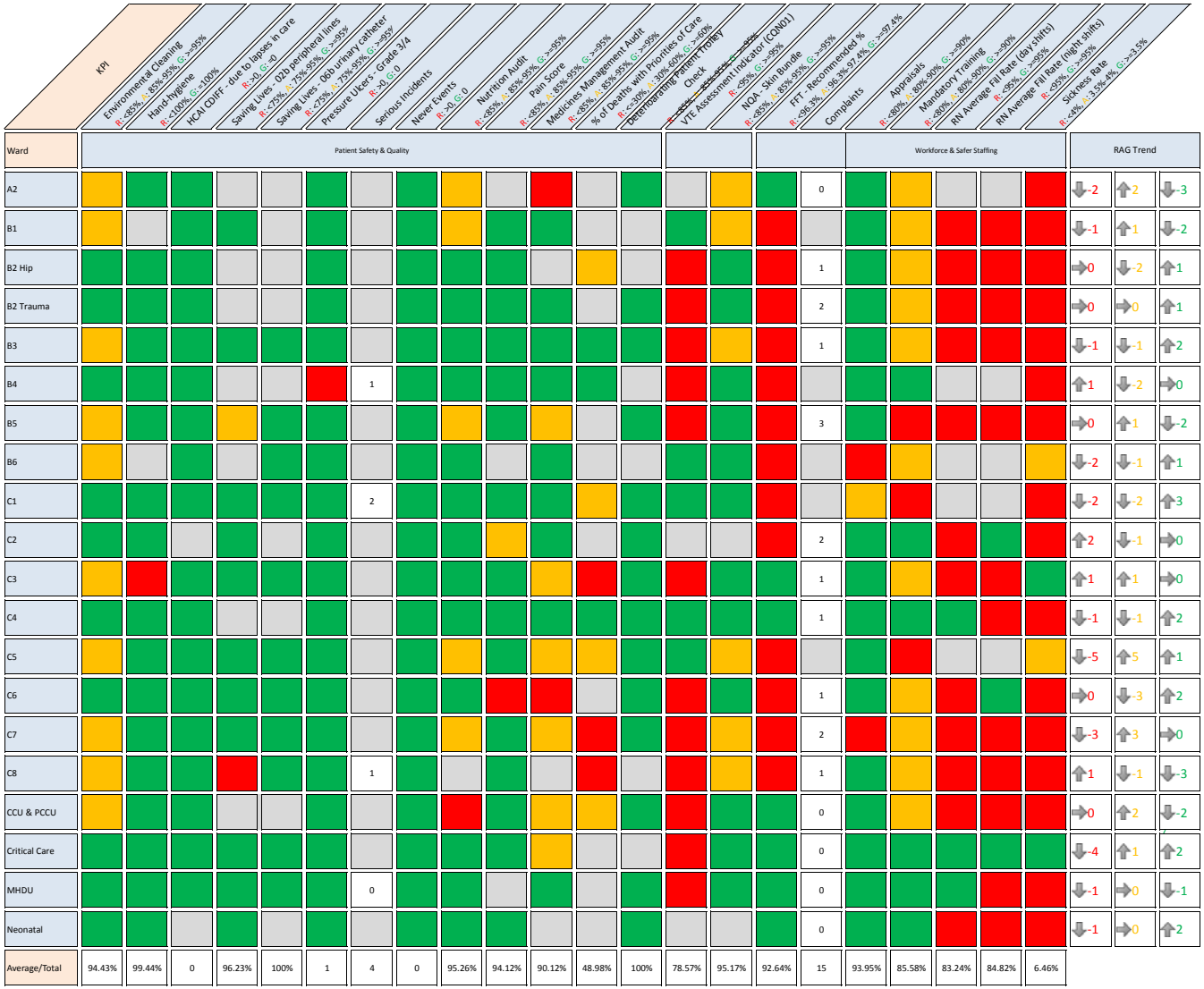
Staff/HR															
Description	LYO	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	YTD	Target
Appraisals	70.5%	17.4%	52.4%	95.6%	95.6%	95.6%	95.6%	95.6%	-	-	-	-	-	95.6%	90%
Mandatory Training	85.9%	87.8%	88.3%	87.6%	88.9%	89.3%	89.3%	88.6%	-	-	-	-	-	88.6%	90%
RN average fill rate (DAY shifts)	89.64%	83.89%	82.99%	81.22%	81.75%	78.2%	78.79%	84.74%	-	-	-	-	-	81.61%	95%
RN average fill rate (NIGHT shifts)	92.85%	85.65%	85.81%	84.64%	85.68%	83.69%	83.65%	88.3%	-	-	-	-	-	85.31%	95%
Sickness Rate	4.40%	3.79%	3.85%	4.17%	4.44%	4.43%	4.84%	4.96%	-	-	-	-	-	4.35%	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	4,473.78	4,359.72	-	-	-	-	-	4,359.72	
Turnover Rate (Rolling 12 Months)	9.74%	9.95%	9.70%	9.56%	9.51%	9.59%	9.48%	9.45%	-	-	-	-	-	9.45%	%
Vacancy Rate	6.63%	10.87%	11.39%	11.30%	11.16%	10.89%	10.40%	9.41%	-	-	-	-	-	9.41%	%

The Dudley Group NHS Foundation Trust

Quality Indicators

Patients will experience safe care

Heat Map - October 2018



Ward	Patient Safety & Quality															Workforce & Safer Staffing					RAG Trend		
A2																0					-2	2	-3
B1																					-1	1	-2
B2 Hip																1					0	-2	1
B2 Trauma																2					0	0	1
B3																1					-1	-1	2
B4							1														1	-2	0
B5																3					0	1	-2
B6																					-2	-1	1
C1							2														-2	-2	3
C2																2					2	-1	0
C3																1					1	1	0
C4																1					-1	-1	2
C5																					-5	5	1
C6																1					0	-3	2
C7																2					-3	3	0
C8							1									1					1	-1	-3
CCU & PCCU																0					0	2	-2
Critical Care																0					-4	1	2
MHDU							0									0					-1	0	-1
Neonatal																0					-1	0	2
Average/Total	94.43%	99.44%	0	96.23%	100%	1	4	0	95.26%	94.12%	90.12%	48.98%	100%	78.57%	95.17%	92.64%	15	93.95%	85.58%	83.24%	84.82%	6.46%			

EAS trajectory for 95% achievement

	ACTUAL	ACTUAL	ACTUAL	ACTUAL	ACTUAL	ACTUAL	ACTUAL	ACTUAL	ACTUAL
Type 1 Minors seen within 4 hours	**30/09/2018**	**07/10/2018**	**14/10/2018**	**21/10/2018**	**28/10/2018**	**04/11/2018**	**11/11/2018**	**18/11/2018**	**25/11/2018**
Number of A&E Attendances - Type 1 - Minors	668	556	627	608	586	458	596	593	530
4 Hour Wait Breaches - Type 1 - Minors	53	29	20	18	2013	8	23	19	19
Percentage Type 1 Minors seen within 4 Hours	92.1%	94.8%	96.8%	97.0%	97.8%	98.3%	96.1%	96.8%	96.4%

Type 1 Majors seen within 4 hours	**30/09/2018**	**07/10/2018**	**14/10/2018**	**21/10/2018**	**28/10/2018**	**04/11/2018**	**11/11/2018**	**18/11/2018**	**25/11/2018**
Number of A&E Attendances - Type 1 - Minors	1405	1446	1415	1469	1368	1450	1517	1567	1604
4 Hour Wait Breaches - Type 1 - Minors	442	459	423	302	196	547	530	464	552
Percentage Type 1 Minors seen within 4 Hours	68.5%	68.3%	70.1%	79.4%	80.8%	62.3%	65.1%	65.6%	65.6%

Type 3 seen within 4 hours	**30/09/2018**	**07/10/2018**	**14/10/2018**	**21/10/2018**	**28/10/2018**	**04/11/2018**	**11/11/2018**	**18/11/2018**	**25/11/2018**
Number of A&E Attendances - Type 1 - Minors	1091	1203	1301	1294	1256	1106	1269	1348	1366
4 Hour Wait Breaches - Type 1 - Minors	0	0	0	0	0	0	0	6	0
Percentage Type 1 Minors seen within 4 Hours	100.0%	100.0%	100.0%	100.0%	98.9%	100.0%	100.0%	99.6%	100.0%

Combined seen within 4 hours	**30/09/2018**	**07/10/2018**	**14/10/2018**	**21/10/2018**	**28/10/2018**	**04/11/2018**	**11/11/2018**	**18/11/2018**	**25/11/2018**
Number of A&E Attendances - Type 1 - Minors	3164	3205	3343	3371	3210	3014	3382	3508	3500
4 Hour Wait Breaches - Type 1 - Minors	495	488	443	320	209	555	553	489	571
Percentage Type 1 Minors seen within 4 Hours	84.4%	84.8%	86.7%	90.5%	93.5%	81.6%	83.6%	86.1%	83.7%

EAS trajectory for 95% achievement

Type 1 Minors seen within 4 hours	03/02/2019	10/02/2019	17/02/2019	24/02/2019	03/03/2019	10/03/2019	17/03/2019	24/03/2019	31/03/2019
Number of A&E Attendances - Type 1 - Minors	616	616	616	616	616	616	616	616	616
4 Hour Wait Breaches - Type 1 - Minors	18	18	16	16	14	12	10	8	6
Percentage Type 1 Minors seen within 4 Hours	97.1%	97.1%	97.4%	97.4%	97.7%	98.1%	98.4%	98.7%	99.0%

Type 1 Majors seen within 4 hours	03/02/2019	10/02/2019	17/02/2019	24/02/2019	03/03/2019	10/03/2019	17/03/2019	24/03/2019	31/03/2019
Number of A&E Attendances - Type 1 - Minors	1453	1453	1453	1453	1453	1453	1453	1453	1453
4 Hour Wait Breaches - Type 1 - Minors	183	176	171	164	159	154	149	144	146
Percentage Type 1 Minors seen within 4 Hours	87.4%	87.9%	88.2%	88.7%	89.1%	89.4%	89.7%	90.1%	90.0%

Type 3 seen within 4 hours	03/02/2019	10/02/2019	17/02/2019	24/02/2019	03/03/2019	10/03/2019	17/03/2019	24/03/2019	31/03/2019
Number of A&E Attendances - Type 1 - Minors	1281	1281	1281	1281	1281	1281	1281	1281	1281
4 Hour Wait Breaches - Type 1 - Minors	14	14	14	14	14	14	14	14	14
Percentage Type 1 Minors seen within 4 Hours	98.9%	98.9%	98.9%	98.9%	98.9%	98.9%	98.9%	98.9%	98.9%

Combined seen within 4 hours	03/02/2019	10/02/2019	17/02/2019	24/02/2019	03/03/2019	10/03/2019	17/03/2019	24/03/2019	31/03/2019
Number of A&E Attendances - Type 1 - Minors	3350	3350	3350	3350	3350	3350	3350	3350	3350
4 Hour Wait Breaches - Type 1 - Minors	215	208	201	194	187	180	173	166	166
Percentage Type 1 Minors seen within 4 Hours	93.6%	93.8%	94.0%	94.2%	94.4%	94.6%	94.8%	95.0%	95.0%

EAS trajectory for 95% achievement

Type 1 Minors seen within 4 hours	02/12/2018	09/12/2018	16/12/2018	23/12/2018	30/12/2018	06/01/2019	13/01/2019	20/01/2019	27/01/2019
Number of A&E Attendances - Type 1 - Minors	616	616	616	616	616	616	616	616	616
4 Hour Wait Breaches - Type 1 - Minors	20	20	20	20	20	20	20	20	20
Percentage Type 1 Minors seen within 4 Hours	96.8%	96.8%	96.8%	96.8%	96.8%	96.8%	96.8%	96.8%	96.8%

Type 1 Majors seen within 4 hours	02/12/2018	09/12/2018	16/12/2018	23/12/2018	30/12/2018	06/01/2019	13/01/2019	20/01/2019	27/01/2019
Number of A&E Attendances - Type 1 - Minors	1453	1453	1453	1453	1453	1453	1453	1453	1453
4 Hour Wait Breaches - Type 1 - Minors	244	237	230	223	216	209	202	195	188
Percentage Type 1 Minors seen within 4 Hours	83.2%	83.7%	84.2%	84.7%	85.1%	85.6%	86.1%	86.6%	87.1%

Type 3 seen within 4 hours	02/12/2018	09/12/2018	16/12/2018	23/12/2018	30/12/2018	06/01/2019	13/01/2019	20/01/2019	27/01/2019
Number of A&E Attendances - Type 1 - Minors	1281	1281	1281	1281	1281	1281	1281	1281	1281
4 Hour Wait Breaches - Type 1 - Minors	14	14	14	14	14	14	14	14	14
Percentage Type 1 Minors seen within 4 Hours	98.9%	98.9%	98.9%	98.9%	98.9%	98.9%	98.9%	98.9%	98.9%

Combined seen within 4 hours	02/12/2018	09/12/2018	16/12/2018	23/12/2018	30/12/2018	06/01/2019	13/01/2019	20/01/2019	27/01/2019
Number of A&E Attendances - Type 1 - Minors	3350	3350	3350	3350	3350	3350	3350	3350	3350
4 Hour Wait Breaches - Type 1 - Minors	278	271	264	257	250	243	236	229	222
Percentage Type 1 Minors seen within 4 Hours	91.7%	91.9%	92.1%	92.3%	92.5%	92.7%	93.0%	93.2%	93.4%

Enclosure 15

The Dudley Group
NHS Foundation Trust

Paper for submission to the Board of Directors on 6 December 2018

TITLE:	**Finance and Performance Committee Exception Report**		
AUTHOR:	Tom Jackson Director of Finance	**PRESENTER:**	Tom Jackson Director of Finance

CLINICAL STRATEGIC AIMS

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

ACTION REQUIRED OF BOARD / COMMITTEE / GROUP:

Decision	Approval	Discussion	Other
		Y	**Y**

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:

The Board is asked to note the contents of the report and in particular the items referred to the Board for decision or action.

CORPORATE OBJECTIVE:

S06 Plan for a viable future

SUMMARY OF KEY ISSUES:

Summary report from the Finance and Performance Committee meeting held on 29 November 2018.

IMPLICATIONS OF PAPER:

RISK	Y		**Risk Description:** BAF592
	Risk Register: Y		**Risk Score:** 20
COMPLIANCE and/or LEGAL REQUIREMENTS	**CQC**	**Y**	**Details:** Well Led
	NHSI	**Y**	**Details:** Achievement of all terms of FT licence
	Other	**N**	**Details:**

Meeting	Meeting Date	Chair	Quorate	
Finance & Performance Committee	**29 November 2018**	**Jonathan Hodgkin**	**yes**	**no**
			Yes	

Declarations of Interest Made

None

Assurances Received

Finance and Efficiency

- A £3.2m deficit is reported to Month 7, £1.4m worse than the plan to date. The forecast for the year has worsened to £9.7m excluding PSF. The Committee sought assurance on the reasonableness of the forecasts and a day long session has been arranged for NHSI in early December to assess the robustness of our in year forecasting. The Committee were updated on progress regarding the potential change to our Control Total forecast with NHSI. This will be brought to the December F and P and the January Board.
- CIP savings of £8.71m had been achieved up to the end of October, which is a positive variance of £1.86m again plan. The forecast full year CIP savings total £15.03m, which is £381,000 behind plan.

Performance

- The 4 hour access standard remains challenging and the Committee received assurances about delivery of the 62 day standard in October and DM01.

Workforce

- Medical and Nursing papers were received and seen by the Committee as informative

Estates and Procurement

- Enhanced efficiency from procurement activities was evidenced with the Trust benchmarking well and improving for both management costs of procurement (17/135) and the impact of procurement activities (47/136).

Board Assurance Framework

- Ongoing determination of MCP risks following the Board to Board with the CCG was noted.

Decisions Made / Items Approved

- AMU/AFU Nursing Budget approved
- Dudley Clinical Services Ltd 2017/18 Accounts approved

Actions to come back to Committee

- None

Performance Issues to be referred into Executive Performance Management Process

- None

Areas of Risk to be escalated onto the Corporate or Divisional Risk Register

- None

Items referred to the Board for decision or action

- None

Enclosure 16

The Dudley Group
NHS Foundation Trust

Paper for submission to the Board on 6th December 2018

TITLE:	**Summary of Workforce & Staff Engagement Committee**		
AUTHOR:	**Andrew McMenemy, Director of Workforce & OD**	**PRESENTER**	**Julian Atkins, Non-Executive Director & Committee Chair**

CLINICAL STRATEGIC AIMS

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

ACTION REQUIRED OF BOARD:

Decision	Approval	Discussion	Other
		Y	

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:

The Board to receive the main items addressed at the Workforce Committee and to be assured that there continues to be good progress alongside the Committee aims that are aligned to the Trust Workforce Strategy.

CORPORATE OBJECTIVE:

SO4: Be the place people choose to work

SO5: Make the best use of what we have

SO6: Deliver a viable future

The Dudley Group
NHS Foundation Trust

SUMMARY OF KEY ISSUES:

This summary of the November Workforce and Staff Engagement Committee meeting provides the Board with assurance that matters associated to the Workforce Strategy are being managed and taken forward effectively and appropriately.

The main topics of interest continue to be effective recruitment leading to a sustainable workforce and the implications associated to this indicator. This is reflected in the Trust BAF and Workforce Risks as well as having significant focus in the Workforce Strategy and Business Plan. The Workforce and Staff Engagement Committee continues to hold those relevant Trust officers to account to ensure all reasonable measures are in place to mitigate the risks associated with recruitment and vacancy levels. This was demonstrated with the draft Business Case associated to Nurse Recruitment.

It is proposed that the vacancy levels and how these are currently accommodated in part by agency and bank staff will be a focus at the Workforce Committee meeting in December 2018.

The other main topic at this time is associated with staff engagement and experience and within that the opportunities for our staff to develop their skills as part of their employment at the Trust. Therefore the Committee has been providing focus on Exit Interview feedback as well as initiatives that support enhanced levels of staff engagement.

IMPLICATIONS OF PAPER:

RISK	**Y**		**Risk Description:**
	Risk Register: Y		**Risk Score**
COMPLIANCE and/or LEGAL REQUIREMENTS	**CQC**	**Y**	**Details:**
	NHSI	**Y**	**Details: Annual Business Planning Process**
	Other	**N**	**Details:**

The Dudley Group NHS Foundation Trust

Committee Highlights Summary to Board

Committee	Meeting Date	Chair	Quorate	
Workforce & Staff Engagement Committee	23rd November 2018	Julian Atkins	**yes**	**no**
			Yes	

Declarations of Interest Made

No declarations registered.

Assurances received

Matters Arising

1. **Medical Revalidation** - The Committee received an updated report regarding Medical Revalidation from Responsible Officer, Mr. Paul Stonelake. The report provided significantly greater levels of assurance than had been provided previously. In particular the report demonstrated progress in performance associated to consultant appraisals with all consultants currently engaged in the process.

Presentations

2. **Training Needs Analysis –** The Committee received a report from Rachel Andrew, Head of Learning and OD regarding the progress associated to developing greater clarity on our Training Records based on the feedback from the recent Appraisal process.

3. **Exit Interview Process –** Becky Cooke, Staff Engagement Lead provided the first report since the introduction of the new Exit Interview process. It is expected that this will be developed further with the introduction of an electronic system in January 2019. The main areas associated with staff turnover were categorised as:

   - Improving communication methods;
   - Upskilling our Managers to deliver better leadership;
   - Having better development opportunities and a career mapping process;
   - Having the right people here at the right time;
   - Ensuring staff get their breaks and more flexibility.

4. **Workforce Planning Update –** Greg Ferris from the Workforce Information Team introduced the new template that is being piloted to support better integration of workforce planning at Divisional and Speciality level. It is also expected that this will align itself to the Annual Planning process and provide greater degree of accuracy associated to assumed workforce projections. Initially the template will be piloted in the areas of Ophthalmology and Renal medicine.

Workforce Strategy

5. **Workforce Strategy Business –** The Director of Workforce provided assurance with progress against the business plan that supports the Workforce Strategy. The Committee were assured of progress alongside objectives.

Workforce Performance

6. **Key Performance Indicators –** Dawn Woods, Head of HR provided an overview and analysis of workforce performance associated to October 2018. The main points of interest were the continuing fall in the Trust turnover rate and continued positive performance associated to Appraisal and Mandatory Training. However, the main areas of concern continue to be the rate of sickness absence alongside the current vacancy rate with particular emphasis on nursing for both of these indicators. The Committee heard of initiatives supporting improved performance but asked that AHP and Nursing recruitment initiatives were part of a focused presentation at the next Workforce Committee.

7. **Staff Friends & Family –** The Committee received disappointing results associated to engagement and response associated with Staff Friends & Family. The Engagement team had prioritised the 'Make it Happen' events as a mechanism for supporting enhancing engagement.

Workforce Governance

8. **Workforce Related Risks/BAF –** The current workforce related risks and BAF were presented to the Committee to highlight any changes to risk scores or adjustments to mitigations. The Director of Workforce highlighted there were no changes to scores proposed at this time. However, a number of the actions to support mitigations had been updated.

9. **Board Appointment Process –** Marcia Hylton, Head of Resourcing provided an update to the Committee regarding a review of the recruitment procedures associated to Executive Director and Non-Executive Director posts. The review had been initiated following the review of current procedures by the CQC alongside reviews initiated by the Trust. The review provided a number of improvements that will be reflected in the relevant Trust policy and will be tested in the forthcoming Executive appointments for the role of Chief Nurse and Director of Governance.

Workforce Change

10. **Draft Business Case to Support Nurse Recruitment –** The Committee received the draft business case on the day of the Committee. The Director of Workforce apologised for the late submission but explained that reaching consensus on the financial analysis of the case had been challenging. The Committee agreed that the challenge continued to be the financial support associated to the case and that if possible should be prioritised in order that the final paper can be received by the Board in December.

Decisions Made / Items Approved

1. To receive outcomes from Workforce Planning pilot;
2. Agreement of Nurse Staffing Business case in principle with further development of financial analysis and case to be developed.

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

The Committee require further feedback regarding:

- AHP & Nurse Recruitment Initiatives;
- Overview of Leadership Development in the Trust;
- NHSI Review of Bank & Agency.

Items referred to the Board for decision or action

The Committee on this occasion requires the Board to consider the Business Case associated to supporting sustainability for Nurse Recruitment.

Enclosure 17

The Dudley Group
NHS Foundation Trust

Paper for Submission to the Board on 6 December

TITLE:	**Trust Surge and Escalation Plan V2**		
AUTHOR:	**Christopher Leach**	**PRESENTER**	**Karen Kelly**

CLINICAL STRATEGIC AIMS

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

ACTION REQUIRED OF COMMITTEE

Decision	Approval	Discussion	Other
		Y	

OVERALL ASSURANCE LEVEL (***Please insert x in one of the boxes***)

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 COMMITTEE

CORPORATE OBJECTIVE:

SO1: Deliver a great patient experience
SO2: Safe and caring services
SO3: Drive service improvements, innovation and transformation

SUMMARY OF KEY ISSUES:

This is the Trust's Surge and Escalation Plan that is currently in place with a review date of June 2019.

It contains action cards pertaining to response actions by the Trust in the event of a capacity surge and the escalation processes to be followed. It also contains the current procedure for full hospital capacity protocol.

This is to be used and read in conjunction with the Trust's current Winter Plan.

The Dudley Group
NHS Foundation Trust

IMPLICATIONS OF PAPER:			
RISK	**N**		**Risk Description:**
	Risk Register: N		**Risk Score**
COMPLIANCE and/or LEGAL REQUIREMENTS	**CQC**	**N**	**Details:**
	NHSI	**N**	**Details:**
	Other	**N**	**Details:**

The Dudley Group
NHS Foundation Trust

SURGE AND ESCALATION POLICY	DOCUMENT TITLE:	SURGE AND ESCALATION POLICY
	Name of Originator/Author /Designation & Specialty:	Christopher Leach – Emergency Planning Manager
	Director Lead:	Karen Kelly- Chief Operating Officer
	Target Audience:	All staff
	Version:	V2
	Date of Final Ratification:	June 2018
	Name of Ratifying Committee:	Finance and Performance
	Review Date:	June 2019
	Registration Requirements Outcome Number(s) (CQC)	Safe Effective Responsive Well Led
	Relevant Documents /Legislation/Standards	Operational pressures escalation levels framework
	Contributors:	**Designation:** Sharon Walford- Emergency Planning and Capacity Officer Megan Higgs- Capacity and Emergency planning Administrator Rachel Howells – Site Coordinator lead
	The electronic version of this document is the definitive version	

CHANGE HISTORY

Version	Date	Reason
1.0	March 2014	New document
1.4	March 2017	Extension to review date
2.0	May 2018	Full review

A translation service is available for this document. The Interpretation/Translation Policy, Guidance for Staff is located on the intranet under Trust-wide Policies.

Contents

THE DUDLEY GROUP NHS FOUNDATION TRUST

SURGE AND ESCALATION POLICY

1. INTRODUCTION

The Trust operates a 4 level escalation procedure

- Level 1: Normal working
- Level 2: Moderate pressure
- Level 3 Severe pressure
- Level 4 Extreme pressure

The trigger details for each of these levels is within (**Appendix 1).**

These triggers are mutually agreed across the health economy and are representative of the pressures relating to emergency flow, and are understood by all involved including WMAS, Dudley Clinical Commissioning Group and the Local Authority.

The escalation process is led by the Capacity Team, however, it is the responsibility of everyone within the Trust to be aware of the current escalation level and respond according to actions required maintaining patient flow 24/7

The escalation level is determined via the Escalation Management System (EMS) and up to date internal information regarding to the escalation level is on the Hub with links to all supporting information

2. STATEMENT OF INTENT/PURPOSE

Aim: to provide the trust with a framework and actions required to respond to a surge within the system, it also enables the trust to activate a full hospital protocol if required

- To provide staff with a clear process for managing services at times of capacity compromises
- To identify the process for the escalation of surge and capacity issues
- To advise of the appropriate action to be taken and the available support mechanisms to access to ensure a safe service is maintained at all times.
- To indicate the process for full hospital capacity procedures

3. DEFINITIONS

CAD	Computer Aided Dispatch
Capacity Management	The management of patient flow through the organisation
CCG	Clinical Commissioning Group
CSC	Clinical Site Co-ordinator
EMS	Escalation Management System

Escalation Plan	The working document that details the actions to be taken
HALO	Hospital Ambulance Liaison Officer
OOH	Out Of Hours
SOC	Strategic Operations Centre (ambulance)
UCC	Urgent Care Centre
WMAS	West Midlands Ambulance Service

4. DUTIES (RESPONSIBILITIES)

1.1. Chief Executive

The Chief Executive of the Trust has overall responsibility for Emergency Resilience and Response (Emergency Planning & Business Continuity). They will ensure that the organisation has all required plans arrangements in place, and that the Board receives regular updates on Emergency Resilience issues including reports on exercises, training and testing undertaken by the organisation. The Chief Executive will also ensure that appropriate resources are made available to allow the discharge of these responsibilities.

The Chief Executive must ensure that Board level responsibility for Emergency Resilience is clearly defined and there are clear lines of accountability throughout the organisation leading to the Board. The Chief Operating Officer as Trust Accountable Emergency Officer (AEO) is designated to take responsibility for the Emergency Resilience Framework and is actively supported by Directors of the Trust

1.2. Chief Operating Officer/Accountable Emergency Officer (AEO)

The Chief Executive has appointed the Chief Operating Officer as having lead responsibility for EPRR within the organisation. This executive team member as Trust Accountable Emergency Officer (AEO) is nominated and accountable to the Trust Board for producing and testing the Emergency Resilience arrangements for the trust. These documents will be reviewed regularly along with all sub-sections. Key stakeholders (external and internal) will be consulted prior to the review and any amendments made.

The nominated Director will ensure that the Board is updated and informed annually on issues relating to Emergency Resilience and will support the nominated Emergency Planning Manager in the execution of their duties.

Specifically the AEO will be responsible for:

- Ensure that Dudley Group NHS FT, and any sub-contractors, are compliant with the EPRR requirements as set out in the CCA 2004, the NHS Act 2006 (as amended) and the NHS Standard Contract, including the NHS England EPRR Framework and the NHS England Core Standards for EPRR
- Ensure that Dudley Group NHS FT is properly prepared and resourced for dealing with an incident
- Ensure that Dudley Group NHS FT, any providers we do/will commission and any sub-contractors have robust business continuity planning

arrangements in place aligned to ISO 22301 or subsequent guidance which may supersede this

- Ensure that Dudley Group NHS FT has a robust surge capacity plan that provides an integrated organisational response and that it is tested with other providers and partner organisations in the local area
- Ensure that Dudley Group NHS FT complies with any requirements of NHS England, or agents of NHS England, in respect of monitoring compliance
- Provide NHS England with such information as it may require for the purpose of discharging its functions
- Ensure that Dudley Group NHS FT is appropriately represented by director level engagement with, and effectively contributes to any governance meetings, sub-groups or working groups of the LHRP and/or LRF, as appropriate

CLINICAL SITE CO-ORDINATOR (CSC) – TRUST WIDE (24/7 Role)

- To co-ordinate the Escalation Plan in support of patient flow.
- Work with the Matrons/Lead Nurses to effect patient movement, discharge & repatriation.
- Use the patient administration system (Oasis) as the management tool for providing real time capacity information.
- To be the first point of call on escalation for the Trust throughout the 24 hour period.
- To ensure that information is maintained for all those involved in the escalation process and that an up to date position is accessible, both internally and externally.
- To maintain accurate records throughout the 24/7 to ensure colleagues can access timely information.
- Co-ordinate problems identified with capacity and escalate to the relevant person (i.e. Capacity Matron) or on call manager and Director (OOH)
- Ensure that de-escalation is co-ordinated.

SURGICAL/ T&O CAPACITY LEAD (24/7 Role)

- To be the nominated capacity lead for Surgical/T&O (Trauma and Orthopaedics) capacity issues and therefore attend the meetings to provide accurate bed state/action plan as appropriate to the level of Trust escalation.
- Ensure effective and timely communication/escalation information is disseminated within their areas.

SHIFT LEAD/LEAD NURSE – ACUTE MEDICAL UNIT (24/7 Role)

- Work to achieve patient flow within the unit, problem solve and to provide solutions where able. Accurate and timely information to be maintained.

NURSE IN CHARGE - EMERGENCY DEPARTMENT (24/7 Role)

- Work to achieve patient flow within the unit, problem solve and to provide solution where able. Accurate and timely information to be maintained and disseminated as required, this will include the ED escalation level.

LEAD NURSE FOR ALL WARDS (24/7 Role)

- To maintain patient flow through the specialty area by effective and timely discharge planning and management, co-ordinate activities in accordance with the Discharge Policy.

MATRON (Role available normal working hours)

- To be responsible for ensuring patient flow through the specialty area by ensuring effective and timely discharge planning and management.

TRUST LEAD FOR HOSPITAL DISCHARGE - TLHD (Non-Emergency Patient Transport available normal working hours)

- To be the point of contact for the escalation of transport arrangements in line with the escalation needs of the Trust. This support is available in normal working hours. Out of hours, information should be accessible to the Clinical Site Co-ordinator or on call Manager.
- To support as required on the prioritising of transport services to create the desired effect e.g. maximum available bed spaces.
- Out of hours or in the absence of the (TLHD) then the Clinical Site Co-ordinator will take this role.

SERVICE MANAGER i.e. Radiology, Cardiology Diagnostics, Therapy, Pharmacy, Pathology (Role available normal working hours)

- To ensure that patient flow is supported by the continued provision of the service as is expected.
- Escalate any pressures within the service provision that may affect patient flow and work with the CSC and Director of Operations as to the possible solutions or by use of the Business Continuity Plan.

MEDICAL SPR

- Hospital 24/7 Clinical Lead, to work closely with the Clinical Site Co-ordinator to maintain patient flow

MANAGER ON CALL (24/7 Role)

- The role is to be the second line in senior management for the Trust.
- Participation on the Teleconference as appropriate.

DIRECTOR ON CALL (24/7 Role)

- Take senior level decisions on behalf of the Trust.

- To agree actions are acceptable and appropriate when dealing with exceptional capacity issues.
- Action cards to identify responsibilities of the above personnel in relation to RAG (Red, Amber and Green) rated Capacity Escalation responsibilities can be found in (**Appendix 2)**.

5. CAPACITY PROCESS

Capacity meetings are held regularly throughout the day to establish the current state of capacity within the Trust, and to understand the anticipated demand.

These meetings are held at:

08:45hrs
12:00hrs
16:30hrs
18:00hrs

The CSCs also have a 22:00hrs meeting following feedback from T&O and surgical bed managers. Capacity emails (which include the capacity planner and actions taken) are sent out to senior staff after every meeting

All meetings during the day are held with senior staff to provide Trust wide clinical and management engagement.

CSC/ Matrons/Lead Nurses should be in constant liaison with each other ensuring a proactive and effective use of capacity at all times. Early escalation of capacity problems such as where actual or predicted demand exceeds available resource is imperative. This should be done in compliance with local escalation procedures, which are located on the Hub, resulting in effective engagement of senior clinicians, Operations Managers, (this includes Service Heads, Directorate Managers, Manager on Call etc.) and Directors.

Escalation should be used to:

- Confirm that all routine capacity management actions, as identified on the Escalation plan have been completed.
- Identify specific actions required to flex capacity in response to increased demand.
- Prioritise other relevant issues e.g. the management and containment of infectious disease, quality & safety risks, adverse weather & staffing shortages.

The first point of call will be the CSC, who will maintain timely information as to the current hospital position. The CSC will work with the Medical Team and the identified Surgical/T&O Capacity Lead for the 24 hour period.

Daily Capacity Management Operational Framework
Day to day capacity management is co-ordinated by means of the consistent use of the Escalation Management System (EMS) which is a 24/7 day a week operational tool, illustrating and communicating hospital escalation levels to

support effective capacity management across the organization. For responsibilities, actions and effects in relation to the Daily Operational Capacity Framework (**Appendix 3)**.

Community Services
Effective use of the community based services will be instrumental to ensuring that patients receive the right service first time. This will be achieved by understanding what services are available. This information will be accessible via the community hub (see below), together with details of services provided by Local Authority Social Care Teams.

The Local Authority provide a 7 day, front door service referred to as Emergency Response Team, contact details are available via the capacity hub page.

- There is a daily multi-disciplinary meeting that discusses patients who do not require an acute bed.
- Matrons need to ensure that if there are concerns re: specific patients, they are referred to this forum in the first instance.

The CCG/WMAS/Local Authority have access to the EMS system and they have a responsibility to access the system to understand escalation level and respond accordingly.

Any ward or area can refer into the Single Point of Access at any time in particular when escalation is at its greatest. The Specialist team's main function is hospital avoidance and they will respond the same day and in many cases within 4 hours.

Community Hub
- Single Point of Access distribute referrals received from both Russell's hall and other community services to the appropriate teams and provide advice to hospital departments to enable the discharge of complex patients.
- Nurse Practitioners for Long Term conditions attend Russell's Hall to review patients who are medically fit to be discharged into the community and to refer as appropriate to the Care Home Nurse Practitioners.
- Community Response Team respond to same day referrals from General Practitioners and Nursing/Care homes for patients at risk of hospitalisation and assess and where appropriate treat patients within the community setting.
- Community Response Team when patients require further care access a five day package of care or hospital avoidance beds to prevent hospital admission.
- Community IV team will support patients back into their own homes who require IV therapy this will enable saving bed days

Ambulance Liaison
WMAS have a Strategic Operations Centre (SOC) that supports the escalation process of Acute Hospitals.

It is anticipated that the CSC will have the regular liaison with their Operational (Bronze) Tier of Management (HALO) and assume that the Manager on Call would liaise at Tactical (Silver) Level followed by the Directors on Call at Strategic (Gold) level.

The following is the WMAS Hospital Desk number **0121 3079119** and is used for liaising with the Ambulance desk in terms of delays, the appropriate challenge of capacity and demand, pathway management or the requirement for Hospital Ambulance Liaison Officer (HALO) services on site.

Ambulance peripheral divert
The Trust can request a peripheral divert for those patients who are border cases e.g. who live equal distance between 2 hospitals to the least busy.

To request support from other hospitals a request has to be made from the Director on call to the corresponding Director at the requested hospital, this will be done via a telephone conversation.

If a hospital escalates to level 3 WMAS should ensure that appropriate volumes of patients are conveyed to the ED. However, patient diverts will only be supported where it can be clearly demonstrated that failure to implement a divert would result in excessive delays in transfer of care. Reroutes are not to be used to manage capacity between hospitals.

Contingency Planning
The use of **extraordinary actions** which are those over and above those shown in the Escalation Plan is seen as a last resort and is only considered once all other actions to manage peaks in demand have been implemented and proved unable to provide a solution.

Extraordinary actions must be agreed by the Chief Operating Officer or Director on Call with the knowledge of the Chief Executive where appropriate.

Each specialty should have created business continuity plans in order that the CSC in collaboration with the Directorate Managers/Manager on Call can commence the required actions. The business continuity plans are held electronically on the hub (emergency planning) and are in hard copy in all areas. These are in the red Major Incident awareness folders.

The CSC should ensure that all information regarding agreement of the plan is communicated and managed as agreed and record information about the use of the plan.

De-escalation
It is essential that as part of this process there is a de-escalation function. This will be led by the CSC who has responsibility for ensuring that this information is fed to the hospital Trust site and external colleagues in order that they can cascade as appropriate.

There should be a clear plan for the closure of contingency beds that includes a timeframe this needs to be led by the Lead Nurse/Matron for the area and shared with the CSC, this must follow the policy for opening additional capacity.

Performance Management
The success of this function has to be monitored as to its effectiveness, consistent approach to escalation and clear and concise planning processes. This will be led by the Capacity Team Leader in-conjunction with the Directorate Managers. Information to be monitored daily can be found in (**Appendix 4)**.

Weekend Arrangements
A weekend plan is emailed to relevant staff every Friday, with confirmation of agency arrangements, Consultant cover, weekend waiting list activity etc.

There will always be the presence of a CSC who will work with the Lead Nurses and they will be supported by the on-site Matron and on call manager. Out of these hours the on call Manager and on call Director are contactable via the hospital switchboard.

Meeting Attendance
Capacity meeting times are identified in section 5. It is expected that the meeting be attended by the following people as a quorum:

- Director of Operations for medicine & Integrated care (chair)
- Site Co-ordinator
- Surgical bed manager
- Medical and surgery women and children capacity Managers
- Capacity Matron of the day
- Director of Operations/Director on Call

At the 16:30 and 18:00hrs meeting the on call Manager and Director for the day will attend so that they are involved in planning for the night ahead.

Specialty Management of Capacity
Timeline is as follows:

08.00 Specialty meetings at ward level between decision maker in charge of patients care, Matron/Lead Nurse, daily action plan completed and forwarded to capacity office. If Level 3, the Directorate Manager (or identified deputy) will follow up with the ward that appropriate actions are being taken and there is resource at ward level to manage the pressure.
08.45 Capacity meeting
09.00 Capacity Team to update EMS
10.00 Clinical Handover
11:00 Medical Lead Nurse meeting
12.00 Capacity meeting
12.30 Discharge Impact Team Meeting
15:00 Medical Lead Nurse meeting
16:30 Capacity meeting
18:00 Capacity meeting
22.00 Hospital 24/7 – Capacity meeting

Tele-conference
The escalation process for teleconferencing is as follows:

Internal
At Weekends and Bank Holidays there will be a teleconference at 14.00. This will be chaired by the CSC and attended by:

- Manager on Call,
- Director on Call,
- Available Band 7 Nursing leads for Medicine and Surgery to include T&O.
- Matron on Call

The contact details for this call will be:

- Teleconferences are hosted via 0800 7836753
- Chairperson code - 19729684 followed by #
- Participants code - 50329326 followed by #

There is a Weekend Teleconference Guidance that is held on the Capacity Hub page that provides contents further operational detail as well as the content to be discussed.

If there is prolonged pressure during the week out of hours then the Manager on Call and Director should agree a teleconference time at 17.00 and communicate appropriately.

External
When Level 3 is reached and cannot be sustained therefore prolonged pressure will ensue then a teleconference at Director Level must be arranged.

These teleconferences will be led by the Director/Senior from the CCG and should include:

- the Director of Operations/Director on Call of Acute,
- Director/Assistant for Adult Services and Community Services Lead,
- Regional Capacity Team as appropriate.

These should be held by 10:30 and any agreed actions/information must be communicated to the Capacity Team for capturing on the EMS system.

Capacity Management Tools
The following system is available on a health economy wide basis for assisting organisations with proactively managing capacity.

Escalation Management System: www.emsplus.nhs.uk

The hospital also has access to the WMAS CAD system that allows instant access to the number of Ambulances at the hospital, en-route, and handover times etc. Access to the system is currently within the Emergency Department, Acute Medical Unit, Surgical Assessment Unit, Maternity and Capacity Team office. It is a web based system that can be accessed elsewhere within the organisation. This can be used to support discussions with the SOC.

Escalation of Trolley Waits
A 12 hour breach must always be treated as a 'local' never event.
The expectation is that the following "NHS England 12 hour breach protocol" is adhered to **(Appendix 6)**

Emergency Access 4 Hour Standard

The trust must consider its aim for the emergency access standard of the 4 hour target which is 95% this must always be maintained and achieved where possible.

6 HEALTH ECONOMY ESCALATION LEVELS

Please refer to the OPEL document for further details

OPEL INCIDENT LEVELS	
LEVEL 1	An incident that can be responded to and managed by a local health provider organisation with their respective business as usual capabilities and Business continuity plans in liaison with local commissioners.
LEVEL 2	An incident that requires the response of a number of health providers within a defined health economy and will require NHS co-ordination by the local commissioner(s) in liaison with the local NHS office.
LEVEL 3	An incident that requires the response of a number of health organisations across geographical areas within a NHS England region. NHS England will co-ordinate the NHS response in collaboration with local commissioners at the tactical level.
LEVEL 4	An incident that requires NHS England national command and control to support the NHS Response. NHS England will co-ordinate the NHS response in collaboration with local commissioners at tactical level.

7 TRAINING/SUPPORT

There is a package of Training that is delivered by the Clinical Site Co-ordinators for new members of staff participating in Escalation.
Any member of staff who requires further training should contact their line manager for additional support.

8 PROCESS FOR MONITORING COMPLIANCE

Monitoring of Compliance Chart

	Lead	Tool	Frequency	Reporting arrangements	Acting on recommendations and Lead(s)	Change in practice / lessons to be shared
Examples of key aspects to include are given below:						
Metrics for compliance against the standards are in place E.g. attendance at capacity meetings Provision of required bed information	Clinical Site Coordinator	Checklist & comments on the Capacity Hub	Daily	• Reported to matrons on daily basis Reported weekly to Ops meeting	• Identify trends of non-compliance GMs to implement improvement actions in the identified poorly performing areas	On the Capacity Hub
EPRR Core Standards	Emergency Planning manager	Core Standards	Annual	• Reported to Board	• Relevant staff	On the Ep Hub page

9 EQUALITY

The Dudley Group NHS Foundation Trust is committed to ensuring that, as far as is reasonably practicable the way we provide services to the public and the way we treat our staff reflects their individual needs and does not discriminate against individuals or groups on any grounds.

Appendix 1 Escalation Levels

	Level 1 - Planned Operational Working		Level 2 - Moderate Pressure		Level 3 - Severe Pressure		Level 4 - Extreme Pressur	
	Acute		Acute		Acute		Acute	
4hr A&E Performance Target	1	No current risk of a patient waiting more than 4 hours to be seen in ED	1	Risk of one or more patients waiting more than 4 hours in ED within the next hour.	1	One or more patients waiting more than 4 hours a decision is unlikely to be made for the next hour.	1	One or more patients waiting more than 4 decision is unlikely to be made for the nex
Transfer of Ambulance patient care	2	Transfer of Ambulance patient care is shorter than 15 minutes.	2	Transfer of Ambulance patient care is between 15 and 30 minutes.	2	Transfer of Ambulance patient care is between 31 and 60 minutes.	2	Transfer of Ambulance patient care is long minutes.
Expected capacity vs expected demand	3	Expected admission capacity greater than or equal to expected admission demand for the next 24 hours.	3	There is an expected admission capacity deficit of less than 10% of expected demand for the next 24 hours.	3	There is an expected capacity deficit of between 10% and 20% of expected demand for the next 24 hours.	3	There is an expected capacity deficit of mo expected demand for the next 24 hours.
Elective Work	4	Elective work proceding as planned.	4	Up to 10% of elective and urgent inpatient work cancelled on the day.	4	10% to 90% elective and urgent inpatient work cancelled for the next 24 hours.	4	More than 90% elective work including on cancelled for the next 24 hours.
8 hour Trolley Waits	5	Patients subject to a decision to admit not at risk of 8 hour trolley waits.	5	Risk of one or more patients subject to a decision to admit at risk of waiting 8 hours on a trolley in the next 2 hours.	5	One or more patients subject to a decision to admit now waiting longer than 8 hours on a trolley.	5	One or more patients subject to a decision waiting longer than 8 hours on a trolley ar waiting longer than 12 hours.
Medical Outliers	6	Medical outliers form less than 0.5% of total inpatient population.	6	Medical outliers form between 0.5% and 1% of total inpatient population.	6	Medical outliers form between 1% and 3% of total inpatient population.	6	Medical outliers form more than 3% of tot population.
Cubicles in A&E	7	Cubicles in A&E are less than 80% occupied.	7	Cubicles in A&E are 80% -100% occupied.	7	All Cubicles in A&E are full and patients are waiting in planned overflow areas.	7	All Cubicles in A&E are full and patients are wait in unplanned overflow areas.
Resuscitation Bays	8	More than 1 resuscitation bay available for immediate use.	8	Only 1 resuscitation bay available for immediate use.	8	No formal resuscitation bay available in A&E for the next 30 minutes.	8	No formal resuscitation bay available in A& hour.
Beds in Assessment Areas	9	Beds in Assessment Areas are less than 90% occupied.	9	Beds in Assessment Areas are 90%-99% occupied.	9	No Assessment area beds for up to 3 hours minimum.	9	No Assessment area beds for more than 3
Planned Additional Bed Capacity	10	Planned additional bed capacity on standby.	10	Planned additional bed capacity open and less than 80% occupied.	10	Planned additional bed capacity open and more than 80% occupied.	10	All planned additional bed capacity open a unplanned capacity in use.
Infection Control Measures	11	No loss of admission bed capacity due to infection control measures.	11	Partial or whole ward closed to admission or discharge due to infection control measures.	11	More than one ward closed to admissions or discharge due to infection control measures with local restrivtions on visiting.	11	More than one ward closed to admissions and whole Hospital closed to visitors due t control measures.
Critical Care Capacity	12	Critical care capacity less than 80% occupied.	12	Critical care capacity is 80%-100% occupied.	12	All formal critical care capacity occupied and planned overflow areas in use.	12	All formal critical care capacity occupied a overflow areas in use. Potential transfers id unresolved.
Gender Specific Bed Availability	13	Gender specific beds available as planned.	13	Patient moves required, expected within 1hr.	13	Patient moves required, expected within 4hrs.	13	Patients waiting for appropriate gender be planned or available.
Medically Fit For Discharge	14	Medically Fit for Discharge cases form less than 9% of the inpatient total.	14	Medically Fit for Discharge cases form between 9% and less than 11% of the inpatient total.	14	Medically Fit for Discharge cases form between 11% and 13% of the inpatient total.	14	Medically Fit for Discharge cases form mor the inpatient total.

Anticipated time to de-escalation. (Indicative)	Anticipated time to de-escalation. (Indicative)	Anticipated time to de-escalation. (Indicative)
Less than 2 hours	Less than 2 hours	Less than 2 hours
2 - 4 hours	2 - 4 hours	2 - 4 hours
4 - 8 hours	4 - 8 hours	4 - 8 hours
Unknown (More than 8 hours)	Unknown (More than 8 hours)	Unknown (More than 8 hours)

Appendix 2
ED escalation triggers

Please use in line with Triage assessment areas procedure

Trigger 1 – Triage Wait Time exceeding 30 minutes

- Triage Nurse (adults and paediatric) to escalate potential delay of over 15 minutes to TAA Team Leader

- TAA Team Leader to assess situation and deploy triage nurse to the additional triage assessment area

Where triage demand exceeds triage staffing availability the contingency will be to assess and step down other areas in ED to support deployment of additional staff to the TAA.

The decision to step down of areas should be a joint decision between the TAA Team Leader and the ED Shift Coordinator following assessment of the whole department, with immediate escalation to the site co-ordinators

There will be a tiered approach to step down based on TAA nursing levels

Tier 1: 3 Triage Nurses
Consider stepping down Fit to Sit and redeploy nurse to support TAA

Tier 2: 2 Triage Nurses
Consider in addition stepping down CDU and redeploy nurse to support TAA

Tier 3: 1 Triage Nurse
Consider in addition stepping down 3 majors cubicles and deploy nurse to support TAA

If a decision is made to step down any clinical area the site co-ordinator **must**:

- Contact the on-call manager to inform them of the delay, and the implementation of escalation actions (stepping down) and advise of the plan and timeline to resume normal service provision

Trigger 2 – Reduced TAA Capacity

Ensuring sufficient TTA capacity at all times is critical in order that patients are assessed and ambulances released within the 15 minutes standards as described within this procedure.

Maximum capacity tolerance levels have been set at **6 assessment spaces**.

In situations where 6 assessment spaces are filled escalation procedures should to be implemented by the TAA Team Leader or available senior clinician.

Level 1 Escalation - 6 assessment spaces in use

TAA Team Leader/Senior Clinician

- Assess current status of all patients ensuring triage and initial management plan and/or investigations have been completed or are progressing within agreed parameters (maximum time in TAA < 30 minutes)
- Identify patient/s that are ready for immediate transfer
- Contact the ED Shift Coordinator or NIC of the receiving clinical area to advise of immediate patient transfer and instruct transfer staff to transfer immediately

Level 2 Escalation - 8 assessment spaces in use

TAA Team Leader/Senior Clinician
- Identify minimum of 3 patients ready for transfer to ED cubicles
- Contact ED Shift Coordinator to request rapid access to 3 ED spaces and agree timeline for transfer (transfer must occur within 15 minutes of level 2 escalation)

In situations where there is no ED capacity owing to high levels of referrals awaiting inpatient beds:

ED Shift Coordinator
- Contact Site Coordinator to alert them to a level 2 escalation, requesting immediate response from AMU and/or speciality wards to facilitate transfer of patients from IMAA or directly from ED
- Ensure 3 patients are identified, prepared and ready for transfer of ED to receiving ward and advise TAA Team Leader of plan

Site Coordinator
- Advise ED Shift Coordinator of receiving ward and confirm timeline for transfers
- Advise receiving ward of the transfer, arrival time and need to 'board' where necessary

Identified patients to commence transfer from ED within 15 minutes of escalation

Level 3 escalation - 9 assessment spaces in use

In the event of 9 spaces in use, with no transfer/decant plans (within 15 mins)

TAA Team Leader/Senior Clinician
- Liaise with ED Shift Coordinator to advise of the situation and request declaration of level 3 escalation
- Review all patients to ensure triage and initial management plan and/or investigations have been progressed/completed

ED Shift Coordinator
- Contact Site Coordinator to advise of level 3 escalation, requesting immediate presence in ED to support and co-ordinate movement/transfer of patients out of ED or IMAA to receiving wards

- **In hours** ED Shift Coordinator to contact ED operational team to request presence in ED to provide managerial support and communication regarding divisional mitigating bed capacity plans
- Identify and prepare ready for transfer patients suitable to 'board' in the appropriate assessment area (PAU, SAU, AMU, IMAA)

- Advise TAA Team Leader of plan

Site Coordinator

- Attend the ED to facilitate communication and transfer of identified patients to receiving wards/clinical areas
- Advise ED Shift Coordinator of receiving ward and confirm timeline for transfers
- Advise receiving ward of the transfer, arrival time and need to ‘board’ where necessary

Appendix 3 Daily Capacity Management Operational Framework

Action	Who	Effect
Use of 6 week rolling average predictor tool to forecast demand for unplanned care. That is provided weekly via the Regional Capacity Team and delivered in a weekly forecasting meeting.	Clinical Site Co-ordinators/ Directorate Managers	Improved processes for managing demand.
Weekly length of stay activity, daily admissions vs discharge activity performa nce reviews. Capacity Indicators access via the hub Visible Bed State	Directorate Managers/ Matrons and Clinical Directors	Identify problems and implement solution.
Using the ED Dashboard that is maintained real time. Rapid intervention of senior medical staff following triage of patients in ED.	ED Medical Service Head / Senior Decision Maker/ Medical Director	Maintain patient flow.
Estimated day and time of discharge recorded for every patient and identified at ward level and on the whiteboard.	Lead Nurse/Matron/ Directorate Managers	Planned discharge and effective use of the Discharge Lounge.
ED to monitor and ensure that every patient is being managed within the target and a solution is found to avoid unnecessary breaches (ED, Ambulance Turnaround, Elective Cases and Length of Stay).	ED Lead Nurse/ ED Medical Service Head Matron/ Clinical Site Co-ordinator	Rapid response and intervention to address performance issues.
Hospital capacity meetings throughout each day ensuring the availability of adequate bed capacity. Meeting time and location to be identified on the Trust hub site.	Clinical Site Co-ordinators/ Operation Managers/ Directorate Managers/ Lead Nurses/ Medical Service Heads/ Director of Operations	Appropriate management of bed capacity.
Consistent use of the *Escalation Management System (EMS)	Clinical Site Co-ordinators	Communication of capacity pressures across the organisation and economy.
Consistent use of the EMS system for community beds.	CCG/Local Authority	Create acute capacity as appropriate.
Active management of >EDD LOS cases.	Matrons/ Medical Service Heads/ Directorate Managers	Reduced LOS Increased bed availability
Utilisation of an effective workforce plan that provides adequate levels of competent staff and the correct skills mix at all time.	Matrons/ Medical Service Heads	Resilient and flexible staffing arrangements providing continuity of care.
Management of the Delayed Discharge Database that generates information on patients who are discharging.	Discharge Co-ordinators/ Matrons	Easy identification of blockages to support releasing acute bed space.
Escalation alerts are generated from the EMS system.	All	24/7 electronic updates on escalation position.
Birmingham & Black Country Sitrep position is provided by the Regional Capacity Team, identifying the current escalation of West Midland Trusts and any capacity specific pressures.	CSC's, Director of Operations/GM's etc.	An understanding of health economy wide pressures to assist in identifying areas for support etc.
Site Co-ordination/Medical Team Hospital 24/7 will be maintained within the Trust.	Directorate Manager for Capacity/ Emergency Specialist Medicine Clinical Director	Single point of management for escalation.

Appendix 4 Action cards

CLINICAL SITE CO-ORDINATOR – TRUST WIDE (24/7 Role)

ESCALATION 1:NORMAL WORKING		
No.	Individual Actions	Time Complete
1.	Lead the escalation meetings throughout the 24 hour period, agree actions and ensure actions are communicated.	
2.	Work with Surgical Capacity Lead ensuring appropriate beds are identified for all electives and emergency capacity is available.	
3.	Ensure Lead Nurses/Matrons accommodate medical elective patients. Ensure patients are communicated with as appropriate.	
4.	With the Ambulance Triage Nurse monitor CAD for increase in ambulance activity taking action as appropriate i.e. contact ambulance control, ensuring that appropriate conveyances are directed to UCC.	
5.	Work with Lead Nurses ensuring repatriations occur as required in accordance with clinical and infection control need	
6.	Identify any blocks to patients flow (clinical or non-clinical) taking action as necessary. Use delayed discharge list as a reference when liaising with lead nurses.	
7.	With ED/EAU maintain patient flow, agree immediate solutions or plan if pressure is likely to be prolonged. If escalation is likely to be triggered inform ED lead nurse, duty matron and/or manager on call	
8.	Work with ED lead nurse and shift lead to manage avoidable delays that may result in a breach and actions to resolve delays	
9.	Are any patients awaiting psychiatric review in ED or AMU, chase for a time of response, escalate to Manager on Call as required	
10.	Intermediate Care team to provide a picture of intermediate care beds for patient transfers	
11.	Local Authority, NHS England, CCG to be kept informed of current escalation level.	
12.	Ensure a capacity statement is on the Trust hub.	
13.	Ensure that EMS is maintained	
14.	Be aware of infection control issues via public health alerts, a regular infection control update and information made available on EMS in relation to bed closures due to infection control issues.	
15.	Ensure aware of the longest trolley wait within ED/CDU/EAU. Ensure a plan is in place to locate the patient, discuss with the appropriate Lead Nurse/Matron	
16.	Work with lead nurses to achieve timely discharge agreeing actions and timescale	
17.	With lead nurses identify issues with terminal cleans, portering support agreeing priorities with Interserve Manager on Call.	
18.	Maintain up to date discharge position. ensuring a SITREP can be produced on predicted length of pressure and if any action is required. If required take immediate action with Lead Nurses etc.	
19.	Escalate any unresolvable patient flow issues to relevant service heads, matron agreeing actions required, if required escalate to Directorate Manager within normal working hours.	
20.	Ensure that supporting service heads are informed of current escalation and where appropriate agree a plan of action	
ESCALATION 2: EARLY SIGNS OF PRESSURE		
1.	Ensure all actions above have been exhausted and that information is timely and relevant for updates	
2.	Consider or agree need for a health economy teleconference if level 2 is unlikely to be sustained within 4 hours.	
3.	Agree a plan with the Discharge Lounge for early ward discharge.	
ESCALATION 3: PROLONGED PRESSURE		

1.	Ensure level 1 & 2 actions are exhausted. A complete and accurate overview of trust capacity is to be available at all times.	
2.	Working with the HALO or WMAS senior representatives manage ambulance cases e.g. redirection of ambulance cases to alternative pathways	
3.	Teleconference to be held with local authority, CCG, NHS England and manager on call for community services regarding additional support to facilitate discharge.	
4.	Contact pharmacy manager to discuss the prioritisation of TTO'S for discharge.	
5.	Contact non urgent hospital transport for prioritisation of inpatient discharge	
6.	Ensure Capacity Team Leader/Directorate Manager is informed of plans and progress (Manager on Call on call after 5pm)	
7.	Agree with Manager on Call/Directorate Manager need for contingency areas availability. Approval required from the Director on Call, site co-ordinator to then follow Appendix 1.	
8.	If any bed capacity is opened the Information Department must be informed to enter patients onto PAS and ADT	
9.	Ensure EMS is updated to level 3 and SitRep is completed.	
ESCALATION 4: EXTREME PRESSURE		
1.	Ensure level 1, 2 & 3 actions have been exhausted. Ensure a complete and accurate overview of Trust Capacity is maintained and available at all times.	
2.	Call a urgent meeting with Hospital 24/7 team, service managers etc. as appropriate to agree urgent actions in support of the continuing pressure.	
3.	Maintain a complete and accurate evaluation of patient admission, discharge and transfers, to be readily available upon request.	

SURGICAL/T&O CAPACITY LEAD (24/7 Role)

ESCALATION CARD 1: NORMAL WORKING		
No.	Individual Actions	Time Complete
1.	Be aware of escalation level and pressure points within your area and ensure all patient information is communicated to site co-ordinator as appropriate.	
2.	Attend all capacity meetings and follow up meetings throughout the day resolving patient flow issues in your area via liaison with the Matron and medical service head.	
ESCALATION CARD 2: EARLY SIGNS OF PRESSURE		
1.	Ensure all actions above have been exhausted and that information is timely and relevant for updates	
ESCALATION CARD 3 - PROLONGED PRESSURE		
1.	Establish capacity availability for the next 4 hours.	
2.	Work with Matron/Medical Service Head to identify earlier discharges as appropriate creating immediate capacity.	
3.	Undertake actions to facilitate contingency plans for your specialty in agreement with the Directorate Manager, Medical Service Head and/or Clinical Director.	
4.	If pressure continues and work cannot be sustained with the Matron, Directorate Manager and /or Clinical Director evaluate the need to cancel elective patients Work with the associate nursing and medical director to implement actions as required.	

SHIFT LEAD/LEAD NURSE – ACUTE MEDICAL UNIT (24/7 Role)

No.	Individual Actions	Time Complete
ESCALATION CARD 1: NORMAL WORKING		
1.	Be aware of escalation level and pressure points within your area ensuring all patient information is communicated to site co-ordinator as appropriate.	
2.	Ensure accurate and timely patient information is available via whiteboard.	
3.	If delays with portering contact Interserve team leader	
4.	Ensure Nurse in Charge attends all Capacity Meetings.	
5.	Any flow or blocks to be identified, and a plan implemented and communicated to overcome the problem.	
6.	Any sudden increase that cannot be accommodated to be highlighted to medical service head/clinician in charge (CIC) and a plan to manage the peak instigated. If unmanageable escalate to site co-ordinator.	
7.	Liaise with Consultant and Registrar for potential discharges and timely transfer of patients	
ESCALATION CARD 2: EARLY SIGNS OF PRESSURE		
1.	CIC or Registrar to check appropriateness of ED referrals and inform them of situation	
2.	If <4 patients are waiting to be seen or clerked within the GP assessment area ensure the Registrar takes charge and uses the GP office as there base.	
3.	EAU Registrar to assess patients and contact on-call specialty teams for input with patient management plans or discharge.	
4.	CIC will deploy EAU/Medical registrar to start clerking. Consider alternative accommodation e.g. Main Outpatients to see patients	
5.	CIC to conduct quick overview round when only 4 trolleys available	
6.	If GP area blocked, NIC to allocate staff to GP area, or assign themselves. Ambulance arrivals to be triaged by NIC	
7.	ED/EAU Matron to be fully updated on changes in pressure or issues disrupting patient flow.	
8.	Inform site co-ordinator of increased GP activity affecting flow	
9.	Ensure no delays to patient transfer to ward, work with site co-ordinator as required.	
10.	NIC to inform infection control/site co-ordinator of patient's requiring side rooms with reasoning. Policies and pathways still apply	
ESCALATION CARD 3 - PROLONGED PRESSURE		
1.	Ensure all Level 2 actions have been exhausted.	
2.	CIC to establish overview of situation within EAU ensuring patient management plans are assessed	
3.	Work with medical team to prioritise patients who can be discharged safely. Work with Matron/Lead Nurse in EAU to ensure that current escalation levels are communicated to GP's so only urgent cases are brought in, schedule non urgent for the following day	
4.	Nurse in Charge/CIC to attend Capacity Meetings.	
5.	EAU CIC/Registrar to supervise all GP and ED referrals.	
6.	If delays with diagnostics are identified i.e. Plain film Xray delay (60> mins). Labs delay (>120 min). NIC to contact department managers discussing actions to remedy delay	
7.	CDU to be used for those awaiting investigation who are likely to go home.	
8.	Consider calling in additional staff	
9.	CIC to contact speciality Consultants to discuss patients who have no exit plan and have been admitted onto EAU > 18 hours.	
ESCALATION CARD 4: EXTREME PRESSURE		
1.	Ensure all previous actions have been taken.	
2.	CIC to ensure flow of patients to each doctor and maintain overview of process. CIC to contact relevant specialist consultants	

3.	CIC to assess ambulance patients waiting for off load and prioritise patients with greatest clinical need	
4.	All patients to be adequately assessed, triaged and monitored. Patients deemed by CIC as clinically less dependent or stable will take second priority	
5.	Junior doctors on full shift (not directly involved with the acute care of a patient should be called to the EAU to help with patient flow. (This will require Trust Level Agreement before this can be instituted).	
6.	If there is an agreement that patients can be transferred to other neighbouring hospitals ED/EAU/CIC will assess suitable stable patients for transport. NIC to inform relatives and carers, and then liaise with transport manager and or WMAS. An accurate record of patient movement must be maintained.	

NURSE IN CHARGE - EMERGENCY DEPARTMENT (24/7 Role)

ESCALATION CARD 1: NORMAL WORKING		
No.	Individual Actions	Time Complete
1.	Be aware of escalation level and pressure points within your area and ensure all patient information is communicated to site co-ordinator as appropriate.	
2.	NIC to monitor patient flow. Blocks to flow to be escalated to senior doctor.	
3.	Site coordinator to be notified of any rapid increase in patient/crew activity	
4.	NIC to ensure specialist clinicians review patients within 2 hours of arrival. If not reviewed within timescale escalate to ED senior doctor	
5.	NIC to escalate any issues delaying patient transfer from ED to Matron	
6.	NIC to inform bed manager of delays in offloading ambulances (30 min turnaround target) or there is a sudden increase in crew/patient activity in ED resulting in delays to patient assessment.	
7.	NIC to attend capacity meetings to update on ED activity and action taken	
8.	Senior doctor & NIC to maintain clear and accurate overview of patient management/progress within ED	
9.	Senior doctor and NIC to re-deploy staff to pressured areas of ED	
ESCALATION CARD 2: EARLY SIGNS OF PRESSURE		
1.	Ensure all level 1 actions have been exhausted.	
2.	Senior doctor to assess need for patients to remain in a cubicle. Identify alternate areas within the ED for patients	
3.	Triage Nurse to assess patients waiting for off load from ambulance. Consider increase of triage capacity if crews are unable to offload	
ESCALATION CARD 3 - PROLONGED PRESSURE		
1.	Ensure all level 2 actions have been exhausted.	
2.	NIC to maintain complete overview of situation within ED.	
3.	Utilise senior decision makers to see, treat and discharge before entering the department	
4.	Establish waiting times of the WIC and ensure information is provided to patients to make informed decisions.	
5.	Consultant in Charge (CIC) and NIC to assess utilising additional areas within the ED this will be dependent on patient's clinical needs, e.g. children's area for adult patient overflow. Resus for patients with increased clinical need etc.	
6.	CIC to ensure doctors are utilised correctly	
7.	CIC to contact specialist Consultants if delays in patient assessment of >2 hours	
8.	NIC to ask patients in waiting room who are suitable, to leave ED and seek advice from GP/Walk-in Centre.	
9.	NIC to maintain communications with EAU NIC regarding patient flow and transfers to EAU.	
ESCALATION CARD 4: EXTREME PRESSURE		
1.	CIC to ensure all previous actions has been exhausted and all areas within ED are fully utilised	
2.	Attendance by CIC and NIC at capacity meetings to provide overview of situation within ED.	
3.	CIC to assess ambulance patients awaiting off load and prioritise patients with greatest clinical need and potential transfers to other hospitals	
4.	CIC to ensure flow of patients to each doctor and maintain overview of process. CIC to contact relevant specialist consultants for patient assessment and/or management plan	
5.	CIC to inform patients in waiting room to visit GP for non-urgent conditions.	

LEAD NURSE FOR ALL WARDS (24/7 Role)

ESCALATION CARD 1: NORMAL WORKING		
No.	Individual Actions	Time Complete
1.	Be aware of escalation level and pressure points within area and ensure that patient information is communicated to site co-ordinator as required	
2.	Ensure that there is daily MDT meeting by 10:00; ensure action plan is created. Directorate Manager/ Service Head to action as required	
3.	Patients identified as a definite or potential discharge are identified on the action plan or via the ADT process ensuring they are followed	
4.	Patients, who meet the criteria for the hospital lounge and are fit for discharge, to be transferred without medications to take home	
5.	Blocks to discharge escalated to bed management team leader/capacity matron	
6.	Patients awaiting diagnostics to be discussed with site co-ordinator who will attempt to accelerate the process as required	
7.	All take home patient medications to be written and sent to pharmacy	
8.	Patients who meet the criteria to be transferred to hospital lounge ASAP	
9.	Any blocks to discharge to be escalated to Matron with an action plan	
10.	Patients requiring side rooms to be communicated to bed management team and infection control as a priority.	
11.	Staffing issues to be communicated at capacity meeting or with matron	
12.	Those requiring stepdown/intermediate care assessment to be identified by 08:30. If no action within 24 hours (not weekends) lead nurse to escalate to capacity management team.	
13.	If no input (24 hours) from discharge co-ordinator escalate to duty co-ordinator on bleep 8911	
14.	Those whose status as fit and safe for discharge changes to be discussed with discharge coordination team.	
15.	Beds to be utilised within 30 minutes of patient discharge.	
16.	Patients requiring repatriation to be notified to the bed management team.	
17.	Lead Nurse, following capacity meeting to contact relevant consultants informing them of trust escalation a ward round to be completed	
18.	Patient admission/discharge/transfers are to be entered into the Oasis	
ESCALATION CARD 2: EARLY SIGNS OF PRESSURE		
1.	Ensure the above is completed and escalate to duty/matron as required	
ESCALATION CARD 3 - PROLONGED PRESSURE		
1.	Lead Nurse to identify non urgent elective patients admitted for Surgery. Capacity Matron to then consider cancellation of procedure.	
2.	All Consultant actions to be communicated at Capacity Meeting.	
3.	Blocks to discharge to be escalated to bed management team leader or capacity matron.	
4.	Delays due to diagnostics to be discussed with site co-ordinator or in capacity meeting. Site co-ordinator to then liaise with service managers.	
5.	Bed Management Team to be notified of any required repatriations	
6.	Lead Nurse to ensure all patient activity within their areas is accurately communicated to the bed management team without delay	
7.	No patients to be moved without agreement of the bed management team	
8.	Lead Nurse to inform site co-ordinator if beds are not filled within 30 minutes of discharge.	
9.	Ensure escalation level is updated to level 3 and SitRep completed	
ESCALATION CARD 4: EXTREME PRESSURE		
1.	Any patient that no longer requires an acute bed to be discharged	
2.	Identification of action plan for specialty ensure communication to Director of Ops/Director on Call – Capacity Team	
3.	Lead Nurse to contact all consultants requesting additional ward rounds and patient reviews	

4.	All consultant action to be communicated at Capacity Meeting and relevant bed managers	
5.	Lead Nurse to ensure timely discharge of cancelled procedures for non-urgent elective patients admitted for surgery. These will be decided by CIC/Capacity Matron and director of Operations.	
6.	Patients identified as, a definite or potential discharge should be communicated to the bed management team immediately.	
7.	Delays due to diagnostics are to be notified to the bed manager and the Capacity Meeting immediately. The bed manager will liaise with service managers to accelerate process	

MATRON (Role available normal working hours)

ESCALATION CARD 1: NORMAL WORKING		
No.	Individual Actions	Time Complete
1.	Be aware of escalation level and pressure points within area and ensure that patient information is communicated to site co-ordinator as required	
2.	Ensure attendance of ward managers/shifts leads at 09:00 MDT ward meeting	
3.	Promote culture of adherence to the discharge process from time of admission	
4.	Ensure infectious patients are correctly nursed in line with Trust policy any issues to be communicated to bed management team.	
5.	Monitor monthly capacity statistics and ensure relevant corrective action is taken where appropriate	
6.	Develop and communicate plan for your ward	
7.	As per capacity policy no bed should be left empty for longer than 30 minutes, if not ensure site co-ordinator is informed as appropriate	
ESCALATION CARD 2: EARLY SIGNS OF PRESSURE		
1.	Ensure ward information is made available for capacity meetings	
2.	Ensure lead nurse/shift lead accurately and responsibly report all patient activity within their areas to the bed management team without delay	
3.	Following communications from site co-ordinator ensure all ward consultants are contacted and trust pressures discussed, report any identified issues to capacity team leader/matron.	
4.	Ensure all extra ordinary information is communicated via lead nurse/shift lead at capacity meetings i.e. Infection Control Outbreaks, staffing issues	
ESCALATION CARD 3 - PROLONGED PRESSURE		
1.	Matron to meet with heads of service and discuss trust pressures and agree a plan of action to provide immediate discharge of patients	
2.	Ensure blocks to patient flow within ward/areas are raised at capacity team meetings and communicated to capacity team leader/matron.	
3.	Ensure immediate transfer of identified patients to the hospital Lounge.	
4.	If deemed necessary inform elective patients that their surgery has been postponed	
5.	Ensure engagement with discussions regarding the opening of additional capacity within the Trust.	
6.	Capacity matron to contact associate nursing ad medical director to discuss trust pressure and further actions to be taken.	
ESCALATION CARD 4: EXTREME PRESSURE		
1.	Work with Clinical team in your area to create capacity by expediting immediate discharges.	
2.	Ensure immediate transfer of identified patients to the hospital lounge.	

DISCHARGE LEAD (Non Urgent Patient Transport Role available normal working hours)

ESCALATION CARD 1: NORMAL WORKING		
No.	Individual Actions	Time Complete
1.	Ensure that any delays to transport are fed to the appropriate lead nurse/matron/site co-ordinator.	
2.	Ensure that resources are appropriately identified for the ward to function at this level.	
ESCALATION CARD 2: EARLY SIGNS OF PRESSURE		
1.	Prioritise discharges as appropriate.	
ESCALATION CARD 3 - PROLONGED PRESSURE		
1.	Consider alternative transport arrangements in discussion with Site Co-ordinator.	
2.	Any agreed plans are communicated to the out of hours team as appropriate.	
ESCALATION CARD 4: EXTREME PRESSURE		
1.	Request priority of Non Urgent Ambulance Transport with the WMAS ambulance manager e.g. Priority 1, as per protocol.	
2.	Explore other methods of transport e.g. 4x4 vehicles for blocked roads.	

SERVICE MANAGER i.e. Radiology, Cardiology Diagnostics, Therapy, Pharmacy, Pathology (Role available normal working hours)

ESCALATION CARD 1: NORMAL WORKING		
No.	Individual Actions	Time Complete
1.	Be aware of the escalation level and ensure your service is aware of the Trust pressures.	
2.	Ensure any delays in service are communicated to the site co-ordinator.	
ESCALATION CARD 2: EARLY SIGNS OF PRESSURE		
1.	Prioritise activity to facilitate discharge.	
2.	Brief the site co-ordinator as to the actions taken.	
ESCALATION CARD 3 - PROLONGED PRESSURE		
1.	Develop and communicate plans by ward.	
2.	Ensure that resources are appropriately identified for the wards to function.	
3.	Consider increasing the working day to accommodate demand as appropriate.	
4.	Brief the Site Co-ordinator as to the actions taken.	
ESCALATION CARD 4: EXTREME PRESSURE		
1.	Continue with action plan as identified at level 3.	
2.	Ensure that resources are appropriately identified for the ward to function at this level.	
3.	Brief the Site Co-ordinator as to the actions taken.	

MEDICAL SPR

ESCALATION CARD 1: NORMAL WORKING		
No.	Individual Actions	Time Complete
1.	Maintain awareness of escalation level and pressure areas within the Trust.	
2.	Attend the capacity meetings at 08:00 and 21:00 to ensure handover/transfer of information has happened.	
3.	Direct the clinical team to support activity as appropriate.	
4.	Work with the site co-ordinator to agree priorities for clinical support.	
5.	Ensure that you are working with the site co-ordinator in the prioritisation of clinical need, discharge arrangements to sustain and de-escalate pressures.	
6.	Agree and communicate plan of actions to clinical teams.	
7.	Respond to pressured areas e.g. ED if the out of hours the decision of the team will affect patient discharge.	
8.	Medical on call registrar continues taking referrals from ED, maintains responsibility for Resus in ED, overall supervision of the on call team and AMU Registrar covering GP area for triage, assessment and supervision.	
9.	Work with the site co-ordinator to ensure actions are complete.	
ESCALATION CARD 2: EARLY SIGNS OF PRESSURE		
1.	Exhaust actions from level 1.	
ESCALATION CARD 3 - PROLONGED PRESSURE		
1.	Exhaust actions from level 2.	
2.	Escalate to on call consultant as appropriate to affect patient care as appropriate.	

MANAGER ON CALL ON CALL (24/7 Role)
Responsible for: Overall tactical management of the site

ESCALATION CARD 1: NORMAL WORKING		
No.	Individual Actions	Time Complete
1.	Participation on the Teleconference as appropriate	
2.	Be aware of escalation levels.	
ESCALATION CARD 2: EARLY SIGNS OF PRESSURE		
1.	Work with the CSC/duty matron to support the decision making process and preparation of the plan in order to create or maintain capacity levels	
2.	Liaise with external manager on calls as per capacity process.	
3.	Assist the CSC in avoidance of breaches and implementation of agreed action plans to maintain patient flow	
4.	If the Trust is moving from a 2 to 3 the Director on Call must be informed of the situation and the actions that are being taken to manage the situation.	
5.	Ensure actions undertaken are communicated as appropriate	
6.	Participation on the Teleconference as appropriate	
ESCALATION CARD 3 - PROLONGED PRESSURE		
1.	Support the Director in the decision making process and actions around containing escalation	
2.	Ensure that actions undertaken are communicated as appropriate	
3.	Participation on the Teleconference as appropriate	

DIRECTOR ON CALL (24/7 Role)
Responsible for: Overall Strategic Management of the site

ESCALATION CARD 1: NORMAL WORKING		
No.	Individual Actions	Time Complete
1.	Be aware of escalation levels.	
ESCALATION CARD 2: EARLY SIGNS OF PRESSURE		
1.	Be aware of escalation levels.	
ESCALATION CARD 3 - PROLONGED PRESSURE		
1.	Within normal working hours ensure that there is a Teleconference with Local Authority and NHS England Director as appropriate. All possible actions to be identified and communicated as appropriate. Information to be recorded on EMS enabling RCMT to be aware of actions being taken to stem the prolonged pressure.	
2.	If pressure continues a divert should be considered, follow the protocol for agreeing a divert	
3.	Brief the Manager on Call/Site Co-ordinator as to the actions agreed from divert or teleconference.	
ESCALATION CARD 4: EXTREME PRESSURE		
1.	Maintain communications with the Director of NHS England/Local Authority/surrounding Acute Trusts as appropriate.	
2.	Ensure that resources are appropriately identified for the Trust to function at this level.	
3.	Ensure that communication from external organisations is communicated within the Trust as appropriate	

Appendix 5
Performance Management

Area to be Monitored	By Who	How/Action
• Daily expected discharges, if failed why?	Matrons/Lead Nurses	Review the EDD, the ADT information provided and any patients who were not discharged inform the Capacity Team Leader as to reason why e.g. transport/TTO's. The Capacity Team Leader will keep a central list that is monitored accordingly.
• Length of stay on the short stay ward e.g. 48 hours	Daily monitoring by Lead Nurse	Any specialty patients should be managed by the Matron/Lead Nurse to ensure the patients are pulled through to the appropriate specialty or arrange a specialty review of the patient for a quick and early management plan.
• Patients awaiting specialty beds, how long have they been waiting.	Matron to monitor the length of time patients are taking to repatriate.	Information to be discussed within the clinical team as to the problems with patient flow.
• How many outliers, length of time to repatriate.	Matron to monitor the length of time patients are taking to repatriate.	Information to be discussed within the clinical team as to the problems with patient flow.
• Accurate and timely information e.g. use of ADT	Matron to ensure ADT is accurate and any problems rectified.	By looking at the ADT to assess for accurate and timely information, are the consultants correct, is the EDD correct etc.
• Use of Discharge Lounge	Capacity Team to provide regular use of the Lounge to the Matron/GM	Matron to ensure that optimum use of the lounge is occurring, problems to be flagged with the GM.
• Use of Community Teams/Red Cross etc.	Capacity Team to provide regular use of Red Cross/Community Referrals to the Matron/GM	Matron to ensure that optimum use of the lounge is occurring, problems to be flagged with the GM.
• Discharge planning letters are they being deployed?	Matron to ensure that patients are given all the appropriate information to support their discharge.	DISCO to ensure that the information relating to issuing of letters is captured on the database.
• Monitor and manage the patients on the delayed discharges list, how long are patients waiting for assessment – escalate accordingly!	Matrons to manage the delays appropriately within their specialty and issues to escalated and actioned as appropriate.	Daily monitoring of the discharge delay list.

Appendix 6
12 hr breach reporting

12 hour Breach Process

Nurse in Charge of ED will inform **Site Coordinator (CSC)** at **8 hours** that there is a **potential 12 hour breach**

↓

CSC to inform **Director/Deputy Director of Ops for Medicine or Manager on Call (OOH)** at **8 hours** that there is a **potential 12 hour breach**

↓

Director to be **notified** and **inform CCG** where there is **no immediate plan**

↓

Director/Deputy Director of Ops for Medicine or Director on Call (OOH) to verify authenticity of breach as soon as it occurs and **complete the "actions following 12 hour breach" (next page)** document and **submit to the email address noted on the document and CCG**

↓

If a **12 hour breach has occurred –Urgent & Emergency Care Directorate Management Team** to be **informed** of the details of the breach; including:
Patient ID
Time of breach
D.O.B
And breach details

↓

Once the above steps have been completed – the Deputy Director – Urgent and Acute Care to complete RCA and submit to the CCG **within 48 hours**

Actions Following 12 Hour Breach

Organisation:

Date of breach

Date template completed:

Completed by: (Name, Title, Contact details)

To be submitted by 09.30 am to: England.wm-localities@nhs.net

Trust Name	Patient gender	Time of A&E arrival	Time of DTA	Time patient moved to bed	Total wait (DTA time admitted to bed)	Main driver for breach *(e.g. lack of capacity)*	Any known harm for patient	Additional factors *(including whether escalation processes were followed, and any actions taken to mitigate against the 12 hour breach occurring)*

NHS England (West Midlands) – Internal 12 hour breach reporting process

Trust

- Manages A&E activity
- Notifies CCG of patients breaching 8 hours
- Responsible for reporting on UNIFY, STEIS (never event), and completing RCA.

CCG

- CCG works with Trust to manage all 8+ hour breaches (including RCA where appropriate)
- At any time over 8 hours, and no later than at the 10 hour wait for a bed, the CCG notifies NHS England 1st on-call (24/7), where breach position is getting worse, support is needed, patient has died, or there is media interest.
- CCG and NHS England 1st On-Call agree frequency/timing and method of updates (eg tel call every 30 minutes, or email update every 20 minutes).
- Where breaches are likely to occur over 12 hours (ie all patients waiting over 11 hours without actions in place to secure an appropriate bed), CCG (and, where appropriate Trust) confer via telephone on actions being taken to prevent breaches & likelihood of 12 hours being breached. Discussions to include whether overall A&E performance is deteriorating (eg long ambulance handover times), and agreed timing and method of updates ((NB: NHS England 1st on-call to report Significant Performance Issues to regional on-call & 2nd on-call.)

NHS England (West Midlands)

- For all 12 breaches, NHS England 1st On-Call obtains initial details including: hospital, gender of patient, time of DTA (Decision To Admit), time admitted to a bed & where, total wait, and reason for delay.
- NHS England 1st On-Call to contact 2nd on-call and NHS England Midlands & East Regional 1st On-Call to report 12 hr breach, and send confirmation email with details to regional inbox at england.me-ops@nhs.net; cc'd to NHS England (West Midlands) inbox at England.wm-localities@nhs.net.
- NHS England 1st On-Call requests that CCG submit further details (time of A&E arrival, potential patient harm, and mitigating actions taken) to England.wm-localities@nhs.net by 09:30 the following day. Template available.
- NHS England 1st On-Call requests that CCG instigates RCA (if not already instigated by trust/CCG), to be completed within 72 hours and sent to England.wm-localities@nhs.net; and confirm with Trust that 12 hour breach is being reported on UNIFY & STEIS.
- Follow-up of 12 hour breaches then transfers from 1st On-Call to Performance.

Performance Locality Leads

- Check England.wm-localities@nhs.net inbox & send the 09:30 report to england.me-ops@nhs.net (cc'd to DCO) on daily basis, also informing Quality & Nursing of 12 hr breach (including cc to england.incidents-ahwat@nhs.net) .
- Check breach is recorded on UNIFY, liaising with Quality & Nursing to ensure it is also recorded on STEIS.
- Liaise with CCG and Quality & Nursing to ensure RCA is completed & submitted within 72 hours .
- Work with Quality & Nursing to ensure RCA is reviewed appropriately.
- Check that 12 hour breach is included on monthly A&E reports and CCG Assurance process & followed up appropriately within performance reviews.

Appendix 7
Trust Full Capacity Protocol

1 Rationale

ED crowding is a challenge in delivering safe, high quality urgent and emergency care. The maintenance of patient safety and the provision of high quality care and a good patient experience are the organization's strategic priorities at all times. Organisational pressures and workload can limit the ability of key areas to provide this along with expected patterns of care. When this pressure stops normal daily functioning, it significantly increases the risk of failure in care with association between ED crowding and

- Mortality
- Increased Length of Stay
- Reduced quality in care
- Poor patient experience
- Impact on staff morale,
- recruitment and retention

In the context of the Trust operating at OPEL 3/4Escalation the Trust needs to operate differently. Balancing and sharing risk is part of the organization's action in discharging its duty of care to patients.

The aim of this document is to provide a framework designed to prevent, mitigate and resolve ED crowding.

Unlike many departments the Emergency Department (ED) are unable to cap demand and close their doors when all available patient care spaces are occupied. The risk of serious incidents happening not only increases with every additional patient that arrives over and above capacity but this is concentrated in one area. This represents a significant risk. As such the risk needs to be shared across the whole organization and the Trust response is one from the whole organization not just the ED. This protocol describes the mandated actions necessary when the ED as the main point of entry for emergency admissions) has more patients than it can potentially safely care for. This policy will also apply when demand for AMU beds also outstrips capacity.

This protocol is a default list of actions to be taken when the Trust is operating at full capacity. It is not necessarily exhaustive. Other measures or situations could still affect the operational safety and are not specifically described here and so should not be excluded.

It should also be appreciated that some measures **should be adopted early** at relatively lower levels of escalation in order to prevent the risks from occurring in the first place.

The full capacity protocol aims to deliver improved sustainable patient flow through the organisation through measures which, as far as possible, have a reasonable evidence base for being effective nationally or locally. There should be an optimization of:

- Front-end assessment and initial treatment activities (and also admission avoidance)
- A focus on discharge to consistently prioritise discharge activities.

2. Emergency Department Crowding

This is a situation where the number of patients occupying the emergency department is beyond the capacity for which the ED is designed and resourced to manage. Whilst there are different causes of crowding including surges in activity, insufficient staffing to manage normal activity but the most common cause of recurrent and persistent crowding is exit block from the department

3. Activation of the Full Capacity Protocol

This protocol is to be used in line with the Trust Escalation Plan: Inter-site Transfer protocol as part of the hospital wide operational planning

In the event that capacity exceeds demand the Full Capacity Protocol will be activated when the following **6** criteria are met:

1. The Trust escalation status is Opel Level 3 or above and actions taken to reduce the level have failed to resolve the pressure and/or the pressure continues to increase
2. The Emergency Department escalation status is RED which is defined through the ED Crowding tool, applied every 2 hours
3. There are patients with decisions to admit in ED and no potential bed to transfer
4. There is no space to assess in ED
5. The AMU is compromised and the number of patients within the unit is beyond the normal occupancy levels with patients being cared for in the ED corridor
6. There is no space for ambulances to offload and waits are greater than 30 minutes

Consideration to instigate the policy will be given if overall levels of acuity of illness in the Emergency Department regardless of absolute numbers are considered to high risk.

4. Responsibility

The Full Capacity Protocol may be instigated at lower levels of escalation and/or demand if this is deemed clinically necessary. It is expected that the protocol will be instigated between the hours of 0700 and 1800in line with the escalation policy with plans in place and agreed to manage the next 8 hours. The request for instigation will be made by the ED Consultant in-charge, Director of operations or Director and Manager on Call in conjunction with the CSC, ACN medicine/Matron.

In the event that the protocol needs to be activated OOH the request will be escalated by the ED on-call Consultant through to the manager on-call. The decision to instigate the policy will be made by the director on-call.

The decision to deactivate the protocol or step-down certain elements of it will also be made by the Chief Operating Officer or Strategic (Gold) On-Call. The Manager on call will ensure that all available information is collated and presented to ensure that this decision is fully informed.

It is anticipated that deputies will be nominated in the absence of the above Directors.

4.1 Definitive Actions

The following actions, in no particular order, must be taken in addition to usual operating procedures.

Leadership: Activating Strategic (Gold) Command and Control Structure

There will be three tiers of leadership for the delivery of the Full Capacity protocol following national standards of incident management:

Strategic (Gold): Chief Operating Officer in hours, Strategic (Gold) (Director) on call out-of-hours

Tactical (Silver): **ACN/Matron** for Acute medicine in hours, Tactical (Silver) (Manager) on call out-of-hours

Operational (Bronze): Clinical Site Coordinator

Out of hours the Senior Manager (Tactical (Silver) should be present in the Trust within 45 minutes of activation of the protocol.

The Strategic (Gold) On-call will be responsible for the overall delivery of the Full Capacity Protocol. The Tactical (Silver) on-call manager, liaising with the clinical site team and ED clinicians as necessary. The Tactical (Silver) on call manager will liaise with the ED Consultant-in-Charge. A checklist of actionable items is given below

Who (Responsible Officer): Tactical (Silver) manager on call) in/out of hours
Where: Site Hub;
When (Timeframe): 45 minutes

4.2 Delaying transfers of care from Paramedics to ED

If there are more than 3 patients waiting to off-load in ED or more than 1 in ambulance triage waiting over 15 minutes , then the Immediate Handover Protocol (see appendix C) will be activated. WAMS control will also be alert by the CSC . In this situation, assistance should be requested from WMAS to provide further assistance so that a single crew can be identified to continue supervision of these patients, allowing other crews to be released. If there is a HALO on site then the last two points will be undertaken by them.

Who (Responsible Officer): ED Consultant in Charge
Where: Emergency Department
When (Timeframe): As required

4.3 Daily Senior Review of ALL Patients

Every patient in every bed on every ward should be reviewed by a senior doctor (registrar or consultant, ideally consultant) every day, including weekends and bank holidays where there is 7/7 cover. Priority should be given to the patients who are most unwell and those that could potentially be discharged as suggested by the Ward Nursing Staff.

As part of the SAFER standards across all the acute wards the Multi-disciplinary team will continue to review the status of all the patients on the wards, deemed ready for assessment and ready for discharge and agree a safe pathway to support patients discharge.

Estimated Discharge Date (EDD) Every patient will have an Estimated Discharge Date agreed by the consultant on admission and recorded on OASIS. This information will be used to aid the clinical site team of potential discharges and enable a safer focus on the planning of discharge

4.4 Transfer of Patients to Wards whilst awaiting a Bed: Plus one on wards

To support the mitigation of risk within the Emergency Department consideration will be given to transfer patients from AMU to a ward without a bed being immediately available but who have a clear expectation that a bed will become available within the next 4 hours. To do so however the following conditions must be met:

- The Daily Facilitated meetings clearly identify the patients EDD and this information is used by each ward team supported by the Matron, lead Nurse to identify the predicted discharges for the day. It is from these predicted discharges that the patients will be identified to vacate their beds if needed.
- There is an expectation that the bed on that ward could become available within a 4 hour time window.
- The bed is likely to become available through the discharge of a patient who is able to sit out in an arm-chair whilst they wait. Ideally the Discharge Lounge should be used but it is acknowledged that sometimes there are clinical reasons why this is not the case. The nurse-in-charge of the ward, supported by the matron, makes the final decision as to who is nursed where and how, and which patient sits out. The transferring nurse will identify which patients are sent to wards.
- The patient will be assisted in vacating their bed within 15 minutes of the request to transfer a patient from AMU/A2
- Each ward will nominate in advance where and how such patients will be nursed and this arrangement will be approved for each ward by the Divisional Chief Nurses.
- A nurse must be clearly identified to look after the patient in a suitable area whilst awaiting discharge.
- The criteria for such patients and appropriate locations for each ward are described in Appendix 2 (Criteria for transfers).
- All patients identified for transfer to a ward will be clinically assessed by the AMU/A2 nursing team for suitability of safe and appropriate transfer with a

full handover to the receiving ward prior to transfer

- The above is clearly explained to the patient by the nurse-in-charge prior to transfer
- Such transfers are termed Plus One transfers.

Who (Responsible Officer):	Chief Operating Officer/Strategic (Gold)
Where:	Wards
When (Timeframe):	As required

4.5 Specialty In-reach to the Emergency Floor

As part of the Strategic (Gold) Command and in response to the crowding in ED each of the 3 clinical divisions shall provide a nominated individual (Manager of the Day) to visit the Emergency Floor at a minimum of three times daily and liaise with the ED Consultant

The first attendance shall be within 30 minutes of the activation of the full capacity protocol and the team will be notified via the managers of the day in hours.

- Example times of expected attendance include: 0930, 1230 and 1700 and form part of the clinical huddle in ED.
- If the department is crowded due to a high number of patients who require initial assessment and decision by a Doctor then the ED Consultant will make the request through the Manager of the Day to identify a senior clinical decision maker (doctor/nurse specialist) from the relevant specialty team (ideally, registrar or consultant) to support the ED and arrange treatment, transfer or discharge of patients.

The ED Consultant in-charge will act as a Clinical Arbiter for cases where there is potential dispute as to which team looks after which patients.

Who (Responsible Officer):	Divisional Chairs
Where:	ED
When (Timeframe):	1 hour

5. Portering

Additional porters should be deployed to the Emergency Floor to assist with transfers across the Emergency Floor.

5.1 Hospital Response and Escalation Plan

The need to consider the following actions **MUST** be taken through a Strategic (Gold) Command and Control Structure and form part of the wider Hospital response plan through the operations meetings

5.2 Cancellation of Non-Urgent Elective Activity

Any consideration for cancelling non-urgent elective surgical procedures must be taken with consideration to the following key points:

- Postponement of elective surgery is a very poor patient experience.

- Deferred surgery increases the likelihood of non-elective admission in the interim, for a number of procedures.
- The DGFT adult surgical elective inpatient ‘take’ is typically between 10 and 15 patients per weekday, out of a bed-base of 158 beds (SAU 10, B5 24, B4 48, B3 42, C6 20, SHDU 8, ITU 6). The surgical emergency admission ‘take’ is typically 30-40 patients per day. Therefore cancelling elective admissions provides a proportionally very limited benefit to the bed base.
- B1 elective Orthopaedic ward cannot be used for non-Orthopaedic cases, therefore elective Orthopaedic work will not be cancelled.

Within the Surgical specialties case by case decisions will be made about the cancellation of all “non-urgent” elective surgery that is not day-case. It must be appreciated that day-case activity has no impact on patient flow in unplanned care; furthermore, most elective surgery that takes place is for complex surgery that cannot be routinely cancelled without a risk-assessment being made. Similar decisions may also need to be made by the medical specialties. Such decisions for surgical patients are to be made only by the Director of Operations for Surgery, Women & Children, or their nominated deputy. Such decisions for medical patients are to be made only by the Director of Operations for Medicine & Integrated Care, or their nominated deputy.

Who (Responsible Officer): Director of Operations (Surgery, Women & Children) and Director of Operations (Medicine & Integrated Care)
Where: Hub
When (Timeframe): 4 hours

5.3 Outlier to alternative specialties / divisions

Please see outlier policy

Who (Responsible Officer): Divisional Manager on call / Directors of Operations
Where: Capacity Hub
When (Timeframe): 4 hours

5.4 Cancellation of all Non-Urgent Meetings, Sub-Committees and Committees

At the discretion of each Meeting/Subcommittee/Committee Chair during activation of the Full Capacity Protocol, it is expected that some staff may be required to leave all but urgent meetings, even at short notice, to ensure the maximum amount of clinical and management time can be devoted to the Full Capacity Protocol.

Who (Responsible Officer): Strategic (Gold)
Where: Capacity Hub
When (Timeframe): 1 hour

Cancellation of Educational Activities

At the discretion of the Medical Director, or nominated deputy, it is expected that all educational activities are cancelled.

Who (Responsible Officer): Strategic (Gold) Command
Where: Site Office
When (Timeframe): 30 minutes

Opening of Escalation Areas: Strategic (Gold) Command

By the time a Full Capacity Protocol is activated, a number of extra beds will have been made available, by definition. However, the order of opening up escalation areas (and extra beds on existing wards) will be considered by the Tactical (Silver) command team (director of operations in hours, manager on call out of hours), this will be done in consultation with COO and Director on call out of hours, whose decision it will be.

Who (Responsible Officer): Strategic (Gold) Command
Where: Hub
When (Timeframe): At all times

6. Discretionary Actions

The following actions, in sequential order, may be taken if circumstances dictate in addition to all of the above and usual operating procedures:

6.1 Cancellation of ALL Consultant SPA Activity

The above additional clinical workload involving consultants will be expected to be shared between consultants via mechanisms such as an on-call rota and the cancellation of occasional sessions not requiring Direct Clinical Care. The Trust Medical Director (or deputy) however may judge that all such activity should be cancelled by all consultants such that all consultant expertise is diverted to direct patient care such as assisting colleagues with ward rounds, clinics or activity on the Emergency Floor.

Who (Responsible Officer): Medical Director (or deputy)
Where: Wards/ED/Clinics
When (Timeframe):

6.2 Diversions

When the Trust and all Divisions are on Opel level 4 escalation status and the ED consultant in Charge still identifies a risk to patient care or safety they will request a divert via the Executive On-Call using the existing WMAS Escalation Framework .

Who (Responsible Officer): COO /Strategic (Gold) on-call
Where: Site Office
When (Timeframe): As required

7. Governance and Monitoring

In order to provide assurance that the activation of the protocol is managed for both appropriateness and the management of organisational risk the following actions will be taken:

OOH the **reporting and recording** of the use of the protocol will be managed by the site team in-line with the agreement taken by Strategic (Gold)/Tactical (Silver) OOH

- Activation to be recorded using as SBAR and recorded in management actions on capacity updates
- Wards involved to be noted along with the checklist completed to ensure process was followed
- The Checklist completed for each activation and record kept for audit purposes
- Triggers to be reported :- > more than 3 times in one week and/or > 6 times in one month to be reported to the COO with a risk assessment for each use

Activating the Full Capacity Protocol: Check List		
No.	Individual Actions	Time Complete
1.	The COO or nominated deputy (in hours) and the Director on call briefed of situation and agree to activate the protocol They then have 30 minutes to get to site from activation of protocol	
2.	Site team to gather potential discharge information following Daily Capacity meetings	
3.	Specialty in-reach to ED if required and requested by the ED senior consultant with the relevant Managers of the Day from the 3 clinical divisions • SWC (including T&O) • Clinical Support Services • Medicine	
4.	Strategic (Gold) Command activated in –line with trust escalation plan and following actions taken	
5.	Cancellation of non-urgent elective activity reviewed	
6.	Reprioritization of meetings, cancellations where non critical	
7.	Cancellation of educational activities	
8.	Arrange additional nursing support	
9.	Arrange additional portering and catering	
10.	Open escalation areas- in-line with procedure	
11.	Ensure record of Strategic (Gold) and Tactical (Silver) actions are maintained, ensure timings are recorded and ensure this record is kept within the site office for the duration of the activation	
12.	All relevant senior nurses made aware of activation and sanctioned for increased number of patients to relevant wards	

7.1 Criteria for patient transfer to wards whilst Full Capacity Protocol is activated

- Patients may be either “incoming” or “outgoing”.
- Due regard should be given to the most appropriate specialty ward for the patients need and be linked to Board rounds and the EDD
- Each ward shall accommodate patients in the designated “plus one” area on that ward.
- As part of the Strategic (Gold) Command and Control structure patient transfers shall only be accommodated 0700 – 1800and not overnight unless a significant event declared which requires this to happen as part of exceptional response
- The most appropriate and suitable patients are identified by the clinical teams: the nurse- in-charge in conjunction with the medical staff.
- Outgoing patients must be clinical safe to sit out in an **arm-chair** if they are not able to be transferred to the Discharge Lounge
- If the patient identified is transferring to a ward as a plus 1 and not able to access a bed space made vacant by a patient suitable for the day room or discharge lounge then the patient must have a NEWS less than not be acutely confused, are not receiving oxygen, and not receiving continuous cardiac monitoring.
- Single-sex accommodation considerations must be observed at all times.
- The nurse-in-charge will explain all of the above to the affected patients
- If the expected bed availability ceases to be the case, then this will be escalated to Clinical Site Coordinator immediately and an alternative bed be sought as a matter of priority. The relevant Matron or Lead Nurse will be informed.
- In the event of any problems, the nurse-in-charge will escalate the situation immediately to the relevant Matron or Divisional Chief Nurse or CSC OOH
- The following ward areas will be excluded from taking one extra patient each under the circumstances detailed above:

  Critical Care
  Coronary Care
  Paediatrics
  Maternity

Plus one areas on Medicine Wards

Area 1: Definite discharge identified and can accommodate Fit to Sit discharge not able to go to lounge
Area 2: Potential discharge identified and can accommodate Fit to Sit discharge not able to go to lounge
Area 3: Accommodation of a bedded patient

Ward	**Area 1**	**Area 2**	**Area 3**
AMU	Corridor		
A2	Seminar room	Quiet room St 3	St 3 bed adjoining renal
C1	Sit out in bay / seminar room	Sit out in bay	St 3 / st 4
C3	FMNU	FMNU	FMNU

C4	Triage space day case area	Triage space day case area	Triage space day case area
C5	Seminar room	Sit out in bay	St 4 / st 2
C7	Seminar room	Sit in bay	Bed in bay
C8	Activity room	Sit in bay st 1	Therapy room

Appendix 8 Dudley Group NHS FT Bed Base

Medical wards	Beds
A2	42
CCU	10
PCCU	16
C1	48
C3	52
C4	22
C5	48
C7	36
C8	44
MHDU	6
AMU	36
Total	360

Surgical/T&O wards	Beds
B1	26
B2	54
B3	26
VASU	4
SAU	10 + 3 triage beds
B4	48
B5	24
B6	17
C6	20
ITU	5
SHDU	8
Total	225 (plus 3 triage trolleys)

Medicine	360
Surg/T&O	225
B6	17
TOTAL ADULT BEDS	585 (602 including B6)

The Dudley Group NHS Foundation Trust

Policy Consultation Form

(This page to be deleted from the document prior to adding to HUB Trust Central document page)

Please ensure that you receive either a confirmation or comments from a stakeholder (via an email) before you add their details to the consultation section on the procedural document

What is the title of the procedural document:			
Surge and Escalation Policy			
Date of Submission:	**29/05/2018**	**Author**	**Christopher Leach**
Director Lead and Date Signed off as Approved.	**Name: Karen Kelly**		**Date Approved:23/05/2018**
Is there a similar/same document already in existence / if so will this document replace this one or is it in addition?			
Replace existing Plan			
In addition to the central HUB page for procedural documents will it need to be linked to any other pages? Please list below			
Emergency Planning hub Page			
Consultation: Please list the stakeholders who have been consulted in the development of this document and the date they confirmed agreement of its content. This is any member of staff/groups who will be part of or affected by this. If this was a group please list attendees:			
Name	**Designation**	**Date confirmed agreement (mm/yy)**	
SPECIALISTS / GROUP/S (if no Specialists Groups consultation identify the reason why)			
Emergency Planning Group	Emergency Planning	Comments requested by 23/05/2018	
Site Coordinators	Site Coordinators	Comments requested by 23/05/2018	
DIVISIONAL MANAGEMENT CONSULTATION (if no Management consultation identify the reason why)			
OTHER			
Michelle Pinto	Matron for Community Nursing	15/05/2018	
Karen Hanson	Deputy Director of Operations – Integrated Care	14/05/2018	
Ned Hobbs	Director of Operations (Surg,W&C)	14/05/2018	
Karen Kelly	Chief Operating Officer	17/05/2018	

Malcolm Tonks	Estates Compliance Manager	30/05/2018

The Dudley Group NHS Foundation Trust

Check List

(This page to be deleted from the document prior to adding to HUB Trust Central document page)

Prior to submission of the Policy for ratification, please ensure you can answer yes to all of the questions below.

	Yes/No
1. Title	
Is the title clear and unambiguous?	Yes
2. Front Sheet Completion	
Is the colour banding strip blue?	Yes
Is the Author identified (name and designation)?	Yes
Is the Director Lead identified?	Yes
Is the target audience identified?	Yes
Is the document version controlled?	Yes
Have the people contributing to the document been identified on the Front cover Sheet as per designation and not individual names?	Yes
Have the CQC registration requirement outcomes been recorded?	Yes
Have relevant documents/legislation standards been recorded if applicable?	Yes
Is there evidence that appropriate consultation has taken place from contributors and consulted? Refer to consultation document which should be submitted with the document?	Yes
Has the change history been fully completed?	Yes
3. Body of the document	
Has the contents page been fully completed and the numbering reflects the document content pages?	Yes
Is there a footer on each page recording; document title, date of issue, version number, page number and number of pages?	Yes
Is the document written in Arial 12pt font?	Yes
Does the document contain individual designations and NOT names?	Yes
Does the numbering run in sequence?	Yes
Does the document follow trust format of; Introduction, Statement of Intent/Purpose, Definitions, Duties, Process, Training/Support, Monitoring, Equality and References for the main body?	Yes
The meaning for any definitions or abbreviations used are clearly stated?	Yes
Are the Duties and Responsibilities inclusive from board to ward/dept and follow the trust format	Yes
Is there identified training or support which includes the process for follow up of non-compliance clearly cited?	Yes
Are procedural documents relating/supporting this document hyperlinked?	Yes
Is the table for Monitoring Compliance fully completed?	Yes
Are references cited in full and comply with the Harvard referencing?	Yes

Attendances (Last hour)	<10	>10-14	> 15-20	> 20
Waiting time for initial assessment	<15 minutes	15-30 minutes	31 – 45 minutes	>45 minutes
Patients in Department- Total	<33	31 - 45	46 - 66	>68
Ambulance off-load times	0 ambulance crews unable to off-load	1 ambulance crew unable to off-loaded within 30 minutes	2-3 ambulance crews unable to off-loaded within 30 minutes	>3 ambulance crews unable to off-loaded within 30 minutes
Ambulance area	<3	4 - 5	6	>6
Majors	<10	11--14	15 – 18	>18
Fit2Sit	<4	5 - 6	7 - 8	>8
Minors	<10	10 – 15	16 - 20	>20
Paediatrics	<4	5 - 7	8 - 10	>10
RESUS	<2	2	3	4 and no patients suitable for transfer
Wait for Clinician **RESUS**	<30MINS <15 minutes	31 minutes- 60 minutes 16-29 minutes	61 minutes – 90mins 30- 59 minutes	>90mins >1HR

PAEDS	<30 minutes	31 - 45 minutes	45 - 59 minutes	>1HR for 'majors' presentations
Wait for Spec from referral	<30 minutes	31 minutes- 45 minutes	46 minutes – 1 hour	>1 hour
Delays in imaging	<60 minutes	1 hr – 1.5 hrs	1.5 hrs – 2 hrs	>2 HRS
Waits for Lab results	<60 minutes	1 hr – 1.5 hrs	1.5 hrs – 2 hrs	>2 HRS
Outstanding unallocated bed requests	0	1 - 3	4 – 5	>5
Patients allocated beds but wards not ready	<0	5 - 6 (1/3 of our major's cubicle capacity)	7- 8 (1/2 of our major's cubicle capacity)	>8
Staffing- day	registered nurses ENP's decision making doctors	registered nurses ENP's decision making doctors	registered nurses ENP's decision making doctors	< registered nurses < ENP's < decision making doctors
Staffing- night	registered nurses 1 + 1 (on-call consultant) decision making doctors	registered nurses	11 registered nurses	<10 registered nurses <1+1 decision making doctors
ACTIONS	Monitor initial assessment to ensure undertaken within 15 minutes of arrival. Liaise closely with EAU coordinator to support patient flow. If patient is within 1 hour of breach due to non-clinical reasons, review patient and escalate to appropriate department (radiology/pathology/portering/transport/social/pharmacy)	Expedite transfer of patients to correct speciality assessment area/ward. Prompt NIC to discuss rapid assessment & treatment process. Escalate delays to CSC office Utilise alternative pathways e.g. AEC	Ensure all previous actions taken in the event that an internal critical incident is declared. Follow instructions as directed by CSC office/Control room.	Internal incident declared

	Review staffing for next 24 hours. If urgent patient referral contact speciality SpR to attend within 30 minutes. Allocate Doctors as required. Maintain overview of all clinical areas: Resuscitation, Majors, Minors, Paediatrics hourly. Ensure appropriate ambulance patients are offloading to waiting room. Provide senior review as required	Review all patients to ascertain who may be able to sit out. Assess feasibility with DIC to initiate rapid assessment & treatment process. Implement nurse –led cannulation/venepuncture if possible. Re-consider staffing allocations Ensure there is a care plan in place for all patients >120mins Consider the initiation of a rapid assessment and treatment process . Liaise with EAU consultant to facilitate flow. Direct junior doctor staff to specific tasks. Request assistance from CSC office for specialist teams to review/assist in ED. In-hours ED Directorate Manager to assist. OOH's request assistance from CSC office to notify on call manager. Communicate delays to patients in the waiting room. Request nursing staff on admin duties to support ED. In-hours ED Deputy Matron to		

		assist if on site. Re-assess all clinical areas with Nurse in charge. Allocate staff to problem areas Adopt a command and control role. Ensure alternative pathways have been considered. Request support from specialist consultants and teams to review all referred patients.		

Enclosure 18

The Dudley Group
NHS Foundation Trust

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

TITLE:	**Guardian of safe working report**		
AUTHOR:	**Mr Babar Elahi – Guardian of safe Working Hours**	**PRESENTER**	**Mr Babar Elahi – Guardian of safe Working Hours**
CLINICAL STRATEGIC AIMS			
	Strengthen hospital-based care to ensure high quality hospital services provided in the most effective and efficient way.		

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

OVERALL ASSURANCE LEVEL			
Significant Assurance	**Acceptable Assurance**	**Partial Assurance**	**No Assurance**
X 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

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

CORPORATE OBJECTIVE:

SO2, SO4, SO5

SUMMARY OF KEY ISSUES:

The report covers the following elements:

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

The Dudley Group
NHS Foundation Trust

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

The Dudley Group
NHS Foundation Trust

Board of Directors

Guardian of Safe Working Report December 2018

Purpose

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

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

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

Background and Links to Previous Papers

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

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

This is the 9th GSW report and covers the period of 30th August to 14th November 2018. The Guardian has been working closely with colleagues from medical staffing and rostering, post graduate medical education staff, human resources and finance to establish his role in the Trust and build relationships.

Challenges

Engagement

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

- Holding regular Guardian Junior doctor forum.
- Introduction to Guardian and his role by attending Junior Doctor Induction Day
- Attending junior doctor forum arranged by Postgraduate Clinical Tutor

- Attending junior doctors' operational forum
- Creating a dedicated Guardian email in the trust
- Creating a webpage on the Trust HUB which carries information on Guardian role as well as how to make exception reports.
- Regular communication to junior doctors through emails
- Using Trust HUB to advertise important information to junior doctors

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

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

Regional Guardian of Safe working and Freedom to Speak up Guardian joint Meeting:

On 28th of November 2018, GMC arranged a joint regional Guardian of Safe working and Freedom to Speak up Guardian meeting in Birmingham. This meeting provided an excellent opportunity to explore a supportive environment for doctors. It aimed at looking at areas of joint working that can be developed. The meeting generated ideas on good practice in our roles and how we can best work together and use our influence within our workplace and other local and regional networks to leverage support for our work and overcome any possible challenges.

Extra Cover Rota Issues:

Issues were raised by foundation doctors at various forums and directly with the Guardian with regards to Extra Cover Rota, where some junior doctors were rostered more hours including weekends than their peers. When investigated it was clear that the Extra Cover Rota and the work schedule it is based on, do not fulfil service requirements. With the support of DME, it has been agreed to make fundamental changes to this rota.

Trust Exception Reporting Policy

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

Exception Reports by Department – From 30th August 2018 – 14th November 2018 total = 20 reports submitted – (30 exceptions in total due to more than one episode reported.

Number of exceptions carried over	Number of exceptions raised	Number of exceptions closed	Number of exceptions outstanding	Specialty
None	30 (more than one episode submitted in one report)	30	0	3 – Paediatrics 1 – Anaesthetics 16 - Surgery

Exception Reports by Grade

Grade	Addressed within 48 hours	Addressed within 7 days	Addressed in longer than 7 days	Still open
FY1	1	1	5	
FY2			9	
ST1			3	
ST7	1			

Exception Reports and Fines.

We have received 20 exception reports by 5 doctors

- No immediate safety concerns
- 3 exception reports agreed as no further action
- 15 exception reports agreed as compensation overtime payment
- 2 exception reports agreed as time off in lieu
- No fines during this period

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

High level data

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

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

Gaps as at Nov 2018

Speciality / Grade	FY1	FY2	ST 1-2	GPV TS	ST 3-8	Total	
Cardiology						0	
Diabetes			1			1	No recruitment requested as short term rotational vacancy
Dermatology						0	
Elderly Care					4	4	Trust Level 1 & 2 recruitments ongoing to fill Deanery gaps. Interviews were held in October 2 offers made for trust dr level 2 post . On calls being covered by long term agency locums booked up until January as a contingency to ensure cover during winter pressures. Trust SHO vacancy due to restriction on a trainee the outcome should be determined by end of October. No recruitment requested for the consultant post.
EAU		1			1	2	None of the ST3 applicants were shortlisted. This vacancy has now being re-advertised and is due to close on the 16/12. The FY2 is being covered internally. Pakistani MTI's helping with cover.
Gastro			1		1	2	No recruitment requested for the ST3 gap. Medical Workforce liaising with Gastro for future recruitment. ST1 gap covered by locum as trainee was kept at previous trust due to restrictions. Outcome pending.

ED					1	1	Discussion regarding the 11 Trust SHO's are ongoing. They were originally earmarked as being part of an Indian MTI but this was put on hold.
Renal				1	1	2	1 year fixed term to cover Deanery ST3+ gap. GP trainee 40% LTFT gap being covered by locums
General Surgery					1	1	1 Clinical Fellow appointed - possible start date of early 2019 awaiting Visa.
ENT			1			1	Previous trainee was extended into a trust appointment contract
Vascular Surgery						0	
Haematology					1	1	Trust Fellow post is going through VAR to cover all vacancies. Consultant is ready for VAR panel awaiting Advert to put on NHS jobs.
T & O						0	
Obs & Gynae						0	
Paeds				1	1	2	The ST3 resignation has been withdrawn. The GP gap is until February. No recruitment requested as being covered internally.
Pathology						0	
Radiology						0	
Respiratory						0	
Rheumatology			1			1	Recruitment not requested. Medical Workforce liaising with department. MW awaiting instruction from department.

Stroke					1	1	Being covered by long term locums. Specialty doctor going through approval process on NHS Jobs
Urology						0	
Ophthalmology						0	
Oral/ Max Fax			1			1	CT 1/2 at advert, due to close 27th November. Specialty Dr post also at advert, due to close 19th November. In the interim, a previous trainee was extended into a trust appointment contract until May 2019.
Anaesthetics						0	
Total	**0**	**1**	**5**	**2**	**12**	**20**	

Next Steps

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

1. Conclusion

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

2. Recommendation

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

The Dudley Group
NHS Foundation Trust

Author	**Babar Elahi** **Guardian of Safe Working**
Executive Lead	**Chief Executive**
Date	**28th November 18**

Enclosure 19

The Dudley Group NHS Foundation Trust

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

TITLE:	**Speak Up (FTSU) Guardian Update**		
AUTHOR:	Derek Eaves, FTSU Guardian, Philippa Brazier, FTSU Guardian	**PRESENTER**	Derek Eaves, FTSU Guardian, Philippa Brazier, FTSU Guardian

CLINICAL STRATEGIC AIMS		
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**
Y		**Y**	

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:

To agree that the actions being taken are appropriate and that consideration should be made in terms of increasing the resources available

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

SUMMARY OF KEY ISSUES:

This paper gives an update on:

- For the last quarter (Q2) and for Q3 up to date, numbers and types of recent concerns raised and an outline of outcomes from some of the concerns raised.
- Numbers of concerns raised at the Trust compared with other Trusts in 2017-18 and in Q2 of 2018/19
- Recent activities and developments which include:
    a) National Guardian Visit
    b) Speak up Month
    c) Speak Up Champions
    d) Triangulation of data with HR
    e) Attendance at staff forums
    f) Executive/Non Executive Leads Meetings
    g) Case Review: Nottinghamshire Healthcare NHS Foundation Trust
    h) Freedom to Speak up Guardian Survey 2018
    i) Evaluation of the implementation of 'Freedom to Speak Up Local Guardians' in NHS England Trusts.
    j) Supporting our doctors and supporting ourselves
- Updated action plan

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	**Y/N**	**Details:**

Freedom to Speak Up (FTSU) Guardian December 2018 update

Numbers of concerns raised at the Trust

The table below indicates the numbers and types of concerns raised with the Guardians a) each full quarter in the last financial year with an annual total and b) in the first two quarters of this year and for Q3 up to the date stated. As previously noted, the National Guardian Office (NGO) has discussed the difficulties in categorising types of concerns being raised and those below are locally based. The majority of concerns being raised are regarding behaviour unrelated to patient care. We have divided the national category on this topic into two: a) perceived bullying and harassment and b) perceived unfair behaviour, the latter includes such concerns as unfair recruitment, unfair rotas and concerns about redeployment of staff. Both of these two types of concerns cover those regarding colleagues, line and senior managers.

2017/18	Number	Anonymously	Patient Safety	Behaviour: Bullying/ Harassment	Behaviour: Unfair/ Inappropriate	Other
Apr-Jun	2	0	0	2	0	0
Jul-Sep	14	3	4	8	2	0
Oct-Dec	17	0	3	8	6	0
Jan-Mar	11	2	2	4	5	0
2017/18	44	5	9	22	13	0
Apr- Jun	15	0	3	8	5	2
Jul – Sep	12	0	2	5	4	2
Oct – Nov*	14	1	2	5	10	2

**To Nov 28th (Others: Operational issues)(One concern may fall into more than one category)*

The table below breaks down the types of staff who are raising the concerns and it can be seen that these come from a cross-section of staff.

2017/18	Number	Nursing	Midwife	Medical	AHP	Clinical Scientist	Administration/ Ancillary	Unknown
Apr-Jun	2	2	0	0	0	0	0	0
Jul-Sep	14	7	2	0	1	0	3	1
Oct-Dec	17	7	0	1	0	1	8^	0
Jan- Mar	11	5	2	2	0	0	2	0
2017/18	44	21	4	3	1	1	13	1
Apr- Jun	15	9	2	2	1	0	1	0
Jul - Sep	12	7	1	1	1	0	1	0
Oct – Nov*	14	5	1	2	4	0	2	0

**To Nov 28th* ^1 of these was a PFI staff member

Actions/Outcomes

The concerns being raised vary considerably in complexity and as a consequence the time and resources required to come to a conclusion do differ markedly. Some issues can be resolved quickly by the Guardian, sometimes with the assistance of the Chief Executive or in liaison with local management while others are handed over, with the agreement of the person raising the concern, to such departments as Human Resources and Complaints.

The following are some latest examples of actions/outcomes as a result of concerns raised on the following topics:

- Arranged an external review into concerns in a department about recruitment and care. Report received and meeting between Chief Executive and relevant staff arranged
- Arranged for internal investigation into behaviour of manager
- Appropriate action agreed with manager regarding concern
- Resolved a working arrangement by obtaining agreement for a staff member to change area of work
- Liaison with the Human Resources Department and resolved a sick leave issue
- Arranged meeting with senior manager and appropriate action taken.

Numbers of concerns raised nationally and local Trust.

On 20th September 2018, the NGO published the full 2017/18 national data. The headlines were:

• 7,087 cases were raised to Freedom to Speak Up (FTSU) Guardians in NHS trusts and foundation trusts.
• More cases (2,223, 31% of the total) were raised by nurses than other professional groups.
• 3,206 (45%) cases included an element of bullying / harassment.
• 2,266 (32%) cases included an element of patient safety / quality.
• 1,254 (18%) cases were raised anonymously.
•361 (5%) cases indicated detriment as a result of speaking up may have been involved.
• 6 NHS trusts either did not make a return or reported that they received no cases through their Freedom to Speak Up Guardian in all four quarters (one of which was a local Trust)

With regards to the full Q2 (2018/19) figures there were 12 concerns raised at the Trust. At the end of November the National Guardian Office (NGO) released the final data of the submissions from Trusts for Q2. The headlines were:

2,604 cases were raised to Freedom to Speak Up Guardians / ambassadors / champions
799 of these cases included an element of patient safety / quality of care
1,093 included elements of bullying and harassment
130 related to incidents where the person speaking up may have suffered some form of detriment
248 anonymous cases were received
11 trusts did not receive any cases through their Freedom to Speak Up Guardian
221 out of 227 NHS trusts sent returns
Highest Trust had 65 cases (Local Trusts: 19, 19, 11 and 7)

Recent actions and future plans

a) **National Guardian Visit:** Dr Henrietta Hughes, the National Freedom to Speak up Guardian presented the Academic Year Inaugural Lecture on 11th October. This was very successful with a 'full house' in the Lecture theatre. Feedback was very positive. Dr Hughes also met a variety of staff, spoke to all of the newly appointed Champions and visited a number of departments.

b) **Speak up Month:** In conjunction with the Trust counter fraud and security specialists, staff engagement lead and Patient Safety Lead the Guardians took part in the national speak up month in October. As well as the visit of the National Guardian, the following occurred to promote Speak Up:

- Walkrounds in clinical and non clinical areas
- Presence in Health Hub and CEC reception area

- Attachment to payslips in September
- Design of Screensaver
- New Twitter Account

c) **Speak Up Champions:** In conjunction with Dr. Nicky Calthorpe 13 FTSU and Patient Safety Champions were appointed in October. They met with the National Guardian at her visit and the champions were officially launched on 1st November. Their first meeting was arranged in October and training in Speak Up and Human Factors has been arranged for December. Six weekly meetings will be arranged. The backgrounds of the thirteen range from nurses, AHPs to a medical secretary and medical records staff.

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

e) **Attendance at staff forums:** When time allows, the guardians are attending the recently formed surgical and medical division staff forums.

f) **Executive/Non Executive Leads meetings:** These continue with the Chief Executive and Doug Wulff.

g) **Case Review: Nottinghamshire Healthcare NHS Foundation Trust**

The NGO undertakes case reviews of the FTSU processes in Trusts when issues are raised with them by either staff or regulators. The NGO states: *'We expect all NHS trusts and foundation trusts to look at our case review reports to identify whether they can adopt the recommendations within to help improve their speaking up culture'*. Due to this when new reviews are published these will be included in these reports. The latest review was at the above Trust after receiving information that the trust may not have responded to one of its workers speaking up in accordance with good practice. Once announcing the review of this case other trust workers contacted the NGO to describe their experiences of speaking up. Following a review of the recommendations by the Guardians none have any specific relevance to the Trust. The report can be provided to any Director who may wish to see it.

h) **Freedom to Speak up Guardian Survey 2018**

This was published in October and a number of recommendations were made. These have been listed below with a response from the Guardians with regards to the Trust position:

1. We continue to recommend that appointments to the Freedom to Speak Up Guardian role are made in a fair and open way.
Fully compliant. The most recent Guardian appointed occurred after advertisement and interview.

2. We recommend that Freedom to Speak Up Guardians undertake 'refresher' training, provided by the National Guardian's Office or guardians trained by the National Office to provide this training, every 12 months.
Fully compliant. Both Guardians have received training and have had updates when necessary.

3. We recommend that all Freedom to Speak Up Guardians regularly assess their training and development needs using the National Guardian Office's Education and Training Guide and that their employers support them by providing the resources needed to enable them to continually develop their skills, knowledge and abilities.
Non-compliant. This will be done prior to the next report.

4. We recommend that regional Freedom to Speak Up Guardian networks seek local opportunities to enable all guardians to learn and improve, including sharing skills and knowledge amongst peers and seeking the support of local partners.
Fully compliant. There is an active regional network

5. We recommend that those in a speaking up role make an assessment of the possible conflicts that any other role that they have may bring. Following this assessment, appropriate action should be taken to mitigate against any conflict. In all cases, where the details of a particular case brought to someone in a Freedom to Speak Up role may indicate the potential for conflict, this should be made clear to the individual bringing the case and an alternative route for speaking up offered.
Fully compliant. Both Guardians are fully aware of this issue and pass on cases to each other as necessary.

6. We recommend that all organisations with a Freedom to Speak Up Guardian make a local assessment of any groups that face particular barriers to speaking up and take action to ensure that those barriers are tackled.
Partially compliant. The appointment of Champions has occurred so that there is local coverage of all areas. Initial discussions occurred with the previous Equality and Diversity lead – when a new appointment is made further action on this will be undertaken.

7. Where a local Freedom to Speak Up network is established, action should be taken to ensure that it reflects the diversity of the workforce that it supports.
Partially compliant. There was an open advertisement for the Champions and the resultant group is diverse in terms of ethnicity, sex and types of staff.

8. We recommend that all organisations with a Freedom to Speak Up Guardian make a full and honest assessment of the time required by a guardian to carry out their role and meet the needs of workers. All guardians must have the ring-fenced time they need to satisfy these basic requirements.
Partially compliant. Both Guardians have some minimal ring fenced time but both are of the view that this needs to be reviewed in the light of the number and complexity of cases being seen, the development of Champions that need support, the increasing requirements from the NGO and when comparing the time given to colleagues at other Trusts.

9. We recommend that all organisations review their mechanisms for seeking feedback on cases raised to Freedom to Speak Up Guardians, take action to ensure that these are compliant with NGO guidance, and ensure that sufficient time is allocated to ensure that this essential activity is undertaken.
Partially compliant. This relates to the answer to the above answer in that at present there is insufficient time to have an effective system in place.

10. We recommended that all organisations with a Freedom to Speak Up Guardian assess arrangements for their guardian to have direct access to their CEO and Non-Executive Director with speaking up as part of their portfolio (or equivalent roles for organisations which do not have these posts as part of their board structure). In all cases Freedom to Speak Up Guardians should have direct access to these posts.
Fully compliant. Direct access occurs.

11. We recommend that all organisations review their Freedom to Speak Up reporting mechanisms and take action to ensure that Freedom to Speak Up Guardians report to their board in person, and are allocated sufficient time to ensure that this is done.
Fully compliant.

12. We recommend that guardians attend regional meetings regularly and work to ensure that their organisation is represented at every regional meeting by a guardian, or a

representative of their local network. Senior leaders within their organisation should ensure that time and any necessary resource is made available to ensure that this can be achieved. *Partially complaint. While the regional meetings occur every 2-3 months the Guardians have only been able to attend one meeting over the last year due to pressures of time.*

In summary, the Trust is in a positive position with regards to the recommendations. However, both Guardians are of the view that the 7.5 hours in two weeks currently allocated to the role needs to be reviewed.

i) **Evaluation of the implementation and normalisation of 'Freedom to Speak Up Local Guardians' in NHS England Acute and Mental Health Trusts.**

The Guardians are participating in the above study funded by the National Institute for Health Research and conducted by the following universities: Cardiff, Surrey, Birmingham and Kings College London.

j) **Supporting our doctors and supporting ourselves**

Following discussion at the Trust with Louise Robinson, the GMC Regional Liaison Adviser, West Midlands Derek Eaves will be attending the above event for both Speak Up Guardians and Guardians of Safe Working organised by the GMC. It is in Birmingham at the office of the Royal College of Surgeons of Edinburgh.

THE DUDLEY GROUP NHS FOUNDATION TRUST

Freedom to Speak Up (FTSU) Action Plan 2018-19

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

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

Enclosure 20

The Dudley Group NHS
NHS Foundation Trust

Paper for submission to the Trust Board on 6 Dec 2018

TITLE:	**Research & Development 6- monthly Report**		
AUTHOR:	**Claire Phillips, R&D Manager; Jeff Neilson, Director of R&D; Gail Parsons Deputy Director of R&D**	**PRESENTER**	**Jeff Neilson, Director of R&D**

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**
		Y	

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:

The Board is requested to note the key issues arising and identify any further actions required.

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:

- NIHR study portfolio balance within the Trust
- Promotion of research to support clinical priorities and better patient outcomes
- Support Department Capacity Issues – pharmacy
- Research Data Archiving
- Training, development and retention of staff within department and across the Trust

IMPLICATIONS OF PAPER:

RISK	**Y**		**Risk Description:** Clinical Trials Pharmacist vacancy is affecting our ability to open new drug trials and process existing study amendments in a timely manner
	Risk Register: Y		**Risk Score:** 8
COMPLIANCE and/or LEGAL REQUIREMENTS	**CQC**	**Y**	**Details:** Well Led The leadership, management and governance of the organisation assures the delivery of high quality person-centred care, supports learning and innovation, and promotes an open and fair culture
	NHSI	**Y**	**Details:** R&D activity included in the Annual Report
	Other	**Y**	**Details:** Recruitment activity is monitored by CRN:WM, NIHR, DH

Research & Development Report

1. Strategic Direction

Our vision is: Together, we will develop, across the trust, a high quality research culture where research will be integrated into the routine clinical care of our patients and seen as everybody's business. We are making progress by widely publicising our successes (section 2), developing our webpage and news letter, and endeavouring to sustainably increase our recruitment figures (section 3). This involves increasing the number of studies we are involved in, increasing the numbers of principle investigators (PIs), increasing the PIs from non-medical backgrounds and increasing the number of chief investigators. We are using existing structures to increase the profile of R&D, for example by including research in the CNS forum and secondments in R&D are proving popular and effective in combining research and clinical practice for nurses (section 8). We hope over time that research will be seen as business as usual rather than 'special'.

2. Accolades for The Dudley Group

Dr Holly John, Consultant Rheumatologist and Head of Service, 'Love Your Heart' project managing cardiovascular disease risk programme, as part of her PhD study at DGH, which is now hosted by the charity NRAS, won the **Meridian Innovation Award** (July 2018) in supporting self-care and prevention of illness

The Department continues to add to the collection of awards. The Clinical Research Network West Midlands awards held October 2018 resulted in Dr Holly John's, 'Love your Heart' project, collecting 'Research Impact Winner' award. We were also 'Highly Commended' for the Business Intelligence Leader' award, for the second year running for up to date and complete data to support the monitoring of the CRN HLO performance, innovative solutions in EDGE database and sharing of best practice.

Dr Terence Pang (Consultant Endocrinologist), first author for the SPARTA study has recently published the results in Diabetic Medicine (DOI: 10.1111/dme.13847). This is a multi-centre UK study to assess the effectiveness of insulin glargine 300 units/ml in treating people with Type 1 diabetes mellitus in routine clinical practice. Dr Steve Jenkins (consultant Haematologist) was successful in his application to the CRN for the post of Research Scholar. This was a competitive process and will facilitate his development as a chief investigator and the CRN will fund two of his sessions to enable this.

3. National developments and performance management

High level objectives

We are currently meeting our HLO1, patient recruitment (currently 104% of target) and activity based funding (ABF), at 103% of target, has increased from June 2018. Our current performance for HLO2 'recruitment to time and target' is at 75% (previously 60%). Performance against HLO4 'time taken to confirm site' (40 days of receiving an initial Health Research Authority assessment letter and full set of documents from the Sponsor), we are rated at 57% (previously 63%). From 'site confirmed to first patient recruited' we are ranked 14/22 West Midlands Trusts.

Research studies

Year	Total number of studies recruiting	Commercial contract studies
2015/16	92	19
2016/17	98	19
2017/18	102	18
% change from 2015/16	11%	-5.3%

Participant involvement in research studies

Year	Total participants in studies	Participants in commercial contract studies
2015/16	1358	120
2016/17	1584	81
2017/18	1660	177
% change from 2015/16	22.3%	47.5%

Please see attached Appendix #2 for NIHR West Midlands Trust League tables.

4. Capacity for research support departments

Procurement and IT approvals continue to delay some studies opening due to approval of research equipment, even though requirements are now sent out to these departments at an earlier stage of study review.

The Clinical Trials Pharmacist vacancy (first advert out July 2018) has proved difficult to recruit to (and appears to be a regional/national problem). Interviews are now to take place 26th November 2018 for this post. This has had a significant impact on the number of new studies that require pharmacy involvement, to be set up and opened since May 2018. We have had to decline approx. 4 studies due to the current capacity within the clinical trials team within pharmacy.

5. Finance and Staffing

The EDGE finance tool has been rolled successfully providing us with the ability to manage income and expenditure more efficiently. We are now able to forecast future income using this database tool. This will be promoted at external local and national meetings/conferences.

We have reviewed current department staff and developed a 2 year plan with identified cost savings equating to approx. £60,000, whilst incorporating staff development roles and a wider skill mix to attempt to retain staff in the department.

6. Electronic Patient Record/IT/Archiving

R&D is represented at the EPR meetings. An ‘alert flag’ for patients participating in research has been developed and is pending final approval.

Some external space at Foxes has been secured to store long term clinical trial data – pending decision as to whether this can now still be used (Space Utilisation Group).

7. General Data Protection Regulations – readiness for research

Amendments have been made to Trust sponsored studies, as required to comply with GDPR Information has also been published on the Trust website and The Hub.

8. Education/Professional Development/Promotion/Service Improvement

The Student Nurse Mentor Programme with Wolverhampton University continues within R&D with positive feedback. Regular presentations also continue and have been delivered at Student Nurse Inductions. Cohorts for 2nd and 3rd year student nurses attend a half day research orientated study session, led by R&D Team. The focus is to embed evidence based practice into their clinical activities from the outset. Introduction to research studies and current activities are reported at CNS Forum monthly meetings.

We continue to support MSc and PhD students from Birmingham University, Warwick University and Wolverhampton University, undertaking single centre or multi centre studies recruiting patients from the Trust.

Lunchtime Research Club meetings were now well established and advertised on the R&D website on the Hub. The aim of these meetings is to support any Trust staff undertaking a research project (MSc/PhD/Audits/Service Evaluations).
Dudley-based half-day refresher courses in Good Clinical Practice for research purposes continue to be led by Margaret Marriott. GCP Fundamentals and PI Master Class are also available.
We have looked at where we can re-structure in the department to be able to offer development opportunities for existing staff to promote career/personal development and staff retention e.g. Research Support Officer, band 4 to Research Co-ordinator (band 5), Data Manager (band 4) to Clinical Research Practitioner (band 5), development post for Research Support Officer, development post for Clinical Trials Pharmacist. We currently have staff undertaking further training as band 7 lead Research Nurse, band 6 nurse development programme, R&D Manager Developing Leaders programme

Secondment opportunities have been introduced within the department, combining clinical practice with research activity and have been successful so far in terms of professional development and career progression. We would like to promote and progress this further, across the Trust in other specialties in the future.

A regular R&D newsletter is also available and accessible on the Hub. This is circulated to all leads and Community Staff.

The R&D pages on The Hub continue to be updated on a regular basis, and the Trust's external website to be updated soon to promote R&D more widely.

The department is now also involved in The New Interventions/Innovations Group Trust-wide, ensuring good clinical practice and patient experience is integrated within the process.

We now have specific R&D Friends & Family forms and post box in place.

Publications

142 publications January 2018 – November 2018. See appendix #1.

The Dudley Group NHS
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Appendix #1 - Published research - January to November 2018

1. Abdullah, M., B. McWilliams and S. U. Khan (2018). "Reliability of the Laboratory Risk Indicator in Necrotising Fasciitis (LRINEC) score." The surgeon : journal of the Royal Colleges of Surgeons of Edinburgh and Ireland.

2. Adizie, T., N. Barkham, S. Elamanchi, A. Prabu, A. V. Pace and R. Laxminarayan (2018). "Knowledge of features of inflammatory back pain in primary care in the West Midlands: a cross-sectional survey in the United Kingdom." Rheumatology International 38(10): 1859-1863.

3. Adlan, A. M., J. Veldhuijzen van Zanten, G. Y. H. Lip, J. F. R. Paton, G. D. Kitas and J. P. Fisher (2018). "Acute hydrocortisone administration reduces cardiovagal baroreflex sensitivity and heart rate variability in young men." The Journal of physiology 596(20): 4847-4861.

4. Agha, A., H. Bajwa, L. Bloomer, W. Walker, H. Horrobin, J. Vamvakopoulos and H. Siddique (2018). "Venous thromboembolism prophylaxis in patient with diabetes-related acute Charcot's arthropathy on total contact cast: A need for protocol." Diabetic Medicine 35: 137.

5. Agha, A. and W. Hanif (2018). "Assessing burnout syndrome among diabetes specialist trainee registrars across England, Scotland and Wales." Diabetic Medicine 35: 177.

6. Al Shakarchi, J. and N. Inston "Early cannulation grafts for haemodialysis: An updated systematic review." The journal of vascular access: 1129729818776571.

7. Alam, B. M. A., C. Koutsianas and H. John (2018). "The use of musculoskeletal ultrasound in new outpatient management: Experience from a single centre." Rheumatology (United Kingdom) 57.

8. Baker, G., S. Smith, M. Lacucci, U. Shivaji, J. O'Rourke, S. Ghosh, B. Lethebe, J. Saltzman, A. Bannaga, A. McCulloch, D. Geh, F. Tahir, H. Fowler, M. Qurashi, P. Lim, S. Khan, T. Gupta, A. Kumar, B. Polewiaowska, M. Widlak and P. Harvey (2018). "The prediction of diminutive/small polyp histology using didactic vs computer based training in gastroenterology trainees." Gut 67.

9. Barnes, T., E. Wong, S. Young-Min, K. Thakrar, K. Douglas, F. Glen, K. Marchbank and A. Ingram (2018). "Switching stable rheumatology patients from an originator biologic to a biosimilar: Resource cost in the UK." Rheumatology (United Kingdom) 57.

10. Barrett-Lee, J., J. Vatish, M. Vazirian-Zadeh and P. Waterland (2018). "Routine blood group and antibody screening prior to emergency laparoscopy." Annals of the Royal College of Surgeons of England 100(4): 322-325.

11. Bashar, K., M. Medani, T. Aherne, T. Moloney, H. Bashar, K. Ahmed and S. R. Walsh (2018). "End-To-Side versus Side-To-Side Anastomosis in Upper Limb

Arteriovenous Fistula for Dialysis Access: A Systematic Review and a Meta-Analysis." Annals of Vascular Surgery 47: 43-53.

12. Brouwer, T. F., R. E. Knops, V. Kutyifa, C. Barr, B. Mondésert, L. V. A. Boersma, P. D. Lambiase, N. Wold, P. W. Jones and J. S. Healey (2018). "Propensity score matched comparison of subcutaneous and transvenous implantable cardioverter-defibrillator therapy in the SIMPLE and EFFORTLESS studies." EP: Europace 20(FI2).

13. Brunning, T. and S. Saba (2018). "Morale and welfare in hospital doctors." British Journal of Hospital Medicine (17508460) 79(5): 244-245.

14. Cadoni, S., P. Gallittu, M. Liggi, D. Mura, L. Fuccio, M. Koo and S. Ishaq (2018). "Underwater endoscopic colorectal polyp resection: Feasibility in everyday clinical practice." United European Gastroenterology Journal 6(3): 454-462.

15. Cadoni, S., C. Hassan, L. Frazzoni, S. Ishaq and F. W. Leung (2018). "Impact of water exchange colonoscopy on endoscopy room efficiency: a systematic review and meta-analysis." Gastrointestinal Endoscopy.

16. Cadoni, S. and S. Ishaq (2018). "How to perform water-aided colonoscopy, with differences between water immersion and water exchange: a teaching video demonstration." VideoGIE 3(5): 169-170.

17. Cadoni, S., M. Liggi, P. Gallittu, D. Mura, L. Fuccio, M. Koo and S. Ishaq (2018). "Underwater endoscopic colorectal polyp resection: Feasibility in everyday clinical practice." United European Gastroenterology Journal 6(3): 454-462.

18. Calderbank, T., A. Karim, M. Wall, A. Syed, R. S. M. Davies and A. Saratzis (2018). "The Effect of Malignancy on Outcomes Following Revascularization for Critical Limb Ischemia: A Case-Control Study." Vascular and Endovascular Surgery.

19. Chaudhry, F. A., S. Z. Ismail and E. T. Davis (2018). "A new system of computer-assisted navigation leading to reduction in operating time in uncemented total hip replacement in a matched population." European Journal of Orthopaedic Surgery and Traumatology 28(4): 645-648.

20. Cooney, H. J., H. E. Banbury and A. C. Plunkett (2018). "Impact of a Hands-free Wireless Communication Device on Communication and Clinical Outcomes in a Pediatric Intensive Care." Pediatric quality & safety 3(2): e074.

21. Crowson, C. S., S. E. Gabriel, E. L. Matteson, S. Rollefstad, E. Ikdahl, T. K. Kvien, A. G. Semb, G. D. Kitas, K. Douglas, A. Sandoo, P. L. C. M. Van Riel, E. Arts, S. Wallberg-Jonsson, L. Innala, G. Karpouzas, P. H. Dessein, L. Tsang, H. El-Gabalawy, C. Hitchon, V. P. Ramos, I. C. Yanez, P. P. Sfkakis, E. Zampeli, M. A. Gonzalez-Gay, A. Corrales, M. Van De Laar, H. E. Vonkeman and I. Meek (2018). "Impact of risk factors associated with cardiovascular outcomes in patients with rheumatoid arthritis." Annals of the Rheumatic Diseases 77(1): 48-54.

22. Douglas, K. M. J. (2018). "Why does peer review matter? Benefits to patients, clinicians and the wider profession." Rheumatology (United Kingdom) 57.

23. Duarte, R. V., T. Lambe, L. Andronis, J. H. Raphael and S. Eldabe (2018). "Intrathecal Drug Delivery Systems for the Management of Chronic Noncancer Pain: A Systematic Review of Economic Evaluations." Pain Practice 18(5): 666-686.

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Hospitals, N. H. S. F. T. Oxford University Hospitals, N. H. S. F. T. Papworth Hospital, N. H. S. T. Pennine Acute, N. H. S. T. Plymouth Hospitals, N. H. S. F. T. Poole Hospital, N. H. S. T. Portsmouth Hospitals, N. H. S. T. Princess Alexandra Hospital, N. H. S. F. T. Queen Elizabeth Hospital, N. H. S. F. T. Queen Victoria Hospital, J. Robert, T. Agnes Hunt Orthopaedic Hospital Foundation, N. H. S. F. T. Rotherham, N. H. S. F. T. Royal Berkshire, B. Royal, N. H. S. F. T. Christchurch Hospitals, N. H. S. T. Royal Cornwall Hospitals, D. Royal, N. H. S. F. T. Exeter, N. H. S. F. T. Royal Free London, L. Royal, N. H. S. T. Broadgreen University Hospitals, N. H. S. F. T. Royal Marsden, N. H. S. T. Royal National Orthopaedic Hospital, N. H. S. F. T. Royal Orthopaedic Hospital, N. H. S. F. T. Royal Surrey County Hospital, N. H. S. T. Royal United Hospitals Bath, N. H. S. T. Royal Wolverhampton Hospitals, N. H. S. F. T. Salford Royal, N. H. S. F. T. Salisbury, Sandwell, N. H. S. T. West Birmingham Hospitals, N. H. S. F. T. Sheffield Teaching Hospitals, Shrewsbury, N. H. S. T. Telford Hospital, H. South Eastern, T. Social Care, Southport, N. H. S. T. Ormskirk Hospital, N. H. S. F. T. South Tees Hospitals, N. H. S. F. T. South Tyneside, N. H. S. F. T. South Warwickshire, N. H. S. T. St George's Healthcare, H. St, N. H. S. T. Knowsley Teaching Hospitals, N. H. S. F. T. Stockport, Surrey, N. H. S. T. Sussex Healthcare, N. H. S. F. T. Tameside Hospital, Taunton, N. H. S. F. T. Somerset, Torbay, N. H. S. F. T. South Devon, N. H. S. T. United Lincolnshire Hospitals, N. H. S. F. T. University College London Hospitals, N. H. S. T. University Hospital of North Midlands, N. H. S. F. T. University Hospital of South Manchester, N. H. S. F. T. University Hospitals Birmingham, N. H. S. F. T. University Hospitals Bristol, C. University Hospitals, N. H. S. T. Warwickshire, N. H. S. T. University Hospitals of Leicester, N. H. S. F. T. University Hospitals of Morecambe Bay, N. H. S. F. T. University Hospital Southampton, N. H. S. T. Walsall Healthcare, Warrington, N. H. S. F. T. Halton Hospitals, H. Western, T. Social Care, N. H. S. F. T. Western Sussex Hospitals, N. H. S. T. West Herts Hospitals, N. H. S. T. Weston Area Health, N. H. S. F. T. West Suffolk, N. H. S. T. Whittington Hospital, N. H. S. F. T. Wirral University Teaching Hospital, N. H. S. T. Worcestershire Acute Hospitals, W. Wrightington, N. H. S. F. T. Leigh, N. H. S. T. Wye Valley, N. H. S. F. T. Yeovil District Hospital and N. H. S. F. T. York Teaching Hospital (2018). "Cancelled operations: a 7-day cohort study of planned adult inpatient surgery in 245 UK National Health Service hospitals." British Journal of Anaesthesia 121(4): 730-738.

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Appendix #1 – NIHR West Midlands League Tables 2017/18

	NIHR Research Activity League Table 2017-2018				
The NIHR Research Activity League Table is published by the National Institute of Health Research (NIHR) Clinical Research Network (CRN). It shows the extent of research activity across all NHS trusts in England, providing a picture of how much clinical research is happening, where, in what types of trusts, and involving how many participants.					
				in order	
Trust Name/CCG	Type	Local network	No. of studies recruiting 2016/17	No. of studies recruiting 2017/18	% change
University Hospitals Birmingham NHS Foundation Trust	Acute	West Midlands	308	298	-3.20%
Heart of England NHS Foundation Trust	Acute	West Midlands	171	190	11.10%
University Hospitals of North Midlands NHS Trust*	Acute	West Midlands	156	176	12.80%
University Hospitals Coventry and Warwickshire NHS Trust	Acute	West Midlands	155	157	1.30%
The Royal Wolverhampton NHS Trust*	Acute	West Midlands	155	150	-3.20%
Birmingham Women's and Children's NHS Foundation Trust*	Acute	West Midlands	143	177	23.80%
Sandwell and West Birmingham Hospitals NHS Trust	Acute	West Midlands	101	108	6.90%
The Dudley Group NHS Foundation Trust	Acute	West Midlands	98	102	4.10%
Shrewsbury and Telford Hospital NHS Trust	Acute	West Midlands	101	96	-5.00%
Worcestershire Acute Hospitals NHS Trust	Acute	West Midlands	62	56	-9.70%
Burton Hospitals NHS Foundation Trust	Acute	West Midlands	48	51	6.30%
Wye Valley NHS Trust	Acute	West Midlands	41	45	9.80%
Staffordshire and Stoke On Trent Partnership NHS Trust	Care	West Midlands	39	44	12.80%
Walsall Healthcare NHS Trust	Acute	West Midlands	36	41	13.90%
South Warwickshire NHS Foundation Trust	Acute	West Midlands	32	36	12.50%

The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust	Acute	West Midlands	28	36	28.60%
George Eliot Hospital NHS Trust	Acute	West Midlands	30	35	16.70%
South Staffordshire and Shropshire Healthcare NHS Foundation Trust	Mental Health	West Midlands	34	31	-8.80%
Birmingham and Solihull Mental Health NHS Foundation Trust	Mental Health	West Midlands	28	30	7.10%
The Royal Orthopaedic Hospital NHS Foundation Trust	Acute	West Midlands	24	25	4.20%
Birmingham Community Healthcare NHS Foundation Trust*	Care	West Midlands	18	25	38.90%
Coventry and Warwickshire Partnership NHS Trust	Mental Health	West Midlands	25	24	-4.00%
Black Country Partnership NHS Foundation Trust*	Mental Health	West Midlands	16	17	6.30%
Worcestershire Health and Care NHS Trust	Care	West Midlands	12	14	16.70%
Dudley and Walsall Mental Health Partnership NHS Trust	Mental Health	West Midlands	12	13	8.30%
North Staffordshire Combined Healthcare NHS Trust	Mental Health	West Midlands	12	9	-25.00%

Enclosure 21

The Dudley Group
NHS Foundation Trust

Paper for submission to the Trust Board on December 2018

TITLE:	**Digital Trust Programme Committee Update**		
AUTHOR:	**Mark Stanton CIO**	**PRESENTER**	**Richard Welford**

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 THE BOARD

Decision	Approval	Discussion	Other
	Y		

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

- Approval of the new DTPC governance arrangements
- Note the change to the programme delivery dates and provide support in terms of prioritisation with other Trust activity.

CORPORATE OBJECTIVE:

SO5: Make the best use of what we have
SO6: Deliver a viable future

SUMMARY OF KEY ISSUES:

DTPC governance

The Digital Trust Programme Committee (DTPC) was formed primarily to support the Business case and procurement process for the provision of an Electronic Patient Record and initiate and govern the project which it has successfully delivered. However, the DTPC has become operationally focused, and is duplicating activity undertaken elsewhere.

Moving forward the Digital strategy needs embedding into other deliveries, such as the MCP, and will be an enabler in the Lean practice. Therefore, the DTPC needs to take a wider view of the Digital strategy of the Trust, and not just the EPR programme. This also supports the focus proposed by the Secretary of State for Health and Social Care.

To facilitate this then it is proposal to move the Operational elements of the DTPC to an IT steering group and a change to the Terms of Reference for the DTPC to focus on the oversight of the Digital strategy.

In addition, the governance schedule will be changed to facilitate better participation from Clinical and Executive leadership.

In summary:

- We will disband the Sunrise Project group which was focused on project activity around Sunrise, this is now covered off in IT weekly programme meetings.
- Create an IT Steering group to operationally manage IT resource and project activity and monitor associated KPI's.
- Refocus the DTPC on the strategic direction described in the TOR.

Digital Trust Programme Deliverables

The Digital Trust Programme continues to deliver the progressive digitalisation of clinical systems (see paper for details). The programme is still forecast to deliver to the original budget with completion in 19/20, however the phasing is being realigned to resources to balance support and delivery activity:

ED – January 2019
Orders Results Management – January 2019
eObs enhancements – January 2019
ePMA - March 2019

Theatres – Q2 19/20 (TBC)
Maternity – Q2 19/20 (TBC)

Population Health Business Case

The committee reviewed the proposed business case for the Population Health IT project, along with the associated strategy document. The significance of this project to the Trust's strategy for the MCP should be noted. Likewise, the successful award by the CCG of this business to represents important recognition of TeraFirma's value as a partner to the MCP initiative.
The committee recommends that the Board of Directors approves this business case.

Further Discussions with Finance after the committee meeting have identified an issue with capitalisation of pre-paid support which will be re-presented at Executive Directors

The Dudley Group
NHS Foundation Trust

IMPLICATIONS OF PAPER:			
RISK	**Y**		**Risk Description: COR089** EPR programme is delayed or fails to deliver benefits
	Risk Register: Y		**Risk Score**
COMPLIANCE and/or LEGAL REQUIREMENTS	**CQC**	**N**	**Details:**
	NHSI	**N**	**Details:**
	Other	**Y**	**Details:** DCB0160 Clinical risk management (section 250 of Health and social care act 2012)

The Dudley Group NHS Foundation Trust

Committee Highlights Summary to Board
July 2018

Committee	Meeting Date	Chair	Quorate	
			yes	no
Digital Trust Programme Committee	21st November 2018	Richard Welford	X	

Declarations of Interest Made

None

Assurances received

Project Status – Digital Trust Programme

Delivery

NEWS2 went live on 8/11/18, The technology delivery was successful, and adoption was supported by the Clinical teams for familiarisation with the new scoring system. It should be noted that NEWS2 was partially delivered in the NEWS1 rollout in May therefore changes from a user perspective were relatively minor.

Business Intelligence

The BIGDATA team continue to provide support to ED in both the development of real-time reporting and understanding the data. A full set of kitemarked Operational and Management reports for eObs are now in full production with eSepsis dashboards to follow this month.

Matrons have been given access to the dashboard to manage eObs compliance at a local level.

Devices

Adoption of Tablet devices is inconsistent across the Trust with a preference for Clinical staff wanting to use Workstations on Wheels (WOW's) which are high cost and limited in quantity The CNIO is undertaking an exercise in engaging with each ward individually and understanding the blockers to using the tablets, where possible we are untethering the devices from the observations carts so Nursing staff can use them as hand held (or with a shoulder strap). We are currently piloting charging banks in ED and C5 and looking for lower cost's options. Usages of the WOW's and other PC devices is good. It should be acknowledged that the Tablet devices are just Version 1 and will continue to develop and improve utilizing feedback from clinical teams.

Project Phases

ED – January 2019
Orders Results Management – January 2019
eObs enhancements – January 2019

ePMA - March 2019

Theatres – Q2 19/20 (TBC)
Maternity – Q2 19/20 (TBC)

Programme Risk

The programme risks (and associated BAF entries) are to reviewed and amended to reflect the current status of the programme. For instance, the risk of programme delivery is currently captured under a single BAF entry – it is more realistic to recognise the multiple phases as different risk profiles. This should reduce the overall risk rating (down from a score of 20 today). Likewise, the loss of the Programme Director to the Lean practice has meant that role is being split between the CIO and Digital Strategy Director to mitigate the risk to the Digital Trust programme – this is impacting the programme schedule, and will potentially limit bandwidth for other high-level IT activity for the next 6-12 months.

Change to the Digital Trust Governance Arrangements

The Digital Trust Programme Committee to date has been focused primarily on the deployment of the Sunrise EPR and at times had got to a relatively detailed level.

Moving forward the Digital strategy needs embedding into other deliveries i such as the MCP and will be an enabler in the Lean practice therefore the DTPC needs to take a wider view of the Digital strategy of the Trust not just the EPR.

The new Secretary of State for health and social care has a focus on Digital adoption with healthcare recently recommending that all Trust boards include a CIO (Note DGFT has had a board level CIO for nearly 3 years) with all IT funding coming through innovation programmes and schemes.

In order for the Digital Trust Programme Committee to be focused on the oversight of Strategic IT then it is proposed to make some changes to the groups reporting into the committee:

1. Disband the Sunrise Project Group – This was formed to manage the EPR rollout plan. However, now we are in delivery phase, this meeting is largely redundant and not timely enough for decision making (which often needs to be daily).
2. Form an IT steering group chaired by the CIO; this group will provide oversight for the project portfolio, service performance and reviewing project requests. This meeting will take place monthly.
3. Digital Trust Programme Committee (DTPC) to focus on driving the right strategic oversight of IT. This meeting will take place every two months, and is proposed to be held on the same day as the Trust Board of Directors meeting (schedule TBC) .
4. TeraFirma (TF) “Board” meetings, to review TF performance and direction, will be taking place quarterly starting from 2019 (schedule TBC).

It should also be noted that lack of Executive participation was discussed again at this committee meeting – the revised schedule and cadence is intended in part to assist with apparent schedule clashes.
Similarly, the expectation of clinical representation was discussed. The meeting was informed about the challenge of maintaining corporate meeting responsibilities in the time made available. It was reiterated that clinical representation in the Digital Trust initiatives was

crucial, but the Chair committed to raising the issue for discussion at the next Board of Directors meeting.

Population Health Business Case

The committee reviewed the proposed business case for the Population Health IT project, along with the associated strategy document.

The significance of this project to the Trust's strategy for the MCP should be noted. Likewise, the successful award by the CCG of this business to represents important recognition of TeraFirma's value as a partner to the MCP initiative.

The committee recommends that the Board of Directors approves this business case.

Further Discussions with Finance after the committee meeting have identified an issue with capitalisation of pre-paid support which will be re-presented at Executive Directors

Decisions Made / Items Approved
• Change to DTPC governance arrangements.
Actions to come back to Committee (items Committee keeping an eye on)
• Improved Clinical and Executive leadership attendance at the DTPC.
Items referred to the Board for decision or action
• Approval and support for the new IT governance arrangements. • Approval of the Population Health business case.
Comments relating to the DTPC from the CCIO
Current timings of DTPC are resulting in poor attendance and underrepresentation by Clinical and Executive leaders; meetings will be re-scheduled as part of new governance arrangements.
Comments relating to the DTPC from the CNIO

None

The Dudley Group NHS
NHS Foundation Trust

Digital Trust Programme Committee

TERMS OF REFERENCE

The Programme will cover the delivery of the Digital Trust Programme and the strategic direction of Technology within the Trust

1. **Alignment of the Digital Strategy to the DGFT 5-year plan.**
2. ***Allscripts Sunrise EPR* – Oversight of the delivery of an Electronic Patient Records (EPR) solution as defined in the Full Business Case presented to the Trust Board November 2016**
3. ***Strategic projects* – The approval and oversight of Key IT projects across the Trust.**
4. ***Oversight of internal and external forces (such as market and industry trends) that shape current technology requirements and innovations as well as the future forces expected to shape the digital landscape***

1. Constitution

1.1 The Trust Board resolves to establish a reporting group to be known as The Digital Trust Programme Committee. The DTPC in its workings will be required to adhere to these Terms of Reference and has no delegated powers outside of these.

2. Membership

Non-Executive Director (Chair)
Non-Executive Director
Finance Director
Medical Director
Director of Strategy and Performance
Directors of Operations (Medicine, Surgery, clinical support)
Chief of Medicine
Chief of Surgery
Chief Nurse
Digital Strategy Director
Chief Information Officer
Chief Clinical Information Officer
Caldecott Guardian

3. Attendance

3.1 All other members of the Trust Board shall be entitled to attend and receive papers to be considered by the DTPC.

3.2 It is expected that all members attend the Programme Committee meeting. Where this is not possible through annual leave, sickness or other circumstances an appropriate deputy or representative may be asked to attend.

3.2 Other managers/staff may be invited to attend meetings depending upon issues under discussion.

4. Quorum

4.1 A quorum shall be four members of the DTPC one of whom must be a Non-Executive Director, an Executive Director (other than the CIO), CIO or CCIO, A senior clinician, Director of Operations.

5. Frequency of Meetings

5.1 The DTPC will meet every 2 months
5.2 Additional meetings may be required at short notice if urgent decisions are required. Under these circumstances, matters may be considered by email, tele-conference, or meetings as appropriate.
5.3 Papers will be issued at least a week before meetings.
5.4 The membership reserves the right to cancel or change the date of scheduled meetings.

6. Authority

6.1 The DTPC is authorised by the Trust Board to investigate any activity within its terms of reference.

7. Duties

item	TOR Duties	Agenda Item
1	Provide a forum for cross functional strategic oversight of the Trust's Digital Strategy.	Welcome, introductions, confirmation of quoracy, and record of any apologies.
2	N/A	Declarations of interest that may be of conflict with any item on today's agenda.
3	Accurate reporting of the committee review process and resulting actions.	Review of previous minutes, matters arising and actions points.
4	Maintain an accurate reflection of the risks associated with delivery of the DGFT Digital Strategy. Define risk containment and mitigation actions to reduce or eliminate risk. Report and escalate risk management to the DGFT Board.	**Board Assurance Framework (BAF) and Corporate Risk (COR) register report** – specifically review progress against the actions agreed, current status, needs for additional action / escalation, and agree any proposed changes to risk scores (reflecting the status to be reported to the next executive management risk and assurance group meeting).
5	Oversee the development and execution of the DGFT Digital Strategy, including the progression of agreed IT projects, and the review of strategic gaps identified. Provide guidance on priorities relating to project delivery.	**Digital Trust Strategy** • Review of the alignment of the Digital Trust Strategy to the Trust's business objectives (current FY). • Receive reports from the committee sub-groups, including the ITSG (to include IT Projects Groups) o Review of projects supporting

		delivery of the Digital Trust Strategy, including Project Sunrise (business case, delivery to plan, performance against budget, risks to delivery, change requests etc.) • Review of strategic gaps identified, and proposed response. • Preparation for Digital Trust Strategy in line with the anticipated DGFT business objectives (next FY – tracking of output from the annual DGFT strategy process, and proactive review of likely Digital Strategy impacts. Also track any external impact to Digital Strategy (such as GDPR/IG)).
7		**AOB**
8	See item 5.	**Revisit the Board Assurance Framework (BAF) and Corporate Risk (COR) register report** – specifically any new / additional items that need to be registered or escalated, including proposed actions as appropriate, based on items reviewed during the meeting.
9	Provide a regular update of items under the scope of the DTPC to the DGFT Board.	**Items to be reported to the Board**
10	N/A	**Reflections on the meeting**
11	N/A	**Close of meeting and date of the next meeting**

8. Reporting

8.1 The DTPB reports to the Trust Board and will produce a report following each meeting for presentation at the Trust board. , IT Projects steering, and Medical Devices Group will report to the DTPC.

9. Review

9.1 The Terms of Reference of the Board shall be reviewed by The Trust Board at least annually.

Enclosure 22

The Dudley Group
NHS Foundation Trust

Paper for submission to the Board of Director on 6 December 2018

TITLE:	**19 November 2018 Audit Committee Summary Report to the Board**		
AUTHOR:	Richard Miner – Committee Chair	**PRESENTER:**	Richard Miner – 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.*

ACTION REQUIRED OF BOARD :

Decision	Approval	Discussion	Other
		Y	**Y**

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:

To note the assurances received via the Committee, the decision taken in accordance with the Committee's terms of reference and action any items referred to the Board.

CORPORATE OBJECTIVE:

All

SUMMARY OF KEY ISSUES:

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

IMPLICATIONS OF PAPER:

RISK	**N**	**Risk Description:**
	Risk Register: N	**Risk Score:**

COMPLIANCE and/or LEGAL REQUIREMENTS	**CQC**	**Y**	**Details:** Links to all domains
	NHSI	**Y/N**	**Details:** Links to good governance
	Other	**N**	**Details:**

Audit Committee highlights report to Board of Directors

Meeting	Meeting Date	Chair	Quorate	
Audit Committee	**19/11/2018**	**Richard Miner**	**yes**	**no**
			x	

Declarations of Interest Made

None

Assurances Received

In respect of completed internal audit reports

- Cost Improvement Programme - Quality Impact Assessments – Reasonable assurance
- Quality Improvement Programme – Financial Delivery – Partial Assurance
- Payments to staff – Substantial Assurance
- Clinical Audit – Reasonable Assurance
-

116 out of 130 Internal Audit recommendations have been closed but 12 remain open and 2 are pending. This is an improvement and there have been no extended dates since the last Audit Committee, but the Director of Finance has been asked to ensure that for the next meeting we have definite actions to clear old and late items.

Progress against the 2018/19 counter fraud plan and that objectives are being met.

That the external auditors are at an early stage of planning the 2018/19 External Audit with the detailed plan and proposed fees due to come to the January 2019 Audit Committee.

The improvement in the level of 2018/19 clinical audits.

The latest iteration of the Business Assurance Framework (BAF) with revised assurances, controls and direction of travel and for further consideration by the Board. 7 risk scores have been increased and in the case of risks 564, 567, 565 and 569 it has not been possible to reduce them due to gaps in assurance.

That losses and special payments remain within acceptable parameters.

Decisions made/Items approved

- Revisions to the 2018/19 Internal Audit Plan which includes work on Learning from Deaths, Data Quality and various clinical processes
- Changes to the 2018/19 Clinical Audit Plan which include the removal of 17 audits noting that rationale for removal was agreed by the clinical effectiveness group, with the approval of the medical director as well as CQSPE.
- Approval of the Caldicott and Information Governance Group terms of reference
- Agreed the closure of BAF608 – that the MCP bid fails
- Approved minor changes to the Audit Committee's Terms of Reference.
- Approved the revised Standing Financial Instructions.
- Approved the procedural document in respect of 2 policies – Misconduct and Fraud Research and Freedom of Information.

Audit Committee highlights report to Board of Directors

Actions to come back to Committee / Group (Items Committee / Group keeping an eye on)

- The gaps in assurance against the risks highlighted above to go back to F&P.
- The 16 overdue Internal Audit recommendations which will come back to the January Committee.
- Recommendations arising from last year's external audit work and process for follow up which should come through in January when the External Audit plan is agreed.
- External audit fee proposals for 2018/19 in the light of possible changes to the External Audit Plan.
- Performance issues around the CIP process which needs to be more robust.

Items referred to the Board / Parent Committee for decision or action

- The need to establish an internal governance structure to specifically monitor and control MCP risks.
- That further work is required on the Business Assurance Framework (BAF)/Corporate Risk Register and to be considered at the Board Workshop on 11 December. In particular, the Committee considers its role is to derive assurance over the process (in order to assure the Board) and that the right process is in place for identifying emerging risks – an oversight role. The Committee also recommends that that the BAF should be moved "up the agenda" for both Committees and the Board to ensure it receives sufficient time and focus.
- Consideration of changes to the way in which the valuation of buildings is applied for accounting purposes.
- Approval of the Standing Financial Instructions Annual Review 2018