The Dudley Group
NHS Foundation Trust

Board of Directors Meeting Public Papers

Thursday 10th September 2020

12:15 – 16:00

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

The Dudley Group
NHS Foundation Trust

BOARD MEETINGS
PUBLIC INFORMATION SHEET

The Dudley Group's Board of Directors ordinarily meet 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. However, due to the COVID-19 restrictions it is not currently possible to hold public meetings face-to-face. The Board of Directors will continue to publish the papers and minutes for these meetings. In addition, there is an option for members of the public to participate using MS Teams. Anyone wishing to participate should email the deputy trust secretary helen.board@nhs.net. Joining instructions will be provided the day before the meeting.

If you wish to submit any questions to the Board for consideration, these should be emailed beforehand. Questions should be kept brief and to the point and sent to the following email link dgft.foundationmembers@nhs.net Responses will either be posted on the Trusts board meeting web page following the meeting or can be found in the minutes published in due course.

1. Introduction

This sheet provides some information about how the board meetings work.

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

Copies of the agenda and papers that are available to the public can be found on the Trust website www.dgft.nhs.uk or may be obtained in advance from the following key contacts:

Helen Benbow
Executive Officer
The Dudley Group NHS Foundation Trust
Tel: 01384 321012 (direct dial) / 01384 456111 ext. 1012
Email: helen.benbow1@nhs.net

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

2. Joining the meeting via MS Teams

Please ensure that your microphone is set to mute from the point of joining the meeting. Please do not record the meeting. Other top tips:

- You've taken a comfort break and are seated comfortably
- You have refreshments to hand
- You have access to the agenda and papers
- Use the chat function to indicate that you wish to ask a question when invited to do so by the chairman – use the format; "Question for [insert name]" to help the chair in tracking

3. 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 of Interests. If you would like to see the register, please contact the trust secretary or visit our website www.dgft.nhs.uk.

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.

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 a 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 Board of Directors for approval, are added to the website at the same time as the papers for that meeting.

6. Future meeting dates

For details of future Board of Directors meetings, please visit the Trust's website www.dgft.nhs.uk

7. Accessibility

If you would like this information in an alternative format, for example in large print, please call us on 0800 073 0510 or email dgft.pals@nhs.net

The Dudley Group
NHS Foundation Trust

THE SEVEN PRINCIPLES OF PUBLIC LIFE

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

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

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

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

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

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

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

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

PUBLIC PAPERS

The Dudley Group NHS Foundation Trust

Board of Directors
Thursday 10 September 2020, 12.15pm, Remotely and at the Clinical Education Centre
AGENDA

	Item	Paper ref	By	Purpose	Time
1	**Chairmans Welcome and Note of Apologies.**		Y Buckland		12.15
2	**Note of Apologies**		Y Buckland	For noting	12.15
3	**Declarations of Interest** Standing declaration to be reviewed against agenda items.		Y Buckland	For noting	12.15
4	**Minutes of Previous meetings:** Minutes of 9 July 2020 Action Sheet 9 July 2020	 Enclosure 12 Enclosure 13	Y Buckland	For approval	12.15
5	**Public Chief Executive's Overview Report**	Enclosure 14	D Wake	For information & discussion	12.25
6	**Chair's public update**	Verbal	Y Buckland	For discussion	12.35
7	**Public Questions**	Enclosure 15	Y Buckland	For discussion	12.45
8	**Chief Nurse Update** - **Neonatal Covid Risk Assessment** - **Infection Control Report**	Enclosure 16 Enclosure 17 Enclosure 18	M Sexton	For assurance	12.55
9	**Integrated Performance Report**	Enclosure 19	K Kelly	For assurance	13.05
10	**QUALITY AND SAFETY**				
10.1	Quality Account	Enclosure 20	M Sexton	For decision	13.15
11	**FINANCE AND PERORMANCE** Public Finance and Performance Committee Report	 Enclosure 21	J Hodgkin	For assurance	 13.25
12	**WORKFORCE AND STAFF ENGAGEMENT**				
12.1	Public Workforce and Staff Engagement Report	Enclosure 22	J Atkins	For assurance	13.35
12.2	Workforce KPIs	Enclosure 23	J Fleet	For assurance	13.45
12.3	WRES/WDES Submission	Enclosure 24	J Fleet	For approval	13.55
12.4	NHS People Plan 2020/21	Enclosure 25	J Fleet	For assurance	14.15
12.5	Freedom to Speak up Guardians	Enclosure 26	D Eaves	For assurance	14.35
12.6	Guardian of Safe Working	Enclosure 27	B Elahi	For assurance	14.45
13	**DIGITAL AND TECHNOLOGY**				

13.1	Public Digital and Technology Committee Report	Enclosure 28	C Holland	For assurance	14.55
13	**GOVERNANCE**				
13.1	Winter Plan	Enclosure 29	K Kelly	For assurance	15.05
13.2	Board Assurance Framework	Enclosure 30	L Nevin	For assurance	15.15
13.3	Annual Medical Revalidation Report	Enclosure 31	J Hobbs	For assurance	15.25
14	**Any Other Business** Limited to urgent business notified to the Chair/ Board Secretary in advance of the meeting	Verbal	Y Buckland		15.35
15	**Reflection on meeting**		All		15.35
16	Date of Next Board of Directors Meeting: 8 October 2020				
17	**Meeting Close**				15.40

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

Enclosure 12

The Dudley Group NHS Foundation Trust

Minutes of the Board of Directors meeting Considering Public Papers held on Thursday 9th July 2020 at Russells Hall Hospital and by Remote Attendance

Present:

JA	Mr Julian Atkins	Non-executive Director	DG NHS FT
YB	Dame Yve Buckland	Chairman **Chair of meeting**	DG NHS FT
GC	Professor Gary Crowe	Non-executive Director	DG NHS FT
JF	Mrs James Fleet	Chief People Officer	DG NHS FT
JH	Mr Jonathan Hodgkin	Non-executive Director	DG NHS FT
JHo	Mr Julian Hobbs	Medical Director	DG NHS FT
CH	Ms Catherine Holland	Non-executive Director	DG NHS FT
LH	Professor Liz Hughes	Non-executive Director	DG NHS FT
TJ	Mr Tom Jackson	Director of Finance	DG NHS FT
KK	Mrs Karen Kelly	Chief Operating Officer	DG NHS FT
RM	Mr Richard Miner	Non-executive Director	DG NHS FT
AT	Mr Adam Thomas	Chief Information Officer	DG NHS FT
DW	Ms Diane Wake	Chief Executive	DG NHS FT

In Attendance:

LA	Mrs Liz Abbiss	Head of Communications	DG NHS FT
FA	Mr Fred Allen*	Public Elected Governor: Central Dudley	DG NHS FT
HB	Mrs Helen Board	Deputy Trust Secretary (Interim)	DG NHS FT
LG	Laura Grady*	Chair, LGBTQ+ Inclusion Network, Therapy Lead	DG NHS FT
IG	Mr Ian James*	Associate Non-executive Director	DG NHS FT
YP	Mrs Yvonne Peers*	Public Elected Governor: North Dudley	DG NHS FT
JP	Julie Penny*	Chair, BAME Inclusion Network, Advance Practitioner, Breast Imaging Department	DG NHS FT
VJ	Mr Vij Randeniya	Associate Non-executive Director	DG NHS FT
KS	Mrs Katherine Sheerin	Director Strategy & Transformation	DG NHS FT
LW	Mr Lowell Williams*	Associate Non-executive Director	DG NHS FT

*part of meeting

Apologies

MA	Mr Mushtaq Ahmed	Chief of Surgery, Womens & Children	DG NHS FT
MH	Dr Mike Healey	Chief of Medicine & Integrated Care	DG NHS FT
LN	Mr Liam Nevin	Trust Secretary	DG NHS FT
LR	Dr Liz Rees	Director of Operations, Clinical Support Services	DG NHS FT

20/201 Note of Apologies and Welcome
1.05pm

Apologies had been received as listed above. It was noted that whilst it had been intended to film the meeting a technical problem had arisen that prevented this and the intention was to address the issue and film the next meeting.

The Chair advised that governors Fred Allen and Yvonne Peers would join the meeting.

The Chair welcomed Katherine Sheerin to the Trust and her first Board meeting as Director of Strategy and Transformation.

The Chair noted that the plan to hold the meeting face-to-face had been reviewed following receipt of further Government guidance received earlier that week and confirmed that meetings would be held in a virtual format until further notice.

CH proposed that a review of the board level leadership engagement and effectiveness in the new virtual world would identify best practice and development opportunities.

Action Review NED engagement and effectiveness in the remote/virtual context **Trust Secretary**

20/202 Declarations of Interest

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

20/203 Minutes of the previous meeting held on 11th June 2020

It was RESOLVED

- **That the minutes of the meeting of the 11th June 2020 be agreed as a true and accurate record of the meeting.**

20/203 Public Chief Executive Overview Report

DW provided an update on the latest COVID-19 figures where the Trust had recorded 1003 positive cases and had recently seen a significant decrease in those testing positive when attending hospital. There remained seven inpatients being treated for COVD-19.

DW reported that face coverings had been introduced across the Trust from 15th June 2020 in line with government guidelines. Temperature checking had also been introduced with a process developed to manage those with a high temperature. All Trust sites were zoned and complying with 2 metres distancing where possible and noted that the 1m distancing measures recently announced by the Government were not applicable to healthcare settings.

GC questioned how well the zoning was working and if testing was supporting the new system effectively.

IJ queried issues related to discharges to care homes and timeliness of testing.

DW replied that the swabbing of all patients scheduled for discharge was in place and the process around this was kept under review. She reiterated the importance placed on ensuring rigorous infection control measures as the Trust increased elective care activity. It was noted that a significant number of patients were declining appointments and the Trust was working hard to reassure the public that their safety was our key priority.

DW advised that the CQC had removed two Section 31 notices that related to Sepsis management and ED staffing. The Notice relating to the triaging of patient within 15 minutes would remain subject to further review. JHo congratulated staff who had worked hard to improve the systems and performance in that department

20/204 Chair's Public Update
13.19pm

The Chair advised that the MCP/ICP discussions had continued with key stakeholder groups. She referenced the Prime Minister's recent visit to Dudley last week and noted that the Trust had received a letter earlier that day from Downing Street that congratulated the Trust on 'a fantastic job the hospital is doing for the community of Dudley.'He had also noted the hard work of the team and indicated that the PM would arrange a future visit to the Hospital.

The Chair noted that NHSI briefings for chairs had continued with a strong focus on restoration and recovery whilst continuing to operate under level 4. There were positive indications that the Trust was making good restoration and recovery progress which had been re-enforced on an earlier conference call with the STP. The chair noted that the introduction of face masks across the Trust had been well organised.

Board to Board meetings had taken place with Dudley Integrated Healthcare Partnership and Black Country Healthcare NHS Foundation Trust to discuss opportunities for integrated services in Dudley.

Action Prime Ministers letter to be circulated and shared widely **LA**

20/205 Chief Nurse Report
13.26
MS summarised the report and noted that the new look report linked the Trust strategic objectives and CQC domains. She highlighted the increase in the closure of complaints in the month and the increased volume of compliments received. She noted that the family support service had been well received. She welcomed the proposed national arrangements to increase student nurse and Allied Health Professionals (AHP) placements. MS referenced the number of Trust vacancies for registered nurses and outlined some of the initiatives and actions being taken to address this including at STP level. JF confirmed that he was the SRO for this work stream at STP level.

Liz Hughes complimented the new style report layout and the number of student nurses choosing to remain with the Trust.

It was **RESOLVED**

- **That the report be noted**

20/206 Integrated Performance Report
13.33pm

KK summarised the report and highlighted the Trust's strong Emergency Access Standard performance noting that the Trust had been first in the region in the last few weeks. She noted the challenges related to restoring diagnostic performance and outlined some of the initiatives being taken. The Trust was continuing to utilise private sector facilities to good effect. KK noted that the Trust was proactively encouraging those patients who were still reluctant to attend their appointments and there were no reported 52 day breaches. She confirmed that two new respiratory consultants had been recruited.

[13.40 Fred Allen joined the meeting at this point]

GC asked for clarification about the monitoring of recovery of waiting lists in consideration of the clinical need of individual patients. KK confirmed that guidance received had been followed closely and all cases had been clinically assessed. She added that the performance information including trajectories was provided to the Finance and Performance committee of Board.

RM queried the impact of the existing bed occupancy impact on nurse staffing cover. He also noted that the report omitted VTE performance. KK explained that zoning still required registered nursing staffing to full establishment to maintain preparedness and noted that there had been a review of bank and agency care support worker staff to offer flexibility. KK confirmed that the VTE tracking had continued and the omission was an oversight and would be rectified in future reports.

YB queried whether modifying the appointment booking system arrangements would help address the issue of patients not attending. KK confirmed that different solutions had been introduced to address including this individually contacting patients in advance.

[Ian James left the meeting at this point]

It was **RESOLVED**

- **That the report be noted**

20/207 QUALITY AND SAFETY

20/207.01 Quality and Safety Committee Report
13.59pm

LH confirmed that the Committee had met on 23rd June and asked that the upward report be taken as read and highlighted the following points:

Assurances were received that the Trust's oxygen supply had been maintained throughout the COVID pandemic and to acknowledge the effectiveness of the Oxygen Escalation Plan. The actions required in response to the Paterson Report were noted. The Committee recognised the ongoing pressure on the breast screening services owing to the national shortage of trained radiologists and radiographers and were continuing to look at service transformation and innovation.

It was **RESOLVED**

- **That the report be noted**

20/208 FINANCE AND PERFORMANCE

20/208.1 Finance and Performance Committee Report
14.04pm

TJ summarised the exception report adding that further restoration and recovery trajectory information would be provided to the next meeting. He added that this information would then support finalisation of the budgets for the remainder of the year which were presently under review based on the recently updated funding formulas and development of different service delivery models. TJ noted that there had been some unexpected increase in costs as a result of the pandemic and gave examples.

It was **RESOLVED**

- **That the report be noted**

20/208.2 Charitable funds
14.10pm

JA advised that the report summarised the items considered at three meetings that had taken place subsequent to the last report. Two of the meetings had been held in response to the overwhelming and generous donations received that has totalled more than £600k and plans had been considered and approved for the allocation of funds in three main categories - business as usual and quick wins with the majority to be spent on longer term projects to deliver strategic benefits to staff. He noted that the balance of funds held had seen a sharp decrease in recent months as a result of poor investments activity. This was to be reviewed to ensure that the funds were invested optimally.

It was **RESOLVED**

- **That the report be noted**

20/209 WORKFORCE AND STAFF ENGAGEMENT

20/209.1 Workforce and Staff Engagement Report
14.13pm

JA advised that the Committee had convened its first deep dive session on 30th June that had comprised a workshop related to staff engagement and had been well attended from a wide range of groups across the Trust. The primary focus was to review the national staff survey results and develop the Trust's response and actions, under-pinned by effective staff engagement and effective methods of monitoring. He confirmed that the next deep dive topic would be inclusion and diversity.

JF confirmed that a programme of deep dive topics had been agreed up until the end of the year. He highlighted the key messages of the report given as enclosure 25 and noted that workforce race equality indicators had been re-introduced as part of the recent health inequalities highlighted during the COVID pandemic and flagged the work underway to aim to improve the race equality aspects of the national staff survey where the Trust had achieved suboptimal scores.

LA presented the proposed staff engagement model for discussion and approval.

YB commended JF on the report format and quality of data adding that equality and diversity would be included as part of the ongoing board development programme.

CH suggested that it would be desirable to receive a short verbal analysis against each of the actions and asked for a narrative to be provided as a summary on the cover sheet for the next month's report.

Action Future Workforce and Staff Engagement report to include a summary narrative on cover sheet **JF**
Action Workforce report to be provided to Council at their next full meeting **Trust Secretary**

It was **RESOLVED**

- **That the report be noted**
- **That the Staff Engagement Model be approved**

20/209.1 Staff equality and inclusion network leads
14.32pm

YB welcomed Julie Penny, who had recently become chair of the BAME Inclusion Network and Laura- Gibbs-Grady who had recently become chair of the LGBTQ+ Inclusion Network.

The Inclusion Network chairs provided a short presentation about the establishment of their respective networks, shared their own personal experiences and highlighted challenges and opportunities that lay ahead. They both acknowledged the positive influence of the Trust's Leadership Development course on their own development.

YB thanked them for sharing their own personal experience and was pleased to hear directly from staff on how they could contribute and lead others.

LH asked if there were plans to establish a disability inclusion network. JF replied that it would be part of the plans as the inclusion networks developed over time. He added that the issue of non-disclosure would be addressed and that the workload would need to be shared to effectively deliver ambitious plans.

YB supported the plans especially as the Trust had a role in tackling disadvantage and inequality in the community and confirmed that every member of the Board would support its delivery and suggested using reverse mentoring.

AT thanked the network chairs for sharing their experiences and invited them to identify what they needed from the Board to support their work.

LG commented that everyone had been very supportive and would collaborate with the network at its next meeting and respond with a considered request.

YB commented that their presentations had been enlightening and expressed her support of the reverse mentoring and referred to her experience of this in a former role and would look forward to watching the networks progress and flourish.

Action Diversity to be included as part of the Board Development programme **Chairman**

Action Chairs of BAME and LGBTQ+ Inclusion Networks be invited to present to governors at a future meeting **Trust Secretary**

[Julie Penny and Laura Gibbs-Grady left the meeting at this point]

20/210 Digital and Technology

20/210.1 Digital Trust Technology Committee

CH RM summarised the Committee exception report and advised that the planned clinically led digital solution for VTE linked to electronic prescribing provided positive assurance and confirmed that the Committee discussions had focussed on a review of broader strategic objectives and the use of digital / technology.

20/211 Public Questions (Enclosure 12)

YB referred to enclosure 12 where two questions had been received. The first related to the impact on provision of GP services in Pensnett following a surgery move to the Brierley Hill Health and Social Care Centre and confirmed that the question had been forwarded to the Dudley CCG. The second question noted the recent press coverage that Dudley was emerging as a COVID hotspot and if the Trust was prepared for a second spike. DW replied that the news reports had been unfounded and that the Trust remained prepared for a further spike.

Action provide the CCG with a note of the question raised by Mr Knowles **Trust Secretary**

20/212 Any Other Business

There was no other business.

Date for the Next Meeting – 10th September 2020

Signed ……

Dated…….....

Enclosure 13

The Dudley Group NHS Foundation Trust

Action Sheet
Minutes of the Board of Directors Public Session
Held on 9th July 2020

Item No	Subject	Action	Responsible	Due Date	Comments
20/201	NED engagement	Review NED engagement and effectiveness in the remote/virtual context	LN	Sept 2020	To be addressed as part of the Board effectiveness review
20/204	Prime ministers letter	Letter to be circulated and shared widely	LA	July 2020	Completed
20/209.1	Workforce and Staff Engagement Report	1. Future report to include a summary narrative on cover sheet 2. Report to be submitted to the Council of Governors	JF	Sept 2020	On Board and CoG Agenda
20/209.1	Diversity and inclusion	To be included as part of the Board Development programme	YB	Mar 2021	Board inclusion events arranged for September and November
20/209.1	Diversity and inclusion	Invite chairs of BAME and LGBTQ+ Inclusion Networks to present to future governor meeting	LN	Mar 2021	Not Due
20/211	Public question	Provide CG with a note of the question raised by Trust member in relation to High Oak Surgery	LN		Completed
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	MS	July 2020	In hand – outcome to be presented to the Workforce Committee later in the year.
19/194	Chief Nurse Report	IPC Assurance Framework to be periodically reviewed by the Board through Quality and Assurance Committee	MS	October 2020	Not Due

Enclosure 14

The Dudley Group NHS Foundation Trust

Paper for submission to the Board of Directors on 10th September 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:

- Coronavirus
- Frailty Assessment Unit Shortlisted in National Awards
- Gold Standards Framework
- Changes to the Friends and Family Test
- Freedom to Speak Up Month
- £3m Funding for Modular Build
- Flu Vaccination
- Healthcare Heroes
- Charity Update
- 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 – 10th September 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 highlight a number of items of interest.

Coronavirus

We are working with our colleagues across the council and care settings to remind our staff and public that avoiding a local lockdown is everyone's responsibility. The advice remains to keep two metres apart, wash hand frequently and wear a face covering in certain situations, for example, when coming to hospital. It is so important that we all follow this advice to keep ourselves and our loved ones safe from the virus.

Frailty Assessment Unit Shortlisted in National Awards

Congratulations to the Frailty Assessment Unit who have been shortlisted in the Nursing Times Awards in the Care of Older People category. This is great news and a credit for all the work they have done to look after our most vulnerable patients. Finalists will find out if they have won a Nursing Times Award live at the awards ceremony which is taking place on Wednesday 14th October 2020.

Gold Standards Framework

Congratulations also to wards C3 and C8, and the Coronary Care Unit for achieving the Gold Standards Framework Accreditation for the highest standard of care for our end of life patients. The Coronary Care Unit is the first in the country to achieve the Gold Standards Framework Accreditation, so very well done. This is absolutely wonderful news. Pre-COVID, individual care plans have included weddings, visits from pets and birthday celebrations, and this is now part of the culture in the Trust to support end of life care. Gold Standards Framework operates in association with Hospice UK and recognises the hard work of the whole team.

Changes to the Friends and Family Test

Patients who use our services will have been offered many ways to give their feedback about the service and care they have received. One of those is the Friends and Family Test. From this month, September 2020, there are some changes. The question is changing. Instead of: 'How likely are you to recommend our services to friends and family'? patients will be asked 'Overall, how was your experience of our service?'

Following feedback from our patients and staff, we are also asking two free-text questions:

- What was good about your visit?
- What would have made it better?

Patients and people who use services should be able to give feedback at any time and should have the opportunity to provide feedback via the FFT if they want to. In maternity services, women should be able to give feedback at any time during their pregnancy rather than waiting until the 36th week. These changes are designed to make the FFT more accessible for all patients.

Freedom to Speak Up Month

October is national Freedom to Speak Up month and our opportunity to raise awareness amongst staff that no issue is too small to raise. Freedom to Speak Up encourages staff to voice any concerns confidentially. This initiative was introduced in all NHS organisations four years ago following Sir Robert Francis's report. We have three Freedom to Speak Up Guardians who help promote an open culture that supports patient safety and staff wellbeing. We will be engaging with staff in a number of ways throughout the month. For more detail on what we have planned, please see separate report in these papers.

£3m Funding for Modular Build

Prime Minister Boris Johnson announced that we are to receive £3m contribution towards our new modular build which is very good news for our patients. The two storey build will be linked to our Emergency Department to provide combined assessment facilities and same day emergency assessment and care. The assessments facilities in the hospital will relocate there freeing up more than 60 beds to help with winter pressure, the safe management of COVID-19 and the requirements for social distancing and segregation. This new facility should be operational by the end of December 2020.

Flu Vaccination

Planning for the flu season is already underway. This year our target is to vaccinate 90 per cent of frontline staff to help keep everyone safe from the flu virus. For most people, flu is unpleasant but we generally recover within a few days. For others, it can cause severe illness and, in some cases, can be life threatening or fatal. Those at particular risk are:

- older people
- the very young
- pregnant women
- those with underlying disease, such as chronic respiratory or cardiac disease
- those who are immunosuppressed

This year, people are also recommended to have the flu vaccine if they are the main carer of an older or disabled person.

Healthcare Heroes

Our monthly Healthcare Hero Awards were paused while our staff and volunteers responded to the coronavirus pandemic. I am so proud of all our staff, both clinical and non-clinical, in the hospital setting and those working in the community and visiting patients' homes. Selecting individual, team and volunteer winners for each month was a happy but difficult task because they are all winners. Listed below are some exceptional people who thoroughly deserve this recognition.

Individual Awards

April

April's Healthcare Heroes individual award went to Matron Simon Gregory. Simon was nominated by a colleague, on behalf of his team. He cares about every member of his team and his dedication to his staff and the ward is a shining example of what a true leader looks like. He never expects any one from his team to carry out something that he wouldn't do himself. Simon is always on hand to help his staff as well as the patients he cares for. Simon's award is yet to be presented.

May

May's Healthcare Heroes individual award went to Roxanne Taylor, who is one of our community leads. Roxanne was nominated by four different people for being a dedicated member of the community nursing team. She has recently taken on a lead role and has been an inspiration to all her colleagues, going above and beyond to ensure the whole team feels supported.

June

June's Healthcare Heroes individual award went to Rachel Willetts who works in our Breast Care Department. The team recently lost a dear colleague to cancer, which was undoubtedly a very emotional and upsetting time for the whole department. Rachel devoted her own time to support her colleague and family during that difficult time, arranging a memorial in her honour.

July

July's Healthcare Heroes individual award went to Rachel Smith for the support she has given to implement our new virtual glaucoma service. Rachel was our first glaucoma technician and ran her very own clinic before the pandemic. She always goes the extra mile to investigate solutions and increase her knowledge of the condition, to not only benefit herself, but her patients and wider team members.

Team Awards

April

April's Healthcare Heroes team award went to the Procurement and Distribution Team. The team was nominated for their selfless and committed attitude in providing around the clock support during the coronavirus pandemic. The team's reaction to an on-going situation has been exemplary and all staff have shown how effective, efficient and professional they are.

May

May's team award went to ward C5 for excelling in their professionalism over the past few months as they battled with coronavirus. They maintained a very strong patient focus and delivered excellent safe, quality care. Despite the challenges, the team pulled through together to make the best out of what has been a devastating situation. They have been very supportive and welcoming to re-deployed staff, making them feel part of the team and looking after their wellbeing.

June

June's team award went to the Infection Prevention and Control team who were nominated by a colleague for their outstanding response to the coronavirus pandemic. They have thrived on excellence and have shown true passion as they have dealt with an ever changing situation. They have been described as inspirational and have demonstrated courage and compassion.

July

July's team award went to the community response team for their dedication to serve the people of Dudley with top class care to the most frail and vulnerable. The team cared for patients with suspected and confirmed COVID-19 despite their own fears of contracting the virus and transmitting it to loved ones. Despite this, the team continued to deliver the best possible care to those who needed it most which came with a high level of risk.

Volunteer Awards

April

April's Healthcare Heroes volunteer award went to Aimee White. Aimee was furloughed from her job during the COVID-19 pandemic so decided to dedicate her time volunteering at the hospital. She worked on main reception taking belongings up to the patients on the wards, collecting wheelchairs and organising the entrances with masks and sanitisers. While volunteering, Aimee took it upon herself to create a rainbow display in the main corridor of the hospital, which brightens up everyone's day.

May

May's volunteer award went to Emma Sherwood. Throughout the pandemic, Emma has made a difference by volunteering for The Dudley Group, coming in up six days a week. She always fills the room with smiles and doesn't hesitate when asked to do something. She has been busy making visors for staff, delivering notes and making drinks for inpatients.

June

June's volunteer award went to Mervyn Cummings. He is described by colleagues as one of the friendliest people they know and is always willing to go above and beyond for his role. Throughout the pandemic, Mervyn has been volunteering five days a week and has been helping with the deliveries from procurement to clinical areas. He completes task quickly and efficiently and always follows the correct procedures.

July

July's Healthcare Heroes volunteer award went to James Hyde. James was nominated by colleagues for his willingness to go above and beyond when volunteering at the Trust. James is always pleasant and takes tasks in his stride such as pushing wheelchairs, taking and collecting patient notes from department to department and making the work lives of our staff that little easier.

Charity Update

NHS Charities Together

www.nhscharitiestogether.co.uk

Stage 1 COVID-19 Crisis Appeal funding totalled £117,000. This has now been allocated. The Trust is now working on Stage 2 funding from **NHS Charities Together**. These are funds allocated to us to share with local charities in order to create collaborative partnerships. Our Trust is part of the Black Country STP led by Johnny Shah from Sandwell and Birmingham Trust Charity. We are currently working with other local NHS charities in order to maximise the value of this partnership.

Charity Pumpkin Trail Challenge

We can now confirm that we will be holding our sponsored Halloween ScareFest pumpkin trail on Saturday 31st October at Baggeridge Country Park. This event has been scaled down to respect social distancing so spaces are limited. Details will be available soon on the charity Facebook page.

Russells Hall Rainbow

We are fundraising to support the installation of a sculpture to be located outside Russells Hall Hospital. The Russells Hall Rainbow will be a permanent reminder to honour and thank local heroes for their work during the Coronavirus pandemic. For more information and to make a donation visit the JustGiving Page: www.justgiving.com/campaign/RussellsHallRainbow

Visits and Events

9th July 2020	Board of Directors
14th July 2020	Live Chat
15th July 2020	Team Brief
16th July 2020	Black Country Cancer Board to Board
22nd July 2020	NHS Leadership Regional Roadshow-Midlands
24th July 2020	Live Chat
27th July 2020	Black Country STP Cancer Board
30th July 2020	Healthier Futures Partnership
31st July 2020	Live Chat
4th August 2020	Charity Fundraising Group
10th August 2020	Healthcare Heroes
10th August 2020	Live Chat
11th August 2020	Healthcare Heroes
12th August 2020	Partnership Board
12th August 2020	Healthcare Heroes
14th August 2020	Extraordinary Board of Directors
14th August 2020	Healthcare Heroes
17th August 2020	Healthcare Heroes
17th August 2020	Black Country STP Cancer Board
19th August 2020	Live Chat
20th August 2020	Team Brief
24th August 2020	Live Chat
3rd September 2020	A&E Delivery Board
3rd September 2020	Live Chat

National NHS news

Roll-out of two new rapid coronavirus tests ahead of winter
Millions of ground-breaking rapid coronavirus tests will be rolled out to hospitals, care homes and labs across the UK to increase testing capacity ahead of winter. The tests will enable clinicians and NHS Test and Trace to quickly advise on the best course of action to stop the spread of the virus. Two new tests – both able to detect the virus in just 90 minutes – will be made available to NHS hospitals, care homes and labs. The two tests will be able to detect both COVID-19 and other winter viruses such as flu and respiratory syncytial virus (RSV). The tests do not require a trained health professional to operate them, meaning they can be rolled out in more non-clinical settings. **GOV.uk (03.08.20)**

NHS set to roll out £160m 'Covid-friendly' cancer initiative
As part of a £160m initiative, the NHS will look to roll out and expand 'COVID-friendly' cancer treatments which are safer for patients during the pandemic, the health service's Chief Executive Sir Simon Stevens has announced. The funding will help pay for drugs which treat patients without having as significant of an impact on their immune system, or which could offer other benefits such as a reduced number of hospital visits. **National Health Executive (03.08.20)**

PPE chaos: Desperate NHS trusts' race to secure lifesaving PPE from unproven suppliers amid catastrophic distribution failures
NHS trusts spent vast sums with unusual and often previously unproven suppliers at the height of the coronavirus outbreak as shortfalls in Britain's PPE supply system left them in a desperate race to keep staff and patients safe, i can reveal. An investigation by i established a catalogue of extraordinary spending as hospitals flooded with COVID-19 patients grappled with finding necessities from gowns to hotel rooms. **iNews (04.08.20)**

GPs should consider home flu jabs for shielding patients, says NHSE
NHS England is targeting 75% uptake of flu vaccinations in at-risk groups this season, with GPs told to consider visiting shielding patients at home, while for others drive-in vaccinations are suggested. **Pulse (05.08.20)**

Thousands of NHS workers to protest this weekend over pay
Unite, which has 100,000 members in the health service, said it is supporting those wishing to attend the socially-distanced protests so that the Government can see the depth of discontent and frustration among NHS staff. A demonstration is organised in London on Saturday morning, while protests will also take place in other towns and cities across the UK. **The Standard (06.08.20)**

Coronavirus: Safety concerns halt use of 50 million NHS masks
The government says the masks, which use ear-loop fastenings rather than head loops, may not fit tightly enough. They were bought for NHS England healthcare workers from supplier Ayanda Capital as part of a £252m contract. Ayanda says the masks met the specifications No 10 had set out. The PM said he was "disappointed" that any protective kit should be unfit for use. An earlier government statement said its safety standards process is "robust". **BBC News (06.08.20)**

Why NHS Test And Trace Isn't Working
The NHS Test and Trace system – which has been branded "world beating" by the prime minister – is meant to be a serious weapon in the government's arsenal in the fight against COVID-19. But serious concerns have been raised about its effectiveness – so much so that some councils are setting up their own procedures.

At the centre of concerns about the Test and Trace service – and whether it can really protect the UK from a second wave – are questions about how many people are actually being reached by contact tracers. Figures released by the government showed on Thursday showed that just 72% of people who tested positive for COVID-19 between July 23 and July 29 were contacted by NHS Test and Trace. **Huff Post (06.08.20)**

Nearly two-thirds' of NHS workers may have had COVID-19 in spring
A large proportion of healthcare workers in England may have been infected with COVID-19 between mid-February and mid-April, researchers have said. Led by the University of East Anglia in collaboration with University College London, a study found that two-thirds of respondents to a survey across one of the largest NHS trusts in the UK had experienced a loss of their sense of taste and smell during the time period. This was before the Government included the symptom among those which would have enabled NHS staff to have a COVID-19 test, which did not happen until May. **Pulse (07.08.20)**

Nurses 'confident' ahead of national pay protests on Saturday
More than 35 demonstrations are scheduled to take place in different parts of the UK with huge numbers of nurses and midwives expected to show up. Organisers told *Nursing Times* they were "extremely confident" the events would have an impact with further local protests planned later in the month. The demonstrations have been sparked by a grassroots movement launched on social media by frontline nurses and midwives. **Nursing Times (07.08.20)**

Staff at London NHS trust lost sense of smell before it was added to symptoms list
Almost two-thirds of staff at a London NHS trust had lost their sense of smell before anosmia was added to national guidance as a coronavirus symptom, a study indicated. Researchers asked staff at London's Barts Health NHS Trust to complete a questionnaire in the week of April 17 to 23, at the height of lockdown. At this time anosmia - a loss of taste or smell - was not listed as an official coronavirus symptom and Covid-19 testing among NHS workers was limited to those displaying symptoms of a new continuous cough or a high temperature over 37.8C. **ITV News (07.08.20)**

Birmingham NHS trust to help improve Shropshire services
NHS experts from Birmingham are stepping in to help improve troubled Shrewsbury and Telford Hospital NHS Trust (SaTH). University Hospitals Birmingham NHS Foundation Trust (UHB) has started an "improvement alliance" with SaTH to provide "leadership expertise". An investigation into maternity care at Shropshire, which is in special measures is reviewing 1,862 incidents. The chairman of the trust since 2018, Ben Reid, has also now stepped down. **BBC News (07.08.20)**

Dozens of NHS trusts tell women seeking IVF to prove they're in a 'stable' relationship - creating infertility 'postcode lottery'

Women seeking IVF treatment on the NHS, in some areas of England, must prove they are in a three-year 'stable' relationship to get funding. However, local policies differ from region to region creating an infertility 'postcode lottery' based on relationship status. **Mail Online (09.08.20)**

NHS Test and Trace service to strengthen regional contact tracing
NHS Test and Trace and Public Health England (PHE) will extend its partnership with local authorities in order to reach more people testing positive and their contacts to stop the spread of COVID-19, the government has announced today. This new way of working will give local areas dedicated ring-fenced teams from the national service. These dedicated teams of NHS Test and Trace contact tracers will focus their work on specific areas, alongside the relevant local public health officials to provide a more tailored service. **GOV.uk (10.08.20)**

Coronavirus: Contact tracers to be reduced by 6,000 in England
The NHS test and trace system in England is cutting 6,000 staff by the end of August, the government has announced. The remaining contact tracers will work alongside local public health teams to reach more infected people and their contacts in communities. It comes after criticism that the national system was not tapping into local knowledge. The approach has been used in virus hotspots like Blackburn and Luton. And it's now being offered to all councils that are responsible for public health in their area. **BBC News (10.08.20)**

Prime Minister confirms funding to prepare the NHS for winter
NHS trusts across the country have today been allocated a share of £300 million to upgrade their facilities ahead of winter, the Prime Minister will confirm. The PM will also urge the public to feel confident to visit A&E for the treatment they need, reassuring those who remain concerned that strict social distancing and hygiene measures are in place to protect patients. **GOV.uk (11.08.20)**

Coronavirus: Deaths of hundreds of frontline NHS and care workers to be investigated
The deaths of hundreds of NHS and social care workers infected with coronavirus are under investigation by medical examiners, *The Independent* has learnt. Ministers have asked medical examiners in England and Wales to review all deaths of frontline health and social care staff infected with the virus to determine whether the infection was caught as a result of their work. The review, which started last month, is likely to cover more than 620 deaths including nurses, doctors and care home staff across England and Wales, since the beginning of March. **Independent (11.08.20)**

Chief nurse urges pupils getting A-Level results to join NHS coronavirus fight
England's Chief Nurse has issued an appeal to every pupil getting A-level results to join the NHS in the battle against coronavirus. The desperate plea by Ruth May for the "COVID generation" to help comes as the National Health Service tries to reset itself after the first wave of infection, with more than 40,000 nursing vacancies. NHS England wants to capitalise on fresh interest in joining the health profession after the outpouring of gratitude towards carers during the pandemic. It will today send direct emails to 50,000 people as well as putting adverts on Facebook, Instagram, Twitter and Snapchat. The messages will appeal to those entering the universities' clearing system to apply for nursing degrees. **Mirror (12.08.20)**

UK records highest number of new coronavirus cases in seven weeks with 1,148 infections and a further 102 deaths

The UK today recorded its highest number of new coronavirus cases in seven weeks with 1,148 infections and a further 102 deaths across the country. The total number of cases today reached 312,789 after the largest rise since June 21, when there were 1,221 new cases. The total number of deaths rose to 46,628 today.

The new rise in cases breaches the ceiling that the Government's Joint Biosecurity Centre said was acceptable to avoid 'flare-ups' of COVID-19, according to Sage documents. **Mail Online (12.08.20)**

COVID-19: New trial for England's revamped NHS contact-tracing app
England's new look NHS contact-tracing app is set to begin public trials today, after months of setbacks. The app will be based on Apple and Google's decentralised model. NHSX has been working with the tech giants to develop a new version of the app after abandoning its original model in June. Both versions of the app used Bluetooth to track time and distance between smartphone devices, but Apple and Google's version was hailed as more privacy-centric as it only sends alerts between devices when COVID-19 is detected, rather than large quantities of data being stored on a central database. **Digital health (13.08.20)**

Only 1 in 5 NHS trust leaders back COVID testing strategy
Only one in five NHS trust leaders in England believe the government has taken the right approach to testing for COVID-19, according to a survey, as a growing number of experts raise concern that the current strategy is not robust enough to prevent a resurgence of the virus in the autumn. And only one-third of trust executives felt that the government's testing strategy would meet the needs of their users over the next three months, according to the study by NHS Providers, which represents hospital, mental health, community and ambulance services. **Financial Times (13.08.20)**

NHS figures reveal long waits for routine ops in England
The number of patients admitted for routine treatment in hospitals in England was down 67% in June compared with the same time last year, NHS figures show. The number of people going to accident and emergency units in England in July was also down on last year, by 30%. The coronavirus pandemic has caused disruption to many areas of the health service. **BBC News (13.08.20)**

Over 50,000 NHS patients forced to wait more than a year for routine operations
More than 50,000 people are waiting more than a year for routine hospital treatment as NHS delays in England soar to the highest level since records began. Figures published today showed the stark impact the coronavirus pandemic has had on NHS services. **The Times (13.08.20)**

NHS braces for increased demand for mental health support in wake of coronavirus pandemic
More health staff are being trained to treat people with post-traumatic stress disorder in preparation for a potential spike in demand for mental health services after the coronavirus crisis. Almost 3,000 trainees are expected to start courses in psychological therapies and former staff are also being asked to consider returning to frontline roles in preparation for growing numbers of people suffering from anxiety and depression and related conditions. **The Telegraph (15.08.20)**

Government recalls 200,000 faulty gowns supplied to NHS staff
Hospitals have been told to check their personal protective equipment stocks to identify the faulty Flosteril gowns and remove them from circulation. Tests showed the gowns fell short of the fluid-resistance standards claimed by the supplier, potentially putting staff at increased risk of coronavirus infection. Some 200,000 defective gowns were estimated to be in circulation across the NHS. **Metro (15.08.20)**

Public Health England to be scrapped and merged with NHS program
Hancock is expected to announce this coming week the merger of the pandemic response work of PHE with the National Health Service (NHS) Test and Trace program to better deal with the coronavirus pandemic, according to the Independent. The new body will be called the Institute for Health Protection, modelled on Germany's Robert Koch Institute, and will become "effective" next month, although it will take until next spring to get the organizational changes completed. **Digital Journal (15.08.20)**

Coronavirus: Cover-up fears as reviews of COVID-19 deaths among NHS staff to be kept secret
Ministers have been accused of trying to cover up the findings from investigations into hundreds of health and social care worker deaths linked to coronavirus after it emerged the results will not be made public. The Independent revealed on Tuesday that medical examiners across England and Wales have been asked by ministers to investigate more than 620 deaths of frontline staff that occurred during the pandemic. The senior doctors will review the circumstances and medical cause of death in each case and attempt to determine whether the worker may have caught the virus during the course of their duties. **Independent (15.08.20)**

Thousands of COVID-19 survivors 'can't access NHS rehabilitation services as no proof they were infected'
Patients want those who believe they had the virus to be able to self-refer themselves to specialists without a GP referral or positive test. Thousands of coronavirus survivors claim they are unable to access NHS rehabilitation services because they have no proof they contracted the virus, an investigation by The Telegraph can reveal. **The Telegraph (15.08.20)**

Cancer patients will live for less time because of NHS care suspension
People with cancer will die sooner because the NHS suspended so much screening, testing and treatment of the disease during the pandemic, according to new research. The chances of people in the UK with breast cancer surviving for five years after diagnosis could fall from 85% to 83.5%, the IPPR thinktank and CF healthcare consultancy found. Five-year survival for bowel cancer could drop from 58.4% to 56.1%, while people with lung cancer would see their chances of being alive after that time fall from 16.2% to 15.4%. **Guardian (16.08.20)**

NHS chief slams ministers for trying to 'shift the blame' for coronavirus failings by AXING Public Health England
Ministers have been accused of seeking to deflect attention from their own handling of the coronavirus crisis after reports Public Health England is to be broken up. The COVID-19 response work of PHE is to be merged with NHS Test and Trace to form a new body designed to deal with pandemics. Other aspects of its operations - such as tackling obesity - could be handed over to councils and family doctors. **Mail Online (16.08.20)**

Dido Harding to run agency replacing Public Health England
Dido Harding, a Conservative peer who heads up England's widely criticised test-and-trace system, has been chosen to run a new institute to replace Public Health England, after the controversial decision to axe the agency. Harding will be named as the chair of the National Institute for Health Protection, which will be charged with preventing future outbreaks of infectious diseases, despite the poor performance of NHS test and trace, which she has led since May. **Guardian (17.08.20)**

NHS braces for £10bn spend on outsourcing work to private hospitals
The NHS could spend £10bn on outsourcing work to private hospital groups over the next four years, HSJ can reveal. A contract notice published today said the work in privately owned facilities would "support the reduction of waiting lists forecast to increase as a result of COVID-19 interrupting and reducing available NHS capacity". The document said private providers had until later this month to register their interest in being on the framework to provide "NHS inpatient and outpatient services (including full supporting pathology and imaging and "NHS inpatient non-elective care"). **Health Service Journal (17.08.20)**

Coronavirus breakthrough: NHS is ready for COVID-19 second wave this winter claims expert
Dr Laurence Buckman, the former chairman of the BMA's GP committee, insisted the NHS is in very good shape and organised amid the coronavirus pandemic. While speaking on TalkRadio with Mike Graham, Dr Buckman admitted he had doubts the UK would even see a second coronavirus wave this winter. He attributed this scepticism to the UK's success in reducing the number of transmissions over the past few months. **Daily Express (18.08.20)**

NHS cannabis guidelines challenged in court
The parents of a three-year-old boy with severe epilepsy are going to court to mount the first legal challenge to the guidelines on prescribing cannabis on the NHS. Charlie Hughes went from having up to 120 seizures a day to fewer than 20, after receiving cannabis oil privately. Although medical cannabis was legalised in November 2018, almost no NHS prescriptions have been handed out. A victory for the family could make the current guidance unlawful. **BBC News (18.08.20)**

Coronavirus fallout: NHS fears 'tsunami' of patients as mental health cases soar
The number of people suffering symptoms of depression has doubled during the coronavirus pandemic, figures show. One in five reported problems including stress and anxiety, up from one in 10 before COVID-19. Experts have warned the situation will only get worse as the economic fallout continues, with what one expert calls a "tsunami" of patients. **Daily Express (19.08.20)**

NHS staff sign up to COVID-19 sniffer dog trial
NHS staff are taking part in a trial to see if dogs can sniff out COVID-19 - even in people who are asymptomatic. Eleven hospitals across the UK are taking part in the study, with scientists hoping at least 3,500 staff will provide "odour samples". Testing has begun to see if medical detection dogs can be trained to smell the disease. If the trial is successful, the dogs could be used at UK airports to screen people arriving from abroad. **BBC News (20.08.20)**

NHS sickness rate hit record high during coronavirus peak, data reveals
The sickness absence rate among NHS staff in England hit its highest level in more than a decade during the coronavirus pandemic, according to new data. The figures, released by NHS Digital, reveal that the monthly sickness rate hit 6.2% in April 2020 – up from 5.4% the month before. This is the highest level recorded in data that goes back to April 2009. **Guardian (20.08.20)**

Matt Hancock's Scrapping Of Public Health England Reignites Debate Over NHS Privatisation
Matt Hancock's decision to scrap Public Health England in the middle of the coronavirus pandemic has sparked fresh claims the Tories are privatising the NHS and putting "profiteering and corporate greed" over the wellbeing of the nation.

The new National Institute for Health Protection (NIHP) will take in some of PHE's responsibilities along with the NHS Test and Trace programme and the work of the Joint Biosecurity Centre. **Huff Post (20.08.20)**

NHS Test and Trace successfully reaches over 80% of close contacts since launch
Statistics from the eleventh week of operation (6 to 12 August) of NHS Test and Trace show that the service has reached more than 272,000 people, helping to stop hundreds of thousands of people at risk of unknowingly passing the virus on. Where communication details have been provided, the service has reached 88.6% of close contacts since launch or 81% of close contacts overall. **GOV.uk (21.08.20)**

NHS sees increase of more than 13,000 nurses in the last year

According to newly-published employment figures from up until the end of May, the number of nurses in the NHS in England has increased by 13,840 compared with last year – while the number of doctors has risen by 9,306 too. The results mean all professionally-qualified clinical staff, doctors, paramedics and support to clinical staff are now at record levels. The figures for May include some former healthcare professionals who responded to a call from the NHS and returned to working on the frontline during the coronavirus pandemic. A total of 592 returning staff were identified in the May statistics – of which there 102 doctors and 157 nurses and health visitors. **National Health Executive (21.08.20)**

Cystic fibrosis drug Kaftrio to be available on NHS after European licence granted
The European commission has licensed a new, potentially lifesaving drug to treat cystic fibrosis, meaning it will be available on the NHS to many who have the condition. The drug, Kaftrio, is produced by Vertex Pharmaceuticals and contains three key ingredients: tezacaftor, ivacaftor and elexacaftor. Clinical trials have shown Kaftrio can increase lung function by between 10% to 14% in people with cystic fibrosis, depending on their genetic makeup, and can improve quality of life. **Guardian (22.08.20)**

NHS Test and Trace fails to ask nearly 30% of COVID contacts to isolate
The NHS Test and Trace programme is still struggling to reach the contacts of those testing positive for COVID-19 to ask them to self-isolate, the latest data has revealed. Official figures showed that only 71.3% of close contacts were reached and asked to self-isolate between 6 and 12 August - and this was down from 74.2% the week prior. It comes after the Government announced it would overhaul the NHS Test and Trace programme to give local authorities a greater role in contact tracing, with the hope of reaching more people to stop the spread of COVID-19. **Pulse (24.08.20)**

Survey of female NHS staff raises concerns over burnout in pandemic
Stress and exhaustion from the COVID-19 crisis threaten to intensify burnout among women working in the NHS just as it prepares to resume most services, according to a survey that has prompted calls for greater support for female staff. The pandemic had amplified alleged bullying, sexism and racism on the part of managers, some workers also warned, while 26% of women said they did not feel safe sharing personal concerns with their boss. **Guardian (25.08.20)**

Parliament officials reject petition over lack of non-COVID NHS care
Parliamentary authorities have been accused of censorship after refusing to accept a charity's petition highlighting non-COVID patients not receiving NHS care during the pandemic.

Action against Medical Accidents (AvMA) submitted the petition in June. It said NHS England's decision in March to restrict most normal care so hospitals could focus on the influx of coronavirus patients "has meant access even to urgent diagnostic procedures and treatment for non-COVID conditions has been severely restricted, putting lives at risk". But parliament's petitions team, which decides which proposals are hosted online, rejected AvMA's petition, saying that reopening NHS services now the pandemic has subsided is not a matter for ministers. **Guardian (26.08.20)**

How a BREATHALYSER could tell if you have coronavirus: NHS is trialling a breath test that diagnoses patients in as little as 10 minutes
Britons could soon be diagnosed with coronavirus by simply exhaling into a tube, if a trial of breathalyser-like technology is successful. NHS doctors are testing out the machine, which could give results in as little as 10 minutes, its creators say. The device works by analysing the chemicals in the air someone breathes out after they blow into a mouthpiece for a minute, and is already used for other illnesses. **Mail Online (26.08.20)**

More than a million people overpaying for NHS prescriptions in England
Last year more than a million NHS patients in England paid more than they needed to for their prescriptions. Freedom of Information figures obtained by MoneySavingExpert.com show 1,058,147 people bought 12 or more prescribed items, on average paying £40 more than they would have with a 'season ticket'. That's because while prescriptions cost £9 last year, the NHS also offers prescription payment certificates costing £104 for a year. These cover the cost of all your prescriptions for 12 months, making them better value for anyone visiting the pharmacist more than 11 times. On average, those who paid for 12 items or more bought 16 items each – meaning the average saving with a prepayment certificate would have been £40. **Mirror (26.08.20)**

Regional NHS news

Potentially life-changing programme for those in region at diabetes risk
People in the West Midlands at high risk of developing Type 2 diabetes can sign themselves up online to join a potentially life-changing programme. The new free local Healthier You NHS Diabetes Prevention service has been launched as part of a series of measures in response to COVID-19. Recent findings show people with diabetes face a significantly higher risk of dying with COVID-19, but better management of the condition can help. **Coventry Observer (01.08.20)**

Incredible prosthetics provide some normality after life-changing injuries
This is the incredible result when the world of art and science collide. Appearing almost life-like, a talented team of technicians create artificial eyes, noses and ears for hospital patients. The delicate crafting process can take months. But the end result means the world to people who have tragically lost precious body parts. The technicians at Russells Hall Hospital can also make fingers as well as nipples for female cancer patients. (Express and Star 01.08.20)

NHS services in West Midlands face one of toughest winters in the history
NHS services across the West Midlands will be preparing to face what will undoubtedly be one of the toughest winters in the history of our health service. So warns British Medical Association West Midlands Regional Council chair Dr Stephen Millar.

“Come the winter our NHS will need to tackle a backlog of care, treat COVID patients, deal with seasonal flu and prepare for further local or national outbreaks of coronavirus. “Empowering local councils to close shops, outdoor events and public spaces, while long overdue, is entirely necessary to help reduce the spread of the virus and keep the pressure off the NHS. **Coventry Observer (03.08.20)**

Bostin' musical duo raising money for Russells Hall Hospital
The Blue Granits - which compromises of Tom Stanton and Billy Spakemon [real name Dr Brian Dakin] - are raising money for a hospital ward at Russells Hall Hospital, in Dudley. The cash raised will go towards buying special lights on the Georgina Unit which cares for haematology [blood diseases] and oncology [cancer] patients. So far the duo have raised almost £2,500 for the cause. **Express and Star (03.08.20)**

Testing key to prevent COVID-19 lockdowns across region, say councils
After new lockdown rules were brought into play in large parts of northern England, council leaders and public health bosses have said widespread testing is now more important than ever to reduce the prospect of similar action in the region. Birmingham, Coventry, Sandwell, Solihull, Dudley, Walsall and Wolverhampton councils are urging people who have COVID-19 symptoms or who have come into contact with anyone who has tested positive to get tested.. **Express and Star (04.08.20)**

Fundraiser launched for Rainbow in honour of our coronavirus heroes
A public fundraiser has been launched to raise cash for a permanent monument to key workers in recognition of their efforts during the coronavirus pandemic. Councillors in Dudley are aiming to raise £30,000 for the Russells Hall Rainbow, a stunning sculpture set to be located outside the hospital of the same name. They say it will serve as a permanent reminder of how local heroes stepped up to the plate during the crisis. **Express and Star (06.08.20)**

Runner’s 12 marathons
A runner has completed a dozen marathons in 2020 to raise more than £300 for the Dudley NHS COVID-19 Crisis Appeal. Farrah Huinter-Coley, from Wombourne, of Dudley Kingswinford Running Club, set a target at the start of the year to run 12 marathons by the end of 2020. **Dudley Chronicle (07.08.20)**

When the virus came to our hospital
As the COVID-19 pandemic loomed, the staff at one hospital in the English Midlands braced themselves. Quickly they found themselves at the centre of a coronavirus hotspot - and nothing turned out as they anticipated. Liz Rees sat down at her dining room table to take the call. It was a Sunday in early March and, from down the line, a voice was telling her about some test results that had just come back from the lab. This wasn't a normal diagnosis. Dudley, the town where Liz has worked for 20 years as a consultant microbiologist, had its first case of COVID-19. That, in itself, wasn't a surprise. She'd watched on TV as the virus had spread from Asia to continental Europe before reaching the south of England; it had already been detected in nearby Birmingham and Wolverhampton. "There was an inevitability about it," she says. "But the first one makes it real." **BBC News (09.08.20)**

Russells Hall Hospital to receive £3 million to upgrade A&E facilities
Mike Wood, MP for Dudley South, has welcomed the news that Russells Hall Hospital is set to receive an additional £3 million to help support its A&E services throughout the winter period. It is expected that the money will contribute to the cost of building new combined assessment facilities.

These facilities will be housed in new modular buildings connected to the Emergency Department and will allow for the same day assessment and care of patients. **Black Country Radio (11.08.20)**

Dudley service 'highly commended'
The Dudley Falls Prevention Service has been highly commended in a national award in recognition of its support to Dudley residents. The service which launched two years ago is delivered in partnership between Dudley Council, Dudley Clinical Commissioning Group and Dudley and Dudley Group of Hospitals NHS Trust. **Your Midlands (12.08.20)**

Russells Hall Hospital wards win national praise for end of life care
Three wards at Russells Hall Hospital have achieved the highest national standard for end of life care. The coronary care unit and wards C3 and C8, which look after elderly and stroke patients, all received Gold Standards Framework after two years of hard work from staff across the wards. The programme works in association with Hospice UK and aims to enable a 'gold standard' of care to help people live well before they die, and to die well in the place and the manner of their choosing. **Dudley News (12.08.20)**

£17m goes to hospitals in case of second wave
Hospitals across the region have received more than £17 million to upgrade facilities ahead of a potential second wave of the coronavirus. Prime Minister Boris Johnson said the cash would allow NHS trusts to maintain essential services should a fresh outbreak lead to a surge in demand… Russells Hall Hospital will get £3m for a new emergency department, which bosses hope will be up and running by the end of the year. **Express and Star (20.08.20)**

Interserve to build £36m emergency department at Walsall Manor Hospital
Interserve Construction will shortly commence enabling works on Walsall Manor Hospital's new Emergency Department and Acute Medical Unit. The new development will incorporate a new emergency department with "front door" access to a new Urgent Treatment Centre and Paediatric Assessment Unit. The first floor will also accommodate a new Acute Medical Unit along with a Medical Ambulatory Emergency Care Unit, within the refurbished existing Emergency Department footprint. Walsall Council's planning committee approved plans for the development last month and said it was a vital project that will improve healthcare. **PBC Today (12.08.20)**

Hospital manager praises community workers for heroic efforts during pandemic
And Edliz Kelly, from the Dudley Group NHS Foundation Trust, paid a huge thanks to frontline workers who have been visiting care homes during the pandemic. Ms Kelly, the team leader at the trust's Community Clinical Hub, revealed things are "most definitely calming down" after a peak of cases back in March and April. Since the outbreak, there have been 52 deaths from coronavirus at Dudley's care homes. However, the last death was recorded seven weeks ago on June 21. **Express and Star (14.08.20)**

NHS staff call for more support as workers given 'sanctuary' weekend
NHS workers have spoken about a need for more support from senior management and state funds for the NHS. One NHS nurse who contracted COVID-19 said she was not given enough support as she struggled with the trauma of recovering from the virus, while others called for more funding for health services. **Express and Star (14.08.20)**

Sandwell links probed as Birmingham virus cases rise
Health bosses say they are concerned about a spike in coronavirus cases in Birmingham – some of which are linked to fresh outbreaks in Sandwell. The number of positive COVID-19 tests in the second city rose to 23.6 per 100,000 in the seven days to August 10, according to the latest figures, with 269 new cases recorded. A West Midlands Combined Authority briefing on the region's handling of the pandemic heard that the increase in positive tests may be linked to three recent outbreaks in Sandwell, which has a region-high rate of 24.7 cases per 100,000. **Express and Star (14.08.20)**

Coronavirus cases nearly double in Birmingham as more people 'flout rules'
The number of people infected with coronavirus has spiked across Birmingham, nearly doubling, amid fears people are failing to follow basic rules while out and about at work and play. New cases are now being reviewed daily as public health chiefs battle to keep the virus at bay and prevent a major outbreak. The number of new cases reported in Birmingham over the most recent seven days, according to NHS Digital data published yesterday, was more than 24 per 100,000 people - the equivalent of around 250 a week. The rate was 12 at the start of August. **Birmingham Live (15.08.20)**

Dudley Group NHS FT accelerates information sharing platform roll-out
The Dudley Group NHS Foundation Trust has accelerated the roll-out of an information sharing platform to support its clinicians during the coronavirus outbreak. The trust is one of the first in the UK to adopt the Allscripts' dbMotion platform and was planning a full-scale deployment this summer, following internal testing and a proof of concept with local GPs. **Digital Health (17.08.20)**

Dignio App launched in Dudley for patients with Covid-19
Patients with suspected coronavirus who are self isolating at home could benefit from a new app launched in Dudley. MyDignio has been commissioned by NHS Dudley Clinical Commissioning Group and will be used to monitor patients who have the virus at home - and follow up those whose clinical condition could deteriorate. **Black Country Radio (17.08.20)**

Spitfire takes to West Midlands skies in NHS thank you
A Spitfire has completed the West Midlands leg of flights across the country in a show of gratitude to the NHS. Bearing a thank you message on the underside of its iconic wings, it took to the skies of Rugby, Coventry, Birmingham, Wolverhampton, Shrewsbury, Telford, Ludlow, Worcester and Hereford, bringing applause from hospital staff below. Thousands of names - nominated by the public - have been added to the plane, reflecting those who have contributed during the battle against coronavirus. The project is raising funds for NHS Charities Together. **BBC News (18.08.20)**

Flu jab rate 'needs to improve'
It is hoped at least three-quarters of at-risk people will get vaccinated this winter, according to official documents. Uptake for the flu jab "needs to improve", according to official documents. Officials are planning to vaccinate more people than ever in the coming flu season. The list of people who qualify for a free flu jab on the NHS has been expanded to reduce seasonal flu pressures hitting the health service at the same time as a possible second peak of coronavirus cases. **Express and Star (18.08.20)**

Annual celebration planned for NHS and key workers
A Black Country council has announced it will hold an annual celebration for NHS and key workers who have been heroes during the pandemic. Sandwell Council says the event will be an opportunity to tell the stories of sacrifice, of lives lost on the front line and of the community's lasting gratitude. The initiative is planned for next Spring. **Express and Star (20.08.20)**

'Drop and collect' coronavirus testing service to launch in Birmingham
A council in the West Midlands is set to carry out a "drop and collect" coronavirus testing service amid the threat of a local lockdown. Councillor Ian Ward, leader of Birmingham City Council, said the move would help combat the "extremely concerning" rise in the city. It will be set up for residents who find it difficult to leave their home for a test as Government chiefs consider implementing harsher restrictions. **Express and Star (21.08.20)**

Birmingham placed on Government watchlist amid virus surge and lockdown fears
Health Secretary Matt Hancock made the move to place the city on the "Area of Enhanced Support" list amid fears over a local lockdown. It means the area will receive additional testing, locally-led contract tracing and "targeted" community engagement to help curb the virus spread. Figures for coronavirus cases, for the seven days leading up to August 17, have revealed a spike in cases in Birmingham – with 332 positive cases and an infection rate of 29.1 per 100,000. **Express and Star (21.08.20)**

Birmingham lockdown 'could spark devastation for manufacturing firms, jobs and economy'
A full-scale lockdown in Birmingham could spark 'devastation' for jobs, firms and the wider region's economy, Unite has warned. The union, which represents local manufacturers including Jaguar Land Rover, urged everyone to do all they can to prevent restrictions tightening back up amid the fears. A localised lockdown would also put public services under further strain and affect the mental health of every resident, it said. **Birmingham Live (25.08.20)**

GPs to vote on £2 billion merged health plan for Black Country and West Birmingham
Doctors are to vote on a reorganisation of primary care in the Black Country and West Birmingham – which could create a £2 billion a year health trust. GPs are being asked to approve the merger of Clinical Commissioning Groups (CCGs) covering Sandwell, Wolverhampton, Dudley, Walsall and West Birmingham which govern surgeries, pharmacists and dental practices. Health bosses say the move will not affect local services to patients – and could even improve them. Dr Ian Sykes, chairman of Sandwell and West Birmingham Clinical Commissioning Group (SWBCCG), said the merger would streamline health care and reduce management costs. **Express and Star (26.08.20)**

Dudley Kingswinford Running Club take on 'cob run' for much-missed teammate
Members of Dudley Kingswinford Running Club raised hundreds of pounds for Russells Hall Hospital and Mary Stevens Hospice on an eight-mile 'Cob Run' in memory of a much-missed member of their team who died last year. The runners took on the annual 'Cob Run' from their Wall Heath clubhouse to The Anchor Inn in Caunsall in memory of long-standing club member John Glover who passed away in 2019. **Dudley News (26.08.20)**

Enclosure 15

The Dudley Group NHS Foundation Trust

Paper for submission to the Board of Directors
10th September 2020

TITLE:	**Public questions**		
AUTHOR:	Helen Board Deputy Trust Secretary (Interim)	**PRESENTER**	Yve Buckland Chairman

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	X

RECOMMENDATIONS:

The Board is asked to note the questions raised by the Council of Governors and the public where indicated.

CORPORATE OBJECTIVE:

All

SUMMARY OF KEY ISSUES:

Public Questions

The Trust Board will continue to meet 'virtually' and won't be holding a public meeting in line with government guidance and to support social distancing. The September meeting will welcome members of the public and the council to join online. The agenda and meeting papers were circulated to the members of the Council of Governors. Additionally, a link to the Trust website and information providing the location of the agenda and papers has been provided to our five local MPs and foundation trust members.

We have provided a facility for governors and members of the public to submit any questions they may have to the Board for consideration. Questions should be kept brief and to the point and sent to the following email link dgft.foundationmembers@nhs.net

Questions received:

Hilary Lumsden – Public Elected Governor: Halesowen

Raised in relation to enclosure 17 - Neonatal Covid-19 risk assessment. There are a few:

Q. what is the total cot capacity on neo-natal unit (NNU) now that reconfiguration has been made?
A. The capacity remains unchanged at 18 cots and is kept under constant review as the Trust manages patient flow in both the NNU and the children's ward.

Q. has the NNU been closed to admissions from delivery suite since reconfiguration?
A. No.

Q. have pregnant/labouring women/premature neonates been transferred to other units since the reconfiguration?
A. Not as a result of the re-configuration. There are some exception pathways where transfer out would be required (babies less than 28 weeks for example, or babies requiring more than 48 hours ventilation).

Q. what effect has the reconfiguration of neonatal services had on parents/grandparents/siblings visiting?
A. Prior to the reconfiguration it had been highlighted that facilities did not meet NLISS/BFI toolkit requirements and social distancing as a result of COVID have exacerbated this. The Unit has visiting restrictions in place to ensure social distancing. Grandparents and siblings are not visiting currently and parents are visiting one at a time. We have introduced virtual interactions via Skype.

Q. Are here any long term plans to extend the footprint of NNU and if not to downgrade to level 1 in the future?
A. There is no plan to downgrade to a level 1 unit. This would have a significant impact on the maternity services that could be delivered and would also impact the Operational Delivery Network. We have already developed an options appraisal to consider the review of the NNU footprint and established a task and finish group with a director sponsor to take this forward.

Mike Heaton – Public Elected Governor : Brierley Hill

Q. Update requested for the development of an adult changing facility at Russells Hall Hospital.

This comment has been raised with the relevant team who will liaise with Mr Heaton directly.

Q. Asks if it might be possible to provide a smoother flatter pathway for wheelchairs from the RHH main entrance to the main visitor car park. He understands the reason for the pimples and wondered if an alternative route could be signposted that would avoid them? He recently had occasion to push a wheelchair and found that it was extremely uncomfortable and distressing for the person in the wheelchair.

This comment has been raised with the estates team who will liaise with Mr Heaton directly.

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:** Well Led
	NHSI	**Y**	**Details:** Well led
	Other	**N**	**Details:**
REPORT DESTINATION	EXECUTIVE DIRECTORS	N	DATE:
	WORKING GROUP	N	DATE:
	COMMITTEE	N	DATE:

Enclosure 16

The Dudley Group
NHS Foundation Trust

Paper for submission to the Board of Directors September 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
   1.2 **Appendix 2** Falls Data
   1.3 **Appendix 3** RN, RM and AHP Career Development Pathway

2 This report will use the nursing and midwifery strategy template to provide the board with information and progress on the work being undertaken by nursing, midwifery and AHP staff to achieve our key priorities and objectives.

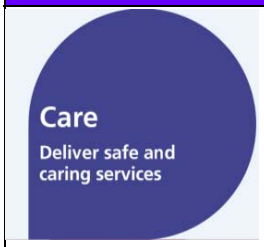
Nursing and Midwifery strategy work streams:

Care: Deliver safe and Caring Services

Compassion: Deliver a great patient experience

Competence: Drive service improvements, innovation and transformation ***Commitment:*** Be the place people choose to work ***Communication:*** Make the best use of what we have ***Courage:*** Deliver a viable future			
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 patients 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:**

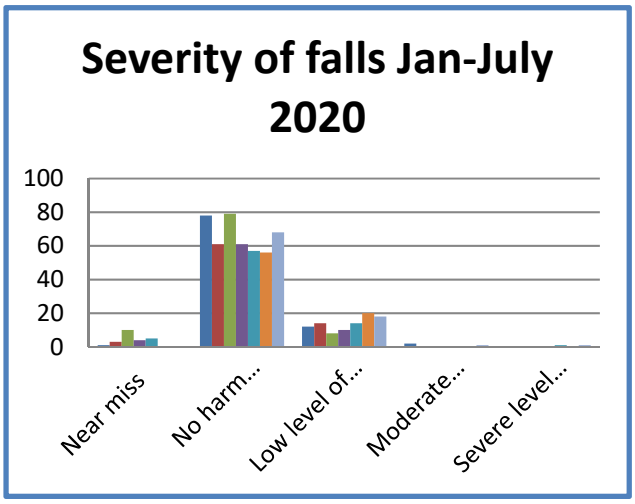
Care Deliver safe and caring services



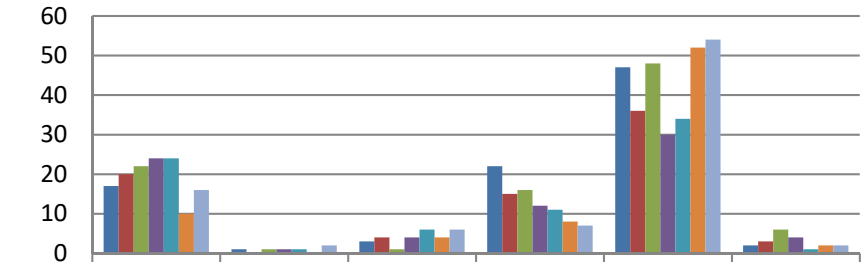
Falls - There were 163 inpatient falls during June and July 2020; 76 in June and 87 in July. While the June number was similar to Apr/May, the increased July number is comparable to March (94) and January (92). There was one serious incident reported following an inpatient fall in July; a fractured neck of femur was sustained. The Root Cause Analysis (RCA) investigation is in progress.

A review of the COVID 19 period with the Regional Falls Group has taken place. The findings were similar across all trusts, acknowledging that it is not possible to determine the exact cause of the increase. However, it was noted that the majority of patient falls were unwitnessed and that the type of patients that remained hospitalised during this time were potentially more unstable and were being nursed in side rooms where visibility was reduced. In addition, some of the staff working on the wards at this time were less familiar with working in inpatient areas, leading to a possible reduction in use of falls prevention strategies. The trust remains below the national average for falls per 1000 bed days.

The large majority of falls result in no patient harm. Most low-level harms are attributed to skin tears or bruising.

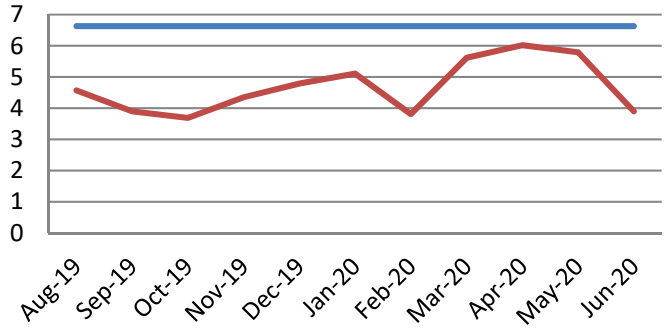


Type of falls Jan-July 2020



	Bed	Commode	Toilet	Chair	Mobilising alone	Mobilising with staff
Jan	17	1	3	22	47	2
Feb	20	0	4	15	36	3
Mar	22	1	1	16	48	6
Apr	24	1	4	12	30	4
May	24	1	6	11	34	1
Jun	10	0	4	8	52	2
July	16	2	6	7	54	2

Falls per 1000 bed days



	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20
National average	6.63	6.63	6.63	6.63	6.63	6.63	6.63	6.63	6.63	6.63	6.63
DGHFT	4.57	3.9	3.69	4.35	4.79	5.11	3.81	5.62	6.02	5.79	3.9

Tissue Viability – There have been no avoidable category 3 or 4 pressure ulcers reported since the last report. Virtual training is now underway for tissue viability to ensure continued training takes place and compliance levels are maintained.

Quality and Safety Reviews /Quality Accreditation Framework -The Quality Accreditation Framework replaces the Quality and Safety reviews. This framework is split into 3 stages and includes; a self – assessment, collection of data/evidence, peer review and presenting to a judging panel.

The framework is designed to be multi-disciplinary, with evidence required from all healthcare professionals

working to provide care to patients in a specific ward/department to move through to the next stage of the framework. The review tools have been developed using the CQC fundamental standards, the Nursing and Midwifery Strategy, the AHP Strategy, the Patient Safety Strategy and the Trust Strategic Objectives.

C4 inpatient ward and C4 Day case are the first area to pilot the new Quality Ward Accreditation framework – they submitted their self-assessment and data/evidence pack on the 18th August 2020, followed by their presentation to the panel on 24th August 2020. The outcome was positive. The Frailty Assessment Unit (FAU) are due to start the process in early September, followed by the Emergency Department shortly after. The process will then be rolled out across the Trust (in both the Community and the Acute setting).

Compassion Deliver a great patient experience

Allied Healthcare Professionals (AHP) – A professional AHP lead post has now been appointed for 12 months to support the delivery of AHP priorities. Jenny Glynn (Speech and Language Therapy manager) and Claire Inglis (extended scope Physiotherapist) will be sharing a portfolio of projects aligned to workforce, quality, safety and efficiency. This work will build on the recent successful AHP engagement events to drive forward innovation, new ways of working and joy in work.

The Physiotherapy Trial in ED has been extended and refined during the COVID 19 response and work is underway to provide an evaluation of the efficacy and benefits in terms of patients experience and outcomes. Headline findings are that physiotherapy presence in ED demonstrates a reduction in re-attendance, reduced admissions for low back pain and high levels of multi-disciplinary staff and patient satisfaction. There are also likely efficiencies during the patient's pathway as many patients can be assessed, diagnosed and discharged home with a self-management strategy or an onward referral.

Complaints – During July 2020, the Trust received 71 new complaints, in comparison to 55 opened for June 2020 and 38 opened for May 2020. For July 2019, we received 73 new complaints so this is consistent year on year whilst we had received fewer complaints during COVID-19. The Trust closed 53 complaints in July compared to 33 in June 2020. Of those 53 closed, 19 (35.8%) were closed within 30 working days. compared to 39.4% for June. The Divisions continue to focus on the timelier response and closure of complaints.

Friends & Family (FFT) - Following guidance received by the Infection Control Team the Trust has now resumed the collection of Friends and Family Test feedback using paper surveys.

2,984 responses across all areas have been received during July 2020 in comparison to 2,761 in June 2020, which is an increase from the previous month.

Changes to the friends and family question were due to be introduced in April 2020; however were postponed due to COVID-19. The new FFT question and reporting processes will commence in September 2020. An action plan is in place for the design, distribution, and promotion of the new question and resources. A summary of the new guidance has been sent to all FFT leads and heads of service.

Compliments – The number of compliments received has increased in July. We received **361** compliments during July 2020 in comparison to 303 in June.

Publication of CQC Inpatient Survey Results - The results of the 2019 Adult Inpatient survey were

published on the CQC website on 2 July 2020 and overall show an improved picture when compared to our previous year's performance.

The Trust is ranked 117 out of 143 Trusts that participated in the survey (compared to 131 out of 144 trusts in 2018) based on the Overall Patient Experience Score (OPES). The OPES ranged from the lowest score in England of 7.4 to the highest trust score in England of 9.2. The Trust score is 7.8 (same as 2018 score).

- 12 out of the 12 sections were performing 'about the same' as other trusts nationally
- The mean average scores for each section have improved for six out of the 12 areas
- There were two questions where we scored significantly higher than the 2018 survey (for food rating and for patients getting enough to drink).
- Scores significantly lower than national average were:
    - Q6 (how do you feel about the length of time you were on the waiting list)
    - Q69 during your hospital stay, did anyone discuss with you whether you would like to take part in a research study (new separate section but previously grouped under overall views of care and services).
- Leaving hospital had the lowest section scores.
- The trust will focus on two key themes for improvement that are reflective of our quality priorities – communication and discharge.

Mental Health – There were 5 patients detained under the Mental Health Act during June and July 2020. Four of these patients were detained under section 5/2 and all were referred to an Acute Mental Health Professional (AMHP). All but 1 of these patients were discharged, the fourth patient was referred on for intensive therapy and support. The fifth patient was held on a section 3 and detained for medical treatment, sadly this patient passed away.

Competence Drive service improvement, innovation and transformation

Professional Development –The professional development team will launch the first of its revised development programmes in September. These were put on hold since the COVID -19 pandemic. They include the band 5 and 6 development programmes, which will be delivered using a combination of face-to-face and virtual sessions.

Continuing Professional Development –Training requests for nurses, midwives, and AHPs have now been finalised, details of this have been submitted to Health Education England along with an analysis of organisational impact.

Advanced Clinical Practitioner (ACP) Pathways – 12 Health Education England funded ACP courses have been commissioned by the trust. This will enable new ways of working and the development of new roles for nurses and AHP's.

RN, RM and AHP career development pathway - As part of the staff retention plan, the Chief Nurse noted that the Trust does not have a robust career development pathway in place for its Nursing, Midwifery and Allied Health Professional (AHP) employees. A guideline is out for consultation to bring together Learning and Development; Leadership and Development; Professional Support and Development; Nursing and Midwifery; Allied Health Professionals teams to outline all learning and development opportunities together in one document.

A draft poster that provides an overview of career pathways from band 2 to band 8+ has been completed for Nursing and Midwifery. Work is currently in progress to add in AHP colleagues training and development opportunities. It had been identified that some nursing/midwifery learning opportunities are applicable and appropriate for AHP colleagues. The same will be true of specific AHP learning opportunities to provide a more rounded multi-disciplinary experience for Nursing, Midwifery and AHP staff.

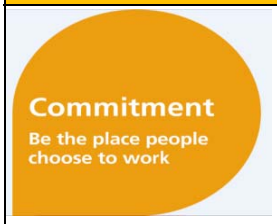
A copy of the poster is attached in appendix 2.

Mouth care campaign - July 2020 saw the launch of the Mouth Care Campaign across the Trust. This collaborative campaign led by Speech and Language Therapy staff and the Nutrition Nurses was successful in raising awareness of the importance of good oral care for our patients and equipping our staff with the knowledge and competence to provide this.

Communication Make the best of what we have

Infection Prevention and Control (IPC)
The IPC team continue to support staff and their teams in managing the COVID 19 pandemic. Preparation for this year's flu campaign is underway; increased numbers of peer vaccinators have been identified and are being trained. A robust communication plan has been developed to enable the Trust to meet and exceed its target of 90% vaccination compliance.

Commitment – Be the place that people choose to work



Agency Controls - All bank and agency requests continue to be assessed by the Divisonal Directors with support from the Divisional Chief Nurses. Executives have agreed, where possible, to promote a zero tolerance for the booking of non-framework agency at the current time. Requests will be individually risk assessed to ensure the safety of our patients and staff is prioritised. All requests for non framework agency remain Chief Nurse or Chief Operating Officer authorisation only in hours; out of hours remains executive authorisation only and this is closely monitored by the Chief Nurse and her deputies.
Nursing Associates –the second cohort of Trainee Nursing Associates(TNAs), consisting of 12 particpants, have now completed their course so have all successfully gained their NA qualification and will be working as band 4's in their placement areas. The Chief Nurse has commissioned a workforce review of the use and requirement of Nursing Associates in clinical areas. This report will be presented to Executives later this month.

Safer staffing – The qualified staff fill rates for June were 85% and 84 % for June during the day, fill rates for nights were 91% for both months. This is a slight reduction on May's daytime fill rates but an increase on nightime fill rates. The overall qualified fill rates was 88% for both months against the target fill rate for qualified staff of 90%. All areas are within the agreed variation of 6.3 or more for the CHPPD (care hours per patient day. Overall the Trust CHPPD is 10.99 for June and 10.30 for July 2020 (qualified and unqualified). Staffing numbers continue to be reviewed twice a day at the safety huddles facilitated by the Divisonal Chief Nurses. Daily asssessment of patient acuity and dependency continues in our inpatient units (see appendix 1).
Year of the Nurse and Midwife – Preparation for the year of the nurse and midwife celebrations continue. The Chief Nurse, in light of continued lock down measures, which will affect a wider nurse and midwifery

celebration, is revising plans. Confirmation of the final plans will be available shortly.

Professional Development – Students on extended placements will complete these placements by the 31st August. 72 out of a possible 78 of these students are due to start substantive posts within the Trust. On the 1st of August, the Trust hosted a celebration day for all of our graduates who had worked with us during the COVID19 pandemic to mark their graduation and to thank them for their commitment to the trust.

Nursing Times Award – Nursing staff on the Frailty Assessment Unit have been shortlisted for a Nursing Times award in the care of older people category. The awards will take place on the 18th of October 2020.

Courage – Deliver a viable future

Safeguarding – Communication continues with senior leads to improve safeguarding level 3 training compliance; each of the Divisions has been asked to produce a compliance trajectory. Recruitment to the Associate Nurse for Safeguarding Adults position is now complete and an appointment has been made. The Named Nurse for children post is out to advert.

The Independent Domestic Violence Advisor (IDVA) in now place in ED; the main purpose of the IDVA is to address the safety of victims at high risk of harm from intimate partners, ex-partners, or family members to secure their safety and the safety of their children.The first safeguarding adult's improvement working Group has taken place; these will be held monthly moveing forward.

The Dudley Group
NHS Foundation Trust

Appendix 1

Safer Staffing Data

	Jun-20						Jul-20				
Ward	Qual Day Fill	UnQual Day Fill	Qual Night Fill	UnQual Night Fill	CHPPD	Ward	Qual Day Fill	UnQual Day Fill	Qual Night Fill	UnQual Night Fill	CHPPD
B1	84%	81%	83%	66%	8.04	B1	65%	74%	58%		19.29
B2(H)	59%	74%	95%	94%	9.31	B2(H)	66%	81%	110%	99%	8.94
B2(T)	90%	80%	97%	89%	7.39	B2(T)	91%	88%	97%	88%	8.30
B3	79%	88%	94%	95%	8.15	B3	85%	83%	97%	94%	8.44
B4	84%	77%	91%	88%	10.53	B4	90%	87%	93%	94%	7.67
B5	94%	85%	92%	90%	23.17	B5	89%	85%	96%	77%	19.89
C1	90%	90%	99%	93%	7.44	C1	91%	88%	96%	90%	6.98
C2	89%	103%	80%	89%	18.56	C2	93%	93%	98%	90%	21.84
C3	99%	95%	99%	93%	8.56	C3	97%	96%	102%	92%	8.17
C4	91%	73%	76%	108%	7.35	C4	91%	84%	76%	103%	7.19
C5	75%	99%	87%	97%	9.30	C5	68%	99%	90%	91%	8.11
C6	96%	95%	96%	96%	7.40	C6	91%	100%	97%	92%	8.08
C7	86%	93%	99%	101%	7.61	C7	85%	60%	92%	106%	6.58
C8	77%	84%	93%	99%	16.26	C8	77%	81%	92%	94%	28.16
CCU_PCCU	78%	47%	84%	30%	10.78	CCU_PCCU	83%	69%	84%	32%	9.78
Critical Care	91%	58%	100%		40.37	Critical Care	86%	73%	90%		34.74
EAU	86%	98%	88%	92%	9.77	EAU	83%	91%	86%	90%	8.25
Maternity	84%	89%	89%	91%	20.08	Maternity	80%	89%	83%	84%	16.89
MHDU	82%	84%	84%	66%	34.02	MHDU	90%	68%	98%	65%	26.40
NNU	94%		90%		10.79	NNU	91%		96%		11.11
TOTAL	**85%**	**87%**	**91%**	**90%**	**10.99**	**TOTAL**	**84%**	**86%**	**91%**	**88%**	**10.30**

Appendix 2

RN, RM and AHP Career Development Opportunities

NHS
The Dudley Group
NHS Foundation Trust

Band 2

Intro to healthcare programme (Novice);
CSW Programme;
Fundamental skills programme;
Level 2 Diploma healthcare support

Band 4

TNA course;
Preceptorship;
Link roles;
Shadowing opportunities for consideration of RN training; AHP Degree apprenticeship

Band 6

Improving/transforming professional practice programme;
Developing Leaders;
Clinical supervisor training;
Managers essentials programme;
Management of recruitment;
Internship; Professional Midwifery Advocate training

Band 8 +

Improving/transforming professional practice programme;
Developing Leaders;
Clinical supervisor training;
Managers essentials programme;
Matron Handbook;
Executive Nurse handbook

Other opportunities

Apprenticeships
Coaching; Research;
In- house courses;
Rotation programmes;
Shadowing other roles;
Internal secondments;
Talent Management; Career Workshops

2020 -2021

Band 3

HCSW Programme;
Level 3 Diploma health care support; AHP Support Worker Development; AHP Support Worker Apprenticeship

Band 5

Student Nurse transition programme;
Preceptorship/Graduate programme; A-EQUIP Midwifery supervision;
EVOLVE;
Preceptorship and clinical supervision;
Management essentials training;
Link roles

Band 7

Improving/transforming professional practice programme;
Developing Leaders;
Clinical supervisor training;
AHP Advanced Clinical Practitioner Apprenticeship;
Management of recruitment;
Deputy Matron development;
Ward leaders handbook

All Bands

Induction;
Competency Packages;
Mandatory Training;
Learning beyond registration (Band 5+);
Clinical skills training;
Career development discussion at annual appraisal; Networking

External opportunities

NHS Leadership Academy Programmes;
External Secondments

Enclosure 17

The Dudley Group NHS Foundation Trust

Paper for submission to the Trust Board on September 2020

TITLE:	**Neonatal COVID 19 Risk Assessment**		
AUTHOR:	**Jo Wakeman** **Karen Anderson** **Emma Fulloway**	**PRESENTER**	**Mary Sexton**

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 June risk assessment is required to be signed off by Trust Board, DIPC and Infection Control Group. The Board is asked to approve the risk assessment for the Neonatal Unit noting the mitigations put in place as a result of COVID 19

CORPORATE OBJECTIVE:

SO1, SO2, SO3, SO4, SO5, SO6

SUMMARY OF KEY ISSUES:

- The paper outlines the Neonatal Unit COVID-19 Risk assessment, and mitigations in place.
- The risk assessment has been reviewed by the Director of Infection, Prevention and Control.
- This paper is in response to the letter dated 17th August 2020 from NHSE/I (appendix 1) to ensure the Neonatal Unit COVID-19 Risk assessment is approved by Trust Board.

IMPLICATIONS OF PAPER:

IMPLICATIONS FOR THE CORPORATE RISK REGISTER OR BOARD ASSURANCE FRAMEWORK

RISK	**N**		**Risk Description:**
	Risk Register: Y		**Risk Score:**
COMPLIANCE	**CQC**	**Y**	**Details:** Safe, Effective, Caring, Responsive, Well Led

and/or LEGAL REQUIREMENTS	**NHSI**	**Y**	**Details:**
	Other	**N**	**Details:**
REPORT DESTINATION	**Board of directors**	**Y**	**DATE:**
	WORKING GROUP	**N**	**DATE:**
	COMMITTEE	**N**	**DATE:**

Introduction

This paper is required to highlight to Trust board the actions that have been taken to prevent COVID-19 outbreak within the neonatal unit and the processes that would be followed should there be a COVID -19 outbreak at the unit.

The Neonatal Unit is a level 2 critical care area with 18 cots. There are 3 intensive care cots, 2 high dependency cots and 13 special care cots. In addition the service has 4 transitional care cots on the maternity unit which is staffed by the neonatal team.

Risk Assessment Completed

On the 11th June the Head of Children's Services completed a social distancing clinical areas risk assessment for the neonatal unit. This identified that with the current capacity social distancing could not be maintained without further controls being utilised.

Room 1 (ITU), room 2 (HDU) and room 6 (Nursery) were unable to maintain 2 metre distancing with the current capacity and restricted space. The risk assessment includes mitigating actions taken to maintain safety, capacity and implement best infection control practice to prevent outbreaks.

Action was taken to reconfigure the spacing between cots. During the summer months there are 8 beds closed on Ward C2 due to planned reduced capacity (the children's ward). In order to maintain the Neonatal Unit capacity 4 beds on C2 have been temporarily re-zoned as neonatal cots. This area is ring fenced for babies requiring special care. The risk assessment will be reviewed at Infection Control Group in September. The issues relating to space and social distancing have been captured in the divisional risk WC1384. The risk will be managed through the SWC Divisional Governance framework. (see appendix 2)

Infection Prevention and Control Procedures in place

IPC practices were reviewed with the Head of Children's Services and IPC Lead Nurse. Social distancing, between cots and chairs was improved to accommodate the 2 metre distance.

Robust use of Personal Protective Equipment is undertaken with staff and visitors wearing surgical face masks as matter of routine. Staff are trained in and have access to high level PPE to be utilised when undertaking aerosol generating procedures. Hand hygiene is undertaken by all clinical staff and visitors.

Staff are routinely checked for COVID-19 symptoms and daily temperature checking is completed. Visitors to the unit are checked for symptoms before entry and there are restrictions to visitors to

the Unit and parents to promote social distancing. Robust decontamination of the neonatal environment is completed by domestic services and the clinical team, ensuring regular touch point cleaning to reduce bioburden.

Isolation facilities are available for high risk babies and those identified as having COVID-19.
There are processes in place should a baby be born to a mother who has COVID-19. The baby would be placed into the isolation cubicle with a dedicated nurse. In line with RCPCH guidance the baby is to be screened for COVID-19 on day 3 and 5 of admission to unit. The Trust test and trace Standard Operating Procedure is in place should a staff member or a baby be identified as COVID-19 positive, with procedures in place for contact tracing and monitoring and testing of contact to prevent spread.

The Trust outbreak procedures would be followed if there was a single case of COVID -19 on the unit due to the acuity of the patients. Stakeholders would be informed and incident meetings held to manage the situation safely.

Conclusion and Action Required
The neonatal unit has made significant changes to ensure the ongoing safety of their patients and staff during the pandemic.

The risk assessment competed in June requires to be signed off by the Director of Infection Prevention and Control, Infection Control Group and Trust Board.

The risk assessment WC1384 identifies ongoing environmental constraints and therefore it is recommended that this must be monitored Divisionally via GAMe and additionally through infection control group and reported to Quality and Safety Group.

It is of note that the Division has convened a task and finish group to develop an options appraisal to address the inadequate footprint for the Neonatal Unit. As part of this the division will address the neonatal capacity issues once the C2 beds are required to re-open for winter activity.

To: Chief Executives of all NHS Trusts and Foundation Trusts

Sent by Email

NHS England and NHS Improvement
St Chad's Court
213 Hagley Road
Edgbaston
Birmingham
B16 9RG

17 August 2020

Dear Colleagues,

Re Infection Prevention and Control (IPC) Guidance for Spacing of Cots in Neonatal Units During COVID-19 Outbreak

Following the recent request for Trusts to provide details of their compliance with the requirements of the national COVID-19 Infection Prevention and Control (IPC) guidance for their individual Neonatal Units, NHS England and NHS Improvement Midlands region would like to thank you for providing the information for us to review.

Trusts have been supportive in identifying the impact of implementing the IPC requirements on their individual Neonatal Service capacity, and the risk assessments shared have detailed a range of mitigating actions that have been taken in order to maintain safety, capacity and best IPC practice in units across the Midlands region.

Many services have indicated that they are able to fully implement the COVID-19 IPC guidance and maintain the 2-metre social distancing between cots. There are some units, often due to the configuration of an older estate, that are unable to implement this element of the guidance and we will be contacting these Trusts individually to discuss what further mitigation actions are required.

Whilst we are aware that you have already completed your risk assessment for your Neonatal Unit, please can you ensure that:

- The Trust risk assessment has fully assessed the risks of not being able to fully implement the COVID-19 IPC guidance and has detailed comprehensive mitigating actions that are being taken for any residual risks that remain for babies, parents and staff. This risk assessment must have been assessed by both your clinical team and your Trust IPC team.
- The risk assessment includes a full and comprehensive assessment of the IPC measures in place, availability and use of PPE for staff, parents and visitors, and a review of estates, housekeeping, and visiting policies and all associated documents to demonstrate such are available should they be requested.
- The Trust risk assessment has been signed off by the Director of IPC, IPC Committee and Trust Board.

NHS England and NHS Improvement

- If, for any reason, the circumstances change (such as a reconfiguration of cots or repurposing of facilities) please ensure the risk assessment is updated and shared with Sylvia.Knight@nhs.net

Following a review of all the information that has been received, please can we also ask you to ensure that the following additional actions have been undertaken:

- Review of the Trust's Management of Outbreaks of Communicable Diseases policy / plan to ensure that it is robust, up to date considering the nuances of the neonatal environment and has been signed off by the Director of IPC, IPC Committee and Trust Board.
- Care plans for neonatal patients consider what actions will be taken if the babies or parents become symptomatic of COVID-19 and are unable to visit.

We are not asking for this additional information to be returned at the present time, however, would ask you to ensure it is in place should it be required for any further work as part of this.

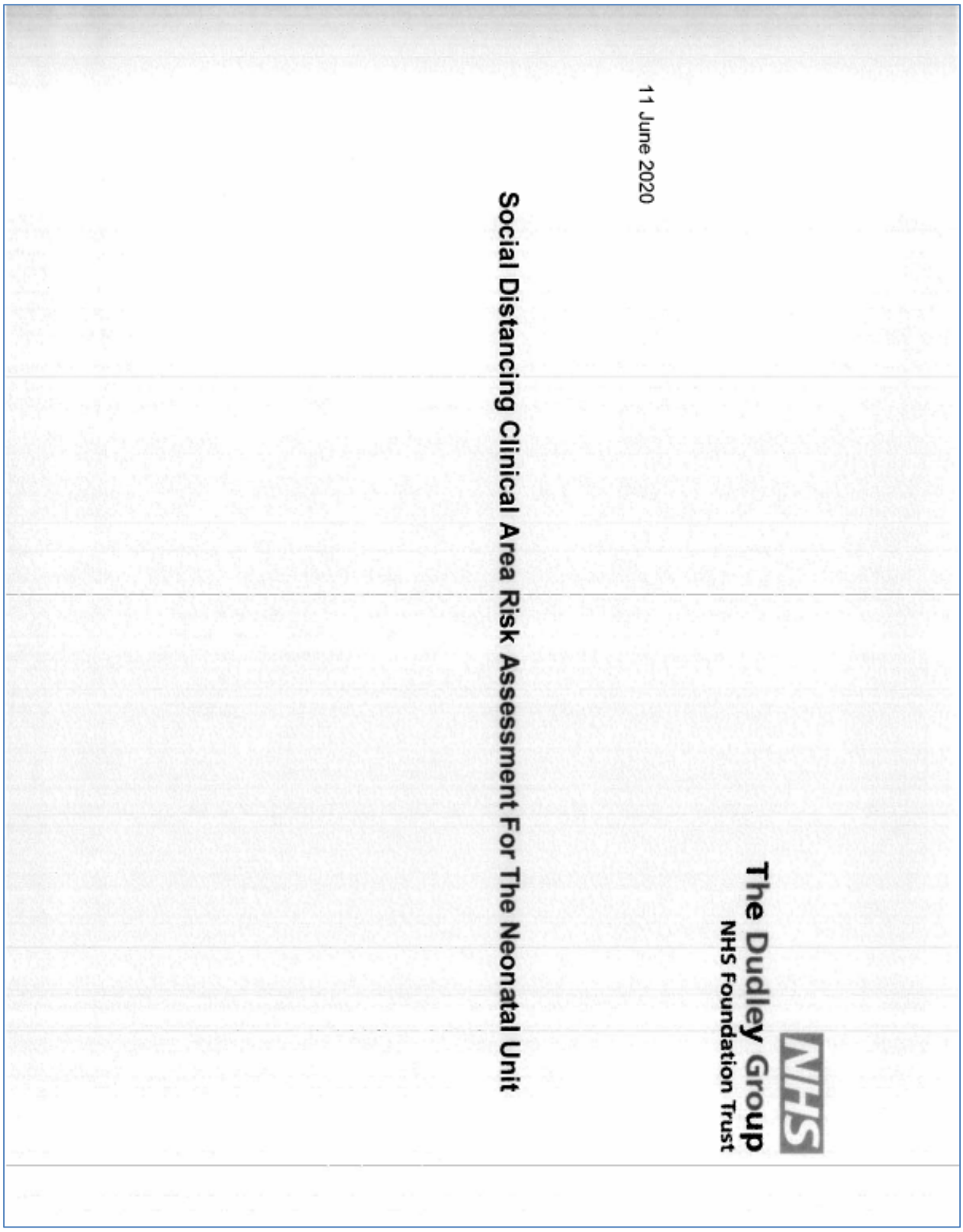
We would like to take this opportunity to thank you and your colleagues again for your continued support and hard work in providing safe and effective care in the Neonatal Services in the Midlands region.

Yours sincerely,

Siobhan Heafield.

Siobhan Heafield
Regional Chief Nurse &
Director of IPC
NHSE/I Midlands Region

Alison Tonge
Regional Director of Commissioning
NHSE/I Midlands Region



NHS
The Dudley Group
NHS Foundation Trust

11 June 2020

Social Distancing Clinical Area Risk Assessment For The Neonatal Unit

The Dudley Group
NHS Foundation Trust

Capacity impact – cot spacing in Neonatal Unit during COVID-19 outbreak

Service Level	Pre-COVID-19 cot base / Outreach capacity	Cot base/ Outreach capacity following implantation of COVID-19 IPC Guidance	Pre-COVID -19 Cot Occupancy Rate (%) (2018/19)	Expected Cot Occupancy Rate (%) resulting from base cot changes
Intensive Care	2	2	34%	34%
High Dependency	3	3	135%	135%
Special Care	13	3	87%	70%
Transitional care	4	4	48%	48%
Community Outreach	7 day cover	7 day cover		

The reduction in the bed base will only affect the provision of special care and will equate to the loss of 3 cot spaces.

The attached risk assessment and action plan identifies the mitigation actions to ensure the service will meet demand with the revised capacity.

Annex A Social Distancing Clinical Area Risk Assessment

Risk assessment for COVID 19 Workplace social distancing

Division: Surgery
Location of Assessment: Neonatal Unit
Person conducting assessment: Julie Marks

Work activities: Care of premature and sick neonates

Date: 09.06.20

What is the hazard?	Who is at risk?	What are the existing control measures?	Severity	Likelihood	Rating	Risk Rating	What additional controls are required?	Severity	Likelihood	Rating	Risk Rating
~~Example:~~ *Inability to maintain 2 metres between staff*	*Administration staff*	• *Hand Hygiene station* • *Robust cleaning schedule* • *Desk clear policy*	*4*	*4*	*16*	*High Risk*	• *Reconfiguration of office space to enable 2 metre social distancing* • *Request to procurement for screen shield between stations*	*2*	*3*	*6*	*Moderate Risk*
Inability to maintain 2 metre distancing with current cot capacity in Room 1 ITU room)	Staff Patients Parents	Access to clinical area for essential staff only Intensive care and high dependency babies nursed in incubators Only one parent allowed to visit at any one time Routine screening of mothers prior to delivery for Covid for Covid 19 Staff do not usually work face to face except for procedures	4	4	16	High	• Remove 2 cot spaces in ITU which will reduce capacity to 4 cots	4	2	8	Mod
Inability to maintain 2 metre distancing with current cot capacity in Room 2 (High Dependency	Staff Patients Parents	and emergency situations Additional 2 hourly cleaning in place PPE utilised in line with National guidance	4	4	16	High	• Remove1 cot space in High dependency which will reduce capacity to 4 cots	4	2	8	Mod
Inability to maintain 2 metre distancing with current cot capacity in Room 6 (Nursery)	Staff Patients Parents	As above	4	4	16	High	• Adjust layout of cot spaces to ensure 2 metre distancing	4	2	8	Mod

Additional measures action plan:

Addition controls required	Action required	Person responsible	Target date	Date completed	Manager sign off
Capacity on NNU reduced to 14 cots plus 1 cubicle for Covid 19 baby	Utilisation of up to 4 spaces on Children's Ward for special care babies. Staffed by NNU medical and nursing team SOP to manage NNU occupancy in relation to maintaining social distancing and potential surge	Julie Marks Julie Taylor	24.06.20		
Limiting access to parent accomadation to mainatin social distancing	Stagger parent access to sitting room to maintain social distancing	Julie Marks	11.06.20		
Limited storage on NNU for equipment from removed cot spaces on NNU	Utilise one parent room for storage Parents rooming in to be transferred to Children's Ward	Julie Marks	13.06.20		

Assessor *Print*:	Julie Marks	**Assessor *Sign*:**	J. Marks	**Date:** 11.06.20
Manager *Print*:	KAREN ANDERSON	**Manager *Sign*:**		**Date:** 11.6.20
Review date:				

Annex B Workplace Inspection social distancing checklist COVID-19

Area	Neonatal Unit	**Directorate/Division**	Surgery
		Person conducting inspection	Julie Marks
Date of Inspection	09.06.20	**Job Title**	Lead Nurse

	Criteria	Yes	No	Comments / Actions
Space				
1	Are staff able to maintain a 2 metre social distance whilst working? (if no go to 1A)		No	
1A	Are staff able to be relocated to other parts of the business? (if no go to 1B)		No	Relocation of 4 special care cots to Children's Ward
1B	Are staff able to be located either side to side or back to back? (if no go to 1C)		No	Not always possible during procedures and emergency situations
1C	Can alternate methods of working be used i.e. working from home, or alternating shifts (if no go to 1D)		No	Staff not able to work remotely but capacity to be relocated
1D	Ensure this is escalated to space utilisation group	Yes		
Protection				
2	Does the area require deployment of protective screening?		No	
3	Is PPE required?	Yes		
Infection Control Measures				
4	Is there a supply of hand cream in the area for staffs use?	Yes		
5	Have staff undertaken skin health surveillance within the last 12 months?	Yes		
6	Is there sufficient space in order to store all equipment that is required for the purpose of the ward / department?		No	Space is restricted on the NNU due to limited storage and the need to store bulky equipment ie ultrasound scanner, incubators etc.
7	Is the workplace cleaned to the relevant standard?	Yes		
8	Are disinfectant wipes available to decontaminate work spaces?	Yes		
9	Work spaces are not cluttered?		No	Difficult to achieve due to lack of storage space, equipment in corridor
10	Are Hand hygiene facilities available? Alcohol hand rub and hand wash basins with soap and paper towels/hand dryers?	Yes		

	Criteria	Yes	No	Comments / Actions
Workforce				
11	Are staff aware that if they are symptomatic to not attend work until they are symptom free for 48 hours?	Yes		
12	Are staff aware of respiratory hygiene practices?	Yes		
Waste Management				
13	Is clinical waste collected as required?	Yes		
14	Is domestic waste collected as required?	Yes		
15	Is there sufficient storage to allow separation of clinical and domestic waste?	Yes		

Action Plan:

Action	Assigned to	Target Date	Completed
1a - d See Clinical Risk assessment plan	Julie Marks		
9 Other storage areas on NNU identified to mitigate risk	Julie Marks		

Signed		**Print**	
Date			
Signed	K ANDERSON	**Print**	K ANDERSON
Date			
Date of next inspection			

Once all actions have been completed inspection sheet to be kept in the local area risk assessment file.

****These sections must not be removed if checklist is to be updated.***

Enclosure 18

The Dudley Group NHS Foundation Trust

Paper for submission to Trust Board 10th September 2020

TITLE:	**Infection Control Report**		
AUTHOR:	**Jo Wakeman** **Emma Fulloway**	**PRESENTER**	**Mary Sexton**

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 of Directors is asked to review and note the change in essential infection control practices put in place to respond to the COVID 19 pandemic, the changes in practice undertaken and the impact on service delivery.

CORPORATE OBJECTIVE:

SO1, SO2, SO3, SO4, SO5, SO6

SUMMARY OF KEY ISSUES:

- This paper is in response to the COVID-19: Guidance for the remobilisation of services within health and care settings.
- The paper outlines the main challenges and potential consequences of preventing the spread of COVID19.
- Board of Directors are asked to note the Trust position against the IPC Assurance Framework measures put in place to adhere to national guidance on infection, prevention and control

IMPLICATIONS OF PAPER:

IMPLICATIONS FOR THE CORPORATE RISK REGISTER OR BOARD ASSURANCE FRAMEWORK

RISK	**N**		**Risk Description:**
	Risk Register: Y		**Risk Score:**
COMPLIANCE and/or LEGAL REQUIREMENTS	**CQC**	**Y**	**Details: Safe, Effective, Caring, Responsive, Well Led, Health and Social Care for Hygiene Code Standards**
	NHSI	**Y**	**Details:**
	Other	**N**	**Details:**
REPORT DESTINATION	**Board of Directors**	**Y**	**DATE: 10th September 2020**
	WORKING GROUP	**N**	**DATE:**
	COMMITTEE	**N**	**DATE:**

1. INTRODUCTION

This report will provide an overview on the impact of capacity and productivity as a direct result of the infection control measures put in place to prevent and minimise the risk of hospital transmission of COVID 19.

Our working practices have needed to change considerably to comply with the nationally mandated infection control practices changes as a result of the COVID 19 pandemic

2. BACKGROUND

As COVID 19 has been an evolving situation there have been multiple changes to existing infection, prevention and control guidance with multiple changes to our working practices since the declaration of the pandemic in the UK in March 2020.

In May the trust was requested by NHSI/E to review the Infection control practices across the trust in line with the Hygiene Code with a focus on COVID19. A board assurance framework (BAF) has been completed and regularly updated reporting into Infection Prevention and Control Committee and The Quality and Safety Committee. A recent review of the BAF has been undertaken by the CQC our commissioners with no issues or concerns raised with positive assurance received. We were also inspected by the CCG on the 20th August in relation to the flow of patients and zoning, personal protective equipment and social distancing. The feedback was extremely positive for the trust with no issues or concerns raised. (Appendix 3)

The following are the changes that have been initiated to minimise the risk of spread of COVID 19 within our trust. Due to the risks associated with COVID 19 spread and transmission the trust has had to significantly change how we work in comparison to 2019 with not a single area unaffected by the changes required.

Trust staff have needed considerable support to amend their practice but have all fully engaged to ensure the safety of our patients and colleagues.

3. Social Distancing

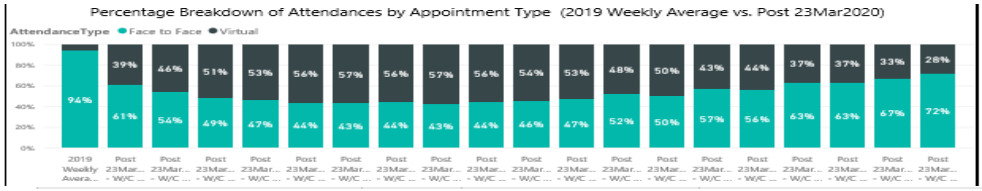
All clinical and non-clinical areas have been reviewed and we have put in place a 2 metre distance standard where possible. Many of our clinical areas have very different ways of working to maintain social distancing. For example:

- Phlebotomy is no longer a walk in service it has converted to an appointment based system.
- Clinical face to face outpatient reviews have where appropriate have been converted to virtual.

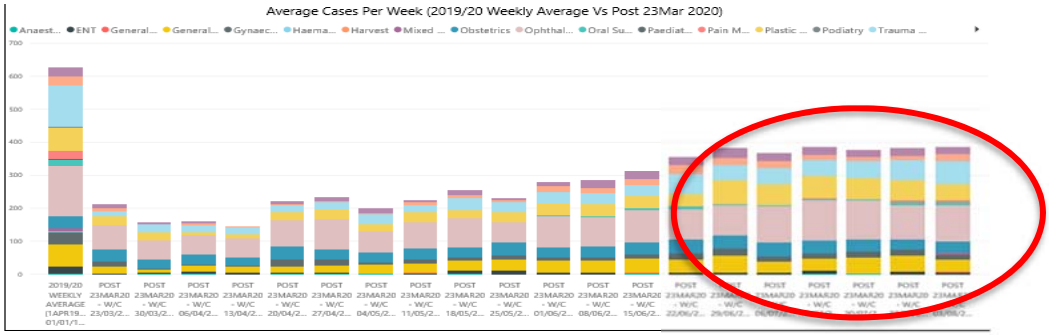
Surgery

Elective Restoration

Main Outpatients

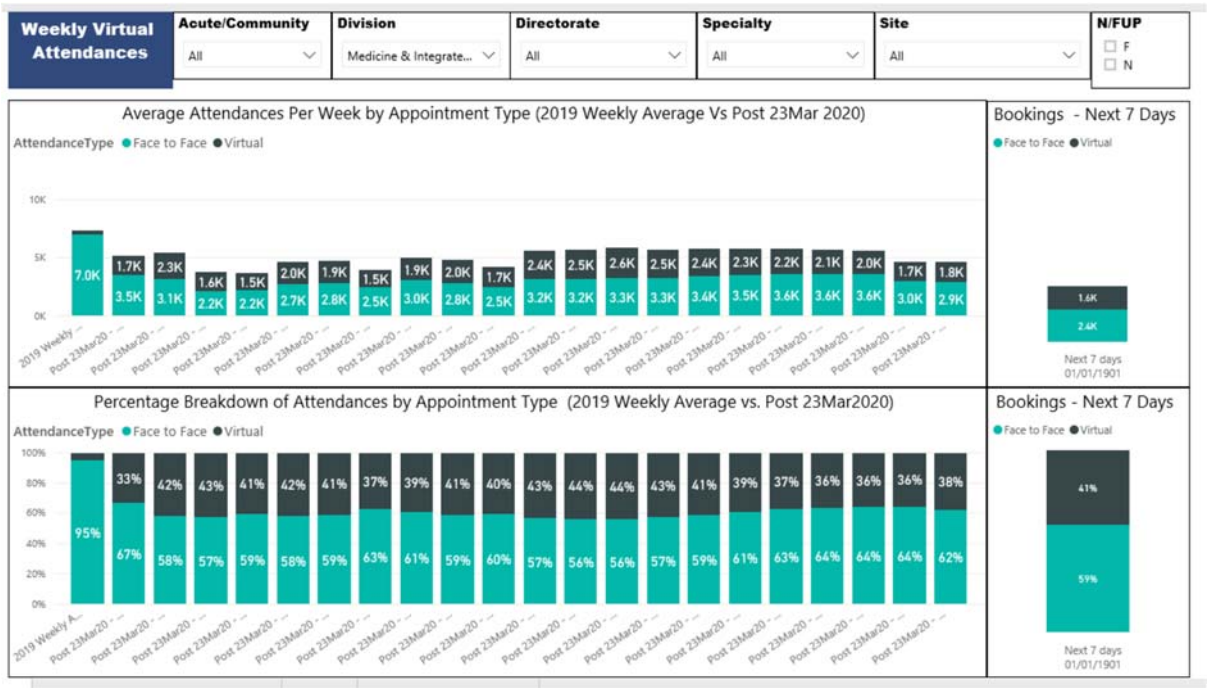


Elective Surgery



Medical

Restoration & Recovery Virtual vs F2F OPD Clinics – Average 40/60 Split up to w/c 10.8.20



- Cot spaces within our neonates have been reconfigured with an overall reduction in four paediatric beds to maintain our compliment of cots.

- Theatres have built in additional time to lists so that theatres can be thoroughly cleaned between patients. Lists will be re ordered to move potential infected patients to last on the list. This will help mitigate potential cross infection within any subsequent patients.

Bed spacing and balancing capacity has meant there are areas particularly in Medicine and Emergency Care where this has been difficult without reducing capacity. The mitigation to date has been to reconfigure furniture to optimise social distance but this remains a risk, where social distancing cannot be adhered staff and patients are required to limit time spent and wear appropriate PPE.

The decision to stop all non-essential visiting has certainly assisted with social distancing particularly within bed spaces. During the height of the pandemic it has helped manage the number of individuals in the Trust. Visiting has been in place for end of life and vulnerable patients and we continue to keep visiting under review.

The requirement to zone hospitals into blue, yellow and green areas (risk) will impact on available capacity due to the segregation of potential, negative and positive COVID patients. This may result in reducing the available list of beds as zones cannot be mixed. Staff can also not work across multiple zones in any given shift.

Fast track COVID testing (12 hourly and 30 x 90 minutes) are available for critical areas to support flow and capacity. The number of fast track testing is restricted nationally with plans to further extend as more laboratory testing becomes available.

All patients are screened for COVID on admission and then again at 5 days (green) if they remain an inpatient.

Pre-operative patients are requested to self-isolate 14 days prior to their date of surgery, they are then tested 72 hours before and requested to isolate from that point prior to surgery.

Compliance with Personal Protective Equipment (PPE)

Wards with Blue beds or areas where Aerosol Generating Procedures (AGPs) are completed have had to utilise side rooms as donning on and Doffing areas (safe use of Personal Protective Equipment (PPE) is pertinent to prevent infection, PPE must be put on –Donned correctly and removed Doffed in the correct manner to prevent contamination, this has an impact on capacity as bed spaces are being used as Donning and Doffing areas, as no other rooms are available.

Donning and Doffing PPE is time consuming for clinical staff it can take 5 mins to Don on and 7 mins to doff off, this level of PPE.

Part of the high level PPE required for aerosol generating procedures is filtering face piece 3 face masks, the specialised face masks have to be fitted to the staff members face to ensure an air tight fit, so they offer maximum protection against COVID-19. The fit testing process can take up to 40mins to complete. The Trust is supplied with many different brands of FFP3 face masks and with each new type of FFP3 face mask supplied the staff member has to be face fit test before use to ensure good fit. This has resulted in staff having to be fitted multiple times for different masks

Following learning Critical care and HDU staff wear FFP3 face masks and visor at all times this was implemented, therefore this staff group regularly have to undertake repeat face fit testing. This will continue.

Workforce

Appropriate measures have been taken to mitigate the risk of staff to staff/staff to patient transmission and spread. Temperature stations are in place on all clinical areas with masks and hand gel available at all entrances. Temperature checks on all staff and patients is carried out daily, any member of staff with a temperature of greater than 37.8 degrees centigrade are sent home until the cause is known.

Risk assessments on all staff are being completed to ensure we appropriately protect our staff and optimising health and wellbeing initiatives particularly feelings of social isolation and emotional and psychological well-being.

If there is a rise in COVID numbers, there is a potential impact on workforce absences the nature of the guidance is:

- 10 days isolation if symptomatic
- 14 days if a contact to positive case
- 14 days isolation if returning from holiday from a high risk area in line with UK guidance on quarantine.

Summary

These restrictions within the trust will undoubtedly impact on our capacity whilst we balance social distancing with the need for capacity. There will be challenges as ED resumes high levels of demand with a greater need for acute beds.

The impact and extent of these measures to protect staff and our patients may vary on a daily basis. The full impact of capacity restrictions on the trusts ability meet demand across the spectrum of services will require further analysis.

Appendices

Appendix 1 - IPC Assurance Framework August 2020

IPC Board Assurance Framework - Aug 20

Appendix 2 – CQC – BAF Review July 2020

CQC review of BAF

Assessment for The Dudley Group NHS F

Appendix 3 – Commissioner Review 20th August 2020

Appendix 3 - CCG IPC Inspection.docx

Enclosure 19

The Dudley Group NHS Foundation Trust

Paper for submission to the Public Board on 10th September 2020

TITLE:	**Integrated Performance Report for Month 1 (July 2020)**		
AUTHOR:	**Karen Kelly** **Chief Operating Officer**	**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: Deliver a great patient experience
SO2: Safe and Caring Services
SO4: Be the place people choose to work
SO5: Make the best use of what we have
SO6: Deliver a viable future

SUMMARY OF KEY ISSUES:

Performance

EAS

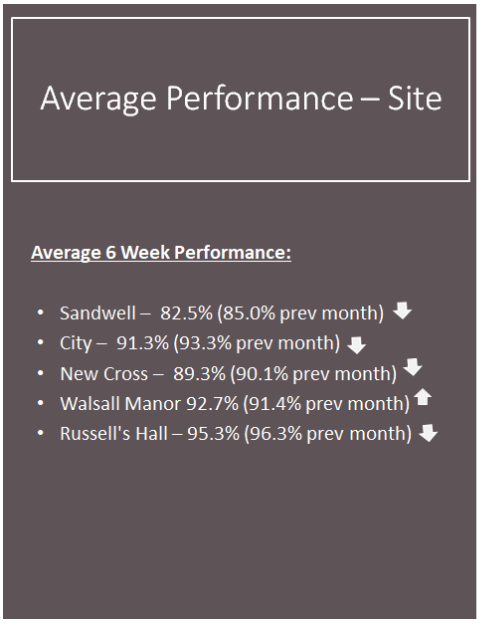
The July position for performance has exceeded the expected Emergency Access Standard and the trust has achieved a combined performance of 97% for the month of July.

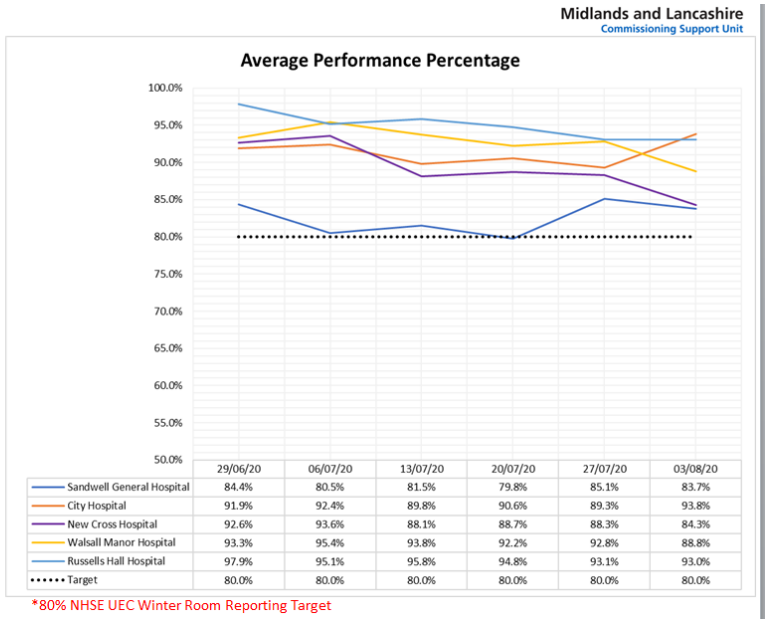
The other main contributory factor to our improved EAS position is the following:

1. Reduction in Delayed Transfers of Care.
2. Reduced numbers of attendance compared to pre-covid levels although there has been a gradual increase in attendances throughout July'20 to 1748 patients per week

Dudley's Emergency Access Standard compared with other neighbouring Black Country Trusts is shown in

the table below





DM01

In July, the Trust achieved 74.31 per cent of diagnostics tests carried out within six weeks wait against the national operational standard of 99 per cent. There was a total of 2124 patients who waited more than 6 weeks for their test.

Under delivery is due to the huge number of cancellations of all non-urgent diagnostic testing in March, in line with national guidance in response to COVID 19. This resulted in:

- Almost six fold increase in the number of patients waited over 6 weeks for their diagnostics test compared to the pre-COVID monthly average. DGFT reported only 349 patients who waited for more than 6 weeks; this number went up to 2124 in July.

This is, however, an improvement from performance in May and June and in line with improvement trajectory.

The Imaging and Endoscopy department has resumed routine diagnostics tests allowing for safe social distancing. The social distancing measure will introduce some delays. With this in mind, Imaging has continued to recover activity.

Endoscopy – Significantly challenged diagnostic

When the Endoscopy Unit recommenced activity in May 2020 there were over 1000 patients waiting for an endoscopy procedure, these included routine, surveillance, urgent and cancer referrals.

There have been a number of limitations that have impacted restoring services to pre-COVID activity levels that include:-

1. Reduced number of patients on endoscopy lists due to AGP/PPE requirements and social distancing. Overall we are running at around 50% capacity compared to pre-COVID levels.
2. Pre-COVID business case was approved for additional room in GI unit – capacity already outweighed demand.
3. Staff who has been risk assessed and adjustments are required that impact on nurses ability to be in the endoscopy room – supporting alternative roles where possible.
4. Shielding of both nursing staff and doctors.
5. Gastroenterology consultant workforce – one vacant post waiting for college approval, we would like to recruit to two more gastroenterologist as part of succession planning.
6. Training limited at present due to lack of physical space to train and also a pause of training.
7. Lack of endoscopists who can undertake specialist work ie: Zenkers, wireless capsule and EMRs.

The challenges at the Trust are no different to other neighbouring Trusts and discussions are happening on an STP footprint to consider further actions. Dudley is working on the following actions to restore Endoscopy to full performance:

1. For diagnostic only flexible sigmoidoscopies we have commenced utilising OPC rooms, WC 10th August 2020, this has already helped to decrease number of flexible sigmoidoscopies from 199 on DM01.
2. Colorectal task and finish group in place which is reviewing the colorectal pathway, to include FIT, CTC etc. We need the GPs to engage with FIT and utilise this so we are not overburdening our services. Capacity has been carved out for cancer pathway patients to help reduce the backlog.
3. Endoscopy 4th room planned to be in place by 28th September 2020 – works in progress. Recruitment to additional admin and nursing staff in place. This will enable the unit to get to pre-COVID activity levels however WLIs will still be required to further reduce the backlog.
4. Risk assessment undertaken in endoscopy unit on recovery space – increased to 5 bed spaces.
5. Review of vetting underway for inpatient referrals to reduce demand on service.
6. ‘BLUE’ room to be utilised for clinic list during the morning and inpatient lists for afternoon use only to increase capacity to pre-covid levels.
7. Bid for mobile unit was submitted to NSHE to assist with the backlog of patients on the waiting list.
8. Bid to NHSI for diagnostics included scope guide to support upskilling of endoscopist.

9. Plans to expand wireless capsule service (additional kit already ordered), Consultant lead commencing training on colon capsule which will act as an alternative to conventional colonoscopy or CTC. One endoscopy nurse practitioner will also be training in small bowel capsule to assist the current service provision.

10. Recruitment in place for 8th Gastroenterologist and plans to further expand workforce for succession planning.

11. Working with informatics team on a scheduling system in endoscopy to support capacity and demand planning.

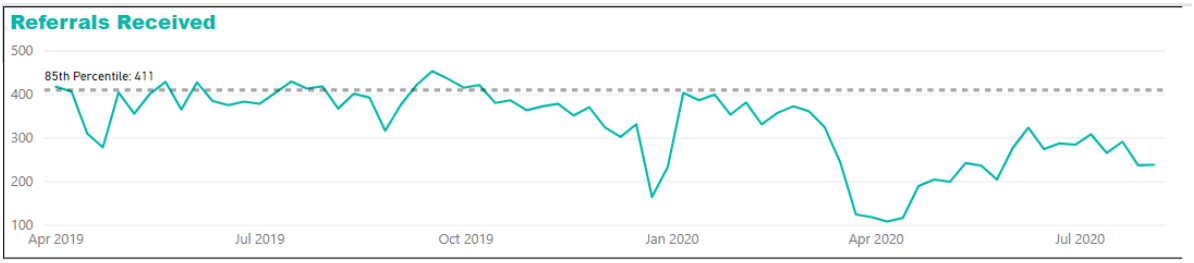
12. Endoscopy STP meeting in place for demand and capacity planning across the region – information submitted awaiting further meeting next week to discuss plans.

13. UGI pathway to be reviewed for inclusion of triaging to aid capacity.

CANCER

Cancer 2ww continues to achieve, performing at 95%, with challenges in both 62 and 104 day waiting times as a consequence of work suspended during COVID-19. Achievement of 2WW is down to low number of referrals and difficulties persuading patients to attend. There is a significant risk of underachievement in future months if referrals return to normal levels whilst clinics only have 50% capacity due to social distancing.

The table below shows the number of 2ww GP referrals over the past year. There is a decrease in the number of referrals from the average per month, however we are beginning to see an increase in specialties



The reduced referrals have been experience across almost all specialties and equates to approximately 50% of previous pre-COVID levels. This is experienced by other organisations and forms part of the Phase 3 letter from the Department of Health. The Trust is working with primary care to support patients to build confidence in presenting with symptoms at primary care.

This table shows the breakdown by specialty for the first 2 weeks in August where referrals remain significantly lower.

Two-Week Wait Comparison 2019 vs 2020		
Ca Site	**2019**	**2020**
Brain	5	2
Breast	157	97
Colorectal	122	69
Gynaecology	63	44
Haematology	4	2
Head and Neck	49	47
Lung	3	5
Paediatric	3	2
Skin	192	117
Upper GI	60	62
Urology	59	27
Grand Total	**717**	**474**

Cancer PTL

The table below shows the total patients on the PTL as of 12th August and the distribution across days on the pathway and by specialty – There are now 1151 patients on the cancer PTL, with 58 patients diagnosed and 1093 remaining to be diagnosed, predominantly in Colorectal specialties.

There has been considerable work across the Divisions to improve the number of patients waiting for their diagnosis or having a no cancer diagnosis confirmed and concentrating on long waiters within that cohort. There is also progress with plans for increasing capacity in the specialties to ensure patients can receive their treatment promptly.

Current forecasting of the 62 day CWT has shown that there are approximately 70 patients who will breach the standard over the coming months and this will impact significantly on the Trusts ability to meet the target. Agreed 62 day recovery trajectory agreed by March 2021.

RTT

In July the RTT position was 63.66%. This was an increase of 1% on the previous month and a reflection of the increase levels of activity seen as part of the Trusts restoration plans. Whilst this is a positive improvement there remains significant operational pressures with the number of patients now waiting for inpatient admission without a date between 20 and 40 weeks at close to 2,000. The implementation of weekend working and the delivery of the final two operating theatres will go some way to improving this position over the next two weeks.

The Trust is now also experiencing pressure on the 52 week breach standard. To date the organisation has performed extremely well against this standard with zero (0) breaches so far this year (April to July). Looking

ahead however August and September are looking far more challenged and there are expected to be breaches of this standard over the summer. The numbers however will be kept to an absolute minimum as long waiters remain one of the priority cohorts for treatment.			
IMPLICATIONS OF PAPER: Risks identified in this paper are linked to the risk (BAF 1b)			
IMPLICATIONS FOR THE CORPORATE RISK REGISTER OR BOARD ASSURANCE FRAMEWORK			
RISK	**Y**		**Risk Description:** BAF 1b - Failure to meet access standards caused by inability to improve patient flow and work effectively with very local partners will result in an adverse outcome for the patient
	Risk Register: Y		Risk Score: BAF 1B – Risk score 15 (AMBER)
COMPLIANCE and/or LEGAL REQUIREMENTS	**CQC**	**Y/N**	**Details:**
	NHSI	**Y/N**	**Details:**
	Other	**Y/N**	**Details:**
REPORT DESTINATION	**EXECUTIVE DIRECTORS**	**Y/N**	**DATE:**
	WORKING GROUP	**Y/N**	**DATE:**
	COMMITTEE	**Y/N**	**DATE:**

The Dudley Group
NHS Foundation Trust

Integrated Performance Report - Board

August 2020

Created by: Informatics
Title of report: Integrated Performance Report
Executive Lead: Performance Chief Operating Officer - Karen Kelly

Performance - KPIs Summary

Executive Lead: Karen Kelly

KPI SUMMARY JULY 2020

	METRIC	TARGET	ACTUAL	VARIATION	ASSURANCE
PERFORMANCE	**Cancer Reporting - TRUST (provisional)**				
	All Cancer 2 week waits	93%	95.66%		
	2 week wait - Breast Symptomatic	93%	96.88%		
	31 day diagnostic to 1st treatment	96%	93.28%		
	31 day subsequent treatment - Surgery	94%	90.91%	17%	N/A
	31 day subsequent treatment - Drugs	94%	83.33%	-17%	N/A
	62 day urgent GP referral to treatment	85%	72.58%		
	62 day screening programme	90%	0.00%		
	62 day consultant upgrades	85%	89.38%		
	Referral to Treatment				
	RTT Incomplete Pathways - % still waiting	92%	64%		
	RTT Incomplete - Cardiology	92%	53%		
	RTT Incomplete - Dermatology	92%	64%		
	RTT Incomplete - ENT	92%	56%		
	RTT Incomplete - Gastroenterology	92%	62%		
	RTT Incomplete - General Medicine	92%	50%		
	RTT Incomplete - Gynaecology	92%	45%		
	RTT Incomplete - General Surgery	92%	64%		
	RTT Incomplete - Geriatric Mediciine	92%	100%		
	RTT Incomplete - Neurology	92%	78%		
	RTT Incomplete - Ophthalmology	92%	90%		
	RTT Incomplete - Oral Surgery	92%	55%		
	RTT Incomplete - Other	92%	71%		
	RTT Incomplete - Plastic Surgery	92%	80%		

Performance - KPIs Summary

Executive Lead: Karen Kelly

KPI SUMMARY JULY 2020

METRIC	TARGET	ACTUAL	VARIATION	ASSURANCE
RTT Incomplete - Respiratory	92%	71%		
RTT Incomplete - Rheumatology	92%	78%		
RTT Incomplete - T&O	92%	78%		
RTT Incomplete - Urology	92%	70%		
RTT Admitted - % treatment within 18 weeks	90%	70%		
RTT Non Admitted - % treatment within 18 weeks	95%	73%		
Wait from referral to 1st OPD	26	14		
Wait from Add to Waiting List to Removal	39	34		
ASI List (Month End)	-	3193		N/A
% Missing Outcomes RTT	-	0.02%		N/A
% Missing Outcomes Non-RTT	-	10.94%		N/A
DM01				
% of Diagnostic tests waiting less than 6 weeks	99%	74%		
No. of Diagnostic tests waiting > 6 weeks (Month End)	0	2124	249	SPC
ED				
ED 4 hour Waits Type 1 & 3 (ED + UCC)	95%	97%		
ED Admitted Patients Waiting Times - 95th Percentile	-	802		N/A
ED Non Admitted Patients Waiting Times - 95th Percentile	-	235		N/A
ED - Time to Initial Assessment - 95th Percentile	-	0		N/A
ED Attendances Type 1	-	7334		N/A
ED Attendances Type 1 & 3 (ED + UCC)	-	12330		N/A
Left Without Being Seen	5%	0.6%		
Unplanned Re Attendances	5%	1.1%		
12 Hours Trolley Waits	0	0	0	N/A

Performance - KPIs Summary

Executive Lead: Karen Kelly

KPI SUMMARY JULY 2020

METRIC	TARGET	ACTUAL	VARIATION	ASSURANCE
Ambulance Convenyances	-	3306		N/A
Ambulance Turnaround Breasches 30-59 minute	-	51		N/A
Ambulance Turnaround Breasches 60+ minute	-	0		N/A
Cancelled Operations				
% Cancelled Operations	1.0%	0.8%		
Cancelled operations - breaches of 28 day rule	0	0	0	N/A
Urgent operations - cancelled twice or more	0	0	0	N/A
Theatre Utilisation				
Theatre Utilisation - Day Case (RHH & Corbett)	N/A	66.9%		N/A
Theatre Utilisation - Main	N/A	80.0%		N/A
Theatre Utilisation - Trauma	N/A	91.0%		N/A
Average Length of stay (Quality Strategy Goal 3)				
Average Length of Stay - Elective	N/A	2.5		N/A
Average Length of Stay - Non-Elective	N/A	4.1		N/A
Outpatient Referrals				
GP Written Referrals - made	-	0	0	SPC
GP Written Referrals - seen	-	0	0	SPC
Other Referrals - Made	-	0	0	SPC
GP Discharge Letters				
GP Discharge Letters	90%	0.8993	0.73%	SPC
Outpatients				
Outpatient Appointment DNA Rate	8%	15%		
New/Follow Up Ratio	2.48	3.30		
Clinic Utilisation	-	73%		N/A
Throughput / Flow				
Patients Discharged with a LoS >= 7 Days	-	7.0%		N/A

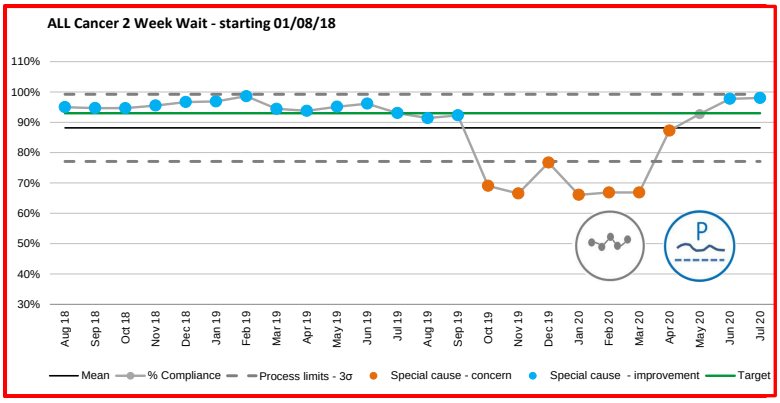
Performance - KPIs Summary

Executive Lead: Karen Kelly

KPI SUMMARY JULY 2020

METRIC	TARGET	ACTUAL	VARIATION	ASSURANCE
Patients Discharged with a LoS >= 14 Days	-	3.0%		N/A
7 Day Readmissions - PbR	-	3.5%	0.50%	SPC
30 Day Readmissions - PbR	-	5.9%	-1.00%	SPC
DTOC Average Monthly by RAG Rating (Amber)	-	0	0	SPC
DTOC Average Monthly by RAG Rating (Red)	-	0	0	SPC
Nationally Reported Delays - Total Days (1 Month in Arrears)	-	0	0	SPC
Nationally Reported Delays - Reimbursable Days (1 Month in Arrears)	-	0	0	SPC
Nationally Reported Delays - DTOC Patients by Agency (1 Month in Arrears)	-	0	0	SPC
No. of Non-Clinical Patient Moves - Between 8pm and 8am	-	191	52	SPC
% Discharged by Midday	-	11.4%	-0.51%	SPC
Bed Occupancy - %	95.0%	76.1%	3.13%	SPC
Bed Occupancy - % Medicine	95.0%	86.9%	6.86%	SPC
Bed Occupancy - % Surgery, W&C	95.0%	73.7%	8.03%	SPC
Bed Occupancy - Paediatric %	95.0%	28.4%	-2.49%	SPC
Bed Occupancy - Orthopaedic Elective %	95.0%	20.1%	-37.08%	SPC
Bed Occupancy - Trauma and Hip %	95.0%	88.9%	0.30%	SPC

Performance Matters (KPIs)



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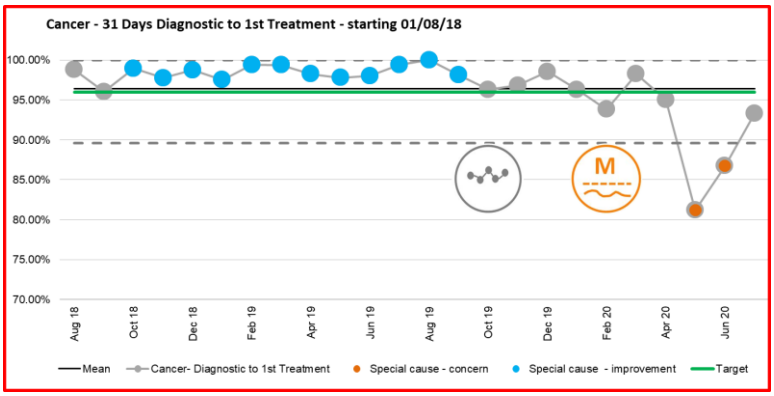

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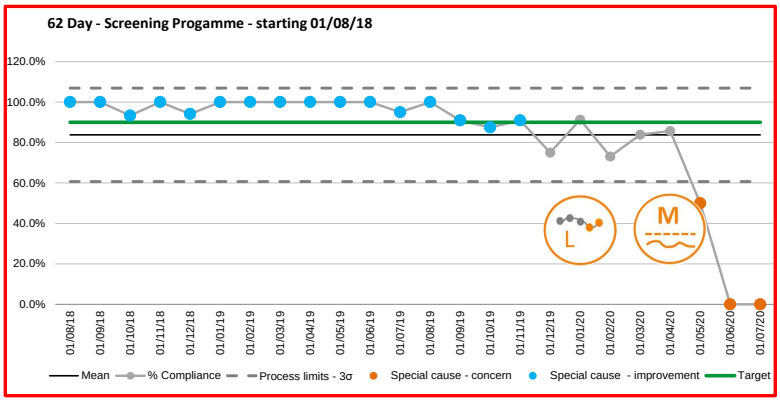

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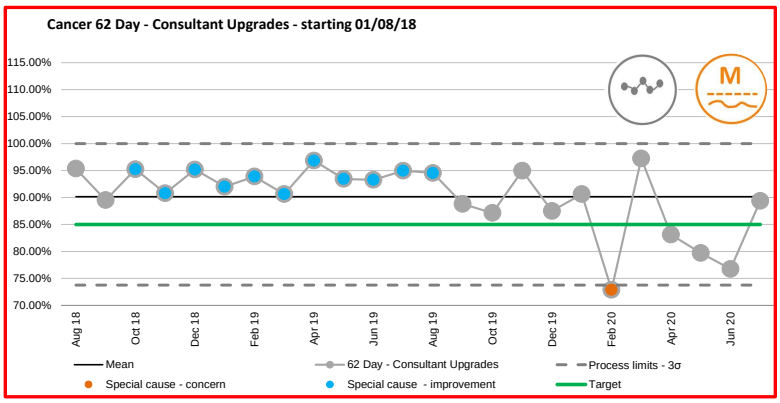

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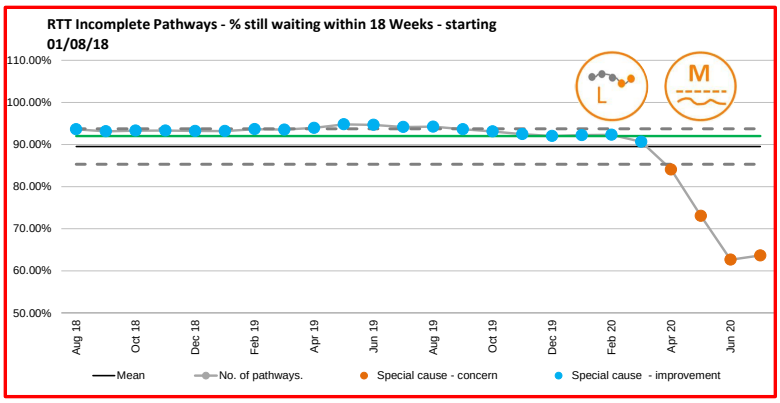

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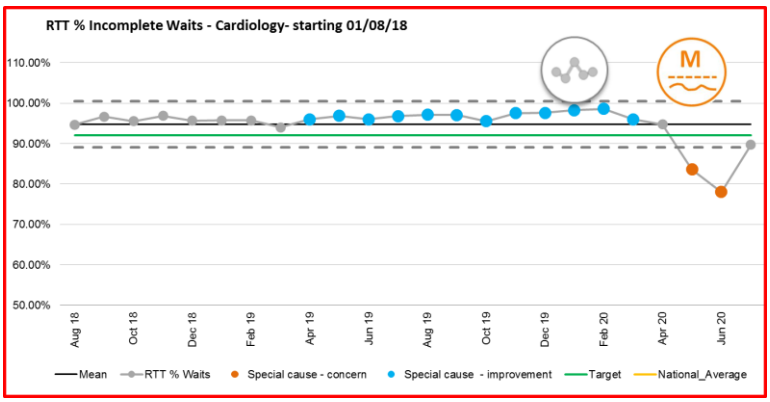

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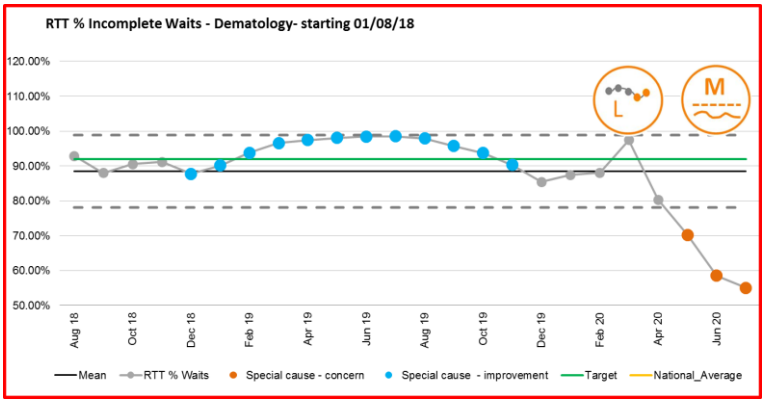

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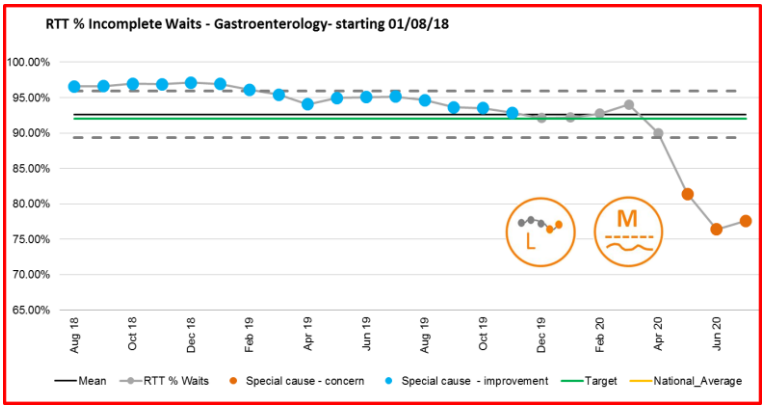

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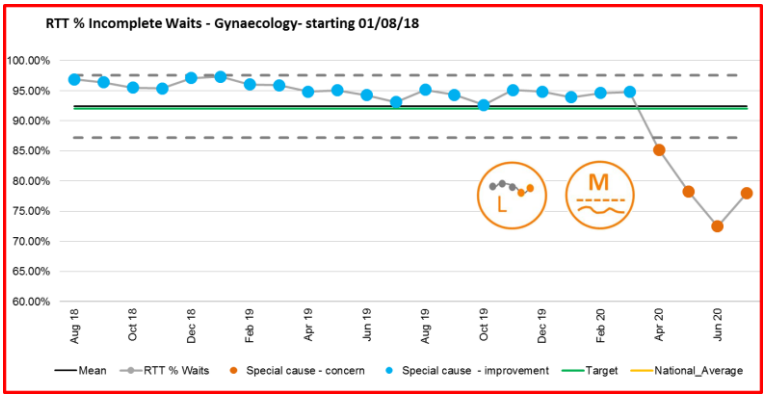

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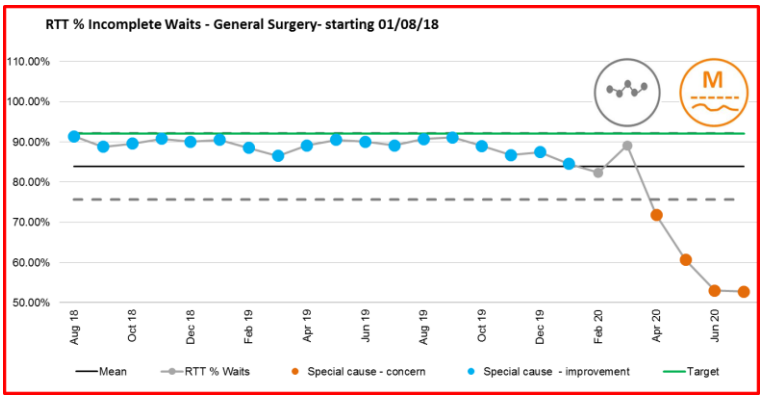

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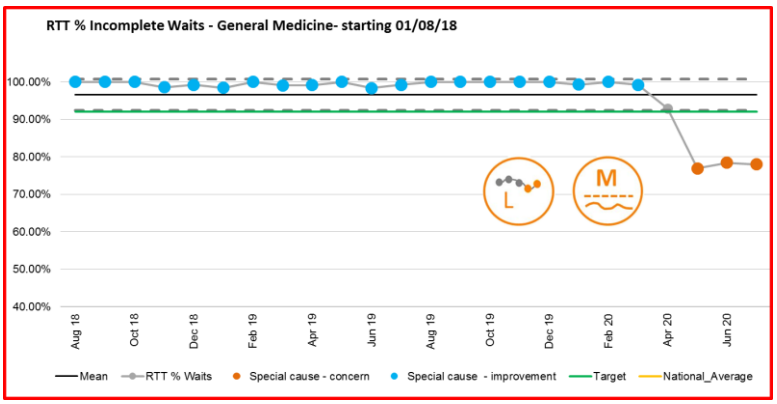

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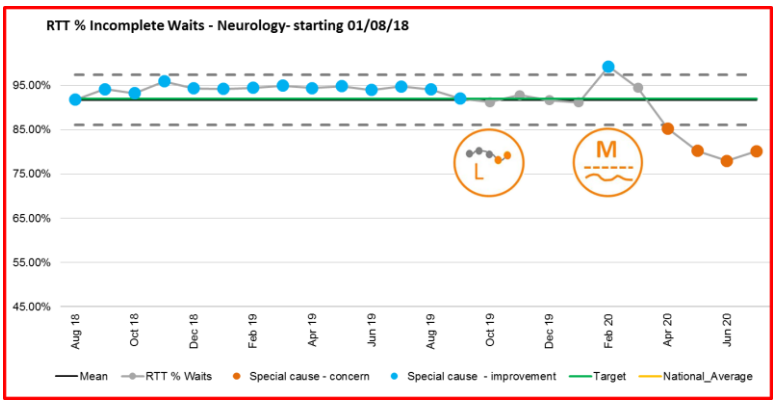

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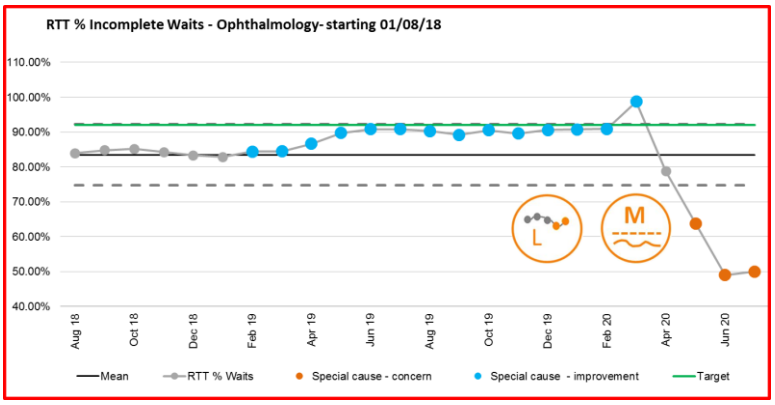

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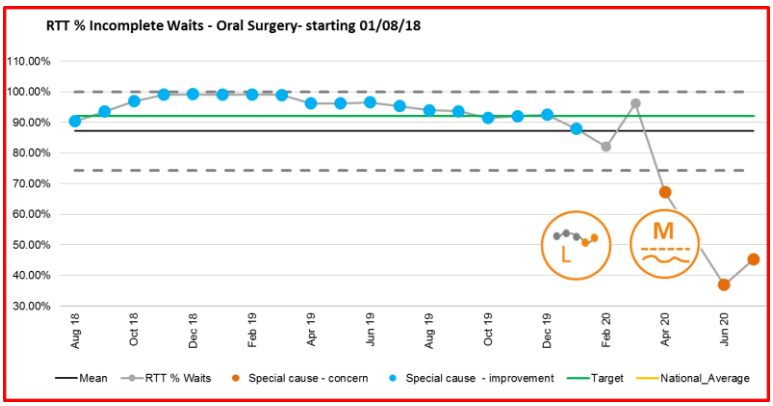

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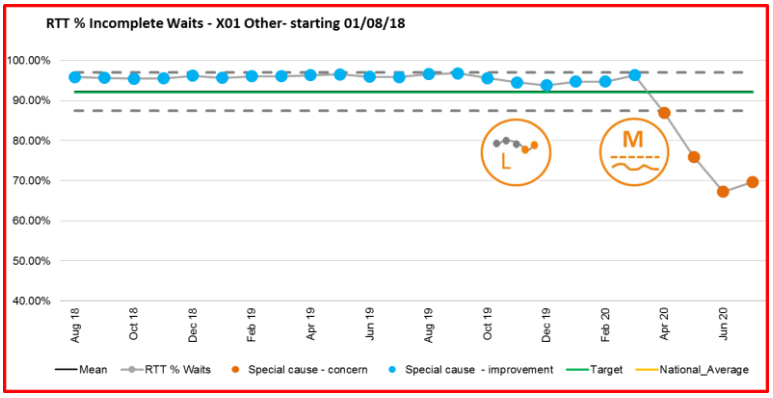

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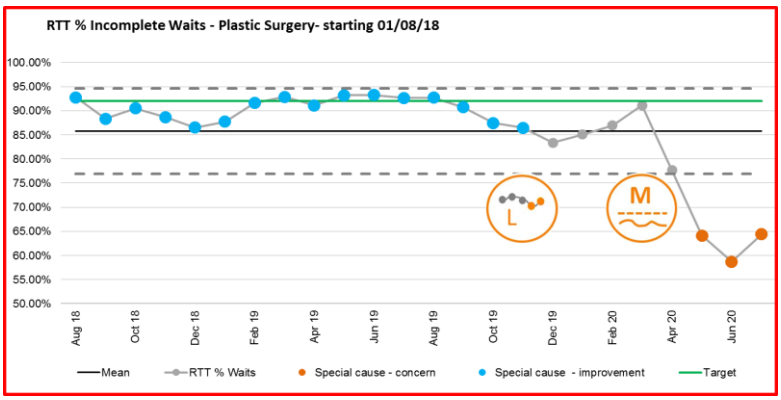

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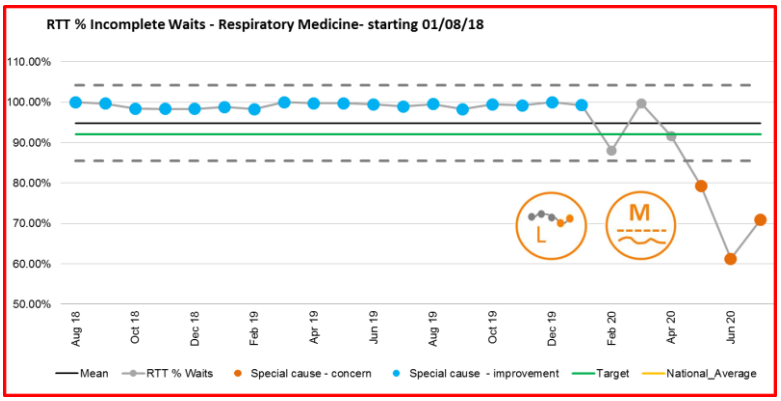

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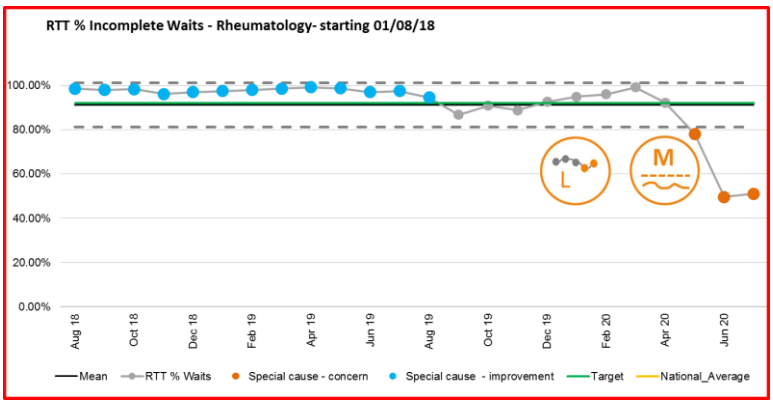

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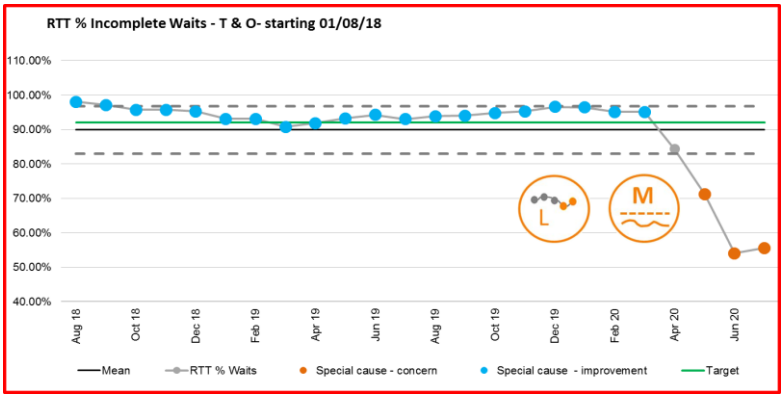

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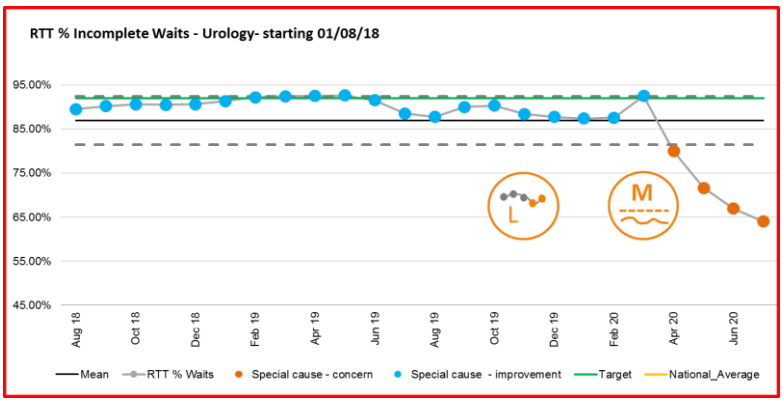

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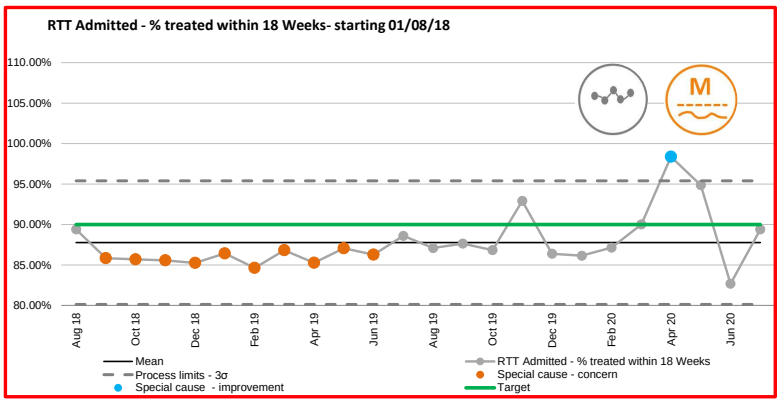

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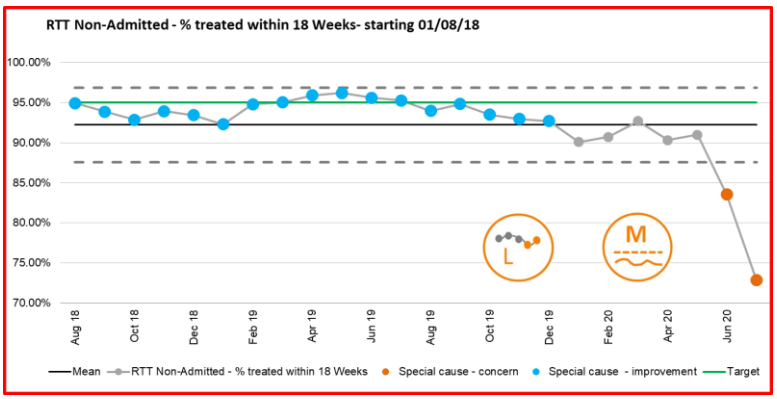

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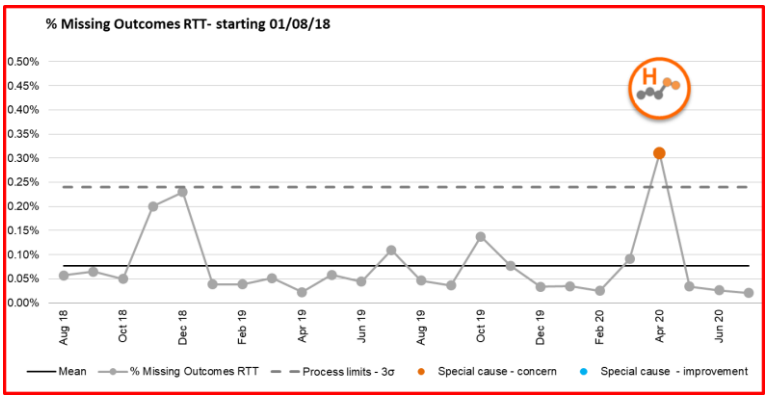

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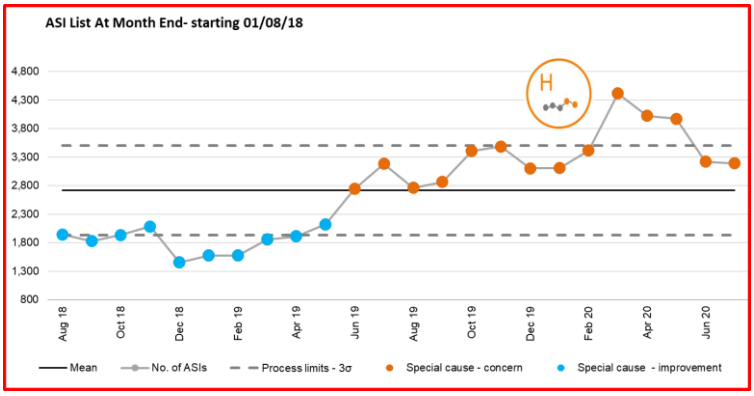
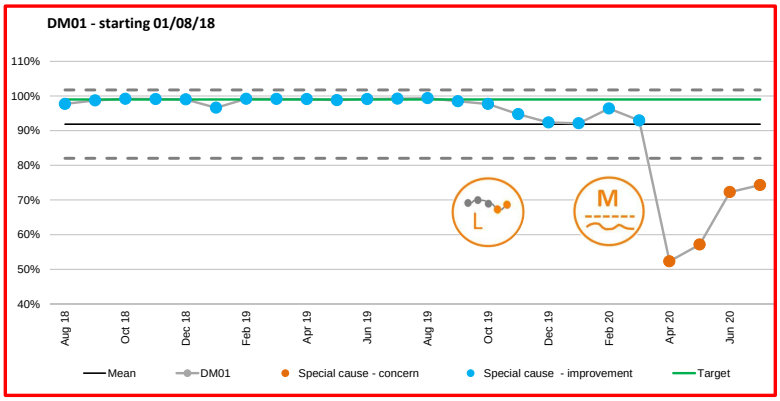
Performance Matters (KPIs)



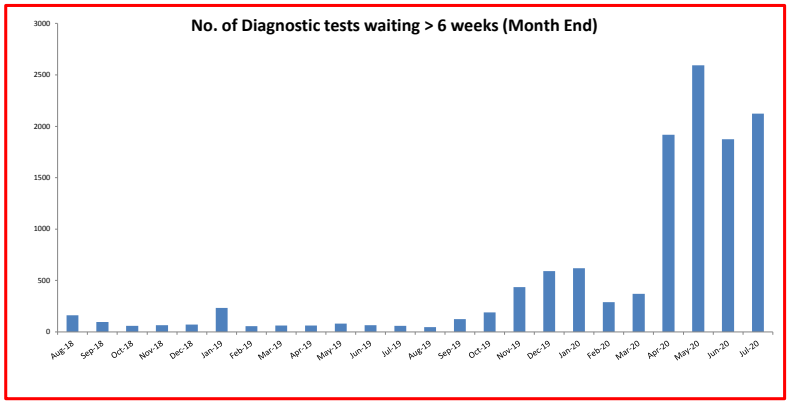
No Narrative Given

Performance Matters (KPIs)



In July, the Trust achieved 74.31 per cent of diagnostics tests carried out within six weeks wait against the national operational standard of 99 per cent. There were total of 2124 patients who waited more than 6 weeks for their test.
Under delivery is due to the huge number of cancellations of all non-urgent diagnostic testing in March, in line with national guidance in response to COVID 19. This resulted in:

• Almost six fold increase in the number of patients waited over 6 weeks for their diagnostics test compared to the pre-COVID monthly average. DGFT reported only 349 patients who waited for more than 6 weeks; this number went up to 2124 in July.
This is, however, an improvement from performance in May and June and in line with improvement trajectory.
The Imaging and Endoscopy department has resumed routine diagnostics tests allowing for safe social distancing. The social distancing measure will introduce some delays. With this in mind, Imaging has continued to recover activity.



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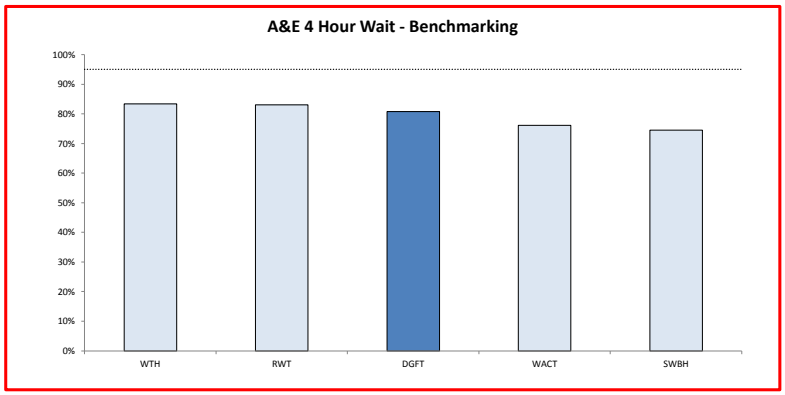

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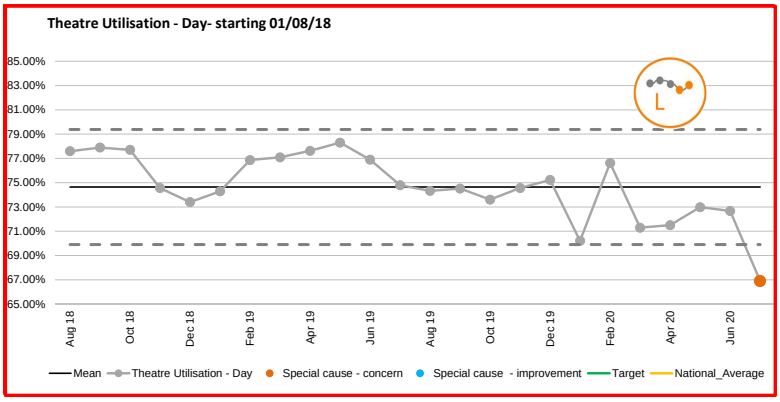

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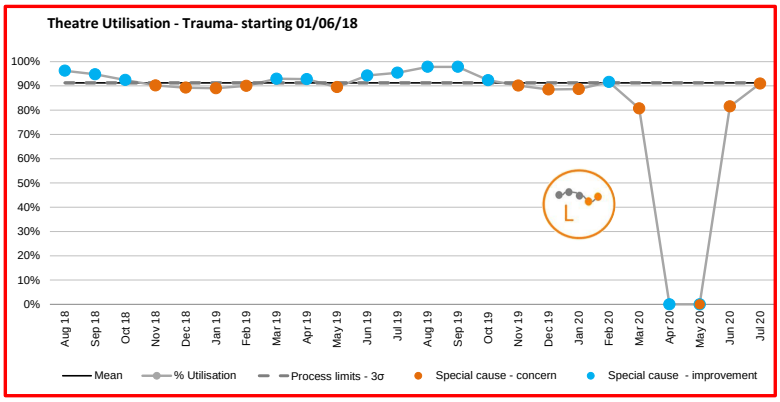

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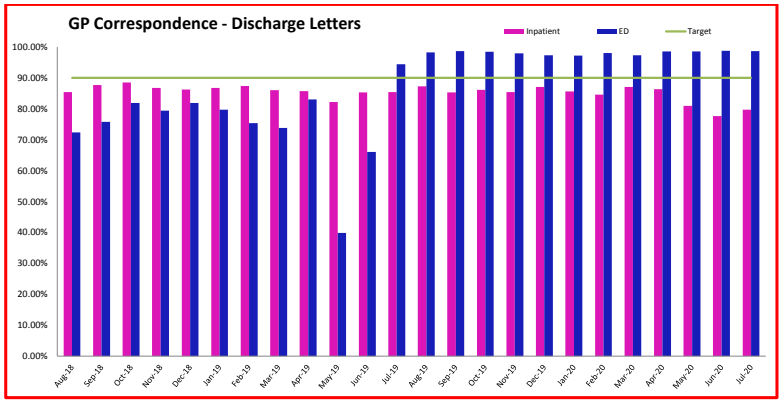

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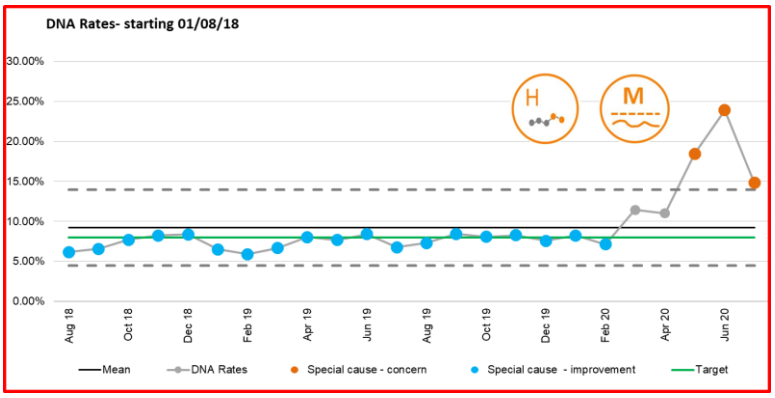

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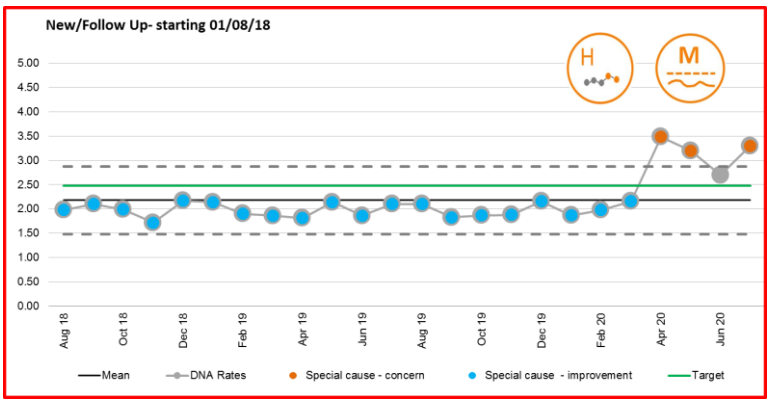

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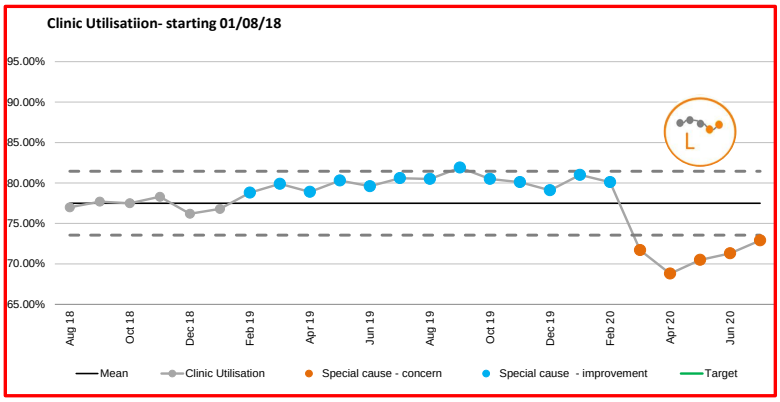
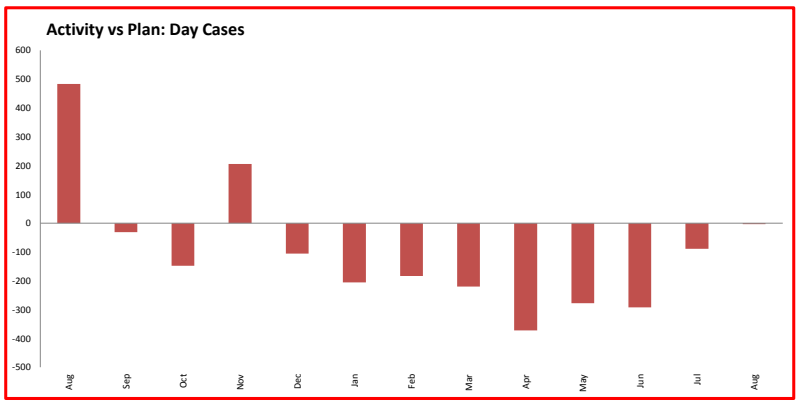


No Narrative Given

Performance Matters

In Month	18/19 Actual	19/20 Plan	19/20 Actual	Variance	%
Elective Day cases	3,786	3,867	3,667	-200	-5%
Elective Inpatients	448	504	471	-33	-7%
Elective Total	4,234	4,371	4,138	-233	-5%
Non Elective	3,670	4,156	4,135	-21	-1%
Outpatients	42,189	43,444	41,168	-2276	-5%
Maternity Pathway	310	331	305	-26	-8%
A&E Attendances - Type 1	9,222	9,072	9,143	71	1%
* Please note excess bed days are not included in these figures.					
Obstetric outpatient attendances are excluded as they are covered by the Maternity Pathways					

No Narrative Given



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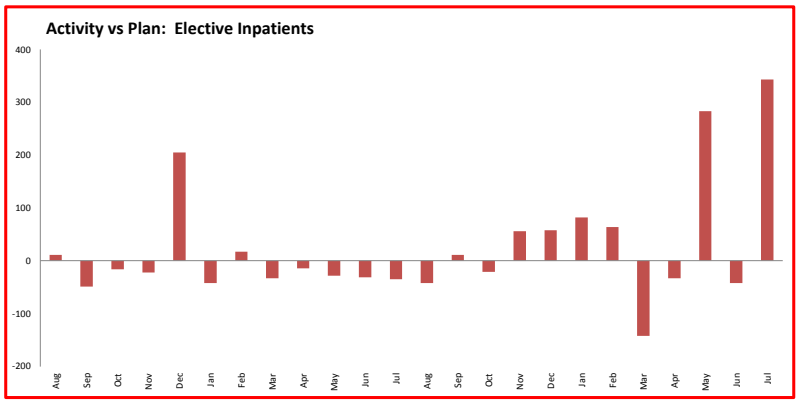

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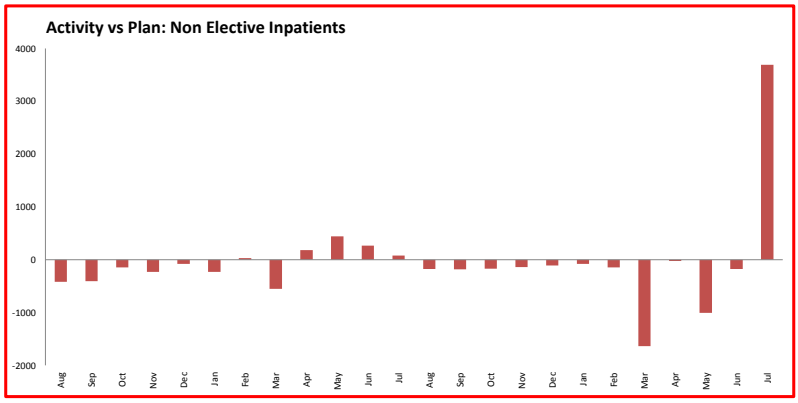

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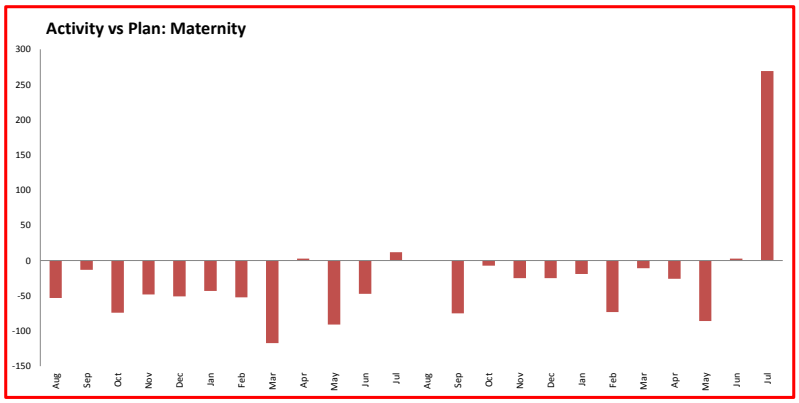
Performance Matters



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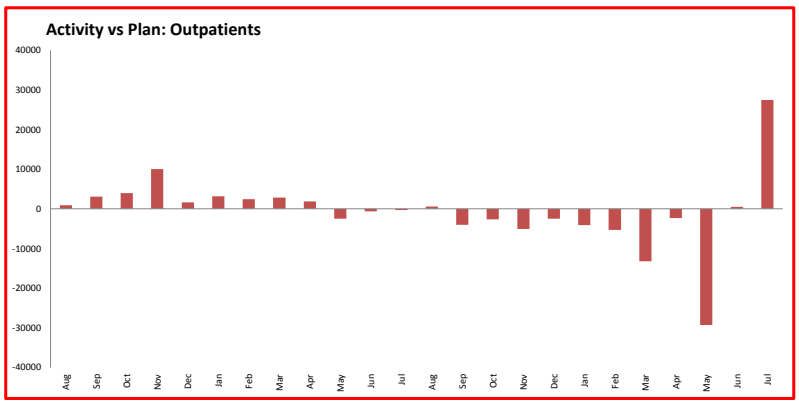

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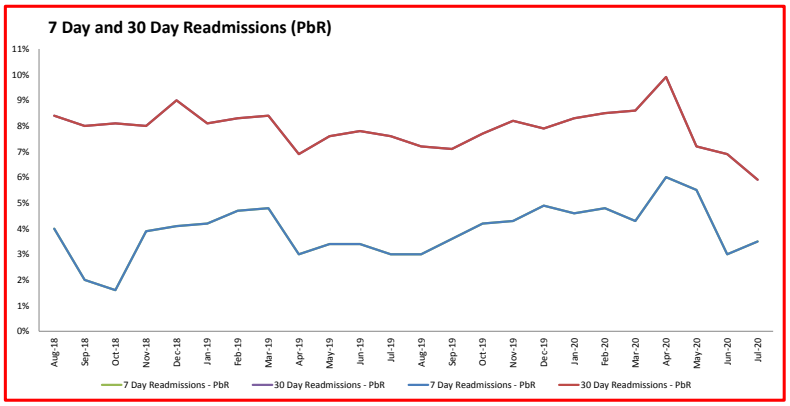
Performance Matters



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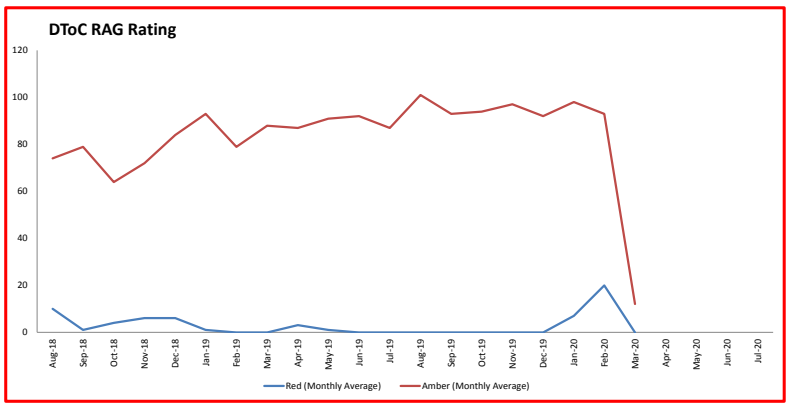

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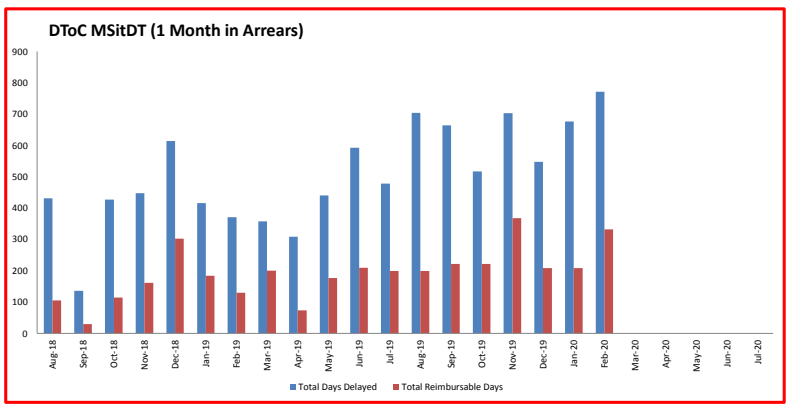

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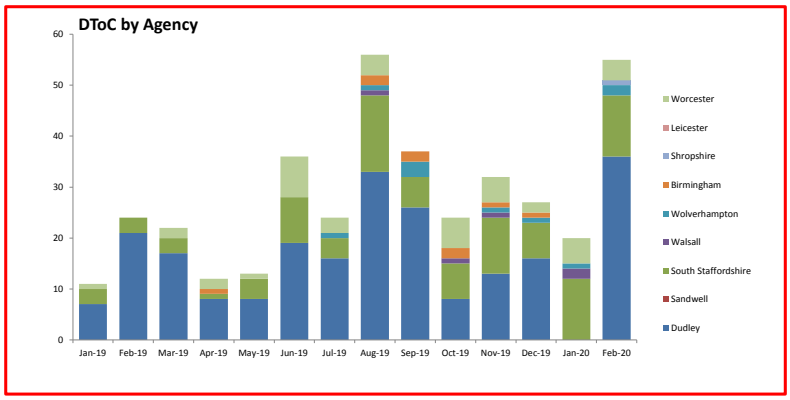
Performance Matters



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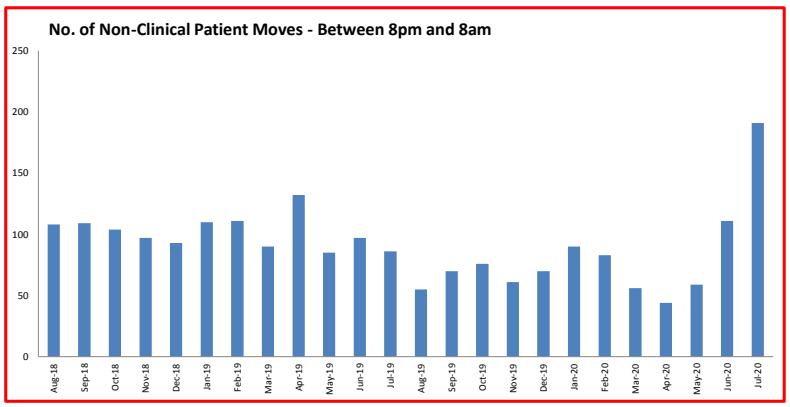

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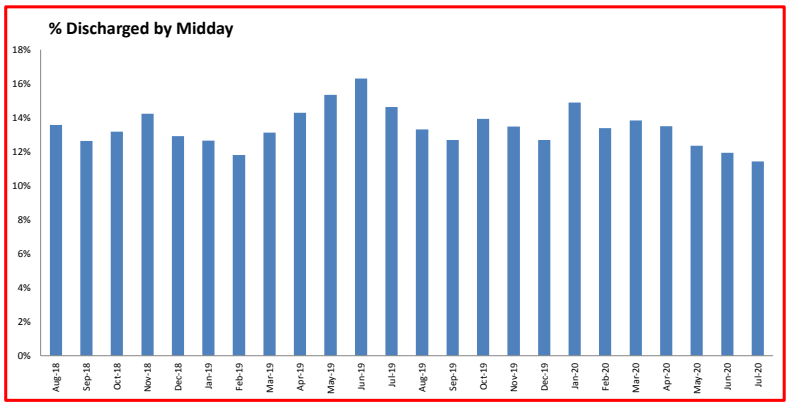

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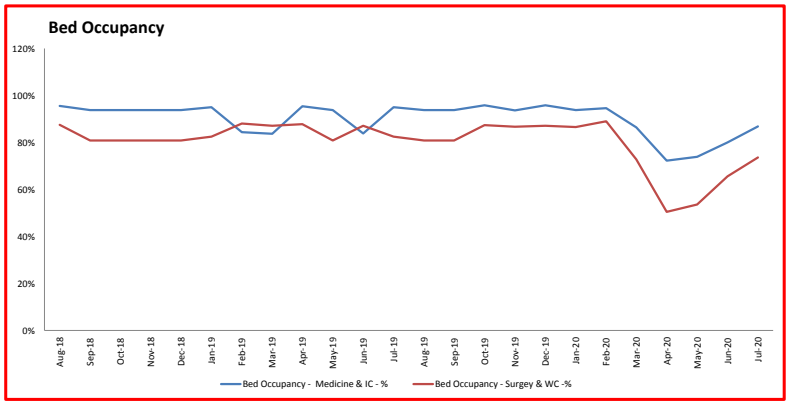

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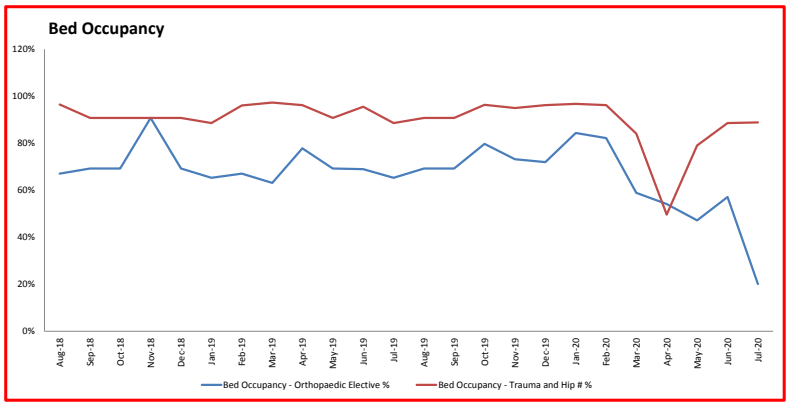
Performance Matters



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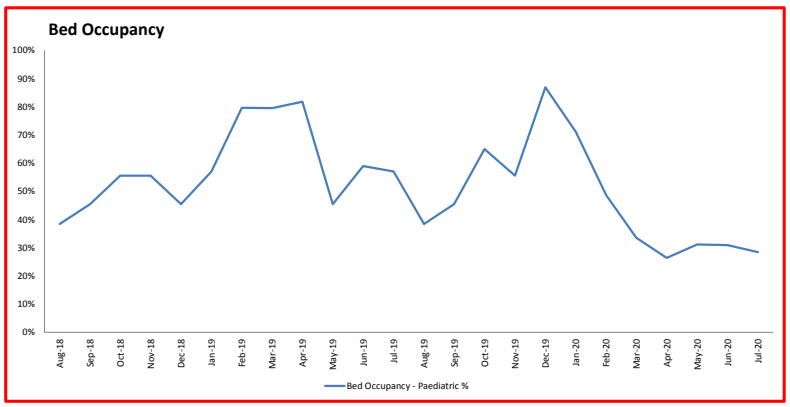

No Narrative Given

Enclosure 20

The Dudley Group
NHS Foundation Trust

Paper for submission to the Board of Directors on 10th September 2020

TITLE:	**Quality Account – 2019/20**		
AUTHOR:	Derek Eaves, Professional Lead for Quality	**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
	√	√	

RECOMMENDATIONS

- To approve the Quality Report and Account 2019/20

CORPORATE OBJECTIVE:

Deliver a great patient experience, Safe and Caring Services, Be the place people choose to work, Make the best use of what we have

SUMMARY OF KEY ISSUES:

Due to the Covid 19 situation, NHSi announced that for the first time the annual Quality Report and Account of Foundation Trusts did not require external audit. The attached Quality Report and Account has been compiled and contains all of the national requirements. Some national and local comparative data has not been available, again due to the Covid 19 situation.

The attached was presented to the Quality and Safety Committee in July and agreed. The Board is asked to approve its publication.

IMPLICATIONS OF PAPER:

IMPLICATIONS FOR THE CORPORATE RISK REGISTER OR BOARD ASSURANCE FRAMEWORK None

RISK	**N**		**Risk Description:**
	Risk Register: N		**Risk Score:**
COMPLIANCE and/or LEGAL REQUIREMENTS	**CQC**	**Y/N**	**Details:**
	NHSI	**Y**	**Details:** As per Quality Account requirements
	Other	**Y**	**Details:** As per DoH Quality Report requirements
REPORT DESTINATION	**EXECUTIVE DIRECTORS**	**N**	**DATE:**
	WORKING GROUP	**Y/N**	**DATE:**
	COMMITTEE	**Y**	**DATE:** Quality and Safety 28th July 2020

NHS
The Dudley Group
NHS Foundation Trust

Quality Report and Account 2019-20

This information can be made available in large print, audio version and in other languages, please call 0800 073 0510.

لغات أخرى، الرجاء بـ للحصول على هذه النشرة بحجم أكبر، وعلى شكل إصدار صوتي و الاتصال بالرقم 08000730510.

此宣传单可提供大字版本、音频版本和其它语言版本，请拨打电话：0800 073 0510。

Ulotka dostępna jest również w dużym druku, wersji audio lub w innym języku. W tym celu zadzwoń pod numer 0800 073 0510.

ਇਹ ਪਰਚਾ ਵੱਡੇ ਅੱਖਰਾਂ, ਬੋਲ ਕੇ ਰੀਕਾਰਡ ਕੀਤਾ ਹੋਇਆ ਅਤੇ ਦੂਸਰੀਆਂ ਭਾਸ਼ਾਵਾਂ ਵਿਚ ਵੀ ਪ੍ਰਾਪਤ ਹੋ ਸਕਦਾ ਹੈ, 0800 073 0510 ਤੇ ਫੋਨ ਕਰੋ ਜੀ।

Aceasta brosura poate fi pusa la dispozitie tiparita cu caractere mari, versiune audio sau in alte limbi, pentru acest lucru va rugam sunati la 0800 073 0510.

یہ کتابچہ آپ کو بڑے حروف کی لکھائی ، سمعی صورت اور دیگر زبانوں میں مہیا کیا جا سکتا ہے۔برائے مہربانی فون نمبر 08000730510پر رابطہ کریں۔

Quality Report and Account 2019/2020

Part 1: Introduction - Chief Executive's Statement

Throughout this document, there are a number of quotes taken from reviews that patients themselves have posted online on NHS Choices and Patient Opinion.

Part 1: Introduction - Chief Executive's statement

During the year, the Trust has continued to strive to provide high quality care and treatment and improve its services. We do this by focusing on providing

- a good patient experience,
- safe care and treatment, and
- a good and effective standard of care.

This quality report describes the quality of care delivered at the Trust over 2019/20, providing an overall account of where we are performing well and where we can make improvements.

Our quality priorities

At the beginning of the report (Part 2) you will find an outline of our priority quality measures and their progress. I am particularly pleased with the steep decline in avoidable pressure ulcers from last and previous years. Three patients developed avoidable category 3 ulcers and no avoidable category 4 ulcers have occurred. We realise that these are three too many and our zero tolerance approach continues. In terms of infection control, while we have had one MRSA bacteraemia case, the first since September 2015, we are under the national target for C. difficile cases arising due to lapses in care. We continue to improve our practice in the other priority areas.

Following consultations with staff, governors, our commissioners and Healthwatch colleagues, we have decided to concentrate our efforts on improving both patient experience and discharge management as our priorities in 2020/21.

The report follows the mandated format with sections on clinical audit, research and development, and data quality. In Part 3 we have included other key quality initiatives and measures, and specific examples of good practice on all of the aspects of quality, which I hope will provide you with a useful picture of what is occurring across the Trust. I am really proud that the care of patients with sepsis has improved significantly. This is testament to our drive for quality of care and to ensure that patients' conditions do not deteriorate unnecessarily (section 3.3.8).

The Care Quality Commission (CQC) visited the Trust in early 2019 and I am pleased to report a number of improvements as well as retention of previous positive ratings since their last assessment. For instance, our end of life services in hospital and community were assessed as Good throughout all five of the CQC categories (Safe, Effective, Caring, Responsive and Well Led) while community caring was seen as Outstanding. Caring in our surgical services was also seen as Outstanding. Critical care was assessed overall as Good. Our urgent and emergency service was seen to have improved overall since the regulator's previous visit in 2018. Unfortunately, our diagnostic imaging service was seen to be Inadequate and so we have a full set of improvement actions in place.

During the year, as well as continually monitoring and striving to improve our own performance, a number of independent reviews of the quality of care at the Trust have been undertaken by outside organisations (see section 2.2.1). This combination of our own and external assessments allows us to assure both patients and ourselves of what we are doing well and the learning we need to take on to further improve and strengthen the care we provide to patients.

I hope the contents show that the Trust does not stand still but is always pursuing a path of improvement.

Measuring quality

This quality account includes many indicators of quality and we have included a number of specific examples of the quality initiatives our skilled, caring and motivated staff are undertaking across the Trust and what patients have said about the care they have received from us. We could not include them all but hopefully these examples, together with the innovation and initiatives that Trust staff have achieved and implemented in the year, give a sense of our quality of care. I would like to make a special mention to all of the staff and departments that have either been nominated, or progressed and gone on to win, both local and national awards (see section 3.4.2).

The Trust and its Board of Directors have sought to take all reasonable steps and have exercised appropriate due diligence to ensure the accuracy of the data reported. Following these steps, to the best of my knowledge, the information in this document is accurate.

Finally, following the emergence of the COVID-19 situation towards the end of this financial year, 2020/21 will bring a series of demands as we begin the restoration and recovery of services. Staff - with tremendous help and support from the local community - have come together to provide exceptional care and treatment in these unprecedented times. As the coming year progresses, there will be national challenges which require us to achieve a range of performance targets within financial constraints and a focus on restoration of our services, continuing to provide high quality care. In addition, we will continue our work with partners across the Dudley system and further integration of clinical pathways that support and improve health outcomes with the community we serve.

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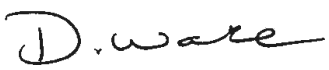
Signed:



Diane Wake
Chief Executive
Date: July 2020

Part 2: Priorities for improvement and statements of assurance from the Board of Directors

2.1 Quality improvement priorities

2.1.1 Summary

The table below provides a summary of the history of our quality priorities over the past four years and outlines the new priorities for 2020/21.

Quality Priority	2016/17	2017/18	2018/19	2019/20	2020/21	Notes
Patient experience Ensure that the percentage of patients who report positively on their experience is better than the national average. Ensure pain control measures improve.	Hospital: 😐 Partially achieved Community: 😐 Partially achieved	Hospital: 😐 Partially achieved Community: 😐 Partially achieved	Hospital: 😐 Partially achieved Community: 😐 Partially achieved	Hospital: 😐 Partially achieved Community: 😐 Partially achieved	**Priority 1**	See page 9 for more information
Pressure ulcers Reduce the occurrence of avoidable pressure ulcers.	Hospital: 😐 Partially achieved Community: 😐 Partially achieved	Hospital: 😐 Partially achieved Community: ☹ Not achieved	Hospital: 😐 Partially achieved Community: ☺ Achieved	Hospital: ☺ Achieved Community: ☺ Achieved		See page 13 for more information
Infection control Reduce our MRSA rate in line with national and local priorities.	☺ Achieved	☺ Achieved	☹ Not achieved	☹ Not achieved		See page 15 for more information
Reduce our Clostridium difficile rate in line with local and national priorities.	☺ Achieved	☺ Achieved	☺ Achieved	☺ Achieved		
Nutrition Ensure there are effective processes in place for nutrition care.	😐 Partially achieved	😐 Partially achieved	😐 Partially achieved	😐 Partially achieved		See page 17 for more information
Hydration Ensure there are effective processes in place for hydration care.						
Medications Ensure effective processes are in place for medicine administration.	☹ Not achieved	☹ Not achieved	☹ Not achieved	☹ Not achieved		See page 20 for more information
Discharge Management **Ensure effective discharge planning systems are in place**			😐 Partially achieved	Hospital: 😐 Partially achieved Community: ☺ Achieved	**Priority 2**	See page 22 for more information
Incident Management **Ensure there is a positive learning culture**			😐 Partially Achieved	😐 Partially Achieved		See page 26 for more information

2.1.2 Choosing our priorities for 2020/21

The quality priorities for 2019/20 covered the following seven topics:

1. Patient experience
2. Infection control
3. Pressure ulcers
4. Nutrition/hydration
5. Medication
6. Discharge management
7. Incident management

These key topics were agreed by the Board of Directors due to their importance both from a local perspective (e.g. based on key issues from patient feedback, both positive and negative) and from a national perspective (e.g. reports from national bodies such as the Health Ombudsman, CQC etc.). The first four topics were agreed five years ago at a collaborative event on the Quality Report, hosted by the chief executive and chief nurse who were in post at the time, attended by staff, governors, Foundation Trust members and others from key outside organisations. These topics have been endorsed in discussions with the Dudley MBC Health and Social Care Scrutiny Committee and Dudley Clinical Commissioning Group. The fifth topic, medication, was added in 2016/17 following a review of patient feedback on their care and treatment.

Following further year-on-year consultations internally; with governors, patients and others who attended the Annual Members Meeting; the public generally via an online questionnaire and our main commissioner, it was agreed in 2018/19 that these topics should be retained with two further topics added - discharge management and incident management. For 2019/20, all of these topics were retained.

To shape priorities for the coming year, a listening event was held in October 2019 to get the views of as many stakeholders as possible. Invited were a variety of Trust staff including nurses, doctors, allied health professionals, and pharmacy and governance staff from both the hospital and community. Colleagues from Dudley CCG were invited as were a number of governors, the chief officer of Healthwatch Dudley and a representative from Dudley MBC.

There was general agreement that the topics should be reduced to enable concentration on two or three. It was agreed the topics should not be either: 1) ‘day to day’ issues that are being monitored for either national or local contracts/requirements (e.g. FFT, MRSA etc) but that these would continue to be monitored for general performance management purposes or 2) topics that had recently improved (e.g. pressure ulcers, MUST scores).

The need to focus on patient experience was considered a priority. The importance of patient flow and effective discharge processes was also seen to be important. The general view was that patient experience was key, particularly in terms of what patients themselves tell us about communication processes. Good listening skills and good patient involvement in their care and treatment plans, for example, were thought to be important issues. It was appreciated however that having specific measurable indicators for such topics may be difficult. A creative thinking event occurred with key staff to suggest a number of specific indicators for these two topics. Suggestions went to the board who agreed the indicators outlined in this report.

2.1.3 Our priorities

Priority 1 of 2019/20: Patient experience
a) Achieve monthly response rates in Friends and Family Test (FFT) for all areas (inpatients, outpatients, maternity, Emergency Department and community) that are equal to or better than the national average. b) Achieve monthly scores in Friends and Family Test (FFT) for all areas (inpatients, outpatients, maternity, Emergency Department and community) that are equal to or better than the national average. c) Improve the overall year score from 2018/19 to 2019/20 for the following question used in our local real-time survey: Were you involved as much as you wanted to be in decisions about your care? d) Improve the overall year score from 2018/19 to 2019/20 for the following question used in our local real-time survey: When you reached the ward, were you given a 'Welcome to Russells Hall Hospital' booklet?

Rationale for inclusion and how we measure and record this priority

- The FFT recommended score and response rates targets have been retained as they remain a national focus, provide valuable benchmarking information and drive improvement to the patient experience. We only saw a slight improvement in the local survey question asked last year and so this has been retained to improve further.
- Our present local survey results show that not all patients are being provided with the hospital welcome booklet that contains useful information for all patients.

The FFT survey provides valuable data to support local actions to improve the patient experience. The NHS Friends and Family Test (FFT) is firmly embedded within the Trust with all patients given the opportunity to complete the survey after each episode of care and treatment in all areas of the organisation. Feedback is captured through a variety of methods (SMS or smartphone app, tablet or kiosk at point of discharge and online once patient is home). The question is also included in the inpatient local surveys and scores are recorded on the internal Friends and Family database. We measure the numbers of responses received against the total number of eligible patients. Our local real time surveys cover the last two items above. We measure this by inviting inpatients who have been given an estimated discharge date and who are expecting to be discharged within 48 hours, to answer these questions. An average of 120 patients are surveyed each month.

Halesowen District Nurses visited my mother following knee replacement surgery. They were unfailingly kind and caring and their visits filled her with confidence and reassurance. Thank you so much for your care.

Developments that occurred in 2019/20

- Increased the availability of the Friends and Family survey online app and promoted widely.
- Refreshed the Friends and Family Test survey cards.
- Continued to hold Feedback Fridays weekly.
- Expanded FFT survey via SMS to include children and maternity specialty areas.
- Increased the number of listening events and focus groups.
- Implemented a publicity drive about the welcome booklets. Examined data and information in more detail to identify teams that are performing well and share best practice.
- Carried out a review of the current process, including how the local survey is deployed across all teams and the current methods of data collection.
- Community services have hosted 'Lunch and Learn' sessions to identify trends and learning.
- Increased patient experience volunteers to carry out ward visits and promote the Friends and Family Test.

Current status

Family and Friends Test

a) Response Rate Update April 2019 – March 2020

Inpatient		A&E	Antenatal	Birth			Postnatal Ward	Postnatal Community	Community		Out-patients
11	1	12	-	7	4	-	-	-	11	1	-

(Where national response rate data is not available, this has been calculated internally using 12 months of NHS England raw data from February 2018 to January 2019).

For April 2019 – March 2020 (47 areas were published) the Trust is achieving the performance indicator on 41 occasions where the percentage response rate score is equal to or better than the national average percentage response rate. The areas not achieving the performance indicator are maternity birth. No national comparative data was published for response rates for maternity antenatal, maternity postnatal ward, maternity postnatal community and outpatients.

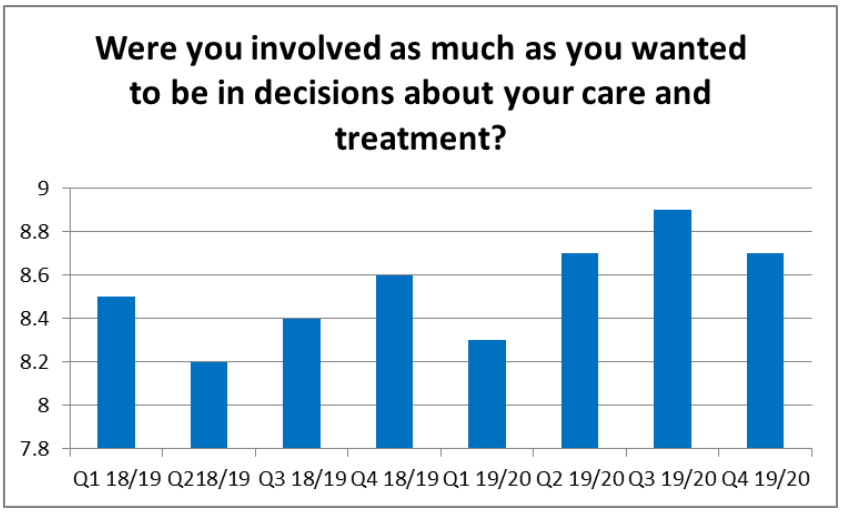
b) Percentage Recommended Update April 2019 - March 2020

Inpatient	A&E		Antenatal			Birth		Postnatal Ward			Postnatal Community			Community	Outpatients	
12	12	7	4	-	7	4	-	4	7	-	8	3	-	12	1	11

(Where national response rate data is not available, this has been calculated internally using 12 months of NHS England raw data from February 2018 to January 2019).

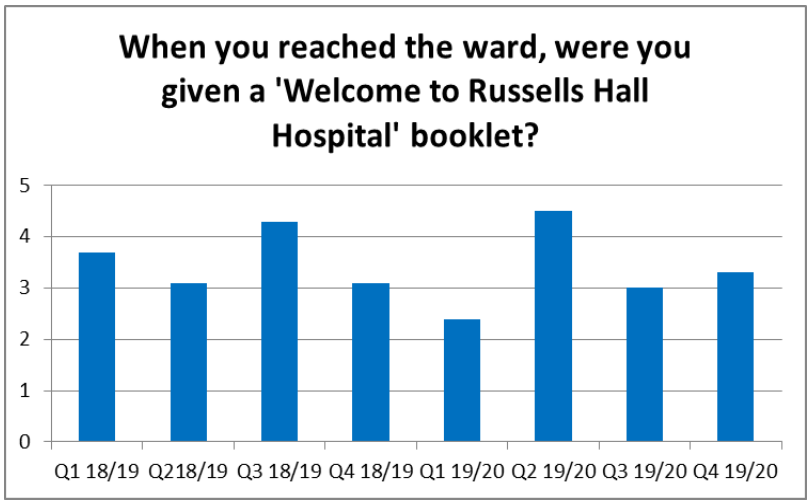
For April 2019 – March 2020 (92 areas have been published) the Trust achieved the performance indicator on 27 occasions where the score is equal to or better than the national average percentage recommended. The areas that are not achieving the performance indicator are inpatients, A&E, community, maternity postnatal ward and outpatients.

c) **Improve the overall year score from 2018/19 to 2019/20 for the following question used in our local real time survey: Were you involved as much as you wanted to be in decisions about your care?**



The scores at the end of each quarter are shown and the 2019/20 full year score was 8.6 in comparison to 8.4 in 2018/2019. This priority has been achieved for the whole year.

d) **Improve the overall year score from 2018/19 to 2019/20 for the following question used in our local real time survey: When you reached the ward, were you given a 'Welcome to Russells Hall Hospital' booklet?**



The scores at the end of each quarter are shown and the 2019/20 full year score was 3.3 in comparison to 3.5 in 2018/2019. This priority has not been achieved for the whole year.

New priority 1 for 2020/21: Patient experience

1. Improve the way we communicate and engage with patients.

   a) 'Do staff treating and examining you introduce themselves?' (National baseline Maternity 2019 99%, Children 2018 93% with the aim being 95% overall).

   b) 'Have you been told what is going to happen to you today (tests etc)?' (Local survey baseline 59% with suggested improvement to 95%)
   (At present, the first question is not part of the local survey but will be added.)

   c) Hold a quarterly forum/focus group with each prioritising two key planned actions and undertaking those actions and measuring the success.

d) Hold the newly developed Citizen Panel at least quarterly (this may be more frequent depending on the views of the attendees at the first meeting).

e) Establish a group of Expert Volunteers to ensure we raise the patient voice so that services are delivered compassionately.

2. Ensure all complaints are responded to in accordance with the Trust complaints and concerns policy. Action plans will be shared for review and learning so that patients and other professionals can see change being made.

a) Improve the percentage of complaints responded to within the internal timeframe of 30 working days (current figure 23%).

Rationale for inclusion

- Providing the best possible patient experience means getting the fundamentals right, making sure our patients feel safe and well-cared for, that they have trust and confidence in the staff caring for them and that they receive excellent quality care in a clean and pleasant environment.
- Having assessed the outcome of the National Inpatient Survey, it was decided to include a new target for a topic where we did not perform as well as other questions.

How we measure and record this priority

- Our local real time surveys cover the first two items above. We measure this by inviting inpatients who have been given an estimated discharge date and who are expecting to be discharged within 48 hours, to answer these questions. An average of 120 patients are surveyed each month.
- We will keep records of when the forum/focus groups, Citizen Panel and Expert Volunteers meet.
- Our complaints database contains a number of recorded dates such as the date the complaint was received and the date of response.

Developments planned for 2020/21

- We will raise the profile of our 'what matters to you' campaign across the Trust and via social media channels. This campaign aims to raise the profile of patient experience across the Trust, capture feedback and share successes. This will be done by using a wide range of mechanisms and reporting on the activity to facilitate organisational learning and improvement in order to achieve the objectives highlighted in the Patient Experience Strategy. There is a communications plan in place for the launch of the campaign.
- The Trust will be developing a 'Patient Panel' to give patients, carers and members of the public the opportunity to have their say on how our services are run and to provide us with feedback on our current service provision and proposals for service redesign and future developments.
- We will be recruiting Patient Voice Volunteers to give patients the opportunity to actively participate in surveys and other health-related activities, give ideas and opinions on how health services can be improved by being part of focus group discussions and workshops, and to use their experiences of health services, as a patient or a carer, to inform and influence the delivery, planning and quality of services we provide. The Patient Voice Volunteers will also represent the interests and views of local patients and carers in the Dudley borough with the overall aim of improving the experiences of people who use our services.
- We will be introducing Patient Reported Experience Measures Survey (PREMs) into the organisation to ensure that more efficient and effective systems are in place to engage with patients and carers to provide feedback on their care. PREMS are used to understand service users' views

on their experience while receiving care, rather than the outcome of that care. This aims to achieve a way of surveying patients using a standard set of questions to capture, understand and use service experience in a consistent way, linked to CQC care standards and cross referencing the findings with the Friends and Family Test as an overall satisfaction score.

Board sponsor: Mary Sexton, chief nurse. **Operational lead:** Jill Faulkner, head of patient experience

The staff in C6 ward could not have done enough for me! The care and attention I received was very thorough and the whole process was explained succinctly and professionally. Thank you very much team, I am on the mend.

Priority 2 of 2019/20: Pressure ulcers	
Hospital	**Community**
a) Ensure that there are no avoidable category 4 hospital acquired pressure ulcers throughout the year. b) Ensure that the number of avoidable category 3 hospital acquired pressure ulcers in 2019/20 reduces from the number in 2018/19 by at least 10 per cent.	a) Ensure that there are no avoidable category 4 pressure ulcers acquired on the district nurse caseload throughout the year. b) Ensure that the number of avoidable category 3 pressure ulcers acquired on the district nurse caseload in 2019/20 reduces from the number in 2018/19 by at least 10 per cent.

Rationale for inclusion

- Pressure ulcers remain a significant healthcare problem despite the knowledge that pressure ulcers are largely preventable.
- Avoidable pressure ulcers are a key indicator of the quality and experience of patient care.
- Feedback from our patients, staff, community groups and governors indicates this should remain a target.

How we measure and record this priority

In order to reduce the incidence of pressure ulcer development, it is important that we measure the incidence and identify the contributing trends and themes.

- When potential pressure damage is identified, the details are entered into the Trust's incident reporting system. Depending on the category of damage, the incidents are reviewed by the lead nurse, matron or the tissue viability team to confirm the category and provide advice and support to the patient's care provider.
- Root cause analysis (RCA) investigation is performed for all acquired pressure ulcers of category 3 and above including Suspected Deep Tissue Injury to allow for a systematic evaluation of the contributing factors.

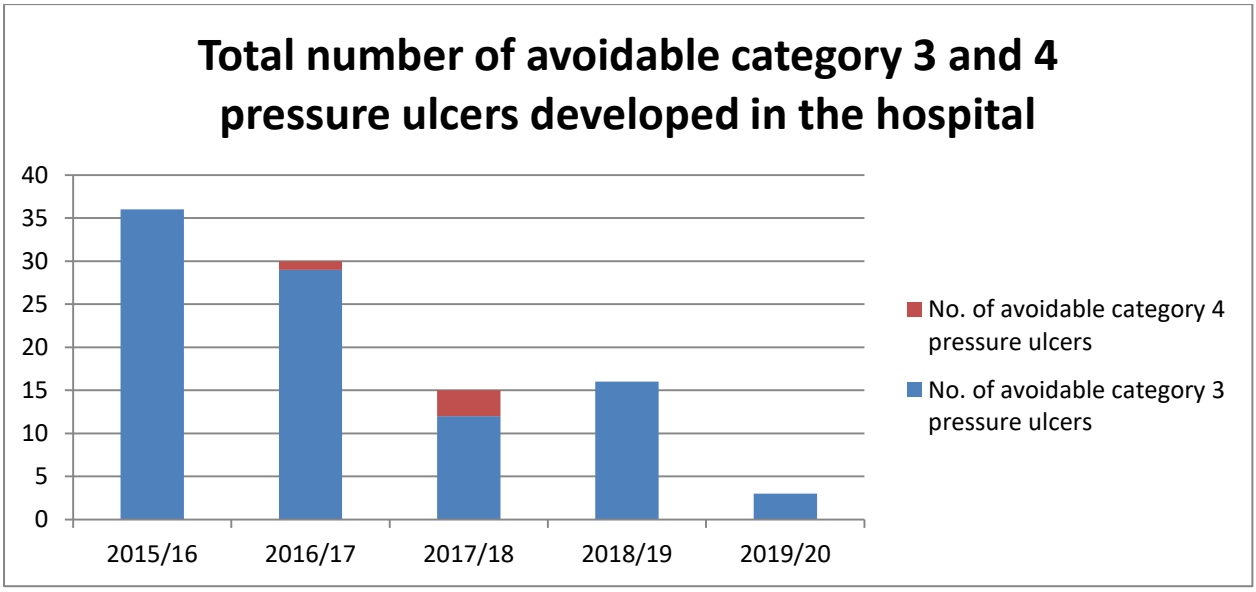
- The duty of candour process ensures that we inform patients and relatives if there have been mistakes in their care that have led to significant harm.

Developments that occurred in 2019/20

- Development of e-learning for all staff.
- Undertook joint working with industrial partners to ensure staff are competent and confident to use treatments and therapies appropriately for the prevention and management of pressure ulcers.
- Fully implemented the NHSi strategy: Pressure ulcers refined definition and measurement to ensure accuracy of reporting.
- Delivered three educational events including 'Pressure ulcers – learning from incidents'. 'Documentation, report writing and fact finding' and 'Complexities of wound healing'.
- Delivered a Trust wide study day 'Coroners Court Experience - is your documentation good enough' sponsored event.
- Delivered the international 'Stop the Pressure' campaign.
- Reported category 2 pressure damage with the aim to reduce the incidents of category 2 pressure damage.
- Reported 'moisture lesions' with an aim to ensure that continence is managed appropriately and reduced.
- Reviewed patient information leaflets and relevant policies for accuracy and update.
- Implemented national guidelines on the prevention and management of skin damage associated with the wearing of PPE during unprecedented COVID-19 period.

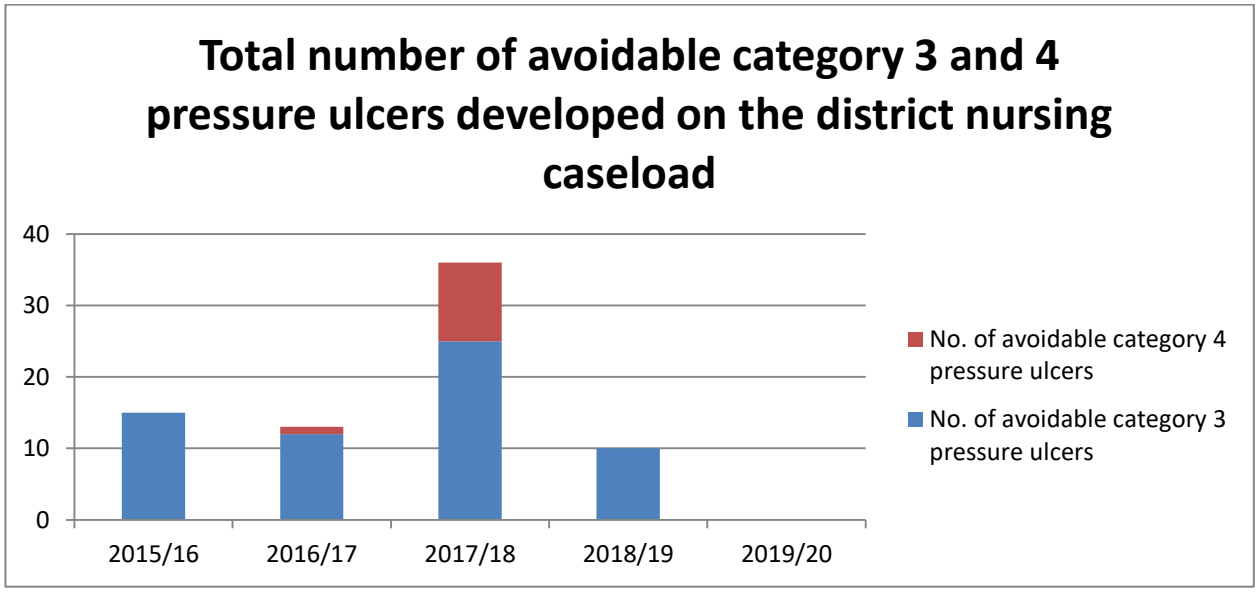
Current status: Hospital

The graph below shows the total number of avoidable category 3 and 4 pressure ulcers that have developed in the hospital from 2015/16 to present. It gives an indication of the fall in numbers due to the hard work of all staff involved. For the full year 2019/20, there have only been three avoidable category 3 ulcers and there have been zero avoidable stage 4 pressure ulcers and so this priority has been achieved.



Current status: Community

Both targets have been achieved this year as there have been no avoidable category 3 or 4 pressure ulcers acquired throughout the year on the district nurse caseload (see graph below).



Board Sponsor: Mary Sexton, chief nurse. **Operational Leads:** Deputy chief nurse Carol Love-Mecrow, divisional chief nurses Julie Pain and Jenny Bree, tissue viability lead nurse Gill Hiskett.

Priority 3 of 2019/20: Infection control	
Maintain or reduce our MRSA and Clostridium difficile (C. diff) rates in line with national and local priorities. All cases will undergo a root cause analysis, the results of which will be discussed jointly by the Trust and Dudley CCG to agree on any avoidability/lapses in care.	
MRSA	**Clostridium difficile**
Have 0 post 48 hour cases of MRSA bacteraemia (blood stream infections).	Have no more than 49 hospital onset healthcare associated (HOHA) cases detected two or more days after admission or community onset healthcare associated (COHA) cases that occur in the community when the patient has been an inpatient in the Trust in the previous four weeks.

Rationale for inclusion and how we measure and record this priority

- The Trust and Council of Governors have indicated that the prevention and control of infections remains a Trust priority.
- NHS England has a zero tolerance of MRSA bacteraemia.
- The Trust has a challenging nationally-set target of no more than 49 C. diff cases for the coming year.

Infections are monitored internally, along with other key quality indicators, on the Trust's electronic dashboard (see section 3.1). In addition, these infections are monitored by our commissioners at quality review meetings. Positive MRSA bacteraemia and C. diff results are reported on the national Healthcare Associated Infections data capture system.

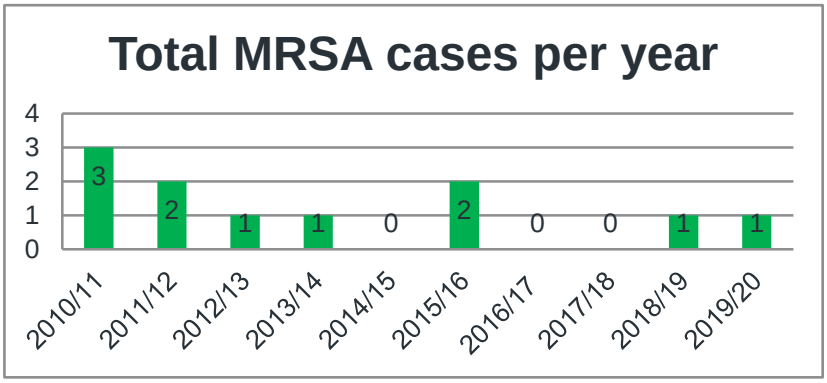
Developments that occurred in 2019/20

- Participated in National Infection Prevention and Control week.
- Participated in WHO Clean Your Hands campaign.
- Contributed to Health Economy Programme to reduce gram negative blood stream infections.
- Took part in Antimicrobial Stewardship Awareness week.
- Reviewed the antimicrobial policy and included clinical teams in the membership of the antimicrobial steering group.
- Monitored compliance with MRSA screening and action plans.
- Commenced divisional reports at Infection Prevention and Control Group.
- Ensured ongoing compliance with mandatory training key performance indicators.

Current status: MRSA

NHS England has set a zero tolerance approach to MRSA bacteraemia. There has been one Trust assigned MRSA bacteraemia in this period. The case has undergone a root cause analysis (RCA) utilising the national tool.

The cause was believed to be a contaminant. The outcomes of the RCA were presented and discussed at a multidisciplinary meeting chaired by the CEO and including representatives from the Dudley Office of Public Health and Dudley CCG. Learning outcomes and actions were identified and shared at ward level via staff meeting/huddle board and with the wider Trust through divisional meetings and the infection prevention group.



Current status: Clostridium difficile

The Trust reports all cases of Clostridium difficile toxin positive disease identified in the hospital laboratory. Changes to the reporting for the 2019/20 year were made to align the UK definitions with international descriptions of disease, however, with regards to the quality priority there are two groups:

- **Hospital onset healthcare associated (HOHA)**: detected in the hospital two or more days after admission
- **Community onset healthcare associated (COHA)**: cases that occur in the community or within two days of hospital admission when the patient had been an inpatient in the Trust reporting the case, within the previous four weeks.

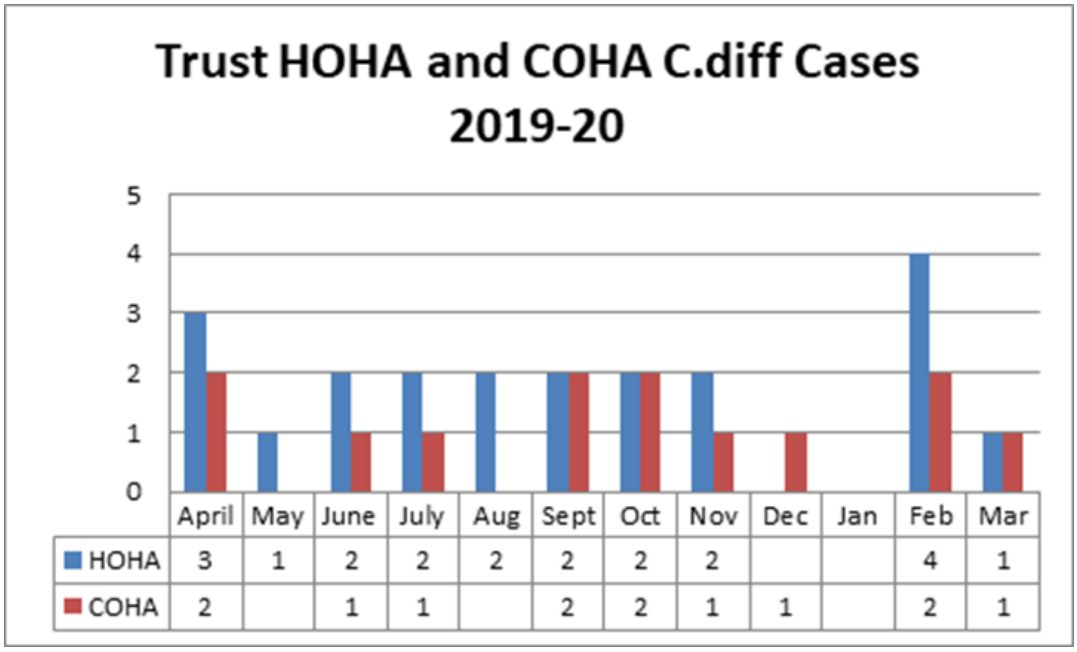
Over the whole year, the number of cases that occurred were:

- 21 hospital onset healthcare associated (HOHA)
- 13 community onset healthcare associated (COHA)

The cases were discussed across the health economy using the national apportionment tool. Themes for the issues identified were antimicrobial stewardship, environmental issues and mandatory training. In order to address issues clinical teams were required to develop action plans which were then monitored locally and via reports submitted by divisions to the Infection Prevention and Control Group.

Of the 34 cases, 18* are where a lapse in care was identified. This means that the threshold of no more than 49 cases has been achieved. (*at the time of writing RCA panel meetings were suspended due to COVID-19 work pressures. There are two HOHA RCAs awaiting review).

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



	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
HOHA	3	1	2	2	2	2	2	2			4	1
COHA	2		1	1		2	2	1	1		2	1

Board sponsor: Mary Sexton, chief nurse, **operational leads:** Director of infection prevention and control Dr Elizabeth Rees, infection prevention and control lead nurse Emma Fulloway.

Priority 4 of 2019/20: Nutrition and hydration

a) At least 95 per cent of acute patients will receive a nutritional assessment within 24 hours of admission to the hospital using the nationally recognised MUST (Malnutrition Universal Screening Tool).
b) With regards to supported mealtimes, 95 per cent of all of the monthly audits will have a positive response to the following three questions:
1) Has all non-essential activity stopped?
2) Is there a nominated qualified nurse overseeing the mealtime?
3) Is there a nominated person to support all patients identified as requiring assistance?

Rationale for inclusion and how we measure and record this priority

- With regards to the MUST target in the hospital, this was not achieved in 2018/19 and so it is retained due to the importance of undertaking a systematic nutritional assessment of all patients who are admitted.
- Supported mealtimes are periods of time over lunch and tea when all non-urgent clinical activity stops. This ensures patients are able to eat their meals in a calm and relaxed environment without unnecessary interruption. It allows nursing staff to monitor and help patients to meet their nutritional

needs which helps to ensure patients don't become malnourished. The newly appointed nutrition nurse has noticed that this system is not universally adopted throughout the hospital.

- Feedback from our patients, staff, community groups and governors indicates this should remain a target.

As part of the monitoring of care relating to nutrition and hydration, a comprehensive audit tool was introduced in 2014. This follows the quality indicator model (see section 3.3.5) and involves auditors checking what is recorded in the nursing notes and asking patients about their experience of being offered drinks and a choice of food. It also includes observations of the environment, for instance whether patients have drinks within reach and whether patients are placed in an optimal position for eating. In total, there are 24 elements to the audit and it is undertaken on 10 patients on every ward each month. The MUST score is also audited as part of the Quality Indicator monitoring.

Developments that occurred in 2019/20

The focus on nutrition and hydration in 2019/20 has focused on five areas:

1. **Increasing staff engagement and awareness**

- Celebratory events such as Nutrition and Hydration Week. This included Trust-wide patient tea parties to increase patient calories in an exciting way, and a host of other events.

- 'MUST is a MUST' trolley dashes which involved visiting areas to 'test and teach' within nutrition hydration competitions.
- Meal Time Matters week where ward areas identified what they thought made the best hospital meal time, including the best board competition.
- Dysphagia awareness day organised with the learning disability team and speech and language team to increase awareness of providing safe nutrition to patients with swallowing difficulties.
- 'Meal time think tank' was completed, this involved clinical support workers, therapy workers and catering teams coming together to strengthen relationships and bring together individual improvement ideas.
- Meal time engagement video filmed in Trust and used in education.
- Healthcare Hero nominations completed when excellent nutrition and hydration practice was seen. The frailty ward was nominated for brilliant individualised meal time observation and patient feedback.
- Launch of the 'best served cold' initiative to increase awareness of individualised dietary supplement provision (flavours and temperature).
- Increased Trust intranet presence by redesigning the nutrition and hydration page and showing screensavers.

2. **Increased education on nutrition and hydration, specifically on the malnutrition universal screening tool**

- E-learning for health on nutrition and hydration easily accessible to all staff.
- Intensive face to face education delivered to developing areas.
- Student nurses, graduate qualified nurses and clinical support workers on a rolling education programme.
- Specialist nutrition nurse and qualified nurse one to one teaching provided to developing ward areas.

3. **Audit**

- Daily deep dive audits completed in areas by specialist nurses, invaluable information gathered to encourage improvement.
- Ward areas increased frequency of audits when underperforming.
- Multidisciplinary Trust-wide meal time audit completed to gather intelligence around baseline themes. This has helped to provide improvement goals for the future.
- Multidisciplinary nutrition task and finish group created.

4. **Food and drink provision**

- Improved patient menu and new meal trolleys introduced throughout the Trust.
- New dysphagia menu developed in line with international descriptors.
- Finger foods added to special menu to help with increasing food intake for patients with dementia/learning disabilities and those with a small appetite.
- Provision of snacks trialled on three ward areas.

5. **New ways of working**

- Pat slide scales trialled in admission areas.
- Volunteers assisting at meal times piloted in one area for four weeks, which is currently under review.

Current status: Nutrition/hydration

a) At least 95 per cent of acute patients will receive a nutritional assessment within 24 hours of admission to the hospital using the nationally recognised MUST (Malnutrition Universal Screening Tool).

Financial Quarter	Percentage
Q1	92.9%
Q2	95.3%
Q3	96.4%
Q4	96.6%
Full year 2019/20	94.4%

- With regards to the MUST result, we have just missed the target of 95 per cent but improved from last year (90 per cent). In a data audit exercise at the end of the year, we discovered a software programming error which meant the score should have been 94.7 per cent. This error has been rectified going forward. In quarter four the ward areas had additional challenges with the COVID-19 response which may have negatively affected the March 2020 results.

b) With regards to supported mealtimes, 95 per cent of all of the monthly audits will have a positive response to the following three questions:

1) Has all non-essential activity stopped?

Financial Quarter	Percentage
Q1	98.0%
Q2	100%
Q3	100%
Q4	96.6%
Full year 2019/20	98.7%

2) Is there a nominated qualified nurse overseeing the mealtime?

Financial Quarter	Percentage
Q1	90.0%
Q2	94.7%
Q3	83.6%
Q4	88.1%
Full Year 2019/20	89.1%

3) Is there a nominated person to support all patients identified as requiring assistance?

Financial Quarter	Percentage
Q1 2019/20	100%
Q2 2019/20	98.2%
Q3 2019/20	100%
Q4	100%
Full Year 2019/20	99.5%

We are pleased to note that we achieved two of the three targets above. Qualified nurse presence at meal times is essential to provide oversight of adequate nutrition and hydration. The target of 95 per cent has not been met this year and so a Trust-wide meal time development plan has been completed to achieve this in 2020/21.

Board sponsor: Mary Sexton, chief nurse **operational leads:** Jenny Bree and Julie Pain, divisional chief nurses, matron Sheree Randall, matron Debra Vasey and Trust nutrition lead Izzie Gibson.

Priority 5 of 2019/20: Medications

a) All patients who have a known potential to have an adverse reaction or have an allergy or sensitivity to a product/medication are clearly identified by having a red identification band in place.
b) Achieve a 50 per cent reduction in the number of patients who are not prescribed analgesia for breakthrough pain when they are prescribed regular opioids for pain management.

a) The audit of red wrist bands only commenced at the end of 2018/19 so we are retaining this target in 2019/20. It is important to reduce and, where possible, eliminate the risk and consequences of exposing a patient who is known to have an adverse reaction or allergy or sensitivity to a medication/product that may be used in their care.

b) Feedback from patient complaints has identified that some patients' pain control is suboptimal. The aim of this work is to ensure that patients receive the lowest effective dose to control their pain and allow both a 'step up and step down approach' to pain management.

How we measure and record this priority and developments planned for 2019/20

a) This information is collected as part of the monthly Quality Indicator monitoring (section 3.3.5)

b) Baseline data was collected during Q1 2019/20 by pharmacists as part of their routine ward visits to inpatient wards. A 'snap-shot' audit tool has been used to record information from inpatient drug charts. No patient identifiable data is recorded. This was followed by a complex intervention combining pharmacist-led feedback and other interventional strategies e.g. education and awareness campaigns, targeted towards nursing, pharmacy and medical staff. Post intervention data collection will then be collected during Q4 2019/20. The variation in prescribing pre- and post- intervention will then be evaluated to identify any improvement. It is assumed that implementing the intervention will improve learning, change in healthcare professional behaviour and improved outcomes for patients.

Developments that occurred in 2019/20

- Educational sessions delivered on pain management to foundation trainee doctors and core medical trainees.
- Education given to pharmacists to encourage prescribing of analgesia that allows drug choice and dosage to be titrated according to patients' individual requirements.
- Chief pharmacist and medication safety officer presented at Emergency Department (ED) team meeting to raise awareness about prescribing the lowest effective dose for pain control for the shortest possible duration.
- 'Audit and feedback' of quantity and duration of opiate prescribing on ED outpatient prescriptions completed.
- Quality improvement project completed on three wards which has enabled inpatients to receive prompter administration of their prescribed analgesia. A governance framework has been developed to facilitate safe implementation on other inpatient wards.

Current status

a) All patients who have a known potential to have an adverse reaction or have an allergy or sensitivity to a product/medication are clearly identified by having a red identification band in place.

Financial Quarter	Percentage
Q1	91.6%
Q2	91.8%
Q3	96.3%
Q4	96.8%
Full Year 2019/20	94.1%

Although there was an improved performance towards the end of the year, overall this target was not achieved. Local ward audits continue monthly and in those areas not achieving 100 per cent the lead nurses are undertaking weekly audits to improve compliance. The divisional chief nurses are addressing this issue at monthly meetings and to further compliance staff are encouraged to complete an incident report when a red wrist band is found not to be in place.

b) Achieve a 50 per cent reduction in the number of inpatients who are not prescribed analgesia for breakthrough pain when they are prescribed regular opioids for pain management.

A baseline snap-shot audit was completed during May 2019 across all inpatient wards receiving a ward-based clinical pharmacy service. Medication charts for 547 patients were reviewed, of which 106 patients were prescribed an opioid on the 'regular section' of the chart for pain management. Of these 106 patients, 20 patients were not prescribed analgesia for breakthrough pain. The audit was repeated post-intervention, during March 2020. Medication charts for 356 patients were reviewed, of which 50 patients were prescribed an opioid on the 'regular section' of the chart for pain management. Of these 50 patients, 13 patients were not prescribed analgesia for breakthrough pain. There was a seven percentage point increase in the number of inpatients who were not prescribed analgesia for breakthrough pain when they were prescribed a regular opioid for pain management and so unfortunately this target was not met. It should be noted that although fewer inpatient charts were reviewed during March 2020 compared to May 2019 both audits included prescribing for inpatients in a range of acute, medical and surgical wards.

Financial Quarter	Number of patients prescribed a regular opioid who were not prescribed PRN analgesia	Number of patients who were prescribed a regular opioid, who were also prescribed PRN analgesia	Percentage of in-patients not prescribed analgesia for breakthrough pain when they are prescribed regular opioids for pain management	Number of in-patients reviewed
Q1	20	106	19%	547
Q4	13	50	26%	356

Board sponsor: Mary Sexton, chief nurse, **operational leads:** Julie Pain and Jenny Bree, divisional chief nurses, matron Sara Davies and lead pharmacist medicines governance Suzanne Cooper.

Priority 6 of 2019/20: Discharge Management (including reduction of inappropriate admissions)

Hospital
a) All patients will have an Expected Discharge Date (EDD) determined by assuming ideal recovery and assuming no unnecessary waiting.
b) All wards will achieve their individually set target for the number of discharges per day.

Community
c) Develop an audit tool, commence monitoring and capture a baseline in Q1.
d) The percentage of patients with an advanced care plan in the community is increased by 10 per cent from the baseline by the end of the year.

Rationale for inclusion

Hospital

- Ensure effective discharge planning starts at the point of admission to ensure patients get the best possible care in the right place.
- Ensure patients feel involved in their discharge planning to ease any anxiety or distress which may be caused by admission to hospital.
- Feedback from patient survey to monitor comments and outcomes from 'Don't waste time this life is mine'.
- Continual use of the Trust electronic discharge database.
- Developments planned with Sunrise with discharge planning proforma.

Community

- Patients dying in place and manner of preference.

- Support for carers in patient's preferred place.
- Reduce unnecessary attendance at Emergency Department.
- Support and implement Gold Standard Framework goals.
- Response to Berwick Report.
- Care coordinated and joined up across the providers.
- Support Dying Matters national initiative.

How we measure and record this priority

Hospital: We measure and record this priority with the estimated discharge date and time of discharge recorded on the electronic patient administration system, which links with the Trust's discharge database. On the database, delays in discharge and the reasons for delays are recorded. These systems make it possible to monitor the above targets.
Community: An audit will be performed to monitor the increase in advance care planning in place as part of the Quality Indicators (see section 3.3.5). This will be undertaken on a monthly basis by the community team. A dataset will be extracted from the computerised patient administration system, comparing the baseline numbers of advance care plans prior to starting the audit.

Developments that occurred in 2019/20

Hospital

- Visual bed states to support effective capacity planning and discharge management rolled out to certain wards as part of a pilot.
- Continued rollout of 'Don't waste time this life is mine' linking with the Red 2 Green principles.
- Further development with the hospital discharge team including social workers and therapists to support effect discharge planning from the point of admission.
- Trusted Assessor service to work across seven days to support productive discharge planning and provide a link to care homes.
- Developed a 'home first' culture across the Trust to ensure all patients have the opportunity to return home.
- Successful new pathway implemented called Transitional Care to support assessments outside of the hospital and allowing people to have time to recover outside of the hospital setting.
- Successful implementation of the 'Long Stay Wednesday' with super stranded reduced significantly.

Community

- Promoted the 'planning for your future care' document.
- Educated and supported patients and relatives to understand the concept of advanced care planning.
- Community team involved in Dudley Improvement Plan to improve the efficiency and effectiveness to core level palliative care with dignity.
- Community team involved in monthly Gold Standard Framework meetings with general practitioners as a multidisciplinary approach.

Current Status

Hospital

a) The number of EDDs set for adult inpatients for each quarter of the year from Q1 to Q4 have been 84.2 per cent, 86.7 per cent, 88.7 per cent and 87.4 per cent. It was realised that the target set at the beginning of the year that all patients would have an EDD would be difficult, especially with patients with complex care needs, but it has helped in improving our performance from last year which had an

overall figure of 73.3 per cent. We will continue next year to emphasise the importance of this so that patients' care is planned in an effective way.

b) Following an assessment of each ward's discharge rates and speciality, two targets per ward were set for weekdays and weekend days. The chart below indicates for each ward the targets for the number of discharges per day with the percentage of times for each quarter (Q1-Q4) that target has been met.

The percentage figures for Q4 have been coloured to indicate whether there has been improved (green) performance compared to Q1 (or compared to Q2 for the wards that were divided at Q2). This indicates there has been an improvement in discharge numbers in 11 of the 18 wards for weekdays and 5 of the 17 wards for weekends.

Surgical Wards			
Ward		Weekday	Weekend
B1	Target	4	4
	Q1	81.5	73.1
	Q2	86.4	61.5
	Q3	86.4	65.4
	Q4	89.2	76.9
B2 Hip	Target	3	3
	Q1	15.4	23.1
	Q2	43.9	34.6
	Q3	75.8	42.3
	Q4	33.8	7.7
B2 Trauma	Target	3	2
	Q1	38.5	57.7
	Q2	69.7	69.2
	Q3	69.7	84.6
	Q4	63.1	53.8
B3	Target	5	4
	Q1	70.8	38.5
	Q2	92.4	61.5
	Q3	86.4	26.9
	Q4	63.1	65.4
B4* B4A/B4B	Target	6 (4/2)	4 (3/1)
	Q1	20	38.5
	Q2	75.8/78.8	15.4/65.4
	Q3	83.3/69.7	19.2/34.6
	Q4	67.7/58.5	42.3/30.8
B5	Target	4	4
	Q1	69.2	57.7
	Q2	93.9	65.4
	Q3	74.2	34.6
	Q4	80	61.5
C6	Target	4	4
	Q1	50.8	46.2
	Q2	87.9	61.5
	Q3	83.3	65.4
	Q4	76.9	34.6
C2	Target	10	9
	Q1	92.3	80.8
	Q2	100	50
	Q3	100	42.3
	Q4	95.4	100

Medical Wards			
Ward		Weekday	Weekend
C1* C1A/C1B	Target	4 (3/1)	3 (2/1)
	Q1	52.3	34.6
	Q2	71.2/47	11.5/34.6
	Q3	54.5/28.8	7.7/57.7
	Q4	23.1/33.8	15.4/15.4
C3* C3/FMNU	Target	5 (4/1)	2 (2/0)
	Q1	67.7	80.3
	Q2	59.1/12.1	50/-
	Q3	66.7/13.6	42.3/-
	Q4	66.2/7.7	30.8/-
C4	Target	2	2
	Q1	15.4	38.5
	Q2	51.5	46.2
	Q3	45.5	34.6
	Q4	44.6	15.4
C5* C5A/C5B	Target	6 (5/1)	4 (3/1)
	Q1	87.7	50
	Q2	71.2/53	26.9/76.9
	Q3	56.1/66.7	34.6/73.1
	Q4	63.1/67.7	26.9/23.1
C7	Target	4	2
	Q1	60	73.1
	Q2	86.4	57.1
	Q3	72.7	57.7
	Q4	63.1	30.8
C8	Target	4	3
	Q1	61.5	53.8
	Q2	87.9	38.5
	Q3	71.2	50
	Q4	36.9	11.5

**A number of wards (B4, C1, C3, C5) were divided after Q1*

The Trust continues to prioritise effective planning of treatment and care and subsequent discharge. This can be seen in initiatives such as work with the Trust improvement team to design 'The Perfect Discharge' to ensure that all patients and family members are aware of the proposed EDD, linking the EDDs with the Trust campaign of 'Don't waste time this life is mine', a front end multidisciplinary model being piloted in Acute Medical Unit, additional morning ward and board rounds to support flow on base wards and agreeing to include this topic in our priorities for next year.

Community

A treatment escalation plan, also known as an Advanced Care Plan (ACP), allows the patient, carers and staff members to all be aware of the agreed most appropriate care and treatment in the event of the patient deteriorating. It also ensures that a patient is not unnecessarily conveyed to hospital and their wishes are being met to die in a preferred place.

In Q1 an audit tool was developed and in the 18 care homes covered by the Trust a baseline of the patients having an ACP in place was found to be 17 per cent. In Q2, in the same care homes there were 675 residents and the audit shows that there had been an increase to 26 per cent of patients having an ACP in place. In the third quarter that increase was sustained; with 28 per cent (177 of the 629) of the residents having an ACP. After further strong endeavours by the team during January to March 2020, over half (347) of the 639 residents had an ACP. As the initial number of patients with an ACP was 17 per cent and this has increased at the end of the year to 54 per cent, the target of an increase of 10 per cent has been well surpassed.

The enhanced care team is continuing to support the care staff to increase their confidence of having discussions with residents and relatives about their future plan of care.

Board sponsor: Karen Kelly, chief operating officer. **Operational leads: Hospital:** Gregg Marson, Trust lead – discharge; Jo Newens, divisional manager; Mushtaq Ahmed, chief of surgery; Mike Healy, chief of medicine and integrated care, and Hassan Paraiso, clinical director of the urgent care directorate. **Community:** Edliz Kelly, lead for enhanced care team.

New priority 2 for 2020/21: Discharge Management

By the end of the year, 20 per cent of patients will be discharged before 10am and 35 per cent before midday.

Rationale for inclusion

Hospital

- It is important that patients are assessed, diagnosed and treated in a timely and effective way and are not in hospital longer than is necessary where there is a greater the risk of developing complications.
- At present, 15 per cent of patients are being discharged before midday.
- Ensure effective discharge planning starts at the point of admission to ensure patients get the best possible care in the right place.
- Ensure patients feel involved in their discharge planning to ease any anxiety or distress which may be caused by admission to hospital.

How we measure and record this priority

We measure and record this priority with the time of discharge recorded on the electronic patient administration system, which links with the Trust's discharge database.

Developments planned in 2020/21

- The creation of a system-wide bed bureau to support patients to move into the correct type of community bed first time.
- Implementation of the Transfer of Care document to support a single assessment, which can be shared between agencies to ensure a joined approach for discharge planning.
- Additional Patient Transport Service to support patients to leave hospital as soon as they are medically fit and safe to transfer.
- Building on the Transitional Care Pathway with therapy and social work to ensure patient's time is valued and no unnecessary delays are encountered.

Board sponsor: Karen Kelly, chief operating officer **Operational lead:** Gregg Marson, Trust lead – discharge; Mushtaq Ahmed, chief of surgery; Mike Healy, chief of medicine and integrated care and Hassan Paraiso, clinical director of the urgent care directorate.

Priority 7 of 2019/20: Incident Management

a) The Trust's reporting rate will increase every quarter, culminating in a five per cent increase for the whole year, and its comparative position on the reporting rate of incidents will improve every six months.

b) To reduce the number of breached incident investigations by 30 per cent.

Rationale for inclusion and how we measure and record this priority

- A positive reporting culture is imperative to ensure learning and the implementation of changes in practice.
- Timely incident investigation is essential to capture and embed learning and the implementation of changes in practice.

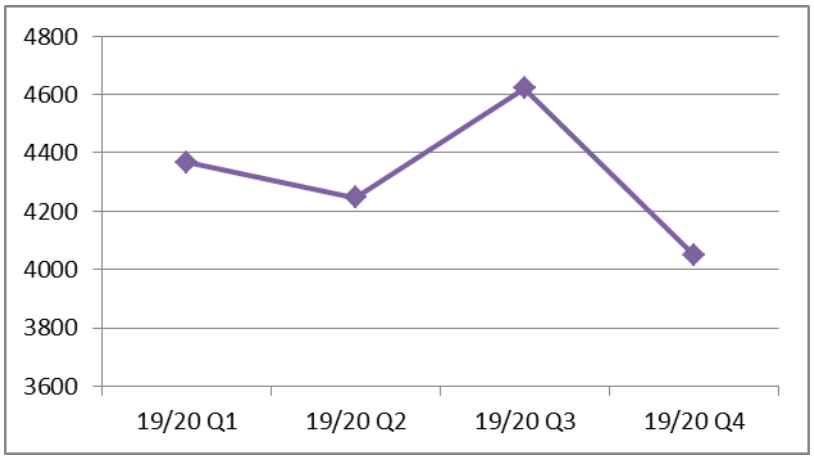
All incidents are recorded within the Trust's incident management system, Datix. Data is extracted from this system monthly and is reported at both an operational level through the respective divisional governance meetings and at a board level through the reporting to the Clinical Quality, Safety and Patient Experience Committee and the board itself. Reported incidents are also recorded within the Trust's integrated performance report and developed ward quality dashboards.

Developments that occurred in 2019/20

- Engaged divisional leaders to understand blockers to complying in timely management of incidents.
- Undertook a scoping exercise of Governance models that would best meet the Trust's requirements.

Current Status

a) Incidents Reported



Although the number of incidents reported increased in the third quarter, there has been a fall in the final quarter. The emergence of the COVID-19 situation occurred in this final quarter which, with the change in patient activity and increased staff sickness and self isolation, may have contributed to this fall. For the whole year, the Trust has seen a five per cent decrease in the number of incidents reported compared to the previous year and therefore the priority has not been achieved. The Trust recognises the need to increase the number of incidents reported as part of its promotion of a safe and open culture. Work continues to reinforce awareness of reporting incidents and embed the subsequent learning.

b) Serious incident investigation timescale breaches

Financial Quarter	Number
Q1	0
Q2	1
Q3	2
Q4	1
Full Year 2019/20	4

In terms of the number of breaches of the timescale to submit a serious incident investigation to the clinical commissioning group, there have been four in total this year so, compared with 50 last year, the fall has been over 90 per cent and so the Trust has achieved this performance measure this year.

Board sponsor: Mary Sexton, chief nurse, **operational leads:** Patient safety manager Justine Edwards, divisional patient safety advisors Helen Hudson, Claire Evans and Alex Thomson.

I would highly recommend the whole department. I went for an initial appointment today and they found I had high pressure in my eye, which was not what I expected. I went for something else, so a complete surprise. Well done everyone, totally professional.

2.2 Statements of assurance from the Board of Directors

2.2.1 Review of services

During 2019/20, The Dudley Group NHS Foundation Trust ('the Trust') provided and/or sub-contracted 59 relevant health services. The Trust has reviewed all the data available to them on the quality of care in 59 of these relevant health services. The income generated by the relevant health services reviewed in 2019/20 represents 98.3 per cent of the total income generated from the provision of relevant health services by the Trust for 2019/20.

The above reviews were undertaken in a number of ways. With regards to patient experience and safety, the Trust executive and non-executive directors, governors and other senior staff, together with representation from Dudley Clinical Commissioning Group, undertake Quality and Safety Reviews of clinical areas (see section 3.3.2). The Trust has a Mortality Surveillance Group, chaired by the medical director, which reviews all matters relating to mortality including the Trust's mortality tracking system. Dudley Clinical Commissioning Group is invited to join the mortality review process. Every month, each of the three clinical divisions at the Trust have a performance review undertaken when they are assessed by directors on a variety of quality indicators.

We monitor safety, clinical effectiveness and patient experience through a variety of other methods:

- Quality Indicators - monthly audits of key nursing interventions and their documentation. Each area has a Quality Dashboard that all staff and patients can view so that the performance in terms of quality care is clear to everyone. The key quality indicators are published, monitored and reported to the Board of Directors every quarter (see section 3.3.5).
- Ongoing patient surveys that give a 'feel' for our patients' experiences in real time allow us to quickly identify any problems and correct them (see section 3.2.2).
- A variety of senior clinical staff attend the monthly three key sub-committees of the board to report and present on performance and quality issues within their area of responsibility: Quality and Safety Committee, Finance and Performance Committee and Workforce and Staff Performance Committee.
- The Trust has an electronic dashboard of indicators for directors, senior managers and clinicians to monitor performance. The dashboard is essentially an online centre of vital information for staff.
- The Trust works with its local commissioners, scrutinising the Trust's quality of care at joint monthly review meetings and the executives from both organisations meet quarterly.
- External assessments of the Trust services, which included the following key ones this year:

With regards to pathology departments, in October 2018, four Trusts (ourselves, the Royal Wolverhampton, Walsall and Sandwell and West Birmingham) signed a Partnership Agreement in which the pathology services in the Black Country would be restructured into a hub and spoke model, known as The Black Country Pathology Services BCPS.

The United Kingdom Accreditation Service (UKAS) visits each pathology discipline separately each year and assesses against the international standard for medical laboratories - ISO 15189:2012 Medical laboratories – Requirements for quality and competence. The pathology departments based at the Trust have maintained their accredited status for another year. Haematology, biochemistry, immunology and microbiology had successful surveillance visits in 2019. Cellular pathology had completed its first four year cycle of assessments and has undergone a full reassessment visit in December 2019 retaining accredited status pending submission of evidence to successfully close out findings raised.

With regards to education and training, there have been no review visits this year. Reviews are now conducted using evidence from several sources; the GMC national trainee survey and the new NETS (National Education Training Survey), plus other sources such as trainees' Annual Review of Competency Progression. The annual GMC Trainee Survey asks trainees for their views on the training that they receive in each Trust by post specialty and programme group. Each area is scored on: overall satisfaction, clinical supervision, clinical supervision out of hours, reporting systems, workload, team work, handover, supportive environment, induction, adequate experience, curriculum coverage, educational governance, educational supervision, feedback, regional teaching, study leave and rota design. The specialties that performed well in the 2019 survey were core anaesthetics, GP training in paediatrics and rheumatology. Areas that require improvement were general surgery for F1s, GP training in obstetrics and gynaecology and emergency medicine. Actions as necessary are being taken in the latter areas. In terms of NETS survey results the Trust has been asked to respond to issues over the past year that have been reported in geriatric medicine concerning the foundation trainees, in paediatrics reported by a GP trainee and T & O reported by a higher surgical trainee. Again, appropriate action has been taken.

GIRFT (Get it Right First Time) is a national programme designed to improve the quality of care within the NHS by reducing unwarranted variations. It identifies changes that will help improve care and patient outcomes, as well as delivering efficiencies such as the reduction of unnecessary procedures and cost savings. It is led by frontline clinicians who are expert in the areas they are reviewing. This year a number of areas of the Trust have been reviewed by GIRFT. There was a vascular GIRFT revisit on the 8th July 2019 and breast care GIRFT visit on the 26th November 2019. Action plans have been drawn up when necessary.

There was a follow-up visit from Paediatric Critical Care Network regarding WMQRS critically ill child on 3rd October 2019. The final completed action plan was submitted and no further actions identified.

In accordance with EL(97)52 the pharmacy aseptic unit was inspected against Quality Assurance of Aseptic Preparation Services Standards (NHS QA Committee 2016) on 25th November 2019. The unit was assigned 'LOW' risk at the time and the overall comments were: the unit is well managed, by knowledgeable and competent staff, committed to delivering a quality assured service. An action plan was agreed with the inspection team to further strengthen the minor non-conformances identified. The action plan is managed by monthly review at the pharmacy directorate governance group and joint meetings with the North West Pharmaceutical Quality Assurance team.

During my stay in Russells Hall hospital, the care from the nurses and treatment I received was top quality on ward B3.

2.2.2 Participation in national clinical audits and confidential enquiries

During 2019/20, 45 national clinical audits and three national confidential enquiries covered relevant NHS services that the Trust provides. During that period the Trust participated in 100 per cent of the national clinical audits and 100 per cent of the national confidential enquiries which it was eligible to participate in. The national clinical audits and national confidential enquiries that the Trust was eligible to participate in, actually participated in, and for which data collection was completed during 2019/20 are listed below. Tables 1 and 2 show the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry. There was no data collection nationally for four national audits.

Table 1

National Clinical Audits	Participation	% submitted
Women		
Maternal, Newborn and Infant Clinical Outcome Review Programme (MBRRACE)	Yes	100%
National Maternity and Perinatal Audit (NMPA)	Yes	100%
Paediatrics and Neonates		
Diabetes (Paediatric) (NPDA)	Yes	100%
National Neonatal Audit Programme (NNAP)	Yes	100%
National Audit of Seizures and Epilepsies in children and young people (Epilepsy 12)	Yes	Data collection started
Acute Care		
British Association of Urological Surgeons (BAUS) - Urology Audits - Nephrectomy	Yes	100%
BAUS - Urology Audits - Percutaneous Nephrolithotomy	Yes	100%
Case Mix Programme (CMP)	Yes	100%
National Cardiac Arrest Audit (NCAA)	Yes	100%
National Emergency Laparotomy Audit (NELA)	Yes	100%
Feverish Children - Care in ED (Emergency Department)	Yes	100%
Vital signs in adults - Care in ED	Yes	100%
VTE risk in Lower Limb Immobilisation - Care in ED	Yes	100%
National Audit of Care at the End of Life (NACEL)	Yes	100%
Adult Community Acquired Pneumonia	Yes	100%
Elective Surgery (National PROMS Programme)	Yes	100%
National audit of Intermediate Care	Yes	100%
Seven day hospital service	Yes	100%
National Mortality case record review programme	Yes	Feasibility Study

Long Term Conditions		
Inflammatory Bowel Disease (IBD) Registry, Biological Therapies Audit	Yes	100%
National Asthma and COPD audit programme	Yes	100%
Learning Disability Mortality Review Programme (LeDeR)	Yes	100%
National Vascular Registry	Yes	100%
National Audit of Dementia	Yes	100%
National Ophthalmology Audit	Yes	100%
National Clinical audit for Rheumatoid and Early Inflammatory Arthritis	Yes	100%
National Diabetes Programme		
National Inpatient Audit Diabetes (Adult)	Yes	100%
National Foot Care Audit	Yes	100%
National Pregnancy in diabetes audit	Yes	100%
Cardiovascular Disease		
Cardiac Rhythm Management (CRM)	Yes	100%
Acute Coronary Syndrome or Acute Myocardial Infarction (MINAP)	Yes	100%
National Heart Failure Audit	Yes	100%
Sentinel Stroke National Audit Programme (SSNAP)	Yes	100%
Cancer		
Bowel Cancer (NBOCAP)	Yes	100%
Lung Cancer (NLCA)	Yes	100%
National Prostate Cancer Audit	Yes	100%
National Audit of Breast Cancer in Older People (NABCOP)	Yes	100%
Head and Neck Cancer Audit	Yes	100%
Oesophago - Gastric Cancer (NAOGC)	Yes	100%
Trauma		
Major Trauma - The Trauma & Audit Research Network (TARN)	Yes	100%
National Joint Registry (NJR)	Yes	100%
Falls and Fragility Fractures Audit Programme (FFFAP)		
Inpatient Falls	Yes	100%
National Hip Fracture database	Yes	100%
Blood Transfusion		
National comparative audit of blood transfusion programme	Yes	100%
Serious Hazards of Transfusion (SHOT)	Yes	100%

Table 2

National Confidential Enquiries				
Name of Study	**No. of Cases included**	**No. and % of clinical questionnaires submitted**	**No. of case notes submitted**	**No. of organisation questionnaires submitted**
Out of hospital cardiac arrest	9	2	7	1
Dysphagia	4	4/100%	1	1

Table 3

The reports of 18 national clinical audits were reviewed by the Trust in 2019/20 and the Trust intends to take the following actions to improve the quality of healthcare provided:

National Audit Title	Details of actions taken or being taken to improve the quality of local services and the outcomes of care.
NHFD – National Hip Fracture database	Theatre efficiency has improved mainly in obstetrics and trauma theatres. The Trust's case mix adjusted mortality has significantly dropped to 5.4%. This reduction is credited to the extensive work undertaken within the department including: an anaesthetic review of all mortalities, the introduction of a 15 minute spinal rule and 20 minute surgical rule and a re-focus on admission to theatre time.
NNAP (Neonatal Annual Audit programme)	Medical staff/nurse practitioners are now recording consultations with parents within 24 hours from admission in the medical notes and BADGER (electronic system). A magnesium sulphate audit is underway to ensure compliance with the required standard.
National Clinical Audit of Rheumatoid and Early Arthritis	All new patient referrals are triaged to ensure inflammatory arthritis patients are seen within three weeks as per standard. For a new diagnosis of arthritis, all patients will receive Arthritis Research UK patient leaflet. Communication with patients will improve by discussing treatment targets at follow up clinics.
7 Day Review Services	This is ongoing work and to drive up the standards a Seven Day Strategy has been developed and a Standard Operating Procedure and a directory of the services available on weekdays and weekends is being developed.
NADIA (Inpatient Diabetes Audit)	The Trust is in the lowest quartile for diabetes-related incidents. 100% of patients receive the diabetic foot assessment within 24 hours of admission.
NPDA – National Audit Paediatric Diabetes	To improve the Trust's compliance rate, a dedicated person will be employed to input all the data into the 'Twinkle' database and a psychologist will form part of the team.
The National Maternity and Perinatal Audit (NMPA)	There are nine key standards that are measured in this audit and the Trust is non-compliant with two and is taking the necessary action.
SSNAP – Sentinel Stroke Audit	The compliance rate in the audit is one of the best in the country. The targets were achieved and exceeded on the following standards: proportion of patients scanned within one hour, proportion of patients reported as requiring occupational therapy, proportion of applicable patients in atrial fibrillation who are discharged on anticoagulants or with a plan to start anticoagulation. There was a demonstrated improvement in mood and continence recording in the audit.
ICNARC (Intensive Care National Audit and Research Centre) CMP	All discharges are now reviewed by a consultant after leaving ICU.

National Emergency Laparotomy Audit (NELA) (4th National Report)	The Trust is compliant with all standards with the exception of two. An action plan is being formulated and will be monitored. Good practice is that the Trust has the fourth lowest mortality in the region.
National Audit of Dementia	A local action plan is being developed to address the low compliance areas.
National Diabetes Foot Care Audit 2014-2016	The Trust is planning to create patient pathways and work closely with the commissioners to improve foot care services.
Pulmonary Rehabilitation: Steps to breathe better	An individualised exercise plan for post-rehabilitation patients has been implemented and care bundles are to be reintroduced.
The National Cardiac Arrest Audit (NCAA).	Our number of cardiac arrest per 1,000 patients is within the national average. Our survival to discharge (alive) rate is 9.6% which is below the national average of 14 - 21%. This may indicate reduced recognition of the deteriorating patient but to ascertain that would require a more in-depth review of cardiac arrest patients' notes and interrogation of observations prior to the arrest. The report may support that there are issues with decision making around DNACPR status and resuscitation of patients where CPR has no realistic chance of success. All necessary actions will be undertaken and will be monitored by the deteriorating patient group.
Royal College of Emergency Medicine (RCEM) Fractured Neck of Femur	The areas of good practice were 90% of ambulance notes available whilst the national comparative was 72%. 72% of the patients were prescribed analgesia pre hospital visit with the national average being 66%. 68% of patients had their pain score taken within 0-5 minutes of arrival. This is much better than the national rate of 23%. There is an issue with the documentation of the cases reviewed and it is important to highlight this. Training sessions for ED staff will occur on the importance of documenting in a timely manner.
RCEM Pain in Children	The areas of good practice that were identified in the audit were that 55% of paediatric patients receive pre hospital administration of analgesia while the national figure is 30%. 99% of patients received an X-ray and 100% were assessed for safeguarding issues around documented evidence that non-accidental injury was considered in the ED. There are issues with prescriptions being completed retrospectively for administration of analgesia and with the triage system capturing pain score information.
RCEM: Procedural Sedation in Adults	The results indicated that only 2% of patients undergoing procedural sedation in the ED did not have documented evidence of pre-procedural assessment. All patients gave informed consent. 60% of cases all had documented monitoring aspects of non-invasive blood pressure, pulse oximetry, capnography and ECG.
COPD – Chronic Obstructive Pulmonary Disease	The national audit for COPD demonstrates that the Trust is doing well in looking after patients with COPD and achieving the Best Practice Tariff (BPT). The key indicators and results for the Trust are below. Oxygen prescribed for the patient – 98% Spirometry result available - 90% Current smokers prescribed smoking cessation pharmacotherapy – 18% Respiratory review with 24 hours – 79% (BPT 60%) Discharge bundle in place – 70% (BPT 60%) There has been a reduction in inpatient mortality from 7.8% in 2008 and 4.3% in 2014 to 3.9%. Respiratory review of admissions within 24 hours has improved from 54.8% in 2017/18. There was a significant improvement in oxygen prescription from 57.3% in 2017/18.

Local clinical audit

The reports of 32 completed local clinical audits were reviewed in 2019/20 and the Trust has taken, or intends to take, the following actions to improve the quality of healthcare provided:

Speciality	Title	Improvements
Safeguarding	Quality of Multi-agency referral forms (MARF)	Regular safeguarding supervision sessions to be provided in the Emergency Department and staff facilitated to attend. This audit to be repeated quarterly with an emphasis on Trust-wide referrals. One focus of the Safeguarding Improvement Plan is to raise awareness and increase referrals as appropriate Trust wide. Named nurse for safeguarding to arrange meeting with learning and development staff to scope the feasibility of a training package to support staff development in completion of MARFs.
Emergency Medicine	Sepsis Six Data Collection.	This audit has been repeated and the learning is to improve the quality of the documentation recorded on the Sunrise sepsis tool.
Gastro-intestinal Medicine	A retrospective 'snap-shot' audit of compliance with prescribing on the endoscopy recovery chart.	4/6 key standards were compliant. The use of an endoscopy chart as a prompt will improve assurance.
Neurology	An audit measuring the compliance with safety controls to reduce the risk of death or severe harm associated with injectable phenytoin.	Electronic Prescribing and Medicines Administration system (ePMA) will be implemented to encourage the installation of prescriber prompts such as mandatory weight entry with parenteral phenytoin prescribing, easy access to drug history and alerts to set infusion rate start and finish times.
Paediatrics	Audit of compliance of current urinary tract infection (UTI) management practices in the Paediatric Unit against NICE guideline (54) on the management of under 16s with UTI.	Improved documentation of risk factors. Children with upper UTI/Pyelonephritis getting the right length of treatment. Implement a UTI admission sheet and re audit in 6 months.
Vascular Surgery	Venous thromboembolism (VTE) audit in the Vascular Department	The audit was at 91% compliance and the interventions put into place were to educate the juniors on VTE assessments, how to fill the form out, the different aspects of the form and the importance of VTE in surgery and to re-audit.
Vascular Surgery	Re-Audit of VTE in the Vascular Department	The re-audit demonstrated 100% compliance that VTE is completed within 12 hours for vascular patients.

Anaesthetics	Cancellation on the day of surgery – Review of pre-op assessment	Continue to use IT solutions (database) to reduce communication problems. Tick box now easy to record patient not suitable for surgery at the Corbett centre when needs extra time for potential difficult airway.
Diabetes & Endocrinology	Audit of DATIX Incidents relating to Insulin	A safe insulin at discharge policy is being created and will be available by Dec 2020.
Trauma and Orthopaedics	An audit of the Trauma and Orthopaedics weekend handover	Consultant ward rounds have been introduced throughout the week.
Gastro-intestinal Medicine	AQUA - Alcohol Liver Related Disease (ARLD) audit	All doctors in ED/AMU to start using the liver care bundle until electronic copies can be used. Re - audit in Oct 2020.
General Surgery	Audit to assess the current practice of IV fluid prescription	Department protocols to be developed, in-house teaching of junior doctors, liaise with nursing staff to improve the intake/ output recording
Safeguarding	Audit of level of recognition of adult issues that may affect their ability to parent their children or pose a risk of harm to their children e.g. substance misuse, mental health issues and domestic abuse who attend the Emergency Department	HEADSS (Home, Education/Employment, Eating, Activities, Drugs, Sexuality, Suicide/Depression, and Safety) tool to be implemented for standard 3.
Safeguarding	Staff awareness and use of the chaperone policy audit	The policy is currently being updated and study sessions are being offered to health professional from West Midlands police.
Trauma and Orthopaedics	Fractured neck of femur admission pathway audit	A new pathway has been proposed and is currently underway.
Rheumatology	To assess whether the non-pharmacological management of patients with new onset Rheumatoid Arthritis are in accordance with NICE guidance (NG100)	Nurses now using Health Assessment Questionnaire (HAQ) form and the clinicians have been trained to interpret the score.
Rheumatology	Audit of NICE quality standard post fracture for Osteoporosis	Rheumatology, Elderly Care ED, Fracture Liaison Service and Community Falls Team to formulate strategy. Re-audit 2021.
Rheumatology	Quality improvement project to evaluate Dudley Osteoporosis Service	Vitamin D guidelines available on the Trust intranet.
Elderly Care Medicine	Audit on Perioperative Catheterisation in Hip Fracture Patients	To have a urinary catheter passport documenting the date and time of insertion with daily questions to check the indication for the catheter to stay in situ and the appropriateness to try without catheter.

Dermatology	Skin surgery booking list – re-audit of 2019 study	Provision to be made for body maps to be kept on site. Photography should be available at Corbett Hospital – iPads to be made available.
Anaesthetics	Audit on airway and intubation problems during general anaesthesia for C-section	Add Difficult Airway Society (DAS) guidelines to QRH (Quick Reference Handbook) in Obstetric Theatres and teach simulation on obstetric difficult airway.
Anaesthetics	Anaesthesia for C-section: technique and failure rate	Update Obstetric Anaesthesia Handbook to potentially include flowsheets on how to troubleshoot problematic regional anaesthesia.
Anaesthetics	Post Anaesthetic Review Audit	Encourage anaesthetists to hand over high risk patients they have been unable to review to their colleagues. Have already included in post-op anaesthetic review SOP.
Anaesthetics	Audit of Endo-tracheal Cuff Pressures in Theatres	Re-auditing is recommended to ensure adherence to normal cuff pressures.
Paediatrics	Measuring growth parameters and Body Mass Index in the Initial health Assessment for Looked After Children in Dudley	Advise clinicians assessing Looked After Children at the Initial Health Assessment to download the Growth Charts App with UK-WHO growth charts which will give the clinician growth centiles.
Neonates	Neonatal (28 days) admissions to the children's ward	Re-audit to monitor neonatal readmissions, and to analyse improvements and trends
Critical Care	Audit of Vancomycin by continuous infusion in Critical Care	Raise awareness of need to follow Trust guideline for prescriptions, specifically ensuring that an accurate actual body weight is used.
Neonates	Identification of infants at risk of foetal alcohol syndrome	A full alcohol history including volume and frequency if concerns of alcohol use. Documentation of hepatitis C status of mother to be documented and followed up on. If maternal alcohol use the baby should be examined for features of foetal alcohol syndrome.
Maxillo Facial	Quality assurance of lateral cephalograms	Action to be taken to improve the quality of the radiographs, to ensure ALARP. Lateral cephalograms are essential to determine skeletal relationship prior to orthodontic treatment, especially in a hospital setting where patients receive orthognathic treatment and these values are required for planning the surgery.
Acute Medicine	DVT Service Audit (AMU)	SUNRISE has been modified for ease of ordering DVT scans.

Acute Medicine	Waiting time for CTPA/VQ scans in ambulatory patients with suspected pulmonary embolism	Noncompliance with the standards and therefore an action plan is in place to increase the numbers of slots for allocation from one to three, also to be divided into morning and afternoon slots. To introduce CTPA during the weekends.

2.2.3 Research and development (R&D)

The number of patients receiving health services provided or sub-contracted by the Trust in 2019/20 that were recruited during that period to participate in research approved by a research ethics committee was 910.

At the end of the year, all non-essential research activity was put on hold due to the COVID-19 pandemic. We commenced participating in COVID-19 Urgent Public Health Research studies, as our priority, with ISARIC (date collection), UKOSS (data collection) and RECOVERY (interventional) trials. More studies were expected to start. We were performing extremely well in these COVID studies, in comparison with other Trusts in the region.

All active West Midlands sites for RECOVERY study, ranked by recruitment rate, from start of trial to date (20/4/20)

Trust	Trial Total	Recruiting Days
University Hospitals Birmingham NHS Foundation Trust	**132**	**26**
University Hospitals Coventry and Warwickshire NHS Trust	**86**	**19**
The Dudley Group NHS Foundation Trust	**64**	**22**
Sandwell and West Birmingham Hospitals NHS Trust	**53**	**25**
Walsall Healthcare NHS Trust	**41**	**21**
The Royal Wolverhampton NHS Trust	**31**	**21**
Shrewsbury and Telford Hospital NHS Trust	**30**	**26**
Worcestershire Acute Hospitals NHS Trust	**17**	**18**
Wye Valley NHS Trust	**16**	**22**
George Eliot Hospital NHS Trust	**15**	**22**
University of North Midlands NHS Trust	**12**	**21**
Birmingham Women's and Children's NHS Foundation Trust	**0**	**5**

Prior to the pandemic, we had a very active, balanced portfolio of clinical research across the majority of specialties (anaesthetics, cancer, cardiology, chemical pathology, critical care, dermatology, diabetes, gastroenterology, genito-urinary medicine (GUM), haematology, maternity, paediatrics, plastic surgery, orthopaedics, ophthalmology, rare diseases, rheumatology, stroke, vascular, general surgery).

The locally designed and sponsored National Institute for Health Research (NIHR) portfolio study 'Recovery after Emergency Laparotomy (REmLap): a prospective, observational, feasibility study' recruited its 50th (final) participant in January 2019. Data analysis is underway and the chief investigator, Dr Julian Sonksen, is preparing for 'REmLap 2'.

Our Anaesthetics Department was also involved in the FLO-ELA study (Fluid Optimisation in Emergency Laparotomy) and we were the top recruiting site with 180 patients recruited by principal investigator (PI) Dr Adrian Jennings with senior research nurse Angela Watts and clinical trial practitioner Stacey Jennings.

Rheumatology continued a long-standing collaboration with the School of Sport and Exercise of Birmingham University; plus a new collaboration with Bangor University. Three PhD students are currently completing their theses with us.

Our research lab recruited a total of 669 participants to the Pathfinder study, looking at rare diseases. The last arm of the study included patients with Gaucher Disease. A double dose of the gene mutation is necessary to cause the disease, which results in a build-up of harmful substances in the liver, bones and spleen. This prevents cells and organs from functioning correctly.

Training and infrastructure

The Research Forum, run by Dr Elizabeth Hale and Dr Gail Parsons, has supported a number of students (allied health professionals, nurses, university students) undertaking degrees or Trust research/audit work. In the last year, at least two candidates have graduated with their PhDs. The student nurse placement programme continues to function well, with student nurses having a one week placement within the Research & Development Department, covering a variety of specialties and introducing the students to research as well as covering a teaching session on their induction programme and to assist with their research module.

We have increased our engagement with all staff groups across the Trust, by introducing and promoting our department at Trust induction for all new staff, presenting at nurse specialist away days, research noticeboards in clinical areas and attending Trust 'Meet the Experts' events. Staff Trust-wide continue to improve their awareness of studies carried out in their own clinical areas, with increasing numbers coming forward to undertake their own project or an educational project or becoming a principal investigator for a study. We continued to host and deliver face-to-face sessions on Good Clinical Practice refresher training, Good Clinical Practice Fundamentals and Principal Investigator Masterclasses.

The R&D administration team continued to use the EDGE clinical research management system and continued to explore improvement and efficiencies by using this system for study management and tracking. We have rolled out a local invoicing system for research studies within the national EDGE database so that income can be more systematically monitored and chased. Staff demonstrated the finance tool aspect of EDGE at a national EDGE Conference March 2020 plus poster presentation. The R&D Department has also been accepted for three poster presentations at the May 2020 NHS R&D Forum national conference (date has now been deferred until later in the year).

The Research and Development team won two awards at the Clinical Research Network West Midlands (CRN WM) awards ceremony held at Everyman Cinema, Birmingham on 7th November 2019. Awards won were for Creative Recruitment and Business Intelligence Leaders. The Business Intelligence Leaders award was given for innovative database work surrounding the management of study finances. The work has been shared as good practice outside of the Trust, locally across the region and at national meetings. The Creative Recruitment award was given for outstanding recruitment in the Pathfinder study, which looked to identify patients with rare diseases from routine pathology results.

Public engagement

The R&D department continues to keep in touch with the Trust's research ambassador (now titled 'Research Champion') who took part in our International Clinical Trials Day event in May 2019 at Russells Hall Hospital's Health Hub and our 'Research Showcase' event in September 2019. He also regularly attends the R&D quarterly departmental meetings to provide a patient presence and perspective.

The department held its very first Listening into Action event in November 2019 for patients who have participated in research in order to collect their views and experiences. The responses were overall very

positive. This is currently being written up to be put into actions for implementation and feedback will be disseminated to those that attended.

Research into practice

The TRACE RA (Trial of Atorvastatin for the primary prevention of Cardiovascular Events in patients with Rheumatoid Arthritis) study has had a lot of media coverage and was recently published in Arthritis & Rheumatology, the official journal of the American College of Rheumatology. This major health study was designed in Dudley, using local patients and has provided evidence on the safety and efficacy of statins for people who have rheumatoid arthritis and are therefore at a higher risk of heart attack and stroke. Professor George Kitas was lead author on the paper. There were 150 volunteers who took part at the Trust, providing the most patients compared to other 100 participating Trusts in the country.

Cancer Team - An NIHR supported prostate cancer trial called STAMPEDE made a global impact in how men presenting with advanced prostate cancer are treated. One particular arm of the trial led to a change in NHS clinical practice for men with high risk, locally advanced metastatic prostate cancer who are starting first line hormone therapy (published in The Lancet). The Trust was one of 125 sites and successfully recruited 107 patients (the study as a whole recruited over 9,000 patients).

Anaesthetics Team – The conclusion of the BALANCED study was that among patients at increased risk of complications after major surgery, light general anaesthesia was not associated with lower one-year mortality than deep general anaesthesia. The trial defined a broad range of anaesthetic depth over which anaesthesia may be safely delivered when titrating volatile anaesthetic concentrations using a processed electroencephalographic monitor. The Trust recruited 35 patients into this study.

Publications

Trust publications for the calendar year 2019, including conference posters, were 110.

2.2.4 Commissioning for Quality and Innovation (CQUIN) payment framework

What are CQUINs and what do they mean for the Trust?

The CQUIN payment framework was introduced in 2009 to make a proportion of providers' income conditional on demonstrating improvements in quality and innovation in specified areas of care. This means that some of the Trust's income is conditional on achieving certain targets that are agreed between the Trust and our commissioners (Dudley Clinical Commissioning Group and NHS England).

A proportion of the Trust's income in 2019/20 was conditional upon achieving quality improvement and innovation goals agreed between the Trust and any person or body they entered into a contract, agreement or arrangement with for the provision of relevant health services, through the Commissioning for Quality and Innovation (CQUIN) payment framework. Further details of the agreed goals for 2019/20 and for the following 12 month period are available at: https://www.england.nhs.uk/nhs-standard-contract/cquin/

The value of CQUINs has been set on a 1.25 per cent of activity contract outturn which equates to a potential income of £3.6million. A total of seven CQUIN schemes were agreed with a combination of locally and nationally agreed goals with associated milestones. At the end of the financial year, it is forecast that we will achieve partial payment for a majority of the indicators. For example, we will have

- achieved the national target set for vaccinating frontline staff against flu;
- achieved medicines optimisation, a reduction in waste and utilise better cost effective drugs;

- achieved for ward areas to implement lying and standing blood pressure and perform a risk assessment to reduce the risk of falls in patients over 65;
- achieved improvement in electronic pathway referrals for oral and maxillo-facial dental patients; and
- reduced the antibiotic prophylaxis in colorectal surgery for patients that are aged 18 years and over.

The indicators we are not expecting to fully achieve are listed below. Mitigating actions have been put in place for 2019/20. These include

- To reduce the antimicrobial risk in patients over 65 years with a UTI. The aim is to reduce the use of a urine dipstick which may provide false readings and change working practices to request laboratory results instead. It was accepted that due to the culture and behaviour changes needed, the first year of this project would be used to raise awareness and learning. Mitigating plans are in place and this is being led by one of our specialist pharmacists.

- Providing lifestyle advice and referral to patients that may benefit from changes regarding alcohol, smoking and drug use. This has required the Trust to invest in additional posts to support the delivery and provide teaching and support into making every contact count. Great improvements have been seen and work will continue into 20/21 to embed this via training and education and implementation tools to maintain these requirements as business as usual.

- To improve pathways for same day emergency care for patients that present within the Trust for pulmonary embolism, bradycardia tachycardia and community acquired pneumonia. The audit results of these pathways have demonstrated that we have strengthened our pathways and are supporting for diagnostics tests and equipment to be made available to support same day care, meaning the patients are admitted, treated and discharged without the need to continue the patient as an inpatient. This will help also reduce some of the pressures on emergency departments. The results have shown a clinical variance and action plans have been developed for each scheme to continue to strive for the improvements needed.

The final CQUIN settlement figure for 2018/19 achieved 97 per cent in total; the final figure received was £5.986M against a target of £6.160M. 2019/2020 is estimated at £3.6m and we are forecasting to achieve 70 per cent by year end.

CQUINs 2019/2020

The achievement for CQUINs for 2019/2020 was not a Full Year Effect due to COVID-19. Based on a trajectory of performance over the quarters and the data that has been provided, it was felt that we would have ended the year as rated in the following table; it is anticipated that 90 per cent overall payment would be received.

Acute and community 2019/2020

Goal No.	CQUIN targets and topics	Quality domains	RAG
1a	Antimicrobial Resistance (AMR) – in lower Urinary Tract Infection in older people	Effectiveness	
1b	AMR – in colorectal surgery	Safety Effectiveness	
2	Staff Flu Vaccination	Safety Effectiveness	
3a/b/c	Alcohol and Tobacco Screening/Brief advice	Effectiveness	
7	3 high impact actions to prevent falls in >65year old	Effectiveness	
CCG11a/b/c	Same Day Emergency Care – PE, Tachycardia Bradycardia and Community Acquired Pneumonia	Safety Effectiveness	

NHS England Specialised Services, Public Health & Dental 2019/2020

Goal No.	CQUIN targets and topics	Quality domains	RAG
1	Proms and Prems Dental	Effectiveness	
GE3	Hospital medicines optimisation	Effectiveness	

	Expected to fully achieve & full payment
	Partial achievement/ Payment
	Not achieved and no payment awarded

CQUINs 2020/21

Due to COVID-19 the CQUIN schemes for 20/21 have been suspended and currently we are unable to determine what the plans and requirements will be post COVID-19.

Below is a list of schemes that were provided prior to the outbreak, which may be applicable.

Acute Provider Schemes for 2020/21

Goal No.	CQUIN targets and topics	Quality domains
1	Recording News2 score, escalation time and response time for unplanned critical care	Safety Effectiveness
2	Treatment of community acquired pneumonia in line with BTS care bundle	Effectiveness
3	Appropriate antibiotic prescribing for UTI in adults aged 16+	Effectiveness
4	Cirrhosis and fibrosis tests for alcohol dependent patients	Effectiveness
5	Rapid rule out protocol for ED patients with suspected acute myocardial infarction (excluding STEMI)	Safety Effectiveness
6	Screening and treatment of iron deficiency anaemia in patients listed for major elective blood loss surgery	Safety Effectiveness
7	Adherence to evidenced based interventions clinical criteria	Safety Effectiveness
8	Staff flu vaccinations	Effectiveness

NHS England specialised services (dental and oral still to be advised)

Goal No.	CQUIN targets and topics	Quality domains
1	Hep C elimination	Safety Effectiveness
2	Antifungal stewardship/medicines optimisation	Effectiveness
3	Severe asthma	Effectiveness
4	Shared decision making	Effectiveness

2.2.5 Care Quality Commission (CQC) registration and reviews

The Dudley Group NHS Foundation Trust is required to register with the Care Quality Commission (CQC) and its current registration status is registered without conditions.

The Trust was inspected in January/February 2019 and the report published in July 2019, the result of which was an overall rating of 'Requires Improvement'. In arriving at this overall assessment the CQC assessed 56 elements within nine areas (see charts below). Of the 56 elements, 32 were rated as 'Good' which meant that for surgery, critical care, end of life care (hospital) and end of life care (community services) the Trust was in fact rated as 'Good'. In addition, surgery at Russells Hall Hospital and end of life care community services were both given an 'Outstanding' rating for 'Caring'. Two of the cores services, diagnostic imaging and urgent and emergency planning, had two and one element respectively rated as 'Inadequate' resulting in an overall rating for diagnostic imaging of 'Inadequate'.

For the service areas where the Trust was rated as 'Inadequate' or 'Requires improvement', a detailed action plan was put in place. The monitoring of the delivery of this improvement plan was reported to the board and the Clinical Quality, Safety and Patient Experience Committee as well as providing formal feedback to the CQC itself.

The CQC issued four Section 31 enforcement notices during the December 2017/January 2018 inspection but none had placed any restrictions on the Trust's licence. The Trust has had to send enhanced assurance over aspects of urgent and emergency services which the Trust has done on a weekly/monthly basis and therefore the Trust is compliant with the registration requirements of the CQC. One of these notices was retracted by the CQC in July 2019.

The Trust has not participated in any special reviews or investigations by the CQC during the reporting period.

The full report of the January 2019/February 2019 inspection is available at www.cqc.org.uk/provider/RNA

Ratings for the whole trust

Safe	Effective	Caring	Responsive	Well-led	Overall
Inadequate ↓ May 2019	Good ↑ May 2019	Good → ← May 2019	Requires improvement → ← May 2019	Requires improvement → ← May 2019	Requires improvement → ← May 2019

The rating for well-led is based on our inspection at trust level, taking into account what we found in individual services. Ratings for other key questions are from combining ratings for services and using our professional judgement.

Ratings for Russells Hall Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Inadequate → ← May 2019	Requires improvement → ← May 2019	Good ↑ May 2019	Requires improvement → ← May 2019	Requires improvement ↑ May 2019	Requires improvement ↑ May 2019
Medical care (including older people's care)	Good → ← Apr 2018	Good → ← Apr 2018	Good → ← Apr 2018	Good → ← Apr 2018	Good → ← Apr 2018	Good → ← Apr 2018
Surgery	Requires improvement ↓ May 2019	Good → ← May 2019	Outstanding ↑ May 2019	Good → ← May 2019	Good → ← May 2019	Good → ← May 2019
Critical care	Good ↑ May 2019	Good ↑ May 2019	Good → ← May 2019	Requires improvement → ← May 2019	Good ↑ May 2019	Good ↑ May 2019
Maternity	Requires improvement ↓ May 2019	Good ↑ May 2019	Good → ← May 2019	Good → ← May 2019	Requires improvement ↓ May 2019	Requires improvement ↓ May 2019
Services for children and young people	Requires improvement → ← May 2019	Good ↑ May 2019	Good → ← May 2019	Requires improvement → ← May 2019	Requires improvement → ← May 2019	Requires improvement → ← May 2019
End of life care	Good ↑ May 2019	Good → ← May 2019	Good → ← May 2019	Good → ← May 2019	Good → ← May 2019	Good → ← May 2019
Outpatients	Requires improvement ↓ May 2019	N/A	Good → ← May 2019	Good ↑ May 2019	Requires improvement ↓ May 2019	Requires improvement ↓ May 2019
Diagnostic imaging	Inadequate May 2019	N/A	Requires improvement May 2019	Requires improvement May 2019	Inadequate May 2019	Inadequate May 2019
Overall*	Inadequate ↓ May 2019	Good ↑ May 2019	Good → ← May 2019	Requires improvement → ← May 2019	Requires improvement → ← May 2019	Requires improvement → ← May 2019

*Overall ratings for this hospital are from combining ratings for services. Our decisions on overall ratings take into account the relative size of services. We use our professional judgement to reach fair and balanced ratings.

Ratings for Corbett Outpatients Centre

	Safe	Effective	Caring	Responsive	Well-led	Overall
Surgery	Requires improvement May 2019	Good May 2019	Good May 2019	Good May 2019	Good May 2019	Good May 2019
Outpatients	Requires improvement May 2019	N/A	Good May 2019	Good May 2019	Requires improvement May 2019	Requires improvement May 2019
Diagnostic imaging	Inadequate May 2019	N/A	Good May 2019	Good May 2019	Inadequate May 2019	Inadequate May 2019
Overall*	Inadequate May 2019	Good May 2019	Good May 2019	Good May 2019	Inadequate May 2019	Inadequate May 2019

*Overall ratings for this hospital are from combining ratings for services. Our decisions on overall ratings take into account the relative size of services. We use our professional judgement to reach fair and balanced ratings.

Ratings for community health services

	Safe	Effective	Caring	Responsive	Well-led	Overall
Community health services for adults	Good Apr 2018	Good Apr 2018	Good Apr 2018	Requires improvement Apr 2018	Good Apr 2018	Good Apr 2018
Community end of life care	Good May 2019	Good May 2019	Outstanding May 2019	Good May 2019	Good May 2019	Good May 2019
Overall*	Good →← May 2019	Good →← May 2019	Outstanding ↑ May 2019	Requires improvement →← May 2019	Good →← May 2019	Good →← May 2019

*Overall ratings for community health services are from combining ratings for services. Our decisions on overall ratings take into account the relative size of services. We use our professional judgement to reach fair and balanced ratings.

The staff on A4 are friendly and do their job well. I would recommend A4 staff to my friends and family.

My stay on B1 was made enjoyable by the professionalism of all the staff and friendly manner by everyone.

2.2.6 Quality of data

The Trust submitted records during 2019/2020 to the Secondary Uses Service (SUS) for inclusion in the Hospital Episode Statistics (HES) latest published data.

The percentage of records in the published data which included the patient's valid NHS number

	The Dudley Group	National average
Admitted patient care	99.9%	99.4%
Outpatient care	99.9%	100%
Accident and emergency care	99.8%	98.0%

The percentage of records in the published data which included the patient's valid General Medical Practice Code

	The Dudley Group	National average
Admitted patient care	100%	98.9%
Outpatient care	100%	97.9%
Accident and emergency care	100%	96.6%

All above figures are for January 2020. Latest available from NHS Digital Data Quality Maturity Indictor DQMI monthly report

The General Data Protection Regulation (GDPR) came into effect last year. It introduces a duty on all organisations to report certain types of personal data breach to the relevant supervisory authority. The Security of Network and Information Systems Directive ("NIS Directive") also requires reporting of relevant incidents to the Department of Health and Social Care (DHSC). The Trust has not had to report a breach of personal data to the National Regulatory Authority during 2019/20.

The Trust was not subject to the Payment by Results clinical coding audit during the reporting period.

The Trust will be taking the following action to improve data quality:

- The Trust continually monitors data quality externally via Secondary Uses Service (SUS) reporting and University Hospitals Birmingham Hospital Evaluation Data tool (HED).

2.2.7 Learning from deaths

1. During 2019/20, 1,783 of the Trust's patients died. This comprised the following number of deaths that occurred in each quarter of that reporting period: 444 in the first quarter; 348 in the second quarter; 464 in the third quarter; 527 in the fourth quarter.

2. By 31st March 2020, 1,189 case record reviews and 41 investigations have been carried out in relation to 1,783 of deaths included above.

In 41 cases, a death was subjected to both a case record review and an investigation. The number of deaths in each quarter for which a case record review or an investigation was carried out was: 355 in the first quarter; 280 in the second quarter; 338 in the third quarter; 216 in the fourth quarter.

3. Three, representing 0.2 per cent of the patient deaths during the reporting period, are judged to be more likely than not to have been due to problems in the care provided to the patient.

In relation to each quarter, this consisted of: 0 representing 0 per cent for the first quarter; two representing 0.6 per cent for the second quarter; one representing 0.2 per cent for the third quarter; 0 representing 0 per cent for the fourth quarter.

These numbers have been estimated using
a) The Trust's mortality review process which includes an initial (Level 1) peer review of all deaths by the department concerned using a standard questionnaire. This may lead to a Level 2 review performed by a mortality panel using a structured case note review data collection as recommended by the National Mortality Case Record Review Programme, b) Coroner Rule 28 cases when making recommendations about future care and c) root cause analysis reports following investigations if a death is reported as a serious incident if that is clinically appropriate (e.g. death potentially avoidable).

4. A summary of what the provider has learnt from case record reviews and investigations conducted in relation to the deaths identified above.

The Trust has identified the following 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 is a need to focus efforts on the recognition and management of the deteriorating patient in the context of sepsis but also in the context of other medical conditions for which sepsis screening parameters might flag e.g. heart failure.
- Mortality tracker information with regards to end of life care is demonstrating achievement of clinical indicators and embedding Priorities for Care of the dying person communication document is being pursued with divisions.
- Need to highlight appropriate care in end of life management over the period when death is imminent.
- Need for clear documentation of all results and investigations when patients admitted/ transferred to ensure appropriate prompt management and communication of escalation plans.
- Patients presenting at the end of life to ED may be more appropriately transferred out of the department more promptly to allow more privacy and dignity for patients and families.
- Lack of understanding of DNACPR and the perception that this is the ceasing/withdrawal of all treatment rather than allowing "natural" death to occur.
- ED reviews triggered due to waiting more than four hours in the department.
- Delay in pending external agencies information (coroner, police etc.) affecting child death review timeliness internally.
- Inappropriate admission to hospital 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 End of Life and expected to die within very short period but may be due to lack of beds.

5. A description of the actions which the provider has taken in the reporting period, and proposes to take following the reporting period, in consequence of what the provider has learnt during the reporting period.

From the cases reviewed, the Trust has taken a number of actions.

•Developed a general pathway for the deteriorating patient. This was presented to the senior consultant body and discussions have occurred with the electronic patient record developers to embed this in the electronic patient record.

•Work has taken place on the EPR to further develop systems for identifying the deteriorating patient.

•Ongoing engagement regarding awareness and recognition of sepsis including human factors training and a recent sepsis debate.

•Implementation of the Gold Standards Framework (GSF) ongoing.

•Work has taken place in developing the medical examiner role and work.

•The Trust end of life working group is reviewing policies, education and governance.

•Increased usage of the priorities of care documentation across the Trust.

•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.

•The Trust is being supported by the Advancing Quality Alliance (AQuA) to look at a number of deteriorating patient pathways. The first condition groups to undertake this work were AKI, sepsis and alcohol related liver disease. Work stream plans have been generated and are in the process of being fully implemented in association with the specific teams and audit department.

•Additional work from our mortality data has revolved around improving pathways for pneumonia. The British Thoracic Society bundle is being implemented.

•The work from the Deteriorating Patient Team and Outreach is giving greater oversight and support for patients with deteriorating parameters. This is ongoing work. Further work around the Hospital at Night team and review of medical handover processes is being undertaken.

•End of life care cell led by Dr Jo Bowen as part of the Dudley Improvement Programme with further work stream to implement RESPECT across Dudley though this is currently delayed due to funding.

•End of Life Care Facilitator – one year fixed term has taken up post to work with community, ED and the wards to implement learning from the Bewick Report.

•A service review to plan integrated services across the health economy was held in November 2019. The feedback was very positive and the success of the service was recognised.

•Gold Standard Framework implementation whole hospital commissioned approach in progress. There is a rolling plan for the remaining adult wards with regards to GSF implementation and accreditation.

6. An assessment of the impact of the actions described above which were taken by the provider during the reporting period.

- 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.
- Further reduction in sepsis mortality.
- Reduction in investigation requests from the coroner.
- Decreased number of serious incidents.
- A positive external assessment of end of life care.

7. 470 case record reviews and 42 investigations were completed after 31st March 2019 which related to deaths which took place before the start of the reporting period.

8. None, representing 0 per cent of the patient deaths before the reporting period, are judged to be more likely than not to have been due to problems in the care provided to the patient.

These numbers have been estimated using
a) The Trust's mortality review process which includes an initial (Level 1) peer review of all deaths by the department concerned using a standard questionnaire. This may lead to a Level 2 review performed by a mortality panel using a structured case note review data collection as recommended by the National Mortality Case Record Review Programme, b) Coroner Rule 28 cases when making recommendations about future care and c) root cause analysis reports following investigations if a death is reported as a serious incident if that is clinically appropriate (e.g. death potentially avoidable).

9. Five representing 0.3 per cent of the patient deaths during 2018/19 are judged to be more likely than not to have been due to problems in the care provided to the patient.

Very pleasant caring experience when admitted to Russells Hall Hospital last year with sepsis, nurses dealt with me straightway with kindness and compassion. 5 stars from me.

2.2.8 Core set of mandatory indicators

All trusts are required to include comparative information and data on a core set of nationally-used indicators. The tables include the two most recent sets of nationally-published comparative data as well as, where available, more up-to-date Trust figures. It should be appreciated that some of the 'Highest' and 'Lowest' performing trusts may not be directly comparable to an acute general hospital, for example, specialist eye or orthopaedic hospitals have very specific patient groups and so generally do not include emergency patients or those with multiple long-term conditions.

Mortality			
Topic and detailed indicators	**Immediate reporting period: Dec 2018 – Nov 2019**	**Previous reporting period: Nov 2018 – Oct 2019**	**Statements**
Summary Hospital-level Mortality Indicator (SHMI) value and banding (Comparison is with all non-specialist acute trusts)	**Value** Trust 1.1336 National average 1 Highest 1.1957 Lowest 0.6909 **Banding** Trust 1 National average 2 Highest 1 Lowest 3	**Value** Trust 1.1098 National average 1 Highest 1.1822 Lowest 0.6776 **Banding** Trust 2 National average 2 Highest 1 Lowest 3	The Trust considers that this data is as described for the following reasons: ● it has noted that the SHMI value is in the expected range but has increased. This is due to the change in recording of the assessment of patients admitted via Ambulatory Emergency Care. The Trust has taken the following action to improve this indicator and so the quality of its services by: ● continuing to improve case note reviews of deaths in hospital.
Percentage of patient deaths with palliative care coded at either diagnosis or specialty level (Comparison is with all non-specialist acute trusts)	Trust 22% National average 36% Highest 59% Lowest 11%	Trust 22% National Average 36% Highest 59% Lowest 11%	The Trust considers that this data is as described for the following reasons: ● there remains a very robust system in place to check accuracy of palliative care coding. The data field has been added to the Trust mortality tracker. The Trust has taken the following actions to improve this percentage, and so the quality of its services: ● ensuring this percentage will always be accurate and reflect actual palliative care.

Both the doctor and all the staff were so helpful, you can tell they enjoy their jobs. All my tests were completed straight after my consultation. My mind was put at rest; I have nothing but praise for this hospital. Thank you. Much appreciated.

Patient Reported Outcome Measures (PROMS)					
Topic and detailed indicators	**Immediate reporting period: 2018/19 Final**		**Previous reporting period: 2017/18 Final**		**Statements**
Hip Replacement Surgery	Trust	0.47	Trust	0.50	The Trust considers that this data is as described for the following reasons: • using feedback data (from NHS Digital) we are very pleased with the outcomes that patient report. Patients who said that their problems are better now when compared to before their operation: • Hip replacement: 98% *(national = 95%).* • Knee replacement 88% *(national = 90%)* The Trust has taken the following actions to improve these scores, and so the quality of its services, by: ensuring the Trust regularly monitors and audits the pre and postoperative healthcare of all patients. Surgical operative outcomes are consistently of high quality and safety, with excellent patient satisfaction for these procedures.
	National average	0.46	National average	0.46	
	Highest	0.56	Highest	0.57	
	Lowest	0.35	Lowest	0.36	
Knee Replacement Surgery	Trust	0.34	Trust	0.33	
	National average	0.34	National average	0.34	
	Highest	0.41	Highest	0.42	
	Lowest	0.24	Lowest	0.23	

To all the doctors, nurses, porters, paramedics in the coronary care unit at Russell's Hall Hospital - a massive THANK YOU. I have nothing but praise for every one that helped me through a difficult few days. The professionalism, service and positive attitude shown by all was marvellous.

Readmissions					
Topic and detailed indicators	**Immediate reporting period: 2018/19**		**Previous reporting period: 2017/18**		**Statements**
% readmitted within 30 days **Aged 0-15**	Trust	8.2%	Trust	11.9%	The Trust considers that this data is as described for the following reasons: **Age 0- 15** • The Trust has demonstrated a progressive reduction of 3.7% in paediatrics readmissions from the previous reporting period; 2017/18. • In addition to this the Trust has evidenced that the readmissions performance is 4.4% below the national average in comparison with the previous year which saw a figure above the national average **Aged 16 and over** • The performance in adult readmission rates has improved by 0.2% against the previous reporting period; 2017/18 • This figure is also below the national average by 1.4% The Trust intends to take the following actions to improve these percentages, and so the quality of its services: • Continue to work closely with Community to support the management of patients and avoid readmission • Undertake an audit to identify readmission trends across the patient groups within the Trust • Develop an action plan to address areas for improvement
	National average	12.5%	National average	11.0%	
	Highest	54.9%	Highest	63.6%	
	Lowest	1.7%	Lowest	2.0%	
(Comparison is with all NHS Trusts) **% readmitted within 30 days** **Aged 16 and over**	Trust	13.2%	Trust	13.4%	
	National average	14.6%	National average	14.1%	
	Highest	29.0%	Highest	27.5%	
	Lowest	5.0%	Lowest	5.1%	

Source: https://digital.nhs.uk/data-and-information/publications/clinical-indicators/compendium-of-population-health-indicators/compendium-hospital-care/current/emergency-readmissions-to-hospital-within-30-days-of-discharge/emergency-readmissions-to-hospital-within-30-days-of-discharge

Responsiveness to inpatients' personal needs					
Topic and detailed indicators	**Immediate reporting period: 2018/19**		**Previous reporting period: 2017/18**		**Statements**
Average score from a selection of questions from the National Inpatient Survey measuring patient experience **(Score out of 100)**	Trust	61.3	Trust	64.8	The Trust considers that this data is as described for the following reasons: ● the Trust is disappointed that this indicator remains lower than the national average. The Trust intends to take the following actions to improve this score, and so the quality of its services: ● to continue to focus on responding to the feedback from our patients, families and carers with sustained quality improvement actions.
	National Average	67.3	National average	68.6	
	Highest	85.0	Highest	85.0	
	Lowest	58.9	Lowest	60.5	

Staff views					
Topic and detailed indicators	**Immediate reporting period: 2019**		**Previous reporting period: 2018**		**Statements**
Percentage of staff who would recommend the Trust to friends or family needing care (Comparison is with all combined Acute and Community trusts)	Trust	59.3%	Trust	56%	The Trust considers that this data is as described for the following reasons: • the Trust is pleased there has been an increase in the percentage of staff who would recommend the Trust as a place to receive treatment. The Trust intends to take/has taken the following actions to improve this percentage, and so the quality of its services by: • building confidence in our services by sharing good practice and successes eg through GREATix (see section 3.3.8), and improving our overall CQC rating • continuing to encourage staff to report any concerns about patient care through our Freedom to Speak Up Guardians and other confidential methods • more improvement practice and coaching projects to improve ways of working and therefore patient experience and care • Development of a staff engagement model that ensures continuous improvement cycle engaging staff in the solutions
	National average	71.0%	National average	69.9%	
	Highest	90.5%	Highest	90.3%	
	Lowest	48.8%	Lowest	49.2%	

Venous Thromboembolism (VTE)					
Topic and detailed indicators	**Immediate reporting period: Q3 Oct – Dec 2019**		**Previous reporting period: Q2 Jul – Sep 2019**		**Statements**
Percentage of admitted patients risk-assessed for Venous Thromboembolism (Comparison is with all Acute trusts)	Trust	93.22%	Trust	94.15%	The Trust considers that this data is as described for the following reasons: ● the Trust is pleased to note that it is near the national average in undertaking these risk assessments. The Trust intends to take the following actions to improve this percentage, and so the quality of its services by: ● continuing the educational sessions with each junior doctor intake, ● continuing with a variety of promotional activities to staff and patients,
	National average	95.25%	National average	95.4%	
	Highest	100%	Highest	100%	
	Lowest	71.59%	Lowest	71.72%	

Infection Control					
Topic and detailed indicators	**Immediate reporting period: 2018/19**		**Previous reporting period: 2017/18**		**Statements**
Rate of Clostridium difficile per 100,000 bed days amongst patients aged 2 or over	Trust	12	Trust	12.6	The Trust considers that this data is as described for the following reasons: ● the rate has improved again over last year's figures with the Trust now reporting fewer cases than the average across the NHS. This is especially pleasing in a climate where nationally numbers of cases are increasing. The Trust intends to take/has taken the following actions to improve this rate, and so the quality of its services: ● the process for reviewing C. diff cases is changing this year in line with the new national framework. The apportionment assessment has been reviewed and the trajectory has changed as cases will be apportioned to acute trusts a day earlier than in previous years. In addition cases diagnosed pre-48 hrs and in the community that are associated with an inpatient
	National average	12	National average	13.7	
	Highest	80	Highest	91	
	Lowest	0	Lowest	0	

					admission within the previous 28 days will be considered as part of the apportionment related to the acute trust. The well-functioning antimicrobial guidelines continue to be updated to reflect national objectives including reductions in carbapenem useage and increased prescribing from within the access list of antibiotics which the Trust is achieving. Treatment protocols continue to be updated to ensure they reflect evidence-based practice.

Clinical incidents					
Topic and detailed indicators	**Immediate reporting period: Apr 2019 – Sep 2019**		**Previous reporting period: Oct 2018 – Mar 2019**		**Statements**
Rate of patient safety incidents	Trust	43.3 (number 4869)	Trust	49.12 (number 5709)	The Trust considers that this data is as described for the following reasons: ● as organisations that report more incidents usually have a better and more effective safety culture, the Trust notes it has improved the average reporting rate and its severe incidents is in line with the national average.
(incidents reported per 1000 bed days)	Average	49.8	Average	46.06	
	Highest	103.8	Highest	95.94	
(Comparison is with 130 acute non-specialist trusts)	Lowest	26.3	Lowest	16.9	The Trust has taken the following actions to improve this rate and the numbers and percentages, and so the quality of its services:
Percentage of patient safety incidents resulting in severe harm or death	Trust	0.1% (number 5)	Trust	0.0% (number 2)	● the Patient Safety Advisors work with the divisions to identify areas where they can improve on the reporting of incidents. ● investment has continued across the year on training staff on incident investigations to enable them to focus on the root cause of the incident and, therefore, develop better action plans.
	National average	0.3%	National average	0.3%	

In addition to the above indicators, NHS England has requested that the Trust includes the latest results of the two following questions that are asked as part of the National Staff Survey:

Staff Survey Results 2019					
Percentage of staff experiencing harassment, bullying or abuse from staff in the last 12 months	Trust	21%	**Percentage of staff believing that Trust provides equal opportunities for career progression or promotion**	Trust	82%
	National average	19%		National average	85%

2.2.9 Seven day hospital services (7DS)

The 7DS programme aim is to provide a standard of consultant led care to all patients presenting urgently or as an emergency such that their outcomes are optimised and there is equity of access nationwide, but also outcomes are not dependant on the time of day or day of the week patients present. We already track and report the key outcomes related to 7DS and report these in our quarterly learning from deaths paper. We are able to provide assurance that there is no significant increase in mortality in patients admitted over the weekend and the difference in SHMI mortality seen in patients admitted over the weekend at the Trust is lower than peers.

NHS Improvement has identified four standards as clinical priorities on the basis of their potential to positively affect patient outcomes and it is against these which the Trust will be assessed for compliance in March 2020. Audit in November 2019 revealed full compliance with two standards - access to diagnostic tests such as ultrasound, computerised tomography (CT), magnetic resonance imaging (MRI), echocardiography, endoscopy, and microbiology and access to consultant directed interventions such as critical care, interventional radiology, interventional endoscopy, emergency surgery, emergency renal replacement. Significant progress has been made against the two remaining standards, especially time to first consultant review within 14 hours of admission for all non-elective patients with 85 per cent compliance against a standard of 90 per cent.

Through supported business cases to aid service redesign such as embedded acute medical consultants in the Emergency Department, adoption of Consultant of the Week models allowing increased presence of senior decision makers over seven days, and introduction of consultant led board rounds, further improvement is expected.

2.2.10 Raising concerns

The Trust recognises that staff being able to raise concerns about any aspect of their experience of work is vital if the organisation is to learn and move forward. Individuals may be worried to speak up about quality of care, patient safety or bullying and harassment but the Trust actively encourages staff to raise such concerns. It welcomes concerns being raised no matter how big or small and is focused on the benefits from voicing concerns as a way to learn, make changes and improve the working place for our staff and ensure the safety of our patients and visitors.

In many circumstances the easiest way to get a concern resolved will be to raise it formally or informally with a staff member's line manager (or lead clinician or tutor). However, when staff do not think this is appropriate or the line manager does not resolve matters, staff have a number of options open to them to seek support.

Key contacts are our Freedom to Speak Up (FTSU) Guardians who are publicised across the Trust. They are supported by our Freedom to Speak Up and Patient Safety Champions, who are locally based staff within allocated areas of the hospital and community. The Trust has a specific medical consultant whom junior doctors can approach with issues around their working hours. All of these people have been trained in receiving concerns and will give staff information about where they can go for more support. The Trust guidelines also contain a list of external bodies staff can contact. Every effort is made to ensure staff do not suffer detriment when raising the concern and the Guardians are always available to support staff who perceive that this is a possibility in their case. Other routes for raising concerns include the Human Resources Department, the Staff Health and Wellbeing Department, staff governors and staff side representatives with the latter sitting on the Trust-wide Freedom to Speak Up Steering Group.

This year has seen a number of developments to encourage staff to raise concerns and improve our ways of responding to them:

- The appointment of a third FTSU Guardian who will be available 30 hours a week.
- The introduction of a FTSU Steering Group with senior and staff representatives to co-ordinate communication, promotion of the service and relevant training of staff.
- An invitation to John Higgins, the co-author of the book 'Speak Up. Say what needs to be said and hear what needs to be heard', to present to staff the outcome of his research into in this topic.
- Commenced training of all staff across the three groups designed by the National Guardian Office: All staff, managers and directors.

2.2.11 Junior doctor rota gaps and the plan for improvement to reduce these gaps

In 2016 a new set of contractual rules were introduced to ensure rotas are designed and managed in a way that allows doctors to meet their training needs, avoid fatigue and overwork and maintain work-life balance, while allowing employers to deliver the service. These were reviewed and updated in 2019. Rota gaps, long-term staff vacancies and intensifying workload continue to be major issues across the NHS. At the Trust, the following gaps have occurred this year:

Rota Gaps				
Speciality	**April – July 2019**		**August – December 2019**	
	Registrars	**SHO**	**Registrars**	**SHO**
Medicine	12	35	10	30
Surgery	2	7	4	8
Clinical Services	0	0	0	0
Total	14	42	14	38

The Trust has taken and intends to take a number of actions to minimise these gaps. These include

- a medical training initiative (MTI) - a two-year training programme has now been in place for two years and established. These doctors help to cover any ongoing Deanery and Trust vacancies at registrar and SHO level. They also help backfill any shifts unfilled by the increasing number of LTFT (less than full time) trainees we are assigned by the Deanery.
- Increased physician associate roles in a number of areas to support SHO level activity. This has been particularly successful this year in the Acute Medical Unit.

- Initial talks with agencies to assess the cost effectiveness of giving them an increasing role in recruitment to offset our own advertisement costs.
- Increasing our internal bank coverage so that, for example, when junior staff leave due to their rotation elsewhere to undertake research, we are arranging for those staff to remain on our internal staff bank.
- Looking at using bank only apps such as Locums Nest, Patchwork or Lantum to increase our bank across the region.
- The use of headhunting agencies to recruit to hard to fill areas such as urology and radiology.
- More effective rostering using the Medirota system for junior doctors. An implementation plan has commenced across the Surgical, Medical and CSS divisions.

2.2.12 Care of patients with Learning Disabilities

The first learning disability improvement standards for NHS trusts were published in June 2018 and in 2018/19. The Trust participated in the NHS Benchmarking Network which collected data on performance against these standards. This year we continue to undertake and monitor the actions in the plan drawn up after the initial survey and the learning disability team has been strengthened to three nurses (the national survey indicates acute trusts have on average one nurse) which allows the team to see all age groups including children. We are also participating in the 2019/20 national data collection.

The team continues with the core activity of supporting people with learning disabilities to access our hospitals and services by working directly with patients, their families and carers whilst they are inpatients, in our Emergency Department and for planned admissions.

This year the team has celebrated 100 years of learning disability nursing, sharing their work within ward areas and with clinical teams. The team has evidenced that their work has addressed some of the health inequalities that people with a learning disability experience when accessing health care by improving patient communication and providing accessible information. They have continued to work in partnership with people with a learning disability by co-production of training sessions and consultations with the experts by experience. The Trust was fortunate to have Paula McGowan attend to deliver a powerful session. Following the untimely death of her youngest child Oliver, Paula has dedicated her life to campaigning for better healthcare for people who have autism and learning disabilities.

Part 3: Other quality information

3.1 Introduction

The Trust has a number of Key Performance Indicator (KPI) reports which are used by a variety of staff groups to monitor quality on a day-to-day basis. The main repository for the reporting of the Trust's key performance measures is a web-based dashboard, which is available to all senior managers and clinicians. This currently contains over 130 measures, grouped under the headings of Quality, Performance, Workforce and Finance.

In addition, continual monitoring of a variety of aspects of quality of care includes weekly reports sent to senior managers and clinicians which include the Emergency Department, Referral to Treatment and stroke and cancer targets. Monthly reports which include a breakdown of performance by ward based on Nursing Care Indicators, ward utilisation, adverse incidents, governance and workforce indicators, and patient experience scores, are also sent to all wards. In the interests of transparency, each ward now displays its quality comparative data on a large information board (see section 3.3.5) for staff, patients and their visitors.

We compare ourselves against other trusts, and use Healthcare Evaluation Data (HED) – a leading UK provider of comparative healthcare information – as a business intelligence monitoring tool.
To ensure quality improvement, the Trust has multiple organisation-wide frameworks from which it shares learning from patient feedback, clinical reviews and incidents. These include:

- **Quarterly Learning Report:**
  A quarterly learning report is produced outlining learning that has occurred across the organisation from all sources; incidents, complaints and reviews. This is presented to the directors and uploaded to the Trust intranet for all staff and shared with Dudley Clinical Commissioning Group.
- **Incident Reporting Database:**
  Every incident that occurs is reported in a central database which is designed to capture changes in practice, learning and good practice to share across the organisation. This data is included in the quarterly learning report and cascaded through divisional meetings.
- **Intranet Learning Page:**
  The Trust has a designated intranet page to which all staff have access.
- **Patient Safety and Experience Bulletin:** This commenced in 2017 and consists of a weekly email sent to all staff on a wide range of topical subjects that have arisen from local incidents and national initiatives. Examples of issues covered include diabetes care, malnutrition in hospital and correct usage of oxygen cylinders.

The following three sections of this report provide an overview, with both statistics and examples, of the quality of care at the Trust, using the three elements of quality as outlined in the chief executive's initial statement:

Patient Experience
Does the Trust provide a clean, friendly environment in which patients are satisfied with the personal care and treatment they receive?

Patient Safety
Are patients safe in our hands?

Clinical Effectiveness
Do patients receive a good standard of clinical care?

The final section includes indicators and performance thresholds set out by NHS Improvement, the Trust regulator, in its Risk Assessment Framework.

Patient Experience

3.2 Does the Trust provide a clean, friendly environment in which patients are satisfied with the personal care and treatment they receive?

3.2.1 Introduction

The Trust actively encourages feedback to help us ensure we meet the needs and expectations of our patients, their families and carers, our staff and our stakeholders. As a foundation trust we are legally obliged to take into consideration the views of our members as expressed through our Council of Governors.

3.2.2 Trust-wide initiatives

We gather feedback in a number of ways, some of which are described in other parts of this report (e.g. complaints, concerns, compliments, quality and safety reviews) and some in more detail below:

- Real-time surveys (face-to-face surveys)
- Patient stories
- The Friends and Family Test (FFT)
- NHS Choices and Patient Opinion online reviews
- National surveys including the National Inpatient Survey
- Listening events and focus groups

Real-time surveys

During the year 1,006 inpatients participated in our real-time surveys. These surveys complement the Friends and Family Test and the results are reported in a combined report to wards and specialties, allowing them to use valuable feedback from patients in a timely manner. The data from these surveys also allows us to react quickly to any issues and to use patient views in our service improvement planning.

Patient stories

The continued use of patient and staff stories at the Board of Directors' meetings during the year enables the patient voice to be heard at the highest level. These stories are circulated to senior managers and shared with frontline staff and used for service development planning and training purposes.

*During the year, **social media** usage has expanded to a point where the Trust now has 4,839 Twitter followers and in a 44 day period had 1,800 likes.*

The Dudley Group Facebook page has accumulated 10,300 'likes' to date and 10,838 Facebook followers.

Below are some examples of the quantity of feedback we received during 2019/20 and more detailed information about some of the methods. These methods alone highlight more than 53,461opportunities for us to listen to our patients' views.

Method	Total
FFT – Inpatient (inc. daycase)	**21,827**
FFT – Emergency department	**9,485**
FFT – Maternity	**2,563**
FFT – Community	**6,067**
FFT – Outpatients	**15,084**
Community patient survey	**86**
Real-time surveys (inpatient 998, AMU 84, maternity 29)	**1,111**

Method	Total
NHS Choices/Patient Opinion	**132**
National surveys Maternity 2019	**87**
National surveys Adult Inpatient 2019	**493**
National surveys Urgent and Emergency Care 2018	**366**
National surveys Children and Young People 2018	**215**
National surveys Cancer Patient Experience	**479**
Other local/department surveys	**589**
Inpatient food surveys	**1,206**

Listening events and focus groups

The Trust has continued to support a growing number of listening events and focus groups hosted by departments and teams across the organisation. This enables the individual areas to use triangulated

performance and feedback information to raise awareness with a focused group of patients, their carers and families. The feedback from these events and the suggestions for improvement are used to develop action plans that provide a continual improvement approach to the patient experience.

During 2019/20 the Trust has hosted events with the following departments and teams: cardiology, dementia services, Dudley Rehabilitation Service, maternity, ophthalmology, pain management, cancer services, stroke services, trauma and orthopaedics, diabetes, respiratory and volunteers. We held a number of drop-in sessions for patients/public to share their ideas and help shape the plans for our Emergency Department redesign which aims to improve patient and visitor flow, enhance patient safety and provide a better environment for staff to give and patients to receive treatment.

Friends and Family Test (FFT)

The Friends and Family test asks patients to answer a simple question 'How likely are you to recommend (the particular service or department) to friends and family if they needed similar care or treatment?' with answers ranging from extremely likely to extremely unlikely. This is followed up with a question asking 'Please tell us why you gave that response'. The results are published on the national NHS England website. The scores, which are updated monthly, are displayed on our website and prominently in our wards/departments for all patients, staff and visitors to see.

We monitor our performance compared to that of our neighbours in the Black Country. The table below shows our FFT scores for the year which indicates our performance together with that of local Trusts. Where organisations have collected fewer than five responses, the figures are not made public.

Inpatients FFT	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20*
Sandwell & West Birmingham	*	90%	92%	91%	91%	89%	89%	89%	86%	89%	90%	
Dudley Group	95%	95%	94%	94%	95%	95%	96%	95%	95%	95%	94%	
Royal Wolverhampton	93%	94%	92%	93%	95%	93%	93%	94%	95%	94%	93%	
Walsall	96%	96%	96%	96%	93%	95%	94%	94%	95%	96%	94%	
Worcester Acute	94%	94%	96%	96%	95%	95%	96%	96%	95%	95%	95%	
National average	96%	96%	96%	96%	96%	96%	96%	96%	96%	96%	96%	
A&E FFT	**Apr-19**	**May-19**	**Jun-19**	**Jul-19**	**Aug-19**	**Sep-19**	**Oct-19**	**Nov-19**	**Dec-19**	**Jan-20**	**Feb-20**	**Mar-20***
Sandwell & West Birmingham	75%	76%	74%	76%	79%	71%	71%	68%	73%	75%	72%	
Dudley Group	72%	72%	73%	80%	76%	79%	77%	91%	75%	76%	76%	
Royal Wolverhampton	84%	87%	84%	86%	87%	88%	87%	85%	84%	85%	85%	
Walsall	71%	79%	74%	72%	77%	79%	74%	72%	73%	77%	74%	
Worcester Acute	86%	83%	82%	76%	87%	83%	81%	82%	81%	83%	85%	
National average	85%	86%	86%	85%	86%	85%	85%	84%	84%	85%	85%	
Maternity Antenatal FFT	**Apr-19**	**May-19**	**Jun-19**	**Jul-19**	**Aug-19**	**Sep-19**	**Oct-19**	**Nov-19**	**Dec-19**	**Jan-20**	**Feb-20**	**Mar-20***
Sandwell & West Birmingham	NA	NA	NA	NA	NA	NA	90%	97%	100%	75%	83%	
Dudley Group	100%	100%	100%	100%	93%	94%	90%	99%	98%	100%	100%	
Royal Wolverhampton	*	*	*	100%	NA	92%	83%	88%	69%	84%	100%	
Walsall	92%	90%	100%	98%	100%	NA	100%	86%	*	94%	99%	
Worcester Acute	97%	96%	95%	97%	97%	98%	97%	99%	98%	99%	99%	
National average	95%	95%	95%	95%	94%	95%	95%	95%	95%	95%	95%	

Maternity Birth FFT	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20*
Sandwell & West Birmingham	100%	94%	95%	91%	67%	100%	94%	97%	94%	95%	97%	
Dudley Group	98%	100%	97%	100%	100%	93%	99%	97%	97%	97%	94%	
Royal Wolverhampton	99%	100%	100%	100%	100%	97%	99%	94%	91%	97%	94%	
Walsall	100%	91%	89%	100%	100%	100%	100%	100%	93%	100%	100%	
Worcester Acute	99%	100%	99%	97%	99%	99%	98%	97%	98%	99%	100%	
National average	96%	97%	97%	97%	96%	97%	97%	96%	97%	97%	97%	
Maternity Postnatal Ward FFT	**Apr-19**	**May-19**	**Jun-19**	**Jul-19**	**Aug-19**	**Sep-19**	**Oct-19**	**Nov-19**	**Dec-19**	**Jan-20**	**Feb-20**	**Mar-20***
Sandwell & West Birmingham	*	*	NA	100%	*	100%	94%	93%	NA	97%	94%	
Dudley Group	100%	99%	89%	100%	96%	89%	94%	91%	90%	97%	91%	
Royal Wolverhampton	100%	100%	100%	96%	91%	89%	93%	96%	92%	88%	92%	
Walsall	87%	90%	*	96%	95%	94%	92%	86%	100%	100%	93%	
Worcester Acute	98%	98%	97%	97%	98%	96%	92%	99%	98%	97%	99%	
National average	95%	95%	95%	95%	96%	95%	96%	94%	95%	95%	95%	
Maternity Postnatal Community FFT	**Apr-19**	**May-19**	**Jun-19**	**Jul-19**	**Aug-19**	**Sep-19**	**Oct-19**	**Nov-19**	**Dec-19**	**Jan-20**	**Feb-20**	**Mar-20***
Sandwell & West Birmingham	NA	NA	NA	NA	NA	NA	92%	NA	NA	NA	NA	
Dudley Group	100%	100%	100%	100%	92%	97%	100%	100%	91%	100%	100%	
Royal Wolverhampton	100%	100%	100%	100%	100%	92%	100%	85%	97%	94%	86%	
Walsall	87%	NA	100%	100%	100%	96%	100%	98%	100%	100%	99%	
Worcester Acute	100%	100%	100%	97%	100%	100%	100%	100%	100%	97%	100%	
National average	98%	98%	98%	98%	98%	89%	98%	98%	98%	95%	98%	
Community	**Apr-19**	**May-19**	**Jun-19**	**Jul-19**	**Aug-19**	**Sep-19**	**Oct-19**	**Nov-19**	**Dec-19**	**Jan-20**	**Feb-20**	**Mar-20***
Sandwell & West Birmingham			-	-	-	-	-	-	-	-	-	
Dudley Group	94%	93%	93%	90%	92%	91%	93%	95%	91%	94%	92%	
Royal Wolverhampton	91%	89%	90%	91%	89%	89%	90%	91%	92%	92%	91%	
Walsall	98%	98%	98%	97%	97%	99%	95%	95%	98%	97%	98%	
Worcester Acute	97%	94%	95%	94%	93%	95%	92%	95%	95%	95%	92%	
National average	95%	95%	95%	95%	96%	95%	96%	96%	95%	95%	96%	
Outpatients	**Apr-19**	**May-19**	**Jun-19**	**Jul-19**	**Aug-19**	**Sep-19**	**Oct-19**	**Nov-19**	**Dec-19**	**Jan-20**	**Feb-20**	**Mar-20***
Sandwell & West Birmingham	90%	90%	90%	88%	89%	87%	87%	89%	89%	89%	89%	
Dudley Group	89%	90%	89%	89%	90%	89%	90%	90%	90%	90%	92%	
Royal Wolverhampton	95%	95%	94%	95%	94%	94%	95%	95%	95%	95%	95%	
Walsall	91%	92%	92%	92%	92%	90%	91%	92%	92%	91%	92%	
Worcester Acute	92%	93%	92%	93%	92%	92%	93%	93%	94%	94%	94%	
National average	94%	94%	94%	94%	94%	94%	94%	94%	94%	94%	94%	

*Figures not yet available

NHS Choices and Patient Opinion

Patients can give feedback about their experience of any of our services on the NHS Choices and Care Opinion websites. Patients can post comments anonymously or choose to give their name. All comments are responded to online.

In the year 2019/20, the Trust received 132 pieces of feedback via NHS Choices and Care Opinion. We actively encourage patients to engage in this way and consistently attract more comments than neighbouring trusts. NHS Choices operates a star rating system where patients can also rate their experience from one to five stars. Not everyone chooses to award a star rating. The average star rating for each of the Trust sites was 4.0 stars. More than 68 per cent all comments received have been positive.

Overall star ratings as per NHS Choices website as at January 2020	
Location	**Overall star rating**
The Dudley Group (no location specified)	 4 stars based on 20 ratings

3.2.3 National survey results

In 2019/20, the Trust participated in the CQC national surveys programme with the following national patient surveys published during the period.

Participants for all national surveys are selected against the sampling guidance issued by the Care Quality Commission (CQC) for the months indicated in the table below:

Survey name	Survey sample month	Trust response rate	National average response rate
2018 Adult Inpatient	July 2018	41%	45%
2018 Cancer Patient Experience Survey	April – June 2018	60%	64%
2019 Women's Experiences of Maternity Services	February 2019	28%	36%
2018 Children and Young People Survey	November – December 2018	24%	26%
2018 Urgent and Emergency Care Survey	October 2018 – March 2019	30%	-

What the results of the surveys told us

Adult Inpatient Survey 2018

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

The Trust is ranked 131 out of 144 Trusts (compared to 134 out of 148 trusts in 2017) based on the Overall Patient Experience Score (OPES). The OPES ranged from the lowest trust score in England of 7.3 to the highest trust score in England of 9.1. The Trust score was 7.7 in comparison to 7.9 in 2017.

The Trust response rate is 41 per cent compared to a national response rate of 45 per cent which sampled 1,190 patients discharged from hospital during July 2018. The Trust maintained 'about the same' in the majority of sections with notable exceptions of the Emergency Department, nurses, operations and procedures and leaving hospital, where the Trust scored 'worse' compared to most other trusts that took part in the survey.

Cancer Patient Experience Survey 2018

The National Cancer Patient Experience Survey 2018 was commissioned and managed by NHS England and is the eighth iteration of the survey. The Trust received a 60 per cent response rate compared to the national response rate of 64 per cent.

Scores were provided for questions that relate directly to patient experience. The Trust's performance was comparable to national results. There are a number of areas where the Trust is performing well and scores have remained above the national average.

Women's Experiences of Maternity Services 2019

The CQC published the results of the 2019 Women's Experiences of Maternity Services survey in January 2019. It sampled women who had given birth during February 2018. The Trust response rate was 28 per cent based on 87 women completing the survey. The national response rate was 36 per cent.

The total number of questions requiring subjective responses totalled 37. The Trust scored better compared to the previous survey for 24 questions, worse for 10 and about the same for three.

Overall we were rated as 'about the same' as other trusts for the questions relating to labour and birth, staff and care in hospital after birth.

Children and Young People Survey 2018

The results were published on 29 November 2019. The survey is comprised of three age-appropriate versions: parent version, child version and a young person version. The Trust response rate was 24 per cent for 2018 compared to 20% in 2016. The average response rate for all organisations was 26 per cent.

A total of 64 questions from the survey could be positively scored. The Trust scored better compared to the previous survey for 31 questions, remained the same for nine questions and worse for 16 questions. There were eight questions in the 2018 survey where no data for comparison was available.

Urgent and Emergency Care Survey 2018

The Trust response was 30 per cent (366 usable responses from a usable sample of 1231 patients who were seen during September 2018). Scores were provided for questions that relate directly to patient experience. The Trust's performance was comparable to national results. The Trust maintained 'about the same' in the majority of sections with notable exceptions of the section on leaving Emergency Department.

Acting on feedback received

We continue to use the feedback from national and local surveys to improve patient experience. Below are some examples of actions taken as a result of patient feedback in the year:

- Our orthopaedic Listening to Action event has enabled us to make changes to our services based on direct feedback from patient on what is important to them:
    - The patient information presentation at 'joint school' has been updated to include 'expectations of surgery', hospital stay, wound care and pain management.

- The time from pre-operative assessment to surgery has been monitored closely to ensure all patients are seen at 'joint school' within two weeks of forthcoming surgery.
- Post-operative retention of urine has been included in the risks/complications discussion prior to surgery.
- Nurse-led discharge has been implemented and supported by all surgeons to address any delays in discharge home.

- We launched our ‘What Matters To You’ campaign in early January. This campaign aims to raise the profile of patient experience across the Trust and capture feedback using a wide range of mechanisms and reporting on this activity to facilitate organisational learning and improvement. This is a great way for us to listen to patients’ thoughts and implement changes to improve the services that we offer.

3.2.4 Examples of specific patient experience initiatives

One Stop Pre-operative assessment service

In January 2020 a One Stop Pre-operative assessment service commenced at the Trust. Patients for surgery are now referred directly from their surgical outpatient appointment. This enables the clinicians to timely optimise patients before surgery (both in terms of assessing chronic medical conditions and detecting any new problems). Benefits of this include reduced on the day of surgery cancellations, better post-operation planning and improved patient experience. This one stop service has helped to reduce the number of times patients have to come to the hospital as the majority of assessments can be completed at the initial visit. Consultant presence throughout the week has ensured that patients receive senior anaesthetic input regarding the risks, benefits and overall decision making regarding the suitability of surgery. The service has also managed to clear a backlog of patients requiring a pre-operative assessment who were awaiting surgery by running additional "Super Sunday" clinics. In addition, there is direct access to a designated frailty clinic for elderly patients and an urgent referral pathway for patients with renal problems, both of which help avoid post-surgery complications for these two groups of patients.

Reducing potential concerns of young people when moving from children to adult services.

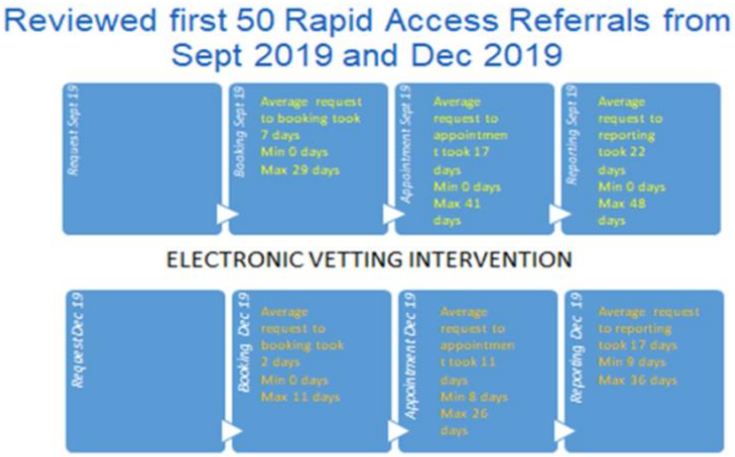
Children and young people with lifelong and life limiting conditions face significant challenges as they move from children's to adult services. Services for paediatric and adults are often very different and can leave young people, their parents and carers struggling to deal with completely new systems of care and treatment with no-one to assist in co-ordinating the move into adult services. In order to improve their experiences we have worked with our specialist nurses to develop clear pathways which will empower young people, parents and carers to understand and take their own decisions for their healthcare but also to move through the process seamlessly. One example is the use of a 'Ready, Steady, Go' document that the young adult is given which explains what to expect.

Courtyard Garden

A new courtyard garden has been created at Russells Hall Hospital to provide patients with a quiet space for relaxation and contemplation during their care and treatment. Funded by The Leukaemia Unit Appeal Fund, the Forget-me-not Garden was officially opened by the Mayor of Dudley, Councillor David Stanley, in November 2019. Special guests at the unveiling were local metal sculptor and furniture maker Lee Woodall from Hausform who made and donated an outdoor sculpture as a thank you for the care his partner received on the Georgina Unit. "My partner Richie spent almost four months on the Georgina Unit last summer, and was not expected to come out," said Lee. "However, he did, and has now made a full recovery thanks to his limitless positivity and the amazing care of all staff on the Georgina Unit. This sculpture is my way of showing my gratitude and thanks." Other guests included representatives from the Leukaemia Appeal Fund, Pro Seal Property Management for constructing the garden and Summit Healthcare for providing ongoing maintenance and extra planting.

Cancer Improvement Collaborative

We participated in the NHS England National Cancer Improvement Collaborative programme for local clinical teams to improve their cancer services. Based on the findings from the National Cancer Patient Experience Survey 2018, the Trust aim was to improve the cancer pathway by working to reduce the diagnostic 'blockers' and acting upon patient feedback to reduce the timescale for receiving the referral to booking the appointment by one day for the first 50 CT patients in December 2019. A correlation can clearly be seen from the data collected in September that the earlier an investigation is booked then appointment and reporting follow suit. See table below.



3.2.5 Complaints, concerns and compliments

Total number of complaints, PALS concerns and compliments

Complaints

In the period April 2019 to March 2020, the Trust received a total of 678 complaints compared to the year total of 566 in 2018/19. The number of complaints received are increasing year on year.

Complaints to the Parliamentary and Health Service Ombudsman (PHSO)

During the year, the PHSO received two new cases about the Trust. Seven cases were carried over from the previous year and all seven were closed within the year. One of the two new cases remains under investigation and the other case has received the draft report indicating that the complaint will be upheld.

Complaints to the Local Government Ombudsman (LGO)

During the year, there have been no new LGO cases. Two were carried over from the previous year. One has been closed (not upheld) and the other was partially upheld. Both cases are now closed and there are currently no LGO cases.

Complaints by type

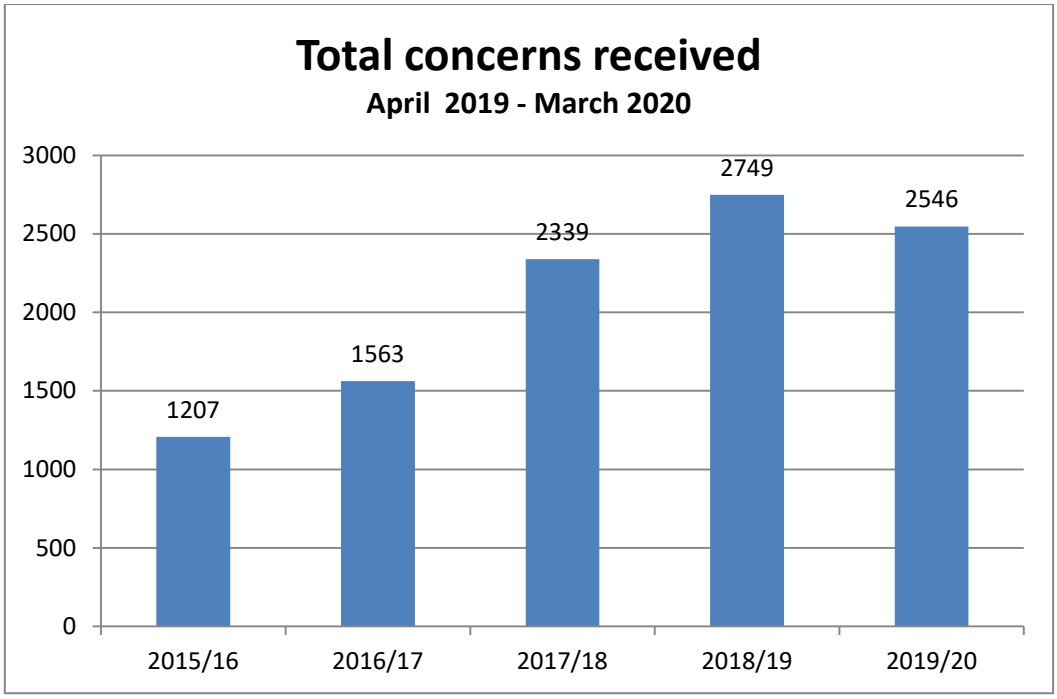
The chart below show the top five types of complaints received in each quarter during the year. The themes of complaints we receive remain similar to last year, reflecting the importance that patients place on effective treatment and communication to help them understand their treatment and patient journey.

Quarter 1, 2019/20	Quarter 2, 2019/20	Quarter 3, 2019/20	Quarter 4, 2019/20
Communications	Communications	Communications	Appointments including delays and cancellations
Clinical treatment – surgical	Values and behaviours – staff	Patient care including nutrition and hydration	Communications
Values and behaviours – staff	Patient care including nutrition and hydration	Values and behaviours – staff	Values and behaviours – staff
Patient care including nutrition and hydration	Clinical treatment – surgical	Clinical treatment – surgical	Clinical treatment – surgical
Admissions/discharges and transfers (excl. delayed discharge due to absence of package of care)	Clinical treatment – Accident and Emergency	Admissions/discharges and transfers (excl. delayed discharge due to absence of package of care)	Clinical treatment – general medicine

Patient Advice and Liaison Service

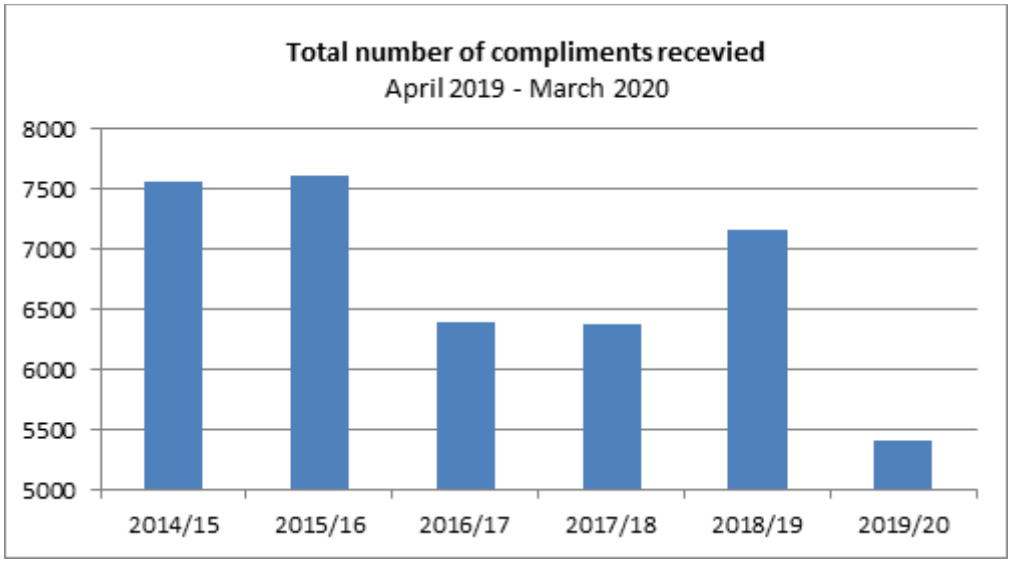
The table below details the total number of concerns and comments raised over the last five years with the Patient Advice and Liaison Service (PALS) with 2019/20 showing the total number of concerns, comments and signposting activity. The Trust places importance on the value of feedback and has worked hard to raise awareness of the PALS services to our patients, carers and their families.

The types of concerns and comments received relate to appointment delays (lack of follow-up appointments being offered, length of time taken for appointments to be offered and cancellations) and communications with patients and relatives. As with the types of complaints received, the themes of concerns reflect the importance that patients place on communication.



Compliments

The table below details the total number of compliments received during the year compared with previous years. It is very pleasing to see how many patients take the time to tell us of their good experiences, with 5,415 compliments received during the year. All compliment letters received by the chief executive and chief nurse are personally acknowledged and shared directly with the individual and teams as appropriate accompanied with a personal letter of thanks.



Examples of actions taken and changes in practice made in response to complaints and concerns

Issue raised by patient/carer	Learning and actions taken
The length of time a patient had been waiting for a 32 day cardiac monitoring investigation.	The demands on the service have increased and due to a shortage of equipment delays have occured. Additional cardiac monitors have been purchased along with an additional analyser. The additional equipment has supported the cardiac physiologists in completing investigations and analysing results in a timelier manner thereby reducing waiting times. There is a business plan to invest further in more equipment to manage the ever increasing demand.
A patient who had mouth pain when eating which was not identified on admission.	The Trust accepted how oral thrush should have been identified on admission to hospital; treatment could have been started earlier thereby reducing the patient's pain and discomfort. It was explained how we recognise mouth care as a vital part of patient care though acknowledged it is not always prioritised by staff. A mouth care screening tool had been introduced on this particular ward. The mouth care screening tool is a new initiative. The use of the tool has been promoted at the twice daily huddle board meetings with the aim for 100% of staff to receive training.
A missed hip fracture in the Emergency Department (ED).	Difficulties can arise in interpreting x-rays. The Painful Hip Protocol was reviewed regarding the safety net for patients who present to ED with a painful hip following a fall. All ED doctors have been cautioned to have a low threshold for CT imaging of a patient's hip in those patients who present with persistent hip pain after falling and a previous clear x-ray.
The breaking of bad news to a palliative care patient.	The doctor acknowledged that he could have waited for the family to arrive before breaking bad news to a patient and should have taken a nurse with him to support the patient. The consultant arranged for the doctor to complete the e-learning in palliative care module and agreed for some time to be spent with the specialist palliative care team. In addition the doctor was asked to reflect on their practice of breaking bad news. The doctor has completed both additional training and reflection.
The length of time an elderly patient was left waiting to be seen in the haematology clinic.	It is acknowledged the impact overbooked clinics has on waiting times. It was identified that the morning clinic on this day was excessively busy and overbooked which impacted on the afternoon clinic. The department has vacancies within the medical workforce which contributed to the inability to provide additional support. The clinic templates were reviewed to ensure clinics can run effectively. The recruitment process for the consultant vacancy is underway with plans to advertise into their clinical fellow post which will assist with clinics. The longer term aspiration is for the team to progress with moving more clinics to the community.

3.2.6 Patient-led Assessments of the Care Environment (PLACE)

PLACE is the national system which focuses exclusively on the environment in which care is delivered; it does not cover the clinical care provision. The PLACE collection underwent a national review which started in 2018 and concluded in summer 2019, which resulted in the question set being refined. Due to the extensive changes, it is important to note that the results of the 2019 assessments are not comparable to earlier assessments.

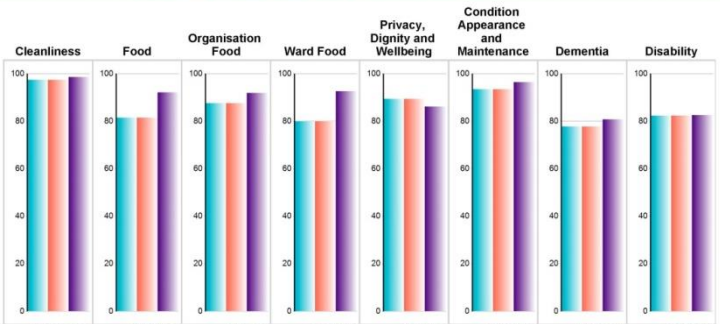
The PLACE team is led by patient assessors (not employed by the Trust) who make up at least 50 per cent of the assessment team. In 2019, the patient assessors who took part where made up of several organisations including Healthwatch, local charities and students from local colleges, along with governors of the Trust. The remaining 50 per cent were staff assessors from the Trust and Summit Healthcare including representation from clinical, patient experience and facilities teams.

The inspection requires 10 wards, outpatient areas, Emergency Department, communal areas and external areas to be assessed for:

- cleanliness,
- the condition, appearance and maintenance of the buildings and fixtures (inside and out),
- how well the building meets the needs of those who use it, e.g. signage,
- the quality and availability of food and drinks,
- how well the environment protects people's privacy, dignity and wellbeing, and
- how the premises are equipped to meet the needs of patients with disability and dementia.

The 2019 scores are identified below.

RUSSELLS HALL HOSPITAL- Collection: 2019



	Cleanliness	Food	Organisation Food	Ward Food	Privacy, Dignity and Wellbeing	Condition Appearance and Maintenance	Dementia	Disability
Achieved Score (Actual)	2160.0000	361.8333	78.8333	283.0000	461.3333	811.0000	685.5000	503.5000
Available Score (Actual)	2218.0000	444.0000	90.0000	354.0000	516.0000	868.0000	882.0000	612.0000
Site Score	97.39%	81.49%	87.59%	79.94%	89.41%	93.43%	77.72%	82.27%
Organisation Average	97.39%	81.49%	87.59%	79.94%	89.41%	93.43%	77.72%	82.27%
National Average	98.60%	92.19%	91.92%	92.62%	86.09%	96.44%	80.70%	82.52%

Apart from the privacy, dignity and wellbeing category the Trust scored lower than the national average in other domains. A Trust action plan has been developed following the assessment. Many actions have been completed associated with cleaning and also the condition, appearance and maintenance of the hospital but the remaining Trust actions are currently being worked through with executive lead involvement.

3.2.7 Single-sex accommodation

We are compliant with the Government's requirement to eliminate mixed-sex accommodation. Sharing with members of the opposite sex only occurs when clinically necessary (for example, where patients need specialist care such as in the critical care unit), or when patients actively choose to share (for instance in the renal dialysis unit). During the year, the Trust has reported 133* breaches of same-sex accommodation. All of these patients were those who were cared for in a specialised unit, such as the intensive care unit or high dependency unit. Following improvement in their condition, the patients were assessed as being able to be moved to a general ward but had to stay in the specialised unit longer than necessary due to there being no general ward beds immediately available. All of these occurred when capacity issues were a major problem both at the Trust and in the NHS generally. (* Due to COVID-19 and the need to release capacity across the NHS to support the response, the collection and publication of this information was suspended in March 2020 and so this figure is from April 2019 to February 2020).

As part of our real time survey programme, patient perception is measured by asking patients whether they shared a room or bay with members of the opposite sex when they were admitted to hospital. Across the year, of the 837 patients who responded to this question, 64 (less than 7.6 per cent) had the perception that they shared a room/bay with members of the opposite sex. This excludes emergency and specialist areas.

3.2.8 Patient experience measures

	Actual 2015/16	Actual 2016/17	Actual 2017/18	Actual 2018/19	Actual 2019/20*	Comparison with other Trusts 19/20
Patients who agreed that the hospital room or ward was clean	9.0	8.8	8.7	8.6	8.8	About the same
Rating of overall experience of care (on a scale of 1-10)**	8.0	7.8	7.9	7.8	7.8	About the same
Patients who felt they were treated with dignity and respect	8.9	8.9	8.8	8.6	8.8	About the same

*The above data is from national inpatient surveys conducted for CQC. ** National range lowest to highest score.*

Patient safety

3.3 Are patients safe in our hands?

3.3.1 Introduction

The Trust ensures the safety of its patients is a main priority in a number of ways, from the quality of the training staff receive, to the standard of equipment purchased. This section includes some examples of the preventative action the Trust takes to help keep patients safe, and what is done on those occasions when things do not go to plan.

3.3.2 Quality and safety reviews

The Trust is committed to the delivery of high quality, safe patient care and has established a system of quality and safety reviews which assess if the areas are 'Safe', 'Effective', 'Caring', 'Responsive' and 'Well-led' (CQC Fundamental Standards). The reviews provide assurance of these areas to the board. They utilise a set of tools that enable a full review of a clinical area and identify both good practice and topics where improvement is required. The wards and departments reviewed are provided with CQC style ratings for each domain and an overall rating, allowing them to prioritise the actions for improvement required. The reviews occur every two weeks and are undertaken by a wide multidisciplinary team. The team also includes non-executive directors, members of the Board of Governors and representation from our CCG. The diversity of the team members allows a broader perspective to be gained during the review. Feedback is provided on the same day following aggregation of the review team's findings. A formal report of the review is sent within one week of the review to the ward manager, matron and divisional chief nurse. Action plans should be produced within 14 days of receiving the report if required and are managed through the relevant division.

In the instance where a poor rating is applied this results in a follow up visit by the team within four weeks to ensure improvements have been made. This multi-dimensional view of our services, coupled with executive director and non-executive director 'back to the floor' walk rounds, ensures that we maximise our opportunity to learn and improve our services for the benefit of our patients and staff.

Some of the findings of the reviews included:

- Staff were able to describe how they have learned from incidents and made changes to improve the patient experience.
- Staff were able to accurately describe the process of staffing escalations.
- Patients' privacy and dignity was maintained during delivery of personal care and during discussions with medical staff.
- Staff were able to describe the correct action to take if they had a safeguarding concern.
- All acute wards displayed a quality dashboard that was visible to the public.
- Evidence of the introduction of daily safety huddles to improve communication.
- Excellent use of noticeboards throughout the areas visited
- Staff were able to articulate the risks for their area

3.3.3 Incident management

The Trust actively encourages its staff to report incidents, believing that to improve safety it first needs to know what problems exist. This reflects the National Patient Safety Organisation which has stated:

"Organisations that report more incidents usually have a better and more effective safety culture. You can't learn and improve if you don't know what the problems are."

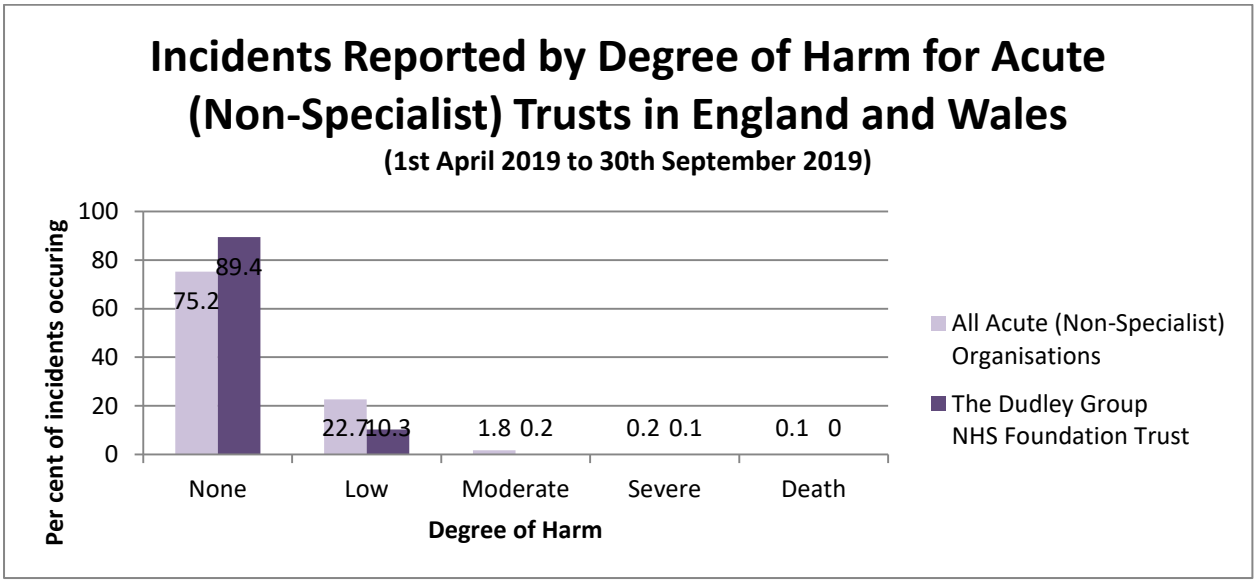
As a Trust, we are committed to learning from incidents. This is supported by an open culture which encourages any incident regardless of the level of harm (including 'near misses') to be reported through the Trust's electronic incident management system Datix. During 2019/2020 the Weekly Meeting of Harm membership has been increased to include the chiefs of division and key individuals are invited to present a potential serious incident to the group. The meeting has been formalised and a terms of reference developed.

The process for the investigation of serious incidents has been reviewed to support the timely completion of investigations. The improvements include ensuring reports are now written by the patient safety team and they are supported by an independent specialist. Regular meetings are held with the investigation team to drive the investigation forward.

The process of the investigation of less serious incidents in the divisions has been reviewed. This has led to the closure of a significant number of these incidents. The process for their identification has also been reviewed and these are now identified through the weekly meeting of harm or review by the speciality leads/deputy chief (i.e. falls/pressure ulcers).

The Integrated Governance report has been reviewed to provide the divisions and directorates a more constructive review of incidents, risks, procedural documents, CAS alerts and inquests/claims. The revised report was agreed within the divisions and launched in October 2019.

The chart below shows the percentage of incidents reported by degree of harm at the Trust and for all acute (non-specialist) trusts in England and Wales, from 1st April 2019 to 30th September 2019.



With regards to the impact of the reported incidents, it can be seen from the chart that the Trust reported similar proportions of incidents to comparable trusts. Nationally, across all acute (non-specialist) trusts 75.2 per cent of incidents are reported as no harm (the Trust reported 89.4 per cent) and 0.1 per cent as death (the Trust reported zero per cent).

During the year, the Trust has had four never events (a special class of serious incident that is defined as a serious preventable adverse incident that should not occur if the available preventative measures have

been implemented). The Trust had 39 serious incidents, all of which underwent investigation in line with the Trust's policy which is based on national requirements and, when relevant, action plans were initiated and changes made to practice. Serious incidents are events in healthcare where the potential for learning is so great, or the consequences to patients, families and carers, staff or organisations are so significant, that they warrant using additional resources to mount a comprehensive response.

Some examples of changes made to practice in response to incidents have been:

- A number of serious incidents have been reported in ED relating to the management of patients presenting to the department with chest pain. This led to the development of a Task and Finish group involving key individuals to look at themes, commonalities and to review the current process for the management of these patients. The group identified a number of improvements were required to improve the pathway for such patients. This has included the development and introduction of a standardised assessment tool. The chest pain pathway has been reviewed and updated providing clear guidance on the management of patients that present with chest pain, clearly identifying the correct management of patients with cardiac and non-cardiac chest pain. The working hours of the cardiac assessment nurse have been extended to provide a service 12 hours per day, seven days a week.
- A never event relating to "wrong body part treated" identified a lack of process in relation to marking the site of removal and this has led to the development and implementation of a Standard Operating Procedure for the marking of the site which clarifies the process of marking a patient's skin prior to a surgical intervention. iPads have been purchased to enable photographs to be taken of the site and staff training has been provided.
- A never event relating to a "retained stylet" in a long intra-arterial line identified that there was a lack of awareness of the Product Evaluation in the Clinical Area Standard Operating Procedure (SOP) for ordering a piece of new equipment. The SOP has been shared with all the divisions and a Patient Safety Bulletin is being completed which will be shared Trust-wide.
- There have been a number of incidents reported in relation to delay in the Surgical Ambulatory Emergency Care (SAEC) area. This has led to a number of improvements to ensure that patients are well informed should there be any delays. Improvements include the introduction of a triage dashboard which will provide the staff with oversight of the patients waiting and ensure that they are seen within timescale. An additional clinical support worker (CSW) has been secured and is based in the waiting area. The CSW is visible to the patients and can answer any concerns and can pass on any concerns to the triage nurse. The area has appointed two advanced care practitioners who will help to improve the flow through the unit. Work is ongoing to move the unit to the front door as part of the ED redesign. This will help to improve efficiency and improve the pathway for patients requiring assessment in this area.
- The Discharge Lounge Standard Operating Procedure has been reviewed which includes ensuring the discharge checklist is fit for purpose. The completion of the discharge checklist has been added to the Perfect Ward audit to ensure compliance is embedded.
- A number of medication incidents have occurred involving drug fridges being unintentionally switched off or unplugged. Drugs that have not been stored in accordance with manufacturers' recommendations may have to be discarded or have their expiry dates shortened. Incidents were also having an impact on the workforce due to the staff time needed to provide advice about whether medicines could be reused or destroyed and carry out tasks such as emptying the fridge, quarantining stock, replacing stock etc. This topic was place on the risk register and an audit has been completed to identify the number of drug fridges and their location. Pharmacy staff have worked with estates staff to establish options to prevent fridges being unplugged e.g. spur or tamper proof cover and costings for these. Options have been discussed at the Safe Medicines Practice Group and it has been agreed that tamper proof covers will be fitted to drug fridges to cover sockets and reduce the risk of fridges being switched off or unplugged.
- A sub category has been added into the Datix system to allow for the pressure ulcers that are related to medical devices to be specifically reported and to allow collation of numbers. A Patient

Safety Bulletin was completed to define what a medical device related pressure ulcer was, detailing examples of these devices and the preventative measures that should be taken, alongside the pressure relieving intervention already available.

- The Trust is one of the top 10 performing acute Trusts nationally for Referral to Treatment (RTT), however unfortunately the Trust has identified two 52 week RTT breaches and these were reported as incidents. Such breaches potentially result in: clinical risk to patients, poor patient experience, financial implications to the organisation and poor organisational reputation. In response immediate actions were taken and internal specialty to specialty referrals are now undertaken electronically and no paper internal referrals are accepted for an outpatient appointment. This is in line with the "national paper switch off" and follows the process already implemented for GP referrals.

3.3.4 Duty of Candour

The aim of this regulation is to ensure that staff are open and honest with patients when things go wrong with their care and treatment. This includes any event when a patient has been harmed. To ensure compliance to the regulation and to ensure this framework is embedded in the organisation, the Trust has taken the following actions to further ensure compliance and improve completion of the necessary documentation:

- The central patient safety team liaises with the lead investigator of an incident to ensure that the duty is completed within the 10 day framework and then on closure of the investigation. The team notify the lead investigator if the patient requires feedback following the completion of the investigation and co-ordinates any written feedback requests.
- Our commissioners are provided with evidence of the completion of the aspects of the initial discussion with families through the national serious incident reporting system (STEIS).
- Duty of Candour training is provided on request to the patient safety team.
- A Standard Operating Procedure is in place detailing the process of how to complete the Duty of Candour documentation and this is available to staff on the Trust's intranet.

3.3.5 Quality Indicators

Every month, nursing records and supporting documentation are audited at random in all general inpatient areas and specialist departments in the hospital, and in every nursing team in the community. A total of 36 wards and departments (approximately 370 records) are audited each month. The purpose of this audit is to ensure nursing staff are undertaking risk assessments, performing activities that patients require and accurately documenting what has taken place. The results of the audit for each area of the Trust compared to the last two years are shown below. In February 2019 the Trust commenced the implementation of 'Perfect Ward'. This is a smart inspection app which is installed on handheld devices. It allows nurses to spend less time on data collection. It also allows nurses to take photographs as a visual aid of both good and poor practice. As soon as an inspection has been undertaken and submitted within the handheld device the results are visible. This means that the key findings can be reviewed immediately by the lead nurse so any required improvements can be addressed straight away.

The results generally show improvement although direct comparison is difficult due to changes in the tools with the introduction of Perfect Ward. Community are currently not undertaking their audits via Perfect Ward, they continue to carry out audits via Snap.

In addition to the above indicators, a number of other more specific audits, such as assessing the care of diabetes, pressure ulcer care and patients at risk of falls, are conducted monthly. The audit tools are reviewed regularly to reflect learning from incidents and changes in practice. These audits have an escalation framework to ensure that issues that could be improved are addressed by the lead nurse and

matron for that area. As well as the monthly audit system, spot checks occur in all areas alongside the wider quality and safety reviews (see section 3.3.2).

(Red=< 85%, Amber 85%-94%, Green ≥95%)

Area of Audit	2017/2018	2018/2019	2019/2020
Community Children's	100%	100%	99%
Community Neonatal	100%	100%	99%
Critical Care	95%	97%	95%
District Nurses	95%	97%	96%
EAU/AMU	86%	91%	80%
ED	90%	94%	88%
General Wards	93%	96%	93%
Maternity	96%	94%	94%
Neo Natal	99%	98%	98%
Paediatric	97%	96%	95%
Renal	98%	97%	94%

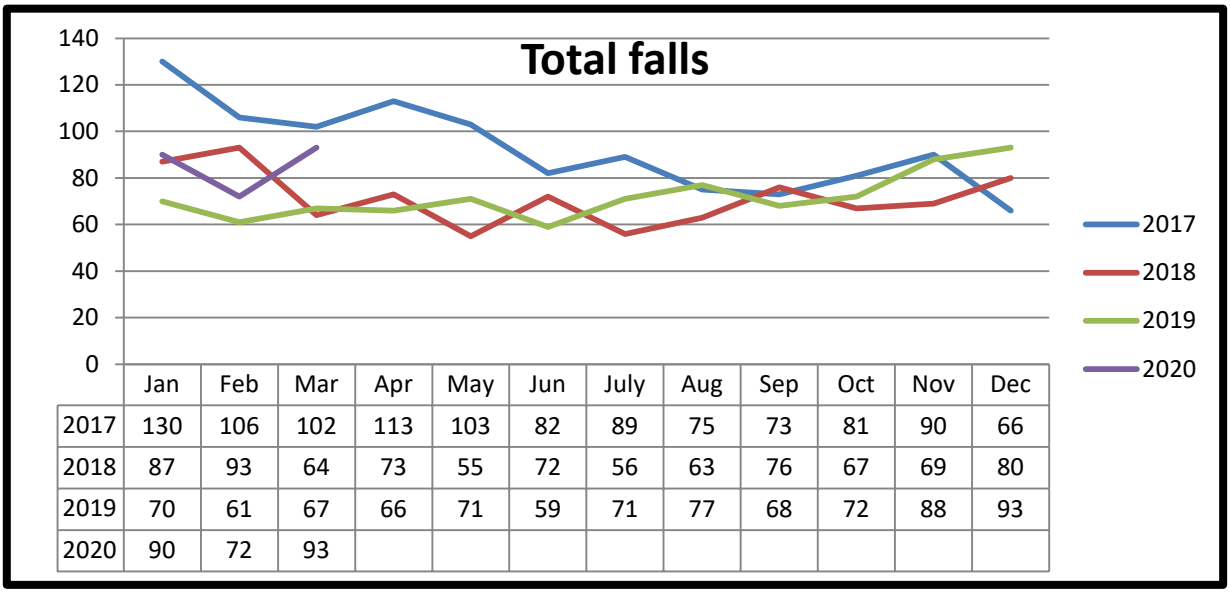
3.3.6 Falls Prevention

In 2019, the Trust continued to work with NHS Improvement as part of their National Falls Practitioner Network which enables trusts to discuss and share ideas and learning. The Trust falls lead was elected as the chair of the network for 2020. The Midlands Regional Falls Network is now well established and there were a number of meetings held in 2019 with the Trust falls lead acting as deputy chair. The main members of this network are from our neighbouring trusts.

A CQUIN (see section 2.2.4) was introduced in 2019 entitled 'Three high impact actions to prevent hospital falls' and additional support was introduced to the falls team to help embed these. The first action related to the recording of lying and standing blood pressure in all applicable patients aged over 65. This is something which was not routinely undertaken prior to the CQUIN introduction but following support from the falls team we successfully achieved the standard required by the CQUIN. The other two actions relate to the risk of falls risk medications and the use of walking aids for inpatients. Both of these areas already have robust systems in place and there are no anticipated difficulties in achieving the CQUIN target.

The Trust had seven serious incidents for falls with harm in 2019. This compares favourably with the 12 serious incidents which occurred in 2018.

The end of 2019 and beginning of 2020 has demonstrated a spike in both falls with and without harm. This may be attributed to the higher dependency of patients in the winter months. Falls figures in February were more in keeping with what the Trust would normally expect but an increase is noted in March – this is being monitored for trends. No falls, with harm, were reported in February with two occurring in March.



	Jan	Feb	Mar	Apr	May	Jun	July	Aug	Sep	Oct	Nov	Dec
2017	130	106	102	113	103	82	89	75	73	81	90	66
2018	87	93	64	73	55	72	56	63	76	67	69	80
2019	70	61	67	66	71	59	71	77	68	72	88	93
2020	90	72	93									

There has been an emphasis on training for the small number of wards where staff have not completed falls prevention training.

3.3.7 Harm Free Care and NHS Safety Thermometer

The NHS Safety Thermometer used for adult patient care was developed as a ‘temperature check’ on four key harm events – pressure ulcers, falls that cause harm, urinary tract infections in patients with a catheter and new venous thromboemboli. It is a mechanism to aid progress towards harm free care and is available across the whole of the NHS.

Each month, on a set day, an assessment is undertaken consisting of interviews with patients, accessing the patient’s bedside nursing documentation and, when required, examining the main health record. On average, 480 adult inpatients (excluding day case patients and those attending for renal dialysis), and 580 patients being cared for in the community are assessed.

To ensure accuracy of audits submitted as well as improved lines of communication, access to the database has been restricted to staff who have received training.

The Children and Young People's Services Safety Thermometer is a national tool that has been designed to measure commonly occurring harms in people that engage with children and young people's services. It is a point of care survey that is carried out on one day per month which supports improvements in patient care and patient experience, prompts immediate actions by healthcare staff and integrates measurement for improvement into daily routines. This process is led by the clinical governance lead for paediatrics. The Maternity Safety Thermometer allows maternity teams to take a temperature check on harm, and records the proportion of mothers who have experienced harm free care, but also records the number of harm(s) associated with maternity care. It supports improvements in patient care and patient experience, prompts immediate actions by healthcare staff and integrates measurement for improvement into daily routines. This process is led by the maternity matron.

The Trust regularly monitors its performance and, although direct comparisons need to be made with caution, it is pleasing to note its harm events fall below the national averages.

As of March 2020, the collection of data for all Safety Thermometers has ceased and the Trust awaits instruction as to a new national data collection tool.

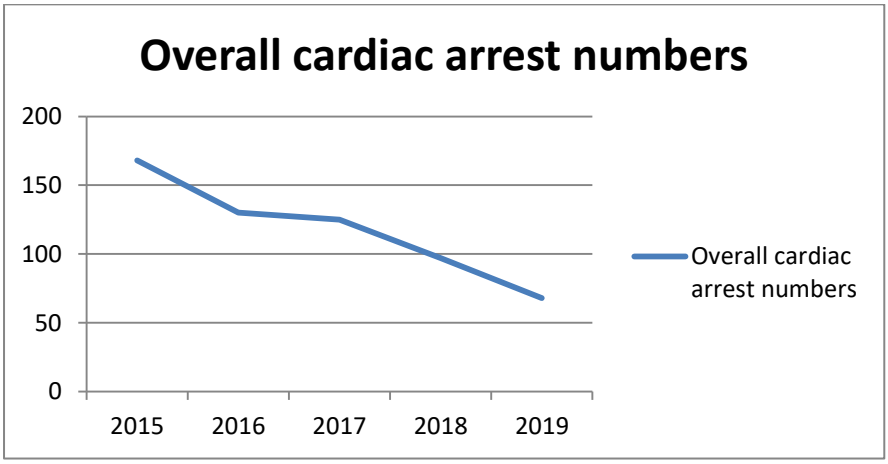
3.3.8 Examples of specific patient safety initiatives

Deteriorating Patient/Sepsis Improvements

The management of the deteriorating patient is a key priority for all our patients in maintaining a safe and holistic approach to care. To achieve this we have worked significantly on the early identification of the cause of deterioration and the appropriate use of trigger tools and care pathways while always accepting some patients may have more than one problem so ensuring that all deteriorating patients have early senior review.

The improvement in our sepsis recognition across the whole organisation and treatment is evident of this. In February 2019 the undertaking of the Sepsis 6 (a bundle of diagnostic and therapeutic steps – all to be delivered within one hour of the initial diagnosis of sepsis) was 53.9 per cent and treatment started within 60 minutes was 67.2 per cent. This has improved to 70 per cent of Sepsis 6 being undertaken and 90 per cent of treatment started within 60 minutes in March 2020. In March 2020, 93 per cent of observations were recorded within the time as indicated by escalation.

Our performance is under continual review and support from a multi-professional approach including the deteriorating patient team (sepsis and resuscitation practitioners), critical care outreach team, Hospital@Night staff alongside parent teams/ward staff and on call teams. We can also see we are recognising the deteriorating patient early by the overall reduction in cardiac arrest events over time.



We achieved early adoption of the NEWS 2 (National Early Warning Score) before the April 2019 national deadline and are working to ensure we do the same with the new national sepsis management guidance.

We see this work as ongoing and are continually asking what more can be done to create the safest environment for our patients. This means also ensuring we learn from critical incidents, have open candour and all cardiac arrest cases are subject to multidisciplinary review.

Hospital@Night

To support sick or deteriorating patients in the hospital and support the junior doctor workforce, we have set up a new service - Hospital@Night. This is a group of nurses with advanced skills in health assessment and management who support our junior doctors out of hours (overnight and weekends). There are six senior nurses who work through the night and on twilight shifts to capture the peaks of activity. They come with a unique skill set and will build on this as their training progresses so that they possess the skills equivalent to our junior doctor workforce and are able to respond quickly to patients who are clinically deteriorating or where nursing staff require support. They carry a mobile device which informs them of the priority of tasks that are required across the hospital.

GREATix

While we learn from when things go wrong, too often we miss the opportunity to learn from when things go right. The aim is to shift our learning from retrospective negative events to prospective learning where we aim to always get things right, resulting in fewer negative events. At the Trust GREATix has been introduced. This is a reporting system which staff can use to report when an individual has done that little bit extra for a patient, a team has worked well together or a system of working/patient episode of care has been especially effective.

The GREATix system is user friendly, easy and quick to complete and can be accessed from inside and outside the Trust via desktops, laptops and mobile phones. The reporter receives a thank you email for submitting the form and the person or team that is being recognised receives an email thanking them for their actions. Submitted forms, which have wider learning for other teams, will be followed up with a learning conversation with a patient safety champion to enable the wider sharing of best practice.

3.3.9 Patient safety measures

	Actual 2015/16	Actual 2016/17	Actual 2017/18	Actual 2018/19	Actual 2019/20
Patients with MRSA infection per 1000 bed days* Trust Vs. national	0.009 Vs. 0.009	0 Vs. 0.009	0 Vs 0.008	0.004 Vs 0.008	0.004 Vs *
Never events – events that should not happen whilst in hospital Source: adverse incidents database+	1	1	3	0	4
Number of cases of deep vein thrombosis presenting within three months of hospital admission+ Source: see below**	130	138	122	116	136

*Data source: For 2015/16 to 2018/19 from National Statistics on www.gov.uk For 2019/20, for Trust figure, numerator data taken from infection control data system and denominator from the occupied bed statistics in patient administration system. No national figure yet available.

**We review all diagnostic tests for deep vein thrombosis and pulmonary embolism (PE), cross referencing positive tests with past admissions. This methodology is only undertaken by relatively few hospitals as it is labour intensive, but is recognised as giving a more accurate figure for hospital acquired thrombosis. As a further check, we receive notification from the bereavement officer if PE was identified as the primary cause of death.

+ For these two indicators benchmarking data is not available.

Clinical effectiveness

3.4 Do patients receive a good standard of clinical care?

3.4.1 Introduction

This section includes the various initiatives occurring at the Trust to ensure patients receive a good standard of care and examples of where we excel compared to other organisations.

3.4.2 Examples of awards received in improving the quality of care

Nursing Times and Forward Healthcare Awards.

During the year our Cardiac Assessment Unit (CAU) team was shortlisted in the Nursing Times Awards and also won the Initiative of the Year Award as part of the Forward Healthcare Awards. The unit has greatly reduced the time patients wait to be seen and has led to the early diagnosis of several myocardial infarctions (MIs) and reduced admissions.

CAU is a six-chaired specialist area near the Emergency Department run by our cardiac nurse specialists and supported by the on-call cardiology consultant/registrar. It sees patients with chest pain and a low to intermediate suspicion of having an acute coronary syndrome (ACS) or other cardiac conditions where patients are ambulant, such as newly-discovered atrial fibrillation (AF) or other arrhythmias. All of these patients get seen within an hour with the current average being 30 minutes. This has led to the early diagnosis of several MIs, the outpatient management of many arrhythmias that historically would have been admitted, and the safe discharge of the majority of patients, many with further outpatient tests.

Cavell Star Award

Midwives Julie Hughes and Tracey Jones were awarded this national award after their intervention proved life-saving for a dad-to-be who was attending a routine antenatal appointment. They noticed that Sam Hutchins was clearly poorly and insisted he was seen by a doctor straight away. He was diagnosed with aplastic anaemia.

The award is given for exceptional care by The Cavell Nurses' Trust. They were nominated by Sam's mum.

Owen Wade Prize

Two of our trainee doctors, Dr Nikita Goel and Dr Carol Wong, won this prize for their medical case presentation on anaphylaxis to the West Midlands Physicians Association meeting. The panel of judges praised them for presenting data on an important clinical issue and explaining the logic followed to reach their diagnosis well. The trainees were mentored by Dr Prasad Rajendran and Dr Darshan Pandit, who both work in the medical high dependency unit and the case related to a rare case in which a patient was allergic to dialysis.

The Owen Wade Prize is awarded for the best case report and is presented in remembrance of the former dean of Birmingham Medical School who was considered one of the founding fathers of clinical pharmacology and therapeutics in the UK.

Clinical Research Network WM (CRN WM) awards

Our research and development team won two awards at the annual Clinical Research Network WM (CRN WM) awards ceremony. The awards celebrate the wide range of high quality clinical research taking place throughout the West Midlands – improving the health and the wealth of the nation through research. The Trust was presented with the awards for both Creative Recruitment and Business Intelligence Leaders. The first award was for our part in the Pathfinder study which looked for rare diseases from routine pathology results. The Trust had committed to recruiting 50 patients and actually recruited 675 – finding three with rare metabolic diseases who were referred for treatment. The Business Intelligence Leaders award was for our innovative database work which has been shared as good practice outside the Trust, locally across the region and at national meetings and conferences.

Dudley Respiratory Assessment Service (DRAS) and Best Use of Sepsis Data

Two of our teams were named as finalists in the Leading Healthcare Awards 2020. Dudley Respiratory Assessment Service (DRAS) and our sepsis screening EPR tool were both up for awards.

The Trust was successful in winning the award in the category of Best Use of Data for our use of data to improve outcomes for sepsis patients. Introducing a sepsis screening EPR tool increased our sepsis screening of eligible Emergency Department patients from 71 per cent to 97.7 per cent, improving our identification and management of sepsis patients, reducing mortality to a historical low and below national average.

The DRAS service was highly commended. This multi-professional team is dedicated to improving the care and quality of life for respiratory patients. By utilising a forward-thinking, innovative approach to respiratory health they are able to integrate services across secondary, primary and community settings ensuring accessible, holistic care for respiratory patients.

3.4.3 Examples of innovation

Intravenous Iron Injections in the Community

International consensus recommends treating all surgical patients who have pre-operative iron deficiency anaemia. National Institute for Health and Care Evidence (NICE) standards state if oral iron is not appropriate, intravenous (IV) iron should be given. Due to capacity issues, The Dudley Group has developed a unique IV iron service with community based administration. Patients due to have major surgery are identified in a consultant-led surgical pre-assessment clinic, and if required, the patient is referred to the community IV team. The referral for a single dose of IV iron is then administered at Brierley Hill Health and Social Care Centre by registered nurses within the community IV team. This dose of IV therapy replenishes the entire body store of iron. We are the first Trust nationally to deliver IV iron in this community setting. It has been popular with patients and ensures we can treat patients promptly. We have demonstrated that this raises the blood count before surgery, making patients fitter for surgery and also reducing the chances of needing a blood transfusion. All doses have been administered successfully and with no adverse reactions. The additional work has increased the knowledge and skills of the community IV

nurses and developed an integrated pathway between hospital and community services to benefit patient care.

Frailty Assessment Unit

On 1st October 2019 the Trust transformed the way we assess frail elderly patients who arrive at the Emergency Department, ensuring they receive optimal care from a dedicated frailty team providing a comprehensive assessment. The changes enable patient to get home sooner while maintaining their independence. In the past, older frail patients would often be admitted to a frailty ward. This could be a lengthy process, time consuming and repetitive. Also, in a ward such patients are at risk of falls as well as immobility, delirium and loss of independence. Now, a specialist consultant, specialist nurses, physio and occupational therapists, dieticians, discharge co-ordinators and social services provide comprehensive assessment and help them return to their place of residence. From 1st October 2019 to 16th January 2020, 621 patients were discharged back to their place of residence on the same day (75.5 per cent discharges).

Giant Cell Arteritis (GCA)/Temporal Arteritis Diagnosis

Since August 2019 we have a same-day diagnostic ultrasound scanning service for patients with suspected Giant Cell Arteritis (GCA)/Temporal Arteritis who we see as urgent referrals in rheumatology outpatients.

Same-day certainty about the diagnosis of GCA/Temporal Arteritis has improved, thus reducing the need for temporal artery biopsy, the previous gold standard of diagnosis.

Physiotherapist-led balance clinics

Physiotherapist-led balance clinics have been introduced this year. These clinics have provided an improved experience for patients with balance problems, seeing shorter waits and fewer investigations. They also free up ear, nose and throat medical staff time in other areas. The six month pilot of the clinics ran from July - December 2019 with two clinics a week. The results were very positive with 159 patients being seen and only 15 requiring referral to an ENT consultant (11 of which were for non-vestibular problems). The median wait for a clinic appointment was 62 days, with a mean assessment to discharge time of 61 days. 98 per cent of patients who completed their treatment improved in one or more outcome measures, with 65 per cent improving in four or more of the five outcome measures completed. 18/18 cases of benign paroxysmal positional vertigo (BPPV) were successfully treated. Patient satisfaction with the service was extremely positive.

The pilot demonstrated the numerous benefits of allied health professionals being the first and effective point of patient contact: firstly that the vast majority of this caseload can be managed within this setting, secondly that it provides significant clinical benefit to patients and also that patients' experience of this clinic is overwhelmingly positive. This example of multidisciplinary working brings together different skillsets and approaches, which broadens the toolkit any service has to offer patients accessing it. The time and expertise physiotherapists have to offer this caseload of patients with problems with dizziness and/or imbalance fill a gap within existing provision, which often results in patients having to access multiple services with associated waits, which often increases the time it then takes for that patient's condition to improve.

3.4.4 Examples of specific clinical effectiveness initiatives

Stroke service success

The Trust is officially the best in the West Midlands for stroke care, according to a major national healthcare quality improvement programme. It placed us in the top 40 trusts nationally.

The Sentinel Stroke National Audit Programme (SSNAP) measures the quality and organisation of stroke care in the NHS and is the single source of stroke data in the UK. It assesses both the clinical processes of care provided to stroke patients, as well as the structure of stroke services against evidence-based standards, including the 2016 National Clinical Guideline for Stroke. It aims to provide timely information to clinicians, commissioners, patients and the public on how well stroke care is being delivered so it can be used as a tool to improve the quality of care that is provided to patients. Our score makes us the best in the West Midlands. This has been achieved through a number of initiatives such as:

- Twice daily consultant-led ward rounds where important clinical decisions are made.
- A 24-hour stroke specialist nurse-led bleep cover for all stroke referrals including pre-notification from the ambulance crew.
- The stroke co-ordinator ensuring that the targets prescribed in the national audit are achieved for patients from admission to discharge, and getting the team together to put action in place where improvement is needed.
- Imaging of stroke patients in the time specified in the national clinical guidelines for stroke, which has improved our performance to Level A.
- Secretaries bringing all Transient Ischaemic Attack (TIA) referrals to the consultant's attention and with the assistance of the specialist stroke nurse team, referrals are triaged appropriately.
- Dudley Stroke Association providing support to the patients and families after discharge from hospital.

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Anaesthetics Accreditation

Our Anaesthetic Department has been recognised for providing the highest quality care to patients by achieving the prestigious Anaesthesia Clinical Services Accreditation (ACSA).

ACSA from the Royal College of Anaesthetists promotes quality improvement and the highest standards of anaesthetic service. To receive accreditation, departments have to demonstrate high standards in areas such as patient experience, patient safety and clinical leadership, meeting 100 per cent in all areas. It means our patients can be assured they are receiving outstanding service. We are the first Trust in the West Midlands to become accredited and only the 33rd in the UK.

Achieving the Joint Advisory Group on Gastrointestinal Endoscopy (JAG) Standards

The GI Unit was awarded the prestigious JAG accreditation on the same day as the actual inspection in June 2019. This is rarely given on the day of inspection, as there is usually a discussion prior to giving this award. JAG shows that the endoscopy services run at the Trust meet with their criteria for service standards in endoscopy. They are marked against four domains: clinical quality, quality of the patient experience, workforce and training. We have two staff members that are now trained as JAG faculty and can deliver JAG accredited courses on endoscopy externally or they can be run from this Trust at cost to attendees.

Dudley Improvement Practice Events

A number of these events have taken place. For example, in ophthalmology the department started their quality improvement journey with a week-long event to understand and implement improvement ideas. The team ensured they put the patient at the centre of the improvement work by using feedback in person from a regular ophthalmology patient. The aim was to optimise machine utilisation and reduce patient appointment time door to door.

Following the event, OCT machine utilisation jumped from 48 per cent to 71 per cent. Quicker patient journeys occurred – a reduction from two hours seven minutes to 50 minutes in the macular clinic. Adapting rooms improved patient experience – 85 per cent of patients stated they had more privacy with the new room layout. There was improved staff efficiency – using specific outcome trays saves 3.6 hours of work a week. The team have maintained their improvement momentum by having regular huddles, using an improvement visual control board and continually involving the team in decisions and changes.

3.4.5 Clinical effectiveness measures

	Actual 2015/16	Actual 2016/17	Actual 17/18	Actual 18/19	Actual 19/20
Trust readmission rate for Medicine and Integrated Care Division *Vs.* National peer group (acute and specialist trusts) *Source: UHB Hospital Healthcare Evaluation Data (HED)*	8.82% Vs. 8.39%	10.37% Vs. 9.38%	8.76% Vs. 9.30%	8.53%* Vs 9.03%*	9.00%** Vs 9.03%**
Number of cardiac arrests*** *Source: Logged switchboard calls*	144	136	118	97	68
% of patients admitted as emergency for fractured neck of femur operated on within 36 hours *Vs.* National average+ *Source: NHFD (National Hip Fracture Database)*	82.3% Vs. 73.8%	82.5% Vs. 71.7%	80.5% Vs. 70.4%	84.0% Vs. 70.8%	75.7% Vs. 67.5%

*These updated figures are for the whole year. Last year's report included the figures available at the time of printing.

** Both Trust and National Peer Figures are April 2019 to January 2020, the latest HES period available.

+ In 2019/20 the indicator was amended from surgery within 36 hours to 'prompt surgery', with prompt surgery being on the same day or the day following the patient presented with the fracture. This new measure is consistent with NICE clinical guidelines (CG124). The results are also now provided by calendar not financial year so the figures for 2019/20 are for the calendar year 2019.

*** For this indicator, benchmarking data is not available.

3.5 Our performance against the thresholds set out in the Risk Assessment and Single Oversight Frameworks of NHS Improvement*

National targets and regulatory requirements	Trust 2015/16	Trust 2016/17	Trust 2017/18	Trust 2018/19	Target 2019/20	National 2019/20**	Trust 2019/20	Target Achieved ?
Maximum time of 18 weeks from point of referral to treatment (RTT) in aggregate – patients on an incomplete pathway	95.06%	95.43%	94.0%	93.64%	92%	85.8%	93.19%	☺
A&E: maximum waiting time of 4 hours from arrival to admission, transfer, discharge	98.18%	94.16%	86.56%	83.96%	95%	84.2%	81.98%	☹
All cancers: 62 day wait for first treatment from urgent GP referral for suspected cancer	84.3%	85.3%	86.3%	82.9%	85%	N/A	78.3%	☹
All cancers: 62 day wait for first treatment from NHS Cancer Screening Service referral	96.2%	98.2%	98.3%	98.1%	90%	N/A	91.2%	☺
Maximum 6 week wait for diagnostic procedures	98.97%	97.41%	97.86%	98.82%	99%	88.91%	96.69%	☹
Venous Thrombolism (VTE) Risk Assessment	95.96%	94.75%	93.38%	94.89%	95%	N/A	93.85%	☹

* Thresholds are also set out for two other indicators the data of which can be found in the following sections: SHMI (section 2.2.8) and C. Difficile (sections 2.1.3/2.2.8)
☺ = Target achieved ☹= Target not achieved
**2019/20 National Figures taken from NHS Statistics and Cancer Waiting Times Database (quarterly figures averaged)
N/A= Not available

3.6 Glossary of terms

A&E	Accident and Emergency (also known as ED)
AAA	Abdominal Aortic Aneurysm
AKI	Acute Kidney Disease
ALARP	As Low As Reasonably Practicable principle
AMU	Acute Medical Unit
ANP	Advance Nurse Practitioner
App	A computing application, especially as downloaded by a user to a mobile device.
Bed Days	Unit used to calculate the availability and use of beds over time
BFI	Baby Friendly Initiative
CAMHS	Child and Adult Mental Health Service
C. diff	Clostridium difficile (C. difficile)
CCG	Clinical Commissioning Group
CMP	Case Mix Programme
CNS	Clinical Nurse Specialist
CPR	Cardio Pulmonary Resuscitation
CQC	Care Quality Commission
CQUIN	Commissioning for Quality and Innovation payment framework
CT	Computed Tomography
CTG	Cardiotocograph
CTPA scan	CT pulmonary angiogram is a CT scan that looks for blood clots in the lungs
DATIX	Company name of incident management system
DNACPR	Do Not Attempt Cardio Pulmonary Resuscitation
DVD	Optical disc storage format
DVT	Deep Vein Thrombosis
EAU	Emergency Assessment Unit
ECG	Electrocardiograph
ED	Emergency Department (also known as A&E)
EmLap	High Risk Emergency Laparotomy Pathway
ENT	Ear, Nose and Throat
FCE	Full Consultant Episode (measure of a stay in hospital)
FFT	Friends and Family Test
FY1/FY2	Foundation Year Doctors
GI	Gastrointestinal
GMC	General Medical Council
GP	General Practitioner
HCAI	Healthcare Associated Infections

HDU	High Dependency Unit
HED	Healthcare Evaluation Data
HES	Hospital Episode Statistics
HQIP	Healthcare Quality Improvement Partnership
HSCIC	Health and Social Care Information Centre
ICNARC	Intensive Care National Audit & Research Centre
IPC	Infection Prevention and Control
IPCS	Intermittent Pneumatic Compression
ISO	International Organization for Standardization
KPI	Key Performance Indicator
LocSSIPS	Local Safety Standards for Invasive Procedures
MBC	Metropolitan Borough Council
MCP	Multispecialty Community Provider (now called Integrated Community Provider)
MDT	Multidisciplinary Team
MRI	Magnetic Resonance Imaging
MRSA	Methicillin-resistant Staphylococcus aureus
MUST	Malnutrition Universal Screening Tool
NatSSIPS	National Safety Standards for Invasive Procedures
NBM	Nil By Mouth
NCEPOD	National Confidential Enquiry into Patient Outcome and Death
NEWS	National Early Warning System
NHSI	NHS Improvement
NICE	National Institute for Health and Care Excellence
NIHR	National Institute for Health Research
NMC	Nursing and Midwifery Council
NPSA	National Patient Safety Agency
NRSA	National Research Service Award
NVQ	National Vocational Qualification
PE	Pulmonary Embolus
PFI	Private Finance Initiative
PHE	Public Health England
PLACE	Patient-led Assessments of the Care Environment
PROMs	Patient Reported Outcome Measures
RAG	Red/Amber/Green
RCA	Root Cause Analysis investigation
RCPCH	Royal College of Paediatrics and Child Health
RECOVERY	Randomised Evaluation of COVID-19 Therapy

SHMI	Summary Hospital-level Mortality Indicator
SMS	Short Message Service is a text messaging service
SOP	Standard Operating Procedure
STEIS	Strategic Executive Information System is the national database for serious incidents
STEMI	ST-Elevation Myocardial Infarct
SUNRISE	Trust electronic patient record system
SUS	Secondary Uses Service
TTO	To take out medications once discharged as an inpatient
UKOSS	UK Obstetric Surveillance System
VQ scan	A ventilation–perfusion (VQ) scan is a nuclear medicine scan that uses radioactive material (radiopharmaceutical) to examine airflow (ventilation) and blood flow (perfusion) in the lungs.
VTE	Venous Thromboembolism
YTD	Year To Date

Annex

Comment from the Trust's Council of Governors (received 18/05/2020)

The Council of Governors have reviewed the 2019/20 Quality Account and acknowledge the Trusts focus on delivering high quality services during another challenging year.

Governors fully support the chief executive's statement in Section 1 of this report.

During yet another challenging year for the NHS and in particular The Dudley Group, the Council of Governors has closely monitored performance and with regular updates and briefings from the Board of Directors. This has provided the Council with the assurance that where effective actions have been taken there has been sufficient evidence to show improvement trajectories or where further action is required.

The governors have supported the board to expand the non-executive cohort to strengthen the skills and expertise with an emphasis on bolstering the clinical leadership of the Trust. Governors have continued to maintain a close working relationship with the non-executive directors in holding them to account for the performance of the Trust in a year that saw a sustained increase in demand on resources.

There has been a particular focus on its registrations and CQC reviews. It was evident that whilst there were many areas in which the Trust was performing well, there were others such as the Emergency Department that the CQC highlighted was performing below the requirements for improved triage time, managing the deteriorating patient and sufficient staffing levels. The Council has continued to challenge the Board and have noted the ongoing and sustained efforts and is assured that whilst the Trust is now performing well in these areas, continual improvements and monitoring remains in place and is under Council scrutiny. The Council acknowledge and endorse the need for the local health economy to work together to ensure effective patient flow is achieved and those patients receive the most appropriate care in the most appropriate setting.

The Council of Governors continue to support the identification and simplification of the quality indicators for 2020/21 and during the year had sought feedback from Foundation Trust members and the wider community at a series of engagement events. Governors participated in a Listening into Action event and used this feedback to identify and support the selection of the Quality Indicators to take forward in to 2020/2021.

The Council have continued to review the performance data over the year against each of the indicators set and for the constitutional performance standards. Regular detailed reports are provided to the full Council and to its sub committees that provide an opportunity to make comments on specific examples of good performance and areas that have performed less well. Governors maintain a regular attendance at the monthly board meetings. Once again governors have been involved in supporting the Trust with its annual planning cycle.

The governors fully support the Trust's ongoing commitment to Dudley Improvement Practice and acknowledge the fantastic developments and achievements the Trust has made including its launch of a one-stop pre-op assessment service, demonstrated acting on feedback received, introducing Greatix and setting up of the frailty assessment unit and improved pressure ulcer management that has positively impacted the lives of many patients.

Governors have played an active role in undertaking quality audits and have supported the Trust with governors attending many of the quality and safety audits by visiting wards, outpatients and community

settings. Again, where areas for improvements are identified, the Council is assured that there are robust mechanisms and processes in place to ensure action is taken and quality sustained.

Members of the Council of Governors have also participated in a wide range of Trust activities including PLACE assessments, observing committees of the Board, supporting patient care and experience initiatives such as Nutrition and Hydration Week, pressure ulcer and sepsis awareness weeks. Governors have also supported the five public facing engagement events held during the year at Russells Hall Hospital, Corbett and Guest outpatient centres and Brierley Hill Health & Social Care Centre.

We have continued to actively engage and participate in a range of community events across the Dudley borough and surrounding areas with regular attendance at the Dudley Public Healthcare forums and attending community and support groups in the Dudley borough, all of which provide an opportunity to gain feedback directly from patients and their families and carers.

The council have been focused on workforce matters and have championed the importance of using the results from the national staff survey to support the development of initiatives to increase staff satisfaction with their work place. The council closely monitor the key performance metrics and seek assurance on the effectiveness of improvement actions. In the Year of the Nurse it is good to see many awards being won by Trust staff.

The Council of Governors wish to place on record their thanks to all staff for their hard work, commitment and dedication to ensuring that the Trust is delivering safe, effective and high quality services to the people of Dudley and those in the surrounding areas.

Comment from the Dudley Clinical Commissioning Group (received 09/06/2020)

We are pleased to comment on the Trust's 2019/20 Quality Account.

The Trust during 2019/ 20 outlined the intention to focus on improving the experience of the patient. The CCG notes key areas for improvement, and it is encouraging to recognise the work undertaken to improve the outcomes for patients with sepsis. This was a key area of focus following the CQC inspection report.

The Trust has demonstrated that they have worked hard to improve the experience of patients who attend the ED department. The CCG particularly recognises the efforts being made to support patients with a learning disability and/or autism, reinforced by working closely with the patient, their families and their carers.

The CCG is pleased that the Trust has reduced the occurrence of pressure ulcers, both in the acute and community settings, this is a positive achievement and will lead to improved patient outcomes. We understand that the introduction of the 'lunch and learn' exercise has been pivotal in achieving these improvements for staff teams. The Trust supported a CCG assurance review in this area.

The CCG welcomes the Trust's commitment to review all deaths as part of the joint mortality group. The Trust has demonstrated that learning from the mortality review process has been of significant benefit and has taken required actions forward to embed the lessons identified.

The ongoing challenge to address the pathway for patients from referral to booking has been a feature for the Trust. It is pleasing to acknowledge the work of the Trust with the cancer collaborative which has served to enhance the clinical pathway for treatment for cancer. Reducing diagnostic blockers and improving the time between referrals and bookings for treatment has been an identified priority. The CCG will require assurance that newly embedded systems and processes are in place to ensure that this area continues to receive focus.

The Trust has continued to achieve a reduction in the number of patients with Clostridium difficile during 2019/20, with one Trust assigned MRSA bacteraemia during this period.

The CQC inspected the Trust during 2019/20 with the Trust receiving an overall rating of 'Requires Improvement'. The CCG commends the work of the Trust during this period which resulted in end of life care and community services achieving an 'Outstanding' rating for 'Caring'. Conversely, diagnostic imaging and urgent and emergency planning was rated as 'Inadequate' and the Trust will need to continue to prioritise these areas identified for improvement.

It is positive to note the awards presented to the dedicated staff who have excelled in service delivery, both in practice, research and innovation. The staff survey, however, shows evidence that there has been a decrease in the percentage of staff who would recommend the Trust as a place to receive treatment from 70 per cent in 2017, although it increased slightly from 56 per cent in 2018 to 59 per cent in 2019. The CCG will be keen to follow the Trust's outlined plans to amend this view held by staff.

The CCG looks forward to the Trust remaining an integral part of the newly introduced Integrated Community Provider (ICP) in Dudley. We will continue to work in partnership with the Trust to improve outcomes for patients.

Neill Bucktin
Dudley Managing Director – Black Country and West Birmingham Clinical Commissioning Groups

Comment from Healthwatch Dudley (received 27/04/2020)

COVID-19

We appreciate that the draft Quality Report and Account 2019/20 was written before the start of the COVID-19 crisis and its huge impacts on the Trust and all of the staff who work there. We want to thank all NHS staff for their outstanding commitment and effort to providing healthcare services for people during a period of unprecedented demand for advice and help.

We acknowledge that much good work has been done to improve services and we make some comments on this work specifically. But, for the most part the remainder of this review of the Quality Report and Account focuses on the opportunities that exist for continuing to improve health and care services for people.

In 2020 there will also be exciting new opportunities to reconfigure and improve how healthcare services work for people when the new Integrated Care Provider organisation becomes fully operational.

Achievements and more to do

We welcome the decision to include a new focus for 2020/21 on improving people's experience of accessing help and care in hospital and on discharge management. At the same time, we acknowledge all of the good work that has been done to deliver on actions designed to improve diagnostic imaging services that were deemed to be inadequate and also sepsis recognition and treatment services. We note that this improvement has occurred against a background of CQC inspection in 2019 which resulted in a disappointing overall rating of Requires Improvement for the Trust.

It is also noted though that recent National Inpatient Survey patient experience indicators that are referred to in the Quality Report and Account document are lower than the national average figures for Trusts. In

turn the percentage of staff who would recommend the Trust to friends or family needing care stands at 59 per cent of those who responded to the question. On the Friends and Family Test the percentage of respondents recommending a service to others was below what would be expected for inpatient, accident and emergency, community, maternal postnatal ward and outpatients services from October 2019 through December 2019. We would like to see evidence of improvement in these indicators for the next Quality Report and Account in 2020/21.

We recognise the range of developments that have occurred to improve patient experience during 2019/20 such as the increased involvement of patient experience volunteers to carry out ward visits and promote the Friends and Family Test.

In the Friends and Family Test response rates we note that in quarter three there was a fall in number of people saying that they had received a 'Welcome to Russells Hall' booklet when they reached the ward. We recognise that this was due to a lack of supplies of booklets during November 2019. We find this disappointing, as Healthwatch Dudley has received feedback from the public on how a lack of information and poor communication impacts on their experience of accessing healthcare services and hope this can be addressed in 2020/21.

Priorities for Improvement

We note the good progress made on reducing the incidence of pressure ulcers in hospital and out in the community. And the work the Trust has been doing to maintain good infection control practice.

- *Patient experience:* This is a welcome new priority with a focus on improving communications and engagement work with the wider public and people accessing hospital services – with the establishment of a Citizens Panel and an Expert Volunteers group. Healthwatch Dudley supported the Trust with two community engagement events in February 2020, where local people discussed their role in helping to shape hospital services. We look forward to seeing how the Trust develops these panels moving forward to ensure the voice of the public is heard, taken seriously and acted upon.

- *Nutrition and hydration:* It would be good to see the system of supported mealtimes adopted throughout the hospital as soon as possible. At the same time, ensuring every person admitted for acute care has a nutritional assessment within 24 hours unless there are very exceptional reasons why this cannot happen. It is good that there is a strong desire to get people's views on mealtimes, using an audit, and to increase volunteer assistance at mealtimes. We want to see evidence of how this is happening in the Quality Report and Account for 2021/22.

- *Medications:* We note there is still more work that can be done to further increase the percentage of people who are known to be at risk of having an adverse reaction to a medication who are identified.

- *Discharge management:* There has been much welcome improvement in the number of Expected Discharge Dates set for adults. There is though still an opportunity to continue to improve on the numbers and we would like to see this happening and reported on. This work could happen alongside the work being done to develop the 'Perfect Discharge' designed to keep people accessing hospital services and their family members informed about what is happening. This has been an area where Healthwatch Dudley has received comments from people on how information, communications and procedures have not always worked as well for them.

Healthwatch Dudley, April 2020

Comment from Dudley MBC Health and Adult Social Care Scrutiny Committee (received 25/06/2020)

Dudley's Health and Adult Social Care Scrutiny Committee is pleased to have been allowed the opportunity to review Dudley Group NHS Foundation Trust's Quality Accounts for 2019-20. Due to restrictions brought about by the COVID-19 pandemic a formal Scrutiny meeting was not possible so the review has been undertaken through Members' written questions and comments. In turn, clarifications by the Trust have been incorporated into the final version of the Quality Accounts.

Within the domain of Patient Experience, Members would like to know more about the experience of patients (and their carers) with dementia when the 2020-21 Quality Accounts are written.

Under Discharge Management, further information about the new multi-disciplinary model in the Acute Medical Unit would be very welcome. Members noted that a relatively low proportion of patients had been discharged in the morning and are pleased to understand that increasing this is a priority for 2020-21.

Members noted that the audit of the exercise program for patients with intermittent claudication had suggested that the current approach is ineffective. We would welcome further work to understand any barriers to patients and so that a service model can be developed that improves patient outcomes.

It is reassuring to see that the total number of reported incidents is increasing which can be the sign of an open and honest culture. We are pleased that the Trust supports staff to join a relevant trade union and would welcome greater visibility to the various ways in which staff could raise concerns.

In subsequent Quality Accounts, Members would be pleased to learn more about medical research that the Trust is undertaking and any awards that have been granted. Members would like to understand more about how the Trust considers its role as an "anchor" organisation in supporting the health, wellbeing, employment and economy of Dudley. Finally, being mindful of the COVID-19 pandemic, Members would like to understand how Dudley Group has mitigated the massive and unexpected challenges brought by the pandemic.

Dr David Pitches, Head of Service, Healthcare Public Health and Consultant in Public Health, Dudley Metropolitan Borough Council

Statement of directors' responsibilities in respect of the Quality Report 2019/20

The directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations to prepare Quality Accounts for each financial year.

NHS Improvement has issued guidance to NHS foundation trust boards on the form and content of annual quality reports (which incorporate the above legal requirements) and on the arrangements that NHS foundation trust boards should put in place to support the data quality for the preparation of the quality report.

In preparing the Quality Report, directors are required to take steps to satisfy themselves that:
• the content of the Quality Report meets the requirements set out in the *NHS foundation trust annual reporting manual 2018/19* and supporting guidance *Detailed requirements for quality reports 2019/2020*
• the content of the Quality Report is not inconsistent with internal and external sources of information including:

- board minutes and papers for the period April 2019 to May 2020
- papers relating to quality reported to the board over the period April 2019 to May 2020
- feedback from commissioners Dudley Clinical Commissioning Group dated 9/06/2020
- feedback from governors dated 18/05/2020
- feedback from local Healthwatch organisation Healthwatch Dudley dated 27/04/2020
- feedback from Overview and Scrutiny Committee Dudley Metropolitan Borough Council Health and Adult Social Care Scrutiny Committee dated 25/06/2020
- the Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated 2019/20
- the latest national patient survey 2019
- the latest national staff survey 2019, dated June 2019
- the Head of Internal Audit's annual opinion over the Trust's control environment dated May 2020
- CQC inspection report dated 12th July 2019

• the Quality Report presents a balanced picture of the NHS foundation trust's performance over the period covered
• the performance information reported in the Quality Report is reliable and accurate
• there are proper internal controls over the collection and reporting of the measures of performance included in the Quality Report, and these controls are subject to review to confirm that they are working effectively in practice
• the data underpinning the measures of performance reported in the Quality Report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review
• the Quality Report has been prepared in accordance with NHS Improvement's annual reporting manual and supporting guidance (which incorporates the Quality Accounts regulations) as well as the standards to support data quality for the preparation of the Quality Report.

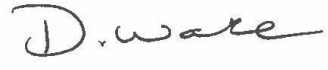
The directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the Quality Report.

By order of the board

Signed: Date: July 2020

Dame Yve Buckland
Chairman

Signed: Date: July 2020



Diane Wake
Chief Executive

Enclosure 21

The Dudley Group NHS Foundation Trust

Paper for submission to the Board of Directors on 10 September 2020

TITLE:	**Exception Report from the Finance and Performance Committee Chair**		
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 from the Finance and Performance Committee held on 30 July and the informal Committee meeting held on 27 August 2020.

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:** 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

EXCEPTION REPORT FROM FINANCE AND PERFORMANCE COMMITTEE CHAIR

Meeting held on: 30 July 2020

MATTERS OF CONCERN OR KEY RISKS TO ESCALATE

- Scale of cyber security risk (score of 25) and whether or not sufficient back up arrangements are in place
- BAF risk 6A remains high (20) largely due to continued uncertainty around the MCP. In particular how would the trust perform in a post event independent review?
- Staff costs remain high, in part due to accrual of untaken leave
- Committee remains concerned that under the existing funding framework it is difficult to identify the underlying performance of the Trust
- Continued delay in decision about funding of the proposed modular ward
- Significant external risks to restoration and recovery of services

MAJOR ACTIONS COMMISSIONED/WORK UNDERWAY

- Budgets for the remainder of the year to be presented to informal F&P meeting in August
- Restoration and recovery report to be further refined for August meeting to focus on key messages around targets, performance, making good performance shortfalls, risks and dependencies

POSITIVE ASSURANCES TO PROVIDE

- Continue to breakeven and cash position remains strong. Existing funding framework will remain in place for month 5 and most likely for month 6 also
- Continued good ED performance despite rising attendances
- Restoration and recovery broadly on track with overall performance of 74% by end June compared to the target of 75%. Trust is performing well compared to peers

DECISIONS MADE

- Cyber security risks transferred to Digital and Technology Committee

Chair's comments on the effectiveness of the meeting: Efficient and business like meeting

The Dudley Group NHS Foundation Trust

EXCEPTION REPORT FROM FINANCE AND PERFORMANCE COMMITTEE CHAIR

Meeting held on: 27 August 2020

MATTERS OF CONCERN OR KEY RISKS TO ESCALATE	MAJOR ACTIONS COMMISSIONED/WORK UNDERWAY
• Funding framework for second half of the year still not entirely clear, but will be based on activity levels with rewards/penalties for over/under delivery at a STP level. There is a risk that the funding provided will not be sufficient to deliver the activity targets set by NHSI • Pay costs £1.7m over plan and bank and agency spend rising. Agency spend now in line with last year • Not expected to meet NHSI's recovery targets, although not out of line with other Trusts in our system in this regard	•
POSITIVE ASSURANCES TO PROVIDE	**DECISIONS MADE**
• Costs broadly in line with block contract and top-up; only £90k extra required in the first four months despite £6m of COVID costs. Costs also broadly in line with same period of the previous year • NHSI has not challenged any of the Trusts financial returns • Current funding framework (and therefore break-even position) extended until the end of September • Cash position remains strong and compliance with Better Practice Payment Code for non-NHS suppliers almost 74% • Budgets for second half of the year to be presented to September F&P	• Board to be updated on the forward view of activity and finances for the remainder of the year, the aspirations for service delivery and the potential financial risks
Chair's comments on the effectiveness of the meeting: Good focus on finance and restoration and recovery of services	

Enclosure 22

Paper for submission to the Board on 10th September 2020

TITLE:	**Workforce and Staff Engagement Committee Report**		
AUTHOR:	**James Fleet** **Chief People Officer**	**PRESENTER**	**Julian Atkins** **NED & Chair WSEC**
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.*	
SO1: Deliver a great patient experience, SO4: Be the place people choose to work			

SUMMARY OF KEY ISSUES:

The Workforce and Staff Engagement Committee convened its second Deep-Dive session, focusing on Equality and Inclusion, on 25th August.

Objectives for the session were:

1. Review to early progress with the Staff Inclusion Networks, including; feedback from the Chairs and Exec/NED sponsors, as well as critically reviewing the steps that are in place to support and champion the Networks to participate in and inform Trust decision making and strategy, including; support to Network Chairs and Equality & Inclusion Comms Strategy
2. Share the plan for establishing the Disability Staff Inclusion Network
3. Share, test and discuss highlights, key messages and actions emerging from the Equality and Inclusion Deep-Dive analysis that has been undertaken.
4. Share, test and discuss the DRAFT WDES/WRES submissions, in advance submission by 31st August.
5. Consider the action required to deliver the Equality & Inclusion requirements from the new national People Plan (We are the NHS: People Plan 2020/21 – action for us all).
6. Update on Board & Senior Leadership Development Programme - Cultural Intelligence (CQ) and Inclusive Leadership Programme
7. Review, test and approve the DRAFT Inclusion Mentoring programme
8. Review, test and approve the planned actions to strengthen Promotion, Progression, Development and Training for Diverse Staff Groups
9. Provide an update on the approach to reviewing all HR Policies to ensure that they reflect Equality & Inclusion best practice.

Overview - Key Actions, Decisions and Updates:

- The Deep-Dive session was well attended session, with strong engagement and participation from all attendees.
- The high quality of the work undertaken on the analysis and papers was excellent and acknowledged by attendees. By way of example the Deep-Dive analysis work that was presented aligns the strong messages from staff that have come through the 2019 Staff Survey with; the Trust's workforce information relating to; representation, recruitment, training/development and career progression.
- I was encouraged by the calibre of the discussions, the focus and evident commitment by attendees that Equality and Inclusion is a high priority for the Trust.
- The analysis that was presented provides a level of detail, insight and clarity that hasn't previously existed and a level of analysis that will help accelerate improvement and transformation, as well as facilitate the work plans for the Engagement Networks. This analysis provides a much more forensic view of the challenges, at Trust, Division/Service, Staff Group and protected characteristic level. Whilst recognising that some of the messages emerging for the analysis are uncomfortable to read, attendees

at the Deep-Dive responded positively and recognise the current position as being the basis from which significant improvements can be made to embed a culture of inclusion, champion diversity and ultimately create a more diverse organisation, at all levels.

- A robust set of Trust level actions, corporate commitments and improvement initiatives were presented, discussed and 'tested', including action across the following domains, with a requirement for Divisional Directors and Professional Leads to develop priority actions, reflecting the 2019 Staff Survey results, the Divisional and staff group analysis from the Deep-Dive analysis and the planned 2020 WDES and WRES submission, for their areas and report back to the September meeting of the WSEC. These plans will be reviewed by the Staff Inclusion Networks at their October meetings, with regular updates to WSEC and ongoing assurance through WSEC :

  - Leadership and cultural transformation;
  - Positive action and practical support
  - Accountability and assurance
  - Monitoring progress and benchmarking

- It was encouraging to hear the positive feedback from the Inclusion Network Chairs from the inaugural meetings of the BAME and LGBTQ+ Networks that were held in July. Plans for launching the Disability Network (Karen Kelly ED Sponsor/Professor Elizabeth Hughes NED Sponsor) were also shared, which draw on the learning from the recent launch of the BAME and LGBTQ+ Networks. The launch meeting foe the Disability Network is planned for September, with support from NHSI/E's national Disability Lead. The Network Chairs provided positive updates from the early discussions within the Networks and outlined some ambitious plans, which was encouraging to hear. The Network Chairs value the support package that the Trust is putting in place for the Networks to help them realise their potential in making a very active and real impact on Trust decision making, strategy and most importantly the lives of diverse staff form across the organisation. The support package includes:

  - Appointing Exec/NED Sponsors
  - Network Chairs to be invited to feedback to Trust Board on a quarterly basis
  - Dedicated budget assigned to each Network
  - Facility time has been secured for the Network Chairs and other Network leads, i.e. LGBTQ+ Network engagement lead. Members of the network are also being supported with release to attend the network meetings/activities
  - Cherron Inko-Tariah MBE (author of *The Incredible Power of Staff Networks*) has been commissioned to provide coaching and mentoring support to the network Chairs, including:
    1. Attending a meeting of the BAME and LGBTQ+ Networks (Sep/October) to; observe Chairs in action; and identify key areas to strengthen the operation of the networks
    2. Provide 1:1 coaching with the Chairs
    3. Review documentation such as Terms of Reference and Work plan
    4. Share observations with the Trust Board and suggestions about how the Board can best support the network to be effective and successful.
    5. Devise and deliver a practical session which aims to empower employee network leaders and equip them with tools to help the network be more effective OR a general webinar helping people understand the power of staff networks.
  - The Inclusion Networks will have regular access to Board members, through the Workforce & Staff Engagement Committee, as well as being invited to feedback to the Trust Board on a regular basis.

- The WDES and WRES submission (due 31st August) evidences some of the challenges that staff from diverse backgrounds experience in the Trust. The 2020 submissions, which will be reported back to the Trust/nationally in October will highlight some areas of improvement, but also a number of areas where the Trust's position has worsened, specifically Disabled staff entering the formal capability process, and BAME staff representation at Board level. Work has also been undertaken to effectively create a 'Dudley WSES', utilising and applying the WDES/WRES framework to the Trust's position in relation to Sexual Orientation. This is excellent work and reflects the scale of the opportunity for Dudley to innovate in the way that we embed an environment of equality and inclusion. We understand that the WRES/WDES results will be shared at a system level and will form a core part of the Black Country People Plan, and the new STP Workforce KPI Dashboard, which is due to be launched in September.

- There was an active discussion on the new national People Plan (We are the NHS: People Plan 2020/21 – action for us all), which specifies a total of 36 requirements for NHS providers, including a range of measures to strengthen equality and inclusion (Chapter 3 – Belonging in the NHS). A Draft Trust level plan was shared, with an action for Divisional and corporate leads to review these and share comments/feedback to James Fleet and Becky Cooke. An updated version of the plan will be reviewed by the Inclusion Networks at their September meeting, and presented to the Board in October.
- An Equality and Diversity Communications Plan was presented, which was well received by the group, which drew on some insightful analysis of comms activity over the past 12 months.
- The DRAFT programme for Inclusion mentoring was shared, which received full support from attendees, this programme will be launched in September and has the potential to deliver huge organisational benefits, including;
  - Providing a platform to shape leadership which addresses diversity and inclusion as core elements;
  - Actively facilitating the participation and confidence of staff from diverse backgrounds, as well as visibility and role modelling for the Trust's wider diverse staff population;
  - Supporting Mentees to develop their capability, cultural awareness, intelligence and insight for leading diverse teams. This programme builds inclusive leadership competencies, such as; adaptability;
  - Mentors broaden their network through building mutually beneficial relationships with senior leaders.
- It was positive to receive an update on the appointment of the new Head of Equality and Inclusion, which is a new leadership role that brings dedicated leadership capacity to help develop and progress the equality and inclusion agenda. Shabir Mohammed Abdul will be joining the Trust at the end of October. Shabir is currently Equality, Diversity and Inclusion Manager at Epsom & St Helier University Hospitals NHS Trust. Shabir is very looking forward to joining the Trust and will be engaging with some individuals ahead of joining in October. Shabir will be building on the work that has bene delivered in recent months, to develop a transformational Equality and Inclusion Strategy for the Trust.

The next Workforce and Staff Engagement Committee Deep-dive session is planned for 27th October and will focus on Organisational Development/Leadership Strategy.

IMPLICATIONS OF PAPER:

RISK	**Y**		**Risk Description: corporate risk register recruitment and retention of staff**
	Risk Register: Y		**Risk Score:**
COMPLIANCE and/or LEGAL REQUIREMENTS	**CQC**	**Y**	**Details: Caring, Well Led**
	NHSI	**Y**	**Details:**
	Other	**N**	**Details:**

ACTION REQUIRED OF COMMITTEE :

Decision	Approval	Discussion	Other
	√	√	

RECOMMENDATIONS FOR COMMITTEE:

Note and support the key developments, actions and decisions.

Enclosure 23

Paper for submission to Board 10th September 2020

The Dudley Group NHS Foundation Trust

TITLE:	**ENC 24: Workforce KPIs**		
AUTHOR:	**James Fleet – Chief People Officer** **Graeme Ratten – Senior Information Analyst**	**PRESENTER:**	**James Fleet – Chief People 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
	X	x	

RECOMMENDATIONS

For the board to receive and note the report and its contents.

CORPORATE OBJECTIVE:

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

SUMMARY OF KEY ISSUES:

- The overall total Sickness Absence value for July was 7.6%, down from 7.8% in June and 9.3% in May. This has continued to fall during August, and on Friday 28th overall Sickness Absence was 5.1%, of which 1% point was due to COVID absences (51 staff).
- Both Bank and Agency usage has remained constant during April, May & June, but has increased slightly in July, despite contracted WTEs increasing slightly.
- Mandatory Training compliance in July was 85.8%, down from 86.7% in June. The categories with the most significant compliance changes are: Infection Control (Clinical) -4.3%, Manual Handling (Patient) -4.1%, Resus (Adult) -3.6%, Resus (Neonatal) -4.1%
- In terms of staff in post, the largest shortfall in Qualified Nurses: Medicine and Integrated Care (MIC) are short 178 WTE, and Surgery are short 126 WTE, giving a total of 304 between these two divisions.
- The current open HR caseload of 45 is dominated by 'Disciplinary' cases at 44%, with 5 current suspensions. Cases related to BAME staff represent 16% of the total, with 67% related to Non-BAME staff (the balance are where staff have not stated their ethnicity).There are currently no suspensions of BAME staff members.

IMPLICATIONS FOR THE CORPORATE RISK REGISTER OR BOARD ASSURANCE FRAMEWORK **(***set out narrative here)*			
RISK	**N**		**Risk Description:**
	Risk Register: Y/N		**Risk Score:**
COMPLIANCE and/or LEGAL REQUIREMENTS	**CQC**	**N**	**Details:**
	NHSI	**N**	**Details:**
	Other	**N**	**Details:**
REPORT DESTINATION	**EXECUTIVE DIRECTORS**	**Y/N**	**DATE:**
	WORKING GROUP	**Y/N**	**DATE:**
	COMMITTEE	**Y/N**	**DATE:**

NHS
The Dudley Group
NHS Foundation Trust

Enc 24 – Workforce Board Report

10th September 2020

James Fleet, Executive Chief People Officer




Summary 1/4	*Performance*	*Action*
Sickness & Absence	o The overall Sickness Absence value for July was 7.6%, down from 7.8% in June and 9.3% in May. o The overall Sickness Absence is at 5.1% as at Friday 28th August. Of this, 1.0% point is accounted for by COVID absences (51staff), and 4.1% points all other sickness. We continue to track and focus on the absence status on a daily basis. o This compares favourably with the Trust target of 3.5% sickness absence, as non-COVID absence performance continues to trend downwards.	✓ A file audit tool has been developed and a monthly file audit process has commenced that will spot check both short and long term absence. ✓ Monthly sickness absence reports are being sent to managers, detailing both short and long term absence. ✓ The operational HR team convene monthly meetings with managers to support, advise and challenge action that is being taken to manage sickness absence, ✓ reports will be provided to Divisional Directors and Heads of Service to ensure sufficient senior leadership oversight.
Bank & Agency Usage	o Both Bank and Agency usage has remained fairly constant during April, May & June, but has increased slightly in July, despite contracted WTEs increasing. o The sum of all WTEs worked is still below the funded establishment.	✓ Tailored action plans are being developed to prioritise recruitment and retention for each Division, to include; cohorting vacancies to create more effective recruitment 'campaigns'. There is also system-wide work being undertaken to consider how system wide recruitment activity can be leveraged. We have recently partnered with Wolverhampton to attract a larger pool of candidates for the Head of Equality & Inclusion. ✓ Authorisation levels have been reviewed and revised within Health Roster to ensure there is senior nursing oversight for agency usage. ✓ Significant improvements have been delivered in the efficiency and effectiveness of the recruitment process., as evidenced through TRAC benchmarking analysis. ✓ Development of the Business Partner model to include monthly operational business meetings to support advise and challenge action that is being in relation to vacancies, retention and bank and agency usage.

Summary 2/4	*Performance*	*Action*
Mandatory Training	o Compliance in July was 85.8%, down from 86.7% in June. The categories with the most significant compliance changes are: Infection Control (Clinical) -4.3%, Manual Handling (Patient) -4.1%, Resus (Adult) -3.6%, Resus (Neonatal) -4.1% o Compliance rates continue to be impacted by staff absence and a reduction in the provision of face to, particularly face training due to social distancing measures. Online training remains available for a number of subjects, areas most impacted include manual handling.	✓ An action plan is being devised along with a trajectory for the Divisions to achieve mandatory training compliance in those areas which have historically failed to deliver compliance, this plan is being presented to the September WSEC. ✓ Restrictions to the amount of attendees continue and exploration of adjusted delivery such as video recording or live streaming of demonstration aspects of sessions. ✓ Additional training sessions have been offered from April to August 2020 to mitigate reduced attendances during in April.
Workforce Profile	o The largest shortfall in staff is in Qualified Nurses: Medicine and Integrated Care (MIC) are short 178 WTE, and Surgery are short 126 WTE, giving a total of 304 between these two divisions. o Clinical Support also shows a significant shortage of 62 WTE Scientific, Therapy and Technical staff.	✓ HR and Professional Development continue to collaborate to support on-going recruitment. Interventions include nursing recruitment days, virtual tours and social media campaigns. ✓ The HR Business partner will work with divisions to understand the gaps across the organisation in correlation to the labour market to understand the supply pipeline. This will include exploring new ways of working and developing career pathways. ✓ We continue to explore collaborative recruitment activity across the STP and to consider where regional/system level recruitment campaigns may offer a greater opportunity to attract high calibre candidates. ✓ A programme of work is being planned with support from HEE to develop new ways of working, new workforce models/new roles, strengthening multi-professional workforce models, increasing flexibility, accessing greater workforce supply and reducing reliance on workforce capacity that is hard to recruit.

Summary 3/4	*Performance*	*Action*
Turnover & Recruitment	o Staff turnover continues to fall, and is at 7.6% in July, down from 7.8% in June, and 7.9% in May. (NB: this is a 12 month rolling average). Turnover is below the average industry rate of 10%. o Leavers for July is 125 (117.8 FTE) 89 of which were fixed term contracts ending. o Foundation Year 1 at 17 (17 FTE) was the most significant starting group in July.	✓ The Human Resources Business Partners are supporting the Divisional Directors to ensure the development and implementation of workforce planning, that understands staffing capacity, establishments, and skill and experience requirements and incorporates into service design to ensure roles are fit for purpose and add value. ✓ Examine trends on planned versus actual staffing levels, triangulated with key quality and outcome measures, including exit interviews and stay interviews.
Equality & Diversity	o DGFT's current (total) workforce at 18.6% BAME, 70.5% White & 10.9% Not stated. o The BAME headcount in band 8 posts has risen from 24 BME in 2019 to 32 BME staff in 2020. Whilst this represents an improvement, as the data in the following slides highlights there is more work to be done to deliver equality and inclusion for BAME staff. o The overall Trust average for staff identifying as being Gay, Lesbian, Bi-sexual and Other Sexuality is 1.6%. o Overall Trust average for disability representation is 3.6%.	✓ The Trust has now established 3 networks: BAME, Sexual Orientation, and Disability. The BAME, and Sexual Orientation Networks have both held their initial meetings, and the Disability Network is being established in September. ✓ A single Equality and Inclusion Strategy is being developed, along with a re-fresh of the Dudley People Plan, to reflect the requirements of the new national People Plan 2020/21. ✓ Each of these networks has both an Executive Director and Non-Executive Director sponsor. In addition, the Chairs of the networks will attend Board meetings. ✓ The Workforce Committee meeting in late August focused on a 'deep dive' by age, band, length of service, and staff group for WDES, WRES, and WSES.

Summary 4/4	*Performance*	*Action*
Staff Health & Wellbeing	o The response time to Managers' referrals has worsened slightly in July due capacity (days from referral to 1st appointment) o Number of appointments in July has increased since June, the majority are in the category 'Ability to Perform Duties'	✓ The SHAW service appointments held showed an increase in March, due mainly to Health Surveillance, and Self Referral levels. ✓ A detailed review of the SHAW service has been undertaken and is due to report back in September, which will include guidance on the optimal operating model for the future.
HR Caseload	o The current open HR caseload of 45 is dominated by 'Disciplinary' cases at 44%, with 5 current suspensions. o Cases related to BAME staff represent 16% of the total cases of BAME staff, with 67% related to Non-BAME staff. There are currently no suspensions of BAME staff members. o There are currently no suspensions of BAME staff members, this is dominated by White British.	✓ It should be noted that in response to COVID-19 nationally NHS Employers and unions agreed that HR process matters, such as disciplinary matters, grievances were paused. Management of these cases has now resumed. ✓ Employee relations cases continue to be proactively managed and supported by the implementation and maintenance of a case tracker. ✓ Work is being undertaken to update, strengthen and improve the Trust's HR policies, including developing stringer guidance for managers, to help improve people management practices. ✓ A Managers Accreditation programme is being launched in November which all line managers from across the Trust will complete over the next 24 months. This programme will improve the capability of people managers across the Trust.

Sickness Absence

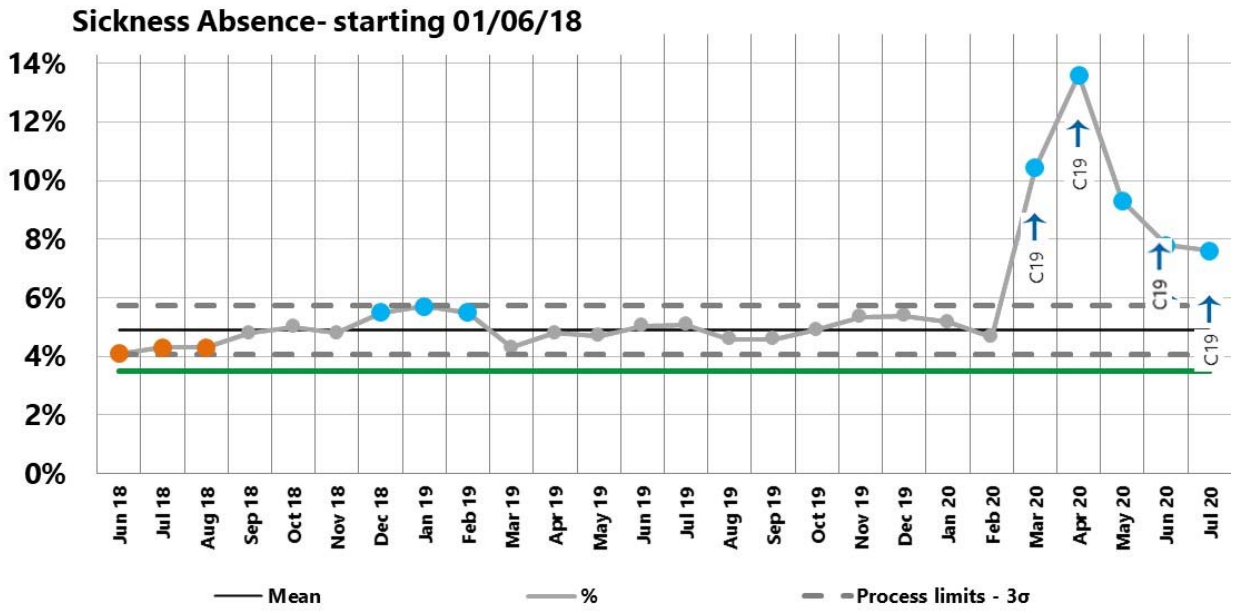
The overall Sickness Absence value for July was 7.6%, down from 7.8% in June and 9.3% in May.

The overall Sickness Absence is at 5.1% as at Friday 28th August. Of this, 1.0% point is accounted for by COVID absences, and 4.1% points all other sickness. We continue to track and focus on the absence status on a daily basis.

This compares favourably with the Trust target of 3.5% sickness absence, as non-COVID absence performance continues to trend downwards.

	Days Absent In July		
	All Other Sicknesses	COVID	Grand Total
Clinical Support	1,040	430	**1,470**
Corporate / Mgt	466	319	**785**
Medicine & Integrated Care	3,093	2,198	**5,291**
Surgery	2,535	2,135	**4,670**
Total	**7,134**	**5,082**	**12,216**

	Current % Sickness / Absence	
	All Other Sicknesses	COVID
Clinical Support	3.9%	0.2%
Corporate / Mgt	2.0%	1.2%
Medicine & Integrated Care	3.5%	0.8%
Surgery	4.9%	1.1%
Total	**3.9%**	**0.9%**



Absence Reason	Days	% of All Reasons
COVID Reasons	5,082	42%
Anxiety/stress/depression/o	2,611	21%
Other musculoskeletal prob	698	6%
Injury, fracture	554	5%
Gastrointestinal problems	505	4%
Genitourinary & gynaecolo	420	3%
Back Problems	303	2%
Other known causes - not e	286	2%
Headache / migraine	252	2%
Chest & respiratory problen	232	2%
Pregnancy related disorders	216	2%
Ear, nose, throat (ENT)	171	1%
Benign and malignant tumo	154	1%
Skin disorders	118	1%
Cold, Cough, Flu - Influenza	116	1%
Endocrine / glandular probl	109	1%
Dental and oral problems	85	1%
Nervous system disorders	84	1%
Unknown causes / Not spec	60	0%
Blood disorders	39	0%
Infectious diseases	36	0%
Asthma	35	0%
Eye problems	25	0%
Heart, cardiac & circulatory	17	0%
Burns, poisoning, frostbite,	8	0%

Covid 19 Absence Profile – 1%, 51 Staff

51 Staff are currently absent with Covid reasons 1%, and this continues to fall.

Shielding has now stopped, although there are still 19 staff who have been absent more than 84 days (12 weeks) with Covid reasons.

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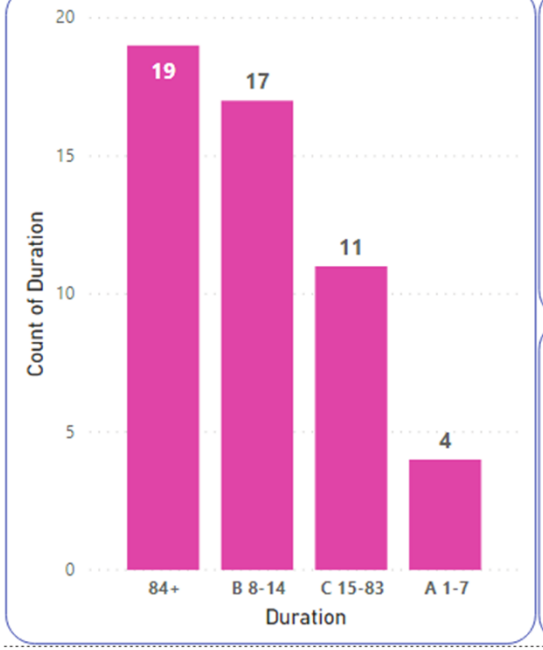
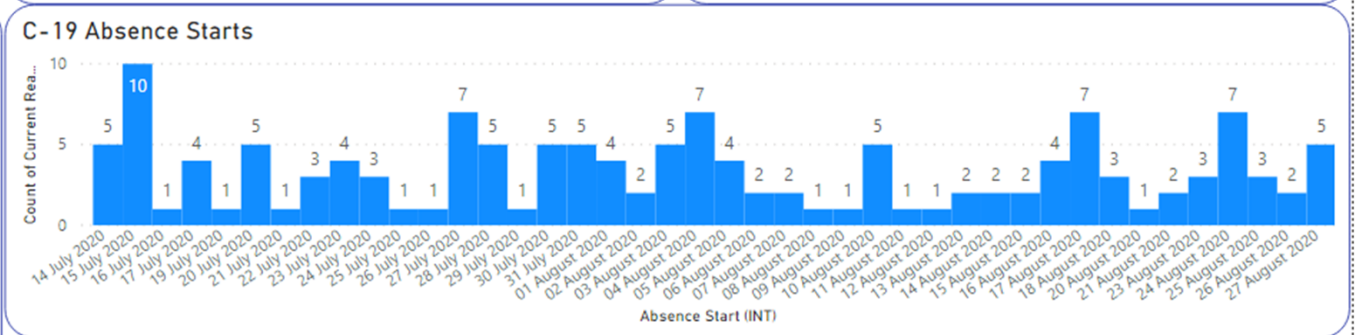
Add Prof Scientific and ... | Additional Clinical Servi... | Administrative and Cler... | Allied Health Professio... | Healthcare Scientists | Medical and Dental | Nursing and Midwifery ...

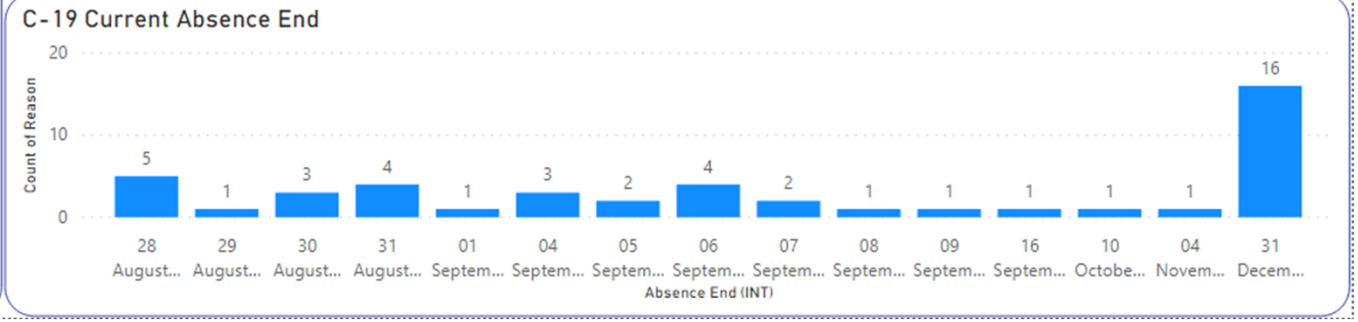
Employee Count Within Selected Staff Group	C19 Absence at some point since since 5 March	Employees with current C19 absence
5139	1144	51

Staff Group	Active Assignment	Covid-19	Other Sickness	Total
Nursing and Midwifery Registered	1657	22	78	**1757**
Medical and Dental	498	7	4	**509**
Healthcare Scientists	49	1	2	**52**
Allied Health Professionals	379	3	11	**393**
Administrative and Clerical	1014	9	26	**1049**
Additional Clinical Services	1088	7	80	**1175**
Add Prof Scientific and Technic	192	2	10	**204**
Total	**4877**	**51**	**211**	**5139**

Staff Group	Active Assignment	Covid-19	Other Sickness	Total
Add Prof Scientific and Technic	94.1%	1.0%	4.9%	**100.0%**
Additional Clinical Services	92.6%	0.6%	6.8%	**100.0%**
Administrative and Clerical	96.7%	0.9%	2.5%	**100.0%**
Allied Health Professionals	96.4%	0.8%	2.8%	**100.0%**
Healthcare Scientists	94.2%	1.9%	3.8%	**100.0%**
Medical and Dental	97.8%	1.4%	0.8%	**100.0%**
Nursing and Midwifery Registered	94.3%	1.3%	4.4%	**100.0%**
Total	**94.9%**	**1.0%**	**4.1%**	**100.0%**





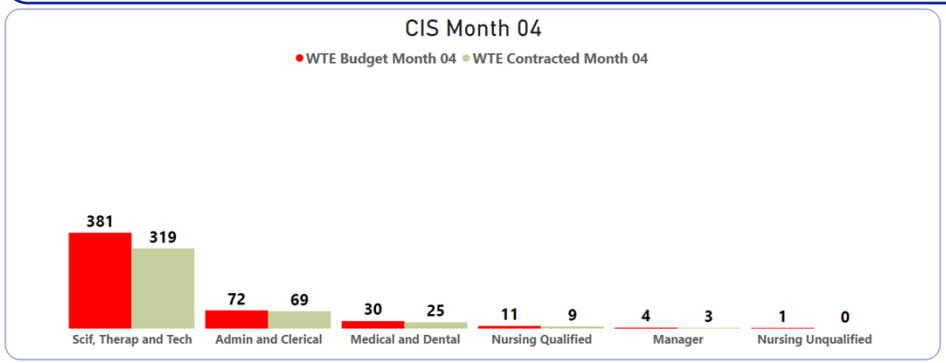


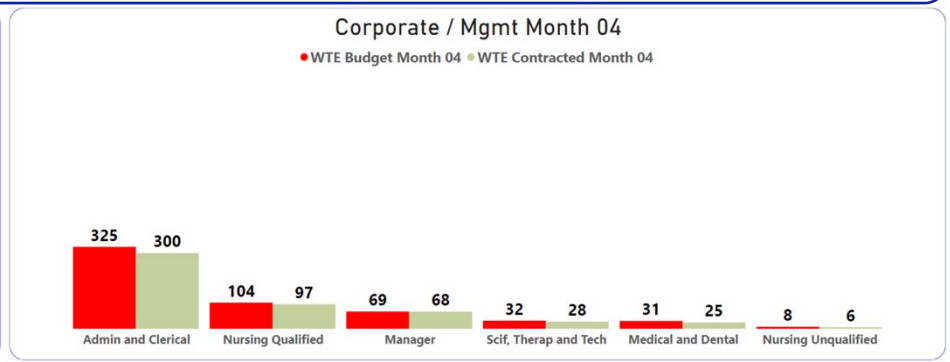
NHS The Dudley Group NHS Foundation Trust

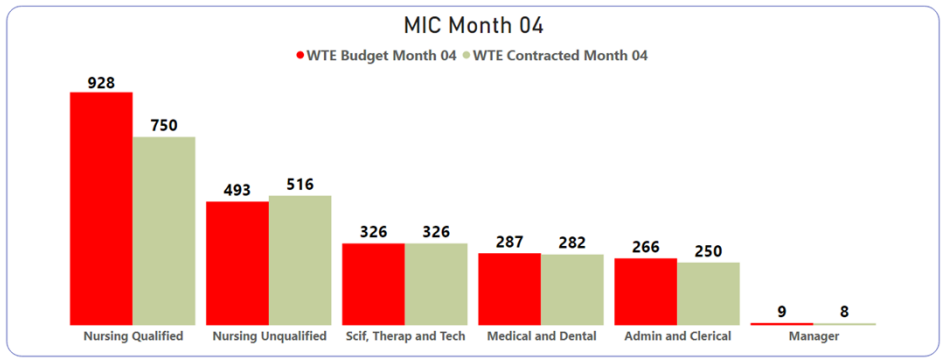
Workforce Profile – Staff in Post

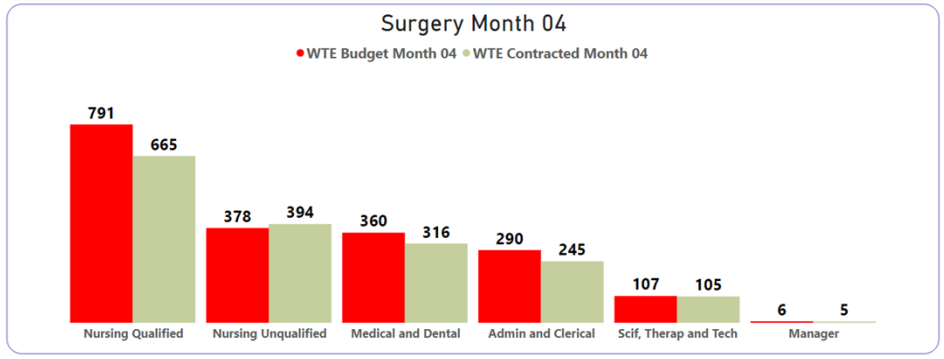
The largest shortfall in staff is in Qualified Nurses: Medicine and Integrated Care (MIC) are short 178 WTE, and Surgery are short 126 WTE, giving a total of 304 between these two divisions.

Clinical Support also shows a significant shortage of 62 WTE Scientific, Therapy and Technical staff.



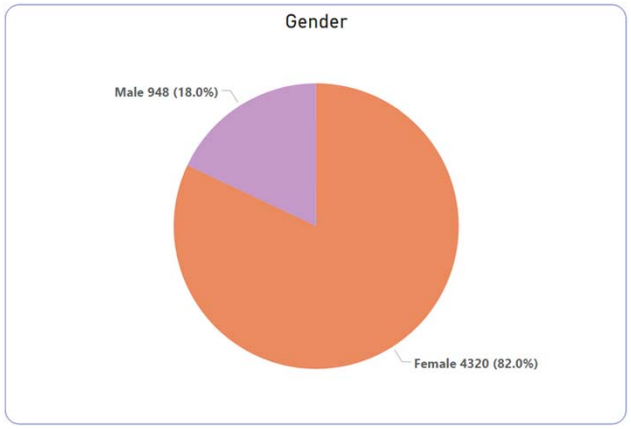


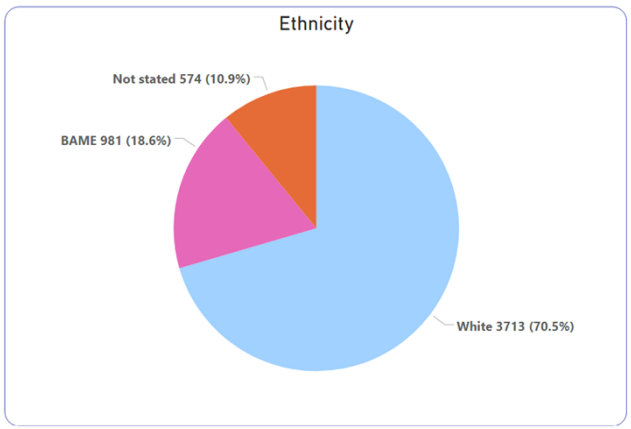


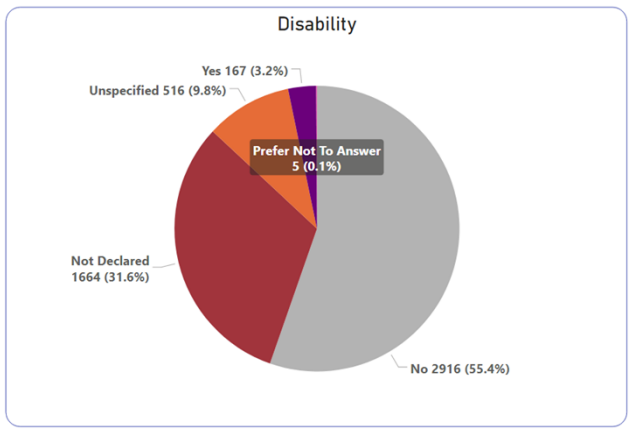


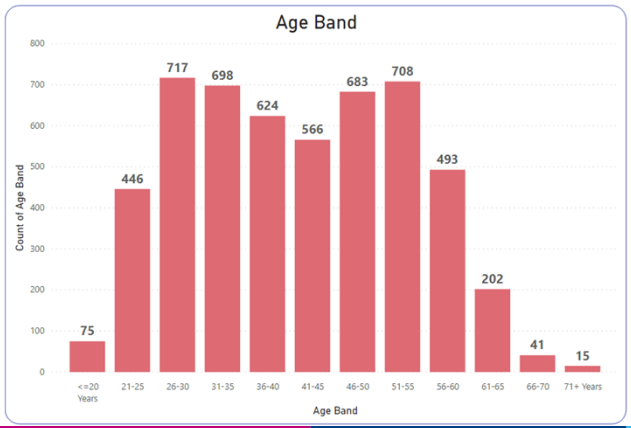
Workforce Profile – Diversity

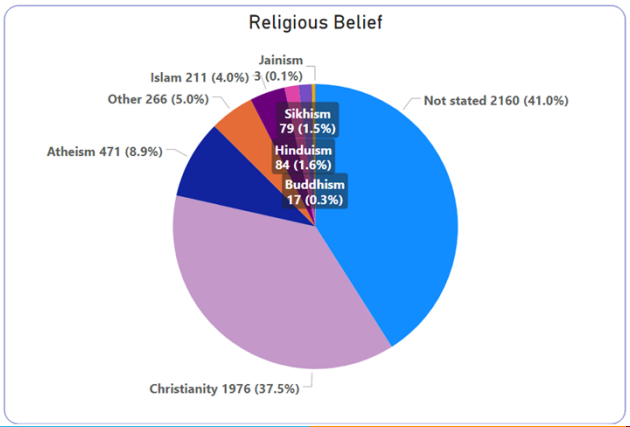
A significant programme of work is being taken forwards to raise the profile of Equality and Diversity and embed a culture of inclusion, for staff from diverse communities and protected characteristics.
The Trust has now established 3 networks: BAME staff, Sexual Orientation, and Disability. The BAME, and Sexual Orientation Networks have both held their initial meetings, and the Disability Network meets in the next few days. Each of these networks has both an Executive Director and Non-Executive Director sponsor. In addition, the chairs of the networks will attend Board meetings.
These staff networks will inform and help to shape the Trusts strategy, policies, processes, systems and most importantly cultures and behaviours.
The Trust has recently joined Stonewall, Employers Network for Equality & Inclusion, and has lined with Regional and National Equality and Inclusion networks. The data below and in the following pages summarises the current workforce profile, shown by diversity categories, with further analysis by staff group and pay band.

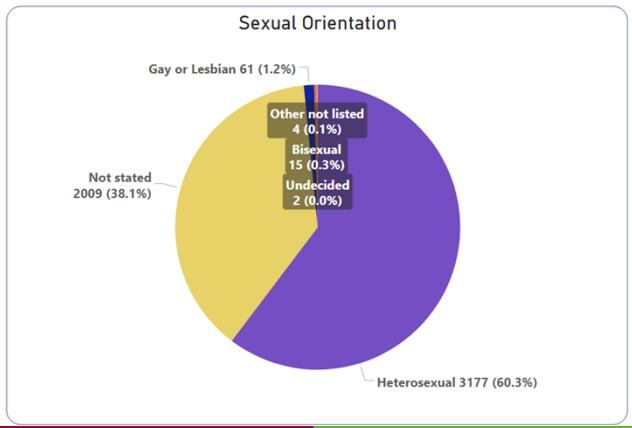






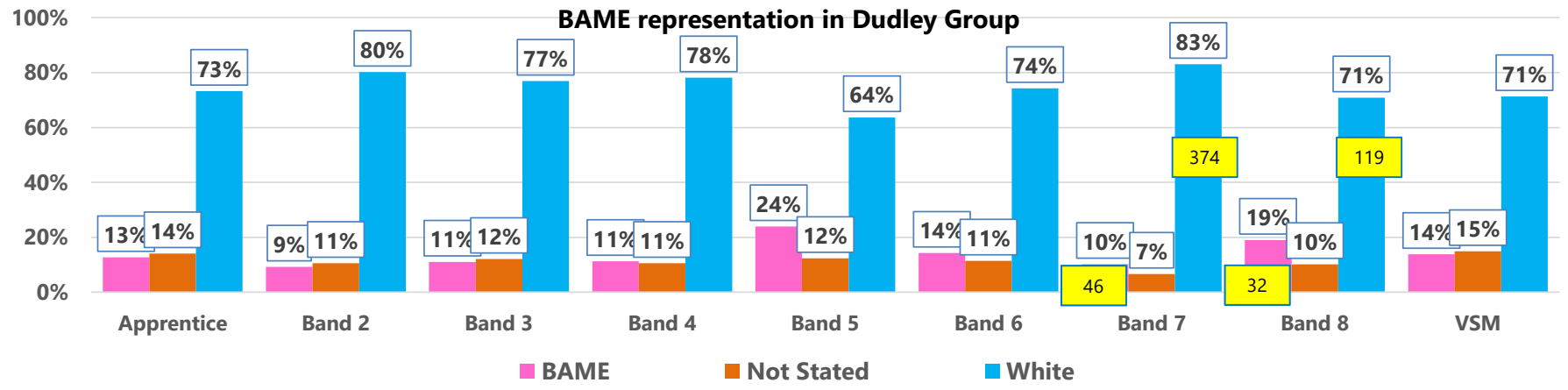


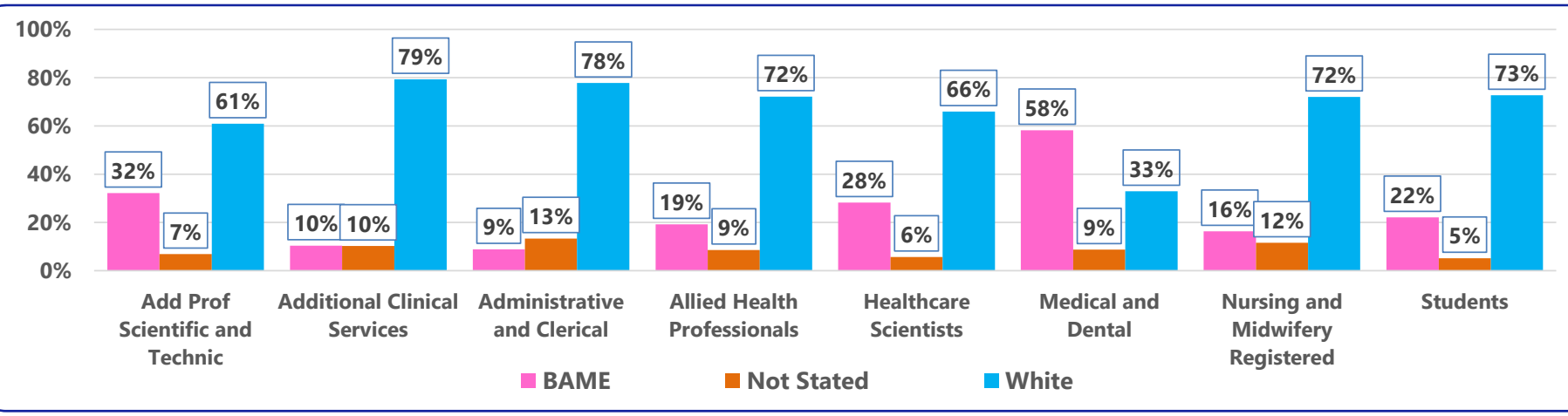




Workforce Profile – Diversity – BAME representation by band & staff group

DGFT's current (total) workforce at 18.6% BAME, 70.5% White & 10.9% Not stated. There is significant variation within staff groups, with Additional Clinical Services (including Health Care Support Workers) at 12%, and Admin and Clerical at 10% well below the Trust average. However Medical & Dental shows 64% BAME staff within the group. There has been an improvement in BME representation at senior levels during the past 6 months, since the 2019 WRES submission. The BAME headcount in band 8 posts has risen from 24 BME in 2019 to 32 BME staff in 2020. Whilst this represents an improvement, as the data in the following slides highlights there is more work to be done to deliver equality and inclusion for BAME staff. The Trust's leadership team is committed to working closely with the BAME Staff Inclusion Group to implement targeted interventions to improve the recruitment, retention and promotion of BAME staff in senior/leadership roles.

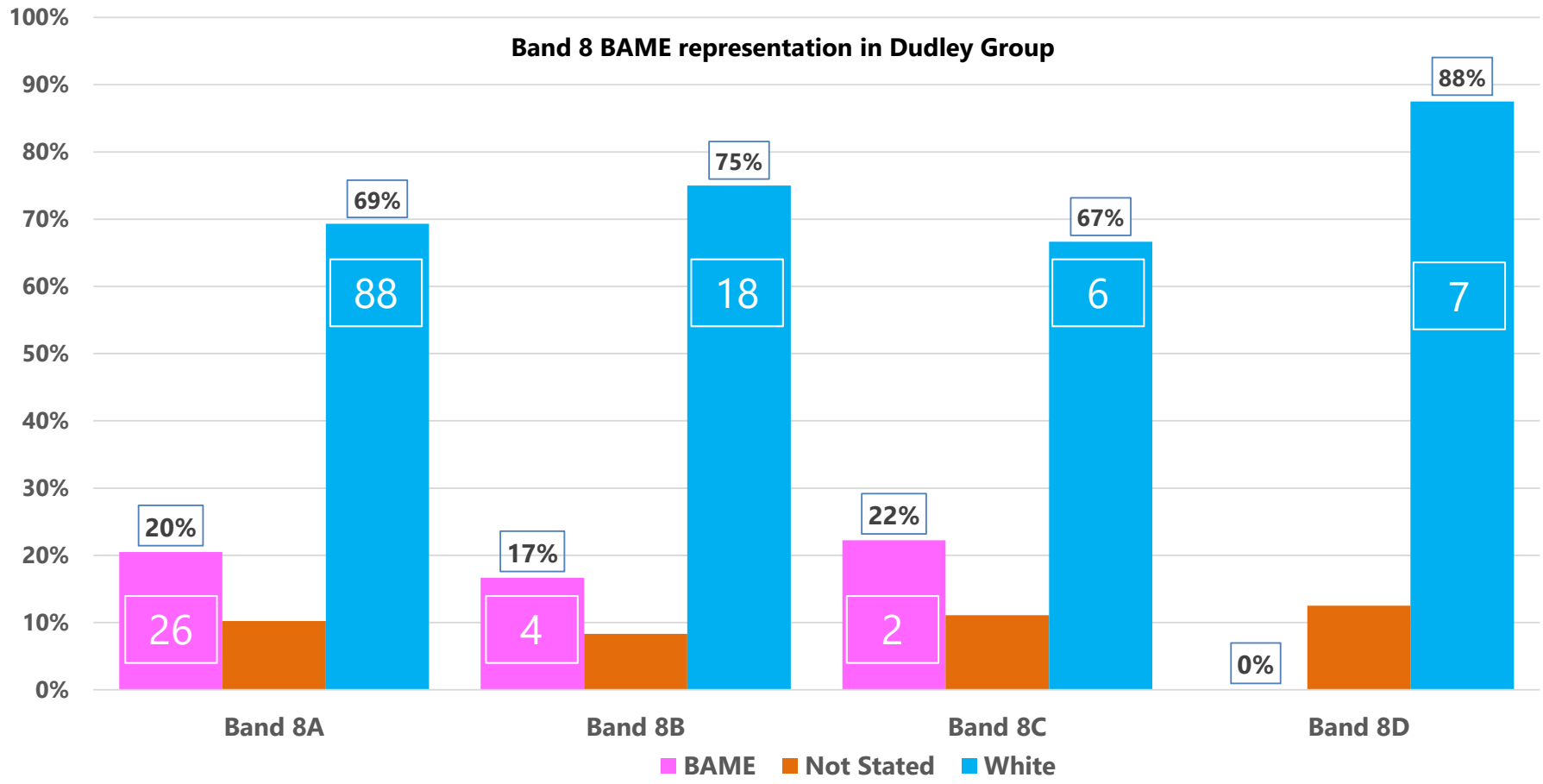




Workforce Profile – Diversity – BAME representation within Band 8

Band 8 has a total BAME representation of 19%, which is in line with the Trust average of 18.6%.

Within the Band 8 grades, A, B, & C are above the Trust average, however there is no BAME representation at grade 8D.

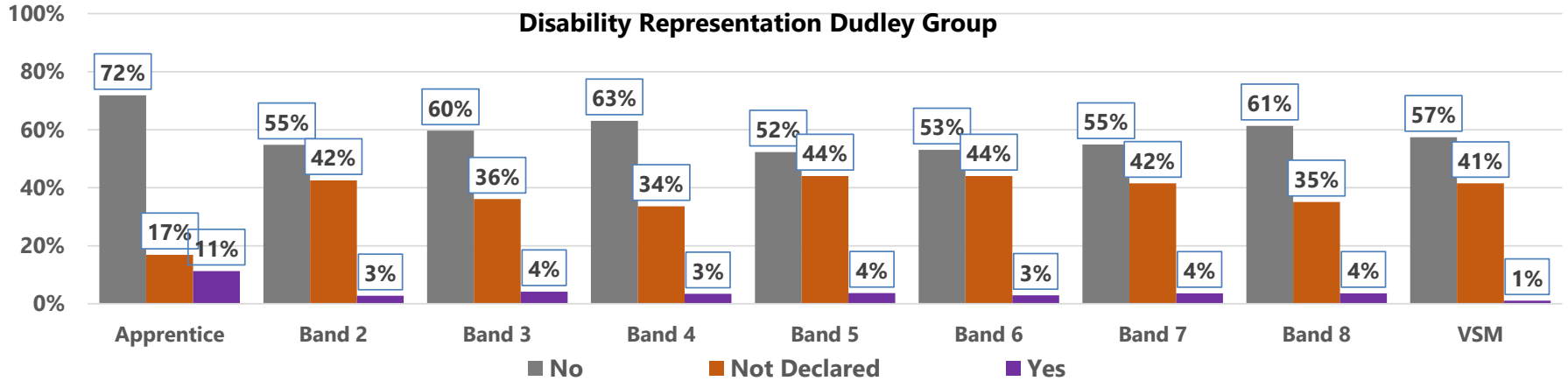


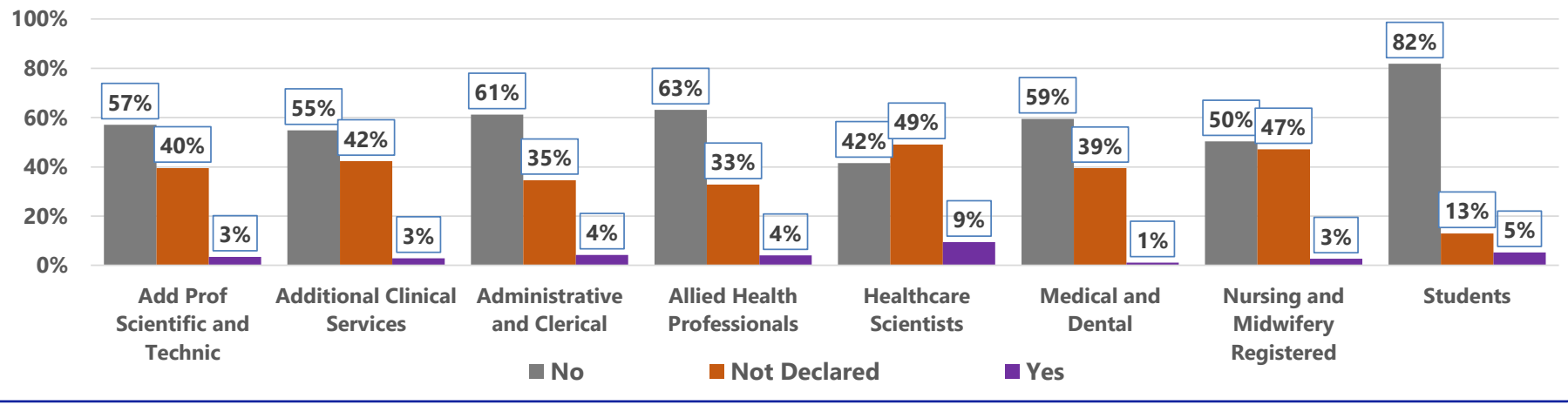
Workforce Profile – Diversity – Disability representation by band & staff group

Overall Trust average for disability representation is 3.6%.

This is consistent across the bands, except at VSM where representation is at 1%.

The Staff Groups show a range of representation with Healthcare Scientists highest at 9%, and Medical & Dental lowest at 1%.

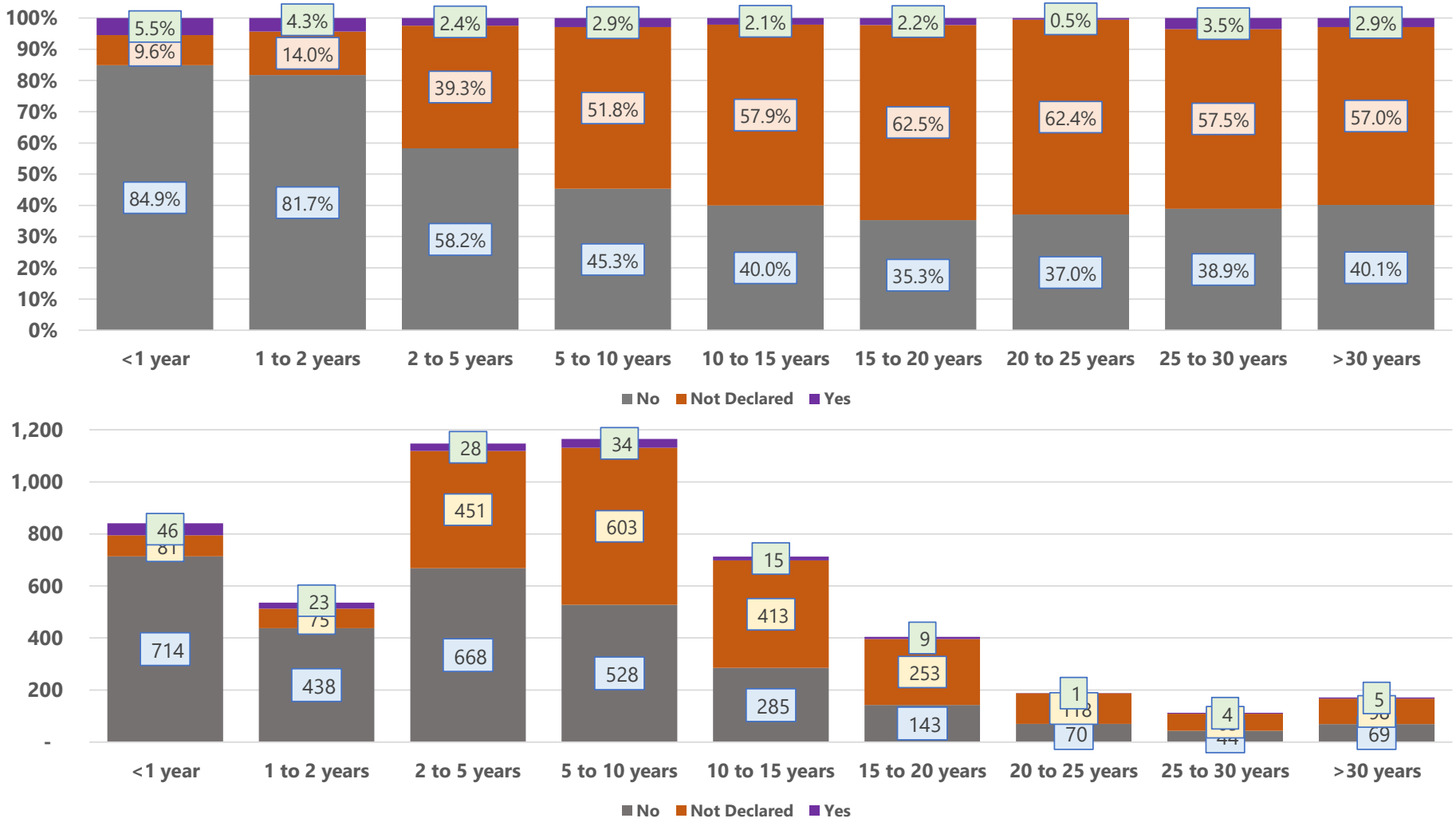




Workforce Profile: Improvement in Staff Declaring Disability

There is a significant improvement in data provided by Staff starting in the last 2 years (i.e. with less than 1 year, and 1 to 2 years service), showing 5.5% and 4.3% declared disability. This is significantly higher than for the Trust average of 3.1%.

Also staff hired within the last 2 years are significantly less likely to 'not declare' if they have a disability or not.

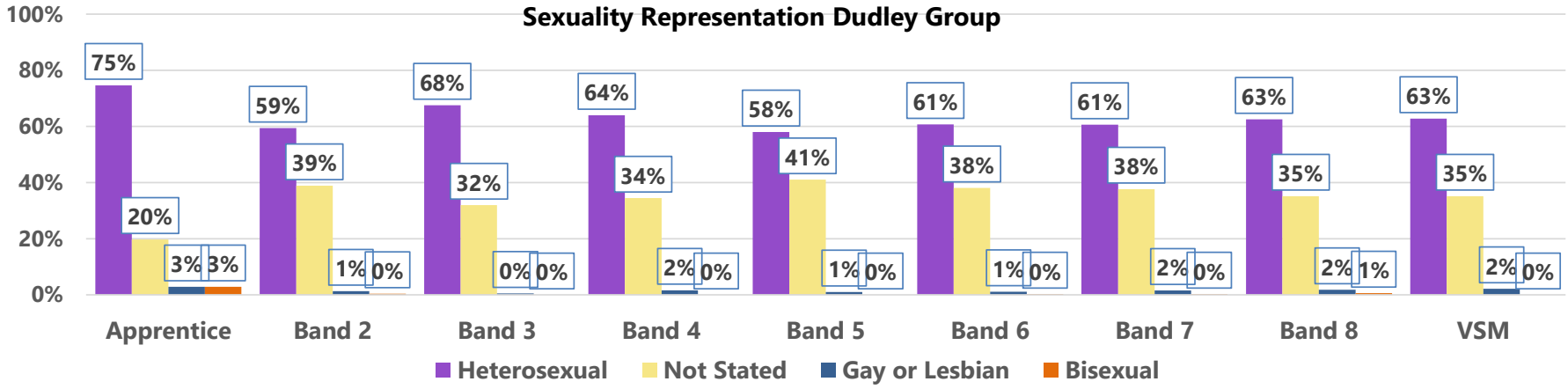


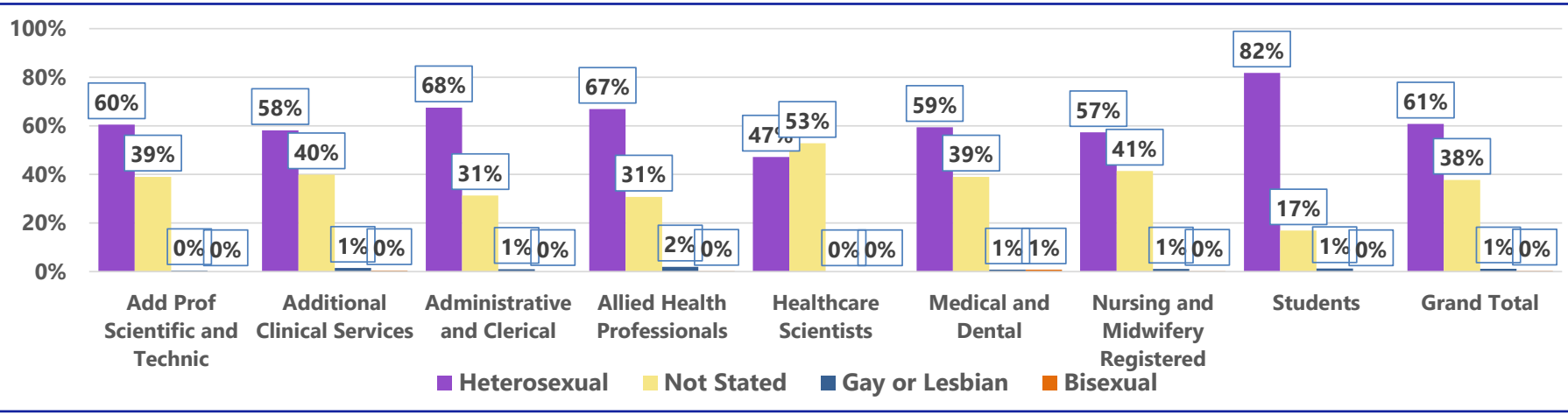
Workforce Profile – Diversity – Sexuality representation by band & staff group

The overall Trust average for staff identifying as being Gay, Lesbian, Bi-sexual and Other Sexuality is 1.6%.

There is very little statistical difference between Bands or the Staff Groups, with the exception of the Apprentices and the Students who are more likely to state their sexuality.

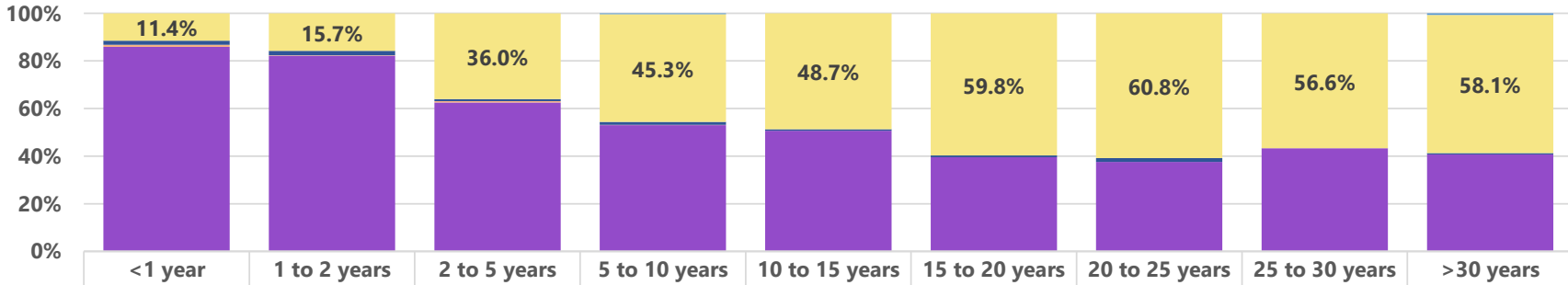
Overall circa 40% of staff have not stated their sexuality.



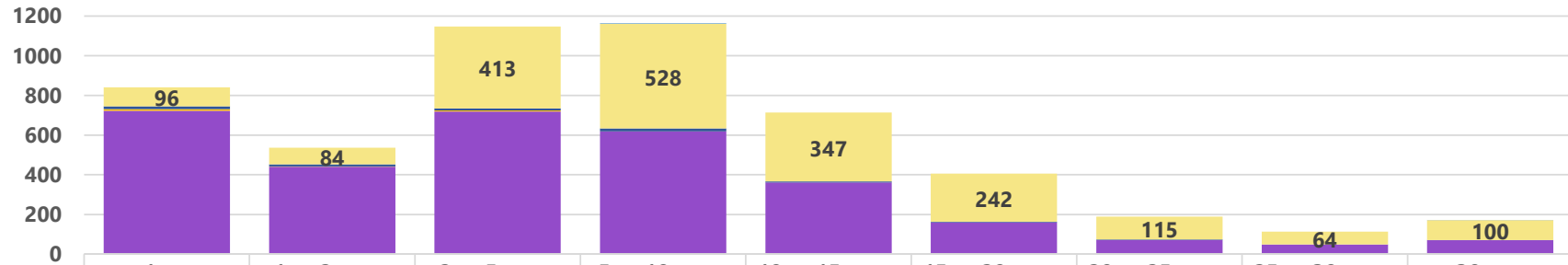


Workforce Profile: Improvement in Staff Declaring Sexual Orientation

There is a significant improvement in data provided by Staff starting in the last 2 years (i.e. with less than 1 year, and 1 to 2 years service), showing a significant reduction in 'not stated' to 11.4% and 15.7%. This down from 36% to 61% in all previous service years.



	<1 year	1 to 2 years	2 to 5 years	5 to 10 years	10 to 15 years	15 to 20 years	20 to 25 years	25 to 30 years	>30 years
Other	0.0%	0.0%	0.0%	0.3%	0.0%	0.0%	0.0%	0.0%	0.6%
Not Stated	11.4%	15.7%	36.0%	45.3%	48.7%	59.8%	60.8%	56.6%	58.1%
Gay or Lesbian	1.8%	1.9%	0.9%	1.3%	0.7%	0.7%	1.6%	0.0%	0.6%
Bisexual	0.8%	0.2%	0.5%	0.1%	0.0%	0.0%	0.0%	0.0%	0.0%
Heterosexual	86.0%	82.3%	62.6%	53.0%	50.6%	39.5%	37.6%	43.4%	40.7%



	<1 year	1 to 2 years	2 to 5 years	5 to 10 years	10 to 15 years	15 to 20 years	20 to 25 years	25 to 30 years	>30 years
Other	0	0	0	3	0	0	0	0	1
Not Stated	96	84	413	528	347	242	115	64	100
Gay or Lesbian	15	10	10	15	5	3	3	0	1
Bisexual	7	1	6	1	0	0	0	0	0
Heterosexual	723	441	718	618	361	160	71	49	70

Workforce Profile – Diversity – Staff Survey Extract - WRES

Using the WRES results highlighted by Dr Habib Naqvi – 'The importance of a BME staff network (Dudley), NHSE&I 24 June 2020', the DGFT position is as shown below.

The 2019 Staff Survey for DGFT shows a worsening position on all of the selected metric descriptions except WRES: BAME *'Percentage of staff experiencing harassment, bullying or abuse from staff in the last 12 months'* which shows a slight improvement over the previous year.

DGFT results are worse than the National Average on all selected metrics.

				DGFT Staff Survey			DGFT	National	DGFT to
			Metric Description	2017	2018	2019	Trend	2019	National
STAFF SURVEY	5	WRES: White	Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months	27.4%	28.5%	31.6%	Worsening	25.4%	Worse
		WRES: BAME		25.6%	30.2%	31.2%	Worsening	28.7%	Worse
		Theme Results: Q13a		26.1%	28.2%	30.6%	Worsening	25.9%	Worse
	6	WRES: White	Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months	19.7%	25.7%	28.4%	Worsening	22.2%	Worse
		WRES: BAME		29.4%	36.3%	33.0%	Improvement Last Year	27.9%	Worse
		Theme Results: Q13c		15.3%	19.8%	20.9%	Worsening	18.0%	Worse
	7	WRES: White	Percentage of staff believing that the organisation provides equal opportunities for career progression or promotion	86.5%	84.3%	84.8%	Worsening	87.4%	Worse
		WRES: BAME		77.8%	74.2%	67.8%	Worsening	72.9%	Worse
	8	WRES: White	Percentage of staff experienced discrimination at work from manager / team leader or other colleagues in last 12 months	5.8%	5.3%	6.3%	Worsening	5.5%	Worse
		WRES: BAME		14.4%	11.6%	17.4%	Worsening	14.8%	Worse
		Theme Results: Q15b		7.2%	6.2%	8.1%	Worsening	6.9%	Worse

Workforce Profile – Diversity – Staff Survey Extract - WDES

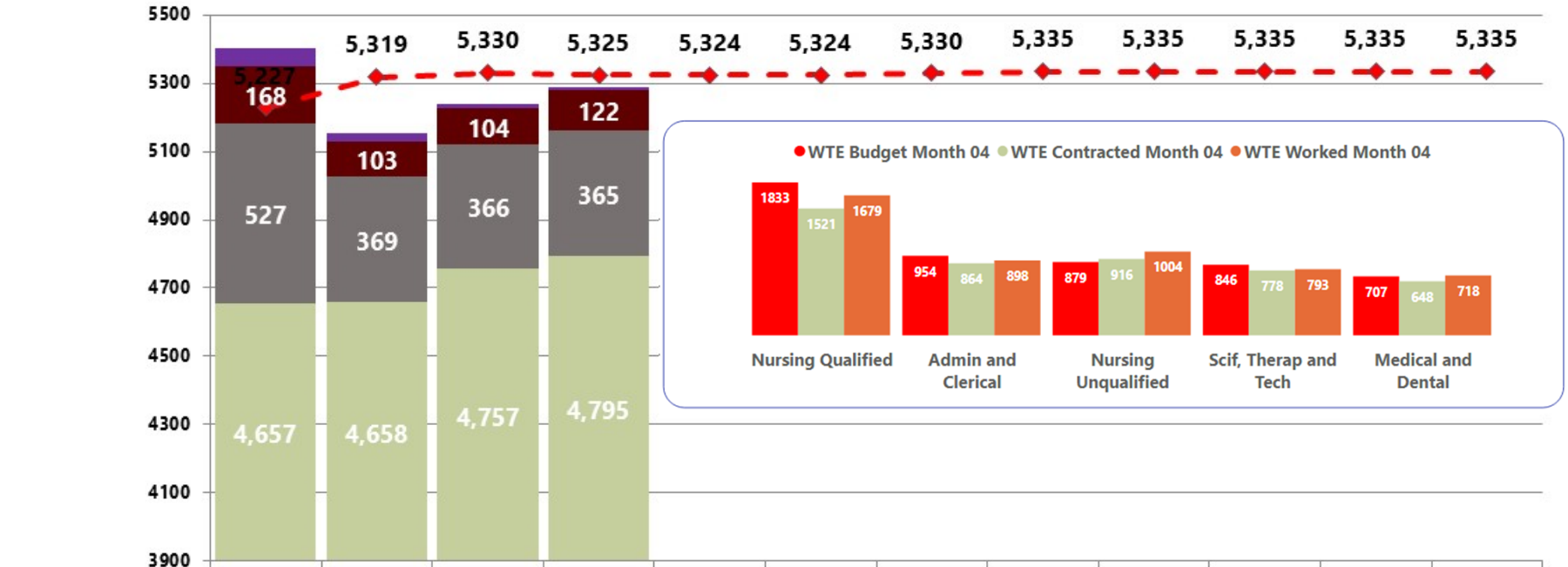
2,049 staff in DGFT completed the 2019 survey, representing 43% of all staff. Within the survey participants, 350 identified themselves as disabled, whereas DGFT ESR data shows 165 (3.1%) staff with disabilities (as at July 2020). NB: 2,157 staff in ESR have 'not declared' if they have a disability or not.

If the 350 disabled survey participants represent 43% of staff within DGFT with a declared or non-declared disability, an extrapolation would give 814 (15.4%) staff with a disability. However non-declared disabled staff may have disproportionately used the Staff Survey as an opportunity to express their views. NB: Staff hired in the last 2 years are less likely to 'not declare' and the disabled cohort is 4.6% in this group

				DGFT Staff Survey				DGFT Trend	National 2019	DGFT to National
				2018		2019				
		Metric Description		Score	Responses	Score	Responses			
STAFF SURVEY	4a	Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months	WDES: Disabled	37.6%	295	37.9%	346	Worsening	31.8%	Worse
			WDES: Non-Disabled	26.7%	1,329	30.3%	1,598	Worsening	24.6%	Worse
		Percentage of staff experiencing harassment, bullying or abuse from manager in last 12 months	WDES: Disabled	21.2%	292	21.7%	345	Worsening	17.7%	Worse
			WDES: Non-Disabled	12.7%	1,326	15.8%	1,591	Worsening	10.0%	Worse
		Percentage of staff experiencing harassment, bullying or abuse from other colleagues in last 12 months	WDES: Disabled	27.8%	295	28.0%	346	Worsening	26.5%	Worse
			WDES: Non-Disabled	18.0%	1,325	19.4%	1,593	Worsening	16.0%	Worse
	4b	Percentage of staff saying that the last time they experienced harassment, bullying or abuse at work, they or a colleague reported it	WDES: Disabled	44.7%	150	47.8%	180	Improvement Last Year	48.5%	Worse
			WDES: Non-Disabled	45.9%	447	46.5%	643	Improvement Last Year	46.7%	Worse
	5	Percentage of staff believing that the organisation provides equal opportunities for career progression or promotion	WDES: Disabled	76.3%	186	74.8%	214	Worsening	79.7%	Worse
			WDES: Non-Disabled	84.2%	888	83.7%	1,069	Worsening	87.1%	Worse
	6	Percentage of staff who have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties	WDES: Disabled	39.7%	194	35.8%	279	Improvement Last Year	32.5%	Worse
			WDES: Non-Disabled	22.4%	652	24.7%	914	Worsening	21.3%	Worse
	7	Percentage of staff satisfied with the extent to which their organisation values their work	WDES: Disabled	27.7%	296	30.0%	350	Improvement Last Year	39.3%	Worse
			WDES: Non-Disabled	37.5%	1,329	39.6%	1,602	Improvement Last Year	50.1%	Worse
	8	Percentage of disabled staff saying their employer has made adequate adjustment(s) to enable them to carry out their work	WDES: Disabled	69.7%	155	66.2%	210	Worsening	73.5%	Worse
	9a	Staff engagement score	WDES: Disabled	6.2	297	6.3	350	Improvement Last Year	6.7	Worse
			WDES: Non-Disabled	6.8	1,334	6.8	1,605	No Change	7.2	Worse

Bank & Agency Usage - Trend

Both Bank and Agency usage has remained fairly constant during April, May & June, but has increased slightly in July, despite contracted WTEs increasing. The sum of all WTEs worked is still below the funded establishment.

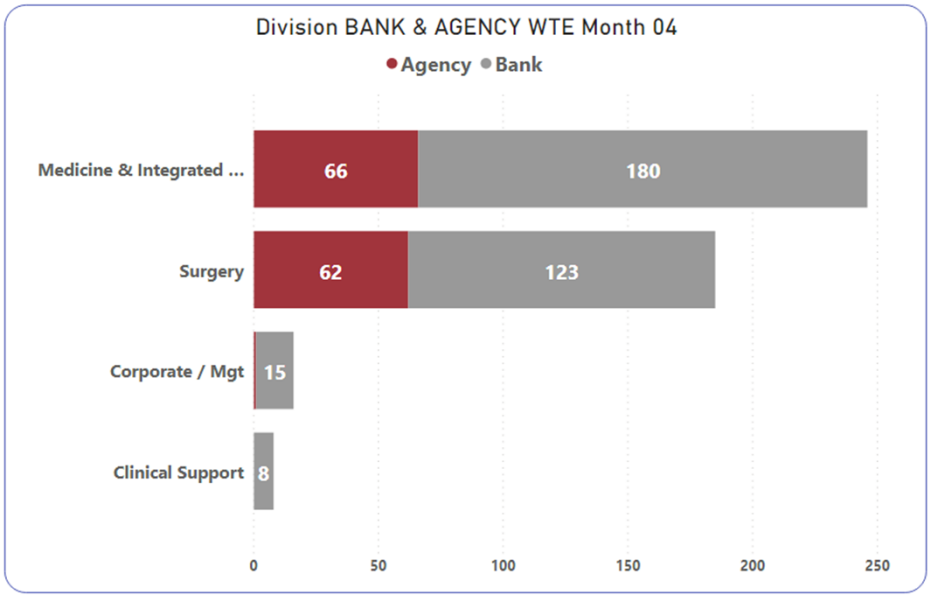


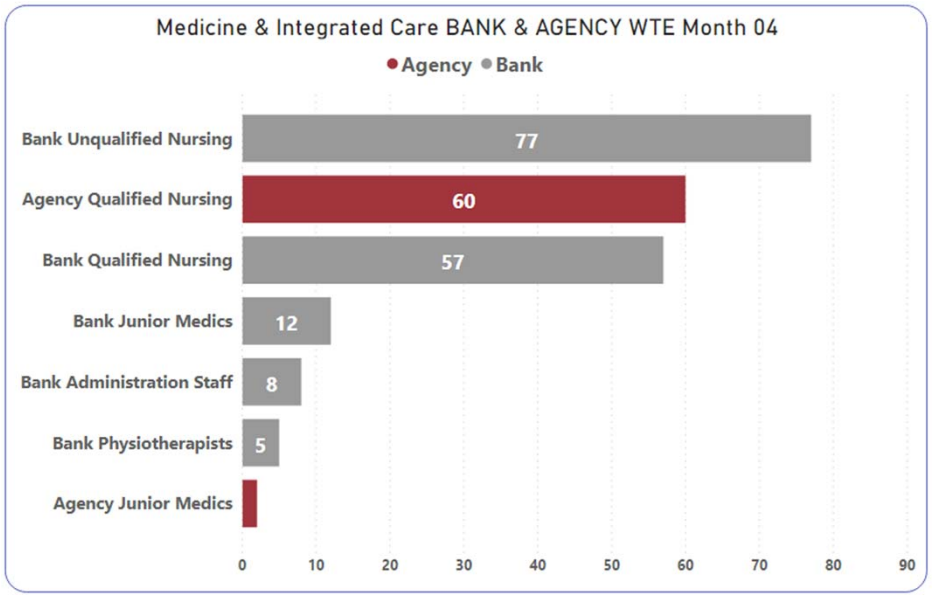
	April	May	June	July	August	September	October	November	December	January	February	March
Overtime/WLI	54	23	12	8								
Agency	168	103	104	122								
Bank	527	369	366	365								
Contracted WTE	4657	4658	4757	4795								
Funded Estab.	5227	5319	5330	5325	5324	5324	5330	5335	5335	5335	5335	5335

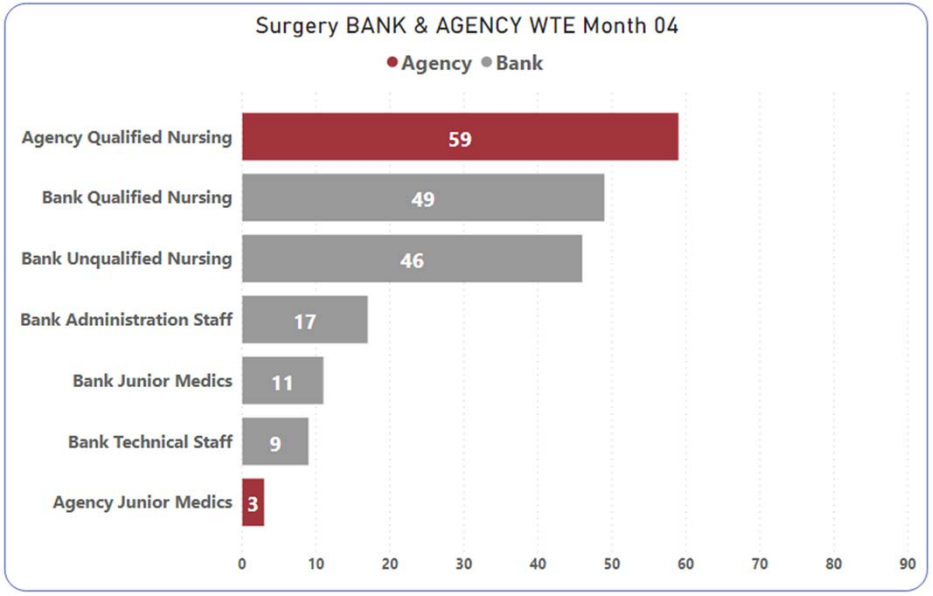
Contracted WTE Bank Agency Overtime/WLI Funded Estab.

Bank & Agency Usage – By Division and Role

Medicine & Surgery both continue to use the Agency and Bank Qualified Nursing to fill funded vacancies.







Turnover

Staff turnover continues to fall, and is at 7.6% in July, down from 7.8% in June, and 7.9% in May. (NB: this is a 12 month rolling average)

Leavers for July is 125 (117.8 FTE) 89 of which were fixed term contracts ending.

Foundation Year 1 at 17 (17 FTE) was the most significant starting group in July.

	Starters	
	Head Count	FTE
Clinical Support	6	5.5
Corporate / Mgt	10	9.5
Medicine & Integrated Care	33	28.8
Surgery	27	23.8
Total	**76**	**67.6**

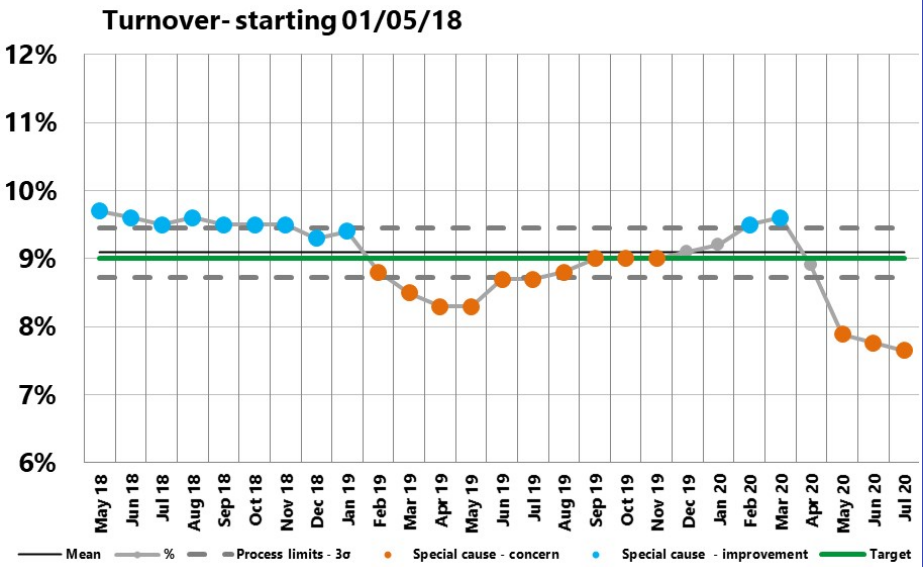
	Leavers	
	Head Count	FTE
Clinical Support	5	5.0
Corporate / Mgt	16	15.3
Medicine & Integrated Care	61	58.0
Surgery	43	39.4
Total	**125**	**117.8**

	Starters	
	Head Count	FTE
Full Time		
Fixed Term Temp	32	32
Permanent	20	20
Part Time		
Fixed Term Temp	5	3.5
Permanent	19	12.1

	Leavers	
	Head Count	FTE
Dismissal - Capability	1	1.0
End of Fixed Term Contract	89	84.6
Has Not Worked	1	1.0
Redundancy - Compulsory	1	0.9
Retirement - Ill Health	2	1.6
Retirement Age	6	5.8
Voluntary Resignation	25	22.8

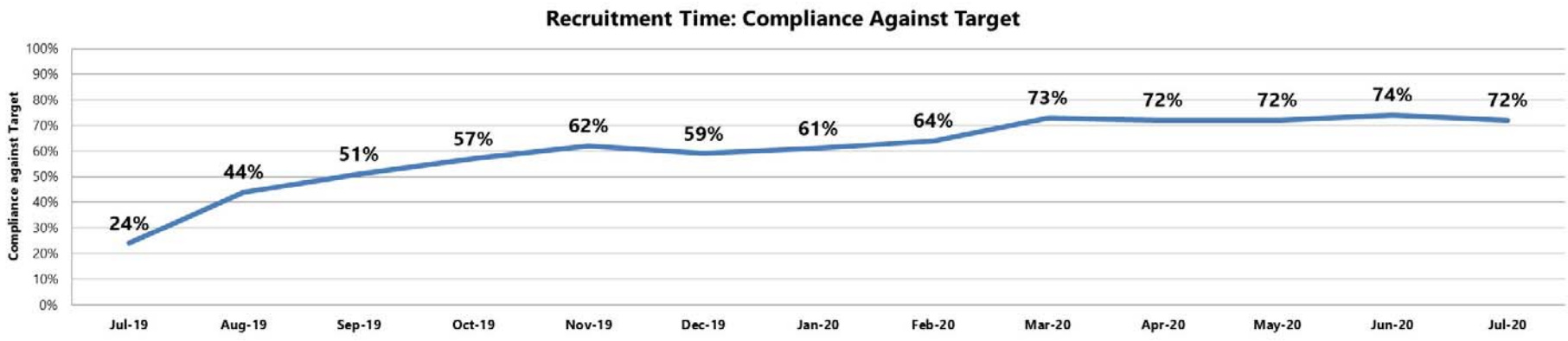
	Starters	
	Head Count	FTE
Assistant	6	5.7
Clerical Worker	5	4.8
Consultant	2	2.0
Foundation Year 1	17	17.0
Foundation Year 2	6	6.0
Health Care Support Worker	7	4.6
Healthcare Assistant	3	2.0
Manager	3	2.8
Medical Secretary	1	1.0
Midwife	1	0.6
Officer	1	1.0
Personal Assistant	1	1.0
Pharmacist	1	0.8
Physician Associate	1	1.0
Radiographer	1	1.0
Senior Manager	2	2.0
Sister/Charge Nurse	1	0.8
Specialist Nurse Practitioner	2	0.9
Specialty Registrar	6	5.3
Staff Nurse	8	6.4
Student Nurse - Adult Branch	1	0.8

	Leavers	
	Head Count	FTE
Advanced Practitioner	1	1.0
Assistant	1	0.9
Chaplain	1	1.0
Clerical Worker	3	1.7
Community Practitioner	1	1.0
Dietitian Specialist Practitioner	1	1.0
Foundation Year 1	20	20.0
Foundation Year 2	22	21.6
Health Care Support Worker	9	7.0
Healthcare Assistant	1	1.0
Midwife	1	1.0
Occupational Therapist	1	1.0
Personal Assistant	1	1.0
Pharmacist	1	1.0
Physiotherapist	6	5.5
Pre-reg Pharmacist	1	1.0
Senior Manager	1	0.9
Sister/Charge Nurse	2	1.4
Specialist Nurse Practitioner	3	2.8
Specialty Registrar	27	26.4
Staff Nurse	4	3.8
Student Nurse - Adult Branch	3	3.0
Technician	2	2.0
Trainee Practitioner	3	1.8
Doctor - Career Grade level	2	2.0
Doctor - Foundation Level	1	1.0
Doctor - Specialty Registrar	6	5.8



Recruitment

July shows a slight overall reduction in performance, notably 'Time from sending invites to interview date'

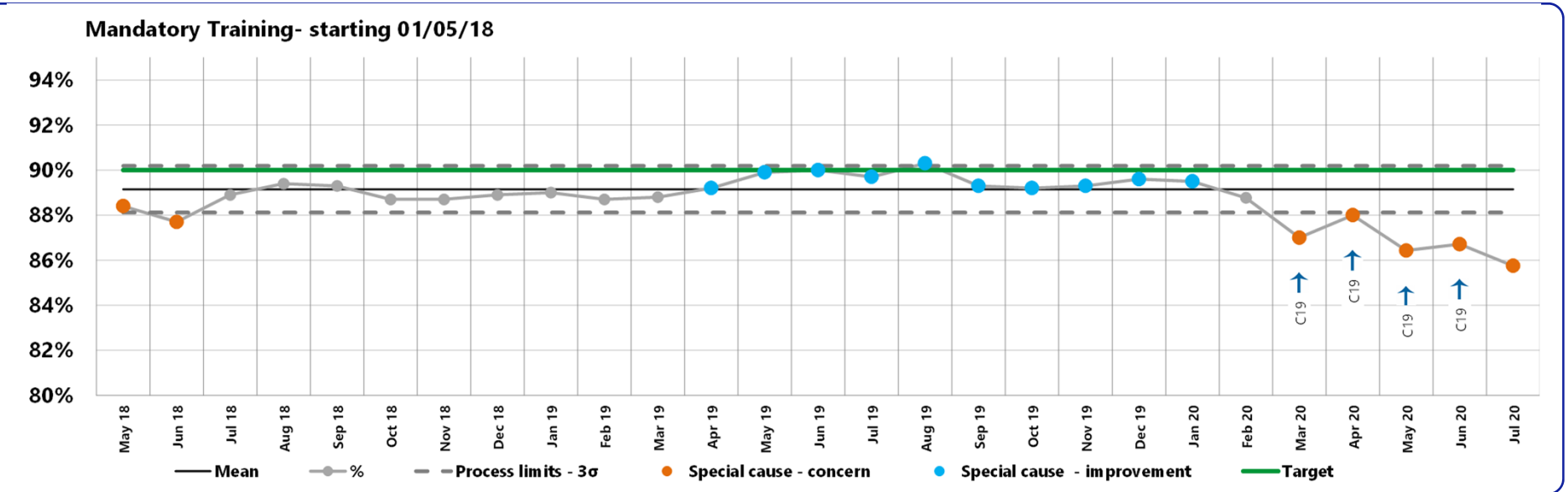


Trust Total Recruitment Time	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20
Time to Approve (8 Days)	48%	75%	60%	61%	63%	59%	73%	70%	72%	72%	85%	90%	95%
Time to Advertise (2 Days)	95%	94%	96%	94%	97%	94%	94%	94%	96%	97%	98%	90%	96%
Time to Shortlist (4 days)	74%	52%	38%	100%	61%	53%	56%	53%	50%	49%	51%	64%	61%
Time to send interview invites after shortlisting (2 Days)	99%	91%	100%	76%	100%	95%	97%	100%	100%	100%	100%	96%	99%
Time from sending invites to interview date (5 Days)	76%	73%	74%	76%	83%	77%	65%	68%	79%	79%	83%	76%	62%
Time from interview to conditional offer sent (2 Days)	53%	77%	72%	77%	84%	80%	55%	58%	68%	68%	54%	85%	88%
Time to complete PE Checks (27 Days)	80%	69%	47%	56%	66%	69%	54%	59%	57%	57%	75%	69%	83%
Total Time to Recruit (50 Days)	24%	44%	51%	57%	62%	59%	61%	64%	73%	72%	72%	74%	72%

Mandatory Training – Performance Trend

Compliance in July was 85.8%, down from 86.7% in June. The categories with the most significant compliance changes are: Infection Control (Clinical) -4.3%, Manual Handling (Patient) -4.1%, Resus (Adult) -3.6%, Resus (Neonatal) -4.1%

Compliance rates continue to be impacted by staff absence and a reduction in the provision of face to, particularly face training due to social distancing measures. Online training remains available for a number of subjects, areas most impacted include manual handling.

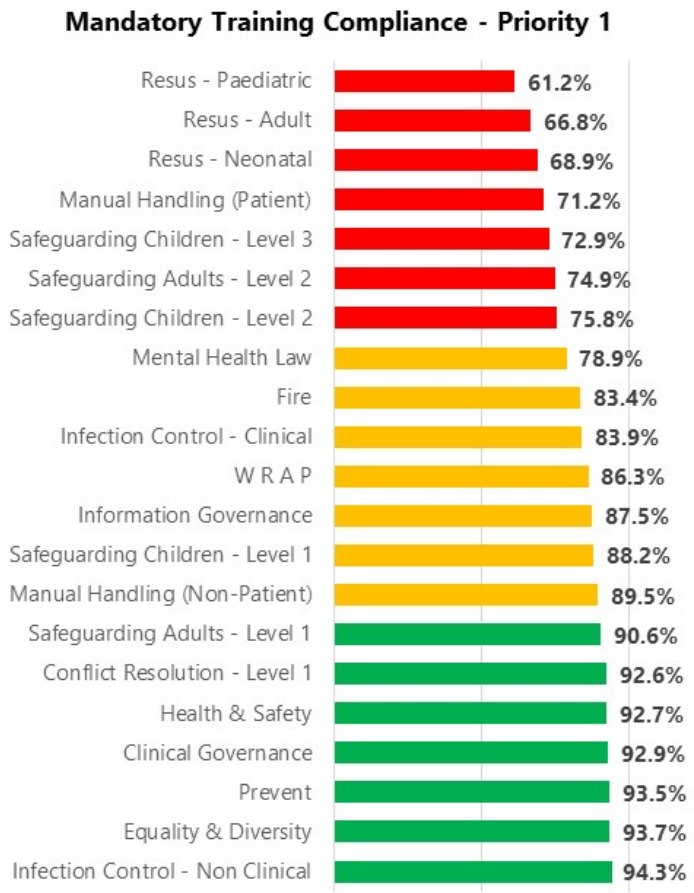


Month	Clinical Governance	Conflict Resolution - Level 1	Equality & Diversity	Fire	Health & Safety	Infection Control - Clinical	Infection Control - Non Clinical	Information Governance	Manual Handling (Non-Patient)	Manual Handling (Patient)	Mental Health Law	Prevent	Resus - Adult	Resus - Neonatal	Resus - Paediatric	Safe-guarding Adults-Level1	Safe-guarding Adults-Level2	Safe-guarding Children-Level1	Safe-guarding Children-Level2	Safe-guarding Children-Level3	W R A P
February	94.1%	92.2%	94.7%	85%	93%	88.8%	93.9%	88.7%	88.8%	84.4%	81.4%	95.4%	75.3%	80.3%	77.4%	91.7%	83.6%	87.4%	84.9%	81.5%	91.9%
March	92.7%	92.4%	93.1%	82.1%	92.3%	85.8%	92.2%	86.9%	86.7%	82.7%	81.9%	93.8%	74%	77.4%	73.5%	90.5%	79.2%	85.1%	80.4%	77.9%	91%
April	94.4%	93.3%	94.8%	83.7%	93.6%	88.1%	94.3%	88.8%	89.4%	80.6%	82.5%	96.2%	72.4%	77.3%	75.4%	91.5%	78.5%	87.3%	80.8%	78.3%	91.3%
May	93.6%	92.2%	94.5%	82.8%	92.9%	87%	94.1%	87.3%	88.7%	76.2%	81.6%	93.8%	74%	77.4%	73.5%	90.5%	79.2%	85.1%	80.4%	77.9%	91%
June	93.9%	92.5%	94.8%	84.5%	93.8%	88.2%	94.9%	88.5%	88.6%	75.3%	80.8%	94.6%	70.4%	73%	62.7%	91%	76.3%	89%	78%	74.9%	88%
July	92.9%	92.6%	93.7%	83.4%	92.7%	83.9%	94.3%	87.5%	89.5%	71.2%	78.9%	93.5%	66.8%	68.9%	61.2%	90.6%	74.9%	88.2%	75.8%	72.9%	86.3%
This Month v Last Month Variance																					
Feb to Mar	-1.4%	0.2%	-1.6%	-2.9%	-0.7%	-3.0%	-1.7%	-1.8%	-2.1%	-1.7%	0.5%	-1.6%	-1.3%	-2.9%	-3.9%	-1.2%	-4.4%	-2.3%	-4.5%	-3.6%	-0.9%
Mar to Apr	1.7%	0.9%	1.7%	1.6%	1.3%	2.3%	2.1%	1.9%	2.7%	-2.1%	0.6%	2.4%	-1.6%	-0.1%	1.9%	1.0%	-0.7%	2.2%	0.4%	0.4%	0.3%
Apr to May	-0.8%	-1.1%	-0.3%	-0.9%	-0.7%	-1.1%	-0.2%	-1.5%	-0.7%	-4.4%	-0.9%	-2.4%	1.6%	0.1%	-1.9%	-1.0%	0.7%	-2.2%	-0.4%	-0.4%	-0.3%
May to June	-0.8%	-1.1%	-0.3%	-0.9%	-0.7%	-1.1%	-0.2%	-1.5%	-0.7%	-4.4%	-0.9%	-2.4%	1.6%	0.1%	-1.9%	-1.0%	0.7%	-2.2%	-0.4%	-0.4%	-0.3%
June to July	-1.0%	0.1%	-1.1%	-1.1%	-1.1%	-4.3%	-0.6%	-1.0%	0.9%	-4.1%	-1.9%	-1.1%	-3.6%	-4.1%	-1.5%	-0.4%	-1.4%	-0.8%	-2.2%	-2.0%	-1.7%

Mandatory Training – Areas of Focus

Particular effort continues on the 7 lowest attainment categories in **RED** shown in the chart below left.

The grid below right shows areas of specific attention around RESUS and SAFEGUARDING.



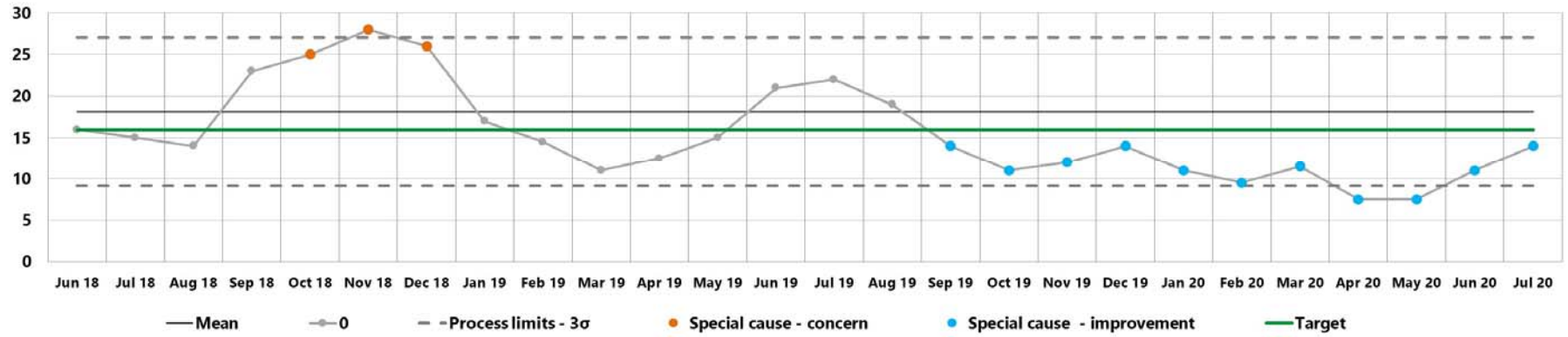
Division	Directorate	Resus - Adult	Resus - Neonatal	Resus - Paediatric	Safeguarding Adults - Level 2 2020	Safeguarding Children - Level 3 2020
253 Clinical Support 82.6% (5108/6179)	253 Breast Screening Service Dir 88.1% (476/540)	92%			92%	
	253 Cancer Services Management Dir 76% (178/234)	100%			100%	
	253 Clinical Support Div Mgt Dir 73.3% (55/75)	100%			50%	
	253 Imaging Dir 83.9% (2252/2684)	84%		53%	82%	
	253 Pathology Dir 76.4% (751/982)	70%		100%	75%	
	253 Pharmacy Dir 83.8% (1396/1664)				81%	
		85%		53%	81%	
253 Corporate / Mgt 86.6% (5402/6237)	253 Board Secretary FT Dir 95.5% (64/67)					
	253 Chief Executive Dir 80.8% (279/345)	100%			50%	
	253 Finance Information and Estate Dir 88% (1356/1540)	0%			33%	
	253 Human Resources Dir 87% (462/531)	50%			100%	
	253 Information Technology Dir 90.2% (738/818)				100%	
	253 Medical Director Dir 86.9% (946/1088)	60%		100%	78%	
	253 Nursing Directorate Dir 89.4% (1070/1196)	62%	100%		92%	70%
	253 Operations Management Dir 71.8% (405/564)	61%			83%	58%
	253 Strategy & Performance Dir 93.1% (82/88)					
		60%	100%	100%	84%	63%
253 Medicine & Integrated Care 83.1% (25232/30351)	253 Integrated Care Dir 86.3% (8545/9899)	78%		92%	79%	75%
	253 Medicine Division Management Dir 91.3% (201/220)	66%			100	
	253 Nursing Medicine Dir 82.4% (11481/13917)	64%	0%	65%	73%	66%
	253 Specialist Medicine Dir 80% (3297/4118)	65%		44%	71%	
	253 Urgent Care Dir 77.7% (1708/2197)	59%		65%	56%	60%
		68%	0%	66%	74%	66%
253 Surgery 81.6% (19958/24437)	253 Maternity Services Dir 83.6% (2870/3432)	55%	75%		76%	79%
	253 Nursing Surgery Dir 84% (6892/8199)	68%	57%	71%	71%	82%
	253 OPD and Health Records Dir 85.6% (1471/1717)	64%			86%	
	253 Specialist Surgery Dir 81% (1586/1958)	73%		71%	75%	
	253 Surgery Division Mgmt Dir 78.5% (117/149)	50%			100%	
	253 Surgery Urology & Vascular Dir 70.1% (812/1158)	31%		100%	51%	
	253 Theatres Anaes & Crit Care Dir 78.7% (4769/6059)	58%		50%	72%	
	253 Trauma & Orthopaedics Dir 81.7% (610/746)	56%			60%	
	253 Women and Children Dir 81.5% (831/1019)	57%	61%	62%	62%	62%
		61%	69%	60%	72%	78%
	OVERALL PERFORMANCE	66.8%	68.9%	61.2%	74.9%	72.9%

Staff Health & Wellbeing – SHAW Service

The response time to Managers' referrals has worsened slightly in July due capacity (days from referral to 1st appointment)

The SHAW service appointments held showed an increase in March, due mainly to Health Surveillance, and Self Referral levels.

Number of appointments in July has increased since June, the majority are in the category 'Ability to Perform Duties'



	2019												2020							
	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Total
Ability to Perform Duties	22	13	22	16	25	18	19	33	15	3	4	5	11	9	16	6	15	7	32	**291**
Counselling Referral	0	4	2	4	1	1	0	1	0	1	0	1	0	0	0	0	0	0	0	**15**
Frequent Short Term Sickness Absence	10	13	20	12	20	18	14	14	9	3	2	7	5	3	2	2	10	2	2	**168**
Long Term Sickness Absence	26	18	19	19	22	18	19	21	15	6	7	7	9	14	4	9	18	10	6	**267**
Manager Referred At Request of Employee	1	0	0	0	1	1	0	0	0	0	1	0	0	1	1	0	0	0	0	**6**
Total	**59**	**48**	**63**	**51**	**69**	**56**	**52**	**69**	**39**	**13**	**14**	**20**	**25**	**27**	**23**	**17**	**43**	**19**	**40**	**747**

HR Caseload

The current open HR caseload of 45 is dominated by 'Disciplinary' cases at 44%, with 5 current suspensions.

Cases related to BAME staff represent 16% of the total cases of BAME staff, with 67% related to Non-BAME staff. There are currently no suspensions of BAME staff members

** Please note Capability UHR currently reports on the number of cases managed at the final stage of the Sickness Absence Policy. There are currently 75 active long term absence cases in the Trust.*

	Suspension	Capability No UHR	Capability UHR	Disciplinary	Further ER Stages - Ref to Prof Reg Body	Grievance	Harassment	Total	% of BAME+Non-BAME
BAME		3	1	1		2		**7**	16%
Non-BAME	5	1	4	15		5		**30**	67%
Z Not Stated				4	1	1	2	**8**	18%
Total	**5**	**4**	**5**	**20**	**1**	**8**	**2**	**45**	

	Suspension	Capability No UHR	Capability UHR	Disciplinary	Further ER Stages - Ref to Prof Reg Body	Grievance	Harassment	Total	% of Total
Additional Clinical Services			2	5			1	**8**	18%
Administrative and Clerical	1	1	1	3		3		**9**	20%
Allied Health Professionals						5	1	**6**	13%
Medical and Dental				1	1			**2**	4%
Nursing and Midwifery Registered	4	3	2	11				**20**	44%
Total	**5**	**4**	**5**	**20**	**1**	**8**	**2**	**45**	

Enclosure 24

The Dudley Group NHS Foundation Trust

Paper for submission to Board 10th September 2020

TITLE:	**ENC 25: WRES submission and WDES submission**		
AUTHOR:	**James Fleet - Chief People Officer**	**PRESENTER:**	**James Fleet – Chief People 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
X		X	

RECOMMENDATIONS

For the committee to receive the report, note the contents, to agree that the work and action being taken to develop action plans to address under-representation is appropriate.

CORPORATE OBJECTIVE:

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

SUMMARY OF KEY ISSUES:

- The WDES and WRES submissions were made on 31 August 2020. This paper seeks to inform the board of the content of the 2020 submissions and describe the changes since the 2019 submissions - showing key areas where the Trust's performance is improving or worsening.
- Both the WDES and WRES submissions are compiled from several sources, i.e. ESR, TRAC recruitment data, HR casework, and the 2019 (October) Staff Survey results (already submitted and published).
- The submissions require the inclusion of action plans to address any imbalances and apparent and perceived inequality. The standard WDES and WRES formats show representation by band in two formats, clinical and non-clinical staff (plus board representation). However, our in-depth analysis considers representation by band, and then expands this into staff group, division, role, age group and length of service – and through the lenses of ethnicity, disability, and sexual orientation.
- Our proposed actions plans have been developed and informed by the Staff Survey Results, the WDES and WRES data requirement, and our in-depth analysis – thus enabling a triangulated and considered approach.

IMPLICATIONS FOR THE CORPORATE RISK REGISTER OR BOARD ASSURANCE FRAMEWORK

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

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

Board Paper - ENC 25: WDES and WDES Submissions 31 August 2020
Prepared by James Fleet, Chief People Officer
Board Meeting: 10th September 2020

1. Workforce Disability Equality Standard (WDES)

1.1. The Workforce Disability Equality Standard (WDES) is a set of ten specific measures (metrics) which enables NHS organisations to compare the workplace and career experiences of Disabled and non-disabled staff.

1.2. WDES provides a high-level view, and in addition to this, we have completed a more detailed analysis to inform our conclusions and action plans.

1.3. The submission is annual at the end of August, followed by a publication deadline of October each year.

1.4. The 10 sections of information in the submission are drawn from several sources, illustrated in the table below:

Workforce Disability Equality Standard:

1. **Workforce Representation**
2. **Recruitment**
3. **Capability**
4. **Harassment, Bullying & Abuse**
5. **Career Progression**
6. **Presenteeism**
7. **Feeling Values**
8. **Workplace Adjustments**
9. **Disabled Staff Engagement**
   - **9b. Facilitate Disabled Voices**
10. **Board Representation**

Sources: **ESR data at 31 March 2020**, **TRAC recruitment data**, **HR Casework**, and **Staff Survey Results from Oct 2019**

1.5. Deep-dive analysis into the Trust's WDES data (i.e. greater detail than the submission requires) has been undertaken to understand the alignment between the WDES results and the key themes from the Trust's workforce profile (as captured within ESR), and the Staff Survey results. This level of analysis has not been undertaken previously, nor has this depth of insight been shared with the Trust Board and/or senior leaders to inform positive action or improvement interventions.

1.6. We have 156 staff declaring a disability however we believe this is significantly lower than the number of staff who have a disability. The Number of staff with a declared disability has increased since 2019 from 1.8% to 3.2%, 156 staff, (at 31 March 2020) however the 2019 Staff Survey was completed by 346 staff identifying themselves as having a disability. 43% of staff completed the Staff Survey, therefore if we extrapolate 346 disabled participants, we get potentially 805 disabled staff in the Trust. (NB: this number may be skewed by non-declared disabled staff using the survey disproportionately to express their views). Furthermore the estimated proportion of the workforce that is disabled in the UK is 12%, therefore further indicating that the 3.2% declaration rate is significantly below the likely disabled staff population within the Trust.

1.7. We are committed, therefore, to support staff in feeling more comfortable declaring disabilities, and a potentially wider range of disabilities, particularly those that are non-visible.

1.8. One of the key results of the 2019 Staff Survey (part of our WDES submission) was the worsening performance in terms of equal opportunities for career progression or promotion. The survey showed a worsening position in DGFT and a worse result than the NHS national average:

	DGFT Staff Survey				DGFT Trend	National 2019	DGFT to National
	2018		2019				
	Score	Responses	Score	Responses			
WDES: Disabled	76.3%	186	74.8%	214	Worsening	79.7%	Worse
WDES: Non-Disabled	84.2%	888	83.7%	1,069	Worsening	87.1%	Worse

1.9. Our analysis of disabled representation by band appears to support the survey result (see the table below), with no disabled staff in bands 8B to 9, and only one at VSM (very senior manager) level 1.1%, which includes board membership: *(NB: this data is drawn from August 2020 ESR, which shows 171 disabled staff, an increase since March 2020)*

All Staff, by Band - all lengths of service

Disability	No		Not declared		Yes	
Band	People	%	People	%	People	%
Apprentice	52	71.2%	13	17.8%	8	11.0%
Band 2	647	55.0%	497	42.2%	33	2.8%
Band 3	261	61.1%	148	34.7%	18	4.2%
Band 4	284	64.3%	143	32.4%	15	3.4%
Band 5	527	53.0%	431	43.3%	37	3.7%
Band 6	500	53.1%	412	43.8%	29	3.1%
Band 7	253	55.5%	186	40.8%	17	3.7%
Band 8A	79	61.2%	44	34.1%	6	4.7%
Band 8B	13	52.0%	12	48.0%		
Band 8C	8	80.0%	2	20.0%		
Band 8D	6	75.0%	2	25.0%		
Band 9	1	100.0%				
Consultant	73	34.6%	138	65.4%		
Doctor	253	76.4%	71	21.5%	7	2.1%
VSM	52	56.5%	39	42.4%	1	1.1%
Total	**3,009**	**56.6%**	**2,138**	**40.2%**	**171**	**3.2%**

0% Disabled Staff

2. WDES Submissions – 2019 to 2020 changes

2.1. The table below shows the differences and an ***'Improving'*** or ***'Worsening'*** position compared to 2019 for the key indicators. TRAC data (recruitment) collection methodologies have changed since the 2019 submission, and we have interpreted this year's numbers to ensure a like-for-like comparison.

	WDES DATA Submission				
	2019		2020		
	Headcount	%	Headcount	%	Status
DISABLED Staff Employed	87	1.8%	156	3.2%	Improving
DISABLED Staff Shortlist to Recruited	20	13.4%	14	8.6%	Worsening
Relative Likelihood of Non-Disabled being Recruited V DISABLED	1.23		2.15		Worsening
NON-DISABLED Staff Entering Capability Process	33	1.7%	33	1.3%	Improving
DISABLED Entering Capability Process	1	1.1%	2	1.3%	Worsening
DISABLED Staff Entering Capability Relative Likelihood	0.69		1.1		Worsening
DISABLED Board Representation	1 (of 15)	6.7%	1 (of 19)	5.3%	Worsening

2.2. The following improvement actions have been developed and informed by; the Staff Survey Results, the WDES and deep-dive analysis, as well as engagement with the Inclusion Networks and through the WSEC Equality and Inclusion Deep-Dive session on 25th August 2020:

Leadership and cultural transformation:

- *Cultural Intelligence training for all senior leaders across the Trusts, clinical and non-clinical.*
- *Targeted career discussion for under-represented groups with actions plans, support plans and training packages offered.*
- *Mentoring schemes offered to under-represented groups including reverse mentoring with Executive and Senior level management.*
- *Executive and Non-Executive Directors to play an active role in mentoring and sponsoring staff with disabilities that have the potential to get to senior / executive role within three years.*
- *Support the leaders of the staff networks and trade union representatives to raise the visibility of their work, and to provide a source of meaningful and sustained engagement with the WDES programmes of work.*
- *All mangers to complete manger essential training to understand how to create an inclusive and compassionate culture*
- *Further develop support package aimed at supporting staff from under-represented groups to progress and have equal opportunities.*

Positive action and practical support:

- *Engage with agencies to target recruitment campaigns to under presented groups i.e. Employers Network for Equality and Inclusion, local employers' associations etc.*
- *Implement targeted Talent Management programme for diverse staff groups*
- *All recruitment panels to become diverse and have a under representative staff groups on all panels.*
- *Develop WDES experts within the Trust within the Equality team and the Disability Network.*

- *Develop and launch a 'Supporting staff with Disabilities' Guidance document for all staff and Managers to utilise*
- *Take immediate next steps to secure 'Disability Confident' level 3*
- *Encourage all staff with more than 2 years' service to re-visit their data and update.*

Accountability and assurance:

- *Regularly report on progress of WDES measures for all staff groups and all divisions, monitor performance.*
- *Embed WDES performance and progress within performance objectives and appraisals of senior leaders*

Monitoring progress and benchmarking:

- *Live Performance data against WDES is monitored and published as part of the monthly KPI pack to help aid concerted support to improve measures.*

3. **Workforce Racial Equality Standard**

3.1. The Workforce Racial Equality Standard (WRES) is a set of nine specific measures (metrics) which enables NHS organisations to compare the workplace and career experiences of BAME and non-BAME staff.

3.2. WRES provides a high-level view, we have therefore completed a more detailed analysis to inform our conclusions and action plans.

3.3. The submission is annual at the end of August, followed by a publication deadline of October each year.

3.4. The 10 sections of information in the submission are drawn from several sources, illustrated in the table below:

Workforce Racial Equality Standard

1. **Workforce Representation**
2. **Recruitment**
3. **Capability**
4. **Training & CPD**
5. **Harassment, Bullying & Abuse from Patients / Public**
6. **Harassment, Bullying & Abuse from Staff**
7. **Career Progression**
8. **Discrimination**
9. **Board Representation**

Sources: **ESR data at 31 March 2020, TRAC recruitment data, HR Casework, and Staff Survey Results from Oct 2019**

3.5. A deep-dive analysis into the Trust's WRES data (in more depth than the submission requires) has also been undertaken to connect the themes from the workforce diversity profile (captured from ESR), and the Staff Survey. This insight has been used as the basis for developing a set of our corporate level actions and commitments, which are being further developed through engagement with the Inclusion Networks, as well as through Divisional and Professional staff engagement forums.

3.6. The WRES submission shows BAME staff as one group, and WHITE staff as one group, however our Trust data contains 54 ethnicity categories, and for the purposes of our deep-dive analysis we have used a more detailed ethnicity grouping since the data suggests that there are distinct issues within the BAME community that require focus.

3.7. One of the key results from the 2019 Staff Survey (part of our WRES submission) was the worsening performance in terms of equal opportunities for career progression or promotion. The survey showed a worsening position in DGFT (67.8%) which is a worse result than the NHS national average:

		DGFT Staff Survey			DGFT	National	DGFT to
	Metric Description	**2017**	**2018**	**2019**	**Trend**	**2019**	**National**
WRES: White	Percentage of staff believing that the organisation provides equal opportunities for career progression or promotion	86.5%	84.3%	84.8%	Worsening	87.4%	Worse
WRES: BAME		77.8%	74.2%	67.8%	Worsening	72.9%	Worse

3.8. Our analysis of BAME representation by band appears to support the survey result (see the table below), showing more detailed ethnicity groupings. The differences in terms of representation at Bands 5, 6 and 7 is significant, since as seniority increases representation of all BAME groups reduces:

Ethnicity Group	Asian		Black		Minority Ethnic		White	
Band	People	%	People	%	People	%	People	%
Apprentice	5	6.8%	3	4.1%			53	72.6%
Band 2	48	4.1%	38	3.2%	9	0.8%	942	80.0%
Band 3	15	3.5%	26	6.1%	6	1.4%	324	75.9%
Band 4	28	6.3%	17	3.8%			345	78.1%
Band 5	98	9.8%	95	9.5%	29	2.9%	625	62.8%
Band 6	76	8.1%	32	3.4%	11	1.2%	701	74.5%
Band 7	31	6.8%	8	1.8%	3	0.7%	380	83.3%

4. WRES Submissions – 2019 to 2020 changes

4.1. The tables below show the differences and an ***'Improving'*** or ***'Worsening'*** position compared to 2019 for the key indicators. TRAC data (recruitment) collection methodologies have changed since the 2019 submission, and we have interpreted this year's numbers to ensure a like-for-like comparison.

4.2. Even though our overall BAME representation is growing, the submission will show representation at each band for both clinical and non-clinical staff and highlight under-representation at more senior grades and particularly at board level.

	WRES DATA Submission				
	2019		2020		
	Headcount	%	Headcount	%	Status
BAME Staff Employed	813	16.6%	931	18.1%	Improving
BAME Staff Shortlist to Recruited	179	13.9%	139	9.6%	Worsening
BAME Staff Relative Likelihood of WHITE Being Recruited V BAME	1.28		2.58		Worsening
BAME Entering Disciplinary Process	11	1.35%	3	0.32%	Improving
BAME Staff Entering Disciplinary Relative Likelihood	1.75		0.74		Improving
BAME Board Representation	1 (of 15)	6.7%	1 (of 19)	5.3%	Worsening

4.3. The following improvement actions have been developed and informed by the Staff Survey Results, the WRES data requirement, the deep-dive analysis, as well as engagement with the Inclusion Networks and testing through the WSEC Equality and Inclusion Deep-Dive session on 25th August 2020:

Leadership and cultural transformation:

- *Cultural Intelligence training for all senior leaders across the Trusts, clinical and non-clinical.*
- *Targeted career discussion for under-represented groups with actions plans, support plans and training packages offered.*
- *Mentoring schemes offered to under-represented groups including reverse mentoring with Executive and Senior level management.*
- *Executive and Non-Executive Directors to play an active role in mentoring and sponsoring BME staff that have the potential to get to senior / executive role within three years.*
- *Support the leaders of the staff networks and trade union representatives to raise the visibility of their work, and to provide a source of meaningful and sustained engagement with the WRES programmes of work.*
- *All mangers to complete manger essential training to understand how to create an Inclusive and compassionate culture.*
- *Further develop support package aimed at supporting staff from under-represented groups to progress and have equal opportunities.*

Positive action and practical support:

- *Engage with agencies to target recruitment campaigns to under presented groups i.e. Stonewall, Employers Network for Equality and Inclusion etc.*
- *Implement targeted Talent Management programme for diverse staff groups*
- *All recruitment panels to become diverse and have a under representative staff groups on all panels.*
- *Develop WRES experts within the Trust within the Equality team and the BME Network.*
- *Re-visit Equal Opportunity and Diversity Policy document with the BME network to ensure its fit for purpose and update accordingly.*
- *Encourage all staff with more than 2 years' service to re-visit their data and update.*

- *Review our Investigation and Disciplinary Policy and ensure underpinned by the provisions of current best practice and guidance detailed in ACAS, GMC and ANC documentation.*

Accountability and assurance:

- *Regularly report on progress of WRES measures for all staff groups and all divisions, monitor performance.*
- *Embed WRES performance and progress within performance objectives and appraisals of senior leaders*

Monitoring progress and benchmarking:

- *Live Performance data against WRES is monitored and published as part of the monthly KPI pack to help aid concerted support to improve measures.*

5. Recommendations

5.1. The Board is being asked to; receive this report by way of update on the status of the Trust's 2020 WRES and WDES submissions, to note the issues and challenges that have been highlighted.

5.2. The Board is also asked to support the work that is actively in place to develop a single Equality and Inclusion Strategy and Improvement programme, which addresses requirements of the WRES/WDES, the 2020/21 People Plan, as well as the emergent priorities, ambitions and aspirations of the new Inclusion Networks.

Enclosure 25

The Dudley Group NHS Foundation Trust

Board of Directors on Thursday 10th September 2020

TITLE:	**We are the NHS: People Plan 2020/21 – Plan Summary & DGHFT Response**		
AUTHOR:	**James Fleet, Chief People Officer**	**PRESENTER**	**James Fleet, Chief People 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
	✓	✓	

RECOMMENDATIONS

The Board is asked to note the content of this paper and support the immediate next steps:

- Trust Board briefing paper – 10th September;
- Chief People Officer to lead a detailed review of the full 2020/21 People Plan employer requirements, as well as the Phase 3 COVID-19 Response Workforce requirements (as captured in 31st July letter from S Stevens/A Pritchard), to be undertaken by end of September, with multi-professional inputs (HR, Ops, Nursing, Medical, AHP) and develop clear actions for internal delivery during next 6-12 months;
- Engage Staff Inclusion Networks (test DRAFT plans) – October meetings
- Engage Staff Side organisations
- DRAFT plan presented to Trust Executive – end Sep
- Final plan presented to Trust Board – 8th October
- Review Dudley People Plan, aligned to Strategy Review process/timeline.

CORPORATE OBJECTIVE:

SO1: Deliver a great patient experience

SO4: Be the place people choose to work

SUMMARY OF KEY ISSUES:

We are the NHS: People Plan 2020/21 ('the plan') - the next phase of the people plan was published on 30th July, having been delayed due to COVID 19. The plan covers immediate actions for 20/21 alongside a People Pledge which makes commitments around values and behaviours which will support the work of people working in the NHS. NHSI/E are expecting to publish the final phase of the People Plan in 2021 once the national spending review has clarified the financial resources available to deliver the plan, particularly in relation to education and training and the need to introduce new roles and further grow the workforce.

The plan sets out guidelines for employers and systems within the NHS, as well as actions for; NHS England and NHS Improvement, Health Education England, Primary Care Networks, Care Quality Commission, Universities and Systems, working collaboratively, throughout the coming months and year.

The central themes of the plan build on the Interim People Plan (IPP), which was published by NHS England, NHS Improvement and Health Education England in June 2019, namely:

- More staff
- Working differently
- Compassionate and inclusive culture.

The plan focuses on the following commitments:

- Looking after our people – with quality health and wellbeing support for everyone;
- Belonging in the NHS – with a particular focus on the discrimination that some staff face;
- New ways of working – capturing innovation, much of it led by our NHS people;
- Growing for the future – how we recruit, train and keep our people, and welcome back colleagues who want to return.

The plan captures a list of detailed actions for employers and systems, within each of the four categories to be delivered during 2020-21. These actions fall under nine headings:

- Health and wellbeing
- Flexible working
- Equality and diversity
- Culture and leadership
- New ways of delivering care
- Growing the workforce
- Recruitment
- Retaining staff
- Recruitment and deployment across systems

Equality & Diversity

The plan emphasises that given recent national and international events, it has never been more urgent for our for NHS leaders to take action to create organisational cultures where everyone feels that they belong. This requires employers to understand, encourage and celebrate diversity in all its forms and in doing so challenge and eliminate discrimination, violence and bullying – which have no place in NHS organisations. The plan sets out a range of actions to be delivered during 2020/21 which will make the culture of the NHS universally understanding, kind and inclusive.

IMPLICATIONS OF PAPER:

RISK	**Y**		**Risk Description: corporate risk register recruitment and retention of staff**
	Risk Register: Y		**Risk Score:**
COMPLIANCE and/or LEGAL REQUIREMENTS	**CQC**	**Y**	**Details: Caring, Well Led**
	NHSI	**Y**	**Details:**
	Other	**N**	**Details:**

The Dudley Group
NHS Foundation Trust

WE ARE THE NHS - NHS People Plan 2020/21

1. INTRODUCTION

1.1. We are the NHS: People Plan 2020/21 ('the plan') was published on 30th July, having been delayed due to COVID 19.The plan covers immediate actions for 20/21 alongside a People Pledge which makes commitments around values and behaviours which will support the work of people working in the NHS.NHSI/E are expecting to publish the final phase of the People Plan in 2021 once the national spending review has clarified the financial resources available to deliver the plan, particularly in relation to education and training and the need to introduce new roles and further grow the workforce.

1.2. The plan sets out guidelines for employers and systems within the NHS, as well as actions for; NHS England and NHS Improvement, Health Education England, Primary Care Networks, Care Quality Commission, Universities and Systems, working collaboratively, throughout the coming months and year.

1.3. The central themes build on the Interim People Plan (IPP), which was published by NHS England, NHS Improvement and Health Education England in June 2019, namely:

- More staff
- Working differently
- Compassionate and inclusive culture.

2. COMMITMENTS, AMBITIONS & ACTIONS

2.1. The plan focuses on the following commitments:

- *Looking after our people* – with quality health and wellbeing support for everyone;
- *Belonging in the NHS* – with a particular focus on the discrimination that some staff face;
- *New ways of working* – capturing innovation, much of it led by our NHS people;
- *Growing for the future* – how we recruit, train and keep our people, and welcome back colleagues who want to return.

2.2. The plan focuses on how NHS organisations foster a culture of inclusion and belonging, as well as action to grow and train the workforce, and work together differently to deliver patient care. The plan is focused principally on the immediate term (2020-21) with an intention for the principles to create longer lasting change. In doing so, the plan reinforces the importance of the work employers have undertaken during the pandemic to better focus on the experience and wellbeing of the workforce.

2.3. The plan also includes 'Our People Promise', which outlines behaviours and actions that staff can expect from NHS leaders and colleagues, to improve the experience of working in the NHS for everyone. This sets out **ambitions** for what people should all be able to say about working in the NHS by 2024. Our NHS People Promise is central to the plan both in the next nine months and in the longer term. It has been developed to help embed a

consistent and enduring offer to all staff in the NHS. From 2021 the annual NHS Staff Survey will be redesigned to align with Our People Promise.

2.4. The plan captures a list of detailed **actions** for employers and systems, within each of the four categories to be delivered during 2020-21. The **actions** within the NHS People Plan fall under nine headings:

- Health and wellbeing
- Flexible working
- Equality and diversity
- Culture and leadership
- New ways of delivering care
- Growing the workforce
- Recruitment
- Retaining staff
- Recruitment and deployment across systems

2.5. The specific actions for each area are captured in Appendix 1. There are 36 individual actions (highlighted in green) for DGHFT, and NHS employers nationally.

2.6. Metrics will be developed by September 2020 with the intention to track progress using the NHS Oversight Framework.

3. SYSTEM WORKING

3.1. The newly established Regional People Board will have oversight of the implementation of the plan and will be supported by systems based People Boards across all 11 systems within the Midlands.

3.2. The interim plan laid down a marker that workforce planning needed to sit alongside other areas of competence for the ICS role in delivering the NHS Long Term Plan.

3.3. We are the NHS: People Plan 2020/21 makes clear the intention to see an increased role for systems to work with its constituent parts, and HEE, to use data to understand workforce and service requirements and support the attraction and deployment of staff within systems.

4. NEXT STEPS

4.1. Executive Discussion – 11th August;
4.2. People Plan 2020/21 Equality & Diversity actions to be reviewed by Workforce & Staff Engagement Committee, Equality & Inclusion Deep-Dive – 25th August;
4.3. Trust Board briefing paper – 10th September;
4.4. Chief People Officer to lead a detailed review of the full 2020/21 People Plan employer requirements, as well as the Phase 3 COVID-19 Response Workforce requirements (as captured in 31st July letter from S Stevens/A Pritchard), to be undertaken by end of

September, with multi-professional inputs (HR, Ops, Nursing, Medical, AHP) and develop clear actions for internal delivery during next 6-12 months;

4.5. Engage Staff Inclusion Networks (test DRAFT plans) – October meetings
4.6. Engage Staff Side organisations
4.7. DRAFT plan presented to Trust Executive – end Sep
4.8. Final plan presented to Trust Board – 8th October
4.9. Review Dudley People Plan, aligned to Strategy Review process/timeline.

APPENDIX 1

PEOPLE PLAN ACTIONS

Health & Wellbeing

	Action	Who	Timeline (where provided)
1	Put in place effective infection prevention and control procedures.	Employers	
2	Ensure all staff have access to appropriate personal protective equipment (PPE) and are trained to use it.	Employers	
3	All frontline healthcare workers should have a vaccine provided by their employer.	Employers	
4	Complete risk assessments for vulnerable staff, including BAME colleagues and anyone who needs additional support, and take action where needed.	Employers	
5	Ensure people working from home can do safely and have support to do so, including having the equipment they need.	Employers	
6	Ensure people have sufficient rests and breaks from work and encourage them to take their annual leave allowance in a managed way.	Employers	
7	Prevent and tackle bullying, harassment and abuse against staff, and a create a culture of civility and respect.	Employers	
8	Prevent and control violence in the workplace – in line with existing legislation.	Employers	
9	NHS violence reduction standard to be launched.	NHS England and NHS Improvement	December 2020
10	Appoint a wellbeing guardian.	Employers	
11	Continue to give staff free car parking at their place of work.	Employers	At least the duration of the pandemic
12	Support staff to use other modes of transport and identify a cycle-to-work lead.	Employers	
13	Ensure staff have safe rest spaces to manage and process the physical and psychological demands of the work.	Employers	
14	Ensure that all staff have access to psychological support.	Employers	
15	Continue to provide and evaluate the national health and wellbeing programme.	NHS England and NHS Improvement	
16	Identify and proactively support staff when they go off sick and support their return to work.	Employers	
17	Ensure that workplaces offer opportunities to be physically active and that staff are able to access physical activity throughout their working day.	Employers	
18	Make sure line managers and teams actively encourage wellbeing to decrease work-related stress and burnout.	Employers	

19	Every member of NHS staff should have a health and wellbeing conversation.	Employers	From August 2020
20	All new starters should have a health and wellbeing induction.	Employers	From October 2020
21	Provide a toolkit on civility and respect for all employers.	NHS England and NHS Improvement	March 2021
22	Pilot an approach to improving staff metal health by establishing resilience hubs.	NHS England and NHS Improvement	
23	Pilot improved occupational health support in line with the SEQOHS standard.	NHS England and NHS Improvement	

Flexible Working

	Action	Who	Timeline (where provided)
1	Be open to all clinical and non-clinical permanent roles being flexible.	Employers	
2	All job roles across NHS England and NHS Improvement and HEE will be advertised as being available for flexible working patterns.	NHS England and NHS Improvement	January 2020
3	Develop guidance to support employers.	NHS England and NHS Improvement	September 2020
4	Cover flexible working in standard induction conversations for new starters and in annual appraisals.	Employers	
5	Requesting flexibility – whether in hours or location, should (as far as possible) be offered regardless of role, team, organisation or grade.	Employers	
6	Board members must give flexible working their focus and support.	Employers	
7	Add a key performance indicator on the percentage of roles advertised as flexible at the point of advertising to the oversight and performance frameworks.	NHS England and NHS Improvement	
8	Support organisations to continue the implementation and effective use of e-rostering systems.	NHS England and NHS Improvement	
9	Roll out the new working carers passport to support people with caring responsibilities.	Employers	
10	Work with professional bodies to apply the same principles for flexible working in primary care.	NHS England and NHS Improvement	
11	Continue to increase the flexibility of training for junior doctors.	Health Education England	

Equality & Diversity

	Action	Who	Timeline (where provided)
1	Overhaul recruitment and promotion practices to make sure that staffing reflects the diversity of the community, and regional and national labour markets.	Employers	By October 2020
2	Discuss equality, diversity and inclusion as part of the health and wellbeing conversations described in the health and wellbeing table.	Employers	From September 2020
3	Publish progress against the *Model Employer* (*A Model Employer: Increasing black and minority ethnic representation at senior levels across the NHS*) goals to ensure that the workforce leadership is representative of the overall BAME workforce.	Employers	
4	51 per cent of organisations to have eliminated the ethnicity gap when entering into a formal disciplinary processes, as set out in *A Fair Experience for All (A Fair Experience for all: Closing the ethnicity gap in rates disciplinary action across the NHS workforce)*.	Employers	By the end of 2020
5	Support organisations to achieve the above goal, including establishing robust decision-tree checklists for managers, post-action audits on disciplinary decisions, and pre-formal action checks.	NHS England and NHS Improvement	From September 2020
6	Refresh the evidence base for action, to ensure senior leadership represents the diversity of the NHS, spanning all protected characteristics.	NHS England and NHS Improvement	From September 2020

Culture & Leadership

	Action	Who	Timeline (where provided)
1	Work with the National Guardians office to support leaders and managers to foster a listening, speaking up culture.	NHS England and NHS Improvement	With immediate effect
2	Promote and encourage employers to complete the free online just and learning culture training and accredited learning packages, and take demonstrable action to model these leadership behaviours.	NHS England and NHS Improvement and Health Education England	With immediate effect
3	Provide refreshed support for leaders in response to the current operating environment.	NHS England and NHS Improvement	From September 2020
4	Work with the Faculty of Medical Leadership and Management to expand the number of placements available for talented clinical leaders each year.	NHS England and NHS Improvement	By March 2021
5	Update the talent management process to make sure there is greater	NHS England and NHS Improvement	By December 2020

	prioritisation and consistency of diversity in talent being considered for director, executive senior manager, chair and board roles.		
6	Launch an updated and expanded free online training material for all NHS line managers, and a management apprenticeship pathway for those who want to progress.	NHS England and NHS Improvement	By January 2021
7	All central NHS leadership programmes to be available in digital format and accessible to all.	NHS England and NHS Improvement and Health Education England	By April 2021
8	Review governance arrangements to ensure that staff networks are able to contribute to and inform decision making processes.	All NHS organisations	By December 2021
9	Publish resources, guides and tools to help leaders and individuals have productive conversations about race, and to support each other to make tangible progress on equality, diversity and inclusion for all staff.	NHS England and NHS Improvement	From October 2020
10	Publish competency frameworks for every board-level position in NHS provider and commissioning organisations.	NHS England and NHS Improvement	By March 2021
11	Place increasing emphasis on whether organisations have made real and measurable progress on equality, diversity and inclusion, as part of the well-led assessment.	Care Quality Commission	Throughout 2020/21
12	Launch a joint training programme for Freedom to Speak Up Guardians and WRES Experts, and recruit more BAME staff to Freedom to Speak Up Guardian roles.	NHS England and NHS Improvement	By March 2021
13	Publish a consultation on a set of competency frameworks for board positions in NHS provider and commissioning organisations.	NHS England and NHS Improvement	During October 2020
14	Finalise a response to the Kark review.	NHS England and NHS Improvement	No timeframe provided
15	Launch a new NHS leadership observatory highlighting areas of best practice globally, commissioning research, and translating learning into practical advice and support for NHS leaders.	NHS England and NHS Improvement	By March 2021

New Ways of Delivering Care

	Action	Who	Timeline (where provided)
1	Use guidance on safely redeploying existing staff and deploying returning staff, developed in response to COVID-19 by NHSEI and key partners, alongside the existing tool to support a structured approach to ongoing workforce transformation.	Employers	
2	Continued focus on developing skills and expanding capabilities to create more flexibility, boost morale and support career progression.	Employers	
3	Use HEE's e-Learning for Healthcare programme and a new online	Employers and organisations	

	Learning Hub, which was launched to support learning during COVID-19.		
4	Work with the medical Royal Colleges and regulators to ensure that competencies gained by medical trainees while working in other roles during COVID-19 can count towards training.	Health Education England	
5	Develop the educational offer for generalist training and work with local systems to develop the leadership and infrastructure required to deliver it.	Health Education England	During 2020/21
6	Support the expansion of multidisciplinary teams in primary care.	Health Education England	End of 2020/21

Growing the Workforce

	Action	Who	Timeline (where provided)
1	Enabling up to 300 peer-support workers to join the mental health workforce and expanding education and training posts for the future workforce.	Health Education England	2020/21
2	Increasing the number of training places for clinical psychology and child and adolescent psychotherapy by 25 per cent (with 734 starting training in 2020/21).	Health Education England	
3	Investing in measures to expand psychiatry, starting with an additional 17 core psychiatry training programmes in 2020/21 in areas where it is hard to recruit, and the development of bespoke return to practice and preceptorship programmes for mental health nursing.	Health Education England	
4	Prioritise the training of 400 clinical endoscopists and 450 reporting radiographers.	Health Education England	2021
5	Training grants are being offered for 350 nurses to become cancer nurse specialists and chemotherapy nurses.	Health Education England	2021
6	Training 58 biomedical scientists, developing an advanced clinical practice qualification in oncology, and extending cancer support-worker training.	Health Education England	2021
7	HEE is funding a further 400 entrants to advanced clinical practice training.	Health Education England	2020/21
8	Investing in an extra 250 foundation year 2 posts, to enable the doctors filling them to grow the pipeline into psychiatry, general practice and other priority areas, notably cancer, including clinical radiology, oncology and histopathology.	Health Education England	2020/21
9	Increase of over 5,000 undergraduate places from September 2020 in	Health Education England	2020/21

	nursing, midwifery, allied health professions, and dental therapy and hygienist courses.		
10	Employers should fully integrate education and training into their plans to rebuild and restart clinical services, releasing the time of educators and supervisors; supporting expansion of clinical placement capacity during the remainder of 2020/21; and providing an increased focus on support for students and trainees, particularly those deployed during the pandemic response.	Employers	2020/21
11	For medical trainees, employers should ensure that training in procedure-based competencies is restored as services resume and are redesigned to sustain the pipeline of new consultants in hospital specialties.	Employers	2020/21
12	Ensure people have access to continuing professional development, supportive supervision and protected time for training.	Employers	2020/21
13	Establish a £10m fund for nurses, midwives and allied health professionals to drive increased placement capacity and the development of technology-enhanced clinical placements.	Health Education England	
14	HEE to further develop its e-learning materials, including simulation, building on the offer provided in response to COVID-19.	Health Education England	2020/21
15	Start delivering a pre-registration blended learning nursing degree programme. The programme aims to increase the appeal of a nursing career by widening access and providing a more flexible approach to learning, using current and emerging innovative and immersive technologies.	Health Education England/ Universities	From Jan 2021
16	HEE to pursue this blended learning model for entry to other professions.	Health Education England	From Jan 2021

Recruitment

	Action	Who	Timeline (where provided)
1	Increase recruitment to roles such as clinical support workers, highlighting the importance of these roles for patients and other healthcare workers as well as potential career pathways to other registered roles.	Employers	
2	Offer more apprenticeships, ranging from entry-level jobs through to senior clinical, scientific and managerial roles.	Employers	
3	Develop lead-recruiter and system-level models of international recruitment, which will improve support to new starters as well as	Systems	

	being more efficient and better value for money.		
4	Primary care networks to recruit additional roles, funded by the additional roles reimbursement scheme, which will fund 26,000 additional staff until 2023/24.	Systems	Immediate
5	Increase ethical international recruitment and build partnerships with new countries, making sure this brings benefit for the person and their country, as well as the NHS.	NHS England and NHS Improvement and Health Education England	
6	HEE will pilot English language programmes – including computer-based tests, across different regions as well as offering English language training.	Health Education England	2020/21
7	Establish a new international marketing campaign to promote the NHS as an employer of choice for international health workers.	NHS England and NHS Improvement	2020/21
8	Encourage our former people to return to practice as a key part of recruitment drives during 2020/21, building on the interest of clinical staff who returned to the NHS to support the COVID-19 response.	Employers and systems	2020/21
9	Continue to work with professional regulators to support returners who wish to continue working in the NHS to move off the temporary professional register and onto the permanent register.	NHS England and NHS Improvement and Health Education England	2020/21

Retaining Staff

	Action	Who	Timeline (where provided)
1	Design roles which make the greatest use of each person's skills and experiences and fit with their needs and preferences.	Employers	
2	Ensure that staff who are mid-career have a career conversation with their line manager, HR and occupational health.	Employers	
3	Ensure staff are aware of the increase in the annual allowance pensions tax threshold.	Employers	
4	Make sure future potential returners, or those who plan to retire and return this financial year, are aware of the ongoing pension flexibilities.	Employers	
5	Explore the development of a return to practice scheme for other doctors in the remainder of 2020/21, creating a route from temporary professional registration back to full registration.	Health Education England	2020/21
6	Develop an online package to train systems in using the HEE star model for workforce transformation.	Health Education England	2020/21
7	Improve workforce data collection at employer, system and national level.	Health Education England	2020/21

8	Support the GP workforce through full use of the GP retention initiatives outlined in the GP contract, which will be launched in summer 2020.	Systems	
9	Strengthen the approach to workforce planning to use the skills of our people and teams more effectively and efficiently.	Systems	
10	Work with HEE and NHSEI regional teams to further develop competency-based workforce modelling and planning for the remainder of 2020/21, including assessing any existing skill gap and agreeing system-wide actions to address it.	Systems	2020/21

Recruitment & Development Across Systems

	Action	Who	Timeline (where provided)
1	Actively work alongside schools, colleges, universities and local communities to attract a more diverse range of people into health and care careers.	Systems	
2	Make better use of routes into NHS careers (including volunteering, apprenticeships and direct-entry clinical roles) as well as supporting recruitment into non-clinical roles.	Systems	By March 2021
3	Develop workforce sharing agreements locally, to enable rapid deployment of our people across localities.	Systems	
4	When recruiting temporary staff, prioritise the use of bank staff before more expensive agency and locum options and reducing the use of ‘off framework’ agency shifts during 2020/21.	Systems, employer and primary care networks	2020/21
5	Work with employers and systems to improve existing staff banks’ performance on fill rates and staff experience.	NHS England and NHS Improvement	

Enclosure 26

Paper for submission to the Board of Directors on 10th September 2020

TITLE:	**Speak Up (FTSU) Guardian Update**		
AUTHOR:	Derek Eaves, FTSU Guardian, Becky Plant, FTSU Guardian	**PRESENTER**	Derek Eaves, FTSU Guardian, Becky Plant, FTSU Guardian

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

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

RECOMMENDATIONS

To agree that the actions being taken are appropriate. To approve the Board FTSU statement.

CORPORATE OBJECTIVE:

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

SUMMARY OF KEY ISSUES:

This paper gives an update on:

- Concerns raised in the last two quarters (Q1) and for Q2 up to 23rd August and an outline of outcomes and feedback from these.
- Recent information, activities and developments.
- Proposed Board statement regarding their commitment to FTSU: the Board is requested to please read and approve this draft.

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:** Recent review of FTSU
	Other	**N**	**Details:**
REPORT DESTINATION	**Board of directors**	**Y**	**DATE:** 10th September 2020
	WORKING GROUP	**N**	**DATE:**
	COMMITTEE	**N**	**DATE:**

EXECUTIVE SUMMARY

From this financial year, in terms of numbers of concerns raised the National Guardian Office (NGO) has asked that when a group of staff have the same concern this should be recorded as the number of staff in the group not one concern. This change is reflected in the amount of concerns that the Guardians now report.

At the start of 20/21 the Guardians received a number of Covid related queries: most of which were quickly dealt with. The assistance of the infection control team and the incident room team, was greatly appreciated.

The Guardian service underwent internal audit recently and more details of this can be found in the main body of this report.

The Guardians and champions are preparing for FTSU month (October): during this time we will be surveying staff for their thoughts on our service.

THE DUDLEY GROUP NHS FOUNDATION TRUST
Freedom to Speak Up (FTSU) Guardian September 2020 update

BACKGROUND INFORMATION

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

- A junior doctor who had used the service decided later to make his concern formal and it was escalated to the Human Resources (HR) Department for investigation. The junior returned after no feedback was given following the investigation and the perceived bullying had recommenced. After discussion with HR staff, this issue has now been resolved.
- A member of staff required support during a perceived unfair disciplinary investigation which was resolved to the satisfaction of all parties.
- A qualified member of staff was concerned about the perceived unprofessional behaviour of a member of staff who was dealing with the discharge arrangements of a parent. Following involvement of a Director an apology was given to the satisfaction of the person raising the concern.
- A variety of concerns raised about Covid related issues at both Russells Hall, The Guest and community such as the use of masks, social distancing etc were taken up with the Chief Executive, Communications Department and those in charge of PPE marshalls and greater monitoring, increased publicity and stronger messaging occurred as a result.
- A Covid concern about inadequate space in certain offices was taken to the relevant managers who took prompt action to ensure appropriate distancing occurred from then on.
- Two registered professionals felt they had been unfairly accused of negative behaviour towards a colleague. Following investigation by their line manager, with HR support, it was decided there was no case to answer.
- One registered professional was concerned about the changes that are taking place in their own department, as part of the restoration plan. No action has been requested at this time but the concerns have been duly noted and support made available.

Feedback

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

'Thank you for all your help and support it was so helpful to me.'

'Take care and once again thank you for your help.'

'Thanks again, good work by yourself as usual'

'Many thanks for taking the time to see me today. It was really helpful and highlighted some pointers that I had missed.'

'Thanks so much for everything and I hope you are keeping safe from the corona virus'.

'Thanks for taking the time to come to the dept and listen to me, its much appreciated.'

'*Just wanted to say thank you for the advice, support and help over the past couple of weeks. It's very much appreciated.'*

'Thank you once again for today'

A breakdown of concerns can be found in Appendix 1.

Internal Audit

RSM, the Trust's internal auditors, undertook a review of FTSU arrangements in August. A final outcome of the review has now been provided. Reasonable assurance was found with a few minor management actions recommended. These are all minor (e.g. leaflets to be updated with the new Guardian's details) or are already part of the action plan of the steering group (e.g. the need for the Trust to undertake the NHSi self-review tool for boards).

Speak Up Champions: Six weekly meetings have now recommenced using a mixture of face to face and Microsoft teams. This is in addition to ad hoc meetings/telephone calls to individuals, as and when required, as part of supportive measures for the network.

Appreciative enquiry training is planned for October: this will link in with an analysis of the first full year of Greatix submissions. Some of the champions have requested that the Greatix summary for their areas be available to them so the information and learning can be shared at local governance meetings.

NGO Case Reviews

There has been one in this period about the Whittington Heath NHS Trust, London. The review was undertaken because workers' indicated the trust's response to their speaking up had not been in accordance with its policies and procedures, or good practice. The review identified areas of improvement regarding how the trust responded to speaking up cases raised by its workers. These included workers not being thanked for speaking up, delays in responding to matters raised and the need to provide better support and information about processes and procedure to those speaking up and handling their cases. A review of the recommendations within the report was undertaken and discussed at the last FTSU steering group. The group were of the view that the key issue for the Trust to take action was to strengthen the use of Exit Interviews. It was agreed that the system needs to be more proactive and there needs to be richer data coming from the system. The possibility of making these compulsory not just at the request of the leaver as the system stands at the moment was raised as was the possibility of them being undertaken not by line managers so staff would be more open if they have work concerns which have contributed to the decision to leave. It was decided to refer up this issue to the Workforce Committee.

Speak Up Month

Preparations have commenced for Speak Up month in October. Consideration is being made for the following:

A walkround schedule of all areas with Non-Executive/Executive involvement with:
- Pens
- Leaflets
- Food

(These are dependent on the Covid situation)

- Potential Steering group meeting opened up to all staff to listen in
- Videos of Guardians and champions explaining their role
- A-Z of Speak up – each day on the Hub to have a champion/Guardian/Steering Group member explain an aspect of Speak Up holding a card for each letter of the alphabet
- Potential of Rachel Clarke [Advocacy and Learning Senior Manager (FTSU) Staff Experience and Engagement, People Directorate, NHS England and NHS Improvement] to present at Grand Round
- Statement for Board to adopt
- Screensavers
- Survey of all staff on their views of aspects of Speaking Up results of which will be used by Rachel Clarke in her assessment of Speak Up at the Trust
- Survey of staff who have raised a concern over the year

RECOMMENDATIONS

FTSU Index and Draft Board statement for approval

Each year, the National Guardian Office publishes the FTSU Index which is based on the results of four questions from the annual National Staff Survey (the four questions are the perception of whether staff involved in an error, near miss or incident are treated fairly, whether the organisation encourages them to report errors, near misses or incidents, if staff were concerned about unsafe practice, would they know how to report it and feeling secure about raising concerns about unsafe clinical practice). Combined acute and community Trusts score on average 79% while the Trust scored 76%. Contact has been made with some of the higher scoring Trusts and the attached draft declaration (Appendix 2) has been adapted from a similar statement from The Royal Bournemouth and Christchurch Hospital NHS Foundation Trust which scored 84.1%.

The Board is asked to consider this statement, and the attached declaration, with a view to approving and adopting it as a group.

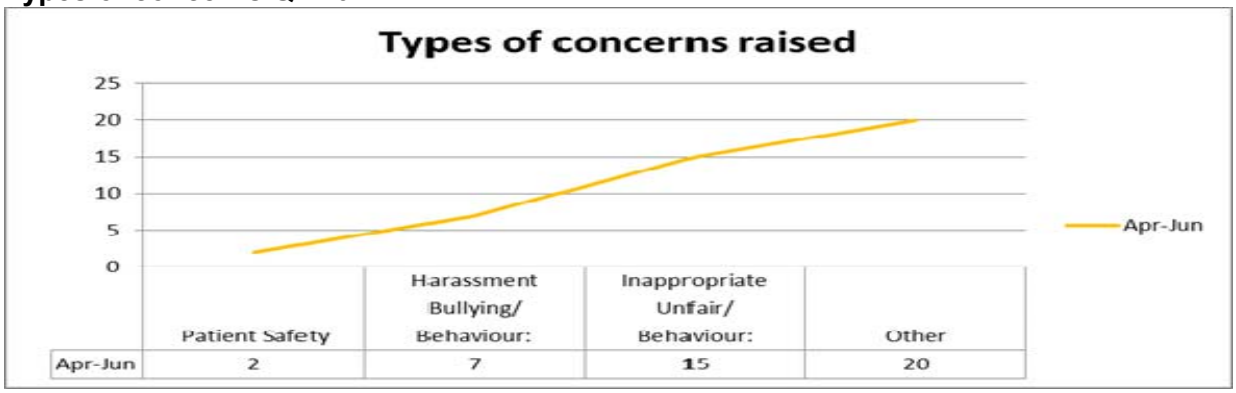
Appendix 1

The table below indicates the numbers and types of concerns raised with the Guardians From this financial year. In terms of numbers of concerns raised, the National Guardian Office (NGO) has asked that when a group of staff have the same concern this should be recorded as the number of staff in the group not one concern (as previously). For comparative purposes we have noted the numbers in the groups underneath the chart below. As previously noted, the National Guardian Office (NGO) has discussed the difficulties in categorising types of concerns being raised and those below are locally based categories. The majority of concerns being raised are regarding behaviour unrelated to patient care although as the Civility Saves Lives Campaign points out, inappropriate behaviour between and towards staff can result in ineffective care. We have divided the national category on this topic into two: a) perceived bullying and harassment and b) perceived unfair behaviour, the latter includes such concerns as unfair recruitment, unfair rotas and concerns about redeployment of staff. Both of these two types of concerns cover those regarding colleagues, line and senior managers.

	Number	Anonymously	Patient Safety	Behaviour: Bullying/ Harassment	Behaviour: Unfair/ Inappropriate	Other
Apr-Jun	2	0	0	2	0	0
Jul-Sep	14	3	4	8	2	0
Oct-Dec	17	0	3	8	6	0
Jan-Mar	11	2	2	4	5	0
2017/18	44	5	9	22	13	0
Apr- Jun	15	0	3	8	5	2
Jul – Sep	12	0	2	5	4	2
Oct – Dec	26	1	4	7	11	4
Jan- Mar	14	0	1	7	4	2
2018/19	67	1	10	27	24	10
Apr–Jun	24	0	5	8	7	4
July–Sep	17	0	3	7	7	0
Oct-Dec	25	1	3	5	16	1
Jan-Mar	18	0	2	6	7	3
2019/20	84	1	13	26	37	8
Apr-Jun	44	1	2	7	15	20+
Jul-Aug 23rd	15	0	0	3	9	3*
2020/21	59	1	2	10	24	23

+ 17 of these were Covid related *3 All of these were Covid related

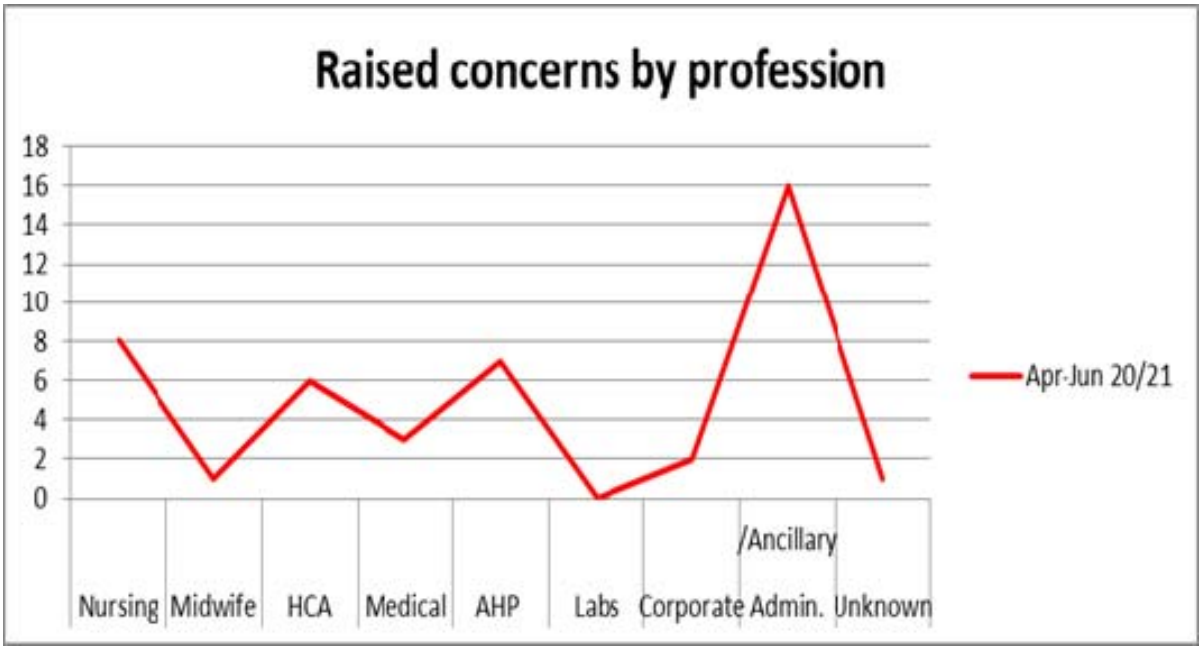
Types of concerns Q1 20/21



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

	Number	Nursing	Midwife	HCA	Medical	AHP	Clinical Scientist	Corporate	Admin. /Ancillary	Unknown
Apr-Jun	2	2	0		0	0	0		0	0
Jul-Sep	14	7	2		0	1	0		3	1
Oct-Dec	17	7	0		1	0	1		8^	0
Jan- Mar	11	5	2		2	0	0		2	0
2017/18	44	21	4		3	1	1		13	1
Apr- Jun	15	9	2		2	1	0		1	0
Jul – Sep	12	8	1		1	1	0		1	0
Oct – Dec	26	10	2		3	3	0		8	0
Jan - Mar	14	6	1		2	0	0		4	1
2018/19	67	33	6		8	5	0		14	1
Apr–Jun	24	7[1]	1	4	1[1]	2	0	4[2]	5[2]	0
July–Sep	17	3	4	3	0	2[2]	0	1	4[1]	0
Oct-Dec	25	8	0	2	0	2[1]	2[2]	6	4[2]	1
Jan- Mar	18	4[1]	1	3	2	2	0	1	5	0
2019/20	84	22	6	12	3	8	2	12	18	1
Apr-Jun	44	8	1	6	3	7	0	2	16	1
Jul-Aug 23rd	15	3	0	3	0	2	0	1	6	0
2020/21	59	11	1	9	3	9	0	3	22	1

^1 of these was a PFI staff member, [1]=One was more than one individual, [2] = Two were more than one individual,



Appendix 2

Statement of commitment to the principles of Freedom to Speak from the Board of Directors.

We are committed to fostering a culture of safety and learning in which all staff feel safe to raise a concern wherever they work.

Speaking up is an essential part of an open and transparent culture, in any sector where safety is at its core. It should be something that everyone feels able to do and is encouraged to do. There should be a shared belief at all levels of the organisation that raising concerns is a positive, not a troublesome activity, and a shared commitment to support and encourage all those who raise honestly held concerns about safety. Without a shared culture of openness and honesty in which the raising of concerns is welcomed, and the staff who raise them are valued, the barriers to speaking up will persist.

The Board absolutely supports the key principles of speaking up and is committed to leading the actions required to implement them and being available for anyone who needs to raise anything. We have support and advice from the Freedom to Speak up Guardians (FTSUG) and a network of Champions to help us make Speaking Up Safe.

The key principles the Board is committed to include:

	Principle	Action
1	Culture of safety	We will actively foster a culture of safety and learning, in which all staff feel safe to raise concerns.
2	Culture of raising concerns	We encourage the raising of concerns as part of the normal routine business of any well led NHS organisation.
3	Culture free from bullying	We will ensure that staff are able to work in a culture which is free from bullying and other oppressive behaviours.
4	Culture of visible leadership	Through visible leadership at all levels in the organization we welcome and encourage the raising of concerns by staff.
5	Culture of valuing staff	We will show that we value staff who raise concerns, and celebrate the benefits for patients and the public from the improvements made in response to the issues identified.
6	Culture of reflective practice	There should be opportunities for all staff to engage in regular reflection of concerns in their work.

7	Raising and reporting concerns	We will ensure we have robust structures to facilitate both informal and formal raising and resolution of concerns.
8	Investigations	When a formal concern has been raised, there will be prompt, swift, proportionate, fair and blame-free investigations to establish the facts.
9	Mediation and dispute resolution	We will consider that there will be given at an early stage the use of expert interventions to resolve conflicts, rebuild trust or support staff who have raised concerns.
10	Training	All staff will receive training in the Trust's approach to raising concerns and in receiving and acting on them.
11	Support	There will be a range of persons to whom concerns can be reported easily and without formality.
12	Support to find alternative employment in the NHS	Where a staff member has raised a concern cannot, as a result, continue in their current employment, we will fulfil our moral obligation to offer support.
13	Transparency	We will be transparent in the way we exercise our responsibilities in relation to the raising of concerns, including the use of settlement agreements.
14	Accountability	Everyone will be expected to be held accountable for adopting fair, honest and open behaviours and practices when raising or receiving and handling concerns.
15	Students and Trainees	All the above principles will be applied with necessary adaptations to education and training settings for students and trainees working towards a career in healthcare.

(The above principles were outlined in 'Freedom to Speak up' by Robert Francis 2015)

Speaking up ANNUAL DECLARATION

Please tick the statements below to confirm that your agreement.

- ☐ I recognise that I have a responsibility for creating a safe culture and an environment which staff are able to highlight problems and make suggestions for improvement.
- ☐ I understand the importance of staff feeling able to speak up and the trusts vision to achieve this
- ☐ I recognise the impact of my own behaviour on the trust's culture. I will therefore reflect on my own behaviour regularly so that it does not inhibit someone speaking up*.
- ☐ I have insight into how my power could silence truth
- ☐ I will welcome approaches from staff and thank them for speaking up. I will ensure that I will provide feedback
- ☐ I will speak up, listen and constructively challenge one another during board meetings
- ☐ I will seek feedback from peers and staff and reflect on how effectively they demonstrate the trust's values and behaviours
- ☐ I will accept challenging feedback constructively, publicly acknowledge mistakes and make improvements.
- ☐ I will be open and transparent and see speaking up as an opportunity to learn.

*It is good practice to test your behaviour with direct and incidental feedback from staff surveys, pulse surveys, social media comments, reverse mentoring, 360 feedback and appraisals.

Signed: _____ Date: _____

Name in block letters: _____

Job title: _____

Approved by Board of Directors (xxxx)
Author: FTSU Guardians
Review: xxxx

Enclosure 27

The Dudley Group NHS Foundation Trust

Paper for submission to the Board on the 10th September 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 September 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 15th GSW report and covers the period from 30th April 2020 – 11th August 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.

COVID 19 Outbreak:

Our junior doctors have continued to perform exceptionally well during COVID 19 outbreak. Currently during restore and living with COVID 19 daily challenges they are performing up to their expectations. There has been slight increase in exception reporting since the last report which indicates junior doctors engagement in the whole process. Guardian has maintained a close contact with junior doctors throughout this time.

Exception Reports by Department – 30th April 2020 – 11th August 2020 total = 11

Number of exceptions carried over	Number of exceptions raised	Number of exceptions closed	Number of exceptions outstanding	Specialty
0	11	7	4 waiting for doctor agreement	A&E – 4 General Surg - 6 Gen med (onc) – 1

Exception Reports by Grade

Grade	Addressed within 48 hours	Addressed within 7 days	Addressed in longer than 7 days	Still open –
F1 – 7 ST1 – 4	0	4	7	4 (waiting doctor agreement)

Exception Reports and Fines.

- 11 exception reports by doctors
- 0 immediate safety concerns
- 0 exception reports agreed as compensation overtime payment
- 0 pending
- 4 waiting for doctor agreement
- 0 request for more info
- 0 exception reports agreed as time in lieu
- 3 exception reports agreed as no further action
- No fines during this period
- 0 exception reports outcome “work schedule review”
- 4 closed due to no response from Doctor or Supervisor

Gaps as at August 2020

Department	DOCTORS IN TRAINING				Total
	FY1	FY2	ST Lower (CT, CMT, GPST	ST Higher	
AMU	0	0	3	2	**5**
ANAESTHETICS	0	0	0	0	**0**
CARDIOLOGY	0	0	1	0	**1**
DERMATOLOGY	0	0	0	0	**0**
DIABETES	0	0	0	0	**0**
ELDERLY CARE	0	0	1	0	**1**
EMERGENCY	0	1	3	0	**4**
ENT	0	0	0	0	**0**
GASTROENTEROLOGY	0	0	0	0	**0**
HAEMATOLOGY	0	0	0	0	**0**
MAX FAC	0	0	0	0	**0**
OBS & GYNAE	0	0	0	0	**0**
ONCOLOGY	0	0	0	0	**0**
OPHTHALMOLOGY	0	0	0	0	**0**
PAEDIATRICS	0	0	1	0	**1**
PAIN MANAGEMENT	0	0	0	0	**0**
RADIOLOGY	0	0	0	0	**0**
RENAL	0	1	1	0	**2**
RESPIRATORY	0	0	1	0	**1**
RHEUMATOLOGY	0	0	0	0	**0**
STROKE	0	0	0	0	**0**
SURGERY (GENERAL)	0	0	0	0	**0**
TRAUMA & ORTHOPAEDICS	0	0	0	0	**0**
UROLOGY	0	0	0	0	**0**
VASCULAR	0	0	0	0	**0**
Total	**0**	**2**	**11**	**2**	**15**

Next Steps

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

The Dudley Group NHS
NHS Foundation Trust

1. Conclusion

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

2. Recommendation

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

Author	**Babar Elahi** **Guardian of Safe Working**
Executive Lead	**Chief Executive**
Date	**31/08/2020**

Enclosure 28

Paper for submission to the Board of Directors on the 10th September 2020

The Dudley Group NHS Foundation Trust

TITLE:	**Public Digital and Technology Committee Report**		
AUTHOR:	**Catherine Holland** (Digital Committee Chair)	**PRESENTER**	**Catherine Holland** (Digital 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 COMMITTEE			
Decision	**Approval**	**Discussion**	**Other**
			ASSURANCE

RECOMMENDATIONS

- That there is positive assurance and mitigation of the High CareCERT (*CC-3563)* 15th July 2020
- That there is positive assurance EPMA and eVTE golive and clinical adoption (DCB0160/0129 compliant clinical safety case report)
- That the Technology Strategy has been revised (V1.1) to account for advances made during Covid.

CORPORATE OBJECTIVE:

SO5 – Make the best use of what we have
SO6 – Deliver a viable future

SUMMARY OF KEY ISSUES:

- Mitigated High CareCERT (*CC-3563)* 15th July 2020, statutory requirement to report to board
- The successful goliive and adoption of EPMA and eVTE. The committee placed on record acknowledgement of the exceptional clinical leadership and workforce approach to adopting this significant change smoothly as exemplar.

IMPLICATIONS OF PAPER:

IMPLICATIONS FOR THE CORPORATE RISK REGISTER

RISK	**Y**		**Risk Description:** CE1083 Risk of cyber a security incident causing widespread impact of Trust operational capability and patient safety
	Risk Register: Y		**Risk Score: 25 - Extreme**
COMPLIANCE and/or LEGAL REQUIREMENTS	**Other**	**Y**	**Details:** DCB0160 and DCB0129 clinical risk management standards (HSCA statue 250)
REPORT DESTINATION	**BOARD**	**Y**	**DATE: 10th September 2020**

UPWARD REPORT FROM Digital and Technology Committee

Date Committee last met 27th August 2020

The Dudley Group NHS Foundation Trust

MATTERS OF CONCERN OR KEY RISKS TO ESCALATE	MAJOR ACTIONS COMMISSIONED/WORK UNDERWAY
	• National Microsoft N365 programme progressing • EPMA and eVTE project live and being embedded into practice • Borough-wide work on securely connecting GPs to health & social care network (HSCN) nears completion • Externally commissioned GP device refresh nears completion • Trust device refresh programme ongoing
POSITIVE ASSURANCES TO PROVIDE • Mitigation, closure and report to board of CareCERT (*CC-3563 – SigRed Windows DNS RCE Vulnerability)* 15th July 2020 • Successful go-live and adoption of electronic prescribing, medicines administration (EPMA) and electronic VTE bleeding risk (eVTE) assessment. Clinical leadership and the wider workforce approach to adopting this significant change smoothly was noted as exemplar.	**DECISIONS MADE** • Ratified revised Technology Strategy (V1.1) as fit for purpose

Chair's comments on the effectiveness of the meeting:

- The virtual meeting format is becoming more familiar to committee members and focus on providing concise jargon free papers improved the quality of discussion and the ability to seek appropriate assurance. A "CIO report" was provided to set context for the 8-week reporting interval, which was well received by the committee.

Enclosure 29

The Dudley Group NHS Foundation Trust

Paper for submission to the Public Board on 10th September 2020

TITLE:	**Winter Plan – 2020/21**		
AUTHOR:	**Karen Kelly** **Chief Operating Officer**	**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 approach to winter planning and preparedness

CORPORATE OBJECTIVE:

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

SUMMARY OF KEY ISSUES:

1. The Trust experienced significant challenges in terms of patient experience, patient outcomes and performance against the constitutional standards in the last winter period and this formed part of our review of the Winter Plan.

2. The winter preparedness and planning process was identified as an area to strengthen and it has been agreed that a more systematic and system wide approach to planning for Winter 20/21 would be adopted leveraging best practice from other Trusts in the STP where appropriate.

3. Due to the specific challenges presented by the current COVID 19 outbreak and the need to prepare for a potential second wave of Acute demand the Winter Plan would need to include planning for these COVID & COVID + Seasonal Flu scenario's as separate escalation plans.

4. The plan needs to set out the expected acute bed demand based on historic information and expected growth (and spikes) minus the operational improvements the system has undertaken to deliver prior to winter which will reduce demand.

N.B. Whilst this review process will consider the implications of COVID-19 on the coming winter period it

does not consider or analyse performance during the period of Wave 1 of the COVID-19 outbreak.

The process of Winter Planning has specific elements which are being delivered in sequence between July and October 2020:

- Review of winter 19/20 to ascertain root cause of challenges, take learning from the analysis and develop solutions and improvements which address these root causes – July 20
- Develop a set of improvement workstreams which can mobilise and implement these solutions and deliver benefit by the coming winter – Aug 20
- Model, based on expected growth in demand and the impact of improvement activity, a forecast of the number of acute beds required to safely manage patients through their treatment and safe discharge during the period Oct 20 to Mar 21 – Sept 20
- Build staffing and financial models that support the plan and adopt this as a Trust – Sept. 20

1. Review of winter 19/20 (July 20)

A detailed review of the winter period was conducted in July 20 and identified a number of key learnings:

- There was a strong correlation between a significant spike in presentations of contagious respiratory illness in December (estimated at 30-35 extra beds of demand over normal levels) and the Trusts resources becoming overwhelmed leading to significant operational and safety challenges
- There was a strong correlation between a significant drop (30/day) in discharges during the period from 24th Dec to 6th Jan and a second surge in patients waiting in ED whilst demand was not notably, or significantly higher than expected
- Both of these issues exacerbated an ongoing situation where general and acute (G&A) bed occupancy was consistently in excess of 90%
- Analysis of the flow from ED to AMU showed a significant (circa 1200/month) number of admitted patients who spent less than 24hrs in a bed after admission. This indicated a potential opportunity to manage some of these patients more effectively through Same Day Emergency Care (SDEC) pathways which would release beds in the AMU area which is critical to achieving flow
- Additionally, through the winter period there were circa 700 patients a month who were given a decision to admit by ED but were not admitted to an acute beds indicating an opportunity to make better use of SDEC pathways
- Finally it was noted that, as part of the COVID-19 response significant improvements have been made to the complex discharge pathways which will, following the most recent NHS guidance, be able to sustain through the winter period and, as a result reduce historic delays for this patient cohort

2. Develop a set of improvement workstreams (Aug 20)

Working with colleagues across the Dudley healthcare economy (Community, CCG, LA and others) through a number of workshops and structured meetings a set of agreed workstreams and improvement projects were agreed. All workstreams have sponsors and all projects have owners. The process of project management aligns the system Unplanned and Emergency Care Ops Group (UECOG) with organisational project groups and reports upwards to A&E Delivery Board who are assured of system wide planning for the winter period.

- These improvements have been grouped into 4 workstreams with a 5th Workstream enabling the process of creating the overall plan (see fig 1):
  - Attendance Avoidance
  - Admission Avoidance
  - Improved Flow
  - Improved Discharge
  - Winter Planning (enabler)

Fig 1.

3. **Model the impact of improvement activity on Acute bed demand (Sept 20)**

This element has two steps:

Agree impact on acute bed demand of each project in each workstream

Model the daily predicted acute bed demand for the winter period based on forecast growth and mitigations

These elements are due to be completed w/e 11th Sept and a draft position presented to the Trust

4. **Build staffing and financial models that support the plan and adopt this as a Trust**

This process should take place during September with a view to adopting a ratified operational plan by end of September 2020

5. **Finalised winter plan**

The final winter plan will be presented to the Trust Board in its October meeting, this will be agreed by key partners. It is expected that Transformational change will need to run concurrently in order for the Winter plan to be delivered successfully.

Current Risks and Issues:

The process has, to date, identified significant opportunities to mitigate growth in admitted demand in the coming winter period and create capacity to safely manage a second wave of COVID-19. The solutions are widely accepted and agreed upon, they are well documented, supported by data and address much of the clinical risk and impact on patient experience seen last winter.

However to create enough improvement to mitigate the expected growth and ensure capacity is available to meet any 'second wave' of COVID-19 safely, prior to the availability of the increased capacity from the proposed modular build, the pace of implementation will need to be very high and transformational in nature, more akin to the pace of change seen during the preparation for COVID-19 than typical change management in the NHS.

To achieve a sustainable and safe position in a timely manner delivery of key elements of the plan will need extensive and intensive support from the trust to mobilise its resources differently and release the associated benefits in a timely manner

IMPLICATIONS OF PAPER: Risks identified in this paper are linked to the risk (BAF 1b)

IMPLICATIONS FOR THE CORPORATE RISK REGISTER OR BOARD ASSURANCE FRAMEWORK			
RISK	**Y**		**Risk Description:** BAF 1b - Failure to meet access standards caused by inability to improve patient flow and work effectively with very local partners will result in an adverse outcome for the patient
	Risk Register: Y		Risk Score: BAF 1B – Risk score 15 (AMBER)
COMPLIANCE and/or LEGAL REQUIREMENTS	**CQC**	**Y/N**	**Details:**
	NHSI	**Y/N**	**Details:**
	Other	**Y/N**	**Details:**
REPORT DESTINATION	**EXECUTIVE DIRECTORS**	**Y/N**	**DATE:**
	WORKING GROUP	**Y/N**	**DATE:**
	COMMITTEE	**Y/N**	**DATE:**

Enclosure 30

The Dudley Group
NHS Foundation Trust

Paper for submission to the Board of Directors on 10 September 2020

TITLE:	**Board Assurance Framework – Quarterly Report**		
AUTHOR:	Liam Nevin	**PRESENTER**	Liam Nevin

CLINICAL STRATEGIC AIMS

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

ACTION REQUIRED OF COMMITTEE

Decision	Approval	Discussion	Other
		Y	

RECOMMENDATIONS

- That the Board note the risks and mitigations as set out in the BAF and summarised in this report.

CORPORATE OBJECTIVE:

All

SUMMARY OF KEY ISSUES:

The report provides an analysis of the corporate risk framework relating to the strategic BAF risks. It provides a composite picture of the strategic risks of the Trust and an analysis of key risk issues against each of the strategic objectives.

IMPLICATIONS OF PAPER:

IMPLICATIONS FOR THE CORPORATE RISK REGISTER OR BOARD ASSURANCE FRAMEWORK

The report is directly concerned with the Board Assurance Framework

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

REPORT DESTINATION	**EXECUTIVE DIRECTORS**	**Y**	**DATE: 4.11.19**
	WORKING GROUP	**Y/N**	**DATE:**
	COMMITTEE	**Y/N**	**DATE: Digital and Technology Committee 25.6.20, Quality and Safety Committee 28.7.20, Workforce Committee 28.7.20, Finance and Performance Committee 30.7.20**

1. EXECUTIVE SUMMARY

This report is accompanied by the Board Assurance Framework (BAF) which follows the revised structure agreed by the Board. The Trust's Risk Management Strategy provides that risks to be included on the Corporate Risk Register include those that *"directly impact on the delivery of the corporate aims,"* and that the BAF risks are *"significant and corporate risks that threaten an objective."* Therefore, the inter-relationship between the two processes means that there is a benefit in presenting an overview of both which triangulates the information and ensures that the Board is sighted on the most significant risks facing the organisation in relation to the attainment of strategic objectives. Included within the BAF is the July Corporate Risk Overview for each Committee and the background information below summarises the key risks arising from the corporate risk environment.

2. BACKGROUND

Set out below are the observations arising from the BAF and the Corporate Risk Register, presented against each of the strategic objectives.

Strategic Objective 1 – Deliver a Great Patient Experience

BAF 1A – We don't always effectively engage with patients in their care or involve them in service improvement as a result we fail to communicate with them effectively resulting in a poor patient experience which means patients will not see us as a provider of choice.

Four new actions have been implemented since the last review period and improvements in controls are recorded in respect of complaints management with increased positive assurance in respect of complaints management and patient engagement. However, FFT response rates continue to remain low and the objective of achieving a 5% increase in incident reporting has not yet been attained (noting that incident reporting dropped during the COVID surge).

The net risk score remains at 9 in this reporting period against a target risk of 6, and a Board risk appetite of 4-6.

There are a further five actions pending and which are designed to bridge the gap between net and target risk.

BAF 1B - Failure to meet access standards caused by inability to improve patient flow and work effectively with very local partners will result in an adverse outcome for the patient.

There are significant revisions to the risk description, causes and impact arising from COVID-19, in relation to patient care generally, but specifically with respect to performance against mandated targets.

The key controls are now focussed on restoration and recovery, with positive assurances reflecting that the Restoration and Recovery Plan is on track. However, there are reduced productivity and activity levels and extended patient waiting times in a number of areas.

The risk score has reduced from 20 to 15, although as the risk has been entirely re-based the scores are no longer comparable.

There are eight actions designed to increase capacity over the remainder of the financial year, in accordance with the Plan.

The target risk score of 8 is higher than the Board Risk Appetite (Cautious 4-6) and there is a significant difference between the level of risk currently being carried and the Board appetite.

Corporate Risk Register

There are two corporate risks that address strategic objective 1 which are overseen by the Quality and Safety Committee. Corporate risk 1010 (failure to comply with local and statutory provisions for complaints management) has remained static and in excess of the target risk score since June 2019. Further positive assurance is reported and which is consistent with the BAF narrative but this has not yet impacted upon the net risk score.

Corporate Risk 1046 (failure to deliver the Imaging CQC post inspection action plan) has a reduced risk score of 12 during this quarter, but it remains above the target score of 8.

Strategic Objective 2 – Safe and Caring Services

BAF 2A – If we do not achieve and demonstrate a good or outstanding rating with CQC and other regulatory standards we may be unable to achieve the level of quality of care and subsequently our reputation may be damaged

Twelve actions have been completed since the last reporting period, and two have slipped. The number of completed actions is substantially higher than the previous reporting period (two with four re-profiled due to slippage). The net risk score has reduced from 16 to 9.

However, the target risk score is 4 which is consistent with the lower end of the Board Risk Appetite (4-6).

BAF 2B – Insufficient effective leadership and capacity may result in the trust being unable to efficiently manage and deliver safe services for our patients

One action has been implemented since the last review, which was to present proposals on the Earned Autonomy framework to the Executive team. Implementation of the framework and the Leadership Development Programme are the two remaining actions in relation to this strategic risk.

The risk score is 8. This is consistent with the target risk score but slightly higher than the Board Risk Appetite (4-6).

Corporate Risk Register

There are six corporate risks that address strategic objective 2 that are overseen by Quality and Safety Committee and one overseen by the Digital and Technology Committee. A number of these risks have arisen from operational areas and are sufficiently serious as to directly impact on corporate aims (1015, 896, 1145, 1185, 1289,1301). There has been a reduction from 8 to 7 in the number of corporate risks since the last reporting period and positive movement against another two risks. However, there is a new corporate risk of 20 in respect of the potential failure of the IT infrastructure which is included against Strategic objective 2.

COVID 19 is identified as a risk cause in BAF risk 1B, as the mitigating measures are concerned with Restoration and Recovery.

Strategic Objective 3 – Drive Service Improvements, Innovation and Transformation

BAF 3A – The Dudley Improvement Strategy may not be delivered due to insufficient transformational leadership capability and capacity, resulting in a lack of innovation and a failure to improve services

There are no changes to report from the previous quarter and no change in the net risk score, which remains within the Board risk appetite.

Strategic Objective 4 – Be the Place People Choose to Work

BAF 4A – Be the place people choose to work

Five actions have been implemented since the last review which has produced three new positive assurances and two partial assurances. There are two new controls relating to international recruitment but also an acknowledged gap in controls as the new assurances are still in the developmental stage.

Two actions have slipped due to COVID 19 since the last reporting period and there are three outstanding actions.

The net risk score remains at 16 against a target of 12

BAF 4B – *If we fail to train and develop our workforce to have the right skills to enable the delivery of our clinical strategy, due to inadequate career development, talent management and leadership development, this may result in poor retention rates, difficulties recruiting and a failure to maximise*

Five actions have been implemented since the last review period and there is one additional positive assurance and three indicators of partial assurance where the actions are in development or not yet fully embedded.

The net risk score remains at 12 against a target of 8.

BAF 4C - Failure to effectively engage and involve our workforce by not listening, innovating and acting on their feedback and communicating effectively could lead to an inability to positively improve culture

Six actions have been implemented since the last review with one positive assurance. The other actions relate to activities that are in development or early stages of implementation and therefore not currently demonstrating impact.

In summary, there is no movement in the net risk scores across the three strategic risks. However, there are a number of new actions implemented which relate to activities that are either in development or the early stages of implementation

Corporate Risk Register

There are three corporate risks that relate to strategic objective 4 being overseen by the Workforce Committee and one being overseen by the Finance and Performance Committee.The BAF risks are

concerned with recruitment, training and development and engagement, whilst the Corporate risks being managed by the Committee concern staff absence (981), pension implications for high earners (1065) and staff engagement and morale (1303). High corporate risk scores on sickness and pensions, and staff morale will influence the strategic BAF risk as they may impact on the place people choose to work (strategic objective 4). There is therefore a consistency in the risk profile of both the BAF and corporate workforce risks, with the latter also not demonstrating any movement in the net risk score over the previous quarter.

Strategic Objective 5 – Make the Best Use of What We Have

BAF 5A – Failure to recognise the importance and impact of our constrained financial position due to a lack of understanding, engagement and financial discipline mean we miss key financial targets, run out of cash and come under greater regulatory scrutiny

The net risk score has remained at 12 since the last reporting period. Five actions have been implemented all of which relate to actions that secured a positive year end outturn and which are reflected in the positive assurances around the control total, PSF and the year- end surplus.

There is one action outstanding.

BAF 5B – Failure to successfully adopt digital workflows, due to competing organisation / clinical pressures, availability of resources and change fatigue; results in clinical risk, reputational risk and inefficiency

Ten actions have been implemented since the last review period and all outstanding actions have now been completed. The net risk score remains at 8 but this is within the Board risk appetite

Corporate Risk Register

A cyber threat is an acknowledged risk in the BAF (5B) in relation to the successful adoption of digital workflows. It is also recorded in the CRR with the highest potential risk score. The mitigations and controls currently included in the CRR have been incorporated into the BAF. The corporate risk does not directly relate to the adoption of digital workflows (the strategic risk) and therefore it is not proposed to amend the net strategic risk score. It does however create an underlying risk to disruption of Trust business including digital workflows, and is therefore a cross organisational risk.

Strategic Objective 6 – Deliver a Viable Future

BAF 6A – Failure of the Trust to influence the local and wider evolving health economy due to a lack of engagement and poor performance undermining our credibility means our clinical and financial viability is undermined as we lose key high value services and opportunities for profitable growth

Five actions have been delayed due to COVID-19. Two of these relate to the MCP following the decision by Dudley IHC to pause the development of the full business case. The new actions implemented and planned reflect the development of an alternative proposal, and the

risk impacts have been updated to reflect the clinical, financial and workforce risks and the risk to Recovery and Restoration.

The net risk remains at 20 reflecting the clinical risks entailed in the delivery of the project and the risk to the financial stability of the Trust, and compliance with its licence conditions. The net risk remains substantially above the target risk score and Board risk appetite.

3. RISKS AND MITIGATIONS

Based on the following criterion:

- Controls and recent actions having limited or no impact on net risk scores
- The gap between current risk score and target risk score
- Significant corporate risks

The failure to meet access standards (1A), Recruitment and Engagement (4A and 4C) and the position of the Trust in the wider health economy (6A) (particularly in relation to the MCP) are the highest risks. The mitigations are set out in the BAF itself.

4. RECOMMENDATIONS

- **That the Board note the risks and mitigations as set out in the BAF and summarised in this report.**

Liam Nevin

Board Secretary

September 2020

Appendix

BOARD ASSURANCE FRAMEWORK and OVERVIEW OF CORPORATE RISKS

Board Assurance Framework – September 2020[1]

KEY

RISK SCORE

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

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

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

Key to Control Levels

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

Board Risk Appetite

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

[1] As of 30 June 2020

RISK PERFORMANCE

Scores calculated: Likelihood x Impact

BAF Risks	CURRENT RISK SCORE	PREVIOUS RISK SCORE	BOARD RISK APPETITE	TARGET RISK SCORE
BAF 1A - We don't always effectively engage with patients in their care or involve them in service improvement as a result we fail to communicate with them effectively resulting in a poor patient experience which means patient's will not see us as a provider of choice	9	9	Cautious 4-6	6
BAF 1B - Failure to meet access standards caused by inability to improve patient flow and work effectively with very local partners will result in an adverse outcome for the patient	15	20	Cautious 4-6	8
BAF 2A - If we do not achieve and demonstrate a good or outstanding rating with CQC and other regulatory standards we may be unable to achieve the level of quality of care and subsequently our reputation may be damaged	9	16	Cautious 4-6	4
BAF 2B - Insufficient effective leadership and capacity may result in the trust being unable to efficiently manage and deliver safe services for our patients	8	16	Cautious 4-6	8
BAF 3A - The Dudley Improvement Strategy may not be delivered due to insufficient transformational leadership capability and capacity, resulting in a lack of innovation and a failure to improve services	8	8	Moderate 8-12	8
BAF 4A - An inability to recruit sufficient numbers of appropriately trained staff due to national and local staff shortages may impact on being unable to meet service demand or provide safe, high quality services resulting in increased temporary workforce spend	16	16	Moderate 8-12	12
BAF 4B - If we fail to train and develop our workforce to have the right skills to enable the delivery of our clinical strategy, due to inadequate career development, talent management and leadership development, this may result in poor retention rates, difficulties recruiting and a failure to maximise the capabilities of staff	12	12	Moderate 8-12	8
BAF 4C - Failure to effectively engage and involve our workforce by not listening, innovating and acting on their feedback and communicating effectively could lead to an inability to positively improve culture	16	16	Moderate 8-12	12

BAF 5A - Failure to recognise the importance and impact of our constrained financial position due to a lack of understanding, engagement and financial discipline mean we miss key financial targets, run out of cash and come under greater regulatory scrutiny	12	12	Moderate 8-12	10
BAF 5B - Failure to successfully adopt digital workflows, due to competing organisation / clinical pressures, availability of resources and change fatigue; results in clinical risk, reputational risk and inefficiency	8	8	Moderate 8-12	12
BAF 6A - Failure of the Trust to influence the local and wider evolving health economy due to a lack of engagement and poor performance undermining our credibility means our clinical and financial viability is undermined as we lose key high value services and opportunities for profitable growth	20	20	Moderate 8-12	12

Strategic Objective		SO1 Deliver a great patient experience				Committee		Exec Lead	
						Quality and Safety Committee		Chief Nurse	
Strategic Risk No	BAF 1a	**Pre Mitigations Risk Score**	L x I 4X3 (12)	**Post Mitigations Current Risk Score**	L x I 4X3 (9)	**Board Risk Appetite**		**Target Score**	L x I 2X3 (6)
						Cautious			

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

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

Quarters – Changes in Post Mitigation Risk Score	**Q1**	**Q2**	**Q3**	**Q4**
	9			

KEY CONTROLS IN PLACE	ASSURANCE THAT CONTROLS ARE EFFECTIVE [Yes / No (if no what action needs to be taken)]	LEVEL of CONTROL 1 = Operational 2 = Committee 3 = External
Patient experience strategy	Yes	2
Quality priorities focussed on reducing harm	Yes	2
Pt feedback actions sought via FFT, patient surveys, feedback Fridays	Yes - though response rate remains low – impacted further by COVID	3
Complaints process and reporting	Yes – response timeliness is an issue but his has seen improvement	1
PALS Reports	Yes	1

Perfect ward quality metrics	Yes	1
Quality priorities metrics reported via IPR	Yes	2
Learning from complaints group and reports	Yes- Learning by experience and Quarterly CLIP reports	2
Patient Experience group and associated work plan	Yes	2
Patient Experience improvement work streams across all services	Yes	1
LIA in place to capture and respond to feedback	Yes	2
Participation in annual patient surveys	Yes	3

ACTIONS IMPLEMENTED SINCE LAST REVIEW	IMPACT OF CONTROLS AND ACTIONS ON RISK/ASSURANCE

• Appointment of additional resource to support divisions to respond to complaints
• Set up citizen panels
• Implementation of the complaints team attending divisional audit meetings to discuss complaints
• You Said We Did feedback boards approved
	Positive Assurance
	• Two band 5 members of staff appointed to support the divisions to respond to complaints
	• Citizens panels have been set up – the first was with Health watch in February 2020 with approx. 30 individuals attending. The two meetings organised for March were cancelled as face to face but have now been set up virtually.
	• Virtual citizen panels have been meetings being set up with other organisations
	• The new You Said We Did boards have been approved to display and share the feedback - these are presently to be put on order
	• Complaints team do attend the divisions audit meetings monthly and go through their complaints to achieve resolution.
	• New quality priorities have been identified these are
	  • Patient Experience (staff introducing themselves, patent told what is happening to them each day, holding quarterly forum/focus groups, holding citizen panels, establishing a group of expert volunteers and improving the percentage of compliant responded to within the internal time frame of 30 working days)
	  • Discharge Management (20% of patients by end of the year will be discharged before 10am and 35% before midday)
	• Complaints reporting robust
	• There has been a reduction in the overdue complaint responses. Reducing from 118 to 50

	• Patient experience trolley has been agreed and will have on this welcome booklets, FFT and 3 C's (complaints, concerns and compliments). This will be launched shortly. **<u>Negative Assurance</u>** • Not achieving the 5% increase of incidents reported – incident reported numbers had dropped significantly during the increased activity of COVID. The numbers reported have now started to increase • FFT response rates were low in April 2020 but May has seen a positive increase – although this continues to require additional improvement

SPECIFIC GAPS IN CONTROL / ASSURANCE	**ACTIONS**	**STATUS:**		
		COMPLETE	**IN PROGRESS**	**OUTSTANDING (BEYOND COMPLETION DATE**
The main areas of weakness which result in ineffective or absent controls / assurance	*Actions required to mitigate the weaknesses*	*Date for completion*		*Action Lead*
Timely response (complaints process~) not occurring at Directorate level	Embed a framework of monitoring compliance and challenge for complaint response rates at performance meetings. – *Performance suspended due to C19 this have been reinstated from July 2020.*	Dec 2019		Karen Kelly
	Appointment of additional resource to support divisions to respond to complaints	Completed		Jill Faulkner
	Continue to raise the profile of Feedback Fridays	Completed ongoing		Jill Faulkner

FFT responses are below agreed trajectory	Embed a framework of volunteers engaged to regularly walk round to encourage feedback needs	Completed ongoing	Jill Faulkner
	Complete audit of effectiveness of volunteers visiting clinical areas to encourage feedback	Completed ongoing	Jill Faulkner
	To embed a framework of actions shared from feedback received on the You Said We Did boards *Action completion date delayed and has been extended due to impact of COVID restricting access to clinical areas and work priorities- boards have been agreed*	~~Jan 2020~~ Sept 2020	Liz Abbiss
	Launch 'what matters to you' National Campaign	January 2020 Completed	Jill Faulkner
	Recruitment of experts by experience	July 2020	Jill Faulkner
	Set up citizen panels	March 2020 Completed	Jill Faulkner
	Development and delivery of a patient experience trolley to be taken to the wards	August 2020	Jill Faulkner

Strategic Objective		SO1 Deliver a great patient experience				Committee	Exec Lead	
						Quality and Safety Committee	Chief Operating Officer	
Strategic Risk No	BAF 1b	**Pre Mitigations Risk Score**	L xC 5x4 (20)	**Post Mitigations Current Risk Score**	L x C 5x3 (15)	**Board Risk Appetite** Cautious	**Target Score**	L x C 2x4 (8)
RISK: Failure to meet access standards by Mar 2021 which includes RTT / DMO1 /Cancer/EAS								

Cause

- Reduced outpatient, diagnostic and treatment capacity due to COVID-19
- Clinicians re-deployed to support other pathways, including emergency to support response to COVID-19
- Reduced patient contact for patient requiring routine consultations, investigations and treatment to reduce infection rate of COVID-19
- Measures and precautions put in place in line with national guidance to support response to COVID-19, including social distancing measures
- Reduction in patients willing to come into hospital for treatment and requesting to delay their appointments in fear of contracting COVID-19.
- National RTT guidance released specifically for COVID-19, does not allow RTT clocks to be stopped as a result of patient initiated delays for COVID-19 reasons.
- Priority has been clinically urgent (including cancer) patients with what operational capacity has been available. Increase referrals over coming months as primary care restarts will increase the likelihood of worsening performance as the denominator of the waiting lists across all statutory targets reduces.

Impact of the Risk

- Harm to patients as a result of waiting times
- Failure to achieve 92% RTT incomplete standard
- Increased risk of 52 week breaches
- Failure to meet DMO1 standard
- Failure to meet 62 day cancer standard
- Poor patient experience
- Delayed patient care potential poorer outcome
- Poor Trust reputation
- Future financial impact
- Staff morale

Quarters – Change in Post Mitigation Scores	Q1	Q2	Q3	Q4
	15			

KEY CONTROLS IN PLACE	ASSURANCE THAT CONTROLS ARE EFFECTIVE [Yes / No (if no what action is being taken)	LEVEL of CONTROL 1 = Operational 2 = Committee 3 = External
Weekly Trust Operational Group	Yes	1
Weekly Trust RTT Meeting	Yes	1
Outpatient Taskforce Meeting	Yes	1
COVID Taskforce Meeting	Yes	1
Theatres Restoration and Recovery Meeting	Yes	1
Access Policy Review & Training in line with national guidance	Yes	1
Weekly Independent Sector Meeting	Yes	3
Weekly Cancer PTL meeting	Yes	1
Monthly Cancer steering group	Yes	2
Monitoring tool to robustly report & monitor activity & performance	Yes	1
Weekly operational restoration & recovery meeting	Yes	1
Interim specialist cancer manager in post	Yes	1

ACTIONS IMPLEMENTED SINCE LAST REVIEW	IMPACT OF CONTROLS AND ACTIONS ON RISK/ASSURANCE
This BAF has been refreshed to in its entirety to reflect the Trusts post c-19 position	<u>Positive Assurance</u> • Re-introduced weekly Trust RTT and Cancer PTL meeting with positive assurance that restoration of services is on track • Restoration of theatres is positive, only 3 theatres currently not operational due to estates works required • Significant improvement on virtual appointments Trust-wide, most outpatient services been restored with 46% of appointments being conducted virtually • Five days a week of independent sector being used in

	theatres for surgical pathways • Routine diagnostics have re-commenced • Training re-issued for staff on new RTT guidance related to COVID-19 • No 52 week breaches at the end of June 2020 • Overall patient waiting list has reduced by circa 1000 patients compared to pre-COVID • Dedicated cancer informatics / business analyst <u>Negative Assurance</u> • Productivity and activity levels seriously affected due to social distancing measures • Reduced activity due to limited operational capacity available • Number of patients waiting over 40 weeks for treatment exceeds 100 • Cancer Patients exceeding 104 days without a diagnosis has increased above pre c-19 levels • Patients waiting more that 6 weeks for DMO1 related diagnostics have increase pre c-19 levels • Number of patients waiting over 18 weeks for treatment and/or review exceeds 4800 patients, approximately 50% are waiting for treatment • Theatre activity levels for elective surgery are at approximately 40% compared to pre-COVID levels. • GP referrals are increasing back towards pre-COVID levels resulting in overall waiting list size to grow • Face to face outpatient appointments reduced due to social distancing measures, resulting in discharge percentage to be less, requiring further appointments

SPECIFIC GAPS IN CONTROL / ASSURANCE	ACTIONS		STATUS: COMPLETE	STATUS: IN PROGRESS	STATUS: OUTSTANDI (BEYOND COMPLETIO DATE
The main areas of weakness which result in ineffective or absent controls / assurance	*Actions required to mitigate the weaknesses*	*Date for completion*	*Action Lead*		
• Lack of treatment capacity, particularly theatre • Reduced outpatient activity overall as restoration continues • Diagnostic waits have increased, impacting overall pathway waiting times • Reduced productivity across all pathways due to social distancing and COVID-19 precautions • GP referrals increasing • High proportion of waits over 18 weeks and ability to treat more patients that are waiting over 18 weeks versus the number that are added each week is not possible at present • Staff fatigue and availability to support increase in capacity out of hours	Independent sector theatre capacity available to Dudley Group would need to treble to increase activity levels to required level	1st August 2020	Simon Illingworth		
	Extend one theatre each day into the evening	1st September 2020	Simon Illingworth		
	Run four all day elective lists each weekend	1st September 2020	Simon Illingworth		
	Build a modular theatre and connect it to main theatres on the 1st floor	31st March 2021	Qadar Zada		
	Increase outpatient levels to pre-COVID state	1st September 2020	Relevant Director of Ops		
	Reduce diagnostic waits to within DM01 standards through provision of additional internal and independent sector capacity.	1st October 2020	Steve Jackson		
	4th endoscopy room in place	1st September 2020	Karen Kelly		
	Have in place dedicated cancer informatics / business analyst	Complete	Qadar Zada		
	Modular build in place to increase capacity	31 December 2020	Qadar Zada		

Strategic Objective		SO2 Safe and Caring services				Committee	Exec Lead	
						Quality and Safety Committee	Chief Operating Officer	
Strategic Risk No	BAF 2a	Pre Mitigations Risk Score	4X4 (16)	Post Mitigations Current Risk Score	3x3 (9)	Board Risk Appetite: Cautious	Target Score	1X4 (4)

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

Cause

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

Impact of the Risk

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

Quarters - Change in Post Mitigation Scores	Q1	Q2	Q3	Q4
	9			

KEY CONTROLS IN PLACE	ASSURANCE THAT CONTROLS ARE EFFECTIVE	LEVEL of CONTROL 1 = Operational 2 = Committee 3 = External
Schedule of positive press releases/media campaigns	Yes	3
Collaborative working with NHSI	Yes	3
Collaborative working with neighbouring trusts as appropriate	Yes	3
Weekly Operational meeting to monitor performance against key regulatory standards	Yes	1

Divisional Performance Meetings	Yes	2
IPR report to CQSPE, F&P & Board	Yes	3
Cancer Alliance Meetings	Yes	3
Quality review visits against each domain	Yes	1
Perfect ward tool to drive local understanding and improvement	Yes	1
Skill mix review undertaken	Yes	1
Nursing & Midwifery strategy	Yes	1
Mortality Review process	Yes	1
Nurse recruitment Lead	Yes	1
Corporate & bespoke recruitment events	Yes	1
MTI Programme	Yes - delayed	3
Workforce Strategy	Yes	1
Developing Leaders Programme	Yes	2
Staff engagement indicators	Yes	2
National staff survey & FFT results	Yes	3
Board, Executive and senior management development programmes	Yes	2
Urgent Care Service Improvement Group	Yes	2

ACTIONS IMPLEMENTED SINCE LAST REVIEW	IMPACT OF CONTROLS AND ACTIONS ON RISK/ASSURANCE
• Mortality process reviewed with Dudley Improvement Practice • New mortality tracker procured and currently being implemented • 200+ COVID SJR's completed • 37 SJR externally moderated • Medical Examiner system launched June 2020 • Out to advert for compliance team to drive improvements and development a robust framework to assess compliance, identify gaps and required actions • Application made to CQC with supporting evidence of improved compliance to remove section 31s • Developing Leaders programme now launched Cohort 10	MIT Programme – delayed as a result of the pandemic. Work is now re-starting but date for completion extended to allow time to seek the required authorisations, advertise and recruit and taking into account current travel restrictions.

• Manager's Essentials programme launched to provide clear support for leadership for all leaders – across all disciplines. • Delivery of leadership content at Clinical Summits and Away Days during Jan-March to support development of medical staff • Review of learning and leadership with Exec Dirs (COO, Medical Dir and Chief Nurse) to align development plans and ensure offer meets needs of all staff groups • Appointment to Chief People Officer	

SPECIFIC GAPS IN CONTROL / ASSURANCE	**ACTIONS**	**STATUS:**		
		COMPLETE	**IN PROGRESS**	**OUTSTANDING (BEYOND COMPLETION DATE**
The main areas of weakness which result in ineffective or absent controls / assurance	*Actions required to mitigate the weaknesses*	*Date for completion*		*Action Lead*
• Increase in demand for specific cancer pathways e.g. Breast • RWT challenged capacity for robotic surgeries for Urology • Increased demand and ambulance arrivals • DM01 – increase in demand overall, and on the day diagnostics • Mortality reviews not sufficiently robust in providing learning that is shared across the trust • Assessment & analysis of recruitment events to inform where to concentrate resources • Expansion of the MTI programme to more countries • Disjointed approach to staff education, development & education • Leadership Programme – gap with medical leaders engagement • Step up to Care programme only provides development at corporate level associated to management development and needs to be broadened to capture other staff development. • Further development of the OD programme	Plan for CT refit commencing June	Completed		S Jackson
	Business Case to redesign & enhance cancer tracking team	July 2020		S Jackson
	EAS System Improvement Plan	Closed		K Kelly
	Review of Mortality meetings & processes	~~August 2019~~ ~~31 March 2020~~ 1 Sep 2020		P Brammer
	MTI programme to be developed alongside one other country and managed effectively within Medical Management fortnightly meetings.	~~Oct 2019~~ Oct 2021		Hassan Paraiso/Jess Haycock
	Review areas of further collaboration across education and training providers under the remit of the Workforce Group	Complete - BAU		Rachel Andrew, Carol Love-Mecrow

			and Atiq Rehman
	Undertake review and audit of data collection systems that record training information to determine what changes can be made to provide better level of detailed analysis and information.	Closed	Becky Cooke
	The introduction of the 'Make it Happen' OD programme supported with the Staff Engagement plan, the behavioural framework and the anti-bullying campaign.	Completed	Rachel Andrew
	Plan to support detailed preparation for the forthcoming Staff Survey in 2019.	Completed	Rachel Andrew
	Development programme to include skills associated to engagement and support for staff and colleagues. This will also be supported by the introduction of anti-bullying campaign	Completed	Rachel Andrew & Becky Cooke
	Modular build to increase capacity	31/12/20	Qadar Zada

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

Cause	Impact of the Risk
• Insufficient time allocated to leadership roles • Operational demands conflict with leadership roles related to governance and engagement. • Staff lack understanding of the potential of leadership to deliver service improvement • No shared vision for the organization	• Quality improvement work not undertaken or is ineffective - Mortality reduction not achieved or maintained - CIP not delivered - EAS, cancer and diagnostic waiting times not achieved • Reduced staff morale and engagement • Negative impact on reputation • Poor recruitment and retention

Quarters – Changes in Post Mitigation Risk Scores	Q1	Q2	Q3	Q4
	8			

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

ACTIONS IMPLEMENTED SINCE LAST REVIEW	IMPACT OF CONTROLS AND ACTIONS ON RISK/ASSURANCE
• Trialling of earned autonomy approach within medical directorates direct reports. Paper outlining approach presented at Executive director.	<u>Positive Assurance</u> • Attendance by medical leaders at Executive, Quality and Safety Committee and Clinical Leaders meetings have improved significantly • Medical leaders are now prioritising internal

	opportunities over external development as a result of improved engagement. • The medical engagement score has shown a 41% improvement • Clinical summits are well attended with multi-professional representation and excellent feedback • Senior leaders have structured and targeted development •

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

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

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

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

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

ACTIONS IMPLEMENTED SINCE LAST REVIEW	IMPACT OF CONTROLS AND ACTIONS ON RISK/ASSURANCE
NHSI consultant vacancy filled as of Nov 2020 (7 months vacant) Exec and Board workshops undertaken to improve awareness and understanding of DIP deployment plans.	Positive Assurance • The programme is reporting to Executive Directors on a weekly basis

Board Improvement Practice Workshop completed December 2019	• Specialist Practice Coach in post to provide senior cover in team and avoid single point of failure Negative Assurance Programme is not currently reporting to Board

SPECIFIC GAPS IN CONTROL / ASSURANCE	**ACTIONS**	**STATUS:**		
		COMPLETE	**IN PROGRESS**	**OUTSTANDING (BEYOND COMPLETION DATE**
The main areas of weakness which result in ineffective or absent controls / assurance	*Actions required to mitigate the weaknesses*	*Date for completion*		*Action Lead*
NHSI consultant vacant post leaving trust without support for several months	DGFT representative involved with NHSE/I recruitment activity to fill post.	Nov 2020		Peter Lowe
It is not possible to reduce the consequence of failure, only the likelihood can be reduced.	Recruitment of specialist practice coach to replace current post holder	Jan 2020		Peter Lowe
Existing three year resource plan (presented Dec 2018) has been superseded by plans to reshape and integrate transformation, business development, financial waste reduction, project management office and Dudley Improvement Practice	Proposal for alignment of resources and single method across transformation directorate. To be reviewed by new Director of Strategy	Apr 2020		James Fleet

Strategic Objective		**SO4 Be the place people choose to work**				**Committee**	**Exec Lead**	
						Workforce and Staff Engagement Committee	Director of Workforce & OD	
Strategic Risk No	BAF 4a	**Pre Mitigations Risk Score**	L x C 4X4 (16)	**Post Mitigations Current Risk Score**	L x C 4X4 (16)	**Board Risk Appetite** **Moderate**	**Target Score**	L x C 3X4 (12)

RISK: An inability to recruit sufficient numbers of appropriately trained clinical staff due to national and local staff shortages may impact our ability to meet service demand and/or provide safe, high quality services resulting in enhanced pay arrangements and/or increased temporary workforce spend				
Cause • External - major workforce supply challenges in hard to recruit roles, locally and nationally • Inconsistency in job bandings/pay between local providers which can result in highly competitive recruitment activity • Delays at multiple stages in the internal recruitment process, resulting in an extended 'time to hire'	**Impact of the Risk** • Lack of substantive clinical capacity to meet service requirements • Higher demand for temporary workforce at premium cost • Impact on consistency and quality of patient care • Low staff morale • Increased sickness absence • High turnover • Patient-related complaints			
Quarters – Changes in Post Mitigation Risk Scores	**Q1**	**Q2**	**Q3**	**Q4**
	16			

KEY CONTROLS IN PLACE	**ASSURANCE THAT CONTROLS ARE EFFECTIVE [Yes / No (if no what action is being taken)**	**LEVEL of CONTROL 1 = Operational 2 = Committee 3 = External**
Nurse recruitment lead established to work alongside departments in order to support innovative ways to recruit new nursing staff.	Y/N	1/2
Corporate recruitment events alongside bespoke recruitment events for areas with high levels of vacancies as well as participating in external recruitment events.	Y	1
Development of local sustainable workforce through extension of the Nursing Associate Programme	No – this is long-term strategy over 1-4 years	1
Development of MTI workforce between the Trust and Pakistan.	Y	1
Further consideration of international recruitment as part of the short term strategy to fill nursing posts alongside longer term strategy of growing our own	Y	1
ACTIONS IMPLEMENTED SINCE LAST REVIEW	**IMPACT OF CONTROLS AND ACTIONS ON RISK AND ASSURANCE**	
Ongoing discussions within STP to establish collaborative banks for nursing and medical workforce	Increased nurse workforce to address shortfall in substantive posts and hard to recruit areas, eg, elderly care	

Arrangements in place through COVID and ongoing on bringing back staff through national campaign	Once implemented, a system wide collaborative bank would provide economy of scale and reduce the reliance on agency staff
Fast-track recruitment for clinical roles during COVID increased speed of recruitment	Increased nurse workforce to address shortfall in substantive posts and hard to recruit areas
Deployment of student nurses and Fi1s as part of national campaign to increase staff. Continuing payment for students nurses until end of August to support reputational trust and ongoing choice as employer	Increased clinical workforce to address shortfall in substantive posts and hard to recruit areas
Black Country and West Birmingham STP recruitment campaign and events during February and March. Ongoing commitment to collaborative working	Increased recruitment during targeted campaign. Proof of concept of STP recruitment – additional activity planned later 2020

SPECIFIC GAPS IN CONTROL / ASSURANCE	**ACTIONS**	**STATUS:**		
		COMPLETE	**IN PROGRESS**	**OUTSTANDING (BEYOND COMPLETION DATE**
The main areas of weakness which result in ineffective or absent controls / assurance	*Actions required to mitigate the weaknesses*		*Date for completion*	*Action Lead*
International recruitment considerations still in its infancy and the Nursing Associate Programme is a longer term strategy that will realise benefits over the next 1-4 years. A fresh approach to new and alternative roles and new ways of working is required to fill some of the longstanding medical vacancies. This requires a focus on workforce transformation. The lack of a comprehensive workforce planning tool to plot the workforce supply and demand over the next 5 years. Inefficiency within the recruitment process.	Development and embedding of a consistent approach to workforce planning including an agreed Dudley Workforce Planning tool.		Revised date Oct 2020	Deputy Director of Workforce
	To implement and achieve recruitment timeline from 77 days to 50 days. Establish a more dynamic approach to recruitment advertising, including social media use, cohorting adverts, selling Dudley/Black Country as well as the Trust, STP collaboration and introducing a one-stop-shop approach to recruiting multiple posts.		Mar 20 Apr 20	Resourcing and PlanningLead
Limited bank only workforce to meet short term supply issues. Insufficient shared oversight of recruitment and retention issues	To significantly increase the population of bank only nursing and AHP staff.		March 20 Ongoing	Resourcing and Planning Lead

	Establish a regular and more detailed report on recruitment activity, for all staff groups to the Workforce Committee through the monthly Workforce KPIs	May 2020 Implemented June2020	Head of HR
	To implement support for locum bank to enhance the availability of locum bank medical staff. To work with the STP to develop collaborative banks for medical and nursing staff	March 20 Apr 20	Resourcing and Planning Lead
	Mobilise the Workforce Transformation – new ways of working programme, which was approved by the Workforce Committee at its January meeting. This work is being supported by Health Education England (HEE), to focus on implementing new roles/ways of working.	Mar 20 Delayed due to COVID. Sept 20	Director of Workforce

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

RISK: Failure to train and develop our workforce, maximising their capabilities so they have the right skills to enable the delivery of our clinical strategy, may impact our ability to recruit and retain due to the lack of/inadequate career/leadership development, succession planning and talent management

Cause	**Impact of the Risk**
• Historic lack of investment and prioritisation of staff development, particularly professional and management development. • Vacancy factor, as well as significant operational pressures making it	• High turnover, particularly in clinical posts • High vacancy rates • Increased sickness absence, particularly relating to stress

difficult for staff to be released for training and development opportunities • Sickness absence levels making it difficult for staff to be released for training and development opportunities • Low staffing resource in Learning & Development/OD to support leadership and development programme	• Low morale amongst staff • Dependency on agency workforce at premium cost • Insufficient support for management development has caused poor management of staff resulting in an impact of delivery against objectives • Failure to deliver the quantity and quality of management and leadership development required • Senior staff acting down to provide disproportionate levels of support, therefore, effecting the impact they have on the organisation • Reputational and operational performance issues.				
Quarters – Changes in Post Mitigation Risk Scores	**Q1**	**Q2**	**Q3**	**Q4**	
	12				
KEY CONTROLS IN PLACE	**ASSURANCE THAT CONTROLS ARE EFFECTIVE [Yes / No (if no what action is being taken)**				**LEVEL of CONTROL 1 = Operational 2 = Committee 3 = External**
• The revised Dudley People Plan providing greater focus on staff development • Trust Board supportive of a learning culture being further developed within the Trust • 'Improvement and Development Culture' in the Dudley People Plan provides the basis for supporting further staff development in the Trust and across the STP.	N – the Dudley People is being further developed to align actions against the revised Strategic Objectives				1/2
• The introduction of the Developing Leaders Programme in 2018 and further continued development in 2019/2020 • Targets set to ensure the Developing Leaders Programme acts as a prerequisite for current and aspirant leaders • Developing Leaders Programme supports the consistency of development aligned to Trust values	Y				2/3

ACTIONS IMPLEMENTED SINCE LAST REVIEW	IMPACT OF CONTROLS AND ACTIONS ON RISK/ASSURANCE
Manager's Essentials programme launched to provide clear support for leadership for all leaders – across all disciplines. Initial bookings indicate commitment from teams to send all line managers (e.g. Theatres, Imaging, Therapies)	Increased skill and knowledge in leadership and management skills in those attending programmes – numbers remain small.
Investment identified to launch Manager's essentials programme at scale/pace during 2020 for 1000 line managers over 12months	Additional investment identified to add capacity and additional products to expand offer – post recruitment under way
Review of leadership, learning and improvement with Exec Dirs (COO, Medical Dir and Chief Nurse) to align development plans and ensure offer meets needs of all staff groups to create strategy and action plan for delivery 2020 and beyond.	When in place, the organisational offer in development with clarity of products and programmes and targeting of staff groups meeting organisational needs
Delivery of leadership content at Clinical Summits and Away Days during Jan-March to support development of clinical staff	Increased skill and knowledge in leadership and management skills to a limited number of clinical leaders. Increased knowledge of available offers and resulted in increased engagement.
National CPD scheme for registered health workers launched April 2020 to enable increased access to development opportunities	

SPECIFIC GAPS IN CONTROL / ASSURANCE	ACTIONS	STATUS: COMPLETE / IN PROGRESS / OUTSTANDING (BEYOND COMPLETION DATE)	
The main areas of weakness which result in ineffective or absent controls / assurance	*Actions required to mitigate the weaknesses*	*Date for completion*	*Action Lead*
• Lack of a robust OD, learning and leadership strategy • Limited access to training until investment/new posts are recruited • Delivery plans for strategy for 2020 need to ensure they are broadened to capture staff development Trust-wide including those not in leadership/management positions • Success of manager's essentials programmes relies on whole organisation engagement and release of staff for 5 day course plus quality framework/accreditation process	Development and delivery of OD and Leadership Strategy (including Talent) following planning sessions at Executive level	July 2020	Head of OD & Culture
	Recruitment of new training team to deliver Manager's Essentials and upskill to deliver programmes	October 2020	Head of OD & Culture
	An outline plan for delivery in 2020/21 with specific programmes of development to meet gaps in knowledge/skills for medical and other leaders	July 2020	Head of OD & Culture

• Enabling access and utilisation of the CPD budget for registered staff to ensure this is effective and supports their CPD and identified learning needs	aligned to existing programme. This will include bespoke programmes to respond to identified areas of need linked to feedback from Staff Survey, performance and improvement priorities.		
	Process for access to CPD funding including link to organisational priorities and individual personal development plans requires development and then communication to all entitled to funding. Reporting and recording system required to enable effective tracking of utilisation and effectiveness in meeting needs	July 2020	Deputy Chief Nurse

Strategic Objective		**SO4 Be the place people choose to work**				**Committee**	**Exec Lead**	
						Workforce and Staff Engagement Committee	Director of Workforce & OD	
Strategic Risk No	BAF 4c	**Pre Mitigations Risk Score**	L x C 4X4 (16)	**Post Mitigations Current Risk Score**	L x C 4X4 (16)	**Board Risk Appetite** **Moderate**	**Target Score**	L x C 3X4 (12)
RISK: Failure to effectively engage and involve our workforce by not actively listening, innovating and acting on their feedback and communicating effectively could lead to an inability to positively improve culture								

Cause

- Insufficient awareness and use of formal and informal mechanisms in place to engage meaningfully with staff at all levels, and across all groups.
- Insufficient investment of resource, focus and capacity to implement a structured and far-reaching staff engagement programme.
- Failure to address matters locally resulting in escalation to inappropriate levels in order to solve staff issues/concerns
- Lack of awareness of the changes that happen as a result of staff feedback

Impact of the Risk

- High levels of sickness
- Low morale
- Increased employee relations issues
- Inability to fulfil the aims of the Trust to the standards expected.
- Lack of trust in managers to respond to staff concerns
- Instability in leadership arrangements creating unnecessary workloads
- Turnover of staff in management/leadership roles due to role dissatisfaction/disempowerment
- Reputation damage caused by low morale leading to recruitment

	challenges • Decrease in engagement metrics in both staff FFT and survey			
Quarters – Change in Post Mitigation Scores	**Q1**	**Q2**	**Q3**	**Q4**
	16			

KEY CONTROLS IN PLACE	ASSURANCE THAT CONTROLS ARE EFFECTIVE [Yes / No (if no what action is being taken)]	LEVEL of CONTROL 1 = Operational 2 = Committee 3 = External
Collection of staff engagement indicators that are published within the workforce KPIs report for Committees	Y	2
Feedback from the national staff survey and FFT results introduced on the basis on 'you said, we did'	Y	2/3
Board, Executive and senior management development programmes provide better understanding of role and responsibility and impact of positive engagement and impact of behaviours	Y – further roll-out of 360 feedback and leadership development throughout 2020	3
Annual staff survey process in place	Participation increased in 2019 but remains below benchmark and performance remains lowest quartile for most indicators	1
Engagement plan for 2019 provided additional opportunities for connection and feedback to staff	Actions were limited in delivery and impact during 2019	1

ACTIONS IMPLEMENTED SINCE LAST REVIEW	IMPACT OF CONTROLS AND ACTIONS ON RISK/ASSURANCE
Staff Survey results published and presented at Board and Divisional level	Survey results demonstrate continued gaps in assurance in terms of engaged staff. Actions identify positive assurance in terms of key actions to improve engagement.
Identified corporate actions on engagement process and initial actions to focus upon	No impact seen yet – planned actions will positively impact engagement and

	reduce risk.
Roll out of Manager's Essentials during June 2020.	Engagement of line managers will increase manager effectiveness and therefore provide assurance in more effective engagement in those teams participating.
Divisional survey engagement plans developed for Surgery, Medicine and Clinical Support services	Engagement plans (due to be rolled out during July) should increase assurance to enable more active engagement from individuals and teams.
Engagement and communication activity during COVID such as additional team briefs, daily briefings (face to face) and daily update	Positive feedback on increased engagement during COVID. This is identified as an area to continue activity in which will reduce risk/increase assurance of engagement with staff.
Approval for pulse survey app to provide additional intelligence more frequently on areas of engaged and disengaged staff	No impact seen yet – planned actions will positively impact engagement and reduce risk by being able to more quickly target areas for improvement and celebrate areas of good practice

Strategic Objective		**SO5 Make the best use of what we have**				**Committee**	**Exec Lead**	
						Finance & Performance	Director of Finance	
Strategic Risk No	BAF 5a	**Pre Mitigations Risk Score**	L x C 4X5 (20)	**Post Mitigations Current Risk Score**	L x C 3X4(12)	**Board Risk Appetite**	**Target Score**	L x C 2X5 (10)
						Moderate		

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

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

Quarters – Change in Post Mitigation Scores	**Q1**	**Q2**	**Q3**	**Q4**
	12			

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

ACTIONS IMPLEMENTED SINCE LAST REVIEW	IMPACT OF CONTROLS AND ACTIONS ON RISK/ASSURANCE
• Final agreement of £8.3m from Dudley CCG secured • Further agreement with NHSI/E for £4.8m secured • Full and final settlements agreed with other commissioners reflecting activity pre-Covid • Additional Covid funds of just over £2m agreed • Technical adjustment to support annual leave accrual of £0.745m agreed	• Successful delivery of control total • Full PSF earned of £6.462m • Surplus achieved of £3.521m • No requirement to borrow cash

SPECIFIC GAPS IN CONTROL / ASSURANCE	ACTIONS	STATUS: COMPLETE	STATUS: IN PROGRESS	STATUS: OUTSTANDING (BEYOND COMPLETION DATE)	
The main areas of weakness which result in ineffective or absent controls / assurance	*Actions required to mitigate the weaknesses*		*Date for completion*	*Action Lead*	

• Understanding the Underlying Position, adherence to policies • Adherence to Business Case processes, link to affordability • Adherence to Resources to deliver • Adherence to Budget Holder Training • Adherence to Scheme of Delegation	Audit of Financial Controls	Mar 2020	Chris Walker

Strategic Objective		**SO5 Make the best use of what we have**				**Committee** Digital Trust Technology committee (DTTC)	**Exec Lead** Chief Information Officer	
Strategic Risk No	BAF 5b	**Pre Mitigations Risk Score**	L x C 3X5 (15)	**Post Mitigations Current Risk Score**	L x C 2X4 (8)	**Board Risk Appetite** **Moderate**	**Target Score**	L x C 3X4 (12)
RISK: Failure to successfully adopt digital workflows, due to competing organisation / clinical pressures, availability of resources and change fatigue; results in clinical risk, reputational risk and inefficiency								

Cause

Staff Engagement:

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

Business Risk / Reputational Risk

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

Clinical Risk

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

Impact of the Risk

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

support	• Trust reputation damaged			
Quarters – Change in Post Mitigation Scores	**Q1**	**Q2**	**Q3**	**Q4**
	8			

KEY CONTROLS IN PLACE	ASSURANCE THAT CONTROLS ARE EFFECTIVE [Yes / No (if no what action is being taken)	LEVEL of CONTROL 1 = Operational 2 = Committee 3 = External
Over 120 senior clinical / operational staff involved in defining requirements and assessing suppliers to identify preferred solution	Y	1
A Chief Clinical Information Officer (Consultant), Clinical Safety Officer (Consultant) and one Chief Nursing Information Officer (Deputy Chief Nurse) roles are in place to provide clinical leadership and ward / dept facing opportunity to engage with the project	Y / N Currently no CSO or CNIO in place. This is being reviewed by the Medical Director and Chief Nurse with the CCIO with consideration of an AHP role to address both elements.	1
The Digital Steering Group will provide clinical governance and workforce engagement and is authorised by the Digital Trust technology Committee to investigate any activity within its terms of reference to deploy technology to meet the trusts prevailing policies, within financial budgets to meet clinical and operational needs.	Y	2
Design is led by clinical / operational governance groups	Y	1
Testing and validation is undertaken by Trust staff	Y	1
Formal (service desk and governance meetings) and informal (regular 'have your say events' CCIO) feedback processes exits to allow improvements and requests to incorporated into the project	Y	1
Trust Comms Dept communication plan provides multi-channel engagement with staff / CCIO runs regular lecture theatre sessions for clinical teams	Y / N	1
Training team and floorwalkers are ward / department facing	Y	1
Engaged divisional Ops teams to capture detail for cut-over planning	Y	1
Engagement of Executive (COO) in go/no-go decision	Y	1
Monitoring of Trust pressures in planning, awareness of project roll out milestones	Y	1
CIO and Executive linked to MCP programme for shared digital workflows across the	Y	3

Dudley health care system		
Trust engaged with Black Country Pathology Service (BCPS) on infrastructure to deliver shared digital workflows	Y	3
Trust engaged with Black Country Local Maternity System (LMS) integration of digital workflows	Y	3
Infrastructure is managed through TeraFirma IT to provide a state-of-the-art infrastructure to support the delivery of shared records population health platform between GPs and DGNHSFT (formally BAF 599)	Y	3
CCIO chaired CAG provides clinical governance authority reporting to CQSPE for digital transformation of clinical work	Y The newly formed Digital Trust Steering Group will have a clinical approval section within the agenda chaired by the CCIO to provide the clinical governance framework to support digital transformation of clinical workflow	2
Allscripts are compliant with DCB0129 – clinical risk management and have a designated clinical safety officer (CSO) Dr Anna Bayes	Y	3
DGNHFT are not currently complaint with DCB0160 – clinical risk management and do not have a designated clinical safety officer (CSO) in post CCIO and CSO roles report to MD clinical executive CNIO reports to CN clinical executive	Currently no CSO or CNIO in place. This is being reviewed by the Medical Director and Chief Nurse with the CCIO with consideration of an AHP role to address both elements. The Trust is meeting the DBC0160 clinical risk management statue through the CCIO clinical safety review process with oversight of the Medical Director and Chief Nurse as as defined in the act as "Top management".	3
Trust is engaged with the Black Country STP digital board to discuss collaborative approaches to digital workflows	Y	**3**
Cyber Security threats are subject to continual proactive monitoring and technology solutions in place including; • CareCERT Management • TeraFirma ISO27001 Information Security Management System accreditation • Windows 10 Advanced Threat Protection • Advanced anti-virus protection and robust patch management • Deployment of an Identity Service Engine network administration product to provide increased endpoint security	Y	1 (and 3 in relation to system accreditation)

ACTIONS IMPLEMENTED SINCE LAST REVIEW	**IMPACT OF CONTROLS AND ACTIONS ON RISK/ASSURANCE**
New Radiology PACS solution deployed Trust wide Jan 2020 and historical data has an extended planned migration completion to VNA date of July 2020.	<u>Positive Assurance</u> ISO27001 Information Security Management System – major audit (3year)

Retirement of the legacy EPR Soarian in December 2020, by replacing with strategic solution "Sunrise" and a historical record luck up supported by clinicians, thus removing risk of EPR failure to organisation Complete work to optimise a resilient application centric infrastructure for key clinical systems, to prevent unplanned down-time and service disruption during essential maintenance, improving confidence / Trust and adoption. Inaugural Digital Trust Technology Committee (DTTC) meeting completed on the 5th March 2020. TOR reviewed and agreed Progress Trust wide network upgrade – Wi-Fi upgrade completed Q1 2020 along with site survey. Technical Project Manager in post 16 June 2020. Clinically lead training, engagement sessions and end-to-end walk through of clinical solutions in EPMA process design. Suspended due to COVID19. Planning technical product Q2 and to be deployed Q3 2020. Medical devices implemented 21/01/20 improving adoption through reduced transcription of observations and associated clinical risk. Secured additional HSLI funding through HSLI Population Health fund (249k CAPex) to support dbMotion project. Implementation of remote working tools during Q1 and Q2 2002. Tools and documentation provided to staff to enable remote working during COVID19. This includes Microsoft Teams, WebEx and access guides NHS Mail Virtual Clinical Safety review process implemented to support the additional Sunrise and Digital Workflow requests raised as part of the Trusts COVID response	accreditation certified - December 2019, action plan for further continual improvements agreed and in place. Positive assurance; Trust internal auditor (RSM) commissioned to assure clinical adoption of technology through European standard HiMMS adoption score planned during 2020 (delayed due to Covid). Positive assurance of enhancement requests from clinical teams that have been met (you said we did) demonstrating adoption and enhancement of digital workflows. Positive assurance on communication to Trust workforce and clinical safety controls lead independently of IT by the CCIO (reports independently to the medical director). Positive assurance, ongoing NHSE reporting on technology updates (W10 / ATP and HSLI) adoption continues Positive assurance - adoption of new electronic order process improved in outpatients and large scale virtualisation of outpatient clinics through deployment of the nationally procured "Attend Anywhere" video consultation product. Positive assurance of wide-scale adoption of productivity solutions and remote working tools during COVID19. <u>Negative Assurance</u> L2 Negative assurance - Clinical Safety Officer post vacant. MD/ CN / CCIO review L2 Negative assurance - Chief Nursing Information Officer vacant post - MD/ CN / CCIO review Await RSM HiMMS adoption audit outcomes (delayed by Covid19.

SPECIFIC GAPS IN CONTROL / ASSURANCE	ACTIONS	STATUS:		
		COMPLETE	IN PROGRESS	OUTSTANDING (BEYOND COMPLETION DATE
The main areas of weakness which result in ineffective or absent controls / assurance	*Actions required to mitigate the weaknesses*		*Date for completion*	*Action Lead*
1. Staff with high levels of digital engagement, leaving a gap to those less eager. 2. Risk appetite lower than current risk level – leading to avoidance disruption / go-live 3. Lack of Staff engagement – creates a block to adopting change 4. Speed of mobilisation and operational readiness leading to lag-time 5. On-going system support, by skilled staff 6. Revenue to recruit and retain adequate skills to deliver projects of this scale 7. New initiatives divert resources away from core project activity 8. Current levels of organisational-wide clinical risk in practice are poorly understood by the workforce, so that something new seems more risk than something familiar. 9. Digital Trust programme perceived as a technology / IT project rather than clinical transformation (see item 1).	Digital committee reinstated, bi-monthly. Committee work plan has been devised such that in the non-meeting months members will support the Digital Steering Group undertaking quality reviews / deep-dives in key areas around the Trust to support the quality committee in establishing clear action plans.		Jul 19	Max Hodges (CCIO)
	Digital strategy re-launched in Board away day. Trust board January 2020 agreed to reinstate committee level oversight, with revised digital / medical devices steering groups. Agreed Digital Trust Technology Committee Terms of Reference and Digital Steering Group ToR in February 2020 Board. Both due to meet Q3		Mar 20	Adam Thomas (CIO)
	Increase exposure of all clinical groups to independent clinical safety review (CSR) of each project roll out, driving digital skills within the wider clinical workforce and better understanding of clinical risk at an organisational level.		Sept 19 continual process	Clinical Safety Officer / Max Hodges (CCIO)

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

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

Cause	**Impact of the Risk**
• A number of acute Trusts within a small geographical area providing similar services. • Private provider in Birmingham for Ophthalmology offering low waiting times • Trust sustainability. Lack of robust evidence base and business case for MCP. • The MCP contract is awarded without adequate mitigation of clinical, workforce and financial risks • Failure to pause the MCP procurement process means that the Trust has inadequate resources to support Restoration and Recovery • • Challenged relationship with CCGs and unitary CCG leadership • Sandwell & West Birmingham Hospitals integrated with a PCN since Apr-20 which is a significant user of our services • Lack of engagement with GP practices and patients and poor performance mean that referral patterns remain unchanged • Block Contract confirmation, likely from CCG, which will impact on 2020/21 income generation	• Not enough patients referred to sustain services if similar services are provided by all local Trusts • Loss of market share for Ophthalmology • Risks to patient safety in the absence of approved clinical pathways that have been subject to QIA • Financial losses that threaten the sustainability of the Trust • Fragile and fragmented clinical services • Loss of activity and income to neighbouring Trusts if referral patterns change • GP and patients refer patients into the private sector with consequent loss of opportunity to benefit from this activity (lack GP engagement or poor performance) • Loss of activity and associated income may destabilise some services impacting on continued provision •

Quarters –Changes in Post Mitigation Risk Scores	**Q1**	**Q2**	**Q3**	**Q4**

	20			

KEY CONTROLS IN PLACE	ASSURANCE THAT CONTROLS ARE EFFECTIVE [Yes / No (if no what action is being taken)]	LEVEL of CONTROL 1 = Operational 2 = Committee 3 = External
Trust's Strategy 2019 - 2021 (identifies market share, opportunities for business growth and use of the Trust by GP practice)	Yes	1
The MCP development is scrutinised by the Board directly with approval sought at each gateway.	Yes	2,3
Specific Trust Board Review of the MCP is planned in March 2020 and monthly thereafter	Yes	2
A comparative analysis of performance is presented to F&P Committee every six months with an evolving range of measures discussed to highlight the Trust's strengths and weaknesses. This includes market share analysis to identify changes in referral patterns	Yes	2
The Director of Strategy and Transformation takes part in a monthly meeting with counterparts to discuss a common approach for specialised and vulnerable services	Yes	3
Service strategies developed with the Medical Service Head and DM's for onward approval and development of monitoring arrangements at Divisional and Exec Board level	Yes	2

ACTIONS IMPLEMENTED SINCE LAST REVIEW	IMPACT OF CONTROLS AND ACTIONS ON RISK/ASSURANCE
Board Level Review of Strategic Case for MCP completed. Trust Board has decided	Positive Assurance

not to support the MCP Strategic Case in its current form but have adopted an approach of "engage and influence". Additional resource has been allocated to project management the impact on the Trust. Trust is petitioning partners for a pause to the procurement and has developed an alternative proposal Development of the content for Orthopaedics has been completed for the Trust website Our Orthopaedic service to be re-branded as Midlands Orthopaedic Service from Sept-20 with new promotional material and signage Development of bespoke communication and PR plans has been achieved for orthopaedics with a number of actions to promote the service and build relationships with local GPs. Engagement meetings with local GPs initiated to listen to experience of the COVID pandemic. Production of GP Brief to be stepped up to monthly to improve communication channels with referring GPs. All referring GPs identified and email distribution list created. Trust has committed to produce GP Brief every month to improve communications with GPs	Risks in the Strategic Case identified and articulated as a condition of support Trust Board has written to the MCP setting out risks, as know at this stage. The Trust has invested in an internal programme team to develop risk/mitigating strategy for MCP development, including developing list of opportunities. <u>Negative Assurance</u> Net risk score has increased reflecting the uncertainties around how risk will be mitigated and the potentially significant effects on the viability of the Trust

SPECIFIC GAPS IN CONTROL / ASSURANCE	**ACTIONS**	**STATUS:**		
		COMPLETE	**IN PROGRESS**	**OUTSTANDING (BEYOND COMPLETION DATE**
The main areas of weakness which result in ineffective or absent controls / assurance	*Actions required to mitigate the weaknesses*		*Date for completion*	*Action Lead*
• No Communication and Engagement plan (including the production of promotional material for our services, regular relationship meetings and				
	Board Level Review of Full Business Case for MCP		March	Tom Jackson

SPECIFIC GAPS IN CONTROL / ASSURANCE	ACTIONS	STATUS:		
		COMPLETE	IN PROGRESS	OUTSTANDING (BEYOND COMPLETION DATE
The main areas of weakness which result in ineffective or absent controls / assurance	*Actions required to mitigate the weaknesses*		*Date for completion*	*Action Lead*
the continuation of competitor analysis and market monitoring). • Limited involvement by Trust staff in the different work streams of the STP. • Lack of visibility by Trust staff of the different work streams of the STP • The system wide financial model is targeted to balance overall. MCP modelling of this is ongoing and the Trust impact will be determined once all information is collated.			2020 – Business Case now due for completion Sep 2020	
	Development of the content for Gynae, Gastro, and General Surgery on the re developed Trust website		July 2020 – delayed due to C-19 so new date set of Oct 2020	Katherine Sheerin
	Development of bespoke communication and PR plans for the following priority services: • Gynaecology • General Surgery • Gastroenterology • Ophthalmology		July 2020 – delayed due to C-19. New target date of Oct 2020.	Katherine Sheerin
	Development of an approach to engagement with GP practices to support business growth -		complete	Tricia Morrison

SPECIFIC GAPS IN CONTROL / ASSURANCE	ACTIONS	STATUS:		
		COMPLETE	IN PROGRESS	OUTSTANDING (BEYOND COMPLETION DATE
The main areas of weakness which result in ineffective or absent controls / assurance	*Actions required to mitigate the weaknesses*		*Date for completion*	*Action Lead*
	Pilot an approach with practices that are high users of trust services in Sandwell & West Birmingham CCG			
	Development of an approach to engagement with GP practices to support business growth - Roll out to other practices during 2019/20		Delayed due to C-19. New target date of March 2021	Katherine Sheerin
	Strengthen engagement with the work streams of the STP by being clear on where DGFT input is on the workstreams and identifying any gaps in engagement /involvement across the Programme. Co-ordinate a regular update to Exec Directors		March 2020 Delayed due to C-19. New target date of Oct 2020.	Katherine Sheerin
The implications of the implementation of the MP model based on current procurement proposal	½ day in March set aside for the Trust Board to review MCP		March 2020 complete	

SPECIFIC GAPS IN CONTROL / ASSURANCE	ACTIONS	STATUS:		
		COMPLETE	IN PROGRESS	OUTSTANDING (BEYOND COMPLETION DATE
The main areas of weakness which result in ineffective or absent controls / assurance	*Actions required to mitigate the weaknesses*		*Date for completion*	*Action Lead*
	Clinical Advisory Groups (CAGs) are taking place to shape the clinical pathways for the services affected by the MCP plan. Need to confirm that output from CAGs is fully considered as part of the development of the Clinical Model.		April 2020 September 2020	Julian Hobbs
	A bespoke MCP risk register has been created and is referred to on a regular basis with steps taken to mitigate any existing or new risks.		Ongoing	Tom Jackson
	Engage with the Commissioners and STP to seek a pause in the procurement process and negotiation of alternative offer for integrated services		July/Aug 2020	
	Require production of sub-contract by the end of July 2020 to assess risks		July/Aug 2020	

Appendix A

Summary of Corporate Risks – Quality and Safety Committee

Exec Lead	Risk Mitigator	Ref	Risk Title	Date entered on Risk Register	Initial Risk Score	Sept 19	Oct 19	Nov 19	Dec 19	Jan 20	Feb 20	Mar 20	Apr 20	May 20	Jun 20	Trend	Target Risk Score
Objectives: SO1 Deliver a great patient experience																	
CN	**Jill Faulkner**	COR1010	Failure to comply with local and statutory provisions for complaints management	08/05/19	5 X 5 (25)	3 X 5 (15)	3 X 5 (15)	3 X 5 (15)	3 X 5 (15)	3 X 5 (15)	3 X 5 (15	3 X 5 (15)	3 X 5 (15)	3 X 5 (15)	3 X 5 (15)	➔	2 X 5 (10)
COO	Rupert Wainwright	COR1046	Failure to deliver the Imaging CQC post inspection action plan and improve CQC Rating	12/06/19	4 X 5 (20)	4 X 4 (16)	4 X 4 (16)	4 X 4 (16)	4 X 4 (16)	4 X 4 (16)	4 X 4 (16)	4 X 4 (16)	3 x 4 (12)	3 x 4 (12)	3 x 4 (12)	➔	2 X 4 (8)
Objectives: SO2 Safe and Caring services																	
MD	**Phil Brammer**	COR1015	Compliance to the identification and action of all deteriorating patient groups	13/05/19	4 X 5 (20)	3 X 5 (15)	3 X 5 (15)	3 X 5 (15)	3 X 5 (15)	3 X 5 (15)	3 X 5 (15)	3 X 5 (15)	3 X 5 (15)	3 X 5 (15)	3 X 5 (15)	➔	2 X 5 (10)
COO	**Ruckie Kahlon**	COR896 (CSS896)	Temperatures in medicines storage rooms exceeding manufacturers recommendations	16/01/19	5 X 3 (15)	5 X 3 (15)	5 X 3 (15)	5 X 3 (15)	5 X 3 (15)	4 X 3 (12)	4 X 3 (12)	4 X 3 (12)	4 X 3 (12)	4 X 3 (12)	4 X 3 (12)	➔	2 X 3 (6)
COO	**Sharon Phillips**	COR748	Governance arrangements from floor to board through the divisional structure not	10/09/18	5 x 4 (20)	3 X 4 (12)	3 X 4 (12)	3 X 4 (12)	3 X 4 (12)	3 X 4 (12)	3 X 4 (12)	3 X 4 (12)	3 X 4 (12)	3 X 4 (12)	2 X 4 (8)	➔	2 X 4 (8)

Exec Lead	Risk Mitigator	Ref	Risk Title	Date entered on Risk Register	Initial Risk Score	Sept 19	Oct 19	Nov 19	Dec 19	Jan 20	Feb 20	Mar 20	Apr 20	May 20	Jun 20	Trend	Target Risk Score
			consistent to identify risks												CLOSED		
MD	Kausar, Dr Shahid	COR1145	Neurosurgical Referral Pathway	18/09/19	4 x 5 (20)	4 x 5 (20)	4 x 5 (20)	4 x 5 (20)	4 x 5 (20)	4 x 5 (20)	4 x 5 (20)	4 x 5 (20)	2 x 5 (10)	2 x 5 (10)	2 x 5 (10)	➔	2 X 5 (10)
MD	Hudson, Paul	COR1185	Lack of systemic process to ensure clinicians review all results for all radiological investigations performed	25/10/19	4 x 4 (16)	NEW	4 x 4 (16)	4 x 4 (16)	4 x 4 (16)	4 x 4 (16)	4 x 4 (16)	4 x 4 (16)	4 x 4 (16)	4 x 4 (16)	4 x 4 (16)	➔	2 X 4 (8)
CN	Karen Kelly	COR1260	Patient safety compromised due to being nursed in corridors	17/12/19	4 X 5 (20)			NEW	4 X 4 (16)	4 X 4 (16)	4 X 4 (16)	3X 4 (12)	3X 4 (12)	3X 4 (12)	3X 3 (9) CLOSED	↓	3 X 3 (9)
CN	Aworinde, Mandy	COR1301	Implementation of Liberty Protection Safeguards	26/02/2020	4 x 3 (12)					NEW	4 x 3 (12)	4 x 3 (12)	4 x 3 (12)	4 x 3 (12)	4 x 3 (12)	➔	2 x 3 (6)
COO	Chris Leach	COR1289	Covid-19	10/02/20	4 X 5 (20)					NEW	4 X 5 (20)	3 x 5 (15)	3 x 5 (15)	3 x 5 (15)	3 x 5 (15)	➔	2 x 5 (10)
Objectives: SO3 Drive Service Improvements, innovations and transformation																	
MD	Bill Dainty	COR1063	Data validation for sepsis reporting	18/06/19	4 X 5 (20)	3 X 4 (12)	3 x 4 (12)	3 x 4 (12)	3 x 4 (12)	3 x 4 (12)	3 x 4 (12)	3 x 4 (12)	2 X 5 (10)	2 X 5 (10)	2 X 5 (10	➔	2 X 5 (10)

Summary of Corporate Risks – Finance and Performance Committee [1]

Exec Lead	Risk Mitigator	Ref	Risk Title	Date entered on Risk Register	Initial Risk Score	Sept 19	Oct 19	Nov 19	Dec 19	Jan 20	Feb 20	Mar 20	Apr 20	May 20	Jun 20	Trend	Target Risk Score
Objectives: SO2 Safe and Caring services																	
CIO	Sarah Ellis	COR1081 (CE1081)	Failure of the IT infrastructure would impact on patient safety and performance	03/07/19	5 x 4 (20)									ESC	4 x 5 (20)	↑	2 x 4 (8)
Objectives: SO4 Be the place people choose to work																	

Exec Lead	Risk Mitigator	Ref	Risk Title	Date entered on Risk Register	Initial Risk Score	Sept 19	Oct 19	Nov 19	Dec 19	Jan 20	Feb 20	Mar 20	Apr 20	May 20	Jun 20	Trend	Target Risk Score
MD	**Julian Hobbs**	COR959	Financial implications of job planning	11/03/19	4 x 4 (16)	4 x 4 (16)	4 x 4 (16)	4 x 4 (16)	4 x 4 (16)	4 x 4 (16)	4 x 4 (16)	4 x 4 (16)	4 x 4 (16)	4 x 4 (16)	4 x 4 (16)	➔	2 x 4 (8)
Objectives: SO6 Deliver a viable future																	
CIO	**Karen Hale**	COR1083 (CE1083)	Risk of cyber a security incident causing widespread impact of Trust operational capability and patient safety	03/07/19	5 x 5 (25)									ESC	5 x 5 (25)	↑	2 x 5 (10)

1 **COR 1081 and 1083 awaiting transfer from Datix to Digital** Trust and Technology Committee, but is being overseen by that committee

Summary of Corporate Risks – Workforce and Staff Engagement Committee

Exec Lead	Risk Mitigator	Ref	Risk Title	Date entered on Risk Register	Initial Risk Score	Sept 2019	Oct 2019	Nov 19	Dec 19	Jan 20	Feb 20	Mar 20	Apr 20	May 20	Jun 20	Trend	Target Risk Score
S&TD	**Rachel Andrew**	COR981	High levels of staff absence resulting in staff shortages and agency expenditure	12/04/2019	5 x 4 (20)	4 x 4 (16)	4 x 4 (16)	4 x 4 (16)	4 x 4 (16)	4 x 4 (16)	4 x 4 (16)	4 x 4 (16)	4 x 4 (16)	4 x 4 (16)	4 x 4 (16)	➔	2 x 4 (8)
S&TD	**Rachel Andrew**	COR1065	Pension implications for high earners	27/06/2019	5 x 3 (15)	5 x 3 (15)	5 x 3 (15)	4 x 3 (12)	4 x 3 (12)	4 x 3 (12)	4 x 3 (12)	4 x 3 (12)	4 x 3 (12)	4 x 3 (12)	2 x 4 (4)	↓	2 x 3 (6)
S&TD	**Rachel Andrew**	COR1303	Staff engagment and morale	11/03/2020	5 x 4 (20)						New	4 x 4 (16)	4 x 4 (16)	4 x 4 (16)	4 x 4 (16)	➔	3 x 4 (12)
Objectives: SO5 Make the best use of what we have																	
S&TD	**Boswell, Andrew**	COR982	Poor compliance to Trust mandatory training in specific areas	12/04/2019	4 x 4 (16)	4 x 4 (16)	4 x 4 (16)	4 x 4 (16)	4 x 4 (16)	4 x 4 (16)	4 x 4 (16)	4 x 4 (16)	4 x 4 (16)	4 x 4 (16)	4 x 4 (16)	➔	2 x 4 (8)

Enclosure 31

NHS Foundation Trust

Paper for submission to Board of Directors on Thursday 10th September 2020

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

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 (Assurance)**
			Y

RECOMMENDATIONS

The board are asked to note the current revalidation compliance and assurance processes in place.

CORPORATE OBJECTIVE:

SO2 Safe and caring services

SUMMARY OF KEY ISSUES:

- Dr Julian Hobbs is appointed as Responsible Officer in addition to the current role of Medical Director in line with other Trusts. Two further senior clinicians have undertaken Responsible Officer Training.
- 428 doctors were connected to DGFT at 19/08/20.
- Revalidations due between March 17th 2020 – March 16th 2021 have been extended by 1 year and the Annual Organisational Audit has been cancelled for 2020 due to COVID19. Despite this appraisals have continued and as at 19/8/20 94.23% of doctors complied with GMC guidelines for appraisal within 9-15 months of previous appraisal.

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, Well Led
	NHSI	**N**	**Details:**
	Other	**Y**	**Details: GMC Good Medical Practice** **NHS Framework for Quality Assurance for**

			Responsible Officers
REPORT DESTINATION	**Board of directors**	**Y**	**DATE: 10/09/20**
	WORKING GROUP	**N**	**DATE:**
	COMMITTEE	**N**	**DATE:**

REPORT OF THE RESPONSIBLE OFFICER TO THE BOARD OF DIRECTORS

September 2020

1. Executive Summary

This report represents the status of Medical Revalidation and Appraisals at The Dudley Group NHS Foundation Trust. It represents the performance of the organisation with regards to the Framework for Quality Assurance for Medical Revalidation (FQA) and the Responsible Officer Regulations and related guidance from the General Medical Council (GMC). Due to COVID-19 the Annual Organisational Audit for 2018/2019 submitted to NHS England has been suspended.

As of 19th August 2020 there were 428 doctors with a prescribed connection to The Dudley Group NHS Foundation Trust as a designated body. The overall compliance rate at 19th August 2020 was 94.23%. All revalidations between March 17th 2020 and March 16th 2021 have been extended by 12 months in light of COVID-19.

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

2. Background

Medical Revalidation was launched in 2012 to strengthen the way that doctors are regulated, with the aim of improving the quality of care provided to patients, improving patient safety and increasing public trust and confidence in the medical system.

Provider organisations have a statutory duty to support their Responsible Officers in discharging their duties under the Responsible Officer Regulations and it is expected that provider boards will oversee compliance by:

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

Dr Julian Hobbs is appointed as Responsible Officer in addition to the current role of Medical Director in line with other Trusts. Two further senior medical staff have also completed Responsible Officer training.

3. Governance

The Responsible Officer is supported by Medical Trust Appraisal Lead and a Medical Appraisal and Revalidation Support Officer. The team meet fortnightly and escalate any issues for discussion at the

Medical Concerns group who meet weekly to discuss concerns arising from medical appraisal, complaints/adverse incidents, performance related issues, GMC communications etc. This Group functions as a senior decision making group in relation to whether to investigate further and if so under which process this should be carried out. It also reviews the outcome of any ongoing investigations and the implementation of any resultant recommendations. The output from this Group forms the basis of the Medical Director's report to the private Trust Board. Assurance in relation to Medical Revalidation and Appraisal is provided by reporting to the Workforce and Engagement Committee bi-annually.

A Revalidation and Appraisal policy is in place and is due for review in July 2022.

4. Medical Appraisal Performance

4.1 Impact of COVID-19

The General Medical Council (GMC) moved revalidation dates for some doctors and amended processes to be more flexible to allow responsible officers to recommend doctors for revalidation in response to the COVID 19 pandemic. Doctors who were due to revalidate between 17 March 2020 and 16 March 2021 have had their revalidation submission dates moved back by one year. To accommodate flexibility in making recommendations, all doctors whose dates have been moved will also be put under notice. This means that responsible officers can submit recommendations to revalidate those doctors at any time up to their new submission date.

Despite these restrictions, appraisals have continued within the Trust and as of 19/8/20 the Trust compliance rate is 94.23%.

2.1 Only Doctors with whom the designated body has a prescribed connection at March 2017	Number of prescribed connections	Completed Appraisals 1A	Completed Appraisals 1B	Approved Incomplete Appraisals or Missed Appraisals	Unapproved Incomplete Appraisals 0 Unapproved appraisals during COVID-19	Total
Consultants	217	94	101	22	0	217
Staff Grade, Associate Specialist, Speciality doctor	120	79	21	20	0	120
Doctors on Performers lists	0	0	0	0	0	0
Doctors with practising privileges	0	0	0	0	0	0
Temporary	81	48	1	32	0	81

or short term contract holders						
Other doctors with a prescribed connection to this designated body	10	3	7	0	0	10
Total	428	224	130	74	0	428

4.2 Appraisers

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

4.3 Quality Assurance

A review of active appraisers was undertaken in July 2020 by the Deputy Medical Director. A random sample of 20 appraisals was scored using the ASPAT recognised Quality Assurance scoring system. This exercise revealed all appraisals to be of satisfactory standard with narrative and evidence recorded in each domain.

Additionally, all appraisee's are required to provide feedback regarding the appraisal before the appraisal can be 'signed off'. A new reporting system has now been put in place by the software company to collate appraisal feedback and provide a report by individual appraiser which can be reviewed by the appraisal team and will also be automatically sent to the appraiser to use as supporting evidence in their own appraisal.

4.4 Access, Security and Confidentiality

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

4.5 Clinical Governance

The PreP Revalidation System for Appraisal and Revalidation ensures that the required domains for Supporting Information for Appraisal and Revalidation are completed and the appraisal meeting is set on the system before the appraisal can be submitted for review by an appraiser. Doctors have access to their individual complaints and incidents via the Trust Governance team

and performance, mortality and morbidity data from the Informatics Team. HED (Health Evaluation Data) reports are available via our Medical Revalidation Support Officer for those Consultants within a Surgery based field.

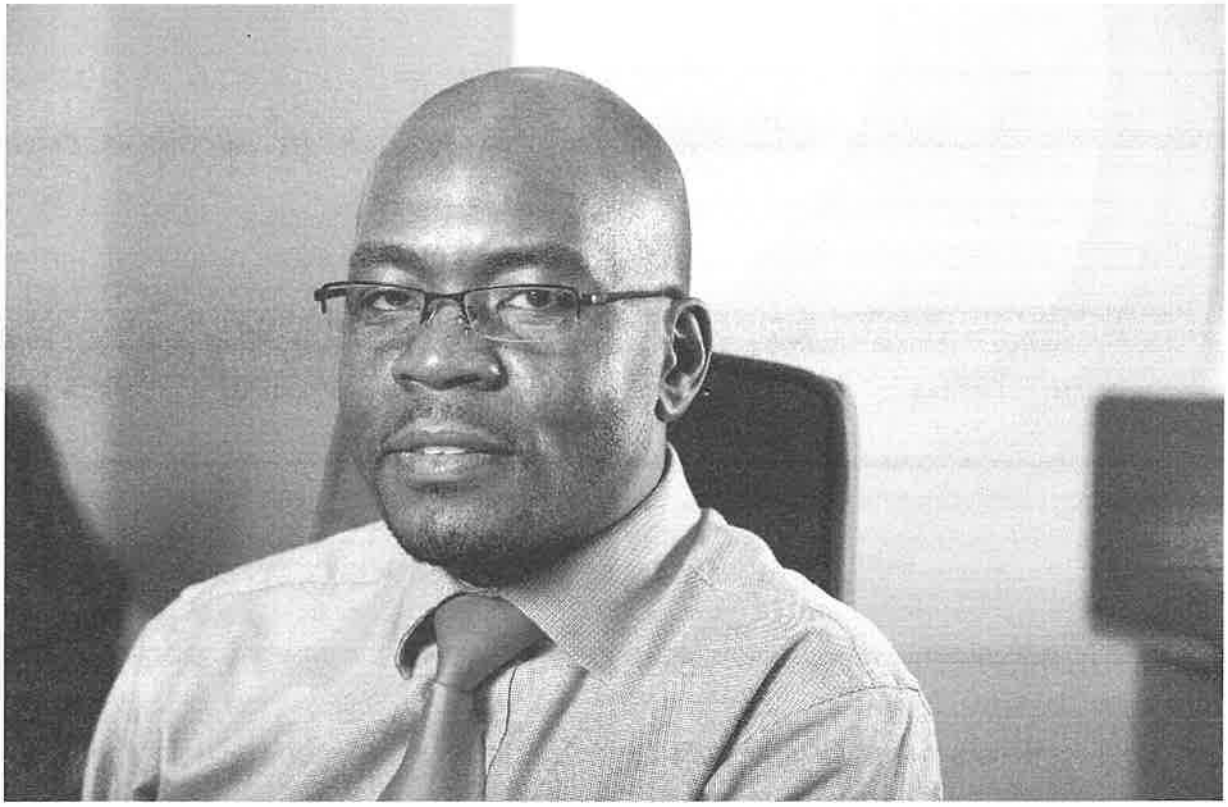
5. Recommendations

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

Dr Julian Hobbs

Responsible Officer

August 2020



A Framework of Quality Assurance for Responsible Officers and Revalidation

Annex D – Annual Board Report and Statement of Compliance.

NHS England and NHS Improvement

A Framework of Quality Assurance for Responsible Officers and Revalidation

Annex D – Annual Board Report and Statement of Compliance.

Publishing approval number: **000515**

Version number: 3.0

First published: 4 April 2014

Updated: February 2019

Prepared by: Lynda Norton, Claire Brown, Maurice Conlon

This information can be made available in alternative formats, such as easy read or large print, and may be available in alternative languages, upon request. Please contact Lynda Norton on England.revalidation-pmo@nhs.net.

Contents

Introduction:

The Framework of Quality Assurance (FQA) for Responsible Officers and Revalidation was first published in April 2014 and comprised of the main FQA document and annexes A – G. Included in the seven annexes is the Annual Organisational Audit (annex C), Board Report (annex D) and Statement of Compliance (annex E), which although are listed separately, are linked together through the annual audit process. To ensure the FQA continues to support future progress in organisations and provides the required level of assurance both within designated bodies and to the higher-level responsible officer, a review of the main document and its underpinning annexes has been undertaken with the priority redesign of the three annexes below:

- **Annual Organisational Audit (AOA):**

  The AOA has been simplified, with the removal of most non-numerical items. The intention is for the AOA to be the exercise that captures relevant numerical data necessary for regional and national assurance. The numerical data on appraisal rates is included as before, with minor simplification in response to feedback from designated bodies.

- **Board Report template:**

  The Board Report template now includes the qualitative questions previously contained in the AOA. There were set out as simple Yes/No responses in the AOA but in the revised Board Report template they are presented to support the designated body in reviewing their progress in these areas over time.

  Whereas the previous version of the Board Report template addressed the designated body's compliance with the responsible officer regulations, the revised version now contains items to help designated bodies assess their effectiveness in supporting medical governance in keeping with the General Medical Council (GMC) handbook on medical governance[1]. This publication describes a four-point checklist for organisations in respect of good medical governance, signed up to by the national UK systems regulators including the Care Quality Commission (CQC). Some of these points are already addressed by the existing questions in the Board Report template but with the aim of ensuring the checklist is fully covered, additional questions have been included. The intention is to help designated bodies meet the requirements of the system regulator as well as those of the professional regulator. In this way the two regulatory processes become complementary, with the practical benefit of avoiding duplication of recording.

[1] Effective clinical governance for the medical profession: a handbook for organisations employing, contracting or overseeing the practice of doctors GMC (2018) [https://www.gmc-uk.org/-/media/documents/governance-handbook-2018_pdf-76395284.pdf]

The over-riding intention is to create a Board Report template that guides organisations by setting out the key requirements for compliance with regulations and key national guidance, and provides a format to review these requirements, so that the designated body can demonstrate not only basic compliance but continued improvement over time. Completion of the template will therefore:

a) help the designated body in its pursuit of quality improvement,

b) provide the necessary assurance to the higher-level responsible officer, and

c) act as evidence for CQC inspections.

- **Statement of Compliance:**

The Statement Compliance (in Section 8) has been combined with the Board Report for efficiency and simplicity.

Designated Body Annual Board Report

Section 1 – General:

The Board / Executive Management Team of the Dudley Group NHS Foundation Trust can confirm that:

1. The Annual Organisational Audit (AOA) for this year has been submitted.

Date of AOA submission: Cancelled due to COVID-19
Action from last year: Continue to improve compliance rates
Comments: Compliance maintained despite the COVID-19 pandemic
Action for next year: Ensure all doctors are supported to comply with appraisal and revalidation requirements in a post pandemic environment

2. An appropriately trained licensed medical practitioner is nominated or appointed as a responsible officer.

Action from last year: N/A
Comments: Responsible Officer has remained in post
Action for next year: N/A

3. The designated body provides sufficient funds, capacity and other resources for the responsible officer to carry out the responsibilities of the role.

Yes
Action from last year: N/A
Comments:
Action for next year:

4. An accurate record of all licensed medical practitioners with a prescribed connection to the designated body is always maintained.

Action from last year: Yes
Comments: All GMC connections are managed
Action for next year: Continue to manage all GMC connections

5. All policies in place to support medical revalidation are actively monitored and regularly reviewed.

Action from last year: None due to COVID-19
Comments: This will be updated post pandemic
Action for next year: As above

6. A peer review has been undertaken of this organisation's appraisal and revalidation processes.

Action from last year: Appraisal audit undertaken on completed appraisals
Comments: Despite COVID-19 this was still undertaken
Action for next year: To continue with appraisal and revalidation audits

7. A process is in place to ensure locum or short-term placement doctors working in the organisation, including those with a prescribed connection to another organisation, are supported in their continuing professional development, appraisal, revalidation, and governance.

Action from last year: All locum and short-term staff are fully supported
Comments: Guidance and support is offered to ensure compliance
Action for next year: To continue with this process

Section 2 – Effective Appraisal

1. All doctors in this organisation have an annual appraisal that covers a doctor's whole practice, which takes account of all relevant information relating to the doctor's fitness to practice (for their work carried out in the organisation and for work carried out for any other body in the appraisal period), including information about complaints, significant events and outlying clinical outcomes.

Action from last year: Despite COVID-19 some appraisals have taken place
Comments: To ensure compliance post pandemic
Action for next year: Continue to improve compliance rates

2. Where in Question 1 this does not occur, there is full understanding of the reasons why and suitable action is taken.

Action from last year: Any missed appraisals are due to COVID-19
Comments: This is a small minority
Action for next year: To improve compliance rates post pandemic

3. There is a medical appraisal policy in place that is compliant with national policy and has received the Board's approval (or by an equivalent governance or executive group).

Action from last year: N/A
Comments: Next update due July 2022
Action for next year: N/A

4. The designated body has the necessary number of trained appraisers to carry out timely annual medical appraisals for all its licensed medical practitioners.

Action from last year: Appraiser course (virtual due to COVID-19)
Comments: Additional appraisers recruited
Action for next year: Appraiser refresher training post pandemic

5. Medical appraisers participate in ongoing performance review and training/ development activities, to include attendance at appraisal network/development events, peer review and calibration of professional judgements (Quality Assurance of Medical Appraisers[2] or equivalent).

Action from last year: N/A due to COVID-19
Comments: Virtual online CPD activities have been undertaken
Action for next year: Post pandemic virtual events/peer reviews and calibration of professional judgements

6. The appraisal system in place for the doctors in your organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group.

Action from last year: Covid-19
Comments: Quality assurance processes remain in place
Action for next year: Continue to improve compliance

Section 3 – Recommendations to the GMC

1. Timely recommendations are made to the GMC about the fitness to practise of all doctors with a prescribed connection to the designated body, in accordance with the GMC requirements and responsible officer protocol.

Action from last year: N/A
Comments: Due to COVID-19 revalidations have been placed under notice by the GMC with a further 12 months additional time to revalidate
Action for next year: We will have resumed timely revalidations by December 2020

[2] http://www.england.nhs.uk/revalidation/ro/app-syst/
[2] Doctors with a prescribed connection to the designated body on the date of reporting.

2. Revalidation recommendations made to the GMC are confirmed promptly to the doctor and the reasons for the recommendations, particularly if the recommendation is one of deferral or non-engagement, are discussed with the doctor before the recommendation is submitted.

Action from last year: Due to COVID-19 revalidations from April were placed under notice by the GMC.
Comments: Post pandemic revalidations are re-commencing
Action for next year: N/A

Section 4 – Medical governance

1. This organisation creates an environment which delivers effective clinical governance for doctors.

Action from last year: N/A
Comments: This may be virtual Clinical Governance
Action for next year: Post pandemic Clinical Governance meetings will resume

2. Effective systems are in place for monitoring the conduct and performance of all doctors working in our organisation and all relevant information is provided for doctors to include at their appraisal.

Action from last year: Yes
Comments: Appraisal evidence is reviewed
Action for next year: To continue to review prior to an appraisal

3. There is a process established for responding to concerns about any licensed medical practitioner's[1] fitness to practise, which is supported by an approved responding to concerns policy that includes arrangements for investigation and intervention for capability, conduct, health and fitness to practise concerns.

Action from last year: Yes
Comments: Responsible Officer
Action for next year: To continue to respond to concerns

4. The system for responding to concerns about a doctor in our organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group. Analysis includes numbers, type and outcome of concerns, as well as aspects such as consideration of protected characteristics of the doctors[3].

[4]This question sets out the expectation that an organisation gathers high level data on the management of concerns about doctors. It is envisaged information in this important area may be

Action from last year: Yes

Comments: Responsible Officer

Action for next year:

5. There is a process for transferring information and concerns quickly and effectively between the responsible officer in our organisation and other responsible officers (or persons with appropriate governance responsibility) about a) doctors connected to your organisation and who also work in other places, and b) doctors connected elsewhere but who also work in our organisation[4].

Action from last year: Yes

Comments: All MPIT forms were completed throughout COVID-19

Action for next year: To continue with this process

6. Safeguards are in place to ensure clinical governance arrangements for doctors including processes for responding to concerns about a doctor's practice, are fair and free from bias and discrimination (Ref GMC governance handbook).

Action from last year: Yes

Comments:

Action for next year: To continue with Safeguards

Section 5 – Employment Checks

1. A system is in place to ensure the appropriate pre-employment background checks are undertaken to confirm all doctors, including locum and short-term doctors, have qualifications and are suitably skilled and knowledgeable to undertake their professional duties.

Action from last year: Pre-employment checks and action HPAN alert notices

Comments: Yes

Action for next year: Pre-employment checks to continue

Section 6 – Summary of comments, and overall conclusion

There are no unapproved appraisals due to COVID-19 as the GMC cancelled the appraisals all late or missed appraisals are approved.

requested in future AOA exercises so that the results can be reported on at a regional and national level.

[4] The Medical Profession (Responsible Officers) Regulations 2011, regulation 11: http://www.legislation.gov.uk/ukdsi/2010/9780111500286/contents

We currently have a Medical Appraisal Rate as of 18/08/2020 at 94.23%

Our Trust has a high level rate of compliance despite the pandemic.

Section 7 – Statement of Compliance:

The Board / executive management team – [*delete as applicable*] of [*insert official name of DB*] has reviewed the content of this report and can confirm the organisation is compliant with The Medical Profession (Responsible Officers) Regulations 2010 (as amended in 2013).

Signed on behalf of the designated body

[(Chief executive or chairman (or executive if no board exists)]

Official name of designated body: The Dudley NHS Foundation Trust_

Name: _Diane Wake _____ Signed: Dwake _____

Role: _Chief Executive _____

Date: _18/08/2020 _____