The Dudley Group
NHS Foundation Trust

Board of Directors Meeting Public Papers

Thursday 13th May 2021

11:45 – 15:25

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

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

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

3. Opportunity for questions

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

4. Debate

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

5. Minutes

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

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

6. Key Contacts

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THE 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 13 May 2021
By MS Teams

AGENDA

	ITEM	PAPER REF	LEAD	PURPOSE	TIME
16	**Chairmans welcome and note of apologies –**		Y Buckland	For noting	11.45
17	**Declarations of Interest** Standing declaration to be reviewed against agenda items.		Y Buckland	For noting	11.45
18	**Minutes of the previous meeting** Thursday 15 April 2021 Action Sheet 15 April 2021	 Enclosure 9 Enclosure 10	Y Buckland	For approval	11.45
19	**Chief Executive's Overview**	Enclosure 11	D Wake	For information & assurance	11.50
20	**Chair's update**	Verbal	Y Buckland	For information	12.05
21	**Public Questions**	Enclosure 12	Y Buckland	For information	12.15
22	**Case Study – Trauma and Orthopaedics**	Enclosure 13	Jack Richards & Hip Nurse Practitioner	Presentation	12.20
23	**GOVERNANCE**				
23.1	**Board Effectiveness Review**	Enclosure 14	L Nevin	For assurance	12.50
24	**QUALITY & SAFETY**				
24.1	Quality and Safety Committee Report - Annual Safeguarding Report	Enclosure 15 Enclosure 16	E Hughes M Sexton	For assurance For assurance	13.00
24.2	Chief Nurse Report	Enclosure 17	M Sexton	For assurance	13.20
24.3	Board Assurance Infection Control Framework	Enclosure 18	M Sexton	For assurance	13.35
24.4	Maternity and Neonatal Safety and Quality Dashboard (including CNST update)	Enclosure 19	M Sexton	For assurance	13.45
25	**FINANCE & PERFORMANCE**				
25.1	Finance and Performance Committee Report	Enclosure 20	J Hodgkin	For assurance	14.00

25.2	Integrated Performance Dashboard	Enclosure 21	K Kelly	For assurance	14.10
26	**WORKFORCE**				
26.1	Workforce and Staff Engagement Committee Report	Enclosure 22	J Atkins	For assurance	14.25
26.2	Workforce KPIs	Enclosure 23	J Fleet	For assurance	14.35
27	**Any Other Business**	Verbal	All		14.55
28	**Reflection on meeting**	Verbal	All		14.55
29	**Date of next Board of Directors meeting** 13 May 2021				15.00

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

Enclosure 9

Minutes of the Public Board of Directors meeting held on Thursday 15th April 2021, by Remote Attendance

The Dudley Group NHS Foundation Trust

Present:

Yve Buckland, **Chair** (YB)
Diane Wake, Chief Executive (DW)
Liz Hughes, Non-executive Director (LH)
Jonathan Hodgkin, Non-executive Director (JH)
Lowell Williams, Associate Non-executive Director (LW)
Tom Jackson, Director of Finance (TJ)
Karen Kelly, Chief Operating Officer (KK)
Vij Randeniya, Non-executive Director (VR)
Julian Atkins, Non-executive Director (JA)
Mary Sexton, Chief Nurse (MS)
Catherine Holland, Non-executive Director (CH)
Gary Crowe, Non-executive Director (GC)
Katherine Sheerin, Director of Strategy & Transformation (KS)
Adam Thomas, Chief Information Officer (AT)

In Attendance:

Liam Nevin, Trust Secretary (LN)

21/042 Note of Apologies and Welcome

The Chair opened the meeting and welcomed members of the public, and the governors identified below, to the meeting:

Governors

Maria Lodge, public elected Brierley Hill
Helen Ashby, public elected Stourbridge
Dr Atef Michael, staff elected Medical & Dental staff
Chauntelle Madondo, public elected Rest of England
Alan Rowbottom, public governor Tipton and Rowley Regis

Foundation Trust Members

Jim Conway, Stourbridge,

Public

Ian Frankom
Dr Raees Lunat
Dr Vidushi Golash

Apologies were received from Julian Hobbs, James Fleet, and Liz Abbiss

21/043 Declarations of Interest

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

21/044 Minutes of the previous meeting held on 11th March 2021

It was **RESOLVED**

- **That the minutes of the meeting of the 11th March 2021 be agreed as a true and accurate record of the meeting.**

The Action log was noted.

21/045 Public Chief Executive Overview Report

DW introduced her report and advised that whilst the Trust could not discuss the details of the tragic cases that were subject to the pending prosecution it was important to re-assure the public that the Trust was committed to learning and improvement and that there had been substantial changes in the Trust since 2018. This included improved care for Sepsis, electronic monitoring of patient observations, early introduction of the NEWS 2 and a focus on improving mortality rates from Sepsis such that the Trust mortality rates were in this respect amongst the best in the West Midlands.

With regard to Restoration and Recovery there was a strong commitment to collaborative working across Birmingham and the Black Country. Acute collaboration work was progressing well and the first board meeting had been held on the 18th March with the programme focussing on clinical improvements. Events were scheduled in June, July and September to work with clinicians on these priorities.

The Board were advised that there continued to be a significant reduction in COVID 19 cases with 19 inpatients currently and only three new admissions in the last seven days.

Action Heart would close its vaccination service on the 17th April and cardiac services would be resumed but it was noted that it may be necessary to use the facility again for vaccinations in the autumn and winter.

It was **RESOLVED**

- **That the report be noted**

21/046 Chair's Public Update

The Chair updated the Board on the various meetings and other matters that she had been involved in. She advised that the Trust had received praise for its work in setting up and running the vaccination programme for the Black Country and it was heartening to report the recognition that the Trust had received for the very hard work done to deliver this programme.

The Chair advised that she was also involved in the ICS Acute Collaboration Programme and she echoed DWs comments that the focus on clinically led programmes across organisational boundaries was a positive initiative for patient care.

The Chair and DW had also met with the new Chair and the CEO of West Midlands Ambulance Service and they had discussed the management of ambulances and the flow of patients through ED at the Trust which continued to be an important area of focus.

The Board were advised that as the NHS had now reduced Incident Control to level 3, the Trust would reintroduce its business as usual schedule of meetings and would also seek to reinstate quality walk abouts with Directors and governors. The arrangements for this would be discussed between the Chair and the Chief Nurse.

21/047 Public Questions

Dr Atef asked:
"Is it possible to have more details about the CQC court case? When, where did we do a root cause analysis and take the most appropriate action to prevent recurrence?"

The Chair stated that the Trust was restricted in what it could say about the case. However, she wished to place on record that the circumstances of these cases were tragic and that the thoughts and sympathies of the Board were with the families.

DW stated that with all cases of harm there were robust governance processes to investigate, with a strong focus on identifying learning and applying this to improve patient safety and care.

Jim Conway asked:
"As the NHS ever so slowly gradually comes out of its third COVID peak what recovery plans does the Trust have in place for getting the spiralling elective surgery under control? What specific challenges are you facing for your plans at Dudley Trust and what are the main stumbling blocks?"

KK responded that all cancer surgery had been maintained during the pandemic. However, in accordance with national NHS directives all routine elective work was postponed. The Trust therefore had a backlog but this compared favourably with neighbouring Trusts. The aim was that by the end of June the backlog of 52 week waits would be cleared, but it was important that this issue was addressed by the NHS black country system as a whole, to ensure equitable treatment for patients, and this would require mutual support between hospitals.
The Trust had also adopted the national prioritisation of waiting lists to categorise patients for surgery and there was a detailed theatre restoration plan through to September.

21/048 Home for Lunch Presentation

Simon Illingworth delivered a presentation explaining the innovations that had been introduced in the delivery of this service

The Board debated the importance of this programme to the improvement of flow through the Trust and ensuring that it maximised capacity to meet the demands on the hospital. The Chair stated that she had met the staff involved and had been impressed by their enthusiasm and pride in the programme. It was important for the Board to hear of these initiatives and she requested that with future presentations more team members attend the Board to speak about their work.

The Chair further added that VJ had agreed to champion this work on behalf of the Board.

21/049 QUALITY AND SAFETY

21/049.1 Quality and Safety Committee Report

LH summarised the exception report before the Board and invited any questions.
The Chair asked whether LH was satisfied with the progress in respect of blood labelling and LH advised that a final report was expected at the May meeting. The optimal solution may entail a digital solution but it was recognised that this may be a longer terms project given competing demands on IT services and budgets.

The Board were advised that the Committee were also recommending an amendment to its Terms of Reference, and it was noted and agreed that the quoracy for the committee should be two NEDS.

It was **RESOLVED**

- **That the report be noted and that the amended terms of reference be approved subject to the further amendment as set out in the preamble to this minute.**

21/049.2 Chief Nurse Report

MS summarised the report and invited questions on its content. JH congratulated MS on the successful recruitment programme and the Chair asked what improvements had been implemented that led to this. MS advised that additional resources had been deployed, there was a more centralised approach, increased use of virtual recruitment techniques and same day offers to reduce the time- period for recruitment. Further recruitment would follow from an initiative to ensure that suitable candidates had the necessary Maths and English qualifications and which was being delivered in partnership with local colleges.

The Chair asked what had led to the reduction in falls now reported and MS advised that a specialist falls lead had reviewed cases with a focus on those that had resulted in harm. This had identified a need for bespoke training in ward areas and which had been introduced initially in the Stroke unit. As a result of the success of this initiative it would be introduced in other areas.

It was **RESOLVED**

- **That the report be noted**

21/049.3 Board Assurance Infection Control Framework

MS advised that compliance against the detailed framework was set out in the papers

A remedial plan for mandatory training had been agreed with the Divisions and this was on track with compliance at 87% as of 14th April.

An NHSE/I peer review with Public Health England had been conducted on the 6th April and this had not identified significant concerns. The inspectors had collated a substantial amount of evidence and the Trust could expect a report within two to three weeks.

MS advised that there was substantial evidence in the framework demonstrating progress in most areas. There had not been any cases of nosocomial infection for 3.5 weeks and the

Trust had maintained one of the lowest rates in the region during the pandemic. There were no open outbreaks with patients and one with the Trust's PFI provider.

It was **RESOLVED**

- **That the report be noted**

21/049.4 Maternity and Neonatal Safety and Quality Dashboard (including CNST Update)

The Chair introduced the item by advising that all Non- Executive Directors had undertaken a briefing session on this issue on the 26th March.

MS advised that there was good progress on the maternity safety actions with only one area (indicator 9) amber. A second continuity of care team had been introduced and this would ensure that the Trust achieved its 35% target under this indicator.

The Board advised that the Safety Champions had now started their walkarounds and there had been good engagement with the maternity teams.

MS advised that the Workforce Plan for neonates had identified the need to address space restrictions and a feasibility study had been agreed to examine how the estate might be reconfigured for maternity provision.

The Chair Challenged that the supporting appendices demonstrated that a number of areas remained amber and she asked what steps were being taken to maintain momentum. MS advised that there were weekly meetings to review progress against the actions.

GC asked how the Trust achieved fill rates to ensure that the service was safe. MS advised that there was an agreed skill mix and she worked closely with heads of service and lead midwives in keeping this under review. When necessary community midwives were called upon to support workload and the Trust was also working to increase university placements so that it could reduce reliance on temporary and agency staff.

It was **RESOLVED**

- **To accept the assurances provided in relation to the maternity safety dashboard**
- **To note that the Board had received and reviewed the Neonatal Nursing and Staffing review**
- **To note that the Non- Executive Directors had undertaken a development session with the Head of Midwifery on the 26th March.**

21/049.5 7 Day Service Progress

Phil Brammer (PB) attended to present this item on behalf of Julian Hobbs.

The Chair challenged whether the Board could be assured that junior doctors had access to consultants at a weekend. PB stated that he could provide this assurance in relation to general medicine, cardiology and elderly care.

The Chair stated that it was important for Board members to undertake evening and weekend walkarounds as this would allow them to triangulate observations with the reported position.

VJ challenged whether consultant availability was defined as personally present or just available on the phone. PB stated that consultants would often undertake morning and evening ward rounds and be available in the intervening periods on the phone. It was not however feasible to have a 24/7 presence for all services.

LH asked what the biggest challenge was for 7 day services and how this was being mitigated and PB advised this was ensuring that patients who are medically active do get reviewed. The mitigation for this was to ensure identification of those who are very sick and those who were medically fit for discharge.

Helen Ashby (governor) stated that the lack of a learning disability liaison nurse being on site for evenings, and weekends resulted in a loss of service at those times and MS stated that this was acknowledged and was under consideration but additional resource would be needed to make this a seven day service.

It was **RESOLVED**

- **That the report be noted**

21/050 FINANCE AND PERFORMANCE

21/050.1 Finance and Performance Committee Report

JH summarised the Committee exception report and advised the Board that operational performance was robust. There would be a break- even financial position in 2020/21 and the Trust would start the year with an improved cash position and an agreed capital expenditure position across the STP. However, the position was less clear for the second half of the year as the national financial position had not been set. Staff costs had increased over the last year and if income reduced to pre-COVID levels this would present cost reduction challenges.

The Committee had also approved minor amendments to its terms of reference and these were now presented to the Board for approval

It was **RESOLVED**

- **That the report be noted and the amended terms of reference for the Committee be approved**

21/050.2 Integrated Performance Report

KK summarised the report and assured the Board that the data generally represented strong performance. In particular;

- DM01 had improved to 82% helped by the use of a mobile CT van
- RTT 18 weeks was stabilising at 77%
- There were currently 454 52 week waits and the Trust was performing well on this compared to neighbouring Trusts. It may be necessary for the Trust to provide assistance to neighbouring Trusts
- A surgical restoration plan was operational and 10 out of 15 theatres were now open

- EAS was performing at between 86-90% against target and this placed the Trust at about 30th of 113 Trusts

The Chair stated that whilst the provision of assistance to other Trusts was the right thing to do it was important that KK ensured that the Trust could report separately on performance against its own cases and be able to quantify the effect on Trust performance by providing this external support.

It was **RESOLVED**

- **That the report be noted**

21/051 AUDIT

21/051.1 Audit Committee Report

GC summarised the exception report and advised that the draft Internal Audit opinion gave a positive assurance around governance and internal controls with some identified areas for improvement.
It was noted that an area of concern was the delay in delivery of the Clinical Audit Plan but this was subject to a robust recovery plan.
DW advised that she had met with the Head of Service to review progress and had been impressed by the rate of progress.

It was **RESOLVED**

- **That the report be noted and that the amended terms of reference for the Committee be approved**

21/052 WORKFORCE

21/052.1 Workforce and Staff Engagement Committee Report

JA summarised the Committee exception report and the matters considered by the Committee, and further work commissioned were both noted.

The Board were advised that the Committee had considered the NHSI review of the FTSU process and had approved an action plan to address the areas for improvement.

It was **RESOLVED**

- **That the report be noted and that the amended terms of reference for the Committee be approved**

21/052.2 Workforce KPIs

The Workforce KPIs were noted.

21/053 CHARITABLE FUNDS

21/053.1 Charitable Funds Committee Report

JA summarised the committee exception report and it was noted that charitable funds had a healthy balance with no concerns or risks to escalate.

It was **RESOLVED**

- **That the report be noted**

21/054 Any Other Business

There was no other business

21/055 Reflections on Meeting

It was agreed that there had been good discussions, and that the clarifiers for acronyms that were explained in the Chat were helpful.
It was further agreed that the presentations on service innovations were an important feature of the public board meeting and it was requested that 2-3 members of the relevant team attend to present in future.

Date for the Next Meeting - 13 May 2021

Signed ……

Date …….....

Enclosure 10

The Dudley Group NHS Foundation Trust

Action Sheet
Minutes of the Board of Directors (Public Session)
Held on 15 April 2021

Item No	Subject	Action	Responsible	Due Date	Comments
21/046	Chair's Update	Chair to agree with Chief Nurse arrangements for reinstating quality walkarounds.	YB/MS	May	To be reinstated in June when lockdown restrictions are lifted.
21/048	Virtual Ward	April and May agenda to include "stories" on trauma services and "home to lunch" initiatives	LA	April and May Board agendas	On Agenda

Enclosure 11

The Dudley Group NHS Foundation Trust

Paper for submission to the Board of Directors on 13th May 2021

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
- Restoration and Recovery
- Action Heart Covid-19 Vaccination Hospital Hub
- Integrated Care Systems Consultation
- Healthcare Heroes
- Committed to Excellence
- Charity Update
- Patient Feedback
- Visits and Events

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 – 13TH May 2021

Coronavirus

We're pleased to see the community infection rate is the lowest we've seen in months and this is reflected in the number of cases we have in hospital. It's important that we all continue to do what we can to reduce the risk of catching or passing on coronavirus and remember Hands. Face. Space. Fresh air. We must continue to wash hands with soap and water for at least 20 seconds or use hand sanitizer regularly throughout the day; continue to wear face covering and maintain social distancing. We ask anyone visiting our premises to wear a surgical mask and use the hand sanitizer at entrances.

Restoration and Recovery

Elective recovery is on plan for all operational recovery targets.

Additional capacity is being provided with additional sessions through weekends. Working four all day lists we have running through the Independent sector focusing on Plastics and Breast work.

In addition the Trust has participated in submitting an STP wide Accelerator bid. The bid, if successful, will attract some additional funding which we intend to use to support additional onsite vanguard capacity, additional support for staffing, digital triage and mobile endoscopy provision. Allocation of this money will be to the STP and the system will need to work together to target interventions that reduce a shared PTL

Action Heart Vaccination Hospital Hub

Our Action Heart gym at Russells Hall Hospital ceased to be a vaccination hub on 17th April 2021 and reopened as a gym on 4th May 2021.

NHS System Oversight Framework Consultation

Integrated Care Systems continue to be increasingly involved in the oversight process and support of organisations in their system as set out by the NHS as the best way to organise resources to deliver high quality, sustainable care is to focus on organising health at both system and organisation level. The Black Country and West Birmingham ICS was authorised on the 1st April 2021 and the Trust is playing an active partner in both system and place based partnerships.

To ensure the correct oversight framework for system to operate, NHS England and NHS Improvement's have launched a consultation on the proposed approach to oversight, one that reinforces system-led delivery of integrated care.

This reflects the vision set out in the NHS Long Term Plan, Integrating care: Next steps to building strong and effective integrated care systems across England, the White Paper Integration and innovation: Working together to improve health and social care for all, and the 2021/22 Operational Planning Guidance.

The consultation can be found here: b0381-consultation-on-a-new-nhs-system-oversight-framework-2021-22.pdf (england.nhs.uk) and closes on the 14th May.

We have submitted our Trust response on the proposed framework.

Healthcare Heroes

Individual

April's individual Healthcare Heroes award went to Jane Barnes, who works on our main reception desk at Russells Hall Hospital. Jane was nominated by one of her close colleagues for the amazing work she has done as our main receptionist over the last 37 years. During that time, Jane has seen many changes to the NHS and over recent years her workload has increased dramatically. She makes her job look easy, but it most certainly isn't! Despite the challenges of the pandemic, Jane has continued to work incredibly hard and adapted to all the unforeseen changes.

Volunteer

Graham Tibbetts was April's Healthcare Heroes volunteer award winner. Graham was nominated by a colleague from a department he works closely with. Graham is known to be a very hard worker. He is punctual and efficient in all the tasks he is assigned. He always has a friendly manner and is extremely welcoming to all the people he sees on a day-to-day basis. He greets everyone by introducing himself which has proven to put patients and visitors at ease and helps to make them feel comfortable.

Committed to Excellence

Our annual staff awards, Committed to Excellence 2021, take place on 19th May. This year it is a virtual event to an invited guest list of 300 people. For the very first time, all our staff will be able to watch the awards being live streamed. Thank you to all staff who nominated colleagues and to patients who nominated our staff in the Patient Choice award. The standard of nominations was extremely high making judging a difficult but enjoyable task.

The COVID pandemic brought out the best in our staff, and those of our partner organisations, both clinical and non-clinical, many of whom were redeployed to support clinical colleagues on the frontline. They did this with the overwhelming support and kindness of our local community. These awards are our way of saying a very big thank you to them and recognising individuals and teams who went the extra mile to give our patients the very best possible care and experience under the most difficult and often traumatic of circumstances.

Patient Feedback

Cardiology: Felt really safe whilst at hospital. No delays. Thorough investigation/ examination. Clear, concise update by all staff.

Medical Photography: The photographer was incredibly professional, made me feel comfortable and at ease with my skin condition on show. I felt safe in the department re COVID, and was very happy with my visit.

Intermediate Care Team (Occupational Therapy): Very understanding about how I felt, scared of everything, however helped build my confidence up.

MHDU: Fantastic treatment throughout. All staff professional & caring your efforts were very, very highly appreciated.

B4: Nurses, Doctors very caring, considerate.

C4: I will never forget their kindness + understanding & empathy not just the medical staff but the support staff.

Pre-assessment unit: Everyone who dealt with me was polite, helpful and kept me fully informed about what would happen next at all points.

Endoscopy: Excellent service, friendly staff made me feel at ease.

ED: Nurses were efficient, caring and respectful.

Visits and Events

16th April	**Live Chat**
16th April	**Diane unveiling the art installation in PAU**
19th April	**STP Cancer Board**
19th April	**Research Project Interview**
20th April	**MCP Community Staff Briefing**
23rd April	**Council of Governors Extraordinary Meeting**
26th April	**Vital Signs Transformation Guiding Board**
29th April	**Performance Review with Surgery, Medicine and Clinical Support Services.**
29th April	**Committed to Excellence Filming**
30th April	**Live Chat**
4th May	**Leading Inclusively with Cultural Intelligence**
5th May	**Live Chat**
5th May	**Siren Study**
11th May	**West Midlands Imaging Network shadow Board meeting**

Enclosure 13

NHS
The Dudley Group
NHS Foundation Trust

Fracture Neck of Femur – Hip pathway




Hip Nurse Practioners Introduction

- Our Hip Nurse Practitioners (HNP) are made up of Band 6 nurses, led by Claire Sylvester. Our team include Ann Allen, Laura Hughes, Arlinda Lago, Carol Shaw and Joyce Sinandima
- HNP's have extended clinical skills to provide an enhanced service to patients.
- HNP provide a seven day service, 365 days a year covering shifts times of 0700-1930.
- Hip Nurse practitioners (HNP) work alongside the consultant, nursing and therapy team; supporting the best outcome for patients with a fractured NOF via the hip aid pathway.
- HNP provide continuity of care to these patients during their stay.

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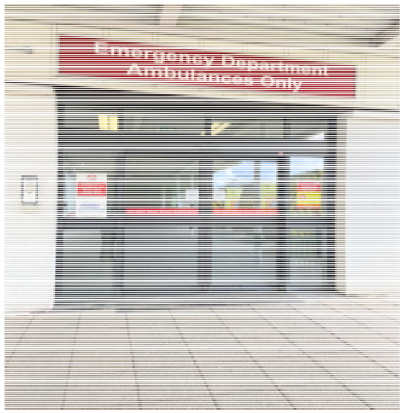
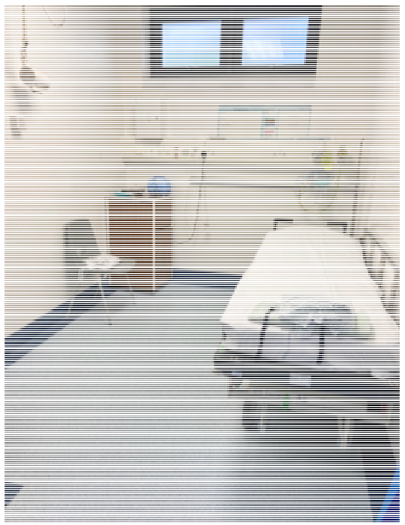
Patient Journey

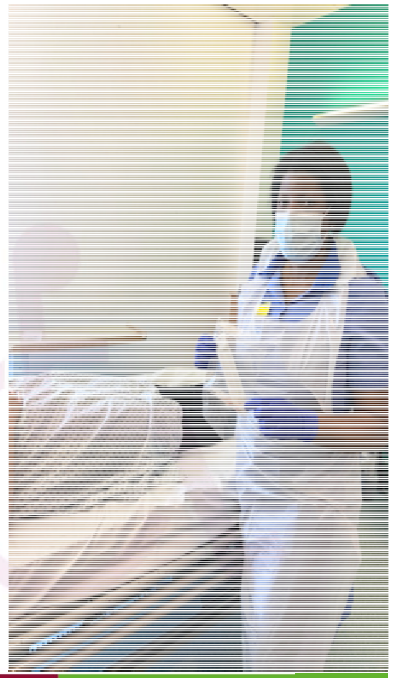
- Mrs A is a 79 year old female who was gardening on a sunny spring day. Mrs A had fallen in the garden and injured her hip. Mrs A had no underlying medical health conditions prior to the fall, normally fit and well.
- An ambulance was called by her family and she was taken to ED.

ED Assessment





- En-route to ED, ambulance staff contacted ED to advise of arrival of a patient who had sustained a potential NOF (neck of femur). ED staff upon receiving this call contacted the Hip Nurse Practitioner (HNP) to notify of arrival.
- Mrs A was taken into Russells Hall ED, handed over by ambulance staff into the ambulance triage area. ED nursing staff, doctors and HNP, assessed her injuries, and completed observations and initial investigations, i.e. ECG, bloods and rapid covid swab. The doctors examined Mrs A for a potential NOF injury.
- Assured that there were no overriding/acute medical issues the HNP accepted Mrs A onto the hip pathway.
- IV fluids were commenced by the HNP in line with the PGD.



X-RAY Journey

The Dudley Group NHS Foundation Trust

- The HNP was able to request the X-ray independently.
- Mrs A, accompanied by the HNP, attended for an x-ray of the hip to determine if there is a fracture.
- Once completed Mrs A was accompanied back to ED and the x-ray was reviewed by the HNP.
- Mrs A was confirmed to have a fractured NOF and consideration was given to undertaking a fascia iliac block for pain management (Undertaken by HNP). HNP arranged for the patient to be transferred to NOF amber side room on B2 Hip Suite.

Next Steps

The Dudley Group NHS Foundation Trust

- Mrs A was transferred by the hip practitioner to B2 Hip Suite, into a side room identified for amber patients. This amber side room is allocated for fractured NOF patients awaiting Covid test result. This is to enhance the patient experience. *Right Patient – Right Place – Right Time*
- Mrs A was transferred safely by the HNP and members of the nursing staff to the bed in the side room. Mrs A was barrier nursed as per infection control until covid swab received.
- Mrs A was settled into her room, the ward clerk booked her into the ward. HNP completed the admission for Mrs A. HNP catheterised Mrs A and completed group and save, informed the T&O on call to consent the patient. HNP contacted the star anaesthetist to inform that Mrs A had arrived. FRAX assessment completed for Mrs A.

Next steps … continued

- HNP completed Mrs A's pressure area checks, observations, and gave patient a welcome booklet, which informed patient of the ward and pressure area information.
- HNP informed the Ortho-Geriatric Team that Mrs A had arrived on the ward.
- HNP liaised with trauma co-ordinator to add patient to the next day's trauma list for surgery .
- All fractured NOF patients should have surgery within 36 hours of attendance.
- HNP requested the doctor to prescribe fluids, and patient's regular medications, and to complete VTE assessment.

The next day – Surgery Day

Mrs A was listed as the golden patient for the trauma theatre list. Golden patient is identified as the first patient on theatre list.

Mrs A was collected by theatre team, and taken to surgery at 0830. Mrs A had a surgery called a hemiarthroplasty.

Surgery was completed in approximately an hour and a half and Mrs A was taken to recovery following surgery.

At 1200 recovery was completed, Mrs A was returned to the ward.

Day 1 Following Surgery

The Dudley Group NHS Foundation Trust

- Mrs A was reviewed by Consultant during the ward round. Ward therapist assessed Mrs A prior to mobilisation.
- Mrs A was sat out of bed.
- Mrs A was closely monitored throughout the day.
- The days following Mrs A had therapy to support her recovery and mobilisation.

Post Surgery

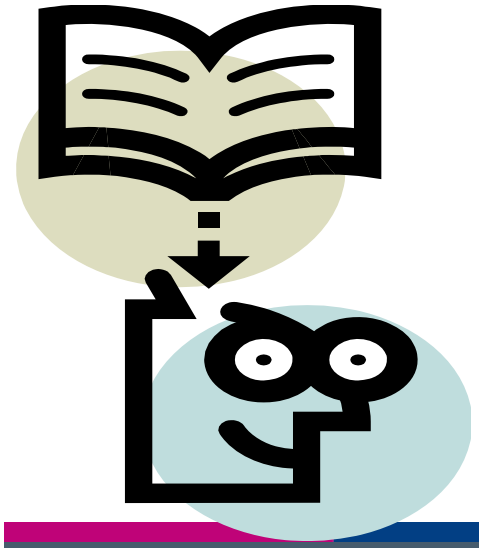
- Mrs A care was transferred to the Ortho-geriatricians, 72 hours post surgery who supported with her recovery.
- Mrs A continued her recovery on the hip fracture suite and was discharged to intermediate care on day 6.
- Mrs A was discharged from intermediate care after two weeks.
- Mrs A is recovering well, and getting back to normal daily activities.

Conclusion

- So why are we proud of the service: “good patient experience” “provide a smooth journey” “improved communication” “patient confidence in the service” “continuity for patients and relatives” “enhanced clinical skills”
- What makes us different to other services in other local trusts? HNP’s are dedicated to this patient pathway and providing excellent care. Through enhanced skills of ordering and interpreting x-ray, it allows the patient to have a good patient experience in the right place at the right time. New cross have just started their pathway and only currently provide a six day surgery, Walsall do not have a service and patients are reviewed by registrar and SHO on call team.
- What are the benefits? The benefits are a higher standard of patient care, continuity of care patients, patients with a fracture NOF are moved to a dedicated amber side room on B2 hip suite. Improved communication, and staff recruitment and retention.
- Reduced LOS average of 15.9 days which is lower that the national average of 16.6 days.
- Best Practice Tariff (BPT) is above the national average with 71.43% of patients having surgery within 36 hours of admission, compared to the national average of 60.6%. Time to surgery average is 31 hours, compared to national average of 32.55 hours. (March 2021)
- How do the MDT get brought together? A monthly QPDT team meeting where current data is reviewed, and suggestions regarding improvements suggested.

What next

- Post Covid identification of Hip Aid pathway cubicle in ED
- Further review of service to consider 24 hour provision
- Explore further opportunities for development of the role



Enclosure 14

The Dudley Group NHS Foundation Trust

Paper for submission to the Board of Directors on May 13th 2021

TITLE:	**Board Effectiveness Review 2021**		
AUTHOR:	Liam Nevin Trust Secretary	**PRESENTER**	Liam Nevin Trust Secretary

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

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

RECOMMENDATIONS

- **That the Board considers any actions that it wishes to implement having regard to the survey findings, and the further matters highlighted in the background information.**
- **That the Board consider moving to a programme of bi-monthly public meetings to develop the capacity for Board development and strategy review.**

CORPORATE OBJECTIVE:

All

SUMMARY OF KEY ISSUES:

It is best practice to undertake an annual review, by way of self-assessment, of the Board and it sub Committee's effectiveness. Each Committee undertook a review in March and April and the outcomes of that, including any recommended changes to terms of reference have been reported up to the Board.

Board members were also asked to complete a questionnaire in relation to the scope and operation of the Board, and a summary of that is appended to this report.

The Board is asked to consider any steps that it wishes to take to address the issues raised in the background information.

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	**CQC**	**Y**	**Details:** Safe, Effective, Caring, Responsive, Well Led
	NHSI	**N**	**Details:**

LEGAL REQUIREMENTS			
	Other	**Y**	**Details: Code of Governance**
REPORT DESTINATION	**Board of directors**	**N**	**DATE:**
	WORKING GROUP	**N**	**DATE:**
	COMMITTEE	**N**	**DATE:** 13 May 2021

Annual Review of effectiveness of the Board
Report to Trust Board on 13th May 2021

The Dudley Group NHS Foundation Trust

1 EXECUTIVE SUMMARY

1.1 It is best practice to undertake an annual review, by way of self-assessment, of the Board and it sub Committee's effectiveness. Each Committee undertook a review in March and April and the outcomes of that, including any recommended changes to terms of reference have been reported up to the Board.

Board members were also asked to complete a questionnaire in relation to the scope and operation of the Board, and a summary of that is appended to this report.

The Board is asked to consider any steps that it wishes to take to address the issues raised in the background information.

2 BACKGROUND INFORMATION

2.1 Questionnaire Self- Assessment Responses

There are four responses where 10% or more of the Board have identified concerns:

- Is the information sufficiently concise?
- The Board receives an appropriate amount of presentations from Clinicians, Managers and other to remain informed
- Is a Succession Plan in Place?
- Does the Board spend sufficient time discussing the organisation's strategic direction?

2.2 Frequency and Content of Meetings

The Board continues to meet monthly and attendance of Directors is very high with absence being exceptional. There have been two periods during the year when as a result of the steps required to address the level 4 status of the pandemic it has been necessary to restrict agendas for committee meetings and to a lesser extent the Board. COVID-19 has also impacted on the capacity to undertake Board development and other informal Board activities. However, it is also important to note that the number of Board and committee meetings has increased in 2020 to 2021 compared to the preceding year (25 Board meetings compared to 24 and 54 committee meetings compared to 41).

Extending the Board development programme will have implications for the maintenance of the current Committee and Board work programme. In addition, although it can't be quantified at this point, the development of system and place based decision making arrangements over the next twelve months will also have implications for decision making and the involvement of Directors (NEDs and EDs) in partnership based fora.

2.3 Post Covid -19 Review

As the Trust is now emerging from the COVID-19 capacity challenges it is an opportune time to review the allocation of resources to formal meetings as opposed to board development, given the challenges identified above and the issues raised by Board members in the self-assessment review. In particular there is an identified need to ensure an additional Board focus on performance against the new strategy, system wide working and Board development. In order to accommodate these demands there would need to be a reduction in formal meetings and one option is that the public Board meeting moves to a bi-monthly schedule with the time freed up being protected for the above activities.

2.4 On Site Meetings

The Board have not met physically since March 2021. Based on the government's current proposals for reviewing the lock down arrangements it is likely that the ability to recommence on site meetings will be granted after the 21st June. The Board are asked to consider the timing for the reintroduction of on-site committee and Board meetings, which will be subject also to any conditions that the Director of Infection Control deems necessary.

2.5 Board Development

Board development in particular has been limited in the last twelve months but is now being relaunched with the NHSI Board development programme and the Diversity and Inclusion Cultural Development Programme both scheduled. The current development programme is appended to this report and this will need to be developed with the outputs from the NHSI/E programme.

Deloittes undertook a Well Led Review for the Trust in late December 2017, and the national guidance is that such reviews should be undertaken every three years and therefore another consideration is whether a further review should be commissioned and if so the timing of this. The CQC are currently reviewing the regulatory framework and the consultation for this concluded at the end of March 2021.

3 RISKS AND MITIGATIONS

3.1 These are identified in the body of this report

4. RECOMMENDATION(S)

4.1 **That the Board considers any actions that it wishes to implement having regard to the survey findings, and the further matters highlighted in the background information.**

4.2 That the Board consider moving to a programme of bi-monthly public meetings to develop the capacity for Board development and strategy review.

Liam Nevin
Trust Secretary
April 2021

APPENDICES:
Appendix 1 – Survey data

Board Effectiveness Annual review 2021

100% agreement	< 100% agreement	> 10% rated as 'below average, poor'

Board Effectiveness: Support and Infrastructure

Does the Board receive timely information?		
All of the time / Fully satisfactory	3/17	18%
Most of the time / Above average	13/17	76%
Some of the time / Average	1/17	6%
Occasionally / Below average	0/17	0%
Hardly ever / Poor	0/17	0%
N/A	0/17	0%

Is the information of the right quality?		
All of the time / Fully satisfactory	3/17	18%
Most of the time / Above average	9/17	53%
Some of the time / Average	5/17	29%
Occasionally / Below average	0/17	0%
Hardly ever / Poor	0/17	0%
N/A	0/17	0%

Is the information sufficiently concise?		
All of the time / Fully satisfactory	2/17	12%
Most of the time / Above average	5/17	29%
Some of the time / Average	6/17	35%
Occasionally / Below average	4/17	24%
Hardly ever / Poor	0/17	0%
N/A	0/17	0%

Is information in the right form to enable the Board to make sound decisions?		
All of the time / Fully satisfactory	1/17	6%
Most of the time / Above average	13/17	76%
Some of the time / Average	3/17	18%
Occasionally / Below average	0/17	0%
Hardly ever / Poor	0/17	0%
N/A	0/17	0%

The number and length of meetings and access to resources is sufficient to allow the Board to fully discharge its duties?		
All of the time / Fully satisfactory	9/17	53%
Most of the time / Above average	5/17	29%
Some of the time / Average	2/17	12%
Occasionally / Below average	1/17	6%
Hardly ever / Poor	0/17	0%
N/A	0/17	0%

Is the agenda sufficient to allow the Board to carry out its functions?

All of the time / Fully satisfactory	8/17	47%
Most of the time / Above average	8/17	47%
Some of the time / Average	1/17	6%
Occasionally / Below average	0/17	0%
Hardly ever / Poor	0/17	0%
N/A	0/17	0%

Does the agenda prioritise the right issues?		
All of the time / Fully satisfactory	3/17	18%
Most of the time / Above average	12/17	71%
Some of the time / Average	2/17	12%
Occasionally / Below average	0/17	0%
Hardly ever / Poor	0/17	0%
N/A	0/17	0%

Sufficient time is spent on each agenda item?		
All of the time / Fully satisfactory	3/17	18%
Most of the time / Above average	11/17	65%
Some of the time / Average	3/17	18%
Occasionally / Below average	0/17	0%
Hardly ever / Poor	0/17	0%
N/A	0/17	0%

The Board receives an appropriate amount of presentations from Clinicians, Managers and others to remain informed?		
All of the time / Fully satisfactory	0/17	0%
Most of the time / Above average	6/17	35%
Some of the time / Average	9/17	53%
Occasionally / Below average	2/17	12%
Hardly ever / Poor	0/17	0%
N/A	0/17	0%

Board Committee meetings are held sufficiently far in advance of Board meetings to allow for the resolution of issues?		
All of the time / Fully satisfactory	3/17	18%
Most of the time / Above average	9/17	53%
Some of the time / Average	4/17	24%
Occasionally / Below average	1/17	6%
Hardly ever / Poor	0/17	0%
N/A	0/17	0%

Board Effectiveness: Structure

Does the Board have the right balance of skills, knowledge and experience to deal with current and anticipated challenges?		
All of the time / Fully satisfactory	9/17	53%
Most of the time / Above average	8/17	47%
Some of the time / Average	0/17	0%
Occasionally / Below average	0/17	0%
Hardly ever / Poor	0/17	0%
N/A	0/17	0%

Board Members are clear on the role of the Board as a whole?		
All of the time / Fully satisfactory	8/17	47%
Most of the time / Above average	9/17	53%
Some of the time / Average	0/17	0%
Occasionally / Below average	0/17	0%
Hardly ever / Poor	0/17	0%
N/A	0/17	0%

The Board is clear as to its role in relation to Governance across the Trust?		
All of the time / Fully satisfactory	9/17	53%
Most of the time / Above average	8/17	47%
Some of the time / Average	0/17	0%
Occasionally / Below average	0/17	0%
Hardly ever / Poor	0/17	0%
N/A	0/17	0%

The Board is the right size to ensure effective decision making?		
All of the time / Fully satisfactory	10/17	59%
Most of the time / Above average	6/17	35%
Some of the time / Average	1/17	6%
Occasionally / Below average	0/17	0%
Hardly ever / Poor	0/17	0%
N/A	0/17	0%

Is a succession plan in place?		
All of the time / Fully satisfactory	2/17	12%
Most of the time / Above average	1/17	6%
Some of the time / Average	8/17	47%
Occasionally / Below average	2/17	12%
Hardly ever / Poor	2/17	12%
N/A	2/17	12%

Board Effectiveness: Leadership

Does the Board periodically review organisational culture and plan to maintain a positive culture?		
All of the time / Fully satisfactory	3/17	18%
Most of the time / Above average	10/17	59%
Some of the time / Average	3/17	18%
Occasionally / Below average	1/17	6%
Hardly ever / Poor	0/17	0%
N/A	0/17	0%

Does the Board collectively and individually model behaviours consistent with organisational values and culture?		
All of the time / Fully satisfactory	5/17	29%
Most of the time / Above average	10/17	59%
Some of the time / Average	2/17	12%
Occasionally / Below average	0/17	0%
Hardly ever / Poor	0/17	0%
N/A	0/17	0%

Does the time spent on strategy result in defined proposals to be incorporated into the business plan?		
All of the time / Fully satisfactory	0/17	0%
Most of the time / Above average	10/17	59%
Some of the time / Average	7/17	41%
Occasionally / Below average	0/17	0%
Hardly ever / Poor	0/17	0%
N/A	0/17	0%

Is the Board satisfied that it has identified the strategic risks facing the organisation, and that it has the controls to manage them?		
All of the time / Fully satisfactory	5/17	29%
Most of the time / Above average	9/17	53%
Some of the time / Average	3/17	18%
Occasionally / Below average	0/17	0%
Hardly ever / Poor	0/17	0%
N/A	0/17	0%

The Board focuses on the right questions and can challenge effectively?		
All of the time / Fully satisfactory	1/17	6%
Most of the time / Above average	14/17	82%
Some of the time / Average	2/17	12%
Occasionally / Below average	0/17	0%
Hardly ever / Poor	0/17	0%
N/A	0/17	0%

Does the Board keep abreast of changes in the external environment and considers their impact on the strategic direction of the Trust?		
All of the time / Fully satisfactory	5/17	29%
Most of the time / Above average	11/17	65%
Some of the time / Average	0/17	0%
Occasionally / Below average	1/17	6%
Hardly ever / Poor	0/17	0%
N/A	0/17	0%

Does the Board spend sufficient time discussing the organisations strategic direction?		
All of the time / Fully satisfactory	3/17	18%
Most of the time / Above average	6/17	35%
Some of the time / Average	5/17	29%
Occasionally / Below average	3/17	18%
Hardly ever / Poor	0/17	0%
N/A	0/17	0%

Board Effectiveness: Effectiveness

The Board assures itself that patient safety and quality issues are being addressed?		
All of the time / Fully satisfactory	3/17	18%
Most of the time / Above average	10/17	59%
Some of the time / Average	4/17	24%
Occasionally / Below average	0/17	0%
Hardly ever / Poor	0/17	0%
N/A	0/17	0%

Is the Board Assurance Framework effective?		
All of the time / Fully satisfactory	2/17	12%
Most of the time / Above average	6/17	35%
Some of the time / Average	9/17	53%
Occasionally / Below average	0/17	0%
Hardly ever / Poor	0/17	0%
N/A	0/17	0%

Communication between the Board and its Committees is adequate and effective?		
All of the time / Fully satisfactory	5/17	29%
Most of the time / Above average	10/17	59%
Some of the time / Average	2/17	12%
Occasionally / Below average	0/17	0%
Hardly ever / Poor	0/17	0%
N/A	0/17	0%

Board Effectiveness: Stakeholder engagement

Does the Board inform and involve key stakeholders in its work and check their views?		
All of the time / Fully satisfactory	0/17	0%
Most of the time / Above average	9/17	53%
Some of the time / Average	7/17	41%
Occasionally / Below average	1/17	6%
Hardly ever / Poor	0/17	0%
N/A	0/17	0%

The Board has clearly identified open channels of communication with Staff and external Stakeholders in order to improve patient care?		
All of the time / Fully satisfactory	1/17	6%
Most of the time / Above average	9/17	53%
Some of the time / Average	6/17	35%
Occasionally / Below average	1/17	6%
Hardly ever / Poor	0/17	0%
N/A	0/17	0%

Does the Chair ensure that there is sufficient challenge on each issue on the Boards agenda?		
All of the time / Fully satisfactory	10/17	59%
Most of the time / Above average	5/17	29%
Some of the time / Average	2/17	12%
Occasionally / Below average	0/17	0%
Hardly ever / Poor	0/17	0%
N/A	0/17	0%

Board Effectiveness: Behaviours

The Chair demonstrates good listening skills?		
All of the time / Fully satisfactory	12/17	71%
Most of the time / Above average	4/17	24%
Some of the time / Average	1/17	6%
Occasionally / Below average	0/17	0%
Hardly ever / Poor	0/17	0%
N/A	0/17	0%

Board meetings encourage a high quality of debate with robust and probing discussions?		
All of the time / Fully satisfactory	7/17	41%
Most of the time / Above average	9/17	53%
Some of the time / Average	1/17	6%
Occasionally / Below average	0/17	0%
Hardly ever / Poor	0/17	0%
N/A	0/17	0%

The Board responds positively and constructively to bad news in order to encourage future transparency?		
All of the time / Fully satisfactory	4/17	24%
Most of the time / Above average	11/17	65%
Some of the time / Average	2/17	12%
Occasionally / Below average	0/17	0%
Hardly ever / Poor	0/17	0%
N/A	0/17	0%

The Chair operates satisfactorily in terms of promoting effective and efficient meetings, with an appropriate level of involvement outside of the formal meetings?		
All of the time / Fully satisfactory	8/17	47%
Most of the time / Above average	6/17	35%
Some of the time / Average	3/17	18%
Occasionally / Below average	0/17	0%
Hardly ever / Poor	0/17	0%
N/A	0/17	0%

Executive and Non-Executive Board members have a frank and open relationship with each other and each Director understands his/her own personal Board level responsibilities?		
All of the time / Fully satisfactory	2/17	12%
Most of the time / Above average	9/17	53%
Some of the time / Average	5/17	29%
Occasionally / Below average	1/17	6%
Hardly ever / Poor	0/17	0%
N/A	0/17	0%

The Board has a good understanding of key people issues, particularly those regarding Transformation?		
All of the time / Fully satisfactory	1/17	6%
Most of the time / Above average	12/17	71%
Some of the time / Average	3/17	18%
Occasionally / Below average	0/17	0%
Hardly ever / Poor	1/17	6%
N/A	0/17	0%

All Board members attend and actively contribute at meetings?		
All of the time / Fully satisfactory	6/17	35%
Most of the time / Above average	10/17	59%
Some of the time / Average	0/17	0%
Occasionally / Below average	1/17	6%
Hardly ever / Poor	0/17	0%
N/A	0/17	0%

All Board members have sufficient time and commitment to fulfil their responsibilities?		
All of the time / Fully satisfactory	3/17	18%
Most of the time / Above average	9/17	53%
Some of the time / Average	5/17	29%
Occasionally / Below average	0/17	0%
Hardly ever / Poor	0/17	0%
N/A	0/17	0%

Board members undertake ongoing personal development?		
All of the time / Fully satisfactory	3/17	18%
Most of the time / Above average	8/17	47%
Some of the time / Average	5/17	29%
Occasionally / Below average	1/17	6%
Hardly ever / Poor	0/17	0%
N/A	0/17	0%

The Dudley Group NHS Foundation Trust

Board Development Plan

Monitoring body	Trust Board of Directors
Executive Lead:	Liam Nevin, Trust Secretary
Date of last review:	April 2021

Table 1: Board and Committee Structure

Ref	Action	Lead	Completion date	Actions Taken	Further Action Required	Status
1.1	Review frequency of committee meetings and structuring of business with Board meetings (bi-monthly committees)	LN	January 2020	Proposal approved -January Board. Committee workplans updated and new model implemented		5
1.3	Re-establish a Digital/Technology Committee and agree terms of reference	LN/AT	June 2020	Approved – January Board	Complete	5
1.4	Well Led Review to assess Ward to Board arrangements – Assurance from reporting groups, Trust Committees and the Trust Board	LN	June 2021	Well Led Review Commissioned	Delayed by COVID – to be reviewed September 2020. Delayed by second COVID wave September – March 2021. To be reviewed June 2021	3
1.5	Review of Committee and Board effectiveness after six months of operating new system	LN	September 2021	Well Led Review Commissioned	To be addressed as part of Well Led Review.	3

Status key:	5	Complete	4	On track	3	Some delay – expect to completed as planned	2	Significant delay – unlikely to be completed as planned	1	Not yet commenced	0	Objective revised

Table 2: Director Induction, Appraisal and Development and Succession Planning

Ref	Action	Lead	Completion date	Actions Taken	Further Actions Required	Status
2.1	Development of a formal induction and checklist for new non-executive directors	LN	Done	-Induction pack created. -Induction checklist of key meetings created. - New NEDS booked onto NHS Providers Induction training		5
2.2	Achieve 100% Mandatory training compliance for all Board members	LN	31/5/21		Two NEDs with outstanding training (as of 12.4.21) – followed up	3
2.3	All Board Members to Undertake 360 degree feedback as part of the appraisal process	Chair/ LN	30/9/21	Completed for 2020/21	Rem Com to consider ED appraisals Council of Governors to consider NED appraisals	5
2.4	Undertake a skills mapping exercise for Board	LN	5/21	Completed and considered by Rem Com	Recruitment of additional NED with clinical experience. Skills assessment report reported to Council of Governors April 2021	5
2.5	Succession Planning for Non-Executive Directors	Chair/LN	30/9/21	As per 2.4 – terms of office extended and two additional Associate NEDs recruited to fill skill gaps	Induction of new Associate Directors	4

Status key:	5	Complete	4	On track	3	Some delay – expect to completed as planned	2	Significant delay – unlikely to be completed as planned	1	Not yet commenced	0	Objective revised

Table 3: Board Effectiveness

Ref	Action	Lead	Completion date	Actions Taken	Further Action Required	Status
3.1	NHSI Development Programme: - Understanding ourselves and the team - Working well as a team together - Managing Board effectiveness - Understanding the role of the Non- Executive Director (NED) and making the best use of their skills and perspective - Positive influence of the Board - Influence in the region and nationally	LN/NHSI – Andy Mullins	TBC	Support from NHSI secured. Project delayed from March 2020. Rescheduled for September 2020 – delayed again by COVID Project commenced in February and March 2021 with 1 to 1 interviews. First Board session held in April 2021	Three further days of Board development tbc, and development programme to be agreed as an output. Board working group to meet in May 2021 to recommend programme design	4
3.2	Undertake Well Led Review	LN	Sept 2021	See 1.4	See 1.4	3
3.3	Prepare a schedule of exec and non-exec assignments to committees and portfolio of responsibilities	Chair/LN	February 2020	Consultation with NEDs undertaken Updated April 2021	Two associate NEDs to be allocated to committee positions and portfolio support	4
3.4	Develop a programme of Board workshops	Chair/LN	Continuous	Inclusive Leadership Board Development Programme x 2 days: May and June 2021	3 days of NHSI Board Team Development Programme to be scheduled with Andy Mullins. Further subjects to be agreed Schedule of Board meetings to be reviewed to free up capacity for Board development – Board report in May 2021	4

Status key:	5	Complete	4	On track	3	Some delay – expect to completed as planned	2	Significant delay – unlikely to be completed as planned	1	Not yet commenced	0	Objective revised

Enclosure 15

Paper for Submission to the Board of Directors 13th May 2021

TITLE:	Quality and Safety Committee		
AUTHOR:	Sharon Phillips – Deputy Director of Governance	**PRESENTER:**	Liz Hughes – Non 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	**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**	**Y**	**Details:**
	NHSI	**Y**	**Details:**
	Other	**N**	**Details:**
REPORT DESTINATION	**EXECUTIVE DIRECTORS**	**N**	**DATE:**
	WORKING GROUP	**N**	**DATE:**
	COMMITTEE	**N**	**DATE:**

CHAIRS LOG

UPWARD REPORT FROM QUALITY AND SAFETY COMMITTEE

Date Committee last met: 27th April 2021

MATTERS OF CONCERN OR KEY RISKS TO ESCALATE	MAJOR ACTIONS COMMISSIONED/WORK UNDERWAY
• There has been a significant rise in the number of falls over the period October 2020-January2021. This rise is in line with other Trusts within the Regional Falls Network and is apportioned to the effects of the COVID-19 pandemic.	• Stroke Services trajectory and action plan for recovery to be brought back to the June 2021 Committee • Cancer services recovery plan quality assurance report to be brought back to the June 2021 Committee
POSITIVE ASSURANCES TO PROVIDE	**DECISIONS MADE**
• Significant assurance received from the End of Life Annual Report showing exemplary practice and innovation to take the service forward locally and across the health economy. Especially in relation to the Gold Standard Framework • Assurance received of the breadth and depth of work undertaken over the year presented in the Safeguarding Annual Report. • Positive assurance received of a comprehensive investigation into a Klebsiella outbreak with the subsequent identification of learning and robust actions resulting in proven improved practice/reduction in falls • Positive assurance received from the Medicines Management Annual Report of work plan delivery and further plans to improve quality and medicines management compliance. • Positive assurance received in the Fall Annual Report of compliance with the quality and safety indicators, progress against the action plan and new ways of working showing a positive outcome of reduced falls March 2021. • Assurance of stroke recovery post COVID and achievement of its trajectory of compliance by June 2021 • Positive assurance following the Health and Safety Executive inspection national report, which focussed on 7 key areas assessing arrangements in place for managing the risk from COVID-19. The Trust showed good compliance across all 7 key areas with recommendations to strengthen consistency of its compliance across all areas.	• Recommended the Safeguarding Annual Report to the Board • Approved the Falls Annual Report • Approved the End of Life Care Annual Report • Approved the Medicines Management Annual Report

• Maternity Safety Standards – Assurance received on progress being made to deliver all 10 standards.	

Enclosure 16

The Dudley Group NHS Foundation Trust

Paper for submission to the Board of Directors
13th May 2021

TITLE:	**Safeguarding Annual Report 2020/2021**		
AUTHOR:	Julie Mullis Head of Safeguarding	**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

The Board is asked to receive and approve the Safeguarding Annual Report.

CORPORATE OBJECTIVE:

SO1: Deliver a great patient experience
SO2: Safe and Caring Services
SO3: Drive service improvements, innovation and transformation
S05: Make the best of what we have

SUMMARY OF KEY ISSUES:

Safeguarding Annual Report providing a declaration of assurance that the Trust is fulfilling its duties and responsibilities in relation to promoting the welfare of children, young people, adults and their families or carers who come into contact with our services.

The report provides a summary of the safeguarding activities across the Trust to demonstrate how the Trust discharges its statutory duties in relation to current safeguarding legislation, national standards and best practice guidelines.

IMPLICATIONS OF PAPER:

IMPLICATIONS FOR THE CORPORATE RISK REGISTER OR BOARD ASSURANCE FRAMEWORK

(set out narrative here including any recommended amendment to the BAF)

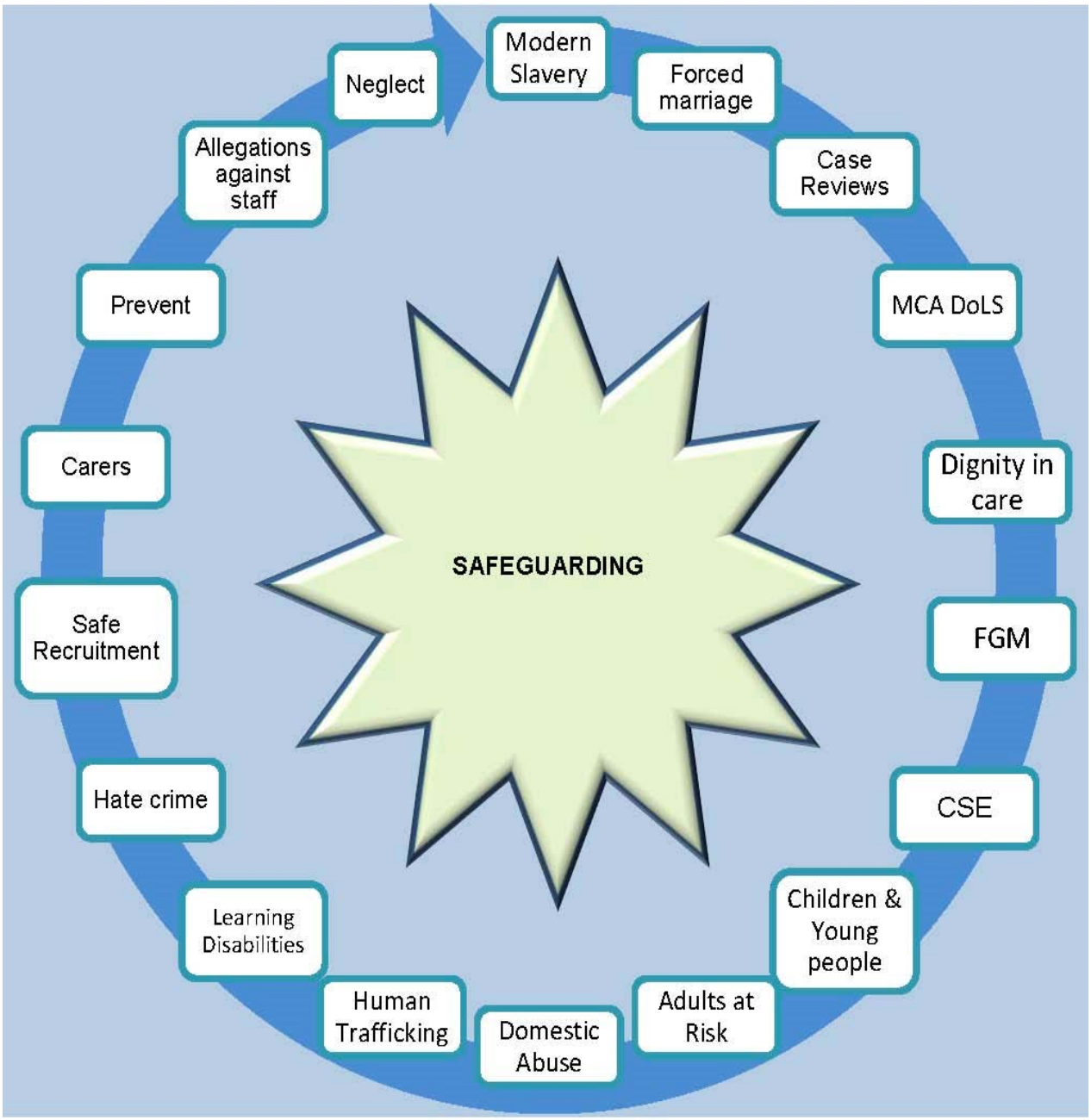
RISK	**N**		**Risk Description:**
	Risk Register: N		**Risk Score:**
COMPLIANCE and/or	**CQC**	**Y**	**Details:** Regulation 13 – Safeguarding service users from abuse and improper treatment

LEGAL REQUIREMENTS	**NHSI**	**Y/N**	**Details:**
	Other	**Y/N**	**Details:** Working together to safeguarding Children 2018 Children Act 2004 Care Act 2014 Mental Capacity Act 2005
REPORT DESTINATION	**EXECUTIVE DIRECTORS**	**Y/N**	**DATE:**
	WORKING GROUP	**Y**	**DATE: Internal Safeguarding Board 26.4.21**
	COMMITTEE	**Y/N**	**DATE: Quality and Safety Committee 27.4.21**

The Dudley Group
NHS Foundation Trust

Safeguarding Annual Report

2020 – 2021


SAFEGUARDING
Modern Slavery
Forced marriage
Case Reviews
MCA DoLS
Dignity in care
FGM
CSE
Children & Young people
Adults at Risk
Domestic Abuse
Human Trafficking
Learning Disabilities
Hate crime
Safe Recruitment
Carers
Prevent
Allegations against staff
Neglect

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1.0 Foreword

The Dudley Group NHS Foundation Trust (DGFT) recognises that effective, timely and robust safeguarding is fundamental to protecting those at risk in our care and that this requires constant vigilance and a readiness to act where we suspect abuse, exploitation or neglect. The landscape of safeguarding is constantly evolving and as a Trust we endeavour to embrace and shape our key priorities in support of this. DGFT is an organisation with a vital role to fulfil in protecting the vulnerable whilst demonstrating a concerted obligation to respond with haste and flexibility to meet new demands as they arise. Above all, we are dedicated to ensuring that we listen to the voices of the vulnerable and act upon what we hear. Safeguarding is everyone's business.

"Safeguarding helps all children and adults who are at risk of abuse. It protects children from harm and neglect and provides them with the best chance of developing into happy, well-adjusted and successful adults. It brings kindness, respect, dignity and support to vulnerable adults, however challenging their lives may be, and protects them from harm. It falls to all of us in the NHS to give our best efforts to these endeavours."

Ref: Dr Peter Green, Chair, National Network of Designated Health Professionals and Designated Doctor for Child Safeguarding, NHS Wandsworth CCG

2.0 Introduction

This annual report reflects the arrangements to safeguard and promote the welfare of children, young people and adults at risk within Dudley Group NHS Foundation Trust for the period April 2020 to March 2021. In doing so, the Trust discharges part of its responsibility for Board-level assurance, scrutiny and challenge of safeguarding practice within the Trust, in line with the statutory requirements of section 11 Children Act (2004), Working Together to Safeguard Children (2018) and the Care Act 2014.

In addition the Trust, as a registered provider with the Care Quality Commission (CQC), must have regard for the Regulations as established under the Health and Social Care Act (2008). In relation to Safeguarding, including but not limited to, Regulation 13 and Regulation 17, relating to protecting service users from abuse and good governance, respectively.

The report highlights areas of priority and activity and those areas requiring further focus and development in order to strengthen the safeguarding processes within the Trust, and meet the increasing complexities of the national and local safeguarding agenda.

3.0 National and local safeguarding Context, Guidance and Key Legislation

Safeguarding is an increasingly complex and challenging environment. For vulnerable adults there is the need to balance the rights and choices of an individual, with the Trust's duty to act in their best interest and protect them from harm. Children and young people continue to experience abuse from within and outside their families, including criminal and sexual exploitation, gang related abuse and radicalisation. This is an area of multi-faceted abuse which is often hidden and can be difficult to identify and monitor.

3.1 Impact of COVID

COVID-19 has brought with it many challenges, but at the forefront of our service delivery has been ensuring the safeguarding of all our patients, visitors and staff.

The COVID-19 Prioritisation with Community Services Guidance, The COVID 2020 Act, Changes to the Care Act 2014 and the various COVID 19 related Guidance, have all emphasised that safeguarding children and adults is as critical during the pandemic as at any other time, and that all statutory requirements still stand.

The global Covid-19 pandemic is unprecedented and the impact for individuals, families, communities and wider society is significant and will be long lasting. Due to the restrictions in place, many children and adults have become at increased risk of harm such as exploitation, domestic abuse and financial scamming. The most vulnerable in our society have been hidden from day to day services that would normally have provided a protective shield, and it is likely that the true impact of harm to these individuals will not be fully known for many more months.

Due to capacity issues across the Trust and restrictions around social distancing, some of the improvement work identified in the Annual Improvement Plan has not been undertaken. Instead, the safeguarding team have prioritised work to mitigate against safeguarding risks associated with the COVID-19 pandemic. The safeguarding

team have continued throughout the pandemic to provide a responsive service to staff who were under increasing pressure:-

- Practical support from the safeguarding team across the Trust to complete safeguarding activities where staff lacked the time or resources to do this.
- Regular liaison with external agencies and CCG designate nurses around local and national safeguarding updates
- Information regarding risks to older people e.g. scams and fraud sent out to senior leads for cascading to teams
- Following up of adult safeguarding referrals from District Nurses to ensure appropriate agency support in place
- Support to discharge liaison team re safe and efficient discharges for patients with safeguarding concerns
- Oversight of arrangements by Trust children's services regarding risk assessments and mitigations in place where face to face services were not being provided to children with known safeguarding concerns or frequency of appointments were decreased
- Input into COVID SOP to ensure safeguarding issues considered for virtual appointments
- 3 x daily visits by associate nurses to ED to support staff in completion of MARFs and give support on complex cases
- Partnership working with Learning Disability team around appropriate documentation of DNARs and implementation of MCA
- More accessible and frequent supervision and advice to midwives to assist in risk assessing vulnerable families
- Named midwife attended child protection conferences of behalf of maternity services.
- Development of RAG rated risk assessment tool to support midwives in decision making regarding safeguarding vulnerable families with reduced home visiting and capacity issues

COVID-19 Vaccination Centre – Black Country Museum

Many of the members of public attending for the first waves of the vaccines in January and February were identified as being adults likely to have care and support needs and that their appointment for the vaccine may well be the first face to face contact with public services since the beginning of the pandemic. In recognition of this the Safeguarding Team has provided resources and support to staff at the vaccination centre. The team have attended the site 3 times a week for the first month to give bitesize training and advice at the morning huddles. An assurance visit and subsequent action plan was completed by the Head of Safeguarding and in partnership with the Vaccine Hub Matron, ensured that all actions were completed.

From the start of the vaccination centre opening in early February 2021 to end of March 2021, the staff at the vaccination centre have identified and reported 11 safeguarding adult concerns, demonstrating positive safeguarding practice.

3.2 Dudley Safeguarding People's Partnership (DSPP)

Dudley Safeguarding People's Partnership has embraced a life course approach to their arrangements, with a focus on an integrated adult and children agenda and emphasis on transitional arrangements to ensure young people reaching adulthood continue to receive the care and support they need.

The priorities 2020-2022 for the Partnership were set out in September 2020:-

- Neglect across the life course
- Harm across the life course
- Exploitation across the life course

The work of the safeguarding team has reflected these priorities via training, learning events, supervision and audit

3.3 ***Key Legislation***

- Children Act 1989
- Human Rights Act 1998
- Sexual Offences Act 2003
- Female Genital Mutilation Act 2003
- Data Protection Act 2018
- United Nations Conventions on the rights of the child 1990
- Children Act 2004; statutory guidance on making arrangements to safeguard and promote the welfare of children under Section 11
- Children and Social Work Act 2017
- Mental Health Act 1983
- Human Rights Act 1998
- Article 5 - Right to Liberty and Security
- Article 8 - Respect for Private and Family Life
- Article 14 - Prohibition of Discrimination
- Mental Capacity Act 2005 and Mental Capacity Amendment Act 2019
- Health & Social Care Act 2008
- Deprivation of Liberty Safeguards 2009
- Care Act 2014
- Counter Terrorism and Security Act 2015
- Serious Crime Act 2015
- Modern Slavery Act 2015

3.4 ***National Guidance***

- Working Together to Safeguard Children 2018
- PREVENT Duty Guidance 2015
- CQC Fundamental Standards Statement on CQC's Roles and Responsibilities For Safeguarding Children and Adults June 2015
- FGM Enhanced Data Set 2015
- RCN 2018 Intercollegiate Document - Safeguarding Adults: Roles and Competencies for Healthcare Staff
- Child Death Review - Statutory and Operational Guidance 2018
- RCN 2019 Intercollegiate Document Safeguarding Children and Young People: Roles and Competencies for Health Care Staff
- NHS England Safeguarding Children, Young People and Adults at Risk in the NHS: Accountability and Assurance Framework updated in 2019.

4.0 <u>The Dudley Group NHS Foundation Trust Safeguarding Team</u>

Safeguarding Team - April 2020 – March 2021

Restructure of the safeguarding team, within current budget, was agreed by the Lead Executive Chief Nurse on 21st April 2020. Recruitment into the new structure was completed in October 2020.

The new safeguarding structure as presented below has specifically provided a small increase of adult named nurse hours from 1.0 to 1.3 WTE. This additional resource has been utilised to provide increased provision of supervision and support for staff in our community services.

The Paediatric Liaison Nurse role was replaced in October 2020 with a Band 6 Associate Nurse for Safeguarding. This nurse continues to undertake the daily review of paediatric attendances but also provides direct support and advice to Trust staff and undertake essential actions as set out on the Trust Safeguarding Improvement Plan. This more

proactive approach has been well received by Trust staff and has proved to be an asset in making improvements in practice.

April 2020-March 2021	
Designation	**WTE**
Head of Safeguarding	1.0 WTE
Lead Nurse for Safeguarding Children/Deputy Head of Safeguarding	1.0 WTE
Named Nurse for Safeguarding Children	0.8 WTE
Named Midwife	1.0 WTE
Named Nurse Safeguarding Adults	1.3 WTE
Lead Nurse Child Death	0.6 WTE
Associate Nurse for Safeguarding Adults	0.8 WTE
Associate Nurse for Safeguarding Children	0.8 WTE
Named Doctor for Safeguarding Children	
Named Consultant for Safeguarding Adults	
Administrative support	2.0 WTE

5.0 *Governance*

The safeguarding team are led by the Head of Safeguarding, with line management from the Deputy Chief Nurse, and the Chief Nurse is the Trust Executive Lead for Safeguarding, providing Board oversight of safeguarding arrangements.

The Named Professionals provide the organisation with operational advice, support and input. The professionals are committed to supporting the workforce in understanding safeguarding, embedding it into 'everyday business' and improving outcomes.

The Trust oversees the governance arrangements through the quarterly Internal Safeguarding Board (ISB), which is chaired by the Chief Nurse. The ISB gains assurance on behalf of the Trust Board that its legal and statutory duties are met in relation to safeguarding of adults, young people and children. The ISB is attended by a safeguarding representative from the Designated Nurse Team in the CCG and senior leaders of Trust departments whose role is to offer scrutiny and challenge and cascade learning to their areas. Areas for escalation from the ISB are reported to the Trust Quality and Safety Committee. The Internal Safeguarding Board monitors progress against the:-

- Annual work and audit plan
- CCG key performance indicators and contractual standards
- Risk register
- Incident reporting
- Local and National learning from Domestic Homicide Reviews, Safeguarding Adult Reviews and Child Safeguarding Practice Reviews
- Performance against statutory standards

The Safeguarding Improvement Group was set up in July 2020 to strengthen the governance and accountability for implementing and embedding actions and learning from internal and external reviews and audits. Unfortunately due to the pressures around COVID-19 pandemic, this group has only met twice this year and was not successful in fulfilling this role. Reinstating this group will be a priority for 2021/22.

5.1 Risk Register Review

A robust Risk Register is required to ensure safe, effective and comprehensive management of risks in relation to safeguarding of children, young people and adults. The identification of risks to the Trust in being able to provide their statutory safeguarding duties, is fundamental to ensuring appropriate mitigations are in place and actions are taken for continued improvement of safeguarding practice. One risk relating to effective implementation of the new Liberty Protection Safeguards has been moved from Corporate risk register to safeguarding risk register. There are 3 risks in relation to domestic abuse. No high risks have been identified within the time frame of this report. See Appendix 1

*5.*2 Partnership working

During 2020/21 the Trust has contributed to engagement and effective partnership working with agencies across Dudley and the wider Black Country footprint.

Due to the reconfiguration of the Dudley Safeguarding People's Partnership, representation from the Chief Nurse is now required at the Safeguarding Adult and Children Groups which report into the overarching Partnership Board. The Head and Deputy Head of Safeguarding provide Trust representation at the four subgroups around operational systems, learning and improvement and exploitation (children's and adults).

The Trust are also represented by the Safeguarding Team at the Domestic Abuse and Sexual Violence Strategic Forum which is led by Dudley and Safe and Sound

The Trust is a virtual member of the Multi Agency Safeguarding Hub [MASH] for adults & children. This process is for the multi-agency sharing of information where a safeguarding concern arises and facilitates effective collaboration.

The safeguarding team also actively contribute to Dudley Safeguarding Adult Reviews, Domestic Homicide Reviews and Child Safeguarding Practice Reviews, both in terms of scoping, Individual Management Reviews and Panel procedures. The safeguarding team have again received positive feedback from authors regarding the high quality of our analysis and report.

The safeguarding team attend Multi-Agency Risk Assessment Conference (MARAC) twice monthly to work in partnership with other agencies to protect people at risk from domestic abuse. This takes on average 45-49 hours a month of Named Nurse time to prepare information and attend the meeting. This has a significant impact on resources and has been listed as a risk on the local safeguarding risk register and raised at the Safeguarding Quality Review Meeting with the Deputy Chief Nurse at Dudley CCG.

The Named Nurse for Children also attends Children Missing Operations Group to feed into the management and monitoring of risk to these children.

The Named Nurse for Adults attends local and regional PREVENT partnership events to ensure the Trust has robust and up to date systems in place to report issues around radicalisation. The Executive Lead role for the Trust is held by the Deputy Chief Operations Officer.

Health Practitioners Care Home Forum – This forum is attended by one of the Safeguarding Adults nurses. It is an informal meeting chaired by the Designated Safeguarding Adults Lead in the CCG. The forum aims to identify and address low level concerns in care homes before they meet the safeguarding threshold. Where there are concerns professionals are identified to engage and support the care homes.

Rough Sleepers meeting – This meeting is chaired by the Head of Housing Options & Support for Dudley Council. The meeting discusses all known homeless people within the Dudley area and seeks to engage with these people with the aim of providing suitable accommodation. The Safeguarding Adults nurses research known rough sleepers to

provide any relevant information which will assist with rehousing safely. There is often a link found by the nurses with frequent attendances to ED and often elements of self-neglect are identified.

5.3 *Safeguarding Training*

Mandatory safeguarding training was subject to an in-depth review in 2019, with a focus upon training needs analysis and workforce requisites. The new training strategy came into force in January 2020 with all staff to complete level 2 training via e-learning and level 3 training being attained via a variety of different learning opportunities, including some learning events and workshops provided by the safeguarding team, and evidenced on a Safeguarding Training Passport. In addition, training compliance is now gained by completing 4 hours of training per year, to make up the 12 hours required over a 3 yearly period.

Safeguarding Training Compliance

Topic/Level	CCG Contractual Compliance Standard	Compliance %
Children Level 1	**90%**	**85.6%**
Children Level 2	**85%**	**72.9%**
Children Level 3	**85%**	**66%**
Children Level 4	**90%**	**100%**
Adults Level 1	**90%**	**87%**
Adults Level 2	**85%**	**72.6%**
Adults Level 3	**85%**	**33.3%**
Adults Level 4	**90%**	**100%**
Prevent Basic Awareness	**90%**	**90.4%**
Prevent WRAP	**90%**	**81.7%**

The safeguarding team acknowledge that mandatory training across the Trust has been impacted by the COVID 19 pandemic. As a result, compliance in all areas of safeguarding training has fallen.

Compliance with the newly introduced Level 3 Adult Safeguarding training

Level 3 adult safeguarding training was introduced to the Trust in January 2020 in line with the Adult Intercollegiate Document. It currently has priority 2 status due to being new training, however this is due to move to priority 1 in April 2021 and will be a statutory requirement for staff to complete. The Head of Safeguarding has promoted the training requirement via regular communication with Clinical and Operational Leads and senior nursing staff.

Accessibility of Training

Level 2 training for adults and children is available to do on line via e-learning packages. Level 3 training is available via self-directed study and face to face events; the Safeguarding Team have offered 14 Level 3 face to face day sessions and 8 evening sessions. Unfortunately these sessions had poor attendance. E-learning packages and resources for self-directed study have been identified by the safeguarding team and shared on Learning and Development hub pages and with senior leads for cascading to staff.

Moving Forward - New Initiatives

The safeguarding team will continue to work closely with senior leads within the Trust to ensure staff are clear on the training requirements and training opportunities, and they will continue to provide monthly learning events. This will be a priority for the safeguarding team over the coming year. In addition the safeguarding team are looking for new ways of providing and increasing access to safeguarding training:-

- Microsoft Teams:- In recognition of the growing trend towards virtual access to training and information, the safeguarding team are now setting up training events via Teams
- Partnership Working: The safeguarding team are working with the Dudley Safeguarding People Partnership to build some level 3 e-learning and/or webinar packages that would be available to agencies across Dudley including DGFT staff.

5.4 Audit and benchmarking

The pressure of the COVID-19 Pandemic has impacted on the team's capacity to complete audits within the annual audit plan. Those that have not been undertaken have been transferred to next year's plan. A number of audits have been undertaken over the last 12 months to provide assurance that policy and procedures are being effectively implemented and to highlight areas which require further action and focus. See Appendix 2 and 3

Key points requiring further action are:-

- Documentation
- Evidencing voice of the child and views and wishes of adult patients
- Improve risk analysis

The Trust has continued to support Dudley Safeguarding People's Partnership with external audits and is committed to meeting its statutory and regulatory requirements in this area.

DSPP Section 11 Audit was completed in August 2020:-

Areas of audit	Overall Rating	Identified Areas for Improvement
Leadership and Accountability	Outstanding	**On Safeguarding Annual Improvement Programme** • Improvement in assurance that staff caring for young people on adult pathways are able recognise indicators of child abuse and know what to do to keep children and young people safe from harm
Policies and Procedures	Outstanding	None
Recruitment and Selection	Outstanding	None
Training and Development	Good	**On Safeguarding Improvement Plan** • Develop and implement an effective method of evaluating the impact of training on practice
Complaints, Allegations and Whistleblowing	Good	**On Safeguarding Risk Register** • Training for managers on implementation of new Managing Allegations Against Staff Policy
Information Sharing	Good	**On Safeguarding Improvement Plan** • Review of safeguarding documentation processes and audit quality of documentation
Listening to Children and Young People	Requires Improvement	**Added onto Safeguarding Improvement Plan** In partnership with Trust Children's Services:- • Improve promotion of safeguarding information for children, young people and their families with coordinated response across the Trust and utilising various methods • Increase evidence of listening to children through: Patient stories, engagement of children and evidence of their ideas and view being acted upon. Audit of documentation • Develop methods of evaluating outcomes of safeguarding practice from view or CYP

West Midlands Domestic Abuse Standards

Some progress has been made in meeting these standards. There is currently a concentration on the work in ED. The aim of the planned Domestic Abuse Strategy is to extend the priority of domestic abuse across the Trust.

Multi-Agency Case File Audit (MACFA)

The Trust has engaged with two DSPP MACFAs this year around child criminal exploitation and permanently excluded children.

The audit plan for 2021/22 has been prepared and will be presented at ISB in April 2021 for agreement and shared with partner agencies at Dudley CCG Safeguarding Quality Review Meeting. The Dudley Safeguarding People Partnership has yet to make their requests for external audits and these will be incorporated as required.

5.5 Assurance visits and external peer reviews

There have been no assurance visits undertaken by the CCG during 2020/21.

CCG Designate nurses attend the Trust ISB to gain assurance around safeguarding activity and procedures and bi-monthly exception reports are submitted to the CCG by the Head of Safeguarding via the Safeguarding Quality Review Meetings. Benchmarking has been completed against the Assurance Tool developed by the Black Country STP Safeguarding Forum. Overall, the Trust meets all areas of assurance, with one requirement to improve safeguarding information available to patients and visitors.

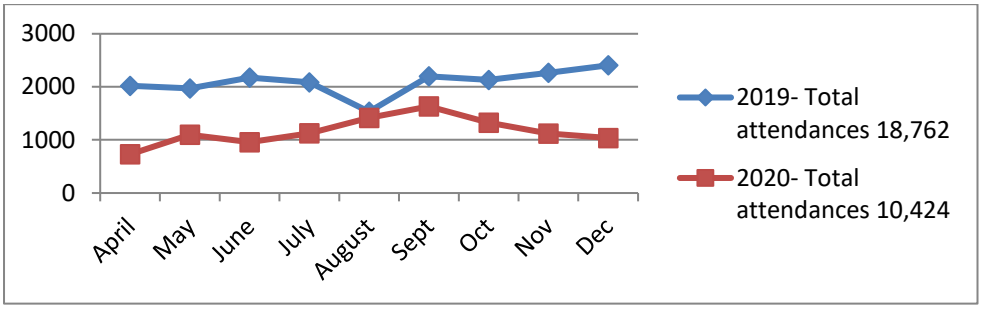
Safeguarding Activity and Performance for 2020/21

Safeguarding activity across DGFT has continued to intensify in volume and complexity which is reflected both nationally and regionally. Safeguarding referrals for children and adults, and the number of Safeguarding Datix™ submitted, has increased for the third year in a row, despite a decrease in footfall throughout the Trust due to COVID-19 pandemic.

6.0 Safeguarding Children Activity 2020/21

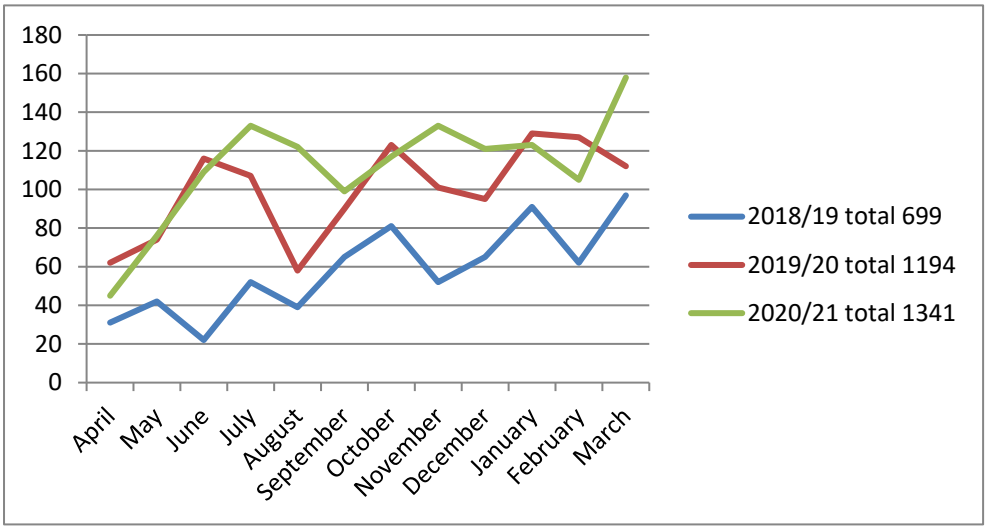
The impact of COVID-19 restrictions on children and young people are visible in the reduced attendance of children in the Trust ED. Attendances to the Emergency Department for Q1 and Q2 in 2020 have decreased by 42% compared to the same period in 2019. This decrease is reflected nationally. There was a sharp increase in attendance of 50% between Q1 and Q2 which coincides with the easing of restrictions from the first national lock down in March 2020.

Emergency Department Paediatric Attendances 2019/2020



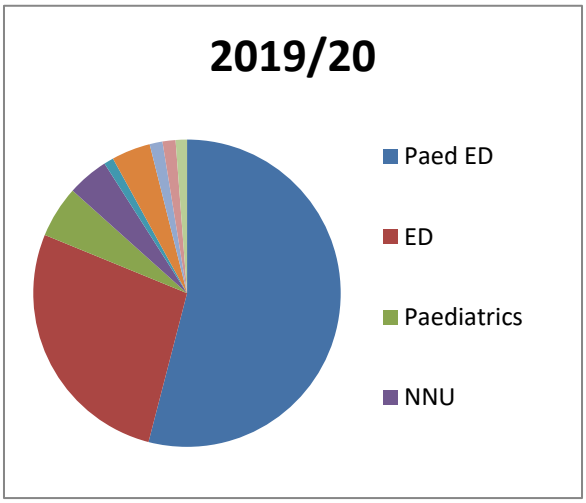
The chart below shows comparative data for the number of safeguarding children referrals made over the last 3 years. Despite there being significantly reduced attendance of children and young people in ED this year due to COVID-19 pandemic, the graph demonstrates that staff still submitted more safeguarding referrals than the previous year. This provides a positive picture of staff identifying and acting upon safeguarding concerns for children and young people.

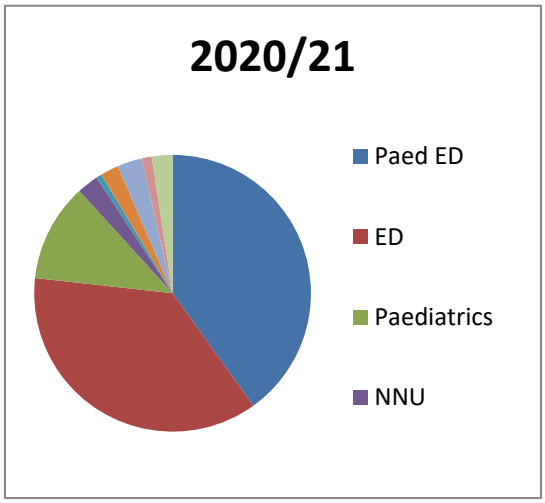
Referrals to Children's Social Care 2018 – 2021



Reporting by Ward/Service/Department

One of the key activities from this year's safeguarding improvement plan was to improve recognition and referral of safeguarding concerns for children across the Trust. The charts below provide a picture of safeguarding concerns reported by departments across the Trust and there is positive evidence that there has been some small but significant evidence of this happening.





The above charts demonstrate that:-

- Adult ED staff are reporting more safeguarding concerns for children and young people as a result of recognising the impact of adult ill-health on their capacity to keep children safe from harm.
- The Trust paediatric services and maternity services reporting has increased by 32%
- Outpatient services across the Trust have increased their reporting of safeguarding concerns by 30%

The reduction in face to face appointments in areas such as CASH and GUM may offer some explanation of why these services have reported nearly 50% less concerns that in 2019/20

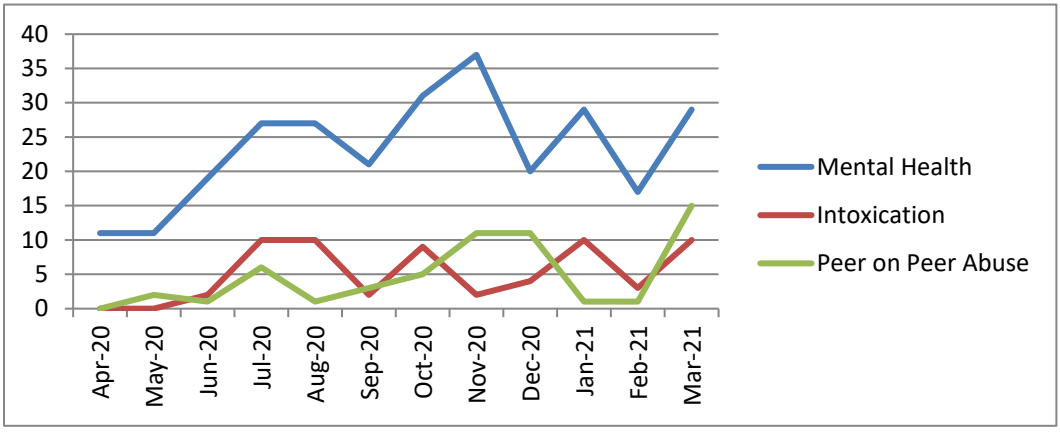
Mental Health, Substance Misuse and Peer on Peer Assault

The restrictions on social movement due to the COVID-19 pandemic, has particularly impacted on children's mental health and wellbeing. The withdrawal of structure and support in many children's lives, the closure of schools, reduced physical activity and wider family stress as well as the loneliness caused by the inability to see friends, is expected to have had a severe impact on some children's mental health (Covid-19 Lockdown: A child and Adolescent Mental Health Crisis, 2020). The safeguarding referrals made by the Trust in relation to mental health support have increased by 83% in Q2 2020 compared to Q1 and have continued to rise in Q3. This would support the evidence that lockdown and social restrictions are having an impact on mental health and wellbeing of children and young people in Dudley. The impact of the increase in admissions for children and young people in mental health crises has had a significant impact on inpatient services, particularly around the management mental health related behaviour and prolonged waits for Tier 4 CAMHS beds.

In addition, there has been an increase of 157% in Q2 compared to Q1 for referrals to Children's Social Care in relation to peer on peer abuse. The graph below shows a direct correlation between the easing of lockdown restrictions and the return to school in March 2021 with a sharp increase in ED attendance with peer on peer assaults.

Children who attend the Emergency Department due to intoxication has also increased in Q2 2020 compared to Q1. This is an 83% increase compared to Q2 in 2019.

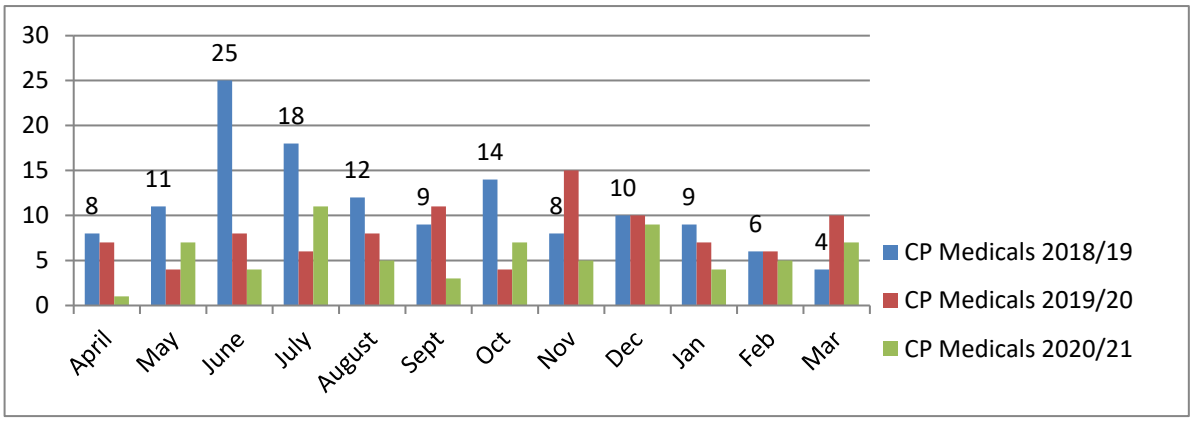
No of safeguarding referrals in relation to Mental Health, Intoxication and Peer on Peer Abuse 2020



These trends and themes have been reported to Trust ISB and the named nurse has worked collaboratively with the Designated Nurse from the CCG and CAMHS consultant to develop a report of the local picture for children and young people, for presentation to Dudley Safeguarding People's Partnership. It is anticipated that there will be a coordinated partnership approach to support these children and young people and there are initial partnership discussions between the Trust, the Violence Reduction Unit, West Midlands Police and Dudley Youth Service to develop an early prevention approach with the Trust Emergency Department.

There is a continuing need in the coming year for the safeguarding team to provide focus on the safeguarding needs of young people aged 16 and 17 years who follow the adult pathways and for whom, outside of ED, there a very few child safeguarding concerns raised.

Child Protection Medicals – 2018 - 2021



During the period 2020/21 there was a total of 68 compared to 96 last year child protection medicals carried out as part of Section 47 enquiries in relation to child protection concerns. The decrease in the number of child protection medicals may be linked to reduced visibility of children due to lockdown restrictions and non-attendance at school due to the COVID-19 pandemic, and subsequent reporting of abuse to Children's Social Care. The Designated Doctor for Safeguarding reviews all Child Protection Medical reports completed by members of the Paediatric Doctors to ensure quality and that clear medical opinion is given regarding likelihood of abuse as part of the report.

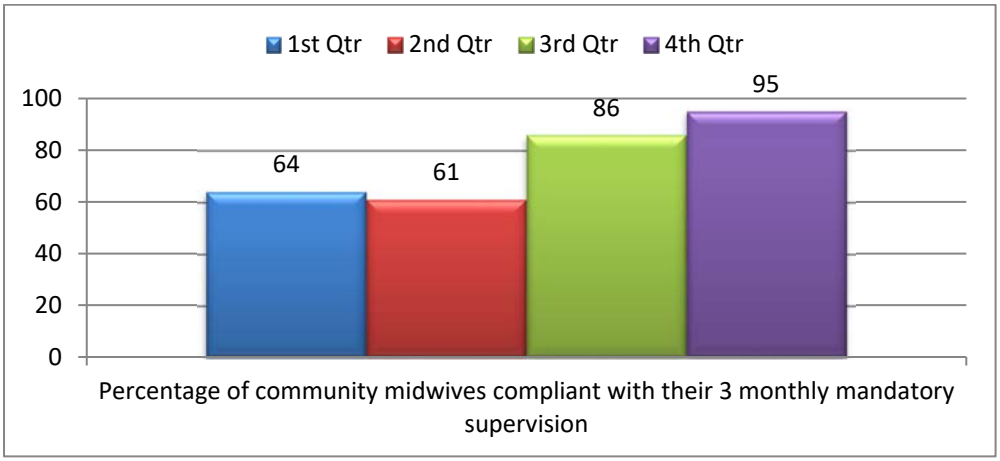
Safeguarding Supervision

DGNHSFT is committed to ensuring that all staff have access to advice and support from competent safeguarding professionals and that staff working with children, young people, adults and families receive safeguarding supervision appropriate to their level of contact and responsibility with children and families in accordance with national and local standards and requirements.

"It is important that staff working with children and families are effectively supervised to support them and to promote good standards of practice in safeguarding children. In line with Working Together, supervision should include reflecting on, scrutinising and evaluating the work carried out, assessing the strengths and weaknesses of the member of staff and providing coaching, development and support"
CQC 2009

During 2020/21 a further 2 members of staff were trained to provide safeguarding supervision; the Named Nurse for Safeguarding Children and a Lead Midwife for Community. The team now consists of six WTE safeguarding supervisors within the Trust. Safeguarding supervisors must have an advanced level of knowledge and understanding of safeguarding children and adults including (but not limited to) the identification of concerns, risk and vulnerability factors, remedies and statutory responsibilities. In 2021, further development is required to ensure that safeguarding supervision is sustainable and of a high quality and across the Black Country funding has been secured from NHSE for further supervision training.
Supervision is provided 1:1 for case loading staff, in group sessions or on an ad-hoc basis.
One to one safeguarding supervision is offered for Community midwives and is a mandatory requirement for them to attend quarterly.

Community midwives' compliance with mandatory one to one supervision for 2020/21



This data demonstrates that the number of community midwives attending for supervision has increased over the 12 month period. This is particularly apparent in the last two quarters of the year.
Themes identified from supervision:

- Lack of communication between multi agencies particularly relating to social care
- Cross-border information sharing
- Documentation and record keeping
- Lack of awareness for challenging decisions of safeguarding thresholds
- Lack of risk assessing skills

Identifying key themes from safeguarding supervision helps to inform future training delivered to the midwifery workforce.

Group safeguarding supervision commenced in April 2019 for those staff who require it. The Named Nurses currently offer four sessions per month and each session can accommodate 6 practitioners. It is recommended that staff in Paediatrics, Neonatal, Emergency Department, CASH/GUM and Maternity services access safeguarding supervision every six months and staff should be encouraged to access this provision. It will also contribute towards Level 3 training requirements and revalidation (Intercollegiate Document 2019). Supervision sessions are documented and supervisees are given a record.

Towards the end of 2020, when the safeguarding team were fully staffed, additional safeguarding supervision has been offered to paediatric staff on Ward C2 and ED.

Safeguarding Supervision Offer to Children's Ward C2 Paediatric Nursing Staff

The Safeguarding Team have offered 4 drop-in safeguarding supervision sessions from November 2020 to February 2021. Staff brought questions around safeguarding and recent cases that they had been involved in. Safeguarding policies and procedures, completion of referrals and voice of the child were discussed. The Safeguarding Team also take the opportunity to communicate updates with staff through supervision sessions. We have used the sessions to discuss topics such as child sexual exploitation, contextual safeguarding, new assessment tools, quality of multi-agency referrals and capturing the voice of the child. Staff have reported they feel more confident and have more understanding in the areas discussed. 18 staff have so far attended for safeguarding supervision from C2, with a further 29 members of staff booked for group sessions.

A common theme that has been discussed during supervision is around the Challenges staff experience when caring for young people/older children and deliberate self-harm. Supervision has also highlighted gaps in understanding and the need for education around CAMHS/iCAMHS processes, criteria and services available to children and young people. This has been shared with leads in such areas.

There have to date been 3 planned supervision sessions and there are five further safeguarding supervision sessions booked to ensure that all staff have had their first of a recommended two safeguarding supervision sessions per year.

Supervision in Emergency Department

A total of 5 drop in supervision sessions have taken place for staff in ED with a regular twice monthly sessions planned throughout the year. Supervision has been for both adult and paediatric staff and feedback from staff has been that it is useful, interesting and staff feel that they have learned from it. Themes from ED sessions have been around the child death process and young people. These sessions have been used to discuss professional curiosity, quality of multi-agency referrals, CSE and voice of the child. This year to date, 25 members of staff have accessed this supervision.

Safeguarding supervision has been strengthened over the last twelve months and all supervision is documented and a database held by the safeguarding team. This now needs to be embedded in the organisation to increase the number of staff accessing supervision by raising staff awareness and rolling out the Safeguarding Supervision Policy.

Safeguarding Children Case Study

Child M was brought into the Emergency Department by ambulance, via the GP, in severe Diabetic Ketoacidosis. The GP information suggested a history of neglect due to a delay presentation. A Multi-Agency Referral Form (MARF) was completed by the Paediatric Emergency Department and Child M was transferred to the paediatric ward for further assessment and care.

Child M was subsequently diagnosed with Type 1 diabetes and their care was supported and monitored by the Specialist Paediatric Diabetes Team. The team provided daily support and education in relation to diabetes management but it soon became evident that the parent was finding it difficult to retain the information, despite adapting their teaching methods, and concerns were emerging in relation to parent's ability to keep Child M safe once at home. The Diabetes Team also identified further concerns following liaison with other professionals involved with the family. They identified an extensive history of neglect, previous social care involvement, poor school attendance, parental mental health issues, parental inability to meet the child's basic needs and evidence of disguised compliance. The outcome of the initial referral from the Emergency Department was for a Children and Young Person's Assessment to be completed under Section 17 of the Children Act 1989. The Specialist Nurse felt this needed to be escalated and arranged a multi-agency professionals meeting to share information in relation to the family and discuss the potential significant risk of harm if Child M was discharged home. This led to a Section 47 Strategy Meeting and progressed to Initial Child Protection Case Conference and Child M was made subject to a Child Protection Plan.

The Diabetes Team have demonstrated excellent safeguarding practice while working with Child M and his parent by acting in the best interests of the child, recognising the cumulative impact of neglect, escalating their concerns, effective communication and multi-agency working, documenting the voice of the child and accessing regular safeguarding supervision and support from the Safeguarding Team.

Paediatric Liaison

Safeguarding liaison between acute and community healthcare settings has been identified as playing an important part in protecting children and young people from harm. Following the Laming Inquiry into the death of Victoria

Climbie (DOH 2003) recommendations were made that information relating to a child's attendance at the Emergency Department, discharge from hospital and follow up appointments should be shared with primary care and community services to ensure an effective handover of care and provision of services.

To ensure there is a robust link between the Trust and community and primary care services, information is shared on a daily basis with our partners regarding the attendance of children and young people to the Trust Emergency Department. The Trust Safeguarding Children's Team review paediatric attendances to the Emergency Department via a comprehensive daily report taken from the ED electronic system, Sunrise. The attendances are checked against a set criteria and relevant information is sent to health partners.

This process has been made more efficient by the improvement in the detail of the daily report of attendance.

Paediatric attendances between April 2019 and March 2021.

Paediatric Liaison Referrals	April 19 – March 20	April 20 – March 21
Total Number of Paediatric Attendances	23,272	11,985
Criteria met for PLN Referral	11,035	5,842

Children Safeguarding Practice Reviews (CSPRs)

The Children and Social Work Act 2017 introduced a new legal framework in respect of local safeguarding arrangements for children. Responsibility of how a system learns lessons from serious child safeguarding incidents now rests with the new National Child Safeguarding Practice Review Panel and the three Safeguarding Partners (Local Authorities, Police and Clinical Commissioning Groups).

Over the past 12 months the Trust has participated in 6 rapid reviews with 2 cases progressing to CSPRs. 2 CSPRs have been published by the DSPPB this year and learning briefings shared across the Trust via Comms and during training and supervision. All actions for the Trust have been undertaken with the exception of midwifery training for Graded Care Profile 2a to support identification of neglect. This training has been on hold due to COVID-19 pandemic. Key learning themes from the rapid reviews are:-

- Appropriate response to non-accidental injury
- Recognition of domestic abuse and mental health on parenting capacity
- Following escalation process
- Managing disguised compliance and hostile parents
- Cross boundary information sharing

7.0 Maternity Annual Safeguarding Report – 2020/21

The last twelve months have proved very challenging for maternity services due to the pandemic. Whilst other specialities within the health service have been restricted maternity care has been sustained. Midwives were not subject to re deployment however due to shielding and sickness services were adjusted to provide best care for the mother and unborn.

The Named Midwife developed a risk assessment vulnerabilities tool. This was used by midwives to ensure the most vulnerable groups of parents and babies were identified and plans initiated to ensure contact and support

maintained. This tool was adopted nationally through the NHS Future Platform. Contact for the most vulnerable was prioritised and home visits were maintained within safe standards

Named Midwife for Safeguarding

The Named Midwife is a statutory safeguarding role for any NHS provider of maternity services as set out in the Safeguarding Children, Young People and Adults at Risk in the NHS: Safeguarding Accountability and Assurance Framework 2019.

Embedding the role of the Named Midwife and also that of the safeguarding team within the maternity speciality has proven challenging over the last twelve months due to infection control restrictions. However through high visibility in the departments, attendance at training events , virtual meetings and via one to one supervision, the Named role and that of safeguarding has been recognised by all staffs and there is an increased understanding of staffs own roles and responsibilities in respect of safeguarding

Maternity Safeguarding Activity

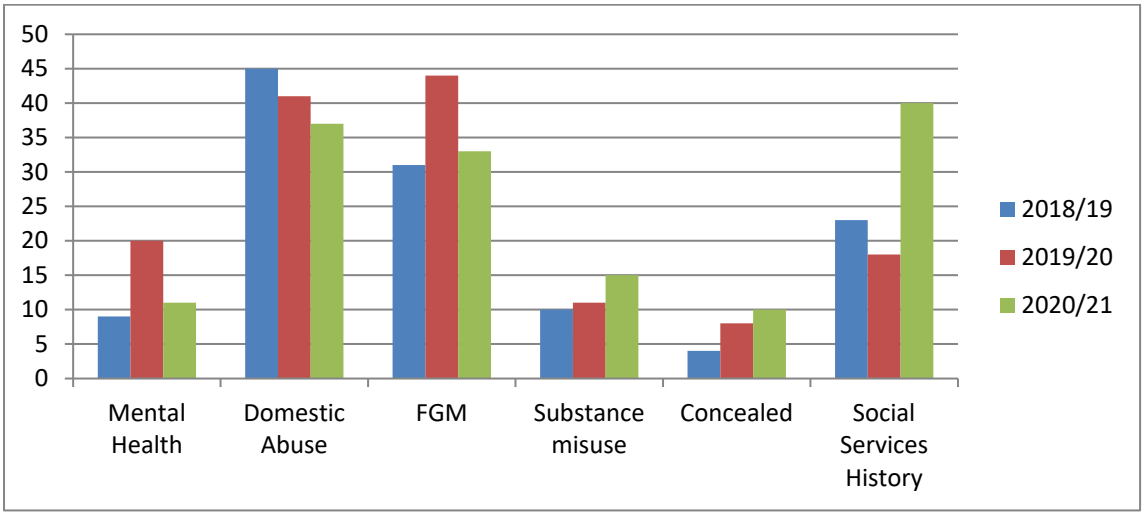
Supporting Vulnerable Families – Incident Reporting

Recognising potential safeguarding concerns and additional support requirements for families is a vital part of a midwives role. Appropriate referral to other agencies, including Children's Social Care ensures an early response to risk assessment and meeting the needs of babies and families.

During 2020/21 maternity services have reported a 146 safeguarding incidents via Datix™ which is comparable to the total of 131 for 2019/20. Not all reported incidents will result in a referral to Children's Social Care. Maternity services have not seen the increase in safeguarding incidents reported, that is evidenced across the rest of the Trust. This may be due to less home visits due to COVID-19 pandemic and midwives not picking up on lower level of need and considering referrals for early help. This is an area which requires further exploration in the coming year.

A maternity safeguarding vulnerabilities pathway has been developed for all maternity staff to follow to ensure consistency. The named midwife has noted that community midwives are now more confident about their responsibilities in relation to how they report incidences and respond to safeguarding concerns.

Maternity Services – Safeguarding incident reporting by category – comparative data – 2018-2021



The trio of vulnerabilities; mental health, domestic abuse and substance misuse are found to be prevalent in over 60% of child deaths subject to local and national reviews. Midwives are well placed to identify trio of vulnerabilities given their unique relationship with women. The above table shows that incident reporting around these

vulnerabilities has reduced or stayed the same. This may be due reduced home visits due to COVID Pandemic, where it is possible that more signs of concern may be easier to observe.

Domestic Abuse

The number of domestic abuse incidents reported by maternity services has not increased given the Compared to data from 2019/20. This does not reflect the rise of 35% in reporting across the Trust or the national data which showed that in April, May and June 2020 during Covid-19 roughly one-fifth (21%, 20% and 19%) of all offences recorded by the police were flagged as domestic abuse-related.

Pregnancy is a trigger for domestic abuse and has negative consequences for the woman and her child.
Sixty per cent of survivors using domestic abuse services are mothers and 1 in 15 are pregnant women.
In recognition that a third of domestic abuse begins or accelerates in pregnancy, the maternity staff routinely screen for domestic abuse in all pregnant women throughout the duration of the pregnancy. During the COVID-19 pandemic, maternity bookings were performed over the telephone and midwives could not be assured that the woman was alone during the booking; therefore the routine enquiry was not completed. Screening when at face to face contact begins at the woman's antenatal appointment with a clear explanation as to why this screening is required. Midwives continue to screen for domestic abuse at every contact when it is safe to do so. Responses from the screening are documented securely within hospital held documentation and in a disguised format within the woman's maternity hand held records. Routine enquiry for domestic abuse has become embedded in all the maternity staff's practice, it has been highlighted via supervision and advice calls that midwives are not asking direct questions of women or asking in a way that does not make it clear to women that we are enquiring about their experience of abuse. Developing staff's skills and confidence in asking direct questions around domestic abuse will be part of ongoing work next year.

Audits of compliance with routine screening in 2020/21 identified that all women were being screened for domestic abuse during their pregnancy. There has been a consistent 100% compliance for screening. Staff have been able to screen women as they have attended their antenatal appointments alone during the pandemic. From 2020 compliance has now increased from 87% to 100%. Monitoring for compliance will continue monthly as part of 2021/22 audit plan.

Unborn Baby Network

The Unborn Baby Network is a multi-agency forum to discuss child protection and safeguarding concerns and referrals for the unborn and new-born child. Its aim is to ensure:

- Good communication and information sharing between agencies
- That appropriate plans are in place to protect vulnerable women and children
- Safeguarding risks are assessed and reviewed and action plans are implemented to reduce/ eliminate risk factors

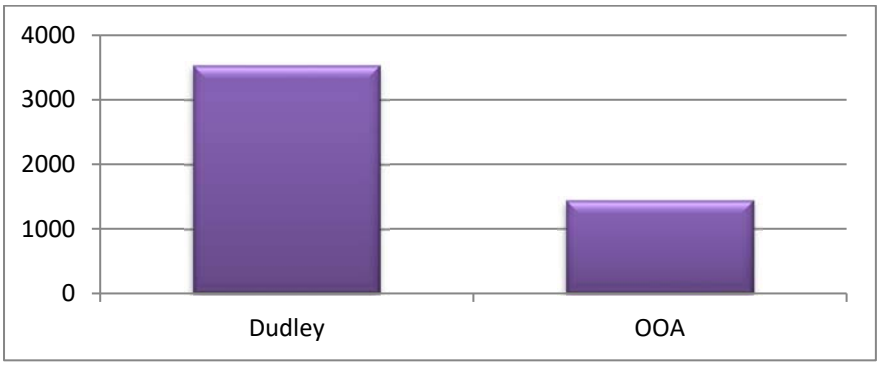
The meeting which is chaired by the Named Midwife is held monthly within the Trust with representation from a range of partner agencies including mental health, social care and substance misuse services.

During 2020/21 there were 124 referrals to the network meeting in comparison to 132 in 2019/20.
Although referrals to the meeting were comparable to the previous year, they noticeably reduced in the first two quarters of the year. The only contributory factor identified relates to staff capacity and the pandemic.
Any agency may refer a case to the meeting to share concerns for the safety and wellbeing of the unborn baby and/or pregnant woman and to identify if the family is known to any of the other services. Actions from discussions are unanimously agreed and information is shared with the practitioner overseeing the family's care.

Information Sharing

In the year 2020/21 there were a total of 4858 maternity bookings to DGFT, this is 5% less than the previous year. Of these, 1438 were bookings for women who lived out of the Dudley borough representing 30% of the total. At least 25% of these are from Sandwell.

Maternity bookings by locality



All of the neighbouring Black Country health care Trusts have an electronic maternity patient record system- Badgernet™. DGFT maternity are due to launch their electronic record within the coming months, however this is not the same system as our neighbouring partners.
Previously challenges around sharing safeguarding information and findings from recent Serious Case Reviews and Child Safeguarding Practice Reviews have identified inadequate information sharing. One of the contributing factors was that DGFT did not have the same patient record system as our neighbours. Shortly DGFT will have an electronic system, however information cannot be directly shared from the Badgernet™ system to DGFT's system. The Named Midwife had initiated an STP response to these concerns however it was recognised that information sharing was well established in all Boroughs with the exception of Sandwell. There is now close liaison between Sandwell and Dudley safeguarding teams through the Named Midwives and actions are being completed within the Sandwell maternity service and Sandwell Childrens Trust to address existing concerns.

More detailed work will be carried out with Dudley midwives to ensure they communicate effectively with partner agencies via supervision and training. Assurance of these processes will be gained as part of the annual audit programme.

Assessment of Neglect

Following participation in a Serious Case Review and a Child Safeguarding Practice Review, action has been taken to better equip community midwives with tools and resources to assess home conditions for signs of neglect.

DGFT is participating in a national pilot for the use of the Graded Care Profile (GCP) 2A – a maternity specific tool to support midwives in working with families to address areas of potential neglect including poor home conditions. The training for the tool has been delayed until June 2021 due to covid but in the meantime midwives are using the Dudley Multi Agency Hoarding Framework for to benchmark their assessment of home conditions and identify if a new-born/child could be at risk of harm. The feedback from staff has been positive.

Maternity have also launched their Continuity of Care (CoC) teams and now have two teams to date. Better Births 2016 – recommended it become a central model of care within 5years.
There is emerging evidence that CoC can have very significant benefits for vulnerable women living with a range of social and psychosocial complexity (Rayment-Jones, 2015; Homer et al 2017).
The CoC teams will be delivering care within the family home and therefore will have greater access to families and provide consistent care throughout the ante, intra and partum periods.

Maternity Safeguarding Case

A Patients Story

Ms A booked her pregnancy for Russells Hall Hospital. She was 17 years old and had a number of vulnerabilities including :

Being a child looked after; history of substance misuse; complex mental health conditions; autistic spectrum disorder; fetal alcohol syndrome and a number of medical conditions.

During her pregnancy she was diagnosed with a pulmonary embolism and received anti-coagulant treatment for the duration of the pregnancy.

The community midwife liaised with a team of multi-agency professionals who supported Ms A, these included:

Family Nurse Practitioner/ Health visitor
GP
Her social worker
Leaving care worker
Unborn baby's social worker
Learning Disabilities team
Specialist Midwives for vulnerable women

Staff became concerned regarding a relationship that developed between Ms A and a male Mr B who was 20 years her senior. Staff were also concerned regarding Ms A increasing physical disabilities of which the cause was unknown. Ms A became doubly incontinent and wheelchair bound, although there was no identifiable cause and no medical diagnosis made. Ms A became more and more reliant on the older male and began to display very child-like behaviours.

Due to growing concerns from professionals regarding the capacity of Ms A to keep herself and the unborn baby safe, the unborn baby became subject of a child protection plan.

By the time baby D was born, Ms A was living with Mr B and was completely reliant on him for personal cares. Baby D was discharged into foster care and Ms A was discharged home to Mr B.

Referrals to adult social care were completed due to the concerns for Ms A and that she may be experiencing abuse from Mr B. Ms A was a very complex lady, she just had her 18th birthday as she delivered her baby and there was a transition from children's services to adult social care.
Throughout her pregnancy, monthly professionals meetings were held to ensure effective information sharing as well as safeguarding meetings for her unborn baby.

The community midwife for Ms A was supported by the safeguarding team and safeguarding supervision was held regularly to discuss progress and developments with the case.

Child Death Review 2020/21

Under the Children Act 2004 there is a statutory requirement that all child deaths are independently reviewed. The Child Death Review Statutory and Operational Guidance (England) (2018) sets out the key features of robust child death review and applies to all organisations involved with child death review processes.

Deaths of children in Dudley are reviewed the Black Country Child Death Overview Panel (CDOP) and is responsible body for ensuring the statutory functions are completed. The CDOP consists of paediatricians and professionals with a role that includes child death responsibilities.

The findings from local reviews are reported to the National Child Mortality Database (NCMD). Analysis of the data is used to inform strategic improvements in health and social care for children, and to help health and social care providers to learn about how they can reduce child deaths.

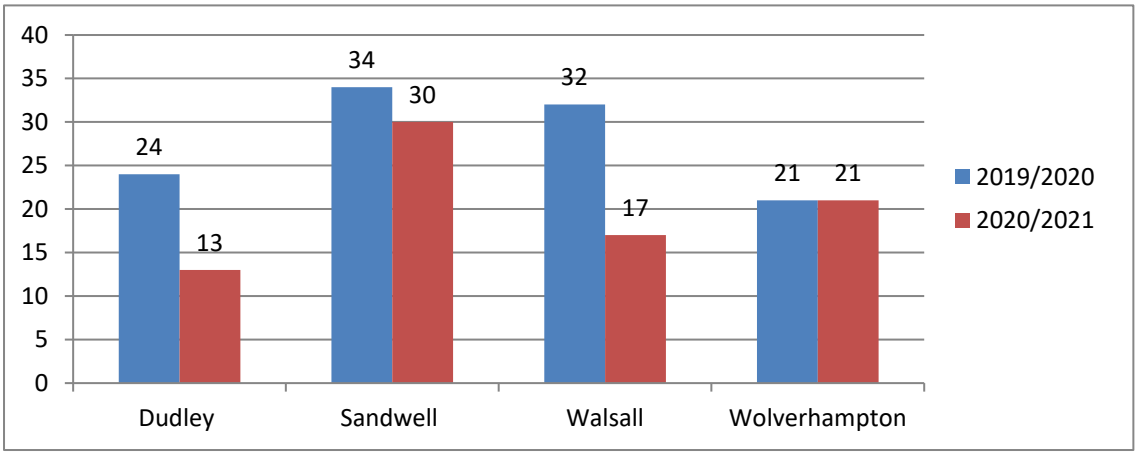
The Dudley Child Death Team.

The lead professionals for the review of child mortality in Dudley are the Designated Consultant for Dudley and the Lead Nurse for Child Mortality. The lead nurse for Children Mortality was recruited to in May 2020. There is also administrative support from the Administrator for Child Protection who sits within the safeguarding team.

These professionals are responsible for the local response to child deaths, reviewing cases through a Child death Review Meeting prior to presenting cases to CDOP. Following review at CDOP and closure of the case the information is submitted to the National Child Mortality Database.

In the year 2020 to 2021 there has been a reduction in child deaths in the four areas that comprise the Black Country Child Death Overview Panel.

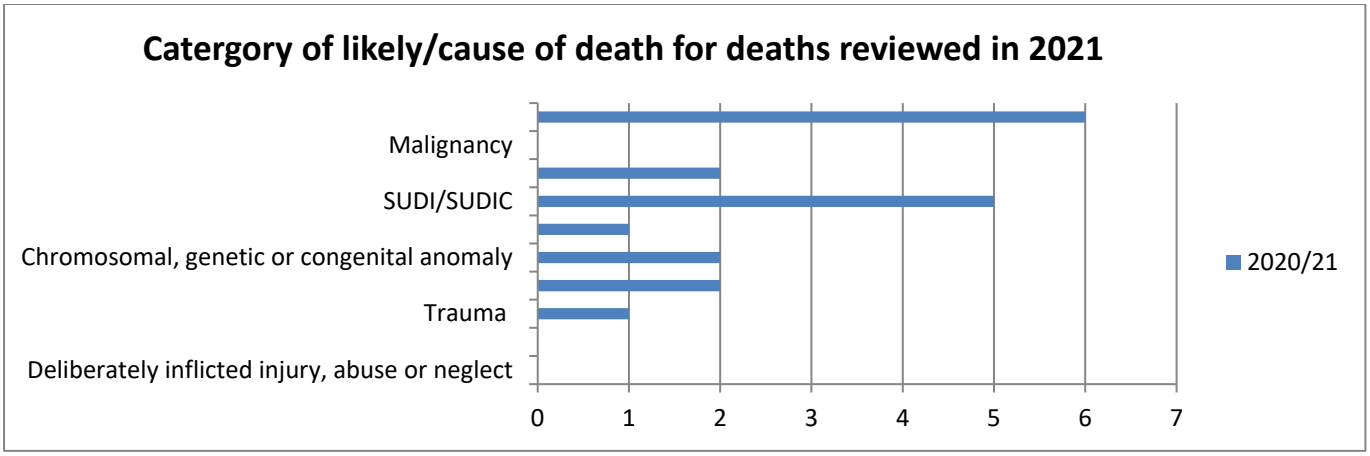
Child Death Comparison in the Black Country 2019 to 2021



It's likely that this decrease is due to reduced number of infections caused by COVID-10 social restrictions. There has also been less opportunity for involvement in accidents including road traffic accidents.

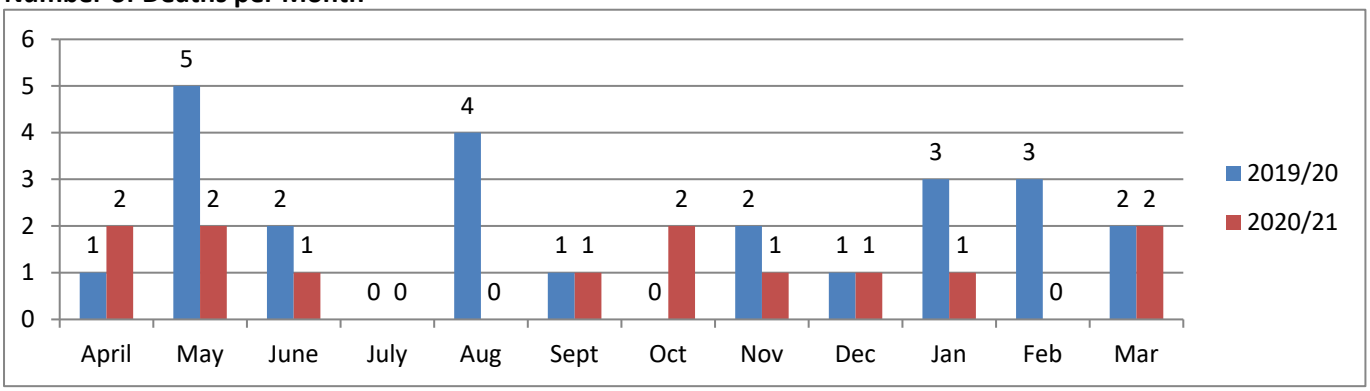
Child Deaths - Age at Death 2018 – 2021

Age at Death (5 year bands)	2018/20	2019/20	2020/21
0-7 Days (Perinatal)	6	6	5
>7 days and <1 month	4	1	2
>1 month and <1 year	9	7	1
1-4 years	2	3	2
5-9 years	0	3	1
10-14 years	3	3	1
15-19 years	0	1	1
TOTAL	**24**	**24**	**13**



N: B Deaths occurred in the year that were reviewed at CDOP

Number of Deaths per Month



Joint Agency Response for Unexpected Child Death

An unexpected death is defined as the death of a child that was not anticipated as a significant possibility 24 hours before their death or where there was a similarly unexpected collapse leading to or precipitating the events that led to the death.

As part of the Joint Agency Response, best practice is for a health professional to accompany a police to conduct a visit to the home of the child who has died. In order to fulfil this requirement cover is provided by the Trust on a 7 day week basis 09:00 to 17:00. Monday to Friday (and Bank Holidays) this is covered by the Lead Nurse for Child Mortality and the Safeguarding Team. Currently the Community Paediatric Nurses cover weekends, however due to a change in their service in 2021/22 this will require review.

The proportion of deaths requiring JAR meetings and home visits was 50% in 2019/20 and 38% in 2020/21. (5 call outs in 2020/21 and 12 in 2019/20).

Number of deaths reviewed in 2019/20 and 2020/21

Child Death Reviews within a CDOP should take place as soon as is practically possible, ideally within six months of the death, although this can be delayed due to:-

Child Death Reviews within a CDOP should take place as soon as is practically possible, ideally within six months of the death, although this can be delayed due to:-

- serious incident investigations

- criminal proceedings
- coronial processes
- serious case reviews/child safeguarding practice reviews
- Length of time it takes to receive, Perinatal Mortality Review Tool (PMRT) reports and final post-mortem reports.
- Some deaths are submitted for HSIB review and cannot be reviewed until that has been completed,
- Where there is a complaint in progress it is usual to wait for the complaint to be completed before the CDOP review.

In 2020/21 a total of 24 reviews were carried out, compared to 16 in 2019/20. The Lead Nurse and Designated Consultant have worked hard to develop positive internal and external agencies to ensure efficient review of all child deaths.

Currently Dudley has 10 outstanding deaths compared with 22 at this time last year. The 10 outstanding are due to:-

- Ongoing police investigations
- Complaints process
- Awaiting PMRT from other hospitals
- Awaiting results of post mortem

Learning from case reviews.

There were 11 Sudden Unexplained Death in Infant (SUDI) cases reviewed during 2020/21; of these 7 children were under 1 year of age. Of these deaths, 4 involved co-sleeping, with a combination of drugs, alcohol and mental health issues.

The learning from these cases has been shared with Midwifery and Paediatrics services and Safer Sleeping messages reinforced via training and supervision. The Lead nurse provides Responding to Child Death training and the Designated Consultant provides feedback to Medical colleagues.

One child death resulted in a Serious Incident investigation and the learning from this case was shared with Paediatrics and the Emergency Department.

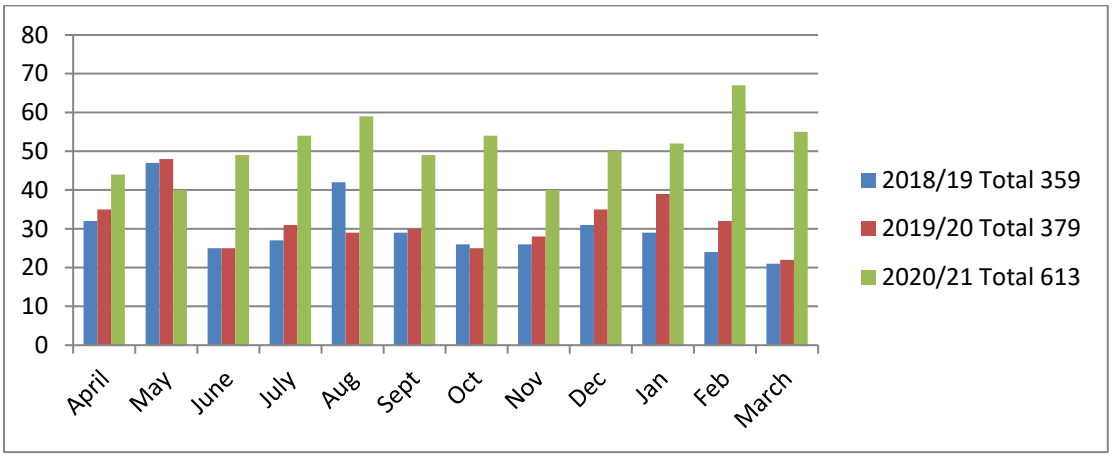
Support for Staff

Supervision and debrief following deaths is provided by the Lead Nurse and Designated Consultant. The Chaplaincy team are also available for support of staff and families.

9.0 Adult Safeguarding Activity 2020/21

Despite a reduced footfall through the hospital during the majority of 2020 due to the COVID-19 pandemic, Trust staff have increased the number of safeguarding referrals they have made when compared to previous years. This data is taken from the Trust Datix reporting systems and therefore some of this increase may be due to increasing awareness of staff to complete a Datix when making a safeguarding referral. However, a significant proportion of this data representing an actual increase in referrals is evidenced in the increased advice and support calls to the safeguarding adult team. This provides positive assurance that staff are growing in confidence around safeguarding and are taking responsibility for keeping patient's safe.

Adult Safeguarding Referrals – comparative data



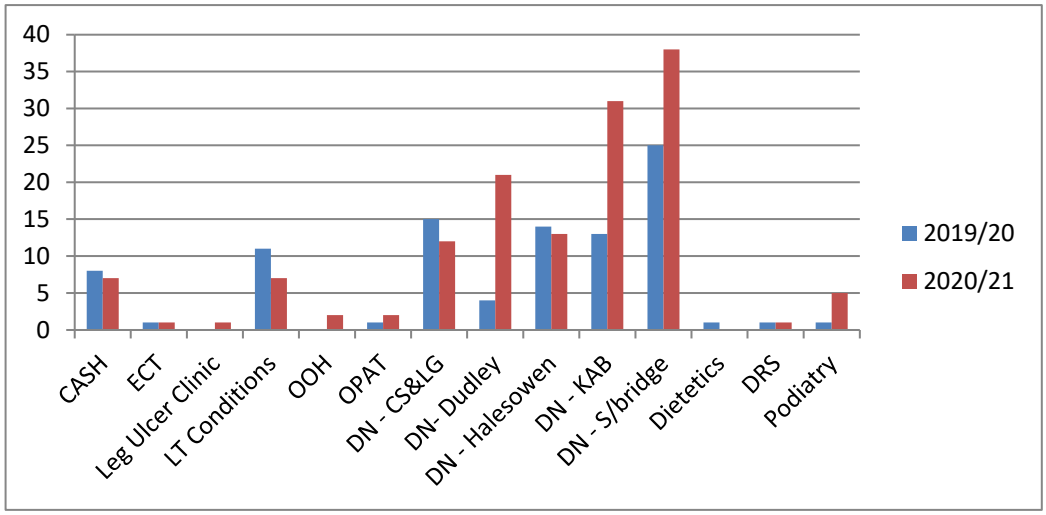
Safeguarding Adults Datix Reports

The numbers of adult safeguarding referrals alone do not give a complete picture of safeguarding activity in the Trust. Staff submit a Datix™ for all safeguarding concerns, whether they result in a safeguarding referral or not. Other risk management activities may take place in conjunction with the views and wishes of the patient that may prevent the need for a safeguarding referral to be made. Therefore analysis of Datix reporting alongside the number of safeguarding referrals provides a more comprehensive view of safeguarding within the Trust.

Community Services Datix Reporting

Since August 2020 a named nurse has been based out in community setting for one day per fortnight providing accessible advice, support and supervision. The table below shows an increase of 48% of safeguarding Datix™ reporting from community services in 2020/21 compared to 2019/20 and an increase of 62% specifically from Community Nursing Services. Some of this increase may be due to staff being more aware of reporting safeguarding concerns via Datix™ however there is a direct correlation between increase in reporting and the improved accessibility of safeguarding support in the community setting.

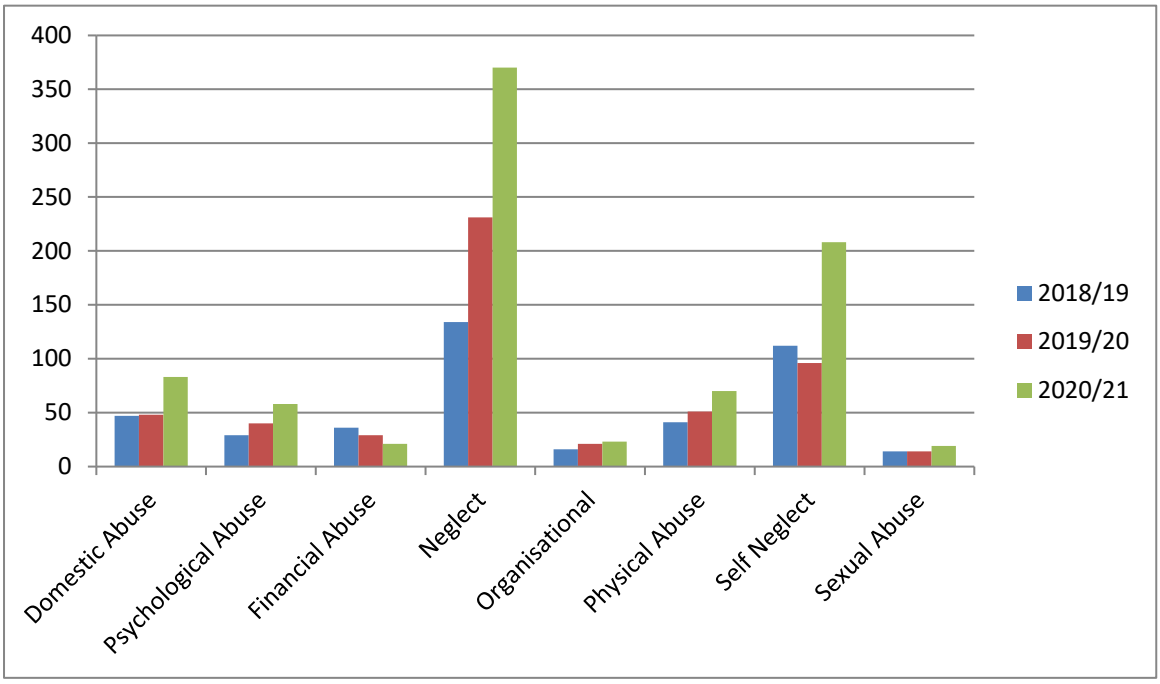
Safeguarding Datix™ reporting from Community Services – Comparable data 2019/20 and 2020/21



Source: Datix reporting system

The graph below demonstrates the most prevalent safeguarding categories that are reported via Datix™ from services across the Trust. Self-neglect and Neglect remains the highest categories reported within Dudley Group with Domestic Abuse being the third highest

Safeguarding Adults Datix by Category 2018 - 2021

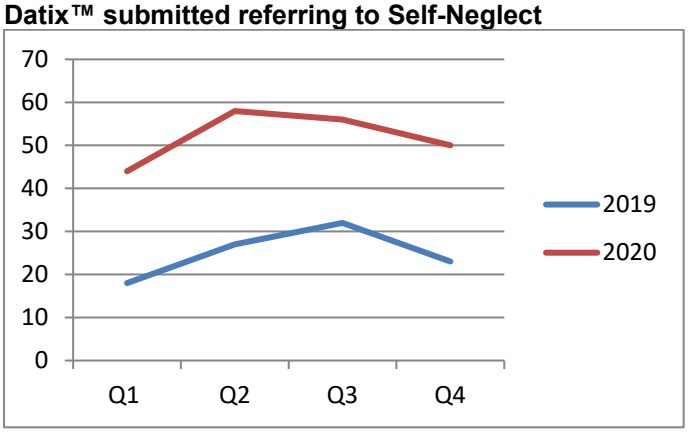


Source: Safeguarding Dashboard

Self-neglect

Neglect (including self-neglect) is a DSPP priority. In previous years self-neglect has been a theme of a number of SARs, Section 42 Enquiries and internal investigations. This year the safeguarding team have worked hard to ensure self-neglect is recognised by staff. This work has included reviewing Datix™ submitted around absconding and self-discharge to identify potential self-neglect issues and additional supervision and support work with our community services who are more likely to be able to identify self-neglect via access to patient's homes, learning events and patient bulletins. It is encouraging to note from the graph below that the recognition of self-neglect has doubled in the last 12 months.

Datix™ submitted referring to Self-Neglect



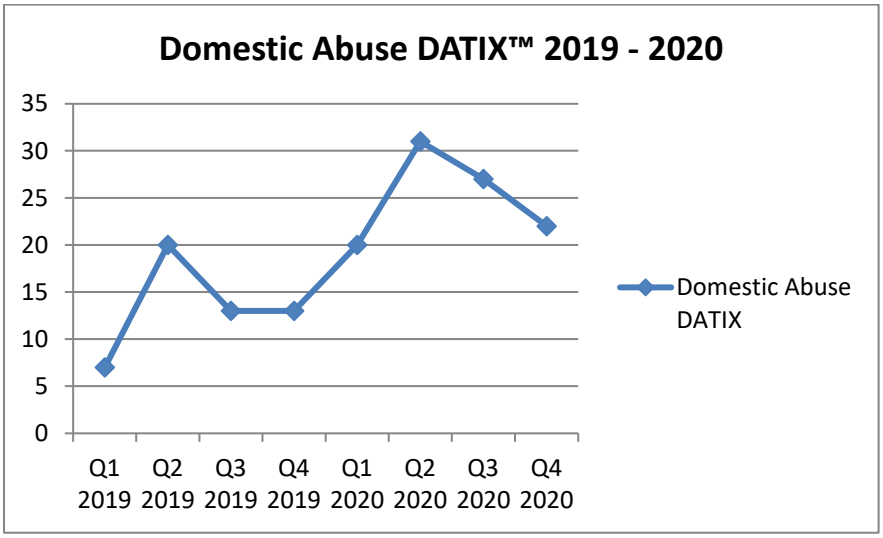
Source: Datix report

Neglect

The number of Datix™ related to neglect has increased by 18% in the last 12 months and 32% in the last 24 months. There has been evidence of an increase in staff identifying safeguarding concerns in relation to pressure ulcers caused by neglect particularly within the community setting

Domestic Abuse

There has been an increase of 72% in submission of Datix™ due to domestic abuse over the last 12 months.



Source: Datix reporting system

This graph demonstrates a 30% increase in domestic abuse reporting in comparison to last year. There has been a steady increase is reporting since Q4 of 2019/20 which coincides with the commencement of the Independent Domestic Violence Advocate. There was also a noticeable spike in attendances which coincided with the reducing of COVID 19 lockdown restrictions and is a pattern that is reflected nationally. The total increase

It is likely that the true incidents of domestic abuse are not recorded via ED attendances in Q4 of this year due to COVID-19 Pandemic restrictions and lockdowns. There have been 2 DHR referrals to Dudley Safe and Sound in the last 4 weeks of Q4 and it is anticipated domestic abuse incidents will increase.

95% of the Datix™ submitted, were from ED. There are very few submitted from other areas of the Trust which highlights a need for further awareness raising and training across key areas in the Trust, particularly our gateway and community services.

An Independent Domestic Violence Advocate (IDVA) commenced in Trust in February 2020. The project is funded from the Innovation Fund via the Local Authority and Dudley Safe and Sound. The project is in partnership between the Trust and Black Country Women's Aid. The role of the IDVA is to support victims of domestic abuse in ED and support and train staff in ED to recognise signs of domestic abuse and give effective support. The COVID pandemic delayed the IDVA presence in the ED and the training to staff. However the IDVA has been based in ED since July 2020 and there has been a direct correlation to the IDVA in ED and the increase in domestic abuse reporting and referrals to Multi-Agency Risk Assessment Conference (MARAC). Initially many of the cases of domestic abuse were identified post-discharge by the IDVA, however there are encouraging signs over the last few months that ED staff are identifying domestic abuse when the patient attends and making direct referrals to the IDVA. Training of ED staff will improve this further.

In recognition of the need to have a coordinated and systemic approach to developing a sustainable response to domestic abuse across the Trust, a Trust domestic abuse strategy is ready for ratification with an aim for a launch in May 2021. This strategy will set out the Trust's vision and commitment to supporting victims of domestic abuse and how this will be achieved. This will be a major work stream for the safeguarding team in the coming months.

A Trust Domestic Abuse Policy and Workplace Domestic Abuse Policy have been ratified and will support staff in following procedures to respond effectively to patients and staff that disclose domestic abuse.

The safeguarding team continue to benchmark our domestic abuse response against national and local standards, to identify areas which require improvement:

- West Midlands Domestic Abuse Standards
- NICE guidance on domestic abuse
- Draft Statutory Guidance Framework, Home Office, July 2020 (Domestic Abuse Bill)
- Safelives Domestic Abuse Pathfinder Project

Note that figures for domestic abuse with children in the household are captured in the Children's Safeguarding report and pregnant women experiencing domestic abuse reported within the Maternity section of this report.

Multi-Agency Risk Assessment Conference (MARAC)

MARAC is a local, multi-agency victim-focused meeting where information is shared on the highest risk cases of domestic violence and abuse between different statutory and voluntary sector agencies.
MARAC is held twice monthly and is attended by the Named Nurses on a rotational basis.

Attending the meeting requires a significant commitment from a planning and research perspective due to the number of cases heard, many of whom will be known to DGFT in some way. The victim, alleged perpetrator and risks to children are discussed and multi-agency plans made to safeguard those at risk of harm.

MARAC Data 2020/21

No MARAC referrals were made last year. Referral to MARAC is usually based on a domestic abuse risk assessment (DASH), however referrals can also be completed using professional judgement. Staff are not currently trained to complete the DASH risk assessment, and the fact that no MARAC referrals were made last year would suggest that staff do not feel confident to complete referrals without the use of a tool.

In 2020/21, 18 MARAC referrals have been made. All of these were made by the ED IDVA. It is anticipated that training of ED staff over the next 12 months, and the continued presence of the IDVA in ED, will assist staff in developing the confidence to make referrals and for some key staff the skills to complete the DASH risk assessment.

Safeguarding Adults Supervision

The Trust Safeguarding Supervision Policy was ratified in May 2020 and in line with the Intercollegiate Document - Safeguarding Adults: Roles and Competencies for Healthcare Staff supervision of adult caseload holders has been included.

Adult Safeguarding Supervision Matrix

Staff required to have Supervision	Method of Supervision	Frequency of Supervision
Adult Community Nursing Staff • Team Leaders • Community Nurses	• One to One • Group	Minimum attendance 2 per year

'Case load holders' have been identified as the 5 community nursing clusters, Leg Ulcer Clinic and the Continence Team. Teams such as Intermediate Care and Enhanced Care Home Team although not theoretically case load holders, due to the nature and contact of their client/patients, it is recommended they follow the Supervision Matrix.

The Safeguarding Team also deliver joint adult and children sessions in the community with teams such as the TB Nurses. Combined sessions are also planned for 2021/22 with CASH and GUM.

Compliance

157 staff in the community have been identified as 'case load holders.' This is a combined total of caseload holders who require one to one or group supervision – 20 staff have received 1 supervision session (13%) to date.

One to one supervision is mainly required by the district nursing team leaders, enhanced care home team and care home practitioners. To date 16 one to one Supervision sessions have been held for this group.

3 Group safeguarding supervisions have been held – 2 sessions with KAB staff with 18% attendance and 1 session with ECHT with 33% attendance

This is a new service for staff and compliance is expected to improve as staff become more familiar with the requirements and capacity issues associated with the COVID-19 pandemic ease.

Themes from Supervision

The increased time given to supervision of adult caseload holders has provided the safeguarding team with information regarding challenges faced by staff and gaps in practice:-

- Need for increase knowledge, confidence and skills around
    - Domestic Abuse
    - Hoarding and self-neglect
    - Mental Capacity Assessments
- Storage and documentation of safeguarding concerns – these are often not appropriate to be stored in patient held records

Feedback from staff and managers regarding the increased accessibility of safeguarding supervision and support has been extremely positive and the increase in advice and support calls and submission of safeguarding Datix™ from community services supports this.

Section 42/Enquiry Requests

The Care Act 2014 (Section 42), Care & Support Statutory Guidance Chapter 14 and the Adult Safeguarding Multi-Agency Policy and Procedures for the Protection of Adults with Care and Support Needs state that a local authority can ask any agency to undertake a Safeguarding Adults Enquiry – Section 42/Other Enquiry – on its behalf. The local authority and other partners must co-operate with each other to ensure the effective safeguarding of the adult experiencing or at risk of abuse or neglect.

The table below indicates how many Enquiries the Trust has been asked to complete month on month for the period 2019/20 and 2020/21. There has been an increase of 20% in Section 42 enquiries against the Trust this year

Safeguarding Enquiries completed by Trust 2019/20

Month	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	TOTAL
2019/20	1	2	1	0	2	2	0	1	1	1	1	0	12
2020/21	2	0	1	4	1	2	0	5	2	1	0	0	18

Section 42 enquiries were in respect of unsafe discharges with the main themes being:-

- Communication to carers/relatives
- Take home medication

- Inadequate assessment of mobility
- Cannula not removed

Other Themes:

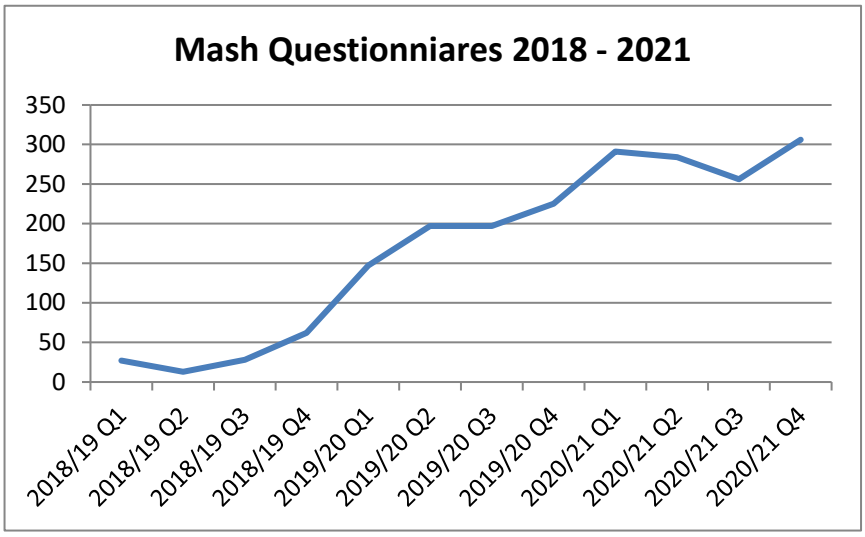
- 3 cases of hospital acquired pressure ulcers (3/18)
- 4 cases involving lack of professional curiosity or failure to recognise or act upon self-neglect
- Poor communication identified in most cases

Multi-Agency Adult Safeguarding Hub (MASH) Questionnaires

MASH electronic questionnaires are sent out to Partner Agencies who do not have a 'physical' presence in the Hub. The questionnaire is a means of gathering information to inform the local authority whether a safeguarding concern meets the threshold for a Planning meeting and/or an investigation is required.

Questionnaires are RAG rated in the MASH based on the level of concern and perceived risk to a person.

RED	-	4 working hour response – immediate/substantial risk identified
AMBER	-	8 working hour response – potential section 42 enquiries where further information is required from partners to accurately determine level of risk
GREEN	-	72 hour response – non section 42 "other" enquiries where low/managed risk is identified



No of MASH questionnaires – comparative data

The table above shows the significant increase year on year in MASH questionnaires received by the Safeguarding Team. There has been an increase of 37% between 2019/20 and 2020/21 and increase of 54% since 2018/19. On average the Questionnaire can takes on average 30 minutes to complete meaning that, on the average hours per month that it takes the safeguarding adult team to respond to questionnaires has risen from 32 hours to 47 hours per month, an increase of 59%. Some questionnaires may take considerably longer if information is required from community staff or if the case is complex with many hospital contacts.

This exponential demand on the adult safeguarding team, together with the increasing workload around MARAC, support and supervision to community services and increase in safeguarding datix reporting across the Trust, has identified the need for a review of named nurse resources in order to meet these demands, ensure the Trust continues to meet their statutory duties and continue to improve safeguarding practice across the Trust.

Safeguarding Adult Reviews (SARs)

The Care Act 2014 (section 44) requires Safeguarding Adults Boards to arrange Safeguarding Adults Reviews (previously known as Serious Case Reviews) if there are concerns that agencies could have worked more effectively to protect an adult from serious harm or abuse; whether the adult has died or not.

The purpose of a Safeguarding Adults Review is to establish whether lessons can be learnt from the circumstances of a case that may improve practice or the way in which agencies and professionals work together to safeguard vulnerable adults.

There are currently 4 ongoing SARs and 1 table top review which the Trust are participating in. 3 of the 4 SARs are in respect of a Sandwell resident

Emerging themes from the SARs are:

- Self-neglect
- Mental health
- Discharge Against Medical Advice
- Missed opportunities to safeguarding

It has been a challenge to hold learning events this year due to COVID-19 restrictions, however events are planned for the coming year to raise awareness of the cases and the learning identified.

Domestic Homicide Reviews (DHR)

The purpose of a Domestic Homicide Review is to establish what lessons are to be learnt from a domestic homicide regarding the way in which local professionals and organisations work individually and together to safeguard victims.

There are 2 ongoing DHRs that the Trust is currently contributing towards. There has been one new DHR commissioned this year.

Actions completed from previous DHRs:

- Independent Domestic Violence Advocate working in the Emergency Department and is supporting and training key staff to ask patient's directly. The IDVA is completing domestic abuse risk assessments and MARAC referrals
- Maternity staff are routinely asking about domestic abuse
- Domestic abuse training includes emphasis on the connection between domestic abuse and substance misuse
- Bespoke training has been provided to enhance awareness and understanding pertaining to parenting risk factors, including domestic abuse and the impact this can have on the child

One outstanding action from previous DHRs is:

- Emergency Department staff to receive bespoke training in regard to alcohol. There is a lack of available training for Health staff which has been escalated via Safeguarding Quality Review Meeting

Serious Incident Reviews (SIRs)

The West Midlands Fire Service aims to investigate all serious fire incidents that result in serious injury or death. The incidents that will require an SIR are:

- Any fire fatality.
- An injury likely to result in a fire fatality.
- An incident involving a person over 70 with significant smoke inhalation.
- Any incident that involves children with burns or significant smoke inhalation.
- Any other incident the Officer in Charge feels will have significant learning both internally and externally.

The Trust has contributed to 1 SIR this year. There was no identified learning for the Trust.

Safeguarding Adult Case Study

Adult Safeguarding Case Study

A 29 year old female, attended the Emergency Department with a facial injury and informed staff that she had been a victim of a mugging the previous day and police had been informed at the time.

The patient was not a resident of Dudley and listed her past medical history to include Lumbar spine fractures from a previous RTC, a mandible fracture from a fall and previous subarachnoid haemorrhage from a fall down the stairs.

Whilst the patient was in the waiting room a male relative was noticed to be waiting for her outside. When questioned by ED nursing staff, the patient told them he was her brother. However reception staff noted that this same male had been identified at booking as the patient's partner.

During the medical assessment, the patient repeated that her injuries were due to the mugging incident. The patient was diagnosed with a facial fracture and a Maxfax outpatient appointment was arranged for a week later. The ED nursing staff then spoke with the patient alone and at length regarding their concerns about her injury and the male who was waiting for her, they asked the patient directly if she was experiencing abuse. The patient denied any domestic abuse and declined the offer of any support, the staff documented that she appeared nervous and was frequently checking her phone. The patient was advised to phone 999 if she felt unsafe and she was discharged home. The ED staff completed a safeguarding adult referral due to their concerns and reported the incident via the Trust internal reporting system (Datix).

Following a review of the Datix™, the Trust safeguarding team made contact with the ED IDVA and WM Police Safeguarding adults department to gather further history and assess whether a MARAC referral may be appropriate. The patient was not known to BCWA, the police had historic Domestic Abuse Victim crimes for the patient, but nothing recent.

The Named Nursed liaised with the out of hour Adult Services Safeguarding team providing information regarding the attendance and past medical history, including serious injuries. The Named Nurse highlighted the concerns of the injuries, the delay in presentation and that the patient was an out of area resident and therefore Russells Hall Hospital was not a local hospital for her and that she had no previous attendances.

From additional checks, Adult Social Services identified that the patient attended a different out of area hospital for each of her historic injuries. Police also identified that her current partner was a serial perpetrator of domestic abuse and had been heard at MARAC multiple times with different

victims. Following this information the patient was referred to MARAC but due to the high risk to her, the Police wanted to make contact sooner.

Arrangements were made for the patient to be seen by a Safeguarding Police Officer and the Named Nurse following her outpatient appointment at DGFT. This took place in a private and discreet room. The patient consented to be seen but continued to deny domestic abuse or that she felt unsafe. The patient declined the offer of Claire's Law disclosure but did accept the Police Officers details.

Although the patient refused support on this occasion, the ED staff demonstrated excellent professional curiosity and confidence in having discussions about domestic abuse. The documentation and safeguarding referral was of good quality. The patient was empowered as a victim as she was given a private opportunity to disclose domestic abuse. The quality of this interaction may enable her to disclose in health settings in the future.

10.0 Person in Position of Trust (PiPoT)

The PiPoT framework and process applies to concerns and allegations about:

- a person who works with adults with care and support needs in a position of trust, whether an employee, volunteer or student (paid or unpaid); and
- where those concerns or allegations indicate the person in a position of trust poses a risk of harm to adults with care and support needs.

These concerns or allegations could include, for example, that the person in a position of trust has:

- behaved in a way that has harmed or may have harmed an adult or child;
- possibly committed a criminal offence against, or related to, an adult or child;
- Behaved towards an adult or child in a way that indicates they may pose a risk of harm to adults with care and support needs.

10.1 Number of Position of Trust referrals made to the Local Authority 2020/21.

April 2021	June 2021	July 20201	Sept 2021	Oct 2021	Nov 2021	Dec 2021	Feb 2021	Total
1	1	2	1	1	2	1	1	10

Two of these referrals were in relation to employees of sub-contractors used by the Trust and they no longer work in the Trust.

Outcomes:-

- Three cases are ongoing investigations external to the Trust and staff have been suspended without prejudice whilst these are carried out
- One case was unfounded
- One member of staff was dismissed following internal investigation and referral made to DBS
- Three members of staff referred are no longer working for the Trust and

In addition information was shared with the Trust via the Local Authority LADO regarding concerns against our staff. One member of staff was a bank worker who no longer works in the Trust and the other investigation is ongoing.

Managing safeguarding allegations against staff working with children and adults with care needs is required under the Children Act (1989/2004) and the Care Act (2014). Working Together to Safeguard Children and Young People (2015) and the Safeguarding Accountability and Assurance Framework (2019) set out expectations that all statutory organisations will have a procedure for managing allegations against staff
In all the above cases, investigations were undertaken in line with Trust procedures, referrals were made to appropriate partner agencies and steps taken in line with guidance from the Dudley Safeguarding People's Partnership to ensure the immediate and ongoing safety of patients, staff, visitors and the wider public.
Last year it was noted that staff were not aware of the correct process to follow when safeguarding allegations are made against staff. This was added to the Safeguarding Risk Register. In response The Trust Managing Allegations Against Staff Policy was ratified in May 2020 and staff awareness raised via the Divisional meetings, Patient Safety Bulletin and mandatory training. Training around managing allegations is also due to become part of the Employee Relations Training in April 2021. There has been an increase in referrals made this year and more awareness demonstrated by an increase in contact with the Head of Safeguarding to discuss possible position of trust concerns. The risk has now been closed.

11.0 The Counter Terrorism and Security Act 2015

The Trust recognises that all members of staff have a duty under the Counter Terrorism and Security Act (2015) to have due regard to the need to prevent people being drawn into terrorism and to act positively to report concerns.

Prevent Activity 2020-21

One Prevent referral has been made this year. The referral did not advance to Chanel Panel but did require a safeguarding response from other agencies. The decrease in footfall within the Trust as a result of the COVID-19 pandemic, is likely to have impacted on staff detecting and reporting radicalisation concerns

The Named Nurse for Safeguarding Adults is the Prevent Lead with Deputy Chief of Operations being Executive Lead. The safeguarding team attend the Dudley Prevent Delivery Group and receive Local intelligence from the Counter Terrorism Unit Officer via the Safe and Sound community forum. Local mandatory training is updated as required to reflect new information.

The Home Office expectation is that all organisations party to the NHS Standard Contract will, as a minimum, achieve 95% compliance for Basic Prevent training and 85% for WRAP.

The Trust aims to embed Prevent into mainstream safeguarding. Training encourages staff to focus on our professional responsibility to understand and recognise that radicalisation is a real risk which could affect any of us.

12.0 Restrictive Interventions

An in depth review of restrictive interventions in the Trust was undertaken this year, with emphasis on policy, training, practice and reporting. A number of improvements were identified and an action plan developed to address these:-

- Restrictive Intervention Policy required review and updated – this has been completed
- A Paediatric restrictive intervention policy is being developed
- Gaps in staff training content and compliance related to violence and aggression, including; Mental Health Law; Conflict Resolution; Dementia Awareness and Learning Disabilities
- Improve staff understanding, recognition and reporting of Assisted Medication Restriction Intervention (AMRI)
- Re-establishment of the Restrictive Intervention Group (RIG) to ensure robust management and review of incidents requiring restrictive intervention.
- Improved documentation of restrictive interventions in the patient records

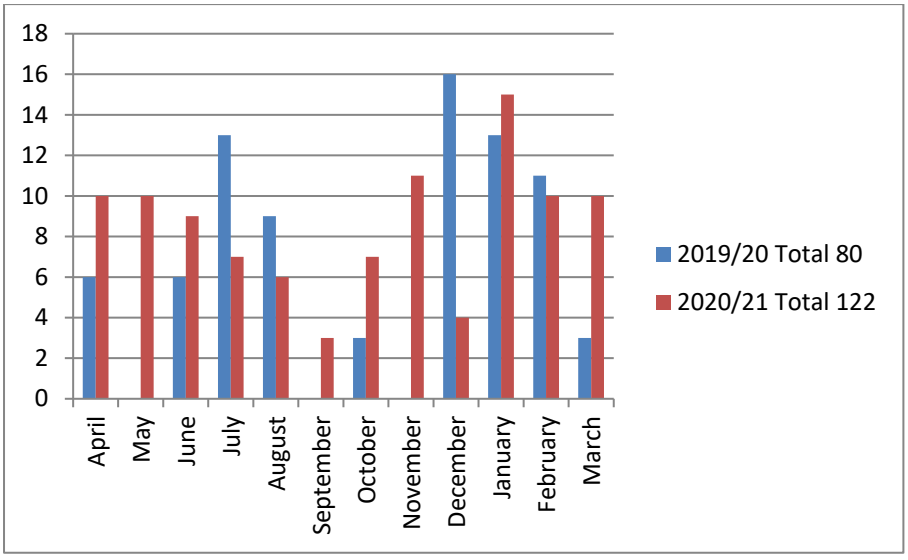
- Improved reported on Datix™ and on Security systems to enable appropriate intervention to prevent recurrence, triangulation of incidences and learning to be shared

The review also highlighted potential unrecognised safeguarding issues associated with lack of Datix™ reporting around absconding and missing patients also possible under-reporting of patients requiring restrictive interventions that may result in a deprivation of liberty. Implementation of identified actions will enable the safeguarding team to ensure missed safeguarding opportunities are actioned

12.1 Deprivation of Liberty Safeguarding (DOLS) and Mental Capacity Act (MCA)

Where patients are under continuous supervision, would not be allowed to leave if they wanted to and lack the capacity to stay in hospital, they are determined under the Mental Capacity Act 2005 to be Deprived of their Liberty. In order for this to be a legal deprivation, the Trust must make an application to the Local Authority to have this deprivation authorised. This process is a safeguard for patients to ensure they are not unlawfully deprived of their liberty and failure to make this application puts the Trust at risk of litigation, reputational damage and allegations of organisational abuse.

DOLS applications by the Trust – Comparable data



Source: Safeguarding Dashboard

Information from NHS Digital shows that the number of applications for DOLS submitted by the Trust, are significantly lower than those submitted by similar size acute Trusts. In March 2021, closer monitoring and review of patients requiring enhanced observation was undertaken with a view to identifying those patients who were being deprived of their liberty. The graph above demonstrates that as a result of this work, there has been a sharp increase in the number of applications.

The Trust Mental Health Team holds responsibility for advising and supporting staff around the implementation of the Mental Capacity Act and the Mental Health Act. Internal and external reviews have identified that staff lack the confidence to appropriately implement the Mental Capacity and Mental Health Acts and understand the interface between the two particularly around detaining or depriving patients of their liberty within a legal framework and utilising the MCA for patients who self-neglect.

Local and National concerns were raised during the COVID-19 pandemic regarding patients where CPR was deemed inappropriate due their underlying health issues. Part of these concerns that were addressed in the Trust were around the use of appropriate Mental Capacity Assessments to ensure patients, families and carers were involved in

discussions around the decision making and ensuring their views and wishes were heard. The DNACPR paperwork and documentation was altered to ensure mental capacity was assessed and evidenced. This has been included in the Trust mandatory training and an accessible video has been distributed via Trust communications and is utilised in the Mental Health Law training.

Liberty Protection Safeguards

Liberty Protection Safeguards (LPS) will replace Deprivation of Liberty Safeguards (DOLS) in April 2022. These new safeguards will radically alter who can authorise the deprivation of liberty and as NHS Trusts will be "Responsible Bodies" it is essential that staff have the confidence, skills and knowledge to implement the Mental Capacity Act. The introduction of LPS is identified as a risk on the Safeguarding Risk Register. Its introduction signifies an opportunity within the Trust to review the management of MCA and liberty safeguards including resources required to fulfil statutory duties. Preparation, training and strategies for these changes must begin as soon as possible to ensure the Trust is ready to fulfil new statutory obligations.

13.0 Conclusion

As with any other area within the Trust, this year has been exceptionally challenging for the safeguarding team due to the impact of the COVID-19 pandemic. The safeguarding team have not been able to fulfil some of their improvement and audit work; and during the height of pandemic training, supervision and visibility of the team has been restricted. However, the increase in recognition and reporting of safeguarding across the Trust, despite the pandemic and a reduced footfall in the Trust, is testament to the impact of the work that the safeguarding team have carried out. They have continued to support staff to deliver a high standard of safeguarding practice and ensure patients, visitors and staff are protected from harm and that the Trust is fulfilling it's statutory duties and responsibilities.

13.1 Achievements for Adults and Children's Safeguarding – 2020/2022

- Successful implementation of safeguarding team re-structure
- Recruitment to:-
    - Associate Nurse for Safeguarding Adults
    - Associate Nurse for Safeguarding Children
    - Lead Nurse for Child Mortality
    - Named Nurse for Children
    - Named Nurse for Adults
    - Safeguarding Administrator
    - Child Protection Administrator
- Recruitment to permanent Named Consultant for Safeguarding Children
- Development of Maternity RAG rating tool for home visiting during COVID-19 pandemic
- Improvement in Position of Trust response within the Trust
- Maintaining quality of safeguarding practice throughout COVID-19 pandemic
- Support to nursing colleagues during COVID-19 pandemic
- Increase in compliance with midwifery safeguarding supervision
- Increase in safeguarding recognition and reporting across the Trust
- Improved recognition of self-neglect following actions from Safeguarding Adult Review
- Partnership working with ED IDVA
- New Policies:-
    - Domestic Abuse Policy
    - Work place Domestic Abuse Policy
    - Managing Allegations Against Staff Policy
    - Safeguarding Supervision Policy
- Reduction in the number of outstanding child death actions
- Group supervision sessions in ED and C2

- Group and 1 to 1 supervision sessions with the community staff
- Increased access to safeguarding support for community services
- Recognition from independent author regarding quality of Internal Management Review
- Consistent positive feedback from CCG via Designate Nurses and SQRM regarding improvements and quality of safeguarding work
- Increased and consistent visibility of the safeguarding team in ED and C2
- Recognition of exceptional safeguarding practice in ED identified from CSPR
- Partnership working with Paediatric staff to strengthen the Was Not Brought process
- Partnership working with Hear4Youth

13.2 Challenges for 2021/2022

- Resources within the safeguarding team to meet growing safeguarding agenda
- Implementation of the Domestic Abuse Strategy
- Preparation for introduction of Liberty Protection Safeguards in April 2022
- Compliance with Safeguarding training

13.3 Key objectives for 2021-2022

Areas for focus and improvements to include:-

Evidence that learning and training is having a positive impact on safeguarding practice
Improve safeguarding practice for older children and young people across the Trust
Increase staff and public awareness of local and national safeguarding agenda and priorities across the Trust
Improve safeguarding documentation systems
Raising profile of FGM across the Trust to increase support provided by the Trust to victims of FGM
Improve opportunities for CYP to be heard and give feedback regarding their experiences

	Opened (date risk identified)	Risk Description	Risk level (initial)	Risk Mitigator	Department	Risk level (current)	Risk level (Target)
Department:							
N1500	25.11.20	Safeguarding patients in nursing homes commissioned/spot purchased	Major	Julie Mullis	Corporate Nursing Division	Major	Minor
N1584	4.3.21	Insufficient resources within the safeguarding team to implement, evaluate and embed the Trust Domestic Abuse Strategy		Justine Morris	Corporate Nursing Division	Moderate	Minor
COR1301	26.2.20	Implementation of Liberty Protection Safeguards	Moderate	Amanda Aworinde	Corporate Nursing Division	Moderate	Minor
N1557	8.2.21	Staff assessment and identification of safeguarding concerns around patient C3/4 pressure ulcers acquired during inpatient stay	Moderate	Jude Page	Corporate Nursing Division	Moderate	Minor

Risk Reference	Opened (date risk identified)	Risk Description	Risk level (initial)	Risk Mitigator	Department	Risk level (current)	Risk level (Target)
Department:							
N1298	29/2/2020	Named Nurse resources due to pressures of preparing for and attending MARAC	Moderate	Justine Morris	Corporate Nursing Division	Moderate	Minor
N1299	29/2/2020	Lack of Compliance for L3 Safeguarding Adults Training	Moderate	Mel Rana	Corporate Nursing Division	Moderate	Minor
N983	12/04/2019	Lack of training for staff to ask 'routine questions' and identify when to ask about domestic abuse	Moderate	Justine Morris	Corporate Nursing Division	Moderate	Minor

Appendix 2 Dudley Group NHS Foundation Trust – Single Agency Audit Plan 2020/21

Month	Audit area	Audit Process	Timescale	Responsible person/Lead	Progress	Presented	RAG Rating
Monthly	Safeguarding Adults and Children	Routine questioning of pregnant women – 15 sets of notes per month	By 15th of each month	Named Midwife and Specialist Midwives	Commenced march 2020- audit ongoing	B Tinsley	
April 2020 – June 2020	Safeguarding Children	Dip sample of 5 patient records per day on Sunrise to identify if any cases of missed opportunities to safeguard children that have not been identified by using PLN criteria	During trial period of utilising PLN criteria for daily ED attendances – complete by 17.7.20 for review and report of trial	PLN	>Commenced April 2020 >One area of concern identified but resolved by enhancement of daily reporting sheet		
April 2020	Safeguarding Children	Was not Brought	May 2020	Named Nurses and Lead Nurse Paediatrics	Commenced April 2020. **14.04.20-**Compliance with the Patient Access Policy is audited quarterly by the Patient Access Team. A report has been requested in relation to those children with safeguarding flags to monitor compliance with the pathway for these children.	J.Morris	July 2020
April 2020	Safeguarding Adults	Safeguarding Adult Referral forms completed– Quality assurance to be undertaken using audit tool specific to this.	Completion deferred from June 2020 to Oct 2020.	Named Nurse Safeguarding Adults	Commenced April 2020 **08/10/20**-Will be completed by end of Oct 2020 for report to ISB Jan 2021	M. Rana	Completed 22/12/2020

May 2020	Safeguarding Children	Outcome of Peer on Peer assault MARFs – Q4 2019/20	Mid-June 2020	PLN/ED Lead Nurse	**08/10/20-**Audit was delayed due to depletion of the safeguarding children team. This has been commenced- awaiting data from social care. **03/11/20- Completed and results included in January ISB report.**	J.Morris	Completed 03.11.20
June 2020 Sept 2020 December 2020 March 2021	Safeguarding Children	Safeguarding Children Referral forms completed (30 per quarter, various areas) – Quality assurance to be undertaken using audit tool specific to this.	4 weeks after start of audit	Named Nurse Safeguarding Children	June audit on ED MARFs completed and reported to ISB in May 2020. **08/10/20-September audit has been delayed due to a depleted team- to be commenced in October 2020.** **23/11/20- Q1 and Q2 completed** **31/12/20- Q3 completed.**	R.Dale	Q1 Completed 23.11.20 Q2 Completed 23.11.20 Q3 Completed 31.12.20 Q4 Completed 31.3.21
June 2020	Safeguarding Adults	Case file audit of safeguarding documentation (to include MSP) using audit across variety of wards/depts.	~~Mid-July 2020~~ Dec 2020	Named Nurse and Associate Nurse for adults	Delayed due to resource issues and depletion of team. **08/10/20- audit completed and will be presented at ISB in Jan 2021.** **22/12/20- Verbal update to ISB in January 2021**		Completed- verbal report to ISB in January 2021.
July 2020	Safeguarding Children	Outcome of ED MARFs – comparison of Q4 2019/20 with Q1 2020/21	Completion by mid-~~September 2020.~~ ~~January 2021~~ March 2021	PLN/ED Lead Nurse	**08/10/20**-Audit was delayed due to depletion of the safeguarding children team. This has been commenced- **awaiting data from social care.**		Commenced 01.12.20 Not completed due to COVID 19 pressures
July 2020	Safeguarding Adults and Children	Maternity safeguarding documentation	August 2020- deferred until Oct 2020.	Named Midwife/Specialist Midwives	08/10/20- Audit commenced Oct 2020. To be presented at ISB in	B Tinsley	Completed December 2020

		audit			January 2021.		
June 2020 Sept 2020 Dec 2020 March 2020	Learning Disability Team	Case file audit to ensure Trust learning from death processes are completed	March 2020	Lead Nurse Learning Disability Team		J.Passmore	Completed Completed Completed Not completed due to depletion of team staff resources
August 2020	Baseline audit of staff knowledge of recognition, referral and Think Family agenda (in identified areas per Annual Improvement Plan)	Staff survey	~~October 2020~~ ~~January 2021~~ March 2021	Safeguarding Team	08/10/20-Audit was delayed due to depletion of the safeguarding children team. Will commence when the Associate Nurses are in post. **22/12/20- audit commenced.**		Not completed due to COVID 19 pressures
September 2020	Safeguarding Children	Case file audit of safeguarding documentation (to include the voice of the child) using audit tool –from variety of depts.	Completion by mid-~~October 2020~~ ~~December 2020~~ March 2021	Named Doctor/Medical students	08/10/20- Commenced October 2020. **22/12/20- update requested from Dr Petkar.** **5/1/21 Update, Students not able to finish audit due to exams, due date changed**		Not completed due to COVID 19 pressures – carried over to next year
September 2020	Baseline audit of staff knowledge and understanding of recognising and responding to domestic abuse	Staff survey	~~December 2020~~ ~~January 2021~~ March 2021	Safeguarding Team	08/10/20- not commenced due to depletion of staff.		Not completed due to COVID 19 pressures – carried over to next year
October 2020	Safeguarding Children and Adults	6 month post level 3 training questionnaire to identify impact on practice	Completion by end of March 2021	Whole safeguarding team/L&D			Not completed due to COVID 19 pressures – carried over to next year
January 2021	Safeguarding Children	6 month post supervision (1 to	Completion by end of March	Named Nurses/Named			Not completed due to COVID 19

		1 or group) to identify impact on practice	2021	Midwife/Specialist Midwives			pressures – carried over to next year
September 2020	Safeguarding Children	Section 11	September 2020	Head of Safeguarding			Completed Sept 2020

Appendix 3 Dudley Group NHS Foundation Trust – Single Agency Audit Plan 2021/22

Month	Audit area	Audit Process	Timescale	Responsible person/Lead	Progress	Presented	RAG Rating
Monthly	Safeguarding Adults and Children	Routine questioning of pregnant women – 15 sets of notes per month	By 15th of each month	Named Midwife and Specialist Midwives			
Monthly	Safeguarding Children	Was not Brought	By 15th of each month	Named Nurses and Lead Nurse Paediatrics			
May 2021	Snap shot audit of staff knowledge of recognition, referral and Think Family agenda (in identified areas per Annual Improvement Plan)	Staff survey	Report to ISB July 2021	Associate nurses for safeguarding			
May 2021	Baseline audit of staff knowledge and understanding of recognising and responding to domestic abuse	Staff survey	Report to ISB July 2021	Safeguarding Team and IDVA			
June 2021	Safeguarding	6 month post	Report to ISB	Whole safeguarding			

	Children and Adults	level 3 training questionnaire to identify impact on practice	July 2021	team/L&D			
June 2021 Sept 2021 December 2021 March 2022	Safeguarding Children	Safeguarding Children Referral forms completed (30 per quarter, various areas) – Quality assurance to be undertaken using audit tool specific to this.	4 weeks after start of audit for reporting annually to ISB	Named Nurse Safeguarding Children		R.Dale	Q1 Q2 Q3 Q4
June 2021 Sept 2021 Dec 2021 March 2022	Learning Disability Team	Case file audit to ensure Trust learning from death processes are completed	March 2022	Lead Nurse Learning Disability Team		J.Passmore	
August 2021	Safeguarding Children	Section 11	Report to ISB October 2021	Head of Safeguarding			
August 2021	Safeguarding Children	6 month post supervision (1 to 1 or group) to identify impact on practice	Report to ISB October 2021	Named Nurses/Named Midwife/Specialist Midwives			
October 2021	Safeguarding Adults	Safeguarding Adult Referral forms completed– Quality assurance to be undertaken using audit tool specific to this.	Report to ISB Jan 2022	Named Nurse Safeguarding Adults			
November 2021	Safeguarding Adults and Children	Maternity safeguarding documentation audit	Report to ISB January 2022	Named Midwife/Specialist Midwives		B.Tinsley	
January 2022	Safeguarding Children	Case file audit of safeguarding	Report to ISB April 2022	Named Doctor/Medical			

		documentation (to include the voice of the child) using audit tool –from variety of depts.		students			
January 2022	Safeguarding Adults	Case file audit of 50 sets of safeguarding documentation (to include MSP) using audit across variety of wards/depts.	Report to ISB April 2022	Named Nurse and Associate Nurse for adults			

Appendix 4 Safeguarding Improvement Plan 2021/22

Area	Safeguarding		**Strategic Objective**	*Strengthen hospital-based care to ensure high quality hospital services provided in the most effective and efficient way.*
Manager/Lead	Head of Safeguarding	Date:- 5.3.21	**Executive Lead**	Mary Sexton Chief Nurse

Action not started	**Action underway not yet completed**	**Action completed and assurance received Action In progress**	**Action to be carried over to 2021/22**

Aim	Objectives	By When	Outcome	Progress to date	
Rationale:-	• Section 11 Audit • Internal Safeguarding Reviews • Safeguarding Adult Reviews, Child Safeguarding Practice Reviews, Domestic Homicide Reviews, Child Death Reviews • Children Act 2004, Care Act 2014, NHS Accountability and Assurance Framework				
1 Evidence that learning and training is having a positive impact on safeguarding practice	1.1 With support from L&D introduce Post Safeguarding Level 2 training evaluation to identify key areas retained and impact on practice		Improved assurance to the Trust Board and external partners that learning has been embedded and training has had a positive impact on practice		
	1.2 Audits of safeguarding practice around themes identified in SARs, DHRs and CSPRs to be built into Annual Audit Plan				
	1.3 Quarterly analysis of data to identify improvements in response to themes identified in internal and external safeguarding reviews - to be included in ISB reports				
	1.4 Use of patient stories to evidence improvements to practice				
	1.5 Collection of data from safeguarding supervision sessions to evidence learning and changes to practice				

Rationale	• Peer reviews and analysis of DATIX identifies that staff lack the confidence and skills to identify and act upon safeguarding concerns for young people • 16 and 17 year olds are treated in the Trust on adult pathways but there are very low numbers of young people referred from outside Trust children's services				
2. Improve safeguarding practice for older children and young people across the Trust	2.1 Scoping with other Trusts – can we work together? Have they identified similar issues? What are they doing?		Increased staff awareness and confidence in identifying and referring safeguarding concerns for older children and young people Increase in number of referrals to Children's social care (outside of ED and C2) regarding safeguarding for older children and young people Increase in No of DATIX (outside of ED and C2) regarding safeguarding for older children and young people		
	2.2 Raising awareness of safeguarding issues affecting 14 to 17 year olds via • Roadshow • Bulletin • Training • Team walkabouts • Information on website and SG Hub • Safeguarding newsletter				
	2.3 Undertake Quality Assurance visits to key target areas with a focus on young people accessing the Trust on an adult pathway				
	2.4 Learning events using outside organisations to raise awareness of issues effecting young people and support available				
	2.5 Develop partnership working with outside agencies who can support increasing number of young people attending ED with mental health and substance misuse				

Rationale:-	• CQC recommendations regarding availability of safeguarding information to the public • Safeguarding Adult Reviews, Child Safeguarding Practice Reviews, Domestic Homicide Reviews, Child Death Reviews • Safeguarding is everyone's responsibility • Children Act 2004, Care Act 2014, NHS Accountability and Assurance Framework				
3. Increased staff and public awareness of local and national safeguarding agenda and priorities across the Trust	3.1 Develop Safeguarding Strategy and roll out across the Trust		Improved training/supervision compliance Increase advice calls to safeguarding team Increase in referrals from depts. who historically did not refer Improved engagement and attendance at ISB Feedback from staff and patients		
	3.2 Regular safeguarding team attendance at divisional/department/service meetings and team meetings				
	3.3 Standardised patient safeguarding information accessible in all areas, wards and depts.				
	3.4 Develop programme of Bi-monthly roadshows and events to promote of individual safeguarding topics				
	3.5 Patient stories to be presented to Trust Board			>Awaiting response from Trust Chair 7.10.20 >Awaiting response. HoS to request again 6.1.21	
	3.6 Development of Safeguarding quarterly newsletter	April 2021			
	3.7 Review and update external website to include information and support around safeguarding for public to access	May 2021			

	3.8 Develop patient friendly information leaflets about safeguarding issues and practice	April 2021		4.1.21 – work commenced on CYP and adult leaflet	
Rationale:	• Poor information sharing between shifts • Events and information not in chronological order • Difficult for staff to keep eye on progress of safeguarding activity for individual patients • Missing information/information not documented • Difficulty with audit and IMR process				
4. Improved safeguarding documentation systems and processes	6.1 Baseline audit of current documentation		Improvement in quality of documentation evidenced in audits Clearer evidence of MSP More efficient audit and IMR process Improved communication between MDT, shift handover and partner agencies	7.10.20 Audit of adult and children safeguarding documentation has commenced but been delayed due to resource issues. Recommendations from audit to be presented at ISB Jan 2021 6.1.21 >Midwifery Documentation audit completed and to be shared at ISB in January >Adult documentation audit underway and to be shared at ISB in April >CYP documentation audit not yet commenced	
	6.2 Scoping of other health partners documentation systems				
	6.3 Develop task and finish group in partnership with key staff for designing and implementing new safeguarding documentation				
Rationale	Female Genital Mutilation Act FGM Enhanced Dataset				

	Low number of FGM Datix outside of midwifery and CASH and GUM				
5. Raising profile of FGM across the Trust to increase support provided by the Trust to victims of FGM	7.1 FGM Roadshow		Increased number of identified FGM cases including areas outside of Maternity and CASH and GUM		
	7.2 Scoping of routine questioning in in-patient setting				
	7.3 Scoping for multi-agency webinar				
	7.4 TNA for Trust FGM training				
Rationale	Section 11 Audit				
6. Improve opportunities for CYP to be heard and give feedback regarding their experiences	8.1 SG team to work with ED staff to request quick feedback info from patients requiring submission of MARF		Feelings and wishes of CYP are captured in referrals and documentation by health professionals A designated forum for CYP to give feedback and opinions regarding their experiences in the hospital	6.1.21 >Associate Nurse is developing a tool for ED staff to use to capture feedback from CYP who have required safeguarding	
	8.2 Request feedback from other professionals following CP medical – *(most children would be too young to give feedback but professional who acts as their advocate would be able to do this)*				
	8.3 Audit of CYP records to evidence if wishes and feelings are included on admission sheet				
	8.4 Scope work with CYP and transition nurse to support development of CYP panel/user group				

	8.5 Audit of MARFs to evidence if wishes and feelings of the child have been sought and documented				

Enclosure 17

The Dudley Group NHS Foundation Trust

Paper for submission to the Board of Directors May 2021

TITLE:	**Chief Nurse Report**		
AUTHOR:	**Jo Wakeman** **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:

This is a new style report; which we will continue to develop over the next few months. All feedback welcomed.

1. Good News Stories:

- Pharmacy Technician support role for drug administration has been submitted for a HSJ award Patient Safety Innovation 2021. .
- All wards have moved onto AMaT from Perfect Ward.
- Implementation of GSF in local care home continues.
- CQC and FTSU held an engagement focussed discussion as part of routine engagement discussions.
- 153 Clinical support workers have joined the Trust.
- 'Keep in touch sessions' with our graduates to aid recruitment
- AHP job planning due to complete in August 2021
- AHPs to join eRostering system.
- Zero COVID-19 outbreaks

2. Areas for Improvement

The Trust received a supportive IPC peer review from NHSI/E on the 6th April 2021.Progress will be monitored through the Quality and Safety Committee.

IMPLICATIONS FOR THE CORPORATE RISK REGISTER OR BOARD ASSURANCE FRAMEWORK			
Risk Corporate Unable to safely staff the wards during the Coronavirus Pandemic due to high levels of absence (sickness/COVID related) leading to risk of inability to meet quality standards and safe care.	**Y**		**Risk Description** COR1529 Unable to safely staff the wards during the Coronavirus Pandemic
			Risk Score :20
RISK BAF 1A Not effectively engaging with patients in their care or involving them in service improvement	**Y**		**Risk Description:** COR1010 Failure to comply with local and statutory provisions for complaints management
	Risk Register: Y		**Risk Score: 9**
COMPLIANCE and/or LEGAL REQUIREMENTS	**CQC**	**N**	**Details:**
	NHSI	**N**	**Details:**
	Other	**N**	**Details:**
REPORT DESTINATION	**EXECUTIVE**	**N**	**DATE:**
	DIRECTORS	**N**	**DATE:**

NHS
The Dudley Group
NHS Foundation Trust

Chief Nurse Report

Trust Board 13th May 2021

Mary Sexton, Chief Nurse

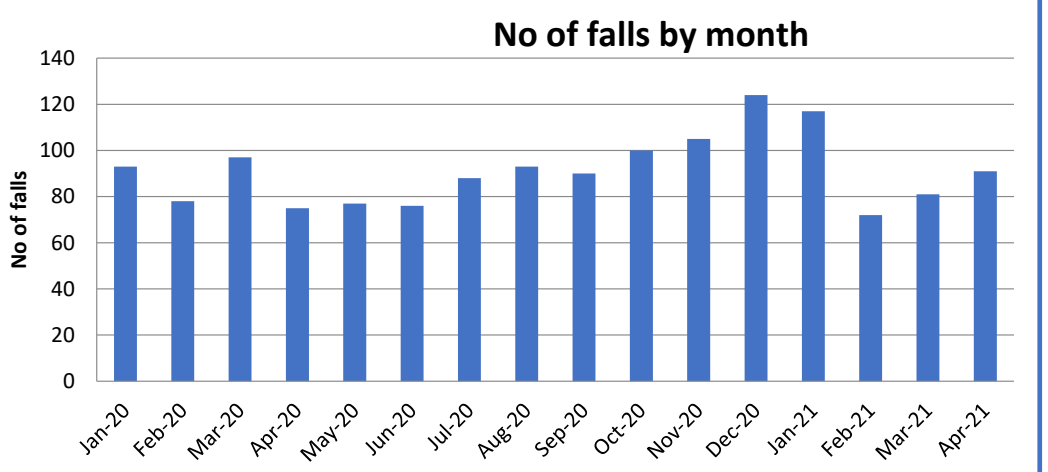



Care - Deliver safe and caring services - Falls

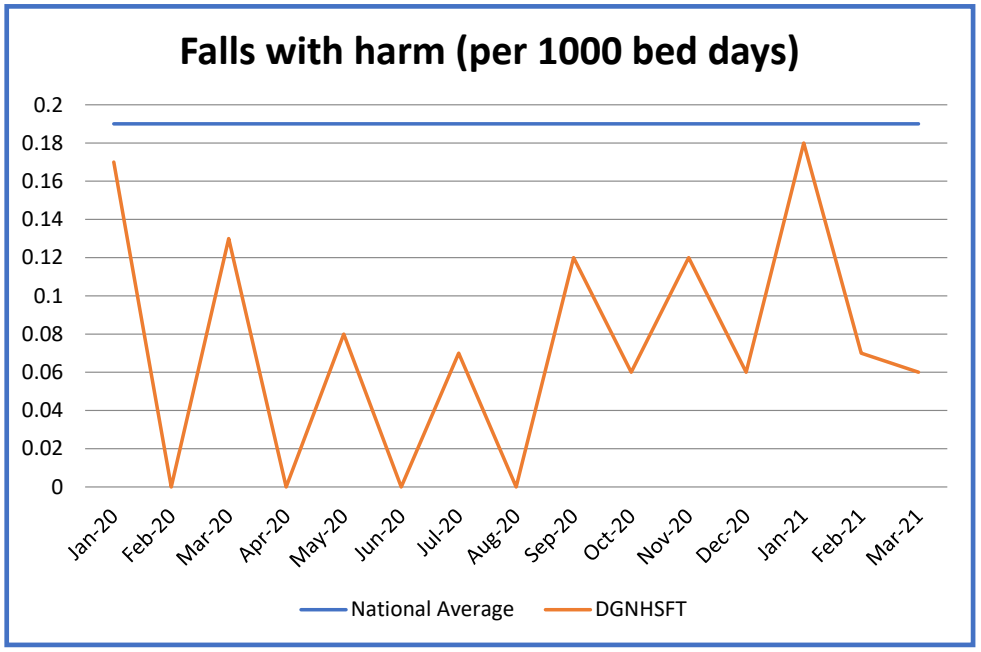
- **Falls –**
- Ongoing work is underway with the support from Clinical Site Team to reduce falls risk to patients being moved overnight. outlier Policy is to be reviewed by relevant staff to acknowledge risk to patients of fallings.
- Falls flag for use in Sunrise is now ready for sign off and will then be ready for roll out across the Trust.

Bed/chair alarms were discussed at the Quality & Safety Group to determine whether their use should be continued Trustwide. Our Falls Lead will undertake scoping exercise and report back to the group.

A falls assessment for the Emergency Department (ED) agreed by ED team and Falls Lead. Is under development and will then be added to Sunrise.



	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21
■	93	78	97	75	77	76	88	93	90	100	105	124	117	72	81	91



Care - Deliver safe and caring services

Extended role trial in Pharmacy

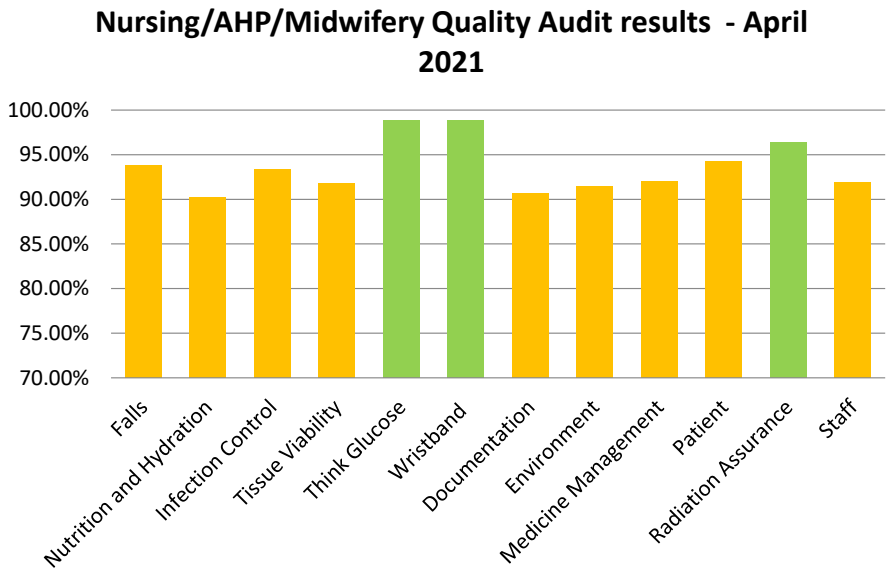
- A trial of the extended role of Pharmacy Technicians Neha Kler and Joshua Moseley within Critical Care Services commenced during January 2021, in response to offering enhanced support to Registered Nurses and the safety requirement of a second check for intravenous medications. Following completion of intravenous drug administration training, from 8th February 2021 onwards, Josh and Neha served as both the second verification check of intravenous drugs with Critical Care areas, then proactively assessed drug usage and ensuring the supply and releasing time otherwise required by Registered Nurses. During the trial, no adverse incidents pertaining to intravenous drug administration were reported, and a comparison of timeliness of due medication time to actual administration time identified a time efficiency saving of 27.2%, particularly as this enhanced role released this medication verification requirement from a second Registered Nurse. This trial and its results will be submitted to the Health and Safety Journal (HSJ) 2021 award nominations in the category of Patient Safety Innovation, as an effective but most crucially a safe means of both improving patient treatment and experience, whilst expanding the role of the highly skilled Pharmacy Technician. It is intended this trial may be replicated across other acute inpatient areas to further support prompt care delivery.

Nursing/AHP/Midwifery Monthly Quality Audits – Move to AMaT

April 2021 saw the successful transition of all the inpatient acute nursing audits from Perfect Ward to AMaT, In total 120 Nursing/AHP/Midwifery teams, out of a possible 126, completed there audits. Those who did not complete were escalated accordingly.

Compliance with audit topics remained comparable with previous monthly submissions, with the exception of Medicines Management which deteriorated from 96.2% to 92%. This has been escalated to the Medicine Management Matron Leads.

Between 1st March 2021 and 30th April 2021, 330 improvement actions have been recorded as completed, out of 362 actions recorded.



Compassion - Deliver a great patient experience

Complaints

April 2021 received an increased number of new complaints when compared to April 2020, although it is recognised that COVID-19 impacted on the number of complaints received during quarter 1 (2020-21) and we saw a reduction in the number of complaints received during this time.

All complainants are given a 30 working day timeframe. Of those 60 closed, 22 (36.6%) were closed within 30 working days. The remaining responses were sent within the extension time agreed with the complainant.

Gold Standards Framework (GSF)

- 1:1 support has been provided to C4 by one of the End of Life Facilitators for their portfolio review ready for GSF submission and 1:1 support given to AMU to review power BI and GSF accreditation process in the future.
- A virtual review for GSF accreditation is due to take place for C1 and B6 – this is planned for May/June 2021.
- GSF for Care Homes continues - mentors have now been assigned and visits have been made to the homes to offer advice and support in implementing the GSF.
- GSF care plans, Advance Care Planning and Priorities for Care of the Dying Person documents have been left with the care homes for feedback and adaption as required to suit their needs.
- A National GSF patient information leaflet has been disseminated to consultants and palliative care champions for their comments and will shortly be adapted for use in Dudley.

Freedom to Speak Up

No exceptions for April 2021

- The FTSU strategy and policy has been ratified and these will be launched in May 2021.
- The FTSU Guardian continues to raise awareness across Trust teams.
- A FTSU engagement focus discussion took place with a CQC engagement lead as part of a routine engagement discussions.

Competence - Drive service improvement, innovation and transformation

Recruitment

- The final cohort of CSW's start this month as part of the major CSW recruitment, we have recruited 153 CSW's into the trust. They are progressing well with their Care certificates and then we plan to progress them onto their Diploma.
- A few wards are trialling a blended role of a CSW and AHP aide; one area involved is C8 to look how this training and support can be achieved This project is being undertaken by Lorraine Allchurch who is seconded as the Lead for AHP support staff.

Pre-registration Team

- Our Nursing students from the University of Wolverhampton and Worcester who opted into supporting the trust with paid employment are coming to an end of this period. Majority of these students have really enjoyed their experience and some have been appointed into a substantive post within the trust once they have completed their qualification in September 2021.
- The first year Nursing students from Wolverhampton University are out on placement after deferring their clinical placement from January, we have had 54 students start with us.
- An evaluation of student placements has been has been completed and reviewed, the majority of areas have evaluated well especially C3/C8 and critical care.

Despite the continued trust pressures in ward areas staff members continue to support students in practice well, there is challenges with support in some areas clinical areas continue to engage with the practice team and the students. Regular student support sessions are positive and enable any issues to be addressed early. The team have received positive feedback from student's regarding the support available to them

Graduates team

- As part of the recruitment initiative, we are now planning "keep in touch" sessions for all our potential new graduates to make them feel part of the trust and providing a regular newsletter prior to starting.
- Graduates are utilising the clinical supervision sessions and finding these beneficial to their new role and the opportunity to reflect on care provided.
- Plans are underway to launch the new Career progression pathway trust wide in May 2021, which will apply to all grades of staff in nursing, midwifery and AHPs.

Apprenticeships

- The Trust will see its first Physiotherapy apprenticeship programme commence this September. Mike Denny who works in acute therapy services started his career at DGFT as a band 3 therapy assistant and is currently a band 4 therapy assistant practitioner. This is another step in supporting career pathways for our support staff.

Communication - Make the best of what we have

Infection Prevention and Control

Since the last update the Trust has seen one COVID -19 outbreak involving two members of staff, this outbreak has now closed.

The Trust received a supportive IPC peer review from NHSI/E the 6th April 2021.An action plan has been developed to progress improvements from the visit.

Allied Health Professionals (AHP)

Service and workforce re-design

- Dudley rehabilitation service are piloting increased admin and assistant time to support the Parkinson's disease pathway and releasing clinicians time to focus on thier complex patient care. Patient phone calls are being responded to in a more timely manner, and patients are receiving the information and advice they need earlier in the pathway. Similarly, the community Multiple Sclerosis service has established a specific MS patient line to enable a quicker response to patient concerns and needs. The service has secured a part time MS CSW to release the specialist nursing time. Plans are in place to pilot a new MS relapse clinic to enable rapid access for patient with exacerbation of symptoms. Patient feedback has been very positive to all of these initiatives

National recognition

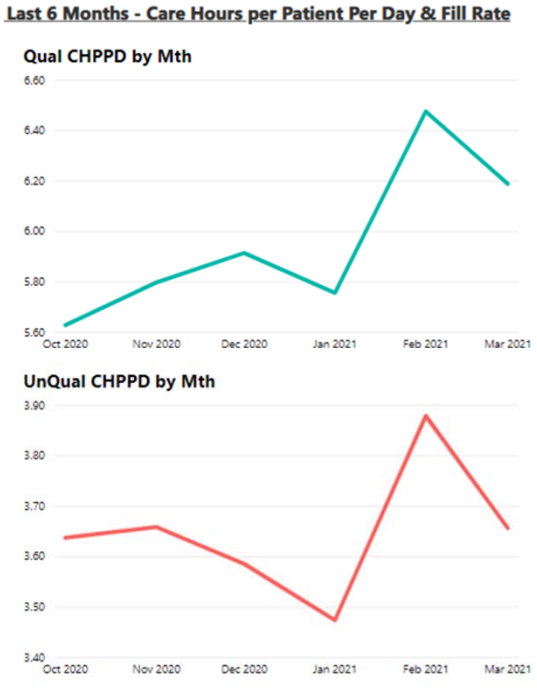
- Lorraine Allchurch Lead AHP support worker has been shortlisted in the Advancing Healthcare awards in the category of rising star. The ceremony and reveal of the winners is on 21st May. Good luck Lorraine!

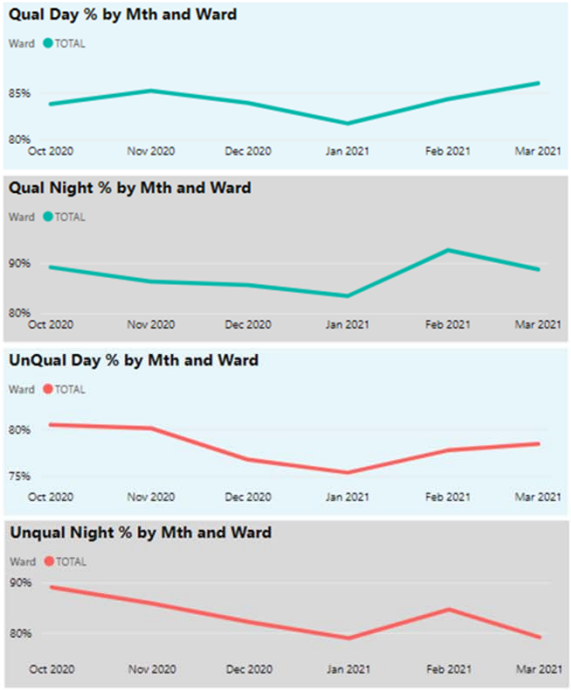
AHP e-roster and e-job planning

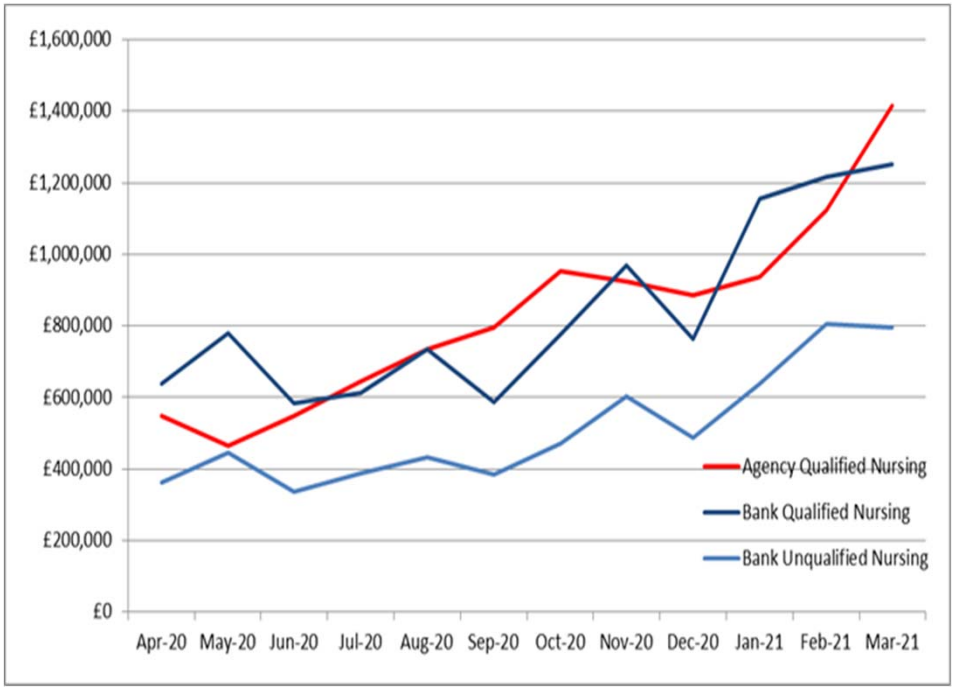
- AHP e-Job Planning has been launched via 'In the Know' on Monday 12th April with a short video and communications from Karen Lewis (Chief Allied Health Professional), Clare Inglis (AHP Professional Lead) and Michael McDonagh (Interim Project Manager). Over 500 user accounts have now been issued and every AHP has been invited to start thier job-planning process. The project team has been available for daily drop-in training sessions via MS Teams since Monday 19th April with 1-1 training being delivered for Managers and Staff..
- New Intranet page launched for AHP Job Planning page, with Trust specific user guides created by the project team and National guidance from NHS England and Improvement. The AHP Job Planning round is set to complete by August 2021 with Managers signing off the job plans throughout July.
- AHP e-rostering commenced mid-March and the majority of service leads have received early engagement re; e-Rostering process and data collection.
- The implementation of e-Rostering will cover the optimisation of teams already live as well as more teams on eroster. A set of 6 teams is planned to go live at the end of May with full implementation by October 2021. Again 1-1 Training session is being provided via MS Team to Unit Managers and budget holders and drop-in sessions will be provided from June onward for staff who need additional information.
- A new Intranet page will be launched for AHP e- Rostering, with Trust specific user guides and information.
- There has been positive engagement across all AHP professional groups and services to date.

Commitment - Be the place that people choose to work

- Bank and agency / CHPPD





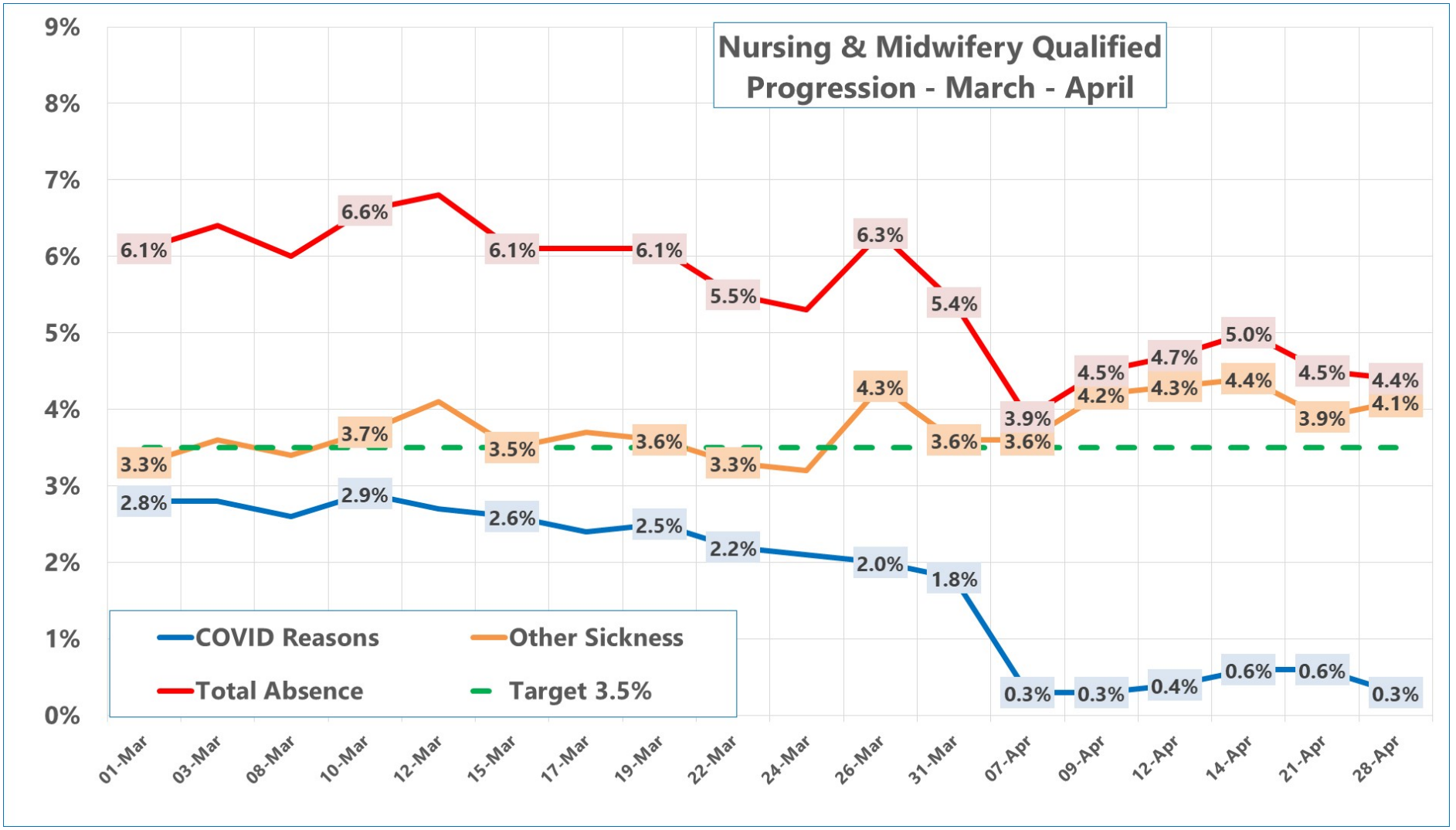


Bank usage during March 2021 appears to be plateauing, we continue to see high agency expenditure primarily driven by ED and Critical Care. Data for April shows a further reduction in bank and agency usage. Fill rates for unqualified staff noted to be less that 80% for day and night. We are expecting this to restore further now all our newly recruited support workers have commenced.

Commitment – COVID Reason Absence Profile

Daily tracking of sickness absence showed a peak of 6.8% on the 12th March, followed by a downwards trend towards the end of the month to 5.4% on the 31st March including 18 staff who were shielding.

Notably, COVID shielding ended at midnight on the 31st March, and the absence position on Wednesday 28th April shows 0.3% of staff absent with COVID our of a total absence of 4.4%.



Courage - Deliver a viable future

Safeguarding

- The Annual Report has been completed and signed off at the Internal Safeguarding Board and Quality and Safety Committee
- Annual Improvement Plan 2021/22 signed off at Internal Safeguarding Board
- Domestic Abuse Strategy and Plan has been approved.
- Joint working with Trust Improvement Practice Department, Local Authority, CCG to map DOLS and LPS process ready for introduction of LPS in April 2022
- Workshops and Learning Events for 2021/22 sent out to clinical and service leads for cascading to their teams
- Patient Safety Bulletin via Comms re Interface between Mental Health Act and Mental Capacity Act and key responsibilities.
- Plans commenced for "Reachable Moments" project in ED to include presence of youth workers within the department to support CYP involved in violence or criminal activities and related mental health and substance misuse issues
- Team walkabouts commenced to include monthly theme – April 2021 will be Chaperoning

April Data

- Adult safeguarding referrals 52
- No of Section 42/other enquiries 0
- Children safeguarding referrals 146

Enclosure 18

The Dudley Group NHS Foundation Trust

Paper for submission to the Trust Board May 2021

TITLE:	**Infection Prevention and Control Board Assurance Frame Work –including summary Updated May 2021**		
AUTHOR:	**Jo Wakeman – Deputy Chief Nurse** **Hannah White and Kim Jarrett Infection Prevention Clinical Nurse Specialists**	**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.*

CORPORATE OBJECTIVE: SO2: Safe and Caring Services

SUMMARY OF KEY ISSUES:

This paper is 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 20028 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.

Updates since last report:

- IPC Mandatory training continues to improve at the time of this report 88.4 % clinical staff) and 93.4% non-clinical against a target of 90%.
- The Trust had a supportive IPC review from NHSI/E on the 6th April 2021. The formal report has been received by the Trust on the 30-04-21. The findings have been reviewed and actions are being taken. A formal report will be submitted to Quality and Safety Committee in May 2021.

There are no red non-compliant areas within the IPC BAF and 11 amber areas with mitigations in place, the IPC Group and wider Trust team continue to progress this work stream.

IMPLICATIONS OF PAPER:

RISK	**Y**	**Risk Description: Risk regarding decontamination of reusable medical devices and lack of clarity regarding Trust**

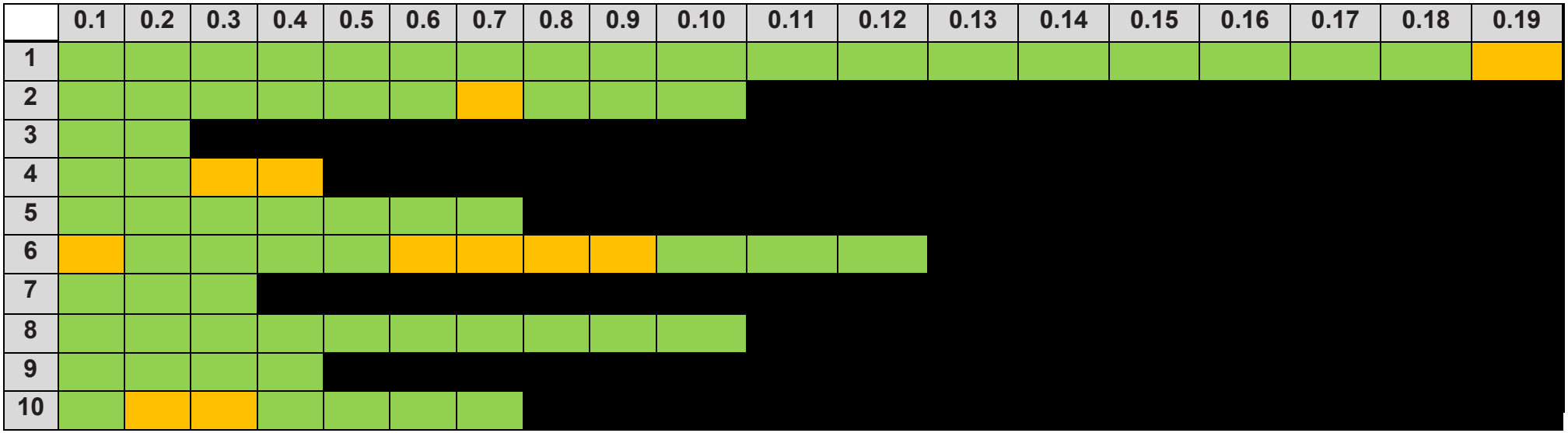
			Decontamination Lead-Risk on IPC Risk Log
	Risk Register: Y		**Risk Score: 12**
COMPLIANCE and/or LEGAL REQUIREMENTS	**CQC**	**Y**	**Details: Safe, Effective, Well Lead**
	NHSI	**Y**	**Details: N1611 Vacant Post in the Lead Nurse for Infection Control and Deputy DIPC – risk score 20**
	Other	**N**	**Details: Advised by NHSI/E with a vacant Lead IPC nurse the trust is ranked red against their Matrix for IPC.**

ACTION REQUIRED OF COMMITTEE / GROUP:

Decision	Approval	Discussion	Other
		✓	

RECOMMENDATIONS FOR THE BOARD /COMMITTEE/GROUP:
The IPC Group and Quality and safety Group are to oversee the continued actions within the IPCTBAF to endure compliance with the health and social care act

BAF Compliance Matrix	KEY	No Gaps	Gaps Identified with mitigation	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	0.11	0.12	0.13	0.14	0.15	0.16	0.17	0.18	0.19
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1	The infection control risk assessment in the admission documentation is limited.
2	No Decontamination Lead for the trust.
3	No GAPs identified
4	Easy read COVID versions are not available on external website. Multilingual versions also not readily available.
5	No GAPs identified
6	Poor IPC training scores for trust
7	No GAPs identified
8	No GAPs identified
9	No GAPs identified
10	There is no formal COVID PPE audit.

Infection Prevention and Control Board Assurance Framework: April 2021

	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:	The Trust has policies and procedures in place to identify alert organisms in patients admitted to the Trust.	N/A		
1.1	• Infection risk is assessed at the front door and this is documented in patient notes	Patients with symptoms are assessed by ED and are placed into the RED Cohort area of ED; all admissions via ED are screened.	N/A	POCT Feb 2021	
1.2	• There are pathways in place which support minimal or avoid patient bed/ward transfers for duration of admission unless clinically imperative	Outpatient flow chart in use. Documentation audits are ongoing monthly.			
1.3	• That on occasions when it is necessary to cohort COVID or non-COVID patients, reliable application of IPC measures are implemented and that any vacated areas are cleaned as per guidance.	Point of care testing in place within Emergency Department that enables streaming of patients thus preventing crowding of patients as a direct result of waiting for COVID-19 swabs.	Frequency of moves not routinely monitored. Re-zoning of clinical areas to meet patient demand often compounds frequent movement of patients.	IPC team monitor movement of any patient positive from COVID and monitor the contacts. Report to be presented at IPC with recommendations for improvement.	
1.4	• monitoring of IPC practices, ensuring resources are in place to enable compliance	Movement of patients restricted to clinical need.	Information not readily		

	with IPC practice		available. Monthly audits reliant on clinical staff assessing their own area. Self-auditing.	Consideration for a trust wide system. Trust wide audit of terminal cleaning of side rooms.	
1.5	• Staff adherence to hand hygiene?	Zoning SOP in place. Lead nurse sign off for terminal cleaning. Cleaning audits. Senior nurse environmental monthly audits. Outbreak meetings three times a week. IPC inspections un announced. Mandatory training, monthly hand hygiene audits. IPC inspections un announced.	N/A	IPC team to do trust wide review, to be included work plan. Compliant.	
1.6	• Patients with possible or confirmed COVID-19 are not moved unless this is essential to their care or reduces the risk of transmission	The Trust has implemented a Zoning system, Yellow, Blue and Green with SOP in place (this is in line with national pathways of low/medium/high) The capacity of the Zones is reviewed 3 times daily at the capacity meetings. IPC attend as	N/A	Infection control attend the capacity meetings as required	

		required. The infection prevention team have the daily ward list which documents the location of COVID 19 patients and their contacts. BI Power Server	IPC ward list not a live document due to current workload pressures not currently updated daily.		
1.7	• Implementation of twice weekly lateral flow antigen testing for NHS patient facing staff, which include organisational systems in place to monitor results and staff test and trace	introduced by Informatics to monitor COVID changes. Any staff member that becomes positive for COVID-19, are followed	LF is currently voluntary Not all front facing staff are recording results. Lack of data. Local data compliance is not readily available.	LAMP testing introduced.	
1.8	• Additional targeted testing of all NHS staff, if your trust has a high nosocomial rate, as recommended by your local and regional infection prevention and control/Public Health team.	up for any breaches in PPE and social distancing. PPE marshalls located around the trust. Staff members encouraged to challenge non-compliance of PPE. Available on all entrances to the trust.	N/A	Compliant.	
1.9	• Training in IPC standard infection control and transmission-based precautions are provided to all staff	Staff lateral flow system set up. Staff encouraged to record lateral flow results.	N/A		
1.10	• Trust Chief Executive, the Medical Director or the Chief Nurse approves and personally signs off, all daily data submissions via the daily nosocomial sitrep. This will ensure the correct and accurate measurement and testing of patient protocols are activated in a timely manner • This Board Assurance Framework is	Whenever outbreaks are identified, the testing evidence is available. Recorded in outbreak meetings. Included in all mandatory training which all staff must completed yearly. Mandatory training is monitored by learning and	N/A	Compliant Complaint	

1.11	reviewed, and evidence of assessments are made available and discussed at Trust board	development team and reminders sent out when training is due to lapse.			
1.12	• Ensure Trust Board have oversight of ongoing outbreaks and action plans	SIITREP data submitted to DIPC daily by 11am for sign off before Incident room submit data by 13.00. IPC collect data mon – fri and covered by incident room at the weekends	N/A N/A	Complaint	
1.13	• There are check and challenge opportunities by the executive/senior leadership teams in both clinical and non-clinical areas.	BAF submitted in timely manner for board review. Updated monthly by IPC, Consultant microbiologist and deputy chief nurse. Board updated by DIPC. DIPC chairs outbreak meetings and have daily updates sent via email by IPC. Minutes of outbreak meeting available as required. Discussed at Quality and safety committee. Via board and Quality and safety committee.	N/A	Complaint Complaint	

	Key lines of enquiry	Evidence	Gaps in Assurance	Mitigating Actions	R.A.G
1.14	• 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. Policy completed to be added to the hub. 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. Completed. 01/12/20 –meeting held for Sunrise prompt care/nursing home patients to be tested for COVID before discharge. Prompt now available on sunrise to trigger screening prior to discharge.	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.	

1.15	• 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. PPE Marshalls are in place, there are posters stating PPE requirements in each of the zones. Executive oversite of PPE stocks. 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. All patients are encouraged to wear surgical masks at all times except overnight.	N/A		

	Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	**R.A.G**
1.16	• 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. Daily situation report to PHE/NHSI/E. Latest updated PHE/NHS IPC guidance is included in Trust SOP's (Test & Trace and Zoning SOP's).	N/A		
1.17	• Changes to guidance are brought to the attention of boards and any risks	COVID 19 taskforce meeting that	N/A	Latest updated PHE/NHS IPC	

	and mitigating actions are highlighted	reports directly to the Executive Board. Updated national guidance for isolation of staff contacts reduced from 14 day to 10.		guidance is going through Trust processes currently.	
	Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	**R.A.G**
1.18	• 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 reviewed to ensure all COVID related risks are documented and reported.			
1.19	• 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	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 Risk Assessment	

		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. IPC admission risk assessment document to be revisited.		has been completed, discussed at IPC Committee agreed to delay the launch until the new year. IPCT representation on EPR meetings to move forward with implementation of IPC Risk assessment check list	

	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**
2.1	Systems and processes are in place to ensure: • Designated teams with appropriate training are assigned to care for and treat patients in COVID-19 isolation or cohort areas	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	Lack of accurate data to demonstrate compliance Robust process required for managing yearly face fit	Now donning and doffing training completed by the IPCT is documented,	

		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.	testing requirements.	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 PPE, are assigned to COVID-19 isolation or cohort areas.	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 for working in COVID cohort areas. An external cleaning training provider has completed a programme of education. Facilities team report yearly training in line with the trust.	N/A	IPCT hold regular meetings to ensure facilities resources are 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 in none COVID areas. The Trust HPV team where possible have completed room disinfections	N/A		

		following the standard terminal cleans within isolation rooms, ward bays.			
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 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	COVID additional cleaning documents and cleaning policy remain in place. 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. Audits against cleaning standards reviewed at the IPC Committee. 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.	N/A		

	fluids electronic equipment, e.g. mobile phones, 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.)	Touch point cleaning continues; this is reviewed 2 weekly by IPC and facilities team. Dedicated staff have been resourced 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.			

	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. 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. Reports from Medical engineering team that wards are not using correct processes, escalation in place to report noncompliance to improve current practice	Evidence of application of policy required Nominated Decontamination Lead required-include on risk log.	Ensure audits continue as planned via the annual audit programme. Use of Datix system to report non-compliance in place. Quality Rounds commenced	
2.8 2.9 2.10	• Review and ensure good ventilation in admission and waiting areas to minimize opportunistic airborne transmission • Monitor adherence environmental decontamination with actions in place to mitigate any identified risk • monitor adherence to the decontamination of shared	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. Communications held with matrons regarding the benefits of periodically opening windows to aid air exchanges within clinical areas.	N/A	Installation of air conditioning units. Periodic opening of windows to dilute air.	

	equipment with actions in place to mitigate any identified risk	Cleaning Audits submitted monthly Audits, spot auditing. De-contamination certificates.	Trust do not currently have a de-contamination lead. Highlighted on risk register.		
	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**
3.1 3.2	Systems and process are in place to ensure: • 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	• 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. Snap shot antimicrobial prescribing audits.	

		shot audits. • Procalcitonin testing introduced as part of covid screening to reduce inappropriate prescribing of antimicrobials.		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. .	N/A		
4.2	• Areas in which suspected or	Signage is placed on entrances to	N/A		

	confirmed COVID-19 patients are where possible being treated in areas clearly marked with appropriate signage and have restricted access	wards and other clinical settings stating restricted access. In addition have zoning SOP, zoning notices and poster with PPE requirements for the area.			
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	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	There is a patient transfer checklist	Assurance required regarding	To be reviewed as	

	the receiving organisation or department when a possible or confirmed COVID-19 patient needs to be moved	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. Documentation audit completed in December has identified 79.5% compliance, for completion of patient transfer checklist, clinical teams have been informed and informed of requirements.	evidence of completion	part of the monthly documentation audit. Clinical teams informed, audit to be repeated to monitor progress.	
	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:	Please refer to section 1.	N/A		

5.1	• Front door areas have appropriate triaging arrangements in place to cohort patients with possible or confirmed COVID-19 symptoms and to segregate them from non COVID-19 cases to minimise the risk of cross-infection	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. Lateral Flow tests for ED patients to be introduced.			
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. Testing is completed on admission via ED, elective cases before admission via drive through system. Patients in green (non COVID) and yellow zones (awaiting results) are monitored for symptoms of COVID and are rescreened if required.	N/A		

		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.			
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 flow chart in place, which describes the contact tracing risk assessments.	N/A		

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. The majority of OPD appointments are being conducted virtually or by telephone.	N/A		
5.5	• Face masks are available for all patients and they are always advised to wear them		Not monitored.	Patient information, staff encouraging patients to wear face masks within the day. Public notices, posters.	
5.6	• Monitoring of Inpatients compliance with wearing face masks particularly when moving around the ward (if clinically ok to do so)	OPD flow chart for COVID screening in place.	Not monitored.		
5.7	• There is evidence of compliance with routine patient testing protocols	Information provided in policies.	Data not gathered and	Dashboard required to monitor compliance.	

		Patients are requested to wear a face mask at all time other than when asleep. Manual process as part of the outbreak meetings that take place three times a week.	reported on.		
	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**
6.1	Systems and processes are in place to ensure: • 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 2020 but now back in place with social distancing, this has reduced face to face capacity. COVID briefing sessions in Lecture theatre were held, now virtually. Face Fit testing Training PPE donning and doffing HUB information with inks to PHE	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 – held by	

		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. Trust compliance for IPC training effective from 31.03.2021 is 84.3%		clinical skills	
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. 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. Half face respirators have been purchased and distributed by the trust. Two staff fully trained as super fit testers. Ability to train the trainers.	N/A	Communications via huddles and email to all to remind staff of PPE requirements	

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.	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	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 PPE could be implemented.	N/A		
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.	N/A	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.		COVID PPE audit, audit tool in draft Quality Rounds Commenced	
6.7 6.8 6.9	• 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 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	The hand hygiene saving lives audits have continued and 100% compliance has been reported across services (that returned an audit). 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.	Independent review of hand hygiene required	IPC Annual audit programme has now commenced	

6.10	• 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.	N/A		
6.11 6.12	• 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 maintain social distancing (2m+) when travelling to work (including avoiding car sharing) and remind staff to follow public health guidance outside of the workplace	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	N/A Not monitored.	 Compliant. Regular updates provided via 'In The Know'	

		Staff requested to continue to follow national guidance on social distancing measures. Communications to all staff regarding trust expectation for all staff to follow national guidance.		communication daily to all members of staff through email.	
	7 Provide or secure adequate isolation facilities				
	Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	**R.A.G**
7.1	Systems and processes are in place to ensure: • 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 (updated January 2021). The capacity of the Zones is reviewed 3 times daily at the capacity meetings	N/A		

		The infection prevention team have the daily ward list which documents the location of COVID patients and patients with resistant/alert organisms. Zoning SOP available on the HUB.			
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. 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 organisms are managed according to local IPC guidance, including ensuring appropriate patient placement	IPCT complete surveillance of alert organisms using ICNet, IPCT document on ICNet actions taken and advice given and if necessary document in patients notes regarding precautions required isolation. IPCT policies in place: isolation, MRSA, CPE, C.diff	N/A		
	8 Secure adequate access to laboratory support as appropriate				
	Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating**	**R.A.G**

				Actions	
8.1 8.2 8.3 8.4 8.5	There are systems and processes in place to ensure: • 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 • That all emergency patients are tested for COVID-19 on admission • That those inpatients who go on to develop symptoms of COVID-19 after admission are retested at the	Staff that are 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 have weekly testing for health care workers who attend care/nursing homes. Prompt now in place on sunrise system to ensure green patients are retested on day 0, day 3 and day 5 as per national guidance Lateral flow testing commenced W/C 23/11/2020. All clinical and non-clinical staff. MRSA screening has continued along with clostridium difficile tests for patients who have diarrhoea. All other screening has continued as pre COVID crisis.	N/A	Matrons informed during Huddles regarding testing required. Information also available on the hub and communications update. Compliant.	

	point symptoms arise				
8.6	• That those emergency admissions who test negative on admission are retested on day 3 of admission, and again between 5-7 days post admission	All Patients tested on admission, routine swabbing for asymptomatic patients, admitted to amber bed whilst awaiting swab result which is back normally within 24 hours (not tested on site). Symptomatic patients are swabbed as an emergency and test on site and results available within 4 hours. Isolated until result available. Any patients who develop symptoms are swabbed and moved into side rooms. Bed in bay to remain blocked until result know as other patients in bay treated as contacts. These patients would have an on site test and results back within 4 hours		Compliant.	
8.7	• That sites with high nosocomial rates should consider testing COVID negative patients daily			Dashboard mitigation.	
8.8	• That those being discharged to a care home are being tested for COVID-19 48 hours prior to discharge (unless they have tested positive within the previous 90 days) and result is communicated to receiving organization prior to discharge			Non-compliant.	
8.9	• That those being discharged to a care facility within their 14 day isolation period should be discharged to a designated care setting, where they should complete their remaining isolation.			Compliant.	

8.10	• That all elective patients are tested 3 days prior to admission and are asked to self-isolate from the day of their test until the day of admission.	Prompts on SUNRISE system. Reviewed as part of the outbreak meetings. Trust have reviewed and are unable. Therefore do not have the resources to carry out daily testing of negative patients. Insufficient capacity. On discharge checklist. Commissioned care home for COVID-19 positive patients. All elective patients are tested. SOP in place.	Not reported anywhere within the trust.	Compliant. Partial compliance. Divisional chief nurse to report compliance within IPC report.	

	9 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**
9.1	Systems and processes are in place to ensure that: • 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.	N/A		
9.2	• Any changes to the PHE national guidance on PPE are quickly identified and effectively communicated to staff	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. (See previous information regarding Incident Room cascading all relevant COVID information throughout the Trust) Zoning SOP being reviewed in light of new guidance	N/A		
9.3	• All clinical waste related to confirmed or suspected COVID-19 cases is	Waste streams on yellow and blue zones are clinical waste: orange bag.	N/A		

	handled, stored and managed in accordance with current national guidance	Some reports received of improper disposal Interserve have communicated issues to areas concerned. 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. Tiger stripe clinical waste stream has be implemented across the wards- when a case has been identified then orange waste stream is used			
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. Half face respirators have been purchased and distributed by the trust	N/A		

	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**
10.1	Appropriate systems and processes are in place to ensure: • 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.	N/A	Vulnerable staff may not disclose to employer, therefore all staff to have risk assessment completed	

		The Trust commenced COVID vaccination programme on 29/12/20 priority is to be given to patients over 80 years and staff with increased risk.			
10.2	• Staff required to wear FFP reusable respirators undergo training that is compliant with PHE national guidance and a record of this training is maintained	Health & Safety are keeping and maintaining records of all staff members that have undertaken FFP3 Face Fit Testing. The trust ordered replacement reusable respirators (half face and hood systems) Small, Medium and large respirators have arrived into the trust and have been distributed.	N/A		

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. .	Appropriate workforce numbers to maintain segregation of zones.	Zoning SOP and areas are segregated with one way systems	
10.4	• All staff adhere to national guidance on social distancing (2 metres) wherever possible,	The Trust has provide staff with detailed guidance with regards of social distancing a standard	N/A		

10.5	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	operating procedure is in place, posters and markings on floors, including one way 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 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.			
10.6	• 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. This information feeds directly in Staff Health and Wellbeing on a daily basis, who then contact the staff	N/A		

		member or 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.			
10.7	• 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, negative results are sent via text and positive results are contacted by SHAW. 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 10 days and can return to work after 10 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.	N/A		

Enclosure 19

The Dudley Group NHS Foundation Trust

Paper for submission to the Board of Directors on 13 May 2021

TITLE:	Maternity and Neonatal Safety and Quality Dashboard		
AUTHOR:	**Dawn Lewis** **Head of Midwifery**	**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

- The Board is invited to accept the assurance provided in this report for each of the items in the maternity safety dashboard
- To record in the minutes the engagement of all Non Executive Directors with the Head of Midwifery at their recent development session.

CORPORATE OBJECTIVE:

SO1, SO2, SO3, SO4, SO5, SO6

SUMMARY OF KEY ISSUES:

- Progress against the CNST Maternity Incentive Scheme 10 safety actions and all are on track to be achieved
- Perinatal mortality information including the quarterly perinatal mortality report for quarter 4 will be presented to the Board in June
- The maternity transformation achievements of 47% of women from BAME communities being cared for by a continuity team
- Staff engagement by maternity safety champions
- Midwifery Workforce and the plans for achieving both BirthRate Plus recommendations and the workforce recommendation following the Ockenden report.

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

REPORTS FOR ASSURANCE

Maternity Monthly Report

Report to Trust Board on 13th May 2021

1 EXECUTIVE SUMMARY

1.1 This paper addresses the minimum dataset advised for the Maternity Safety Dashboard as recommended by NHS England and Improvement in the response following the publication first Ockenden report of services at Shrewsbury and Telford NHS Trust .

The topics covered within this paper include:

- Progress against the CNST Maternity Incentive Scheme
- Perinatal mortality
- Maternity Improvement Plan
- Service User Feedback
- Midwifery staffing forApril
- Maternity staffing requirements

1.2 The Board should be aware of the current situation in maternity services within the Trust specifically related to these topics as indicated in the safety dashboard and any actions proposed or required to address areas for improvement.

2 BACKGROUND INFORMATION

2.1 Following the First Ockenden report of services at Shrewsbury and Telford NHS Trust published in December 2020 all Trusts with maternity services were advised by NHS England / Improvement that a monthly report on maternity services should be delivered to Trust Board. Trust Boards are are encouraged to ask themselves whether they really know that mothers and babies are safe in their maternity units and how confident they are that the best quality care is being provided in their organisation. Trust Boards are expected to robustly assess and challenge the assurances provided and have developed a dashboard with a minimum set of measures from which trusts should build a local dashboard

2.2 **CNST Maternity Incentive Scheme –NHS Resolution Year 3 Progress as at April 2021**

2.2.1 This section provides an update to the Board in relation to compliance with the third year of the Clinical Negligence Scheme for Trusts (CNST) Incentive Scheme for Maternity Safety Actions. The scheme offers a financial rebate of up to 10% of the maternity premium for Trusts that are able to demonstrate progress against a list of ten safety actions.

2.2.2 NHSR has published the Maternity Incentive Scheme for the third year running. This scheme for 2020/21 builds on previous years to evidence both sustainability and on-going quality improvements. The safety actions described if implemented are considered to be a contributory factor to achieving the national ambition of reducing stillbirths, neonatal deaths, perinatal morbidity and maternal deaths by 50 % by 2025

2.2.3 NHSR published an update for Year 3 of of the incentive scheme on 4th February 2020. Since then the scheme has been updated and relaunchedin October 2020 following the pause due to Covid-19. A further update extending the final submission date to 15th July 2021 was received by the Trust in December 2020. A third and final update was published in March 2021

2.2.4 The maternity service has assessed itself against the current incentive scheme and considers that there are 4 areas for focus if the scheme is to be achieved successfully and in full.

Action	Maternity Safety Action	Current Position	Update	Deadline
1	Are you using the National Perinatal Mortality Review Tool to review and report perinatal deaths to the required standard?		All areas of this action are on track. This is monitored monthly and learning from the reviews are included in the quarterly perinatal mortality report and widely disseminated. In April we relaunched the governance newsletter that also includes learning from reviews.	June 2021
2	Are you submitting data to the Maternity Services Data Set to the required standard?		The December data achieved the required standar as has the January data however significant additional workaround has to be done to ensure data is complete. The introduction of the maternity EPR will negate the need for this workaround	May 2021
3	Can you demonstrate that you have transitional care services to support the Avoiding Term Admissions Into Neonatal units Programme?		All areas of the requirements have been achieved attached are the results of the audit required. Further audit is in place and will be reported via future papers.	June 2021
4	Can you demonstrate an effective system of medical workforce planning to the required standard?		The obstetric staffing audit has been completed to requirements. There were no obstetric and gynaecology trainees who responded 'Disagreed or Strongly disagreed to the 2019 GMC National Trainees Survey question 'In my current post, educational/training opportunities are rarely lost due to gaps in the rota'. Therefore no formal action plan is required The anaesthetic medical workforce – 100% of ACSA standards are met. The specific requirements for the neonatal workforce as indicated by BAPM and an action plan to address	June 2021

			the gaps The workforce plan incorporates all the gaps highlighted in the Neonatal Critical Care Transformation review and incorporates both nursing and medical workforce. The nursing action plan has been forwarded to the Royal College of Nursing as indicated in the guidance	
5	Can you demonstrate an effective system of midwifery workforce planning to the required standard?		The last Birthrate plus assessment was carried out in 2017. A table top Birthrate assessment has been carried out on a 6 monthly basis since then and a formal Birthrate Plus assessment has been requested in line with the NICE guideline Safe midwifery staffing for maternity settings. A full report of maternity staffing for the past 12 months will be included in the next Board paper. The Trust has recently submitted its bid for additional midwifery and obstetric staffing via the Black Country and West Birmingham LMNS as part of the national funding to achieve Birthrate plus staffing levels	June 2021
6	Can you demonstrate compliance with all five elements of the Saving Babies' Lives care bundle?		The Trust is fully compliant with the five elements of the care bundle, a a further improvement since last month. We are in the process of recruiting to a dedicated fetal wellbeing midwife.	March 2021
7	Can you demonstrate that you have a patient feedback mechanism for maternity services and that you regularly act on feedback?		The Maternity Voices Partnership has continued to meet virtually during 2020 and into 2021. The group is actively working to ensure the voice of black , Asian and minority ethnicity women is prioritised and have co -produced a communication strategy to ensure that information is both culturally sensitive but also widely disseminated. Collaborative working across the Black Country and West Birmingham LMNS offers support and sharing of best practice amongst the four Trusts and other Stakeholders.	

8	Can you evidence that 90% of each maternity unit staff group have attended an 'inhouse' multi-professional maternity emergencies training session within the last training year?		This is on target for compliance despite the challenges posed by wave 3 of COVID19 and the demands on all staff but especially theatre and anaesthetic teams	June 2021
9	Can you demonstrate that the trust safety champions (obstetrician and midwife) are meeting bi-monthly with Board level champions to escalate locally identified issues?		The maternity safety champion has continued to meet with the Board level safety champion on a monthly basis. February was the first opportunity for the Non Executive Board Maternity champion to accompany the Chief Nurse as Executive Board maternity and neonatal board safety champion on the walkaround in maternity and neonatal areas. A number of members of the Trust Executive team visited the maternity unit on International Day of the Midwife. The Chief Nurse as maternity safety champion visits the unit on a monthly basis to engage with staff formally but also visits on a less formal basis almost weekly. An action plan is in progress to progress the requirement to achieve Continuity of Care pathways for 35% of women currently we have 25% of women booked onto a continuity pathway. A further continuity of care team has been established and went live on 1st April 2021.	June 2021
10	Have you reported 100% of qualifying 2019/20 incidents under NHS Resolution's Early Notification scheme?		This is up to date and requires no additional actions	June 2021

.

2.3 Perintatal Mortality.

2.3.1 **Stillbirths** - There have been 0 stillbirth during the month of April .

2.3.2 **Neonatal Deaths** – There have been 0 neonatal deaths during the month of April

2.4 Serious Incidents

2.4.1 There have been no serious incidents in maternity reported in April 202

2.5 **Maternity Transformation**

2.5.1 The term 'continuity of carer' describes consistency in the midwife or clinical team that provides care for a woman and her baby throughout the three phases of her maternity journey: pregnancy, labour and the postnatal period (NHS England 2017). Women who receive midwifery-led continuity of carer are 16% less likely to lose their baby, 19% less likely to lose their baby before 24 weeks and 24% less likely to experience pre-term birth and report significantly improved experience of care across a range of measures (Sandall et al 2016). Preterm birth is a key risk factor for neonatal mortality. Continuity of carer can significantly improve outcomes for women from ethnic minorities and those living in deprived areas There are significant and widening health inequalities in maternity care. When compared to babies of White ethnicity: Black/Black British babies have a 121% increased risk for stillbirth and 50% increased risk for neonatal death and the gap has been widening since 2013; Asian/Asian British babies have a 66% increased risk of neonatal mortality and this risk is rising and an increased risk of stillbirth of around 55%. Babies born to mothers in the most deprived quintile have a 30% increased risk neonatal mortality and the gap between the most deprived and the least deprived quintiles is widening. Draper et al 2018. This difference has been highlighted more during the pandemic and the national direction for supporting improved outcomes for this population has been via continuity of care, with the ambition 75% of this group being on a continuity of care pathway. The revised ambition is for 35% of women to be booked on a pathway by March 2021, this has been particularly hard to achieve due to the pandemic and the effects on workforce and service provision. The Trust is working in collaboration with the Black Country Local Maternity and Neonatal System to enact the findings of Better Birth's (2016) and transform services across the Black Country and West Birmingham.

2.5.2 The Trust now has two Continuity of Carer teams Poppy and Daisy. The teams are looking after a high proportion of the black Asian and minority ethnicity women in the Dudle borough together with women who live in areas of the top decile of deprivation. 47% of women from BAME communities are receiving continuity of carer and 100% of those lining in areas of top decile of deprivation.

2.5.3 Overall there are 25% of all women booked onto a continuity of carer pathway at the end of March 2021 which does fall short of the expected 35%. However there is confidence that the introduction of the second continuity team with further teams planned for 2021 that 51% by the end of March 2022 is achievable.

2.5.4 The maternity team is working cloely with other stakeholders within Dudley to ensure that the Early Years Transformation Academy project is delivered. Extending the continuity of care through health visiting, early years and the community and voluntary sectors. The ultimate aim is to improve school readiness for some of our most disadvantaged children.

2.6 **Service User Voice Feedback**

2.6.1 The Maternity Voices Partnership - MVP has continued to meet vitually on a regular basis.

2.6.2 There are terms of reference and the meeting minutes indicate the consistent involvement of staff.

2.6.3 The group have met with Gateway services to plan training for lay MVP members, enabling them to provide feedback reports for Trust Board .

2.6.4The group is actively working to ensure the voice of black , Asian and minority ethnicity women is prioritised and have co -produced a communication strategy to ensure that information is both culturally sensitive but also widely disseminated.

2.6.5The MVP ratified our "Choice and Personalisation" booklets recently returned from the printers. All women receiving maternity care at theTrust will be given a a booklet to aid discussions about their choices and help to plan personalised care.

2.6.6 Last year the Maternity Voices Partnership prepared and delivered a bid for some money via the community and volunteer service and were successful. The funds have been used to purchase promotional mugs and bags to be given out by MVP volunteers in antenatal clinic.

2.6.7 Social media platforms are widely used to ensure that messages are circulated in a variety of ways

2.7 **Staff Feedback from frontline champions and walk-abouts**

2.7.1 The Executive and Non Executive Board level safety champions have continued with monthly walkabouts to talk to staff and listen to any concerns or suggestions. Staffing and activity are the main themes raised. The plans for improving staffing are discussed in further detail in 2.8 below.

2.7.2 Staff feedback is encouraged and the introduction of the virtual staff forum has enabled more staff to join meetings at times when they are not on duty.

2.7.3 The Chief Executive and Chief People Officer also organised some engagement sessions with the maternity team at the end of March and have recently fed back to the divisional team . The whole team will work collaboratively to resolve issues raised.

2.8 **Workforce**

2.8.1 The last Birthrate plus (BR+) review was undertaken in 2017 and reported in 2018, this showed a deficit of 13.59 wte clinical midwives, 5.18 non clinical midwives and 11.32 band 3 maternity support workers. Since this last review the birthrate has decreased by approx 300 births per year.

2.8.2 Funding has been secured from the Black Country and West Bimingham LMNS to carry out a Birthrate + review based on current birthrate this is awaited.

2.8.3 In the interim a table top review has been carried out and this demonstrates that there is a requirement for a further 8 WTE band 3 maternity support workers. Following the Ockenden report recommendation the senior midwifery team also requires a Consultant midwife post and additional leadership posts .

2.8.4 Based on the external Birthrate plus assessment a submission has been made formoney from national funds to support staffing to birthrate plus

2.8.4The crude birth to midwife ratio is calculated monthly using Birth Rate Plus methodology and the rolling annual delivery rate, it is included on the maternity dashboard. The most recent calculation was a ratio of 1:31 although this was calculated against

establishment in post and did not take into account maternity leave and Covid absence. The recommended ratio based on the previous Birthrate Plus assessment should be 1:27

2.8.5 There are vacancies in both community midwifery and in patient areas within the current funded worforce of 4.3 wte and recruitment to this is ongoing.

2.8.6 The following table outlines percentage midwifery fill rates for the in patient areas for April

	Day qualified %	Night qualified%
April 2021	84	87

3 RISKS AND MITIGATIONS

3.1 The Trust has not achieved the ambition of 35% of women on a continuity of carer pathway by the end of March 2021 but did achieve 25% . It is recognised that the challenges faced over the past year by all maternity services have impacted on the ability to achieve this indicator. However we are progressing with the actions to extend the number of teams providing continuity of care in April 2021 and beyond. This demonstrates our commitment to the ambition for the new financial year.

3.2 Midwifery staffing requires significant investment in order to achive Birthrate plus recommended levels and also achieve all aspects of the requirements for the Ockenden assurance. The Trust has submitted a bid for the national funding for staffing.

4. RECOMMENDATION(S)

4.1 The Board is invited to accept the assurance provided in this report

Name of Author Dawn Lewis
Title of Author Head of Midwifery
Date report prepared 4.5.2021

Enclosure 20

The Dudley Group NHS Foundation Trust

Paper for submission to the Board of Directors on 13 May 2021

TITLE:	**Exception Report from the Finance and Performance Committee Chair**		
AUTHOR:	Jonathan Hodgkin F & P Committee Chair	**PRESENTER**	Jonathan Hodgkin F & P Committee Chair

CLINICAL STRATEGIC AIMS

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

ACTION REQUIRED OF COMMITTEE

Decision	Approval	Discussion	Other
		X	

RECOMMENDATIONS:

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

CORPORATE OBJECTIVE:

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

SUMMARY OF KEY ISSUES:

Summary from the Finance and Performance Committee held on 29 April 2021.

IMPLICATIONS OF PAPER:

IMPLICATIONS FOR THE CORPORATE RISK REGISTER OR BOARD ASSURANCE FRAMEWORK

RISK	**Y**		**Risk Description:** BAF 5a
	Risk Register: Y		**Risk Score:** 12
COMPLIANCE and/or LEGAL REQUIREMENTS	**CQC**	**Y**	**Details:** Well Led
	NHSI	**Y**	**Details:** Achievement of Financial Targets
	Other	**Y**	**Details:** Value for Money
REPORT DESTINATION	**EXECUTIVE DIRECTORS**	**N**	**DATE:**
	WORKING GROUP	**N**	**DATE:**
	COMMITTEE	**N**	**DATE:**

The Dudley Group NHS Foundation Trust

EXCEPTION REPORT FROM FINANCE AND PERFORMANCE COMMITTEE CHAIR

Meeting held on: 29th April 2021

MATTERS OF CONCERN OR KEY RISKS TO ESCALATE	MAJOR ACTIONS COMMISSIONED/WORK UNDERWAY
• Continued high agency costs • Continued uncertainty around the financial envelope for 2021/22 H2 and expectation that it will be more challenging than for H1	• CIP plan to be presented to next F&P • Outcome of accelerator bid and, assuming successful, proposals for monitoring delivery to be presented to next F&P • Plan for assessment of overseas nurse recruitment trial to be presented to next F&P
POSITIVE ASSURANCES TO PROVIDE	**DECISIONS MADE**
• Trust achieved a small surplus for 2020/21, delivered the capital expenditure control total and ended the year with a stronger cash position than originally expected. Well placed for the start of 2021/22 • Although H1 system deficit not fully resolved, there is a reasonable degree of confidence that the Trust will secure sufficient funding for H1, with the potential for more through restoration and recovery performance • Continued outstanding performance of the vaccination employment bureau and full recovery of costs incurred in 2020/21 • Continued robust operational performance both nationally and against regional peers. Restoration and recovery accelerator bid submitted by the system	• Agreed to invest £413k (plus possibly £1k per person if quarantine required) in one year trial to partner with ICS partners to recruit and onboard 75 international nurses

- **Chair's comments on the effectiveness of the meeting:** Good participation with robust debate around nurse recruitment particularly

Enclosure 21

The Dudley Group NHS Foundation Trust

Paper for submission to the Board of Directors, 13 May 2021

TITLE:	**Integrated Performance Report for Month 12 (March 2021)**		
AUTHOR:	**Diane Povey** **Interim General Manager**	**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:

That the report be noted

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

Key Areas of Success

- Cancer recovery is ahead of expectations despite COVID – Breast and Breast symptomatic services continue to have a capacity shortfall due to social distancing precautions.
- Despite cessation of most of the routine 6 week wait (DM01) Diagnostics remain in the third upper quartile and the numbers waiting over 6 weeks has reduced further from 1556 at the end of February to 1412 at the end of March.
- Despite the necessary cessation of routine elective services the Trusts 18 Week RTT position continues to compare well with Peers both nationally and regionally.
- The recovery of elective activity is on track as presented in the roadmap.
- There is a continued reduction in 52 week waits which reduced further during March to 457 ahead of trajectory.

Key Areas of Concern

- Staffing absence continues to impact on Theatre activity and has been highlighted to executives.

Performance Comparison (latest data available)

Constitutional Standard & KPI		Target	Actual			
			DGFT	SWT	RWT	WHT
Emergency Access Standard (Feb 21)	Combined 4 hr Performance	95%	*90%*	*81.8%*	*85.4%*	*84%*
Cancer Targets (Jan 21)	2ww	93%	*85.9%*	*80.2%*	*82.0%*	*75.2%*
	31 Day	96%	*93.3%*	*88.1%*	*82.1%*	*100%*
	62 Day	85%	*70.6%*	*60.2%*	*45.7%*	*75.3%*
Referral to Treatment (Jan 21)	RTT incomplete	92%	*80.6%*	*76.8%*	*73%*	*69.8%*
Diagnostics (Jan 21)	DM01- achieved within 6 weeks	99%	*73.5%*	*80.6%*	*51.7%*	*95.1%*

The above table shows DGFT comparison with peers for constitutional performance targets and below the ranking

Target	KPI	DGFT Ranking
EAS	4 hr access	1
Cancer	2ww	1
	31 Day	2
	62 Day	2
RTT	% incomplete	1
Diagnostics	% in 6 weeks	3

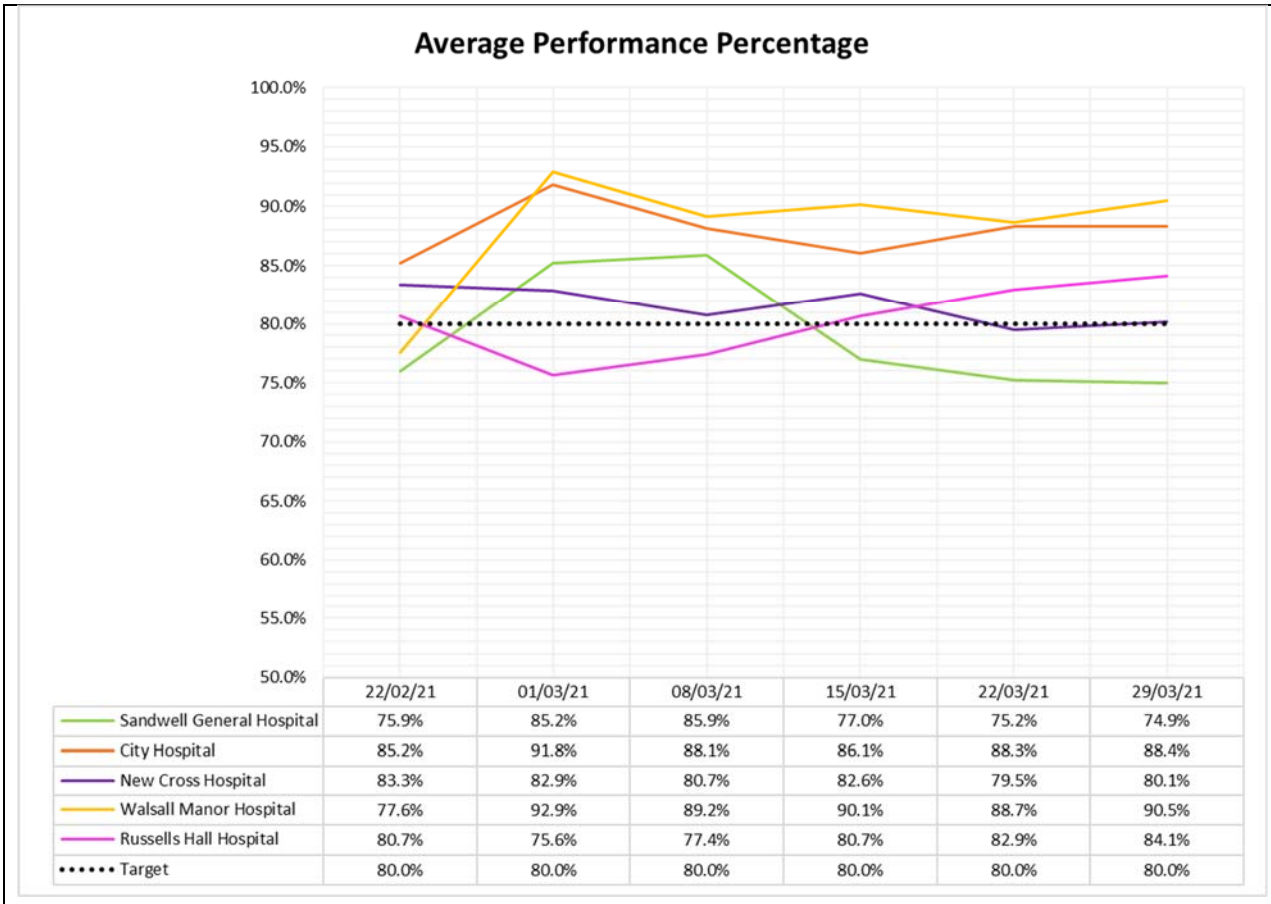
EAS

1. The March position for performance remains below the expected Emergency Access Standard, 95% the Trust has achieved a combined performance of 89.3%. The Trust is nationally ranked 5th out of 15 comparable Trusts.

The main contributory factors to our EAS position are as follows:

2. Breach analysis for strongly suggests that capacity, diagnostics and specialty referrals have consistently been the highest reason for emergency Access (EAS) Breaches.

The latest comparison for Dudley's Emergency Access Standard compared with other neighbouring Black Country Trusts is shown in the table below:



	22/02/21	01/03/21	08/03/21	15/03/21	22/03/21	29/03/21
Sandwell General Hospital	75.9%	85.2%	85.9%	77.0%	75.2%	74.9%
City Hospital	85.2%	91.8%	88.1%	86.1%	88.3%	88.4%
New Cross Hospital	83.3%	82.9%	80.7%	82.6%	79.5%	80.1%
Walsall Manor Hospital	77.6%	92.9%	89.2%	90.1%	88.7%	90.5%
Russells Hall Hospital	80.7%	75.6%	77.4%	80.7%	82.9%	84.1%
Target	80.0%	80.0%	80.0%	80.0%	80.0%	80.0%

CANCER

All cancer performance figures have 2 month validation process, on that basis the current performance is unvalidated and may be subject to change.

Current in month performance is as follows:

a. 2ww & 31 day achievement remains stable and above target.
b. 62 day achievement has reduced to 55.9% during March.

The number of patients waiting over 104 days at the end of March remains at 44, but this has reduced during April to 36. This may be due to the necessary amendments to the counting methodology for the 104 day measure which have been put in place to prepare for 62 Day standards change from April 2021.

Covid-19 pressures continue to affect all cancer pathways due to patient reluctance to attend and the reduction of diagnostic capacity. There remains a capacity reduction in 1st face to face outpatient in Breast and Breast Symptomatic due to social distancing precautions.

The Cancer management team submitted a recovery trajectory for the 62 day pathway to NHSE in August 2020 outlining an expected position with the aim of full recovery by Mar-21. Current 62 day performance is in line with this plan.

RTT

The RTT position continues to be adversely affected by Covid-19 P2 & P3 waits are being prioritised in line with 21/22 planning guidance with March performance stable at 77.4%. DGFT continues to compare well with

peers for both RTT performance being 11th Nationally & the best locally. The number of 52 week breaches continues to reduce and are ahead of trajectory with 457 at the end of March.

Elective Theatre activity continues to recommence in line with the roadmap agreed with executives. Bids have been submitted to the Black Country & West Birmingham STP to support Elective recovery. Additional new outpatient appointments have increased as Medical consultants support to rotas has decreased.

DM01

The Trust improved achievement during March to 82.7% of diagnostic tests carried out within 6 weeks against the national operational standard of 99%. Based on DM01 national benchmarking for January the Trust continues to be positioned in the third upper quartile.

There has also been a further reduction in the number waiting over 6 weeks during March to 1412. DM01 recovery is forecast for March 22.

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

IMPLICATIONS FOR THE CORPORATE RISK REGISTER OR BOARD ASSURANCE FRAMEWORK

RISK	**Y**		**Risk Description:** BAF 1b - Failure to meet access standards caused by inability to improve patient flow and work effectively with very local partners will result in an adverse outcome for the patient
	Risk Register: Y		Risk Score: BAF 1B – Risk score 15 (AMBER)
COMPLIANCE and/or LEGAL REQUIREMENTS	**CQC**	**Y**	**Details:** Compliance with Quality Standards for safe & effective care.
	NHSI	**Y**	**Details:** Achievement of National Performance and Recovery targets.
	Other	**N**	**Details:**
REPORT DESTINATION	**EXECUTIVE DIRECTORS**	**N**	**DATE:**
	WORKING GROUP	**N**	**DATE:**
	COMMITTEE	**Y**	**DATE: Board of Directors, 13 May 2021**

Performance KPIs

29th April 2021 Report (March 2021 Data)

NHS
The Dudley Group
NHS Foundation Trust

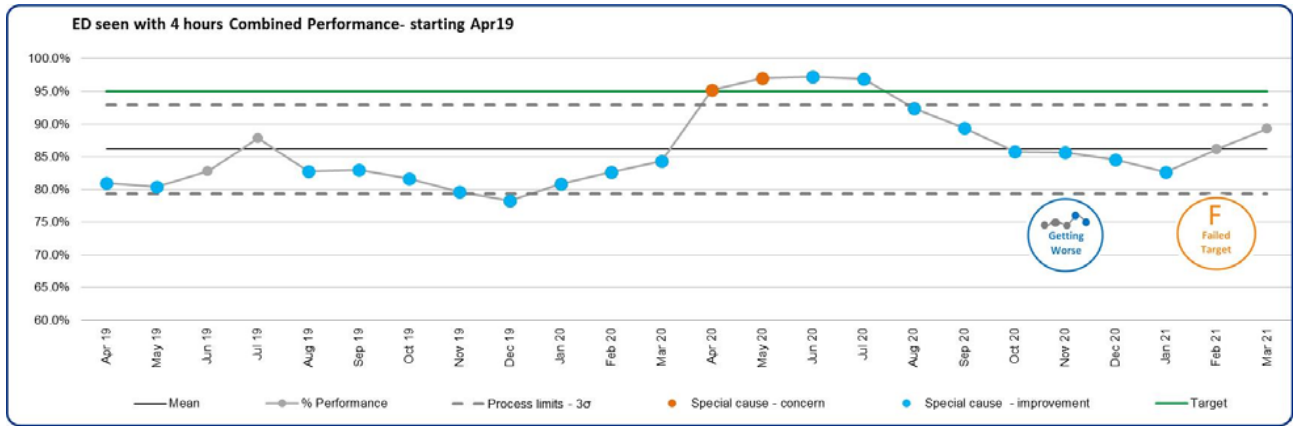
Karen Kelly, Chief Operating Officer




Constitutional Performance

Constitutional Standard and KPI		Target	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Status	
Emergency Access Standard (EAS)	Combined 4hr Performance	95.0%	85.8%	85.7%	84.5%	82.7%	86.1%	89.3%	Getting Worse	F Failed Target
Cancer	Cancer 62 Day - Urgent GP Referral to Treatment	85.0%	63.6%	70.9%	60.0%	70.6%	68.5%	55.9%	Getting Worse	F Failed Target
	Cancer 31 Day -	96.0%	96.2%	92.2%	95.2%	93.3%	96.3%	96.8%	In normal range	F Failed Target
	All Cancer 2 Week Waits	93.0%	68.0%	79.5%	94.1%	85.9%	98.0%	96.6%	In normal range	P Passed Target
Referral to Treatment (RTT)	RTT Incomplete	92%	82.8%	83.9%	83.1%	80.5%	77.8%	77.4%	Getting Worse	F Failed Target
Diagnostics	DM01 - Diagnostics achieved within 6 weeks	99%	77.6%	84.3%	77.5%	73.5%	78.4%	82.7%	Getting Better	F Failed Target
VTE	% Assessed on Admission	95%	93.2%	93.8%	93.6%	92.1%	95.5%	96.4%	In normal range	F Failed Target

ED Performance MARCH'21



89.3%	0	5th th As at 16/04/21
EAS 4 hour target 95% for Type 1 & 3 attendances (inc of booked appointments)	DTA 12 hour breaches - target zero	DGFT ranking out of 19 Midlands area Trusts

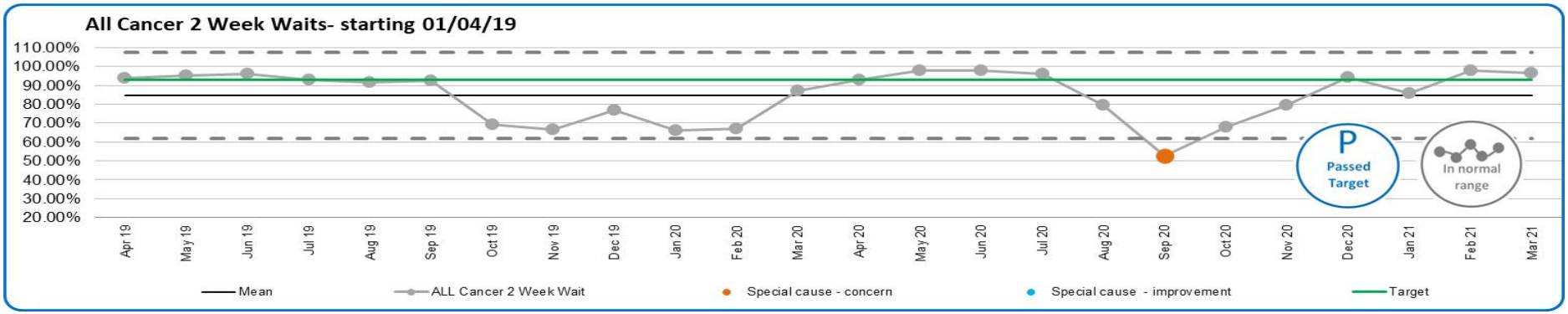
Performance

- During March the Trust achieved 89.3% of ED attendances being seen in 4 hrs, this represents an improvement on February achievement but remaining below the target of 95% which has not been met since July 20.
- RHH is ranked 5th out of 15 Trusts nationally with similar size and activity levels for performance against EAS target (all types)
- Breach analysis for strongly suggests that capacity, diagnostics and specialty referrals have consistently been the highest reason for emergency Access (EAS) Breaches. However, due to emergency department overcrowding, lack of space to treat patients and challenging flow to specialty wards there was an increase in EAS breaches during March'21 due to delayed Senior Clinical Decision by an ED Doctor or ACP/ENP)
- March saw 0 12 hour breaches following a decision to be admitted (DTA) compared to February'21, 8, january'21, 86,
- There was significant increase in attendances to 7346 (February'21 5960)

Action

- The ED Consultants rota has been changed to reflect ED Consultants working up to 12 o'clock midnight in order to provide cover for the busiest time of the day within DCC.
- Community in reach into ED and Acute Medicine continues 5 days in-reach service.
- We have commenced renewing of the ED Tracker Job Role and Responsibility
- ED has been stopped using Discharge Lounge as ED Patients are Amber, formal concern has been placed with Divisional Nurse, COO and Director of IMT regarding this decision. This has contributed to a decline in ED 4 hr EAS Performance, poor patient experience and delays in Ambulance Handovers.
- COVID19 point of care testing (POCT) has been implemented at night in ED POCT facility with an excellent effect on performance and utilisation of capacity. Formal concern has been raised with pathology as we are unable to extend the service during day light hours.

Cancer Performance – 2 Week Wait



96.6%

All cancer 2 week waits – target 93%

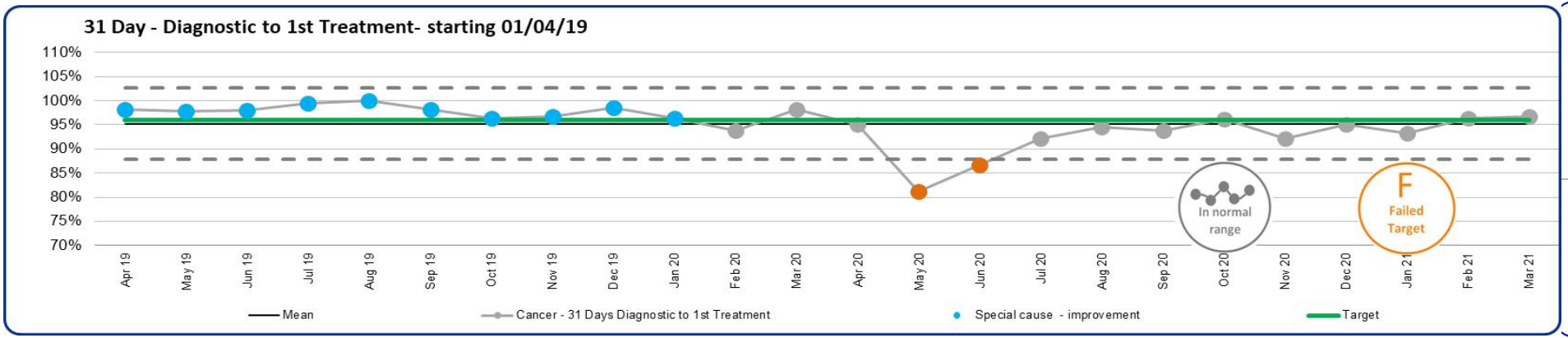
Performance

- Validation of Cancer performance figures run at a 2 month lead time. Therefore latest month position is un-validated.
- Achievement against the 2ww target remains within normal limits and was achieved for March performance.
- There remains a capacity shortfall with Face-to-Face first outpatient appointments primarily in Breast & Breast Symptomatic. Breast capacity is reduced by 33% due to social distancing, this continues to impact on both suspected and symptomatic pathways – however this is being mitigated successfully by additional clinics and Super weekends.

Action

- ✓ A zero day booking process has now been implemented for the majority of specialties together with a forward look to support mitigation of any reduction in clinics. A Daily escalation process has been robustly implemented with a 72 hour booking expectation.
- ✓ Breast patients are contacted 24 hours before appointment to ensure attendance and to maximise slot utilisation.
- ✓ A Forward look review of rapid access clinics continues to mitigate any potential dropped clinics and to expand on current capacity.

Cancer Performance – 31 Day



96.8%

31 day waits – target 96%

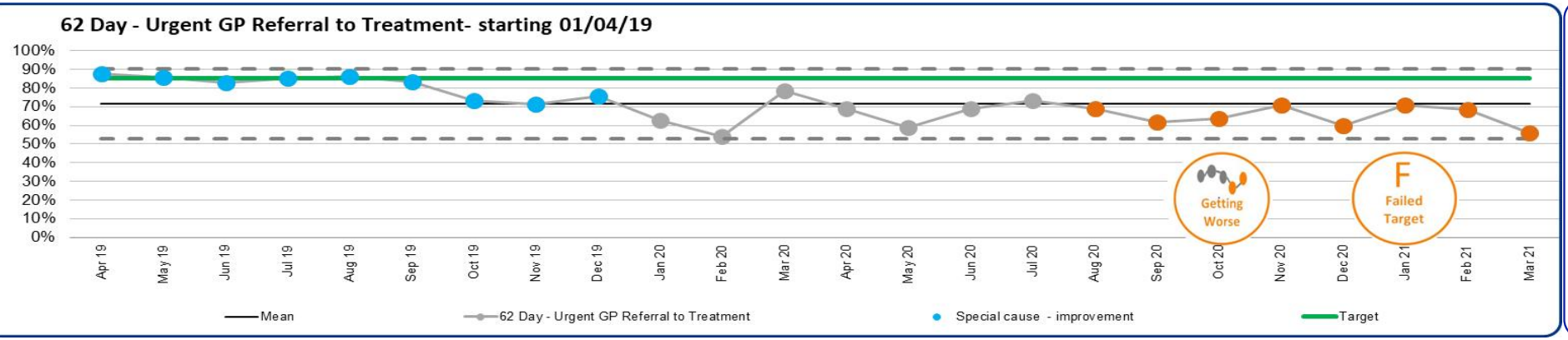
Performance

- Validation of Cancer performance figures run at a 2 month lead time. Therefore latest month position is un-validated.
- The 31 day target performance remains within normal limits and continues to be met for the 2nd Month running. Achievement is currently at 96.8% for March-21 performance - Please note, due to the smaller numbers of treatments and may decrease on validation.

Action

- ✓ A 31 day pathway training and education package continues to be cascaded to the multi-disciplinary team to ensure understanding of the issues, help to encourage timely escalation and to expedite improvement in performance.
- ✓ This target is being monitored and progressed daily, with every single breach risk identified being escalated.

Cancer Performance – 62 Day



55.9%

All cancer 62 day waits – target 85%

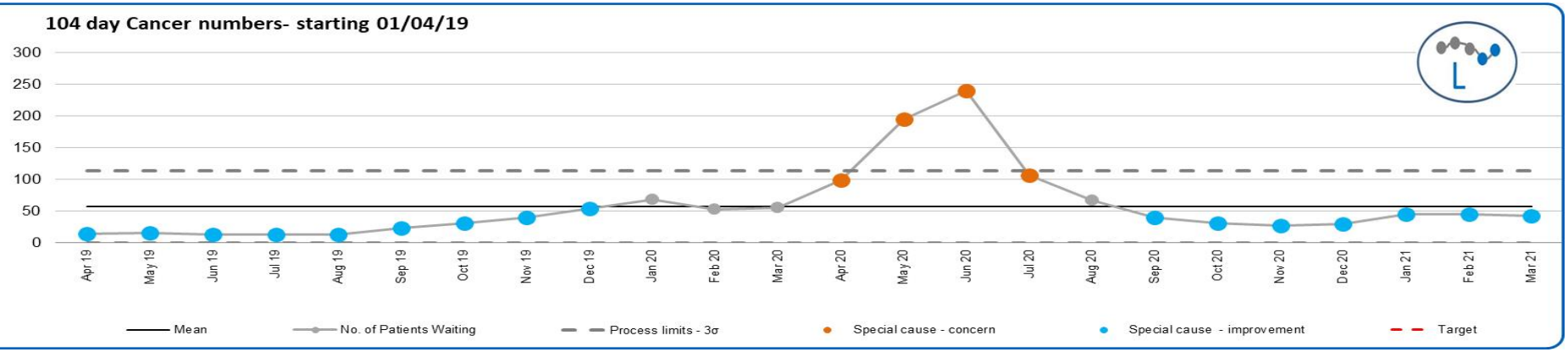
Performance

- Performance remains within normal limits, however the target of 85% has not been achieved target since August19.
- Covid-related delays have impacted at all stages of the pathway due to reduction in capacity due to social distancing, patients remain reluctant to attend for treatment and appointments. In addition the reduction of diagnostic capacity and the invasive nature of some procedures means additional precautions need to be taken which has further reduced capacity. These issues are having a significant impact on all cancer pathways.
- Patients who have waited the longest continue to be prioritised.
- In March-21, we treated 16 patients over 104 days

Action

- ✓ The Cancer management team have submitted a revised recovery trajectory for the 62 day pathway to the STP in outlining an expected position with aim of full recovery by Mar-22.
- ✓ A revised assurance process with weekly escalations to Medicine, Surgery and CSS, has been re-introduced with positive feedback received, targeting potential tipover and mitigating performance risk.

Cancer Performance – 104 Day



44

As at 31/03/2021

All 104 week waits, target zero

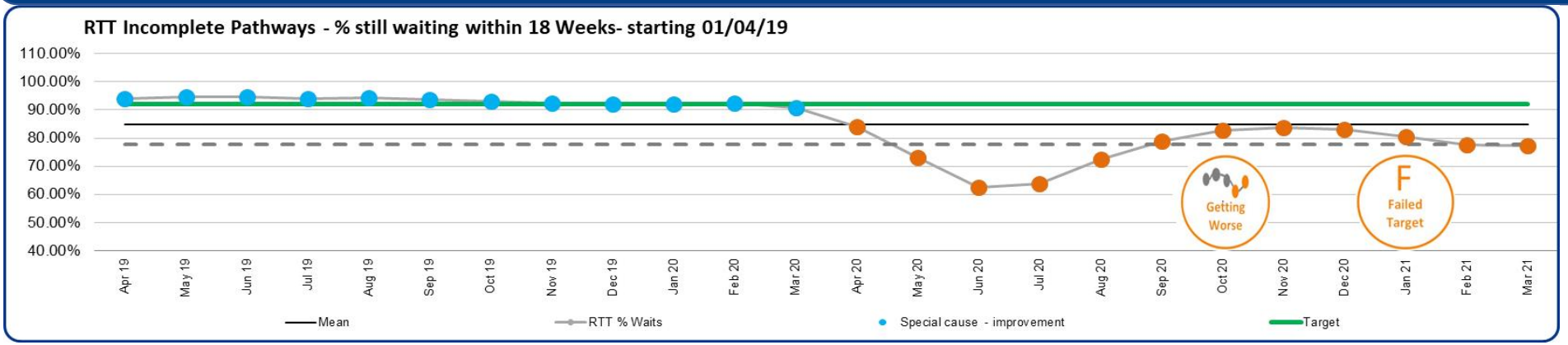
Performance

- As of 21/04/2021, the number of patients waiting 104 days stood at 36, a reduction of 8 from the 31st March :
  - 62 Day Traditional pathway : 14
  - 62 Day Upgrade/Screening Pathway: 22
- At the end of June 2020 the Trust had >200 patients waiting over 104 days, this number consistently reduced until December 20 and has remained stable since despite the Covid-19 surge.

Action

- ✓ A daily process of validating and escalating all patients waiting over 62 days has now been implemented across all cancer pathways.
- ✓ Backlog co-ordinator identified within Cancer Services to support reducing the number of patient over 63 days, in line STP request and trajectory.

RTT Performance



77.4%

RTT Incomplete pathways target 92%

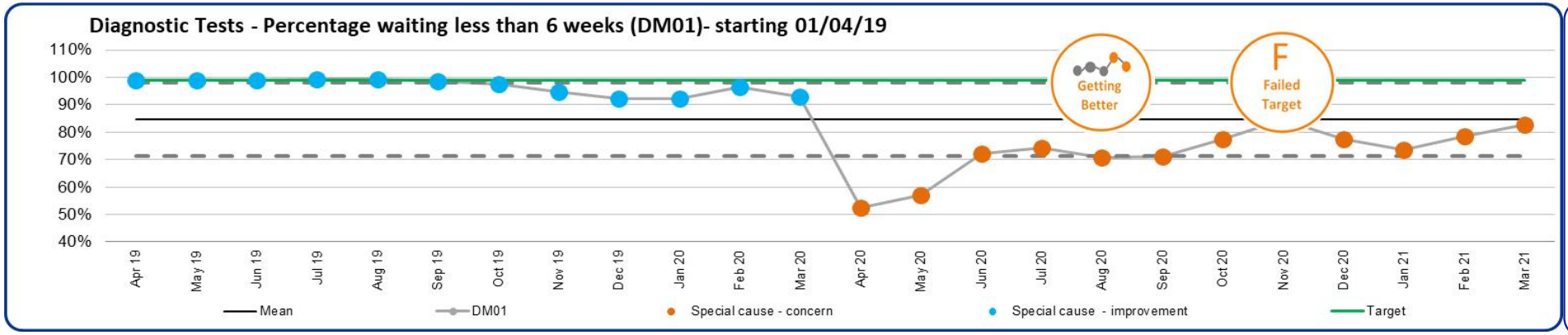
Performance

- The Referral to treatment target was not met During March, Performance has remained static around 77.5% with fluctuation between 75.5% and 77.5% in Month.
- February national data at 77.8% saw the Trust perform 11th best nationally and the best regionally.
- P2/P3 patients are being prioritisation over long waiters work as per 21/22 planning guidance.
- There has been a reduction in 52 week breaches in March 457 reduced from 467 in February. We remain on Trajectory and continue to reduce 52 week breaches in April with view to clearing them by the end of June.
- Performance is predicated on reduced elective activity.

Action

- ✓ Increased theatre activity continuing as per the roadmap presented at Execs.
- ✓ Additional Theatre activity online from w.c 19th April.
- ✓ Additional capacity put into Black Country & West Birmingham restoration & recovery bid which if approved would include Vanguard Theatre.
- ✓ Continued validation of P2/P3 categories.

DM01 Performance



82.7%

DM01 combining 15 modalities - target 99%

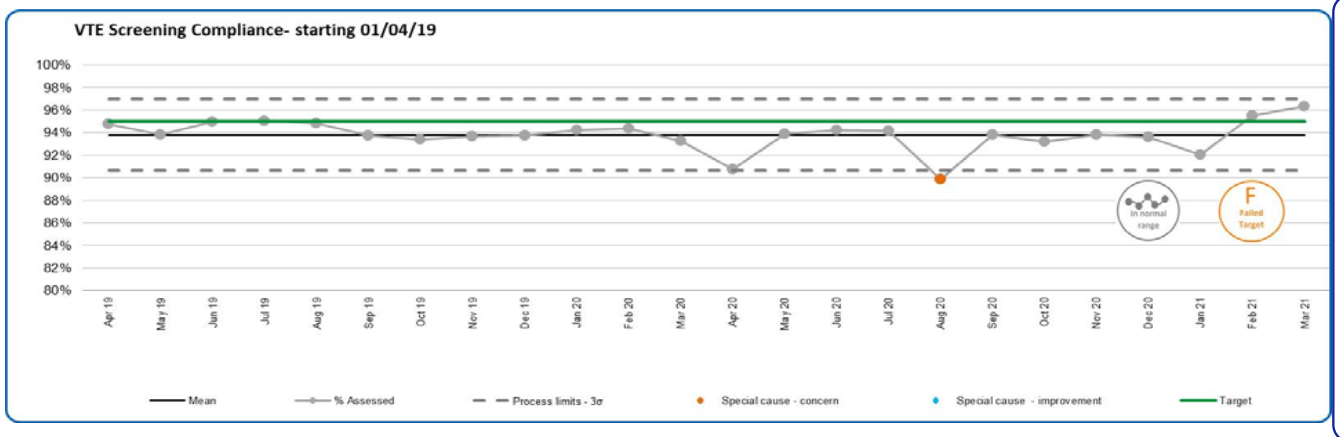
Performance

- In March the Trust achieved 82.7% of diagnostic tests carried out within 6 weeks against the national operational standard of 99% although within normal limits this is a improvement on February.
- Based on DM01 national benchmarking for February the Trust is positioned in the third upper quartile.
- The number of patients waiting over 6 weeks has further reduced during March to 1412 from 1556.
- Non-obstetric ultrasound (NOU), Cardiac CT (CTCA) and Colonoscopy contributed to low performance in March due to staffing and social distancing precautions reducing capacity.
- Overall DM01 recovery is forecast for March 2022.

Action

- ✓ **CT:** Mobile CT scanner will be returning on site for a series of dates during Spring/Summer to support and maintain cancer treatment and reduce the number of patients on the overall CT waiting list. Further support is required to reduce the current Cardiac CT backlog and a plan is in development to address, including additional WLI's and scoping potential to utilise capacity at Spire Little Aston.
- ✓ **Non-obstetric ultrasound**: Activity is outsourced on weekends, additional WLI's are being undertaken and Ramsay Healthcare are providing additional capacity from 1st April. Bank sonographer recruitment is almost complete.
- ✓ **Endoscopy:** Waiting list initiatives are still in place and are ongoing to support Cancer patients. All patients have ongoing vetting. Surveillance patients who come onto the DM01 are validated on a monthly basis to identify those whose surveillance interval could be extended.

VTE Performance



96.4%	97.1%	95.3%
Trust overall Position	**Medicine & IC**	**Surgery, W & C**

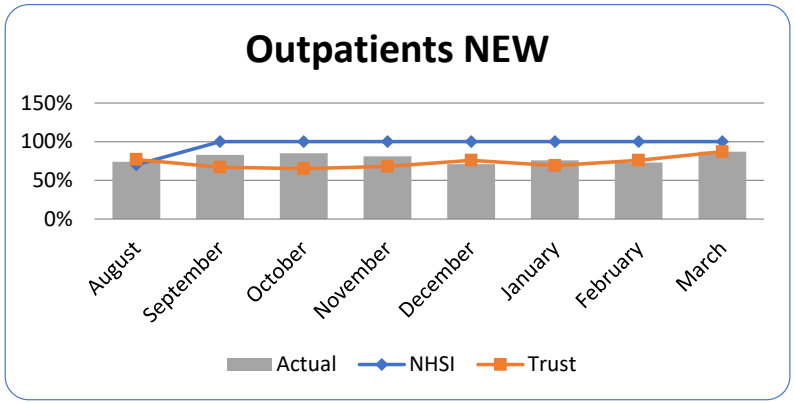
Performance

- VTE performance for February is un-validated and therefore subject to change.
- VTE assessment overall has met the target of 95% for the 2nd Month running, however the Surgical Division have failed to meet the target.
- The bank holiday may have been responsible for a small dip in the figure for start of April.
- Performance is expected to be maintained if not improved for the end of April.

Action

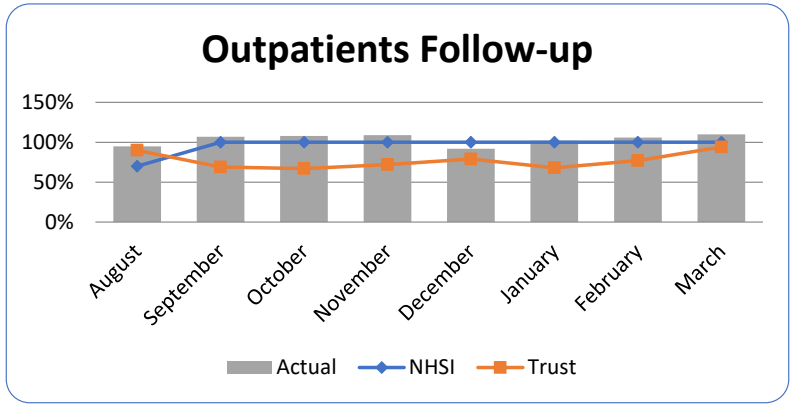
- There has been a lot of good work with our teams in Surgery and this is shown in the steady improvement in the level of VTE assessment as evident in the monthly report.

Recovery and Restoration - Outpatients



March

87%



March

110%

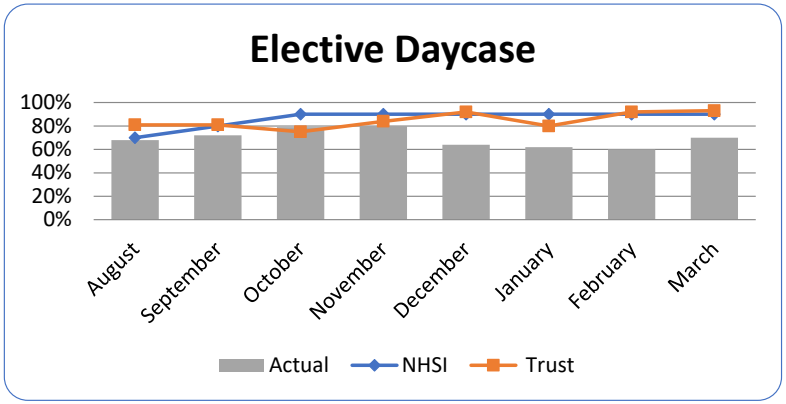
Performance

- The agreed target for follow up of outpatient appointments (OP) has been exceeded.
- There is increasing delivery of New patients following an increase in capacity availability due to reduction of medical rotas.
- Levels of over 30% of all OP appointments in virtual settings are being maintained.
- Follow up appointments continue to be seen virtually.
- Unable to increase Face to Face footprint on site until social distance regulations reviewed.

Action

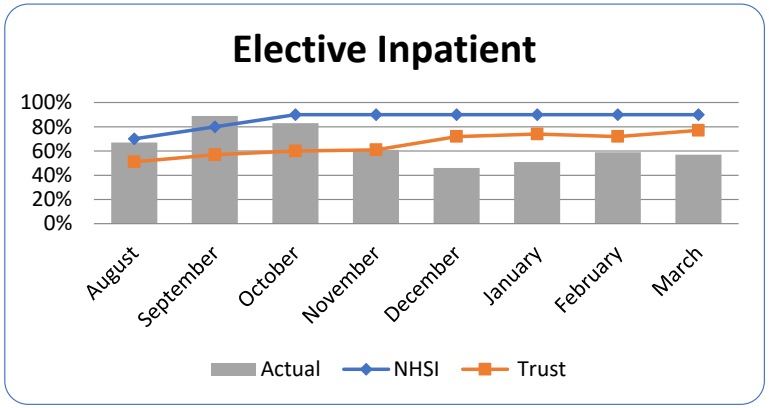
- Delivery of virtual appointments is monitored in the OP steering group.
- Social distancing within the OP department been reviewed by Infection Prevention & Control (IPC).
- OP templates have been reviewed by the OP triumvirate and fed back into the OP Steering Group for action.
- Overdue follow ups to be validated and monitored through the OP steering group.
- Patient initiated follow up (PIFU) has been launched in T&O and further specialties are planned to go live in April and May 2021 with the opportunity to convert overdue follow up direct to PIFU.

Recovery and Restoration - Electives



March

70%



March

57%

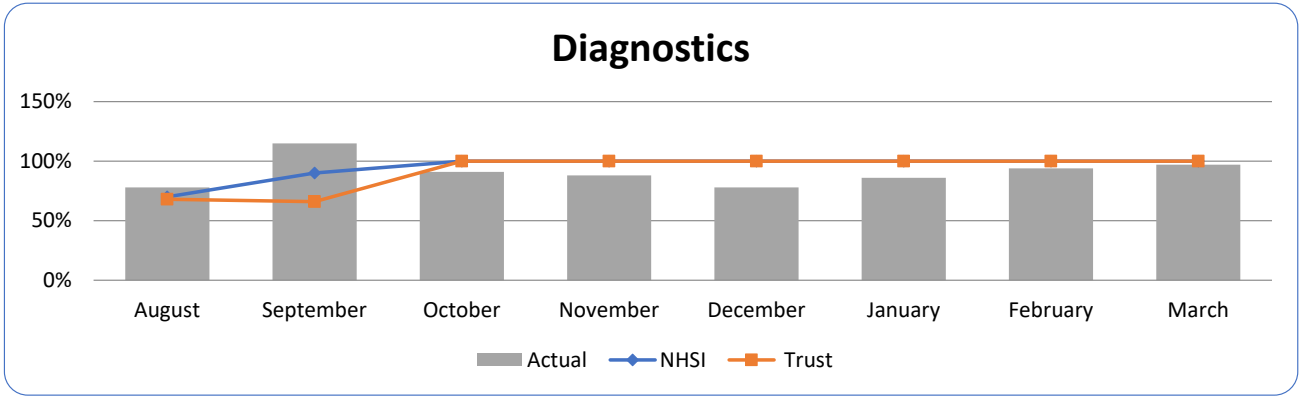
Performance

- Both daycase and inpatient activity has failed to meet the agreed target for elective for March.
- Daycase and Inpatient activity are increasing in line with projected activity in the Theatre roadmap.
- Extensive estates work is underway in Interventional Radiology (IR), Obstetrics and Corbett Theatre reducing ability to further release further theatres to support increased activity.
- Staffing absence is also impacting Theatre activity as highlighted in paper to execs.
- Staff continue to support additional critical care areas, Area A, B and C as these are still operational.

Action

- Discuss earlier finish to refurbishment work with Estates.
- Recruitment and retention strategy in development to fill staffing gaps in Theatre.
- Staff are encouraged to take annual leave to support wellbeing as per planning guidance and operational plan.
- Further Theatres are going online as per the roadmap presented to Execs on w.c 19th April, with the aim of all Theatres being operational from 1st September.
- New bank rates are in use for Theatre staffing at weekends and evenings.
- Ward B1 is used as green elective zone as required by planning guidance.

Recovery and Restoration - Diagnostics



March

97%

Performance

- Diagnostics achievement of pre -covid activity increased further to 97% during March.
- Non-obstetric ultrasound (NOU), Cardiac CT (CTCA) and Colonoscopy contributed to low performance in March due to staffing and social distancing precautions reducing capacity
- Endoscopy was impacted due to Covid demand as capacity was re-directed and Consultants continue to support ED red rota and the Outlier rota.

Action

- ✓ A mobile CT scanner will be returning on site for a series of dates during Spring/Summer to support and maintain cancer treatment and reduce the number of patients on the overall CT waiting list. Further support is required to reduce the current Cardiac CT backlog and a plan is in development to address, including additional WLI's and scoping potential to utilise capacity at Spire Little Aston.
- ✓ Non-obstetric ultrasound activity is being outsourced on weekends, additional WLI's are being undertaken and Ramsay Healthcare are providing additional capacity from 1st April. Bank sonographer recruitment is almost complete.
- ✓ Blue room in Endoscopy is now being scaled back and 3 lists have been converted back to elective lists. WLI's are still in place and are ongoing to support Cancer patients'

Enclosure 22

The Dudley Group NHS Foundation Trust

Paper for submission to the Board of Directors on Thursday 13th May 2021

TITLE:	**Summary of Workforce and Staff Engagement Committee meeting on Tuesday 27th April 2021**		
AUTHOR:	**Julian Atkins – Non-executive Director**	**PRESENTER:**	**Julian Atkins – Non-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**
	X	**X**	

RECOMMENDATIONS

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

CORPORATE OBJECTIVE:

SO3:Drive service improvement, innovation and transformation
SO4: Be the place people choose to work
SO5: Make the best use of what we have
SO6: deliver a viable future

SUMMARY OF KEY ISSUES:

As detailed in the paper.

IMPLICATIONS OF PAPER:

IMPLICATIONS FOR THE CORPORATE RISK REGISTER OR BOARD ASSURANCE FRAMEWORK

RISK	**Y**		**Risk Description:**
	Risk Register: Y		**Risk Score:**
COMPLIANCE and/or LEGAL REQUIREMENTS	**CQC**	**Y**	**Details:** Well Led
	NHSI	**Y**	**Details:** Annual Business Planning Process
	Other	**N**	**Details:**
REPORT DESTINATION	**BOARD OF**	**Y**	**DATE: 15/04/2021**

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

The Dudley Group NHS Foundation Trust

CHAIR'S LOG
UPWARD REPORT FROM WORKFORCE & STAFF ENGAGEMENT COMMITTEE
Date Committee last met: 27th April 2021

MATTERS OF CONCERN OR KEY RISKS TO ESCALATE	MAJOR ACTIONS COMMISSIONED/WORK UNDERWAY
• The low compliance numbers for Resus mandatory training were discussed again at this month's WSEC. The Committee had been anticipating a recovery plan for 2021. This plan will be presented to the next business meeting of WSEC (June 21); the plan is being developed by Bill Dainty and Helen Bromage, with the support of Mary Sexton.	• The Committee received a detailed analysis report, full of rich data on the Trust's gender pay gap. The deep dive report highlighted that there is a gender pay gap within the Trust, which is most noticeable in the Medical workforce. The analysis prompted wide discussion regarding actions and next steps, given that the Women's Inclusion Network isn't yet fully established, and recognising the need for pace and focus to this key area of inclusion. A task group will be established to establish immediate priorities and actions, based on the robust deep-dive analysis undertaken This task group will report back to WSEC. • The Committee supported the proposed EDI Delivery Model, which captures how the EDI programme aligns with the Staff Engagement Model, including the Staff Partnership Forums and Divisional Engagement Forums. This will form the basis for the Trust EDI Strategy which is being developed and will be presented to the WSEC at a later meeting.
POSITIVE ASSURANCES TO PROVIDE	**DECISIONS MADE**
• The Committee was updated on the progress of the AHP e-Rostering and e-Job Planning project. Progress to date was positive with AHP and Divisional leads well engaged and welcoming the implementation. The Trust is one of the first to implement both projects at the same time and was therefore invited to join the NHSI/E project group, developing a suite of resource for other trusts, sharing best practise. • The 'Happy App' pilot is being launched in June, with four teams keen to trial it. Following the pilot, the app will be rolled out across the trust and integrated as a core part of the Trust's approach to improving staff engagement and experience. The app provides valuable local real-time management information, to inform management action to improve their working experience of their people. Support from OD and DIP will also be provided to managers.	• The Committee have asked that additional detail be included into the Workforce KPI report to distinguish between BAU bank/agency staffing usage and bank/agency staff for the Workforce Bureau.

• Positive assurances were provided in the Workforce KPI report, including a reduction in sickness absence and turnover. The Trust remains below the NHS average for turnover. • The Committee heard from the Head of EDI and Inclusion Network Chairs who provided positive updates on the WRES Delivery Plan, Network Priority Plans and the EDI Delivery Model. Assurance was given that robust plans are in place to ensure the Trust develops and maintains a diverse and inclusive culture. Key actions include training and embedding Inclusion Champions on interview panels and assessing the organisation against best practice standards such as the Stonewall Employers Index. It was also reported that the Trust had recently been chosen to take the lead on developing the BCWB STP's equality and inclusion strategy. • The Committee received a progress report on divisional staff engagement plans. Each of the Divisional Directors presented their plans and milestone measures, supported by Peter Lowe/DIP. Regular updates will be provided to WSEC. • The Head of Medial Education shared the outstanding feedback following the assessment of training and education given to medical students from University of Birmingham. The Trust has built a great reputation for its training and education programmes, meaning students often return to the Trust for roles after completing training. For example, 70% of the foundation workforce come from University of Birmingham Medical School. • The Medical Director briefed the Committee on the excellent results of the Medical Engagement Score Report, where the majority of the themes were RAG rated green. A full report and action plan will be presented at the next meeting.	

Chair's comments on the effectiveness of the meeting:

This was the first full WSEC business meeting for some time, therefore there was a full agenda. I was pleased with the high levels of engagement across the different agenda items, and particularly impressed by the quality, rigour and granularity of the Divisional Staff Engagement plans, which are being actively supported by the Dudley Improvement Practice. The Committee welcomes the deep-dive analysis into the gender pay gap which will inform focused and targeted improvement action. It was also good to see the EDI Delivery model, which the Committee supported. This will form the basis for the Trust's EDI Strategy.

Enclosure 23

NHS
The Dudley Group
NHS Foundation Trust

Paper for submission to Board 13th May 2021

TITLE:	**Workforce KPI Report**		
AUTHOR:	**Karen Brogan – Head of Operational HR** **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 was 4.98% in March, which is a significant reduction from 7.75% in February. CIS is the division with the highest sickness absence rate at 6.47%, which is a reduction from 8.38% in February.
- Daily absence tracking shows C19 absences reducing and shielding stopped at the end of March which reduced COVID reason absences to 0.5%.
- COVID reason absences was the highest category, followed by 'Anxiety/stress/depression'. ED and Pathology were highest, followed by Ward B1 and Critical Care.
- Bank usage increased from 742 WTE in February to 1126 WTE in March, the significant increase is caused by DGFT's role as Lead Employer for the BCWB vaccination programme (cost of which is fully recovered). Agency usage increased from 226 WTE in February to 290 WTE in March. COVID vax programme BANK = 475 WTE, £1,865K, AGENCY = 66 WTE, £889k
- Contracted WTE staff has increased to 4,913 WTE in March, the total vacancies stand at 501 WTE (calculated as the difference between Budgeted WTE and Contracted WTE in Month 12) this is a reduction 0f 64 WTE since February. This equates to 9%.
- Registered Nursing vacancies are at 287 WTE, Unregistered Nursing at 17 WTE, Radiographers at 49 WTE. This is a reduction of 9 Registered Nursing vacancies and a reduction of 41 Unregistered Nursing.
- Overall staff turnover is at 7.4% (rolling average 12 months). High turnover is expected Medical & Dental staff groups and is seen in the Student category as a direct result of the employment and deployment of students in response to the pandemic . Of the remainder, AHPs are highest at 10%, Nursing &Midwifery Registered at 4%, and Healthcare Scientists at 0%.

- Mandatory Training: overall compliance increased in March to 82.54%. The priority areas continue to be RESUS, MANUAL HANDLING and SAFEGUARDING; however, the delivery of mandatory training was disrupted across two periods to support the Trusts response to the pandemic.
- Mandatory training compliance amongst BAME staff was lower than the DGFT average. BAME staff compliance is lower across all staff groups. Non-mandatory training is also lower within the BAME staff group (59%) compared to the Non-BAME group (65%).
- BAME staff Trust representation is at 19.4%, down 0.2% from last month. Disabled staff Trust representation is at 3.7%.

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	**Y**	**Details:** *in accordance with Trust policies and procedures developed and maintained to comply with prevailing legislation as required.*
REPORT DESTINATION	**EXECUTIVE DIRECTORS**	**N**	**DATE:**
	WORKING GROUP	**N**	**DATE:**
	COMMITTEE	**N**	**DATE: Workforce Committee Monthly**

NHS
The Dudley Group
NHS Foundation Trust

Workforce KPI Report

13th May 2021

James Fleet, Executive Chief People Officer




Summary 1/3	*Performance*	*Action*
Sickness & Absence	o Overall Sickness/Absence was 4.98% in March, which is a significant reduction from 7.75% in February. o CIS is the division with the highest sickness absence rate at 6.47%, which is a reduction from 8.38% in February o Daily absence tracking shows C19 absences reducing, and shielding stopped at the end of March which reduced COVID reason absences to 0.5%. o COVID reason absences was the highest category, followed by 'Anxiety/stress/depression'. ED and Pathology were highest, followed by Ward B1 and Critical Care.	✓ Centralised Sickness Absence Reporting has continued for Covid-related absence, this feeds directly into the Staff Testing process to enable staff to return to work as quickly as possible. ✓ All Covid-related absence is screened and challenged to ensure staff are self-isolating appropriately and scheduled returners are managed daily to facilitate a return to work. ✓ Monthly sickness absence reports are being sent to Managers, Divisional Directors and Heads of Service detailing both short and long term absence, with the operational HR teams supporting the development of management action plans. ✓ 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 Bank usage increased from 742 WTE in February to 1126 WTE in March, the significant increase is caused by DGFT's role as Lead Employer for the BCWB vaccination programme (cost of which is fully recovered) o Agency usage increased from 226 WTE in February to 290 WTE in March. o COVID vax programme BANK = 475 WTE, £1,865K, AGENCY = 66 WTE, £889k	✓ An action plan has been developed to prioritise recruitment and retention, concentrating specifically on HCSW's and Registered Nurses initially, to reduce reliance on agency and bank usage. ✓ 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 Contracted WTE staff has increased to 4,913 WTE in March, The total vacancies stands at 501 WTE (calculated as the difference between Budgeted WTE and Contracted WTE in Month 12) this is a reduction 0f 64 WTE since February. This equates to 9%. o Registered Nursing vacancies are at 287 WTE, Unregistered Nursing at 17 WTE, Radiographers at 49 WTE. This is a reduction of 9 Registered Nursing vacancies and a reduction of 41 Unregistered Nursing o Overall staff turnover is at 7.4% (rolling average 12 months). High turnover is expected Medical & Dental staff groups and is seen in the Student category as a direct result of the employment and deployment of students in response to the pandemic . Of the remainder, AHPs are highest at 10%, Nursing &Midwifery Registered at 4%, and Healthcare Scientists at 0%.	✓ 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. ✓ A methodology is being developed that will examine trends on planned versus actual staffing levels, triangulated with key quality and outcome measures, including exit interviews and stay interviews. ✓ An action plan has been developed to prioritise recruitment and retention, concentrating specifically on HCSW's and Registered Nurses.

Summary 2/3

	Performance	*Action*
Mandatory Training	o Mandatory Training: overall compliance increased in March to 82.54%. o The priority areas continue to be RESUS, MANUAL HANDLING and SAFEGUARDING, however the delivery of mandatory training was disrupted across two periods to support the Trusts response to the pandemic. o Mandatory training compliance amongst BAME staff was lower than the DGFT average. BAME staff compliance is lower across all staff groups. o Non-mandatory training is also lower within the BAME staff group (59%) compared to the Non-BAME group (65%). o The most challenged services are Psychiatry Medics, Medical Staff (Oncology), and General Surgery Medical Staff.	✓ 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, staff absence continued to be a factor. ✓ Meetings held with SMT Lead and Gen Managers for MIC, Surgery, and CSS, with out-of-hours additional sessions run throughout September up to December to capture Clinicians and increase overall compliance.
Equality, Diversity & Inclusion	o BAME staff Trust representation is at 19.4%, down 0.2% from last month. o Disabled staff Trust representation is at 3.7%.	✓ The Trust has now established 3 networks: BAME, LGBTQ+, and Disability. The BAME, and LGBTQ+ Networks which are now underway with growing membership and regular meetings and events ✓ Each of these networks has both an Executive Director and Non-Executive Director sponsor. In addition, the Chairs of the networks are attending Board meetings. ✓ A delivery plan for the key elements of the Dudley People Plan and for WDES, WRES, and WSES actions has been developed to ensure there is a key focus on Equality.

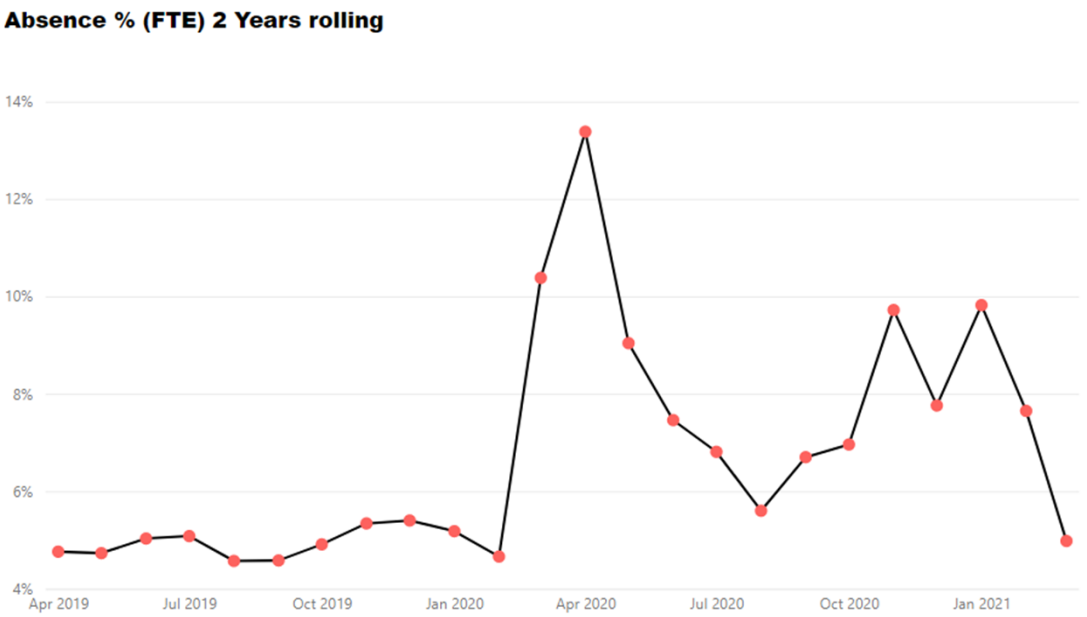
Summary 3/3	*Performance*	*Action*
Staff Health & Wellbeing	o Referrals received in March increased to 105 over 67 in February. o The largest category is 'Ability to perform duties' at 58%. o The average days from referral to appointment was 13 days in March, compared to the target of 15 days.	✓ Review 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 (not including suspensions) has 32 live cases, the majority being grievances (13) at 40.6%. This represents an increase of 4 cases. o The are currently 2 suspensions o BAME staff represent 40% of active cases. o The HR dashboard is being developed to include mean and median lead times for case resolution.	✓ 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. ✓ The development of innovative and supportive Employee Relations policies continue to be a focus, with both the 'Helping Resolve Problems Policy (Grievance Policy) and Disciplinary Policy having been reviewed in line with best practice and now in the Trust's consultation ratification process

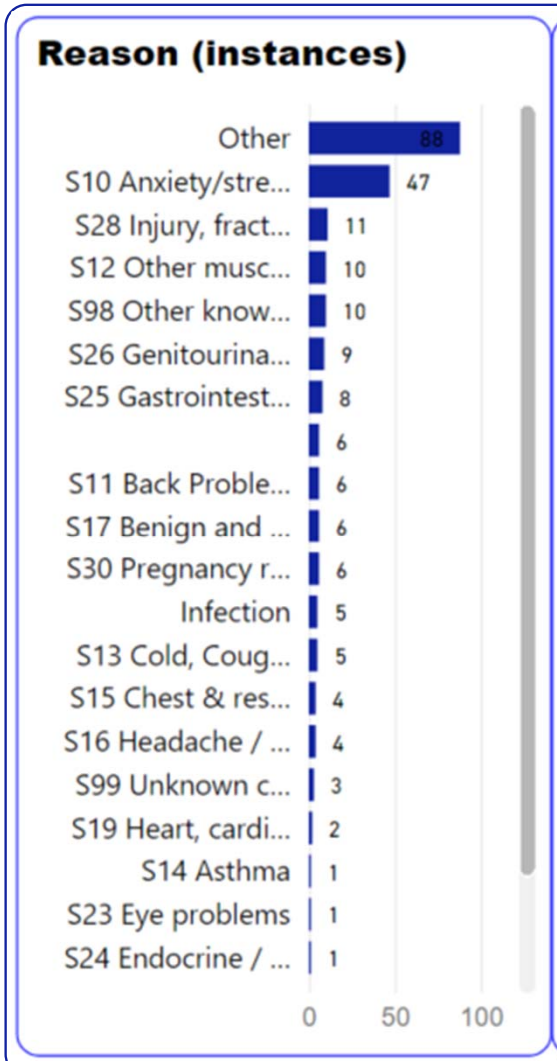
Sickness Absence

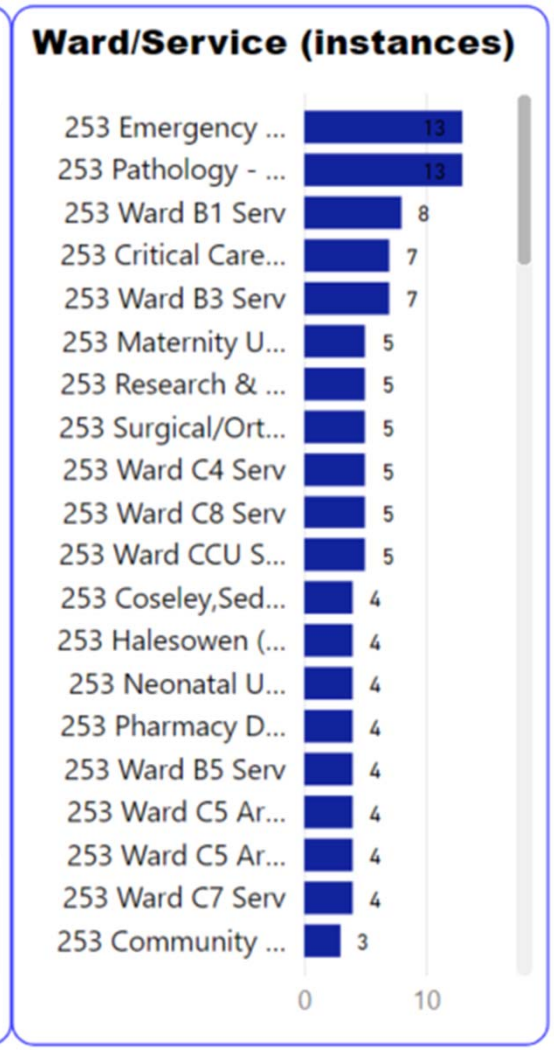
Overall Sickness/Absence was 4.98% in March, with CIS the highest at 6.47%.

Daily absence tracking shows C19 absences reducing, and shielding stopped at the end of March which reduced COVID reason absences to 0.5%.

COVID reason absences ('other' in the table to the right below) was the highest category, followed by 'Anxiety/stress/depression'. In terms of instances of sickness/absence, ED and Pathology were highest, followed by Ward B1 and Critical Care.



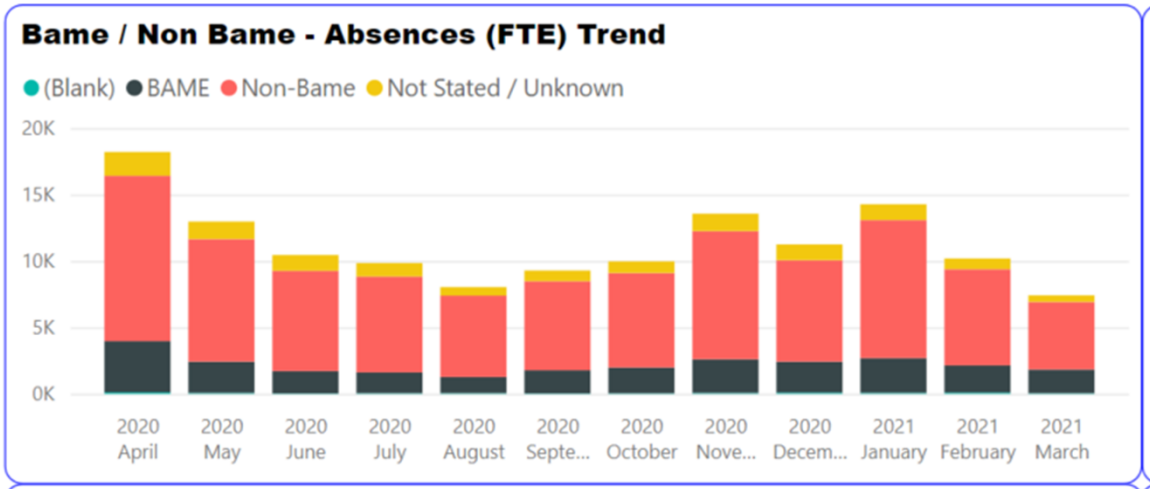


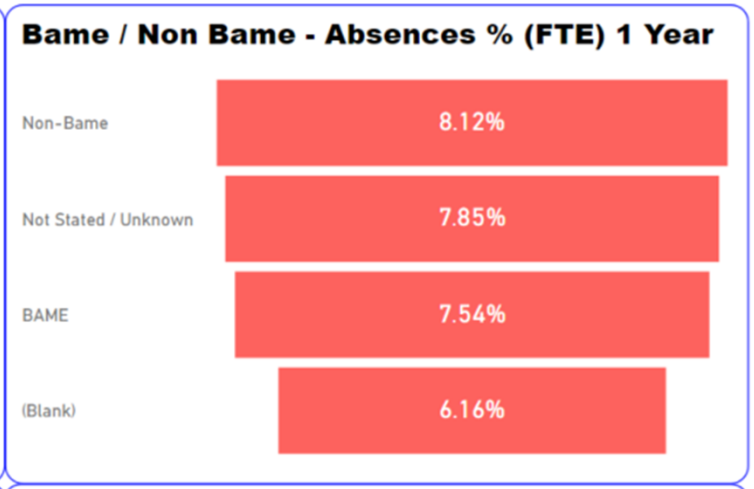


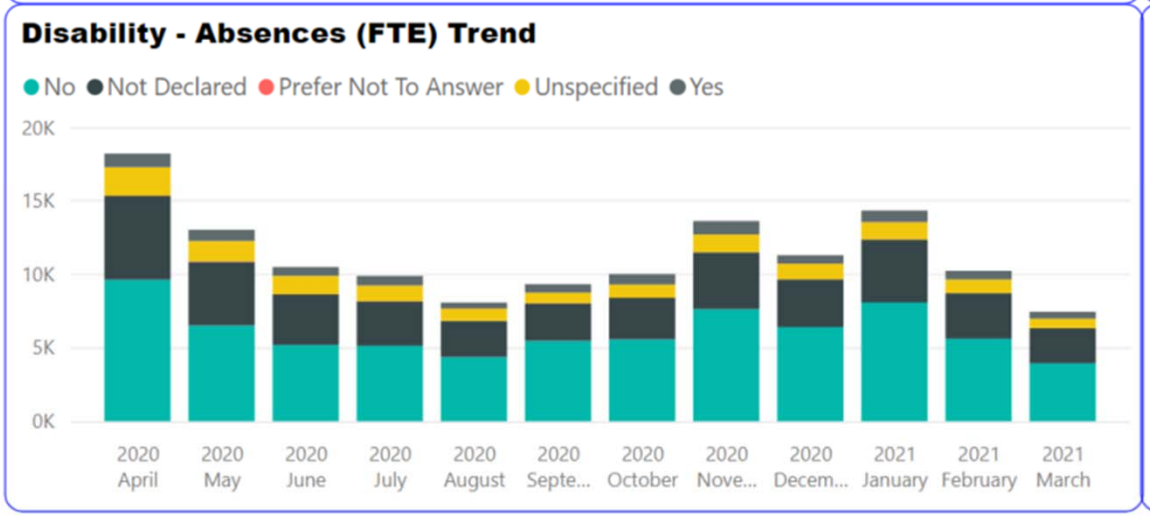
Sickness Absence - Detail

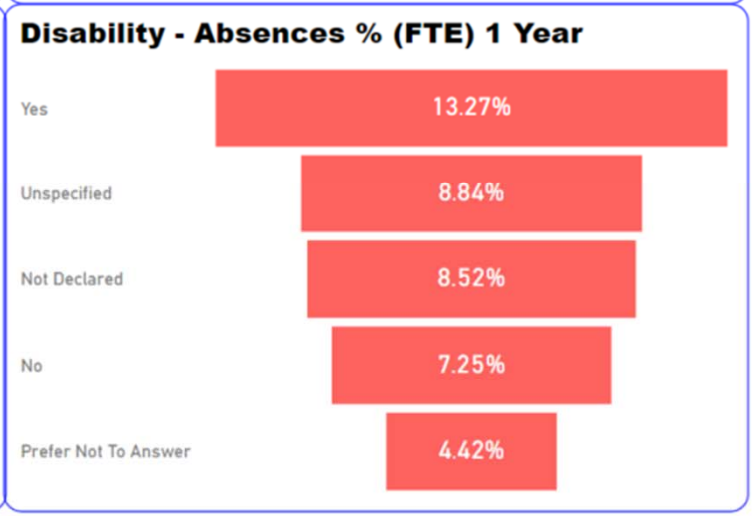
BAME colleagues show absence levels 0.58% lower that white colleagues.

In terms of disability, the chart to the right highlights the absence levels of disabled colleagues (for the 12 months to March 2021, including the COVID effect).









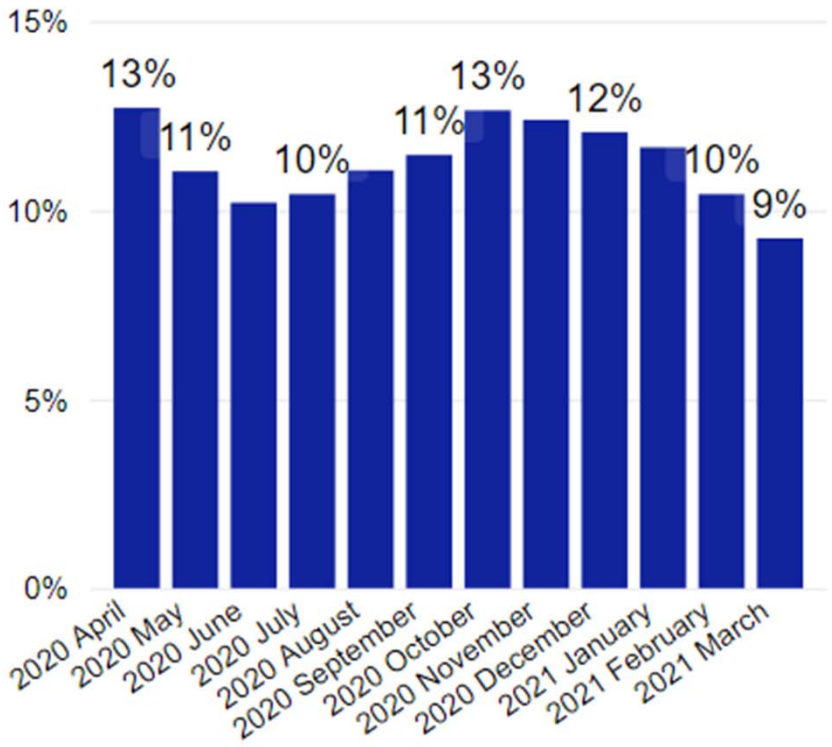
Vacancies – Staff in Post + Bank & Agency – Total Trust

Contracted WTE staff has increased to 4,913 WTE in March, up 60 from February. The overall number of vacancies has dropped to 9%. Bank usage increased from 742 WTE in February to 1126 WTE in March, the significant increase is caused by DGFT's role as Lead Employer for the BCWB vaccination programme (cost of which is fully recovered).

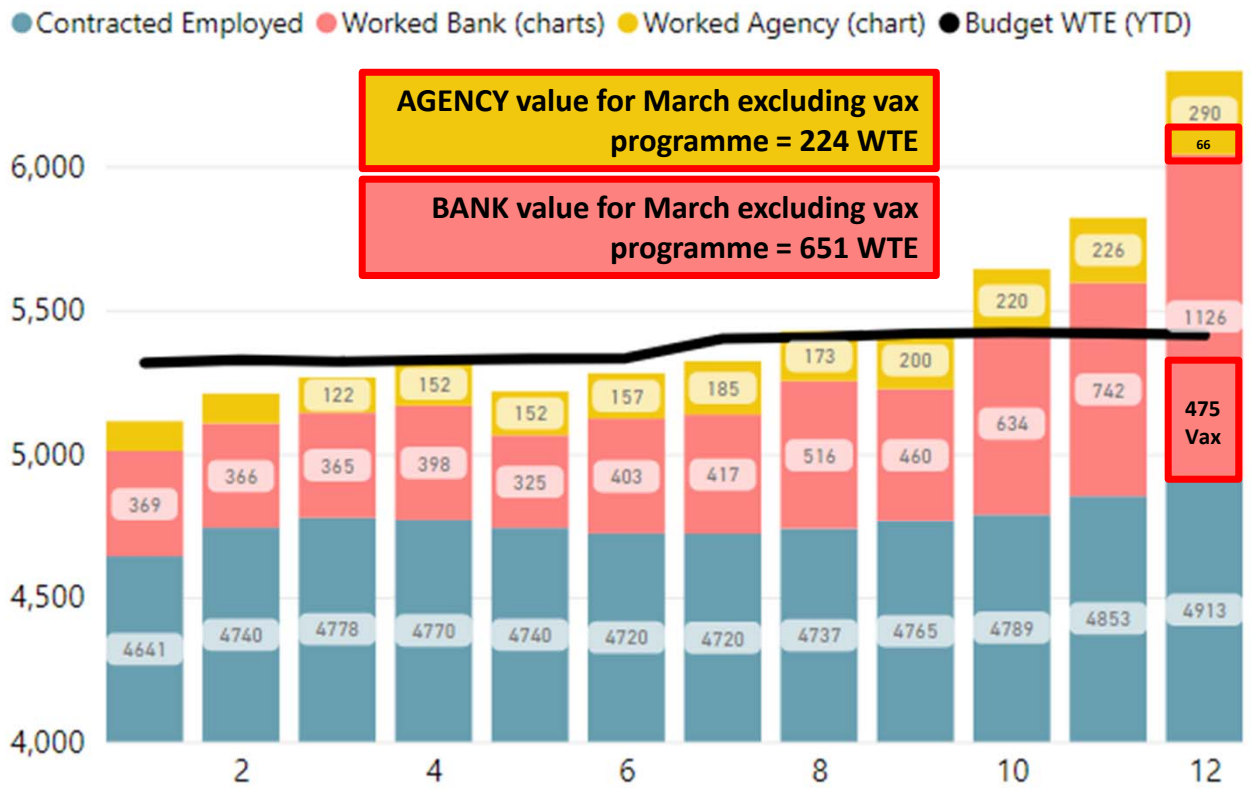
COVID vax programme BANK = 475 WTE, £1,865K, AGENCY = 66WTE, £889k

Trust	CS	Corporate	MIC	Surgery
9%	15%	0%	8%	12%

Vacancy %



Contracted Employed, Worked Bank & Agency



Vacancies – Total Trust + Bank & Agency Spend

The total vacancies stands at 501 WTE (calculated as the difference between Budgeted WTE and Contracted WTE in Month 12) and equates to 9%.

Qualified Nursing vacancies are at 287 WTE, Unqualified Nursing at 17 WTE, Radiographers at 49 WTE.

Worked BANK WTE numbers are inflated by DGFT's role as Lead Employer for the BCWB vaccination roll-out programme, and is counted under Corporate.

COVID vax programme BANK = 475 WTE, £1,865K, AGENCY = 66 WTE, £889k

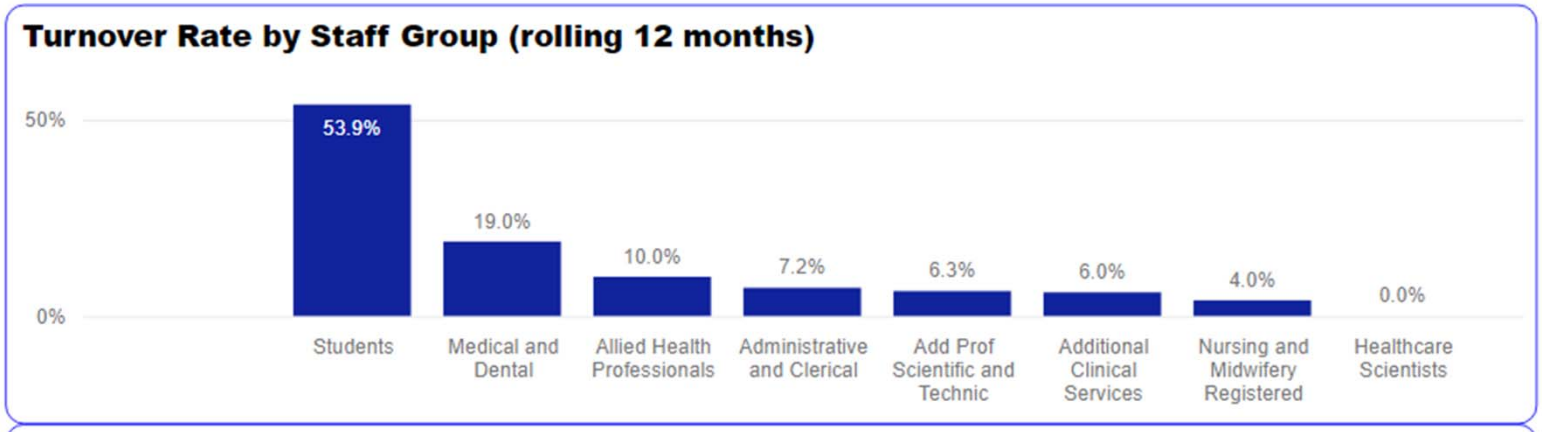
CC1 Desc	Budget WTE	Contracted WTE	Vacancy WTE	Vacancy %	Worked Bank	Bank (£)	Worked Agency	Agency (£)	Bank & Agency
Clinical Support	529.36	450.83	78.53	15%	57.68	£196,215	7.13	£125,336	£321,552
Corporate / Mgt	567.66	565.35	2.31	0%	524.22	£2,023,670	60.30	£823,653	£2,847,323
Medicine & Integrated Care	2,377.10	2,184.48	192.62	8%	322.81	£1,667,012	117.96	£829,577	£2,496,588
Surgery	1,939.45	1,711.39	228.06	12%	221.75	£918,777	104.88	£732,675	£1,651,453
Total	**5,413.57**	**4,912.05**	**501.52**	**9%**	**1,126.46**	**£4,805,674**	**290.27**	**£2,511,241**	**£7,316,915**

EH4 Description	Budget WTE	Contracted WTE	Vacancy WTE	Vacancy %	Worked Bank	Bank (£)	Worked Agency	Agency (£)	Bank & Agency
Qualified Nursing	1,857.99	1,571.04	286.95	15%	290.65	£1,252,843	204.86	£1,414,111	£2,666,954
Administration Staff	986.94	936.10	50.84	5%	269.80	£556,740	18.64	£123,797	£680,537
Unqualified Nursing	882.89	865.84	17.05	2%	341.88	£794,496	24.51	£107,742	£902,238
Senior Medical Staff	369.69	313.23	56.46	15%	26.91	£514,490	2.67	£55,428	£569,919
Junior Medical Staff	365.42	387.72	-22.30	-6%	47.62	£521,904	7.22	£120,381	£642,286
Technical Staff	243.26	212.27	30.99	13%	25.78	£94,419	1.00	£13,817	£108,236
Radiographer	213.49	164.64	48.85	23%	21.60	£62,891	2.53	£81,094	£143,985
Physiotherapists	140.86	145.04	-4.18	-3%	8.65	£34,673	1.47	£15,021	£49,694
Pharmacists	62.93	57.56	5.37	9%	80.95	£941,172	16.07	£228,532	£1,169,704
Total	**5,413.57**	**4,912.05**	**501.52**	**9%**	**1,126.46**	**£4,805,674**	**290.27**	**£2,511,241**	**£7,316,915**

Staff Turnover

Overall staff turnover is at 7.4% (rolling average 12 months). High turnover is expected within the Student and Medical & Dental staff groups. Of the remainder, AHPs are highest at 10%, Nursing &Midwifery Registered at 4%, and Healthcare Scientists at 0%.

Trust	CS	Corporate	MIC	Surgery
7.4%	8.4%	9.7%	7.6%	6.1%



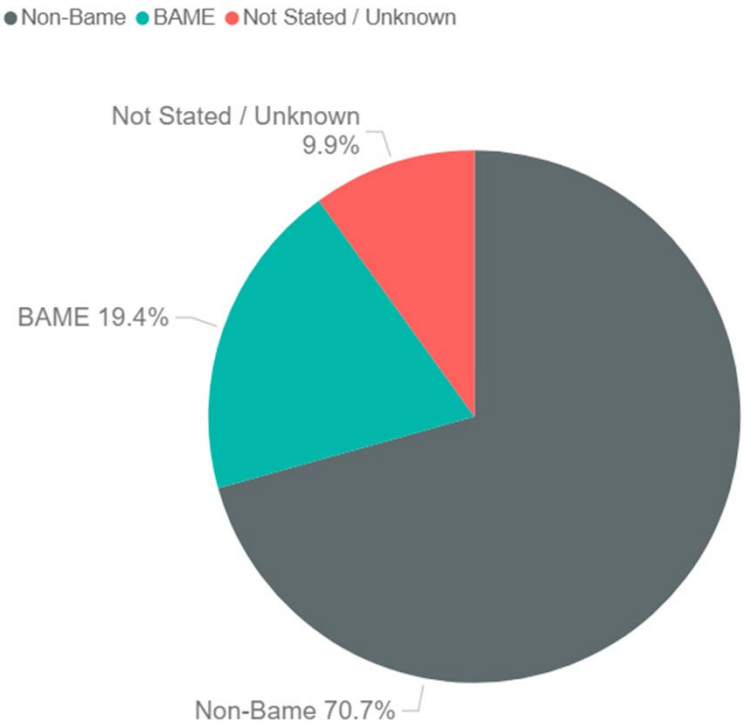
Workforce Profile - Ethnicity – Representation by Division and Grade

BAME staff Trust representation is at 19.4%.

The new HR dashboard enables detailed analysis of representation by grade and department, and mirrors the WRES submission to enable monthly tracking.

NB: there is a data quality issue at VSM, where ESR is incorrectly coded to show 1 BAME staff member. There are 7 VSM staff of which non are stated as BAME.

Ethnicity Profile



BAME/Non-BAME by Division

Mapping Org L2	BAME No.	BAME %	Non-Bame No.	Non-Bame %	Not Stated / Unknown No.	Not Stated / Unknown %	Total No.	Total %
253 Surgery	378	20.1%	1324	70.6%	174	9.3%	1876	100.0%
253 Medicine & Integrated Care	456	19.1%	1681	70.3%	254	10.6%	2391	100.0%
253 Corporate / Mgt	76	12.4%	464	75.8%	72	11.8%	612	100.0%
253 Clinical Support	137	26.6%	343	66.5%	36	7.0%	516	100.0%
Total	**1047**	**19.4%**	**3812**	**70.7%**	**536**	**9.9%**	**5395**	**100.0%**

BAME/Non-BAME by Pay Grade (grouped)

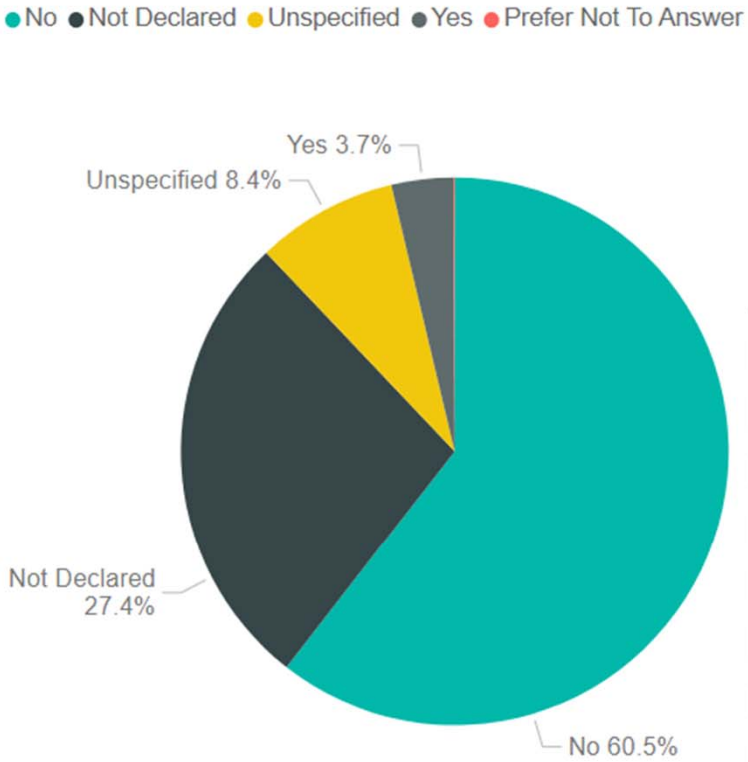
Mapping Mapping	BAME No.	BAME %	Non-Bame No.	Non-Bame %	Not Stated / Unknown No.	Not Stated / Unknown %	Total No.	Total %
Ad Hoc			1	100.0%			1	100.0%
Apprentice	8	13.1%	50	82.0%	3	4.9%	61	100.0%
Band 2	124	10.1%	971	79.1%	133	10.8%	1228	100.0%
Band 3	28	7.8%	290	81.0%	40	11.2%	358	100.0%
Band 4	50	11.9%	327	77.9%	43	10.2%	420	100.0%
Band 5	255	24.8%	661	64.2%	113	11.0%	1029	100.0%
Band 6	155	15.8%	735	74.9%	91	9.3%	981	100.0%
Band 7	55	11.3%	401	82.7%	29	6.0%	485	100.0%
Band 8a	34	22.2%	105	68.6%	14	9.2%	153	100.0%
Band 8b	5	11.4%	35	79.5%	4	9.1%	44	100.0%
Band 8c	2	15.4%	10	76.9%	1	7.7%	13	100.0%
Band 8d	1	8.3%	10	83.3%	1	8.3%	12	100.0%
Band 9	2	25.0%	6	75.0%			8	100.0%
Consultant	117	48.5%	96	39.8%	28	11.6%	241	100.0%
Non-Consultant	208	66.0%	83	26.3%	24	7.6%	315	100.0%
Trust contract	2	5.3%	26	68.4%	10	26.3%	38	100.0%
VSM	1	12.5%	5	62.5%	2	25.0%	8	100.0%
Total	**1047**	**19.4%**	**3812**	**70.7%**	**536**	**9.9%**	**5395**	**100.0%**

Workforce Profile - Disability – Representation by Division and Grade

Disabled staff Trust representation is at 3.7%.

The new HR dashboard enables detailed analysis of representation by grade and department, and mirrors the WDES submission to enable monthly tracking.

Disability



Disability by Division

Org L2	No	Not Declared	Prefer Not To Answer	Unspecified	Yes
253 Clinical Support	65.5%	24.4%		6.3%	3.8%
253 Corporate / Mgt	67.8%	20.8%	0.3%	5.0%	6.0%
253 Medicine & Integrated Care	60.4%	26.7%	0.0%	8.8%	4.1%
253 Surgery	57.0%	31.2%	0.1%	9.5%	2.3%
Total	**60.5%**	**27.4%**	**0.1%**	**8.4%**	**3.7%**

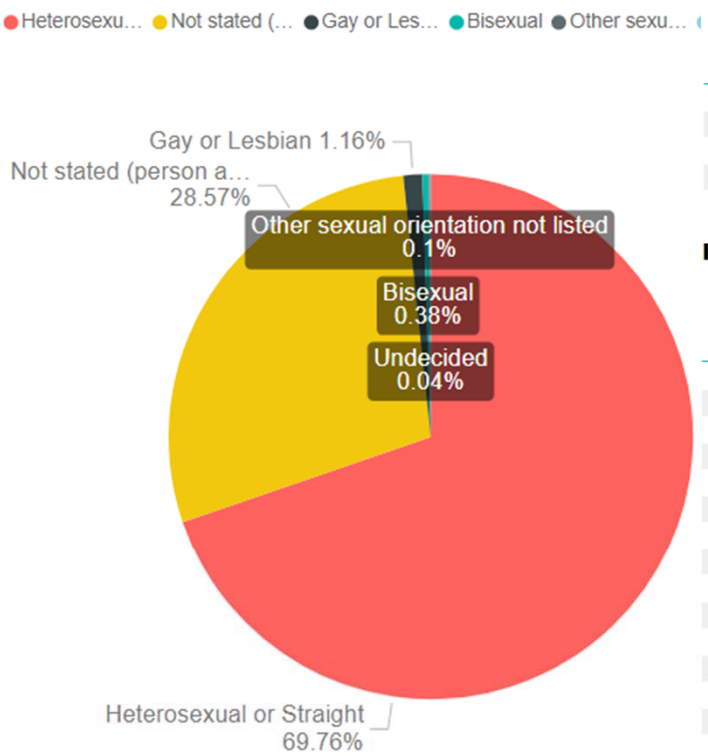
Disability by Pay Grade (grouping)

Mapping	No	Not Declared	Prefer Not To Answer	Unspecified	Yes
Ad Hoc		100.0%			
Apprentice	75.0%	7.8%		1.6%	15.6%
Band 2	58.1%	27.2%	0.1%	11.9%	2.8%
Band 3	59.6%	26.7%		8.1%	5.6%
Band 4	67.8%	22.0%		7.3%	2.8%
Band 5	59.3%	26.5%		9.8%	4.4%
Band 6	58.9%	30.0%		7.5%	3.6%
Band 7	60.6%	31.6%	0.2%	3.1%	4.5%
Band 8a	66.7%	22.0%		6.7%	4.7%
Band 8b	60.5%	34.9%		4.7%	
Band 8c	84.6%	15.4%			
Band 8d	66.7%	33.3%			
Band 9	87.5%				12.5%
Consultant	41.6%	49.4%	0.4%	8.6%	
Non-Consultant	77.9%	13.6%		6.0%	2.5%
Trust contract	61.5%	25.6%		12.8%	
VSM	25.0%	50.0%	12.5%		12.5%
Total	**60.5%**	**27.4%**	**0.1%**	**8.4%**	**3.7%**

Workforce Profile – LGBTQ+ – Representation by Division and Grade

LGBTQ+ staff representation is shown as % since absolutely numbers are low.

LGBTQ+



LGBTQ+ by Division

Org L2	Bisexual	Gay or Lesbian	Heterosexual or Straight	Not stated (person asked but declined to provide a response)	Other sexual orientation not listed	Undecided
253 Clinical Support	0.6%	0.4%	71.6%	26.9%	0.4%	
253 Corporate / Mgt	0.7%	0.9%	78.3%	20.0%		0.2%
253 Medicine & Integrated Care	0.3%	1.8%	70.4%	27.5%	0.0%	
253 Surgery	0.3%	0.7%	65.5%	33.3%	0.1%	0.1%
Total	**0.4%**	**1.2%**	**69.8%**	**28.6%**	**0.1%**	**0.0%**

LGBTQ+ by Pay Grade (grouped)

Mapping	Bisexual	Gay or Lesbian	Heterosexual or Straight	Not stated (person asked but declined to provide a response)	Other sexual orientation not listed	Undecided
Ad Hoc			100.0%			
Apprentice		3.2%	82.5%	14.3%		
Band 2	0.8%	1.8%	68.1%	29.0%	0.3%	
Band 3		0.9%	73.9%	25.2%		
Band 4		1.0%	73.5%	25.0%	0.3%	0.3%
Band 5	0.3%	0.8%	69.6%	29.3%		
Band 6	0.2%	1.0%	69.4%	29.4%		
Band 7	0.2%	1.1%	68.7%	29.8%	0.2%	
Band 8a		1.4%	75.2%	23.4%		
Band 8b		2.4%	61.9%	35.7%		
Band 8c			75.0%	25.0%		
Band 8d			66.7%	33.3%		
Band 9			100.0%			
Consultant		0.9%	46.0%	52.7%		0.4%
Non-Consultant	1.3%	0.7%	82.2%	15.8%		
Trust contract		2.9%	64.7%	32.4%		
VSM			87.5%	12.5%		
Total	**0.4%**	**1.2%**	**69.8%**	**28.6%**	**0.1%**	**0.0%**

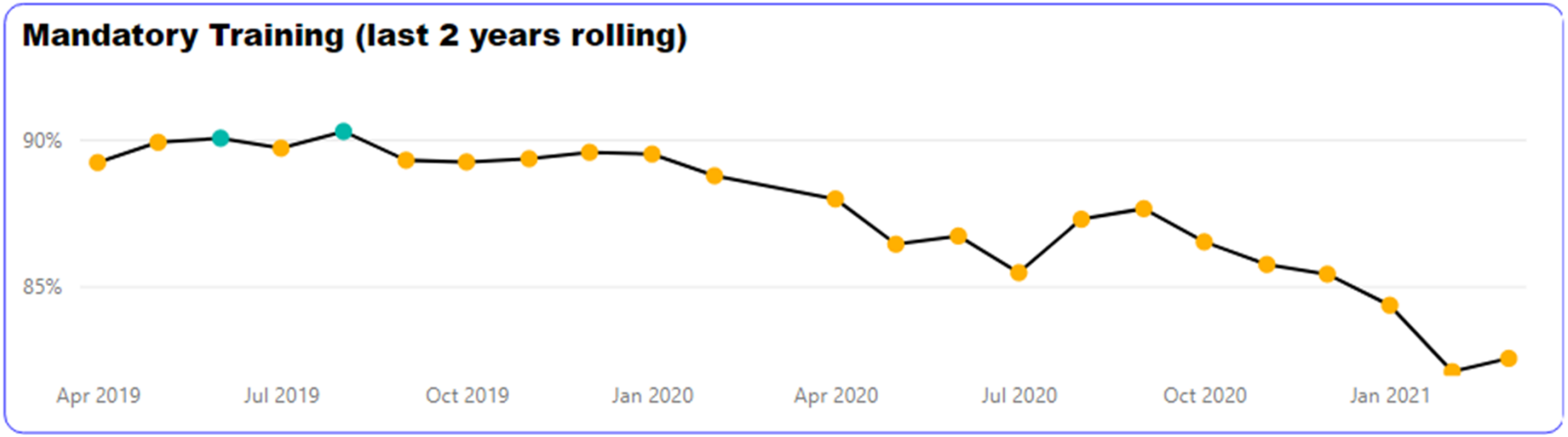
Mandatory Training – Performance Trend

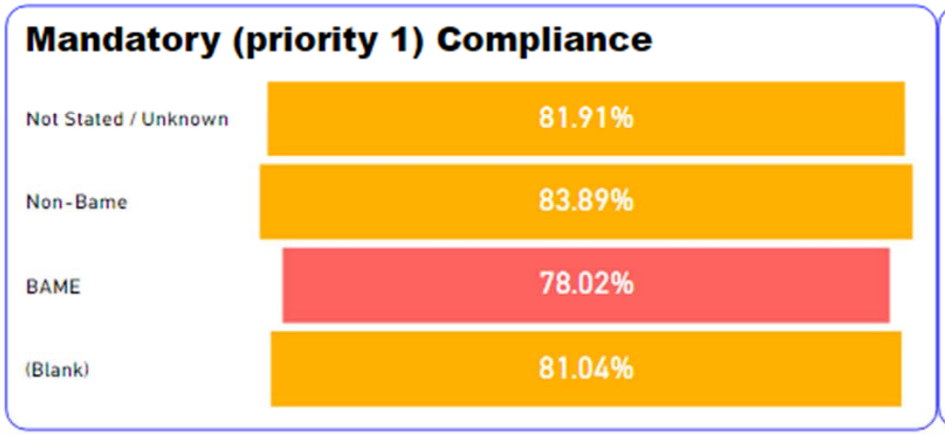
Mandatory Training: overall compliance increased in March to 82.54%.

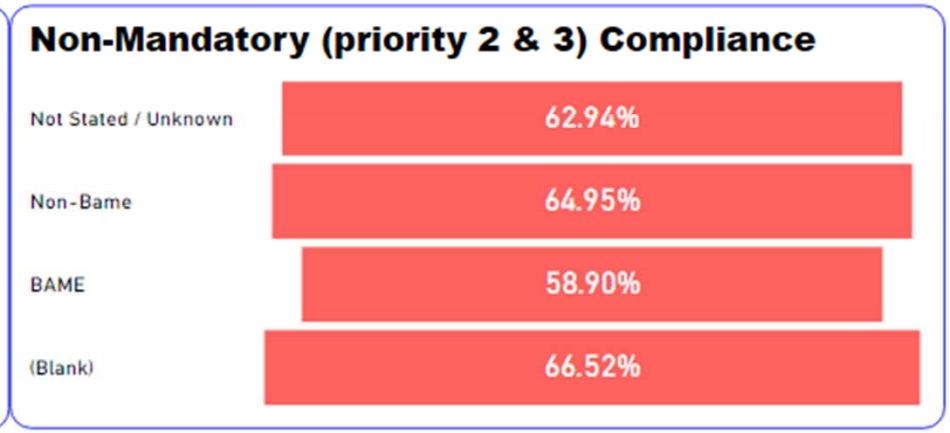
Mandatory training compliance amongst BAME staff was lower than the DGFT average. BAME staff compliance is lower across all staff groups.

Non-mandatory training is also lower within the BAME staff group (59%) compared to the Non-BAME group (65%).

Trust	CS	Corporate	MIC	Surgery
82.54%	84.96%	84.43%	83.46%	80.23%





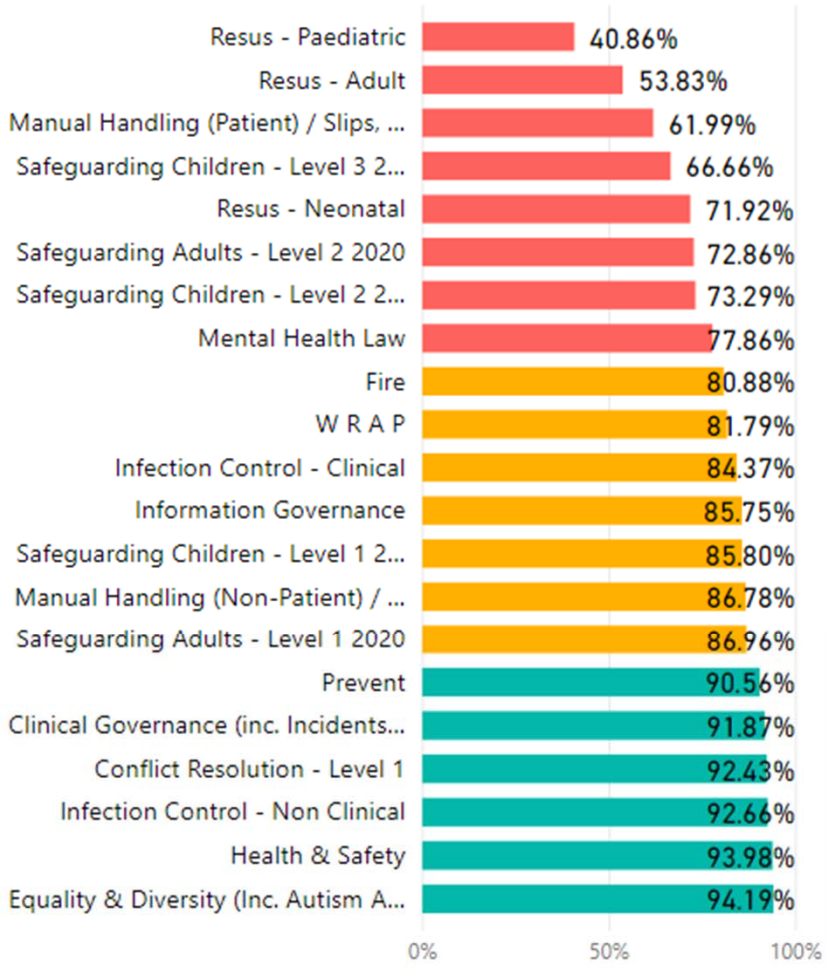


Mandatory Training – Areas of Focus

The priority areas continue to be RESUS and SAFEGUARDING.

The most challenged services are Psychiatry Medics, Medical Staff (Oncology), and General Surgery Medical Staff.

Course Compliance (based on selections)



Ward/Service (based selections)

Group5Description	Actual	No. >90%	%' tage
253 Psychiatry Medics Rechg PCT Serv	5	12	27.77%
253 Medical Staff (Medical Oncology) Serv	13	13	46.42%
253 General Surgery Medical Staff Serv	287	244	48.72%
253 Covid Vaccination Programme Mgt Serv	10	8	50.00%
253 HR Director Serv	21	15	52.50%
253 Medical Staff Renal Serv	87	48	58.00%
253 Medical Director Serv	40	21	59.70%
253 Medical Discharge Ward Serv	23	12	60.52%
253 Operations Management Serv	145	64	62.50%
253 Med Secs Emergency Medicine Serv	19	8	63.33%
253 Mgt Team Clinical Support Div Serv	58	24	63.73%
253 CNS Paediatrics Serv	36	15	64.28%
253 Discharge Co-ordinator Serv	169	67	64.50%
253 Infection Control Serv	80	31	65.04%
253 T&O Medical Staff Serv	325	117	66.19%
253 Trust Capacity Management Serv	118	43	66.29%
253 CNS Colorectal Serv	79	28	66.94%
253 Imaging - Nuclear Medicine Serv	53	19	67.08%
253 Theatres Emergency & Other Serv	471	159	67.28%
253 Medical Staff GP Medicine Serv	66	23	67.34%
253 Theatres Recovery & Anaesth Serv	369	123	67.58%
253 Urology Medical Staff Serv	110	36	67.90%
253 Theatres T&O Serv	233	73	68.73%
253 Paediatric Medical Staff Serv	210	63	69.30%
Total	**54,359**	**4912**	**82.54%**

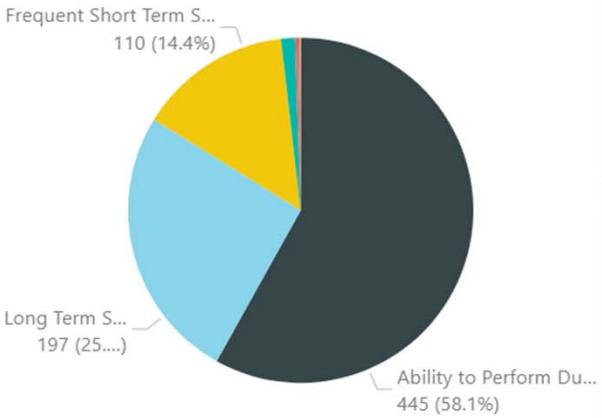
Staff Health & Wellbeing – SHAW Service – Manager Referrals

Referrals received in March increased to 105 over 67 in February.

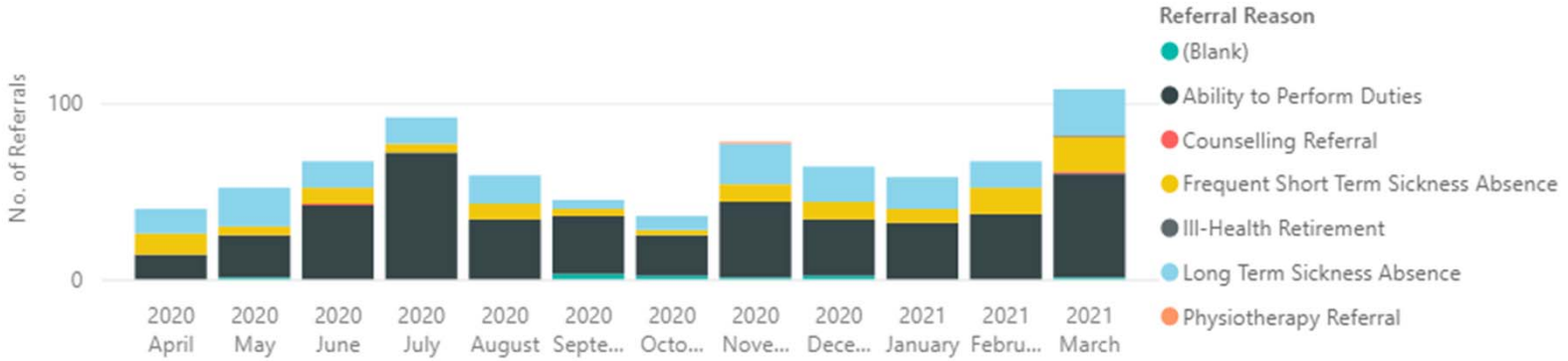
The largest category is 'Ability to perform duties' at 58%.

The average days from referral to appointment was 13 days in March, compared to the target of 15 days.

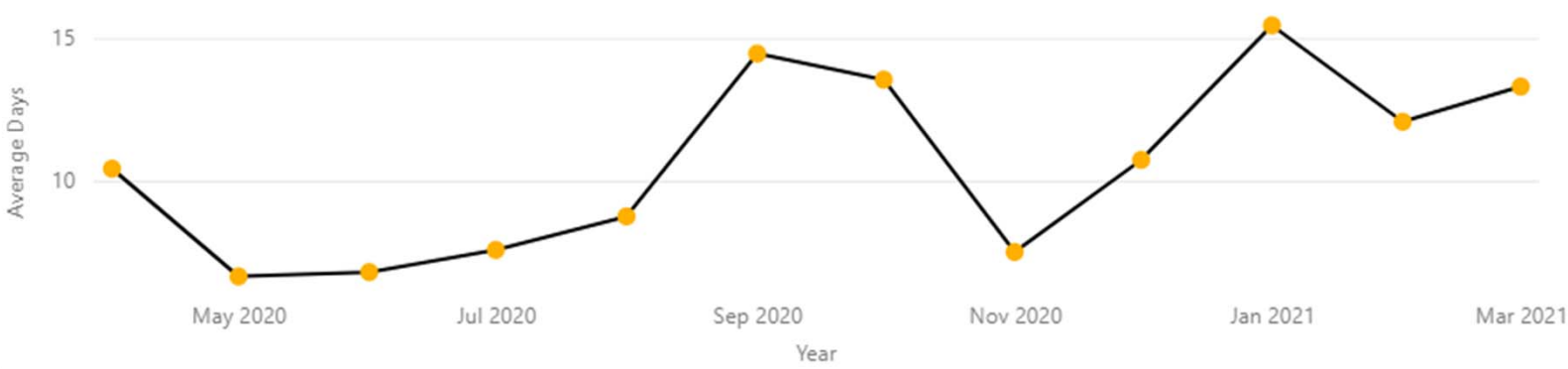
SHAW Referrals by Reason



SHAW Referrals Trended



SHAW - Mean Average Wait (Weekdays. Based on Referral to 1st Appointment Offer)



HR Caseload

The HR caseload (not including suspensions) has 32 live cases, the majority being grievances (13) at 40.6%.

BAME staff represent 40% of active cases.

There are currently suspensions in the trust, 1 x admin and clerical and 1 x HCSW.

The HR dashboard is being developed to include mean and median lead times for case resolution.

Caseload By Type

Caseload by Staff Group

Employee Relations Type	Capability No UHR		Capability UHR		Disciplinary		Further ER Stages - Appeal		Further ER Stages - Ref to Prof Reg Body		Grievance	
Staff Group	Count	%	Count	%	Count	%	Count	%	Count	%	Count	%
Add Prof Scientific and Technic											1	100.0%
Additional Clinical Services			2	28.6%	3	42.9%					2	28.6%
Administrative and Clerical	1	11.1%	1	11.1%	4	44.4%	1	11.1%			2	22.2%
Allied Health Professionals					2	66.7%					1	33.3%
Medical and Dental					1	14.3%			1	14.3%	5	71.4%
Nursing and Midwifery Registered	1	20.0%			2	40.0%					2	40.0%
Total	**2**	**6.3%**	**3**	**9.4%**	**12**	**37.5%**	**1**	**3.1%**	**1**	**3.1%**	**13**	**40.6%**

Caseload by Job Role

Employee Relations Type	Capability No UHR		Capability UHR		Disciplinary		Further ER Stages - Appeal		Further ER Stages - Ref to Prof Reg Body		Grievance	
Ethnicity	Count	%	Count	%	Count	%	Count	%	Count	%	Count	%
A White - British	2	14.3%	2	14.3%	7	50.0%	1	7.1%			2	14.3%
C White - Any other White background											1	100.0%
CA White English					1	100.0%						
H Asian or Asian British - Indian					1	20.0%					4	80.0%
J Asian or Asian British - Pakistani											2	100.0%
M Black or Black British - Caribbean			1	100.0%								
N Black or Black British - African					1	50.0%					1	50.0%
PD Black British					1	50.0%					1	50.0%
PE Black Unspecified					1	100.0%						
Z Not Stated									1	33.3%	2	66.7%
Total	**2**	**6.3%**	**3**	**9.4%**	**12**	**37.5%**	**1**	**3.1%**	**1**	**3.1%**	**13**	**40.6%**