The Dudley Group
NHS Foundation Trust

Board of Directors Meeting Public Papers

Thursday 12th November 2020

11:15 – 13:40

The Dudley Group
NHS Foundation Trust

BOARD MEETINGS
PUBLIC INFORMATION SHEET

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

1. Introduction

This sheet provides some information about how Board meetings work.

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

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

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

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2. Board Members' interests

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

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

3. Opportunity for questions

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

4. Debate

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

5. Minutes

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

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

6. Key Contacts

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The Dudley Group
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THE SEVEN PRINCIPLES OF PUBLIC LIFE

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

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

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

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

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

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

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

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

IN PUBLIC

The Dudley Group NHS Foundation Trust

Board of Directors
Thursday 12 November 2020 at 11.15am
MS Teams
AGENDA

	ITEM	PAPER REF	LEAD	PURPOSE	TIME
14	**Chairmans welcome and note of apologies –**		Y Buckland	For noting	11.15
15	**Declarations of Interest** Standing declaration to be reviewed against agenda items.		Y Buckland	For noting	11.15
16	**Minutes of the previous meeting** Thursday 8 October 2020 Action log 8 October 2020	 Enclosure 10 Enclosure 11	 Y Buckland L Nevin	 For approval For noting	11.15
17	**Chief Executive's Overview**	Enclosure 12	D Wake	For information & assurance	11.20
18	**Chair's update**	Verbal	Y Buckland	For information	11.30
19	**Public Questions**	Enclosure 13	Y Buckland	For information	11.40
20	**QUALITY & SAFETY**				
20.1	Quality and Safety Committee Report	Enclosure 14	E Hughes	For assurance	11.50
20.2	Chief Nurse Report	Enclosure 15	M Sexton	For assurance	12.00
20.3	Board Assurance Infection Control Framework	Enclosure 16	M Sexton	For assurance	12.10
21	**FINANCE & PERFORMANCE**				
21.1	Finance and Performance Committee Report	Enclosure 17	J Hodgkin	For assurance For decision	12.20
21.2	Integrated Performance Dashboard	Enclosure 18	K Kelly	For assurance	12.30
22	**WORKFORCE**				
22.1	Workforce and Staff Engagement Committee Report (i) People Plan	Enclosure 19 Enclosure 20	J Atkins	For assurance For approval	12.45
22.2	Workforce KPIs	Enclosure 21	J Fleet	For assurance	13.00
23	**GOVERNANCE**				
23.1	Board Assurance Framework	Enclosure 22	L Nevin	For assurance	13.15
24	**DIGITAL AND TECHNOLOGY**				

24.1	Digital Trust Technology Report	Enclosure 23	C Holland	For assurance	13.25
25	**Any Other Business**	Verbal	All		13.35
26	**Reflection on meeting**	Verbal	All		13.35
27	**Date of next Board of Directors meeting** 10 December 2020				13.40

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 8th October 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)
James Fleet, Chief of People (JF)
Katherine Sheerin, Director of Strategy (KS)
Richard Miner, Non- Executive Director (RM)
Adam Thomas, Chief Information Officer (AT)

In Attendance:

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

20/239 Note of Apologies and Welcome

The Chair opened the meeting and welcomed members of the public, the press, a representative of Health Watch, local GPs and Yvonne Peers, Governor, all of whom had joined the meeting.

The Chair noted that it was Freedom to Speak up Week and she had spent time meeting with front line staff to discuss issues of interest and concern to them, which had proven very informative.

Apologies were received from Catherine Holland.

20/240 Declarations of Interest

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

20/241 Minutes of the previous meeting held on 10th September 2020

It was RESOLVED

- **That the minutes of the meeting of the 10th September 2020 be agreed as a true and accurate record of the meeting.**

The action log was noted.

20/242 Public Chief Executive Overview Report

DW summarised her Overview Report and advised that the MCP and Acute Collaboration projects were currently absorbing significant capacity in the Trust.
It was noted that the number of admissions with COVID 19 were beginning to increase and that the R rate for infection in the Midlands was between 1.2 and 1.5.
JF advised that the impact of COVID on staff was understood and that the staff health and well- being offer had been increased to reflect this. An additional Occupational Health nurse had been deployed, fast track physio had been made available and an employee assistance programme including round the clock counselling support had also been made available.

The Chair asked what steps were being taken to protect BAME staff and JF advised that the key themes arising from risk assessments, and which had been acted upon was the need to provide opportunities to discuss concerns and stress. In addition all BAME staff had now had engagement with the Staff Health and Welfare service.

DW advised that the Trust was now preparing for a second surge of COVID 19 cases. It had reflected on the lessons from the first phase and would act on these and it would continue to ensure an adequate supply of PPE as had been done for the first phase.

Work had started on the modular build on the 29th September and this would provide 60 beds co-located with ED.
There had been significant take up of the first batch of flu vaccinations and a further batch was expected in approximately 20 days.

MCP

TJ stated that the Trust had worked intensively with system partners over the last six weeks on this project which would include community services, and some diagnostic and outpatient services. Further work was necessary to assess the Full Business Case and the Trust would respond to this following more detailed consideration of the proposals.

The Chair invited questions from the Board and members of the public and there being none she concluded that the Trust remained committed to integrated care and would carefully consider the Business Case before responding to Dudley Integrated Health Care and NHSE/I.

20/243 Chair's Public Update

The Chair advised that the Trust was focussing on Restoration and Recovery as well as preparing for a further wave of COVID 19 infections. In addition there was a strong focus on infection control and the Board was pleased to see the evidence of the assurance work that had been done to confirm that effective measures were in place.

Appraisals had now been completed for all NEDs and the Chair, and the Chair's appraisal would be submitted to the Council of Governors and then NHSI.

20/244 QUALITY AND SAFETY

20/244.1 Quality and Safety Committee Report

LH summarised the matters highlighted for referral to the Board in the Committee report.

With respect to mandatory training JHO noted that this had inevitably dropped during the first wave of COVID. However, senior medical staff were now providing additional training, particularly around resuscitation.

MS advised that all training had been stopped for four months so it would be difficult to recover this in year. In addition whilst a significant amount of training had been moved on-line, some required physical attendance and the social distancing requirements would also impact upon the capacity to deliver this training.

20/244.2 Learning from Deaths Report

JHO summarised the report and advised that the number and percentage of deaths remained consistent and within the national tolerance. One measure showed a higher than expected rate but this arose from a recoding in 2017. There were three measures of assurance reflected in the report; the medical examiner system, the local review of mortality cases, and a detailed review of mortality associated with particular conditions such as respiratory. These processes had not identified any avoidable mortality and there was also considerable assurance around the quality of care. Improvements in outcomes for treatment of pneumonia and sepsis were set out in the report and in respect of the latter this was below the national average over the last twelve months.

LH advised that this had been the subject of in depth discussion at the Quality and Safety Committee and there was good assurance around the metrics and review systems.

20/244.3 Chief Nurse Report

MS summarised the report and advised that there had been an increase in falls in August and whilst the recorded number was high for the Trust it remained below the national average.

The analysis of complaints received demonstrated that the predominant concerns were communication, information around discharge, and access. Further work in particular was being done around discharge recognising that this was a quality priority this year.

The Board discussed the extent of nursing staffing vacancies and sickness and JA advised that this had been considered by the Workforce Committee which had been assured of both short term actions and a long term plan in development. MS added that this was a national problem with approximately 40-50 thousand nursing vacancies.

The Chair noted that the collaboration agenda presented real opportunities for the Black Country health system to work collectively on recruitment and development of the workforce of the respective Trusts.

GC asked whether there were any concerns of particular note and asked for a summary of the position with the maternity service. MS advised that there were 16 vacancies in August and a high number of staff on maternity leave. . However, a cohort of 15 staff had started in

September which had relieved some of the pressure. There was a high vacancy rate noted on ward C7.

20/244.4 Board Assurance Infection Control Framework

MS advised that she was presenting the report in her capacity as Director of Infection Control. The position had been reviewed at the Quality and Safety Committee and there was substantial assurance both in relation to COVID 19 and more generally with regard to infection control standards. It was confirmed that there had been no patient related outbreaks and in relation to staff there had been outbreaks in IT, Radiology and in a community setting.
The flu vaccination had been launched at the beginning of the week and approximately 2,000 had been administered already.

It was **RESOLVED**

- **That the reports be noted**

20/245 FINANCE AND PERFORMANCE

20/245.1 Finance and Performance Committee Report

JH summarised the committee report and advised that there was a high level of confidence around the financial position and some assurance had been taken from reviewing benchmarking data with peers. It was expected that the regime would become more demanding although budgets for the second half of the year had not been available at the last committee. The intention was to review these at the October committee meeting.

There were some concerns around staffing levels and the impact of these on performance and the committee had asked for some further work to be done to summarise the key data and to track performance against trajectories for internal performance targets and constitutional standards.

It was **RESOLVED**

- **That the report be noted**

20/245.2 Integrated Performance Dashboard

KK summarised the report and it was noted that cancer referrals had increased back to pre-COVID levels.
JA noted that the report did not contain VTE assessment figures and AT confirmed that reporting had been suspended until the end of March. However, he could confirm that performance was well above 90%.
IJ queried the position on discharges and KK advised that this remained good but there was emerging pressure around delayed packages of care.
The Chair requested that further work be done on the performance report so that the Board received a clear narrative summary and performance data that showed performance against trajectory and benchmarked against neighbouring Trusts.

It was **RESOLVED**

- **That the report be noted**

20/245.3 Recovery and Restoration Deep Dive
KK delivered the presentation which set out the Trust performance on Restoration and Recovery as against its internal target and the NHSE/I target.

The Board debated the current performance and it was noted that Recovery was progressing well based on activity levels and that all services had been restored.

The Chair advised that if the escalation of COVID-19 cases required a change to the Trust's plans these would need to be discussed with system partners. It was also agreed that the Trust clinicians must focus on Restoration and Recovery and COVID 19 during the immediate future.

20/246 WORKFORCE

20/246.1 Workforce and Staff Engagement Report

JA summarised the Committee report to the Board and it was noted that increasingly the Divisions were taking a larger role in the work of the Committee.

It was **RESOVLED**

- **That the report be noted**

20/246.2 Workforce KPIs

JF advised that COVIID sickness had risen to 130 in September but had now reduced to 84. However, the increased rate of sickness had resulted in increased use of agency and bank staff and the nursing challenges had been discussed on the Board agenda earlier.
The Board were advised that the reference to 406 nursing vacancies was a typographical error and the actual number was 306. There were immediate actions being implemented to mitigate this including adjustment to pay levels for bank staff and the introduction of e-rostering.
The Board were advised that 97.5% of COVID risk assessment had been completed and performance was in the upper quartile nationally.

RM asked whether the appraisal system was identifying staff from BAME backgrounds as promotion prospects and JF advised that development conversations were now a requirement of the People Plan and guidance was being developed for that purpose.

The Chair stated that the Board needed to visibly support the work of the Trust in relation to diversity and inclusion and asked that JF used appropriate opportunities to do this.

20/247 GOVERNANCE

20/247.1 Acute Collaboration Update

KS introduced the paper and summarised that the national policy was to develop collaboration between providers and that STPs had to demonstrate provider collaboration in order to be designated as an Integrated Care System. The Trust was keen to explore how it could help strengthen services but it was noted that very ambitious timescales had been set

with Boards expected to consider proposals in December leading to interim arrangements for management and governance by April. The Trust would be pressing for a realistic timescale that would allow for a more inclusive clinically led approach.
GC stated that it was important that the project was clinically led and that an appropriate timescale was agreed that would facilitate this and allow for the necessary review and challenge by Boards.
The Chair agreed and stated that a report to the Board was required in November which would facilitate the Board in setting out its view of the draft plan, its expectations of how it would develop and the role that Boards would have in shaping it. It was agreed that the Chief Executive would write with this expectation to the STP lead on the project.

It was RESOLVED

- **That the report be noted;**
- **That the Board consider its response to the draft proposals at its November meeting**
- **That the Chief Executive writes to the STP setting out the expectations of the Board in respect of the development of the plan.**

20/247.2 Winter Plan

KK introduced the plan and advised that it modelled the potential impact of both flu and COVID 19 over the period October 2020 to March 2021.

The plan set out the steps being taken to address the projections of peak demand and it was noted that without these initiatives the demand would exceed capacity.
RM asked if the model of demand could be adapted to accommodate changing evidence and AT advised that it had been developed so that changing variables could be inputted.

JA asked what the likelihood was that the Modular Build could not be staffed and DW advised that staffing was a known risk and that measures to mitigate this were being considered. MS advised that consideration of greater flexibility on the use of AHPs was part of this consideration.

LH stated that the Modular Build represented best clinical practice because it would provide a facility for those patients who did not require admission.

The Chair asked how the plan would be monitored and it was agreed that an update on the plan and performance against the measures of success would be provided over the next few months.

It was **RESOLVED**

- **That the plan be noted and that updates on implementation of the Plan against the measures of success be reported to the Finance and Performance Committee.**

20/247.3 Audit Committee Report

RM summarised the report and recommended the approval of the Standing Financial Instructions and Risk Management Strategy.

It was **RESOLVED**

- **That the Standing Financial Instructions and the Risk Management Strategy be approved.**

20/247.4 Charitable Funds Committee Report

JA provided an update on the business conducted at the July and September meetings of the Committee

It was **RESOLVED**

- **That the report be noted**

20/247.5 Constitution

The Chair advised that the proposals to amend the constitution arose from the annual review and she recommended these to the Board with one amendment; In relation to Standing Order 4.2 of Annex 8 it was proposed that an urgent decision should also be subject to a relevant Committee Chair being consulted by the decision takers.
Subject to this amendment;

It was **RESOLVED**

- **That the amendments to the Constitution be recommended to the Council of Governors subject to the proviso identified in the preamble to this minute.**

20/247.6 Veterans Aware Trust Accreditation

MS presented the paper and it was **RESOLVED**

- **That the Board agree and sign up to the Trust's involvement with the Veterans Covenant Healthcare Alliance.**

20/248 Any Other Business

There was no other business

20/249 Reflection on Meeting

It was noted that there had been a full agenda with a number of challenging and important matters that had been thoroughly discussed

Date for the Next Meeting - 12 November 2020

Signed ……

Date …….....

Enclosure 11

The Dudley Group NHS Foundation Trust

Action Sheet
Minutes of the Board of Directors Public Session
Held on 8th October 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	December 2020	Awaiting NHSI Report.
20/247.1	Acute Collaboration	Board to consider a report on the proposals in order to formulate a position	KS	Nov 2020	On Agenda

Enclosure12

The Dudley Group NHS Foundation Trust

Paper for submission to the Board of Directors on 13th November 2020

TITLE:	**Public Chief Executive's Report**		
AUTHOR:	**Diane Wake** **Chief Executive**	**PRESENTER**	**Diane Wake** **Chief Executive**

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

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

RECOMMENDATIONS

The Board are asked to note and comment on the contents of the report.

CORPORATE OBJECTIVE:

SO1, SO2, SO3, SO4, SO5, SO6

SUMMARY OF KEY ISSUES:

- Coronavirus
- Modular Build
- Flu Vaccination
- Healthcare Heroes
- Honorary Professor
- Acute Collaboration
- Charity Update
- Patient Feedback
- Visits and Events
- National News
- Regional News

IMPLICATIONS OF PAPER:

IMPLICATIONS FOR THE CORPORATE RISK REGISTER OR BOARD ASSURANCE FRAMEWORK

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

Chief Executive's Report – Public Board – 12th November 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 seeing an increase in the numbers of inpatients testing positive for COVID. As at 30th October 2020, the rate per 100,000 of population in Dudley was 257.8. As Dudley moves through the local COVID alert levels, we have joined forces with our local authority and public health colleagues to reinforce the importance of following the guidance, especially keeping two metres apart, remembering Hands, Face, Space – keep washing your hands regularly, wear a face covering in enclosed spaces and stay at least two metres apart. Patients and visitors who come onto our hospital or outpatient sites are asked to wear a surgical mask and follow the one-way systems in place. We have lots of helpful signage on our sites to remind staff, patients and visitors to follow the guidance. This week saw the installation of more familiar signage above ward doors across all our sites.

Modular Build

Work is progressing on the modular build outside Russells Hall Hospital. The two-storey building will provide assessment facilities on the ground floor and facilities for a short stay ward on the second floor. Below is a digital image of the build when it is finished.

Flu Vaccination

The Trust's flu campaign started on 5th October with a target of 90 per cent of staff being vaccinated by February 2021 but 100 per cent of frontline staff. We have a team of vaccinators who are able to vaccinate staff quickly to provide them with the very best protection again the flu virus. At close of play on 28th October, 47% of our eligible staff had been vaccinated against the flu. Uptake is going well and we have vaccinated more than 2600 staff so far. We have enlisted the help of football legend Steve Bull to encourage staff to have the flu jab. He is appearing in a series of four videos to get the message across.

Healthcare Heroes

Team Award

October's Healthcare Heroes team award went to the Clinical Pharmacy Ward Services team. This team was proudly nominated by their manager for their involvement in the EPMA electronic prescribing launch along with the Digital Trust team. Each member of staff went above and beyond, worked extended hours before, during and after the system went live. They have shown great resilience to ensure the role out of this went smoothly and used their skills to support our clinical services.

Volunteer Award

October's Healthcare Hero Volunteer award went to Kevin Smith. Kevin was nominated by several colleagues for the continuous support he gives as a volunteer at the Trust. Kevin has volunteered for a number of years, coming in three afternoons a week, even through the height of the pandemic. He walks miles around the hospital delivering notes, transporting patients and generally being a friendly individual. His fellow colleagues say he always gives 100% in everything he does and we are lucky to have him, along with our team of volunteers, supporting staff and services.

The individual award is yet to be presented.

Honorary Professor

I am delighted to announce that consultant vascular surgeon Mr Atiq Rehman has been awarded the title of Honorary Professor in the Institute of Clinical Sciences by the University of Birmingham. Mr Rehman joins the university's distinguished academic community and his appointment will last for three years. This is very well deserved.

Acute Collaboration

Work has continued on acute collaboration across the 4 trusts in the Black Country and West Midlands. A case for change is in development and will be shared at a meeting of Chairs and CEOs on 4th November 2020. Feedback from this meeting will be provided verbally.

Charity Update

Patients Care Bags: We are almost ready to distribute our first 300 patient care bags. These are part of the NHS Charities Together funding and include various items such as water bottles, puzzle books, and toiletries.

Charity Pumpkin Trail Challenge: Originally planned as a Halloween sponsored walk over Baggeridge Country Park, this event was scaled down to respect social distancing so spaces were limited. However, over three days, 200 people had a 'spooktacular' time and £1,000 was raised for our charity.

Christmas: Our fundraising team are working on a Christmas plan to help bring some festive cheer. Regulations allowing, our plans include a scaled down charity shop in main reception at Russells Hall Hospital and a 'new look' Santa Dash.

Patient Feedback

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

GI Unit: The staff were very courteous and explained everything they were doing. They took my wishes into account. It was a really nice calm atmosphere in the department.

Cardiology: Very concise and efficient discussion of requirements. Your consultant was polite and understanding offering helpful advice.

Emergency Department: Excellent treatment by all staff including reception areas. My problem was dealt with in a speedy manner with all staff keeping a friendly demeanour.

General Community: So quick to respond very polite talked so you really calmed down very professional.

Coronary/Post Coronary Care: 1 very good A+++, I gave the answer because I was treated with respect and I found every single person on the ward helpful professional and hard-working, long hours and always with a smile under their mask the team on CCU and PCCU are a credit to your hospital and should be more recognised, they could not have done any more.

Radiology: Excellent experience; reassured and kept informed at all times. Very kind staff.

B4: Excellent medical care, both from surgeons and nursing staff.

Chemical Pathology: staff were exceptionally professional, friendly and polite. I was kept informed and supported throughout my visit.

General Outpatients: All went very well, technician/nurse (Rebecca) was very efficient, helpful, and courteous. First class could not be improved upon.

Trauma & Orthopaedics: Everything was well run and on time. Staff were friendly and professional.

Visits and Events

5th October 2020	Virtual GIRFT Deep Dive- Plastic Surgery, Burns and Hand Surgery Review
5th October 2020	Dudley System Meeting
6th October 2020	Acute Collaboration Meeting
8th October 2020	Board of Directors
9th October 2020	Regional Leadership Call with Simon Stevens, CEO and Amanda Pritchard COO NHSE/I
12th October 2020	Dudley Integrated Care Provider Community Briefing
12th October 2020	Dudley System Meeting
14th October 2020	FTSU Walkabouts
15th October 2020	Health and Adult Social Care Scrutiny Committee
16th October 2020	Live Chat
19th October 2020	BCPS Chief Medical Officer Interviews

21st October 2020	Siren Study
21st October 2020	Inclusive Board Development Workshop
26th October 2020	Virtual Signs Guiding Board
29th October 2020	Freedom to Speak Up Meeting
29th October 2020	School of Nursing/ Health for Dudley
30th October 2020	Suzanne Web visit to Corbett Hospital

National NHS News

Diagnostic 'one stop shops' recommended in the community
Community diagnostic hubs, which would overhaul the way the NHS delivers MRI, CT and other diagnostic services to patients, have been recommended as part of a new major report commissioned by the health service. These 'one stop shops' would be created across the country, away from hospitals, to enable patients to receive life-saving checks close to their home. The centres could be set up in free space on the high street or retail parks.
National Health Executive (30.09.20)

Most of Boris Johnson's promised 40 new hospitals will not be totally new
Ministers have set out more details of Boris Johnson's much-scrutinised election promise to build 40 new hospitals in England, revealing that the bulk of the projects involve rebuilding or consolidation, and that only four have been started. The scheme comes with a promised spending package of £3.7bn. However, NHS Providers, which represents hospital trusts, said the real cost of building 40 new hospitals would be more like £20bn.
The Guardian (02.10.20)

Coronavirus: NHS cancer tests for thousands could be delayed as they sit in warehouse due to 'logistics failure'
A "logistical failure" means essential tests - including for COVID-19 and cancer - are sitting in a warehouse unable to be shipped to NHS laboratories, the head of the Institute of Biomedical Science (IBMS) has said. Sky News has learned that thousands of patients could miss out on vital blood tests and screening because of the breakdown in the supply chain to the NHS. ***Sky News (08.10.20)***

NHS 111 call centre hit by coronavirus outbreak
More than 40 staff at an NHS 111 call centre in the West Midlands contracted coronavirus. Dozens of NHS 111 call handlers working in a call centre run by West Midlands Ambulance Service have been infected with coronavirus. In total 44 staff at the Brierley Hill centre, in Dudley, were infected after an outbreak in the 24-hour centre which employs over 1,000 staff answering vital NHS patient calls. One member of staff told The Independent they had struggled to get information from managers and news of the outbreak had left staff feeling worried and anxious. ***The Independent (09.10.20)***

Coronavirus: Police get access to NHS Test and Trace self-isolation data
People in England who have been told to self-isolate through NHS Test and Trace could have their details shared with the police on a "case-by-case basis". Forces will have access to information telling them if an individual has been told to self-isolate, the Department of Health and Social Care (DHSC) said. But the British Medical Association said it was worried police involvement might put people off being tested. ***BBC News (18.10.20)***

Additional £15m staff mental health support welcomed
The announcement of an additional £15m investment by NHS England to bolster mental health support for nurses, paramedics, therapists, pharmacists and support staff has been welcomed by health organisations. The investment will help fund outreach work among those staff deemed most at risk, such as critical care staff. Staff referred by themselves or colleagues will be rapidly assessed and treated by local expert mental health services. Those with the most severe needs will be referred to a specialist centre of excellence. ***National Health Executive (20.10.20)***

NHS told to improve after 'potentially avoidable' death of autistic teenager
The death of an autistic teenager who was given anti-psychotic medication by NHS staff against his and his parents' wishes was "potentially avoidable", a new independent review has concluded. The parents of Oliver McGowan are now calling for fundamental changes to the way the deaths of people with learning disabilities and autism are examined by the NHS after their son's case exposed weaknesses in the national system which examines more than 4,000 reported deaths a year. ***The Independent (21.10.20)***

Mass cancellations of NHS operations inevitable this winter, say doctors
The BMA says hospitals have too few beds and staff to maintain surgery and diagnostic testing for non-Covid illnesses during the pandemic. Mass cancellations of routine operations in England are inevitable this autumn and winter despite an NHS edict that hospitals must not again disrupt normal care, doctors' leaders have said. Organisations representing frontline doctors, including the British Medical Association (BMA), also criticised NHS England for ordering hospitals to provide "near normal" levels of non-Covid care in the second wave of the pandemic, and demanded that fines for failing to meet targets be scrapped. ***The Guardian (23.10.20)***

NHS denies elderly people were refused care during early Covid
NHS bosses have denied claims that thousands of frail elderly people were denied potentially life-saving care at the peak of the pandemic in order to stop the health service being overrun. NHS England took the unusual step on Sunday of issuing a 12-page rebuttal to allegations in the Sunday Times that patients deemed unlikely to survive were "written off" by being refused intensive care. Prof Stephen Powis, NHS England's national medical director, said: "These untrue claims will be deeply offensive to NHS doctors, nurses, therapists and paramedics, who have together cared for more than 110,000 severely ill hospitalised Covid-19 patients during the first wave of the pandemic, as they continue to do today. ***The Guardian (25.10.20)***

Better food to be served across NHS hospitals
Tastier, healthier and better-quality meals are set to be served for millions of NHS patients and staff following an independent review of hospital food, led by a panel of advisers including chef and restaurateur Prue Leith. The review, which has been published today, includes recommendations on how NHS trusts can prioritise food safely and provide more nutritious meals to both staff and patients. ***National Health Executive (26.10.20)***

Regional NHS News

NHS staff helped with a 5% contribution towards their deposit on a new home.
Since the launch in May of the NHS Deposit Contribution Scheme, Worcestershire developer, Barratt Homes West Midlands, have helped 45 NHS employees secure a new home.

The scheme sees NHS employees receive a 5% contribution towards their deposit, up to £15,000, to help them buy a new home as a thank you for their hard work during the COVID-19 crisis. The incentive has helped NHS workers across areas of Staffordshire, Shropshire, Oxfordshire, Worcestershire, Cheshire and Warwickshire with 45 properties reserved. ***Your Area (06.10.20)***

Far fewer patients begin cancer treatment than pre-pandemic at Midland hospitals
Express & Star (12.10.20). Far fewer patients started treatment for cancer at hospital trusts across the Black Country in Staffordshire than before the coronavirus pandemic, new figures reveal.

Macmillan Cancer Support says the continued disruption to cancer treatment caused by Covid-19 is traumatising people six months into the pandemic – as a second wave threatens further setbacks. NHS England data shows 178 patients started treatment for cancer at The Royal Wolverhampton NHS Trust in August – 48 fewer than the 226 to do so in August 2019. A total of 128 patients started treatment in August at the Dudley Group NHS Foundation Trust – compared with 162 in the same month last year.
Express & Star (12.10.20)

Year-long treatment waits hit record highs as pandemic hits health services
Patients are waiting more than a year for routine hospital treatment, due to extreme delays caused by the Covid-19 pandemic. New data from the NHS shows patients across the Black Country and Staffordshire were on the waiting list for more than 52 weeks for elective operations or treatment. ***Express & Star (18.10.20)***

Russells Hall Rainbow within a whisker of hitting £30k fundraising target
A campaign for a permanent sculpture to honour Dudley's Covid-19 heroes is within a whisker of hitting its funding target. The Saleem Foundation has donated to the Russells Hall Rainbow project. Organisers say they are extremely close to meeting the £30,000 target for the Russells Hall Rainbow, set to sit outside the borough's main hospital as a permanent reminder of the work done locally by the NHS, key workers and community volunteers during the pandemic. ***Express & Star (22.10.20)***

44 West Midlands Ambulance staff contract coronavirus after 'cross-infection' at Dudley call centre
A coronavirus outbreak at an ambulance service call centre saw 44 staff members infected with the virus. "Evidence of cross-infection" was detected at the regional NHS 111 base, near Dudley, last month, West Midlands Ambulance Service bosses have said. In a report for the governing trust, nursing and commissioning executive director Mark Docherty and executive medical director Alison Walker write the outbreak was formally declared over on October 13. ***Birmingham Live (27.10.20)***

Dudley and Staffordshire to move into Tier 2 Covid restrictions this week
Dudley and Staffordshire will move into Tier 2 Covid restrictions this week – with talks planned for the whole West Midlands to move under the highest Tier 3 measures. The two areas will join Wolverhampton, Walsall, Sandwell and Birmingham under Tier 2 "high" level restrictions after cases continued to surge in recent days. The new restrictions could be announced as early as Wednesday and are likely to come into force later this week. Talks are due to take place between local leaders and Ministers next week, with the possibility of moving the whole region into Tier 3 "very high" alert measures at the top of the agenda.
Express & Star (27.10.20)

Enclosure 14

The Dudley Group NHS Foundation Trust

Paper for Submission to the Board of Directors 12th November 2020

TITLE:	Quality and Safety Committee		
AUTHOR:	Sharon Phillips – Deputy Director of Governance	**PRESENTER:**	Liz Hughes – None Executive Director

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

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

RECOMMENDATIONS FOR THE GROUP

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

CORPORATE OBJECTIVE:

All

SUMMARY OF KEY ISSUES:

- As detailed in the paper

IMPLICATIONS OF PAPER:

IMPLICATIONS FOR THE CORPORATE RISK REGISTER OR BOARD ASSURANCE FRAMEWORK

RISK	**Y**		**Risk Description:**
	Risk Register: Y		**Risk Score:** Numerous across the BAF, CRR and divisional risk registers
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	**N**	**DATE: Quality and Safety Committee 27 October 2020**

The Dudley Group NHS Foundation Trust

CHAIRS LOG

UPWARD REPORT FROM QUALITY AND SAFETY COMMITTEE

Date Committee last met: 27 October 2020

MATTERS OF CONCERN OR KEY RISKS TO ESCALATE	MAJOR ACTIONS COMMISSIONED/WORK UNDERWAY
• Radiology unreported x-rays harm review - The 6 remaining will be undertaken on the 26/11/20 on receipt of follow up investigations to determine potential harm. Others confirmed as no harm • Significant increase in the number of complaints received over the last quarter. This is having a negative impact on the timeliness of responses • Trust compliance to mandatory fire training is at 83.7% (target score 90%) • Maternity Incentive Scheme – considerable work to be undertaken to achieve 3 of the standards, this is especially relevant for Safety Standard 2 submission of data sets within set timescales • Breast screening restoration impacted by significant staff shortages There is a national shortage, trust doing active recruitment and discussion NHSE to look at new roles • For maternity routine screening services for partners to be present at all scans work underway to address environmental issues to enable this to take place.	
POSITIVE ASSURANCES TO PROVIDE	**DECISIONS MADE**
• Significant assurance received for the Clinical Support Services Governance arrangements and positive progress in reviewing and reducing risks across the Division • Learning disability and vulnerable people deep dive provided a good level of assurance and clearly identified challenges and actions to drive improvement • Positive assurance of engagement with Covid-19 research projects by the Research Team / department	• Health and Safety Annual Report received. The Committee accepted the report as a final version • Revised Terms of Reference for the Clinical Support Divisional Governance meeting to be presented at the November Quality and Safety Committee

Chair's comments on the effectiveness of the meeting:

Enclosure 15

The Dudley Group NHS Foundation Trust

Paper for submission to the Board of Directors November 2020

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

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

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

RECOMMENDATIONS

For the Board to review and note the exceptions presented.

CORPORATE OBJECTIVE:

SO1: Deliver a great patient experience
SO2: Safe and Caring Services
SO3: Drive service improvements, innovation and transformation
SO4: Be the place people choose to work
SO5: Make the best use of what we have
SO6: Deliver a viable future

SUMMARY OF KEY ISSUES:

1. The Chief Nurse has professional responsibility for nurses, midwives and Allied Health Professionals (AHPs) within the Trust however, does not operationally manage the majority of these staff. The oversight and management of staff within the Trust is within the divisional management structure, which reports to the Chief Operating Officer (COO) via the Divisional Directors.
   1.1 **Appendix 1** Staffing data

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

Nursing and Midwifery strategy work streams:

Care*: Deliver safe and Caring Services*
Compassion*: Deliver a great patient experience*
Competence*: Drive service improvements, innovation and transformation*
Commitment*: Be the place people choose to work*
Communication*: Make the best use of what we have*
Courage*: Deliver a viable future*

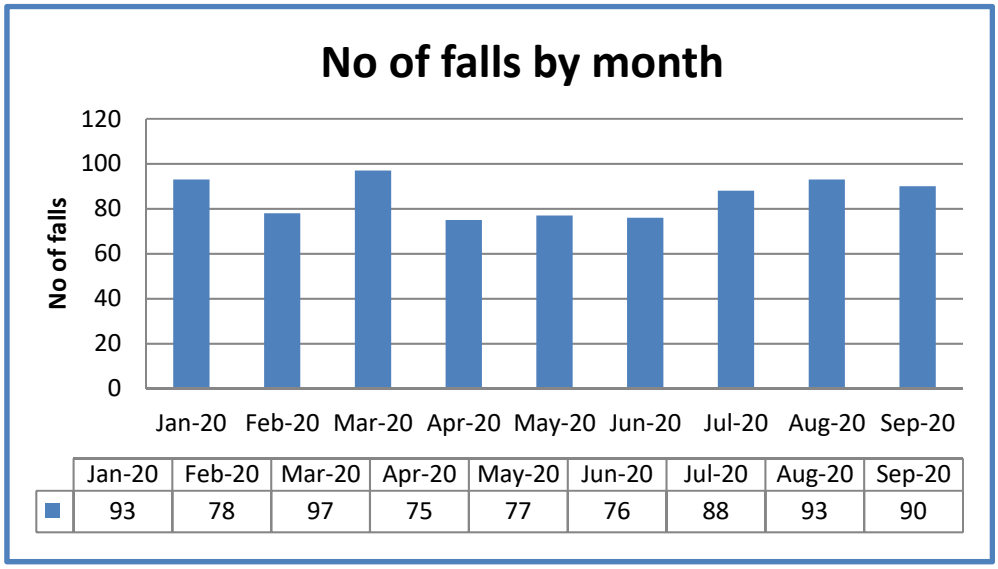
<table>
<tr><th colspan="4">IMPLICATIONS FOR THE CORPORATE RISK REGISTER OR BOARD ASSURANCE FRAMEWORK</th></tr>
<tr><td rowspan="2">RISK BAF 1A Not effectively engaging with patients in their care or involving them in service Improvement</td><td colspan="2">Y</td><td>Risk Description: We don’t always effectively engage with patients in their care or involve them in service improvement as a result we fail to communicate with them effectively resulting in a poor patient experience which means patients will not see us as a provider of choice.</td></tr>
<tr><td colspan="2">Risk Register: Y/N</td><td>Risk Score: 12</td></tr>
<tr><td rowspan="3">COMPLIANCE
and/or
LEGAL REQUIREMENTS</td><td>CQC</td><td>Y</td><td>Details: Safe and caring services</td></tr>
<tr><td>NHSI</td><td>N</td><td>Details:</td></tr>
<tr><td>Other</td><td>N</td><td>Details:</td></tr>
<tr><td>REPORT DESTINATION</td><td>BOARD</td><td>Y</td><td>DATE: 12.11.20</td></tr>
</table>

Care Deliver safe and caring services

Falls - There has been a slight decrease in the number of falls for September with 90 falls compared with August when there were 93. This is reflective of the continued impact of deconditioning of patients following COVID-19.

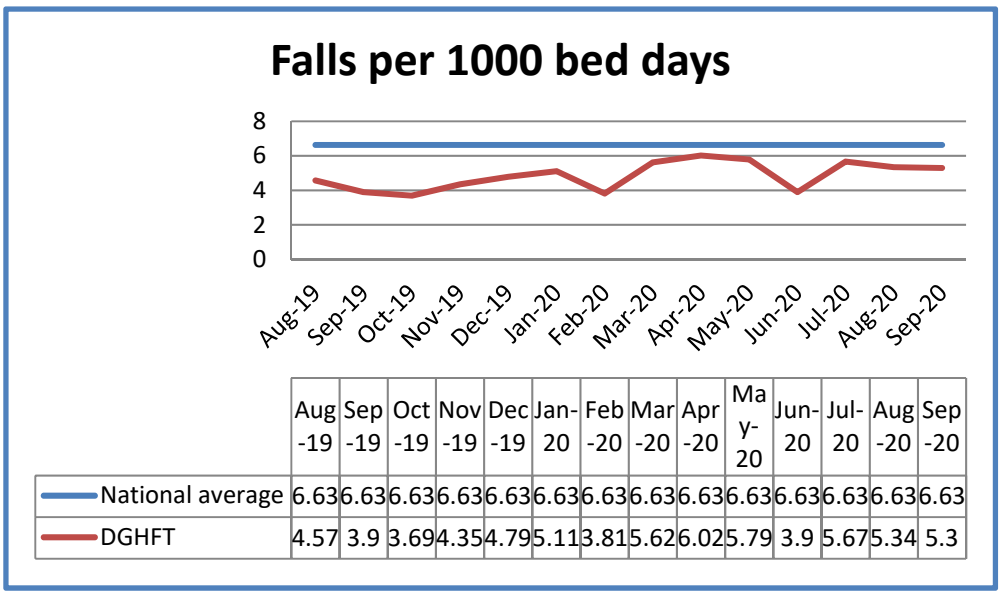
Tables 1 and 2 show the total number of falls and falls per 100 bed days; the falls rate for the Trust remains below National average despite an increase in the overall number of falls.

Table 1



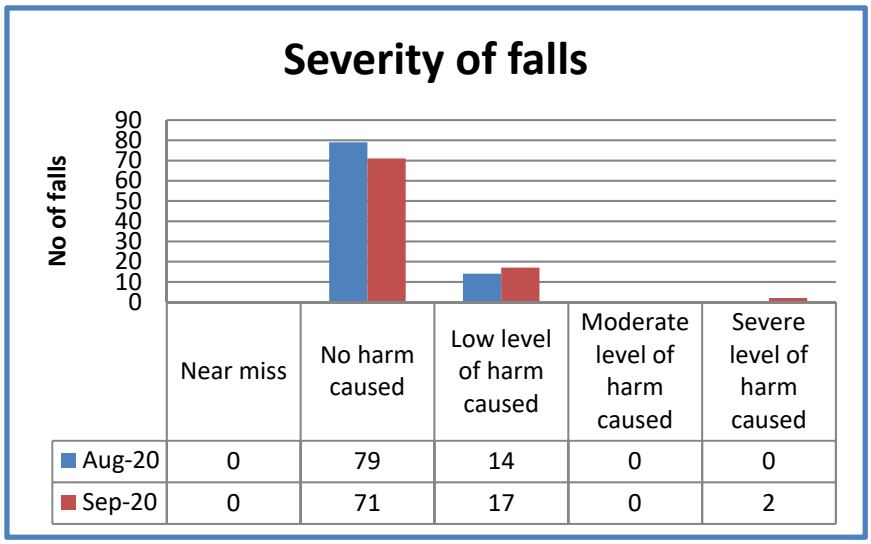
	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20
■	93	78	97	75	77	76	88	93	90

Table 2



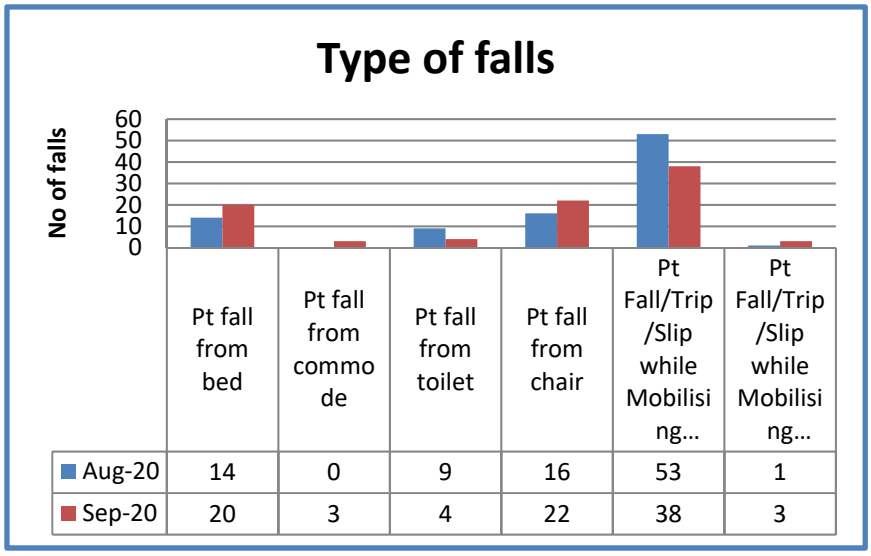
	Aug -19	Sep -19	Oct -19	Nov -19	Dec -19	Jan-20	Feb -20	Mar -20	Apr -20	May-20	Jun-20	Jul-20	Aug -20	Sep -20
National average	6.63	6.63	6.63	6.63	6.63	6.63	6.63	6.63	6.63	6.63	6.63	6.63	6.63	6.63
DGHFT	4.57	3.9	3.69	4.35	4.79	5.11	3.81	5.62	6.02	5.79	3.9	5.67	5.34	5.3

Table 3



	Near miss	No harm caused	Low level of harm caused	Moderate level of harm caused	Severe level of harm caused
Aug-20	0	79	14	0	0
Sep-20	0	71	17	0	2

Table 4



	Pt fall from bed	Pt fall from commode	Pt fall from toilet	Pt fall from chair	Pt Fall/Trip/Slip while Mobilising…	Pt Fall/Trip/Slip while Mobilising…
Aug-20	14	0	9	16	53	1
Sep-20	20	3	4	22	38	3

Tables 3 and 4 show the types of fall and the severity. Two falls resulted in harm in September. The majority of falls occurred when patients were mobilising alone and the fall was unwitnessed. The number of inpatient falls due to mobilising alone or attempting to mobilise from a chair has risen overall in the last 3 months, which could suggest that patients may incorrectly judge their ability to mobilise without assistance.

Tissue Viability – There have been no avoidable category 3 or 4 pressure ulcers reported since the last report. October 12th saw the start of *Leg Matters* week stressing the importance of always looking at patient's legs; including **the removal of dressings and bandages on admission** to the Trust so that we know what is underneath. This ensures that we can intervene in a timely manner and supports care to our patients. A number of activities took place throughout the week to raise awareness by the Tissue Viability nursing team.

The Tissue Viability Lead, Gill Hiskett, has had an article published in the 'Journal of Practice Nursing' in the September 2020 edition, on the subject of 'Shared care in wound management'. The article can be found at http://www.journalofpracticenursing.co.uk

Compassion Deliver a great patient experience

Complaints - During September 2020, the Trust received 88 new complaints compared to 59 in August. The majority of the complaints relating to treatment received during the COVID-19 pandemic.

Closures for divisions for September 2020 are as follows:

- 33 closed for Surgery
- 36 closed for Medicine & Integrated Care
- 1 closed for Clinical Support Services
- 1 closed for Corporate Services

Friends and Family Test

- 3,280 responses across all areas have been received during September 2020 in comparison to 3,286 in August 2020.
- New cards have now been printed and distributed to all departments and wards.
- Following changes to the Friends and Family test in September 2020 a FFT policy has been developed to provide a framework that sets out the standards, guidance for all staff in regards to implementing the Friends and Family test, and in addition, a Standard Operating Procedure has been written to provide details of the FFT process.

Compliments The Trust received **333** compliments in September compared to 295 compliments in August 2020.

Carers COVID packs

- The Trust is working in collaboration with Dudley Clinical Commissioning Group (CCG), Dudley Carers Network and DGFT Carers Coordinator to produce a 'COVID Carers Pack'.
- The content of the pack will be reviewed by the Dudley Carers Alliance Group and approved by the CCG Carers Update Group.
- A recurring theme from the inpatients survey is lack of support post-discharge on social care and providing information to families/carers so the carers pack will be an additional resource for staff to share information on the local support available to patients/carers.

Mental Health – There was one patient detained under the Mental Health Act during September 2020.

Competence Drive service improvement, innovation and transformation

Professional Development

Pre-Registration - Normal supernumerary placements for student nurses have resumed from September 2020 as per the university flow through. In partnership with Birmingham City University (BCU) we are supporting 7 Adult branch students from March 2021. Confirmation is still awaited on the numbers for September 2020. Final numbers of students from University of Wolverhampton are still awaited; the provisional allocation to the trust is 75 students

Continuing Professional Development – Internships A meeting has taken place to discuss the possibility and process of commencing an internship in the Trust. The Post Registration Lead and Consultant Nurse for Trauma and Orthopaedics are leading on this work and are looking to obtain academic accreditation from one of our local universities.

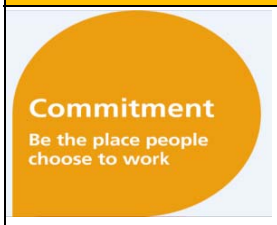
Communication Make the best of what we have

Infection Prevention and Control (IPC) The IPC team continue to support staff and their teams in managing the COVID 19 pandemic.

Flu Campaign This year's flu campaign has got off to a good start on the 5th October. Peer vaccinators staffed the main entrance and provided flu vaccinations on all sites of the Trust. All of the first 2000 vaccines supplied to the trust were administered in the first week. Compliance at the time of the report was 51%.

Allied Health Care Professionals Physiotherapists have changed the way they work to support patients in our fracture clinic. By providing a presence in clinics, patients are seen at the right time in the right place by the right clinician. Women's health Physiotherapist, Ruth Hopper, has designed a suite of resources from videos to leaflets to educate patients with continence issues on self-management and rehabilitation.

Commitment – Be the place that people choose to work



Agency Controls - All bank and agency requests continue to be assessed by the Divisonal Directors with support from the Divisional Chief Nurses. Executives have agreed, where possible, to promote a zero tolerance for the booking of non-framework agency at the current time. Requests will be individually risk assessed to ensure the safety of our patients and staff is prioritised. All requests for non framework agency remain Chief Nurse or Chief Operating Officer authorisation only in hours; out of hours remains executive authorisation only and this is closely monitored by the Chief Nurse and her deputies.

Allied Healthcare Professionals - October 14th was AHP day - This year, AHP day was held as a virtual event, to give staff a chance to come together and celebrate all 14 allied health professions that we have across the NHS. We were very honoured that Suzanne Rastrick the Chief Allied Health officer for England chose Dudley Group to join in the celebrations and made the key note speech as well as presenting awards across 5 categories. The day was an amazing success with all AHP staff receiving a specially designed mug featuring the hashtag ***#ProudtobeaDudleyAHP*** with a thank you from the Deputy Chief AHP, Karen Lewis and Chief Nurse. There was 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 day was closed with reflections from the Chief Nurse.

Safer staffing – The qualified staff fill rates for September were 81% during the day, fill rates for nights were 89%, this is similar to 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 8.99 for September 2020 (qualified and unqualified). Staffing numbers continue to be reviewed twice a day at the safety huddles facilitated by the Divisonal Chief Nurses (appendix 1). However, efforts continue to address staffing concerns in a number of areas, which have been exacerbated by the effects on staff working during the COVID-19 pandemic.

Sustainable Nurse Resourcing Strategy – Work continues with Human Resources and the nursing directorate to develop a nursing resource strategy.

Professional Development – **Clinical Support staff -** The process has started to recruit an additional 100 CSW (Clinical Support Workers) to the trust, the first set of interviews commenced on the 19th October to start in the Trust in November 2020. Further cohorts will be recruited during December and January.

Courage – Deliver a viable future

Safeguarding – The appointment of the Lead Nurse for Safeguarding who will also act as the Deputy to Head of Safeguarding in the absence of the Head of Safeguarding is now complete. The new associate nurse for safeguarding adults has commenced in post on a 12-month secondment.

Provision of evening face-to-face training sessions to improve level 3 compliance was poorly attended. There is continued communication with senior leads to improve safeguarding level 3 training compliance.

Partnership working with Dudley Safeguarding Protection Partnership Board has commenced around Level 3 webinar and e-learning packages.

The Domestic Abuse Policy is now complete and ready for ratification at the next Internal Safeguarding Board.

Appendix 1

Safer Staffing Data

Safer Staffing Summary — Sep — Days in Month 30

	Day RN	Day RN	Day CSW	Day CSW	Night RN	Night RN	Night CSW	Night CSW							Actual CHPPD		
Ward	Plan	Actual	Plan	Actual	Plan	Actual	Plan	Actual	Qual Day	UnQual Day	Qual N	UnQual N	Sum 24:00 Occ	Average Occupancy	Registered	Care staff	Total
B1	130	82	65	45	90	66			63%	69%	73%		292	37%	5.80	2.78	8.58
B2(H)	120	98	190	150	89	88	157	152	82%	79%	99%	97%	691	77%	3.23	5.13	8.36
B2(T)	120	101	123	117	90	84	95	85	84%	95%	94%	90%	660	92%	3.38	3.68	7.05
B3	280	218	181	134	240	222	153	143	78%	74%	92%	94%	1,143	91%	4.52	2.91	7.42
B4	249	202	256	204	186	170	210	173	81%	80%	91%	83%	1,260	88%	3.46	3.59	7.06
B5	241	196	159	131	207	191	123	93	81%	83%	92%	76%	532	74%	8.91	4.95	13.86
C1	243	214	241	239	176	168	189	181	88%	99%	96%	96%	1,399	97%	3.20	3.60	6.80
C2	271	245	65	56	219	206	64	53	91%	87%	94%	83%	434	48%	12.20	2.96	15.16
C3	202	202	380	362	161	177	338	327	100%	95%	110%	97%	1,532	98%	2.96	5.28	8.25
C4	157	132	65	61	120	90	60	82	85%	93%	75%	136%	597	90%	4.36	2.76	7.12
C5	231	178	243	221	188	180	181	164	77%	91%	96%	90%	1,186	82%	3.66	3.89	7.55
C6	94	80	96	60	61	59	90	79	85%	63%	97%	88%	513	86%	3.16	3.26	6.42
C7	192	152	220	147	152	147	206	183	79%	67%	97%	89%	987	91%	3.56	4.02	7.58
C8	313	240	212	153	271	234	182	166	77%	72%	86%	91%	1,242	94%	4.49	3.08	7.57
CCU_PCCU	242	198	61	34	211	182	30	27	82%	55%	86%	90%	615	79%	7.26	1.19	8.44
Critical Care	458	381	89	44	462	395			83%	49%	85%		317	66%	29.36	1.67	31.03
EAU AMU 1	467	369	390	327	417	351	359	302	79%	84%	84%	84%	2,332	130%	3.63	3.23	6.86
Maternity	907	656	240	176	514	405	171	145	72%	73%	79%	85%	709	54%	14.25	5.31	19.57
MHDU	163	141	40	31	151	140	30	25	86%	76%	93%	83%	171	57%	19.70	3.72	23.42
NNU	157	134			144	128			86%		89%		274	51%	11.48	0.00	11.48
TOTAL	**5,237**	**4,220**	**3,317**	**2,693**	**4,148**	**3,683**	**2,638**	**2,381**	**81%**	**81%**	**89%**	**90%**	**16,886**		**5.40**	**3.59**	**8.99**

Enclosure 16

The Dudley Group NHS Foundation Trust

Paper for submission to the Board of Directors 12 November 2020

TITLE:	**Infection Prevention and Control Board Assurance Frame Work –including summary Updated October 2020**		
AUTHOR:	**Emma Fulloway IPCL Nurse**	**PRESENTER**	**Emma Fulloway IPCL Nurse**

CLINICAL STRATEGIC AIMS

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

CORPORATE OBJECTIVE: SO2: Safe and Caring Services

SUMMARY OF KEY ISSUES:

This paper is being presented 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. 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.
The colour coded matrix over the page (before the detailed IPC BAF) demonstrates the many areas which the trust is able to give assurance as evidence of compliance can be confirmed:

- We have identified as having no gaps in assurance such as, 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 supported by a standing operating procedure. The Trust has robust cleaning processes, facilitated through the IPCT working closely with our interserve partners.
- Robust and prompt testing systems in place for patients suspected of COVID. The Trust can evidence vigorous procurement procedures for PPE management and distribution.
- Face fit testing completed is now recorded on a database there compliance can be monitored

The Trust is continuing with work on:

- The IPCT are working with the medical devices team and wards to increase compliance of device decontamination before maintenance.
- 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.
- Staff outbreaks have highlighted that FFP3 face masks have been worn inappropriately
- Assurance is being sought for day 5 COVID testing and work continues to implement a prompt on Sunrise for staff to COVID test before discharge to care/nursing homes.
- Outbreaks within the Trust are managed in line with Trust outbreak procedures to ensure timely mitigation to safe guard patients and staff.

IMPLICATIONS OF PAPER:

RISK	**Y**	**Risk Description: Risk regarding decontamination of reusable medical**

			devices and lack of clarity regarding Trust Decontamination Lead-Risk on IPC Risk Log
	Risk Register: Y		Risk Score: see appendix
COMPLIANCE and/or LEGAL REQUIREMENTS	CQC	Y	Details: Safe, Effective, Well Lead
	NHSI	Y	Details: The IPC Board Assurance frame work was requested by NHS/I
	Other	N	Details:

ACTION REQUIRED OF COMMITTEE / GROUP:

Decision	Approval	Discussion	Other
		✓	

RECOMMENDATIONS FOR THE BOARD

To note the continued actions within the IPCTBAF to endure compliance with the Health and Social Care Act

NHS
The Dudley Group
NHS Foundation Trust

BAF Compliance Matrix

KEY	No Gaps	Gaps Identified with mitigations	Gap No Mitigation	No line of enquiry

	0.1	0.2	0.3	0.4	0.5	0.6	0.7	0.8	0.9	0.10	Comments
1											1.3 audit required to identify compliance with discharges to care, nursing and LD homes. 1.8 Improve IPC risk assessment required on admission documents.
2											2.1 unable to guarantee that there is no cross over of staff, however the different zones are identified with notices to make staff aware they are moving into a different zone. 2.2 training records required
3											3.1 Micro/Antimicro Pharmacist rounds reduced, Virtual Antimicrobial stewardship meetings held, Pharmacists actively referring patients to antimicrobial pharmacist for queries, EPMA now in place.
4											4.3 COVID-19 information is produced by DH the trust website does have an accessibility button-that will read information and enlarges words. 4.5 patient check list in place for transfers and discharges-assurance check required.
5											5.1 trust zoning SOP notes that suspected COVID cases are located in ED red zone, urgent care COVID area in place SOP being produced.
6											6.1 face to face training session capacity has been reduced due to social distancing, eLearning has been promoted to staff to improve mandatory training. 6.2 face fit testing database now developed. Mandatory training now includes donning and doffing training. 6.3.IPC Mandatory training record monitored. 6.4/6.5 face shields were reused at the start of the pandemic. 6.6 general audits commenced audit tool being devised, for PPE.
7											7.2 Zoning SOP in place and social distancing. EPR COVID policy in draft going through trust sign off. Standalone IPC COVID policy in initial draft policy, now being reviewed due to new guidance.
8											8.1 Work continues to ensure compliance with national testing on discharge to other care providers. Day 5 after admission retest prompted for Green patients in place
9											9.1 Quality Rounds commenced independent review of saving lives returns required
10											10.1 All staff to be risk assessed, returns monitored by HR. 10.2 Database for face fit testing in place. 10.3 movements of staff between zones cannot be

The Dudley Group NHS Foundation Trust

Infection Prevention and Control Board Assurance Framework: May-October 2020

1. Systems are in place to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of service users and any risks posed by their environment and other service users				
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	**R.A.G**
Systems and processes are in place to ensure: **1.1** • infection risk is assessed at the front door and this is documented in patient notes	The Trust has policies and procedures in place to identify alert organisms in patients admitted to the Trust. Patients with symptoms are assessed by ED and are placed into the RED Cohort area of ED; all admissions via ED are screened. Covid -19 flow.pdf OPD - symptoms of COVID (2)...docx Outpatient flow chart: Urgent care area draft SOP in progress COVID area identified Documentation audits are ongoing monthly. No clinical incidents have been identified.	No gaps identified		
1.2 • patients with possible or confirmed COVID-19 are not moved unless this is essential to their care or reduces the risk of	The Trust has implemented a Zoning system, Yellow, Blue and Green with SOP in place The capacity of the Zones is reviewed 3 times daily at the capacity meetings. The infection prevention team have the daily ward list which	No gaps identified	Infection control attend the capacity meetings	

transmission	documents the location of COVID 19 patients and also have a contact list to track patient contacts. There are no datix reports of zoning failures. 12/10/20 Zoning SOP updated			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	**R.A.G**
1.3 • compliance with the national guidance around discharge or transfer of COVID-19 positive patients	Patients who are to be discharged to another care facility (Nursing/Care/LD Home) are screened for COVID 19 as per national guidance. Draft policy awaiting ratification. COVID results are provided to other care providers on transfer with discharge information. COVID status will be added as a separate item on the discharge and transfer information. Where tests are processed in house DMBC PH are informed of any COVID cases in care/nursing homes to enable follow up of patients. 12/10/20 –meeting held for Sunrise prompt care/nursing home patients to be tested for COVID before discharge, next meeting planned 19/10/20.	This process is awaiting audit, as some gaps have been identified by stakeholders, where by patients have been discharged to a home without being tested.	Where a patient has been missed the ward is contacted to make them aware. Discharge check lists to be updated. Work commenced with Site Team and Sunrise to engineer a prompt for staff to swab patients before discharge to Care/Nursing Homes.- this could be used to generate audit data.	
1.4 • patients and staff are protected with PPE, as per the PHE national guidance	PHE guidance in relation to PPE has changed during the COVID pandemic. Staff are updated promptly when new guidance is released via the daily communications. Staff have access to PPE as per PHE guidance. At the start of the pandemic PPE Marshalls were in place, there are posters stating PPE requirements in each of the zones. Executive oversite of PPE stocks.	No gaps identified		

	Patients are offered surgical mask upon entry to the hospital. In-Patients are to be offered face masks if they are placed in waiting area, or bay with other patients.			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	**R.A.G**
1.5 • national IPC guidance is regularly checked for updates and any changes are effectively communicated to staff in a timely way	The Incident Room, established in response to the pandemic receives all internal and external information in relation to COVID and then forward this, on a daily basis, to all relevant departments. The IPCT review the PHE website daily for updated PPE and infection control guidance. Changes are communicated to staff via IPCT visiting clinical areas, Matrons meeting, daily brief, HUB page, COVID emails and CEO briefing. Recent issue: CAS alert regarding tiger eye, eye protection was actioned within 24 hours of receipt of alert. Daily situation report to PHE/NHSI/E. Latest updated PHE/NHS IPC guidance is going through Trust processes currently.	No gaps identified		
1.6 • changes to guidance are brought to the attention of boards and any risks and mitigating actions are highlighted	A COVID19 briefing paper is presented to the private board on monthly basis. COVID 19 taskforce meeting that reports directly to the Executive Board. Quality and safety committee and IPCC meetings were suspended in March and April due to due work force challenges during the pandemic, they have now recommenced	No gaps identified	Latest updated PHE/NHS IPC guidance is going through Trust processes currently.	

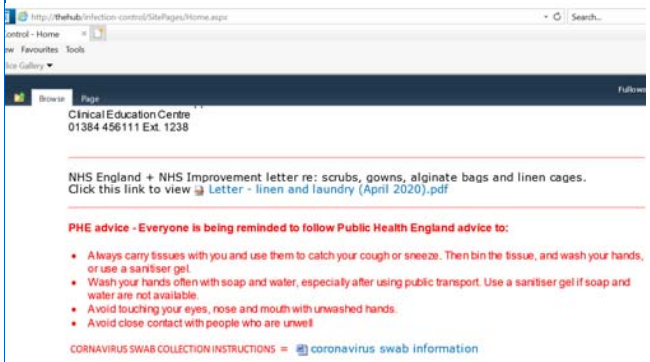
Key lines of enquiry	Evidence	Gaps in Assurance	Mitigating Actions	R.A.G
1.7 • risks are reflected in risk registers and the Board Assurance Framework where appropriate	COVID Operational risks are contained within the corporate and divisional risk registers. The infection prevention framework document will be presented to Board for suggestion of inclusion on the corporate risk register. Risk registers to be reviewed to ensure all COVID related risks are documented and reported.			
1.8 • robust IPC risk assessment processes and practices are in place for non COVID-19 infections and pathogens	Admission assessments include an infection control section which asks if patients have an infection. There are policies and procedures in place to identify alert organisms in admitted patients. These are audited and presented to the Infection Prevention and Control Group for reporting up through the organisation. Surveillance of alert organisms is completed by the IPCT utilising ICNet surveillance system and the national MESS database. Any positive results are reported via sunrise system to inform clinical teams. The PAS is updated with significant infection risks as per policy. Sepsis screens are completed via sunrise.	Gaps Identified The infection control risk assessment in the admission documentation is limited. ICNEt system issues – COVID results not always transferred	Live link to sunrise system in place, for COVID-19 results IPCT representation on EPR meetings to move	

	A draft formal IPC admission risk assessment has been devised this is due to be signed off at October IPC Group.		forward with implementation of IPC Risk assessment	

2 Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections				
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	**R.A.G**
Systems and processes are in place to ensure: **2.1** • designated teams with appropriate training are assigned to care for and treat patients in COVID-19 isolation or cohort areas	Training of staff reallocated from theatres to COVID ITU. Staff caring for COVID patients, are supported by Matrons, Consultants and IPCT. The medical rotas were adjusted to ensure that those with respiratory experience were assigned to the high COVID areas. IPCT have provided training for Donning and Doffing of PPE, the team commenced in March-but did not capture training attendance until April. Face fit testing undertaken locally and by the clinical skills team.	Gaps Identified Lack of accurate data to demonstrate compliance Robust process required for managing yearly face fit testing requirements. Current face fit testing list not complete	Now donning and doffing training completed by the IPCT is documented, going forward this will be included in mandatory training Database for fit testing now in use and compliance is being monitored	
2.2 • designated cleaning teams with appropriate training in required techniques and use of	Cleaning contractor has ensured that 310 facilities staff were face fit tested and trained regarding PPE requirements. Additional training has been offered to cleaning contract staff to ensure they are aware of appropriate cleaning techniques	No evidence of overall compliance for face fit testing	IPCT hold regular meetings to ensure facilities resources are	

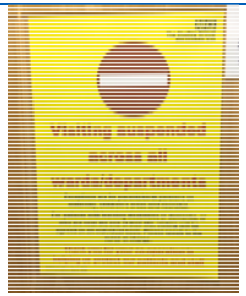
PPE, are assigned to COVID-19 isolation or cohort areas.	for working in COVID cohort areas. An external cleaning training provider has completed a programme of education. Facilities Team training compliance reviewed at September 2020 IPG, discussion to be held regarding increasing infection control frequency of staff group from 3 yearly to 1 yearly.		focused in risk areas	
2.3 • decontamination and terminal decontamination of isolation rooms or cohort areas is carried out in line with PHE and other national guidance	Terminal cleans completed when a COVID patient vacates a bed space or area The Trust HPV team where possible have completed room disinfections following the standard terminal cleans within isolation rooms, ward bays.	No Gaps identified		
2.4 Increased frequency, at least twice daily, of cleaning in areas that have higher environmental contamination rates as set out in the PHE and other national guidance attention to the cleaning of toilets/bathrooms, as COVID-19 has frequently been found to contaminate surfaces in these areas cleaning is carried out with neutral detergent, a chlorine-based disinfectant, in	COVID additional cleaning documents and cleaning policy remain in place. 04.05.20 COVID 19 Additional daily clean Cleaning policy.pdf COVID 19 Additional daily cleaning schedu ED Ambulance Triage Cubicle cleaning in Touchpoint checklist C3.pdf Touchpoint checklist C3 back.pdf The Trust facilities team and infection prevention team have reviewed cleaning requirements through the pandemic, assessing cleaning standards through the audit programme and by gaining feedback from clinical teams. Cleaning audits were recommenced end of April. Auditing of cleaning was suspended during March/April due to	No Gaps identified		

the form of a solution at a minimum strength of 1,000ppm available chlorine, as per national guidance. If an alternative disinfectant is used, the local infection prevention and control team (IPCT) should be consulted on this to ensure that this is effective against enveloped viruses manufacturers' guidance and recommended product 'contact time' must be followed for all cleaning/disinfectant solutions/products as per national guidance: 'frequently touched' surfaces, e.g. door/toilet handles, patient call bells, over-bed tables and bed rails, should be decontaminated at least twice daily and when known to be contaminated with secretions, excretions or body fluids electronic equipment, e.g. mobile phones,	work force challenges, this is now back in place. The trust utilises Clinell wipes for decontamination of medical devices and surfaces-Gamma state the wipe are against enveloped viruses and that 60 seconds contact time is required. Touch point cleaning continues; this is reviewed 2 weekly by IPC and facilities team. As the COVID cases within the hospital have continued to rise the trusts facilities manager has ensured cleaning resources are increased in high risk areas.			

desk phones, tablets, desktops and keyboards should be cleaned at least twice daily rooms/areas where PPE is removed must be decontaminated, timed to coincide with periods immediately after PPE removal by groups of staff (at least twice daily.)				
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	**R.A.G**
2.5 • linen from possible and confirmed COVID-19 patients is managed in line with PHE and other national guidance and the appropriate precautions are taken	COVID positive linen is managed in line with Elis policy (placed into alginate bag and the white bag) which is compliant with PHE guidance-which is available on the Trust, HUB screen shot below:  Clinical Education Centre 01384 456111 Ext. 1238 NHS England + NHS Improvement letter re: scrubs, gowns, alginate bags and linen cages. Click this link to view Letter - linen and laundry (April 2020).pdf PHE advice - Everyone is being reminded to follow Public Health England advice to: • Always carry tissues with you and use them to catch your cough or sneeze. Then bin the tissue, and wash your hands, or use a sanitiser gel. • Wash your hands often with soap and water, especially after using public transport. Use a sanitiser gel if soap and water are not available. • Avoid touching your eyes, nose and mouth with unwashed hands. • Avoid close contact with people who are unwell CORNAVIRUS SWAB COLLECTION INSTRUCTIONS = coronavirus swab information **Standard precaution policy has been updated to include the colour code**	Noted that the Trust does not have a linen policy, a section on linen is included in the standard precaution policy this is currently being updated to include the contractors colour coding which is currently in place across the clinical areas	Information regarding the correct bagging is held on the Hub and the practice is monitored via annual audit process and Quality Rounds	

2.6 • single use items are used where possible and according to Single Use Policy	As far as possible single use items have been used, as documented in the Decontamination and decontamination of medical devices policy available on the HUB. There is an audit programme in place via the ward audits which look at single use items and appropriate decontamination. IPCT annual audits were recommenced in June	Due to COVID crisis frequency of audits has been reduced.	IPC Annual audits have now commenced and Quality Rounds	
2.7 • reusable equipment is appropriately decontaminated in line with local and PHE and other national policy	Reusable non-invasive medical devices are decontaminated using disinfectant wipes or Chlorine releasing agent in line with Trust policy and/or manufactures instructions. Decontamination and decontamination of medical devices policy available on the HUB. The trust has an ongoing incident regarding Pseudomonas infections following Cystoscopies, incident team have devised an action plan to ensure safety of patients. Decontamination risk on IPCT Risk Log. This was reported as an SI. Service has recommenced with mitigations in place. Reports from Medical engineering team that wards are not using correct processes, escalation in place to report noncompliance to improve current practice	Gaps Identified Evidence of application of policy required	Ensure audits continue as planned via the annual audit programme. Quality Rounds commenced	
2.8 • review and ensure good ventilation in admission and waiting areas to minimise opportunistic airborne transmission	The Estates department as part of the hot weather plans have been installing where possible portable air conditioning units and have reviewed ventilation at the Trust. The estates team hold details regarding air changes according to site plans	No Gap Identified	Installation of air conditioning units	

3 Ensure appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance				
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	**R.A.G**
Systems and process are in place to ensure: **3.1** • arrangements around antimicrobial stewardship are maintained • mandatory reporting requirements are adhered to and boards continue to maintain oversight	• Antimicrobial Pharmacy referrals in place. • AMS ward rounds (Antimicrobial Pharmacist led) • AMS annual report provided. • AMS update is regularly provided to Medicines management Group and Drugs and therapeutics Group. • Consultant Microbiologists available via switch board 24/7 for consultation. • Antimicrobial prescribing Snap shot audits. • Procalcitonin testing introduced as part of covid screening to reduce inappropriate prescribing of • antimicrobials.	• Antimicrobial stewardship group meetings. • Micro/Antimicrobial Pharmacist ward rounds not happening as often as before Pandemic due to isolations and remote working. • Rigorous monitoring not possible currently.	Virtual Antimicrobial stewardship group meetings during pandemic (via email/ teams). All clinical Pharmacists actively referring patients to antimicrobial Pharmacist for stewardship queries. Band 7 antimicrobial Pharmacist post recruited. Snap shot antimicrobial prescribing audits. Infection control Nurses to support AMS activity. EPMA now in place to allow	

			ongoing monitoring of prescriptions	
4 Provide suitable accurate information on infections to service users, their visitors and any person concerned with providing further support or nursing/ medical care in a timely fashion				
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	**R.A.G**
4.1 Systems and processes are in place to ensure: • implementation of national guidance on visiting patients in a care setting	 The trust currently has restricted visiting in place due to social distancing and government essential travel restrictions. Visitors are to wear PPE when visiting. This has been communicated by, nursing staff to patients and visitors, via social media, switch board and posters as pictured around the hospital. Visiting Policy to be updated to reflect current visiting advice. Information regarding visiting during the COVID crisis is provided via automated message on calling direct to Trust switchboard. Although visiting remains suspended, as we are coming out of	No gaps identified		

	the pandemic the Trust is to devise social distanced visiting, whereby visitors have specified slots to prevent overcrowding.			
4.2 • areas in which suspected or confirmed COVID-19 patients are where possible being treated in areas clearly marked with appropriate signage and have restricted access	Signage is placed on entrances to wards and other clinical settings stating restricted access. In addition have zoning SOP (attached above), zoning notices and poster with PPE requirements for the area. 	No gaps identified		
4.3 • information and guidance on COVID-19 is available on all Trust websites with easy read versions	COVID information is available on the Trust Intranet and External website in line with national communications materials available	Gaps Identified Easy read versions are not available on external website. Multilingual versions also not readily available.	COVID information is currently produced by DH and has been directed through this route. The Trusts website does have a clear information button which reads information to users and enlarges font	

			and gives an explanation of words used amongst other accessibility tools.	
4.4 infection status is communicated to the receiving organisation or department when a possible or confirmed COVID-19 patient needs to be moved	There is a patient transfer checklist which asks-infection type if the patient requires barrier nursing or side room and requests current observations. As previously documented there is a discharge and transfer checklist (which will be updated to specifically include COVID) and COVID status is included in all discharge documentation to all other healthcare providers. COVID test results for intra trust transfers are documented on Sunrise	Gaps Identified Assurance required regarding evidence of completion	To be reviewed as part of the monthly documentation audit.	
5 Ensure prompt identification of people who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to other people				
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	**R.A.G**
Systems and processes are in place to ensure: **5.1** • front door areas have appropriate triaging arrangements in place to cohort patients with possible or confirmed	Please refer to section 1. There is the zoning document for in-patient admissions which covers patient placement. ED have a flow chart describing the designated 'red area' which is separate to the rest of ED with dedicated staff for suspected COVID patients.	No Gaps Identified Assurance required regarding urgent care		

COVID-19 symptoms and to segregate them from non COVID-19 cases to minimise the risk of cross-infection	Work on going with urgent care provider to ensure they are triaging patients COVID area in place COVID SOP Draft Neonatal team have produced the attached document about screening suspected cases and placement of patients. Environment alterations made to promote social distancing. **Outpatient departments have a flow cart in place to identify visitors with symptoms of infection**	processes Urgent care SOP, IPC visit 24/07/2020		
5.2 • patients with suspected COVID-19 are tested promptly	As per national guidelines testing for acute admissions is completed on admission to ED (detail included in both zoning SOP and patient flow policies). A process for screening of elective cases is in place and delivered via a drive through system. Audits completed weeks commencing 27th April and 5th May demonstrate the following: Testing is completed on admission via ED, elective cases before admission via drive through system. 20 ED Patient records were reviewed for timeliness of COVID testing: 11 pts were not admitted -discharged and no swab required 1 patient admitted but not swabbed. 8 patients were swabbed, time from first observation to test varied from 1 hour to 11hours. Patients in green (non COVID) and yellow zones (awaiting results) are monitored for symptoms of COVID and are rescreened if required. Patients' observations are input into sunrise which will set an alert when news scores is triggered. Requests are made via the Sunrise system; the results are reported via this system also.	No gaps identified		

5.3 • patients that test negative but display or go on to develop symptoms of COVID-19 are segregated, tested and instigation of contract tracing as soon as possible	As described in the zoning SOP and draft COVID policy. Symptomatic patients are treated in side rooms where possible. Patients in green (non COVID) and yellow zones (awaiting results) are monitored for symptoms of COVID and are rescreened if required. Patients observations are input into sunrise which will set an alert when news scores is triggered. Requests are made via the Sunrise system, the results are reported via this system also. New cases which occur within the hospital setting 2> days after admission are contact traced by the ICT. A list of contacts is kept by IPCT to monitor the for their location and symptoms, contacts are then tested on day 5 after contact. Test and trace draft flow chart in place, which describes the contact tracing risk assessments.	No gaps identified		
5.4 • patients that attend for routine appointments who display symptoms of COVID-19 are managed appropriately	Where possible out patients appointments are conducted virtually or by telephone. Some clinics are appointments, before patients attend they are asked if they have symptoms, if patients has symptoms and they have to attend they are asked to wear a surgical mask and decontaminate hands and would be placed last on the list. Phlebotomy clinics have commenced at the main hospital patients have to book appointments and social distancing is in place. Currently all patients attending the OPD are screened via symptom enquiry and temperature check if necessary, asked to decontaminate hands and wear a face mask.	No gaps identified		

	The majority of OPD appointments are being conducted virtually or by telephone. OPD flow chart for COVID screening in place.			
6 Systems to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection				
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	**R.A.G**
Systems and processes are in place to ensure: **6.1** • all staff (clinical and non- clinical) have appropriate training, in line with latest PHE and other guidance, to ensure their personal safety and working environment is safe	IPC mandatory training via e learning has continued, face to face training was suspended during March but now back in place with social distancing, this has reduced face to face capacity. COVID briefing sessions in Lecture theatre were held. Face Fit testing Training PPE donning and doffing HUB information with inks to PHE guidance and videos The core IPC mandatory training has been updated to include specific COVID training. Trust reviewing the updated PHE/NHS IPC Guidance for implementation at the Trust.	General face to face IPC training was suspended; therefore training compliance has reduced. Prompts sent by divisional leads to remind staff to complete training.	IPC Mandatory training is now in place. Face fit testing database now in place	
6.2 • all staff providing patient care are trained in the selection and use of PPE appropriate for the clinical situation and on how to safely don and doff it	At the height of the pandemic PPE marshals were trained by IPCL Nurse to enable them to complete checks and assist staff, PPE marshal role has now ceased. IPCT, Matrons have provided training to clinical areas posters are displayed at ward entrances stating what PPE is required and within the donning and doffing areas posters are displayed with pictures of how to don and doff. PHE videos are also available.	Gap in assurance identified Incident whereby a clinician wore FFP3 without face fit testing, issue to be raised as an incident and staff	Communications via huddles and email to all to remind staff of PPE requirements	

	PPE Marshal role has now recommenced due to the increase of COVID cases -26/10/20.	member to be face fit tested. Incident where a staff member worn a FFP3 with a beard-should of worn a hood.		
6.3 • a record of staff training is maintained	IPC Mandatory training records are held centrally in ESR. Fit test records are held by staff and divisional managers. Donning and Doffing Training: Records were kept from beginning of April for ad hock PPE training (training had taken place in March but not recorded).	The central database for face fit testing does not hold all details of staff face fit tested	Live data base in place for face fit testing. Face fit testing, Donning and Doffing included in priority 1 training requirement	
6.4 • appropriate arrangements are in place that any reuse of PPE in line with the CAS alert is properly monitored and managed	During the pandemic phase the only requirement to reuse PPE related to eye protection. Orthopaedic surgeons found a novel way of producing eye protection. Stocks are monitored by the procurement team and perceived deficits are reported to the executives so mitigation actions can be instigated promptly. If required in acute shortages the PHE guidance for reuse off	No gaps identified		

	PPE could be implemented.			
6.5 • any incidents relating to the re-use of PPE are monitored and appropriate action taken	Datix system analysed for any reports of PPE being reused- none identified. Since visors were reused in March this was not raised as a risk	No Gaps identified	Staff reminded to report re-use of PPE via datix. Procurement team monitor stock levels	
6.6 • adherence to PHE national guidance on the use of PPE is regularly audited	There is no formal COVID PPE audit. PPE Marshalls in place, matron, lead nurse and IPCT checks completed Clinical team complete stock checks. Developing a specific audit for PPE use. PPE use is included as part of the routine ward audit. Datix reports of failure to follow PPE advice are reviewed.	Gap identified	COVID PPE audit, audit tool in draft Quality Rounds Commenced	
6.7 • staff regularly undertake hand hygiene and observe standard infection control precautions • hand dryers in toilets are associated with greater risk of droplet spread than paper towels. Hands should be dried with soft, absorbent, disposable	The hand hygiene saving lives audits have continued and 100% compliance has been reported across services (that returned an audit) in Q4 and Q1. This level of compliance requires an independent review the IPCT are planning to launch IPC quality rounds to support clinical staff with auditing. Hand Hygiene training is covered within mandatory training. Hand dryers are not located within clinical areas, paper towels in dispenser are provided in line with national guidance along with instructions of how to perform hand hygiene- including drying.	Gap Identified: Independent review of hand hygiene required	IPC Annual audit programme has now commenced	

paper towels from a dispenser which is located close to the sink but beyond the risk of splash contamination, as per national guidance • guidance on hand hygiene, including drying, should be clearly displayed in all public toilet areas as well as staff areas				
6.8 • staff understand the requirements for uniform laundering where this is not provided for on site	Uniform policy in place, reminders sent out in communications via COVID update email Limited changing room facilities availability across the trust.	No gaps identified		
6.9 • all staff understand the symptoms of COVID-19 and take appropriate action in line with PHE and other national guidance if they or a member of their household display any of the symptoms	Staff Huddles competed, information shared via intranet, email and posters. Sickness is reported and monitored via a dedicated line, staff are screened if they or a family members have symptoms, staff are aware of isolation procedures in line with PHE guidance. Staff Temperature Checking in progress Test and trace flow chart in place and communications distributed regarding self-isolation	No gaps identified		

7 Provide or secure adequate isolation facilities				
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	**R.A.G**
Systems and processes are in place to ensure: **7.1** • patients with suspected or confirmed COVID-19 are isolated in appropriate facilities or designated areas where appropriate	The Trust has implemented a Zoning system, Yellow, Blue and Green with SOP in place. The capacity of the Zones is reviewed 3 times daily at the capacity meetings The infection prevention team have the daily ward list which documents the location of COVID patients and patients with resistant/alert organisms. The IPCT have re-distributed the zoning SOP to ward teams- 27/07/20 as COVID remains a risk to patient and staff safety.	No gaps identified		
7.2 • areas used to cohort patients with suspected or confirmed COVID-19 are compliant with the environmental requirements set out in the current PHE national guidance	Cohorting of (positive/negative and patients awaiting results) patients into bays, patients have to be spaced with curtains drawn in between patients, no fans and doors closed. Zoning SOP is in place and Draft policy. The hospital has limited space to have separate services therefore the Trust has segregated areas by utilising pods and physical barriers and one way systems.	Gap identified, mitigated for this trust	Hospital environment limited Areas segregated and social distancing in place Zoning SOP in place Policy is in draft	
7.3 • patients with resistant/alert	IPCT complete surveillance of alert organisms using ICNet, IPCT document on ICNet actions taken and advice given and	No gaps identified		

organisms are managed according to local IPC guidance, including ensuring appropriate patient placement	if necessary document in patients notes regarding precautions required isolation. IPCT policies in place: isolation, MRSA, CPE, C.diff			
8 Secure adequate access to laboratory support as appropriate				
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	**R.A.G**
There are systems and processes in place to ensure: **8.1** • testing is undertaken by competent and trained individuals • patient and staff COVID-19 testing is undertaken promptly and in line with PHE and other national guidance • screening for other potential infections takes place	Staff obtaining swab samples are trained to do so. A training package has been devised; staff have the opportunity to shadow and then complete a screen under supervision. Testing of the COVID swabs is undertaken in accredited laboratories. Community staff weekly testing requirement: collaborative approach with CCG and DMBC PH to introduce weekly testing for health care workers who attend care/nursing homes. The following audit was undertaken on 11th May: 20 ED Patient records were reviewed for timeliness of COVID testing: 11 pts were not admitted -discharged and no swab required 1 patient admitted but not swabbed. 9 patients were swabbed, time from first observation to test varied from 1 hour to 11hours. Prompt now in place on sunrise system to ensure green patients are retested on day 5 of admission as per national guidance	Gap identified Testing patients upon discharged and green patients on day 5. The timing of swabbing is indicated in the acute admission flow diagram.	Matrons informed during Huddles regarding testing required	

	Staff who are absent with COVID symptoms are reported by their manager to the COVID absence email and documented on ESR. A daily testing list is produced and shared with staff health and wellbeing for them to invite the staff in for testing. MRSA screening has continued along with clostridium difficile tests for patients who have diarrhoea. All other screening has continued as pre COVID crisis.			
09 Have and adhere to policies designed for the individual's care and provider organisations that will help to prevent and control infections				
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	**R.A.G**
Systems and processes are in place to ensure that: **9.1** • staff are supported in adhering to all IPC policies, including those for other alert organisms	IPC policy adherence is completed by IPCT visits, training and via Saving Lives audits.	No gaps identified		
9.2 • any changes to the PHE national guidance on PPE are quickly identified and effectively	The IPCT receive email alerts from PHE which describe any changes in guidance, the IPCT also review the PHE website daily for updated PPE and infection control guidance. Changes are communicated to staff via IPCT visiting clinical areas, Matrons meeting, daily brief, HUB page, COVID emails and CEO briefings.	No gaps identified		

communicated to staff	(See previous information regarding Incident Room cascading all relevant COVID information throughout the Trust)			
9.3 • all clinical waste related to confirmed or suspected COVID-19 cases is handled, stored and managed in accordance with current national guidance	Waste streams on yellow and blue zones are clinical waste: orange bag. Some reports received of improper disposal Interserve have communicated issues to areas concerned. Incident reports have been made identifying that PPE had been incorrectly disposed of in black and recycling bin waste in public areas of trust-communications have been sent out and recycling bins removed and replaced with clinical bins where possible. The national guidance for the disposal of face masks has been updated to stated that face masks which have not been used for clinical tasks can be disposed of in to the domestic waste stream. As we have significantly less COVID cases tiger stripe clinical waste stream has be implemented across the wards-when a case has been identified then orange waste stream is used	No Gaps identified		
9.4 • PPE stock is appropriately stored and accessible to staff who require it	A central store is maintained by procurement, who distribute PPE according to need to ensure adequate stocks, there is out of hours access. On entrance to clinical areas there is available stock of PPE. Staff obtain replacement stock directly from procurement. IPCT sit on PPE Cell meetings with Health and Safety, Procurement and clinical skills.	No gaps identified		

10 Have a system in place to manage the occupational health needs and obligations of staff in relation to infection				
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	**R.A.G**
Appropriate systems and processes are in place to ensure: **10.1** • staff in 'at-risk' groups are identified and managed appropriately including ensuring their physical and psychological wellbeing is supported	Staff in the following groups have been identified: • Over 70's • Pregnant Staff • BAME Staff • Staff with underlying conditions Line managers of 'at-risk' groups have been tasked with completing risk assessments to identify risks and consider adjustments where appropriate with the support of Staff Health & Wellbeing and HR. Staff members identified as vulnerable are being supported appropriately to ensure both their physical and psychological wellbeing is supported. There has been an active programme of undertaking risk assessments for all staff, this is an on-going process which line managers will review appropriately. The risk assessment process is ongoing and returns continue to be monitored.	Gaps in assurance identified	Awaiting collation of risk assessment results. Vulnerable staff may not disclose to employer, therefore all staff to have risk assessment completed	
10.2 • staff required to wear FFP reusable respirators undergo training that is	Health & Safety are keeping and maintaining records of all staff members that have undertaken FFP3 Face Fit Testing. The trust has ordered replacement reusable respirators (half	Gaps in assurance identified		

compliant with PHE national guidance and a record of this training is maintained	face and hood systems) and are awaiting their delivery (due December), to high risk areas ITU, MHDU, SHDU, C5 where AGPS are performed.			
10.3 • consistency in staff allocation is maintained, with reductions in the movement of staff between different areas and the cross-over of care pathways between planned and elective care pathways and urgent and emergency care pathways, as per national guidance	Zoning SOP sets out that staff should not work across areas where possible, although due to patient safety issues movement of staff may occur. During the height of the pandemic the Trust Interserve partner worked with IPCT to organise 'runners' for clinical areas where COVID patients were cohorted, this was required to reduce footfall. In response to the current fall in cases the resource has been utilised for touch point cleaning within out-patients and main hospital corridors. The hospital has limited space to have totally separate services therefore the Trust has segregated areas by utilising pods and physical barriers and one way systems. As we come out of the pandemic and have fewer cases, nursing staff will be allocated to care for COVID patient per shift. As cases have increased, blue zone capacity within the hospital has been increased, with dedicated nursing teams as far as practicable.	Gaps in assurance identified	Zoning SOP and areas are segregated with one way systems	
10.4 • all staff adhere to national guidance on social	The Trust has provide staff with detailed guidance with regards of social distancing a standard operating procedure is in place, posters and markings on floors, including one way	No gaps identified		

distancing (2 metres) wherever possible, particularly if not wearing a facemask and in non-clinical areas • consideration is given to staggering staff breaks to limit the density of healthcare workers in specific areas	systems in some areas and floor markings within lifts including maximum capacity. Staff are provided with face masks when they enter the building and can obtain face masks from their manager. Precautions are in place with regards of staff completing touch point cleaning as described within the social distancing SOPs Staff do not have to wear face masks if they are able to demonstrate that the environment is COVID secure-this does not apply to any clinical areas, but to office areas where there are no patients/visitors, with social distancing in place. The Trust has reviewed staff rest area space as they are currently limited within ward areas-breaks are being staggered and the trust is now providing tables with 1 or 2 chairs within the main canteen areas. CCG Quality visit completed 20/08/2020 no issues identified and embedded processes found.			
10.5 • staff absence and well-being are monitored and staff who are self-isolating are supported and able to access testing	All COVID related absence is reported centrally through a COVID Workforce inbox to ensure that all absence is monitored and reviewed on a daily basis, with the exception of weekends and bank holidays where it is actioned on the next working day. This information feeds directly in Staff Health and Wellbeing on a daily basis, who then contact the staff member or	No gaps identified		

	associated member to provide access to staff testing. Line managers are expected to maintain contact and ensure support is in place for all staff self-isolating and the Trust maintains a returner profile, identifying when staff are predicted to return.			
10.6 • staff that test positive have adequate information and support to aid their recovery and return to work.	If the staff member has been swab tested by the Trust, swab results are given verbally over the phone, with an offer of written confirmation. If the staff member has received a test for antibodies by the Trust, test results are given via text message-this service has now ceased. Regarding a positive result staff are advised to stay off work for a minimum of 7 days and can return to work after 7 days if they are symptom free for 48 hours, in line with PHE guidance. The Trust have increased the Staff Health and Wellbeing provision, including access to an Occupational Health Physician and 24/7 access to personalised, on-demand advice and support from our team of mental health, financial, and legal experts.	No gaps identified		

Enclosure 17

The Dudley Group NHS Foundation Trust

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

TITLE:	**Update from the Finance and Performance Committee**		
AUTHOR:	Jonathan Hodgkin Finance & Performance Committee Chair	**PRESENTER**	Jonathan Hodgkin Finance & Performance Committee Chair

CLINICAL STRATEGIC AIMS

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

ACTION REQUIRED OF COMMITTEE

Decision	Approval	Discussion	Other
		X	

RECOMMENDATIONS:

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

CORPORATE OBJECTIVE:

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

SUMMARY OF KEY ISSUES:

Summary report from the Finance and Performance Committee meeting held on 29th October 2020 to include items:

- raised as concerns
- for assurance,
- major actions commissioned / work underway
- items submitted for decision
  - Patient Administration System (PAS) Oracle and Supplier Support Contract Renewal business case
  - Budget for the second half of the financial year 2020/2021

IMPLICATIONS OF PAPER:

IMPLICATIONS FOR THE CORPORATE RISK REGISTER OR BOARD ASSURANCE FRAMEWORK

RISK	**Y**		**Risk Description:** BAF 3a (8), BAF 5a (8), BAF 6a (20)
	Risk Register: N		**Risk Score:**
COMPLIANCE and/or LEGAL REQUIREMENTS	**CQC**	**Y**	**Details:** Well Led
	NHSI	**Y**	**Details:** Achievement of Financial Targets
	Other	**Y**	**Details:** Value for Money
REPORT DESTINATION	**EXECUTIVE DIRECTORS**	**N**	**DATE:**
	WORKING GROUP	**N**	**DATE:**
	COMMITTEE	**Y**	**DATE:** 29/10/2020

The Dudley Group NHS Foundation Trust

UPWARD REPORT FROM FINANCE AND PERFORMANCE COMMITTEE

Date Committee last met: 29th October 2020

MATTERS OF CONCERN OR KEY RISKS TO ESCALATE	MAJOR ACTIONS COMMISSIONED/WORK UNDERWAY
• Top-up required for Month 6 of £2.4m may, given its size, be subject to external audit by NHSI and is therefore at risk • £2.54m of COVID related capex not yet approved by NHSI and therefore at risk • BAF risk 6A remains at 20 despite a large number of mitigating actions completed and underway • Lack of clarity about the underlying financial position and concern that if the position is poor it could limit the Trust's strategic flexibility	• Update on ED Redesign project to be brought to the next meeting of the Committee • Paper on the underlying financial position to be brought to the next meeting of the Committee
POSITIVE ASSURANCES TO PROVIDE	**DECISIONS MADE**
• Rebased budgets for the second half of the year are in place. These include a £3.5m efficiency challenge and along with central and STP funding are intended to deliver an agreed £2m deficit • Performance against constitutional standards broadly stable to improving • Restoration and recovery activity levels are on, or ahead of, plan except for day case, which are 1% behind • BAF risks 3A and 5A remain within accepted risk tolerance	• Recommendation from the Committee to the Board to approve the Patient Administration System (PAS) Oracle and Supplier Support Contract Renewal business case • Approved budgets for second half of the year

Chair's comments on the effectiveness of the meeting:

Committee is to consider changing from the formal/informal cycle of meetings to formal meetings monthly, but alternating between meetings with more operational and more strategic focus. Work plan in development to support the proposals.

Enclosure 18

The Dudley Group NHS Foundation Trust

Paper for submission to the Board of Directors November 12th 2020

TITLE:	**Integrated Performance Report for Month 6 (September 2020)**		
AUTHOR:	**Qadar Zada** **Deputy Chief Operating Officer**	**PRESENTER**	**Karen Kelly** **Chief Operating Officer**

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

ACTION REQUIRED OF COMMITTEE :

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

RECOMMENDATIONS:

To note and discuss the current performance against KPIs.

CORPORATE OBJECTIVE:

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

SUMMARY OF KEY ISSUES:

Performance

EAS

The September position for performance is below the expected Emergency Access Standard and the Trust has achieved a combined performance of 89.4% for the month of September, a deterioration of 3% since August.

The main contributory factors to our decreased EAS position is the following:

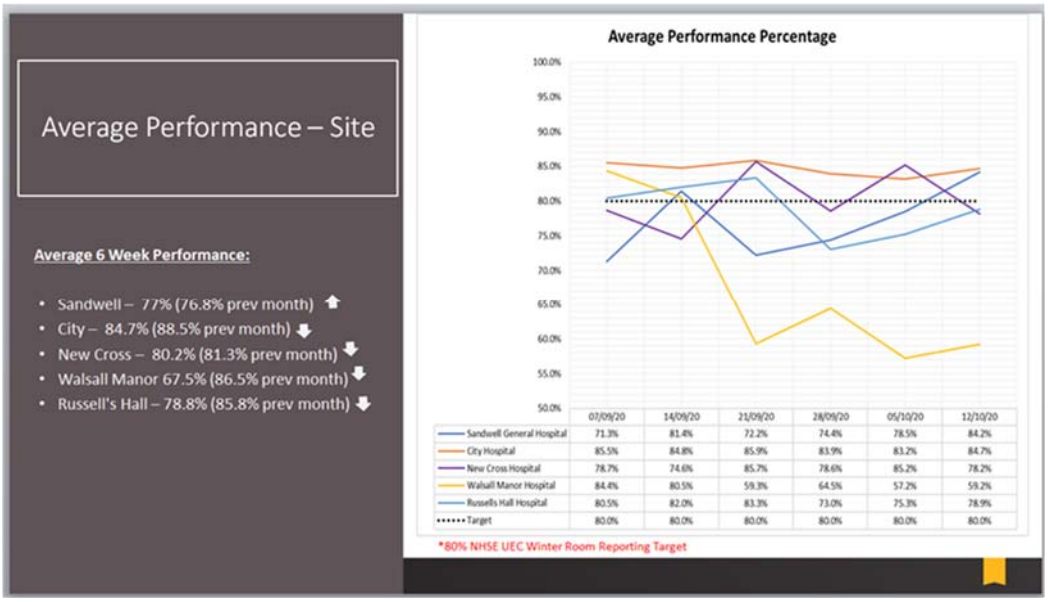
1. Patient flow has been the main driver for the reduction in performance which has been impacted by high bed utilisation.

2. We have seen increased COVID symptomatic patients with an increased level of acuity requiring a longer length of stay and a reduced level of available community care packages.

3. We have had to operationalise an increased level of infection control including zoning of wards. This has delayed movement out of ED

4. Our WMAS conveyances continue to rise and we are comparable with Pre-covid levels of conveyance.

Dudley's Emergency Access Standard compared with other neighbouring Black Country Trusts is shown in the table below. ED attendances are comparable with pre-COVID levels. Trust performance ranks 10th across the Midlands & East regions ahead of its neighbouring providers.



CANCER

All cancer performance figures have 2 month validation process current performance is therefore unvalidated and may be subject to change.

Current in month performance is as follows:

- 2ww achievement for September is 51.6%.
- 31 day is 90.8%.
- 62 day is 62.1%

Demand for services is increasing and reduced capacity due to Covid precautions remains challenging. This is impacting the whole cancer pathway and is further affected by patient reluctance to begin treatment.

Numbers of patients waiting over 104 days has reduced further since last Month to 39

Current forecasting of the 62 day CWT has shown that there are remains a number of patients who will breach the standard over the coming Months and this will impact significantly on the Trusts ability to meet the target.

RTT

The September RTT position has improved to 78.9%, an improvement of 5.9%. The position continues to improve at a steady rate. This has seen us move from 7th highest performing Trust nationally to 4th.

Nationally there are high numbers of 52 week breaches due to long waiting patients being prioritised and as a result of reduced capacity earlier in the year due to COVID impact. The Trust has nine 52 week breaches at September month end which is likely to be the best performing by far in the region.

DM01

In September, the Trust achieved 71% of diagnostics tests which were carried out within six weeks against the national operational standard of 99%. This represents an improvement of 1% compared to last Month (August).

There is concern regarding an increasing number of patients waiting over 6 weeks for their test at Month end, a total of 2404 compared with last Month (August) 2262 an increase of 142 due to reduced capacity.

Each of the pathways that contribute to the DMO1 standard has a recovery trajectory which may be further impacted by wave 2 of covid-19 due to doctors needing to contribute to an emergency medicine pathway. This position will be reviewed on a weekly basis.

IMPLICATIONS OF PAPER: Risks identified in this paper are linked to the risk (BAF 1b)

IMPLICATIONS FOR THE CORPORATE RISK REGISTER OR BOARD ASSURANCE FRAMEWORK

RISK	**Y**		**Risk Description:** BAF 1b - Failure to meet access standards caused by inability to improve patient flow and work effectively with very local partners will result in an adverse outcome for the patient
	Risk Register: Y		Risk Score: BAF 1B – Risk score 15 (AMBER)
COMPLIANCE and/or LEGAL REQUIREMENTS	**CQC**	**N**	**Details:**
	NHSI	**N**	**Details:**
	Other	**N**	**Details:**
REPORT DESTINATION	**EXECUTIVE DIRECTORS**	**Y**	**DATE: Weekly**
	WORKING GROUP	**N**	**DATE:**
	COMMITTEE	**Y**	**DATE: Finance and Performance Committee 29th October 2020**

NHS
The Dudley Group
NHS Foundation Trust

Performance KPIs

October 2020 Report (September Data)

Karen Kelly, Chief Operating Officer



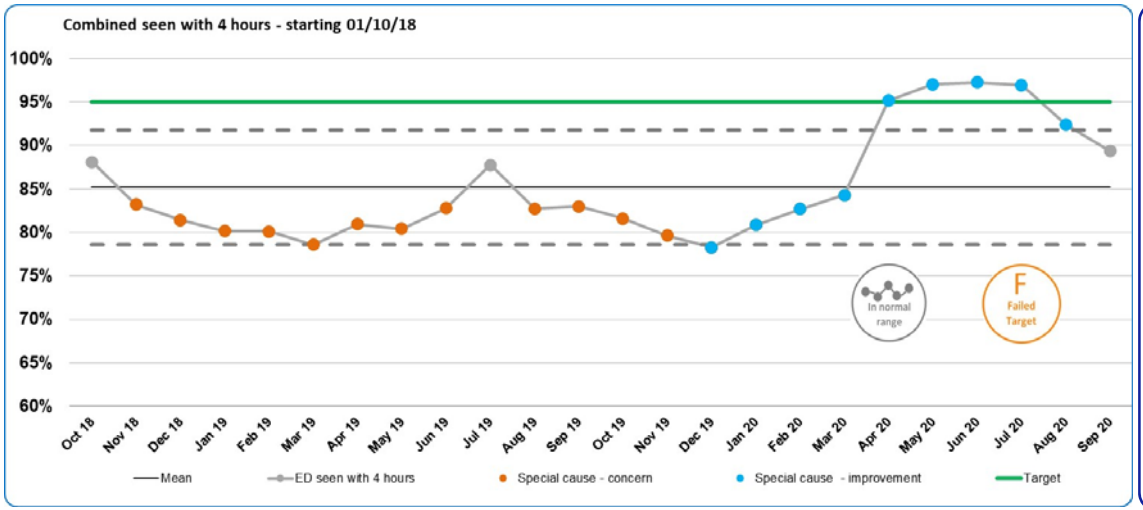

Constitutional Performance

Constitutional Standard and KPI		Target	Actual 20/21						Status	
			April	May	June	July	Aug	Sept		
Emergency Access Standard (EAS)	Combined 4hr Performance	95%	95.2%	97.1%	97.3%	97.0%	92.4%	89.4%	In normal range	F Failed Target
Cancer	Cancer 62 Day - Urgent GP Referral to Treatment	85%	66.7%	56.2%	68.3%	72.6%	63.6%	62.1%	In normal range	F Failed Target
	Cancer 31 Day	95%	95.0%	81.2%	86.7%	92.2%	94.5%	90.8%	In normal range	F Failed Target
	All Cancer 2 Week Waits	95%	97.3%	97.8%	95.7%	98.1%	79.4%	51.6%	In normal range	F Failed Target
Referral to Treatment (RTT)	RTT Incomplete	92%	84.1%	73.1%	62.7%	63.7%	72.5%	78.9%	Getting Worse	F Failed Target
Diagnostics	Diagnostics achieved within 6 weeks	99%	52.1%	57.1%	72.3%	74.3%	70.8%	71.1%	Getting Worse	F Failed Target

Making Numbers Count - Icon Key

Is the Process Stable?					Will the target be met?			Non-SPC Measures			Admin		
H	L	H	L		P	F	?	P	F	N/A	SPC	DNP	NNP
GETTING BETTER		GETTING WORSE		STABLE	YES	NO	MAYBE	PASS	FAIL	NO TARGET SET	NON-SPC	DATA NOT PROVIDED BY SERVICE	NARRATIVE NOT PROVIDED BY SERVICE

ED Performance



89.4%	0	10th
EAS 4 hour target 95% for Type 1 & 2 attendances	DTA 12 hour breaches - target zero	DGFT ranking out of 30 Midlands area Trusts

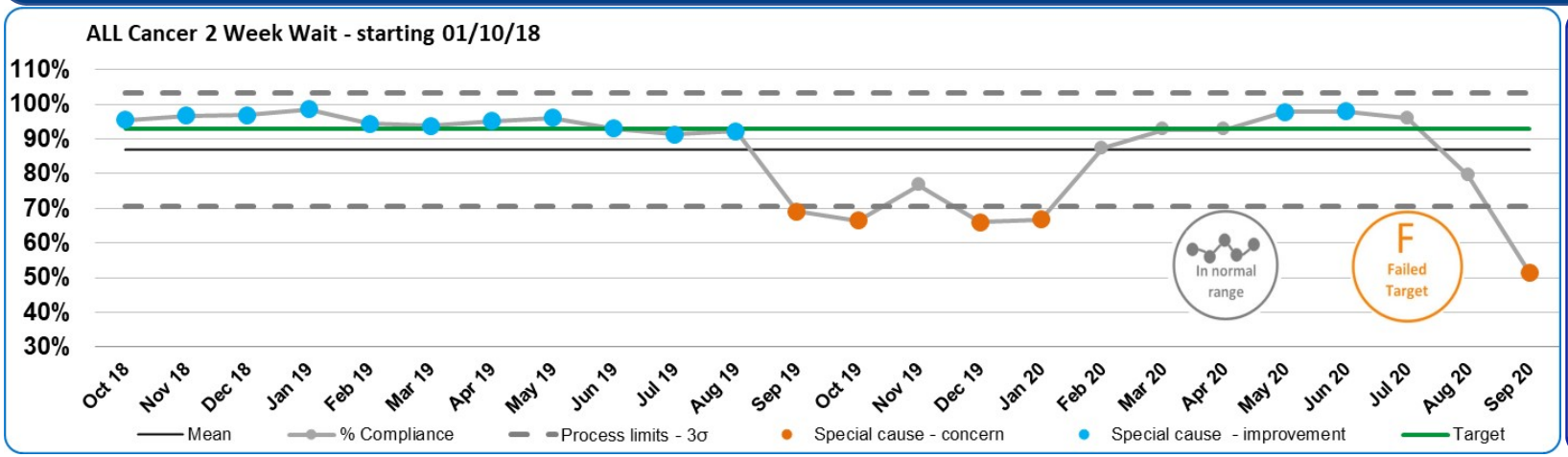
Performance

- ED attendances are comparable with pre-COVID levels. Pressures are increasing throughout the health system with only 9 trusts out of 114 able to achieve the 4 hour wait target during September. Trust performance ranks 10th across the Midlands & East regions ahead of its neighbouring providers.
- Patient flow has been the main driver for the reduction in performance.
- Bed utilisation is high and flow has been impacted by the need to place patients in designated zoned areas of the hospital as they await COVID testing results.
- We have seen increased COVID symptomatic patients with an increased level of acuity requiring a longer length of stay and a reduced level of available community care packages.

Action

- ✓ Ambulatory pathways continue to be provided to support the pressure on ED.
- ✓ Rapid Access and Treatment(RAT) and Same Day Emergency Care(SDEC) pathways are being reviewed and expanded upon to streamline processes.
- ✓ Amber-zoned areas have been increased to allow more ability to flex with emergency admission demand.
- ✓ Availability of COVID swab tests has been increased.
- ✓ Care package availability being addressed in collaboration with local council.
- ✓ Contract arrangements have been agreed with a local care home to increase intermediate care capacity for step-down.

Cancer Performance – 2 Week Wait



51.6%

All cancer 2 week waits – target 95%

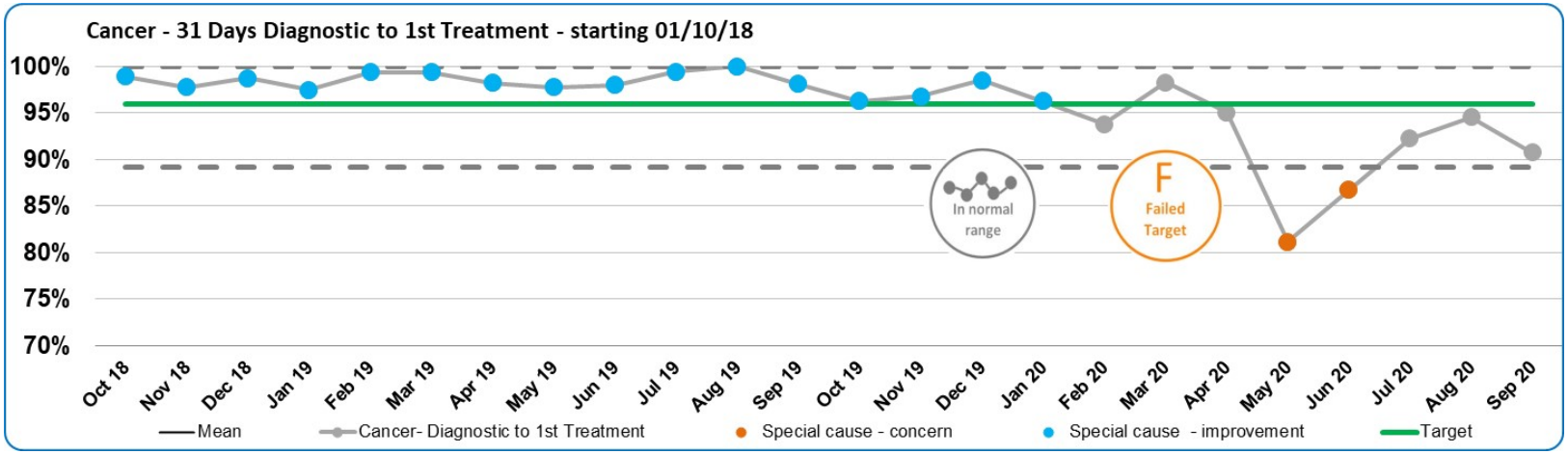
Performance

- Validation of Cancer performance figures run at a 2 month lead time. Therefore latest month position is unvalidated.
- Demand for services is increasing to pre-COVID levels.
- Significant reduction in capacity due to social distancing & COVID precautions specifically in Skin\ breast and endoscopy diagnostics.
- The 2WW trajectory is; Oct = 89%. Nov = 92%, Dec = 88%, Jan = 101%, Feb = 113%, Mar = 100%.

Action

- ✓ Daily patient list review process and escalation plans have been developed and are now in place to improve visibility of longer waiting patients.
- ✓ Additional weekend and evening clinics have been put in place with the support of locums and Trust staff to address the reduced capacity in Skin and Breast cancer pathway patients
- ✓ A 4th Endoscopy room became available 28th September to increase urgent diagnostic capacity
- ✓ A Demand and Capacity review and escalation plan is being developed with specialties, to allow flex of capacity between specialities as required.
- ✓ Visibility of the improvement by these measure is expected from October 2020 onwards.

Cancer Performance – 31 Day



90.8%

31 day waits – target 95%

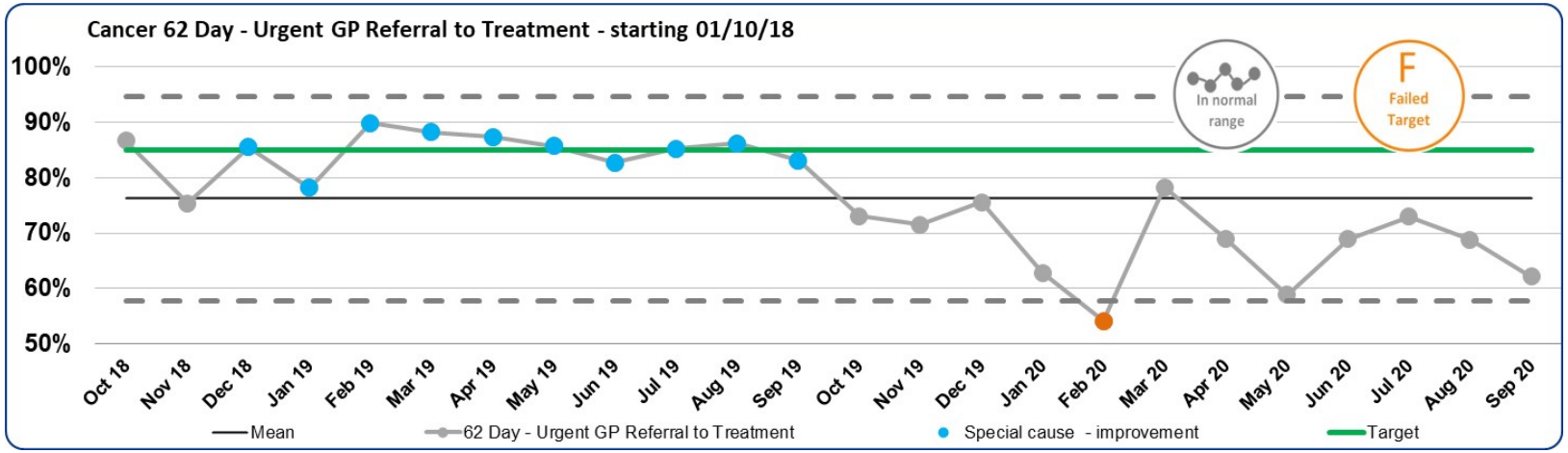
Performance

- Validation of Cancer performance figures run at a 2 month lead time. Therefore latest month position is unvalidated.
- There are currently 12 out of a total of 131 patients breaching the 31 day decision to treat target.
- Performance across the cancer pathway is impacted by the reduced capacity at 2 week wait.
- Further impact is seen with patients reluctant to begin cancer treatment due to perceived risk of COVID.
- The 31 day trajectory is; Oct = 91%. Nov = 99%, Dec = 95%, Jan = 119%, Feb = 103%, Mar = 94%.

Action

- ✓ Daily patient list review process and escalation plans have been developed and are now in place to improve visibility of longer waiting patients.
- ✓ Additional weekend and evening clinics have been put in place with the support of locums and Trust staff to address the reduced capacity in Skin and Breast cancer pathway patients
- ✓ A 31-day pathway training and education package is to be cascaded to the multi-disciplinary team to ensure understanding of the issues and help to encourage timely escalation and to expedite improvement.
- ✓ Engaging with patients and their GPs to review personal risks of delay to treatment, consider alternative treatments and assure our processes to be as COVID secure as possible.

Cancer Performance – 62 Day



62.1%

All cancer 62 day waits – target 95%

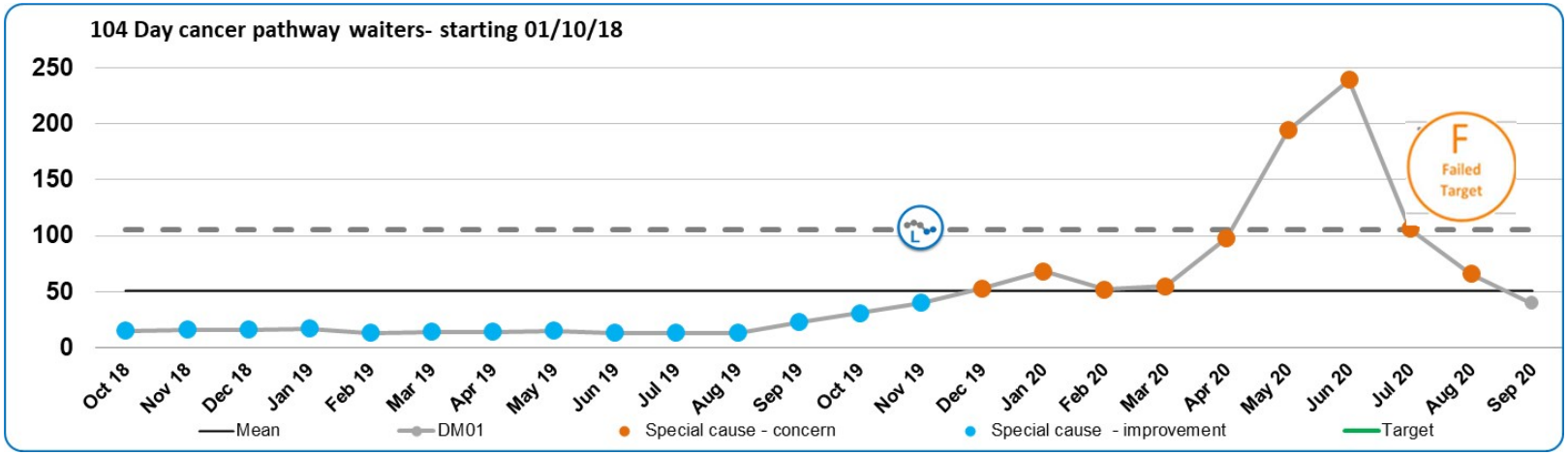
Performance

- Validation of Cancer performance figures run at a 2 month lead time. Therefore latest month position is unvalidated.
- Performance across the cancer pathway is impacted by the reduced capacity at 2 week wait.
- Of 82.5 patients treated 14 had waited over 104 days.
- Performance across the cancer pathway is impacted by the reduced capacity at 2 week wait.
- Further impact is seen with patients reluctant to begin cancer treatment due to perceived risk of COVID.

Action

- ✓ Daily patient list review process and escalation plans have been developed and are now in place to improve visibility of longer waiting patients.
- ✓ Additional weekend and evening clinics have been put in place with the support of locums and Trust staff to address the reduced capacity in Skin and Breast cancer pathway patients.
- ✓ The cancer management team have developed a recovery plan which outlined an expected recovery by Mar-21.
- ✓ Engaging with patients and their GPs to review personal risks of delay to treatment, consider alternative treatments and assure our processes to be as COVID secure as possible.

Cancer Performance – 104 Day



39

All 104 week waits, target zero

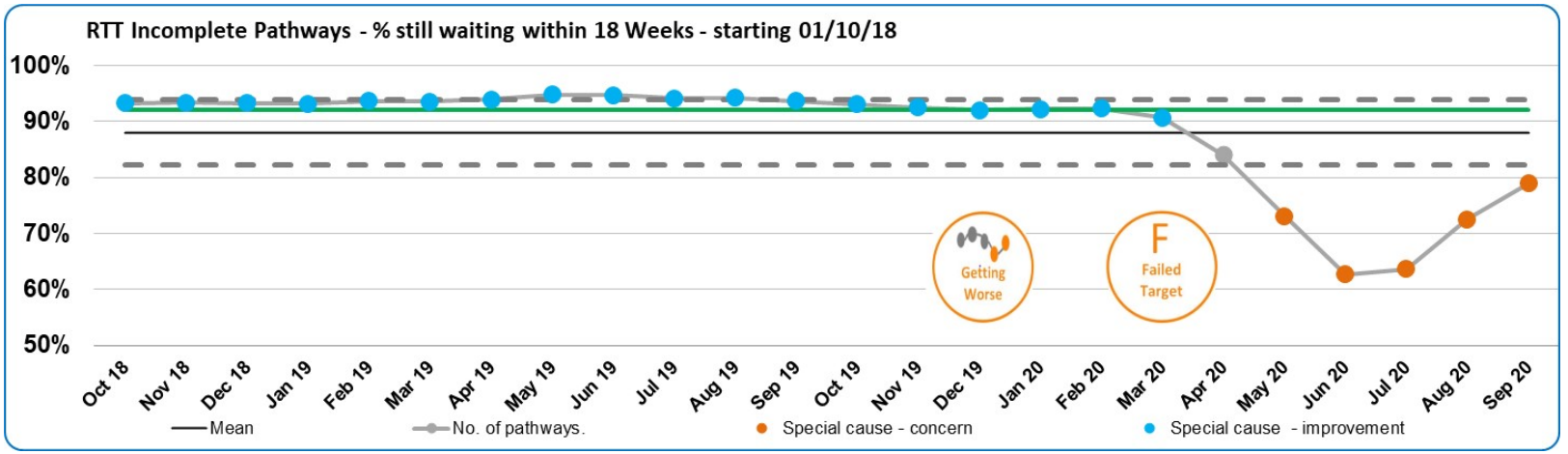
Performance

- Validation of Cancer performance figures run at a 2 month lead time. Therefore latest month position is unvalidated.
- Numbers of patients waiting for cancer treatment for 104 days or more rose rapidly at the start of the COVID crisis in March 20 due to reduced capacity.
- Around a 3rd of the long waiters are in colorectal patients due to the invasive nature of tests required.
- Performance across the cancer pathway is impacted by the reduced capacity at 2 week wait.
- Further impact is seen with patients reluctant to begin cancer treatment due to perceived risk of COVID.

Action

- ✓ Daily patient list review process and escalation plans have been developed and are now in place to improve visibility of longer waiting patients.
- ✓ Additional weekend and evening clinics have been put in place with the support of locums and Trust staff to address the reduced capacity in Skin and Breast cancer pathway patients.
- ✓ The cancer management team have developed a recovery plan which outlined an expected recovery by Mar-21.
- ✓ Engaging with patients and their GPs to review personal risks of delay to treatment, consider alternative treatments and assure our processes to be as COVID secure as possible.

RTT Performance



78.9%

RTT Incomplete pathways % waiting, target zero

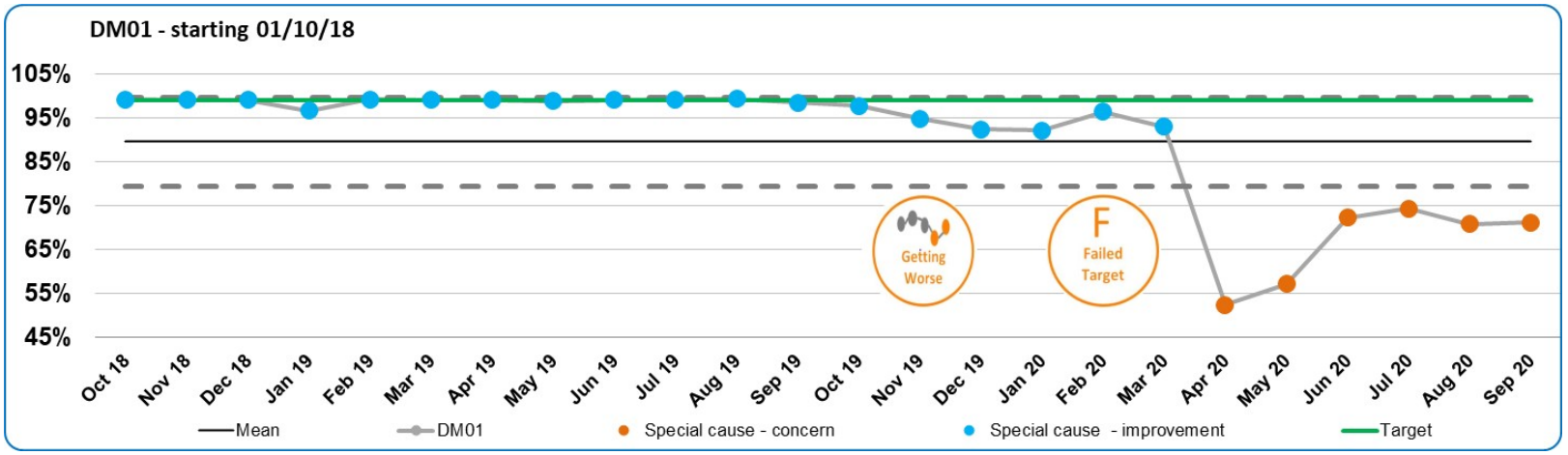
Performance

- RTT improved to 78.9% over August at 72.51%. DGFT is the 4th best performing Trust nationally and the best regionally. Currently the Trust is achieving 81% with 352 Month end breaches, the best position regionally. We moved earlier than our peers with robust plans to recover and restore services.
- Nationally there are high numbers of 52 week breaches due to long waiting patients being prioritised leaving a 'bulge' in numbers waiting between 16 and 52 weeks as a result of reduced capacity earlier in the year due to COVID impact. The Trust has nine 52 week breaches at September month end which is likely to be the best performing by far in the region.
- In addition there is a smaller % of patients waiting less than 8 weeks due to reduced referrals earlier in the year.
- Trajectory for the of October 2020 = 82.5%, end Nov = 85.5%, end Dec = 87%, Jan = 87%, Feb = 90%, March = 92%.

Action

- ✓ Long waiters and urgent patients are being prioritised in line with clinical need which has resulted in reduced numbers of patients waiting over 52 weeks.
- ✓ Additional capacity at alternative providers is being utilised where possible, including independent sector.
- ✓ Virtual clinics have been implemented to optimise the ability to maintain services due to reduced face to face capacity, this is particularly important in some specialties which have been significantly impacted by social distancing.
- ✓ Referral assessment and advice & guidance is also being utilised to reduce the need for unnecessary appointments and is currently deflecting approximately 20% of referrals back to the referrer.
- ✓ Under performance is reviewed and challenged at the Outpatient steering group weekly.
- ✓ A deep dive is underway with Cardiology which is particularly challenged to understand and resolve any issues.

DM01 Performance



71.1%

DM01 combining 15 modalities - target 99%

Performance

- In September, the Trust achieved 71% of diagnostics tests which were carried out within six weeks against the national operational standard of 99%. This represents an improvement of 1% compared to last Month (August).
- Of concern is the increasing number of patients waiting over 6 weeks for their test at Month end, a total of 2404 compared with last Month (August) 2262 an increase of 142.
- While this can be misleading without the number of referrals received for comparison, the pattern is showing an increase which is explained by the shortfall of 145 referrals per week in imaging alone, a 22 shortfall per week in Cardiology and 9 short per week in gastroscopy against the capacity & demand model.
- DM01 trajectory: end Oct = 76.5%, Nov = 84.6%, Dec = 87.4%, Jan = 90.1%, Feb = 92.0%, Mar = 93.0%

Action

- ✓ An Ultrasound productivity and efficiency program is underway to ensure that capacity is maximised alongside the use of independent providers
- ✓ Additional capacity has been introduced by utilising outpatient rooms and the opening of a 4th endoscopy room on 28th September.
- ✓ A colorectal task & finish group has been established to review pathway and to engage GP's and the upper GI pathway is being reviewed.
- ✓ Training in new technologies (bowel capsule) is being undertaken to reduce the need for conventional colonoscopy increasing capacity.
- ✓ Overall DM01 recovery is now forecasting compliance against the target by February 2021.

Enclosure 19

The Dudley Group NHS Foundation Trust

Paper for submission to the Board on 12th November 2020

TITLE:	**WSEC Deep-Dive – Employment Relations/Partnership Working – Chair's Upward Report**		
AUTHOR:	**James Fleet** **Chief People Officer**	**PRESENTER**	**Julian Atkins** **NED & Chair WSEC**

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

SO1: Deliver a great patient experience, SO4: Be the place people choose to work

SUMMARY OF KEY ISSUES:

The Workforce and Staff Engagement Committee convened its third Deep-Dive session, focusing on Employment Relations/Partnership Working on 27th October.

Objectives for the session were:

1. To undertake a baseline review of current employment relations practice, including Partnership Working, at DGHFT, against the principles developed by the national NHS Staff Partnership Forum and the 10 Behaviours Model.
2. To review examples of employee relations best practice from the wider NHS, by way of taking on board and adopting key learnings.
3. Discuss and assess the benefits for staff and patients of strengthening partnership working at DGHFT.
4. Define DGHFT's ambitions for partnership working, including:
    - Greater staff engagement.
    - Improved staff morale.
    - TU support in developing and delivering major workforce programmes/initiatives/interventions.
    - Partnership approach to embedding equality, diversity, and inclusion.
    - Reduction in formal employment disputes.
    - Effective and dynamic HR policy development.
    - Strategic engagement with TU's in Trust strategy development/implementation.
5. Present, discuss and approve the DRAFT Partnership Agreement, which confirms the Trust's commitment to establish a dynamic model of partnership working, which optimises the capacity and capability of trade union partners to improve the experience of staff and patients. The Partnership Agreement recognises the role of trade unions not only in representing individual staff members, but as strategic partners in the Trust's business.
6. Review and approve the DRAFT Dudley People Plan, for onward ratification by the Trust Board, with support and sponsorship from Trade Union colleagues.

Overview - Key Actions, Decisions and Updates:

- The Deep-Dive session was well attended session, with strong engagement and participation from all attendees, including attendance by Regional Officers of the Royal College of Nursing (RCN) and also the British Medical Association (BMA), in addition to Rebecca Knight (UNISON) – Staff Side Lead. It was a pleasure to welcome TU guests, who provided a major contribution to the session.

- The quality of papers was excellent and acknowledged by attendees. The DRAFT Partnership Agreement has been co-developed with Divisional leaders, Professional leads and through strong engagement with staff side colleagues, including regional officers – this was evident in the quality and applicability of the paper that was presented to WSEC. Furthermore, trade union colleagues commended the document, as well as the partnership working and effort that had gone into it production, socialisation and iterative development over recent weeks, including taking account of their comments and feedback. There was unanimous support from the WSEC to approve and support the Partnership Agreement. The only outstanding items to ensure its full implementation and embedding are the agreements regarding facilities time which will be key to making this important document a reality. It is evident that facilities time for staff side colleagues hasn't been reviewed for some time.
- I was assured to see that the Partnership Agreement and its associated provisions will further support the implementation of the DGHFT Staff Engagement Model and furthermore deliver the major commitments within the Dudley People Plan, which was approved by WSEC in July and Trust Board in August. There is a strong and very clear 'golden thread' through the range of initiatives that have been supported by WSEC in recent weeks, which gives much greater confidence of delivery, as well consistency in messaging to staff across the Trust. Furthermore, the Partnership Agreement and Staff Engagement Model both provide very practical commitments to collaboration, joint working and co-development to improve the experience of staff and patients. I was pleased to see the very positive response from Divisional Directors who will have a key leadership role in making all of this a day-to-day reality.
- The final DRAFT Dudley People Plan was presented, which was widely supported by WSEC, including our TU colleagues which was very positive, furthermore the regional officers were happy for the Trust to formally assign their logos to the front cover of the document – which will be a first for the Trust and a very real and positive sign of the joint commitments to working dynamically in partnership. A governance dashboard is being developed to track progress; this will be used for progress reporting and assurance to WSEC at each of its business meetings.
- The committee approved a revised work programme for the development and implementation of HR policies, which was well received.
- The detailed workforce KPI report was presented, which included an additional detailed section on workforce capacity, in particular capturing lost capacity through vacancy and sickness absence (COVID/non-COVID) which has been developed to support the programme of actions that were discuss at the October Board meeting to address the capacity challenges within the nursing workforce.

The following documents were approved:

- Partnership Agreement
- Dudley People Plan
- Workforce Policy Review Process

The following document was received for information/assurance:

- Workforce KPI Report

The next Workforce and Staff Engagement Committee Deep-dive session is planned for 15th December and will focus on Organisational Development/Leadership Strategy.

IMPLICATIONS OF PAPER:

RISK	**Y**		**Risk Description: corporate risk register recruitment and retention of staff**
	Risk Register: Y		**Risk Score:**
COMPLIANCE and/or LEGAL REQUIREMENTS	**CQC**	**Y**	**Details: Caring, Well Led**
	NHSI	**Y**	**Details:**
	Other	**N**	**Details:**

ACTION REQUIRED OF COMMITTEE :

Decision	Approval	Discussion	Other
	√	√	

RECOMMENDATIONS FOR COMMITTEE:

Note the new Dudley Group Staff Engagement Model, following approval by the Workforce and Staff Engagement Committee.

Enclosure 20

The Dudley Group NHS Foundation Trust

Paper for submission to Trust Board on Thursday 12th November 2020

TITLE:	**Dudley People Plan**		
AUTHOR:	**James Fleet, Chief People Officer**	**PRESENTER**	**James Fleet, Chief People Officer**

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

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

RECOMMENDATIONS

The Board is asked to review and approve the Dudley People Plan for publication, promotion and deployment across the Trust.

And to note that:

The final DRAFT version of the Dudley People Plan was approved by the Workforce & Staff Engagement committee on Tuesday 27th October 2020, in partnership with Trade Union partners, as part of a collaborative deep-dive focus on employee relations.

CORPORATE OBJECTIVE:

SO1: Deliver a great patient experience

SO4: Be the place people choose to work

SUMMARY OF KEY ISSUES:

The Dudley People Plan reflects:

- Key learnings from COVID Phase 1;
- Feedback from clinical, operational and corporate colleagues
- Messages from the 2019 annual Staff Survey, feedback from staff side/trade union colleagues
- Input from the Trust's Inclusion Networks,
- NHS: People Plan 2020/21 ('the plan')
- BCWB People Plan and the associated system level work programmes.

The Dudley People plan sets out an ambitious set of actions to deliver the five key pillars of the Dudley People plan, namely:

1. Workforce for now and the future

2. A caring, kind and compassionate place
3. Equality, fairness and inclusion
4. Improvement and development culture
5. Using Technology to innovate.

Governance, including progress and performance updates, will be through WSEC - a standard People Plan KPI report is being developed for this purpose.

IMPLICATIONS OF PAPER:			
RISK	**N**		
	Risk Register: N/A		**Risk Score:**
COMPLIANCE and/or LEGAL REQUIREMENTS	**CQC**	**Y**	**Details: Caring, Well Led**
	NHSI	**N**	**Details:**
	Other	**N**	**Details:**
REPORT DESTINATION	**Workforce Committee**	**Y**	**Date: 27th October 2020**

NHS
The Dudley Group
NHS Foundation Trust

Dudley People Plan

12th November 2020

Dudley People Plan current status aligned to the NHS People Plan categories

Dudley People Plan Actions








Dudley People Plan – A workforce for now and for the future			
Objective	**Action Required**	**Who**	**When**
Be open to all clinical and non-clinical permanent roles being flexible.	Undertake Flexible Working review and establish a work stream to develop a Trust wide plan is developed to embed Flexible Working.	Chief People Officer/Deputy Chief People Officer	01-Mar-21
	A review of the Flexible Working Employment Options Policy .To include management toolkits and resources.		
Cover flexible working in standard induction conversations for new starters and in annual appraisals.	Promote National Flexible Working Week in March 2021.	Deputy Chief People Officer and Head of Communications	01-Mar-21
	Implement the flexible working guidance due to be developed by NHSE/I.	Head of People - Workforce, Wellbeing, and Employee Relations	
Requesting flexibility – whether in hours or location, should (as far as possible) be offered regardless of role, team, organisation or grade.	Implement a standard template to promote flexible working for all job adverts.	Head of People - Workforce, Wellbeing, and Employee Relations	
	Produce managers guidance to support the implementation of flexible working policy.		
Board members must give flexible working their focus and support.	Review local induction to ensure new starters are welcome and supported in joining the Trust. To include Flexible working options	Head of People - Organisational Development, Culture, and Learning	
	CEO to provide a Trust commitment to flexible working, supported by regular communications.	Chief Executive Officer and Head of Communications	
Add a key performance indicator on the percentage of roles advertised as flexible at the point of advertising to the oversight and performance frameworks.	Formal register to be put in place to capture flexible working requests	Head of People - Workforce, Wellbeing, and Employee Relations	
	Managers at all levels to take an active role in facilitating and accomodating flexible working requests.	Divisional Directors	01-Nov-20
	Add a key performance indicator on the percentage of roles advertised as flexible at the point of advertising and on appointment.	Head of People - Workforce, Wellbeing, and Employee Relations	01-Mar-21
Continue the implementation and effective use of e-rostering systems.	E-rostering unused hrs report + recommendations for strengthening practices + use of technology	Deputy Chief People Officer, Chief Nurse, and Chief Operating Officer	01-Nov-20
	Full rostering programme to be developed for roll-out from November 2020.		
	Review indicators for rostering to ensure they support improvement and adoption.		01-Dec-20
Roll out the new working carer's passport to support people with caring responsibilities.	Roll-out of Carers' Passport across the Trust by engaging with Carers UK to set up and embed a Carer Passport scheme	Head of People - Organisational Development, Culture, and Learning, and Head of Patient Experience	01-Feb-21
	Carer employee network to be established to share experience, allow the Trust to listen, learn and respond.		

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Dudley People Plan – A workforce for now and for the future			
Objective	**Action Required**	**Who**	**When**
To develop and improve the recruitment and retention of our workforce and reduce the vacancy factor	Develop a robust workforce planning approach that includes: staffing capacity, establishments, skills & experience, service design, trends of plan v actual staffing. Align to STP workforce planning work stream.	Deputy Chief People Officer	01-Dec-20
	Develop tailored recruitment and retention strategies for each division.	Head of People - Workforce, Wellbeing, and Employee Relations and Divisional Directors	01-Dec-20
	Take action to sustain the Trusts turnover rate below 10%. Utilise Staff Engagement Forums to agree action, review and track progress. Regular updates provided to WSEC.		ongoing
	Develop a coordinated employer brand to support retention and recruitment.	Head of Communications and Head of People - Workforce, Wellbeing, and Employee Relations	01-Dec-20
Design roles which make the greatest use of each person's skills and experiences and fit with their needs and preferences.	Triangulate data between workforce planning and key quality and outcome metrics to support workforce transformation.	HR Business Partners and HR Analyst	31-Jan-21
	Work with Health Education England to implement workforce transformation; new ways of working and new roles programme for multi-disciplinary teams.	Chief People Officer, Chief Nurse, Deputy Chief AHP and Head of People - Organisational Development, Culture, and Learning	30-Nov-20
	Implement Recruitment and Selection Policy to support the design of roles, use of secondments and retention of skills.	Resourcing Lead and Divisional Directors	31-Jan-21
	Create and raise awareness of secondment opportunities in support services as a way to broaden knowledge of trust services		
Ensure that staff who are mid-career have a career conversation with their line manager, HR and occupational health.	Develop a career conversation template with support from staff side colleagues and build these into the appraisal process.	Head of People - Organisational Development, Culture, and Learning	01-Mar-21
	Implement talent strategy which includes formal and informal intelligence gathering to support retention.		01-Dec-20
	Develop health and wellbeing surgeries.	Deputy Chief People Office and Head of People - Workforce, Wellbeing, and Employee Relations	01-Jan-21
	Reinstate pension surgeries.	Head of People - Workforce, Wellbeing, and Employee Relations and Payroll Manager	
Make sure future potential returners, or those who plan to retire and return this financial year, are aware of the ongoing pension flexibilities.	Develop a guide/toolkit for flexible retirement for staff, including career conversations.	Payroll Manager	31-Jan-21
	Provide training as part of the pre-retirement course on the provisions of pre-retirement making clear that staff can retire and return to different roles.		
When recruiting temporary staff, prioritise the use of bank staff before more expensive agency and locum options and reduce the use of 'off framework' agency shifts during	Review and strengthen Trust staff bank model to improve staff bank performance on fill rates and staff experience, aiming to increase the number of staff registered with banks. Include support to system collaborative bank workstream.	Chief People Officer and Head of People - Workforce, Wellbeing, and Employee Relations	31-Mar-21

Dudley People Plan – A caring, kind and compassionate place			
Objective	**Action Required**	**Who**	**When**
Put in place effective infection prevention and control procedures.	Ongoing monitoring in relation to effectiveness and responding to national changes/recommendations.	IPC Lead Nurse	01-Sep-20
Ensure all staff have access to appropriate personal protective equipment (PPE) and are trained to use it.	Purchase single person use half face masks for departments where guidance requires use of FFP3 masks.	Emergency Planning Manager and Health & Safety Manager	01-Sep-20
	Four staff members taking fit to fit accredited exam.		
All frontline healthcare workers should have vaccinations provided by their employer.	Recruit, train and deploy peer vaccination programmes.	Chief Nurse	01-Dec-20
	Implement the flu communications plan.	Head of Communications	05-Oct-20
	Performance monitoring during the vaccination campaigns.	Chief Nurse	05-Oct-20
Complete risk assessments for vulnerable staff, including BAME colleagues and anyone who needs additional support, and take action where needed.	Maintain 98+% compliance, new staff and those returning to work.	Head of People - Workforce, Wellbeing & Employee Relations and Divisional Directors	01-Sep-20
	Undertake quality audit of risk assessments and report to Workforce and Staff Engagement Committee on quarterly basis.		Ongoing
	Update risk assessments as part of line management responsibility at a minimum of twice yearly.	Chief People Office, Chief Operating Officer and Divisional Directors	Ongoing
	Include risk assessments in the wellbeing induction for new starters.	Head of People - Organisational Development, Culture, and Learning	01-Mar-21
	Include monitoring information on completion of staff risk assessments in monthly Workforce KPI Report. Divisional teams to update on action being taken to achieve 100% compliance.	Chief People Officer and Divisional Directors	01-Oct-20
Ensure people working from home can do safely and have support to do so, including having the equipment they need.	Develop remote working registers for all divisions to be reviewed with HR and divisions on a six monthly basis.	Head of People - Workforce, Wellbeing & Employee Relations and Divisional Directors	01-Aug-20
	Report on remote working in workforce KPI report.	Head of People - Workforce, Wellbeing & Employee Relations and HR Analyst	31-Oct-20
	Robust process in place for undertaking home working assessments including identifying where additional support and equipment is required for staff.	Head of People - Workforce, Wellbeing & Employee Relations, Health and Safety Manager & Divisional Directors	01-Nov-20
Ensure people have sufficient rests and breaks from work and encourage them to take their annual leave allowance in a managed way	Ensure staff take appropriate leave and monitor using rostering system. Assurance provided through reporting to Workforce and Staff Engagement Committee.	Head of People - Workforce, Wellbeing & Employee Relations and Divisional Directors	In place
	Develop and implement comprehensive wellbeing strategy with a twelve month calendar of activities and events., to include; mental and physical well-being support, lifestyle, fitness, relaxation, diet and hydration support.	Head of People - Organisational Development, Culture, and Learning	01-Nov-20

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Dudley People Plan – A caring, kind and compassionate place			
Objective	**Action Required**	**Who**	**When**
Prevent and tackle bullying, harassment and abuse against staff, and create a culture of civility and respect.	Review and combine the Dignity at Work policy and Grievance policy providing a framework to focus on an informal facilitated resolution.	Head of People - Workforce, Wellbeing & Employee Relations	01-Dec-20
	Recruit and train mediators.	Head of People - Organisational Development, Culture, and Learning	31-Jan-21
	Further develop organisational culture to support civility and respect led by CEO and championed by Board.	Chief People Officer, Deputy Chief People Officer and Divisional Directors	ongoing
	Develop and implement support package for the Behaviour Framework through a communication and development plan.	Head of People - Organisational Development, Culture, and Learning and Head of Communications	01-Feb-21
	Establish Staff Partnership Forums at Divisional and Trust level through a partnership agreement.	Head of People - Workforce, Wellbeing & Employee Relations, Chief People Officer, Deputy Chief People Officer and Divisional Directors	
	Deliver training for leaders on Freedom To Speak Up and on how to raise and respond to concerns.	Head of People - Organisational Development, Culture, and Learning and Head of Improvement	31-Jan-21
	Roll out Manager's Essentials and Manager Accreditation to all people managers.		31-Oct-20
	Undertake deep dive on culture and leadership through the Workforce and Staff Engagement Committee.		20-Dec-20
Prevent and control violence in the workplace – in line with existing legislation.	Triangulate data and establish actions in relation to risk. Report incidents and actions to Workforce and Staff Engagement, and Risk and Assurance Committees.	Head of People - Organisational Development, Culture, and Learning and Health and Safety Manager	01-Mar-21
	Implement the NHS Violence Reduction Standard when published.		31-Mar-21
Appoint a wellbeing guardian.	Identify a Non Executive Director as the Wellbeing Guardian (NHS Staff and Learners' Mental Wellbeing Commission)	Chief People Officer	01-Dec-20
	Appoint a workplace wellbeing lead to work alongside the Wellbeing Guardian.		
	Establish a Wellbeing Steering Group.	Head of People - Organisational Development, Culture, and Learning and Health and Safety Manager	01-Oct-20
	Ensure wellbeing is included as part of the Divisional Partnership Forums agenda.	Head of People - Organisational Development, Culture, and Learning and Head of People - Workforce, Wellbeing & Employee Relations and Divisional Directors	01-Dec-20
Continue to give staff free car parking at their place of work.	Review on an ongoing basis access to free staff carpark.	Chief People Officer	At least the duration of the pandemic
Support staff to use other modes of transport and identify a cycle-to-work lead.	Conduct a staff travel survey, and use the data to develop plans to encourage more staff to travel to work sustainably.	Deputy Chief People Officer and the Green Plan Working Group	01-Dec-21
Ensure staff have safe rest spaces to manage and process the physical and psychological demands of the work.	Undertake a review of local access to staff rest spaces. Develop and communicate a guide for staff.	Head of People - Organisational Development, Culture, and Learning and Head of People - Workforce, Wellbeing & Employee Relations and Estates	28-Feb-21
	Identify additional spaces and mobile resources as part of wellbeing strategy.		

Dudley People Plan – A caring, kind and compassionate place			
Objective	**Action Required**	**Who**	**When**
Ensure that all staff have access to psychological support.	Review of Staff Health & Wellbeing service and development of an ongoing service model with outline of additional support required.	Deputy Chief People Officer	01-Dec-20
	Promote awareness of RISE wellbeing support services across the organisation.	Head of People - Organisational Development, Culture, and Learning, Head of Communications and Divisional Directors	31-Oct-20
	Implement the BMA Wellbeing Charter.	Chief People Officer and Medical Director (in partnership with the BMA/LNC)	31-Dec-20
	Recruit and train wellbeing champions to support and promote access to wellbeing.	Head of People - Organisational Development, Culture, and Learning and Head of Communications	01-Feb-21
	Develop a staff microsite (HUB and external webpage) on wellbeing support.		31-Jan-21
Identify and proactively support staff when they go off sick and support their return to work.	Implement revised Absence and Wellbeing policy and manager's toolkits.	Head of People - Workforce, Wellbeing & Employee Relations	31-Mar-21
	Review and implement revised workforce metrics to include measures of support for staff.	Head of People - Workforce, Wellbeing & Employee Relations, HR Analyst and Divisional Directors	01-Jan-21
	Embed the HR Business Partner model across divisions to support more effective support for wellbeing and return to work.	Head of People - Workforce, Wellbeing & Employee Relations	01-Nov-20
Ensure that workplaces offer opportunities to be physically active and that staff are able to access physical activity throughout their working day.	Deliver promotional activities as part of wellbeing strategy and calendar of events with a specific focus on increasing the physical activity of staff.	Head of People - Organisational Development, Culture, and Learning and Head of Communications	01-Jan-21
	Promote monthly physical activity challenges through engagement, wellbeing and charity events.		01-Jan-21
	Promote use of on-site gym	Head of People - Organisational Development, Culture and Learning; Head of Communications; Action Heart Manager.	01-Jan-21
Make sure line managers and teams actively encourage wellbeing to decrease work-related stress and burnout.	Enhance Manager's Essentials wellbeing module to support managers in maintaining the wellbeing of their staff.	Head of People - Organisational Development, Culture and Learning	01-Jan-21
	Develop a staff microsite (HUB and external webpage) on wellbeing support.	Head of People - Organisational Development, Culture and Learning and Head of Communications.	31-Jan-21
	Deliver a range of activities as part of the wellbeing strategy and calendar of events with a specific focus on decreasing work-related stress and strategies to support minimising the risk of burnout.		01-Dec-20
Every member of NHS staff should have a health and wellbeing conversation.	Develop process, timetable and guidance for annual wellbeing conversations and reporting arrangements for each conversation (wellbeing, inclusion and talent).	Head of People - Organisational Development, Culture and Learning	01-Dec-20
	Offer an annual health check to staff as part of the wellbeing strategy.	Deputy Chief People Officer and Divisional Directors	31-Jan-21
	Develop key measures to demonstrate compliance and impact/quality of conversations. Report to WSEC on quarterly basis.	Head of People - Organisational Development, Culture and Learning and Divisional Directors	01-Jan-21
All new starters should have a health and wellbeing induction.	Develop and launch revised corporate induction including wellbeing action plans.	Head of People - Organisational Development, Culture and Learning	01-Feb-21
	Develop guidance for delivery of local induction to include wellbeing, improvement and learning.		01-Mar-21
Developing and embedding a compassionate culture	Develop and deliver a learning and leadership strategy which outlines support for embedding a compassionate culture.	Head of People - Organisational Development, Culture and Learning and Head of Improvement	01-Feb-21
	Review values-based delivery of core elements of the employee journey and provide guidance and training for line managers and staff. This will include recruitment, induction, employee relations and appraisal.	Head of People - Organisational Development, Culture and Learning and Head of Improvement; Head of People - Workforce, Wellbeing and Employee Relations	01-Mar-21

Dudley People Plan – Equality, Fairness and Inclusion			
Objective	**Action Required**	**Who**	**When**
Review governance arrangements to ensure that staff networks are able to contribute to and inform decision-making processes.	Develop Divisional action plans from WRES/WDES submission and E&I Deep-Dive session.	Chief People Officer with Divisional Directors	01-Dec-21
	Develop and publish dashboard reporting on equality KPI's to establish monitoring of impact of activity.	Chief People Officer, HR Analyst and Divisional Directors	30-Nov-20
	Develop Equality & Inclusion Strategy	Head of Inclusion with Inclusion Network Chairs	01-Jan-21
	Deliver Cultural Intelligence Training to Board and Senior Leaders.	Inclusion Coordinator	Nov 20 and Jan 21
	Implement Communications Plan for Inclusion Networks	Head of Inclusion with Inclusion Network Chairs and Head of Communications	01-Dec-20
	Promote membership of Networks and increase participation. Reporting on activity, membership to Workforce and Staff Engagement Committee on a bi-monthly basis.	Head of Inclusion, Inclusion Network Chairs and Divisional Directors	Ongoing
	Support Inclusion Network Chairs to participate in Workforce and Staff Engagement Committee.	Chief People Officer and Head of Inclusion	Ongoing
	Support Inclusion Network Chairs to attend Trust Board on a quarterly basis. Executive and Non Executive members to actively support inclusion activities, including attendance at network meetings/activities.	Head of People - Organisational Development, Culture and Learning	01-Jul-20
	Provide additional development activities, mentoring and coaching to Inclusion Network Chairs.	Head of People - Organisational Development, Culture and Learning	01-Dec-20
Overhaul recruitment and promotion practices to make sure that staffing reflects the diversity of the community, and regional and national labour markets.	Implement focused talent strategy for under-represented staff.	Head of People - Organisational Development, Culture, and Learning, Head of People - Workforce, Wellbeing & Employee Relations and Divisional Directors	31-Dec-20
	Convene focus groups with BAME nursing staff to understand the reasons for lack of career progression for BAME nurses and develop robust support going forwards	Chief People Officer and Chief Nurse	01-Aug-21
	Implement Mentoring for Inclusion schemes offered to underrepresented groups including reverse mentoring with Board and Senior level management.	Board Directors, Head of People - Organisational Development, Culture and Learning and Inclusion Network Chairs	31-Jan-21
	Review recruitment strategy and processes to ensure this reflects best practice and implement any new processes.	Chief People Officer/Deputy Chief People Officer/Head of People - Workforce, Wellbeing & Employee Relations	01-Oct-20
	Engage with agencies to target recruitment campaigns to under-represented groups i.e. Stonewall, Employers Network for Equality and Inclusion etc.	Head of Resourcing, Head of Inclusion and Head of Communications	01-Aug-21
	Develop KPI measures on progression and development and report through Workforce Committee and Board as part of the Inclusion Dashboard.	Head of Inclusion, HR Analyst and Divisional Directors	01-Dec-20
	Annual review of WDES/WRES to identify further actions and measure impact.		01-Aug-21
Discuss equality, diversity and inclusion as part of the annual health and wellbeing conversations expected between managers and employees.	Establish a template and toolkit for wellbeing and inclusion conversations and reporting schedule.	Head of People - Organisational Development, Culture and Learning and Head of Inclusion and Divisional Directors	01-Sep-20
	Undertake a review of outputs and themes from conversations to inform development and wellbeing strategies.		01-Apr-21
	Implement package of inclusion support activities including the networks for advocacy and development support.		01-Nov-20
	Develop measures to support KPI monitoring of completed conversations and undertake quality audits annually.		01-Sep-21





A WORKFORCE FOR NOW AND | A CARING, KIND AND COMPASSIONATE | EQUALITY, FAIRNESS AND | IMPROVEMENT AND DEVELOPMENT | USING TECHNOLOGY TO INNOVATE

Dudley People Plan – Equality, Fairness and Inclusion

Objective	Action Required	Who	When
Publish progress against the *Model Employer* (*A Model Employer: Increasing black and minority ethnic representation at senior levels across the NHS*) goals to ensure that the workforce leadership is representative of the overall BAME workforce.	Undertake a deep dive into Equality and Diversity to outline the actions planned to meet areas of development from WRES.	Chief People Officer, Chief Operating Officer and Divisional Directors	01-Sep-20
	Launch Mentoring for Inclusion programme launched for staff at grade 7 and above.	Head of People - Organisational Development, Culture and Learning and Head of Inclusion	01-Sep-20
	Embed WRES within the appraisal process of senior managers.		01-Nov-20
	Review of Recruitment training for managers to focus on values based and inclusive practice	Head of Resourcing/Head of People - Workforce, Wellbeing & Employee Relations	01-Mar-21
	Implement NHSI toolkit on good practice on recruitment and retention (shortlisting; interviews; appraisals and development) once developed.	Head of Resourcing and Head of People - Organisational Development, Culture and Learning	31-Mar-21
	Ensure all recruitment panels have a BME representative on all panels.	Head of Inclusion and Head of Resourcing and Divisional Directors	01-Apr-21
	Develop WRES experts within the Trust within the Equality team and the BME Network.	Head of Inclusion and Inclusion Network Chairs	01-Jan-21
	Develop tailored career discussions for talent management programmes for BME managers and underrepresented staff groups.	Head of Inclusion and Head of People - Organisational Development, Culture and Learning and Divisional Directors	01-Dec-20
	Ensure all managers complete Manager Essentials training and Managers Accreditation.		01-Nov-22
	Develop plans to support the leaders of the staff networks and trade union representatives to raise the visibility of the WRES, WDES and WSES programmes of work.	Head of Inclusion, Inclusion Network Chairs and Head of Communications	01-Dec-20
	Establish dashboard reports on progress of career progression and recruitment data for all staff groups, monitor performance to Workforce Committee bi-monthly.	Head of People - Organisational Development, Culture and Learning, Head of Inclusion, HR Analyst and Divisional Directors	31-Mar-21
	Embed WRES & WDES performance and progress within performance objectives and appraisals of senior leaders (annually)	Head of Inclusion and Head of People - Organisational Development, Culture and Learning	01-Mar-21
	Undertake a deep dive through the Workforce and Staff Engagement Committee into recruitment activity, practice and data to better understand barriers in order to take positive action.	Head of Inclusion, Resourcing Lead and Divisional Directors	01-Apr-21

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

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Dudley People Plan – Equality, Fairness and Inclusion

Objective	Action Required	Who	When
51 per cent of organisations to have eliminated the ethnicity gap when entering into formal disciplinary processes, as set out in *A Fair Experience for All (A Fair Experience for all: Closing the ethnicity gap in rates disciplinary action across the NHS workforce)* .	Review our Investigation and Disciplinary Policy and implement revised policy based on a just and learning culture principles.	Head of People - Workforce, Wellbeing and Employee Relations and Head of Inclusion	01-Mar-21
	Deliver training for all case managers, case investigators and any panel Members to ensure that best practice principles are applied.	Head of People - Workforce, Wellbeing and Employee Relations, Head of People - Organisational Development, Culture and Learning and Head of Inclusion	01-Jan-21
	All suspensions or continued suspension / exclusion of any individual will be formally reviewed (risk assessment / fairness / inclusive practice) on a weekly basis.	Head of People - Workforce, Wellbeing and Employee Relations	01-Mar-21
	Ensure referrals for health and wellbeing support for staff entering disciplinary processes are mandated as part of new policy, training and toolkits.		01-Mar-21
	Establish KPI reporting mechanisms to report bi monthly to Workforce Committee on training, referrals and practice of staff as part of dashboard.		01-Mar-21
	Undertake quarterly case investigation processes and report to ensure the principles of inclusion and just learning are embedded		01-Mar-21
Support organisations to achieve the above goal, including establishing robust decision-tree checklists for managers, post-action audits on disciplinary decisions, and pre-formal action checks	Decisions to place staff through the formal disciplinary process will be reviewed on a quarterly basis. A quarterly report will also be provided to the WSEC.	Head of Equality, Diversity and Inclusion and Head of People - Workforce, Wellbeing & Employee Relations	01-Mar-21
	Reports and learning from case reviews will be shared with all line managers, through monthly meetings with HRBP's, to ensure learning from the process is undertaken. Any training requirements will be identified and added to training programme.		
	Establish KPI reporting mechanisms to report bi monthly to Workforce Committee and through to Board to monitor activity and provide assurance of reducing inequality.		
	Auditing case investigation processes and reports to ensure the principles of inclusion and just learning are embedded with reports to Workforce Committee on a bi-annual basis.		
	Embedded programme of activity to support increased development of staff in under-represented characteristics.		
Refresh the evidence base for action, to ensure senior leadership represents the diversity of the NHS, spanning all protected characteristics.	Apply national good practice in terms of monitoring and evidence-based action to increase representation in senior leadership roles.	Head of Equality, Diversity and Inclusion	01-Feb-21
	KPI measures on progression and development reported bi-monthly to Workforce Committee and Board.	DGFT Board Secretary and Divisional Directors	
	Annual review of WDES/WRES and associated data on senior leadership to identify progress and further actions.	Head of E&I	
To promote behaviours and actions of staff that support the development of an inclusive culture.	Review all workforce policies and procedures to ensure they fully support the expectations of the behavioural framework and demonstrate our values of Care, Respect and Responsibility.	Head of People - Workforce, Wellbeing and Employee Relations	01-Dec-21





Dudley People Plan – Improvement and Development Culture			
Objective	**Action Required**	**Who**	**When**
Use guidance on safely redeploying existing staff and deploying returning staff, developed in response to COVID-19 by NHSEI and key partners, alongside the existing tool to support a structured approach to ongoing workforce transformation.	Implement Workforce Transformation programme (optimising multi-professional workforce models) with support and input from Health Education England (HEE).	Chief People Officer, Chief Nurse, Deputy Chief AHP and Head of People - Organisational Development, Culture, and Learning	30-Nov-20
Continued focus on developing skills and expanding capabilities to create more flexibility, boost morale and support career progression.	Develop a broad programme of training and development activities across the Trust to support career progression.	Head of People - Organisational Development, Culture, and Learning, Head of Non- Medical Education and Head of Medical Education	01-Dec-20
	Implement a learning and leadership strategy		31-Mar-21
	Support for staff at the beginning and end of their careers – embedding flexibility and changing the rigid culture.		28-Feb-21
	Develop and promote opportunities for career start and end including: get into the NHS, entry level roles, apprenticeships, and work experience across all professions.		28-Feb-21
	Deliver Improvement fundamentals to 50% of staff within 2 years.		31-Mar-21
	Provide training, support and opportunity for involvement in improvement activity using the Trust approved method. Targeting 80% of improvement activity to be using DIP method by March 2023.		31-Mar-21
Improve access to career opportunities and support a learning culture	Enhance opportunities for leaders and aspirant leaders to undertake external development such as NHS Leadership Academy programmes.	Head of People - Organisational Development, Culture, and Learning and Divisional Directors	01-Apr-21
Employers should fully integrate education and training into their plans to rebuild and restart clinical services, releasing the time of educators and supervisors; supporting expansion of clinical placement capacity during the remainder of 2020/21; and providing an increased focus on support for students and trainees, particularly those deployed during the pandemic response.	Implement Nursing and AHP progression pathway and Learning and leadership strategy	Chief People Officer, Chief Nurse and Deputy Chief AHP	01-Mar-21
	Develop frameworks for placement capacity expansion and models for supporting students for Dudley and the STP as part of Placement Projects.	Head of People - Organisational Development, Culture, and Learning, Head of Non- Medical Education and Head of Medical Education and Deputy Chief Nurse	
	Review student support arrangements for all trainees including supporting the development of supervisors/educators.		
For medical trainees, employers should ensure that training in procedure-based competencies is restored as services resume and are redesigned to sustain the pipeline of new consultants in hospital specialties.	Deliver continuous improvement training as part of development plans for Drs in training including CI certification and supporting consultants in their service improvement activity using the DIP approach.	Head of Postgraduate Education and Medical Director	01-Mar-21





Dudley People Plan – Improvement and Development Culture			
Objective	**Action Required**	**Who**	**When**
Ensure people have access to continuing professional development, supportive supervision and protected time for training.	Specific time identified during appraisals for Improvement training and involvement in service improvement activity	Head of People - Organisational Development, Culture, and Learning, Head of Non- Medical Education and Head of Medical Education and Divisional Directors	01-Mar-21
	Increase awareness of responsibility in all roles for service development/improvement.		
	Implement the Managers accreditation framework including requirement to demonstrate application of the trust's CI approach (DIP) to deliver improvements in their service.		
	Managers to receive training to increase awareness of the link between service improvement and professional development.		
Increase recruitment to roles such as clinical support workers, highlighting the importance of these roles for patients and other healthcare workers as well as potential career pathways to other registered roles.	Undertake a workforce profile review. Review international nurse recruitment options, including available funding sources.	Chief People Office, Chief Nurse and Divisional Directors	31-Jan-21
	Undertake an analysis of the labour market to understand the supply "pipeline".		
	Collaboration on 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	Chief People Officer/Deputy Chief People Officer/Head of People - Workforce, Wellbeing and Employee Relations and Chief Nurse	
	Exploration of the Nurse Apprenticeship Model		
	Develop a local workforce plan, particularly addressing recruitment and retention	Head of People - Workforce, Wellbeing and Employee Relations and Divisional Directors	
Offer more apprenticeships, ranging from entry-level jobs through to senior clinical, scientific and managerial roles.	Embed Apprenticeship First Commitments, using apprenticeships as development/pathway tools and utilising Levy contributions.	Apprentice Lead through to Head of People - Organisational Development, Culture, and Learning.	Apprentice Week 2021
	Campaigns on new standards when approved		
	Promotion through apprentice week, appraisals and in workforce redesign programmes through Business Partners and Divisions.		
Encourage our former people to return to practice as a key part of recruitment drives during 2020/21, building on the interest of clinical staff who returned to the NHS to support the COVID-19 response.	To fully participate with phase 2 of the BBS programme and engage with the Reservists programme which is being coordinated on a system approach.	Head of People - Workforce, Wellbeing and Employee Relations Recruitment and Retention Lead and Chief Nurse	01-Mar-21
Increase nursing recruitment and retention	Develop and implement a nursing recruitment and retention strategy that includes attraction, role/career development, flexible working and new ways of working	Chief People Officer, Deputy Chief People Officer, Chief Nurse. Head of People - Workforce, Wellbeing and Employee Relations and Divisional Directors	01-Apr-21





A WORKFORCE FOR NOW AND THE FUTURE

A CARING, KIND AND COMPASSIONATE PLACE

EQUALITY, FAIRNESS AND INCLUSION

IMPROVEMENT AND DEVELOPMENT CULTURE

USING TECHNOLOGY TO INNOVATE

Dudley People Plan – Using Technology to Innovate			
Objective	**Action Required**	**Who**	**When**
To develop skills and motivation within our workforce to take a "digital-first" approach and better use technology every day	Align the Digital Trust strategy and Dudley People plans	CIO	01-Dec-21
	Develop enhanced training with local partners to support the skills staff need in order to think "digital-first"	CIO / Chief People Officer	01-Dec-21
	Create a forum of staff where we ensure a "digital-first" approach is expected – to influence the culture aroun	CIO / Chief People Officer	01-Dec-21
	Develop and deploy a skills framework for "digital-first"	CIO / Chief People Officer	01-Dec-21
To create an environment that supports innovation, making our workforce more flexible and adaptive to change.	Support teams within the Dudley Improvement Practice in speaking with data and to employ data based decisio	CIO / Chief People Officer	01-Dec-21
Using technology to promote continuity of care, safe staffing and develop a flexible and responsive workforce	Fully Implement E-Rostering across the Trust	CIO / Chief People Officer	01-Dec-21
	Fully explore the use of Bank technology to ensure temporary staff are only used when necessary, the technology is in place to enable a streamlined end-to-end process from rostering to booking across permanent and temporary staff.	CIO / Chief People Officer	01-Dec-21
	Implement Self-service ESR to Self-service to enable every ESR user to manage their own data, increasing the accuracy, quality and timeliness of information so that the flow of information is streamlined, consistent and instantly available.	CIO / Chief People Officer	01-Dec-21
	Fully explore the use of a collaborative bank across the STP to promote reduced agency spend, economies of scale on back office costs, increased transparency and increased supply	CIO / Chief People Officer	01-Dec-21

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

Supported by our values of Care, Respect and Responsibility

DudleyGroupNHS

Care better every day

NHS People Plan - Status

NHS Employers
Part of the NHS Confederation

PEOPLE PLAN ACTIONS

Category	NHS People Plan Actions	Current Status
FLEXIBLE WORKING	Be open to all roles being flexible	In progress
	Cover flexible working in induction and annual appraisals.	In progress
	Requesting flexibility available to all	In progress
	Board members commitment	In progress
	Monitor performance on advertising flexible roles	In progress
	Implementation of e-rostering systems	In progress
	Roll out the working carers passport	In progress
RETAINING STAFF	Role design to ensure meet needs of staff	In progress
	Mid –career conversations	In progress
	Staff awareness of pension tax threshold	In progress
	Awareness of ongoing pension flexibilities	In progress

NHS People Plan - Status

NHS Employers
Part of the NHS Confederation

PEOPLE PLAN ACTIONS

Category	NHS People Plan Actions	Current Status
HEALTH & WELLBEING	Effective infection prevention & control	Completed
	Access and training in appropriate (PPE)	Completed
	Provide a flu vaccine to all	In progress
	Risk assessments for vulnerable staff	In progress
	Safe home working	In progress
	Rests and breaks from work	Completed
	Create a culture of civility and respect	In progress
	Prevent and control workplace violence	Completed
	Appoint a wellbeing guardian	In progress
	Staff free car parking	Completed
	Support other modes of transport and identify a cycle-to-work lead	In progress
	Safe rest spaces	In progress
	Access to psychological support.	In progress
	Support to staff who are sick	In progress
	Encourage physical activity	In progress
	Managers encourage wellbeing and reduce stress	In progress
	Health and wellbeing conversation for all	In progress
	Health and wellbeing induction for new starters	In progress

NHS People Plan - Status

NHS Employers
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PEOPLE PLAN ACTIONS

Category	NHS People Plan Actions	Current Status
DIVERSITY & INCLUSION	Overhaul recruitment and promotion practices	In progress
	Equality, diversity and inclusion included in annual wellbeing conversations	In progress
	Publish progress against the *Model Employer* goals	Completed
	Eliminate the ethnicity gap in formal disciplinary processes	In progress
	Support mechanisms for eliminating the ethnicity gap in disciplinary processes	In progress
	Refresh the evidence base representation in the diversity of the NHS	Completed
CULTURE & LEADERSHIP	Enable staff networks contribute to decisions	In progress
NEW WAYS OF DELIVERING CARE	Ongoing workforce transformation	Completed
	Developing skills and expanding capabilities to support career progression	In progress
	Promote online learning	Completed
GROWING THE WORKFORCE	Releasing the time of educators, expand placements, support students & trainees	Completed
	For medical trainees, develop the pipeline of new consultants in hospital specialties	Completed
	Access to continuing professional development and protected training time	In progress
RECRUITMENT	Increase recruitment to clinical support worker roles and promote careers	In progress
	Offer more apprenticeships	Completed
	Encourage our former people to return to practice	In progress
	Prioritise the use of bank staff reducing the use of 'off framework' agency shifts	In progress

Enclosure 21

Paper for submission to Board 12th November 2020

The Dudley Group NHS Foundation Trust

TITLE:	**Workforce KPIs**		
AUTHOR:	**James Fleet – Chief People Officer** **Graeme Ratten - Analyst**	**PRESENTER:**	**James Fleet – Chief People Officer**

CLINICAL STRATEGIC AIMS

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

ACTION REQUIRED OF COMMITTEE

Decision	Approval	Discussion	Other
		X	

RECOMMENDATIONS

For the board to receive the report and note the contents.

CORPORATE OBJECTIVE:

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

SUMMARY OF KEY ISSUES:

- Overall Sickness Absence for the month of September increased to 6.8% from 5.7% in August. COVID reason absences increased from 1.4% to 2.2%, and all other sickness reasons increased from 4.4% to 4.7%. The underlying non-COVID sickness/absence is still above the target of 3.5%. In this and subsequent reports forward we are using an enhanced reporting style to show monthly absence values instead of 12 month rolling averages, please note that this produces slightly different values for September compared to the rolling averages used in the WSEC report.
- Agency use increased slightly in September (157 FTE) compared to August (152 FTE). Bank usage increased more significantly from 325 FTE in August to 403 FTE in September. Contracted staff in September fell by 22 FTE (4,758 to 4,736). The sum of the contracted, bank, agency, and overtime in September added up to 5,335 FTE, against a total establishment budget of 5,336 FTE.
- Turnover continues to fall and is at 7.2% for September. For comparison, the STP average turnover (latest data is for August) shows 11.4%. We are making further reporting developments to align and comparison with the new STP/ICS Workforce Metrics, and from next month will incorporate ‘standard’ and ‘normalised’ (which excludes fixed term contracts) turnover numbers, as well as retention rates at 12 months and 24 months.
- There is an overall improvement in recruitment compliance against targets, with an increase from 75% in August to 79% in September. We are developing additional metrics via the TRAC system to provide better visibility of recruitment campaigns showing numbers of applicants, shortlists,

interviews, offers and resulting new starters – these will be incorporated into future KPI reports.

- Mandatory training compliance improved in September to 87.6%, up from 85.5% in August. Resus continues to be a weak area with Paediatric at 65% and Adult at 67%. Surgery is the most challenged division (63% adults, 60% paediatrics). Safeguarding Children Level 3 is also weak at 72% with MIC the most challenged division (77% adults, 71% paediatrics).
- BAME representation is trending upwards from 18.6% in June 2020 to 19.9% in September 2020. Disability representation remains constant at 3.5%.
- The HR caseload has reduced from 50 in August to 45 in September, and BAME staff are represented in 22% of cases.
- COVID risk assessments: the overall position has improved since the submission on 31st August, up from 95% to 98%. MIC has the largest number of outstanding assessments (73).

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 27 October 2020**

NHS
The Dudley Group
NHS Foundation Trust

Workforce KPI Report

Board 12th November 2020

James Fleet, Executive Chief People Officer




Summary 1/3	*Performance*	*Action*
Sickness & Absence	o Overall Sickness Absence for the month of September increased to 6.8% from 5.7% in August. COVID reasons increased from 1.4% to 2.2%, and all other sickness reasons increased from 4.4% to 4.7%. (NB: these numbers are monthly actuals, whereas the WSEC report used rolling averages producing slightly different numbers) o The underlying non-COVID sickness/absence is still above the target of 3.5% o COVID reason absences increased in September to 2.2%, however the daily absence values dropped in the first half of October and have been rising again during the second half. On Tuesday 3rd November 2.7% of staff are absent with COVID reasons.	✓ Centralised Sickness Absence Reporting has recommenced for Covid-related absence, this feeds directly into the Staff Testing process to enable staff to return to work as quickly as possible, if appropriate. ✓ All Covid-related absence is screened and challenged to ensure staff are self-isolating appropriately. ✓ Monthly sickness absence reports are being sent to Managers, Divisional Directors and Heads of Service detailing both short and long term absence. ✓ The operational HR team convene monthly meetings with managers to support, advise and challenge action that is being taken to manage sickness absence.
Bank & Agency Usage	o Agency use increased slightly in September (157 FTE) compared to August (152 FTE). o Bank usage increased more significantly from 325 FTE in August to 403 FTE in September. Contracted staff in September fell by 22 FTE (4,758 to 4,736). o The sum of the contracted, bank, agency, and overtime in September added up to 5,335 FTE, against a total establishment budget of 5,336 FTE.	✓ Action plan being developed to prioritise recruitment and retention. ✓ Authorisation levels have been reviewed and revised within Health Roster to ensure there is senior nursing oversight for agency usage. ✓ 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.
Turnover & Recruitment	o Turnover continues to fall, and is at 7.2% for September. For comparison the STP average turnover (latest data is for August) shows 11.4%. o Leavers was low for the month at 35, of which 13 were 'End of Fixed Term Contract'. Starters was 99 people (90.5 FTE), with Specialty Registrars at 20, and Staff Nurses at 8. o Other significant starter roles include; Staff Nurses 22, Health Care Support Workers 12, and Specialist Nurse Practitioners 10. o There is an overall improvement in recruitment. Compliance against targets, with an increase from 75% in August to 79% in September.	✓ Turnover continues to fall and is well below the average industry rate of 10%. ✓ The HR Business Partners will be supporting the Divisional Directors to ensure the development and implementation of workforce planning, that understands staffing capacity, establishments, and skill & experience requirements and incorporates into service design to ensure roles are fit for purpose and add value. ✓ Examine trends on planned versus actual staffing levels, triangulated with key quality and outcome measures, including exit interviews and stay interviews. ✓ Further recruitment KPIs are being developed for next report.

Summary 2/3	*Performance*	*Action*
Mandatory Training	o Mandatory training compliance improved in September to 87.6%, up from 85.5% in August. o Most topics improved with the exception of: RESUS Adults -1.9% Neonatal – 2.0% Paediatric -1.0%, and Safeguarding Children Level 3 – 3.2% o Resus continues to be a weak area, at Paediatric at 65% and Adult at 67%, with Surgery the most challenged (63% adults, 60% paediatrics) o Safeguarding Children Level 3 is also weak at 72% with MIC the most challenged (77% adults, 71% paediatrics).	✓ An action plan has been devised along with a trajectory for the Divisions to achieve mandatory training compliance. ✓ Restrictions to the amount of attendees and exploration of adjusted delivery continues ✓ Meetings held with SMT Lead and Gen Managers for MIC, Surg, and CSS, with out-of-hours additional sessions run throughout September up to December to capture Clinicians particularly
Workforce Profile	o Month 6 shows an overall vacancy factor of 600 FTE calculated as the difference between the Budgeted FTE (5,336) and the Contracted FTE (4,736). With 308 Qualified Nurse vacancies in total. o MIC has 272 vacancies, of which 172 are Qualified Nurses and 37 Unqualified Nurses. o SURGERY has 235 vacancies of which 128 are Qualified Nurses and 13 Unqualified Nurses. o CIS has 42.3 FTE Radiographer vacancies across all bands, mainly in the Breast Screening Service and Imaging.	✓ HR and Professional Development continue to collaborate to support on-going recruitment. Interventions include nursing recruitment days, virtual tours and social media campaigns. ✓ 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
Equality, Diversity & Inclusion	o BAME representation is trending upwards from 18.6% in June 2020 to 19.9% in September 2020. o Progression appears to be an issue with BAME staff under-represented at Bands 6, 7, 8C, 8D, Trust Director, and Trust Senior Manager grades. o Disability representation remains constant at 3.5%. o Compared to the Trust average of 3.5%, disabled staff appear to be under represented at Band 2, Bands 8B+C+D, and Trust Senior Manager level.	✓ 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. ✓ Each of these networks has both an Executive Director and Non-Executive Director sponsor. In addition, the Chairs of the networks will attend Board meetings. ✓ The Workforce Committee meeting in late August focused on a 'deep dive' by age, band, length of service, and staff group for WDES, WRES, and WSES.

Summary 3/3	*Performance*	*Action*
Staff Health & Wellbeing	o Appointments held in September reduced to 15, down from 29 in August. o The SHAW service continues to offer appointments within the 15 day target.	✓ Review of Staff Health & Wellbeing service in progress to identify the service model and additional support required. ✓ Interim support provided to support the service and review processes and practices in the short term.
HR Caseload	o The HR caseload has reduced from 50 in August to 45 in September. o BAME staff are represented in 22% of cases. o Overall, disciplinary cases account for 47% of cases (excluding suspensions).	✓ Employee relations cases continue to be proactively managed and supported by the implementation and maintenance of a case tracker. ✓ There is a focus on the Just Culture framework, with shared learning and early resolution where possible.
COVID: Staff Risk Assessment	o The overall position has improved since the submission on 31st August, up from 95% to 98%. o MIC has the largest number of outstanding assessments (73). o Two staff groups add up to the majority of outstanding assessments; Additional Clinical Services, and Nursing and Midwifery Registered.	✓ Monthly performance on risk assessments will be sent to Managers, Divisional Directors and Heads of Service detailing compliance and outstanding assessments. ✓ The operational HR team have incorporate into their monthly meetings with managers to support, advise and challenge action that is being taken. ✓ A 'prompt' has been incorporated into the Trac recruitment system to prompt completion for new starters.

Sickness Absence

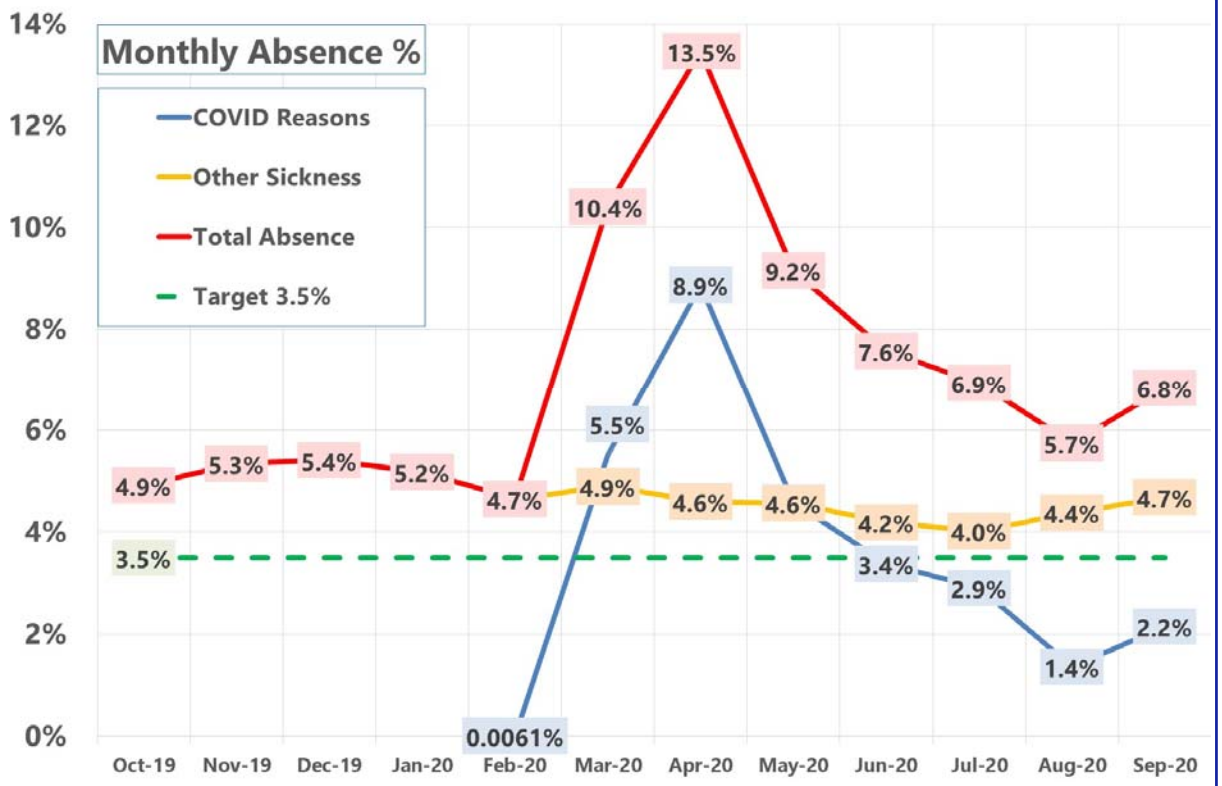
Overall Sickness Absence for the month of September increased to 6.8% from 5.7% in August. COVID reasons increased from 1.4% to 2.2%, and all other sickness reasons increased from 4.4% to 4.7%.

The underlying non-COVID sickness/absence is still above the target of 3.5%

Clinical Support Division has the highest overall absence at 8.3%, but the lowest COVID absence at 1.5%.

NB: We have changed the reporting graphics from rolling averages to the month actual values.

September Sickness / Absence	COVID Absence %	Other Absence %	Total Absence %
Clinical Support	1.5%	6.8%	**8.3%**
Corporate / Mgt	1.9%	2.7%	**4.6%**
Medicine & Integrated Care	1.9%	4.7%	**6.6%**
Surgery	2.7%	4.8%	**7.5%**
Grand Total	**2.2%**	**4.7%**	**6.8%**



Absence Reason	Days	% of All Reasons
COVID reasons	3,634	32%
Anxiety/stress/depression/other psychiat	2,170	19%
Other musculoskeletal problems	853	7%
Injury, fracture	600	5%
Gastrointestinal problems	578	5%
Cold, Cough, Flu - Influenza	447	4%
Pregnancy related disorders	421	4%
Genitourinary & gynaecological disorders	401	4%
Headache / migraine	388	3%
Back Problems	350	3%
Other known causes - not elsewhere class	285	3%
Chest & respiratory problems	222	2%
Ear, nose, throat (ENT)	180	2%
Infectious diseases	177	2%
Unknown causes / Not specified	150	1%
Nervous system disorders	136	1%
Benign and malignant tumours, cancers	74	1%
Dental and oral problems	69	1%
Eye problems	68	1%
Skin disorders	60	1%
Asthma	53	0%
Blood disorders	37	0%
Endocrine / glandular problems	32	0%
Burns, poisoning, frostbite, hypothermia	7	0%

Covid 19 Absence Profile – All Staff at Tuesday 3rd November

Following an increase in COVID reason absences in September to 2.2%, the daily values dropped in the first half of October and have been rising again during the second half. On Tuesday 3rd November 2.7% of staff are absent with COVID reasons.

03/11/2020 08:12:47

Add Prof Scientific ... | Additional Clinical S... | Administrative and ... | Allied Health Profes... | Healthcare Scientists | Medical and Dental | Nursing and Midwif... | Students

Employee Count Within Selected Staff Group

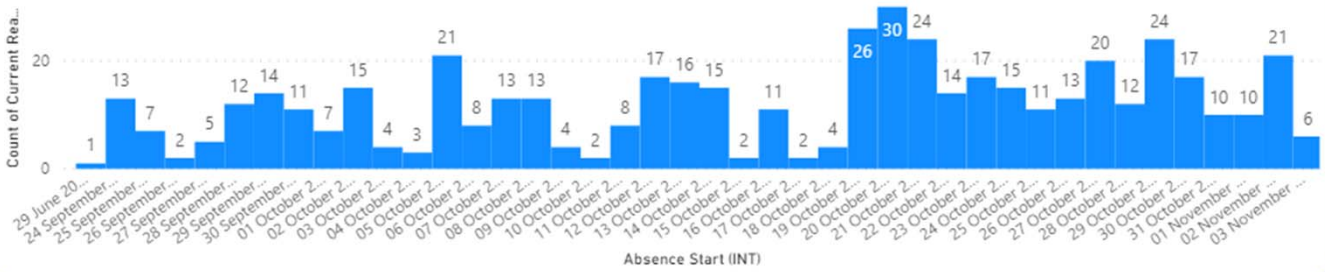
5248

Staff Group	Active Assignment	Covid-19	Other Sickness	T
Add Prof Scientific and Technic	94.1%	3.4%	2.5%	
Additional Clinical Services	91.0%	3.8%	5.2%	
Administrative and Clerical	95.8%	1.2%	3.0%	
Allied Health Professionals	97.0%	1.5%	1.5%	
Healthcare Scientists	96.4%		3.6%	
Medical and Dental	95.2%	2.6%	2.2%	
Nursing and Midwifery Registered	92.7%	3.3%	4.0%	
Students	89.5%	10.5%		
Total	**93.6%**	**2.7%**	**3.6%**	

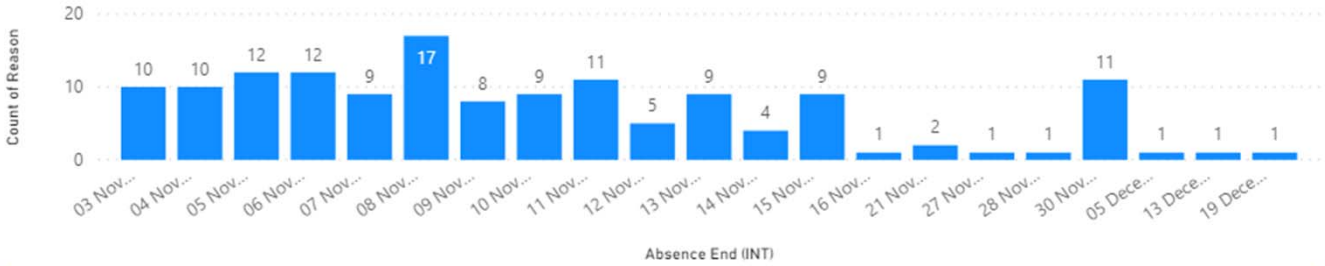
DIVISION	Active Assignment	Covid-19	Other Sickness	Total
253 Clinical Support	472	18	21	**511**
253 Corporate / Mgt	573	7	8	**588**
253 Medicine & Integrated Care	2129	67	89	**2285**
253 Surgery	1740	52	72	**1864**
Total	**4914**	**144**	**190**	**5248**

DIVISION	Active Assignment	Covid-19	Other Sickness	Total
253 Clinical Support	92.4%	3.5%	4.1%	**100.0%**
253 Corporate / Mgt	97.4%	1.2%	1.4%	**100.0%**
253 Medicine & Integrated Care	93.2%	2.9%	3.9%	**100.0%**
253 Surgery	93.3%	2.8%	3.9%	**100.0%**
Total	**93.6%**	**2.7%**	**3.6%**	**100.0%**

C-19 Absence Starts



C-19 Current Absence End



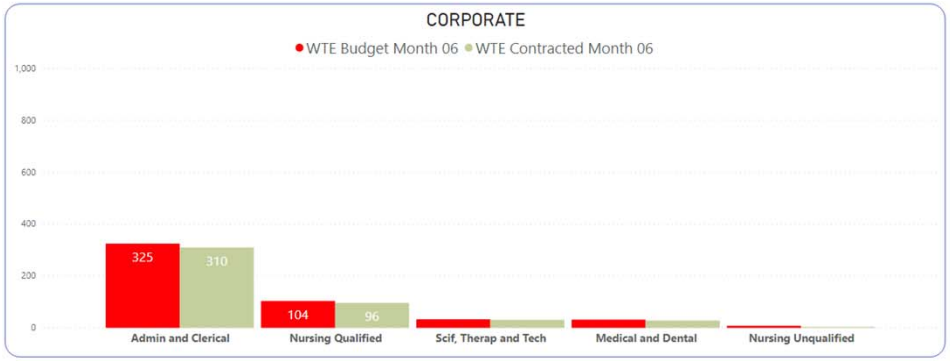
NHS The Dudley Group NHS Foundation Trust

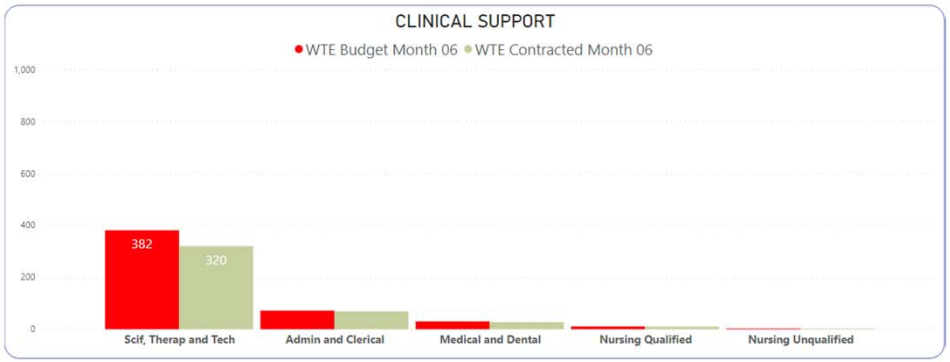
Workforce Profile – Staff in Post

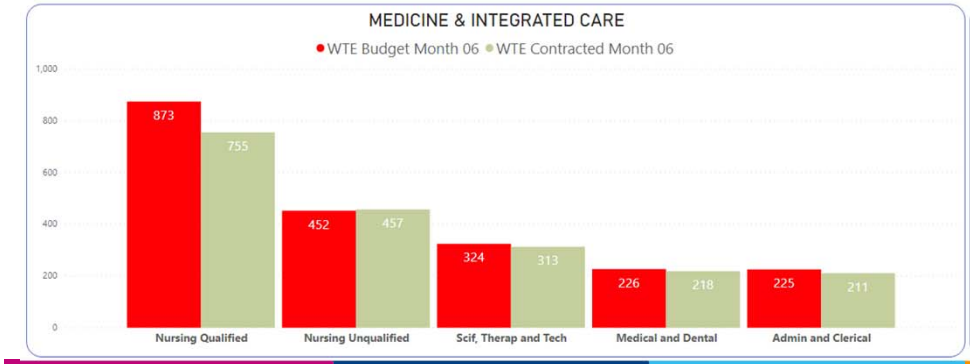
Month 6 shows an overall vacancy factor of 600 FTE calculated as the difference between the Budgeted FTE (5,336) and the Contracted FTE (4,736).

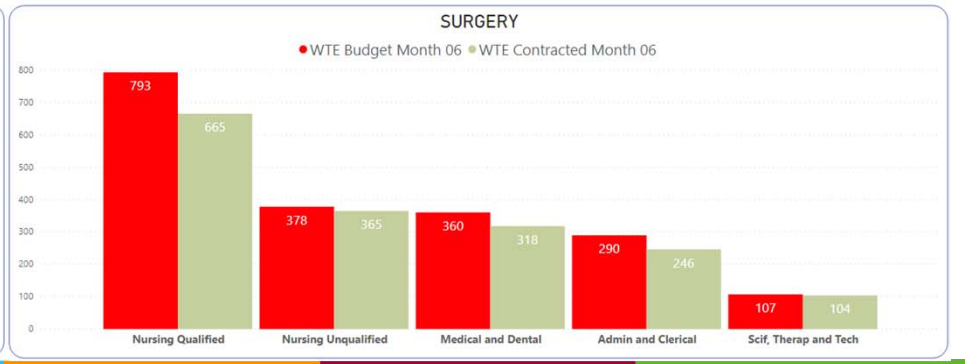
MIC has 272 vacancies, of which 172 are Qualified Nurses and 37 Unqualified Nurses.

SURGERY has 235 vacancies of which 128 are Qualified Nurses and 13 Unqualified Nurses.









Workforce Profile – Overall Vacancy Factor

Month 6 shows an overall vacancy factor of 600 FTE calculated as the difference between the Budgeted FTE and the Contracted FTE. (Workforce Planning Technical Guidance 2017/18).

There are 308 Qualified Nurse vacancies across the Trust - MIC has 272 vacancies, 172 are Qualified Nurses and 37 Unqualified Nurses. SURGERY has 235 vacancies 128 are Qualified Nurses and 13 Unqualified Nurses.

DIVISIONS Budget V Contracted

CC1 Description	WTE Budget Month 06	WTE Contracted Month 06	Vacancy Factor (Budget FTE - Contracted FTE)
Clinical Support	499	430	-69
Corporate / Mgt	570	544	-25
Medicine & Integrated Care	2,329	2,057	-272
Surgery	1,939	1,704	-235
Total	**5,336**	**4,736**	**-600**

PAY GROUP Budget V Contracted

Monitor Pay Group	WTE Budget Month 06	WTE Contracted Month 06	Vacancy Factor (Budget FTE - Contracted FTE)
Admin and Clerical	953	868	-85
Manager	88	93	5
Medical and Dental	708	641	-67
Nursing Qualified	1,834	1,527	-308
Nursing Unqualified	882	827	-55
Other	27	13	-13
Scif, Therap and Tech	846	768	-78
Total	**5,336**	**4,736**	**-600**

MIC Budget V Contracted

Monitor Pay Group	WTE Budget Month 06	WTE Contracted Month 06	Vacancy Factor (Budget FTE - Contracted FTE)
Admin and Clerical	267	242	-24
Manager	9	8	-1
Medical and Dental	286	267	-18
Nursing Qualified	927	756	-172
Nursing Unqualified	495	458	-37
Other	21	13	-8
Scif, Therap and Tech	324	313	-11
Total	**2,329**	**2,057**	**-272**

SURGERY Budget V Contracted

Monitor Pay Group	WTE Budget Month 06	WTE Contracted Month 06	Vacancy Factor (Budget FTE - Contracted FTE)
Admin and Clerical	290	246	-43
Manager	6	7	1
Medical and Dental	360	318	-42
Nursing Qualified	793	665	-128
Nursing Unqualified	378	365	-13
Other	5	0	-5
Scif, Therap and Tech	107	104	-3
Total	**1,939**	**1,704**	**-235**

Workforce Profile – Overall Lost Capacity – M6 Vacancies + Sickness/Absence

Month 6 shows an overall vacancy factor of 600 FTE calculated as the difference between the Budgeted FTE and the Contracted FTE.

Substantive staffing has 600 (FTE) vacancies – 11.2%, with Clinical Support highest at 13.8%. Overall Sickness & Absence for September was 6.8%, with Clinical Support highest at 8.3%.

September (M6) Budget v Contracted WTE

Division	Sum of WTE Budget Month 06	Sum of WTE Contracted Month 06	Vacancy Factor	Vacancy %
Clinical Support	498.7	429.9	68.7	**13.8%**
Corporate / Mgt	569.6	544.5	25.1	**4.4%**
Medicine & Integrated Care	2,328.9	2,057.3	271.5	**11.7%**
Surgery	1,939.3	1,704.3	234.9	**12.1%**
Grand Total	**5,336.4**	**4,736.1**	**600.3**	**11.2%**

September (M6) Sickness & Absence

COVID Absence %	Other Absence %	Total Absence %
1.5%	6.8%	**8.3%**
1.9%	2.7%	**4.6%**
1.9%	4.7%	**6.6%**
2.7%	4.8%	**7.5%**
2.2%	**4.7%**	**6.8%**

September (M6) Budget v Contracted WTE

Monitor Pay Group	Sum of WTE Budget Month 06	Sum of WTE Contracted Month 06	Vacancy Factor	Vacancy %
Admin and Clerical	952.8	867.7	85.1	**8.9%**
Manager	87.5	92.9	-5.4	**-6.2%**
Medical and Dental	707.7	640.9	66.8	**9.4%**
Nursing Qualified	1,834.5	1,526.9	307.5	**16.8%**
Nursing Unqualified	881.6	826.7	54.9	**6.2%**
Other	26.6	13.4	13.2	**49.6%**
Scif, Therap and Tech	845.7	767.5	78.2	**9.2%**
Grand Total	**5,336.4**	**4,736.1**	**600.3**	**11.2%**

ESR September (M6) Sickness & Absence

COVID Absence %	Other Absence %	Total Absence %	Staff Group
1.7%	3.0%	**4.7%**	Add Prof Scientific and Technic
2.1%	8.4%	**10.5%**	Additional Clinical Services
2.7%	3.1%	**5.8%**	Administrative and Clerical
0.8%	5.3%	**6.1%**	Allied Health Professionals
2.0%	4.6%	**6.6%**	Healthcare Scientists
2.1%	1.4%	**3.6%**	Medical and Dental
2.3%	4.4%	**6.7%**	Nursing and Midwifery Registered
0.7%	3.1%	**3.7%**	Students
2.2%	**4.7%**	**6.8%**	**Grand Total**

NB: 'Monitor Pay Group' used by finance does not map to 'Staff Group' used in ESR

Workforce Profile – MIC Qualified Nursing Vacancies + Absence (M6)

121.5 WTE (out of 172) of the Qualified Nurse vacancies in MIC are in ED and the Ward areas shown below. The largest numbers of vacancies are in EAU=26.9, ED=16.5, C8=15.7, and C7=10.3.

Qualified Nurse absences for September split between COVID reasons and all other sicknesses are aligned on the right.

Source: Finance Files M6	Sum of WTE Budget Month 06	Sum of WTE Contracted Month 06	WTE Vacancies	Vacancy %	ESR COVID Absence %	ESR Other Absence %	ESR Total Absence %
Emergency Department Nursing	102.1	85.6	16.5	16.2%	3.9%	4.5%	8.4%
Emergency Minor Injuries Area	13.7	13.5	0.2	1.2%	1.4%	5.8%	7.2%
Ward AEC	12.1	12.7	-0.6	-5.1%	1.2%	6.2%	7.4%
Ward B6 FAU	17.4	15.3	2.1	11.9%	1.5%	1.9%	3.3%
Ward C1 Area A	19.8	14.0	5.8	29.3%	2.9%	12.3%	15.2%
Ward C1 Area B	19.8	15.5	4.3	21.8%	1.8%	3.3%	5.1%
Ward C3	25.6	18.4	7.2	28.0%	1.2%	1.3%	2.4%
Ward C3 Forget Me Not	11.6	8.2	3.4	29.7%	4.5%	3.5%	8.0%
Ward C4	27.6	23.1	4.5	16.4%	3.2%	4.5%	7.7%
Ward C4 Onc Day OP	15.9	11.3	4.6	28.9%	2.9%	8.5%	11.4%
Ward C5 Area A	19.8	11.1	8.7	44.2%	7.0%	7.2%	14.2%
Ward C5 Area B	19.8	14.4	5.4	27.0%	0.3%	1.3%	1.6%
Ward C7	31.0	20.7	10.3	33.3%	3.8%	9.3%	13.2%
Ward C8	49.9	34.2	15.7	31.4%	3.3%	7.5%	10.8%
Ward CCU	45.0	38.5	6.5	14.5%	2.5%	3.7%	6.2%
Ward EAU	81.2	54.3	26.9	33.1%	1.5%	2.6%	4.1%
Grand Total	**512.1**	**390.7**	**121.5**	**23.7%**	**2.8%**	**4.9%**	**7.6%**

Workforce Profile – SURGERY Qualified Nursing Vacancies + Absence (M6)

93 WTE (out of 128) of the Qualified Nurse vacancies in SURGERY are in Maternity, Theatres, and the Ward areas shown below. The largest numbers of vacancies are in B3=20, Maternity Unit=11.9, RHH Day Case Theatre=9.6, and MHDU=8.3.

Qualified Nurse absences for September split between COVID reasons and all other sicknesses are aligned on the right.

Source: Finance Files M6	Sum of WTE Budget Month 06	Sum of WTE Contracted Month 06	WTE Vacancies	Vacancy %	ESR COVID Absence %	ESR Other Absence %	ESR Total Absence %
Maternity Unit	105.0	93.1	11.9	11.3%	1.3%	5.7%	6.9%
RHH Day Case Ward	24.6	19.1	5.5	22.5%	4.5%	6.0%	10.5%
RHH Day Case Theatre&Recovery	20.6	11.1	9.6	46.5%	2.3%	4.7%	7.0%
Theatres Emergency & Other	28.6	23.8	4.8	16.9%	3.3%	6.9%	10.1%
Theatres Recovery & Anaes	12.2	12.1	0.0	0.2%	1.6%	10.6%	12.2%
Theatres T&O	6.7	10.1	-3.4	-50.1%	3.6%	4.5%	8.2%
Ward B1	20.1	16.0	4.2	20.6%	5.4%	4.7%	10.1%
Ward B2 (H)	23.6	19.3	4.3	18.3%	1.4%	4.8%	6.2%
Ward B2 (T)	19.6	15.2	4.4	22.5%	3.7%	3.2%	6.9%
Ward B3	37.8	17.7	20.0	53.1%	1.1%	5.7%	6.7%
Ward B4	17.4	12.4	5.1	29.0%	1.1%	4.8%	5.8%
Ward B4b	20.1	13.4	6.7	33.2%	1.5%	1.5%	3.0%
Ward B5	42.3	35.4	6.9	16.3%	1.0%	2.4%	3.4%
Ward C2	44.3	45.1	-0.8	-1.7%	1.7%	2.5%	4.2%
Ward C6	16.8	11.3	5.4	32.5%	5.4%	8.1%	13.5%
Ward MHDU	28.3	20.0	8.3	29.3%	2.3%	7.4%	9.7%
Grand Total	**468.1**	**375.1**	**93.0**	**19.9%**	**2.1%**	**5.0%**	**7.0%**

Workforce Profile – CIS Vacancies

CIS is most challenged in the Breast Screening Service and Imaging with a total of 42.3 WTE Radiographer vacancies.

Source: Finance Files M6	Sum of WTE Budget Month 06	Sum of WTE Contracted Month 06	WTE Vacancies	Vacancy %
Breast Screening Service	**37.2**	**21.5**	**15.7**	**42.3%**
Radiographers Band 4	6.8	4.6	2.2	32.4%
Radiographers Band 5	1.0	3.7	-2.7	-266.0%
Radiographers Band 6	16.2	5.5	10.7	66.0%
Radiographers Band 7	6.2	3.7	2.5	40.3%
Radiographers Band 8a	1.9	2.0	-0.1	-6.4%
Radiographers Band 8c	5.1	2.0	3.1	60.9%
Imaging	**120.8**	**94.2**	**26.6**	**22.0%**
Radiographers Band 4	1.6	1.4	0.2	10.0%
Radiographers Band 5	39.9	21.8	18.1	45.3%
Radiographers Band 6	41.5	40.0	1.5	3.5%
Radiographers Band 7	31.8	24.9	6.9	21.6%
Radiographers Band 8a	6.0	6.0	0.0	0.0%
Grand Total	**158.0**	**115.7**	**42.3**	**26.8%**

Workforce Profile – CORPORATE Vacancies

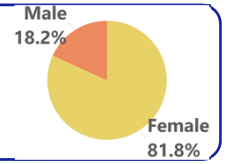
The largest vacancy factors are in the Medical Director cost centre = 9.8 WTE, Nursing = 9.4 WTE, Information Technology = 7.1 WTE, and Strategy & Transformation = 5 WTE.

Source: Finance Files M6	Sum of WTE Budget Month 06	Sum of WTE Contracted Month 06	WTE Vacancies	Vacancy %
Board Secretary FT	6.9	6.9	0.0	0.0%
Chief Executive	19.7	26.6	-6.9	-35.0%
Discharge Team	22.7	23.3	-0.6	-2.8%
Estates FM & PFI Management	24.0	22.0	1.9	8.1%
Finance & Information Director	56.6	51.8	4.8	8.4%
Finance Information & Estates	4.1	5.1	-1.0	-24.2%
Financial Services	38.9	36.2	2.6	6.7%
Human Resources	55.3	54.1	1.3	2.3%
Information Technology	96.0	88.8	7.1	7.4%
Medical Director	79.7	69.9	9.8	12.3%
Nursing	104.0	94.6	9.4	9.0%
Operations Management	11.2	18.9	-7.8	-69.5%
Research & Development	31.4	32.5	-1.1	-3.3%
Strategy & Transformation	9.5	4.5	5.0	52.6%
Trust Capacity Management	13.0	11.5	1.5	11.5%
Grand Total	**572.8**	**546.8**	**26.1**	**4.6%**

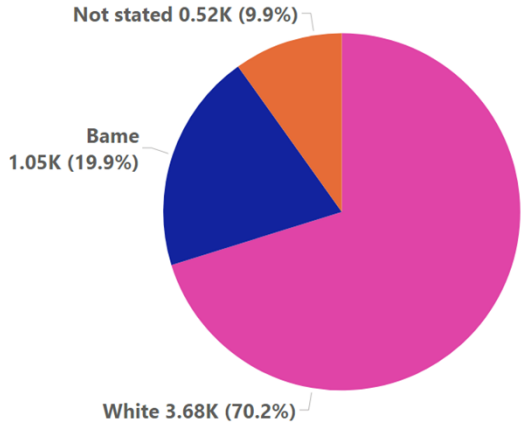
Workforce Profile – Diversity

BAME representation is trending upwards from 18.6% in June 2020 to 19.9% in September 2020. Disability representation remains constant at 3.5%.

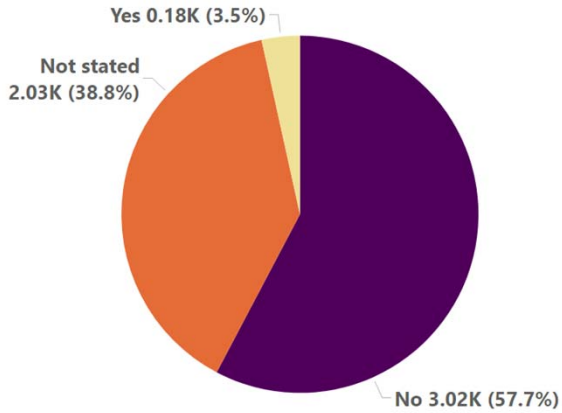
The numbers of staff who have 'Not stated' remains high in Disability 39%, Religious Belief 39%, and Sexual Orientation 36%.



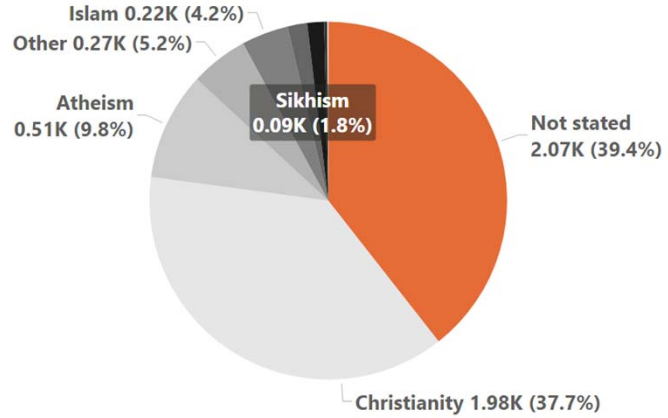
ETHNICITY



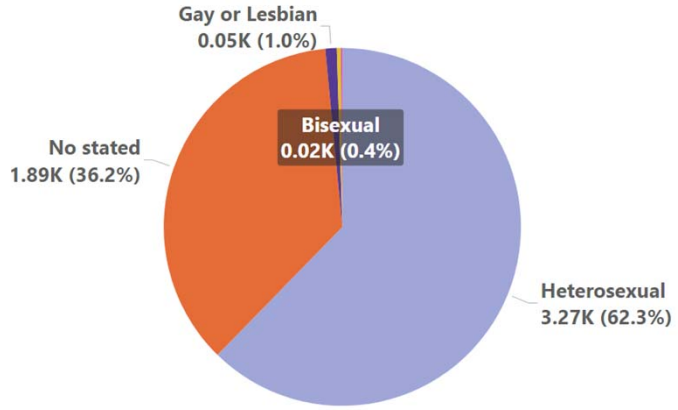
DISABILITY



RELIGION



SEXUAL ORIENTATION



Workforce Profile - Ethnicity – Representation by Division & Staff Group

BAME staff are underrepresented in Corporate Division at 12.5% compared to the Trust average of 19.9%.

The highest representation by staff group is in Medical & Dental at 59%. BAME staff are underrepresented in Additional Clinical Services at 10.9%, and Admin and Clerical at 10.3%.

All Staff

Org L2	Bame	Not stated	White
253 Clinical Support	26.8%	8.3%	65.0%
253 Corporate / Mgt	12.5%	12.5%	75.1%
253 Medicine & Integrated Care	19.2%	10.3%	70.5%
253 Surgery	21.3%	9.0%	69.7%
Total	**19.9%**	**9.9%**	**70.2%**

All Staff

Org L2	Bame	Not stated	White	Total
253 Clinical Support	136	42	330	**508**
253 Corporate / Mgt	73	73	440	**586**
253 Medicine & Integrated Care	439	235	1607	**2281**
253 Surgery	397	167	1300	**1864**
Total	**1045**	**517**	**3677**	**5239**

Excluding Medical & Dental

Org L2	Bame	Not stated	White
253 Clinical Support	24.8%	8.1%	67.0%
253 Corporate / Mgt	11.8%	12.5%	75.7%
253 Medicine & Integrated Care	15.2%	10.3%	74.6%
253 Surgery	14.3%	9.4%	76.3%
Total	**15.5%**	**10.0%**	**74.5%**

Excluding Medical & Dental

Org L2	Bame	Not stated	White	Total
253 Clinical Support	119	39	321	**479**
253 Corporate / Mgt	67	71	429	**567**
253 Medicine & Integrated Care	313	212	1,539	**2,064**
253 Surgery	228	149	1,213	**1,590**
Total	**727**	**471**	**3,502**	**4,700**

All Staff

Staff Group	Bame	Not stated	White
Add Prof Scientific and Technic	35.3%	5.8%	58.9%
Additional Clinical Services	10.9%	9.5%	79.6%
Administrative and Clerical	10.3%	12.0%	77.7%
Allied Health Professionals	21.2%	7.2%	71.6%
Healthcare Scientists	29.1%	5.5%	65.5%
Medical and Dental	59.0%	8.5%	32.5%
Nursing and Midwifery Registered	17.5%	10.5%	72.0%
Students	26.3%	5.3%	68.4%
Total	**19.9%**	**9.9%**	**70.2%**

All Staff

Staff Group	Bame	Not stated	White	Total
Add Prof Scientific and Technic	73	12	122	**207**
Additional Clinical Services	127	110	927	**1,164**
Administrative and Clerical	113	131	848	**1,092**
Allied Health Professionals	86	29	290	**405**
Healthcare Scientists	16	3	36	**55**
Medical and Dental	318	46	175	**539**
Nursing and Midwifery Registered	307	185	1,266	**1,758**
Students	5	1	13	**19**
Total	**1,045**	**517**	**3,677**	**5,239**

Workforce Profile - Ethnicity – Representation by Grade (excl. Medical & Dental)

The highest proportional representation is at Band 5 at 25.9% (excluding Band 9 at 66% with only 3 staff in total).

Progression appears to be an issue with BAME staff under-represented at Bands 6, 7, 8C, 8D, Trust Director, and Trust Senior Manager grades.

Excluding Medical & Dental

Grade	Bame	Not stated	White
Band 2	10.8%	9.6%	79.5%
Band 3	8.8%	11.4%	79.8%
Band 4	11.8%	10.1%	78.1%
Band 5	25.9%	11.0%	63.1%
Band 6	15.2%	10.4%	74.4%
Band 7	12.0%	5.7%	82.3%
Band 8A	20.7%	11.1%	68.1%
Band 8B	17.4%	4.3%	78.3%
Band 8C	8.3%	8.3%	83.3%
Band 8D	12.5%	12.5%	75.0%
Band 9	66.7%		33.3%
Local Apprentice Scale	14.1%	11.3%	74.6%
Trust Director	11.1%	22.2%	66.7%
Trust Senior Manager	12.7%	15.2%	72.2%
Total	**15.5%**	**10.0%**	**74.5%**

Excluding Medical & Dental

Grade	Bame	Not stated	White	Total
Band 2	127	113	933	**1,173**
Band 3	31	40	281	**352**
Band 4	47	40	311	**398**
Band 5	265	113	647	**1,025**
Band 6	145	99	709	**953**
Band 7	55	26	377	**458**
Band 8A	28	15	92	**135**
Band 8B	4	1	18	**23**
Band 8C	1	1	10	**12**
Band 8D	1	1	6	**8**
Band 9	2		1	**3**
Local Apprentice Scale	10	8	53	**71**
Trust Director	1	2	6	**9**
Trust Senior Manager	10	12	57	**79**
Total	**727**	**471**	**3,501**	**4,699**

Workforce Profile – Disability – Representation by Division & Staff Group

Disabled staff appear to be under represented in Surgery Division at 2.6% compared to the Trust average of 3.5%.

By staff group Medical & Dental has the lowest representation at 1.7%.

All Staff

Org L2	No	Not stated	Yes
253 Clinical Support	62.6%	33.3%	4.1%
253 Corporate / Mgt	66.4%	28.7%	4.9%
253 Medicine & Integrated Care	57.6%	38.8%	3.6%
253 Surgery	53.9%	43.6%	2.6%
Total	**57.7%**	**38.8%**	**3.5%**

All Staff

Org L2	No	Not stated	Yes	**Total**
253 Clinical Support	318	169	21	**508**
253 Corporate / Mgt	389	168	29	**586**
253 Medicine & Integrated Care	1313	885	83	**2281**
253 Surgery	1004	812	48	**1864**
Total	**3024**	**2034**	**181**	**5239**

All Staff

Staff Group	No	Not stated	Yes
Add Prof Scientific and Technic	59.4%	36.7%	3.9%
Additional Clinical Services	54.2%	43.0%	2.8%
Administrative and Clerical	64.0%	31.3%	4.7%
Allied Health Professionals	65.7%	29.6%	4.7%
Healthcare Scientists	41.8%	49.1%	9.1%
Medical and Dental	60.1%	38.2%	1.7%
Nursing and Midwifery Registered	53.5%	43.3%	3.1%
Students	89.5%	5.3%	5.3%
Total	**57.7%**	**38.8%**	**3.5%**

All Staff

Staff Group	No	Not stated	Yes	**Total**
Add Prof Scientific and Technic	123	76	8	**207**
Additional Clinical Services	631	500	33	**1164**
Administrative and Clerical	699	342	51	**1092**
Allied Health Professionals	266	120	19	**405**
Healthcare Scientists	23	27	5	**55**
Medical and Dental	324	206	9	**539**
Nursing and Midwifery Registered	941	762	55	**1758**
Students	17	1	1	**19**
Total	**3024**	**2034**	**181**	**5239**

Workforce Profile – Disability – Representation by Grade (excl. Medical & Dental)

Compared to the Trust average of 3.5%, disabled staff appear to be under represented at Band 2 (2.8%), Bands 8B (0%)+C (0%)+D (0%), and Trust Senior Manager level (1.3%).

Excluding Medical & Dental

Grade	No	Not stated	Yes
Band 2	55.4%	41.8%	2.8%
Band 3	57.7%	38.1%	4.3%
Band 4	64.3%	32.7%	3.0%
Band 5	56.4%	39.1%	4.5%
Band 6	55.5%	41.3%	3.1%
Band 7	58.1%	38.0%	3.9%
Band 8A	63.0%	32.6%	4.4%
Band 8B	52.2%	47.8%	
Band 8C	83.3%	16.7%	
Band 8D	75.0%	25.0%	
Band 9	66.7%		33.3%
Local Apprentice Scale	73.2%	14.1%	12.7%
Trust Director	33.3%	55.6%	11.1%
Trust Senior Manager	59.5%	39.2%	1.3%
Total	**57.4%**	**38.9%**	**3.7%**

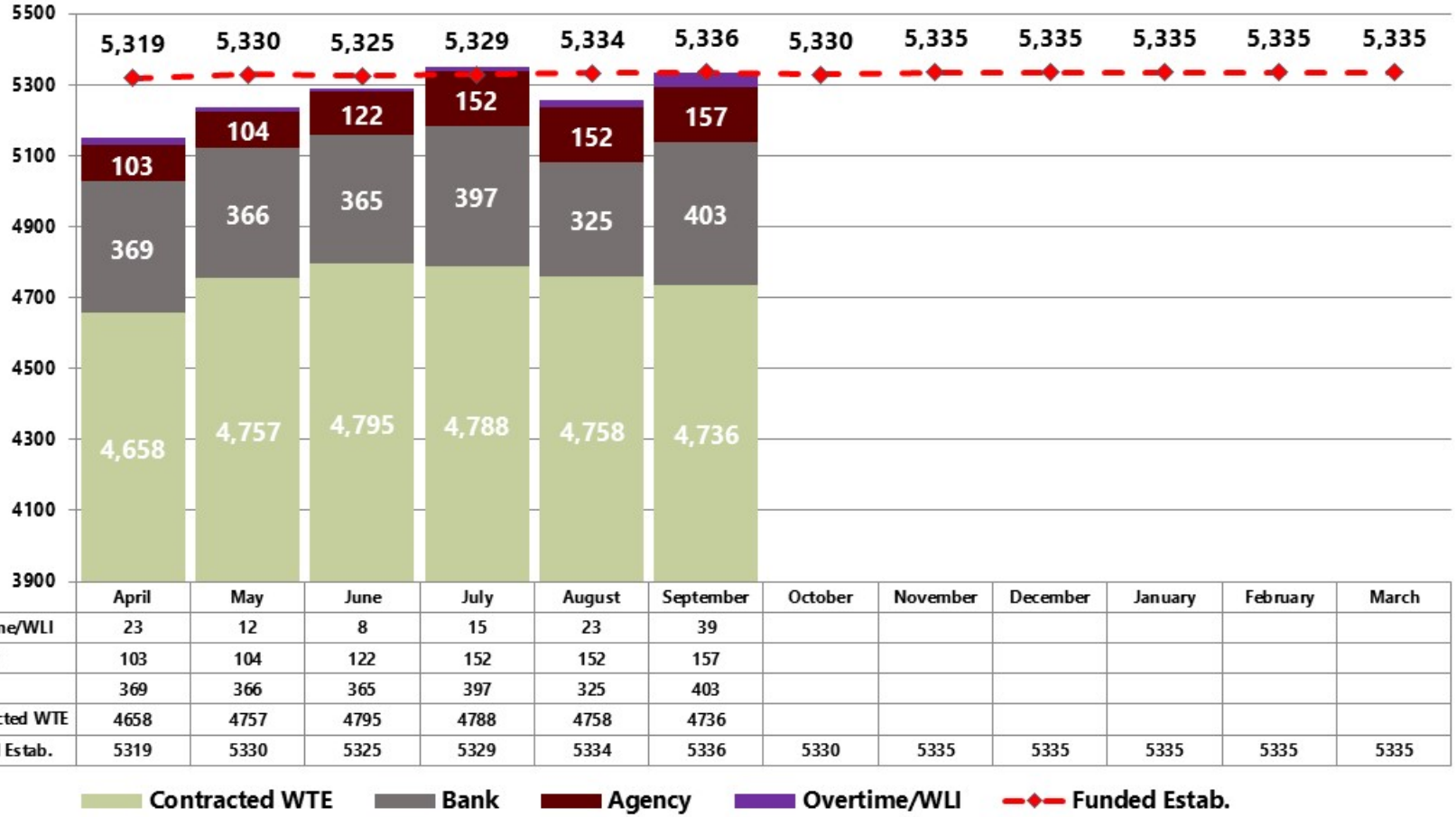
Excluding Medical & Dental

Grade	No	Not stated	Yes	Total
Band 2	650	490	33	**1,173**
Band 3	203	134	15	**352**
Band 4	256	130	12	**398**
Band 5	578	401	46	**1,025**
Band 6	529	394	30	**953**
Band 7	266	174	18	**458**
Band 8A	85	44	6	**135**
Band 8B	12	11		**23**
Band 8C	10	2		**12**
Band 8D	6	2		**8**
Band 9	2		1	**3**
Local Apprentice Scale	52	10	9	**71**
Trust Director	3	5	1	**9**
Trust Senior Manager	47	31	1	**79**
Total	**2,699**	**1,828**	**172**	**4,699**

Bank & Agency Usage - Trend

Agency use increased slightly in September (157 FTE) compared to August (152 FTE). Bank usage increased more significantly from 325 FTE in August to 403 FTE in September. Contracted staff in September fell by 22 FTE (4,758 to 4,736).

The sum of the contracted, bank, agency, and overtime in September added up to 5,335 FTE, against a total establishment budget of 5,336 FTE.



	April	May	June	July	August	September	October	November	December	January	February	March
Overtime/WLI	23	12	8	15	23	39						
Agency	103	104	122	152	152	157						
Bank	369	366	365	397	325	403						
Contracted WTE	4658	4757	4795	4788	4758	4736						
Funded Estab.	5319	5330	5325	5329	5334	5336	5330	5335	5335	5335	5335	5335

Bank & Agency Usage – By Division and Role

BANK:

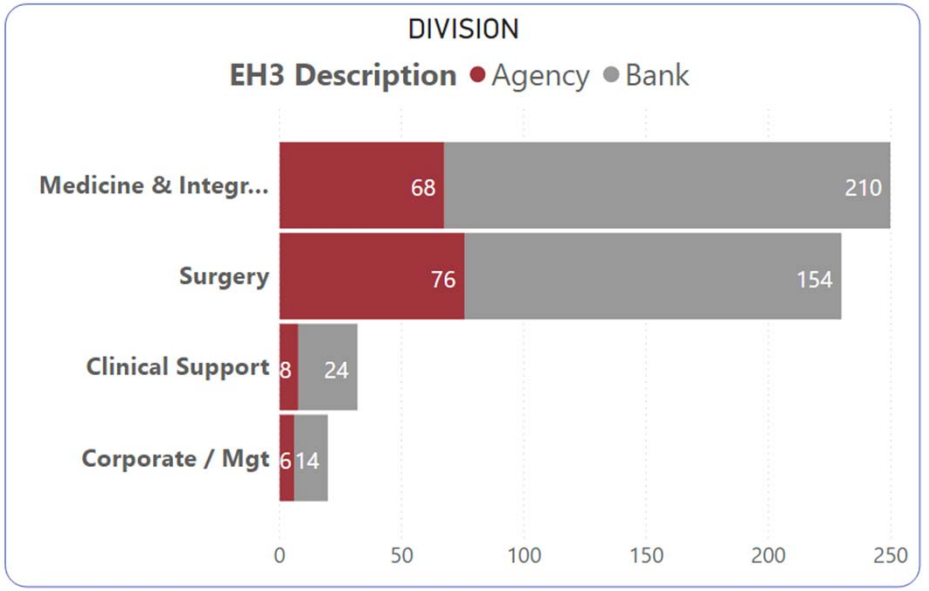
MIC's highest use of bank FTEs was in Unqualified Nursing at 79, followed by Qualified Nursing at 65.

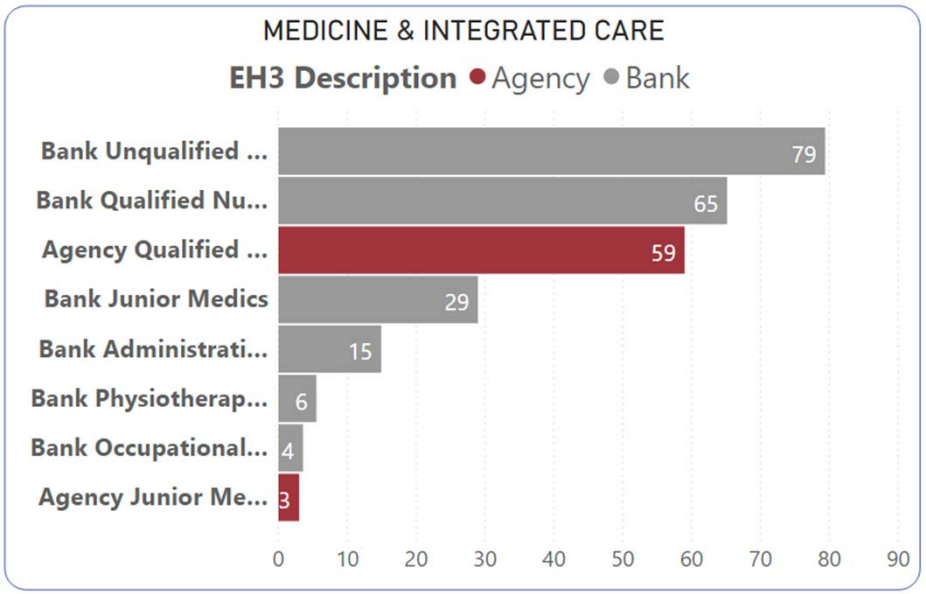
SURGERY used 53 FTE Qualified Nurses, and 51 FTE Unqualified Nurses.

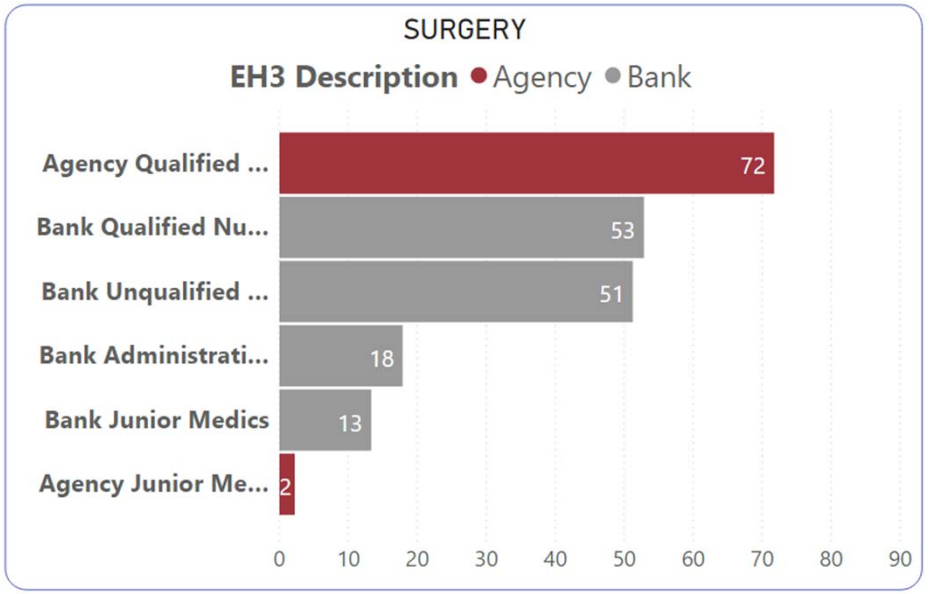
AGENCY:

SURGERY used 72 FTE Qualified Nurses/

MIC used 59 FTE Qualified Nurses.







Turnover

Turnover continues to fall, and is at 7.2% for September. For comparison the STP average turnover (latest data is for August) shows 11.4%.

Leavers was low for the month at 35, of which 13 were 'End of Fixed Term Contract'

September had 99 new people starting (90.5 FTE), with Specialty Registrars at 20, and Staff Nurses at 8.

	Starters	
	Head Count	FTE
Clinical Support	16	13.5
Corporate / Mgt	13	12.8
Medicine & Integrated Care	32	29.9
Surgery	38	34.3
Total	**99**	**90.5**

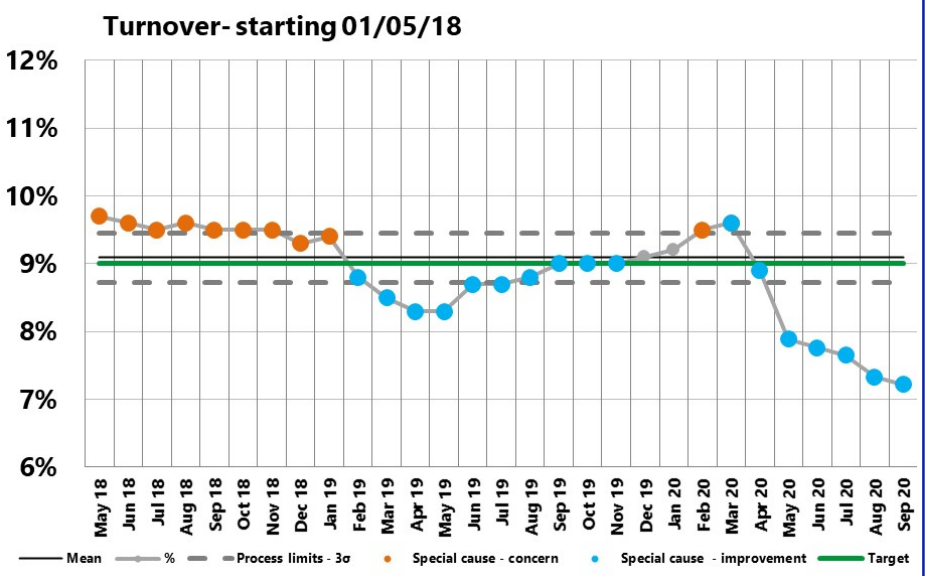
	Leavers	
	Head Count	FTE
Clinical Support	5	4.2
Corporate / Mgt	2	2.0
Medicine & Integrated Care	15	13.7
Surgery	13	10.9
Total	**35**	**30.8**

	Starters	
	Head Count	FTE
Full Time		
Fixed Term Temp	33	33
Permanent	42	42
Part Time		
Fixed Term Temp	7	4.4
Permanent	17	11.0
Total	**99**	**90.5**

	Leavers	
	Head Count	FTE
End of Fixed Term Contract	13	12.7
Has Not Worked	2	1.8
Retirement Age	9	6.2
Voluntary Resignation	11	10.0
Total	**35**	**30.8**

	Starters	
	Head Count	FTE
Specialty Registrar	20	19.3
Staff Nurse	8	7.0
Specialist Nurse Practitioner	5	4.4
Clerical Worker	5	4.4
Health Care Support Worker	5	3.8
Consultant	5	5.0
Doctor - Speciality Registrar	4	4.0
Assistant	4	3.6
Officer	4	4.0
Midwife	3	2.6
Technician	3	2.4
Physiotherapist	3	3.0
Manager	3	3.0
Medical Secretary	3	2.6
Radiographer - Diagnostic	3	2.8
Doctor - Foundation Level	2	2.0
Doctor - Career Grade Level	2	2.0
Dental Core Trainee	2	2.0
Healthcare Science Assistant	2	1.1
Analyst	2	2.0
Personal Assistant	2	1.5
Dietitian	1	1.0
Trainee Practitioner	1	0.6
Trainee Nursing Associate	1	1.0
Adviser	1	1.0
Secretary	1	0.8
Practitioner	1	1.0
Advanced Practitioner	1	1.0
Community Nurse	1	0.6
Receptionist	1	1.0

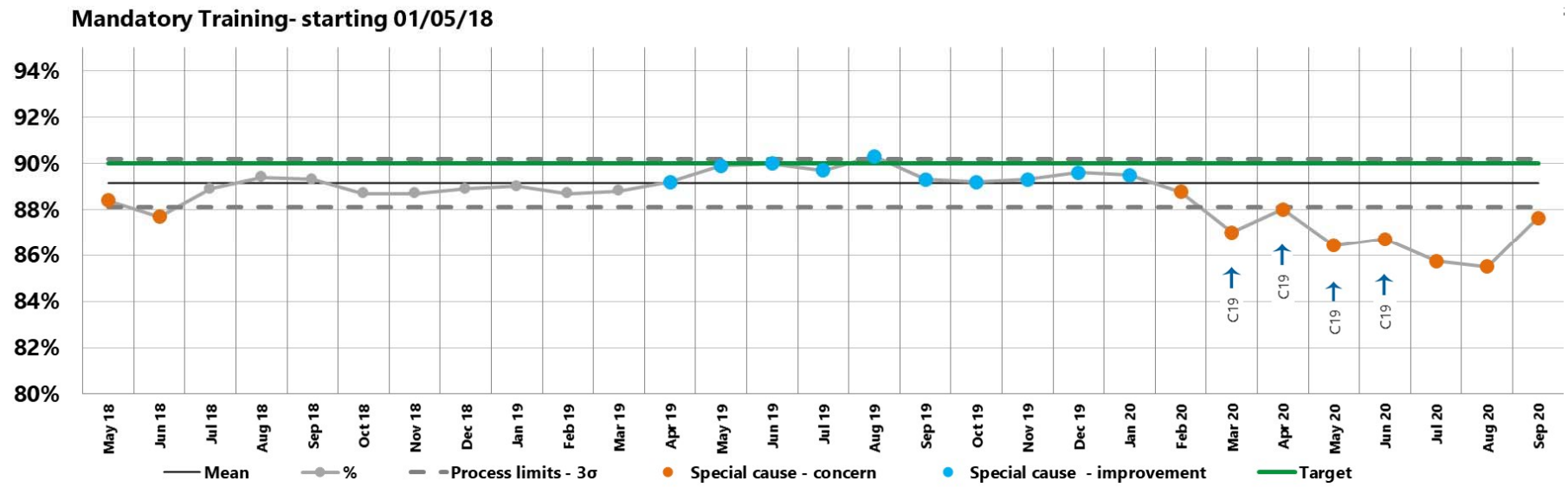
	Leavers	
	Head Count	FTE
Assistant	1	0.4
Clerical Worker	1	1.0
Dietitian	2	2.0
Foundation Year 2	1	1.0
Health Care Support Worker	4	3.2
Healthcare Assistant	1	0.8
Manager	2	2.0
Midwife	2	1.5
Officer	1	1.0
Radiographer - Diagnostic	1	0.4
Senior Manager	1	1.0
Sister/Charge Nurse	1	1.0
Specialist Nurse Practitioner	1	0.5
Specialty Registrar	11	10.7
Speech and Language Therapist	1	0.8
Staff Nurse	2	1.4
Trust Grade Doctor - Specialty Registrar	2	2.0
Total	**35**	**30.8**



Mandatory Training – Performance Trend

Mandatory training compliance improved in September to 87.6%, up from 85.5% in August.

Most topics improved with the exception of: RESUS Adults **-1.9%** Neonatal **– 2.0%** Paediatric **-1.0%**, and Safeguarding Children Level 3 **– 3.2%**



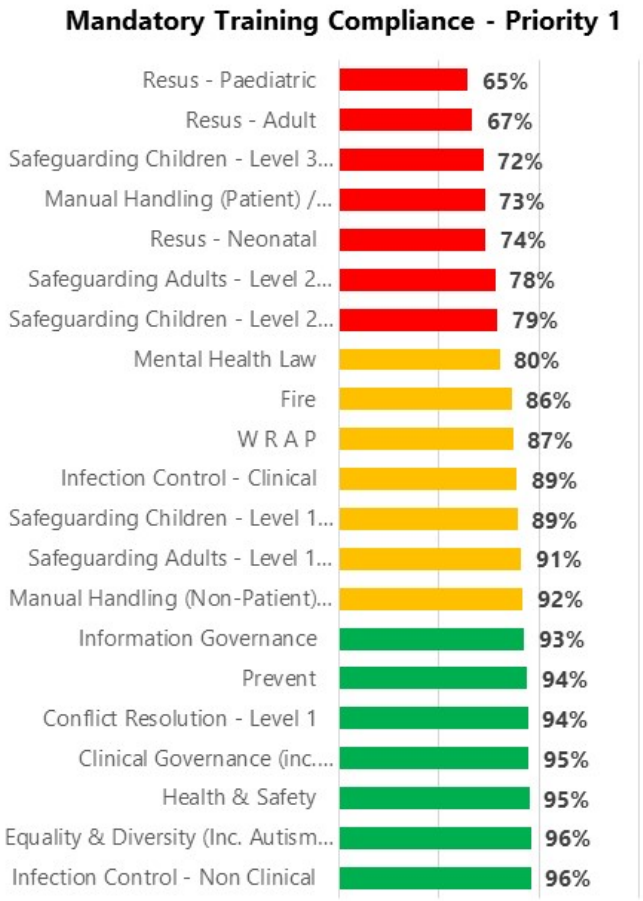
Month	Clinical Governance	Conflict Resolution - Level 1	Equality & Diversity	Fire	Health & Safety	Infection Control - Clinical	Infection Control - Non Clinical	Information Governance	Manual Handling (Non-Patient)	Manual Handling (Patient)	Mental Health Law	Prevent	Resus - Adult	Resus - Neonatal	Resus - Paediatric	Safe-guarding Adults-Level1	Safe-guarding Adults-Level2	Safe-guarding Children-Level1	Safe-guarding Children-Level2	Safe-guarding Children-Level3	W R A P
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%
September	95.0%	94.4%	96.0%	86%	95.3%	89.0%	96%	93%	92.0%	73.2%	80.4%	94.2%	66.7%	73.5%	64.5%	91.2%	78.3%	89.2%	79.3%	72.4%	87.2%
This Month v Last Month Variance																					
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%
Aug to Sep	0.3%	0.1%	0.3%	0.4%	0.9%	1.2%	0.1%	0.9%	0.9%	1.3%	0.0%	-0.1%	-1.9%	-2.0%	-1.0%	-0.2%	1.0%	0.3%	1.0%	-3.2%	0.0%

Mandatory Training – Areas of Focus

Resus continues to be a weak area, at Paediatric at 65% and Adult at 67%, with Surgery the most challenged (63% adults, 60% paediatrics)

Safeguarding Children Level 3 is also weak at 72% with MIC the most challenged (77% adults, 71% paediatrics)

Selected Mandatory Training Categories	Resus - Adult	Resus - Neonatal	Resus - Paediatric	Safeguarding Adults - Level 2 2020	Safeguarding Children - Level 3 2020
CLINICAL SUPPORT TOTAL	85%		72%	81%	
CORPORATE TOTAL	62%	100%	100%	87%	63%
MIC TOTAL	71%	0%	69%	77%	71%
SURGERY TOTAL	63%	75%	60%	74%	79%

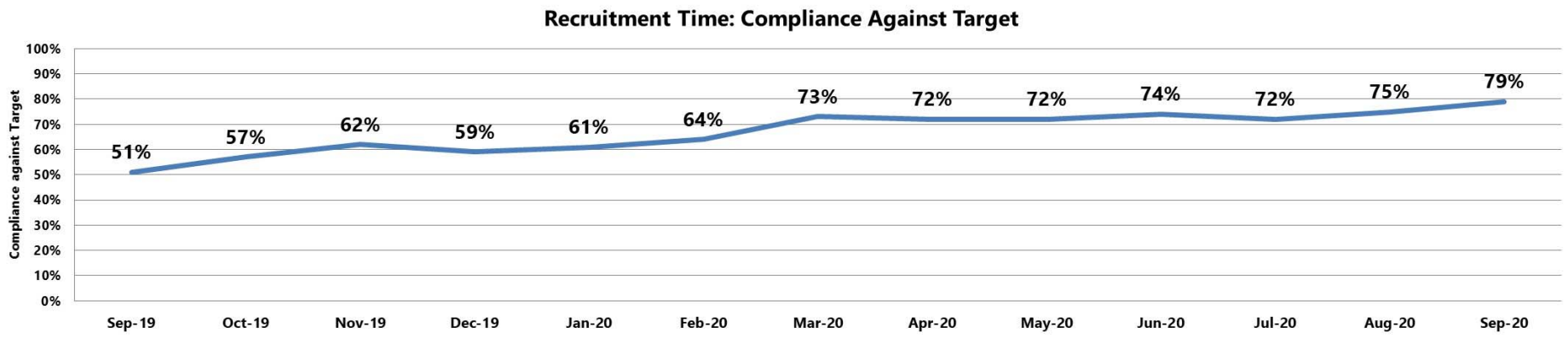


Selected Mandatory Training Categories		Resus - Adult	Resus - Neonatal	Resus - Paediatric	Safeguarding Adults - Level 2 2020	Safeguarding Children - Level 3 2020
Division	Directorate	>=90% >=80%	>=90% >=80%	>=90% >=80%	>=90% >=80%	>=90% >=80%
253 Clinical Support 84.7% (5194/6126)	253 Breast Screening 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%	
	CLINICAL SUPPORT TOTAL	85%		72%	81%	
253 Corporate / Mgt 89.4% (5572/6228)	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% (923/1033)	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 Strategy & Performance Dir 93.5% (72/77)					
	CORPORATE TOTAL	62%	100%	100%	87%	63%
253 Medicine & Integrated Care 85.7% (25474/29690)	253 Integrated Care Dir 88.9% (8648/9724)	79%		100%	82%	75%
	253 Medicine Division Management Dir 93.1% (205/220)	100%			100%	
	253 Nursing Medicine Dir 84.1% (11533/13699)	65%	0%	66%	75%	73%
	253 Specialist Medicine Dir 84.5% (3435/4064)	69%		45%	76%	
	253 Urgent Care Dir 83.3% (1653/1983)	71%		77%	66%	64%
	MIC TOTAL	71%	0%	69%	77%	71%
253 Surgery 84.3% (20311/24093)	253 Maternity Services Dir 87.8% (2868/3266)	64%	76%		79%	79%
	253 Nursing Surgery Dir 85.5% (7027/8216)	68%	82%	69%	72%	82%
	253 OPD and Health Records Dir 88.1% (1503/1706)	57%			88%	
	253 Specialist Surgery Dir 84.6% (1622/1917)	72%		80%	82%	
	253 Surgery Division Mgmt Dir 79% (121/153)	33%			50%	
	253 Surgery Urology & Vascular Dir 72.9% (783/1074)	41%		100%	59%	
	253 Theatres Anaes & Crit Care Dir 80.9% (4970/6139)	58%		48%	74%	
	253 Trauma & Orthopaedics Dir 89.9% (583/648)	68%			76%	
	253 Women and Children Dir 85.6% (834/974)	65%	65%	82%	69%	66%
	SURGERY TOTAL	63%	75%	60%	74%	79%
	OVERALL PERFORMANCE	68.6%	75.5%	65.5%	77.3%	75.6%

Recruitment

There is an overall improvement in compliance against targets, with an increase from 75% in August to 79% in September.

'Time to Shortlist' continues to be the most challenged area at 60% compliance to target.

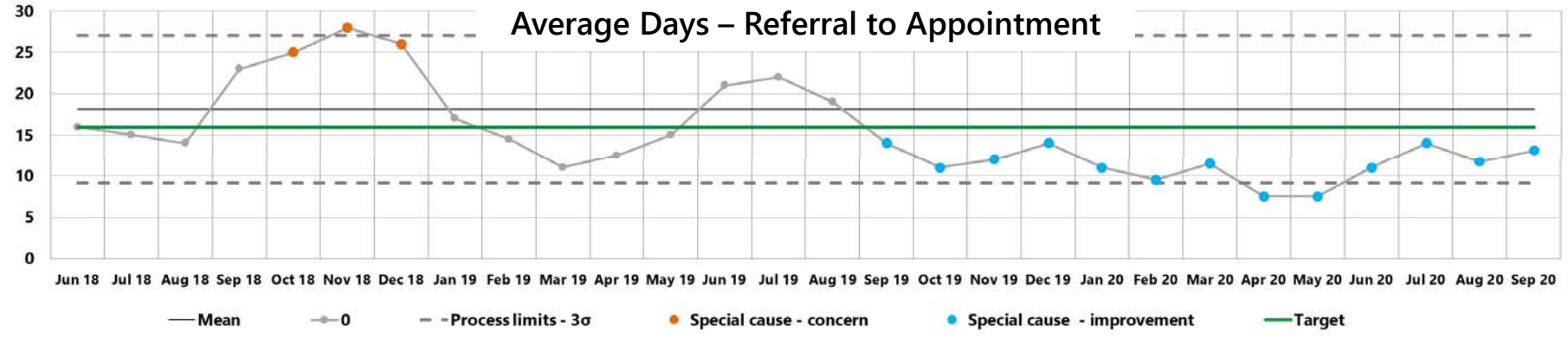


Trust Total Recruitment Time	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20
Time to Approve (8 Days)	60%	61%	63%	59%	73%	70%	72%	72%	85%	90%	95%	87%	91%
Time to Advertise (2 Days)	96%	94%	97%	94%	94%	94%	96%	97%	98%	90%	96%	95%	99%
Time to Shortlist (4 days)	38%	100%	61%	53%	56%	53%	50%	49%	51%	64%	61%	63%	60%
Time to send interview invites after shortlisting (2 Days)	100%	76%	100%	95%	97%	100%	100%	100%	100%	96%	99%	99%	100%
Time from sending invites to interview date (5 Days)	74%	76%	83%	77%	65%	68%	79%	79%	83%	76%	62%	76%	75%
Time from interview to conditional offer sent (2 Days)	72%	77%	84%	80%	55%	58%	68%	68%	54%	85%	88%	94%	92%
Time to complete PE Checks (27 Days)	47%	56%	66%	69%	54%	59%	57%	57%	75%	69%	83%	77%	85%
Total Time to Recruit (50 Days)	51%	57%	62%	59%	61%	64%	73%	72%	72%	74%	72%	75%	79%

Staff Health & Wellbeing – SHAW Service – Manager Referrals

Appointments held in September reduced to 15, down from 29 in August.

The SHAW service continues to offer appointments within the 15 day target.



Appointments Held

	2019													2020									
	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	%	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	%
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	11	**55%**
Counselling Referral	0	4	2	4	1	1	0	1	0	1	0	1	**3%**	0	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	2	**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	2	**32%**
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	0	**1%**
Total	**59**	**48**	**63**	**51**	**69**	**56**	**52**	**69**	**39**	**13**	**14**	**20**		**25**	**27**	**23**	**17**	**43**	**19**	**40**	**29**	**15**	

HR Caseload

The HR caseload has reduced from 50 in August to 45 in September. BAME staff are represented in 22% of cases. Overall, disciplinary cases account for 47% of cases (excluding suspensions).

	Suspension	Capability No UHR	Capability UHR	Disciplinary	Grievance	Total	% of Total
BAME		3	1	5	1	10	22%
Non-BAME	7	1	5	10	8	31	69%
Z Not Stated			1	3	0	4	9%
Total	**7**	**4**	**7**	**18**	**9**	**45**	

	Suspension	Capability No UHR	Capability UHR	Disciplinary	Grievance	Total	% of Total
Additional Clinical Services	1	0	4	2	0	7	16%
Administrative and Clerical		1	1	4	2	8	18%
Allied Health Professionals	1			2	7	10	22%
Medical and Dental				2		2	4%
Nursing and Midwifery Registered	5	3	2	8		18	40%
Total	**7**	**4**	**7**	**18**	**9**	**45**	

COVID: Staff Risk Assessment – 31 Aug Submission V Status at 16 September

The overall position has improved since the submission on 31st August, up from 95% to 98%. MIC has the largest number of outstanding assessments (73). Two staff groups add up to the majority of outstanding assessments; Additional Clinical Services, and Nursing and Midwifery Registered.

31 Aug Submission	Status at 0900 Monday 20 October				Progression
	Row Labels	Not Received	Received	Grand Total	% Complete	
97%	253 Clinical Support	13	445	458	97.2%	Improvement
98%	253 Corporate / Mgt	7	519	526	98.7%	Improvement
89%	253 Medicine & Integrated Care	73	2036	2109	96.5%	Improvement
100%	253 Surgery	3	1755	1758	99.8%	No Change
95%	**Grand Total**	**96**	**4755**	**4851**	**98.0%**	Improvement

Status at 0900 Monday 20 October				
Row Labels	Not Received	Received	Grand Total	% Complete
Add Prof Scientific and Technic		196	196	100.0%
Additional Clinical Services	32	1071	1103	97.1%
Administrative and Clerical	12	1003	1015	98.8%
Allied Health Professionals	6	364	370	98.4%
Healthcare Scientists	2	47	49	95.9%
Medical and Dental	19	465	484	96.1%
Nursing and Midwifery Registered	24	1551	1575	98.5%
Students	1	58	59	98.3%
Grand Total	**96**	**4755**	**4851**	**98.0%**

COVID: Staff Risk Assessment – by Division and Directorate

MIC has improved since last month up from 92.4% to 96.5%, with 73 assessments outstanding on 20th October.

Status at 0900 Monday 20 October				
Row Labels	Not Received	Received	Grand Total	% Complete
253 Medicine & Integrated C	**73**	**2036**	**2109**	**96.5%**
253 Integrated Care Dir	11	672	683	**98.4%**
253 Medicine Division Management Dir		19	19	**100.0%**
253 Nursing Medicine Dir	35	905	940	**96.3%**
253 Specialist Medicine Dir	21	289	310	**93.2%**
253 Urgent Care Dir	6	151	157	**96.2%**
Grand Total	**73**	**2036**	**2109**	**96.5%**

Status at 0900 Monday 20 October				
Row Labels	Not Received	Received	Grand Total	% Complete
253 Corporate / Mgt	**7**	**519**	**526**	**98.7%**
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 Managemer	1	49	50	**98.0%**
253 Strategy & Performance Dir		8	8	100.0%
Grand Total	**7**	**519**	**526**	**98.7%**

Status at 0900 Monday 20 October				
Row Labels	Not Received	Received	Grand Total	% Complete
253 Surgery	**3**	**1755**	**1758**	**99.8%**
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 Ca	3	421	424	**99.3%**
253 Trauma & Orthopaedics Dir		59	59	**100.0%**
253 Women and Children Dir		79	79	100.0%
Grand Total	**3**	**1755**	**1758**	**99.8%**

Status at 0900 Monday 20 October				
Row Labels	Not Received	Received	Grand Total	% Complete
253 Clinical Support	**13**	**445**	**458**	**97.2%**
253 Breast Screening Service Dir		40	40	**100.0%**
253 Cancer Services Manage	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%**
Grand Total	**13**	**445**	**458**	**97.2%**

Enclosure 22

The Dudley Group NHS Foundation Trust

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

TITLE:	**Board Assurance Framework – Quarterly Report**		
AUTHOR:	Liam Nevin	**PRESENTER**	Liam Nevin

CLINICAL STRATEGIC AIMS

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

ACTION REQUIRED OF COMMITTEE

Decision	Approval	Discussion	Other
		Y	

RECOMMENDATIONS

- That the Board note the risks and mitigations as set out in the BAF and summarised in this report.

CORPORATE OBJECTIVE:

All

SUMMARY OF KEY ISSUES:

The report provides an analysis of the corporate risk framework relating to the strategic BAF risks. It provides a composite picture of the strategic risks of the Trust and an analysis of key risk issues against each of the strategic objectives.

IMPLICATIONS OF PAPER:

IMPLICATIONS FOR THE CORPORATE RISK REGISTER OR BOARD ASSURANCE FRAMEWORK

The report is directly concerned with the Board Assurance Framework

RISK	**Y**		**Risk Description:** Covers all risks
	Risk Register: Y		**Risk Score:** Covers all risks
COMPLIANCE and/or LEGAL REQUIREMENTS	**CQC**	**Y**	**Details:** all Domains
	NHSI	**Y**	**Details:** Well led framework
	Other	**N**	**Details:**

REPORT DESTINATION	**EXECUTIVE DIRECTORS**	**N**	**DATE:**
	WORKING GROUP	**N**	**DATE:**
	COMMITTEE	**Y**	**DATE: Quality and Safety Committee 27.10.20, Workforce Committee 27.10.20, Finance and Performance Committee29.10.20**

1. EXECUTIVE SUMMARY

This report is accompanied by the Board Assurance Framework (BAF) which follows the revised structure agreed by the Board. The Trust's Risk Management Strategy provides that risks to be included on the Corporate Risk Register include those that *"directly impact on the delivery of the corporate aims,"* and that the BAF risks are *"significant and corporate risks that threaten an objective."* Therefore, the inter-relationship between the two processes means that there is a benefit in presenting an overview of both which triangulates the information and ensures that the Board is sighted on the most significant risks facing the organisation in relation to the attainment of strategic objectives. Included within the BAF is the October Corporate Risk Overview for each Committee and the background information below summarises the key risks arising from the corporate risk environment.

2. BACKGROUND

Set out below are the observations arising from the BAF and the Corporate Risk Register, presented against each of the strategic objectives.

Strategic Objective 1 – Deliver a Great Patient Experience

BAF 1A – We don't always effectively engage with patients in their care or involve them in service improvement as a result we fail to communicate with them effectively resulting in a poor patient experience which means patients will not see us as a provider of choice.

Five new actions have been implemented since the last review period and positive assurances are reported in respect of the varied forms of engagement that have been introduced (including Patient Voice Volunteers, You Said We Did Boards and Patient Panels.) However, it remains the case that FFT targets are not being achieved. In addition there is an increase in the number of complaints received and outstanding during the latter part of the reporting period.

The net risk score remains at 9 in this reporting period against a target risk of 6.

There are a further five actions pending (two of which have been delayed by COVID and are re-profiled) and which are designed to bridge the gap between net and target risk.

BAF 1B - Failure to meet access standards caused by inability to improve patient flow and work effectively with very local partners will result in an adverse outcome for the patient.

There are significant revisions to the risk description, causes and impact arising from COVID-19, in relation to patient care generally, but specifically with respect to performance against mandated targets.

The key controls are now focussed on restoration and recovery, with positive assurances reflecting that the Restoration and Recovery Plan is on track. However, there are reduced productivity and activity levels and extended patient waiting times in a number of areas. The control gaps remain the same as for the previous reporting period and there are five actions to increase capacity over the remainder of the financial year. Two of these actions are dependent upon the Modular Build.

The net risk score remains at 15. The target risk score of 8 is higher than the Board Risk Appetite (Cautious 4-6) and there is a significant difference between the level of risk currently being carried and the Board appetite.

In relation to the key controls, twelve of the fifteen are operational (and therefore the effectiveness of these controls is not subject to some form of validation outside of the service). This is a particularly high ratio.

Corporate Risk Register

There are two corporate risks that address strategic objective 1 which are overseen by the Quality and Safety Committee. Corporate risk 1010 (*failure to comply with local and statutory provisions for complaints management*) has remained in excess of the target risk score since June 2019.

Corporate Risk 1046 (*failure to deliver the Imaging CQC post inspection action plan*) has remained at 12 during this quarter, and it remains above the target score of 8.

Strategic Objective 2 – Safe and Caring Services

BAF 2A – If we do not achieve and demonstrate a good or outstanding rating with CQC and other regulatory standards we may be unable to achieve the level of quality of care and subsequently our reputation may be damaged

Two actions have been completed since the last review period. There are no changes to the controls or the gaps in assurance. There are four actions due over the rest of the financial year, two of which are new actions and one has slipped from its programmed completion date.

The net risk score remains at 9 and the target risk score is 4 which is consistent with the lower end of the Board Risk Appetite (4-6).

Nine of the twenty one key controls are operational (and therefore the effectiveness of these controls is not subject to some form of validation outside of the service) which is slightly higher than the expected ratio.

BAF 2B – Insufficient effective leadership and capacity may result in the trust being unable to efficiently manage and deliver safe services for our patients

Five actions have been implemented since the last review and these have provided two additional positive assurances and one partial assurance.

The risk score remains at 8. This is consistent with the target risk score but slightly higher than the Board Risk Appetite (4-6).

Corporate Risk Register

There are six corporate risks that address strategic objective 2 that are overseen by Quality and Safety Committee. A number of these risks have arisen from operational areas and are sufficiently serious as to directly impact on corporate aims (1015 *Deteriorating Patient Groups*, 896 *Temperatures in Medicine Storage Rooms*, 1145 *Neurosurgical Referral Pathways*, 1185 *review of radiological investigations*, 1301 *Implementation of Liberty Protection Safeguards*). The risk scores remain consistent with the last reporting period.

Strategic Objective 3 – Drive Service Improvements, Innovation and Transformation

BAF 3A – The Dudley Improvement Strategy may not be delivered due to insufficient transformational leadership capability and capacity, resulting in a lack of innovation and a failure to improve services

There are no changes to report from the previous quarter and no change in the net risk score, which remains within the Board risk appetite.

Strategic Objective 4 – Be the Place People Choose to Work

BAF 4A – Be the place people choose to work

Four actions have been implemented since the last review although there is no change in key controls, positive or negative assurances. There are eleven significant further actions planned during this financial year to address the supply issues encapsulated in this risk, and these can be broadly categorised as strategy development, planning and targeted recruitment programmes.

The net risk score remains at 16 against a target of 12.

BAF 4B – *If we fail to train and develop our workforce to have the right skills to enable the delivery of our clinical strategy, due to inadequate career development, talent management and leadership development, this may result in poor retention rates, difficulties recruiting and a failure to maximise*

Five actions have been implemented since the last review period and an additional key control is now in place (implementation of the Managers Essential Programme). Three of the actions relate to the recent implementation of initiatives in respect of which it is too early to assess their effectiveness on the control environment.

A further five actions are planned over the remainder of the financial year.

The net risk score remains at 12 against a target of 8.

BAF 4C - Failure to effectively engage and involve our workforce by not listening, innovating and acting on their feedback and communicating effectively could lead to an inability to positively improve culture

Six actions have been implemented since the last review. Four of the actions are reporting positive assurance, and an additional control has been implemented with the introduction of the new staff engagement model. The development of effective Divisional Engagement Plans is a recognised gap in control and there is an action to address this by January 2021.

The net risk score has reduced from 16 to 12 and is now aligned with the target risk score.

In summary, two of the risk scores (4A and B) remain the same as the last reporting period, but there is an improvement on the engagement risk score (4C).

Corporate Risk Register

There are two corporate risks that relate to strategic objective 4.The BAF risks are concerned with recruitment, training and development and engagement, whilst the Corporate risks being managed by the Committee concern staff absence (981), and staff engagement and morale (1303). High

corporate risk scores on sickness and staff morale will influence the strategic BAF risk as they may impact on the place people choose to work (strategic objective 4).

Strategic Objective 5 – Make the Best Use of What We Have

BAF 5A – Failure to recognise the importance and impact of our constrained financial position due to a lack of understanding, engagement and financial discipline mean we miss key financial targets, run out of cash and come under greater regulatory scrutiny

Two new actions have been implemented since the last review period and the enhanced cash position and avoidance of borrowing has resulted in a reduction of the net risk score to eight. This is within risk appetite and the target risk score.

There is one action outstanding.

BAF 5B – Failure to successfully adopt digital workflows, due to competing organisation / clinical pressures, availability of resources and change fatigue; results in clinical risk, reputational risk and inefficiency

Eleven actions have been implemented since the last review period. The net risk score remains at 8 but this is within the Board risk appetite.

Corporate Risk Register

A cyber threat is an acknowledged risk in the BAF (5B) in relation to the successful adoption of digital workflows. It is also recorded in the CRR with the highest potential risk score. The mitigations and controls currently included in the CRR have been incorporated into the BAF. The corporate risk does not directly relate to the adoption of digital workflows (the strategic risk) and therefore it is not proposed to amend the net strategic risk score. It does however create an underlying risk to disruption of Trust business including digital workflows, and is therefore a cross organisational risk.

Strategic Objective 6 – Deliver a Viable Future

BAF 6A – Failure of the Trust to influence the local and wider evolving health economy due to a lack of engagement and poor performance undermining our credibility means our clinical and financial viability is undermined as we lose key high value services and opportunities for profitable growth

The risk causes and impacts have been substantially rebased to reflect the level of challenge and uncertainty in the local health economy currently.

Correspondingly, the controls have been reviewed and updated to reflect the changes to the risks and causes and the key actions are focussed on the strategic issues requiring further assurance, notably engagement, the development and implications of the ICP, and the Acute Collaboration project.

Sixteen high level actions/activities have been implemented since the last review. This is the most significant activity recorded on the BAF during this quarter, reflecting the significant resource commitment that the Trust is investing in mitigation of these risks. However, the net risk score remains at 20, which continues to be the highest risk on the BAF.

Corporate Risk Register

There are no corporate risks impinging on the BAF strategic risks.

3. RISKS AND MITIGATIONS

Based on the following criterion:

- Controls and recent actions having limited or no impact on net risk scores
- The gap between current risk score and target risk score
- Significant corporate risks

The failure to meet access standards (1A), Recruitment (4A) and the position of the Trust in the wider health economy (6A) (particularly in relation to the MCP) are the highest risks. The mitigations are set out in the BAF itself.

4. RECOMMENDATIONS

- **That the Board note the risks and mitigations as set out in the BAF and summarised in this report.**

Liam Nevin

Board Secretary

November 2020

Appendix

BOARD ASSURANCE FRAMEWORK

Board Assurance Framework –November 2020[1]

KEY

RISK SCORE

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

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

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

Key to Control Levels

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

Board Risk Appetite

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

[1] As of 12 October 2020

RISK PERFORMANCE

Scores calculated: Likelihood x Impact

BAF Risks	CURRENT RISK SCORE	PREVIOUS RISK SCORE	BOARD RISK APPETITE	TARGET RISK SCORE
BAF 1A - We don't always effectively engage with patients in their care or involve them in service improvement as a result we fail to communicate with them effectively resulting in a poor patient experience which means patient's will not see us as a provider of choice	9	9	Cautious 4-6	6
BAF 1B - Failure to meet access standards caused by inability to improve patient flow and work effectively with very local partners will result in an adverse outcome for the patient	15	15	Cautious 4-6	8
BAF 2A - If we do not achieve and demonstrate a good or outstanding rating with CQC and other regulatory standards we may be unable to achieve the level of quality of care and subsequently our reputation may be damaged	9	9	Cautious 4-6	4
BAF 2B - Insufficient effective leadership and capacity may result in the trust being unable to efficiently manage and deliver safe services for our patients	8	8	Cautious 4-6	8
BAF 3A - The Dudley Improvement Strategy may not be delivered due to insufficient transformational leadership capability and capacity, resulting in a lack of innovation and a failure to improve services	8	8	Moderate 8-12	8
BAF 4A - An inability to recruit sufficient numbers of appropriately trained staff due to national and local staff shortages may impact on being unable to meet service demand or provide safe, high quality services resulting in increased temporary workforce spend	16	16	Moderate 8-12	12
BAF 4B - If we fail to train and develop our workforce to have the right skills to enable the delivery of our clinical strategy, due to inadequate career development, talent management and leadership development, this may result in poor retention rates, difficulties recruiting and a failure to maximise the capabilities of staff	12	12	Moderate 8-12	8
BAF 4C - Failure to effectively engage and involve our workforce by not listening, innovating and acting on their feedback and communicating effectively could lead to an inability to positively improve culture	12	16	Moderate 8-12	12

BAF 5A - Failure to recognise the importance and impact of our constrained financial position due to a lack of understanding, engagement and financial discipline mean we miss key financial targets, run out of cash and come under greater regulatory scrutiny	8	12	Moderate 8-12	10
BAF 5B - Failure to successfully adopt digital workflows, due to competing organisation / clinical pressures, availability of resources and change fatigue; results in clinical risk, reputational risk and inefficiency	8	8	Moderate 8-12	12
BAF 6A - Failure of the Trust to influence the local and wider evolving health economy due to a lack of engagement and poor performance undermining our credibility means our clinical and financial viability is undermined as we lose key high value services and opportunities for profitable growth	20	20	Moderate 8-12	12

Strategic Objective		SO1 Deliver a great patient experience				Committee		Exec Lead	
						Quality and Safety Committee		Chief Nurse	
Strategic Risk No	BAF 1a	**Pre Mitigations Risk Score**	L x I 4X3 (12)	**Post Mitigations Current Risk Score**	L x I 4X3 (9)	**Board Risk Appetite** Cautious		**Target Score**	L x I 2X3 (6)

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

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

Quarters – Changes in Post Mitigation Risk Score	**Q1**	**Q2**	**Q3**	**Q4**
	9	**9**		

KEY CONTROLS IN PLACE	ASSURANCE THAT CONTROLS ARE EFFECTIVE [Yes / No (if no what action needs to be taken)]	LEVEL of CONTROL 1 = Operational 2 = Committee 3 = External
Patient experience strategy	Yes	2
Quality priorities focussed on reducing harm	Yes	2
Pt feedback actions sought via FFT, patient surveys, feedback Fridays	Yes – now being done virtually, response rates have improved with the re-opening of the paper form but remain lower than pre Covid. National FFT programme will recommence December 20	3
Complaints process and reporting	Yes – in place and routinely reported at team/ divisional level	1

PALS Reports	Yes	1
Perfect ward quality metrics	Yes	1
Quality priorities metrics reported via IPR	Yes	2
Learning from complaints group and reports	Yes- Learning by experience and Quarterly CLIP reports	2
Patient Experience group and associated work plan	Yes	2
Patient Experience improvement work streams across all services	Yes	1
LIA in place to capture and respond to feedback	Yes	2
Participation in annual patient surveys	Yes	3
Patient Panels	Yes – being held virtually reported through Patient Experience Group	3

ACTIONS IMPLEMENTED SINCE LAST REVIEW	IMPACT OF CONTROLS AND ACTIONS ON RISK/ASSURANCE
• Identification of bedside tablets to be piloted across identified clinical areas – tablets purchased • Patient Panels implemented remotely • Purchase of ‘‘What Matter to You Matters to Us’ Patient Experience feedback trolley • Framework of monitoring compliance and challenge for complaint response rates at performance meetings is in place • Implementation of the complaints team attending divisional audit meetings to discuss complaints	**Positive Assurance** • Patient Panels occurring via Teams, Positive outcomes identifying areas of good practice and areas for development – reported through the Patient Experience Group • Roll out initially virtually due to covid to prevent delay in its implementation and benefits the ‘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 when they are able to go into clinical areas • 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. • The new You Said We Did boards have been approved to display and share the feedback - these are presently to be put on order. • Complaints now attend the divisions audit meetings monthly and go through their complaints to achieve resolution. • Divisions present as part of their report for the Performance Meeting their number of complaints and compliance to completion in timescale this remains a concern

	regarding % compliance with timeliness of responses. **<u>Negative Assurance</u>** • Embedding of a framework of volunteers engaged to regularly walk round to encourage feedback has been temporarily suspended due to Covid 19 restrictions around social distancing and risks for vulnerable groups who act as volunteers. Recruitment has been negatively impacted. This is negatively impacting on responses • For FFT as of August 2020 inpatient departments had not achieved their monthly percentage response rate targets with no areas achieving their percentage recommended FFT scores. From September the FFT process/question has changed and the Trust will no longer be measured on response rates and the timeframe has been removed. We will now be measured on action taken to improve % recommended scores. • There has been an increase in the number of complaints received in September 2020 with 88 received compared to 59 for August and 71 for July. There are a total of 214 complaints open compared to 199 as of 3 September 2020 and 77 complaints awaiting a written response in the backlog (previously 70)

SPECIFIC GAPS IN CONTROL / ASSURANCE	**ACTIONS**	**STATUS:**		
		COMPLETE	**IN PROGRESS**	**OUTSTANDING (BEYOND COMPLETION DATE**
The main areas of weakness which result in ineffective or absent controls / assurance	*Actions required to mitigate the weaknesses*	*Date for completion*		*Action Lead*
Timely response (complaints process~) not occurring at Directorate level	Embed a framework of monitoring compliance and challenge for complaint response rates at performance meetings.	Dec 2019		Karen Kelly

	Appointment of additional resource to support divisions to respond to complaints	Completed	Jill Faulkner
	Continue to raise the profile of Feedback Fridays	Completed ongoing	Jill Faulkner
FFT responses are below agreed trajectory	Embed a framework of volunteers engaged to regularly walk round to encourage feedback needs	Completed ongoing	Jill Faulkner
	Complete audit of effectiveness of volunteers visiting clinical areas to encourage feedback	Completed ongoing	Jill Faulkner
	To embed a framework of actions shared from feedback received on the You Said We Did boards *Action completion date delayed and has been extended due to impact of COVID restricting access to clinical areas and work priorities- boards have been agreed*	~~Jan 2020~~ January 2021	Liz Abbiss
	Launch 'what matters to you' National Campaign	January 2020 Completed	Jill Faulkner
	Recruitment of experts by experience *Action completion date delayed and has been extended due to impact of COVID restricting access to clinical areas – although attempts are to be made to recruit virtually*	~~July 2020~~ March 2021	Jill Faulkner
	Set up Patient Panels	March 2020 Completed	Jill Faulkner

	Development and delivery of a patient experience trolley to be taken to the wards	August 2020 Completed	Jill Faulkner
	Review possible recruitment of Patient Voice Volunteers	January 2021	Tracy Cross
	1 month Pilot of tablets by each bedside which will contain welcome booklets, FFT, surveys, menus, Trust Website Etc	January 2021	Jill Faulkner

Strategic Objective		**SO1 Deliver a great patient experience**				**Committee**	**Exec Lead**	
						Quality and Safety Committee	Chief Operating Officer	
Strategic Risk No	BAF 1b	**Pre Mitigations Risk Score**	L xC 5x4 (20)	**Post Mitigations Current Risk Score**	L x C 5x3 (15)	**Board Risk Appetite** Cautious	**Target Score**	L x C 2x4 (8)
RISK: Failure to meet access standards by Mar 2021 which includes RTT / DMO1 /Cancer/EAS								

Cause	**Impact of the Risk**
• Reduced outpatient, diagnostic and treatment capacity due to COVID-19 • Clinicians re-deployed to support other pathways, including emergency to support response to COVID-19 • Reduced patient contact for patient requiring routine consultations, investigations and treatment to reduce infection rate of COVID-19 • Measures and precautions put in place in line with national guidance to support response to COVID-19, including social distancing measures	• Harm to patients as a result of waiting times • Failure to achieve 92% RTT incomplete standard • Increased risk of 52 week breaches • Failure to meet DMO1 standard • Failure to meet 62 day cancer standard • Poor patient experience • Delayed patient care potential poorer outcome

• Reduction in patients willing to come into hospital for treatment and requesting to delay their appointments in fear of contracting COVID-19. • National RTT guidance released specifically for COVID-19, does not allow RTT clocks to be stopped as a result of patient initiated delays for COVID-19 reasons. • Priority has been clinically urgent (including cancer) patients with what operational capacity has been available. Increase referrals over coming months as primary care restarts will increase the likelihood of worsening performance as the denominator of the waiting lists across all statutory targets reduces.	• Poor Trust reputation • Future financial impact • Staff morale

Quarters – Change in Post Mitigation Scores	Q1	Q2	Q3	Q4
	15	15		

KEY CONTROLS IN PLACE	ASSURANCE THAT CONTROLS ARE EFFECTIVE [Yes / No (if no what action is being taken)	LEVEL of CONTROL 1 = Operational 2 = Committee 3 = External
Weekly Trust Operational Group	Yes	1
Weekly Trust RTT Meeting	Yes	1
Outpatient Taskforce Meeting	Yes	1
COVID Taskforce Meeting	Yes	1
Theatres Restoration and Recovery Meeting	Yes	1
Access Policy Review & Training in line with national guidance	Yes	1
Weekly Independent Sector Meeting	Yes	3
Weekly Cancer PTL meeting	Yes	1
Monthly Cancer steering group	Yes	2
Monitoring tool to robustly report & monitor activity & performance	Yes	1
Weekly operational restoration & recovery meeting	Yes	1

Interim Cancer manager in post	Yes	1
Weekly Executive meeting	Yes	1
Finance and Performance Committee	Yes	2
STP Restoration and Recovery	Yes	1

ACTIONS IMPLEMENTED SINCE LAST REVIEW	IMPACT OF CONTROLS AND ACTIONS ON RISK/ASSURANCE
This BAF has been refreshed to in its entirety to reflect the Trusts post c-19 position	Positive Assurance • Re-introduced weekly Trust RTT and Cancer PTL meeting with positive assurance that restoration of services is on track • Restoration of theatres • Independent sector being used in theatres for surgical pathways • Routine diagnostics have re-commenced • Small number of 52 week breaches in August and September • RTT improved • Overall patient waiting list has reduced by circa 1000 patients compared to pre-COVID • Dedicated cancer informatics / business analyst in post • 77% reduction in patients over 104 days cancer on track to deliver agreed activity levels • Continue to deliver virtual appointments • Increase in face to face appointments where required Negative Assurance • Productivity and activity levels affected due to social distancing measures • Reduced activity due to limited operational capacity available • Patients waiting more that 6 weeks for DMO1 related

	diagnostics have increase pre c-19 levels • GP referrals are increasing back towards pre-COVID levels resulting in overall waiting list size to grow • Face to face outpatient appointments reduced due to social distancing measures, resulting in discharge percentage to be less, requiring further appointments • Theatre activity levels not to pre-Covid levels as yet • Weekend lists currently being discussed to be confirmed November 2020 • Currently clinicians are not redeployed to other pathways

SPECIFIC GAPS IN CONTROL / ASSURANCE	**ACTIONS**	**Completed**	**In progress**	**Outstanding (beyond completion date)**
The main areas of weakness which result in ineffective or absent controls / assurance	*Actions required to mitigate the weaknesses*			*Date for completion*
• Lack of treatment capacity, particularly theatre • Reduced outpatient activity overall as restoration continues • Diagnostic waits have increased, impacting overall pathway waiting times • Reduced productivity across all pathways due to social distancing and COVID-19 precautions • GP referrals increasing • High proportion of waits over 18 weeks and ability to treat more patients that are waiting over 18 weeks versus the number that are added each week is not possible at present • Staff fatigue and availability to support increase in capacity out of hours	Independent sector theatre capacity available to Dudley Group would need to treble to increase activity levels to required level			Completed
	Extend one theatre each day into the evening			Completed
	Run four all day elective lists each weekend			1st November 2020
	Build a modular theatre and connect it to main theatres on the 1st floor			31st March 2021
	Increase outpatient levels to pre-COVID state Restoration and Recovery Plan March 2021 Trajectory			March 2021

	Reduce diagnostic waits to within DM01 standards through provision of additional internal and independent sector capacity.	28 February 2021
	4th endoscopy room in place	Completed
	Have in place dedicated cancer informatics / business analyst	Completed
	Modular build in place to increase capacity	31 December 2020

Strategic Objective		**SO2 Safe and Caring services**				**Committee**	**Exec Lead**	
						Quality and Safety Committee	Chief Operating Officer	
Strategic Risk No	BAF 2a	**Pre Mitigations Risk Score**	4X4 (16)	**Post Mitigations Current Risk Score**	3x3 (9)	**Board Risk Appetite** Cautious	**Target Score**	1X4 (4)

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

Cause / Effect

- Failure to demonstrate we deliver care in line with regulatory standards
- Perceived reputational damage
- Risk of harm to patients as statutory standards not met
- Impact on staff morale
- Impact on recruitment and retention
- Increased scrutiny resulting in clinicians potentially being diverted from direct patient care

Impact of the Risk

- Reduced influence with external organisations e.g. NHSI, CCG
- Potential impact on ability to recruit staff particularly to senior management positions
- Reduced ability of the Trust to take independent decisions
- Staff become disengaged
- Increased vacancies and over reliance on agency staff
- Increased sickness
- Staff wellbeing is affected
- Patients at risk of not receiving timely interventions
- Poor overall patient/family experience

Quarters - Change in Post Mitigation Scores	**Q1**	**Q2**	**Q3**	**Q4**
	9	9		

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

ACTIONS IMPLEMENTED SINCE LAST REVIEW	IMPACT OF CONTROLS AND ACTIONS ON RISK/ASSURANCE
• Lead Medical Examiner appointed and in post • Additional senior doctor input to Mortality Process recruited and in post	MTI Programme – delayed as a result of the pandemic. Work is now re-starting but date for completion extended to allow time to seek the required authorisations, advertise and recruit and taking into account current travel

• Revised TOR and meeting structure to include speciality level input for MSG • Care bundles implemented for AKI/ALD/Sepsis and Pneumonia	restrictions.

SPECIFIC GAPS IN CONTROL / ASSURANCE	**ACTIONS**	**STATUS:**		
		COMPLETE	**IN PROGRESS**	**OUTSTANDING (BEYOND COMPLETION DATE**
The main areas of weakness which result in ineffective or absent controls / assurance	*Actions required to mitigate the weaknesses*	*Date for completion*		*Action Lead*
• Increase in demand for specific cancer pathways e.g. Breast • RWT challenged capacity for robotic surgeries for Urology • Increased demand and ambulance arrivals • DM01 – increase in demand overall, and on the day diagnostics • Mortality reviews not sufficiently robust in providing learning that is shared across the trust • Assessment & analysis of recruitment events to inform where to concentrate resources • Expansion of the MTI programme to more countries • Disjointed approach to staff education, development & education • Leadership Programme – gap with medical leaders engagement • Step up to Care programme only provides development at corporate level associated to management development and needs to be broadened to capture other staff development. • Further development of the OD programme	Plan for CT refit commencing June	Completed		S Jackson
	Business Case to redesign & enhance cancer tracking team	July 2020		S Jackson
	EAS System Improvement Plan	Closed		K Kelly
	Review of Mortality meetings & processes	Completed		P Brammer
	MTI programme to be developed alongside one other country and managed effectively within Medical Management fortnightly meetings.	~~Oct 2019~~ Oct 2021		Hassan Paraiso/Jess Haycock
	Review areas of further collaboration across education and training providers under the remit of the Workforce Group	Complete - BAU		Rachel Andrew, Carol Love-Mecrow and Atiq Rehman
	Undertake review and audit of data collection systems that record training information to determine what changes can be made to provide better level of detailed analysis and information.	Closed		Becky Cooke

	The introduction of the 'Make it Happen' OD programme supported with the Staff Engagement plan, the behavioural framework and the anti-bullying campaign.	Completed	Rachel Andrew
	Plan to support detailed preparation for the forthcoming Staff Survey in 2019.	Completed	Rachel Andrew
	Development programme to include skills associated to engagement and support for staff and colleagues. This will also be supported by the introduction of anti-bullying campaign	Completed	Rachel Andrew & Becky Cooke
	Modular build to increase capacity	31/12/20	Qadar Zada
	Further IT input required to develop electronic order sets for deteriorating patient pathways.	31/03/21	Adrian Jennings

Strategic Objective		**SO2 Safe and Caring services**				**Committee**	**Exec Lead**	
						Quality and Safety Committee	Medical Director	
Strategic Risk No	BAF 2b	**Pre Mitigations Risk Score**	L x I 4X4 (16)	**Post Mitigations Current Risk Score**	L x I 2X4 (8)	**Board Risk Appetite** **Cautious**	**Target Score**	L x I 2X4 (8)

Insufficient effective leadership and capacity may result in the trust being unable to efficiently manage and deliver safe services for our patients

Cause	**Impact of the Risk**
• Insufficient time allocated to leadership roles • Operational demands conflict with leadership roles related to governance and engagement. • Staff lack understanding of the potential of leadership to deliver service improvement	• Quality improvement work not undertaken or is ineffective - Mortality reduction not achieved or maintained - CIP not delivered - EAS, cancer and diagnostic waiting times not achieved • Reduced staff morale and engagement

• No shared vision for the organization	• Negative impact on reputation • Poor recruitment and retention			
Quarters – Changes in Post Mitigation Risk Scores	**Q1**	**Q2**	**Q3**	**Q4**
	8	8		

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

ACTIONS IMPLEMENTED SINCE LAST REVIEW	IMPACT OF CONTROLS AND ACTIONS ON RISK/ASSURANCE
• Appointment of Lead Medical Examiner and additional senior medical input to drive forward leaning from deaths • Development of Clinical Leaders Programme • Implementation of AQ Methodology (Pathway Bundles and understanding of QI) • Launch of CAG framework led by Clinical Service Lead	• Positive assurance - Team now in post and contributing to leadership of learning from deaths • Initial work underway – too early to assess impact on controls • Positive assurance - Compliance reported in LfD board paper • Partial assurance - developing leadership in system working and pathway development

SPECIFIC GAPS IN CONTROL / ASSURANCE	ACTIONS	STATUS:

		COMPLETE	IN PROGRESS	OUTSTANDING (BEYOND COMPLETION DATE

The main areas of weakness which result in ineffective or absent controls / assurance	*Actions required to mitigate the weaknesses*	*Date for completion*	*Action Lead*
Assessment of effectiveness.	Staff survey	Dec 20	HRD
Earned autonomy /Competency framework	Develop earned autonomy framework	Dec 19	CofMed / CofSur
Participation in Chief Registrar Programme	Applications for 2021 programme due to open December 2020	Dec 20	HRD

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

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

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

Quarters – Change in Post Mitigation Scores	**Q1**	**Q2**	**Q3**	**Q4**
	8	**8**		

KEY CONTROLS IN PLACE	**ASSURANCE THAT CONTROLS ARE EFFECTIVE [Yes / No (if no what action is being taken)**	**LEVEL of CONTROL**

		1 = Operational 2 = Committee 3 = External
Contract with NHSI/E until June 2021 provides support from an Improvement consultant for 2 days per week and an executive coach for 8 days per annum	Yes	3
Training at three levels of competency is in place and currently being undertaken by the exec team	Yes	1
The Improvement Practice team has a total of four members of staff and 3 additional posts have been approved from April 2021, bringing the team capacity in line with the national average for the Vital Signs cohort of 8 trusts.	Yes	2

ACTIONS IMPLEMENTED SINCE LAST REVIEW	**IMPACT OF CONTROLS AND ACTIONS ON RISK/ASSURANCE**
The DIP team were redeployed for 4 months during the Covid peak to assist with running the Incident room. The Gastro pathway event scheduled for April 2020 was postponed. To relaunch the Gastro pathways improvement work stream, an exec workshop was held in August and the event rescheduled for October.	Positive Assurance • Rather than postpone for second time, an alternative format for the event is being trialled since social distancing rules do not allow for a large number of people to use the same physical space. This ensures that the Continuous Improvement programme is not delayed further. Negative Assurance • The team building and motivational effect of an in-person event will not be fully replicated in the new trial format but it will still launch the Gastro improvement activity for the coming months.
DIP has been repositioned within the People Directorate in order to achieve integration between Organisational Development and Continuous Improvement.	Positive Assurance • Aligning OD with DIP provides a greater ability to shape a culture of improvement across the trust by integrating the staff and the method from both departments. CI using the DIP approach is now an integral part of the large leadership development programme which commenced in October 2020.

SPECIFIC GAPS IN CONTROL / ASSURANCE	ACTIONS	STATUS:			
		COMPLETE	IN PROGRESS	OUTSTANDING (BEYOND COMPLETION DATE	
The main areas of weakness which result in ineffective or absent controls / assurance	*Actions required to mitigate the weaknesses*			*Date for completion*	*Action Lead*
NHSI consultant vacant post leaving trust without support for several months	DGFT representative involved with NHSE/I recruitment activity to fill post.			Nov 2020	Peter Lowe
It is not possible to reduce the consequence of failure, only the likelihood can be reduced.	Recruitment of specialist practice coach to replace current post holder			Jan 2020	Peter Lowe
Existing three year resource plan (presented Dec 2018) has been superseded by plans to reshape and integrate transformation, business development, financial waste reduction, project management office and Dudley Improvement Practice.	Integration of Organisational Development with Dudley Improvement Practice has been achieved by moving DIP from the Strat & Transformation directorate to the People Directorate. 3 posts approved for DIP from 01/04/2021 with delivery metrics agreed aligned to Staff Survey performance and Line Manager capability development.			Apr 2021	James Fleet

Strategic Objective		**SO4 Be the place people choose to work**				**Committee**	**Exec Lead**	
						Workforce and Development Committee	Chief People Officer	
Strategic Risk No	BAF 4a	**Pre Mitigations Risk Score**	L x C 4X4 (16)	**Post Mitigations Current Risk Score**	L x C 4X4 (16)	**Board Risk Appetite**	**Target Score**	L x C 3X4 (12)
						Moderate		
RISK: An inability to recruit sufficient numbers of appropriately trained clinical staff due to national and local staff shortages may impact our ability to meet service demand and/or provide safe, high quality services resulting in enhanced pay arrangements and/or increased temporary workforce spend								

Cause	Impact of the Risk
• External - major workforce supply challenges in hard to recruit roles, locally and nationally • Inconsistency in job bandings/pay between local providers which can result in highly competitive recruitment activity • Delays at multiple stages in the internal recruitment process, resulting in an extended 'time to hire'	• Lack of substantive clinical capacity to meet service requirements • Higher demand for temporary workforce at premium cost • Impact on consistency and quality of patient care • Low staff morale • Increased sickness absence • High turnover • Patient-related complaints

Quarters – Changes in Post Mitigation Risk Scores	Q1	Q2	Q3	Q4
	16	16		

KEY CONTROLS IN PLACE	ASSURANCE THAT CONTROLS ARE EFFECTIVE [Yes / No (if no what action is being taken)	LEVEL of CONTROL 1 = Operational 2 = Committee 3 = External
Nurse recruitment lead established to work alongside departments in order to support innovative ways to recruit new nursing staff. Collaborative working with HR/Recruitment team.	Y	1/2
Corporate recruitment events alongside bespoke recruitment events for areas with high levels of vacancies as well as participating in external recruitment events.	Y	2
Development of local sustainable workforce through extension of the Nursing Associate Programme (band 4). Work undertaken to profile the nurse workforce, to identify the maximum opportunity to utilise Nursing Associates (Band 4) in ward areas.	No – this is long-term strategy over 1-4 years	1
Development of MTI workforce between the Trust and Pakistan.	Y	1
Explore opportunities for international recruitment as part of the short term strategy to fill nursing posts alongside longer term strategy of growing our own	Y	2
Robust recruitment KPI reporting	Y	2

ACTIONS IMPLEMENTED SINCE LAST REVIEW	IMPACT OF CONTROLS AND ACTIONS ON RISK AND ASSURANCE
Dudley Chief People Officer has been appointed as the STP lead for the	Greater transparency and insight into workforce issues, including recruitment.

Collaborative Bank programme for the system. This work programme will deliver a detailed implementation plan, with costed benefits (financial/non-financial) by March 2021.	Strengthened governance.
Implemented more detailed workforce reporting on recruitment activity, for all staff groups to the Workforce Committee through the monthly Workforce KPIs	It is estimated that there is a large no of nurses who work bank shifts on a full time basis within the system. Dudley doesn't current have access to this resource but would through collaborative bank arrangements. Once implemented, a system wide collaborative bank would provide economy of scale and reduce the reliance on agency staff
Major recruitment campaign launched to recruit HCSW's.	200+ applications received for HCSW posts, to join the Trist's training programme. Interviews in October. Plan to 'over recruit' recognising nurse staffing challenges. Reduce the existing nurse staffing pressures.
Extended nurse bank enhancements.	Incentivised bank fill rates, though further consideration required due to low fill levels.

SPECIFIC GAPS IN CONTROL / ASSURANCE	**ACTIONS**	**STATUS:**			
		COMPLETE	**IN PROGRESS**	**OUTSTANDING (BEYOND COMPLETION DATE**	
The main areas of weakness which result in ineffective or absent controls / assurance	*Actions required to mitigate the weaknesses*			*Date for completion*	*Action Lead*
International recruitment considerations still in its infancy, The Nursing Associate Programme is a longer term strategy that will realise benefits over the next 1-4 years.	Development and embedding of a consistent approach to workforce planning including an agreed Dudley Workforce Planning tool.			Revised date to January 2021	Deputy Chief People Officer
A fresh approach to new and alternative roles and new ways of working is required to fill some of the longstanding medical vacancies. This requires a focus on workforce transformation. The lack of a comprehensive workforce planning tool to plot the workforce supply and demand over the next 5 years.	The Trust is engaging and supporting a collaborative system wide international nurse recruitment initiative, being led by Wolverhampton, to bid for central money/resource that is being made available to support international nurse recruitment.			March 2021	Chief People Officer/Chief Nurse

Inefficiency within the recruitment process. E-rostering not optimised across clinical workforce groups, low level of attainment Limited substantive bank only workforce to meet short term supply issues. Low bank fill rates by substantive staff Clinical staff tired following COVID Phase 1. Less motivation and good will to draw upon entering winter and COVID 2.	Establish a more dynamic approach to recruitment advertising, including social media use, cohorting adverts, selling Dudley/Black Country as well as the Trust, STP collaboration and introducing a one-stop-shop approach to recruiting multiple posts.	January 2021	Resourcing and Planning Lead
	Establish an optimal future staff bank model and implement, in conjunction with STP collaborative bank programme	January 2021	Chief People Officer
	To significantly increase the population of bank only nursing and AHP staff.	March 2021 Ongoing	Resourcing and Planning Lead
	Mobilise the Workforce Transformation – new ways of working programme, which was approved by the Workforce Committee at its January meeting. This work is being supported by Health Education England (HEE), to focus on implementing new roles/ways of working.	Mar 20 Delayed due to COVID. Sept 20	Chief People Officer
	Develop and implement a comprehensive Nurse Resource Strategy, to include: o Over recruiting CSW's o Strengthening the comms channels used to recruit (i.e. social media) o Refreshing the recruitment offer/marketing, greater focus on development/career progression offer o Exploring local Partnerships, inc Dudley College o Exploring alternative staff bank options, including outsource and technology options o Optimising e-rostering to utilise all available	March 2021	Chief People Officer

	clinical workforce capacity to best effect, include bidding for capital being made available centrally o Explore immediate fixed term enhancements to pay rates/reward to secure greater uptake of bank shifts		
	The Chief People Officer and Chief Nurse are launching a programme of work with HEE to accelerate workforce transformation and new ways of working. This work is being mobilised in October 2020.	March 2021	Chief People Officer
	Focused work with BAME nurses to address barriers to career progression.	March 2021	Chief people Officer/Chief Nurse
	Joint recruitment/training programme with Dudley College (particularly for HCSW's)	March 2021	Chief People Officer/Chief Nurse
	Full well-being strategy being launched	Nov 2020	Chief People Officer

Strategic Objective		**SO4 Be the place people choose to work**				**Committee**	**Exec Lead**	
						Workforce and Development Committee	Chief People Officer	
Strategic Risk No	BAF 4b	**Pre Mitigations Risk Score**	L x C 4X4 (16)	**Post Mitigations Current Risk Score**	L x C 3X4 (12)	**Board Risk Appetite** **Moderate**	**Target Score**	L x C 2X4 (8)
RISK: Failure to train and develop our workforce, maximising their capabilities so they have the right skills to enable the delivery of our clinical strategy, may impact our ability to recruit and retain due to the lack of/inadequate career/leadership development, succession planning and talent management								
Cause • Historic lack of investment and prioritisation of staff development,					**Impact of the Risk** • High turnover, particularly in clinical posts			

particularly professional and management development. • Vacancy factor, as well as significant operational pressures making it difficult for staff to be released for training and development opportunities • Sickness absence levels making it difficult for staff to be released for training and development opportunities • Previously low staffing resource in Learning & Development/OD to support leadership and development programme • Recent impact of COVID on availability of staff to be released for development/training • Limited ability to deliver training / impact of paused activity due to physical distancing restrictions	• High vacancy rates • Increased sickness absence, particularly relating to stress • Low morale amongst staff • Dependency on agency workforce at premium cost • Insufficient support for management development has caused poor management of staff resulting in an impact of delivery against objectives • Failure to deliver the quantity and quality of management and leadership development required • Senior staff acting down to provide disproportionate levels of support, therefore, effecting the impact they have on the organisation • Reputational and operational performance issues.			
Quarters – Changes in Post Mitigation Risk Scores	**Q1**	**Q2**	**Q3**	**Q4**
	12	12		

KEY CONTROLS IN PLACE	ASSURANCE THAT CONTROLS ARE EFFECTIVE [Yes / No (if no what action is being taken)]	LEVEL of CONTROL 1 = Operational 2 = Committee 3 = External
• The revised Dudley People Plan providing greater focus on staff development • Trust Board supportive of a learning culture being further developed within the Trust • 'Improvement and Development Culture' in the Dudley People Plan provides the basis for supporting further staff development in the Trust and across the STP.	N – Delivery of the outcomes is at an early stage as the Dudley People Plan is currently undergoing an update/relaunch with actions linked to the NHS People Plan.	1/2
• The introduction of the Developing Leaders Programme in 2018 and further continued development in 2019/2020, 20/21 • Targets set to ensure the Developing Leaders Programme acts as a prerequisite for current and aspirant leaders • Developing Leaders Programme supports the consistency of development	Y	2/3

aligned to Trust values		
• Manager's Essentials programme launched to provide clear support for leadership for all leaders – across all disciplines. Programme running twice monthly from Sept; and weekly from Jan 2021	N – impact is too early to measure as programme and accreditation are not yet at critical mass. Initial feedback from participants is positive.	

ACTIONS IMPLEMENTED SINCE LAST REVIEW	**IMPACT OF CONTROLS AND ACTIONS ON RISK/ASSURANCE**
Recruitment of new training team to deliver Manager's Essentials and upskill to deliver programmes in post as of 12/10/2020	Increased skill and knowledge in leadership and management skills in those attending programmes – numbers remain small to date.
Launch of Manager's Accreditation programme to support a supportive management culture including personal and team development	Impact is as yet un-evidenced as process launched Sept/Oct. When embedded, leaders and managers will support their own development and the development of their teams.
Launch of additional team development and an admin development programme to add to the core/existing offer	When in place, the organisational offer in development with clarity of products and programmes and targeting of staff groups meeting organisational needs
Restarted face-face and virtual delivery for all development programmes including Manager's Essentials, Developing Leaders and Evolve/Inspire programmes	Take up/nominations to courses are indicating engagement and spread of access to development opportunities. This is evidence of higher number of staff accessing development programmes.
Corporate Nursing team have developed a draft Career/Progression framework for staff from entry roles through to senior leadership which provides structure and clarity on how to develop at Dudley	When in place and spread, this will provide options for staff to explore their career journey and associated development which will meet an expressed need. This is not yet widely embedded and so impact is as yet limited.

SPECIFIC GAPS IN CONTROL / ASSURANCE	**ACTIONS**	**STATUS:**		
		COMPLETE	**IN PROGRESS**	**OUTSTANDING (BEYOND COMPLETION DATE**
The main areas of weakness which result in ineffective or absent controls / assurance	*Actions required to mitigate the weaknesses*		*Date for completion*	*Action Lead*
• Lack of a robust OD, learning and leadership strategy • Delivery plans are still under development and activity is tactical rather	Revised date for the development and delivery of OD and Leadership Strategy (including Talent) to be reviewed as part of the WSEC Deep Dive on OD and		Dec 2020	Head of OD & Culture

than strategic. Requires focus on strategy for 2020/21 to ensure a full programme of activity meets the needs and requests of staff across all parts of the organisation • Engagement across the organisation with manager's essentials programme and accreditation may limit impact where this is not widespread. • Enabling access and utilisation of the CPD budget for registered staff to ensure this is effective and supports their CPD and identified learning needs • Embedding of AHP and Nursing Progression framework to inform staff of opportunities available	Learning in December 2020		
	Revised date for further delivery of plans for 2021 with specific programmes of development to meet gaps in knowledge/skills and ensure programmes are available for all.	Dec 2020	Head of OD & Culture
	Review of take-up and access to Manager's Essentials programme to ensure engagement from across the organisation and mitigate any risks of poor engagement and target appropriately	Dec 2020	Head of OD & Culture
	Process for access to CPD funding including link to organisational priorities and individual personal development plans requires development and then communication to all entitled to funding.	July 2020	Deputy Chief Nurse
	Promotion of Nursing and AHP career pathways from entry to Chief Nurse. Embed and share across whole organisation. Undertake career conversations to support promotion of pathways. Include as part of Induction and appraisal conversations	April 2021	Deputy Chief Nurse

Strategic Objective		**SO4 Be the place people choose to work**				**Committee**	**Exec Lead**	
						Finance & Performance Sub working group: Workforce	Chief People Officer	
Strategic Risk No	BAF 4c	**Pre Mitigations Risk Score**	L x C 4X4 (16)	**Post Mitigations Current Risk Score**	L x C 3X4 (12)	**Board Risk Appetite** **Moderate**	**Target Score**	L x C 3X4 (12)
RISK: Failure to effectively engage and involve our workforce by not actively listening, innovating and acting on their feedback and communicating effectively could lead to an inability to positively improve culture								
Cause • Insufficient awareness and use of formal and informal mechanisms in place to engage meaningfully with staff at all levels, and across all groups. • Insufficient investment of resource, focus and capacity to implement a					**Impact of the Risk** • High levels of sickness • Low morale • Increased employee relations issues			

structured and far-reaching staff engagement programme. • Failure to address matters locally resulting in escalation to inappropriate levels in order to solve staff issues/concerns • Lack of awareness of the changes that happen as a result of staff feedback	• Inability to fulfil the aims of the Trust to the standards expected. • Lack of trust in managers to respond to staff concerns • Instability in leadership arrangements creating unnecessary workloads • Turnover of staff in management/leadership roles due to role dissatisfaction/disempowerment • Reputation damage caused by low morale leading to recruitment challenges • Decrease in engagement metrics in both staff FFT and survey

Quarters – Change in Post Mitigation Scores	**Q1**	**Q2**	**Q3**	**Q4**
	16	12		

KEY CONTROLS IN PLACE	**ASSURANCE THAT CONTROLS ARE EFFECTIVE [Yes / No (if no what action is being taken)**	**LEVEL of CONTROL 1 = Operational 2 = Committee 3 = External**
Collection of staff engagement indicators that are published within the workforce KPIs report for Committees	Y	2
Feedback from the national staff survey and FFT results introduced on the basis on 'you said, we did'	Y	2/3
Board, Executive and senior management development programmes provide better understanding of role and responsibility and impact of positive engagement and impact of behaviours	Y – further roll-out of 360 feedback and leadership development throughout 2020	3
Annual staff survey process in place	Participation increased in 2019 but remains below benchmark and performance remains lowest quartile for most indicators	1
Engagement plan for 2019 provided additional opportunities for connection and feedback to staff	Actions were limited in delivery and impact during 2019	1

New Staff Engagement Model launched in July 2020, with quarterly Divisional & Professional Staff Group Engagement Events. Progress and action to be monitored through Workforce & Staff Engagement Committee.	New Staff Engagement Model has recently launched. Annual diary of engagement events now firmly diarised for 2020/21. Regular reporting to WSEC.	2

ACTIONS IMPLEMENTED SINCE LAST REVIEW	**IMPACT OF CONTROLS AND ACTIONS ON RISK/ASSURANCE**
First Staff Engagement Forums launched in July 2020	Staff engaged in work to establish highest impact improvement opportunities.
Local staff engagement plans and delivery priorities defined and prioritised. Action plans produced, shared with Inclusion Networks and finalised.	Clear plans in place to deliver prioritised staff engagement improvement actions. More active staff engagement and participation.
Managers Accreditation Programme developed, including roll-out plan for 2020/21	This will cover all people managers during the next 24 months, increasing the capability of line managers to engage, support and motivate their staff/teams
Engagement and communication activity during COVID such as additional team briefs, daily briefings (face to face) and daily update	Positive feedback on increased engagement during COVID. This is identified as an area to continue activity in which will reduce risk/increase assurance of engagement with staff.
Provisional plan to launch pulse survey's during November/December 2020 to provide additional intelligence more frequently on areas of engaged and disengaged staff.	No impact seen yet – planned actions will positively impact engagement and reduce risk by being able to more quickly target areas for improvement and celebrate areas of good practice
SHAW provision and capacity has been bolstered (including purchase of an Employee Assistance Programme) to support staff, given the impact of COVID phase 1.	Greater support is in place for staff. However, take up has been relatively low.

SPECIFIC GAPS IN CONTROL / ASSURANCE	**ACTIONS**	**STATUS:**		
		COMPLETE	**IN PROGRESS**	**OUTSTANDING (BEYOND COMPLETION DATE**
The main areas of weakness which result in ineffective or absent controls / assurance	*Actions required to mitigate the weaknesses*		*Date for completion*	*Action Lead*
• Due to COVID and the recent launch of the new Engagement Forums there was a limited level of staff engagement for these first sessions. There is a need to increase the level of engagement, particularly for front line staff in future engagement forums.	Now that the engagement sessions have bene diarised for the next 12 months, line managers will encourage and support higher levels of participation by front line staff. Enhancing participation levels will deliver more robust plans/actions and priorities.		January 2021	Head of Communications/Deputy Chief People Officer

• The first cut of the Divisional Engagement Plans need to be strengthened, including greater detail and granularity re-actions and next steps. • Given the major impact that COVID has had on staff during the past 6 months, staff feel tired and disengaged despite the launch of the Engagement Model and bolstered SHAW provision. Once launched the Pulse Surveys will provide additional insight and intelligence.	Engagement plans to be improved and regularly reviewed through WSEC.	January 2021	Head of Communications/Deputy Chief People Officer

Strategic Objective		**SO5 Make the best use of what we have**				**Committee**	**Exec Lead**	
						Finance & Performance	Director of Finance	
Strategic Risk No	BAF 5a	**Pre Mitigations Risk Score**	L x C 4X5 (20)	**Post Mitigations Current Risk Score**	L x C 2X4(8)	**Board Risk Appetite**	**Target Score**	L x C 2X5 (10)
						Moderate		

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

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

Quarters – Change in Post Mitigation Scores	**Q1**	**Q2**	**Q3**	**Q4**
	12	8		

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

ACTIONS IMPLEMENTED SINCE LAST REVIEW	IMPACT OF CONTROLS AND ACTIONS ON RISK/ASSURANCE
• Final agreement of £8.3m from Dudley CCG secured in 2019/20 • Further agreement with NHSI/E for £4.8m secured in 2019/20 • Full and final settlements agreed with other commissioners reflecting activity pre-Covid • Additional Covid funds of just over £2m agreed in 2019/20 • Significant additional resources in the first 6 months of 2020/21 • One month's contract payments made in advance during 2019/20	• Successful delivery of control total • Full PSF earned of £6.462m in 2019/20 • Surplus achieved of £3.521m in 2019/20 • No requirement to borrow cash and an enhanced cash position • Public Sector Payment Policy targets have improved significantly

SPECIFIC GAPS IN CONTROL / ASSURANCE	ACTIONS	STATUS:			
		COMPLETE	IN PROGRESS	OUTSTANDING (BEYOND COMPLETION DATE	
The main areas of weakness which result in ineffective or absent controls / assurance	*Actions required to mitigate the weaknesses*		*Date for completion*	*Action Lead*	

• Understanding the Underlying Position, adherence to policies • Adherence to Business Case processes, link to affordability • Adherence to Resources to deliver • Adherence to Budget Holder Training • Adherence to Scheme of Delegation	Audit of Financial Controls	Mar 2020	Chris Walker

Strategic Objective		**SO5 Make the best use of what we have**				**Committee** Digital Trust Technology committee (DTTC) Sub working group: Digital Steering Group	**Exec Lead** Chief Information Officer	
Strategic Risk No	BAF 5b	**Pre Mitigations Risk Score**	L x C 3X5 (15)	**Post Mitigations Current Risk Score**	L x C 2X4 (8)	**Board Risk Appetite** **Moderate**	**Target Score**	L x C 3X4 (12)

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

Cause

Staff Engagement:

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

Business Risk / Reputational Risk

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

Clinical Risk

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

Impact of the Risk

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

Quarters – Change in Post Mitigation Scores	Q1	Q2	Q3	Q4
	8	8		

KEY CONTROLS IN PLACE	ASSURANCE THAT CONTROLS ARE EFFECTIVE [Yes / No (if no what action is being taken)	LEVEL of CONTROL 1 = Operational 2 = Committee 3 = External
Deployment of new workflows and enhancement of existing functionality follows clinically / operationally led design, process mapping and acceptance testing – with directorate / divisional operational ownership. Major commissioned work go-lives run through an operational Go/No-Go process and link to associated governance groups	Y	1
There are a number of forums where the wider the workforce can contribute to ongoing quality improvement. This includes transparently displaying you said we did on the digital trust intranet pages for reference and regularly updated training support content.	Y	1
Interlinked Corporate risk COR1083 - Risk of cyber a security incident causing widespread impact of Trust operational capability and patient safety COR1081 - Failure of the IT infrastructure would impact on patient safety and performance – dynamically address ongoing operational response to the risk environment, with controls in place	Y – controls are dynamically updated in the Corp risk register. Whilst cyber-awareness in the organisation is one part pf the overall cybersecurity risk, there are a number of other key factors including ongoing investments in technology, as well as the increased UK cyber-threat level due to Covid-19.	1
The Digital Steering Group will provide clinical governance and workforce engagement and is authorised by the Digital Trust technology Committee to investigate any activity within its terms of reference to deploy technology to meet the trusts prevailing policies, within financial budgets to meet clinical and operational needs.	Y	2

DGNHFT currently manage the clinical risk management standard DCB0160 by exception through the roles of the medical director and chief nurse (in accordance with the provisions in the statute). There is currently no designated clinical safety officer (CSO) in post CCIO and CSO roles report to MD clinical executive. CNIO reports to CN clinical executive	Currently no CSO or CNIO in place. This is being reviewed by the Medical Director and Chief Nurse with the CCIO with consideration of an AHP role to address both elements. The Trust is meeting the DBC0160 clinical risk management statue through the CCIO clinical safety review process with oversight of the Medical Director and Chief Nurse as as defined in the act as "Top management".	2
Board level involvement in ICP programme, including awareness of risks linked to shared digital workflows across the Dudley health care system. In dependent due-diligence reports assess the position of digitally supported clinical pathways.	Y	3
Trust engaged with Black Country Pathology Service (BCPS) on infrastructure to deliver shared digital workflows	Y	3
Trust engaged with STP and new Midlands regional digital boards including priority setting, of local health care records (LHCR), the Black Country Local Maternity System (LMS) integration, and national procurements for virtualised of digital workflows	Y	3
Infrastructure is managed through TeraFirma IT to provide a state-of-the-art infrastructure to support the delivery of shared records population health platform between GPs and DGNHSFT (formally BAF 599)	Y	3
Allscripts are compliant with DCB0129 – clinical risk management and have a designated clinical safety officer (CSO) Dr Anna Bayes	Y	3

ACTIONS IMPLEMENTED SINCE LAST REVIEW	**IMPACT OF CONTROLS AND ACTIONS ON RISK/ASSURANCE**
Insignia, radiology Picture Archiving and Communication System (PACS) upgraded successfully improving radiology digital workflows across the Trust Trust wide electronic prescribing and medicines administration (EPMA) and electronic Venous ThromboEmbolism (eVTE) risk assessments deployed across adult inpatients Trust wide. Digital Trust Technology Committee (DTTC) governance embedding. Digital Steering Group meetings commenced and formulating clear work plan and priority	<u>Positive Assurance</u> L1 Positive assurance – Positive assurance of enhancement requests from clinical teams that for EPMA and deteriorating patient (you said we did) demonstrating adoption and enhancement of digital workflows. L1 Positive assurance – ongoing use of video conferencing solution *Attend Anywhere* within outpatient workflows L2 Positive assurance – Trust internal auditor (RSM) commissioned to assure

recommendations. Group includes clinical risk management agenda / workplan. Digital Committee ratifies trust Technology Strategy revision (post covid learning). Community and Radiology technical deep-dive work – improvement plan and business case owned by radiology progressing. Immediate issues in community addressed to support covid, wider strategic elements support ICP due diligence. Continued work to progress ICP and understand Trust and system risks associated. Service level agreement and contract in place and extended for DIHC until 31st March 2021. Progress Trust wide network upgrade after successful business case. Over 1800 laptops in use across the organisation, refresh continues to support workforce access to remote and flexible onsite working. NHSMail upgraded to Outlook online and Microsoft office N365 project commenced – preparing training material and roll out plan. Ongoing delivery against the connected care objective in the technology strategy of boroughwide record sharing and population health platform (HSLI funded) rolling out to GPs. Preparing e-Rostering national funding bid with Workforce team to build digital maturity in rostering across wider staff groups (to included AHPs).	clinical adoption of technology through European standard HiMMS adoption score planned during 2020 (delayed due to Covid) – dates now arranged for Q3 L2 Positive assurance – digital committee recognises the need to re-cast technology BAF against the refreshed Trust strategy as adoption of what we have improves – provision of digital service transformation is required. L3 Positive assurance Positive assurance, ongoing NHSE reporting on technology updates (W10 / ATP and HSLI) adoption continues L3 Positive assurance – ISO27001 Information Security Management System – excellent progress on action plan, further continual improvements and annual re-certification audit planned for Q3 <u>Negative Assurance</u> L2 Negative assurance - Clinical Safety Officer post vacant. MD/ CN / CCIO review L2 Negative assurance - Chief Nursing Information Officer vacant post - MD/ CN / CCIO review L3 Negative assurance - National funding and central contract for the currently free-of-charge Attend Anywhere solution has been extended to March 31st 2020, at which point it will cease. L3 Negative assurance - Lack of clarity on DIHC technology proposal and plans and ICP full busines case / subcontract position, leads to uncertainty and lack of provision for community teams

SPECIFIC GAPS IN CONTROL / ASSURANCE	ACTIONS	STATUS:		
		COMPLETE	IN PROGRESS	OUTSTANDING (BEYOND COMPLETION DATE
The main areas of weakness which result in ineffective or absent controls / assurance	*Actions required to mitigate the weaknesses*		*Date for completion*	*Action Lead*
~~1. Dissemination of clear messages into wider clinical community by members of the CAG do not always occur / inconsistent leading to disenfranchised staff.~~ 2. Staff with high levels of digital engagement, leaving a gap to those less eager. ~~3. Original strategy launched under different executive / senior leadership teams leaving an awareness Gap~~ ~~4. Risk appetite lower than current risk level – leading to avoidance disruption / go-live~~ 5. Lack of Staff engagement – creates a block to adopting change 6. Speed of mobilisation and operational readiness leading to lag-time	~~Embedding of Digital Transformation through clinically led Board committee's (CQPSE) and groups to ensure that digital first forms part of a reasonable assurance processes and avoids false assurances.~~ Digital committee reinstated, bi-monthly. Committee work plan has been devised such that in the non-meeting months members will support the Digital Steering Group undertaking quality reviews / deep-dives in key areas around the Trust to support the quality committee in establishing clear action plans.		Jul 19	Max Hodges (CCIO)
7. On-going system support, by skilled staff 8. Revenue to recruit and retain adequate skills to deliver projects of this scale 9. New initiatives divert resources away from core project activity ~~10. Lack of clarity on HSLI Pop Health fund matching (approved case in 18/19 funding held back) carrying forward into 19/20~~ ~~11. Clarity on MCP strategic formation~~	Digital strategy re-launched in Board away day. Trust board January 2020 agreed to reinstate committee level oversight, with revised digital / medical devices steering groups. Agreed Digital Trust Technology Committee Terms of Reference and Digital Steering Group ToR in February 2020 Board. Both due to meet Q3		Mar 20	Adam Thomas (CIO)
~~12. Changes in BCPS priorities and co-dependent risk (transferred Corp risk CE008)~~ ~~13. Failure of existing EPR (Soarian) may mean electronic record is irrecoverable. Sunrise Go-live is only mitigation (Corp Risk CE009 / COR091)~~ ~~14. Operational No-Go decision protracts existing higher levels of clinical risk~~	Increase exposure of all clinical groups to independent clinical safety review (CSR) of each project roll out, driving digital skills within the wider clinical workforce and better understanding of clinical risk at an organisational level.		Sept 19 continual process	Clinical Safety Officer / Max Hodges (CCIO)

~~/ dual systems of work and chance of Soarian failure.~~ 15. Current levels of organisational-wide clinical risk in practice are poorly understood by the workforce, so that something new seems more risk than something familiar. 16. Digital Trust programme perceived as a technology / IT project rather than clinical transformation (see item 1).	

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

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

Causes	**Impact of the Risk**
Relationships • Challenged relationship with main commissioner • Lack of engagement with GP practices to jointly develop new service models • Lack of profile as the Trust as an anchor institution in the community **Competition** • A number of acute Trusts within a small geographical area providing	• Loss of activity and associated income may destabilise some services impacting on continued provision • Loss of ability to income generate resulting in CIPs being more focused on cuts to services. • Fragile and fragmented clinical services which become unsafe • Financial losses that threaten the sustainability of the Trust

similar services. • Private provider in Birmingham for Ophthalmology offering low waiting times • Sandwell & West Birmingham Hospitals integrated with a PCN since Apr-20 which is a significant user of our services **Policy direction** • Implementation of Integrated Care Partnerships at 'place' level has locally been interpreted as the establishment of new organisation (DICH ICP) to deliver and sub-contract for range of services currently provided by DGFT. Could result in loss of services valued at c£80m. • Development of Integrated Care Systems are predicated on greater provider collaboration; RWT very ambitious to lead across the Black Country. • Block Contract arrangements for 20/21 affect ability to income generate; arrangements for 21/22 not yet known.	

KEY CONTROLS IN PLACE	ASSURANCE THAT CONTROLS ARE EFFECTIVE [Yes / No (if no what action is being taken)]	LEVEL of CONTROL 1 = Operational 2 = Committee 3 = External
Clinical Strategy Board, Clinical Advisory Groups and GP Engagement meetings in place to build relationships with primary care and co-design new service models.	Yes	1
Dedicated Executive support in place to work through the development of the ICP in order to ensure risks to DGFT are mitigated.	Yes	2,3
The ICP development is scrutinised by the Board directly with approval sought at each gateway.	Yes	2, 3

A comparative analysis of performance is presented to F&P Committee every six months with an evolving range of measures discussed to highlight the Trust's strengths and weaknesses. This includes market share analysis to identify changes in referral patterns	Yes	2
Director of Strategy and Transformation part of STP team to develop the case for change, options appraisal and implementation plan for acute collaboration, reporting to Chairs and CEOs.	Yes	3
Board and Governors to have full oversight of proposals and required to approve any changes in governance.	Yes	2

ACTIONS IMPLEMENTED SINCE LAST REVIEW	IMPACT OF CONTROLS AND ACTIONS ON RISK/ASSURANCE
GP Engagement • Clinical engagement meetings now established between DGFT and primary care, with sub-group working on developing shared agenda, ensuring actions are followed through, etc. • CSB / CAGs were established, with terms of reference and work plan. However, these have been temporarily stood down given current status of negotiations with DIHC and DGFT's position regarding the ICP overall (see below). **ICP** • External independent review of the draft Full Business Case commissioned, highlighting significant clinical and financial risks. • Following Board debate, intense period of negotiation supported by Executive team members to work through risks with DIHC undertaken. • As resolution could not be reached, approach made regarding finding pragmatic solution. • Notice letter from CCG undercut this, resulting in CAGs being stood down. • Full briefing for Board to consider its position on 8/10.	<u>Positive Assurance</u> Risks in the Full Business Case identified and articulated. Progress made with financial aspects of the transaction – fully documented. <u>Negative Assurance</u> Still significant uncertainties around how risk will be mitigated and the potentially effects on the viability of the Trust

Acute Collaboration • Working group established across 4 acute providers to begin to develop high level case for change, with a view to reaching consensus on a preferred option across each organisation by Dec 2020, and to have shared leadership / governance arrangements in place for April 2021. • PA Consulting appointed by the STP to support production of financial and activity analysis; DGFT fully contributing to this. • Board and Governors fully briefed. • Soft launch of DGFT Orthopaedics as Midlands Orthopaedic Service from Oct 20 with new promotional material and signage **Strategy Refresh** • Refresh of strategy has commenced to provide framework for how the organisation develops over the next 3 – 5 years, including in its role as an anchor institution. • Individual discussions held with all NEDs and EDs, and workshops held with Exec directors to form key themes. • Key themes tested with staff groups at meetings. • Staff and governor survey undertaken with 110 and 133 responses respectively. • Board workshop planned for November 2020 to develop the draft strategy.	

SPECIFIC GAPS IN CONTROL / ASSURANCE	ACTIONS	STATUS:		
		COMPLETE	IN PROGRESS	OUTSTANDING (BEYOND COMPLETION DATE
The main areas of weakness which result in ineffective or absent controls / assurance	*Actions required to mitigate the weaknesses*		*Date for completion*	*Action Lead*
• ICP – lack of signed sub-contract.	Pragmatic way forward to be developed and proposed.		Oct 2020	Tom Jackson
• ICP – lack of clarity regarding whether the FBC is approved by NHSE/I	Scenario planning for DGFT to be undertaken should FBC succeed.		Oct 2020	Tom Jackson
	Decision regarding how CSB and CAGs are taken forward to be made.		Nov 2020	Julian Hobbs / Mary Sexton
• Trust's existing strategy reliant on income growth in time of greater collaboration.	Board development session to refresh strategy		Nov 2020	Katherine Sheerin
	Draft strategy to be presented to Board in Dec 2020		Dec 2020	Katherine Sheerin
	Stakeholder analysis and action plan to be produced to underpin the strategy		Feb 2021	Liz Abbiss

SPECIFIC GAPS IN CONTROL / ASSURANCE	ACTIONS	STATUS:		
		COMPLETE	IN PROGRESS	OUTSTANDING (BEYOND COMPLETION DATE
The main areas of weakness which result in ineffective or absent controls / assurance	*Actions required to mitigate the weaknesses*		*Date for completion*	*Action Lead*
• No promotional material for our services and limited regular relationship meetings.	Comms materials to be produced in discussion with practices through clinical engagement meetings		March 2021	Liz Abbiss
	Routine relationship meetings to be set up with other key partners, including commissioners, LA, etc		Jan 2021	Katherine Sheerin
• Limited involvement by Trust staff in the different work streams of the STP / ICS	Strengthen engagement with the work streams of the STP by being clear on where DGFT input is on the work streams and identifying any gaps in engagement /involvement across the Programme. Co-ordinate a regular update to Exec Directors		Dec 2020	
	Active engagement in acute collaboration work.		March 2021	

Enclosure 23

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

The Dudley Group NHS Foundation Trust

TITLE:	**Public Digital and Technology Committee Report**		
AUTHOR:	**Catherine Holland** (Digital Committee Chair)	**PRESENTER**	**Catherine Holland** (Digital Committee Chair)

CLINICAL STRATEGIC AIMS

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

ACTION REQUIRED OF COMMITTEE

Decision	Approval	Discussion	Other
			NOTING

RECOMMENDATIONS:

- The Board of Directors note the upward report.

CORPORATE OBJECTIVE:

SO5 – Make the best use of what we have
SO6 – Deliver a viable future

SUMMARY OF KEY ISSUES:

- Digital Trust Technology Committee NEDs were in support of the NHS Providers Digital Boards Programme Proposal, with three NEDs and three ED roles acting as board advocates.
- Two RSM internal audit commissioned for April now arranged for November
- Electronic Venous Thromboembolism Bleeding Risk Assessment (eVTE) is now established as a digital record, KPIs improving.
- Strategic support for the APAS and Oracle business case was provided, that will be submitted to this board.

IMPLICATIONS OF PAPER:

IMPLICATIONS FOR THE CORPORATE RISK REGISTER OR BOARD ASSURANCE FRAMEWORK

RISK	**Y**		**Risk Description:** BAF 5b – Failure to adopt digital workflows. Positive strategic assurance
	Risk Register: N		**Risk Score:**
COMPLIANCE and/or LEGAL REQUIREMENTS	**Other**	**Y**	**Details:** DCB0160 and DCB0129 clinical risk management standards (HSCA statue 250)
REPORT DESTINATION	**BOARD**	**Y**	**DATE: 12th November 2020**

UPWARD REPORT FROM DIGITAL TRUST TECHNOLOGY COMMITTEE

The Dudley Group NHS Foundation Trust

Date Committee last met: 22nd October 2020

MATTERS OF CONCERN OR KEY RISKS TO ESCALATE	MAJOR ACTIONS COMMISSIONED/WORK UNDERWAY
• Continued, heightened risks of Cyber threat remains. Actions in place. • National updates (outside of Trust control) to the NHSMail system causing local disruption with calendars and mailboxes • IT Service Desk performance continues to be pressured and impacted by the rapid expansion of technology. The impact of the National NHSmail box changes also contributes to support calls	• RSM commissioned to undertake internal audit into digital adoption a gap analysis (HiMMS) and baseline 'cyber-awareness' assessment across the Trust workforce, commencing November • NHS Providers – Digital Boards programme proposal supported (see below) – linked to Dudley People Plan • National Windows 10 & Advanced Threat Protection roll out continues • PC Refresh and laptop deployment continues • National Microsoft Office N365 Project
POSITIVE ASSURANCES TO PROVIDE	**DECISIONS MADE**
• Electronic Venous Thromboembolism Bleeding Risk Assessment (eVTE) is now established as a digital record, KPIs improving. Ongoing clinical vigilance by the Thrombosis Group will continue with oversight at the Quality &, Safety Committee. • Clinical Risk Management vigilance of Electronic Prescribing and Medicines Administration (EPMA) continues (statutory standard: DCB0160) • EPMA adoption remains high – BAF5b positive assurance	• Digital Trust Technology Committee NEDs were in support of the NHS Providers Digital Boards Programme Proposal, with three NEDs and three ED roles acting as board advocates. • Strategic support for the APAS and Oracle business case was provided. The case will proceed to F&P and then Trust Board.

Chair's comments on the effectiveness of the meeting:

Challenges to a wider attendance and wider contributions due to current competing pressures and challenges acknowledged.