The Dudley Group
NHS Foundation Trust

Public Board of Directors Meeting

Thursday 12th March 2020

12.30 – 14.40

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

The Dudley Group
NHS Foundation Trust

BOARD MEETINGS
PUBLIC INFORMATION SHEET

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

1. Introduction

This sheet provides some information about how Board meetings work.

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

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

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

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

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

2. Board Members' interests

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

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

3. Opportunity for questions

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

4. Debate

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

5. Minutes

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

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

6. Key Contacts

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The Dudley Group
NHS Foundation Trust

THE SEVEN PRINCIPLES OF PUBLIC LIFE

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

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

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

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

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

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

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

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

IN PUBLIC

The Dudley Group NHS Foundation Trust

Board of Directors
Thursday 12 March 2020 at 12.30am
Clinical Education Centre
AGENDA

	ITEM	PAPER REF	LEAD	PURPOSE	TIME
14	**Chairmans welcome and note of apologies –**		Y Buckland	For noting	12.30
15	**Declarations of Interest** Standing declaration to be reviewed against agenda items.		Y Buckland	For noting	12.30
16	**Minutes of the previous meeting** Thursday 13 February 2020 Action log 13 February 2020	 Enc 14 Enc 15	 Y Buckland L Nevin	 For approval For noting	 12.30 12.30
17 **17.1**	**Staff Story** **Communications – Key Messages**	Enc 16 & Presentation Enc 17	L Abbiss L Abbiss	For discussion For discussion	12.35 12.45
18	**Chief Executive's Overview**	Enc 18	D Wake	For information & assurance	12.55
19	**Chair's update**	Verbal	Y Buckland	For information	1.05
20	**GOVERNANCE**				
20.1	Charitable Funds Committee Report	Enc 19	J Atkins	For assurance	1.15
21	**QUALITY & SAFETY**				
21.1	Update from the Quality and Safety Committee	Enc 20	E Hughes	For assurance	1.25
21.2	Chief Nurse Report	Enc 21	M Sexton	For assurance	1.35
21.3	Learning from Deaths Report	Enc 22	J Hobbs	For assurance	1.45
22	**FINANCE & PERFORMANCE**				
22.1	Update from the Finance and Performance Committee	Enc 23	J Hodgkin	For assurance	1.55
22.2	Integrated Performance Dashboard	Enc 24	K Kelly	For assurance	2.05
23	**WORKFORCE**				
23.1	Update from Workforce and Staff Engagement Committee	Enc 25	J Atkins	For assurance	2.15
23.2	Looking after our Doctors: (i) Guardians of Safe Working	 Enc 26	 B Elahi	 For assurance	 2.25

	(ii) Doctors Vision for Change in the NHS – BMA Report	Enc 27		For information	
24	**Any Other Business**	Verbal	All		2.35
25	**Reflection on meeting**	Verbal	All		2.35
26	**Date of next Board of Directors meeting** 16 April 2020, Clinical Education Centre				2.40

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

Enclosure 14

The Dudley Group NHS
NHS Foundation Trust

Minutes of the Public Board of Directors meeting held on Thursday 13th February 2020, in the Clinical Education Centre.

Present:

Yve Buckland, Interim Chair (YB)
Diane Wake Chief Executive (DW)
Liz Hughes Non-Executive Director (LH)
Jonathan Hodgkin Non-Executive Director (JH)
Lowell Williams Non- Executive Director (LW)
Tom Jackson, Director of Finance (TJ)
Karen Kelly Chief Operating Officer (KK)
Vij Randeniya, Non- Executive Director (VR)
Richard Miner, Non-Executive Director (RM)
Julian Hobbs, Medical Director (JHO)
Julian Atkins, Non-Executive Director (JA)
Mary Sexton, Chief Nurse (MS)
Catherine Holland, Non-Executive Director (CH)
Gary Crowe, Non-Executive Director (GC)
Ian James, Non- Executive Director (IJ)

In Attendance:

Adam Thomas, Chief Information Officer (AT)
James Fleet, Interim Director of Strategy (JF)
Liam Nevin, Trust Secretary (LN)
Liz Abbiss Head of Communications (LA)

19/150 Note of Apologies and Welcome

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

No apologies were received

19/151 Declarations of Interest

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

19/152 Minutes of the previous meeting held on 16th January 2020 and Action Log

The action log was noted.

It was **RESOLVED**

- **That the minutes of the public meeting of the 16th January be agreed as a true and accurate record of the meeting.**

19/153 Patient Story and Patient Story Rationale

LA advised that the paper presented was in response to the request of the Board to assist understanding of how the patients' stories fitted into the broader patient experience strategy of the Trust. The intention was to cover all areas of the organisation in a planned way providing a good coverage of areas and services with stories that fitted with the strategic objectives of the Trust, highlighted service innovations and the quality of patient experience, with both good and bad stories.

CH suggested that it would be helpful for the stories to be accompanied by a summary of the learning that the Trust had taken from a patient story and what had changed as a result.

Thereafter the Board watched the patient story of Susan Perks who was the first patient in Dudley to undergo same day discharge for joint replacement.

VR and GC stated that patients should periodically be invited to attend the Board for this item, particularly when their experience had not been a positive one.

Dr Gee (a member of the Council of Governors) asked if there was any evidence to show the long term benefits of this approach to joint replacement and JHO stated that patients who were involved in their care had a better functional outcome, particularly in relation to orthopaedics.

It was **RESOLVED**

- **That the Board will receive a patient story schedule on a bi-annual basis**
- **That the Patient story be circulated with papers to include the rationale for selection as set out in the preamble to this minute**
- **That the Patient Story be noted.**

19/154 Chief Executive's Overview

DW summarised the report and advised the Board that the flu vaccination rate was now at 79% and whilst this was a pleasing outcome, the Executive would be evaluating how to get a better momentum from the start of the campaign for next year.

DW further advised that the Trust was following guidance from Public Health England and the Director of Infection Control in relation to the screening of patients for Coronavirus. Dr Gee asked whether provision had been made in the Urgent Care Centre for any patients presenting with the virus and DW advised that the Trust had set up pods for the treatment of patients and in doing so it was following national guidance.

It was noted that this month's Healthcare Heroes individual award went to Kerri Faulds, clinical support worker in the Maternity Team. The team award went to the Palliative Support Community Nursing Team, and the volunteer award went to the chaplaincy service. The Board commended each of the recipients of the monthly award.

It was **RESOLVED**

- **That the report be noted**

19/155 Chair's Update

The Chair advised that she and LW had met with Mike Wood and James Morris MP to update them on progress being made by the Trust as well as some of the challenges around winter pressures and the Emergency Department. In addition the Chair had spent time with the Surgery Team and this provided a valuable insight into how the team were addressing pressures in the service.

19/156 Quality and Safety

19/156.1 Update from the Clinical Quality, Safety and Patient Experience Committee

LH summarised the report up from the Committee and advised that there was positive assurance around the resolution of the referral to the HSE complaint in Podiatry, and there had also been improvement in Achieving Excellence requirements.
However, the Committee were concerned about the low compliance with VTE assessments and had requested an improvement plan. In addition, medicine prescribing on the endoscopy recovery chart was showing improvement but was not yet at acceptable standards of compliance. The Committee had requested the Clinical Leader to attend the next committee to present the plan.

The Committee were also concerned about the poor compliance rate for mandatory training amongst clinical staff and JHO advised that there continued to be issues around recording of mandatory training and the data was currently being reconciled, with the reporting period also being shortened to fortnightly rather than the current six week cycle. Letters had been sent to all clinicians who were non- compliant and this would be addressed individually. In addition, the Trust would be introducing bi-annual full day training to allow for all mandatory training to be done in the course of a day.

The Committee had also approved the Premises Assurance Model and were recommending an amendment to the Terms of Reference and which were now before the Board. In relation to the terms of reference DW suggested that some further consideration be given to the Committee membership and it was agreed that a decision on this be deferred pending further discussion.

It was **RESOLVED**

- **That the report be noted**
- **That the Clinical, Quality, Safety, and Patient Experience Committee be re-named the Quality and Safety Committee but that other amendments to the terms of reference be deferred.**

19/156.2 Chief Nurse Report

MS summarised the report. It was noted that the University of Wolverhampton had advised the Trust that it was unlikely to meet the student placement target for the March cohort and at present it was likely that only five students against a cohort of 58 would be provided. An urgent meeting was being arranged to discuss this with the University representatives.

CG sought assurance that the safer staffing levels detailed in the report were subject to oversight in the Quality and Safety Committee and it was confirmed that the data was reviewed through the groups reporting into the Committee.

The Chair challenged that the rate of reported falls was high and MS assured the Board that whilst the number was higher than expected each case had been reviewed and no common trends had been observed. Further training had been undertaken on two wards following the review.

It was **RESOLVED**

- **That the report be noted**

19/157 Finance and Performance

19/157.1 Integrated Performance Dashboard

JHO noted that the VTE improvement plan had been discussed earlier in the meeting and it was notable that mortality had fallen again with the SHMI now at 111. It had been falling since March 2018 and was now within the expected range following an audit review

KK advised that significant pressures on ED were continuing and there had been a number of 12 hour breaches up to mid- January. An increase in attendance and lower discharges over Monday and Tuesday had resulted in additional breaches this week.

There was strong challenge from the Non –Executive Directors in relation to the 12 hour breaches and KK summarised the measures that had been taken to limit the risk of these occurring.

KK summarised performance against the mandated targets. In relation to DM01, a mobile MRI scanner and additional endoscopy support was being sourced and subject to this it was expected that performance would return to target by the end of March. It was further expected that the two week cancer wait performance would revert to target at the end of March.

DW advised that in relation to DM01 the Director of Operations had devised a programme of interventions that was being overseen by the Executive Team.

JF advised that the IPR confirmed that the Trust was in the lower quartile for sickness absence and actions were being brought to the Workforce Committee.

19/157.2 Update from the Workforce and Staff Engagement Committee

JA provided the Committee update. It was noted that mandatory training compliance had also been identified as a key concern by the Committee, and succession planning was also an issue that the Committee had identified as requiring further work.

It was proposed to refresh the People Plan and the associated Behavioural Framework strategy.

As positive assurance, the Board were advised that the Q2 results for FFT were a substantial improvement on Q1.

19/158 Governance

19/158.1 Digital Trust Committee Terms of Reference

The Terms of Reference were agreed subject to the following amendments:

- Any Executive Director may attend the meeting
- The SIRO be named as an attendee

It was RESOLVED

- **That subject to the amendments identified in the preamble to this minute that the terms of reference be approved**

19/158.2 Committee Membership Non-Executive Directors

The proposed allocation of Non-Executive Directors to committees and other functions was approved without debate

19/158.3 Board Development Plan and Workplan

The Board Development Plan and Workplan was approved without debate

19/159 Any Other Business

There was no other business

Date for the Next Meeting - 12 March 2020

Signed ……

Date ……

Enclosure 15

The Dudley Group NHS Foundation Trust

Action Sheet
Minutes of the Board of Directors Public Session
Held on 13 February 2020

Item No	*Subject*	*Action*	*Responsible*	*Due Date*	*Comments*
19/021.4	Organ Donation Report	Results of work on tissue donation to be included in the next report.	K Lazenby	Jan 2020	Deferred
19/097.5	Freedom to Speak Up Report	NHSI to review implementation of their recommendations in July 2020	JF	July 2020	Not Due
19/133.3	Research and Development Report	Develop a plan with KPIs that will sustain and develop research capacity	Jeff Neilson (JN)	March 2020	R&D Report to April Board.
19/133.4	Learning from Deaths Quarterly Report	Future reports to include a graph with trend data and peer comparison	JHO	March 2020	Report on Agenda.
19/143	Outcomes from the Board Away Day	Periodic review by the Board of progress against Action Plan	LN	April 2020 (quarterly review)	Not Due
19/146.3	Integrated Performance Report	IPR to provide SPC charts consistently with supporting narrative and remove duplicate data in different format	KK	13/2/2020	Several meetings held with Infomatics. Latest position as at 3rd February – confirmation given to COO that this work will be available for March IP report. The update requires a full system change to how the IPR is reduced.

19/156.1	Report of the Clinical, Quality, Safety, and Patient Experience Committee (Quality and Safety Committee)	Defer decision on terms of reference to consider membership of committee	LN	March 2020	Amendments to be agreed between the CEO, Chief Nurse, Board Secretary and Committee Chair

Enclosure 16

The Dudley Group NHS Foundation Trust

Paper for submission to the Board of Directors on 12th March 2020

TITLE:	**Staff story**		
AUTHOR:	**Jackie Dietrich, communications manager**	**PRESENTER**	**Liz Abbiss, head of communications**

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	

STAFF STORY OUTLINE

Edliz Kelly is the interim operational lead for Dudley Clinical Hub. After spending ten years as an emergency care nurse (seven of those in Dudley), Edliz lost her passion for the role and hit a dark negative place emotionally. With the support of the Trust and her managers, she moved to a non-clinical role in community where she says she is thriving. In the process, she rediscovered her passion for healthcare. She was also encouraged to take part in the leadership course that allowed her to network with colleagues, which she found inspirational. She talks openly about how the Trust enabled her to get the best from herself.

The Dudley Clinical Hub is a single point of access for patients to be referred to community practitioners such as district nurses, advanced nurse practitioners, care home nurse practitioners and long-term condition nurses. The hub teams manage patients out of the hospital and reduce unplanned hospital admission, ambulance call outs and GP visits.

CORPORATE OBJECTIVE:

SO1, SO2, SO3, SO4, SO5, SO6

SUMMARY OF KEY ISSUES:

- Edliz reflects on the Behaviour Charter and what it means for her.
- How, through the People Plan, she has been given opportunities to develop and improve.
- How excited she feels by the aims of the Integrated Care Provider to give patients the right care, in the right place at the right time.

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	**Y**	**Details:**
	Other	**N**	**Details:**
REPORT DESTINATION	**Board of directors**	**Y**	**DATE: 12th March 2020**
	WORKING GROUP	**N**	**DATE:**
	COMMITTEE	**N**	**DATE:**

Enclosure 17

The Dudley Group NHS Foundation Trust

Paper for submission to the Board of Directors on Thursday 12th March 2020

TITLE:	**Trust highlights report**		
AUTHOR:	**Liz Abbiss, head of communications**	**PRESENTER**	**Liz Abbiss, head of communications**

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

Trust board note the contents of the report and members use the facts and information contained within.

CORPORATE OBJECTIVE:

SO1, SO2, SO3, SO4, SO5, SO6

SUMMARY OF KEY ISSUES:

- This report shares some of the key highlights and facts for some of our services for information for board members.

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	**Y**	**Details:**
	Other	**N**	**Details:**
REPORT DESTINATION	**Board of directors**	**Y**	**DATE:12.03.2020**

	WORKING GROUP	**N**	**DATE:**
	COMMITTEE	**N**	**DATE:**

The Dudley Group NHS Foundation Trust - key facts March 2020

The Trust became a foundation trust in 2008. It serves a population of approximately 450,000 people from three hospital sites at Russells Hall Hospital, Guest Outpatient Centre in Dudley and Corbett Outpatient Centre in Stourbridge. The Trust provides the full range of secondary care services and some specialist services for the wider populations of the Black Country and West Midlands region. The Trust also provides specialist adult community based care in patients' homes and in more than 40 centres in the Dudley Metropolitan Borough Council community.

Referral to Treatment

Overall RTT is consistently in the top ten trusts nationally. We are routinely in the top 10 trusts nationally for the 18 weeks from referral to treatment times. We have some of the shortest waiting times in the country for planned procedures, e.g. for hip and knee replacements where patients wait on average just over 6 weeks after they are listed for surgery.

Most recently orthopaedics has done their first ever home same day partial knee replacement with plans to increase these procedures where appropriate with lists planned.

Emergency Department

We won the bid for £20.3m investment in a refurbishment of our ED, and planning is well underway. Part of the redesign work has meant greater collaboration with GP colleagues on pathways of care.

We are the top performing trust in the west midlands region for streaming to urgent care and minors performance. The minors performance is also top performing and this is mainly due to the introduction of ENP led services 24/7.

Ambulance triage (patients being assessed within 15 minutes of arrival) remains above 95% consistently, however majors remains a challenge.

We have set up a Single Point in the community which gives GPs direct access to assessment areas across the Trust without the need to go via ED we are extending this to WMAS patients too.

The children's area of ED has moved into much bigger, better accommodation providing better environment for our emergency children. We also have an ED charitable funds appeal we'd love people to get engaged with us to raise £1m to support the transformation of our ED.

Gastroenterology team

We have a very forward thinking team including Professor Sauid Ishaq who has pioneered several procedures that are only conducted here in Dudley. Sauid has travelled the globe to educate other countries, such as Japan, in the techniques and sees patients from across the country for procedures such as underwater colonoscopy (much less painful than air). The

Zenkers procedure treats patients with swallowing difficulties in a less invasive way and was shortlisted in the 2018 HSJ awards.

Sepsis

We have consistently achieved and exceeded the national standard for sepsis screening, and 95 per cent of patients arriving by ambulance are assessed within 15 minutes of arrival. Our sepsis mortality is below the national average and below what was expected for the Trust. The Getting it Right First Time national team have asked for our sepsis recording and monitoring processes as a case study however this is not published yet. Our sepsis data and the way it is used in ED has been shortlisted in the Leading Healthcare 2020 awards for data quality

Finance

The Trust has a turnover of £394m in 2019-20. The Trust has been in a deficit position for the past three financial years. The current forecast for 2019-20 is a deficit of £1.5m (£6.1m without PSF). This position includes a settlement agreement with Dudley CCG of £8.3m which is included in the forecast position. The continued deficit position has resulted in the Trust having to manage its cash flow and without the assistance of Dudley CCG the Trust would have needed to borrow cash this financial year.

From 2020-21 onwards the financial regime is very much based on a system wide approach with STP wide financial targets. Each individual Trust will need to manage within a financial trajectory which can be moved across the STP as long as the STP wide financial target is achieved.

Stroke

We are the best performing stroke service in the West Midlands according to the Sentinel Stroke National Audit Programme, which is the single source of stroke data in the UK. We have a Level ‘A’ rating. Meaning our patients get swift world class stroke care near to their home

Hip Fracture best practice

Having Orthogeriatric assessment is essential to our patients who are admitted with hip fractures. Evidence shows that mortality rates are lower for hip fracture patients who have orthogeriatrician assessment and the necessity for it is supported by National Best Practice Tariff and NICE guidelines.

For Dudley Group to be one of the nine Trusts in the UK to achieve such a consistent orthogeriatric assessment for our hip fracture patients, supports reduced mortality and improved quality of care.

Anaesthetics

We are the first Trust in the West Midlands to receive the prestigious Anaesthesia Clinical Services Accreditation, demonstrating 100% in patient experience, patient safety and clinical leadership, a real benchmark for quality standards in our anaesthetics team.

The Dudley Endometriosis Centre awarded BSGE Accreditation.

Our endometriosis centre has (Feb 2020) achieved national accreditation from the British Society for Gynaecological Endoscopy (BSGE) for 2020.

This will raise the Trust's profile and help us attract patients seeking specialised endometriosis care as well as trainees seeking experience in advanced laparoscopic (keyhole) surgery.

Accreditation, from the BSGE, is dependent on meeting the criteria based on an audit of work undertaken in 2019.

Our centre's total number of cases operated on in 2019 was 20. This compares favourably with other local centres including Birmingham (19) and Derby (15) and even the Imperial Endometriosis Centre (17). The BSGE requirement for us was a minimum of 12 operations. We are now recognised as an accredited centre on a national level, having been chosen as a provisional centre in 2019. Our endometriosis centre details are now published online on a national database on the BSGE website.

Diabetes

We provide a seven-day inpatient diabetes nurse service and review all patients admitted with a diabetic emergency within 24 hours. This enables patients to recover more quickly and be discharged earlier.

The Diabetes Antenatal Team was chosen to be part of the National Diabetes in Pregnancy Quality Improvement Programme. We set up a pioneering virtual clinic for monitoring diabetes in pregnancy. Dudley Group was one of the first Trusts in the country to use Flash Glucose monitoring to enable mums-to-be to optimise their glucose control during pregnancy, and we can now offer this treatment to all women with type 1 diabetes who become pregnant. Flash glucose monitoring uses a small device worn on the upper arm, which continuously records interstitial glucose levels.

We have developed a fast-track service to enable diabetes to be optimised before elective surgery. This has reduced cancelled operations due to poor diabetes control and enables safer surgery and faster post-operative recovery

Our integrated foot care team delivers award-winning care to people with foot problems, enabling faster healing and preventing avoidable amputations

Endocrinology

We have a dedicated thyroid, parathyroid and adrenal multi-disciplinary teams, working together to deliver the best outcomes for patients with endocrine disorders. We also have strong links to the QE for pituitary surgery.

Our recent GIRFT review was exemplary and commented that we are "well-managed, delivering high-quality care and fantastic research work!"

Cardiology

Our British Society of Echocardiography approved department performs up to 1000 Echos per month. Our specialist multi-disciplinary cardiac team treat around 1,500 patients per

year, implanting over 350 devices in the Cardiac Catheter Lab. Our 15 cardiology clinical staff completed over 22,000 non-invasive investigations in the last year.

Our Cardiac Assessment Unit won Initiative of the Year in the Leading Healthcare Awards for our work with ED in managing low-risk chest pain in a specialised unit co-located next to ED and pulling chest pain patients directly to the cardiac team. This unit has extended opening hours following the successful pilot.

Respiratory

Our Dudley Respiratory Assessment Service (DRAS) has recently been shortlisted in the leading healthcare awards 2020 in the Team of the Year category. Dudley Respiratory Assessment Service is a multi-professional team dedicated to improving the care and quality of life for respiratory patients. By utilising a forward thinking innovative approach to respiratory health we are able to integrate services across secondary, primary and community settings ensuring accessible, holistic care for respiratory patients.

Children's ward

#hospitalsarefun is the strapline for our children's ward who have started monthly 'fun' activities and themed days to support children to feel more comfortable during their stay everything from pirates and fairies to sports days – these have been very well received by patients and their families. They also host one of very few scouts groups in a hospital and we believe one of the first outside a specialist children's hospital.

Learning disabilities team

The award winning Learning Disabilities Nursing use innovative approaches to LD training, they recruited two patients with LD themselves to work with the Trust's simulation lead Katie O'Connor to improve student nurse clinical and communication skills by giving them a real understanding of the needs of people with a learning disability when they use hospital services. The Trust has invested in the LD team to increase its capacity.

Pharmacy

We introduced specialist pharmacists with prescribing and advanced practice in high flow clinical areas to support medicines optimisation and medicines reconciliation. This approach has enriched the multidisciplinary team and supports patient experience. A transfer of care of medicines to community pharmacy project has been implemented to strengthen our integration with pharmacists in other sectors and to support patients at discharge.

Our oncology pharmacists support consultant led clinics specialising in toxicity management of patients undergoing chemotherapy. This service was highly commended by the West Midlands Academic Health Sciences Network and picked up the AHSN Medicines Optimisation award. These pharmacists also manage our Aseptic Unit where tailored cancer chemotherapy is prepared for our patients and the unit is externally inspected QA services.

Our pharmacists contribute to national, regional and local medicines optimisation programmes and lead on safer medicines prescribing initiatives such as Better Training Better Care that support foundation doctor prescribing. Close links with higher education

institutes are in place through the development of joint teacher practitioner posts to support workforce development.

We successfully received NHS England funding to pilot the Integrated Pharmacy Medicines Optimisation project within the Black Country & West Birmingham STP due to the highly collaborative health economy approach of the Pharmacy teams. The Chief Pharmacist is co-chair of the STP Pharmacy Leadership Group and is supporting Pharmacy service transformation programme across the STP.

As an early adopter of medicines automation the Pharmacy service dispenses over 500,000 items per year and uses prescription tracking software to provide real time data. The service is supporting the implementation of electronic prescribing and medicines administration across the Trust in 2020 to further improve digitalisation of medicines

Urology

Starting to work as a network across the STP.

We carry out innovative kidney stone surgery Mini – PCNL(percutaneous nephro-lithotomy) less invasive and reduces risk of bleed and allows patients to recover more quicker reducing long of stay from 3-5 days to 24 hours.

Other

- Our R&D department won two awards at the Clinical Research Network WM Awards 2019
- We won a Top Hospitals Award for the quality of our data (acute sector) 2019
- Procurement have been awarded Level 1 status by the Department of Health under the NHS Standards of Procurement
  An interactive online video programme to help patients with rheumatoid arthritis (RA) at increased risk of cardiovascular disease has won a prestigious award (2018). The innovation was praised for its thoughtful approach. Love Your Heart is a joint project between our consultant rheumatologist Dr Holly John and the National Rheumatoid Arthritis Society (NRAS).
- Dudley Fall Prevention Service a partnership between the trust, adult social care and Dudley CCG is shortlisted for the LGC awards. It has reduced the number of falls in adults over 65 and hospital admissions.
- Janine Barnes is a neurology specialist pharmacist leading innovative work in Parkinson's disease and her role was the first in the UK to combine prescribing and managing the condition of Parkinson's disease with educating primary and secondary care staff on neurology.She works with the National Institute for Health and Care Excellence – in drawing up the updated Parkinson's disease guidelines. She has been chosen to sit on the NICE guideline committee which will review the use of cannabis products in neurological conditions.
- Liz Hughes, NED, - awarded MBE in queens New Year's Honours list for work in health and education. Liz is deputy medical director for Health Education England and a Consultant in chemical pathology and metabolic medicine at Sandwell and West Birmingham Hospitals Trust and Honorary Professor at both the University of Birmingham and University of Aston and visiting Professor at Worcester University.

Enclosure 18

The Dudley Group NHS Foundation Trust

Paper for submission to the Board of Directors on 12th March 2020

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:

- Operational Performance
- MCP
- Coronavirus
- Dudley Improvement Practice
- Flu Vaccination
- Strategy Update
- Senior Executive Appointments
- Charity Update
- Annual Staff Awards
- Healthcare Heroes
- Visits and Events
- 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 – March 2020

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.

Operational Performance

The executive team remain focused on improving the Emergency access target and have been working with clinical teams to do this. Work is underway to develop a business case for further acute and general beds on the Russell's Hall site. Occupancy within acute medicine is over 95% and this is impacting on flow from the emergency department in to the bed base. External issues relating to social care funding and delays in packages of care being available to medically fit patients is also having a significant impact due to the numbers. We are working in partnership as a system to resolve this but it is anticipated that this will be a ongoing issue. The Emergency care improvement support team (ECIST) commence work with the Trust on the 9th March to support further improvement work.

A reset week has begun on the 5th March to focus on patient pathways to eradicate delays in decision making internally and externally this is being supported by ECIST.

Diagnostic wait target - we have an agreed improvement trajectory and have committed to achieving 99% by the end of March 2020

Cancer 2WW – we have agreed recovery by the 1st April 2020 and work is underway with the speciality teams to ensure delivery.

Cancer 62 days- this has been impacted on due to diagnostics and delays in the 2WW standard, this will be recovered by July 2020

Referral to treatment time (RTT) - the trust is delivering this standard consistently and has some of the best access times in the Midlands

MCP

The MCP Strategic Case has been reviewed by the NHSI/E national team and a number of concerns known as 'red flags' have been raised to focus further work. The Trust continues to work with the MCP partners and NHSI/E to address the 'red flag' concerns and risks identified by the Trust. We have initiated clinically led pathway groups for services within the scope of the MCP and they have made recommendations to enhance pathway development and areas for further work.

Coronavirus (Covid19)

As of the 4th March 2020, a total of 16,659 people have been tested in the uk, 16,574 were confirmed negative. 85 confirmed positive.

A COVID19 planning team has been established and is comprised of all key partners that are required within trust to ensure all aspects of COVID19 are considered and planned for

Dudley Group NHS FT has established a Pod whereby we can offer swabbing on site if required, however as required under the national guidance and ask we have established a community swabbing team in conjunction with Local Authority Public Health staff, this has is swabbing patients as required, referrals are made by 111 into the single point of access (SPA) in the Community Team, this service is open between 0800-1800 7 days a week to support the local area response

In Trust there have been a lot of arrangements put in place to receive and as required admit patients into the organisation, this includes cohorting, surge and escalation and cohorting, this work is ongoing and subject to change as national guidance is updated

PPE is being ordered at departmental level in line with national requesting and guidance. These stocks are being advised on and monitored by the COVID19 planning team.

The Trust is well engaged with all local arrangements and national planning.

Dudley Improvement Practice

Emergency Theatre event + 30 day report

Following the improvement event in January, the theatres team have maintained momentum led by Lesley Leddington (Matron and Directorate Manager), Tracy Simner (Deputy Nursing and Directorate Manager), Theagh Bytheway (Theatre Manager) and Dr Jenny Wright (Consultant Anaesthetist).

Turnaround time between procedures from the previous patient entering recovery area to the start of anaesthetic on the next patient has reduced from an average of 45 minutes before the event to 29 minutes. Over the course of a day, the cumulative effect is that sometimes an extra operation can be carried out and there are fewer operations being performed after 0200 which is better for patient experience and recovery time.

There has also been a fall in the number of shifts filled by agency staff which is an indicator of improving staff morale resulting in lower sickness absence. 30 days is insufficient time for data to be conclusive and we'll continue to monitor at 60 and 90 days.

By optimising the theatre patient trolley processes, the team are reducing the number in circulation. The Emergency Department were about to buy eight new trolleys at a cost of approximately £38K, Theatres have now been able to release some of their spare trolleys to ED and as work continues it is hoped that there will not be a need to purchase any.

Preparations continue for the Gastro-Intestinal pathways improvement event at the end of April and Diane Wake has agreed to be executive sponsor with support from James Fleet. Jonathan Hodgkin has agreed to be Non-exec Sponsor.

Flu Vaccination

As our flu vaccination campaign comes to an end, I am delighted that we have achieved the national target to vaccinate 80 per cent of our staff. Our current vaccination rate stands at 81 per cent. It is great to see so many people protecting themselves and others from the flu virus. This also means the Trust receives £660,000 income on the back of this performance.

Strategy Update

A key area of focus for the board development session in December was the Trust's Strategy. Board members discussed the extent to which the existing Trust Strategy (2019-2021) and strategic objectives are ambitious enough and align sufficiently with the STP strategy and changing system landscape, including the launch of the MCP, provider collaboration, as well as the 'system first' focus on financial recovery and sustainability.

Given the range of challenges and opportunities that exist for the Dudley Group FT, the Board is keen to strengthen its focus on the Strategy within its work plan. Board members were keen to take the opportunity to re-calibrate the focus and ambition of the Trust's strategic objectives, as well as strengthen the existing measures, reporting and alignment to the BAF.

The Board's Strategy work plan has been strengthened, and a programme of work has been launched to; improve the existing strategic measures, develop a Board Strategy score card and implement quarterly reporting to Board. Work has also been undertaken with divisional and corporate teams to implement a robust framework and approach to embed medium term planning, which provides the key framework for aligning Strategy and delivery.

A work plan and timetable has also been developed to re-fresh the Trust's Strategy over the next 6 months, including an active programme staff, patient and system partner engagement. This work will align the Trust's energies and efforts across a range of strategic improvement activities, including; embedding the Dudley People Plan and associated Behavioural Framework and accelerating the adoption of the Dudley Improvement Practice and QI across the Trust. The DRAFT timetable is being presented to the March Board.

Senior Executive Appointments

We recently went out to advert for a new chief people officer and interviews for this new director post took place on 9th March 2020. We hope to announce the successful candidate soon. We will shortly be interviewing for a director of strategy and performance.

Charity Update

Parents beds for the Children's Unit: Our Trust Governors have pledged to raise £3,400 to purchase four beds which will allow parents to spend the night by the side of their child. They have already raised over £1,400. The charity are pleased to say they were successful with an grant application for £6,700 from the Goodyear Foundation, also to purchase parents beds.

Charity Merchandise: We will soon be holding regular sales in main reception at Russells Hall Hospital selling items such as water bottles, re-usable coffee mugs, notebooks, pens, to help raise funds for the Trust charity.

Dates for your diary for 2020

June: **Super Hero 5k**. on Sunday 21 June 2020 at Himley Hall
July: **Family Fun Day** on Saturday 11 July at Dudley Kingswinford Rugby Club
October: **Will Fortnight** on 5-16 October, Waldrons Solicitors
October: **Black Country Business Challenge** on Thursday 15 October at Baggeridge Country Park
October: **Scarefest** Sponsored Walk on Saturday 21 October at Baggeridge Country Park
November: **Sparkle Party** on Friday 20 November at the Copthorne Hotel
December: **Twilight Santa Dash and Christmas Fair** at Russells Hall Hospital, Corbett and Guest

Our Annual Staff Awards

I am delighted that we are launching our annual staff awards Committed to Excellence 2020 to celebrate the hard work and dedication of our clinical and non-clinical staff. These awards are open to all colleagues with a special Patient Choice Award for members of the public. Patients who have received excellent care at any Dudley Group hospital site or community service have the chance to say thank you by nominating a team of individual member of staff. They will be able to complete a paper nomination form or complete an online nomination form. I am very pleased to announce that our host for the awards ceremony on 5th June will be Midlands Today broadcaster Nick Owen. We will be launching the awards across our social media platforms and on our Trust website.

Healthcare Heroes

Individual Award

This month's Healthcare Heroes individual award went to Andrew Swan, patient experience assistant. Andrew was nominated by two colleagues for his enthusiasm, drive and focus for improving patient care. He is doing an amazing job at leading on the implementation of the new Friends and Family Test reporting system. Andrew has been described as an absolute unsung hero who is fabulous at interacting with patients. He shows empathy and supports patients to ensure their needs are met.

Team Award

The team award went to the Emergency Department Team. The team was nominated for their diligence, effective management and professionalism when an older patient collapsed on arrival with cardiac arrest. Within 8 minutes the patient regained a heartbeat, highlighting great teamwork. Despite winter challenges, the team has maintained a very strong patient focus and delivers excellent safe, quality care which is highlighted in weekly audits. Managers describe the team as resilient, courageous, committed and determined.

Volunteer Award

This month's volunteer award went to Safeen Akhtar after being nominated by a regular patient. The patient said he is always at reception with a big smile on his face, ready to help anyone. He pushes patients in wheelchairs to their appointments and always makes everyone feel welcome with a friendly attitude. Safeen always takes the time to ask the patient how their day has been, which has made a huge difference to the nominators experience.

Visits and Events

11th February	Live Chat
13th February	Board of Directors
14th February	Clinical Summit
	Team Brief
17th February	Dudley System Review Meeting
	Black Country STP Cancer Board
	Trust Management Group
24th February	Vital Signs Transformation Guiding Board
25th February	Leadership Forum
26th February	Meet our Experts
27th February	NHS Midlands Monthly Business Development Meeting
2nd March	Board MCP FBC Walkthrough
5th March	Board Workshop
9th March	Collaborative Leadership Team

National NHS News

Grandma, 81, died after eating NHS hospital sandwich contaminated with listeria
A grandma has died after eating a chicken mayonnaise sandwich contaminated with **listeria** while she was in hospital, an inquest found. Brenda Elmer, 81, was presumed to have been recovering from an operation, but was in fact battling listeria picked up from a sandwich made by Good Food Chain company. Brenda, from Gravesend, Kent, was one of nine patients who contracted listeria after eating NHS sandwiches or salads following a national outbreak from the sandwich provider which supplied 43 health trusts. **The Mirror (05.02.2020)**

Coronavirus: NHS orders UK hospitals to create isolation pods as fears of epidemic rise
Professor Keith Willett, NHS strategic incident director, has instructed all hospitals to have the pods up and running no later than Friday. The letter seen by The Independent, reportedly dated January 31, was sent to hospital bosses throughout England. In it, Professor Willet, who is leading the NHS's response to coronavirus, told NHS bosses: "Plans have been developed to avoid a surge in emergency departments due to coronavirus. **Express online (05.02.20)**

More than 100,000 A&E patients waiting hours for beds, NHS figures show
There were 100,578 patients delayed more than four hours, of whom 2,846 waited more than 12 hours from decision to admit to admission, according to performance statistics released by NHS England. For both delays, this is the highest number of so-called trolley waits since records began. It is an increase of 20.4% and 353.9% respectively from the same month a year ago, when there were 83,554 four-hour waits and just 627 12-hour waits. The NHS figures also show that ambulances attended 750,238 incidents in January, making it the busiest January on record.
The National (13.02.2020)

Coronavirus: Woman with deadly disease took Uber taxi to A&E
The woman, who contracted the virus in China, turned up at Lewisham hospital's A&E department in south London on Sunday and spoke to staff at the reception desk. Public Health England (PHE) has been advising anyone who thinks they may have symptoms of coronavirus to stay at home and call NHS 111, who will send out a specialist team if needs be. Two staff from Lewisham hospital are now in isolation at home after coming into contact with the woman, believed to be a Chinese national. **The News (13.02.2020)**

Baby's death must lead to lasting change at NHS trust, grandfather says
The tragic death of baby Harry Richford must lead to "lasting change" and safe maternity care, Harry's grandfather has said. The Government announced an independent review into East Kent Hospitals University NHS Foundation Trust on Thursday. Harry died seven days after his emergency delivery in a "wholly avoidable" tragedy, contributed to by neglect, in November 2017, an inquest found. **Hampshire Chronicle (16.02.2020)**

Thousands of patients potentially harmed by undelivered NHS mail
The NHS has launched a patient safety inquiry after a private contractor failed to send more than 28,000 pieces of confidential medical correspondence to GPs, the Guardian can reveal. NHS bosses are trying to find out if any patients have been harmed after 28,563 letters detailing discussions at outpatient appointments were not sent because of a mistake by Cerner, an IT company. The letters should have been sent by doctors at Barnet and Chase Farm hospitals in north London to GPs after consultations with 22,144 patients between June last year and last month.
The Guardian (18.02.2020)

NHS hails next generation of surgical robots to help treat bowel cancer
Next generation surgical robots have been hailed by doctors as "a leap forward in surgical precision" in the UK. Western General Hospital in Edinburgh was first to use the new Versius robotic arm technology in Europe, followed by Milton Keynes University Hospital NHS Trust in Buckinghamshire. The tool is used to perform minimal access surgery – also known as keyhole or laparoscopic surgery – and could reduce patient recovery times and pain. Versius mimics a human arm, working in a similar way to a computer games console, with the ability to move and rotate its "wrists" in a unique fashion. **The National (20.02.2020)**

Staff survey ranks Sussex and Surrey NHS trust among best in country
The trust was ranked highly as a place to work and receive care in the latest national survey of NHS employees. Staff rated the organisation the best in the country among comparable acute trusts when asked if they would recommend it as a place to work, SASH said. SASH was also ranked highest in the country among comparable trusts when staff were asked whether care of patients is the organisation's top priority. The trust serves east Surrey, north-east West Sussex, and South Croydon, including Horsham and Crawley. In January 2019 Surrey and Sussex Healthcare NHS Trust was rated outstanding by the Care Quality Commission. **The County Times (20.02.2020)**

NHS trust urges staff to shave beards so masks fit in coronavirus fight
NHS staff have been asked to shave their beards to allow masks to fit more securely in a bid to limit the spread of coronavirus. Bosses at Southampton University NHS Trust sent a mass email to tackle a “known problem” with ill-fitting masks on hairy faces. Medical director Derek Sandeman attached an image with 36 different kinds of facial hair showing if they are acceptable or not based on whether they fit inside a mask. However, staff with beards for religious or cultural reasons are exempt. **Review St Albans and Harpenden (27.02.2020)**

Coronavirus: Western General Hospital sets up 'drive-through' test
A HEALTH board in Scotland has introduced a "drive-through" testing centre for Covid-19.Some patients with an appointment are being tested for coronavirus in their cars at the Western General Hospital in Edinburgh. It was introduced as NHS Lothian steps up preparations for a possible spread of the virus. NHS Lothian medical director Dr Tracey Gillies said: "This service is for patients who have been assessed by the specialist team so it is an appointment-only service. "It is not a drop-in clinic and it is important to stress that patients cannot be seen without an appointment. **The National (28.02.2020)**

Twelve new coronavirus cases confirmed in England

Twelve new coronavirus cases have been confirmed in England as the number of people infected across the UK climbed to 35. Health Secretary Matt Hancock admitted it was “inevitable” the deadly virus would continue to spread, and did not rule out following China’s lead in shutting down cities if the Covid-19 outbreak escalates. Three of the latest cases are family members of a man from Surrey who tested positive on Friday, becoming the first person to contract the virus within the UK. All four are adults, including one more from Surrey and two from West Sussex, and are not GPs or health workers. **The Herald (01.03.2020)**

Regional NHS News

‘Reports of Britain's third coronavirus case - an infected 'Chinese soldier in a Walsall hospital' - turn out to be a FALSE ALARM’
Reports of a third patient testing positive for the coronavirus in the UK have turned out to be a false alarm. A Chinese soldier from Shanghai was reportedly being cared for at the Manor Hospital, Walsall, West Midlands. It was thought he had arrived at the hospital on Friday or in the early hours of Saturday, with a source claiming he had coronavirus. But the Department of Health said the claims were untrue. **Mail Online (02.02.2020)**

‘Ian Paterson: Surgeon wounded hundreds amid 'culture of denial'
A culture of "avoidance and denial" allowed a breast surgeon to perform botched and unnecessary operations on hundreds of women, a report has found.
An independent inquiry into Ian Paterson's malpractice has recommended the recall of his 11,000 patients for their treatment to be assessed. Paterson is serving a 20-year jail term for 17 counts of wounding with intent. **BBC News (04.02.2020)**

‘No new UK coronavirus patients says NHS, after video sparks fears of Worcester case’
NHS chiefs have confirmed no new cases of the coronavirus have been diagnosed today, after a video showed a man wearing a protective suit while emerging from an ambulance at Worcestershire Royal Hospital. **Worcester News (04.02.2020)**

'Nurse suspended after death in 'inadequate' Shropshire A&E'
An agency nurse has been suspended following an unexpected death at an "inadequate" hospital trust. The death in A&E, on 14 December, was one of eight serious incidents at Shrewsbury and Telford Hospital NHS Trust (SaTH) that month. In a report, the trust's board said the nurse involved had been suspended pending an investigation. **BBC News (06.02.2020)**

'West Midlands smear test results delayed by 10 weeks'
Women are facing a 10-week delay to receive results of their smear tests. Thousands of women in the West Midlands are thought to be affected by the backlog that built up after Royal Wolverhampton NHS Trust took over the service. **BBC News (06.02.2020)**

'Alcohol hospital admissions hit record high in Birmingham'
The latest figures from NHS Digital show that there were 41,552 hospitalisations in our region related to drinking alcohol in 2018/19. **Birmingham Live (06.02.2020)**

'EXCLUSIVE - 'I am profoundly sorry... I can't put it right': NHS chief criticised over 'cover up' of butcher breast doctor says he tried to protect patients and did not know scale of Ian Paterson's crimes'
The NHS Trust chief accused of covering up the actions of disgraced breast surgeon Ian Paterson today apologised to the thousands of victims. Mark Goldman was head of the Heart of England NHS Foundation Trust (Heft) while Paterson worked there. The doctor is thought to have performed up to 1,000 botched and unnecessary operations over a 14-year period. Mr Goldman, from St Albans, announced his retirement as chief executive of Heft in 2010 - three months before news of a recall of Ian Paterson's patients hit the headlines. **Mail Online (07.02.2020)**

'Coronavirus UK: NHS install assessment cabins in car parks to keep suspected victims away from A&Es'
TEMPORARY cabins in car parks are the NHS' latest weapon in the fight against the coronavirus outbreak — as the ninth UK case was confirmed. Every hospital has been ordered to set up "assessment pods" to keep suspected victims away from A&Es. Anyone thought to have the virus can go there instead and call a specialist team on a dedicated phone. Medics will then test the patient if they are deemed a potential risk — and if positive they will be taken to an isolation ward. **The Sun (12.02.2020)**

'Stourbridge's Corbett Hospital evacuated after chemical leak'
Patients and staff have been evacuated following a chemical leak at Stourbridge's Corbett Hospital. A total of 10 people were checked over by ambulance staff, with one being sent to Russells Hall, in Dudley, as a precaution. All clinics have been postponed while West Midlands Fire Service contains the spill at the outpatient centre, in Vicarage Road, Amblecote. Bosses at Dudley Group NHS Foundation Trust say there is no risk to the public**.**
Express & Star (13.02.2020)

'Shocking number of West Midlands ambulance staff attacked by patients or relatives'
More than half of West Midlands ambulance staff who deal directly with the public have been victims of violence at the hands of patients or their relatives, according to a major survey of NHS staff. At West Midlands Ambulance Service, 52.7% of staff who took part in the survey and frequently have contact with patients said they had personally experienced physical violence from patients or their relatives at least over the past year. Ambulance workers are most likely to be victims but hospital staff also face abuse.

At University Hospitals Birmingham NHS Foundation Trust, which runs hospitals in Birmingham and Solihull, 18% of staff who work with patients, more than one in five, said they had experienced violence. **Birmingham Live (18.02.2020)**

'Paramedic 'attacked by patient' outside Birmingham's New Street Station'
A West Midlands Ambulance spokeswoman said: "We were called at 11.46pm last night to reports of a medical incident at New Street Station in Birmingham. "We sent one ambulance and paramedic officer to the scene. Unfortunately, whilst treating the male patient, a crew member was assaulted. "Thankfully, they only suffered minor injuries and were able to continue with their job and took the patient to City Hospital for further treatment. **Birmingham Live (19.02.2020)**

'Thousands more going to hospital due to alcohol'
The number of people going to hospital with alcohol-related conditions has risen by 20 per cent across the Black Country and Staffordshire since 2013, according to new NHS figures. **Express & Star (19.02.2020)**

'Walsall Manor Hospital moves up A&E wait rankings despite performance woes'
Walsall Manor Hospital rose from 108th nationally last April to 58th in December for length of waits. It also jumped from 15th place out of 21 in the West Midlands region to fourth. **Express & Star (20.02.2020)**

''Inadequate' doctors' surgery threatened with closure in West Bromwich'
A West Bromwich GP surgery has been threatened with closure after health inspectors rated it inadequate – highlighting fears over its safety. The Clifton Medical Centre has been given the Care Quality Commission's (CQC) lowest rating for safety, effectiveness, responsiveness and management while care was described as requiring improvement. **Birmingham Live (20.02.2020)**

'Advanced Oncotherapy reaches deal with Birmingham NHS trust'
Proton therapy developer Advanced Oncotherapy has reached agreement with University Hospitals Birmingham NHS Foundation Trust (UHB), the acute service provider delivering general hospital services for Birmingham and specialist treatments for the West Midlands and nationally, to install a 'LIGHT' system, it announced on Thursday. **ShareCast (20.02.2020)**

'Suspected coronavirus patient was wrongly told to go to hospital where he sat for 10 minutes in a packed waiting room without a mask amid fears NHS is not prepared for an outbreak'
A Briton suspected of having coronavirus after returning from Italy claims he was left coughing in a packed NHS hospital waiting room without a mask - sparking fears the UK is not prepared for an outbreak. Paul Godfrey, from Walsall, West Midlands, sat in the foyer 'for 10 minutes' among sick, old and frail members of the public before panicked medics in hazmat suits whisked him into a cubicle and tested him for the killer virus. He was wrongly told to go to hospital by NHS 111 operators after returning from Milan on Friday and developing flu-like symptoms the following day. **Mail Online (27.02.2020)**

'One in three mums in region felt pressure to wean their baby within six months, new data shows'
ONE in three mums in the West Midlands felt pressure to wean their baby before six months, new research shows. Public Health England (PHE) data shows it happened to 34 per cent of those surveyed. **Solihull Observer (27.02.2020)**

'Doctor tried to dodge M6 speeding charge by claiming she was rushing to carry out transplant surgery'

Jodi Parikh forged letters, including one from West Midlands Ambulance Service, claiming she was part of emergency team travelling between hospitals for life-saving surgery. Doctor Jodi Parikh forged letters stating she was on her way to carry out transplant surgery in a bid to have speeding points knocked off her licence. The 33-year-old, who now lives in Solihull, forged letters purporting to be from the North West and West Midlands Ambulance Service and she doctored a letter from her GP. **Birmingham Live (27.02.2020)**

'CRUSHED AT WORK Mechanic whose hand was crushed in a machine is suing the NHS after doctors sent him home with painkillers'

A MECHANIC whose hand was crushed in a horrific work accident is suing the NHS after doctors sent him home with antibiotics. Jamie Keefe, 26, was rushed to A&E after his right hand was mangled in a machine as he worked on a car's brakes. Doctors at Heartlands Hospital in Birmingham cleaned the wound and sent Keefe on his way with antibiotics on December 11 2018. But days later, the skin on Jamie's hand started turning black with infection and he was rushed to the city's Queen Elizabeth Hospital.

Surgeons stepped in and managed to save his hand by cutting away the dead skin and grafting tissue from his thigh. Since the dreadful accident Jamie, from Dudley, West Midlands, has almost completely lost feeling in his hand which has forced him to give up his dream job. **The Sun (29.02.2020)**

Enclosure 19

The Dudley Group NHS Foundation Trust

Paper for submission to the Board of Directors on 12 March 2020

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**
☐	☒	☐	☐
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 27 February 2020

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: 27 February 2020

MATTERS OF CONCERN OR KEY RISKS TO ESCALATE

- It was reported that there was a negative variance against the income and expenditure plan to the end on January 2020 of £105,299. It was noted that donations/legacies had reduced significantly and it was agreed that there should be an action on the Fundraising Manager to promote these further.

MAJOR ACTIONS COMMISSIONED/WORK UNDERWAY

- It was reported that four companies had nominated the Charity as their 'Partner Charity'.
- It was noted that the 'Will Fortnight' had raised a record £7,000 and that the Sparkle Party had raised £5,400.
- It was reported that the Chief Executive is leading a new Charity Fundraising Group to generate new ideas for events and initiatives throughout the year.
- Promotion of the Staff Lottery has been increased with the intention of doubling membership in 2020.
- Mrs Taylor provided an update on the ongoing consolidation of funds

POSITIVE ASSURANCES TO PROVIDE

- Total fund balances at the end of January 2020 stood at £2.175m.
- For the period ending 31st January 2020, total income was £268,979 whilst total expenditure was £385,344.
- The balance available to spend across the general funds totalled £60,811.
- Professor Ishaq attended the meeting to provide an update on the spending plans for his funds.
- Mr Ali was unable to attend but provided a written update on his spending plans for the Breast Reconstruction Fund.

DECISIONS MADE

- Three requests were presented and approved:
  - Large format noticeboards, a strata display system and information display screens to improve staff and patient communication - £14,507
  - Sensory equipment for Cubicle 9 in ED - £3,736
  - Adult and Children Inpatient Welcome Booklets £5,000 (£10,000 was requested but it was noted that a review of patient communication is underway and £5,000 was considered sufficient pending the outcome of the review).

Chair's comments on the effectiveness of the meeting:

The meeting was effective and attendance was satisfactory.

Enclosure 20

The Dudley Group NHS Foundation Trust

Paper for submission to Board of Directors (PUBLIC Session)
Thursday 12th March 2020

TITLE:	**Quality & Safety Committee Highlights Report for 25th February 2020**		
AUTHOR:	**Julie Everingham**	**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**	

RECOMMENDATIONS

- 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:

IMPLICATIONS FOR THE CORPORATE RISK REGISTER OR BOARD ASSURANCE FRAMEWORK

RISK	**Y/N**		**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:**
REPORT DESTINATION	**EXECUTIVE DIRECTORS**	**N**	**DATE:**
	WORKING GROUP	**N**	**DATE:**
	COMMITTEE	**N**	**DATE:**

The Dudley Group NHS Foundation Trust

UPWARD REPORT FROM QUALITY & SAFETY COMMITTEE (FORMERLY CQSPE) TO PUBLIC BOARD

Date Committee last met: 25/02/20

MATTERS OF CONCERN OR KEY RISKS TO ESCALATE

- The Committee noted concerns regarding COSHH certificates for cleaning products under the responsibility of Interserve. Interserve has been asked to provide generic COSHH assessments for wards and units where appropriate. An update was requested for the next Committee.
- Timeliness of complaints responses remain a concern.

MAJOR ACTIONS COMMISSIONED/WORK UNDERWAY

- The Quality Priority Accounts - further work was requested to refine and strengthen focus on patient experience measures.
- The Committee noted that actions were underway to address the prescribing practice in the GI Unit and requested a joint report from the GI Unit and Pharmacy to come to May 2020 meeting.
- The Committee noted that actions were underway to address concerns about blood tubes being incorrectly labelled. Additional printers had been purchased and a new process is being agreed. The Committee required a further report to the next meeting to confirm that the new process had been fully implemented, and to receive a report on the number of incidents reported.

POSITIVE ASSURANCES TO PROVIDE

- The Committee was assured of positive actions being taken to improve overdue follow-ups in Ophthalmology and Paediatrics
- Good progress has been made regarding mandatory training. Significant work has been done to improve data quality and this has enabled managers to address individuals when non-compliant.
- Assurance was received that the majority of actions under the CQC Improvement Plan had been completed.

DECISIONS MADE

- The Committee were invited to reduce the risk score on 2 BAF risks:
  - *BAF 1b: Failure to meet access standards caused by inability to improve patient flow and work eff3ectively with very local partners will result in an adverse outcome for the patient.*
  - *BAF 2b: Insufficient effective leadership and capacity may result in the trust being unable to efficiently manage and deliver safe services for our patients.*

  The Committee agreed that both risks remained vulnerable the decision was made to maintain the current risk scores in both cases.

Chair’s comments on the effectiveness of the meeting:

- There is further work to do on papers to provide key assurances and focus on the quality of papers
- Papers need to demonstrate greater assurance through action trackers
- Minutes are to be updated prior to the meeting
- There was greater emphasis on positive improvements
- The change in membership was agreed to be an improvement

Enclosure 21

The Dudley Group
NHS Foundation Trust

Paper for submission to the Board of Directors on 12th March 2020

TITLE:	**Chief Nurse Report**		
AUTHOR:	**Carol Love-Mecrow Deputy Chief Nurse**	**PRESENTER**	**Mary Sexton 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:

1. 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.

1.1 **Appendix 1** Staffing data

2. <u>Safer Staffing (Appendix 1)</u>

2.1 The qualified staff fill rates for January 2020 were 89% during the day and 94% during the night; this is an increase on last month's figures. The overall qualified staff fill rates was 88%. The target fill rate for qualified staff is set at 90% since December 2018.

2.2 All areas are within the agreed variation of 6.3 or more for the CHPPD. Overall Trust CHPPD is 9.43 for January 2020 (qualified and unqualified).

2.3 A review of the inpatient ward skill mix that was conducted in June has been reviewed and has been presented to Executives.

2.4 Review of staffing numbers through safety huddle continues twice a day facilitated by the Divisional Chief Nurses.

2.5 Assessment of patient acuity and dependency continues daily in bedded units.

2.6 An evaluation of the staffing review undertaken in June 2019 has been presented to the Executives. Comparing the present establishments after the review in mid-2019 and the establishments calculated from the Safer Nursing Care tool in November 2019, show that they are proportionate and reflect patient dependency. Overall, the nursing care indicators have remained stable over the six month period which gives a level of assurance that the changes made have had a positive impact on patient safety. There remains concern regarding the placing of patients in the ED corridor when the department is full. Work continues, to improve patient flow throughout the hospital to negate the need to nurse patients in the corridor and this is kept under close scrutiny.

3. Agency Controls

3.1 All bank and agency requests continue to be assessed by the Divisional Directors with the support of the Divisional Chief Nurses.

3.2 All requests for non-framework agency remain Chief Nurse or Chief Operating Officer authorisation only in hours, out of hours remains Executive authorisation only.

4. Allied Healthcare Professionals (AHP)

4.1 Physiotherapists are currently participating in a pilot which involves triaging musculoskeletal patients in ED. The aim is to reduce musculoskeletal related admissions (e.g. back pain) and onward referrals to physiotherapy by assessing and treating patients as they present in ED. The pilot which commenced end Jan 2020 is funded through winter pressures monies and will run until end March 2020.

5. Falls

5.1 The new Falls Lead will commence at the beginning of June 2020. In the interim, secondment opportunities are being explored to ensure this specialist support continues.

5.2 There were three falls with harm; these have all been reported as serious incidents and are subject to senior review and investigation.

6. Infection Control

6.1 The Teams working in partnership with the EPPR Lead, has been responding to and preparing our teams in respect of COVID19.

7. Mental Health

7.1 There was one patient detained under the Mental Health Act; section 5/2 in January. This patient was subsequently discharged home.

8. Patient Experience

8.1 The *"What matters to you, matters to us"* campaign is a priority within our Patient Experience strategy. The campaign aims to raise the profile of patient experience across the Trust and we will capture feedback using a wide range of mechanisms and reporting on this activity to facilitate organisational learning and improvement.

8.2 The Head of Patient Experience has attended several community meetings to promote the campaign and so far the Trust has signed up 28 members of the public to be part of our citizen panel and two others are interested in becoming 'volunteer experts'. The branding of the campaign is out to public vote via social media and further demonstrates our commitment to working in partnership with our community.

9. Professional Development

9.1 Clinical Support

9.1.1 Divisional chief nurses are currently reviewing placements for the new intake of Trainee Nursing Associates (TNAs) for the March 2020 cohort.

9.2 Pre–Registration

9.2.1 The University of Wolverhampton and members of the Professional Development Team held a recruitment event at the Merry Hill shopping centre on 8th and 9th February 2020 to aid recruitment to the March cohort of student nurse coming to the Trust. Discussions are underway with the university to try and increase the numbers of students currently allocated to the trust. The trust will be taking student nurses from Worcester and Birmingham City universities, commencing in March. Final numbers are yet to be confirmed.

9.3 Post Registration

9.3.1 January 2020 saw a cohort of 35 newly qualified registered nurses commence employment in the trust.

10. Recruitment

10.1 Recruitment

10.1.1 Work is underway to increase recruitment activity across the trust. This will include:

- A revamp of the internal recruitment events with a larger social media advertising

campaign to be actioned.

- Attendance at external events at local Universities will continue along with a scoping exercise to attend Universities out of area to try to attract students to consider the organisation as a place of work on registration.
- Organised events such as the RCNi event in Birmingham will be attended with any other company events explored for potential recruitment.
- A recruitment campaign and recruitment film has been commissioned with support from the communications team.
- A recruitment advertising campaign pack is being produced.

11.2 **Retention**

11.2.1 Clinical supervisor training continues monthly to increase the number of available supervisors to provide access to clinical supervision, access to clinical supervision will be clearer and thematic outputs will be noted and shared.

11. Tissue Viability

11.1 The avoidable category 3 pressure ulcer on B1 reported last month, has been reclassified as unavoidable following a review of the RCA.

11.2 The study day held on February 5th 2019 focusing on the attendance at coroners in relation to pressure ulcers being identified as a causal factor in patient death was attended by over 100 delegates and evaluated exceptionally well.

12. Year of the Nurse & Midwife

Work is underway to prepare for the year of the nurse and midwife celebrations within the trust. These celebrations are planned to be held w/c 11th May 2020.

IMPLICATIONS FOR THE CORPORATE RISK REGISTER OR BOARD ASSURANCE FRAMEWORK

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:**

The Dudley Group NHS Foundation Trust

Appendix 1

Safer Staffing Data

Safer Staffing Summary **Jan** Days in Month 31

Ward	Day RN Plan	Day RN Actual	Day CSW Plan	Day CSW Actual	Night RN Plan	Night RN Actual	Night CSW Plan	Night CSW Actual	Qual Day	UnQual Day	Qual N	UnQual N	Sum 24:00 Occ	Average Occupancy	Actual CHPPD Registered	Actual CHPPD Care staff	Actual CHPPD Total
B1	129	106	75	77	94	84	73	70	82%	104%	89%	96%	597	74%	3.73	2.89	6.62
B2(H)	194	167	300	251	125	120	242	235	86%	84%	96%	97%	1,072	115%	3.14	5.20	8.34
B2(T)	124	105	129	124	92	86	98	100	85%	96%	93%	102%	692	93%	3.31	3.89	7.20
B3	212	159	178	156	156	144	134	124	75%	87%	92%	92%	927	71%	3.93	3.62	7.55
B4	258	229	300	257	156	148	228	223	88%	86%	95%	98%	1,430	96%	3.08	3.94	7.02
B5	255	223	186	179	218	207	118	110	88%	96%	95%	93%	649	87%	7.78	5.21	12.98
C1	244	212	299	279	186	179	218	210	87%	93%	96%	97%	1,461	98%	3.18	3.97	7.15
C2	298	283	82	79	248	244	66	65	95%	96%	98%	98%	548	59%	11.27	2.99	14.27
C3	223	207	394	394	188	186	354	345	93%	100%	99%	98%	1,606	100%	2.94	5.40	8.34
C4	191	173	93	85	126	101	66	84	91%	91%	80%	127%	673	99%	4.75	2.89	7.64
C5	242	196	255	279	188	185	190	187	81%	110%	98%	98%	1,452	98%	3.15	3.85	7.00
C6	122	105	87	68	63	61	88	81	86%	78%	97%	92%	554	89%	3.51	3.23	6.74
C7	193	183	222	178	156	150	194	177	95%	80%	96%	91%	1,086	97%	3.59	3.85	7.44
C8	292	250	222	196	250	237	187	190	86%	88%	95%	102%	1,308	96%	4.37	3.54	7.91
CCU_PCCU	251	228	64	59	220	213	34	32	91%	92%	97%	94%	692	86%	7.65	1.58	9.23
Critical Care	425	415	76	69	409	395			98%	91%	97%		357	72%	26.65	2.23	28.88
EAU AMU 1	656	556	509	440	560	487	447	471	85%	87%	87%	105%	2,398	129%	5.22	4.56	9.78
Maternity	885	810	238	232	528	492	155	154	92%	97%	93%	99%	719	53%	17.22	6.12	23.34
MHDU	185	171	36	36	186	175	8	8	92%	100%	94%	100%	261	84%	15.91	1.80	17.70
NNU	168	150			155	150			89%		97%		341	61%	10.12	0.00	10.12
TOTAL	**5,544**	**4,928**	**3,745**	**3,439**	**4,304**	**4,045**	**2,899**	**2,865**	**89%**	**92%**	**94%**	**99%**	**18,823**		**5.48**	**3.95**	**9.43**

Enclosure 22

The Dudley Group NHS Foundation Trust

Paper for submission to Board of Directors March 2020

TITLE:	**Learning from Deaths**		
AUTHOR:	**Dr Philip Brammer** **Deputy Medical Director**	**PRESENTER:**	**Dr Julian Hobbs** **Medical Director**

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

ACTION REQUIRED OF COMMITTEE

Decision	Approval	Discussion	Other
		✓	

RECOMMENDATIONS

- Acknowledge the assurance within the report documenting the learning from deaths at a condition specific, Trust-wide and individual patient basis and the action supporting this.
- To note the continued reduction in mortality since March 2018 following a rebasing exercise in September 2017.

CORPORATE OBJECTIVE:

S04: Safe and Caring Services

SUMMARY OF KEY ISSUES:

- Mortality continues to fall and SHMI has reduced to 110. This is in the expected range.
- The Trust has also noted a reduction in crude mortality
- We are in receipt of three mortality alerts for AKI, ALD and acute bronchitis. Detailed action plans have been drawn up with using AQ pathways. Business cases to support informatics and e-pathways modelled on e-Sepsis are in progress.
- The Trust has recorded 1946 deaths year to date (this total includes all inpatient and ED deaths). 74% have been reviewed at speciality level, with 16% being completed within the 30 day standard. 187 deaths have triggered for a second stage review with 65% of these reviews being completed. To achieve our targets for review we have appointed medical examiners as of 1st April 2020 and additional PAs are being provided for secondary reviews.
- Themes from our LFD process include EOL care and resuscitation decisions.
- Previous themes around sepsis and the deteriorating patient continue to improve with Sepsis SHMI now at 91 (from 132).

IMPLICATIONS OF PAPER:			
IMPLICATIONS FOR THE CORPORATE RISK REGISTER OR BOARD ASSURANCE FRAMEWORK			
RISK	**Y**		**Risk Description:** Corporate Risk
	Risk Register: Y		**Risk Score:** 6 (currently rated as 12)
COMPLIANCE and/or LEGAL REQUIREMENTS	**CQC**	**Y**	**Details:** Safe, Effective, Responsive, Caring, Well Led
	NHSI	**N**	**Details:**
	Other	**N**	**Details:**
REPORT DESTINATION	**Board of directors**	**Y**	**DATE:**
	WORKING GROUP	**N**	**DATE:**
	COMMITTEE	**N**	**DATE:**

The Dudley Group
NHS Foundation Trust

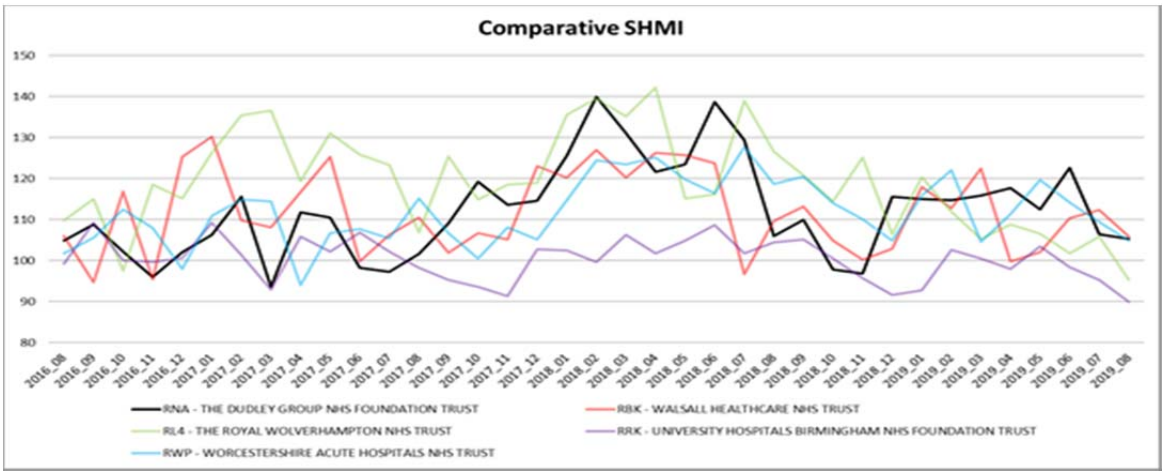
Learning from Deaths

1.0 Introduction

Following the publication of the National Guidance on Learning from Deaths (March 2017) the Trust is required to report via the Trust Board the approach and key learning from deaths occurring in the Trust. This paper provides an update on progress.

2.0 Mortality Measures

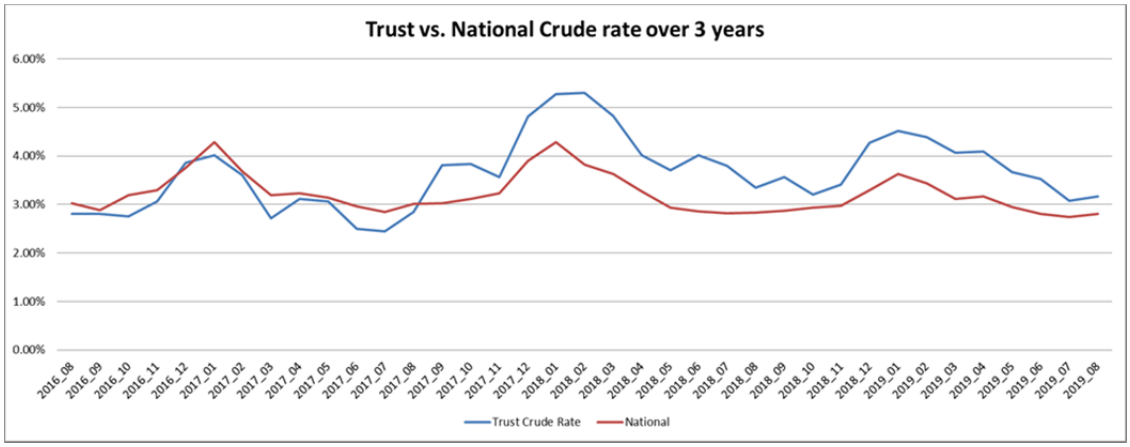
Parameter	Previous Period		Previous Period		Current Period	
Crude Mortality	October 2017 to September 2018	1643 – 3.43%	April 2018 to March 2019	1660 – 3.86%	April 2018 – March 2019	1726 - 3.30%
SHMI	December 2017 to November 2018	1.15	April 2018 to March 2019	1.13	October 2018 – September 2019	1.10
HSMR	November 2017 to October 2018	115.2	June 2018 to May 2019	114	October 2018 – September 2019	117

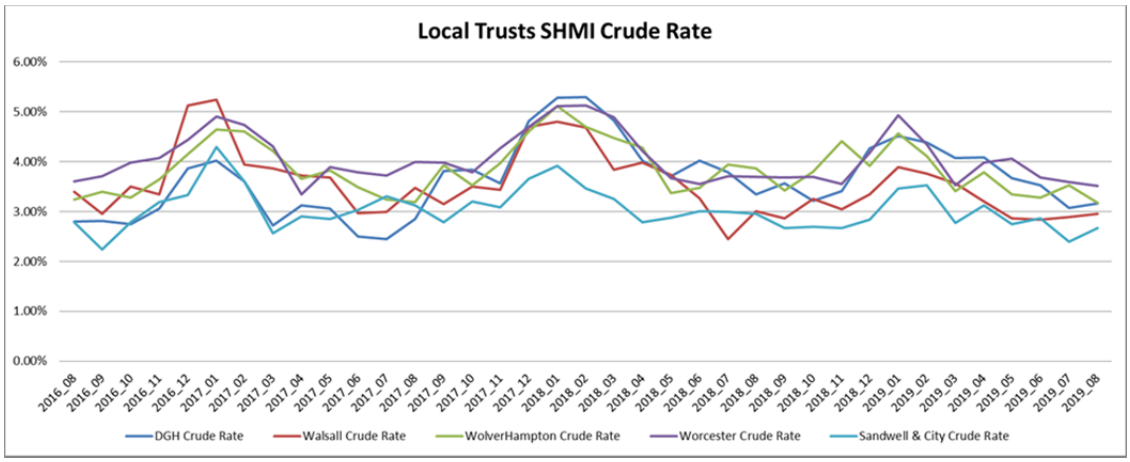


Dudley Group crude rates increased in September 2017 when we changed activity recording as has been previously documented. The data suggests that the Trust follows the trend exhibited nationally. It similarly follows patterns experienced by other Trusts within the West Midlands. The HSMR crude rate does show a marked spike in the 17/18 winter but this was matched by Walsall though the cause of this is not necessarily clear.

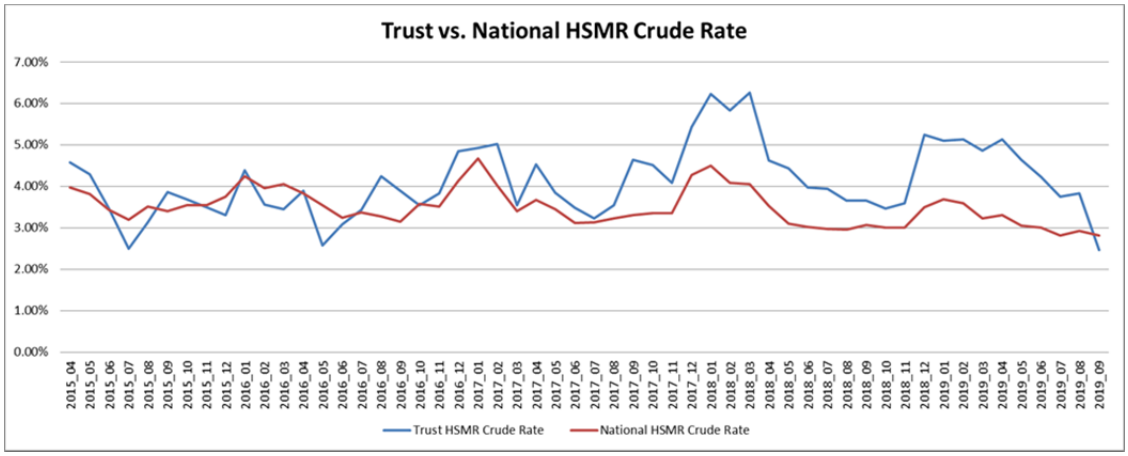
The overall HSMR shows a slight increase but this may simply reflect the patterns of the previous year. HSMR was low between May and June 2018 and this has dropped off the subsequent reporting period. This has led to an increase in the average for the rolling year period. Further monthly data from HED dated to November 2019 shows the HSMR reduced to 102. We will continue to review this data and examine patterns in individual diagnostic groups for further assurance.

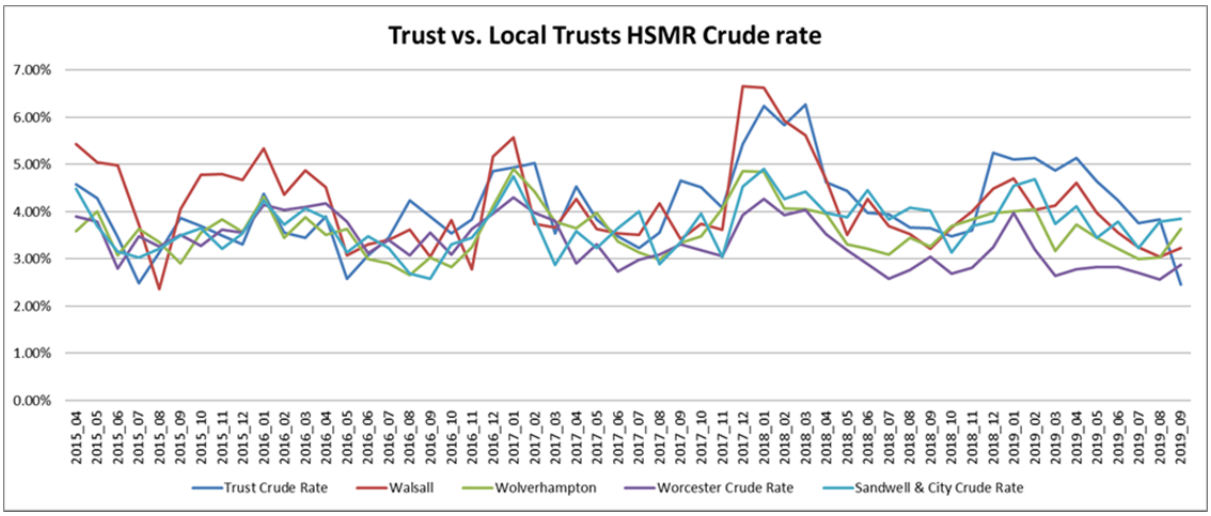
SHMI Crude Rate Comparison





HSMR Crude comparison





3.0 Mortality Reviews

	Number of Deaths	First Review	Second Review (SJR Triggered)	SJR (Completed)
Inpatient deaths	1717	1278	74	46
LeDeR deaths	9	9	9	9
ED deaths	202	202	86	58
Paediatric deaths (inc Neonates)*	18	18	18	9
Total	**1946**	**1507**	**187**	**122**

* Child Death Review

The Trust has a tiered mortality review process with an initial stage review by clinical teams and a second mortality review using formal Structured Judgement Review (SJR) processes for any cases that are highlighted. The Trust has commenced formal systematic improvement practice work in order to refine the whole mortality review process and we have recently appointed Medical Examiners. We anticipate this will compliment and improve our mortality and bereavement processes

We receive a quarterly report on mortality detailing mortality rates, quality of care indicators and system/process measures that may affect the quality of care. The report includes comparison data for the West Midlands against other regions in England, along with data differences for the 12 Trusts in the West Midlands and detailed information for Dudley.

From 1st January to 31st December 2019 there have been 1726 inpatient deaths recorded on the Mortality Tracking System. The following tables provide a breakdown of compliance with review:

Deaths Recorded YTD	1726
Deaths audited at speciality level YTD	1254 (73% compliance)
Deaths audited at speciality level within 30 days YTD to 31/12/19	16%
Deaths triggered for SJR following speciality review YTD	83
SJR Complete YTD	55 (66%) (55/83)

ED Mortality Reviews:

Deaths Recorded YTD	202
Deaths audited at speciality level YTD	202
Deaths audited at speciality level within 30 days YTD to 31/12/19	202
Deaths triggered for SJR following speciality review YTD	86 (42.5% of total ED deaths)
SJR Complete YTD	58 (67%)

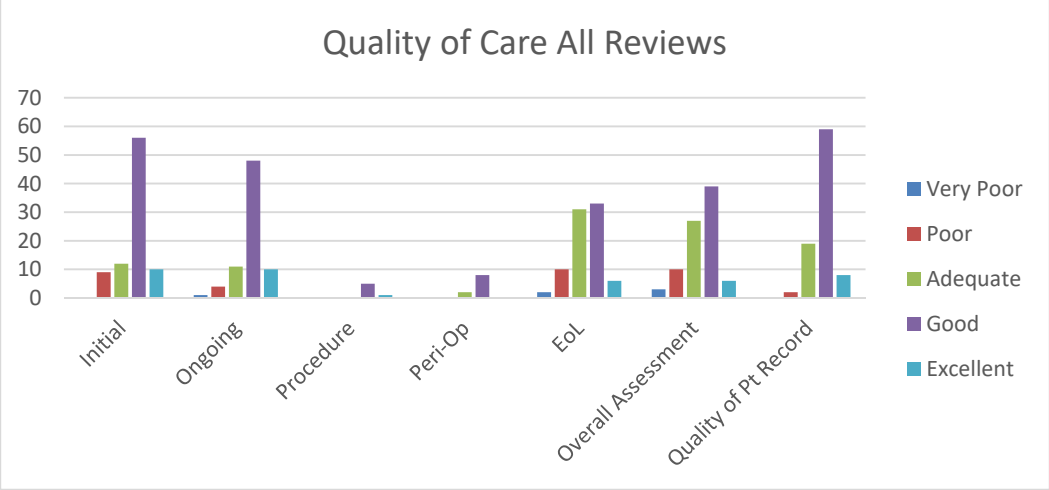
Considerable progress has been made with SJR reviews and work has been undertaken to get up to date with the second reviews. An additional 34 reviews for episodes of Acute Bronchitis, 32 for alcohol related liver disease and 31 for Acute and Unspecified Renal Failure have been undertaken based on outlier alerts.

3.1 Quality of Care and Measures of Avoidability

The national programme of LFD uses two measures SJR quality of care and the Hogan scale of avoidability. However these two measures correlate poorly. SJR review has classified care as poor in 0.05% of cases (within the range expected). Avoidability (Hogan one to three) has not been established in any case in this reporting period.

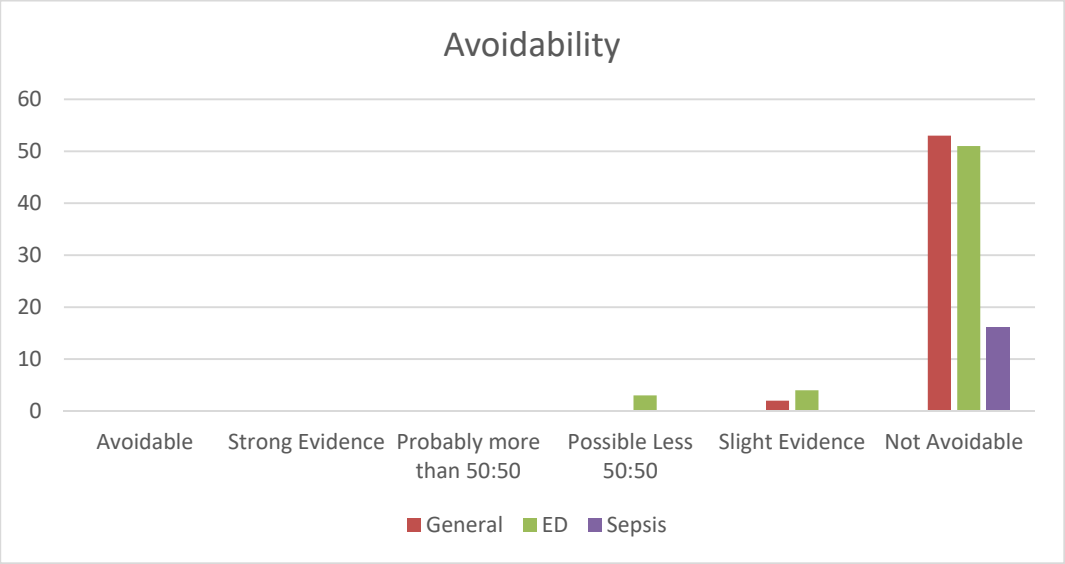
Within the inpatient groups, the care was commonly rated as good, but end of life care was sometimes lacking and was more frequently rated as adequate.

Within ED, initial care was more frequently rated as poor as was end of life care. This did not often reflect care from ED but simply reflected that a significant number of very frail individuals at the end of life were being admitted and died in ED.



Avoidability

Of 129 cases reviewed, there was no evidence of avoidability (Hogan 1→3: avoidable → avoidability probably more than 50:50). There were no concerns whatsoever in 120 cases (93%).



The determination of avoidability was based on the assessment of the clinical reviewers. In 9 cases, the reviewers thought that some degree of avoidability existed such that it was possible but not probable and certainly not causative. It was primarily deemed that there was scope for learning and improvement rather than error. The individual teams have been contacted for further consideration and review of their processes related to the learning.

Three cases were deemed possible avoidability. Two cases involved initial review by clinical teams where the initial assessment de-escalated treatment but the subsequent decline suggested alternative action may have been considered. One patient had multiple problems and received a number of treatments promptly but there was some diagnostic uncertainty which was not clearly recorded from the notes reviewed.

Six cases were deemed to have slight evidence of avoidability. Two cases involved treatment/documentation specifically from West Midlands Ambulance Service (WMAS). One case involved slight delay in antibiotics in otherwise very frail patient recently discharged from hospital and another patient died after a very atypical presentation of a ruptured thoracic aortic aneurysm.

3.2 Structured Judgement Reviews

Of the 202 SJRs requested the following breakdown applies for completion:

Speciality	SJR Requested	SJR Complete	SJR Outstanding
General (inc Sepsis)	83	55	28
ED	86	58	28
Paediatrics	33	28	5
Total	202	141	61 (30%)

There are 56 reviews waiting for review for both ED and IP. However, we did not receive notification for 20 ED and 5 IP reviews until January so significant progress has been made.

3.3 Learning Disabilities Deaths

LD Deaths YTD	9
LD Reviews Completed	9
LD Reviews in progress	0
External LeDeR Reviews Completed	6

The notes of all learning disability deaths are reviewed regardless of whether they trigger during audit. The Trust's Learning Disability Liaison Nurse completes a preliminary review and attends a Mortality Review Panel to review her findings prior to any external LeDeR review request. There have been 2 external LeDeR reviews completed as of 31st December 2019. Data from the National review team is still awaited.

3.4 Paediatric Deaths

Overarching Child Death Review Policy clearly sets out the child death review process within DGNHSFT as part of our statutory and legal obligations in line with the published arrangements by the Black Country Child Death Overview Panel (BCCDOP) in June 2019. The processes regarding cross boarder resident children has raised some queries across the Black Country which delayed the production of the Child Death Review Policy beyond the original stated time frame.

The paediatric deaths are reviewed externally as part of the BCCDOP and primarily relate to cases where there were significant cardiac, chromosomal abnormalities, road traffic accidents or SIDS. A Safer Sleeping learning event will be taking place and also some re-education around SIDs. There was no specific learning for the Trust.

National Perinatal Mortality Tool (Safety Action 1)

Is the Trust using the Perinatal Mortality Review Tool (PMRT) to review perinatal mortality to the required standard?

Maternity governance arrange for all stillbirths and neonatal deaths to have a review at the weekly incident review MDT meeting and the Perinatal Mortality Review Tool is updated appropriately. All the criteria as set out in Safety Action 1 is followed. A quarterly mortality report which is reviewed and endorsed by the Head of Midwifery (HOM) Dawn Lewis is presented at the Maternity Quality and Governance Divisional meeting chaired by the HOM. Following this the HOM forwards copies of the reports to the Board as assurance for the completion of Safety Action 1.

3.5 Agreed Action to Improve Timeliness of Review

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

- Dudley Improvement Practice working group is continuing to address review process and ensure consistency across directorates.
- Medical examiners have been appointed and are planned to start formally 1st April 2020 after initial training period.
- Weekly monitoring of 30 day standard has been circulated to Divisions since September 2019.

There will be 5 Medical Examiners in post by April 2020 (one other is due to return from maternity leave and two other posts will be appointed to in the near future and interested candidates have been approached). The aim is for all initial reviews to be undertaken by the Medical Examiners and with formal SJR process implemented within 30 days by June 2020. In the initial implementation there will be ongoing review of the process to optimise timely review.

4.0 **Learning**

4.1 Learning from Reviews

Themes highlighted during reviews continue to be around:

DNACPR:	- None in place or unable to locate, family refusal - In place but no clearly defined Advanced Care Plan - Lack of understanding of DNACPR and the perception that this is the ceasing/withdrawal of all treatment rather than allowing "natural" death to occur.
Appropriateness of Admission:	Inappropriate admission from care homes.
Place of Death:	Some patients do die within the Emergency Department – this may sometimes be because it would have been inappropriate to move them due to EoL and expected to die within very short period and sometimes due to timeliness of transfer to ward due to bed capacity.

Other Learning:

- Importance of recognition of deteriorating patients where initial diagnosis is unclear and no clear pathway evident
- Awareness of need to respond to changing parameters and ensure clear clinical decision making. Need to be aware of human factors involved in the process.
- Ensure that all appropriate patients are commenced on EMLAP pathway
- Recognition of potential for diagnostic overshadowing in patients with complex neurological problems and learning disability.
- There were 68 cardiac arrests in the Trust. These cases are all reviewed by the resuscitation team. However, we have now instigated formal SJR review for all such cases as it is recognised that some patients are receiving CPR when a DNACPR decision may have been more appropriate. We hope to generate further learning from this process.

4.2 Condition Specific Alerts and Associated Learning

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

4.3 Sharing of Learning and Supporting Staff

- A regular patient safety bulletin is issued to all staff with topics arising from lessons learnt across the Trust. Sepsis remains a prominent topic and clear medical handover has been highlighted.
- Grand rounds have been arranged to share learning on identification of atypical aortic aneurysm and cardiac arrest.
- All cardiac arrest deaths are now being reviewed by the Mortality Panel and Resuscitation Team.
- A Grand Round presentation was undertaken on 23rd January 2020 on the pneumonia pathway.
- Cases with learning are highlighted to the specialty and also discussed at the Joint Mortality Meeting held quarterly with the CCG.

5.0 Trust-wide Developments to Strengthen Learning from Deaths

5.1 Palliative Care Developments

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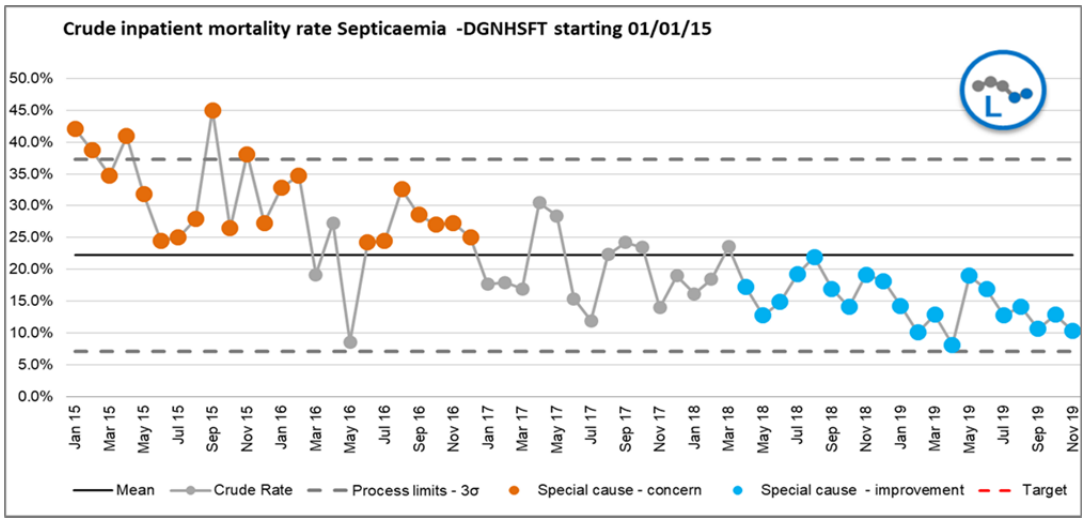

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The Dudley Group
NHS Foundation Trust

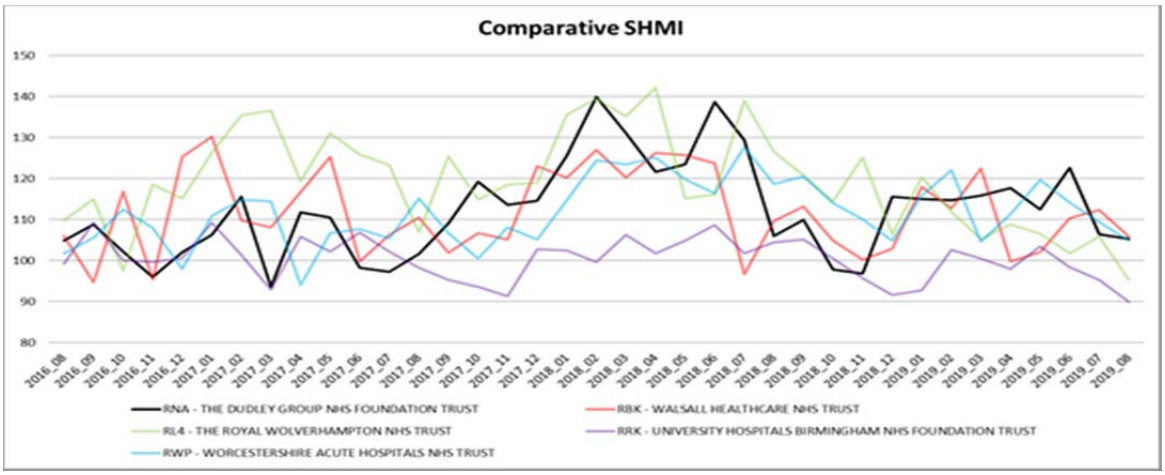
Learning from Deaths

1.0 Introduction

Following the publication of the National Guidance on Learning from Deaths (March 2017) the Trust is required to report via the Trust Board the approach and key learning from deaths occurring in the Trust. This paper provides an update on progress.

2.0 Mortality Measures

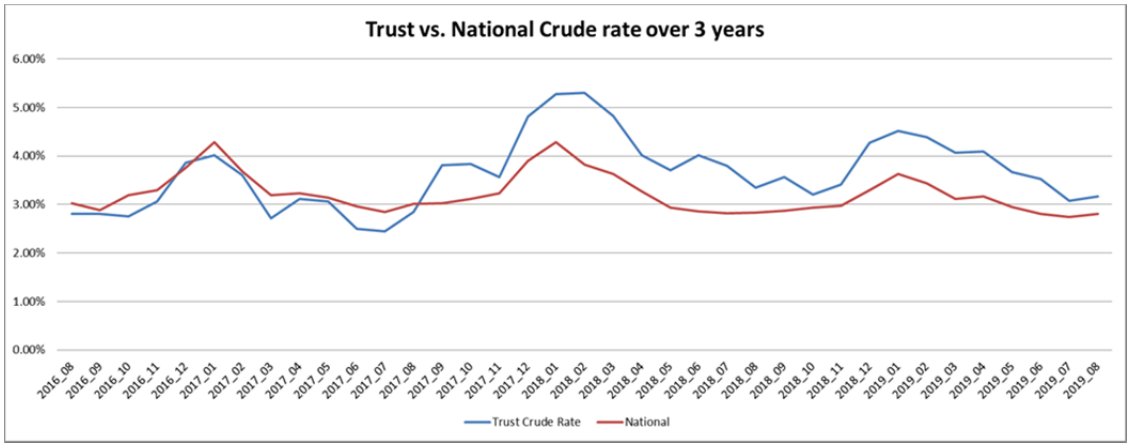
Parameter	Previous Period		Previous Period		Current Period	
Crude Mortality	October 2017 to September 2018	1643 – 3.43%	April 2018 to March 2019	1660 – 3.86%	April 2018 – March 2019	1726 - 3.30%
SHMI	December 2017 to November 2018	1.15	April 2018 to March 2019	1.13	October 2018 – September 2019	1.10
HSMR	November 2017 to October 2018	115.2	June 2018 to May 2019	114	October 2018 – September 2019	117

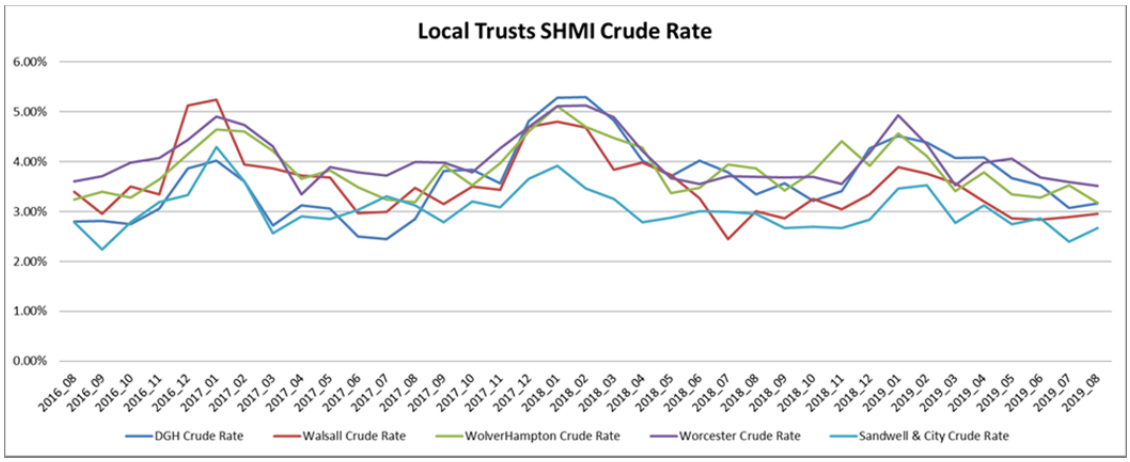


Dudley Group crude rates increased in September 2017 when we changed activity recording as has been previously documented. The data suggests that the Trust follows the trend exhibited nationally. It similarly follows patterns experienced by other Trusts within the West Midlands. The HSMR crude rate does show a marked spike in the 17/18 winter but this was matched by Walsall though the cause of this is not necessarily clear.

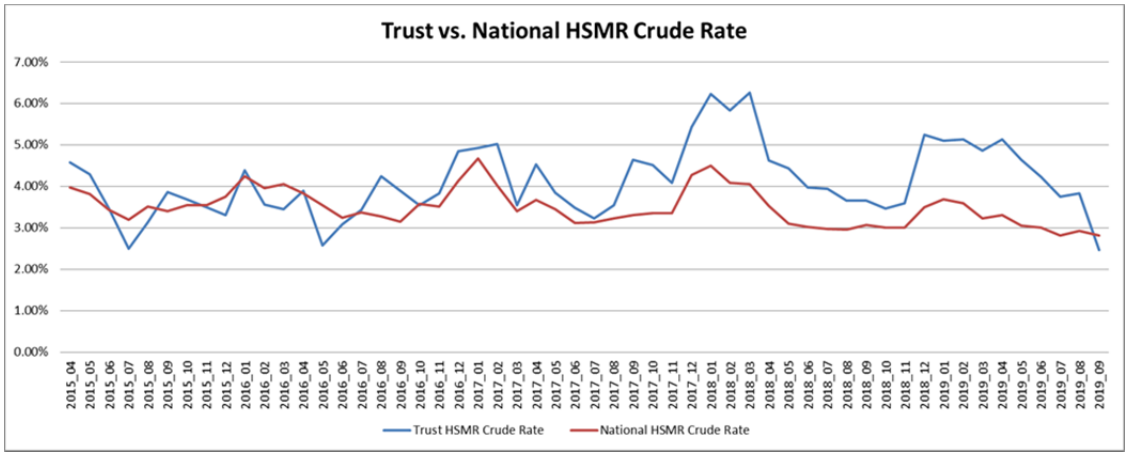
The overall HSMR shows a slight increase but this may simply reflect the patterns of the previous year. HSMR was low between May and June 2018 and this has dropped off the subsequent reporting period. This has led to an increase in the average for the rolling year period. Further monthly data from HED dated to November 2019 shows the HSMR reduced to 102. We will continue to review this data and examine patterns in individual diagnostic groups for further assurance.

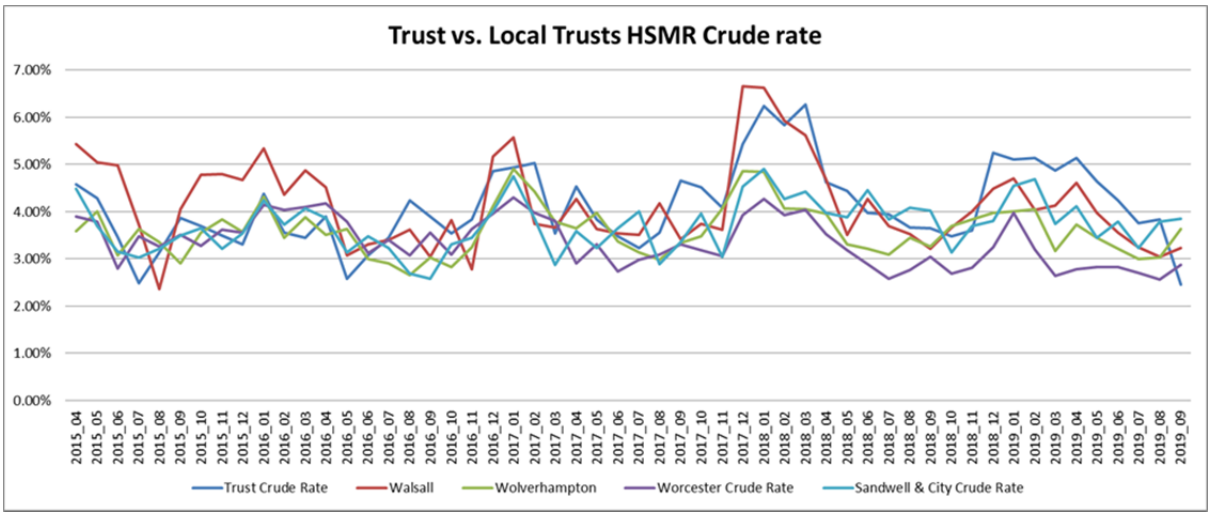
SHMI Crude Rate Comparison





HSMR Crude comparison





3.0 Mortality Reviews

	Number of Deaths	First Review	Second Review (SJR Triggered)	SJR (Completed)
Inpatient deaths	1717	1278	74	46
LeDeR deaths	9	9	9	9
ED deaths	202	202	86	58
Paediatric deaths (inc Neonates)*	18	18	18	9
Total	**1946**	**1507**	**187**	**122**

* Child Death Review

The Trust has a tiered mortality review process with an initial stage review by clinical teams and a second mortality review using formal Structured Judgement Review (SJR) processes for any cases that are highlighted. The Trust has commenced formal systematic improvement practice work in order to refine the whole mortality review process and we have recently appointed Medical Examiners. We anticipate this will compliment and improve our mortality and bereavement processes

We receive a quarterly report on mortality detailing mortality rates, quality of care indicators and system/process measures that may affect the quality of care. The report includes comparison data for the West Midlands against other regions in England, along with data differences for the 12 Trusts in the West Midlands and detailed information for Dudley.

From 1st January to 31st December 2019 there have been 1726 inpatient deaths recorded on the Mortality Tracking System. The following tables provide a breakdown of compliance with review:

Deaths Recorded YTD	1726
Deaths audited at speciality level YTD	1254 (73% compliance)
Deaths audited at speciality level within 30 days YTD to 31/12/19	16%
Deaths triggered for SJR following speciality review YTD	83
SJR Complete YTD	55 (66%) (55/83)

ED Mortality Reviews:

Deaths Recorded YTD	202
Deaths audited at speciality level YTD	202
Deaths audited at speciality level within 30 days YTD to 31/12/19	202
Deaths triggered for SJR following speciality review YTD	86 (42.5% of total ED deaths)
SJR Complete YTD	58 (67%)

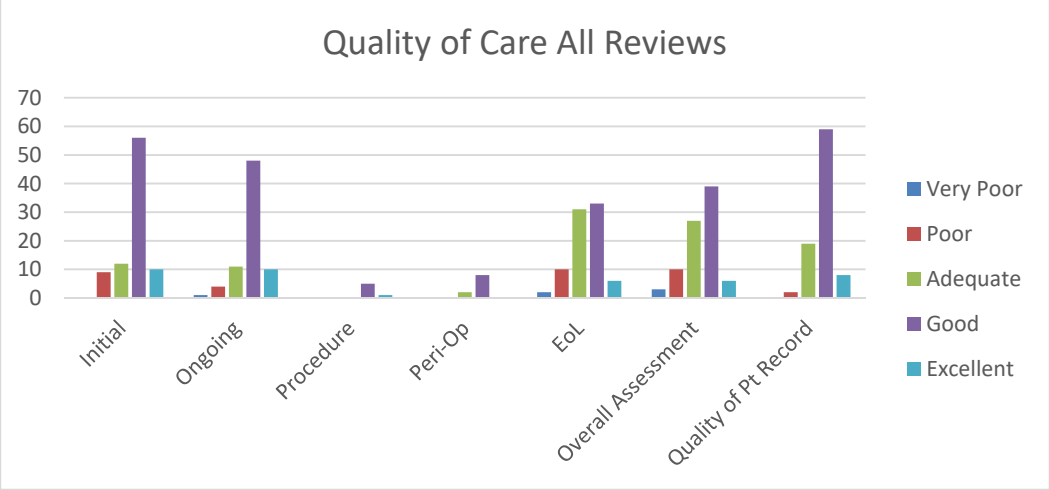
Considerable progress has been made with SJR reviews and work has been undertaken to get up to date with the second reviews. An additional 34 reviews for episodes of Acute Bronchitis, 32 for alcohol related liver disease and 31 for Acute and Unspecified Renal Failure have been undertaken based on outlier alerts.

3.1 Quality of Care and Measures of Avoidability

The national programme of LFD uses two measures SJR quality of care and the Hogan scale of avoidability. However these two measures correlate poorly. SJR review has classified care as poor in 0.05% of cases (within the range expected). Avoidability (Hogan one to three) has not been established in any case in this reporting period.

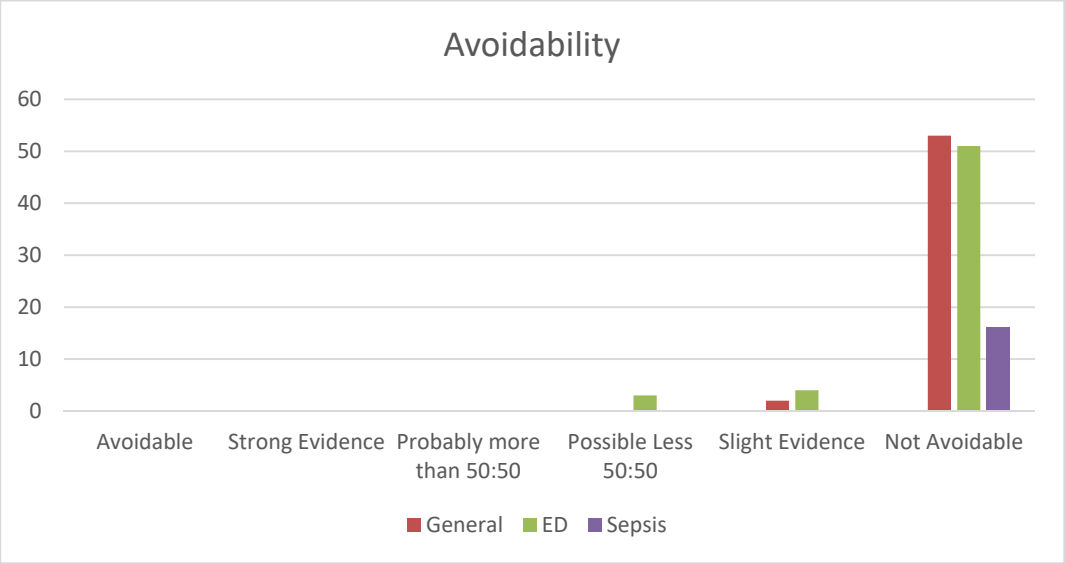
Within the inpatient groups, the care was commonly rated as good, but end of life care was sometimes lacking and was more frequently rated as adequate.

Within ED, initial care was more frequently rated as poor as was end of life care. This did not often reflect care from ED but simply reflected that a significant number of very frail individuals at the end of life were being admitted and died in ED.



Avoidability

Of 129 cases reviewed, there was no evidence of avoidability (Hogan 1→3: avoidable → avoidability probably more than 50:50). There were no concerns whatsoever in 120 cases (93%).



The determination of avoidability was based on the assessment of the clinical reviewers. In 9 cases, the reviewers thought that some degree of avoidability existed such that it was possible but not probable and certainly not causative. It was primarily deemed that there was scope for learning and improvement rather than error. The individual teams have been contacted for further consideration and review of their processes related to the learning.

Three cases were deemed possible avoidability. Two cases involved initial review by clinical teams where the initial assessment de-escalated treatment but the subsequent decline suggested alternative action may have been considered. One patient had multiple problems and received a number of treatments promptly but there was some diagnostic uncertainty which was not clearly recorded from the notes reviewed.

Six cases were deemed to have slight evidence of avoidability. Two cases involved treatment/documentation specifically from West Midlands Ambulance Service (WMAS). One case involved slight delay in antibiotics in otherwise very frail patient recently discharged from hospital and another patient died after a very atypical presentation of a ruptured thoracic aortic aneurysm.

3.2 Structured Judgement Reviews

Of the 202 SJRs requested the following breakdown applies for completion:

Speciality	SJR Requested	SJR Complete	SJR Outstanding
General (inc Sepsis)	83	55	28
ED	86	58	28
Paediatrics	33	28	5
Total	202	141	61 (30%)

There are 56 reviews waiting for review for both ED and IP. However, we did not receive notification for 20 ED and 5 IP reviews until January so significant progress has been made.

3.3 Learning Disabilities Deaths

LD Deaths YTD	9
LD Reviews Completed	9
LD Reviews in progress	0
External LeDeR Reviews Completed	6

The notes of all learning disability deaths are reviewed regardless of whether they trigger during audit. The Trust's Learning Disability Liaison Nurse completes a preliminary review and attends a Mortality Review Panel to review her findings prior to any external LeDeR review request. There have been 2 external LeDeR reviews completed as of 31st December 2019. Data from the National review team is still awaited.

3.4 Paediatric Deaths

Overarching Child Death Review Policy clearly sets out the child death review process within DGNHSFT as part of our statutory and legal obligations in line with the published arrangements by the Black Country Child Death Overview Panel (BCCDOP) in June 2019. The processes regarding cross boarder resident children has raised some queries across the Black Country which delayed the production of the Child Death Review Policy beyond the original stated time frame.

The paediatric deaths are reviewed externally as part of the BCCDOP and primarily relate to cases where there were significant cardiac, chromosomal abnormalities, road traffic accidents or SIDS. A Safer Sleeping learning event will be taking place and also some re-education around SIDs. There was no specific learning for the Trust.

National Perinatal Mortality Tool (Safety Action 1)

Is the Trust using the Perinatal Mortality Review Tool (PMRT) to review perinatal mortality to the required standard?

Maternity governance arrange for all stillbirths and neonatal deaths to have a review at the weekly incident review MDT meeting and the Perinatal Mortality Review Tool is updated appropriately. All the criteria as set out in Safety Action 1 is followed. A quarterly mortality report which is reviewed and endorsed by the Head of Midwifery (HOM) Dawn Lewis is presented at the Maternity Quality and Governance Divisional meeting chaired by the HOM. Following this the HOM forwards copies of the reports to the Board as assurance for the completion of Safety Action 1.

3.5 Agreed Action to Improve Timeliness of Review

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

- Dudley Improvement Practice working group is continuing to address review process and ensure consistency across directorates.
- Medical examiners have been appointed and are planned to start formally 1st April 2020 after initial training period.
- Weekly monitoring of 30 day standard has been circulated to Divisions since September 2019.

There will be 5 Medical Examiners in post by April 2020 (one other is due to return from maternity leave and two other posts will be appointed to in the near future and interested candidates have been approached). The aim is for all initial reviews to be undertaken by the Medical Examiners and with formal SJR process implemented within 30 days by June 2020. In the initial implementation there will be ongoing review of the process to optimise timely review.

4.0 **Learning**

4.1 Learning from Reviews

Themes highlighted during reviews continue to be around:

DNACPR:	- None in place or unable to locate, family refusal - In place but no clearly defined Advanced Care Plan - Lack of understanding of DNACPR and the perception that this is the ceasing/withdrawal of all treatment rather than allowing "natural" death to occur.
Appropriateness of Admission:	Inappropriate admission from care homes.
Place of Death:	Some patients do die within the Emergency Department – this may sometimes be because it would have been inappropriate to move them due to EoL and expected to die within very short period and sometimes due to timeliness of transfer to ward due to bed capacity.

Other Learning:

- Importance of recognition of deteriorating patients where initial diagnosis is unclear and no clear pathway evident
- Awareness of need to respond to changing parameters and ensure clear clinical decision making. Need to be aware of human factors involved in the process.
- Ensure that all appropriate patients are commenced on EMLAP pathway
- Recognition of potential for diagnostic overshadowing in patients with complex neurological problems and learning disability.
- There were 68 cardiac arrests in the Trust. These cases are all reviewed by the resuscitation team. However, we have now instigated formal SJR review for all such cases as it is recognised that some patients are receiving CPR when a DNACPR decision may have been more appropriate. We hope to generate further learning from this process.

4.2 Condition Specific Alerts and Associated Learning

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

4.3 Sharing of Learning and Supporting Staff

- A regular patient safety bulletin is issued to all staff with topics arising from lessons learnt across the Trust. Sepsis remains a prominent topic and clear medical handover has been highlighted.
- Grand rounds have been arranged to share learning on identification of atypical aortic aneurysm and cardiac arrest.
- All cardiac arrest deaths are now being reviewed by the Mortality Panel and Resuscitation Team.
- A Grand Round presentation was undertaken on 23rd January 2020 on the pneumonia pathway.
- Cases with learning are highlighted to the specialty and also discussed at the Joint Mortality Meeting held quarterly with the CCG.

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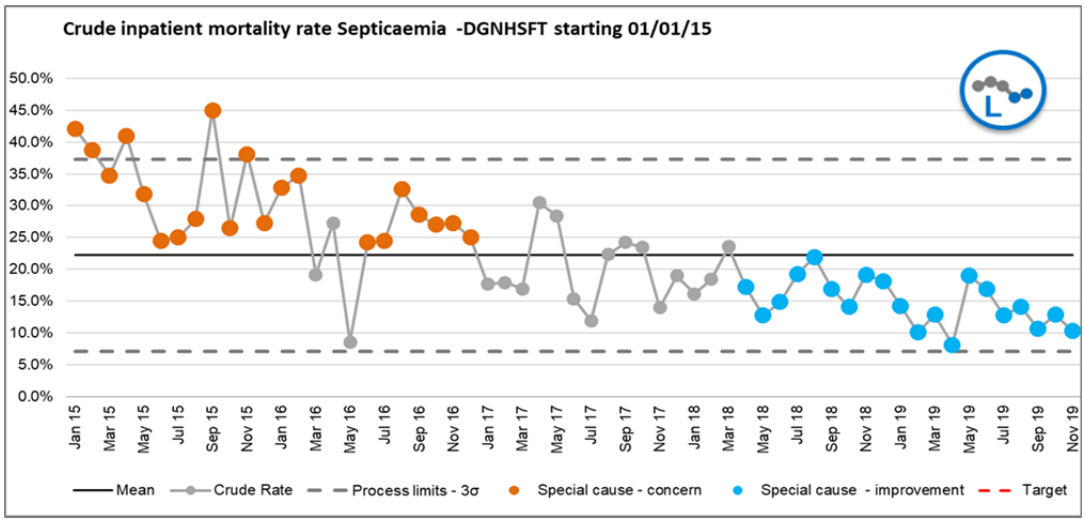

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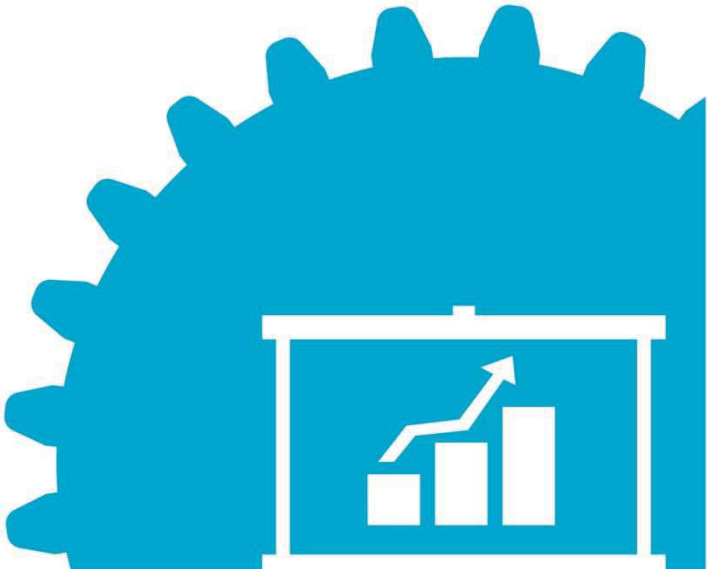
Quarterly Mortality Report

Report No. 26

23rd October 2019

Edition prepared for:

The Dudley Group of Hospitals NHS Foundation Trust



Author: Paul Hawgood

Version: 1.0

Contents

INTRODUCTION

This is the twenty-sixth quarterly report on Mortality produced by AQuA Analytics for the benefit of its members.

The report provides information on mortality rates, quality of care indicators and system/process measures that may affect the quality of care. The report does focus on the data, however, this is only one part of understanding the issues that may affect a Trust's mortality rate. They are an indicator, a sign-post, a prompt to looking at the wider system issues; these issues and themes are explored in detail in AQuA's Mortality Lessons Learned publication (May 2013).

Many of the indicators contained within this report relate to Standardised Mortality Ratios. There are several different methodologies available for the calculation of these ratios – see Appendix A for a summary of the differences between the three main methodologies. Throughout this report, data relating to the Summary Hospital-level Mortality Indicator [SHMI] has been used. This is because this methodology is used and published by the NHS Digital [NHSD].

This report is set out in five sections:

- Section 1 compares the West Midlands with other regions of England.
- Section 2 looks at the differences in data for the 12 Trusts in the West Midlands for which NHS Digital produces a SHMI.
- Section 3 provides more detailed information for your trust.
- Section 4 focuses on a particular subject. This quarter it is Acute Myocardial Infarction [AMI].

Some inferences and conclusions have been drawn from the data, however, these need to be set in the context of the wider health-economy. AQuA has a rolling programme of Mortality Reviews in order to support the understanding of issues surrounding mortality and the quality of care provided in a Trust and the health economy that it serves. Detailed trust-level analysis and inferences are best placed within this programme.

This report has been prepared following the publication of the SHMI for the period April 2018 – March 2019; Appendix B details the metadata for the information contained within this report.

SECTION 1 – The West Midlands

1.1 Crude Mortality Rate

The West Midlands has the sixth highest crude in-hospital mortality rate in England with a rate that is similar to the overall rate for England – see chart 1. The rates for both England and the West Midlands had been reducing over the past few years although a recent divergence means that West Midlands currently has a rate of 2.42% which is higher than the England average of 2.14% – see chart 2. (Comparison between 2018/19 data and previous years should be treated with some caution. Due to delays in release of data from NHS Digital to HED, we have used estimated figures in this chart in order to avoid unnecessary delay in the production of this report. These figures do not include patient opt-outs for either the numerator or denominator.)

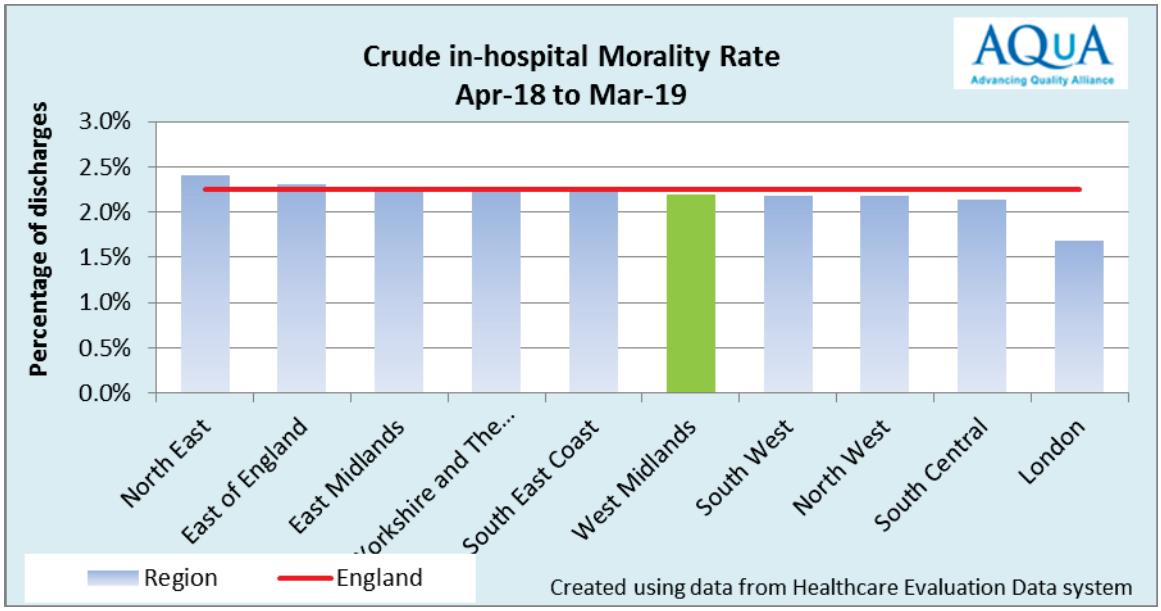


Chart 1 – crude in-hospital mortality rate

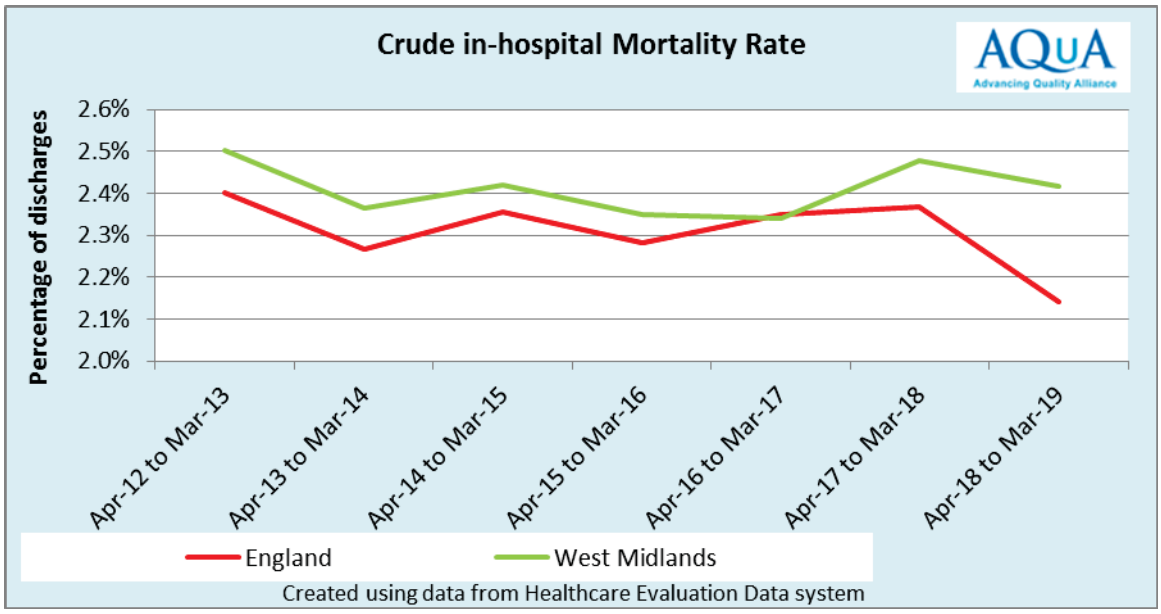


Chart 2 – crude in-hospital mortality rate time-series

Across the former SHAs, crude in-hospital mortality rates for non-elective [NEL] activity are between five and ten times higher than for elective [EL] activity; the crude NEL mortality rate for England being 2.5% and the crude EL mortality rate for England being 0.4% (nine times higher) – see chart 3. For deaths occurring within 30 days of discharge, there is a five-fold difference between those following a non-elective admission and those following an elective admission [1.1% and 0.2%, respectively] with less regional variation (four to six fold difference). When reviewing the underlying causes of high(er) mortality rates, it would, therefore, be beneficial to explore pathways relating to emergency care.

Due to delays in release of data from NHS Digital to HED, we have been unable to update the figures used for this chart.

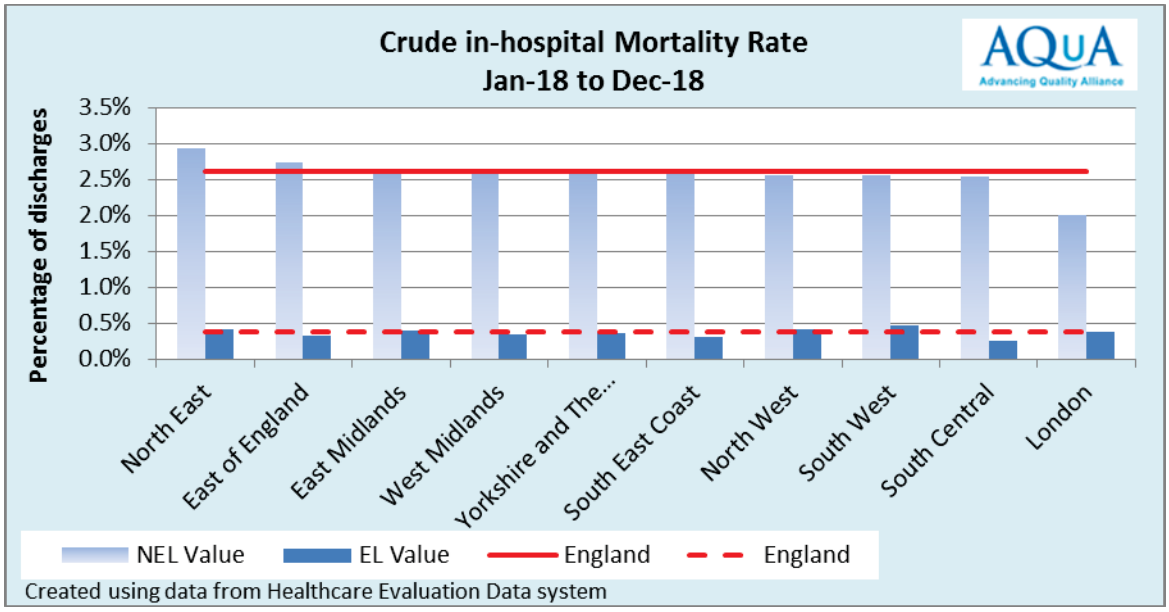


Chart 3 – crude in-hospital mortality rate, NEL & EL split

1.2 SHMI

This report does not aim to describe the SHMI methodology in detail, nor to compare the SHMI methodology to other methodologies e.g. HSMR. Appendix A shows a summary of the differences between the three main methodologies and further information is available from AQuA Analytics.

Although the West Midlands has a crude mortality rate that is very similar to the England rate, it has the highest SHMI [1.05] – see chart 4a. In essence, this means that, given our demographic make-up, the case-mix that we treat and the other illnesses that our patients have, it is to be expected that our crude rate would be lower than it is.

A regional SHMI is, of course, constructed from its constituent trusts. Chart 4b is a funnel-plot chart showing the position of each of our trusts alongside all trusts in England. This chart shows the Upper and Lower Dispersal Limits which are used to determine the SHMI band that each trust is in – see Chart 11 for a version showing trust codes.

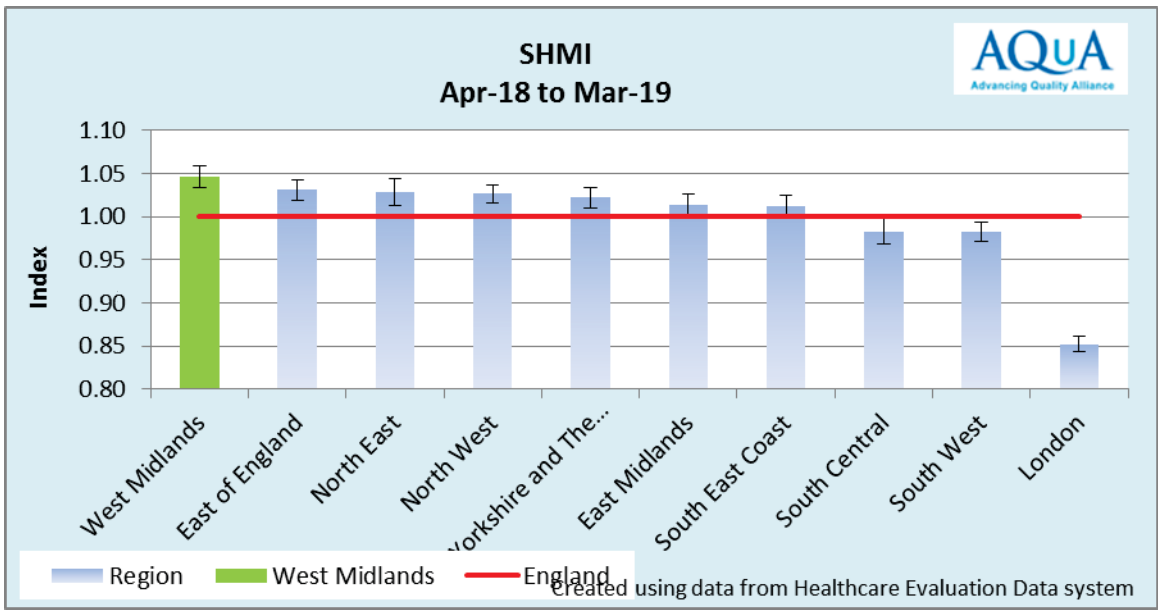


Chart 4a – latest SHMI

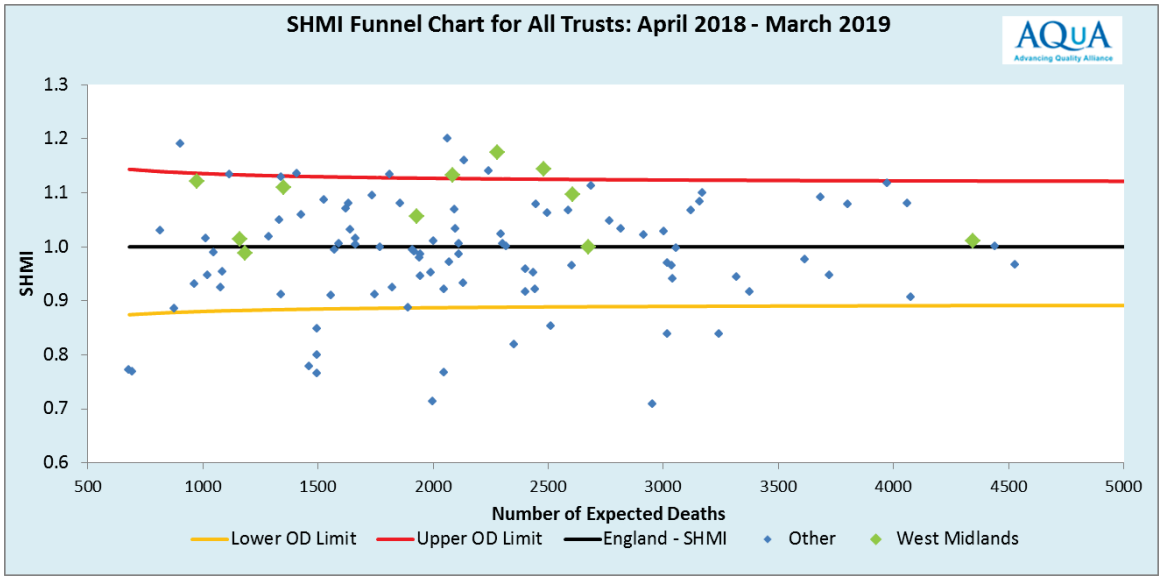


Chart 4b – latest SHMI Funnel Plot

The SHMI for the West Midlands had been fairly stable from the period of first release until 2017 when the SHMI started increasing. However, there has been a reduction in the latest three release which has brought the value back to its historical 'normal' calue of c. 1.04 – see chart 5.

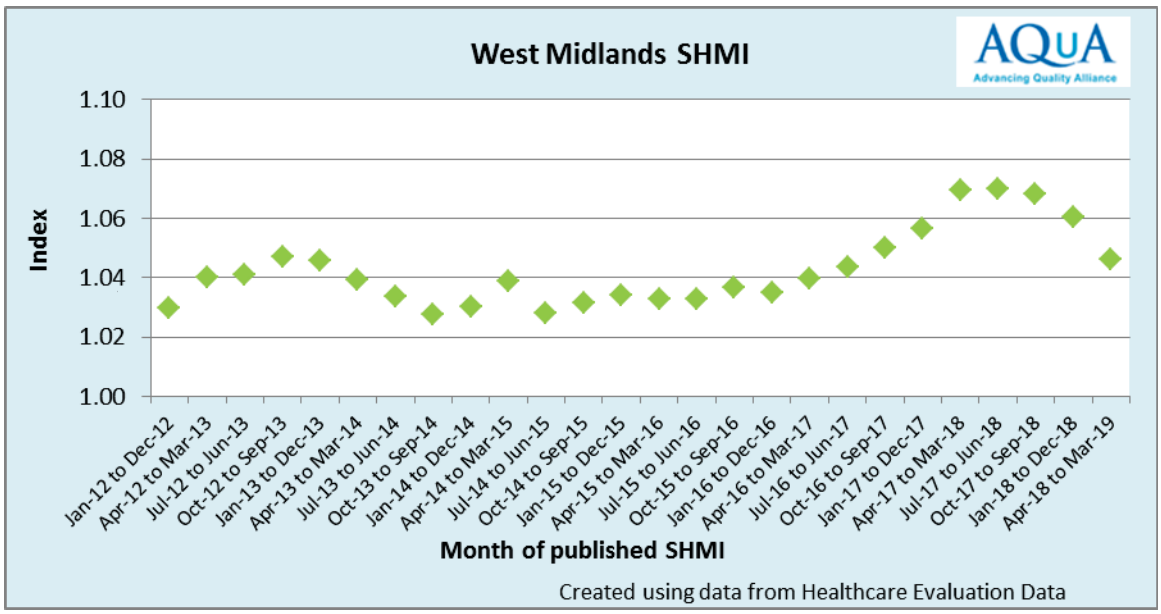


Chart 5 – WM SHMI time-series

The SHMI is a relative-risk model centered around England having a value of 1.00 for each publication. Factors that affect this risk model such as Signs and Symptoms coding and levels of co-morbidity are described later in the report.

The impact of the modelling is illustrated in chart 6 where several phases in the trends of the data can be seen. For the first five phases, the number of Observed deaths and the number of Expected deaths have risen and fallen pretty much in parallell. From the period July 2016 to June 2017 a reduction in Expected deaths has been seen, whereas the number of Observed deaths has remained the same. This sixth-phase divergeance is casue of the increase in the SHMI value.

From the period January 2018 to December 2018, a seventh phase appears to be starting with a reduction in Observed deaths occurring at a rate faster than any reduction in Expected deaths.

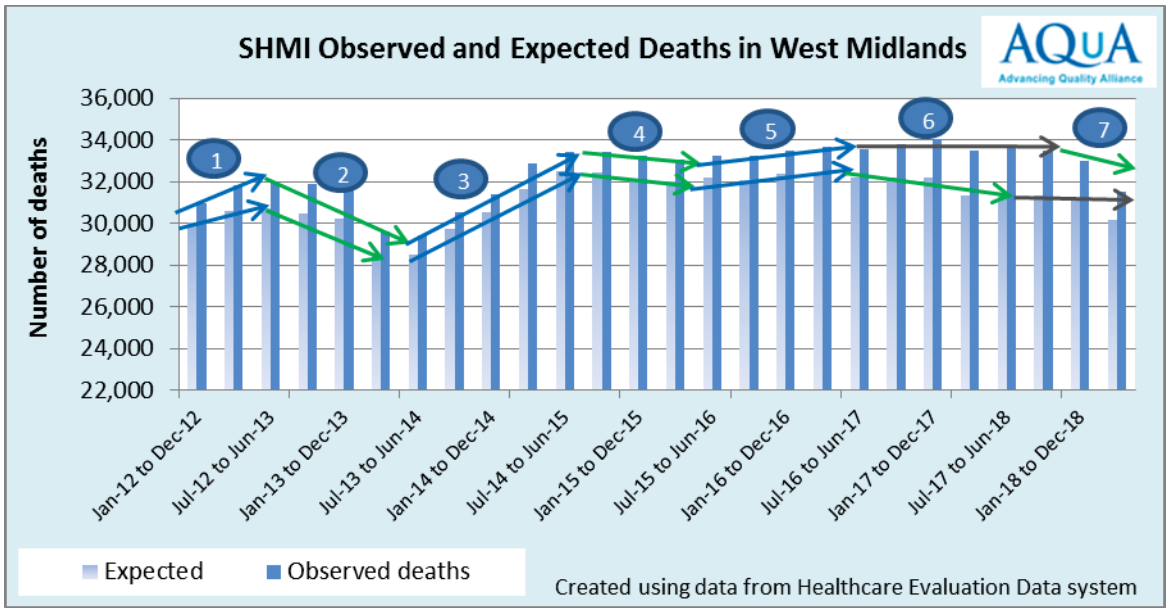


Chart 6 – WM SHMI Observed & Expected deaths

1.3 SHMI – proportion of deaths that occur in-hospital

SHMI is calculated using deaths that occurred in-hospital and those that occurred within 30 days of discharge. Chart 7 shows the proportion of the total number of deaths that have occurred in-hospital. Low levels of in-hospital deaths could be due to several factors including patients being discharged too early and high levels of nursing, residential and hospice care. The West Midlands has a similar rate to the England average. This topic was covered in more detail in Section 4 of Issue 07 and Issue 13.

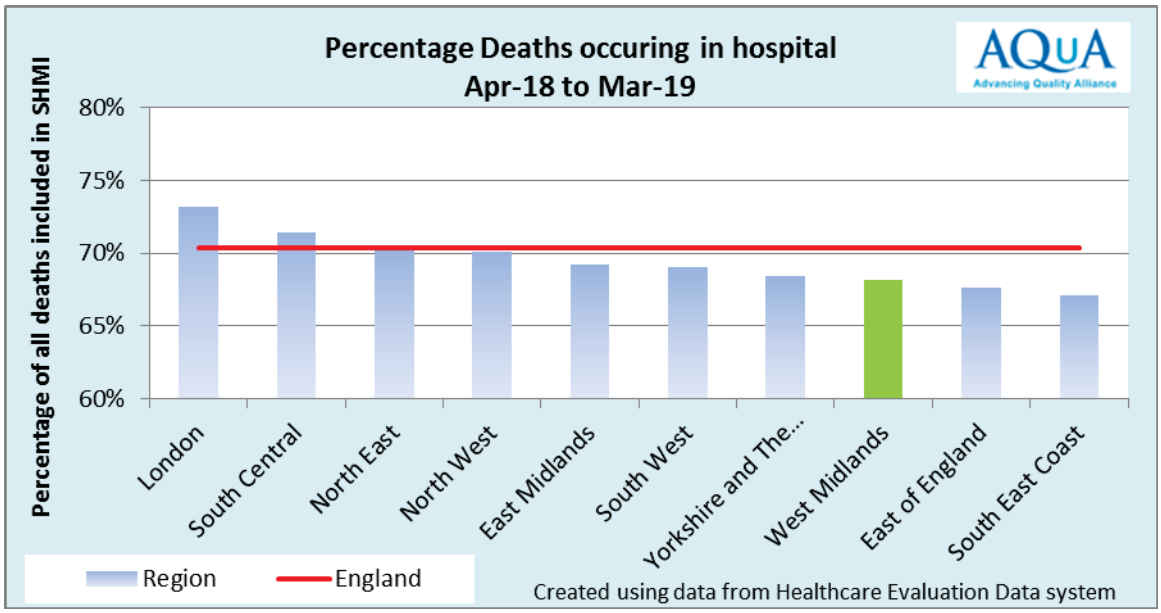


Chart 7 – Percentage of deaths occurring in-hospital

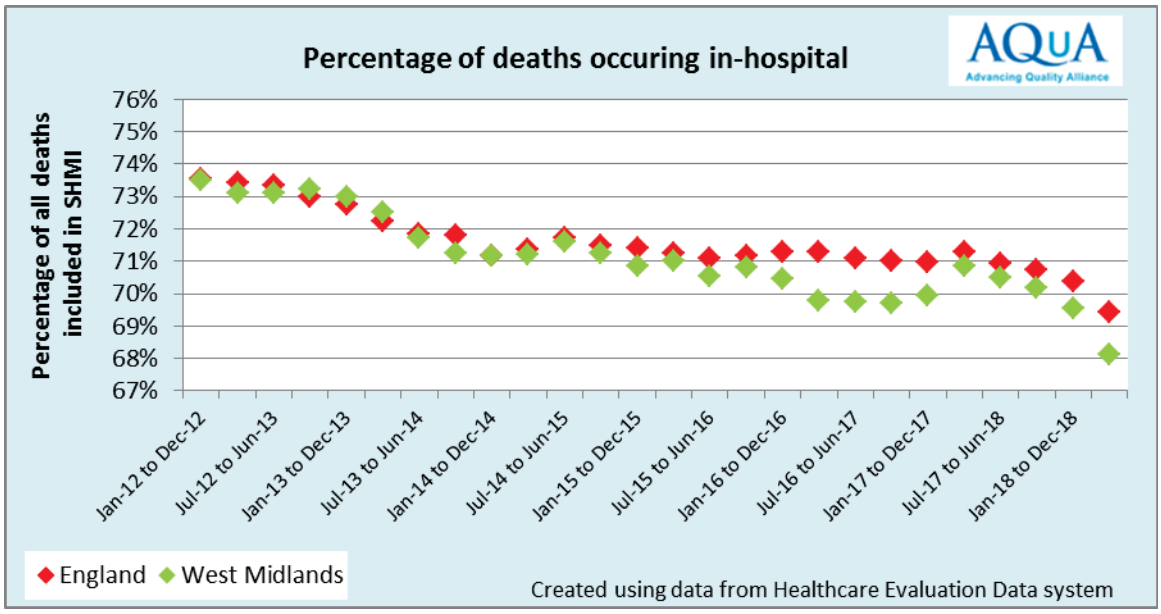


Chart 8 – Percentage of deaths occurring in-hospital time-series

SECTION 2 – Trusts in the West Midlands

2.1 Crude Mortality Rate

Based upon the latest published SHMI data, crude in-hospital mortality rates in West Midlands hospitals varies from c.1.8% to c.3.1% - nearly a two-fold difference – see chart 9.

Due to delays in release of data from NHS Digital to HED, we have used estimated figures in this chart in order to avoid unnecessary delay in the production of this report. These figures do not include patient opt-outs for either the numerator or denominator.

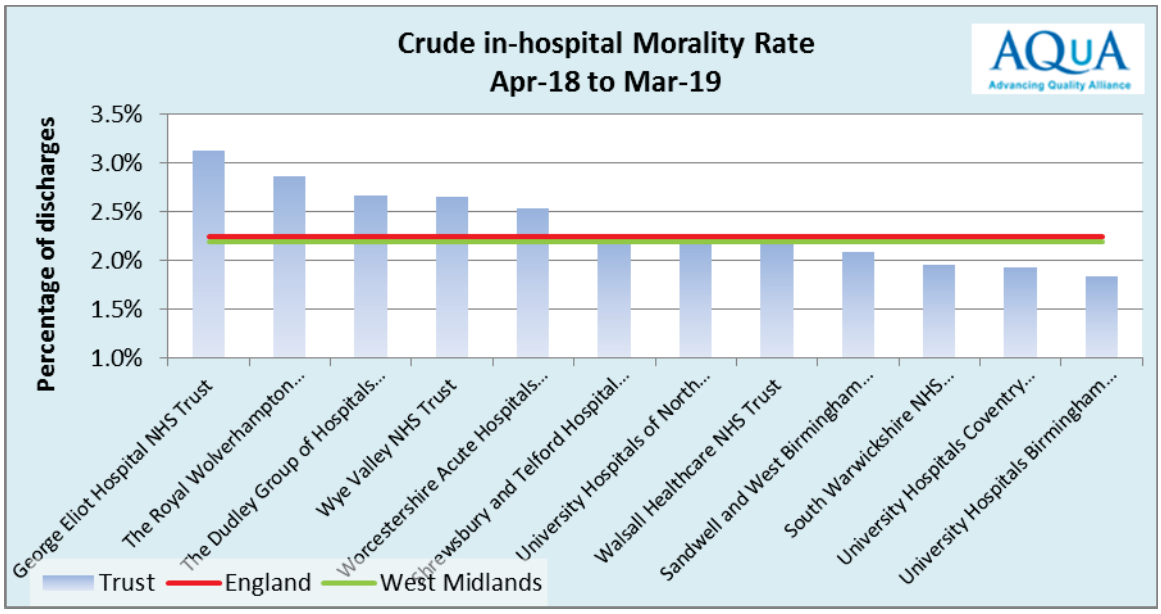


Chart 9 – crude in-hospital mortality rate by trust

There is usually a similar degree of variance for in-hospital deaths for non-elective admissions – from 1.7% to 3.6% - see chart 10. Although crude rates are a useful starting point in understanding the situation regarding a trust's mortality, direct comparisons between trusts should be treated with caution due to potential differences in case-mix and the age-profile of the patients treated. Case-mix variables may be subtle or as fundamental as either not providing a relatively low-risk service [e.g. paediatrics] or of providing a relatively high-risk service [e.g. sub-regional trauma centre] (both examples having the effect of increasing the crude rate). These are, of course, some of the very differences that standardised rates adjust for.

Due to delays in data being released from NHS Digital to HED, it has not been possible to update this chart. This being our first report for the West Midlands region, there is no prvious chart to show.

Chart 10 – crude in-hospital NEL mortality rate by trust

2.2 SHMI

Chart 11 shows a funnel-plot chart of the latest SHMI for the 12 Trusts in the West Midlands of England. The red (upper) and green (lower) lines show the limits beyond which variance is deemed to be statistically significant and unlikely to be due to random variation [chance]. Trusts within the range of red and green lines / control limits fall within Band 2 – "As expected"; trusts below the lower control limit fall within Band 3 – "Lower than expected" and trusts above the upper control limit fall within Band 1 – "Higher than expected". Beyond the three bandings, there is no inference to be taken from different SHMI values.

A list of Trust codes and names can be found in Appendix C.

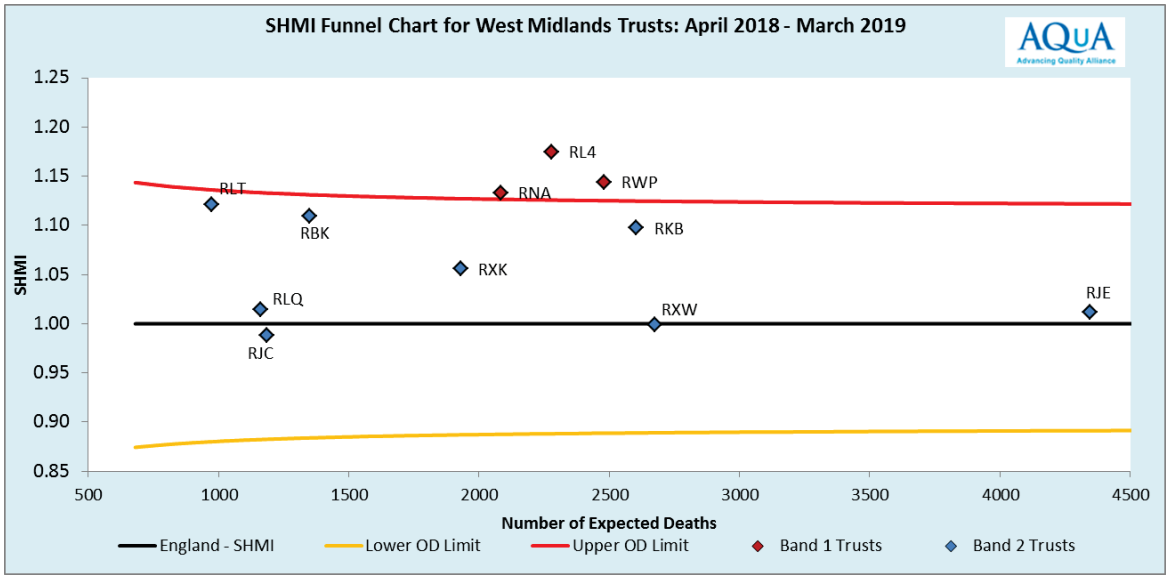


Chart 11 – latest SHMI by trust

2.3 Palliative Care coding

NHS Digital releases contextual information alongside the SHMI – one of these domains is Palliative Care. A patient can be deemed to have received Palliative Care by virtue of Specialty Code 315 being present in any other their episodes or by having ICD10 Code Z515 in any diagnosis in any episode. The charts below [12 and 13] show the rate of coding where either the Specialty Code or the Diagnosis Code is present during the Spell; chart 12 is for all patients and chart 13 is where the patient died.

As can be seen, there is quite a variance in the levels of the recording of Palliative Care. This variance is repeated nationally and is one of the main reasons why Palliative Care is not adjusted for in SHMI.

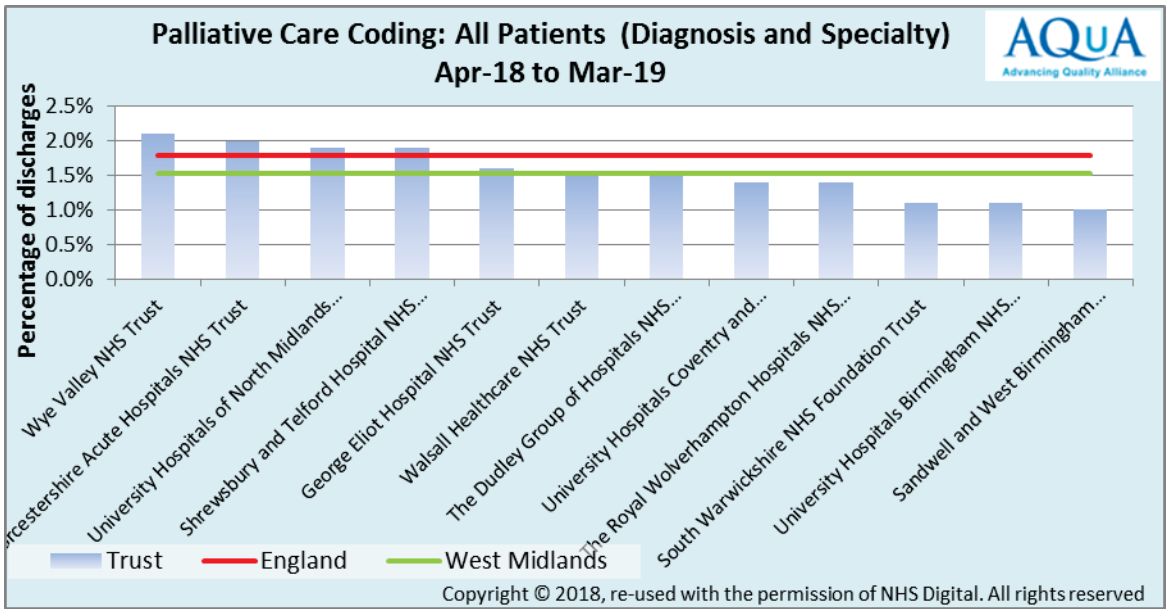


Chart 12 – Palliative Care coding by trust, all patients

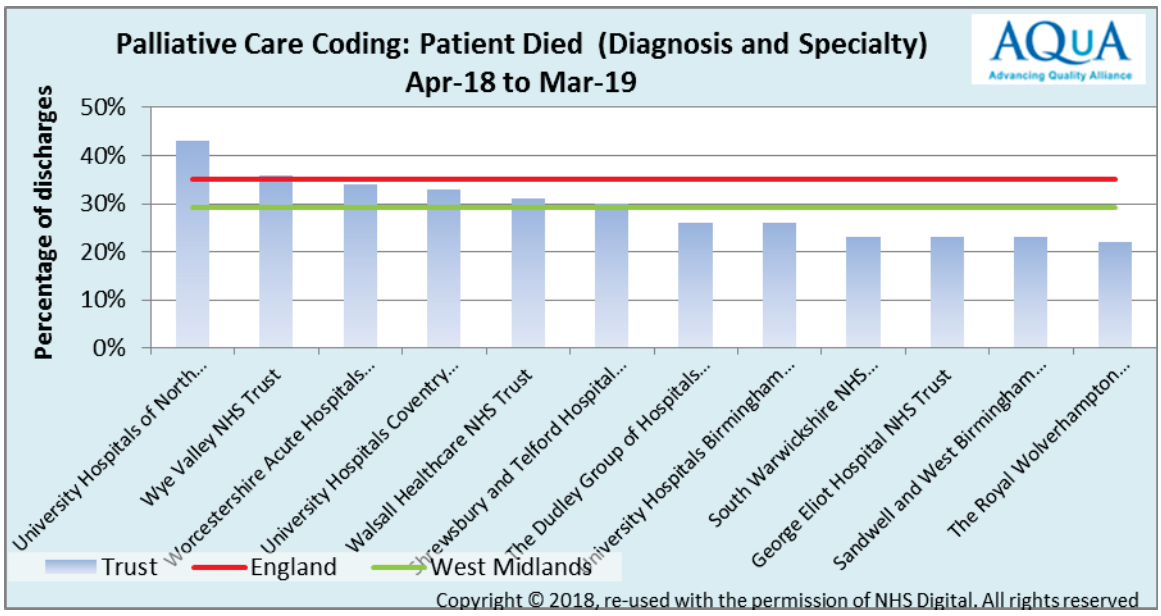


Chart 13 – Palliative Care coding by trust, patient died

2.4 Signs and Symptoms coding

The level of Signs and Symptoms coding [R codes] is important because it has inferences on the quality of care and has an impact on the calculations used to create SHMI.

High levels of R codes may imply lower access to senior medical opinion and later commencement of appropriate treatment. If R codes remain as the primary diagnosis through the first few episodes of a patient's pathway then this could be indicative of multiple hand-overs within a short period of time i.e. during the period of diagnostic investigation.

R codes remaining as the primary diagnosis for the first two episodes affects the calculation of the SHMI, often in an adverse way. SHMI uses the primary diagnosis of the first episode to assign the CCS Group of that admission. If the primary diagnosis of the first episode is an R code then the primary diagnosis of the second episode is used. However, should the diagnosis of the second episode also be an R code then SHMI will revert back to the first episode's primary diagnosis.

The CCS groups that R codes map to have relatively low mortality rates and, therefore, low numbers of expected deaths. If a trust has a high level of R coding then it is more likely to have a higher level of deaths with an R code as the primary diagnosis (first and second episode).

Chart 14 shows the general use of R Codes – there is a two-fold difference between the trust with the highest usage of R codes in the primary diagnosis [20.8%] (all episodes of a Spell where the first episode was non-elective) and the trust with the lowest [11.1%].

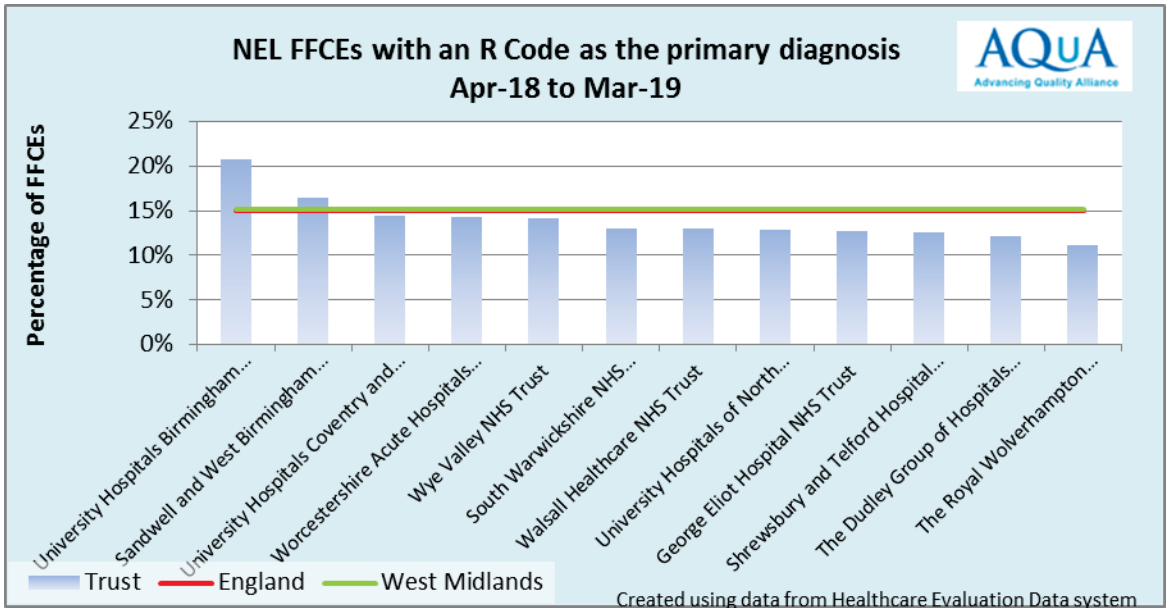


Chart 14 – Signs & Symptoms coding by trust, NEL, all episodes, all patients

Chart 15 shows the use of R Codes in the first episode – here, there is a two-fold difference between the trust with the highest usage of R codes in the primary diagnosis [23.9%] and the trust with the lowest [12.7%].

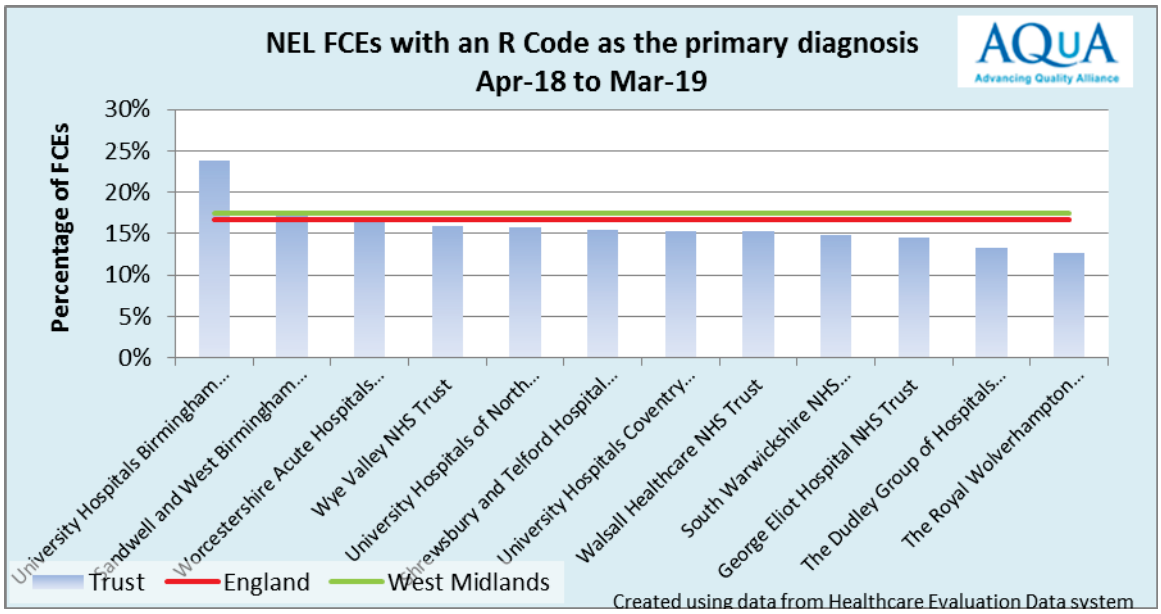


Chart 15 – Signs & Symptoms coding by trust, NEL, first episode, all patients

The number of expected deaths for a trust is calculated on all discharges so, whilst the data shown in Chart 16 has no greater effect on the SHMI than the data shown in Chart 15 [indeed, the patients reported in chart 16 will also have been reported in charts 14 & 15] higher levels of patients who died and had an R Code as their primary diagnosis in the last episode of their care might warrant further investigation.

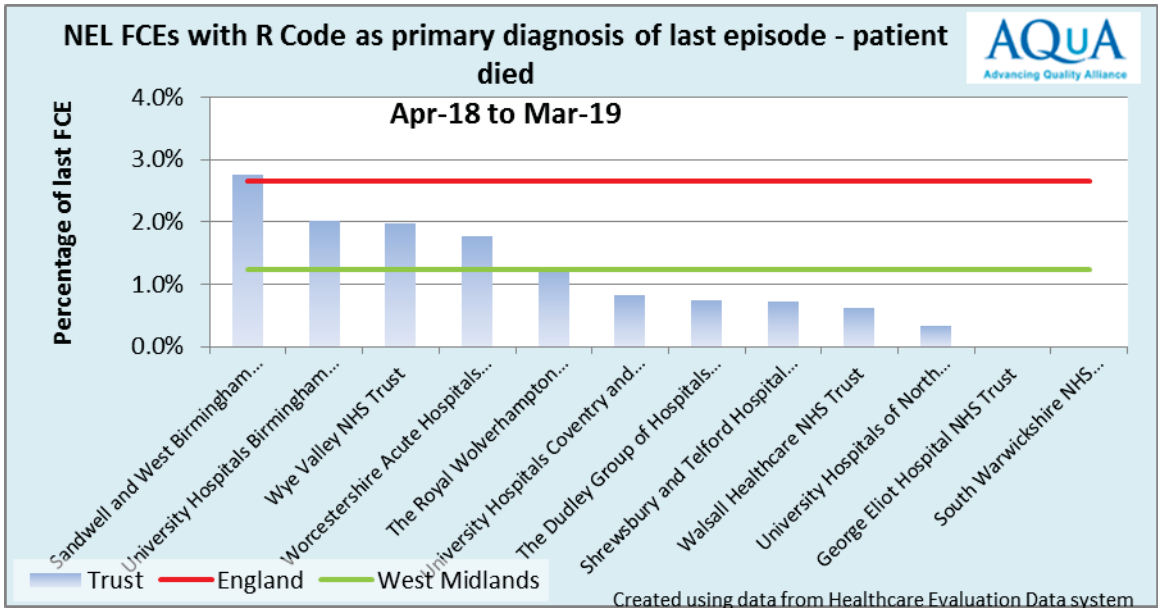


Chart 16 – Signs & Symptoms coding by trust, NEL, patient died (note two trusts' data has been supressed by HED due to small numbers)

2.5 Co-morbidity

Levels of coding are important for several reasons. Accurate and comprehensive recording of co-morbidities will better reflect the state of health of the patients that the trust is treating. Lower levels may be due to:

- this information not being recorded by the clinician in the patient's notes
- this information not being recorded clearly enough
- this information not being recorded fully on the Trust's PAS
- healthier patients

Levels of co-morbidity are used in both SHMI and HSMR. A relatively high level of co-morbidity increases the expected number of deaths in these calculations and so has the effect of reducing the standardised mortality ratio.

Comparative levels of co-morbidity are arrived at using the Charlson Co-morbidity Index. This Index assigns a weighting to 17 different conditions – the higher the weighting, the higher the perceived impact of that co-morbidity on a patient's risk of dying. A full list of these conditions, their weighting and the underlying ICD10 codes used are available on request from AQuA Analytics.

For non-elective episodes, there is a fair range of average Charlson values per episode* between trusts in the West Midlands [from 3.9 to 5.7] – see chart 17. This may be a reflection of the relative health of the population that each trust serves or different case-mixes but it could also reflect more comprehensive coding processes.

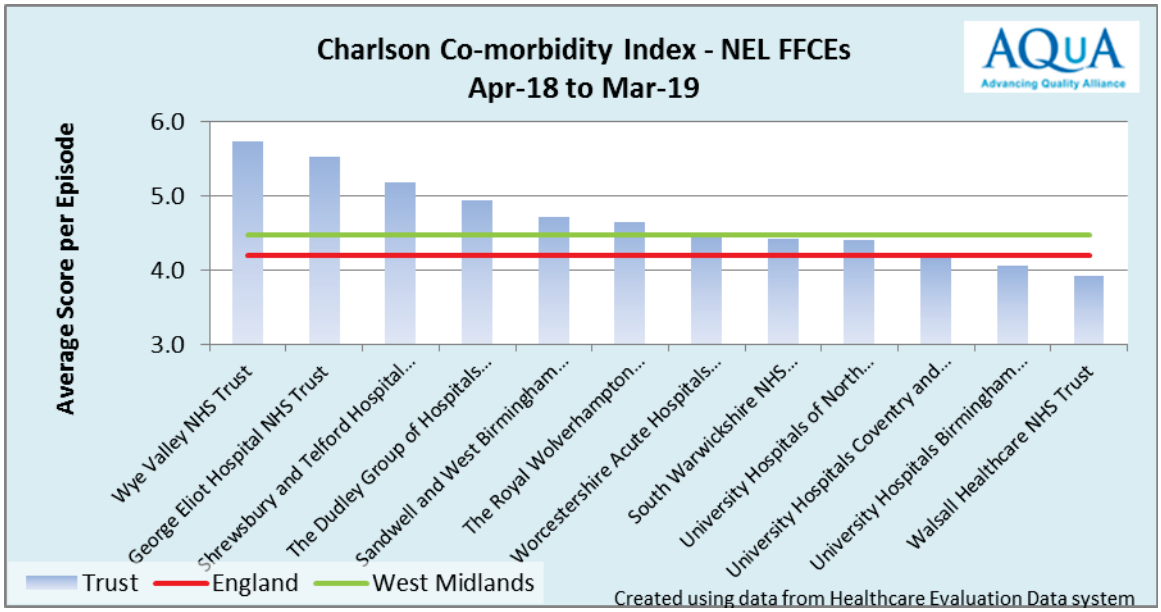


Chart 17 – Co-morbidity score by trust, NEL

* This data shows the Index Score for the first episode only as, in the vast majority of cases, it is the score for this episode that is used in the SHMI calculation.

SECTION 3 – Your Trust

This section shows information for your Trust. The *West Midlands* edition of this report is not specific to any particular trust; there is, therefore, no data to show in the "Trust" row of the tables below.

The data relates to the same domains as in Section 2 but shows a time-series in order to show whether areas are showing improvement or deterioration.

Trust Name	**The Dudley Group of Hospitals NHS Foundation Trust**
Trust Code	RNA

3.1 Crude Mortality Rate

Fin. Year	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19
Trust	**2.61%**	**2.40%**	**2.52%**	**2.17%**	**2.18%**	**2.60%**	***2.66%***
West Midlands	2.50%	2.37%	2.42%	2.35%	2.34%	2.48%	*2.19%*
England	2.40%	2.27%	2.35%	2.28%	2.35%	2.37%	*2.14%*

Note: comparison between 2018/19 data and previous years should be treated with caution.

Due to delays in release of data from NHS Digital to HED, we have used estimated figures for 2018/19 in this table in order to avoid unnecessary delay in the production of this report. 2018/19 figures do not include patient opt-outs for either the numerator or denominator.

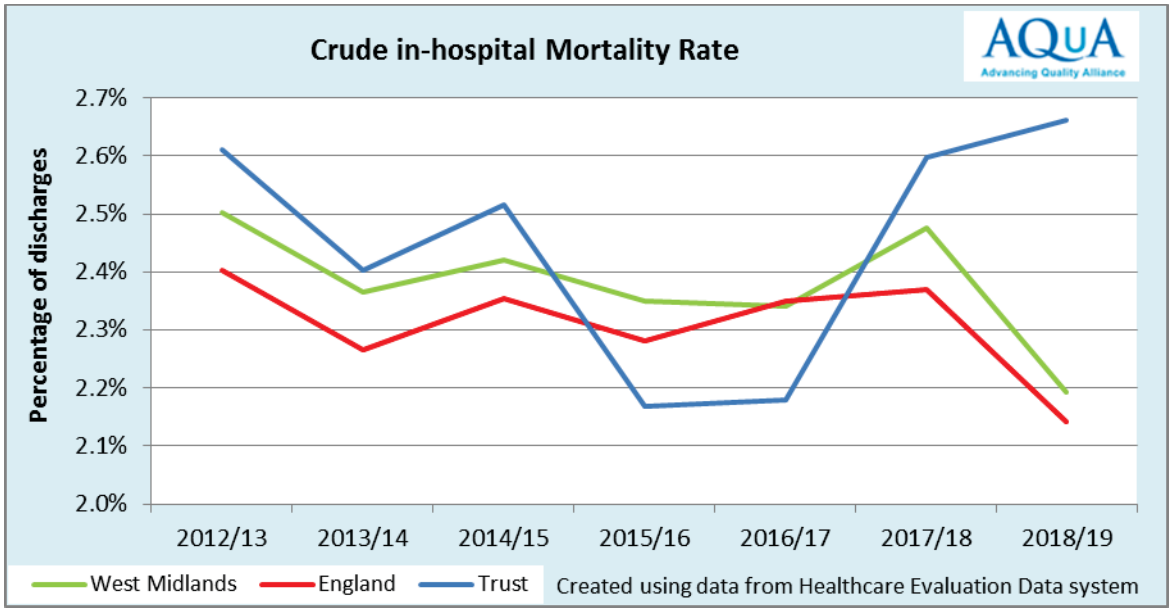


Chart 18 – trust crude in-hospital mortality rate time-series

3.2 SHMI

Period	Jan 12 - Dec 12	Apr 12 - Mar 13	Jul 12 - Jun 13	Oct 12 - Sep 13	Jan 13 - Dec 13	Apr 13 - Mar 14	Jul 13 - Jun 14	Oct 13 - Sep 14
Trust	**1.08**	**1.11**	**1.13**	**1.11**	**1.08**	**1.07**	**1.04**	**1.03**
West Midlands	1.03	1.04	1.04	1.05	1.05	1.04	1.03	1.03

Period	Jan 14 - Dec 14	Apr 14 - Mar 15	Jul 14 - Jun 15	Oct 14 - Sep 15	Jan 15 - Dec 15	Apr 15 - Mar 16	Jul 15 - Jun 16	Oct 15 - Sep 16
Trust	**1.04**	**1.02**	**1.03**	**1.02**	**1.00**	**0.98**	**0.96**	**0.98**
West Midlands	1.03	1.04	1.03	1.03	1.03	1.03	1.03	1.04

Period	Jan 16 - Dec 16	Apr 16 - Mar 17	Jul 16 - Jun 17	Oct 16 - Sep 17	Jan 17 - Dec 17	Apr 17- Mar 18	Jul 17 - Jun 18	Oct 17– Sep 18
Trust	**0.99**	**1.00**	**1.00**	**1.00**	**1.04**	**1.11**	**1.15**	**1.18**
West Midlands	1.04	1.04	1.04	1.05	1.06	1.07	1.07	1.07

Period	Jan 18- Dec 18	Apr 18- Mar 19
Trust	**1.15**	**1.13**
West Midlands	1.06	1.05

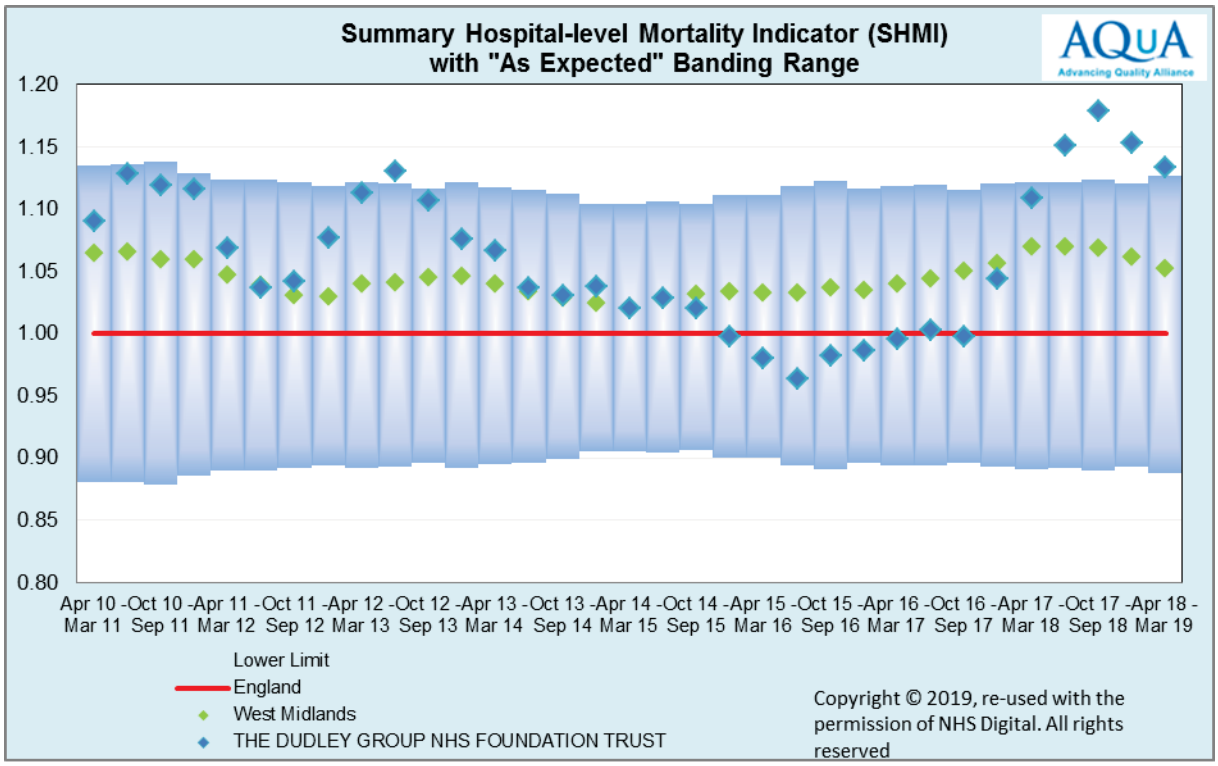


Chart 19 – trust SHMI time-series

The Quarterly Focus of Issue 06 of our report related to the monitoring of the levels of Observed and Expected deaths. The text box below contains the text of Issue 06 which still holds true.

> The SHMI is calculated as a ratio of Observed deaths to Expected deaths. When exploring changes and trends in your SHMI, it is useful to know whether this is being driven by a change in the number of Observed deaths or the number of Expected deaths. Chart 27 shows these figures for your Trust for each of the SHMI releases.
>
> Variation in case-mix and acuity notwithstanding, changes in the Observed number of deaths may indicate a change in the level of care [both during the time in hospital and up to 30 days after discharge].
>
> Changes in the Expected number of deaths will be reflective of the afore-mentioned variation in case-mix together with any changes in coding/recording/classification practice. Some of the main contributing areas that affect the number of Expected deaths have been described in sections 2 and 3 e.g. R codes and co-morbidity. Changes in the number of Expected deaths can occur [relatively] rapidly.
>
> Any unexpected change in the numbers of Observed deaths or Expected deaths or a sudden divergence or convergence of the two numbers should be explored so that the underlying reasons can be understood. One way of undertaking this is to analyse the data to see if any particular CCS Groups are driving the change. Further information and support on this can be provided by AQuA Analytics on request.

Having continued to study this area in detail, we have seen some substantial changes in the number of Expected deaths, often over short periods of time, and this has, in turn, had a substantial effect on the SHMI value for a trust. Gradual changes in the Expected numbers of deaths are often the result of slowly changing case-mixes and improvements in coding; rapid changes are more often associated with a step-change in the number of discharges. For this reason, we have included the number of discharges alongside the Observed and Expected values. When reviewing your trust's chart, ask yourself whether the changes being seen are anticipated consequences of changes in operational, coding or classification practice.

Period	Jan 12 - Dec 12	Apr 12 - Mar 13	Jul 12 - Jun 13	Oct 12 - Sep 13	Jan 13 - Dec 13	Apr 13 - Mar 14	Jul 13 - Jun 14	Oct 13 - Sep 14
Observed	2,182	2,332	2,362	2,304	2,231	2,171	2,107	2,139
Expected	2,026	2,096	2,090	2,083	2,074	2,035	2,032	2,075
Discharged	66,539	65,650	65,947	66,736	67,128	67,578	67,981	68,689

Period	Jan 14 - Dec 14	Apr 14 - Mar 15	Jul 14 - Jun 15	Oct 14 - Sep 15	Jan 15 - Dec 15	Apr 15 - Mar 16	Jul 15 - Jun 16	Oct 15 - Sep 16
Observed	2,273	2,377	2,477	2,451	2,359	2,295	2,262	2,325
Expected	2,190	2,330	2,408	2,403	2,364	2,343	2,347	2,367
Discharged	70,286	71,631	73,833	74,972	75,855	77,421	77,894	78,903

Period	Jan 16- Dec 16	Apr 16 - Mar 17	Jul 16 - Jun 17	Oct 16- Sep 17	Jan 17- Dec 17	Apr 17- Mar 18	Jul 17 - Jun 18	Oct 17– Sep 18
Observed	2,381	2,416	2,435	2,435	2,433	2,533	2,544	2,546
Expected	2,415	2,427	2,428	2,441	2,332	2,283	2,210	2,159
Discharged	79,094	78,805	79,461	78,452	74,252	69,688	64,400	61,076

Period	Jan 18- Dec 18	Apr 18- Mar 19
Observed	2,490	2,365
Expected	2,160	2,085
Discharged	61,545	61,625

*Note – From the Jan 18-Dec 18 release NHS Digital began supressing all observed, expected and discharge figures by rounding to the nearest 5.

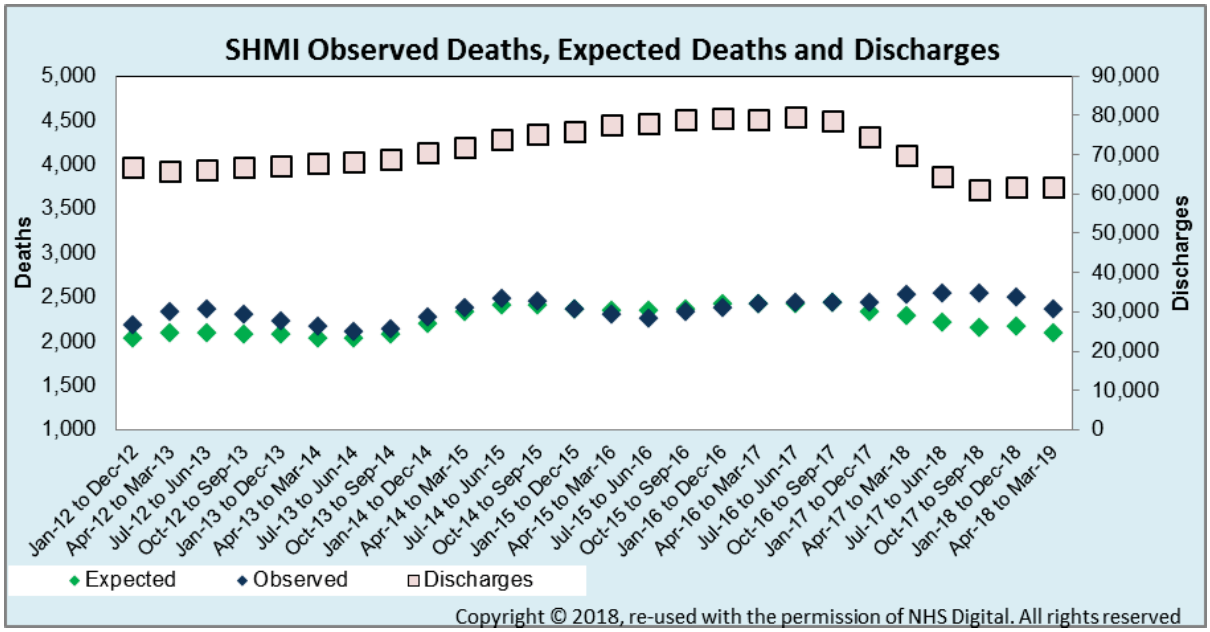


Chart 20 – Observed Deaths, Expected Deaths and Discharges Time Series

3.3 Palliative Care Coding

The first table and chart relate to all patients admitted; the second table and chart relate to patients that died.

Period	Jan 12 - Dec 12	Apr 12 - Mar 13	Jul 12 - Jun 13	Oct 12 - Sep 13	Jan 13 - Dec 13	Apr 13 - Mar 14	Jul 13 - Jun 14
Trust	**1.40%**	**1.40%**	**1.50%**	**1.40%**	**1.30%**	**1.30%**	**1.30%**
West Midlands	1.16%	1.23%	1.26%	1.30%	1.35%	1.42%	1.43%
England	1.06%	1.12%	1.14%	1.18%	1.22%	1.27%	1.29%

Period	Oct 13 - Sep 14	Jan 14 - Dec 14	Apr 14 - Mar 15	Jul 14 - Jun 15	Oct 14 - Sep 15	Jan 15 - Dec 15	Apr 15 - Mar 16
Trust	**1.30%**	**1.30%**	**1.25%**	**1.20%**	**1.18%**	**1.21%**	**1.22%**
West Midlands	1.46%	1.48%	1.50%	1.50%	1.51%	1.55%	1.66%
England	1.31%	1.34%	1.38%	1.39%	1.42%	1.45%	1.48%

Period	Jul 15 - Jun 16	Oct 15 - Sep 16	Jan 16 - Dec 16	Apr 16 - Mar 17	Jul 16 - Jun 17	Oct 16 - Sep 17	Jan 17- Dec 17
Trust	**1.25%**	**1.33%**	**1.31%**	**1.37%**	**1.38%**	**1.36%**	**1.41%**
West Midlands	1.71%	1.74%	1.73%	1.68%	1.61%	1.56%	1.58%
England	1.51%	1.54%	1.58%	1.63%	1.64%	1.66%	1.71%

Period	Apr 17- Mar 18	Jul 17 - Jun 18	Oct 17- Sep 18	Jan 18- Dec 18	Apr 18- Mar 19
Trust	**1.41%**	**1.50%**	**1.54%**	**1.50%**	**1.50%**
West Midlands	1.52%	1.51%	1.53%	1.54%	1.54%
England	1.75%	1.77%	1.78%	1.78%	1.80%

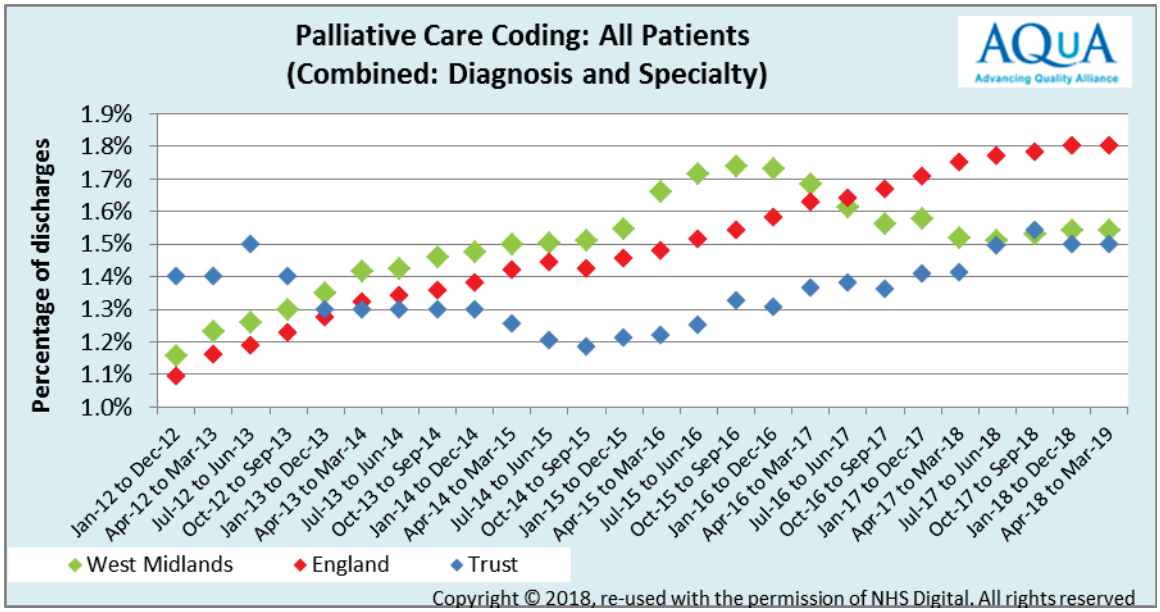


Chart 21 – trust Palliative Care coding time-series, all patients

Period	Jan 12 - Dec 12	Apr 12 - Mar 13	Jul 12 - Jun 13	Oct 12 - Sep 13	Jan 13 - Dec 13	Apr 13 - Mar 14	Jul 13 - Jun 14	Oct 13 - Sep 14
Trust	**27.5%**	**26.4%**	**26.0%**	**25.3%**	**25.1%**	**26.2%**	**27.1%**	**27.5%**
West Midlands	20.1%	21.0%	21.2%	21.7%	23.0%	24.7%	25.9%	26.9%
England	19.1%	19.9%	20.2%	20.9%	22.0%	23.6%	24.6%	25.3%

Period	Jan 14 - Dec 14	Apr 14 - Mar 15	Jul 14 - Jun 15	Oct 14 - Sep 15	Jan 15 - Dec 15	Apr 15 - Mar 16	Jul 15 - Jun 16	Oct 15 - Sep 16
Trust	**27.9%**	**27.2%**	**25.9%**	**26.6%**	**28.1%**	**29.5%**	**31.3%**	**31.5%**
West Midlands	26.8%	26.4%	26.2%	26.4%	27.7%	30.3%	31.3%	32.0%
England	25.7%	25.7%	26.0%	26.6%	27.6%	28.5%	29.2%	29.7%

Period	Jan 16 - Dec 16	Apr 16 - Mar 17	Jul 16 - Jun 17	Oct 16 - Sep 17	Jan 17- Dec 17	Apr 17- Mar 18	Jul 17 - Jun 18	Oct 17- Sep 18
Trust	**29.7%**	**29.3%**	**28.5%**	**27.6%**	**27.0%**	**24.8%**	**24.5%**	**24.0%**
West Midlands	31.5%	30.4%	29.2%	28.0%	27.7%	26.7%	26.5%	27.8%
England	30.1%	30.7%	32.2%	31.5%	32.2%	32.5%	33.1%	33.6%

Period	Jan 18- Dec 18	Apr 18- Mar 19
Trust	**26.0%**	**26.0%**
West Midlands	29.2%	29.2%
England	34.3%	35.0%

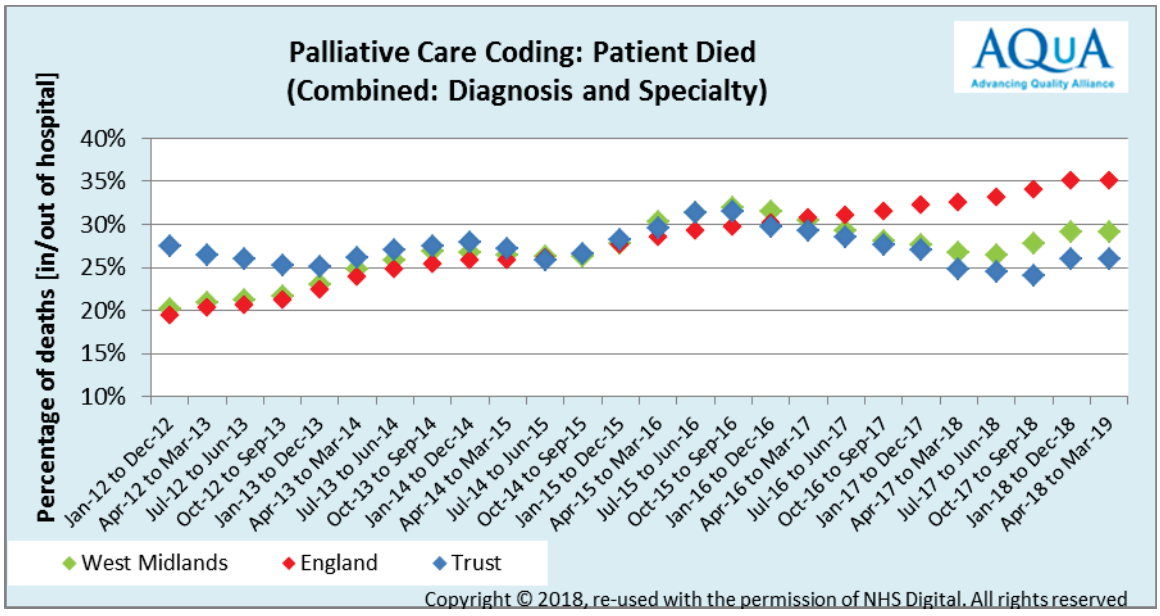


Chart 22 – trust Palliative Care coding time-series, patients died

3.4 Signs and Symptoms coding

All non-elective FCEs.

Fin. Year	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19
Trust	**14.9%**	**15.1%**	**17.3%**	**15.0%**	**16.1%**	**15.0%**	**12.0%**
West Midlands	13.9%	14.6%	14.3%	14.1%	14.0%	16.2%	15.2%
England	14.8%	15.1%	14.4%	14.0%	14.3%	18.0%	14.0%

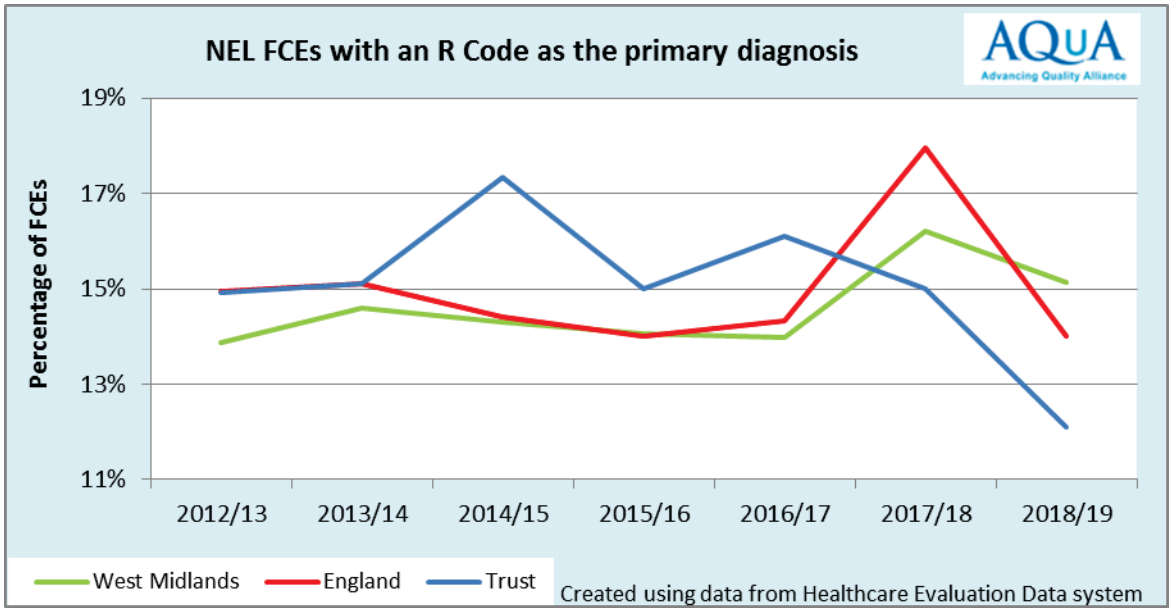


Chart 23 – trust Signs & Symptoms coding time-series, NEL, all patients

First Episode of the non-elective Spell.

Fin. Year	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19
Trust	**15.9%**	**16.3%**	**19.7%**	**16.9%**	**17.3%**	**15.5%**	**13.3%**
West Midlands	15.5%	16.4%	16.3%	16.1%	15.9%	18.0%	17.4%
England	15.9%	16.0%	15.8%	15.7%	15.8%	19.2%	16.2%

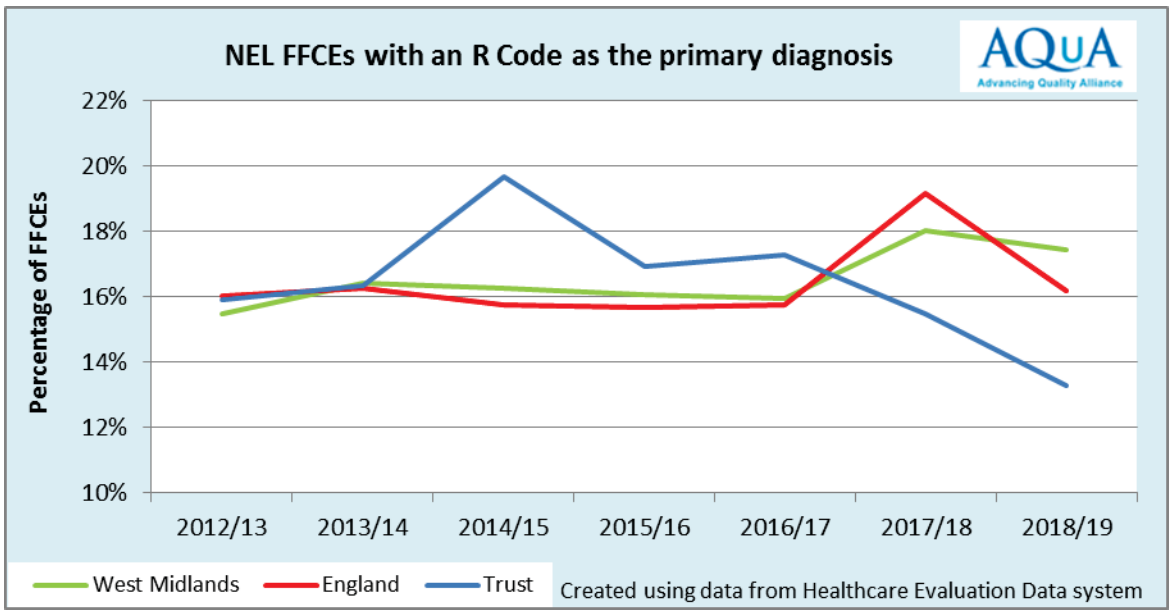


Chart 24 – trust Signs & Symptoms coding time-series, NEL, all patients

Last Episode of the non-elective Spell where the patient has died.

Fin. Year	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19
Trust	**1.7%**	**0.0%**	**0.7%**	**0.3%**	**2.2%**	**4.4%**	**0.8%**
West Midlands	1.5%	1.2%	0.6%	0.9%	0.4%	2.4%	1.2%
England	2.3%	2.1%	1.7%	2.0%	2.1%	5.1%	2.2%

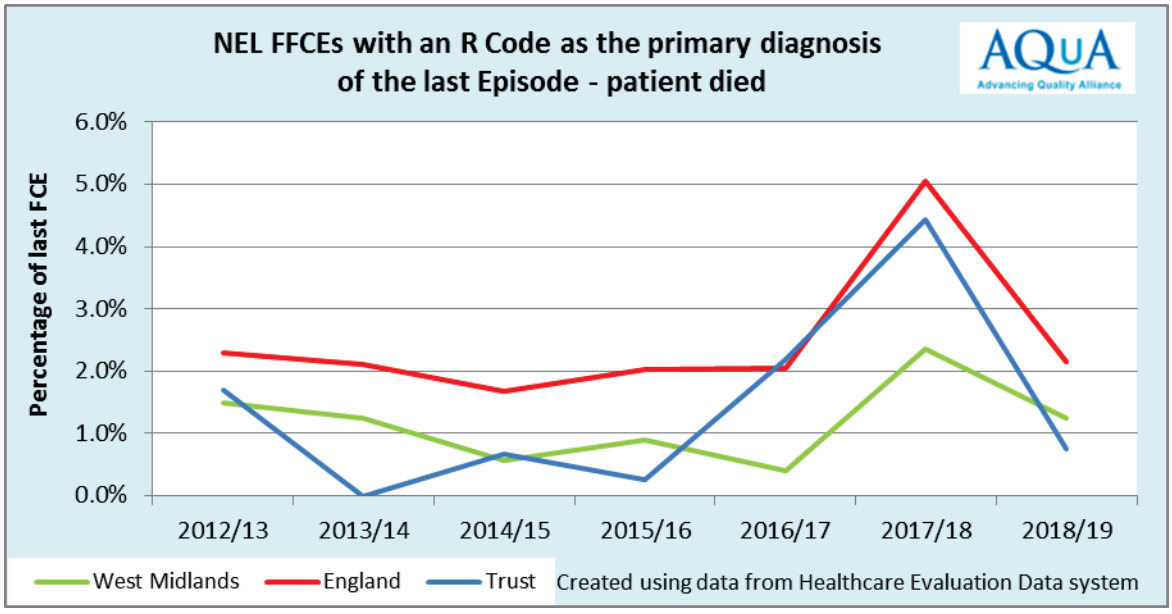


Chart 25 – trust Signs & Symptoms coding time-series, NEL, patient died

3.5 Co-morbidity

Fin. Year	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19
Trust	**3.0**	**3.2**	**3.9**	**3.5**	**3.6**	**4.0**	**4.9**
West Midlands	3.2	3.5	3.8	4.0	4.1	4.2	4.5
England	3.0	3.1	3.3	3.8	3.9	4.0	4.2

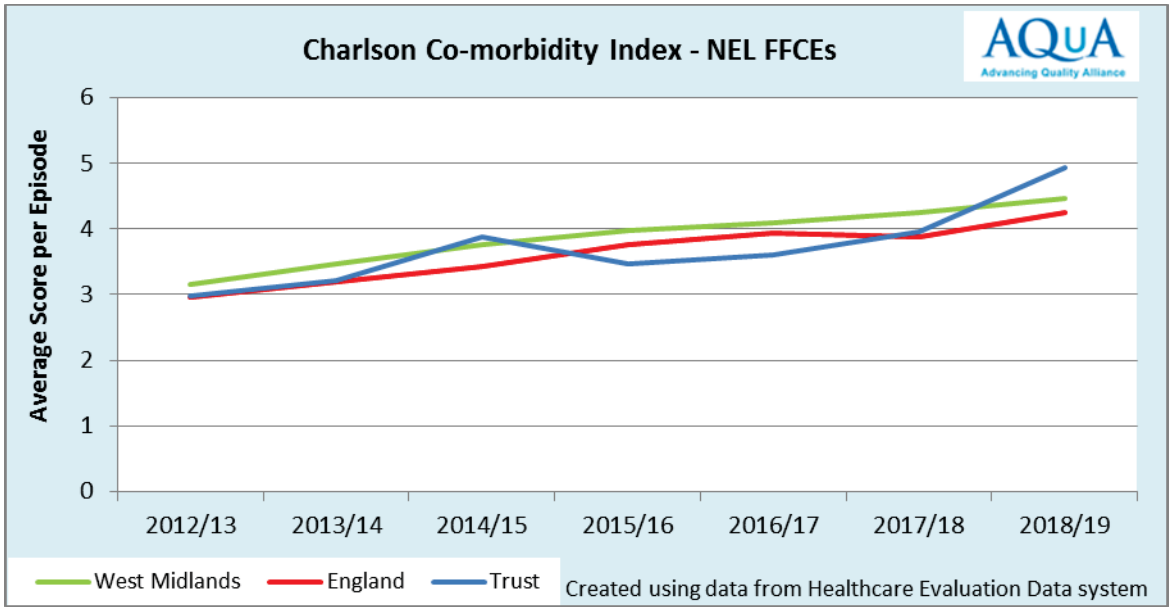


Chart 26 – Charlson Co-Morbidity Index time-series, NEL

SECTION 4 – Quarterly Focus

4.1 Acute Myocardial Infarction

This quarter, the subject of focus is Acute Myocardial Infarction [AMI]. AMI (CCS Group 57) is the 11th largest CCS group for observed deaths in England accounting for 2.1% of these during the April 2018 – March 2019 SHMI period.

An AMI (heart attack) is a serious medical emergency in which the supply of blood to the heart is suddenly blocked, usually by clot.

Coronary Heart Disease is the leading cause of heart attacks. It is a condition in which the major blood vessels that supply the heart get clogged up with deposits of cholesterol, known as plaques. Before a heart attack, one of the plaques bursts (ruptures), causing a blood clot to develop at the site of the rupture. The clot may block the supply of blood to the heart, triggering a heart attack.

There are two types of heart attack known as ST segment elevation myocardial infarction (STEMI) and Non-ST segment elevation myocardial infarction (NSTEMI). A STEMI is the most serious type of heart attack, where there is a long interruption to the blood supply. This is caused by a total blockage of the coronary artery, which can cause extensive damage to a large area of the heart.

An NSTEMI can be less serious; this is because the blood supply to the heart may only be partially, rather than completely, blocked. A smaller section of the heart may be damaged, however, without treatment it can progress to serious heart damage or STEMI.

NHS.UK

Management of STEMI often requires immediate specialised treatment. A primary percutaneous coronary intervention (PCI) is the preferred reperfusion procedure.

Patients with NSTEMI should be managed in a cardiac ward and assessed by a cardiologist. NICE guidelines suggest a benefit for diagnostic coronary angiography with PCI (if necessary) when performed up to 96 hours after admission to hospital for NSTEMI patients estimated to be at moderate to high risk.

Certain drugs have been shown to reduce the likelihood of subsequent heart attacks in both STEMI and NSTEMI. Secondary prevention medication should be prescribed to the patient whilst in hospital and continued post discharge and include, ACE inhibitors, Aspirin, Beta blocker and statins.

NICOR.org

The Myocardial Ischaemia National Audit Project (MINAP) was established in 1999 to examine the quality of management of heart attacks (myocardial infarction) in hospitals in England and Wales. Part of the National Cardiac Audit Programme (NCAP), the audit aims to improve the quality of care and outcomes of patients who have heart attacks. It aims to improve the whole pathway from the call to the emergency services, to the prescription of preventive medications on discharge from hospital. Annual reports are produced to measure performance and care for patients.

NICOR.org

There are steps that can be taken to reduce the risk of having a heart attack (or having another heart attack)

- Smokers should quit smoking
- lose weight if you are overweight
- take regular exercise
- eat a low-fat high fibre diet with plenty of fresh fruit and vegetables
- moderate alcohol consumption

(NHS.UK)

4.2 More to Explore

https://www.nicor.org.uk/wp-content/uploads/2018/11/MINAP-Summary-Report-2016-17.pdf

https://www.nicor.org.uk/national-cardiac-audit-programme/myocardial-ischaemia-minap-heart-attack-audit/

https://www.nhs.uk/conditions/heart-attack/diagnosis/

https://www.nhs.uk/conditions/heart-attack/

4.3 Funnel Plots and VLADs

The charts below show funnel-plots for the latest SHMI release (April 2018 – March 2019) and Variable Life-Adjusted Displays [VLADs] for the most recent twelve-month period available for CCS group 57 (June 2018 – May 2019).

Funnel-plot charts identify whether or not a trust is a statistical outlier at any particular point in time. Being an outlier on one occasion for one CCS Group is not, in itself, cause for concern or action but if the trust is repeatedly an outlier, or an outlier in several, related conditions (as shown here), then a review should be undertaken.

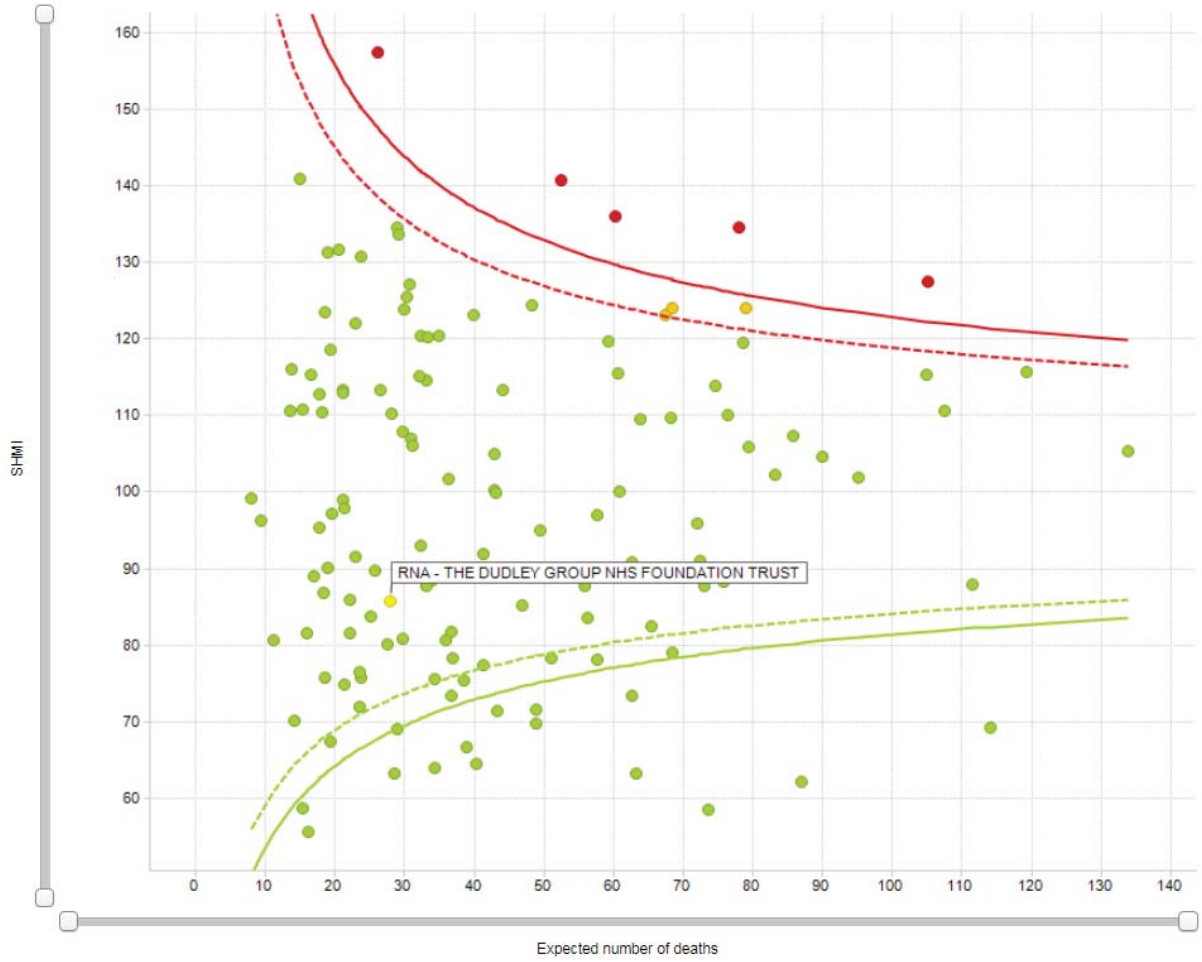


Chart 27 – Funnel Plot CCS group 57 April 18-March 19

One method of monitoring how an organisation is fairing over time is through Variable Life-Adjusted Display charts [VLAD charts]. A VLAD chart shows a plot of the cumulative sum of the difference between the expected and observed mortality outcome. By way of example, if there was a 5% risk of death associated with admission for a certain condition then each patient that survived would add a value of 0.05 to the cumulative sum and each patient that died would deduct a value of 0.95.

CuSum control limits can be added to VLAD charts in order to facilitate the generation of alerts. By setting control limits to a desired level of sensitivity, the observer is able to see when these alert levels have been triggered. Investigations should then take place in order to establish the root cause of the deterioration or improvement and take any appropriate action. Control limits are also useful in monitoring any statistically significant change in survival rates following a known, planned change in a process. When an alert is triggered, the relevant control limit is re-set until another alert is generated and so on. Please contact AQuA Analytics if you require more information about the interpretation of VLAD charts.

The chart below shows the VLAD for AMI using the SHMI risk-model for CCS Group 57 for the period June 2018 to May 2019.

- The blue line shows the cumulative sum of the difference between the expected and observed mortality outcome for your Trust
- The green line shows the lower CuSum control limit of 5
- The red line shows the upper CuSum control limit of 5

Should the value for the Trust reach the value of the lower control limit (green line) then a statistically significant positive change has occurred since the start of the observed period. Conversely, should the value for the Trust reach the value of the upper control limit (red line) then a statistically significant adverse change has occurred since the start of the observed period.

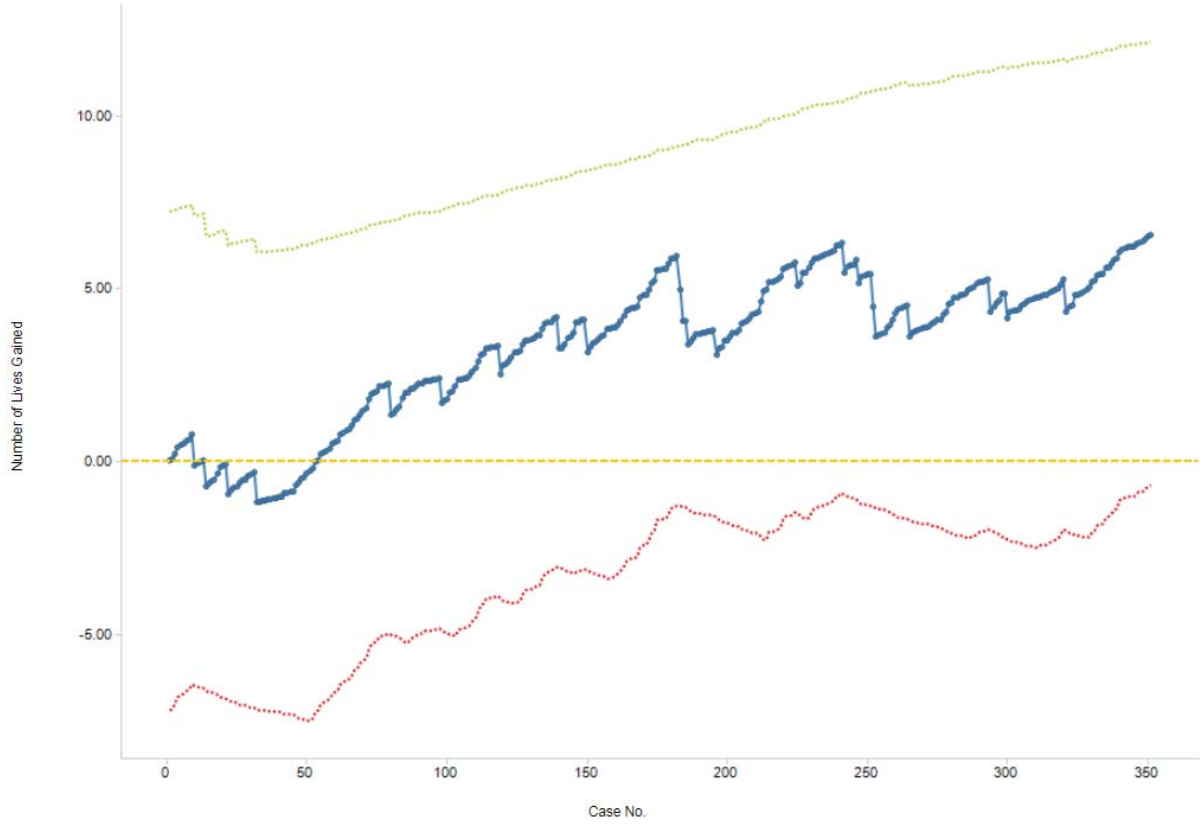


Chart 28 – VLAD CCS group 57 June 18-May 19

Appendix A: Differences between HSMR, RAMI and SHMI

	Hospital Standardised Mortality Rate (HSMR)	**Risk Adjusted Mortality Index (RAMI)**	**Summary Hospital-level Mortality Indicator (SHMI) ****
Observed	All spells culminating in death at the end of the patient pathway, defined by specific diagnosis codes for the primary diagnosis of the spell: uses 56 diagnosis groups which contribute to approx. 80% of in hospital deaths in England*	Total number of observed in-hospital deaths	Number of observed in-hospital deaths plus deaths out of hospital within 30 days of discharge
Expected	Expected number of deaths	Expected number of deaths *Calculated using a 10 year data set (as of 2012) to get the risk estimate*	Expected number of deaths *Calculated using a 36 month data set to get the risk estimate*
Adjustments	▪ Sex ▪ Age in bands of five up to 90+ ▪ Admission method ▪ Source of admission ▪ History of previous emergency admissions in last 12 months ▪ Month of admission ▪ Socio economic deprivation quintile (using Carstairs) ▪ Primary diagnosis based on the clinical classification system ▪ Diagnosis sub-group ▪ Co-morbidities based on Charlson score ▪ Palliative care ▪ Year of discharge	▪ Sex ▪ Age ▪ Clinical grouping (HRG) ▪ Primary and secondary diagnosis ▪ Primary and secondary Procedures ▪ Hospital type ▪ Admission method Further detailed methodology information is included in CHKS products, or specific enquiries to CHKS www.chks.co.uk	▪ Sex ▪ Age group ▪ Admission method ▪ Co-morbidity ▪ Year of dataset ▪ Diagnosis group Details of the categories above can be referenced from the methodology specification document at http://www.ic.nhs.uk/services/summary-hospital-level-mortality-indicator-shmi
Exclusions	Excludes day cases and regular attendees	Excludes mental illness, obstetrics, babies born in or out of hospital, day cases, and patients admitted as emergencies with a zero length of stay discharged alive and spells coded as palliative care (Z515)	▪ Specialist, community, mental health and independent sector hospitals. ▪ Stillbirths ▪ Day cases, regular day and night attenders
Whose data is being compared and how much data is used for comparison e.g. all trusts or certain proportion etc.	All England provider trusts via SUS Data attributed to all Trusts within a 'super-spell' of activity that ends in death	UK database of Trust data and HES Data attributed to Trust in which patient died	All England non-specialist acute trusts except mental health, community and independent sector hospitals. Data attributed to Trust in which patient died or was discharged from

*HSMR does not exclude 20% of deaths, it looks for the diagnosis groups that account for the majority of deaths, and the figure of 80% is quite variable dependent on the case mix of the trust. HSMR

could just as easily cover 100% of activity. It covers 80% of activity mostly for historical reasons and the fact that you get little extra value from the other 20%.

** NHS Digital publishes the SHMI indicator as observed, expected, denominator, value, upper control limits, lower control limits and banding. The term numerator is not used in the publication.

Appendix B: Metadata

Resource type	Title	Description	Coverage	Numerator	Denominator	Date	Source
Mortality	Charts 1 & 9	Crude in-hospital mortality rate	131 SHMI Trusts	Discharge Method = 4	All discharges	Latest published SHMI (12 month period)	HED
Mortality	Charts 2 & 18	Crude in-hospital mortality rate	131 SHMI Trusts (12 in West Midlands)	Discharge Method = 4	All discharges	April 2009 – most recent month	HED
Mortality	Charts 3 & 10	Crude in-hospital mortality rate	131 SHMI Trusts	Discharge Method = 4 OR Died within 30 days	All discharges	Latest published SHMI (12 month period)	HED
				Split as per Appendix B.3 of the SHMI Indicator Specification i.e. Elective = Admission Method 11, 12, 13 Acute [NEL] = 21, 22, 23, 24, 28, 31, 32, 81, 82, 83, 84, 89, 98			
Mortality	Chart 4a	SHMI - SHA	131 SHMI Trusts	Observed deaths	Expected deaths	Latest published SHMI (12 month period)	NHS Digital
Mortality	Chart 4b & 11	SHMI – Funnel Plot	131 SHMI Trusts	Observed deaths	Expected deaths	Latest published SHMI (12 month period)	NHS Digital
Mortality	Charts 5 & 19	NW SHMI	12 Trusts in West Midlands	Observed deaths	Expected deaths	Latest published SHMI (12 month period)	HED
Mortality	Chart 6	Observed and Expected deaths	12 Trusts in West Midlands	N/A	N/A	October 2009 – latest month	HED
Mortality	Chart 7	% Deaths occurring in-hospital	131 SHMI Trusts	Discharge Method = 4	Discharge Method = 4 plus deaths from the HES-ONS linked mortality data file	Latest published SHMI (12 month period)	HED
Mortality	Chart 8	% Deaths occurring in-hospital	131 SHMI Trusts (21 in West Midlands)	Discharge Method = 4	Discharge Method = 4 plus deaths from the HES-ONS linked mortality data file	October 2009 – Latest month	HED
Clinical Coding	Chart 12 &	Palliative Care	12 Trusts in	Patients with ICD10	All discharges	Latest published	NHS Digital

Resource type	Title	Description	Coverage	Numerator	Denominator	Date	Source
	21	coding	West Midlands	Code Z515 in any position of any episode or Specialty Code 315 in any episode		SHMI (12 month period)	
Clinical Coding	Chart 13 & 22	Palliative Care coding	12 Trusts in West Midlands	Patients with ICD10 Code Z515 in any position of any episode or Specialty Code 315 in any episode (where Discharge Method = 4)	Discharge Method = 4 plus deaths from the HES-ONS linked mortality data file	Latest published SHMI (12 month period)	NHS Digital
Clinical Coding	Charts 14 & 23	Signs & Symptoms coding	12 Trusts in West Midlands	ICD10 "R" code in primary diagnosis of any episode. Admission Method = 21 – 28, 31, 32, 81 – 89, 98.	Number of episodes	Latest FY for which data has been published	HED
Clinical Coding	Charts 15 & 24	Signs & Symptoms coding	12 Trusts in West Midlands	ICD10 "R" code in primary diagnosis of the first episode. Admission Method = 21 – 28, 31, 32, 81 – 89, 98	Number of first episodes [i.e. Spells]	Latest FY for which data has been published	HED
Clinical Coding	Charts 16 & 25	Signs & Symptoms coding	12 Trusts in West Midlands	ICD10 "R" code in primary diagnosis of last episode. Admission Method = 21 – 28, 31, 32, 81 – 89, 98 (where Discharge Method = 4)	Number of last episodes [i.e. Spells] Discharge Method = 4	Latest FY for which data has been published	HED
Clinical Coding	Chart 17 & 26	Charlson Co-morbidity Index	12 Trusts in West Midlands	Total co-morbidity score for all relevant codes[1] in Diag02 – Diag20 for the first episode[2]	Number of first episodes [i.e. Spells]	Latest published SHMI (12 month period)	HED

[1] See Appendix D.1 of SHMI Methodology

[2] This most closely reflects the episodes that are used in the SHMI calculation. Only a small proportion of second episodes are used [i.e. where the primary diagnosis of the first episode is an "R" code and the second episode has a primary diagnosis other than an "R" code].

Appendix C: Trust Codes and Names

Trust Code	Trust Name
RBK	Walsall Healthcare NHS Trust
RJC	South Warwickshire NHS Foundation Trust
RJE	University Hospital of North Staffordshire NHS Trust
RKB	University Hospitals Coventry and Warwickshire NHS Trust
RL4	The Royal Wolverhampton Hospitals NHS Trust
RLQ	Wye Valley NHS Trust
RLT	George Eliot Hospital NHS Trust
RNA	The Dudley Group of Hospitals NHS Foundation Trust
RRK	University Hospitals Birmingham NHS Foundation Trust
RWP	Worcestershire Acute Hospitals NHS Trust
RXK	Sandwell and West Birmingham Hospitals NHS Trust
RXW	Shrewsbury and Telford Hospital NHS Trust

Enclosure 23

The Dudley Group
NHS Foundation Trust

Paper for submission to the Board of Directors on 12 March 2020

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 27 February 2020.

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:** (COR1012) 15 (COR1011) 8
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: 27 February 2020

MATTERS OF CONCERN OR KEY RISKS TO ESCALATE	MAJOR ACTIONS COMMISSIONED/WORK UNDERWAY
• Costs on a rising trajectory; agency costs have exceeded £1m per month since October • £0.6m behind recovery plan agreed at January Board • Continue to miss Emergency Access Standard (EAS), cancer and diagnostic targets	• Continued focus to deliver recovery plan and control total • Mechanism for assuring that consultancy projects are properly specified and benefits are realised and embedded
POSITIVE ASSURANCES TO PROVIDE	**DECISIONS MADE**
• Gradual improvement in EAS performance – currently approximately 82% • Following cancer "super weekend" planned for 7 & 8 March anticipated return to targets are - breast symptomatic March, 2 week wait April and 62 day by July • Following completion of 4th endoscopy room in May, DM01 expected to be consistently above target by July	• Approved EPRR Annual Plan • Agreed to transfer BAF risk 5B to Digital Trust Technology Committee • Rejected request to reduce BAF risk 3A score from 12 to 8 • Delegated authority to Director of Finance to negotiate 2020/21 financial plan within agreed approach • Agreed to pause Trainee Nurse Associates programme pending review of workforce planning

Chair's comments on the effectiveness of the meeting:

Lengthy agenda, but approach of only noting rather than discussing some papers created space for greater detail on key issues. Would benefit from greater participation by all attendees

Enclosure 24

The Dudley Group
NHS Foundation Trust

Paper for submission to the Board of Directors on 12 March 2020

TITLE:	**Integrated Performance Report for Month 10 (January) 2020**		
AUTHOR:	**Board of Directors**	**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**

RECOMMENDATIONS

To note and discuss the current performance against KPIs

CORPORATE OBJECTIVE:

SO1, SO2, SO3, SO4, SO5, SO6

SUMMARY OF KEY ISSUES:

Performance

EAS

- Improved EAS performance for January in comparison to December. A significant contributing factor in this is the protection of the 8 Rapid Access Bay (RAB) trolleys on AMU which enables those patients who require medical input but not an admission to be moved out of ED.

- The main challenge in January was the number of 12 hour breaches that occurred due to delays of patients accessing a bed. A number of measures have been put in place in February to address this, the main one being the delivery of a reduction in length of stay (LOS) on AMU to ensure increased discharges from this area. a weekly oversight meeting has been put in place with non-executives and executive directors to ensure full oversight is maintained. Emergency Care Improvement Support Team (ECIST) have been contacted and are supporting the trust in the planning of a “Reset” week whereby patient flow processes will be scrutinised and improved in real time to further support flow.

- A weekly oversight meeting of EAS performance is chaired by the Chair of the Trust.

SURGERY

- RTT performance standard continues to be met, albeit under some pressure. In January the Trust achieved 92.22% against the 92% standard. Although this is level of performance is historically low

for Dudley, it remains one of the best levels of RTT performance in the country.

- Following a number of operational challenges in January within Theatres there was a significant increase in the number of patients cancelled on the day of the surgery and as a consequence one patient was not readmitted within 28 days. There have been improvements into February in this.

- The Trust achieved the RTT standard for January, delivering 92.22% against the national standard of 92%. This performance standard remains a challenge but continues to be delivered. The following specialties remain key in the delivery of improved RTT: General Surgery, Urology and Ophthalmology. Recovery plans are in place with each of these services and continue to be managed weekly. Of particular note, General Surgery is targeting additional theatre capacity in March to improve RT standard before the end of the financial year.

DIAGNOSTIC PERFORMANCE (DM01)

- The Trust has not been able to achieve the DM01 standard that less than 1% of patients should wait 6 weeks or more for a diagnostics test.

- DM01 Validation for January 2020 has been completed and the Trust ended the month at 92.11% with total breaches of 620. The main areas of failure continue to be attributable to both the failure of the Endoscopy Decontamination Unit in September and October 2019, in addition to the ongoing backlog of Cardiac MRI's. In addition, there were a significant number of other MRI breaches (143) due to a now confirmed mismatch between current levels of demand and capacity, as identified via an independent review conducted by PA Consulting, who are supporting Imaging in a number of key areas including a workforce requirements review.

- The numbers of breaches incurred during January 2020 were also increased due to the focus on 12 hour DTA breach avoidance which resulted in further routine outpatient slots turned over to inpatients and supporting ED flow.

CANCER PERFORMANCE

- Cancer performance continues to fail against the main targets but recovery is beginning to show in the numbers.

- 2 week wait is set to decrease to 67% in January. The drop in performance has been driven by more breaches in the colorectal speciality (275), with breast (237) and urology/prostate (77) being the other poorly performing areas. Recovery of the 2 week wait standard is dependent on extra capacity being provided to work through the referral backlog. Each speciality is working to provide extra capacity using either substantive staff or bank/agency.

- The Breast symptomatic target will be reported at 4.7% for December against a target of 93%. Demand on this pathway is approx. 100 per week and capacity is also approx. 100 per week provided no clinics are dropped. It is therefore taking extra activity to work through the backlog built up in the latter half of 2019 and in many cases extra activity provided is then lost when regular activity is dropped due to sickness or A/L. Progress has been slow to recover this target but the current booking day is 16. For January the forecast is 11% showing slight improvement.

- The 62 Day target will be the slowest to recover as it will require the preceding targets to be back on track and a significant amount of work to clear a backlog of over 62 day patients (244 undiagnosed and already past day 62, and 47 diagnosed). Performance has not improved in recent months, moving from 73% in October, to 71.5% in November to forecast 73% in December. Success is predicated on timely first appointments (2 week wait) and rapid diagnostic testing which is currently

delayed due to a backlog in endoscopy/GI.

- Overall PTL size is currently 1,545 which is very high and a result of such high numbers in the latter stages awaiting diagnostics and diagnosis. Colorectal has 139 patients already past 62 days with only 2 being diagnosed due to the endoscopy issues and backlog. The PTL also shows larger than normal undiagnosed numbers in the day 42-62 bracket which is further evidence of diagnostic delays.

- The longest waiters in the 104+ day bracket are of the most concern and harm reviews are carried out every fortnight to provide assurance to the trust. The PTL has 68 of these long waits at present which is very high, of which 30 are on the Colorectal pathway, a result of the backlog and long waits to be seen and a further 10 are from Urology, which is expected as the known long wait for robot assisted surgery has been a popular patient choice for over 12 months.

Improving Cancer Performance

- Improving cancer performance requires continued efforts to increase capacity for first appointments (2 week wait), reduction in delays during the diagnostic stages in Imaging, Endoscopy, Surgery and a targeted approach to long waiters to ensure decision makers are progressing pathways towards a definitive treatment or outcome.

- Based on current performance action plans being enacted it is expected that DM01 performance will be circa 94-95% in February 2020 and a return to performance is predicted based on known levels of demand for March 2020.

WORKFORCE

- Following feedback, the format of reporting has been improved through the use of SPC charts. Further improvements are being made for the March report, including; reflecting the workforce metrics which have been launched by the STP and including a 'key messages' and 'action' narrative.

- Sickness absence has reduced in January from 5.4% to 5.26%, but remains above the Trust's target and above the peer average.

- Capacity issues in Staff Health & Wellbeing have impacted the number of staff seen by the service; whilst there has been a reduction in the number of management referrals, there has been an increase in other interventions, as well as the demand associated with the flu campaign. To support the Trust's health and wellbeing agenda, a service review will take place over the next couple of months, to highlight concerns and make recommendations to improve our ability to support staff and effectively manage absence.

- Whilst intervention from the Learning and Development Team has increased the availability of statutory and mandatory training, the attached report highlights that the Trust is expected to consistently miss the target. Twice-monthly reporting has commenced to support managers/Divisions in addressing local issues. Divisional Directors are due to report their recovery plans and compliance trajectories to Workforce Committee.

IMPLICATIONS OF PAPER:

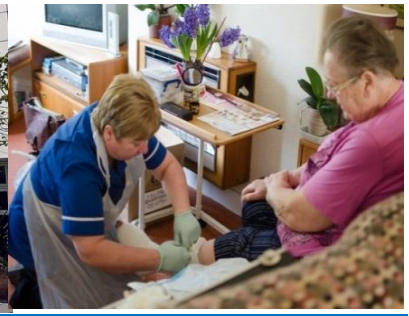
IMPLICATIONS FOR THE CORPORATE RISK REGISTER OR BOARD ASSURANCE FRAMEWORK

RISK	**N**		**Risk Description:**
	Risk Register: N		**Risk Score:**
COMPLIANCE and/or LEGAL REQUIREMENTS	**CQC**	**Y**	**Details:** Safe, Effective, Caring, Responsive, Well Led
	NHSI	**Y**	**Details:**
	Other	**N**	**Details:**
REPORT DESTINATION	**Board of directors**	**Y**	**DATE:**
	WORKING GROUP	**N**	**DATE:**
	COMMITTEE	**N**	**DATE:**

The Dudley Group
NHS Foundation Trust

Integrated Performance Report - .21-NJŘ



February 2020

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

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

Executive Summary

FFT Response Rate

A total of 4,521 responses across all areas have been received during January 2020, an increase since December 2019 .For April 2019 – January 2020 (72 areas were published) the Trust is achieving the target on 33 occasions where the percentage response rate score is equal to or better than the national average percentage response rate. A&E, inpatients, maternity and community have achieved the target this month.

FFT Percentage Recommended

Response rates have increased for all areas in January 2020

Action taken to improve scores

Scores and methods of data collection have been examined in more detail to identify teams that are performing well and share best practice. Results were presented at the Patient Experience Group in January 2020.

Our 'What Matters You' Campaign has been launched in the Trust to promote the accessibility of giving feedback and to raise the profile of patient experience across the Trust.

Under the new FFT guidance patients are encouraged to give feedback during all stages of their patient journey.

Complaints & PALS

PALS received 217 concerns, 16 comments and 73 signposting contacts totalling 306 in January 2020.

During January 2020, the Trust received 63 new complaints, in comparison to 64 for December 2019 and 68 for November 2019.

There have been 12 re-opened complaints for January 2020.

Dementia (I month in arrears)

The find /assess element whilst below target has improved from previous month and is showing an upward trend. This remains a priority for escalation between matrons.

Investigate has improved and now falls 0.5% below compliance

The refer element is compliant against target.

Falls

There were a total of 90 inpatient falls - this is a slight decrease from December 2019.

Three patients have sustained # neck of femur during January 2020.

Two of the patients have been successfully operated on and one has been discharged.

Pressure Ulcers

There have been no reported avoidable category 3 or 4 pressure ulcers in the Community

There was 1 unavoidable category 3 in the acute setting; this has been reported as an SI

MSA Breaches

There were 19 Mixed sex breaches in January -ICU = 4 breaches, SHDU = 10 breaches And MHDU = 5 breaches

This is an increase from previous month

There continues to be a high demand for beds

Infection Control

MRSA -0

MSSA -1

E Coli -2 Patients were admitted with symptoms

Executive Summary

Stroke (1 month in arrears)

All stroke targets have been met for the month of December 2019

VTE

Trust performance for VTE for January is 94.2%

To be discussed in next Thrombosis group meeting to identify any further potential changes which may improve compliance

Incidents

There was 2 Never Events reported in January 2020:

- INC67875 (2020/903) – Never Event - Interventional Radiology.
- INC67442 (2020/152 – Never Event – Theatres

A further 6 Serious Incidents were reported to STEIS in January 2020:

4 falls resulting in harm (1 in December and 3 in January)

1 unavoidable pressure ulcer

1 in Maternity (Baby was born at 33+2 weeks gestation in poor condition and required transfer to tertiary unit)

% of deaths with priorities of care (8 weeks in arrears)

Trust performance for January is 66%

This is now current data

Moving forward this data will be captured from the GSF log on the hub.as agreed at CQSPE

This will continue to improve when staff improves compliance with using and accessing the GSF log

Safety Thermometer

Patients with harm free care for January is 95.82%.

The Dudley Group NHS Foundation Trust

Executive Summary

EAS Summary

• Improved EAS performance for January in comparison to December. A significant contributing factor in this is the protection of the 8 Rapid Access Bay (RAB) trolleys on AMU which enables those patients who require medical input but not an admission to be moved out of ED.

• The main challenge in January was the number of 12 hour breaches that occurred due to delays of patients accessing a bed. A number of measures have been put in place in February to address this, the main one being the delivery of a reduction in length of stay (LOS) on AMU to ensure increased discharges from this area. a weekly oversight meeting has been put in place with non-executives and executive directors to ensure full oversight is maintained. Emergency Care Improvement Support Team (ECIST) have been contacted and are supporting the trust in the planning of a "Reset" week whereby patient flow processes will be scrutinised and improved in real time to further support flow

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Cancer Performance

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Improving cancer performance requires continued efforts to increase capacity for first appointments (2 week wait), reduction in delays during the diagnostic stages in Imaging, Endoscopy, Surgery etc, and a targeted approach to long waiters to ensure decision makers are progressing pathways towards a definitive treatment or outcome.

Executive Summary

DM01 Validation for January 2020 has been completed and the Trust ended the month at 92.11% with total breaches of 620. The main areas of failure continue to be attributable to both the failure of the Endoscopy Decontamination Unit in September and October 2019, in addition to the ongoing backlog of Cardiac MRI's. In addition, there were a significant number of other MRI breaches (143) due to a now confirmed mismatch between current levels of demand and capacity, as identified via an independent review conducted by PA Consulting, who are supporting Imaging in a number of key areas including a workforce requirements review. The numbers of breaches incurred during January 2020 were also increased due to the focus on 12 hour DTA breach avoidance which resulted in further routine outpatient slots turned over to inpatients and supporting ED flow.

Based on current performance action plans being enacted it is expected that DM01 performance will be circa 94-95% in February 2020 and a return to performance is predicted based on known levels of demand for March 2020.

SURGERY

• RTT performance standard continues to be met, albeit under some pressure. In January the Trust achieved 92.22% against the 92% standard. Although this is level of performance is historically low for Dudley, it remains one of the best levels of RTT performance in the country

• Following a number of operational challenges in January within Theatres there was a significant increase in the number of patients cancelled on the day of the surgery and as a consequence one patient was not readmitted within 28 days. There have been improvements into February in this

• The Trust achieved the RTT standard for January, delivering 92.22% against the national standard of 92%. This performance standard remains a challenge but continues to be delivered. The following specialties remain key in the delivery of improved RTT: General Surgery, Urology and Ophthalmology. Recovery plans are in place with each of these services and continue to be managed weekly. Of particular note, General Surgery is targeting additional theatre capacity in March to improve RT standard before the end of the financial year

WORK FORCE

• Following feedback, the format of reporting has been improved through the use of SPC charts. Further improvements are being made for the March report, including; reflecting the workforce metrics which have been launched by the STP and including a 'key messages' and 'action' narrative.

• Sickness absence has reduced in January from 5.4% to 5.26%, but remains above the Trust's target and above the peer average.

• Capacity issues in Staff Health & Wellbeing have impacted the number of staff seen by the service; whilst there has been a reduction in the number of management referrals, there has been an increase in other interventions, as well as the demand associated with the flu campaign. To support the Trust's health and wellbeing agenda, a service review will take place over the next couple of months, to highlight concerns and make recommendations to improve our ability to support staff and effectively manage absence.

• Whilst intervention from the Learning and Development Team has increased the availability of statutory and mandatory training, the attached report highlights that the Trust is expected to consistently miss the target. Twice-monthly reporting has commenced to support managers/Divisions in addressing local issues. Divisional Directors are due to report their recovery plans and compliance trajectories to Workforce Committee

Patients will experience safe care - "At a glance"

Executive Lead: Mary Sexton

Patients will experience safe care - Quality & Experience

	Target (Amber)	Target (Green)	Dec-19	Jan-20	Financial YTD	Trend	Month Status
Friends & Family Test - Response Rate							
Friends & Family Test - ED	12.3%	19.4%	19.8%	19.0%	19.3%	↓	
Friends & Family Test - Inpatients	26.9%	37.0%	29.8%	27.2%	33.7%	↓	
Friends & Family Test - Maternity - Overall	21.9%	38.0%	22.2%	33.3%	22.9%	↑	
Friends & Family Test - Outpatients	4.9%	11.9%	4.1%	27.2%	5.2%	↑	
Friends & Family Test - Community	3.3%	8.1%	3.1%	4.6%	4.4%	↑	
Friends & Family Test - Percentage Recommended							
Friends & Family Test - ED	88.7%	94.5%	74.7%	76.2%	75.7%	↑	
Friends & Family Test - Inpatients	96.7%	97.4%	94.5%	94.7%	94.8%	↑	
Friends & Family Test - Maternity - Overall	97.1%	98.5%	96.4%	97.9%	97.0%	↑	
Friends & Family Test - Outpatients	95.3%	97.4%	90.0%	90.4%	89.5%	↑	
Friends & Family Test - Community	96.2%	97.7%	90.8%	94.5%	92.7%	↑	
Complaints							
Total no. of complaints received in month	-	-	64	63	582	↓	
Complaints re-opened	-	-	11	12	95	↑	
PALs Numbers	-	-	223	306	2528	↑	
Complaints open at month end	-	-	187	190	-	↑	
Compliments received	-	-	909	543	5353	↓	
Dementia							
Find/Assess	-	90%	71.3%	79.4%	77.5%	↑	
Investigate	-	90%	86.5%	89.5%	77.9%	↑	
Refer	-	90%	99.3%	97.8%	97.3%	↓	
Falls							
No. of Falls	-	-	93	90	755	↓	
No. of Multiple Falls	-	-	13	8	65	↓	
Pressure Ulcers (Grades 3 & 4)							
Hospital	-	-	0	0	3	↔	
Community	-	-	0	0	0	↔	
Handwash							
Handwashing	-	95%	99.7%	99.9%	99.8%	↑	
Mixed Sex Accommodation Breaches							
Single Sex Breaches		0	11	19	114	↑	

Patients will experience safe care - Patient Safety

	Target (Green)	Dec-19	Jan-20	Financial YTD	Trend	Month Status
Mortality (Quality Strategy Goal 3)						
HSMR Rolling 12 months	105	-	115	-		
SHMI Rolling 12 months	1.05	-	1.11	-		
HSMR Year to date (**Not available**)	-	-	-	-		
Infections						
Cumulative C-Diff due to lapses in care	49	1	0	26		
MRSA Bacteraemia	0	0	0	1	↔	
MSSA Bacteraemia	0	2	1	18	↓	
E. Coli	0	3	2	28	↓	
Stroke (1 month in arrears)						
Stroke Admissions: Swallowing Screen	75%	90.5%	-	94.3%	-	
Stroke Patients Spending 90% of Time on Stroke Unit	85%	95.1%	-	94.9%	-	
Suspected High Risk TIAs Assessed and Treated <24hrs	85%	88.9%	-	95.5%	-	
Stroke Admissions to Thrombolysis Time	50%	44.4%	-	53.3%	-	
VTE - Provisional Figures						
VTE On Admission	95%	93.6%	94.2%	94.3%	↑	
Incidents						
Total Incidents	-	1498	1490	14641	↓	
Recorded Medication Incidents	-	357	Missing	3021	↑	
Never Events	-	0	2	3	↑	
Serious Incidents	-	4	6	36	↑	
of which, pressure ulcers	-	0	1	1	↑	
Incident Grading by Degree of Harm						
Death	-	1	1	7	↔	
Severe	-	0	4	15	↑	
Moderate	-	13	12	71	↓	
Low	-	167	211	1528	↑	
No Harm	-	831	924	8988	↑	
Near Miss	-	486	336	4030	↓	
Percentage of incidents causing harm	28%	44.5%	38.0%	15.3%	↓	
Safety Thermometer						
Patients with harm free care (and old harms)	-	95.77%	95.82%	-	↑	

Performance - "At a glance"

Executive Lead: Karen Kelly

The Dudley Group NHS Foundation Trust

Performance - Key Performance Indicators

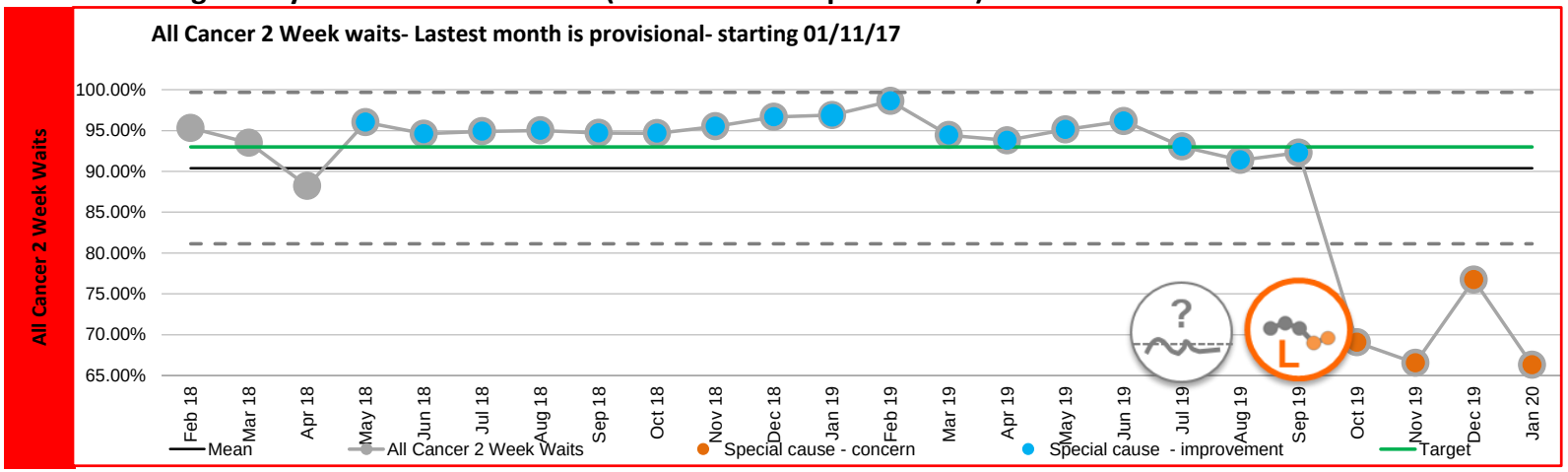
	Target	Dec-19	Jan-20	Actual YTD	Trend	Month Status
Cancer Reporting - TRUST (provisional)						
All Cancer 2 week waits	93%	76.72%	66.3%	84.1%	↓	
2 week wait - Breast Symptomatic	93%	4.7%	9.6%	69.6%	↑	
31 day diagnostic to 1st treatment	96%	98.5%	94.1%	97.8%	↓	
31 day subsequent treatment - Surgery	94%	100.0%	100.0%	97.8%	↔	
31 day subsequent treatment - Drugs	94%	100.0%	100.0%	99.3%	↔	
62 day urgent GP referral to treatment	85%	75.6%	57.0%	79.4%	↓	
62 day screening programme	90%	75.0%	89.5%	93.5%	↑	
62 day consultant upgrades	85%	87.5%	80.6%	91.7%	↓	
Referral to Treatment						
RTT Incomplete Pathways - % still waiting	92%	92.0%	92.2%	93.5%	↑	
RTT Admitted - % treatment within 18 weeks	90%	86.4%	86.2%	87.5%	↓	
RTT Non Admitted - % treatment within 18 weeks	95%	92.7%	90.1%	94.1%	↓	
Wait from referral to 1st OPD	26	23	28	253	↑	
Wait from Add to Waiting List to Removal	39	34	44	382	↑	
ASI List		3104	3107	0	↑	
% Missing Outcomes RTT		0.03%	0.03%	0.1%	↑	
% Missing Outcomes Non-RTT		3.3%	4.3%	4.1%	↑	
DM01						
No. of diagnostic tests waiting over 6 weeks	0	592	620	2269	↑	
% of diagnostic tests waiting less than 6 weeks	99%	92.4%	92.1%	97.0%	↓	
ED - TRUST						
Patients treated < 4 hours Type 1 & 3 (ED + UCC)	95%	78.3%	80.8%	81.7%	↑	
Emergency Department Attendances	N/A	9972	8719	92959	↓	
12 Hours Trolley Waits	0	115	115	291	↔	
Ambulance to ED Handover Time - TRUST						
15-29 minutes breaches		2074	1767	17457	↓	
30-59 minute breaches		638	613	4190	↓	
60+ minute breaches		73	54	392	↓	
Ambulance to Assessment Area Handover Time - TRUST						
30-59 minute breaches		16	16	162	↔	
60+ minute breaches		2	3	22	↑	

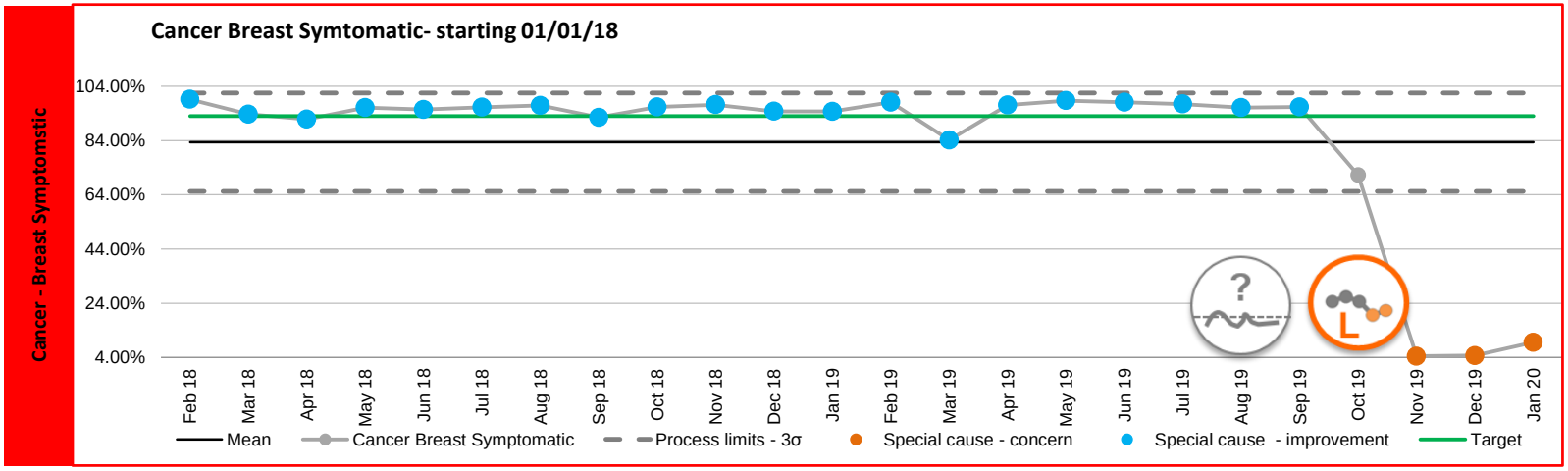
Performance - Key Performance Indicators cont.

	Target	Dec-19	Jan-20	Actual YTD	Trend	Month Status
Cancelled Operations - TRUST						
% Cancelled Operations	1.0%	1.3%	2.6%	1.9%	↑	
Cancelled operations - breaches of 28 day rule	0	0	1	8	↑	
Urgent operations - cancelled twice	0	0	0	0	↔	
GP Discharge Letters						
GP Discharge Letters	90%	92.9%	91.6%	86.6%	↓	
Theatre Utilisation - TRUST						
Theatre Utilisation - Day Case (RHH & Corbett)		75.2%	70.2%	75.0%	↓	
Theatre Utilisation - Main		84.7%	80.9%	85.9%	↓	
Theatre Utilisation - Trauma		88.5%	88.7%	91.6%	↑	
GP Referrals						
GP Written Referrals - made		5671	7054	69031	↑	
GP Written Referrals - seen		5240	6055	58500	↑	
Other Referrals - Made		3812	4547	38097	↑	
Throughput						
Patients Discharged with a LoS >= 7 Days		6.20%	6.10%	6%	↓	
Patients Discharged with a LoS >= 14 Days		2.97%	3.28%	3%	↑	
7 Day Readmissions		4.9%	4.6%	4%	↓	
30 Day Readmissions - PbR		7.9%	8.3%	8%	↑	
Bed Occupancy - %		92%	91%	89%	↓	
Bed Occupancy - % Medicine & IC		96%	94%	93%	↓	
Bed Occupancy - % Surgery, W&C		87%	86.6%	85%	↓	
Bed Occupancy - Paediatric %		87%	71%	58%	↓	
Bed Occupancy - Orthopaedic Elective %		72%	84%	73%	↑	
Bed Occupancy - Trauma and Hip %		96%	97%	94%	↑	
Number of Patient Moves between 8pm and 8am		70	90	822	↑	
Discharged by Midday		12.7%	14.9%	14%	↑	
Outpatients						
New outpatient appointment DNA rate	8%	8.74%	7.17%	7.8%	↓	
Follow-up outpatient appointment DNA rate	8%	7.0%	9.0%	7.9%	↑	
Total outpatient appointment DNA rate	8%	7.6%	8.2%	78.8%	↑	
Clinic Utilisation		79.1%	81.0%	80.3%	↑	
Average Length of stay (Quality Strategy Goal 3)						
Average Length of Stay - Elective	2.4	2.37	2.47	2.8	↑	
Average Length of Stay - Non-Elective	3.4	4.8	4.9	4.8	↑	

Performance Matters (KPIs)

SPC charts-Regulatory Performance - Cancer (Latest month is provisional)

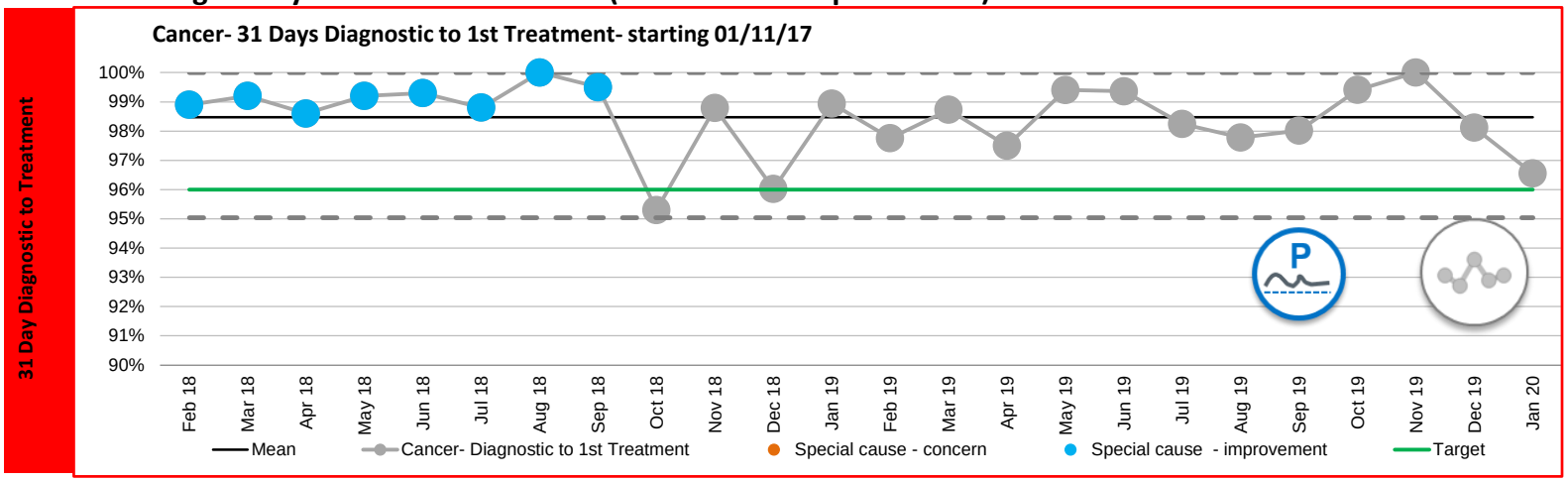


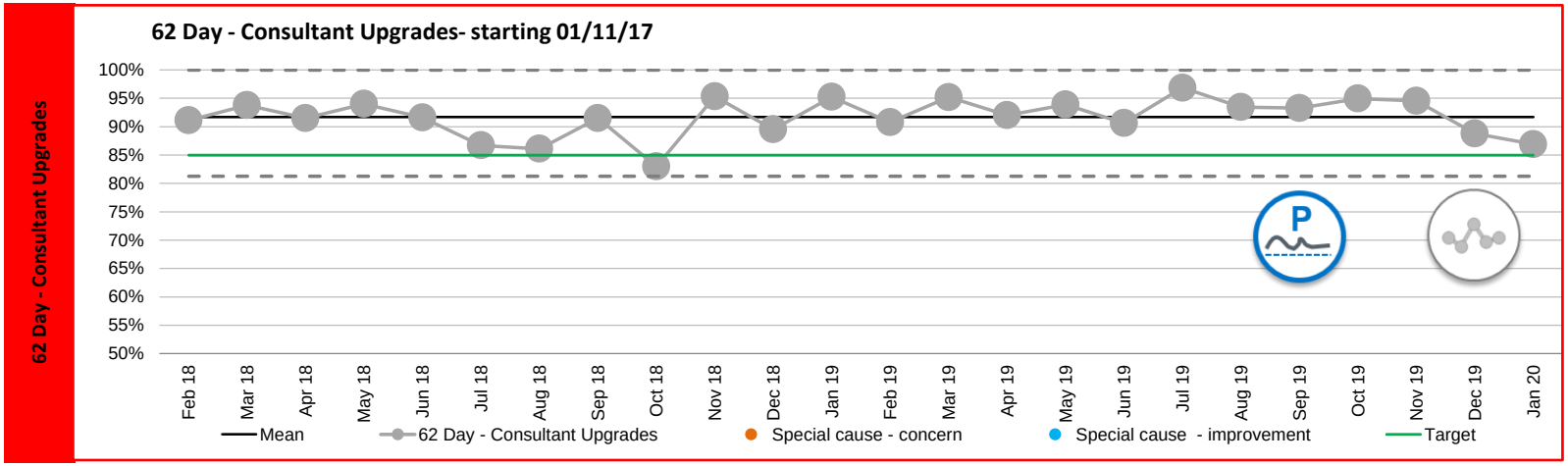


Performance Matters (KPIs)

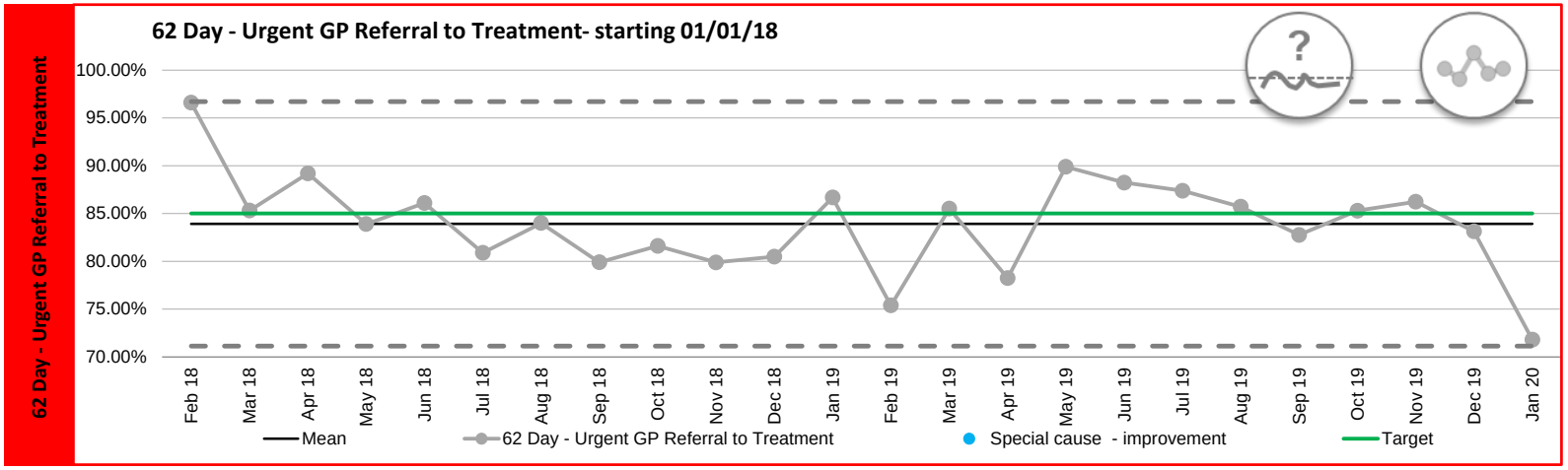
The Dudley Group NHS Foundation Trust

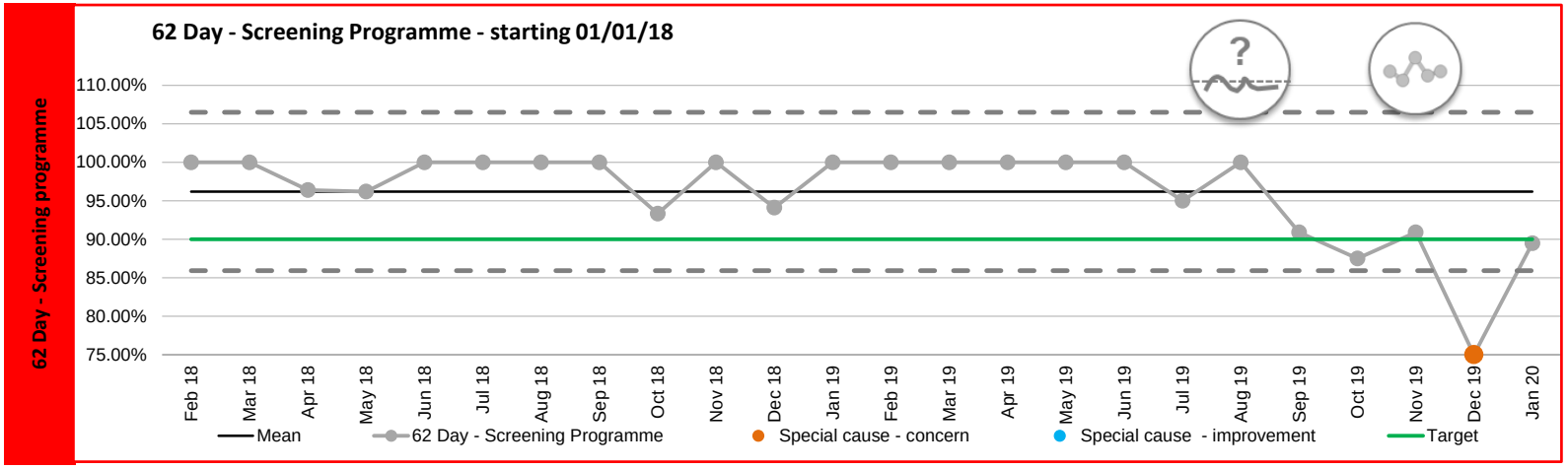
SPC charts-Regulatory Performance - Cancer (Latest month is provisional)





Performance Matters (KPIs)





The Dudley Group NHS Foundation Trust

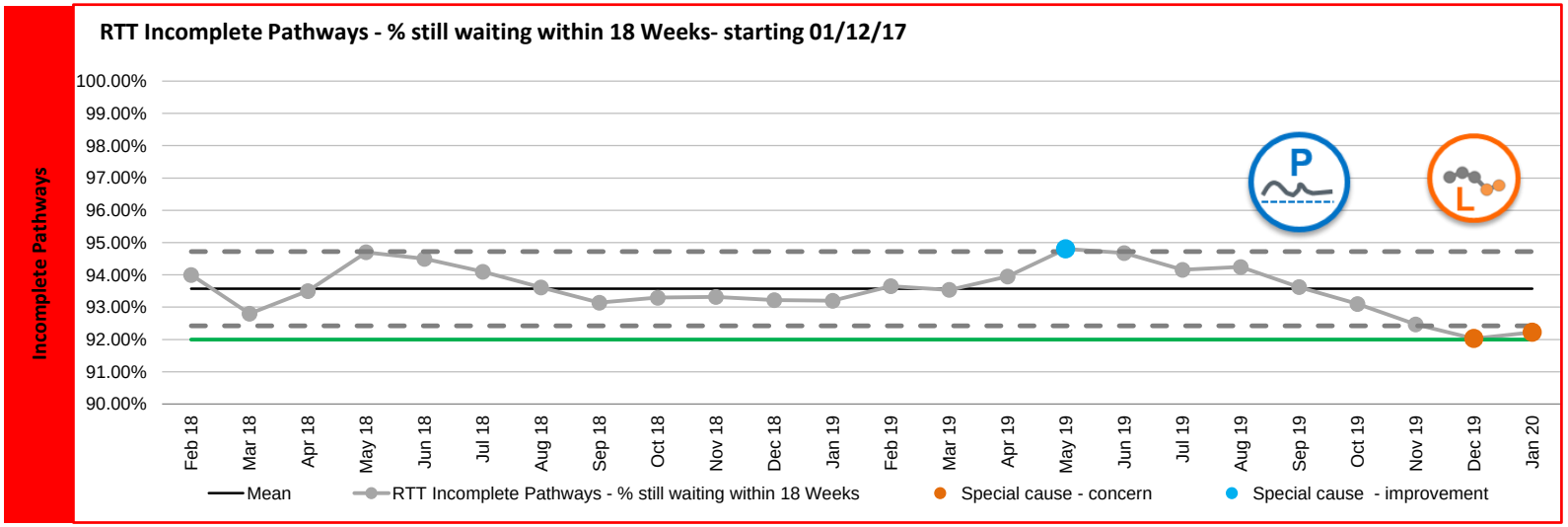
Performance Matters (KPIs)

Regulatory Performance - 18 Week Referral to Treatment

RTT 18 Week Performance - Wl·yδzl·Wè 2019

Validated Position

Specialty	Incompletes - Target 92%			
	<18	>18	Total	%
100 - General Surgery	993	182	1175	84.5%
101 - Urology	1274	184	1458	87.4%
110 - Trauma & Orthopaedics	1501	57	1558	96.3%
120 - ENT	1339	43	1382	96.9%
130 - Ophthalmology	1744	178	1922	90.7%
140 - Oral Surgery	530	73	603	87.9%
160 - Plastic Surgery	758	133	891	85.1%
300 - General Medicine	2	0	2	100.0%
301 - Gastroenterology	1580	134	1714	92.2%
320 - Cardiology	697	12	709	98.3%
330 - Dermatology	1111	160	1271	87.4%
340 - Respiratory Medicine	392	3	395	99.2%
400 - Neurology	585	57	642	91.1%
410 - Rheumatology	668	36	704	94.9%
430 - Geriatric Medicine	131	1	132	99.2%
502 - Gynaecology	1047	68	1115	93.9%
Other	3893	218	4111	94.7%
Total	**18245**	**1539**	**19784**	**92.2%**

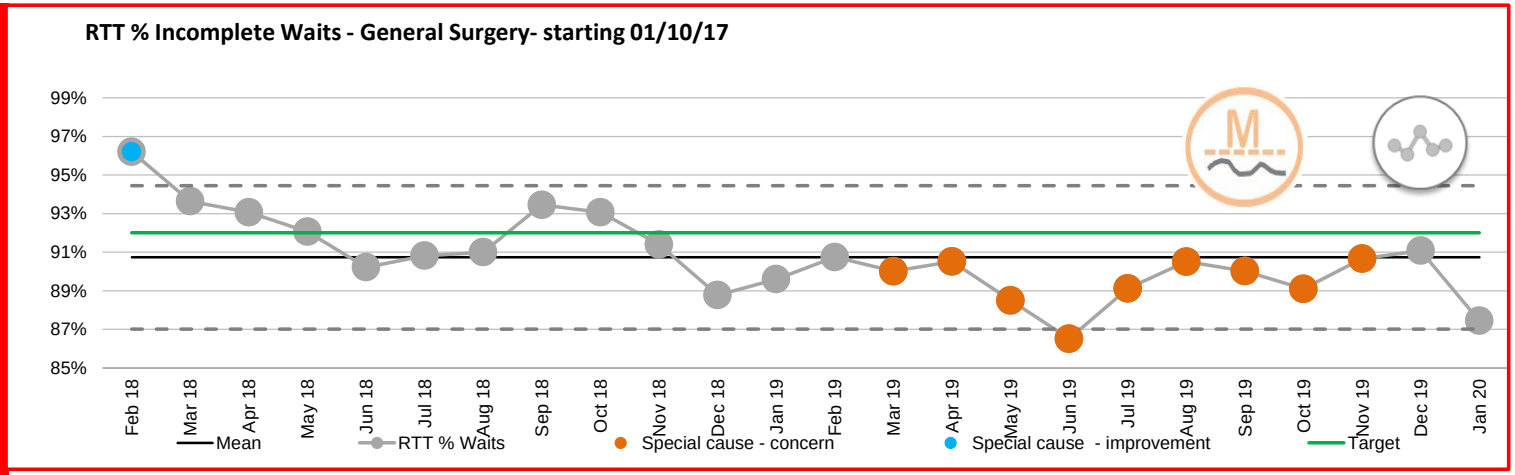


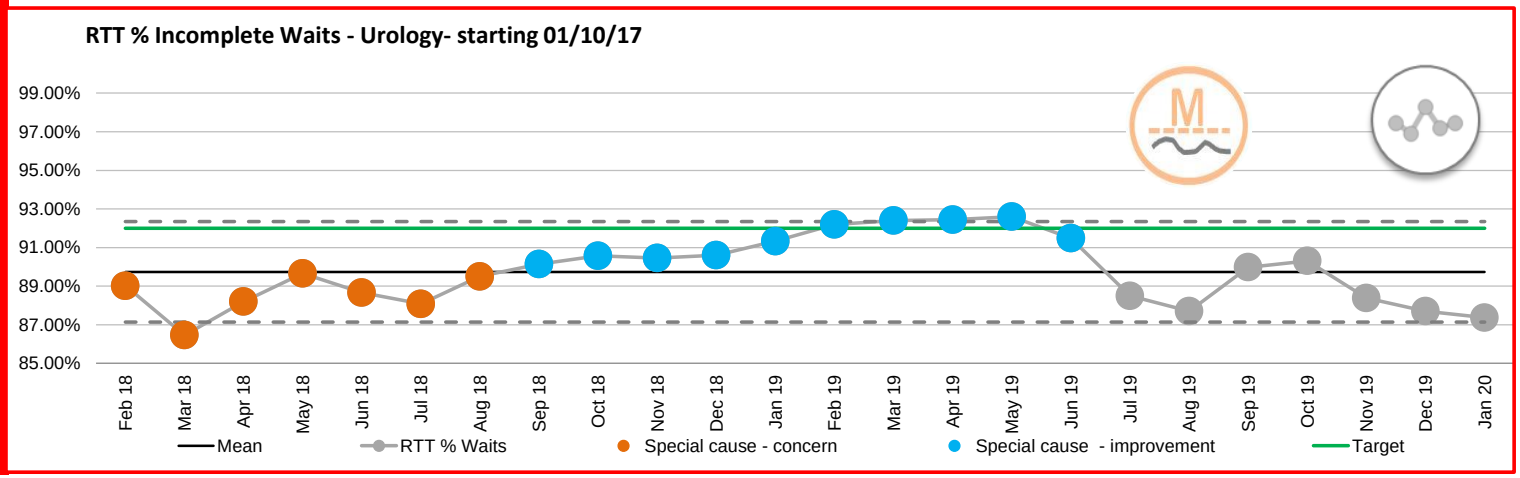
Performance Matters (KPIs)

The Dudley Group NHS Foundation Trust

Regulatory Performance - 18 Week Referral to Treatment

RTT Incomplete - Specialities Missing Target



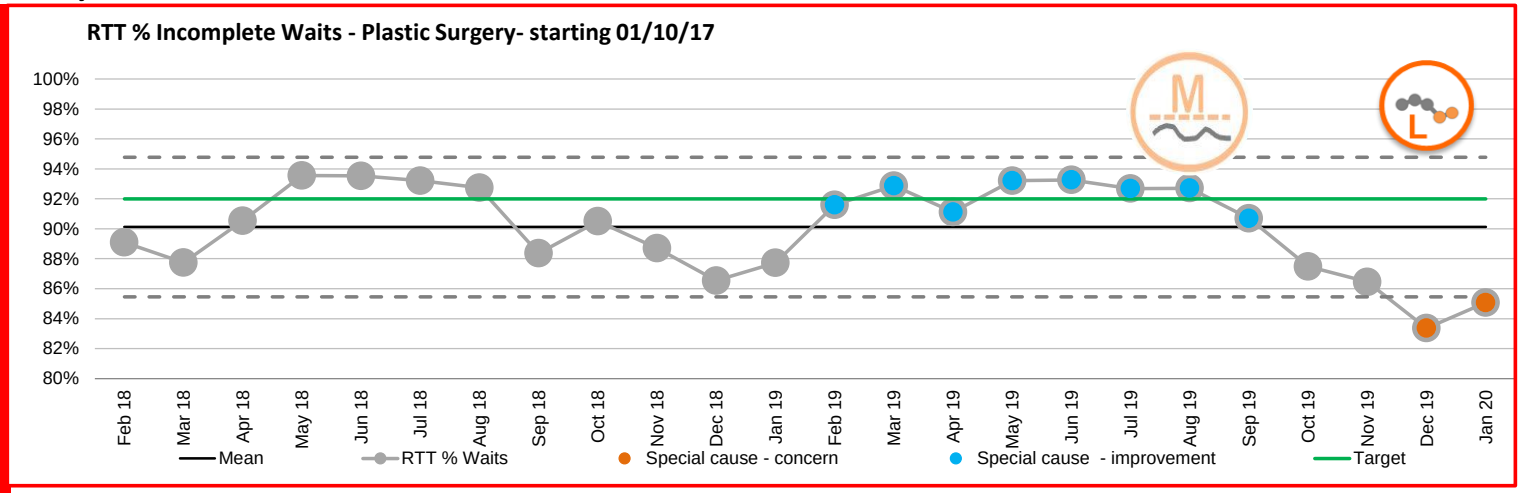


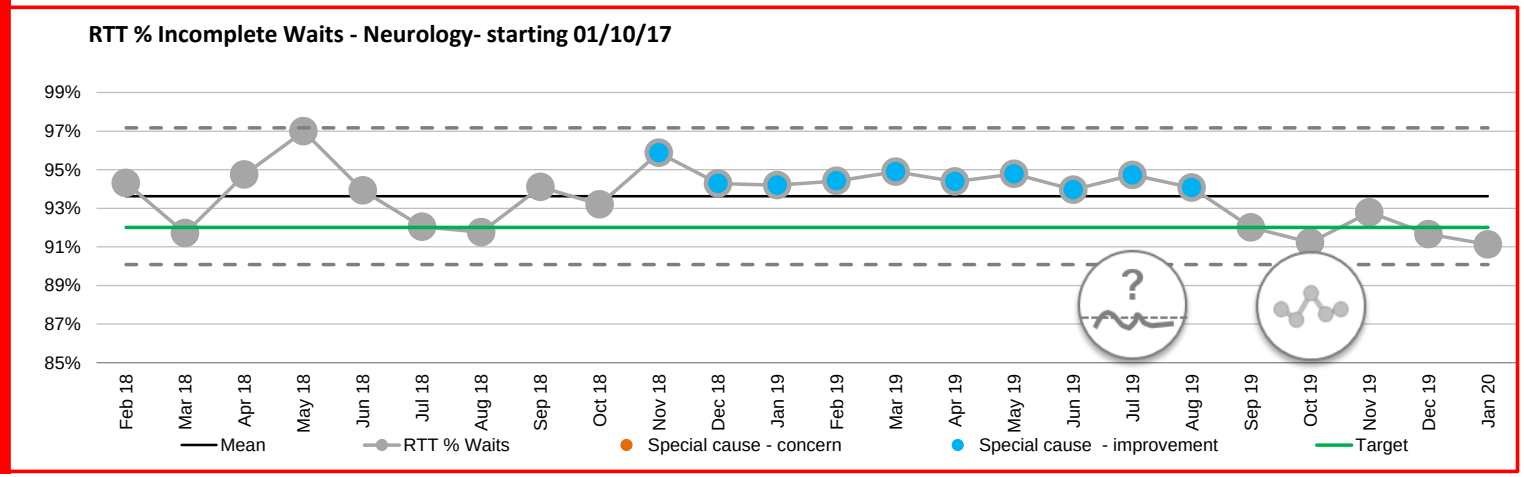
Performance Matters (KPIs)

The Dudley Group NHS Foundation Trust

Regulatory Performance - 18 Week Referral to Treatment

RTT Incomplete - Specialities Missing Target



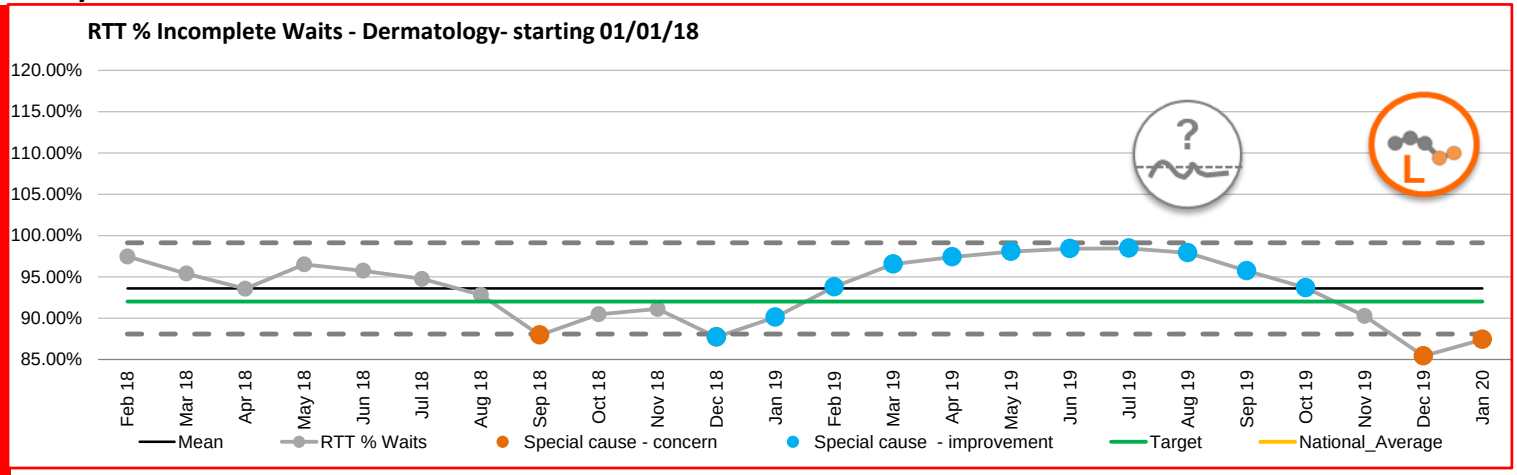


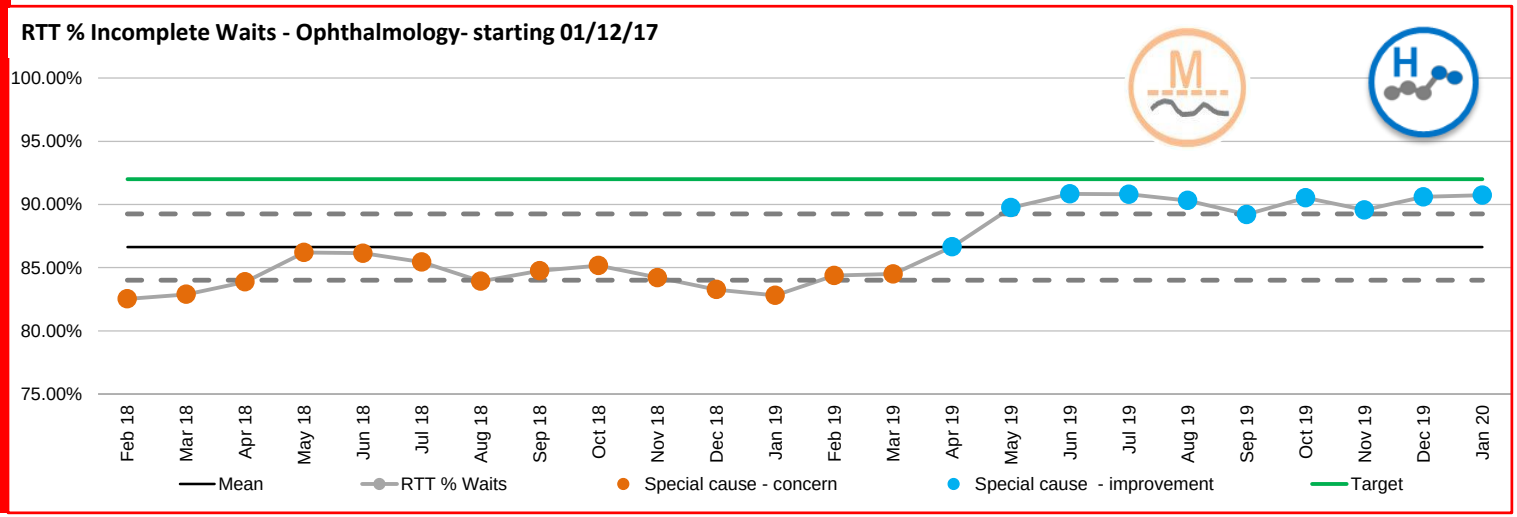
Performance Matters (KPIs)

The Dudley Group NHS Foundation Trust

Regulatory Performance - 18 Week Referral to Treatment

RTT Incomplete - Specialities missing target

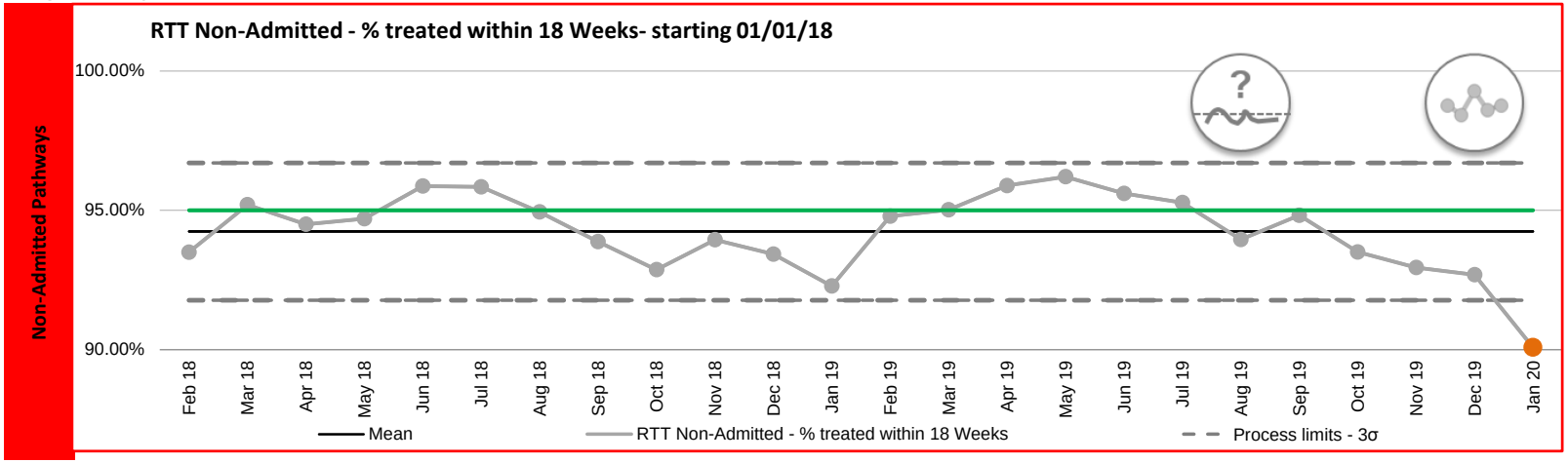


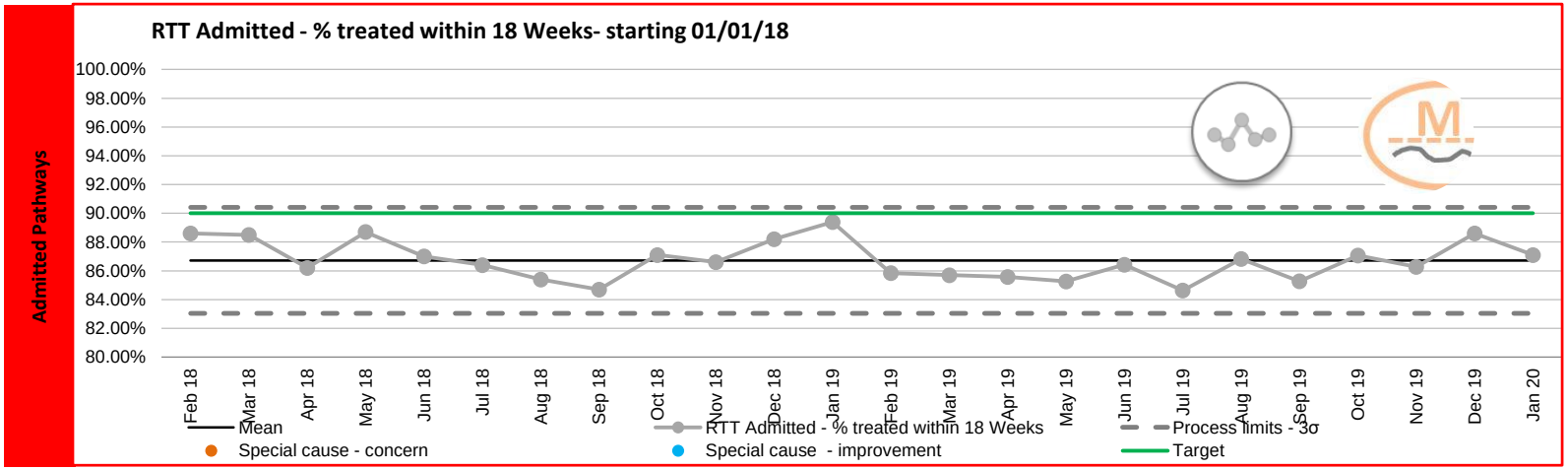


Performance Matters (KPIs)

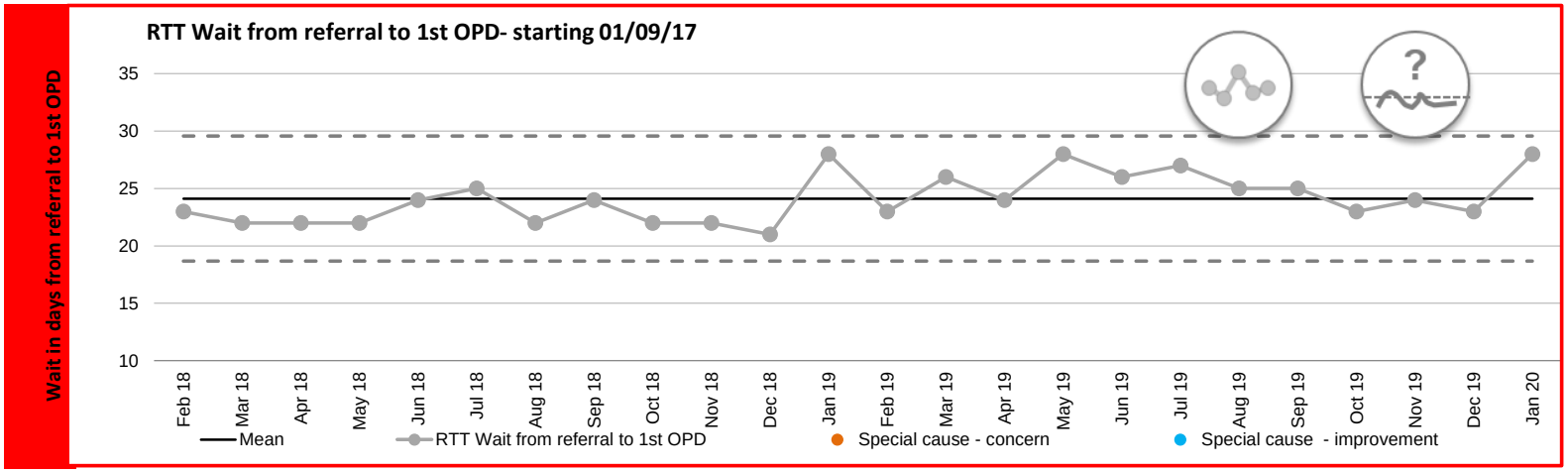
The Dudley Group NHS Foundation Trust

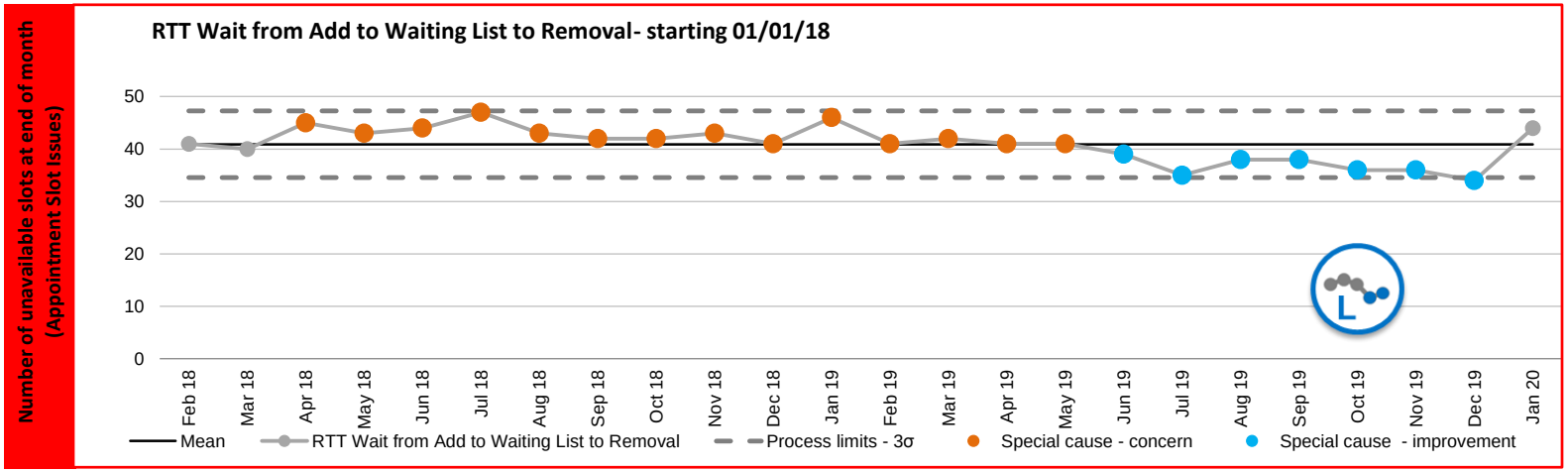
Regulatory Performance



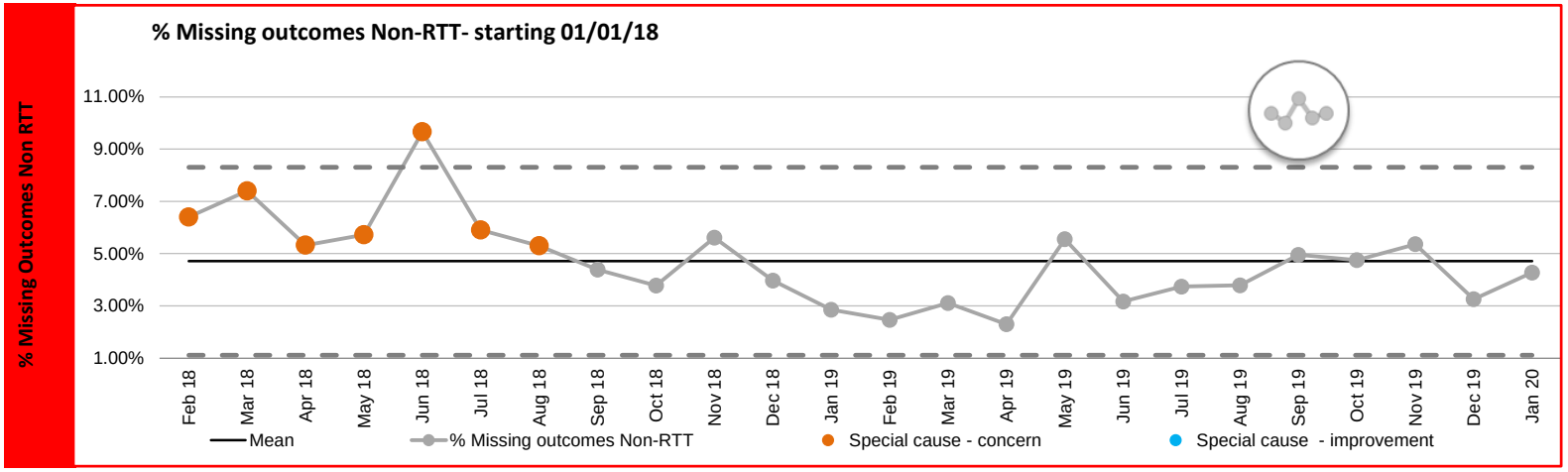


Performance Matters (KPIs)





Performance Matters (KPIs)

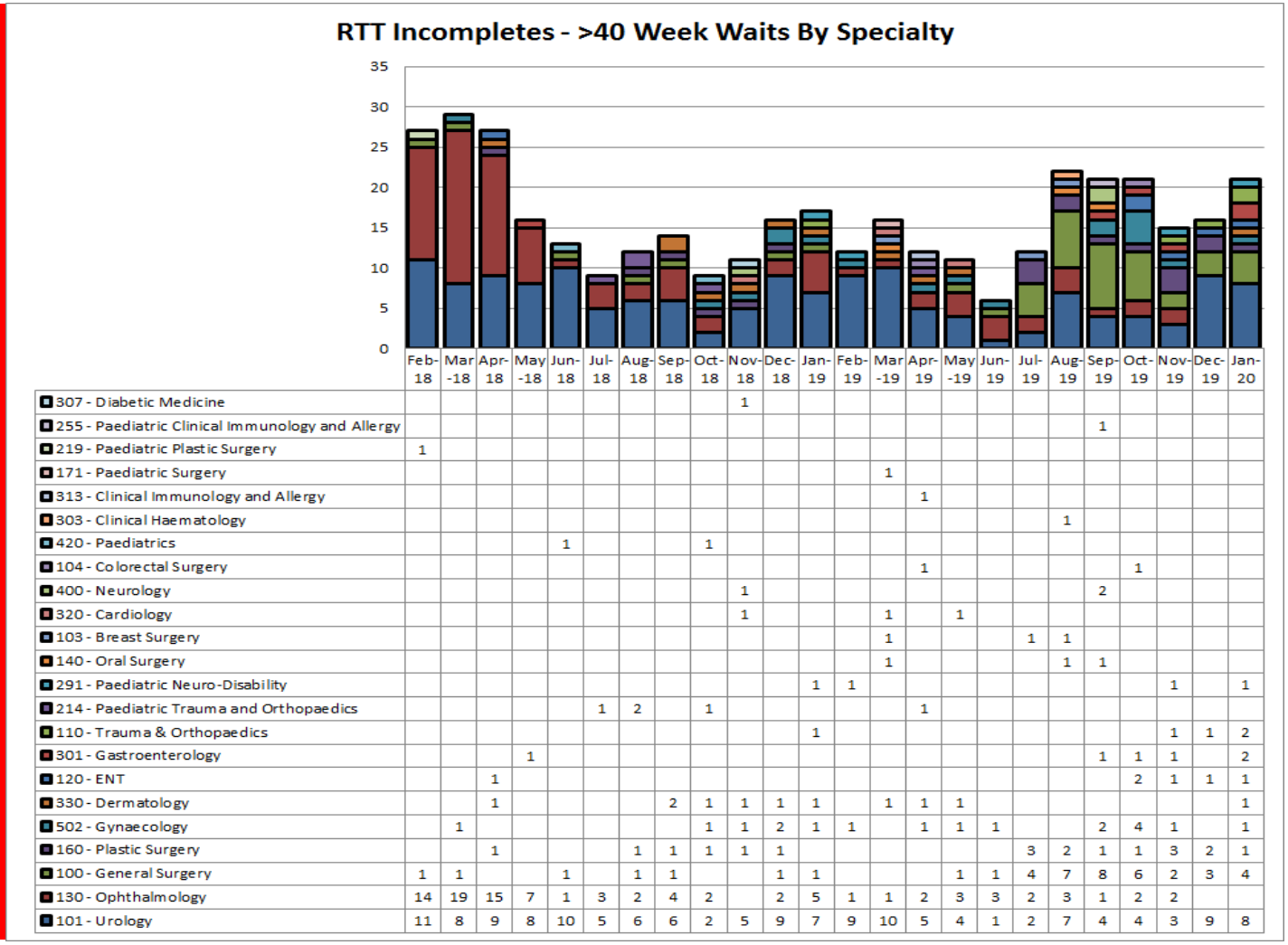


The Dudley Group NHS Foundation Trust

Performance Matters (KPIs)

Regulatory Performance

RTT Incompletes by Specialty

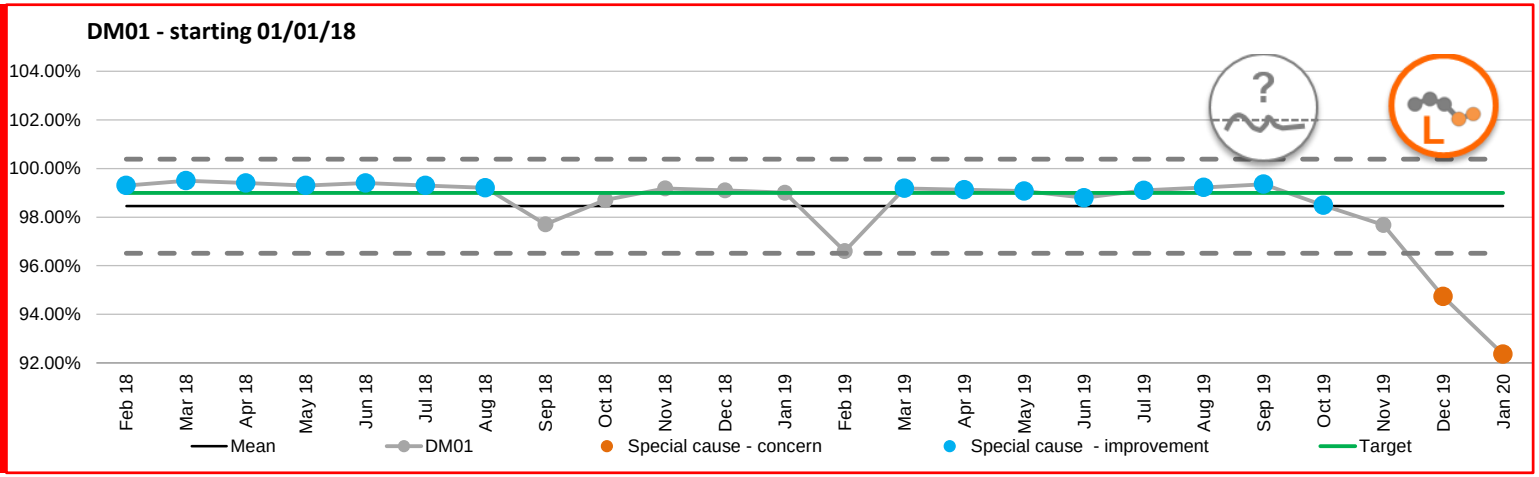


	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20
307 - Diabetic Medicine										1														
255 - Paediatric Clinical Immunology and Allergy																				1				
219 - Paediatric Plastic Surgery	1																							
171 - Paediatric Surgery														1										
313 - Clinical Immunology and Allergy															1									
303 - Clinical Haematology																			1					
420 - Paediatrics					1				1															
104 - Colorectal Surgery															1						1			
400 - Neurology										1										2				
320 - Cardiology										1				1		1								
103 - Breast Surgery														1				1	1					
140 - Oral Surgery														1					1	1				
291 - Paediatric Neuro-Disability												1	1									1		1
214 - Paediatric Trauma and Orthopaedics						1	2		1						1									
110 - Trauma & Orthopaedics												1										1	1	2
301 - Gastroenterology				1																1	1	1		2
120 - ENT			1																		2	1	1	1
330 - Dermatology			1					2	1	1	1	1		1	1	1								1
502 - Gynaecology		1							1	1	2	1	1		1	1	1			2	4	1		1
160 - Plastic Surgery			1				1	1	1	1	1							3	2	1	1	3	2	1
100 - General Surgery	1	1			1		1	1			1	1				1	1	4	7	8	6	2	3	4
130 - Ophthalmology	14	19	15	7	1	3	2	4	2		2	5	1	1	2	3	3	2	3	1	2	2		
101 - Urology	11	8	9	8	10	5	6	6	2	5	9	7	9	10	5	4	1	2	7	4	4	3	9	8

Performance Matters (KPIs)

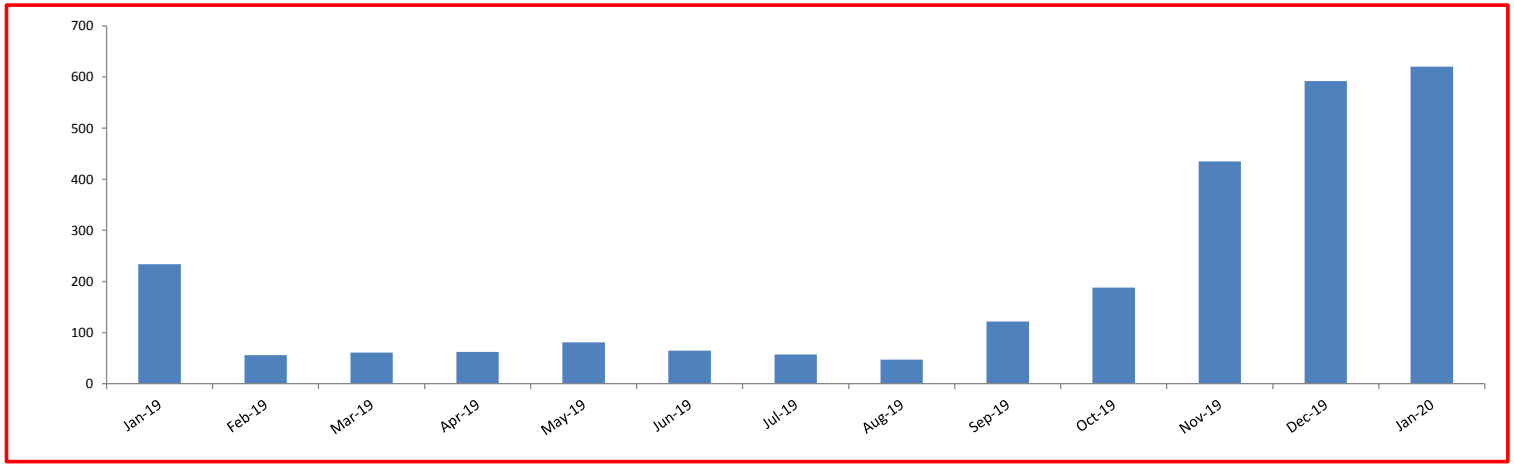
The Dudley Group NHS Foundation Trust

DM01 Performance



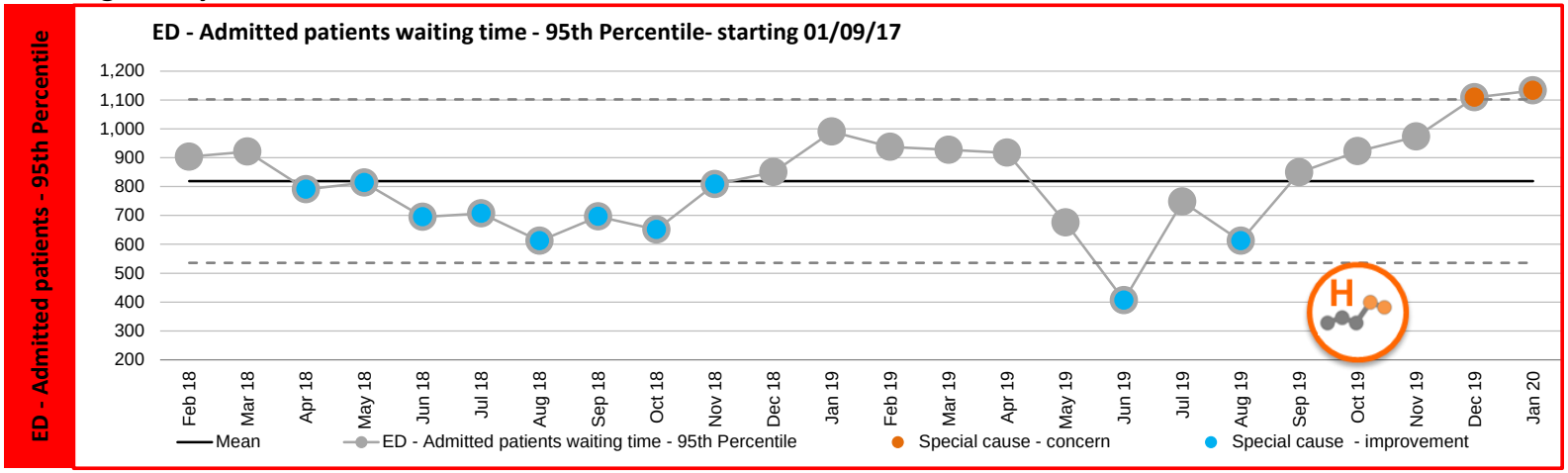
SPC

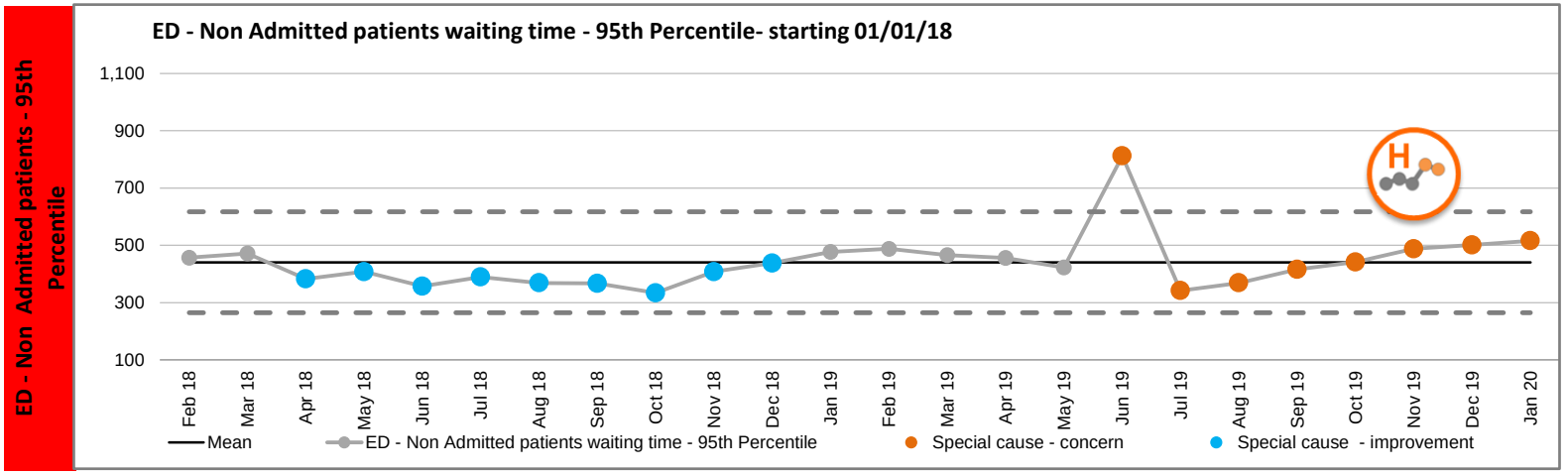
DM01 - Number of patients waiting over 6 weeks at month end (breaches)



Performance Matters (KPIs)

SPC Regulatory Performance - ED

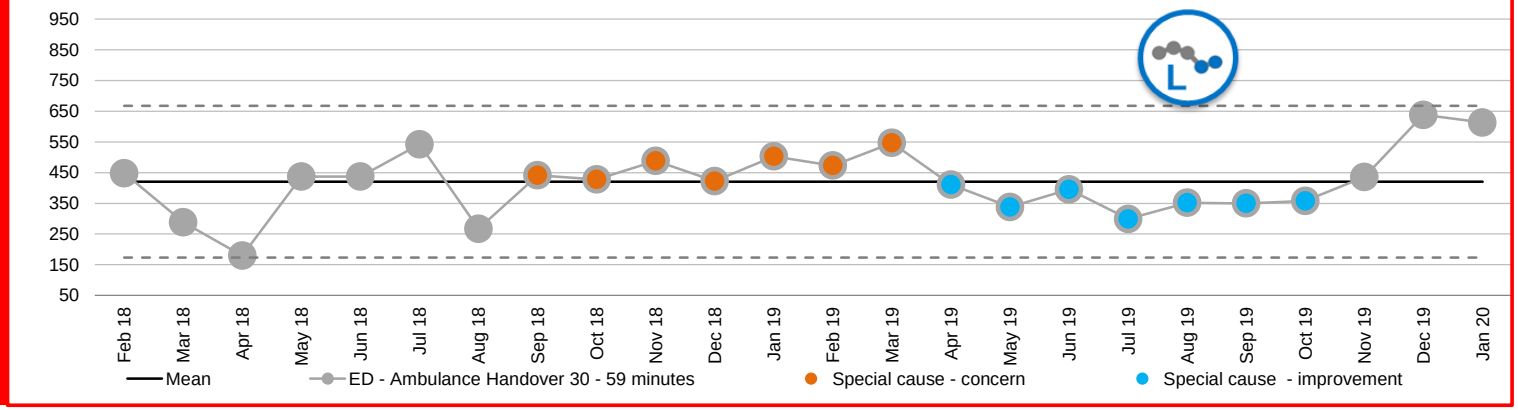




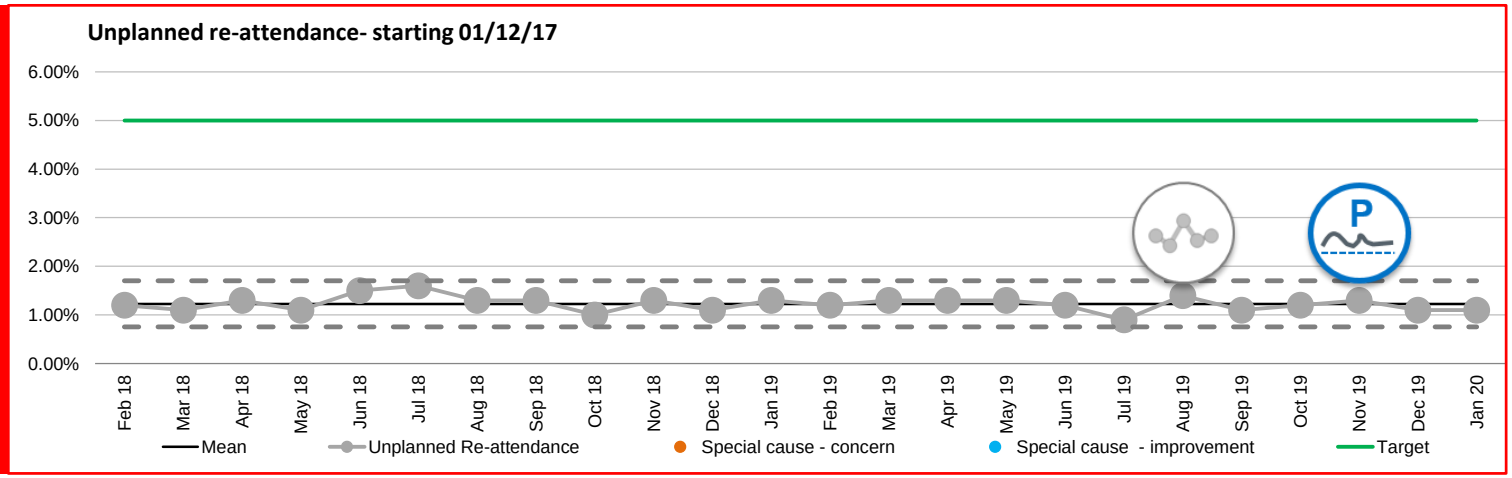
The Dudley Group NHS Foundation Trust

Performance Matters (KPIs)

Ambulance Handover - 30 - 59 mins

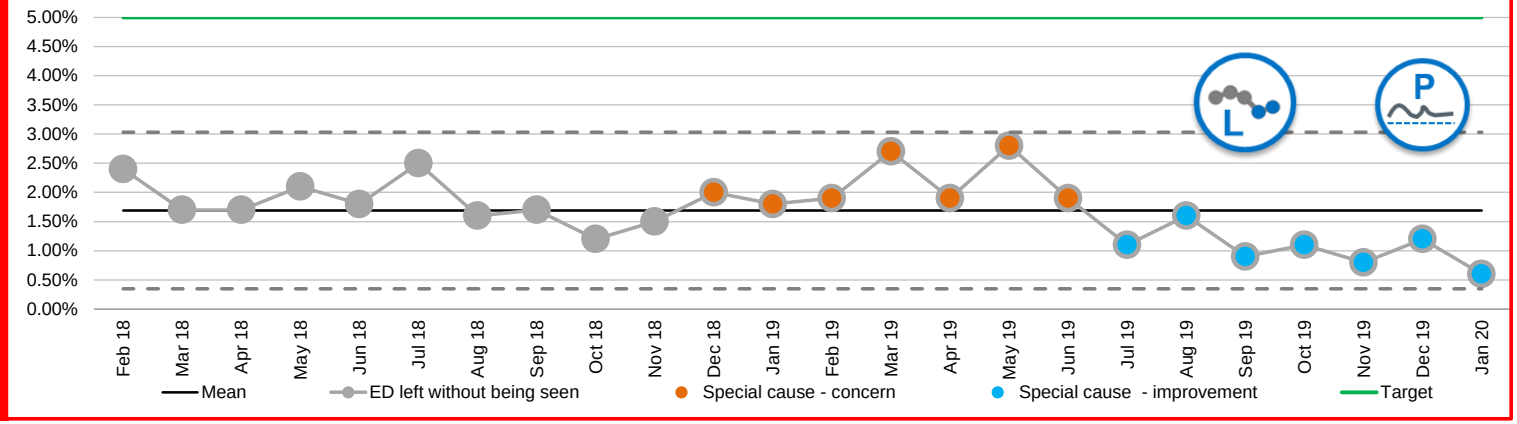


Unplanned Re-attendance

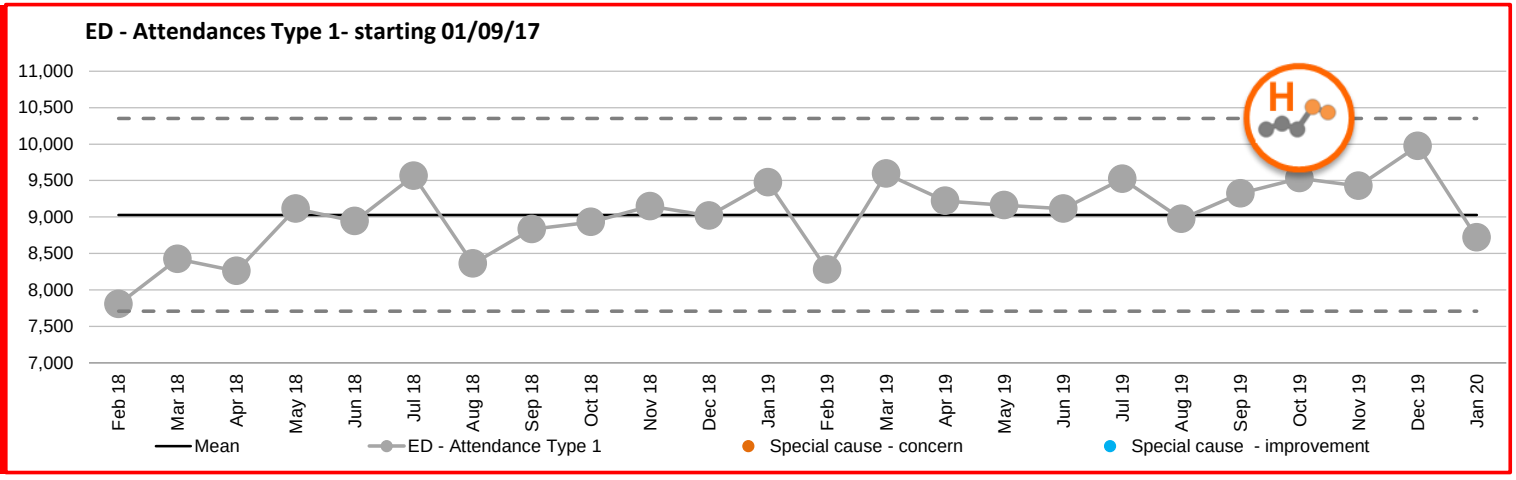


Performance Matters (KPIs)

ED - Left without being seen



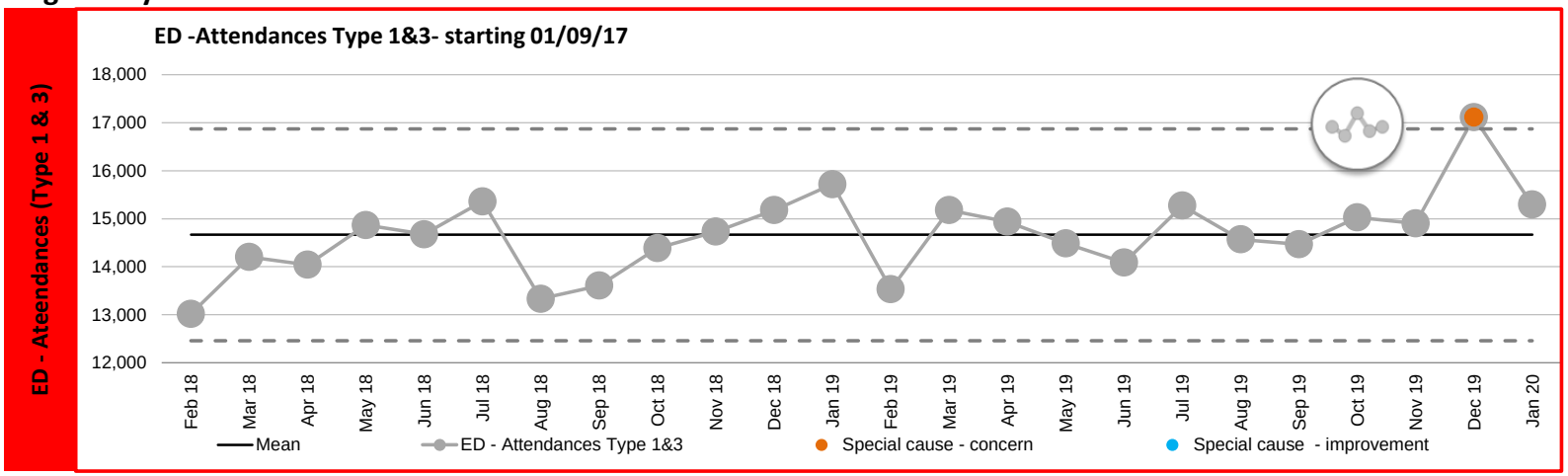
ED - Attendances (Type 1)

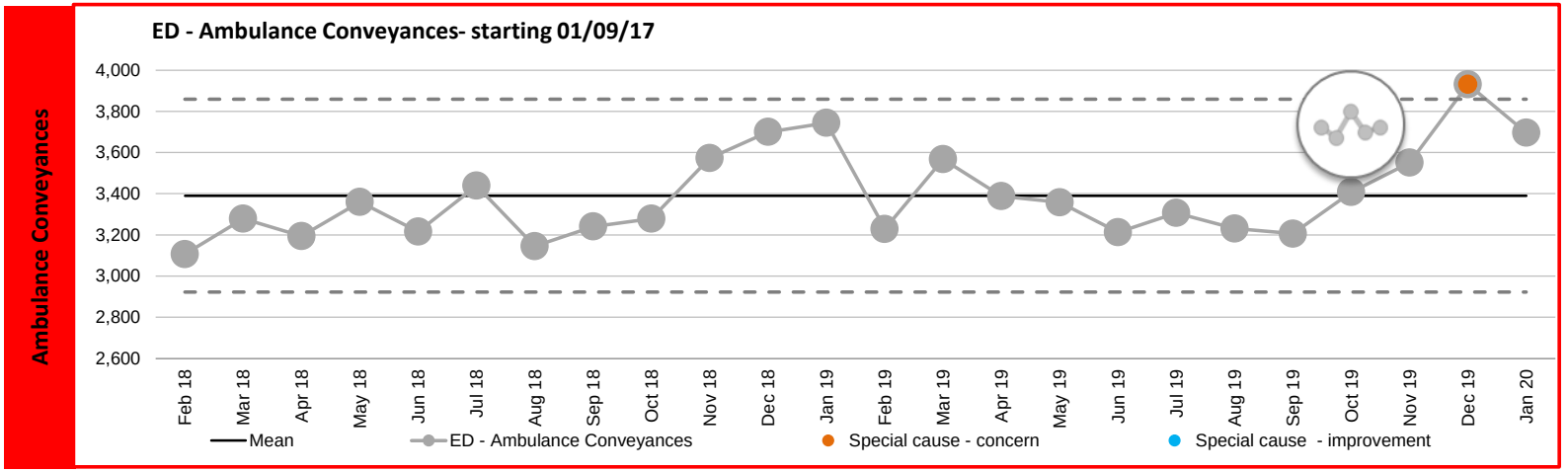


Performance Matters (KPIs)

The Dudley Group NHS Foundation Trust

Regulatory Performance - ED





The Dudley Group NHS Foundation Trust

Workforce - "At a glance"

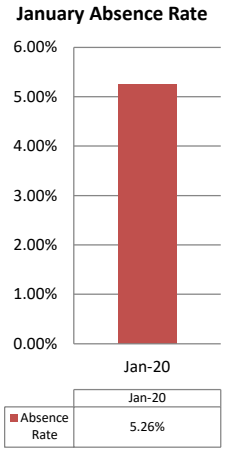
Executive lead:

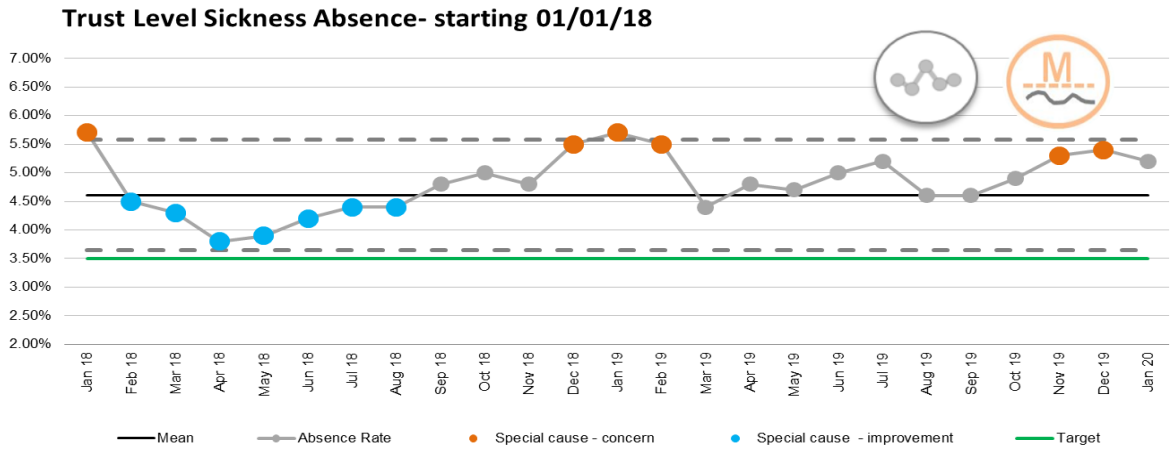
People	Target			Actual		Month
	19/20	Dec-19	Jan-20	YTD	Trend	Status
Workforce						
Sickness Absence Rate	3.50%	4.55%	5.26%	4.98%	↑	
Staff Turnover	8.5%	9.13%	9.13%	8.80%	↔	
Mandatory Training	90.0%	89.5%	89.5%	89.8%	↔	
Appraisal Rates - Total	90.0%	95.5%	95.5%	83.0%	↔	

Workforce Performance

The Dudley Group NHS Foundation Trust

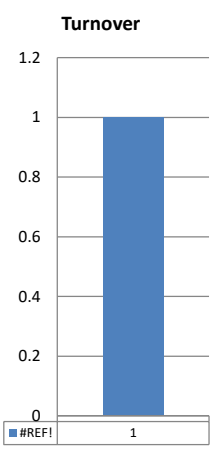
Sickness Absence - Target 3.50%

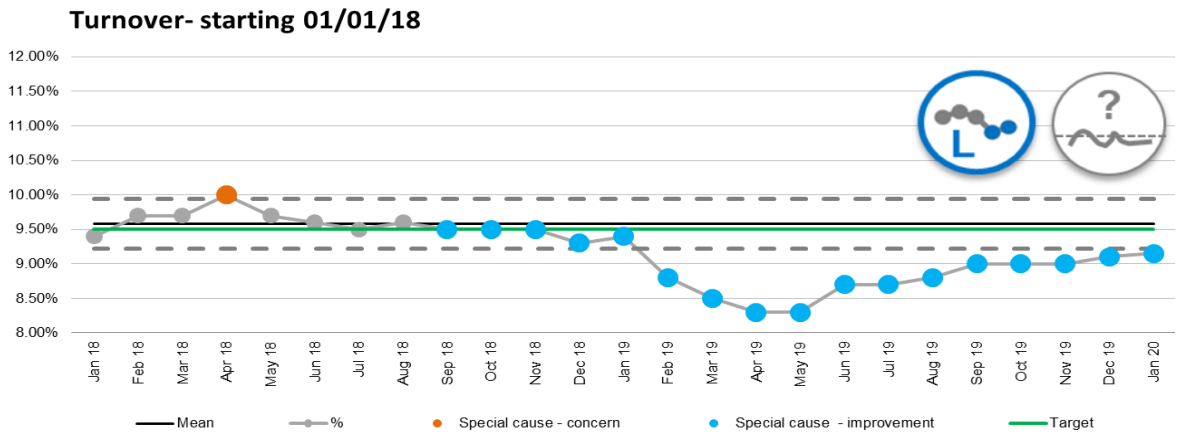




SPC review indicates that the Trust is expected to consistently miss the target. Sickness absence remains relatively constant at 5.26% in January when compared to the previous month. Whilst there have been decreases in the amount of time lost due to stress/anxiety this is still the most common reason (by time lost) for absence. Additionally whilst the amount of time lost due to 'Cough/colds' has decreased slightly the amount of time lost is still high and in addition a there has been an increase in the amount of time lost due to 'chest infections''.

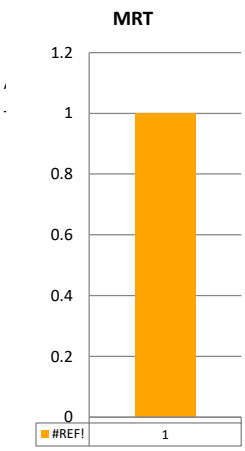
Turnover 8.5%

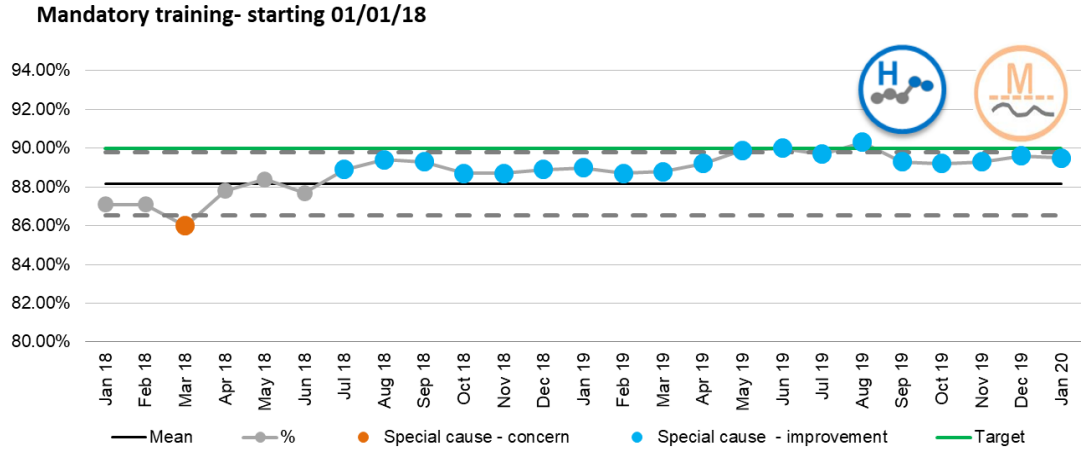




SPC review indicates that the Trust is expected to either achieve or miss the target subject to random variation. There has been a rotation of medical staff in February as well as a number of starters within the Trust Nursing Graduate scheme. These numbers will be reflected in next month (February activity) rerpots.

Mandatory Training - Target 90%





SPC review indicates that the Trust is expected to consistently miss the target. Mandatory Training remains just under the target of 90% with 89.50% performance. There are 21 statutory training subjects of which 18 subject hold either amber or green performance. There are three subjects which presently have red performance and are Resus Adult (75.85%) , Resus Paediatric (77.70%) and Reus Neonatal (76.02%).

Quality Indicators

Heat Map - January 2020

Ward	Patient Safety & Quality																		Clinical Indicators			Patient Experience				Workforce & Safer Staffing					Ward RAG Trend		
	KPI	Environmental Cleaning	Hand-hygiene	MRSA Screening - elective	MRSA Screening - emergency	HCAI CDIFF - due to lapses in care	Saving Lives - 02b peripheral lines	Saving Lives - 06b urinary catheter	Datix Incidents reported	Falls, Injuries or Accidents	Pressure Ulcers - Grade 3/4	Serious Incidents	Never Events	Nutrition Audit	Pain Score	Medicines Management Audit	% of Deaths with Priorities of Care with GSF	Fluid Balance Management Audit	VTE Assessment Indicator	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			N/A					98	0		1												2	2						-3	-1	1
B1				N/A				15	4		1												1	2						0	-1	2
B2 Hip								20	4														1	17						1	1	-2
B2 Trauma								6	5		2												0	1						0	-1	1
B3								29	8														0	0						-2	1	1
B4			N/A					31	9														2	1						-3	-3	6
B5			N/A					14	1					N/D	N/D								1	1						0	1	1
C1								19	4														1	46						-4	2	1
C2			N/A	N/A	N/A		N/A	48	1														2	0						1	2	-3
C3			N/A					15	0														0	21						0	0	-1
C4								11	1											N/D			0	38						-1	1	1
C5								22	3														1	0						-2	1	1
C6								10	2														1	1						-5	0	3
C7			N/A					32	9														6	10						-1	1	0
C8			N/A					29	19		1									N/D			1	24						1	2	-3
CCU & PCCU			N/A					15	3														1	0						-1	-2	1
Critical Care			N/A					44	1														1	8						0	1	1
Maternity			N/A	N/A				88	0		1		N/A					N/A		N/A			3	9						1	0	0
MHDU								30	0														1	17						-2	0	2
Neonatal			N/A	N/A	N/A		N/A	18	N/A											N/A			0	32						-1	1	1
Trust Total	93%	100%	97.80%	92.10%		97%	99%	1490	109		6	2	96.30%	92.50%	95.50%	29%	97%	94.20%	97.50%				63	543	95%	89.50%						
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%			

Enclosure 25

The Dudley Group
NHS Foundation Trust

Paper for submission to the Board of Directors (public session) on Thursday 12th March

TITLE:	**Summary of Workforce and Staff Engagement Committee meeting on Tuesday 25th February 2020**		
AUTHOR:	**Julian Atkins**	**PRESENTER**	**Julian Atkins**

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**	

RECOMMENDATIONS

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

CORPORATE OBJECTIVE:

SO3:Drive service improvement, 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:

As detailed in the paper.

IMPLICATIONS OF PAPER:

IMPLICATIONS FOR THE CORPORATE RISK REGISTER OR BOARD ASSURANCE FRAMEWORK

RISK	**Y**		**Risk Description:**
	Risk Register: Y		**Risk Score:**
COMPLIANCE and/or LEGAL REQUIREMENTS	**CQC**	**Y**	**Details: Well led**
	NHSI	**Y**	**Details:** Annual Business Planning Process
	Other	**N**	**Details:**
REPORT DESTINATION	**EXECUTIVE**	**Y/N**	**DATE:**

	DIRECTORS		
	WORKING GROUP	**Y/N**	**DATE:**
	COMMITTEE	**Y/N**	**DATE:**

The Dudley Group NHS Foundation Trust

CHAIRS LOG

UPWARD REPORT FROM WORKFORCE & STAFF ENGAGEMENT COMMITTEE - Date Committee last met: 25th February 2020

MATTERS OF CONCERN OR KEY RISKS TO ESCALATE

- Whist the **staff survey** results highlight some areas of improvement, the Committee highlighted some clear messages regarding the way that staff feel about, and experience their working lives.
- The Committee heard that the Trust's **occupational health service** has significant delays in access to medical management referrals (average waiting time for an employee to see the Staff Health and Wellbeing Doctor is two months). There was also a broader discussion regarding the limited nature of the existing occupational health provision, including the lack of well-being services. The Interim Director of Strategy & Transformation is undertaking a compete review of the OH service and presenting recommendations and a plan for improving the service and its impact of supporting staff to stay at work and return to work.
- The Committee noted an increase in the **BAF risk score** from 12 to 16 for 4A 'Be the place people choose to work', to reflect staff survey results and other key indicators. A more substantial set of actions have been assigned to the key risks.

MAJOR ACTIONS COMMISSIONED/WORK UNDERWAY

- Based on a paper summarising the Trusts current position relating to **equality and inclusion** activity, the Trust's equality and inclusion work programme will be re-launched and re-energised. There has been limited activity and/or success promoting equality and inclusion during the past 12 months, furthermore the commitments within the Trusts People Plan (domain 3; Equality, Fairness & Inclusion) have not been delivered. A detailed work plan will be developed, in partnership with staff side colleagues and presented to the Committee in May.
- A campaign of active engagement with staff and staff side organisations is being launched to co-develop **staff survey improvement plans**. This work is being led by the Trust CEO and Interim Director of Strategy & Transformation, working closely with Divisions and includes a series of CEO staff survey roadshows and visits to areas which have produced poor staff engagement results. Other action includes; a joint statement of commitment to staff engagement by the CEO and staff side lead, detailed updates published on hub and also the introduction of regular pulse surveys for all staff to capture real-time feedback on how staff are feeling across the Trust.

POSITIVE ASSURANCES TO PROVIDE

- A significant level of work has been undertaken by the Training Team and Divisions to improve the level of **mandatory training compliance**. Surgery Medicine and CSS Divisions all articulated clear recovery plans/trajectories. Andrew Boswell and the training team have provided additional training capacity to increase the number of individuals being trained.
- Positive progress has been made on rolling-out **medical e-rostering** (Medirota) across the Trust. All staff are due to be on the system by June and 'live' by August. The Dudley Group are the first Trust to undertake a full roll-out within Medicine.
- The Trust has enrolled onto the **Stonewall Diversity programme** and will

DECISIONS MADE

- Committee members discussed and agreed that a competency framework and associated **line manager's accreditation** programme is required to build greater line management capacity, capability, core skills and competencies. This work will report back to the Committee in May. This will include a detailed plan and trajectory for roll-out to all line managers, with resource/cost implications.
- A review will be undertaken to establish how effectively **nurse rostering** has been embedded in wards across the Trust. This work will also include developing a plan for rolling out e-rostering/safe-care to community nursing and also AHP's. The Interim Director of Strategy & Chief Nurse will lead this work.

be working closely with Stonewall to launch an active LGBT+ inclusion network. • A **workforce transformation programme** has been launched with HEE, to develop and introduce new ways of working, new workforce models and new roles for multi-professional staff groups. Karen Lewis will be the SRO (Deputy Chief AHP) for this work. Further regular updates will be provided to the Workforce Committee. • The Committee was pleased to receive the **workforce KPI report**, presented in-part in the form of SPC charts. Further improvements are being made to the report, including the addition of trajectories, key messages and action narrative.	• The workforce transformation work streams will report into the Committee on a regular and rotating basis. .

Chair's comments on the effectiveness of the meeting:

This month's meeting was again well attended and had full Divisional representation. The new style agenda, aligned to the domains of the Dudley People Plan, worked well, as did the strategic workforce transformation updates. The quality of papers has improved and it was encouraging to get some assurance on the work that has been undertaken to improve mandatory training compliance, which has been an area of significant concern in previous meetings.
I will be working with the Interim Director of Strategy & Transformation to improve the flow and format of the meeting, through streamlining the agenda and the core attendees.

The Dudley Gr
NHS Foundation Trust

Enclosure 26

Paper for submission to the Board on the 12th March 2020

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

CORPORATE OBJECTIVES:

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

The report covers the following elements:

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

IMPLICATIONS OF PAPER:

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

ACTION REQUIRED OF BOARD

Decision	Approval	Discussion	Other
			Y

RECOMMENDATIONS FOR THE BOARD

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

The Dudley Group NHS
NHS Foundation Trust

Board of Directors

Guardian of Safe Working Report
March 2020

Purpose

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

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

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

Background and Links to Previous Papers

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

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

This is the 13th GSW report and covers the period from 21st November 2019 – 25th February 2020. The Guardian has been working closely with colleagues from medical staffing and rostering, post graduate medical education staff, human resources and finance to establish his role in the Trust and build relationships.

Challenges

<u>Engagement</u>

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

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

how to make exception reports.

- Regular communication to junior doctors through emails
- Using Trust HUB to advertise important information to junior doctors
- Holding regular monthly one to one meeting with Junior doctors representative

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

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

Resilience / Wellbeing Lead Role

The role of resilience / wellbeing lead for the junior doctors was highlighted in the GSW Board report of April 2019.This initiative has been adopted by other neighbouring Trusts now. Recently the Chair has discussed the potential of such a role in the Trust with the Guardian. It will also provide leadership opportunity to aspiring junior doctors for future guardian role.

Induction Pack for Junior Doctors

Guardian office and Medical Workforce created a detailed induction pack for junior doctors. It was done based on the feedback from the juniors. This pack contains all the relevant documents, contact information, process of exception reporting in the Trust and any other relevant information.

Exception Reports by Department – From 21st November 2019 – 25th February 2020 total = 19

Number of exceptions carried over	Number of exceptions raised	Number of exceptions closed	Number of exceptions outstanding	Specialty
0	19	18	1 - pending	11 - Diabetes and endocrine 2 – gen med 3 – geriatric medicine 1 – gen surg 2 - gastro

Exception Reports by Grade

Grade	Addressed within 48 hours	Addressed within 7 days	Addressed in longer than 7 days	Still open –
13 – FY1 4 – FY2 2 – ST1	5	11	2 –due to doctor submitting late	1 - pending

Exception Reports and Fines.

- 19 exception reports by doctors
- 1 immediate safety concern was incorrectly flagged and addressed within a few hours.
- 1 exception reports agreed as compensation overtime payment
- 1 pending
- 5 exception reports agreed as time in lieu
- 7 exception reports agreed as no further action
- No fines during this period
- 5 exception reports outcome “work schedule review”

High level data

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

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

Gaps as at May 2019

Speciality / Grade	**FY1**	**FY2**	**ST 1-2, GPVTS**	**ST 3-8**	**Total**
Cardiology					0
AMU				1	1
Diabetes					0
Dermatology					0
Elderly Care				1	1
EAU					0
Gastro			1		1
ED			1	1	2
Renal					0

General Surgery			1		1
ENT			1		1
Vascular Surgery					0
Haematology					0
T & O					0
Obs & Gynae			1		1
Paeds			1		1
Pathology					0
Radiology					0
Respiratory			1		1
Rheumatology					0
Stroke					0
Urology					0
Ophthalmology					0
Oral/ Max Fax					0
Anaesthetics					0
Total	**0**	**0**	**7**	**3**	**10**

Next Steps

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

1. Conclusion

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

2. Recommendation

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

Author	**Babar Elahi** **Guardian of Safe Working**
Executive Lead	**Chief Executive**
Date	**01/03/2020**

Enclosure 27

BMA

Caring, supportive, collaborative

Doctors' vision for change in the NHS

Interim report prepared for ARM 2019

Caring, supportive, collaborative <> a future vision for the NHS

Foreword from Dr Chaand Nagpaul

'What needs to change to improve the working lives of doctors in the NHS?'

This is the question I asked when we launched the *Caring, supportive, collaborative* project in early 2018. I issued a call to our members to share their experiences, views – and critically, solutions – for a new blueprint for the NHS; one that is underpinned by adequate funding and terms and conditions for doctors. One that puts a caring and supportive culture, collaborative working and high-quality patient care at its centre.

As the only medical organisation that represents doctors and students from across the entire breadth of the profession and with access to the experiences of over 150,000 members working in today's health service, we are uniquely placed to influence government and policy-makers with proposals that reflect the true voice of doctors.

Our backdrop is a health service that is grossly underfunded, under-doctored and under-bedded. Doctors feel that they are increasingly expected to treat patients in an unsafe, unsupportive environment, in which a persistent culture of fear and blame stifles learning. This is contributing to a vicious cycle of low morale and poor rates of recruitment and retention, resulting in endemic workforce shortages.

These were the findings from the BMA's all-member survey, published in September 2018, of the views of almost 8,000 doctors working across the health service:

- nine in 10 doctors say they work in an environment in which they are fearful that systemic pressures and lack of capacity will cause them to make an error
- even worse, more than half of doctors worry that they might be unfairly blamed for such an error and, as a result, nearly 50% say they practise defensively
- 60% of doctors surveyed say the quality and safety of patient care is compromised as a result of problems and barriers between primary and secondary care – and yet over nine in 10 doctors in England want GPs and hospital doctors to work more collaboratively and in a coordinated manner.

These results provided the basis for consultative workshops with BMA members across the UK; from Plymouth to Newcastle, Leeds to Birmingham, Cardiff, Edinburgh and Belfast, we asked doctors to help us develop innovative solutions to the key issues facing our health systems. I would like to thank all elected and grassroots members who participated in our events. This report is a culmination of that work.

The report – and project – covers three core themes. To describe:

- an NHS that has a **culture** that is not rooted in blame but supports and encourages learning and improvement, and that is inclusive, with equality of opportunity and reward
- an NHS that has the right organisational systems in place to support **collaboration** across the interface between different settings, and where taxpayers' money is spent on delivering patient care – not squandered on transaction costs, fragmentation and bureaucracy
- an NHS that values its **workforce** and supports doctors to be able to work safely at the top of their licence, with the right skill mix to support doctors to meet the changing needs of patients.

These ideas are just the beginning of our aim to set out clear, ambitious proposals for change in the health service. Drawing on the excellent work that has already begun through the BMA's current campaigns – such as safe staffing and bullying and harassment – we will use this report to support our call for better working conditions for doctors, establishing a roadmap to an NHS that is truly caring, supportive and collaborative.

Dr Chaand Nagpaul, chair of council

Executive summary

A supportive culture

We know a supportive culture is key to providing safe, high-quality patient care. Health systems that support staff are also better places to work. Doctors have told us that the culture of the NHS needs to change if we are to achieve this. It means developing a culture that focuses on the wellbeing of doctors and all staff, and promotes learning. It is also an NHS where diversity is celebrated, everyone feels included and valued, and there is equality of opportunity and reward.

Our vision:	Making it happen:
A shift in culture to recognise that staff wellbeing is essential to good patient care	– Create protected time for staff to meet, share experiences and build strong and supportive relationships – Require NHS organisations to put in place measures that support and encourage staff wellbeing
A learning culture in which staff feel able to raise concerns without fear or blame, knowing that these will be acted on to improve care	– Leaders should demonstrate the value placed on openness and learning by using past incidents, especially from their own practice, in training exercises – Provide designated contacts within organisation that can people can speak to informally and in confidence if they have concerns – Acknowledge the role multiple system and human factors can play and consider these as part of any investigation – Recognise the impact of a patient safety incident on the doctor and provide them with support
A fair and proportionate system of regulation that understands context and is part of a culture of learning	– Regulators should highlight the pressures within the health system and, with healthcare professionals, advocate for change – System regulators should ask employing organisations to demonstrate that working environments are supportive, inclusive and staff feel able to raise concerns – In England, remove aggregate ratings and create a system that supports improvement rather than penalising providers
A focus on improving patient care, not hitting financial or political targets	– Abandon crude financial targets and replace them with financial assessments that recognise the context in which local providers are working – Prioritise developing better metrics on quality of care, staff engagement and culture, and encourage more of a focus on them
A compassionate working environment in which staff treat each other with respect	– Create a professional code of conduct for NHS managers, strengthening compassionate leadership and accountability – Make sure there is clarity about standards of behaviour, enable early intervention by managers and empower bystanders to tackle unprofessional behaviour – Create safe spaces for staff to reflect together on their experiences of providing care, cutting across hierarchies and professional boundaries
An NHS where everyone feels included, where diversity is celebrated and there is equality of opportunity and reward	– Make inclusivity a core competency for NHS leaders, something they are expected to demonstrate and be held accountable for – Develop and promote more flexible career pathways – Ensure access to appropriate mentors and adequate peer support, particularly for those from minority or under-represented groups – Provide proper inductions for overseas-qualified doctors and ensure they have access to ongoing support

A valued workforce

The NHS is facing a workforce crisis, with too few doctors to meet the growing needs of patients. While the BMA will continue to call for increased resources and expanded recruitment, doctors have told us there are also measures that need to be taken now to improve retention, reduce workload and improve IT infrastructure. A valued workforce is one where everyone who works in the NHS feels part of a properly resourced team, working in harmony and with the right mix of skills and tools to do the job.

Our vision:	Making it happen:
No one should have to work in a consistently under-staffed and under-resourced environment	– Make retaining staff a top priority, including dealing with excessive workload, offering flexible working opportunities, altering workload and removing barriers to older doctors playing a bigger role – Clarify accountability for safe staffing levels (including, where needed, through legislative change) in each nation of the UK – Ensure doctors have clear mechanisms to speak out when staffing has fallen below safe levels
Doctors feeling valued, supported and fairly rewarded throughout their working lives	– Act swiftly to change NHS pension taxation rules that financially penalise senior doctors, ending the current situation in which experienced clinicians who decide to work extra hours are being hit with tax bills greater than the value of the hours worked
Doctors' skills being used in the most effective way, as part of multi-disciplinary teams	– Set clear definitions and lines of responsibility for new clinical roles, so that these can be introduced in a way that relieves workload, does not impact on junior doctors training and allows doctors to focus on tasks where their expertise is most needed – Ensure that all MAPs (medical associate professionals) are regulated and awarded prescribing rights to ensure they can work safely within their clinical teams – Introduce non-clinical roles such as doctors' assistants and medical scribes to help reduce doctors' workload – Make sharing good practice between employers a system-wide priority whenever new roles are introduced
The right IT, equipment and facilities to provide the best care for patients	– Make broadband available in all care settings and ensure the NHS is an early adopter of 5G technology – Invest in basic technological infrastructure as a priority to improve workload, morale, retention and patient outcomes – Make full digitisation of all patient records a priority to ensure that doctors can put new technology to full use – Provide clinicians with access to AI tools designed to support, but not replace, medical decision-making – Involve doctors in the design of new tools and provide adequate training in new technologies – Harness the workload-reducing potential of AI through tools that promote self-care, provide clinicians with crucial patient information and ease administrative burdens.

A collaborative structure

Despite a growing need for care to be integrated around the needs of patients increasingly living with multiple morbidities, doctors say they are prevented from providing such joined-up care by bureaucratic barriers, communication gaps and competing organisational priorities. Working in silos is bad for both patients and doctors. Removing obstacles to collaboration can help doctors reduce their workload and cut down unnecessary waste of time and resources. A new, more collaborative approach is needed in each of the four nations of the UK, so that doctors and all NHS staff are empowered to work together across traditional organisational divides.

Our vision:	Making it happen:
Systems that encourage services to work together to achieve shared goals and outcomes, and funding flows that encourage collaboration	– Bring together doctors, other healthcare professionals and patients to design systems built on trusting relationships between previously isolated parts of the NHS – Change how NHS organisations are held to account, encouraging a whole-system approach over narrow organisational priorities – Create more opportunities for doctors to experience training and working in different settings – In England, scrap funding mechanisms that incentivise increased activity, and agree new models that encourage joint working
Care pathways designed around patients, not organisational boundaries	– Develop shared budgets for elements of care that cut across traditional divides between primary and secondary care, including joint prescribing budgets – Provide funding and support for schemes designed to build professional and social connections between clinicians across traditional working divides – work with doctors to spread the use of dedicated phone lines and other forms of two-way communication between GPs and hospital clinicians
Compatible IT systems that support safe sharing of patient data to improve care	– Prioritise investment in fully interoperable IT systems, including a shared record and electronic communication between primary and secondary care – Explore fully automated messaging and document checking services across health and social care services
Involving both those who work in the NHS and the public in decisions about how it is run	– Create a programme of clinically led quality improvement, focused on supporting clinicians and other healthcare professionals to come together to input into service redesign
Service planning informed by population and patient need, free from the restrictions of competition legislation	– Reform legislation in England to remove the requirement to put NHS contracts out to competitive tender – Support public health services to play a central role in bringing all parts of local health systems together to assess the health needs of their populations and plan services.

1. Introduction

This report sets out the interim findings of the BMA's *Caring, supportive, collaborative* project. Its purpose is to inform debate at the BMA's ARM (annual representative meeting) in June 2019, after which a final report will be published.

The *Caring, supportive, collaborative* project was set up by the BMA in 2018 with the aim of establishing a vision for change in the NHS informed by the views of doctors across the UK, covering three key themes: culture, workforce and collaboration. This paper sets out that vision, alongside practical solutions, ideas and recommendations to make it a reality.

Asking doctors: what needs to change?

The findings of this report are underpinned by over a year of engagement with doctors of all branches of practice working on the front line of the NHS. We asked doctors across the UK what they feel needs to change in the NHS where they work to improve their working lives and enhance patient care. This programme of consultation included:

- an open session at the ARM in June 2018, at which delegates gave their views on the challenges facing the NHS across the themes of culture, workforce and collaboration
- a major survey of over 8,000 doctors and medical students across the UK, the findings of which were published by the BMA in September 2018[1]
- a series of 15 local and regional consultative workshop events held in England between November 2018 and May 2019
- a workshop with members of the BMA's UK council held in January 2019
- discussions at the BMA's national councils in Scotland (March 2019), Wales (April 2019) and Northern Ireland (February 2019)
- input and feedback from UK-level branch of practice committee meetings
- extensive engagement online and through social media, including 'vox pop' videos of members putting forward ideas for change, and infographics setting out the findings of our survey report.

The aims of the project have also been taken forward through a range of initiatives across the four nations of the UK, including:

- work across the UK on safe staffing. This includes engagement with the Welsh Government and NHS Wales Employers through the Safe Staffing Levels Task and Finish Group and lobbying around new legislation, passed in May 2019, on safe staffing in Scotland
- the development of a vision document for secondary care in Scotland and a strategy for consultants in Northern Ireland, both due to be published later this year
- work across the UK on tackling bullying and harassment in the NHS, including a project on Promoting Positive Workplace Culture in Scotland
- ongoing work to influence the implementation workstreams for the inquiry into hyponatraemia-related death, particularly around the proposals on individual duty of candour with criminal sanctions, in Northern Ireland
- roundtable meetings on each of the three themes of the project in England with senior representatives from the Department of Health and Social Care, NHS England and NHS Improvement as well as NHS Employers.

Doctors' vision for change

Throughout this, doctors have told us that radical change is needed if we are to build an NHS that is truly caring, supportive and collaborative, where doctors are valued, and patient safety is prioritised. Informed by our engagement with doctors across the UK, the BMA has developed a vision for the future of the NHS, set out below, which articulates the key changes doctors want to see.

The BMA's vision for change

A supportive culture, where doctors work in an environment that supports their wellbeing, promotes learning and encourages the development of systems which improve safety and quality of care – and where diversity is celebrated and there is equality of opportunity and reward. This means:

- a shift in culture to recognise that staff wellbeing is essential to good patient care
- a learning culture in which staff are genuinely engaged and feel able to raise concerns without fear or blame, knowing that these will be acted on to improve care and safety
- a compassionate working environment in which staff treat each other with respect
- a fair and proportionate system of regulation that understands context and is part of a culture of learning and improvement
- a focus on improving patient care, not hitting financial or political targets.

A valued workforce, where everyone who works in the NHS feels part of a properly resourced team working in harmony and with the right mix of skills to do the job. This means:

- no one should have to work in a consistently under-staffed and under-resourced environment
- clinical teams providing care within manageable workloads
- protected time for professional development, innovation and research
- the right IT, equipment and facilities to provide the best care for patients
- doctors' skills being used in the most effective way, as part of multi-disciplinary teams
- doctors feeling valued, supported and fairly rewarded throughout their working lives.

A collaborative structure, where doctors and all NHS staff are empowered to work together across traditional organisational divides, so that patients receive seamless care. This means:

- systems that encourage services to work together to achieve shared goals and outcomes, and funding flows that encourage collaboration
- compatible IT systems that support safe sharing of patient data to improve care
- care pathways designed around patients, not organisational boundaries
- full involvement of both those who work in the NHS and the public in decisions about how it is run
- service planning informed by population and patient need, free from the restrictions of competition legislation
- a focus on ensuring patients are cared for in a setting appropriate to their needs.

All underpinned by sufficient funding and resources to do the job, in line with the growing needs of patients.

The following sections of this report set out the ideas and solutions that doctors have proposed to help achieve this vision in each of the three areas: culture, workforce and collaboration.

2. A supportive culture

We need to move away from blame towards a learning and supportive culture

We need an NHS where doctors can work safely and are supported to do their best for patients. This requires a learning environment rather than one in which doctors are fearful of being blamed when things go wrong. There should also be equality of opportunity, respect for diversity and inclusion for all staff.

Unfortunately, our survey revealed that this is currently not the case. An overwhelming majority of doctors (95%) say they are sometimes, or often, fearful of making mistakes. Many (55%) say they are more fearful than they were five years ago. Doctors tell us that the main reason is growing pressure and lack of capacity. Rather than feeling supported while trying to do the best for patients in such pressurised environments, doctors tell us they increasingly fear being unfairly blamed for errors that may occur (reflected in the reaction to the case of Dr Hadiza Bawa-Garba). Half of doctors say this culture of blame is making them practise defensively. A minority (40%) say they are content to report errors. Just over two-fifths say they are now anxious about recording reflective practice.

Box 1: Cath Dixon, GP, Knaresborough, at a BMA member event

'It's very difficult to keep practising when something's gone wrong... or when you've had a complaint... You're distracted and it can be incredibly difficult. There's a big blame culture – trying to find the person to blame for something that's gone wrong. Unfortunately, in medicine, lots of things don't go to plan and that's not because anyone hasn't tried. As doctors, we are committed to trying to do our best for our patients.'

In his 2013 report on patient safety in the NHS, Professor Don Berwick stated that 'fear is toxic to both safety and improvement'. He pointed out that in the vast majority of cases it is not individual staff that are to blame when things go wrong, it is the systems, environment, procedures and constraints that they work under. He called for greater transparency, openness about sharing data, and for the NHS to become a learning organisation. To facilitate this, staff need to be trusted and supported to learn, patients need to be listened to, and the safety and quality of care needs to be the overriding priority.

Inadequate resourcing impacts on culture

The impact of the lack of resources and staffing shortages on culture must be recognised and addressed as a patient safety issue. 78% of doctors say that lack of resources is affecting safety and quality of care. Nine in 10 doctors say that pressure or lack of capacity in their workplace is the main reason they are anxious about making errors. Working in a system under pressure also impacts on human interactions and behaviour. It takes its toll on staff wellbeing and mental health. It makes it harder for people to exercise good judgement and be open to collaboration. People being under pressure was the top reason given by doctors (65%) for why bullying or harassment is a problem in their workplace. Workload pressure was also the top reason (59%) for why they did not feel confident raising concerns about patient care.

Proposed solutions

Governments must:

– recognise the link between resourcing and patient safety, and the duty they have to ensure adequate resources.

Creating a culture focused on quality of care starts from the very top

Quality of care and patient safety must be the clear overriding objective for the NHS. As Robert Francis QC said when introducing his report into failings at Mid-Staffordshire, it should be 'patients – not numbers – which counted'. He found that a high priority had been placed in that organisation on the achievement of targets. Three-quarters of doctors tell us that they believe national targets and directives, or achieving financial targets, are still prioritised over the quality of care. The pressure to hit targets or other national directives

sometimes creates perverse incentives and can lead to a cascading culture of pressure and anxiety, as well as undermine the provision of safe, good quality care.

Targets, directives or interventions from the top need to be clinically led. They need to take into account the challenging and complex environment in which staff are working, and be effective in supporting them to maintain good quality care or deliver improvements. Reorganising the same resources to try to achieve more – and more challenging – targets yields diminishing benefits over time. When organisations are already struggling, more support is needed so they can reach ambitious goals.

Proposed solutions

Governments and NHS organisations need to:

- abandon crude financial targets and replace them with financial assessments that recognise the context in which local providers are working
- prioritise developing better metrics on quality of care, staff engagement and culture, and encourage more of a focus on them
- replace performance targets with plans that reflect the context within which the organisation is operating
- focus on supportive, evidence-based interventions for under-performing organisations rather than on judgements and ratings which can exacerbate pressure and demoralise staff
- disseminate good practice across the whole system, identifying examples of teams or organisations that have improved in a range of different settings, so that those facing similar challenges can find relevant examples to learn from.

Psychological safety is key to creating learning cultures

Learning from errors and quality improvement cannot happen unless staff feel safe in being open, reporting errors and raising concerns. Various steps have been taken to encourage greater openness and transparency in the NHS in recent years, such as the introduction of duties of candour, reporting systems for patient safety and, in England, guardians for speaking up.

However, doctors have told us they are still afraid or discouraged from speaking up in many workplaces. They fear they will be blamed for errors they report and are anxious about how the information will be used – half say they are fearful that they might be unfairly blamed or suffer adverse consequences, and half say they are discouraged by the lack of feedback when they or colleagues have reported concerns. The processes often require persistence and resilience too – a majority of doctors (59%) say that workload pressures make it difficult to find the time to report concerns.

An open and learning culture is one characterised by high levels of psychological safety and low levels of interpersonal risk, ie people are not afraid of being punished or humiliated by others when they speak up. Creating safe spaces and protections for reflective practice will help give the reassurance that doctors and healthcare staff need, by assuring them that openness is being encouraged to enable learning rather than seeking to apportion blame.

Strong and supportive working relationships with colleagues are also key to creating greater psychological safety at work. BMA members in our local engagement events have reflected often on the lack of time and opportunities, as pressures have increased, to regularly meet with colleagues (eg in weekly team meetings or informally during coffee breaks). They feel that working relationships are more distant and not as good as a result. Greater investment in staff facilities and ensuring staff have adequate time to rest and meet colleagues away from immediate work pressures and patient-facing environments should be recognised as key to creating a more open and learning culture.

Leaders, managers and senior staff have a key role to play in creating a climate in which people are not fearful of voicing concerns or questioning practices. In the NHS, there is growing recognition that there needs to be a more collaborative, compassionate and inclusive leadership style to help define that climate of open communication and learning. This is not easy to deliver in such a complex and pressurised working environment, with

entrenched hierarchies and boundaries between professions and organisations. Not all doctors will become medical or clinical directors, but many will lead teams or become supervisors or managers at some stage in their careers. Leading multi-disciplinary teams, educating and developing the next generation, managing people and dealing with conflict at work are not simple tasks, and are not often part of undergraduate medical training. It is therefore not surprising that some doctors feel there is a lack of support and little or inadequate training to help them in these roles.

Doctors also need protected time for learning and professional development activities as well as study leave funding. It is concerning that half of doctors say they do not currently have adequate time for this. Only a fifth of GPs agree they have sufficient time for learning and development activities. This has consequences for quality improvement, safety and staff retention. The GMC's annual training survey has also highlighted the pressures on trainees and trainers, with half of trainees saying they regularly work beyond rostered hours, and as a result 30% say training opportunities are being lost due to rota gaps. In addition, a third of doctors with training responsibilities say they find it hard to find the time to fulfil their educational roles.

Box 2: Schwartz Rounds

The Point of Care Foundation promotes and supports Schwartz Rounds in NHS organisations. They provide a unique forum for clinical and non-clinical healthcare staff to come together to reflect on the emotional and psychological impact of their work. Rounds have been found to benefit participants, with the process of sharing and reflecting on experiences increasing empathy for patients and each other, reducing feelings of isolation and improving communication with colleagues. Evidence shows people who attend rounds are less stressed and in better psychological health than their non-attending colleagues. It also identifies ripple effects for the organisations hosting rounds, including reduced isolation, improved teamwork and improved communication.

Box 3: Lucy Henshall, GP Health Service Clinical Lead, East of England at a BMA member event

'One of the questions we've been discussing is how to make the culture of the NHS a better place. I think it boils down to some very fundamental human behaviours. Somewhere along the line, not just our profession but the NHS itself has forgotten kindness, civility, and good behaviours toward each other. I think if we were to reinject those very simple behaviours on a day-to-day basis we would enable our colleagues to feel more supported... On top of that we should be adding supervision, mentoring, space and time to learn, time in which to debrief and share the emotional burden of the work we do... And my call to action to my colleagues is: look sideways, look across the room in your workplace, take care of your colleagues because what you give you will get back, in spades.'

Solutions

NHS organisations should:

- create opportunities and protected time for staff to meet, share experiences and build strong and supportive relationships
- improve the physical environment so that staff have proper rest facilities (see the BMA's fatigue and facilities charter) and a space to relax and meet with colleagues
- consider adopting Schwartz Rounds or other safe spaces for staff to meet, reflect and share experiences of working in healthcare to help break down hierarchies or professional boundaries
- demonstrate the value placed on openness and learning within organisations by using past incidents, especially from leaders' own practice, in training exercises, where possible involving patients and carers too

– ensure positive patient feedback is shared so that learning comes from reinforcement of positive behaviours and outcomes too
– provide sufficient protected time for learning and development, including in the GP contract, as well as resources for educational course and conference costs, so doctors can develop professionally and support quality and safety improvements throughout their careers.

Those responsible for workforce at a national level should:
– review and ensure adequate provision of management and leadership training, mentoring or coaching so that those with managerial, leadership or supervisory responsibilities are supported in taking a non-punitive, compassionate and collaborative approach
– develop a professional code of conduct as well as accountability of NHS managers for patient safety and a learning culture in their organisations.

Effective and consistent interventions are needed to address bullying and harassment

The BMA's project on bullying and harassment has identified endemic problems in some parts of the profession and NHS. It is clear that formal policies and procedures that rely upon individuals formally reporting incidents for investigation are insufficient to address the problem. Those who are bullied or harassed are often in a weak and isolated position and feel anxious about putting their head above the parapet. In some instances, they may be actively discouraged from saying anything with threats to their future career, or being told that they should just put up with things, as raising concerns would make matters worse or not achieve anything.

There needs to be clarity about values and behaviours. Treating people with compassion and respect, being inclusive and collaborative, and actively listening when people do speak up, needs to be consistently demonstrated by senior leaders, managers and staff. More encouragement, support and routes for raising concerns about bullying and harassment are needed – not just on an individual but a collective basis. If behaviour goes unchallenged and the silence around it persists, then it becomes tolerated and spreads. There needs to be greater focus on early intervention to address unprofessional behaviour that may escalate to bullying or harassment, and upskilling of staff and managers so they can do that effectively. Organisations also need to ensure they act on the underlying causes of bullying and harassment, including the fear, anxiety and pressure in the system.

Proposed solutions

NHS organisations should:
– make sure there is clarity about standards of behaviour, so people know when they are justified in raising concerns, and when things like performance management or banter risk crossing the line into bullying and harassment
– provide designated contacts within the organisation that people can speak to informally and in confidence if they have concerns about bullying or harassment
– use anonymous surveys and other feedback sources to gather information about the prevalence and nature of bullying and harassment concerns, and ensure senior leaders consider in detail and are held accountable for acting upon the findings
– encourage bystanders to be more active and give people the tools to challenge effectively when they see or experience bullying or harassing behaviour
– improve how formal complaints are handled in practice in the NHS, ensuring sufficient resourcing, capacity and independence of investigations
– encourage and enable early intervention to tackle unprofessional behaviour, and provide better training and support for those with managerial and supervisory responsibilities
– embed human factors in medical selection, education, training and work practices so people understand the paramount importance of good interpersonal communication and teamwork to deliver effective patient care.

Box 4: Case study: Sturrock review of 'bullying culture' in NHS Highland, Scotland
In September 2018, four doctors in NHS Highland (three GPs and a consultant radiologist) publicly alleged a decade-long bullying culture within their NHS board and called for an independent inquiry. The Scottish Government listened, and in November 2018 John Sturrock QC was commissioned by the cabinet secretary for health and sport to carry out a full independent external review into allegations of a bullying culture at NHS Highland. In his final report, he asks:

'For those who have been affected, how will [we] move from fear to safety, from anger to compassion, from blame to kindness, from shame to dignity?'

He notes:

'Whatever procedures and policies are available, they are unlikely to be effective unless people are civil to one another, especially when under pressure. This comes from the top and cascades through the whole organisation.'

Among the specific proposals made by Sturrock in his report are:
- a need for people-centred leadership; a need for civility and respect at all levels; daily contact between management and frontline staff
- adequate facilities for staff to rest, reflect, meet and talk to colleagues away from immediate work pressures and patient-facing environments
- a clear and concise definition of bullying and harassment
- a carefully designed, comprehensive training programme so that people are more able to manage differences and have difficult conversations in real time
- and consideration of the Francis Report on how to encourage a culture where people have freedom to speak up.

In a section entitled 'Clinical Engagement in the Contemporary NHS' Sturrock also recommends:

'Reassessment of the relationship between clinicians and management seems to be an essential part of building a collaborative and mutually respectful and supportive culture. Apparently, evidence from around the world shows that improved clinical outcomes follow greater clinician involvement in management. Thus, there should be reflection on the manner and benefits of clinical involvement in leadership. This may entail changes of attitude and behaviour for some as they move towards a more collaborative approach.'

The benefits of diversity need to be realised through inclusive workplace cultures

The medical profession and wider NHS workforce are increasingly diverse but the experiences of staff and the opportunities for development are not equal. A striking finding from the BMA all-member survey was that only 55% of BME doctors think there is respect for diversity and a culture of inclusion in their workplace compared to 75% of white doctors. There is a similar ethnicity gap in the proportion of doctors who agree there is effective teamwork in their main place of work (57% of BME doctors compared to 72% of white doctors). BME doctors are also almost twice as likely to say they would not feel confident raising concerns about patient care. Given that over a third of GPs and two-fifths of hospital doctors are from BME backgrounds, this suggests a significant proportion of the medical workforce lacks a sense of belonging, safety and respect at work. The barriers that BME doctors who qualified overseas face are often compounded by poor induction and support, and a lack of curiosity or recognition of the experience they bring from their previous practice. Recent research[2] has shown that BME consultants earn 4.9% less than white consultants on average.

Doctors with disabilities or long-term health conditions have shared experiences through the BMA's bullying and harassment project and local engagement events on disability. They face difficulties in accessing the support and adjustments they need to perform to the best of their ability and serve patients effectively – or even to remain in work. There is a frustration that they are most often seen as a problem in the workplace, with a focus on what they cannot do, rather than on the abilities, insights and benefits that they bring to the profession and patient care.

Women, especially those who have taken time out or worked less than full time, also highlight how difficult it can be to challenge assumptions about their commitment and ability, and to access the same progression and development opportunities of male or full-time colleagues. The interim findings of the independent review of the gender pay gap in medicine shows there is a pay gap of 17%, with women being under-represented among consultants, GP partners and in higher-paying specialties.

The BMA and GLADD (Gay and Lesbian Association of Doctors and Dentists) have found many LGBT doctors routinely experience undermining comments or harassment linked to their sexual orientation or gender presentation.

Diversity in the profession and NHS brings significant dividends. If the workforce reflects the diversity in the population they serve, it is likely there will be greater understanding, compassion and civility in all staff-patient interactions. Diverse teams have also been shown to outperform non-diverse teams as they benefit from different perspectives and a wider range of experiences and skills. But these dividends will only be fully realised if the culture is one in which everyone feels included, valued and able to speak up.

Box 5: Rajeev Gupta, paediatric consultant in Barnsley and Yorkshire regional council chair, at a BMA member event

'One of the important things that is increasingly being recognised is how diversity can be seen as a problem. So a simple thing is to give people a voice so people who are from a BME background shouldn't fear raising concerns. The second thing is to set up a BME network in each hospital... The third thing would be to have a body that constantly provides background support and mentoring to these doctors, because there's a disproportionately low number of the BME doctors compared to their white counterparts in leadership positions. If we provide a more diverse NHS... we will have a more powerful NHS.'

Proposed solutions

NHS organisations should:

- provide proper inductions for overseas-qualified doctors, for example by encouraging and giving them time to attend GMC 'Welcome to UK practice' courses, and by ensuring there is ongoing accessible support with orientation and living and practising in the UK
- ensure peer support and mentoring is routinely available to all medical students and doctors, ensuring those from minority or under-represented groups have access to appropriate mentors that can relate to and support them through the particular challenges they may face
- ensure there is early identification of those who may be in need of additional or more tailored support, which may be throughout their careers or at certain stages, and ensure this is provided in an effective, timely and positive way
- develop and promote more flexible career pathways and improve the support for less than full-time working options and return to practice after periods of leave or careers breaks
- develop and deliver effective training and development for all doctors, medical students and non-medical managers on the value of diverse teams and the importance of inclusion, giving them the skills to manage and work effectively within them, and emphasising that supporting fellow doctors is a shared responsibility
- make skills that support inclusivity a core part of leadership development in the NHS, with inclusion seen as a core competency that leaders are expected to demonstrate and will be accountable for.

Replace the blame culture with a 'just culture' approach

When patient safety incidents occur, the first question should be what went wrong in the system rather than who was to blame. This is a natural follow-on from the recognition that many errors in the NHS are due to multiple factors and systems as opposed to pure individual culpability, as the Berwick report identified. Organisations should not rush to formal investigations of individuals but instead should start with examining the system factors that may have played a part, and how they can make changes to prevent errors or failings happening again.

This approach will facilitate a more positive climate for speaking up as staff will be more likely to openly and willingly engage with investigating and learning from incidents. It is also likely to focus resources on learning and improvement rather than on individual disciplinaries, suspensions and the direct and indirect costs associated with litigation and defensive practice.

Proposed solutions

In response to a patient safety incident, NHS organisations should:

- acknowledge that multiple system and human factors will always be at play and consider these as part of any investigation
- recognise the impact on staff of a patient safety incident; they should be provided with support rather than made to be fearful of investigation and punishment (most will already feel devastated and upset to have been involved in something that has caused harm)
- signpost support for staff going through any investigation, disciplinary or fitness-to-practise process (such as that provided by the BMA or other bodies)
- investigate incidents promptly, and look to resolve cases involving individuals quickly, without the need for formal procedures if possible and appropriate
- involve patients, their carers and relatives at the early stages of investigations, keeping them informed of developments, learnings and outcomes
- share the learning from the case as widely as appropriate, including to national learning databases and reviews, to maximise any positive outcomes from these inherently negative incidents.

Box 6: Case study: a just and learning culture approach at Mersey Care[3]

Mersey Care is an NHS organisation that has realised learning cannot happen from mistakes if employees are too afraid to report those mistakes. Its work to embrace 'a Just and Learning Culture' has centred on the desire to create an environment where staff feel supported and empowered to learn when things do not go as expected, rather than feeling blamed. In the case of an adverse event, it instinctively asks 'what was responsible, not who is responsible'. It is not finger-pointing and not blame-seeking. But it is also not an uncritically tolerant culture where anything goes. It says that would be as inexcusable as a blame culture.

Regulation needs to encourage improvement and support a learning culture

Professional regulation

The primary role of the GMC is to protect patients. It does this by setting the standards doctors need to follow throughout their careers and by acting to prevent a doctor from putting patient safety at risk.

It has recently announced a programme of work[4] to address the issues doctors have raised about the environments in which they work, and the impact of system pressures on medical practice – this includes improving support for doctors to raise and act on concerns, and making sure all doctors referred to it are treated fairly. All GMC fitness-to-practise decision makers, case examiners and clinical experts will now receive human factors training so that the role of systems and workplaces in events is fully considered. The GMC has also pledged to introduce steps designed to reduce the number of single clinical-incident investigations it carries out.

However, the GMC has acknowledged[5] that its fitness-to-practise processes are slow, inflexible and heavy-handed, and many doctors are aware of how stressful they can be, especially for those who may be vulnerable or unwell. Regulatory reform is necessary to deliver improvements, with the BMA supportive of the GMC's efforts to seek legislative change. More can be done to reduce both the burden and fear that come with being a regulated healthcare professional.

Proposed solutions

The GMC should:

- ensure its processes and procedures are fair, timely and proportionate, and are streamlined to reduce the personal impact of investigations on doctors – it should employ a supportive, explanatory approach at tribunals as opposed to an adversarial one
- work to reduce the personal workload associated with medical appraisals and revalidation, ensuring these support reflection and professional development
- use its voice to highlight to Government and health service leaders the underlying causes of a system under pressure, and robustly advocate for change
- become a repository for learning, sharing good practice and continually encouraging improvements.

Provider regulation

Although there are differences in the specific approaches taken by the UK's system regulators (the Care Quality Commission in England, the Regulation and Quality Improvement Authority in Northern Ireland, Health Improvement Scotland and Healthcare Inspectorate Wales), doctors and healthcare workers throughout the UK feel overwhelmed with the regulatory requirements placed on service providers, which they feel often takes them away from caring for their patients. While attempting to assess whether healthcare services provide safe, high-quality care, existing regulatory approaches fail to recognise that wider system issues significantly affect delivery of care. Doctors also tell us that system regulators, when assessing employing organisations, often fail to place enough weight on the importance of staff wellbeing. Doctors feel this simplistic and judgemental approach by regulators does little to support and encourage improvements in patient care.

Proposed solutions

All system regulators should:

- ask employing organisations to demonstrate that all health service staff, whether in the NHS or other organisations, work in an environment where they are engaged, feel supported, are confident in raising concerns in a spirit of learning, and have equality of opportunity
- demand employing organisations take robust and proactive steps to ensure workplaces are fully inclusive and free from a culture of bullying, undermining and harassment
- require employing organisations to put in place measures that support and encourage staff wellbeing, for example by hospitals and trusts providing appropriate rest facilities with access to food and drink
- ask employing organisations to demonstrate that doctors are aware of and feel comfortable in using mechanisms that exist to support raising concerns (eg exception reporting and safe working guardians in England)
- ensure employing organisations provide accurate pictures of staffing needs so that issues can be addressed quickly and effectively, as poor workforce planning has a detrimental effect on staff wellbeing and patient care
- acknowledge and understand current workforce pressures and provider budgetary constraints to support bespoke solutions and improvements to be considered and implemented at a local level
- engage directly with doctors and other healthcare professionals at all levels before, during and after inspections, providing powerful opportunities to drive improvement in the quality of care delivered locally and nationally
- be prepared to robustly use the powers they hold to enforce standards to uphold safety.

The CQC (Care Quality Commission)

In England, GP practices and hospital and community providers are assessed by the CQC, which gives providers a rating of inadequate, requires improvement, good or outstanding.

Our member survey findings strongly suggest that CQC regulation is contributing to an already stressful working environment for doctors. 79% of doctors say inspections divert time and resources away from patient care, while 71% feel they add to fear in the workplace. These figures are much higher among GPs.

It is particularly concerning that so few doctors (just 9%) feel inspections consider system pressures, given that these are now having an increasingly damaging impact on providers in the NHS all year round.

In addition, the overall ratings used by the CQC cannot capture the quality of individual services provided in a hospital or GP surgery, nor the complexities of delivering healthcare. Aggregate ratings risk misleading patients with simplistic judgements and can demotivate staff providing high-quality services within an overall negative rating. Conversely, they conceal areas of poorer care in providers with a high overall rating.

Proposed solutions

In England, the Government and CQC should:

- remove aggregate care-quality ratings of providers
- remove pejorative terms such as 'inadequate' in the judgement of quality of services
- provide reports based on a matrix of the range of services provided
- provide recommendations for change that are tailored to each service inspected, offering advice and support for achieving improvements rather than simply identifying areas of under-performance
- introduce a fully reformed and proportionate regulatory system based on targeted assessments of essential standards and quality assurance processes and reduce the time required by providers in preparing for and participating in an inspection
- overhaul the bureaucratic nature of its registration system which, for example, unnecessarily duplicates much of the work GP practices are required to report on to NHS England. Regulatory registration requirements and processes must be tailored to the specific services being delivered by providers.

The wider regulatory landscape

Both professional and provider regulators are part of a wider system that investigates patient safety incidents. This now includes HSIB (the Healthcare Safety Investigation Branch) tasked with investigating incidents, disclosing information to others where appropriate, and sharing learning across the system. Regulation also overlaps with the criminal justice system and over the last 18 months, the Government and GMC have conducted their own reviews of the law on gross negligence manslaughter.

There are gaps in the wider systems, and our members question whether managers – not currently regulated – should be subject to some form of accountability, and what form this should take.

Finally, as statutory bodies, existing regulators lack the flexibility to adapt to a changing context which can hamper initiatives to improve processes.

Proposed solutions

All governments should:

- ensure that the legislative framework gives professional regulators enough flexibility (provided there is appropriate accountability in place) to adapt their approach to the needs of the professions they regulate. In England this would require a radical reform of the CQC inspection process and rating system
- introduce a regulatory mechanism for holding senior non-clinical managers to account, with the appropriate scrutiny of individuals seeking to work in senior management positions

- create UK-wide legal 'safe spaces' (like those adopted by HSIB as part of their investigation process) in which doctors and other healthcare professionals are supported in disclosing information and the learning from an incident is available to the system
- fully implement the recommendations of the Williams review into gross negligence manslaughter in healthcare to reduce the criminalisation of medical errors
- given the professional sanctions in place, an individual duty of candour with criminal sanctions should not be implemented in Northern Ireland.

3. A valued workforce

Doctors across the UK are working in a health service that is underfunded, under-doctored and over-stretched. There are simply not enough doctors to look after patients safely – of the European OECD countries, only Poland and Slovenia have fewer doctors per head of population than the UK[6]. Nine in 10 respondents (91%) to our survey of BMA members confirmed this, telling us that current staffing levels are not adequate to deliver safe, high-quality patient care. More than seven in 10 say this has worsened in their main place of work over the last 12 months. This means nine in every 10 respondents now work more hours each week than contracted and paid for. Even though so many doctors go the extra mile, nearly a third say their hospital or GP practice cannot usually provide cover for doctor absences or unfilled vacancies.

Training more doctors is part of the solution, but it will take time

We must increase the number of doctors working across the UK. 53% of GPs and 68% of hospital doctors responding to our survey highlighted the lack of doctors, rota gaps[7] and vacancies as a factor affecting their ability to deliver safe patient care. We must create more medical school places and ensure that medicine is an attractive career prospect for children from a young age. However, it will take over a decade for increases in medical school places to provide relief to overstretched services. To support doctors now with their current unsafe workload it is clear that we need more immediate solutions.

Efforts must be made to retain current staff

In an environment in which we do not have enough doctors, we cannot afford to lose any more. Six out of 10 consultants intend to retire from the NHS before or at the age of 60[8], while four in 10 GPs intend to quit general practice in the next five years[9]. Retaining existing staff is crucial. Respondents to our survey told us that current difficulties with retaining staff are due to:

- excessive workload pressures (78%)
- a blame culture with increased risk of prosecution or GMC referral compared to other nations (50%)
- and a negative workplace culture with a lack of valuing and respect for staff (49%).

Unsatisfactory pay and working conditions (47%) and a system that does not support work-life balance and non-traditional career paths (47%) also featured highly. In short, many doctors currently work in unhappy environments, causing them to want to leave. Older doctors who are considering leaving or have left the profession because of burnout, to seek a better work-life balance, or retirement, still have a lot to offer and can be incentivised to continue to work by offering flexible working opportunities, altering their workload (see Box 8) and tackling unfair pensions tax rules (see Box 9).

If a doctor wishes to reduce their clinical workload, they can still play a crucial part by taking on roles in management, teaching, research or as appraisers. Barriers that prevent doctors taking on these roles when they are not clinically active should be reassessed and where possible removed[10]. Where doctors have already left the profession, more can be done to ensure that retraining, GMC registration requirements and appraisal and revalidation are not seen as prohibitive, while better workplace culture would help make returning to work an attractive prospect.

Solving these issues and boosting retention will take time. Taken together, the recommendations on workforce, culture and collaboration set out as part of this report will address these issues and should start making health services across the UK places where doctors enjoy working and want to continue to work.

Box 7: Gary Marlowe, GP and London regional council chair, at a BMA member event
'We have a very demoralised workforce that does not feel valued. From talking to hospital colleagues: the fact that they have very little ability to forward plan because they can't see their rotas in advance, the fact that they can't get a hot meal if they're working late at night. Those very simple things make us feel valued and I think will improve the morale of the workforce without being massive financial costs.'

Box 8: Source: the BMA's *Supporting an ageing medical workforce* report[11] (February 2019)
'I am a GP and last year I left the practice where I had been a partner for 30 years. I had always planned to retire from my practice at the age of 55 due to the fact that my job was highly pressurised and I thought this was a reasonable aim for my own wellbeing, and I made my financial plans accordingly. However, when it came to it, I took the opportunity instead, at 53, to reduce my clinical commitments to the practice. This has made continuing to 59 sustainable.

'In my later years my stamina was not the same. I began to find it harder to draw on the necessary reserves of emotional energy to give top-class engagement to all my patients. On the other hand, I had also reached a level of skill and insight where I could try different consultation styles and put more truly in to practise shared decision making. Without the opportunity to reduce my hours in the practice I would undoubtedly have left before 59.

'I remain on the Performers List as a GP and I would like to continue to be active locally, for example in helping service design/commissioning and teaching medical students. Now I am nearly a year out of clinical practice I do not think I will return to the workforce; sadly many opportunities to work in local health service development or teaching require applicants to be currently engaged in clinical work.'

Box 9: Current pensions tax rules are unfairly penalising senior doctors
Urgent action is needed to change current pension taxation rules that financially penalise senior doctors for working additional hours. The current rules mean that experienced clinicians who decide to work extra hours are at risk of breaching annual and lifetime pension allowance limits and therefore being hit with large unexpected tax bills, sometimes in excess of their earning from the additional time worked. Six out of 10 of the 4,000 consultants in England who responded to a BMA survey in early 2019 said they were planning to retire early, with many citing this issue as a chief driver.

Career breaks are increasingly the norm – the system must adapt

Doctors take breaks from full-time NHS work at different stages of their career and for a wide range of reasons. Some gain valuable experience working abroad in different health systems or for NGOs in developing countries, and these doctors are often discouraged from returning to work in the NHS by difficulties in regaining their licence to practise. Instead, we must encourage and facilitate their return and make it clear that the NHS wants and needs their contribution.

Each year, the number of F2 doctors progressing directly to specialty training reduces; it was 71% in 2011 and 38% in 2018. With doctors' increasing desire to take a gap year at this stage, it is important to recognise that the NHS is in competition with a range of career options and health services around the world; 45% of respondents in our member survey say 'better opportunities to work as a doctor elsewhere' are a major retention problem. Part of tackling this is about developing a good working culture (see section 2, 'A supportive culture'), but we also need a flexible career structure which makes it easy for doctors in training to take a career break and then return.

Other professionals can help ease the burden on doctors

One area where we can make a difference now is excessive workload pressure. Doctors are currently over-worked. At least half of doctors (52%) say they spend 1-3 hours per day on work that could be done by another non-medical clinical professional.

While they cannot and should not be a substitute for doctors, other clinical professionals can help support doctors, and there is a significant level of support for this among the profession, with nearly half of doctors (47%) supporting the expansion of the non-medical clinical workforce to ease pressures (compared to 25% who disapprove of this approach).

Roles such as clinical pharmacists, medical associate practitioners (including physician associates) and advanced nurse practitioners are already providing valuable clinical care in some settings to complement doctors. Employers should work with doctors to review which parts of their workload could be carried out by these other members of the team, keeping in mind the need for safeguards and risk of overloading senior doctors with a workload consisting entirely of high-intensity work.

Safeguards are crucial to getting the most from new clinical roles

While new clinical roles should not be seen as replacements for doctors, they can help to support doctors. To ensure they are genuinely able to do this and do not add extra pressure or undermine the role of doctors, several important safeguards are needed:

- **Ensure new roles are not considered as cheaper options for care provision in place of doctors' expertise**. Patient care must not be compromised. 50% of our survey respondents were concerned about the risk of lowering standards due to non-medical practitioners providing care that doctors are better placed to provide.
- **Ensure that doctors' training is not compromised**. With MAPs (medical associate professionals[12]) being employed in permanent roles within teams, they naturally over time earn the confidence of senior doctors and are often chosen over junior doctors to assist on work that would be essential experience for a doctor in training. All departments and care settings must take measures to balance the service provision benefits of MAPs with the training priorities of doctors in training. It is also crucial that the training of non-medical practitioners does not negatively affect junior doctor training, a concern raised by 39% of our survey respondents.
- **There must be regulation and clarity around accountability for the new professions**. More than seven in 10 respondents to our survey were worried that doctors would be carrying responsibility for the non-medical clinical workforce, who often currently lack accountability for their actions. This is further complicated by the fact that some non-medical practitioners currently work unregulated (raised by 51% of survey respondents). All clinicians should be regulated appropriately for the tasks they perform, which is why we have called for statutory regulation for each of the MAPs. Regulation has been announced for PAs (physician associates) and AAs (anaesthesia associates); this needs to be implemented swiftly, and regulation expanded to the other MAPs (surgical care practitioners, advanced critical care practitioners). Once PAs and AAs are regulated, these clinicians should be awarded prescribing rights to ensure they provide the maximum contribution to their teams and are genuinely able to take pressure off doctors. Clarity is needed regarding how MAPs' status as dependant practitioners can be reconciled with prescribing rights and clinical lines of accountability.
- **It is important that patients, the public and other clinicians have a better understanding of the roles that MAPs perform**. Every member of the multi-disciplinary team needs to have a clear understanding of their colleagues' scope of practice, lines of accountability and supervision responsibilities. We are currently working on good practice guidance on how MAPs work with doctors and as part of the clinical team. Alongside this it is crucial that employers share good practice with each other whenever a new role is introduced, and that the roles display some degree of consistency between different employers.

The establishment of MDTs (multi-disciplinary teams) can make a real difference

In parts of the UK, programmes are underway to more formally embed MDTs into the system (see Box 10), presenting a real opportunity to reduce doctors' workload and improve patient outcomes. Box 11 describes the introduction of clinical pharmacists in primary care, and Box 12 shows how MDTs can also benefit secondary care environments, if the right safeguards are in place.

Box 10: How the UK nations are tackling workload with workforce and MDT innovations

The first-ever Scotland GP contract (2018) committed to reducing GP and GP practice workload, with new staff being employed by NHS boards and attached to practices and clusters as part of MDTs. Alongside reducing GP workload, the new staff were intended to increase protected time to allow GPs to maintain and develop their training and skills.

Reflecting on the first year in his local area, GP Chris Black from Ayrshire and Arran local medical committee said: 'We've seen some good progress in the first 12 months of the new contract. We're now in a position where almost every practice in Ayrshire and Arran has, or soon will have, access to a pharmacist. This has had a huge impact on GP workload for the better.'

In Wales, the Pacesetter Programme is testing new approaches to MDTs with a range of locally determined projects. In England, the 2019 GP contract included the development of primary care networks which plan to add 22,000 staff in primary care, including clinical pharmacists, social prescribers, first contact physiotherapists, physician associates and community paramedics. Pilot funding has also been provided by the Department of Health for the establishment of primary care MDTs in Northern Ireland to help address the pressures identified by their GPs.

Box 11: How a clinical pharmacist helped GPs save time and become safer prescribers

Karen Acott has been a clinical pharmacist at the Wallingbrook Health Group in Devon since 2004. She is a full partner in the group, and as a prescribing pharmacist, she sees patients in clinics and delivers phone consultations, handling all aspects of medication management. Her work has reduced the need for patient GP appointments by 30%, making a significant impact on GP workloads and patient outcomes. A 2016/17 audit of workload impact showed that having a pharmacist working four sessions a week resulted in over 400 hours of GP time saved over the course of the year. Diana Wielink, senior partner at the practice, says: 'Having a pharmacist in our organisation has enabled our health group to become safer and a more cost-effective prescriber.'[13]

Box 12: How PAs helped reduce workload and freed up time for training junior doctors

A junior doctor at Guy's and St Thomas' in London described how physician associates had a positive impact in his department, freeing up doctors to do ward rounds and spend time with patients in a way that has been missing for many years. In the department, the presence of the PA picking up the more day-to-day burden of work has increased training opportunities for doctors. In this department there were clear lines of supervision, with a 'lead PA' acting as the PAs' direct supervisor and although it had not been communicated formally to the team, the PAs' scope of practice was consistent and clear.

New non-clinical professionals can play a part in reducing doctors' administrative burden

A huge amount of doctors' time is taken up by non-clinical work, such as making notes, filling in forms, dealing with correspondence, writing discharge summaries and completing mandatory coding and compliance sections on computer systems. This work is essential, but much of it does not require the attention of a highly trained medical professional. Instead this work could, and should, be carried out by dedicated members of non-clinical staff, such as medical scribes and doctors' assistants. 44% of respondents to our survey said that between one and three hours of their work each day could be carried out by a non-clinical member of staff.

Box 13 describes a doctors' assistant role which is being piloted in secondary care to free up junior doctors' time.

Box 13: Can doctors' assistants free up time for secondary care?

In East Sussex, a trial is underway in secondary care for a new doctors' assistant role designed to support junior doctors with a combination of clinical and administrative tasks. The role is being trialled in direct response to the fact that junior doctors spend 40-70% of their time on administrative tasks and in recognition that this is not the best use of their time. In the role, tasks such as discharge summaries, patient notes and booking follow-up clinics sit alongside some more basic clinical tasks, such as phlebotomy, intravenous cannulation, ECG recording and dementia screening.[14]

In the long term, guaranteed safe medical staffing levels are needed

We want working conditions for doctors that are safe at all times. In primary care this is about limiting the number of consultations per session to a safe number. In secondary care, comprehensive e-rostering systems are essential to ensure doctors are not overworked and can take leave as necessary. Electronic job planning, where functioning effectively and used as part of a collaborative approach, will be a useful tool for planning and managing doctor activity too.

Yet even in the best MDTs, staffing levels sometimes fall short. Where clinicians feel that staffing levels in their care setting have fallen below a safe level, it is important that they are able to call this out. There must be clear lines of accountability for staffing levels, from employers up to health ministers across the UK, and concerns must be acknowledged and acted upon. Processes such as exception reporting must be consistently applied across all employers and accessible to all, so that doctors can raise concerns about unsafe staffing.

Once more immediate concerns have been addressed about the shortage of doctors and improving the management of supply and demand, minimum staffing levels will, in the longer term, help secure appropriate working conditions for all doctors and NHS staff. Nearly six in 10 respondents to our survey said guaranteed safe levels of medical staffing would improve their day-to-day working life. In Wales, the Nursing Staff Levels (Wales) Act has already come into force, setting a precedent for enshrining minimum staffing levels into law. In Scotland, safe staffing legislation (see Box 14) will provide a legal basis for addressing the concerns our members identified in our 2018 survey.

Box 14: How legislation is being used to tackle unsafe staffing
On 2 May 2019, the Scottish Parliament passed the Health and Care (Staffing) (Scotland) Bill, which places a legal requirement on NHS boards and care services in Scotland 'to ensure appropriate numbers of suitably trained staff are in place, irrespective of where care is received'. The legislation includes several key amendments sought by BMA Scotland, notably the inclusion of a clear requirement for a system of escalation of concern for any member of staff who is working in what they believe are unsafe levels of staffing; and risk monitoring. The Act includes a duty for boards to have real-time staffing assessment in place, and a duty to have risk escalation processes in place. The Bill is now an Act, and BMA Scotland will provide input to follow up ministerial guidance on implementation. This will be a key opportunity for the BMA to influence practical and innovative ways to support safe staffing and to help shape the guidance in a way that maximises support to the profession.

We have recently launched a project on safe staffing levels, which will include qualitative research with doctors, a proposal to introduce a safe working charter, and recommendations for consistent and effective doctor escalation processes and clear employer accountability. The project will also look in further detail at ways to reduce administrative bureaucracy.

Proposed solutions
Governments and national NHS authorities must:
- take urgent measures to retain staff, including dealing with excessive workload, offering flexible working opportunities, altering workload and removing barriers to older doctors playing a bigger role (see also *Supporting an ageing medical workforce*, BMA, 2019)
- act swiftly to change NHS pension taxation rules that financially penalise senior doctors, ending the current situation in which experienced clinicians who decide to work extra hours are being hit with tax bills greater than the value of the hours worked
- set clear definitions and lines of responsibility for new clinical roles, so they can be introduced in a way that relieves workload and allows doctors to focus on tasks where their expertise is most needed
- ensure that all MAPs are regulated and awarded prescribing rights where appropriate to ensure they can work safely as important contributors to their clinical teams
- introduce non-clinical roles such as doctors' assistants and medical scribes to help reduce doctors' workload and allow doctors to focus on tasks where their expertise is most needed
- encourage sharing good practice between employers as a system-wide priority whenever new roles are introduced. Employers should also work with doctors to review whether the work they currently do day-to-day is the best use of their time, keeping in mind the risk of overloading senior doctors with a workload consisting entirely of high-intensity work
- create clear lines of accountability for safe staffing levels. Doctors must have clear mechanisms to speak out when staffing has fallen below safe levels
- ensure public health doctors are free to move between organisations without detriment to their terms and conditions and without medical public health capacity in those organisations being compromised.

Better IT systems can reduce workload and give doctors more time to care for patients

While on the one hand AI is steadily making its way into health service provision, on the other, the NHS still often lacks basic IT. A BMA survey and focus groups on NHS IT in 2018 showed there are serious deficiencies in current IT systems. Examples cited as part of this work and the local events undertaken for our *Caring, supportive, collaborative* project include: the use of obsolete technology such as fax machines, broken printers, a lack of broadband, incompatible systems with multiple logins, both within the same care setting and between care settings (an attendee at one of our events cited 36 different systems in use in his hospital, which while still separate, had at least now been brought together onto a single website by his trust), as well as frequent system failures (such as the recently publicised delay of test results being sent to primary care, with significant risks to patient safety).

These deficiencies result in additional workload, stress and compromised patient safety. Over half (56%) of respondents to our 2018 IT survey reported that the current IT infrastructure significantly increases their day-to-day workload, with over a quarter (27%) losing more than four hours a week because of inefficient hardware and systems.

Investing in basic technological infrastructure must now be a priority and the process of updating systems be treated as an ongoing running cost for the NHS. This would mean increased productivity, more time for patient-facing activities and better staff morale. Nearly three quarters (72%) of respondents to our IT survey said the main barrier to good IT in healthcare is a lack of funding. For further details and recommendations on how basic IT in the NHS can and should be improved, see *Technology, infrastructure and data supporting NHS staff*, BMA, 2019.

Digitising patient records will allow new workload-reducing technology to flourish

Not all patient records are currently in digital form. This undermines any system that relies on knowing a patient's entire history, as well as hampering collaboration between clinicians working across the primary/secondary care interface (an issue explored more fully in section 4, on collaboration) and between physical and mental healthcare. The full digitisation of all patient records and funding to make this happen must be a priority to ensure that new technology can be put to full use. Clinicians should be able to see patients' records, observations, results and background notes from any location, ideally in real time. Not only will this help with emergencies, where the SCR (summary care record) should already be readily available, but the ability to remotely add information to a file would save an enormous amount of collective time and effort across the NHS. More than half of respondents to our survey (53%) say they want to see more effective IT systems that are interoperable and that this would improve their day-to-day working life.

Interoperability would improve doctors' working lives

Doctors have been clear about their priority for improving basic systems. They need to be interoperable. The lack of interoperability can mean unnecessary duplication of effort and time wasted in asking patients to repeat information already provided in other care settings. 53% of respondent to our survey say 'more effective IT systems that are interoperable' would improve their day-to-day working lives (see also section 4 on collaboration).

To ensure a speedy move to interoperability but allow for local flexibility, clear standards for interoperability should apply to all future systems procurements across the NHS, and doctors and other clinicians should be consulted on the usefulness of proposed changes before expensive systems purchases are made.

For systems to be more interoperable, it is essential that they can connect to the internet. Incredibly, services in some parts of the UK are still hindered by a lack of broadband, while many care settings do not have wi-fi. The NHS should be an early adopter of 5G internet access, which should allow these connectivity problems to be overcome.

AI (artificial intelligence) can transform the NHS for doctors and patients

There are many areas in a doctor's daily work where technological advances can help reduce workload and improve patient outcomes. Developments in the realms of AI and 'big data' have, over time, the potential to significantly transform the NHS for doctors and patients. Broadly speaking, AI refers to computing technologies whose processes bear some resemblance to human intelligence, such as reasoning, learning, sensory understanding and interaction.[15] More recently, technological advances have brought about 'machine learning' capabilities, where systems 'learn' and make decisions from data without being explicitly programmed to do so.

AI is still in its infancy in healthcare, so it cannot solve all the problems the NHS currently faces. However, there is a significant opportunity through this developing technology to support doctors, provided proper consideration is given to the patient safety, educational and ethical implications.

AI can give patients tools to look after their own health and as a result reduce demand on doctors. AI is already at work in self-care tools such as wearable fitness trackers (described in Box 15), an arthritis virtual assistant giving personalised information and advice about medication, diet and exercise,[16] and apps for diabetics which give bespoke advice based on blood sugar readings. Just over three in 10 respondents to our survey said greater patient empowerment to self-care would improve their day-to-day working life.

Box 15: How self-care AI can help patients monitor their health and reduce doctors' workload

One in seven adults in the UK owns a wearable fitness tracker.[17] These wearables can monitor a range of health-related information, such as heart rate and exercise. AI can use this information to give people up-to-date information about their health and wellbeing, and suggest health-improving modifications to behaviour. The app Noom, for example, uses AI to analyse a person's exercise and eating habits and suggests bespoke diets and fitness plans. Wearables can also be used to detect early signs of deterioration in patients living at home and prevent hospital admission.

Alongside this, there are AI tools that directly reduce pressure on doctors. For example, software is already available to automatically populate letters and forms, while more sophisticated applications can carry out the analysis of medical imaging to identify diseases such as pneumonia, breast and skin cancers or eye diseases. Making this technology available across the NHS will have a huge impact on the amount of time spent on more mundane administrative tasks, as well as reducing workload and freeing up doctors to care for patients.

AI cannot replace a doctor's expertise, but it can improve clinical efficiency and save clinicians time by performing certain tasks thousands of times faster than humans can do them. Task-specific 'decision support tools' (such as 'C the signs' described in Box 16) which employ 'machine learning' could increase doctors' confidence in managing cases of clinical uncertainty, or less familiar types of condition. There are now AI-controlled robotic tools that can carry out specific tasks like keyhole surgery, perform stitching or interpret anatomical data. AI also has the potential to support the early identification of infectious disease epidemics in public health, with earlier identification supporting quicker intervention and reducing pressure on the health service.

Box 16: How decision support tools can reduce workload and help doctors to reach the right outcome

Decision support tools such as 'C the signs' help healthcare professionals identify patients at risk of cancer early on. Unlike other conditions, there is no single symptom that can alert clinicians to a potential cancer diagnosis. The tool uses advanced algorithms combined with optimisation and prioritisation systems to reflect the natural decision-making process of doctors, translating complex research and guidelines into a simple and intuitive journey for the user. It is fast enough to be used during the consultation to speed up decision-making, ensuring at-risk patients are identified and access the right service at the right time for their clinical needs.

With so many opportunities presented by AI and new technology, it is essential that there is enough funding to roll out technology that works, and that clinicians are brought along on the journey. All staff should have dedicated time for training on new systems and this must be factored in during procurement and into job plans. Staff must be at the heart of the development of these new tools in the first place, to ensure they work and are genuinely able to support doctors and improve patient care.

Proposed solutions

Governments and NHS authorities should ensure:

- broadband is made available in all care settings, and that the NHS is an early adopter of 5G technology to overcome connectivity deficiencies and aid interoperability
- investment in basic technological infrastructure is made a priority, as this will have a positive impact on workload, morale, retention and patient outcomes
- the full digitisation of all patient records is a priority to ensure doctors can put new technology to full use and are able to work effectively across health service interfaces
- clinicians have access to AI tools designed to support, but not replace, medical decision-making. They should be involved in its design and receive adequate training in new technologies
- the workload-reducing potential of AI is harnessed across the NHS through tools that promote self-care, provide clinicians with crucial patient information and take on administrative burdens.

4. A collaborative structure

Across the UK, doctors say the NHS needs to be more collaborative

Despite a growing need for care to be integrated around the needs of patients increasingly living with multiple morbidities, doctors say they are prevented from providing joined-up care by bureaucratic barriers, communication gaps and competing organisational priorities. This affects the quality and safety of patient care. 60% of doctors say care quality and safety are being compromised by barriers between primary and secondary care, and only 9% say patients experience coordinated care between hospitals and general practice.

Working in silos is bad for both patients and doctors. Removing obstacles to collaboration can help doctors reduce their workload and unnecessary wastes of time and resources. Seven in 10 doctors say current organisational barriers between primary and secondary care are resulting in increased bureaucracy and administrative costs. Feeling connected to a wider team working across traditional divides also has the power to improve morale – just 16% of doctors feel there are clear channels of communication between primary and secondary care, causing frustration and making it difficult for clinicians and staff to feel part of the same team working together to improve care for patients.

Although the specific challenges differ between England, Scotland, Wales and Northern Ireland, these are issues that all four health systems need to tackle.

Health systems need to be designed so that they embed collaboration

To achieve a more collaborative health service, we must encourage the different organisations – such as hospitals, GP practices, public health, community services and others – involved in providing care to people in a defined geographical area to act together as one system. They should work to the same set of priorities focused around patient care, the promotion of wellbeing and the prevention of ill health. Too often, current NHS structures place an emphasis on individual providers meeting their own immediate organisational priorities, often reinforced through narrow financial and operational targets.

Box 17: The BMA's five principles for integrated care

All models of integrated care must:

1. ensure the national pay and conditions of all NHS staff are fully protected
2. protect the partnership model of general practice and GPs' independent contractor status
3. only be pursued with demonstrable engagement with frontline clinicians and the public, and must allow local stakeholders to meaningfully and constructively challenge plans
4. be given proper funding and time to develop, with patient care and the integration of services prioritised ahead of financial imperatives and savings
5. be operated by NHS and publicly accountable bodies, free from competition and privatisation.

Moving beyond this requires change at all levels of the NHS, from overarching legal structures (such as the formal requirements placed on foundation trusts in England) to embedding a culture of collaboration and team working at a local level.

Proposed solutions

Governments and national NHS authorities should:

- encourage and incentivise all NHS bodies to work together as one system defined by agreed geographical boundaries. This will involve bringing together clinicians, public health specialists and other healthcare professionals and patients to design systems built on trusting relationships between previously isolated parts of the NHS. We have set out five principles to help guide this process in Box 17
- reform how individual NHS providers are held to account, focusing on encouraging behaviours that improve patient care in the health system as a whole rather than narrow

organisational priorities. In England, the Government should abolish the statutory requirements on foundation trusts and reform incentives that encourage trusts to focus on their financial performance above all other priorities
- support public health services to play a central role in bringing all parts of local health systems together to assess the health needs of their populations, plan services and inform local commissioning accordingly, with an emphasis on the prevention of ill health wherever possible
- create a programme of clinically led quality improvement focused on supporting clinicians and other healthcare professionals to come together to input into service redesign, backed up with investment to provide doctors with protected time to achieve this. This should take inspiration from the Buurtzorg, or 'neighbourhood care', model developed in the Netherlands (see Box 18), which emphasises the development of self-managing teams of health professionals. The experience of involving clinicians in system redesign in Canterbury, New Zealand (Box 19) also provides a useful model.

Box 18: Buurtzorg model of self-organising teams in the Netherlands
This pioneering model of home care is nurse-led, strictly non-hierarchical, and based around collaborative planning and delivery of care. The model is organised into small, independent and self-organising teams of up to 12 nurses, covering between 40 and 60 patients. Each team takes collective responsibility for co-ordinating the care they provide and focus on using technology and direct support to help patients better care for themselves. This approach has been highly successful, with high levels of both patient and staff satisfaction, reports of reduced acute care admissions, and strong financial performance. The approach is now being implemented in parts of the NHS, with Guy's and St Thomas' and Kent Community Health Trust recently adopting the model.

Box 19: Clinical engagement in Canterbury, New Zealand
Both doctors and non-clinical staff were heavily involved in the creation and implementation of a shared vision for integration in Canterbury, New Zealand. Senior leaders were given specific training to empower staff to lead change and a large-scale 'Showcase' programme, which ran for six weeks, brought over 2,000 staff together to discuss and devise solutions to the problems facing their health and care economy. Both approaches were considered successful in ensuring clinicians and frontline staff saw themselves as active participants in system transformation.

Payment mechanisms must deliver for patients

Current payment mechanisms result in perverse incentives for providers, encouraging workload and resource shifts between health settings. They also create unnecessary bureaucracy and transaction costs. Instead of providing financial incentives for NHS providers to increase activity, we should be moving to mechanisms that encourage health systems to work together to prevent ill health and reduce the need for patients to be admitted to hospitals wherever possible. They should also ensure there is sufficient capacity to meet patients' needs in and out of hospital. Currently, in England in particular, hospitals are effectively penalised for helping to keep patients out of hospital, because much of their funding is linked directly to levels of activity. Some areas in England have already started to move beyond this (see Box 20).

Proposed solutions

Governments and national NHS authorities should:
- scrap activity-based payment models, such as the national tariff in England, which encourage NHS bodies to increase levels of activity in order to generate additional funding. These should be replaced with less complex funding arrangements – such as block contracts or shared funding mechanisms for specific service pathways – designed to empower NHS bodies to work together to plan how they will make best use of resources to meet the expected needs of patients in their local areas

– encourage the development of shared budgets for elements of shared care that cut across traditional divides between primary and secondary care. As part of this, GP practices and hospitals should be encouraged to work together to establish joint prescribing budgets, which have the potential to reduce costs and unnecessary workload.

Box 20: Block contracts: Northern, Eastern and Western Devon CCG

Northern, Eastern and Western Devon CCG has stopped using the Payment by Results (national tariff) system, moving to block contracts instead. This move has enabled commissioners and providers to focus on how they proactively manage expected demand, rather than reactively responding to higher levels than expected, and the financial pressures these cause among providers or commissioners. The CCG was able to go from having the largest cumulative deficit in the NHS in England to breaking even in 2019.

Since this shift in contracting arrangements, the CCG has also been able to save £4m in operating costs. The organisational focus of the CCG has been narrowed to focusing on 'delivering best value while servicing demand' since moving away from payment by results. In addition, the move away from activity-focused contracts has reduced the bureaucratic burden for both commissioners and providers.

The NHS should be free from wasteful competition rules

Current competition rules in England are incompatible with creating a collaborative NHS. Rules requiring NHS services to be put out to competitive tender, and the artificial and inefficient purchaser-provider split have created unnecessary waste and misdirection of resources within the NHS in England. They have made it more difficult for health systems to develop the trusting long-term connections needed for more integrated ways of working.

Proposed solutions

In England, the Government should:

– amend legislation based on NHS England's proposals to revoke Section 75 of the Health and Social Care Act 2012 and remove rules requiring CCGs to put contracts out to competitive tender, and make NHS providers the default option under the new proposed 'best value' test.

Better communication between primary and secondary care must be promoted

Only 16% of doctors feel there is currently clear communication between primary and secondary care, and only 28% say there are good relationships across the divide. Organisational interests and perverse financial incentives lead to a situation where doctors from the same local health system work in silos. It therefore becomes more difficult to establish the professional relationships necessary to collaborate effectively. For example, doctors report a common frustration in not being able to make contact (eg by phone) with a named person elsewhere in the health system to discuss the best course of action for a patient. Setting out common rules and processes (such as the approach in Wales described in Box 21) can help to some extent, but more can be done to improve communication and relationships between different parts of our health services.

Box 21: Standardised communication between primary and secondary care, Wales
In Wales, a Health Circular from the chief medical officer/medical director of NHS May 2018 officialised the adoption of Bro Taf LMC's standards as the All Wales Communication Standards between primary and secondary care. The guidelines give clarity on the respective roles and responsibilities of primary and secondary care when a patient is referred for treatment, with the aim of reducing problems that arise when these are not clear.

Since their adoption, BMA Wales has been monitoring their use across Wales to ensure changes happen in communication and collaboration across the interface.

Proposed solutions
Governments and national NHS authorities should:
- ensure organisational interests and perverse financial incentives are not hampering the ability of doctors to work collaboratively and the design of a seamless patient journey
- encourage more widespread use of dedicated phone lines and other forms of communication between GPs and hospital doctors, in both directions, and with other standalone community, mental health and social care services. These need to be developed in partnership with clinicians to ensure the potential workload impact is managed accordingly – eg that sufficient time is allocated to job plans and work schedules. These systems should be developed within the NHS, building on existing best practice
- maximise the use of shared records and electronic communication between primary and secondary care – eg electronic advice and guidance systems, and Skype consultations in which a patient and their GP can speak directly to a secondary care doctor
- support local health systems to develop and agree referral templates and pro formas to standardise information sharing
- enable hospital doctors to request investigations in the community and prescribe medications that can be collected in a community pharmacy, including provision of electronic prescriptions
- provide funding and support for schemes designed to build professional and social connections between clinicians across traditional working divides, building on existing liaison schemes (see Boxes 22 and 23).

Box 22: Connecting professionals: the BRIDGES initiative in Yorkshire, Lincolnshire and Humberside
The BRIDGES[18] project focuses on building trust and relationships between those working across health and social care (clinical and non-clinical) across north and east Yorkshire, Humberside and Lincolnshire. Led by NHS Collaborate, it takes the form of a series of events, run outside of working hours and away from the workplace, in which participants are encouraged to build relationships, acquire new skill sets and develop a readiness to take on new ways of working and thinking. The project has received funding through the GP retention fund but is not aimed exclusively at GPs.

Mike Holmes, GP in York and Hull, co-founder of NHS Collaborate, and RCGP vice-chair said:
'Essentially this is a peer-supported leadership development programme focussed on building relationships between colleagues across health and social care.

'At our first event in May, we invited people to volunteer at a local charity for homeless and vulnerable people. We served food to 40 people. It was a really positive experience. Our observation is that when we are working together outside our comfort zone, relationships form very quickly. Our next events are planned in July.'

Box 23: GP-consultant liaison, Wessex
GPs based in Wessex have developed a low-resource and high-impact reciprocal exchange programme between doctors across primary and secondary care. The scheme, known as the GP-Consultant Liaison Scheme, first started in 2015 in Portsmouth and has since been replicated in Southampton and Basingstoke. Participating doctors are paired, spending half a day shadowing each other in their respective places of work, followed by reflections on quality improvement, appraisal and revalidation. Each scheme counts for about eight hours of CPD. Clinicians volunteer to take part in the scheme but often practices are provided with funding for backfill while hospital clinicians' time is covered in SPA time.

Invest in IT systems that allow information to be shared securely

Lack of adequate IT infrastructure is one of the biggest barriers to creating a more collaborative NHS. Just like patients, doctors report frustrations with not being able to quickly and securely share vital information between primary and secondary care, as well as with other parts of the health service.[19] Different parts of the healthcare system have developed IT systems largely in isolation, with the resulting lack of 'interoperability' meaning that patients often report a disjointed experience in navigating different parts of the NHS, which appear to struggle to communicate effectively with each other (see Section 3).

For collaboration to work, clinicians must be able to see patients' records, observations, results and background notes from any location, ideally in real time. Box 24 gives an example where this has been implemented successfully in east London. However, although a number of areas are exploring solutions to the problem of interoperability, there is a risk this could create an uneven landscape with wide variation between areas in terms of the quality of interoperable IT systems available.

Box 24: Virtual e-clinic for kidney disease, Tower Hamlets
Specialist kidney doctors based at Barts Health Trust and GPs in Tower Hamlets, east London, are working together to provide more effective joined-up care to patients suffering from chronic kidney disease using a pioneering new e-clinic approach. Clinicians on both sides of the primary-secondary care interface have worked together to develop an interoperable IT system that gives consultants access to all patients' health records and also sends automatic trigger alerts to GP practices about patients most at risk following routine blood test results. Under this new system, outpatient appointments have reduced significantly, with over 70% of referrals that can be managed without the need for patients to attend a hospital appointment. As a consequence, waiting times for patients who require a face-to-face appointment have also dropped significantly. In 2015, the average wait for a renal clinic appointment was 64 days; with the e-clinic, the time to get nephrology advice was reduced to five days on average by 2017.

Box 25: Rajeev Gupta, paediatric consultant in Barnsley and Yorkshire regional council chair, at a BMA member event
'Doctors – whether hospital consultants or GPs – want to work together because we have a common motive of achieving better patient care. However, due to political reasons… there has been a division. To make the situation even worse, the computer systems of the two places don't work together.'

Box 26: Jon Puntis, paediatric gastroenterology consultant (retired), at a BMA member event

'For doctors, it seems basic really that we should be able to relay stuff electronically so that GPs can pick it up straight away on their computers... [It] shouldn't be difficult for people to do a discharge summary, for example, electronically and then it's immediately available to the GP practice.'

Proposed solutions

Governments and national NHS authorities should:

- ensure primary and secondary care settings are digitised at the same time to enable interoperability to be built in by system developers
- explore the implementation of fully automated messaging and document checking services, eg NHS Digital's NMAS, across health and social care services
- publish an assessment of the likely cost of achieving interoperability in the next five years and produce an 'interoperability map' to assess progress so far.

Embed collaboration into how we train doctors and other health professionals

Changing to a more collaborative way of working in the NHS will require changes to the way we train doctors and other health professionals. Current approaches to medical training remain siloed – having started their careers together in medical school and foundation training, doctors tend to fairly quickly split off into different professional groups. The result can often be different groups of professionals, with different cultures, who do not feel part of the same team. This is the case between primary and secondary care clinicians, in particular, and between public health doctors and other parts of the system.

There needs to be an assessment of how doctors' and other clinicians' training could be improved to support cross-sector collaboration and integrated care. In England, local training hubs could be a suitable vehicle for multi-agency integration and collaboration on both workforce planning and the delivery of training and education.

In addition, medical education, training and development must evolve alongside the population's health requirements and ever-changing technological practices. The NHS needs doctors who are technically specialised but also have broader generalist skills to treat complex patients in a holistic way. There are already training programmes for specialist-generalist care, geriatric care and general paediatrics and, like doctors in other specialties, a large proportion of physicians with general internal medicine training combine this with a specialist interest.

Proposed solutions

National training authorities, NHS and employing organisations need to:

- conduct a thorough assessment of how the current system of education, training and development of doctors and other clinicians could be improved to encourage and enable cross-sector collaboration and integrated care
- meet the need for more generalist care first through existing groups of doctors – GPs and hospital generalist specialties – with investment in and sensible deployment of these doctors
- work with doctors to redefine the role of GPs and specialists as co-providers of care – eg with specialists and generalists increasingly working together in the same settings.

5. Next steps: making our ambitious vision a reality

After discussing the proposed solutions set out in this report at the ARM in June 2019, the BMA's findings will be published in full this summer. We will then embark on a programme of lobbying policy makers – at UK, national and local level – to implement the changes doctors have proposed.

As outlined above, the work of promoting many of the emerging findings of the project has already begun, through initiatives such as our safe staffing campaign and work across the UK on combatting bullying and harassment. We have already started to engage senior policy makers through our series of roundtables in England and through high-level meetings in Scotland, Wales and Northern Ireland. This work will continue.

Following the ARM, we will also continue to engage the BMA's members, asking for their ongoing insight into the pressures and opportunities facing doctors in the NHS. We will also be asking doctors to join us in putting pressure on policy makers to take action based on the proposed solutions outlined in this document.

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19 In England, 95% of doctors agreed that patient data should be shared between primary and secondary care for the purposes of direct patient care.

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