The Dudley Group
NHS Foundation Trust

Public Board of Directors Meeting

Thursday 5th September 2019

10.45am – 1.30pm

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 Benbow
Executive Officer
The Dudley Group NHS Foundation Trust
DDI: 01384 321012 (Ext. 1012)
Email: helen.benbow1@nhs.net

Liam Nevin
Board Secretary
The Dudley Group NHS Foundation Trust
Tel: 01384 321114 ext 1114
email: liam.nevin@nhs.net

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

Liam Nevin
Board Secretary
The Dudley Group NHS Foundation Trust
Tel: 01384 321114 ext 1114
email: liam.nevin@nhs.net

Helen Benbow
Executive Officer
The Dudley Group NHS Foundation Trust
DDI: 01384 321012 (Ext. 1012)
Email: helen.benbow1@.nhs.net

The Dudley Group
NHS Foundation Trust

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 5th September, 2019 at 10.45am
Clinical Education Centre
AGENDA

Meeting in Public Session

All matters are for discussion / decision except where noted

	Item	Enc. No.	By	Action	Time
11.	**Chairmans Welcome and Note of Apologies**		Y Buckland	To Note	10.45
12.	**Declarations of Interest** Standing declaration to be reviewed against agenda items.		Y Buckland	To Note	10.45
13.	**Announcements**		Y Buckland	To Note	10.45
14.	**Minutes of the previous meeting**				
	14.1 Thursday 4 July 2019	Enclosure 11	Y Buckland	To Approve	10.45
	14.2 Action Sheet 4 July 2019	Enclosure 12	Y Buckland	To Action	10.50
15.	**Patient Story**	Video	L Abbiss	To Note & Discuss	10.55
16.	**Chief Executive's Overview Report**	Enclosure 13	D Wake	To Discuss	11.05
17.	**Safe and Caring**				
	17.1 Chief Nurse Report	Enclosure 14	M Sexton	To note assurances & discuss any actions	11.15
	17.2 Clinical Quality, Safety, Patient Experience Committee Report	Enclosure 15	C Holland	To note & discuss	11.25
	17.3 Learning from Deaths Report	Enclosure 16	J Hobbs	To note assurances & discuss	11.35
18.	**Responsive and Effective**				
	18.1 Integrated Performance Dashboard	Enclosure 17	K Kelly	To note assurances & discuss	11.45
	18.2 Finance and Performance Committee Exception report	Enclosure 18	J Hodgkin	To note assurances & discuss	11.55

	18.3 Annual Plan Quarterly Report	Enclosure 19	T Jackson	To note & discuss	12.05
19.	**Well Led**				
	19.1 Workforce Committee Report	Enclosure 20	J Atkins	To note & discuss	12.15
	19.2 Audit Committee Report	Enclosure 21	R Miner	To note & discuss	12.25
	19.3 Annual Revalidation Report	Enclosure 22	J Hobbs	To note	12.35
	19.4 Digital Trust Report	Enclosure 23	A Thomas	To note & discuss	12.45
	19.5 Freedom to Speak Up Report	Enclosure 24	D Eaves/P Brazier	To note assurances	12.55
	19.6 Guardian of Safe Working Report	Enclosure 25	B Elahi	To note assurances	1.05
	19.7 EPRR Core Standards	Enclosure 26	C Leach	To Approve	1.15
20.	**Any other Business**		Y Buckland		1.25
21.	**Reflection on Meeting**		Y Buckland		1.25
22.	**Date of Next Board of Directors Meeting** 3rd October, 2019 Clinical Education Centre		Y Buckland		1.30
23.	**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		1.30

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 4th July, 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
Andrew McMenemy, Director of Human Resources
Ian James, Non Executive Director
Gary Crowe, Non Executive Director
Catherine Holland, Non Executive Director

In Attendance:

Helen Forrester, EA
Gilbert George, Interim Director of Governance
Liz Abbiss, Head of Communications
Adam Thomas, Chief Information Officer
Paul Hudson, Deputy Medical Director (item 19/083.4)

19/075 Note of Apologies and Welcome
12.05pm

The Chairman welcomed members of the gallery and new Non Executive Directors Ian James and Gary Crowe to their first Board meeting. Apologies were received from Natalie Younes.

The Chairman confirmed that there would be a short break at 1pm to attend the Senior Hospital Consultant's Committee.

19/076 Declarations of Interest
12.06pm

Gary Crowe confirmed that he was also a Non Executive Director at University Hospitals North Midlands.

There were no other declarations of interest.

19/077 Announcements
12.07pm

There were no other announcements to note.

19/078 Minutes of the previous Board meeting held on 6th June, 2019 (Enclosure 11)
12.07pm

The minutes were amended at page 3 to read "the Committed to Excellence Awards are the first Friday in the month".

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

19/079 Action Sheet, 6th June, 2019 (Enclosure 12)
12.07pm

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

19/080 Patient Story
12.08pm

The Head of Communications presented the staff story. This was from the Clinical Nurse Specialist for Nutrition at the Trust.

The Nurse described the benefits and challenges for staff and patients at the Trust. She confirmed that her goal was for all staff including the Board to be engaged in the prevention and management of malnutrition.

The Head of Communication confirmed that it was important to hear the feedback from a member of staff for one of the Trust's key Quality Priorities.

The Chief Information Officer welcomed hearing such a powerful story from a member of staff.

The Director of HR confirmed that in relation to hydration a number of new hydration stations would be installed across the Trust in the coming weeks.

Mr Atkins, Non Executive Director, was pleased to note the importance of nutrition and hydration being recognised for patients.

The Medical Director highlighted the importance of multi-disciplinary team working for the benefit of the patients.

The Chairman asked about food preparation. The Head of Communications confirmed that a new menu system had recently been implemented. Food was cooked on site and frozen. There were also options for special food groups such as Halal, vegetarian and vegan.

The Chairman and Board noted the story and asked that a note of thanks was passed to the member of staff from the Board.

There were questions from the gallery relating to ward hand-overs and round nutritional requirements bring discussed appropriately.

Thanks to be passed to member of staff from the Board.

19/081 Board Assurance Framework (Enclosure 13)
12.25pm

The Interim Director of Governance/Board Secretary presented the Board Assurance Framework given as Enclosure 13. The Board noted the following key issues:

- This was a new format Board Assurance Framework (BAF) following discussion at a number of Board Workshops.

- A new reporting cycle had been established and the BAF would be presented to the Board on a quarterly basis.

- Key elements for consideration by the Board were highlighted on the cover sheet, including:

  - Risk Performance: A performance table was now included in the BAF showing risk score, assurance level, effective control and whether actions are on track.

  - 2 BAF risks were currently being reviewed: 3a and 6a.

  - The Board was asked to approve a recommendation from the Finance and Performance Committee to include the pension risk on the Corporate Risk Register. The Board approved the inclusion of this risk.

- The Board noted that the BAF had not been reviewed through the Clinical Quality, Safety and Patient Experience Committee (CQSPE), it was confirmed that a thorough review has been undertaken at the Finance and Performance Committee however.

- The Board discussed the risk in relation to ED/Emergency Access Standard. The Medical Director stated that the standard was a marker for quality within the organisation. If purely treated as a KPI it would not be the organisation's biggest risk.

- The Chief Executive confirmed that there was also significant financial and reputational risk for the organisation.

- The Interim Chief Nurse suggested splitting out risk 2a. The Chief Executive suggested waiting for the Oversight meeting on 1st August.

- The Chief Information Officer highlighted an error in section 8 of the BAF.

The BAF would be presented to the CQSPE Committee at the end of the month.

The Strategic risks would be discussed at the next Private Board meeting.

The Chairman and Board noted the report and discussion around the key risks for the organisation.

BAF to be presented to the July CQSPE Committee. Strategic Risks to be included on the next Private Board agenda – S Phillips

19/081.1 Corporate Risk Register (Enclosure 14)
12.37pm

The Interim Director of Governance/Board Secretary presented the Corporate Risk Register given as Enclosure 14. The Board noted the following key issues:

- The Register had also been on a journey similar to the BAF, for the Trust to decide how it defined its corporate risks.

- The paper was included for Board members to be sighted on the Trust's Corporate Risks.

Prof. Crowe, Non Executive Director, suggested that it would be useful to show the flow of assurance and risk between the BAF document and the Cooperate Risk Register, so that the escalation process was clear.

The Interim Chief Nurse confirmed that a lot of work had been undertaken to streamline the Register but it was still work in progress. A summary of assurance flow would be included in the next report.

Mr Miner, Non Executive Director, commented that there should not be any repetition of risk. The Interim Chief Nurse confirmed that there was still work to do in the description and refinement of risks.

There was a question from the gallery in relation to drug storage cupboard temperatures. The Board members gave assurance that this was monitored and managed.

The Chairman and Board noted the report.

A summary of assurance flow to be included in the next report to Board.

19/082 Chief Executive's Overview Report (Enclosure 15)
12.45pm

The Chief Executive presented her Overview Report given as Enclosure 15. This included the following highlights:

- Staff Committed to Excellence Awards: Taking place tomorrow. The Board noted the Chairman's apologies as she had a long standing engagement in her diary.

- Improvement Practice Event: This had gone well and learning shared across organisations. KATA training was being rolled out throughout the organisation.

- CHKS Award: The Trust had received an award for Data Quality.

- A&E Delivery Board: Met on 19th June and discussed system resilience against the Emergency Access Standard. An Executive meeting with the CCG was taking place on Monday.

Prof. Crowe, Non Executive Director, asked if the Board or one its Committees receives feedback from the A&E Delivery Board. The Chief Executive confirmed that feedback was to the weekly Executive Team meeting. Prof. Crowe asked that thought be given to how the Board receives assurance from this meeting through the existing Board Committee structure.

The Chairman and Board noted the report.

The Executive Team to consider how the Board receives assurance from the A&E Delivery Board including through the existing Board Committee Structure.

19/083 Safe and Caring

19/083.1 Chief Nurse Report (Enclosure 16)
12.51pm

The Interim Chief Nurse presented the Chief Nurse Report given as Enclosure 16.

The Board noted the following key issues:

- Fitness to Practice: Successful event held.

- Standard for Supporting Students: New standard from the NMC, shared at the Fitness to Practice event.

- The event was attended by Bev Matthews on "Breaking the Rules" and accepting change.

- The Trust had commenced work with Clinical Nurse Specialists as part of workforce transformation.

- Trainee Nurse Associate Programme: Commenced with 22 new starters. Trainees have been recruited locally.

Mr Atkins, Non Executive Director, raised the check and challenge meetings and asked how the Board can be assured on effectiveness. The Chief Nurse confirmed that the Trust had seen improvements in e-rostering and agency spend.

Mr Hodgkin, Non Executive Director, asked about progress with the Acuity Tool. Findings from the tool had been shared with Lead Nurses and Matrons. There were some issues with CIP requirements. All budgets had been signed off.

Prof. Crowe, Non Executive Director, asked about preparedness for the level of change for the Interim Chief Nurse confirmed that the Trust was confident that it could cope with and manage the additional numbers.

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

19/083.2 Clinical Quality, Safety, Patient Experience Committee Report (Enclosure 17) 1.10pm

Non-Executive Director, Catherine Holland, presented the Clinical Quality, Safety, Patient Experience Committee Report, given as Enclosure 17.

It was noted that the Board Secretary will produce future reports from the Committee to Board.

Matters of concern included:

North Block Fire Report: The Committee noted that current arrangements were suitable.

Hydrotherapy Incident: Minor injuries to staff and property due to failure to test the water. A new warning system had been put in place.

Glide Away Bed Incident: A member of staff had lost a finger tip. No fault found and the matter had been reported to the HSE. Correct use of the beds has been emphasised.

Six single sex breaches: Contractual breaches noted and related to flow from HDU back into the bed base. The Chief Executive confirmed that there was a piece of work being undertaken on flow and capacity and this would be reported to the Clinical Quality, Safety Patient Experience Committee (CQSPE) when available.

The Committee expressed concern over the VTE target not being met.

The Committee would review the CQC report once the final document was received.

The Chief Executive confirmed that the National Patients Safety Strategy had now been received and the organisation needed to ensure that its own Trust Strategy aligned with this.

Prof. Crowe, Non Executive Director, suggested including BAF risks on the Committee upward reporting template.

The Chairman and Board noted the report.

The outcome of the bed base and flow review to be presented to CQSPE when available. The Patient Safety Strategy to be aligned with the new National Strategy and presented at the CQSPE in July.

19/083.3 Annual Infection Control Report (Enclosure 18)
1.21pm

The Interim Chief Nurse presented the Annual Infection Control Report given as Enclosure 18. The Board noted the following key issues:

It was a national requirement for the Board to receive a report on Infection Control on an annual basis. The report detailed compliance against the Hygiene Code against which the Trust was fully compliant.

There was 1 MRSA case last year against a zero target. This was the first case in 5 years.

There were 20 C.Diff apportioned cases against an upper limit of 28. The limit for this year was 48 cases. The Trust would continue to aim for the lowest number of cases possible.

The Trust had made significant progress with reducing antimicrobial prescribing.

Mr Atkins, Non Executive Director, asked about the mandatory training target being rated as green. The Infection Control Group had debated the target and agreed that the Trust was meeting the individual criteria.

Mr Miner, Non Executive Director, asked how the Trust ensured standards w ere maintained. The Interim Chief Nurse confirmed that there was a work plan and audit programme in place and the Trust was working on ensuring a consistent approach to IPC was in place across the organisation.

The Chairman and Board approved the report and noted the mandatory training issue and green rating.

19/083.4 7 Day Services/Critical Care Update Report (Enclosure 19)
1.30pm

The Deputy Medical Director presented the 7 Day Services/Critical Care Update report given as Enclosure 19.

The Board noted the following key issues:

- Previous paper presented to the Board in June.
- The report detailed the latest audit results.
- Significant progress had been made in the audit results. The Trust continues to meet standards 5 and 6 but was expected to fail to meet target 8. The Trust would achieve the standard by March 2020.

- Orthopaedics, General Surgery, Paediatrics and Critical Care business cases were being produced.

Mr Miner, Non Executive Director, asked about standard 8 and whether the Trust was sufficiently monitoring these patients. The Deputy Medical Director confirmed that all patients were receiving daily review and all level 2 patients were receiving enhanced care.

Mr Atkins, Non Executive Director, highlighted an error on the number of patients audited.

The Medical Director confirmed that the Trust was making significant progress and this was due to the availability of granular data. The Trust was also starting to see the positive impact of job planning.

The Chairman and Board noted the report.

19/083.5 Inpatient Survey Report (Enclosure 20)
1.40pm

The Interim Chief Nurse presented the Inpatient Survey Report given as Enclosure 20.

The Board noted the following key issues:

- Survey carried out on an annual basis in July.
- 488 responses received from a sample of 1100.
- There was a nationally declining trend for patient experience.
- The Trust was ranked 131 out of 144 Trusts which is a slight improvement on last year.
- There was significant work to be undertaken as an organisation to improve patient experience.
- The Trust had already commenced making improvements and individual action plans were in place.
- There needed to be further consideration by the Board as to how to drive improvements.

Mr Miner, Non Executive Director, asked what the best trusts were doing to get higher up the performance table and asked if there was a bigger issue around culture. The Interim Chief Nurse confirmed that it was more around the bigger picture and we should not just focus on addressing specific questions and responses.

The Chief Executive stated that regulatory scrutiny often results in poor results.

Mr Atkins, Non Executive Director, commented that the results did not correlate with patient stories.

Mrs Holland, Non Executive Director, added that the way we meet and greet new staff was also important. The Director of Human Resources confirmed that there had been some changes to the induction process with positive feedback.

The Interim Chief Nurse commented that getting the discharge process right was fundamental to patients leaving with a positive experience.

The Interim Chief Nurse confirmed that she had developed a plan. The inpatient survey results correlate with the staff survey. Staff need time to meet and agree priorities the Trust needed to focus on to improve perception.

The Medical Director stated that meaningful change took time. There were pockets of outstanding practice and spreading good practice is a shortcut to success. The Chairman confirmed that good patient and staff experience should start with the Board and follow the values of the organisation. All Board members should be visible within the organisation.

Mr Atkins, Non Executive Director, suggested a review of the Trust values to include improvement was needed.

The Board patient story should be considered in respect of survey results and patient experience.

The Chairman and Board noted the report and recognised the need for change.

There was a question from the gallery in relation to working with local Councils in order to improve delayed discharges.

The Chief Nurse to consider the approach for improving patient perception of care and treatment and report back to the CQPSE in September.

19/084 Responsive and Effective

19/084.1 Integrated Performance Report (Enclosure 21)
2.00pm

The Chief Operating Officer presented the Integrated Performance Report given as Enclosure 21.

The Board noted the following key issues:

- Performance for May 2019.
- ED Emergency Access Standard: Still an issue for the organisation. Numbers continued to increase through the front door. There were periods of high acuity of attendees. A review of minors has been undertaken and this had now been moved to a new area resulting in a reduction in breaches.

Staff were going through management of change to work 24 hours in this area. Breach management was a high priority for the organisation. The system improvement plan had been submitted. The Executive Team were meeting with the CCG on Monday. There was an improving position for July and this needed to be sustained. The organisation needed to model its workforce to meet peaks in demand.

- Cancer key metrics: Good performance with green for all metrics for the 4th consecutive month.
- RTT: 4th in the country for performance.
- DM01: Issue with age of CT scanners. Both scanners failed resulting in a breach of the target.
- Delayed Discharges: Reduced from 90 to 58.
- Appraisals: 91% achieved to date.

Prof. Crowe, Non Executive Director, raised ambulance handovers and the plan to improve long waits. The Chief Operating Officer confirmed that the Trust was working with the Ambulance Services to ensure that all attendees were appropriate and also on a single point of access. There had been recent approval for funding for a 2nd HALO in ED and two rapid assessment bays had been established to turnround patients.

The Chairman suggested invited someone senior from the Ambulance Service to a future Board meeting.

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

Senior representative from the Ambulance Service to be invited to attend a future Board meeting.

19/084.2 Finance and Performance Committee Exception Report (Enclosure 22) 2.20pm

Mr Hodgkin, Committee Chair, presented the Finance and Performance Committee Exception Report, given as Enclosure 22.

The Board noted the following key issues:

- Main area of concern is around delivery of Q2 financial targets. The Trust was on track to deliver Q1.

- There was a likely requirement for cash borrowing in September.
- The Committee discussed the BAF risks.
- The Committee agreed that it will undertake regular benefits realisation reviews on approved business plans.
- Agreed to reinstate the Workforce Committee as a formal subcommittee of the Board.

The Chairman and Board noted the report.

19/085 Well Led

19/085.1 Trust Constitution and Scheme of Delegation (Enclosure 23)
2.22pm

The Chairman and Board noted the approved Constitution.

19/085.2 Charitable Funds Committee Report (Enclosure 24)
2.23pm

Mr Atkins. Chair of The Charitable Funds Committee Chair presented the Committee Report given as Enclosure 24.

The Board noted the following key issues:

- The fund balance was just under £2.2m.
- Expenditure was slightly behind income.
- The Baby Bereavement bid had raised £68k.
- Neon dash was noted to be very successful.
- Attendance was poor at the meeting and this must improve going forward for the Committee to be successful.

The Chairman and Board noted the report.

To remind Board members of the meeting dates for the Charitable Fund Committee of their responsibility as corporate trustee of the charity.

19/085.3 Reinstatement of Workforce Committee Report (Enclosure 25)
2.25m

The Chairman and Board noted and approved the reinstatement of the Workforce Committee as a formal subcommittee of the Trust Board.

19/085.4 Committee Membership Report (Enclosure 26)
2.26pm

The Chairman to consider and discuss membership of the Board Committees with the Non Executive Directors.

19/086 Any Other Business
2.27pm

The Chief Executive confirmed that this was the Interim Director of Governance's last meeting and thanked him for his contribution.

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

19/087 Reflection on the Meeting
2.30pm

Mr Atkins confirmed that the more strategic Board discussions were positive.

Mrs Holland confirmed that she would like a more extended gap between meetings.

Mr Hodgkin confirmed it was good to note the challenge from new Board members.

19/088 Date of Next Meeting
2.31pm

The next Board meeting will be held on Thursday, 5th September, 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 4 July 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	Discussed at CQSPE on 25th June.
19/080	Patient Story	Thanks to be passed to member of staff from the Board.	LA	5/9	Done
19/023.3	Digital Trust Committee Report	Population Health to be included on a future Board Workshop agenda.	AT/GG	Sept/Oct	To future Board Workshop – date to be confirmed.
19/068	Patient Story	Chief Operating Officer/Director of Finance to consider opportunities for the use of the Hydrotherapy pool.	TJ/KK	5/9	Previously reviewed and no scope to take this forward due to down time for cleaning and the amount of people who can use the pool.
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	Done and met on 29/7
19/033.1	Staff Survey Presentation	Update on the Staff Survey to the Board in 6 months.	AM	5/9	To October Board
19/058.5	Learning from Deaths	Update on Palliative Care to be included in an overarching Learning from Deaths Annual Report.	JH	5/9	Learning from Deaths Report on Agenda – Palliative Care included in report.
19/081 & 19/081.1	Board Assurance Framework & Corporate Risk Register	BAF to be presented to the July CQSPE Committee. Strategic Risks to be included on the next private Board agenda including a summary of assurance flow.	SP SP	23/7 5/9	Done BAF/BAF process under review.

19/082	Chief Executives Report	The Executive Team to consider how the Board receives assurance from the A&E Delivery Board through the existing Board Committee structure.	EDs	5/9	Reports to Executive Directors and any actions are reflected in the System Improvement Plan.
19/083.2	Clinical Quality, Safety, Patient Experience Committee Report	The outcome of the bed base and flow review to be presented to CQSPE when available. The Patient Safety Strategy to be aligned with the new National Strategy and presented to CQSPE in July.	KK JH	27/8 23/7	Presented to CQSPE on 27th August. Presented to CQSPE on 23rd July.
19/084.1	Integrated Performance Report	Senior representative from the Ambulance Service to be invited to attend a future Board meeting.	KK	TBC	WMAS attend A&E Delivery Board.
19/085.2	Charitable Funds Committee Report	To remind Board members of the meeting dates for the Charitable Fund Committee meetings and remind members of their responsibility as corporate trustees of the charity.	TJ/JA	29/8	Done.
19/083.5	Inpatient Survey Report	The Chief Nurse to consider the approach for improving patient perception of care and treatment and report back to CQSPE in September.	MS	24/9	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 of Directors on 5th Sept 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
- Adult Health and Social Care Scrutiny Committee
- Anaesthetics Accreditation
- Stroke Services – Best in the West Midlands
- ED Redesign
- CQC Oversight Meetings
- Population Health Funding Award
- Forward Healthcare Awards
- Healthcare Heroes
- Charity Update

- 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 – September 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

5th July	Clinical Summit
17th July	A&E Delivery Board
	Live Chat
18th July	Annual Members Meeting
26th July	Extraordinary Overview and Scrutiny Committee
29th July	Black Country Chairs and Chief Executives
1st August	Overview and Assurance Group
5th August	STP Cancer Board
19th August	Live Chat
21st August	A&E Delivery Board
22nd August	Back to the Floor
28th August	Adult Health and Social Care Scrutiny Committee
29th August	STP Partnership Board
30th August	STP System Review Meeting

Improvement Practice Update – Improvement Practice Leadership Event

Dudley Improvement Practice focuses on supporting **our staff** as the experts in **their** own area of work to implement **their** ideas for improving services for patients. Staff are invited to attend a leadership event on Friday 6th September find out what changes they can make in their area to make it the best service it can be. Guest speaker is national director of the Improvement Practice Programme Alan Martyn. Within one of their weeklong events, the Dudley Improvement Practice team helped the Ophthalmology Department transform their service and patient experience. The work has resulted in, for example, improved patient experience by changing room layout – 85 per cent of patients feel they had more privacy and dignity since the improvements.

Successful feedback has also been received following the recent Ward C3 Discharge Improvement Event. Everyone involved felt very positive that the changes made and planned will have a great effect on patient experience and patient care by reducing length of stay and delayed transfers of care. It was a great opportunity for many of the staff to present for the first time and they all did brilliantly, I am looking forward to continuing to receive feedback from their improvement journey.

Adult Health and Social Care Scrutiny Committee

The Dudley Adult Health and Social Care Overview and Scrutiny Committee held a scrutiny meeting to review the Trust's most recent Care Quality Commission report and ratings. This was an opportunity to share with the committee and members of the public the recommendations made in the report and the actions we have put in place to improve our services.

The meeting was held on the 28th August and focused on the main areas for improvement in the last inspection report dated July 2019. I would like to thank all the staff who attended to present to the committee and to the councillors who listened to our progress and asked questions and shared feedback with us.

The Committee will make the following recommendations to the Council:

1. Welcome the assurances given by the Dudley Group National Health Service (NHS) Foundation Trust on the changes being implemented to respond to the Care Quality Commission (CQC) inspections and support the continuous improvement of the services provided in Dudley Borough Hospitals.
2. Place on record its appreciation of the hard work and dedication of all staff involved.
3. Support the proactive and collaborative approach to partnership working between the NHS, the Council, the Clinical Commissioning Group and all partners to continue the improvement journey following the CQC report.
4. Endorse the further development of a joint, co-ordinated strategy to reduce the numbers of people who attend the Emergency Department unnecessarily.
5. Note that a detailed action plan has been submitted to the CQC and that arrangements are in place to ensure the ongoing monitoring of progress.

Anaesthetics Accreditation

Our Anaesthetics Department has received national recognition for the service it provides to our patients. It achieved the prestigious Anaesthesia Clinical Services Accreditation (ACSA) for providing the highest quality care to patients. ACSA from the Royal College of Anaesthetists promotes quality improvement and the highest standards of anaesthetic service. To receive accreditation, departments demonstrate high standards in areas such as patient experience, patient safety and clinical leadership, meeting 100% in all areas. It means our patients can be assured they are receiving outstanding service. We are the first Trust in the West Midlands to become accredited, and only the 33rd in the UK.

Stroke Services – Best in the West Midlands

We are officially the best in the West Midlands for stroke care, according to a major national healthcare quality improvement programme. It places us in the top 40 trusts nationally. The Sentinel Stroke National Audit Programme (SSNAP) measures the quality and organisation of stroke care in the NHS and is the single source of stroke data in the UK. SSNAP measures both the processes of care (clinical audit) provided to stroke patients, as well as the structure of stroke services (organisational audit) against evidence-based standards, including the 2016 National Clinical Guideline for Stroke.

The overall aim of SSNAP is to provide timely information to clinicians, commissioners, patients and the public on how well stroke care is being delivered so it can be used as a tool to improve the quality of care that is provided to patients. Our score of 82 – Level A – makes us the best in the West Midlands, and there are only 39 trusts out of 216 in the country that are ahead of us in the SSNAP score.

ED Redesign

We are consulting with our staff on an opportunity to redesign our Emergency Department. We found out in December 2018 that that our bid for £20.3 million to radically redesign our Accident and Emergency Department was successful. Following the development of the Emergency Treatment Centre, it was always our intention to look at the rest of the department. We want an Emergency Department that better support patient flow and offers a better patient experience. We are in the very early stages of the business plan.

CQC Oversight Meetings

I am delighted to confirm that following the last Oversight meeting with our regulators in respect of CQC concerns, it has been decided that these meetings will no longer take place in recognition of the progress that the Trust has made. This is good news. However it is important that we remain focused and have the right governance in place to oversee the remaining S31 notices and oversight of the improvement plan for the Trust.

This will be done in various established meetings:

- The Journey to Excellence Group, chaired by the Chief Nurse, will report on our improvement plan to the Clinical Quality, Safety and Patient Experience (CQSPE) - this is all aspects of our core services

- The Urgent Care Improvement Group, chaired by the Chief Operating officer, will report to both CQSPE and the Finance & Performance Committee (F&P) as some issues are performance some are safety.

- The A&E Delivery Board will also receive assurance on all areas of urgent care and performance, this covers urgent care working across our health care system

- Reports to the Board will be covered in the committee reports but on an exception basis; more detailed reports will be received as requested by the Chair or committee chairs or executive team

A&E leaders attended the Private Board meeting to talk about their journey and the improvements that have been made. This will be a real opportunity to acknowledge this and recognise the progress.

Population Health Funding Award

The Trust is pleased to announce it will receive a £1.4m funding award to support our Population Health platform. Funding has been approved centrally and will focus on expanding current licenses and essential project staff resource to deliver the project with pace.

This will be a UK first and will be comparable with world leading integration for care systems. This is an opportunity to put Dudley on the map for STP integration and to support the MCP as well.

Forward Healthcare Awards

I am proud to announce that the Trust has been shortlisted for the Forward Healthcare Awards 2019. This is for the collaboration between ED and the Cardiac Assessment Unit and its achievements in improving patient care pathways. We are looking forward to the outcome of the judging of our highly commended entry on 25th September.

Healthcare Heroes July 2019

Congratulations to July's healthcare heroes! Dudley Rehab Service received the team award after they were nominated by a patient who lives with a neurological disease. The patient said the staff are always filled with happiness, compassion, dedication and empath, and always have a smile on their faces. When they see their patients, they are solely focused on them and their families, regardless of how busy they are. The person who nominated and their family feel whatever problems they face; the team will try their utmost to solve it or pass on to other healthcare professionals if they cannot.

IT technician Mike Platt was nominated by a colleague and picked up the July's induvial award. Mike is described as hard working, responsive, dedicated, cheerful and knowledgeable. The nominator said he is the backbone of the NHS. Mike repairs, maintains and solves IT problems across the Trust, offering technical support to those that need it. Mike appreciates the importance of maintaining equipment which is needed to allow our staff to do their jobs effectively.

July's volunteer healthcare hero was Barry Pilkington. At 82 years old, Barry volunteers every afternoon walking miles around the hospital, collecting and delivering notes. After retiring from Wordsley Hospital, he began volunteering at Russells Hall Hospital and has been doing so for 16 years. Despite having major surgery, he came back to volunteering, always offering his time to help others. He is always so cheerful.

Healthcare Heroes August 2019

Congratulations to August's healthcare heroes! The Renal Unit received this month's team award after being nominated by a member of staff for helping a young pregnant woman on dialysis go on to give birth to her baby, which is very hard and rare to do. Most women on dialysis unfortunately miscarry but, thanks to the team's dedication and best possible care, the baby was delivered healthy. Mom and baby are both doing really well!

Consultant anaesthetist Adrian Jennings is August's individual healthcare hero. He was nominated by a colleague for his incredible efforts supporting the anaesthetic department's national accreditation, which means the department has been recognised for providing the highest quality of care to our patients. Adrian's colleague described his unrelenting passion for the project as infectious.

August's volunteer healthcare hero is Pat Lowe. Pat was nominated by a colleague for being hardworking, extremely dedicated and very pleasant. She often takes long bus journeys to and from Russells Hall Hospital to volunteer in anticoag and main reception. To top it off, she also works at Guest Outpatient Centre, booking people into the anticoag clinic. Pat's dedication often means she doesn't get home till really late, yet she's always so willing to help other people.

DGFT Charity Update

Free tickets to the Rugby for NHS Staff
Our staff will enjoy a great game of local rugby with free entry for all NHS staff, and their families. The Stourbridge Rugby First Team match is on Saturday 14th September and is an opportunity to enjoy the game and help support our charity. Everyone is welcome.

Charity Sparkle Party
Bookings are now being taken for our Sparkle Party on Friday 22 November 2019 in aid of our Children's Emergency Department Appeal. It's taking place at the Copthorne Hotel Brierley Hill and we are inviting staff and members of the public to come along, have some fun and support our charity. For an early bird discount, deposits need to be paid by 9 September 2019. Tickets cost £35 each (or £30 early booking discount). It's easy to buy tickets. Our general office accepts cash, credit card payments or bank transfer. The office is open between 9am and 12 noon; 2pm and 4pm Monday to Friday. Anyone interested should contact general office on 01384 244252.

National NHS News

Overseas couple couldn't take baby's body home - because they couldn't afford £10,000 NHS fee

There are fresh calls to suspend charging overseas patients for NHS care in England - months after a dad who was denied a heart transplant died. The Royal College of Midwives has claimed charges must be suspended until it is clear it is not harming people. The body told the BBC it has written to ministers urging them to suspend the system. The calls follow the heartbreaking tale of a couple who were not able to take the body of their baby home - because they could not stump up £10,000 in medical fees. The heartbroken parents did not have a valid European Health Insurance Card (EHIC). **Birmingham Live (10.07.19)**

Amazon Alexa now gives NHS health advice

Amazon Alexa devices can now provide expert NHS advice, the government has announced. As of this week, users can ask health-related questions and receive information directly from the NHS website using their voice-assisted device.

The government has said it could reduce the demand on the health service. **Coventry Live (10.07.19)**

NHS patients forced to endure long trolley waits
There has been a huge rise in the number of NHS patients enduring trolley waits during the summer months, new data shows. Trolley waits refer to the time A&E patients spend on trolleys or chairs while a bed is found for them. New figures from NHS England show that, in May and June, 119,320 patients endured a trolley wait of more than four hours. **News and Star (11.07.19)**

NHS trialling smartphone cystitis test that lets you get treatment without seeing a GP
NHS England is trialling a smartphone app that allows women suffering with urinary tract infections to get treatment without seeing a GP. Urinary tract infection (UTI) - also known as cystitis - is one of the most common bacterial infections seen by GPs, with suspected UTIs account for up to 3% of all GP visits. **Mirror (17.07.19)**

Mentally-ill child forced to travel length of country for NHS treatment
Despite NHS pledges to end out-of-area placements, a lack of inpatient beds saw 587 youngsters admitted to mental health inpatient units away from home in the first six months of 2018/19. A mentally-ill child was forced to travel almost the length of the country for NHS care. The child was sent 339 miles from their home, the equivalent of driving from Brighton to near Newcastle. **Mirror (22.07.19)**

Health secretary announces £20m NHS young people careers funding
The health and social care secretary has announced £20m funding to support 10,000 young people from all backgrounds to get a career in the NHS. This will be matched by £7m from the Prince's Trust. The 3-year pre-employment programme will begin later this year and will involve up to 150 NHS trusts in England. **National Health Executive (24.07.19)**

'GAME-changing' OVARIAN CANCER DRUG RECEIVES NHS APPROVAL
A "game-changing" drug for women living with ovarian cancer has received approval as a first stage treatment on the NHS. The drug, named Lynparza (olaparib), is being made available through the Cancer Drugs Fund to help women with a genetic form of the cancer. The medication has been found to extend lives by more than doubling the number of patients whose cancer is prevented from getting worse, and could offer a cure for some women. **Independent (25.07.19)**

Twenty big NHS building projects that need Boris' cash
With the new prime minister poised to announce NHS building projects, HSJ has identified 20 of the most significant hospital infrastructure schemes that require big injections of capital funding, often to address pressing problems with care quality. **HSJ News (01.08.19)**

NHS to receive £1.8bn cash injection to upgrade hospitals
Boris Johnson is to announce a £1.8bn immediate cash injection for the National Health Service to help clear a massive maintenance backlog and upgrade hospitals. About £850m of the new sum will be earmarked for building projects at 20 hospitals, with details to be announced on Monday. **Financial Times (03.08.19)**

Johnson insists 'drop in the ocean' £1.8 billion for the NHS is 'new' money
The prime minister has insisted that £1.8 billion of "extra spending" for the NHS is "new" money, despite critics claiming the money was not enough and had been recycled by hospitals cutting costs. Addressing claims from the Health Foundation that the new money is a "drop in the ocean", Boris Johnson said: "Don't forget that this is £1.8 billion of new money. It wasn't there 10 days ago." **ITV News (04.08.19)**

NICE draft guidance and NHS England review highlight need for more research on cannabis-based medicinal products
The draft guidance, which is open for public consultation until 5 September 2019, considers the use of these products for people with intractable nausea and vomiting as a result of chemotherapy, chronic pain, spasticity, and severe treatment-resistant epilepsy. NHS England has also today published a review aimed at assessing the barriers to prescribing cannabis-based medicinal products where it is safe and clinically appropriate. **NICE (08.08.19)**

Government pledges £250m for NHS national artificial intelligence lab
The government has announced it is setting up a national artificial intelligence laboratory, accompanied by £250m in funding to help enhance patient care and research using AI. The third announcement for the NHS from Boris Johnson's government in as many days, the prime minister said the funding will help the NHS become a world leader in using artificial intelligence to improve healthcare. **National Health Executive (08.08.19)**

Treat NHS patients in private hospitals to cut waiting lists, government urged
NHS patients have a legal right to choose to be treated in private hospitals, at no extra cost to the NHS, but only half are aware of this option. The private sector delivers about 500,000 NHS operations every year, according to the NHS Confederation, of which the Independent Healthcare Providers Network is a member. **Independent (09.08.19)**

Asthma Deaths Have Risen By A Third In 10 Years – And A Lack of 'Basic Care' Could Be To Blame
Asthma deaths have risen by around a third in 10 years, according to figures analysed by a national charity. More than 1,400 people died from an asthma attack last year in England and Wales – around an 8% increase compared to 2017, Asthma UK said. The data, from the Office for National Statistics (ONS), shows the number of deaths have increased by 33% in a decade, up from 1,071 in 2008. The figures also show an increase in men dying from the condition – as 436 men died in 2018 compared to 370 the previous year. **Huffpost (09.08.19)**

NHS declares national emergency over shortage of feed for babies and disabled patients
The NHS has declared a national emergency over shortage of feed for babies and disabled patients, with some patients being told to go to Accident & Emergency departments. Medics said vulnerable patients were being left starving for several days, with some being admitted to hospital because of malnutrition. Hundreds of NHS patients, including children, who depend on intravenous nutrition, have been experiencing delays in deliveries. It follows an inspection by watchdogs which found manufacturers were failing to meet safety standards, and the presence of potentially fatal bacteria. **The Telegraph (13.08.19)**

NHS systems still reliant on Windows XP
Over 2,000 NHS systems are still running on Windows XP five years after it stopped receiving security updates. It's the latest hammer blow to the NHS' reputation for being well behind the curve in terms of keeping its IT systems up-to-date and secure **ITPRO (17.08.19)**

Hospital food review announced by government
The review follows the deaths of 6 people linked to an outbreak of listeria in contaminated food earlier this year. It aims to improve public confidence in hospital food by setting out clear ambitions for delivering high-quality food to patients and the public. Chair of the Hospital Food Review, Phil Shelley, will meet with catering managers at trusts across the country, looking at best practice from those leading the way in food quality and innovation. **GOV UK (23.08.19)**

Scottish-wide cancer plan introduced after NHS Tayside death
A national approach to treating cancer is being introduced in the wake of revelations some patients received a lower dosage of chemotherapy drugs than in other parts of Scotland. A new "Once for Scotland" approach is to be brought in as part of a bid to encourage rapid sharing and adoption of best practice across regional cancer networks and NHS boards. Scotland's top doctor, Chief Medical Officer Dr Catherine Calderwood, said the move would "help ensure that cancer patients across Scotland have access to the same high level of care and treatment, regardless of where they live". **The Scotsman (26.08.19)**

Reason to be cheerful? 'Optimists live longer' study reports
"Optimists are more likely to live longer than those who have a more negative approach to life, a US study has found," BBC News reports. The Mail Online reports on the same study claiming that "Optimists are up to 70% more likely to live to be 85".The study used information collected from male war veterans and female nurses taking part in 2 long-running studies in the US. The participants were around 60 to 70 years old when they completed optimism questionnaires, and the researchers looked at whether optimism was linked to living longer. **NHS (27.08.19)**

Foreign health tourists leave NHS with £150m of unpaid bills which could pay for 6,000 nurses as medics say charging them is 'racist'
Two London hospitals are each owed £28million with one still chasing a £500,000 bill from a Nigerian mum who gave birth to quadruplets in 2016. The huge total is enough to pay for 5,500 junior doctors, a staggering 22,000 heart bypasses and 6,000 extra nurses.Some 23 NHS hospitals across the UK are still owed more than £1million from foreign patients and 91 trusts have outstanding bills totalling **£149.5million. The Sun (27.08.19)**

Regional NHS News

Vape shops open inside two West Midlands NHS hospitals
Vape shops have opened in two NHS hospitals in the West Midlands, in a bid to eradicate smoking. Sandwell General Hospital in West Bromwich, and Birmingham City Hospital, both of which are run by Sandwell and West Birmingham Hospitals NHS Trust, have had vape shops open up. The shop's opening comes as the NHS Trust tries to clamp down on smoking within its grounds. From July 5, those caught smoking on hospital grounds will be hit with a £50 fine. Police are even rolling out security cameras to catch smokers on site. **ITV News (10.07.19)**

The thousands of Birmingham kids being treated for these mental health conditions
New NHS figures reveal that 8,870 children under the age of 18 in the area accessed NHS-funded community mental health treatments in 2018/19. Nearly 9,000 children in Birmingham were treated for mental health illnesses like anxiety, depression and eating disorders last year- but campaigners say there is "still a very long way to go" to help kids in need. **Birmingham Live (18.07.19)**

Stoke-on-Trent mum's cancer misdiagnosis down to 'human error'
A mother underwent a double mastectomy after doctors wrongly diagnosed her with an aggressive form of cancer. Sarah Boyle, 28, was told she had triple negative breast cancer after she had difficulty breastfeeding her baby. The hospital that treated her apologised, saying it was "human error" that led to her being misdiagnosed. Mrs Boyle is now pursuing a legal claim against the trust, which has admitted liability. **BBC News (19.07.19)**

British Armed Services veterans' suicides may continue unless lessons are learned, coroner tells authorities
A coroner has warned that more military veterans suffering PTSD may take their own lives unless urgent action is taken to improve their care. Emma Brown, the coroner for Birmingham and Solihull, has written to NHS services and police highlighting a catalogue of failures in the treatment of Lance Corporal Dave Jukes in the months leading up to his suicide. In a strongly worded letter seen by The Sunday Telegraph, she has urged NHS England, Birmingham and Solihull Mental Health Trust and West Midlands Police to learn from mistakes in the soldier's treatment. **The Telegraph (27.07.19)**

Sports day
Young patients at Russells Hall Hospital joined in with the summer of sporting success when staff on the children's ward held a sports day especially for them. Forget the excitement of the Cricket World Cup and the Open golf – the real action was on Ward C2 with sports and games for children, staff team events and a karate demonstration by students from the Shukokai Karate Federation, Brandon Taylor and Matt Anderson who are national and international medallists for kata and kumite. **Express & Star (30.07.19)**

Listeria outbreak: Sixth person dies in illness linked to NHS sandwiches
A sixth person has died after eating pre-packaged sandwiches and salads linked to the NHS listeria outbreak. Public Health England said the person fell ill with listeriosis from Good Food Chain products while a patient at Western Sussex Hospitals NHS Foundation Trust. It comes after five patients died in four different hospital trusts in the north and Midlands earlier this year. **Evening Standard (01.08.19)**

'Widespread improvements' at Shropshire Community Health NHS trust
A community health trust which was told it required improvement has been rated "good" after an inspection. Inspectors from the Care Quality Commission (CQC) reported "widespread improvements" at Shropshire Community Health NHS Trust. They particularly commended end-of-life care which was previously criticised for a lack of strategy. The trust's chief executive Jan Ditheridge said she was "so proud" of the "tremendous progress". **BBC News (01.08.19)**

West Midlands Hospital Trust Gets Share of £850 Million
University Hospitals Birmingham NHS Foundation Trust is one of the 20 health organisations to receive a share of £850 million in new funding. The Trust will receive £97.1 million, which will go towards providing a new purpose-built hospital facility at Heartlands Hospital in Birmingham, to replace outdated outpatient, treatment and diagnostic accommodation. **Heart (05.08.19)**

Shropshire hospitals welcome 150 new junior doctors
The junior doctors have come to The Shrewsbury and Telford Hospital NHS Trust (SaTH) to continue their training and will work across a wide range of specialties, including medicine, surgery and women and children's services. Dr Jenni Rowlands, director of postgraduate education at SaTH, which runs Royal Shrewsbury Hospital and Princess Royal Hospital in Telford, said: "We are delighted to have welcomed more than 150 new doctors to the trust. **Shropshire Star (08.08.19)**

Mental health of nearly 14,000 children across Shropshire 'in danger of being sidelined'
Nearly 14,000 children across Shropshire who have been abused or neglected could be sidelined by mental health services as a result of changes being introduced by the NHS, according to research by a children's charity. The NSPCC is now calling on NHS England to set out how it will prioritise the needs of vulnerable children and for more transparency over how mental health services commissioning decisions are made. The charity analysed the latest annual mental health plans published by NHS clinical commissioning groups (CCGs).

The plans set out how they will care for children's mental health, and the NSPCC found that 82 per cent across England were not properly planning for the needs of vulnerable children. **Shropshire Star (09.08.19)**

Businesses across borough urged to open up doors to nurses
CAFES, restaurants and petrol stations across the borough are being asked to open their doors to allow hard-working community nurses to take a break between shifts. Bosses at the Dudley Group NHS Foundation Trust are launching the campaign to help community nurses who often work out and about for hours at a time without being able to have a comfort break. **E&S, Stourbridge, Dudley & Halesowen News (17.08.19)**

'Infertile' Stourbridge renal patient has healthy baby
A woman with kidney disease who was told she could never have children has given birth to a "miracle" baby girl. Ellie Pierce-Oliver, 28, from Stourbridge, West Midlands, had dialysis for three hours a day, six days a week, in the final five months of her pregnancy. Fewer than 7% of women on dialysis conceive, said Dudley Group NHS Trust. It is the first birth at the trust for a female renal patient in more than 20 years, a spokesperson added. Ms Pierce-Oliver's daughter Nicci was delivered by caesarean at Russells Hall Hospital, Dudley. **BBC News (18.08.19)**

Tears as non-emergency ambulance contract is lost to private company
MORE than 80 ambulance service staff have been left fearing for their jobs says the union Unison, after West Midlands Ambulance Service (WMAS) lost the contract for non-emergency patient transport. It came after the Worcestershire clinical commissioning groups (CCGs) of local doctors awarded the service to private firm E-zec Medical Transport. Unison said this was in spite of the fact WMAS had run the service for 30 years and received an outstanding Care Quality Commission review. So far E-zec, which currently runs the non-emergency ambulance transport service for Herefordshire CCG, has not confirmed if it will keep the current stations in Kidderminster, Bromsgrove and Worcester. **Worcestershire Observer (18.08.19)**

Bags of cash as nurses switch
Ward staff from Russells Hall Hospital teamed up with a Kingswinford supermarket to raise money for poorly children. Nurses from the children's ward and their families spent a Saturday at Morrisons supermarket in Stallings Lane packing bags to raise funds for the ward and also Clic Sargeant, Morrisons' designated charity, which supports children and young people with cancer. **Express & Star (19.08.12)**

National recognition for Dudley Group anaesthetics
Anaesthetists at Dudley Group NHS Foundation Trust have been recognised for providing the highest quality care to their patients by achieving the prestigious Anaesthesia Clinical Services Accreditation (ACSA) from the Royal College of Anaesthetists (RCoA). **Express & Star (20.08.19)**

West Midlands Ambulance Service to take over NHS 111 service
West Midlands Ambulance Service will take over the running of the NHS 111 service for the majority of the region in November, it has emerged. It will take over from Care UK in all areas except Staffordshire, where the 24-hour-a-day, seven-day-a-week health phone line will continue to be run by Vocare. Workers will transfer over to WMAS, which intends to boost staff numbers ready for the busy winter period. **Express & Star (20.08.19)**

Up to 10,000 West Midlands children not up to date with MMR vaccine
Health officials are warning that up to 10,000 West Midlands five-year-olds are not fully immunised against MMR. Public Health England (PHE) is urging parents of primary school starters urged to check their children's immunisation records, saying that thousands may not be fully up-to-date with the 4-in-1 pre-school booster.
The estimates, released as part of PHE's Value of Vaccines campaign, show that some four and five-year-olds are starting school at risk of contracting serious diseases compared to the majority of their classmates.
Express & Star (20.08.19)

West Midlands Ambulance Service initiative shortlisted for award
West Midlands Ambulance Service has been nominated for a national award for its work supporting veterans and serving military personnel. WMAS has made it through to the final of the 2019 Health Service Journal (HSJ) awards for its Two Uniforms, One Job scheme, which supports employees who currently serve or have served in the military. **Express & Star (21.08.19)**

West Midlands hospital trust takes over its ninth GP practice
Nine GP practices have been subcontracted to a West Midlands hospital trust as part of a 'vertical integration' scheme, with a further practice set to follow, the trust has announced. The Royal Wolverhampton NHS Trust (RWT), which already had responsibility for eight practices across the area, has confirmed it had taken on an additional surgery in June. **GPOnline (22.08.19)**

Changes to emergency dental services in Coventry and the West Midlands
A consultation has been launched on plans to cut emergency dental services in the West Midlands. NHS England and Improvement is proposing to reduce the number of out of hours weekend and bank holiday sites from 13 to eight, with longer opening hours for those remaining. It also plans to reduce weekday evening sites from eight to five with longer opening hours. Two Warwickshire sites in Bedworth and Stratford-upon-Avon are among those to close, alongside one in Solihull. **Coventry Live (22.08.19)**

NHS spends £92 million on private ambulances and taxis to attend 999 calls
Research shows England's ambulance trusts spent more than £92 million in the last year on private ambulances and taxis to transport patients. Major ambulance trusts are increasingly relying on private ambulances to attend 999 calls, an investigation has found. **Birmingham Live (27.08.19)**

Enclosure 14

The Dudley Group NHS Foundation Trust

Paper for submission to the Board of Directors Sept 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.
Appendix 1 Staffing report for June
Appendix 2 Safeguarding update

Specialist Nurse Away Day

The first Specialist Nurse away day was held on the 8th July 2019. This event was attended by 45 specialist nurses from the hospital and community. The day focused on celebrating the achievements of our Specialist Nurses and making plans for the future of this specialist resource within the organisation. The day showcased the work of some of our specialist nurses, alongside presentations related to the advancement of specialist nursing. The day included:

- Virtual Clinics for Biologics
- The Gold Standards Framework
- Research activity and involvement
- Listening into Action and Patient Experience
- The role of the Nurse Consultant in lung cancer
- RCN accreditation for advanced practice
- Academic Advancement for Specialist Nurses

The day was very well received and has provided the basis for ongoing development work with this group of staff.

Safer Staffing and Skill Mix Review

- The Inpatient wards skill mix review was completed in June 2019 using a triangulated approach in line with the National Quality Board recommendations.
- The recommended ward nursing establishment was implemented in July 2019

.**AHP Update**

Ear Nurse and Throat (ENT) pilot

- The physiotherapy led consultant ENT vestibular clinic commenced on 2nd July 2019, two days a week and the pilot will run until the end of December 2019.
- The idea is to utilise specialist physiotherapists who are trained in treating dizziness replacing of consultants. This will reduce waiting times in ENT, reduced onwards referrals to physiotherapy and Dudley Rehabilitation Service and improve patient satisfaction with a more efficient patient pathway. It is anticipated that this will generate cost savings for the Trust. Long term, the plan is to support the physiotherapist to complete their prescribing qualification which will support a reduction in consultant referrals.

Frailty pilot

- The pilot commenced on Monday 8th July and is scheduled to complete Friday 26th July.
- Therapies have the use of up to 7 cubicles in the ambulance triage area in the Emergency Department (ED) as the 'Fit to Sit (FTS)' area. Therapy cover is from 08:00 to 18:00 every day for the duration of the trial. Staffing for the pilot is via extra shifts from the therapy team who cover ED/FAU/AMU, as well as a number of individuals from other teams. The team has also had shifts offered by community and local authority occupational therapy (OT) colleagues (including Intermediate Care Team, Macmillan, Reablement and Assessment & Independence/Moving & Handling teams).
- The team are screening all patients in ED (majors and minors) and ambulance triage, identifying the frail elderly patients who have no urgent medical needs, commencing assessment, treatment and discharge plans in these areas before they even need to move to the Frailty FTS area; they will do the same for any appropriate patients in FTS.
- They will prioritise those patients who can be discharged directly from any of these areas, with

the appropriate care/support/signposting. They will also initiate assessment and treatment plans for those patients who will be admitted, which can then be progressed by the ward teams. The Medical Directorate are evaluating the pilot with the view to full implementation. The Therapists involved are very positive regarding the benefit for patients.

Agency Controls

- All bank and agency requests are now being assessed by the Divisional Directors with the support of the Divisional Chief Nurses.
- All requests for non-framework agency are by Executive authorisation only.
- Reduction in Agency utilisation has been demonstrated for July 19.

Recruitment Activity

The trust held a corporate recruitment event on the 20th August 2019 9.30am -12pm in main reception health hub. This event recruited two substantive members of staff and one bank member of staff.

Local recruitment events held and recruited to are:

Recruitment Event	Date of Event	Number of conditional offers made
Corporate recruitment event	4th July	Attendance of 2 External Students due to qualify September 2019 and January 2020, and 1 experienced nurse. Conditional offers for substantive posts made to all 3.
ED	5th June 2019	Attendance 5 students (4 Dudley and 1 external) Conditional offers made for 3 Dudley January intake students and 1 Dudley September student.
B3	19th June 2019	Attendance 2 experienced nurses Conditional offers made to both.
C8	11th July 2019	1 attended but not appointed as just wished to visit the area, sign posted to rolling advert if considered applying.
C3	17th July 2019	0 attended
Community	26th July 2019	0 attended

No areas have local events booked for August 2019, but events are scheduled for September 2019.

At the time of the report, a total of 21.45 WTE experienced staff Band 5 and above are currently going through recruitment clearances. (This is an approximate figure from a raw TRAC report at the time of the report)

31.12 WTE Dudley and 20.96 WTE external graduates ***(total 52.08 WTE)*** have been recruited and offered posts within the Acute, Community and Paediatrics areas for September 2019, with a further 1

WTE Dudley and 2.6 WTE external students ***(total 3.6 WTE)*** due to commence in October (This is a raw data search of graduates engaged in the process at the time of the report).
This equates to a ***total 55.68 WTE*** commencing October/September 2019.

Professional Development

- **Trainee Associates Project**
- 19 TNA S started at Worcester University on 15th July 2019. Two of the candidates were deferred due to annual leave at the start of the programme and 5 were deferred due to EFSA (Education and Skills Funding Agency) funding not accepting their qualifications, despite these qualifications being accepted by the university.
- 11 of the TNAs are external candidates therefore we will be reviewing what additional support they will require compared to our internal Clinical Support Workers.
- We are currently interviewing for the September cohort at Wolverhampton University, we have accepted 18 candidates to date on the next intake with additional interviews being arranged.
- The NMC has announced changes to the new TNA curriculum; it is now 50% practice and 50% theory also protected practice time compared to 20% theory and 80% practice previously.

Deteriorating Patient Pathway

- The Deteriorating Patient Lead post has now been appointed to. The successful applicant will commence in October 2019

Pre-Registration

- The trust has been successful in a bid to increase the number of pre-registration students from September. Discussions with universities are underway. This further demonstrates the Trust commitment to nursing teams.
- We continue to raise awareness of the new NMC standards through the health HUB and other forums.

Safeguarding

- Recruitment to The Head of Safeguarding post has been successful. The new post holder will commence early November 2019.
- The Deputy Chief Nurse is maintaining operational management of the safeguarding team.
- An offer has been made for the designated Doctor post.
- Annual Report 2018/19 has been reviewed and approved by the Clinical, Quality, Safety and Patient Experience Committee and will now be published on the Trust website.

Falls

- Becky Plant, inpatient falls prevention lead, has been elected as chair of the National Falls Practitioner Network.
- There was one fall with harm was reported in July 2019. A patient fell and sustained a fractured neck of femur which has been successfully repaired and the patient is recovering on the hip suite.
- Falls C-QUIN auditing is completed for Q1 and 59% overall compliance is expected.

Mental Health Act

- During July 2019 there were two patients detained under the Mental Health Act. The first was detained under section 5/2 and was then discharged home. The second was detained under section 2 and subsequently admitted to the mental health Trust. Lead for Mental Health has been absent for an extended period this has been highlighted as a risk within the Division.

Tissue Viability

- There has been one upstaged category 3 - 4 on B1 reported as a serious incident.

Patient Experience

- The Leukaemia Appeal Fund has funded the 'special garden' at Russells Hal Hospital. The garden is situated in the ground floor courtyard close to the Bushey Fields entrance. This will be a quiet place for our end of life patients to spend precious time with their families as well as other groups of patients. Work has begun on the garden which will be completed by the end of August 2019. The Head of Patient Experience is working with the appeal fund on a plaque and a name for the garden. There will be an official opening once the work is completed.

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:**

The Dudley Group NHS Foundation Trust

Appendix 1

Paper for submission to the Finance and Performance Committee 25th July 2019

TITLE:	**Nurse Staffing Report – June 2019**		
AUTHOR:	**Mitchell Fernandez -** Deputy Chief Nurse & CNIO	**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.*	

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

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

RECOMMENDATIONS FOR THE Finance and Performance Committee

To receive the report and note the contents.

CORPORATE OBJECTIVE:

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

SUMMARY OF KEY ISSUES:

Safer Staffing

- The qualified staff fill rates for June 2019 were 86% during the Day and 89% during the Night. The overall qualified staff fill rates was 87%. The target fill rate for qualified staff is set at 90% since December 2018.
- All areas are within the agreed variation of 6.3 or more for the CHPPD. Overall Trust CHPPD is

9.65 (qualified and unqualified) in June 2019.

- Inpatient wards skill mix review was conducted in June 2019 using a triangulated approach and reduction in WTE was implemented in July 2019.
- There were 47 incidents reported during the month of June 2019. Forty five of these were recorded as no harm and near miss whilst two were of low harm. The two low harms pertain to staffing shortfall due to sickness and no ward doctor available on Saturday delaying TTOs and patients discharge by the on call doctor.
- Thirty two out of 47 incidents were reported from Maternity services. Mitigations include Midwifery daily response meeting and staff redeployment
- There were no staffing incidents during April-June 2019 reported as causing moderate to severe harm
- Review of staffing numbers through safety huddle continues twice a day facilitated by the Divisional Chief Nurses.
- Conduct of patient acuity and dependency continues daily in bedded units and information are utilised in managing staffing resources and staff movements between wards

Agency Controls

- There was a slight decrease in June 2019 (1,845) agency usage in comparison to previous month usage of 2,205 agency shifts.
- There was continued reduction of overall temporary staffing usage including agency since March 2019.
- All bank and agency requests continue to be risk assessed by the Divisional Chief Nurses to ensure continued patient safety and financial balance supporting the overall reduction in temporary staffing use.
- A new rule was introduced in July 2019 whereby requests for temporary staff (bank and agency) can only be made in exceptional circumstances and authorised by the Divisional Director

Recruitment and Retention update

- At the time of the report, a total of 48.1 WTE experienced staff are currently going through recruitment clearances.
- 37.64 WTE Dudley and 23.96 WTE external graduates have been recruited and offered posts within the Acute, Community and Paediatrics areas for September 2019
- Targeted and monthly recruitment events continue.

IMPLICATIONS OF PAPER:

RISK	**Yes**	• **Risk Description:** ➢ Nurse Recruitment – unable to recruit to vacancies to meet NICE guidance for nurse staffing ratios ➢ Finance – Unable to remain within divisional Budget due to spend on Temporary Staff.

	Risk Register: Yes		**Risk Score: 20**
COMPLIANCE and/or LEGAL REQUIREMENTS	**CQC**	**Yes**	**Details:** CQC Fundamental Standards: Staffing
	NHSI	**Yes**	**Details:** Capping of agency
	Other NQB	**Y/N**	**Details:** National Quality Board (NQB) guidance; 'How to Ensure the Right People, with the Right Skill, are in place at the Right time'

Safer Staffing

The Safer Staffing Summary (Appendix 1) shows the qualified staff and unqualified staff fill rates for both day and night shifts for each area of the Trust based on the establishments that commenced in July 2018. In addition, the table shows the actual Care Hours per Patient Day (CHPPD) for the last three months. We provide this information to NHS Improvement and part of it is utilised in informing the National Model Hospital data.

As previously indicated, the report is based on the establishments set in July 2018 with the data coming from Allocate. The new wards nursing establishment based on 2019 skill mix review implemented in July 2019 will be reflected in future nurse staffing reports planned hours and fill rates.

The table 2 below indicates that fill rates have been improving when taking a Trust wide view since June 2018.

Table 2 – Trust position against fill rates

	Qualified Day	Unqualified Day	Qualified Night	Unqualified Night
June 2018	81%	90%	84%	96%
July 2018	80%	89%	84%	94%
Aug 2018	77%	89%	84%	94%
Sept 2018	78%	84%	83%	90%
Oct 2018	82%	87%	88%	92%
Nov 2018	84%	91%	88%	96%
Dec 2018	81%	87%	86%	91%
Jan 2019	83%	83%	87%	93%
Feb 2019	82%	85%	87%	93%
March 2019	83%	84%	88%	94%
April 2019	85%	89%	88%	94%
May 2019	87%	89%	90%	94%
June 2019	86%	90%	89%	94%

In June 2019, overall qualified fill rates was 87%. This is lower in comparison to previous month overall fill rate of 88% (May 2019) but higher in comparison to the same period last year, June 2018 fill rate of 82%.

Appendix 1 shows the details of all the wards staffing fill rates during the day and night for the first quarter of 2019/20 and the overall CHPPD.

Mitigation /action to manage staffing:

- Matrons review staffing numbers twice daily through a safety huddle in the morning and afternoon. The safety huddle is facilitated by a Divisional Chief Nurse and this includes review of wards' staffing numbers, skill mix, occupancy, patient acuity and dependency.

Staffing shortfalls are mitigated by moving staff between wards. Staffing issues are also discussed at the capacity meetings and support is requested when required.

- Lead Nurses and Matrons continue to meet regularly with the Divisional Chief Nurses to discuss staffing challenges, whilst maintaining patient safety and sustaining financial balance. Monitoring and contingency processes are in place daily to ensure that staffing is sufficient to meet patients' acuity and dependency.
- Each ward and department has a bespoke recruitment and retention action plan with monthly rolling adverts on NHS jobs.

Skill Mix Review Inpatient Wards:

Inpatient wards skill mix review was conducted in June 2019 using a triangulated approach:

- the use of evidence-based tools (Safer Nursing Care Tool - SNCT),
- professional judgement (discussion with senior nurses, divisions)
- and comparison with peers (usage of CHPPD for benchmarking through the Model Hospital)

A total of 17 WTE (11 RN & 6 HCAs) reductions was identified and agreed as a result of the skill mix review which equates to £609,024 financial savings. It comes to light that Medicine division has an agreed CIP contribution through nursing spend reduction commitment in 2019/20 with a total of £757,776.

The total financial savings on nursing spend based on the skill mix review plus Medicine Division CIP contribution is £1.36 million (see table below)

Skill Mix Review and Nursing Spend CIP Financial Impact		
Skill Mix Review (Acuity & Dependency 2019)	Surgery	£406,362
	Medicine	£202,662
	A&D Total	£609,024
Nursing Spend CIP 2019/20 (Medicine Division)	ED	£143,772
	AMU	£308,004
	CCU	£165,600
	C5	£123,600
	C4	£16,800
	Total CIP	£757,776
Total Nursing Financial Savings		£1,366,800

Care Hours per Patient Day (CHPPD)

Following the publication of the Carter Review (2016) NHS Improvement have issued new guidance which requires all Trusts to report Care Hours per Patient Day. From May 2016 CHPPD has become the principle measure of nursing and care support deployment. CHPPD provides a single consistent metric of nursing and healthcare support worker deployment on inpatient wards and units. Care hours per patient day (CHPPD) (Appendix 1) for the majority of ward areas remain within the nationally agreed variation of 6.3 CHPPD and 16.8 CHPPD for general wards (Carter Review, 2016).

Overall Trust CHPPD is 9.65 (qualified and unqualified) in June 2019. Based on the latest Model Hospital data, the Trust CHPPD (9.2) in February 2019 is higher in comparison to national (8.1) and peer (7.5) median. The June 2019 data in Model Hospital is not yet available at the time of writing this report.

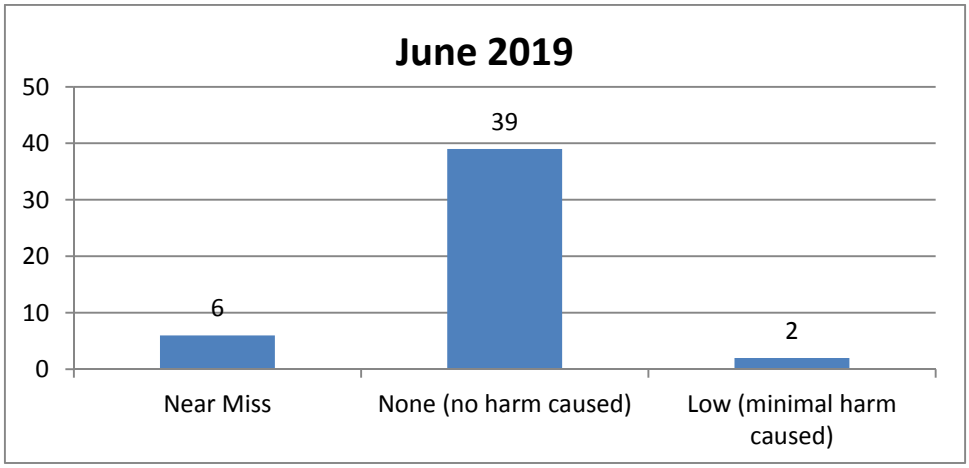
Quality Indicators and Clinical Incidents

Triangulation of data against staffing incidents and quality dashboard KPIs provides the oversight that safe, quality care is being delivered to our patients. Appendix 2 shows the wards quality heat map for the month of May 2019 (June 2019 is not yet available at the time of writing this report). The heat map is presented at the CQSPE as part of the Integrated Performance Report.

Tables 3 and 4 below detail the number of clinical incidents reported on DATIX during June 2019 that relates to staffing. There were 47 incidents reported during the month of June 2019. Forty five of these were recorded as no harm and near miss whilst two were of low harm. The two low harms pertain to staffing shortfall due to sickness and no ward doctor available on Saturday delaying TTOs and patients discharge by the on call doctor.

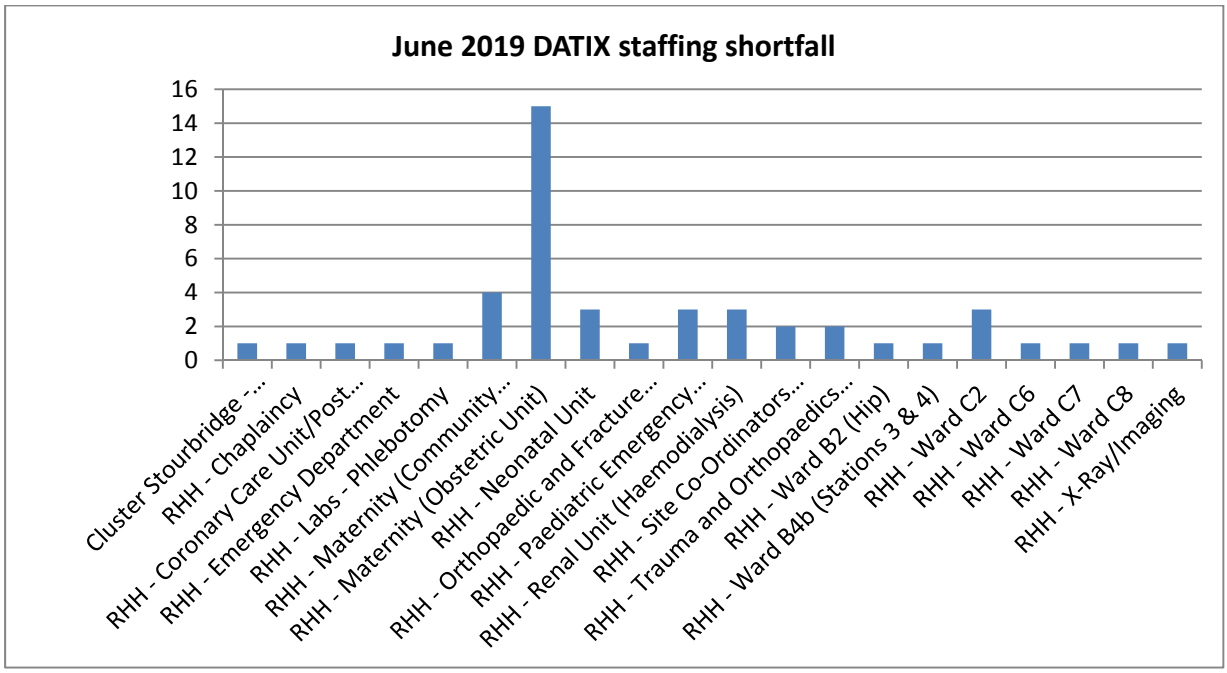
Thirty two out of 47 incidents were reported from Maternity services. Mitigations include Midwifery daily response meeting and staff redeployment.
There were no staffing incidents reported during June 2019 that was stated as causing moderate to severe harm.

Table 3



	Jun 2019
Near Miss	6
None (no harm caused)	39
Low (minimal harm caused)	2
Total	47

Table 4



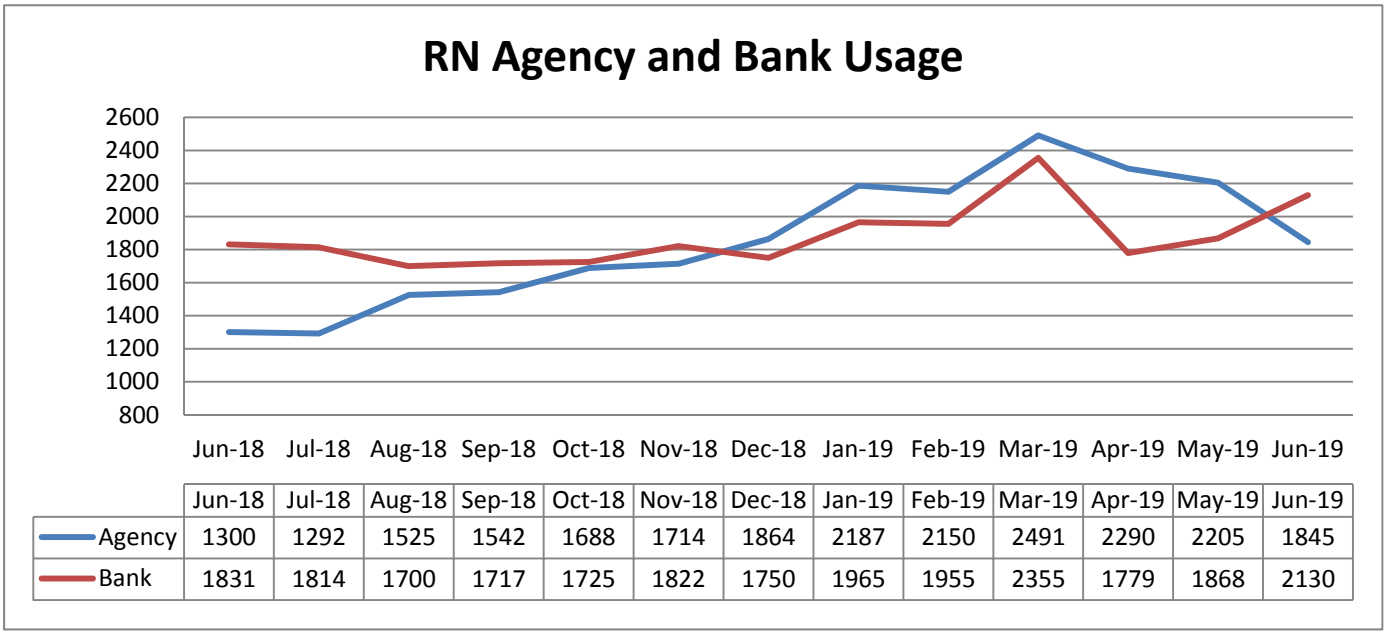
Agency Controls

All bank and agency requests continue to be risk assessed by the Divisional Chief Nurses to ensure continued patient safety and financial balance supporting the overall reduction in temporary staffing use. A new rule was introduced in July 2019 whereby requests for temporary staff (bank and agency) can only be made in exceptional circumstances and authorised by the Divisional Director.

Table 5 shows the comparison usage of bank and agency. During June 2019, bank and agency usage for qualified and unqualified has seen a slight decrease in comparison to previous month. There was continued reduction of overall temporary staffing usage including agency since March 2019.
The controls against agency usage for CSW staff have been maintained with zero shifts during this period (table 6).

Agency and Bank RN monthly usage

Table 5



	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19
Agency	1300	1292	1525	1542	1688	1714	1864	2187	2150	2491	2290	2205	1845
Bank	1831	1814	1700	1717	1725	1822	1750	1965	1955	2355	1779	1868	2130

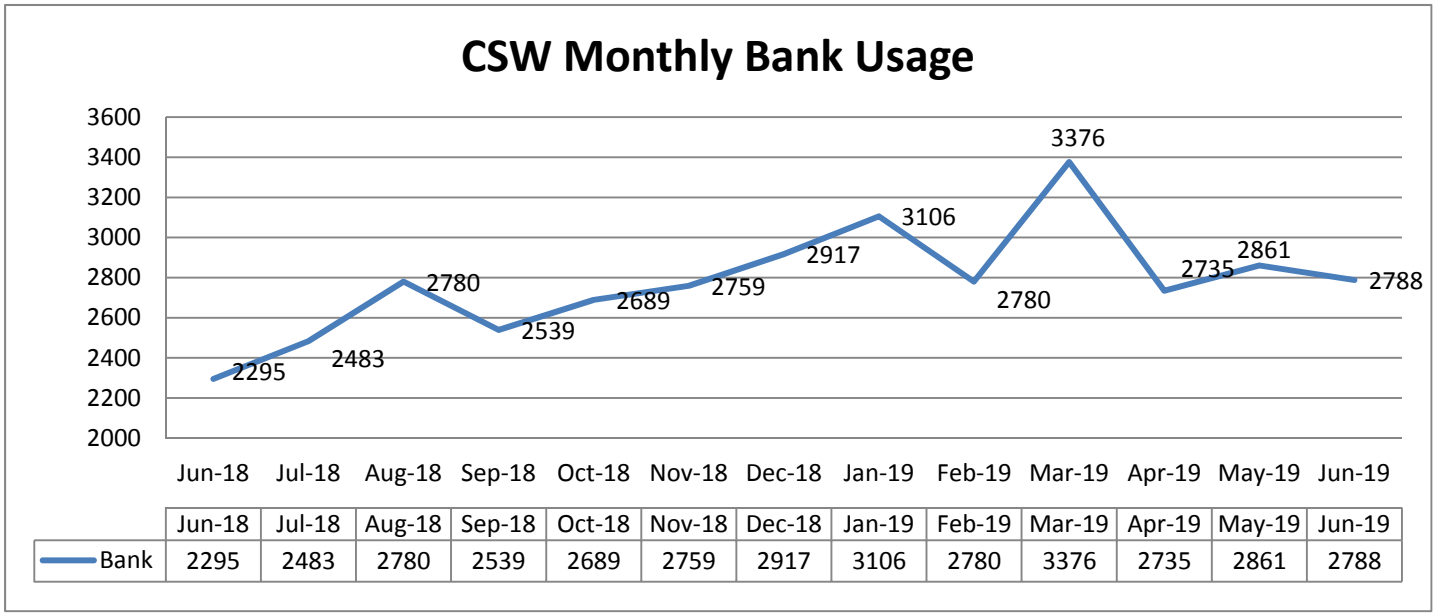
Top 5 areas for Agency use in the last three months

Ward	Apr-19
Emergency Dept Nursing Dept	317
AMU 1	245
B3 Emergency Surgery	155
Critical Care (ITU)	144
C8 Stroke Rehab Dept	142

Ward	May-19
Emergency Dept Nursing Dept	249
AMU 1	227
B3 Emergency Surgery	158
RHH Day Case Theatre & Recovery	143
Critical Care (ITU)	135

Ward	Jun-19
AMU 1	223
Emergency Dept Nursing Dept	148
B3 Emergency Surgery	129
RHH Day Case Theatre & Recovery	127
Coronary Care Unit Dept	119

CSW monthly bank usage
Table 6



	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19
Bank	2295	2483	2780	2539	2689	2759	2917	3106	2780	3376	2735	2861	2788

Summary situation of staffing and potential recruitment over the next year

Internal Recruitment Events

The next corporate recruitment event is scheduled for the 4th July 2019 9.30am -12pm in main reception health hub. The event will advertise for 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 are:

Recruitment Event	Date of Event	Number of conditional offers made
Corporate recruitment event	11th April 2019	Attendance of 3 student & 3 experienced nurses. Conditional offers made to 4.
C5 & CCU Local Area event	30th April 2019	2 conditional offers made to CCU
Community Local Area event	1st May 2019	1 internal transfer from acute & 1 Dudley student for September graduate programme offered conditional offers.
RCNi keep in touch event	1st May 2019	6 graduate's nurses attended who had been already offered posts at the RCNi event and confirmed acceptance for a commencement on the September graduate programme.
BCU University careers fair	8th May 2019	25 contacts made and names taken to showcase the Trust. No opportunity to interview but invited to our corporate events in May and June at the Trust.
Corporate recruitment event	10th May 2019	Attendance of 3 student nurses, 7 experienced nurses. Conditional offers made to 7.
Corporate recruitment event	14th June 2019	Attendance of 3 Dudley January Intake students & 1 external

		Derby student for September 2019 start & 5 experienced nurses. Conditional offers for substantive posts made to 4 students and 2 experienced nurses. 2 experienced nurses recruited for bank only.
ED	5th June 2019	Attendance 5 students (4 Dudley and 1 external) Conditional offers made for 3 Dudley January intake students and 1 Dudley September student.
B3	19th June 2019	Attendance 2 experienced nurses Conditional offers made to both.

The following areas have local events booked for July 2019:

- C8 – 11th July 2019
- C3 – 17TH July 2019
- Community 26th July 2019

External Recruitment
Booked Events
We have no external events booked, University events dates TBC Universities. No external events with a cost attached have been booked due to no resource or budget.

Recruitment Activity
At the time of the report, a total of 48.1 WTE experienced staff are currently going through recruitment clearances.
37.64 WTE Dudley and 23.96 WTE external graduates have been recruited and offered posts within the Acute, Community and Paediatrics areas for September 2019

The above numbers recruited are prone to change due to withdrawals, deferrals for non-completion of nurse training, personal reasons and external candidates taking posts in their training Trusts. This data is raw data and approximates of current recruitment activity taken from The TRAC system at the time of the report.

RN Predictor Tool Current and New Establishments

The summarised version of the RN predictor tool (Appendix 3) reflects all nursing vacancies across the Trust within clinical and non-clinical roles. It enables a clearer picture of the staffing situation across each group and the whole organisation. As of May 2019, there are 338 WTE vacancies against the nursing establishment set in previous staffing review (June 2018).

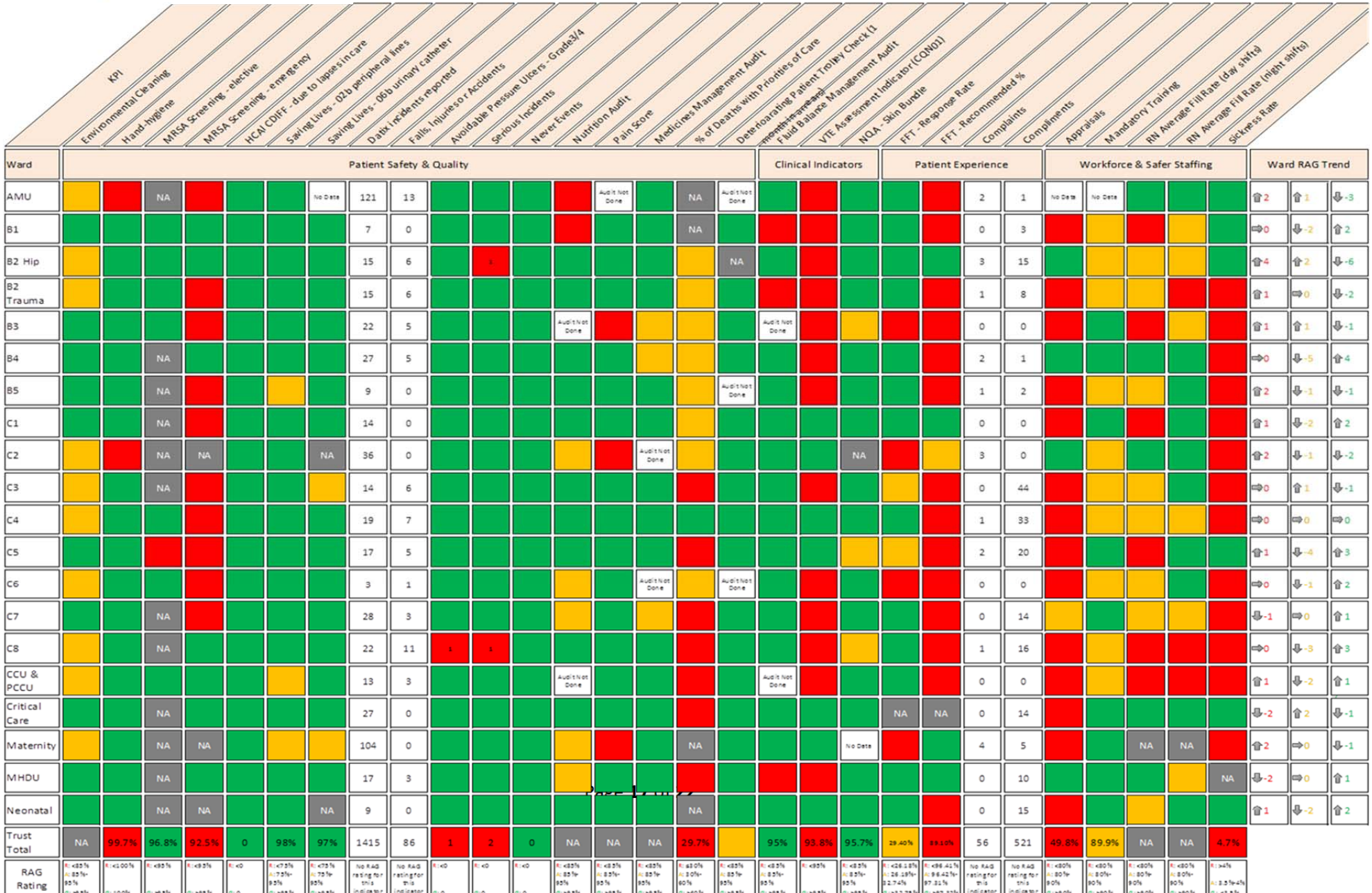
Appendix 1 – Percentage Fill rates by ward and CHPPD (April-June 2019) Q1 2019/20

	Apr-19					May-19					Jun-19				
Ward	Qual Day Fill	UnQual Day Fill	Qual Night Fill	UnQual Night Fill	CHPPD	Qual Day Fill	UnQual Day Fill	Qual Night Fill	UnQual Night Fill	CHPPD	Qual Day Fill	UnQual Day Fill	Qual Night Fill	UnQual Night Fill	CHPPD
B1	81%	109%	96%	89%	6.58	78%	110%	90%	98%	6.87	75%	117%	92%	98%	6.82
B2(H)	83%	73%	81%	97%	7.94	83%	78%	86%	99%	8.86	81%	80%	93%	95%	8.21
B2(T)	84%	86%	72%	91%	6.90	85%	90%	77%	94%	7.06	83%	90%	95%	94%	7.28
B3	69%	74%	83%	95%	7.97	78%	80%	88%	92%	8.35	71%	73%	77%	80%	7.76
B4	86%	80%	88%	89%	7.07	91%	89%	90%	95%	7.35	88%	86%	87%	98%	7.47
B5	86%	95%	96%	99%	11.12	87%	91%	96%	100%	11.61	91%	103%	95%	119%	12.53
C1	76%	96%	92%	94%	6.83	80%	97%	93%	99%	6.93	80%	95%	96%	97%	7.16
C2	92%	97%	94%	95%	10.54	92%	93%	95%	98%	14.52	93%	85%	93%	89%	12.03
C3	82%	99%	95%	92%	8.24	86%	91%	95%	91%	8.87	85%	100%	96%	99%	8.97
C4	93%	94%	85%	124%	7.03	91%	95%	84%	118%	6.94	88%	89%	64%	113%	7.35
C5	80%	106%	92%	100%	6.85	78%	110%	93%	97%	7.02	79%	105%	92%	96%	6.95
C6	89%	82%	98%	94%	7.64	89%	80%	97%	97%	7.22	89%	71%	98%	92%	7.47
C7	89%	84%	80%	91%	6.46	87%	89%	82%	96%	7.00	92%	92%	86%	97%	6.89
C8	71%	83%	76%	95%	8.03	74%	86%	76%	98%	8.48	70%	87%	79%	95%	8.51
CCU_PCCU	75%	118%	70%	116%	7.86	77%	117%	72%	119%	8.81	86%	98%	73%	97%	8.38
Critical Care	86%	77%	80%		30.75	93%	85%	92%		29.34	83%	86%	77%		30.34
EAU	88%	89%	89%	92%	11.78	97%	78%	99%	81%	13.12	97%	82%	102%	84%	13.30
Maternity	93%	90%	94%	92%	21.02	90%	87%	93%	94%	21.68	89%	89%	91%	86%	19.49
MHDU	95%	90%	92%	58%	19.68	95%	96%	86%	25%	21.57	93%	86%	90%	67%	19.48
NNU	95%		108%		8.09	87%		106%		11.32	86%		100%		10.83
TOTAL	**85%**	**89%**	**88%**	**94%**	**9.20**	**87%**	**89%**	**90%**	**94%**	**9.75**	**86%**	**90%**	**89%**	**94%**	**9.65**

NHS
The Dudley Group
NHS Foundation Trust

Heat Map - May 2019

Appendix 2



Qual Nurses Band 5 and Above		May 2019		To end of May 2019		June 2019				July 2019				August 2019				September 2019				October 2019				
Div	Team	Contracted Vacancy Vs OLD ESTABLISHMENT	Contracted Vacancy Vs NEW ESTABLISHMENT	Adjustments to end of month	Vacs	All Recruit	Net Leave (8%)	Agency RAG	Vacs	All Recruit	Net Leave (8%)	Agency RAG	Vacs	All Recruit	Net Leave (8%)	Agency RAG	Vacs	All Recruit	Net Leave (8%)	Agency RAG	Vacs	Targeted Recruit	General Recruit (4.3%)	Net Leave (8%)	Agency RAG	Vacs
Medicine & Integrated	Ward A2 AMU 2 incl EAU	0.00	0.00	0.00	0.00	0.00	0.00		0.00	0.00	0.00		0.00	0.00	0.00		0.00	0.00	0.00		0.00	0.00	0.00	0.00		0.00
	Ward C1	4.04	11.71	0.00	11.71	0.54	0.18		11.35	0.00	0.18		11.53	0.00	0.18		11.72	0.85	0.18		11.05	0.00	0.10	0.19		11.13
	Ward C3	10.11	10.45	0.00	10.45	0.00	0.17		10.62	0.00	0.16		10.78	0.00	0.16		10.94	1.70	0.16		9.40	0.00	0.09	0.17		9.48
	Ward C4	0.49	2.03	0.00	2.03	0.00	0.17		2.20	0.00	0.17		2.36	0.00	0.17		2.53	0.85	0.16		1.84	0.00	0.09	0.17		1.92
	Ward C4 Onc Day OP	3.00	5.04	0.00	5.04	0.00	0.08		5.12	0.00	0.08		5.20	0.00	0.08		5.28	0.85	0.08		4.50	0.00	0.04	0.08		4.54
	Ward C5 Area A	1.86	6.05	0.00	6.05	0.00	0.09		6.14	0.00	0.09		6.23	0.00	0.09		6.32	0.00	0.09		6.40	0.00	0.05	0.09		6.45
	Ward C5 Area B	3.34	7.53	0.00	7.53	0.00	0.08		7.61	0.00	0.08		7.69	0.00	0.08		7.77	0.00	0.08		7.85	0.00	0.04	0.08		7.88
	Ward C7	7.57	11.46	(0.83)	12.29	0.00	0.15		12.44	0.85	0.15		11.73	0.00	0.15		11.88	0.85	0.15		11.18	0.00	0.08	0.15		11.25
	Ward C8	10.51	26.87	0.52	26.35	0.00	0.18		26.53	0.00	0.18		26.71	0.00	0.18		26.89	0.85	0.18		26.22	0.00	0.10	0.18		26.30
	Ward CCU	10.40	17.62	0.00	17.62	0.00	0.18		17.80	0.34	0.18		17.64	0.85	0.18		16.96	3.40	0.18		13.75	0.00	0.11	0.20		13.84
	Acute Med Unit (EAU)	18.45	23.67	0.00	23.67	0.00	0.38		24.05	0.00	0.37		24.42	0.00	0.37		24.79	7.48	0.37		17.68	0.00	0.22	0.42		17.87
	Ward Ambulatory Emergency Care	1.79	0.35	0.00	0.35	0.00	0.08		0.43	0.00	0.08		0.50	0.00	0.08		0.58	0.00	0.08		0.66	0.00	0.04	0.08		0.69
	Emergency Department Nursing	(14.99)	13.65	0.35	13.30	0.82	0.53		13.01	0.00	0.53		13.54	0.00	0.54		14.08	9.35	0.52		5.25	0.00	0.30	0.59		5.54
	Community Nursing	26.89	18.62	0.00	18.62	0.00	0.84		19.46	0.00	0.83		20.29	0.00	0.83		21.11	5.64	0.82		16.29	0.00	0.46	0.85		16.69
	All Other Med & Int Care Teams	(12.75)	47.76	0.15	47.61	0.43	1.72		48.91	0.43	1.71		50.19	0.00	1.70		51.90	1.28	1.69		52.32	0.00	0.91	1.69		53.10
Surgery	Ward B1	5.91	7.06	0.09	6.97	0.00	0.08		7.05	0.00	0.08		7.14	0.00	0.08		7.22	0.85	0.08		6.45	0.00	0.05	0.09		6.49
	Ward B2 (T)	5.00	7.66	0.00	7.66	0.00	0.07		7.73	0.00	0.06		7.79	0.00	0.06		7.85	1.70	0.06		6.22	0.00	0.04	0.07		6.25
	Ward B2 (H)	1.60	9.33	0.00	9.33	0.00	0.14		9.47	0.00	0.14		9.62	0.00	0.14		9.76	0.00	0.14		9.90	0.00	0.07	0.14		9.96
	Ward B3	14.32	20.81	0.00	20.81	0.00	0.11		20.92	0.00	0.11		21.04	0.00	0.11		21.15	0.85	0.11		20.41	0.00	0.06	0.12		20.46
	Ward B4	(0.16)	2.45	0.00	2.45	0.00	0.11		2.56	0.68	0.10		1.98	0.00	0.11		2.09	1.70	0.11		0.50	0.00	0.06	0.12		0.55
	Ward B4B	(1.04)	1.75	0.00	1.75	0.00	0.11		1.86	0.00	0.11		1.97	0.00	0.11		2.08	1.70	0.11		0.49	0.00	0.06	0.12		0.55
	Ward B5	(3.18)	0.92	0.00	0.92	0.00	0.25		1.17	0.00	0.25		1.43	0.00	0.25		1.68	2.55	0.25		(0.62)	0.00	0.14	0.26		(0.50)
	Ward C6	4.48	3.75	0.00	3.75	0.00	0.08		3.83	0.00	0.08		3.92	0.00	0.08		4.00	0.00	0.08		4.08	0.00	0.04	0.08		4.12
	Ward C2	(0.68)	7.43	0.00	7.43	0.00	0.26		7.69	0.00	0.26		7.95	0.00	0.26		8.20	3.40	0.25		5.06	0.00	0.15	0.27		5.18
	Neonatal Unit	0.76	0.46	0.00	0.46	0.00	0.26		0.72	0.00	0.26		0.98	0.00	0.26		1.23	0.00	0.25		1.49	0.00	0.14	0.25		1.60
	I.T.U.	12.54	17.12	0.00	17.12	0.00	0.39		17.51	0.00	0.38		17.89	1.70	0.38		16.57	8.50	0.39		8.46	0.00	0.24	0.44		8.66
	Ward MHDU	(8.16)	2.52	0.00	2.52	0.00	0.17		2.69	0.00	0.17		2.86	0.00	0.17		3.03	0.85	0.17		2.35	0.00	0.09	0.17		2.43
	Theatres (Excl ODP's)	19.30	28.24	0.01	28.23	0.00	0.32		28.55	0.00	0.32		28.86	0.00	0.31		29.18	5.95	0.31		23.54	0.00	0.19	0.35		23.70
	Day Case Theatres (Excl ODP's)	2.40	8.66	0.00	8.66	0.00	0.30		8.96	0.00	0.29		9.25	0.85	0.29		8.69	0.85	0.29		8.13	0.00	0.16	0.30		8.27
	Maternity unit	8.48	8.87	0.01	8.86	0.00	0.64		9.50	0.00	0.64		10.14	0.00	0.63		10.77	0.00	0.63		11.40	0.00	0.34	0.62		11.69
	All other Surgery Teams	(21.09)	2.28	(0.34)	2.62	0.43	1.17		3.36	0.43	1.16		4.10	0.00	1.16		5.26	1.28	1.15		5.14	0.00	0.62	1.15		5.67
Corp	All Corp Teams	(18.62)	6.19	0.00	6.19	0.00	0.29		6.48	0.00	0.29		6.77	0.00	0.29		7.06	0.00	0.29		7.35	0.00	0.33	0.62		7.64
Total Qualified Nurses		92.56	338.31	(0.04)	338.35	2.21	9.56		345.70	2.72	9.51		352.49	3.40	9.48		358.57	63.27	9.42		304.72	0.00	5.43	10.13		309.42

Notes:

- The above figures report on Trust start date rather than end of supernumerary period so new staff in a particular month are unlikely to work independently until the following month.

- Adjustments are required to bring current period up to date to the end of the month due to staff starting / leaving / transferring department mid way through the month

- Attrition rate of 15% applied to known future recruitment based on historic average

- Agency RAG Rating is used to guide approval of Agency requests:
  Green = Under old budgeted establishment and high level of vacancies. **Amber** = 5-10% Vacancy rate, **Red** = Over old budgeted establishment or less than 5% vacancy rate

- New Establishment uses M12 2018/19 budgeted establishment which represents best fit to future planned level of staffing. This does not reconcile to in month WTE budget as reported in finance F&P report.

The Dudley Group NHS Foundation Trust

Group Highlights Summary to Clinical Quality, Safety and Patient Experience Committee

Meeting	Safeguarding Board	**Chair**	Mary Sexton Interim Chief Nurse	**Quorate**		**Declarations of Interest made**	
Meeting Date	18/07/19	**Report completed by**	Jo Wakeman Deputy Chief Nurse	**Yes**			**None**

Item	Details	Action as a result	Update / Progress
	Gap in leadership role within Mental Health – Liberty protection safeguarding arrangements are due to be in place by September 2020. This involves devolution of deprivation of liberty assessments from Local Authority to local providers.	Risk to be added to safeguarding risk register and Medicines risk register. Meeting with Chief Nurse and Divisional Chief Nurse (Medicine) to discuss mitigations.	
	Annual Safeguarding report presented 2018/19	Approved for public sharing following minor amendments. Agreed Rachael Collins would complete narrative for mental health to be added to the report.	
	Development of new dashboard that will provide the framework for reporting to Inturnal Safeguarding Board.	Dashboard to be reviewed and developed and presented at each quarterly Internal Safeguarding Board.	
	Risk Register reviewed	Noted by Chief Nurse some dates missing to be added onto the risk register. Risk relating to key leadership role within mental health to be added.	

Item	Details	Action as a result	Update / Progress
	The 9 STP safeguarding work streams across the black country presented showing Dudley Group of Hospitals representation.	Chair requested an update from each of the representatives at each quarterly meeting.	
	A new approach to safeguarding training was presented. This clearly demonstrated which staff required level,1,2 & 3 training. Requested a start date 1st November 2019.	Chair requested that a solution regarding monitoring and recording of completed and partial training be reviewed. To prevent compliance of level 2 and 3 training radically reducing within high risk areas as we transition across. The committee members agreed that the principle of the new training was a much better way of ensuring appropriate learning continues over a three year period.	
	Workforce presented an update on current position relating to DBS checks. Noted 600 clinical staff including high risk areas was out of date for three year checks.	Advised this was already highlighted as a risk on the workforce risk register. A business plan has been developed for consideration to centralize DBS checks back into recruitment rather than carried out locally. To be reported on each month with updates on the business plans.	
	It was reported by the Learning Disability Lead that that there had been 5 deaths of patients who had learning disabilities. As part of Learning From Deaths (2017) each death involving a patient who has learning difficulties must have a cross professional boundary standardized independent review. No evidence of a mortality review due to inappropriate coding.	Datix incident Ensure Lead for mortality review informed of cases. Coding issue identified and resolved.	

Item	Details	Action as a result	Update / Progress
	Child Death Lead highlighted concerns of 5 cases whereby form B had not been completed by Paediatrician. This information is required to assist in the Child Death overview Panel meetings. Escalated within Division.	Escalate concerns to the Medical Director Meeting Wednesday 24th July 2019.	
Decisions made by the Group **As highlighted within actions.**			
• Safeguarding Annual Report to be submitted to CQSPE next month for approval prior to publication • A solution regarding monitoring and recording of completed and partial Safeguarding Training be reviewed • The Group approved of the proposed business case to re-centralise DBS Checks within the HR Department			

Enclosure 15

The Dudley Group
NHS Foundation Trust

Paper for submission to the Board of Directors (Public Session) on Thursday 5th September 2019

TITLE:	**Clinical, Quality, Safety & Patient Experience (CQSPE) Highlights Reports for 23 July 2019 and 27th August 2019**		
AUTHOR:	**Mary Sexton**	**PRESENTER**	**Julian Atkins/ Catherine Holland**

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:

The Board to note the assurances provided by the Committee the matters for escalation and the decisions made by the Committee.

CORPORATE OBJECTIVE:

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

The Dudley Group
NHS Foundation Trust

SUMMARY OF KEY ISSUES:			
As detailed in the paper.			
IMPLICATIONS OF PAPER:			
RISK	**Y**		**Risk Description:**
	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: 23/07/2019

MATTERS OF CONCERN OR KEY RISKS TO ESCALATE	MAJOR ACTIONS COMMISSIONED/WORK UNDERWAY
• Integrated Performance Report not received due to unavailability of data • Increase of number of policies and SoPs and guidelines out of date. • Lack of quoracy for the Sterile Services Group resulting in meetings being cancelled. Opportunities to learn from incidents are being lost. • No Designated Safeguarding Doctor appointed within the Trust. • Triage and shortage of ESI nurses. Chief Operating Officer to report next month. • Greater focus and forward planning required for future Annual Waste Management Inspections.	• A review of the current process for reviewing policies, SoPs and guidelines was requested by the Committee. • Initiatives to embed learning Trustwide. • Greater shared learning initiatives required to ensure there is shared and embedded Trustwide learning from incidents.
POSITIVE ASSURANCES TO PROVIDE	**DECISIONS MADE**
• A Private CQSPE meeting took place after the main meeting to present and discuss referrals to professional bodies. This will continue on a quarterly basis. • Paediatric Follow-up service is being reviewed to prevent backlogs re-occurring. • Requesting of Chest X-Rays on Sunrise. An assurance was provided and action closed. • CQC Action plans have been combined into one single plan through the Achieving Excellence Group. • A new paper combining complaints, litigation, incidents and PALS was presented and will be brought on a quarterly basis. • Letter received from CQC amending the Section 31 notice for ED. • Assurance was provided regarding an HSE concern made by a Junior Doctor regarding the safe transfer of highly critical patients by ambulance. A letter of response was sent to HSE and risk added to the risk register.	• 8 policies were brought to the Committee and were ratified. • Patient Experience Strategy was approved. • The Committee formally acknowledged receipt of the CQC Inspection Report.

Chair's comments on the effectiveness of the meeting:

- **A good level of positive challenge and discussion**
- **There is a requirement for a Clinical Non-Executive Director to join the membership of this Committee.**

UPWARD REPORT FROM CQSPE

The Dudley Group NHS Foundation Trust

Date Committee last met: 27/08/2019

MATTERS OF CONCERN OR KEY RISKS TO ESCALATE	MAJOR ACTIONS COMMISSIONED/WORK UNDERWAY
• Corporate Risk TAC017 – Interserve cannot guarantee uninterruptable power supply to theatres with the potential for adverse patient outcomes. This was challenged and a paper requested next month. • Trust is unable to complete RCAs within the 90 day timeframe when case is referred to the HSIB due to their timeframes.	• Live CQC Action Plan to be shown to the Committee next month to provide assurance • Paper requested regarding uninterruptable power supply to theatres to include assurance around longer term planning to ensure sufficient power supply to the site when upgrades take place. • An external audit has been commissioned to provide analysis of mortality data, standards of care for patients with sepsis, review work undertaken to date and recommend additional steps. • Work underway with Divisions to merge overlapping policies where possible
POSITIVE ASSURANCES TO PROVIDE	**DECISIONS MADE**
• No children are waiting longer than 20 weeks for paediatric follow-up.	• Safeguarding Annual Report approved for external publication • 4 policies ratified, as recommended by the Policy Group • The Committee endorsed the closure of one Serious Incident considered by the Patient Safety Team

Chair's comments on the effectiveness of the meeting:

- The Committee shifted to a higher level of function at this meeting, with a focus on governance and challenge for assurance
- It was suggested that all papers from visitors are tabled at the beginning of the meeting in future
- Consistent themes were about risk, assurance and mitigation.

Enclosure 16

The Dudley Group NHS Foundation Trust

Paper for submission to Trust Board September 2019

TITLE:	**Learning from Deaths**		
AUTHOR:	**Dr Philip Brammer Deputy Medical Director**	**PRESENTER**	**Dr Julian Hobbs, Medical Director**
CLINICAL STRATEGIC AIMS			
	Strengthen hospital-based care to ensure high quality hospital services provided in the most effective and efficient way.		
CORPORATE OBJECTIVE:SO2: Safe and Caring Services			

SUMMARY OF KEY ISSUES:

- Mortality continues to fall and SHMI has reduced to 113. This is at expected range.
- The Trust has recorded 1096 deaths year to date. 52% have been reviewed at speciality level, with being completed within the 30 day standard. 260 deaths have triggered for a second stage review with 70% of these reviews being completed.
- To strengthen the review process a working group has been established supported by the Dudley Improvement Practice and a full time learning from Deaths Officer employed.
- Improvement work is underway with the Advancing Quality Alliance (AQuA) regarding deteriorating patient pathways.

IMPLICATIONS OF PAPER:

RISK	**Y**		**Risk Description: Corporate Risk**
	Risk Register: Y		**Risk Score: 1016 (currently rated as 12)**
COMPLIANCE and/or LEGAL REQUIREMENTS	**CQC**	**Y**	**Details: Safe, Effective, Responsive, Caring, Well Led**
	NHSI	**N**	**Details:**
	Other	**N**	**Details:**

ACTION REQUIRED OF BOARD

Decision	Approval	Discussion	Other
		X	

The Dudley Group
NHS Foundation Trust

Learning from Deaths

1.0 Introduction

Following the publication of the National Guidance on Learning from Deaths (March 2017) the Trust is required to report via the Trust Board the approach and key learning from deaths occurring in the Trust. This paper updates on progress year to date since 1/1/2019.

2.0 Mortality Measures

	Parameter	Period	Numbers	Previous Period	Previous Numbers
Mortality	Crude mortality	Apr 2018 to Mar 2019	1660 – 3.86%	Oct 2017 to Sep2018	1643 – 3.43%
	SHMI	Apr 2018 to Mar 2019	1.13	Dec 2017 to Nov 2018	1.15
	HSMR	Jun 2018 to May 2019	1.14	Nov 2017 to Oct 2018	115.2

3.0 Mortality Review

At 16th August 2019 1096 deaths have been recorded on the Mortality Tracking System from January 1st 2019. The following table provides a breakdown of compliance with review;

Deaths Recorded YTD	1096
Deaths audited at speciality level YTD	568 (52% compliance)
Deaths audited at speciality level within 30 days YTD to 30/6/2019	16.89%
Deaths triggered for SJR following speciality review YTD	260
SJR Complete YTD	182 (70% compliance)

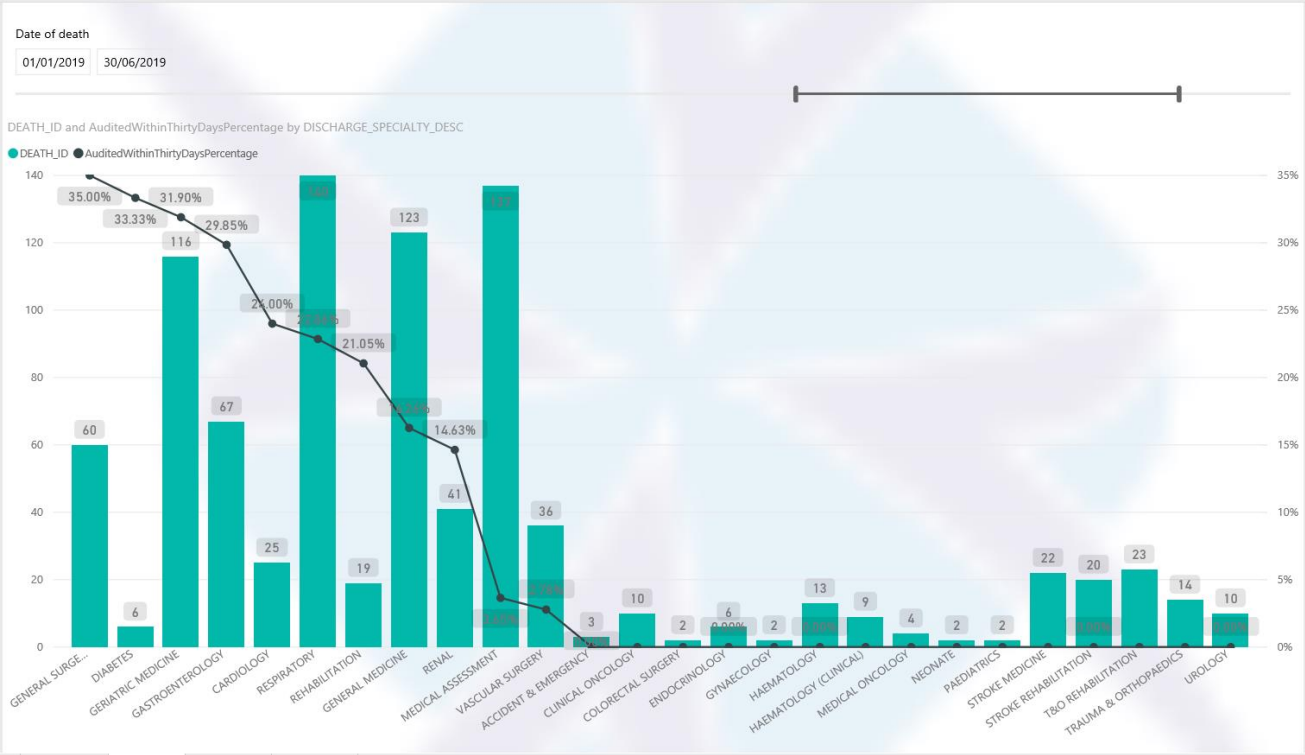
3.1 Quality of care and measures of avoidability

The national programme of LFD uses two measures SJR quality of care and the Hogan scale of avoidability. However these two measures correlate poorly. SJR review has classified care as poor in 0.3% of cases (within the range expected). Avoidability (Hogan four to six) has not been established in any case in this reporting period.

3.2 Speciality Level Review

The Learning from Deaths Policy states that speciality level audit should be completed within 30 days of death. Of deaths occurring in this year to 30/6/2019 16.89% have been completed within the 30 day window.

Below is a breakdown by speciality of compliance YTD.



3.3 SJR

Of the 260 SJRs requested the following breakdown applies for completion;

Speciality	SJR Requested	SJR Complete	SJR Outstanding
General	76	5	71
ED	60	41	19
Paediatrics	33	28	5
Total	169	74	95

3.4 Learning Disabilities Deaths

An issue has been identified that has resulted in LD deaths not being flagged on the Mortality Tracking System. This has now been resolved and reviews are being undertaken by the Learning Disabilities Liaison Nurse.

LD Deaths YTD	7
LD Reviews Completed	0
LD Reviews in progress	4
LeDeR Reviews Completed	3

3.5 Paediatric Deaths

Overarching Child Death Review Policy clearly sets out our statutory and legal obligations in line with Black Country Child Death Overview Panel (BCCDOP) to be implemented by September 2019. From 1st April the Trust has been reviewing child deaths internally through a multi-agency approach including Police, school and any other agencies as necessary. The current outstanding reviews are awaiting Coroners, Police input and post mortems. The Trust is working to strengthen compliance of B. Reporting Forms for Child Death Review processes and is developing an escalation pathway and IT infrastructure to support these requirements.

3.6 Agreed Action to improve timeliness of review

A series of actions have been agreed and implemented to address the timeliness of reviews as follows;

- Full time Learning from Deaths officer in post from August 2019.
- Dudley Improvement Practice working group formed to address review process and ensure consistency across directorates.
- Panel dates agreed for remainder of 2019.
- Weekly monitoring of 30 day standard to be circulated to Divisions from September 2019.

4.0 Learning

4.1 Learning from Review

The following themes have emerged from the reviews undertaken to date;

- DNACPR – none in place, unable to locate, family refusal.
- Lack of understanding of DNACPR and the perception that this is the ceasing/withdrawal of all treatment rather than allowing “natural” death to occur. To address this 3 sessions on DNACPR have been held for senior medical staff with the support of Trust solicitors.
- EAS 2 in ED triggering for concerns with care.
- Delay in pending external agencies information (Coroner, Police etc.) affecting Child Death review timeliness internally.

4.2 Condition Specific Alerts and associated learning

The Trust receives ‘Condition Specific Alerts’ from a variety of sources and has adopted a standardised approach to responding to alerts as detailed in the Learning from Deaths Policy. Recent specific condition alerts have included;

- Acute and unspecified renal failure
- Liver disease, alcohol-related

A summary of these alerts and action taken is detailed in Appendix.

4.3 Case specific learning:

The Trust receives 'Condition Specific Alerts' from a variety of sources and has adopted a standardised approach to responding to alerts as detailed in the Learning from Deaths Policy. Recent specific condition alerts have included;

- Acute and unspecified renal failure
- Liver disease, alcohol-related

A summary of these alerts and action taken is detailed in Appendix 1.

4.4 Case specific learning:

1. 91 year old DNACPR not in place despite recent admission and patient's wishes not to be resuscitated- DNACPR could have been implemented at an earlier stage.
2. Oesophageal Ca – option for DNACPR prior to final admission.
3. MS patient PEG fed – died in ambulance returning from OPD visit to hospice.
4. CPR for 1 hour in patient with terminal lung cancer.
5. CPR in bed bound and very frail individual– nil DNACPR in community.
6. Severe COPD – cardiac arrest in community? DNACPR previously completed.
7. Severe end stage lung disease where family produced DNA CPR form only after prolonged CPR by ambulance crew.
8. Cardiac arrest in community for patient with end stage cardiac failure who had been referred to community Macmillan team- unclear as to whether DNA CPR form completed prior to discharge.

A summary of case specific learning recently collated is available at Appendix 2.

4.5 Learning from Section 28 Notices

The Trust has received no Section 28 notice since January 2019.

4.6 Sharing of learning and supporting staff

- The Trust has recently reintroduced Schwartz rounds.
- A regular patient safety bulletin is issued to all staff with topics arising from lessons learnt across the Trust. Recent topics have included sepsis, mouth care and NG tube replacement.
- Divisional and departmental governance meetings discuss learning from death and the work being undertaken with the Dudley Improvement Practice will look and strengthen this sharing of information by standardising the mortality information shared.
- Sharing of learning using learning Portal.

5.0 Trust wide developments to strengthen Learning from Deaths

5.1 Palliative Care Developments

A number of pieces of work are currently underway worth noting;

- End of life care cell led by Dr Jo Bowen as part of the Dudley Improvement programme with a focus on inappropriate deaths in ED as identified in the Bewick report as main metric of success.
- End of Life care facilitator to be appointed Sept 2019.
- Focus groups with families in pilot.
- Baby bereavement suite in place in maternity.
- Clinical supervision available for those involved in deaths within the Trust.
- Seven day services to be implemented service Trust wide in September 19.
- A service review to plan integrated services across the health economy has been commissioned via the national team in conjunction with Mary Stevens Hospice.
- Introduction of Gold Standard Framework.

5.2 Sepsis improvement work

The Trust continues its work to improve outcomes for patients with sepsis

- The sepsis dashboard and eSepsis are live across the Trust.
- eNews2 has been implemented.
- Two additional sepsis nurses have been recruited.
- An additional band 7 to support sepsis management in ED.

The impact of this work has been to improve sepsis outcomes Trust wide. Current sepsis mortality is now below the national average (SHMI 0.95).

5.3 Identifying and supporting the deteriorating patient

The Trust is being supported by the Advancing Quality Alliance (AQuA) to look at a number of deteriorating patient pathways. Clinical leads, informatics colleagues and audit colleagues joined AQuA on 14th August for an introductory session to the methodology and a project group has been established to enable the Trust to collect data and receive feedback on current pathways in order to drive developments. The first condition groups to undertake this work are AKI, Sepsis and ALD. It is anticipated that data collection will commence in October 2019 with a long term ambition to integrate the collection fields into the EPR.

Interventions include:

- Hospital at night team implemented.
- Cardiac chest pain unit implemented.
- Daily troponin lists.

5.4 Dudley Improvement Practice

It is recognised that the current compliance rates with review standards are below what we would expect at both speciality and secondary review. A working group is being supported by the Dudley Improvement Practice to streamline the process. Initial include additional weekly review meetings and improved availability of notes through active tracking.

5.5 Appointment of Learning from Deaths Officer

As of 12th August 2019 a full time Learning from Deaths officer is employed by the Trust to support the review process and sharing of learning. The post will also support the Medical Examiner's office once established.

5.6 Summary and recommendation

The Trust board are asked to:

1. Acknowledge the assurance within the report documenting the learning from deaths at a condition specific, trust wide and individual patient basis and the action supporting this.
2. To note the continued reduction in mortality since March 2108 following a rebasing exercise in September 17.

Appendix 1: <u>Condition Specific Alerts</u>

Alert Route	Date	Condition	Lead	Process	Summary Findings	Agreed Action
CQC	April 2019	Acute and unspecified renal failure	Renal Team	Audit / Coding Review	Level 1 hospital mortality review was conducted in 97% of cases and no cases were put forward for secondary review. No evidence of avoidability. Some areas of learning were identified in 3 cases in relation to preferred place of death and timeliness of referral to the renal team. The review concluded that some of the excess mortality would seem to be secondary to inaccuracy of coding from initial admitting diagnosis.	AQ pathway work commenced August 2019 Education of front door admitting teams regarding accurate AURF/AKI definitions and management. Education programme for clinicians and coding staff.
CQC	April 2019	Liver disease, alcohol-related	Gastro Team	Audit/ Coding Review	The level 1 mortality review was completed in 88% of cases (30/34- 2 missing cases were ITU admissions and may have been reviewed separately at the time) and 1 case came forward for SJR. No concerns were raised in the quality of care at the initial review. Learning identified from these cases at the time included the management of one patient on an outlier ward, although no problems with care were identified and the timeliness of end of care life decisions. The majority of these patients presented to Accident and Emergency with advanced end stage liver disease. All patients were managed appropriately with the majority having resuscitation and escalation decisions made appropriately and in a timely manner.	AQ Pathway work commenced August 2019. Liaising with Dudley CCG to implement the improvement work related to ALD.

Appendix 2: Case Specific Learning

Theme	Action taken	Assurance
Escalation	• eOBS • ESepsis • NEWS2	Weekly audit return External AQuA review
DNARCPR	• Awareness sessions facilitated by Trust solicitors • Working with WMAS • Exploring electronic DNACPR	Work in progress through Deteriorating Patient Group
Cardiac pathway including Troponin	• Daily list reviewed by cardiology • Cardiac assessment unit established	Clinical governance oversight with case audit
Handover	• Hospital 24/7 team established • e Handover module being explored	Sept 19 Visits to mid Cheshire and RLBUHT
Verification of death	• Revised policy in place	May 18
Sepsis delivery	• eOBS • ESepsis, • NEWS2	Implemented Trust wide audit and report to clinical governance

Theme	Action taken	Assurance
Senior oversight	• EPIC role adopted • RCEM sign off	RCEM sign off with EPIC Clinical audit review of EPIC
Team Communication	• Team huddles NIC/ EPIC • ESI implemented	External assurance External review, validation
Observations	• eOBS • ESepsis • NEWS2	External assurance External review, validation
Triage	• ESI triage tool implemented	External assurance External review, validation
Availability of Paeds consultants	• Training updated and audit • Job planning complete • Second registrar	
Escalation to ITU of high NEWS	• Hospital at Night team established • Second registrar rota filled	

Enclosure 17

The Dudley Group
NHS Foundation Trust

Paper for submission to the Public Board
On 5th September 2019

TITLE:	**Integrated Performance Report for Month 4 (July) 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

Diagnostic Performance (DM01)

The diagnostic standard (DM01) was achieved for July 2019 with a performance of 99.22% against the target of 99% patients seen in less than 6 weeks. As per previous months the greatest area of risk to the target remains within MRI, which accounted for 49 out of a total of 57 breaches. Work in ongoing in respect to reducing the remaining backlog which consists of Cardiac MRI and GA MRI and additional lists completed and planned for August and September respectively should bring these down to manageable levels. In order to sustain performance, a number of positive meetings have been held with Cardiology and Imaging with a view to ensuring that job planned capacity is cross-covered during times of annual leave and Cardiology on call commitments.

Looking forward the Imaging Department is set to commence the replacement of the two CT scanners at the Russells Hall Hospital site from 9th September 2019 which is now to be completed in two phases, CT 1 during September – November 2019 and CT 2 during February – April 2020. During these periods it will be essential to maintain the Cardiac CT service in order to continue to achieve the DM01 standard. Agreements from Consultant Cardiologists have been received and will see them complete these scans at the start of each day, Monday to Friday, on the one in-house CT scanner.

Cancer

The Trust's performance against the National cancer standards continues to be very positive and at the time of writing, subject to final validation and agreement with local tertiary centres, all ten cancer metrics have been achieved. Two week wait for July was extremely challenging across a numbers of specialties, in particular Urology, Colorectal and Skin, and performance against this target was the closest in recent memory with a performance of 93.04% against the 93% target. The primary reason for this was due to a number of teams facing capacity challenges, exacerbated by the pension implications of consultants performing additional clinics. Whilst a very high level of breaches were incurred this was matched by a higher than average total activity, hence the target was achieved. The challenges regarding two week wait have continued into August and all is being done to avoid failure. Performance against the 62 day target at the time of writing is 85.1% against the 85 % target, again very tight given capacity challenges, but testament to the amount of work being undertaken to achieve this high profile and important performance target.

Whilst performance remains largely positive, the 28 day faster diagnosis is likely to come into effect from April 2020 (a new and additional target) and shadow monitoring to-date suggests there is work to do across a number of areas to achieve this, in addition to sustaining performance against the existing metrics. Key areas of focus for us include:

- Endoscopy / colonoscopy diagnostics
- Fusion biopsies (Urology)
- More timely diagnostic imaging and reporting
- More timely histology reporting

Regulatory Performance – 18 Week Referral Treatment

The Trust achieved the RTT standard for July, delivering 94.15% against the national standard of 92%. Pressures remain in Urology, General Surgery & Ophthalmology. Additional sessions continue to be arranged to manage demand, although pressure is greater for admitted patients than non-admitted, although the recent reduction in theatre sessions coverage as extra is now impacting on this, particularly in Ophthalmology.

Demand for outpatient services has increased overall this year in the following specialties.

Regulatory Performance – 18 Week Referral Treatment - Incompletes

The total number of incomplete pathways has increased in recent months, although July was down slightly on the June position. In particular there has been an overall increase in incomplete pathways in the following specialties: Urology, Colorectal, Vascular, Oral Surgery and Peads ENT. There remains a continued focus on these specialties on reducing the total number of incomplete pathways.

Operational Efficiency – Theatre Utilisation, Theatre Cancellation DNA Rates

There remains more work to be done on Theatre efficiency and this is being delivered through the Theatre Task and Finish Group. Particular areas of focus in this project are directed towards scheduling, booking and improving notes availability. Currently utilisation of theatres (actual operating time used versus planned time) is around 65%.

Cancellations have increased in recent months and the main reason for this was missing notes. A separate task and finish group has been set up to look at reducing the impact of missing notes and an amendment to the notes policy has been agreed.

Workforce

Staff Appraisals

The appraisal window for all non-medical appraisals closed on 30th June 2019 and therefore the Trust continued its good level of compliance at 95.52% for completed appraisals. A review of the process has been undertaken in light of the new Dudley People Plan and the new Behavioural Framework. Therefore work has commenced in consultation with colleagues to develop and enhance the quality of the appraisal paperwork alongside the appraisal meeting and outcomes.

Mandatory Training

The compliance rate continues at the stable level of 89.7%. This represents good performance in terms of overall compliance. However, the focus continues to be on the areas where there are risks associated to continued non-compliance. This is demonstrated with particular non-compliance for some subjects alongside specific staff groups where compliance could be significantly improved.
The subject areas where compliance is Rag rated red and highlights the most significant risk are:

- Child Safeguarding Level 3 – 77.1%;
- Resuscitation Adult – 72%;
- Resuscitation Paediatric – 60.4%.

These 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.

However, this continued non-compliance creates a risk to our patients and staff that requires immediate mitigation. It is intended that all staff who continue to demonstrate non-compliance in these areas will be communicated to regarding their responsibility to have these mandated courses completed within a reasonable timescale.

Sickness Rate

The absence rate has continued to deteriorate from 5.01% in June 2019 to 5.15% in July 2019. The main areas of concern associated to staff group continue to be Care Support staff at 7.88% and nursing & midwifery staff at 5.32%.

In terms of Divisional trends, Clinical Support Services continue to demonstrate the highest levels of absence at 6.49%. Therefore, focus is being provided on particular areas of high absence to ensure efficient turnaround of absence management and therefore staff returning to work.

In addition, the Finance & Performance Committee as well as the Workforce & Staff Engagement have highlighted their concerns as the continued rise in absence levels and a plan to demonstrate and support improvement. Therefore an initial plan is being presented to the Workforce & Staff Engagement Committee on 27th August 2019 prior to Board feedback in October 2019. Long term sickness is driving the increase in our overall sickness absence rates at 3.10%. Therefore, the strategy going forward in the first instance will be to focus on the areas and staff groups demonstrating high levels of long term sickness as a matter of priority.

Turnover Rate

The turnover rate continues to represent positive retention of our staff and currently sits at 8.73% which is consistent with the previous month. The Trust Turnover target is 8.5% and therefore the Trust continue to demonstrate consistently positive performance. The Trust turnover rate is also below the average turnover rate for acute NHS Trusts in England. The continued focus on staff engagement and development 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 embed the action plans based on the feedback from the national staff survey and regular pulse surveys.

Recruitment/Staff in Post

The Trust 'staff in post' performance demonstrated another rise within the substantive workforce with a further 54 wte since April 2019 with the current contracted wte at 4469.01 The most significant increase has been within the Care Support staff Group, Nursing & Midwifery and Allied Health Professionals.

In supporting our workforce plans for substantive staff it is important that we continue to be more efficient in our recruitment process. We have recently changed our recruitment timeline from 77 days to 50 days. The introduction of new technology supporting the recruitment process has improved our performance against the 77 day target. Therefore the change to the 50 day timeline being introduced in August 2019 will further support effectiveness over the increase for staff in post as well a supporting our continued reduction in agency expenditure.

We are also developing an enhanced recruitment plan to engage more bank only workers to further aid the reduction in agency expenditure.

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:**

Integrated Performance Report - Board




August 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 McMenemyJ**

Executive Summary

Key Messages

CQSPE

FFT Response Rate

A total of 7,025 responses across all areas have been received during July 2019, an increase from June 2019 (6,164). Maternity birth is showing the biggest increase in response rates this month at 16.6%, which is an improvement from June 2019 (10.5%). Inpatient department remains on target for response rates again this month. No data was published for response rates for outpatients in June. The national average percentage response rates are not available at the time of writing this report.

FFT Percentage Recommended

Percentage recommended scores have improved for inpatient, emergency department, maternity birth, and postnatal ward in July 2019. The emergency department shows the biggest improvement in percentage recommended scores in July 2019 at 80% in comparison to 72.7% in June and is the highest score for the emergency department this quarter.

Inpatients, emergency department, outpatients and community are not achieving the target. The national average percentage recommended scores are not available at the time of writing this report.

Action taken to improve scores

1. Feedback Friday is promoted to raise awareness and capture responses. Pop up workshops are situated in the reception areas.
2. Volunteers have concentrated on the wards and outpatients department to encourage patients to fill in the FFT forms.
3. FFT champion meetings are taking place bi-monthly to encourage staff to promote FFT.
4. The Trust Board Performance Dashboard is emailed out monthly to wards and printed copies are brought to the Friends & Family Champion's Meetings.
5. Community are hosting 'Lunch and Learn' sessions to identify trends and learning.
6. We have increased patient experience volunteers to carry out ward visits and promote the Friends and Family Test.
7. The Patient Experience Group will oversee and review the actions within the Patient Experience Strategy to ensure we achieve our quality priorities for patient experience.
8. We have sent communications to all heads of service and departments to ensure that FFT cards are being sent in to patient experience or collected by volunteers at the end of each month to ensure that these are inputted before the deadline for data submission, as a large number of cards were not entered due to a lack of volunteers to input them.
9. A meeting has been arranged with the volunteer coordinator to arrange for a number of volunteers to be inputting FFT cards on a regular basis.
10. We have changed FFT reporting within the outpatients department, as data is currently recorded by location and not by clinic, to ensure that FFT scores can be more closely monitored.

Complaints & PALS

PALS received 237 concerns, 6 comments and 74 signposting contacts (signposting includes letters/emails/telephone calls/face-to-face enquiries) totalling 317 in July 2019 The total of the concerns (237) and the total of comments (6) equal 243.

During July 2019, the Trust received 73 complaints. This is a 108% increase from June 2019 (35). July 2018 received similar number of complaints.

The Surgical Division received 39 complaints for July 2019 compared to 17 for June 2019. Medicine & Integrated Care Division received 29 complaints for July 2019 compared to 15 for June 2019. Clinical Support Division received two complaints for July 2019, the same as for June 2019. Corporate Services, Corporate Nursing and External (Security) received 1 complaint each in July 2019.

There have been 13 re-opened complaints for July 2019.

The common theme for complaints is communications, specifically communications with the patient and relatives.

Executive Summary

Key Messages

CQSPE

Dementia

Due to the implementation of Sunrise, the way in which the dementia data is calculated has had to be updated. Going from Sorian to Sunrise means that the way data is inputted has changed, staff are working hard to ensure they are inputting data correctly.

Pressure Ulcers

In July 1 Unstageable grade 3/4 pressure ulcer (SI) was reported in the Acute Trust (Ward B1). There were no reported SI's for pressure ulcers reported in the community setting.

MSA

In July there were a total of 5 breaches. 3 on MHDU and 2 for Critical Care.

MRSA

MRSA Screening - emergency has a compliance of 93.4% this is an improvment on previous months performance. The target is 95%.

Infection Control

High Impact Interventions July 2019
HII 1: Ventilator Associated Pneumonia 100%
HII 2a: Peripheral Vascular Access Devices – Insertion 100%
HII 2b: Peripheral Vascular Access Devices - Ongoing Care 99%
HII 3a: Central Venous Access Devices - Insertion 98% -Increase from last month by 23%
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 100%
HII 6b: Urinary Catheter - Maintenance & Assessment 99%
Hand hygiene 99%
Commode Audits 100%
There were zero C diff cases due to lapses in care reported during July 2019.

MSSA

Patient 1 - Patient had a previous admission with infected skin cancer wounds. Treated with antibiotics .This admission he presented with sepsis? Source? Community acquired pneumonia and suffered a fall at home which resulted in #NOF. On 9th July he had pyrexia of 39.5. Has been a patient on B2 ward, no issues with Infection control audits. Probable source of infection = Skin wounds from skin Cancer.

Patient 2 - Patient admitted with alcoholic liver disease, fatty liver and ascites. Commenced on triple antibiotic therapy. No lines in -situ, just a newly inserted peripheral cannula. No issues on C7 with saving lives scores.

E-Coli

Patient 1- Admitted with UTI , treated with antibiotics.
Patient 2 - This lady is a long term in-patient since early June. Intermittent temperature spikes and continuing chest infection post hip fracture repair.

VTE

Trust performance for VTE for July 19 is 95.19%.
- Previous measures continue
- Escalation policy to be used where non-compliance identified

Incidents

4 Serious Incident has been reported in July 2019:
o INC58617 (2019/15266) – Delay in the review of MRI results resulting in a delay in identifying a spinal cord abnormality (large thoracic syrinx with atrophic cord).
o INC59602 (2019/16547) – Fall resulting in a fractured neck of femur - C5
o INC54013 (2019/15287) – Death of a 21 year old, following presentation to ED on 2 occasions prior to his death.
o INC56617 (2019/15501) – Avoidable Category 3 pressure ulcer - B1

All incidents moderate and above are reviewed by the patient safety team and identified as a serious incident or the incident is downgraded. This is reflected in the 'incident grading by degree of harm', as in July 19 there are 6 incidents graded moderate and above. At the time of the report the incidents may have been under review.

Executive Summary

Key Messages

CQSPE

Falls

There were 71 inpatient falls for the month of July. 1 patient fell and sustained a fractured neck of femur which required surgery. The has been reported as avoidable. Level of falls consistent with trend.

Stroke

'Stroke Admissions to Thrombolysis Time' - achieved a compliance of 60%, reaching the target of 50%. (6 patients achieved this target out of 10). This target not being met may be due patients' medical condition.

'High Risk TIA' - achieved a complaince of 83.3%, just missing the target of 85%. (5 patients achieved this out of 6). This target not being met may be due to the low number of high risk TIA's.

% of deaths with priorities of care

It is not currently possible to identify expected/non-expected deaths within the data; however national evidence suggests that 75% of all adult (aged 18 years and over) in patient deaths are expected.

The current Trust target has been set at 60% of patients with expected deaths should have a Priorities for Care of the dying person communication tool initiated as soon as this is recognised. This is to ensure that all conversations, decisions are recorded and that individualised care plans are developed for patients, families and those important to them.

This metric is measured by coding identifying where there is a death and if the patient was known to the specialist palliative care team or where the there is a document in place. The exemptions/exclusions are deaths in the emergency department. Any greyed out cells for wards represent where there were no deaths for the reporting period. Please note the data reported is a month in arrears to account for coding.

The specialist palliative care team are monitoring compliance and driving improvements. Trust wide progress is monitored through the Trust End of Life Working Group.

Safety Thermometer

Safety Thermometer for July 19 - 97.79%

Please note: this figure is made up from the number of patients, number of patients

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 87.8%

	Attendances	Breaches	Performance
UCC/A&E Combined (Type1+3)	15271	1798	87.8%

Cancer Waits

The Trust's performance against the National cancer standards continues to be very positive and at the time of writing, subject to final validation and agreement with local tertiary centres, all ten cancer metrics have been achieved. Two week wait for July was extremely challenging across a numbers of specialties, in particular Urology, Colorectal and Skin, and performance against this target was the closest in recent memory with a performance of 93.04% against the 93% target. The primary reason for this was due to a number of teams facing capacity challenges, exacerbated by the pension implications of consultants performing additional clinics. Whilst a very high level of breaches were incurred this was matched by a higher than average total activity, hence the target was achieved. The challenges regarding two week wait have continued into August and all is being done to avoid failure. Performance against the 62 day target at the time of writing is 85.1% against the 85 % target, again very tight given capacity challenges, but testament to the amount of work being undertaken to achieve this high profile and important performance target.

Whilst performance remains largely positive, the 28 day faster diagnosis is likely to come into effect from April 2020 (a new and additional target) and shadow monitoring to-date suggests there is work to do across a number of areas to achieve this, in addition to sustaining performance against the existing metrics. Key areas of focus for us include:

- Endoscopy / colonoscopy diagnostics
- Fusion biopsies (Urology)
- More timely diagnostic imaging and reporting
- More timely histology reporting

2WW

The target was achieved once again in month. During this period a total of 1417 patients attended a 2ww appointment with 106 patients attending their appointments outside of the 2 week standard, achieving a performance 93% against the 93% target.

Referral to Treatment (RTT)

The Trust achieved the RTT standard for July, delivering 94.15% against the national standard of 92%. Pressures remain in Urology, General Surgery & Ophthalmology. Additional sessions continue to be arranged to manage demand, although pressure is greater for admitted patients than non-admitted, although the recent reduction in theatre sessions coverage as extra is now impacting on this, particularly in Ophthalmology. Demand for outpatient services has increased overall this year.

Executive Summary by Exception cont.

Key Messages

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

Cumulative deficit of £4.399m for April-July (including PSF) and following consolidation of the pharmacy company and other technical changes. This position is £1.811m behind the control total so the Trust has a significant financial challenge if it is to recover this adverse variance over August and September. The actual July position was approximately £0.6m worse than forecast and as such the year end predicted deficit has deteriorated to £6.601m (now reflecting a deterioration from the base case assumptions approved by the Board (deficit of £5.780m). This assumes the land sale occurs (profit reduced by £0.180m) and that the Trust only earns the Q1 PSF. This position is £9.544m worse than the control total plus a further £5.117m of lost PSF resource. A worse case forecast is estimated to be a further deterioration of £3.8m from the reported position. An upside view is estimated at a £3.9m improvement.

Executive Summary by Exception cont.

Key Messages

Workforce **Committee: F&P**

Staff Appraisals

The appraisal window for all non-medical appraisals closed on 30th June 2019 and therefore the Trust continued its good level of compliance at 95.52% for completed appraisals. A review of the process has been undertaken in light of the new Dudley People Plan and the new Behavioural Framework. Therefore work has commenced in consultation with colleagues to develop and enhance the quality of the appraisal paperwork alongside the appraisal meeting and outcomes

Mandatory Training

The compliance rate continues at the stable level of 89.7%. This represents good performance in terms of overall compliance. However, the focus continues to be on the areas where there are risks associated to continued non-compliance. This is demonstrated with particular non-compliance for some subjects alongside specific staff groups where compliance could be significantly improved.

The subject areas where compliance is Rag rated red and highlights the most significant risk are:

- Child Safeguarding Level 3 – 77.1%;
- Resuscitation Adult – 72%;
- Resuscitation Paediatric – 60.4%.

These 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.

However, this continued non-compliance creates a risk to our patients and staff that requires immediate mitigation. It is intended that all staff who continue to demonstrate non-compliance in these areas will be communicated to regarding their responsibility to have these mandated courses completed within a reasonable timescale.

Sickness Rate

The absence rate has continued to deteriorate from 5.01% in June 2019 to 5.15% in July 2019. The main areas of concern associated to staff group continue to be Care Support staff at 7.88% and nursing & midwifery staff at 5.32%.

In terms of Divisional trends, Clinical Support Services continue to demonstrate the highest levels of absence at 6.49%. Therefore, focus is being provided on particular areas of high absence to ensure efficient turnaround of absence management and therefore staff returning to work.

In addition, the Finance & Performance Committee as well as the Workforce & Staff Engagement have highlighted their concerns as the continued rise in absence levels and a plan to demonstrate and support improvement. Therefore an initial plan is being presented to the Workforce & Staff Engagement Committee on 27th August 2019 prior to Board feedback in October 2019. Long term sickness is driving the increase in our overall sickness absence rates at 3.10%. Therefore, the strategy going forward in the first instance will be to focus on the areas and staff groups demonstrating high levels of long term sickness as a matter of priority.

Turnover Rate

The turnover rate continues to represent positive retention of our staff and currently sits at 8.73% which is consistent with the previous month. The Trust Turnover target is 8.5% and therefore the Trust continue to demonstrate consistently positive performance. The Trust turnover rate is also below the average turnover rate for acute NHS Trusts in England. The continued focus on staff engagement and development 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 embed the action plans based on the feedback from the national staff survey and regular pulse surveys.

Executive Summary by Exception cont.

Key Messages

Workforce — **Committee: F&P**

Recruitment/Staff in Post

The Trust 'staff in post' performance demonstrated another rise within the substantive workforce with a further 54 wte since April 2019 with the current contracted wte at 4469.01 The most significant increase has been within the Care Support staff Group, Nursing & Midwifery and Allied Health Professionals.

In supporting our workforce plans for substantive staff it is important that we continue to be more efficient in our recruitment process. We have recently changed our recruitment timeline from 77 days to 50 days. The introduction of new technology supporting the recruitment process has improved our performance against the 77 day target. Therefore the change to the 50 day timeline being introduced in August 2019 will further support effectiveness over the increase for staff in post as well a supporting our continued reduction in agency expenditure.

We are also developing an enhanced recruitment plan to engage more bank only workers to further aid the reduction in agency expenditure.

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 commenced in July 2019 with further intakes expected in September 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 Dudley People Plan alongside the Dudley Behavioural Framework aligned to the NHS interim People Plan provides an emphasis on supporting our staff to improve our services. The Workforce Team continue engaging with staff to share the main elements of the Dudley People Plan and Behavioural Framework within the next iteration of the 'Make it Happen' events that have been successfully launched in August 2019.

Patients will experience safe care - "At a glance"

Executive Lead: Mary Sexton

Patients will experience safe care - Quality & Experience

	Target (Amber)	Target (Green)	Jun-19	Jul-19	Financial YTD	Trend	Month Status
Friends & Family Test - Response Rate							
Friends & Family Test - ED	12.3%	19.4%	18.6%	19.3%	19.1%	↑	
Friends & Family Test - Inpatients	26.9%	37.0%	34.4%	31.2%	34.3%	↓	
Friends & Family Test - Maternity - Overall	21.9%	38.0%	15.4%	21.6%	20.9%	↑	
Friends & Family Test - Outpatients	4.9%	11.9%	7.1%	6.3%	5.2%	↓	
Friends & Family Test - Community	3.3%	8.1%	4.5%	4.3%	4.3%	↓	
Friends & Family Test - Percentage Recommended							
Friends & Family Test - ED	88.7%	94.5%	72.7%	80.0%	74.2%	↑	
Friends & Family Test - Inpatients	96.7%	97.4%	94.2%	94.3%	94.7%	↑	
Friends & Family Test - Maternity - Overall	97.1%	98.5%	96.9%	100.0%	99.3%	↑	
Friends & Family Test - Outpatients	95.3%	97.4%	88.8%	88.7%	89.0%	↓	
Friends & Family Test - Community	96.2%	97.7%	92.8%	90.5%	92.5%	↓	
Complaints							
Total no. of complaints received in month			35	73	214	↑	
Complaints re-opened			10	13	35	↑	
PALs Numbers			272	243	1084	↓	
Complaints open at month end			199	171	-	↓	
Compliments received			545	468	1958	↓	
Dementia							
Find/Assess		90%	83.7%	78.4%	86.0%	↓	
Investigate		90%	83.0%	86.3%	88.1%	↑	
Refer		90%	95.3%	95.4%	94.3%	↑	
Falls							
No. of Falls			59	71	268	↑	
Falls per 1000 bed days			3.60	4.06	3.90	↑	
No. of Multiple Falls			4	3	17	↓	
Falls resulting in moderate harm or above			0	1	2	↑	
Falls resulting in moderate harm or above per 1000 bed days			0.19	0.19	-	↔	
Pressure Ulcers (Grades 3 & 4)							
Hospital			0	1	4	↑	
Community			0	0	0	↔	
Handwash							
Handwashing			99.7%	99.8%	99.7%	↑	

Patients will experience safe care - Patient Safety

	Target (Green)	Jun-19	Jul-19	Financial YTD	Trend	Month Status
Mixed Sex Accommodation Breaches						
Single Sex Breaches	0	7	5	27	↓	
Mortality (Quality Strategy Goal 3)						
HSMR Rolling 12 months (**Latest data Jan 19**)	105	118	115	-		
SHMI Rolling 12 months (**Latest data 18/19 Q1**)	1.05	N/A	1.13	-		
HSMR Year to date (**Not available**)				-		
Infections						
Cumulative C-Diff due to lapses in care	49	2	5	5	↑	
MRSA Bacteraemia	0	0	0	0	↔	
MSSA Bacteraemia	0	0	2	7	↑	
E. Coli	0	4	2	12	↓	
Stroke (1 month in arrears)						
Stroke Admissions: Swallowing Screen	75%	95.0%	-	94.7%		
Stroke Patients Spending 90% of Time on Stroke Unit	85%	95.6%	-	93.5%		
Suspected High Risk TIAs Assessed and Treated <24hrs	85%	100.0%	-	100.0%		
Stroke Admissions to Thrombolysis Time	50%	60.0%	-	52.9%		
VTE - Provisional Figures						
VTE On Admission	95%	94.0%	95.3%	94.8%	↑	
Incidents						
Total Incidents		1458	1401	5623	↓	
Recorded Medication Incidents		386	0.952639	1395	↓	
Never Events		0	0	0	↔	
Serious Incidents		4	4	14	↔	
of which, pressure ulcers		0	1	4	↑	
Incident Grading by Degree of Harm						
Death		1	0	2	↓	
Severe		0	3	3	↑	
Moderate		3	3	9	↔	
Low		138	175	573	↑	
No Harm		877	861	3424	↓	
Percentage of incidents causing harm	28%	39.8%	38.5%	14.6%	↓	
Safety Thermometer						
Patients with harm free care (and old harms)	-	96.45%	-	-	↑	

Performance - "At a glance"

Executive Lead: Karen Kelly

The Dudley Group NHS Foundation Trust

Performance - Key Performance Indicators

	Target	Jun-19	Jul-19	Actual YTD	Trend	Month Status
Cancer Reporting - TRUST (provisional)						
All Cancer 2 week waits	93%	96.15%	93.0%	94.5%	↓	
2 week wait - Breast Symptomatic	93%	98.1%	97.4%	97.8%	↓	
31 day diagnostic to 1st treatment	96%	98.0%	100.0%	98.4%	↑	
31 day subsequent treatment - Surgery	94%	95.7%	94.4%	97.3%	↓	
31 day subsequent treatment - Drugs	94%	100.0%	100.0%	98.2%	↔	
62 day urgent GP referral to treatment	85%	82.8%	81.1%	84.5%	↓	
62 day screening programme	90%	100.0%	100.0%	100.0%	↔	
62 day consultant upgrades	85%	93.3%	89.9%	93.4%	↓	
Referral to Treatment						
RTT Incomplete Pathways - % still waiting	92%	94.7%	94.2%	94.4%	↓	
RTT Admitted - % treatment within 18 weeks	90%	86.3%	88.6%	86.8%	↑	
RTT Non Admitted - % treatment within 18 weeks	95%	95.6%	95.3%	95.7%	↓	
Wait from referral to 1st OPD	26	26	27	105	↑	
Wait from Add to Waiting List to Removal	39	39	35	156	↓	
ASI List		2741	3183	0	↑	
% Missing Outcomes RTT		0.04%	0.11%	0.1%	↑	
% Missing Outcomes Non-RTT		3.2%	3.7%	3.7%	↑	
DM01						
No. of diagnostic tests waiting over 6 weeks	0	65	57	265	↓	
% of diagnostic tests waiting less than 6 weeks	99%	99.1%	99.2%	99.0%	↑	
ED - TRUST						
Patients treated < 4 hours Type 1 & 3 (ED + UCC)	95%	82.8%	80.4%	81.2%	↑	
Emergency Department Attendances	N/A	9112	7674	35167	↓	
12 Hours Trolley Waits	0	0	0	10	↔	
Ambulance to ED Handover Time - TRUST						
15-29 minutes breaches		1615	1652	6841	↑	
30-59 minute breaches		395	299	1443	↓	
60+ minute breaches		33	41	167	↑	
Ambulance to Assessment Area Handover Time - TRUST						
30-59 minute breaches		10	12	44	↑	
60+ minute breaches		3	1	6	↓	

Performance - Key Performance Indicators cont.

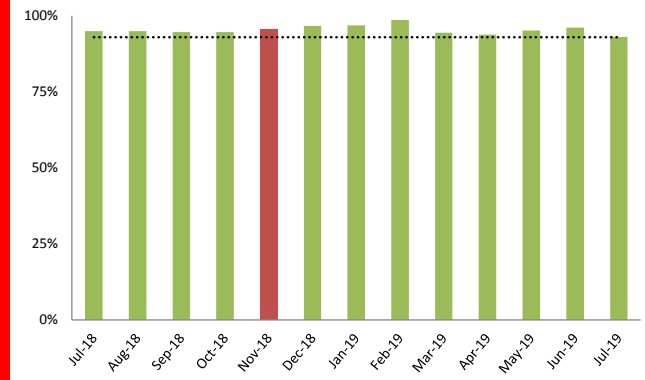
	Target	Jun-19	Jul-19	Actual YTD	Trend	Month Status
Cancelled Operations - TRUST						
% Cancelled Operations	1.0%	2.3%	2.4%	1.9%	↑	
Cancelled operations - breaches of 28 day rule	0	0	1	1	↑	
Urgent operations - cancelled twice	0	0	0	0	↔	
GP Discharge Letters						
GP Discharge Letters	90%	74.6%	90.3%	77.3%	↑	
Theatre Utilisation - TRUST						
Theatre Utilisation - Day Case (RHH & Corbett)		76.9%	74.8%	76.9%	↓	
Theatre Utilisation - Main		84.9%	85.6%	86.4%	↑	
Theatre Utilisation - Trauma		94.3%	95.4%	92.9%	↑	
GP Referrals						
GP Written Referrals - made		6193	6986	27158	↑	
GP Written Referrals - seen		5551	6455	23152	↑	
Other Referrals - Made		3677	3932	15229	↑	
Throughput						
Patients Discharged with a LoS >= 7 Days		6.40%	6.40%	6%	↔	
Patients Discharged with a LoS >= 14 Days		3.08%	2.77%	3%	↓	
7 Day Readmissions		3.4%	3.0%	3%	↓	
30 Day Readmissions - PbR		7.8%	6.8%	7%	↓	
Bed Occupancy - %		84%	89%	88%	↑	
Bed Occupancy - % Medicine & IC		84%	95%	92%	↑	
Bed Occupancy - % Surgery, W&C		87%	82%	84%	↓	
Bed Occupancy - Paediatric %		59%	57%	59%	↓	
Bed Occupancy - Orthopaedic Elective %		69%	65%	70%	↓	
Bed Occupancy - Trauma and Hip %		96%	89%	93%	↓	
Number of Patient Moves between 8pm and 8am		97	86	400	↓	
Discharged by Midday		16.3%	14.6%	15%	↓	
Outpatients						
New outpatient appointment DNA rate	8%	8.06%	7.32%	7.9%	↓	
Follow-up outpatient appointment DNA rate	8%	8.6%	6.4%	7.5%	↓	
Total outpatient appointment DNA rate	8%	8.4%	6.8%	30.9%	↓	
Clinic Utilisation		79.6%	79.6%	79.6%	↔	
Average Length of stay (Quality Strategy Goal 3)						
Average Length of Stay - Elective	2.4	2.42	2.60	2.6	↑	
Average Length of Stay - Non-Elective	3.4	4.7	4.4	4.8	↓	

The Dudley Group NHS Foundation Trust

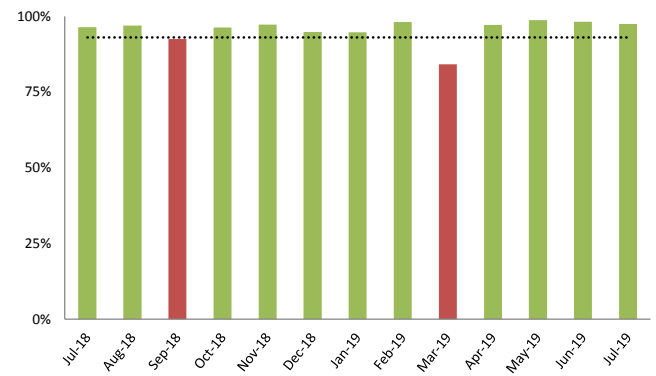
Performance Matters (KPIs)

Regulatory Performance - Cancer (Latest month is provisional)

All Cancer 2 Week Waits

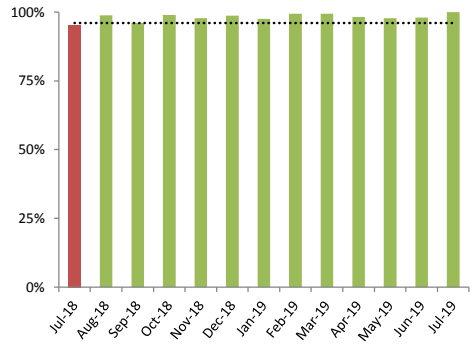


Breast Symptomatic

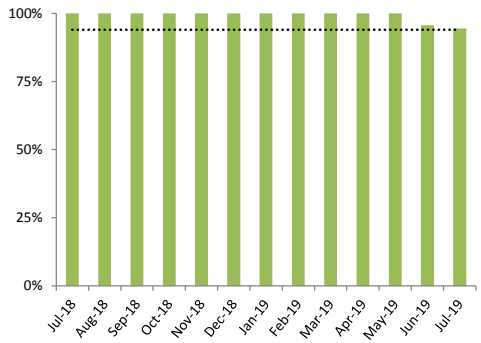


31 Day - Targets

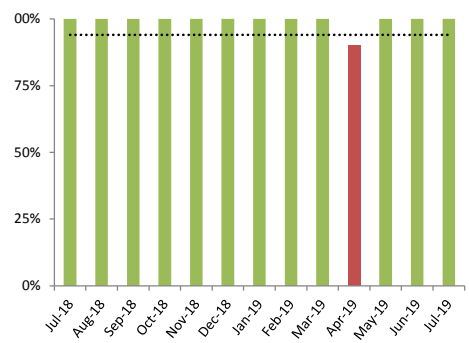
31 Day Diagnostic to Treatment



31 Day Subsequent Treatment (Surgery)



31 Day Subsequent Treatment (Drugs)

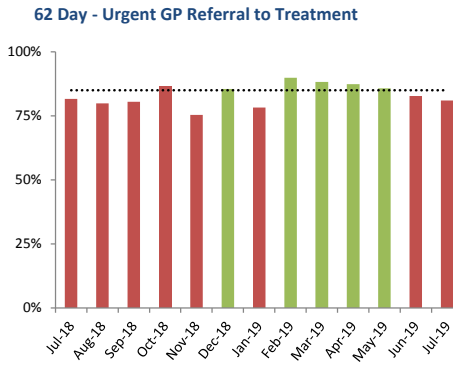


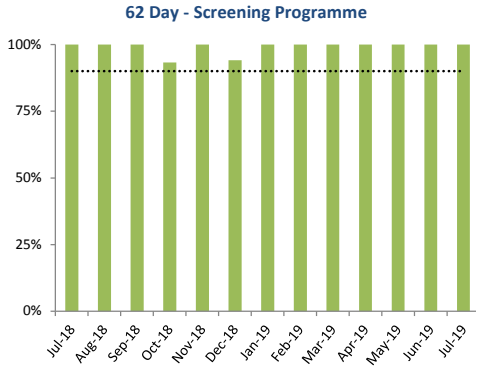
The Dudley Group NHS Foundation Trust

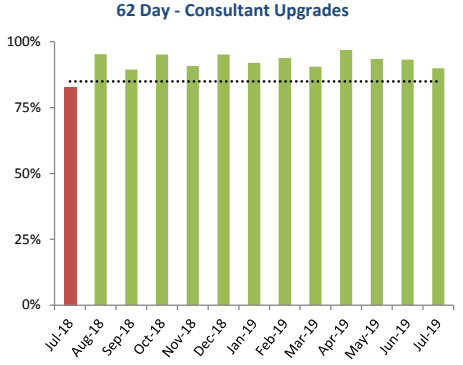
Performance Matters (KPIs)

Regulatory Performance - Cancer (Latest month is provisional)

62 Day Cancer Targets



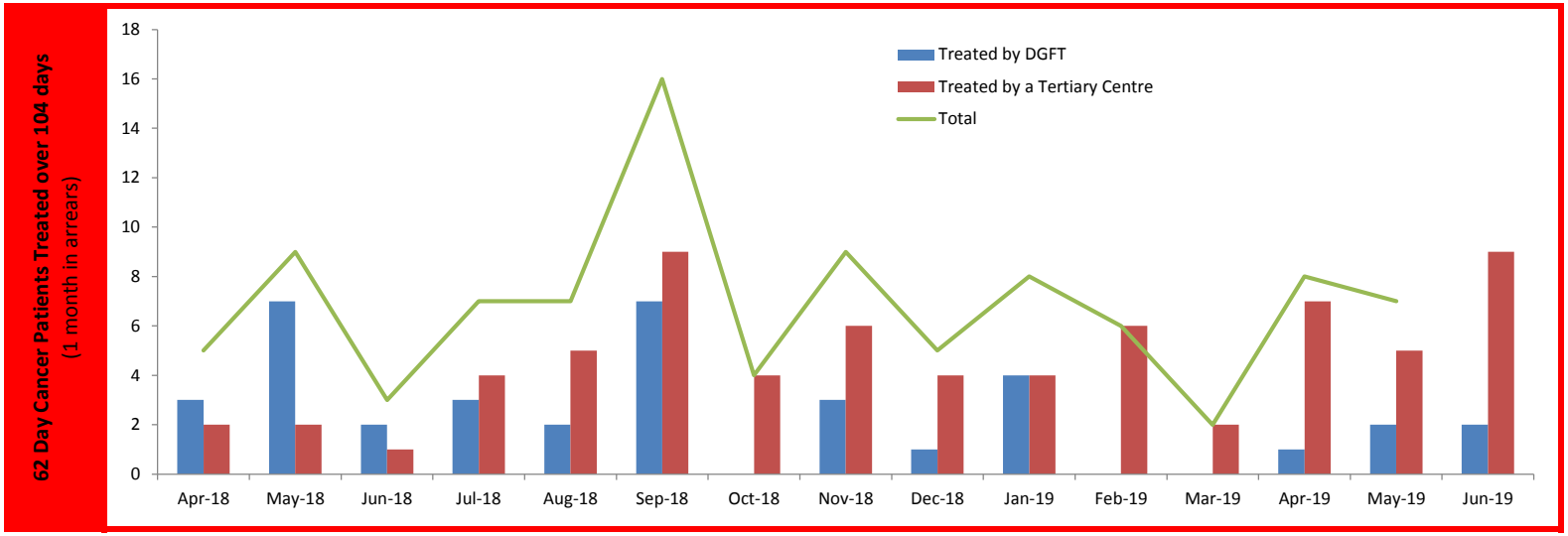




The Dudley Group NHS Foundation Trust

Performance Matters (KPIs)

Regulatory Performance - Cancer (1 month in arrears)



Regulatory Performance - Cancer (Latest month is provisional)

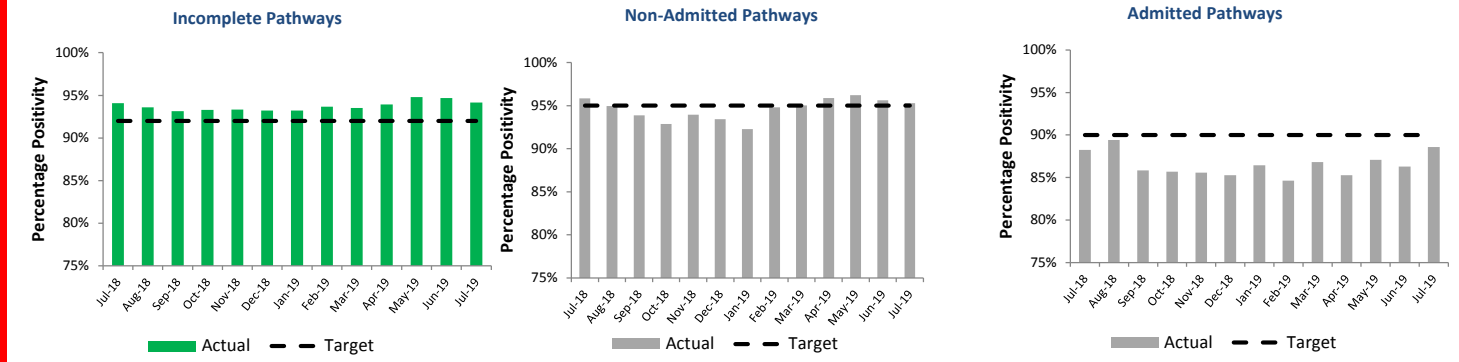
Comments

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 - July 2019

Validated Position

Specialty	Incompletes - Target 92%			
	<18	>18	Total	%
100 - General Surgery	930	103	1033	90.0%
101 - Urology	1226	114	1340	91.5%
110 - Trauma & Orthopaedics	1869	114	1983	94.3%
120 - ENT	1330	24	1354	98.2%
130 - Ophthalmology	1914	193	2107	90.8%
140 - Oral Surgery	640	23	663	96.5%
160 - Plastic Surgery	859	62	921	93.3%
300 - General Medicine	4	0	4	100.0%
301 - Gastroenterology	1274	66	1340	95.1%
320 - Cardiology	553	23	576	96.0%
330 - Dermatology	931	15	946	98.4%
340 - Respiratory Medicine	389	2	391	99.5%
400 - Neurology	607	39	646	94.0%
410 - Rheumatology	691	22	713	96.9%
430 - Geriatric Medicine	120	2	122	98.4%
502 - Gynaecology	1137	69	1206	94.3%
Other	4194	179	4373	95.9%
Total	**18668**	**1050**	**19718**	**94.7%**

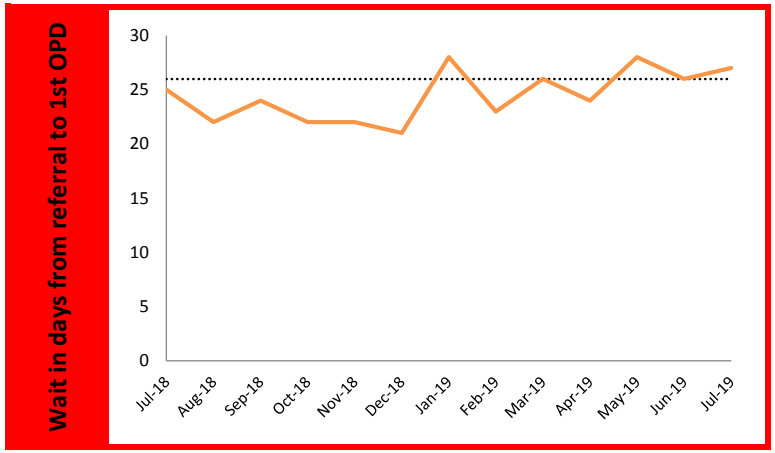
Comments

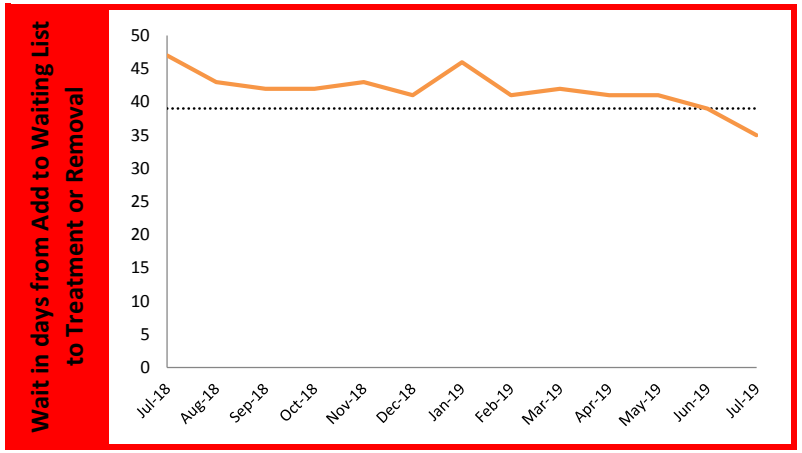
The total number of incomplete pathways has increased in recent months, although July was down slightly on the June position. In particular there has been an overall increase in incomplete pathways in the following specialties; urology, colorectal, vascular, oral surgery and peads ENT. There remains a continued focus on these specialties on reducing the total number of incomplete pathways.

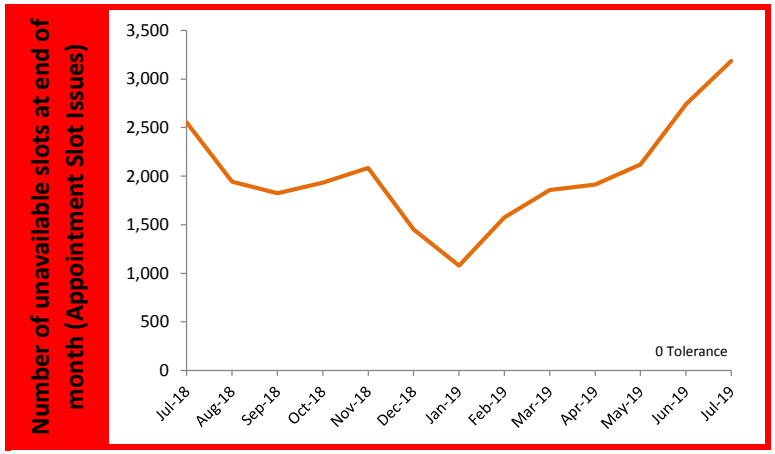
The Dudley Group NHS Foundation Trust

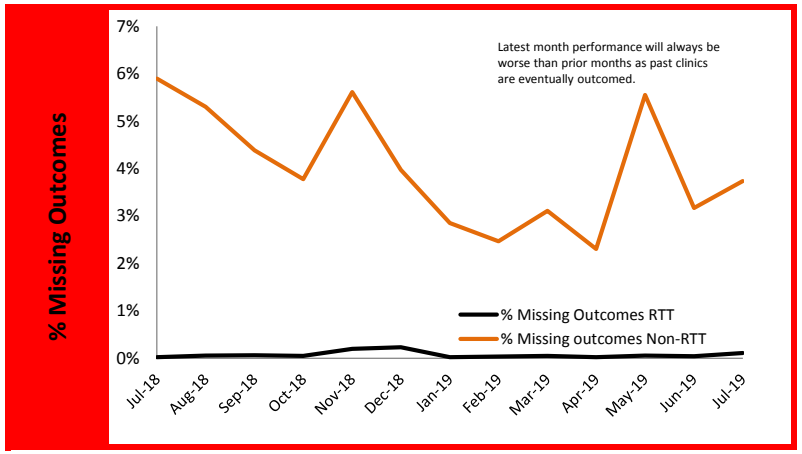
Performance Matters (KPIs)

Regulatory Performance - 18 Week Referral to Treatment







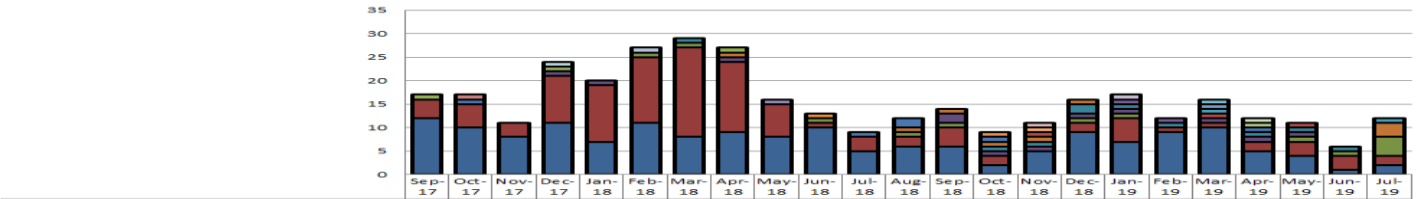


The Dudley Group NHS Foundation Trust

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	Jun-19	Jul-19
107 - Vascular Surgery				1																			
110 - Trauma & Orthopaedics																	1						
313 - Clinical Immunology and Allergy																				1			
400 - Neurology															1								
219 - Paediatric Plastic Surgery						1																	
307 - Diabetic Medicine															1								
171 - Paediatric Surgery																			1				
301 - Gastroenterology									1														
104 - Colorectal Surgery																				1			
255 - Paediatric Clinical Immunology and Allergy		1																					
140 - Oral Surgery																			1				
420 - Paediatrics										1				1									
103 - Breast Surgery																			1				1
291 - Paediatric Neuro-Disability																	1	1					
120 - ENT	1			1				1															
320 - Cardiology															1				1		1		
214 - Paediatric Trauma and Orthopaedics		1									1	2		1						1			
160 - Plastic Surgery								1				1	1	1	1	1							3
502 - Gynaecology							1							1	1	2	1	1		1	1	1	
330 - Dermatology				1	1			1					2	1	1	1	1		1	1	1		
100 - General Surgery						1	1			1		1	1			1	1				1	1	4
130 - Ophthalmology	4	5	3	10	12	14	19	15	7	1	3	2	4	2		2	5	1	1	2	3	3	2
101 - Urology	12	10	8	11	7	11	8	9	8	10	5	6	6	2	5	9	7	9	10	5	4	1	2

Comments

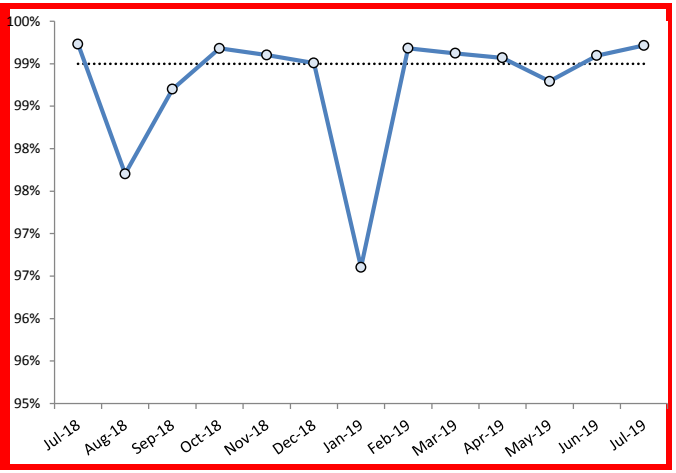
There is 0 RTT waits over 52 weeks

The Dudley Group NHS Foundation Trust

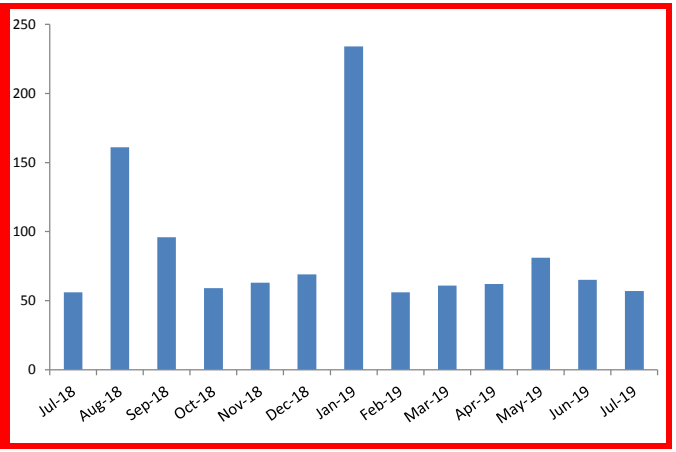
Performance Matters (KPIs)

Diagnostics

DM01 Performance



DM01 - Number of patients waiting over 6 weeks at month end (breaches)



DM01 Comments

The diagnostic standard (DM01) was achieved for July 2019 with a performance of 99.22% against the target of 99% patients seen in less than 6 weeks. As per previous months the greatest area of risk to the target remains within MRI, which accounted for 49 out of a total of 57 breaches. Work in ongoing in respect to reducing the remaining backlog which consists of Cardiac MRI and GA MRI, and additional lists completed and planned for August and September respectively should bring these down to manageable levels. In order to sustain performance, a number of positive meetings have been held with Cardiology and Imaging with a view to ensuring that job planned capacity is cross-covered during times of annual leave and Cardiology on call commitments.

Looking forward the Imaging Department is set to commence the replacement of the two CT scanners at the Russells Hall Hospital site from 9th September 2019 which is now to be completed in two phases, CT 1 during September – November 2019 and CT 2 during February – April 2020. During these periods it will be essential to maintain the Cardiac CT service in order to continue to achieve the DM01 standard. Agreements from Consultant Cardiologists has been received and will see them complete these scans at the start of each day, Monday to Friday, on the one in-house CT scanner.

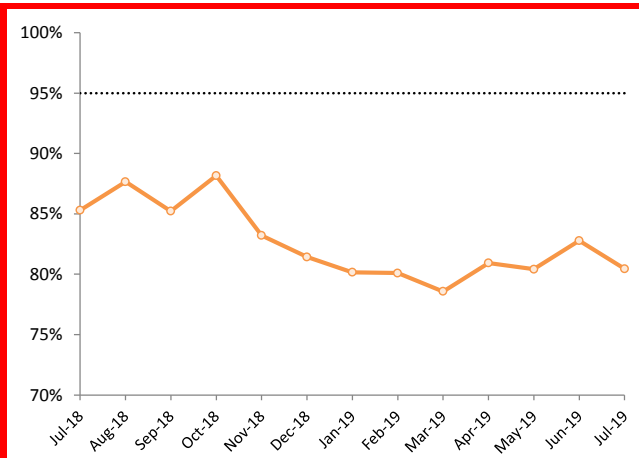
The Dudley Group NHS Foundation Trust

Performance Matters (KPIs)

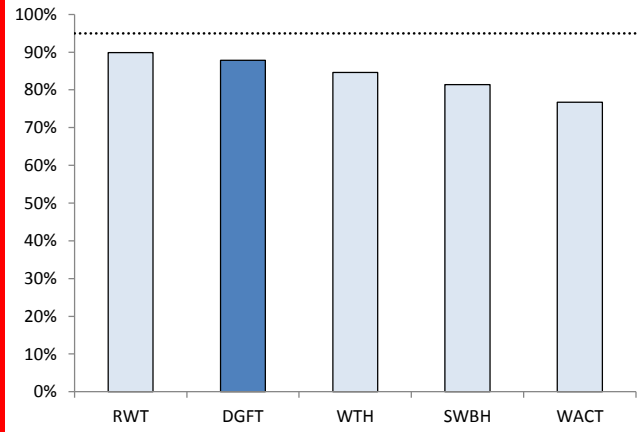
Regulatory Performance - ED

Please note: HEFT and UHB data has been merged

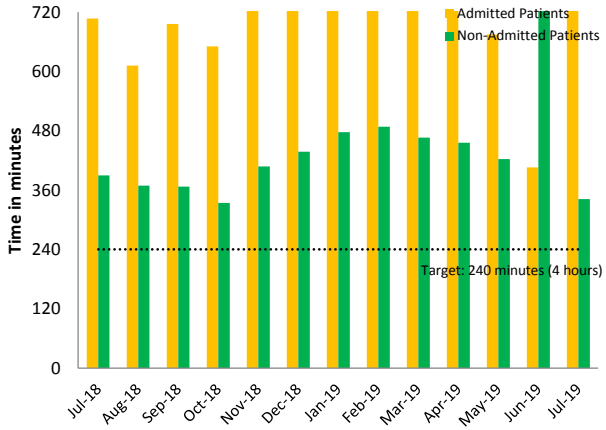
A&E 4 Hour Wait - Combined



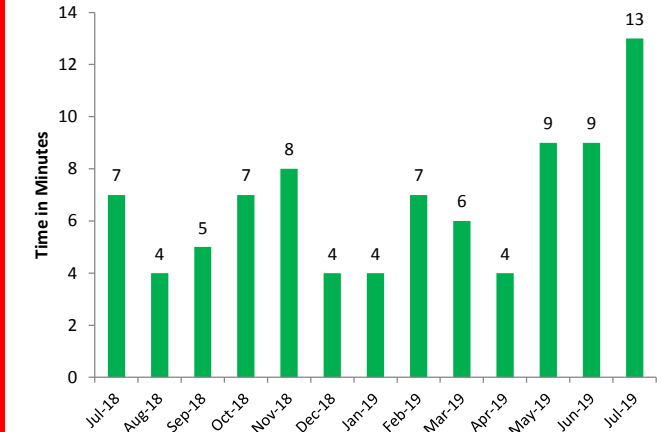
A&E 4 Hour Wait - Benchmarking



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

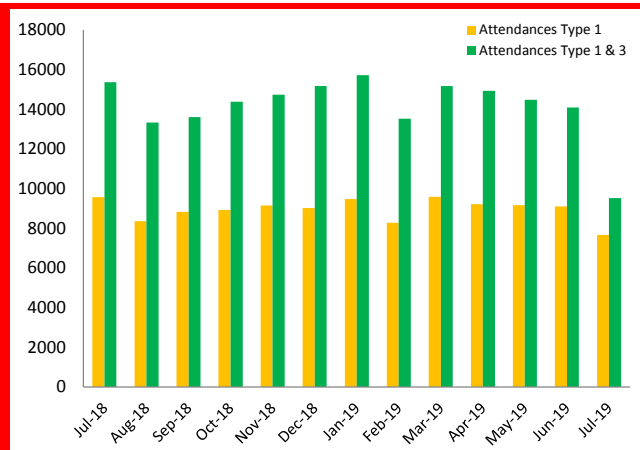


The Dudley Group NHS Foundation Trust

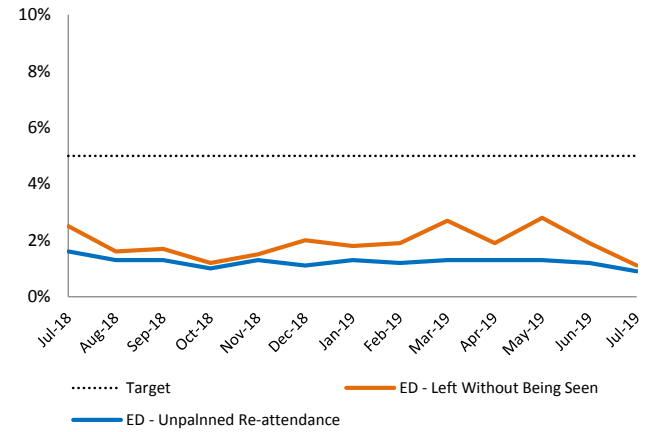
Performance Matters (KPIs)

Regulatory Performance - ED

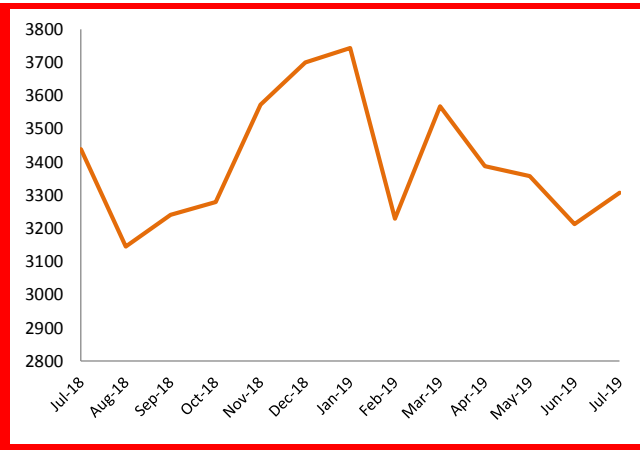
Number of Attendances



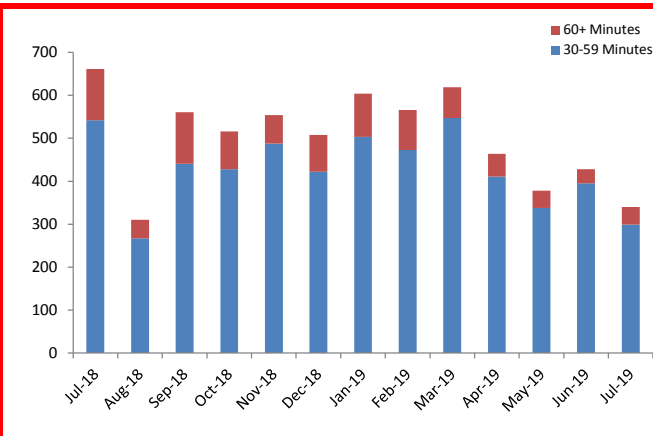
A&E Left without being seen & Unplanned Re-attendances Rates



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	541	506	-6.5%	-15	1,469	1,378	-6.2%	-91
Day Cases	4,043	3,860	-4.5%	611	12,158	13,838	13.8%	1,680
Non-elective inpatients	3,830	3,913	2.2%	-483	12,236	10,749	-12.2%	-1,487
Outpatients	44,232	43,921	-0.7%	1,067	115,593	114,578	-0.9%	-1,015
A&E	9,380	7,674	-18.2%	305	25,595	26,316	2.8%	721
Total activity	**62,026**	**59,874**	-3.5%	**1,485**	**167,051**	**166,859**	-0.1%	**-192**
CIP	**£'000**	**£'000**		**£'000**	**£'000**	**£'000**		**£'000**
Income	206	384	86.3%	178	652	953	46.2%	301
Pay	276	644	133.4%	368	1,094	1,347	23.2%	253
Non-Pay	1,723	263	-84.7%	-1,460	2,469	879	-64.4%	-1,590
Total CIP	**2,205**	**1,291**	**-41.5%**	**-914**	**4,215**	**3,180**	**-24.6%**	**-1,035**
INCOME	**£'000**	**£'000**		**£'000**	**£'000**	**£'000**		**£'000**
NHS Clinical	30,977	30,276	-2.3%	-701	117,836	117,058	-0.7%	-778
Other Clinical	439	307	-30.0%	-131	1,358	1,176	-13.4%	-182
STF Funding	431	431	0.0%	0	1,400	1,776	26.9%	376
Other	1,544	1,881	21.8%	336	6,941	7,476	7.7%	535
Total income	**33,391**	**32,895**	**-1.5%**	**-496**	**127,534**	**127,486**	**0.0%**	**-48**
OPERATING COSTS	**£'000**	**£'000**		**£'000**	**£'000**	**£'000**		**£'000**
Pay	-19,608	-19,452	-0.8%	157	-78,956	-78,533	-0.5%	423
Drugs	-3,018	-2,953	-2.2%	65	-11,600	-12,393	6.8%	-792
Non-Pay	-6,542	-8,381	28.1%	-1,839	-30,625	-31,794	3.8%	-1,169
Other	-1,900	-1,843	-3.0%	57	-7,541	-7,436	-1.4%	105
Total Costs	**-31,068**	**-32,628**	**5.0%**	**-1,560**	**-128,722**	**-130,156**	**1.1%**	**-1,434**

Performance - Financial Overview - TRUST LEVEL ONLY

	Month Plan	Month Actual	Variance %	Variance	Plan YTD	Actual YTD	Variance %	Variance
	£'000	**£'000**		**£'000**	**£'000**	**£'000**		**£'000**
EBITDA	**4,219**	**2,128**	**-49.6%**	**-2,091**	**6,335**	**4837**	**-23.6%**	**-1,498**
Depreciation	-756	-739	--2.2%	17	-2,987	-2964	--0.8%	23
Restructuring & Other	0	0	n/a	0	0	0	n/a	0
Financing Costs	-1,147	-1,107	--3.5%	40	-4,566	-4485	--1.8%	81
SURPLUS/(DEFICIT)	**2,316**	**282**	**-87.8%**	**-2,034**	**-1,218**	**-2612**	**114.5%**	**-1,394**
SOFP	**£'000**	**£'000**		**£'000**	**£'000**	**£'000**		**£'000**
Capital Spend	-1,297	-554	-57.3%	743	-4,317	-1,993	-53.8%	2,324
Inventory					3,530	3,685	4.4%	155
Receivables & Prepayments					14,804	15,826	6.9%	1,022
Payables					-28,567	-27,910	-2.3%	657
Accruals							n/a	0
Deferred Income					-3,391	-3,963	16.9%	-572
Cash & Loan Funding	**£'000**	**£'000**		**£'000**	**£'000**	**£'000**		**£'000**
Cash					4,401	7,835	78.0%	3,434
Loan Funding							n/a	0
KPIs								
EBITDA %	14.6%	7.4%	-7.2%		2.4%	1.8%	-0.5%	
Deficit %	8.0%	1.0%	-7.0%		-0.5%	-1.0%	-0.5%	
Receivable Days					0.0	0.0	n/a	
Payable (excluding accruals) Days					0.0	0.0	n/a	
Payable (including accruals) Days					0.0	0.0	n/a	
Use of Resource metric					3	4		

The Dudley Group NHS Foundation Trust

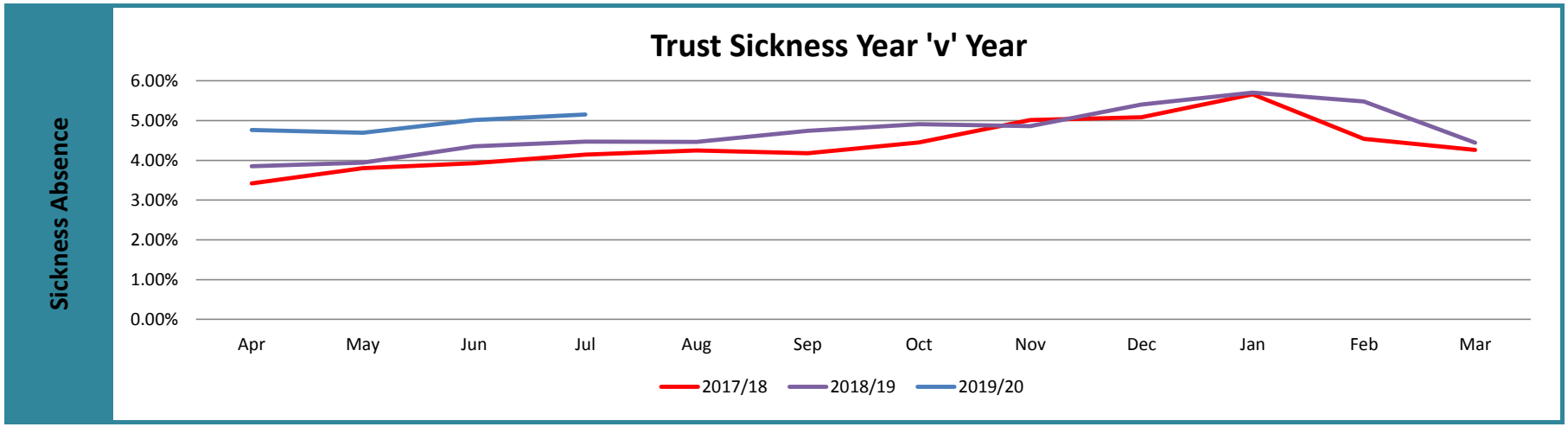
Workforce - "At a glance"

Executive Lead: Andrew McMenemy

	People					
	Target			Actual		Month
	18/19	Jun-19	Jul-19	YTD	Trend	Status
Workforce						
Sickness Absence Rate	3.50%	4.76%	5.01%	4.90%	↑	
Staff Turnover	8.5%	8.66%	8.72%	8.47%	↑	
Mandatory Training	90.0%	90.0%	89.7%	89.7%	↓	
Appraisal Rates - Total	90.0%	95.5%	95.5%	64.2%	↔	

People will be proud to work for us

Workforce



Quality Indicators

Heat Map - July 2019

Ward	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	Pressure Ulcers - Grade 3/4	Serious Incidents	Never Events	Nutrition Audit	Pain Score	Medicines Management Audit	% of Deaths with Priorities of Care	Fluid Balance Management Audit	VTE Assessment Indicator (CQN01)	Pressure Ulcer Audit	FFT - Response Rate	FFT - Recommended %	Complaints	Compliments	Appraisals	Mandatory Training	RN Average Fill Rate (day shifts)	RN Average Fill Rate (night shifts)	Sickness Rate	Ward RAG Trend		
	Patient Safety & Quality																Clinical Indicators			Patient Experience				Workforce & Safer Staffing								
AMU			NA					131	11					ND								6	1		ND			ND	0	2	-2
B1								11	1		1					NA						1	19						1	-5	5
B2 Hip								15	2													2	1						1	2	-1
B2 Trauma								10	4				ND				ND					2	14						0	1	-2
B3								20	0													0	0						0	-1	3
B4			NA					64	3													0	0						-1	-5	6
B5								12	0													2	2						1	-1	1
C1	ND		NA					26	1													0	49						0	-3	3
C2			NA	NA			NA	24	4							NA			NA			2	1						-1	-2	1
C3			NA	NA				32	3									ND				2	49						-3	1	0
C4								10	0													0	24						2	-3	2
C5								43	3		1											0	30						-1	-4	6
C6								37	3							NA						0	0						1	-3	3
C7								34	2													1	0						-3	3	1
C8								38	1									ND				0	9						-1	-2	3
CCU & PCCU								13	0							NA						1	2						1	-1	2
Critical Care			NA					26	6													0	0						-4	2	1
Maternity			NA	NA				135	8							NA			NA			4	37						0	1	-4
MHDU			NA					20	4										ND			0	18						-4	0	3
Neonatal			NA				NA	33	0							NA			NA			0	10						-2	0	3
Trust Total		99.8%	95.7%	93.4%	0			1475	94	0	4	0				46.0%				26.00%	89.60%	73	468								
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: <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%	73.39%	80.58%	-	-	-	-	-	-	-	-	73.17%	%
A&E - 4 Hour UCC Dept Only % (Type 3)	99.69%	99.45%	100.00%	99.95%	99.77%	-	-	-	-	-	-	-	-	99.78%	%
A&E - 4 Hour UCC/A&E Combined % (Type 1+3)	83.96%	80.93%	80.41%	82.77%	87.8%	-	-	-	-	-	-	-	-	83.03%	95%
A&E - Patients who Left Without Being Seen %	1.9%	1.9%	2.8%	1.9%	1.1%	-	-	-	-	-	-	-	-	1.9%	5%
A&E - Time to Initial Assessment (95th Percentile)	6	4	9	9	13	-	-	-	-	-	-	-	-	13	15
A&E - Time to Treatment Median Wait (Minutes)	94	68	80	34	58	-	-	-	-	-	-	-	-	58	60
A&E - Total Time in A&E (95th Percentile)	732	743	526	583	524	-	-	-	-	-	-	-	-	524	240
A&E - Unplanned Re-Attendance Rate %	1.3%	1.3%	1.3%	1.2%	0.9%	-	-	-	-	-	-	-	-	1.2%	5%
Activity - A&E Attendances	107,524	9,188	9,129	9,102	9,531	-	-	-	-	-	-	-	-	36,950	35,367
Activity - Cancer MDT	5,960	508	559	501	531	-	-	-	-	-	-	-	-	2,099	2,148
Activity - Community Attendances	426,917	35,549	36,448	33,163	37,744	-	-	-	-	-	-	-	-	142,904	139,969
Activity - Critical Care Bed Days	8,211	651	683	591	662	-	-	-	-	-	-	-	-	2,587	2,910
Activity - Diagnostic Imaging whilst Out-Patient	54,126	4,481	4,645	4,051	4,771	-	-	-	-	-	-	-	-	17,948	19,283
Activity - Direct Access Pathology	2,140,369	187,105	196,682	200,092	220,863	-	-	-	-	-	-	-	-	804,742	695,004
Activity - Direct Access Radiology	76,758	6,367	6,436	5,931	6,623	-	-	-	-	-	-	-	-	25,357	26,082
Activity - Elective Day Case Spells	49,959	3,679	3,672	3,533	3,874	-	-	-	-	-	-	-	-	14,758	15,331
Activity - Elective Inpatients Spells	5,469	439	471	469	508	-	-	-	-	-	-	-	-	1,887	2,017
Activity - Emergency Inpatient Spells	43,701	3,629	4,143	3,759	3,930	-	-	-	-	-	-	-	-	15,461	14,615
Activity - Excess Bed Days	8,242	941	814	623	361	-	-	-	-	-	-	-	-	2,739	3,904
Activity - Maternity Pathway	7,361	589	556	477	546	-	-	-	-	-	-	-	-	2,168	2,329
Activity - Neo Natal Bed Days	7,236	134	106	93	106	-	-	-	-	-	-	-	-	439	417
Activity - Outpatient First Attendances	171,763	15,109	15,644	15,302	17,103	-	-	-	-	-	-	-	-	63,158	58,500
Activity - Outpatient Follow Up Attendances	324,962	26,444	27,818	26,370	29,569	-	-	-	-	-	-	-	-	110,201	116,430
Activity - Outpatient Procedure Attendances	73,394	6,710	6,659	6,162	5,610	-	-	-	-	-	-	-	-	25,141	24,544
Activity - Rehab Bed Days	22,862	1,624	2,480	2,318	2,521	-	-	-	-	-	-	-	-	8,943	6,862
Activity - Renal Dialysis	49,399	4,157	4,282	3,961	4,287	-	-	-	-	-	-	-	-	16,687	16,734
Ambulance Handover - 30 min – breaches (DGH view)	5,165	411	338	395	299	-	-	-	-	-	-	-	-	1,443	0
Ambulance Handover - 30 min – breaches (WMAS view)	6,669	545	454	531	395	-	-	-	-	-	-	-	-	1,925	0
Ambulance Handover - 60 min – breaches (DGH view)	916	53	40	33	41	-	-	-	-	-	-	-	-	167	0
Ambulance Handover - 60 min – breaches (WMAS view)	1,071	65	47	43	47	-	-	-	-	-	-	-	-	202	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%	95.1%	96.1%	93.0%	-	-	-	-	-	-	-	-	94.4%	93%
Cancer - 14 day - Urgent GP Breast Symptom Referral to date first seen	94.5%	97.1%	98.7%	98.1%	97.4%	-	-	-	-	-	-	-	-	97.7%	93%
Cancer - 31 day - from diagnosis to treatment for all cancers	98.4%	98.2%	97.7%	98.0%	98.7%	-	-	-	-	-	-	-	-	98.2%	96%
Cancer - 31 Day For Second Or Subsequent Treatment - Anti Cancer Drug Treatments	100%	90%	100%	100%	100%	-	-	-	-	-	-	-	-	98.2%	98%
Cancer - 31 Day For Second Or Subsequent Treatment - Surgery	100.0%	100%	100%	95.6%	94.8%	-	-	-	-	-	-	-	-	97.4%	94%
Cancer - 31 Day For Subsequent Treatment From Decision To Treat	100.0%	97%	100%	97.5%	95.8%	-	-	-	-	-	-	-	-	97.6%	96%
Cancer - 62 day - From Referral for Treatment following a Consultant Upgrade	91.4%	96.8%	93.4%	93.2%	90.3%	-	-	-	-	-	-	-	-	93.4%	85%
Cancer - 62 day - From Referral for Treatment following national screening referral	98.1%	100.0%	100.0%	100%	91.3%	-	-	-	-	-	-	-	-	98%	90%
Cancer - 62 day - From Urgent GP Referral to Treatment for All Cancers	82.8%	87.3%	85.7%	82.7%	82.9%	-	-	-	-	-	-	-	-	84.7%	85%
Maternity: Breastfeeding Data Coverage Rates	100%	100%	100%	100%	100%	-	-	-	-	-	-	-	-	100%	0%
Number of Births Within the Trust	4,315	348	343	334	362	-	-	-	-	-	-	-	-	1,387	
RTT - Admitted Pathways within 18 weeks %	86.3%	85.2%	87%	86.2%	88.5%	-	-	-	-	-	-	-	-	86.8%	90%
RTT - Incomplete Waits within 18 weeks %	94%	93.9%	95%	95%	94%	-	-	-	-	-	-	-	-	94.4%	92%
RTT - Non-Admitted Pathways within 18 weeks %	94.5%	95.8%	96.20%	95.6%	95.20%	-	-	-	-	-	-	-	-	95.7%	95%
Waiting Time - Diagnostic 6 Week Maximum Wait (VSA05)	98.82%	99.06%	98.79%	99.1%	99.2%	-	-	-	-	-	-	-	-	99.04%	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	£1,017k	£1,066k	-	-	-	-	-	-	-	-	£4,450k	k
Bank spend	£20,035k	£1,673k	£1,651k	£1,811k	£1,667k	-	-	-	-	-	-	-	-	£6,801k	k
Budgetary Performance	(£13,226)k	£657k	(£378)k	£296k	(£2,056)k	-	-	-	-	-	-	-	-	(£1,482)k	£0k
Capital v Forecast	88.1%	12.3%	40.2%	47.6%	46.2%	-	-	-	-	-	-	-	-	46.2%	95%
Cash Balance	£8,928k	£7,005k	£5,154k	£2,825k	£7,835k	-	-	-	-	-	-	-	-	£7,835k	k
Cash v Forecast	64.9%	87.4%	97.8%	77.8%	178%	-	-	-	-	-	-	-	-	178%	95%
Creditor Days	22.7	19.7	20.3	19.8	18	-	-	-	-	-	-	-	-	18	15
Debt Service Cover	0.8	0.08	0.61	0.57	0.76	-	-	-	-	-	-	-	-	0.76	2.5
Debtor Days	8.6	13.2	13.2	12.9	10.2	-	-	-	-	-	-	-	-	10.2	15
I&E (After Financing)	(£4,987)k	(£1,597)k	(£233)k	(£1,106)k	£267k	-	-	-	-	-	-	-	-	(£2,670)k	k
Liquidity	-15.65	-12.66	-13.44	-14.78	-15.16	-	-	-	-	-	-	-	-	-15.16	0
SLA Performance	£3,277k	£55k	(£656)k	(£464)k	(£784)k	-	-	-	-	-	-	-	-	(£1,848)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%	95.5%	95.5%	95.5%	95.5%	95.5%	95.5%	95.5%	95.5%	95.5%	95.5%	95.5%	90%
Mandatory Training	88.8%	89.2%	89.9%	90.0%	89.7%	-	-	-	-	-	-	-	-	89.7%	90%
RN average fill rate (DAY shifts)	81.83%	85.42%	87.35%	85.68%	84.64%	-	-	-	-	-	-	-	-	85.76%	95%
RN average fill rate (NIGHT shifts)	86.43%	88.14%	90.74%	88.87%	87.8%	-	-	-	-	-	-	-	-	88.86%	95%
Sickness Rate	4.66%	4.80%	4.79%	5.09%	5.15%	-	-	-	-	-	-	-	-	4.96%	3.50%
Staff In Post (Contracted WTE)	4,397.87	4,376.76	4,405.40	4,418.19	4,431.60	-	-	-	-	-	-	-	-	4,431.60	
Turnover Rate (Rolling 12 Months)	8.48%	8.25%	8.25%	8.66%	8.72%	-	-	-	-	-	-	-	-	8.72%	%
Vacancy Rate	9.35%	13.73%	13.33%	13.03%	12.74%	-	-	-	-	-	-	-	-	12.74%	%

Enclosure 18

The Dudley Group NHS Foundation Trust

Paper for submission to the Board of Directors on 3 September 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 meetings held on 25 July and 29 August 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: 25 July 2019

MATTERS OF CONCERN OR KEY RISKS TO ESCALATE

- Delivery of Q2 financial plan at high risk despite encouraging trends around agency/bank and CIP scheme identification
- 62 day cancer target just missed at 84.7%, but target achieved for Q1

MAJOR ACTIONS COMMISSIONED/WORK UNDERWAY

- A & E Delivery Board to report to F & P on progress against EAS system wide improvement plan
- Best case scenario shows current forecast shortfall of £2.9m against Q2 plan. Action required for divisions as a matter of urgency to identify options for delivering the £2.9m gap
- Extra-Ordinary F & P to be held in August to review the divisional plans for delivering the £2.9m gap
- Shadow reporting against new access standards coming in 1 April 2020

POSITIVE ASSURANCES TO PROVIDE

- Delivered Q1 financial and received PSF £969k
- Encouraging discussions with partners on smoothing cash payments which may negate the need to borrow cash. To be confirmed at next F & P

DECISIONS MADE

- None made

Chair's comments on the effectiveness of the meeting:

An interactive meeting with good discussion from all present around challenge and seeking assurance

A good presentation of positive performance received from the Clinical Support Services Division

Further work required by Divisions to ensure Divisional risk register are up to date

UPWARD REPORT FROM FINANCE AND PERFORMANCE COMMITTEE

Date Committee last met: 29 August 2019

MATTERS OF CONCERN OR KEY RISKS TO ESCALATE	MAJOR ACTIONS COMMISSIONED/WORK UNDERWAY
• July income and expenditure performance was £2m behind budget, reducing the year end forecast to £1m worse than base plan • Some progress has been made with Dudley CCG to assist us with our cash position, but we are still forecasting the need for cash borrowing in December 2019 • Continuing to miss the Emergency Access Standard (EAS) and there is also a risk of failure of the cancer 2 week wait in August • Potential £200k risk to income in ED from operational issues arising from the deployment of Sunrise	• Validate and allocation to Divisions £4.5m of previously unidentified Cost Improvement Programme (CIP) • Detailed breakdown of EAS performance by category and key drivers to be reported regularly to Finance and Performance Committee • Detailed benefits realisation review of EPR to be presented to the Committee in November 2019
POSITIVE ASSURANCES TO PROVIDE	**DECISIONS MADE**
• Received and responded to high Cybersecurity CareCert vulnerability, with mobilisation and patching implemented	• None made

Chair's comments on the effectiveness of the meeting:

Heavy agenda resulted in meeting over running and insufficient time devoted to future actions around CIP. However there was good challenge throughout the meeting

Enclosure 19

The Dudley Group
NHS Foundation Trust

Paper for submission to Trust Board on the 6th September 2019

TITLE:	**Annual Plan 2019/20: Monitoring for Quarter One**		
AUTHOR:	**Tricia Morrison Deputy Director:Strategy and Business Development**	**PRESENTER**	**Tom Jackson Director of Finance**

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 DIRECTORS:			
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 DIRECTORS

- To note the monitoring of progress against the Annual Plan Strategic Objectives for Quarter One.
- To discuss if any new risks should be added to the Corporate Risk register.

CORPORATE OBJECTIVE:

All Strategic objectives

SUMMARY OF KEY ISSUES:

Proposals for refreshing the monitoring arrangements for the Trust Annual Plan 2019/20 were supported by the Finance and Performance Committee at the end of the last financial year. A new look prototype report is attached at Appendix 1.

The report sets out a summary of the headlines for each of the Strategic Objectives providing a commentary on what is going well, what is not going so well and any related risks and mitigation.

This is very much a work in progress, as we acknowledge that this needs to be developed in tandem with the changes to the IPR and associated performance reporting across the Trust. Work has started to refresh the look of the IPR to incorporate the recommendations of 'Making Data Count' (#plotthedots). This will be further developed following the Board Workshop scheduled for mid -September with Sam Riley from NHS Improvement.

Next Steps

A Board workshop on #plotthedots has been scheduled for September which will provide an opportunity to discuss how 'Making Data Count' can be incorporated into the Trust.

The format and content of what will be reported monthly in the IPR and what should form the content of quarterly monitoring will be one of the outcomes of this piece of work.

IMPLICATIONS OF PAPER:

RISK	**RISK:** **N**		**Risk Description:**
	Risk Register:		**Risk Score:**
COMPLIANCE and/or LEGAL REQUIREMENTS	**CQC**	**Y**	**Details**: Well-led
	NHSI	**Y**	**Details:** Operational Plan is submitted to & approved by NHSI
	Other	**N**	**Details:**

The Dudley Group
NHS Foundation Trust

Appendix 1

ANNUAL PLAN 2019/20: MONITORING FOR QUARTER 1

This report provides a summary of progress against the Annual Plan covering the period April - June 2019.

A summary against each of the six Strategic Objectives in the Annual Plan is shown in the attached table.

The Dudley Group NHS Foundation Trust

SUMMARY BY STRATEGIC OBJECTIVE

Strategic Objective	Lead	What is going well	What is not going so well	Risks and mitigation
 **Deliver a great patient experience**	**Chief Operating Officer**	• At the end of June the Trust had the third best performance against the Referral to Treatment (RTT) target in the country at 94.7% • Cancer waiting times targets have been achieved. Discussions have started concerning the Trust providing support to Royal Wolverhampton to temporarily alleviate pressure on their breast cancer service by taking some of their referrals • To improve communication between the Trust and its stakeholder practices, a timetable for the production of GP Brief has been produced with the first edition distributed in early August • 'Living the values' has been incorporated into Trust Induction for all new starters to improve communication between staff and patients	• Results from the National Patient Survey 2018 show a declining picture with the Trust ranked 131 out of 144 • The FFT recommendation rate is below the national average with the exception of maternity. A&E and outpatient recommendation rates are currently in the bottom quartile nationally • There has been no reduction in the number of overdue complaints • The Emergency Access Standard was not achieved in any month this quarter	• A new Patient Experience Strategy has been drafted and is ready to be ratified by the appropriate groups • FFT App has been deployed in additional areas including community to improve response rates • Dudley Improvement Practice have been working with the Patient Experience Team to improve the efficiency and effectiveness of the complaints process • A Frailty Assessment Area has been trialled in ED which has demonstrated that patients are seen quicker and are more likely to be discharged home. A proposal to make this a permanent service will be considered by the executive team • A 24 hour service in minors in ED has been piloted during July • Information about the Trust's waiting time performance has been added to the public

Strategic Objective	Lead	What is going well	What is not going so well	Risks and mitigation
				website from July
 **Deliver Safe and Caring Services**	**Chief Nurse**	• A Patient Safety Strategy was ratified in May • A review of Datix has been undertaken and the system streamlined to encourage staff to report incidents • The process for reviewing deaths in ED has been aligned to the process in the rest of the Trust • Inpatient mortality rate is within the expected range • A Clinical Summit took place on 5 July with facilitation from the Kings Fund • AHP service leads are working with external consultants to apply a multi-professional approach to filling vacancies • There have been improvements in the number of pregnant women tested for carbon monoxide (CO) at the time of booking (>90%) and after delivery (>98%)	• The final CQC inspection report was published on 12 July with the overall rating remaining 'requires improvement' • There was one never event in April • Performance against VTE has declined in recent months and the 95% target was not achieved between November and May but was achieved in June • Medical and nursing vacancy rates remain above the 10% target • Completion of consultant job planning has plateaued at 70% after significant increases at the end of last year	• Actions already identified from the latest CQC inspection are being progressed in the Achieving Excellence Group • Learning reports from incidents are compiled quarterly and the lessons distributed to staff via regular Patient Safety Bulletins • Outstanding VTE reports are circulated daily to all relevant leads • A revised consultant job planning policy is being discussed with the Joint Local Negotiating Committee • The trust is achieving 20% of pregnant women booked on to a continuity of carer pathway but there is a risk of not achieving 35% by March 2020 given current levels of staffing

Strategic Objective	Lead	What is going well	What is not going so well	Risks and mitigation
 **Drive Service Improvement, Innovation and transformation**	**Chief Operating Officer**	• The Chair of the MCP has been appointed and an Operational Director starts from 1st August • An 'All Together Better' event was held on 18th July for clinicians to share, shape and challenge the clinical vision of the future for local services facilitated by the Kings Fund • Dudley Borough has shared data on changing demographics and health needs and identified options for closer working in the future • Task and Finish Groups to address improved clinical productivity in outpatients, theatres, endoscopy and catheter lab have been started with the support of external consultants • Rapid Assessment Bays (RAB) in AMU have been in operation since April • All posts to the Dudley Improvement Practice team have been recruited to • A week long improvement event in Ophthalmology run by DIP in May led to an increase from 48 to 71% of the OCT machine	• An audit against 7-day standards was submitted at the end of June showing that the Trust is an outlier compared to national and regional peers for time to first consultant review and on-going review by consultants • Theatre utilisation in day surgery did not achieve 80% in any of the last 12 months	• Additional general surgery consultants will be appointed following the approval of a Business Case to improve access to 7-day services • There is a proposal to increase the length of nursing shifts in day surgery to improve utilisation • The new model for pre-assessment (one-stop) is increasing the pool of patients assessed fit for surgery

Strategic Objective	Lead	What is going well	What is not going so well	Risks and mitigation
 **Be the place people choose to work**	**Director of Workforce**	• Appraisal rate has exceeded the 90% target with 95.5% of staff receiving their appraisal within the three month window • Total time to recruitment within 77 days was 87% in May 2019, a marked improvement on recent months • The first intake of the Trainee Nurse Associates (20) started in July with a further intake planned for September • A behavioural framework has been launched • Newly appointed matrons are receiving 360 degree feedback to inform their development plans	• Agency spend in each month was above target but has been reducing each month • Sickness Absence rates remain in the range of 4.7 - 5% and above the 3.5% target	• The target time for recruitment will be reduced to 50 days from 1st July • New measures to control agency spend have been introduced from 1st July • Sickness absence for the top 20 cases in each Division have been identified are being actively managed • Sickness Absence Policy will be amended following an audit conducted in conjunction with the trade unions
 **Make the best use of what we have**	**Director of Finance**	• All budgets have been signed off with the budget holder • At the end of quarter 1 the Trust reported a consolidated deficit of £2.88m which was slightly better than plan meaning that the Trust will qualify for the Provider Sustainability Fund (PSF) in quarter 1 • Working with external consultants, the trust has outlined a further £7 - £10m of opportunities to contribute to the CIP target • The Financial Improvement Group has been strengthened to reflect the new delivery and governance model • Tighter controls on spending have	• At 6% of turnover, the Trust's CIP target of £22.4m this year is challenging and places us an outlier	• Communication about the financial position of the Trust has been cascaded to all staff including the tighter controls on spending • Finance are developing a revised training package for budget holders to be rolled out from quarter two

Strategic Objective	Lead	What is going well	What is not going so well	Risks and mitigation
		been developed and implemented from 1st July • An additional eight First Contact Practitioners (FCP) have been appointed and will start in quarter two. This enables a scaling up of the FCP programme which introduces physiotherapy into primary care teams to improve care for musculo-skeletal (MSK) conditions • Hours of operation of the Cardiac Assessment Unit will be extended following approval of a business case. The Unit has been shortlisted in the Nursing Times Awards • A Working Group is looking to introduce a standardised approach to Demand & Capacity modelling with support from the national Demand & Capacity programme		
 **Deliver a viable future**	**Director of Strategy & Business Develop-ment**	• The Dudley Provisional Endometriosis Centre has begun with the aim of getting formal recognition in 2020 • Elective sessions at weekends for orthopaedics started in July for a three month pilot utilising the Limited Liability Partnership (LLP). This will reduce waiting times and contribute to increased market share • Visits to practices in Sandwell & West Birmingham have commenced and been well-received. As well as	• Plans to expand specialised services in Gastroenterology and Plastic Surgery are dependent on the acceptance of business cases for new investment • Arranging mutually convenient times to meet with GP practices is taking longer than expected • Recruitment and activity based funding did not achieve target in 2018/19 (86% and 92%) and funding for this year has been	• The case for the expansion of Endoscopy suite has been forwarded to the STP • The development of Mohs surgery (Plastic Surgery) is dependent on a business case being accepted by NHS E Specialised Commissioning • The Trust is ensuring appropriate representation on all relevant work streams

Strategic Objective	Lead	What is going well	What is not going so well	Risks and mitigation
		promoting the services provided by the Trust, the visits are building stronger relationships with stakeholder practices, regardless of CCG • Work has started on developing the Business Case to secure capital monies for the redevelopment of urgent and acute care (£20.3m)	reduced	of the STP • The time scale for the production of the response to the NHS LTP by the STP requires active engagement by the Trust

Enclosure 20

The Dudley Group
NHS Foundation Trust

Paper for submission to the Trust Board on 5 September 2019

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

CLINICAL STRATEGIC AIMS

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

ACTION REQUIRED OF BOARD:

Decision	Approval	Discussion	Other
		Y	

OVERALL ASSURANCE LEVEL:

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

RECOMMENDATIONS FOR THE BOARD:

The Board to receive the main items addressed at the Workforce and Staff Engagement Committee and to be assured that there continues to be good progress alongside the Committee aims that are aligned to the Dudley People Plan.

CORPORATE OBJECTIVE:

SO4: Be the place people choose to work

SO5: Make the best use of what we have

SO6: Deliver a viable future

SUMMARY OF KEY ISSUES:

This summary of the Committee meetings that took place in July & August 2019 provide the Trust Board with assurance regarding matters associated to the Workforce and the Dudley People Plan are being managed and taken forward effectively and appropriately.

IMPLICATIONS OF PAPER:

RISK	**Y**		**Risk Description:**
	Risk Register: Y		**Risk Score**
COMPLIANCE	**CQC**	**Y**	**Details: Well Led**

and/or LEGAL REQUIREMENTS	**NHSI**	**Y**	**Details: Annual Business Planning Process**
	Other	**N**	**Details:**

The Dudley Group NHS Foundation Trust

CHAIRS LOG

UPWARD REPORT FROM WORKFORCE & STAFF ENGAGEMENT COMMITTEE - 29th July 2019

MATTERS OF CONCERN OR KEY RISKS TO ESCALATE	MAJOR ACTIONS COMMISSIONED/WORK UNDERWAY
• The risk associated with pension implications for staff earning above the relevant threshold was escalated alongside mitigations to manage the risk. It was advised that this risk has also been added to the Corporate Risk Register.	• The Committee acknowledged the changes to the training associated to the Nursing Associate Programme from September 2019. It was therefore determined that work would be commissioned to revise the business case associated to the Nursing Associate Programme accordingly.
POSITIVE ASSURANCES TO PROVIDE	**DECISIONS MADE**
• Taking consideration of the workforce efficiency and transformation programmes assurance was provided regarding interim changes in the Workforce Directorate to better manage these challenges. • The Committee received a positive update associated to the Trust progress regarding Apprenticeships. The progress against target to meet the levy as well as the development and implementation of the new speciality standards was noted. • The quarter 4 Staff Friends and Family results provided positive assurance based on a significant increase on feedback received alongside improvements with the feedback for those recommending the Trust as a place to receive care and to work. The Committee recognised the 'Make it Happen' OD programme as having a positive impact that has supported this assurance.	• It was agreed to accept and ratify the new Dudley People Plan. It was also agreed that the Plan should be presented to the Trust Board in October 2019. • The Committee received an option appraisal regarding the Staff Survey for 2019. The options allowed for a sample of staff to undertake the survey against a full census of staff. It was determined by the Committee that although there were constructive arguments for the sample, that the full census was the recommended way forward for this year. • The Committee ratified the Medical Staff Appraisal Policy as well as the Senior Medical Leave Policy.

Chair's comments on the effectiveness of the meeting:

The meeting was reasonably well attended and included good levels of challenge and debate.

The Dudley Group NHS Foundation Trust

CHAIRS LOG

UPWARD REPORT FROM WORKFORCE & STAFF ENGAGEMENT COMMITTEE - Date Committee last met: 27th August 2019

MATTERS OF CONCERN OR KEY RISKS TO ESCALATE	MAJOR ACTIONS COMMISSIONED/WORK UNDERWAY
• The report associated to Consultant Job Planning raised partial assurance that Job Plans were being reviewed and completed. The risks associated to the Job Plans related to their alignment to the business planning process and whether they were annualised, which the Committee accepted would be the next stage of Job Planning implementation. • The Committee received further detail associated to the risks regarding Priority One Mandatory Training subjects that demonstrated unsatisfactory compliance rates below 80% that require further escalation. • The Committee acknowledged the capacity restraints on the Workforce Directorate, taking consideration the significant workforce agenda and recommended that this was escalated to the relevant risk register.	• The Committee received a comprehensive presentation regarding the actions to support improved levels of staff attendance. A separate work stream has been commissioned with the Director of Workforce as SRO and Becky Cooke as Operational Lead. This work would also involve relevant Divisional, Professional and staff representation and it was agreed to take the form of Listening in Action. • It was decided that a review of Mandatory Training would be initiated alongside Subject Matter Experts, the Corporate Nursing Team and the Workforce Directorate. The aim being to create a more efficient process that provides the relevant training framework for all staff.
POSITIVE ASSURANCES TO PROVIDE	**DECISIONS MADE**
• The Medical Revalidation Annual Organisational Report provided positive assurance associated to revalidation of the medical workforce. • The Workforce Key Performance Indicators in relation to turnover, appraisal rates and recruitment timeline demonstrated continued good progress and assurance. • The Head of Learning & OD provided assurance regarding the framework for training associated to Safeguarding. • The Medical Director provided assurance that all Consultant Job Plans would have their annual review completed by the end of this financial year.	• To support the Freedom to Speak up Action Plan that included the relevant training for FTSU Guardians as well as relevant others to support staff raising concerns. • It was agreed that individuals demonstrating non-compliance regarding Priority One Mandatory Training areas would be communicated to by the Director of Workforce & Chief Nurse prior to further escalation. • The corporate risks associated to workforce were presented and it was determined that notwithstanding some additions to the mitigations, that the risk scores should remain at this time.

Chair's comments on the effectiveness of the meeting:

The meeting was well attended and included good levels of challenge and debate. However, the main contributions were provided by either Board members or staff from the Workforce Directorate. The Committee will be more effective with more ownership from Divisional representatives. Therefore I will work alongside the Director of Workforce & OD to develop the agenda that encourages greater ownership from Divisional leads.

Enclosure 21

The Dudley Group
NHS Foundation Trust

Paper for submission to the Board of Directors on 5 September 2019

TITLE:	**Audit Committee Exception Report**		
AUTHOR:	Richard Miner Audit Committee Chair	**PRESENTER:**	Richard Miner Audit 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:

SO3: Drive service improvements, innovation and transformation
SO5: Make the best use of what we have
SO6: Deliver a viable future

SUMMARY OF KEY ISSUES:

Summary report from the Audit Committee meeting held on 19 August 2019.

IMPLICATIONS OF PAPER:

RISK	N		**Risk Description:**
	Risk Register: N		**Risk Score:**
COMPLIANCE and/or LEGAL REQUIREMENTS	**CQC**	**Y**	**Details:** Well Led
	NHSI	**N**	**Details:**
	Other	**Y**	**Details:** Good Governance

The Dudley Group NHS Foundation Trust

UPWARD REPORT FROM AUDIT COMMITTEE

Date Committee last met: 19 August 2019

MATTERS OF CONCERN OR KEY RISKS TO ESCALATE	MAJOR ACTIONS COMMISSIONED/WORK UNDERWAY
• Format and structure of the Board Assurance Framework (BAF) to be reviewed as felt to still be too complex • Premature close down of internal audit recommendations before full evidence is available to support closure • Roll out of full implementation of ED rostering on Allocate	• Continuation of BAF review by Interim Chief Nurse and Board Secretary with proposals being presented to Executive Directors and Board • Reinforce, by directors to mangers responsible, importance of fully implementation of internal audit recommendations before being closed down • Internal Audit and Mr Atkins (through Workforce Committee) to follow up implementation of the ED rostering on Allocate
POSITIVE ASSURANCES TO PROVIDE	**DECISIONS MADE**
• Good level of progress made against the 2019/20 clinical audit plan • Good level of progress made against Internal Audit work undertaken • Good level of progress made against the LCFS work plan • Significantly reduced losses and special payments during Q1	• Approval of 2018/19 Clinical Audit Annual Report • Approval of 2019/20 Clinical Audit Plan • Approved changes to the reopened internal audit recommendations implementation dates • Accepted the changes to the Internal Audit 2019/20 plan • Approved the action plan arising from recommendations made following external auditors review of 2018/19 Quality Accounts

Chair's comments on the effectiveness of the meeting:

Short and effective meeting with key issues to follow up

Enclosure 22

The Dudley Group
NHS Foundation Trust

Paper for submission to the Board on 6th September 2019

TITLE:	**Medical Revalidation Update**		
AUTHOR:	Dr Julian Hobbs, Medical Director	**PRESENTER**	Dr Julian Hobbs, Medical Director

CORPORATE OBJECTIVE:
SO2: Safe and Caring Services
SO4: Be the place people choose to work

SUMMARY OF KEY ISSUES:

- As of 1st April 2019 Dr Julian Hobbs was appointed as Responsible Officer in addition to the current role of Medical Director in line with other Trusts.
- 388 doctors were connected to DGFT at 31/3/19
- At 31/3/19 80.7 % complied with GMC guidelines for appraisal within 9-15 months of
- previous appraisal, there were 6 unapproved incomplete appraisals as of 31/03/2019 which have now all been completed.
- The number of revalidation recommendations required is set to increase from 55 (2018) to 96 in 2019 and a further 110 revalidations due in 2020.
- From 31/03/2018 to 01/04/2019 no rev 6 referrals to the GMC have been required.

IMPLICATIONS OF PAPER:

RISK	**N**		**Risk Description:**
	Risk Register: N		**Risk Score:**
COMPLIANCE and/or LEGAL REQUIREMENTS	**CQC**	**Y**	**Details: SAFE; WELL LED**
	Monitor	**Y**	**Details:**
	Other	**Y**	**Details: GMC Good Medical Practice NHS Framework for Quality Assurance for Responsible Officers**

ACTION REQUIRED OF BOARD:

Decision	Approval	Discussion	Other
		✓	

RECOMMENDATIONS FOR THE BOARD

The Board is asked to note the contents of this report and to support plans for improved quality assurance of Revalidation processes.

The Dudley Group
NHS Foundation Trust

REPORT OF THE RESONSIBLE OFFICER TO THE BOARD OF DIRECTORS

September 2019

1. Executive Summary

This report represents the status of Medical Revalidation and Appraisals at The Dudley Group NHS Foundation Trust as of 31st March 2019. It represents the performance of the organisation with regards to the Framework for Quality Assurance for Medical Revalidation (FQA) and the Responsible Officer Regulations and related guidance from the General Medical Council (GMC) which forms the basis of the Annual Organisational Audit for 2018/2019 submitted to NHS England.

As of 31st March 2019 there were 388 doctors with a prescribed connection to The Dudley Group NHS Foundation Trust as a designated body. The overall compliance rate at 31st March was 80.7%.

A programme of appraiser training and quality assurance is in place with no current concerns regarding the quality of appraisals. Timely recommendations to the GMC for revalidation were carried out with no missed recommendations

2. Background

Medical Revalidation was launched in 2012 to strengthen the way that doctors are regulated, with the aim of improving the quality of care provided to patients, improving patient safety and increasing public trust and confidence in the medical system.
Provider organisations have a statutory duty to support their Responsible Officers in discharging their duties under the Responsible Officer Regulations and it is expected that provider boards will oversee compliance by:

- Monitoring the frequency and quality of medical appraisals in their organisations;
- Checking there are effective systems in place for monitoring the conduct and performance of their doctors;
- Confirming that feedback from patients is sought periodically via a designated distributor so that their views can inform the appraisal and revalidation process for their doctors; and ensuring that appropriate pre-employment background checks (including pre-engagement for Locums) are carried out to ensure that medical practitioners have qualifications and experience appropriate to the work performed.

The Board has directly, and via the Workforce and Engagement Committee, received assurance for the last 5 years from the Responsible Officer that the organisation meets the above duties and responsibilities as set out in the Regulations.

As of 1st April 2019 Dr Julian Hobbs was appointed as Responsible Officer in addition to the current role of Medical Director in line with other Trusts.

3. Governance

The Responsible Officer is supported by Medical Trust Appraisal Lead and a Band 4 Medical Appraisal and Revalidation Support Officer. The team meet fortnightly and escalate any issues for discussion at the Medical Concerns group who meet weekly to discuss concerns arising from medical appraisal, complaints/adverse incidents, performance related issues, GMC communications etc. This Group functions as a Senior decision making group in relation to whether to investigate further and if so under which process this should be carried

out. It also reviews the outcome of any ongoing investigations and the implementation of any resultant recommendations. The output from this Group forms the basis of the Medical Director's report to the private Trust Board.

Assurance in relation to Medical Revalidation and Appraisal is provided by reporting to the Workforce and Engagement Committee biannually.

The Directorate recognise that the current support arrangement for the process requires strengthening and plans are in place to train an additional member of the Medical Directorate support team to reduce the risk of a single point of contact to support medical staff requiring support.

4. Medical Appraisal Performance

4.1 Appraisal and Revalidation Data at 31/3/2109

Grade	Number of connections	Completed Appraisal at 31/3/2019	Approved Incomplete or missed	Unapproved Incomplete or missed
Consultant	210	91.9%	11 (5.2%)	6 (2.9%)
Trust	108	79.6%	22 (20.4%)	0
Temporary	62	43.5%	35 (56.5%)	0
Other	8	87.5%	1 (12.5%)	0
Overall	388	80.7%	69 (17.5%)	6 (1.5%)

A concerted effort was made from around March 2018 to educate doctors regarding the standards required to meet our Trust policy which states appraisals should be completed within 56 days of the due date. This has resulted in a much improved situation whereby at August 2019 95.46% of all doctors (we have 397 doctors with a prescribed connection at present) have completed their appraisals within 12 months and 100% within 15 months. There are currently no non-engaging doctors. Work continues to increase the engagement of our SAS workforce across the Trust with an allocated lead appointed and regular meetings taking place.

4.2 Appraisers
There are a total of 64 Medical Appraisers within the Trust. Recruitment of new appraisers is taking place with all interested being directed to new appraiser training courses, Refresher training sessions for existing appraisers are held within the Trust and Appraiser training is also promoted for doctors who wish to undertake the role of Medical Appraiser, this is funded by the doctors study leave. Some appraisers have undergone enhanced mentorship training. This should allow the Trust to draw from this same pool of doctor's suitable mentors for newly appointed Consultants and other doctors where mentorship is required.

4.3 Quality Assurance
A review of active appraisers was undertaken in July 2019 by the Medical Trust Appraisal Lead. A random sample of 20 appraisals was scored using the ASPAT recognised QA scoring system (see Trust Appraisal Policy). This exercise revealed all appraisals to be of satisfactory standard scoring > out of a maximum of 50 points. It is intended to repeat this exercise quarterly.

Additionally, all appraisee's are required to provide feedback regarding the appraisal before the appraisal can be 'signed off'. A new reporting system has now been put in place by the software company to collate appraisal feedback and provide a report by individual appraiser

which can be reviewed by the Appraisal Team and will also be automatically sent to the appraiser to use as supporting evidence in their own appraisal.

4.4 Access, Security and Confidentiality
Information governance guidelines, storage and access to appraisal documentation are set out in the Medical Appraisal and Revalidation Policy. There have been no incidents with regards to security and confidentiality in the last financial year with regards to appraisal documentation.

4.5 Clinical Governance

The PreP Revalidation System for Appraisal and Revalidation ensures that the required domains for Supporting Information for Appraisal and Revalidation are completed and the appraisal meeting is set on the system before the appraisal can be submitted for review by an appraiser. Doctors have access to their individual complaints and incidents via the Trust Governance team and performance, mortality and morbidity data from the Informatics Team. HED (Health Evaluation Data) reports are available via our Medical Revalidation Support Officer for those Consultants within a Surgery based field.

5. Revalidation Recommendations
The Trust has made timely recommendations to the GMC for all doctors due revalidation in 2018/19 with no missed recommendations. 91 doctors are due in 2019 with no missed recommendations.as yet. 55 recommendations have been made- to date up to (06/09/2019) and 36 are remaining for the year. One remains on hold by the GMC and the Medical Revalidation team are aware. 110 revalidations are due in 2020.

6. Recommendations
The Board is asked to note the contents of this report and to continue to satisfy its statutory duties to support the Responsible Officer in delivering Medical Appraisal and Revalidation.

Appendix 1; Annual Organisational Audit 2018/19

Dr Mike Prentice
Revalidation Lead
NHS England
Quarry House
Quarry Hill
Leeds
LS2 7UE

PA Contact Details:
Tracy.calvert@nhs.net
Tel: 0113 825 3052

18 July 2019

Our Ref: 199
Publications Approval 000740

Mr Paul Stonelake
Responsible Officer
The Dudley Group NHS Foundation Trust

Dear Mr Stonelake

Medical Revalidation Annual Organisational Audit (AOA) Comparator Report for: 199 - The Dudley Group NHS Foundation Trust

I am writing to thank you for submitting a return to the NHS England 18/19 Annual Organisational Audit (AOA) exercise.

Please find enclosed a report setting out your response to the exercise. The report also compares your organisation's submission with that of other designated bodies across England, both in a similar sector and nationwide.

The 2018/19 slimmed down version of the AOA was designed to concentrate primarily on the quantitative measures of previous AOAs, the number of doctors with a prescribed connection and their appraisal rates. In this the sixth year of the AOA, I am pleased to report a continuing upward trend in the overall appraisal rate. This is extremely reassuring and I would like to thank you once again for your continued work. There is emerging evidence that creating the right environment for doctors to reflect on their clinical practice through appraisal is one which enables them to thrive and develop professionally. This benefits the patients that they look after and allows doctors to have confidence in their professional practice.

As well as revising the AOA, a review of reporting the other important aspects of the responsible officer function (monitoring of practice, responding to concerns, and identity/language checks) have moved to the annual Board report. The Board report, combined with the annual Statement of Compliance, has been re-designed to support a conversation within the designated body to review all the responsible officer's obligations and to agree an action plan for areas where further development is identified.
Assurance of the totality of the designated body's work on the responsible officer's duties will therefore be provided to the higher level responsible officer through both completion of the AOA and the statement of compliance, as signed off by the designated body's Board or equivalent management body.

Board-level accountability for the quality and effectiveness of appraisal rates is extremely important and this report, along with the resulting action plan, should be presented to your board, or an equivalent management body. It is also good practice to include the report in an NHS organisation's Quality Account.

If you need support in improving any element of your revalidation systems, your local revalidation team (contact details below) can help you.

Your higher level responsible officer	Dr David Levy
Your local revalidation team's lead contact	Christopher Parsons & Sharron Hogan
Your local revalidation team's contact details	england.revalidation-midlandsandeast@nhs.net

This letter has been sent to the responsible officer recorded in the AOA return at 31 March 2019. If you are no longer the responsible officer, please pass this report on to the new responsible officer immediately, or to the Chief Executive of the organisation. If there are any changes to notify, or you have any queries, please contact your local revalidation team.

Please note that for transparency and openness, your submitted AOA return will be shared with your higher level responsible officer and some elements of the return will be shared with the appropriate regulatory bodies.

A more detailed report including the anonymised results of all organisations involved in this AOA exercise will be published in the autumn.

I would like to take this opportunity to thank you for providing the required assurance to your higher level RO, and to NHS England.

Further information on revalidation can be found at www.england.nhs.uk/revalidation

Yours sincerely

Doctor Mike Prentice
Revalidation Lead
NHS England

cc: Your higher level responsible officer
cc: Your local revalidation team's lead contact

YOUR ANNUAL ORGANISATIONAL AUDIT

Analysis is based on the total of 862 returns from designated bodies (DBs) to the 2018/19 Annual Organisational Audit (AOA) exercise for the year ending 31 March 2019

The following information is presented as per your own AOA submission.

Name of designated body:	The Dudley Group NHS Foundation Trust
Name of responsible officer:	Mr Paul Stonelake
Sector:	Acute hospital/secondary care foundation trust
Prescribed connection to:	NHS England (Regional Team - Midlands and East)

Please note:

a) In some instances, data was not suitable for comparative reporting. In these cases your own response may be reported, but comparative data is not. An explanation is given for this within the report. If you require further information on these areas, please contact your local revalidation lead:

Christopher Parsons & Sharron Hogan at england.revalidation-midlandsandeast@nhs.net.

b) Only the questions asked are presented below. Please refer to AOA 2018/19 for the full indicator definitions if required.

2018/19 AOA indicator SECTION 1: The Designated Body and the Responsible Officer		Your organisation's response	Same sector: DBs in sector: 96	All sectors: Total DBs: 862
		Your organisation's response	No. of DBs in same sector and (%) that said 'Yes'	No. of DBs in all sectors and (%) that said 'Yes'
1.4	A responsible officer has been nominated/appointed in compliance with the regulations.	Yes	94 (97.9%)	851 (98.7%)

2018/19 AOA indicator SECTION 2: Appraisal		Your organisation's response	Same sector: DBs in sector: 96	All sectors: Total DBs: 862
2.1	**Number of doctors with whom the designated body has a prescribed connection as at 31 March 2019**	No. of doctors (in organisation)	Total no. of doctors (in SAME sector)	Total no. of doctors (across ALL sectors)
2.1.1	Consultants	210	28190	53177
2.1.2	Staff grade, associate specialist, specialty doctor	108	5592	12543
2.1.3	Doctors on Performers Lists	0	35	47422
2.1.4	Doctors with practising privileges	0	1	1870
2.1.5	Temporary or short-term contract holders	62	8870	22314
2.1.6	Other doctors with a prescribed connection to this designated body	8	689	7128
2.1.7	**Total number of doctors with a prescribed connection**	388	43377	144454

2018/19 AOA indicator SECTION 2 (cont): Appraisal		Your organisation's response	Same sector: DBs in sector: 96	All sectors: Total DBs: 862
		Completed appraisals (1)		
2.1	**Number of doctors with whom the designated body has a prescribed connection on 31 March 2019 who had a completed annual appraisal between 1 April 2018 – 31 March 2019**	Your organisation's response and (%) calculated appraisal rate	Same sector appraisal rate	ALL sectors appraisal rate
2.1.1	Consultants	193 (91.9%)	93.5%	93.7%
2.1.2	Staff grade, associate specialist, specialty doctor	86 (79.6%)	88.8%	88.2%
2.1.3	Doctors on Performers Lists	N/A	91.4%	95.2%
2.1.4	Doctors with practising privileges	N/A	100.0%	92.7%
2.1.5	Temporary or short-term contract holders	27 (43.5%)	77.8%	81.8%
2.1.6	Other doctors with a prescribed connection to this designated body	7 (87.5%)	72.1%	87.9%
2.1.7	**Total number of doctors who had a completed annual appraisal**	313 (80.7%)	89.3%	91.5%

2018/19 AOA indicator SECTION 2 (cont): Appraisal		Your organisation's response	Same sector: DBs in sector: 96	All sectors: Total DBs: 862
		Approved incomplete or missed appraisal (2)		
2.1	**Number of doctors with whom the designated body has a prescribed connection on 31 March 2019 who had an Approved incomplete or missed appraisal between 1 April 2018 – 31 March 2019**	Your organisation's response and (%) calculated appraisal rate	Same sector appraisal rate	ALL sectors appraisal rate
2.1.1	Consultants	11 (5.2%)	4.4%	4.2%
2.1.2	Staff grade, associate specialist, specialty doctor	22 (20.4%)	8.8%	8.6%
2.1.3	Doctors on Performers Lists	N/A	0.0%	4.2%
2.1.4	Doctors with practising privileges	N/A	0.0%	5.1%
2.1.5	Temporary or short-term contract holders	35 (56.5%)	17.1%	13.6%
2.1.6	Other doctors with a prescribed connection to this designated body	1 (12.5%)	22.5%	10.5%
2.1.7	**Total number of doctors who had an approved incomplete or missed appraisal**	69 (17.8%)	7.9%	6.4%

2018/19 AOA indicator SECTION 2 (cont): Appraisal		Your organisation's response	Same sector: DBs in sector: 96	All sectors: Total DBs: 862
		Unapproved incomplete or missed appraisal (3)		
2.1	**Number of doctors with whom the designated body has a prescribed connection on 31 March 2019 who had an Unapproved incomplete or missed annual appraisal between 1 April 2018 – 31 March 2019**	Your organisation's response and (%) calculated appraisal rate	Same sector appraisal rate	ALL sectors appraisal rate
2.1.1	Consultants	6 (2.9%)	2.1%	2.2%
2.1.2	Staff grade, associate specialist, specialty doctor	0 (0%)	2.4%	3.2%
2.1.3	Doctors on Performers Lists	N/A	8.6%	0.6%
2.1.4	Doctors with practising privileges	N/A	0.0%	2.2%
2.1.5	Temporary or short-term contract holders	0 (0%)	5.1%	4.6%
2.1.6	Other doctors with a prescribed connection to this designated body	0 (0%)	5.4%	1.6%
2.1.7	**Total number of doctors who had an unapproved incomplete or missed annual appraisal**	6 (1.5%)	2.8%	2.1%

2018/19 AOA indicator **SECTION 3:**		**Your organisation's response**
3.1	The last Annual Board report was signed off on:	06/09/2018 00:00:00
	The last Statement of Compliance was signed off on:	06/09/2018 00:00:00

2018/19 AOA indicator SECTION 4: Comments		Your organisation's response
4.1		

Enclosure 23

The Dudley Group
NHS Foundation Trust

Paper for submission to Trust Board 5th September 2019

TITLE:	**Digital Trust Update**		
AUTHOR:	**Adam Thomas (CIO)**	**PRESENTER**	**Adam Thomas (CIO)**

CLINICAL STRATEGIC AIMS

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

ACTION REQUIRED OF 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:

Review and accept assurances.

CORPORATE OBJECTIVE:

SO5: Make the best use of what we have (BAF 5b)

SUMMARY OF KEY ISSUES:

Key Assurances

- Mandatory GCHQ-certified Board Cyber Security training
- Recruitment; Head of cyber security & IT governance and; Digital portfolio manager posts
- Functioning Digital Trust governance processes
- Independent business continuity review of Sunrise ED / Orders and Results go-live in May.
- HSLI Funding to expand the scope of Trust's interoperable population health platform

IMPLICATIONS OF PAPER:

RISK	**Y**		**Risk Description: BAF 5b,**
	Risk Register: Y		**Risk Score: CE1081, CE1083**
COMPLIANCE and/or LEGAL REQUIREMENTS	**CQC**	**Y**	**Details WELL LED / RESPONSIVE**
	NHSI	**N**	**Details:**
	Other	**N**	**Details:**

1. Summary

The primary drivers for and outcomes of digitally enabled care is to drive quality, reduce unwarranted variation and use a systematic approach to support patient safety. The NHS long-term plan and Black Country STP strategies are clear on the opportunities for a digitally enabled workforce in the NHS. This update report provides assurances on the ongoing deliveries within the Digital Trust Strategy in accordance with strategic object 5 – making the best use of what we have and board assurance framework (BAF) 5b.

2. GCHQ Certified Cybersecurity training

The Trust board will undertake mandatory and free-of-charge GCHQ-Certified Cyber Security Training on the 3rd of September 2019. This training meets the Board's obligations under the National Data Guardian data security standards, the National Cyber Security Centre's 10 steps to Cyber Security and recommendations of the CIO review of WannaCry. Internal assurance of board level cyber awareness also forms part of the well-led assessment that the CQC seek, to assure the cyber security of the Trust.

3. Appointments

In the last reporting period two key appointments have been made by the IT department to key strategic positions where there has been an assurance gap. A Digital Portfolio Manager has been recruited and came to post in mid-June specifically to support assurances on the extensive portfolio of digital trust work. A Head of Cyber Security and IT Governance has been appointed supporting internal workforce development, the post will be formally in commence from 1st September 2019.

4. Digital Trust Programme

The Digital Trust provides board assurance under strategic objective 5 – making the best use of what we have, and is focused on building an electronic record platform for quality and safety, that can be used for transformation and innovation in the future. The Digital Trust Programme Group has a functioning governance process supported by Terms of Reference and currently reports to the Finance and Performance Committee of the board. Commercially sensitive items and exempt from disclosure are reported as such through Finance and Performance Committee to the private board agenda.

The Digital Trust programme is an extensive portfolio that includes the delivery of the Trust's organisational wide (enterprise) single electronic patient record strategy. The programme also includes management and optimisation of a significant number of sub-systems that support day-to-day operational activities, insights that can be derived from data, creating an interoperable population health platform to support innovation in new models of care and delivering underpinning mandatory standards – such as cyber security, data security and clinical safety. IT representation is now also embedded in each of the Trusts waste reduction and annual planning workstreams to ensure digital enablement is considered and reviewed properly.

The Trust took the formal decision to alter its approach to the deployment of Sunrise in January 2018 to focus on a pressing need to improve the management of deteriorating patients, changing from a 'big bang' approach to an incremental deployment with a view of maximising access to clinical, quality and safety benefits reframing the project. Successful deliveries throughout 2018/19 have supported significant quality improvements, as evidenced by clinical reporting committees.

In the last reporting period, a major functional release was undertaken on 15th May 2019, which included replacement of the legacy Emergency Department electronic record and delivered Trust wide orders and results management (ORM), ePhlebotomy and single-document scanning.

The most recent roll out, was the largest technology deployment the organisation has undertaken. There has been a period of extended warranty that was not anticipated. A number of requests for enhancements, improvements or quality benefits has persisted over the last few months, requiring further configuration and development. This has provided significant lessons learned and updated intelligence on Trust technology deployments, providing additional planning context to future delivery.

Importantly, it is noted that the clinical enthusiasm to build optomised order-set pathways in this extended warranty period evidences a change in approach within the organisation to embrace technology to seek incremental improvement, which is positive. In support of this drive to 'digital adoption' the Digital Trust programme has continued to support these requests, beyond the expected early-life support period. 'Demand management' has now become a new challenge, as the resource to support incremental improvement and delivering the next large-scale functional deployments is in competition. This is being actively managed and is under review.

The next step for the programme is the deployment of electronic prescribing and medicines administration (EPMA) commencing in the emergency department (ED) and rolling out to the rest of the Trust after steady state is reached in the ED. This is predicated on clinical safety assurance following the DCB0160 standards resulting in sign-off from the clinical safety officer followed by operational approval to go-live.

5. Digital Trust Independent business continuity review

Following the major deployment of Sunrise functionality on 15th May 2019, which included replacement of the legacy Emergency Department electronic record and delivered Trust wide orders and results management (ORM), ePhlebotomy and single-point scanning.

The acting CIO commissioned the Emergency Planning Manager to undertake an internal independent review of Emergency Preparedness Resilience and Response (EPRR), against the following scope;

- **Preparation / Plan;** Quality and Business Continuity
- **Execution of Plan;** Performance**,** Communications**,** Command and Control**,** Capacity (major cyber threat/major incident)**,** Business Continuity
- **Follow up;** Sustainability - “early life-support"**,** Business Continuity

A summary report (Exec Summary attached), and a facilitated de-brief session to inform lessons learned has been delivered. The report highlights a shared 6-point action plan which is under way. The report deems the roll out largely successful with no major issue or fall-out. The IT team continue to work closely with the EPRR team.

6. Health System Lead Investment (HSLI)

A successful bid for £1.4M capital funding to support expansion of the Trust’s existing population health technology platform has been secured. The interoperability platform works as a translation service (using semantic normalisation) that allows disparate electronic record systems in different care settings to communicate. The bid was supported by the STP digital board and approved by NHS England / Improvement. This programme of work supports the Trusts commitment to the NHS long-term plan and meets the national and regional strategies of electronic record convergence, that is an essential requirement to secure funding.

The Dudley Group NHS
NHS Foundation Trust

Sunrise Roll Out Report – Executive Summary

TeraFirma
HEALTH IT AS A SERVICE

EXECUTIVE SUMMARY

- A full debrief was held on 10th July 2019, facilitated by the EPRR Team
- Typically EPRR debriefs do not draw conclusions. However, the Sunrise Rollout is deemed a largely successful implementation with no major issues or fall-out occurring. The issues and subsequent recommendations are highlighted in the spirit of continuous improvement, adoption of best practices and key learnings for next time.
- In conjunction with completing the specified 6 actions recommended in the Sunrise Roll-out Report, it is noted that the EPRR and IT Teams should continue to undertake reviews of the Sunrise Business Continuity Plan and the Dudley Group Business Continuity Recovery and Response SOP.

Enclosure 24

The Dudley Group NHS Foundation Trust

Paper for submission to the Board of Directors on 5th September 2019

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

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

ACTION REQUIRED OF BOARD:			
Decision	**Approval**	**Discussion**	**Other**
Y		**Y**	

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

RECOMMENDATIONS FOR THE BOARD:

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

CORPORATE OBJECTIVE:

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

SUMMARY OF KEY ISSUES:

This paper gives an update on:

- For the last quarter (Q1) and for Q2 up to date, numbers and types of recent concerns raised and an outline of outcomes and feedback from these.
- Recent information, activities and developments which include:
    - Numbers of concerns raised nationally and local Trusts.
    - Latest situation with Speak Up Champions
    - Situation with NHSI/E FTSU Assessment
    - Working with the patient safety lead
    - FTSU Self Review 2018/Strategy Action plan and ongoing actions from National Freedom to Speak Up Guardian Survey 2018
    - NGO Case Reviews
        Brighton and Sussex University Hospital NHS Trust
        Royal Cornwall Hospitals NHS Trust
    - Plans for National Speak Up Month – October 2019
    - Discussion with external consultancy staff reviewing the Imaging Department following the recent CQC report.
    - Letter to all Chief Executives from the National Guardian

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	**Y**	**Details:** Recent review of FTSU and recommendations
	Other	**Y/N**	**Details:**

THE DUDLEY GROUP NHS FOUNDATION TRUST
Freedom to Speak Up (FTSU) Guardian September 2019 update

Numbers of concerns raised at the Trust

The table below indicates the numbers and types of concerns raised with the Guardians a) each full quarter in the last two financial years with annual totals and b) in the first three months of this year with the numbers for the ongoing Q2. As previously noted, the National Guardian Office (NGO) has discussed the difficulties in categorising types of concerns being raised and those below are locally based. The majority of concerns being raised are regarding behaviour unrelated to patient care although as the Civility Saves Lives Campaign points out, inappropriate behaviour between and towards staff can result in ineffective care. We have divided the national category on this topic into two: a) perceived bullying and harassment and b) perceived unfair behaviour, the latter includes such concerns as unfair recruitment, unfair rotas and concerns about redeployment of staff. Both of these two types of concerns cover those regarding colleagues, line and senior managers.

	Number	Anonymously	Patient Safety	Behaviour: Bullying/ Harassment	Behaviour: Unfair/ Inappropriate	Other
Apr-Jun	2	0	0	2	0	0
Jul-Sep	14	3	4	8	2	0
Oct-Dec	17	0	3	8	6	0
Jan-Mar	11	2	2	4	5	0
2017/18	44	5	9	22	13	0
Apr- Jun	15	0	3	8	5	2
Jul – Sep	12	0	2	5	4	2
Oct – Dec	26	1	4	7	11	4
Jan- Mar	14	0	1	7	4	2
2018/19	67	1	10	27	24	10
Apr – Jun	25	1	5	8	8	4
July – 27th Aug	12	0	2	5	5	0

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

	Number	Nursing	Midwife	Medical	AHP	Clinical Scientist	Admin. /Ancillary	Unknown
Apr-Jun	2	2	0	0	0	0	0	0
Jul-Sep	14	7	2	0	1	0	3	1
Oct-Dec	17	7	0	1	0	1	8^	0
Jan- Mar	11	5	2	2	0	0	2	0
2017/18	44	21	4	3	1	1	13	1
Apr- Jun	15	9	2	2	1	0	1	0
Jul – Sep	12	8	1	1	1	0	1	0
Oct – Dec	26	10	2	3	3	0	8	0
Jan - Mar	14	6	1	2	0	0	4	1
2018/19	67	33	6	8	5	0	14	1
Apr – Jun	25	9	3	1*	2	0	10+	0
July – 27th Aug	12	6	1	0	1	0	4	0

^1 of these was a PFI staff member, * = a group, + = 2 of 10 were groups of more than 1 person

Actions/Outcomes

The concerns being raised vary considerably in complexity and as a consequence the time and resources required to come to a conclusion do differ markedly. Some issues can be resolved quickly by the Guardian, sometimes with the assistance of the Chief Executive or in

liaison with local management while others are handed over, with the agreement of the person raising the concern, to such departments as Human Resources and Complaints. The following are some latest examples of cases and actions/outcomes as a result of concerns raised:

- Discussion with senior manager, local Champion and Guardian resulted in agreeing the need for further training, an improved system for agreeing annual leave and an improved process when a staff member calls in sick and redeployment of existing staff is needed. It also resulted in clarification of the role of the champion both from the champion and manager perspective.
- Allegation of bullying by junior doctor resolved through the Human Resources processes to the satisfaction of the junior doctor.
- Concern about a Governor's behaviour escalated to the Chair.
- Person leaving the Trust raised a number of concerns about behaviour in the workplace. Initially wished for the issues to be raised after exiting the Trust but then not at all. Anonymous letter received by another person about similar issues about the same manager.
- Meeting arranged between person raising concern and manager with Guardian presence leading to expressed improved working relationship.
- Midwife concerned about the behaviour of a consultant. Issue raised with Clinical Director who is presently dealing with this issue.
- Concern raised regarding behaviour of manager generally then the behaviour during a sickness monitoring meeting. This has now been taken down the Grievance route.
- Several members of staff from the same area raised concerns with a Guardian about bullying by a colleague. One also wrote to the Chief Executive and another contacted Staff Engagement Lead. The triangulation of information led to the Chief Nurse being made aware and an independent investigation has commenced.
- A previous concern that was raised at the beginning of the year and thought to be resolved by all parties has now been raised again. It has been escalated to a senior manager and results are awaited. If no response is received shortly then the relevant Director will be informed.
- A concern about favouritism was raised by a group of staff who agreed to speak with a senior manager. Following monitoring of the progress this was apparently resolved but this issue has now returned and a meeting has been arranged to take this forward.
- A concern about inappropriate behaviour of a senior staff member has been raised and the person has agreed for the relevant line manger to be involved who is now taking advice from Human Resources staff. A further concern about the same senior staff member has been raised independently by another junior colleague but they state they do not wish to take the issue further because of potential repercussions.
- A concern has been raised about the incompleteness of an investigation following a perceived inappropriate discharge which was reported on Datix. The concern includes the grading of the incident and the lack of feedback which has led to a reduced confidence in reporting. Further details are being obtained before appropriate action is taken.

Six of the twelve concerns in this period were initially raised with champions who provided the initial advice and then they highlighted the issues with the Guardians, who took appropriate action as necessary.

Feedback
It is not always possible to get written feedback from those who raise concerns but five have stated:

'Many thanks for your help and support with this'.

Following reassurance about confidentiality: *Hi, It was good to speak with you too. I must admit I am quite worried by speaking out for fear of repercussions but here goes...*

'You have been very supportive and we both thank you so much……'

'That all sounds good! Thanks so much for your help…..'

'Thank you for having this conversation and resolving this issue, you were very understanding and I was able to speak to you in confidence really well. I'm glad you have spoken as I hope x will be mindful in future of how x approaches, and speak to other members of staff. Thanks once again for your time, thanks for sparing time out to look further into this matter'

The Guardians have a series of written questions sent to those who raise concerns but these have very rarely been returned. In future, the questions will be asked verbally which should increase the feedback.

Numbers of concerns raised nationally and local Trusts.
With regards to the full Q4 (2018/19) figures there were 14 concerns raised at the Trust. The national picture showed:

- 3,406 cases were raised.
- 928 of these cases included an element of patient safety / quality of care
- 1,312 included elements of bullying and harassment
- 122 related to incidents where the person speaking up may have suffered some form of detriment
- 506 anonymous cases were received
- 5 trusts did not receive any cases through their Freedom to Speak Up Guardian
- 220 out of 227 NHS trusts sent returns
- Highest Trust had 100 cases (Local Trusts: 11, 31, 17 and 7)

The NGO has changed its software supplier and so national figures for Q1 (2019/20) are not yet available.

Speak Up Champions: There are now 19 FTSU and Patient Safety Champions with two further staff from ED now showing an interest. The Champion details have been placed on screensavers. Meetings are arranged on a 6-8 week basis for the champions. These have are not always well attended with the latest one on 20th May having five champions present. For National Speak up month all champions will be having individual posters that they can place in appropriate places (e.g. staff rooms) within their areas. New champions are attending Speak up training in Birmingham and Shrewsbury.

NHSI/E FTSU Assessment
This report by NHSI/E was commissioned after the findings of the Capsticks review. It contains a number of recommendations which have been based on interviews (five persons), an anonymous survey (133 responses) and a number of 1 to 1 phone calls (11 persons) as well as a review of a number of Trust and national documents. The recommendations have been assed and an action plan drawn up. This was presented to and approved by the Workforce Committee on the 27th August. It is attached here as Appendix 1.

Working with the patient safety lead

As well as having joint meetings with the patient safety lead and champions, the Guardians have assisted the lead in testing the recently introduced GREATix system and have undertaken the appreciative enquiry training as a basis for agreeing the future topics to consider for such enquiries once there is a significant number of GREATix reports.

FTSU Self Review 2018/Strategy Action plan and ongoing actions from National Freedom to Speak Up Guardian Survey 2018

The above resulted in a number of ongoing actions. The full list of actions and recommendations has been included in previous quarterly reports. Attached in Appendix 1 is just those actions that were outstanding at our last report. Some of these overlap with the NHSI/E FTSU Assessment recommendations/planned actions discussed above and so will be combined with those in future reports.

NGO Case Reviews

The NGO undertakes case reviews of the FTSU processes in Trusts when issues are raised with them by either staff or regulators. The NGO states: 'We expect all NHS trusts and foundation trusts to look at our case review reports to identify whether they can adopt the recommendations within to help improve their speaking up culture'.

a) Brighton and Sussex University Hospital NHS Trust

The latest review (June 2019) was at the above Trust after receiving information from some current and former trust workers that suggested there was not a positive speaking up culture in the trust, particularly in relation to issues raised by black, Asian and minority ethnic (BME) members of staff. The recommendations within the report consist of those specific to the Trust, some for the NGO itself and some with implications for all Trusts. The latter are together with actions being taken:

1) Within 6 months the trust should take reasonable steps to ensure that its network of cultural ambassadors reflects the diversity of the workforce that it supports.

Action: Requested all 19 Champions to complete their diversity information so that such an assessment can be undertaken.

2) Within 12 months the trust completes the work it identifies as necessary to help ensure that workers, in particular those responsible for responding to speaking up matters, have the appropriate skills to handle difficult conversations.

Action: Most *champions and both Guardians trained in Speak Up. Discussions have commenced with Learning and Development regarding training in dealing with difficult conversations.*

3) Within 3 months the trust should take all appropriate steps to implement the actions identified in its gap analysis of National Guardian Office case review recommendations.

Action: Gaps have been found and these are being looked at – see assessment of recommendations from Royal Cornwall Hospitals review below which occurred in December 2018 and not reviewed until now.

.

4) Within 12 months the trust should revise its speaking up policy, to ensure it is in line with the amendments required by NHS Improvement quoted in this report.

Action: Policy has been updated and agreed by NHSI

b) Royal Cornwall Hospitals NHS Trust

The recommendations within the report consist of those specific to the Trust, some for the NGO itself and some with implications for all Trusts. The latter are listed below:

1) Trust leaders develop and begin the implementation of a strategy to improve the speaking up culture across its workforce. The plan should contain measures to identify the main issues the trust should address, clear actions to address those issues and steps to measure the effectiveness of those actions.
2) The trust should take appropriate steps to ensure that its response to workers speaking up, including the investigations of those issues and the implementation of learning resulting from them, is undertaken by suitably independent trained investigators.
3) The trust should take appropriate steps to ensure that the confidentiality of workers who speak up is appropriately supported, in accordance with trust policy and procedure and good practice.
4) The trust should ensure that it responds to the issues raised by its workers strictly in accordance with its policies and procedures and in accordance with good practice.
5) The trust should revise its new speaking up policy, to ensure it is in line with the NHS Improvement national speaking up policy.
6) The trust should take steps to ensure all existing and new workers are aware of the contents and meaning of its revised freedom to speak up policy.
7) The trust should put effective systems in place to monitor the development of a positive speaking up culture.
8) The trust should ensure that the content of any speaking up training it provides for its workers is consistent with guidance issued by the National Guardian's Office and NHS Improvement, including findings and recommendations from NGO case reviews and the Freedom to Speak Up Survey 2017 and board guidance from NHSI.
9) The trust should take appropriate steps to identify the necessary resources required to ensure the Guardian role meets the needs of workers and then provide those resources.
10) The trust should ensure that reports for board members regarding the trust's speaking up arrangements continue to contain appropriate levels of detail, in accordance with joint guidance from NHS Improvement and the National Guardian's Office.

All of the above recommendations mirror those in the recent NHSI/E assessment of Speak Up at the Trust (see above). Actions being taken on these recommendations are included in the action plan from the NHSI/E assessment

National Speak Up Month

The NGO has declared October as the National Speak Up month. Planning has started regarding how the Trust will take part. The following has been/is being organised:

- John Higgins to present at the Grand Round on 7th November. John has been working alongside Professor Megan Reitz of Ashridge Business School for over five years investigating what it takes for truth to be spoken to power. As well as their recently published book (Speak Up! Say what needs to be said and hear what needs to be heard) they have had four recent articles in the Harvard Business Review and a piece in the Journal of the Royal Society of Medicine (If whistleblowing's the answer, ask a better question). During his talk he will introduce some of the key findings from their research and give people the opportunity to engage with some of the frameworks the two of them have developed. As well as his work with Megan, John works closely with the NHS London Leadership Academy running 'Speak up, Listen up' workshops.

- Helene Donnelly OBE has agreed to come and speak (details of date/time being arranged) – Helene whistleblower at Mid Staffordshire Hospital and now

Ambassador for Cultural Change / Freedom to Speak Up Guardian at Midlands Partnership NHS Foundation Trust

- Speak Up Surgeries by the Guardians and Julian Atkins to be held at Corbett Training Room (15th October 12.00 to 13.30 and RHH Undergraduate Centre 16th October 11.00 to 14.00 have been arranged
- In conjunction with Dr Calthorpe, Trust Patient Safety Lead, a) promotion and recruitment of more Champions in the month b) arrange for all champions to have individual posters designed for their areas and have these in place by October.
- A schedule of walkabouts covering 11 days in the month has been drawn up when the Guardians an champions will visit all areas of the Trust with water/doughnuts and pens

Discussion with external consultancy staff reviewing the Imaging Department following the recent CQC report.

The Guardians were asked about their potential support to the department. The department now has a new Champion in place and one of the Guardians is attending one of their staff meetings soon.

Letter to all Chief Executives from the National Guardian

On 23rd July Dr Hughes wrote to all Chief Executives asking them to ask their Guardians about the support they need to undertake the role. A meeting was held on 6th August regarding this matter. With the report from NHSI/E of its assessment of Speak Up across the whole Trust made available at that meeting for the first time, it was agreed that the action plan covers this with the setting up of a steering group together with the additional Guardian and support hours.

THE DUDLEY GROUP NHS FOUNDATION TRUST **ACTION PLAN FROM NHSI/E FTSU ASSESSMENT 2019** **APPENDIX 1**

Recommendations					
Guardian/champion resource		**WHO**	**WHEN**	**Comments**	**Progress at……**
1	Increase the amount of time the Guardians and champions have to enable them to carry out all of the tasks associated with their role. Once you have decided how much extra time they will have, recruit (not select) the Guardian	CEO/CN/ Guardians	October	Agree further hours (4 days per week with administrative support of 2 days) and recruit to the posts. Continually assess at each of the six weekly champion meetings the time available given to champions and liaise with managers if time constraints arise	
2	Increase the diversity in your Guardian/champions in order to better represent your staff in order to encourage vulnerable staffing groups to speak up (ie LGBT, BME, disability, agency, volunteers etc)	Guardians	Sept 2019 & ongoing	Requested all champions to complete diversity information so an assessment can be made	
3	Recruit more champions in order to improve awareness and reduce likelihood of a conflict of interest	Guardians	Sept 2019 & ongoing	Recruitment is ongoing with new recent champions in imaging and AMU. Two persons have shown an interest in ED. There are 19 at present.	
4	Seek advice from other trusts on developing a code of conduct and regular assessment process for champions	Guardians	October 2019	A local code of conduct already exists although it wasn't called this and so it has now been updated to reflect this. The regional group have been asked about methods of assessment. After August meeting all regular meetings will have action learning (group supervision) at the end of each meeting	
5	Establish a FTSU steering group to act as a sounding board to FTSU ideas.	CEO/CN	October 2019	Agreed initially to include CEO, CN, Governance rep, Guardians, reps from HR and Comms. To meet every six weeks, TOR to be drawn up and agreed	
6	Complete the missing gap analysis of the NGO case reviews and really question whether there is evidence to show you are meeting the recommendations.	Guardians	Sept 2019	Commenced in September with Royal Cornwall Case Review. All analyses to be more systematic	
7	Review your strategy against NHSI's revised guidance on strategy development to ensure that it is effective and at least include measures and targets and involve employees in some way.	CEO/ Guardians	October 2019	Review to take place at first meeting of Steering Group.	

8	Map and evaluate assurance based on FTSU strategy.	CEO/ Guardians	Ongoing from October	To be undertaken by Steering Group with a paper to the Board level committee.	
9	Improve the quality of the Guardian Report so that the Board receives assurance and or where a risk exists has full understanding of risk and mitigation. issues	Guardians	September 2019 onwards	To ensure the quarterly reports are more systematic in their content. Risks to be clearly defined within the report. From October 2019 to include the deliberations/decisions of the Steering Group	
10	Develop a sustained, creative and engaging communication strategy that raises awareness of the value of speaking up, all of the speaking up channels (inc the Guardian), but most importantly publicises the good that comes from speaking up. We will evaluate our comms strategy at regular intervals.	Comms	October 2019	Development to occur at the first meeting of the Steering Group in October. The group will be responsible for the evaluation of the strategy which will highlight the positivity of speaking up.	
11	Develop/review a programme of engagement between senior leaders and employees.	HRD		To build on the present initiatives of: monthly one off events such as anti-bullying week and Movember (November), live chat, team brief behaviour framework, newsletter 'rest, rehydrate, refuel, refreshed' initiative. Further developments will be considered at the FTSU Steering Group and in particular by the HR rep	
12	Develop/review a process to encourage all managers to effectively cascade information and seek feedback.	HRD	September onwards	This is being built into the existing leadership development programmes. In addition, the NGO has recently (August 2019) published their expectations on Speak Up training at Trusts which it is stated should be treated with parity to other 'mandatory' training . This training covers three groups: 1) All Staff 2) Line and middle managers and 3) Senior leaders. The Learning and Development Department has a plan to cover these requirements to be covered in induction with e-learning for existing staff (1), managers essential training (2) and the use of Deloittes (3) as part of	
13	Include FTSU, alongside other cultural and leadership topics in your Board development programme	HRD/CEO/CN /Non Exec			
14	Develop/review training programme to enable workers to access training, coaching, peer support to enable them to develop the skills to speak up, give feedback and to constructively challenge.	HRD			
15	Ensure that management and leadership training/appraisal process enables all managers to develop the skills required to have effective conversations and carry out fair and confidential	HRD			

	investigations. The quality of the training and the appraisal process should be evaluated.			the existing Board development programme. 360 degree appraisal is planned to be introduced in 2020 at least for managers rolling out to all other staff after then. The FTSU steering group will review the plans to ensure all aspects and staff are covered and that the levels of training expected are met.	
16	Develop a system to triangulate information to identify wider or emerging patient safety and staff experience problems	CEO	October 2019	This will be one of the key oversight functions of the FTSU Steering Group which will be set up in October 2019. FTSU information will be cross referenced and collated against HR and patient safety data.	
17	Develop routine ways to find out how workers feel about the FTSU culture and then act on that feedback	Comms	November 2019 onwards	The communications and HR department will be asked to liaise to undertake regular staff surveys on this topic the results of which will be considered by the FTSU Steering Group and an action plan developed as necessary.	
18	Develop/review a process to evaluate the experience of people after they have spoken up and to act on any evidence of victimisation.	Guardians	October 2019	The Guardians always ask all those who approach them with concerns about feedback. This will however be undertaken in a more systematic way in future by a set of specific questions and any learning themes/trends will be reflected within the Guardian report to the Board.	
19	Re run the FTSU Board review when NHSI publish its updated guidance (July/Aug) and seek feedback from workers.	CEO/CN	November 2019	The CEO/Chief Nurse will ensure that this is completed and discussed by the Board and the findings shared across the Trust.	

APPENDIX 2 THE DUDLEY GROUP NHS FOUNDATION TRUST - Freedom to Speak Up (FTSU) Action Plan 2018-19

Action	Source	By Whom	By When	Progress
Undertake a LiA.	SA/S	Guardians	Mar 19	Deferred. Was awaiting the results of the NHSI/E review which was based on staff views (survey and telephone calls). The useful ness of having a LiA will be decided by the FTSU Steering Group which will be established following that review.
Working on strengthening the processes to facilitate wider learning from concerns raised with the Guardian.	SA	Medical Director/ Chief Nurse	Mar 19	Learning is now placed on the Hub page and quarterly reports. The FTSU Steering group will discuss different ways of publicising these as part of a planned communications strategy.

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

National Freedom to Speak Up Guardian Survey 2018

• We recommend that those in a speaking up role make an assessment of the possible conflicts that any other role that they have may bring. Following this assessment, appropriate action should be taken to mitigate against any conflict. In all cases, where the details of a particular case brought to someone in a Freedom to Speak Up role may indicate the potential for conflict, this should be made clear to the individual bringing the case and an alternative route for speaking up offered.

Now complete. The situation has not arisen but the Guardians have an agreed system to pass concerns on to the other or in exceptional circumstances to one of the champions, when appropriate.

• We recommend that all organisations with a Freedom to Speak Up Guardian make a local assessment of any groups that face particular barriers to speaking up and take action to ensure that those barriers are tackled.

Partial. The champions come from a variety of areas, disciplines and bandings/seniority across the hospital and community although improvements with this can always be made. One of the Guardians is part of the newly formed Inclusion Group.

• Where a local Freedom to Speak Up network is established, action should be taken to ensure that it reflects the diversity of the workforce that it supports.

Partial – see item above.

• We recommend that all organisations with a Freedom to Speak Up Guardian make a full and honest assessment of the time required by a guardian to carry out their role and meet the needs of workers. All guardians must have the ring-fenced time they need to satisfy these basic requirements.

Now Complete. A post will be advertised.

• We recommend that guardians attend regional meetings regularly and work to ensure that their organisation is represented at every regional meeting by a guardian, or a representative of their local network. Senior leaders within their organisation should ensure that time and any necessary resource is made available to ensure that this can be achieved.

Now Complete. Guardians attend dependant on their other commitments. When both Guardians cannot attend a champion has been asked to attend.

Enclosure 25

The Dudley Group NHS
NHS Foundation Trust

Paper for submission to the Board on the 5th September 2019

TITLE:	**Guardian of safe working report**		
AUTHOR:	**Mr Babar Elahi – Guardian of safe Working Hours**	**PRESENTER**	**Mr Babar Elahi – Guardian of safe Working Hours**

CORPORATE OBJECTIVES:

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

The report covers the following elements:

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

IMPLICATIONS OF PAPER:

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

ACTION REQUIRED OF BOARD

Decision	Approval	Discussion	Other
			Y

RECOMMENDATIONS FOR THE BOARD

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

The Dudley Group NHS
NHS Foundation Trust

Board of Directors

Guardian of Safe Working Report September 2019

Purpose

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

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

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

Background and Links to Previous Papers

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

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

This is the 12th GSW report and covers the period of 22nd May to 28th August 2019. The Guardian has been working closely with colleagues from medical staffing and rostering, post graduate medical education staff, human resources and finance to establish his role in the Trust and build relationships.

Challenges

Engagement

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

- Holding regular Guardian Junior doctor forum.
- Introduction to Guardian and his role by attending Junior Doctor Induction Day
- Attending junior doctor forum arranged by Postgraduate Clinical Tutor
- Attending junior doctors' operational forum
- Creating a dedicated Guardian email in the trust
- Creating a webpage on the Trust HUB which carries information on Guardian role as well as

how to make exception reports.

- Regular communication to junior doctors through emails
- Using Trust HUB to advertise important information to junior doctors

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

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

Junior Doctors Guardian Forum

JD Guardian forum took place on 19th of August 2019. It was attended by juniors from various specialities and of various grades. Any concerns raised by the junior doctors were escalated to ensure prompt resolution.

Exception Reports by Grade

Grade	Addressed within 48 hours	Addressed within 7 days	Addressed in longer than 7 days	Still open –
FY1		7	1	
FY2	3			1 (pending meeting)
ST2				

Exception Reports and Fines.

- 12 exception reports by doctors
- 0 immediate safety concerns
- 4 exception reports agreed as compensation overtime payment
- 1 pending meeting between ES and trainee
- 7 exception reports agreed as time in lieu
- 0 exception reports agreed as no further action
- No fines during this period

High level data

Number of doctors/dentists in training (total): **198** (this number includes current vacancies and MTI posts)

Number of doctors/dentists in training on 2016 TCS (total): **198**

Gaps as at May 2019

Speciality / Grade	**FY1**	**FY2**	**ST 1-2, GPVTS**	**ST 3-8**	**Total**	

Cardiology					0		
AMU			1		1	Maternity Leave	
Diabetes			1		1	1 x CMT vacancy from 07/08 to 04/12. Post re-advertised, closing date 30/08/19	
Dermatology			1		1	Post Advertised. Closing Date 22/08/19	
Elderly Care			1	2	3	2 ST vacancies from 02/09/19. 2 long term full time locums have been in post for some months as requested 1 x GPST vacancy from 07/08/19 to 04/02/20 and 1 x CMT vacancy from 07/08/19 to 03/12/19 CMT 4 month post out at advert, closing date 16/09	
EAU					0		
Gastro			1		1	1 x GPST vacancy from 07/08/19 to 04/02/20	
ED			1	2	3	1 x GPST vacancy due to LTS from 07/08/19 to 04/02/20 - unclear from Deanery whether this is confirmed that gap will be for full 6 month period. 2 x ST3 vacancies, post advertised	
Renal			1		1	1 X GPST vacancy from 07/08/19 to 04/02/20.	
General Surgery					0		
ENT		1	2		3	1 X F2 vacancy from 07/08/19 to 03/12/19, 2 x CT vacancies from 07/08/19 to 03/12/19.	

Vascular Surgery					0	
Haematology					0	
T & O		1	2		3	1 x F2 vacancy from 07/08/19 to 03/12/19, 2 x ST vacancies from 07/08/19.
Obs & Gynae					0	
Paeds			1		1	1 X GPST vacancy from 07/08/19 to 04/02/20.
Pathology					0	
Radiology					0	
Respiratory					0	
Rheumatology					0	
Stroke			1		1	1 x GPST vacancy from 07/08/19 to 04/02/20.
Urology					0	
Ophthalmology					0	
Oral/ Max Fax					0	.
Anaesthetics					0	
Total	**0**	**2**	**13**	**4**	**19**	

Next Steps

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

The Dudley Group NHS
NHS Foundation Trust

1. Conclusion

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

2. Recommendation

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

Author	**Babar Elahi** **Guardian of Safe Working**
Executive Lead	**Chief Executive**
Date	**28th August 2019**

Enclosure 26

The Dudley Group
NHS Foundation Trust

Paper for Submission to Board on 5th September 2019

TITLE:	EPRR Core Standards 2019-20		
AUTHOR:	**Christopher Leach**	**PRESENTER**	**Christopher Leach**

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

ACTION REQUIRED OF COMMITTEE			
Decision	**Approval**	**Discussion**	**Other**
	Y		

OVERALL ASSURANCE LEVEL (***Please insert x in one of the boxes***)			
Significant Assurance	**Acceptable Assurance**	**Partial Assurance**	**No Assurance**
☐ High level of confidence in delivery of existing mechanisms / objectives	☒ General confidence in delivery of existing mechanisms / objectives	☐ Some confidence in delivery of existing mechanisms / objectives, some areas of concern	☐ No confidence in delivery

RECOMMENDATIONS FOR THE COMMITTEE

To note and approve the EPRR Core Standards submission for Dudley Group NHS FT

CORPORATE OBJECTIVE:

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

SUMMARY OF KEY ISSUES:

Each year the trust is asked to submit core standards self-assessment in relation to Emergency Preparedness, Resilience and Response (EPRR), for 2019-20 the trust have graded ourselves as substantially compliant evidencing a good level of assurance in our preparedness for emergencies and adverse events.

A small number of standards require further action to attain full compliance this will be completed in the next 6 months to attain full compliance

The Dudley Group
NHS Foundation Trust

IMPLICATIONS OF PAPER:			
RISK	**N**		**Risk Description:**
	Risk Register:		**Risk Score**
COMPLIANCE and/or LEGAL REQUIREMENTS	**CQC**	**N**	**Details:**
	NHSI	**Y**	**Details: NHS England Core Standards**
	Other	**Y**	**Details: Civil Contingencies Act 2004, Health and Social Care Act 2012**

The Dudley Group
NHS Foundation Trust

Tel: 01384 321000

Ref: EPRR Core Standards 2019

Date: 29th July 2019

Karen Kelly
Chief Operating Officer
Dudley Group NHS FT
Russells Hall Hospital
Pensnett Road
Dudley
West Midlands
DY1 2HQ

Dear Sir/Madam

Re: EPRR Core Standards 2019

In accordance with your letter dated 9th July 2019, please find enclosed the following documents as requested to support The Dudley Group NHS Foundation Trust Core Standard 2019 submission:

- Core Standards Submission
- Copy of the last two tabletop exercises post exercise report (Exercise Eris and Brexit)
- We have not attached our last Live exercise report, as in line with the statutory requirements we are completing this year, we will be able to provide post exercise reports for the below towards the e/o August and September 2019
    - Live CBRN Exercise (due to be held 13th August 2019)
    - Exercise Phoenix (due to be held 14th September 2019)
- Copy of the last EPRR Annual Report
- Copy of the latest WMAS CBRN report
- Copies of the last two sets of minutes from the trusts EPRR Group
- Copy of the training record pertaining to Strategic and Tactical Commanders
- Core Standards have been presented and approved by the Board of Directors on the 23rd July 2019 and will be presented at Public Board on the 5th September 2019

Based on this information, I can confirm that against the 2019 NHS England Core Standards The Dudley Group NHS Foundation Trust has self-assessed to be ***Substantially*** compliant.

Yours Sincerely

Karen Kelly

Karen Kelly
Chief Operating Officer (Accountable Emergency Officer)

Please select type of organisation: **Acute Providers**

Publishing Approval Reference: 000719

Core Standards	Total standards applicable	Fully compliant	Partially compliant	Non compliant
Governance	6	6	0	0
Duty to risk assess	2	2	0	0
Duty to maintain plans	14	14	0	0
Command and control	2	2	0	0
Training and exercising	3	3	0	0
Response	7	5	2	0
Warning and informing	3	3	0	0
Cooperation	4	3	1	0
Business Continuity	9	9	0	0
CBRN	14	13	1	0
Total	64	60	4	0

Deep Dive	Total standards applicable	Fully compliant	Partially compliant	Non compliant
Severe Weather response	15	13	2	0
Long Term adaptation planning	5	4	1	0
Total	20	17	3	0

Overall assessment:	Substantially compliant

Instructions:
Step 1: Select the type of organisation from the drop-down at the top of this page
Step 2: Complete the Self-Assessment RAG & remaining columns in the 'EPRR Core Standards' tab
Step 3: Complete the Self-Assessment RAG & remaining columns in the 'Deep dive' tab
Step 4: Ambulance providers only: Complete the Self-Assessment in the 'Interoperable capabilities' tab
Step 5: Click the 'Produce Action Plan' button below

Ref	Domain	Standard	Detail	Acute Providers	Evidence - examples listed below
1	Governance	Senior Leadership	The organisation has appointed an Accountable Emergency Officer (AEO) responsible for Emergency Preparedness Resilience and Response (EPRR). This individual should be a board level director, and have the appropriate authority, resources and budget to direct the EPRR portfolio. A non-executive board member, or suitable alternative, should be identified to support them in this role.	Y	• Name and role of appointed individual
2	Governance	EPRR Policy Statement	The organisation has an overarching EPRR policy statement. This should take into account the organisation's: • Business objectives and processes • Key suppliers and contractual arrangements • Risk assessment(s) • Functions and / or organisation, structural and staff changes. The policy should: • Have a review schedule and version control • Use unambiguous terminology • Identify those responsible for ensuring policies and arrangements are updated, distributed and regularly tested • Include references to other sources of information and supporting documentation	Y	Evidence of an up to date EPRR policy statement that includes: • Resourcing commitment • Access to funds • Commitment to Emergency Planning, Business Continuity, Training, Exercising etc.
3	Governance	EPRR board reports	The Chief Executive Officer / Clinical Commissioning Group Accountable Officer ensures that the Accountable Emergency Officer discharges their responsibilities to provide EPRR reports to the Board / Governing Body, no less frequently than annually. These reports should be taken to a public board, and as a minimum, include an overview on: • training and exercises undertaken by the organisation • summary of any business continuity, critical incidents and major incidents experienced by the organisation • lessons identified from incidents and exercises • the organisation's compliance position in relation to the latest NHS England EPRR assurance process	Y	• Public Board meeting minutes • Evidence of presenting the results of the annual EPRR assurance process to the Public Board
4	Governance	EPRR work programme	The organisation has an annual EPRR work programme, informed by: • lessons identified from incidents and exercises • identified risks • outcomes of any assurance and audit processes.	Y	• Process explicitly described within the EPRR policy statement • Annual work plan
5	Governance	EPRR Resource	The Board / Governing Body is satisfied that the organisation has sufficient and appropriate resource, proportionate to its size, to ensure it can fully discharge its EPRR duties.	Y	• EPRR Policy identifies resources required to fulfill EPRR function; policy has been signed off by the organisation's Board • Assessment of role / resources • Role description of EPRR Staff • Organisation structure chart • Internal Governance process chart including EPRR grou
6	Governance	Continuous improvement process	The organisation has clearly defined processes for capturing learning from incidents and exercises to inform the development of future EPRR arrangements.	Y	• Process explicitly described within the EPRR policy statement
7	Duty to risk assess	Risk assessment	The organisation has a process in place to regularly assess the risks to the population it serves. This process should consider community and national risk registers.	Y	• Evidence that EPRR risks are regularly considered and recorded • Evidence that EPRR risks are represented and recorded on the organisations corporate risk register
8	Duty to risk assess	Risk Management	The organisation has a robust method of reporting, recording, monitoring and escalating EPRR risks.	Y	• EPRR risks are considered in the organisation's risk management policy • Reference to EPRR risk management in the organisation's EPRR policy document
9	Duty to maintain plans	Collaborative planning	Plans have been developed in collaboration with partners and service providers to ensure the whole patient pathway is considered.	Y	Partners consulted with as part of the planning process are demonstrabl in planning arrangements
11	Duty to maintain plans	Critical incident	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to a critical incident (as defined within the EPRR Framework).	Y	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required
12	Duty to maintain plans	Major incident	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to a major incident (as defined within the EPRR Framework).	Y	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required
13	Duty to maintain plans	Heatwave	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to the impacts of heatwave on the population the organisation serves and its staff.	Y	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required
14	Duty to maintain plans	Cold weather	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to the impacts of snow and cold weather (not internal business continuity) on the population the organisation serves.	Y	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required
15	Duty to maintain plans	Pandemic influenza	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to pandemic influenza.	Y	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required

16	**Duty to maintain plans**	**Infectious disease**	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to an infectious disease outbreak within the organisation or the community it serves, covering a range of diseases including High Consequence Infectious Diseases such as Viral Haemorrhagic Fever. These arrangements should be made in conjunction with Infection Control teams; including supply of adequate FFP3 and PPE trained individuals commensurate with the organisational risk.	Y	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required
17	**Duty to maintain plans**	**Mass countermeasures**	In line with current guidance and legislation, the organisation has effective arrangements in place to distribute Mass Countermeasures - including arrangement for administration, reception and distribution of mass prophylaxis and mass vaccination. There may be a requirement for Specialist providers, Community Servic Providers, Mental Health and Primary Care services to develop or support Mass Countermeasure distribution arrangements. Organisations should have plans to support patients in their care during activation of mass countermeasure arrangements. CCGs may be required to commission new services to support mass countermeasure distribution locally, this will be dependant on the incident.	Y	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required
18	**Duty to maintain plans**	**Mass Casualty**	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to mass casualties. For an acute receiving hospital this should incorporate arrangements to free up 10% of their bed base in 6 hours and 20% in 12 hours, along with the requirement to double Level 3 ITU capacity for 96 hours (for those with level 3 ITU bed).	Y	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required
19	**Duty to maintain plans**	**Mass Casualty - patient identification**	The organisation has arrangements to ensure a safe identification system for unidentified patients in an emergency/mass casualty incident. This system should be suitable and appropriate for blood transfusion, using a non-sequential unique patient identification number and capture patient sex.	Y	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required
20	**Duty to maintain plans**	**Shelter and evacuation**	In line with current guidance and legislation, the organisation has effective arrangements in place to shelter and/or evacuate patients, staff and visitors. This should include arrangements to shelter and/or evacuate, whole buildings or sites, working in conjunction with other site users where necessary.	Y	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required
21	**Duty to maintain plans**	**Lockdown**	In line with current guidance and legislation, the organisation has effective arrangements in place to safely manage site access and egres for patients, staff and visitors to and from the organisation's facilities. This should include the restriction of access / egress in an emergency which may focus on the progressive protection of critical areas.	Y	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required
22	**Duty to maintain plans**	**Protected individuals**	In line with current guidance and legislation, the organisation has effective arrangements in place to respond and manage 'protected individuals'; Very Important Persons (VIPs), high profile patients and visitors to the site.	Y	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required
23	**Duty to maintain plans**	**Excess death planning**	The organisation has contributed to, and understands, its role in the multiagency arrangements for excess deaths and mass fatalities, including mortuary arrangements. This includes arrangements for rising tide and sudden onset events.	Y	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required
24	**Command and control**	**On-call mechanism**	A resilient and dedicated EPRR on-call mechanism is in place 24 / 7 to receive notifications relating to business continuity incidents, critical incidents and major incidents. This should provide the facility to respond to or escalate notifications to an executive level.	Y	• Process explicitly described within the EPRR policy statement • On call Standards and expectations are set out • Include 24 hour arrangements for alerting managers and other key staff.
25	**Command and control**	**Trained on-call staff**	On-call staff are trained and competent to perform their role, and are in a position of delegated authority on behalf of the Chief Executive Officer / Clinical Commissioning Group Accountable Officer. The identified individual: • Should be trained according to the NHS England EPRR competencies (National Occupational Standards) • Can determine whether a critical, major or business continuity incident has occurred • Has a specific process to adopt during the decision making • Is aware who should be consulted and informed during decision makin • Should ensure appropriate records are maintained throughout.	Y	• Process explicitly described within the EPRR policy statement
26	**Training and exercising**	**EPRR Training**	The organisation carries out training in line with a training needs analysis to ensure staff are competent in their role; training records are kept to demonstrate this.	Y	• Process explicitly described within the EPRR policy statement • Evidence of a training needs analysis • Training records for all staff on call and those performing a role within the ICC • Training materials • Evidence of personal training and exercising portfolios for key staff
27	**Training and exercising**	**EPRR exercising and testing programme**	The organisation has an exercising and testing programme to safely test major incident, critical incident and business continuity response arrangements. Organisations should meet the following exercising and testing requirements: • a six-monthly communications test • annual table top exercise • live exercise at least once every three years • command post exercise every three years. The exercising programme must: • identify exercises relevant to local risks • meet the needs of the organisation type and stakeholders • ensure warning and informing arrangements are effective. Lessons identified must be captured, recorded and acted upon as part of continuous improvement	Y	• Exercising Schedule • Evidence of post exercise reports and embedding learning

28	Training and exercising	Strategic and tactical responder training	Strategic and tactical responders must maintain a continuous personal development portfolio demonstrating training in accordance with the National Occupational Standards, and / or incident / exercise participation	Y	• Training records • Evidence of personal training and exercising portfolios for key staff
30	Response	Incident Co-ordination Centre (ICC)	The organisation has a preidentified Incident Co-ordination Centre (ICC) and alternative fall-back location(s). Both locations should be annually tested and exercised to ensure they are fit for purpose, and supported with documentation for its activation and operation.	Y	• Documented processes for establishing an ICC • Maps and diagrams • A testing schedule • A training schedule • Pre identified roles and responsibilities, with action cards • Demonstration ICC location is resilient to loss of utilities, including telecommunications, and external hazard
31	Response	Access to planning arrangements	Version controlled, hard copies of all response arrangements are available to relevant staff at all times. Staff should be aware of where they are stored and should be easily accessible.	Y	Planning arrangements are easily accessible - both electronically and hard copies
32	Response	Management of business continuity incidents	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to a business continuity incident (as defined within the EPRR Framework).	Y	• Business Continuity Response plans
33	Response	Loggist	The organisation has 24 hour access to a trained loggist(s) to ensure decisions are recorded during business continuity incidents, critical incidents and major incidents. Key response staff are aware of the need for keeping their own personal records and logs to the required standards.	Y	• Documented processes for accessing and utilising loggists • Training records
34	Response	Situation Reports	The organisation has processes in place for receiving, completing, authorising and submitting situation reports (SitReps) and briefings during the response to business continuity incidents, critical incidents and major incidents.	Y	• Documented processes for completing, signing off and submitting SitReps • Evidence of testing and exercising
35	Response	Access to 'Clinical Guidelines for Major Incidents and Mass Casualty events'	Key clinical staff (especially emergency department) have access to the 'Clinical Guidelines for Major Incidents and Mass Casualty events' handbook.	Y	Guidance is available to appropriate staff either electronically or hard co
36	Response	Access to 'CBRN incident: Clinical Management and health protection'	Clinical staff have access to the PHE 'CBRN incident: Clinical Management and health protection' guidance.	Y	Guidance is available to appropriate staff either electronically or hard co
37	Warning and informing	Communication with partners and stakeholders	The organisation has arrangements to communicate with partners and stakeholder organisations during and after a major incident, critical incident or business continuity incident.	Y	• Have emergency communications response arrangements in place • Social Media Policy specifying advice to staff on appropriate use of personal social media accounts whilst the organisation is in incident response • Using lessons identified from previous major incidents to inform the development of future incident response communications • Having a systematic process for tracking information flows and logging information requests and being able to deal with multiple requests for information as part of normal business processes • Being able to demonstrate that publication of plans and assessments is part of a joined-up communications strategy and part of your organisation's warning and informing work
38	Warning and informing	Warning and informing	The organisation has processes for warning and informing the public (patients, visitors and wider population) and staff during major incidents, critical incidents or business continuity incidents.	Y	• Have emergency communications response arrangements in place • Be able to demonstrate consideration of target audience when publishing materials (including staff, public and other agencies) • Communicating with the public to encourage and empower the community to help themselves in an emergency in a way which compliments the response of responders • Using lessons identified from previous major incidents to inform the development of future incident response communications • Setting up protocols with the media for warning and informing
39	Warning and informing	Media strategy	The organisation has a media strategy to enable rapid and structured communication with the public (patients, visitors and wider population) and staff. This includes identification of and access to a trained media spokespeople able to represent the organisation to the media at all times.	Y	• Have emergency communications response arrangements in place • Using lessons identified from previous major incidents to inform the development of future incident response communications • Setting up protocols with the media for warning and informing • Having an agreed media strategy which identifies and trains key staff in dealing with the media including nominating spokespeople and 'talking heads'
40	Cooperation	LRHP attendance	The Accountable Emergency Officer, or an appropriate director, attends (no less than 75% annually) Local Health Resilience Partnership (LHRP) meetings.	Y	• Minutes of meetings
41	Cooperation	LRF / BRF attendance	The organisation participates in, contributes to or is adequately represented at Local Resilience Forum (LRF) or Borough Resilience Forum (BRF), demonstrating engagement and co-operation with partner responders.	Y	• Minutes of meetings • Governance agreement if the organisation is represented
42	Cooperation	Mutual aid arrangements	The organisation has agreed mutual aid arrangements in place outlining the process for requesting, coordinating and maintaining mutual aid resources. These arrangements may include staff, equipment, services and supplies. These arrangements may be formal and should include the process for requesting Military Aid to Civil Authorities (MACA) via NHS England.	Y	• Detailed documentation on the process for requesting, receiving and managing mutual aid requests • Signed mutual aid agreements where appropriate
46	Cooperation	Information sharing	The organisation has an agreed protocol(s) for sharing appropriate information with stakeholders, during major incidents, critical incidents or business continuity incidents.	Y	• Documented and signed information sharing protocol • Evidence relevant guidance has been considered, e.g. Freedom of Information Act 2000, General Data Protection Regulation and the Civil Contingencies Act 2004 'duty to communicate with the public'.
47	Business Continuity	BC policy statement	The organisation has in place a policy which includes a statement of intent to undertake business continuity. This includes the comitmement to a Business Continutiy Management System (BCMS) in alignment to the ISO standard 22301.	Y	Demonstrable a statement of intent outlining that they will undertake BC Policy Statement
48	Business Continuity	BCMS scope and objectives	The organisation has established the scope and objectives of the BCMS in relation to the organisation, specifying the risk management process and how this will be documented.	Y	BCMS should detail: • Scope e.g. key products and services within the scope and exclusions from the scope • Objectives of the system • The requirement to undertake BC e.g. Statutory, Regulatory and contractual duties • Specific roles within the BCMS including responsibilities, competencies and authorities. • The risk management processes for the organisation i.e. how risk will be assessed and documented (e.g. Risk Register), the acceptable level of risk and risk review and monitoring process • Resource requirements • Communications strategy with all staff to ensure they are aware of their roles • Stakeholders
49	Business Continuity	Business Impact Assessment	The organisation annually assesses and documents the impact of disruption to its services through Business Impact Analysis(s).	Y	Documented process on how BIA will be conducted, including: • the method to be used • the frequency of review • how the information will be used to inform planning • how RA is used to support
50	Business Continuity	Data Protection and Security Toolkit	Organisation's Information Technology department certify that they are compliant with the Data Protection and Security Toolkit on an annual basis.	Y	Statement of compliance

51	**Business Continuity**	**Business Continuity Plans**	The organisation has established business continuity plans for the management of incidents. Detailing how it will respond, recover and manage its services during disruptions to: • people • information and data • premises • suppliers and contractors • IT and infrastructure These plans will be reviewed regularly (at a minimum annually), or following organisational change, or incidents and exercise	Y	• Documented evidence that as a minimum the BCP checklist is covered by the various plans of the organisation
52	**Business Continuity**	**BCMS monitoring and evaluation**	The organisation's BCMS is monitored, measured and evaluated against established Key Performance Indicators. Reports on these and the outcome of any exercises, and status of any corrective action are annually reported to the board.	Y	• EPRR policy document or stand alone Business continuity policy • Board papers
53	**Business Continuity**	**BC audit**	The organisation has a process for internal audit, and outcomes are included in the report to the board.	Y	• EPRR policy document or stand alone Business continuity policy • Board papers • Audit reports
54	**Business Continuity**	**BCMS continuous improvement process**	There is a process in place to assess the effectivness of the BCMS and take corrective action to ensure continual improvement to the BCMS.	Y	• EPRR policy document or stand alone Business continuity policy • Board papers • Action plans
55	**Business Continuity**	**Assurance of commissioned providers / suppliers BCPs**	The organisation has in place a system to assess the business continuity plans of commissioned providers or suppliers; and are assured that these providers business continuity arrangements work with their own.	Y	• EPRR policy document or stand alone Business continuity policy • Provider/supplier assurance framework • Provider/supplier business continuity arrangements

Ref	Domain	Standard	Detail	Acute Providers	Evidence - examples listed below	Organisational Evidence	Self assessment RAG **Red (not compliant) =** Not compliant with the core standard. The organisation's EPRR work programme shows compliance will not be reached within the next 12 months. **Amber (partially compliant) =** Not compliant with core standard. However, the organisation's EPRR work programme demonstrates sufficient evidence of progress and an action plan to achieve full compliance within the next 12 months. **Green (fully compliant) =** Fully compliant with core standard.	Action to be taken	Lead	Timescale	Comments
Deep Dive - Severe Weather **Domain: Severe Weather Response**											
1	Severe Weather response	Overheating	The organisation's heatwave plan allows for the identification and monitoring of inpatient and staff areas that overheat (For community and MH inpatient area may include patients own home, or nursing/care home facility)	Y	The monitoring processes is explicitly identified in the organisational heatwave plan. This includes staff areas as well as inpatient areas. This process clearly identifies relevant temperature triggers and subsequent actions.	in place in the adverse weather SOP	Fully compliant				
2	Severe Weather response	Overheating	The organisation has contingency arrangements in place to reduce temperatures (for example MOUs or SLAs for cooling units) and provide welfare support to inpatients and staff in high risk areas (For community and MH inpatient area may include patients own home, or nursing/care home facility)	Y	Arrangements are in place to ensure that areas that have been identified as overheating can be cooled to within reasonable temperature ranges, this may include use of cooling units or other methods identified in national heatwave plan.	in place in the adverse weather SOP portable units managed through 3rd party company	Fully compliant				
3	Severe Weather response	Staffing	The organisation has plans to ensure staff can attend work during a period of severe weather (snow, flooding or heatwave), and has suitable arrangements should transport fail and staff need to remain on sites. (Includes provision of 4x4 where needed)	Y	The organisations arrangements outline: - What staff should do if they cannot attend work - Arrangements to maintain services, including how staff may be brought to site during disruption - Arrangements for placing staff into accommodation should they be unable to return home	in place in the adverse weather SOP	Fully compliant				
4	Severe Weather response	Service provision	Organisations providing services in the community have arrangements to allow for caseloads to be clinically prioritised and alterative support delivered during periods of severe weather disruption. (This includes midwifery in the community, mental health services, district nursing etc)	Y	The organisations arrangements identify how staff will prioritise patients during periods of severe weather, and alternative delivery methods to ensure continued patient care	in place in the adverse weather SOP	Fully compliant				
5	Severe Weather response	Discharge	The organisation has polices or processes in place to ensure that any vulnerable patients (including community, mental health, and maternity services) are discharged to a warm home or are referred to a local single point-of-contact health and housing referral system if appropriate, in line with the NICE Guidelines on Excess Winter Deaths	Y	The organisations arrangements include how to deal with discharges or transfers of care into non health settings. Organisation can demonstrate information sharing regarding vulnerability to cold or heat with other supporting agencies at discharge		Partially compliant	Discharge team to engage with EPRR to complete this action	Gregg Marson	Dec-19	
6	Severe Weather response	Access	The organisation has arrangements in place to ensure site access is maintained during periods of snow or cold weather, including gritting and clearance plans activated by predefined triggers	Y	The organisation arrangements have a clear trigger for the pre-emptive placement of grit on key roadways and pavements within the organisations boundaries. When snow / ice occurs there are clear triggers and actions to clear priority roadways and pavements. Arrangements may include the use of a third party gritting or snow clearance service.	Managed through countrywide	Fully compliant				
7	Severe Weather response	Assessment	The organisation has arrangements to assess the impact of National Severe Weather Warnings (including Met Office Cold and Heatwave Alerts, Daily Air Quality Index and Flood Forecasting Centre alerts) and takes predefined action to mitigate the impact of these where necessary	Y	The organisations arrangements are clear in how it will assesses all weather warnings. These arrangements should identify the role(s) responsible for undertaking these assessments and the predefined triggers and action as a result.	key partners and responders in trust are sent alerts for weather to ensure preparedness, EPRR can provide interpreation as required	Fully compliant				
8	Severe Weather response	Flood prevention	The organisation has planned preventative maintenance programmes are in place to ensure that on site drainage is clear to reduce flooding risk from surface water, this programme takes into account seasonal variations.	Y	The organisation has clearly demonstratable Planned Preventative Maintenance programmes for its assets. Where third party owns the drainage system there is a clear mechanism to alert the responsible owner to ensure drainage is cleared and managed in a timely manner	In place as part of estates management processes	Fully compliant				
9	Severe Weather response	Flood response	The organisation is aware of, and where applicable contributed to, the Local Resilience Forum Multi Agency Flood Plan. The organisation understands its role in this plan.	Y	The organisation has reference to its role and responsibilities in the Multi Agency Flood Plan in its arrangements. Key on-call/response staff are clear how to obtain a copy of the Multi Agency Flood Plan	In place DGFT sits on DRF for consultation on a variety of plans	Fully compliant				
10	Severe Weather response	Warning and informin	The organisation's communications arrangements include working with the LRF and multiagency partners to warn and inform, before and during, periods of Severe Weather, including the use of any national messaging for Heat and Cold.	Y	The organisation has within is arrangements documented roles for its communications teams in the event of Severe Weather alerts and or response. This includes the ability for the organisation to issue appropriate messaging 24/7. Communications plans are clear in what the organisations will issue in terms of severe weather and when.	Comms in place through exisiting comms arrangements and also through the adverse weather SOP	Fully compliant				
11	Severe Weather response	Flood response	The organisation has plans in place for any preidentified areas of their site(s) at risk of flooding. These plans include response to flooding and evacuation as required.	Y	The organisation has evidence that it regularly risk assesses its sites against flood risk (pluvial, fluvial and coastal flooding). It has clear site specific arrangements for flood response, for known key high risk areas. On-site flood plans are in place for at risk areas of the organisations site(s).	Managed through Interserve and Summit as property owners for RHH	Partially compliant	Confirmation of NHSPS plan for the data centre (FMC)	IT service manager	Jul-19	
12	Severe Weather response	Risk assess	The organisation has identified which severe weather events are likely to impact on its patients, services and staff, and takes account of these in emergency plans and business continuity arrangements.	Y	The organisation has documented the severe weather risks on its risk register, and has appropriate plans to address these.	Contained in EPRR Strategy	Fully compliant				
13	Severe Weather response	Supply chain	The organisation is assured that its suppliers can maintain services during periods of severe weather, and periods of disruption caused by these.	Y	The organisation has a documented process of seeking risk based assurance from suppliers that services can be maintained during extreme weather events. Where these services can't be maintain the organisation has alternative documented mitigating arrangements in place.	Yes through 3rd party BC Processes	Fully compliant				
14	Severe Weather response	Exercising	The organisation has exercised its arrangements (against a reasonable worst case scenario), or used them in an actual severe weather incident response, and they were effective in managing the risks they were exposed to. From these event lessons were identified and have been incorporated into revised arrangements.	Y	The organisation can demonstrate that its arrangements have been tested in the past 12 months and learning has resulted in changes to its response arrangements.	Yes Adverse Weather Exercise takes place each year	Fully compliant				
15	Severe Weather response	ICT BC	The organisations ICT Services have been thoroughly exercised and equipment tested which allows for remote access and remote services are able to provide resilience in extreme weather e.g. are cooling systems sized appropriately to cope with heatwave conditions, is the data centre positioned away from areas of flood risk.	Y	The organisations arrangements includes the robust testing of access services and remote services to ensure the total number of concurrent users meets the number that may work remotely to maintain identified critical services	IT have BC in place for all eventualities, there is a back up resilient data centre to support should primary fail, cooling and resilence is considered in the data centres set up	Fully compliant				
Domain: long term adaptation planning											
16	Long term adaptation planning	Risk assess	Are all relevant organisations risks highlighted in the Climate Change Risk Assessment are incorporated into the organisations risk register.	Y	Evidence that the there is an entry in the organisations risk register detailing climate change risk and any mitigating actions		Partially compliant	climate change to be included onto trust risk register	Christopher Leach, Emergency Planning Manager	31/07/2019	EPRR risks to be included onto risk register pertaining to climate change
17	Long term adaptation planning	Overheating risk	The organisation has identified and recorded those parts of their buildings that regularly overheat (exceed 27 degrees Celsius) on their risk register. The register identifies the long term mitigation required to address this taking into account the sustainable development commitments in the long term plan. Such as avoiding mechanical cooling and use of cooling higherachy.	Y	The organisation has records that identifies areas exceeding 27 degrees and risk register entries for these areas with action to reduce risk	In place managed by estates through DATIX and Interserve	Fully compliant				
18	Long term adaptation planning	Building adaptations	The organisation has in place an adaptation plan which includes necessary modifications to buildings and infrastructure to maintain normal business during extreme temperatures or other extreme weather events.	Y	The organisation has an adaptation plan that includes suggested building modifications or infrastructure changes in future	Lifecycle process managed by Summit as landlords	Fully compliant				
19	Long term adaptation planning	Flooding	The organisations adaptation plans include modifications to reduce their buildings and estates impact on the surrounding environment for example Sustainable Urban Drainage Systems to reduce flood risks.	Y	Areas are identified in the organisations adaptation plans that might benefit drainage surfaces, or evidence that new hard standing areas considered for SUDS	Lifecycle process managed by Summit as landlords	Fully compliant				
20	Long term adaptation planning	New build	The organisation considers for all its new facilities relevant adaptation requirements for long term climate change	Y	The organisation has relevant documentation that it is including adaptation plans for all new builds	Lifecycle process managed by Summit as landlords	Fully compliant				

Overall assessment:										
Ref	**Domain**	**Standard**	**Detail**	**Evidence - examples listed below**	**Organisation Evidence**	**Self assessment RAG** **Red (not compliant) =** Not compliant with the core standard. The organisation's EPRR work programme shows compliance will not be reached within the next 12 months. **Amber (partially compliant) =** Not compliant with core standard. However, the organisation's EPRR work programme demonstrates sufficient evidence of progress and an action plan to achieve full compliance within the next 12 months. **Green (fully compliant) =** Fully compliant with core standard.	**Action to be taken**	**Lead**	**Timescale**	**Comments**
30	**Response**	**Incident Co-ordination Centre (ICC)**	The organisation has a preidentified Incident Co-ordination Centre (ICC) and alternative fall-back location(s). Both locations should be annually tested and exercised to ensure they are fit for purpose, and supported with documentation for its activation and operation.	• Documented processes for establishing an ICC • Maps and diagrams • A testing schedule • A training schedule • Pre identified roles and responsibilities, with action cards • Demonstration ICC location is resilient to loss of utilities, including telecommunications, and external hazards	ICC is resilient, and has an alternate location identified, there is a testing schedule and key roles are trained in its usage	Partially compliant	SOP for set up requires formal sign off	Christopher Leach, Emergency Planning Manager	31/10/2019	Due to potential changes in the location of the Primary Tactical and Strategic Control rooms the SOP to indicate set up has been delayed, this is in draft containing all details requested by the standard
34	**Response**	**Situation Reports**	The organisation has processes in place for receiving, completing, authorising and submitting situation reports (SitReps) and briefings during the response to business continuity incidents, critical incidents and major incidents.	• Documented processes for completing, signing off and submitting SitReps • Evidence of testing and exercising	Process in place in strategy to sign off document, contained in BC Policy	Partially compliant	Requires formal inclusion into Major Incident and Mass Casualty Policy and also the Critical Incident Policy	Christopher Leach, Emergency Planning Manager	31/10/2019	Process is in place SITREPS can be compelted and signed off, requires formal addition into Major Incident and Mass Casualty Policy to ensure completeness
40	**Cooperation**	**LRHP attendance**	The Accountable Emergency Officer, or an appropriate director, attends (no less than 75% annually) Local Health Resilience Partnership (LHRP) meetings.	• Minutes of meetings	attendance at 50% of meetings	Partially compliant	further person has been identifed to attend the LHRP providing full coverage and improvement of attendance percentage	Karen Kelly	next 12 months	Karen Kelly (AEO) designated attender Gerry Fogarty-delegated deputy
59	**CBRN**	**Decontamination capability availability 24 /7**	The organisation has adequate and appropriate decontamination capability to manage self presenting patients (minimum four patients per hour), 24 hours a day, 7 days a week.	Rotas of appropriately trained staff availability 24 /7	45 staff trained this year, 96 trained in total with some requiring updates	Partially compliant	Sessions are booked and being delivered, these are being attended by small numbers each time hence the amount of time that is being taken to downgade this action	ED	31/08/2019	
5	**Severe Weather response**	**Discharge**	The organisation has polices or processes in place to ensure that any vulnerable patients (including community, mental health, and maternity services) are discharged to a warm home or are referred to a local single point-of-contact health and housing referral system if appropriate, in line with the NICE Guidelines on Excess Winter Deaths	The organisations arrangements include how to deal with discharges or transfers of care into non health settings. Organisation can demonstrate information sharing regarding vulnerability to cold or heat with other supporting agencies at discharge		Partially compliant	Discharge team to engage with EPRR to complete this action	Gregg Marson	Dec-19	
11	**Severe Weather response**	**Flood response**	The organisation has plans in place for any preidentified areas of their site(s) at risk of flooding. These plans include response to flooding and evacuation as required.	The organisation has evidence that it regularly risk assesses its sites against flood risk (pluvial, fluvial and coastal flooding). It has clear site specific arrangements for flood response, for known key high risk areas. On-site flood plans are in place for at risk areas of the organisations site(s).	Managed through Interserve and Summit as property owners for RHH	Partially compliant	Confirmation of NHSPS plan for the data centre (FMC)	IT service manager	Jul-19	
16	**Long term adaptation planning**	**Risk assess**	Are all relevant organisations risks highlighted in the Climate Change Risk Assessment are incorporated into the organisations risk register.	Evidence that the there is an entry in the organiations risk register detailing climate change risk and any mitigating actions		Partially compliant	climate change to be included onto trust risk register	Christopher Leach, Emergency Planning Manager	31/07/2019	EPRR risks to be included onto risk register pertaining to climate change