

# Board of Directors Meeting Public Papers

Thursday 8<sup>th</sup> October 2020

11:45 – 15:35



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

## **BOARD MEETINGS PUBLIC INFORMATION SHEET**

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

### **1. Introduction**

This sheet provides some information about how Board meetings work.

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

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

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

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### **2. Board Members' interests**

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

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

### **3. Opportunity for questions**

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

#### **4. Debate**

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

#### **5. Minutes**

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

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

#### **6. Key Contacts**

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## THE SEVEN PRINCIPLES OF PUBLIC LIFE

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

### **Selflessness**

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

### **Integrity**

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

### **Objectivity**

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

### **Accountability**

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

### **Openness**

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

### **Honesty**

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

### **Leadership**

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

**Board of Directors**  
**Thursday 8 October 2020 at 11.45am**  
**Clinical Education Centre**  
**AGENDA**

	ITEM	PAPER REF	LEAD	PURPOSE	TIME
15	<b>Chairmans welcome and note of apologies –</b>		Y Buckland	For noting	11.45
16	<b>Declarations of Interest</b> Standing declaration to be reviewed against agenda items.		Y Buckland	For noting	11.45
17	<b>Minutes of the previous meeting</b>  Thursday 10 September 2020 Action log 10 September 2020	Enclosure 10 Enclosure 11	Y Buckland L Nevin	For approval For noting	11.45 11.50
18	<b>Chief Executive's Overview</b>  - MCP Report	Enclosure 12 Enclosure 12a	D Wake	For information & assurance	11.55
19	<b>Chair's update</b>	Verbal	Y Buckland	For information	12.05
20	<b>QUALITY &amp; SAFETY</b>				
20.1	Quality and Safety Committee Report (i) Learning from Deaths Report	Enclosure 13 Enclosure 14	E Hughes	For assurance	12.15
20.2	Chief Nurse Report	Enclosure 15	M Sexton	For assurance	12.30
20.3	Board Assurance Infection Control Framework	Enclosure 16	M Sexton	For assurance	12.40
21	<b>FINANCE &amp; PERFORMANCE</b>				
21.1	Finance and Performance Committee Report	Enclosure 17	J Hodgkin	For assurance	12.50
21.2	Integrated Performance Dashboard	Enclosure 18	K Kelly	For assurance	13.00
21.3	Recovery and Restoration Deep Dive	Enclosure 19	K Kelly	For assurance	13.10
22	<b>WORKFORCE</b>				
22.1	Workforce and Staff Engagement Committee Report	Enclosure 20	J Atkins	For assurance	13.40
22.2	Workforce KPIs	Enclosure 21	J Fleet	For assurance	13.50
23	<b>GOVERNANCE</b>				
23.1	Acute Collaboration Update	Enclosure 22	K Sheerin	For discussion	14.00
23.2	Winter Plan	Enclosure 23	K Kelly	For assurance	14.20

<b>23.3</b>	Audit Committee Report (i) Risk Management Strategy (ii) Standing Financial Instructions	Enclosure 24	R Miner	For assurance For decision For decision	14.50
<b>23.4</b>	Charitable Funds Committee Report	Enclosure 25	J Atkins	For assurance	15.00
<b>23.5</b>	Review of the Constitution	Enclosure 26	L Nevin	For recommendation	15.10
<b>23.6</b>	Veteran Aware Trust Accreditation	Enclosure 27	M Sexton	For decision	15.20
<b>24</b>	<b>Any Other Business</b>	Verbal	All		15.30
<b>25</b>	<b>Reflection on meeting</b>	Verbal	All		15.30
<b>26</b>	<b>Date of next Board of Directors meeting</b> 12 November 2020				15.35

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

**Minutes of the Public Board of Directors meeting held on Thursday 10<sup>th</sup> September 2020, by Remote Attendance**

**Present:**

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

**In Attendance:**

Liam Nevin, Trust Secretary (LN)  
Liz Abbiss Head of Communications (LA)  
Yvonne Peers, Governor (YP)  
Hilary Lumsden Governor (HL)

**20/213 Note of Apologies and Welcome**

The Chair opened the meeting and advised that governors and members of the public had been invited to join the meeting.

Apologies were received from Richard Miner and Adam Thomas and YP and HL were welcomed to the meeting.

**20/214 Declarations of Interest**

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

**20/215 Minutes of the previous meeting held on 9<sup>th</sup> July 2020**

**It was RESOLVED**

- That the minutes of the meeting of the 9th July be agreed as a true and accurate record of the meeting.

**20/216 Public Chief Executive Overview Report**

DW summarised her Overview Report and advised that nationally and locally there was an increase in COVID-19 cases. These were not currently impacting on hospital admissions but the situation was being carefully monitored and the Trust's Situation Room remained open. There had been a small outbreak in one of the Trust teams and this was being appropriately dealt with through the Trust's infection control procedures and employee support arrangements. Restoration and Recovery was progressing well in the Trust and the aim was to be on track with constitutional standards, some by October 2020 others would take more time.

Congratulations were offered 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. It was noted that the Coronary Care Unit is the first in the country to achieve the Gold Standards Framework Accreditation.

The meeting was advised that considerable planning was being done in preparation for winter challenges, including progressing the modular build project. Flu vaccinations would start around the 2<sup>nd</sup> October and the target was to vaccinate 90% of staff, although the Trust would aim for 100%.

### **20/217 Chair's Public Update**

The Chair advised that she was actively involved in discussions around service restoration, and that the MCP project continued to require significant time dedicated to it as the Trust was involved in detailed negotiations. Discussions across the Black Country system were also now underway in relation to acute collaboration and this would be kept on the public agenda so that progress could be reported over the next few months.

### **20/218 Public Questions**

Questions had been received from Hilary Lumsden and Mike Heaton and these were summarised along with the response. Mrs Lumsden confirmed that she had no follow up questions and thanked the Trust for the response.

### **20/219 Chief Nurse Report**

The Chair introduced the item by reminding the Board of the importance of carefully scrutinising infection control measures and that procedures were sufficiently rigorous as services were stepped up.

MS summarised the main body of the report and advised the Board that the number of falls had remained consistent. Since the last meeting one patient had suffered significant harm and this was subject to a root cause analysis. The Trust remained significantly below the national average in respect of the number of falls.

The Board were advised of other key developments:

- A quality accreditation framework was being piloted in two areas
- Friends and Family Test was being reinstated from December and would be included in the IPR from this point
- The patient survey demonstrated some improvements but also pointed to the need to do further work on improving the patient experience
- Staff development and retention – a career pathway was being developed for nursing, midwifery and AHP staff.

The Chair challenged that the number of complaints had risen and asked what steps were being taken to address this. MS advised that activity had returned to pre-COVID levels and recurring themes were about restricted access to the hospital and access to treatment and services that had been suspended.

GC noted that the safer staffing data included a number of red or amber areas and he challenged whether there were any specific concerns that the Board should be made aware of.

MS advised that ward C7 and Critical Care were both challenging because of the number of staff vacancies.

Ms drew the attention of the Board to the Neonatal COVID risk assessment and the Infection Control report. In relation to the former a full risk assessment was included in the papers which had been undertaken in line with IPC guidance. The unit had been measured out and reconfigured to address the requirements of the guidance. There were no significant infection control issues and the Board was asked to approve the risk assessment and to be clear about the measures that had been put in place.

Mrs Lumsden noted that only one parent at a time had been allowed to visit as a result of the COVID restrictions which had concerned parents, but which was unavoidable as a result of space constraints. MS advised that the Trust had adopted digital solutions for families to keep in touch and had received some good feedback from these initiatives.

The Chair questioned whether the risk assessment had also been reviewed by the Infection Control Group and MS confirmed that it had.

MS then summarised the Infection Control framework which reflected the work undertaken to comply with the national guidance. The CQC had undertaken a full engagement meeting with the Trust through which they had reviewed the Trust processes and the CCG had also inspected with a particular focus on compliance with PPE and social distancing.

The Board were advised of the steps taken to ensure appropriate social distancing in the hospital, including the use of zoning, appointment and virtual appointment based systems, and reorganisation of theatre capacity. There were regular audits of clinical and non-clinical areas.

GC challenged and asked for an example of how the audit and compliance work was operating effectively. MS stated that a recent incident of staff infection had resulted in a full review of the office arrangements and the communal areas and changes were made to usage of kitchen areas and removal of reusable crockery, although there was no evidence of transmission between the staff. The number of unannounced audits had also been increased.

The Chair stated that it was important to ensure that an infection control summary was received at each Board meeting.

It was **RESOLVED**

- **That the Chief Nurse report be noted**
- **That the Neonatal Unit COVID-19 Risk assessment be approved.**
- **That the Board note the Trust position against the IPC Assurance**

**Framework measures put in place to adhere to national guidance on infection, prevention and control.**

**20/220 Integrated Performance Report**

KK summarised the report and advised that the Trust continued to perform well in relation to the emergency access standards. However, there had been a downward trend in recent weeks as demand had increased combined with the need for zoning and swabbing.

DMO1 was performing at 74% against a target of 99%. There were challenges with colonoscopy and endoscopy particularly with donning and doffing and social distancing requirements that were impacting on performance.

The Chair challenged that the cancer waiting time figures suggested that there was significant pent up demand in the system and she asked what action was being taken to address that. KK advised that the 62 day position may result in a decline in September but that the Trust was performing well in relation to the 104 day target.

JH asked whether the Trust would hit its phase three recovery targets and KK advised that the target for each specialty for 80% restoration would not be achieved by the end of September but as a system it was expected that performance would be close to this.

The Chair proposed a deep dive at the next Board into Recovery and Restoration and asked that the Board be provided with a summary graph of what the targets are, what current performance is, and how this compares to trajectory and the performance of neighbouring Trusts.

It was **RESOLVED**

- **That the report be noted**

**20/222 QUALITY AND SAFETY**

**20/222.1 Quality Account**

MS explained that whilst this would ordinarily be part of the annual report, it had been delayed by COVID and was now presented in accordance with the revised guidance. The detail had been considered by the Quality and Safety Committee and the Board were required to approve the Account prior to publication.

There being no questions it was **RESOLVED**

- **That the Quality Account be approved**

**20/223 FINANCE AND PERFORMANCE**

**20/223.1 Public Finance and Performance Committee Report**

JF summarised the committee report and advised that the Trust was on a sound financial footing. However, a concern was the trend in pay costs and the increase in agency costs. The current financial regime would cease at the end of September and there was also concern that block payments may not be sufficient to meet the Recovery aspirations. These matters would be considered further in the Finance and Performance Committee

It was **RESOLVED**

- **That the report be noted**

## **20/234 WORKFORCE AND STAFF ENGAGEMENT**

### **20/234.1 Public Workforce and Staff Engagement Report**

JA advised the Board that the most recent meeting of the Committee had undertaken a deep dive into Equality and Inclusion which had involved consideration of a range of issues including leadership development, diversity, and talent development of staff with protected characteristics.

JF advised that the next stage of the work was to develop a leadership strategy that focussed on encouraging diversity and challenging stereotypes around leadership skills. This was a clear action arising from the WRES and WDES review.

The Chair commended the work on developing a talent pipeline and reflected on her own experience of how this approach had helped with gender diversity when there were few women in senior positions.

The Committee was commended on the work undertaken and

It was **RESOLVED**

- **That the report be noted**

### **20/234.2 Workforce KPIs**

JF advised that sickness absence was reducing and that turnover was also below the system average, with the majority of departures related to the ending of fixed term contracts

The Board was advised that in relation to equality and diversity it was clear that nurses were not moving through the ranks to more senior positions. Steps were being taken to bring together groups of BAME nurses, to understand their experience and then to develop solutions through the BAME network.

LW challenged that the percentage of local people in leadership roles was also out of balance, and this was closely related to the underrepresentation of the BAME community. Addressing this was key to developing the aspiration of the hospital being at the heart of the community.

It was **RESOLVED**

- **That the report be noted**

### **20/234.3 WRES/WDES Submission**

**It was agreed that the issues arising from the submission had been debated under the preceding agenda items**

It was **RESOLVED**

- **That the report be noted**

### **20/234.4 NHS People Plan 2020/21**

The report was taken as read and

**It was RESOLVED**

- **That the report be noted**

#### **20/234.5 Freedom to Speak up Guardians**

The FTSU guardians Derek Eaves and Rebekah Plant joined the Board for this item.

In response to a question from the Chair RP advised that there were no underlying concerns from the cases reported and that she was contacting consultants to publicise her role as there was limited recourse to the Guardians from the medical staff.

The Chair stated that the Freedom to Speak Up month in October presented a good opportunity for Directors to publicise the valuable service and speak with staff to get a sense of the issues concerning them. It was noted that the Guardians were seeking support for the statement contained in the appendix to the paper, and it was confirmed that the Board would adopt this statement.

**It was RESOLVED**

- **That the update from the Freedom to Speak Up Guardians be noted**
- **That the statement contained in the appendix to the report be endorsed and adopted by the Board.**

#### **20/234.6 Guardian of Safe Working**

Dr Elahi joined the Board for this item and advised the Board that there had been minimal exception reports received from junior doctors during the period covered by the report.

The Chair stated that the Board was keen to encourage the engagement of junior doctors and suggested a Teams conversation joined by some members of the Board. DW proposed that the Junior Doctors Forum had proven to be an effective and informal setting for the discussion of issues, concerns and positive experiences and it was agreed that JHO would convene a meeting and an invitation would be circulated to all members of the Board. Dr Elahi welcomed this approach and the Chair on behalf of the Board thanked him for his continuing work in this area.

**It was RESOLVED**

- **That the report be noted**

#### **20/235 DIGITAL AND TECHNOLOGY**

CH summarised the Committee report and advised that the Committee had received good quality papers. It was pleasing to report that there had been a successful Go Live for Electronic VTE and Prescribing which was a credit to the technical staff and clinical leadership.

**It was RESOLVED**

- **That the report be noted**

## **20/236 GOVERNANCE**

### **20/236.1 Winter Plan**

The Chair introduced the item by advising the Board that this was an update on progress which would be followed by the full plan at the October Board.

KK explained that the context for the development of the plan was the need to ensure capacity and resilience over the winter months, with an expected COVID outbreak and an increase in major illnesses. In addition there was a need to ensure that robust infection control procedures were maintained.

The Chair noted that new guidance on discharge arrangements had been published and she challenged the steps taken to address this. KK stated that the guidance was under review with the Trust's Discharge Coordinators

JA asked what flexibility was being built into the plan to accommodate an upsurge in COVID admissions. KK advised that a decision to cease elective services would be a decision for NHSE/I and this would link to the Trust's Business Continuity Plan.

LH questioned what provision of social care was being planned for and how quickly this would be made available and KK advised that there was no change in the pathways for patients discharged into social care and work was being done with private care homes to identify capacity in the event of a surge.

### **20/236.2 Board Assurance Framework**

LN presented the quarterly report and advised that the report reflected the first quarter of the year and presented the Board with a summary of both the strategic risks and those identified through the Corporate risk framework which may impinge upon strategic objectives. It was noted that there were eleven risks, three of which were within risk appetite.

The Board were advised that on the basis of risks that were high, significantly above the net risk score and which were also impacted by high scoring corporate risks the most significant strategic risks were the failure to meet access standards, recruitment and engagement, and the Trust's position in the wider health economy particularly in relation to the MCP. LN advised that this was consistent with the balance of the agenda under discussion by the Board.

GC noted that some risk had a high number of operational controls and he invited consideration of whether a higher number of committee and external controls should be introduced.

VR challenged that the Board risk appetite risk score may be not be achievable based on the mitigations proposed.

LN advised that board risk appetite should be linked to the measures for delivering the strategic objectives and the extent to which the Board were more or less risk adverse in relation to the options available. However, this was an area of the framework that was undeveloped and this needed to be addressed alongside the review of the Trust Strategy.

The Chair stated that VRs challenge was well made and warranted consideration of what further external assurance should be sought which the Chair would address with LN.

### **20/236.3 Annual Medical Revalidation Report**

JHO advised that the annual report was before the Board. This had been impacted by COVID which had resulted in a deferment of revalidation requirements for twelve months. However, the Trust had during this time focussed on quality improvement, targeted CPD and PDP, and as a consequence 94.8% of appraisals had been undertaken as compared to 85% three years ago.

It was **RESOLVED**

- **That the report be noted**

### **20/237 Any Other Business**

There was no other business

### **20/238 Reflection on Meeting**

It was noted that with significant volumes of papers a Board Pack administrative system would help with the administration of documents and it was agreed that LN would investigate this further.

**Date for the Next Meeting - 8 October 2020**

Signed .....

Date .....

**Action Sheet**  
**Minutes of the Board of Directors Public Session**  
**Held on 10<sup>th</sup> September 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 Development work with NHSI
20/209.1	Diversity and inclusion	To be included as part of the Board Development programme	YB	Mar 2021	Board inclusion events arranged for October 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
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	Considered by Quality & Safety Committee on 22 <sup>nd</sup> September. On Board Agenda.
20/220	IPR Report	Board to do deep dive into Recovery and Restoration – include graph on what the target is, how the Trust is performing against target and neighbouring Trusts performance, and trajectory.	KK	October 2020	On Agenda.
20/234.6	Guardian of Safe Working	Convene a Junior Doctors Forum – all Board members to be invited to attend	JHO	October 2020	Done – held on Monday 21 <sup>st</sup> September.

**Paper for submission to the Board of Directors on 8<sup>th</sup> October 2020**

<b>TITLE:</b>	<b>Public Chief Executive's Report</b>		
<b>AUTHOR:</b>	<b>Diane Wake Chief Executive</b>	<b>PRESENTER</b>	<b>Diane Wake Chief Executive</b>
<b>CLINICAL STRATEGIC AIMS</b>			
<i>Develop integrated care provided locally to enable people to stay at home or be treated as close to home as possible.</i>		<i>Strengthen hospital-based care to ensure high quality hospital services provided in the most effective and efficient way.</i>	<i>Provide specialist services to patients from the Black Country and further afield.</i>
<b>ACTION REQUIRED OF COMMITTEE</b>			
<b>Decision</b>	<b>Approval</b>	<b>Discussion</b>	<b>Other</b>
		X	
<b>RECOMMENDATIONS</b>			
The Board are asked to note and comment on the contents of the report.			
<b>CORPORATE OBJECTIVE:</b>			
SO1, SO2, SO3, SO4, SO5, SO6			
<b>SUMMARY OF KEY ISSUES:</b>			
<ul style="list-style-type: none"> <li>• Coronavirus</li> <li>• Modular Build</li> <li>• Flu Vaccination</li> <li>• Staff survey</li> <li>• Healthcare Heroes</li> <li>• Charity Update</li> <li>• Patient Feedback</li> <li>• Visits and Events</li> <li>• National News</li> <li>• Regional News</li> </ul>			
<b>IMPLICATIONS OF PAPER:</b>			
<b>IMPLICATIONS FOR THE CORPORATE RISK REGISTER OR BOARD ASSURANCE FRAMEWORK</b>			
<b>RISK</b>	<b>N</b>	<b>Risk Description:</b>	

	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 – 8<sup>th</sup> October 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 face covering in certain situations, for example, when coming to hospital you must wear a surgical face mask unless exemptions apply. It is so important that we all follow this advice to keep ourselves and our loved ones safe from the virus – Hands, Face Space!

We are beginning to see an increase in the numbers of Coronavirus inpatients attending hospital. The rate per 100,000 of the population in Dudley as of 29<sup>th</sup> September 2020 was 46.2.

The Trust currently has 9 inpatients and has sadly seen 3 deaths in the last 7 days. Preparations and planning is underway to ensure the hospital is prepared for a second surge in Covid cases. National guidance is to continue delivering the Restoration and Recovery Plan whilst managing any impact of Covid. The staff have been very responsive and continue to work with us to keep our patients safe in our care.

### **Modular Build**

Building work has started on a new modular build that will run the length of Russells Hall Hospital. It will provide extra beds as well as assessment facilities for patients, which will be a great help over winter when we see more people come to hospital. During the works, heavy machinery, Portakabins etc will be taking out a number of car park spaces. The modular build should be up and running by the end of December.

### **Flu Vaccination**

In 2019/20, the NHS in England achieved a record flu vaccination uptake rate among frontline health care staff of 74.3%. This is an increase of 4.0ppts compared to last year (70.3%), with more than 33,000 more staff vaccinated. Uptake has increased every year since 2015/16 and is one of the highest rates in Europe. The Trust achieved over 80% of staff vaccinated last year.

The Trust flu campaign begins on the 5<sup>th</sup> October with a target of 90% of staff being vaccinated by February 2021 but 100% of front line staff. We are aiming to vaccinate as many staff as quickly as possible to provide staff with the very best protection against this virus as soon as possible.

### **Staff Survey 2020**

The National Staff Survey 2020 is underway.

This year has been a year like no other and the national staff survey is one way that staff can tell us what it was like for them working through the pandemic.

Picker, an independent organisation, is again running the survey for us. Like every year, this means that all your responses go to them and they only provide the Trust with an anonymous report summarising staff responses.

Some of the questions will be the same as in previous years, while others will relate to staff experiences during the pandemic and suggestions for improvement.

### **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.

Our guardians and champions have lots planned to raise awareness of the importance of speaking up. Speaking up improves patient care and our working lives. We have a host of things happening throughout October to highlight the importance of speaking up, including;

- FTSU Guardians and Champions, plus our execs and non-execs, will be out and about across all our sites raising awareness
- Look out for the Alphabet of Speak Up - from anonymity to zero tolerance – videos on Twitter and the Hub, #SpeakUpABC.
- Guardians, FTSU and Patient Safety Champions will explain their roles on video.
- Our Board and divisional management teams are all signing a statement supporting Speak Up.



## Healthcare Heroes

August – individual award



August's Healthcare Heroes individual award went to Ranbir Purewall, who works in our IT department. He was nominated by colleagues for the commitment he shows to his team. Even with the additional pressures of the pandemic, he worked tirelessly and without complaint to ensure our IT services continued to work smoothly.

September – individual award



September's individual award went to Jayne Tranter, one of our district nurse team leads. She was nominated for having such a positive impact on the community nursing team since taking on the manager's role two years ago. Every member of her team feels values and supported and say it is a pleasure coming to work knowing that Jayne is there.

## NHS Charities Together

[www.nhscharitiestogether.co.uk](http://www.nhscharitiestogether.co.uk)

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. We are currently working with other local NHS charities in order to maximise the value of this partnership.

## Charity Scarefest Pumpkin Trail

We can now confirm that we will be holding our sponsored Halloween ScareFest pumpkin trail From Thursday 29<sup>th</sup> to Saturday 31 October at Baggeridge Country Park. This event has been scaled down to respect social distancing so spaces are limited. Details will be available on the charity Facebook page @DudleyGroupNHSCharity

## Patient Feedback

The Trust regularly receives compliments from service users, highlights of these are given below:

**C4 Day Case:** "I was diagnosed with classic Hodgkin's Lymphoma on Christmas Eve last year and started treatment the first week in January. I can honestly say that every member of staff I came across in C4 was amazing, from my consult meetings with Dr Neilson alongside Angela to the amazing staff on the ward.

For context to my story up until this time last year I could easily pass out just by talking about injections, but with the caring and support of your staff whilst I still need to lie down for comfort I can happily now have blood taken. You can well imagine my anxiety on the first day of treatment as my wife sat next to me in tears just through the relief of getting the cannula into me let alone what was about to come. As treatment continued the super staff continued to help and support every time I was in for treatment but then with the added complications of Covid I watched with great amazement how the staff continued to go about their work whilst trying to keep things normal! Whilst I am running out of adjectives to describe the staff the pinnacle of their care came when I had the sudden unexpected news that my dad passed away of a sudden heart attack on the 31st March. Whilst my wife rang C4 the next morning as I was due to have treatment that day, they swiftly and confidently took the decision out of my hands and moved my treatment. As I finished my treatment in the middle of April in the height of Covid I cannot fault the staff for their continuing work ethic! I understand what it takes to be at the pinnacle of someone's profession as I am about to restart my career working in professional sport. I decided very early on after my treatment finished I would write to the Trust and tell them of all the superlatives that happen at C4 and I hope that you will pass these on to the Board at the Trust! Whilst thank you does not really do it justice, I can only thank the staff at C4 and I have already put wheels in motion for a golf day next year in order to raise money for the ward."

**CAU:** "Taking care of people's health is a major responsibility and I can say that you do it amazingly well, I'm impressed by the dedication and the way you do it."

**B1:** "The staff were lovely, ward was quiet. The procedure I had was well explained and I was discharged with plenty of information and advice."

**GI Unit:** "All the staff who looked after me were friendly, informative and very professional. Took good care of me, and took time to explain results and next steps. Whole process from start to finish was over a lot quicker than I anticipated."

**Locality Wide Continence:** "I cannot praise the staff enough, they were kind and caring towards my father with temporal lobe dementia, they are true professionals."

**ENT:** "With everything that is going on today with COVID-19 I felt very safe all staff had masks and gloves on there was also hand sanitizer for patients to use the waiting room was set out and all chairs were 2 meters apart I felt very safe to be there."

**Gynaecology:** "My appointment was on time. The consultant and nurses who dealt with me were excellent. In a delicate and personal situation I was treated professionally and with respect and kindness. There was nothing they could have done better. Thank you NHS."

## Visits and Events

8 <sup>th</sup> September 2020	STP Collaboration Meeting
8 <sup>th</sup> September 2020	Health and Adult Social Care Scrutiny
9 <sup>th</sup> September 2020	Partnership Board
9 <sup>th</sup> September 2020	Governors Meeting
9 <sup>th</sup> September 2020	Live Chat
10 <sup>th</sup> September 2020	Board of Directors

11 <sup>th</sup> September 2020	Black Country and West Birmingham STP SRM System Review MTG
14 <sup>th</sup> September 2020	Black Country STP Cancer Board
16 <sup>th</sup> September 2020	Team Brief
17 <sup>th</sup> September 2020	Live Chat
21 <sup>st</sup> September 2020	Virtual Signs Transformation Guiding Board
23 <sup>rd</sup> September 2020	Siren Study
23 <sup>rd</sup> September 2020	Disability Network Event
24 <sup>th</sup> September 2020	Healthier Futures Partnership Board
25 <sup>th</sup> September 2020	Live Chat
25 <sup>th</sup> September 2020	Council of Governors Meeting
29 <sup>th</sup> September 2020	Healthcare Hero's
30 <sup>th</sup> September 2020	Live Chat
1 <sup>st</sup> October 2020	A&E Delivery Board

## National NHS news

**Soup-and-shake diet offered on NHS to fight diabetes.** Thousands more people in England with type 2 diabetes will be offered the chance to try a soup-and-shake diet weight-loss plan for free on the NHS. Studies show switching to the low-calorie liquid diet can put diabetes into remission. Experts say they want to help people to be as fit as possible, particularly during the coronavirus pandemic. Obesity and type 2 diabetes are linked and both increase the risk of complications from Covid-19. **BBC News (01.09.20)**

**What is the new NHS type 2 diabetes diet?** THOUSANDS of people in England with type 2 diabetes are being offered the chance to try a new weight-loss plan. Some 5,000 patients will get access to the new soups and shakes diet programme on the NHS after trials showed it could reverse the condition. The government hopes that as well as helping people live happier, healthier lives, more action will save the health service money and free up staff time. **The Sun (01.09.20)**

**Disease diagnosis to be boosted by £50m NHS AI funding boost.** Major improvements are set to be made to speeding up the diagnosis of deadly diseases such as cancer, following a £50m investment into diagnostic centres of excellence, which seek to develop the effective use of artificial intelligence (AI) across the NHS. Under the new funding, the work of existing Digital Pathology and Imaging Artificial Intelligence Centres of Excellence – which were launched in 2018 to develop cutting-edge digital tools to improve the diagnosis of disease – will be scaled up, providing potentially improved outcomes for millions of patients and freeing up value NHS staff time. **National Health Executive (01.09.20)**

**Mum who had to deal with baby dying in hospital alone calls for coronavirus rule change.** The experience of discovering she was pregnant before losing the child has been a deeply traumatic one for Jade, made worse by the fact she endured it alone. Under legislation brought in under the pandemic patient support has been severely restricted, meaning thousands of women across the UK have suffered miscarriages without a friendly face beside them. Now Jade, a GP's receptionist and Instagram influencer, is calling on the government to change the policy so women have proper support. **Mirror (01.09.20)**

**Patients at risk as cash-strapped councils outsource services in middle of pandemic, warn NHS bosses.** [Nurses](#) and essential healthcare staff could be left redundant in the middle of the pandemic as local authorities look to make changes to healthcare contracts that would leave patients facing major disruption, [NHS](#) bosses have warned. [NHS Providers](#), which represents all NHS trusts, and [NHS Confederation](#), which represents health and care organisations, said that the decision to put contracts for public health services out to tender as workers battle [coronavirus](#) in the community is “completely inappropriate” and a “damaging distraction”, creating uncertainty for those who have spent the past six months on the [Covid-19](#) frontline. **The Independent (01.09.20)**

**Twenty-one ‘wholly preventable’ patient safety incidents reported in private hospitals last year.** There were 21 “wholly preventable” patient safety incidents of the most serious category at private hospitals last year, new data has shown, as NHS bosses prepare to invest up to £10bn in the sector. This is the first time that a comprehensive dataset of so-called ‘Never Events’ within private hospitals has been published in the UK, and comes ahead of plans to outsource both inpatient and outpatient services, routine surgery operations and cancer treatment to private providers. **The Independent (02.09.20)**

**Candidates invited to apply for new HEE digital health fellowships.** Health Education England (HEE) has opened the application process for 35 new digital health fellowships, which will support clinical professionals to build digital health expertise into their careers and better harness the potential of new digital technologies and practices. The fellowships represent the second cohort of the Topol Programme for Digital Fellowships – which closely follows recommendations laid out in the 2019 Topol Review to ensure the NHS remains world-leading in using innovative technology to benefit patients. **National Health Executive (02.09.20)**

**NICE green light for immunotherapy Bavencio.** The National Institute for Health and Care Excellence (NICE) has now published final guidelines endorsing NHS use of Merck and Pfizer’s immunotherapy Bavencio (avelumab) in combination with axitinib as a first-line treatment for kidney cancer. Current NHS treatment for untreated advanced renal cell carcinoma (RCC) includes sunitinib, pazopanib, tivozanib or cabozantinib. **PharmaTimes (02.09.20)**

**Covid lockdown eased in two of England's worst-hit areas despite surge in cases.** Restrictions on social gatherings for more than half a million people in two of England’s worst-hit areas have been lifted, despite councils warning the government it was too soon to lift the measures. The government pressed ahead with the lifting of restrictions for more than 520,000 people in Bolton and Trafford in north-west England overnight despite a surge in the number of cases in both areas. **The Guardian (02.09.20)**

**New Lighthouse Lab to boost NHS Test and Trace capacity.** A new Lighthouse Lab near Loughborough will join Britain’s largest network of diagnostic testing facilities in history to increase coronavirus testing capacity. The new lab will be brought into the lab network this month and will be able to process around 50,000 tests per day by the end of the year. This comes as the weekly statistics from NHS Test and Trace show that the service continues to reach the majority of those testing positive and their contacts, in week 13 reaching 80% of contacts where contact information was available. **GOV.uk (03.09.20)**

**NHS leaders raise concerns over test and trace as Covid cases rise.** Ministers have set out plans to ramp up testing for coronavirus, as NHS leaders expressed deep concern about problems in the test-and-trace system. With figures showing a steady rise in the number of new infections, the government announced a new laboratory in Loughborough that it said would be able to process 50,000 tests a day by the end of the year.

It also revealed two new pilot projects for saliva tests as a part of a £500m investment in what it called the "next generation" of testing. **The Guardian (03.09.20)**

**Coronavirus: NHS to buy Skye covid outbreak care home.** A privately-run care home where 10 residents died during a Covid-19 outbreak is to be taken over by NHS Highland. The health board has received government funding of £900,000 to buy Home Farm in Portree from HC-One. Health Secretary Jeane Freeman confirmed the purchase as newly-published inspection reports revealed concerns about care at the home in May. They included reports that residents were lying in urine and faeces. A total of 30 residents and 29 staff tested positive for Covid-19 during the outbreak. **BBC News (03.09.20)**

**GMB's Dr Hilary fears it would be 'tragedy' for the NHS if local chemists close.** Dr Hilary Jones warned on Good Morning Britain that it would be a "tragedy" if local chemists were lost amid the pandemic. He warned that local chemists take pressure off the already overwhelmed health service and are paramount in some communities. His comments came amid a damning report that found thousands of independently owned pharmacies could be forced to close down. It predicts 72% of the family businesses will be losing money within four years if things go on as they are. **Mirror (04.09.20)**

**More than 1,000 doctors 'want to leave the NHS after pandemic mishandling'.** In a survey conducted by Doctors' Association UK, two-thirds of respondents had either intended to move abroad, switch to the private sector or take a break within the next three years. The government's treatment of the NHS during the pandemic was cited as a key factor in the mounting disillusionment. **Metro (06.09.20)**

**Covid: at least six English NHS trusts could be overwhelmed this winter.** More than 100 NHS trusts in England could be at or above full capacity this winter if they faced a second wave of coronavirus admissions on top of the usual seasonal workload, with figures suggesting that dozens would have 10% fewer beds than needed. **The Guardian (06.09.20)**

**Two-thirds of black Britons believe NHS gives white people better care, finds survey.** Almost two-thirds of black Britons think the NHS does less to protect their health than that of white people, research has found. That negative view of the health service is shared by a majority of black people of almost all ages, and is held especially strongly by black women, according to findings of a study commissioned by a parliamentary committee. **The Guardian (07.09.20)**

**Coronavirus: Crab shells may protect NHS staff from virus.** Crab shells could be used to protect NHS staff from coronavirus by killing germs on medical equipment, Welsh scientists have said. It is hoped a coating which has long-lasting "virus destroying" properties could be made from chitosan, a chemical naturally found in the shells. It is being developed in north Wales by the firm Pennotec and chemists at Bangor University. They hope it can be used on protective equipment to halt virus spread. **BBC News (07.09.20)**

**'Confidential' document warns second covid peak could hit NHS five times harder.** Modelling being used by NHS officials forecasts that hospital admissions could peak at five times the level seen in April without additional measures to control the virus, HSJ can reveal. **HSJ (07.09.20)**

**Coronavirus: People unable to get COVID-19 tests after labs reach 'critical pinch-point'.** People across the country are unable to get coronavirus tests because laboratories have reached a "critical pinch-point" in processing them. Sarah-Jane Marsh, the director of testing at NHS Test and Trace, has apologised and said "we are doing all we can to expand quickly". She added that other facilities that could process the tests are due to "open up imminently". **Sky News (08.09.20)**

**Covid symptoms in children: NHS advice on coronavirus signs for kids – and the evidence around diarrhoea and vomiting.** Children can get coronavirus, though it tends to be less prevalent than in adults, and also less serious. However, it can also be harder to identify. The NHS lists just three official symptoms of Covid-19 in children. There are calls for diarrhoea and vomiting to be added to this list, following a study at Queen's University Belfast. **iNews (08.09.20)**

**Lessons learned from 'frantic, difficult months' creating Covid app – NHSX boss.** There have been "frantic, difficult months" during the development of a coronavirus contact tracing app but lengthy testing was the right approach, the head of an NHS innovation division has said. England's app, which uses bluetooth to keep an anonymous log of those in close proximity, has been held back by delays and currently has no release date in sight. Officials initially pushed for creating their own system but it was marred by technical issues and concerns about privacy. **Express and Star (08.09.20)**

**Keir Starmer warns NHS Test and Trace system 'on the verge of a collapse' as public struggle to attend appointments.** Sir Keir Starmer has warned that the NHS Test and Trace system is "on the verge of collapse", after a senior official apologised to those who have been unable to get a check for coronavirus. The Labour leader called on Boris Johnson to "take responsibility" for a system which he said had told people needing tests that none were available or asked them to travel hundreds of miles for an appointment. The service's director of testing Sarah-Jane Marsh today offered a "heartfelt apology" to anyone unable to get a Cover-19 test, explaining that while testing sites have capacity, the system was experiencing a "pinch-point" in laboratory processing. **The Independent (08.09.20)**

**NHS misses target of having half its top jobs held by women.** Some NHS trusts in England showing only 15.4% of senior board roles occupied by women, finds care body. The NHS has missed its own target of ensuring that half of its top jobs be filled by women by 2020. Although it has made progress it is still falling short with just 44.7% on [NHS](#) trusts' boards in England being female. In some trusts the percentage is just 15.4% of the most senior roles in women's hands, though in others it is as high as 77.8%. The failure by the service to achieve 50:50 gender equality is revealed in a report published this Tuesday by the [NHS Confederation](#), which represents providers of care. **The Guardian (09.09.20)**

**NHS Test and Trace chief insists system is working despite contact-tracing reaching record low.** The head of NHS Test and Trace has insisted the system is working despite the number of close contacts being reached falling to a record low. Statistics published by the Department of Health and Social Care (DHSC) on Thursday, showed 69.2 per cent of close contacts of people who tested positive were reached by Test and Trace in the week to September 2. **Evening Standard (10.09.20)**

**One in 50 NHS patients have now been waiting a YEAR or more for planned surgery as 4.5-month wait list surges to highest level for 12 years.** NHS England data released today shows 83,000 patients (2.1 per cent of the total) referred for routine operations have still not been treated 52 weeks later. Those affected are patients waiting for planned, non-urgent surgery such as hip and knee replacements, cataract surgery or kidney stone removal. **Mail Online (10.09.20)**

**NHS's own helpline staff were told to give people tests even if they didn't have symptoms.** Matt Hancock claimed the 'message is clear' that people without symptoms shouldn't get a coronavirus test. But his own helpline staff were being told to wave through tests for asymptomatic people until last week. **Mirror (10.09.20)**

**NHS cleaners twice as likely to be infected with Covid-19 than frontline doctors.**

Intensive care staff were the least likely hospital workers to contract the virus, according to the shock findings of a study conducted in the West Midlands at the height of the pandemic. Researchers say the disparities could be down to the type of personal protective equipment (PPE) worn. **Mirror (11.09.20)**

**NHS heroes take to the streets to demand a pay rise from Tory Ministers.** Frontline health staff who risked their lives during the coronavirus pandemic are set to take to the streets on Saturday to demand pay justice. It comes after they were left out of a public sector wage hike this summer – triggering dismay, anger and hurt. Unions, MPs and campaigners have called on the Government to reward workers' vital service with a salary hike. Demonstrations will take place in more than 20 towns and cities as protesters call for a 15% pay rise. **Mirror (11.09.20)**

**1,300 pharmacies beg chemist's son Rishi Sunak to save them from closure.** More than 1,300 local chemists have appealed to pharmacist's son Rishi Sunak to save them from closure. A letter to the Chancellor, whose mother was a pharmacist, pleads with him to urgently look again at pharmacy funding. **Mirror (13.09.20)**

**60 MPs sign letter calling for partners to be allowed at births and scans.** For many mothers-to-be during the pandemic, going to hospital without loved ones has been a major cause of anxiety. Restrictions have meant pregnant women have been unable to have partners with them at scans, and even during labour. Last week, guidance in England was changed to say expectant fathers should be allowed to go to antenatal scans and clinics as well as be at the birth. Campaign group Pregnant then Screwed claims two-thirds of NHS trusts are yet to update their policies. **ITV News (13.09.20)**

**NHS tells GPs they must offer patients face-to-face appointments.** GP practices are being told they must make sure patients can be seen face to face when they need such appointments. NHS England is writing to all practices to make sure they are communicating the fact doctors can be seen in person if necessary, as well as virtually. It's estimated half of the 102 million appointments from March to July were by video or phone call, NHS Digital said. The Royal College of GPs said any implication GPs had not been doing their job properly was "an insult". **BBC News (14.09.20)**

**'Utter shambles': GPs and medics decry NHS test-and-trace system.** Doctors have criticised the coronavirus testing system as "an utter shambles" after it emerged that some are being told to undertake round trips of up to 522 miles to get swabbed. Hospital medics and GPs have described how delays of up to four days to get a test and five days to receive the result forces them to isolate and means they cannot work normally in the NHS. **The Guardian (14.09.20)**

**Rule of six comes into effect to tackle coronavirus.** New laws prohibiting social gatherings of more than six people come into effect today (Monday 14 September) as the Government calls on the public to remain vigilant in the fight against coronavirus. The new "rule of six" simplifies and strengthens the rules on social gatherings, making them easier to understand and easier for the police to enforce. **Gov UK (14.09.20)**

**Coronavirus: NHS staff off work due to testing shortages, say bosses.** A lack of coronavirus tests for NHS staff is leading to staff absences and services being put at risk, hospital bosses have warned.

NHS Providers, which represents English hospital trusts, said staff are having to self-isolate because they cannot get tests for themselves or family members. It comes after widespread reports of people struggling to get tested. **BBC News (15.09.20)**

**Rotherham printing firm recruits 400 for NHS face masks.** A South Yorkshire firm will more than double its workforce after winning a contract to supply NHS face masks. Online printing company Bluetree in Rotherham said it would produce 1.7m medical grade masks per day, employing an extra 400 people. The company said the Type IIR masks were the most sought-after in UK healthcare. **BBC News (15.09.20)**

**Private labs unable to process all Covid tests, NHS email reveals.** Laboratories that analyse swabs from people in the community, including care homes, were stretched to capacity even in late August, unable to process all the Covid test samples coming in and seeking help from the NHS, the Guardian can reveal.

On 24 August, all NHS labs, which process hospital Covid tests, were sent an email from NHS England “regarding the urgent call for support from the pillar 2 team” – the Lighthouse labs analysing the community swabs. **The Guardian (15.09.20)**

**NHS Spitfire fly-past timings for Newcastle, Gateshead Northumberland, Sunderland and Durham.** The country is in for a treat this Wednesday when a Spitfire takes to the skies in an eye-catching tribute to the NHS. Spectators across the nation will get to see tiny aircraft - the dogfight hero of the Second World War - soar overhead bearing the names of NHS workers nominated by members of the public and raising money for charity. **Chronicle Live (15.09.20)**

**NHS England's top GP apologises after 'offensive' face-to-face appointments letter.** NHS England medical director for primary care Dr Nikki Kanani has apologised for ‘any hurt’ caused by a letter reminding GPs of their responsibility to offer face-to-face appointments, after a furious backlash from GPs. On 14 September NHS England urged GPs to remind patients that face-to-face appointments remain available during the pandemic after it found some people were ‘experiencing difficulty’ accessing family doctors. **GP online (15.09.20)**

**Coronavirus: Facebook and NHS team up to call for blood donations ahead of second wave.** The NHS is partnering with Facebook to enlist new blood donors in England, Wales and Northern Ireland ahead of a potential second wave of COVID-19. The feature on Facebook will allow users to sign up to receive notifications to donate at local centres, as well as encourage their friends to donate too. **Sky News (16.09.20)**

**Covid-safe mask for ENT procedures offered to NHS for free.** A protective device against coronavirus for at-risk doctors is to be provided free to the NHS. The SNAP device for ear, nose and throat surgeons was created after Burton-upon-Trent consultant Amged El-Hawrani died with Covid-19 in March. He was one of the UK's first senior medics to die with the virus, his death showing that they were at serious risk. The device clips over patients' masks to prevent the virus spreading through coughs and sneezes. **BBC News (16.09.20)**

**'I feel mentally done in': how the NHS fails people with depression and spinal injuries.** Almost half of all adults with a mental illness have a long-term physical disability. We desperately need joined-up healthcare. **The Guardian (16.09.20)**

**NHS launches 'vital' staff flu vaccination drive.** Senior clinicians and leaders have urged their frontline colleagues across the health and care sectors to get their annual flu jab as soon as possible, with the first vaccine deliveries due to start reaching local employers this week. The calls come alongside an expanded flu vaccination programme for both public and frontline health and social care workers, with a record 30 million people eligible for a free vaccine this year. **National Health Executive (16.09.20)**

### **England's 'failing' Test and Trace scheme causes problems for NHS**

As the system struggles to cope with soaring demand, people have been turning up to accident and emergency to ask for Covid-19 tests. Bolton NHS Foundation Trust said that a "high volume" of patients arrived to the A&E requesting tests. Trust chair Professor Donna Hall said people in Bolton - which has the highest infection rate in England - had been trying to get tests via their GPs and the hospital when they could not get them online or at mobile testing units. **The National (16.09.20)**

### **Coronavirus: patients needing A&E in England urged to book through NHS 111**

Patients who need to go to A&E in England will be urged to book an appointment first through NHS 111 as part of a shake-up of emergency services. If the pilot schemes are successful, the system could be rolled out to all NHS trusts in December, with patients told they should call ahead to book a space in the emergency department. The government hopes to reduce the strain on emergency departments as staff battle winter pressures, including from coronavirus and seasonal flu. **The Guardian (17.09.20)**

### **Swab left inside new mum after she gives birth at Mid Yorkshire NHS Trust hospital**

A medical swab was left inside a new mum after she gave birth in hospital, it's been revealed. The Mid Yorkshire trust runs maternity units at Pinderfields and Dewsbury Hospitals, but declined to say which site the incident took place at. The object was misplaced as the woman underwent a procedure shortly after she had her baby, publicly released NHS papers said. The Mid Yorkshire NHS Trust, which runs both sites, declined to confirm at which hospital it took place, but apologised and said a full investigation is still underway. **Dewsbury Reporter (18.09.20)**

### **Rise in number of women and girls treated in hospital for abuse**

The number of women and girls being treated in English hospitals after suffering physical, mental or sexual abuse has increased by almost a third in five years, analysis of NHS statistics shows. NHS admissions data shows hospitals in England treated 1,012 female assault victims in 2019-20, where the cause of admission was a form of maltreatment which includes physical or sexual abuse, torture or mental cruelty. That was an increase of 31% compared with 2015-16, when 774 cases were recorded. Rape or sexual assault of female victims also increased by 89% since 2015-16, rising from 116 to 219.

**Press Association (22.09.20)**

### **NHS COVID-19 app launches across England and Wales**

Businesses are now required by law to display the official NHS QR code posters from today so people can check-in at different premises with the app. People across England and Wales are being urged to download the NHS COVID-19 app to help control the spread of coronavirus and protect themselves and their loved ones as case numbers rise. It will be available to those aged 16 and over in multiple languages. It forms a central part of the NHS Test and Trace service in England and the NHS Wales Test, Trace, Protect programme – identifying contacts of those who have tested positive for coronavirus. **GOV.UK (24.09.20)**

### **Number of NHS staff dying in service double that of previous years**

Multiple sources now estimate that over 650 health and social care workers have now died. The number of NHS staff who have died in service is nearly double that of previous years, according to official figures. Official workforce figures published by NHS Digital show that in the first quarter of 2020 a total of 403 NHS workers in England died while employed by the health service. In real terms, this means an increase of 188 deaths when compared with an average of the past ten years. A report for the Office of National Statistics (ONS) in June revealed that occupations, such as nurses, with high potential exposure to COVID-19, had elevated rates of deaths registered involving COVID-19. **Nursing Notes (24.09.20)**

### **Flaw in NHS Covid-19 app leaves users struggling to alert others of test results**

Official NHS COVID-19 contact tracing app for England and Wales has finally been launched after months of delay. The long-awaited NHS Covid-19 app does not permit users to alert others to the results of coronavirus test conducted in NHS hospitals or Public Health England labs, it has emerged. The app is intended to keep track of people that users come into contact with – via a system of Bluetooth tracking and check-ins at venues – and alert anyone who may have been exposed to a positive case of coronavirus.

However, it has emerged that a substantial portion of the people tested each day are not provided the codes that would allow them to share their results via the app. **inews (26.09.20)**

### **NHS Covid-19: App issue fixed for people who test positive**

The government has fixed a problem with its new NHS coronavirus app in England and Wales which meant many positive test results were not being logged. Users were unable to record a positive test result, if they had booked a test elsewhere and not via the app. But the Department of Health said everyone who tests positive can now log it, however they booked the test. However, people who test negative are still unable to share their result if they did not book it via the app. **BBC News (27.09.20)**

## **Regional NHS News**

**Dudley rainbow monument is £5,000 away from target.** Councillors in Dudley are aiming to raise £30,000 for the Russells Hall Rainbow, a locally-designed sculpture set to be located outside the town's main hospital. And they are now just £5,000 short of their target following a series of donations from members of the public and local businesses. Taylor Wimpey West Midlands is the latest firm to get involved, donating £1,000 towards the creation of the monument. **Express and Star (04.09.20)**

**NHS staff can raise concerns at Speak Up Day.** Sandwell and West Birmingham NHS Trust, which runs Sandwell General and Birmingham City hospitals, held a Speak Up Day on Wednesday (9th). The event was part of an ongoing campaign to encourage staff to voice any concerns they may have about safety at work, either relating to staff or patients. Bosses said they want staff to feel assured they can raise any workplace issues they have. Lesley Writtle, non-executive director at the trust, who is the trust board's Freedom to Speak Up lead, said: "We have a number of Freedom to Speak Up guardians who staff can approach and speak to about any concerns they may have." **Express and Star (08.09.20)**

**Birmingham could be hit with tough new Covid-19 controls after cases rocket.** There are growing signs tough new Covid-19 lockdown measures could be imposed across Birmingham by the end of the week after infections rocketed. The infection rate in Birmingham now stands at 62.4 cases per 100,000 in the seven days to September 5, compared to 28.1 the week before, according to latest NHS data.

Only two weeks ago, the city narrowly avoided a restrictive local lockdown such as those imposed in Leicester and Greater Manchester, after an increase in positive test results.

**Shropshire Star (08.09.20)**

**Steve plays peak-y blinder to help out charities.** Former Dudley mayor Steve Waltho MBE has donated funds raised from climbing 25 peaks in 25 hours to Russells Hall Hospital and Access in Dudley. Councillor Steve Waltho MBE completed the challenge of climbing 25 peaks in the Lake District in 25 hours back in March to help raise funds for Russells Hall Hospital and the charity Access In Dudley. **Express & Star (10.09.20)**

**Tough new Covid-19 restrictions expected across Birmingham.** The West Midlands mayor Andy Street said further lockdown-style measures were “very likely” after a rise in infections. Tough new Covid-19 restrictions look set to be imposed across Birmingham after infections rocketed. The city of 1.14 million people is widely expected to have tighter rules imposed on Friday, following two days of discussions between Government and regional health and local authority leaders. **Express & Star (11.09.20)**

**Disabled patients missing out on free parking at some hospitals.** One hospital has introduced free parking for certain patient groups following an announcement from the Government last year, while others have not.

Russells Hall Hospital in Dudley has scrapped parking charges for blue badge patients and the parents of sick children staying overnight, while frequent attendees are given concessions. **Express & Star (15.09.20)**

**Boris Johnson to face MPs as testing ‘failure’ puts NHS under ‘huge pressure’.** Boris Johnson will face a grilling from senior MPs amid a warning that the “failure” of the test and trace system is placing huge pressure on the health service. The Prime Minister will be questioned by deputy Labour leader Angela Rayner during PMQs after a turbulent 24 hours in which the Government announced coronavirus tests would now need to be rationed. **Express & Star (15.09.20)**

**Facebook rolls out blood donation feature to parts of UK.** Facebook is introducing its blood donation feature to parts of the UK in a bid to help the NHS top up the pipeline with much-needed “new blood”. The tech giant has partnered with NHS blood service providers across England, Wales and Northern Ireland, allowing users aged between 18 and 65 to sign up to receive updates. **Dudley News (15.09.20)**

**Residents asked to protect their friends and family.** The leader of Dudley Council has issued a stark warning today, after recorded Covid-19 cases almost doubled in the borough last week. Residents are being called upon to reduce household transmission by staying apart wherever possible. Under the government’s ‘rule of six’, which came into force yesterday, it is now illegal for people anywhere in the country to meet in groups of more than six, indoors or outside. **Dudley Metropolitan Borough Council (15.09.20)**

**Coronavirus infection rates are falling across the West Midlands, according to the latest NHS data.** Coronavirus infection rates have fallen in almost every part of the West Midlands, according to the latest NHS data. That includes Birmingham, Solihull and Sandwell borough, the areas currently affected by special restrictions designed to slow the spread of the virus. However, these three areas continue to have the highest infection rates in the region. The one exception in the wider West Midlands region is Warwickshire, where Covid-19 cases have risen.

The NHS data covers the period from September 9 to September 15, and shows how infection rates have changed compared to seven days previously. **Birmingham Live (18.09.20)**

**NHS Nightingale hospital in Birmingham on high alert to reopen as cases soar**

The NHS Nightingale hospital in Birmingham has been placed on "higher alert" to reopen in the next 48-72 hours, it is reported. Dr David Rosser of University Hospitals Birmingham said the temporary hospital at the NEC arena has been placed back onto "higher alert" footing, meaning it can be reopened in two to three days if needed. The hospital, which had been mothballed for some weeks, is being readied so it could be brought back into use more quickly if needed. **Mirror (18.09.20)**

**Deaths at standstill in the region's.** There have been no new coronavirus deaths in hospitals that have been reported in the region. It means the total number of coronavirus deaths in hospitals across the Black Country, Birmingham and Staffordshire stands at 2,571. **Express & Star (19.09.20)**

**Two more coronavirus deaths recorded in West Midlands.** The deaths were recorded at the University Hospitals Birmingham NHS Foundation Trust earlier this week. One person died on Wednesday and another died a day later at the trust, which runs the Queen Elizabeth Hospital. It means the total number of coronavirus deaths in hospitals across the Black Country, Birmingham and Staffordshire stands at 2,573.

In England, the death toll in hospitals increased by 16 to 29,735. The UK-wide figure has not yet been released. **Express & Star (19.09.20)**

**First coronavirus death in two months confirmed at Russells Hall Hospital**

The first coronavirus death for more than two months has been confirmed at Russells Hall Hospital in Dudley. The person was one of five Covid-19 patients in the region confirmed to have died today, with the other four deaths announced in Birmingham. The patient died at Russells Hall on Sunday, becoming the first coronavirus patient to die at the Dudley Group NHS Foundation Trust since July 10 and taking the death toll at the trust to 265. The five deaths announced today takes the total number of coronavirus deaths in Black Country, Staffordshire and Birmingham hospitals to 2,580. **Express & Star (22.09.20)**

**Russells Hall Hospital reports first Covid death in two months**

DUDLEY'S Russells Hall Hospital has reported its first coronavirus related death in two months, according to latest statistics published by NHS England. A patient who had tested positive for Covid-19 passed away at the hospital on Sunday September 20, the figures show, bringing the Dudley Group NHS Foundation Trust's coronavirus death toll to 265 since the pandemic began back in March. The hospital had suffered no coronavirus related deaths since July 10. Similarly - Sandwell and West Birmingham NHS Trust had reported no deaths linked to Covid-19 since August 26 but a patient with the virus passed away on Saturday September 19 - the NHS data shows - bringing the trust's Covid death toll to 384.

**Stourbridge News (23.09.20)**

**Hospitals, mental health and community trusts to receive multi-million boost in bid to recruit more nurses**

HOSPITALS, mental health and community trusts are set to receive a multi-million pound boost to help recruit thousands more nurses. Staff shortages have hit health trusts up and down the country, including Worcestershire Acute Hospitals NHS Trust which runs both the Alexandra Hospital and Worcestershire Royal Hospital.

With the NHS continuing to respond to the Covid-19 pandemic, bringing all routine services back online and preparing for winter, England's chief nursing officer, Ruth May, has written to nurse leaders setting out support available to help accelerate recruitment. The financial offer includes a £28m fund to support international nurses and midwives who are waiting to join the NHS front line.

**Droitwich Standard (26.09.20)**

**Public health chief urges NHS to reveal coronavirus patient numbers to thwart 'hoax nonsense'** A public health chief is pressing the NHS to publish daily data on how many patients are being admitted to hospital with coronavirus to help silence conspiracy theorists. Dr Lisa McNally, Sandwell's director of public health, spoke out amid concerns that national health chiefs are discouraging hospitals from releasing data about how many patients they are currently treating. A handful of hospitals - among them University Hospitals Birmingham - is going against guidance from NHS England and revealing statistics about how many patients are currently in hospital and on life support. But others, including Sandwell and West Birmingham Hospitals, are complying with national guidance and not releasing the information when asked - instead referring inquiries to the NHS's selected national and regional data. **Birmingham Live (28.09.20)**

## Paper for Submission to the Board of Directors 8<sup>th</sup> October 2020

<b>TITLE:</b>	Quality and Safety Committee		
<b>AUTHOR:</b>	Sharon Phillips – Deputy Director of Governance	<b>PRESENTER:</b>	Liz Hughes – None Executive Director
<b>CLINICAL STRATEGIC AIMS</b>			
<i>Develop integrated care provided locally to enable people to stay at home or be treated as close to home as possible.</i>		<i>Strengthen hospital-based care to ensure high quality hospital services provided in the most effective and efficient way.</i>	<i>Provide specialist services to patients from the Black Country and further afield.</i>
<b>ACTION REQUIRED OF COMMITTEE :</b>			
Decision	Approval	Discussion	Other
	Y	Y	
<b>RECOMMENDATIONS FOR THE GROUP</b>			
The Board to note the assurances provided by the Committee, the matters for escalation and the decisions made by the Committee.			
<b>CORPORATE OBJECTIVE:</b>			
All			
<b>SUMMARY OF KEY ISSUES:</b>			
<ul style="list-style-type: none"> <li>As detailed in the paper</li> </ul>			

<b>IMPLICATIONS OF PAPER:</b>			
<b>IMPLICATIONS FOR THE CORPORATE RISK REGISTER OR BOARD ASSURANCE FRAMEWORK</b>			
<b>RISK</b>	<b>Y</b>		<b>Risk Description:</b>
	<b>Risk Register: Y</b>		<b>Risk Score:</b> Numerous across the BAF, CRR and divisional risk registers
<b>COMPLIANCE and/or LEGAL REQUIREMENTS</b>	<b>CQC</b>	<b>Y</b>	<b>Details:</b>
	<b>NHSI</b>	<b>Y</b>	<b>Details:</b>
	<b>Other</b>	<b>N</b>	<b>Details:</b>
<b>REPORT DESTINATION</b>	<b>EXECUTIVE DIRECTORS</b>	<b>N</b>	<b>DATE:</b>
	<b>WORKING GROUP</b>	<b>N</b>	<b>DATE:</b>
	<b>COMMITTEE</b>	<b>N</b>	<b>DATE:</b>

**CHAIRS LOG**  
**UPWARD REPORT FROM QUALITY AND SAFETY COMMITTEE**

**Date Committee last met: 22 September 2020**

<p style="text-align: center;"><b>MATTERS OF CONCERN OR KEY RISKS TO ESCALATE</b></p> <ul style="list-style-type: none"> <li>• VTE compliance data shows 79.9%, further data validation is underway</li> <li>• 2 new Corporate Risks added to the risk register of which the Quality and Safety Committee have oversight</li> <li>• Quality concern reference mandatory training compliance.</li> <li>• No dedicated information support to enable the production of robust informatics quality and safety reports</li> <li>• Compliance of staff for PPE and social distancing</li> <li>• Compliance across the organisation for DSE assessments</li> </ul>	<p style="text-align: center;"><b>MAJOR ACTIONS COMMISSIONED/WORK UNDERWAY</b></p> <ul style="list-style-type: none"> <li>• Annual Health and Safety Report referred for further work</li> <li>• Robust action plan to address compliance of PPE and social distancing of staff</li> </ul>
<p style="text-align: center;"><b>POSITIVE ASSURANCES TO PROVIDE</b></p> <ul style="list-style-type: none"> <li>• Controlled drug administration in the GI Unit – robust assurance received of actions taken and matters addressed</li> <li>• Estates and facilities good compliance across all sites of cleaning standards. Positive impact of point cleaning.</li> <li>• Implementation of Medical Examiners role having a positive impact</li> <li>• No Never Events reported in July or August 2020</li> <li>• Never event 'Retained balloon cover following an angioplasty to the left leg' closed – assurance of all actions completed</li> <li>• Annual report for neonatal unit and detailed assurance received.</li> <li>• Ligature – Plan in place to address gaps in assurance</li> </ul>	<p style="text-align: center;"><b>DECISIONS MADE</b></p> <ul style="list-style-type: none"> <li>• Commissioned a focus session on learning disability and vulnerable people on a future committee</li> </ul>
<p><b>Chair's comments on the effectiveness of the meeting:</b></p>	

**Paper for submission to the Board of Directors  
on 8<sup>th</sup> October 2020**

<b>TITLE:</b>	<b>Mortality Update</b>		
<b>AUTHOR:</b>	<b>Dr P Brammer Deputy Medical Director</b>	<b>PRESENTER</b>	<b>Dr P Brammer Deputy Medical Director</b>
<b>CLINICAL STRATEGIC AIMS</b>			
		<i>Strengthen hospital-based care to ensure high quality hospital services provided in the most effective and efficient way.</i>	
<b>ACTION REQUIRED OF COMMITTEE</b>			
<b>Decision</b>	<b>Approval</b>	<b>Discussion</b>	<b>Other</b>
		<b>X</b>	
<b>RECOMMENDATIONS</b>			
The committee are asked to note the assurance provided in relation to learning from deaths at the Trust and plans to further reduce mortality by improving the care of the deteriorating patient			
<b>CORPORATE OBJECTIVE:</b>			
SO1, SO2, SO3, SO4, SO5, SO6			
<b>SUMMARY OF KEY ISSUES:</b>			
<ul style="list-style-type: none"> <li>The Trust has recorded an increase in SHMI for the last 2 reporting periods with the latest value of 121</li> <li>The increase in SHMI relates to a winter spike in mortality in December followed by a visible impact of COVID19. Over 200 COVID related deaths received a full Structured Judgement Review (SJR) with overall care rated as good or excellent in 73.5% of cases and deaths were deemed unavoidable in 99.5% of cases.</li> <li>The Trust has a number of measures in place to deliver specific care bundles which have been shown to deliver reductions in mortality in other Trusts. These commenced in February 2020 . Compliance is shared with service leads and actions agreed.</li> <li>SJR's related to 12 hour breaches and subsequent deaths in December and January have commenced with over half completed. This review shows prompt and appropriate care despite the delay in most cases.</li> <li>The Medical Examiner System is now operating within the Trust and has scrutinised 350 deaths since June 2020.</li> <li>A new mortality tracking system based on AMAT is being launched in the Trust that will include speciality level reviews, structured judgement reviews and Medical Examiner review.</li> </ul>			

<b>IMPLICATIONS OF PAPER:</b>			
<b>IMPLICATIONS FOR THE CORPORATE RISK REGISTER OR BOARD ASSURANCE FRAMEWORK</b>			
<b>RISK</b>	<b>Y</b>		<b>Risk Description: COR 1015: Compliance to the identification and action of all deteriorating patient groups</b>
	<b>Risk Register: N</b>		<b>Risk Score: 15</b>
<b>COMPLIANCE and/or LEGAL REQUIREMENTS</b>	<b>CQC</b>	<b>Y</b>	<b>Details: Safe, Effective, Caring, Responsive, Well Led</b>
	<b>NHSI</b>	<b>N</b>	<b>Details:</b>
	<b>Other</b>	<b>N</b>	<b>Details:</b>
<b>REPORT DESTINATION</b>	<b>Board of directors</b>	<b>Y</b>	<b>DATE:</b>
	<b>WORKING GROUP</b>	<b>N</b>	<b>DATE:</b>
	<b>COMMITTEE</b>	<b>N</b>	<b>DATE: Quality and Safety Committee 22<sup>nd</sup> September 2020</b>

## **Mortality Update**

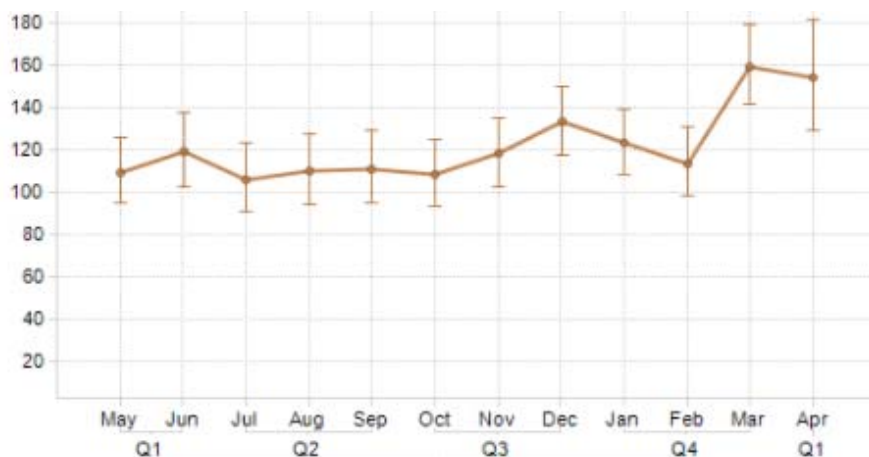
### **Executive Summary**

- The Trust has recorded an increase in SHMI for the last 2 reporting periods with the latest value of 121
- The increase in SHMI relates to a winter spike in mortality in December followed by a visible impact of COVID19. Over 200 COVID related deaths received a full Structured Judgement Review (SJR).
- The Trust has a number of measures in place to deliver specific care bundles which have been shown to deliver reductions in mortality in other Trusts. These commenced in March 2020 . Compliance is shared with service leads and actions agreed.
- SJRs related to 12 hour breaches and subsequent deaths in December and January have commenced with over half completed.
- The Medical Examiner System is now operating within the Trust
- A new mortality tracking system based on AMAT is being launched in the Trust that will include speciality level reviews, structured judgement reviews and Medical Examiner review.

### **1.0 Current benchmarking position**

The Trust SHMI has shown an increase in the last reporting period to 1.21

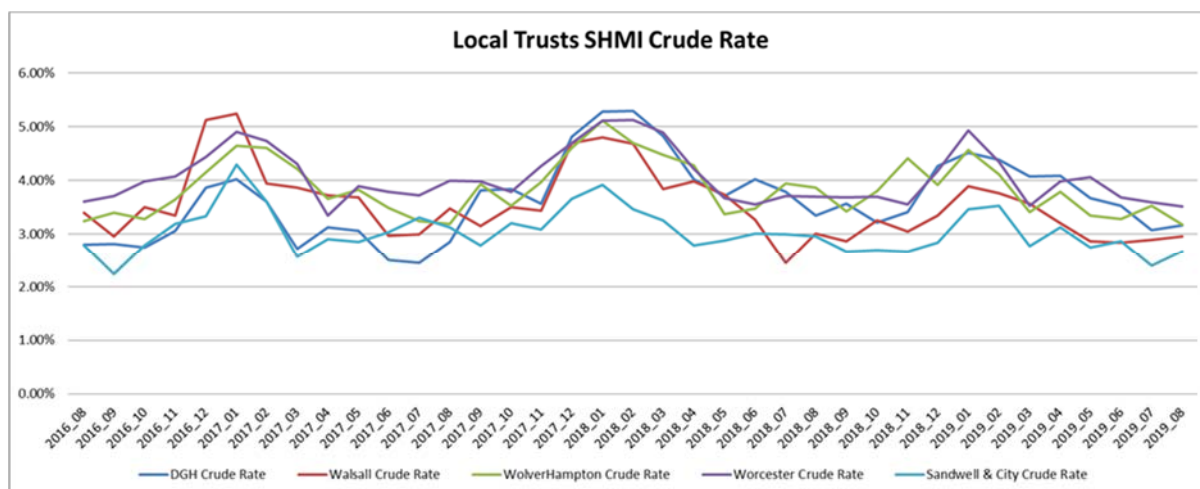
Fig 1 : SHMI May 2019-April 2020



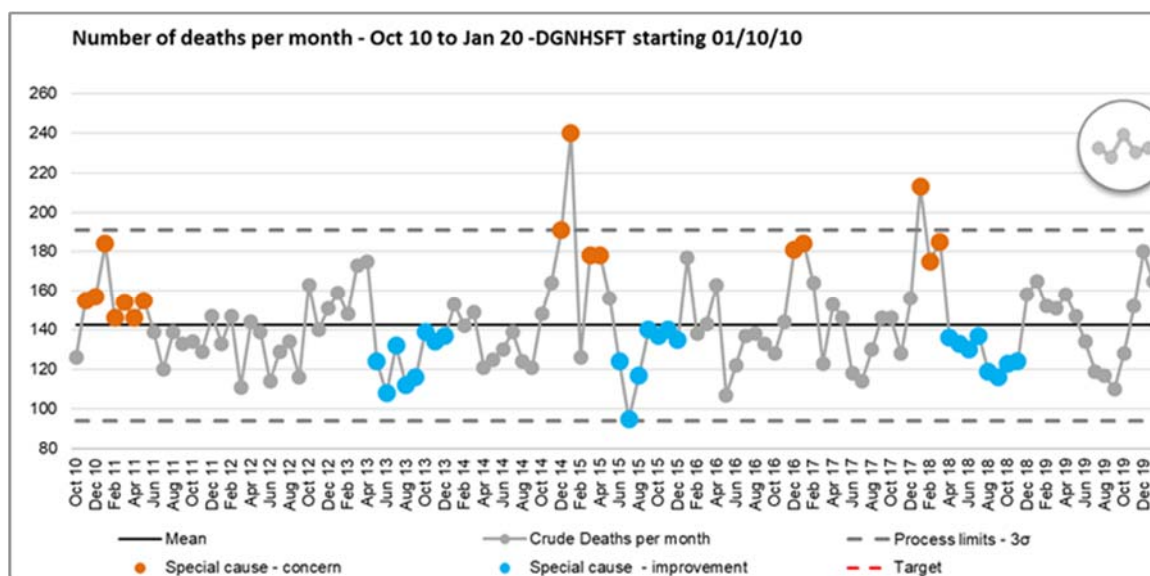
The impact of COVID-19 is evident in this reporting period as well as a spike in winter mortality previously reported.

Winter mortality data from the Integrated Performance Report was investigated and suggested an increase in weekly death rates in December 2019/ January 2020 and further analysis by Trust informatics was undertaken. This showed that winter spikes in deaths were experienced by most Trusts to a greater or lesser extent and that the Trust followed the trend exhibited

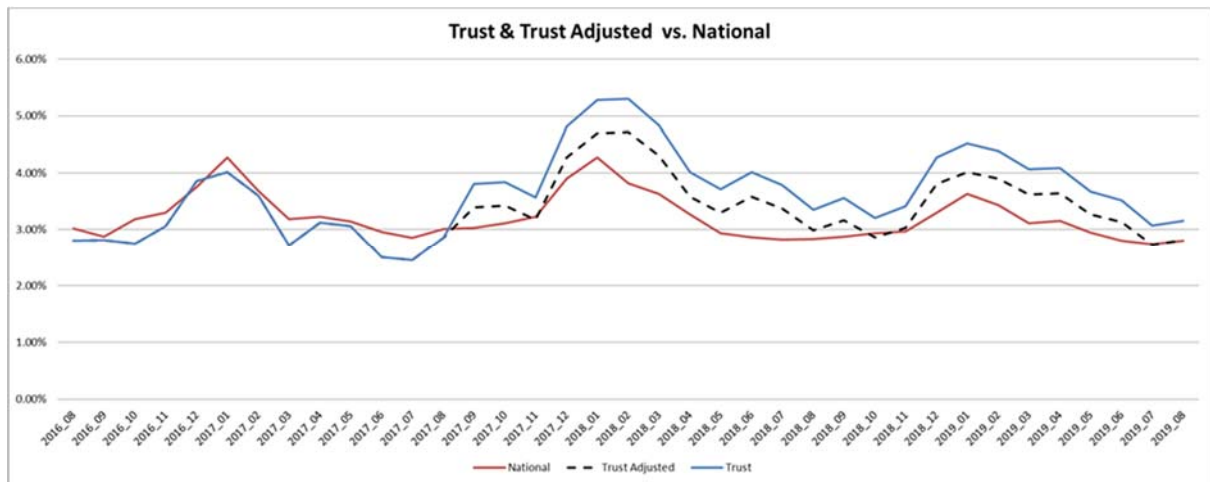
nationally. Given that SHMI is generated as a comparative measure this does not explain our rise outside the expected range.



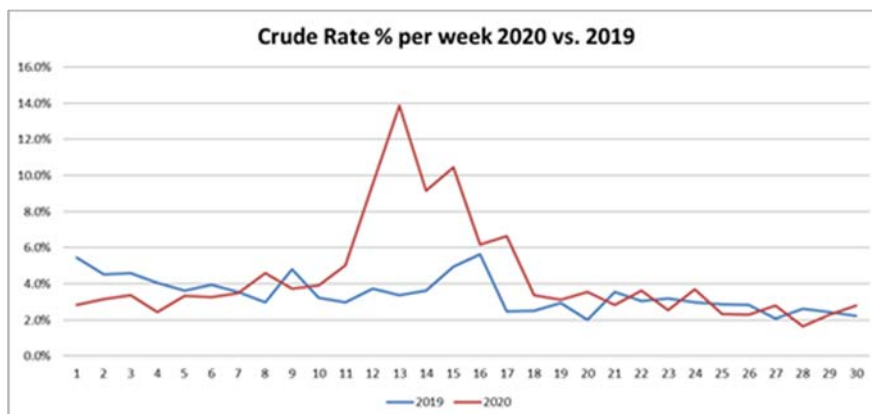
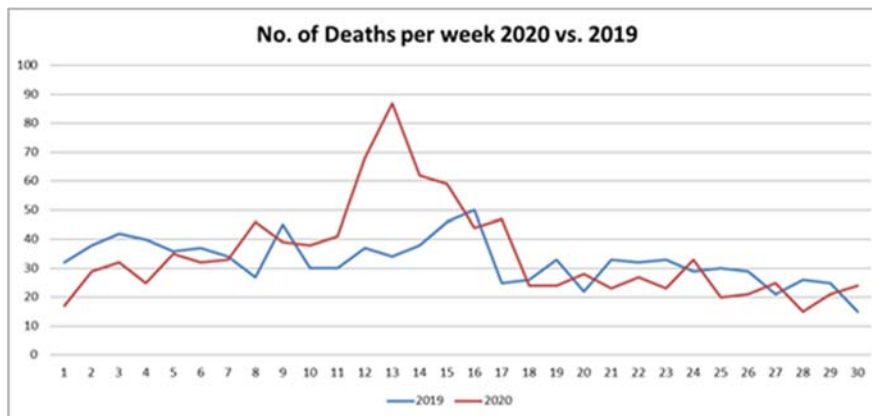
The data on HSMR/SHMI was several months behind but suggested that the Trust was less of an outlier for winter mortality based on previous years' experience. January deaths were reviewed by informatics and winter mortality appeared to have stabilised. The previous prediction was an expected 181 deaths in January but this had reduced to 165. The number of deaths per month displayed below showed that the number of deaths per month had been within statistical expectations since April 2018.



The Trust Head of Informatics has also looked at our data and adjusted for the change in recording of activity after September 2017 and replotted the Crude Rate graph below. There were certain caveats in that this data was estimated but it seemed that the Trust was not an outlier. The chart shows our data as it stood against National Crude Mortality Rates with the coding adjustment in the dotted line. These were an estimate based on the effect on our coded admissions previously exhibited but it was felt that the trend data was representative.



It is also worth noting the following 2 tables which describe weekly mortality 2019 and 2020 from the beginning of the year. These show that any excess deaths in December are not an on-going feature.



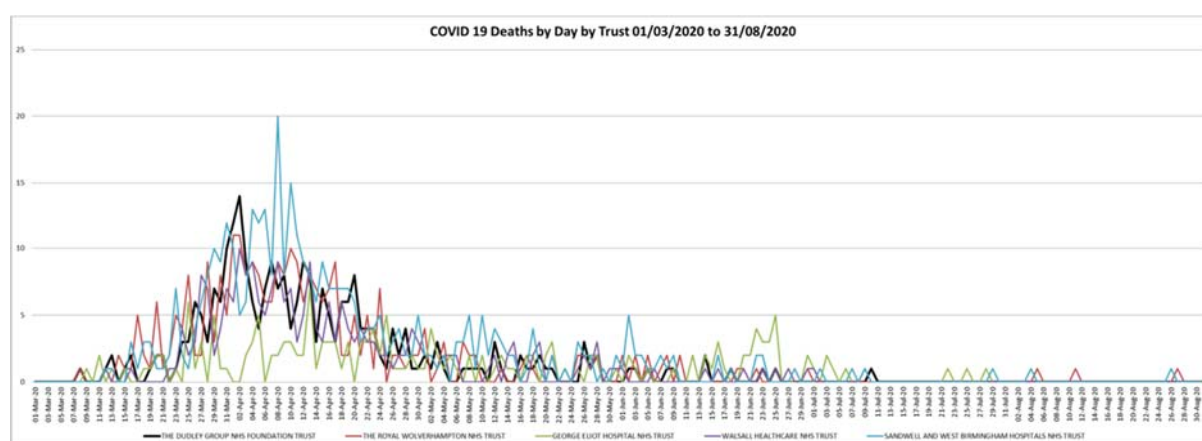
## 1.1 Impact of COVID-19

The effect of COVID on mortality statistics has been to create a slightly confusing picture as not all Trusts have been affected at the same time and to the same extent from a geographical perspective.

Crude mortality has increased nationally by 20% and out of hospital deaths have also increased compared to March 2019. HSMR and SHMI are not designed to model pandemic activity. The models are cross-sectional and rely on a period of training data to predict the effects of case-mix on death. The ICD10 code for covid19 patients has only been in the HES data for March so it is not possible to calculate an accurate 'expected' mortality rate. Furthermore, there have been significant changes in volume and case-mix of non-covid patients which will again affect the HSMR and SHMI as time goes on. In effect a skewed subset of patients will have presented at hospital.

Coding of covid19 has not been captured fully across providers as a large increase has been seen for diagnosis 'R69X – Unknown and unspecified causes of morbidity'. Patients with confirmed or suspected covid19 must also have finished their admission in hospital before being included in March figures and many patients who have been admitted in March will not be discharged by the end of the month. It is felt that it may not be until subsequent months and with improvements in coding that the true extent of covid19 begins to show in the figures. The current information from HED dated 1/9/2020 states that COVID patients have not been excluded from the modelling for March 2020 but that they will be excluded from April 2020 as that accounted for the bulk of patients (>80% nationally). The intent is that all COVID patients will be excluded from the modelling at the next refresh.

The chart below shows our COVID deaths over the recent period in comparison with other local Trusts (Dudley shown in the black line). This shows that the pattern of our COVID deaths is similar to other local Trusts though the peak for each Trust has varied slightly.



## 2.0 How do we provide assurance of quality of care?

### 2.1 Learning from Case Note Review

The Trust regularly undertakes Structured Judgement Reviews(SJR) and during COVID has undertaken over 200 for patients who died following a positive test. This is out of a total of 264 deaths from COVID as of 30/7/20. We have used the standard measures of quality of care and avoidability to reach a conclusion as to the overall outcomes.

Avoidability	Definitely avoidable	Strong evidence of avoidability	Probably avoidable (more than 50:50)	Possible avoidable but not very likely (less than 50:50)	Slight evidence of avoidability	Definitely not avoidable	Total
	0	0	1	2	10	187	200
Overall Assessment of care	Very poor	Poor	Adequate	Good	Excellent		
	0	7	46	116	31		200
Quality of Notes	Very poor	Poor	Adequate	Good	Excellent		
	0	1	33	144	22		200

Overall care was rated as *good or excellent* in 73.5% of cases.

Deaths were deemed unavoidable in 99.5% of cases.

The one case that was deemed as probably avoidable actually relates to care prior to admission to hospital where a patient was admitted with an unclassifiable sacral sore.

Two cases that were deemed *possibly avoidable but not very likely* were in relation to where plans for MDT management were delayed resulting in long in patient stays in patients with major co-morbidities.

For those cases with *slight avoidability*, (5%) there were concerns that patients had been in hospital for prolonged periods.

The reviews identified areas for learning as detailed :

- There were a number of cases where end of life care could have been improved by improving communication with patients, families and primary care.
- A significant number of cases were admitted from nursing homes at end of life and passed away shortly after admission. Many of these were deemed avoidable admissions.
- Delays in discharge of elderly frail patients resulted in 4 cases where patients had been medically fit for up to 6-8 weeks. Some patients developed COVID during hospital stay. Other cases where shorter delays in discharge also resulted in development of COVID

- Initial cohorts of patients on PCCU and orthopaedic ward where outbreaks occurred led to clustering of cases and potential spread to other patients. However, in both cohorts, patients reviewed to date were extremely frail and were often deemed at end of life even before COVID diagnosis made.

A further exercise is ongoing to review patients who experienced a 12 hour breach in ED and subsequently died. A total of 13 such reviews have now been completed and a further 13 are expected to be finalised by mid October. The reviews have shown evidence that patients delayed in the department had regular reviews by nursing staff and had been seen by acute and speciality medical teams during the delay. The patient cohort were frail and one delay was due to a patient with advanced bowel cancer and a request from family to discharge home for end of life care. The delay in ED was due to facilitating this request. Prompt and appropriate care was evident despite the delay.

1 patient with acute myeloid leukaemia had recently been discharged and the junior doctor was slow to identify the patient had potential neutropenic sepsis. The patient was on an acute ward for a further 3 weeks and the initial delay in treatment is not thought to be contributory to the death.

1 further patient with a known huntingdon chorea and a known terminal illness was brought in to the department from a care home and there was a prolonged delay in ED. Patient was missed on post take ward round and the review panel felt the patient received appropriate treatment but the delay was inappropriate due to the known terminal illness.

All cases apart from the two highlighted were noted as receiving adequate or good care and there was no evidence of avoidability in any case. There was evidence of good and holistic care where the patient remained in ED for a prolonged period.

The Trust reviews SJR data and provides a report to the Executive and Trust Board.

## **2.2 Review of Mortality Data from HED Data/ NHS Digital**

The Trust informatics team regularly review HED data and alert the Medical Director/ Deputy Medical Director of areas of concern and whether they require specific intervention at the time of the alert.

## **2.3 Interactions between the Mortality Surveillance Group (MSG) and the Deteriorating Patient Group (DPG)**

The stated aim of the MSG and DPG is to reduce SHMI to levels below 100 which were last attained by the Trust before coding of admissions were changed in September 2017. This will require systems to monitor and deliver improvement on a month by month basis with evidence of adherence to set pathways and compliance data. Specific mortality alerts are highlighted to the DPG and specific interventions are instigated. A refresh of both groups is currently being undertaken, led by the Head of Clinical Effectiveness. This will include a new TOR and the commencement of a rolling programme of attendance from specialities to discuss mortality data and care bundle compliance.

## **2.4 Medical Examiner System**

The national requirement to establish a Medical Examiners system has been operationalised as of July 2020. The Trust is providing 7 sessions of Medical Examiner time to scrutinise deaths and liaise with both the coroner and families. The Medical Examiners are reporting any concerns through the Weekly Meeting of Harm to initiate any formal investigation required. Work is currently ongoing with the Emergency Department to ensure that all deaths (ED and inpatient) are referred to the coroner in the most appropriate way.

### **Medical Examiner delivery data : 15/06/2020 – 15/09/2020**

Total deaths scrutinised	350
Deaths referred to coroners (outcome from referral below)	54 *includes 6 ED deaths that were referred by ED and returned to ME
o allowed to issue death certificates	28
o issued by GP	1
o inquest without post mortem o post mortem	22
Referred for SJR	4
Referred for M & M	36
ED deaths that have been referred directly to coroner	33

## **3.0 Care Bundle Implementation**

The implementation of care bundles for high impact pathways has been proven to reduce mortality in other Trusts. A deteriorating patient dashboard has been developed for the following condition groups ;

- Chest pain Pathway
- Acute Kidney Injury
- Alcoholic Liver disease

Additional dashboards are planned for pneumonia and NORSE pathways.

The COPD discharge bundle is already in place but the BTS COPD admission bundle will be delivered in addition to optimise quality of care.

Mortality Figures will be generated on a monthly basis to assess progress in relation to implementation of the Bundles.

Further development of the Deteriorating Patient Dashboard has been requested to allow further oversight on Sunrise of interventions made in response to high NEWS scores. This will be embedded into the processes for the Hospital at Night Teams.

Further development work for order sets on Sunrise has been requested to deliver pathways and follow up. Safety Bulletins and education on pathways have commenced to engage clinicians. A copy of the recent patient safety bulletin is attached as Appendix 1.

### **3.1 Outcomes**

Compliance against pathway bundles is monitored on a weekly basis;

#### **SEPSIS**

Component	% completion previous seven days	Week of End the 16 <sup>th</sup> August %	23 <sup>RD</sup>	30 <sup>TH</sup>	6 <sup>TH</sup> / 9
<b>Sepsis 6</b>	<b>73.7</b>	<b>70.7</b>	<b>68.4</b>	<b>75</b>	<b>78.2</b>
Oxygen	88.7	88.7	85	85.9	90.8
Iv Antibiotics	88.7	85	83.5	87.5	91.1
Blood samples	86.5	88	84.2	87.5	93.5
Iv fluids	84.2	81.2	82.7	84.2	85.5
Fluid balance	87.2	86.5	84.2	90.8	92.7
Serial lactates	89	85.7	90.2	82.2	90.3

#### **Sepsis Screen**

Component	3/8-9/8	10/8-16/8	23 <sup>RD</sup>	30 <sup>TH</sup>	6 /9 <sup>TH</sup>
Sepsis Screen %	93.8	93	93.9	93.9	94.4

**MET activity Green Decrease, Amber same, Red increase From base level 9<sup>th</sup> /8**

Component	End 9 <sup>th</sup> /8	End 16 <sup>th</sup> /8	23 <sup>RD</sup>	30 <sup>TH</sup>	6 <sup>TH</sup> 9
MET/CA week day	4	2	9	7	5
MET/CA week night	16	9	21	13	11
MET/CA weekend day	3	3	4	2	0
MET/CA weekend night	3	4	5	4	5

## **AKI AND TREATMENT PARAMETERS**

Base line set of data. Power BI tool launched to identify patient cohort

			16 <sup>TH</sup>	23 <sup>rd</sup> AKI/ AKI 3	30 <sup>th</sup> AKI/ AKI 3
AKI n = 600  March-July 2020	1. USS	10%	19%	16%	
	2. Repeat bloods	79%	100%	91	90
	3. Urinary catheter/fluid	5%	50%	79	95
	4. Fluid challenge	-	-	79	95
	5. Renal referral	-	-	10	-
	6. Sepsis screening as indicated at time.	40%	-	66	-
	7. Urine dipstick	<5%	-	-	-

## **Clinical priority interventions**

Sepsis team will be initiating the repeat bloods through AKI order set in all identified patients who do not have sets already applied. **19/09/2020**

## **CAP**

BTS bundle n = 101  From March 2020	1. CXR	99%	100%	100%	100%
	2. Antibiotics	94%	100%	100%	100%
	3. Curb 65 score	10%	100%	30%	25%
	4. Repeat chest x-ray	-	100%	-	-
	5. Sepsis screening	99%	-	100%	100%
	6. O2	100%	100%	100%	100%

## **ALD**

	1.	Baseline	Wk Ending 9/8/20	16 <sup>TH</sup>
ALD bundle n = 10	2. Bloods	68%	100%	100%

	3. Referral	60%	100%	100%
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### Cardiac arrest events

Ongoing review of cardiac arrests shows that opportunities to implement DNA CPR decisions have been missed. During the period of the initial COVID outbreak, such episodes were avoided as there was far greater awareness to make clear decisions.

The data sets are being disseminated to medical service leads and Nursing/ AHP Leads with a requirement to present to Deteriorating Patient Group with a formal action plan against the RAG rating.

### 3.2 Known interventions to increase bundle compliance

#### Sepsis

- Source control - ***now being recorded and prioritised on emergency theatre booking system***
- Second dose of iv antibiotics, iv fluids and repeat lactate – ***will be captured through EPMA***
- Time to initiation of vasopressors- ***EPMA and critical care review document***

**Action Date from 12/8/20- Theatres Team and Pharmacy/EPMA delivery team, Sepsis Team**

#### ALD

- ALD lead – **Dr Fisher**
- Alcohol liaison nurse- **business case in progress**
- Referral to liver team- **requirement for integration into Sunrise as a pathway to generate report**
- Ascitic tap- **Data to be recorded in Sunrise as specific laboratory results with ability to generate report**

**Action Date 12/11/20- GI team and Data Analytics Team**

#### AKI

- IV fluid delivery –**will be captured through EPMA**
- Time to renal review- **requirement for integration into Sunrise as a pathway to generate report**
- Completion of prescribing review- **EPMA will capture pharmacy review**

**Action Date 12/11/2020 – Pharmacy/ EPMA delivery team; Data Analytics Team; Renal Team**

#### Pneumonia & COPD

- Implementation of BTS COPD admission document- **DRAS Team will initiate but requirement for integration into Sunrise as a pathway to generate report**
- Arrange follow up CXR - **CAP pathway in sunrise to generate FU CXR as part of order set process**

## Action Date 12/11/20- Respiratory Team and Data Analytics Team

### Chest Pain Pathway

- Time to ECG- - requirement for integration into Sunrise as a pathway to generate report
- Time to specialist review- requirement for integration into Sunrise as a pathway to generate report
- Time to definitive care- EPMA/ Chest pain dashboard

## Action 12/11/20 – Data Analytics Team/ IT team

### 4.0 Workplan summary: Future Actions Planned as Part of Process to Deliver Improvements in SHMI

Workstream	Action	Progress	Implementation Date
Governance	Implementation of new mortality tracker to include Medical Examiner, SJR, Speciality Mortality Reviews and potentially GSF	Task and finish group established to implement AMAT mortality module	December 2020
Outcomes	Implementation of care bundles Trust wide	Bundles for Sepsis, AKI, ALRD launched and promoted via Trust channels. Ongoing work regarding orderset development.	Implemented – ongoing review
Governance	Establish a rolling programme of speciality level presentations at MSG	TOR drafted and agreed to include rolling programme	October 2020
Assurance and Improvement	Condition specific audits to be undertaken to investigate alerts; <ul style="list-style-type: none"><li>• UTI</li><li>• Epilepsy</li><li>• Peritonitis and Intestinal Abscess</li><li>• Bronchiectasis</li><li>• COPD which will take place as part of submission of data to National Audit</li></ul>	UTI audit complete. Report being typed. Epilepsy audit underway. Peritonitis and Intestinal Abscess audit underway To report to MSG October 2020	Ongoing
Outcomes	Deteriorating patient options appraisal for future development	Option appraisal completed by Dr Jennings. Presented to Trust Executive. IT requests for development logged	Appraisal complete. Awaiting IT input
Assurance and Improvement	Participate in AQUA AQ programme to benchmark performance and identify areas for improvement	Sepsis script written and tested. AKI and ALRD will require partial manual input until sunrise developments are made	November 2020
Support	LfD post to be revised and	Job description refreshed. To be	December 2020

	advertised	formally banded and recruited to	
Assurance	<p>Reviews of Case specific coding will be undertaken to determine the following:</p> <ul style="list-style-type: none"> <li>• accuracy of the coding</li> <li>• accuracy of clinicians in determining the primary diagnosis and recording of comorbidities</li> <li>• timeliness of investigations to ensure that primary diagnosis is made with full access to all investigations to improve accuracy</li> </ul> <p>Feedback to admitting teams on the accuracy of data being generated</p>		December 2020

## 5.0 Resource Considerations

Additional clear resource to support the above measures may be required to fully deliver the expected outcomes. The following areas need specific consideration:

- Data analysis and informatics support
- IT support for developing existing projects in Sunrise
- Support in event of a further COVID surge over the next few months to ensure ongoing review and audit activity
- The generation of a business case to embed the care bundles in the EPR

## **Appendix 1 Patient Safety Bulletin**



Hello and welcome to our Patient Safety and Experience Bulletin. Each edition is guest edited by a subject matter expert. In this edition we look at **clinical pathways** with guest editor **Dr Adrian Jennings**, consultant anaesthetist, clinical lead for theatres and implementation lead for the deteriorating patient pathway.

## Clinical pathways

The Trust Patient Safety Strategy was ratified by the board in 2019. A key theme is optimising the care of the deteriorating patient. Key pathways ensure the care provided is consistent and in line with national recommendations. The Trust has chosen a series of patient pathways to focus upon, these are most likely to influence patient outcome and for which there are established key performance indicators.

Clinical pathways describe best practice and remove variations in care. They can be used for all patient groups, especially those who are identified as deteriorating or sick on NEWS2 electronic observations. Deteriorating patients should always have a sepsis toolkit completed on Sunrise and be escalated to senior clinicians for review. The relevant clinical pathway document(s) must then be followed if the patient has one of the identified conditions.

Several clinical pathways already exist, and more are in development. Existing pathways include:

- sepsis (Sunrise-based)
- community acquired pneumonia
- acute kidney injury
- acute liver failure
- acute neurosurgical emergencies (NORSE)
- chest pain
- emergency laparotomy
- end of life care



These pathways are largely paper-based but will become embedded in Sunrise in the future.

**Completion of the clinical pathway will ensure key management steps are consistently performed in a timely manner. Completion of these pathways is audited and supported by the deteriorating patient team.**

When a patient is on a clinical pathway, this should be communicated at handover.

Paper for submission to the Board of Directors 8th October 2020

<b>TITLE:</b>	<b>Chief Nurse Report</b>		
<b>AUTHOR:</b>	<b>Carol Love-Mecrow</b> Deputy Chief Nurse	<b>PRESENTER</b>	<b>Mary Sexton</b> Chief Nurse
<b>CLINICAL STRATEGIC AIMS</b>			
<i>Develop integrated care provided locally to enable people to stay at home or be treated as close to home as possible.</i>		<i>Strengthen hospital-based care to ensure high quality hospital services provided in the most effective and efficient way.</i>	<i>Provide specialist services to patients from the Black Country and further afield.</i>
<b>ACTION REQUIRED OF COMMITTEE</b>			
<b>Decision</b>	<b>Approval</b>	<b>Discussion</b>	<b>Other</b>
		<b>x</b>	
<b>RECOMMENDATIONS</b>			
For the Board to review and note the exceptions presented.			
<b>CORPORATE OBJECTIVE:</b>			
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			
<b>SUMMARY OF KEY ISSUES:</b>			
<ol style="list-style-type: none"> <li>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 <b>Appendix 1</b> Staffing data</li> <li>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.</li> </ol> <p><b>Nursing and Midwifery strategy work streams:</b></p> <p><b>Care:</b> Deliver safe and Caring Services</p> <p><b>Compassion:</b> Deliver a great patient experience</p> <p><b>Competence:</b> Drive service improvements, innovation and transformation</p>			

**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

<b>RISK</b> BAF 1A Not effectively engaging with patients in their care or involving them in service improvement	<b>Y</b>		<b>Risk Description:</b> 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.
	<b>Risk Register: Y/N</b>		<b>Risk Score: 12</b>
<b>COMPLIANCE and/or LEGAL REQUIREMENTS</b>	<b>CQC</b>	<b>N</b>	<b>Details:</b>
	<b>NHSI</b>	<b>N</b>	<b>Details:</b>
	<b>Other</b>	<b>N</b>	<b>Details:</b>
<b>REPORT DESTINATION</b>	<b>EXECUTIVE DIRECTORS</b>	<b>N</b>	<b>DATE:</b>
		<b>Y</b>	<b>DATE: Board 8.10.20</b>

## Care Deliver safe and caring services

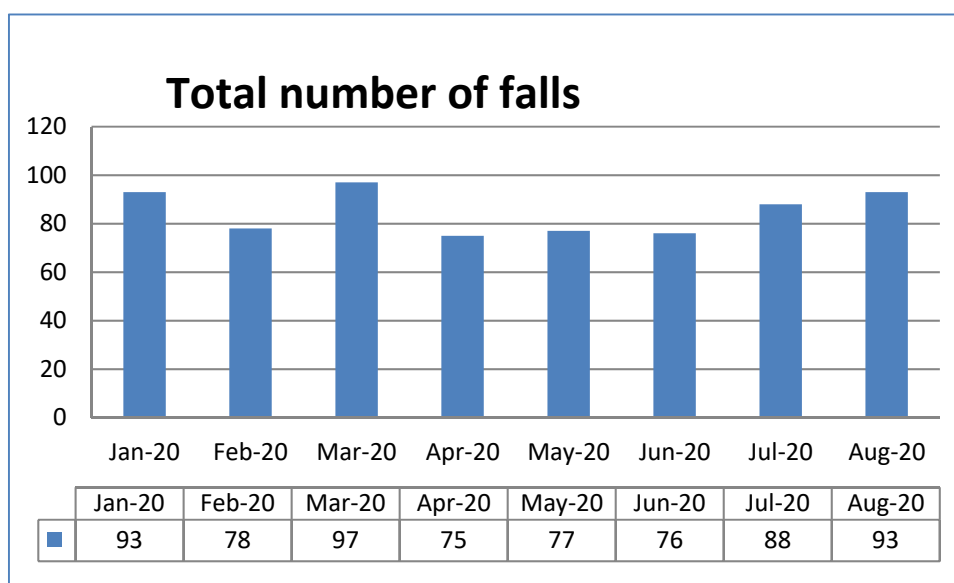
### Care

Deliver safe and caring services

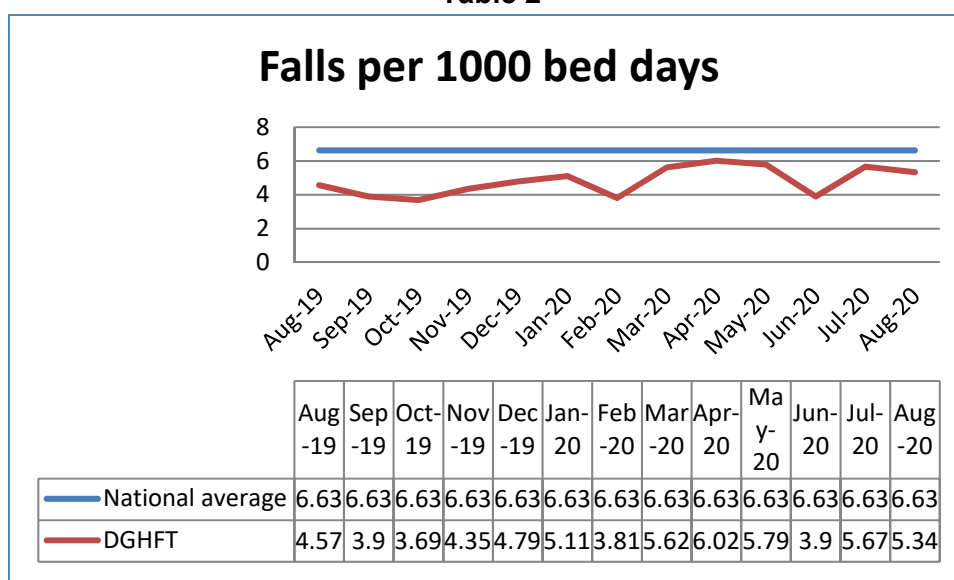
**Falls** - There has been an overall increase in the number of falls for August compared with previous months. This is potentially, because of deconditioning of patients following COVID-19. Ward areas report staffing levels being low over the summer holiday period.

Tables 1 and 2 show the total number of falls and falls per 100 bed days

**Table 1**



**Table 2**



**Table 3**

<b>August 2020 falls data</b>	
<b>No of inpatient falls</b>	93
<b>No of patients assisted to the floor</b>	4
<b>Outpatient falls</b>	2 external 1 Renal day case 1 C2 day case
<b>Levels of harm</b>	79 falls-no harm 14 falls-low harm
<b>Repeat fallers</b>	5 repeat fallers
<b>Serious Incidents</b>	Nil
<b>Yellow investigations</b>	2
<b>Areas of significance/interest</b>	<ul style="list-style-type: none"> <li>• Higher number of falls than normal-C1 and B2 equally split</li> <li>• 5/93 patient had a bed chair alarm in use</li> <li>• 38/93 falls occurred overnight</li> </ul>

Table 3 above shows the falls detail for August. The leads on C1 and B2 are monitoring falls incidence in their areas.

Additional plans to reduce the incidence of falls are:

- The trial of the Falls Passport has been launched on B2, B3, C8 and FAU to run from 21/09/20-14/12/20. The Passport is completed by staff and stays with the patient throughout their journey. This has been discussed at the Regional Falls Network who are keen to see how this is received.
- The development of a timeframe flowchart for staff to follow when completing RCAs is now in use to support staff to be involved in the process to ensure ownership. Matrons are now being asked to sign off falls RCAs and take to their governance meeting or equivalent. Falls steering group Matron to share the learning from all yellow investigations to share learning trust wide.
- Leads are being asked to complete a one sheet Learning Page to display snapshot of outcome and lessons learnt.
- The first monthly falls champions meeting was held on 22/09/20 to assist with training, ward falls prevention and management of compliance, and support with rolling out updates etc.
- Discussion have been held with the IT team regarding a falls flag on Sunrise-they are taking the idea forward for discussion to determine whether it is possible to add a falls assessment onto Sunrise which will then automatically add a flag onto the tracking board if the patient is assessed as being a falls risk.
- The Fall Lead is currently undertaking a post falls neurological observation audit for September.
- Auditing of the use of bed chair alarms and continence related falls during September is underway and discussions are taking place regarding the purchase of more bed chair alarms. It is important to note that bed chair alarms are not used by the Regional Falls Network and are not part of NICE

recommendations.

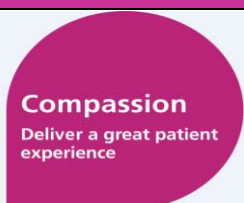
- The post fall care plan has been emailed to all leads to remind them that they must ensure these are completed following every fall.

**Deteriorating Patient-** The deteriorating patient team now has its first authorised non-medical prescriber. This will help to expedite the treatment of septic and deteriorating patients. The Sepsis Nurse Practitioner has completed a Nursing Times webinar on deteriorating patients for sepsis awareness month (link attached) <https://www.nursingtimes.net/nt-connects/>

**Never Event 2020/903** – This Never Event, relating to a retained balloon cover following an angioplasty to the left leg was closed at September's Quality and Safety Committee. The investigation concluded that the balloon cover was retained due to two factors that together could have prevented the incident. A robust competency programme would have ensured that the Scrub nurse would have been aware to remove balloon covers prior to the procedure. In doing so this would have ensured that the cover was not inserted into the patient with the balloon.

**Tissue Viability** – There have been no avoidable category 4 pressure ulcers reported since the last report. However, there has been one avoidable category 3 pressure ulcer reported following failure to remove compression bandaging to accurately check pressure areas. The tissue viability team are recirculating the guidance around caring for patients that come into hospital with compression bandaging and a safety bulletin is being prepared by the Tissue Viability Lead.

### Compassion Deliver a great patient experience



**Complaints** - During August 2020, the Trust received 59 new complaints, in comparison to 71 opened for July 2020 and 55 opened for June 2020.

In August 2020, the Trust closed 50 complaints compared to 53 in July 2020. Of those 50 closed, 14 (26.4%) were closed within 30 working days compared to 19 (35.8%) were closed within 30 working days for July 2020.

Closures for divisions for August 2020 are as follows:

- 21 closed for Surgery
- 27 closed for Medicine & Integrated Care
- 1 closed for Clinical Support Services
- 1 closed for Corporate Nursing

### Friend and Family Test

- A total of **3,286** responses across all areas have been received during August 2020 in comparison to **2,984** in July 2020.
- New FFT cards have now been printed with the new standard question and ratings. These are to be distributed around the Trust and the new reporting to start end of October in line with the national timeline.
- A number of communications have been sent out to promote the new changes to the friends and family question.

- A separate survey has been added on the back of the FFT card, which includes questions about dignity and respect, involvement in decisions about care, and whether patients were provided with enough information about their care and treatment.
- To support teams to improve percentage recommended scores we are carrying out the following initiatives:
  - Two patient panels have been held to give patients/carers and members of the public the opportunity to have their say on how our services are run and proposals for future service redesign.
  - Patient Voice Volunteers (PVV) - the Trust is looking to recruit a number PVV's to use their experiences of services to inform and influence the delivery, planning and quality of services we provide.
  - Our 'What Matter to You Matters to Us' Patient Experience feedback trolley - this is a joint co-ordinated effort between the patient experience team, volunteers and staff to proactively obtain real-time feedback and act on concerns. Welcome booklets will also be distributed.

**Compliments** - The Trust received **295** compliments in August.

**COVID panel/surveys/LIAs** - Help us shape future service planning and development of services we implemented a short survey and a patient panel to capture people's views and experiences of accessing services during the COVID-19 pandemic. The results regarding telephone consultations were positive with more than half of respondents rating their experience of telephone consultations as very good/good. A small proportion (30%) felt that their experience was poor/very.

**Mental Health** – There were 5 patients detained under the Mental Health Act during August 2020. Four of these patients were detained under section 5/2. Two were referred to an Acute Mental Health Professional (AMHP) and subsequently discharged. One was referred for further treatment and one was invalidated due to the incorrect documentation being used, this is being investigated. The fifth patient was detained on a section 3 and detained for medical treatment.

### Competence Drive service improvement, innovation and transformation



**Professional Development** –The professional development team have launched the first of its revised development programmes in September. These programme are using a blended approach of virtual and face to face learning. Early feedback from participants has been very positive.

**Continuing Professional Development** – CPD monies are available for nursing, midwifery and AHP staff, Leads have been asked to consider developments and support for their staff using this funding.

**International clinical trial of nursing care for COVID-19 patients** – The Trust has been given the opportunity to participate in the very first international clinical trial of nursing care for COVID-19 patients. The 'COVID –NURSE' trial is funded by the National Institute for Health Research and the UK Research and Innovation and is a randomised controlled trial of an innovative nursing care protocol, designed by nurses and patients, specifically for COVID-19 patients. The trial will evaluate the impact of this protocol on patient experience, care quality and clinical outcomes and in addition the impact of using the protocol for nurses themselves. The trial will take place from October 2020 to March 2021 and will be undertaken by 18

hospitals across the country.

The trial is being co-ordinated and led by the University of Exeter in collaboration with the universities of Leicester, Nottingham, Southampton and Kings College.

Following the trial, the results will be available to all NHS Trusts including free open access to the protocol and the training materials.

### Communication Make the best of what we have

#### Communication Make the best use 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 continues; increased numbers of peer vaccinators have now been trained. A rota of peer vaccinators for staffing the entrances to provide the vaccine to staff is being developed to ensure that the Trust meets its target of 90% vaccination compliance. The campaign will launch on the 5<sup>th</sup>

October 2020.

### Commitment – Be the place that people choose to work

#### Commitment Be the place people choose to work

**Agency Controls** - All bank and agency requests continue to be assessed by the Divisional 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.

**Allied Healthcare Professionals** - October 14<sup>th</sup> is AHP day - This year, AHP day will be held as a virtual event, to give staff a chance to come together and celebrate all 14 allied health professionals that we have across the NHS. We are very honoured that Suzanne Rastrick the Chief Allied Health officer for England has chosen Dudley Group to join in the celebrations and will be making a key note speech and presenting awards across 5 categories. There will also be an interactive session on mindfulness and mental health and several opportunities for AHPs to showcase their project work, service development and response to COVID- 19. The days is open to all Dudley Group employees from all staff groups, so we can learn, grow and celebrate together and will be closed by reflections from the Chief Nurse.

**Safer staffing** – The qualified staff fill rates for August were 80% during the day, fill rates for nights were 90% This is a slight reduction on last months day and night time fill rates. The overall qualified fill rates was 85% 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 9.28 for August 2020 (qualified and unqualified). Staffing numbers continue to be reviewed twice a day at the safety huddles facilitated by the Divisonal Chief Nurses. Daily assessment of patient acuity and dependency continues in our inpatient units (see appendix 1).

However despite these encouraging metrics there are staffing concerns in a number of areas, which have been exacerbated by the effects staff working during the COVID-19 pandemic. Most notably increased sickness and challenges in filling shifts with temporary staff to ensure that vacant posts do not adversely impact on patient care. The short term goal is to maintain our patients safety and ensure our staff's

wellbeing as we enter into the next phase of the COVID -19 pandemic. The longterm aim is to secure sustainable nurse recruitment for the trust.

**Sustainable Nurse Resourcing Strategy** – Work is underway with Human Resources and Nursing to develop a nurse resource strategy; which will include:

- **More dynamic approach to recruitment** (i.e. recruitment campaigns, selling the black country/Dudley as a place to live and work, emphasising the Trusts commitment to investing in development and progression for nurses in both professional and leadership careers pathways,
- **Retention - improve the development and progression offer to nurses** (to include addressing the barriers to equitable progression for BAME nurses)
- **Implement E-rostering effectively across the Trust**, this is also a key requirement of the new national People Plan
- **Strengthening of the existing nurse bank** – to include non-substantive staff as we currently only have effectively a ‘substantive bank’.

**Year of the Nurse and Midwife** –Confirmation of the final plans will be available shortly.

**Professional Development** – A Clinical Support Worker (CSW) programme will be advertised on 25<sup>th</sup> September for the aim to recruit 35 experienced CSW’s that would be used to back fill for the staff as part of the recruit for the new modular build and also current CSW vacancies. The CSW programme will commence on 30<sup>th</sup> November, then a Novice CSW apprenticeship programme will commence 25<sup>th</sup> January for 35 apprentices.

**Trainee Nursing Associates (TNAs)** Cohort 7 commenced their training at Worcester University on Monday 14<sup>th</sup> September. The TNA’s will be coming into trust on 28<sup>th</sup> September. We have 14 TNA’s in this cohort placed in clinical areas throughout the trust.

Cohort 3 is due to submit final practice assessment documents and qualify at the end of October 2020. We have 6 that will be coming out into their areas as Nursing Associates.

### **Courage – Deliver a viable future**



**Safeguarding** – Communication continues with senior leads to improve safeguarding level 3 training compliance and provision of evening training sessions are now being offered. Section 11 audit has been completed – areas requiring improvement are reflected in the annual improvement plan. Supervision for community staff has commenced and all District Nurse Team leaders have had 1 to 1 with the named nurse for safeguarding. The Communications department have distributed the

Learning from Safeguarding Adult Review around supporting and protecting patients who self-neglect. A 12 month secondment of Registered Children’s Nurse from C2 has been made to the post of Associate Named Nurse for Children

# Appendix 1

## Safer Staffing Data

Safer Staffing Summary									Actual CHPPD					
Aug									31					
Days in Month														
Day RN														
Day RN														
Day CSW														
Day CSW														
Night RN														
Night RN														
Night CSW														
Night CSW														

**Paper for submission to the Board of Directors 2020**  
**8<sup>th</sup> October 2020**

<b>TITLE:</b>	<b>Infection Prevention and Control Board Assurance Frame Work.</b>		
<b>AUTHOR:</b>	<b>Emma Fulloway IPCL Nurse</b>	<b>PRESENTER</b>	<b>Mary Sexton Chief Nurse</b>
<b>CLINICAL STRATEGIC AIMS</b>			
<i>Develop integrated care provided locally to enable people to stay at home or be treated as close to home as possible.</i>	<i>Strengthen hospital-based care to ensure high quality hospital services provided in the most effective and efficient way.</i>	<i>Provide specialist services to patients from the Black Country and further afield.</i>	
<b>CORPORATE OBJECTIVE: SO2: Safe and Caring Services</b>			
<b>SUMMARY OF KEY ISSUES:</b>  <p>This is a summary of the paper presented to the IPC Group and Quality and Safety Committee to demonstrate Trust compliance with the Health and Social Care Act 2008 and highlight gaps in assurance for action. In May 2020 NHSI/E requested that the Infection Prevention board assurance framework template is completed and shared with Trust board. The full Board Assurance Framework was submitted to the September Board.</p> <p>One of the key areas to combating the COVID crisis relates to robust infection control standards and practices across the Trust. The framework adopts the same headings as the Health and Social Care Act 2008 listing the 10 criterion.</p> <p>There are many areas in which the trust is able to give assurance as evidence of compliance can be confirmed:</p> <ul style="list-style-type: none"> <li>- We have identified as having no gaps in assurance; infection risk is assessed at front door areas of the Trust such as ED and outpatient departments, renal unit and elective. The zoning of the hospital site is supported by a standing operating procedure. The Trust has robust cleaning processes, facilitated through the IPCT working closely with our Interserve partners.</li> <li>- Robust and prompt testing systems in place for patients suspected of COVID. The Trust can evidence vigorous procurement procedures for PPE management and distribution.</li> <li>- Face fit testing completed is now recorded on a database where compliance can be monitored</li> </ul> <p>Areas for improvement:</p> <ul style="list-style-type: none"> <li>- The IPCT are working with the medical devices team and wards to increase compliance of device decontamination before maintenance.</li> <li>- Infection Control mandatory training compliance is not at the current Trust standard of 95% compliance, training figures have been impacted by reduction in capacity due to social distancing the training has to include training on COVID as a standard.</li> <li>- The Trust has developed standard operating procedures in response to the pandemic, but an overarching IPC COVID policy is required. This is in draft although it will need revising in light of the New PHE/NHE IPC guidance. The Infection Control Team have worked with the Emergency Planning Team to devise the Pandemic repose policy in draft.</li> </ul> <p>Overall the Trust has been able to respond to the pandemic in a safe and timely manner, with no outbreaks or evidence of cross infection within the Trust since the start of the pandemic. The Trust needs to focus on restoration and continue to demonstrate compliance with the Health and Social Care acts 10 criterion to ensure quality, safe care is delivered to our patients.</p>			
<b>IMPLICATIONS OF PAPER:</b>			

<b>RISK</b>	Y		<b>Risk Description:</b> Risk regarding decontamination of reusable medical devices and lack of clarity regarding Trust Decontamination Lead-Risk on IPC Risk Log
	<b>Risk Register:</b> Y		<b>Risk Score:</b>
<b>COMPLIANCE and/or LEGAL REQUIREMENTS</b>	<b>CQC</b>	Y	<b>Details:</b> Safe, Effective, Well Lead
	<b>NHSI</b>	Y	<b>Details:</b> The IPC Board Assurance frame work was requested by NHS/I
	<b>Other</b>	N	<b>Details:</b>
<b>ACTION REQUIRED OF COMMITTEE / GROUP:</b>			
<b>Decision</b>	<b>Approval</b>	<b>Discussion</b>	<b>Other</b>
		✓	
<b>RECOMMENDATIONS FOR THE BOARD /COMMITTEE/GROUP:</b> <i>The IPC Group and Quality and Safety Group are to oversee the continued actions within the IPCTBAF to endure compliance with the Health and Social Care Act</i>			

**Paper for submission to the Board of Directors on 8 October 2020**

<b>TITLE:</b>	<b>Exception Report from the Finance and Performance Committee Chair</b>		
<b>AUTHOR:</b>	Jonathan Hodgkin F & P Committee Chair	<b>PRESENTER</b>	Jonathan Hodgkin F & P Committee Chair
<b>CLINICAL STRATEGIC AIMS</b>			
<i>Strengthen hospital-based care to ensure high quality hospital services provided in the most effective and efficient way.</i>			
<b>ACTION REQUIRED OF COMMITTEE</b>			
<b>Decision</b>	<b>Approval</b>	<b>Discussion</b>	<b>Other</b>
		<b>X</b>	
<b>RECOMMENDATIONS:</b>			
The Board is asked to note the contents of the report and in particular the items referred to the Board for decision or action.			
<b>CORPORATE OBJECTIVE:</b>			
S05 Make the best use of what we have S06 Plan for a viable future			
<b>SUMMARY OF KEY ISSUES:</b>			
Summary from the Finance and Performance Committee held on 24 September 2020.			
<b>IMPLICATIONS OF PAPER:</b>			
<b>IMPLICATIONS FOR THE CORPORATE RISK REGISTER OR BOARD ASSURANCE FRAMEWORK</b>			
<b>RISK</b>	<b>Y</b>		<b>Risk Description:</b>
	<b>Risk Register: Y</b>		<b>Risk Score:</b>
<b>COMPLIANCE and/or LEGAL REQUIREMENTS</b>	<b>CQC</b>	<b>Y</b>	<b>Details:</b> Well Led
	<b>NHSI</b>	<b>Y</b>	<b>Details:</b> Achievement of Financial Targets
	<b>Other</b>	<b>Y</b>	<b>Details:</b> Value for Money
<b>REPORT DESTINATION</b>	<b>EXECUTIVE DIRECTORS</b>	<b>N</b>	<b>DATE:</b>
	<b>WORKING GROUP</b>	<b>N</b>	<b>DATE:</b>
	<b>COMMITTEE</b>	<b>N</b>	<b>DATE:</b>

## EXCEPTION REPORT FROM FINANCE AND PERFORMANCE COMMITTEE CHAIR

Meeting held on: 24 September 2020

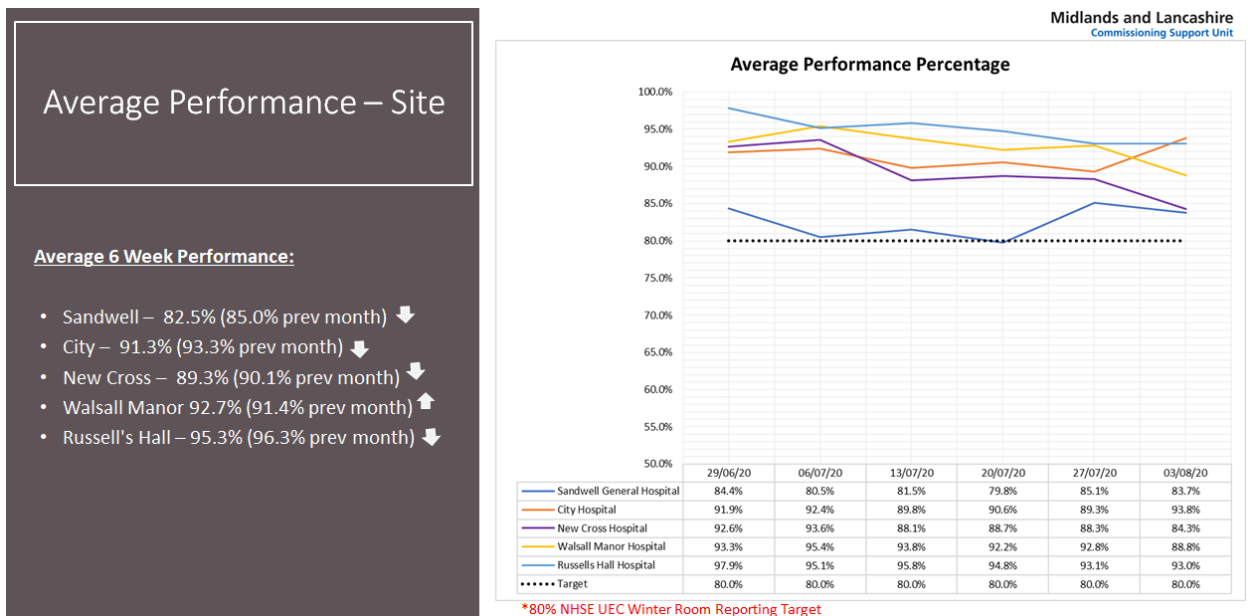
<p><b>MATTERS OF CONCERN OR KEY RISKS TO ESCALATE</b></p> <ul style="list-style-type: none"> <li>• Nurse staffing levels, slow recruitment, declining willingness of staff to move between wards and under-reporting of incidents is beginning to impact quality of service and flow through the hospital</li> <li>• Still do not have a clear view of the financial envelope for the remainder of the year and so unable to set budgets. However, initial indications are that an efficiency programme will be required if the Trust is to break-even over the full year</li> <li>• EAS performance has declined to 90% under pressure from volume and acuity</li> </ul>	<p><b>MAJOR ACTIONS COMMISSIONED/WORK UNDERWAY</b></p> <ul style="list-style-type: none"> <li>• Divisions asked to proactively push recruitment of CSWs</li> <li>• Board to be made aware of the need for a longer term, more strategic, workforce strategy that makes the best of local opportunities for recruitment and development</li> <li>• Better graphical/diagrammatic presentation of restoration and recovery performance requested</li> </ul>
<p><b>POSITIVE ASSURANCES TO PROVIDE</b></p> <ul style="list-style-type: none"> <li>• I&amp;E performance remains close to the central NHSI allocation</li> <li>• Regional benchmarking provides assurance that spend levels are appropriate and better than at Sandwell and Walsall</li> <li>• Restoration and recovery of activity levels remains broadly on track</li> <li>• On track to meet constitutional standards for diagnostics, cancer and referral to treatment by March 2021</li> <li>• Work has started on the construction of the modular ward</li> </ul>	<p><b>DECISIONS MADE</b></p> <ul style="list-style-type: none"> <li>• Approved updated EPRR strategy</li> <li>• Ratified revised Hearing Aids and Mobile Phone for Staff policies</li> </ul>
<p>• <b>Chair's comments on the effectiveness of the meeting:</b> Efficient meeting with good challenge and debate</p>	

**Paper for submission to the Board of Directors 8<sup>th</sup> October 2020**

<b>TITLE:</b>	<b>Integrated Performance Report for Month 5 (August 2020)</b>		
<b>AUTHOR:</b>	<b>Qadar Zada</b> Deputy Chief Operating Officer	<b>PRESENTER</b>	<b>Karen Kelly</b> Chief Operating Officer
<b>CLINICAL STRATEGIC AIMS</b>			
<i>Develop integrated care provided locally to enable people to stay at home or be treated as close to home as possible.</i>		<i>Strengthen hospital-based care to ensure high quality hospital services provided in the most effective and efficient way.</i>	<i>Provide specialist services to patients from the Black Country and further afield.</i>
<b>ACTION REQUIRED OF COMMITTEE :</b>			
<b>Decision</b>	<b>Approval</b>	<b>Discussion</b>	<b>Other</b>
<b>N</b>	<b>N</b>	<b>Y</b>	<b>N</b>
<b>RECOMMENDATIONS:</b>			
To note and discuss the current performance against KPIs.			
<b>CORPORATE OBJECTIVE:</b>			
<b>SO1: Deliver a great patient experience</b> <b>SO2: Safe and Caring Services</b> <b>SO4: Be the place people choose to work</b> <b>SO5: Make the best use of what we have</b> <b>SO6: Deliver a viable future</b>			
<b>SUMMARY OF KEY ISSUES:</b>			
<b>Performance</b>  <b>EAS</b> The August position for performance is below the expected Emergency Access Standard and the Trust has achieved a combined performance of 92% for the month of August.  The other main contributory factor to our decreased EAS position is the following: <ol style="list-style-type: none"> <li>4 Hour Wait August's performance for type 1 has decreased from 93.41% to 84.17%, please note that patients move to RED Zone now have their discharge time amended to the time they were move to RED Zone</li> <li>ED Attendances (excluding &lt;16's) for August has increased over July, but is still not back to pre COVID levels of attendances (walk-in, WMAS, referrals). However, WMAS activities in August'2020 were very similar to WMAS attendances from August 2019.</li> <li>Emergency admissions from ED by age (excludes those aged 16 and under) August has decreased slightly over July, but we have had an increase in acutely and sub-acute patients.</li> </ol>			

4. Number of patients arriving by ambulance has increased slightly from last month, the long term trend is still up, but not back to pre COVID levels Dec'19 – Feb'20, however, nearly the same as last year 2019 WMAS attendances in ED 2019.
5. Age ranges visits all have increased disproportionately against acuity of presentations – highest acuity measured for cohort 35-55 (M+F).
6. Main breach reason for August was "A3-1 Capacity Issues - Bed Management" 417 followed by Diagnostics 153, please note that patients attending and subsequently moved to RED Zone with suspected COVID and breach will be contained within the Breach reason A2-6

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



## DM01

In August, the Trust achieved 70% of diagnostics tests carried out within six weeks wait against the national operational standard of 99 per cent. There were total of 2,262 patients who waited more than 6 weeks for their test.

This is a 4% decline in performance compared to last month with 138 more breaches. The performance issues in Ultrasound are the cause of this and there is already a recovery plan in place that will address the DM01 underperformance by December.

MRI, CT and DEXA performance are all showing recovery based on updates to the model and better understanding of the assumptions behind it. Overall DM01 recovery is now showing compliance against the target by February 2021.

## **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 and doctor.
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 10<sup>th</sup> 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 4<sup>th</sup> room planned to be in place by 28<sup>th</sup> 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 8<sup>th</sup> Gastroenterologist 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 98%, 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 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 build confidence in presenting with symptoms at primary care.

This table shows the breakdown by specialty in August where referrals remain significantly lower.

Two-Week Wait Comparison 2019 vs 2020		
Ca Site	2019	2020
Brain	7	3
Breast	345	312
Colorectal	287	213
Gynaecology	145	100
Haematology	12	12
Head and Neck	115	88
Lung	9	10
Paediatric	8	3
Skin	432	329
Upper GI	141	139
Urology	150	108
Grand Total	1651	1317

## **Cancer PTL**

The table below shows the total patients on the PTL as of 17<sup>th</sup> September and the distribution across days on the pathway and by specialty – There are now 1,659 patients on the cancer PTL, which is an increase of 508 from previous month.

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 August the RTT position was 73%. This was an increase of 7% on the previous month and a reflection of the increase levels of activity seen as part of the Trusts restoration plans.

RTT incompletes continues to improve at a steady rate. In the Trust were 7<sup>th</sup> highest performing Trust nationally. This increased to 73% August and as of 17<sup>th</sup> September is just over 75%.

General Surgery – the number of ELA cases that undated over 40 weeks continues to drop and now stands at 53 from approximately 100 at start of September. Working with CSL to pool cases to next available list

Urology – The number of ELA over 40 weeks undated has dropped from 15 to 2. General clinics continue to be delivered virtually

Ophthalmology – delivering virtual clinic 40% which reduces the strain on face to face clinics due to social distancing. Theatres list have restored back – utilisation remains lower than Pre-Covid due to Covid guidance. Dating longest waiters with risk of 52 week breaches mitigated with the restoration plan. Anticipate a steady rate of increase in performance. Longest waiting for injections also taking place at Corbett and RHH

Oral – dating longest waiters first. Significant amount of 52 week breaches at month end avoided. Long waits remain a challenge due to single consultant service. New starter starting in November/December to increase capacity. Oral has significant constraints due to Covid guidance and APG. Having a low number of referrals that skewing data.

Plastics – Additional 9 lists performed in August which is reflected in the increase in performance. Plans for October weekend lists for LA lists. Challenges remain with GA lists which being reviewed within Divisional allocation. Additional 90 slots in outpatients in September which has supported recovery and cancer. Exploring use of Cinapsis as part of the Outpatient strategy.

T+O – Increase in performance in August due to longest waiters being dated. Additional space at Ramsey given to T+O to support loss of activity at Corbett. T+O remain a number of lists down, which would be mitigated by Stourside in part for moving Day Case activity to IS. This is not agreed nationally and escalated to COO. Delivering additional OP capacity also virtual OP being delivered

## **Out Patients**

DNA rate for the Trust in August 2020 is 12%

Outpatient steering group remains active and attended by all divisions. RAS phase 3 going live as well as Patient initiated Follow up. Social distancing remains a constraint and services being delivered virtually where clinically appropriate. Specialty virtual performance as below:

ENT 26%  
Ophthalmology 57%  
Oral 20%  
Plastic 18%  
T+O 39%  
Breast 5%  
Colorectal 74%  
General Surgery 60%  
Urology 28%  
Vascular 50%  
Pain 90%  
Gynae 20%  
Paeds – 60%

## **Theatres**

Theatre Utilisation is at 65% for Day Cases, 82% for main and 87% for Trauma for August 2020  
Theatre utilisation remains a challenge due to Covid guidance impacting turnaround times. Staffing within Theatres is a significant constraint and has deteriorated in September due to covid related sickness/special leave. This has resulted in elective and emergency capacity being cancelled. Divisional Chief Nurse aware of constraints and shifts escalated to Chief Nurse

## **Cancelled Operations**

Cancelled Operations is at 0.7% with 2, 28 day rule breaches in August 2020. Elective performance remains above Phase 3 plan

Day Case activity increase is reliant on Stourside and use of IS.  
Cancelled operations have been seen in September due to staffing sickness and patients being more complex.

Theatre improvement group to start in September 2020  
Restart of theatre meeting remains in place picking up restoration plan and continued recovery

<b>IMPLICATIONS OF PAPER:</b> Risks identified in this paper are linked to the risk (BAF 1b)			
<b>IMPLICATIONS FOR THE CORPORATE RISK REGISTER OR BOARD ASSURANCE FRAMEWORK</b>			
<b>RISK</b>	<b>Y</b>		<b>Risk Description:</b> 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
	<b>Risk Register: Y</b>		Risk Score: BAF 1B – Risk score 15 (AMBER)
<b>COMPLIANCE and/or LEGAL REQUIREMENTS</b>	<b>CQC</b>	<b>N</b>	<b>Details:</b>
	<b>NHSI</b>	<b>N</b>	<b>Details:</b>
	<b>Other</b>	<b>N</b>	<b>Details:</b>
<b>REPORT DESTINATION</b>	<b>EXECUTIVE DIRECTORS</b>	<b>Y</b>	<b>DATE: 15<sup>th</sup> September 2020</b>
	<b>WORKING GROUP</b>	<b>N</b>	<b>DATE:</b>
	<b>COMMITTEE</b>	<b>Y</b>	<b>DATE: Finance Committee 24 September 2020</b>



# Integrated Performance Report - Board



October 2020 Meeting - August 2020 Data

Created by: Informatics

Title of report: Integrated Performance Report

Executive Lead: Performance Chief Operating Officer - Karen Kelly

## Guide to Icons on SPC Charts.

### ICONS

Where KPIs are unsuitable to be produced as a SPC Chart the following icon will appear



The key below is for SPC suitable KPIs

Variation				Assurance			
Special Cause - Concern		Special Cause - Note/Investigate		Common Cause Variation	Consistently hit target	Hit and miss target / subject to random	Consistently miss target
High	Low	High	Low				

**Special Cause Concern** – this indicates that special cause variation is occurring, with the variation being in an adverse direction

Low (**L**) indicates that the variation is downwards in a KPI where performance is ideally above a target line, e.g. RTT. High (**H**) is where the variance is upwards for a below target line KPI, e.g. DNA Rate.

**Special Cause Note** - this indicates that special cause variation is occurring, with the variation being in a favourable direction

High (**H**) indicates that the variation is upwards in a KPI where performance is ideally above a target line, e.g. RTT. Low (**L**) is where the variance is downwards for a below target line KPI, e.g. DNA Rate.

For Non-SPC KPIs or measures the following icons will be used.

Met the target	Missed the target	No Target



# Performance - KPIs Summary

Executive Lead: Karen Kelly

## KPI SUMMARY

	METRIC	TARGET	ACTUAL	VARIATION	ASSURANCE
PERFORMANCE	Cancer Reporting - TRUST (provisional)				
	All Cancer 2 week waits	93%	98.09%		
	2 week wait - Breast Symptomatic	93%	90.91%		
	31 day diagnostic to 1st treatment	96%	93.20%		
	31 day subsequent treatment - Surgery	94%	93.75%	2%	
	31 day subsequent treatment - Drugs	94%	83.33%	-2%	
	62 day urgent GP referral to treatment	85%	63.57%		
	62 day screening programme	90%	100.00%		
	62 day consultant upgrades	85%	96.25%		
	Referral to Treatment				
	RTT Incomplete Pathways - % still waiting	92%	73%		
	RTT Incomplete - Cardiology	92%	59%		
	RTT Incomplete - Dermatology	92%	68%		
	RTT Incomplete - ENT	92%	70%		
	RTT Incomplete - Gastroenterology	92%	76%		
	RTT Incomplete - General Medicine	92%	53%		
	RTT Incomplete - Gynaecology	92%	33%		
	RTT Incomplete - General Surgery	92%	72%		
	RTT Incomplete - Geriatric Medicine	92%	100%		
	RTT Incomplete - Neurology	92%	81%		
	RTT Incomplete - Ophthalmology	92%	92%		
	RTT Incomplete - Oral Surgery	92%	76%		
	RTT Incomplete - Other	92%	90%		
	RTT Incomplete - Plastic Surgery	92%	87%		



## Performance - KPIs Summary

Executive Lead: Karen Kelly

### KPI SUMMARY

METRIC	TARGET	ACTUAL	VARIATION	ASSURANCE
RTT Incomplete - Respiratory	92%	69%		
RTT Incomplete - Rheumatology	92%	83%		
RTT Incomplete - T&O	92%	84%		
RTT Incomplete - Urology	92%	75%		
RTT Admitted - % treatment within 18 weeks	90%	69%		
RTT Non Admitted - % treatment within 18 weeks	95%	73%		
Wait from referral to 1st OPD	26	18		
Wait from Add to Waiting List to Removal	39	42		
ASI List (Month End)	-	2689		
% Missing Outcomes RTT	-	0.03%		
% Missing Outcomes Non-RTT	-	11.47%		
<b>DM01</b>				
% of Diagnostic tests waiting less than 6 weeks	99%	71%		
No. of Diagnostic tests waiting > 6 weeks (Month End)	0	2262	138	
<b>ED</b>				
ED 4 hour Waits Type 1 & 3 (ED + UCC)	95%	92%		
ED Admitted Patients Waiting Times - 95th Percentile	-	482		
ED Non Admitted Patients Waiting Times - 95th Percentile	-	285		
ED - Time to Initial Assessment - 95th Percentile	-	3		
ED Attendances Type 1	-	7806		
ED Attendances Type 1 & 3 (ED + UCC)	-	13014		
Left Without Being Seen	5%	0.8%		
Unplanned Re Attendances	5%	1.3%		
12 Hours Trolley Waits	0	0	0	



## Performance - KPIs Summary

Executive Lead: Karen Kelly

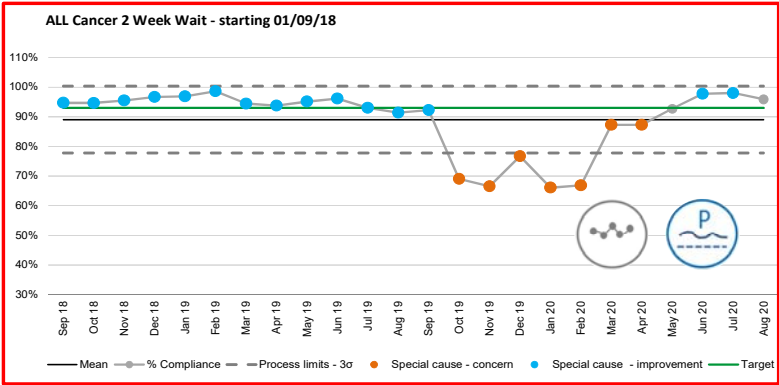
KPI SUMMARY					
METRIC		TARGET	ACTUAL	VARIATION	ASSURANCE
	Ambulance Convenyances	-	3396		
	Ambulance Turnaround Breasches 30-59 minute	-	109		
	Ambulance Turnaround Breasches 60+ minute	-	15		
	Cancelled Operations				
	% Cancelled Operations	1.0%	0.7%		
	Cancelled operations - breaches of 28 day rule	0	2	2	
	Urgent operations - cancelled twice or more	0	0	0	
	Theatre Utilisation				
	Theatre Utilisation - Day Case (RHH & Corbett)	N/A	65.1%		
	Theatre Utilisation - Main	N/A	82.3%		
	Theatre Utilisation - Trauma	N/A	86.8%		
	Average Length of stay (Quality Strategy Goal 3)				
	Average Length of Stay - Elective	N/A	2.8		
	Average Length of Stay - Non-Elective	N/A	4.4		
	Outpatient Referrals				
	GP Written Referrals - made	-	0	0	
	GP Written Referrals - seen	-	0	0	
	Other Referrals - Made	-	0	0	
	GP Discharge Letters				
	GP Discharge Letters	90%	0.7607	-13.86%	
	Outpatients				
	Outpatient Appointment DNA Rate	8%	12%		
	New/Follow Up Ratio	2.48	2.21		
	Clinic Utilisation	-	75%		
	Throughput / Flow				
	Patients Discharged with a LoS >= 7 Days	-	7.5%		



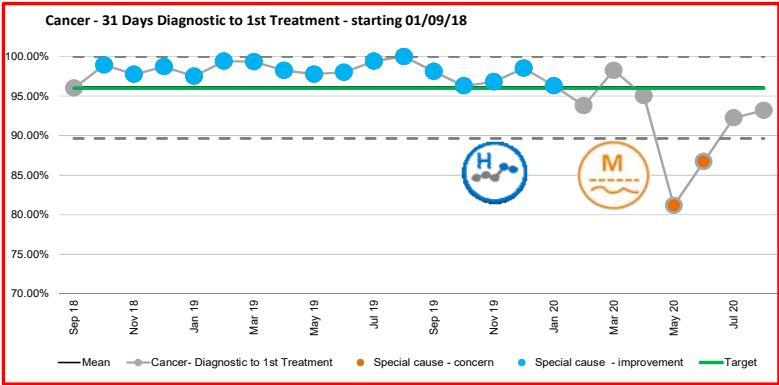
## Performance - KPIs Summary

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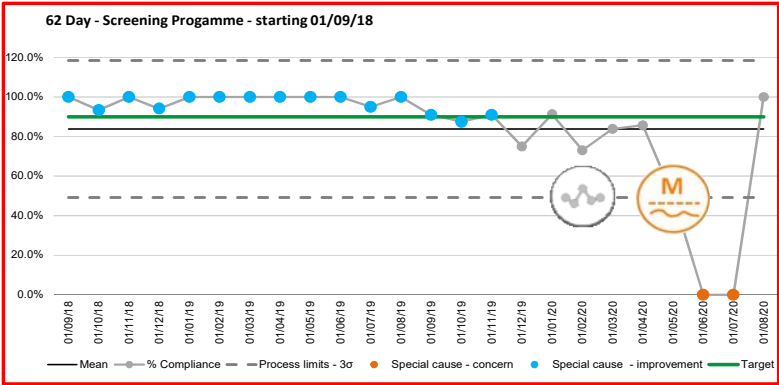
KPI SUMMARY					
METRIC	TARGET	ACTUAL	VARIATION	ASSURANCE	
Patients Discharged with a LoS >= 14 Days	-	3.0%		N/A	
7 Day Readmissions - PbR	-	3.2%	0.40%	SPC	
30 Day Readmissions - PbR	-	7.1%	4.27%	SPC	
DTOC Average Monthly by RAG Rating (Amber)	-	0	0	SPC	
DTOC Average Monthly by RAG Rating (Red)	-	0	0	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	-	218	80	SPC	
% Discharged by Midday	-	10.9%	-0.57%	SPC	
Bed Occupancy - %	95.0%		#VALUE!	SPC	
Bed Occupancy - % Medicine	95.0%		#VALUE!	SPC	
Bed Occupancy - % Surgery, W&C	95.0%		#VALUE!	SPC	
Bed Occupancy - Paediatric %	95.0%		#VALUE!	SPC	
Bed Occupancy - Orthopaedic Elective %	95.0%		#VALUE!	SPC	
Bed Occupancy - Trauma and Hip %	95.0%		#VALUE!	SPC	



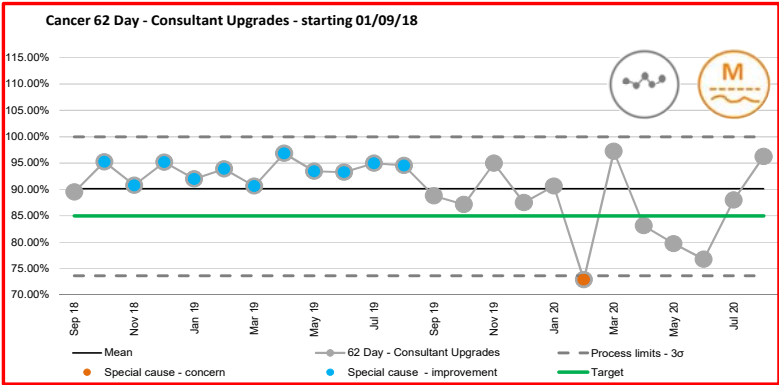
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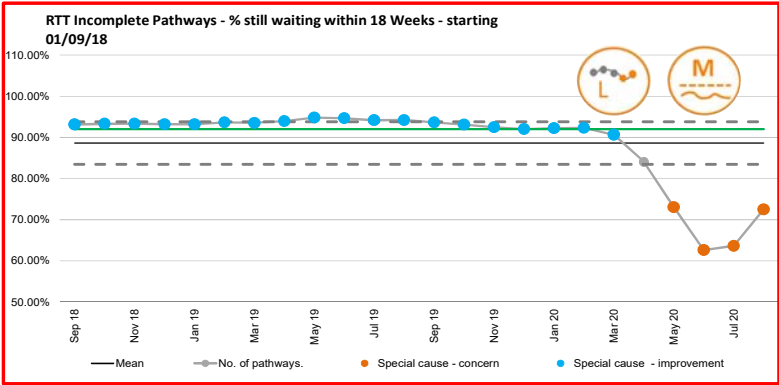
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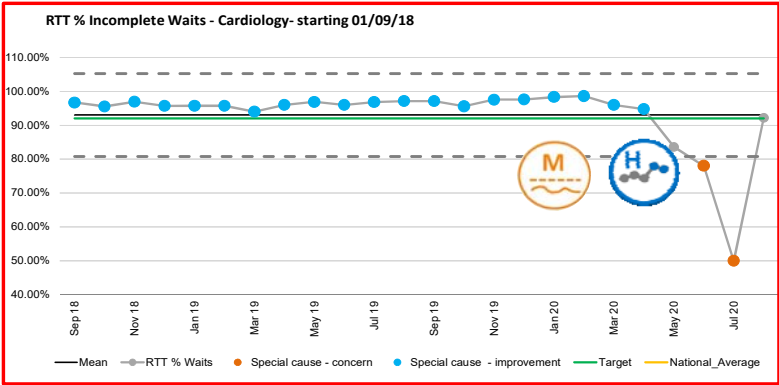
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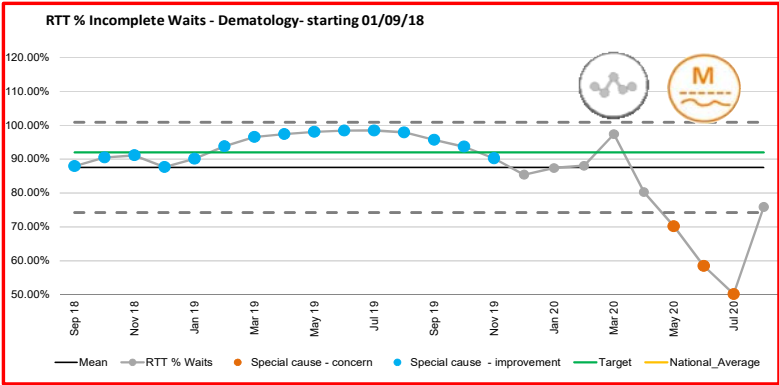
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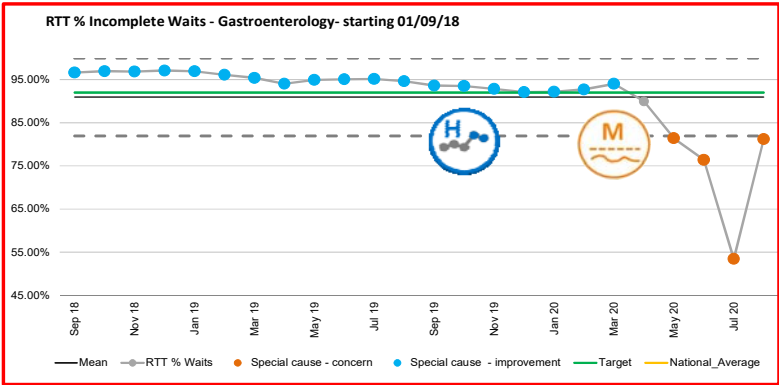
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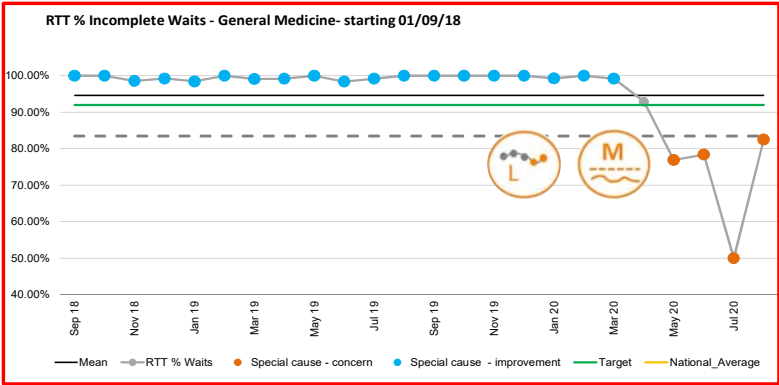
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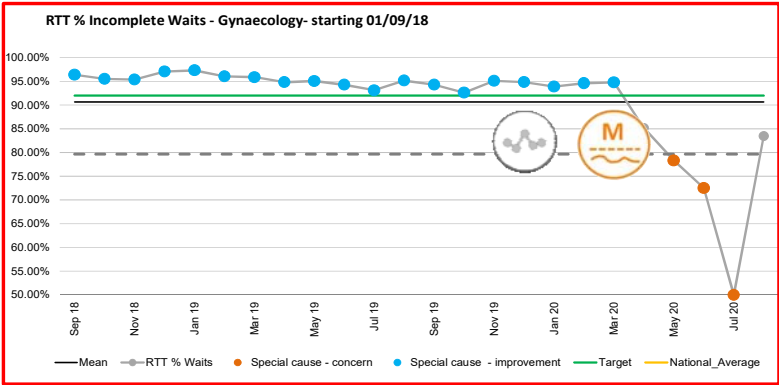
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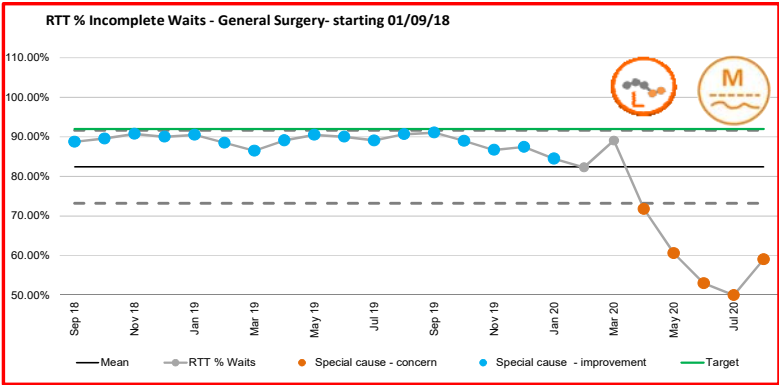
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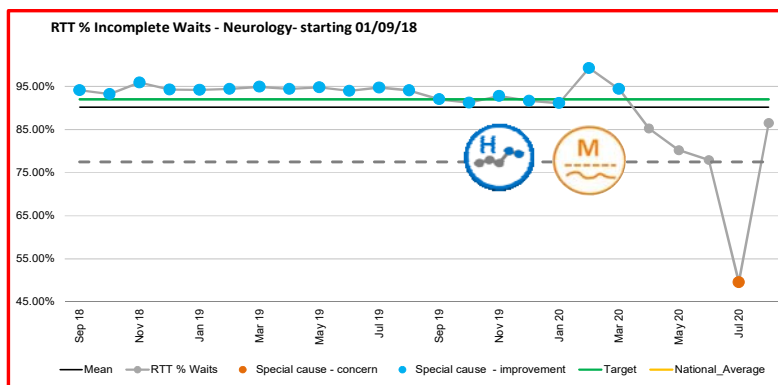


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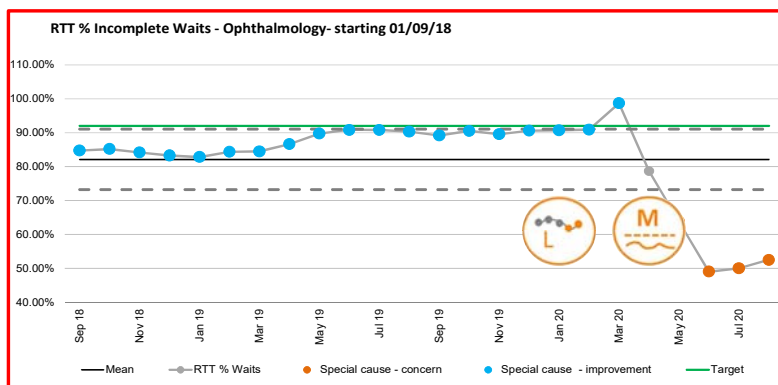


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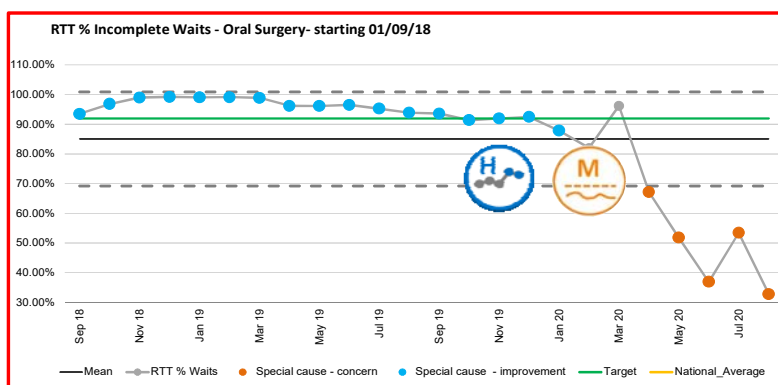
## Performance Matters (KPIs)



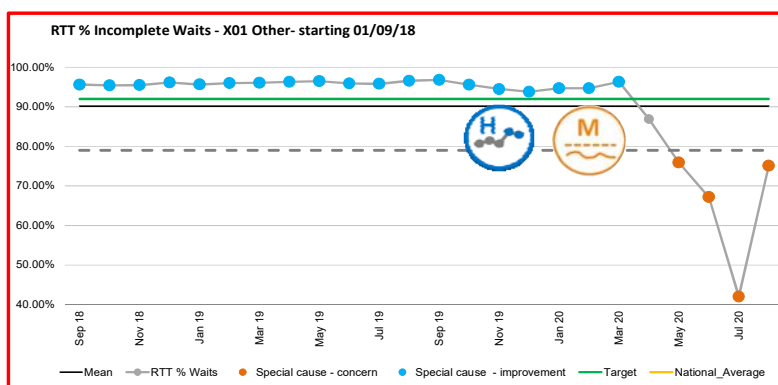
No Narrative Given



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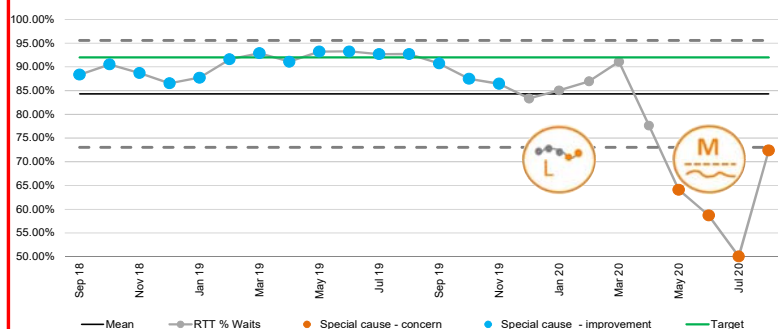


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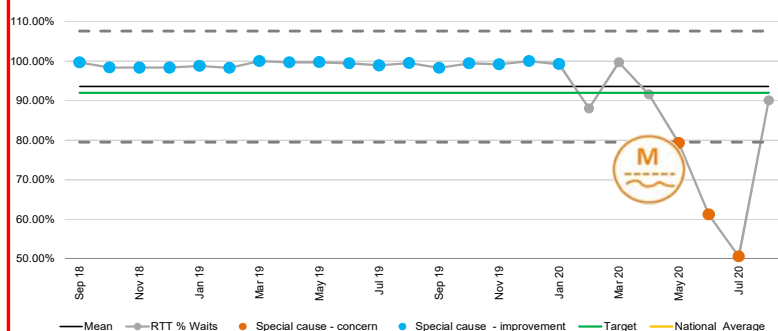
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RTT % Incomplete Waits - Plastic Surgery- starting 01/09/18



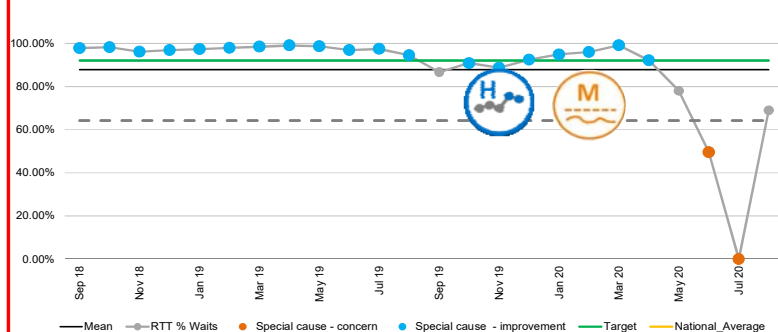
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RTT % Incomplete Waits - Respiratory Medicine- starting 01/09/18



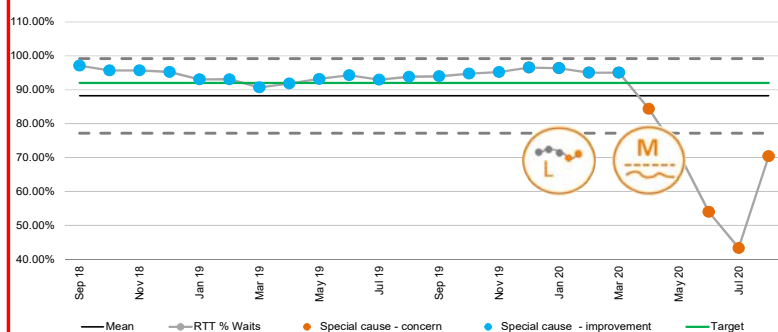
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RTT % Incomplete Waits - Rheumatology- starting 01/09/18

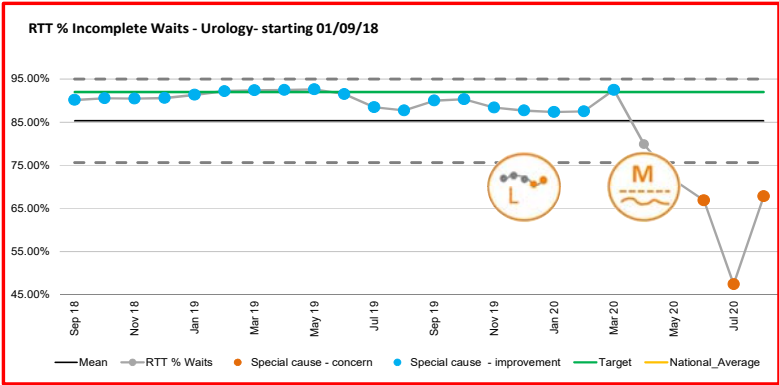


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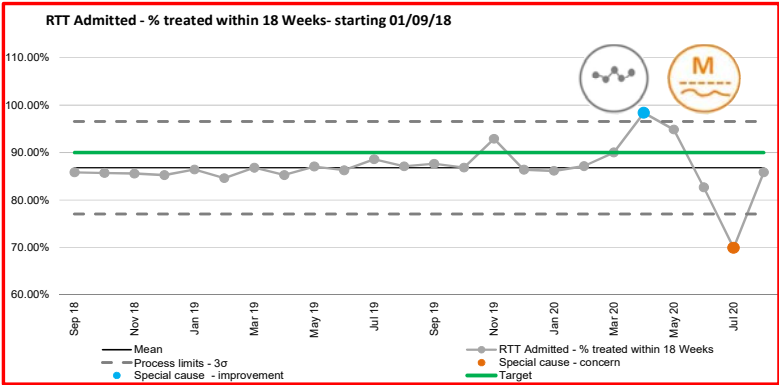
RTT % Incomplete Waits - T &amp; O- starting 01/09/18



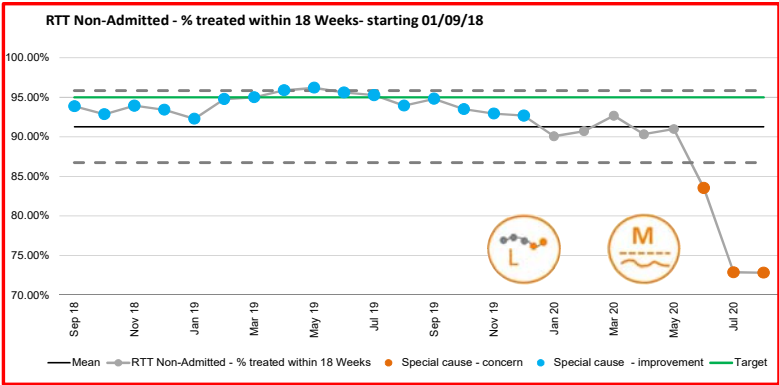
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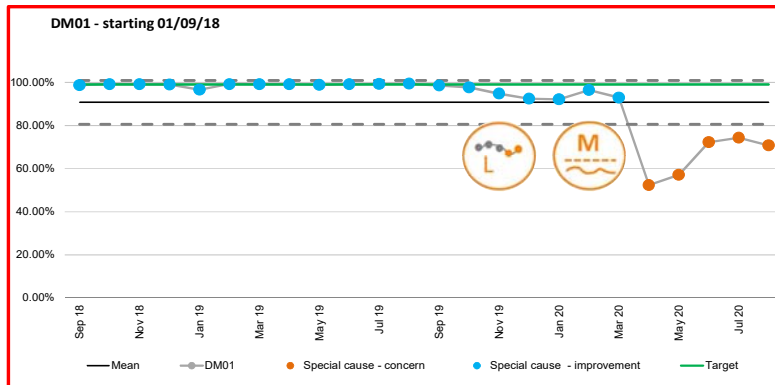


No Narrative Given



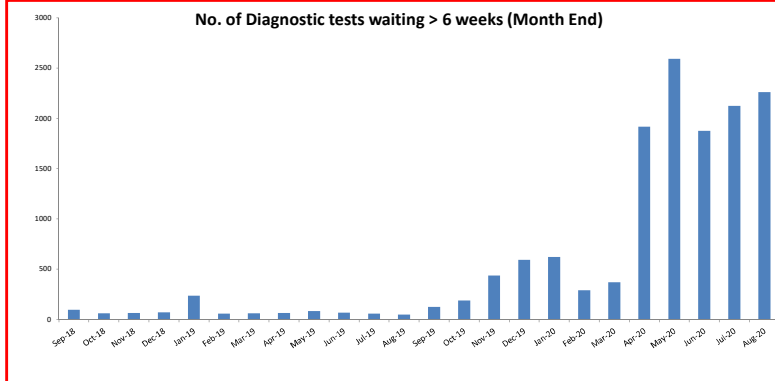
No Narrative Given

## Performance Matters (KPIs)



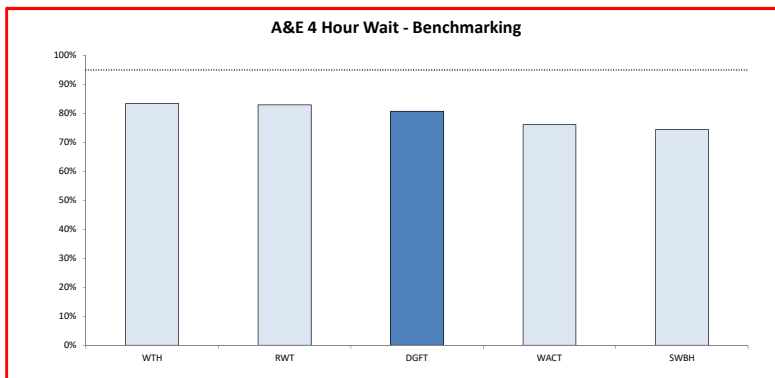
In August, the Trust achieved 70.80 per cent of diagnostics tests carried out within six weeks wait against the national operational standard of 99 per cent. There were total of 2262 patients who waited more than 6 weeks for their test. This is a 4% decline in performance compared to last month with 138 more breaches. The performance issues in Ultrasound are the cause of this and there is already a recovery plan in place that will address the DM01 underperformance by December. MRI, CT and DEXA performance are all showing recovery based on updates to the model and better understanding of the assumptions behind it. Overall DM01 recovery is now showing compliance against the target by February 2021.

SPE

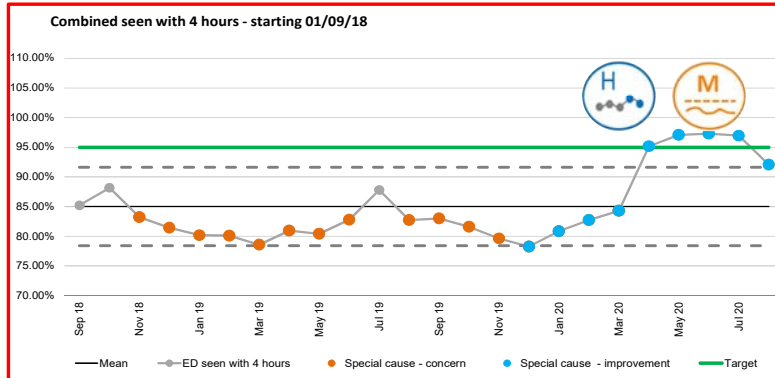


No Narrative Given

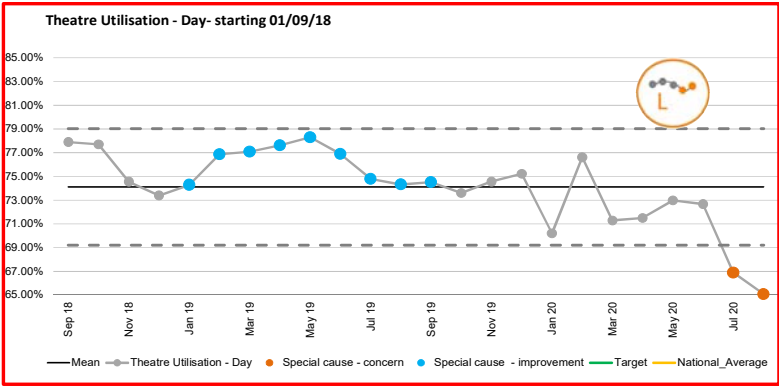
SPE



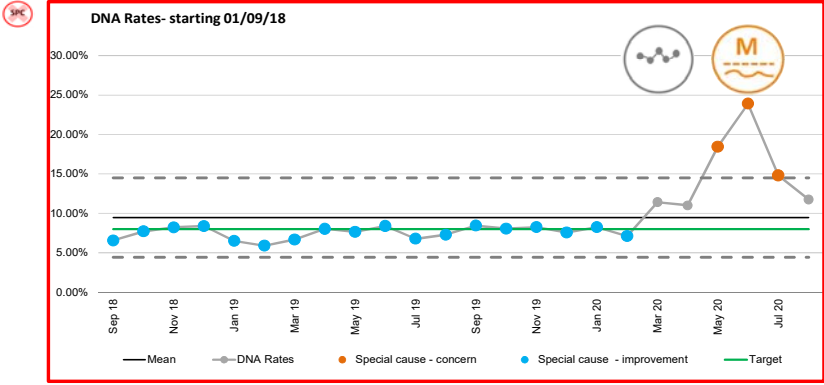
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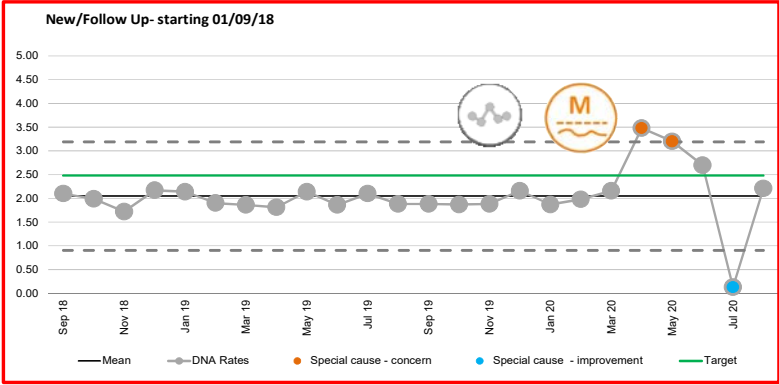
4 Hour Wait August's performance for type 1 has decreased from 93.41% to 84.17% if you include our type 3 (UCC) this increases to 90.78%, therefore the graph is wrong in the F&P report. ED Attendances (excluding <16's) for August has increased over July, but is still not back to pre COVID levels Number of patients arriving by ambulance has increased slightly from last month, the long term trend is still up, but not back to pre COVID levels Main breach reason for August was "A3-1 Capacity Issues - Bed Management" 417 followed by Diagnostics, please note that patients attending and subsequently moved to RED Zone with suspected COVID and breach will be contained within the Breach reason A2-6 these include patients that have their discharge time amended to enable us to track their breach before amendment. Improvement Plans: Implement RAT Model in ED - anticipated start by end Sep'20 Implement Emergency Observation Unit by end of Oct'20 We have implemented ED Consultant till 24 o'clock from August'20 We have recruited to all ED Consultants vacancies - all in place and shadow rota developed to be activated in an event of spike in COVID19 attendances, therefore ED will have a reciprocal response ED Nursing is recruiting actively to all ED Nursing Vacancies. Commenced regular Meetings with Surgery and Diagnostics to minimise / improve their support to ED



Theatre Utilisation remains a challenge due to covid guidance impacting turnaround times. Staffing within Theatres is a significant constraint and has deteriorated in September due to covid related sickness/special leave. This has resulted in elective and emergency capacity being cancelled. Divisional Chief Nurse aware of constraints and shifts escalated to Chief Nurse



No Narrative Given



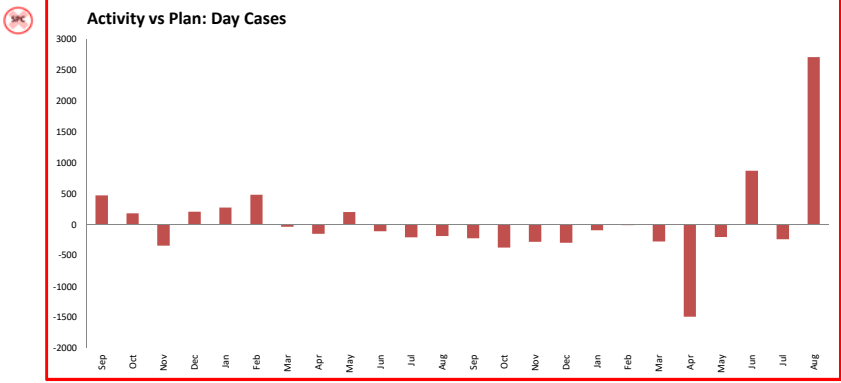
Outpatient steering group remains active and attended by all divisions. RAS phase 3 going live as well as Patient initiated Follow up. Social distancing remains a constraint and services being delivered virtually where clinically appropriate. Specialty virtual performance as below:

- ENT 26%
- Ophthalmology 57%
- Oral 20%
- Plastic 18%
- T+O 39%
- Breast 5%
- Colorectal 74%
- General Surgery 60%
- Urology 28%
- Vascular 50%
- Pain 90%
- Gynae 20%
- Paeds – 60%

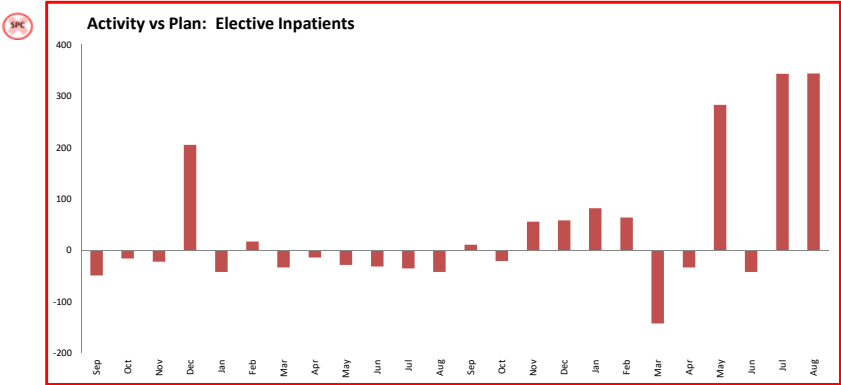


In Month	18/19	19/20	19/20	Variance	%
	Actual	Plan	Actual		
Elective Day cases	3,786	3,867	3,667	-200	-5%
Elective Inpatients	448	504	471	-33	-7%
Elective Total	4,234	4,371	4,138	-233	-5%
Non Elective	3,670	4,156	4,135	-21	-1%
Outpatients	42,189	43,444	41,168	-2276	-5%
Maternity Pathway	310	331	305	-26	-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					

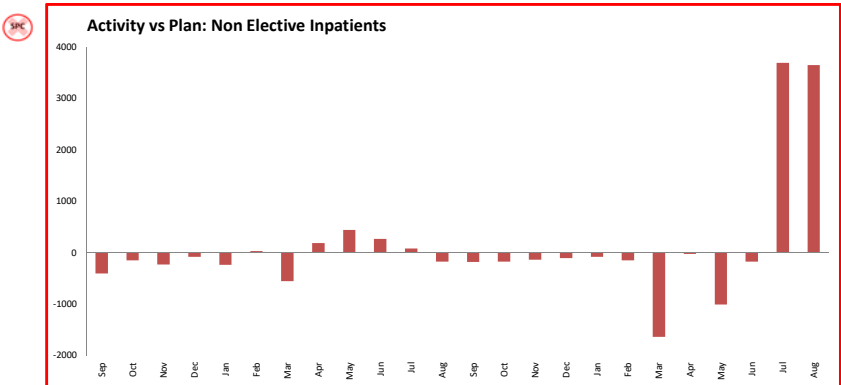
No Narrative Given



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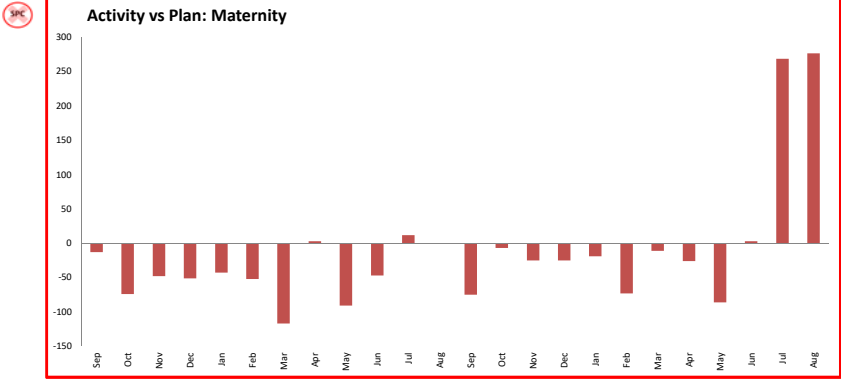


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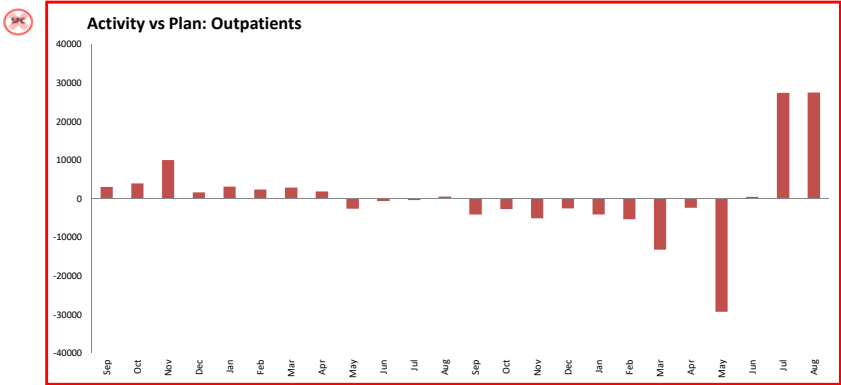


No Narrative Given

Performance Matters

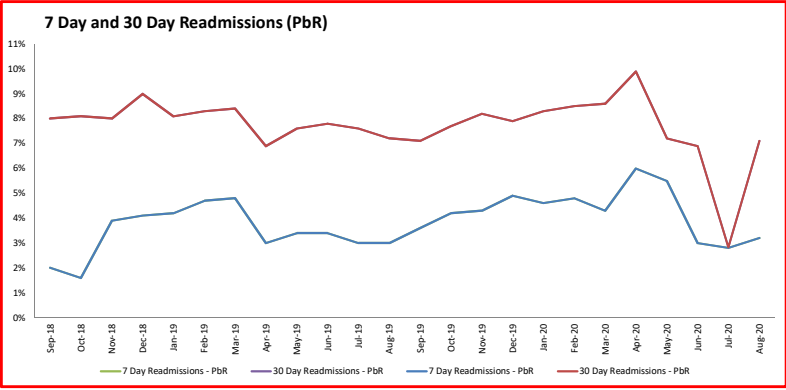


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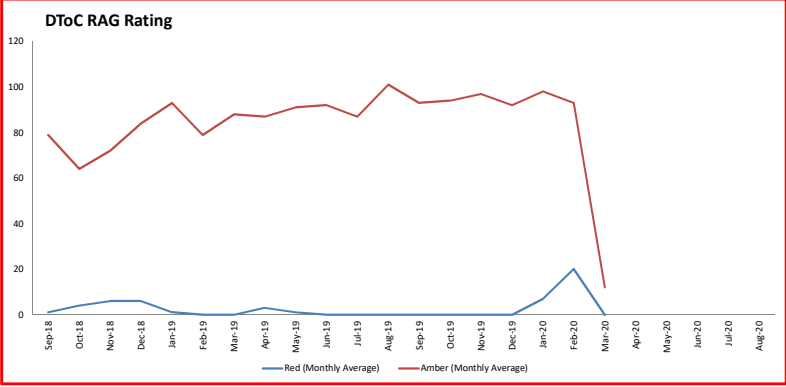


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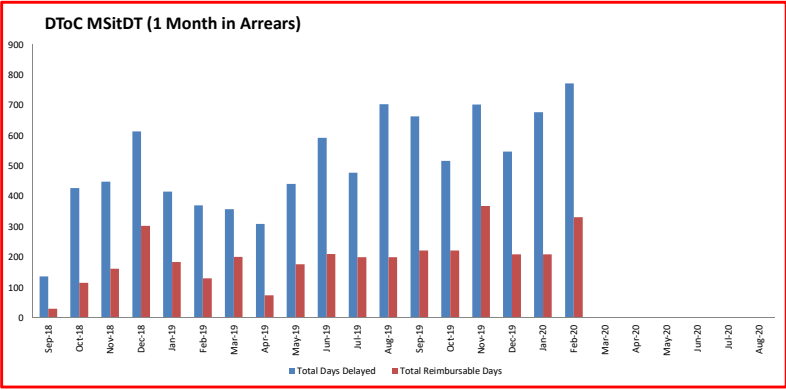
Performance Matters



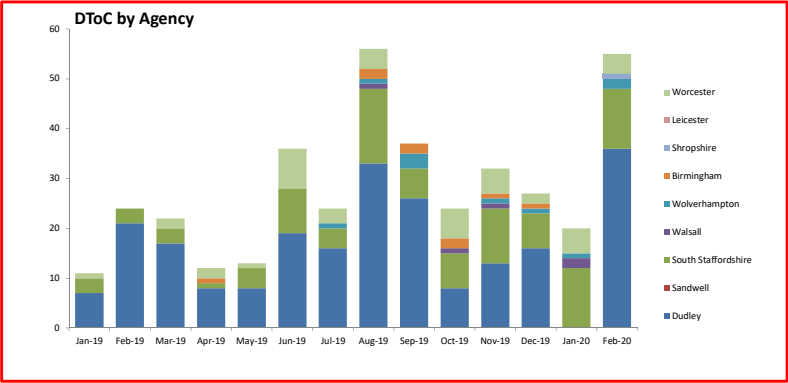
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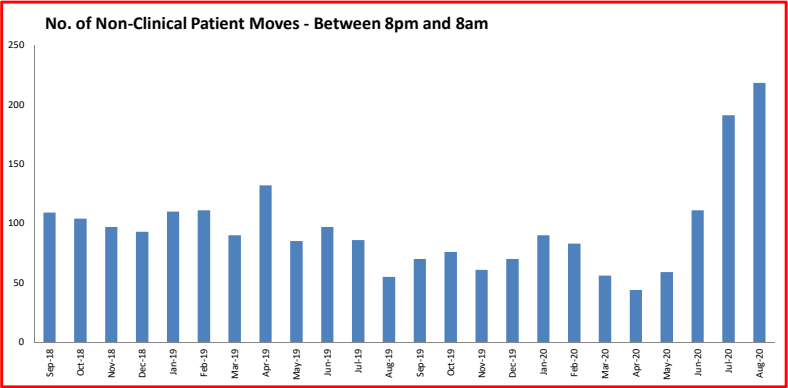
MSitDT has been suspended Unitl March 2021



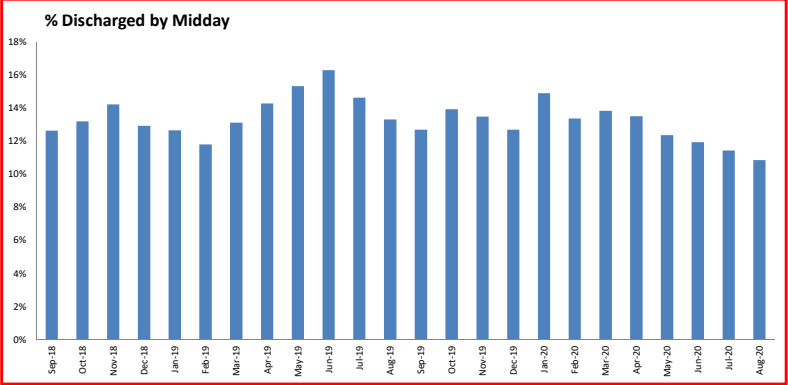
MSitDT has been suspended Unitl March 2021



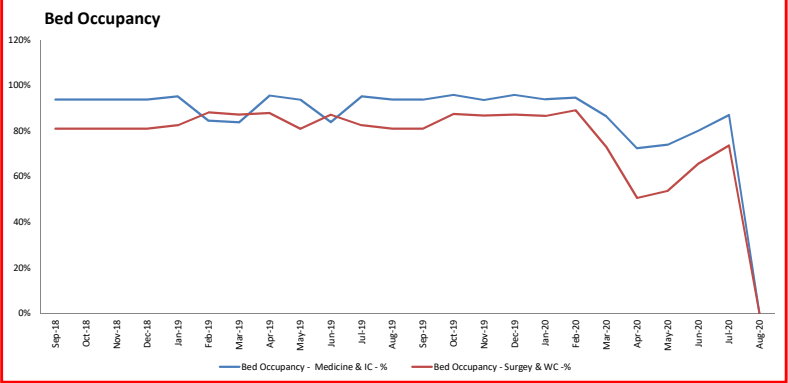
MSitDT has been suspended until March 2021



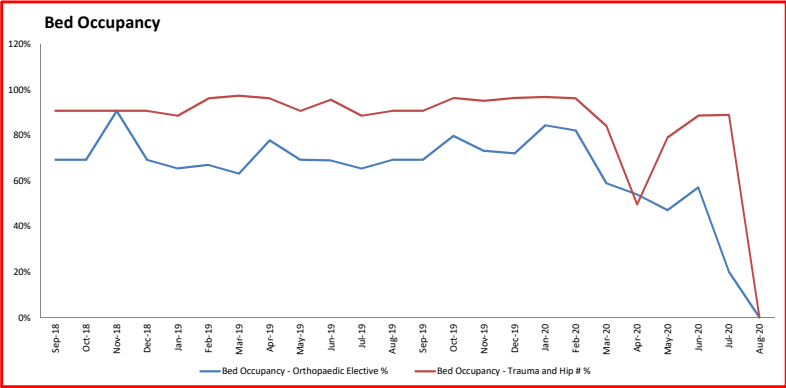
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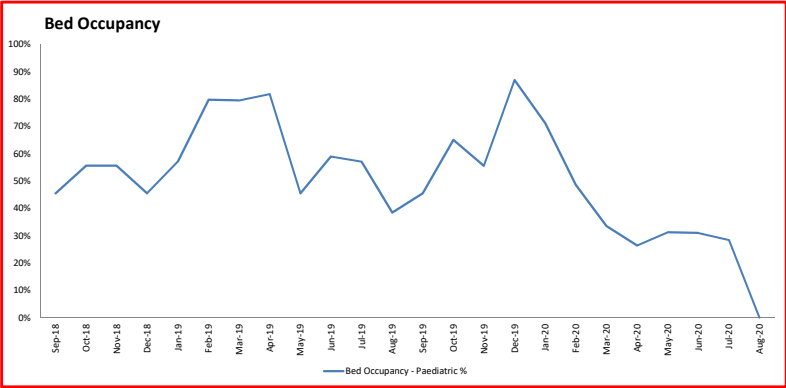
No Narrative Given



No Narrative Given



No Narrative Given



No Narrative Given

**Paper for submission to the Board of Directors**  
**Thursday 8 October 2020**

<b>TITLE:</b>	<b>Deep Dive – Restoration and Recovery of services post COVID-19</b>		
<b>AUTHOR:</b>	Qadar Zada, Deputy Chief Operating Officer	<b>PRESENTER</b>	Karen Kelly Chief Operating Officer
<b>CLINICAL STRATEGIC AIMS</b>			
<i>Develop integrated care provided locally to enable people to stay at home or be treated as close to home as possible.</i>		<i>Strengthen hospital-based care to ensure high quality hospital services provided in the most effective and efficient way.</i>	<i>Provide specialist services to patients from the Black Country and further afield.</i>
<b>ACTION REQUIRED OF COMMITTEE</b>			
<b>Decision</b>	<b>Approval</b>	<b>Discussion</b>	<b>Other</b>
<b>N</b>	<b>N</b>	<b>Y</b>	<b>N</b>
<b>RECOMMENDATIONS</b>			
<ul style="list-style-type: none"> <li>To note the report</li> </ul>			
<b>CORPORATE OBJECTIVE:</b>			
<b>SO1: Deliver a great patient experience</b> <b>SO2: Safe and Caring Services</b> <b>SO4: Be the place people choose to work</b> <b>SO5: Make the best use of what we have</b> <b>SO6: Deliver a viable future</b>			
<b>SUMMARY OF KEY ISSUES:</b>			
<ul style="list-style-type: none"> <li>The Trust is largely achieving planned activity level as submitted to NHSI</li> <li>All services out of 42 except for Bowel Screening have now been restored and there plans to restore this by October</li> <li>Breast Screening Services will be fully restored from October, and three of the four mobile vans will be modified to support COVID 19 rules</li> <li>Referral Assessment Service has been implemented successfully in some Specialties and as a result has seen an approximately 15-20% in SWC and up to 29% in MIC of referrals rejected/returned to GP with appropriate advice. Further Specialties to go live from October 2020. This will reduce activity numbers</li> <li>Out Patient First and Follow up activity is performing well against the R&amp;R trajectories. Latest figures indicate that Follow Up activity was at 101% against Pre- COVID trajectory of 88%. Elective activity has been impacted by COVID 19 restrictions such as social distancing and infection control Diagnostic activity is at 78% Pre-COVID levels. Further work in MRI &amp; CT will be undertaken</li> <li>The Trust has restored services as requested in the DOH Phase 2 letter (31.7.20)</li> </ul>			

- The Trust has responded to the requirements of the Phase 3 letter and highlighted the risks associated with delivery
- Performance at other Trust's is not available at this stage, however based on discussions held performance is comparable to other neighbouring Trust
- Capacity constraints continue to be highlighted, this is due to social distancing
- Endoscopy is the most vulnerable area for recovery if impacted by Covid wave 2 due to nature of procedure
- Performance is not linked to restoration of activity levels in its entirety and therefore it must be noted that delivery of activity does not relate to delivery of constitutional standards
- Delivery of activity levels to Pre-COVID levels may not be necessary provided that services are restored fully, accessed correctly and waiting times are acceptable, this is because the way services are being delivered has changed
- The Day Case rate is anticipated to increase from October assuming that the new Day Case unit "Stourside" at Ramsey is included in national contract. This is vital for phase 3 recovery

#### IMPLICATIONS OF PAPER:

#### IMPLICATIONS FOR THE CORPORATE RISK REGISTER OR BOARD ASSURANCE FRAMEWORK

- Risks associated with the restoration and recovery plan are detailed in the report

<b>RISK</b>	<b>Y</b>		<b>Risk Description: BAF RISK 1B</b>
	<b>Risk Register: N</b>		<b>Risk Score: 15</b>
<b>COMPLIANCE and/or LEGAL REQUIREMENTS</b>	<b>CQC</b>	<b>Y</b>	<b>Details: Safe, Effective, Caring, Responsive, Well Led</b>
	<b>NHSI</b>	<b>Y</b>	<b>Details: Phase 2 and Phase 3 letters</b>
	<b>Other</b>	<b>N</b>	<b>Details:</b>
<b>REPORT DESTINATION</b>	<b>Board of directors</b>	<b>Y</b>	<b>DATE: 8 October 2020</b>
	<b>WORKING GROUP</b>	<b>N</b>	<b>DATE:</b>
	<b>COMMITTEE</b>	<b>N</b>	<b>DATE:</b>

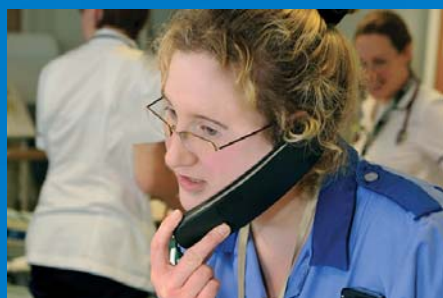
**NHS**

**The Dudley Group**  
NHS Foundation Trust

# Recovery & Restoration Deep Dive

September 2020

**Karen Kelly, Chief  
Operating Officer**



## Phase 3 Recovery means Activity ...

**NB-The Recovery & Restoration trajectory does not relate to constitutional performance standards**

- NHSI required Providers to submit plans to NHSI to detailing trajectory for return to pre-Covid activity for :
  - ❖ Outpatients New & Follow-up, 80% for September
  - ❖ Day case activity, 80% for September
  - ❖ Overnight elective activity, 80% for September
  - ❖ Diagnostic activity , swiftly returning to 90 % and to 100% by October for :
    - ☐ MRI,
    - ☐ Computer tomography (CT)
    - ☐ Endoscopy
    - ☐ Non-obstetric ultrasound



# Black Country Activity Submission Comparison



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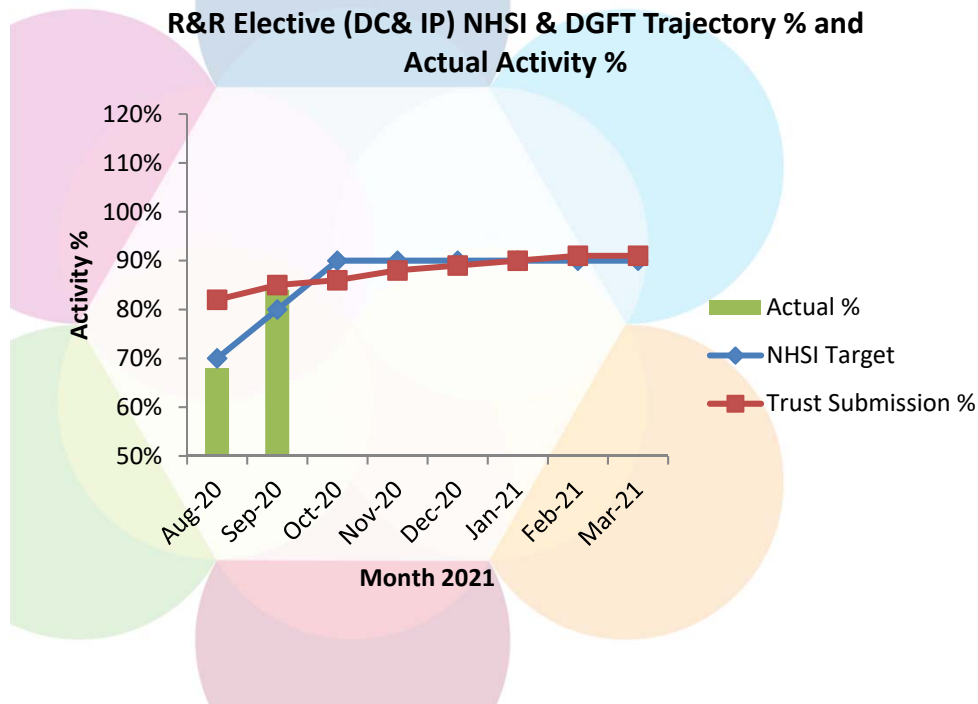
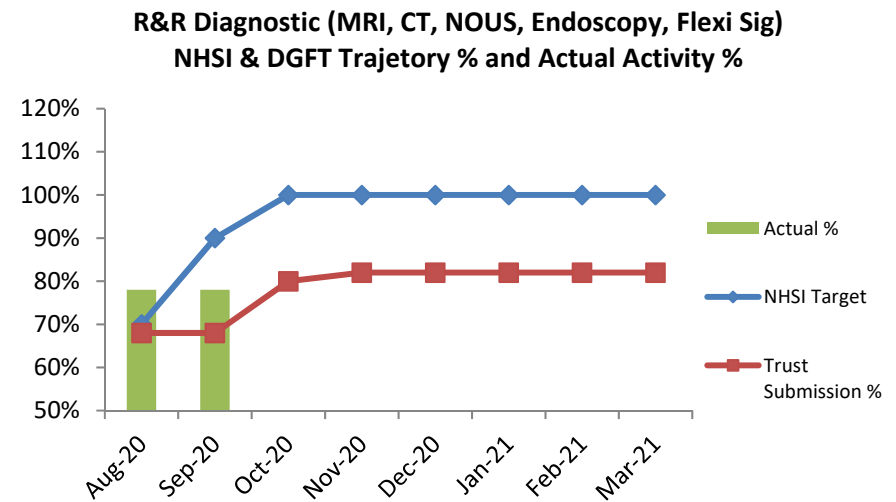
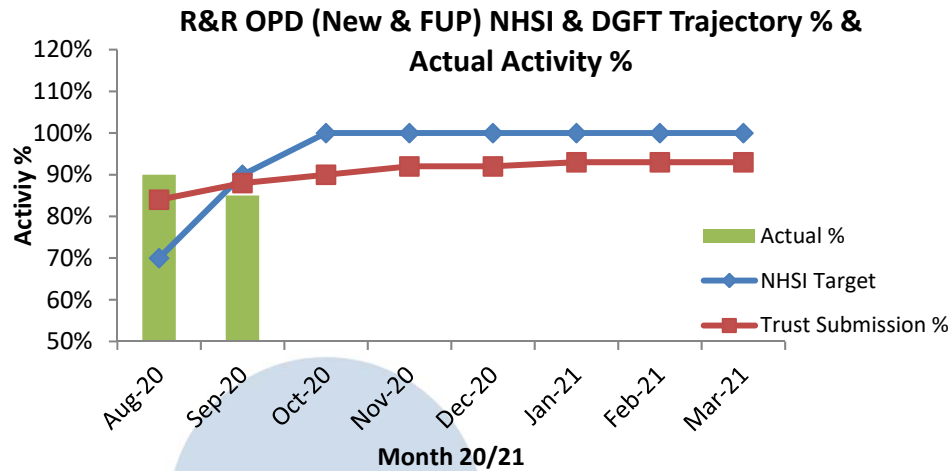
Title	WHT	SWB	RWHT	DGFT
RTT				
Outpatients				
Consultant-led first outpatient attendances (face-to-face)	87%	78%	71%	67%
Consultant-led follow-up outpatient attendances (face-to-face)	90%	46%	45%	69%
Total Outpatient Attendances	86%	107%	80%	94%
Electives				
Day Case spells	57%	91%	84%	81%
Ordinary spells	71%	87%	93%	57%
Total Elective spells	59%	91%	85%	78%
Non Elective				
0 day length of stay	119%	104%	183%	104%
+1 length of stay - Non-COVID	83%	117%	130%	93%
Total Non elective admissions	98%	114%	144%	96%
Diagnostic Activity				
Diagnostic Tests - Magnetic Resonance Imaging	100%	90%	100%	92%
Diagnostic Tests - Computed Tomography	100%	113%	100%	95%
Diagnostic Tests - Non-Obstetric Ultrasound	82%	95%	63%	81%
Diagnostic Tests - Colonoscopy	80%	145%	100%	63%
Diagnostic Tests - Flexi Sigmoidoscopy	56%	135%	53%	27%
Diagnostic Tests - Gastroscopy	68%	115%	39%	40%
Cancer				
All patients urgently referred with suspected cancer by their GP who received a first outpatient appointment in the given month	95%	66%	111%	71%
Number of patients receiving first definitive treatment following a diagnosis within the month, for all cancers	59%	116%	79%	68%
Cancer 62 day pathways waiting 63 days or more after an urgent suspected cancer referral at the end of the reporting period	58%	108%	113%	181%



# Targets and Trajectories submitted to NHSI



**The Dudley Group**  
NHS Foundation Trust



NHSI	NHS improvement
OPD	Outpatients
FUP	Follow up
MRI	Magnetic resonance imaging
R & R	Restoration % recovery
CT	Computerised Tomography
NOUS	Non-Obstetric Ultrasound
Flexi - sig	Flexi sigmoidoscopy
DC	Day case
IP	Inpatient

## August achievement % is...

OPD-90%  
DC/Elective-68%  
Diagnostic-78%



## August Restoration Headlines

Activity against plan and performance, phase 3

August Activity	Pre-COVID Activity	Actual Activity	Planned Activity	% of August plan achieved	Phase 3 Delivery (Aug activity against 100% of pre-covid)
New	9,180	6,803	7,097	95.9%	74%
FU	14,723	13,941	13,320	104.7%	95%
Elective Inpatient	350	235	179	131.6%	67%
Day Case	3470	2,371	2,796	85%	68%
Diagnostics	8,398	6,875	6,848	100%	82%

- The Trust is broadly on plan
- Inpatient ,urgent, long waiters and cancer patients are being Prioritised ahead of day cases
- Approx. 3 week lag in reporting for diagnostics for Ramsay activity
- DGFT did not support full recovery against STP ask



## August Performance Challenges and remedial actions

D/C / Electives Specialities		Remedial Actions
Plastic Surgery	40 below plan	Increase WLI clinic s during September
		Increase clinic numbers in line with Social distancing
Ophthalmology	200 below plan	Ophthalmology slow to fully restore elective work <ul style="list-style-type: none"> <li>Recent agreement to increase operating and laser capacity from October</li> <li>Increases in injections planned from October</li> </ul>
		Conversion from outpatients coding delayed
Gastroenterology	50 below plan	Additional WLI clinics during September
		4th room for Endoscopy to increase capacity
		Change in clinical pathways to reduce number of unnecessary procedures



## September Restoration Headlines (Month to Date)

Activity against plan and performance, phase 3

September month to date	Pre-COVID Activity	Actual Activity	Planned Activity	% of September plan achieved	Phase 3 Delivery (Sept activity against 100% of pre-covid)	Phase 3 target for September
New	9,180	6,928	7,325	95.0%	75%	80%
FU	14,723	14,017	13,414	103.7%	95%	80%
Elective Inpatient	350	294	187	157.2%	84%	80%
Day Case	3470	2,394	2,843	85%	69%	80%
Diagnostics	8,398	6,510	6,848	95%	78%	90%

- Note: September is part month & not fully validated
- Pre-Covid levels of activity are increasing month on month & we are still on track
- Inpatient ,urgent, long waiters and cancer patients are being Prioritised ahead of day cases
- Approx. 3 week lag in reporting for diagnostics for Ramsay activity
- Staffing availability is reduced following increases in self isolation
- DGFT did not support full recovery against STP ask



# Summary

- The Trust is achieving planned activity level as submitted to NHSI in the main
- All services out of 42 except for Bowel Screening have now been restored and plans are to restore this by October
- Breast Screening Services will be fully restored from October, three of the four mobile vans will be modified to support COVID 19 rules
- Referral Assessment Service has been implemented successfully in some Specialties and as a result has seen an approximately 15-20% in SWC and up to 29% in MIC of referrals rejected/returned to GP with appropriate advice. Further Specialties to go live from October 2020. This will reduce activity numbers
- OPD First and Follow up activity is performing well against the R&R trajectories. Latest figures indicate that Follow Up activity was at 101% against Pre- COVID trajectory of 88%. Elective activity has been impacted by COVID 19 restrictions such as social distancing and infection control
- Diagnostic activity is at 78% Pre-COVID further work in MRI & CT will be undertaken.
- Endoscopy is the most vulnerable area for recovery if impacted by Covid wave 2 due to nature of procedure
- Performance is of course focused on the delivery of constitutional targets which must also be managed alongside the restoration of activity levels.

# R&R Risks

- Workforce availability, Vacancies and Recruitment
- COVID Wave 2
- Delivery of activity levels to Pre-COVID levels may not be necessary provided that services are restored fully, accessed correctly and waiting times are acceptable, this is because the way services are being delivered has changed, as detailed below
- The Day Case rate is anticipated to increase from October assuming that the new Day Case unit “Stourside” at Ramsey is included in national contract. This is vital for phase 3 recovery, Currently Stourside is not included – Trust would incur costs if used
- Further priority changes from NHSi/DOH

## Constitutional performance standards-July



The Dudley Group  
NHS Foundation Trust

Target	Target	August	Trajectory to delivery
Diagnostic tests within 6 weeks	99%	70%	Feb 21 (validated in March)
Cancer 2ww	93%	82%	November 20
31 day diagnosis to 1 <sup>st</sup> treatment	96%	95%	November 20
31 day subsequent treatment-surgery	94%	93%	November 20
31 day subsequent treatment-drugs	94%	83%	December 20
62 day urgent referral to treatment	85%	64%	March 21
104 days	Reduced from 233 (June)	44	>77% reduction
RTT incomplete	92%	73%	March 21
EAS	95%	91%	

Paper for submission to the Board of Directors  
on Thursday 8<sup>th</sup> October 2020

<b>TITLE:</b>	<b>Summary of Workforce and Staff Engagement Committee meeting on Tuesday 29<sup>th</sup> September 2020</b>		
<b>AUTHOR:</b>	Julian Atkins	<b>PRESENTER</b>	Julian Atkins
<b>CLINICAL STRATEGIC AIMS</b>			
<i>Develop integrated care provided locally to enable people to stay at home or be treated as close to home as possible.</i>		<i>Strengthen hospital-based care to ensure high quality hospital services provided in the most effective and efficient way.</i>	
<i>Provide specialist services to patients from the Black Country and further afield.</i>			
<b>ACTION REQUIRED OF COMMITTEE</b>			
<b>Decision</b>	<b>Approval</b>	<b>Discussion</b>	<b>Other</b>
	X	X	
<b>RECOMMENDATIONS</b>			
The Board to note the assurances provided by the Committee, the matters for escalation and the decisions made by the Committee.			
<b>CORPORATE OBJECTIVE:</b>			
SO3: Drive service improvement, innovation and transformation SO4: Be the place people choose to work SO5: Make the best use of what we have SO6: deliver a viable future			
<b>SUMMARY OF KEY ISSUES:</b>			
As detailed in the paper.			
<b>IMPLICATIONS OF PAPER:</b>			
<b>IMPLICATIONS FOR THE CORPORATE RISK REGISTER OR BOARD ASSURANCE FRAMEWORK</b>			
<b>RISK</b>	<b>Y</b>		<b>Risk Description:</b>
	<b>Risk Register: Y</b>		<b>Risk Score:</b>
<b>COMPLIANCE and/or LEGAL REQUIREMENTS</b>	<b>CQC</b>	<b>Y</b>	<b>Details:</b> Well Led
	<b>NHSI</b>	<b>Y</b>	<b>Details:</b> Annual Business Planning Process
	<b>Other</b>	<b>N</b>	<b>Details:</b>
<b>REPORT DESTINATION</b>	<b>EXECUTIVE DIRECTORS</b>	<b>Y/N</b>	<b>DATE:</b>

	<b>WORKING GROUP</b>	<b>Y/N</b>	<b>DATE:</b>
	<b>COMMITTEE</b>	<b>Y/N</b>	<b>DATE:</b>

## CHAIRS LOG

### UPWARD REPORT FROM WORKFORCE & STAFF ENGAGEMENT COMMITTEE - Date Committee last met:

29<sup>th</sup> September 2020

MATTERS OF CONCERN OR KEY RISKS TO ESCALATE	MAJOR ACTIONS COMMISSIONED/WORK UNDERWAY
<ul style="list-style-type: none"> <li>The level of nurse vacancies remains a significant concern for WSEC, as also highlighted in the September meeting of the Finance &amp; Performance Committee. There are currently over 400 registered nurse vacancies within the Trust, with acute staffing challenges in some areas. The Workforce Team, Nursing Teams and Divisional leadership Teams are working closely together to implement some immediate measures to reduce risks and alleviate the nurse staffing pressures. At the same time the Chief People Officer and Chief Nurse are rapidly developing a Nurse Resource Strategy, which will put in place sustainable medium-longer term measures to prevent this situation reoccurring, as it has over recent years. The Nurse Resourcing Strategy will address all of the key levers that impact on effective nurse staffing; recruitment, retention, development-career progression, resourcing inc e-rostering and action to create an effective nurse bank.</li> <li>Whilst the Workforce KPI Report highlights some improvements in mandatory training during August, compliance against Resus and Safeguarding continue to remain a concern for WSEC. WSEC received an outline plan from Andrew Boswell and William Dainty for addressing compliance in these areas during the remainder of the year. This plan was supported by the Divisional Directors, who committed to releasing staff to attend mandatory training. A set of recommendations, including additional resources and space was discussed, which will be picked up by the Executive Team for decision and action. This remains a key area of risk for WSEC, which will be reviewed at each meeting to ensure that the actions outlined are having the necessary impact and delivering an improved trajectory.</li> </ul>	<ul style="list-style-type: none"> <li>The DRAFT Dudley People Plan was shared with WSEC. This plan sets out the specific actions that will be delivered to realise the 5 people commitments that the Board approved in 2019. Furthermore, this plan will implement all of the 36 requirements that the new National People Plan places on individual providers. The final Dudley People Plan will be presented to the Trust Board in November for formal ratification. Ahead of presentation to the Board comments and inputs are being received from leaders, staff, Inclusion Networks, operational teams, professional teams as well as staff side organisations. The final DRAFT version of the Dudley People Plan will be presented to the WSEC meeting in October as part of the Deep-Dive into Employment Relations.</li> <li>WSEC received a full and positive update on the launch of the Disability Inclusion Network, following the launch meeting earlier this month which was supported by NHSI/E. The update also included a high-level summary of the work plan, including working towards achieving Disability Confident Leader (level 3) status, which will be reported into WSEC.</li> <li>Divisional colleagues presented their local staff engagement action plans and equality and inclusion priorities, this is a significant and positive development. These plans will be further strengthened and monitored through WSEC.</li> </ul>
POSITIVE ASSURANCES TO PROVIDE	DECISIONS MADE
<ul style="list-style-type: none"> <li>In response to a recent internal audit report, which highlighted a risk that some staff may be undertaking bank shifts for additional remuneration</li> </ul>	<ul style="list-style-type: none"> <li>WSEC were pleased to receive and approve the Quality Leadership / Line Manager Framework. This framework sets out the process and</li> </ul>

<p>whilst ‘owing’ the Trust contracted time, as indicated by a significant level of ‘un-used hrs’ within ward rosters – a detailed review has been undertaken by the Nursing and Workforce Team, led by the Divisional Chief Nurse for Surgery. A report detailing the review, along with a number of immediate recommendations was presented to WSEC. This report provides assurance that the ‘unused hrs’ within the rosters reflect historical issues with the rostering process/system, which have not been contemporaneously corrected. The report firmly concludes that “there is no evidence to support the assertion that staff may have unused contracted hrs and are then working bank shifts”. This report was positively received by the WSEC and recognised as being a robust piece of work. The WSEC also noted that the optimisation of e-rostering for all clinical staff groups is a key requirement of the new National People Plan, as well as the DRAFT Dudley People Plan. On this basis a programme of work is being launched by the Chief People Officer and Chief Nurse to accelerate the Trusts existing progress in rolling-out e-rostering to nurses, medical staff and AHP’s. Rolling out e-rostering to all clinical staff is a key part of the Trust’s strategy for address clinical workforce supply and capacity challenges. Capital funds are being made available for Trusts and systems to access to help inject greater pace into embedding e-rostering. The Trust will be submitting a bid for these capital monies.</p> <ul style="list-style-type: none"> <li>WSEC was pleased to receive a positive update from the Inclusion Network Chairs/representatives, for the LGBTQ+ and BAME Networks. WSEC was advised that the Networks have identified leads for major areas of work and are developing their ambitious work plans. It was also good to see that the Divisional Directors have engaged with the Networks to plan specific local actions/interventions to embed equality and inclusion. The Executive and NED Sponsors have also now met with Network Chairs, which has been well received. WSEC will receive monthly updates from the Inclusion networks.</li> </ul>	<p>arrangements that are being out in place to launch the new Managers Accreditation Programme. The framework received positive feedback from WSEC.</p> <ul style="list-style-type: none"> <li>The detailed arrangements for the Mentoring for Inclusion Go Live were presented, with the full support of the WSEC membership. It was encouraging to hear from the Inclusion Network Chairs that the Networks have already identified mentors to participate and that the Networks see the launch of the Mentoring programme as a step change in the Trusts approach to embedding cultural competence. The Divisions have also committed their support for the mentoring programme, particularly in releasing the staff to engage.</li> <li>The Committee received the final version of the Transitioning Guidelines for Managers to approve. The Transitioning Guidelines were presented by the newly appointed Gender Lead for the LGBTQ+ Inclusion Network (Jay). The WSEC recognise the launch of these guidelines as an important early success in the work programme for the LGBTQ+ Network. A comms release is being planned to support the launch of these guidelines.</li> </ul>
<p><b>Chair’s comments on the effectiveness of the meeting:</b></p> <p>I am pleased to say that the papers, contributions, and engagement at WSEC meetings continue to improve with each meeting. The level and quality of Divisional participation for the September meeting was excellent, particularly with Divisional leaders presenting their local staff engagement action plans and equality and inclusion priorities, which have been co-developed with the Inclusion Networks and working with the HR and OD Team. Delivery against these plans will now fall within the governance of WSEC, through regular reporting and updates. It was good to see the progress that has been made on developing the Dudley People Plan, which sets out an ambitious plan for establishing The Dudley Group as the place that people will choose to work. I have welcomed the new workforce KPI report, which sets a much higher standard of workforce data and management information and Divisional colleagues advised that they believe this will add huge value locally when rolled-out to Divisions in the</p>	

coming weeks. Lastly, whilst receiving so many positive updates on key pieces of strategic and developmental work, the Committee was reminded that we are in a challenging and vulnerable position, facing a second wave of COVID and with many staff still feeling jaded by phase one. The WSEC is keen to see future updates and assurances on staff health and wellbeing.

Paper for submission to Board of Directors on 8<sup>th</sup> October 2020

<b>TITLE:</b>	<b>ENC 21: Workforce KPIs</b>		
<b>AUTHOR:</b>	<b>Graeme Ratten - Analyst</b>	<b>PRESENTER:</b>	<b>James Fleet – Chief People Officer</b>
<b>CLINICAL STRATEGIC AIMS</b>			
<i>Develop integrated care provided locally to enable people to stay at home or be treated as close to home as possible.</i>	<i>Strengthen hospital-based care to ensure high quality hospital services provided in the most effective and efficient way.</i>	<i>Provide specialist services to patients from the Black Country and further afield.</i>	
<b>ACTION REQUIRED OF COMMITTEE</b>			
<b>Decision</b>	<b>Approval</b>	<b>Discussion</b>	<b>Other</b>
		<b>X</b>	
<b>RECOMMENDATIONS</b>			
For the board to receive the report and note the contents.			
<b>CORPORATE OBJECTIVE:</b>			
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			
<b>SUMMARY OF KEY ISSUES:</b>			
<ul style="list-style-type: none"> <li>In August overall days lost due to Sickness Absence reduced to 6.9%, of which 1.9% was COVID reasons. Staff absence due to all '<b>COVID Reasons</b>' has reduced back to 1.6% (85 staff) from 2.5% (132 staff) since Tuesday 22<sup>nd</sup> Sept.</li> <li>Agency in August at 152 WTE was the same as July. Both up from June at 122 WTE. Bank has reduced in August (325 WTE) compared to July (397 WTE). The net difference is minus 72 WTEs, with Agency level and Bank down 72 WTE.</li> <li>Mandatory training compliance in August has improved in most categories, and whilst performance is going in the right direction, focus continues to be required particularly in Resus and Safeguarding.</li> <li>August (4,758) shows a slight drop in contracted staff in post since July (4,795) (<i>Source: finance data based on contracted WTE whole month</i>). Qualified Nursing continues to be the most challenged area, with SURGERY 226 WTE, and MEDICINE 180 WTE below budgeted establishment – a combined total of 406 between these two divisions.</li> <li>Leavers appears high at 110 staff, however 67 are due to External Rotation. Starters also appears high at 132 staff, and is driven by the new rotation with FY1 = 19, FY2=23, Specialist Registrar=42</li> <li>The Equality &amp; Diversity deep-dive confirmed under representation for BAME and Disabled staff at higher grades within the Trust. A range of measures are being implemented to strengthen the representation of diverse groups at all levels, including; launching the Mentoring for Inclusion</li> </ul>			

scheme, targeted development interventions for key groups (i.e. BAME nursing staff) and clear Trust level recruitment commitments. The Inclusion Networks are also working closely with the Divisions to support local plans to embed inclusive recruitment practices. The DRAFT Dudley People Plan also sets out a range of actions to accelerate progress in implementing the WRES and WDES requirements, including stronger representation.

- HR Cases related to BAME staff represent 22% of the total cases of BAME staff, with 78% related to Non-BAME staff. Slightly higher than our BAME representation of 19% within DGFT.
- COVID risk assessments: overall submission on the 31<sup>st</sup> August showed 95% compliance, mid-September was 96%, at 30<sup>th</sup> September the status has improved to 97.5%. 123 risk assessments are outstanding, the majority (100) in MIC (improved by 62 assessments in the last 2 weeks).

## 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	N	Details:
	NHSI	N	Details:
	Other	N	Details:
REPORT DESTINATION	EXECUTIVE DIRECTORS	N	DATE:
	WORKING GROUP	N	DATE:
	COMMITTEE	Y	DATE: Workforce Committee 29.9.20

# Enc 21 – Workforce KPIs

8<sup>th</sup> October 2020

**James Fleet, Executive Chief People Officer**

**Summary**

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**COVID Risk Assessment**

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Summary <sup>1/4</sup>	Performance	Action
Sickness & Absence	<ul style="list-style-type: none"> <li>○ In August overall days lost due to Sickness Absence reduced to 6.9%, of which 1.9% was COVID reasons.</li> <li>○ COVID Reasons was the single largest reason for lost days in August at 28%</li> <li>○ In terms of a daily headcount snapshot, Through September, we saw an increase to 2.5%, however, this has dropped to 1.6% (at 29 Sept).</li> <li>○ Staff absence due to all '<b>COVID Reasons</b>' has reduced back to 1.6% (85 staff) from 2.5% (132 staff) since Tuesday 22<sup>nd</sup> Sept.</li> </ul>	<ul style="list-style-type: none"> <li>✓ A file audit tool has been developed and a monthly file audit process has commenced.</li> <li>✓ Monthly sickness absence reports are being sent to Managers, Divisional Directors and Heads of Service detailing both short and long term absence.</li> <li>✓ The operational HR team convene monthly meetings with managers to support, advise and challenge action that is being taken to manage sickness absence,</li> <li>✓ Centralised Sickness Absence Reporting has recommenced for Covid-related absence.</li> </ul>
Bank & Agency Usage	<ul style="list-style-type: none"> <li>○ Agency in August at 152 WTE was the same as July. Both up from June at 122 WTE.</li> <li>○ Bank has reduced in August (325 WTE) compared to July (397 WTE).</li> <li>○ The net difference is minus 72 WTEs, with Agency level and Bank down 72 WTE.</li> </ul>	<ul style="list-style-type: none"> <li>✓ Action plan being developed to prioritise recruitment and retention.</li> <li>✓ Authorisation levels have been reviewed and revised within Health Roster to ensure there is senior nursing oversight for agency usage.</li> <li>✓ 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.</li> </ul>

Summary <sup>2/4</sup>	Performance	Action
Mandatory Training	<ul style="list-style-type: none"> <li>○ Mandatory training compliance in August has improved in most categories, and whilst performance is going in the right direction, focus continues to be required particularly in:               <ul style="list-style-type: none"> <li>➢ Resus Neonatal 75.5% +6.6%, Resus Adult 68.6% +1.8%, Resus Paediatric 65.5% +4.3%, Manual Handling (Patient) at 71.9% -0.7%,</li> <li>➢ Safeguarding Adults Level 2 77.3% +2.4%, and Safeguarding Children Level 2 78.3% +2.5% and Level 3 75.6% +2.7%</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>✓ An action plan has been devised along with a trajectory for the Divisions to achieve mandatory training compliance.</li> <li>✓ Restrictions to the amount of attendees continue and exploration of adjusted delivery such as video recording or live streaming of demonstration aspects of sessions.</li> <li>✓ Additional training sessions have been offered from April to August 2020 to mitigate reduced attendances during in April.</li> </ul>
Workforce Profile	<ul style="list-style-type: none"> <li>○ August (4,758) shows a slight drop in contracted staff in post since July (4,795) (<i>Source: finance data based on contracted WTE whole month</i>)</li> <li>○ Qualified Nursing continues to be the most challenged area, with SURGERY 226 WTE, and MEDICINE 180 WTE below budgeted establishment – a combined total of 406 between these two divisions.</li> </ul>	<ul style="list-style-type: none"> <li>✓ HR and Professional Development continue to collaborate to support on-going recruitment. Interventions include nursing recruitment days, virtual tours and social media campaigns.</li> <li>✓ 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.</li> <li>✓ We continue to explore collaborative recruitment across the STP and to build upon existing streamlining work to enable appropriate functions to be delivered at regional level on behalf of constituent organisations e.g. recruitment campaigns</li> </ul>

Summary <sup>3/4</sup>	Performance	Action
Turnover & Recruitment	<ul style="list-style-type: none"> <li>Leavers appears high at 110 staff, however 67 are due to External Rotation.</li> <li>Starters also appears high at 132 staff, and is driven by the new rotation with FY1 = 19, FY2=23, Specialist Registrar=42</li> </ul>	<ul style="list-style-type: none"> <li>✓ Turnover continues to fall and is below the average industry rate of 10%.</li> <li>✓ The Human Resources Business Partners will be 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.</li> <li>✓ Examine trends on planned versus actual staffing levels, triangulated with key quality and outcome measures, including exit interviews and stay interviews.</li> </ul>
Equality & Diversity	<ul style="list-style-type: none"> <li>ESR demonstrates a 20% points increase in 'White' representation between Band 5 to Band 7 whilst the representation of all other ethnicities reduces significantly. This identifies a concern with progression opportunities across our BAME staff group.</li> <li>Disabled staff are under-represented at senior levels – only one staff member (VSM) about band 8A</li> </ul>	<ul style="list-style-type: none"> <li>✓ 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 meets in the next few days.</li> <li>✓ 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.</li> <li>✓ The Workforce Committee meeting in late August focused on a 'deep dive' by age, band, length of service, and staff group for WDES, WRÉS, and WSES.</li> </ul>

Summary <small>4/4</small>	Performance	Action
Staff Health & Wellbeing	<ul style="list-style-type: none"> <li>○ Average time from referral to first appointment increased slightly in August to 14 days, however still below the target of 15 days.</li> <li>○ <b>'Ability to Perform Duties'</b> referrals are constant (15-16 per month) on average, however represent 54% of all referrals in 2020 – driven mainly by a reduction in referrals for <b>'Frequent Short Term Sickness Absence'</b> have reduced compared to the previous year.</li> </ul>	<ul style="list-style-type: none"> <li>✓ Review of Staff Health &amp; Wellbeing service in progress to identify the service model and additional support required.</li> </ul>
HR Caseload	<ul style="list-style-type: none"> <li>○ The current open HR caseload of 50 is dominated by 'Disciplinary' cases at 48%</li> <li>○ Cases related to BAME staff represent 22% of the total cases of BAME staff, with 78% related to Non-BAME staff. Slightly higher than our BAME representation of 19% within DGFT.</li> </ul>	<ul style="list-style-type: none"> <li>✓ 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.</li> <li>✓ Employee relations cases continue to be proactively managed and supported by the implementation and maintenance of a case tracker.</li> </ul>
COVID Risk Assessment	<ul style="list-style-type: none"> <li>○ Overall submission on the 31<sup>st</sup> August showed 95% compliance, mid September was 96%, current status has improved to 97.5% (at 30<sup>th</sup> September)</li> <li>○ 123 risk assessments outstanding, 100 in MIC (improved by 62 assessments in the last 2 weeks)</li> <li>○ Outstanding assessments by staff group, Additional Clinical Services at 40 and Nursing &amp; Midwifery at 37 are highest.</li> </ul>	<ul style="list-style-type: none"> <li>✓ Monthly performance on risk assessments will be sent to Managers, Divisional Directors and Heads of Service detailing compliance and outstanding assessments.</li> <li>✓ The operational HR team have incorporate into their monthly meetings with managers to support, advise and challenge action that is being taken.</li> <li>✓ A 'prompt' has been incorporated into the Trac recruitment system to prompt completion for new starters.</li> </ul>

# Sickness Absence

In August overall days lost due to Sickness Absence reduced to 6.9%, of which 1.9% was COVID reasons.

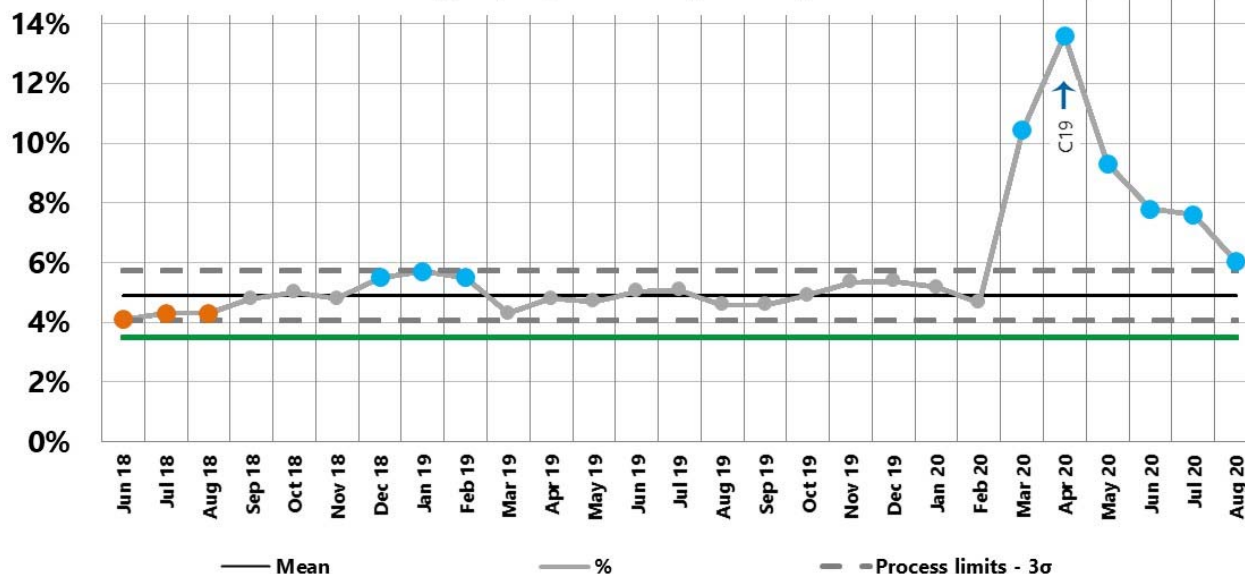
COVID Reasons was the single largest reason for lost days in August at 28%

In terms of a daily headcount snapshot, over the last week COVID reasons absences have increased from 1% to 1.6%

	Days Absent Compared to Days Worked In August						Headcount Sickness Snapshot: Tuesday 15th September					
	COVID reasons		All other sickness		Grand Total		COVID Reasons		All other sickness		Total	
	Days	%	Days	%	Days	%	People	%	People	%	People	%
Clinical Support	313	2.3%	960	7.2%	1,273	9.5%	3	0.6%	19	3.9%	22	4.5%
Corporate / Mgt	173	1.1%	444	2.7%	617	3.8%	10	1.8%	13	2.3%	23	4.1%
Medicine & Integrated Care	1,257	1.9%	3,115	4.8%	4,372	6.8%	24	1.1%	81	3.6%	105	4.7%
Surgery	1,076	2.0%	2,881	5.5%	3,957	7.5%	43	2.3%	90	4.9%	133	7.2%
<b>Total</b>	<b>2,819</b>	<b>1.9%</b>	<b>7,400</b>	<b>5.0%</b>	<b>10,219</b>	<b>6.9%</b>	<b>80</b>	<b>1.6%</b>	<b>203</b>	<b>4.0%</b>	<b>283</b>	<b>5.6%</b>

Absence Reason	Days	% of All Reasons
COVID reasons	2,823	28%
Anxiety/stress/depression/other	2,438	24%
Other musculoskeletal problems	932	9%
Gastrointestinal problems	632	6%
Injury, fracture	607	6%
Back Problems	417	4%
Genitourinary & gynaecological	383	4%
Pregnancy related disorders	381	4%
Headache / migraine	334	3%
Chest & respiratory problems	244	2%
Ear, nose, throat (ENT)	137	1%
Cold, Cough, Flu - Influenza	115	1%
Skin disorders	109	1%
Nervous system disorders	105	1%
Benign and malignant tumours	96	1%
Unknown causes / Not specified	87	1%
Dental and oral problems	86	1%
Endocrine / glandular problems	84	1%
Asthma	81	1%
Infectious diseases	67	1%
Burns, poisoning, frostbite, hypothermia	31	0%
Eye problems	22	0%
Blood disorders	12	0%

Sickness Absence- starting 01/06/18 Rolling Average - 12 mths



# Covid 19 Absence Profile – All Staff at Wednesday 29 September

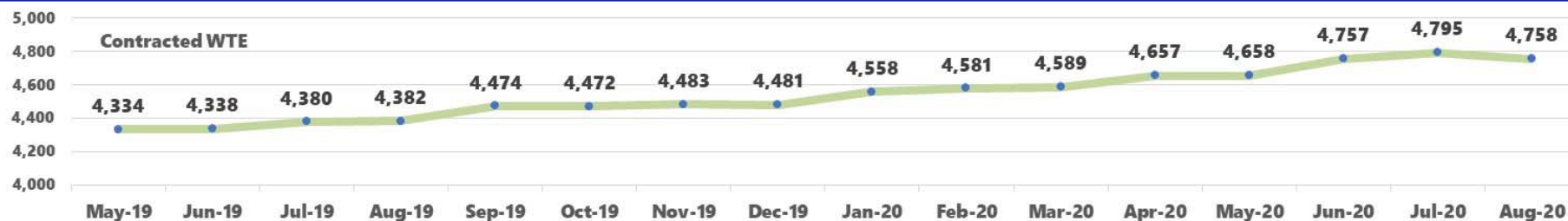
Staff absence due to all '**COVID Reasons**' has reduced back to 1.6% (85 staff) from 2.5% (132 staff) since Tuesday 22<sup>nd</sup> Sept.



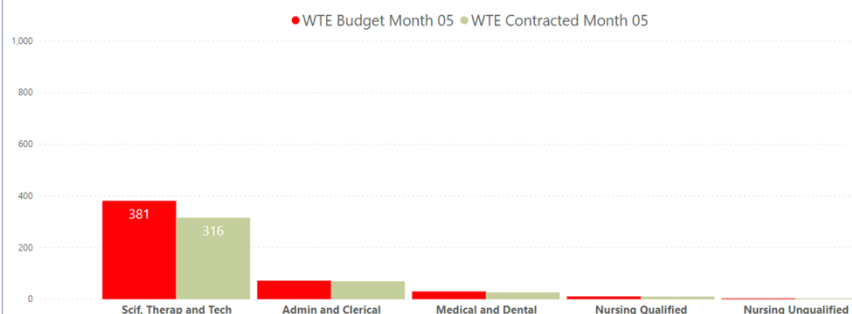
# Workforce Profile – Staff in Post

August (4,758) shows a slight drop in contracted staff in post since July (4,795) (Source: finance data based on contracted WTE whole month)

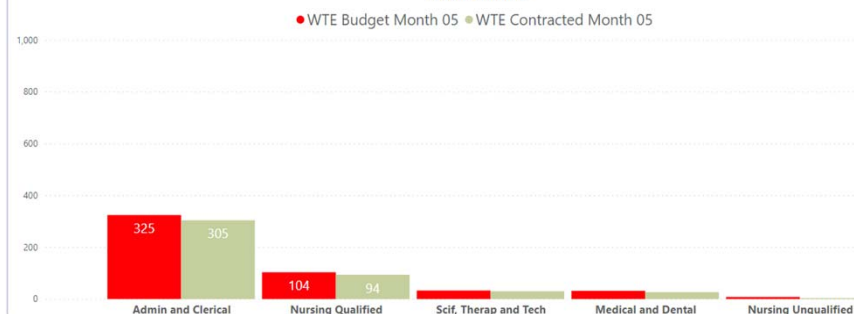
Qualified Nursing continues to be the most challenged area, with SURGERY 226 WTE, and MEDICINE 180 WTE below budgeted establishment – a combined total of 406 between these two divisions.



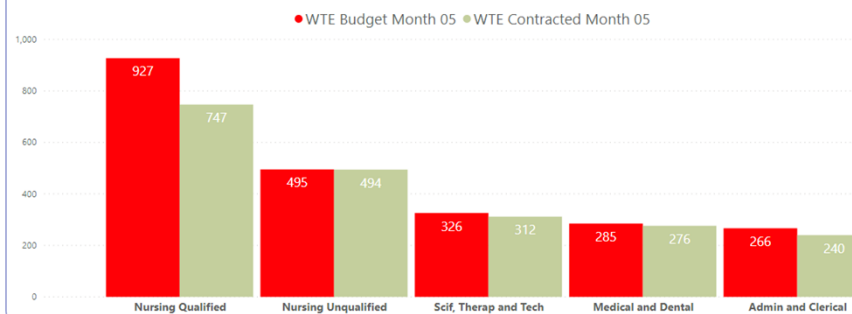
## CLINICAL SUPPORT



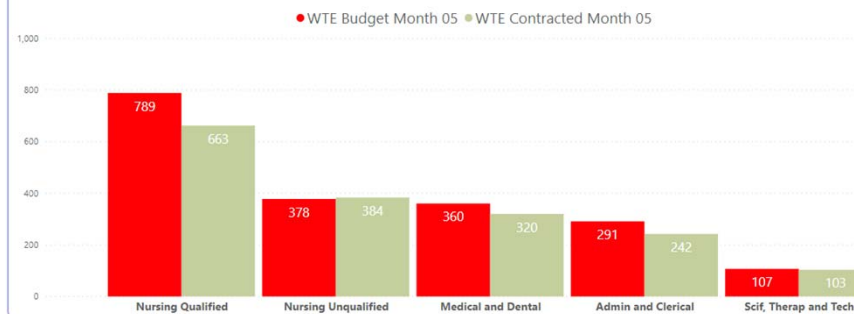
## CORPORATE



## MEDICINE & INTEGRATED CARE



## SURGERY



## Emergent Priorities: Ethnicity – BAME – All Trust Staff

	Metric Description	DGFT Staff Survey			DGFT Trend	National	DGFT to
		2017	2018	2019		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

Ethnicity Group Band	Asian		Black		Minority Ethnic		White	
	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%

**20%  
points  
increase in  
'White'  
representation  
Band 5 to  
Band 7**

# Emergent Priorities: Disability – Career Progression or Promotion

		DGFT Staff Survey				DGFT Trend	National 2019	DGFT to National
		2018		2019				
Metric Description		Score	Responses	Score	Responses			
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

## All Staff, by Band - all lengths of service

Disability Band	No		Not declared		Yes	
	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%
<b>Total</b>	<b>3,009</b>	<b>56.6%</b>	<b>2,138</b>	<b>40.2%</b>	<b>171</b>	<b>3.2%</b>

**0%**  
Disabled Staff

## All Staff, by Division

Disability Staff Group	No		Not declared		Yes	
	People	%	People	%	People	%
Add. Clinical Services	690	55.2%	522	41.8%	37	3.0%
Add. Prof Scient & Technic	117	57.1%	80	39.0%	8	3.9%
Administrative and Clerical	653	62.0%	355	33.7%	46	4.4%
Allied Health Professionals	258	63.7%	130	32.1%	17	4.2%
Healthcare Scientists	22	41.5%	26	49.1%	5	9.4%
Medical and Dental	326	60.1%	209	38.6%	7	1.3%
Nursing & Midwifery Regd.	879	50.7%	807	46.6%	47	2.7%
Students	64	83.1%	9	11.7%	4	5.2%
<b>Total</b>	<b>3,009</b>	<b>56.6%</b>	<b>2,138</b>	<b>40.2%</b>	<b>171</b>	<b>3.2%</b>

**Disabled staff are under-represented in:**

- 1.3%** Medical and Dental
- 2.7%** Nursing & Midwifery Regd.
- 1.1%** VSM very senior managers

# Sexual Orientation: Representation – Overview DGFT + ONS data

Our data on Sexual Orientation is collected at the point of recruitment. Staff with a length of service over 5 years had a tendency to 'not state' their sexuality. This has improved significantly in the last 2 to 3 years, giving us more complete data.

The table below shows our current position, including the 'not stated' cohort of 37.2% of staff. Subsequent slides include an overall view, plus the data for staff recruited in the last 2 years, where the 'not stated' group drops closer to 10%, thereby providing a more complete view.

The comparative data in the table to the right is the ONS Annual Population Survey 2017, and the Trusts overall total data is comparable. For illustration, the **ONS data shows people identifying as 'Gay or lesbian' 1.3%** compared to the **DGFT staff of 1.2%**. If we use data from people recruited in the last 2 years, then DGFT's number is 1.7%- 1.8%.

Sexual orientation	2017
Heterosexual or straight	93.2
Gay or lesbian	1.3
Bisexual	0.7
Lesbian, gay or bisexual (LGB)	2.0
Other	0.6
Do not know or refuse	4.1

Source: Office for National Statistics - Annual Population Survey - <https://www.ons.gov.uk/peoplepopulationandcommunity/culturalidentity/sexuality/bulletins/sexualidentityuk/2017>

## All Staff, by Staff Group, all lengths of service

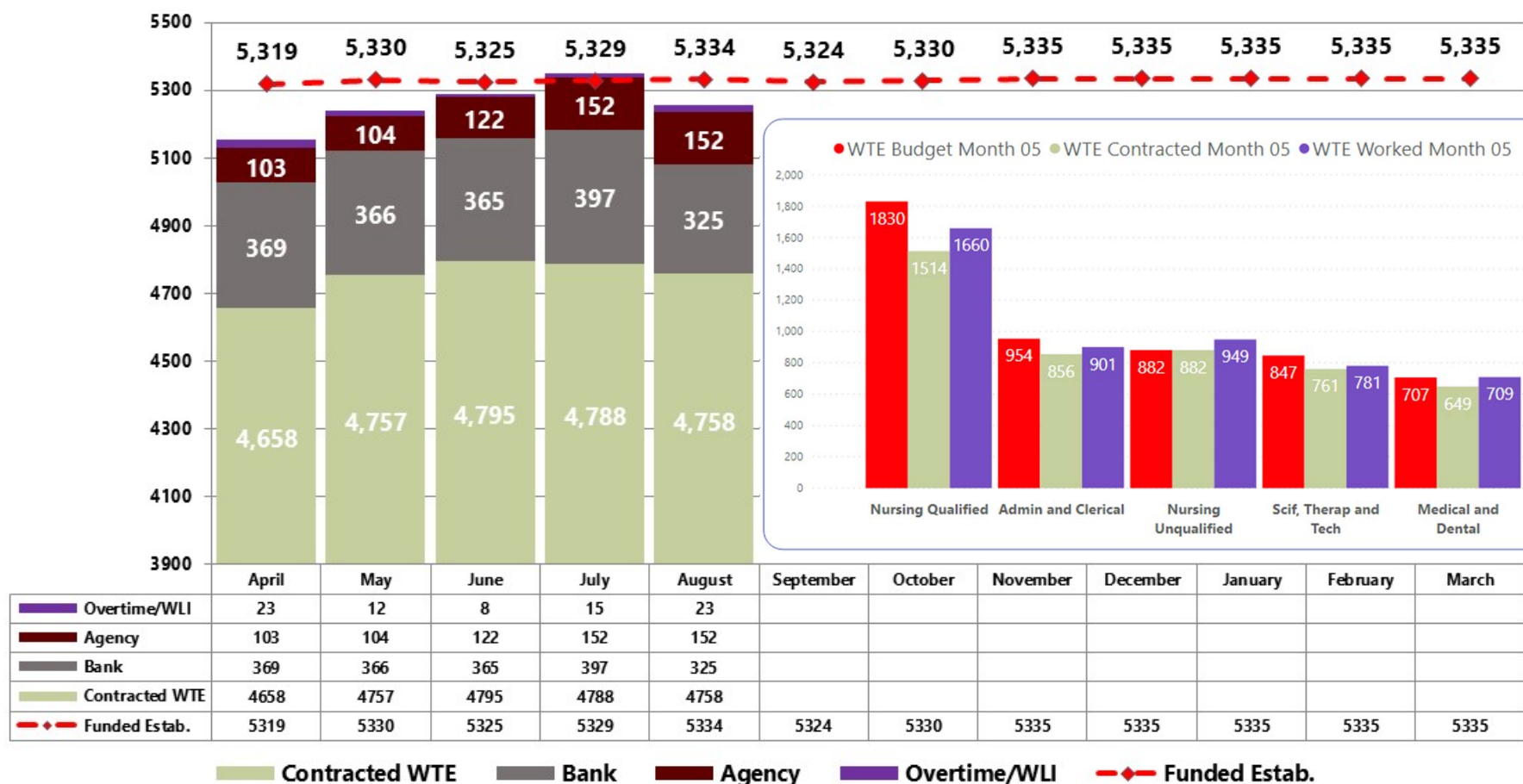
Sexual Orientation Staff Group	Bisexual		Gay or Lesbian		Heterosexual		Not stated		Other sexual	
	People	%	People	%	People	%	People	%	People	%
Add. Clinical Services	5	0.4%	21	1.7%	727	58.2%	493	39.5%	3	0.2%
Add. Prof Scient & Technic			1	0.5%	125	61.0%	79	38.5%		
Administrative and Clerical	1	0.1%	10	0.9%	716	67.9%	326	30.9%	1	0.1%
Allied Health Professionals	2	0.5%	8	2.0%	276	68.1%	119	29.4%		
Healthcare Scientists					25	47.2%	28	52.8%		
Medical and Dental	5	0.9%	4	0.7%	327	60.3%	206	38.0%		
Nursing & Midwifery Regd.	3	0.2%	18	1.0%	996	57.5%	715	41.3%	1	0.1%
Students			1	1.3%	64	83.1%	12	15.6%		
<b>Total</b>	<b>16</b>	<b>0.3%</b>	<b>63</b>	<b>1.2%</b>	<b>3,256</b>	<b>61.2%</b>	<b>1,978</b>	<b>37.2%</b>	<b>5</b>	<b>0.1%</b>

## Bank & Agency Usage - Trend

Agency in August at 152 WTE was the same as July. Both up from June at 122 WTE.

Bank has reduced in August (325 WTE) compared to July (397 WTE).

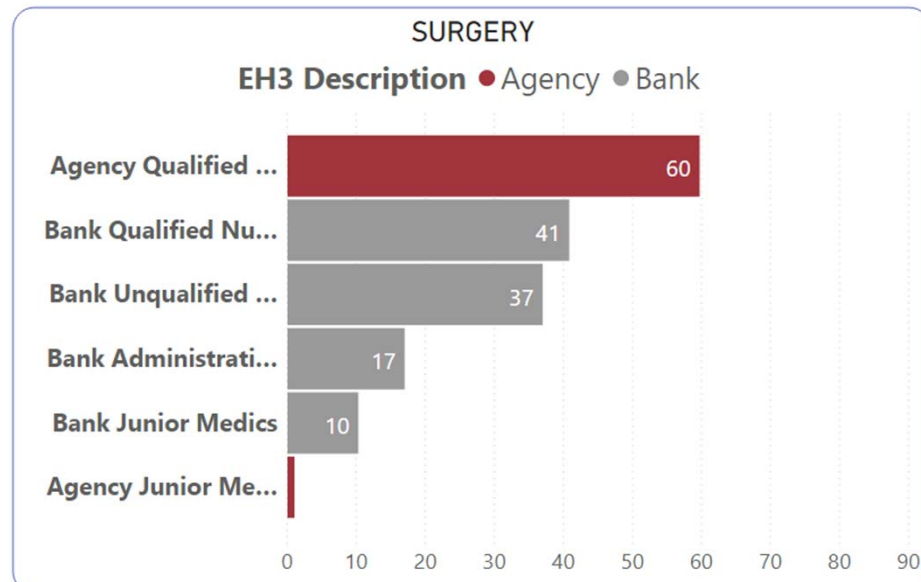
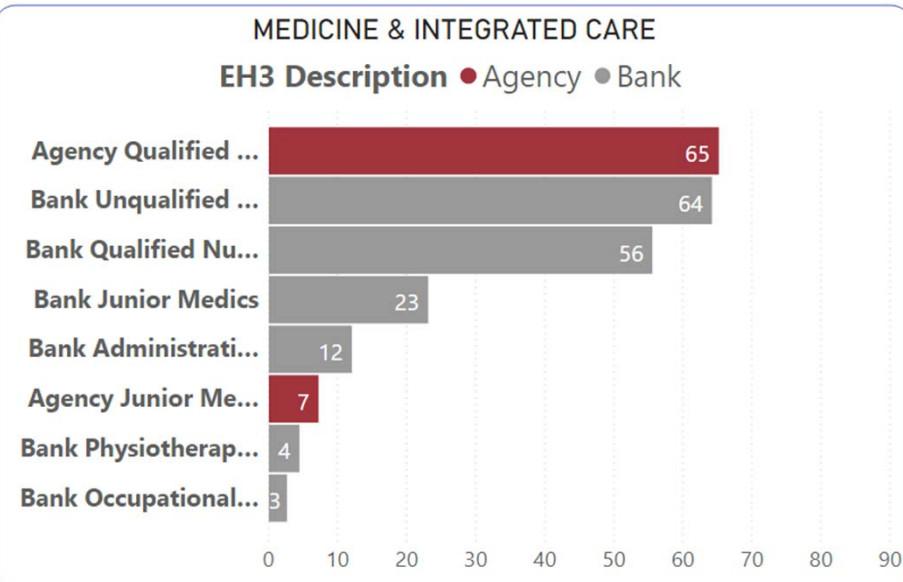
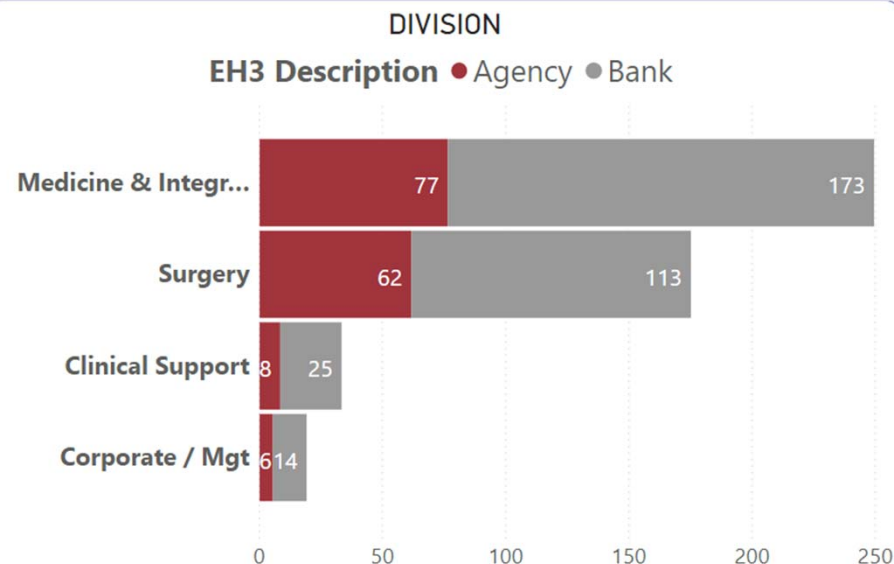
The net difference is minus 72 WTEs, with Agency level and Bank down 72 WTE.



# Bank & Agency Usage – By Division and Role

The majority of the agency spend in August (M05) was on Qualified Nurses

MIC accounted for 65 WTE and SURGERY for 60 WTE (worked during the month)



# Turnover

Leavers appears high at 110 staff, however 67 are due to External Rotation.

Starters also appears high at 132 staff, and is driven by the new rotation with FY1 = 19, FY2=23, Specialist Registrar=42

	Starters	
	Head Count	FTE
Clinical Support	6	5.8
Corporate / Mgt	22	21.8
Medicine & Integrated Care	56	52.9
Surgery	48	45.3
<b>Total</b>	<b>132</b>	<b>125.8</b>

	Leavers	
	Head Count	FTE
Clinical Support	6	4.7
Corporate / Mgt	9	8.8
Medicine & Integrated Care	51	46.3
Surgery	44	40.9
<b>Total</b>	<b>110</b>	<b>100.8</b>

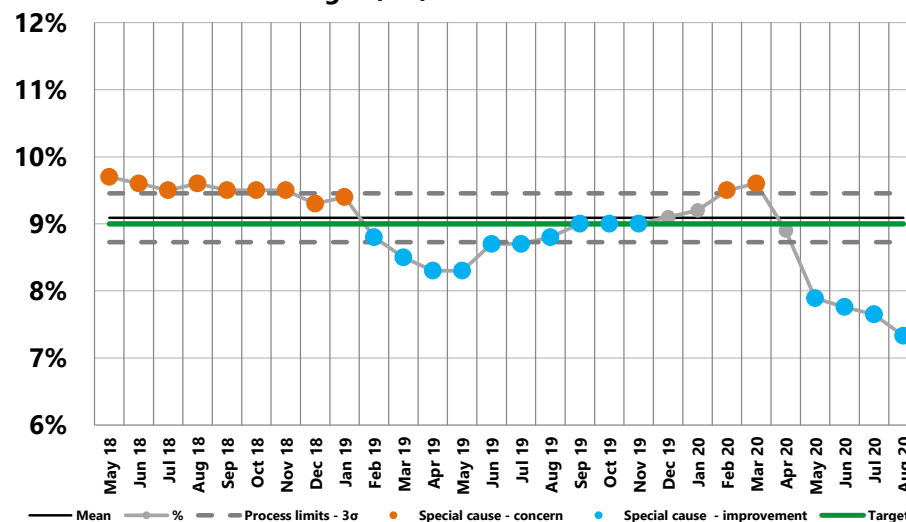
	Starters	
	Head Count	FTE
<b>Full Time</b>		
Fixed Term Temp	96	96
Permanent	20	20
<b>Part Time</b>		
Fixed Term Temp	7	4.4
Permanent	9	5.4

	Leavers	
	Head Count	FTE
End of Fixed Term Contract	21	18.3
End of External Rotation	67	65.6
Retirement Age	5	3.8
Voluntary Resignation	17	13.1
<b>Total</b>	<b>110</b>	<b>100.8</b>

	Starters	
	Head Count	FTE
Advanced Practitioner	1	1.0
Assistant	2	1.6
Clerical Worker	7	6.6
Consultant	2	2.0
Foundation Year 1	19	19.0
Foundation Year 2	23	23.0
Health Care Support Worker	1	0.5
Healthcare Assistant	2	1.6
Manager	2	2.0
Occupational Therapist	1	0.8
Officer	3	3.0
Optometrist	1	0.2
Personal Assistant	1	1.0
Physician Associate	1	1.0
Physiotherapist	2	2.0
Pre-reg Pharmacist	4	4.0
Receptionist	1	1.0
Senior Manager	2	2.0
Specialist Nurse Practitioner	3	2.4
Specialty Registrar	42	40.1
Staff Nurse	6	5.3
Technician	2	2.0
Doctor - Career Grade level	1	0.6
Doctor - Foundation Level	1	1.0
Doctor - Specialty Registrar	2	2.0

	Leavers	
	Head Count	FTE
Assistant	2	1.6
Clerical Worker	1	1.0
Foundation Year 1	17	17.0
Foundation Year 2	22	21.6
Health Care Support Worker	7	5.6
Healthcare Science Assistant	2	1.1
Hospital Practitioner	1	0.1
Midwife	3	2.0
Pharmacist	1	1.0
Physiotherapist	2	1.4
Physiotherapist Manager	1	0.4
Senior Manager	1	1.0
Sister/Charge Nurse	2	1.0
Specialist Nurse Practitioner	1	1.0
Specialty Registrar	30	29.4
Staff Nurse	1	1.0
Student Nurse - Adult Branch	2	2.0
Technician	1	1.0
Trainee Practitioner	3	1.8
Doctor - Career Grade level	2	2.0
Doctor - Foundation Level	2	2.0
Doctor - Specialty Registrar	6	5.8

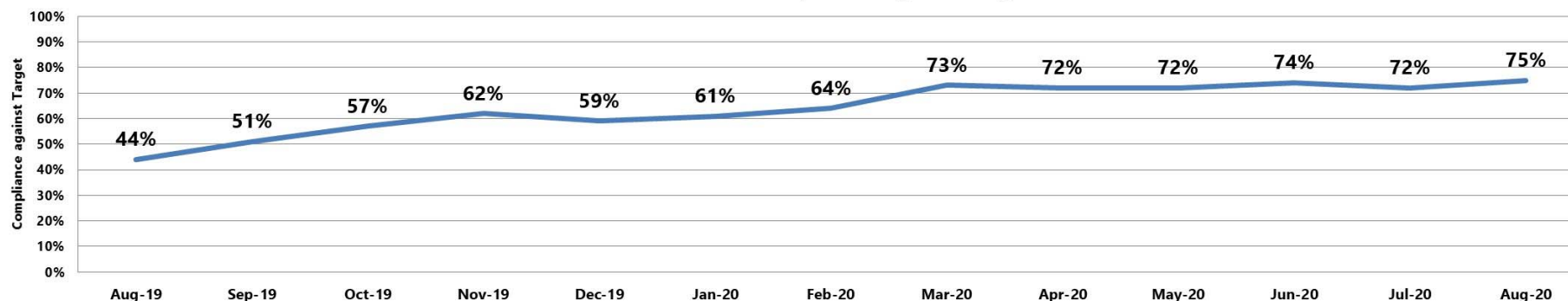
Turnover- starting 01/05/18



# Recruitment

Performance in August shows improvement across all individual elements of the process. Focus is required on 'Time to Shortlist'.

Recruitment Time: Compliance Against Target



Trust Total Recruitment Time	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20
Time to Approve (8 Days)	75%	60%	61%	63%	59%	73%	70%	72%	72%	85%	90%	95%	87%
Time to Advertise (2 Days)	94%	96%	94%	97%	94%	94%	94%	96%	97%	98%	90%	96%	95%
Time to Shortlist (4 days)	52%	38%	100%	61%	53%	56%	53%	50%	49%	51%	64%	61%	63%
Time to send interview invites after shortlisting (2 Days)	91%	100%	76%	100%	95%	97%	100%	100%	100%	100%	96%	99%	99%
Time from sending invites to interview date (5 Days)	73%	74%	76%	83%	77%	65%	68%	79%	79%	83%	76%	62%	76%
Time from interview to conditional offer sent (2 Days)	77%	72%	77%	84%	80%	55%	58%	68%	68%	54%	85%	88%	94%
Time to complete PE Checks (27 Days)	69%	47%	56%	66%	69%	54%	59%	57%	57%	75%	69%	83%	77%
Total Time to Recruit (50 Days)	44%	51%	57%	62%	59%	61%	64%	73%	72%	72%	74%	72%	75%

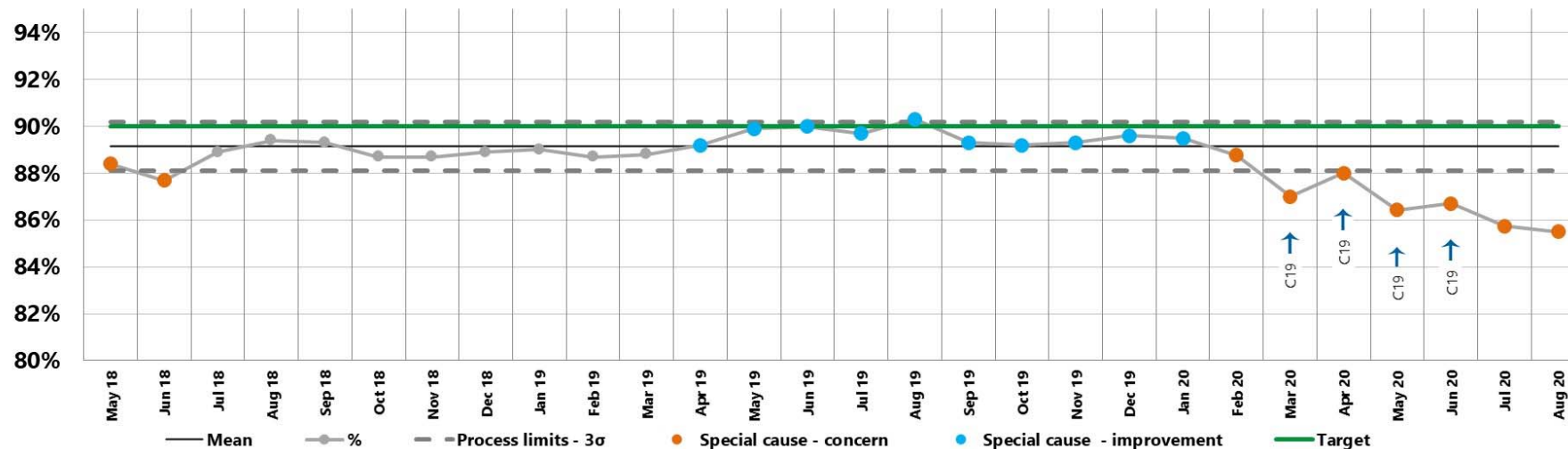
# Mandatory Training – Performance Trend

Mandatory training compliance in August has improved in most categories, and whilst performance is going in the right direction, focus continues to be required particularly in:

Resus Neonatal 75.5% +6.6%, Resus Adult 68.6% +1.8%, Resus Paediatric 65.5% +4.3%, Manual Handling (Patient) at 71.9% -0.7%, Safeguarding Adults Level 2 77.3% +2.4%, and Safeguarding Children Level 2 78.3% +2.5% and Level 3 75.6% +2.7%

**Mandatory Training- starting 01/05/18**

NB: The SPC chart is a rolling average – August improved over July but both are lower than the previous averages



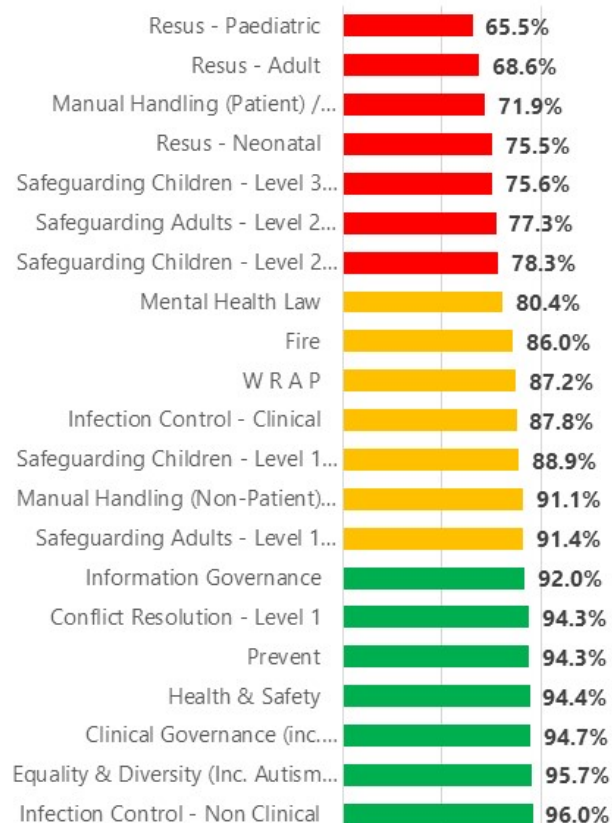
Month	Clinical Governance	Conflict Resolution - Level 1	Equality & Diversity	Fire	Health & Safety	Infection Control - Clinical	Infection Control - Non Clinical	Information Governance	Manual Handling (Non-Patient)	Manual Handling (Patient)	Mental Health Law	Prevent	Resus - Adult	Resus - Neonatal	Resus - Paediatric	Safeguarding Adults-Level1	Safeguarding Adults-Level2	Safeguarding Children-Level1	Safeguarding Children-Level2	Safeguarding Children-Level3	W R A P
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%
August	94.7%	94.3%	95.7%	86%	94.4%	87.8%	96%	92%	91.1%	71.9%	80.4%	94.3%	68.6%	75.5%	65.5%	91.4%	77.3%	88.9%	78.3%	75.6%	87.2%
<b>This Month v Last Month Variance</b>																					
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%
July to Aug	1.8%	1.7%	2.0%	2.6%	1.7%	3.9%	1.7%	4.5%	1.6%	0.7%	1.5%	0.8%	1.8%	6.6%	4.3%	0.8%	2.4%	0.7%	2.5%	2.7%	0.9%

# 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, MANUAL HANDLING (Patient) and SAFEGUARDING.

## Mandatory Training Compliance - Priority 1

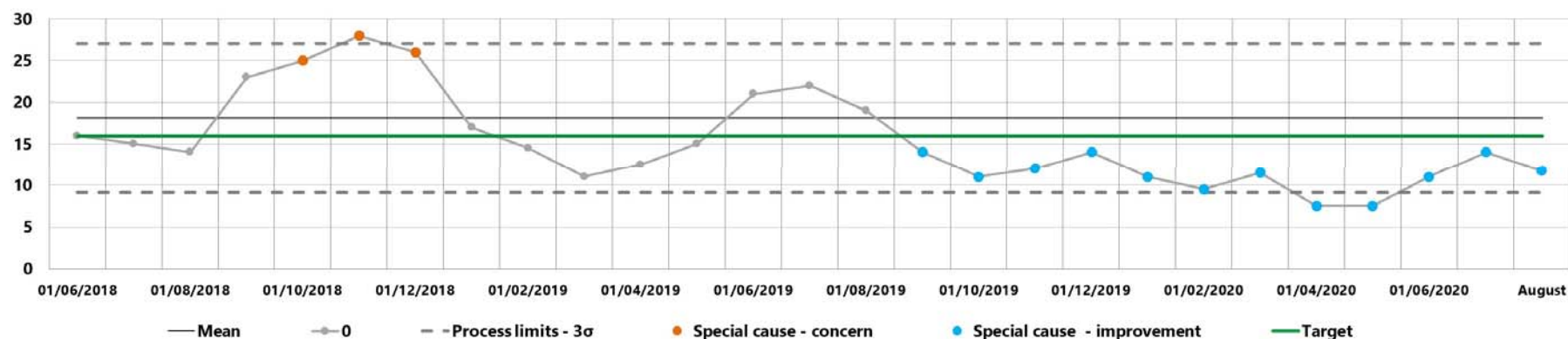


Selected Mandatory Training Categories		Resus - Adult	Resus - Neonatal	Resus - Paediatric	Safeguarding Adults - Level 2 2020	Safeguarding Children - Level 3 2020
Division	Directorate	≥90% ≥90%	≥90% ≥90%	≥90% ≥90%	≥90% ≥90%	≥90% ≥90%
253 Clinical Support 84.7% (5194/6126)	253 Breast Screening Service Dir 92% (487/529)	88%			92%	
	253 Cancer Services Management Dir 78.6% (184/234)	100%			100%	
	253 Clinical Support Div Mgt Dir 73.3% (55/75)	100%			50%	
	253 Imaging Dir 86.3% (2334/2702)	85%		71%	82%	
	253 Pathology Dir 77.5% (743/958)	70%		100%	75%	
	253 Pharmacy Dir 85.4% (1391/1628)				81%	
253 Corporate / Mgt 89.4% (5572/6228)		85%		72%	81%	
	253 Board Secretary FT Dir 98.5% (66/67)					
	253 Chief Executive Dir 82.6% (285/345)	100%			50%	
	253 Finance Information and Estate Dir 92.4% (1413/1529)	0%			33%	
	253 Human Resources Dir 90.5% (491/542)	66%			100%	
	253 Information Technology Dir 90.8% (743/818)				100%	
	253 Medical Director Dir 89.3% (823/1033)	61%		100%	89%	
	253 Nursing Directorate Dir 92.5% (1127/1218)	62%	100%		90%	70%
	253 Operations Management Dir 75.4% (452/599)	61%			85%	58%
253 Medicine & Integrated Care 85.7% (25474/29690)	253 Strategy & Performance Dir 93.5% (72/77)	62%	100%	100%	87%	63%
		79%		100%	82%	75%
	253 Integrated Care Dir 88.9% (8648/9724)	100%			100%	
	253 Medicine Division Management Dir 93.1% (205/220)	65%	0%	66%	75%	73%
	253 Nursing Medicine Dir 84.1% (11533/13699)	69%		45%	76%	
253 Surgery 84.3% (20311/24093)	253 Specialist Medicine Dir 84.5% (3435/4064)	71%		77%	66%	64%
	253 Urgent Care Dir 83.3% (1653/1983)	71%	0%	69%	77%	71%
		64%	76%		79%	79%
	253 Maternity Services Dir 87.8% (2868/3266)	68%	82%	69%	72%	82%
	253 Nursing Surgery Dir 85.5% (7027/8216)	57%			88%	
	253 OPD and Health Records Dir 88.1% (1503/1706)	72%		80%	82%	
	253 Specialist Surgery Dir 84.6% (1622/1917)	33%			50%	
	253 Surgery Division Mgmt Dir 79% (121/153)	41%		100%	59%	
	253 Surgery Urology & Vascular Dir 72.9% (783/1074)	58%		48%	74%	
	253 Theatres Anaes & Crit Care Dir 80.9% (4970/6139)	68%			76%	
	253 Trauma & Orthopaedics Dir 89.9% (583/648)	65%	65%	82%	69%	66%
	253 Women and Children Dir 85.6% (834/974)	63%	75%	60%	74%	79%
OVERALL PERFORMANCE		68.6%	75.5%	65.5%	77.3%	75.6%

# Staff Health & Wellbeing – SHAW Service – Manager Referrals

Average time from referral to first appointment increased slightly in August to 14 days, however still below the target of 15 days.

'**Ability to Perform Duties**' referrals are constant (15-16 per month) on average, however represent 54% of all referrals in 2020 – driven mainly by a reduction in referrals for 'Frequent **Short Term Sickness Absence**' have reduced compared to the previous year.



	2019													2020									
	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	%	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	%	
Ability to Perform Duties	22	13	22	16	25	18	19	33	15	3	4	5	35%	11	9	16	6	15	7	32	25	54%	
Counselling Referral	0	4	2	4	1	1	0	1	0	1	0	1	3%	0	0	0	0	0	0	0	0	0%	
Frequent Short Term Sickness Absence	10	13	20	12	20	18	14	14	9	3	2	7	26%	5	3	2	2	10	2	2	0	12%	
Long Term Sickness Absence	26	18	19	19	22	18	19	21	15	6	7	7	36%	9	14	4	9	18	10	6	4	33%	
Manager Referred At Request of Employee	1	0	0	0	1	1	0	0	0	0	1	0	1%	0	1	1	0	0	0	0	0	1%	
Total	59	48	63	51	69	56	52	69	39	13	14	20		25	27	23	17	43	19	40	29		

## HR Caseload

The current open HR caseload of 50 is dominated by 'Disciplinary' cases at 48%

Cases related to BAME staff represent 22% of the total cases of BAME staff, with 78% related to Non-BAME staff.

	Suspension	Capability No UHR	Capability UHR	Disciplinary	Grievance	Total	% of Total
<b>BAME</b>		3	1	5	2	11	22%
<b>Non-BAME</b>	7	1	5	15	5	33	66%
<b>Z Not Stated</b>			1	4	1	6	12%
<b>Total</b>	<b>7</b>	<b>4</b>	<b>7</b>	<b>24</b>	<b>8</b>	<b>50</b>	

	Suspension	Capability No UHR	Capability UHR	Disciplinary	Grievance	Total	% of Total
<b>Additional Clinical Services</b>	1	0	4	5	0	10	20%
<b>Administrative and Clerical</b>		1	1	4	3	9	18%
<b>Allied Health Professionals</b>	1			3	5	9	18%
<b>Medical and Dental</b>				2		2	4%
<b>Nursing and Midwifery Registered</b>	5	3	2	10		20	40%
<b>Total</b>	<b>7</b>	<b>4</b>	<b>7</b>	<b>24</b>	<b>8</b>	<b>50</b>	

# COVID: Staff Risk Assessment – 31 Aug Submission V Status at 30 September

Overall submission on the 31<sup>st</sup> August showed 95% compliance, mid September was 96%, current status has improved to 97.5%

123 risk assessments outstanding, 100 in MIC (improved by 62 assessments in the last 2 weeks)

Outstanding assessments by staff group, Additional Clinical Services at 40 and Nursing & Midwifery at 37 are highest.

31 Aug Submission	Status at 0900 Wednesday 30th September					Progression
	Row Labels	Not Received	Received	Grand Total	% Complete	
97%	253 Clinical Support	13	445	458	97.2%	No Change
98%	253 Corporate / Mgt	7	519	526	98.7%	No Change
89%	253 Medicine & Integrated Care	100	2009	2109	95.3%	Improvement
100%	253 Surgery	3	1755	1758	99.8%	No Change
95%	<b>Grand Total</b>	<b>123</b>	<b>4728</b>	<b>4851</b>	<b>97.5%</b>	<b>Improvement</b>

Status at 0900 Wednesday 30th September				
Row Labels	Not Received	Received	Grand Total	% Complete
Add Prof Scientific and Technic		196	196	100.0%
Additional Clinical Services	40	1063	1103	96.4%
Administrative and Clerical	13	1002	1015	98.7%
Allied Health Professionals	6	364	370	98.4%
Healthcare Scientists	3	46	49	93.9%
Medical and Dental	20	464	484	95.9%
Nursing and Midwifery Registered	37	1538	1575	97.7%
Students	4	55	59	93.2%
<b>Grand Total</b>	<b>123</b>	<b>4728</b>	<b>4851</b>	<b>97.5%</b>

# COVID: Staff Risk Assessment – by Division and Directorate

MIC is the most challenged with 100 outstanding assessments – Nursing = 51, Integrated Care = 20, Specialist Medicine = 22  
CIS is next in percentage terms, with 13 outstanding assessments, or which 10 are in Imaging.

Status at 0900 Wednesday 30th September				
Row Labels	Not Received	Received	Grand Total	% Complete
<b>253 Medicine &amp; Integrated Ca</b>	<b>100</b>	<b>2009</b>	<b>2109</b>	<b>95.3%</b>
253 Integrated Care Dir	20	663	683	97.1%
253 Medicine Division Management Dir		19	19	100.0%
253 Nursing Medicine Dir	51	889	940	94.6%
253 Specialist Medicine Dir	22	288	310	92.9%
253 Urgent Care Dir	7	150	157	95.5%
<b>Grand Total</b>	<b>100</b>	<b>2009</b>	<b>2109</b>	<b>95.3%</b>

Status at 0900 Wednesday 30th September				
Row Labels	Not Received	Received	Grand Total	% Complete
<b>253 Corporate / Mgt</b>	<b>7</b>	<b>519</b>	<b>526</b>	<b>98.7%</b>
253 Board Secretary FT Dir		7	7	100.0%
253 Chief Executive Dir		22	22	100.0%
253 Finance Information and Estate Dir		138	138	100.0%
253 Human Resources Dir		49	49	100.0%
253 Information Technology Dir		73	73	100.0%
253 Medical Director Dir	6	77	83	92.8%
253 Nursing Directorate Dir		96	96	100.0%
253 Operations Management	1	49	50	98.0%
253 Strategy & Performance Dir		8	8	100.0%
<b>Grand Total</b>	<b>7</b>	<b>519</b>	<b>526</b>	<b>98.7%</b>

Status at 0900 Wednesday 30th September				
Row Labels	Not Received	Received	Grand Total	% Complete
<b>253 Surgery</b>	<b>3</b>	<b>1755</b>	<b>1758</b>	<b>99.8%</b>
253 Maternity Services Dir		221	221	100.0%
253 Nursing Surgery Dir		584	584	100.0%
253 OPD and Health Records Dir		139	139	100.0%
253 Specialist Surgery Dir		142	142	100.0%
253 Surgery Division Mgmt Dir		14	14	100.0%
253 Surgery Urology & Vascular Dir		96	96	100.0%
253 Theatres Anaes & Crit Car	3	421	424	99.3%
253 Trauma & Orthopaedics Dir		59	59	100.0%
253 Women and Children Dir		79	79	100.0%
<b>Grand Total</b>	<b>3</b>	<b>1755</b>	<b>1758</b>	<b>99.8%</b>

Status at 0900 Wednesday 30th September				
Row Labels	Not Received	Received	Grand Total	% Complete
<b>253 Clinical Support</b>	<b>13</b>	<b>445</b>	<b>458</b>	<b>97.2%</b>
253 Breast Screening Service Dir		40	40	100.0%
253 Cancer Services Managem	1	18	19	94.7%
253 Clinical Support Div Mgt Dir		6	6	100.0%
253 Imaging Dir	10	188	198	94.9%
253 Pathology Dir	2	62	64	96.9%
253 Pharmacy Dir		131	131	100.0%
<b>Grand Total</b>	<b>13</b>	<b>445</b>	<b>458</b>	<b>97.2%</b>

**Paper for submission to the Board of Directors on 8<sup>th</sup> October 2020**

<b>TITLE:</b>	Update on discussions regarding acute collaboration in the Black Country and West Birmingham		
<b>AUTHOR:</b>	Katherine Sheerin	<b>PRESENTER</b>	Diane Wake
<b>CLINICAL STRATEGIC AIMS</b>			
Develop integrated care provided locally to enable people to stay at home or be treated as close to home as possible. X		Strengthen hospital-based care to ensure high quality hospital services provided in the most effective and efficient way. X	Provide specialist services to patients from the Black Country and further afield. X
<b>ACTION REQUIRED OF COMMITTEE</b>			
<b>Decision</b>	<b>Approval</b>	<b>Discussion</b>	<b>Other</b>
		X	
<b>RECOMMENDATIONS</b>			
That the Board note the discussions regarding acute collaboration in the Black Country and West Birmingham.			
<b>CORPORATE OBJECTIVE:</b>			
SO1, SO2, SO3, SO4, SO5, SO6			
<b>SUMMARY OF KEY ISSUES:</b>			
<p>The NHS Long Term Plan (2019) set out the requirement for the creation of Integrated Care Systems (ICSs) across England by April 2021. A significant element of ICSs is built on provider collaboration, with providers working together to optimise health outcomes, service delivery and efficiency for the population served.</p> <p>As such, driven by the submission by the Black Country and West Birmingham STP to achieve ICS status, discussions regarding collaboration between acute trusts have recently recommenced.</p> <p>This paper sets out the background to the discussions, the requirements set out by NHSE/I locally, the response from Black Country providers and the timeframe for the next steps.</p>			
<b>IMPLICATIONS OF PAPER:</b>			

IMPLICATIONS FOR THE CORPORATE RISK REGISTER OR BOARD ASSURANCE FRAMEWORK			
RISK	Y		Risk Description: BAF 6a: Deliver a viable future
	BAF: Y		Risk Score: 20
COMPLIANCE and/or LEGAL REQUIREMENTS	CQC	Y	Details: Safe, Effective, Caring, Responsive, Well Led
	NHSI	Y	Details: NHS Long Term Plan (2019)
	Other	N	Details:
REPORT DESTINATION	Board of directors	Y	DATE: 8 <sup>th</sup> October 2020
	WORKING GROUP	N	DATE: Executive Team discussions
	COMMITTEE	N	DATE:

## **Update on discussions regarding acute collaboration across the Black Country and West Birmingham**

### **1. Introduction**

The NHS Long Term Plan (2019) set out the requirement for the creation of Integrated Care Systems (ICSs) across England by April 2021. A significant element of ICSs is built on provider collaboration, with providers working together to optimise health outcomes, service delivery and efficiency for the population served.

As such, driven by the submission by the Black Country and West Birmingham STP to achieve ICS status, discussions regarding collaboration between acute trusts have recently recommenced.

This paper sets out the background to the discussions, the requirements set out by NHSE/I locally, the response from Black Country providers and the timeframe for the next steps.

### **2. Background**

There is a long history of discussions in the Black Country to bring acute providers into closer working arrangements. It is acknowledged that most of these have not been successful, though there have been some achievements, for example in Stroke, Vascular and Pathology Services.

There is a belief by some that organisational arrangements need to be fixed first, in order for service reconfiguration to be achieved. For others, the starting point is service need, with organisational form to flow from this. However, it is likely that we are at a juncture where both need to be considered equally, in order that optimal models of care can be delivered for people requiring both local and more specialised services at Borough and cross- Black Country levels.

### **3. Recent developments**

#### **3.1 Application for Black Country and West Birmingham STP to become an Integrated Care System**

The NHS Long Term Plan (Jan 2019) signaled the requirement for far closer collaboration between commissioners and providers, with a move towards integration and away from competition, primarily driven through the creation of Integrated Care Systems across the country by April 2021.

The operating standards for an ICS area as follows:-

### System functions:

- **System capabilities** in place to perform the dual roles of an ICS, to co-ordinate transformation activity and collectively manage system performance, clearly defined at system, place and neighbourhood. These will include areas such as population health management, service redesign, provider development, partnership building and communications, workforce transformation, and digitisation. The system should also agree a sustainable model for resourcing these collective functions or activities. NHSEI will contribute part-funding for system infrastructure in 2020/21.
- **Streamlined commissioning** arrangements, including typically one CCG per system with clearly defined commissioning functions at system, place and neighbourhood.

### System planning:

- **System plans** that reflect the key local recovery, performance and delivery challenges and that incorporate a development plan for the system. This should explicitly reference delivery across the system architecture, i.e. place and provider collaborative(s).
- **Capital and estates plans** agreed at a system level, as the system becomes the main basis for capital planning, including technology.

### System Leadership and Governance:

- **A leadership model** for the system, that explicitly includes the following:
  - **ICS core leadership team**
  - **Place leadership** arrangements for each place within the system, ensuring that primary care (as a provider) is reflected in these arrangements.
  - **Provider collaborative(s)** lead arrangements for “hospital systems”, ambulance services and “acute mental health systems”
- **System-wide governance** arrangements to set out clear roles of each organisation and enable a collective model of responsibility, and nimble decision-making between system partners. These arrangements will include a system partnership board that sits in public and should be complemented by a public engagement approach that ensures full transparency of decision-making. The system-wide governance arrangements should be underpinned by agreed decision-making arrangements across the system architecture (i.e. place and neighbourhoods/PCNs) and agreements with respect to financial transparency.

This is being progressed in the Black Country and West Birmingham, with an application submitted in August 2020 with a view to going live from November 2020. As part of this, a shared management team has been established across the 4 CCGs with an application for them to formally merge from April 2021 in train.

### **3.2 Taking forward acute collaboration**

In August 2020, NHSE/I wrote to the leadership of the Black Country and West Birmingham STP to ask for plans to be set out for acute collaboration in line with the operating requirements for an ICS. This followed on from correspondence and discussions earlier in the year which were paused due to the Covid-19 pandemic.

Specifically, the letter requested that the system should agree with NHSE/I Midlands its acute collaboration plan including key milestones by the end September 2020.

The Chief Executives of the 4 acute provider trusts considered the letter and agreed that a small working group of nominated directors from each trust should consider the options and prepare a draft response for Chairs and CEOs to review. A workshop was held in August, facilitated by Deloitte LLP who were engaged by the STP to support this process.

### **3.3 Options considered**

Five main options for collaboration were considered:

- A merger between the four Trusts
- A 'tight link' chain
- A 'loose link' chain
- A shared CEO for an interim period to steer the system towards a chain approach in due course
- An alliance or partnership between the four Trusts

**(Please see appendix 1 for further explanation of each option.)**

## **4. Next Steps**

At this point, whilst all four Trusts agree that some form of collaboration is required, there is not a jointly agreed preferred option. Views range from having a chain model to an alliance / partnership, with merger ruled out at this stage.

As such, the Trusts have confirmed a plan with the STP and NHSE/I to undertake some more detailed work over the coming months to develop a case for change and to work towards agreeing a preferred option to take forward.

The plan is for a consensus position in relation to a preferred option to be reached in December for each Board to consider, with a view to having jointly agreed interim governance and leadership arrangements in place by April 2021.

This will require a full analysis of the risks and opportunities associated with each option, and should be driven by the need to improve health outcomes, reduce inequalities and ensure safe, high quality, effective services. This will need to be undertaken transparently, and to appropriately involve staff, patients, the public and our partners in any changes.

In addition, DGFT has been very clear that any changes in governance would require full consultation and engagement with the Council of Governors.

Simultaneously, a parallel work programme will be launched to develop the full clinical strategy for the Black Country and West Birmingham. This will be led by the Clinical Leadership Group and will review all clinical services across the system over a longer-term timeframe.

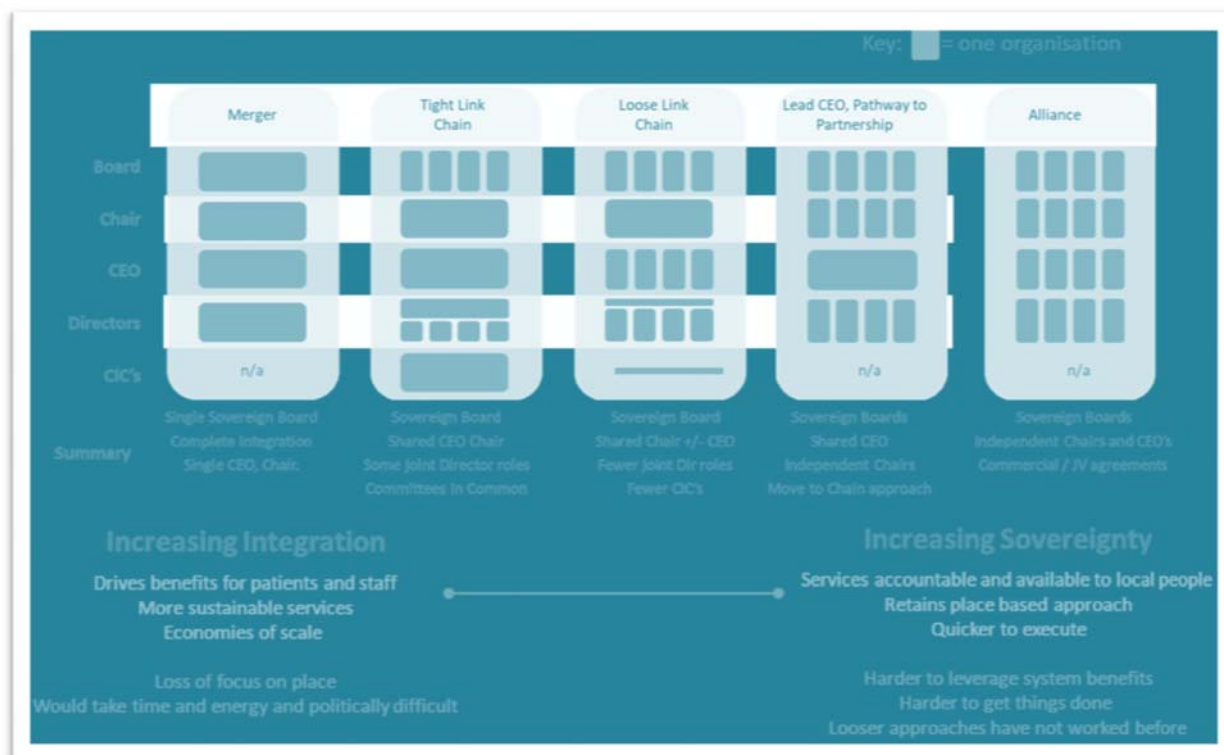
## **5. Recommendation**

The Board is asked to note the discussions regarding acute collaboration across the Black Country and West Birmingham.

**Katherine Sheerin**  
**Director of Strategy and Transformation**  
**October 2020**

## Appendix 1

### Models of collaboration



**Paper for submission to the Trust Board**  
**8th October 2020**

<b>TITLE:</b>	<b>Winter Plan</b>		
<b>AUTHOR:</b>	Qadar Zada, Deputy Chief Operating Officer	<b>PRESENTER</b>	Karen Kelly Chief Operating Officer
<b>CLINICAL STRATEGIC AIMS</b>			
<i>Develop integrated care provided locally to enable people to stay at home or be treated as close to home as possible.</i>		<i>Strengthen hospital-based care to ensure high quality hospital services provided in the most effective and efficient way.</i>	<i>Provide specialist services to patients from the Black Country and further afield.</i>
<b>ACTION REQUIRED OF COMMITTEE</b>			
<b>Decision</b>	<b>Approval</b>	<b>Discussion</b>	<b>Other</b>
<b>N</b>	<b>Y</b>	<b>Y</b>	<b>N</b>
<b>RECOMMENDATIONS</b>			
<ul style="list-style-type: none"> <li>The Trust Board is asked to note and approve the contents of the Winter plan</li> <li>The Trust Board is asked to note that this plan has been developed with input from partners in the health and social care system, further local organisation specific plans are also in development and will be discussed and monitored through the A&amp; E Delivery Board</li> </ul>			
<b>CORPORATE OBJECTIVE:</b>			
<b>SO1: Deliver a great patient experience</b> <b>SO2: Safe and Caring Services</b> <b>SO4: Be the place people choose to work</b> <b>SO5: Make the best use of what we have</b> <b>SO6: Deliver a viable future</b>			
<b>SUMMARY OF KEY ISSUES:</b>			
<ul style="list-style-type: none"> <li>The Trust has completed a review of last winter and the summary findings are included in the detail of the winter plan.</li> <li>Modelling for this winter is based on possible scenarios for presentation of COVID-19, there is no nationally accepted model for this as variation exists and further work is still taking place</li> <li>The Trust has been working on a number of interventions, which are in place to support winter. Further work is required in strengthening the Trusts resilience</li> <li>The winter plan relies on a number of further initiatives that need to be implemented and these are documented on page 16 of the plan. Largely these relate to changes in clinical pathways, in particular implementation of SDEC</li> <li>Owing to the unpredictable nature of this years winter, this plan will continue to evolve as we understand the presentation of COVID -19 in wave 2 and the adjustments that need to be made to strengthen the resilience further.</li> </ul>			

IMPLICATIONS OF PAPER:			
IMPLICATIONS FOR THE CORPORATE RISK REGISTER OR BOARD ASSURANCE FRAMEWORK			
<ul style="list-style-type: none"> <li>Risks associated with the restoration and recovery plan are detailed in the report</li> </ul>			
RISK	Y		Risk Description: BAB 1B Failure to Meet Access Standards
	Risk Register: N		Risk Score: 15
COMPLIANCE and/or LEGAL REQUIREMENTS	CQC	Y	Details: Safe, Effective, Caring, Responsive, Well Led
	NHSI	Y	Details:
	Other	N	Details:
REPORT DESTINATION	Board of directors	Y	DATE: 8 <sup>th</sup> October 2020
	WORKING GROUP	N	DATE:
	COMMITTEE	N	DATE:

# WINTER RESILIENCE PLAN 2020/21



**Active Period**  
1st October 2020 to  
31st March 2021

**Version: Final**

Executive Lead

Karen Kelly  
Chief Operating Officer

**The Dudley Group NHS Trust**  
Trust Headquarters | Rusells Hall | Dudley | West Midlands | DY1 2HQ

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## 1.0 Foreword

Winter is not an emergency or considered an unusual event, but is recognised as a period of increased pressure due to demand in the clinical acuity of the patients and the capacity demands on resources within the Trust. Winter 2020/21 will undoubtedly present challenges to the NHS that are unprecedented, with the likelihood of seasonal flu and a further wave of COVID-19. This plan's purpose is intended to describe the priorities for the next few months, together with actions that have already been taken to build resilience ahead of winter.

Last winter was a challenging period for the NHS. Thanks to the huge efforts of frontline staff, patients continued to receive safe care during this period. Despite the seasonal changes it is clear that the system remains under pressure, and in order to meet the challenges of this winter we need to learn from the experiences of last year and that is why we have undertaken an in depth review of the lessons learnt from last year and these have informed the plan for this winter.

The priorities within this plan are:

1. The reduction of overcrowding in ED through the increase of streaming patients to services outside of the department
2. The reduction and sustained reduction of Delayed Transfers Of Care
3. Implementation of schemes that promote discharge and reduce admissions to achieve 90% bed occupancy, this will improve flow
4. Implementation of the national discharge guidance
5. Reducing the variation in practice across ward areas and increasing standardisation
6. Reforming and redesigning the wider Urgent and Emergency Care system
7. The implementation of Same Day Emergency Care pathways
8. The reduction and avoidance of admissions through the better use of services within the community, the clinical hub and other ambulatory services for patients
9. Building upon the already established system wide working with partners across the Dudley and Black Country system.

Thank you to colleagues who have played a part in developing this plan, and who will contribute additional time to managing our patients over the winter. We know that there are so many people out there that help the people in Dudley to stay well and help to keep the town going throughout winter. I would like to take this opportunity to say thank you for your continued support at what is often the most challenging time of the year.

Karen Kelly

**Chief Operating Officer**

**Executive Lead for Emergency Planning**

## 2.0 Executive Brief

The health economy in Dudley, including all the relevant partners, prepares for peaks in demand throughout the year. Contingency arrangements for unscheduled and planned care activity are required.

During the winter period, however, a number of pressures will be prevalent which will have an impact on our ability to manage demand and capacity. These include:

- Increased demand for non-elective care.
- Higher rate of admissions to hospital.
- More acutely unwell patients
- More patients waiting to be discharged from hospital and requiring subsequent care packages to support discharge.
- Decreased workforce resilience (festive holidays and sickness absence).
- Requirement to balance the elective programme with management of unplanned care demand.
- Need to provide additional health and social care capacity in acute hospital and community settings.

*N.B. Additionally, and specifically this year the system must prepare itself to manage all of these pressures alongside an expected surge in cases of COVID-19.*

The Health Economy A&E Delivery Board member organisations have been tasked to ensure robust arrangements are in place for the winter. This ensures inappropriate admissions are avoided and patients are discharged home or closer to home, in a safe and timely manner. Operational responsibility for delivering the winter arrangements sits with the relevant operational leads, including the Chief Officers of the organisational partners.

The Urgent and Emergency Care Operational Group sets out the expected demand on services during the winter months, a set of mitigations (improvements) to increased demand, and detailed forecasting of operational and financial requirements.

The plan in this document sets out how the health and social care partners in Dudley are preparing for the additional peaks in demand from November 2020 through to March 2021. It builds on previous winter planning and demonstrates how the learning from the previous year has translated into a set of improvement workstreams which aim to further reduce bed demand on the Trust, despite the continuing rise in both Emergency Department demand and subsequent numbers of admitted patients.

The planned improvements from the workstreams have been used to build a model of how we expect inpatient demand to arrive on a weekly basis, and the subsequent number of acute hospital beds we will need to have open to safely manage inpatient demand.

The ambition and expectation of this plan is that the system will mitigate and manage the expected 8% growth (NHSE / CSU agreed forecast) in bed demand through the winter period (9077 bed days or 50 beds) to a point where we are planning to deliver the coming winter period without the requirement for increased G&A bed capacity year on year and within a financial envelope of Winter-specific interventions that is no greater than last year.

Additionally it will set out plans to accommodate a spike in COVID-19 which allows it to be addressed and accommodated safely within the acute footprint

### 2.1 This document sets out:

- The purpose of this document, its target audience and how it should be used along with any and all associated supporting documentation (as appendices)
- The approach taken to winter planning
- The required operational plan for winter including details of interventions
- Clinical and operational operating principles and standards
- Operational, Clinical and financial governance and reporting structures
- Specific protocols for opening capacity areas

- External reporting methodologies and requirements (Unify2, SitRep etc)

An After Action Review of Winter 2019/20 highlighted a number of issues relating to the way in which demand spiked during Dec 19 and how reduced capacity during the post-Christmas period, led to the challenges which were observed.

The plan, once complete will pass through a robust assurance process both within the Trust and externally through a range of partner organisation forums.

### **3.0 Purpose of this document**

3.1 The purpose of this Winter Plan document is to:

- Inform all relevant organisations and individuals of the way in which the system intends to manage winter demand over 2020/21
- Provide a collective overview of actions that will support operational resilience at Dudley Group NHS Foundation Trust over the winter period (1st October 2020 to 31 March 2021)
- Document information on the approach taken to building the winter plan
- Collate historical data, learning from past winter periods and knowledge of the current position that has been used in the development of these arrangements within the appendices
- Provide 'organisational memory' of what was agreed, how and why.
- Provide a platform to monitor demand and performance variance as a means to understand variance in subsequent performance and operational pressures

3.2 The winter plan should be read and supported by:

- Members of A&E Delivery Board and the Urgent & Emergency Care Operational Group
- Trust Board members
- Triumvirate Divisional Teams
- Matrons
- Clinical Directors in all non-elective specialties
- Senior operational managers in the Trust
- All colleagues who are on an on-call rota
- Senior operational managers in all system partner organisations
- Infection Control Leads
- Informatics Leads

There is a significant volume of work that has been undertaken by this group to compile the winter plan. Inclusion of all this documentation within the body of the document would make it cumbersome and difficult to be used as an operational reference document as intended.

This being the case the relevant documentation has been collated in the appendices which accompanies the main text of the document.

3.3 This document should be read in conjunction with the following documents, plans and arrangements:

- The appendix to this document
- Dudley A&E Delivery Board Improvement Plan
- Escalation policy – Full Hospital Protocol
- Major Incident Plan
- Local business continuity arrangements
- Severe Weather Plan
- Dudley Council Severe Weather Partnership

## **4.0 Approach to planning for winter**

4.1 The over-arching methodology for winter planning is grounded in a PDSA approach.

- Plan - In partnership with senior operational representatives of the health system create a document setting out the way in which we will approach managing winter pressure.
- Do - Deliver the plan as described/prescribed
- Study - Measure delivery against the plan. Identify deviations and agree improvements
- Act - Improve the plan based on recommendations from the study phase

4.2 This process has been completed using the 19/20 winter plan as a starting point and a full After Action Review of the implementation of the plan.

The After Action Review generated a set of recommendations for further improvement which drove a set of improvement workstreams which were agreed and sponsored by the Chief Officers of the A&E Delivery Board.

This improvement work and its associated expected benefit were offset against the forecast and expected growth in demand for unplanned care during 19/20 and a forecast of expected demand was created which forms the basis of the capacity and demand plan for 20/21.

The approach to delivering a safe robust winter period consists of 3 key elements:

- A full review of the previous winter plan and assessment of its success
- Pre-emptive improvement work which builds on learning from the previous year to design and implement changes which reduce the burden of winter demand
- Pro-active, robust actions and interventions during the winter period which ensure the system is resilient to winter pressure and assists in the management of escalated pressure when necessary.

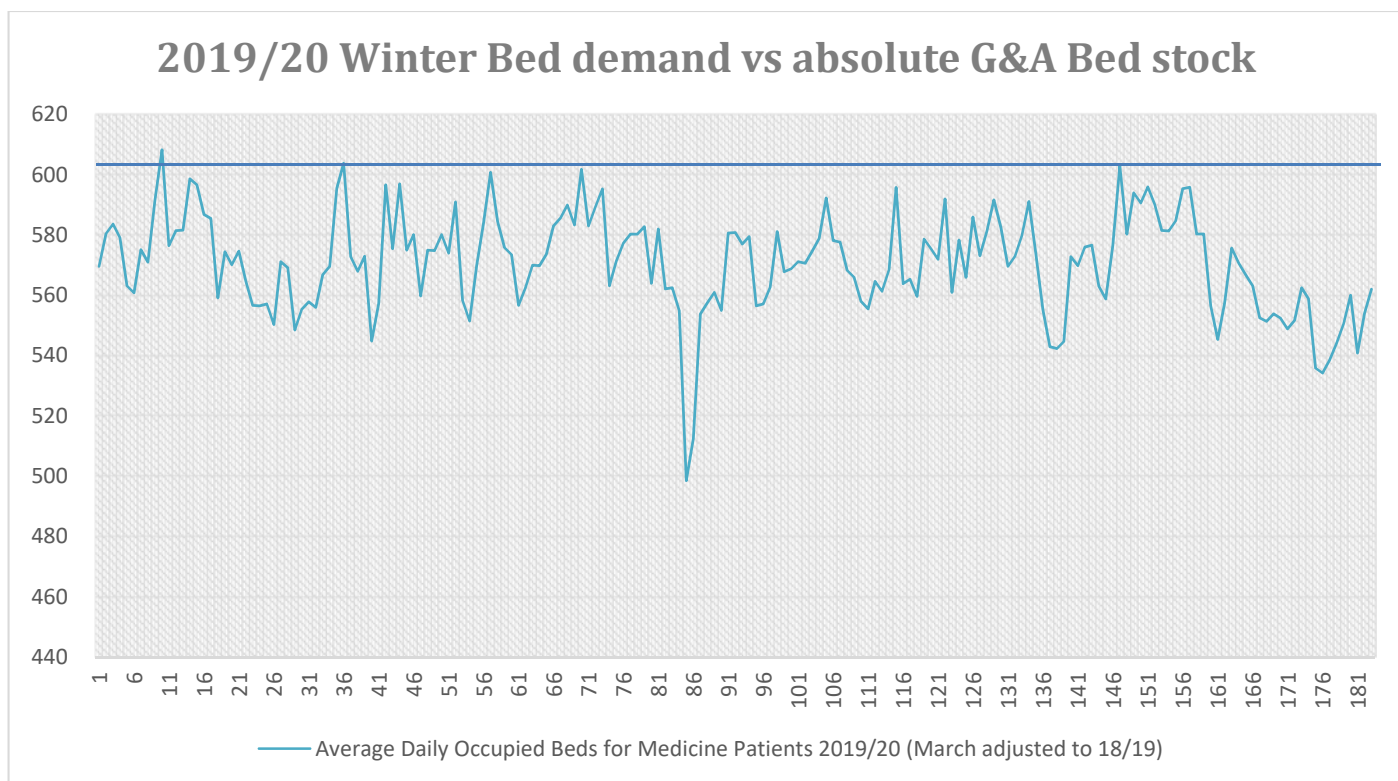
### **Review of winter 19/20**

To understand and agree the approach to managing the winter period it was critical that a group undertook a deep analysis of the actual way demand and capacity was managed through the winter period.

This was achieved through the undertaking of an 'After Action Review'. The After Action Review delivered a full, detailed analysis of how the winter was delivered.

The key findings of this analysis are detailed over page.

## 19/20 Winter Bed Demand



### Summary

- 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 24<sup>th</sup> Dec to 6<sup>th</sup> 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% leading to issues with flow
- 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
- The high occupancy and 'churn' of same day patients in AMU also had the potential to inhibit timely moves of patients to available specialty beds

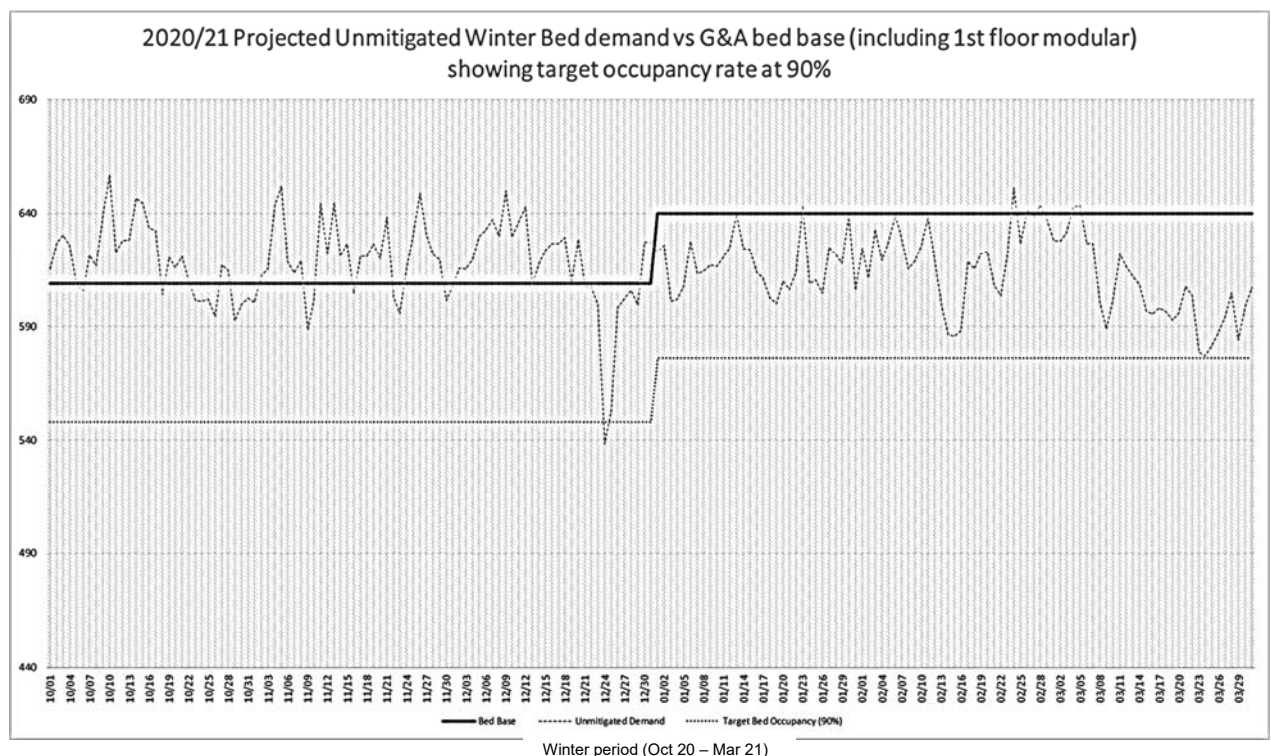
- Finally it was noted that, as part of the COVID-19 response significant improvements have been made to the complex discharge pathways which will, following the most recent NHS guidance, be able to sustain through the winter period and, as a result reduce historic delays for this patient cohort.

Recommendations were considered by the system leads and operational managers and a set of improvements for the coming year was agreed. These projects and workstreams became the mechanism for implementation of the recommendations through pre-emptive mitigation and pro-active management.

The Review of Winter 2019/20 was presented to system partners during July and August 2020 its key findings were as follows:

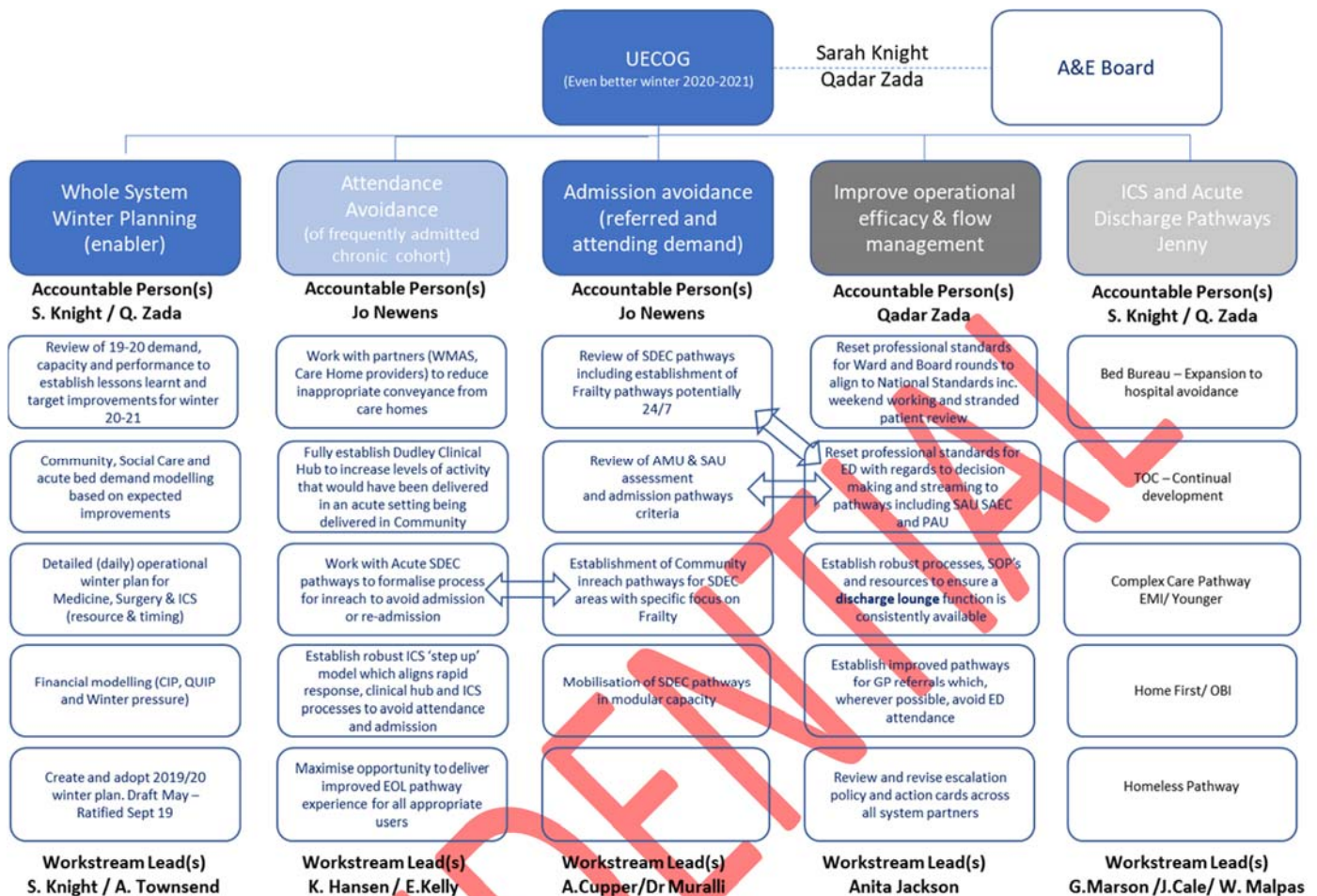
### Pre-emptive mitigation of demand

The system model for expected demand in 20/21 without any mitigation is as follows:



This demonstrates that, even with the projected opening of the modular capacity, the Trust will consistently be overwhelmed this coming winter.

To mitigate this, the pre-emptive element of winter planning consists of a number of identified workstreams and projects which address the recommendations made in the After Action Review. The following diagram illustrates the workstreams and projects identified for implementation during the period March 2020 - October 2020 along with the workstream sponsors and owners.



## Pro Active management

Pro-active management can be described as an activity which is aimed at reducing inpatient bed demand in real time, such as increased senior medical resources at key times of the week / day. In addition to these interventions it was separately recognised that during the winter period 2019/20 the primary driver for opening capacity beds at the beginning of January was not actually increased demand (through emergency admissions) but the cumulative impact of low levels of discharges in the preceding 15 days of the festive period. In this period the Trust was exposed to 6 weekend days and 3 bank holidays, all of which had significantly lower discharge rates than 'normal' working days.

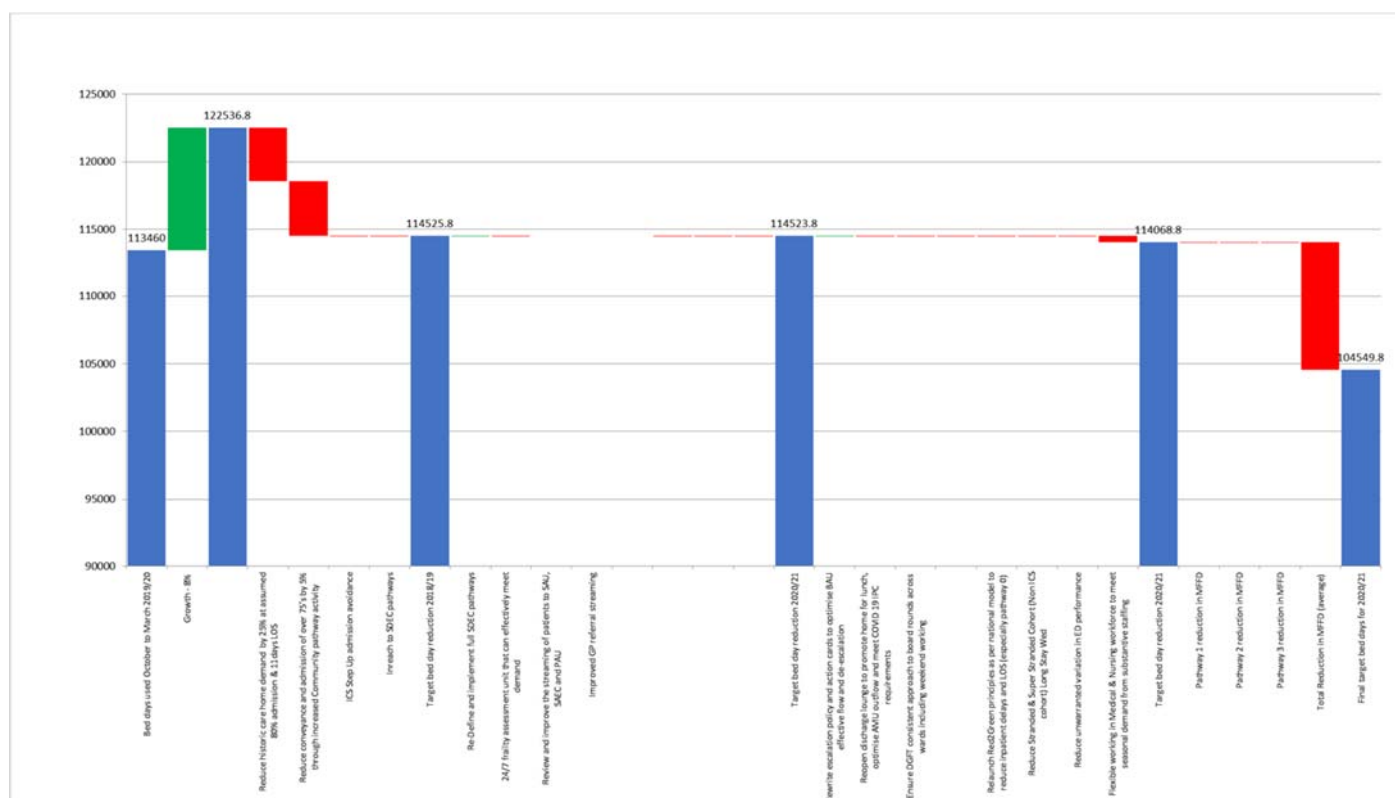
The Trust will strive to deliver a full 7 days service during the 'Festive Period' but this will be subject to staffing availability and financial affordability.

## Calculating the expected impact of planned interventions

The expected benefits of these two separate approaches were subject to scrutiny and are evidence based.

After the expected benefit calculations were completed (in a currency of bed day reductions). This benefit was then used to demonstrate, at project level, the expected impact on demand that each project (and workstream) was committing to deliver.

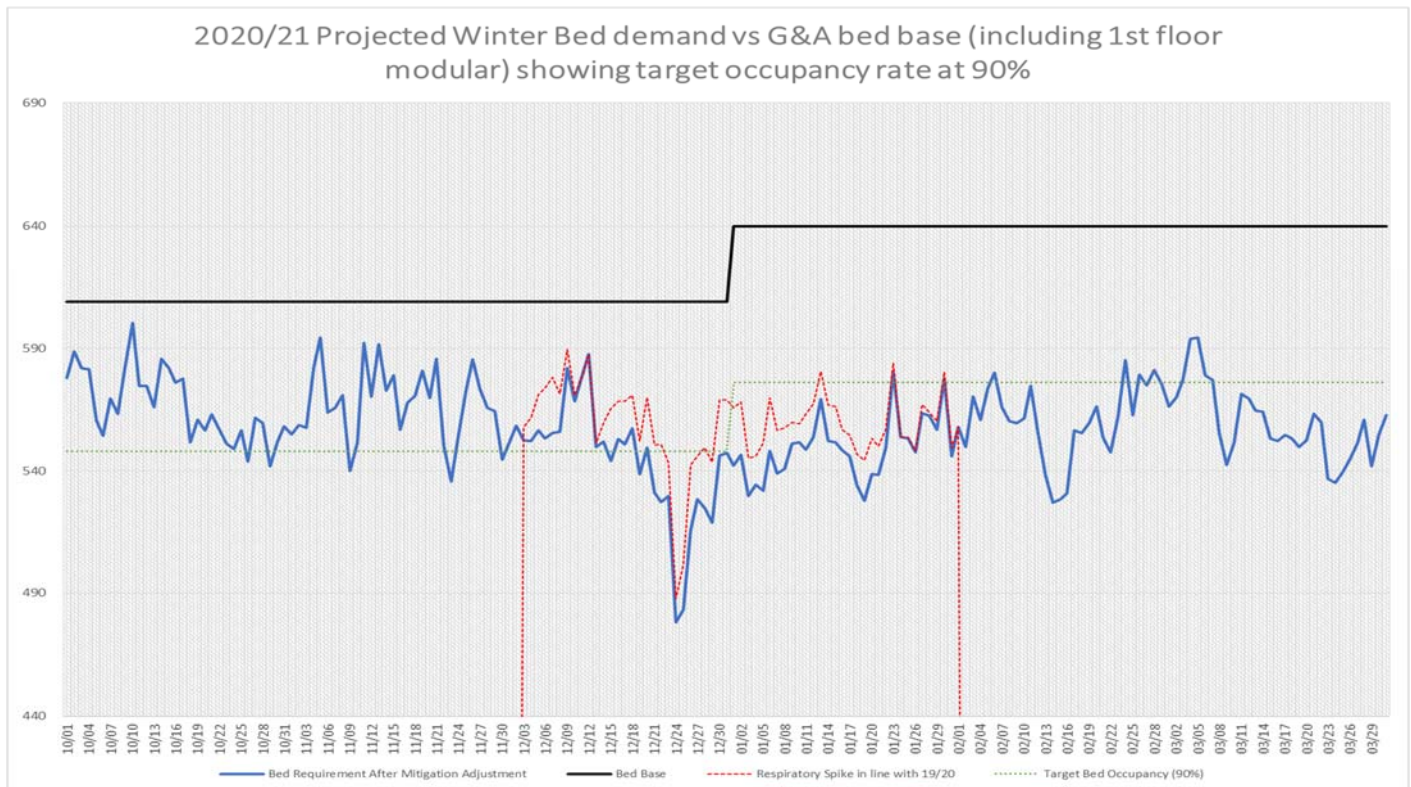
This is articulated in a 'waterfall' visualisation which showed historic levels of bed day activity plus forecasted growth minus benefit improvements giving a forecast of annual bed demand for the coming year:



The benefit of these collective actions – including both pre-emptive and pro-active benefits – has created a new forecast for the overall bed demand required to operate safely over the winter period. We have used this to generate a graphical representation of the way in which bed demand is predicted to increase and fall over the period. Critically this projection includes the phased realisation of benefits from the improvement work as it moves to full year effect.

This modelled demand was then used to inform and agree a viable and deliverable operational plan for managing acute bed stock through the winter period and, more specifically, identify times when the Acute Trust would need to consider opening additional inpatient capacity to safely manage demand.

As at 10<sup>th</sup> Sept 20 this is the current forecast of demand on acute beds with the expected mitigations in place.

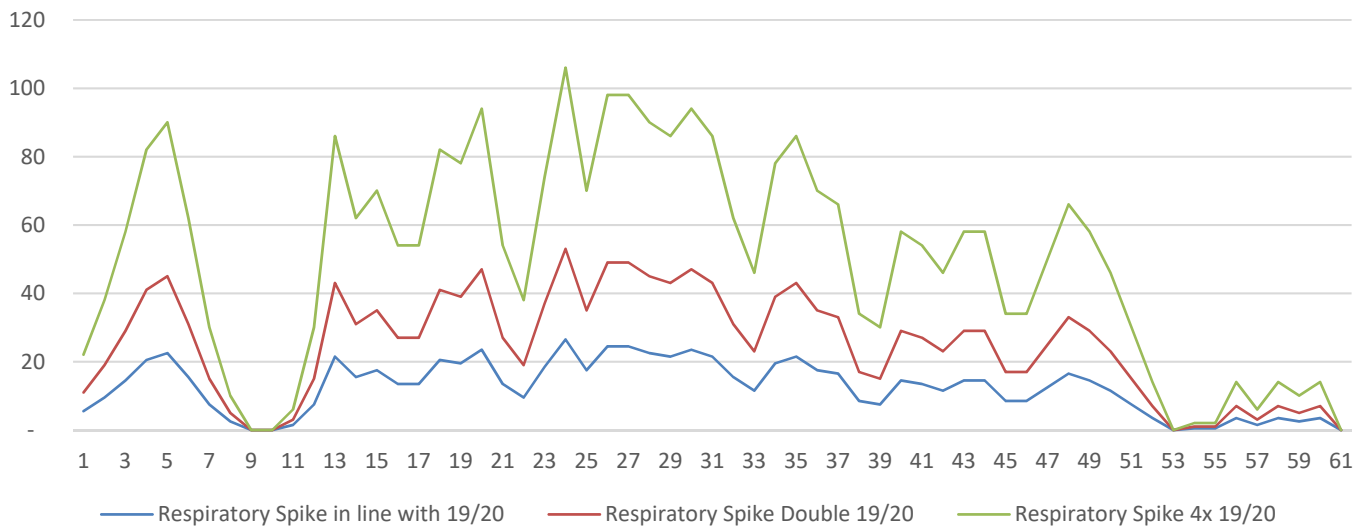


**AT THIS POINT UNLESS ALL IDENTIFIED BENEFIT IS REALISED PRIOR TO OCTOBER IT IS UNLIKELY THAT ANY BED STOCK COULD BE CLOSED PRIOR TO THE WINTER PERIOD. ON THIS BASIS PLANS SHOULD BE MADE TO STAFF THE CURRENT BED CAPACITY THROUGHOUT THE WINTER PERIOD.**

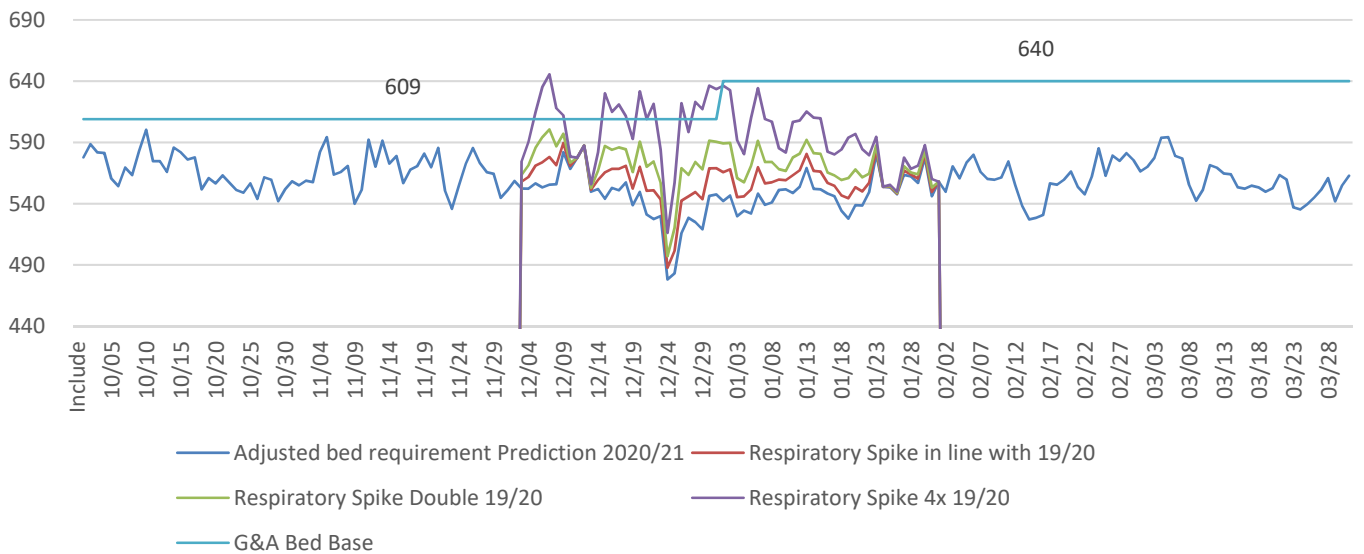
In addition to the expected winter demand this forecast has been modelled to understand the likely demand that would be created by a spike in COVID-19 or Flu like admitted demand. This demand has been modelled to show its impact if it were to arrive in the same distribution as the spike experienced in Dec 19.

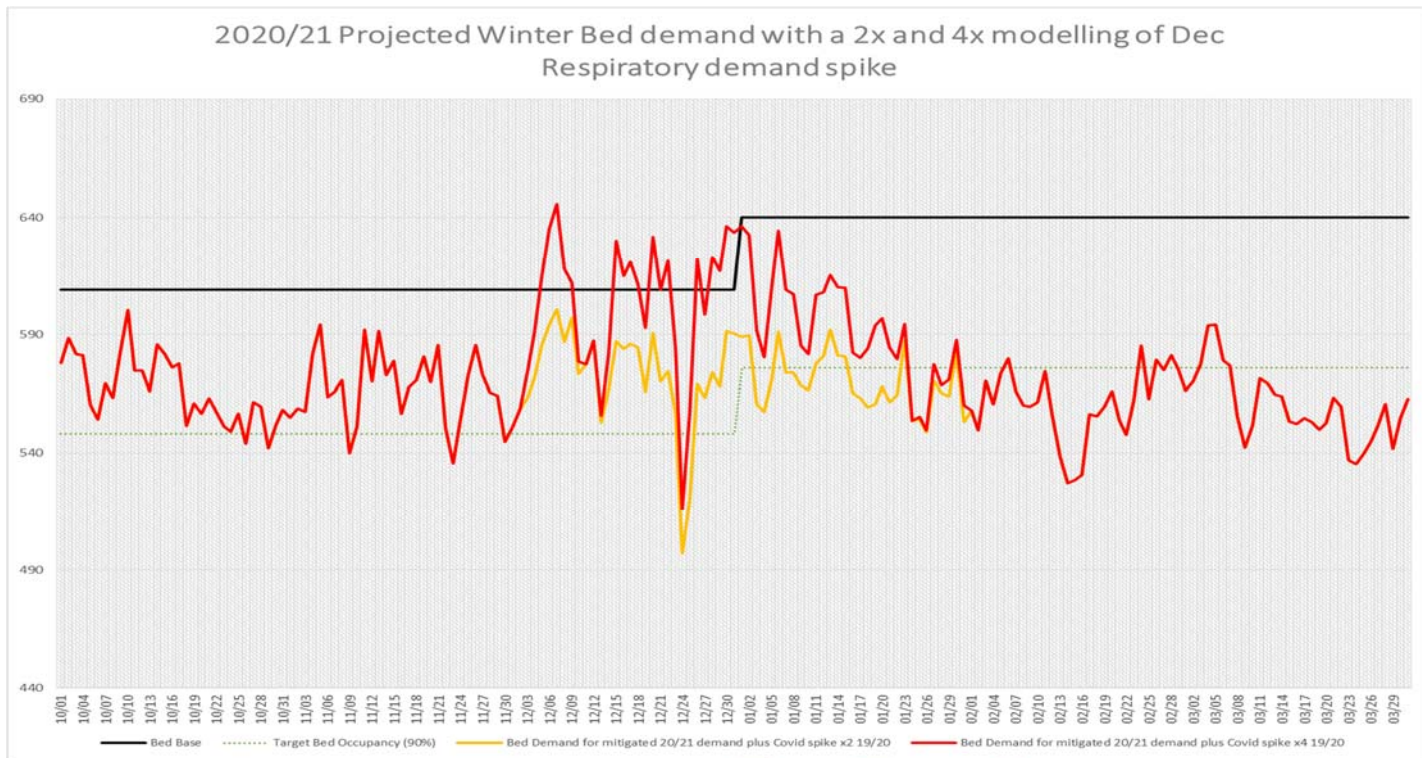
Whilst a spike of the same magnitude has been included in the base plan scenarios have also been considered where the demand is x2 and x4 of the demand. This has been modelled arriving in the same month and separately as a 'surge plan' in isolation to demonstrate the pure number of beds required.

### Modelling of Likely Bed demand for Covid -19 Spike of Same, x2 and x4 of last year Dec spike



### Absolute G&A bed requirement for expected (mitigated) demand plus covid spikes of Dec spike, x2 and x4 magnitude spikes





N.B.

*We are aware that the exact timing and size of any peak is much more unpredictable than the rise in demand in the post-Christmas period. Equally there is a reasonable likelihood that, should a Covid-19 spike occur, elective surgical and non-elective medicine will reduce at the same time but to what extent is not yet known. This being the case we will review the levels of demand dynamically over the period October and November and only open capacity areas at a time it is agreed the expected rise in demand is being seen.*

The expectation in this plan is that this forecast demand has then been used to drive detailed operational, fully costed models for delivery. These detailed plans are set out in the Detailed Winter Plan in the next chapter.

## 5.0 Detailed Winter Plan

Plan for the period 1<sup>st</sup> October to 31<sup>st</sup> March 21.

### Winter initiatives

The following document shows the planned interventions which will be in place and aim to reduce inpatient demand 'in the moment'. They typically add resources into existing pathways to make them more robust or able to deliver services over longer periods (into the evening or at weekends for example). These actions are now "business as usual" and are based on lessons learned from previous winter:

- Investment in acute medicine nursing and ED nursing to reflect acuity of patients.
- Improved and enhanced triage – increased number of nurses to undertake this function in ED
- Focus on frailty – co-located frailty unit and the creation of a dedicated short stay frailty unit.
- Improved, dedicated paediatric facility in ED – larger and improved lay out resulting in a better family and child experience
- Minors 24/7 – investment and recruitment to Advance nurse practitioners to staff this area 24 hours per day

## **Medicine**

- An Additional acute care physician in ED 4 late shifts per week to ensure all medicine referrals that are not moved to a bed within 30 minutes have an appropriate clinical plan in place. This action will also maximise the opportunity to discharge patients from ED. This will be enhanced and reviewed as SDEC is embedded to ensure that it supports the planned improvement of reducing numbers of patients held in ED or admitted with a length of stay of less than 1 day.
- Discharge Doctor attached to the discharge lounge to support prescribing of TTOs to enable patients to be transferred to the discharge lounge earlier in the day thus releasing beds
- Out Patient clinics limited to essential clinical need only, during bank holiday weeks
- Transfer nurses booked x2 per shift to support patient moves from ED and wards resulting in more timely moves and to enable ward and ED nurses to remain in these areas
- Therapy 7 day working across all in patient areas to support discharges and consideration given to front door therapy provision in line with the review of clinical pathways
- Frailty Assessment Unit in ED over 7 days x 70 hours per week
- The Trust has employed a full time consultant to support with the management of medical outliers in surgery/ orthopaedics to ensure patient receive a senior review and have a clear plan of care. This consultant is supported by the MDT already in existence within the base wards to ensure care and discharge is progressed in line with the outlier policy.

## **Surgery**

- Resident Paeds Rota – 1st October to the 31st March
- List primarily day cases during the first two weeks of January 1<sup>st</sup> 2021 to 14th March 2021
- Stranded patients management – expand the daily review of patients to include those with a LOS between 7 to 20 days.
- Open day surgery to 10pm to avoid conversion of patients from Day Surgery to In-Patients
- Ensure a ring fenced (x1) #NOF bed on the trauma ward B2.

## **Staffing**

- Escalation actions support the release of corporate nursing staff to be released from duties to support direct clinical care.
- 7 day working plan allowing all staff to be deployed to critical areas as required and ensuring staff do not need to work extended hours during winter periods, this must include nursing initiatives such as back to the floor which is now an embedded operational process every Wednesday
- Supporting staff with incentives to encourage staff to take on additional bank shifts throughout the period.
- Block booked agency at reduced rates being sourced for key areas.

## **Diagnostics**

- During key periods i.e. Christmas bank holidays into New year and first week of January ensure that diagnostics can be accelerated and that there are more slots available for patients that require diagnostics completion
- Additional radiographer in place each evening to support increased attendance in ED
- One scanner to remain 'not booked' Monday to Friday to accommodate in-patients and urgent scans
- Increased radiologists on site weekends and bank holidays.

## **Pharmacy**

- Pharmacy now has pre packed TTOs in place for commonly prescribed medications to support quicker discharges.

- Medi-Box process and the SLA for this provision have been extended for winter period. 2 x daily drop offs are now in place with extended cut off time to midday. Additional pick up slots can be arranged and flexed as needed and will be managed by the discharge team in collaboration with pharmacy.

### **Community Nursing**

- Community Hub referral pathways are utilised to promote hospital avoidance, with communication to ensure inappropriate conveyances to ED are shared between providers
- WMAS dedicated phone line in place to support admission avoidance
- Hydration Pathway into Community IV Team in place to support early hospital discharge
- Long Term Conditions Nurses to in-reach into Russell's Hall each day and report to Capacity Hub, Frailty Assessment Unit, C3, AEC to support early discharges.
- Frail elderly to receive in reach from the community supporting discharge
- Dudley Rehab service to work with local authority re-ablement service to support early discharges.
- Red Cross and other Voluntary organisations to be utilised effectively to support admission avoidance and early discharges.
- Work with local authority to facilitate urgent packages of care as required to support admission avoidance and early discharge.
- Satellite equipment store (Brierley Hill Health & Social Care Centre) is well stocked to meet needs of admission avoidance patients.

### **Modular build**

The winter plan relies on the introduction of a modular build comprising:

- Ground floor – An Assessment Unit with 32 trolleys
- First floor - 30 beds Ward

This additional capacity is expected to be introduced towards the end of the calendar year (December) and this has been modelled into the winter plan. The modular build will enable the Trust and the division of medicine to increase at pace and scope the Assessment of medical patients and the capacity of Same Day Emergency Care (SDEC) services. Currently the Acute Medical Unit (AMU) is a bed based service and in the Division of Medicine SDEC is delivered from a variety of locations covering Ambulatory Emergency Care (AEC), Frailty Assessment Unit (FAU), Cardiac Assessment Unit (CAU) and when space runs out in these areas in ED itself.

### **SDEC Model**

The Majority of SDEC patients tend to have a low (some moderate) acuity which means that many can walk or be moved in a wheelchair. Such patients can be moved easier to AEC/FAU/CAU which is some distance from ED, there is little benefit for these services to being close to ED. The benefits of merging these services into one clinical space in the same footprint allows for working 'Smart' and sharing similar physical resources giving maximum utility.

In summary, the benefits to this model of care are:

- Reducing admission for overnight stay by increasing assessment capacity
- Reduction in transfer time from ED to assessment space by co-locating the area next to ED
- Increasing SDEC services which reduce attendance at ED and ultimately admissions.

- The vacated footprint of the current AMU will enable the Trust to flex into additional beds when peaks in demand necessitate.

## **Elective Phasing**

Reducing elective activity plans will be reduced from the end of December and throughout January. This reduction in routine activity will continue between Christmas and New Year. During the first two weeks of January the Surgical Division will continue to book cancer, urgent and day case surgery as a priority. This intervention will release bed capacity to support the increased pressure. It is planned that surgical activity will return to standard levels from the beginning of February

## **Supporting our Emergency Department**

The Trusts Emergency department will experience increased pressures over winter. Review of previous winter demand and management have identified the likely impact on our ED:

1. Increased case mix of frail patients who experience difficulties in winter months (increased demand)
2. Increased demand at times of holidays when patients delay receipt of treatment and/or expose themselves to increased risk of injury/illness (increased demand)
3. Reduced in support and availability in primary care GP through during winter holidays and patients that decide not to use alternative services (increased demand)
4. Reduced flow and inpatient bed availability increasing exit block (reduced capacity)

The range of interventions identified in our plan will be a supportive response to this increase in pressure.

## **Ambulance Handover**

The Trust works closely with WMAS to improve handover times and the impact that ED overcrowding and pressure can have on released ambulance crews in a timely way.

In response to this, the trust will introduce further measures:

1. Continue with senior triage for ambulance patients
2. Enhance the recently introduced Rapid Assessment and Triage (RAT)
3. Subject to staffing, provide additional capacity for ambulance triage. Potential space for this to operate has been identified

## **Intermediate Care Pathways**

In addition, in light of no Better Care fund allocations and in recognition of COVID-19 presentation, commissioning colleagues are working through an extension of the enhanced intermediate care facility to support during winter. The initiatives include:

1. Integrated Bed Bureau for ease of decision making and flexible and collective use of bed stock
2. Additional bed capacity in nursing homes
3. Directly employed physiotherapy support into residential and nursing homes

## Further interventions

In addition to the interventions that have been implemented as part of the workstream to reduce admissions, the following is yet to be in place:

- Dedicated medical Outlier team to ensure timely review of patients
- Discharge doctor to support timely TTOs
- Respiratory Assessment team to review patients attending ED
- Hot clinics for to enable primary access
- NHS 111 bookable slots

## Festive Period interventions

This year Christmas Eve, where the sites commonly have increased discharges, falls on a Thursday. Through the capacity team and the transformational flow work stream, effort will be made to maximise discharges under a “home for Christmas” initiative. This will include where possible, additional medical and pharmacy staffing to ensure patients are ready to go as well as securing increased capacity from transport providers to ensure that demand is matched at this important time. After the holiday period we anticipate increased pressure on the system and are therefore planning additional staffing to start from the last day of the holiday to ease flow back into the week.

## Communications Plan

Key operational leaders will work with the trust Communications department to release key messages for the public to promote “choose well messages” and for staff around areas of transformation work that is taking place. This communication will be based on a range of methods including internal and external communications.

The Trust is also part of a system communications forum through the COVID oversight groups and it will utilise these opportunities too, this will ensure consistent messaging across the system and across partners.

## **6.0 Risk and Action Logs**

Whilst the authors and contributors to this plan are confident in its methodology and assumptions they also recognise that some of its actions assume an availability of additional staff resource, both nursing and clinical, the absolute volumes of which continue to be tested to their limit within the entire health economy both locally and nationally. Equally, whilst we have planned for, and mitigated against expected public health events such as COVID-19, influenza, c-difficile, norovirus et al we have not experienced a significant, major event in recent years. Finally there are specific events and or incidents which cannot be planned for, owing to the unique nature of this winter and the likely presentation of wave 2 COVID-19, however we need to recognise that they may emerge and the plan should be considered as evolving. Additional interventions may need to be implemented to manage these events as they are presented.

## **7.0 Measures of Success**

Whilst the Winter Plan's overall priority is to ensure the building blocks are in place to deliver a safe and effective winter there are a number of statutory and operational metrics by which the Winter Plan must be judged. These will be:

- The Acute Trust will achieve 4hr performance in line with its committed trajectory agreed with NHS Improvement:
- The Trust will achieve 100% performance against the 12-hour decision to admit standard
- The number of incidents that directly relate to patient harm will reduce Year on Year
- The Trust will achieve a target of there being no serious incidents associated with the delivery of the Winter Plan.

## **8.0 Operational and Clinical principles & standards**

**8.1** This section sets out a series of key mandatory operational and clinical principles and standards, applicable to all areas, which will assist patient flow during the winter period whilst maintaining service quality and patient experience.

### **8.2 Emergency department**

The Emergency Department should primarily be accessed for serious and life threatening conditions and therefore all patients will spend as little time as possible within the Emergency Department and in any event will not spend more than 4-hours waiting wherever possible.

- All patients will undergo triage within 15 minutes of attending ED.
- All patients in Emergency Department requiring assessment or admission will be 'pulled' into the appropriate short stay areas or speciality bed within the 4-hour waiting time.
- The Trust and all System Partners will adopt the Actions set out in the NHS Discharge Guidance (Aug 20) and audit performance against the action cards within this document
- All patients will be assessed where required by an appropriate decision maker working to a service agreed care pathway.
- All specialities will review all emergency patients daily – 7 days a week – and continue a multi professional Board and Ward round approach to be completed each morning based on clinical need.
- The comprehensive Board and Ward Rounds (9am) will ensure early identification of definite and potential discharges ensuring communication to the Bed Bureau in a timely manner.
- The Trust, in accordance with national best practice, which is recognised by the appropriate Royal Colleges, will embrace the principles of SAFER as a mechanism for optimising Patient Flow:

- Senior Review (**S**) – All patients will have a senior review before midday.
- All patients (**A**) – Will have expected discharge date and clinical criteria for discharge.
- Flow (**F**) – Commencing at the earliest opportunity, first patients by 10am.
- Early discharge (**E**) – 33% of patients discharged before midday.
- Review (**R**) – Multi-disciplinary team reviews of patients with extended length of stay.

8.3 The afternoon Board Rounds will focus the identification of definite discharges for the following morning with patients moving by 10am.

8.4 Re-ablement will be offered where appropriate to allow considered decisions about long-term care.

8.5 All appropriate patients will be discharged via the Discharge Lounge 5 days per week. These patients will be, wherever clinically appropriate, moved to discharge lounge between 10am and 2pm. Wherever possible a 'golden patient' will be identified daily, in advance by each ward with the aim being to move this patient to the discharge lounge no later than 10 am the following day.

8.6 Specialities will provide appropriate in-reach to admission areas to:

- a. Provide specialist support in inpatient management
- b. Ensure appropriate patients are identified and rapidly moved to speciality wards
- c. Discharge/early supported discharge is expedited by specialist opinion/community management

## 9.0 Operational model for opening and closing capacity

Although a significant amount of work has been undertaken to mitigate bed demand the forecast still shows that we will experience times of pressure during the winter months that will require us to open additional capacity. Equally our modelling predicts times when we can reasonably de-escalate these capacity areas as demand reduces. The opening of additional capacity areas carries significant financial, operational and clinical risk so it is critical to the success of the winter plan that, at the point a capacity area needs to be opened it is done in as effective and safe way as possible. Equally de-escalating capacity areas quickly mitigates risk across the whole hospital which might other-wise remain if the capacity areas remain open, staffed but underutilised.

A fundamental and guiding principle of the operational approach to managing demand is that it is far safer, in the face of variable demand which will most likely continue to outstrip the bed base on multiple weeks over a longer period, to open a capacity area and staff it with a significant and relatively substantive staff group. The expected opening of the Modular block on 31<sup>st</sup> Dec will meet much of the expected rise in demand and revenue funding to staff this area is available however the clinical model and staffing levels have not (at Sept 9<sup>th</sup> been agreed) . Agreement of the clinical model and staffing levels is currently being sought to enable recruitment to be achieved.

Furthermore whilst we expect this capacity to be required the exact opening and subsequent closing date of any excess capacity is subject to ongoing review based on demand.

Opening additional planned capacity will only be undertaken with prior approval of the Chief Operating Officer and/or Director On-Call.

Care must be taken to ensure all patients meet appropriate criteria for admittance to additional capacity areas and consideration given to the maintenance of good care provision

The need to open capacity areas will be kept under constant review in terms of capacity and demand. Opening of additional capacity beds will not be taken as a last minute decision, but reviewed formally by capacity team and site manager throughout the day and night. The Divisional Director of Operations for Medicine and community or Surgery will approve the plan to open such areas following agreement with senior medical, nursing & managerial colleagues.

***Considerations when opening additional capacity:***

- i. Not just the current but the following 3 days requirement for the space
- ii. The number of beds required and available
- iii. The suitability of patients
  - 1. IVs, CDs
  - 2. Planned discharge for the following day is preferred to acutely ill patients
- ii. Nurse staffing
- iii. Medical cover (how will each patient be seen)
- iv. Equipment, medical gases

All such decisions must include senior nursing and managerial contribution.

**10.0 Operational, Clinical and financial governance arrangements**

10.1 Three governance levels exist that ensure our clinical operating principles and standards are maintained, and quality as well as patient safety standards are not compromised throughout the winter period. The three levels are Strategic, Tactical and Operational. Each of these levels is well established and embedded within the arrangements of the Trust.

**10.2 Operational Governance**

In addition to the 3 x daily bed meetings and Friday 'Weekend Cabinet' Meeting the Weekly Operational Group (chaired by the Chief Operating Officer) will review the prior week's adherence to plan. The Weekly Operational Group will meet periodically and the discussion will be informed by a Weekly PDCA Report. This process ensures that the Trust will adhere to the principles of PDSA methodology and the Trust becomes an organisation with a memory. The meeting will highlight any required adjustments to the plan based on information and insight from the following pro forma:

**Tactical Review**

Delivery of the winter plan will be a standing agenda item on the Trust Management Board agenda

The Board will receive updates on:

- i. Proposed plans for Winter
- ii. Monitoring the monthly feedback on progress against the plan
- iii. Risk mitigations to be put in place
- iv. Overall performance against the standards and criteria identified with the plan

**Strategic Review**

In line with reporting of the constitutional standards the winter plan will be strategically reviewed at Finance and Performance Committee. The operational and tactical reviews generated above will drive the narrative that supports the document but the winter plan will not be reported separately to avoid duplication of existing Finance and Performance Committee reports.




The focus of discussion at each of the above meeting will be the development of actions and plans to recover the expected trajectory and Trust position if required.

## 11.0 External Reporting

Early reporting of data that indicates emerging problems, is seen as a key element in the effective management of winter. Trusts are required to use UNIFY2 for reporting local winter pressures. Clarity regarding SITREPs contents will follow in due course, current expectations are:

- temporary A&E closures;
- A&E diverts;
- ambulance handover delays over 30 minutes;
- trolley-waits of over 12 hours;
- cancelled elective operations;
- urgent operations cancelled in the previous 24 hours and those operations cancelled for the second or subsequent time in the previous 24 hours;
- availability of critical care, paediatric intensive care and neonatal intensive care beds;
- non clinical critical care transfers out of an approved group and within approved critical care transfer group (including paediatric and neonatal);
- Bed stock numbers (including escalation, numbers closed, those unavailable due to delayed transfers of care etc.);
- And details of actions being taken if trust has considers that it has experienced serious operational problems.
- COVID related reporting returns are expected as is the case at present

## Appendices

- Appendix A-Winter Planning Position Paper September 2020   
appendix A Winter Planning position paper
- Appendix B- DGOH Normal Winter projections 20/21   
appendix B DGOH Norm Winter Projecti
- Appendix C-DGOH Covid winter projections 20/21   
Appendix C DGOH Covid Winter Projecti



**The Dudley Group**  
NHS Foundation Trust

**Paper for submission to the Private Board of Directors on 8 October 2020**

<b>TITLE:</b>	<b>Audit Committee Meeting – 14 September 2020</b>		
<b>AUTHOR:</b>	Richard Miner Audit Committee Chair	<b>PRESENTER</b>	Richard Miner Audit Committee Chair
<b>CLINICAL STRATEGIC AIMS</b>			
<i>Strengthen hospital-based care to ensure high quality hospital services provided in the most effective and efficient way.</i>			
<b>ACTION REQUIRED OF COMMITTEE</b>			
<b>Decision</b>	<b>Approval</b>	<b>Discussion</b>	<b>Other</b>
<b>x</b>		<b>x</b>	
<b>RECOMMENDATIONS:</b>			
To note the issues discussed at the Audit Committee on 14 September and action two recommendations.			
<b>CORPORATE OBJECTIVE:</b>			
SO3: Drive service improvements, innovation and transformation SO5: Make the best use of what we have SO6: Deliver a viable future			
<b>SUMMARY OF KEY ISSUES:</b>			
Positive assurances and recommendations for the Board. Details of outstanding work being followed up.			
<b>IMPLICATIONS OF PAPER:</b>			
<b>IMPLICATIONS FOR THE CORPORATE RISK REGISTER OR BOARD ASSURANCE FRAMEWORK</b>			
<b>RISK</b>	<b>N</b>		<b>Risk Description:</b>
	<b>Risk Register: N</b>		<b>Risk Score:</b>
<b>COMPLIANCE and/or LEGAL REQUIREMENTS</b>	<b>CQC</b>	<b>Y</b>	<b>Details:</b> Well Led
	<b>NHSI</b>	<b>N</b>	<b>Details:</b>
	<b>Other</b>	<b>Y</b>	<b>Details:</b> Good Governance
<b>REPORT DESTINATION</b>	<b>EXECUTIVE DIRECTORS</b>	<b>N</b>	<b>DATE:</b>
	<b>WORKING GROUP</b>	<b>N</b>	<b>DATE:</b>
	<b>COMMITTEE</b>	<b>N</b>	<b>DATE:</b>

## UPWARD REPORT FROM AUDIT COMMITTEE

Date Committee last met: 14 September 2020

<p><b>MATTERS OF CONCERN OR KEY RISKS TO ESCALATE</b></p> <ul style="list-style-type: none"> <li>• None</li> </ul>	<p><b>MAJOR ACTIONS COMMISSIONED/WORK UNDERWAY</b></p> <ul style="list-style-type: none"> <li>• Reconciliation of internal audit recommendations tracker (there are some inconsistencies between our own records and those of RSM)</li> <li>• Review of Cyber Security risk score given mitigating actions.</li> </ul>
<p><b>POSITIVE ASSURANCES TO PROVIDE</b></p> <ul style="list-style-type: none"> <li>• Good progress on clinical/quality improvement audit plan</li> <li>• Whistle blowing – reasonable assurance report from RSM</li> <li>• Data quality (sepsis) – reasonable assurance</li> <li>• Detailed challenge and ongoing work around BAF/Corporate Risk Register</li> <li>• Losses and special payments report show good control</li> <li>• Declaration of Interests and impasse on policy resolved across Trust</li> <li>• Good level of Trust awareness around Cyber Security</li> <li>• Deep dive on unused contracted hours and radiology actions have assuaged concerns</li> </ul>	<p><b>DECISIONS MADE</b></p> <ul style="list-style-type: none"> <li>• Reviewed and recommend updated standing financial instructions to Board for approval,</li> <li>• Reviewed and recommend Risk Management Strategy for ratification by the Board</li> <li>• Agreed changes to internal audit plan</li> </ul>
<p><b>Chair's comments on the effectiveness of the meeting:</b> A thorough and detailed discussion with good challenge</p>	

**Paper for submission to the Public Board of Directors on 8 October 2020**

<b>TITLE:</b>	Charitable Funds Committee Summary Report		
<b>AUTHOR:</b>	Julian Atkins Committee Chair	<b>PRESENTER:</b>	Julian Atkins Committee Chair
<b>CLINICAL STRATEGIC AIMS</b>			
<i>Develop integrated care provided locally to enable people to stay at home or be treated as close to home as possible.</i>		<i>Strengthen hospital-based care to ensure high quality hospital services provided in the most effective and efficient way.</i>	
<i>Provide specialist services to patients from the Black Country and further afield.</i>			
<b>ACTION REQUIRED OF COMMITTEE</b>			
<b>Decision</b>	<b>Approval</b>	<b>Discussion</b>	<b>Other</b>
			X
<b>RECOMMENDATIONS</b>			
The Board is asked to note the contents of the report.			
<b>CORPORATE OBJECTIVE:</b>			
S01 – Deliver a great patient experience S05 – Make the best use of what we have			
<b>SUMMARY OF KEY ISSUES:</b>			
Summary of key issues discussed and approved by the Charitable Funds Committee at an extraordinary meeting on the 30 <sup>th</sup> July and the scheduled meeting on 14 <sup>th</sup> September. The extraordinary meeting was called in response to the large volume of donations received by the Trust following the Covid-19 outbreak.			
<b>IMPLICATIONS OF PAPER:</b>			
<b>IMPLICATIONS FOR THE CORPORATE RISK REGISTER OR BOARD ASSURANCE FRAMEWORK</b>			
<b>RISK</b>	<b>N</b>		<b>Risk Description:</b>
	<b>Risk Register: N</b>		<b>Risk Score:</b>
<b>COMPLIANCE and/or LEGAL REQUIREMENTS</b>	<b>CQC</b>	<b>N</b>	<b>Details:</b>
	<b>NHSI</b>	<b>N</b>	<b>Details:</b>
	<b>Other</b>	<b>Y</b>	<b>Details: Charity Commission</b>
<b>REPORT DESTINATION</b>	<b>Board of Directors</b>	<b>Y</b>	<b>DATE: 8 October 2020</b>
	<b>Working Group</b>	<b>N</b>	<b>DATE:</b>
	<b>Committee</b>	<b>N</b>	<b>DATE:</b>

## UPWARD REPORT FROM CHARITABLE FUNDS COMMITTEE

**Date Committee met:** 30 July 2020

### MATTERS OF CONCERN OR KEY RISKS TO ESCALATE

- Concern was raised in the meeting that an approved budget of £50,000 for expenditure in respect of Covid-19 donations had been exceeded (£63,290).  
It was agreed that the Terms of Reference for the Committee should be reviewed to ensure that there was correct governance around funding decisions between meetings.  
Committee members also ask to be notified if such a situation arose again.

### MAJOR ACTIONS COMMISSIONED/WORK UNDERWAY

- The Committee were informed that work is underway to request further monies from NHS Charities in accordance with their procedures.
- It was reported that a small Covid-19 Funding Task Group had been set up to help identify staff wellbeing initiatives.

### POSITIVE ASSURANCES TO PROVIDE

- It was reported that the Trust had received £137,000 from NHS Charities.

### DECISIONS MADE

- Mrs Abbiss reported that Matrons/heads of service had been asked to review further suggestions that had been received for the spending of Covid-19 related donations and that this had resulted in 16 suggestions for consideration by the Committee. The Committee approved spending the £137,000 received from NHS Charities and asked Trust Officers to prioritise the requests.
- A package of well-being initiatives which includes mental health support for staff was approved (£55,000).

**Chair's comments on the effectiveness of the meeting:** The meeting was effective and attendance was good.

## UPWARD REPORT FROM CHARITABLE FUNDS COMMITTEE

**Date Committee met:** 14 September 2020

### MATTERS OF CONCERN OR KEY RISKS TO ESCALATE

- Due to Covid-19 some planned events have had to be cancelled.

### MAJOR ACTIONS COMMISSIONED/WORK UNDERWAY

- The Committee were informed that the next stage of funding from NHS Charities will be for the Black Country STP and that Sandwell & West Birmingham Trust Charity have offered to manage this. £623k will be shared across the STP. A stipulation of the funding is that it must be used in partnership with local charities. Work to identify which charity/charities to partner with is underway.

### POSITIVE ASSURANCES TO PROVIDE

- It was confirmed that the Charitable Funds Terms of Reference had been reviewed to reflect authorised spending limits and that these were in line with Standing Financial Instructions.
- It was agreed that, if in future, spending between meetings is likely to exceed pre-authorised limits, members will be contacted to seek additional approval.
- It was reported that income to 31 August 2020 was £726,000 and total expenditure £186,000. Total fund balances were £2,589,000.
- The balance available to spend across the general funds totalled £189,359.

### DECISIONS MADE

- It was agreed to consult with Divisions/Directors regarding the strategy for the further spending of Covid-19 related funds.
- Five bids for funding were received of which three were approved.
  - Bladder scanner for Community Nurses (to enable scan to be done in patient's home) - £6,554.
  - Muscle Stimulators and Mirror Boxes for Corbett Rehabilitation Centre - £4,145.
  - Nursing Leadership online support from Florence Nightingale Foundation - £5,000.

**Chair's comments on the effectiveness of the meeting:** The meeting was effective and well attended.

**Paper for submission to the Board of Directors on  
8<sup>th</sup> October 2020**

<b>TITLE:</b>	<b>Constitution – Annual Review</b>		
<b>AUTHOR:</b>	<b>Liam Nevin Board Secretary</b>	<b>PRESENTER</b>	<b>Liam Nevin Board Secretary</b>
<b>CLINICAL STRATEGIC AIMS</b>			
<i>Develop integrated care provided locally to enable people to stay at home or be treated as close to home as possible.</i>		<i>Strengthen hospital-based care to ensure high quality hospital services provided in the most effective and efficient way.</i>	<i>Provide specialist services to patients from the Black Country and further afield.</i>
<b>ACTION REQUIRED OF COMMITTEE</b>			
<b>Decision</b>	<b>Approval</b>	<b>Discussion</b>	<b>Other</b>
	<b>X</b>	<b>X</b>	
<b>RECOMMENDATIONS</b>			
That the proposed amendments to the Constitution of the Trust be approved by the Board and recommended to the Council of Governors for approval			
<b>CORPORATE OBJECTIVE:</b>			
All			
<b>SUMMARY OF KEY ISSUES:</b>			
<p>An annual review of the constitution is undertaken to ensure that the principal governing constitutional document of the Trust remains fit for purpose and to identify any improvements that will improve the robustness and clarity of the document.</p> <p>A schedule is appended to this report identifying the proposed amendments and briefly explaining whether these are minor drafting changes or substantive amendments. With respect to the latter a brief explanation is given for these.</p>			
<b>RISK</b>	<b>N</b>	<b>Risk Description:</b>	
	<b>Risk Register: N</b>	<b>Risk Score:</b>	
<b>COMPLIANCE</b>	<b>CQC</b>	<b>N</b>	<b>Details:</b>

<b>and/or LEGAL REQUIREMENTS</b>	<b>NHSI</b>	<b>N</b>	<b>Details:</b>
	<b>Other</b>	<b>Y</b>	<b>Details: Code of Good Governance</b>
<b>REPORT DESTINATION</b>	<b>EXECUTIVE DIRECTORS</b>	<b>Y</b>	<b>DATE:22<sup>nd</sup> September 2020</b>
	<b>WORKING GROUP</b>	<b>N</b>	<b>DATE:</b>
	<b>COMMITTEE</b>	<b>N</b>	<b>DATE:</b>

## Trust Constitution Review – Schedule of Amendments

Paragraph	Reason for Amendment
<b>1.Interpretation and Definition</b>	
Board of Directors	Amended to include the requirements of the legislation
Council of Governors	Minor drafting amendment to define by reference to the legislation
<b>8.Automatic membership by default</b>	Amended to clarify that automatic membership is afforded to employed staff and designated partner organisations  Sub-clauses deleted as they don't relate to the main clause
<b>14. Council of Governors – disqualification and removal</b>	Minor drafting changes for clarity
<b>16. Council of Governors - duties</b>	Inclusion of all duties of Council of Governors in one clause for ease of reference and completeness
<b>26.Board of Directors – appointment and removal of chairman, deputy chairman and other non-executive directors</b>	Inclusion of Senior Independent Director as a designated non-executive Board position
<b>27. Board of Directors- appointment of chairman, senior independent director and deputy chair and other voting non-executive directors</b>	Removal of provisions duplicated from paragraphs 24 and 26  Common saving provision added so that decisions of the Trust can't be challenged because of a technical defect in appointment of a director
<b>28. Board of Directors – appointment and removal of the Chief Executive and other executive directors</b>	Minor drafting amendment for clarity.  Removal of clause 28.4 as it duplicates clause 29 - Disqualification
<b>29. Board of Directors- disqualification</b>	Amended to link specifically to the Fit and Proper Persons Regulations.  Introduces an obligation to notify the Trust Secretary when a person <u>fails to continue</u> to meet the FPP requirements (Constitution is currently silent on this)
<b>31. Board of Directors Voting</b>	Amended to clarify that a simple majority of votes is based on Directors who are present and voting. Current wording is ambiguous and

	change is consistent with usual voting rules
<b>33. Board of Directors – conflicts of interest of Directors</b>	In some cases Directors with an interest can be permitted to vote. The change makes clear that the majority of directors without that conflict must vote to exercise this provision. Otherwise a director with a conflict may be permitted to vote on their own conflict of interest.
<b>36. Admission to and removal from the registers</b>	Minor drafting change – Secretary is the Trust Secretary
<b>42. Annual report and forward plans and non NHS work</b>	Minor amendment to clarify that proposals must be approved by more than half of Governors voting- consistent with usual voting rules
<b>45. Amendment of the Constitution</b>	Amendments to the constitution to be approved by more than half of the Board and the Council of Governors and not three quarters – this brings the Trust into line with the modular constitution
<b>48. Mergers and Significant Transactions</b>	Amended from more than three quarters of members required to vote in favour of a significant transaction to more than half. This is required by the legislation and so must be changed.
<b>Annex 1 Constituency</b>	Amendment of constituency from Rest of West Midlands to Rest of England. The Trust currently has members in surrounding areas that are not in the West Midlands. In addition, non-executive directors must live in a public constituency and some live outside of the West Midlands. This change is consistent with other constitutions reviewed.
<b>Annex 2 The Staff Constituency</b>	Deletion of a section duplicated from paragraph 8 Additional drafting to clarify that “independent contractors” must be designated by the Trust as a partner organisation for staff voting rights to apply.
<b>Annex 4 Composition of Council of Governors</b>	Amendment from Rest of “West Midlands” to “Rest of England” to be consistent with Annex 1
<b>Annex 6 – Additional Provisions Council of Governors</b>	Paragraphs 15-18 are currently drafted as grounds for automatic exclusion, but they are not as each requires a judgement as to whether the circumstance exists – additional sentence added to clarify that a majority of Council of Governors voting must decide to exclude being satisfied that the conditions are satisfied.  Paragraph 17 – minor amendment so that it presents as a condition.  Paragraph 19 – deleted as duplicates paragraph 8 in the main body of the constitution

<p><b>Annex 7 – Standing Orders of the Council of Governors</b></p>	<p>Definition of Committee Members changed as definition was not accurate – included membership beyond the Council of Governors and was inconsistent with clause 5 in the main body of the constitution.</p> <p>Definition of Independent Regulator (NHSI England and Improvement) as the term is used in the Annex.</p> <p>Standing Order 3.3 – “Role and Responsibilities of the Council of Governors” - deleted as the powers of the Council of Governors are set out in clause 16 of the main body of the constitution. Also, the information does not belong in Standing Orders, as these should address the conduct of meetings.</p> <p>Standing Order 4.1.1 – “Admission of the Public” - amended to make clear that the paragraph concerns admission of the public and press to meetings.</p> <p>Standing Order 4.7 – “Notices of Motion” - Additional words to make clear that the power to move or amend a motion is subject to the rights of the Chair to rule on relevance under Standing Order 4.11</p> <p>Standing Order 4.17 – “Quorum” - Additional sentence added to formalise electronic meetings (post COVID change)</p> <p>Standing Order 6.1.4 “Declarations of Interest and Register of Interests” - Amended wording – existing words are too remote and imprecise to constitute an interest</p> <p>Standing Order 6.1.5 – deleted as it repeats standing order 7</p> <p>Standing Order 6.1.9 - wording deleted as the Chair’s ruling on an interest held by a governor must relate to that interest and not participation generally by the governor at a future meeting.</p> <p>Standing Order 8.2.2 “Interests of Governors in Contracts” – Amended to make clear that employment or business relationships that may conflict with the interests of the Trust must be added to the Register of Interests</p>
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	Standing Order 8.4.3 “Relatives of Members of the Council or Officers” – amended so that any relationship to other Council member or officer of the Trust must be added to the Register of Interests.
<b>Annex 8 Standing Orders for the Practice and Procedure of the Board of Directors</b>	Standing Order 2.6 “Composition of the Board” – amended to reflect the composition of voting and non- voting Board members.
	Standing Order 3.6 “Meetings of the Trust” – clarifying words added to explain when a failure to serve notice invalidates the meeting.
	Standing Order 3.11 “Notice of Motion” – Additional words to make clear that the power to move or amend a motion is subject to the rights of the Chair to rule on relevance under Standing Order 3.16.
	Standing Order 3.35 –“Quorum” - Additional sentence added to formalise electronic meetings (post COVID change)
	Standing Order 4.2 amended to reflect the statutory requirement that the decision maker must be either the Board, Committee, Sub-Committee, or CEO/Executive Director. It also allows for urgent decisions to be taken electronically or by telephone.
	Standing Order 7.5 –“Disability of Directors on Account of a Pecuniary Interest” – existing wording is an error. The clause has been reworded as intended – to deal with a minimal shareholding held by a Director in a company doing business with the Trust. The amendment makes it consistent with Standing Order 7.5 of the Council of Governors which addresses the same issue.
	Standing Order 8.6 –“Standards of Business Conduct” – Words of clarification added.

## Paper for Submission to the Board of Directors 8<sup>th</sup> October 2020

<b>TITLE:</b>	The Veterans Covenant Healthcare Alliance (VCHA) Veteran Aware Trust Accreditation		
<b>AUTHOR:</b>	Jill Faulkner, Head of Patient Experience	<b>PRESENTER</b>	Mary Sexton, Chief Nurse
<b>CLINICAL STRATEGIC AIMS</b>			
<i>Develop integrated care provided locally to enable people to stay at home or be treated as close to home as possible.</i>		<i>Strengthen hospital-based care to ensure high quality hospital services provided in the most effective and efficient way.</i>	<i>Provide specialist services to patients from the Black Country and further afield.</i>
<b>ACTION REQUIRED OF COMMITTEE</b>			
Decision	Approval	Discussion	Other
		<b>X</b>	
<b>RECOMMENDATIONS</b>			
The Board is asked to discuss, agree and sign up to the Trust's involvement with the Veterans Covenant Healthcare Alliance. The commitment required to meet the standards set out in the Veteran Aware Manifesto to ensure the principles of the Armed Forces Covenant are embedded across our organisation, and to adhere to the standards in relation to the NHS Standards contract.			
<b>CORPORATE OBJECTIVE:</b>			
SO1, SO2, SO3, SO4, SO5, SO6			
<b>SUMMARY OF KEY ISSUES:</b>			
The Trust has been asked to consider making a commitment to adopting the Armed Forces Covenant, as part of our ongoing priority to deliver a great patient experience.			
<b>IMPLICATIONS OF PAPER:</b>			
<b>IMPLICATIONS FOR THE CORPORATE RISK REGISTER OR BOARD ASSURANCE FRAMEWORK</b>			
<b>RISK</b>	<b>N</b>		<b>Risk Description:</b>
	<b>Risk Register: N</b>		<b>Risk Score:</b>
<b>COMPLIANCE and/or LEGAL REQUIREMENTS</b>	<b>CQC</b>	<b>Y</b>	<b>Details:</b> Safe, Effective, Caring, Responsive, Well Led
	<b>NHSI</b>	<b>Y</b>	<b>Details:</b>
	<b>Other</b>	<b>N</b>	<b>Details:</b>
<b>REPORT DESTINATION</b>	<b>EXECUTIVE TEAM</b>	<b>Y</b>	<b>DATE:</b> 8 September 2020
	<b>WORKING GROUP</b>	<b>N</b>	<b>DATE:</b>
	<b>COMMITTEE</b>	<b>N</b>	<b>DATE:</b>

**The Veterans Covenant Healthcare Alliance (VCHA)**  
**Veteran Aware Trust Accreditation**

**Introduction**

A request has been made by the Veterans Alliance for the Trust to fully adopt and demonstrate a commitment to the Armed Forces Covenant, as part of our ongoing priority to deliver a great patient experience this paper provides discussion on the invitation to be part of the VCHA. The VCHA is being established off the back of the work of 'Getting It Right First Time' (GIRFT) programme (now part of NHS Improvement in partnership with the Royal National Orthopedic Hospital) and the Chavasse report.

The Chavasse Report built on the GIRFT report highlighted the need to re-energise and re-communicate the Armed Forces Covenant across all NHS organisations to ensure that service personnel are made aware of their rights and the network of care available to them, in order to ensure veterans receive timely access to both routine and specialist treatment from the NHS.

Under the NHS standard contract, the Trust is required to adhere to the standards of the Armed Forces Covenant in relation to identifying and ensuring access to services. The contract specifies in Services Conditions 2020-2021:

- 1.4 The Parties must ensure that, in accordance with the Armed Forces Covenant, those in the armed forces, reservists, veterans and their families are not disadvantaged in accessing the services.*

In line with the principles set out in the Armed Forces Covenant, the VCHA is a group of healthcare providers working together to develop, share and drive the implementation of best practice that will improve UK Armed Forces veterans care. The VCHA provides links to armed forces charities and resources to enhance the recovery pathway for veterans in our care. Trusts that can demonstrate best practice care for the armed forces community will be accredited as 'Veteran Aware' and can display the Veteran Aware Accreditation mark.

The only reference to Armed Forces in our Specialised Services draft 2020-21 Contract (i.e. Schedule 6) is the entry below (received from the Finance Department).

3. Patient treatment list (PTL) for all Armed Forces personnel and their families (based on the presence of registered GP practice shown as a Defence Medical Service practice).	Monthly	Template available here <a href="https://www.england.nhs.uk/nhs-standard-contract/dc-reporting/">https://www.england.nhs.uk/nhs-standard-contract/dc-reporting/</a>	Submission via DLP in accordance with the timetable in S6A5 APPENDIX - Timetable for Data-Flows  (See also item 8.4)	AF
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The Trust does have a KPI where data is submitted via the contracting team in regards to patients that fall under this category.

### **Veteran Aware Manifesto**

The Veteran Aware Manifesto sets out the objectives of the VCHA, the standards expected from Veteran Aware healthcare providers and the support that can be provided. To receive 'Veteran Aware' accreditation the Trust is required to evidence and showcase the standards from the Manifesto, which are:

#### *a) Joining the Alliance and commitment to the Armed Forces Covenant*

VCHA members will be required to demonstrate commitment to the underlying principles of the Armed Forces Covenant and have designated champions to lead on the implementation of the manifesto.

#### *b) Supporting the armed forces community as an employer*

Veteran aware trusts will be signed up to initiatives that support the employment of veterans and reservists in the NHS workforce.

#### *c) Best practice in treatment and care in the hospital*

Displaying posters in waiting rooms and wards, encouraging people to make their veteran status known, providing a definition and explaining the purpose. Ensuring staff receive training on the armed forces covenant and care and treatment of veterans.

#### *d) Linking in with other services*

Linking in with other services, signposting and referring appropriately to improve the care offered to the armed forces community. Veteran aware trusts will have established links, where appropriate, to MOD or NHS Rehabilitation services, to ensure shared learning and smooth transfer of patients.

### **Veteran Aware Trust Accreditation**

To join the VCHA and receive accreditation, the Trust is asked to express an interest to the VCHA and to nominate a clinical champion and a management champion for the Trust. The accreditation process will involve the implementation of the standards from the VCHA manifesto with support from our GIRFT regional veteran lead, to demonstrate the commitment to the Armed Forces Covenant.

As members of the VCHA the Trust will be required to complete an annual accreditation report and provide evidence of demonstrating standards, and to raise awareness of the accreditation and display the kite-mark.