The Dudley Group
NHS Foundation Trust

Public Board of Directors Meeting

Thursday 4th July 2019

12noon – 2.25pm

Meeting rooms 7 & 8,
Clinical Education Centre,
First Floor, South Block,
Russells Hall Hospital

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:

Helen Forrester
Executive Officer
The Dudley Group NHS Foundation Trust
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Gilbert George
Inteim Director of Governance/ Board Secretary
The Dudley Group NHS Foundation Trust
Tel: 01384 321114 ext 1114
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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 4th July, 2019 at 12.00noon
Clinical Education Centre
AGENDA

Meeting in Public Session

All matters are for discussion / decision except where noted

	Item	Enc. No.	By	Item Related to Strategic Objective	Action	Time
11.	**Chairmans Welcome and Note of Apologies**		Y Buckland		To Note	12.00
12.	**Declarations of Interest** Standing declaration to be reviewed against agenda items.		Y Buckland		To Note	12.00
13.	**Announcements**		Y Buckland		To Note	12.00
14.	**Minutes of the previous meeting**					
	14.1 Thursday 6 June 2019	Enclosure 11	Y Buckland		To Approve	12.00
	14.2 Action Sheet 6 June 2019	Enclosure 12	Y Buckland		To Action	12.05
15.	**Staff Story**	Video	L Abbiss		To Note & Discuss	12.10
16.	**Board Assurance Framework**	Enclosure 13	G Gilbert		To Discuss	12.20
	Corporate Risk Register	Enclosure 14	M Sexton			12.30
17.	**Chief Executive's Overview Report**	Enclosure 15	D Wake	All	To Discuss	12.40
18.	**Safe and Caring**					
	18.1 Chief Nurse Report	Enclosure 16	M Sexton	SO1&2	To note assurances & discuss any actions	12.50
	18.2 Clinical Quality, Safety, Patient Experience Committee Report	Enclosure 17	M Sexton	All	To note & discuss	1.00
	18.3 Annual Infection Control Report	Enclosure 18	M Sexton	All	To note assurances & discuss actions	1.10

	18.4 7 Day Services/Critical Care Update Report	Enclosure 19	P Hudson		For Assurance	1.20
	18.5 Inpatient Survey Report	Enclosure 20	M Sexton		To note & discuss	1.30
19.	**Responsive and Effective**					
	19.1 Integrated Performance Dashboard	Enclosure 21	K Kelly	SO1,2,4,5,6	To note assurances & discuss any actions	1.40
	19.2 Finance and Performance Committee Exception report	Enclosure 22	J Hodgkin	SO6	To note assurances & discuss actions	1.50
20.	**Well Led**					
	20.1 Trust Constitution and Scheme of Delegation	Enclosure 23	G George		To Approve	2.00
	20.2 Charitable Funds Committee Report	Enclosure 24	J Atkins		To note	2.05
	20.3 Reinstatement of Workforce Committee Report	Enclosure 25	G George		To Approve	2.10
	20.4 Committee Membership Report	Enclosure 26	G George		To note	2.15
21.	**Any other Business**		Y Buckland			2.20
22.	**Reflection on Meeting**		Y Buckland			2.20
23.	**Date of Next Board of Directors Meeting** 5th September, 2019 Clinical Education Centre		Y Buckland			2.25
24.	**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).		Y Buckland			2.25

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

Enclosure 11

The Dudley Group NHS Foundation Trust

Minutes of the Public Board of Directors meeting held on Thursday 6th June, 2019, in the Clinical Education Centre.

Present:

Yve Buckland, Interim Chair
Julian Atkins, Non Executive Director
Richard Miner, Non Executive Director
Karen Kelly, Chief Operating Officer
Diane Wake, Chief Executive
Mary Sexton, Interim Chief Nurse
Jonathan Hodgkin, Non Executive Director
Julian Hobbs, Medical Director
Tom Jackson, Director of Finance

In Attendance:

Helen Forrester, EA
Gilbert George, Interim Director of Governance
Liz Abbiss, Head of Communications
Derek Eaves, Freedom to Speak Up Guardian (item 19/070.6)
Philippa Brazier, Freedom to Speak Up Guardian (item 19/070.6)
Babar Elahi, Guardian of Safe Working (item 19/070.7)
Jeff Neilson, Director of Research and Development (item 19/072.2)
Paul Hudson, Deputy Medical Director (item 19/072.3)

19/063 Note of Apologies and Welcome
11.43am

The Chairman welcomed members of the gallery. Apologies received from Catherine Holland, Adam Thomas, Andrew McMenemy and Natalie Younes.

19/064 Declarations of Interest
11.44am

The Chairman confirmed that she was also Chair of the Royal Orthopaedic Hospital, Pro-Chancellor of Aston University and Chair of the Tessa Jowell Act for Cancer Charity.

There were no other declarations of interest.

19/065 Announcements
11.40am

There were no announcements to note.

19/066 Minutes of the previous Board meeting held on 2nd May, 2019 (Enclosure 10)
11.42am

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

19/067 Action Sheet, 2nd May, 2019 (Enclosure 11)
11.45am

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

19/068 Patient Story
11.46am

Gail Parsons, Trauma and Orthopaedic Clinical Nurse Specialist, joined the meeting for the patient story.

The Head of Communications presented the patient story. This was from 2 patients that had received total knee replacements. The patients had experienced some issues with their recovery and had attended the Trauma and Orthopaedic Listening into Action event to share their experiences.

Gail welcomed the Listening into Action opportunity to hear about patients concerns which have been fed back to the MDT in order to consider the issues and how processes can be improved. Both patients will be invited back to the Trust in 6 months time to see the actions that have been taken from the learning.

Mr Miner emphasised the importance of communication.

The Chief Operating Officer raised the issue of physiotherapy. Gail confirmed that senior Physiotherapists now attend the post-operative joint schools. Expert patients are also being invited to attend the joint school to share their experiences.

The Interim Chief Nurse acknowledged that patients need to be seen holistically. Gail confirmed that the one patient had been a nurse so had enhanced knowledge which staff should have listened to.

Mr Atkins asked about the benefit from using Hydrotherapy. Gail confirmed that it had excellent benefits and all patients confirm they see positive results from using it. The Chairman suggested that we could explore opportunities for private use at evenings/weekends.

The Chief Executive thanked Gail for her excellent presentation.

The Director of Finance to consider opportunities for the use of the Hydrotherapy pool.

19/069 Chief Executive's Overview Report (Enclosure 12)
12.10pm

The Chief Executive presented her Overview Report given as Enclosure 12. This included the following highlights:

- Staff Committed to Excellence Awards: Taking place on the first Thursday in July. The Trust has received over 600 nominations for awards. One of the awards had been renamed in commemoration of Steve Ford.

- Sunrise: Successful launch as the Trust moves forward with becoming paperless.

- Healthcare Heroes: The Community Ear Nose and Throat Department were awarded 'team of the month' and the individual award was given to Fiona Freeman, Lead Nurse in the Acute Pain Team.

- Ramadan: The Trust had held an Iftar dinner with nearly 200 members of staff attending.

- Smoke Free: Went live at the Trust on Monday. The organisation is supporting staff and patients that smoke.

- Charity: Board members are encouraged to participate in the Neon Dash taking place on Sunday at Himley Park.

- Stroke Quarterly Report: Achieved Level A status for all indicators.

The Chairman and Board noted the report.

19/070 Safe and Caring

19/070.1 Chief Nurse Report (Enclosure 13)
12.16pm

The Interim Chief Nurse presented the Chief Nurse Report given as Enclosure 13.

The Board noted the following key issues:

- Celebrated International Nurses week across the organisation.

- Relaunched Nursing and Midwifery Strategy

- AHP update included in the paper. The Trust will have a visit from AHP national leads in July.

Mr Hodgkin asked about agency and bank usage. The Interim Chief Nurse confirmed that there are defined controls in place across the organisation and usage is now showing a gradual decrease. Monthly check and challenge sessions take place at a divisional level with all senior nurses.

The Chairman asked about the acuity tool. The Interim Chief Nurse confirmed that this now had traction and was providing excellent oversight on the position.

The Chief Executive confirmed that the Executive Team discuss the data in detail at each of their meetings.

The Chairman and Board noted the report and the actions underway.

19/070.2 Quality Accounts Report (Enclosure 14)
12.21pm

The Interim Chief Nurse presented the Quality Accounts Report given as Enclosure 14.

The Accounts are required to be published by 30th June. A summary of the position is included in the papers.

The Trust did not fully achieve all of the previous priorities and the Interim Chief Nurse is working with the teams to ensure that all priorities are achieved in year.

The Board noted the progress made in relation to avoidable pressure ulcers, nutrition and hydration and medications.

The Chairman asked about the priorities for 2019/20. The Interim Chief Nurse confirmed that they were the same headings but with different requirements under each heading.

The Chairman asked if the Governors have a priority. The Board noted that there was not a specific priority but Governors had been consulted.

The Chief Executive acknowledged the excellent infection prevention performance and reduction to serious incidents and how learning from incidents was becoming embedded across the Trust.

Mr Atkins welcomed the excellent Community pressure ulcer performance.

The Chairman and Board noted the report.

19/070.3 Staffing Skill Mix Review Update
12.28pm

The Interim Chief Nurse presented an update on the Staffing Skill Mix Review

The Board noted the following key issues:

- National Guidance: All organisations are required to undertake an annual staffing and skill mix review.

- Challenges: Balance between safety and cost, acuity and dependency, number of complex patients, unprecedented financial pressures and high cost agency usage and national shortage of nursing workforce.

- Trust Compliance and National Quality Board Guidance: The Trust is fully compliant.

- Safer Nursing Care Tool: This is one method that the Trust uses to determine optimal nurse staffing levels.

- Acuity and Dependency Study: Undertaken in May 2019.

- Study Results: Thirteen wards have ratios above the recommended level. A total of 49 WTE reduction was identified which equates to £1.6m financial savings. No ward will have more than 7 patients to one registered nurse during the day. The Medical Director stated that it would be good to see the data for senior nurse staffing over the weekend. The Chief Executive confirmed that the Trust has a greater number of Band 6 nurses than other organisations. The Board noted that the Trust had invested in and increased the number of Sepsis nurses available within the organisation and was also investing in its Hospital at Night team.

- Divisional breakdown of data provided by area.

- Board recommendations: Noted work undertaken and support the use of the acuity and dependency study results, professional judgement and CHPPD in staffing establishment reviews. Support the proposed nurse/patient ratio for 2019/20 and the reduction of 49 WTE from identified wards/units and achieve the financial saving of £1.6m as a result.

Mr Miner welcomed the presentation and asked if the reduction in WTE would mean a reduction in vacancy levels. The Interim Chief Nurse confirmed that it would.

Mr Hodgkin asked how the saving was calculated. The Interim Chief Nurse confirmed that this was calculated by using mid point Band 5. The Board noted that there would be a knock on effect in agency usage delivering additional savings.

The Chief Executive asked about the under-staffed areas. The Interim Chief Nurse confirmed that this was taken into account within the 49 WTE.

Mr Atkins asked about the anticipated response from staff. The Interim Chief Nurse confirmed that the change was expected as staff had become familiar with the use of the acuity tool.

The Director of Finance supported the work and confirmed that it aligns with budget setting and improvement practice process.

The Chairman and Board noted the report and agreed the recommendations. The Clinical Quality, Safety and Patient Experience Committee will monitor progress and update the Board as required.

19/070.4 Clinical Quality, Safety, Patient Experience Committee Report (Enclosure 15) 12.55pm

The Interim Chief Nurse presented the Clinical Quality, Safety, Patient Experience Committee Report, given as Enclosure 15, including the following key issues:

- Ophthalmology Waiting Lists for Follow Up Appointments: Business case recently approved by the Executive Team.
- Complaints backlog: Further work agreed with Divisions.
- Mixed Sex Breaches: Related to capacity issues.
- Speech and Language Therapy Vacancies: Committee noted risk.
- External Visits: Plans in place at a divisional level.

The Chairman suggested bringing in an Associate Non Executive Director to provide Committee support.

The Chairman and Board noted the report. A reporting matrix from Committees will be presented to the Board going forward.

19/070.5 Patient Safety Strategy (Enclosure 16)
1.00pm

The Medical Director presented the Patient Safety Strategy given as Enclosure 16. The Board noted the following key issues:

The language in the report had been simplified and now aligned with the Trust Strategy.

Mr Miner asked how the Patient Safety culture will become embedded. The Medical Director confirmed that a series of stakeholder events for all staff members across the Trust will be arranged. Staff need to know that patient safety is at the heart of everything we do at the Trust. There will be an agreed escalation process put in place with staff for raising concerns. This will be monitored by weekly and monthly reporting and hard metrics around outcomes along with softer measures by the use of surveys.

The Chairman welcomed the strategy but confirmed that KPIs appear to be process rather than outcome related. The Medical Director confirmed that only the high level KPIs were identified in the strategy, other KPIs are tracked and monitored through different routes such as the Quality Accounts.

The Chairman asked that the Strategy is presented to the Clinical Quality, Safety, Patient Experience Committee (CQSPE) for further debate around KPIs and approval.

The Chairman and Board noted the Strategy.

The Patient Safety Strategy to be presented to CQSPE for further debate around KPIs and approval.

19/070.6 Freedom to Speak Up Guardian's Report (Enclosure 17)
1.10pm

The Freedom to Speak Up Guardian's presented their report given as Enclosure 17.

The Board noted the following key issues:

- Numbers increased by 50% for the last financial year. Main concerns relate to unfair treatment/bullying/behaviour issues.
- 15 concerns raised in the last 2 months.
- There was a rise in the number of medical staff and AHPs raising concerns.
- Julian Atkins has taken on the role of Non Executive Director lead for Freedom to Speak Up.
- The Guardians had attended a session with junior doctors and a number of concerns were raised. Issues included annual leave entitlement and experience within specialties.
- Concern had been raised around exit interviews and these had been escalated to line managers.
- Speak Up Champions are also Patient Safety Champions. The Trust needs to identify a champion for Maternity.
- Speak Up posters are on display across the Trust and Speak Up surgeries are taking place in June and November.

The Chairman expressed her support for this area and welcomed the initiatives.

The Chairman asked about benchmarking. The Guardians confirm that we do benchmark against local Trust's and our numbers have increased slightly.

The Chief Executive thanked the Guardian's for their positive work.

The Chairman and Board noted the report.

19/070.7 Guardian of Safe Working Report (Enclosure 18)
1.22pm

The Guardian of Safe Working presented his report given as Enclosure 18.

The Board noted the following key issues:

- 11th report to the Board.
- Challenges remain with engagement.
- 14 Exception reports received. All reports now closed.
- Most reports relate to overtime payments.
- Guardian holds a regular forum with junior doctors.

The Chairman confirmed that she had visited some junior doctors during a walkround with the Guardian and most concerns were process rather than personal issues. The medical rota in ED had raised some process and pathway issues they felt impacted on patient safety. This had been referred to the Chief Operating Officer.

The Board noted that the Trust had not experienced any tragic cases.

The Chairman and Board noted the report.

19/071 Responsive and Effective

19/071.1 Integrated Performance Report (Enclosure 19)
1.30pm

The Chief Operating Officer presented the Integrated Performance Report given as Enclosure 19.

The Board noted the following key issues:

- Performance for April 2019.
- ED Emergency Access Standard: Still an issue for the organisation. An improvement trajectory had been submitted to NHSI. Will be zero tolerance to over 30 minute ambulance delays and the Trust is working closely with the Ambulance Service on this.
- Cancer key metrics: Good performance with green for all metrics.
- RTT: On track, monitoring General Surgery. Achieved over 95% performance.
- DM01: Continue to perform well against target - 99.1% performance.
- Chest Pain Assessment Unit: Extended opening hours agreed.
- Bed Review: Being undertaken looking at specialty bed base.
- Mixed Sex Breaches: This is as a result of capacity issues.

- Appraisals: Window open and good responses so far.
- Sickness: Slight increase seen.
- Turnover: Positive reduction.
- Mandatory Training: Staff being released to attend training.

The Interim Director of Governance asked about the never event identified in the report. The Chief Executive confirmed that this related to an incorrect mole removal and immediate actions had been put in place to ensure that this could not reoccur and learning is shared across the Trust.

Mr Atkins asked about the VTE target. The Chief Operating Officer confirmed that AMU is a red area.

A "plot the dots" session is being arranged for Board members in July.

The Chairman proposed that the Workforce Committee be reinstated when the number of Non Executive Directors had increased.

The Chairman and Board noted the report, actions and performance against key performance indicators.

Workforce Committee to be reinstated after the 4th July, once the number of Non Executive Directors has increased.

19/071.2 Finance and Performance Committee Exception Report (Enclosure 20) 1.43pm

Mr Hodgkin, Committee Chair, presented the Finance and Performance Committee Exception Report, given as Enclosure 20.

The Board noted the following key issues:

- 3 key risks to delivery – agency usage, delivering budgets and CIP gap. The Medical Director will present plans to reduce medical agency spend to a future Committee.
- Medicine presented their divisional deep dive.
- Benefits realisation review undertaken of FourEyes Consulting which had been disappointing.
- Approved reference costs submission.

- Approved business case for urgent care redesign.

The Chairman and Board noted the report.

19/071.3 Annual Audit Committee Report 2018/19 (Enclosure 21)
1.47pm

The Audit Committee Chair presented the Committee Annual Report for 2018/19, given as Enclosure 22.

The Board noted the following key issues:

- Covers the work of the Audit Committee which met 5 times during the year.
- Change in membership of the Committee and good attendance was noted.
- Looks at relationship with auditors and work of clinical audit.

The Chairman and Board noted the report.

19/071.4 Audit Committee Report (Enclosure 22)
1.50pm

The Audit Committee Chair presented the Audit Committee Report, given as Enclosure 22.

The Committee approved the Annual Accounts for 2018/19, noted the Trust Annual Report for 2018/19, approved the Quality Report and Accounts and representation letter for the auditors in respect of the Trust Charitable Fund Accounts.

The Committee approved the Counter Fraud Annual Report and Audit Committee Annual Report.

The Chairman and Board noted the report.

19/072 Well Led

19/072.1 Brexit Report (Enclosure 23)
1.51pm

The Chief Operating Officer presented the Brexit Report given as Enclosure 23.

The Board noted the following key issues:

- New exit date will be in October.
- Planning meetings continue to take place.
- All required actions in place.
- No national concerns relating to stocks of medications.

The Chairman and Board noted the report and current position.

19/072.2 Research and Development Report (Enclosure 24)
2.15pm

The Director of Research and Development presented the Research and Development Report given as Enclosure 24.

The Board noted the following key issues:

- Making steady progress against the R&D Strategy.
- Away Day held and showcase event being arranged.
- Making strong process against CRN high level objectives.
- Funding model changing to provide a more steady income.

Mr Miner confirmed that the report was previously presented to the Audit Committee and it was felt that it was not the correct Committee in terms of assurance relating to clinical trials.

The Chairman and Board noted the report and progress against Strategy.

19/072.3 7 Day Services Update Report (Enclosure 25)
1.53pm

The Deputy Medical Director presented the 7 Day Services Update Report given as Enclosure 25.

The Board noted the following key issues:

- Second report to Board, previous report presented in April.
- Deadline for submission of the report nationally is the end of the month.

- Progress noted against standard 2.

- Risks with General Surgery and Critical Care. Ongoing work in place to resolve.

The Chairman raised concern around non compliance. Dr Hudson was concerned about the position with critical care due to the number of available doctors in the system. The Trust was looking at the model of the unit to achieve compliance.

The Medical Director confirmed that this is a priority for the organisation and an update will be provided at the next Board meeting.

The Chief Executive stated that the lack of medical critical care workforce should be raised within the STP.

Mr Atkins raised the assurance level shown on the cover sheet. Dr Hudson confirmed that significant assurance relates to the position in March 2020.

The Chairman and Board noted the report and confirmed that future reports would be presented to CQSPE before coming too Board.

Future reports to be presented to the CQSPE Committee prior to presentation to Board. An update on 7 Day Services/Critical Care compliance will be presented to the July Board meeting.

19/072.4 Trust Constitution and Scheme of Delegation (Enclosure 26)
2.05pm

The Interim Director of Governance presented the Trust Constitution and Scheme of Delegation given as Enclosure 26.

The authority to approve the Constitution lies with the Council of Governors.

Changes to the Constitution were highlighted in red.

The composition/voting rights of the Board to be clarified in the report.

The final approved Constitution will be presented back to the Board.

The Chairman and Board noted the Constitution and suggested amendments/areas for clarification.

Composition/voting right to be clarified within the report. The final approved Constitution to be presented back to the Board.

19/073 Any Other Business
2.30pm

19/073.1 Board Licence Self Certification

The Board approved self-certifying that the Trust was non-compliant with condition G6, but was compliant with condition CoS7.

The Board deferred a decision on compliance with condition FT4 until it receives feedback from the CQC on its section 31's.

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

19/074 Date of Next Meeting
2.40pm

The next Board meeting will be held on Thursday, 4th July, 2019, in the Clinical Education Centre.

Signed ……

Date …….....

Enclosure 12

The Dudley Group NHS Foundation Trust

Action Sheet
Minutes of the Board of Directors Public Session
Held on 6 June 2019

Item No	*Subject*	*Action*	*Responsible*	*Due Date*	*Comments*
19/070.5	Patient Safety Strategy	The Patient Safety Strategy to be presented to CQSPE for further debate around KPIs and approval.	JH/NC	23/7	Not Due.
19/072.3	7 Day Services Report	Future reports to be presented to the CQSPE Committee prior to presentation to Board. An update on 7 Day Services/Critical Care compliance will be presented to the July Board meeting.	PH	25/6 & 4/7	On CQSPE and Board Agendas.
19/023.3	Digital Trust Committee Report	Population Health to be included on a future Board Workshop agenda.	AT/GG	July/Aug	To future Board Workshop – date to be confirmed.
19/035.2	Workforce Committee Exception Report	Workforce Strategy to be presented to the June Board.	AM	June/July	To Workforce and Finance and Performance Committees
19/048.6	Board and Committee Effectiveness Review	Director of Governance to consider improvement actions required in response to Board Effectiveness Review and provide plan to the Chair/Chief Executive.	GG	4/7	To July Board – on Agenda.
19/068	Patient Story	The Director of Finance to consider opportunities for the use of the Hydrotherapy pool.	TJ	4/7	Under Review.
19/072.4	Trust Constitution and Scheme of Delegation	Composition/voting rights to be clarified and the final report to be represented back to Board for approval.	GG	4/7	On Agenda.
19/072.1	Brexit Report	Board to consider adding a Brexit risk onto the Board Assurance Framework at its July meeting.	GG	4/7	On Agenda.

19/071.1	Integrated Performance Report	The Workforce Committee to be reinstated after the 4th July, once the number of Non Executive Directors has increased.	AM	July/ Aug	Not Due
19/033.1	Staff Survey Presentation	Update on the Staff Survey to the Board in 6 months.	AM	5/9	Not Due.
19/058.5	Learning from Deaths	Update on Palliative Care to be included in an overarching Learning from Deaths Annual Report.	JH	5/9	Not Due
19/021.4	Organ Donation Report	Results of work on tissue donation to be included in the next report.	K Lazenby	Jan 2020	Not Due

Enclosure 13

The Dudley Group NHS Foundation Trust

Paper for submission to the Board 4 July 2019

TITLE:	**Board Assurance Framework**		
AUTHOR:	Gilbert George Interim Director of Governance	**PRESENTER**	Gilbert George Interim Director of Governance

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

ACTION REQUIRED OF 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 BOARD

The Board is required, in light of the presented reports, to:

- note matters for board attention (see section 6 and 7 of the repot)
- consider a pension related risk being added to the Corporate Risk Register and not the BAF (see section 3 of the report)
- consider the correctness of the overall assurance level for each BAF risk (see section 4 of the report)
- consider the effectiveness of controls (see appendix A)
- consider the correctness of the current risk score (post mitigation), see appendix A
- make any recommendations to Committees (including Audit) or the Executive team

CORPORATE OBJECTIVE:

All

SUMMARY OF KEY ISSUES:

The Trust Board has overall responsibility for ensuring that systems and controls are in place and are adequate to mitigate any significant strategic risks which threaten the achievement of the Trust's strategic objectives. As part of this process we aim to use the Board Assurance Framework (BAF) as a dynamic tool to drive Trust Board and Committee business.

<table>
<tr><td colspan="4">This report presents the Board Assurance Framework (BAF) which identifies the strategic risks to achieving the Trust's objectives (appendix A).</td></tr>
<tr><td colspan="4">IMPLICATIONS OF PAPER:</td></tr>
<tr><td rowspan="2">RISK</td><td colspan="2">Y</td><td>Risk Description: Covers all risks</td></tr>
<tr><td colspan="2">Risk Register: Y</td><td>Risk Score: Covers all risks</td></tr>
<tr><td rowspan="3">COMPLIANCE
and/or
LEGAL REQUIREMENTS</td><td>CQC</td><td>Y</td><td>Details: all Domains</td></tr>
<tr><td>NHSI</td><td>Y</td><td>Details: Well led framework</td></tr>
<tr><td>Other</td><td>Y</td><td>Details:</td></tr>
</table>

KEY

Risk Score

	Impact score				
Likelihood	**1 Negligible**	**2 Minor**	**3 Moderate**	**4 Major**	**5 Catastrophic**
5 Almost certain	5	10	15	20	25
4 Likely	4	8	12	16	20
3 Possible	3	6	9	12	15
2 Unlikely	2	4	6	8	10
1 Rare	1	2	3	4	5

For grading risk, the scores obtained from the risk matrix are assigned grades as follows

1 - 4	Low risk
5 - 12	Moderate risk
15 - 16	High risk
20 - 25	Extreme risk

Key to Control Levels

Level Of Assurance	Definition
Level 1 Operational	The lowest level of assurance and relates to local assurances provided by operational management, self-assessment.
Level 2 Executive	Moderate level of assurance and relates to assurances provided by executive management/ Board, independent assessment (internal) e.g. clinical audit.
Level 3 External	The strongest level of assurance and relates to e.g. external Reviews, CQC, external audit, external inspections etc.

Board Risk Appetite

Appetite	Descriptor	Risk level
OPEN	Eager to be innovative and to choose options based on those that offer the highest probability of productive outcomes. Prepared to accept high and even extreme rated risks in pursuit of our objectives in this area to realise potential rewards.	**15-25**
MODERATE	Willing to consider all potential delivery options and choose based on delivery of an acceptable level of reward (and VfM). Prepared to accept that risks are likely to occur in the pursuit of our objectives in this area and that we will need to tolerate risks up to a rating of 'high' to realise potential rewards.	**8-12**
CAUTIOUS	Preference for safe delivery options that have a low degree of inherent risk and may have more limited potential for reward. Willing to expend some time and resource to mitigate risks, but accepting that some risks in this are will not, or cannot, be mitigated below a moderate level.	**4-6**
AVERSE	Preference for ultra-safe delivery options that have a low degree of inherent risk and only limited reward potential. Prepared to expend significant time and resource to mitigate risks in this area to a minimal level.	**1-3**
AVOID	No appetite, not prepared to tolerate risk above a negligible level.	**0**

Key to Executive Leads

CE	Chief Executive	DSBD	Director of Strategy and Business Development
MD	Medical Director	DG	Director of Governance
CN	Chief Nurse	DHR&OD	Director of HR & OD
DF	Director of Finance	CIO	Chief Information Officer
COO	Chief Operating officer		

1. Background

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

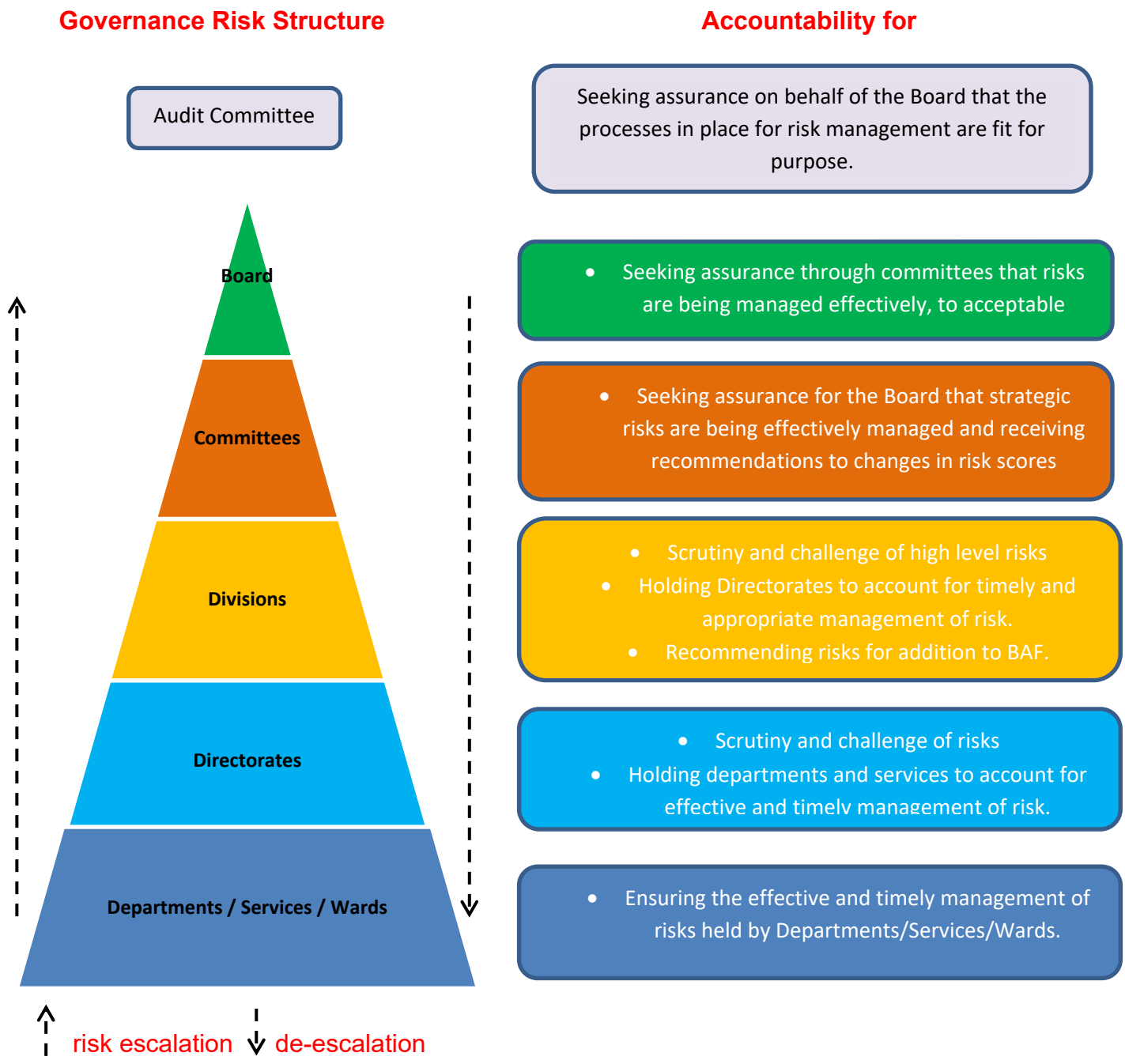
The BAF records the key risks, assessed by the Executive team and challenged by the Board to the achievement of the Trust's stated objectives and annual goals. The BAF enables the Board to challenge whether management are effective in their management of the key risks to the delivery of the Trust's strategic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

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

The following table provides an overview the assurances received in the last quarter for each of the BAF risks, in addition it identifies if there has been any movement in relation to the risk score. Further detail for each risk can be found at appendix 1.

2. Governance and accountability structure for risk management at the Trust

The Trust adopts a structured approach to risk management, whereby risks are identified, assessed and controlled and if appropriate, escalated or de-escalated through the governance mechanisms of the Trust.



3. NEW RISKS

Concerns have been raised that recent changes to the pension tax regime were encouraging doctors to reduce the amount they worked. The annual allowance taper, introduced in 2016, restricts the amount of tax relief available to those with a threshold income over £110,000, reducing it from £40,000 to £10,000. This has led to some people incurring large tax bills on their pension contributions.

The Finance and Performance committee at its 27 June meeting deliberated if a pension related risk should be on our risk registers. The committee agreed a risk should be on the corporate risk register and not the BAF.

4. RISK PERFORMANCE

BAF Risks (11 in total)	Risk Score (post mitigation)	Overall Assurance Level	Effective Control	Actions on track	Risk movement (first report)
BAF 1A - We don't always effectively engage with patients in their care or involve them in service improvement as a result we fail to communicate with them effectively resulting in a poor patient experience which means patient's will not see us as a provider of choice	12	Acceptable	YES	YES	
BAF 1B - Failure to meet access standards caused by inability to improve patient flow and work effectively with very local partners will result in an adverse outcome for the patient	20	Partial	YES / NO	YES	
BAF 2A - If we do not achieve and demonstrate a good or outstanding rating with CQC and other regulatory standards we may be unable to achieve the level of quality of care and subsequently our reputation may be damaged	16	Partial	YES / NO	YES	
BAF 2B - Insufficient effective leadership and capacity may result in the trust being unable to efficiently manage and deliver safe services for our patients	16	Partial	YES	YES	
*** BAF 3A -** The Dudley Improvement Strategy may not be delivered due to insufficient transformational leadership capability and capacity, resulting in a lack of innovation and a failure to improve services	12	Acceptable	YES	YES	
BAF 4A - An inability to recruit sufficient numbers of appropriately trained staff due to national and local staff shortages may impact on being unable to meet service demand or provide safe, high quality services resulting in increased temporary workforce spend	12	Partial	YES	YES	

BAF 4B - If we fail to train and develop our workforce to have the right skills to enable the delivery of our clinical strategy, due to inadequate career development, talent management and leadership development, this may result in poor retention rates, difficulties recruiting and a failure to maximise the capabilities of staff	12	Partial	YES	YES	
BAF 4C - Failure to effectively engage and involve our workforce by not listening, innovating and acting on their feedback and communicating effectively could lead to an inability to positively improve culture	16	Partial	YES / NO	YES	
BAF 5A - Failure to recognise the importance and impact of our constrained financial position due to a lack of understanding, engagement and financial discipline mean we miss key financial targets, run out of cash and come under greater regulatory scrutiny	15	Partial	YES / NO	YES	
BAF 5B - Failure to successfully adopt digital workflows, due to competing organisation / clinical pressures, availability of resources and change fatigue; results in clinical risk, reputational risk and inefficiency	10	Acceptable	YES	YES	
*** BAF 6A -** Failure of the Trust to influence the local and wider evolving health economy due to a lack of engagement and poor performance undermining our credibility means our clinical and financial viability is undermined as we lose key high value services and opportunities for profitable growth	16	Partial	YES / NO	YES	

** BAF Risks under full review following Finance & Performance meeting 27 June*

5. HEAT MAP

	Consequence				
Likelihood	**1 Negligible**	**2 Minor**	**3 Moderate**	**4 Major**	**5 Catastrophic**
5 Almost certain	5	10 5b	15 5a	20	25
4 Likely	4	8	12 3a 4a 4b	16 2a 2b 4c 6a	20 1b
3 Possible	3	6	9	12 1a	15
2 Unlikely	2	4	6	8	10
1 Rare	1	2	3	4	5

6. MATTERS FOR BOARD ATTENTION

The board is asked to note that following the Finance and Performance 27 June committee meeting, BAF risk No 3a (transformational leadership capability and capacity) and 6a (failure of the Trust to influence the local and wider evolving health economy) are undergoing a full review in including risk descriptors.

The HR related risks (4a, 4b & 4c) which were originally assessed as having acceptable assurance was challenged at the Finance and Performance Committee and moved to partial assurance.

BAF Risk Highlights:

- **The risks with the highest risk score post mitigation (controls)**:

  BAF 1b - access standards (risk score 20, L5xC4)

- **The risks with the widest risk score gap (post mitigation and target score) are:**

  BAF 1b - access standards (risk score post mitigation 20 less – target 8) = 12
  BAF 2a - CQC - achieving good (risk score post mitigation 16 less target 4) = 12

- **The risk with Amber (Yes / No) effective controls:**

  BAF 1b - access standards
  BAF 2a - CQC - achieving good or outstanding
  BAF 4c - engage and involve workforce
  BAF 5a – financial targets
  BAF 6a – failure to influence local and wider health economy

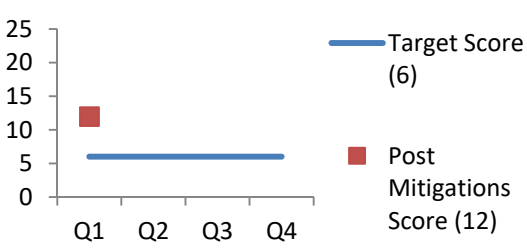
7. RECOMMENDATIONS

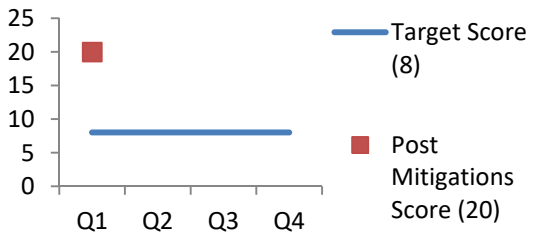
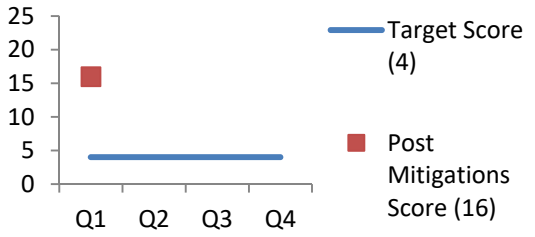
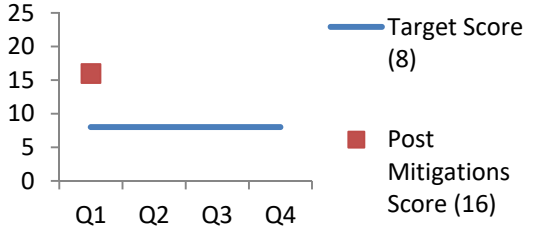
A pension related risk should be entered to the Corporate Risks Register

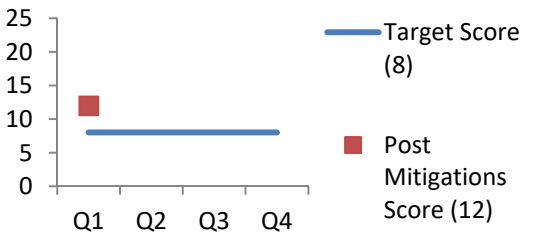
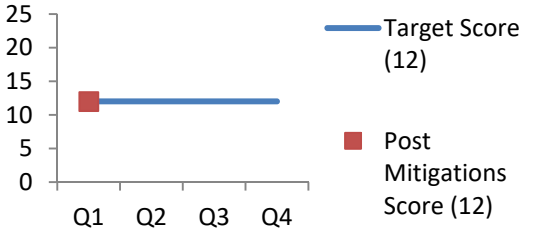
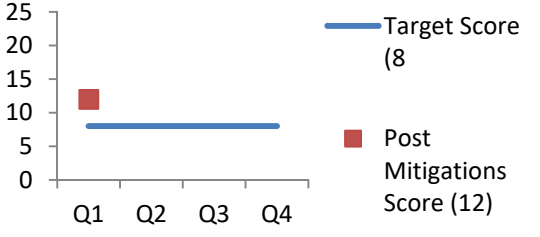
8. BOARD ASSURANCE FRAMEWORK SUMMARY

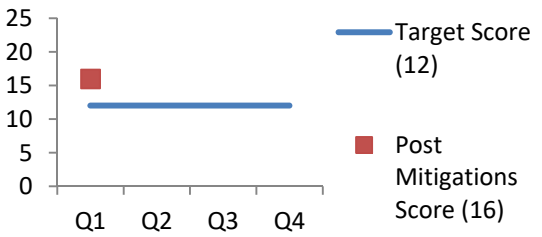
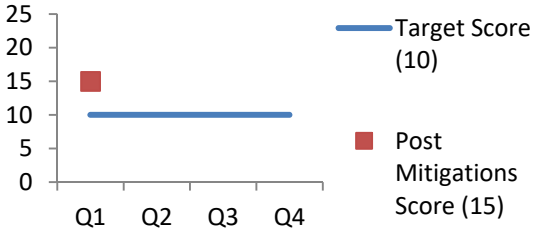
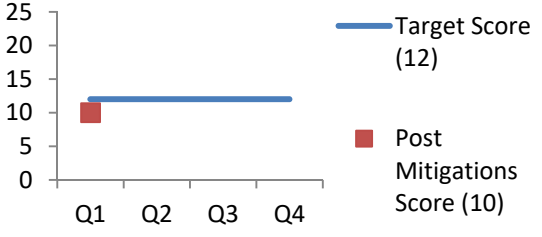
Assurance Descriptor

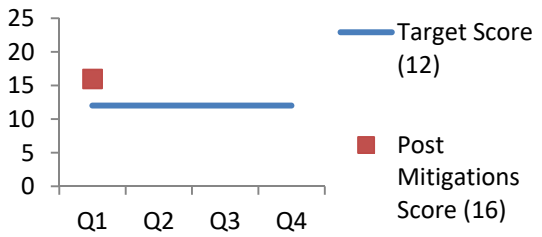
Significant Assurance	Acceptable Assurance	Partial Assurance	No Assurance
High level of confidence in delivery of existing mechanisms / objectives	General confidence in delivery of existing mechanisms / objectives	Some confidence in delivery of existing mechanisms / objectives, some areas of concern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

STRATEGIC OBJECTIVE	STRATEGIC RISK	Pre mitigations Score	Quarterly Assurance Rating				Overall Controls Effective? GAPS) Y/N	Post Mitigations Score v Target Risk Score	Oversight Committee	Exec Lead	Actions on Track?
			Q1	Q2	Q3	Q4					
SO1 Deliver a great patient experience	**BAF 1A** We don't always effectively engage with patients in their care or involve them in service improvement as a result we fail to communicate with them effectively resulting in a poor patient experience which means patient's will not see us as a provider of choice.	L x C 4X3 (12)	Green: Acceptable				YES		Clinical Quality Safety and Patient Experience	CN	YES

STRATEGIC OBJECTIVE	STRATEGIC RISK	Pre mitigations Score	Quarterly Assurance Rating				Overall Controls Effective? GAPS) Y/N	Post Mitigations Score v Target Risk Score	Oversight Committee	Exec Lead	Actions on Track?
			Q1	Q2	Q3	Q4					
	BAF 1B Failure to meet access standards caused by inability to improve patient flow and work effectively with very local partners will result in an adverse outcome for the patient	L x C 5X4 (20)	Yellow: Partial				YES / NO		Clinical Quality Safety and Patient Experience	COO	YES
SO2 Safe and Caring services	**BAF 2A** If we do not achieve and demonstrate a good or outstanding rating with CQC and other regulatory standards we may be unable to achieve the level of quality of care and subsequently our reputation may be damaged	L x C 4X4 (16)	Yellow: Partial				YES / No		Clinical Quality Safety and Patient Experience	COO	YES
	BAF 2B Insufficient effective leadership and capacity may result in the trust being unable to efficiently manage and deliver safe services for our patients	L x C 4X4 (16)	Yellow: Partial				YES		Clinical Quality Safety and Patient Experience	MD	YES

STRATEGIC OBJECTIVE	STRATEGIC RISK	Pre mitigations Score	Quarterly Assurance Rating				Overall Controls Effective? GAPS) Y/N	Post Mitigations Score v Target Risk Score	Oversight Committee	Exec Lead	Actions on Track?
			Q1	Q2	Q3	Q4					
SO3 Drive Service improvements, innovation and transformation	**BAF 3A** The Dudley Improvement Strategy may not be delivered due to insufficient transformational leadership capability and capacity, resulting in a lack of innovation and a failure to improve services	L x C 4X4 (16)	Green: Acceptable				YES		Finance & Performance	DSBD	YES
SO4 Be the place people choose to work	**BAF 4A** An inability to recruit sufficient numbers of appropriately trained staff due to national and local staff shortages may impact on being unable to meet service demand or provide safe, high quality services resulting in increased temporary workforce spend	L x C 4X4 (16)	Yellow: Partial				YES		Finance & Performance (Sub working group:	HRD	YES
	BAF 4B If we fail to train and develop our workforce to have the right skills to enable the delivery of our clinical strategy, due to inadequate career development, talent management and leadership development, this may result in poor retention rates, difficulties recruiting and a failure to maximise the capabilities of staff	L x C 4X4 (16)	Yellow: Partial				YES		Finance & Performance (Sub working group:	HRD	YES

STRATEGIC OBJECTIVE	STRATEGIC RISK	Pre mitigations Score	Quarterly Assurance Rating				Overall Controls Effective? GAPS) Y/N	Post Mitigations Score v Target Risk Score	Oversight Committee	Exec Lead	Actions on Track?
			Q1	Q2	Q3	Q4					
	BAF 4C Failure to effectively engage and involve our workforce by not listening, innovating and acting on their feedback and communicating effectively could lead to an inability to positively improve culture	L x C 4X4 (16)	Yellow: Partial				YES / NO		Finance & Performance (Sub working group:	HRD	YES
SO5 Make the best use of what we have	**BAF 5A** Failure to recognise the importance and impact of our constrained financial position due to a lack of understanding, engagement and financial discipline mean we miss key financial targets, run out of cash and come under greater regulatory scrutiny	L x C 4X5 (20)	Yellow: Partial				YES / NO		Finance &	DoF	YES
	BAF 5B Failure to successfully adopt digital workflows, due to competing organisation / clinical pressures, availability of resources and change fatigue; results in clinical risk, reputational risk and inefficiency	L x C 3X5 (15)	Blue: Significant				YES		Finance & Performance (Sub working group:	CIO	YES

STRATEGIC OBJECTIVE	STRATEGIC RISK	Pre mitigations Score	Quarterly Assurance Rating				Overall Controls Effective? GAPS) Y/N	Post Mitigations Score v Target Risk Score	Oversight Committee	Exec Lead	Actions on Track?
			Q1	Q2	Q3	Q4					
SO6 Deliver a viable future	**BAF 6A** Failure of the Trust to influence the local and wider evolving health economy due to a lack of engagement and poor performance undermining our credibility means our clinical and financial viability is undermined as we lose key high value services and opportunities for profitable growth	L x C 5X4 (20)	Yellow: Partial				YES / NO		Finance & Performance	DSBD	YES

APPENDIX 1

DETAILED - BOARD ASSURANCE FRAMEOWRK (includes controls, actions and assurances)

Strategic Objective		**SO1 Deliver a great patient experience**				**Committee**	**Exec Lead**	
						Clinical Quality Safety and Patient Experience Committee	Chief Nurse	
Strategic Risk No	BAF 1a	**Pre Mitigations Risk Score**	L x C 4X3 (12)	**Post Mitigations Current Risk Score**	L x C 4X3 (12)	**Board Risk Appetite**	**Target Score**	L x C 2X3 (6)
						Cautious		

RISK: We don't always effectively engage with patients in their care or involve them in service improvement as a result we fail to communicate with them effectively resulting in a poor patient experience which means patient's will not see us as a provider of choice.

Cause / Effect

- Patient's are not informed regarding their care and options for treatment.
- We do not robustly seek or respond to feedback
- Patients / Carers views are not actively sought as part of service improvements/ redesign
- Loss of confidence in trust services

Impact of the Risk

- Patients individualised needs are not met.
- Patient's come to harm whilst in our care.
- Service redesign does not meet patient need.
- Reputational damage due to patient not feeling they are not receiving individualised patient care opt to go to another health provider

Quarters					**Q1**	**Q2**	**Q3**	**Q4**
Assurance Rating Key: Assurance rating of achieving Target Risk Score by Mar 2021	Significant Assurance	Acceptable Assurance	Partial Assurance	No Assurance	Acceptable Assurance			

KEY CONTROLS IN PLACE	ASSURANCE THAT CONTROLS ARE EFFECTIVE [Yes / No (if no what action needs to be taken)	LEVEL of CONTROL 1 = Operational 2 = Committee 3 = External
Patient experience strategy	No, current strategy, being refreshed	2
Quality priorities focussed on reducing harm	Yes	2
Pt feedback actions sought via FFT, patient surveys, feedback Fridays	Yes - though response rate remains low	3
Complaints process and reporting	Yes – response timeliness is an issue	1
PALS Reports	Yes	1
Perfect ward quality metrics	Yes	1
Quality priorities metrics reported via IPR	Yes	2
Learning from complaints group and reports	Yes	2
Patient Experience group and associated workplan	Yes	2
Patient Experience improvement workstreams across all services	Yes	1
LIA in place to capture and respond to feedback	Yes	2
Participation in annual patient surveys	Yes	3
Dudley Improvement practice	Yes	2

SPECIFIC GAPS IN CONTROL / ASSURANCE	ACTIONS	STATUS: COMPLETE	IN PROGRESS	OUTSTANDING (BEYOND COMPLETION DATE
The main areas of weakness which result in ineffective or absent controls / assurance	*Actions required to mitigate the weaknesses*	*Date for completion*		*Action Lead*
Out of date Patient Experience strategy	Rewrite patient experience and engagement strategy	Jun 2019		Jill Faulkner
Timely response (complaints process~) not occurring at Directorate level	Delivery of complaint recovery plan at Divisional level	Jun 2019		Divisional Leads
FFT responses are below agreed trajectory	Increased response rate to be prioritised at team level	Jul 2019		Julie Pain Jenny Bree and Dawn Lewis

Strategic Objective		SO1 Deliver a great patient experience				Committee	Exec Lead	
						Clinical Quality Safety and Patient Experience Committee	Chief Operating Officer	
Strategic Risk No	BAF 1b	**Pre Mitigations Risk Score**	L xC 5x4 (20)	**Post Mitigations Current Risk Score**	L x C 5x4 (20)	**Board Risk Appetite** Cautious	**Target Score**	L x C 2x4 (8)

RISK: Failure to meet access standards caused by inability to improve patient flow and work effectively with very local partners will result in an adverse outcome for the patient

Cause / Effect

- Concerns flagged by CQC during inspection review
- Concerns verified by increased scrutiny by MD, COO and CN.
- Loss of public Trust
- Elective flow effected by outlying patients potential cancellations for elective procedures
- Increased DTOC may result in opening contingency areas (potential poor patient experience and patient safety).
- The need to spot purchase
- No agreement around level of delays in the community - consequence is fewer discharges from the Acute Trust
- Increase in waiting list initiatives
- Activity and outcome plans not meeting trajectory's
- Skill mix & availability of staff
- Increased ambulance activity
- Current ED environment hinders flow
- Lack of operational capacity to deliver improvements
- Lack of available packages of care
- Same day access to diagnostics
- 7 day working

Impact of the Risk

- Failure to achieve 4 hour ED target
- Poor patient experience
- Poor regulatory inspection rating
- Possible increased mortality and clinical outcome
- Delayed patient care potential poorer outcome.
- Capacity outweighing demand in ED compromising safety, poor care and increase stress staff
- Consequence of delays at the front door & inability to manage Ambulance Handover (financial penalties)
- Failure to maintain 18 week RTT pathways
- An increase to bed based requires increased staffing demands
- Significant impact on spend as costs increase significantly
- Potential for fining for non-achievement of hospital targets e.g. EAS, RTT
- Inability to deliver the Dudley Health Economy Delayed Transfers of Care Improvement Plan
- Failure to achieve DM01
- Increased agency spend as a result of additional areas opened
- Increased risk of 12 hour trolley waits
- Staff morale
- Diminished staff recruitment
- Less influential in system working across the STP

Quarters					**Q1**	**Q2**	**Q3**	**Q4**
Assurance Rating Key: Assurance rating of achieving Target Risk Score by Mar 2021	Significant Assurance	Acceptable Assurance	Partial Assurance	No Assurance	Partial Assurance			

KEY CONTROLS IN PLACE	**ASSURANCE THAT CONTROLS ARE EFFECTIVE [Yes / No (if no what action is being taken)**	**LEVEL of CONTROL 1 = Operational 2 = Committee 3 = External**
USCIG – chaired by COO	Yes – pace of change not as required	2
Active members of UCOG	Yes	2
A&E Delivery Board	Yes – pace of change not as required	2
New models of working, CAU, RAB, FAU	Yes	1
Performance Meetings (monthly)	Yes	1
Reports to CQSPE & Board	Yes	2
Policies and guidelines to support deteriorating patient and sepsis management	Yes	1
Support from Medical Director to Clinical Leads	Yes	1
Oversight Committee with attendance from CQC, CCG, NHSI	Yes	3
Expansion and reconfigure of the Emergency Department	Yes - in hand	1
Development and Implementation of a robust triage framework	Yes	1
Development and resource a 24/ 7 paediatric area	Yes	1
Surgical and paediatric pathways reviewed	No - work in progress	1
Implemented medical model	Yes	1
Review Medical Model	No - to commence in July	1
Completion of staffing review	Yes	1
Daily reporting of the DTOC position, 7 days a week	Yes	1
Daily meetings to manage patients ready for discharge	Yes – part of LOS reduction programme	1

Monitoring of the process at economy wide groups	Yes	1
The MOU for Dudley Economy (excludes out of area authorities)	Yes	3
Financial commitment from economy partners	Yes – not enough capacity in health economy for patients needs	3
Utilisation of red to green to identify ward delays	No - work in progress	1
Weekly stranded patient reviews	Yes	1
Trust ops weekly meeting and performance reviews	Yes	1
Increased Discharge facilitators to each ward	Yes	1
Frailty pathway	Yes	1
Trust engage local partners in daily conference calls to control flow of patients into Trust	Yes – in place but requires strengthen	3
Work with ECIST	Yes	3
Identification of underperforming services and action plans in place	Yes	1
Deputy Director of Operations/Nursing to lead flow	Yes	1

SPECIFIC GAPS IN CONTROL / ASSURANCE	**ACTIONS**	**STATUS:**		
		COMPLETE	**IN PROGRESS**	**OUTSTANDING (BEYOND COMPLETION DATE**
The main areas of weakness which result in ineffective or absent controls / assurance	*Actions required to mitigate the weaknesses*	*Date for completion*		*Action Lead*
• EAS not complaint • Reliance on agency staff due to continued increase in demand on the services • New models of working not embedded • Nursing & medical vacancies across medical specialities and ED • Lack of system wide response plan to surge in demand at peak times • Lead Facilitator for Red2Green and Flow initiatives • WMAS have conflicting targets to the Trust that affects the discharge	Receive and act on RSEM recommendations	Dec 2019		Hassan Paraiso
	Implementation of RAB model in AMU	Apr 2019		Anita Cupper
	Recruit into all vacancies across nursing & acute medicine	June 2019		Anita Cupper
	Deliver the Dudley Health Economy Delayed Transfers of Care Improvements Plan	Dec 2020		Gregg Marson
	Develop and implement an operational demand/capacity management tool	Sep 2019		Gerry Fogarty

support for patients out of area. • Both Local Authority and CCG resort to panel outcomes for financial decisions which creates a further delay. • Limited access to specialist beds e.g. Neuro Rehab (West Park/ Mosley Hall) • Capacity outstrips demand • Unknown impact of intelligent conveyancing from WMAS • Operational capacity to deliver changes • Configuration of current ED footprint does not support good patient flow - STP funding bid successful for ED redesign. Timescales for full business case & delivery tbc.	Scope speciality bed base demand to inform any future bed modelling and changes	Jul 2019	Karen Kelly
	Staffing Review and funding agreed for additional nursing staff into ED	Mar 2019	Karen Kelly
	Audit of AMU RAB model(model commenced Apr 19)	Jul 2019	Anita Cupper
	Strengthen actions from daily system calls	Jun 2019	Gregg Marson
	Identify Red2Green Lead	May 2019	Gerry Fogarty
	Strengthen engagement with WMAS	Mar 2019	Karen Kelly
	Receive data and have a voice in Intelligent Conveyancing via Black Country representative in SEL Group	May 2019	Karen Kelly
	Arrange away day to look at future working across the system to give system support for complex patients	Mar 2019	Karen Kelly
	Full business case for new ED redesign	Jun 2020	Karen Kelly

Strategic Objective		SO2 Safe and Caring services				Committee	Exec Lead	
						Clinical Quality Safety and Patient Experience Committee	Chief Operating Officer	
Strategic Risk No	BAF 2a	**Pre Mitigations Risk Score**	4X4 (16)	**Post Mitigations Current Risk Score**	4X4 (16)	**Board Risk Appetite** Cautious	**Target Score**	1X4 (4)

RISK: If we do not achieve and demonstrate a good or outstanding rating with CQC and other regulatory standards we may be unable to achieve the level of quality of care and subsequently our reputation may be damaged

Cause / Effect

- Failure to demonstrate we deliver care in line with regulatory standards
- Perceived reputational damage
- Risk of harm to patients as statutory standards not met
- Impact on staff morale
- Impact on recruitment and retention
- Increased scrutiny resulting in clinicians potentially being diverted from direct patient care

Impact of the Risk

- Reduced influence with external organisations e.g. NHSI, CCG
- Potential impact on ability to recruit staff particularly to senior management positions
- Reduced ability of the Trust to take independent decisions
- Staff become disengaged
- Increased vacancies and over reliance on agency staff
- Increased sickness
- Staff wellbeing is affected
- Patients at risk of not receiving timely interventions
- Poor overall patient/family experience

Quarters					Q1	Q2	Q3	Q4
Assurance rating key: Assurance rating of achieving Target Risk Score by Mar 2021	Significant Assurance	Acceptable Assurance	Partial Assurance	No Assurance	Partial Assurance			

BAF Risk 2a continued

KEY CONTROLS IN PLACE	ASSURANCE THAT CONTROLS ARE EFFECTIVE	LEVEL of CONTROL 1 = Operational 2 = Committee 3 = External
Schedule of positive press releases/media campaigns	Yes	3
Collaborative working with NHSI	Yes	3
Collaborative working with neighbouring trusts as appropriate	Yes	3
Weekly Operational meeting to monitor performance against key regulatory standards	Yes	1
Divisional Performance Meetings	Yes	2
IPR report to CQSPE, F&P & Board	Yes	3
Cancer Alliance Meetings	Yes	3
CQC Improvement Group	Yes	2
Quality review visits against each domain	Yes	1
Perfect ward tool to drive local understanding and improvement	Yes	1
Skill mix review undertaken	Yes	1
Nursing & Midwifery strategy	Yes	1
Mortality Review process	Yes	1
Nurse recruitment Lead	Yes	1
Corporate & bespoke recruitment events	Yes	1
MTI Programme	Yes	3
Workforce Strategy	Yes	1
Developing Leaders Programme	Yes	2
Staff engagement indicators	Yes	2
National staff survey & FFT results	Yes	3
Board, Executive and senior management development programmes	Yes	2
Urgent Care Service Improvement Group	Yes	2

BAF Risk 2a continued

SPECIFIC GAPS IN CONTROL / ASSURANCE	ACTIONS	STATUS:		
		COMPLETE	IN PROGRESS	OUTSTANDING (BEYOND COMPLETION DATE
The main areas of weakness which result in ineffective or absent controls / assurance	*Actions required to mitigate the weaknesses*	*Date for completion*		*Action Lead*
• Increase in demand for specific cancer pathways e.g. Breast • RWT challenged capacity for robotic surgeries for Urology • Increased demand and ambulance arrivals • Increase in DTOC and Out of Area delays • DM01 – increase in demand overall, and on the day diagnostics • Multiple plans to address and drive improvement with regulatory standards • Mortality reviews not sufficiently robust in providing learning that is shared across the trust • Assessment & analysis of recruitment events to inform where to concentrate resources • Expansion of the MTI programme to more countries • Disjointed approach to staff education, development & education • Leadership Programme – gap with medical leaders engagement • Step up to Care programme only provides development at corporate level associated to management development and needs to be broadened to capture other staff development. • Further development of the OD programme • Preparation for the 2019 staff survey with detailed approach and strategy	Plan for CT refit commencing June	Sep 2019		Anne-Marie Williams
	Business Case to redesign & enhance cancer tracking team	Jun 2019		Anne-Marie Williams
	Introduced CAU, FAU & RAB to stream patients from ambulance triage	Jul 2019		Anita Cupper
	CQC working group to be refocused to lead on addressing non compliance	Jun 2019		Mary Sexton
	Streamlining of actions into a single improvement plan at Divisional Level	Jul 2019		Mary Sexton/
	EAS System Improvement Plan	Sep 2019		K Kelly
	Review of Mortality meetings & processes	Aug 2019		P Brammer
	Audit of recruitment campaigns	Oct 2019		Carol Love-Mecrow/Dawn Woods
	MTI programme to be developed alongside one other country and managed effectively within Medical Management fortnightly meetings.	Oct 2019		Hassan Paraiso/Jess Haycock
	Review areas of further collaboration across	Mar 2020		Rachel

in the months leading up to the survey demonstrating learning from previous year and aspiration for the future.	education and training providers under the remit of the Workforce Group		Andrew, Carol Love-Mecrow and Atiq Rehman
	Undertake review and audit of data collection systems that record training information to determine what changes can be made to provide better level of detailed analysis and information.	Mar 2020	Becky Cooke
	The introduction of the 'Make it Happen' OD programme supported with the Staff Engagement plan, the behavioural framework and the anti-bulling campaign.	Mar 2020	Rachel Andrew
	Plan to support detailed preparation for the forthcoming Staff Survey in 2019.	Oct 2019	Rachel Andrew
	Development programme to include skills associated to engagement and support for staff and colleagues. This will also be supported by the introduction of anti-bulling campaign	Oct 2019	Rachel Andrew & Becky Cooke

Strategic Objective		SO2 Safe and Caring services				Committee	Exec Lead	
						Clinical Quality Safety and Patient Experience Committee	Medical Director	
Strategic Risk No	BAF 2b	**Pre Mitigations Risk Score**	L x C 4X4 (16)	**Post Mitigations Current Risk Score**	L x C 4X4 (16)	**Board Risk Appetite** **Cautious**	**Target Score**	L x C 2X4 (8)
Insufficient effective leadership and capacity may result in the trust being unable to efficiently manage and deliver safe services for our patients								

Cause / Effect

- Insufficient time allocated to leadership roles
- Operational demands conflict with leadership roles related to governance and engagement.
- Staff lack understanding of the potential of leadership to deliver service improvement
- No shared vision for the organization

Impact of the Risk

- Quality improvement work not undertaken or is ineffective
  - Mortality reduction not achieved or maintained
  - CIP not delivered
  - EAS, cancer and diagnostic waiting times not achieved
- Reduced staff morale and engagement
- Negative impact on Reputation
- Poor recruitment and retention

Quarters					Q1	Q2	Q3	Q4
Assurance rating key: Assurance rating of achieving Target Risk Score by Mar 2021	Significant Assurance	Acceptable Assurance	Partial Assurance	No Assurance	Partial Assurance			

BAF Risk 2b continued

KEY CONTROLS IN PLACE	ASSURANCE THAT CONTROLS ARE EFFECTIVE [Yes / No (if no what action is being taken)	LEVEL of CONTROL 1 = Operational 2 = Committee 3 = External
Trust leadership programme	Yes	2
Trust management group	Yes	1
Medical leaders group	Yes	3
Nursing leadership events	Yes	3
Away days	Yes	3
Communications plan	Yes	1
Safety strategy	Yes	1

SPECIFIC GAPS IN CONTROL / ASSURANCE	ACTIONS	STATUS: COMPLETE	IN PROGRESS	OUTSTANDING (BEYOND COMPLETION DATE
The main areas of weakness which result in ineffective or absent controls / assurance	*Actions required to mitigate the weaknesses*		*Date for completion*	*Action Lead*
Accountability framework	Draft Accountability framework		Sep 19	DofG
Earned autonomy	Medical engagement score		Jun 19	MD
Assessment of effectiveness.	Staff survey		Apr 20	HRD
Competency framework	Develop earned autonomy framework		Sep 19	CofMed / CofSur
	Leadership Development Programme		Apr 20	HRD

THIS BAF IS UNDER FULL REVIEW

Strategic Objective		SO3 Drive Service improvements, innovation and transformation				Committee	Exec Lead	
						Finance & Performance	Medical Director	
Strategic Risk No	BAF 3a	**Pre Mitigations Risk Score**	L x C 4X4 (16)	**Post Mitigations Current Risk Score**	L x C 3X4 (12)	**Board Risk Appetite** **Moderate**	**Target Score**	L x C 2X4 (8)

RISK: The Dudley Improvement Strategy may not be delivered due to insufficient transformational leadership capability and capacity, resulting in a lack of innovation and a failure to improve services

Cause / Effect	**Impact of the Risk**
• If the Improvement Practice Programme is discontinued due to lack of leadership support and commitment, the trust would need to find an alternative approach to continuous quality improvement.	• Cost of an alternative programme is likely to be in excess of £0.5m and would take at least 1 year to establish. • Without a standard approach to improvement, there could be a slow decline in the quality and cost of services.

Quarters					**Q1**	**Q2**	**Q3**	**Q4**
Assurance Rating Key: Assurance rating of achieving Target Risk Score by Mar 2021	Significant Assurance	Acceptable Assurance	Partial Assurance	No Assurance	Acceptable Assurance			

KEY CONTROLS IN PLACE	ASSURANCE THAT CONTROLS ARE EFFECTIVE [Yes / No (if no what action is being taken)	LEVEL of CONTROL 1 = Operational 2 = Committee 3 = External
Contract with NHSI/E until June 2021 provides support from an Improvement consultant for 2 days per week and an executive coach for 8 days per annum	Yes	3
Training at three levels of competency is in place and currently being undertaken by the exec team	Yes	1
The Improvement Practice team has four members of staff and a plan to grow beyond 2019	Yes	2

BAF Risk 3a continued

SPECIFIC GAPS IN CONTROL / ASSURANCE	ACTIONS	STATUS:			
		COMPLETE	IN PROGRESS	OUTSTANDING (BEYOND COMPLETION DATE	
The main areas of weakness which result in ineffective or absent controls / assurance	*Actions required to mitigate the weaknesses*			*Date for completion*	*Action Lead*
Regular Board update (suggest quarterly) to provide assurance and request support to unblock issues.	Seek agreement for quarterly reporting to Board – GG, HF			Jun 2019	Pete Lowe
It is not possible to reduce the consequence of failure, only the likelihood can be reduced.	Recruit Specialist Practice Coach (start mid-May) to avoid single point of failure in deploying the Practice.			Jun 2019	Pete Lowe

Strategic Objective		SO4 Be the place people choose to work				Committee	Exec Lead	
						Finance & Performance Sub working group: Work Force	Director of Workforce & OD	
Strategic Risk No	BAF 4a	**Pre Mitigations Risk Score**	L x C 4X4 (16)	**Post Mitigations Current Risk Score**	L x C 3X4 (12)	**Board Risk Appetite** **Open**	**Target Score**	L x C 3X4 (12)

RISK: An inability to recruit sufficient numbers of appropriately trained staff due to national and local staff shortages may impact on being unable to meet service demand or provide safe, high quality services resulting in increased temporary workforce spend

Cause / Effect	**Impact of the Risk**
• The impact of not recruiting the sufficient numbers required, especially in clinical roles such as medical staff, nursing and AHPs, this therefore creates higher demand for temporary workforce solutions with the effect of an inconsistent workforce at premium cost.	• Not having sufficient staff numbers will have an impact financially due to increase in the temporary workforce as well as an impact on consistency of care provided as a result of daily changes of the workforce. There will also be an impact on staff morale when areas are not substantively staffed to meet the demands of patient care.

Quarters					**Q1**	**Q2**	**Q3**	**Q4**
Assurance Rating KEY: Assurance rating of achieving Target Risk Score by Mar 2021	Significant Assurance	Acceptable Assurance	Partial Assurance	No Assurance	Partial Assurance			

KEY CONTROLS IN PLACE	ASSURANCE THAT CONTROLS ARE EFFECTIVE [Yes / No (if no what action is being taken)	LEVEL of CONTROL 1 = Operational 2 = Committee 3 = External
Nurse recruitment lead established to work alongside departments in order to support innovative ways to recruit new nursing staff	Y	1
Corporate recruitment events alongside bespoke recruitment events for areas with high levels of vacancies as well as participating in external recruitment events	Y	1
Development of MTI programme alongside college of physicians in Pakistan Fortnightly meetings of senior medical management team to consider gaps in rota and actions associated to long standing vacant posts in order to encourage a substantive solutions	Y	1

BAF Risk 4a continued

KEY CONTROLS IN PLACE	ASSURANCE THAT CONTROLS ARE EFFECTIVE [Yes / No (if no what action is being taken)]	LEVEL of CONTROL 1 = Operational 2 = Committee 3 = External
Nurse recruitment lead established to work alongside departments in order to support innovative ways to recruit new nursing staff	Y	1
Corporate recruitment events alongside bespoke recruitment events for areas with high levels of vacancies as well as participating in external recruitment events	Y	1
Development of MTI programme alongside college of physicians in Pakistan Fortnightly meetings of senior medical management team to consider gaps in rota and actions associated to long standing vacant posts in order to encourage a substantive solutions	Y	1

SPECIFIC GAPS IN CONTROL / ASSURANCE	ACTIONS	STATUS:			
		COMPLETE	IN PROGRESS	OUTSTANDING (BEYOND COMPLETION DATE	
The main areas of weakness which result in ineffective or absent controls / assurance	*Actions required to mitigate the weaknesses*			*Date for completion*	*Action Lead*
• Further work required to align the work for nursing recruitment to the booking process for bank/agency staff in order to minimise requests and reduce costs. • Assessment and analysis of what recruitment is effective in order to concentrate the limited resource in activities that are successful. There is also a continued gap associated in brand management for the Trust. As	Work being undertaken as part of NHSI review to align nurse recruitment with bank/agency bookings.			April 20	Marcia Hylton/Carol Love-Mecrow
	Revised workforce plans associated to Divisional/department level and by staff group to consider assumptions and recruitment requirements			April 20	Dawn Woods/Marcia

much as Pakistan has been successful the MTI programme is not restricted to one country and therefore opportunities should be considered within other prospective countries such as Nigeria, especially as the Trust has links to this and other countries. • As much as Pakistan has been successful the MTI programme is not restricted to one country and therefore opportunities should be considered within other prospective countries such as Nigeria, especially as the Trust has links to this and other countries. The meetings do not always proceed and are not well attended therefore the attention required on actions associated to long standing vacancies is not as robust as would be expected. • The meetings do not always proceed and are not well attended therefore the attention required on actions associated to long standing vacancies is not as robust as would be expected.	to mitigate risks.		Hylton
	Audit of recruitment campaigns.	Oct 19	Carol Love-Mecrow/Dawn Woods
	MTI programme to be developed alongside one other country and managed effectively within Medical Management fortnightly meetings.	Oct 19	Hassan Paraiso/Jess Haycock

Strategic Objective		SO4 Be the place people choose to work				Committee	Exec Lead	
						Finance & Performance Sub working group: Work Force	Director of Workforce & OD	
Strategic Risk No	BAF 4b	**Pre Mitigations Risk Score**	L x C 4X4 (16)	**Post Mitigations Current Risk Score**	L x C 3X4 (12)	**Board Risk Appetite** **Moderate**	**Target Score**	L x C 2X4 (8)

RISK: If we fail to train and develop our workforce to have the right skills to enable the delivery of our clinical strategy, due to inadequate career development, talent management and leadership development, this may result in poor retention rates, difficulties recruiting and a failure to maximise the capabilities of staff

Cause / Effect	**Impact of the Risk**
• The Trust historically has not committed sufficient resource to staff development with a particular emphasis on professional development and management development. This has therefore had the effect of clinical staff leaving to find opportunities for professional development elsewhere while management capability has been depleted.	• The impact on insufficient professional development has been higher turnover in particular clinical posts that have led to higher vacancy rates leading to stress and morale issues alongside further dependency on agency workforce at premium cost. The insufficient support for management development has caused poor management of staff that has not always allowed effective delivery of business objectives and has ultimately led to senior staff acting down to provide disproportionate levels of support therefore effecting the impact they have on the organisation. This has caused reputational and operational performance issues.

Quarters					**Q1**	**Q2**	**Q3**	**Q4**
Assurance Rating Key: Assurance rating of achieving Target Risk Score by Mar 2021	Significant Assurance	Acceptable Assurance	Partial Assurance	No Assurance	Partial Assurance			

KEY CONTROLS IN PLACE	ASSURANCE THAT CONTROLS ARE EFFECTIVE [Yes / No (if no what action is being taken)]	LEVEL of CONTROL 1 = Operational 2 = Committee 3 = External
The revised Workforce Strategy provides greater focus on staff development with the Trust Board supportive of a learning culture being developed within the Trust	Y	1
The introduction of the Developing Leaders Programme in 2018 with targets set to ensure this acts as a prerequisite for current and aspirant leaders. This will ensure consistency of development aligned to Trust values	Y	3
Further resource provided to support the Professional development team support their ambitions and better meet the need of the clinical workforce	Y	1
Workforce key performance indicators that indicate levels of participation in development programmes	Y	1

SPECIFIC GAPS IN CONTROL / ASSURANCE	ACTIONS	STATUS: COMPLETE	IN PROGRESS	OUTSTANDING (BEYOND COMPLETION DATE)
The main areas of weakness which result in ineffective or absent controls / assurance	*Actions required to mitigate the weaknesses*		*Date for completion*	*Action Lead*
• There continues to be a disjointed approach to staff education and development with medical, nursing, AHP and corporate development sitting separately and therefore not always having a coordinated approach • As this programme was the first leadership development initiated in the Trust it is at the start of a long journey to support management development and capability. The immediate gaps are engagement with medical leaders to ensure they have the appropriate skill set to deliver on	Further collaboration with areas of development supported by the outcomes expressed in the Workforce Strategy.		Mar 20	Rachel Andrew
	Medical and clinical leaders programme introduced in 2019 aligned to existing programme but in the context of the different roles in medical/clinical leadership.		Mar 20	Rachel Andrew
	Review areas of further collaboration across		Mar 20	Rachel

their responsibilities and lead teams effectively. • Additional support has been provided to meet the Step up to Care programme but further review of resource to meet future need may be required. This only provides development at corporate level that is associated to management development and therefore needs to be broadened to capture other staff development.	education and training providers under the remit of the Workforce Group		Andrew, Carol Love-Mecrow and Atiq Rehman
• This only provides development at corporate level that is associated to management development and therefore needs to be broadened to capture other staff development.	Undertake review and audit of data collection systems that record training information to determine what changes can be made to provide better level of detailed analysis and information.	Mar 20	Becky Cooke

Strategic Objective		SO4 Be the place people choose to work				Committee	Exec Lead	
						Finance & Performance Sub working group: Work Force	Director of Workforce & OD	
Strategic Risk No	BAF 4c	**Pre Mitigations Risk Score**	L x C 4X4 (16)	**Post Mitigations Current Risk Score**	L x C 4X4 (16)	**Board Risk Appetite** **Moderate**	**Target Score**	L x C 3X4 (12)

RISK: Failure to effectively engage and involve our workforce by not listening, innovating and acting on their feedback and communicating effectively could lead to an inability to positively improve culture

Cause / Effect	**Impact of the Risk**
• Failure to engage effectively can create misinformation and losing the opportunity to develop and maintain good levels of morale and therefore an effective workforce that can deliver our strategic aims.	• The impact is higher levels of sickness, poor morale, increased employee relations issues all leading to an inability to fulfil the aims of the Trust to the standards expected.

Quarters					**Q1**	**Q2**	**Q3**	**Q4**
Assurance rating Key: Assurance rating of achieving Target Risk Score by Mar 2021	Significant Assurance	Acceptable Assurance	Partial Assurance	No Assurance	Partial Assurance			

EY CONTROLS IN PLACE	ASSURANCE THAT CONTROLS ARE EFFECTIVE [Yes / No (if no what action is being taken)	LEVEL of CONTROL 1 = Operational 2 = Committee 3 = External
Collection of staff engagement indicators that are published within the workforce KPIs report for Committees	Y	2
Feedback from the national staff survey and FFT results introduced on the basis on 'you said, we did'	Y	3
Board, Executive and senior management development programmes provide better understanding of role and responsibility and impact of positive engagement and impact of behaviours	Y	3

SPECIFIC GAPS IN CONTROL / ASSURANCE	ACTIONS	STATUS: COMPLETE	STATUS: IN PROGRESS	STATUS: OUTSTANDING (BEYOND COMPLETION DATE)	
The main areas of weakness which result in ineffective or absent controls / assurance	*Actions required to mitigate the weaknesses*			*Date for completion*	*Action Lead*
• The OD programme requires further sophistication, development and resource to allow it to continually support greater levels of effective engagement. • Further plans to prepare for 2019 staff survey with detailed approach and strategy in the months leading up to the 2019 survey demonstrating learning from previous year and aspiration for the future. • This is only been provided to a limited number of managers at this time and will develop throughout the year.	The introduction of the 'Make it Happen' OD programme that provides a collective description of engagement events initiated in the Trust since Autumn 2018. This will be supported with the Staff Engagement plan, the behavioural framework and the anti-bulling campaign.			Mar 2020	Rachel Andrew
	Plan to support detailed preparation for the forthcoming Staff Survey in 2019.			Oct 2019	Rachel Andrew
	Explicit requirement for development programme to include skills associated to engagement and support for staff and colleagues. This will also be supported by the introduction of anti-bulling campaign			Oct 2019	Rachel Andrew & Becky Cooke

Strategic Objective		SO5 Make the best use of what we have				Committee	Exec Lead	
						Finance & Performance	Director of Finance	
Strategic Risk No	BAF 5a	**Pre Mitigations Risk Score**	L x C 4X5 (20)	**Post Mitigations Current Risk Score**	L x C 3X5 (15)	**Board Risk Appetite**	**Target Score**	L x C 2X5 (10)
						Moderate		

RISK: Failure to recognise the importance and impact of our constrained financial position due to a lack of understanding, engagement and financial discipline mean we miss key financial targets, run out of cash and come under greater regulatory scrutiny

Cause / Effect	**Impact of the Risk**
• Failure to fully understand the actual, forecast and underlying financial Income and Expenditure and cash position can lead to a lack of financial discipline and awareness.	• Poor decision making and a weakened ability to manage a deteriorating financial position such as when to seek support for the cash position, budget holders uncertain of resource availability, efficient use of resources and reputation

Quarters					**Q1**	**Q2**	**Q3**	**Q4**
Assurance Rating Key: Assurance rating of achieving Target Risk Score by Mar 2021	Significant Assurance	Acceptable Assurance	Partial Assurance	No Assurance	Partial Assurance			

KEY CONTROLS IN PLACE	ASSURANCE THAT CONTROLS ARE EFFECTIVE [Yes / No (if no what action is being taken)	LEVEL of CONTROL 1 = Operational 2 = Committee 3 = External
Financial Management, Control and Planning Policies	Yes	2
Business Cases	Yes	2
Financial Improvement Programme	No - work in progress (continuous improvement through financial year	1
Budget Holder Training	Yes	1
SFI's	Yes	2
Scheme of Delegation	Yes	2

SPECIFIC GAPS IN CONTROL / ASSURANCE	ACTIONS	STATUS:		
		COMPLETE	IN PROGRESS	OUTSTANDING (BEYOND COMPLETION DATE
The main areas of weakness which result in ineffective or absent controls / assurance	*Actions required to mitigate the weaknesses*		*Date for completion*	*Action Lead*
• Understanding the Underlying Position, adherence to policies • Adherence to Business Case processes, link to affordability • Adherence to Resources to deliver • Adherence to Budget Holder Training • Adherence to Scheme of Delegation	Reporting of the Underlying Position		Jun 2019	Richard Price
	Budget Holder Training		Jun 2019	Richard Price
	Audit of Financial Controls		Mar 2020	Chris Walker
	CIP proposals proposed and fully reviewed		Sep 2020	Natalie Younes

Strategic Objective		SO5 Make the best use of what we have				Committee	Exec Lead	
						Finance & Performance Sub working group: Digital Trust	Chief Information Officer	
Strategic Risk No	BAF 5b	**Pre Mitigations Risk Score**	L x C 3X5 (15)	**Post Mitigations Current Risk Score**	L x C 2X5 (10)	**Board Risk Appetite** **Moderate**	**Target Score**	L x C 3X4 (12)

RISK: Failure to successfully adopt digital workflows, due to competing organisation / clinical pressures, availability of resources and change fatigue; results in clinical risk, reputational risk and inefficiency

Cause / Effect

Staff Engagement:

- Competing organisational priorities / change fatigue – failure to adapt new work flows and system

Business Risk / Reputational Risk

- Operational / clinical pressures – delayed roll out leading to risk of legacy system failing with no strategic mitigation
- Cyberthreats and major failure of legacy systems / infrastructure impact staff adoption of digital workflows and Trust reputation
- Failure to deliver infrastructure for interoperable digital workflows impact DGNHSFT sustainability / STP goals

Clinical Risk

- Not delivering maintains current levels of clinical risk with no systematic mitigation
- Lack of resources caused by delayed roll outs – leads to insufficient go-live support

Impact of the Risk

- Failure to deliver improved efficiencies and patient outcomes
- Increased clinical risk or sustained current state clinical risk
- Exposure to a Trust wide failure of legacy Soarian EPR impacting service
- Failure to meet NHS standard contract terms
- Fail NHS Long term-plan / Personalised Health and Care 2020 vision and objectives
- Adverse impact on patient outcomes or delays to patient care
- Failure to deliver sustainability in a future platform for strategic objective 'SO3 Drive Service improvements, innovation and transformation' for future years transformation plans
- Failure to support new models of care and future adoption of digital workflows
- Inability to attract clinical work in the region
- Inability to meet increasing demands for data returns in short timescales (remaining manual)
- Loss of revenue
- Trust reputation damaged

Quarters					Q1	Q2	Q3	Q4
Assurance Rating Key: Assurance rating of achieving Target Risk Score by Mar 2021	Significant Assurance	Acceptable Assurance	Partial Assurance	No Assurance	Acceptable Assurance			

KEY CONTROLS IN PLACE	ASSURANCE THAT CONTROLS ARE EFFECTIVE [Yes / No (if no what action is being taken)	LEVEL of CONTROL 1 = Operational 2 = Committee 3 = External
Over 120 senior clinical / operational staff involved in defining requirements and assessing suppliers to identify preferred solution	Y	1
A Chief Clinical Information Officer (Consultant), Clinical Safety Officer (Consultant) and one Chief Nursing Information Officer (Deputy Chief Nurse) provide clinical leadership and ward / dept facing opportunity to engage with the project	Y / N	1
The clinical approvals group (CAG) provides clinical governance and workforce engagement	Y	2
Design is led by clinical / operational governance groups	Y	1
Testing and validation is undertaken by Trust staff	Y	1
Formal (service desk and governance meetings) and informal (regular 'have you say events' CCIO) feedback processes exits to allow improvements and requests to incorporated into the project	Y	1
Trust Comms Dept communication plan provides multi-channel engagement with staff / CCIO runs regular lecture theatre sessions for clinical teams	Y / N	1
Training team and floorwalkers are ward / department facing	Y	1
Engaged divisional Ops teams to capture detail for cut-over planning	Y	1
Engagement of Executive (COO) in go/no-go decision	Y	1
Monitoring of Trust pressures in planning, awareness of project roll out milestones	Y	1
CIO and Executive linked to MCP programme for shared digital workflows across the Dudley health care system	Y	3
Trust engaged with Black Country Pathology Service (BCPS) on infrastructure to deliver shared digital workflows	Y	3
Trust engaged with Black Country Local Maternity System (LMS) integration of digital workflows	Y	3

Infrastructure is managed through TerFirma IT to provide a state-of-the-art infrastructure to support the delivery of shared records population health platform between GPs and DGNHSFT (formally BAF 599)	Y	3
CCIO chaired CAG provides clinical governance authority reporting to CQSPE for digital transformation of clinical work	Y	2
Allscripts are compliant with DCB0129 – clinical risk management and have a designated clinical safety officer (CSO) Dr Anna Bayes	Y	3
DGNHFT are complaint with DCB0160 – clinical risk management and have a designated clinical safety officer (CSO) – Mr Olu Oluwajobi	Y	3
CCIO and CSO report to MD clinical executive	Y	1
CNIO reports to CN clinical executive	Y	1
Trust is engaged with the Black Country STP digital board to discuss collaborative approaches to digital workflows	Y	**3**

SPECIFIC GAPS IN CONTROL / ASSURANCE	**ACTIONS**	**STATUS:**		
		COMPLETE	**IN PROGRESS**	**OUTSTANDING (BEYOND COMPLETION DATE**
The main areas of weakness which result in ineffective or absent controls / assurance	*Actions required to mitigate the weaknesses*		*Date for completion*	*Action Lead*
1. Dissemination of clear messages into wider clinical community by members of the CAG do not always occur / inconsistent leading to disenfranchised staff. 2. Staff with high levels of digital engagement, leaving a gap to those less eager. 3. Original strategy launched under different executive / senior leadership teams leaving an awareness Gap 4. Risk appetite lower than current risk level – leading to avoidance disruption / go-live 5. Lack of Staff engagement – creates a block to adopting change	Go-Live with strategic EPR solution (Sunrise) to replace legacy Soarian system (ED / ORM) removes dual systems of work and corporate risk of legacy system failure Corp Risk CE009 / COR091)		May 19	Adam Thomas (CIO), Dr Max Hodges (CCIO) Mitchell Fernadez (CNIO) Mr Olu Oluwajobi (CSO)

6. Speed of mobilisation and operational readiness leading to lag-time 7. On-going system support, by skilled staff 8. Revenue to recruit and retain adequate skills to deliver projects of this scale 9. New initiatives divert resources away from core project activity 10. Lack of clarity on HSLI Pop Health fund matching (approved case in 18/19 funding held back) carrying forward into 19/20 11. Clarity on MCP strategic formation 12. Changes in BCPS priorities and co-dependent risk (transferred Corp risk CE008) 13. Failure of existing EPR (Soarian) may mean electronic record is irrecoverable. Sunrise Go-live is only mitigation (Corp Risk CE009 / COR091) 14. Operational No-Go decision protracts existing higher levels of clinical risk / dual systems of work and chance of Soarian failure. 15. Current levels of organisational-wide clinical risk in practice are poorly understood by the workforce, so that something new seems more risk than something familiar. 16. Digital Trust programme perceived as a technology / IT project rather than clinical transformation (see item 1).	Relaunch a refresh Digital Trust Strategy to Executive and Trust board linked to current operating context and NHS long-term plan	Sep 19	Adam Thomas
	Reinforce clinically led Trust wide communications following the approved Digital Trust Communications Plan	Sep 19	Dr Max Hodges / Liz Abbiss
	Embedding of Digital Transformation through clinically led Board committee's (CQPSE) and groups to ensure that digital first forms part of a reasonable assurance processes and avoids false assurances.	Jul 19	Dr Max Hodges / Mitchell Fernadez
	Increase exposure of all clinical groups to independent clinical safety review (CSR) of each project roll out, driving digital skills within the wider clinical workforce and better understanding of clinical risk at an organisational level.	Sep 19	Mr Olu Oluwajobi
	Seek Clarity on STP funding, HSLI Pop Health fund matching (approved case in 18/19 funding held back) carrying forward into 19/20	Sep 19	Adam Thomas

THIS BAF IS UNDER FULL REVIEW

Strategic Objective		**SO6 Deliver a viable future**				**Committee**	**Exec Lead**	
						Finance & Performance	Director of Strategy and Business Development	
Strategic Risk No	BAF 6a	**Pre Mitigations Risk Score**	L x C 5X4 (20)	**Post Mitigations Current Risk Score**	L x C 4X4 (16)	**Board Risk Appetite**	**Target Score**	L x C 3X4 (12)
						Open		

RISK: Failure of the Trust to influence the local and wider evolving health economy due to a lack of engagement and poor performance undermining our credibility means our clinical and financial viability is undermined as we lose key high value services and opportunities for profitable growth

Cause / Effect	**Impact of the Risk**
• A number of acute Trusts within a small geographical area providing similar services. • Competition from Royal Wolverhampton to host the vascular hub. • Patient flows not align with the emerging Integrated Care Systems (patients can reside in one CCG but are referred to a provider in a neighbouring CCG. • Neighbouring Trusts reported to be changing referral patterns • Lack of engagement with GP practices and patients and poor performance mean that referral patterns remain unchanged	• Not enough patients referred to sustain services if similar services are provided by all local Trusts • If lack of agreement of location of vascular services this will hinder the future development of the service. • Loss of activity and income to neighbouring Trusts if referral patterns change • GP and patients refer patients into the private sector with consequent loss of opportunity to benefit from this activity (lack GP engagement or poor performance) • Loss of activity and associated income may destabilise some services impacting on continued provision

Quarters					**Q1**	**Q2**	**Q3**	**Q4**
Assurance Rating KEY: Assurance rating of achieving Target Risk Score by Mar 2021	Significant Assurance	Acceptable Assurance	Partial Assurance	No Assurance	Partial Assurance			

BAF Risk 6a continued

KEY CONTROLS IN PLACE	ASSURANCE THAT CONTROLS ARE EFFECTIVE [Yes / No (if no what action is being taken)	LEVEL of CONTROL 1 = Operational 2 = Committee 3 = External
Trust's Strategy 2019 - 2021 (identifies market share, opportunities for business growth and use of the Trust by GP practice)	Yes	1
A comparative analysis of performance is presented to F&P Committee every six months with an evolving range of measures discussed to highlight the Trust's strengths and weaknesses. This includes market share analysis to identify changes in referral patterns	Yes	2
The Director of Strategy and Business Development takes part in a monthly meeting with counterparts to discuss a common approach for specialised and vulnerable services	Yes	3
Service strategies developed with the Medical Service Head and DM's for onward approval and development of monitoring arrangements at Divisional and Exec Board level	Yes	2

SPECIFIC GAPS IN CONTROL / ASSURANCE	ACTIONS	STATUS: COMPLETE	STATUS: IN PROGRESS	STATUS: OUTSTANDING (BEYOND COMPLETION DATE)	
The main areas of weakness which result in ineffective or absent controls / assurance	*Actions required to mitigate the weaknesses*			*Date for completion*	*Action Lead*
• No Communication and Engagement plan (including the production of promotional material for our services, regular relationship meetings and the continuation of competitor analysis and market monitoring). • Limited involvement by Trust staff in the different work streams of the STP. • Lack of visibility by Trust staff of the different workstreams of the STP	Development of proposal for re-development of the Trust website			Nov 2019	Tricia Morrison
	Development of the content for the 5 specialties on the re developed Trust website			Dec 2019	Tricia Morrison
	Development of bespoke communication and PR plans for each priority service: • Orthopaedics • Gynaecology • General Surgery • Gastroenterology • Ophthalmology			Sep 2019	Ian Chadwell
	Development of an approach to engagement with GP practices to support business growth - Pilot an approach with practices that are high users of trust services in Sandwell & West Birmingham CCG			Jun 2019	Natalie Younes
	Development of an approach to engagement with GP practices to support business growth - Roll out to other practices during 2019/20			Mar 2020	Natalie Younes
	Strengthen engagement with the work streams of the STP by having named individuals working on designated work streams			Sep 2019	Natalie Younes

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Enclosure 14

The Dudley Group NHS Foundation Trust

Paper for submission to the Board of Directors 4th July 2019

TITLE:	**Corporate Risk Register**		
AUTHOR:	Sharon Phillips – Deputy Director of Governance	**PRESENTER**	Gilbert George – Director of Governance and Board Secretary

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

- To make any observations and challenge to the respective Risk Leads for the Corporate risks with regards to:
  - Risk Scores
  - Actions
  - Controls
  - Assurances
  - Concerns
- Following discussion and debate of agenda items to identify any additional risks that are felt to be omitted or require escalation or de-escalation

CORPORATE OBJECTIVE:

All

SUMMARY OF KEY ISSUES:

New Risks

1. **NEW CORPORATE RISKS (refer sections 4 (table) and section 5)**
   6 risks were been added to the Corporate Risk register in June 2019. Of these 5, there were 4 new risks, 1 rewritten risk and 1 escalated from the Clinical Support Division by the Board in

June 2019

- COR1046 Failure to deliver the Imaging CQC post inspection action plan and improve CQC Rating (new rewrite)
- COR1016 Temperatures in medicines storage rooms exceeding manufacturers recommendations (escalated)
- COR1041 Access to 7 day clinical services to deliver key standards, patient outcomes and contribute to clinical networks (new)
- COR1054 Inability to achieve contract indicators (new)
- COR1063 Data Validation for sepsis reporting (rewritten)

Risk to be added to the Corporate Risk Register

There is 1 risk that was identified at Junes 2019 Board meeting to be added as a corporate risk this is in relation to

Pension issues impacting high earners particularly consultants

RISK ACTIONS (refer section 5)

There is 1 corporate risk where all the actions have been completed but is not achieving its target score.
COR1012 Failure to remain financially sustainable in 2019/20

MOVEMENT OF CORPORATE RISKS (refer section 5)

The risk score for one corporate risk 'COR1028 Poor experience for patients and families at end of life' has increased from 8 (2X4) to 12 (3X4).

ASSURANCE (refer to section 4/5)

Of the 19 corporate risks 5 had had negative assurance in June 2019. In summary

IMPLICATIONS OF PAPER:

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

1. BACKGROUND

The purpose of the report is to highlight the risks that sit on the corporate risk register and board assurance against each. Each corporate risk has an Executive Lead who has oversight of the risk and is responsible to drive completion and provide assurance to the Board.

The Board sub-committees have a responsibility for the oversight of the corporate risks linked to their terms of reference. This allows these to be considered and challenged against the debate and activity of the committee. The risks highlighted in this report have oversight by this committee.

2. NEW CORPORATE RISKS

6 risks were added to the Corporate Risk register in June 2019. Of these 5, there were 4 new risks, 1 rewritten risk and 1 escalated from the Clinical Support Division by the Board in June 2019

- COR1046 Failure to deliver the Imaging CQC post inspection action plan and improve CQC Rating (new rewrite)
- COR1016 Temperatures in medicines storage rooms exceeding manufacturers recommendations (escalated)
- COR1041 Access to 7 day clinical services to deliver key standards, patient outcomes and contribute to clinical networks (new)
- COR1054 Inability to achieve contract indicators (new)
- COR1063 Data Validation for sepsis reporting (rewritten)

Risk to be added to the Corporate Risk Register

There is 1 pending risk that was identified at Junes 2019 Board meeting to be added as a corporate risk this is in relation to

- Pension issues impacting high earners particularly consultants

4 RISK ACTIONS

There is 1 corporate risk where all the actions have been completed but is not achieving its target score.

- COR1012 Failure to remain financially sustainable in 2019/20

There are no risk actions that have breached their identified dates for completion on the Corporate Risk register

3. MOVEMENT OF CORPORATE RISKS

Increased Risk score

The risk score for one corporate risk 'COR1028 Poor experience for patients and families at end of life' has increased from 8 (2X4) to 12 (3X4). This was due to

- It not presently being possible to identify expected/non-expected deaths within the data, although this will be included in Electronic Patient Record (EPR) during 2019. In addition the coding does not accurately reflect if a palliative care patient is expected to die on any given admission and therefore there is no assurance a Priories of Care document is put in place

Closure of risk

There was one risk 'COR1053 Sepsis screening no longer an integral part of NEWS in rollout of Sunrise' reviewed by the Medical Director who determined the risk had been mitigated with the exception of the validation of sepsis compliance date. This risk was rewritten as a new risk 'COR1063 Data Validation for sepsis reporting'

4. ASSURANCE (refer section 5)

Of the 19 corporate risks 5 had had negative assurance in June 2019. In summary

- COR1028 Poor experience for patients and families at end of life (refer to section 3 current risk score increased from 8 (2X4) to 12 (3X4)). This was due to the inability currently to identify expected/non-expected deaths within the data (this will be included in Electronic Patient Record (EPR) during 2019). Not all palliative care patients are expected to die on any given admission and therefore not all would have a Priories of Care document in place.

- COR1054 Inability to achieve contract indicators (current risk score remained 4X4 (16)). This was due as a result of the 52 LQR's, 37 were reportable in May. 11 failed against the target and only 1 met the trajectory.

- COR578 Not delivering on the agreed CQUIN requirements (current risk score remained 4X3 (12)). This was due to 15 action plans for CQUINS to achieve £3 million. Of the 15 there are 9 expected to achieve part payment results only. Lack of clinical engagement currently to deliver the schemes. Robust pathways will need to be embedded to support same day emergency care requirements. May need additional investment to support delivery.

- COR1011 Failure to maintain liquidity in 2019-20 and beyond (current risk score remained 5X4 (20)). This was due to the Trusts liquidity position remaining at risk. The current forecast cash flow shows the Trust running out of cash in September using the latest I&E forecasts.

- COR748 Governance arrangements from floor to board through the divisional structure not consistent to identify risks (current risk score remained 4X4 (16)). This was highlighted by CQC of inconsistencies in the governance arrangement and documentation used within the Divisions.

Overview of movement of corporate risks

The following table provides an overview of the corporate risks and shows its month my month movement in relation to the current risk score. Further detail for each risk can be found at section 4 in relation to action and assurances.

Exec Lead	Risk Mitigator	Ref	Risk Title	Date entered on Risk Register	Initial Risk Score	Current Risk Score											
						May 2019	June 2019									Trend	Target Risk Score
	Objectives: SO1 Deliver a great patient experience																
CN	**Jill Faulkner**	COR1010	Failure to comply with local and statutory provisions for complaints management	08/05/19	5 X 4 (20)	4 X 4 (16)	4 X 4 (16)									➔	2 X 3 (6)
COO	**Ann-Marie Williams**	COR1046	Failure to deliver the Imaging CQC post inspection action plan and improve CQC Rating	12/06/19	4 X 5 (20)	NEW	4 X 4 (16)										2 X 4 (8)
COO	**Johanne Newens**	COR1002	Maintaining high performance in national operational performance Standards and capacity meeting demand	02/05/19	5 x 4 (20)	5 x 4 (20)	5 x 4 (20)									➔	2 x 4 (8)
	Objectives: SO2 Safe and Caring services																
MD	**Phil Brammer**	COR1016	Mortality reviews generate learning that is not widely shared across the organisation	13/05/19	3 X 4 (12)	3 X 4 (12)	3 X 4 (12)									➔	1 X 4 (8)
MD	**Phil Brammer**	COR1015	Compliance to the identification and action of all deteriorating patient groups	13/05/19	4 X 5 (20)	3 X 5 (15)	3 X 5 (15)									➔	2 X 5 (10)
CN	**Jo Wakeman**	COR1026	Compliance to statutory Safeguarding processes, systems and practice	21/05/19	5 X 4 (20)	4 X 4 (16)	4 X 4 (16)									➔	2 X 4 (8)
CN	**Mitchel Ferndandez**	COR1028	Poor experience for patients and families at end of life	22/05/19	3 X 4 (12)	2 X 4 (8)	3 X 4 (12)									➔	1 X 4 (4)
COO	**Ruckie Kahlon**	COR896 (CSS896)	Temperatures in medicines storage rooms exceeding manufacturers recommendations	16/01/19	5 X 3 (15)	ESC	5 X 3 (15)										2 X 3 (6)
COO	**Karen Kelly**	COR578	Not delivering on the agreed CQUIN requirements	24/04/19	5 x 3 (15)	5 x 3 (15)	5 x 3 (15)									➔	2 x 3 (6)
DF	**Chris Walker**	COR844	Failure of the PFI Contract FM Provider Interserve	07/12/18	4 x 5 (20)	3 x 5 (15)	3 x 5 (15)									➔	2 x 5 (10)

Exec Lead	Risk Mitigator	Ref	Risk Title	Date entered on Risk Register	Initial Risk Score	Current Risk Score										Target Risk Score
						May 2019	June 2019								Trend	
HRD	Andrew McMenemy	COR982	Poor compliance to Trust mandatory training in specific areas	12/04/19	4 x 4 (16)	4 x 4 (16)	4 x 4 (16)								➲	1 x 4 (4)
BS	Gilbert George	COR748	Governance arrangements from floor to board through the divisional structure not consistent to identify risks	10/09/18	5 X 4 (20)	4 x 4 (16)	4 x 4 (16)								➲	2 X 4 (8)
	Objectives: SO3 Drive Service Improvements, innovations and transformation															
MD	Bill Dainty	COR1053	Sepsis screening no longer an integral part of NEWS in rollout of Sunrise	18/06/19	3 X 5 (15)	2 x 5 (10)	Closed									2 x 5 (10)
MD	Bill Dainty	COR1063	Data Validation for sepsis reporting	26/06/19	4 X 5 (20)	NEW	3 x 4 (12)									2 x 4 (8)
MD	Paul Hudson	COR1041	Access to 7 day clinical services to deliver key standards, patient outcomes and contribute to clinical networks	10/06/19	4 x 5 (20)	NEW	3 x 4 (12)									2 x 4 (8)
	Objectives: SO4 Be the Place People Choose to Work															
HRD	Andrew Mcmenemy	COR 981	High levels of staff absence resulting in staff shortages and agency expenditure	12/04/19	5 x 4 (20)	4 x 4 (16)	4 x 4 (16)								➲	2 x 4 (8)
	Objectives: SO5 Make the best use of what we have															
MD	Julian Hobbs	COR959	Financial implications of job planning	11/03/19	4 x 4 (16)	4 x 4 (16)	4 x 4 (16)								➲	2 x 4 (8)
	Objectives: SO6 Deliver a viable future															
DF	Richard Price	COR1012	Failure to remain financially sustainable in 2019/20	01/04/19	5 x 4 (20)	5 x 4 (20)	5 x 4 (20)								➲	2 x 4 (8)
DF	Chris Walker	COR1011	Failure to maintain liquidity in 2019-20 and beyond	08/05/19	5 x 4 (20)	5 x 4 (20)	5 x 4 (20)								➲	2 X 4 (8)
COO	Karen Kelly	COR1054	COR1054 Inability to achieve contract indicators	19/06/19	5 x 4 (20)	NEW	4 x 4 (16)									2 X 4 (8)

5. ACTIONS AND ASSURANCE OF RISKS - CORPORATE

The following table provides an overview of the risk and the identified actions to mitigate the risk. In addition this identifies any assurances since the last report of actions taken, performance or compliance. This has been grouped under the director lead to facilitate discussion

Exec Lead	Risk Mitigator	Current Score	Ref	Risk Title	Open Action	Date to be completed by	Action Lead	Assurance
CHIEF NURSE								
CN	Jo Wakeman	4 X 4 (16)	COR1026	Compliance to statutory Safeguarding processes, systems and practice	Advertise Head of Safeguarding post (job description re written)	05/07/19	Jo Wakeman	**Positive Assurance** The Safeguarding Audit plan was agreed in April 2019 The Deputy Chief Nurse has established links with the Clinical experts to ensure that statutory obligations are met or escalated The risk register has been reviewed to ensure that the organisation is sighted on any potential risks
					Advertise Designated Doctor post	05/07/19	Julian Hobbs	
CN	Jill Faulkner	4 X 4 (16)	COR1010	Failure to comply with local and statutory provisions for complaints management	Development and submission of business case for resources	30/06/19	Jill Faulkner	**Positive Assurance** Development and submission of business case- completed and with finance. Review of function of the complaints learning and review group completed and developed into a learning event- 'Learning Through Experience'. First event held on 17 June 2019 with good attendance Next event will be held in September 2019 (quarterly). Implementation of education and development programme- continues to be under development.
					Implementation of education and development programme	30/06/19	Jill Faulkner	
					Review the efficiency and effectiveness of the complaints process as part of Dudley Improvement Practice Initiative	30/06/19	Jill Faulkner	

Exec Lead	Risk Mitigator	Current Score	Ref	Risk Title	Open Action	Date to be completed by	Action Lead	Assurance
								Review of complaints process- Meeting held 17 June 2019, several actions outstanding with divisions.
CN	Mitchel Fernandez	3 X 4 (12)	COR1028	Poor experience for patients and families at end of life	Invite the Head of Learning and Organisational Development to the End of Life group meeting	31/07/19	Mitchell Fernandez	**Positive Assurance** Review undertaken with informatics team on how the required information and data will be collected accurately and reported to the quality dashboard. **Negative Assurance** It is not currently possible to identify expected/non-expected deaths within the data (this will be included in Electronic Patient Record (EPR) during 2019) It was identified that not all palliative care patients would be expected to die on any given admission and therefore not all would have a Priories of Care document in place.
					Include EOL eLearning training compliance in the EOL group meeting agenda	31/07/19	Mitchell Fernandez/ Jo Bowen	
					Undertake the manual collection and audit on Priorities for Care documentation and review sustainability	31/07/19	Andy Troth (Informatics & Clinical Coding)	
					Undertake a snapshot audit on compliance with regards to Priorities of Care documentation for patient referred to Specialist Palliative Team	31/07/19	Katherine Hall	
					A meeting with Quality Team and Perfect ward provider to consider Inclusion of Priorities of Care documentation as part of Perfect ward audit	31/08/19	Katherine Hall/ Amanda Jones	
CHIEF OPERATING OFFICER								
COO	Newens, Johanne	5 x 4 (20)	COR1002	Maintaining high performance in national operational performance Standards and capacity meeting demand	Set up group to assist with reducing delays in transfers of care	30/08/2019	Karen Kelly	**Positive Assurance** The Trust is part of a national plan to reducing length of stay which will reduce delayed transfers of care. Group being led by COO, Chief Nurse and Medical Director to assist with reducing the delays.
					Adherence to national planning to reduce length of stay	30/09/2019	Johanne Newens	

Exec Lead	Risk Mitigator	Current Score	Ref	Risk Title	Open Action	Date to be completed by	Action Lead	Assurance
COO	Kelly, Karen	4 x 4 (16)	COR1054	Inability to achieve contract indicators	Informatics to review the data and ensure it is reporting the KPI	31/07/2019	Andy Troth	**Negative Assurance** From 52 LQR's, 37 were reportable in May. 11 failed against target and 1 met trajectory. From 42 LIR's, 15 were reportable, 14 were reported and 1 is still under review with informatics.
					Check and challenge to be implemented	31/08/2019	Richard Price	
					Address tighter control for mitigation plan at Ops Meetings	30/09/2019	Karen Kelly	
					Escalation of non-receipt of exception reports for underperforming indicators to be reported at Ops Meeting	30/09/2019	Karen Kelly	
COO	Ann-Marie Williams	4 X 4 (16)	COR1046	Failure to deliver the Imaging CQC post inspection action plan and improve CQC Rating	Completion of the Imaging CQC Action Plan	31/12/20	Whiles, Julie	**Positive Assurance** Significant progress on the Must and Should do's from the CQC inspection
					Completion of the Imaging staffing review	31/07/19	Whiles, Julie	
COO	Kelly, Karen	3 X 5 (15)	COR578	Not delivering on the agreed CQUIN requirements	Develop and Deliver all CQUIN schemes	31/03/2020	Karen Kelly	**Positive Assurance** Audits are being performed to give an oversight and upfront position before reporting to support changes required to support delivery. Check and Challenge sessions have been revisited and a more robust performance framework has been implemented. **Negative Assurance** There are 15 action plans for CQUINS to achieve £3 million. Of the 15, 9 are expected to achieve part payment results only. Lack of clinical engagement currently to deliver the schemes. Robust pathways will need to be embedded to support same day emergency care requirements. May need additional investment to support delivery.

Exec Lead	Risk Mitigator	Current Score	Ref	Risk Title	Open Action	Date to be completed by	Action Lead	Assurance
COO	Ruckie Kahlon	5 X 3 (15)	COR896 (CSS896)	Temperatures in medicines storage rooms exceeding manufacturers recommendations	Set up task and finish group to develop plans for a business case	28/06/19	Ruckie Kahlon	NEW
					Develop a business case to describe options to mitigate medicine storage temperature excursion risk	31/07/19	Ruckie Kahlon	
MEDICAL DIRECTOR								
MD	Phil Brammer	3 X 5 (15)	COR1015	Compliance to the identification and action of all deteriorating patient groups	Development of Diploma in the management of the deteriorating patient	31/07/19	Nicola Calthorpe	**Positive Assurance** Human Factors Training being delivered throughout the Trust.
					Ensure implementation of the Deteriorating Patient Pathway	31/07/19	Phillip Brammer	
					Review of rota management and medical staffing	30/09/19	Mr Atiq Rehman	
MD	Edwards, Rebecca	4 X 4 (16)	COR959	Financial implications of job planning	Review of policy with JLNC	31/07/2019	Rebecca Edwards	**Positive Assurance** Meetings held with the Finance Team to discuss concerns. Agreement for change forms to be returned to directorates for approval as not appropriate for medical director to approve budget changes. A job planning steering Group has been established with representation from finance, divisions and medical workforce to provide thorough review of proposed changes to job plans. There has been a re-audit of the job planning process
MD	Hudson, Dr Paul	3 X 5 (15)	COR1041	Access to 7 day clinical services to deliver key standards, patient	Development and implementation of 7 day service SOP to meet standards by 2020	01/03/2020	Hudson, Dr Paul	**Positive Assurance** A directory of 7 day services has been developed

Exec Lead	Risk Mitigator	Current Score	Ref	Risk Title	Open Action	Date to be completed by	Action Lead	Assurance
				outcomes and contribute to clinical networks	Completion of medical workforce and staffing review	01/11/19	Julian Hobbs	
MD	Bill Dainty	2X 5 (10)	COR1053	Sepsis screening no longer an integral part of NEWS in rollout of Sunrise	Revision of the sepsis document	31/08/19	Bill Dainty	**Risk Closed** Risk reviewed by Dr Hobbs and Dr Brammer, determined this had been mitigated and the requirement to be rewritten to be reflective of current risk – refer to new risk COR1063
					Advice from Terafirma to investigate linking the flowsheet to the document	31/08/19	Bill Dainty	
MD	Bill Dainty		COR1063	Data validation for sepsis reporting	AQUA external review of sepsis data and outcomes	24/08/19	Rebecca Edwards	NEW
					External data validation	31/08/19	Rebecca Edwards	
					Complete Trust data validation tool	31/08/19	Rebecca Edwards	
MD	Phil Brammer	3 X 4 (12)	COR1016	Mortality reviews not robust in provision of learning to a wider audience	Learning from Deaths paper to be discussed at Directorate and Divisional Governance Meetings	28/08/19	Phillip Brammer	
					Sharing of mortality data at Divisional and Directorate level	30/07/19	Rebecca Edwards	
DIRECTOR OF FINANCE								
DF	Walker, Chris	5 X 4 (20)	COR1011	Failure to maintain liquidity in 2019-20 and beyond	Trust to develop a financial plan that improves on the base case 2019-20 financial plan approved by F&P in March 2019	30/06/2019	Jackson, Tom	**Negative Assurance** The Trusts liquidity position remains at risk. The current forecast cash flow shows the Trust running out of cash in September using the latest I&E forecasts.
					Trust to ensure sale of surplus land is transacted in 2019-20 as early as possible in the financial year	31/08/2019	Walker, Chris	
					Robust CIP plans to be developed to achieve the £25m CIP requirement as agreed at FIP	30/06/2019	Younes, Natalie	
					Trust to ensure borrowing administration and process is in place should the cash position at	30/06/2019	Walker, Chris	

Exec Lead	Risk Mitigator	Current Score	Ref	Risk Title	Open Action	Date to be completed by	Action Lead	Assurance
					the end of June highlight the need to borrow cash in Q2			
DF	Price, Richard	5 X 4 (20)	COR1012	Failure to remain financially sustainable in 2019/20	All Actions completed as of 21 June 2019			**Positive Assurance** It has been ensured there is a contingency reserve for meet unforeseen CQC/Winter pressures Identification of further CIP schemes to offset unidentified gaps An income position has been agreed in with Dudley CCG
DF	Walker, Chris	3 x 5 (15)	COR844	Failure of the PFI Contract FM Provider Interserve	Summit to provide the Trust with a report that shows where the building is not operating at the latest statutory requirements, HTM's, mandatory requirements and good practice requirements. For items that are Summits responsibility all areas to be made	30/06/2019	Rigby, Andrew	**Positive Assurance** Summit have presented revised contingency plan to Trust Board. Plan has been completed and published. Meetings have continued to take place with Summit/Interserve executives. No further issues arising in terms of Interserve's business position. Management of the PFI contract continues to be robust by the Trusts contract management team.
					The Trust to review the HTM compliance report for items that are enhancements to the building and carry out a risk assessment to establish what works are required and what works are to be mitigated.	30/06/2019	Rigby, Andrew	
HUMAN RESOURCE DIRECTOR								
HRD	Woods, Dawn	4 x 4 (16)	COR981	High levels of staff absence resulting in staff shortages and agency expenditure	Enhanced staff support for MSK	31/10/2019	Dawn Woods	
					Implementation of staff engagement plans	29/11/2019	Rachel Andrew	
HRD	Rachel Andrew	4 x 4 (16)	COR982	Poor compliance to Trust mandatory training in specific areas	To report on areas of risk associated to non compliance that allows local managers and staff to immediately mitigate risk.	29/11/2019	Rachel Andrew	**Positive Assurance** Development of a draft behaviour charter and revised reporting framework for arrangements for concerns. This is being launched in July alongside further events on

Exec Lead	Risk Mitigator	Current Score	Ref	Risk Title	Open Action	Date to be completed by	Action Lead	Assurance
								civility with a guest speaker. Manager Essentials training to support effective engagement through team leadership - is currently being designed with workshops launching in September 2019. A new development framework has been created to outline opportunities to learn at Dudley. This this will support the outcomes of appraisals completed during the April-June appraisal window. Mandatory training - compliance continues to increase across the Trust. Work has been undertaken to offer targeted training to both specific areas and specific staff groups. This also includes developing additional e-learning and offering training at twilight/evenings. Plans are in place for trainee Drs joining the Trust in July/August to track completed training and avoid duplicating any training already completed This revised process for 2019 should provide compliance for most trainees within the first month of appointment. Resus training continues to be below target. The training lead is working on a range of activities to address this and has reported to both risk and workforce committee.

Exec Lead	Risk Mitigator	Current Score	Ref	Risk Title	Open Action	Date to be completed by	Action Lead	Assurance
BAORD SECRETARY								
BS / COO	Sharon Phillips	4x4 (16)	COR748	Governance arrangements from floor to board through the divisional structure not consistent to identify risks	Review Governance reporting Structure in Divisions	31/07/2019	Sharon Phillips	**Positive Assurance** Draft templates for reporting structure, meeting documentation, framework, guideline developed to be reviewed and challenged at the workshop on the 31st July 2019 **Negative Assurance** CQC highlighted inconsistencies in the governance arrangement and documentation used within the Divisions and felt they were not assured risks would be identified.
					Development and agreement of divisional Governance Framework	31/08/2019	Sharon Phillips	
					Development of guideline to clearly show the requirements for the Divisions	31/08/19	Sharon Phillips	
					Relaunch of Divisional governance framework and supporting documentation	31/08/19	Sharon Phillips	
					Review Divisional Governance meeting templates and get agreed as the mandated set for the Divisions	31/08/19	Sharon Phillips	
					Re audit of divisional governance framework and documentation to assess compliance	30/09/2019	Sharjeel Shakeel Sonia Jones	
					Hold a Divisional Governance work shop to review, challenge and confirm divisional arrangements, templates and structure	31/07/2019	Karen Kelly	

Enclosure 15

The Dudley Group
NHS Foundation Trust

Paper for submission to the Board of Directors on 4th July 2019

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
- Improvement Practice Update
- CHKS Awards
- Committed to Excellence
- A&E Delivery Board
- Healthcare Heroes
- Message from Ian Dalton
- Charity Update
- Midland's STPs/Population Health
- National News
- Regional News

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

The Dudley Group
NHS Foundation Trust

Chief Executive's Report – Public Board – July 2019

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

3rd June	Back to the Floor – Ward C2
4th June	Non Executive Director Interviews
5th June	Midlands Leaders Event
6th June	Board of Directors
7th June	Team Brief
	STP Workshop
11th June	MCP Chair Interviews
12th June	STP Board
	CHKS Awards
13th June	Disney Day – Children's Ward
17th June	Healthcare Heroes
19th June	A&E Delivery Board
21st June	Live Chat
24th June	Vital Signs Transformation Guiding Board
26th June	Oversight and Assurance Group
	Health and Wellbeing Board

Improvement Practice Update – Care Better Every Day – Vital Signs

Last month Dudley hosted a share and learn event for the other six Trust Improvement Practice leads, all representatives said how much they had learned from seeing how Dudley has progressed with its approach to events, Executive wall and Improvement Practice Team (IPT) control room as well as Kata training. Derby and Burton NHS Foundation Trust (Derby) then requested a second visit for more of their team and there is growing benefit being gained from all by sharing experiences across the seven Trusts.

Derby recently held a Practice Event for ward discharge and we are learning from their experience in preparation for our own C3 Discharge event in August.

Policy Deployment – After Executive's have completed their Practice Coach A3 projects, this section of the Executive wall will be used to track progress against the Trust's six strategic objectives.

CHKS Awards

The Trust has won a national award for the quality of our data. The CHKS Top Hospitals Awards are given to acute sector organisations for their achievements in healthcare quality and improvement.

The data quality award for England, Wales and Northern Ireland is given in recognition of the importance of clinical coding and data quality, and the essential role they play in ensuring appropriate patient care and financial reimbursement from commissioners.

CHKS, part of Capita Healthcare Decisions, bases its award decision on the data that comes from the information regularly submitted by hospitals to NHS Digital to help track performance.

We received the award at the presentation evening at The Royal College of Physicians in London earlier this month.

We are delighted to have received this award for the quality of our data, which is critical for enabling us to be innovative in our patient care. Our data informs change and allows us to benchmark ourselves against other organisations. All of this feeds back into constantly improving patient care.

Staff Awards - Committed to Excellence 2019

Our annual Oscar's style staff awards takes place on Friday 5th July. Congratulations to everyone who received a nomination and good luck to all our finalists. The standard of nominations has been particular high this year making judging really tough. There is so much great work happening here in Dudley it would be lovely to give everyone an award.

A&E Delivery Board – 19th June 2019

The A&E Delivery Board met on 19th June, 2019. This meeting is attended by Partner organisations across the Dudley system, including the CCG and representation from NHS Midlands

The Urgent Care Improvement Group and Urgent Care Operational Group (UCOG) report formally to the Board.

There was focus and discussion on system improvement and an agreement that UCOG formally report to the Board on the agreed priority areas to be delivered within 30, 60 and 90 days. Each work area has a lead identified across the Dudley System as follows:

1. Out of hospital care focusing on frequent attendees, care coordination for long term conditions and 7 day working.
2. Ambulance conveyances - demand management and use of the single point of access by the crews.
3. Front door and assessment – same day emergency care, UTC streaming, patient flow and frailty pathways.
4. Internal flow-todays work today, SAFER, medibox prescribing and therapy services.
5. Discharge – care co-ordination, End of life care fast track process, out of area delays and processes.
6. Mental Health – Dementia care, managing mental health assessment delays in the system, physical health for patients with a mental health conditions.
7. System Integration – demand and capacity modelling, system wide therapy integration, workforce planning and winter plan 2019-2020.

Healthcare Heroes June 2019

Congratulations to June's healthcare heroes! The Cardiac Assessment Unit received this month's team award due to being nominated by a family member of a patient who received care from the team. The family member was ever so thankful for the swift and professional treatment their father received within the unit. The patient and the family were extremely well looked after by the nurses on duty, making a difficult time slightly more bearable.

Darshan Pandit, a consultant on the Medical High Dependency Unit, received the award after receiving very positive feedback from his patients and their families for making time to speak to them about their or their loved ones care and for his passion in fighting for and providing the best possible care for his patients. Darshan has also had great comments about his teaching abilities from the junior doctors.

We are very proud to announce that we have created a volunteers' category to Healthcare Heroes. This will recognise all of their hard work and dedication that is appreciated by members of staff and the public. Avtar Bansal, received the award after several nominations and one by a member of staff who says he is a ray of sunshine whose happy and warm demeanour rubs off on everyone he greets.

Message from Ian Dalton

Ian Dalton, Chief Executive of NHS Improvement wrote to NHS Trusts on 20th June, notifying them of his departure and pass on his thanks for their support over the past year and a half.

He confirmed that as we know, it was decided a few months ago that as NHS Improvement works ever more closely with NHS England, a model based on two chief executives was not fit for the future, and that a new leadership structure was needed. In light of these changes, he has decided to leave NHS Improvement to allow the new structure to be created. He will be stepping down at the end of next week to take up a new role (to be announced soon).

Amanda Pritchard has been appointed as the Chief Operating Officer of the combined organisation and Amanda will take up the post full time on 31 July. Until Amanda takes up post, Bill McCarthy will act as NHS Improvement's Accounting Officer. He will continue to act as North West Regional Director at the same time as fulfilling these interim duties.

DGFT Charity Update

Neon Dash
Thank you to everyone who supported our Neon Dash. We were lucky to have one of the only sunny days in June and we certainly made the most of it. So far we have raised over £4,000 for the neonatal unit with donations still coming in.

Sparkle Party
Information will soon be on the hub for this year's Sparkle Party. **So put the date in your diary – Friday 22nd November.** This year's event will be at the Copthorne Hotel in Dudley. So put your sparkle on and get your Christmas festivities off to a great start.

Midland's STPs are on their way to Population Health Management (PHM)

"Local NHS organisations will increasingly focus on population health – moving to integrated Care Systems (ICSs) everywhere" - NHS Long Term Plan (2019)

Health and social care leaders from STPs and an ICS across the Midlands came together on the 14th June in Birmingham for an inaugural System Leaders Symposium on Population Health.

The event saw the launch of the Midlands wide Population Health Development Academy* and Community of Practice. This programme of work provides an enormous opportunity to improve the health and wellbeing of the people that live and work in the Midlands, as well as those that provide their care.

With 10 STPs and one ICS in the Midlands covering 18% of England's population, this ambitious project also has the power to influence the national state of the NHS at a time when transformation is needed more than ever. The programme will harness the huge potential of applying PHM at scale, with the Midlands championing PHM and trail blazing the way for the rest of the country.

The programme has been commissioned by NHS England and NHS Improvement in the Midlands and designed collaboratively with the national team responsible for population health, Public Health England (PHE), the Local Government Association (LGA) and STPs.

The Strategy Unit of Midlands and Lancashire CSU will deliver the Academy, which enables multi-disciplinary teams to develop their population health approach by applying the skills learnt to a system priority area. STP analysts will hone their skills in building population based intelligence using these to inform strategy development and service improvement. The work will help systems deliver the triple aim of enhancing experience of care; improving the health and wellbeing of the population and improving value for money, whilst delivering quality services.

Phase 1 of the Academy includes: Birmingham and Solihull STP; Black Country and West Birmingham STP; Coventry and Warwickshire STP; Herefordshire and Worcestershire STP; Staffordshire and Stoke-on-Trent and Shropshire, Derbyshire STP and Nottinghamshire STP.

National NHS News

Investigation reveals doubling in NHS rationing of cataract surgery
NHS rationing of cataract operations has doubled in just two years, with patients increasingly denied cases until they are at risk of blindness, an investigation reveals. Charities warned of "shocking" restrictions, which are in defiance of national guidance. The figures from across the country show a sharp increase in the number of areas where the NHS is refusing to fund the operations until vision is badly compromised.
The Telegraph (23.05.19)

New NHS online support for type 2 diabetes
NHS advice will be offered online to people with type 2 diabetes to help them manage their condition via a first of its kind service, NHS England has announced. The new offer, will mean people with type 2 diabetes have evidence-based information and support available via an online portal, giving them convenient and quick help to deal with the physical and mental challenges of diabetes. The resource will make the right advice available from home, work or on the move, helping people manage their health and wellbeing independently, potentially preventing the need for extra medical attention or the condition becoming worse.
Diabetes Ties (29.05.19)

'Recruitment crisis' blamed for nearly 140 GP surgery closures in one year
GP surgeries are closing at an alarming rate – with almost two million patients affected – and a 'recruitment crisis' is to blame, according to GP leaders. An investigation by Pulse found that surgery closures rose almost eight-fold in six years, hitting record levels in 2018. Almost 140 surgeries closed last year alone - more closures than in any previous year and almost eight times the number seen in 2013, a Freedom of Information request by Pulse revealed.
ITV News (31.05.19)

NANNY HEALTH SERVICE New NHS vending machines to sell only 'healthy' snacks with less than 150 calories in bid to tackle obesity
NEW NHS hospital vending machines will only sell snacks containing less than 150 calories to tackle obesity, it was reported last night. In a move that will anger some, health service jobsworths have signed-off on a contract to stock only healthy options in the machines. New NHS vending machines will only contain 'healthy' snacks like wholegrain popcorn and zero-sugar drinks.
The Sun (02.06.19)

NHS pension overhaul aims to stem loss of UK doctors
The UK government has promised to review pension changes that have led to National Health Service doctors retiring early or cutting their working hours to avoid high tax bills — but the profession's leaders said the plan failed to go far enough. The Cabinet Office and health department announced on Monday that ministers would "consult on proposals to offer senior clinicians a new pensions option". This would enable "them to build their NHS pension more gradually over their career by making steadier contributions towards their pension, without facing regular significant tax charges", the statement added. The overhaul would enable clinicians "to freely take on additional shifts to reduce waiting lists, fill rota gaps or take on further supervisory responsibilities". A proposal known as a 50:50 option "would allow clinicians to halve their pension contributions in exchange for halving the rate of pension growth", the statement said. Under the current rules there was no flexibility over the high rate at which a pension was built, with the highest-earning consultants contributing 14.5 per cent of their pensionable pay each month, the government said. The situation was exacerbated in 2016 by the introduction of a restriction on the amount of tax relief handed to top earners saving for retirement.
Financial Times (03.06.19)

The NHS cannot become a bargaining chip in our desperate deal-making with the US
With a no-deal Brexit looming, Tory MPs are rushing to defend our health service from Trump – but they can't be trusted. 'Trump's blustering is irrelevant: who truly believes he understands the issues at hand? But the discussion over parceling off NHS services will be dominated by American interests.' Even when it's in the process of being deliberately run down by the Conservatives so it can finally be privatised, our National Health Service makes America's arrangements look monstrous by comparison. **The Guardian (05.06.19)**

Number of girls and young women reporting self-harm in England on the rise
"Self-harm in girls and young women rising at 'alarming' rate," reports Sky News. A study based on 3 surveys of people in England aged 16 to 74 found a worrying rise in people who say they have ever self-harmed. The overall numbers rose from 2.4% in 2000 to 6.4% in 2014. The increase in reported self-harm was biggest among women and girls aged 16 to 24, with 19.7% of those questioned in 2014 saying they'd self-harmed. **NHS (05.06.19)**

The North West needs more men to donate blood, says the NHS
There's an urgent appeal for more men to become blood donors here in the North West, as new figures released as part of National Blood Week (June 10 to 16) show more women than men donate. The figures show that only 48% of the blood donors currently registered at the donor centres in Liverpool and Manchester are male. Nationally, the number of male donors has also been dropping worryingly quickly.
NHS Blood and Transplant is now asking men in Liverpool and Manchester to make an appointment to donate for the first time at their donor centres in Dale Steet (Liverpool), Norfolk Street (Manchester) and Plymouth Grove (Manchester).
ITV News (10.06.19)

Sleeping with light or TV on linked to weight gain in women
"Falling asleep in front of the TV could increase the risk of obesity," The Daily Telegraph reports, while the Daily Mirror suggests it's specifically women who sleep with a light who are more likely to gain weight. Both headlines are reporting a study aiming to see whether light exposure at night could be linked with obesity. The researchers used data collected from 50,000 US and Puerto Rican women. The data was originally investigating genetic and environmental links with breast cancer. In this latest study researchers carried out further analysis to see if there was a link between sleep patterns and weight gain. **NHS (12.06.19)**

Most NHS trusts missing cancer targets as waiting times soar
Almost two in three trusts are missing NHS cancer targets, amid warnings that patients are being put at risk as waiting times grow longer. MPs said patients were facing “unacceptable” and “agonising” delays, with more than half of trusts also forcing patients into long waits for surgery. The report by the Public Accounts Committee accuses health bodies of “a lack of curiosity” about the risks that patients would come to harm as result of increasingly long waiting times. Last month the Telegraph revealed a doubling in NHS negligence payments linked to delays and misdiagnosis, over a five year period. In 2017/18 the NHS paid out £655 million in compensation for such cases – an increase from £327 million in 2013/14.
The Telegraph (12.06.19)

Long NHS waiting times are harming patients, MPs warn
Patient suffering is being overlooked as NHS performance against waiting time targets for cancer care and non-urgent care continues to “spiral downwards,” a report by MPs has warned. The Public Accounts Committee said that national NHS bodies seemed to “lack curiosity” and to understand little about how longer waits can harm patients. Published on 12 June, the committee’s report found that less than half of NHS trusts and foundation trusts currently met the 18 week waiting time standard for elective treatment, and only 38% met the 62 day standard from referral to treatment for cancer patients. Doctors’ leaders and health analysts backed the committee’s concerns that worsening waiting times were “unacceptable” and said that control must be restored.
The BMJ (12.06.19)

Number of people diagnosed with dementia hits record high
The number of older people living with dementia hit a record high last month, new figures show. A total of 453,881 over-65s were living with the condition in May, NHS England said. This number has increased by 7% since the data was first recorded in June 2016, from 424,390 diagnoses. With numbers increasing rapidly some hospitals, such as Royal Free Hospital in north London, have moved to look after dementia patients differently. They've decorated the ward to look like an old seaside resort to allow them to see the "outside world and trigger pleasant memories" - but every bed is taken and the waiting list is lengthy.
ITV News (13.06.19)

More patients than ever are forced to wait for cancer test
In April, just 89.9 percent of those sent by GPs for examination waited only a fortnight or less, new figures from NHS England revealed yesterday. The percentage was the lowest since October 2009, when records began. The target is 93 percent. The proportion of cancer patients receiving their first treatment within 62 days of an urgent referral was also below the 85 percent target, at 77 percent for January to March. Cervical cancer: Four things you need to know about smear tests
NHS England said the problem was a surge in the number of people needing treatment. However, charities and experts warned the latest NHS performance figures are "heading in the wrong direction". Siva Anandaciva, chief analyst at the King's Fund think-tank, blamed staff shortages, saying: "There are 4.4 million people waiting for consultant-led care and the proportion of patients who began their treatments or got diagnostic tests done within NHS time limits were both at their worst level for more than a decade. "Despite the best efforts of NHS staff, it is hard to see how the NHS can get back to delivering its performance standards while it remains in the grip of a workforce crisis." Dr Rob Harwood, chairman of the British Medical Association consultants' committee, said: "This latest set of NHS figures show a health service descending into an ever-deepening crisis and closer to a system unfit for purpose.
Express (14.06.19)

Listeria outbreak: Health secretary orders NHS food review
A "root and branch" review of hospital food has been ordered by the health secretary after two more deaths were linked to an outbreak of listeria. The number of deaths related to pre-packed sandwiches and salads at hospitals had risen from three to five, Public Health England said on Friday. It said evidence suggested the deceased ate the products before 25 May. Products from the Good Food Chain, which supplied to 43 NHS trusts, have been withdrawn and production halted. "I have been incredibly concerned by this issue and strongly believe that we need a radical new approach to the food that is served in our NHS," Health Secretary Matt Hancock said. "I have instructed the NHS to conduct a root and branch review of hospital food."
BBC News (15.06.19)

NHS plans for faster treatment of stroke 'will save thousands of lives'
Small hospitals must stop treating stroke emergencies in order to save thousands of lives, England's top doctor will today say. The national medical director will say NHS trusts across the country must centralise services, so that victims get the right help sooner. Professor Stephen Powis will say hospitals should follow a controversial model pioneered in London and Manchester, which is now saving around 170 lives a year. In both cities, local stroke wards were closed, with ambulances instead taking victims not to nearest hospital, but to larger centres with access to brain scans, clot-busting drugs and specialist procedures. As a result, the numbers dying or suffering long-term disability have fallen significantly. **The Telegraph (20.06.19)**

West Midlands News

Woman infertile after surgeon removed wrong fallopian tube
A woman who suffered an ectopic pregnancy is unable to have children naturally after a surgeon removed her healthy fallopian tube by mistake. Chelsie Thomas was admitted to Walsall Manor Hospital with the pregnancy in her right tube in March last year. **BBC News (29.05.19)**

The NHS is struggling to recruit enough Birmingham nurses and midwives
New figures from the NHS have revealed that there were 268 full time equivalent nursing and midwifery positions advertised in our city. Nurses and midwives have warned that recruitment and retainment difficulties are impacting people's care, as NHS vacancies in Birmingham rise. New figures from the NHS have revealed that there were 268 full time equivalent nursing and midwifery positions advertised in our city at the end of March this year. That’s up from 223 in March 2018 - an increase of 20% in a single year. The situation in Birmingham reflects a national trend, which has seen nursing and midwifery vacancies rise to their highest level on recent record. Across England, there were 12,262 vacancies advertised at the end of March - up from 11,483 in 2018, and just 9,420 in 2015, when the figures began. In the West Midlands the number has risen from 897 in 2015 to 1,057 in March this year, which is again the highest number on recent record.
Birmingham Live (31.05.19)

West Midlands Ambulance confirm 300 new ambulances
West Midlands Ambulance Service is set to maintain its position of being the only ambulance service with no operational vehicles over five years old with the announcement of an order for 300 new ambulances. **Advertizer (06.06.19)**

Breaking the habit? Some hospitals yet to ban smoking on site
"Many patients or visitors will be going through difficult times but smoking remains England's biggest preventable killer and it is time for the NHS to stop smoking within its hospital grounds, everywhere. It cannot be right that it is more acceptable in some hospitals to smoke at the front door than it is outside a pub." Both the Black Country Partnership NHS Foundation Trust and the Midlands Partnership NHS Foundation Trust ban smoking on its premises, with smokers urged to leave the site if they want to smoke. Smoking policies are in place allowing smoking in designated outdoor areas at The Royal Wolverhampton NHS Trust and University Hospitals of North Midlands. A total ban on smoking is in the pipeline at Sandwell and West Birmingham Hospitals NHS Trust, which will go smoke-free this July. Staff at Walsall Healthcare NHS Trust are in the midst of preparing to become smoke-free in the new year, while a total ban on smoking will be in place at Sandwell and West Birmingham Hospitals NHS Trust from next month. Sandwell and West Birmingham Hospitals NHS Trust will ban smoking across its sites, including in cars if parked on site - with £50 fines dished out to visitors and disciplinary action for staff if caught.
Express and Star (10.06.19)

Post discharge phone calls and home visits linked to near halving of readmissions
Hospital readmissions for elderly patients could be almost halved, using relatively simple aftercare measures, such as post-discharge phone calls and home visits, suggests research* published in Future Healthcare Journal. A community nurse, offering straightforward telephone advice on medicines management, through to referrals to community health providers, including GPs and pharmacists, were associated with a 41% fall in the number of readmissions patients within 30 days among older patients, the findings showed. The research looked at two groups of elderly patients in Solihull, West Midlands: 303 whom community nurses attempted to contact to offer a home visit after discharge, and a comparison group of 453 who were not contacted. Successful telephone contact was made with 288 of the 303 patients, 202 of whom received a home visit. Almost 16% of the comparison group were readmitted as emergencies within 30 days of leaving hospital. But among those whom community nurses contacted and visited, that figure was only 9%. This indicates that patients who weren't contacted were almost twice as likely to be readmitted to hospital within 30 days of discharge.
On Medica (14.06.19)

Listeria outbreak: More affected hospitals named
Eight hospitals in seven NHS Trusts have reported cases of listeria linked to pre-packed sandwiches and salads eaten by patients, Health Secretary Matt Hancock has confirmed. The list includes Leicester Royal Infirmary and two hospitals in Western Sussex NHS Foundation Trust, along with hospitals in Derby, Liverpool, Manchester and Wexham. Nine patients have been affected, of whom five have died. The food involved has been withdrawn.
BBC News (17.06.19)

Children's hospices 'to shut if NHS does not increase funding'
Children's hospices in England will be forced to cut services or shut unless the NHS increases its funding, a charity has warned. Together for Short Lives, which helps terminally ill children, highlighted a "dangerous cocktail" of higher costs and a drop in state funding.
BBC News (17.06.19)

Shrewsbury and Telford Hospital NHS Trust confirms new chief executive
A temporary new boss has been announced for a troubled health trust after its chief executive quit last month. Paula Clark takes over at Shrewsbury and Telford Hospital NHS Trust on 1 July following Simon Wright's announcement he was leaving after nearly four years in the job. Ms Clarke has been chief executive of the Dudley Group Foundation Trust and Burton Hospitals Foundation Trust. **BBC News (21.06.19)**

Hundreds more cases in Shropshire baby deaths review
The number of cases uncovered by a maternity review at hospitals in Shropshire has more than doubled. In 2017, then Health Secretary Jeremy Hunt announced an investigation into avoidable baby deaths at SaTH, which runs Royal Shrewsbury Hospital and Telford's Princess Royal. NHS Improvement has now asked for the total of deaths, still births and babies with brain damage since 1998. It said they were not necessarily the result of sub-standard care. BBC Social Affairs Correspondent Michael Buchanan said 300 new cases of concern had come to light since NHSI asked SaTh for details on all cases of potential errors. The independent review, being led by midwife Donna Ockenden, was already investigating 250 cases.
BBC News (24.06.19)

Trust news

Smoking at Russells Hall Hospital is banned on site for first time
Russells Hall Hospital in Dudley is going smoke-free for the first time.
It's been banned in hospital buildings since 2007 but now smoking shelters are being removed from the site. It means patients, visitors and staff will have to go off the grounds if they want to light up or vape. One in three hospitals across England still allow smoking on site though. But there are calls for a ban. **Free Radio (01.06.19)**

Russells Hall Hospital staff set for charity 'march for men'
STAFF at Russell's Hall Hospital will be stepping out for charity this weekend when they take part in a 10k walk for prostate cancer research. Members of the urology team at the Dudley hospital will be taking part in the March for Men in aid of Prostate Cancer UK on Sunday June 9 at Cannon Hill Park in Birmingham. **Stourbridge News (06.06.19)**

Staff dress up to raise money for ward
Snow White and Alice in Wonderland joined other popular children's favourites for a day of Disney Fun at Russells Hall Hospital in Dudley. Staff dressed up as various colourful characters to raise money for the children's ward. As well as classic characters including Belle from Beauty and the Beast, there were also more modern Disney figures such as Elsa and Anna from Frozen and Olaf the snowman. Staff at the hospital said it was a 'lovely day' which the children hugely enjoyed.
Express and Star (17.06.19)

Toy Story favourites drop into hospital
Youngsters went to infinity and beyond at Russells Hall Hospital as characters from Disney's Toy Story dropped in to open a new children's ward department. Woody and Buzz Lightyear joined staff at Russells Hall to officially open its new childrens emergency department. Students from the Midlands Academy of Musical Theatre also attended the department signing songs from the Toy Story films to entertain guests and hospital patients.
Express and Star (Press Release) (26.06.19)

Enclosure 16

The Dudley Group NHS Foundation Trust

Paper for submission to the Board of Directors July 2019

TITLE:	**CHIEF NURSE REPORT**		
AUTHOR:	**Carol Love-Mecrow, Deputy Chief Nurse**	**PRESENTER:**	**Mary Sexton Interim 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

The Board is requested to review and note the report and the work being undertaken to address areas of risk associated with complaints activity.

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.

NMC/ Horizons Workshop

On the 17th June the 3rd half day workshop for Lead Nurses and matrons was held at Himley Hall. The event was attended by 36 senior nurses and focused on the new Nursing and Midwifery Council Fitness to Practice standards presented by Tony Newman our NMC Regulation Advisor and a *Breaking The Rules* workshop presented by Bev Matthews, a former Dudley Nurse, now working with the Horizons Team. NHS Horizons is a specialist team within the Improvement Directorate of NHS England/NHS Improvement. Her workshop focused on the *rules* that can get in the way of staff feeling that they can actively contribute to the organisation.
Both presentations were very well received by our staff and provoked a lot of interesting debate. The whole workshop was captured in pictures by our resident artist Frankii Tibbetts (Flu Campaign Coordinator).

Clinical Nurse Specialist (CNS)Forum

The CNS forum was held on the 6th of June. 30 CNSs from both hospital and community attended an out of hours session to discuss their views on the future of the CNS role and also to gain their views on the content of their first CNS away day which will be held on the 8th July 2019. The main areas of discussion were clarification of roles, competency and clear job plans.

Safer Staffing and Skill Mix Review

The safer staffing review has now been shared with Lead Nurses and Matrons and, following a few minor amendments, work to implement the recommendations from the review will commence from July 2019.

AHP Update

- AHP Lead, Pam Ricketts presented a paper at the Royal College of Occupational Therapists Annual Conference on 18th June 2019. This is a national conference and Pam presented following the successful submission of an abstract outlining her research in November 2018 on occupational therapists views on clinical leadership.

- The Dudley Falls Prevention Service has been selected as finalists for the Chief Allied Health Professions Officer Awards 2019. The service submitted their entry on the development of a multifactorial assessment based on NICE guideline CG161 and Quality Standard QS86, which also includes a tool to identify individuals at risk of loneliness and social isolation, under the category *NICE into Action*. These are national awards and winners will be announced on 17th July 2019.

- Karen Lewis (new Head of Therapy) is undertaking a therapy services workforce and structure review. She is working with external consultants to explore how AHPs can support the Trust in addressing current finance and workforce challenges.

- The AHP Leadership workshop is arranged for 22nd July 2019. The workshop will be facilitated by Dr Jo Fillingham and Stuart Palma from NHSE. This workshop will focus on the NHS long-term plan on how AHPs can significantly support the demand profile faced by the NHS. It will provide space and time to explore how AHPs can deliver our AHP strategy, support current workforce challenges and effect change.

Agency Controls

- All bank and agency requests continue to be assessed daily by the Divisional Chief Nurses to ensure continued patient safety and financial balance.
- The Chief Nurse, Deputies and Divisional Chief Nurses are analysing in detail the use and authorisation of bank and agency nurses to ensure effective control.
- Check and challenge meetings led by the Divisional Chief Nurses continue across the Divisions.

Recruitment and Retention

- The next corporate recruitment event is scheduled for the 4th July 2019. This event is focused on experienced nurses, staff looking to return to the NHS from the private sector localities such as nursing homes, practice nursing and other care settings, as well as student nurses due to qualify.

Local recruitment events held and recruited to:

Recruitment Event	Date of Event	Number of conditional offers made
Corporate recruitment event	14th June 2019	Conditional offers for substantive posts made to 4 students and 2 experienced nurses. 2 experienced nurses recruited for bank only.
ED	5th June 2019	Conditional offers made for 3 Dudley January intake students and 1 Dudley September student.
B3	19th June 2019	Conditional offers made to 2 experienced nurses.

- C8 have a recruitment event planned for 11th July 2019
- At the time of the report, a total of 48.1 WTE experienced staff are currently going through recruitment clearances.

Professional Development

- **Trainee Associates Project**

- Recruitment to the Trainee Nursing Associates role for the July cohort at Worcester University is now completed. 24 candidates have been appointed and will commence in the Trust on the 15th July 2019.
- Applications for the September cohort have now closed and interviews will be taking place on 16th July. It is hoped that 30 candidates will be successfully recruited.

- **Deteriorating Patient Pathway**

- Development of the Deteriorating Patient strategy is nearing completion.
- The Sepsis Practitioners are working with teams to support early implementation of care, shared learning around not all patients who deteriorate have sepsis but need the same level of planning and review using the deteriorating patient pathway.

- **NMC standards for supporting students**

- We continue to raise awareness of the new NMC standards through the health HUB and other forums.
- Engagement processes continue with all stakeholders including registered practitioners to relay changes to student support and assessment in practice and their roles.
- Preparatory sessions for the new standards for current associate mentors/mentors and signoff mentors are underway (dates are circulated to clinical areas and hub).
- A review of capacity is ongoing to increase student numbers and support the new curriculum and standards (hospital and community).
- A scoping exercise has been commenced within the Trust to ensure we are utilising every available departments suitable to host students.
- We continue to engage and collaborate with the University of Wolverhampton and the University of Worcester on student processes to support new curriculums and assessment in practice.

Safeguarding

- Operational management of the safeguarding team continues to be undertaken by the Deputy Chief Nurse.
- Recruitment to The Head of Safeguarding post is underway. Shortlisting will commence shortly. Interest in the post has been encouraging with a number of suitable applicants having applied.

Falls

- There was one fall with harm reported during May 2019. The patient sustained a fractured hip which has been repaired. The RCA is underway to determine avoidability. Falls without harm remain below the national average.
- The appointment of a band 4 support worker has been agreed to help with the data collection to support the falls CQUIN. The recording of lying and standing blood pressure still remains challenging. To help address this, the Falls Lead has completed a safety bulletin and is visiting ward areas to educate staff

regarding this.

Mental Health Act

- During May 2019 there were two patients detained under the Mental Health Act. The first was detained under section 2 and was then transferred to the Mental Health Trust services. The second was detained under section 5/2, subsequently discharged from the section and then discharged home.

Patient Experience

- The business case submitted by the Head of Patient Experience to increase staffing levels in complaints, PALs and the patient experience department is being reviewed.

Tissue Viability

- There has been no Category 4 pressure ulcers reported as a serious incident in either in the hospital or community during May 2019.
- There was one category 3 pressure ulcer reported as avoidable which developed in the hospital during May 2019. An RCA is in progress.

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:**

Enclosure 17

The Dudley Group
NHS Foundation Trust

Paper for submission to the Board 4 July 2019

TITLE:	**Clinical Quality, Safety, Patient Experience (CQSPE) summary report from meeting held 25 June 2019**		
AUTHOR:	Catherine Holland, Non-executive Director, Committee Chair Mary Sexton, Interim Chief Nurse	**PRESENTER**	Catherine Holland, Non-executive Director, 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 COUNCIL

The Board are asked to receive the summary report from the last meeting of the CQSPE held on 25 June and note the

- Matters of concerns and key risks to escalate
- Major actions commissioned/work underway
- Positive assurances received
  Decisions made

CORPORATE OBJECTIVES:

SO1: Deliver a great patient experience

SO2: Safe and Caring Services

SO3: Drive service improvements, innovation and transformation

SO4: Be the place people choose to work

SO5: Make the best use of what we have

SO6: Deliver a viable future

SUMMARY OF KEY ISSUES:

Please refer to the table on the following page.

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:**

UPWARD REPORT FROM CQSPE

The Dudley Group NHS Foundation Trust

Date Committee last met: 25/06/2019

MATTERS OF CONCERN OR KEY RISKS TO ESCALATE	MAJOR ACTIONS COMMISSIONED/WORK UNDERWAY
• North Block Fire Report – It was deemed the building can stay in its current form but will be subject to an alterations notice. In the meantime a vertical evacuation is in place. • Hydrotherapy incident – failure to test the hydrotherapy pool for correct chlorine levels prior to use and damage to swimwear and damage for jewellery and swimwear for patients and staff. All appropriate follow-up actions have been taken. It was not a RIDORR reportable incident. • Glide away bed incident – Member of staff lost a tip of the finger in an accident operating a glide away bed. No fault was found with the manufacturer or the instructions. Matter was reported to HSE. • Six single sex breaches note: this represents a contractual breach • Concern raised over VTE targets still not being met	• Delays in reporting CTC and MRI Scans causing concern. The committee requested a report on the impact to patients of the backlog • The Quality Improvement Plan incorporating CQC actions will be reported at the next meeting
POSITIVE ASSURANCES TO PROVIDE	**DECISIONS MADE**
• The Committee noted improvements in the complaints management process and expect to see improvements in timeliness and satisfaction levels • The Committee noted the establishment of the Achieving Excellence Group where quality improvement actions will be consolidated (including CQC actions)	• The Committee approved the Patient Safety Strategy • The Committee approved 2 policies: Intravenous Immunoglobulin (IVIG) Policy and Safe Use of Insulin Policy

Chair's comments on the effectiveness of the meeting:

- A good level of positive challenge
- Constructive work done around reports. Greater emphasis in future reports to describe actions taken resulting from concerns.

Enclosure 18

NHS Foundation Trust

Paper for submission to Public Board July 2019

TITLE:	**Infection Prevention and Control Annual Report 2018/19**		
AUTHOR:	**Dr E Rees, Director of Infection Prevention and Control**	**PRESENTER**	**Ms M Sexton, Chief Nurse, DGFT**

CLINICAL STRATEGIC AIMS

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

CORPORATE OBJECTIVE:

SO1: Deliver a great patient experience

SO2: Safe and Caring Services

SO3: Drive service improvements, innovation and transformation

SO4: Be the place people choose to work

SO5: Make the best use of what we have

SO6: Deliver a viable future

SUMMARY OF KEY ISSUES:

The Dudley Group NHS Foundation Trust is committed to ensuring that a robust infection prevention and control function operates within all clinical areas of the organisation which supports the delivery of high quality healthcare and protects the health of its service users and staff.

The Annual report seeks to provide assurance to the organisation with regards to the progress of the prevention, control and management of infection from April 2018 to March 2019.

IMPLICATIONS OF PAPER:

RISK	**Y**		**Risk Description: Failing to meet minimum standards**
	Risk Register: Y		**Risk Score:**
COMPLIANCE and/or LEGAL REQUIREMENTS	**CQC**	**Y**	**Details:** Safe and effective care
	NHSI	**Y**	**Details:** MRSA and C. difficile targets
	Other	**Y**	**Details:** Compliance with Health and Safety at Work Act.

ACTION REQUIRED OF COMMITTEE: To receive the report and note the contents.

Decision	**Approval**	**Discussion**	**Other**

		√	

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

Statement of Compliance with the Hygiene Code

The summary information below provides information of compliance with the Code of Practice (The Health and Social Care Act 2008): Code of Practice on the Control of Infections and Related Guidance, July 2015) to monitor the Trust's performance against the code with the intention of declaring full compliance by the end of the financial year for the year 2018/19.

Compliance Criterion	What the registered provider will need to demonstrate	RAG rating
1	Systems to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of service users and any risks that their environment and other users may post to them.	
Assurance: A risk log of all infection prevention risks identified across the Trust is maintained and updated regularly.		
2	Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections.	Cleaning is actively audited and any deficiencies are rectified within 1 hr.
Assurance: A Cleaning Policy and associated environmental audits provide assurance that a clean and appropriate environment is maintained. The HPV posts are now in place.		
3	Ensure appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse event and antimicrobial resistance.	Antimicrobial CQUIN – the elements regarding reduction high risk antimicrobial usage has been met.
Assurance: There is an Antimicrobial Policy in place with appropriate stewardship recommendations. Audits demonstrate compliance with policy.		
4	Provide suitable accurate information on infections to service users, their visitors and any person concerned with providing further support or nursing / medical care in a timely fashion.	
Assurance: Patient and visitor information is available for a variety of healthcare associated infection issues on the website. Patients identified with infections in hospital are visited and provided with information leaflets including contact information for further support.		
5	Ensure prompt identification of people who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to other people.	MRSA elective screening 96.4%and

		emergency screening is 94.2% for April 2019 .
Assurance: Patient records are flagged with information about previous healthcare associated infections. Patient admission documentation includes screening questions to identify patients at risk.		
6	Systems to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection.	Mandatory IC training has moved to an annual programme for clinical staff. Work is being undertaken to achieve compliance. The Trustwide high impact intervention audits are currently green.
Assurance: Staff are provided with mandatory infection control training to ensure they are aware of their responsibilities for the prevention and control of infection. The Trust also undertakes monthly audits in the clinical areas which are observational audits (high impact interventions) which provide assurance that staff are putting into practice the knowledge and skills obtained during training.		
7	Provide or secure adequate isolation facilities.	A business case for isolation pods for critical care areas has been created and funding for the pod secured.
Assurance: There is a policy in place to ensure that patients are isolated appropriately. 25% of the inpatient beds take the form of single ensuite rooms.		
8	Secure adequate access to laboratory support as appropriate.	
Assurance: The Trust has access to a CPA/UKAS accredited Microbiology and Virology laboratory.		
9	Have adherence to policies, designed for the individuals' care and provider organisations that will help to prevent and control infections.	Overall Trustwide scores all green to present.
Assurance: All policies, as recommended in the Hygiene Code, are in place. Audit data confirms compliance with policies and identifies areas for improvement.		
10	Providers have a system in place to manage the occupational health needs and obligations of staff in relation to infection.	
Assurance: There is in house provision of Staff Health and Wellbeing. There are regular reports to the Infection Prevention and Control Forum detailing any issues raised within this system.		

The Dudley Group
NHS Foundation Trust

INFECTION PREVENTION AND CONTROL ANNUAL REPORT

2018/19

CONTENTS

LIST OF ABBREVIATIONS

C.diff	Clostridium difficile
CQC	The Care Quality Commission – the integrated regulator of health and adult social care
DH	Department of Health
D and/or **V**	Diarrhoea and/or Vomiting
DIPC	Director of Infection Prevention and Control. An individual with overall responsibility for infection control and accountable to the registered provider
E-Coli	Escherichia coli
ESBL	Extended-Spectrum Beta-Lactamases (ESBLs) are enzymes that can be produced by bacteria making them resistant to cephalosporins e.g. cefuroxime, cefotaxime and ceftazidime - which are the most widely used antibiotics in many hospitals
GQC	Governance and Quality Committee
GRE	Glycopeptide-Resistant Enterococci
HCAI	Health Care Associated Infections
IPC	Infection Prevention and Control
IPCC	Infection Prevention and Control Committee
IPCLN	Infection Prevention and Control Lead Nurse
IPCT	Infection Prevention and Control Team
MRSA	Meticillin-resistant Staphylococcus aureus
MSSA	Meticillin-sensitive Staphylococcus aureus
OHD	Occupational Health Department
PLACE	Patient Led Assessment of the Care Environment
PPE	Personal Protective Equipment
SLA	Service Level Agreement
UTI	Urinary Tract Infection

1.0 EXECUTIVE SUMMARY

The Dudley Group NHS Foundation Trust is committed to ensuring that a robust infection prevention and control function operates within all clinical areas of the organisation which supports the delivery of high quality healthcare and protects the health of its service users and staff. Effective prevention and control of infection must be part of everyday practice and applied consistently by everyone.

The report provides assurance that systems are in place and working effectively to minimise and avoid hospital acquired infection and that the Trust is compliant with the Hygiene Code.

2.0 INTRODUCTION

The Dudley Group NHS Trust continuously strives to improve infection prevention and control practice and has engaged with other organisations and partners to ensure there are robust infection prevention plans, policies and capacity to reduce healthcare associated infections (HCAI) across the healthcare community. Infection prevention and control is the responsibility of everyone in the healthcare community and is only truly successful when everyone works together. The Infection Prevention Team (IPT) continues to develop innovative ways of delivering important messages across to our staff, patients and visitors. The work programme is aligned with the Hygiene Code.

The Health and Social Care Act 2008 (2015): *Code of practice for the prevention and control of healthcare associated infections (Hygiene Code)* details 10 compliance criteria to which the Trust must adhere to in relation to preventing and controlling the risk of avoidable healthcare associated infections (HCAIs).

The criteria are listed below against which is the Trust's assurance that it meets the requirements as stated in the Hygiene Code.

Compliance Criterion	What the registered provider will need to demonstrate	RAG rating
1	Systems to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of service users and any risks that their environment and other users may post to them.	
Assurance: A risk log of all infection prevention risks identified across the Trust is maintained and updated regularly.		
2	Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections.	Cleaning is actively audited and any deficiencies are rectified within 1 hr.
Assurance: A Cleaning Policy and associated environmental audits provide assurance that a clean and appropriate environment is maintained.		
3	Ensure appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse event and antimicrobial resistance.	Antimicrobial CQUIN – the elements regarding

		reduction high risk antimicrobial usage has been met.
Assurance: There is an Antimicrobial Policy in place with appropriate stewardship recommendations. Audits demonstrate compliance with policy.		
4	Provide suitable accurate information on infections to service users, their visitors and any person concerned with providing further support or nursing / medical care in a timely fashion.	
Assurance: Patient and visitor information is available for a variety of healthcare associated infection issues on the website. Patients identified with infections in hospital are visited and provided with information leaflets including contact information for further support.		
5	Ensure prompt identification of people who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to other people.	MRSA elective screening 96.4% compliance and emergency screening 94.2% compliance for April
Assurance: Patient records are flagged with information about previous healthcare associated infections. Patient admission documentation includes screening questions to identify patients at risk.		
6	Systems to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection.	Mandatory IC training has moved to an annual programme for clinical staff. Work is being undertaken to achieve compliance by March 2019.
Assurance: Staff are provided with mandatory infection control training to ensure they are aware of their responsibilities for the prevention and control of infection.		
7	Provide or secure adequate isolation facilities.	A business case for the isolation pods for critical care areas has been created and funding the for the ITU pod secured.
Assurance: There is a policy in place to ensure that patients are isolated appropriately. 25% of the inpatient beds take the form of single ensuite rooms.		
8	Secure adequate access to laboratory support as	

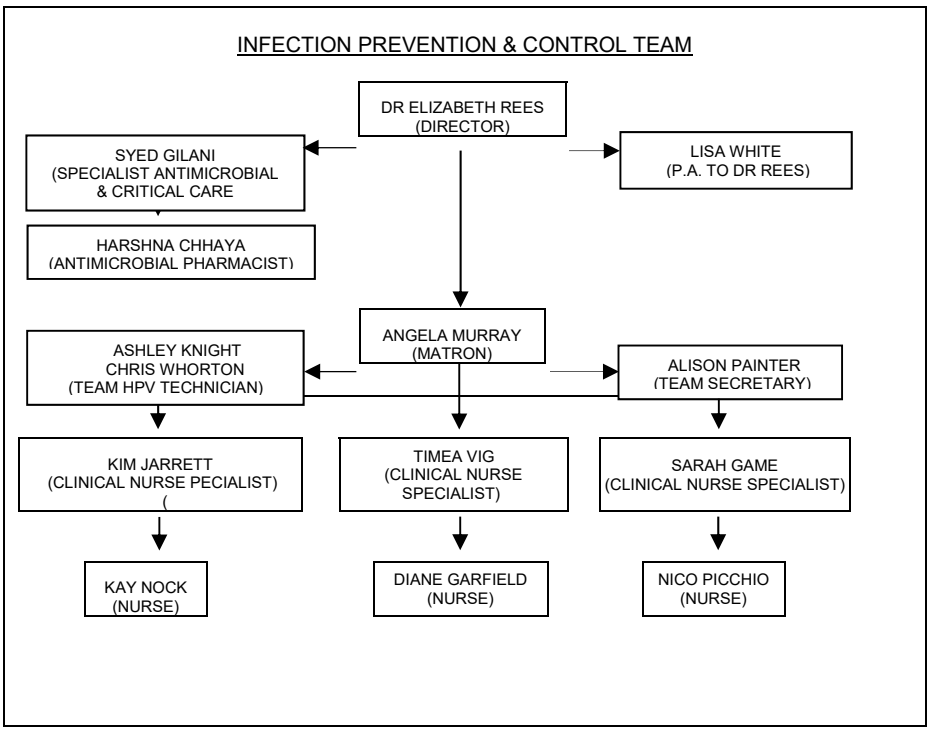
	appropriate.	
Assurance: The Trust has access to a CPA/UKAS accredited Microbiology and Virology laboratory.		
9	Have adherence to policies, designed for the individuals' care and provider organisations that will help to prevent and control infections.	Trustwide scores all green to present.
Assurance: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

3.0 INFECTION PREVENTION AND CONTROL ARRANGEMENTS

Within the Trust the DIPC role is within the portfolio of the Consultant Microbiologist / Infection Control Doctor. A key responsibility of the DIPC is to produce an annual report. Additional support is provided by the antimicrobial pharmacists and Matron for Infection Prevention and Control.

The role and function of the IPC Service is to provide specialist knowledge, advice and education for staff, service users and visitors. All work undertaken by the service supports the Trust with the full implementation of and on-going compliance to the Code.

INFECTION PREVENTION & CONTROL TEAM



4.0 THE INFECTION PREVENTION AND CONTROL GROUP

The Infection Prevention and Control Group meet monthly and is chaired by the DIPC.

The purpose of the forum is to oversee compliance of the Health Act 2008 Code of Practice for the Prevention and Control of Healthcare Associated Infections. The Forum provides assurance that risks are appropriately managed and that appropriate arrangements are in place to achieve a safe clinical environment. The IPCG reports to the Clinical Quality, Safety and Patient Experience Committee and is required to comply with any reporting requirements set by the Clinical Quality, Safety and Patient Experience Committee as to format and frequency

The membership of the forum is multidisciplinary and also includes representatives from The Office of Public Health at Dudley Metropolitan Borough Council and Public Health England. This forum provides assurance to The Board that the infrastructure for infection prevention and control is in place. In addition to this there is representation from the Trusts private finance initiative partners.

The Group is responsible for:

a) Reviewing and monitoring the progress of the annual programme and assisting and affecting implementation.

b) Developing relevant policies, procedures, care pathways and clinical guidelines.

c) Assessing the impact of all existing and new relevant plans and policies on infection prevention and control and make recommendations for change.
d) Ensuring, through the DIPC, that the Chief Executive and associated committees are advised of any significant issues relating to infection control.

e) To receive the Annual Infection Prevention and Control Report.

5.0 SURVEILLANCE

The Department of Health requires mandatory surveillance of:

1. MRSA positive blood cultures (bacteraemia)
2. *Clostridium difficile* toxin positive results
3. MSSA positive blood cultures (bacteraemia)
4. E-coli positive blood cultures (bacteraemia)

The above are reported monthly via HCAI data capture system which is managed by Public Health England and signed off on behalf of the Chief Executive.

5.1 MRSA Bacteraemia

The NHS has set a zero tolerance approach to MRSA bloodstream infections. For the purposes of this report **1** case has been attributed to The Trust in the last year.
A root cause analysis was undertaken utilising the national audit tool. The outcomes of the RCA were presented and discussed at a multidisciplinary meeting chaired by the CEO and included representatives from the Dudley Office of Public Health and Dudley CCG. 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
- Ensure that all staff members collecting blood cultures are following local guidelines to reduce the risk of obtaining a contaminated sample.

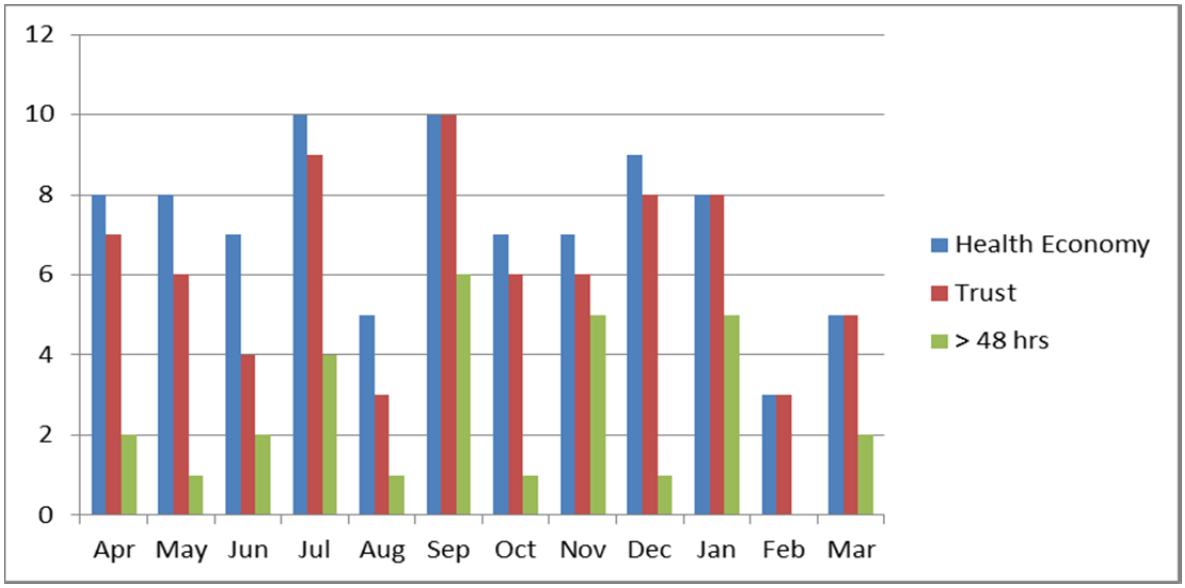
Learning outcomes to be shared at ward level via staff meeting/huddle board and with the wider trust through divisional meetings and the infection prevention group.

5.2 Clostridium difficile

The Trust reports all cases of Clostridium difficile toxin positive disease identified in the hospital laboratory. For this financial year we have reported a total of 28 cases of Clostridium difficile of which 20 have been recognised as being due to a lapse of care and attributed to the Trust. Lapses in care were identified as being associated with failure to meet the mandatory training compliance, reduced environmental scores, antimicrobial stewardship and bowel habit not recorded on admission.

The Trust objective was to have no more than 28 cases where a lapse in care was identified. All cases were scrutinised using a robust root cause analysis process in conjunction with the Office of Public Health Dudley Metropolitan Borough Council and Dudley CCG. The learning from these cases was shared across the organisation in order to improve practice.

The table below demonstrates the number of Clostridium difficile positive cases identified at The Dudley Group NHS Foundation Trust for this reporting period.



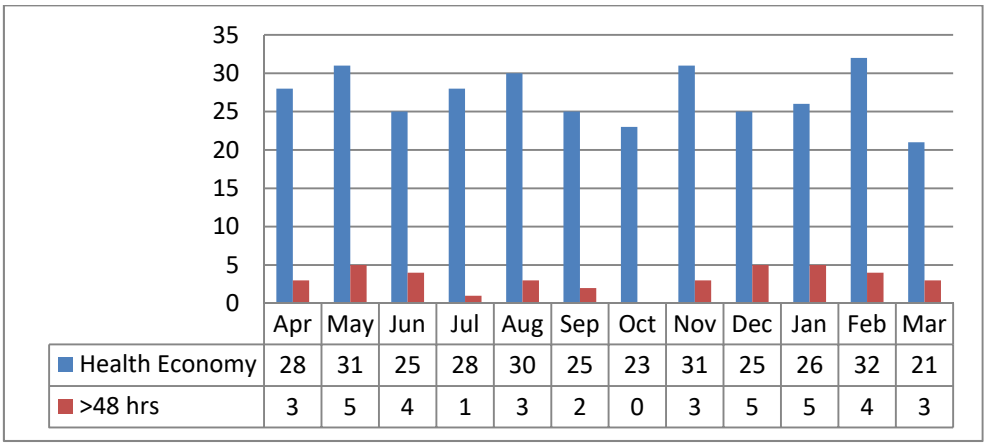
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Health Economy	8	8	7	10	5	10	7	7	9	8	3	5
Trust	7	6	4	9	3	10	6	6	8	8	3	5
> 48 hrs	2	1	2	4	1	6	1	5	1	5	0	2

5.3 Escherichia Coli Bacteraemia

Escherichia coli (commonly referred to as *E. coli*) is also found in the gut and is part of the normal flora. The commonest infection caused by *E. coli* is infection of the urinary tract. Invasion from the primary infection site, such as the urinary tract, to the bloodstream leads to blood stream infection (*E. coli* bacteraemia). Antibiotic resistance has increased in recent years with some *E.coli* able to produce enzymes that confer resistance to multiple antibiotics. The aim of the surveillance is to allow more accurate determination of possible interventions to prevent avoidable bacteraemia.

There is work ongoing that is part of the national agenda for health and social care economies to reduce the number of Gram-negative bloodstream infections (BSIs) with an initial focus on Escherichia coli (E.coli). To date this has focused on the management of patients with long term urinary catheters. Across the Dudley health economy a catheter 'passport' has been agreed and approved and builds upon the catheter bundle that is already in use across the Trust. The passport was launched at the end of August 2018 and also been launched across the Health Economy.

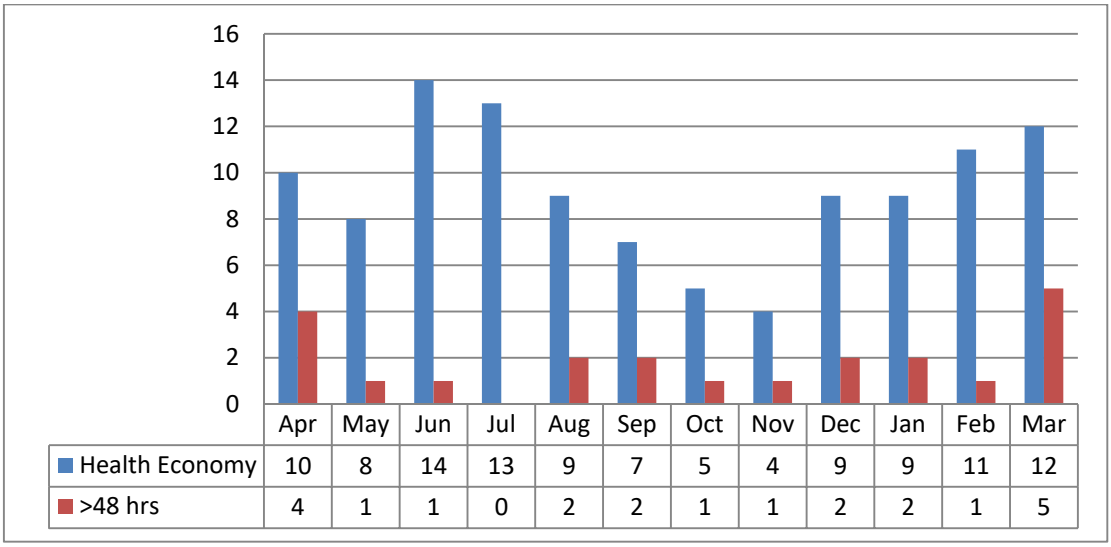
The table below demonstrates the number of E. coli positive cases identified at The Dudley Group NHS Foundation Trust for this reporting period. The Trust undertook enhanced surveillance of E. coli bacteraemia as part of a whole health economy ambition to reduce Gram-negative bloodstream infections. Themes identified as sources of bacteraemia were urinary tract and hepatobiliary infection which is in line with national data.



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Health Economy	28	31	25	28	30	25	23	31	25	26	32	21
>48 hrs	3	5	4	1	3	2	0	3	5	5	4	3

5.4 Meticillin Sensitive Staphylococcus aureus (MSSA) Bacteraemia.

Mandatory reporting of all MSSA bacteraemia commenced in January 2011. A total of 111 MSSA bacteraemia cases were reported during 2018/2019. Of these, 22 were trust apportioned (i.e. occurred 48 hours or more after admission). There is currently no target associated with MSSA bacteraemia incidence. The Trust continues to fulfil its mandatory requirement and contributes to this enhanced national surveillance scheme. No themes were identified for this reporting period, however education, training and support was provided to drive improvements in practice in invasive devices insertion, management and documentation of ongoing care. No reduction trajectory for MSSA has been set nationally.



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Health Economy	10	8	14	13	9	7	5	4	9	9	11	12
>48 hrs	4	1	1	0	2	2	1	1	2	2	1	5

6.0 SURGICAL SITE SURVEILLANCE

Surgical site infections (SSIs) are an important cause of Healthcare Associated Infections (HCAI), accounting for 20% of all HCAIs, and have serious consequences for both the patient and the Healthcare organisation.

Surveillance of surgical site infection following orthopaedic surgery has been included in the mandatory healthcare-associated infection surveillance system in England since April 2004. The National Surveillance Scheme enables hospitals in England to undertake surveillance of healthcare associated infection, compare their results and national aggregated data, and use the information to improve patient outcomes.

All NHS Trusts where orthopaedic surgical procedures are performed are expected to carry out a minimum of three months surveillance in at least one of four orthopaedic categories:

- Total hip replacements
- Knee replacements
- Repair of neck of femur
- Reduction of long bone fracture

Summary of Orthopaedic SSI rates April to June 2018

The data has been submitted to Public Health England and the official reports are now available to view on the PHE Surgical Site Surveillance database. The results of the surveillance are detailed in the table below. This includes the trust percentage for the period of surveillance undertaken by DGH and also the national average over the last 5 years.

Surgery	Total operations	Inpatient/ readmission SSIs	Trust Rate %	National Average %
Hip replacement	104	0	0%	0.9%

*Knee replacement	90	1	1.1%	1.3%

The Surgical site infection that was identified is detailed below:

Surgical Site Infections

*Knee Replacement (identified post discharge – patient reported only)

7.0 OUTBREAKS / PERIOD OF INCREASED INCIDENCE (PII)

Different outbreaks / incidents demand different responses but are managed with collaborative working between the multi-disciplinary teams across the Health Economy.

Norovirus

Norovirus is a self – limiting diarrhoea and vomiting bug that usually lasts 48-72 hours and is more prevalent during the winter months

In common with other acute trusts, DGFT managed patients an increasing number of patients who presented with diarrhoea and /or vomiting which required restrictions to the movements of patients. The IPCT actively managed and monitored these patients providing advice to ward staff and departments'. This proactive management resulted in the prevention outbreaks within the hospital.

We had no confirmed outbreaks of Norovirus for 2018/19

Clostridium Difficile

A period of increased incidence of *clostridium difficile* is defined as 2 cases of toxin positive Clostridium *difficile*, acquired post 48 hours, on the same ward, within a period of 28 days.
We identified 1 period of increased incidence of Clostridium *difficile* in March 2019 this occurred on our Gastroenterology ward. A meeting was held, ward audits were conducted, and cleaning scores reviewed and typing of specimens was requested. Investigation concluded that ribotype of each case was different, confirming that the cases were not linked. No further cases were identified.

Influenza Campaign

The Policy for the Management of Patients with Influenza and guidance on treatment was revised in accordance with national guidance and actions were implemented to support staff in clinical areas. The microbiology laboratory introduced a rapid test method to increase turn-around time for flu test results. This allowed all patients to be given a specific diagnosis on the day of testing and enabled improved prescribing of influenza treatment. The prompt identification of positive patients enbled rapid isolation of patients reducing the risk of outbreaks in hospital. In addition the IPC Nurses provide an on-site presence at week-ends.

8.0 INFECTION PREVENTION LINK WORKERS

The IPC Link workers continue to support the function of the IPC team and are an important and effective means of disseminating information and good practice. Link

workers act as visible role models and local and advocate high standards of IPC. They provide a link between their colleagues and the IPC team in order to facilitate good practice and improve standards within their teams.. There is a link worker in every department both inpatient and community areas. Link workers meet with the IPCT bi-monthly to discuss best practice and share their learning and experience.

9.0 AUDIT

Saving Lives Audit

The Saving Lives programme (DH, 2008) was introduced to support healthcare providers in reducing healthcare associated infections. The Saving Lives Audit within the Trust is undertaken on a monthly basis. As of the 1st April 2018 the new version of the Saving Lives released in November 2017 has been implemented. High Impact Interventions relate to key clinical procedures or care processes based on evidence based approach

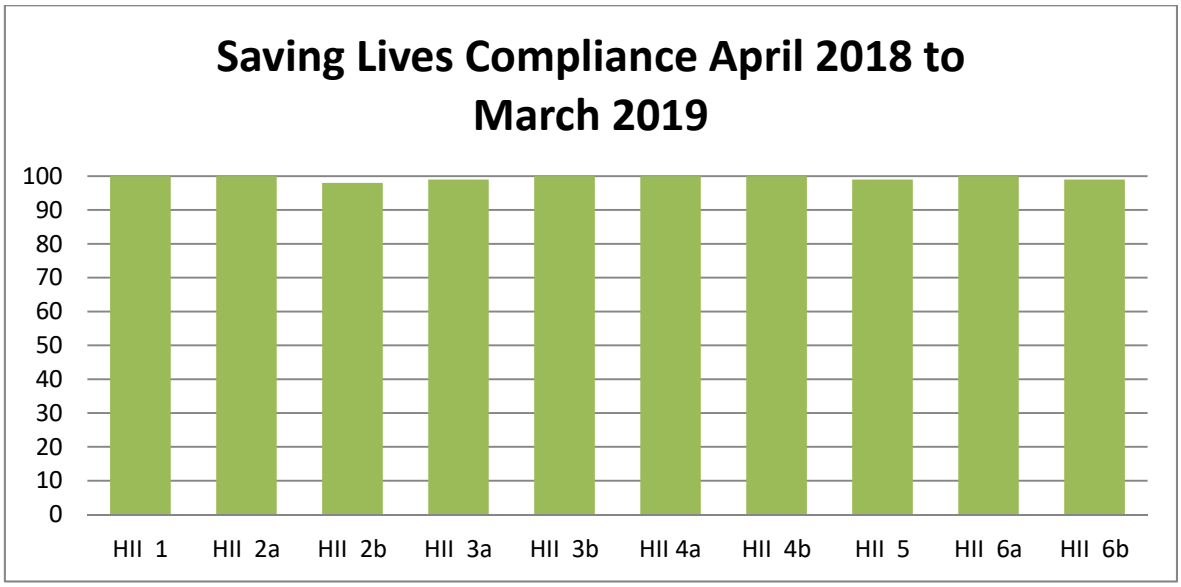
This system can be accessed by Heads of Nursing, Matrons and Lead Nurses enabling users to review and monitor individual performance.

Areas that submit scores of less than 95% are required to complete an action plan to identify how they will rectify the overall score and how this will be cascaded across the areas.

The updated HIIs audits include:

- HII No 1 Ventilator associated pneumonia
- HII No 2a Peripheral Vascular Access Devices – Insertion
- HII No 2b Peripheral Vascular Access Devices – Ongoing Care
- HII No 3a Central Venous Access Devices – Insertion
- HII No 3b Central Venous Access Devices – Ongoing Care
- HII No 4a Surgical Site Infection Prevention – Preoperative
- HII No 4b Surgical Site Infection Prevention – Intraoperative actions
- HII No 5 Infection Prevention in Chronic Wounds
- HII No 6a Urinary Catheter Insertion
- HII No 6b Urinary Catheter – Maintenance and assessment

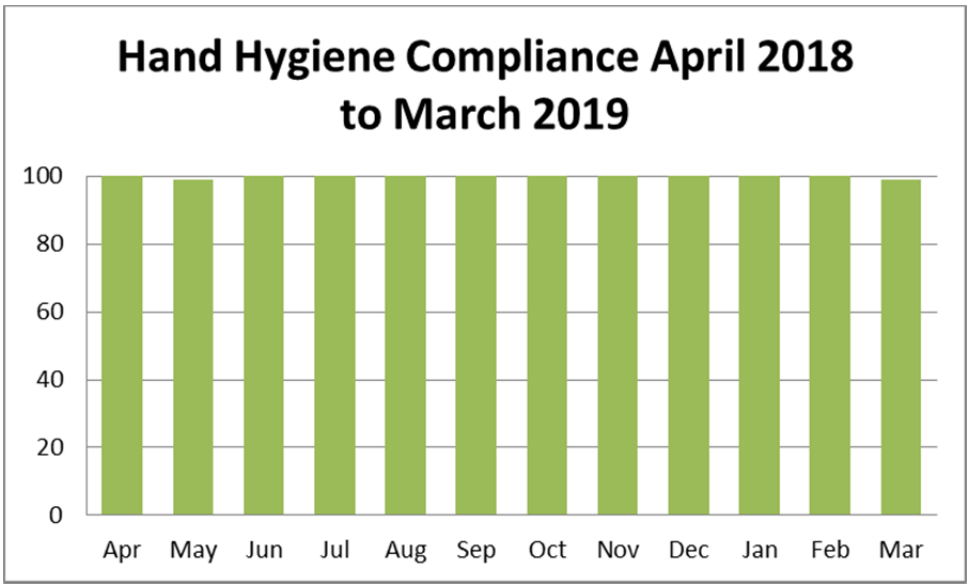
The graph below demonstrates overall Trust compliance with Saving Lives Audits for the year April 2018 to March 2019.



Hand Hygiene Audit

It is well recognised that hand hygiene is the single most important factor in reducing and preventing avoidable illnesses, e.g. healthcare associated infections. All staff within healthcare settings in particular must recognise this and perform hand hygiene effectively and in a timely fashion. Audit is one of a number of in healthcare settings.

Hands can only be decontaminated effectively by ensuring that the correct technique is used which encompasses the wrists and therefore it is imperative that staff comply with 'Bare Below the Elbow' in order to facilitate this. Monthly audits are undertaken in all areas across the Trust. Audits are undertaken by Link Workers and supplemented by unannounced spot-check audits by the Infection Prevention and Control Team. The results for this year demonstrate high standards of infection control practice across the organisation.



Hand Hygiene Products

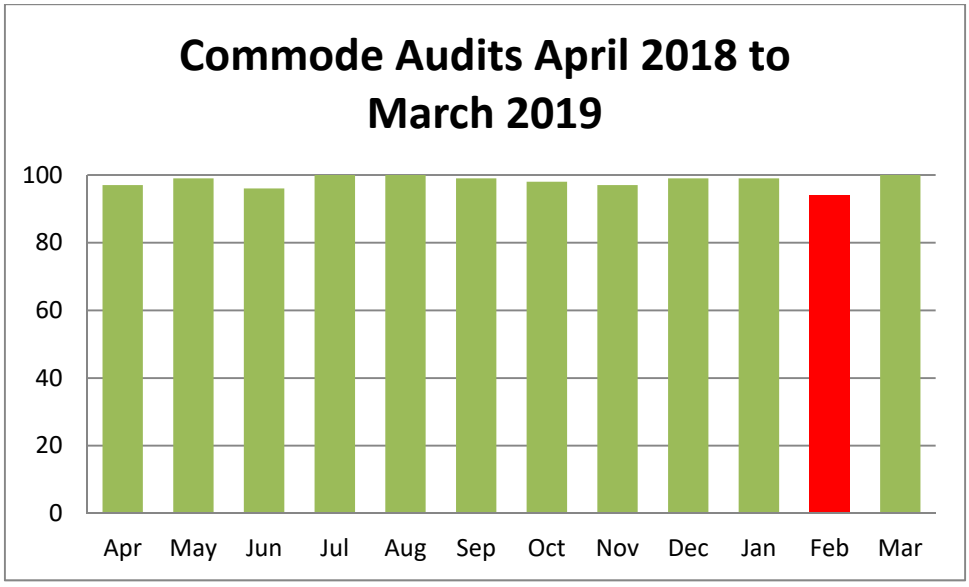
A review of the hand hygiene products used within the organisation concluded that there was no single supplier of hand hygiene products and that skin moisturiser was not readily available therefore increasing the risk of dermatitis to staff. Following this report the Trust

supported the move to a single supplier of hand hygiene products including availability of hand moisturiser for staff. A new supplier for soap, hand sanitiser and moisturiser has now been sourced and completed on the Russells Hall Site. Work is planned to install across Corbett and Guest. Ongoing skin surveillance is being undertaken by Staff Health and Wellbeing.

Commode Audit

Monthly commode audits are undertaken by clinical areas to ensure the condition and the cleanliness of commodes are monitored. Broken commodes are removed and replaced as necessary.

The graph below demonstrates overall Trust compliance for commode audits for the year April 2018 to March 2019.



The audit highlighted a reduced compliance score for February 2019. The issues identified were due failure to follow procedure for labelling equipment that has been cleaned. This issue was addressed immediately.

10.0 WARD AUDITS

An audit of clinical areas has been undertaken utilising the Infection Prevention Society audit tool, prioritising areas with poor environmental scores, low MRSA admission screening rates, poor or lacking High impact intervention scores, high Clostridium difficile rates and NHSI/CQC feedback.

All of the inpatient areas, admission wards, day case units, imaging departments were audited. In addition the majority of clinics and outpatient areas were visited.

The aim of the auditing process is to:

- make wards aware of shortfalls in practice and compliance with IPC policies
- escalate environmental concerns which might compromise patient, visitor and staff safety to the relevant departments/teams (environment, water safety, ventilation, domestic and nursing cleaning scores)

- provide Lead nurses, matrons and link practitioners with the expected IPC standards

The infection Control Team completed a baseline audit for all the inpatient and majority of the outpatient areas during the first quarter on the current financial year. Good practice was noted and feedback was provided to the audited areas. Shortfalls were also noted and the most common themes identified were:

- Infection control: inappropriate use and disposal of Personal Protective Equipment (PPE), noncompliance with the isolation policy, lack of cleaning schedules for equipment and toys.

- Housekeeping: lime scale on taps, mould on seal around sinks, dirty macerator seal and rim, low and high dust in places

- Estates: holes in the sink back panels, sink seals damaged/discoloured, wall paint damaged/discoloured, ceiling tiles looking dusty, plugs on chains on some hand wash sinks

A new cleaning schedule was devised and disseminated to all clinical areas, providing assurance that all the equipment in use is cleaned, reducing the risk of cross contamination.

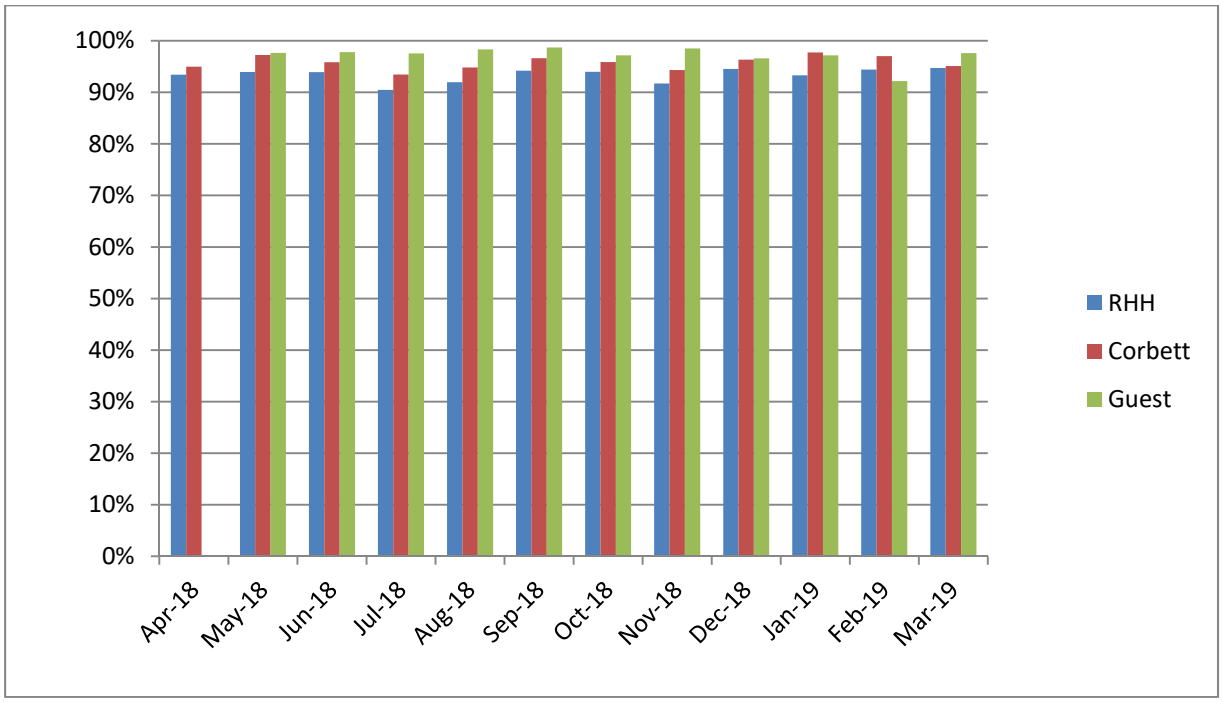
A Cleaning and Disinfection Guidance for Foam Mattresses, Static Air Mattresses and Bedframes poster was designed following the NHSI visit from March 2018.

11.0 ESTATES & FACILITIES

11.1 Environmental Audits

The Trust recognises its duty to provide safe and clean environments where patients, staff and other visitors can expect to be protected from the risk of Infection. The environmental cleaning service is provided by Interserve (Facilities Management) Ltd (IFM) as part of the Trusts PFI contract with Summit Healthcare (Dudley) Ltd (Summit). The contract is managed by the Trust's Facilities and Property Development Department. Environmental audits are undertaken by the Trust Auditors in partnership with IFM and clinical staff.

The table below outlines the cleaning scores for The Trust for this reporting period.



Cleaning scores across the Trust have plateaued over the past 12 months. In the main, Corbett and Guest Hospital continue to achieve above the 95% threshold on a monthly basis. However, Russells Hall has not achieved 95% in any month but is achieving in excess of 90% and for the past 2 months in excess of 94%. The Trust has continued to audit all areas of the hospital as outlined in the Trust's Cleaning and Disinfection policy and continued to apply the performance management mechanisms within the PFI contract throughout this period. The Trust's Facilities Team has worked closely with Summit and IFM during this time.

In collaboration with Summit Healthcare, a service review of the cleaning service has taken place by Delia Cannings, Director from Environmental Excellence Training & Development Ltd, who is also a member of the Association of Healthcare Cleaning Professionals. Whilst it was felt that the service being delivered was of an acceptable standard, a number of recommendations have also been identified within the final report. Progress is now being made to agree the way forward with IFM and Summit.

A Trust cleaning manual has been developed with support from Infection Control and a copy issued to all wards for reference. A copy is also available on The Hub. This manual includes supporting documentation such as authorised cleaning and disinfection products, colour coding, cleaning schedules, cleaning risk categories, cleaning frequencies, cleaning responsibilities, element standards used for auditing etc.

Following the implementation of the Trust's revised Cleaning & Disinfection Policy, updated cleaning schedules have been issued to all wards and are in place on the entrance to each clinical department.

It is expected that during 2019 NHS Improvement will issue the new National Standards for Healthcare Cleanliness, although this should not affect Interserve's contractual obligations.

11.2 PLACE 2018

Patient-Led Assessments of the Care Environment (PLACE) is the national system of assessing how the environment supports the provision of clinical care. All Trusts are required to undertake these inspections annually to a prescribed timescale.

PLACE teams consist of both Patient and Staff Assessors. As a minimum, Patient Assessors should make up 50% of the assessing team. There were 13 Trust and Interserve representatives and 13 Patient Assessors from local Healthwatch and also Trust Governors. The number of areas to be visited across the site are set out within the guidelines of PLACE and the inspection covers wards, out-patient areas, communal areas and external areas, as well as the Emergency Department and generates scores for the following:

- Cleanliness
- The quality and availability of food and drinks
- How well the environment protects people's privacy, dignity and wellbeing
- Condition, appearance and maintenance of the buildings (inside and out)
- How the premises are equipped to meet the needs of patients with disability and dementia

PLACE by its very nature is a snap shot of one day and does not rely on the application of any technical or scientific tools, it can be influenced either way by what is seen on the day. At the end of the assessment period, Patient Assessors are required to complete their own assessment form on how the overall assessment has been undertaken. This includes questions such as were their views taken on board and was sufficient time given to undertake the assessment etc.

The PLACE Scores for 2015 / 2016 / 2017 / 2018 were as follows;

	2015	2016	2017	2018
Cleanliness	99.06%	99.14%	98.09%	98.85%
Food (Combined)	86.08%	80.74%	88.76%	83.95%
Food (Organisational)	75.19%	83.46%	87.04%	92.18%
Food (Ward)	88.47%	80.01%	89.21%	82.02%
Privacy, Dignity and Wellbeing	85.87%	84.01%	88.89%	88.64%
Condition, Appearance and Maintenance	94.97%	96.59%	93.35%	96.35%
Dementia	74.13%	80.95%	77.60%	85.45%
Disability	-	-	83.99%	92.28%

The Dudley Group NHS FT were shown to be better than the national average in six of the eight categories including; Cleanliness, Organisational food, Privacy, dignity & wellbeing, Condition, appearance and maintenance, Disability and Dementia. As food was an area for concern for the Trust based on the PLACE scores and also patient feedback, an action plan was developed in order to address the issues identified, this has included Interserve changing to a new food supplier, Apetito, and a new patient menu being implemented in December 2018, as well as the purchase of new food regeneration trolleys for all wards.

In February 2018 the Trust commenced a programme of mini-PLACE assessments to assess the patient environment. In addition to Trust and IFM/Summit involvement, these assessments are supported by Patient Assessors including Trust Governors, local Healthwatch and also the Trust's volunteers. Actions arising from each of the assessments are recorded and monitored via the Patient Experience Improvement Group (PEIG).

Hydrogen Peroxide Vaporisation (HPV) is a method of environmental bio-decontamination whereby a machine creates a fine vapour which is released into the atmosphere of a sealed space (i.e. room on a ward). The vapour will circulate and settle on surfaces, providing a highly effectively means of surface disinfection and decontamination.

HPV decontamination is advised whenever the spread of infection is considered a risk. It is highly recommended that HPV decontamination of single or multi-bedded rooms is undertaken where patients have been known to have had infections that are easily transmitted.

The HPV business case approved funds for a service for 6 months in order to obtain robust information regarding the number HPV cleans required against those delivered in order to review the effectiveness of the service. The service is to provide an adjunct to terminal cleans for specific alert organisms and to deliver a rolling programme of equipment decontamination in high risk areas of the Trust. The service offered is: Monday to Friday 9am – 7pm and Saturday to Sunday 11am – 7pm. The team commenced employment and training on 6th August 2018.

Operators visit the wards each morning and later in morning, and throughout day to see if any patients are planned to be discharged and advise staff to arrange 'fogging ' of room. However, the trend appears to be that patients are discharged out of HPV operators hours (most likely due to waits for TTO's, transport) and rooms are not always fogged. However as many areas and side rooms as possible have been fogged throughout each month. HPV operators have successfully fogged (as part of a rolling programme) all bathrooms on most wards.

Due to the success of the trial we have now appointed to 2 substantive posts to ensure the rolling programme of HPV cleaning to bathrooms, equipment and side rooms continues. We also have a part time vacancy which we plan to appoint to very soon

12.0 ANTIBIOTIC STEWARDSHIP

Antimicrobial Stewardship Report 2018-19

This paper provides an update and an assurance of compliance with standards set out by Health and Social care IPC code of practice for Antimicrobial stewardship, Department of Health "Start Smart then Focus" and NICE NG15 (2015) Antimicrobial Stewardship: systems and processes for effective antimicrobial medicines use.

CQUIN: Reducing the impact of serious infections (Antimicrobial Resistance and Sepsis)

For 2018-19 Dudley participated in the national CQUIN: Reducing the impact of serious infections. The antimicrobial team took responsibility for part C and D. The goal of this CQUIN was to reduce antibiotic consumption with a focus on antimicrobial stewardship and ensuring antibiotic review within 72 hours. Indiscriminate and inappropriate antibiotic prescribing has been identified as a key driver for antibiotic resistance, therefore the CQUIN aimed to reduce total antibiotic usage, usage of key broad-spectrum antibiotics and ensure antibiotics are appropriately reviewed after initiation.

Part 2c of CQUIN: **Antibiotic review between 24-72 hours of initiation in patients with sepsis who are still inpatients at 72 hours.**

Dudley achieved all four milestones for antibiotic review within 72 hours, with a final result of ***94.3% (Q4)*** for antibiotic prescriptions (sepsis patients) receiving a review within 72 hours.

In order to further the excellent achievements to date, the Trust has recruited additional sepsis nurses and an antimicrobial pharmacist to support initiatives to improve sepsis outcomes and stewardship.

An online sepsis tool has been created for antimicrobial/sepsis teams based on e-obs which allows identification of patients who are flagged as septic. The tool facilitated review of those patients within 72 hours by the antimicrobial team which helped in achieving the quarter 4 target of 90% for antibiotic review.

This successful strategy was showcased at West Midlands Innovation day as a poster and was highly commended.

Part 2d Antimicrobial Consumption

Part 2d of the CQUIN is further divided into 3 individual targets,

1. Reduce total antibiotics consumption by 2%.
2. Reduce carbepenem consumption by 2%.
3. Increase access list antibiotics proportion to 55% of the total antibiotics consumption.

When compared with national consumption data reported on Public Health England Fingertips, Dudley falls in the 2nd lowest percentile for total antibiotic usage (5069 Defined Daily Doses (DDDs)/1000 admissions vs. 4945 DDDs/1000 admissions for Dudley and national average, respectively).

The antibiotic consumption targets and local achievements are detailed in table 1.

Table 1

Measure	Baseline	Target	End of year
Total ABX	4048.4	3967.4	+33.1%
Access group ABX >55% of consumption	55%	55%	56.50%
Carbepenem	133.1	130.4	-39.4 %

Quarterly summary is as following:

Q1 total antibiotic consumption DDDs/1000 admissions= 5141.6 ***(+30.5%)***
Q1 Carbapenem consumption DDDs/1000 admissions= 82 ***(-30.9%)***
Q1 Access list proportion consumption = ***52.37%***
Q2 total antibiotic consumption DDDs/1000 admissions= 5141.6 ***(+27%)***
Q2 Carbapenem consumption DDDs/1000 admissions= 82 ***(-39.1%)***
Q2 Access list proportion consumption = ***56.00%***
Q3 total antibiotic consumption DDDs/1000 admissions= 5674.5 ***(+30%)***
Q3 Carbapenem consumption DDDs/1000 admissions= 79 ***(-38.6%)***
Q3 Access list proportion consumption = ***59.02%***
Q4 total antibiotic consumption DDDs/1000 admissions= ***(+33.1%)***
Q4 Carbapenem consumption DDDs/1000 admissions= ***(-39.4%)***
Q4 Access list proportion consumption = ***56.5%***

Compared to similar Trusts, Dudley performed well in reducing Carbapenem and Pip/Taz usage however, because of the switch to triple therapy i.e. 3 narrow spectrum antibiotics rather than one broad spectrum antibiotic and other factors such as change in admission data during 2017/18 the total antibiotic consumption figure has significantly increased.
Learning from 2017/2018 we reviewed all our antibiotic guidelines individually and changed guidelines based on national recommendations and local resistance patterns.
The following Figures (1, 2, 3 &4) are from Define benchmarking software:

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

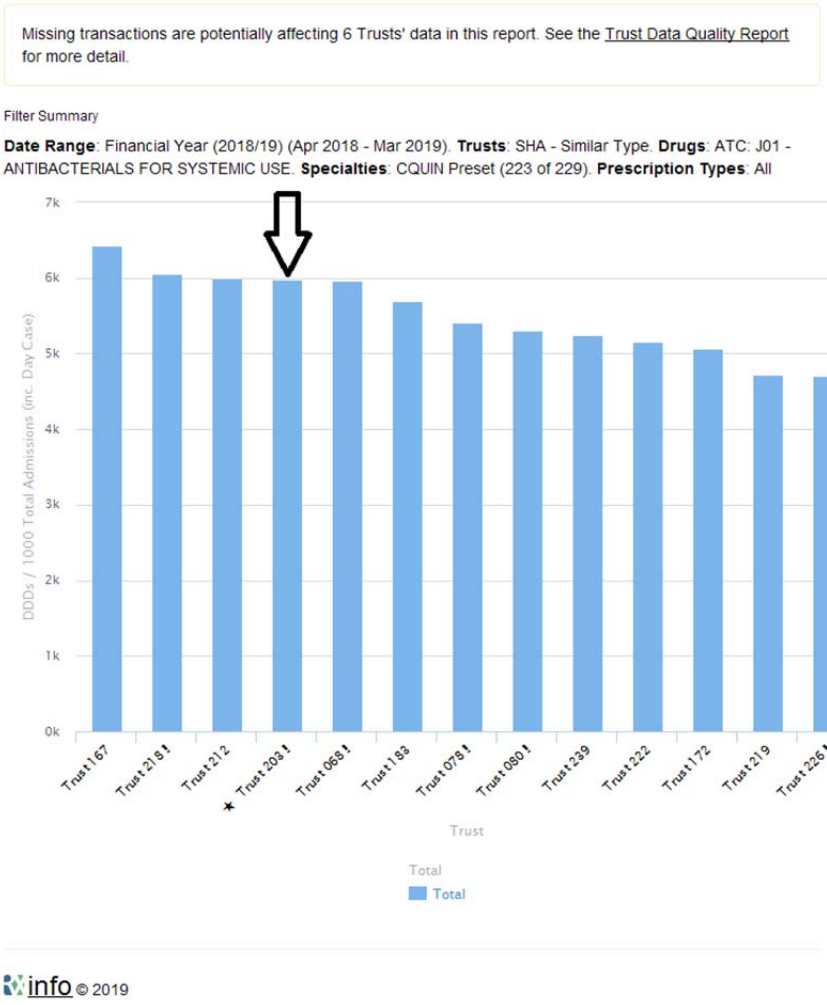


Figure 2, Total Carbapenem Consumption (DDDs/1000 admission) compared to similar Trusts.

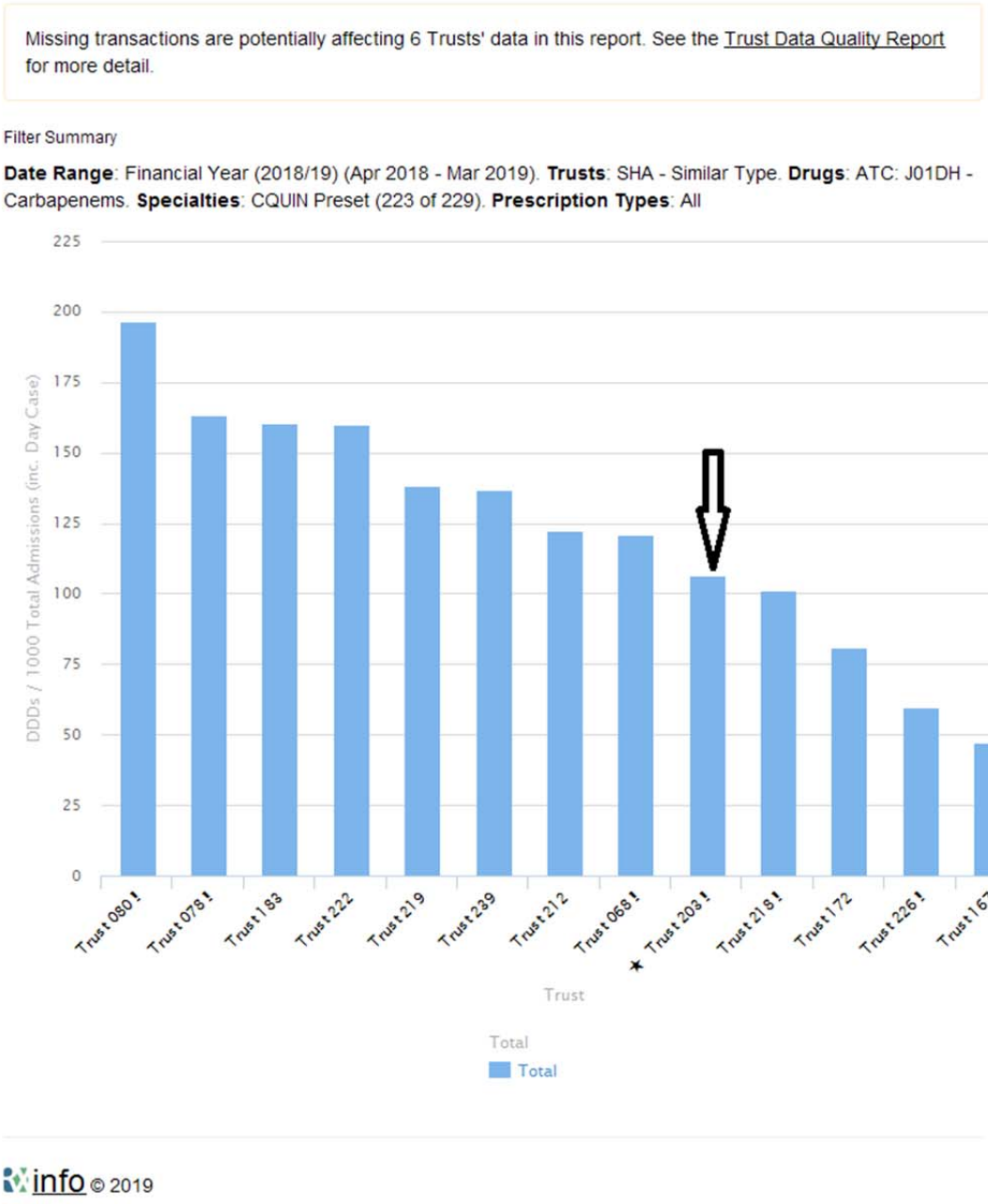


Figure 3, Total Pip/Taz consumption (DDDs/1000 admission) compared to similar Trusts

Missing transactions are potentially affecting 6 Trusts' data in this report. See the Trust Data Quality Report for more detail.

Filter Summary

Date Range: Financial Year (2018/19) (Apr 2018 - Mar 2019). **Trusts**: SHA - Similar Type. **Drugs**: ATC: J01CR05 - Piperacillin and beta-lactamase inhibitor. **Specialties**: CQUIN Preset (223 of 229). **Prescription Types**: All

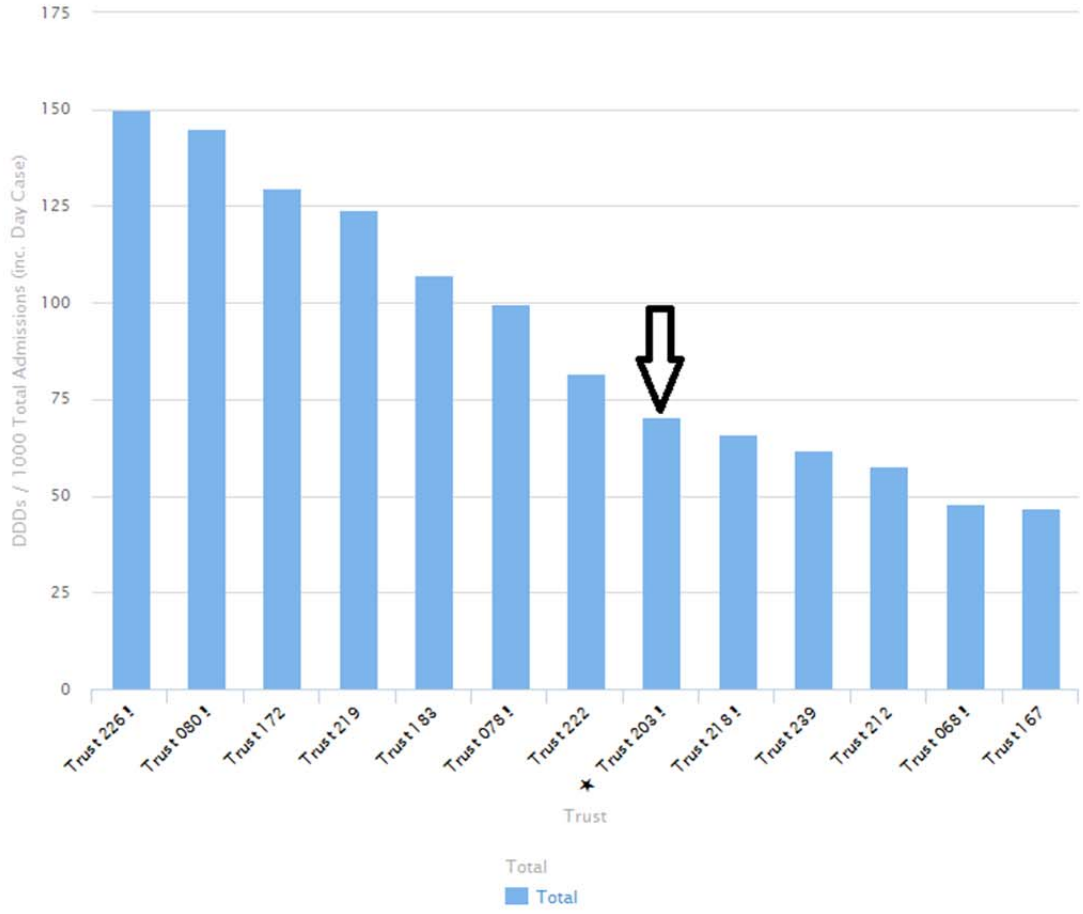
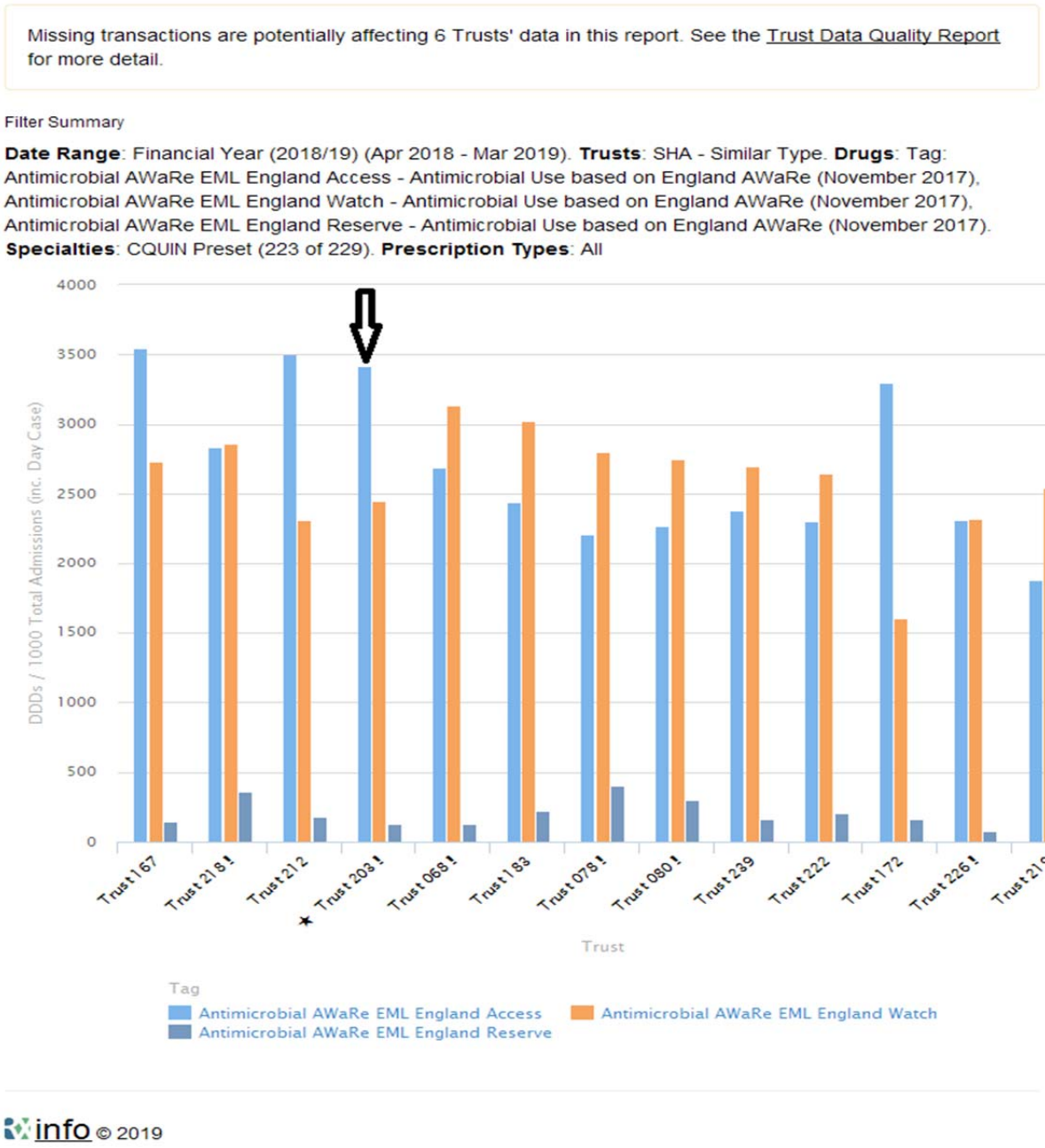


Figure 4, Proportion of Access list antibiotics DDDs per 1000 admissions

The Dudley Group NHS Foundation Trust is in the 75th percentile to best nationally for using access list antibiotics.



Antimicrobial Prescribing snap shot audit

Antimicrobial snap shot audits were carried out during 2018/19. The results are summarised in the following tables:

April 2018

23 April 2018		Percentage	Regional target
Number of occupied beds	550	-	
Allergy Status recorded on chart (NKDA, Yes, No)	540	98.2	> 98%
Number of patients with an allergy who have the nature of the allergy documented	61	38.4	> 98%
Number of patients on Antibiotics	234	42.5	
Number of Patients on intravenous antibiotics	110	20.0	
Number of patients on intravenous antibiotics over 48 hours (>72hrs Jan 2013)	44	40.0	
Number of patients where total course over 5 days (>7days Jan 2013)	14	6.0	
Number of patients where stop / review date documented on the prescription chart	135	57.7	> 70%
Has the indication been documented on the chart?	180	76.9	> 70%
Is patient on Meropenem/Ertapenem? (Of those patients on an IV abx)	16	14.5	< 10%

September 2018

10 September 2018		Percentage	Regional target
Number of occupied beds	535	-	
Allergy Status recorded on chart (NKDA, Yes, No)	526	98.3	> 98%
Number of patients with an allergy who have the nature of the allergy documented	52	27.5	> 98%
Number of patients on Antibiotics	196	36.6	
Number of Patients on intravenous antibiotics	91	17.0	
Number of patients on intravenous antibiotics over 48 hours (>72hrs Jan 2013)	38	41.8	
Number of patients where total course over 5 days (>7days Jan 2013)	16	8.2	
Number of patients where stop / review date documented on the prescription chart	86	43.9	> 70%
Has the indication been documented on the chart?	150	76.5	> 70%
Is patient on Meropenem/Ertapenem? (Of those patients on an IV abx)	3	3.3	< 10%

February 2019

Dudley Group NHS Foundation Trust - Snap shot audit			
01 February 2019		Percentage	Regional target
Number of patients audited	456	-	
Allergy Status recorded on chart (NKDA, Yes, No)	454	99.6	> 98%
Number of patients with an allergy who have the nature of the allergy documented	58	34.7	> 98%
Number of patients on Antibiotics	245	53.7	
Number of Patients on intravenous antibiotics	117	25.7	
Number of patients on intravenous antibiotics over 48 hours (>72hrs Jan 2013)	46	39.3	
Number of patients where total course over 5 days (>7days Jan 2013)	12	4.9	
Number of patients where stop / review date documented on the prescription chart	157	64.1	> 70%
Has the indication been documented on the chart/notes?	234	95.5	> 70%
Is patient on Meropenem/Ertapenem? (Of those patients on an IV abx)	4	3.4	< 10%

All the results from the snapshot audits carried out over the last year shows significant improvement.

The audit tool has been modified to collect more useful information i.e. indication and compliance with Trust guidelines. Nature of allergy is further clarified during the medicines reconciliation process by ward pharmacy teams when needed.

The documentation of stop/review date seems low however, data collected within the snapshot audit is limited to prescription charts and does not include documentation od stop/review in the medical notes.

Patients on restricted antibiotics e.g. meropenem & piperacillin/tazobactam (which are not recommended in the Trust guidelines or approved by microbiology) are referred to the antimicrobial pharmacists.

The pharmacy team monitor and raise awareness at ward level on how to correctly document allergy status on drug charts. A pre-registration pharmacist has recently completed an audit regarding documentation of drug allergies and the data is being analysed.

Interventions over past 12 months to improve Antimicrobial Stewardship at DGH

The targets were achieved with the help of multiple initiatives i.e.

- Project group formed including medical director, chief pharmacist, AMS team, Sepsis leads and service improvement
- IV to oral (IV2PO) switch stickers.
- Collaboration with sepsis team.
- Feedback to the divisions provided via ASG
- Executive level reporting to influence change.
- Antibiotic review section on drug chart.
- Referrals to antimicrobial pharmacists.
- Review of OPAT use of IV antibiotics
- Complete review of antibiotic treatment guideline choices, reducing a large proportion of pip/taz use.
- Course lengths in antibiotic guidelines rationalised
- Teaching with pharmacists to empower challenge of prescriptions
- AMS ward rounds started initially on critical care and then extended to medical and surgical high dependency units and acute medicine wards.
- Developed a new sepsis tool based on e-obs to identify sepsis patients (presented poster at west midland innovation day).
- Monthly CQUIN report compiled.
- ITU stewardship ward rounds started 3 times a week.
- Surgical prophylaxis guidelines updated.
- Endocarditis guidelines updated.
- Sinusitis guidelines updated.
- C diff guidelines updated.
- Junior Drs antimicrobial prescribing audit analysed and reported.
- Vancomycin/Gentamicin dialysis prescriptions updated.
- Communication to highlight the criteria for the new CQUIN part c and antimicrobial stewardship completed –
- Communication message published on HUB highlighting importance of 72 hours review.
- Medical/surgical representation in Antimicrobial stewardship group.
- Awareness session for pharmacists on sepsis and antimicrobial review has been delivered.
- Antimicrobial snapshot audits completed.
- Guidelines for (HAP, CAP, Aspiration pneumonia and Cholecystitis) updated to include more access group antibiotics.

- Hub Communication around guidelines changes.
- Antimicrobial stewardship talk to OPAT sisters delivered (prescribers).
- Antimicrobial stewardship update at Grand round in July 2018.
- Antimicrobial pharmacist's referrals started for ward pharmacists.
- Communication (antibiotics aware theme) to all clinicians/prescribers from (Medical director/Chief Pharmacist/DIPC) in form of email completed on 1/8/18
- Pip/Taz removed from ward stock lists with a few exceptions i.e. acute medicine, oncology/haematology wards for neutropenic sepsis.
- Teaching session for acute medicine directorate completed.
- Antimicrobial prescribing session for FY1s completed.
- Antimicrobial prescribing session for FY2s completed.
- Antimicrobial prescribing session for CMTs completed.
- Extended antimicrobial stewardship ward rounds started covering MHDU and acute medical wards.
- Snap shot audit of acute medicines ward completed along with consultant microbiologists.
- Influenza Guidelines updated.
- Raised awareness around AWaRe list of antibiotics provided by Public Health England.
- Antimicrobial awareness week from 12th November to 18th November.
- Directorate meetings and feedback to Clinicians on standards of antimicrobial prescribing in their areas was provided.

Education and Training

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

Pharmacists receive regular feedback on antimicrobial prescribing in their clinical areas after the snapshot audits, pharmacist prescribers' complete online modules on antimicrobial prescribing.
Feedback is provided to clinicians after every RCA for C. diff infections. The newly recruited band 7 Specialist Antimicrobial Pharmacist is enrolled onto an independent pharmacist prescribing course which will further strengthen the antimicrobial stewardship activities across the Trust.

Research

The antimicrobial stewardship team has applied to be a part of the national research project ARK and is awaiting response from the project recruiters.

ARK is developing and testing a bundle of strategies – the '**A**ntibiotic **R**eview **K**it' – to help doctors, nurses, pharmacists and patients stop antibiotics in hospital when they are no longer needed.

Current Challenges

- Encouraging already stretched clinicians to represent their areas at ASG meetings.

- Capacity of AMS team is limited therefore ward presence is low. Currently 1 x Consultant Microbiologist vacancy with one substantive and one Locum in post. This limits pro-active monitoring through limited ward visits.

- Antibiotic shortages are unpredictable and require frequent guidance changes leading to prescriber confusion.

- Lack of e-PMA to support real time tracking of antibiotic consumption, guidance compliance and improved data reporting / time management on reporting. Roll out of chosen e-PMA (Sunrise – Allscripts)

- In the absence of live prescribing system it will be challenging to capture the data for new CQUINs i.e. prescribing for lower UTIs in over 65s and prophylactic antibiotics in elective colorectal surgeries.

Plans for 2019/2020

- Develop a strategy for achieving 2019/20 national CQUIN targets around antimicrobial stewardship i.e.

  Part CCG1a: Improving the management of lower urinary tract infections in older people
  Part CCG1b: Improving surgical prophylaxis in elective colorectal surgery

- Review guidelines in view of new NICE guidance issued lately.

- Continue working as a part of sepsis work streams: created “Sepsis team” (4x sepsis nurse practitioners band 7s + 2 x antimicrobial pharmacists+ Consultant Physician)

- Focus on drive for IV2PO switch – septic patients flagged to antimicrobial team. Reinforce the need for a high standard antimicrobial stewardship at pharmacist clinical huddles.

- Training sessions with all pharmacists to highlight the changes and rationale.

- Engage clinicians from medical and surgical divisions to attend ASG meetings and feedback to respective directorates.

- Regular snap shot audits to assess antimicrobial prescribing.

- Increase the frequency of AMS ward rounds currently 3 days a week on critical care, 1 day a week on Medical HDU and 1 day a week on acute medical wards.

- Regular communication in the form of patient safety alerts, screen savers, trust wide communication emails on changes in processes and guidance.

- Develop antimicrobial review page on upcoming electronic prescribing system (sunrise) to help achieve required standards of antimicrobial review.

- Scope development of antifungal stewardship.

- Support postgraduate diploma pharmacists in conducting clinical audits as part of their infectious disease module.

- Support 2019/20 pre-registration pharmacists with antimicrobial audits if required.

- Patient safety bulletin around diagnosis and management of lower UTIs in over 65 patients (as per NICE guidance)

- Liaise with Acute medicine Consultants and Colorectal Surgeons to bring them on board for 2019/20 CQUIN.

- Organise and promote Antibiotic awareness week 2019.

- Identify opportunities for research and development around antimicrobial stewardship.

13.0 NHSi Infection Control Visit

A visit by Dr Adams**,** Senior Infection Prevention and Control Advisor NHSi was conducted on 18th July 2018 to visit and review infection control arrangements and practice within the hospital. This was a follow up visit from and earlier inspection where some failings were identified with basic practices. Following the visit, the trust was rated green on the NHSI IPC escalation matrix. No future visits were scheduled

14.0 EDUCATION AND TRAINING

Infection Prevention and Control is identified as a Priority 1 mandatory core subject that all employees are required to receive. As of March 2018 Infection Prevention and Control Training for Clinical Staff was required to be completed on an annual basis with a KPI of 90%. The training for non-clinical staff continues to be required 3 yearly. A report is published each month by Learning and Development identifying compliance across the 4 divisions.

The Infection Prevention and Control Team delivers training sessions during Trust induction and Mandatory refresher training each month to various staff groups across the Trust. Following the session there is a requirement for all staff to complete a competency test, and the pass rate for this is 80%.

Staff also have access to an eLearning module for Infection Prevention and Control which can be located on the Learning and Development Page of the hub. It is also necessary for staff to complete a competency test if they choose to complete the session via this route and again the pass rate is 80%.

The table below indicates the mandatory training figures for Infection Prevention and Control the period 2018/2019, broken down by division.

Division	**Infection Control – Clinical**	**Infection Control – Non Clinical**
Clinical Support	83%	98%
Corporate	85%	95%
Medicine & Integrated Care	88%	96%
Surgery	86%	94%
Trust Compliance	**87%**	**96%**

In order to reach 90% compliance trajectory for IC mandatory training for clinical staff the plan, to ensure outstanding staff are trained, is to identify these staff via their appraisal, during the current 3-month appraisal window, with the intention that all outstanding staff will be compliant with IC training by the end of this 3 month period.

15.0 INFLUENZA VACCINATION PROGRAMME

This year the Trust made excellent progress with regard to the 2018/19 flu vaccine campaign having achieved **77%** of front line staff vaccinated. The CQUIN target was therefore achieved. Peer vaccinators were identified in all ward areas and departments to increase the number of opportunities for staff to receive the vaccination along with additional sessions held at the Health Hub.

16.0 POLICIES

The IPCT recognises the importance of providing staff with easy access to a full range of IPC policies and guidelines. Throughout 2018-18 the IPCT continued to review and revise these documents to take account of the latest IPC best practices. Polices for IPC are reviewed and monitored collaboratively with. Public Health England, the Office of Public Health in Dudley and Dudley CCG. Consideration of new national guidance such as National Institute for Clinical Excellence (NICE) Quality Standards, Department of Health directives and developments in practice for IPC are considered for inclusion.

There is an ongoing programme of policy review and for new policies to be added as required. All policies subject to consultation through the Infection Prevention and Control Group prior to submission to the Trust's Guidelines Group.

17.0 CONCLUSION

Eliminating avoidable healthcare associated infection has remained a top priority for the public, patients and staff. In response, a robust annual programme of work has been implemented over the last year which has been led by an experienced and highly motivated Infection Prevention and Control Team and supported by colleagues at all levels of the organisation. The successes over the last year have only been possible due to the commitment for infection prevention and control that is demonstrated at all levels within the organisation. High standards of infection prevention and control and antimicrobial stewardship will remain crucial to minimise the risk of infection and limit the emergence and spread of multi-drug resistant organisms.

Enclosure 19

The Dudley Group NHS Foundation Trust

Paper for submission to the Board on 04/07/2019

TITLE:	**Seven Day Services (7DS) Report**		
AUTHOR:	**Dr. P. Hudson Interim DMD**	**PRESENTER**	**Dr. P. Hudson Interim DMD**

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
N	N	N	To note

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 be aware of forthcoming business cases to drive changes in working models to allow delivery of 7DS.

CORPORATE OBJECTIVE:

SO2: Safe and Caring Services
SO3: Drive service improvements, innovation and transformation

SUMMARY OF KEY ISSUES:

The reporting of compliance with 7DS has transitioned to a biannual Board assurance Framework, a trial version of which was submitted to NHSE/NHSI on 28/02/2019. An updated version based on 2019 data was submitted on 28/06/2019.
This paper outlines:

- Compliance with 2 of the 4 priority standards with benchmarking data
- Significant progress towards compliance in standard for timeliness of first Consultant review.
- Strategy for achieving compliance by target date of March 2020
- Ongoing monitoring and risks.

Achieving compliance will reduce variation in care throughout the week

IMPLICATIONS OF PAPER:

RISK	**Y**		**Risk Description: May not achieve full compliance by 2020**
	Risk Register: To be added		**Risk Score: 20**
COMPLIANCE and/or LEGAL REQUIREMENTS	**CQC**	**Y**	**Details: Effective & Well Led**
	NHSI	**Y**	**Details: expected compliance by March 2020**
	Other	**N**	**Details:**

The Dudley Group
NHS Foundation Trust

Update on Seven Day Service (7DS) Clinical Standards.

The Dudley Group NHS Foundation Trust

Trust Board 4th July 2019.

Introduction

The 7DS standards were initially introduced in 2013 by NHS Improvement to include 10 clinical standards. With the support of the Academy of Medical Royal Colleges, four of the ten standards were identified as clinical priorities on the basis of their potential to positively affect patient outcomes and it is against these which will the Trust will be assessed through a Board Assurance Framework (BAF). Progress against the six remaining 7DS Standards will not be measured through the collection of data or formal self-assessments, but the Trust will include summary progress information about their delivery in its report.

This paper will outline progress of the Trusts 7DS clinical strategy demonstrated by the most recent audit performance.

Objective

The 7DS programme's aim is to provide a standard of consultant led care to all patients presenting urgently or as an emergency such that their outcomes are optimised and there is equity of access nationwide but also outcomes are not dependant on the time of day or day of the week patients present.

Outcomes

We already track and report the key outcomes related to 7DS and report these in our quarterly learning from deaths paper. In addition to mortality we monitor avoidable harm and also staff feedback related to patient safety through our GMC and local surveys. Centres with established 7DS have also reported reductions in length of stay, attendance to admission conversion rates and requests for diagnostic investigations.

The Four Priority Clinical Standards

- **Standard 2** - Time to first Consultant review- within 14 hours of admission for all non-elective patients
- **Standard 5** - Access to diagnostic tests - ultrasound, computerised tomography (CT), magnetic resonance imaging (MRI), echocardiography, endoscopy, and microbiology.
    - Within 1 hour for critical patients
    - Within 12 hours for urgent patients
    - Within 24 hours for non-urgent patients
- **Standard 6** - Access to consultant directed interventions - Critical Care, Interventional Radiology, Interventional Endoscopy, Emergency Surgery, Emergency Renal Replacement

Therapy, Urgent Radiotherapy, Stroke Thrombolysis, Percutaneous Coronary Intervention and Stroke Thrombolysis

- **Standard 8** - Ongoing review by consultant twice daily if high dependency patients, daily for others

BAF reporting timeline

28/02/2019 - Trust submitted a Seven Day service Assessment Tool (7DSAT) based on audit data captured in the March 2018 7DS audits.

28/06/19 – Trust will submit further 7DSAT based on 2019 audit data (appendix 1)

Autumn 2019 - Trust will submit further 7DSAT from repeat audit data

Spring 2020 - Trust will submit further 7DSAT with the expectation that we will be compliant with the 4 priority standards.

Audit process for June 2019.

No clear guidance from NHSI/E on what constituted a representative sample. DGFT adopted a devolved approach where all specialities have been asked to audit a sample proportional to the numbers of patient's they admit e.g. acute medicine 30 patients stroke medicine 5. Approach well received by NHSI/E and shared at regional events and webinars and subsequently adopted by other trusts.

170 patients included in this year's audit – analysis of specilaity mix demonstrating a representative sample.

Summary of June 2019 position

March 2018 data is included in brackets for comparison.

Standard 2 (target 90%) – achieved 81% (67%) not met.
Standard 5 **– met**
Standard 6 **– met** (with exception of urgent radiotherapy)
Standard 8 (target 90%) – once daily achieved 77% (77%) and twice daily 39% (71%) - **not met**

Key points:

- Significant progress made against standard 2 – mainly due to greatly enhanced Consultant presence in Acute Medicine, the largest single admitting speciality.
- Performance against standard 2 maintained over weekend
- Divisional discrepancy with medicine outperforming surgery due to most medical specialities adopting a Consultant of the week model
- Continued compliance with standards 5 & 6
- Consistent results for standard 8 for patients requiring daily review

- Deterioration in performance of patients requiring a second daily review. Analysis revealed a high proportion of patients included in this year's audit as requiring twice daily review being located on the Coronary Care Unit and Medical High Dependency Unit (MHDU).
- Difficulty in identifying patients for which Consultant review could be delegated and therefore not required. NHSI have suggested inpatient population could be segmented into medically active (requiring daily consultant face to face review), medically optimised (daily consultant input at board round but review can be delegated) and medically fir for discharge (excluded from daily consultant face to face review)

More detailed analysis can be found in Appendix 1.

We are seeking clarification as to whether CCU patients should be included as requiring twice daily review. CCU is not recognised as being a formal Intensive Care area and as such does not fall under the remit of the Guidelines for the Provision of Intensive Care Services (GPICS) which mandates a twice daily Consultant ward round. 7DS guidelines are "that new emergency admissions in high dependency areas should be seen twice daily by a consultant until they are established on a clear pathway of care". However they also state that "for the purposes of this standard, 'high dependency' refers to the patient rather than the clinical area in which they are situated".

Current issues.

Paediatrics:
Implementation of Consultant of the week model with daily ward rounds and resident Consultant cover until 20:00 to improve compliance with standard 2. Ongoing risk of single consultant covering C2 and neonatal unit at the weekend so dependent on activity levels there is a risk to compliance with standards 2 & 8, including neonatal unit patients who require twice daily review.

Actions: business case in development to expand Consultant workforce to allow separation of paediatric and neonatal duties and include resident Consultant cover overnight.

Speciality Medicine:
All specialities now operate Consultant of the week model with daily review of inpatients on weekdays. Variable presence at weekends and evenings.

Actions: Deputy Medical Director to attend speciality medicine audit and department meeting s to facilitate service design.

Trauma & Orthopaedics:
Business case agreed to expand Consultant workforce to implement consultant of the week model and free on call Consultant from operating theatre duties. Expected compliance with standards 2 & 8 by October 2019.

General Surgery:

Second largest admitting speciality with 26% of patients in 2018 audit return. 58% weekday and 67% weekend compliance with standard 2 and no weekend presence of Consultant for ward rounds of inpatients. Previously no timetabled weekday Consultant ward rounds in job plans, rectified in 2018 job planning round.
Actions: Business case in developed to expand Consultant workforce from 8 to 12 to allow reduction of on call periods (currently 1 Consultant working 48-72 hours per on call), resident Consultant until 20:00 7 days a week and weekend ward rounds of in-patients, thus ensuring compliance with standards 2 & 8. Presented at Directors May 2019 and further clarification sought over metrics that will be used to measure performance outcomes.

Critical Care:
GPICS mandates all patients in level 2 facilities require twice daily Consultant review. Unique set up of 3 independent areas (ITU, SHDU and MHDU) mean inconsistent second daily review especially at weekends. Audit has also demonstrated that not all patients on SHDU/MHDU are true level 2 patients but admitted for enhanced monitoring or care pathways e.g. EmLap
Actions.
All 3 units now under remit of one directorate. Enhanced handover of higher acuity true level 2 SHDU and MHDU to on call ITU Consultant out of hours. Business case in development to centralise into bigger mixed ITU/HDU leaving enhanced specialty care “level 1+” units in place of SHDU/MHDU for lower acuity patients. Will requires significant expansion of both junior and senior workforce in a speciality with significant workforce challenges.

Next Steps

- Publication of 7DS directory
- Together with multidisciplinary team Implementation of board rounds with identification of patients were review can be delegated or isn’t necessary.

Summary and recommendation.

In previous reports to board we highlighted the static position that that had existed over the previous three years in the delivery of 7DS and the critical steps to delivering compliance. The board is asked to note the report, recognise the progress made and the ongoing work to introduce new models of care to meet the target date for compliance of March 2020.

The Dudley Group NHS Foundation Trust: 7 Day Hospital Services Self-Assessment - Spring/Summer 2019/20

Priority 7DS Clinical Standards

Clinical standard	Self-Assessment of Performance	Weekday	Weekend	Overall Score
Clinical Standard 2: All emergency admissions must be seen and have a thorough clinical assessment by a suitable consultant as soon as possible but at the latest within 14 hours from the time of admission to hospital.	Please see additional paper submitted with audit detail	No, the standard is not met for over 90% of patients admitted in an emergency	No, the standard is not met for over 90% of patients admitted in an emergency	Standard Not Met

Clinical standard	Self-Assessment of Performance		Weekday	Weekend	Overall Score
Clinical Standard 5: Hospital inpatients must have scheduled seven-day access to diagnostic services, typically ultrasound, computerised tomography (CT), magnetic resonance imaging (MRI), echocardiography, endoscopy, and microbiology. Consultant-directed diagnostic tests and completed reporting will be available seven days a week: • Within 1 hour for critical patients • Within 12 hour for urgent patients • Within 24 hour for non-urgent patients	Q: Are the following diagnostic tests and reporting always or usually available on site or off site by formal network arrangements for patients admitted as an emergency with critical and urgent clinical needs, in the appropriate timescales?	Microbiology	Yes mix of on site and off site by formal arrangement	Yes mix of on site and off site by formal arrangement	Standard Met
		Computerised Tomography (CT)	Yes mix of on site and off site by formal arrangement	Yes mix of on site and off site by formal arrangement	
		Ultrasound	Yes mix of on site and off site by formal arrangement	Yes mix of on site and off site by formal arrangement	
	Subject to ongoing audit.	Echocardiography	Yes mix of on site and off site by formal arrangement	Yes mix of on site and off site by formal arrangement	
		Magnetic Resonance Imaging (MRI)	Yes mix of on site and off site by formal arrangement	Yes mix of on site and off site by formal arrangement	
		Upper GI endoscopy	Yes mix of on site and off site by formal arrangement	Yes mix of on site and off site by formal arrangement	

Clinical standard	Self-Assessment of Performance		Weekday	Weekend	Overall Score
Clinical Standard 6: Hospital inpatients must have timely 24 hour access, seven days a week, to key consultant-directed interventions that meet the relevant specialty guidelines, either on-site or through formally agreed networked arrangements with clear written protocols.	Q: Do inpatients have 24-hour access to the following consultant directed interventions 7 days a week, either on site or via formal network arrangements?	Critical Care	Yes mix of on site and off site by formal arrangement	Yes mix of on site and off site by formal arrangement	Standard Met
		Interventional Radiology	Yes mix of on site and off site by formal arrangement	Yes mix of on site and off site by formal arrangement	
		Interventional Endoscopy	Yes mix of on site and off site by formal arrangement	Yes mix of on site and off site by formal arrangement	
		Emergency Surgery	Yes mix of on site and off site by formal arrangement	Yes mix of on site and off site by formal arrangement	
	Should we be non compliant for urgent radiotherapy service. Should we be N/A and perhaps someone could provide a definition.	Emergency Renal Replacement Therapy	Yes mix of on site and off site by formal arrangement	Yes mix of on site and off site by formal arrangement	
		Urgent Radiotherapy	Yes mix of on site and off site by formal arrangement	No the intervention is not available	
		Stroke thrombolysis	Yes mix of on site and off site by formal arrangement	Yes mix of on site and off site by formal arrangement	
		Percutaneous Coronary Intervention	Yes mix of on site and off site by formal arrangement	Yes mix of on site and off site by formal arrangement	
		Cardiac Pacing	Yes mix of on site and off site by formal arrangement	Yes mix of on site and off site by formal arrangement	

Clinical standard	Self-Assessment of Performance	Weekday	Weekend	Overall Score
Clinical Standard 8: All patients with high dependency needs should be seen and reviewed by a consultant TWICE DAILY (including all acutely ill patients directly transferred and others who deteriorate). Once a clear pathway of care has been established, patients should be reviewed by a consultant at least ONCE EVERY 24 HOURS, seven days a week, unless it has been determined that this would not affect the patient's care pathway.	Please see additional paper submitted with audit detail	Once Daily: No the standard is not met for over 90% of patients admitted in an emergency	Once Daily: No the standard is not met for over 90% of patients admitted in an emergency	Standard Not Met
		Twice Daily: No the standard is not met for over 90% of patients admitted in an emergency	Twice Daily: No the standard is not met for over 90% of patients admitted in an emergency	

7DS Clinical Standards for Continuous Improvement

Self-Assessment of Performance against Clinical Standards 1, 3, 4, 7, 9 and 10
A self assessment tool to be developed for each standard by March 2020.

7DS and Urgent Network Clinical Services

	Hyperacute Stroke	Paediatric Intensive Care	STEMI Heart Attack	Major Trauma Centres	Emergency Vascular Services
Clinical Standard 2	Yes, the standard is met for over 90% of patients admitted in an emergency	N/A - service not provided by this trust	Yes, the standard is met for over 90% of patients admitted in an emergency	N/A - service not provided by this trust	Yes, the standard is met for over 90% of patients admitted in an emergency
Clinical Standard 5	Yes, the standard is met for over 90% of patients admitted in an emergency	N/A - service not provided by this trust	Yes, the standard is met for over 90% of patients admitted in an emergency	N/A - service not provided by this trust	Yes, the standard is met for over 90% of patients admitted in an emergency
Clinical Standard 6	Yes, the standard is met for over 90% of patients admitted in an emergency	N/A - service not provided by this trust	Yes, the standard is met for over 90% of patients admitted in an emergency	N/A - service not provided by this trust	Yes, the standard is met for over 90% of patients admitted in an emergency
Clinical Standard 8	Yes, the standard is met for over 90% of patients admitted in an emergency	N/A - service not provided by this trust	Yes, the standard is met for over 90% of patients admitted in an emergency	N/A - service not provided by this trust	Yes, the standard is met for over 90% of patients admitted in an emergency

Assessment of Urgent Network Clinical Services 7DS performance (OPTIONAL)
Details within the Directory of Services.

Template completion notes

Trusts should complete this template by filling in all the yellow boxes with either a free text assessment of their performance as advised or by choosing one of the options from the drop down menus.

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Board Assurance Framework additional information.

Audit results for June 2019:

Summary of June 2019 BAF results:

Standard 2 (target 90%) – achieved 81 % not met.
Standard 5 – **met**
Standard 6 – **met** (with exception of urgent radiotherapy)
Standard 8 (target 90%) – achieved 77% (once daily) and 46% (twice daily) – not met

Audit method

There was no clear guidance form NHSI/E on what constitutes a representative sample. DGFT have adopted a devoluted approach where all specialities have been asked to audit a sample proportional to the numbers of patient's they admit e.g. acute medicine 30 patients respiratory medicine 10.

The audit was undertaken and 170 patient's records were reviewed. 25 patients were excluded from the results due to incomplete documentation for timings of reviews, therefore the total reported on for the audit was 155. It is of note that all patients excluded from the audit had been reviewed by a Consultant on admission

There was a good spread of specialties within the audit as demonstrated below in the table. There were 100 reviewed within the Medical division and 55 from the surgical division which is representative of the differing activity levels.

Acute Medicine	31
Cardiology	20
Diabetes	11
Elderly Care	17
GI Medicine	10
General Surgery	23
Gynaecology	10
Paediatrics	20
Respiratory Medicine	10
Trauma and Orthopaedics	10
Renal Medicine	8
	170

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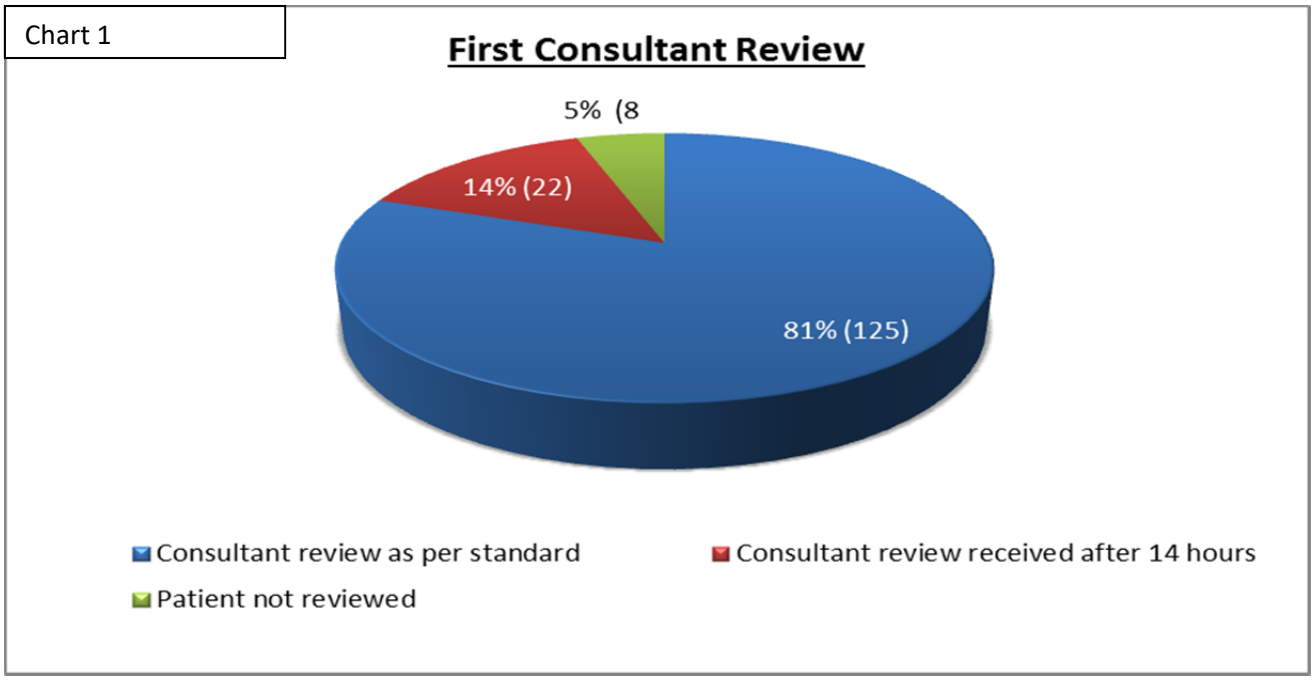
Standard 2: Time to first Consultant review

The figures in the table below show that the compliance rate for standard 2 has increased since the last audit in March 2018.

	September 2016	March 2017	April 2018	June 2019
Proportion of patients reviewed by a Consultant within 14 hours of admission at hospital	**66%**	**64%**	**65%**	**81%**

Chart 1 demonstrates the figures overall for the first consultant review. With 125/155 **(81%)** the standard was not met, however significant progress has been made. The tables below provides the breakdown of the review by the day of the week and whether weekday or weekend. This demonstrates consistent performance throughout the week with review being completed in 80% of the cases on a weekday and 83% of cases on a weekend.

Chart 1



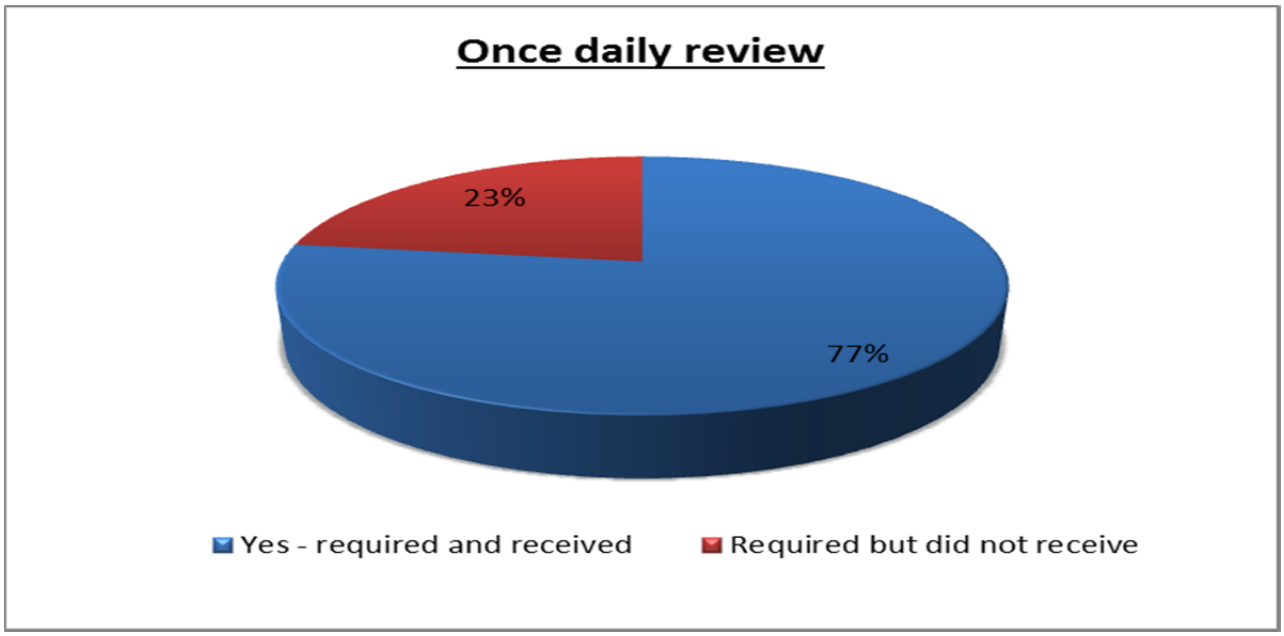
As demonstrated in the above table 95% of patients were reviewed by a Consultant on admission

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Consultant review as per standard	79%	65%	88%	78%	91%	80%	87%
Consultant review received after 14 hours	17%	15%	12%	17%	9%	15%	13%
Patient not reviewed	4%	19%		4%		5%	

Standard 8: Ongoing review by consultant twice daily if high dependency patients, daily for others

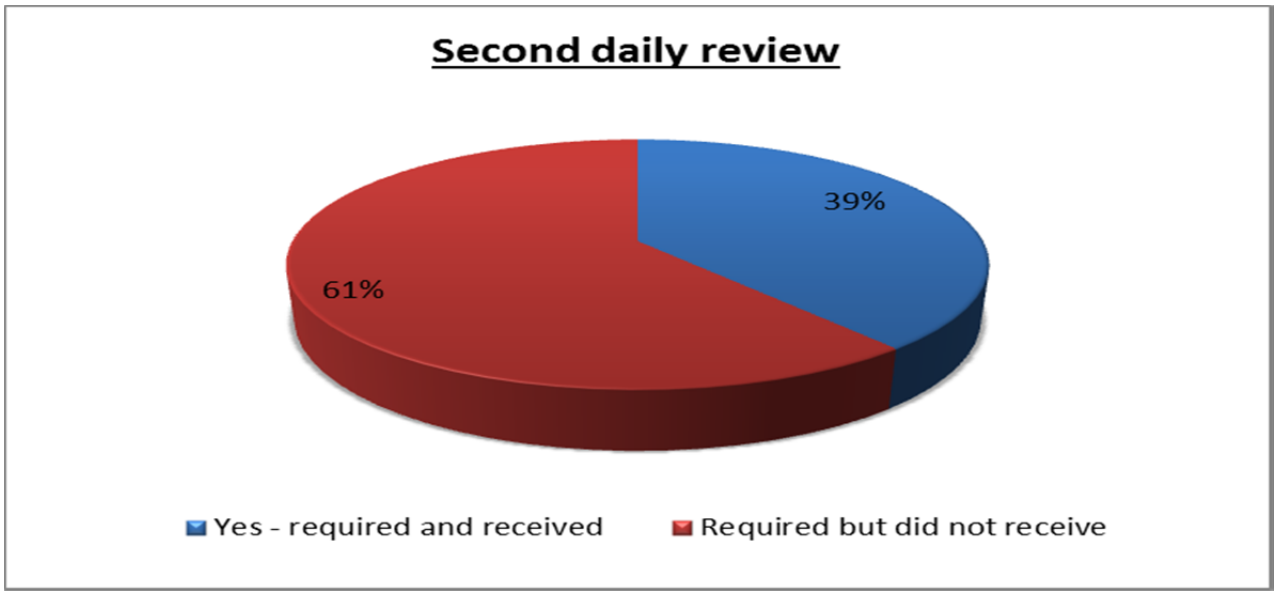
Once daily review

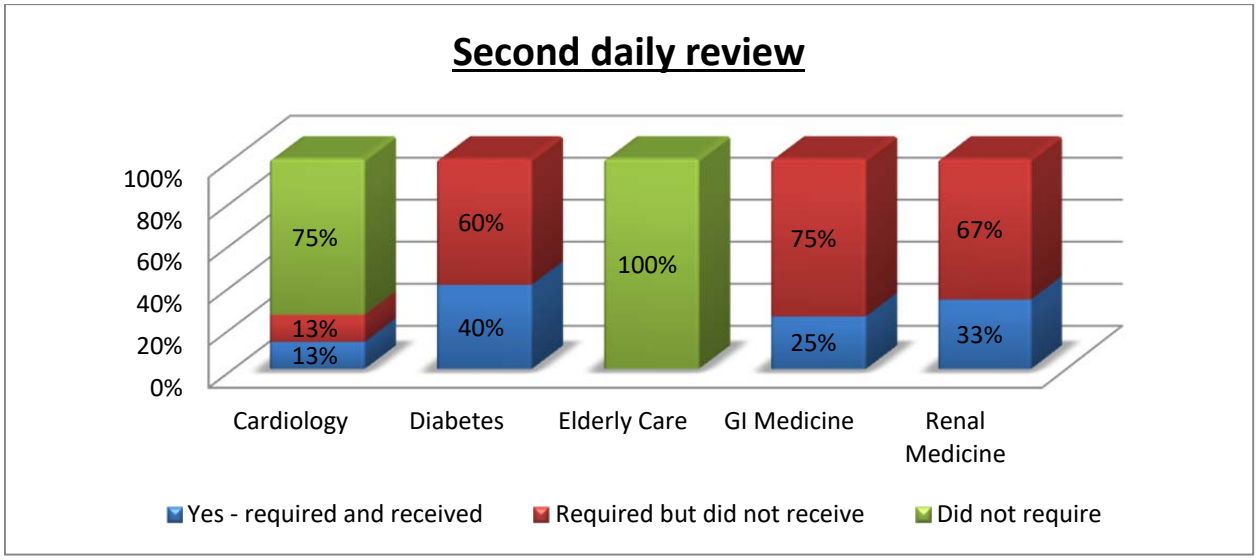
The results from the audit demonstrate that on a weekday **72%** of the patients are having a daily review with weekend admissions reviewing **81%** of the patients giving an overall complaince of 77% for patients requiring a once daily Consultant review. This is consistent with performance data from previously submitted audits.



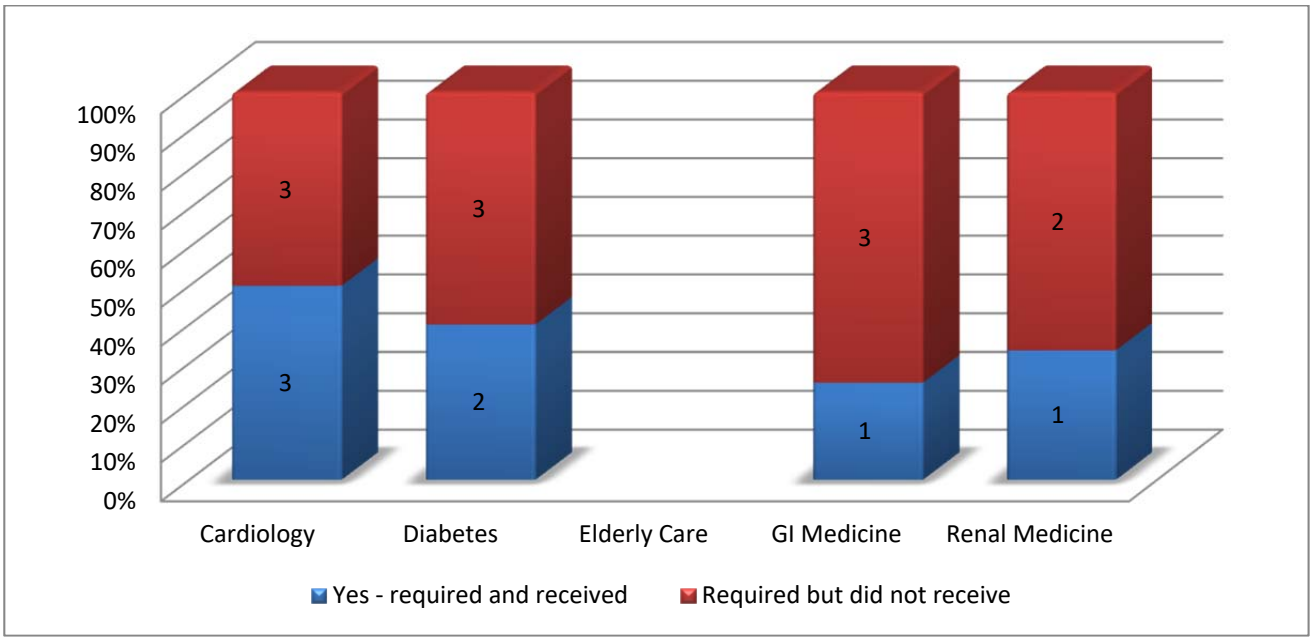
Twice daily review

The audit demonstrated that for patients requiring a second daily review this happened in 39% of cases a deterioration in performance from last previous data. All of these patients received a daily review





	Cardiology	Diabetes	Elderly Care	GI Medicine	Renal Medicine
Yes - required and received	3	2		1	1
Required but did not receive	3	3		3	2
Did not require	18		1		
	24	**5**	**1**	**4**	**3**



Key points:

- Significant progress made against standard 2 – mainly due to greatly enhanced Consultant presence in Acute Medicine, the largest single admitting speciality.
- Performance against standard 2 maintained over weekend
- Divisional discrepancy with medicine outperforming surgery due to most medical specialities adopting a Consultant of the week model
- Continued compliance with standards 5 & 6
- Consistent results for standard 8 for patients requiring daily review
- Deterioration in performance of patients requiring a second daily review. Analysis revealed all of the patients included in this year's audit as requiring twice daily review being located on the Coronary Care Unit (CCU) and Medical High Dependency Unit (MHDU). None were identified as being from SHDU or ITU.
- Risk previously identified as due to unique set up of 3 independent areas (ITU, SHDU and MHDU) mean inconsistent second daily review especially at weekends. Internal audit has also demonstrated that not all patients on SHDU/MHDU are true level 2 patients but admitted for enhanced monitoring or care pathways e.g. post-operative recovery after elective surgery. Actions put in place to ensure patient safety such as enhanced handover of higher acuity true level 2 SHDU and MHDU to on call ITU Consultant out of hours
- Difficulty in identifying patients for which Consultant review could be delegated and therefore not required. NHSI have suggested inpatient population could be segmented into medically active (requiring daily consultant face to face review), medically optimised (daily consultant input at board round but review can be delegated) and medically fir for discharge (excluded from daily consultant face to face review)

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Progress since March 2018

Acute Medicine:

There is now a greatly enhanced Consultant presence in the evening. It now includes a Consultant resident in the Emergency Department in addition to the two twilight ward rounds on the Acute Medical unit(AMU), 7 days per week. Acute Medicine is the largest single admitting speciality, accounting for 37% of total patients in 2018 audit. Previously 82% weekday and 56% weekend compliance with standard 2 in March 2018 but previous internal audits after change demonstrated full compliance with standard 2.

Paediatrics:

Implementation of Consultant of the week model with daily ward rounds and resident Consultant cover until 20:00 to improve compliance with standard 2 (previously 55% weekday and 20% weekend accounting for 8% of admissions.) Ongoing risk of single consultant covering C2 and neonatal unit at the weekend so dependent on activity levels there is a risk to compliance with standards 2 & 8, including neonatal unit patients who require twice daily review.

Actions: business case in development to expand Consultant workforce to allow separation of paediatric and neonatal duties and include resident Consultant cover overnight.

Speciality Medicine:

All specialities now operate Consultant of the week model with daily review of inpatients on weekdays. Variable presence at weekends and evenings.

Actions: Deputy Medical Director to attend speciality medicine audit and department meeting s to facilitate service design as part of ongoing job plan review process.

Trauma & Orthopaedics:

Business case agreed to expand Consultant workforce to implement consultant of the week model and free on call Consultant from operating theatre duties. Expected compliance with standards 2 & 8 by October 2019, dependent on successful appointments.

Cardiology:

Opening of cardiac assessment unit and implementation of Consultant of week model with Consultant resident until 20:00 weekdays and 16:00 weekends.

General Surgery:

Second largest admitting speciality with 26% of patients in 2018 audit return. 58% weekday and 67% weekend compliance with standard 2 and no weekend presence of Consultant for ward rounds of inpatients. Previously no timetabled weekday Consultant ward rounds in job plans. Included in 2018 job planning round

Actions: business case developed to expand Consultant workforce from 8 to 12 allow reduction of on call periods (currently 1 Consultant working 48-72 hours per on call), resident Consultant until 20:00 7 days a week and weekend ward rounds of in-patients, thus ensuring compliance with standards 2 & 8. Presented at directors May 2019 and further clarification sought over metrics that will be used to measure performance outcomes.

Critical Care:

All patients in level 2 facilities require twice daily Consultant review. Inconsistent Consultant presence across 3 units ITU, SHDU and MHDU, especially at weekends.

Actions.

All 3 units now under remit of one directorate. Enhanced handover of higher acuity true level 2 SHDU and MHDU to on call ITU Consultant out of hours. Business case in development to centralise into bigger mixed ITU/HDU leaving enhanced specialty care "level 1+" units in place of SHDU/MHDU for lower acuity patients. Will require significant expansion of both junior and senior workforce in a speciality with significant workforce challenges – previous Consultant recruitment process unsuccessful.

MRI:

Previously reported compliant with standard 5. Currently MRI available 7 days a week up to 20:00, with a network arrangement with UHB to undertake urgent or emergency scans outside these times. However NHSI Spinal Services GIRFT report highlighted that this is not meeting national standards for investigation of spinal cord compression.

Actions: to be added to divisional risk register. Chief of division exploring regional solution with neighbouring trusts.

Risk Assessment:

The risk to service delivery and patient outcomes of non-compliance with the 7DS standards has been added to the corporate risk register.

Next steps:

- Publication of 7DS directory
- Together with multidisciplinary team Implementation of board rounds with identification of patients were review can be delegated or isn't necessary.
- Internal audit of ITU/MHDU/SHDU for reassurance of second daily review.

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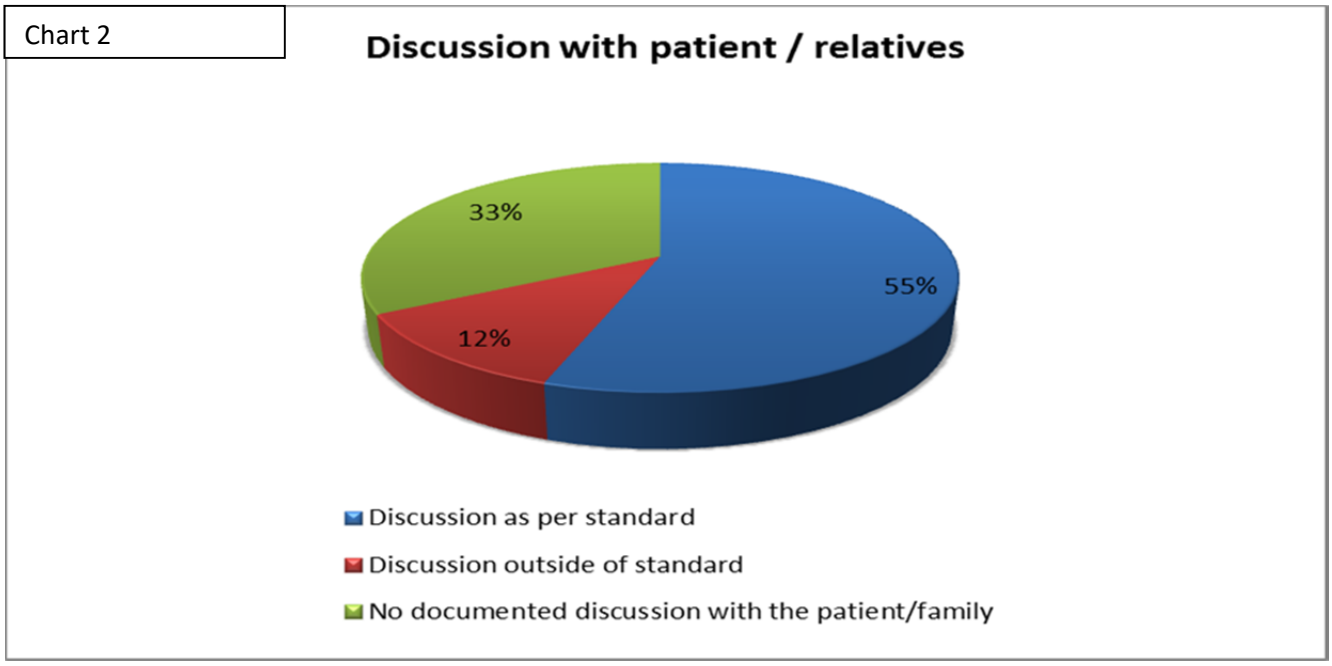
Remaining standards update

Standard 1 : Patient Experience

Of the 155 patients the discussion with patient/relatives was documented in 61%.

Chart 2



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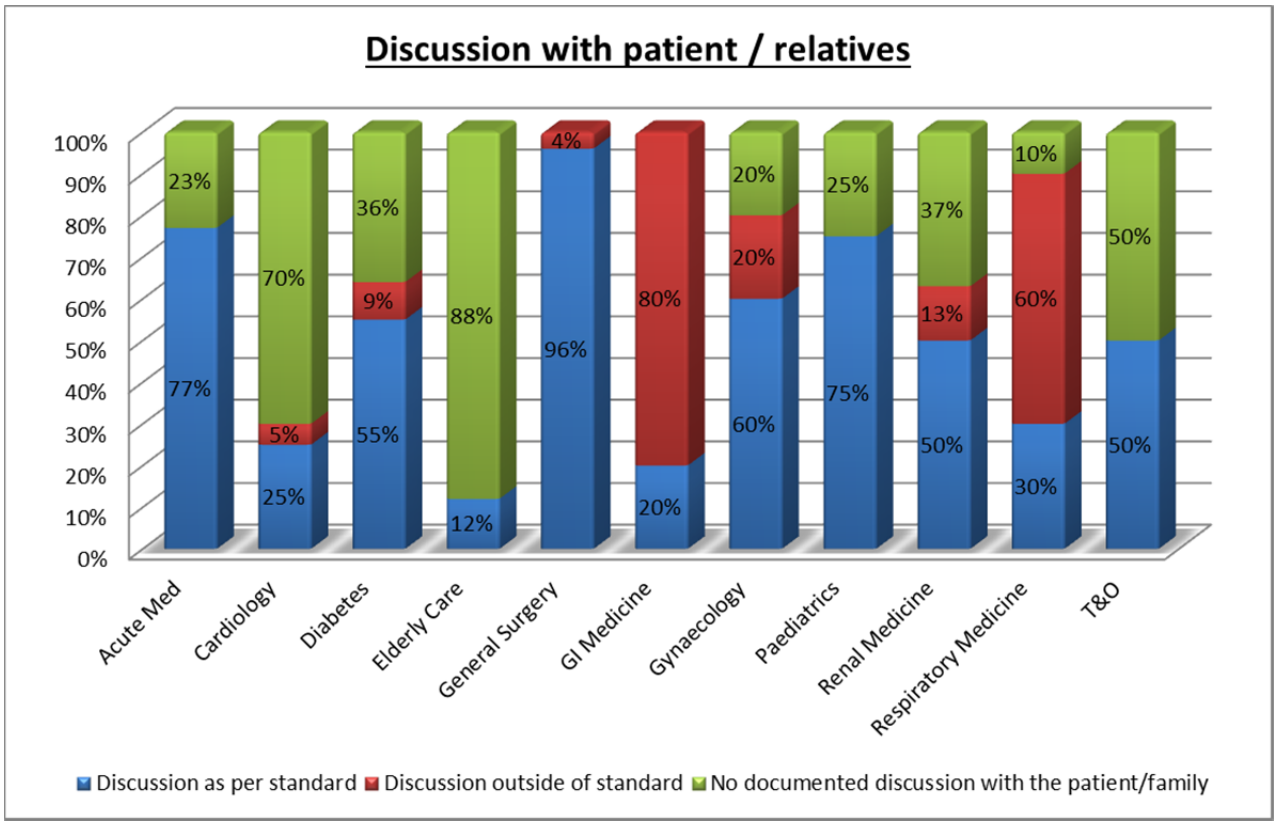

Enclosure 20

The Dudley Group
NHS Foundation Trust

Paper for submission to the Board on 06 July 2019

TITLE:	**CQC publication of 2018 Adult Inpatient Survey results**		
AUTHOR:	Jill Faulkner, Head of Patient Experience Tracy Cross, Patient Experience and Engagement Lead	**PRESENTER**	Mary Sexton, Chief Nurse

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

To receive the CQC results of the 2018 Adult Inpatient Survey and note the performance when benchmarked to trusts nationally.

To support the work of the Patient Experience Improvement Group in reviewing and monitoring the results and action plans from this and other national survey activity.

CORPORATE OBJECTIVE:

SO1: Deliver a great patient experience

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SUMMARY OF KEY ISSUES:

Summary

The results of the 2018 Adult Inpatient survey were published on the CQC website on 20 June 2019 and overall show a declining picture when compared to our previous year's performance.

The Trust are ranked **131** out of **144** Trusts that participated in the survey (compared to 134 out of 148 trusts in 2017) based on the Overall Patient Experience Score (OPES). The OPES ranged from the lowest trust score in England of 7.3 to the highest trust score in England of 9.1.

The Trust response rate is 41% (488 usable responses from a usable sample of 1190 patients discharged from hospital in July 2018), compared to a national response rate of 45%.

The report benchmarks our performance against trusts nationally and shows:

- Seven out of the eleven sections were performing 'about the same' as other trusts nationally
- The Trust scored 'worse' in four of the eleven sections: Emergency/A&E Department, Nurses, Operations and Procedures, and Leaving Hospital
- In the outlier report we are listed in the appendix as one of eight trusts identified as being 'worse than expected' for medical care.

The table in appendix 1 illustrates our ratings since 2014 where we have maintained 'about the same' in a number of sections for 2018, with notable exceptions of Emergency/A&E Department, Nurses, Operations and Procedures, and Leaving Hospital where the Trust is performing 'worse' in comparison to most other trusts. In 2017 the Trust performed worse in one section only; the overall views of care and services. The mean average scores for all sections have declined compared to the 2017 survey, with the exception of Waiting Lists and Planned Admissions, and the Hospital and Ward, in which the 2018 scores have remained the same as the previous year.

The 2018 results have been used to deliver a host of improvement actions for assurance that the Trust is committed to listening to patients' views and is taking action to make improvements to support the Trust's number one strategic objective to deliver a great patient experience.

The full report at appendix 2 contains individual graphs showing how our Trust compares to all trusts taking part in the survey.

Next steps

The results have been used to develop an action plan with contributions from all divisions across the Trust. This includes agreeing the assignment of actions and target dates for completion following recommendations from the 2018 survey and triangulating findings with patient experience feedback from all other sources.

The action plan will be monitored by the Patient Experience Improvement Group which is chaired by the Chief Nurse and meets monthly.

IMPLICATIONS OF PAPER:			
RISK	**N**		**Risk Description:**
	Risk Register: N		**Risk Score:**
COMPLIANCE and/or LEGAL REQUIREMENTS	**CQC**	**Y**	**Details:** Effective, caring, responsive, well led, safe
	NHSI	**N**	**Details:**
	Other	**N**	**Details:**

Care Quality Commission

Survey Coordination Centre

Patient survey report 2018

Adult Inpatient Survey 2018

The Dudley Group NHS Foundation Trust

NHS Patient Survey Programme
Adult Inpatient Survey 2018

The Care Quality Commission

The Care Quality Commission is the independent regulator of health and adult social care in England. We make sure health and social care services provide people with safe, effective, compassionate, high-quality care and we encourage care services to improve. Our role is to register care providers, and to monitor, inspect and rate services. If a service needs to improve, we take action to make sure this happens. We speak with an independent voice, publishing regional and national views of the major quality issues in health and social care.

Adult Inpatient Survey 2018

To improve the quality of services that the NHS delivers, it is important to understand what people think about their care and treatment. One way of doing this is by asking people who have recently used health services to tell us about their experiences.

The 2018 survey of adult inpatient (sixteenth iteration of the survey) involved 144 acute and specialist NHS trusts. 76,668 people responded to the survey, yielding an adjusted response rate of 45%.

Patients were eligible for the survey if they were aged 16 years or older, had spent at least one night in hospital and were not admitted to maternity or psychiatric units. Trusts sampled patients discharged during July 2018[1]. Trusts counted back from the last day of July 2018, including every consecutive discharge, until they had selected 1,250 patients (or, for a small number of specialist trusts who could not reach the required sample size, until they had reached 1st January 2018). Fieldwork took place between August 2018 and January 2019.

Surveys of adult inpatients were also carried out in 2002 and annually from 2004 to 2018. Although questionnaire redevelopments took place over the years, the survey results for this year are largely comparable to those from previous iterations.

The Adult Inpatient Survey is part of a wider programme of NHS patient surveys which covers a range of topics, including children and young people's services, community mental health services, urgent and emergency care services and maternity services. To find out more about the programme and to see the results from previous surveys, please see the links in the 'Further information' section.

CQC will use the results from the survey in the regulation, monitoring and inspection of NHS acute trusts in England. We will use data from the survey in our system of CQC Insight, which provides inspectors with an assessment of performance in areas of care within an NHS trust that need to be followed up. Survey data will also be used to support CQC inspections. NHS England will use the results to check progress and improvement against the objectives set out in the NHS mandate, and the Department of Health and Social Care will hold providers to account for the outcomes they achieve. NHS Improvement will use the results to inform their oversight model for the NHS.

This research was carried out in accordance with the international standard for organisations conducting social research (accreditation to ISO20252:2012; certificate number GB08/74322).

Interpreting the report

This report shows how your trust scored for each evaluative question in the survey, compared with other trusts that took part. It uses an analysis technique called the '**expected range**' to determine if your trust is performing 'about the same', 'better' or 'worse' compared with most other trusts. For more information on the expected range, please see the 'methodology' section below. This approach is designed to help understand the performance of individual trusts, and to identify areas for improvement.

[1] 39 trusts sampled additional months because of small patient throughputs.

This report shows the same data as published on the CQC website (http://www.cqc.org.uk/surveys/inpatient). The CQC website displays the data in a more simplified way, identifying whether a trust performed 'better', 'worse' or 'about the same' as the majority of other trusts for each question and section.

Standardisation

People's characteristics, such as age and gender, can influence their experience of care and the way they report it. For example, research shows that men tend to report more positive experiences than women, and older people more so than younger people. Since trusts have differing profiles of people who use their services, this could potentially affect their results and make trust comparisons difficult. A trust's results could appear better or worse than if they had a slightly different profile of people.

To account for this, we 'standardise' the data, which means we apply a weight to individual responses to account for differences in demographic profile between trusts. For each trust, results have been standardised by age, gender and method of admission (emergency or elective) of respondents to reflect the 'national' age-gender-admission type distribution (based on all respondents to the survey). This helps to ensure that no trust will appear better or worse than another because of its respondent profile. It therefore enables a more accurate comparison of results from trusts with different population profiles. In most cases this standardisation will not have a large impact on trust results; it does, however, make comparisons between trusts as fair as possible.

Scoring

For each question in the survey, the individual (standardised) responses are converted into scores on a scale from 0 to 10. A score of 10 represents the best possible response and a score of zero the worst. The higher the score for each question, the better the trust is performing.

It is not appropriate to score all questions in the questionnaire as not all of the questions assess the trust. For example, they may be descriptive questions such as Q1 asking respondents if their inpatient stay was planned in advance or an emergency; or they may be 'routing questions' designed to filter out respondents to whom the following questions do not apply. An example of a routing question would be Q44 "During your stay in hospital, did you have an operation or procedure?" For full details of the scoring please see the technical document (see 'Further information' section).

Section scoring is computed as the arithmetic mean of questions' score after weighting is applied.

Graphs

The graphs in this report show how the score for the trust compares to the range of scores achieved by all trusts taking part in the survey. The black diamond shows the score for your trust. The graph is divided into three sections:

- If your trust's score lies in the grey section of the graph, its result is 'about the same' as most other trusts in the survey;
- If your trust's score lies in the orange section of the graph, its result is 'worse' compared with most other trusts in the survey;
- If your trust's score lies in the green section of the graph, its result is 'better' compared with most other trusts in the survey.

The text to the right of the graph states whether the score for your trust is 'better' or 'worse' compared with most other trusts. If there is no text, the score is 'about the same.' These groupings are based on a rigorous statistical analysis of the data, as described in the following 'Methodology' section.

Methodology

The 'about the same,' 'better' and 'worse' categories are based on an analysis technique called the '**expected range**' which determines the range within which the trust's score could fall without differing significantly from the average, taking into account the number of respondents for each trust and the scores for all other trusts. If the trust's performance is outside of this range, it means that it

performs significantly above or below what would be expected. If it is within this range, we say that its performance is ‘about the same’. Where a trust is identified as performing ‘better’ or ‘worse’ than the majority of other trusts, it is very unlikely to have occurred by chance.

In some cases, there will be no orange and/or no green area in the graph. This happens when the expected range for your trust is so broad it encompasses either the highest possible score for all trusts (no green section) or the lowest possible score for all trusts (no orange section). This could be because there were few respondents and/or a lot of variation in their answers.

Please note that if fewer than 30 respondents have answered a question, no score will be displayed for this question (and the corresponding section[2]). This is because the uncertainty around the result is too great.

A technical document providing more detail about the methodology and the scoring applied to each question is available on the CQC website (see ‘Further information’ section).

Tables

At the end of the report you will find tables containing the data used to create the graphs, the response rate for your trust and background information about the people that responded.

Scores from last year's survey are also displayed where available. The column called 'Change from 2017' uses arrows to indicate whether the score for this year shows a statistically significant increase (up arrow), a statistically significant decrease (down arrow) or has shown no statistically significant change (no arrow) compared with 2017. A statistically significant difference means that the change in the result is very unlikely to have occurred by chance. Significance is tested using a two-sample t-test with a significance level of 0.05.

Please note that comparative data is not shown for sections as the questions contained in each section can change year on year.

Where a result for 2017 is not shown, this is because the question was either new this year, or the question wording and/or the response categories have been changed. It is therefore not possible to compare the results as we do not know if any change is caused by alterations in the survey instrument, or variation in a trust's performance.

Comparisons are also not able to be shown if a trust has merged with other trusts since the 2017 survey, or if a trust committed a sampling error in 2017.

Notes on specific questions

Please note that a variety of acute trusts take part in this survey and not all questions are applicable to every trust. The section below details modifications to certain questions, in some cases this will apply to all trusts, in other cases only to some trusts.

All trusts

Q50 and Q51: The information collected by Q50 “On the day you left hospital, was your discharge delayed for any reason?” and Q51 “What was the main reason for the delay?” are presented together to show whether a patient's discharge was delayed by reasons attributable to the hospital.

The combined question in this report is labelled as Q51 and is worded as: “Discharge delayed due to wait for medicines/to see doctor/for ambulance.”

Q52: Information from Q50 and Q51 has been used to score Q52 “How long was the delay?” This assesses the length of a delay to discharge for reasons attributable to the hospital.

Q53 and Q56: Respondents who answered Q53 “Where did you go after leaving hospital?” as “I was transferred to another hospital” were not scored for Q56 (“Before you left hospital, were you given any written or printed information about what you should or should not do after leaving

[2]The section score is not displayed as it would include fewer questions compared with other trusts hence it is not a fair comparison.

hospital?"). This decision was taken as there is not a requirement for hospital transfers.

Trusts with female patients only

Q11: If your trust offers services to women only, the score for Q11 "While in hospital, did you ever share a sleeping area, for example a room or bay, with patients of the opposite sex?" is not shown.

Trusts with no A&E Department

Q3 and Q4: The results to these questions are not shown for trusts that do not have an A&E department.

Notes on question comparability

The following questions were new questions for 2018, and it is therefore not possible to compare with previous years:

Q66. *Was the care and support you expected available when you needed it?* (section 9 "Leaving hospital")

Q69. *During this hospital stay, did anyone discuss with you whether you would like to take part in a research study?* (section 10 "Overall views of care and services")

The following question was removed from the 2018 questionnaire (2017 numbering):

Q59. *Were you told how to take your medication in a way you could understand?*

For more information on questionnaire redevelopment and the rationale behind adding or removing individual questions please refer to the Survey Development Report, available here:
http://nhssurveys.org/survey/2117

Further information

The full national results are on the CQC website, together with an A to Z list to view the results for each trust (alongside the technical document outlining the methodology and the scoring applied to each question):
http://www.cqc.org.uk/inpatientsurvey

The results for England, and trust level results, can be found on the CQC website. You can also find a 'technical document' here which describes the methodology for analysing the trust level results:
http://www.cqc.org.uk/inpatientsurvey

The results for the adult inpatient surveys from 2002 to 2017 can be found at:
http://www.nhssurveys.org/surveys/425

Full details of the methodology for the survey, including questionnaires, letters sent to patients, instructions for trusts and contractors to carry out the survey, and the survey development report, are available at:
http://www.nhssurveys.org/surveys/1203

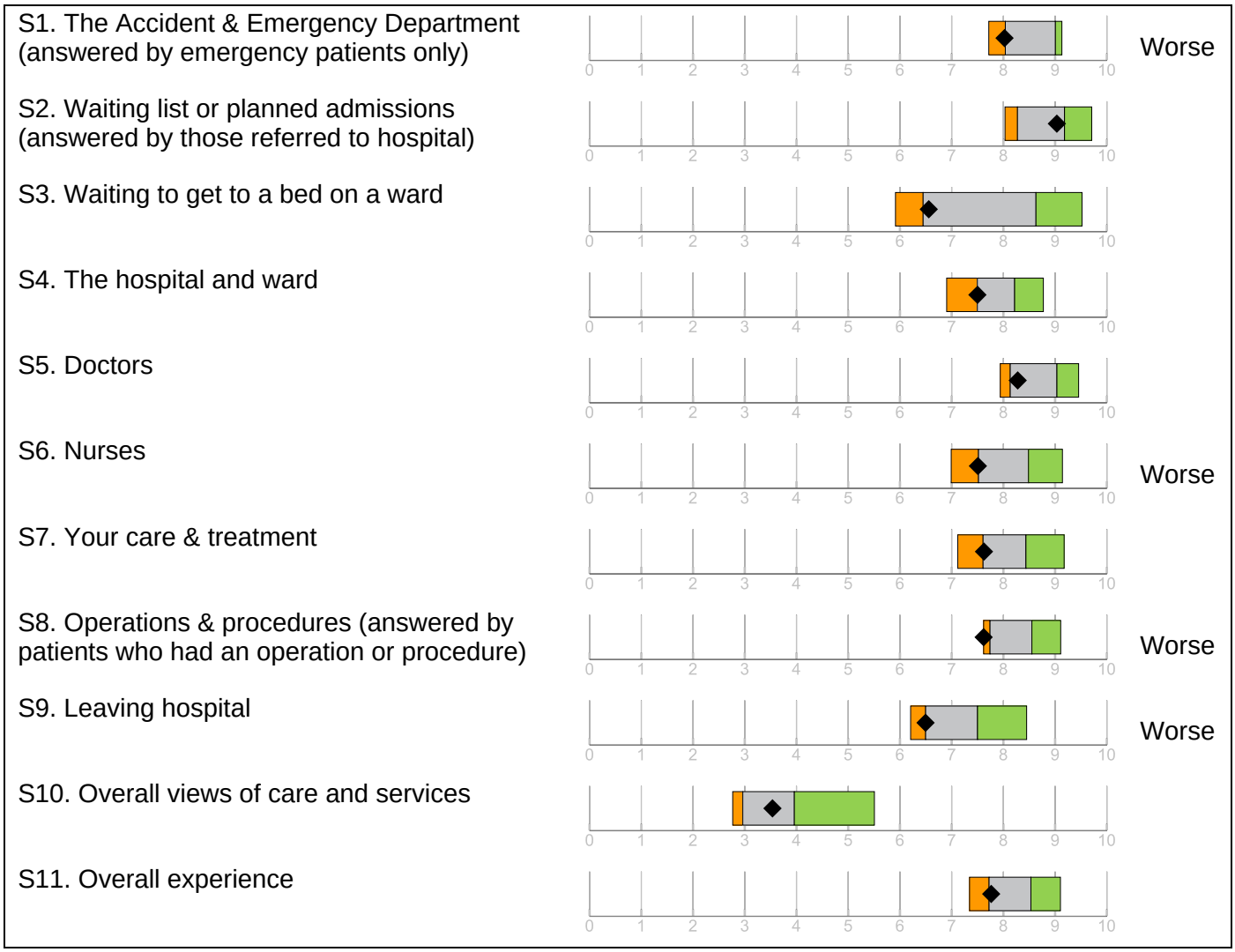
More information on the NHS Patient Survey Programme, including results from other surveys and a schedule of current and forthcoming surveys can be found at:
http://www.cqc.org.uk/content/surveys

More information about how CQC monitors hospitals is available on the CQC website at:
http://www.cqc.org.uk/what-we-do/how-we-use-information/monitoring-nhs-acute-hospitals

Adult Inpatient Survey 2018

The Dudley Group NHS Foundation Trust

Section scores



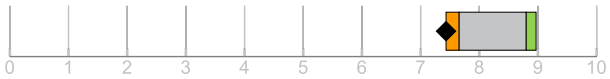
Best performing trusts	'Better/Worse'	Only displayed when this trust is better/worse than most other trusts
About the same	◆	This trust's score (NB: Not shown where there are fewer than 30 respondents)
Worst performing trusts		

Adult Inpatient Survey 2018

The Dudley Group NHS Foundation Trust

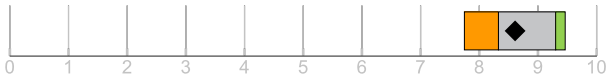
The Accident & Emergency Department (answered by emergency patients only)

Q3. While you were in the A&E Department, how much information about your condition or treatment was given to you?



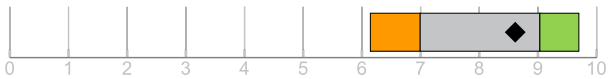
Worse

Q4. Were you given enough privacy when being examined or treated in the A&E Department?



Waiting list or planned admissions (answered by those referred to hospital)

Q6. How do you feel about the length of time you were on the waiting list?



Q7. Was your admission date changed by the hospital?

Better

Q8. Had the hospital specialist been given all necessary information about your condition/illness from the person who referred you?

Waiting to get to a bed on a ward

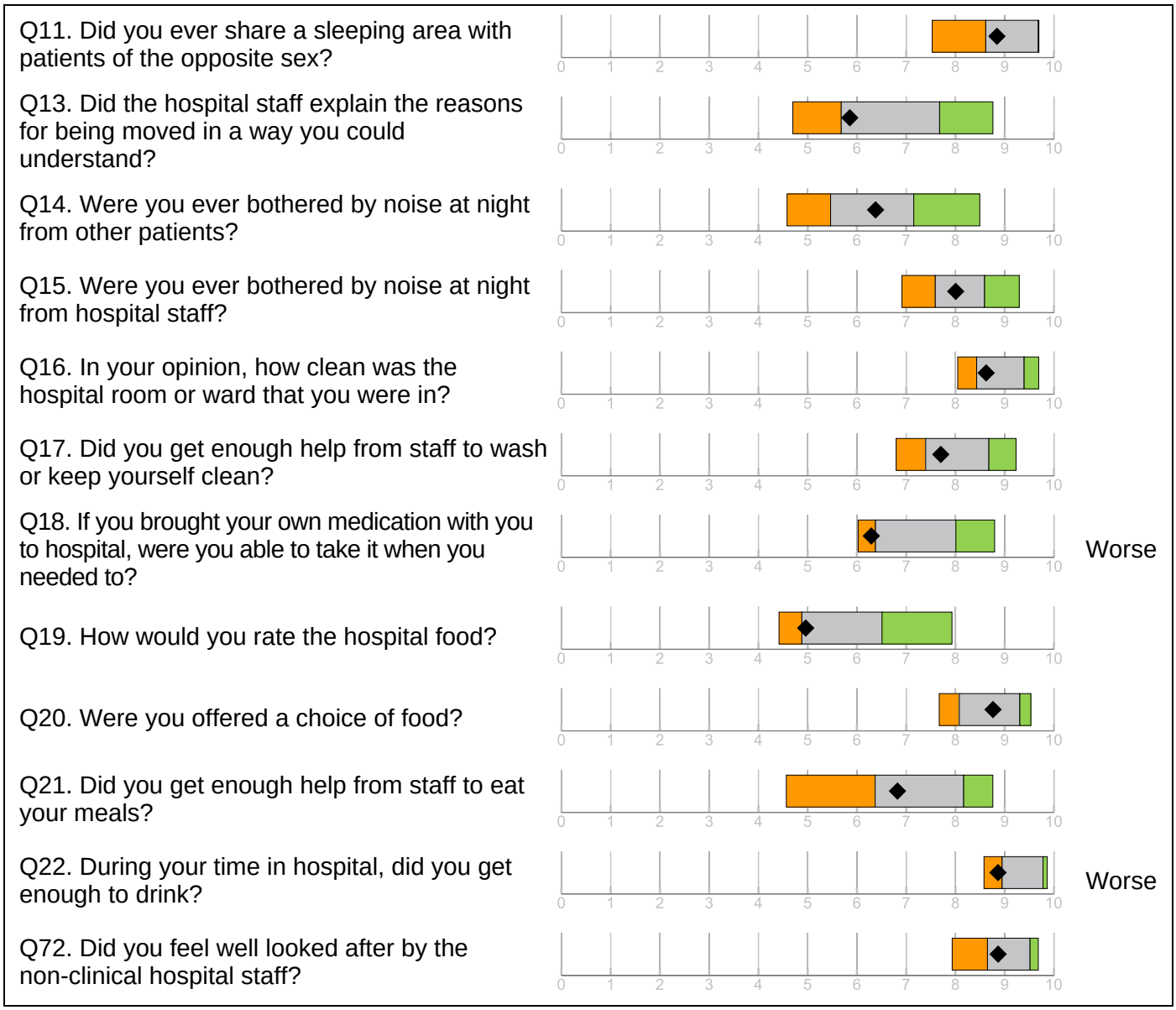
Q9. From the time you arrived at the hospital, did you feel that you had to wait a long time to get to a bed on a ward?

Best performing trusts	'Better/Worse'	Only displayed when this trust is better/worse than most other trusts
About the same	◆	This trust's score (NB: Not shown where there are fewer than 30 respondents)
Worst performing trusts		

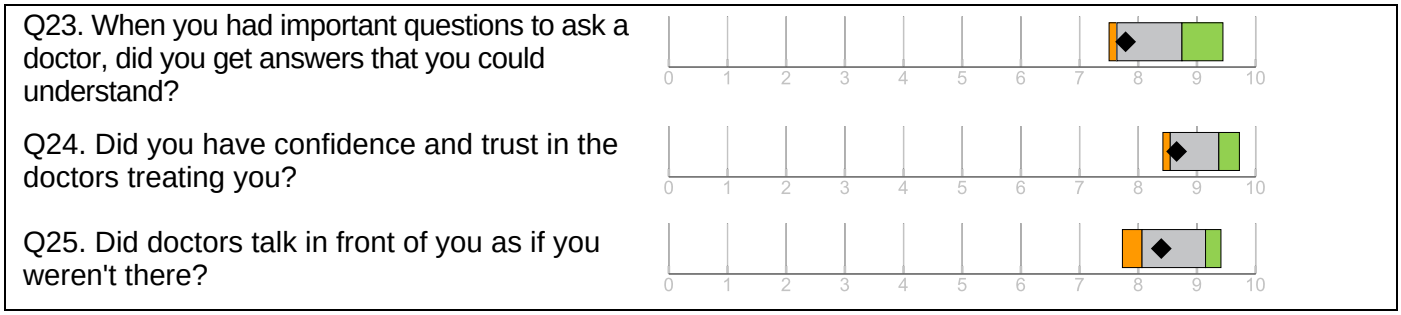
Adult Inpatient Survey 2018

The Dudley Group NHS Foundation Trust

The hospital and ward



Doctors

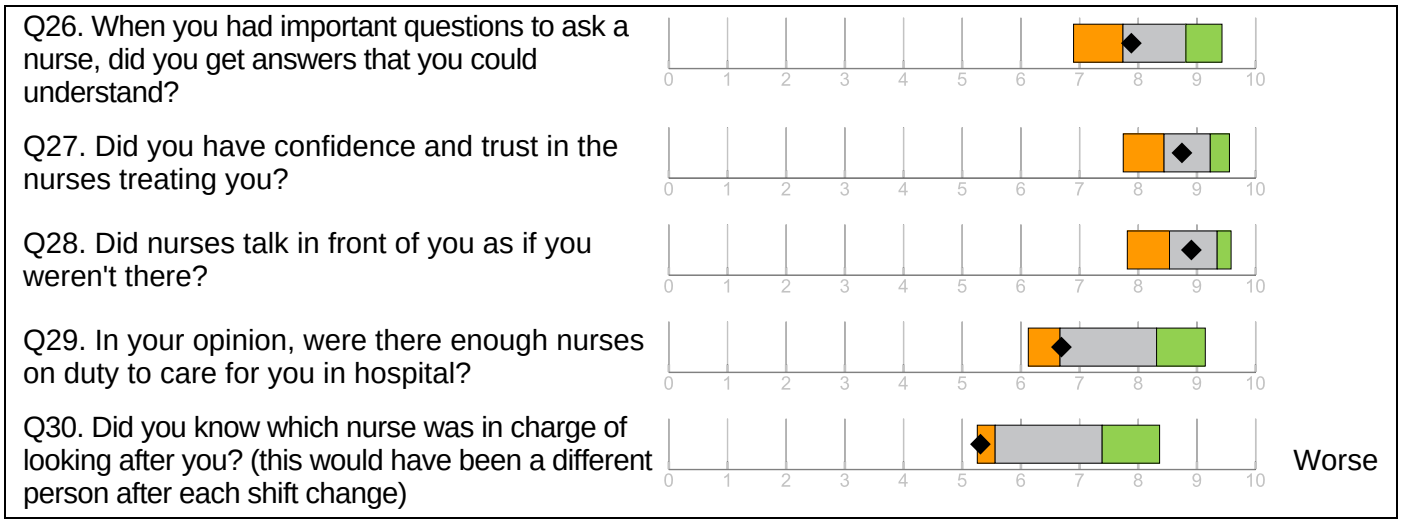


Best performing trusts	'Better/Worse'	Only displayed when this trust is better/worse than most other trusts
About the same	◆	This trust's score (NB: Not shown where there are fewer than 30 respondents)
Worst performing trusts		

Adult Inpatient Survey 2018

The Dudley Group NHS Foundation Trust

Nurses

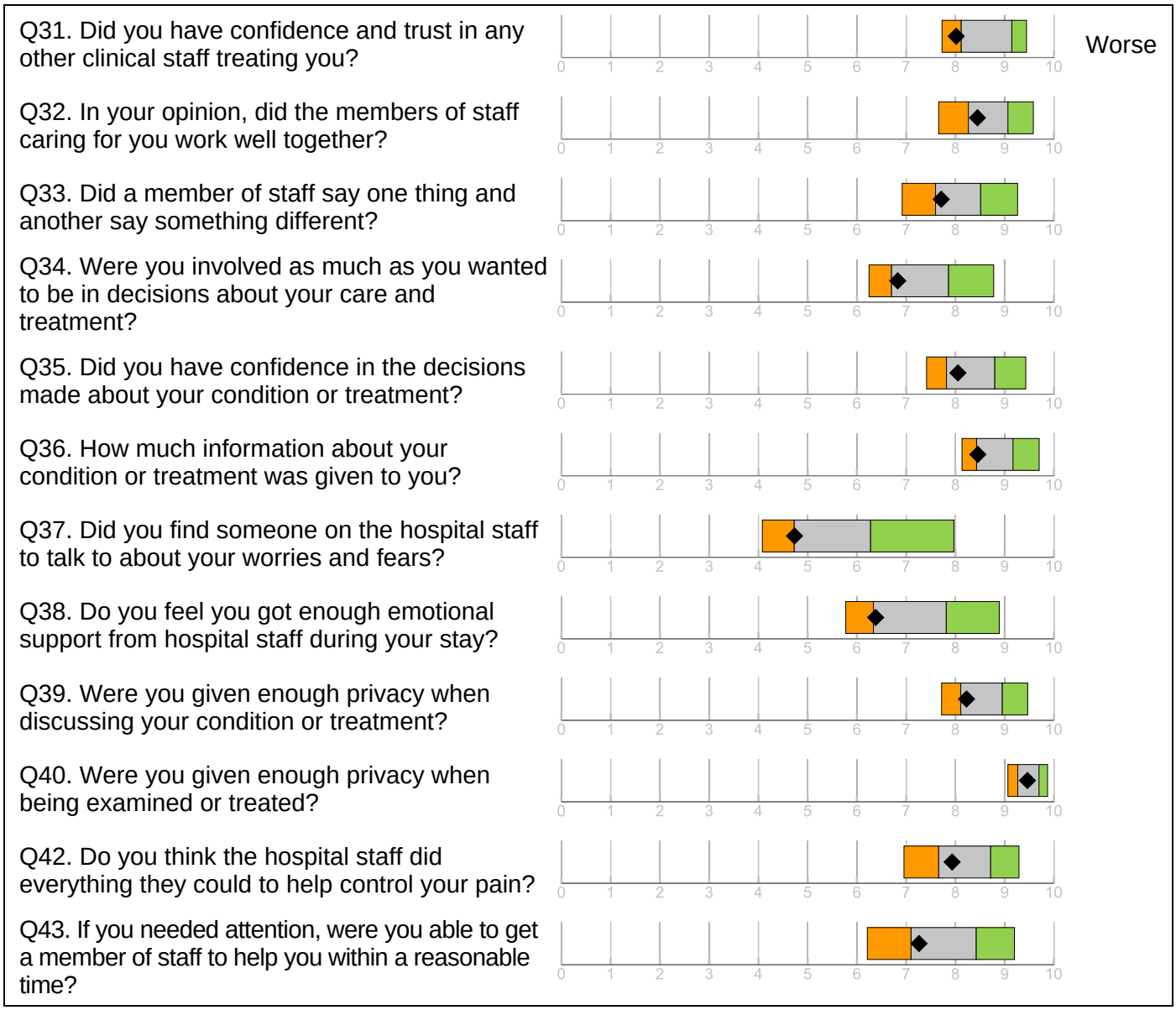


Best performing trusts	'Better/Worse'	Only displayed when this trust is better/worse than most other trusts
About the same	◆	This trust's score (NB: Not shown where there are fewer than 30 respondents)
Worst performing trusts		

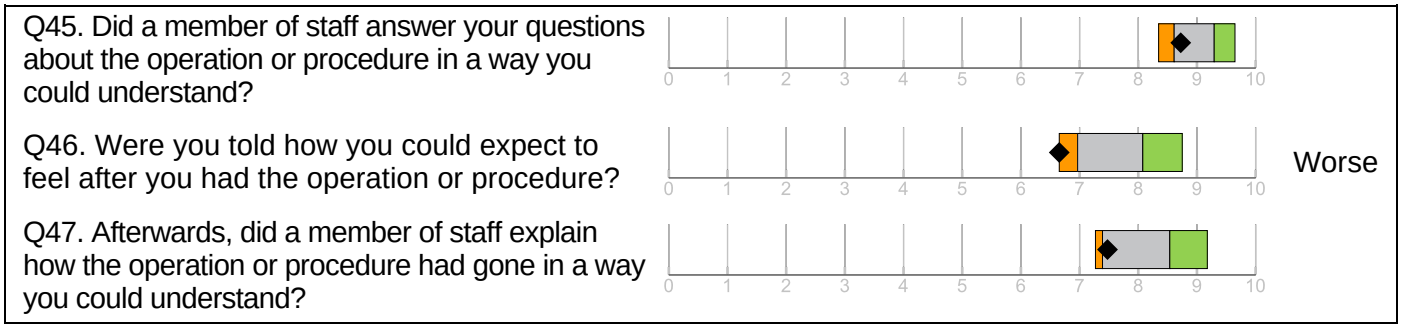
Adult Inpatient Survey 2018

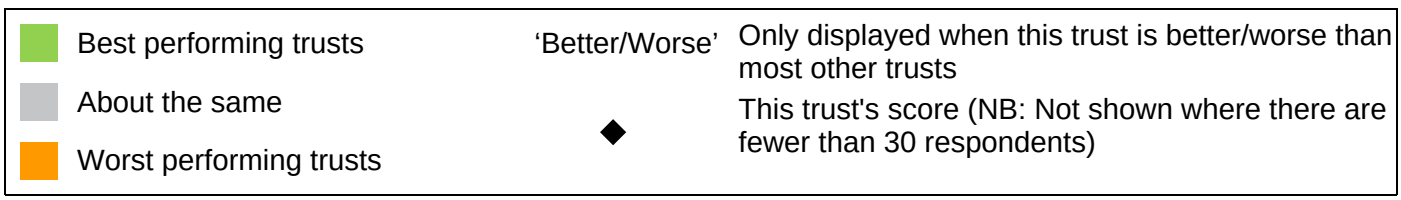
The Dudley Group NHS Foundation Trust

Your care & treatment



Operations & procedures (answered by patients who had an operation or procedure)

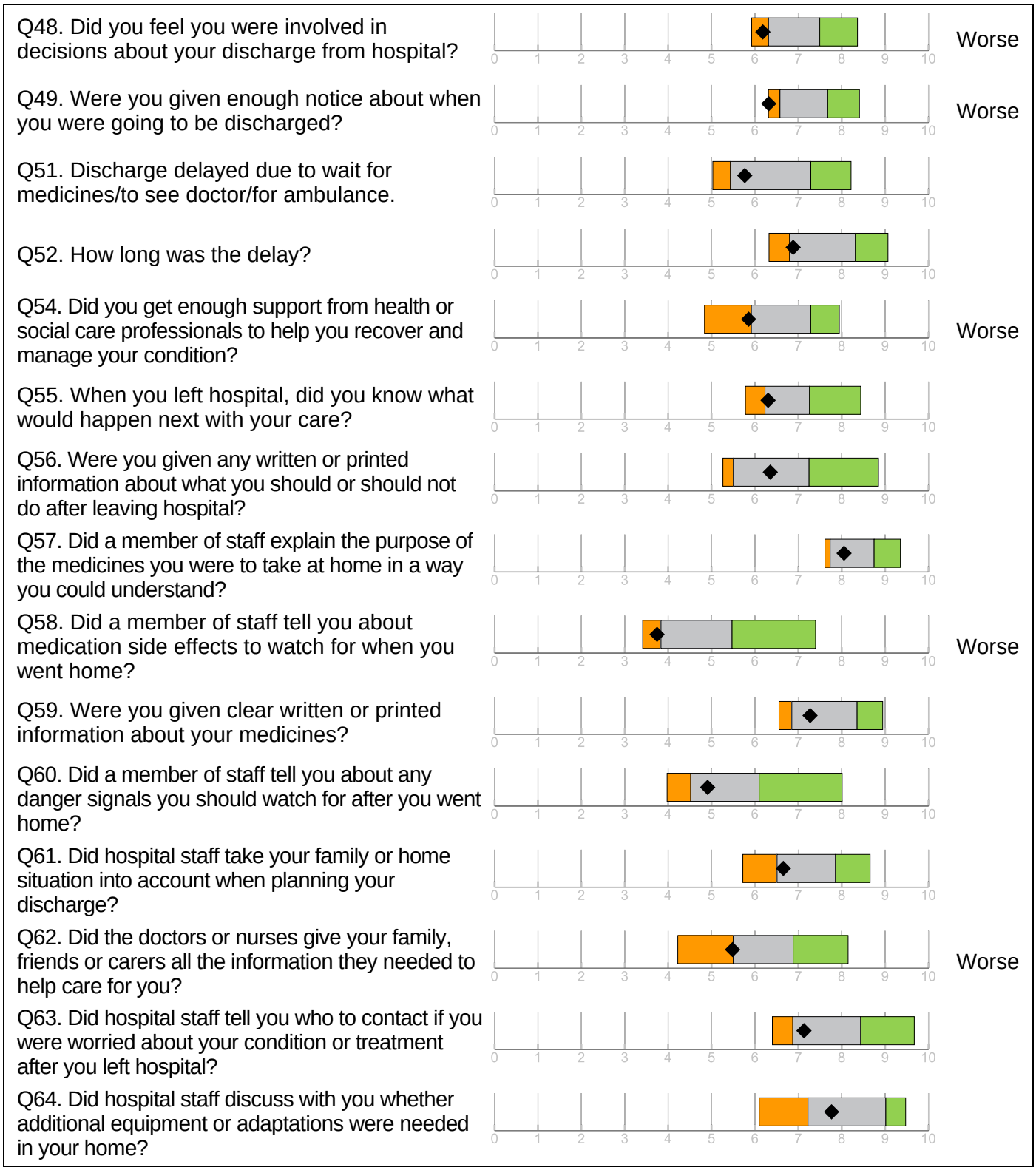




Adult Inpatient Survey 2018

The Dudley Group NHS Foundation Trust

Leaving hospital

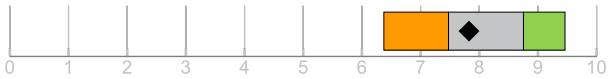


Best performing trusts	'Better/Worse'	Only displayed when this trust is better/worse than most other trusts
About the same	◆	This trust's score (NB: Not shown where there are fewer than 30 respondents)
Worst performing trusts		

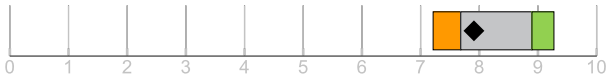
Adult Inpatient Survey 2018

The Dudley Group NHS Foundation Trust

Q65. Did hospital staff discuss with you whether you may need any further health or social care services after leaving hospital?



Q66. Was the care and support you expected available when you needed it?

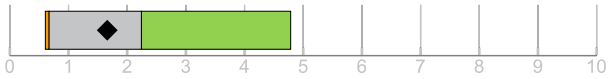


Overall views of care and services

Q67. Overall, did you feel you were treated with respect and dignity while you were in the hospital?

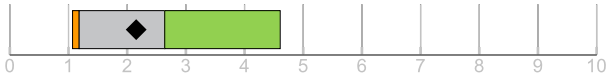
Worse

Q69. During this hospital stay, did anyone discuss with you whether you would like to take part in a research study?



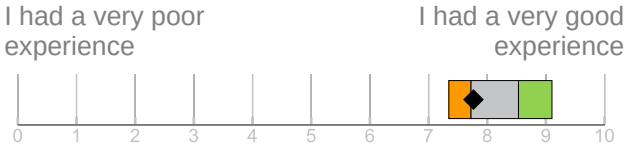
Q70. During your hospital stay, were you ever asked to give your views on the quality of your care?

Q71. Did you see, or were you given, any information explaining how to complain to the hospital about the care you received?



Overall experience

Q68. Overall...



Best performing trusts	‘Better/Worse’	Only displayed when this trust is better/worse than most other trusts
About the same	◆	This trust's score (NB: Not shown where there are fewer than 30 respondents)
Worst performing trusts		

Adult Inpatient Survey 2018

The Dudley Group NHS Foundation Trust

		Scores for this NHS trust	Lowest trust score in England	Highest trust score in England	Number of respondents (this trust)	2017 scores for this NHS trust	Change from 2017
The Accident & Emergency Department (answered by emergency patients only)							
S1	Section score	8.0	7.7	9.1			
Q3	While you were in the A&E Department, how much information about your condition or treatment was given to you?	7.4	7.4	9.0	265	7.8	
Q4	Were you given enough privacy when being examined or treated in the A&E Department?	8.6	7.7	9.5	301	8.7	
Waiting list or planned admissions (answered by those referred to hospital)							
S2	Section score	9.0	8.0	9.7			
Q6	How do you feel about the length of time you were on the waiting list?	8.6	6.1	9.7	134	8.3	
Q7	Was your admission date changed by the hospital?	9.5	8.3	9.9	132	9.2	
Q8	Had the hospital specialist been given all necessary information about your condition/illness from the person who referred you?	9.0	7.9	9.6	132	9.6	↓
Waiting to get to a bed on a ward							
S3	Section score	6.6	5.9	9.5			
Q9	From the time you arrived at the hospital, did you feel that you had to wait a long time to get to a bed on a ward?	6.6	5.9	9.5	467	6.7	

↑ or ↓	Indicates where 2018 score is significantly higher or lower than 2017 score (NB: No arrow reflects no statistically significant change) Where no score is displayed, no 2017 data is available.

Adult Inpatient Survey 2018

The Dudley Group NHS Foundation Trust

		Scores for this NHS trust	Lowest trust score in England	Highest trust score in England	Number of respondents (this trust)	2017 scores for this NHS trust	Change from 2017
The hospital and ward							
S4	Section score	7.5	6.9	8.8			
Q11	Did you ever share a sleeping area with patients of the opposite sex?	8.8	7.5	9.7	471	9.0	
Q13	Did the hospital staff explain the reasons for being moved in a way you could understand?	5.9	4.7	8.8	117	6.8	
Q14	Were you ever bothered by noise at night from other patients?	6.4	4.6	8.5	469	5.9	
Q15	Were you ever bothered by noise at night from hospital staff?	8.0	6.9	9.3	468	7.8	
Q16	In your opinion, how clean was the hospital room or ward that you were in?	8.6	8.0	9.7	470	8.7	
Q17	Did you get enough help from staff to wash or keep yourself clean?	7.7	6.8	9.2	295	7.8	
Q18	If you brought your own medication with you to hospital, were you able to take it when you needed to?	6.3	6.0	8.8	226	6.4	
Q19	How would you rate the hospital food?	5.0	4.4	7.9	454	4.8	
Q20	Were you offered a choice of food?	8.8	7.7	9.5	462	8.7	
Q21	Did you get enough help from staff to eat your meals?	6.8	4.6	8.8	113	6.6	
Q22	During your time in hospital, did you get enough to drink?	8.9	8.6	9.9	458	8.9	
Q72	Did you feel well looked after by the non-clinical hospital staff?	8.9	7.9	9.7	423	8.8	
Doctors							
S5	Section score	8.3	7.9	9.5			
Q23	When you had important questions to ask a doctor, did you get answers that you could understand?	7.8	7.5	9.4	416	8.1	
Q24	Did you have confidence and trust in the doctors treating you?	8.7	8.4	9.7	468	8.8	
Q25	Did doctors talk in front of you as if you weren't there?	8.4	7.7	9.4	469	8.4	

↑ or ↓	Indicates where 2018 score is significantly higher or lower than 2017 score (NB: No arrow reflects no statistically significant change) Where no score is displayed, no 2017 data is available.

Adult Inpatient Survey 2018

The Dudley Group NHS Foundation Trust

		Scores for this NHS trust	Lowest trust score in England	Highest trust score in England	Number of respondents (this trust)	2017 scores for this NHS trust	Change from 2017
Nurses							
S6	Section score	7.5	7.0	9.1			
Q26	When you had important questions to ask a nurse, did you get answers that you could understand?	7.9	6.9	9.4	401	7.9	
Q27	Did you have confidence and trust in the nurses treating you?	8.7	7.7	9.6	473	8.6	
Q28	Did nurses talk in front of you as if you weren't there?	8.9	7.8	9.6	472	8.8	
Q29	In your opinion, were there enough nurses on duty to care for you in hospital?	6.7	6.1	9.1	470	7.0	
Q30	Did you know which nurse was in charge of looking after you? (this would have been a different person after each shift change)	5.3	5.3	8.4	471	6.0	↓

↑ or ↓	Indicates where 2018 score is significantly higher or lower than 2017 score (NB: No arrow reflects no statistically significant change) Where no score is displayed, no 2017 data is available.

Adult Inpatient Survey 2018

The Dudley Group NHS Foundation Trust

		Scores for this NHS trust	Lowest trust score in England	Highest trust score in England	Number of respondents (this trust)	2017 scores for this NHS trust	Change from 2017
Your care & treatment							
S7	Section score	7.6	7.1	9.2			
Q31	Did you have confidence and trust in any other clinical staff treating you?	8.0	7.7	9.4	272	8.1	
Q32	In your opinion, did the members of staff caring for you work well together?	8.4	7.7	9.6	445	8.4	
Q33	Did a member of staff say one thing and another say something different?	7.7	6.9	9.3	470	7.8	
Q34	Were you involved as much as you wanted to be in decisions about your care and treatment?	6.8	6.2	8.8	469	7.1	
Q35	Did you have confidence in the decisions made about your condition or treatment?	8.1	7.4	9.4	471	8.2	
Q36	How much information about your condition or treatment was given to you?	8.5	8.1	9.7	447	8.7	
Q37	Did you find someone on the hospital staff to talk to about your worries and fears?	4.7	4.1	8.0	270	5.1	
Q38	Do you feel you got enough emotional support from hospital staff during your stay?	6.4	5.8	8.9	286	6.8	
Q39	Were you given enough privacy when discussing your condition or treatment?	8.2	7.7	9.5	464	8.3	
Q40	Were you given enough privacy when being examined or treated?	9.5	9.1	9.9	470	9.4	
Q42	Do you think the hospital staff did everything they could to help control your pain?	7.9	7.0	9.3	285	7.7	
Q43	If you needed attention, were you able to get a member of staff to help you within a reasonable time?	7.3	6.2	9.2	422	7.2	
Operations & procedures (answered by patients who had an operation or procedure)							
S8	Section score	7.6	7.6	9.1			
Q45	Did a member of staff answer your questions about the operation or procedure in a way you could understand?	8.7	8.3	9.6	221	9.0	
Q46	Were you told how you could expect to feel after you had the operation or procedure?	6.7	6.7	8.7	235	7.4	↓
Q47	Afterwards, did a member of staff explain how the operation or procedure had gone in a way you could understand?	7.5	7.3	9.2	235	7.9	

↑ or ↓	Indicates where 2018 score is significantly higher or lower than 2017 score (NB: No arrow reflects no statistically significant change) Where no score is displayed, no 2017 data is available.

Adult Inpatient Survey 2018

The Dudley Group NHS Foundation Trust

		Scores for this NHS trust	Lowest trust score in England	Highest trust score in England	Number of respondents (this trust)	2017 scores for this NHS trust	Change from 2017
Leaving hospital							
S9	Section score	6.5	6.2	8.4			
Q48	Did you feel you were involved in decisions about your discharge from hospital?	6.2	5.9	8.4	450	6.6	
Q49	Were you given enough notice about when you were going to be discharged?	6.3	6.3	8.4	471	6.9	↓
Q51	Discharge delayed due to wait for medicines/to see doctor/for ambulance.	5.8	5.0	8.2	443	6.1	
Q52	How long was the delay?	6.9	6.3	9.1	441	7.2	
Q54	Did you get enough support from health or social care professionals to help you recover and manage your condition?	5.9	4.8	7.9	232	6.8	↓
Q55	When you left hospital, did you know what would happen next with your care?	6.3	5.8	8.4	394		
Q56	Were you given any written or printed information about what you should or should not do after leaving hospital?	6.4	5.3	8.8	447	5.6	↑
Q57	Did a member of staff explain the purpose of the medicines you were to take at home in a way you could understand?	8.1	7.6	9.4	317	7.9	
Q58	Did a member of staff tell you about medication side effects to watch for when you went home?	3.7	3.4	7.4	282	4.3	
Q59	Were you given clear written or printed information about your medicines?	7.3	6.6	8.9	294	7.9	
Q60	Did a member of staff tell you about any danger signals you should watch for after you went home?	4.9	4.0	8.0	336		
Q61	Did hospital staff take your family or home situation into account when planning your discharge?	6.7	5.7	8.7	294	7.2	
Q62	Did the doctors or nurses give your family, friends or carers all the information they needed to help care for you?	5.5	4.2	8.1	297	6.5	↓
Q63	Did hospital staff tell you who to contact if you were worried about your condition or treatment after you left hospital?	7.1	6.4	9.7	411	7.6	
Q64	Did hospital staff discuss with you whether additional equipment or adaptations were needed in your home?	7.8	6.1	9.5	164	8.3	
Q65	Did hospital staff discuss with you whether you may need any further health or social care services after leaving hospital?	7.8	6.4	9.5	240	7.8	
Q66	Was the care and support you expected available when you needed it?	7.9	7.2	9.3	283		

↑ or ↓	Indicates where 2018 score is significantly higher or lower than 2017 score (NB: No arrow reflects no statistically significant change) Where no score is displayed, no 2017 data is available.

Adult Inpatient Survey 2018

The Dudley Group NHS Foundation Trust

		Scores for this NHS trust	Lowest trust score in England	Highest trust score in England	Number of respondents (this trust)	2017 scores for this NHS trust	Change from 2017
Overall views of care and services							
S10	Section score	3.5	2.8	5.5			
Q67	Overall, did you feel you were treated with respect and dignity while you were in the hospital?	8.6	8.2	9.8	462	8.8	
Q69	During this hospital stay, did anyone discuss with you whether you would like to take part in a research study?	1.7	0.6	4.8	400		
Q70	During your hospital stay, were you ever asked to give your views on the quality of your care?	1.7	0.5	3.7	406	1.8	
Q71	Did you see, or were you given, any information explaining how to complain to the hospital about the care you received?	2.2	1.1	4.6	383	2.7	
Overall experience							
S11	Section score	7.8	7.3	9.1			
Q68	Overall...	7.8	7.3	9.1	451	7.9	

↑ or ↓	Indicates where 2018 score is significantly higher or lower than 2017 score (NB: No arrow reflects no statistically significant change) Where no score is displayed, no 2017 data is available.

Adult Inpatient Survey 2018
The Dudley Group NHS Foundation Trust

Background information

The sample	This trust	All trusts
Number of respondents	488	76668
Response Rate (percentage)	41	45

Demographic characteristics	This trust	All trusts
Gender (percentage)	(%)	(%)
Male	46	48
Female	54	52
Age group (percentage)	(%)	(%)
Aged 16-35	4	5
Aged 36-50	5	8
Aged 51-65	18	23
Aged 66 and older	73	64
Ethnic group (percentage)	(%)	(%)
White	92	89
Multiple ethnic group	0	1
Asian or Asian British	3	3
Black or Black British	1	1
Arab or other ethnic group	0	0
Not known	4	5
Religion (percentage)	(%)	(%)
No religion	12	18
Buddhist	0	0
Christian	80	75
Hindu	0	1
Jewish	0	0
Muslim	3	2
Sikh	1	1
Other religion	2	1
Prefer not to say	2	2
Sexual orientation (percentage)	(%)	(%)
Heterosexual/straight	95	94
Gay/lesbian	0	1
Bisexual	0	0
Other	0	1
Prefer not to say	3	4

NHS Patient Survey Programme

2018 Adult Inpatient Survey

Identification of outliers within trust-level results

Published June 2019

Contents

Summary

The 2018 adult inpatient survey received feedback from 76,668 patients who received care in 144 NHS acute and NHS foundation trusts during July 2018.

We have published analysis of the national results on our website. This separate analysis identifies trusts where patients experience is better, or worse than expected, when we compare survey results across trusts. The analysis methodology used in this report allows for an overall picture of performance across the survey as a whole, based on considering the results for all evaluative (scored) questions simultaneously. It supplements the approach used in trust level benchmark reporting, which provides results for individual questions.

More information on the difference between approaches used to explore differences in patients' experiences between trusts is available within the section 'difference between outlier analysis and trust-level benchmark reports'.

Each trust has been assigned one of five bands: 'much worse than expected', 'worse than expected', 'about the same', 'better than expected' or 'much better than expected'.

Eight acute specialist trusts have been categorised within the highest band, identified as 'much better than expected' with results that indicate patient experience was substantially better than elsewhere. One of these, The Royal Orthopaedic Hospital NHS Foundation Trust, was also rated 'much better than expected' in 2017, and six were also rated 'much better' in both the 2016 and 2017 surveys: Liverpool Heart and Chest Hospital NHS Foundation Trust, The Christie NHS Foundation Trust, The Clatterbridge Cancer Centre NHS Foundation Trust, The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust, Queen Victoria Hospital NHS Foundation Trust, and The Royal Marsden NHS Foundation Trust. The Royal Brompton & Harefield NHS Foundation Trust have scored 'much better than expected' this year for the first time.

Patients from three other trusts experienced care that was 'better than expected': Royal National Orthopaedic Hospital NHS Trust, Royal Papworth Hospital NHS Foundation Trust, and The Newcastle Upon Tyne Hospitals NHS Foundation Trust.

Seven trusts have been identified as achieving 'worse than expected' results: Bradford Teaching Hospitals NHS Foundation Trust, Southend University Hospital NHS Foundation Trust, North Middlesex University Hospital NHS Trust, Lewisham and Greenwich NHS Trust, Medway NHS Foundation Trust, Pennine Acute Hospitals NHS Trust, Sandwell and West Birmingham Hospitals NHS Trust

Patients from one trust reported experiencing care that was 'much worse than expected' in 2018: Croydon Health Services NHS Trust.

Our Chief Inspector of Hospitals, Professor Ted Baker, has written to all trusts identified as better or worse in the statistical release. The eight trusts identified as being worse, or much worse, will be asked to review their results and to outline what actions they will take to address the areas of concern. CQC will review their progress on their next planned inspections.

Interpreting the results

To provide a comprehensive picture of inpatient experience within each NHS trust, we have calculated the overall proportion of responses each trust received for the 'most negative', 'middle' and 'most positive' answer option(s) across most of the scored questions in the survey.[a]

We use the following question from the 2018 adult inpatient survey to show how responses are categorised as either 'most negative', 'middle' and 'most positive':

Q16. In your opinion, how clean was the hospital room or ward that you were in?

- Very clean – **most positive**
- Fairly clean – **middle**
- Not very clean – **middle**
- Not at all clean – **most negative**

Where people's experiences of a trust's inpatient care are better or worse than elsewhere, there will be a significant difference between the trust's result and the average result across all trusts. Each trust is then assigned a banding of either 'much worse than expected', 'worse than expected', 'about the same', 'better than expected' or 'much better than expected' depending on how significant that variation is. Consistent with our trust-level benchmarking methodology, specialist and non-specialist trusts have been compared with one another.

For example, a trust's proportion of responses breaks down as: 'most negative' 12%, 'middle' 14% and 'most positive' 74%. This is then compared to the average of 'most negative' 16%, 'middle' 18% and 'most positive' 66% for all trusts. An 'adjusted z-score'[b] is calculated for the difference between 'most negative' trust proportions, which in this example is -2.92. This means this trust has a higher proportion of 'positive' responses than average, but not the 'most positive'. This is considered significant with a p-value of less than 0.25 but not less than 0.01. As a result, the trust is classed as 'better'.

In order to provide more granular analysis, we have also re-run the analysis according to whether patients received 'medical' or 'surgical' care.

Finally, each table within the report includes the most recent trust-wide CQC rating. For full details of the analytical method used to calculate these results, please see appendix C.

[a] Filter questions, such as Q1 *'Was your most recent hospital stay planned in advance or an emergency?',* were not included within this analysis.
[b] Z scores give an indication of how different a trust's proportion is from the average.

Results

Trusts achieving ‘much better than expected’ results

Eight acute trusts were classed as ‘much better than expected’ in 2018. Seven of these had the same banding in 2017 and six had the same banding in 2016, demonstrating consistently high levels of positive patient experience. All of these trusts are classed as specialist trusts.

	Historic results	Overall results				Core service		Overall CQC rating
	2017	2018	Most Negative (%)	Middle (%)[c]	Most Positive (%)	Medical care	Surgery	
Trust average			**16**	**18**	**66**			
The Christie NHS Foundation Trust	MB	MB	9	12	79	MB	MB	O
The Clatterbridge Cancer Centre NHS Foundation Trust	MB	MB	11	13	76	MB	N/A	G
Liverpool Heart and Chest Hospital NHS Foundation Trust	MB	MB	10	12	78	MB	MB	O
Queen Victoria Hospital NHS Foundation Trust	MB	MB	9	11	81	MB	MB	G
Royal Brompton & Harefield NHS Foundation Trust	B	MB	11	14	75	MB	B	G
The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust	MB	MB	8	11	81	MB	MB	G
The Royal Marsden NHS Foundation Trust	MB	MB	8	12	80	MB	MB	O
The Royal Orthopaedic Hospital NHS Foundation Trust	MB	MB	10	15	75	N/A	B	G

Key:

Trust performance	About the same (**S**)	Better (**B**)	Much better (**MB**)	
CQC rating	Inadequate (**I**)	Requires Improvement (**RI**)	Good (**G**)	Outstanding (**O**)

[c] Where a number of options lay between the negative and positive responses, they are placed at equal intervals along the scale. For example, ‘yes, sometimes’ is the middle option (scored as 5/10) for the question *‘When you had important questions to ask a doctor, did you get answers that you could understand?’.*

Trusts achieving ‘better than expected’ results

Three trusts were classed as ‘better than expected’ across the entire survey. The Newcastle Upon Tyne Hospitals NHS Foundation Trust was also ‘better than expected’ in 2017, while last year Royal Papworth Hospital NHS Foundation Trust had achieved a higher band of ‘much better than expected’. Royal National Orthopaedic Hospital NHS Trust has gone from ‘about the same’ in 2017, to ‘better than expected’ this year.

	Historic results	Overall results				Core service		Overall CQC rating
	2017	2018	Most Negative (%)	Middle[d] (%)	Most Positive (%)	Medical care	Surgery	
Trust average			**16**	**18**	**66**			
The Newcastle Upon Tyne Hospitals NHS Foundation Trust	B	B	13	15	72	B	S	O
Royal National Orthopaedic Hospital NHS Trust	S	B	12	16	73	B	S	G
Royal Papworth Hospital NHS Foundation Trust	MB	B	12	14	74	MB	S	G

Key:

Trust performance	About the same (**S**)	Better (**B**)	Much better (**MB**)	
CQC rating	Inadequate (**I**)	Requires Improvement (**RI**)	Good (**G**)	Outstanding (**O**)

[d] Where a number of options lay between the negative and positive responses, they are placed at equal intervals along the scale. For example, ‘yes, sometimes’ is the middle option (scored as 5/10) for the question *‘When you had important questions to ask a doctor, did you get answers that you could understand?’.*

Trusts achieving ‘worse than expected’ results

Seven trusts were classed as ‘worse than expected’. Four trusts had the same banding in 2017, but Lewisham and Greenwich NHS Trust, Medway NHS Foundation Trust and Southend University Hospital NHS Foundation Trust have gone from ‘about the same’ in 2017 to ‘worse than expected’ for this year.

	Historic results	Overall results				Core service		Overall CQC rating
	2017	2018	Most Negative (%)	Middle (%)[e]	Most Positive (%)	Medical care	Surgery	
Trust average			**16**	**18**	**66**			
Bradford Teaching Hospitals NHS Foundation Trust	**W**	**W**	20	22	58	**W**	**W**	**RI**
Lewisham and Greenwich NHS Trust	**S**	**W**	20	20	60	**W**	**W**	**RI**
Medway NHS Foundation Trust	**S**	**W**	20	20	61	**MW**	**S**	**RI**
North Middlesex University Hospital NHS Trust	**W**	**W**	20	23	57	**W**	**W**	**RI**
Pennine Acute Hospital NHS Trust	**W**	**W**	19	19	62	**S**	**W**	**RI**
Sandwell and West Birmingham Hospitals NHS Trust	**W**	**W**	19	20	61	**S**	**S**	**RI**
Southend University Hospital NHS Foundation Trust	**S**	**W**	19	19	62	**W**	**S**	**G**

Key:

Trust performance	About the same (**S**)	Worse (**W**)	Much worse (**MW**)	
CQC rating	Inadequate (**I**)	Requires Improvement (**RI**)	Good (**G**)	Outstanding (**O**)

[e] Where a number of options lay between the negative and positive responses, they are placed at equal intervals along the scale. For example, ‘yes, sometimes’ is the middle option (scored as 5/10) for the question *‘When you had important questions to ask a doctor, did you get answers that you could understand?’.*

Trusts achieving ‘much worse than expected’ results

One trust was identified as ‘much worse than expected’ when assessing overall experiences for all patients.

	Historic results	Overall results				Core service		Overall CQC rating
	2017	2018	Most Negative (%)	Middle (%)[f]	Most Positive (%)	Medical care	Surgery	
Trust average			**16**	**18**	**66**			
Croydon Health Services NHS Trust	**S**	**MW**	21	24	56	**W**	**W**	**RI**

Key:

Trust performance	About the same (**S**)	Worse (**W**)	Much worse (**MW**)	
CQC rating	Inadequate (**I**)	Requires Improvement (**RI**)	Good (**G**)	Outstanding (**O**)

[f] Where a number of options lay between the negative and positive responses, they are placed at equal intervals along the scale. For example, ‘yes, sometimes’ is the middle option (scored as 5/10) for the question *‘When you had important questions to ask a doctor, did you get answers that you could understand?’*

Appendix A: Analysis methodology

Identifying worse than expected patient experience

The analytical approach to identifying those trusts where patient experience was 'worse than expected' uses responses for most scored questions (question 68 "Overall…" is excluded).

For each trust, a count of the number of responses scored as '0' (the most negative option) is calculated. This is then divided by the total number of responses scored as 0 to 10 to calculate the trust-level proportion of poor experience. A higher percentage of negative responses indicates poor patient experience.

Within the analysis, we use z-scores that give an indication of how different a trust's poor experience proportion is from the average.

There are two thresholds for flagging trusts with concerning levels of poor patient experience:

- **Worse than expected**: z-score lower than -1.96
- **Much worse than expected**: z-score lower than -3.09

Appendix C provides full technical detail of the analytical process used.

Identifying better than expected patient experience

In order to identify 'better than expected' patient experience a count of the number of responses scored as '10' (the most positive option) is calculated for each trust.

This is then divided by the total number of responses scored as 0 to 10 to calculate the trust-level proportion of poor experience.

A higher percentage of positive responses indicates good patient experience.

Our analysis has found that those trusts with the highest proportion of positive responses also have the lowest proportion of negative responses.

There are two thresholds for identifying trusts with high levels of good patient experience:

- **Better than expected**: z-score lower than -1.96
- **Much better than expected**: z-score lower than -3.09

Medical care and surgery core service results

For this analysis, a patient is counted as a medical case or surgical case based on the 'treatment function code' assigned to them during their time as an inpatient. Surgical care includes most surgical activity in a hospital. Surgical disciplines include (where they are provided) trauma and orthopaedics, urology, ENT, cardiac surgery, vascular, ophthalmic surgery, neurosurgery and general surgery. Medical care includes services that involve assessment, diagnosis and treatment of adults by means of medical interventions rather than surgery.

Core service results have been included to give trusts an indication of where improvement is most needed. We acknowledge that due to the different respondent numbers across trusts when looking at medical care and surgery experiences separately, some trusts with small samples may not have flagged as ‘better’ or ‘worse’ because their measurement error is too great.

When comparing experiences across all trusts for all inpatients (medical care and surgery combined), this limitation is mitigated as each trust has similar sample sizes and data for all questions.

Weighting

As in the national tables, results have been standardised by the age, sex and method of admission (emergency or elective)[g] of the sample to make sure that no trust will appear better or worse than another because of its respondent profile.

Standardisation enables a more accurate comparison of results from trusts with different population profiles. In most cases, this will not have a large impact on trust results. However, it does make comparisons between trusts as fair as possible.

Scoring

For each question in the survey, the individual (standardised) responses are converted into scores on a scale from 0 to 10. A score of 10 represents the best possible response and a score of 0 the worst. The higher the score for each question, the better the trust is performing.

It is not appropriate to score all questions in the questionnaire as not all of the questions assess a trust’s performance. For example, they may be descriptive questions such as Q1 asking respondents if their inpatient stay was planned in advance or an emergency.

[g] For medical care and surgery core service analysis, results have instead been weighted by age, gender and to the average medical care / surgery profile.

Appendix B: Difference between outlier analysis and trust-level benchmark reports

To analyse trust variation in this report, we focused on identifying significantly higher levels of better or worse patient experience **across the entire survey**.

This holistic approach is different to the technique used to analyse results within trust benchmarking reports that have already been made available to each trust. Within those reports trust results, for each scored question, are assigned bands of either 'better', 'worse' or 'about the same' when compared with the findings for all other trusts. However, trust benchmark reports do not attempt to look across all questions concurrently and as a result do not provide an overall assessment of the proportion of positive or negative patient experience reported across the entire survey.

Analysis of individual questions can hide variation in people's experiences as the scores are 'averaged' in that analysis. This approach allows CQC to identify that variation and highlight potential concerns raised by people across the survey.

Appendix C: Analytical stages of the outlier model

The analytical approach to identifying outliers is based on all evaluative items in the survey. These are the questions that are scored for benchmarking purposes. The scored variables are the source data, and are required at case level. These variables take values between 0 (representing the worst rating of experience) and 10 (representing the best rating). The approach also makes use of the standardisation weight for the survey.

1. Count the poor-care ratings made by each respondent[h]

Count of the '0' responses across the scored questions answered by each respondent (excluding the "Overall…" question).

2. Count the questions given specific (scored) answers by each respondent

Count of all '0 to 10' responses across the scored questions answered by each respondent (excluding the "Overall…" question).

3. Weight the data

Apply the standardisation weight for respondents. The weight adjusts the population of respondents within each trust to the national average proportions for age, gender and route of admission.

4. Aggregate to trust-level and compute proportion of poor ratings

Obtain a weighted numerator and denominator for each trust. Divide the numerator by the denominator to obtain the trust-level proportion of poor care ratings. For example, the overall percentage of responses which were scored as 0.

5. Compute the mean of the trust-level proportions

Sum all proportions and divide by the number of trusts to obtain the average trust-level proportion of poor care ratings.

[h]The analytical approach used to identify positive patient experience uses a numerator count of the '10' responses across all scored questions (excluding the "overall…" question) to calculate the 'good-care ratings'. There are no other differences between the analytical approaches for identifying poor and good patient experience.

6. Compute the z-score for the proportion

The Z-score formula used is:

$$z_i = -2\sqrt{n_i}\left\{sin^{-1}\left(\sqrt{p_i}\right) - sin^{-1}\left(\sqrt{p_0}\right)\right\} \qquad (1)$$

where: n_i is the denominator for the trust

p_i is the trust proportion of poor care ratings

p_0 is the mean proportion for all trusts

7. Winsorize the z-scores

Winsorizing consists of shrinking in the extreme Z-scores to some selected percentile, using the following method:

1. Rank cases according to their naive Z-scores.

2. Identify Z_q and $Z_{(1-q)}$, the 100q% most extreme top and bottom naive Z-scores. For this work, we used a value of q=0.1

3. Set the lowest 10% of Z-scores to Z_q, and the highest 10% of Z-scores to $Z_{(1-q)}$. These are the Winsorized statistics.

This retains the same number of Z-scores but discounts the influence of outliers.

8. Calculate dispersion using Winsorized z-scores

An over dispersion factor $\hat{\phi}$ is estimated which allows us to say if the data are over dispersed or not:

$$\hat{\phi} = \frac{1}{I}\sum_{i=1}^{I} \boldsymbol{Z}_i^2 \quad (2)$$

Where I is the sample size (number of trusts) and z_i is the Z score for the *i*th trust given by (1). The Winsorized Z scores are used in estimating $\hat{\phi}$.

9. Adjust for overdispersion

If I $\hat{\phi}$ is greater than (I - 1) then we need to estimate the expected variance between trusts. We take this as the standard deviation of the distribution of p_i (trust proportions) for trusts, which are on target, we give this value the symbol $\hat{\tau}$, which is estimated using the following formula:

$$\hat{\tau}^2 = \frac{I\hat{\phi} - (I-1)}{\sum_i w_i - \sum_i w_i^2 / \sum_i w_i} \quad (3)$$

where $s_i = (p_i - p_o)/z_i$, $w_i = 1/s_i^2$ and $\hat{\phi}$ is from (2). Once $\hat{\tau}$ has been estimated, the Z_D score is calculated as:

$$z_i^D = \frac{p_0 - p_i}{\sqrt{s_i^2 + \hat{\tau}^2}} \quad (4)$$

Appendix D: Additional core service results

As part of this analysis, a number of trusts were identified as being worse/better than expected for either medical care or surgery, but not when combining experiences of patients across these services.

Medical care only

Eight trusts were identified as being **'much better than expected'** for medical care experiences:

- The Christie NHS Foundation Trust
- The Clatterbridge Cancer Centre NHS Foundation Trust
- Liverpool Heart and Chest Hospital NHS Foundation Trust
- Queen Victoria Hospital NHS Foundation Trust
- The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust
- Royal Papworth Hospital NHS Foundation Trust
- The Royal Marsden NHS Foundation Trust
- Royal Brompton and Harefield NHS Foundation Trust

Three trusts were classed as **'better than expected'** for medical care:

- Liverpool Women's NHS Foundation Trust
- The Newcastle Upon Tyne Hospitals NHS Foundation Trust
- Royal National Orthopaedic Hospital NHS Trust

Eight trusts were identified as being **'worse than expected'** for medical care experiences:

- Bradford Teaching Hospitals NHS Foundation Trust
- Croydon Health Services NHS Trust
- The Dudley Group NHS Foundation Trust
- Isle of Wight NHS Trust
- Lewisham and Greenwich NHS Trust
- North Middlesex University Hospital NHS Trust
- Southend University Hospital NHS Foundation Trust
- Tameside and Glossop Integrated Care NHS Foundation Trust

One trust was identified as being **'much worse than expected'** for medical care experiences:

- Medway NHS Foundation Trust

Surgery only

Five trusts were identified as being **‘much better than expected’** for surgery experiences:

- The Christie NHS Foundation Trust
- Liverpool Heart and Chest Hospital NHS Foundation Trust
- The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust
- Queen Victoria Hospital NHS Foundation Trust
- The Royal Marsden NHS Foundation Trust

Four trusts were identified as being **‘better than expected’** for surgery experiences:

- Northumbria Healthcare NHS Foundation Trust
- Sherwood Forest Hospitals NHS Foundation Trust
- The Royal Orthopaedic Hospital NHS Foundation Trust
- University Hospitals Bristol NHS Foundation Trust

Eight trusts were identified as being **‘worse than expected’** for surgery experiences:

- Bradford Teaching Hospitals NHS Foundation Trust
- Croydon Health Services NHS Trust
- East and North Hertfordshire NHS Trust
- Lewisham and Greenwich NHS Trust
- London North West University Healthcare NHS Trust
- North Middlesex University Hospital NHS Trust
- Northern Lincolnshire and Goole NHS Foundation Trust
- Pennine Acute Hospitals NHS Trust

No trusts were identified as being **‘much worse than expected’** for surgery experiences.

How to contact us

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Please contact us if you would like a summary of this document in another language or format.

Enclosure 21

The Dudley Group
NHS Foundation Trust

Paper for submission to the Board
On 4th July 2019

TITLE:	**Integrated Performance Report for Month 2 (May) 2019**		
AUTHOR:	**Informatics**	**PRESENTER**	**Karen Kelly** **Chief Operating Officer**

CLINICAL STRATEGIC AIMS

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

ACTION REQUIRED OF COMMITTEE:

Decision	Approval	Discussion	Other
N	N	Y	N

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 COMMITTEE:

To note and discuss the current performance against KPIs

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:

Performance

A&E target

Performance in month at 78.6% did not achieve the planned trajectory of 85%. The system implementation in May had a direct impact on efficiency and ultimately performance of the department, however staff are now more familiar with and becoming fully competent in its use. Further actions in place to improve performance include:

- Urgent review of Minors for a 24 hour service
- Breach management with Divisional Teams
- Submission of System Improvement plan to improve performance across the health economy with 30/60/90 day actions. Plan to be monitored by Urgent Care Operational Group & A&E Delivery Board

Cancer

The Trust has continued to deliver against all ten performance standards in May 2019, which is the fourth consecutive month of delivery in this area.

Referral to Treatment (18 week)

The 18 week Referral to Treatment standards continues to be met by the Trust with the Trust exceeding the 92% target by achieving 94.80%. This month's performance is a further improved position of 0.85% from the previous month.

Referral to treatment – Incompletes(18 week)

Specialty	Summary of Recovery actions
General Surgery	• A locum consultant commenced in May 2019 to fill a vacancy • Strong grip to ensure the specialty utilises 23-26 theatre sessions per month
Ophthalmology	• Additional weekend lists have been secured to manage the backlog of long waiting patients • Additional outpatient capacity has been secured to minimise patient on the Appointment Slot Issue list.

Diagnostics (DM01)

The standard narrowly failed in May 2019 due to failure of equipment during the last four days of the month. Assurances have been received around June's performance and attention is now turning to July 2019 to ensure this is sustained.

Quality

Mixed sex accommodation

There were 6 MSA breaches in month.

Never Events

The Trust reported 0 never events.

Finance

Cumulative deficit of £1.780m for April-May (including PSF) and following consolidation of the pharmacy company and other technical changes. This position is £0.329m better than the control total so the Trust remains on course to achieve PSF in Q1. The forecast position shows a deficit of £5.780m in line with the base case assumptions approved by the Board. This assumes the land sale occurs and that the Trust only earns the Q1 PSF. This forecast also necessitates the identification and delivery of an additional £3.965m of CIP over and above the current plans. This position is £8.342m worse than the control total plus a further £5.493m of lost PSF resource.

Workforce

Staff Appraisals

The appraisal window for all non-medical appraisals is now open across the Trust and will close on the 30th June 2019.

As of the 20th June the Trust compliance rate of completed appraisals is 74.77% with further appraisals to be undertaken in June that will allow the Trust to realise its 90% target.

In order to support an above 90% compliance rate twice weekly reports are being provided to all managers detailing appraisals completed and booked highlighting any current gaps. The current projected compliance rates have been flagged as a risk at all Divisional meetings and will Divisional Management teams expected to demonstrate achievement within their monthly performance report. All Managers are required to focus on completing appraisals for their staff within the appraisal window.

Mandatory Training

The compliance rate has improved and continues at the stable level of 89.9%. This represents good performance that continues to improve. The areas where more concentrated efforts are required are associated with Resus and manual handling training. In terms of staff groups the area of highest non-compliance continues to be medical staff, their compliance rate has fallen to 82.14% at the end of May. The Clinical Support Division continues to be the team with the lowest compliance rates, however they are demonstrating improvements to 88.72%.

Adult Resuscitation and Paediatric Resuscitation below the 80% R.A.G.-rating threshold, with potential for risk in terms of appropriate response to deterioration or cardiac arrest. There has been a further drop in compliance in Paediatric Resuscitation in May and this subject is now at 66.2%. Neonatal Resuscitation is now amber (previously green) at 89.3%. These three subjects are managed via the Head of Non-Medical Education and Training, who has presented current and future intended actions for improvement to both Workforce and the Risk and Assurance Group.

Conflict resolution has now reached the compliance target this month and has moved from amber to green.

Sickness Rate

The absence rate has improved from 4.77% in April 2019 to 4.69% in May. Although sickness absence has decreased the Trust sickness absence levels remain above the Trust Target. The main areas of concern associated to staff group are Care Support staff at 7.87% and nursing & midwifery staff at 4.66%.

In terms of Divisional trends, Clinical Support Services continue to demonstrate the highest levels of absence at 6.19%. Therefore, focus is being provided on particular areas of high absence to ensure efficient turnaround of absence management and therefore staff returning to work.

Turnover Rate

The turnover rate continues to represent a positive retention of our staff and currently sits at 8.25% which is consistent with the previous month. The Trust Turnover target is 8.5% and with this continued reduction the Trust target has been achieved for the first time in recent years. The Trust turnover rate is also 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 develop the action plans based on the feedback from the national staff survey.

IMPLICATIONS OF PAPER:			
RISK	**Y**		**Risk Description:** High level 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 (COR 079)
COMPLIANCE and/or LEGAL REQUIREMENTS	**CQC**	**Y**	**Details:** Safe, Effective, Caring, Responsive, Well Lead
	NHSI	**Y**	**Details:** A sustained reduction in performance could result in the Trust being found in breach of Foundation Trust licence
	Other	**N**	**Details:**

The Dudley Group
NHS Foundation Trust

Integrated Performance Report - Board




May 2019

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**

Executive Summary

Key Messages

CQSPE

FFT Response Rate

A total of 7,273 responses across all areas have been received during May 2019. Response rates for May have improved in all areas. The area missing the target in May 2019 is the Outpatients Department, which has continued to remain below target. ED is above target in May 2019 which is an improvement from April 2019. The national average percentage response rates are not available at the time of writing this report.

FFT Percentage Reccomended

Percentage recommend scores for May have improved in all areas with the exception of Community. However, Inpatients, ED, Outpatients and Community are not achieving the target. Maternity (overall) remains above target for May 2019. The national average percentage recommend scores are not available at the time of writing this report.

FFT Actions

- The Friends and Family (FFT) App has been deployed on iPads used in the C4 day case area and community Lenovos.
- 15 teams in Community are now using the FFT App
- The App is available on the Trust website and can be accessed by anyone with an internet connection
- Feedback Friday is promoted to raise awareness and capture responses and staff have set up pop up workshops in the reception area.
- Volunteers have concentrated on the wards and Outpatients department to encourage patients to fill in the FFT forms.
- FFT champion meetings are taking place bi-monthly to encourage staff to promote FFT
- Community are hosting 'Lunch and Learn' sessions to identify trends and learning

Complaints & PALS

PALS received 191 concerns, 12 comments and 71 signposting contacts (signposting includes letters/emails/telephone calls/face-to-face enquiries) totalling 274 in May 2019 compared to 295 received in April 2019.

During May 2019, the Trust received 56 new complaints, in comparison to 50 opened for April 2019 and 52 opened for March 2019. This is a 12% increase from April 2019 for open complaints.

The Surgical Division received 31 new open complaints for May 2019 compared to 21 for April 2019. Medicine & Integrated Care Division received 22 new open complaints for May 2019 compared to 28 for April 2019. Clinical Support Division received three new open complaints for May 2019 compared to one for April 2019.

In terms of complaints by service, the emergency department received the largest number of complaints (12). SAU followed with 4.
There have been 6 re-opened complaints for May 2019.

The largest number of concerns raised across divisions related to communication.

Dementia

The Trust remains above the target of 90 % for find/assess, investigate and refer.

Falls

Falls with and without harm remained within expected limits for May. One patient fell and sustained a fractured hip which has been repaired.

Pressure Ulcers

There was 1 pressure ulcer reported as avoidable developed in the Acute Trust in May. This pressure ulcer was reported on C8.

MSA

In May there were a total of 6 breaches. There were 2 on ICU and 4 on SHDU.

Infection Control

Interventions April 2019:
HII 1: Ventilator Associated Pneumonia 100%
HII 2a: Peripheral Vascular Access Devices - Insertion 99%
HII 2b: Peripheral Vascular Access Devices - Ongoing care 98%
HII 3a: Central Venous Access Devices - Insertion 100%
HII 3b: Central Venous Access Devices - Ongoing Care 100%
HII 4a: Surgical Site Infection Prevention - Preoperative 100%
HII 4b: Surgical Site Infection Prevention - Intraoperative Actions 100%
HII 5: Infection Prevention in Chronic Wounds 100%
HII 6a: Urinary Catheter - Insertion 99%
HII 6b: Urinary Catheter - Maintenance & Assessment 97%
Hand Hygiene 100%
Commode Audits 100%
There were zero C diff cases due to lapses in care reported during May 2019.

Executive Summary

Key Messages

CQSPE

VTE

Trust performance for VTE for May 19 is 93.8%.

The trust continues to highlight regular daily reports to clinicians and lead nurses to action outstanding completion/logging of VTE RA.

Visual display to wards via the whiteboard and daily overview by Matron to challenge issues where outstanding.

Overview of compliance by Thrombosis CNS , highlighting areas with reduced compliance for further support.

Matron's are continuing to review daily, all notes retrieved for May and checked on SAEC/SAU and unfortunately 75% were not completed by Doctors. This has been fed back to management and a report sent to consultants for action. Approval of new ANP for SAEC which will hopefully improve compliance as will have 6 day working. Rn's checking x4 times per shift to ensure logging is completed.

Incidents

A review of datix has been undertertaken and the system streamlined to encourage staff to report incidents.

Safety Thermometer

Safety Thermometer for May 2019 – 98.6%

Please note: this figure is made up from the number of patients, number of patients with harm free care, and number of patients with old harms. (safety thermometer website)

Deteriorating Trolley Checks

This audit is collected on the audit tool Perfect Ward, Perfect Ward will only accept Yes, No or N/A as a response to this question. If a ward has failed one patient trolley check, results appear as 0% for the month.

% of patients with priorities of care

For May 19 - 29.7%

Introduction and embedding of GSF reported to be very positive.

The Dudley Group NHS Foundation Trust

Executive Summary by Exception

Key Messages

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

A&E 4 hour wait

The combined Trust and UCC performance was below target in month at 80.41%

	Attendances	Breaches	Performance
UCC/A&E Combined (Type1+3)	14487	2838	80.93%

Cancer Waits

The Trust has continued to deliver against all ten performance standards in May 2019, which is the fourth consecutive month of delivery in this area. Work continues to strengthen and sustain performance with the next area of focus to enhance the diagnostic aspects of pathways even further.

2WW

The target was achieved once again in month. During this period a total of 1266 patients attended a 2ww appointment with 68 patients attending their appointments outside of the 2 week standard, achieving a performance 94.9% against the 93% target.

Referral to Treatment (RTT)

The 18 week Referral to Treatment standards continues to be met by the Trust with the Trust exceeding the 92% target by achieving 94.80%. This month's performance is a further improved position of 0.85% from the previous month.

Diagnostic waits

The standard narrowly failed in May 2019 due to failure of equipment during the last four days of the month. Assurances have been received around June's performance and attention is now turning to July 2019 to ensure this is sustained.

The Dudley Group NHS Foundation Trust

Executive Summary by Exception cont.

Key Messages

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

Cumulative deficit of £1.780m for April-May (including PSF) and following consolidation of the pharmacy company and other technical changes. This position is £0.329m better than the control total so the Trust remains on course to achieve PSF in Q1. The forecast position shows a deficit of £5.780m in line with the base case assumptions approved by the Board. This assumes the land sale occurs and that the Trust only earns the Q1 PSF. This forecast also necessitates the identification and delivery of an additional £3.965m of CIP over and above the current plans. This position is £8.342m worse than the control total plus a further £5.493m of lost PSF resource.

Executive Summary by Exception cont.

Key Messages

Workforce — **Committee: F&P**

Staff Appraisals

The appraisal window for all non-medical appraisals is now open across the Trust and will close on the 30th June 2019.

As of the 20th May the Trust compliance rate of completed appraisals is 24% with a further 1000 appraisals to be undertaken in June. The projection rate should all booked appraisals be completed currently stands at 73.90%. However, the current rate of compliance is consistent with the same time last year and therefore it is expected that the Trust will fulfil the target of over 90% of staff appraised.

In order to support an above 90% compliance rate twice weekly reports are being provided to all managers detailing appraisals completed and booked highlighting any current gaps. The current projected compliance rates have been flagged as a risk at all Divisional meetings and will Divisional Management teams expected to demonstrate achievement within their monthly performance report. All Managers are required to focus on completing appraisals for their staff within the appraisal window.

Mandatory Training

The compliance rate has improved and continues at the stable level of 89.21%. This represents good performance without being excellent. The areas where more concentrated efforts are required are associated with Resus, manual handling and Information Governance training. In terms of staff groups the area of highest non-compliance continues to be medical staff, their compliance rate has fallen to 80.16% at the end of April. The Clinical Support Division continues to be the team with the lowest compliance rates, however they are demonstrating improvements to 86.4%.

Adult Resuscitation, Paediatric Resuscitation, and Patient Moving and Handling are below the 80% R.A.G.-rating threshold, with potential for risk in terms of appropriate response to deterioration or cardiac arrest, or potential for harm or injury through inappropriate patient handling where this knowledge and practical competence is not maintained. These three subjects are managed via the Head of Non-Medical Education and Training, has presented current and future intended actions for improvement and the Risk and Assurance Group. Conflict resolution has now reached the compliance target this month and has moved from amber to green.

Sickness Rate

The absence rate has improved from 4.77% in April 2019 to 4.69% in May. Although sickness absence has decreased the Trust sickness absence levels remain above the Trust Target. The main areas of concern associated to staff group are Care Support staff at 7.87% and nursing & midwifery staff at 4.66%.

In terms of Divisional trends, Clinical Support Services continue to demonstrate the highest levels of absence at 6.19%. Therefore, focus is being provided on particular areas of high absence to ensure efficient turnaround of absence management and therefore staff returning to work.

Turnover Rate

The turnover rate continues to represent a positive retention of our staff and currently sits at 8.25% which is consistent with the previous month. The Trust Turnover target is 8.5% and with this continued reduction the Trust target has been achieved for the first time in recent years. The Trust turnover rate is also 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 develop the action plans based on the feedback from the national staff survey.

Executive Summary by Exception cont.

Key Messages

Workforce cont. **Committee: F&P**

Recruitment/Staff in Post

The Trust 'staff in post' performance demonstrated another rise within the substantive workforce with a further 30 wte from April 2019 with the current contracted wte at 4444.59. The most significant increase has been within the Care Support staff Group with small increases in both nursing and medical staff.

In supporting our workforce plans for substantive staff then it is important that we continue to be more efficient in our recruitment process. We currently provide a 77 day timeline for recruitment of staff. The introduction of new technology supporting the recruitment process has improved our performance against this target. In addition, this will support the Trust moving towards a recruitment timeline of 50 days with work commenced to get this established.

Staff Development

The Developing Leaders programme continues to demonstrate significant success with over 140 staff now commenced or booked on the programme. It is intended that targets will be set this year that ensure we work towards all staff in a leadership role having undertaken this programme. We will also be working towards all aspirant leaders being part of the programme as a pre-requisite to their leadership role.

In terms of our use of the apprenticeship levy we are pleased that we are currently on track to achieve our end of year target of 109 apprentices. This will be supported with the Nursing Associate apprentices where the first 30 will commence in July 2019.

Staff Engagement

The recent 'Make it Happen' events have concentrated on receiving feedback from staff as part of a strategy to undertake a pulse survey to benchmark against themes from the National Staff Survey. The feedback on the whole has been extremely positive with nearly 90% of staff recommending the Trust as a place to work with almost the same proportion recommending the Trust as a place where they would recommend as a place for a friend or relative to receive care.

The publication of the NHS interim People Plan provides a national emphasis on the workforce strategy aligned to the Long term Plan. The Workforce Team will be engaging with staff to share the main elements of the Interim Plan and using this as an opportunity to develop a People Plan in the context of Dudley Group NHS Trust.

Patients will experience safe care - "At a glance"

Executive Lead: Mary Sexton

Patients will experience safe care - Quality & Experience

	Target (Amber)	Target (Green)	Apr-19	May-19	Actual YTD	Trend	Month Status
Friends & Family Test - Response Rate							
Friends & Family Test - ED	12.3%	19.4%	18.9%	19.5%	19.2%	↑	
Friends & Family Test - Inpatients	26.9%	37.0%	35.4%	36.4%	35.9%	↑	
Friends & Family Test - Maternity - Overall	21.9%	38.0%	21.6%	24.1%	22.8%	↑	
Friends & Family Test - Outpatients	4.9%	11.9%	4.0%	4.3%	4.2%	↑	
Friends & Family Test - Community	3.3%	8.1%	3.9%	4.4%	4.1%	↑	
Friends & Family Test - Percentage Recommended							
Friends & Family Test - ED	88.7%	94.5%	71.5%	71.9%	71.7%	↑	
Friends & Family Test - Inpatients	96.7%	97.4%	94.6%	95.5%	95.0%	↑	
Friends & Family Test - Maternity - Overall	97.1%	98.5%	99.5%	99.6%	99.6%	↑	
Friends & Family Test - Outpatients	95.3%	97.4%	88.9%	89.7%	89.3%	↑	
Friends & Family Test - Community	96.2%	97.7%	93.8%	92.9%	93.3%	↓	
Complaints							
Total no. of complaints received in month			50	56	106	↑	
Complaints re-opened			6	6	12	↔	
PALs Numbers			295	274	569	↓	
Complaints open at month end			188	207	-	↑	
Compliments received			424	521	945	↑	
Dementia (1 month in arrears)							
Find/Assess		90%	96.6%	-	96.6%	↑	
Investigate		90%	100.0%	-	100.0%	↑	
Refer		90%	90.9%	-	90.9%	↑	
Falls	National average 6.63 per 1000 bed days						
No. of Falls			66	72	138	↑	
Falls per 1000 bed days		6.63	3.72	4.18	3.95	↑	
No. of Multiple Falls			2	8	10	↑	
Falls resulting in moderate harm or above			0	1	1	↑	
Falls resulting in moderate harm or above per 1000 bed days		0.19	0.00	0.06	0.06	↑	
Pressure Ulcers (Grades 3 & 4)							
Hospital Avoidable		0	2	1	3	↓	
Community Avoidable		0	0	0	0	↔	
Handwash							
Handwashing			99.6%	99.7%	99.7%	↑	

Patients will experience safe care - Patient Safety

	Target (Amber)	Target (Green)	Apr-19	May-19	Actual YTD	Trend	Month Status
Mixed Sex Accommodation Breaches							
Single Sex Breaches		0	9	6	15	↓	
Mortality (Quality Strategy Goal 3)							
HSMR Rolling 12 months (**Latest data Jan 19**)	110	105	118	115	-		
SHMI Rolling 12 months (**Latest data 18/19 Q1**)	1.10	1.05	N/A	1.13	-		
HSMR Year to date (**Not available**)					-		
Infections							
Cumulative C-Diff due to lapses in care		28	1	0	0	↓	
MRSA Bacteraemia		0	0	0	0	↔	
MSSA Bacteraemia		0	1	4	5	↑	
E. Coli		0	4	2	6	↓	
Stroke (1 month in arrears)							
Stroke Admissions: Swallowing Screen		75%	91.1%	-	91.1%	↑	
Stroke Patients Spending 90% of Time on Stroke Unit		85%	91.1%	-	91.1%	↑	
Suspected High Risk TIAs Assessed and Treated <24hrs		85%	100.0%	-	100.0%	↑	
VTE - Provisional Figures							
VTE On Admission		95%	95.0%	93.8%	94.4%	↓	
Incidents							
Total Incidents			1359	1416	2775	↑	
Recorded Medication Incidents			380	0.938064	767	↓	
Never Events			1	0	1	↓	
Serious Incidents			6	2	8	↓	
of which, pressure ulcers			2	1	3	↓	
Incident Grading by Degree of Harm							
Death			0	0	0	↔	
Severe			0	1	1	↑	
Moderate			1	0	1	↓	
Low			113	171	284	↑	
No Harm			834	833	1667	↓	
Percentage of incidents causing harm		28%	38.6%	41.2%	14.6%	↑	
Safety Thermometer							
Patients with harm free care (and old harms)	-	-	97.08%	98.60%	-	↑	

Performance - "At a glance"

Executive Lead: Karen Kelly

The Dudley Group NHS Foundation Trust

Performance - Key Performance Indicators

	Target	Apr-19	May-19	Actual YTD	Trend	Month Status
Cancer Reporting - TRUST (provisional)						
All Cancer 2 week waits	93%	93.79%	95.0%	94.4%	↑	
2 week wait - Breast Symptomatic	93%	97.1%	98.7%	97.8%	↑	
31 day diagnostic to 1st treatment	96%	98.2%	96.9%	97.6%	↓	
31 day subsequent treatment - Surgery	94%	100.0%	100.0%	100.0%	↔	
31 day subsequent treatment - Drugs	94%	90.0%	100.0%	96.2%	↑	
62 day urgent GP referral to treatment	85%	87.4%	83.4%	85.5%	↓	
62 day screening programme	90%	100.0%	100.0%	100.0%	↔	
62 day consultant upgrades	85%	96.9%	86.4%	91.8%	↓	
Referral to Treatment						
RTT Incomplete Pathways - % still waiting	92%	94.0%	94.8%	94.4%	↑	
RTT Admitted - % treatment within 18 weeks	90%	85.3%	87.1%	86.2%	↑	
RTT Non Admitted - % treatment within 18 weeks	95%	95.9%	96.2%	96.1%	↑	
Wait from referral to 1st OPD	26	24	28	52	↑	
Wait from Add to Waiting List to Removal	39	41	41	82	↔	
ASI List		1913	2121	0	↑	
% Missing Outcomes RTT		0.02%	0.06%	0.0%	↑	
% Missing Outcomes Non-RTT		2.3%	5.6%	3.9%	↑	
DM01						
No. of diagnostic tests waiting over 6 weeks	0	62	81	143	↑	
% of diagnostic tests waiting less than 6 weeks	99%	99.1%	98.8%	98.9%	↓	
ED - TRUST						
Patients treated < 4 hours Type 1 & 3 (ED + UCC)	95%	78.6%	80.9%	80.9%	↑	
Emergency Department Attendances	N/A	9220	9161	18381	↓	
12 Hours Trolley Waits	0	10	0	10	↓	
Ambulance to ED Handover Time - TRUST						
15-29 minutes breaches		1776	1980	3756	↑	
30-59 minute breaches		411	338	749	↓	
60+ minute breaches		53	40	93	↓	
Ambulance to Assessment Area Handover Time - TRUST						
30-59 minute breaches		14	8	22	↓	
60+ minute breaches		1	1	2	↔	

Performance - Key Performance Indicators cont.

	Target	Apr-19	May-19	Actual YTD	Trend	Month Status
Cancelled Operations - TRUST						
% Cancelled Operations	1.0%	1.7%	1.4%	1.5%	↓	
Cancelled operations - breaches of 28 day rule	0	0	0	0	↔	
Urgent operations - cancelled twice	0	0	0	0	↔	
GP Discharge Letters						
GP Discharge Letters	90%	84.3%	59.7%	71.9%	↓	
Theatre Utilisation - TRUST						
Theatre Utilisation - Day Case (RHH & Corbett)		77.6%	78.3%	78.0%	↑	
Theatre Utilisation - Main		87.4%	87.7%	87.5%	↑	
Theatre Utilisation - Trauma		92.8%	89.5%	91.1%	↓	
GP Referrals						
GP Written Referrals - made		7098	6881	13979	↓	
GP Written Referrals - seen		5538	5608	11146	↑	
Other Referrals - Made		3556	4064	7620	↑	
Throughput						
Patients Discharged with a LoS >= 7 Days		6.20%	6.19%	6%	↓	
Patients Discharged with a LoS >= 14 Days		3.10%	3.08%	3%	↓	
7 Day Readmissions		3.0%	3.4%	3%	↑	
30 Day Readmissions - PbR		6.9%	7.6%	7%	↑	
Bed Occupancy - %		92%	86%	89%	↓	
Bed Occupancy - % Medicine & IC		95%	94%	95%	↓	
Bed Occupancy - % Surgery, W&C		88%	81%	84%	↓	
Bed Occupancy - Paediatric %		82%	45%	59%	↓	
Bed Occupancy - Orthopaedic Elective %		78%	69%	73%	↓	
Bed Occupancy - Trauma and Hip %		96%	91%	93%	↓	
Number of Patient Moves between 8pm and 8am		132	85	217	↓	
Discharged by Midday		14.3%	15.3%	15%	↑	
Outpatients						
New outpatient appointment DNA rate	8%	7.58%	8.57%	8.1%	↑	
Follow-up outpatient appointment DNA rate	8%	8.4%	7.1%	7.7%	↓	
Total outpatient appointment DNA rate	8%	8.0%	7.7%	15.7%	↓	
Clinic Utilisation		78.9%	80.3%	79.6%	↑	
Average Length of stay (Quality Strategy Goal 3)						
Average Length of Stay - Elective	2.4	2.77	2.81	2.7	↑	
Average Length of Stay - Non-Elective	3.4	5.0	4.8	5.2	↓	

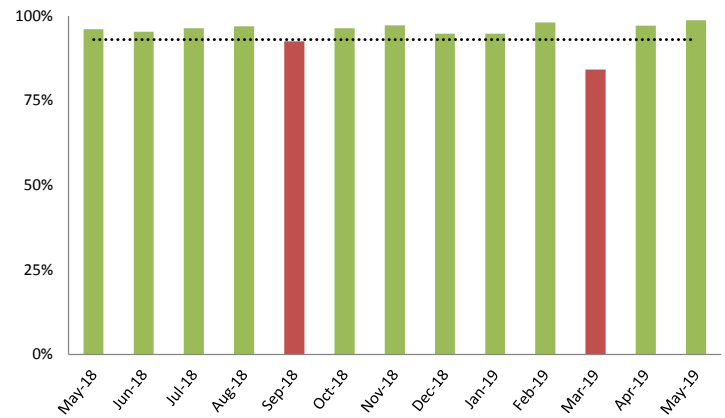
The Dudley Group NHS Foundation Trust

Performance Matters (KPIs)

Regulatory Performance - Cancer (Latest month is provisional)

All Cancer 2 Week Waits

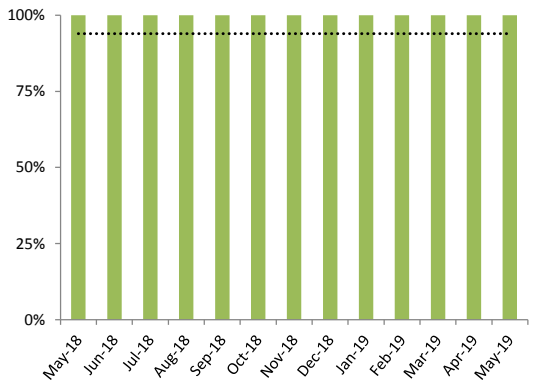
Breast Symptomatic



31 Day - Targets

31 Day Diagnostic to Treatment

31 Day Subsequent Treatment (Surgery)



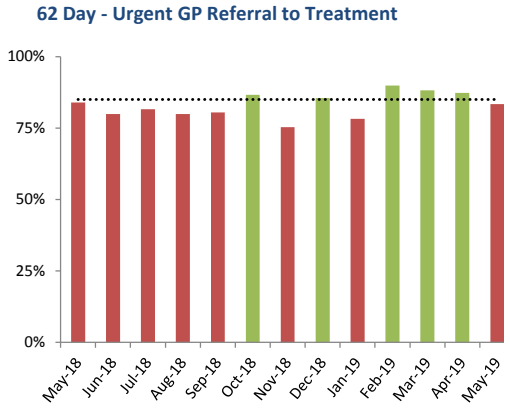
31 Day Subsequent Treatment (Drugs)

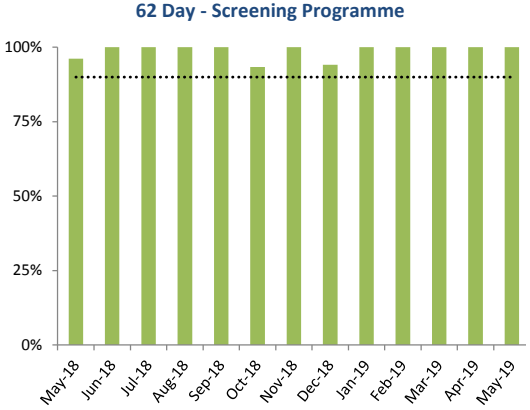
The Dudley Group NHS Foundation Trust

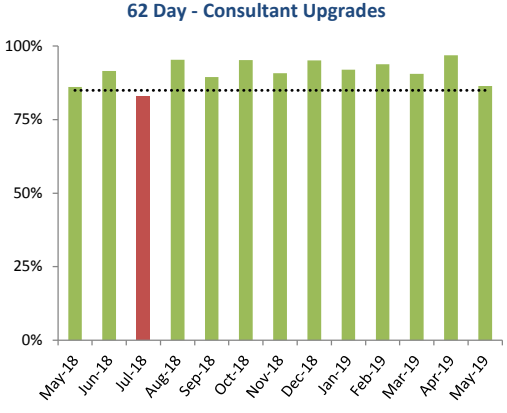
Performance Matters (KPIs)

Regulatory Performance - Cancer (Latest month is provisional)

62 Day Cancer Targets





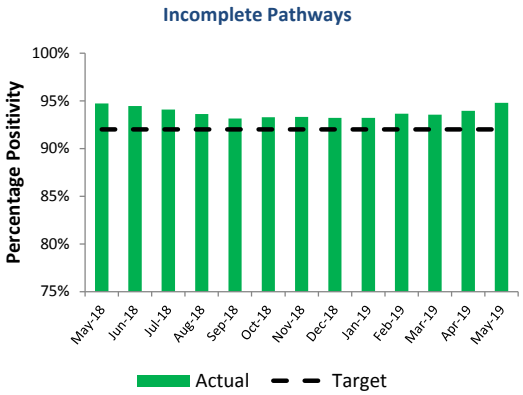


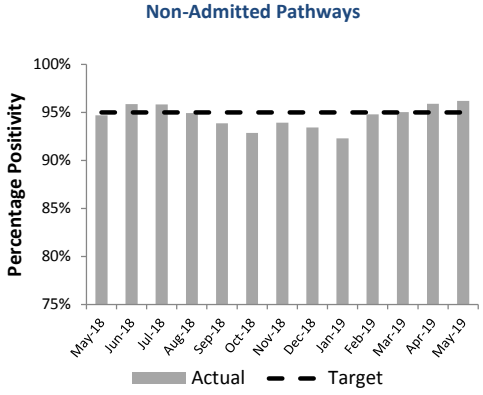
The Dudley Group NHS Foundation Trust

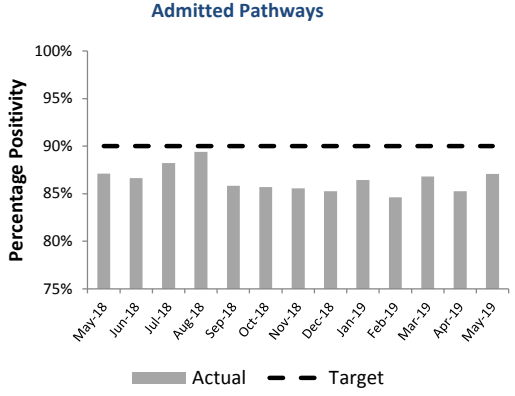
Performance Matters (KPIs)

Regulatory Performance - 18 Week Referral to Treatment

Consultant 18 Week Referral to Treatment







RTT 18 Week Performance - May 2019

Validated Position

Specialty	Incompletes - Target 92%			
	<18	>18	Total	%
100 - General Surgery	945	99	1044	90.5%
101 - Urology	1252	100	1352	92.6%
110 - Trauma & Orthopaedics	1852	135	1987	93.2%
120 - ENT	1328	21	1349	98.4%
130 - Ophthalmology	1997	228	2225	89.8%
140 - Oral Surgery	680	27	707	96.2%
160 - Plastic Surgery	797	58	855	93.2%
300 - General Medicine	5	0	5	100.0%
301 - Gastroenterology	1200	64	1264	94.9%
320 - Cardiology	591	19	610	96.9%
330 - Dermatology	912	18	930	98.1%
340 - Respiratory Medicine	389	1	390	99.7%
400 - Neurology	582	32	614	94.8%
410 - Rheumatology	667	9	676	98.7%
430 - Geriatric Medicine	101	0	101	100.0%
502 - Gynaecology	1179	61	1240	95.1%
Other	4138	149	4287	96.5%
Total	**18615**	**1021**	**19636**	**94.8%**

Comments

General Surgery

- A locum consultant commenced in May 2019 to fill a vacancy
- Strong grip to ensure the specialty utilises 23-26 theatre sessions per month

Ophthalmology

- Additional weekend lists have been secured to manage the backlog of long waiting patients
- Additional outpatient capacity has been secured to minimise patient on the Appointment Slot Issue list.

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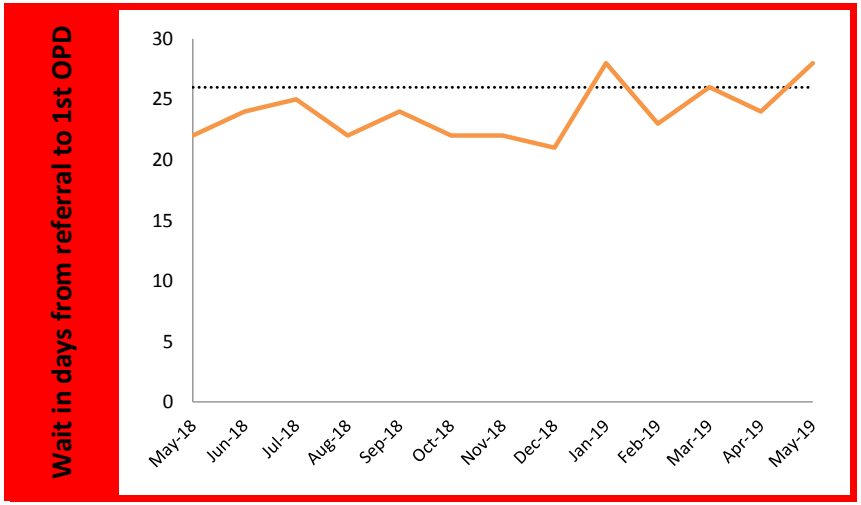
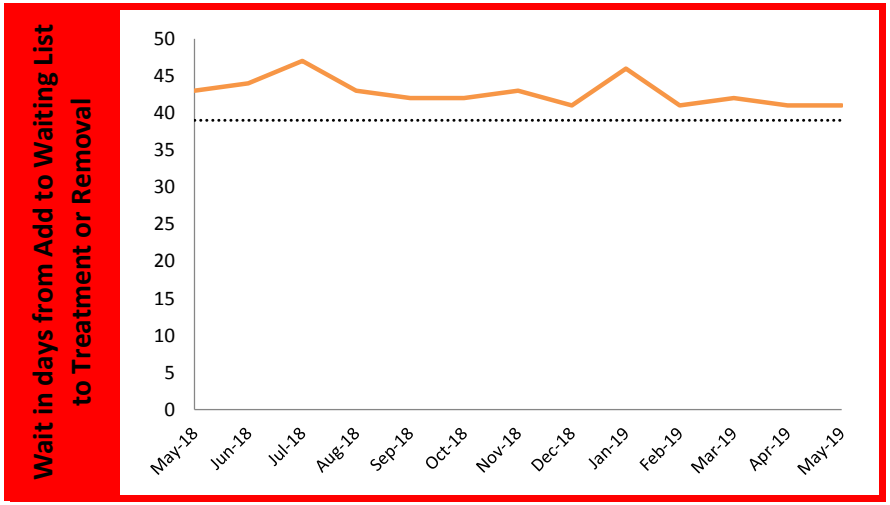
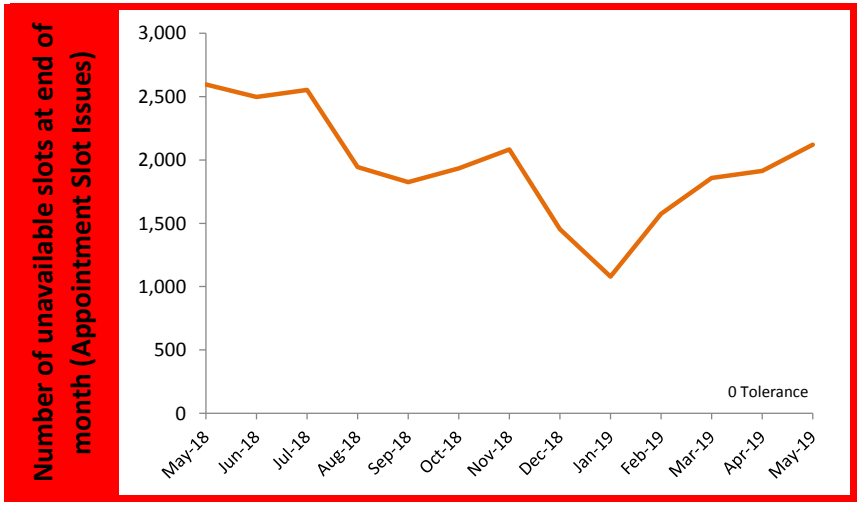
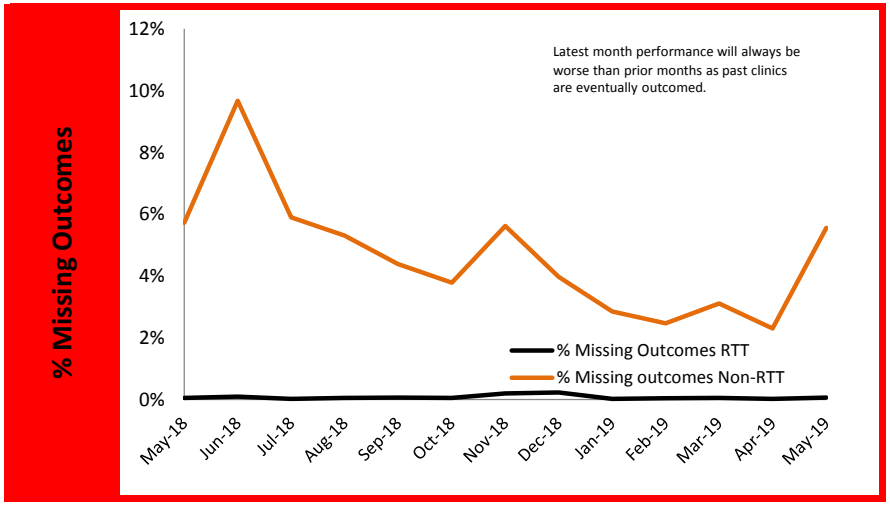
Performance Matters (KPIs)

Regulatory Performance - 18 Week Referral to Treatment









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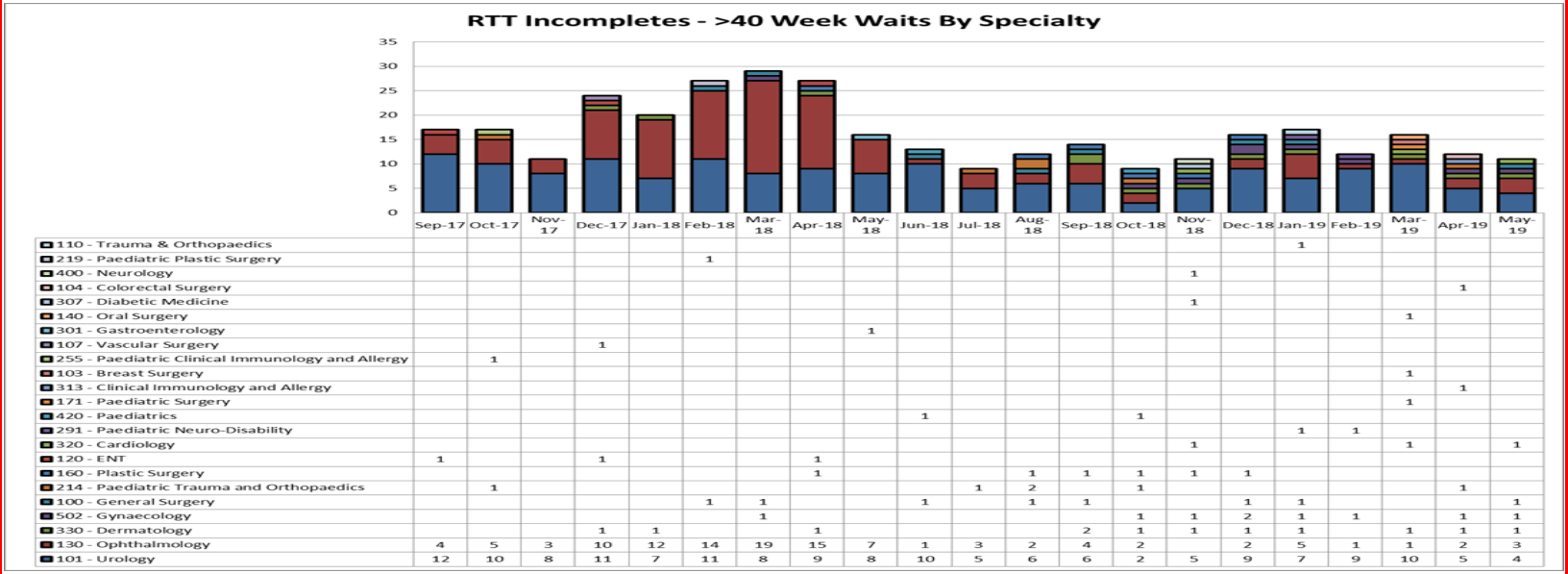
Performance Matters (KPIs)

Regulatory Performance - RTT Incompletes

RTT Incompletes by Specialty



	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19
110 - Trauma & Orthopaedics																	1				
219 - Paediatric Plastic Surgery						1															
400 - Neurology															1						
104 - Colorectal Surgery																				1	
307 - Diabetic Medicine															1						
140 - Oral Surgery																			1		
301 - Gastroenterology									1												
107 - Vascular Surgery				1																	
255 - Paediatric Clinical Immunology and Allergy		1																			
103 - Breast Surgery																			1		
313 - Clinical Immunology and Allergy																				1	
171 - Paediatric Surgery																			1		
420 - Paediatrics										1				1							
291 - Paediatric Neuro-Disability																	1	1			
320 - Cardiology															1				1		1
120 - ENT	1			1				1													
160 - Plastic Surgery								1				1	1	1	1	1					
214 - Paediatric Trauma and Orthopaedics		1									1	2		1						1	
100 - General Surgery						1	1			1		1	1			1	1				1
502 - Gynaecology							1							1	1	2	1	1		1	1
330 - Dermatology				1	1			1					2	1	1	1	1		1	1	1
130 - Ophthalmology	4	5	3	10	12	14	19	15	7	1	3	2	4	2		2	5	1	1	2	3
101 - Urology	12	10	8	11	7	11	8	9	8	10	5	6	6	2	5	9	7	9	10	5	4

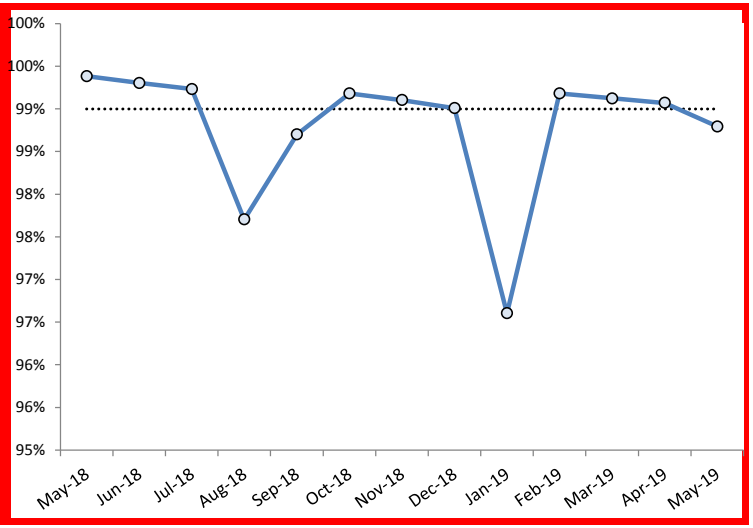
Comments

There is 0 over 52 weeks

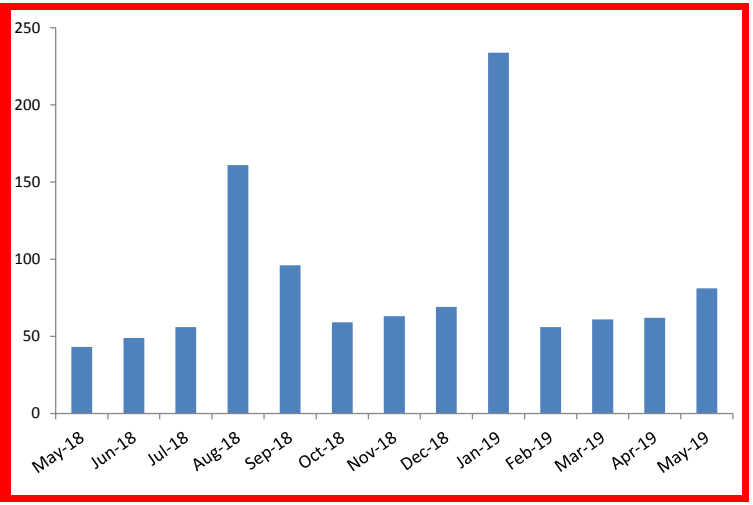
Performance Matters (KPIs)

Diagnostics

DM01 Performance



DM01 - Number of patients waiting over 6 weeks at month end (breaches)



DM01 Comments

The DM01 target was failed in May 2019 with a performance of 98.79% against the target of 99%, with the reason for failure associated with the four days of downtime (28th – 31st May 2019) of the ECG software on the Cardiac CT scanner and resulted in 19 patients being cancelled. This however was against growing backlogs for both Cardiac CT and Cardiac MRI, with good progress continuing to be made against the GA MRI backlog.

During June 2019, the Imaging department has created capacity at the Guest Outpatient Centre to allow for the backlog of Cardiac CT's to be remedied, along with further lists to reduce both the Cardiac MRI and GA MRI backlogs. At the time of writing, assurances have been received that the DM01 standard will be delivered in June 2019 and work is currently underway to review the deliverability of the capacity required for July 2019.

To put this into context this is the first time we have failed this target since January 2019 and prior to that August and September 2018. In both instances there were known one-off issues which caused the failure, i.e. failure of 1 x MRI room for 8 days. As a comparator, data published in April 2019 showed that none of the seven NHS England / NHS Improvement regions met the 99% standard, with regional performances ranging from 97.8% (Midlands) to 93.5% (South West) and a National average of 96.4%.

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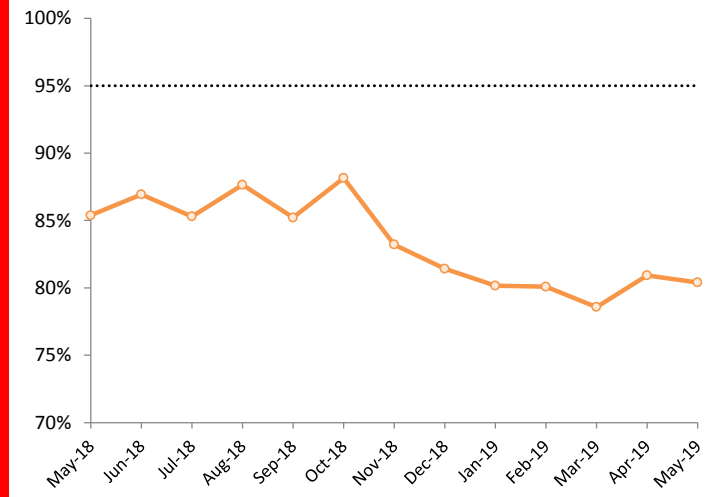
Performance Matters (KPIs)

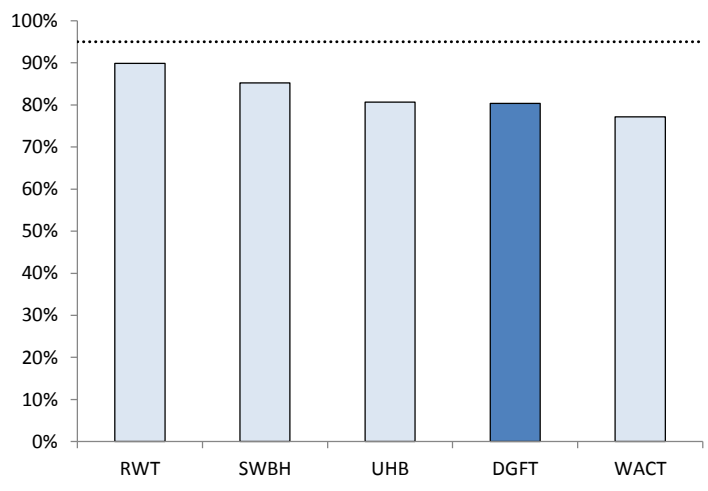
Regulatory Performance - ED

Please note: HEFT and UHB data has been merged

A&E 4 Hour Wait - Combined

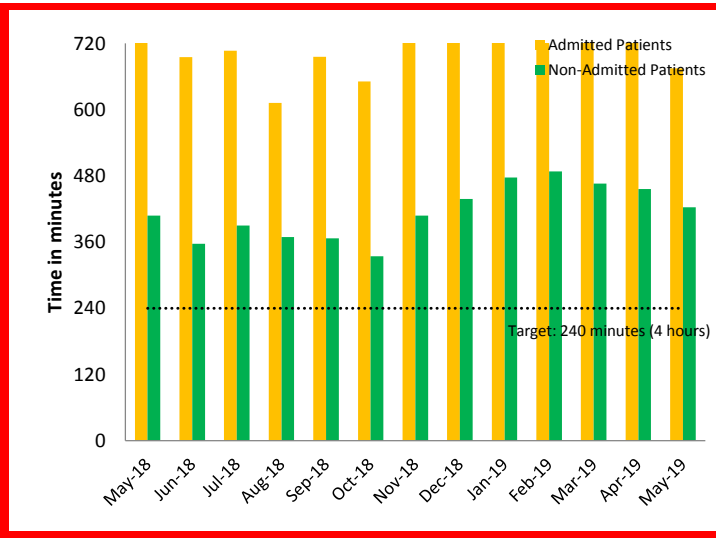


A&E 4 Hour Wait - Benchmarking



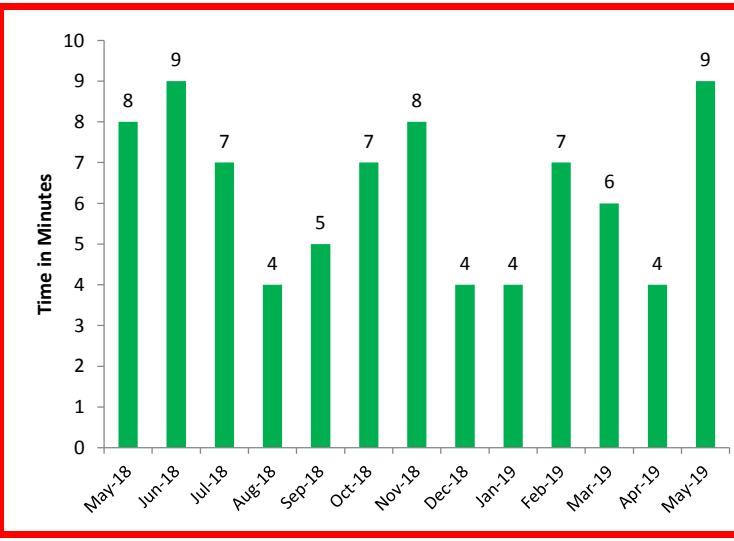
Waiting time in ED

95% of patients waited no longer than this



Waiting Time to Initial Assessment

95% of patients waited no longer than this



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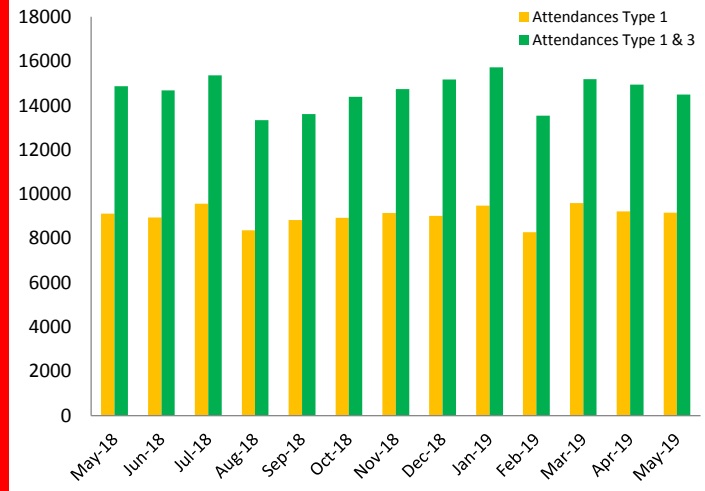
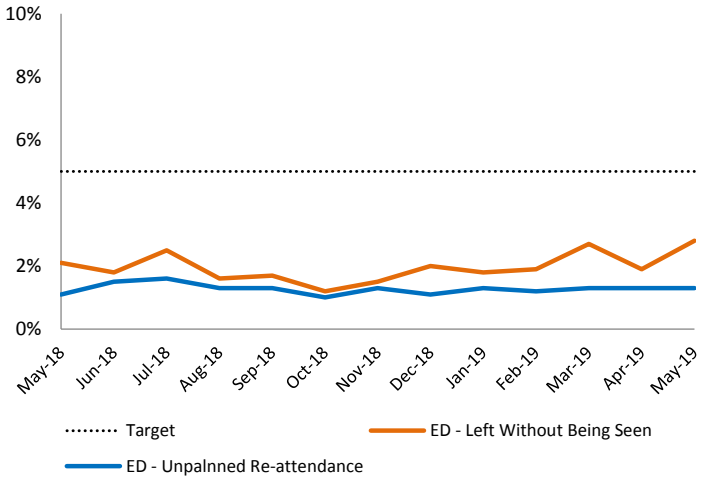
Performance Matters (KPIs)

Regulatory Performance - ED

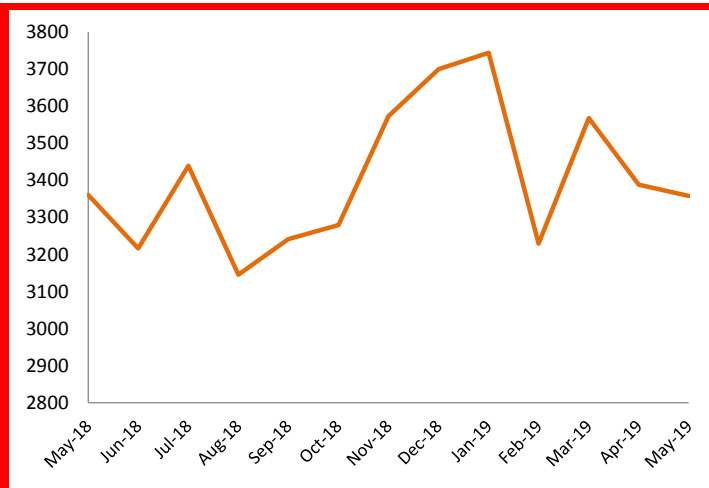
Number of Attendances



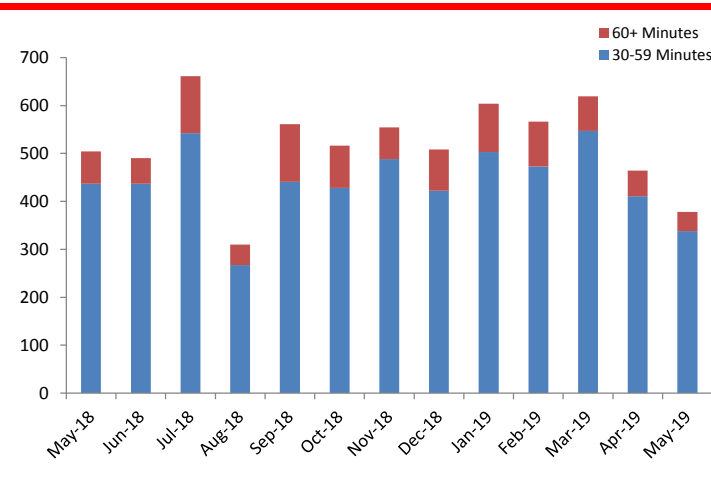
A&E Left without being seen & Unplanned Re-attendances Rates



No. of Ambulance Conveyances



Ambulance Handovers



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	504	476	-5.6%	-15	1,469	1,378	-6.2%	-91
Day Cases	3,867	3,762	-2.7%	611	12,158	13,838	13.8%	1,680
Non-elective inpatients	3,768	4,210	11.7%	-483	12,236	10,749	-12.2%	-1,487
Outpatients	43,480	40,975	-5.8%	1,067	115,593	114,578	-0.9%	-1,015
A&E	9,072	9,161	1.0%	305	25,595	26,316	2.8%	721
Total activity	**60,691**	**58,584**	-3.5%	**1,485**	**167,051**	**166,859**	-0.1%	**-192**
CIP	**£'000**	**£'000**		**£'000**	**£'000**	**£'000**		**£'000**
Income	160	217	35.6%	57	284	365	28.5%	81
Pay	279	232	-17.0%	-47	555	485	-12.5%	-70
Non-Pay	230	203	-11.5%	-27	448	368	-17.8%	-80
Total CIP	**669**	**652**	**-2.5%**	**-17**	**1,287**	**1,219**	**-5.3%**	**-68**
INCOME	**£'000**	**£'000**		**£'000**	**£'000**	**£'000**		**£'000**
NHS Clinical	30,237	29,668	-1.9%	-569	58,360	58,462	0.2%	102
Other Clinical	308	282	-8.6%	-26	616	477	-22.7%	-140
STF Funding	323	323	0.0%	0	646	646	0.0%	0
Other	1,740	1,818	4.4%	77	3,603	3,720	3.3%	117
Total income	**32,609**	**32,091**	**-1.6%**	**-518**	**63,226**	**63,305**	**0.1%**	**79**
OPERATING COSTS	**£'000**	**£'000**		**£'000**	**£'000**	**£'000**		**£'000**
Pay	-19,535	-19,442	-0.5%	93	-39,748	-39,472	-0.7%	276
Drugs	-2,936	-3,159	7.6%	-223	-5,819	-6,491	11.5%	-671
Non-Pay	-8,105	-7,858	-3.0%	247	-16,003	-15,455	-3.4%	549
Other	-1,888	-1,865	-1.2%	23	-3,764	-3,718	-1.2%	46
Total Costs	**-32,464**	**-32,324**	**-0.4%**	**140**	**-65,335**	**-65,135**	**-0.3%**	**200**

Performance - Financial Overview - TRUST LEVEL ONLY

	Month Plan	Month Actual	Variance %	Variance	Plan YTD	Actual YTD	Variance %	Variance
	£'000	**£'000**		**£'000**	**£'000**	**£'000**		**£'000**
EBITDA	**2,029**	**1,657**	**-18.3%**	**-372**	**1,647**	**1930**	**17.2%**	**283**
Depreciation	-743	-724	--2.6%	19	-1,486	-1448	--2.6%	38
Restructuring & Other	0	0	n/a	0	0	0	n/a	0
Financing Costs	-1,148	-1,146	--0.2%	2	-2,284	-2278	--0.3%	6
SURPLUS/(DEFICIT)	**138**	**-213**	**-254.3%**	**-351**	**-2,123**	**-1796**	**-15.4%**	**327**
SOFP	**£'000**	**£'000**		**£'000**	**£'000**	**£'000**		**£'000**
Capital Spend	-497	-502	1.0%	-5	-1,450	-619	-57.3%	831
Inventory					3,275	3,641	11.2%	366
Receivables & Prepayments					12,521	18,915	51.1%	6,394
Payables					-34,171	-34,595	1.2%	-424
Accruals							n/a	0
Deferred Income					-2,416	-2,979	23.3%	-563
Cash & Loan Funding	**£'000**	**£'000**		**£'000**	**£'000**	**£'000**		**£'000**
Cash					5,270	5,145	-2.4%	-125
Loan Funding							n/a	0
KPIs								
EBITDA %	7.0%	5.7%	-1.3%		0.6%	0.7%	0.1%	
Deficit %	0.5%	-0.7%	-1.2%		-0.8%	-0.7%	0.1%	
Receivable Days					0.0	0.0	n/a	
Payable (excluding accruals) Days					0.0	0.0	n/a	
Payable (including accruals) Days					0.0	0.0	n/a	
Use of Resource metric					1	3		

The Dudley Group NHS Foundation Trust

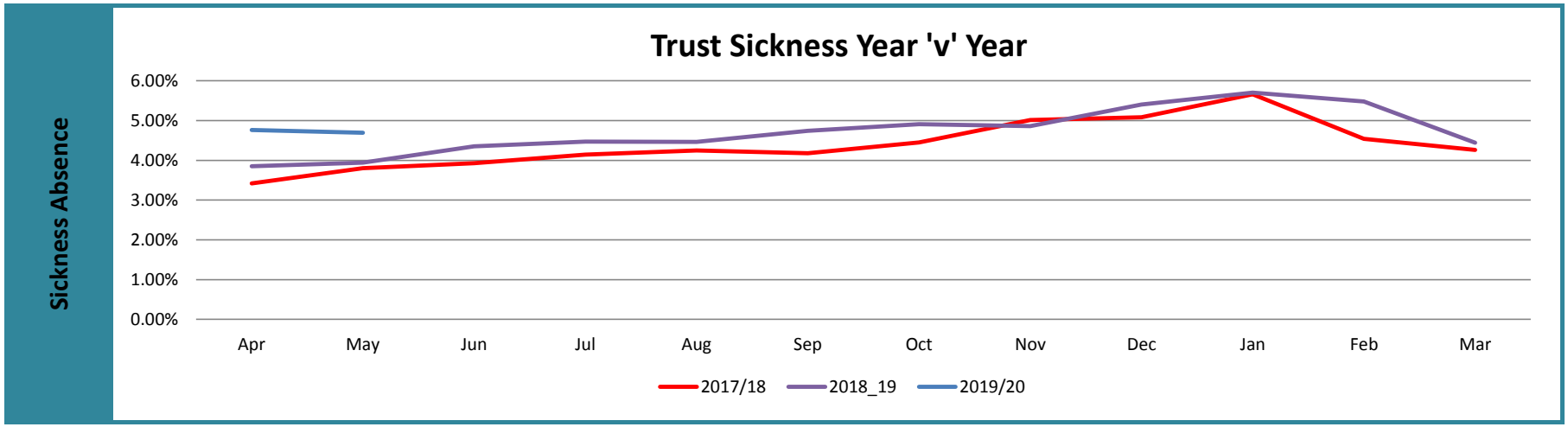
Workforce - "At a glance"

Executive Lead: Andrew McMenemy

	People					
	Target			Actual		Month
	19/20	Apr-19	May-19	YTD	Trend	Status
Workforce						
Sickness Absence Rate	3.50%	4.76%	4.69%	4.69%	↓	
Staff Turnover	8.5%	8.25%	8.25%	8.25%	↔	
Mandatory Training	90.0%	89.2%	89.9%	89.9%	↑	
Appraisal Rates - Total	90.0%	16.1%	49.7%	49.7%	↑	

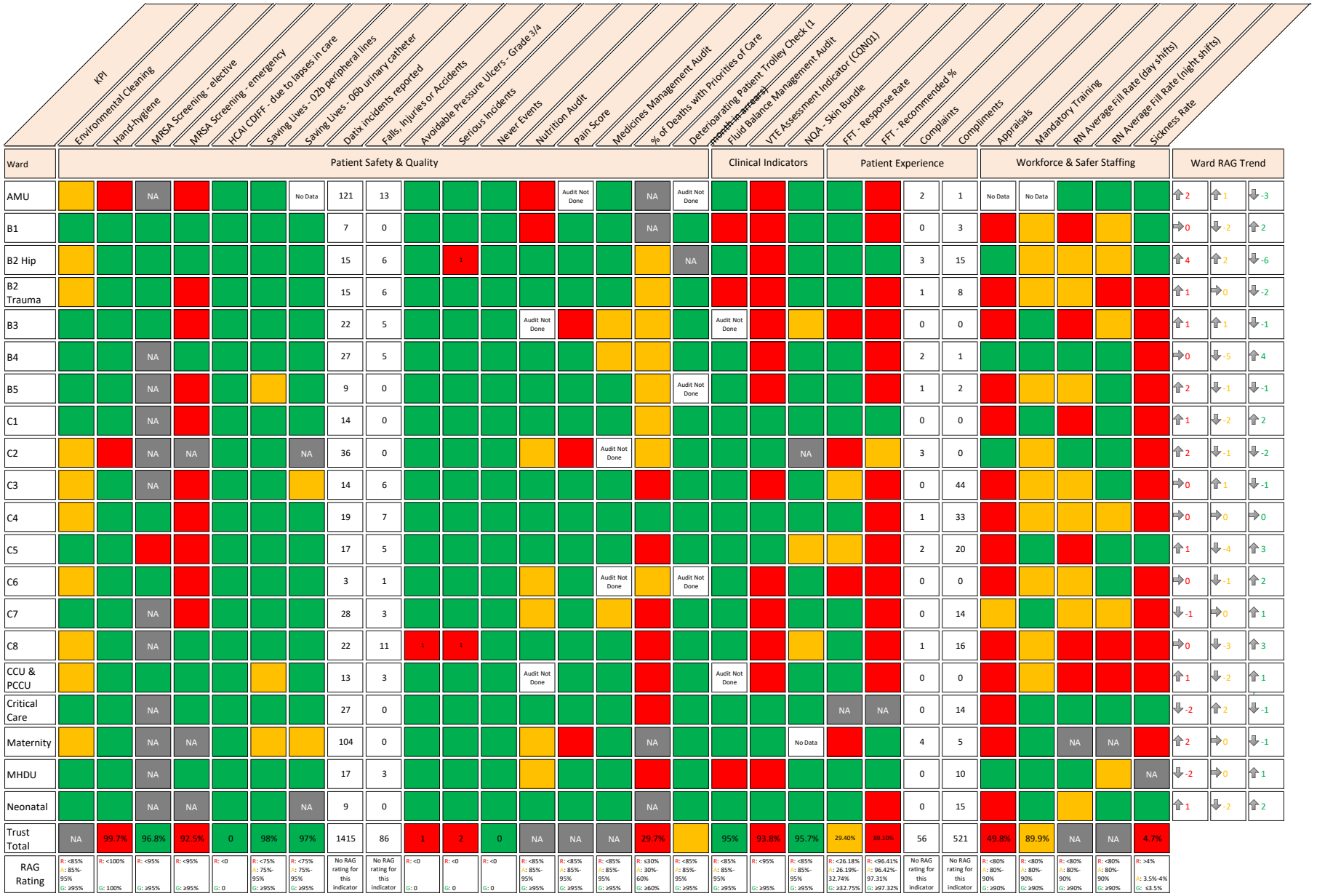
People will be proud to work for us

Workforce



Quality Indicators

Heat Map - May 2019



Ward	Patient Safety & Quality																	Clinical Indicators			Patient Experience				Workforce & Safer Staffing					Ward RAG Trend		
KPI	Environmental Cleaning	Hand-hygiene	MRSA Screening - elective	MRSA Screening - emergency	HCAI CDIFF - due to lapses in care	Saving Lives - 02b peripheral lines	Saving Lives - 06b urinary catheter	Datix incidents reported	Falls, Injuries or Accidents	Avoidable Pressure Ulcers - Grade 3/4	Serious Incidents	Never Events	Nutrition Audit	Pain Score	Medicines Management Audit	% of Deaths with Priorities of Care	Deterioarating Patient Trolley Check (1 ~~month in arrears~~)	Fluid Balance Management Audit	VTE Assessment Indicator (CQN01)	NQA - Skin Bundle	FFT - Response Rate	FFT - Recommended %	Complaints	Compliments	Appraisals	Mandatory Training	RN Average Fill Rate (day shifts)	RN Average Fill Rate (night shifts)	Sickness Rate			
AMU			NA				No Data	121	13					Audit Not Done		NA	Audit Not Done						2	1	No Data	No Data				2	1	-3
B1								7	0							NA							0	3						0	-2	2
B2 Hip								15	6		1						NA						3	15						4	2	-6
B2 Trauma								15	6														1	8						1	0	-2
B3								22	5				Audit Not Done					Audit Not Done						0	0					1	1	-1
B4			NA					27	5														2	1						0	-5	4
B5			NA					9	0								Audit Not Done						1	2						2	-1	-1
C1			NA					14	0														0	0						1	-2	2
C2			NA	NA			NA	36	0						Audit Not Done					NA				3	0					2	-1	-2
C3			NA					14	6														0	44						0	1	-1
C4								19	7														1	33						0	0	0
C5								17	5														2	20						1	-4	3
C6								3	1						Audit Not Done		Audit Not Done						0	0						0	-1	2
C7			NA					28	3														0	14						-1	0	1
C8			NA					22	11	1	1												1	16						0	-3	3
CCU & PCCU								13	3				Audit Not Done					Audit Not Done						0	0						1	-2	1
Critical Care			NA					27	0												NA	NA	0	14						-2	2	-1
Maternity			NA	NA				104	0							NA				No Data			4	5			NA	NA		2	0	-1
MHDU			NA					17	3														0	10					NA	-2	0	1
Neonatal			NA	NA			NA	9	0							NA							0	15						1	-2	2
Trust Total	NA	99.7%	96.8%	92.5%	0	98%	97%	1415	86	1	2	0	NA	NA	NA	29.7%		95%	93.8%	95.7%	29.40%	89.10%	56	521	49.8%	89.9%	NA	NA	4.7%			
RAG Rating	R: <85% A: 85%-95% G: ≥95%	R: <100% G: 100%	R: <95% G: ≥95%	R: <95% G: ≥95%	R: <0 G: 0	R: <75% A: 75%-95% G: ≥95%	R: <75% A: 75%-95% G: ≥95%	No RAG rating for this indicator	No RAG rating for this indicator	R: <0 G: 0	R: <0 G: 0	R: <0 G: 0	R: <85% A: 85%-95% G: ≥95%	R: <85% A: 85%-95% G: ≥95%	R: <85% A: 85%-95% G: ≥95%	R: ≤30% A: 30%-60% G: ≥60%	R: <85% A: 85%-95% G: ≥95%	R: <85% A: 85%-95% G: ≥95%	R: <95% G: ≥95%	R: <85% A: 85%-95% G: ≥95%	R: <26.18% A: 26.19%-32.74% G: ≥32.75%	R: <96.41% A: 96.42%-97.31% G: ≥97.32%	No RAG rating for this indicator	No RAG rating for this indicator	R: <80% A: 80%-90% G: ≥90%	R: <80% A: 80%-90% G: ≥90%	R: <80% A: 80%-90% G: ≥90%	R: <80% A: 80%-90% G: ≥90%	R: >4% A: 3.5%-4% G: ≤3.5%			

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)	74.15%	69.44%	69.02%	-	-	-	-	-	-	-	-	-	-	69.23%	%
A&E - 4 Hour UCC Dept Only % (Type 3)	99.69%	99.45%	100.00%	-	-	-	-	-	-	-	-	-	-	99.71%	%
A&E - 4 Hour UCC/A&E Combined % (Type 1+3)	83.96%	80.93%	80.41%	-	-	-	-	-	-	-	-	-	-	80.67%	95%
A&E - Patients who Left Without Being Seen %	1.9%	1.9%	2.8%	-	-	-	-	-	-	-	-	-	-	2.3%	5%
A&E - Time to Initial Assessment (95th Percentile)	6	4	9	-	-	-	-	-	-	-	-	-	-	9	15
A&E - Time to Treatment Median Wait (Minutes)	94	68	80	-	-	-	-	-	-	-	-	-	-	80	60
A&E - Total Time in A&E (95th Percentile)	732	743	526	-	-	-	-	-	-	-	-	-	-	526	240
A&E - Unplanned Re-Attendance Rate %	1.3%	1.3%	1.3%	-	-	-	-	-	-	-	-	-	-	1.3%	5%
Activity - A&E Attendances	107,524	9,222	9,089	-	-	-	-	-	-	-	-	-	-	18,311	17,207
Activity - Cancer MDT	5,960	508	559	-	-	-	-	-	-	-	-	-	-	1,067	1,074
Activity - Community Attendances	426,917	35,512	37,478	-	-	-	-	-	-	-	-	-	-	72,990	70,089
Activity - Critical Care Bed Days	8,211	654	686	-	-	-	-	-	-	-	-	-	-	1,340	1,455
Activity - Diagnostic Imaging whilst Out-Patient	54,126	4,475	4,553	-	-	-	-	-	-	-	-	-	-	9,028	9,656
Activity - Direct Access Pathology	2,140,369	187,105	196,682	-	-	-	-	-	-	-	-	-	-	383,787	346,221
Activity - Direct Access Radiology	76,758	6,366	6,422	-	-	-	-	-	-	-	-	-	-	12,788	13,060
Activity - Elective Day Case Spells	49,959	3,783	3,762	-	-	-	-	-	-	-	-	-	-	7,545	7,489
Activity - Elective Inpatients Spells	5,469	448	476	-	-	-	-	-	-	-	-	-	-	924	973
Activity - Emergency Inpatient Spells	43,701	3,643	4,209	-	-	-	-	-	-	-	-	-	-	7,852	7,252
Activity - Excess Bed Days	8,242	966	424	-	-	-	-	-	-	-	-	-	-	1,390	1,952
Activity - Maternity Pathway	7,361	588	539	-	-	-	-	-	-	-	-	-	-	1,127	1,161
Activity - Neo Natal Bed Days	7,236	122	106	-	-	-	-	-	-	-	-	-	-	228	208
Activity - Outpatient First Attendances	171,763	15,941	15,287	-	-	-	-	-	-	-	-	-	-	31,228	29,062
Activity - Outpatient Follow Up Attendances	324,962	27,211	26,951	-	-	-	-	-	-	-	-	-	-	54,162	58,084
Activity - Outpatient Procedure Attendances	73,394	5,497	6,943	-	-	-	-	-	-	-	-	-	-	12,440	12,290
Activity - Rehab Bed Days	22,862	1,592	2,499	-	-	-	-	-	-	-	-	-	-	4,091	3,431
Activity - Renal Dialysis	49,399	4,166	4,325	-	-	-	-	-	-	-	-	-	-	8,491	8,447
Ambulance Handover - 30 min – breaches (DGH view)	5,165	411	338	-	-	-	-	-	-	-	-	-	-	749	0
Ambulance Handover - 30 min – breaches (WMAS view)	6,669	545	454	-	-	-	-	-	-	-	-	-	-	999	0
Ambulance Handover - 60 min – breaches (DGH view)	916	53	40	-	-	-	-	-	-	-	-	-	-	93	0
Ambulance Handover - 60 min – breaches (WMAS view)	1,071	65	47	-	-	-	-	-	-	-	-	-	-	112	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	95.0%	93.8%	94.9%	-	-	-	-	-	-	-	-	-	-	94.3%	93%
Cancer - 14 day - Urgent GP Breast Symptom Referral to date first seen	94.5%	97.1%	98.7%	-	-	-	-	-	-	-	-	-	-	97.8%	93%
Cancer - 31 day - from diagnosis to treatment for all cancers	98.4%	98.2%	97.0%	-	-	-	-	-	-	-	-	-	-	97.6%	96%
Cancer - 31 Day For Second Or Subsequent Treatment - Anti Cancer Drug Treatments	100%	90%	100%	-	-	-	-	-	-	-	-	-	-	96.5%	98%
Cancer - 31 Day For Second Or Subsequent Treatment - Surgery	100.0%	100%	100%	-	-	-	-	-	-	-	-	-	-	100%	94%
Cancer - 31 Day For Subsequent Treatment From Decision To Treat	100.0%	97%	100%	-	-	-	-	-	-	-	-	-	-	99%	96%
Cancer - 62 day - From Referral for Treatment following a Consultant Upgrade	91.4%	96.8%	87.2%	-	-	-	-	-	-	-	-	-	-	92.0%	85%
Cancer - 62 day - From Referral for Treatment following national screening referral	98.1%	100.0%	100.0%	-	-	-	-	-	-	-	-	-	-	100%	90%
Cancer - 62 day - From Urgent GP Referral to Treatment for All Cancers	82.8%	87.3%	84%	-	-	-	-	-	-	-	-	-	-	86%	85%
Maternity: Breastfeeding Data Coverage Rates	100%	100%	100%	-	-	-	-	-	-	-	-	-	-	100%	0%
Number of Births Within the Trust	4,315	348	343	-	-	-	-	-	-	-	-	-	-	691	
RTT - Admitted Pathways within 18 weeks %	86.3%	85.2%	87%	-	-	-	-	-	-	-	-	-	-	86.1%	90%
RTT - Incomplete Waits within 18 weeks %	94%	93.9%	95%	-	-	-	-	-	-	-	-	-	-	94.3%	92%
RTT - Non-Admitted Pathways within 18 weeks %	94.5%	95.8%	96.20%	-	-	-	-	-	-	-	-	-	-	96.0%	95%
Waiting Time - Diagnostic 6 Week Maximum Wait (VSA05)	98.82%	99.06%	98.8%	-	-	-	-	-	-	-	-	-	-	98.93%	99%

The Dudley Group NHS Foundation Trust

Staff/HR

Finance Dashboard

Finance															
Description	LYO	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	YTD	Target
Agency spend	£13,550k	£1,221k	£1,146k	-	-	-	-	-	-	-	-	-	-	£2,366k	k
Bank spend	£20,035k	£1,673k	£1,651k	-	-	-	-	-	-	-	-	-	-	£3,324k	k
Budgetary Performance	(£13,226)k	£657k	(£378)k	-	-	-	-	-	-	-	-	-	-	£279k	£0k
Capital v Forecast	88.1%	12.3%	40.2%	-	-	-	-	-	-	-	-	-	-	40.2%	95%
Cash Balance	£8,928k	£7,005k	£5,154k	-	-	-	-	-	-	-	-	-	-	£5,154k	k
Cash v Forecast	64.9%	87.4%	97.8%	-	-	-	-	-	-	-	-	-	-	97.8%	95%
Creditor Days	22.7	19.7	20.3	-	-	-	-	-	-	-	-	-	-	20.3	15
Debt Service Cover	0.8	0.08	0.61	-	-	-	-	-	-	-	-	-	-	0.61	2.5
Debtor Days	8.6	13.2	13.2	-	-	-	-	-	-	-	-	-	-	13.2	15
I&E (After Financing)	(£4,987)k	(£1,597)k	(£233)k	-	-	-	-	-	-	-	-	-	-	(£1,830)k	k
Liquidity	-15.65	-12.66	-13.44	-	-	-	-	-	-	-	-	-	-	-13.44	0
SLA Performance	£3,277k	(£107)k	(£556)k	-	-	-	-	-	-	-	-	-	-	(£663)k	£0k

Staff/HR Dashboard

Staff/HR															
Description	LYO	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	YTD	Target
Appraisals	95.6%	16.1%	49.7%	-	-	-	-	-	-	-	-	-	-	49.7%	90%
Mandatory Training	88.8%	89.2%	89.9%	-	-	-	-	-	-	-	-	-	-	89.9%	90%
RN average fill rate (DAY shifts)	81.83%	85.42%	87.35%	-	-	-	-	-	-	-	-	-	-	86.34%	95%
RN average fill rate (NIGHT shifts)	86.43%	88.14%	90.74%	-	-	-	-	-	-	-	-	-	-	89.36%	95%
Sickness Rate	4.66%	4.76%	4.69%	-	-	-	-	-	-	-	-	-	-	4.72%	3.50%
Staff In Post (Contracted WTE)	4,397.87	4,402.30	4,432.72	-	-	-	-	-	-	-	-	-	-	4,432.72	
Turnover Rate (Rolling 12 Months)	8.48%	8.25%	-	-	-	-	-	-	-	-	-	-	-	8.25%	%
Vacancy Rate	9.35%	13.82%	13.49%	-	-	-	-	-	-	-	-	-	-	13.49%	%

Enclosure 22

The Dudley Group
NHS Foundation Trust

Paper for submission to the Board of Directors on 4 July 2019

TITLE:	**Finance and Performance Committee Exception Report**		
AUTHOR:	Tom Jackson Director of Finance	**PRESENTER:**	Jonathan Hodgkin F & P 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 / COMMITTEE / GROUP:

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

CORPORATE OBJECTIVE:

S05 Make the best use of what we have
S06 Plan for a viable future

SUMMARY OF KEY ISSUES:

Summary report from the Finance and Performance Committee meeting held on 27 June 2019.

IMPLICATIONS OF PAPER:

RISK	Y		**Risk Description:**
	Risk Register: Y		**Risk Score:** 20
COMPLIANCE and/or LEGAL REQUIREMENTS	**CQC**	**Y**	**Details:** Well Lead
	NHSI	**Y**	**Details:** Achievement of Financial Plan
	Other	**N**	**Details:**

The Dudley Group NHS Foundation Trust

UPWARD REPORT FROM FINANCE AND PERFORMANCE COMMITTEE

Date Committee last met: 27 June 2019

MATTERS OF CONCERN OR KEY RISKS TO ESCALATE

- Delivery of Q2 financial plans, in particular unidentified CIP
- Likelihood of requirement of cash borrowing in Sept

MAJOR ACTIONS COMMISSIONED/WORK UNDERWAY

- Review BAF 6a – health economy engagement
- Proactive management of CQUIN risk required
- Divisional benefit realisation reviews to be carried out by Divisions and summary reported to F & P

POSITIVE ASSURANCES TO PROVIDE

- Cyber-security – CareCert CC3057 (HIGH) 15th May 19. Mitigated. Zero impact. Status: updated on central National CareCert portal. Linked NHSD 3rd- Party Patch survey completed
- Successful Sunrise GoLive: Emergency Department and Trust wide orders, results management (ORM) 15th May 2019. This GoLive controlled clinical risks of dual systems and mitigating the corporate risk of Soarian failure

DECISIONS MADE

- F & P to receive benefits realisation reviews for business cases approved by the Committee
- Approved re-establishment of Workforce and Staff Engagement Committee
- Agreed that pension risk should be managed on the Corporate Risk Register and not on BAF
- Agreed that for BAF 3a, 4a, 4b, 4c, assurance rating should be reduced from acceptable to partial

Chair's comments on the effectiveness of the meeting:

Informative Divisional presentation received from Surgery and Women & Children, which enabled detailed discussion on risk and opportunities

Good valuable discussion on BAF and Corporate Risk Register

Enclosure 23

The Dudley Group
NHS Foundation Trust

Paper for submission to the Board 4 July 2019

TITLE:	**Trust Constitution**		
AUTHOR:	Gilbert George – Interim Director of Governance	**PRESENTER**	Gilbert George – Interim Director of Governance

CLINICAL STRATEGIC AIMS

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

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

- To note that the Council of Govenors at its 27 June meeting approved the updates to the Trust Constitution.
- The updated Constitution will be made available to members at the Members Annual meeting, 18 July.

CORPORATE OBJECTIVES:

SO1: Deliver a great patient experience

SO2: Safe and Caring Services

SO3: Drive service improvements, innovation and transformation

SO4: Be the place people choose to work

SO5: Make the best use of what we have

SO6: Deliver a viable future

SUMMARY OF KEY ISSUES:

No major issues to note.

The constitution has been reviewed and updated following board discussion in March and June 2019 and updates were approved by the Council of Govenors at its 27 June meeting.

The updates reflects current best practise in the following sections:

- Conflicts of interest
- Council of Governors duties
- Annex 11 Reservation of powers and scheme of delegation (approved by the Finance performances Committee)
- Annex 12 Annual Members meeting

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 D… NHS Foundation Trust

Enclosure 24

Paper for submission to the Board of Directors on 4 July 2019

TITLE:	**Charitable Funds Committee Summary Report**		
AUTHOR:	Julian Atkins - Committee Chair	**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**
			Y

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 contents of the report.

CORPORATE OBJECTIVE:

S01 – Deliver a great patient experience
S05 – Make the best use of what we have

SUMMARY OF KEY ISSUES:

Summary of key issues discussed and approved at the Charitable Funds Committee on 30 May 2019.

IMPLICATIONS OF PAPER:

RISK	**N**		**Risk Description:**
	Risk Register: N		**Risk Score:**
COMPLIANCE and/or LEGAL REQUIREMENTS	**CQC**	**N**	**Details:**
	NHSI	**N**	**Details:**
	Other	**Y**	**Details:** Charity Commission

The Dudley Group NHS Foundation Trust

UPWARD REPORT FROM CHARITABLE FUNDS COMMITTEE

Date Committee last met: 30 May 2019

MATTERS OF CONCERN OR KEY RISKS TO ESCALATE

- Attendance at the meeting was poor and the meeting was not quorate at the beginning. Committee membership details do not seem to have been communicated following recent changes. This has now been addressed.

MAJOR ACTIONS COMMISSIONED/WORK UNDERWAY

- It was reported that the Baby Bereavement Appeal raised over £60,000 and that the allocated room is in the process of being renovated.
- The Committee were informed that over 100 participants had registered for the 'Neon Dash' on the 9th June.
- It was reported that plans are underway to launch the £100,000 appeal to support the Emergency Department.

POSITIVE ASSURANCES TO PROVIDE

- Total fund balances at the end of April 2019 stood at £2.192m. Income for April was £25,035 whilst expenditure was £20,382.
- The balance available to spend across the general funds totalled £117,426.
- The Charitable Funds financial statements and Annual report for 2018/2019 were presented. Total income received was £666,000 whilst total expenditure was £527,000. Fund balances at the year end were £2.188m. It was noted that these documents had been approved at the May Audit Committee.
- The Committee discussed the Committee Effectiveness Review and agreed that no changes to the Committee's Terms of Reference were required.

DECISIONS MADE

- Two bids were received and approved:
  - A two year Schwarz Rounds Licence to provide a structured forum for all staff to discuss emotional and social aspects of working in healthcare - £4,450.
  - Participation in the 2019 cohort project ChloeQuIC-ER to launcn new pathways to reduce time to urgent Cholecystectomy for eligible patients with acute biliary pain, cholecystitis or gallstone pancreatitis - £8,000.

Chair's comments on the effectiveness of the meeting:

Whilst the meeting was quorate and appropriate decisions were made, attendance was poor and must be improved for future meetings to ensure that there is effective discussion and decision making.

Enclosure 25

The Dudley Group NHS Foundation Trust

Paper for submission to Board 4 July 2019

TITLE:	**The Workforce and Staff Engagment Group to be re-established as a Commitee of the Board.**		
AUTHOR:	**Gilbert George – Interim Director of Governance**	**PRESENTER**	**Gilbert George – Interim Director of Governance**

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

ACTION REQUIRED OF COMMITTEE:			
Decision	**Approval**	**Discussion**	**Other**
	X	**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

- Re-establish the Workforce and Staff Engagment Group as a Committee of the board, to be known as the Workforce and Staff Engagment Committee
- Aprrove Workforce and Staff Engagment Committee subjcet to further review

CORPORATE OBJECTIVE:

SO5: Make the best use of what we have
SO6: Deliver a viable future

SUMMARY OF KEY ISSUES:

Temporary measures were put in place following NED's vacancies in March which included the Workforce and Staff Engagement Committee becoming a working group chaired by an Executive Director reporting to the Finance and Performance Committee.

With the appointment of a Non-Executive Director and an Associate Non-Executive Director in June, the capacity of NEDs to chair board committees will now increase.

The Trust Chair has recommended that the Workforce and Staff Engagement Group be re-

established as a Committee of the board and be known as the Workforce and Staff Engagement Committee chaired by a nominated NED.

The Finance and Performance Committee at its meeting on 27 June 2019 endorsed the recommendation from the Trust Chair to re- establish the Workforce and Staff Engagement Committee.

The Terms of Reference of the Workforce and Staff Engagement Committee have been amended to reflect these changes and are here presented for comment and approval.

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

WORKFORCE AND STAFF ENGAGEMENT COMMITTEE

TERMS OF REFERENCE

1. Constitution

The Workforce and Staff Engagement Committee is a committee of the board and chaired by a Non-Executive Director.

2. Membership

Non Executive Director (Chair)
Non Executive or Associate Director (Deputy Chair)
Director of Workforce & OD
(Medical Director (or Deputy)
Chief Operating Officer (or deputy)
Chief Nurse (or deputy)
Director of Operations Medicine and Integrated Care (or Chief of Medicine)
Director of Operations Surgery and Women and Children (or Chief of Surgery)
Director of Operations Support Services (or Chief of Support Services)
Director of Governance (or deputy)
Head of Human Resources
Head of Learning & Organisational Development
Head of Communications
Head of Medical Education
Head of Non-Medical Education
Allied Health Professional Lead

3. Attendance

3.1 In attendance
Health, Safety and Fire Manager
Staff Side Chair
Board Secretary

3.2 Other managers/staff may be required to attend meetings depending upon issues under discussion. The Committee has the power to co-opt, or to require to attend, any member of Trust staff, as necessary and to commission input from external advisors as agreed by the Chair

3.3 The Director of Workforce & OD will ensure that an efficient secretariat service is provided to the Committee.

4. Quorum

4.1 A quorum will consist of three members including the Chair (or designated deputy) and one Executive Director (voting or non-voting member) of the Trust Board

5. Frequency of meetings

5.1 The Committee will meet no less than 6 times during the year and members will attend at least half of the meetings in the year.

5.2 The Agenda will be circulated with papers 7 days before the meeting.

5.3 Additional meetings may be held at the discretion of the Chair of the Committee.

6. Authority

6.1 The purpose of the Committee is to provide the Board with assurance concerning all aspects of workforce and organisational development relating to the provision of care and services in support of getting the best clinical outcomes and experience for patients and staff; challenging assumptions and decisions as necessary and holding senior staff to account.

6.2 The Committee will ensure the completion of the workforce strategy and the key strategic initiatives to deliver it and will approve the workforce plan element of each year's planning submission to NHSI.

6.3 The Committee is authorised by the Board to investigate any activity within its Terms of Reference and is expected to make recommendations to the full Board. It is authorised to seek any information it requires from any employee and all employees are directed to co-operate with any request made by the Committee.

6.4 The Committee is authorised by the Board to obtain outside legal or other independent professional advice and to secure the attendance of others from outside the Trust with relevant experience and expertise, if it considers it necessary. This authority will only be used in exceptional circumstances and prior approval of the Board is required.

6.5 The Committee has no executive powers other than those specifically delegated in these Terms of Reference.

7. Duties and Key Responsibilities

7.1 Review and monitor the workforce strategy, applying challenge where necessary to ensure the delivery of the underlying plan on workforce issues including the efficient deployment of staffing to meet service requirements.

7.2 To receive details of workforce planning priorities that arises from the annual business planning process. To obtain assurance that the identified workforce priorities are addressed, challenged as necessary and progress against identified action is monitored.

7.3 To review the establishment and maintenance of an effective system of Human Resources and Workforce Planning across the whole of the organisation's activities (both clinical and non-clinical) that supports the achievement of the organisation's strategic and operational objectives.

7.4 The Committee shall review Workforce priorities, Workforce Planning, Learning and Development and Staff Engagement to ensure adequate evaluation and monitoring within the Trust and to ensure local and national priorities are being addressed and that the Trust's ability to recruit, retain and develop its workforce is adequately supported.

7.5 To review, challenge and agree progress against the workforce key performance indicators with specific responsibility for the monitoring of staff appraisals and compliance with mandatory training.

7.6 To approve the annual workforce data prior to submission to NHSI.

7.7 To receive and discuss key strategic risks relating to workforce and employment practice; to consider, challenge as necessary and monitor plans for mitigation, to maintain the risk at the lowest realistic level and to advise the Board as appropriate.

7.8 To receive regular reports, on Organisational Development including leadership capability and to review and challenge progress as necessary.

7.9 To ensure that feedback from the National and other Staff Surveys is appropriately analysed, reported and actions identified and taken. To specifically receive, analyse and ensure feedback is available and provided to the organisation and the Trust Board in relation to local staff survey results; ensuring appropriate actions are identified and monitored.

7.10 To oversee the development and implementation of a comprehensive education and training strategy to include corporate learning and development requirements associated to the Local Workforce Action Board (LWAB).

7.11 To receive, discuss, challenge as necessary regular reports relating to medical and non-medical education priorities and plans, ensuring they reflect Trust priorities and that actions are monitored.

7.12 To oversee the development and implementation of the Equality and Diversity Strategy; in relation to workforce, ensuring identified actions are monitored and challenged as appropriate.

7.13 Review local population demography to allow meaningful comparisons with the Trust's existing workforce and inform the development of action plans as deemed appropriate.

7.14 To oversee, monitor and challenge as necessary the development and implementation of the Health and Wellbeing Strategy.

7.15 To oversee the development and implementation of the Trust's Staff Engagement Strategy; specifically monitoring and challenging as necessary the development and implementation of plans to address the priorities identified for meaningful staff engagement and partnership working across the Trust.

7.16 To monitor compliance with CQC standards that relate to employment ensuring completion of actions.

7.17 To oversee the adequacy of arrangements for the management of and compliance with the Health and Safety at Work Act 1974 and subsequent amendments including the reporting of non-clinical workforce related incidents and RIDDORS. To specifically receive reports and to provide detail to the Trust Board of the key themes and actions taken in response to non-clinical workforce related RIDDOR incidents

8. Policies

8.1 The Committee will receive notification of policies on subjects related to the Committees terms of reference for final ratification.

9. Reporting

9.1 The Committee reports to the Board. The Committee shall make whatever recommendations to the Board it deems appropriate on any area within its remit where action or improvement is needed or where it has significant concerns for escalation to the Board.

9.2 The committee will receive the following reports:

- Local Education and Training Committee (LWAB)

9.3 The minutes of the meetings of the Committee shall be received by Board members. The Committee shall carry out a self-assessment in relation to its own performance annually reporting the results to the Board of Directors

10. Review of Effectiveness

10.1 The Committee shall formally consider its effectiveness using any tools specified for the purpose on an annual basis.

10.2 The Terms of reference of the Committee shall be reviewed by the Board at least annually.

Enclosure 26

The Dudley Group NHS Foundation Trust

TITLE:	**Trust Board Committees Membership**		
AUTHOR:	Gilbert George – Interim Director of Governance	**PRESENTER**	Gilbert George – Interim Director of Governance

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

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

- Chair and Deputy Chair of the Workforce Committee to be nominated
- CQSPE 3rd Non-Executive Director to be nominated
- To note that a review of the Board's Committee structure, Committees Terms of Reference and reporting groups (including membership) will be undertaken within the coming month

CORPORATE OBJECTIVES:

SO1: Deliver a great patient experience

SO2: Safe and Caring Services

SO3: Drive service improvements, innovation and transformation

SO4: Be the place people choose to work

SO5: Make the best use of what we have

SO6: Deliver a viable future

SUMMARY OF KEY ISSUES:

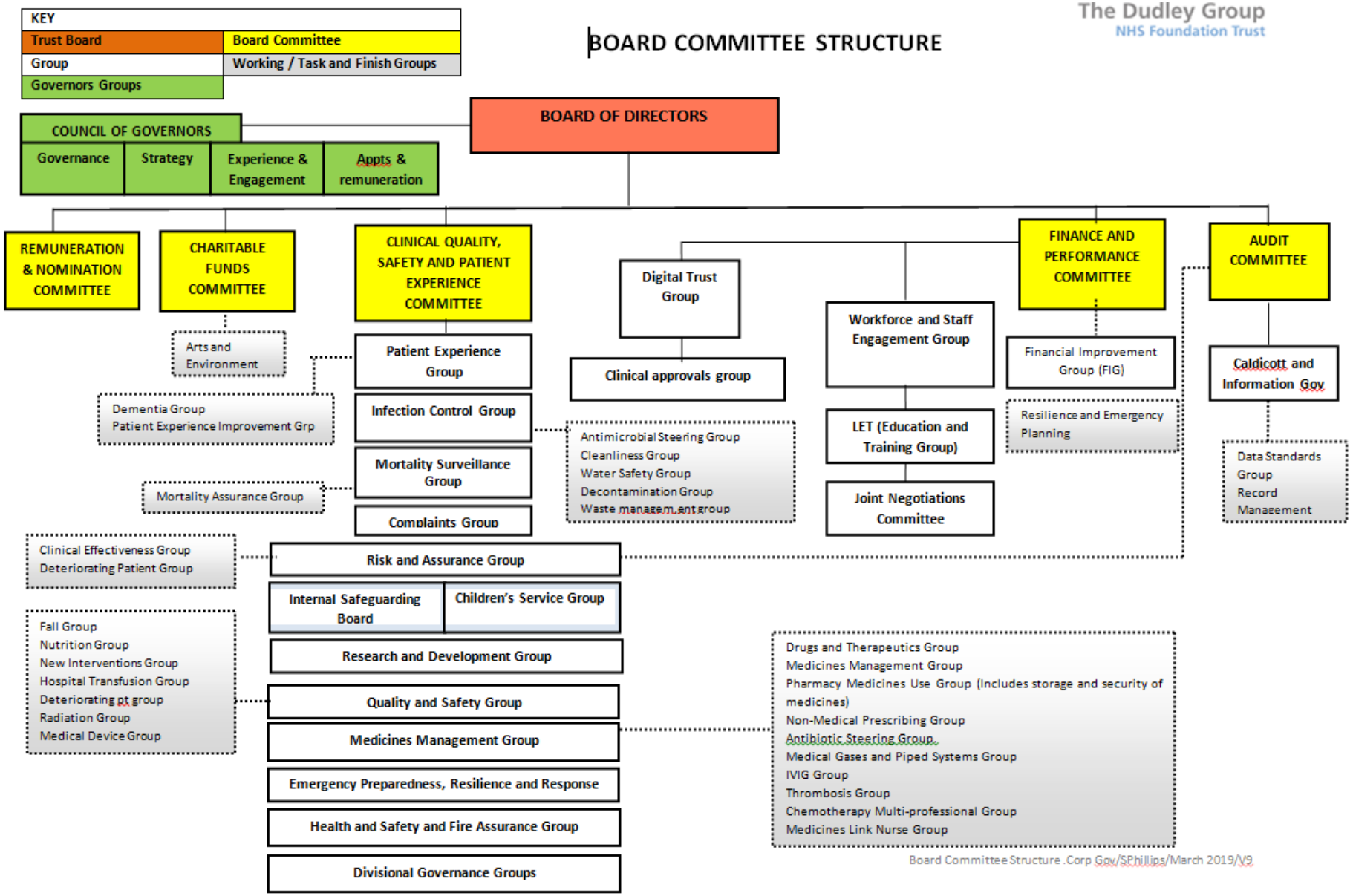
The Trust recognises there is a need to undertake a detailed review of the Board Committee structure and reporting groups. This is essential to ensure this is streamlined, that the flow of information clearly identifies risk and mitigation, has the correct membership to ensure challenge and to hold individuals to account and ensures learning. The Trust acknowledges its reporting structures requires a full review to have assurance its structure achieves its objectives.

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:**

COMMITTEE	MEMBERSHIP (as identified TOR)
Workforce and Staff Engagement Committee (re-established as a Committee of the board June 2019)	**2x Non-Executive Directors** Non-Executive Director (Chair) – to be nominated Non-Executive or Associate Director (Deputy Chair) - to be nominated Director of Workforce & OD (Medical Director (or Deputy) Chief Operating Officer (or deputy) Chief Nurse (or deputy) Director of Operations Medicine and Integrated Care (or Chief of Medicine) Director of Operations Surgery and Women and Children (or Chief of Surgery) Director of Operations Support Services (or Chief of Support Services) Director of Governance (or deputy) Head of Human Resources Head of Learning & Organisational Development Head of Communications Head of Medical Education Head of Non-Medical Education Allied Health Professional Lead
Clinical Quality Safety and Patient Experience Committee	**3x Non-Executive Directors** Chair – Catherine Holland Deputy Chair – Julian Atkins Non-Executive – to be nominated Chief Executive Medical Director (or deputy) Chief Nurse (or deputy) Chief Operations Officer (or deputy) Director of Human Resources (or deputy) Chief of Medicine (or Director of Operations Medicine and Integrated Care) Chief of Surgery (or Director of Operations Surgery and Women & Children) Chief of Support Services (or Director of Support Services) Chief Clinical Information Officer Director of Governance (or deputy) Associate Chief Nurse Medicine Associate Chief Nurse Surgery Chief Pharmacist Head of Communications Deputy Finance Director

COMMITTEE	MEMBERSHIP (as identified TOR)
Finance and Performance Committee	**3 Non-Executive Directors** Chair – Jonathan Hodgkin Deputy Chair – Richard Miner Non-Executive Director – Catherine Holland Chief Executive Officer Chief Operating Officer Director of Finance
Audit Committee	**3 Non-Executive Directors** Chair – Richard Miner Deputy Chair – Jonathan Hodgkin Non-Executive Director - Julian Atkins Director of Finance and Information Director of Governance/Board Secretary Internal Auditors External Auditors
Charitable Funds Committee	Core Membership – All voting Board members are exofficio members of the Sub-Committee. Core membership: **3 Non-Executive Directors** Chair - Julian Atkins Deputy Chair - Richard Miner Non-Executive Director - Jonathan Hodgkin Chief Executive Director of Finance & Information


KEY
Trust Board
Board Committee
Group
Working / Task and Finish Groups
Governors Groups
The Dudley Group
NHS Foundation Trust
BOARD COMMITTEE STRUCTURE
BOARD OF DIRECTORS
COUNCIL OF GOVERNORS
Governance
Strategy
Experience & Engagement
Appts & remuneration
REMUNERATION & NOMINATION COMMITTEE
CHARITABLE FUNDS COMMITTEE
CLINICAL QUALITY, SAFETY AND PATIENT EXPERIENCE COMMITTEE
Digital Trust Group
FINANCE AND PERFORMANCE COMMITTEE
AUDIT COMMITTEE
Arts and Environment
Dementia Group
Patient Experience Improvement Grp
Patient Experience Group
Infection Control Group
Mortality Surveillance Group
Mortality Assurance Group
Complaints Group
Clinical approvals group
Antimicrobial Steering Group
Cleanliness Group
Water Safety Group
Decontamination Group
Waste management group
Workforce and Staff Engagement Group
LET (Education and Training Group)
Joint Negotiations Committee
Financial Improvement Group (FIG)
Resilience and Emergency Planning
Caldicott and Information Gov
Data Standards Group
Record Management
Clinical Effectiveness Group
Deteriorating Patient Group
Risk and Assurance Group
Internal Safeguarding Board
Children's Service Group
Research and Development Group
Quality and Safety Group
Medicines Management Group
Emergency Preparedness, Resilience and Response
Health and Safety and Fire Assurance Group
Divisional Governance Groups
Fall Group
Nutrition Group
New Interventions Group
Hospital Transfusion Group
Deteriorating pt group
Radiation Group
Medical Device Group
Drugs and Therapeutics Group
Medicines Management Group
Pharmacy Medicines Use Group (Includes storage and security of medicines)
Non-Medical Prescribing Group
Antibiotic Steering Group
Medical Gases and Piped Systems Group
IVIG Group
Thrombosis Group
Chemotherapy Multi-professional Group
Medicines Link Nurse Group
Board Committee Structure .Corp Gov/SPhillips/March 2019/V9