The Dudley Group
NHS Foundation Trust

Public Board of Directors Meeting

Thursday 3rd October 2019

11.30 – 14.10

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
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The Dudley Group NHS Foundation Trust
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Email: helen.benbow1@nhs.net

Liam Nevin
Board Secretary
The Dudley Group NHS Foundation Trust
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2. Board Members' interests

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

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

3. Opportunity for questions

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

4. Debate

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

5. Minutes

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

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

6. Key Contacts

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The Dudley Group
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THE SEVEN PRINCIPLES OF PUBLIC LIFE

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

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

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

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

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

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

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

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

IN PUBLIC

The Dudley Group NHS Foundation Trust

Board of Directors
Thursday 3 October at 11.30h
Clinical Education Centre
AGENDA

	ITEM	PAPER REF	LEAD	PURPOSE	TIME
12	**Chairmans welcome and note of apologies**		Y Buckland	For noting	11:30
13	**Declarations of Interest** Standing declaration to be reviewed against agenda items.		Y Buckland	For noting	11:30
14	**Minutes of the previous meeting**				
14.1	Thursday 5 September 2019	Enclosure 7	Y Buckland	For approval	11:35
14.2	Action log 5 September 2019	Enclosure 8	L Nevin	For noting	11:40
15	**Patient Story**	Presentation	Liz Abbiss	For discussion	11:45
16	**Chief Executive's Overview**	Enclosure 9	D Wake	For information & assurance	11:55
17	**Chair's update**	Verbal	Y Buckland	For information	12:05
18	**QUALITY & SAFETY**				
18.1	Update from the Clinical Quality, Safety and Patient Experience Committee	Enclosure 10	C Holland	For assurance	12:15
18.2	Chief Nurse Report including Infection Control Report	Enclosure 11	M Sexton	For assurance	12:25
19	**FINANCE & PERFORMANCE**				
19.1	Update from the Finance & Performance Committee	Enclosure 12	J Hodgkin	For assurance	12:35
19.2	Update from the Charitable Funds Committee	Enclosure 13	J Atkins	For assurance	12:45
19.2	Finance report	Enclosure 14	T Jackson	For assurance	12:55
19.3	Integrated Performance Dashboard	Enclosure 15	K Kelly	For assurance	13:05
20	**WORKFORCE**				
20.1	People Plan - Implementation	Enclosure 16	A McMenemy	For assurance	13:15
20.2	Staff Survey update	Enclosure 17	A McMenemy	For assurance	13:25
21	**CORPORATE GOVERNANCE AND COMPLIANCE**				
21.1	Board Assurance Framework Proposals	Enclosure 18	L Nevin	For assurance	13:35
21.2	Scheme of Delegations	Enclosure 19	L Nevin	For decision	13:45

21.3	Maternity CNST Board Declaration	Enclosure 20	M Sexton	For approval	13:55
22	**MATTERS FOR INFORMATION – TO BE TAKEN BY EXCEPTION ONLY**				
22.1	**Health & Safety Annual Report**	Enclosure 21			
23	**Any Other Business**	Verbal	All		14:05
24	**Reflection on meeting**	Verbal	All		14:05
25	**Date of next Board of Directors meeting** 7 November 2019, Clinical Education Centre				14:10

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

Enclosure 7

The Dudley Group NHS
NHS Foundation Trust

Minutes of the Public Board of Directors meeting held on Thursday 5th September 2019, in the Clinical Education Centre.

Present:

Yve Buckland, Interim Chair (YB)
Tom Jackson, Director of Finance (TJ)
Karen Kelly, Chief Operating Officer (KK)
Richard Miner, Non-Executive Director (RM)
Jonathan Hodgkin, Non-Executive Director (JH)
Ian James, Non-Executive Director (IJ)
Julian Hobbs, Medical Director (JHO)
Diane Wake, Chief Executive (DW)
Julian Atkins, Non-Executive Director (JA)
Mary Sexton, Interim Chief Nurse (MS)
Catherine Holland, Non-Executive Director (CH)
Gary Crowe, Non-Executive Director (GC)
Andrew McMenemy, Director of HR (AM)
Adam Thomas, Chief Information Officer (AT)

In Attendance:

Liz Abbiss, Head of Communications
Liam Nevin, Trust Secretary (LN)

19/089 Note of Apologies and Welcome

The Chairman welcomed members of the public and governors to the meeting.

No apologies were received

19/090 Declarations of Interest

No declarations of interest were received other than those contained on the register

19/091 Announcements

The Chairman introduced Liam Nevin the new Board Secretary and Adam Thomas was congratulated on his appointment as the Chief Information Officer.

The Chairman reported her pride in all of the clinical staff who had attended the Overview and Scrutiny Committee during the previous week. The Committee had given a strong endorsement to the Trust in respect of the significant improvements that had been made.

19/092 Minutes of the previous meeting held on 4th July, 2019

IJ noted that he was not present as recorded and subject to that amendment the minutes were agreed as a true and accurate record of the meeting.

19/092.1 Action Sheet 4 July 2029

There were no exceptions to be reported.

19/093 Patient Story

The Board observed the video patient story of Cheryl Scriven from November 2018.

Thereafter the Board discussed the experience of Ms Scriven and the learning to be derived.

It was noted that the case study was a salutary lesson in process failures and KK explained the steps that had been taken to improve surgical pathways and referrals from Urgent Care.

It was further noted that a feature of this case was the poor patient experience around pathways and KK was asked what checks were in place to evidence that Ms Scriven's experiences was not a recurring issue, and how this was tracked through governance processes. KK explained that weekly validation was undertaken and that AS standards were considered by the Executive team each week. In addition, all avoidable harm incidents were reviewed.

MS stated that complaints that identified gaps in care or treatment were also considered by her on a weekly basis and a decision was taken as to whether the matter was dealt with through the complaint or incident processes, with feedback provided to the patients.

The Chair asked that thanks be conveyed to Ms Scriven for sharing her experience with the Board.

19/094 Chief Executive's Overview Report

DW highlighted the good work undertaken through the Improvement Practice Programme. Notably, the Ophthalmology Department had transformed their services and improved patient experience, and the exemplar ward project in C3 had also been a success.

The Anaesthetics Department had this week received the prestigious Anaesthesia Clinical Services Accreditation, being one of only thirty three Trusts to receive this recognition.

In relation to the CQC, the Trust reporting requirements had now been relaxed in recognition of the progress that the Trust had made.

It was **RESOLVED**

- **That the report be noted**

19/095 Safe and Caring

19/095.1 Chief Nurse Report

MS highlighted the following key developments;

- An in-house survey of the Trust's specialist nurses had been completed leading to a programme of work to optimise their roles
- The appointment of fifty graduate nurses to start in September and which would reduce reliance on agency staff
- Appointment to the Head of Safeguarding role, with the post holder commencing in November

A member of the public asked about the success of the recruitment programme locally given the challenging national picture. In reply it was noted that the Trust was on plan to meet its target of developing one hundred associate nurses but that the national picture was challenging particularly since the removal of bursary support. However, the Trust was using the apprenticeship levy to offset this as far as possible.

It was **RESOLVED**

- **That the report be noted**

19/095.2 Clinical Quality, Safety, Patient Experience Committee Report

CH introduced the item and advised the Board that the Integrated Performance Report had not been received at the July meeting. In addition, the Committee expressed some concern at this meeting at the number of policies and SOPS that were out of date and it had been agreed that work would be undertaken to examine the scope for consolidating the number of policies.

The Committee currently did not have the benefit of a member with clinical expertise but had benefitted from the advice of Kathryn Sallah who was assisting as a co-optee. It was noted that the Trust would be undertaking recruitment for this role in the next couple of weeks.

At the August meeting it had been noted that a corporate risk had been identified that Interserve could not guarantee an uninterrupted power supply to theatres and the Committee had requested further information and discussion on this matter.

It was noted that the Committee had received a report on the CQC action plan but the format did not facilitate interrogation of the detail and this would therefore be reconsidered at the next meeting.

It was further noted that the Trust faced a challenge to comply with the CCG 90 day timescales for RCAs when cases were referred to the HSIB because they had limited capacity to carry out investigations in the required timescale.

It was noted that the Safeguarding Board had reported that programmed DBS checks were outstanding in respect of six hundred clinical staff. MS clarified that these were cyclical three year refresher checks and that additional actions and escalation procedures were in place. In addition, all timelines were now embedded in the ESR system.

It was **RESOLVED**

- **That the report be noted**

19/095.3 Learning from Deaths Report

JH presented this report and advised the Board that mortality measures continued to improve and that at 113, SHMI was at the expected range.

It was confirmed that all deaths were included in the review.

It was **RESOLVED**

- **That the report be noted**

19/096 Safe and Caring

19/096.1 Integrated Performance Dashboard

KK presented the report and advised that the Trust continued to outperform most Trusts in relation to RTT. In addition with a performance of 99.22% the diagnostic performance standard was also achieved for July.

It was acknowledged that emergency access standards were not acceptable and further work was being done on earlier in-day discharges. DW stated that Sandwell had demonstrated improvements with similar metrics to the Trust and KK and her team would be visiting to identify best practice.

It was **RESOLVED**

- **That the report be noted**

19/096.2 Finance and Performance Committee Exception Report

JH presented the report and advised that the Trust had secured PSF for the first quarter but in relation to the second quarter the Trust was currently approximately £2 million behind budget. There was £4 million in CIP that was currently being validated and allocated to divisions and the Trust was opening discussions with the Clinical Commissioning Group in relation to its forecast and cash flow.

It was **RESOLVED**

- **That the report be noted**

19/096.3 Annual Plan Quarterly Report

TJ introduced this report and advised that it remained a work in progress. Following discussion it was agreed that the report did not materially add value beyond the information provided in the Integrated Performance Report and that no further iterations would be developed.

It was **RESOLVED**

- **That the report be noted but that no further iterations were required to be presented to subsequent Board meetings.**

19/097 Well Led

19/097.1 Workforce Committee Report

JA presented the report and advised the Board that the Committee had been pleased to see that the Quarter 4 Staff Friends and Family results recorded a significant increase in the feedback received and the numbers recommending the Trust as a place to receive care and work.

JA thereafter summarised the key concerns and assurances arising from the meeting. AM advised that sickness absence had been running at over 5% for two months and divisional managers and staff side representatives were engaged in measures to address this. MS

noted that it was necessary to look beyond the average sickness rate as some teams were experiencing substantially higher rates of absence.

The Board discussed whether absence rates demonstrated any patterns and AM advised that stress related absence and musculoskeletal conditions were a trend and the two were often related.

It was agreed that the Committee would examine best practice in staff welfare to inform further discussion at the Board.

It was **RESOLVED**

- **That the report be noted**

19/097.2 Audit Committee Report

RM summarised the key concerns and assurances arising from the meeting and the Board were reminded that an action arising from the Committee was that further consideration be given to the format and structure of the BAF report.

It was **RESOLVED**

- **That the report be noted**

19/097.3 Annual Revalidation Report

JHO presented the report which represents the status of Medical Revalidation and Appraisals at the Trust as of 31st March 2019. The Committee noted the performance of the Trust 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.

It was **RESOLVED**

- **That the contents of the report be noted and that the plans for improved quality assurance of the Revalidation processes be approved.**

19/097.4 Digital Trust Report

AT summarised the key assurances set out in the supporting paper following which the Board discussed the digital advances necessary to transform patient services. It was agreed that such developments were integral to the development of integrated services and that the matter should be the subject of a Board development session.

It was **RESOLVED**

- **That the report be noted and that digital services be subject to a Board development session**

19/097.5 Freedom to Speak Up Report

The Chairman welcomed Derek Eaves and Philippa Brazier, the Freedom to Speak up Guardians to the meeting and invited them to summarise the report before the Board.

Thereafter, the Board noted the increase in reported cases and questioned whether this indicated increased confidence in reporting concerns or demonstrated signs of underlying problems. The Guardians advised that whilst neither conclusion could necessarily be drawn from the data there were no trends in the issues reported.

It was agreed that the data presented was valuable but needed also to be triangulated against other sources of information to establish whether the Trust culture encouraged reporting of concerns. It was further agreed that NHSI would be asked to review the implementation of the recommendations that they made after twelve months.

It was noted that the Trust survey and the national staff survey would also ask questions that correlated with the Freedom to Speak up process and the Board asserted their support for maximising the different opportunities for people to speak up.

The Chairman thanked the presenters for their work and attendance at the Board.

It was **RESOLVED**

- **That the Board endorse the work done and actions being taken be the Freedom to Speak Up Guardians and that the NHSI be asked to review the implementation of their recommendations after twelve months.**

19/097.6 Guardian of Safe Working Report

Babar Elahi presented the report the purpose of which was to give assurance to the Board that Junior Doctors in Training (JDT) are safely rostered and that their working hours are compliant with the Terms and Conditions of Service for NHS Doctors and Dentists in Training.

The Board were advised that in the period covered by the report there had been twelve exception reports, ten of which had been dealt with in seven days, and two had taken longer to address because of leave. No immediate safety concerns arose from these cases.

The Board were further advised that the Junior Doctor forum had been well attended and it was agreed that the dates of future meetings would be made available to Board members if they wished to attend.

A governor stated that having listened to Mr Elahi's summary their question concerning whistleblowing arrangements had been addressed.

The Chair thanked Babar Elahi for attending the Committee and for the valuable work undertaken as the Guardian of Safe Working

It was **RESOLVED**

- **That the Board note the report and the assurances concerning safe rostering and working hours for junior doctors in training**

19/097.7 EPRR Core Standards

Chris Leach attended to present the report and he advised that 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 has graded itself as substantially compliant, evidencing a good level of assurance in its preparedness for emergencies and adverse events.

The Board were advised of the work undertaken to substantiate the assessment and DW commended Chris on the quality of the work, reflecting that the Trust was in a much stronger position in its preparedness as a result.

The Chair noted that some governors had expressed concerns about site safety at the hospital and requested that Chris attend a forthcoming meeting to address them on site safety and emergency planning.

It was **RESOLVED**

- **That the EPRR Core Standards submission for Dudley Group NHS FT be approved**

19/098 Any Other Business

There was no other business

19/099 Reflection on Meeting

GC stated that it was not always clear if a report had been prior considered by a Committee and whether the follow up actions in relation to the reports was routed back through a Committee.

YB stated that she wanted the opportunity to consider draft Board reports prior to dispatch and therefore a pre-issue deadline would need to be introduced to improve quality assurance. In addition it would be necessary to re-align the Board and Committee meetings from January 2020.

GC questioned the assurance boxes on the front cover of reports and suggested that these could be misleading. LN advised that the format was only familiar to him as an assurance tool from internal audit reports.

Signed ……

Date …….....

Enclosure 8

The Dudley Group NHS Foundation Trust

Action Sheet
Minutes of the Board of Directors Public Session
Held on 5 September 2019

Item No	*Subject*	*Action*	*Responsible*	*Due Date*	*Comments*
19/033.1	Staff Survey Presentation	Update on the Staff Survey to the Board in 6 months.	AM	5/9	To October Board
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
19/097.1	Workforce Committee Report	Committee to review best practice to address workforce stress prevention and mental health and to review against current Trust practice	AM	November	Not Due
19/097.4	Digital Trust Report	Board development session on digital integration and facilitating integrated care systems	LN/AT	November	Not Due
19/097.5	Freedom to Speak Up Report	NHSI to review implementation of their recommendations in July 2020	AM	July 2020	Not Due
19/097.6	Guardian of Safe Working Report	Dates for junior doctor forums to be provided to Board members	LN	October	27/11/19 29/1/20 25/3/20 Board members wishing to attend to contact LN
19/097.7	EPRR Standards	Chris Leach to attend future Council of Governors meeting to discuss emergency planning and site security	LN/CL	December	Completed
19/099	Reflection on Meeting	• Standard report format to be amended to remove assurance boxes • Pre-dispatch deadline for Board papers to be introduced for Chair review • Re-alignment of Board and Committee meetings from Jan 2020	LN	October	Completed

Enclosure 9

The Dudley Group NHS Foundation Trust

Paper for submission to the Board of Directors on 3rd October 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 COMMITTEE

Decision	Approval	Discussion	Other
		X	

RECOMMENDATIONS

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
- NHS Staff Survey 2019
- Flu Vaccination Campaign
- Charity Update
- AHP Day and Celebrations
- Governor Elections
- Major Incident Training Exercise
- National News
- Regional News

IMPLICATIONS OF PAPER:

IMPLICATIONS FOR THE CORPORATE RISK REGISTER OR BOARD ASSURANCE FRAMEWORK

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:**
REPORT DESTINATION	**EXECUTIVE DIRECTORS**	**N**	**DATE:**
	WORKING GROUP	**N**	**DATE:**
	COMMITTEE	**N**	**DATE:**

Chief Executive's Report – Public Board – October 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 September	Board of Directors
6th September	Team Brief
11th September	MCP Transition Board
16th September	Live Chat
	Black Country STP Cancer Board
19th September	Non Executive Director Interviews
	Council of Governors
30th September	Dudley System Review Meeting
2nd October	Midlands Leaders Event

Improvement Practice Update

In August the Improvement Practice team hosted another successful 5-day event, this time focusing on improving discharge procedures.

Estimated Date of Discharge (EDD) is now used in the board rounds held at a newly designed capacity board which tracks progress towards safe discharge from 24 hours after the patient arrives on the ward. A community long-term conditions nurse is also now present at these board rounds to expedite transfer of care out of hospital.

These and other changes made on ward C3 will be monitored closely against discharge and length of stay performance at 30, 60 and 90 days with the intention of replicating successful change on other wards before winter. At the 30 day review, average length of stay on C3 had reduced by half a day. The team will continue to support ward staff to improve on this further.

Early stage planning for the next event – Emergency Theatre begins in late November/early December.

Year One Review

NHSE/I held a review (19/09/19) with the programme leads from the eight sites and this will be fed back to the Chief Executive's at the next Improvement Practice Guiding Board. There have been lots of successes and lots of learning about what's worked and what hasn't but all sites are still completely committed to continuing with the programme.

Evidence that the Improvement Practice is starting to embed at Dudley is growing. However we expect it to be several years before we can be sure of transformation to a culture of continuous improvement.

The requests for improvement support from departments now exceeds the capacity of the team and there are several advocates starting to appear who are talking about their experiences of the Improvement Practice. E.g. Julia Phillips Lead nurse in Ophthalmology spoke in team brief about the ongoing improvements in her department following the Improvement Practice Event in May. A CSW on Ward C3; Jordan Fox gave a great presentation in the lecture theatre about his experience.

Board Development

As part of the subscription with NHSI, we have access to an Exec Sensei; David Fillingham, he has been working with Executive's on developing leadership to support improvement and we have planned to do a workshop with the full board early in the new year.

NHS Staff Survey 2019

The National Staff Survey 2019 is open from Tuesday 8th October – please use it to tell us about your service and the Trust. If change is what you are seeking, this is your chance!

All staff will receive an email with a link and password unique to them to enable them to log in to the National Staff Survey and tell us what they think about their job and the Trust.

We're using outside company Picker to run the survey for us – this means that all responses go to them and they only provide the Trust with an anonymous report. It ensures everything people want to say is treated in confidence.

Flu Vaccination Campaign

As we head into winter we will once again be offering all staff free flu vaccines to help protect themselves their families and patients. Vaccines will be available from October. All NHS organisations have been asked to sign off their commitment to flu vaccinations. We will be bringing that for Board sign off in November. All trusts have been asked to aim for 100% vaccination rate

DGFT Charity Update

We are looking for enthusiastic and energetic staff to join a brand new charity fundraising group led by Chief Executive Diane Wake to raise money and make a real difference to patients.

If you have a passion for improving patient care and experience, and you are brimming with brilliant fundraising ideas, be part of an exciting group with BIG ideas to raise BIG money.

There are lots of wonderful staff in the Trust who regularly take part in fundraising events for charitable causes and I want to tap into that talent to boost the funds of our own Dudley Group Charity.

NHS Rugby Day

We hosted a successful staff engagement event for the MCP with over 480 NHS staff attending the Stourbridge Rugby Club Saturday 14th September, thanks to a free ticket. A home win meant some generous donations in the charity buckets which raised £160.

Sparkle Party

We are pleased to announce we are almost at full capacity with tickets sales for the Sparkle Party on Friday 22 November. We would be really grateful for any support with obtaining auction items and raffle prizes. Contact Liz Abbiss or Karen Phillips.

Will Fortnight

Waldrons Solicitors have reported that they have already made a substantial amount of appointments for Will Fortnight. The campaign, which runs from 7 – 18 October, raises funds for the General Fund. It costs £80 for a single will and £150 for a couples will. The solicitors donate their time free of charge so we get all of the donation. Details on the hub.

AHP Day Celebrations and Awards

National AHP Day is on Monday 14th October! Celebrate and congratulate your AHP colleagues by nominating them for the AHP awards and if you're an AHP book onto the celebration event!

Join us for a fantastic day of celebrating all things AHP! The Health and Care Professions Council will be joining us for a professional talk at the AHP Awards 2019!

There will also be plenty of opportunity to network with other colleagues from the twelve AHP professions that our Trust employs. Nominate colleagues for awards via the link on the hub.

Governor Elections

We have vacancies for governors in two staff constituencies and are looking for colleagues to put themselves forward to take on this important role. There are vacancies in the following:

- Nursing and midwifery
- Non-clinical staff

If you would like to stand as a governor for these areas, you have until Friday 11th October to get your nomination in.

Major Incident Training Exercise

We had a very successful major incident fire training exercise in North Block on Saturday 14th September 2019. Fire and ambulance crews were on site and this was an opportunity for the fire service to use our hospital to practice their procedures for search and evacuation.

It also tested our response to a large scale incident. Karen Kelly was Strategic (Gold) Commander and Jo Newens was Tactical (Silver) Commander. Feedback from the NHSE & I observer was extremely complimentary about how the incident was managed. So it was a valuable exercise for the Trust and our co-responders and I would like to thank all staff who took part.

National NHS News

MPs highlight 'secret scandal' of radiotherapy access as NHS dispute figures
Politicians have criticised the "secret scandal" of poor radiotherapy provision amid a dispute with the NHS over how many cancer patients may not be getting treatment. A report from MPs across the political spectrum estimates that 20,000 patients are missing out on treatment each year. The report said it had observed "consensus" and "widespread acknowledgement" of the estimate, based on analysis from the charity Action Radiotherapy of Government data. **ITV News (30/08/19)**

South Tyneside Hospital almost replaced knee with wrong prosthetic
A patient was almost given a prosthetic knee for the wrong leg at a North East hospital, a report says. Another patient at a nearby hospital had surgery on their elbow instead of their wrist. The procedures at South Tyneside General Hospital and Sunderland Royal Hospital are being investigated by NHS bosses as so-called "never events". The trust responsible for both hospitals has apologised and stressed that no-one came to serious harm. A patient at South Tyneside Hospital, in South Shields, was almost given a prosthetic intended for the other leg, the report revealed.
BBC News (30.08.19)

NHS Nurses to be given £1,000 each to spend on training in bid to stop staff leaving
Nurses will be given £1,000 each over three years to help their careers develop in an effort by the Government to stop staff leaving the NHS. Chancellor Sajid Javid will announce a new multi-million pound package of support to train and retain the nurses the health service needs as part of the Spending Round on Wednesday. The increase to national training budgets for nurses as well as midwives and other frontline health professionals across the NHS is part of the government's commitment to improving patient care and securing a sustainable future for the NHS through the Long Term Plan.
I News (02.09.19)

National pharmacy NHS 111 referral service to launch on October 29
Pharmacies across England will receive £14 for each consultation resulting from a referral from NHS 111 under a new advanced service launching at the end of October. Pharmacies in England can from today (September 2) register their interest in providing the Community Pharmacist Consultation Service (CPCS), which will see them receive referrals from NHS 111 from October 29 for minor illnesses – such as rashes, constipation and vaginal discharge – and urgent medicines supply. The advanced service follows on from two pilots – the Digital Minor Illness Referral Service (DMIRS) and the NHS Urgent Medicine Supply Advanced Service (NUMSAS) – and aims to establish community pharmacy as the "first port of call" for low acuity conditions, as well as reduce demand on urgent care services, NHS England said. **Chemist and Druggist (02.09.18)**

NHS SOS Major NHS hospitals plans for 'referral ONLY' A&E appointments to ease extreme pressure
TWO major NHS hospitals are planning to make A&E appointments "referral only" in an attempt to ease extreme pressure on services. Walk-in patients at Ipswich and Colchester hospitals will have to visit an urgent treatment centre before being able to access emergency care. Nick Hulme, chief executive of East Suffolk and North Essex Foundation Trust which runs the hospitals, unveiled the plans to HSJ. He said the proposals are part of a major reorganisation - backed by £35million of capital funding - that is hoped will cut A&E activity by 50 per cent. Mr Hulme said: "Instead of [walk-in patients arriving at the] ED… patients will arrive in the urgent care centre and only be referred into ED [if necessary]." **The Sun (02.09.19)**

115,000 missed out on early cancer diagnosis amid NHS staff shortages – charity
More than 100,000 cancer sufferers missed out on early diagnosis in one year, largely due to staffing pressures, a charity has said. Around 115,000 patients in England were diagnosed with stage three or four cancer in 2017, according to Cancer Research UK. The figure, from Public Health England, could be larger as for 19% of patients there is no record of what stage their cancer was diagnosed. The charity said staff shortages are a large contributor to delays and Government inaction is "crippling" the NHS. Emma Greenwood, Cancer Research UK's director of policy, said there is no plan to increase the number of NHS staff as demand rises.
News & Star (02.09.19)

No-Deal Brexit: Doctors union BMA warns of pre-winter exit
A NO-DEAL Brexit on October 31 will have a devastating impact on the NHS as services prepare for the onslaught of winter pressures, a leading doctors' union has warned. In a briefing paper published today, the British Medical Association (BMA) says exiting the EU without an agreement on Halloween could ravage the NHS. Entitled A health service on the brink: dangers of a 'No-Deal' Brexit, it states the "NHS is already routinely overwhelmed by seasonal pressures" and how "the addition of another, complicating factor is certain to dramatically exacerbate that problem". BMA council chairman Dr Chaand Nagpaul said: "Cancelled operations, missed cancer treatment targets and patients in corridors waiting for hours on end to be seen; recent winters have seen unprecedented scenes unfold in our hospitals, GP surgeries and across the NHS, with patients suffering and staff under increasing pressure as resources and capacity struggle to keep up with rocketing demand.
The National (02.09.19)

Defence and National Rehabilitation Centre may treat NHS patients
The £300m Defence and National Rehabilitation Centre (DNRC), at Stanford Hall, Nottinghamshire, was opened in June 2018. The facility deals with military amputees and complex brain injuries. Director Miriam Duffy said an NHS centre could be built on the 360-acre site to share facilities. She added a new facility could service 800 rehab patients a year, more than double the number that are currently catered for in the East Midlands. Nottingham University Hospitals NHS Trust (NUH) is "on track" to make a business case to build the new rehabilitation facility on the military site, she said. It comes after a patient complained about the quality of rehab facilities available to NHS patients in Nottinghamshire. **BBC News (03.09.19)**

Council denies NHS service is to be scrapped in Cornwall because people didn't use it
It has been claimed that the current NHS Health Check scheme is to be scrapped in Cornwall after a report revealed only 21% of eligible people had participated in the scheme. But Cornwall Council has said the county will not be losing the scheme.

The report by GP provider Medicspot compares regional NHS data on the use of Health Checks, a free service offered by the NHS to everyone aged 40 to 74 to prevent premature death from heart disease, stroke, kidney disease and type 2 diabetes.
Cornwall Live (04/09/19)

NHS England appoints Dr Nikita Kanani as primary care medical director
Dr Nikita Kanani has been appointed as NHS England's new primary care medical director. Dr Kanani was previously acting director of primary care for NHS England and Bexley CCG chief clinical officer. She continues to practise as a GP in London. Awarded an MBE for services to primary care in 2017, she was chosen for the role following the resignation of the previous primary care director Dr Arvind Madan last year, after he suggested in his interview with Pulse that GPs should be 'pleased' when small practices close. **Pulse (04.09.19)**

One-off injection will save children from inherited blindness
NHS England is to pay for a cutting-edge genetic treatment that will save children with a rare inherited disorder from going blind. A one-off injection will prevent babies born with poor sight because of an inherited retinal dystrophies disorder from losing their vision entirely, which usually happens during childhood. The list price is high, at £613,410 per patient, but the NHS has done a deal with Novartis, the UK supplier of voretigene neparvovec, also known as Luxturna, and the numbers needing treatment are low. The company estimates that 86 people in England could benefit now, and about three to five babies with the genetic mutation are born every year.
The Guardian (04.09.19)

National CCIO says AI Lab will 'rigorously' test tech to see if it can deliver
During a panel session at NHS Expo on 4 September, Simon Eccles was questioned over the £250m lab, which was announced by the government in August. The lab, which will be run by NHSX and is due to be launched in April 2020, will be used help to develop treatments for cancer, dementia and heart disease. **Digital Health (06.09.19)**

London GPs told to restrict specialist referrals under new NHS 'rationing' plan
GPs will be urged against referring patients to hospital specialists and consultants, and some outpatient appointments will be axed, as part of a controversial programme of NHS "rationing" to be introduced in London. Health chiefs hope the programme, which will affect millions of Londoners, will plug a gaping hole in healthcare budgets by saving more than £60m in the next few months.
The Guardian (08/09/19)

Health tourist leaves behind the highest ever unpaid NHS bill after racking up a staggering £632,000 worth of care
The patient, whose name or nationality are not known, failed to settle their bill for care they received from Mid Essex NHS Trust. Health bosses who manage hospitals in Chelmsford, Braintree and Maldon claim revealing any information about the patient, including the care they had, would be a breach of data protection laws. Patient support groups and campaigners have slammed the NHS for allowing the money to go unpaid with the Health Service already under immense pressure.
Daily Mail (09.09.19)

1 in 4 people take 'addictive' medicines, finds review
Mail Online and The Guardian report that a staggering 1 in 4 people in England – nearly 12 million people – are taking addictive prescription medicines such as antidepressants, sleeping pills and opioid painkillers. They say: "the NHS must take action". The news reports follow a review by Public Health England that assessed the number of prescriptions issued for 5 common medicines in England used to treat depression and anxiety, insomnia and chronic pain.

There was evidence that stopping antidepressants can be linked with withdrawal symptoms such as insomnia, depression, physical symptoms and suicidal thoughts. The other 4 drugs are also linked with risk of dependence and withdrawal symptoms when stopping.
NHS (10.09.19)

NHS to provide treatment to children with rare nervous system condition
The announcement from NHS England comes after the health service struck a deal with drug manufacturers. Batten Disease usually starts in childhood, and can cause seizures, visual impairment, mobility loss and early death. It is a very rare condition, with an estimated 25-40 children living with the condition in England. Drug cerliponase alfa has been shown to extend the lives of youngsters who take it, and now NHS England has secured a deal with the manufacturer of the product to bring the treatment onto the healthcare service at a fair price which the NICE committee was able to recommend as an effective use of NHS resources.
National Health Executive (11.09.19)

NHS pension overhaul announced to help tackle workforce challenges
Ministers from the Department of Health and Social Care (DHSC) have announced a major overhaul of the NHS pension scheme, in efforts to prevent doctors cutting their hours in order to avoid tax penalties. Following recent changes, senior clinicians had seen sizeable potential tax hits for working additional hours, leading to many reducing their time spent on shift, forcing the cancellation of countless operations. The DHSC has launched a consultation on three planned new flexibilities it is seeking to offer GPs, senior nurses and consultants in the hopes of addressing the issue. If implemented, the proposed flexibilities would see these staff able to choose at the start of the tax year how much their pension pot should grow and adjust their contributions accordingly. **National Health Executive (11.09.19)**

Scottish NHS is first in UK to approve new cystic fibrosis drugs
DRUGS that can help extend the life of people with cystic fibrosis (CF) will be made available on the NHS in Scotland after a deal was reached on costs. Scotland is the first part of the UK to approve Orkambi and Symkevi for routine NHS use. It is estimated that about 400 patients will benefit. Among those who welcomed the deal was SNP MP Marion Fellows, whose three-year-old granddaughter has CF. Pharmaceutical firm Vertex International has reached a pricing agreement with the Scottish Government. The drugs will be made available for five years with a “confidential discount”. **The National (12.09.19)**

Britain to use millions of NHS patients' histories to seek cures
Britain is about to start using information about millions of NHS patients’ medical histories to boost the search for cures for ailments such as cancer, asthma and mental illness. Seven new “data hubs” are set to revolutionise medical research by giving doctors, scientists and academics access to unprecedented data about who gets ill in the first place and who responds best to treatment. However, the move is likely to raise anxiety about possible breaches of patients’ privacy and also the commercialisation of patient records because drug companies are among those with whom the data will be shared. **The Guardian (12.09.19)**

Hundreds of patients suffer due to NHS errors
Hundreds of patients have suffered due to NHS blunders so serious they should never happen, new data shows. Some 621 “never events” occurred in NHS hospitals between April 2018 and July this year – the equivalent of nine patients every week, according to data obtained by PA news agency.

The figures show doctors have operated on the wrong body parts and left surgical tools (including surgical gloves, chest drains and drill bits) inside patients many times over. One patient had the wrong toe amputated, while another had the wrong part of their colon removed.
Daily Echo (16.09.18)

Regional NHS News

Dudley's NHS anaesthetists recognised with prestigious award
ANAESTHETISTS at Dudley's NHS trust have become the first in the West Midlands to receive top marks from the prestigious Royal College of Anaesthetists. The team at the Dudley Group NHS Foundation Trust have received the respected accreditation, the Anaesthesia Clinical Services Accreditation (ACSA), in recognition of the department's high standards of care, patient safety and clinical leadership.
Halesowen News (31/08/19)

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Plea for families to discuss organ donation as 50 people in Worcestershire wait for life-saving transplant
MORE than 50 people in the county are still waiting for a life-saving organ transplant, as the NHS launches an urgent plea for donors. Last year, 29 people in Worcestershire had their lives saved by an organ transplant and NHS Blood and Transplant is encouraging families to discuss donating in a bid to attract more donors. **Bromsgrove advertiser (02/09/19)**

Almost half of West Midland cancer patients diagnosed late
Almost half of cancer patients in the West Midlands are diagnosed too late to give them the best chance of survival, according to new calculations. In just one year, around 12,500 cancer patients in the West Midlands are diagnosed late, at stage three or four – according to the figures released by Cancer Research UK. And of these, around 7,500 are diagnosed at the most advanced stage – stage four – leaving them with fewer treatment options and less chance of surviving their disease.
In England, almost half of all cancers are diagnosed late. In one year, this is around 115,000 cancer patients. And of these, around 67,000 people are diagnosed at the most advanced stage. **Express & Star (02.09.19)**

Apology and payout to family of Solihull man found drowned
A mental health trust has apologised to the family of a man found drowned behind a psychiatric hospital. The body of Gary Parfitt, 41, from Solihull, was found in 2017, days after leaving The Oleaster unit in Birmingham while awaiting an assessment. Birmingham and Solihull Mental Health NHS Foundation Trust said care "fell below" what he was entitled to expect. The family's legal team has secured an undisclosed settlement, Irwin Mitchell said. It stated this had been divided between Mr Parfitt's children. **BBC News (04.09.19)**

Sandwell and West Birmingham Hospitals: Maternity deaths probe
The patients at the centre of the probe into Sandwell and West Birmingham Hospitals Trust were deemed high-risk. In one case, a woman was given treatment that worsened her haemorrhaging, the report said. The trust said while there was no evidence the deaths were preventable, it was working to improve services.

External experts in childbirth and midwifery reviewed the women's cases in conjunction with the trust, although the trust and not the independent parties published the report. Its document states "five maternal deaths in our care over a two-year period" were examined, with four women dying while pregnant or during childbirth, and one within a month of giving birth. Outcomes for the babies are not addressed.
BBC News (05.09.19)

Work on Midland Metropolitan Hospital could re-start by end of year
A date of December for work to re-start on the £475m Midland Metropolitan Hospital Carillion was building before its collapse could still be possible if the Government gives the go-ahead in the next six weeks, health bosses have said. Contractor Balfour Beatty and the NHS trust responsible for completing the hospital Carillion are yet to agree on when the £267m project can be finished.
The Business Desk (06.09.19)

Parking charges for New Cross Hospital cancer patients cut
Royal Wolverhampton NHS Trust will now charge a flat rate of 70p per day for the patients, down from £1.50. But an MP in the city has called for the trust to go one step further and get rid of the parking fee altogether. Eleanor Smith, MP for Wolverhampton South West, said: “I’m pleased to announce New Cross Hospital has revised car parking charges for cancer patients. I wrote to the New Cross chief executive David Laughton in June asking for a review of charges after being contacted by a constituent. “I appreciate this reduction to 70p per day – down from £1.50 – is a real saving, and as such will be welcomed.
Express & Star (07.09.19)

Planning begins for £20m Russells Hall A&E revamp
The A&E at Russells Hall in Dudley will be modernised after bid for £20 million of Government funding was successful. Bosses say the emergency department is in desperate need of improvements and hope the changes will help patient flow.
Express & Star (07/09/19)

Fly infestation forced hospital to cancel all operations
A Black Country hospital was forced to cancel all operations due to FLIES. West Midlands Hospital, based in Halesowen, had two operating theatres standing idle on Thursday, August 30 due to the insect infestation. A source close to the private hospital, who wished to remain anonymous, revealed: "The fly infestation meant that all operations had to be cancelled until they were given the all clear." West Midlands Hospital, which also carries out NHS procedures, has confirmed the problem had now been resolved**. Birmingham Live(14.09.19)**

Proton beam therapy target reached for Shifnal woman
A woman, diagnosed with a brain tumour following an eye test, has raised enough money for advanced treatment. Friends and family of Christel Callow, 26, from Shropshire, had hoped to raise £62,000 to have proton beam therapy, which she did not qualify for on the NHS. They have now raised over £73,000, and she hopes to begin treatment later this month.
BBC News (17.09.19)

Birmingham tackling its biggest health challenges with new partnership health policy

A new collaboration plans to speed up and improve research in the four main health challenges faced by the West Midlands, using real-time clinical trials and health data. This will include improvements to cancer care, maternity services, child health, obesity, and dementia. Birmingham Health Partners (BHP) are set to collaborate with the Association of the British Pharmaceutical Industry (ABPI) and its members with a view to put Birmingham at the forefront of developing precision medicines based on varying factors including environmental, lifestyle and genetic.

National Health Executive 17.09.19

Enclosure 10

The Dudley Group
NHS Foundation Trust

Paper for submission to the Board of Directors (Public Session) on Thursday 3rd October 2019

TITLE:	**Clinical, Quality, Safety & Patient Experience (CQSPE) Highlights Reports for 24th September 2019**		
AUTHOR:	**Mary Sexton**	**PRESENTER**	**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

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: 24/09/2019

MATTERS OF CONCERN OR KEY RISKS TO ESCALATE	MAJOR ACTIONS COMMISSIONED/WORK UNDERWAY
• The number of out of date procedural documents has increased from 6 to 23 (policies, SoPs and guidelines). The Committee asked for this to be added to the Corporate Risk Register • Significant issues causing challenges within Cancer Services and Neurology Services which include consultant vacancies. • Blood Labelling concerns. This has a potential for harm. No evidence of actual harm was reported. The Committee recognised the level of anecdotal concern is high and has requested this is subject to review and scrutiny and reported back to the Committee to further understand level of risk.	• Vascular GIRFT Action plan to be formulated with clear demonstration of progress and clear explanations to allow committee to support or challenge decisions • CQC Action plan "Must Do" areas of which 4 are off track and will be monitored by the Committee • Procedure for reviewing out of date procedural documents to be subject to formal review
POSITIVE ASSURANCES TO PROVIDE	**DECISIONS MADE**
• Patient Safety Operational Plan presented and will be reviewed in 12 months to include any national updates	• Medicines Management Annual report was approved by the Committee • 2 policies were ratified as recommended by the Policy Group

Chair's comments on the effectiveness of the meeting:

- Reduction in number of attendees was observed and a number of people entered, and left the meeting
- Divisional coverage was not adequate and a number of Divisional Leads left the
- Important discussion enabling triangulation of issues was helpful and led to discussion being more rounded in consideration of concerns/issues

Enclosure 11

The Dudley Group NHS Foundation Trust

Paper for submission to the Board of Directors on October 3rd 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 COMMITTEE			
Decision	**Approval**	**Discussion**	**Other**
		x	

RECOMMENDATIONS

For the Board to review and note the exceptions presented.

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 CNS Feedback

Specialist Nurse Feedback

Following the first Specialist Nurse away day held on the 8th July 2019, the specialist nurses were asked to complete a feedback questionnaire to help facilitate the development work being undertaken with this group of staff. A subsequent forum was held with this group to discuss the analysis of this data and the work required moving forward Appendix 1 gives an overview of the feedback and the questions generated. A subsequent forum was held on 2nd September and the discussions and actions are currently being finalised and will be shared with the Specialist Nurses at the next forum 21st October 2019.

AHP Update

The National AHP Day is on Monday 14th October AHPs can be nominated in the categories detailed below for the AHP awards

The 6Ps	
Professional	Upholding professional standards of practice and governance in order to provide high quality patient care.
Personalised	Focused on ensuring that the people we support have a great patient experience throughout their AHP journey and colleagues have a great staff experience.
Promoting	Raising the profile of AHPs across the Trust. Promoting the skills and knowledge of AHPs within the Trust to contribute to each patient journey.
Progressive	Forward thinking, looking to the future, evidence based, pioneering, innovative, focused on quality improvement, supporting leadership development and career progression.
Passionate	Creating enthusiastic and passionate people to deliver a great patient experience.
Proactive	To be a driving force in Trust developments. Autonomous in identifying solutions for challenges within individual services and the Trust. Open to collaborative working.

Agency Controls

- All bank and agency requests continue to be assessed by the Divisional Directors with the support of the Divisional Chief Nurses.
- All requests for non-framework agency remain Chief Nurse or Chief Operating Officer only in hours, out of Hours Executive authorisation only.

Recruitment and Retention

- The next corporate recruitment event is scheduled for the 24th September 2019 9.30am - This 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	22nd August 2019	Attendance of 6 both student nurses and experienced staff. Conditional offers for substantive posts made to all 2 and 1 bank staff. 1 unsuccessful and 2 only viewing areas declined interviews.
NNU	10th September 2019	0 attended

The following areas have local events booked for September 2019:

- C1 – 30th September 2019
- C8 – 30th September 2019

Recruitment Activity

- At the time of the report, a total of 22.52 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)
- 26.8 WTE Dudley and 15.6 WTE external graduates ***(total 42.4 WTE)*** have been recruited and offered posts within the Acute, Community and Paediatrics areas for September 2019, with a further 2 WTE Dudley and 0.64 WTE external students ***(total 2.64 WTE)*** due to commence in October and 1 WTE Dudley and 1 WTE external student ***(total 2 WTE)*** in November 2019.

(This is a raw data search of graduates engaged in the process at the time of the report).

- This equates to a ***total 47.04 WTE*** commencing October/September/November 2019 at the time of the report. This figure is lower than last month's report due to withdrawals from the graduate programme.

Professional Development

- The recently vacated post of Non-Medical Education Lead has been appointed to on a six month secondment basis. The new post holder is Philippa Brazier previously Professional Development Lead and Freedom to Speak up Guardian.

➢ **Trainee Associates Project**

- Rostering of the TNAs has been reviewed and it is now planned to move TNA's onto a band 2 trainee post rather than presently sat in a band 2 CSW post. This will enable greater control in achieving the required supernumerary status

➢ **Pre-Registration**

- The mentor database review n in underway Transferring across to a new database to link to SSSA (student support supervision and assessment) standards
- Increased capacity across Wolverhampton and Worcester as per HEE funding initiative:
- University of Wolverhampton Adult up to 82; child 6;MH 4 across (2 cohorts)
- University of Worcester Adult up to 32; Midwifery 5
- It has not been confirmed if the increase of numbers has been recruited to by all of the universities.
- A meeting with BCU is planned to discuss potential student placements for 2020.
- University of Wolverhampton have escalated concerns re the CQC report in particular related to students allocations to Imaging and ED. Awaiting outcome of discussions with University Heads of Department and Trust Nursing Heads
- There is one student escalations investigation outstanding in Trust related to an assignment written by a student following his placement
- Student placement evaluations remain positive on the whole, one areas of concern is C7 an action plan is in place to address student support A meeting is scheduled with the Lead nurse and the Pre-registration team on 24/9/19

- The new curriculum commenced September. The first cohort is due out for observation week 18/11/19 their fulltime HUB placements will start from 27/1/20
- There is one Return to Practice student due to commence from BCU at the end of September 2019. The previous 2 RTP students supported have now been recruited to the Trust

➢ **Post Registration**

- The Band Development programme started on 4th September with 17 candidates
- The Senior Band 5 development programme will commence on the 2nd October, currently there are 12 participants confirmed
- The Graduate programme starts on the 30th September with provisionally 42 newly qualified nurses to start the Trust

Safeguarding

- The start date for the Head of Safeguarding post has now been confirmed as the 3rd December 2019.
- The Deputy Chief Nurse is maintaining operational management of the safeguarding team until the new post holder commences

Falls

- Unfortunately we have seen an increase in the number of falls this month. No specific area or trend has been noted
- There have been no falls with harm in August
- The Fall Lead has sent an email to all Lead Nurses to make them aware of this and raise it with staff at the Huddle Boards

Tissue Viability

- There have been no Category 3 or 4 pressure ulcers reported as a serious incident in either in the hospital or community during August 2019
- The CCG completed a visit to review pressure ulcer management 16th -18th September. Initial feedback from this was extremely positive in particular B2 Hip and Trauma, C5 and Community

Infection Control

- The Infection Control Lead post is back out to advert, after a number of suitable candidates withdrew The service is currently being managed by one of the senior band 7s acting up with the support of the previous post holder doing two days a week on the bank

IMPLICATIONS OF PAPER:

IMPLICATIONS FOR THE CORPORATE RISK REGISTER OR BOARD ASSURANCE FRAMEWORK
(*set out narrative here)*

RISK BAF 1A Not effectively engaging with patients in their care or involving them in service improvement	**Y**	**Risk Description:** We don't always effectively engage with patients in their care or involve them in service improvement as a result we fail to communicate with them effectively resulting in a poor patient experience which means patient's will not see us as a provider of choice.

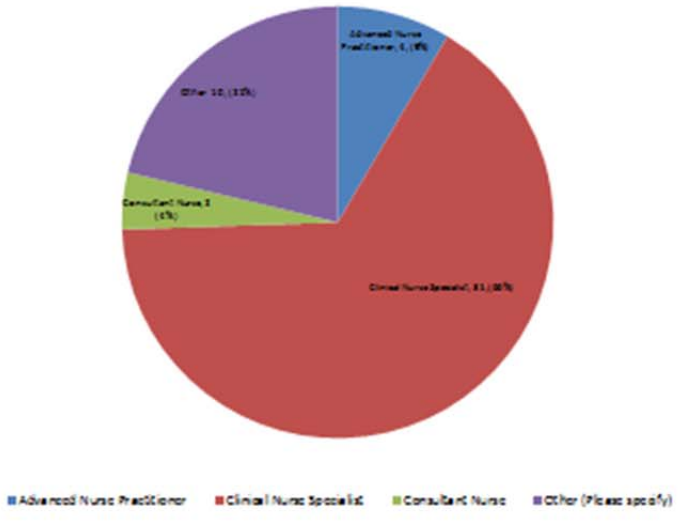
	Risk Register: Y/N		**Risk Score: 12**
COMPLIANCE and/or LEGAL REQUIREMENTS	**CQC**	**Y/N**	**Details:**
	NHSI	**Y/N**	**Details:**
	Other	**Y/N**	**Details:**
REPORT DESTINATION	**EXECUTIVE DIRECTORS**	**Y/N**	**DATE:**
		Y/N	**DATE:**
		Y/N	**DATE:**

Appendix 1

Feedback Results

- The online survey was sent to 64 specialist nurses
- To date 47 surveys have been returned a return of **73%**
- In addition to the 64 nurses sent the original survey recent ESR data identified an additional 56 that have a specialist role that are not currently being captured and have not been engaging in the recent specialist nurse activity.
- Feedback from these staff will be sought separately

Which title best describes your role

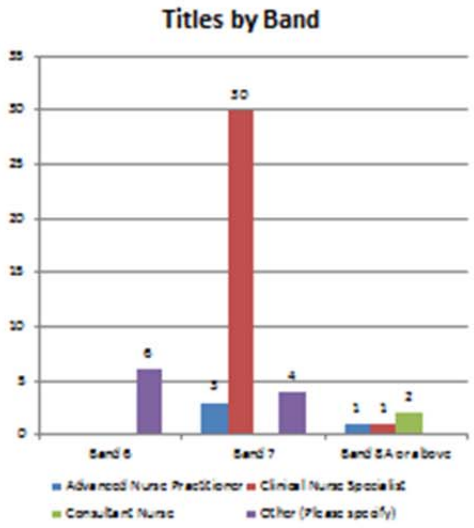


Other

Which title best describes your role when *Other* Selected	Count
Clinical Governance Lead for Children's Services	1
End of Life Care Facilitator	1
Lung Cancer Specialist Support Sister	1
Ophthalmic Nurse Practitioner	1
Respiratory Nurse Specialist	1
Specialist Sister	1
Support sister	1
Trust Sepsis Nurse Practitioner	1
Trust Sepsis Nurse Practitioner (trainee ACP)	1
VTE Prevention Nurse	1
Grand Total	**10**

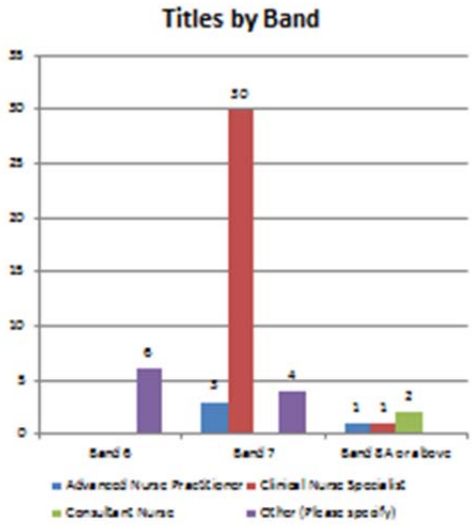
- There are numerous titles used to describe specialist nurses
- What are the origins of these titles?
- There are specialist nurse that do not easily fit into the CNS/ACP OR Consultant mould, where is the support for these roles?

Titles by band



- 41 out of 41 respondents are paid at band 7 or above
- The majority of CNS s are paid at band 7
- Only 4 of the respondents are paid at 8a or above
- 6 of the 10 respondents who do not class themselves as CNS/ANP or Consultant Nurse are paid at band 7
- Recommendation for the ANP role is an 8a following completion of training.

Titles by band



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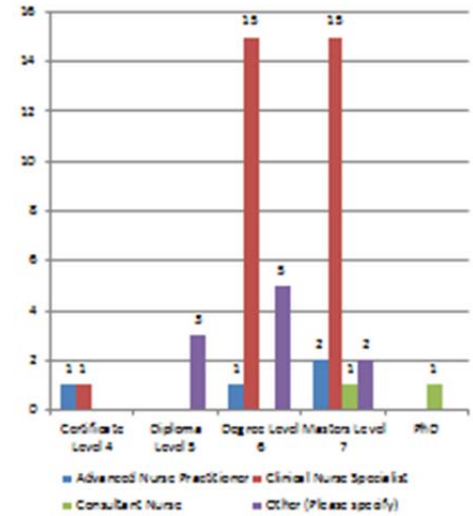
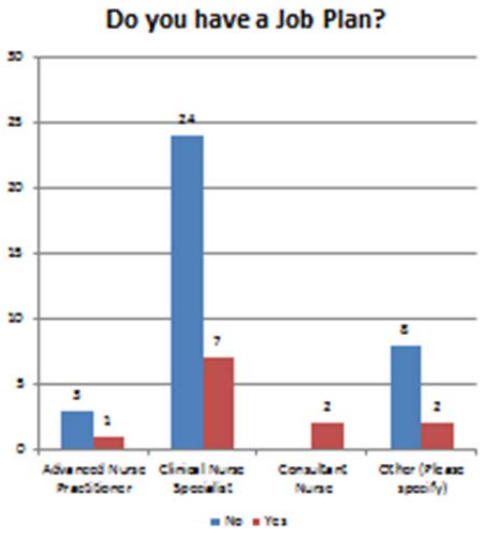
- Recommendation for the ANP role is an 8a following completion of training.

Academic Level



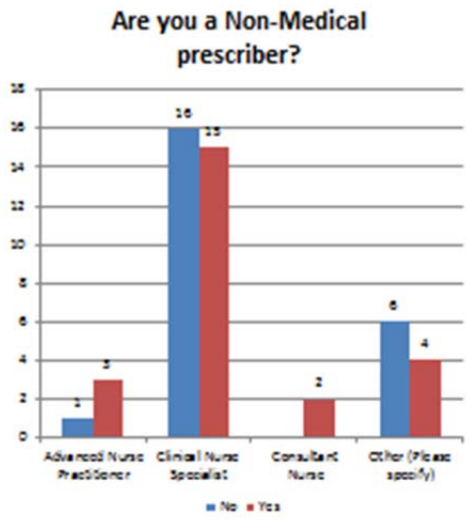
- Only 5 of our respondents are currently below degree level.
- This shows an appropriate level of academia has been achieved by the majority of our specialist staff
- Of the remaining 5, it recognised within the Trust that these individuals will be functioning clinically with a high level of expertise and may wish to consider demonstrating their academic level of achievement with an academic portfolio of achievement that could be APELed .

Job Plans



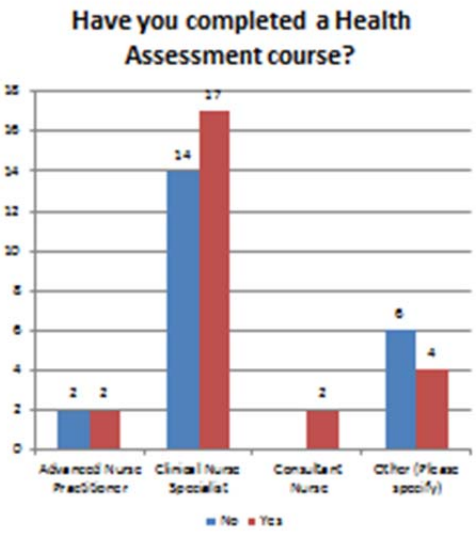
- Only 12 respondents have a job plan
- Why?
- Are job plans necessary?
- Would it be beneficial to complete a job planning template?

Prescribing



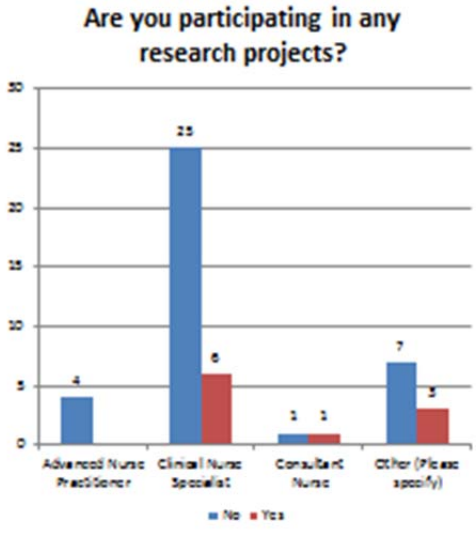
- More than 50% of our respondents are prescribers.
- Its clear that this is considered integral to the role of the specialist nurse.
- Of those who haven't are there any barriers to this?

Health Assessment



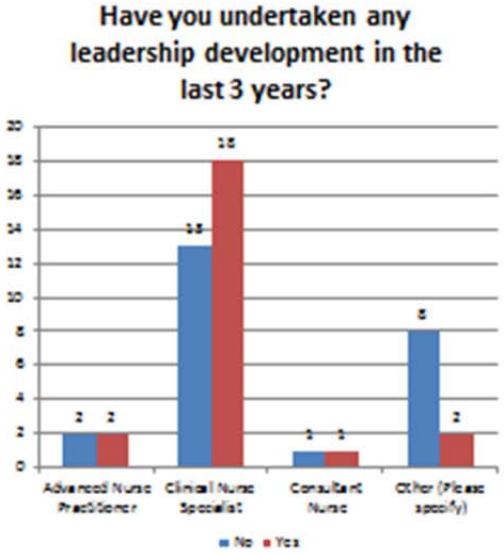
- Over 50% of respondents have completed health assessment
- This is a pre-requisite for prescribing
- For those who do not prescribe assessing patients is an integral part of the majority of specialist role
- Have the remaining respondents been assessed as competent in health assessment and if so how is this evidenced?

Research



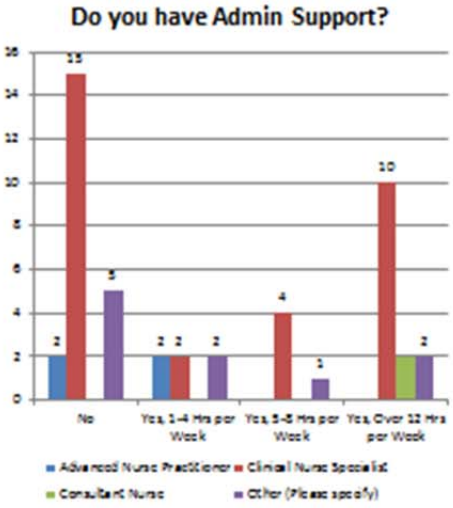
- Disappointingly research participation is low
- Are specialist nurses afforded sufficient time to participate?
- Are specialist nurses sufficiently confident and competent to undertake research?
- What needs to be put in place to support this?

Leadership



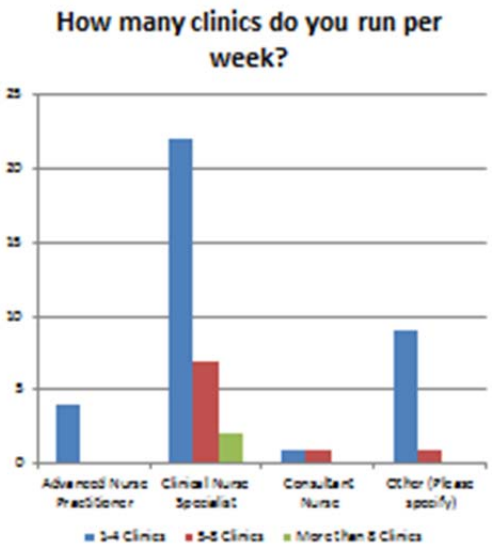
- Encouragingly nearly 50% of respondents have undertaken some leadership development in the last 3 years.
- Would it be valuable to make this a focus for an upcoming forum?

Admin Support



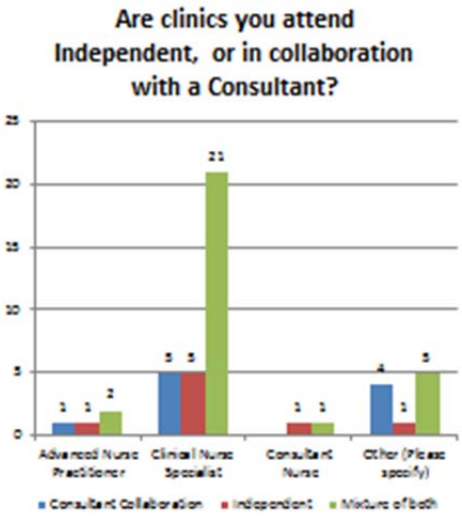
- Nearly 50% of our respondents have no access to admin support.
- Of the remaining respondents 21 % have access to over 12 hours admin support per week.
- Can we pool resources to support each other?

Clinic Activity



- Clinic activity is varied among the respondents
- Majority of specialist nurses complete between 5-8 clinics per week with only 2 respondents doing more than 8 clinics.
- Is clinic activity above or below expectations

Clinic Activity



- Over 50% of respondents engage in both nurse led and Consultant led clinics
- Not all specialist nurses engage in clinic activity
- 8 of our respondents run nurse led clinics only.
- Is there scope for more nurse led clinics?
- Are we capturing all of the activity from the clinics we run, is there potential for additional revenue?

Conclusion

- Response to the survey was very positive and gives us a collective overview
- There is clear engagement from specialist staff
- There is evidence of academic progression
- Support is required to facilitate more commitment to research projects
- The completion of clear up-to-date job plans needs to be facilitated
- Clinic activity needs to be reviewed to ensure that all revenue potential is being realised

Enclosure 12

The Dudley Group NHS Foundation Trust

Paper for submission to the Board of Directors on 3 October 2019

TITLE:	**Update from the Finance and Performance Committee**		
AUTHOR:	Jonathan Hodgkin F & P Committee Chair	**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 COMMITTEE

Decision	Approval	Discussion	Other
		X	

RECOMMENDATIONS:

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

CORPORATE OBJECTIVE:

S05 Make the best use of what we have
S06 Plan for a viable future

SUMMARY OF KEY ISSUES:

Summary report from the Finance and Performance Committee meeting held on 26 September 2019.

IMPLICATIONS OF PAPER:

IMPLICATIONS FOR THE CORPORATE RISK REGISTER OR BOARD ASSURANCE FRAMEWORK

RISK	**Y**		**Risk Description:** Failure to remain financially sustainable in 2019/20 (COR1012) Failure to maintain liquidity in 2019-20 and beyond (COR1011)
	Risk Register: Y		**Risk Score:** 20
COMPLIANCE and/or LEGAL REQUIREMENTS	**CQC**	**Y**	**Details:** Well Led
	NHSI	**Y**	**Details:** Achievement of Financial Targets
	Other	**Y**	**Details:** Value for Money
REPORT DESTINATION	**EXECUTIVE DIRECTORS**	**N**	**DATE:**
	WORKING GROUP	**N**	**DATE:**
	COMMITTEE	**N**	**DATE:**

The Dudley Group NHS Foundation Trust

UPWARD REPORT FROM FINANCE AND PERFORMANCE COMMITTEE

Date Committee last met: 26 September 2019

MATTERS OF CONCERN OR KEY RISKS TO ESCALATE	MAJOR ACTIONS COMMISSIONED/WORK UNDERWAY
• Good performance against statutory performance measures with the exception of Emergency Access Standard (EAS), which was 82.5% for August and the cancer 2 week wait was also failed. • Quality of the narrative in risk reports does not permit full scrutiny.	• Regular reporting to Finance and Performance Committee of performance of different components of EAS and impact of recovery actions. • Finance and Divisions to develop plans for implementation of SLR tool.
POSITIVE ASSURANCES TO PROVIDE	**DECISIONS MADE**
• Broadly on track to deliver internal plan. • Discussions underway with Dudley CCG to improve financial position. • Recovered a third of potential £200,000 lost income in Emergency Department following introduction of Sunrise.	• Agreed to recommend to Board the extension of the Trauma and Orthopaedic LLP for four weeks. • Agreed to recommend to Board approval of procurement waiver in relation to the Trust's population health interoperability platform. Noted that this will be referred to the Chair and CEO for approval under emergency powers.
Chair's comments on the effectiveness of the meeting: Detailed discussion around EAS, Brexit preparedness and Finance. Very informative demonstration of Service Line Reporting tool.	

Enclosure 13

The Dudley Group
NHS Foundation Trust

Paper for submission to the Board of Directors on 3 October 2019

TITLE:	**Charitable Funds Committee Summary Report**		
AUTHOR:	Julian Atkins - Committee Chair	**PRESENTER:**	Julian Atkins – Committee Chair

CLINICAL STRATEGIC AIMS

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

ACTION REQUIRED OF BOARD:

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

OVERALL ASSURANCE LEVEL

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

RECOMMENDATIONS FOR THE BOARD:

The Board is asked to note the contents of the report.

CORPORATE OBJECTIVE:

S01 – Deliver a great patient experience
S05 – Make the best use of what we have

SUMMARY OF KEY ISSUES:

Summary of key issues discussed and approved at the Charitable Funds Committee on 29 August 2019.

IMPLICATIONS OF PAPER:

RISK	**N**		**Risk Description:**
	Risk Register: N		**Risk Score:**
COMPLIANCE and/or LEGAL REQUIREMENTS	**CQC**	**N**	**Details:**
	NHSI	**N**	**Details:**
	Other	**Y**	**Details:** Charity Commission

The Dudley Group NHS Foundation Trust

UPWARD REPORT FROM CHARITABLE FUNDS COMMITTEE

Date Committee last met: 29 August 2019

MATTERS OF CONCERN OR KEY RISKS TO ESCALATE

- The Fundraiser's report detailing the breakdown of income and expenditure was missing from the overall fundraising report. It was requested that this be included in all future reports.

MAJOR ACTIONS COMMISSIONED/WORK UNDERWAY

- Planning to support the ED Appeal is underway. The Appeal will be run over two years and the initial plan is to raise £100,000 each year. The Committee felt this could be more ambitious and will be subject to further review.
- Several fundraising events were being planned for the remainder of 2019. These included an NHS rugby match at Stourbridge Rugby Football Club in September, a 'Will Fortnight' in October and a 'Sparkle Party' in November.

POSITIVE ASSURANCES TO PROVIDE

- Total fund balances at the end of July 2019 stood at £2.127m.
- For the period ending 31st July, income received was £100,918 whilst expenditure committed was £161,979.
- The balance available to spend across the general funds totalled £94,857.

DECISIONS MADE

- One funding request was approved – two Philips V4 observation monitors at a cost of £2,772.
- It was agreed that a bid for £8,400 for staff engagement and inclusion activities should be funded from a non-pay revenue budget on a recurrent basis instead.
- It was noted that monies (£28,208) to fund a CAMNS cubicle (a safe space cubicle for children and young people with mental health and behavioural crisis) had been allocated from capital funds and that charitable funds were no longer required.
- It was agreed that a mouth care project which had previously been allocated funds should become a Trust wide project rather than be limited to the initial trial wards.

Chair's comments on the effectiveness of the meeting:

The meeting was effective and attendance was much improved from the previous meeting. Of particular note was the Committee's request for greater ambition in respect of fundraising targets.

Enclosure 14

The Dudley Group NHS Foundation Trust

Paper for submission to the Board of Directors on 3rd October 2019

TITLE:	**Finance Report**		
AUTHOR:	Tom Jackson Director of Finance	**PRESENTER**	Tom Jackson Director of Finance

CLINICAL STRATEGIC AIMS

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

ACTION REQUIRED OF COMMITTEE

Decision	Approval	Discussion	Other
		X	

RECOMMENDATIONS:

To note and discuss the contents of the report

CORPORATE OBJECTIVE:

SO3 Drive Service Improvements, innovation and transformation
SO5 Make the best use of what we have
SO6 Plan for a viable future

SUMMARY OF KEY ISSUES:

Update for the Board on the financial position of the Trust at the end of August 2019 (month 5)

IMPLICATIONS OF PAPER:

IMPLICATIONS FOR THE CORPORATE RISK REGISTER OR BOARD ASSURANCE FRAMEWORK

RISK	**Y**		**Risk Description:** Failure to remain financially sustainable in 2019/20 (COR1012) Failure to maintain liquidity in 2019-20 and beyond (COR1011)
	Risk Register: Y		**Risk Score:** 20
COMPLIANCE and/or LEGAL REQUIREMENTS	**CQC**	**Y/N**	**Details:** Well Led
	NHSI	**Y/N**	**Details:** Achievement of financial plan
	Other	**Y/N**	**Details:** Value for money
REPORT DESTINATION	**EXECUTIVE DIRECTORS**	**Y/N**	**DATE:**
	WORKING GROUP	**Y/N**	**DATE:**
	COMMITTEE	**Y/N**	**DATE:**

The Dudley Group
NHS Foundation Trust

Finance Report – Month 5 2019/20

1) Purpose

The purpose of this report is to update the Board on 2019/20 financial performance as at Month 5.

2) Income and Expenditure

The financial and operational plans for 2019/20 were submitted to NHSI with a side letter agreed by the Board identifying the key risks to delivery. The most significant risk being the delivery of a £22.4m (6%) CIP. On 29th March 2019 the Chief Executive and Director of Finance attended a Dudley system planning escalation meeting with senior representatives from NHSE/I, the CCG and the STP. The tone was broadly supportive of the Trust's position and the size of the financial challenge it was facing in 2019/20. On 4th April NHSE/I wrote to the STP Executive Lead to acknowledge the £8m residual financial gap and to request 5 actions of the local system to support the delivery of the Trusts plans. The actions included; an update of the system deficit, a consolidated system wide efficiency plan, an action plan to close the gap and further actions on a system footprint. A further system review meeting is planned for 30th September 2019.

The year to date position is a £5.3m deficit with assumed additional resources from the Provider Sustainability Fund of £2.2m giving a £3.0m year to date deficit. This is £2.3m worse than the plan to deliver the control total target of £2.8m.

3) Cashflow

The cash position is monitored very closely and every effort is being made to maintain liquidity. The August cash position is better than planned and indeed is the highest this financial year. However, the Trust is still forecasting a requirement for additional borrowing as we work through the year.

4) Financial Improvement Programme

The Financial Improvement Programme continues to provide oversight and governance to an enhancement of waste improvement measures and spend controls as we seek to bridge the gap to control total delivery. Additional controls were implemented from 1st July, largely around workforce as we push to reduce premium payments. The CIP is now planned to deliver £15m. Taken with other baseline movements, the financial gap for 2019/20 remains in the region of £8m. For the third quarter (October to December) the programme will seek to embed current grip and control measures, implement budgetary rectification plans and implement further transformational waste improvement schemes. We continue to have constructive conversations with partners to address the structural financial challenges faced by the Trust. There are encouraging trends emerging in the use of agency staff and the underlying financial position.

5) Summary

The Trust continues to work very hard to contain expenditure. This has led to encouraging in year movements in cashflow, CIP delivery, agency spend and the underlying position. However, there remains a £8m financial gap this year as set out in the initial planning discussions. STP and commissioner support will be required to address the in-year and structural financial position.

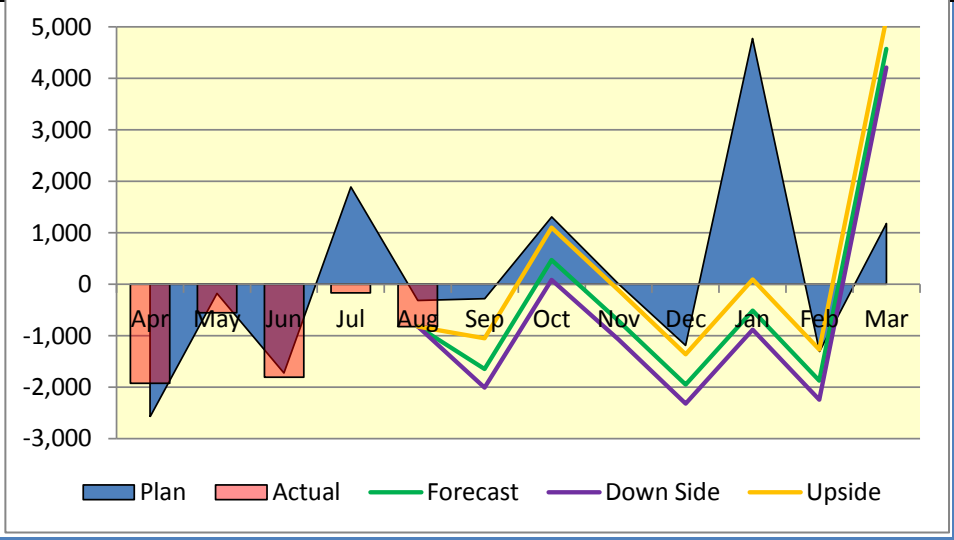
Tom Jackson
Director of Finance

TRUST BOARD FINANCIAL SUMMARY DASHBOARD — AUGUST 2019

TRUST I&E PERFORMANCE (PRE & POST PSF) as at AUGUST 2019

	CURRENT MONTH			
	PLAN	ACTUAL	VARIANCE	
INCOME	£30,763	£31,275	£512	
EXPENDITURE	-£31,078	-£32,098	-£1,020	
TOTAL PRE PSF	**-£315**	**-£823**	**-£508**	
PSF	£431	£431	£0	
TOTAL POST PSF	**£116**	**-£392**	**-£508**	
	CUMULATIVE TO DATE			
	PLAN	ACTUAL	VARIANCE	
INCOME	£156,897	£156,985	£88	
EXPENDITURE	-£159,800	-£162,253	-£2,453	
TOTAL PRE PSF	**-£2,903**	**-£5,269**	**-£2,366**	
PSF	£1,831	£2,207	£376	
TOTAL POST PSF	**-£1,072**	**-£3,062**	**-£1,990**	

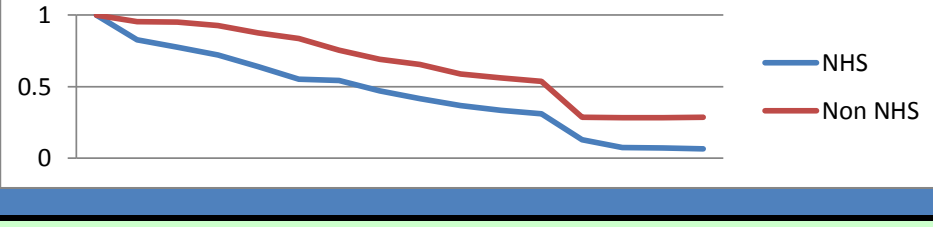
YEAR END FORECAST 2019/20 (net of PSF)



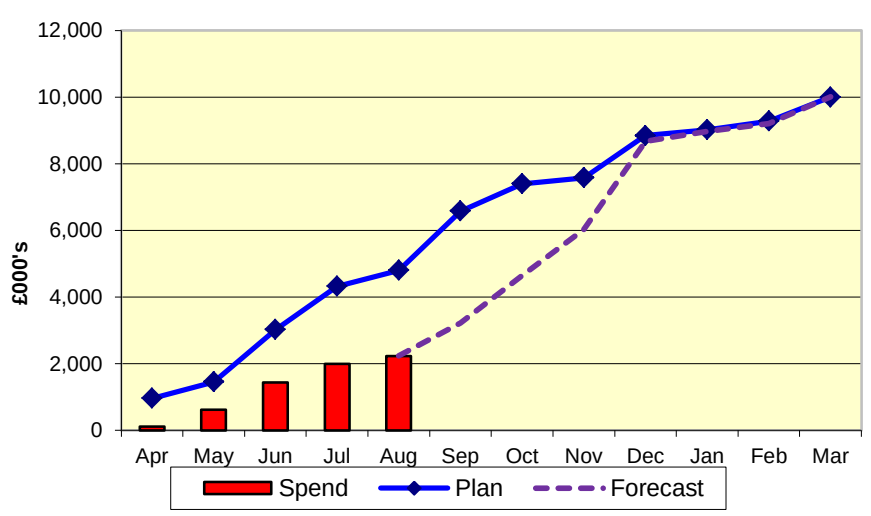
CONTROL TOTAL

	DIST. FROM CONTROL TOTAL			
	Plan	Current	Cumul.	Forecast
NET POSITION	£8,055	-£508	-£1,990	-£13,616
Less PSF	-£6,462	£0	-£376	£5,117
Less TECHNICAL	-£4,424	-£29	£76	£161
CONTROL TOTAL	**-£2,831**	**-£537**	**-£2,290**	**-£8,338**

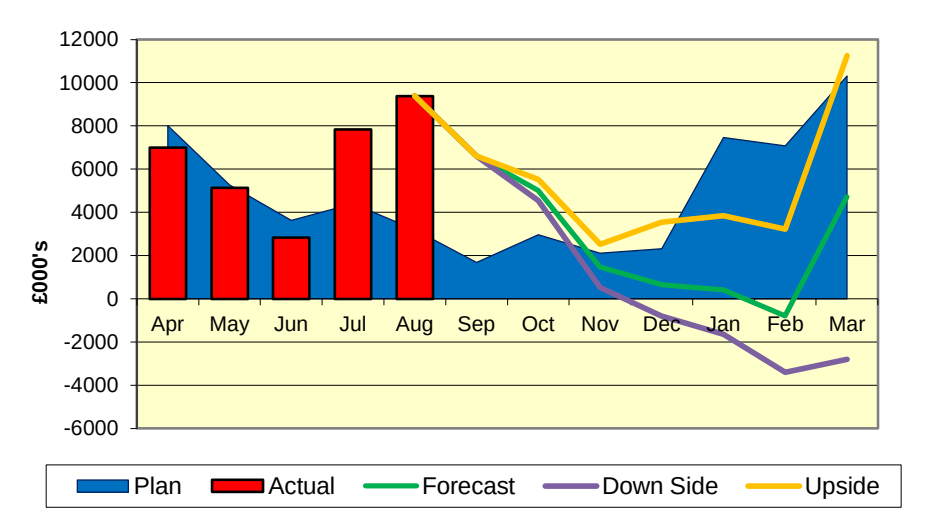
UNDERLYING POSITION



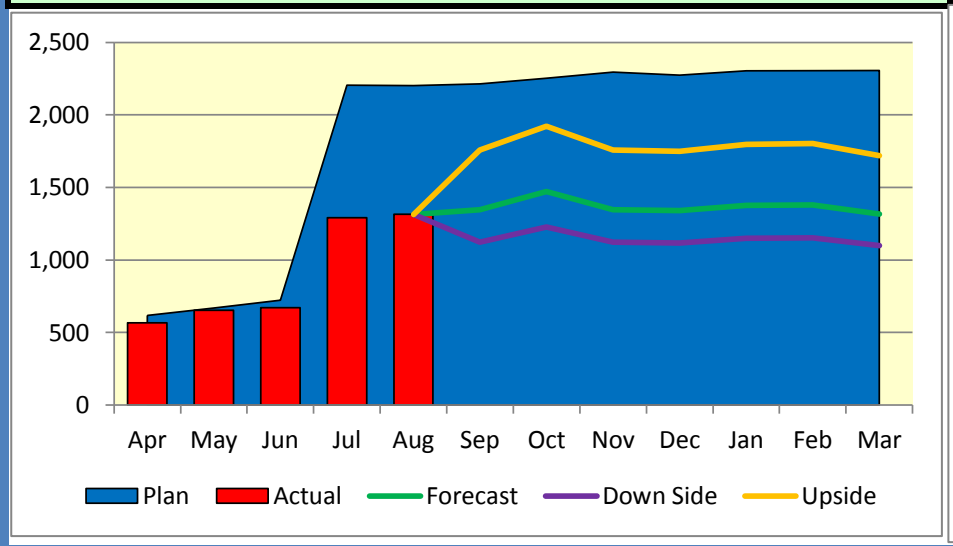
CAPITAL EXPENDITURE 2019/20



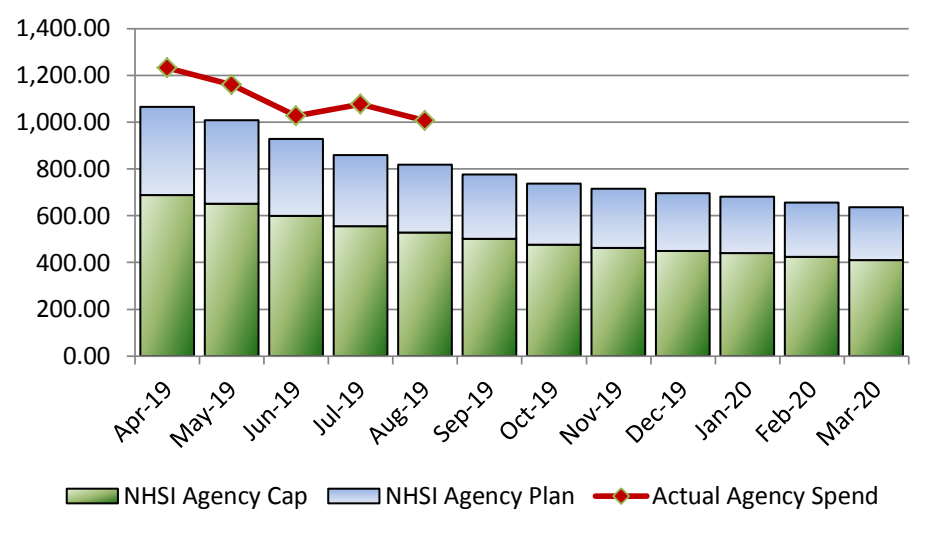
CASH FLOW 2019/20



CIP PERFORMANCE 2019/20



AGENCY PERFORMANCE 2019/20



RISK RATINGS

	Q2 PLAN	YTD	
CAPITAL SERVICE COVER RATING	4	4	
LIQUIDITY RATING	4	4	
I&E MARGIN RATING	3	4	
CONTROL TOTAL VAR RATING	1	3	
AGENCY RATING	4	4	
RISK RATING AFTER OVERRIDES	3	4	

BETTER PAYMENT PRACTICE CODE (APRIL 2018 TO DATE)

DIVISIONAL/CORPORATE VARIANCE

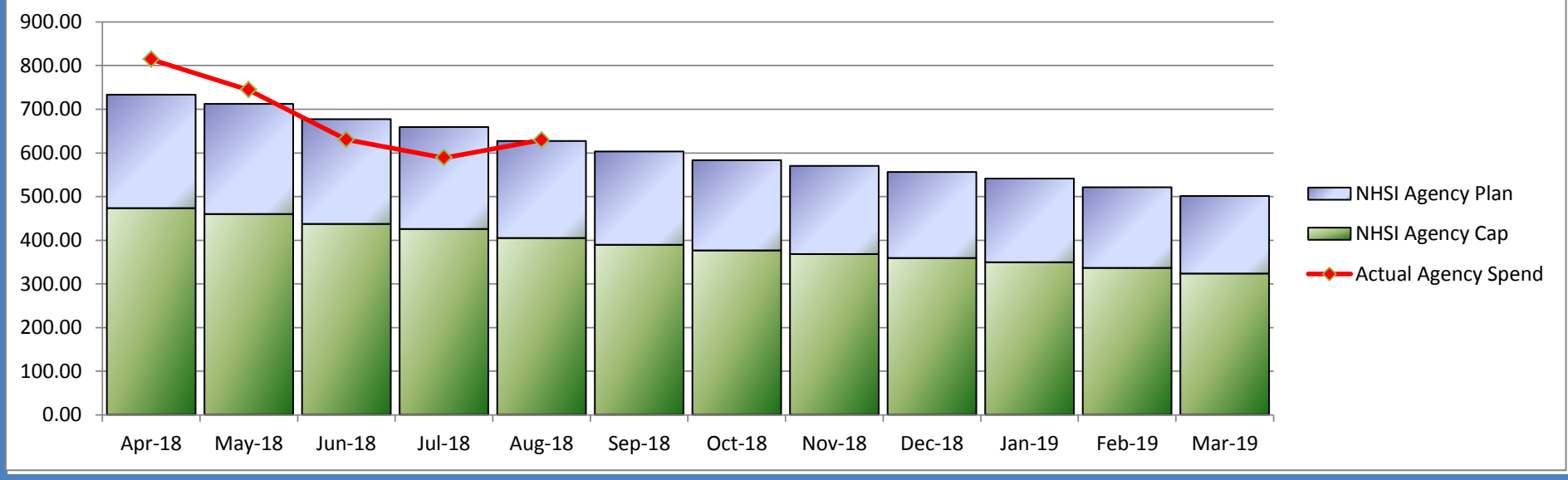
	CURRENT	YTD	FORECAST	
MEDICINE	£368	£812	£733	
SURGERY	-£189	-£1,917	-£2,300	
CLINICAL SUPPORT	£176	£343	£67	
CORPORATE	£286	£1,178	£1,897	
TRUST WIDE	-£326	£38	-£6,175	
RESERVES	-£848	-£2,575	-£7,702	
OTHER	£26	£131	-£114	
TOTAL	**-£508**	**-£1,990**	**-£13,593**	

TRUST TOP 10 OVERSPENDING BUDGETS AS AT AUGUST 2019

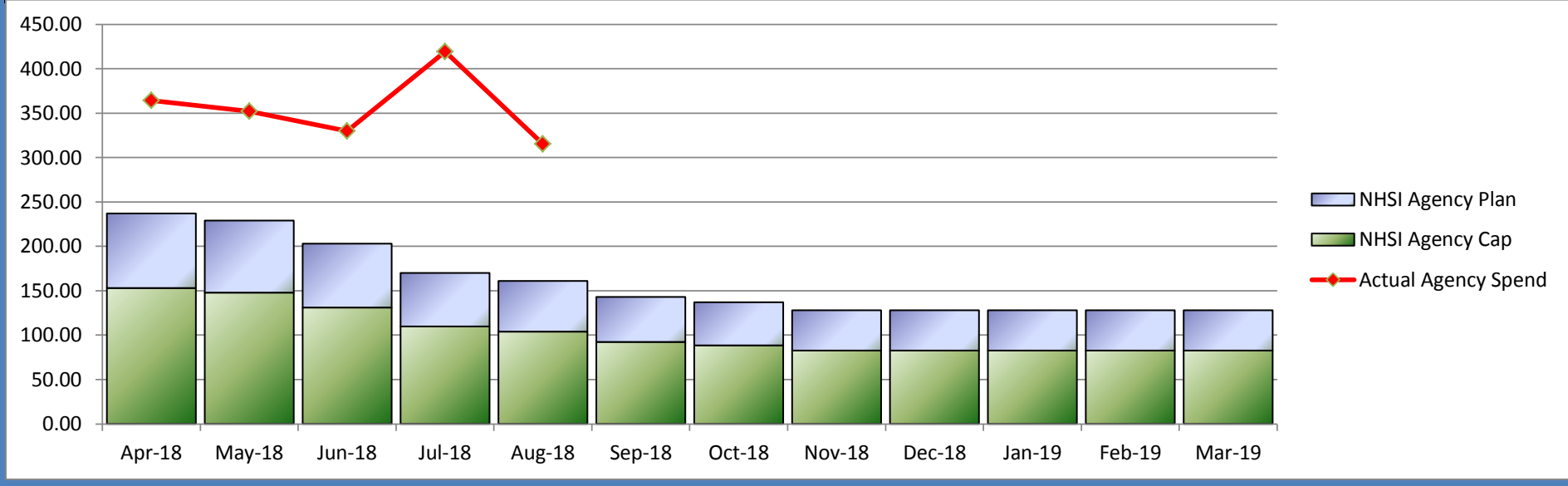
BUDGET CENTRE	DIRECTORATE	OVERSPEND	%
Surgery Division Contract Inc	Surgery Division Cont Income	-£2,044,976	-3%
Mgt Team - Theatres	Theatres Anaes and Crit Care	-£208,350	-58%
Medical Staff Acute Medicine	Urgent Care	-£159,880	-6%
Information Tech Data Centre	Information Technology	-£157,049	-15%
Medical Staff General Medicine	Urgent Care	-£153,843	-74%
Ward C3	Nursing Medicine	-£131,769	-10%
Surgery Mgt Team	Division Management	-£97,765	-24%
RHH Day Case Theatre&Recovery	Theatres Anaes and Crit Care	-£95,743	-12%
Medical Staff Emergency Dept	Urgent Care	-£82,527	-2%
Health Records	OPD and Health Records	-£80,541	-7%

TRUST BOARD AGENCY SUMMARY DASHBOARD **AUGUST 2019**

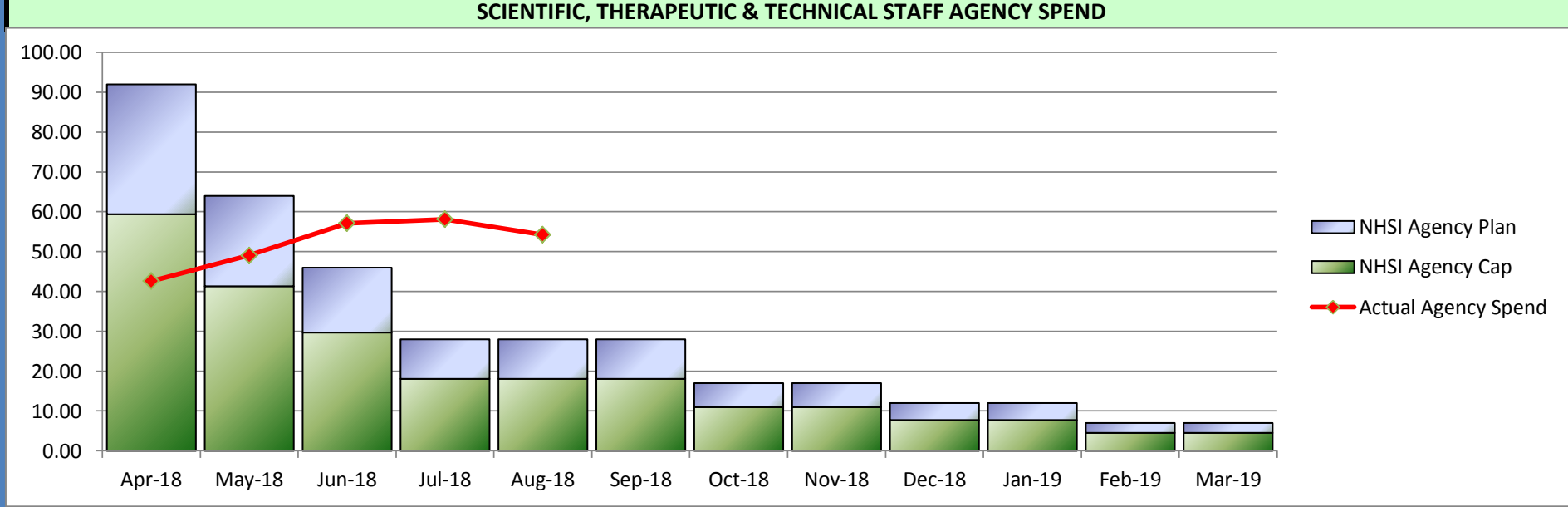
QUALIFIED NURSING STAFF AGENCY SPEND



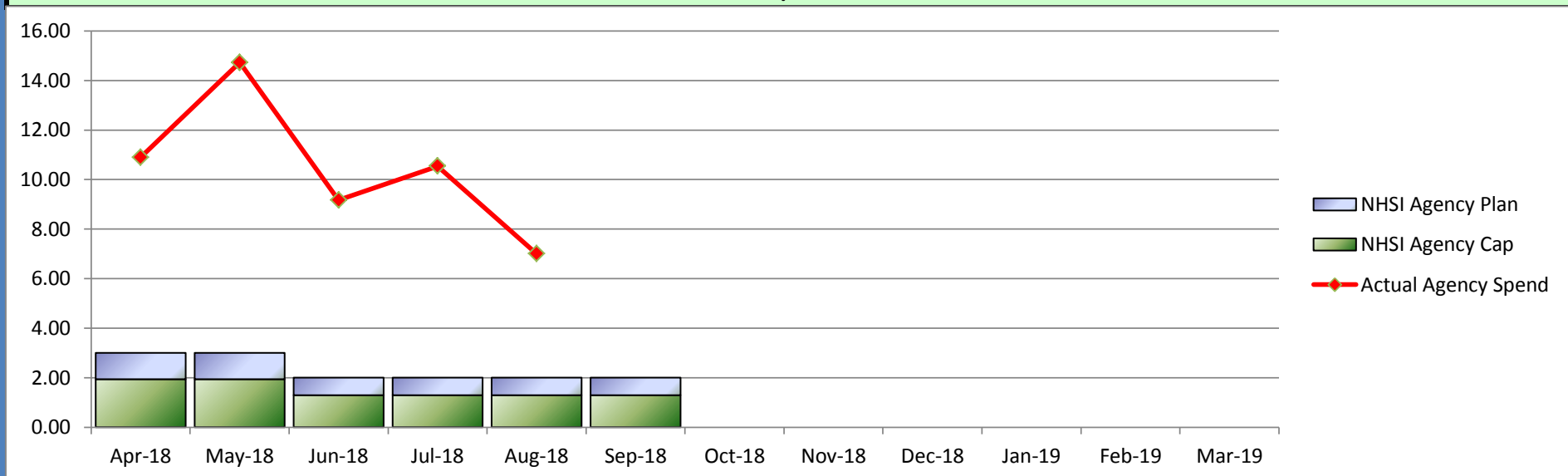
MEDICAL STAFF AGENCY SPEND



SCIENTIFIC, THERAPEUTIC & TECHNICAL STAFF AGENCY SPEND



ADMIN & CLERICAL STAFF/MANAGER AGENCY SPEND



Enclosure 15

The Dudley Group
NHS Foundation Trust

Paper for submission to the Public Board
On 3rd October 2019

TITLE:	**Integrated Performance Report for Month 5 (August) 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 August 2019 with a performance of 99.35% against the target of 99% patients seen in less than 6 weeks. It should be noted that this is the best performance against the standard for some time, and is a reflection of the level of effort made by Imaging and other diagnostic services to ensure patients receive their diagnostic tests in line with the National target. In line with previous months the largest concentration of breaches were to be found within MRI, which accounted for 31 out of a total of 47 breaches. This signifies a reduction in the MRI backlog in line with the performance improvement trajectory, with further additional GA MRI and Cardiac MRI lists planned for September 2019 to reduce this further.

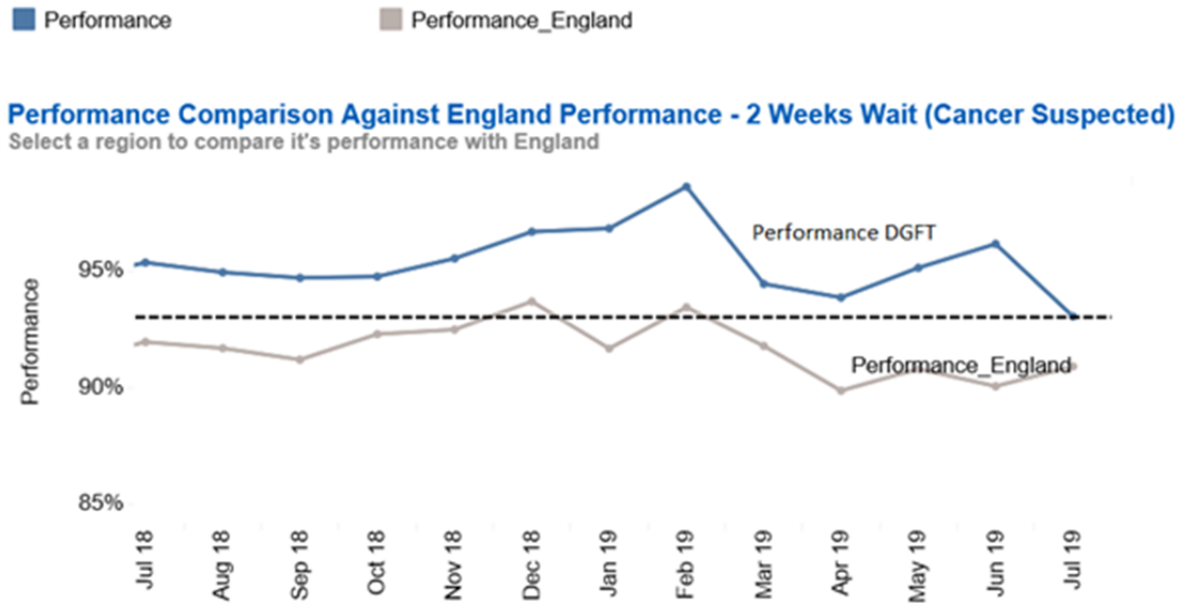
The Imaging Department has now commenced the replacement of the first CT scanner at the Russells Hall Hospital site which is due to complete in November 2019. During this period significant effort is being made to ensure continued delivery of the DM01 standard at the same time as maintaining an effective inpatient and ED service.

Cancer Performance

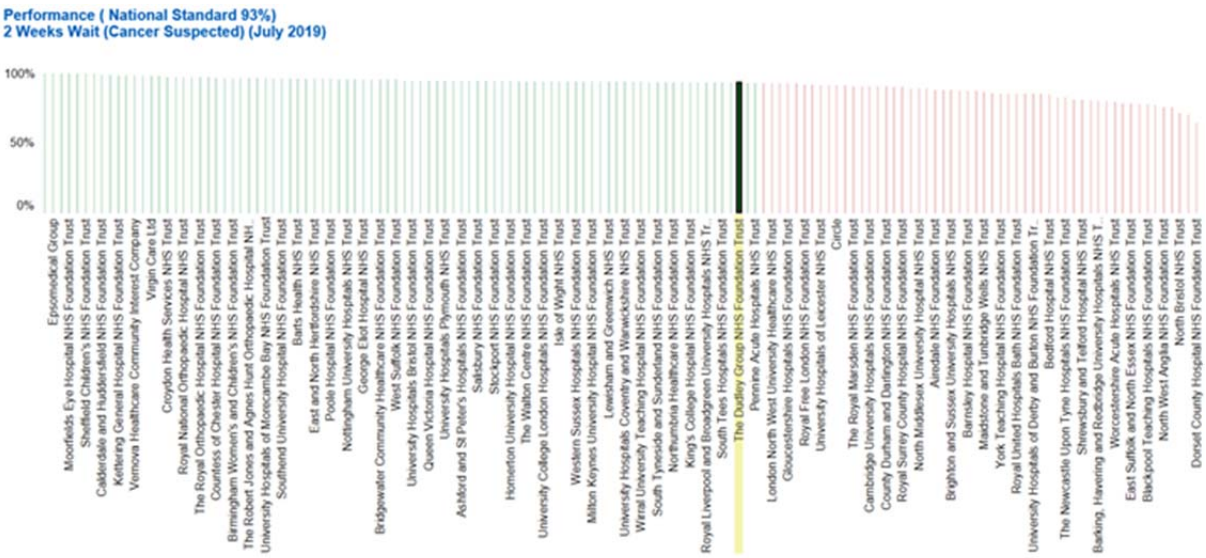
The Trust's performance against the National cancer standards continues to be very positive and at the time of writing, subject to final validation and agreement with local tertiary centres, the Trust has achieved 9 out of 10 targets in August 2019, the exception being two week wait (2ww). As requested at last month's Finance and Performance Committee a deep dive was conducted into the reasons for this failure, and this can be found below. It should be noted that the challenges faced in August continued somewhat into September, and at the time of writing the position of 2ww for September remains extremely tight, however is also subject to validation.

2 Week Wait Suspected Cancer – August Performance Deep Dive

England average performance against the 93% 2 week wait standard has been below target since January 2019. Historically Dudley performs well against the target and challenges felt nationally are reflected in our own local performance as shown in the graph below. Note that generally the trends mirror each other.



We had significant local issues in July that lead to a decline in performance that was not in-line with the national performance. These issues did not result in us failing the standard but our benchmarked performance for July was in the lower half of the table which is an unusual position for Dudley.



The local problems have continued into August, causing the 2ww performance to fail the target of 93%. Unpublished data for August is showing performance at 91.4% with 125 breaches against 1453 patients seen in target.

In order to achieve 93%, a further 333 appointments would need to have been completed (1786 total), which is much higher than the normal rate of referrals received each month. We would also have achieved the target if we had incurred 24 fewer breaches and as with the other cancer targets it is breach avoidance that means the difference between pass and fail.

Although seasonal patient choice delays (holidays) contribute to the breaches, unexpected equipment failure in Urology and local capacity issues within Urology, Colorectal and Skin are the main reasons we failed the target.

Specialty	No Pt Seen	No. Breaches
Brain	5	0
Breast	161	0
Colorectal	299	41
Gynaecology	130	2
Haematology	12	5
H&N	95	8
Lung	5	0
Paediatric	2	0
Skin	457	35
Upper GI	**133**	**4**
Urology	154	30
Grand Total	**1453**	**125**

Delay Reasons	
Administrative	**4**
Colorectal	1
Head and Neck	1
Urology	2
Clinic cancellation	**1**
Skin	1
Other reason (to be validated /clarified)	**20**
Breast	4
Colorectal	1
Head and Neck	1
Skin	11
Upper GI	1
Urology	2
Out-patient capacity inadequate	**58**
Colorectal	26
Haematology	5
Head and Neck	2
Skin	9
Urology	16
Patient choice delay relating to first outpatient appointment	**42**
Breast	2
Colorectal	8
Gynaecology	2
Head and Neck	4
Skin	14
Upper GI	3
Urology	9
Grand Total	**125**

Colorectal - High numbers of referrals have been received for colorectal, and despite additional capacity provided, there has still been a shortfall in the number of slots provided.

Urology - Ongoing issues with Urology capacity due to consultant leave/non take up of WLI's. An ongoing issue with a decontamination unit at Corbett resulted in a build-up of unscheduled patients in July that affected performance in August. The current situation is partially resolved and the weekly slots are 12 instead of the full 16. Efforts to secure additional Urology Clinical staff to assist with backlog reduction and breach avoidance were unsuccessful.

Skin – Seasonal referral peaks affected the service with 457 patients seen in August. Clinic cancellations due to illness resulted in breaches. Additional capacity was provided but was insufficient to avoid breaches.

General – Patients are consistently booked into their 1st appointment on between Day 11 – 14. This creates issues when patients wish to reschedule appointments taking them over the 2 week wait. In order to remedy this problem, polling rate needs to be reduced to around 7 days to enable reschedule within target. Pathway reviews for both Colorectal and Urology are underway with an action to reduce polling to 7 days.

Forecast and Learning from August:

Performance for September is expected to be very close to 93% and a return to the sort of numbers we produced in July. This is by no means assurance that 2 week wait is guaranteed but the partial recovery of the Haematuria position means we won't incur such an unexpectedly high number of breaches.

Cancer speciality establishments in Dudley are reliant on extra consultant and clinic activity beyond the normal job plans to deliver performance. It is well known at this point that consultant tax issues have significantly reduced the willingness of highly paid consultants to provide extra activity which has impacted the 2 week wait target. The trusts decision to put financial controls in place has had a similar effect on clinic staff. Specialities have been asked to address this by filling vacancies and investing in more staff but in many specialities there is a national shortage of expertise so this has not been possible.

The issue with the decontamination unit that caused the high number of Urology Haematuria breaches in July and August was communicated to cancer management throughout the months but the speciality was not able to find a solution to the problem.

Capacity issues in several specialities and an inability to provide first appointments at 7 days or less are the main reasons the performance is not above the 93% standard.

Pathway workshops with surgical specialities are underway, with Colorectal's first meeting complete and Urology to follow. These are addressing some of the pathway inefficiencies that mean we don't provide first appointments within 7 days.

Specialities like Skin must also prepare a more robust plan for seasonal variation – which should be expected.

Cancer management provide a daily report to all specialities detailing exactly what appointment need to be offered to maintain performance. They also provide a twice weekly report aggregating all this into one view for management information. These feed into the twice weekly performance meetings where speciality managers are asked to provide assurance that patients will be seen within 2 weeks.

Workforce

High levels of sickness absence is an ongoing concern, though August saw a 0.55% reduction to 4.6%, the lowest since March 2019. An Interim HR Project Manager will be focussing on the top 10 long-term sickness areas, supporting staff, managers and HR colleagues to adopt a more proactive approach and considering the health and well-being of our people. Challenges remain with non-compliance in mandatory training, specifically Adult Resuscitation, Paediatric Resuscitation and Child Safeguarding Level 3. The Director of Workforce & OD has written to c500 staff to draw attention to their non-compliance with an instruction to complete training within three months. In other areas, we are approaching a key time of staff engagement with Black History month in October, and the launch of the Flu Campaign on 1 October and National Staff Survey on 7 October.

IMPLICATIONS OF PAPER:			
RISK	**Y**		**Risk Description:** High level of activity could impact on the delivery of KPIs – particularly the Emergency Access target and RTT. The latter would be impacted by increased levels of outliers resulting in cancelled operations
	Risk Register: Y		**Risk Score:** 20 (COR 079)
COMPLIANCE and/or LEGAL REQUIREMENTS	**CQC**	**Y**	**Details:** Safe, Effective, Caring, Responsive, Well Lead
	NHSI	**Y**	**Details:** A sustained reduction in performance could result in the Trust being found in breach of Foundation Trust licence
	Other	**N**	**Details:**

The Dudley Group
NHS Foundation Trust

Integrated Performance Report - Board




September 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**

Safety Thermometer

Key Messages

CQSPE

FFT Response Rate

A total of 4,787 responses across all areas have been received during August 2019, a decrease since July 2019 (5,023). There has also been a decline in response rates for Maternity. Inpatient departments remain on target for response rates again this month and ED Department has shown an increase in response rates and is achieving the target for August 2019.

FFT Percentage Recommended

Percentage recommended scores have improved slightly for the Inpatient departments, Community and Outpatients in August 2019. There has been a decline in percentage recommended scores for ED, Maternity Antenatal, Maternity Postnatal Ward and Maternity Postnatal Community. Maternity Birth continues to achieve the target.

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 Performance Dashboard is emailed out monthly to wards and printed copies are presented 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 wards 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.
11. We will continue to email matrons and leads to encourage completion of FFT cards and to ensure that these are returned to Patient Experience Department by 2nd each month to be inputted by 5th each month.

Complaints & PALS

PALS received 185 concerns, 6 comments and 51 signposting contacts (signposting includes letters/emails/telephone calls/face-to-face enquiries) totalling 242 in August 2019.

During August 2019, the Trust received 44 complaints. This is a 39.7% decrease from July 2019 for complaints (73).

The Surgical Division received 18 complaints for August 2019 compared to 39 for July 2019. Medicine & Integrated Care Division received 23 complaints for August 2019 compared to 29 for July 2019. Clinical Support Division received one complaint for August 2019 compared to two for July 2019. Corporate Services and Corporate Nursing received 1 complaint each in August 2019.

In terms of complaints by service, Medicine & Integrated Care Division received the most complaints for the Emergency Department (ED) (13). Surgery Division received three for Ward B2 (hip).Common themes for complaints is Communication, and failure to diagnose /delay with treatment

There have been 8 re-opened complaints for August 2019.

Safety Thermometer

Key Messages

CQSPE

Dementia

There has been a reduction in compliance with dementia screening and assessment due to our reporting system being transitioned in May 2019 from Soarian to Sunrise which resulted in orders being duplicated and also difficulty with the processing of information. From June 2019 we have had a screening service 4 days per week and previous to this we were able to provide a seven day a week service with the support of the Acute Confusion Team. There was also a period of sickness of the Clinical Lead for Mental Health who has now returned and so the performance should improve in the coming months.

MSA

In August there were a total of 6 breaches. 3 on SHDU, 2 on MHDU and 1 on ITU.

MSSA

1. This patient was admitted with back pain and weakness in left leg. MRI of spine carried out with contrast .Neuro-oncology referral made several days later. Met call, as temp 39.1. IV antibiotics given. There was some redness and swelling around previous cannula site? Phlebitis. Patient went to QE for CT and neurological assessment. Had 4 cannulas inserted during admission. No care delivery issues identified on review.
2. This patient was admitted with black stools for 9 weeks? Secondary to iron tablets. Patient developed a raised temp and raised respiratory rate and coughing up green sputum, Patient treated as sepsis of unknown origin? Drs discussed with microbiologist and following further review regarding source of bacteraemia? Infective endocarditis identified, source unknown
3. The patient was an inpatient on Ward C7 and died. Death certificate completed and cause of death is bilateral bronchopneumonia and metastatic oesophageal cancer. The source of the bacteraemia is unknown.

E-Coli

1. Patient admitted with cellulitis and not responding to flucloxacillin and was switched to alternative antibiotics Patient spiked a temperature and blood culture grew coliform, isolate found to be resistant and Pip Taz recommended. Whilst on C3 no hand hygiene issues, all lines documented and observed and no issues identified.
2. Patient had Open mesh repair of hernia, and presented as febrile, and with necrotic stoma. Benzylpenicillin and metronidazole, given. Microbiology suggested switch of antibiotics. No issues on ward with saving lives audits or hand hygiene score. Source not known

VTE

Trust performance for VTE for August 19 is 94.84%.

- Previous measures continue
- Escalation policy to be used where non-compliance identified
- Awaiting to implement changes in potential Cohorting of Pts in assessment areas for short period
- Mat pts attending for Anti D Inj only, to be amended imminently to be cohorted

Incidents

4 Serious Incident has been reported in August 2019:

o INC59502 (2019/16962) – Delay in diagnosis
o INC60583 (2019/18296) – Fall resulting in a fractured neck of femur
o INC60250 (2019/17852) – An attempted suicide
o INC58923 (2019/16943) – Delay in diagnosis

All incidents moderate and above are reviewed by the patient safety team and identified as a serious incident or the incident is downgraded. At the time of report there may be incidents that are currently under review and these may be identified as a serious incident or the incident will be downgraded.

Safety Thermometer

Key Messages

CQSPE

Falls

Total inpatient falls (including one in ED and one in Maternity) are 77 for August. This is a slightly higher figure than previous month (although equivalent almost to September 2018).

Stroke

All Stroke targets have been met for the month of August 19.

% 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.

Safety Thermometer

Safety Thermometer for July 19 - 99.33%

Safety Thermometer

Executive Lead: Mary Sexton

Patients will experience safe care - Quality & Experience

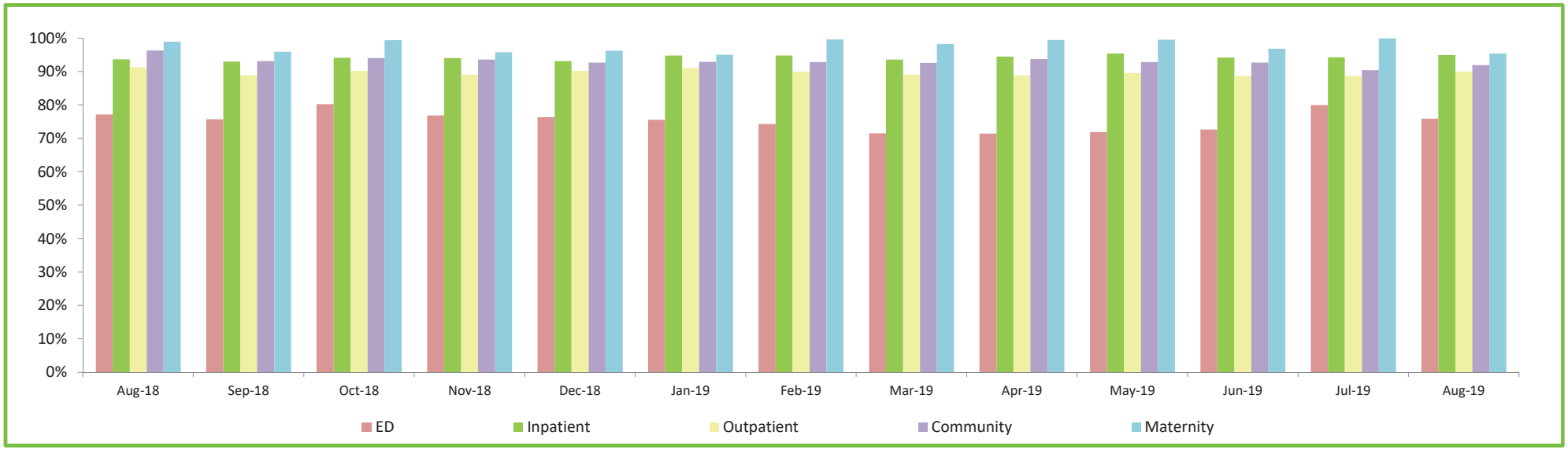
	Target (Amber)	Target (Green)	Jul-19	Aug-19	Financial YTD	Trend	Month Status
Friends & Family Test - Response Rate							
Friends & Family Test - ED	12.3%	19.4%	19.3%	20.4%	19.4%	↑	
Friends & Family Test - Inpatients	26.9%	37.0%	31.2%	33.6%	34.2%	↑	
Friends & Family Test - Maternity - Overall	21.9%	38.0%	21.6%	17.6%	20.2%	↓	
Friends & Family Test - Outpatients	4.9%	11.9%	6.3%	5.3%	5.2%	↓	
Friends & Family Test - Community	3.3%	8.1%	4.3%	4.6%	4.3%	↑	
Friends & Family Test - Percentage Recommended							
Friends & Family Test - ED	88.7%	94.5%	80.0%	75.9%	74.6%	↓	
Friends & Family Test - Inpatients	96.7%	97.4%	94.3%	95.0%	94.7%	↑	
Friends & Family Test - Maternity - Overall	97.1%	98.5%	100.0%	95.5%	98.6%	↓	
Friends & Family Test - Outpatients	95.3%	97.4%	88.7%	90.1%	89.2%	↑	
Friends & Family Test - Community	96.2%	97.7%	90.5%	92.0%	92.4%	↑	
Complaints							
Total no. of complaints received in month			73	44	258	↓	
Complaints re-opened			13	8	43	↓	
PALs Numbers			243	191	1275	↓	
Complaints open at month end			171	169	-	↓	
Compliments received			468	424	2382	↓	
Dementia							
Find/Assess		90%	78.4%	72.5%	83.2%	↓	
Investigate		90%	86.3%	72.2%	84.2%	↓	
Refer		90%	95.4%	99.1%	95.5%	↑	
Falls							
No. of Falls			71	77	345	↑	
Falls per 1000 bed days			4.06	4.57	4.03	↑	
No. of Multiple Falls			3	8	25	↑	
Falls resulting in moderate harm or above			1	0	2	↓	
Falls resulting in moderate harm or above per 1000 bed days			0.06	0.00	-	↓	
Pressure Ulcers (Grades 3 & 4)							
Hospital			1	0	3	↓	
Community			0	0	0	↔	
Handwash							
Handwashing			99.8%	99.0%	99.7%	↓	

Patients will experience safe care - Patient Safety

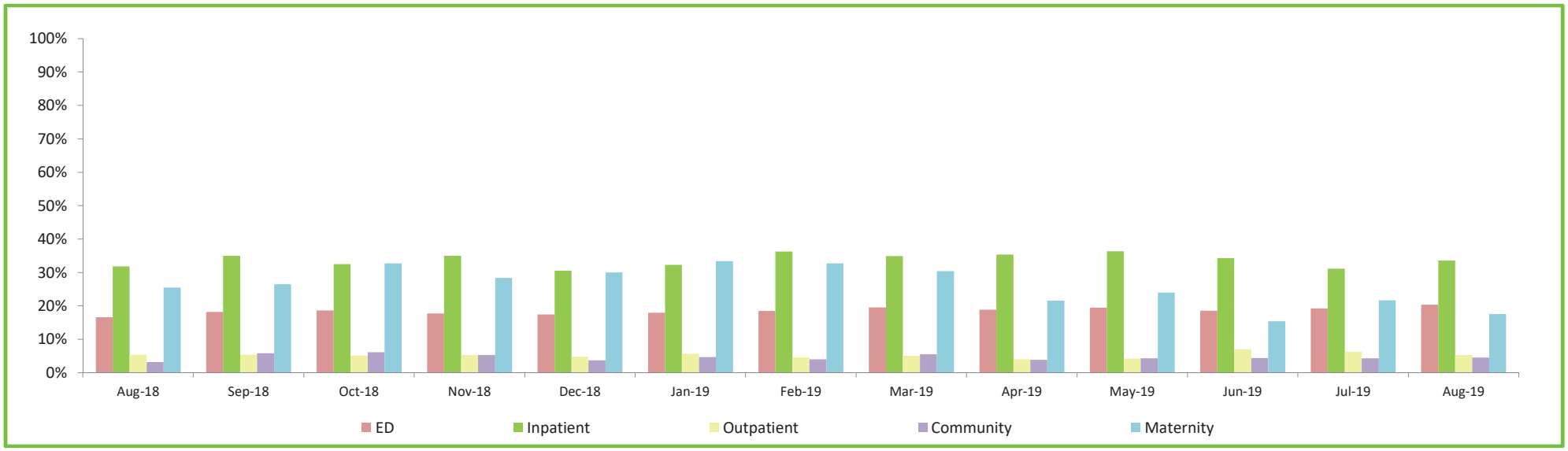
	Target (Green)	Jul-19	Aug-19	Financial YTD	Trend	Month Status
Mixed Sex Accommodation Breaches						
Single Sex Breaches	0	5	6	33	↑	
Mortality (Quality Strategy Goal 3)						
HSMR Rolling 12 months (**Latest data Jan 19**)	105	118	115	-		
SHMI Rolling 12 months (**Latest data 18/19 Q1**)	1.05	N/A	1.13	-		
HSMR Year to date (**Not available**)				-		
Infections						
Cumulative C-Diff due to lapses in care	49	-	-	3		
MRSA Bacteraemia	0	0	0	0	↔	
MSSA Bacteraemia	0	2	3	10	↑	
E. Coli	0	2	2	14	↔	
Stroke (1 month in arrears)						
Stroke Admissions: Swallowing Screen	75%	96.9%	-	95.1%		
Stroke Patients Spending 90% of Time on Stroke Unit	85%	90.2%	-	92.7%		
Suspected High Risk TIAs Assessed and Treated <24hrs	85%	100.0%	-	96.7%		
Stroke Admissions to Thrombolysis Time	50%	50.0%	-	52.6%		
VTE - Provisional Figures						
VTE On Admission	95%	94.0%	94.8%	94.8%	↑	
Incidents						
Total Incidents		1401	1439	7062	↑	
Recorded Medication Incidents		247	318	1723	↑	
Never Events		0	0	0	↔	
Serious Incidents		4	4	18	↔	
of which, pressure ulcers		1	0	3	↓	
Incident Grading by Degree of Harm						
Death		0	0	2	↔	
Severe		3	0	3	↓	
Moderate		3	2	11	↓	
Low		175	156	729	↓	
No Harm		861	859	4283	↓	
Percentage of incidents causing harm	28%	12.9%	11.0%	10.5%	↓	
Safety Thermometer						
Patients with harm free care (and old harms)	-	97.79%	99.33%	-	↑	

Safety Thermometer

Friends and Family Test - Percentage Recommended

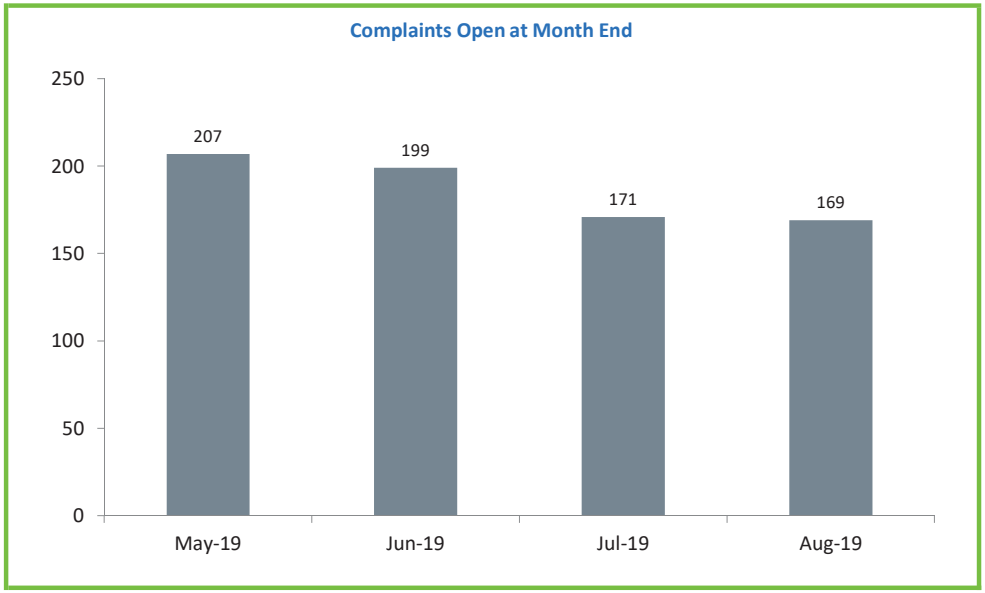


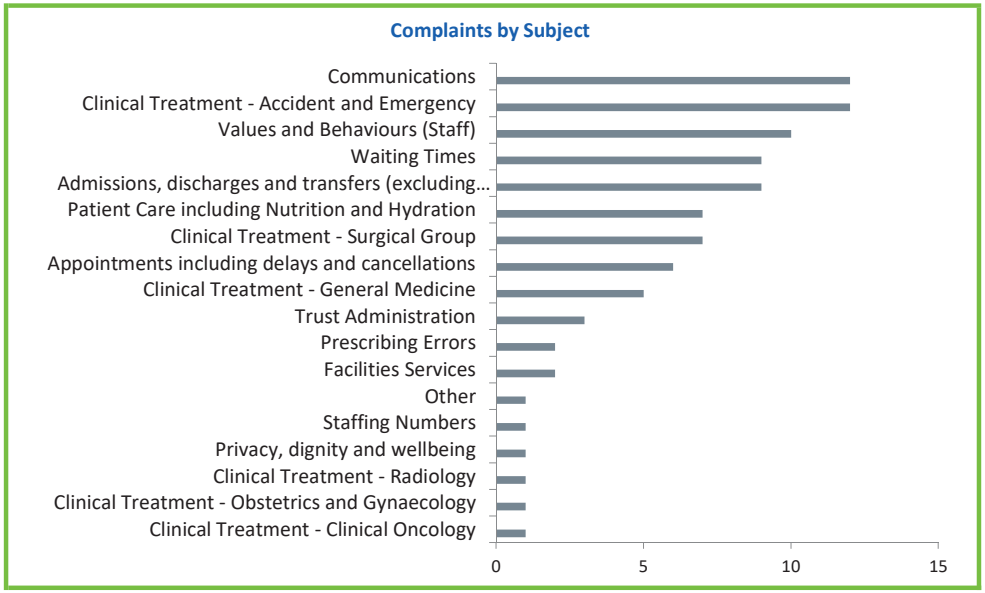
Friends and Family Test - Response Rate

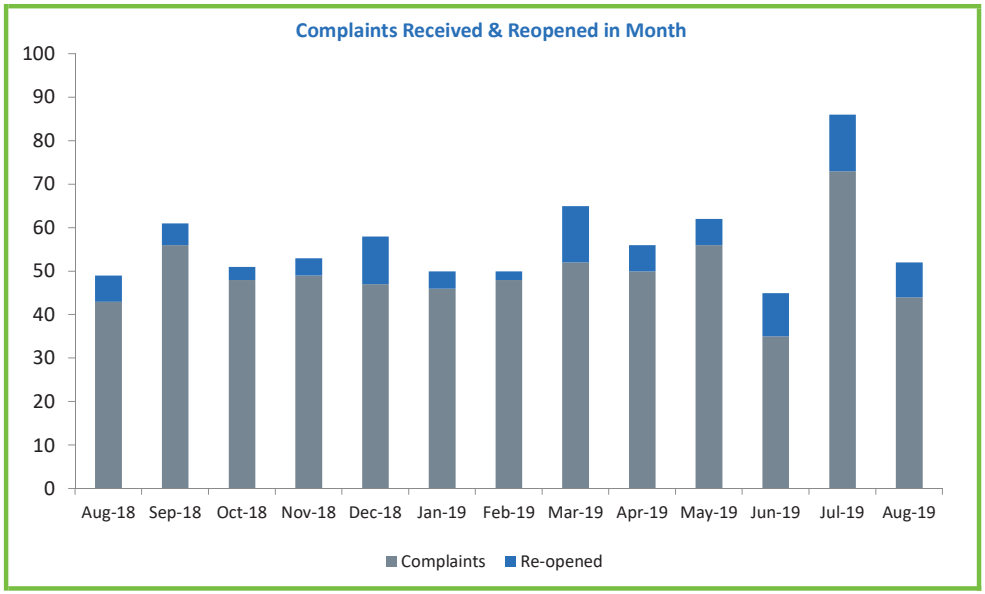


Safety Thermometer

Complaints

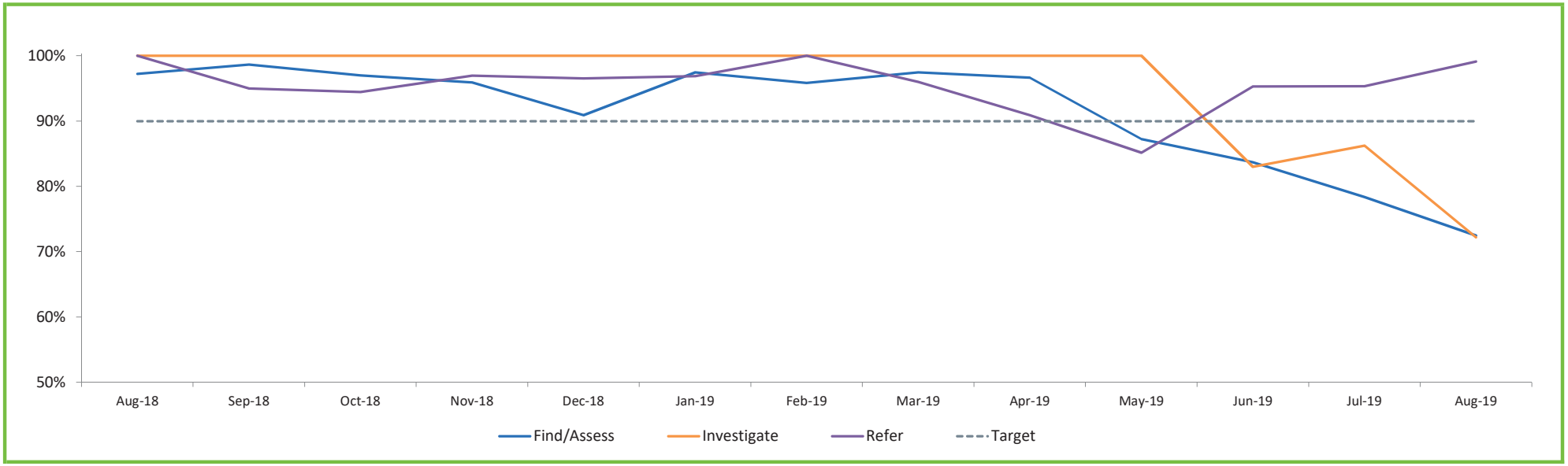






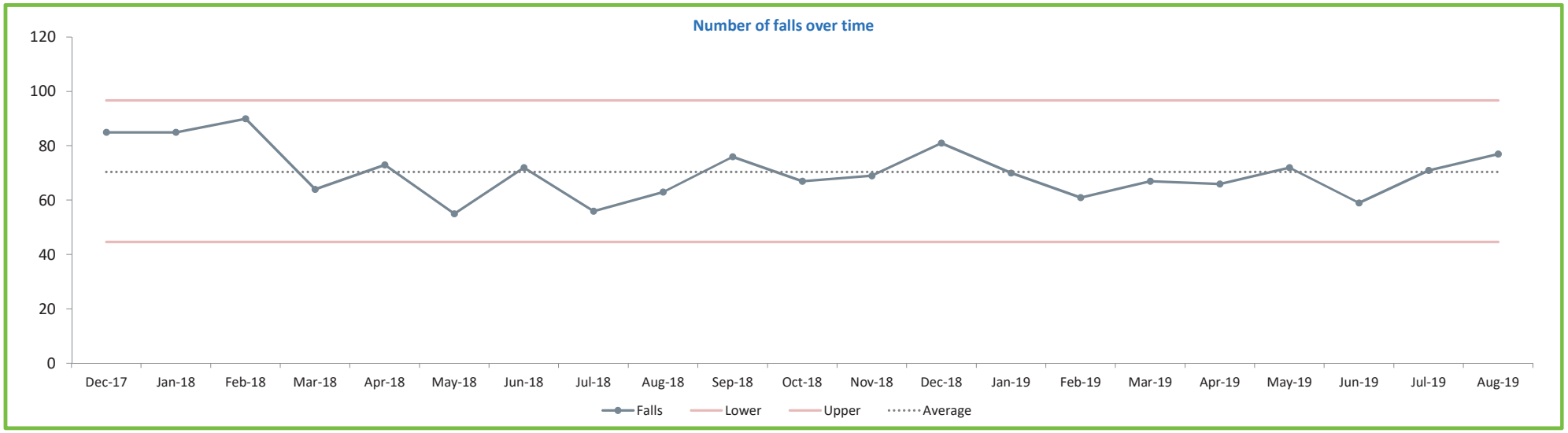
Safety Thermometer

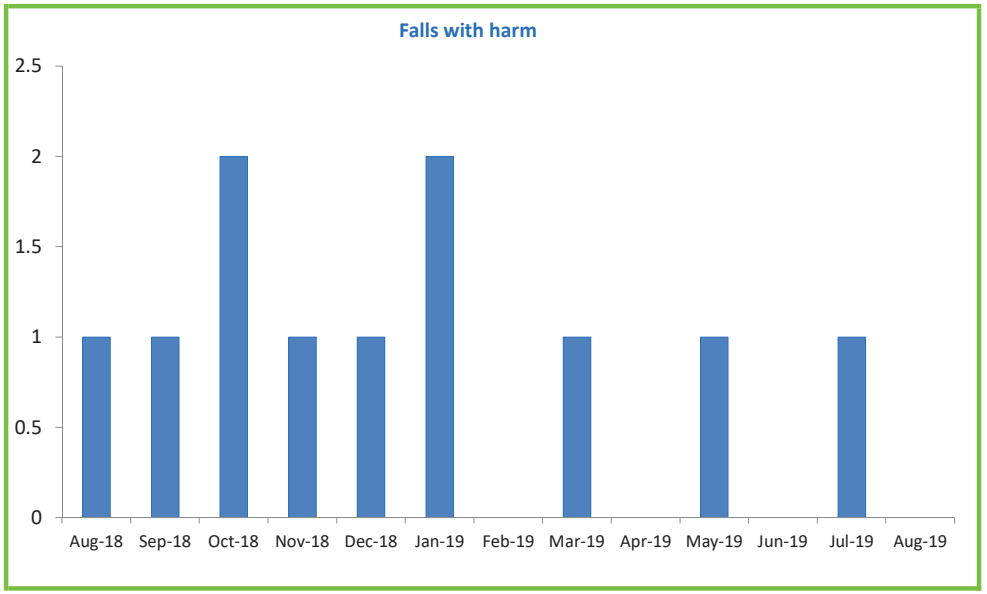
Dementia Performance

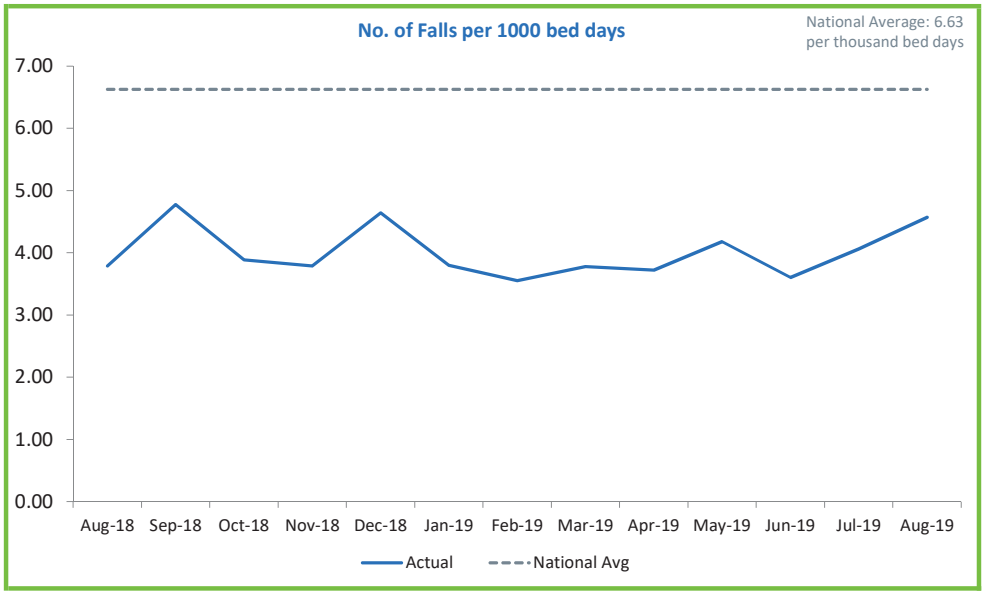


Safety Thermometer

Falls

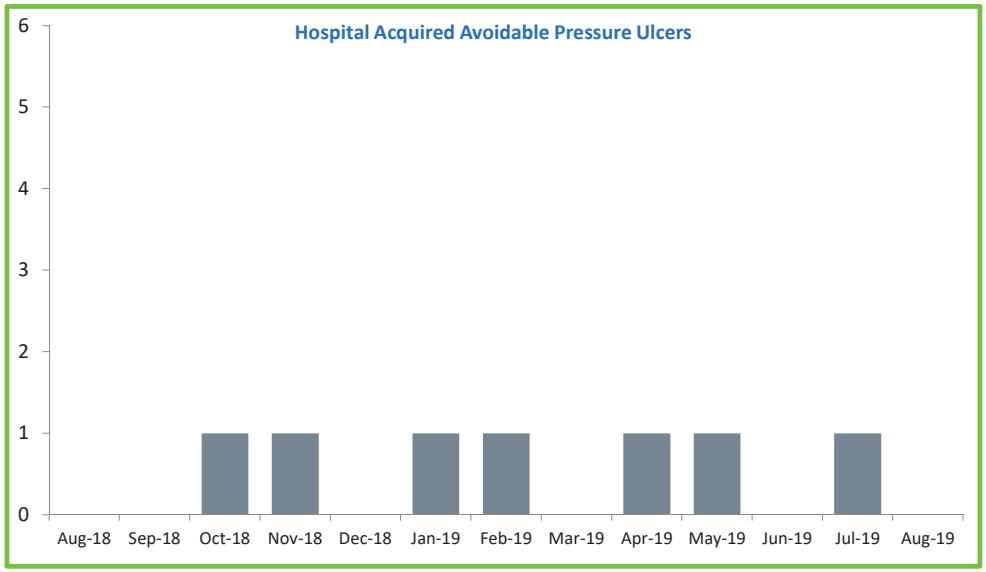


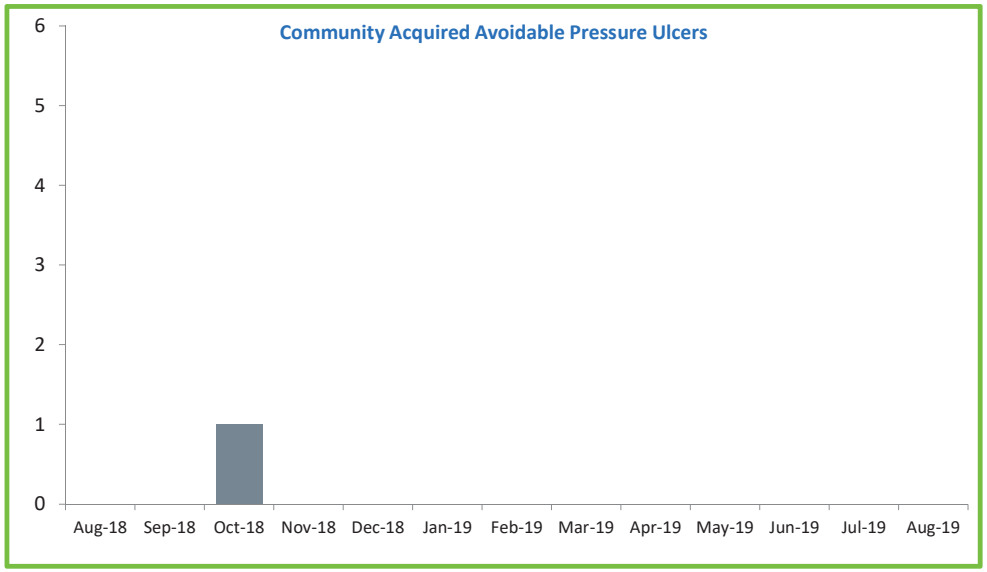




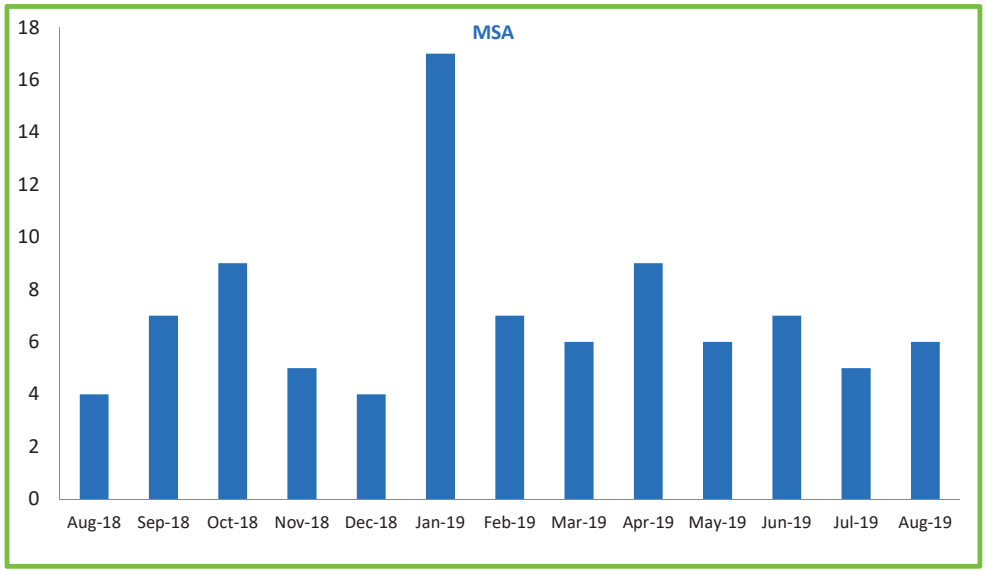
Safety Thermometer

Pressure Ulcers



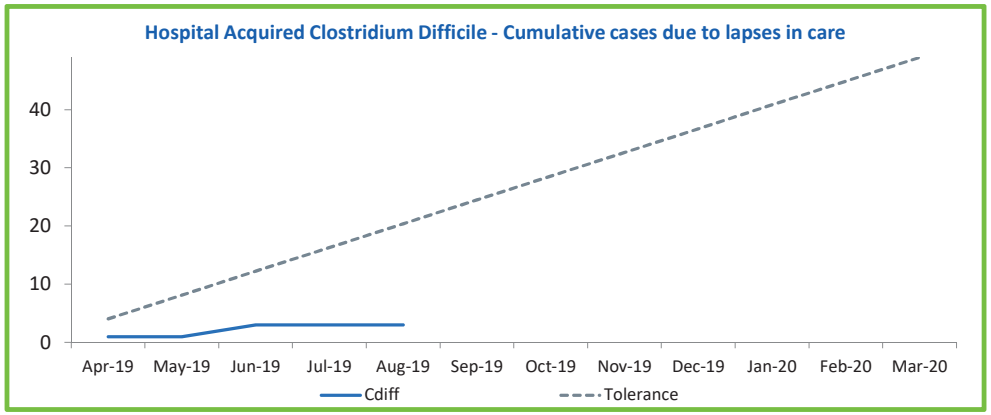


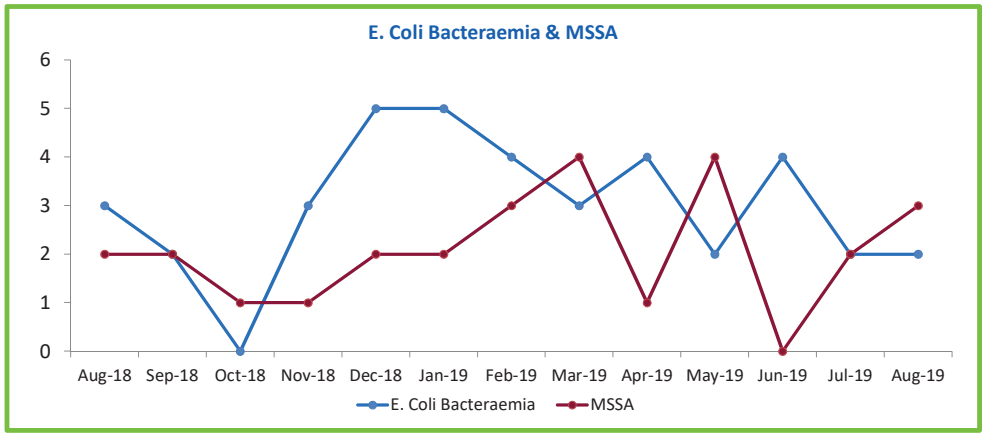
Mixed Sex Accomodation

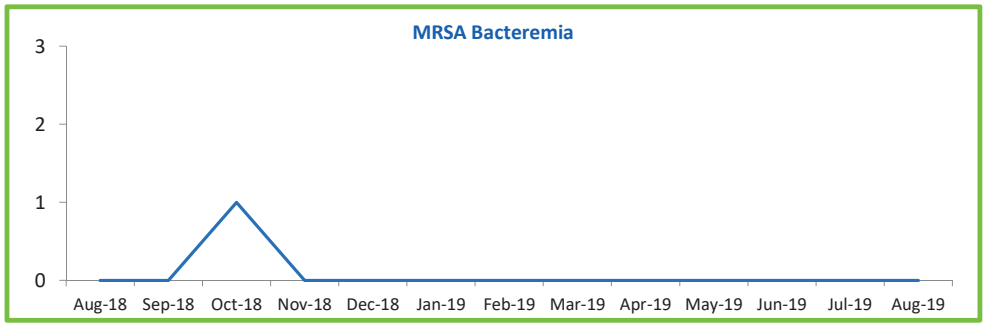


Safety Thermometer

Infection Control



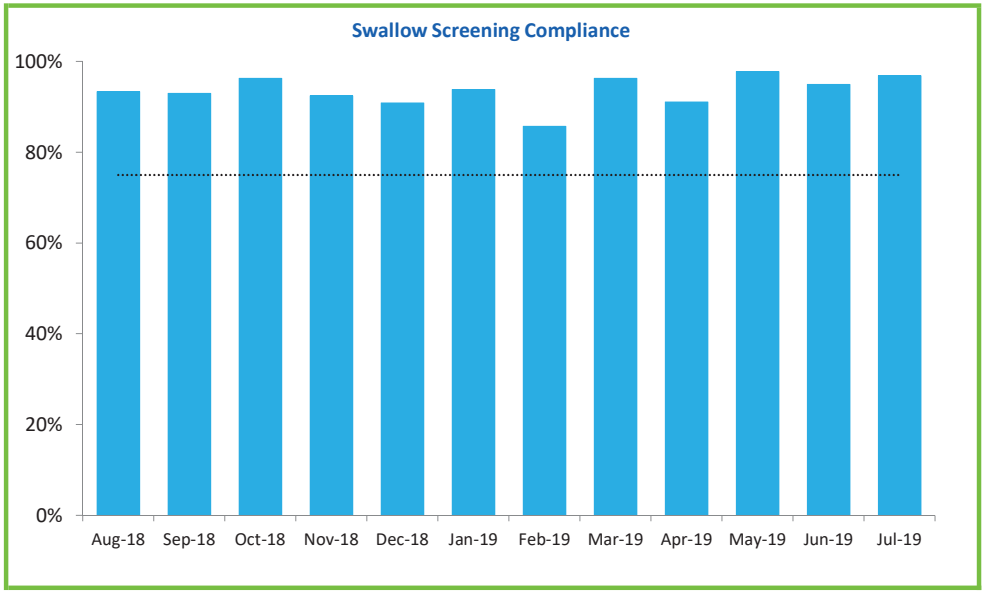


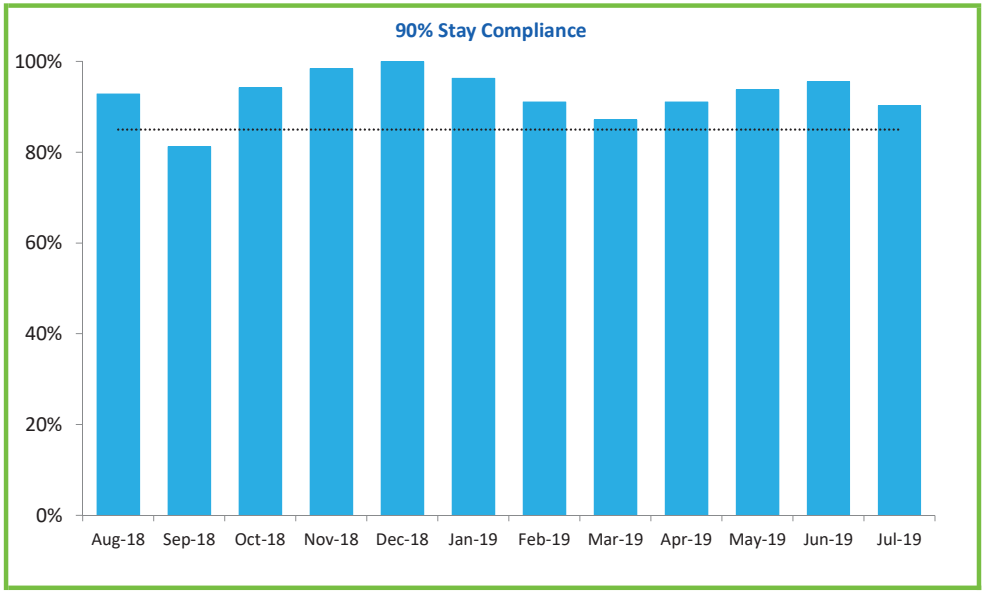


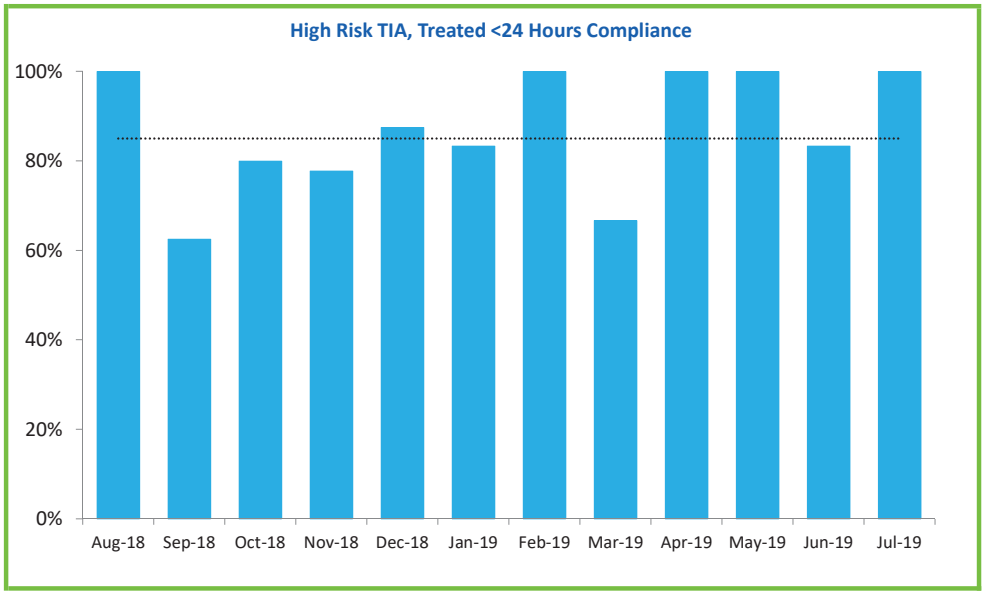
High Impact Interventions		August 2019
HII 1:	Ventilator Associated Pneumonia	100%
HII 2a:	Peripheral Vascular Access Devices - Insertion	98%
HII 2b:	Peripheral Vascular Access Devices - Ongoing Care	98%
HII 3a:	Central Venous Access Devices - Insertion	100%
HII 3b:	Central Venous Access Devices - Ongoing Care	97%
HII 4a:	Surgical Site Infection Prevention - Preoperative	100%
HII 4b:	Surgical Site Infection Prevention - Intraoperative Actions	100%
HII 5:	Infection Prevention in Chronic Wounds	98%
HII 6a:	Urinary Catheter - Insertion	100%
HII 6b:	Urinary Catheter -Maintenance & Assessment	100%
Hand hygiene		99%
Commode Audits		99%

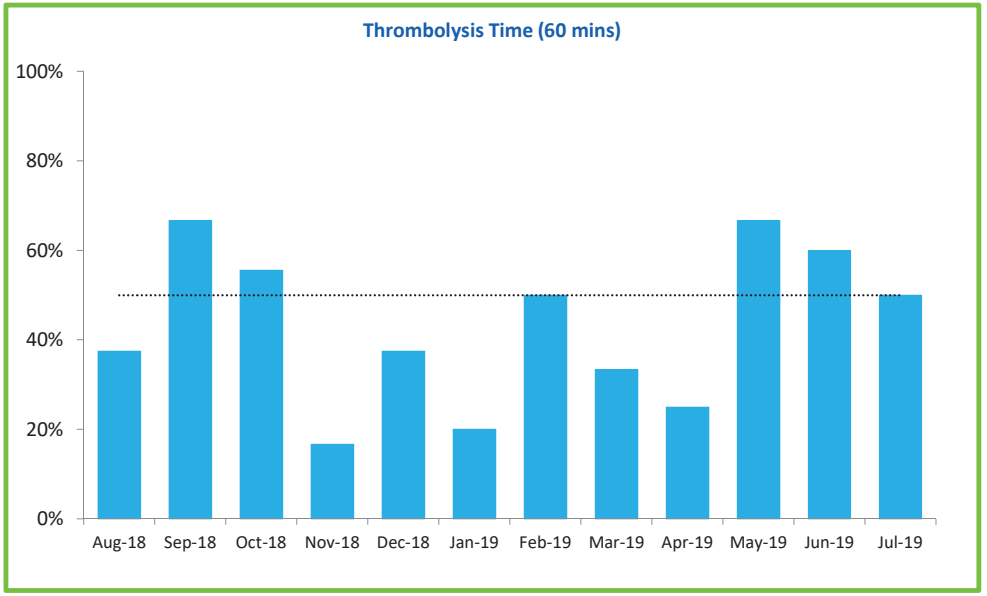
Safety Thermometer

Stroke (1 month in arrears)



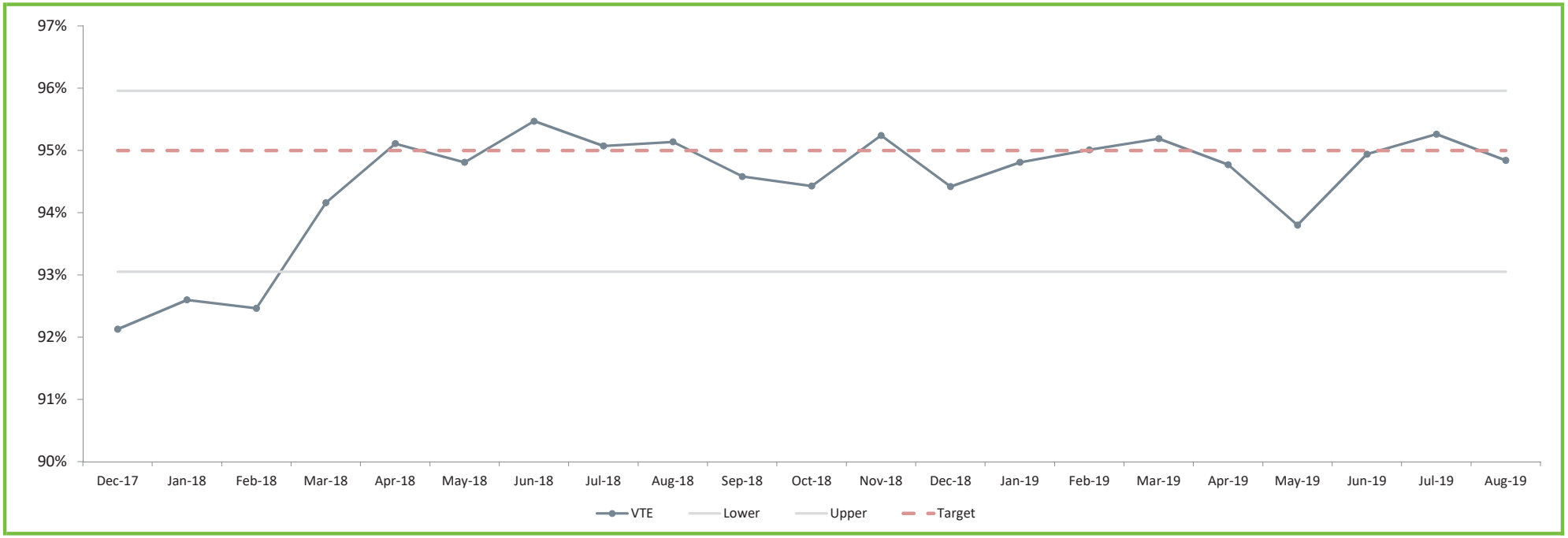






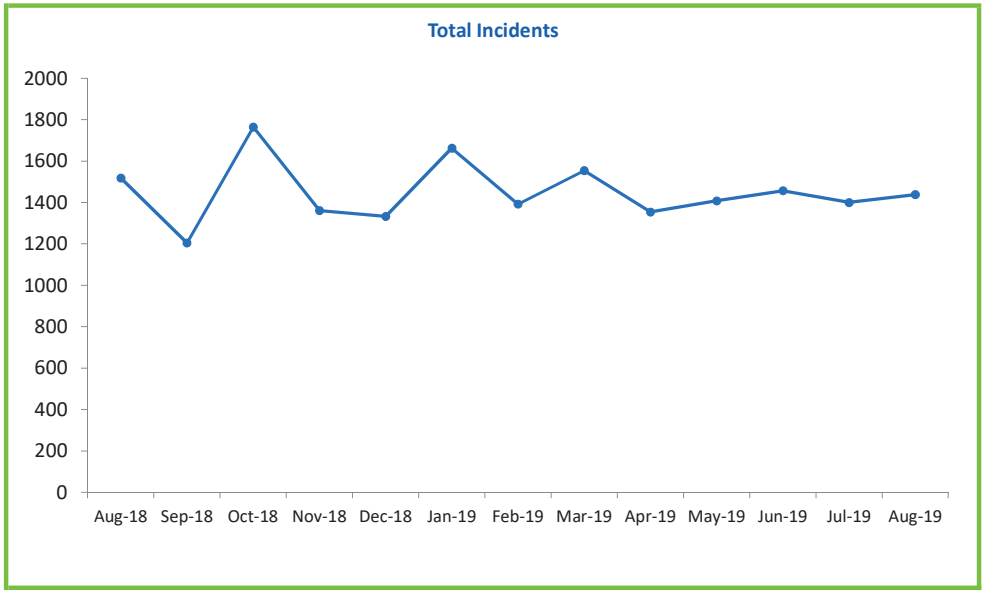
Safety Thermometer

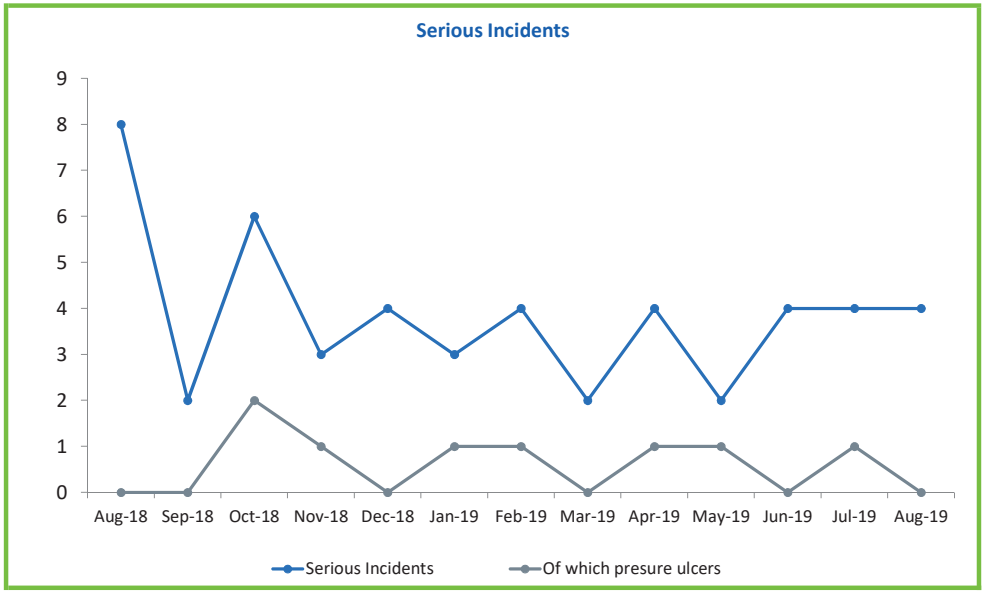
VTE



Safety Thermometer

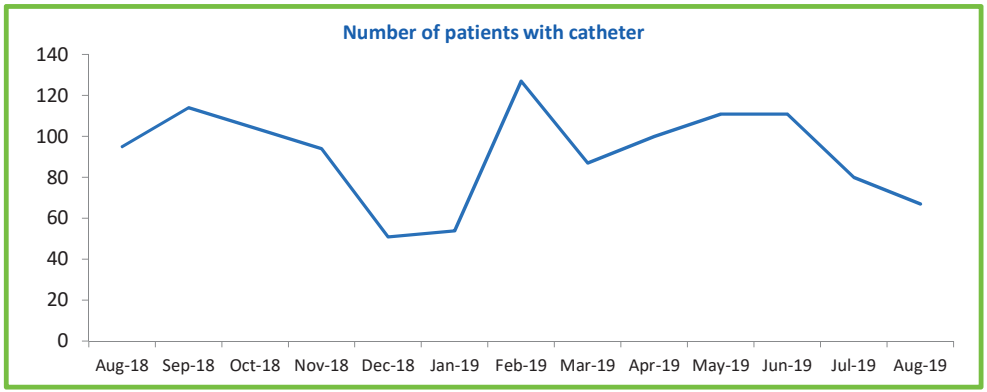
Incidents

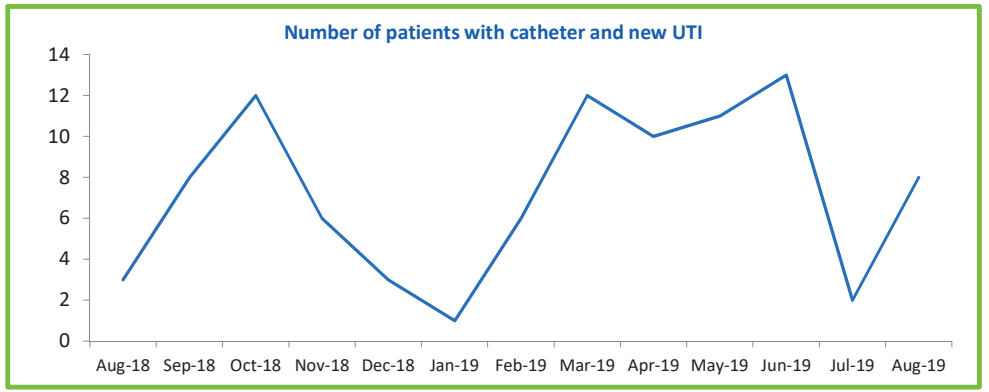




Safety Thermometer

Catheters & UTIs





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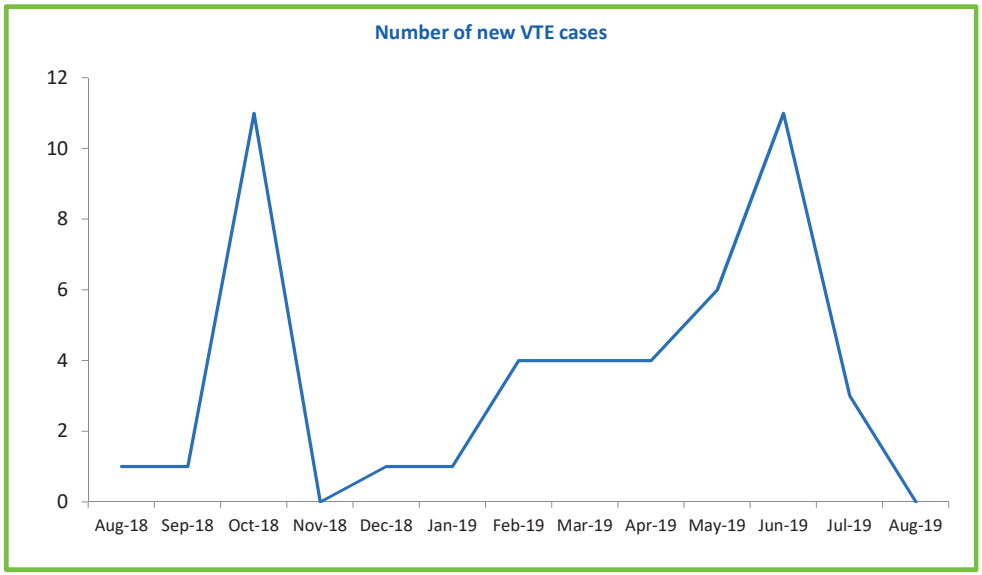
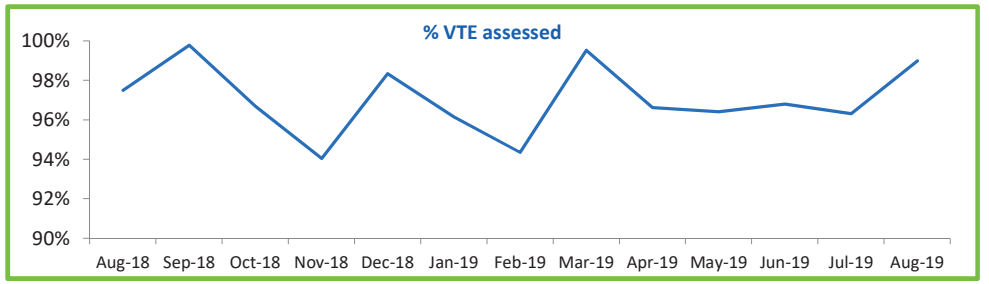
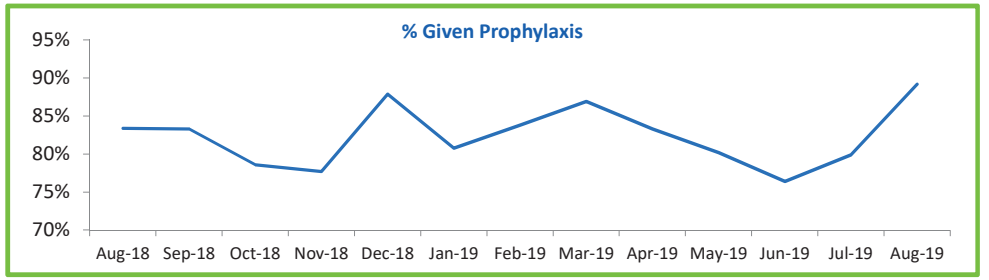






The Dudley Group NHS Foundation Trust

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 82.7%

	Attendances	Breaches	Performance
UCC/A&E Combined (Type1+3)	14569	2519	82.7%

EAS

- ED Attendances, for adults has slightly decreased in August
- Emergency admissions from ED in the over 70s age group has increased slightly
- Number of patients arriving by ambulance has slightly decreased
- Main breach reason for August was "Capacity Issues – Bed Management"

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, the Trust has achieved 9 out of 10 targets in August 2019, the exception being two week wait (2ww). As requested at last month's Finance and Performance Committee a deep dive was conducted into the reasons for this failure, and this can be found below. It should be noted that the challenges faced in August continued somewhat into September, and at the time of writing the position of 2ww for September remains extremely tight, however is also subject to validation.

Referral to Treatment (RTT)

The Trust achieved the RTT standard for August, delivering 94.24% against the national standard of 92%. The challenges are arising in the admitted pathways as there is a reduction of additional theatre sessions being undertaken both from a consultant and theatre team perspective. This is being driven by the pension tax taper allowance and a change in pay arrangements for theatre staff.
Areas of pressure are Urology, General Surgery, Plastic Surgery, and Ophthalmology. Additional sessions continue to be arranged to manage demand in addition to continued close monitoring of open pathways.

Executive Summary by Exception cont.

Key Messages

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

Cumulative deficit of £2.986m for April-August (including PSF). This position is £2.290m behind the control total so the Trust has a significant financial challenge if it is to recover this adverse variance over September. The actual August position was approximately £0.5m worse than plan but this represented an improvement in comparison to the forecast from the previous month. The year end forecast is now back in line with the Trust internal plan and is consistent with the revised CIP forecast of £14m. This position is £8.5m worse than the control total plus a further £5.117m of lost PSF resource.

Executive Summary by Exception cont.

Key Messages

Workforce — **Committee: F&P**

Staff Appraisals

Completed appraisals remained at 95.52% in August, above the Trust target of 90%.

Performance is above target in all areas with the exception of Clinical Support Services, where Administrative & Clerical (82.26%), Healthcare Scientists (40%) and Nursing & Midwifery (54.55%) are below target. In Medicine & Integrated Care, staff in Add Prof S&T are below target at 42.86%. Additional support will be offered if required.

Consultation is continuing relating to the appraisal process and associated paperwork.

Absence

Absence in August 2019 saw a decrease of 0.55% (4.6%) compared to July 2019 (5.15%), this is the lowest since March 2019 but remains above the Trust target of 3.5%. The estimated 12-month rolling cost of absence is c£6.6M.

Clinical Support Services, Medicine & Integrated Care and Surgery Divisions remain above target at 5.52%, 5.23% and 4.3% respectively. Absence is highest amongst our Care Support Staff (7.04%) and given their high levels of absence over the past 12 months, ie, above 6.5%, some additional focus will be given to understanding any issues and supporting staff and managers in this area.

Short-term sickness absence was 1.64%, compared to 2.05% in July. The HR team will be working closely with Divisions to address any patterns of absence and to support the proactive management of cases, as well as supporting staff to remain in work or return to work more quickly, including a review of alternative working arrangements to facilitate this. A review of management referrals to Occupational Health is ongoing to ensure that staff are supported promptly and effectively through appropriate channels.

In August, long-term sickness absence was 2.96%, down 0.14% since July (3.10%). A paper was submitted to the Workforce & Staff Engagement Committee on 27 August, which highlighted concerns with long-term sickness absence. A HR Project Manager has now commenced, and she will focus on the top 20 long-term sickness cases and address any issues with our processes and support an early resolution where possible. In addition, additional coaching and training will be provided to enable managers to fully appreciate their roles and responsibilities, and the importance of having effective and timely meetings/conversations with staff.

In addition to the proactive work outlined above, the Sickness Absence Policy is under review, with input from managers, staff and Trade Union colleagues. We will also be looking at increasing our offering and staff awareness of health and wellbeing options at the Trust.

Mandatory Training

Compliance was above target at 90.27% in August, an increase of 0.57%; all Divisions are above or close to the Trust target of 90%.

Trust Priority 1 (statutory) was at 90.52%, Priority 2 (Trust-mandated) at 78.57% and Priority 3 (extended role) was at 61.75%.

Continued non-compliance creates a risk to our patients and staff and, therefore, the Director of Workforce & OD has written to c500 staff that have been non-compliant for 12+ months; resources are in place to support the necessary training to achieve compliance over the next few months.

The lease compliant Priority 1 subject areas where compliance is rag-rated red and the most significant risk are:

- Child Safeguarding Level 3 – 80.5% (up from 77.1% in July);
- Resuscitation Adult – 74.25% (up from 72% in July);
- Resuscitation Paediatric – 83% (up from 60.4% in July).

These subjects are managed via the Head of Non-Medical Education and Training who has presented current and future intended actions for improvement to the Workforce & Staff Engagement Committee and the Risk and Assurance Group.

Executive Summary by Exception cont.

Key Messages

Workforce — **Committee: F&P**

Turnover

The turnover rate was 8.72% in August, a decrease of 0.01% compared to July. Whilst the Trust target is 8.5%, we rate below the average turnover rate for acute NHS Trusts in England. However, turnover remains high in Clinical Support Services (12.89%) and Corporate/Management (12.92%).

We are continuing to engage with our staff, and are analysing feedback from exit interviews, listening to staff and developing strategies to improve retention at the Trust, and this will be embedded into action plans which will build on the feedback from the National Staff Survey and regular pulse surveys.

Recruitment/Staff in Post

In August, the number of staff in post was 4380.25 (fte); all Divisions remain within their funded establishments. There have been increases in Care Support, AHP, and Mental & Dental staff groups

The monthly RN vacancy rate increased by 0.52% to 18.46% against the Trust target of 8.5%.

Due to August rotation, figures are not available for medical vacancies. The usual data will be available next month.

As reported in July, the Resourcing team have changed the recruitment timeline to 50 days (originally 77 days). Ongoing changes are being implemented with the help of new technology and training for managers, as well as improving local processes. There has been a 20% improvement against the 50 day target, although we recognise there is still work to be done to achieve our aim to reduce the time to hire, increase the number of substantive staff and reduce agency expenditure.

Work is also ongoing to improve our bank offering, with the intention to triple the number of bank staff over the next 12 months.

Staff Health and Wellbeing

As indicated above, a review of management referrals to Occupational Health has been taking place, and this has resulted in a reduction from 101 in July to 72 in August.

The number of days it takes to be offered an appointment with Occupational Health is slowly reducing, and this will be addressed by the HR Project Manager looking at long-term sickness and the HR Operational team as they continue to address absence issues.

The Flu Campaign will launch on 1 October, and the Trust target this year is 80% (we achieved 77% last year).

Leadership & Development

106 leaders have completed the Leadership & Development programme. There are 20 enrolled onto Cohort 8 commencing in September, and a further 34 are booked onto Cohorts 9, 10 and 11. 1386 leaders are yet to enrol.

We remain on track to achieve our end of year target of 109 apprentices; 32% (35) have been recruited to date.

Executive Summary by Exception cont.

Key Messages

Workforce — **Committee: F&P**

Staff Engagement

A calendar has been produced to include local and national events, which includes the staff survey launch events leading up to the official launch of the National Staff Survey on 8 October. Preparations are also ongoing for the Flu Campaign launch on 1 October.

October is Black History Month a number of activities have been planned, but the team would welcome any ideas/input for events throughout the month.

Work continues to support awareness and implementation of the Dudley People Plan and the Trust's Behavioural Framework; both are aligned to NHS Improvement's Interim People Plan.

HR Operations

There are 6 formal cases ongoing relating to capability with underlying health reasons.

The Interim Deputy Director of HR will be getting an overview of all cases, processes, policies and procedures over the next few weeks and will discuss any potential improvements with the team and Trade Union colleagues, before seeking wider discussion with managers and staff.

A new schedule has been produced for Employee Relations training for managers, including Disciplinary, Grievance, and dates are available each month until the end of December.

Safety Thermometer

Executive Lead: Mary Sexton

Patients will experience safe care - Quality & Experience

	Target (Amber)	Target (Green)	Jul-19	Aug-19	Financial YTD	Trend	Month Status
Friends & Family Test - Response Rate							
Friends & Family Test - ED	12.3%	19.4%	19.3%	20.4%	19.4%	↑	
Friends & Family Test - Inpatients	26.9%	37.0%	31.2%	33.6%	34.2%	↑	
Friends & Family Test - Maternity - Overall	21.9%	38.0%	21.6%	17.6%	20.2%	↓	
Friends & Family Test - Outpatients	4.9%	11.9%	6.3%	5.3%	5.2%	↓	
Friends & Family Test - Community	3.3%	8.1%	4.3%	4.6%	4.3%	↑	
Friends & Family Test - Percentage Recommended							
Friends & Family Test - ED	88.7%	94.5%	80.0%	75.9%	74.6%	↓	
Friends & Family Test - Inpatients	96.7%	97.4%	94.3%	95.0%	94.7%	↑	
Friends & Family Test - Maternity - Overall	97.1%	98.5%	100.0%	95.5%	98.6%	↓	
Friends & Family Test - Outpatients	95.3%	97.4%	88.7%	90.1%	89.2%	↑	
Friends & Family Test - Community	96.2%	97.7%	90.5%	92.0%	92.4%	↑	
Complaints							
Total no. of complaints received in month			73	44	258	↓	
Complaints re-opened			13	8	43	↓	
PALs Numbers			243	191	1275	↓	
Complaints open at month end			171	169	-	↓	
Compliments received			468	424	2382	↓	
Dementia							
Find/Assess		90%	78.4%	72.5%	83.2%	↓	
Investigate		90%	86.3%	72.2%	84.2%	↓	
Refer		90%	95.4%	99.1%	95.5%	↑	
Falls							
No. of Falls			71	77	345	↑	
Falls per 1000 bed days			4.06	4.57	4.03	↑	
No. of Multiple Falls			3	8	25	↑	
Falls resulting in moderate harm or above			1	0	2	↓	
Falls resulting in moderate harm or above per 1000 bed days			0.06	0.00	-	↓	
Pressure Ulcers (Grades 3 & 4)							
Hospital			1	0	3	↓	
Community			0	0	0	↔	
Handwash							
Handwashing			99.8%	99.0%	99.7%	↓	

Patients will experience safe care - Patient Safety

	Target (Green)	Jul-19	Aug-19	Financial YTD	Trend	Month Status
Mixed Sex Accommodation Breaches						
Single Sex Breaches	0	5	6	33	↑	
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	-	-	3		
MRSA Bacteraemia	0	0	0	0	↔	
MSSA Bacteraemia	0	2	3	10	↑	
E. Coli	0	2	2	14	↔	
Stroke (1 month in arrears)						
Stroke Admissions: Swallowing Screen	75%	96.9%	-	95.1%		
Stroke Patients Spending 90% of Time on Stroke Unit	85%	90.2%	-	92.7%		
Suspected High Risk TIAs Assessed and Treated <24hrs	85%	100.0%	-	96.7%		
Stroke Admissions to Thrombolysis Time	50%	50.0%	-	52.6%		
VTE - Provisional Figures						
VTE On Admission	95%	94.0%	94.8%	94.8%	↑	
Incidents						
Total Incidents		1401	1439	7062	↑	
Recorded Medication Incidents		247	318	1723	↑	
Never Events		0	0	0	↔	
Serious Incidents		4	4	18	↔	
of which, pressure ulcers		1	0	3	↓	
Incident Grading by Degree of Harm						
Death		0	0	2	↔	
Severe		3	0	3	↓	
Moderate		3	2	11	↓	
Low		175	156	729	↓	
No Harm		861	859	4283	↓	
Percentage of incidents causing harm	28%	38.5%	40.3%	14.8%	↑	
Safety Thermometer						
Patients with harm free care (and old harms)	-	97.79%	99.33%	-	↑	

Performance - "At a glance"

Executive Lead: Karen Kelly

The Dudley Group NHS Foundation Trust

Performance - Key Performance Indicators

	Target	Jul-19	Aug-19	Actual YTD	Trend	Month Status
Cancer Reporting - TRUST (provisional)						
All Cancer 2 week waits	93%	93.04%	91.5%	93.9%	↓	
2 week wait - Breast Symptomatic	93%	97.4%	96.1%	97.5%	↓	
31 day diagnostic to 1st treatment	96%	99.4%	98.7%	98.4%	↓	
31 day subsequent treatment - Surgery	94%	97.4%	92.9%	97.2%	↓	
31 day subsequent treatment - Drugs	94%	100.0%	100.0%	98.5%	↔	
62 day urgent GP referral to treatment	85%	85.3%	80.5%	84.4%	↓	
62 day screening programme	90%	95.0%	100.0%	99.1%	↑	
62 day consultant upgrades	85%	95.0%	94.1%	94.6%	↓	
Referral to Treatment						
RTT Incomplete Pathways - % still waiting	92%	94.2%	94.2%	94.4%	↑	
RTT Admitted - % treatment within 18 weeks	90%	88.6%	87.1%	86.9%	↓	
RTT Non Admitted - % treatment within 18 weeks	95%	95.3%	94.0%	95.4%	↓	
Wait from referral to 1st OPD	26	27	25	130	↓	
Wait from Add to Waiting List to Removal	39	35	38	194	↑	
ASI List		3183	2761	0	↓	
% Missing Outcomes RTT		0.11%	0.05%	0.1%	↓	
% Missing Outcomes Non-RTT		3.7%	3.8%	3.7%	↑	
DM01						
No. of diagnostic tests waiting over 6 weeks	0	57	47	312	↓	
% of diagnostic tests waiting less than 6 weeks	99%	99.2%	99.4%	99.1%	↑	
ED - TRUST						
Patients treated < 4 hours Type 1 & 3 (ED + UCC)	95%	87.8%	82.7%	83.0%	↑	
Emergency Department Attendances	N/A	9523	8973	45989	↓	
12 Hours Trolley Waits	0	0	0	10	↔	
Ambulance to ED Handover Time - TRUST						
15-29 minutes breaches		1652	1692	8533	↑	
30-59 minute breaches		299	352	1795	↑	
60+ minute breaches		41	26	193	↓	
Ambulance to Assessment Area Handover Time - TRUST						
30-59 minute breaches		12	18	62	↑	
60+ minute breaches		1	1	7	↔	

Performance - Key Performance Indicators cont.

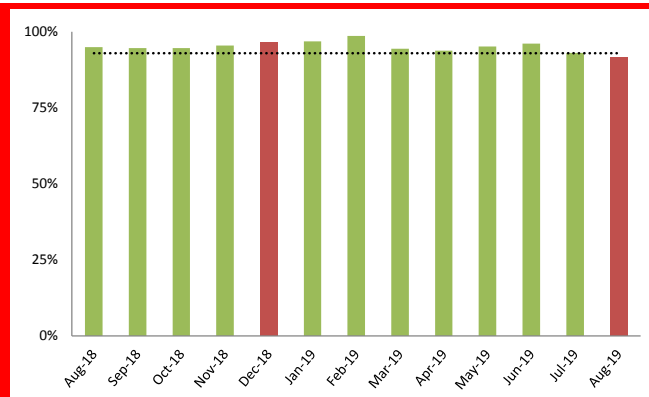
	Target	Jul-19	Aug-19	Actual YTD	Trend	Month Status
Cancelled Operations - TRUST						
% Cancelled Operations	1.0%	2.4%	2.2%	2.0%	↓	
Cancelled operations - breaches of 28 day rule	0	1	2	3	↑	
Urgent operations - cancelled twice	0	0	0	0	↔	
GP Discharge Letters						
GP Discharge Letters	90%	90.3%	93.4%	80.4%	↑	
Theatre Utilisation - TRUST						
Theatre Utilisation - Day Case (RHH & Corbett)		74.8%	74.3%	76.4%	↓	
Theatre Utilisation - Main		85.6%	87.2%	86.6%	↑	
Theatre Utilisation - Trauma		95.4%	97.8%	93.0%	↑	
GP Referrals						
GP Written Referrals - made		6986	6630	33788	↓	
GP Written Referrals - seen		6455	5445	28597	↓	
Other Referrals - Made		3932	3458	17467	↓	
Throughput						
Patients Discharged with a LoS >= 7 Days		6.40%	6.30%	6%	↓	
Patients Discharged with a LoS >= 14 Days		2.77%	3.02%	3%	↑	
7 Day Readmissions		3.0%	3.0%	3%	↔	
30 Day Readmissions - PbR		6.8%	6.2%	7%	↓	
Bed Occupancy - %		89%	87%	88%	↓	
Bed Occupancy - % Medicine & IC		95%	94%	92%	↓	
Bed Occupancy - % Surgery, W&C		82%	81%	84%	↓	
Bed Occupancy - Paediatric %		57%	38%	54%	↓	
Bed Occupancy - Orthopaedic Elective %		65%	69%	70%	↑	
Bed Occupancy - Trauma and Hip %		89%	91%	92%	↑	
Number of Patient Moves between 8pm and 8am		86	55	455	↓	
Discharged by Midday		14.6%	13.3%	15%	↓	
Outpatients						
New outpatient appointment DNA rate	8%	7.32%	9.13%	8.1%	↑	
Follow-up outpatient appointment DNA rate	8%	6.4%	10.2%	8.0%	↑	
Total outpatient appointment DNA rate	8%	6.8%	9.7%	40.6%	↑	
Clinic Utilisation		80.6%	80.5%	80.0%	↓	
Average Length of stay (Quality Strategy Goal 3)						
Average Length of Stay - Elective	2.4	2.60	2.73	2.7	↑	
Average Length of Stay - Non-Elective	3.4	4.4	4.8	4.7	↑	

The Dudley Group NHS Foundation Trust

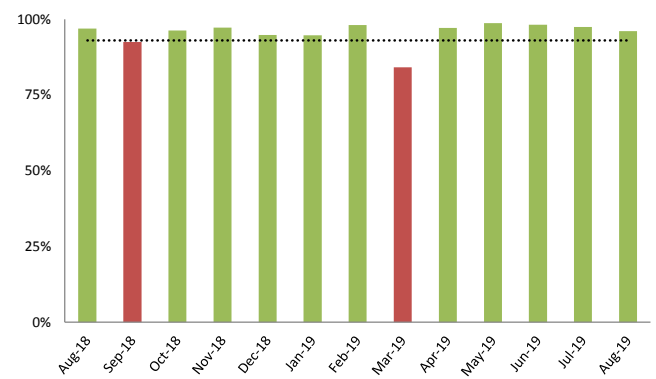
Performance Matters (KPIs)

Regulatory Performance - Cancer (Latest month is provisional)

All Cancer 2 Week Waits



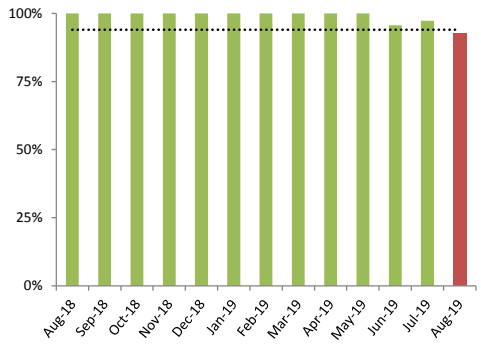
Breast Symptomatic



31 Day - Targets

31 Day Diagnostic to Treatment

31 Day Subsequent Treatment (Surgery)



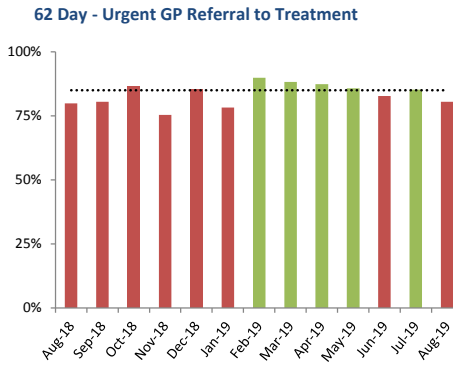
31 Day Subsequent Treatment (Drugs)

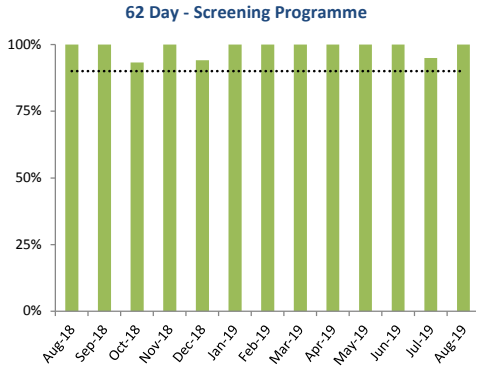
The Dudley Group NHS Foundation Trust

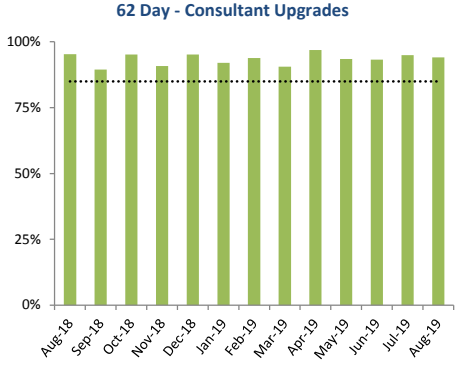
Performance Matters (KPIs)

Regulatory Performance - Cancer (Latest month is provisional)

62 Day Cancer Targets





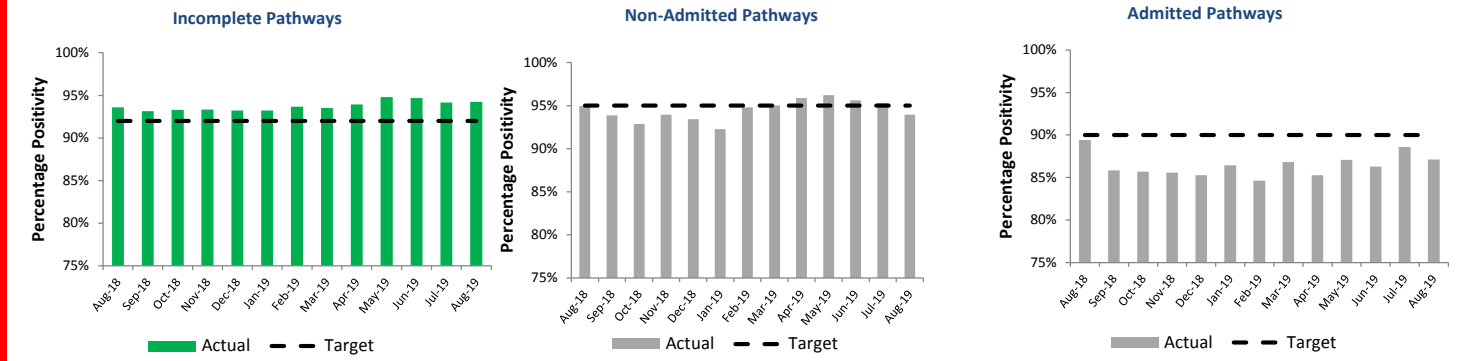


The Dudley Group NHS Foundation Trust

Performance Matters (KPIs)

Regulatory Performance - 18 Week Referral to Treatment

Consultant 18 Week Referral to Treatment



RTT 18 Week Performance - August 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%**

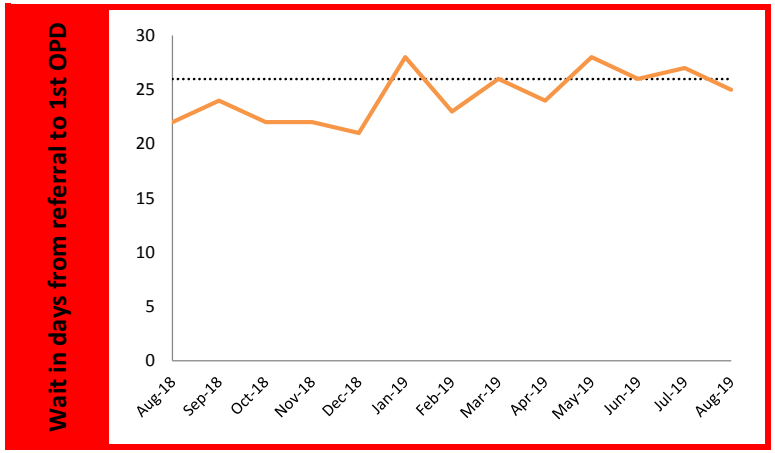
Comments

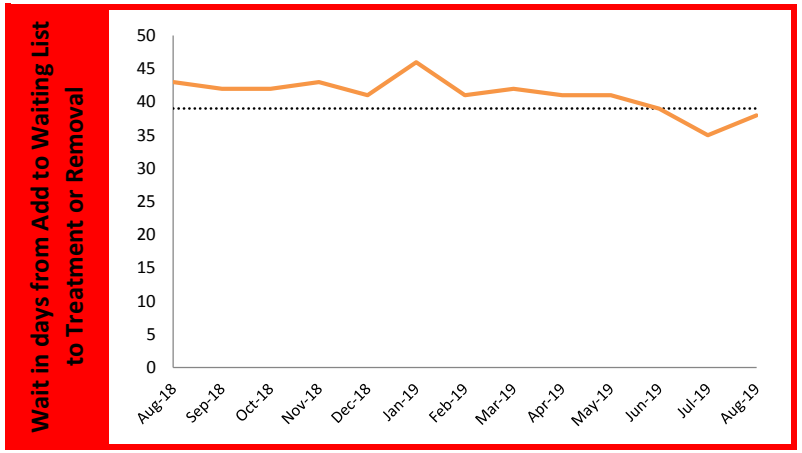
The total number of incomplete pathways has increased over the recent months by 5%, in particular there has been an overall increase in incomplete pathways in the following specialties: Urology, Colorectal, Vascular, Oral Surgery and Paediatric ENT. There remains a continued focus on these specialties on reducing the total number of incomplete pathways

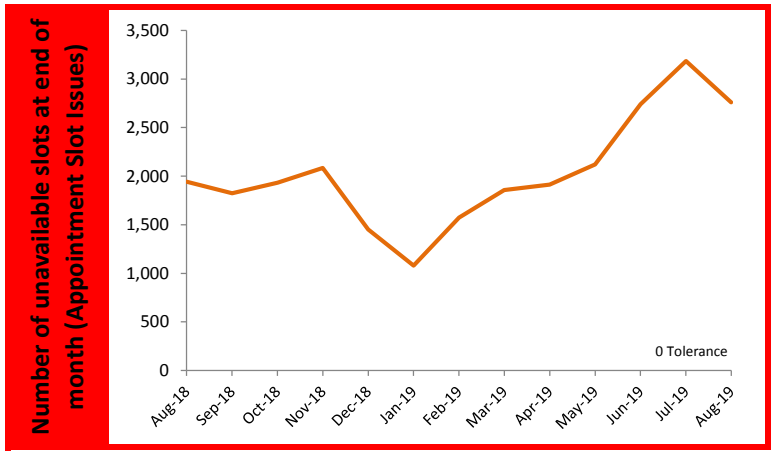
The Dudley Group NHS Foundation Trust

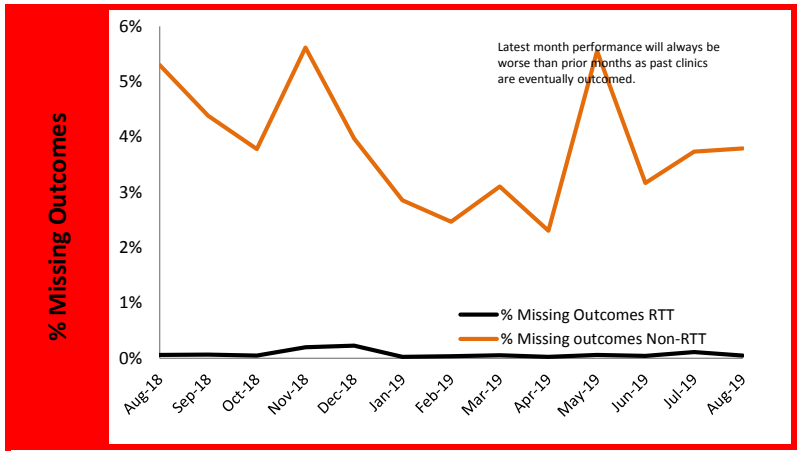
Performance Matters (KPIs)

Regulatory Performance - 18 Week Referral to Treatment









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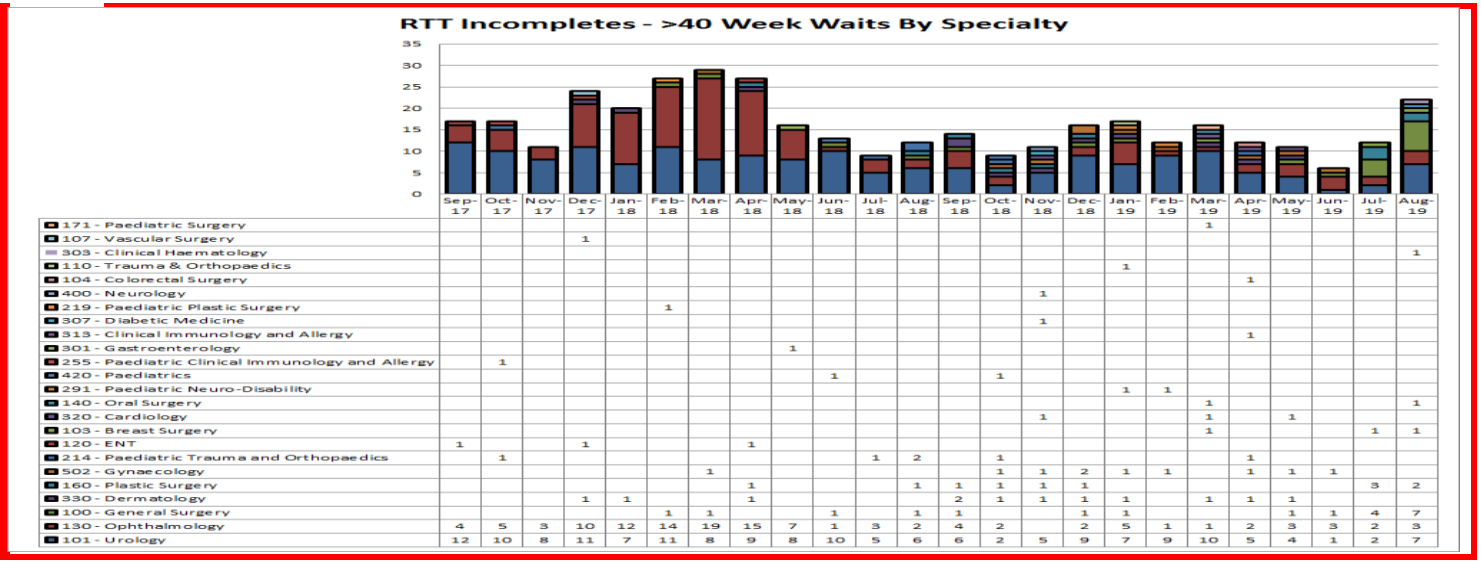
Performance Matters (KPIs)

Regulatory Performance - RTT Incompletes

RTT Incompletes by Specialty



	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19
171 - Paediatric Surgery																			1					
107 - Vascular Surgery				1																				
303 - Clinical Haematology																								1
110 - Trauma & Orthopaedics																	1							
104 - Colorectal Surgery																				1				
400 - Neurology															1									
219 - Paediatric Plastic Surgery						1																		
307 - Diabetic Medicine															1									
313 - Clinical Immunology and Allergy																				1				
301 - Gastroenterology									1															
255 - Paediatric Clinical Immunology and Allergy		1																						
420 - Paediatrics										1				1										
291 - Paediatric Neuro-Disability																	1	1						
140 - Oral Surgery																			1					1
320 - Cardiology															1				1		1			
103 - Breast Surgery																			1				1	1
120 - ENT	1			1				1																
214 - Paediatric Trauma and Orthopaedics		1									1	2		1						1				
502 - Gynaecology							1							1	1	2	1	1		1	1	1		
160 - Plastic Surgery								1				1	1	1	1	1							3	2
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	7
130 - Ophthalmology	4	5	3	10	12	14	19	15	7	1	3	2	4	2		2	5	1	1	2	3	3	2	3
101 - Urology	12	10	8	11	7	11	8	9	8	10	5	6	6	2	5	9	7	9	10	5	4	1	2	7

Comments

There is 0 RTT waits over 52 weeks

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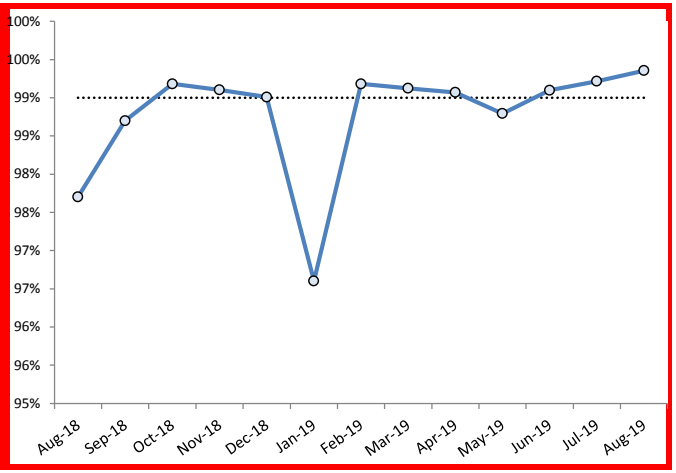
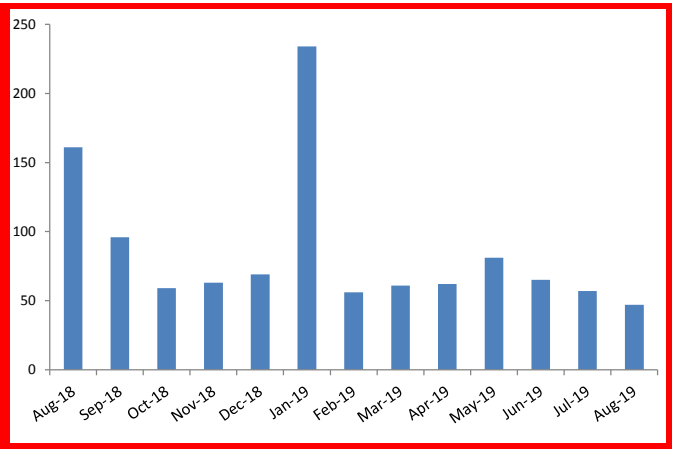
Performance Matters (KPIs)

Diagnostics

DM01 Performance



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



DM01 Comments

The diagnostic standard (DM01) was achieved for August 2019 with a performance of 99.35% against the target of 99% patients seen in less than 6 weeks. It should be noted that this is the best performance against the standard for some time, and is a reflection of the level of effort made by Imaging and other diagnostic services to ensure patients receive their diagnostic tests in line with the National target. In line with previous months the largest concentration of breaches were to be found within MRI, which accounted for 31 out of a total of 47 breaches. This signifies a reduction in the MRI backlog in line with the performance improvement trajectory, with further additional GA MRI and Cardiac MRI lists planned for September 2019 to reduce this further.

The Imaging Department has now commenced the replacement of the first CT scanner at the Russells Hall Hospital site which is due to complete in November 2019. During this period significant effort is being made to ensure continued delivery of the DM01 standard at the same time as maintaining an effective inpatient and ED service.

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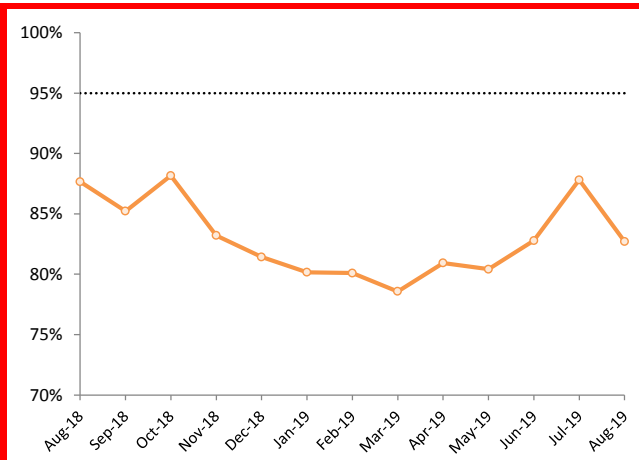
Performance Matters (KPIs)

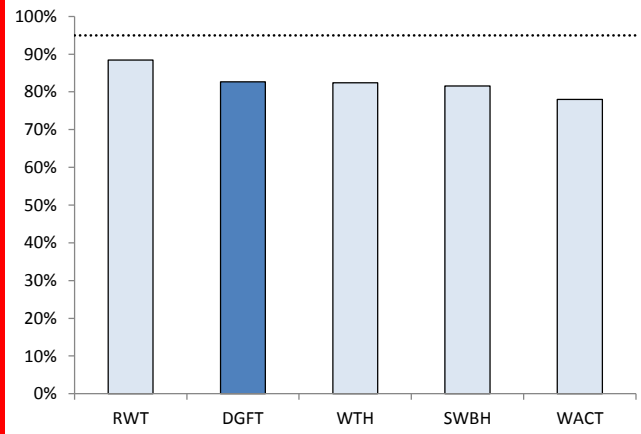
Regulatory Performance - ED

Please note: HEFT and UHB data has been merged

A&E 4 Hour Wait - Combined

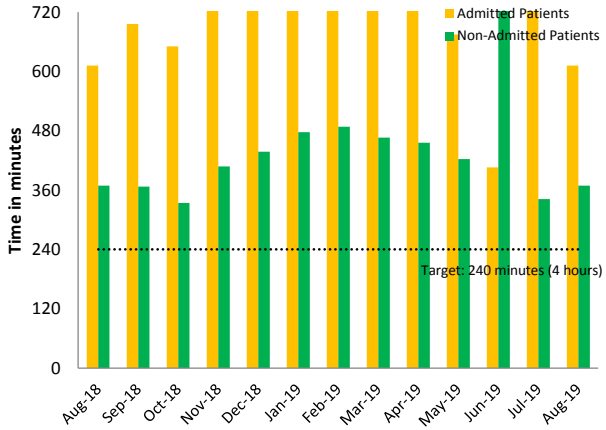


A&E 4 Hour Wait - Benchmarking



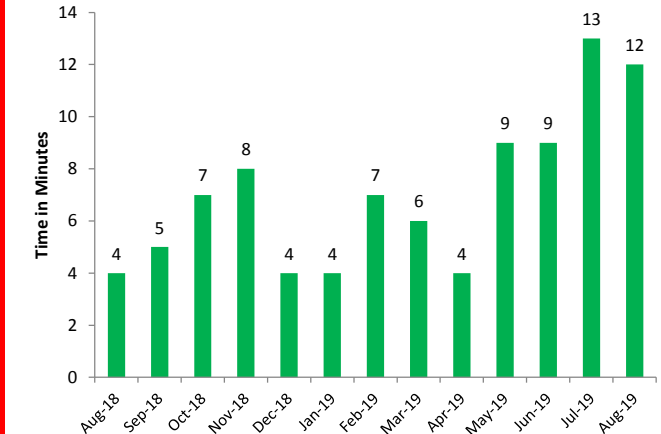
Waiting time in ED

95% of patients waited no longer than this



Waiting Time to Initial Assessment

95% of patients waited no longer than this



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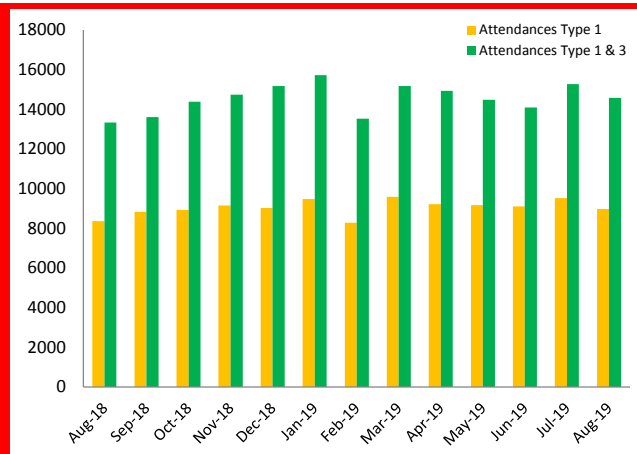
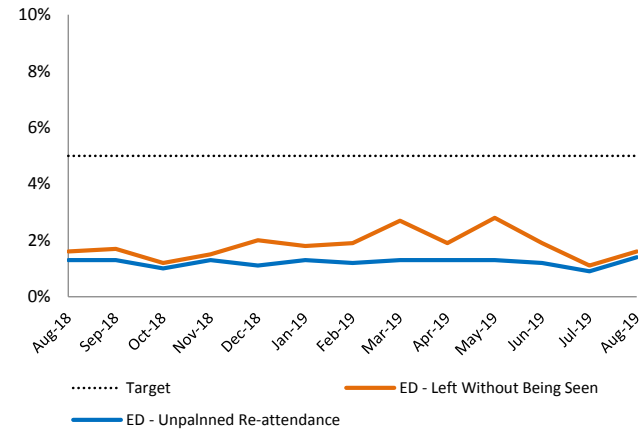
Performance Matters (KPIs)

Regulatory Performance - ED

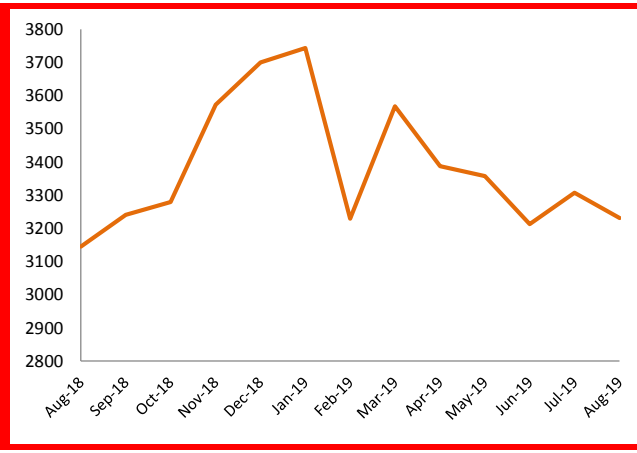
Number of Attendances



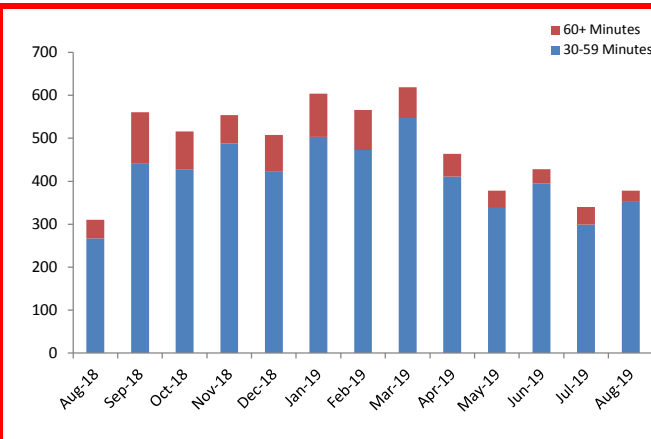
A&E Left without being seen & Unplanned Re-attendances Rates



No. of Ambulance Conveyances



Ambulance Handovers



Financial Performance - "At a glance"

Executive Lead: Tom Jackson

The Dudley Group NHS Foundation Trust

Performance - Financial Overview

	Month Plan	Month Actual	Variance %	Variance	Plan YTD	Actual YTD	Variance %	Variance
ACTIVITY LEVELS (PROVISIONAL)								
Elective inpatients	502	460	-8.4%	-15	1,469	1,378	-6.2%	-91
Day Cases	3,740	3,520	-5.9%	611	12,158	13,838	13.8%	1,680
Non-elective inpatients	3,921	3,750	-4.4%	-483	12,236	10,749	-12.2%	-1,487
Outpatients	39,928	40,517	1.5%	1,067	115,593	114,578	-0.9%	-1,015
A&E	8,779	8,973	2.2%	305	25,595	26,316	2.8%	721
Total activity	**56,870**	**57,220**	0.6%	**1,485**	**167,051**	**166,859**	-0.1%	**-192**
CIP	**£'000**	**£'000**		**£'000**	**£'000**	**£'000**		**£'000**
Income	202	634	213.9%	432	854	1,587	85.8%	733
Pay	278	387	39.1%	109	1,372	1,734	26.4%	362
Non-Pay	1,722	294	-82.9%	-1,428	4,191	1,174	-72.0%	-3,017
Total CIP	**2,202**	**1,315**	**-40.3%**	**-887**	**6,417**	**4,495**	**-30.0%**	**-1,922**
INCOME	**£'000**	**£'000**		**£'000**	**£'000**	**£'000**		**£'000**
NHS Clinical	28,976	29,197	0.8%	221	146,811	146,255	-0.4%	-557
Other Clinical	310	216	-30.3%	-94	1,667	1,392	-16.5%	-276
STF Funding	431	431	0.0%	0	1,831	2,207	20.5%	376
Other	1,478	1,862	26.0%	385	8,418	9,338	10.9%	920
Total income	**31,194**	**31,706**	**1.6%**	**512**	**158,728**	**159,192**	**0.3%**	**464**
OPERATING COSTS	**£'000**	**£'000**		**£'000**	**£'000**	**£'000**		**£'000**
Pay	-19,657	-19,336	-1.6%	321	-98,614	-97,869	-0.8%	745
Drugs	-2,903	-3,051	5.1%	-149	-14,503	-15,444	6.5%	-941
Non-Pay	-6,616	-7,835	18.4%	-1,219	-37,241	-39,628	6.4%	-2,388
Other	-1,902	-1,876	-1.4%	26	-9,443	-9,312	-1.4%	131
Total Costs	**-31,078**	**-32,098**	**3.3%**	**-1,020**	**-159,800**	**-162,253**	**1.5%**	**-2,453**

Performance - Financial Overview - TRUST LEVEL ONLY

	Month Plan	Month Actual	Variance %	Variance	Plan YTD	Actual YTD	Variance %	Variance
	£'000	**£'000**		**£'000**	**£'000**	**£'000**		**£'000**
EBITDA	**2,014**	**1,510**	**-25.0%**	**-504**	**8,349**	**6347**	**-24.0%**	**-2,002**
Depreciation	-758	-739	--2.5%	19	-3,745	-3703	--1.1%	42
Restructuring & Other	0	0	n/a	0	0	0	n/a	0
Financing Costs	-1,147	-1,142	--0.4%	5	-5,713	-5627	--1.5%	86
SURPLUS/(DEFICIT)	**109**	**-371**	**-440.4%**	**-480**	**-1,109**	**-2983**	169.0%	**-1,874**
SOFP	**£'000**	**£'000**		**£'000**	**£'000**	**£'000**		**£'000**
Capital Spend	-477	-236	-50.5%	241	-4,794	-2,229	-53.5%	2,565
Inventory					3,529	3,668	3.9%	139
Receivables & Prepayments					14,661	13,767	-6.1%	-894
Payables					-28,632	-28,342	-1.0%	290
Accruals							n/a	0
Deferred Income					-2,491	-4,041	62.2%	-1,550
Cash & Loan Funding	**£'000**	**£'000**		**£'000**	**£'000**	**£'000**		**£'000**
Cash					3,197	9,384	193.5%	6,187
Loan Funding							n/a	0
KPIs								
EBITDA %	7.0%	5.2%	-1.7%		3.1%	2.4%	-0.7%	
Deficit %	0.4%	-1.3%	-1.7%		-0.4%	-1.1%	-0.7%	
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

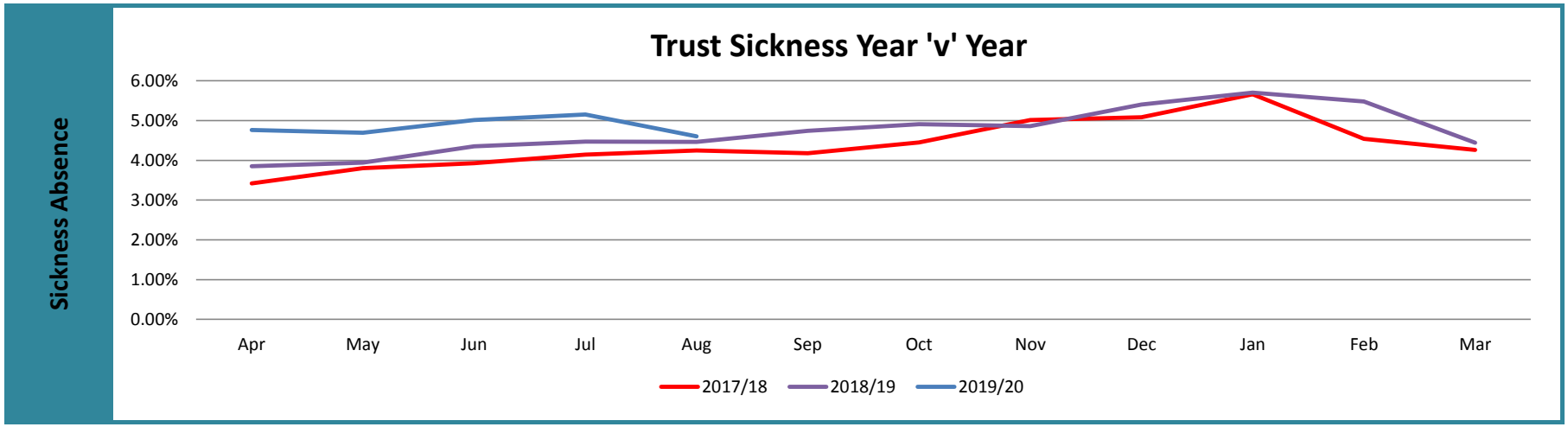
Workforce - "At a glance"

Executive Lead: Andrew McMenemy

	People					
	Target			Actual		Month
	19/20	Jul-19	Aug-19	YTD	Trend	Status
Workforce						
Sickness Absence Rate	3.50%	4.76%	4.60%	4.97%	↓	
Staff Turnover	8.5%	8.72%	8.89%	8.55%	↑	
Mandatory Training	90.0%	89.7%	92.2%	90.2%	↑	
Appraisal Rates - Total	90.0%	95.5%	95.5%	70.5%	↔	

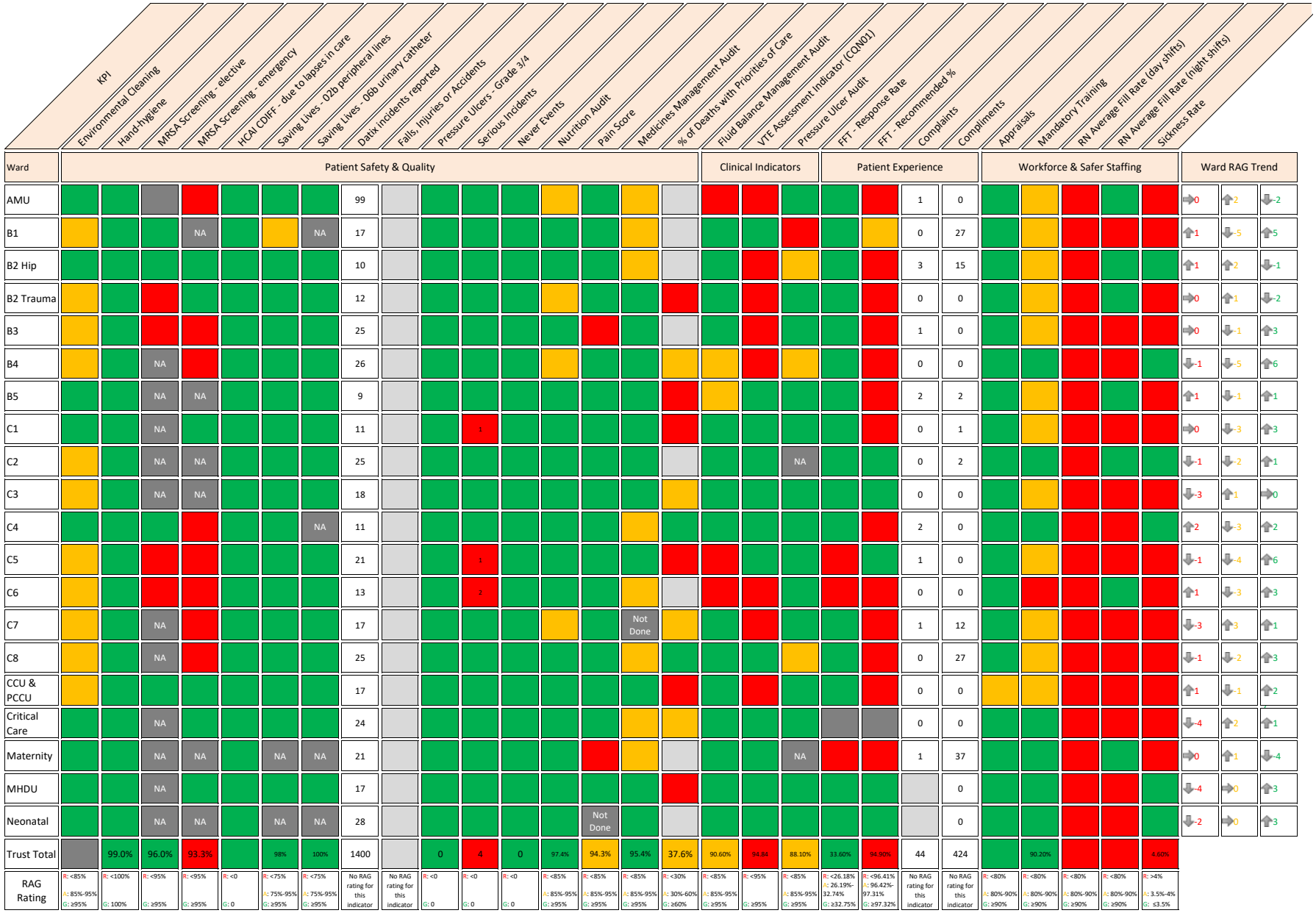
People will be proud to work for us

Workforce



Quality Indicators

Heat Map - August 2019



Ward	Patient Safety & Quality																Clinical Indicators			Patient Experience				Workforce & Safer Staffing					Ward RAG Trend		
	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			
AMU								99														1	0						0	2	-2
B1				NA			NA	17														0	27						1	-5	5
B2 Hip								10														3	15						1	2	-1
B2 Trauma								12														0	0						0	1	-2
B3								25														1	0						0	-1	3
B4			NA					26														0	0						-1	-5	6
B5			NA	NA				9														2	2						1	-1	1
C1			NA					11			1											0	1						0	-3	3
C2			NA	NA				25											NA			0	2						-1	-2	1
C3			NA	NA				18														0	0						-3	1	0
C4							NA	11														2	0						2	-3	2
C5								21			1											1	0						-1	-4	6
C6								13			2											0	0						1	-3	3
C7			NA					17						Not Done								1	12						-3	3	1
C8			NA					25														0	27						-1	-2	3
CCU & PCCU								17														0	0						1	-1	2
Critical Care			NA					24														0	0						-4	2	1
Maternity			NA	NA		NA	NA	21											NA			1	37						0	1	-4
MHDU			NA					17														0							-4	0	3
Neonatal			NA	NA		NA	NA	28						Not Done								0							-2	0	3
Trust Total		99.0%	96.0%	93.3%		98%	100%	1400		0	4	0	97.4%	94.3%	95.4%	37.6%	90.60%	94.84	88.10%	33.60%	94.90%	44	424		90.20%			4.60%			
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%	71.92%	-	-	-	-	-	-	-	72.93%	%
A&E - 4 Hour UCC Dept Only % (Type 3)	99.69%	99.45%	100.00%	99.95%	99.77%	100%	-	-	-	-	-	-	-	99.83%	%
A&E - 4 Hour UCC/A&E Combined % (Type 1+3)	83.96%	80.93%	80.41%	82.77%	87.8%	82.7%	-	-	-	-	-	-	-	82.96%	95%
A&E - Patients who Left Without Being Seen %	1.9%	1.9%	2.8%	1.9%	1.1%	1.6%	-	-	-	-	-	-	-	1.8%	5%
A&E - Time to Initial Assessment (95th Percentile)	6	4	9	9	13	12	-	-	-	-	-	-	-	12	15
A&E - Time to Treatment Median Wait (Minutes)	94	68	80	34	58	66	-	-	-	-	-	-	-	66	60
A&E - Total Time in A&E (95th Percentile)	732	743	526	583	524	598	-	-	-	-	-	-	-	598	240
A&E - Unplanned Re-Attendance Rate %	1.3%	1.3%	1.3%	1.2%	0.9%	1.4%	-	-	-	-	-	-	-	1.2%	5%
Activity - A&E Attendances	107,524	9,188	9,129	9,102	9,537	8,948	-	-	-	-	-	-	-	45,904	44,162
Activity - Cancer MDT	5,960	508	559	501	531	537	-	-	-	-	-	-	-	2,636	2,685
Activity - Community Attendances	426,917	35,549	36,448	33,316	38,256	36,576	-	-	-	-	-	-	-	180,145	172,391
Activity - Critical Care Bed Days	8,211	651	683	592	738	692	-	-	-	-	-	-	-	3,356	3,649
Activity - Diagnostic Imaging whilst Out-Patient	54,126	4,481	4,645	4,269	5,039	4,539	-	-	-	-	-	-	-	22,973	23,826
Activity - Direct Access Pathology	2,140,369	187,105	196,682	200,092	221,103	194,852	-	-	-	-	-	-	-	999,834	858,420
Activity - Direct Access Radiology	76,758	6,367	6,436	5,950	6,635	5,917	-	-	-	-	-	-	-	31,305	32,061
Activity - Elective Day Case Spells	49,959	3,679	3,672	3,520	3,860	3,532	-	-	-	-	-	-	-	18,263	19,153
Activity - Elective Inpatients Spells	5,469	439	471	460	506	486	-	-	-	-	-	-	-	2,362	2,490
Activity - Emergency Inpatient Spells	43,701	3,628	4,141	3,750	3,912	3,890	-	-	-	-	-	-	-	19,321	20,235
Activity - Excess Bed Days	8,242	941	814	641	566	832	-	-	-	-	-	-	-	3,794	4,897
Activity - Maternity Pathway	7,361	589	556	542	609	519	-	-	-	-	-	-	-	2,815	2,905
Activity - Neo Natal Bed Days	7,236	134	106	99	94	121	-	-	-	-	-	-	-	554	523
Activity - Outpatient First Attendances	171,763	15,081	15,576	15,290	16,797	14,496	-	-	-	-	-	-	-	77,240	71,924
Activity - Outpatient Follow Up Attendances	324,962	26,395	27,727	27,090	28,649	25,702	-	-	-	-	-	-	-	135,563	143,604
Activity - Outpatient Procedure Attendances	73,394	6,707	6,656	6,221	7,442	6,313	-	-	-	-	-	-	-	33,339	30,464
Activity - Rehab Bed Days	22,862	1,624	2,480	2,291	2,523	2,580	-	-	-	-	-	-	-	11,498	8,605
Activity - Renal Dialysis	49,399	4,157	4,282	3,961	4,077	4,282	-	-	-	-	-	-	-	20,759	21,038
Ambulance Handover - 30 min – breaches (DGH view)	5,165	411	338	395	299	352	-	-	-	-	-	-	-	1,795	0
Ambulance Handover - 30 min – breaches (WMAS view)	6,669	545	454	531	395	458	-	-	-	-	-	-	-	2,383	0
Ambulance Handover - 60 min – breaches (DGH view)	916	53	40	33	41	26	-	-	-	-	-	-	-	193	0
Ambulance Handover - 60 min – breaches (WMAS view)	1,071	65	47	43	47	37	-	-	-	-	-	-	-	239	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%	91.3%	-	-	-	-	-	-	-	93.8%	93%
Cancer - 14 day - Urgent GP Breast Symptom Referral to date first seen	94.5%	97.1%	98.7%	98.1%	97.4%	96.1%	-	-	-	-	-	-	-	97.4%	93%
Cancer - 31 day - from diagnosis to treatment for all cancers	98.4%	98.2%	97.7%	98.0%	99.4%	99.3%	-	-	-	-	-	-	-	98.5%	96%
Cancer - 31 Day For Second Or Subsequent Treatment - Anti Cancer Drug Treatments	100%	90%	100%	100%	100%	100.0%	-	-	-	-	-	-	-	98.5%	98%
Cancer - 31 Day For Second Or Subsequent Treatment - Surgery	100.0%	100%	100%	95.6%	97.3%	100%	-	-	-	-	-	-	-	98.6%	94%
Cancer - 31 Day For Subsequent Treatment From Decision To Treat	100.0%	97%	100%	97.5%	98.0%	100%	-	-	-	-	-	-	-	98.5%	96%
Cancer - 62 day - From Referral for Treatment following a Consultant Upgrade	91.4%	96.8%	93.4%	93.2%	94.9%	93%	-	-	-	-	-	-	-	94.3%	85%
Cancer - 62 day - From Referral for Treatment following national screening referral	98.1%	100.0%	100.0%	100%	95.0%	100%	-	-	-	-	-	-	-	99.1%	90%
Cancer - 62 day - From Urgent GP Referral to Treatment for All Cancers	82.8%	87.3%	85.7%	82.7%	85.2%	84.1%	-	-	-	-	-	-	-	85.1%	85%
Maternity: Breastfeeding Data Coverage Rates	100%	100%	100%	100%	100%	100%	-	-	-	-	-	-	-	100%	0%
Number of Births Within the Trust	4,315	348	343	334	362	387	-	-	-	-	-	-	-	1,774	
RTT - Admitted Pathways within 18 weeks %	86.3%	85.2%	87%	86.2%	88.5%	87.1%	-	-	-	-	-	-	-	86.8%	90%
RTT - Incomplete Waits within 18 weeks %	94%	93.9%	95%	95%	94%	94.2%	-	-	-	-	-	-	-	94.3%	92%
RTT - Non-Admitted Pathways within 18 weeks %	94.5%	95.8%	96.2%	95.6%	95.2%	93.9%	-	-	-	-	-	-	-	95.3%	95%
Waiting Time - Diagnostic 6 Week Maximum Wait (VSA05)	98.82%	99.06%	98.79%	99.09%	99.21%	99.35%	-	-	-	-	-	-	-	99.11%	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	£999k	-	-	-	-	-	-	-	£5,448k	k
Bank spend	£20,035k	£1,673k	£1,651k	£1,811k	£1,667k	£1,754k	-	-	-	-	-	-	-	£8,556k	k
Budgetary Performance	(£13,226)k	£657k	(£378)k	£296k	(£2,056)k	(£508)k	-	-	-	-	-	-	-	(£1,990)k	£0k
Capital v Forecast	88.1%	12.3%	40.2%	47.6%	46.2%	46.5%	-	-	-	-	-	-	-	46.5%	95%
Cash Balance	£8,928k	£7,005k	£5,154k	£2,825k	£7,835k	£9,384k	-	-	-	-	-	-	-	£9,384k	k
Cash v Forecast	64.9%	87.4%	97.8%	77.8%	178%	293.5%	-	-	-	-	-	-	-	294%	95%
Creditor Days	22.7	19.7	20.3	19.8	18	1680.0%	-	-	-	-	-	-	-	16.8	15
Debt Service Cover	0.8	0.08	0.61	0.57	0.76	0.8	-	-	-	-	-	-	-	0.8	2.5
Debtor Days	8.6	13.2	13.2	12.9	10.2	8.5	-	-	-	-	-	-	-	8.5	15
I&E (After Financing)	(£4,987)k	(£1,597)k	(£233)k	(£1,106)k	£267k	(£392)k	-	-	-	-	-	-	-	(£3,062)k	k
Liquidity	-15.65	-12.66	-13.44	-14.78	-15.16	-15.79	-	-	-	-	-	-	-	-15.79	0
SLA Performance	£3,277k	£73k	(£572)k	(£436)k	(£533)k	£128k	-	-	-	-	-	-	-	(£1,340)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%	90.2%	-	-	-	-	-	-	-	90.2%	90%
RN average fill rate (DAY shifts)	81.83%	85.42%	87.35%	83.62%	84.64%	82.21%	-	-	-	-	-	-	-	84.62%	95%
RN average fill rate (NIGHT shifts)	86.43%	88.14%	90.74%	88.87%	87.8%	86.11%	-	-	-	-	-	-	-	88.28%	95%
Sickness Rate	4.66%	4.78%	4.76%	5.08%	5.14%	4.60%	-	-	-	-	-	-	-	4.87%	3.50%
Staff In Post (Contracted WTE)	4,397.87	4,376.76	4,405.40	4,418.19	4,431.60	4,444.82	-	-	-	-	-	-	-	4,444.82	
Turnover Rate (Rolling 12 Months)	8.48%	8.25%	8.25%	8.66%	8.82%	8.89%	-	-	-	-	-	-	-	8.89%	%
Vacancy Rate	9.35%	13.73%	13.33%	13.03%	12.74%	12.68%	-	-	-	-	-	-	-	12.68%	%

Enclosure 16

The Dudley Group NHS Foundation Trust

Paper for submission to the Board of Directors on 3rd October 2019

TITLE:	**The Dudley People Plan**		
AUTHOR:	**Andrew McMenemy, Director of Workforce & OD**	**PRESENTER**	**Andrew McMenemy, Director of Workforce & OD**

CLINICAL STRATEGIC AIMS

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

ACTION REQUIRED OF COMMITTEE

Decision	Approval	Discussion	Other
		Y	

RECOMMENDATIONS

- To consider the Dudley People Plan and to be assured that this appropriately aligns to the overall Trust Strategy, including key workforce development, transformation and well-being initiatives.
- To endorse the expected delivery outcomes and measures of success highlighted in the enclosed paper.
- To acknowledge the role of the Workforce & Staff Engagement Committee to receive regular updates from the proposed sub-groups on the five priority areas.
- To support the receipt of an annual report form the Director of Workforce & OD to the Board that demonstrates overall progress of the Dudley People Plan.

CORPORATE OBJECTIVE:

SO4: Be the place people choose to work

SUMMARY OF KEY ISSUES:

The enclosed paper provides the Board of Directors with an overview of the five year Dudley People Plan and the priority areas where particular focus will be provided. The priority areas are:

Key Area One - A Workforce for Now and in the Future;
Key Area Two - A Caring, Kind and Compassionate Place;
Key Area Three - Equality, Fairness and Inclusion;
Key Area Four - Improvement and Development Culture;
Key Area Five - Using Technology to Innovate.

The paper also provides supporting information regarding the expected outcomes as well as measures of success associated to each of the key priority areas.

Finally the paper describes how the implementation stage will be taken forward alongside the ongoing performance management of the Dudley People Plan in conjunction with the Workforce & Staff Engagement Committee and the Board of Directors.

IMPLICATIONS OF PAPER:			
IMPLICATIONS FOR THE CORPORATE RISK REGISTER OR BOARD ASSURANCE FRAMEWORK The Dudley People Plan acts as an enabling strategy that provides mitigations alongside the Workforce related risks highlighted both within the Board Assurance Framework as well as the Corporate Risk Register.			
RISK	**Y**		**Risk Description:** COR981, COR1065, COR982
	Risk Register: Y		**Risk Score:** 16, 15, 16.
COMPLIANCE and/or LEGAL REQUIREMENTS	**CQC**	**Y**	**Details:** Well Led
	NHSI	**N**	**Details:**
	Other	**N**	**Details:**
REPORT DESTINATION	**EXECUTIVE DIRECTORS**	**Y**	**DATE:** 24th September 2019

Introduction

The Dudley People Plan was developed in the early part of 2019 following the conclusion of the previous Workforce Strategy. The review of the Strategy to support workforce priorities took consideration of the work being undertaken nationally regarding the NHS People Plan. It also considered developing workforce themes in areas such as digitisation, inclusion and compassion as well the move towards integration of NHS provision.

The review of the Workforce Strategy that became the Dudley People Plan considered the views of stakeholders across the Trust while engaging with colleagues both regionally and nationally. The Dudley People Plan also took consideration of the views from our staff based on feedback from 'Make it Happen' events as well as the national Staff Survey.

When developing the Dudley People Plan I was also mindful of aligning the Plan to the new Trust Strategy ensuring that the Plan supported the strategic objectives and vision of the Trust over the next 5 years.

Therefore the Five Key Areas of the Dudley People Plan identifies the Trust's workforce priorities over the next 5 years with alignment directly with the Trust Strategy 2019-2021 (Care Better Every Day) as well as consideration of the NHS 10 year plan.

The vision demonstrated in the Trust Strategy is our commitment to be – ***Trusted to provide safe, caring and effective services because people matter.***

This vision is supported by our six strategic objectives:

- Deliver a great patient experience;
- Deliver safe and caring services;
- Drive service improvement, innovation and transformation;
- Be the place people choose to work;
- Make the best use of what we have;
- Deliver a viable future.

The Dudley People Plan therefore supports and acts as an enabler for our staff to achieve the six strategic objectives within our Trust Strategy underpinned by our values of Care, Respect and Responsibility.

The period of development associated to the Dudley People Plan considered all the feedback collated ensuring that the priority areas regarding workforce were relevant for Dudley. The Workforce and Staff Engagement Committee dedicated an extended forum to allow a broad range of views to be considered to ensure the Plan captured the main themes that were important to our staff.

Following ratification of the content at the Workforce and Staff Engagement Committee the Plan design and presentation was considered in order to make it accessible and attractive to all staff. In Appendix one and two of this paper the final version of the Dudley People Plan as well as the Behavioural Framework has been attached.

Strategic Priorities that Underpin the Workforce Strategy

The Dudley People Plan is supported by five key areas alongside a business plan that provides details of the main aims associated to each of the priority areas as well as measurable initiatives and outcomes. The Plan and its associated outcomes are described over a five year period with the intention to review annually. The detail below highlights the five priority areas supported by some of the expected delivery outcomes and measures for success.

Key Area One - A Workforce for Now and in the Future

Aim – We make Dudley the place people want to be and stay.

Expected Delivery Outcomes – To transform workforce models across clinical and non-clinical staff groups, considering roles and ways of working. This will include utilising multi-professional capacity and competencies that will deliver workforce sustainability, greater resilience, flexibility, productivity and also enhanced quality of care.

To establish a more sophisticated and credible workforce planning mechanism that aligns our workforce to predicted future changes in the service as well as managing the expected demands within the annual cycle. To use the workforce plans to identify gaps in the workforce that support transformation alongside linking with the workforce efficiencies and lean methodology.

To develop recruitment and retention models alongside colleagues in the STP to allow the system to maximise the benefits of integration and shared best practice for both recruiting staff but also retention models.

Measures for Success – Transforming the profile of the workforce over the next 3-5 years to be 'Future Fit'. i.e. transitioning a proportion of the medical workforce to new multi-professional roles – AHP's/Nurse/Healthcare Scientists.

To embed the revised workforce planning process within the first year and have this aligned with the annual planning process and approach to professional education commissioning.

The planning process will align also align all workforce initiatives, interventions and support processes under the People Plan to ensure maximum impact and benefits for recruitment, retention, staff well-being, engagement, productivity and sustainability.

The measure for success would be the realisation of sustained vacancy levels under 10% across the workforce with particular focus on clinical posts for recruitment, retention and transformation. Therefore supporting sustained retention rates in relevant areas and within relevant skilled posts, below the rate of 8%.

Key Area Two - A Caring, Kind and Compassionate Place

Aim – We support people to have joy in work and to treat each other with compassion and kindness.

Expected Delivery Outcomes – The introduction of the Behaviour Framework that demonstrates the expectations the Trust has of staff to support the Trust values of Care, Respect and Responsibility. To develop a supportive well-being framework with an emphasis on support for managers to assist with difficult discussions, emphasising people over process.

Measures for Success – That the initiatives supporting well-being provide a cultural shift within the Trust towards being more people focused and empathetic. It is therefore expected that this will support improved outcomes in staff feedback within the FFT and national staff survey results. It is the expectation that the Trust will move towards being in the top 20% of Trusts based on Staff Survey feedback.

It is also expected that the cultural developments towards a people focused working environment will provide sustained rates of increased attendance at work with absence rates continually below 3.5%.

Key Area Three - Equality, Fairness and Inclusion

Aim – We have an inclusive culture where we all believe in and live by our Trust values.

Expected Delivery Outcomes – The Trust currently fulfils the legal requirements within the Workforce Race & Disability Equality Schemes. It is expected that this will continue to be enhanced alongside the Workforce Planning developments. This will support a wholesale review of workforce diversity that includes all protected characteristics as well as enhanced training for all staff. The Managers Essential Programme will include the new Diversity Toolkit to provide a guide towards an inclusive culture.

There will also be further work to support inclusive recruitment and induction of staff that supports values based initiatives alongside a commitment to supporting diversity within the recruitment procedure.

We will actively work alongside the NHS Equality & Diversity Council to support the Trust continuously improve its performance on equality. This includes initiatives such as the LGBT in Britain: Health Report published by Stonewall in 2018 where the Trust will be supporting the recommended standard that aims to tackle discrimination of LGBT staff.

Measures for Success – In year one it is expected that at least 50% of those within a supervisory or managerial role undertake the Managers Essential Programme. This will develop further in year two alongside our expectations of participation to the Developing Leaders Programme.

A further measure of success will be the launch of the Diversity toolkit alongside an audit that measures the impact and the success for both managers and staff. The initiatives associated to recruitment and retention will support a demonstration of greater levels of diversity across all levels of the workforce and therefore become more reflective of the local population.

Key Area Four - Improvement and Development Culture

Aim – We create a place that supports you becoming what you want to be. There are opportunities for development and improvement for everyone.

Expected Delivery Outcomes – The Developing Leaders Programme will continue to develop to meet the needs of the Trust and prepare current and aspirant managers to demonstrate effective managerial skills and behaviours. In year one a 'Festival Learning' will take place over a period of a week that will provide an opportunity to provide guidance for staff of available development.

Alongside local opportunities it is also expected that the Trust will support our staff to undertake regional and national development schemes where this is relevant and as a way of developing talent. The succession and talent management will also be supported with availability of dedicated and trained mentors and coaches in the Trust.

Measures for Success – It is expected that in year one that at least 30% of designated leaders will have undertaken the Developing Leaders or equivalent programme. That will be supported with at least 60% of those entering a leadership role for the first time will attend the Developing Leaders Programme within the first 12 months from their appointment.

In future years it is intended that relevant programmes, support alongside mentoring and coaching will be in place for all staff in a leadership role at the Trust. It is also expected that the Development Programme will extend across the STP encouraging development across traditional boundaries.

Key Area Five - Using Technology to Innovate

Aim – We create a place that embraces technology to support different ways of working.

Expected Delivery Outcomes – To work alongside our partners in the STP to support awareness and training that supports staff to think 'digital first'. This will be aligned to the Dudley Improvement Practice to maximise opportunities to develop new ways of working alongside digital solutions.

Technology will free-up valuable workforce capacity, thereby increasing patient facing time, as well as opportunities for more visible leadership and greater investment in staff development.

Technology will also support the Trust's ambitious cross-cutting workforce transformation and productivity programmes, including the current programme aligned to administrative and clerical staff.

The establishment of a combined Digital and Workforce sub-group to consider best practice initiatives from within and outside healthcare that supports new ways of working while integrating technology.

Measures for Success – The establishment of the Digital Workforce group with representation across the Trust with an emphasis on digital skills as well as role. To support all staff to be appropriately trained to support them in their role and deploy the skills framework for 'Digital First'.

To demonstrate service improvements and improve patient outcomes linked to clinical informatics and new and innovative ways of working.

Implementation of the Dudley People Plan

Since the launch of the Dudley People Plan in July 2019 there has been an active promotional campaign using social media, the Make it Happen programme as well as presentations at Team Brief and Divisional and Departmental meetings.

The next stage of the implementation plan will be to seek relevant stakeholders to populate and lead the proposed sub-groups that will lead on the expected delivery outcomes for each of the five priority areas.

It is expected that the chair of each of the sub-groups will provide regular reports to the Workforce & Staff Engagement Committee demonstrating progress against the expected outcomes and measures for success. A relevant dashboard will be developed that will provide a mechanism for reporting progress to the Committee on each of the five priority areas highlighting risks and mitigations.

A relevant update will be provided to Board in the monthly summary reports alongside an annual reflection to Board on overall progress associated to the Dudley People Plan.

Appendix 1

The Dudley Group
NHS Foundation Trust

Dudley People Plan

Our Vision

Our vision is to be trusted to provide safe, caring and effective services, because people matter.

This is delivered through us living the values of **Care, Respect and Responsibility**, and together we create a place people choose to work.

Our Dudley People Plan has five key areas of focus:

A WORKFORCE FOR NOW AND THE FUTURE

We make Dudley the place people want to be and stay.

A CARING, KIND AND COMPASSIONATE PLACE

We support people to have joy in work and to treat each other with compassion and kindness.

EQUALITY, FAIRNESS AND INCLUSION

We have an inclusive culture where we all believe in and live by our Trust values.

IMPROVEMENT AND DEVELOPMENT CULTURE

We create a place that supports you becoming what you want to be. There are opportunities for development and improvement for everyone.

USING TECHNOLOGY TO INNOVATE

We create a place that embraces technology to support different ways of working.

#joyinwork

Check out the full Dudley People Plan on the hub or follow the chat on Twitter.

Supported by our values of Care, Respect and Responsibility

DudleyGroupNHS

Care better every day

DudleyGroupNHS

Appendix 2

NHS
The Dudley Group
NHS Foundation Trust

Behaviour framework

for everyone to support our values

CARE

A CARING, KIND AND COMPASSIONATE PLACE: We will support people to have joy in work and to treat each other with compassion and kindness.

RESPECT

A PLACE WHERE COLLEAGUES RESPECT ONE ANOTHER: We will behave with respect towards everyone we meet to encourage an inclusive culture where we all believe in and live by our Trust values.

RESPONSIBILITY

A WORKFORCE FOR NOW AND THE FUTURE: Making Dudley the place people want to be and stay because everyone has a role to play and takes responsibility for themselves and their teams.

⊕ ESSENTIAL BEHAVIOURS

- Say Hello my name is... for patients and say hello to colleagues
- Keep smiling
- Listen to others and focus on them
- Help others
- Stay positive
- Take pride in your job
- Be kind to everyone
- Be thoughtful
- Be compassionate

- Adult to adult behaviour
- Communicate well
- Understand how others feel
- Take time with others
- Acknowledge others
- Be polite and professional
- Work as a team
- Think before you speak
- Apologise when wrong/made a mistake
- Respect the views of others

- Look after your health and wellbeing
- Be honest
- Help people when they need it
- Do the best you can
- Work as a team
- Take measured risks
- Welcome change even if nervous
- Support your manager & team members
- Keep yourself up to date
- Treat everyone fairly and equally

⊖ INAPPROPRIATE BEHAVIOURS

- Being negative
- Being unhelpful
- Ignoring or ridiculing others
- Silo working, not a team player
- Being rude or aggressive towards others
- Being dismissive of others
- Bullying or harassing behaviour
- Disregard for others feelings
- Being abrupt

- Gossiping about others
- Negative or unhelpful comments
- Slamming doors / items around
- Shouting or swearing
- Interrupting others
- Walking away mid-sentence
- Excluding people
- Not listening to others
- Avoiding giving feedback
- Posting inappropriate content on social media

- Being unfair towards others
- Doing the bare minimum
- Ignoring others when they need help
- Being reactive rather than proactive
- Working on your own agenda at the expense of others
- Accepting poor performance
- Avoiding taking action
- Blaming others
- Favouring friends at work

Supported by our values of Care, Respect and Responsibility

Care better every day

Enclosure 17

The Dudley Group NHS Foundation Trust

Paper for submission to the Board of Directors on Thursday 3rd October 2019

TITLE:	**Staff Survey 2018 Update and Preparation for 2019**		
AUTHOR:	**Becky Cooke – Acting Head of HR & Rachel Andrew, Head of Learning and OD**	**PRESENTER**	**Andrew McMenemy, Director of Workforce**

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

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

RECOMMENDATIONS

The Board is requested to:

- agree the actions suggested to act as champions for the Staff Survey 2019;
- note the actions and progress on themes identified from the 2018 Staff Survey;
- agree the actions and plan outlined for the delivery of the 2019 Staff Survey.

CORPORATE OBJECTIVE:

SO4 – Be the place people choose to work
SO2 – Safe, caring and effective services

SUMMARY OF KEY ISSUES:

- Good progress has been made on delivering the key activities identified from the 2018 Staff Survey with ongoing work highlighted in development, engagement and in tackling bullying and harassment.
- The report also outlines the planned approach to the 2019 Staff Survey.

IMPLICATIONS OF PAPER:

There are implications for the Corporate Risk Register and/or the Board Assurance Framework, ie, engagement, as measured through the National Staff Survey, remains a key risk as this has an impact on workforce performance.

RISK	**Y**		**Risk Description: Engagement of Staff and impact on retention**
	Risk Register: Y		**Risk Score:**
COMPLIANCE and/or LEGAL REQUIREMENTS	**CQC**	**Y**	**Details: Well Led**
	NHSI	**Y**	**Details:** Staff Survey part of 2019/20 metrics
	Other	**Y/N**	**Details:**
REPORT DESTINATION	**EXECUTIVE DIRECTORS**	**Y**	**DATE: 24th September 2019**
	COMMITTEE	**Y/N**	**DATE: Workforce 30th September 2019**
	WORKING GROUPS	**Y/N**	**DATE:**

The Dudley Group NHS Foundation Trust

National Staff Survey –
Progress from 2018 and Action Plan for 2019

This report provides an update on engagement and actions from the 2018 Staff Survey alongside an outline of the delivery plan for 2019.

Key themes and actions from 2018

The table below provides an outline summary of the key themes from last year's Staff Survey and the planned activities, which have been regularly reported to Board and Workforce and Staff Engagement Committee.

A number of activities linked to cultural change, eg, staff engagement, improved communications, dignity at work, will continue.

The actions outlined were cascaded through the 'Make it Happen' campaign in March/April 2019 and flyers/posters distributed through teams locally.

ACTIONS	ACTIVITIES	DELIVERY DATE
Dignity and Respect between colleagues		
Implement a Behaviour Charter for all staff outlining expected behaviours at work in line with Trust values.	• Develop a Trust behaviour standard including consultation with staff. • Agree and publish Framework. • Develop and deliver Living the values training to all staff to support embedding of charter.	BehaviourAL Framework developed and launched alongside Dudley People Plan. 'Make it happen' mocktail trolley in August 2019. 'Living the Values' training under construction for delivery early 2020.
Review and re-launch Bullying and Harassment reporting and resolution process	• Task and finish group to review reporting of bullying and harassment to inform understanding of what is happening. • Develop and communicate new reporting process for bullying and harassment to ensure clarity on acceptable/unacceptable behaviour and action expected. • Relaunch reporting process and undertake anti-bullying campaign. • Training for staff on raising	Task and finish group initially met March 2019. Work underway to map processes and review policies. Flowchart and fact sheet produced and launched with Behavioural Framework. Anti-bullying campaign November 2019 during anti bullying week. Manager Essential training launching October 2019.

ACTIONS	ACTIVITIES	DELIVERY DATE
	concerns. • Training for managers on supporting staff who raise concerns/resolving concerns	
Staff Engagement/Communication		
Working effectively with managers and staff	Continue #makeithappen engagement with teams and departments	Quarterly 'Make it Happen' events during 2019/20, plus additional themed inclusion and engagement activities ongoing. A review of this is underway to identify the best method going forward.
Improving communication	Expand methods and tools of communication for staff – including cascade of messages from Team brief, utilising social media to share, expanding Twitter membership and usage, launch of whatsapp Groups on areas.	Ongoing through 2019/20 – additional activities include Chief Executive's live chat, Director Blogs, Back to the floor. There is a visible increase of Dudley group Twitter activity including local accounts for C3/FAU, Speech and Language Therapy and individuals using it to promote/interact. A workshop is included on twitter for the AHP Conference.
Increase training for managers	Deliver Manager's Essentials toolkit and training to provide a consistent standard for managers and communication with staff	Launch programme October 2019 with delivery ongoing until all managers have completed.
Staff health and wellbeing		
Increase awareness	Promote services available to staff through Staff Health and Wellbeing and increase training available to staff on managing absence and promoting access to wellbeing support services.	Active promotion of services through Health and Wellbeing team, Absence workshops, HR team and Manager Essentials. Ongoing through 2019. The rest, rehydrate and refuel campaign was delivered and will be

ACTIONS	ACTIVITIES	DELIVERY DATE
		revisited; work underway to provide rest stops for community staff. An Employee Assistance Programme offering phone access to support was introduced and Remploy are being used to support anyone suffering with work related stress.
Increase our offering	Expand services to support staff including expansion of support services for musculoskeletal conditions	MSK business case approved for 6 months of delivery from Sept 2019. Review of Staff Wellbeing services and a project to support long term absence have commenced Sept 2019.
Staffing Resource		
Nursing Associates	Business case to expand opportunities to fill posts.	Actions underway with Cohort 1 delivered July and further cohorts timetabled for September and October 2019.
Proactive recruitment	Continued active recruitment campaign	Ongoing activity continues
New roles / ways of working	Expanding delivery of alternative healthcare roles and broader solutions such as ACPs, MTI recruitment and expansion.	Plans for 2019/20 to be developed through recruitment leads for nursing, AHPs and medical staff. 4 ACPs sponsored to commence training in September 2019. Additional focussed work on medical workforce transformation and exploring new roles.

Preparation for the 2019 Survey

The 2019 National Staff Survey will launch on 8th October 2019 and remain open until 29th November 2019.

Picker have been selected as the Staff Survey provider and, following discussion at Workforce and Staff Engagement Committee, they have been commissioned to deliver a full census of staff so all staff will again receive an online copy of the survey in 2019; this gives us an opportunity to benchmark and our data and highlight any progress/decline.

From previous Staff Surveys, key issues for staff have been:

- Lack of motivation to complete the survey - they say it is too long;
- Time taken to complete – on average it takes 30 minutes to complete the survey;
- Concerns about confidentiality and comments being able to identify individuals.

The priority this year is to engage with teams and service managers promoting the importance of the Staff Survey in having a voice and letting us know how they feel. Therefore, the focus on activities will be on line managers' accountability for their own team's participation.

The central coordination team, HR and Communications will provide a campaign plan with 'You said, We did' posters, briefing notes and league tables throughout the campaign, supporting individual line managers to enable their staff to participate.

The plan in Appendix 1 outlines our approach to the launch of this year's Staff Survey.

Line managers

The key activities for line managers will be to:

- Cascade the key messages about the staff survey including the actions undertaken from 2018 and how feedback links to change.
- Enable their staff to have the time to complete surveys – this could be through arranging a rota of completions in the lead nurse office, appointing department champions to help create time and space or by offering to cover work in order to release staff.
- Monitor weekly league tables to enable them to monitor their teams and focus attention accordingly.
- Encourage teams to promote locally especially areas where they are active on Twitter and other relevant social media platforms.

Senior and Divisional Leaders

The key activities for senior and divisional leaders will be to:

- Agree actions and support required for their teams to enable completion.
- Cascade the key messages about the staff survey including the actions undertaken from 2018 and how feedback links to change.
- Enable their line managers to support staff to have the time to complete surveys.

- Monitor weekly league tables to enable them to monitor their teams and focus attention accordingly.
- Encourage teams to promote locally especially areas where they are active on Twitter

Board Members

The key activities for Board members will be to:

- Use every opportunity with staff at both individual and group level (meetings, back to the floor etc) to talk about the importance of having their say and how we act on feedback.
- Support Divisions, senior leaders and line managers to enable staff to have time to complete.
- Cascade the key messages about the Staff Survey including the actions undertaken from 2018 and how feedback links to change.
- Tweet about completing your surveys and take part in the social media countdown.

Results

The survey period closes on 29th November and initial results will be received by the Trust by 13th December 2019, with the final publication of results in mid-February to early March 2020.

The response rate in the previous two years has been around 36% - with the average performance of Acute and Community combined Trusts being around 42%. Although the work outlined above and other activity has improved the engagement of staff, there remains a challenge in staff participation in giving feedback and this is likely to be reflected in response rates.

The good work highlighted above, combined with other positive work undertaken, may not be recognised in this year's survey as the impact of some of the activities are too soon to be felt across the Trust, so it will be important for the key messages to share ongoing work in relation to 'You said, We did'.

We are expecting to see a similar response rate and scoring pattern as was reflected in the 2018 survey.

Recommendation for Board

The Trust Board is asked to:

1. Agree the actions suggested to act as champions for the Staff Survey 2019.
2. Note the actions and progress on themes identified from the 2018 Staff Survey.
3. Agree the actions and plan outlined for the delivery of the 2019 Staff Survey.

The Dudley Group NHS Foundation Trust

APPENDIX 1

2019 Staff Survey Action Plan

Ref	Objective	Measure of Success / Outcome	Target / Date	Lead	Progress	RAG
1	Prepare leaflet and posters to talk through what we have done so far and the plan for this year.	Departments understand the 'You said, We did'.	End of June 2019	HR and Comms	Leaflet and posters printed.	Green
2	Send out a hub story with the launch date on and ask everyone to check email access.	We limit the issue of people unable to log in.	Early Sept 19	HR and Comms	Hub story published.	Green
3	Prepare brief for all divisional leads to understand the timelines of the survey.	Divisional leads are engaged and drive completion.	September 2019	HR	Initial communication, meetings arranged for action plans/support before launch date.	Amber
4	Send out Manager Essential training dates so people know this is happening to help them see progress from last year.	People see progress from last year's results and are able to answer development questions.	Early Sept 19	HR, L&D and Comms	Trainer in place, due to launch with first cohort on 7th October. Initial mailing complete. Further promotion ongoing.	Amber
5	Prepare league table information to send weekly with divisional performance.	We send it weekly and it drivers completion rates.	Start of Launch & every week	HR and Comms	Format agreed and ready. Publication w/c 15/10 and weekly thereafter.	Amber
6	Distribute posters and leaflets in staff areas and hand out leaflets.	Everyone can see the survey is coming and 'you said' 'we did' information to help them answer this year's questions better.	w/c 23/9	HR	Materials ready for distribution.	Amber
7	Speak to IT about people's log on	We limit the issue of people	Early Sept	HR and IT	Meeting arranged w/c 23/9 to	Amber

	details and can we have a push on updating before launch	unable to log in.	19		agree support from IT service desk.	
8	Prepare key messages for Board and senior leaders to identify how they can support delivery.	The Board of Directors are fully engaged and can describe the process.	September 2019	HR	Agenda item on Workforce and Board Sept/Oct.	Green
9	Share top tips for managers on how to encourage their staff to complete the staff survey.	For managers to support and encourage staff to have their say by giving them the time to complete it.	September 2019	HR	Ready for distribution in the week prior to launch.	Amber
10	Prepare a countdown on social media prior to the launch and publicise compliance on the front of the Hub page.	To prepare staff for the launch and encourage them to take part in the survey.	End of September 2019	HR and Comms	Countdown timetable planned.	Amber

Enclosure 18

The Dudley Group
NHS Foundation Trust

Paper for submission to the Board of Directors on 3 October

TITLE:	**BAF and Corporate Risk Reporting**		
AUTHOR:	Liam Nevin	**PRESENTER**	Liam Nevin

CLINICAL STRATEGIC AIMS

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

ACTION REQUIRED OF COMMITTEE

Decision	Approval	Discussion	Other
	Y		

RECOMMENDATIONS

- That the volume and frequency of risk reporting is reduced as proposed in the body of the report
- That the structure of the BAF is amended as set out in the body of the report and the appendix
- That the proposed reporting timetable as set out in the report is agreed
- For the Board to consider its preferred approach to reviewing the BAF
- That subject to the above recommendations being accepted, the Risk Management Strategy is amended to give effect to the changes proposed by the report.

CORPORATE OBJECTIVE:

All

SUMMARY OF KEY ISSUES:

- A review of the structure of the BAF has not identified any significant concerns about the structure of the document but it could be reduced in size by about 1/3 without losing essential data and it would benefit from greater clarity in showing movement of net risk scores.
- There is a need to ensure that the evidence to support risk mitigation is clearer and that there is a stronger analytical assessment of the evidence that planned actions and implemented actions are, or will be effective, in achieving Board risk appetite.
- Adequate time should be allocated for Board review of the BAF and Corporate risks on a quarterly basis, and the Board should consider how a more in-depth analysis can best be facilitated (for example through deep dives into specific strategic objective)
- The extent and volume of reporting of risks to the Board and Committees needs to be streamlined

IMPLICATIONS OF PAPER:

IMPLICATIONS FOR THE CORPORATE RISK REGISTER OR BOARD ASSURANCE FRAMEWORK **The proposals in this report concern the form, content and frequency of Board and Committee risk reporting.**			
RISK	**Y**		**Risk Description:** Covers all risks
	Risk Register: Y		**Risk Score:** Covers all risks
COMPLIANCE and/or LEGAL REQUIREMENTS	**CQC**	**Y**	**Details:** all Domains
	NHSI	**Y**	**Details:** Well led framework
	Other	**Y**	**Details:**
REPORT DESTINATION	**EXECUTIVE DIRECTORS**	**Y/N**	**DATE: 17.9.19 and 24.9.19**
	WORKING GROUP	**Y/N**	**DATE:**
	COMMITTEE	**Y/N**	**DATE:**

1. EXECUTIVE SUMMARY

Concerns have been expressed about the Board Assurance Framework which has led to a review of the structure of the document, and the current arrangements for risk reporting to the Committees and the Board. The purpose of the review was to determine whether improvements are needed to the content of what is being reported as well as the volume and frequency of reporting.

2. BACKGROUND

The Trust's Risk Management Strategy requires that the Corporate Risk Registers and the BAF are reported to committees at each meeting and that the BAF is also reported to the Board of Directors quarterly.

From a desk top review the following issues are apparent;

- The BAF is 45 pages and the Committee risk reports are approximately 22 pages in length. A monthly reporting regime of approximately 70 pages dedicated to risk management and repeated across each of the Committees is excessive.
- The value of the BAF is contained in Appendix 1 "the Detailed Board Assurance Framework" and much of the preface could be reduced or removed.
- The cover report summarises some points of note but does not amount to an exception report
- Approximately 2/3 of the Risk Report addresses divisional and significant risks which, within the context of the corporate and strategic risks that the Trust is addressing, may be better addressed by the Risk and Assurance Group.
- There are some inconsistencies within the BAF, for example two risks are already within the Trust risk appetite but have a number of further mitigations, and one risk has a more onerous target than the Board appetite. These oversights may be indicative of the volume of risk information being produced.
- Actions are identified to address the control gaps and bridge from the current risk score to the target risk score. However, there was no obvious evidence of how the efficacy in reducing control gaps of completed actions are assessed, and what the evidence is to support that judgement.
- Five of the eleven risks have the same pre and post- mitigation risk scores. This requires consideration of whether the remaining actions identified against the control gaps will be successful in further mitigating the risks.

3. RISKS AND MITIGATIONS

The principal risks from the current arrangements are;

- The exception reporting is not sufficiently robust to assess the effectiveness of actual and prospective mitigations
- The structure of the BAF whilst generally sound is overly long, contains significant detail on assurance ratings that is not clearly evidenced, and does not facilitate the analysis of the effectiveness of mitigations.
- The volume and frequency of reporting on risk is not conducive to focussing on key business and strategic risks

The proposed mitigations are detailed below in the detailed recommendations. Whilst these recommendations are put forward as "a package" they provide the Board with options to adopt some or all of them as opposed to continuing with the status quo.

4. RECOMMENDATIONS

(a) Reduce the Frequency of Reporting

This would entail reducing the frequency of the BAF reports to committees and the Board to a quarterly cycle. There are unlikely to be significant changes to the risk profile against strategic objectives on a monthly basis. The Corporate risk reports would continue to be presented to each committee.

This change would require an amendment to the Risk Management Strategy

(b) Provide More Focussed and Tailored Reporting Arrangements

The BAF should be accompanied by an exception report that provides the following:

- New risks escalated to the BAF
- Changes to post- mitigation scores with reasons[1]
- Actions implemented against gaps in controls[2]

In terms of the existing structure of the BAF, the current practice of reporting on a quarterly assurance rating is not helpful as the level of assurance should be determined by comparing the current net risk score against the Board appetite risk score and the effectiveness of actual and planned

mitigations. However, although this information is presented over approximately seven pages there is no obvious relationship between the quarterly assurance rating and the net risk position. In addition, one of the points raised by the CQC was that some risks remained at an intolerably high level for too long, and therefore it would be more helpful for this section to identify quarterly changes in the net risk position so that the Board have summary trend information.

[1] and [2] will also require an addition to the structure of the document as there is currently no provision to address these points.

With these amendments, the presentation of the BAF would be reduced by approximately 1/3.

The draft structure proposed is appended.

(c) Volume of Reporting

A significant reduction in the volume of the risk reporting could be achieved by adopting some or all of the following;

- Reporting solely to Committees against the risks "owned" by that Committee with the amended structure proposed above and appended.
- Combine the quarterly BAF and risk reports to Committees and focussing the risk report on corporate risks.
- Consideration of divisional risks by the Risk and Assurance Group

(d) Board Review of the BAF

As a strategic tool the value of the BAF is dependent on a regular review of the effectiveness of the key controls in place, the degree of assurance that planned actions will achieve the target risk score and the extent to which the evidence demonstrates that completed actions are impacting on net risk. In their last review the CQC found that there was insufficient scrutiny of the planned actions to test the evidential basis upon which they were deemed likely to have the required impact. As actual impact is not currently assessed I presume that by implication the same point is applicable. In part, this is because the structure of the document does not lend itself to this analysis. However, a more probing assessment of these issues will require the Board to devote more time to the BAF as part of its quarterly review (an hour agenda slot is suggested). A further option to enhance this scrutiny would be to "deep dive" into three of the six risks at each meeting, examining the ongoing efficacy of the existing control measures, the progress made and impact of the implementation of actions, and a review of progress with planned actions.

Proposed Timetable

Dates	Executive Directors	Committees	Trust Board
October		CRR	
November	BAF	BAF/CRR	BAF/CRR
December		CRR	
January		CRR	
February	BAF	BAF/CRR	BAF/CRR
March		CRR	
April		CRR	
May	BAF	BAF/CRR	BAF/CRR
June		CRR	
July		CRR	
August			
September	BAF	BAF/CRR	BAF/CRR

Liam Nevin

Trust Secretary

September 2019

Appendix

BAF PROPOSED ASSURANCE FRAMEWORK

Proposed Framework

The Dudley Group NHS Foundation Trust

KEY

Risk Score

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

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

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

Key to Control Levels

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

Board Risk Appetite

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

Key to Executive Leads

CE	Chief Executive	DSBD	Director of Strategy and Business Development
MD	Medical Director	DG	Director of Governance
CN	Chief Nurse	DHR&OD	Director of HR & OD

DF	Director of Finance	CIO	Chief Information Officer
COO	Chief Operating officer		

1. HEAT MAP

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

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

Example of structure to be replicated for each risk

Strategic Objective		**SO1 Deliver a great patient experience**				**Committee**		**Exec Lead**	
						Clinical Quality Safety and Patient Experience Committee		Chief Nurse	
Strategic Risk No	BAF 1a	**Pre Mitigations Risk Score**	L x C 4X3 (12)	**Post Mitigations Current Risk Score**	L x C 4X3 (12)	**Board Risk Appetite**		**Target Score**	L x C 2X3 (6)
						Cautious			
RISK: We don't always effectively engage with patients in their care or involve them in service improvement as a result we fail to communicate with them effectively resulting in a poor patient experience which means patient's will not see us as a provider of choice.									
Cause / Effect • Patient's are not informed regarding their care and options for treatment. • We do not robustly seek or respond to feedback • Patients / Carers views are not actively sought as part of service improvements/ redesign • Loss of confidence in trust services						**Impact of the Risk** • Patients individualised needs are not met. • Patient's come to harm whilst in our care. • Service redesign does not meet patient need. • Reputational damage due to patient not feeling they are not receiving individualised patient care opt to go to another health provider			
Quarters – Changes in Post Mitigation Risk Score						**Q1**	**Q2**	**Q3**	**Q4**
						12	**12**		

Comment [WU1]: New section to replace "Quarters Assurance Rating Key"

KEY CONTROLS IN PLACE	ASSURANCE THAT CONTROLS ARE EFFECTIVE [Yes / No (if no what action needs to be taken)	LEVEL of CONTROL 1 = Operational 2 = Committee 3 = External
Patient experience strategy	No, current strategy, being refreshed	2
Quality priorities focussed on reducing harm	Yes	2
Pt feedback actions sought via FFT, patient surveys, feedback Fridays	Yes - though response rate remains low	3

Complaints process and reporting	Yes – response timeliness is an issue	1
PALS Reports	Yes	1
Perfect ward quality metrics	Yes	1
Quality priorities metrics reported via IPR	Yes	2
Learning from complaints group and reports	Yes	2
Patient Experience group and associated workplan	Yes	2
Patient Experience improvement workstreams across all services	Yes	1
LIA in place to capture and respond to feedback	Yes	2
Participation in annual patient surveys	Yes	3
Dudley Improvement practice	Yes	2

ACTIONS IMPLEMENTED SINCE LAST REVIEW	EVIDENCE OF IMPACT ON RISK

Comment [WU2]: New Section

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

The Dudley Group NHS Foundation Trust

BAF CURRENT STRUCTURE

KEY

Risk Score

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CAUTIOUS	Preference for safe delivery options that have a low degree of inherent risk and may have more limited potential for reward. Willing to expend some time and resource to mitigate risks, but accepting that some risks in this are will not, or cannot, be mitigated below a moderate level.	**4-6**
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Key to Executive Leads

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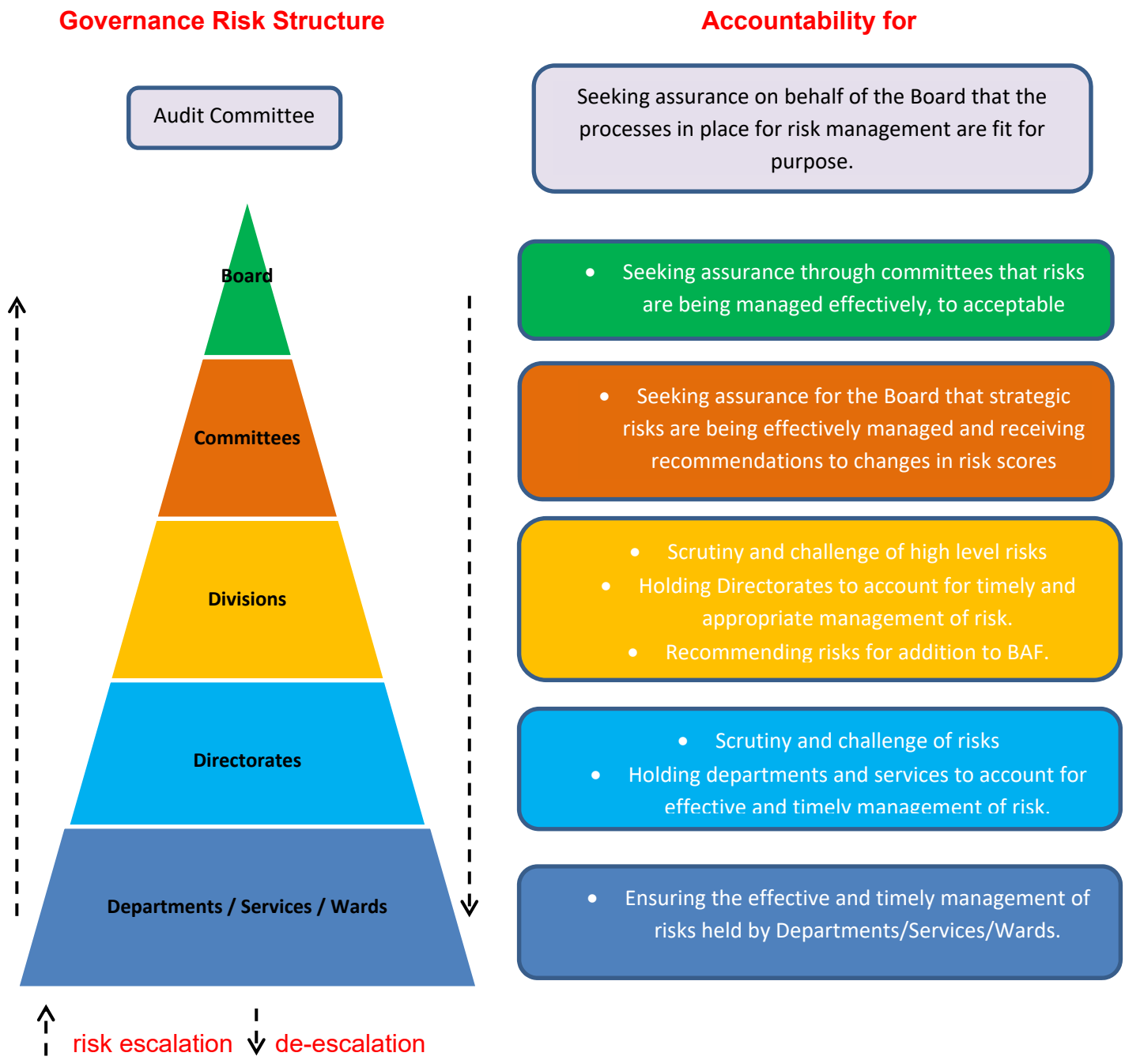
MD	Medical Director	DG	Director of Governance
CN	Chief Nurse	DHR&OD	Director of HR & OD

DF	Director of Finance	CIO	Chief Information Officer
COO	Chief Operating officer		

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

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



RISK PERFORMANCE

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

BAF 5A - Failure to recognise the importance and impact of our constrained financial position due to a lack of understanding, engagement and financial discipline mean we miss key financial targets, run out of cash and come under greater regulatory scrutiny	15	Partial	YES / NO	YES	
BAF 5B - Failure to successfully adopt digital workflows, due to competing organisation / clinical pressures, availability of resources and change fatigue; results in clinical risk, reputational risk and inefficiency	10	Acceptable	YES	YES	
*** BAF 6A -** Failure of the Trust to influence the local and wider evolving health economy due to a lack of engagement and poor performance undermining our credibility means our clinical and financial viability is undermined as we lose key high value services and opportunities for profitable growth	16	Partial	YES / NO	YES	

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

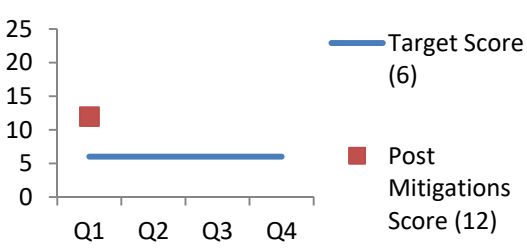
2. HEAT MAP

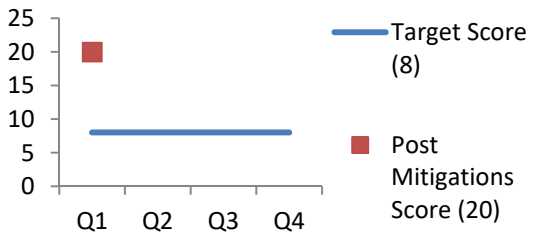
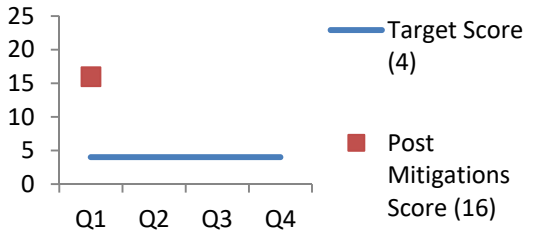
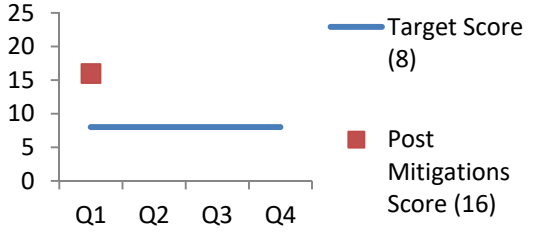
	Consequence				
Likelihood	**1 Negligible**	**2 Minor**	**3 Moderate**	**4 Major**	**5 Catastrophic**
5 Almost certain	5	10 5b	15 5a	20	25
4 Likely	4	8	12 3a 4a 4b	16 2a 2b 4c 6a	20 1b
3 Possible	3	6	9	12 1a	15
2 Unlikely	2	4	6	8	10
1 Rare	1	2	3	4	5

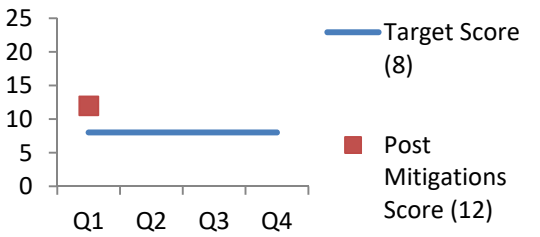
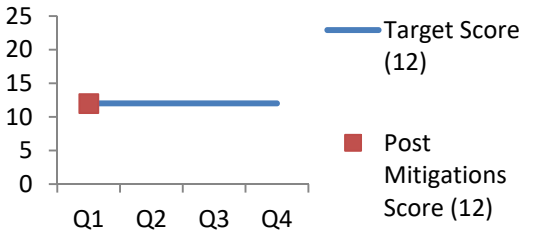
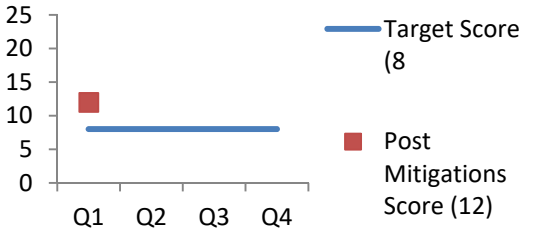
3. BOARD ASSURANCE FRAMEWORK SUMMARY

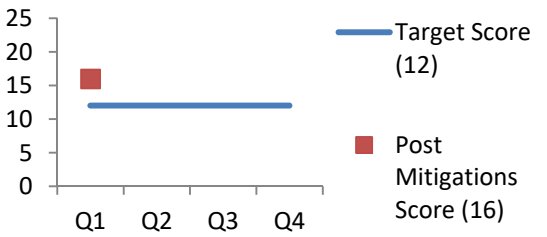
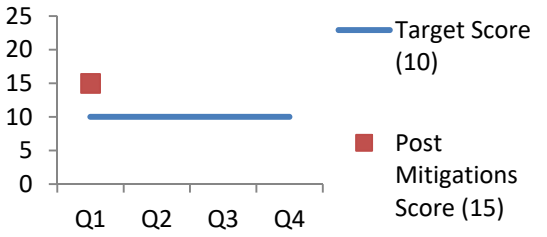
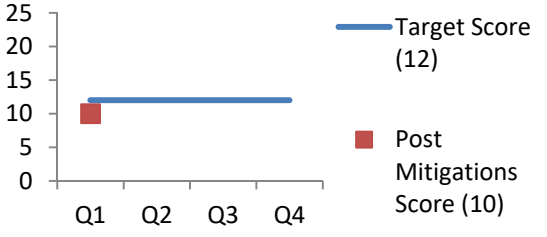
Assurance Descriptor

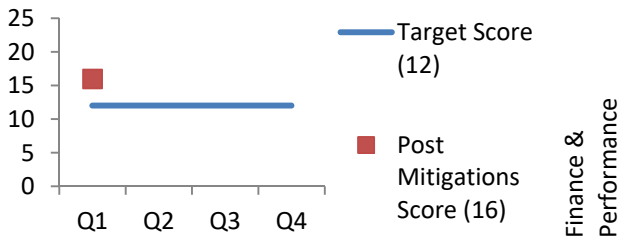
Significant Assurance	Acceptable Assurance	Partial Assurance	No Assurance
High level of confidence in delivery of existing mechanisms / objectives	General confidence in delivery of existing mechanisms / objectives	Some confidence in delivery of existing mechanisms / objectives, some areas of concern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

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

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

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

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

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

APPENDIX 1

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

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

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

Cause / Effect	**Impact of the Risk**
• Patient's are not informed regarding their care and options for treatment. • We do not robustly seek or respond to feedback • Patients / Carers views are not actively sought as part of service improvements/ redesign • Loss of confidence in trust services	• Patients individualised needs are not met. • Patient's come to harm whilst in our care. • Service redesign does not meet patient need. • Reputational damage due to patient not feeling they are not receiving individualised patient care opt to go to another health provider

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

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

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

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

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

Cause / Effect

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

Impact of the Risk

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

BAF Risk 1b continued

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

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

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

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

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

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

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

Cause / Effect	**Impact of the Risk**
• Failure to demonstrate we deliver care in line with regulatory standards • Perceived reputational damage • Risk of harm to patients as statutory standards not met • Impact on staff morale • Impact on recruitment and retention • Increased scrutiny resulting in clinicians potentially being diverted from direct patient care	• Reduced influence with external organisations e.g. NHSI, CCG • Potential impact on ability to recruit staff particularly to senior management positions • Reduced ability of the Trust to take independent decisions • Staff become disengaged • Increased vacancies and over reliance on agency staff • Increased sickness • Staff wellbeing is affected • Patients at risk of not receiving timely interventions • Poor overall patient/family experience

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

BAF Risk 2a continued

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

BAF Risk 2a continued

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

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

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

Cause / Effect

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

Impact of the Risk

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

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

BAF Risk 2b continued

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

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

THIS BAF IS UNDER FULL REVIEW

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

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

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

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

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

BAF Risk 3a continued

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

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

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

Cause / Effect

- The impact of not recruiting the sufficient numbers required, especially in clinical roles such as medical staff, nursing and AHPs, this therefore creates higher demand for temporary workforce solutions with the effect of an inconsistent workforce at premium cost.

Impact of the Risk

- Not having sufficient staff numbers will have an impact financially due to increase in the temporary workforce as well as an impact on consistency of care provided as a result of daily changes of the workforce. There will also be an impact on staff morale when areas are not substantively staffed to meet the demands of patient care.

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

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

BAF Risk 4a continued

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Cause / Effect

Staff Engagement:

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

Business Risk / Reputational Risk

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

Clinical Risk

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

Impact of the Risk

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

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

BAF Risk 5b continued

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

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

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

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

THIS BAF IS UNDER FULL REVIEW

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

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

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

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

BAF Risk 6a continued

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

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

Enclosure 19

The Dudley Group
NHS Foundation Trust

Paper for submission to the Board of Directors on 3 October 2019

TITLE:	**Scheme of Delegations**		
AUTHOR:	Liam Nevin	**PRESENTER**	Liam Nevin

CLINICAL STRATEGIC AIMS

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

ACTION REQUIRED OF COMMITTEE

Decision	Approval	Discussion	Other
	Y		

RECOMMENDATIONS

- That the Draft Scheme of Delegations is approved

CORPORATE OBJECTIVE:

All

SUMMARY OF KEY ISSUES:

- A scheme of delegations provides an additional level of granularity to the Trust Constitution in transparently setting out where authority and accountability sit as between the Board, its Committees and Executive Directors
- The Scheme of Delegations is solely a matter for the Trust Board and should be a free standing document that complements but is not part of the Constitution

IMPLICATIONS OF PAPER:

IMPLICATIONS FOR THE CORPORATE RISK REGISTER OR BOARD ASSURANCE FRAMEWORK

There are no specific impacts on the Risk Register or the BAF.

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

and/or LEGAL REQUIREMENTS	**NHSI**	**N**	**Details:** Well led framework
	Other	**N**	**Details:** N/A
REPORT DESTINATIONS	**EXECUTIVE DIRECTORS**	**Y**	**DATE:** 17.9.19
	WORKING GROUP	**N**	
	COMMITTEE	**N**	

1. BACKGROUND

Substantial work has been done on a draft scheme of delegations and it was originally proposed to include this as an appendix to the Trust constitution. However, the Scheme of Delegations is ordinarily a “second line” governance document, i.e. it contains a level of granularity that complements but is not part of the constitution.

In addition, the Scheme of Delegations is concerned with how the Board discharges its functions to deliver safe and effective services. It is solely a matter for the Board to determine and keep under review the appropriateness of how it organises the discharge of its functions, through its Scheme of Delegations. By including this level of detail within the Constitution, there is a risk of confusing the respective roles of the Board and the Council of Governors and, in addition, it makes amendment to the Scheme (often for minor and granular changes) a potentially cumbersome and time consuming process. For these reasons it is recommended that the Scheme of Delegations is approved as a free-standing document.

Following review of the draft Scheme of Delegations some amendments are proposed to the structure and content of the document and these have also been informed by a review of a random sample selection of Schemes of Delegation from other Trusts. The form and content proposed is broadly similar to other examples reviewed.

The Dudley Group
NHS Foundation Trust

SCHEME OF DELEGATION

September 2019

CONTENTS

1. Introduction

This document sets out the powers reserved to the Board of Directors and the Scheme of Delegation (the Scheme). Notwithstanding any specific delegation, the Board of Directors remains accountable for all of its functions, including those which have been delegated.

The Scheme is to be used in conjunction with the Standing Orders and Standard Financial Instructions of the Trust.

All powers of the Trust which have not been reserved to the Board of Directors or delegated to a Board Committee shall be exercised on behalf of the Board of Directors by the Chief Executive or other Executive Directors.

The Chief Executive is the Accounting Officer of the Trust and the Scheme sets out the additional responsibilities and duties of the Chief Executive, in relation to the discharge of these functions.

2. Reservation of Powers to the Board of Directors

Notwithstanding any provision of this Scheme, the Board of Directors may elect to determine any matters within its competence.

3. Delegation to Committees

The Board of Directors may determine that certain of its powers shall be exercised by Standing Committees. The composition and terms of reference of such committees shall be that determined by the Board of Directors from time to time taking into account any regulatory requirements.

4. RESERVATION OF POWER TO THE BOARD OF DIRECTORS

Constitutional Provisions

Reserved Matter
To approve variations or amendments to the Trusts constitution in conjunction with the Council of Governors
To approve the Scheme of Delegations of the Trust
To approve the Standing Financial Instructions of the Trust
To approve Trust Standing Orders for the regulation of its proceedings and business
To suspend vary or amend Standing Orders
To determine the composition of the Board of Directors in conjunction with the Council of Governors
To appoint, in conjunction with the Council of Governors, one of the Non-Executive Directors to act as the Senior Independent Director.
To ratify any urgent decisions taken by the Chair and Chief Executive in accordance with Standing Orders
To receive the declarations of Board members interests and determine the extent to which that Member may remain involved in the matter under consideration
To resolve to exclude members of the public and press from any meeting or part of a meeting
To appoint to Outside Bodies
To authorize the use of the Trust Seal

Regulation and Controls

Reserved Matter
To keep under review and ensure that the Trust provides the mandatory goods and services as required by the Provider Licence
To determine the establishment and dissolution of the Committees that report directly to the Board of Directors.
To determine the terms of reference and reporting arrangements of all Committees established by the Board of Directors
To receive reports from Board Committees and determine any recommendations thereof
To determine and resolve any breaches of the Constitution, the Scheme or Standing Orders and any consequential actions that the Board of Directors deems necessary.
To approve and apply the Code of Conduct for the Board of Directors
To appoint appraise, discipline and dismiss Executive Directors and the Trust Secretary
To approve and monitor the Trust's Risk Management framework
To approve arrangements for dealing with complaints
To approve arrangements for dealing with complaints
To approve the Trust's banking arrangements
To approve arrangements relating to the discharge of the Trust's responsibilities as a corporate trustee for funds held on trust.
To approve arrangements relating to the discharge of the Trust's responsibilities for patient property for which the Trust is the Bailee.
To approve the Care Quality Commission registration declaration
To approve the Trust's Quality Report prior to submission
To approve any monitoring returns to Regulators or the Secretary of State required of the Board of Directors and to take any appropriate action thereon
To approve the Annual Letter of Representation having considered the advice of the Audit Committee
To receive the annual Management Letter of the external auditor and agree any consequential actions having considered the advice of the Audit Committee
To consider any public interest report produced by the External Auditor having considered the advice of the Audit Committee

Strategy, Plans and Financial Arrangements

Reserved Matter
To determine the strategic objectives of the Trust
To approve the Annual Plan
To approve the Trust's Forward Plan in conjunction with the Council of Governors
To approve the Annual Report and the Annual Accounts
To approve the annual revenue and capital budgets and the capital programme
To receive and consider such Trust wide annual reports as may be specified from time to time in the Trust Board annual work plan
To approve proposals for acquisition, disposal or change of use of land or buildings
To approve any new capital investments or business cases in accordance with the thresholds determined in the Standing Financial Instructions
To approve any new contracts or variation to contracts of 500k or more
To write off bad debts at a value in excess of any delegation set out in the Standing Financial Instructions
To approve expenditure in excess of any value determined by Standing Financial Instructions
To approve individual compensation payments over £10k except where these are made in accordance with the NHS Litigation Authority instruction

5. POWER DELEGATED BY THE BOARD TO COMMITTEES

The Board of Directors shall determine the extent and nature of any powers delegated to Committees of the Board and which are more particularly set out in the Terms of Reference.

Any amendment to the Terms of Reference of a Committee as approved by the Board shall be deemed to be an amendment to the Scheme of Delegations

Reserved to/ Delegated to	Reserved / Delegated Matter
Audit Committee	The duties of the Committee can be categorised as follows: **Governance Risk Management and Internal Control** The Committee will review the establishment and maintenance of an effective system of integrated governance, risk management and internal control, across the whole of the organisation's activities (both clinical and non clinical), that supports the achievement of the organisation's objectives. In particular, the Committee will review the adequacy and effectiveness of: • all risk and control-related disclosure statements (in particular the Annual Governance Statement), together with an accompanying Head of Internal Audit statement, External Audit Opinion or other appropriate independent assurances, prior to endorsement by the Board of Directors. • The underlying assurance processes that indicate the degree of achievement of corporate objectives, the effectiveness of the management of principal risks and the appropriateness of the above disclosure statements. • The policies for ensuring compliance with relevant regulatory, legal and code of conduct requirements and related reporting and self-certification. The policies and procedures for all work related to fraud and corruption as set out in Secretary of State's Directions and as required by the NHS Counter Fraud Authority (formally NHS Protect). • The Committee will seek assurance over the effectiveness of the Trust's whistleblowing processes In carrying out this work the Committee will primarily utilise the work of Internal Audit, External Audit and other assurance functions, but will not be limited to these sources. It will also seek reports and assurances from directors and managers as appropriate, concentrating on the over-arching systems of integrated governance, risk management and internal control, together with indicators of their effectiveness. This will be evidenced through the Committee's use of an effective Assurance Framework to guide its work and that of the audit and assurance functions that report to it.

Reserved to/ Delegated to	Reserved / Delegated Matter
	Internal Audit The Committee shall ensure that there is an effective Internal Audit function that meets Government Internal Audit Standards and provide appropriate independent assurance to the Audit Committee, Chief Executive and Board. This will be achieved by: • Consideration of the provision of the Internal Audit service, the cost of the audit and any questions of resignation and dismissal. • Review and approval of the Internal Audit Strategy , Operational Plan and more detailed programme of work, ensuring that this is consistent with the audit needs of the Trust as identified in the Assurance Framework. • Considering the major findings of Internal Audit work (and management's response), and ensuring co-ordination between the Internal and External Auditors to optimise audit resources. • Ensuring that the Internal Audit function is adequately resourced and has appropriate standing within the organisation • An annual review of the effectiveness of Internal Audit. **External Audit** The Committee shall review the work and findings of the External Auditors and consider the implications and management's responses to their work. This will be achieved by: • Consideration of the appointment and performance of the external auditors, as far as the rules governing the appointment permit. • Discussion and agreement with the external auditors, before the audit commences, of the nature and scope of the audit as set out in the Annual Plan, and ensuring co-ordination, as appropriate, with other external auditors in the local health economy. • Discussion with the external auditors of their local evaluation of audit risks and assessment of the Trust and associated impact on the audit fee • Review of all external audit reports, including the Report to those charged with Governance and any work undertaken outside the Annual Audit Plan, together with the appropriateness of management responses. • Review of the report on Quality Accounts.

Reserved to/ Delegated to	Reserved / Delegated Matter
	Other Assurance Functions The Audit Committee shall review the findings of other significant assurance functions, both internal and external to the Trust and consider the implications for the governance of the organisation. These will include, but will not be limited to, any reviews by Department of Health arm's length bodies or regulators/inspectors (for example, NHS Improvement, the Care Quality Commission, NHS Resolution (formerly NHSLA) etc) and professional bodies with responsibility for the performance of staff or functions (for example, Royal Colleges, accreditation bodies etc.). In addition, the Committee will review the work of other committees within the Trust whose work can provide assurance to the Audit Committee's own scope of work. In particular, this will include the Clinical Quality, Patient Safety and Experience Committee and risk management groups established as reporting groups at 8.5 below. **Counter Fraud** The Committee shall satisfy itself that the organisation has adequate arrangements in place for countering fraud and shall review the outcomes of counter fraud work. **Management** The Committee shall request and review reports and positive assurances from directors and managers on the overall arrangements for governance, risk management and internal control. The Committee may also request specific reports from individual functions within the organisation (for example, clinical audit) as they may be appropriate to the overall arrangements. **Financial Reporting** The Audit Committee shall monitor the integrity of the financial statements of the Trust and any formal announcements relating to the Trust's financial performance. The Committee should ensure that the systems for financial reporting to the Board, including those of budgetary control, are subject to review as to completeness and accuracy of the information provided to the Board. The Audit Committee shall review the Annual Report, Quality Accounts and financial statements before submission to the Board, focusing particularly on: • The wording in the Annual Governance Statement and other disclosures relevant to the terms of reference of the Committee. • Changes in, and compliance with, accounting policies, practices and estimation techniques.

Reserved to/ Delegated to	Reserved / Delegated Matter
	• Unadjusted mis-statements in the financial statements. • Significant judgements in preparation of the financial statements. • Significant adjustments resulting from the audit. • Letter of representation. • Qualitative aspects of financial reporting. • Contents of Quality Accounts
Remuneration and Nominations Committee	The Committee will: Determine the terms and conditions and pay levels and non-pay benefits for the Trust Chief Executive and Executive Directors. Determine any monetary severance arrangements for the Trust Chief Executive and Executive Directors. Determine the implementation of the agreed policy for any performance-related pay scheme applicable to the Trust Chief Executive and Executive Directors. Review pay levels annually in line with inflation and relevant labour markets. Review and determine expenses payable to Governors. Review the size, structure and composition of the Board of Directors and make recommendations to the Board of Directors and Council of Governors, as appropriate. Evaluate the balance of skills, knowledge and experience on the Board of Directors and to identify those required for appointments of the Trust Chair, Non-Executive Directors, Chief Executive and Executive Directors Explore any reported concerns relating to the Trust Chief Executive and Executive Directors in relation to Fit and Proper Person demands. Review the skills and expertise needed on the Board, taking account of current and future challenges and opportunities. For the appointment of the Chief Executive and Executive Directors, to agree a job description and person specification for the role and capabilities required. Identify and nominate suitable candidates for Chief Executive and Executive Director vacancies. To agree and manage the nominations, appointments and re-appointments processes for:

Reserved to/ Delegated to	Reserved / Delegated Matter
	• Chief Executive • Executive Directors In doing this, the Committee will agree the size and composition of the selection panel for these appointments. To recommend its proposed appointment for the Chief Executive post to the Council of Governors for approval. To meet, without the Chair, Chief Executive and Director of Human Resources, to review the performance of the Chair on a regular basis.
Clinical Quality Safety and Patient Experience Committee	The Committee will ensure that the Trust has appropriate and effective systems in place that cover all aspects of Clinical Quality, Clinical Effectiveness, Patient Safety and Experience. The duties of the Committee can be summarised as follows: - To undertake detailed scrutiny of regular reports, relating to Clinical Effectiveness, Patient Safety and Patient Experience utilising best practice metrics that provide robust clinical governance processes to deliver safe, high quality and patient centred care. Holding senior staff to account, to challenge assumptions and decisions as necessary, to monitor progress, and to provide assurance to the Board. To approve, challenge as necessary and monitor progress of the Divisions' plans to drive an improvement culture to promote excellence in patient care across the organisation. To set clear quality performance expectations and ensure the development of high quality care and continuous improvements through innovation and the use of levers such as CQUINS. To scrutinise and monitor progress against performance expectations, challenging progress where appropriate and managing actions where timeframes are breached. To identify and advise on quality improvement priorities of service areas, to receive exception reports and external reviews of provider services and ensure appropriate action is identified and monitored. To ensure that the Trust fulfils its obligations with regard to the Health Act (2009) and NHSI in the production of an Annual Quality Account and Report. To monitor performance of all reporting groups; to review and challenge performance, assumptions and decisions as necessary with individual Clinical Units and Directorates. Ensuring robust remediation is implemented if appropriate and holding senior staff to account.

Reserved to/ Delegated to	Reserved / Delegated Matter
	To take a lead for Quality and Patient Safety within the organisation and provide assurance to the Board on the standards of care provided across the range of Trust services, including actions in place to drive improvements and mitigate risks. To take the lead for Patient Experience across the organisation and receive regular reports; challenge assumptions and decisions as necessary, and monitor progress to enable it to provide assurance to the Board on the arrangements in place to capture and report on Patient Experience and systems in place to drive improvements and learn from issues and complaints. Review and manage information from Complaints and Claims, receiving both quarterly and annual Complaints and Claims reports. Monitor the effectiveness of the Trust's systems for complaints handling, and reviewing trends and themes, monitoring the effectiveness of the Trust's system for advocacy and the encouragement of feedback from patients and relatives. Ensuring appropriate actions are identified and implementation of changes and improvements are implemented and progress monitored. Receive a quarterly claims report (incorporating an analysis of Solicitors Risk Management Reports) identifying trends and themes and lessons learned and ensuring Divisions have identified appropriate actions; that these are implemented within agreed timeframes and challenging assumptions and decisions as necessary.
Workforce and Staff Engagement Committee	The Committee will: Review and monitor the workforce strategy, applying challenge where necessary to ensure the delivery of the underlying plan on workforce issues including the efficient deployment of staffing to meet service requirements. To receive details of workforce planning priorities that arises from the annual business planning process. To obtain assurance that the identified workforce priorities are addressed, challenged as necessary and progress against identified action is monitored. To review the establishment and maintenance of an effective system of Human Resources and Workforce Planning across the whole of the organisation's activities (both clinical and non-clinical) that supports the achievement of the organisation's strategic and operational objectives. The Committee shall review Workforce priorities, Workforce Planning, Learning and Development and Staff Engagement to ensure adequate evaluation and monitoring within the Trust and to ensure local and national priorities are being addressed and that the Trust's ability to recruit, retain and develop its workforce is adequately supported. To review, challenge and agree progress against the workforce key performance indicators with specific responsibility for the monitoring of staff appraisals and compliance with mandatory training.

Reserved to/ Delegated to	Reserved / Delegated Matter
	To approve the annual workforce data prior to submission to NHSI. To receive and discuss key strategic risks relating to workforce and employment practice; to consider, challenge as necessary and monitor plans for mitigation, to maintain the risk at the lowest realistic level and to advise the Board as appropriate. To receive regular reports, on Organisational Development including leadership capability and to review and challenge progress as necessary. Workforce and Staff Engagement Group March 2019 Page 3 To ensure that feedback from the National and other Staff Surveys is appropriately analysed, reported and actions identified and taken. To specifically receive, analyse and ensure feedback is available and provided to the organisation and the Trust Board in relation to local staff survey results; ensuring appropriate actions are identified and monitored. To oversee the development and implementation of a comprehensive education and training strategy to include corporate learning and development requirements associated to the Local Workforce Action Board (LWAB). To receive, discuss, challenge as necessary regular reports relating to medical and non- medical education priorities and plans, ensuring they reflect Trust priorities and that actions are monitored. To oversee the development and implementation of the Equality and Diversity Strategy; in relation to workforce, ensuring identified actions are monitored and challenged as appropriate. Review local population demography to allow meaningful comparisons with the Trust's existing workforce and inform the development of action plans as deemed appropriate. To oversee, monitor and challenge as necessary the development and implementation of the Health and Wellbeing Strategy. To oversee the development and implementation of the Trust's Staff Engagement Strategy; specifically monitoring and challenging as necessary the development and implementation of plans to address the priorities identified for meaningful staff engagement and partnership working across the Trust. To monitor compliance with CQC standards that relate to employment ensuring completion of actions. To oversee the adequacy of arrangements for the management of and compliance with the Health and Safety at Work Act 1974 and subsequent amendments including the reporting of non-clinical workforce related incidents and RIDDORS. To specifically receive reports and to provide detail to the Trust Board of the key themes and actions taken in response to non-clinical workforce related RIDDOR incidents.

Reserved to/ Delegated to	Reserved / Delegated Matter
Finance and Performance Committee	The purpose of the Finance and Performance Committee is to seek assurances on behalf of the Board on finance and performance matters. It is also the means by which issues arising from the Workforce and Digital Trust Groups will be escalated to the Board. The Committee will have a rotating agenda as agreed from time to time by the Chair of the Committee and the Director of Finance and attached as an annex to these terms of reference. Specifically the Committee will: **Strategic and Business Planning** Scrutinise the Trust Annual Plan, Cost Improvement Plan and Budgets before they are submitted to the Board of Directors to assure itself that they are realistic, financially sound and appropriately stretching. Consider and provide advice to the Board on regular financial performance reports and forecasts, focusing particularly on risks and assumptions. Monitor performance compared to the Annual Plan, Cost Improvement Plan and Budgets; investigate variances and seek assurance that appropriate actions are in place to remediate any shortfalls. Monitor the underlying financial position and oversee multi-year financial plans. Oversee the development, management and delivery of the Trust's capital programme. Consider financial aspects of Business Cases for significant revenue or capital expenditure, ensuring benefits realisation is detailed and appropriate. Receive benefits realisation reviews for all Business Cases for return on investment/benefits realisation. Review opportunities for increasing activity/income from market intelligence analyses. **Performance Management** Scrutinise the performance dashboard; review and challenge performance and ensure that any necessary action to mitigate poor performance is appropriate. Consider performance against external performance targets set by the Care Quality Commission, NHSI and as agreed in legally binding contracts, ensuring appropriate actions are in place to remediate any shortfalls. Review benchmarking information and procurement performance to challenge whether the Trust is achieving best value for money.

Reserved to/ Delegated to	Reserved / Delegated Matter
	Receive and undertake detailed scrutiny of the PFI contract performance with Summit, specifically receiving updates on performance evaluation of catering, cleaning services, estates, sterile services, security and medical device maintenance. Maintain ongoing scrutiny of those risks detailed in the Trust's Board Assurance Framework for which the Committee is designated responsible and seek assurance that the risks are being managed appropriately. **Legally Binding Contracts with Third Parties** Consider regular reports of Trust and Directorate performance in respect of contracts agreed with third party organisations and require appropriate action to be taken. **Trust Subsidiary Companies** The Committee shall monitor the financial and operational performance of any subsidiary companies wholly or partly owned by the Trust. The Committee shall receive an annual report on the activities and profitability of such companies, which will provide assurance on business effectiveness and profitability to the Board of Directors.
Charitable Funds Committee	The duties of the Sub-Committee can be categorised as follows: To manage the affairs of the Charity within the terms of its declaration of Trust, and appropriate legislation. To manage the investment of funds in accordance with the Trustee Act 2000 and if necessary to appoint fund managers to act on its behalf. To set out annual objectives. To determine a Charitable Funds Marketing Strategy, to ensure the fundraising element of the Charitable Funds Strategy works within recognised good practice frameworks and identifies methods of fundraising appropriate for the Charity. To ensure funding decisions are appropriate and are consistent with the Charity's objectives, to ensure such funding provides added value and benefit to the patients and staff of the Trust, above those afforded by the Exchequer funds. To receive regular reports on the performance of the charitable fundraising activities. To implement as appropriate, procedures and policies to ensure that accounting systems are robust, donations received and coded as instructed and that all expenditure is reasonable, clinically and ethically appropriate.

Reserved to/ Delegated to	Reserved / Delegated Matter
	To approve the annual report and accounts and to ensure that relevant information is disclosed.

6. SUMMARY OF PRESCRIBED AUTHORITY AND ACCOUNTABILITY (Accountable Officer Memorandum)

Reserved to/ Delegated to	Reserved / Delegated Matter	Details / Reference
Chief Executive	• Accountable through the NHS accounting officer to parliament for stewardship of the Trust resources	Accountable Officer Memorandum
Chief Executive and Director of Finance	• Ensure the accounts of the Trust are prepared under principles and in a format directed by NHSI. Accounts must disclose a true and fair view of the Trust income and expenditure and its state of affairs • Sign the accounts on behalf of the Board	Accountable Officer Memorandum
Chief Executive	• Sign a statement in the accounts outlining responsibilities as the accounting officer • Sign a statement in the accounts outlining responsibilities in respect of Internal Control	Accountable Officer Memorandum

Chief Executive	• Ensure effective management systems that safeguard public funds and assist the Trust chairman to implement requirements of corporate governance including ensuring managers:
	  • Have a clear view of their objectives and the means to assess achievements in relation to those objectives;
	  • Be assigned well defined responsibilities for making best use of resources; and,
	  • Have the information, training and access to the expert advice they need to exercise their responsibilities effectively
		Accountable Officer Memorandum

Reserved to/ Delegated to	Reserved / Delegated Matter	Details / Reference
Chair	• Implement requirements of corporate governance.	Accountable Officer Memorandum
Chief Executive	• Achieve value for money from the resources available to the Trust and avoid waste and extravagance in the organisation's activities • Follow through the implementation of any recommendations affecting good practice as set out on reports from such bodies as the Audit Commission, the National Audit Office (NAO) and Regulators	Accountable Officer Memorandum
Director of Finance	• Operational responsibility for effective and sound financial management and information	Accountable Officer Memorandum
Chief Executive	• Primary duty to see that director of finance discharges this function	Accountable Officer Memorandum
Chief Executive	• Ensuring that expenditure by the Trust complies with Parliamentary requirements	Accountable Officer Memorandum
Chief Executive & Director of Finance	• The chief executive, supported by director of finance, to ensure appropriate advice is given to the Board on all matters of probity, regularity, prudent and economical administration, efficiency and effectiveness	Accountable Officer Memorandum
Chief Executive	• If the chief executive considers the Board or chairman is doing something that might infringe probity or regularity, he/she should set this out in writing to the chairman and the Board. If the matter is unresolved, he/she should ask the Audit Committee to inquire and if necessary the Board.	Accountable Officer Memorandum
Chief Executive	• If the Board is contemplating a course of action that raises an issue not of formal propriety or regularity but affects the chief executive's responsibility for value for money, the chief executive should draw the relevant factors to the attention of the Board.	Accountable Officer Memorandum

7. DELEGATION TO THE CHIEF EXECUTIVE AND EXECUTIVE DIRECTORS

Those functions of the Trust which have not been reserved to the Board or delegated to other committees shall be exercised on behalf of the Trust by the Chief Executive and the Executive Directors in accordance with the functions and responsibilities allocated to such post holders by the Board of Directors.

Nothing in the Scheme shall negate or impair the direct accountability to the Board of the Directors

Enclosure 20

The Dudley Group
NHS Foundation Trust

Paper for submission to Trust Board Meeting on 3rd October 2019

TITLE:	Clinical Negligence Scheme for Trusts (CNST) incentive scheme compliance with the 10 maternity safety actions to the required standards.		
AUTHOR:	**Dawn Lewis** **Head of Midwifery**	**PRESENTER**	**Mary Sexton** **Interim Chief Nurse**
CLINICAL STRATEGIC AIMS			
	Strengthen hospital-based care to ensure high quality hospital services provided in the most effective and efficient way.		

CORPORATE OBJECTIVE:

SO1: Deliver a great patient experience

SO2: Safe and Caring Services

SO3: Drive service improvements, innovation and transformation

SO5: Make the best use of what we have

SO6: Deliver a viable future

SUMMARY OF KEY ISSUES:

- The background to the opportunity to apply for the CNST maternity incentive scheme
- Issues that have been overcome to achieve some of the standards required
- Achievement of all 10 standards
- Evidence to assure the Trust Board of the achievement
- The paper was submitted to the Directors meeting initially and circulated to Non-Executive Directors in order to comply with submission dates to NHS-R. A number of questions were posed by Non-Executive Directors and some amendments in text have been made to respond to those questions.
- In addition post submission to NHS-R the paper in full was considered by the Clinical Quality and Patient Experience Committee at its meeting on 27th August and upwardly reported to the Trust Board as part of the CQPSE Chairs report on September 5th 2019.

IMPLICATIONS OF PAPER:

RISK	**N**	**Risk Description:**

	Risk Register: N		**Risk Score:**
COMPLIANCE and/or LEGAL REQUIREMENTS	**CQC**	**Y**	**Details** SAFE Are patients protected from abuse and avoidable harm WELL LED The leadership, management and governance of the organisation assures the delivery of high quality person-centred care, supports learning and innovation, and promotes an open and fair culture
	NHSI	**N**	**Details:**
	Other	**Y**	**Details: NHS resolution- CNST**

ACTION REQUIRED OF BOARD

Decision	Approval	Discussion	Other
	✓		

RECOMMENDATIONS FOR THE BOARD

To accept this paper as assurance that there is satisfactory evidence to show compliance and achievement of the 10 maternity safety actions year 2 to the required standard. The Trust Board to sign the self-certification as accurate

The Dudley Group
NHS Foundation Trust

Introduction

In December 2018 the Trust received a contribution notice from NHS Resolution, detailing the organisation's calculated contribution that was required by the Clinical Negligence Scheme for Trusts – CNST. The notification also included details of the maternity incentive scheme year 2 which would be implemented for 2019/2020.

The national Safer Maternity Care update to the Maternity Safety Strategy[1] sets out the Department of Health's ambition to reward those who have taken action to improve maternity safety. Obstetric claims represent the biggest area of spend for all CNST members around £500million in 2016/17. Obstetric claims represent 10% of the volume and 50% of the value of all claims.

Similar to the previous year the maternity element of CNST contributions will be increased by 10% above all Trusts standard for the financial year 2019/20, to create a national maternity incentive fund. Maternity services that can demonstrate achievement of a specified set of 10 requirements detailed in the aforementioned notice letter will be eligible for a share of that incentive fund of at least 10% of their base contribution, it is not clear if the Trust will be considered for a share of the balance of undistributed funds, as was indicated in 2018/19. The specific 10 safety actions were detailed in a strategy document[2] and will be explained in more detail within this paper. In order to qualify for refund of 10% of the premium the Trust must be able to demonstrate progress to the required standard against all 10 of the safety actions.

Maternity services that are unable to demonstrate achievement are requested to submit an action plan detailing the requirements to achieve all 10 standards in the future and they may be allocated a smaller sum from the fund to support them to implement the required actions.

The Trust was provided with full details for each action including the evidence required to demonstrate achievement and the proposed verifications process that would be undertaken. Once the full results are available for all maternity providers, NHS Resolution will confirm the value of the credit to be made to members.

Background

The Maternity Safety Strategy involves a number of initiatives with the overall aim of reducing stillbirth, perinatal deaths, maternal deaths and hypoxic brain injury. The intention is to make improvements in the areas of clinical care, multidisciplinary training, clinical leadership and overall leadership, involvement of women in the development of services and improving the quality of reviews when there are deaths or when babies show signs of brain injury due to hypoxia.

The Trust is heavily involved in the Maternity Transformation Programme (MTP) via the Local Maternity System (LMS) within the STP and the golden thread of safety runs through all of the work streams in progress. Additionally the Perinatal Mental

[1] https://www.gov.uk/government/publications/safer-maternity-care-progress-and-next-steps

[2] https://resolution.nhs.uk/wp-content/uploads/2018/12/maternity-incentive-scheme-year-two.pdf

Health strategy is developing alongside the LMS work with the intention of improving perinatal mental health care for all women with additional needs. This is an important factor as mental health issues were the leading cause of indirect maternal mortality in the last MBRRACE report on maternal mortality in 2017. We have successfully implemented a perinatal mental health liaison clinic with staff from the Barberry unit in Birmingham following a three month pilot. This clinic has formally been in place since April 2018, funded by monies from a bid for a Black Country perinatal mental health liaison programme.

The Trust actively participated in the 2nd Wave of the Maternity Neonatal Safety Collaborative. A small multidisciplinary team (Head of Midwifery, Matron - Outpatients & Community, Governance Midwife and Consultant Obstetrician & Gynaecologist) attended the learning events over the 12 months to enable the whole Maternity and Neonatal team to embark on a quality improvement programme, focused on the aims of the Maternity Safety Strategy. The aim chosen was to reduce incidence of smoking at time of delivery and small successes have been achieved and demonstrated at the annual national meeting in March 2018. This work continues and DGFT is now offering support to the 3rd wave Trust within our LMS via the local learning sets. As part of the Maternity Neonatal Safety Collaborative, a Safety Culture Survey – SCORE was carried out. The survey was extended to theatres and the sonography service, who work closely with maternity and neonatal teams. The senior maternity management team asked staff from the HR team to lead the discussions of the results and for staff to identify key areas for improvement. An action plan was devised with a small group of staff and then shared with all staff.

The work of the Black Country and West Birmingham Local Maternity System-BCLMS part of the STP has gained pace over the past 12 months. The consensus of the LMS has been to focus on the Saving Babies Lives Care Bundle version 1 and latterly version 2. Approaching implementation of version 2 as an LMS to reduce inconsistencies and improve standardisation in the delivery of services connected to the care bundle.

The 10 standards for 2019/20 remained the same as the previous year in respect of the subject matter, however the evidential requirements for each standard has significantly stretched in comparison. The main focus is the Trust Board engagement with the maternity team and that the Trust Board are sighted on safety within the maternity service.

Challenges encountered included the significant amount of work undertaken by the information team to ensure that the data submitted satisfied the MSDS version 2. The team have been informed that the requirements next year will be even more challenging.
A number of compliance dates were included for several of the required standards however very recently an email has been received in Trust indicating that the dates re guides and if actions are completed outside of the dates the Trust will still be viewed as compliant.

The Dudley Group
NHS Foundation Trust

Outline of 10 Safety Actions

Safety Action 1- Are you using the National Perinatal Mortality Review Tool to review deaths to the required standard?

Required Standard
a) A review of 95% of all deaths of babies suitable for review using the Perinatal Mortality Review Tool (PMRT) occurring from Wednesday 12 December 2018 have been started within four months of each death.
b) At least 50% of all deaths of babies who were born and died in your trust (including any home births where the baby died) from Wednesday 12 December 2018 will have been reviewed, by a multidisciplinary review team, with each review completed to the point that a draft report has been generated, within four months of each death.
c) In 95% of all deaths of babies who were born and died in your trust (including any home births where the baby died) from Wednesday 12 December 2018, the parents were told that a review of their baby's death will take place and that their perspective and any concerns about their care and that of their baby have been sought.
d) Quarterly reports have been submitted to the trust Board that include details of all deaths reviewed and consequent action plans

The Perinatal Mortality Review Tool (PMRT) was launched in February 2018 providing a standardised approach to perinatal mortality. The tool is located within the MBRRACE (Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK) platform. The Trust submits data related to perinatal mortality via MBRRACE and has done since its inception in 2013. The use of the Mortality Review Tool can be cross checked against cases reported via MBRRACE.

The multi-disciplinary team has used the tool for all eligible cases occurring since January 2018 onwards The NPRT is utilised as the template for the weekly incident review meeting and the cases are then further discussed at the 6 weekly perinatal mortality meeting.

In respect of the three required standards:

a) 100% of all deaths suitable for review using the PMRT occurring since Wednesday 12 December 2018 have been started within 4 months of each death
b) Of the deaths occurring from Wednesday 12 December 2018 and reviewed using the tool all have been completed to the point of a draft report, within 4 months of each death.
c) Initially informing parents of the review was not consistently carried out. However utilising our bereavement midwife and the lessons learned we have ensured that we have informed parents retrospectively that a review is taking place if missed initially. All staff have been reminded to discuss with parents as appropriate and as part of the bereavement care.

d) A quarterly perinatal mortality report is presented at divisional governance meeting. Stillbirth and neonatal mortality data and analysis is included in the maternity report at clinical quality safety and patient experience CQSPE meeting.

Safety Action 2- Are you submitting data to the Maternity Services Data Set (MSDS) to the required standard?

NHS Digital will issue a monthly scorecard to data submitters (trusts) that can be presented to the Board.
The scorecard will be used by NHS Digital to assess whether each MSDS data quality criteria has been met and whether the overall score is enough to pass the assessment. It is necessary to pass all three mandatory criteria and 14 of the 19 other criteria (please see table below for details).

The Maternity Services Data Set (MSDS) collects information on each stage of care for women as they go through pregnancy. Since June 2015 there has been a requirement to submit this data centrally. Version 2.0 of the Maternity Services Data Set (MSDS) went live in April 2019.

The Maternity Services Data Set (MSDS) sets out national definitions for the extraction of data for:

- routine booking appointment activities
- maternity care plan
- dating scan
- antenatal screening tests
- structural fetal anomaly screening
- labour & delivery
- newborn screening
- maternal or neonatal death

The MSDS provides a national standard for gathering data from Maternity healthcare providers in England. It covers key information captured from NHS-funded maternity services.

The MSDS will provide reliable information for:

- payment of Maternity Services
- local and national monitoring
- reporting for effective commissioning
- monitoring outcomes
- addressing health inequalities

A significant amount of work has been carried out by the Information team to ensure that DGFT are submitting data to the required standard.

The requirement was to successfully submit data from MSDS v1 from October 2018 until March 2019 and successfully submit MSDSv2 data from April 2019 by June 2019. NHS digital have confirmed that the DGFT submission for April 2019 met both the mandatory and optional categories.

Safety Action 3- Can you demonstrate that you have transitional care services to support the Avoiding Term Admissions Into Neonatal (ATAIN)units Programme?

The ATAIN programme has been developed to Avoid Term Admissions Into Neonatal units. Primarily the programme seeks to address the clinical care that can avoid or reduce the effect of respiratory conditions, hypoglycaemia, jaundice and asphyxia (perinatal hypoxia–ischaemia). Effective use of transitional care beds also reduces the need for mother and baby to be separated for an admission of baby to t

Required Standard
a) Pathways of care for admission into and out of transitional care have been jointly approved by maternity and neonatal teams with neonatal involvement in decision making and planning care for all babies in transitional care.
b) A data recording process for transitional care is established, in order to produce commissioner returns for Healthcare Resource Groups (HRG) 4/XA04 activity as per Neonatal Critical Care Minimum Data Set (NCCMDS) version 2.
c) An action plan has been agreed at Board level and with your Local Maternity Systems (LMS) and Operational Delivery Network (ODN) to address local findings from Avoiding Term Admissions Into Neonatal units (ATAIN) reviews.
d) Progress with the agreed action plans has been shared with your Board and your LMS & ODN

a) The Trust utilises the principles of Transitional care as determined by the British Association of Perinatal Medicine BAPM. The pathways of care for admission have been jointly agreed between maternity and neonatal services. The neonatal team oversee the care planning for all babies cared for in transitional care.

b) All babies cared for on the transitional care pathways are recorded on Badgernet neonatal system as per XA04 2016 NCCMDS .
c) An action plan has been developed to address some of the issues identified during the reviews of term admissions to neonatal unit.
d) The action plan and its progress have been presented to the Executive Directors team meeting and to Clinical Quality Safety and Patient Experience meeting. The action plan has also been shared with the Local Maternity System and to the Operational Delivery Network. It has been agreed within the LMS that next year we will present each action plan at the same meeting and also discuss the common themes across the LMS and action them together.
A working group within Trust from both maternity and neonatal are looking at the local ongoing issues identified through the MDT review of term admissions. The action plan has been updated with further improvements.

Safety Action 4 - Can you demonstrate an effective system of medical workforce planning?

Required Standard

a) Formal record of the proportion of obstetrics and gynaecology trainees in the trust who 'disagreed/strongly disagreed' with the 2018 General Medical Council National Training Survey question: *'In my current post, educational/training opportunities are rarely lost due to gaps in the rota.'* In addition, a plan produced by the trust to address lost educational opportunities due to rota gaps.
b) An action plan is in place and agreed at Board level to meet Anaesthesia Clinical Services Accreditation (ACSA) standards 1.2.4.6, 2.6.5.1 and 2.6.5.6.

A report for the executive directors on 2nd July 2019 identified the proportion of O&G trainees who felt that training opportunities had been lost due to gaps in the rota. The report also outlined the remedial action taken to ensure that training opportunities were recovered.

The report also advised that 100% of the Anaesthesia Clinical Services Accreditation standards are met by DGFT.

The minutes of the meeting and action plan for the medical staffing standard were shared with workforce at the Royal College of Obstetrics and Gynaecology.

Safety Action 5 - Can you demonstrate an effective system of midwifery workforce planning to the required standard?

Required Standard

a**) A systematic, evidence-based process to calculate midwifery staffing establishment has been done.**
b) The obstetric unit midwifery labour ward coordinator has supernumerary status (defined as having no caseload of their own during that shift) to enable oversight of all birth activity in the service
c) Women receive one-to-one care in labour (this is the minimum standard that Birthrate+ is based on)
d) A bi-annual report that covers staffing/safety issues is submitted to the Board

a)A full Birthrate plus assessment has been carried out , however birth rate numbers have reduced by approx. 100 since the calculations were carried out and included in the report. The midwife to birth ratio advised by Birthrate plus is 1:27 which takes

into account the acuity and co morbidities of the women birthing at DGFT. In addition table 6 of the NICE guidance is reviewed on a six monthly basis The midwife to birth ratio is included on the monthly maternity dashboard.
b) The lead midwife acting as labour ward coordinator on each shift has supernumerary status. If for any reason this is not possible it is a red flag incident and included on the labour ward Birthrate plus acuity tool, it is also Datixed. Supernumerary status of the labour ward coordinator has not been compromised within the past 12 months.
c) Women in labour receive one to one care. If this is not possible it is recorded on the Birthrate plus acuity tool ad included on the maternity dashboard. As indicated on the maternity dashboard 1:1 care in labour has not been compromised during the past 12 months.
d) The head of midwifery has also carried out a table top Birthrate plus assessment and the results of this were presented to the Executive Directors on 2nd July 2019. The report included details of red flag incidents related to staffing, which are also reported via Datix. Daily staffing meetings take place on the maternity unit reviewing staffing for that day and for the week ahead. Plans are discussed to address any deficits in the planned staffing.

Safety Action 6- Can you demonstrate compliance with all 4 elements of the Saving Babies' Lives (SBL) care bundle?

Saving Babies' Lives is designed to tackle stillbirth and early neonatal death and a significant driver to deliver the ambition to reduce the number of stillbirths, bringing four elements of care together:

1. Reducing smoking in pregnancy
2. Risk assessment and surveillance for fetal growth restriction
3. Raising awareness of reduced fetal movement
4. Effective fetal monitoring during labour

The package was developed by groups brought together by NHS England, including midwives, obstetricians and representatives from stillbirth charities. Though the NHS already follows much of this best practice, this is the first time that guidance specifically for reducing the risk of stillbirth and early neonatal death has been brought together in a coherent package.

The Trust has been submitting data since 2014 when the care bundle was in development. Each of the four elements of the care bundle has a number of metrics to evidence the degree of compliance. The Trust can show implementation and compliance with each of the elements and his has been shared via the maternity report to CQSPE on a regular basis

Safety Action 7 – Can you demonstrate that you have a patient feedback mechanism for maternity services, such as Maternity Voices Partnership Forum and that you regularly act on feedback?

A Maternity Voices Partnership (MVP) is a team of women and their families, commissioners and providers (midwives and doctors) working together to review and contribute to the development of local maternity care.

Chaired by a previous service user, this group develops is increasingly involved in all decisions about the transformation of maternity services.

Staff attend the quarterly meetings and take along learning from complaints for discussion. The maternity survey action plan has been shared with the group. Members of the MVP have also taken part in Maternity 15 Steps review within the past 12 months.

The use of comments from the Friends and Family returns has allowed the service to utilize the 'you said ,we did' approach. Each month an example of this feedback and actions that have resulted is included within the divisional governance meeting and within the Divisional Performance Review meeting presentation to Executive directors.

Safety Action 8- Can you evidence that 90% of each maternity unit staff group have attended an 'in house' multi professional maternity emergencies training session within the last training year?

In house multi-professional training for midwives and obstetric staff for emergency situations has been a feature of mandatory training for a number of years. In 2017 a multi-disciplinary team including anaesthetic staff attended education and training sessions funded by money from the Maternity Safety Training fund. A planned programme of multi professional skills drills training is carried out utilising the SIM lab.

The sessions are devised to enable inclusion of all anaesthetic and theatre staff who regularly work in maternity theatres on a planned and emergency basis

This has resulted in over 90% compliance for emergency skills training for all staff groups in the maternity multidisciplinary team.

Records of the topics included in each session and the names and designation of staff attending are maintained by the Practice Development Midwife.

Action 9- Can you demonstrate that the trust safety champions (obstetrician and midwife) are meeting bi-monthly with Board level champions to escalate locally identified issues?

Required Standard

a) The Executive Sponsor for the Maternal and Neonatal Health Safety Collaborative (MNHSC) is actively engaging with supporting quality and safety improvement activity within:

i. the trust
ii. the Local Learning System (LLS)

b) The Board level safety champions have implemented a monthly feedback session for maternity and neonatal staff to raise concerns relating to relevant safety issues

c) The Board level safety champions have taken steps to address named safety concerns and that progress with actioning these are visible to staff

The Chief Nurse is our Executive Sponsor for the MNHSC and as such attended the National Learning event at the end March 2019. During the past year both the Chief Executive and the Chief Nurse have met with the Head of Midwifery and Clinical Director regularly to discuss safety concerns. Until May 2019 the maternity team provided a monthly report to CQSPE related to the maternity improvement plan and included the summary of the quality improvement work related to the MNHSC , SCORE survey action plan and details of maternity dashboard. Following discussion the plan is to provide a bi monthly report specifically related to each of the safety actions. Each of the action plans related to maternity safety have been shared with the staff within the maternity unit. Updates are provided on a monthly basis. The Head of Midwifery meets with staff at a monthly drop in session to discuss issues related to improving safety. The Executive Sponsor and the Head of Midwifery have conducted three safety walkarounds since January 2019, the last one on 2nd August 2019, no safety issues raised by staff during these times.

Safety Action 10- Have you reported 100% of qualifying 2018/19 incidents under NHS Resolution's Early Notification scheme?

The Trust governance department takes this responsibility. With the development of the Early Notification Scheme a process was developed to ensure good communication of potential cases to the Trust Patient Safety Officer via the Governance and Risk midwives. This process has worked well to date and 100% of qualifying incidents have been reported via the electronic platform.

The Dudley Group NHS Foundation Trust

Board report on The Dudley Group NHS Foundation against the Clinical Negligence Scheme for Trusts (CNST) incentive scheme maternity safety actions

Date: 15th May 2018

SECTION A: Evidence of Trust's progress against 10 safety actions:

W:\Maternity\CNST Incentive scheme maternity for folders containing evidence for each action.

Safety action – please see the guidance for the detail required for each action	Evidence of Trust's progress	Action met? (Y/N)
1). Are you using the National Perinatal Mortality Review Tool (NPMRT) to review perinatal deaths?	• Evidence is held on perinatal mortality review tool. • MBRRACE data will be utilised NHS R to cross check against cases reviewed NHS Resolution will also use data from MBRRACE to verify the Trust's progress against this action.	**Yes**
2). Are you submitting data to the Maternity Services Data Set (MSDS) to the required standard?	• Submissions to NHS Digital • Email included on 'W' drive confirming satisfactory submission of all 10 elements • NHS Resolution will also use data from NHS Digital to verify the Trust's progress against this action.	**Yes**
3). Can you demonstrate that you have transitional care	• Notes of task and finish group working to improve compliance with ATAIN programme	**Yes**

facilities that are in place and operational to support the implementation of the ATAIN Programme?	• Action Plans • Minutes of LMS meeting and email from ODN • BAPM standards included to cross reference actions taken • Physical presence of Transitional Care facility on a day to day basis • BadgerNet records of babies cared for as transitional care NHS Resolution may cross-check trusts' self-reporting with Neonatal Operational Delivery Networks and Local Maternity System to verify the Trust's progress against this action.	
4). Can you demonstrate an effective system of medical workforce planning?	• Copy of report to Executive Directors • Confirmation email from RCOG of receipt of submission W:\Maternity\CNST Incentive scheme maternity\Action 4\Copy of WC 2.4.18.xlsx	**Yes**
5). Can you demonstrate an effective system of midwifery workforce planning?	• Copy of paper submitted to weekly Executive Directors meeting • Above includes Birthrate plus table top exercise • Table 6 from NICE safer staffing – also submitted as CQC evidence following the inspection in December • Full Birthrate Plus review report	**Yes**
6). Can you demonstrate compliance with all 4 elements of the Saving Babies' Lives (SBL) care bundle?	• Copies of the quarterly submission of compliance for Saving Babies Lives for the past year	**Yes**

7). Can you demonstrate that you have a patient feedback mechanism for maternity services, such as the Maternity Voices Partnership Forum, and that you regularly act on feedback?	• Maternity Voices Partnership minutes of newly formed group meeting • Friends and family feedback 'You said, We did' log for past year • Action plan from Maternity 15 Steps	**Yes**
8). Can you evidence that 90% of each maternity unit staff group have attended an 'in-house' multi-professional maternity emergencies training session within the last training year?	• Evidence of all attendances at the multi disciplinary emergency skills drills training. • Additional sessions held to include anaesthetic and theatre staff	**Yes**
9). Can you demonstrate that the trust safety champions (obstetrician and midwife) are meeting bi-monthly with Board level champions to escalate locally identified issues?	• Minutes of the monthly CQSPE meeting • Action plans for SCORE survey	**Yes**
10). Have you reported 100% of qualifying 2017/18 incidents under NHS Resolution's Early Notification scheme?	• Email evidence of the submissions made by Trust Governance team to the NHS Resolution's Early Notification scheme.	**Yes**

NHS
The Dudley Group
NHS Foundation Trust

SECTION B: Further action required:

If the Trust is unable to demonstrate the required progress against any of the 10 actions, please use this section to set out a detailed plan for how the Trust intends to achieve the required progress and over what time period. Where possible, please also include an estimate of the additional costs of delivering this.

The National Maternity Safety Champions and Steering group will review these details and NHS Resolution, at its absolute discretion, will agree whether any reimbursement of CNST contributions is to be made to the Trust. Any such payments would be at a much lower level than for those trusts able to demonstrate the required progress against the 10 actions and the 10% of the maternity contribution used to create the fund. If made, any such reimbursement must be used by the Trust for making progress against one or more of the 10 actions.

SECTION C: Sign-off

……..

For and on behalf of the Board of The Dudley Group NHS Foundation Trust confirming that:

- **The Board are satisfied that the evidence provided to demonstrate compliance with/achievement of the maternity safety actions meets the required standards and that the self-certification is accurate.**
- **The content of this report has been shared with the commissioner(s) of the Trust's maternity services**
- **If applicable, the Board agrees that any reimbursement of CNST funds will be used to deliver the action(s) referred to in Section B**

Position: …….

Date: ……..

We expect trust Boards to self-certify the Trust's declarations following consideration of the evidence provided. Where subsequent verification checks demonstrate an incorrect declaration has been made, this may indicate a failure of board governance which the Steering group escalate to the appropriate arm's length body/NHS System leader.

……..

Enclosure 21

The Dudley Group
NHS Foundation Trust

Paper for submission to the Trust Board on 3rd October 2019

TITLE:	**Health, Safety and Fire Assurance Annual Report**		
AUTHOR:	Helen Watkiss, Health and Safety and Fire Manager	**PRESENTER**	Karen Kelly, Chief Operating Officer

CLINICAL STRATEGIC AIMS		

ACTION REQUIRED OF COMMITTEE			
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 COMMITTEE

This paper is presented to the Board to overview the previous 12 months work within Health, Safety and Fire and the progress made on the key projects identified as priorities. The report also includes the key projects moving forward into the next 12 month period.

The report identifies the areas of concern that exist within the Trust in regards to compliance to the Health and Safety at Work etc. Act 1974 and the Regulatory Reform Fire Safety Order 2005, and the measures being implemented to ensure compliance can be achieved.

The Board is asked to approve the work stream for the next 12 month period.

CORPORATE OBJECTIVE:

SO2 Safe and Caring Services

SUMMARY OF KEY ISSUES:

Actions from 2018/19 Report – Health and Safety

- Safer Sharps
- General Risk Assessments
- Audit of Compliance

- Trust Wide Schedule – Air Monitoring
- Ligature Points

Key Priorities for Health and Safety 2019/ 2020

- Trust Wide Air Monitoring
- Overarching Audit and Inspection
- Health Surveillance Compliance

Actions from 2018/2019 Report – Fire

- Standardised Approach to Community Fire Safety
- Evacuation Exercises
- North Block Review

Key Priorities for Fire 2019/2020

- North Block
- Fire Door Review
- Extension Lead Compliance
- Executive Team Fire Training

Incident Data

- Health and Safety Incident Data
- RIDDOR Data
- Fire Incident Data

Enforcement Authority Interest in the Trust

IMPLICATIONS OF PAPER:

RISK	**Y**		**Risk Description:** Failure to comply with Fire Safety requirements.
	Risk Register: Y		**Risk Score:** Moderate
COMPLIANCE and/or LEGAL REQUIREMENTS	**CQC**	**Y**	**Details:**
	NHSI	**N**	**Details:**
	Other	**Y**	**Details:** Health and Safety Executive, West Midlands Fire Service

Overview

This report is presented to the Board to give an overview of the actions completed during 2018/19 identified in the previous annual report and the work plan for Health and Safety and Fire for 2019/20.
The report also includes an overview of the reactive incident data for Health and Safety and Fire.
Interest from Enforcement Agencies, Health and Safety Executive (HSE) and West Midlands Fire Service.

Actions from 2018/19 Report – Health and Safety

Safer Sharps

Reviews have been undertaken on the use of safer sharps and whilst the incident trend analysis identifies that sharps and needle stick incidents remain the highest recurring incident within the Trust, this is still low in comparison to other Hospitals of similar size.

The review has identified that one of the main causes of needle stick incidents is the suture needle, which as yet no safer sharps system has been developed.

Working with the BCP Procurement Team it has been identified that there is a Neo Natal and Paediatric cannula that is a safe sharp system, this has been introduced in Paediatrics and a trial is being completed on Neo-Natal with a view to introduce the safer system in this department by Winter 2019.

A significant number of incidents are in relation to disposal and sharps being found in the incorrect waste streams and reported as near misses.
Waste champions are being identified and trained within all areas to support the appropriate segregation and management of waste at the point of generation.
It is anticipated that the implementation of this role will assist in reducing the incidents of incorrect disposal.

Action - Completed
Incident data to be monitored to ensure continued reduction in harm incidents. Procurement to monitor new safer sharps being introduced for trial within the Trust. Waste champions to support with correct segregations at source.

General Risk Assessments

A review of risk assessments was undertaken in respect to general risk assessments relating to the work activities and work environments.
It was identified that a number of areas did not have any assessments completed. A meeting was held in March 2019 to discuss the concerns and plan of action to bring the Trust to a point of compliance.

Training day was agreed and Divisions were responsible for identifying members of their teams to attend to understand the principles and application of the risk

assessment process with a view to returning to their areas to complete the necessary assessments.
The training day was held on 16th April 2019 which was attended by 43 members of staff. A further training day was held on 28th May 2019 of which 8 members of staff attended.

To support the teams with the development of the risk assessments general risk assessments have been completed by the Health and Safety Manager for the following work activities and environments:-

- In-patient ward area
- Out-patient Department area
- Office area

These can be used to develop the local risk assessments covering the hazards associated with the work activities. This will enable the teams to have a starting point and should with minor amendments satisfy the local areas requirements.

These assessments are located on the HUB to enable access to all teams. These assessments will be reviewed on an annual basis to ensure that the detail is still relevant and will include findings from incidents and issues raised throughout the year to encapsulate the hazards and mitigation measures required.

Action – Continued Compliance
Responsible persons to be identified and attend relevant training. Completion of general risk assessments within the local departments

Audit of Compliance

An audit of compliance with the Control of Substances Hazardous to Health (COSHH) policy was undertaken during October 2018 identified that there was a lack of assessments within all areas.

Previously as with general risk assessment, staff had been allocated responsibility for the management of the assessments within the wards and departments, unfortunately as this is in addition to staff member's roles, this has not been maintained to a level that would be considered in accordance with the Trust's duty.

To support the teams to enable compliance and reduce the workload on the staff members given responsibility for the COSHH Assessments, a bank of COSHH assessments have been completed and are available on the HUB for all commonly used cleaning products throughout the Trust.
These assessments ensure that there is a consistent approach to products used by all departments and reduce the work load on teams, leaving only the speciality specific chemicals to be assessed.

The assessments are available on the HUB and are the responsibility of the Health and Safety Manager to review and update as required.

As it was identified that there is a lack of general risk assessments and COSHH assessments and it was known from previous inspections that there is a lack of DSE Assessments within the Trust. The development of the full audit tool was suspended as this would be reiterating the above findings and the focus needed to be centred on resolving the known concerns.

Action – Continued Compliance
Responsible persons to be identified and attend relevant training. Completion of specific COSHH risk assessments within the local departments

Trust wide schedule of air monitoring - Inclusion of Diathermy

This action has not been completed in the absence of the COSHH Assessments for the substances used within the wards / departments outside of the general substances that are used across all areas that do not have any air monitoring requirements.

Action - Outstanding
Key point to be carried over to the next 12 month period.

Ligature Points

An Estates and Facilities alert was received by the Trust to review all ligature risk assessments and ensure that low level risk factors such as taps are included as ligature points.

The Trust at the time had not considered the ligature risk from an assessment perspective; this is mainly due to the requirements for anti-ligature fittings and considerations being applicable to Mental Health Trusts and not Acute within the Health Building Notes.

As a result of the alert the Trust identified the ligature points within the wards and departments where patients are able to spend time alone and unsupervised. This has been amalgamated into an overarching Trust wide risk assessment highlighting the areas of concern and potential mitigation measures.

The findings of the assessments and subsequent testing carried out identified that there are a significant number of ligature points around the Trust due to the build and fittings, these include curtain rails, taps, door handles and self-closing devices.
The curtain tracks within the Trust were originally fitted as anti-ligature but due to high numbers of incidents of the rails falling onto staff and patients whilst closing the curtains, the rails were secured in place to prevent falling, subsequently removing the anti-ligature element. The only area of the Trust that has the anti-ligature rails is Children's Ward (C2).

As a result of the risk assessment a Business Case has been developed identifying the options available for the Trust to ensure the safety of patients who are known or suspected as being at risk, whilst receiving acute treatment until such time as deemed fit for transfer to a more suitable facility.

To ensure the Trust remains compliant with the requirements of the alert the risk assessment templates policy has been updated to include a ligature identification assessment tool that must be completed on an annual basis, to identify local mitigation whilst also supporting the review of the Trust wide assessment to ensure the mitigation put in place is still suitable and sufficient to the risk factor.

To ensure staff are confident in completing the assessment the general risk assessment training currently delivered to staff nominated to take responsibility for the assessments within their local areas, has been updated to include the ligature identification assessment tool to enable competence to be evidenced.

Action – Works to be completed
Decision on action from Business Case Works to be completed.

Key priorities for 2019 / 2020

Trust Wide Air Monitoring
Action carried forward. Utilising the material safety data sheets for all products commonly used within the Trust and the departmental / speciality specific chemicals, identify the products in which air monitoring is required and formulate a programme based on frequency of exposure and risk to monitor the levels and ensure the mitigation measures are suitable and sufficient to the data received.

Overarching Audit and Inspection
Development of an audit and inspection programme to ensure that the assessments being developed and implemented within the local areas, including general risk, COSHH, DSE and Stress are in place, actions implemented and reviewed accordingly to ensure no re-occurrence in the gap in compliance.

Health Surveillance Compliance
Working with Staff Health and Well Being, utilising the data from the general risk assessments completed within the local wards and departments, findings of COSHH assessments and material safety data sheet and recognised guidance ensure that the health surveillance required for the monitoring of exposure to varying hazards within the Trust is adequately implemented for all staff.

Action from 2018/19 Report – Fire

Standardised approach to Community Fire Safety

Fire risk assessments for the community properties where staff are based have been completed and actions arising have been circulated and assurance received that these are completed.

Arrangements for fire marshalls have been updated and agreed with the property landlord, given the flexibility and working methods adopted in the community.

Monthly fire inspections have been implemented within the community properties to ensure that any issues identified have a formal escalation route to the relevant teams.

Regular meetings are held with the landlord's fire representatives to identify any areas of concern raised by the Trust in regards to the assessments or monthly inspections. It also is an opportunity for the landlords to raise any concerns they have identified whilst carrying out their inspections of the premises.

Community fire safety policy has been developed that outlines the methods in which the Trust meets its duties under the Regulatory Reform Fire Safety Order 2005. This also identifies the co-operation between the landlord and the Trust when in multi-occupancy buildings ensuring the safety of staff and patients.

Action - Completed
Continual review of assessments

Evacuation Exercises

During 2018 / 19 an evacuation was completed within North Block following the changes made to the strategy within the area. This identified some actions that needed to be implemented to ensure that patients, once evacuated, are moved back to the Hospital as soon as possible.

North Block has also been tested in respect to the structural elements such as alarms and doors during the EPRR Exercises Phoenix. As a result of this exercise the fire procedure for RHH will be reviewed and updated.

Community properties have undertaken evacuation exercises ensuring that staff and patients are able to evacuate in a controlled and organised manner. Learning from all exercises is discussed at the liaison meetings and any actions agreed and implemented.

The evacuation exercise held at Brierley Hill Health and Social Care Centre highlighted concern with the assembly point which has resulted in a change of location. This has been agreed and is being re-tested during October to ensure that the information and instruction has been communicated effectively.

Action - Completed
On-going planning of exercises

North Block Review

Following the extensive reviews for assurance on the cladding type used as the external envelope around the North Block building, concern was raised through the reports in respect to the lack of cavity barriers. *(Cavity barriers sit in the gap between the outside wall of the building and the inside of the cladding, the function is to prevent rapid fire spread engulfing the internal gap causing potential break into the building at multiple points).*

The Trust commissioned a full report into the internal structure for assurance that the internal building was in accordance with the requirements of fire safety. The report was completed by Seymour Harris Architects, (SHA), who are familiar with the Trust site and were the Organisation that completed the initial feasibility and design work for the cladding. Following the SHA report a further review of compartmentation was completed by Total Fire Safety (TFS), this considered the actual number and locations of the breaches within the compartment and sub-compartment walls along with the fire doors.
Both reports were used to compile the North Block risk assessment and sit as appendices to the document for accuracy.

The reports were received by the Trust and the findings of the studies identified a number of issues in respect to the building and the fire protection measures.

The issues highlighted that the building could not safely remain in progressive evacuation, as this would entail holding people within the building, a change to a vertical all out evacuation was required. This has been implemented and has been in place since October 2018.

On receipt of the report the Trust invited West Midlands Fire Service, Fire Safety Officer, to attend site to discuss the implications of the report and the immediate measures being adopted to ensure life and property safety. Initial safety measures were agreed and subsequent meetings held to discuss the output from the reports.

The Fire Service have since requested the fire risk assessment for North Block detailing the mitigation measures in place and the higher risk works being planned for completion.

At the time of completing this report, the Fire Service have rejected the initial assessment stating that the planned works are not considered suitable and sufficient to manage the risks known from the report. The West Midlands Fire Service Legal Team have reviewed the full SHA report detailing the issues identified within the building and a meeting is being scheduled for late September to discuss the requirements from the Fire Service.

Due to the extent of the issues identified the cost for the corrective works is significant. A business case has been developed outlining the options available to the Trust, this will be presented to the Executive Team once a decision from the Fire Service is known.

Action – Works to be agreed and completed
Works identified as required to be completed in accordance with the requirements of the West Midlands Fire Service.

Key priorities for 2019 / 2020

North Block
Ensure that all works are completed in accordance with the outcome of the West Midlands Fire Service meeting and the Trust Business Case.

Fire Door Review
As one of the most significant risks in respect to the structural fire safety of the building, a review of the fire doors in respect to maintenance and repair to be completed to ensure compliance with the relevant British Standard and also the overall Trust risk assessment. Where actions are required these are implemented to ensure that the passive action works as intended in alarm activation situations. Ensure that vision panels are clear and are able to be utilised as intended.

Extension Lead Compliance – in accordance with Trust Policy
After fire doors the use of unapproved extension leads is a fire risk within the Trust that is unquantified. Review of the extension leads utilised within the Trust and ensure that they are approved in accordance with the requirements of the Trust Policy, where non-compliance is identified actions are advised and implemented.

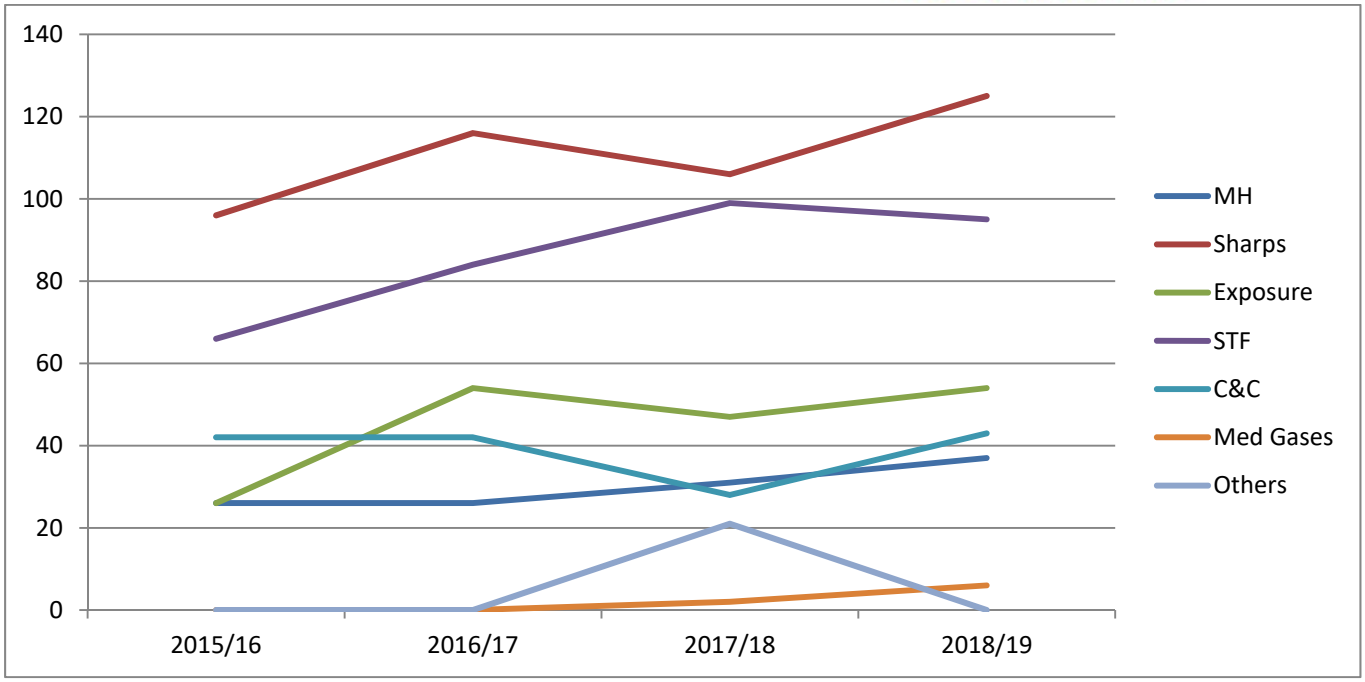
Executive Team Fire Training
Development of an Executive Mandatory Fire Training Package specific to the role and responsibilities undertaken to incorporate evacuation and shelter.

Incident Data April 2018 – March 2019

Health and Safety

The table gives an overview of the total number of incidents affecting staff reported over this above financial year and the previous three years.

Incident Category	Incidents during 2015/16	Incidents during 2016/17	Incidents during 2017/2018	Incidents during 2018/2019
Manual Handling	26	26	31	37
Needle sticks and Sharps	96	116	106	125
Exposure to hazardous substances	26	54	47	54
Slips, Trips and Falls	66	84	99	95
Collisions and Contacts	42	42	28	43
Medical Gases	N/A	N/A	2	6
Others	0	0	21	0
Total number of reported incidents	**256**	**322**	**334**	**360**



There has been an increase of 7.2% in overall incidents reported during 2018/19. The increase covers all incident categories with the exception of slips, trips and falls as this category saw a reduction over the year.

The continued increase in total numbers of incidents reported identifies a good reporting culture within the Trust. Below is a breakdown of the incidents reported as near miss and no harm to highlight the positive reporting culture that has developed in openness on incidents that could have caused harm, however on this occasion did not thereby giving opportunity for mitigating measures to be put in place to prevent re-occurrence and potential injury.

Near miss incident reporting has increased during the majority of the time period with a slight decrease during 2017/18.

Collectivly the number of incidents reported over the comparison period the number of incidents reported as near miss or no harm has risen significantly since 2015/16 where 9.7% of the incidents reported caused no harm whereby 2018/19 56% of all incidents were catagorised as near miss / no harm.

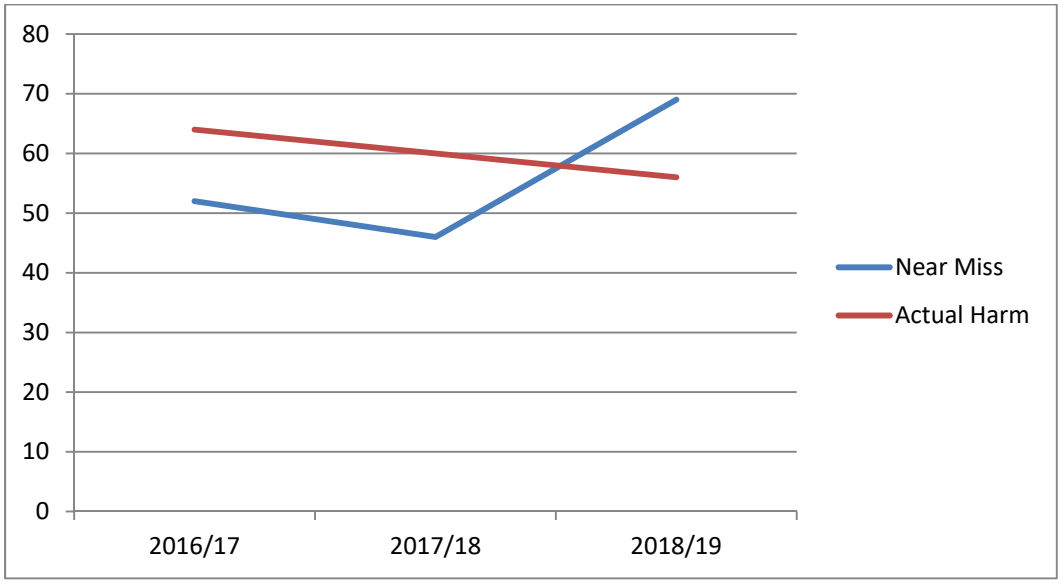
Reporting year	Total reported incidents	Number of near miss / no harm incidents reported	Total %
2015/16	256	25	9.7%
2016/17	322	209	65%
2017/18	334	150	45%
2018/19	360	202	56%

During the reporting year 2018/19 the number of reported needlestick incidents increased by 5.2% compared to the numbers reported during 2017/18 where by a decrease in the reports was seen.

A review of the incident data over the reporting periods 2016/17, 2017/18 and 2018/19 identified the following seperation between the reported near miss needlesticks and incidents where a sharps injury was caused.

The graph below shows the increase in near miss incidents over this reporting period and the gradual reduction in actual harm incidents.

Reporting year	Total number of incidents	Number of reported near misses	% of near misses	Number reported of actual harm	% of actual harm
2016/17	116	52	44.8%	64	55.2%
2017/18	106	46	43.3%	60	56.7%
2018/19	125	69	55.2%	56	44.8%



The second most significant increase is within collision and contact incidents, the numbers reported within this category increased by 4.2%. The main sections within the category where incidents were reported included:

- Struck by moving object
- Collision with stationary object

The incidents sections that increased during 2018/19 included contact with hot liquid, this increased from 1 in the previous reporting year to 6 during the reporting period. Bitten / injured by an animal increased by 4 incidents with none reported during 2017/18.

During 2019 the “others” category has been removed due to the amount of incorrectly categorised incidents that were placed within this section that related to non-Health and Safety situations.

RIDDOR Data

Incident Category	Incidents During 2015/16	Incidents During 2016/17	Incidents During 2017/18	Incidents During 2018/19
Over seven day injury	13	11	8	0
Dangerous Occurrence	2	4	2	2
Disease	1	0	0	0
Major Injury	1	1	2	5
Total number of RIDDOR reports affecting staff.	**17**	**16**	**12**	**7**
Total number of RIDDOR reports affecting patients.	**17**	**20**	**4**	**1**
Total number of RIDDOR Reports.	**34**	**36**	**16**	**8**

The RIDDOR data for this reporting period shows a significant decrease in total number of incidents reported.

The number of incidents reported to the HSE that are patient related have drastically reduced from 2015/16 to the current reporting year. This is due to a reduction in the number of falls within the Trust that cause harm and the review process that is adopted into every RCA to determine if the fall was avoidable or unavoidable which has an impact on the reporting criteria.

The lack of incidents reported to the HSE in respect to over-seven day absence or restrictions to duty due to a work related injury is concerning. Information in respect to the categories for RIDDOR Reporting was included within the Health and Safety and Fire Manager's report to the Health, Safety and Fire Assurance Group in February 2019 to ensure attendees for the areas were aware and can cascade down the information to ensure accurate reporting to the Health and Safety and Fire Manager for external reporting.

The number of major injuries reported for staff increased this year significantly from 2 to 5. Injuries reported under the category of major injury include fractures to any bones with the exception of fingers, toes and thumb, amputations and 24 hour admittance to hospital.

During the reporting period incidents resulting in staff suffering fractures increased with 4 reporting the following fractures:-

- 1 of these incidents involved a member of staff slipping on a wet floor on the hospital corridor,
- 2 involved staff walking across the roadway / grassed areas from the hospital towards the multi storey carpark.
- 1 involved a member of staff that tripped on loose wires under a desk.

A report was also made to the HSE following a staff member who sustained an amputation to the tip of their finger following use of a guest bed on one of the Wards.

The Trust received no contact from HSE as a result of any reports made under RIDDOR.

Fire Incidents

During the annual period the Trust had received 16 fire alarm activations across the Trust premises, this includes Corbett and Guest. This is a decrease of 69% in comparison to the data from the last annual period.

There were no actual fires reported within this period.

Below is a table detailing the causations for the false alarms experienced on site, comparative for the previous two year period:

Activation Type	2016/17	2017/18	2018/19
Steam leak in plantrooms	11	14	2
Equipment fault / fume	6	6	4
Smoking / vaping	4	7	1
Dust	4	2	2
Contractor caused activation	8	10	2
Cooking	7	2	1
Visitor activated in error thinking it was door control	7	5	3
Smoke external to the building	0	4	0
Intentional activation	1	0	1
Not recorded	0	3	0
TOTAL	**48**	**53**	**16**

Enforcement Authority Interest in the Trust

During the reporting period the Trust received no contact from either HSE or West Midlands Fire Service.

During the current financial year the Trust is in contact with West Midlands Fire Service in respect to North Block and the findings of the surveys undertaken.

HSE has also been in contact on two occasions following contact from a concerned staff member in respect to the transfer of critically ill patients between hospitals and the security of the equipment.

Public Health England also reported the Trust for a case a Legionella contracted by an in-patient whilst staying at the Hospital.

Responses have been sent into HSE on both of the issues raised, no further communication from the agency has been received at the time of completing this paper.