The Dudley Group
NHS Foundation Trust

Board of Directors Meeting Public Papers

Thursday 10th June 2021

12:20 – 16:15

The Dudley Group
NHS Foundation Trust

BOARD MEETINGS
PUBLIC INFORMATION SHEET

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

1. Introduction

This sheet provides some information about how Board meetings work.

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

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

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

Helen Benbow
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The Dudley Group NHS Foundation Trust
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Email: helen.benbow1@nhs.net

Liam Nevin
Board Secretary
The Dudley Group NHS Foundation Trust
Tel: 01384 321114 ext 1114
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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 10 June 2021
By MS Teams

AGENDA

	ITEM	PAPER REF	LEAD	PURPOSE	TIME
17	**Chairmans welcome and note of apologies –**		Y Buckland	For noting	12:20
18	**Declarations of Interest** Standing declaration to be reviewed against agenda items.		Y Buckland	For noting	12:10
19	**Minutes of the previous meeting** Thursday 13 May 2021 Action Sheet 13 May 2021	 Enclosure 13 Enclosure 14	 Y Buckland	 For approval	12:20
20	**Chief Executive's Overview**	Enclosure 15	D Wake	For information & assurance	12:25
21	**Chair's Update**	Verbal	Y Buckland	For information	12:45
22	**Public Questions**	Enclosure 16	Y Buckland	For information	12:55
23	**Ophthalmology Case Study**	Enclosure 17	B Elahi	For discussion	13:00
24	**GOVERNANCE**				
24.1	Audit Committee Exception Report	Enclosure 18	G Crowe	For assurance	13:30
24.2	Acute Collaboration	Enclosure 19	K Sheerin	For assurance	13:40
24.3	Board Assurance Framework	Enclosure 20	L Nevin	For assurance	13:50
25	**QUALITY & SAFETY**				
25.1	Quality and Safety Committee Report	Enclosure 21	E Hughes	For assurance	14:00
25.2	Quality Accounts	Enclosure 22	S Phillips	For decision	14:10
25.3	Chief Nurse Report	Enclosure 23	J Wakeman	For assurance	14:20
25.4	Board Assurance Infection Control Framework	Enclosure 24	J Wakeman	For assurance	14:40
25.5	Maternity and Neonatal Safety and Quality Dashboard	Enclosure 25	D Lewis	For assurance	14:50
25.6	Research and Development Bi- Annual Report	Enclosure 26	J Neilson	For assurance	15:00

25.7	Learning from Deaths	Enclosure 27	J Hobbs	For assurance	15:10
26	**FINANCE & PERFORMANCE**				
26.1	Finance and Performance Committee Report	Enclosure 28	J Hodgkin	For assurance	15:20
26.2	Integrated Performance Dashboard	Enclosure 29	K Kelly	For assurance	15:30
27	**WORKFORCE**				
27.1	Workforce and Staff Engagement Committee Report	Enclosure 30	J Atkins	For assurance	15:50
27.2	Workforce KPIs	Enclosure 31	J Fleet	For assurance	16:00
28	**Any Other Business**	Verbal	All		16:10
29	**Reflection on meeting**	Verbal	All		16:10
33	**Date of next Board of Directors meeting** 15th July 2021				16:15

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

Enclosure 13

Minutes of the Public Board of Directors meeting held on Thursday 13th May 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)
James Fleet Chief People Officer (JF)
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)
Julian Hobbs Medical Director (JHO)
Gurjit Bhogal (GB) (Associate Non-Executive Director)
Thuvarahan Amuthalingham (TA) (Associate Non-Executive Director)

In Attendance:

Liam Nevin, Trust Secretary (LN)
Liz Abbiss (LA)

21/056 Note of Apologies and Welcome

The Chair opened the meeting, noted the celebration of Eid al-Fitr, and welcomed members of the public, and the governors identified below, to the meeting:

Governors

Helen Ashby, public elected Stourbridge

Public

Harry Friesner, foundation trust member

Ian Francombe, IPSEN

Jamie Brassington, Express & Star

There were no apologies.

The Chair introduced and welcomed Gurjit Bhogal and Thuvarahan Amuthalingham to their first Board meeting.

21/057 Declarations of Interest

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

21/058 Minutes of the previous meeting held on 15th April 2021

It was **RESOLVED**

- **That the minutes of the meeting of the 15th April 2021 be agreed as a true and accurate record of the meeting.**

The Action log was noted.

21/059 Public Chief Executive Overview Report

DW introduced her report and advised that the number of patients with COVID-19 continued to improve with 9 in-patients currently. There had been 3135 patients since the pandemic began and 2098 since 1st September, with 755 deaths.

Sickness absence in the Trust was also improving and had reduced to 4.3% of the workforce.

In response to a question from Jamie Brasington concerning the Indian variant of COVID-19 DW advised that the Trust would take the same measures that it had used throughout the pandemic which would be focussed on good infection prevention and control.

The Board were advised that the Trust was on track to achieve all Restoration and Recovery targets by March 2022 and that all providers locally and nationally would draw on mutual aid to address backlogs in treatment.

The Trust was benchmarking well on performance and progress against cancer targets was particularly positive. Challenges remained with diagnostics and the local NHS system was looking at shared capacity to make optimum use of facilities.

Congratulations were given to the April Healthcare Heroes Jane Barnes and Graham Tibbetts. Further awards would be given at the forthcoming Committed to Excellence presentations which would celebrate examples of excellent performance by staff.

GC queried staff uptake of vaccinations and DW confirmed that this was currently approximately 80%, and conversations were continuing with staff to encourage further uptake.

It was **RESOLVED**

- **That the report be noted**

21/060 Chair's Public Update

The Chair reminded the Board that International Nurses Day was held on the 13th May, which was an opportune moment to remind the public of the outstanding work done by nursing staff.

The meeting was advised that Ted Baker, the Chief Executive of the CQC would be visiting the Trust later in the month and he would be shown improvements that the Trust had made around the Sepsis pathway, as well as visiting other areas of the hospital.

Briefings for NHS Chairs from the centre had indicated the continuing importance of Restoration and Recovery and the Board were advised that there was an impressive case study on the agenda that would follow.

21/061 Public Questions

It was noted that these were addressed by DW in her update and there were no supplementary questions from members of the pubic in attendance.

21/062 Case Study – Trauma and Orthopaedics

The Chair welcomed Jack Richards, Claire Sylvester and Carol Shaw to the meeting and they proceeded to deliver a presentation on the fracture neck of femur- hip pathway, from initial treatment in ED through to post surgery recovery.

The Chair thanked the team for the insight provided by the presentation and the evident commitment to patient care demonstrated by the team.

GB asked whether there was any data on patient admissions outside of scheduled hours and whilst this data was not to hand the team confirmed that demand tended to peak in the afternoon, but some evening admissions were dealt with.

JHO stated that the data would be extracted from Sunrise and the answer would be emailed to Board members. He added that outcomes for femur fractures were good and a significant reason for this was the enthusiasm and commitment to patient care demonstrated by the team.

The Chair suggested that there was an opportunity for the Trust to lead on Orthopeadics and JHO agreed and advised that the Trust had launched the Midlands Orthopaedic Centre, had recruited well and had short waiting lists. A good service was provided.

21/063 GOVERNANCE

21/063.1 Board Effectiveness Review

LN summarised the report and the areas for further consideration identified. In particular the need for a stronger focus on Board development and strategy was apparent and the number and frequency of formal business meetings was not conducive to this.

GC stated that the report was thorough and he agreed that there was a need to free up time to ensure that the Board could undertake development work and provide an additional focus on strategy. He supported a reduction in formal Board meetings to achieve that.

The Chair stated that the Board schedule of meetings would be reviewed to facilitate this and reporting arrangements for Committees would also be reviewed to reflect these changes.

It was **RESOLVED**

- **That the frequency of Board meetings be reviewed to address the matters referred to in the preamble to this minute**

21/064 QUALITY AND SAFETY

21/064.1 Quality and Safety Committee Report

LH summarised the exception report before the Board and invited MS to summarise the actions taken in relation to the Klebsiella outbreak. MS summarised the steps taken to strengthen infection control arising from this outbreak and advised the Board that this was the first such outbreak in 2.5 years and came at a time of extraordinary pressure as a result of the pandemic.

CH asked how front- line staff had been engaged in the review, noting that the reasons for the outbreak were the result of procedural and behavioural issues. MS advised that a review of practices in the Critical Care team had been carried out and all team members had been involved in this.

It was **RESOLVED**

- **That the report be noted.**

21/064.2 Annual Safeguarding Report

MS summarised the report and advised that it demonstrated how the Trust was meeting its obligations in respect of safeguarding. It was notable that there had been a significant rise in cases, both adult and children, but also a rise in the number of cases of young people with mental health and substance related issues. The Trust was working closely with partners on these cases.

The Chair commended the report and the team for their hard work. It was agreed that representatives of the team be invited to attend the Board to discuss their work and in particular in relation to learning disability

It was **RESOLVED**

- **That the Annual Safeguarding Report be approved**

21/064.3 Chief Nurse Report

MS summarised the report. There was a continuing focus on falls prevention with reviews being undertaken in specific service areas.

CQC engagement continued during April and an engagement meeting had been held in relation to FTSU for which formal feedback was awaited.

GG stated that the pathway development work and innovations in relation to the pharmacy technicians set out in the report were welcome and he questioned the progress being made on nursing recruitment and retention. MS advised that there had been intensive work on this since January and recruitment of support workers for nursing staff had been successful. Attrition rates for nursing staff were relatively low but recruitment of registered nurses

remained a challenge which reflected the national picture. Staff were continuing to work closely with student placements to encourage them to take up substantive positions following training, and the international recruitment programme was now also underway.

JF advised that the vacancy factor was now 9% overall and there had been a reduction of 64 vacancies since February.

It was **RESOLVED**

- **That the report be noted**

21/064.4 Board Assurance Infection Control Framework

MS advised that there had been no patient COVID related outbreaks since March, and one outbreak with a PFI partner which had no impact on patients or the clinical setting. Mandatory training was now on an upward trajectory and there were no outstanding “red” rated areas on the framework.

It was **RESOLVED**

- **That the report be noted**

21/064.5 Maternity and Neonatal Safety and Quality Dashboard (including CNST Update)

MS reported that there was good progress with no still births or neo natal deaths in April and no serious incidents in maternity units. A lot of work was being done on the Maternity Transformation Plan and the Continuity of Care Team was focussing on communities with the highest level of deprivation. There was a target of 35% for this indicator and performance was currently at 25%. Safety walkabouts by LH and MS continued

VR noted the good progress on CNST standards and questioned whether the Trust had accessed additional funding available from the Ockenden review. MS advised that a bid had been submitted on the 6th May and a decision was expected shortly.

It was **RESOLVED**

- **That the report be noted**

21/065 FINANCE AND PERFORMANCE

21/065.1 Finance and Performance Committee Report

JH summarised the Committee exception report. The Board discussed the investment in the recruitment of international nurses and JHO advised that it would be necessary over the year to assess whether the programme was value for money. It was agreed that the retention rate for this programme should be tracked separately to the rest of the workforce.

It was **RESOLVED**

- **That the report be noted.**

21/065.2 Integrated Performance Report

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

- Cancer performance was good and RTT was outperforming initial trajectories for recovery
- ED performance was the fifth highest in the Midlands. A recent ESIS review had provided good feedback including recommendations on streaming into alternative pathways

The Chair asked whether the Trust had seen an increase in complaints in respect of cancer patients and KK advised that there was no rise in complaints in this area. The assessment process for all 104 day waits included ringing all patients and this process had evidenced that there was no significant harm caused to patients by delays.

The Chair further asked whether the Executive were considering the use of diagnostics through primary care given the extraordinary pressures on hospitals. JHO advised that there was under provision across the black- country but this option was being explored in addition to blood tests closer to home.

KK advised that in relation to Restoration and Recovery diagnostic services and day cases were ahead of plan. Elective recovery was on track.

JA asked for clarification of the position with staffing and use of theatres and the impact this was having on elective surgery. KK advised that there had been issues with staffing in critical care and theatres and these were closely related. Work had been undertaken to increase recruitment and improve succession planning and theatres had been opened in a staged way.

The Chair questioned whether theatre usage was efficient and KK advised that whilst improvements on start times were necessary there had been an increase in lists during the early stages of restoration.

GB asked whether the increasing use of digital technology could increase inequality in access to services and KK advised that work was undertaken with religious institutions and with Public Health in relation to improving access for those without internet facilities.

It was **RESOLVED**

- **That the report be noted**

21/066 WORKFORCE

21/066.1 Workforce and Staff Engagement Committee Report
JA summarised the exception report which was noted and accepted by the Board

It was **RESOLVED**

- **That the report be noted**

21/066.2 Workforce KPI Report

The Workforce KPIs were noted.

21/067 Any Other Business

There was no other business

21/068 Reflections on Meeting

It was agreed that there had been inclusive and informative discussions. The presentation was well received and the Board expressed an interest in hearing from more front line teams.

Date for the Next Meeting - 10 June 2021

Signed ……

Date …….....

Enclosure 14

The Dudley Group NHS Foundation Trust

Action Sheet
Minutes of the Board of Directors (Public Session)
Held on 13 May 2021

Item No	Subject	Action	Responsible	Due Date	Comments
21/062	Presentation Hip Fracture Pathway	Outcome data for femur fractures to be circulated to Board	JHO	1.6.21	Circulated 2nd June.

Enclosure 15

The Dudley Group NHS Foundation Trust

Paper for submission to the Board of Directors on 10th June 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
- Committed to Excellence
- Patient Feedback
- Event with Local Third Sector Groups
- Update from Healthwatch Dudley
- Prof. Ted Baker Visit
- Dudley Partnership Board
- 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 – 10th June 2021

Coronavirus

In response to an increase in new variants within the Dudley borough, we are asking everyone to do their bit to stay vigilant. The single most important thing people can do is take up both doses of the vaccine when it is offered and to keep their close contacts with people as low as possible. If meeting up with people inside homes, they should open windows and doors for good ventilation. People are also advised to carry out regular symptom-free testing, wear a face covering as much as possible and wash hands regularly.

Committed to Excellence

We were very pleased to be able hold our staff awards, Committed to Excellence, on 19th May 2021. This year the event was virtual with the awards presentation pre-recorded and streamed 'as live' during the event.

The awards are our way of saying a huge thank you to our clinical and non-clinical staff, and staff in our partner organisations, who continued to strive for excellence in an extremely challenging year. To reflect the extraordinary year, we presented a number of special awards that highlighted their efforts during COVID.

We were also extremely delighted to present two awards to external organisations who supported us during this pandemic. Special guests included Suzanne Webb MP and then Cllr David Stanley.

Patient Feedback

ED: The staff where excellent and courteous, they reassured me and explained everything. We have truly got the best NHS service, I really do appreciate them and take my hat off to them all, our doctors and nurses all deserve a medal.

Dermatology (Corbett): Well organised, warm staff who were very thorough, clear and reassuring.

C1: I was treated with respect and dignity by the fantastic staff.

DRS (Rehab pathway): Delighted with the care I received from everyone that I had dealings with. They could not have been kinder.

C4 (Day case): Always polite and caring.

Maternity: The midwifes were very caring and listened to my needs.

Ward B6: I got new crutches, the treatment I needed and the staff were super. The care I received was excellent and so good I would book in for a holiday.

GUM: Every precaution taken for COVID-19. All staff polite and I was given duty of care and confidentiality.

Children's Outpatients: Everything was excellent, Staff were friendly and clear.

Community Heart Failure: Very efficient and supportive, also listened to what patient had to say.

C4 (Georgina): The whole team was so helpful and amazing.

AMU - Everything was excellent. Everyone was so nice and gentle. I'm very happy with the experience.

GI unit - Very good and friendly staff making you feel at ease and comfortable throughout.

Event with Local Third Sector Groups

I was delighted to lead an event with Health Watch Dudley and Dudley CVS which brought together more than 20 local community organisations with Trust clinicians to explore how we can work together better to improve services for patients. The event had three themes – cancer services, children's services and improving discharge arrangements for patients, and there were lots of ideas exchanged. This is the second joint event we have held with Health Watch and Dudley CVS who have been great partners in supporting how we can connect better with local people and groups. The three organisations have committed to continue this work and to build and deepen relationships through these conversations. The next event will be particularly focused on groups who can help us connect better with people facing inequalities.

Update from Healthwatch Dudley

Jayne Emery, Chief Officer of Health Watch Dudley, is leaving the service to become a Practice Manager in a local practice. Jayne will be a great loss to Health Watch – she has been a great partner for The Dudley Group over many years and has consistently championed the voice of people and patients. I am sad to see her leave but very pleased that she will continue to have significant role in the health system in Dudley. We wish her every success in her new role.

Prof. Ted Baker Visit

Professor Ted Baker, Chief Inspector of Hospitals for the Care Quality Commission, visited the organisation on 27th May. Professor Baker was accompanied by Fiona Allinson, Interim Deputy Chief Inspector and Sarah Dunnett, Lead Inspector Manager for the Region.

Professor Baker and his colleagues spent some time with the Executive team and then visited a number of our services including the Emergency Department, Ward C5, Emergency Surgical Hub as well as the Undergraduate Centre and the SIM lab. In each of the services and teams visited time was spent with front line clinical staff exploring their experiences over the last year relating to the covid pandemic and focusing on the improvements made to the quality and safety of the services and the impact on patient and staff experiences.

Dudley Partnership Board

I have recently taken over as Chair of the Dudley Partnership Board. This has been in place for a number of years now, bringing together health providers, commissioners, the local authority, Health Watch and Dudley CVS to work on improving health and care for the people of the Borough. Over recent months, the Partnership Board has been working through a development programme to refresh its direction in light of the forthcoming changes to the NHS described in the White Paper 'Integration and Innovation: working together to improve health and social care for all'. This development programme has offered time to consider the priorities for action, with an initial focus on services for children to explore the Partnership Board's role.

The Partnership Board is working through how it takes on the additional responsibilities expected of an Integrated Care Partnership, including having a clear approach to Population Health Management and potentially holding delegated budgets in the future. A workshop to explore and confirm our approach is planned for July 2021.

A full report on progress and key issues will be brought back to the Board in August 2021.

Visits and Events

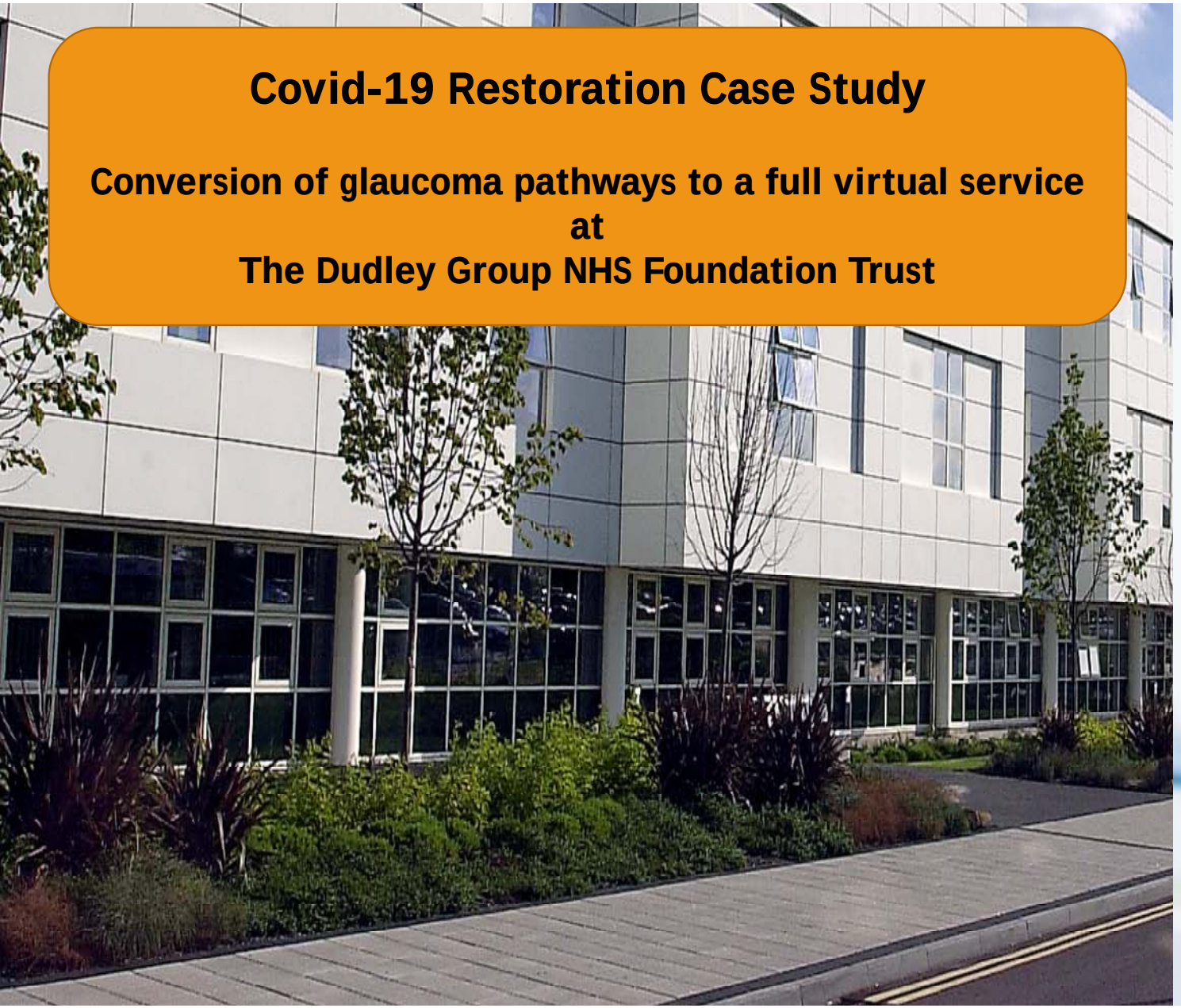
14th May 2021	**Midlands Elective Delivery Programme / Regional Learning Event**
14th May 2021	**Black Country and West Birmingham Quarterly STP SRM**
17th May 2021	**Trust Management Team**
17th May 2021	**Team Brief**
17th May 2021	**STP Cancer Board**
19th May 2021	**Committed to Excellence**
20th May 2021	**Acute Collaboration Programme Board**
21st May 2021	**Live Chat**

24th May 2021	**Adoption of ReSPECT in Dudley (Presentation by Clinical Lead/RCUK).**
24th May 2021	**Vital Signs Transformation Guiding Board**
26th May 2021	**Provider Collaboratives: New Ways of Working with Sir David Dalton**
26th May 2021	**Live Chat**
26th May 2021	**BCWB Elective Diagnostic Strategic Board**
27th May 2021	**Healthier Futures Partnership Board**
8th June 2021	**Leading Inclusively with Cultural Intelligence Workshop**

Enclosure 17

Covid-19 Restoration Case Study

Conversion of glaucoma pathways to a full virtual service at The Dudley Group NHS Foundation Trust



ITV News Report on Dudley Ophthalmic Hub

Ophthalmology Challenges

- Ophthalmology referrals to hospital eye services rose just over 12% from 2013/14 to 2017/18 and now account for just over 8% of outpatient appointments (NHS Digital, 2017).
- Ophthalmology is the busiest outpatient specialty in the NHS, and the vast majority of patients are treated in the outpatient department.
- Clinical prioritisation should be on a subspecialty basis to preserve sight in the highest risk groups.

How we responded to this challenge at RHH

Virtual Glaucoma Facility (Ophthalmic Diagnostic HUB) at Corbett Hospital

Summary

- Increase in value-adding, virtual appointments for glaucoma service
- Reduction in patients waiting follow up appointments with clinicians
- Reduction in patient attendances on acute site (Potential COVID free environment)
- Diagnostics Hub set up at off-site, outpatients centre to aid ‘one-stop’ shop for tests, reducing frequency of appointments
- Reduced on-the-day waiting times for patients

Pre-COVID Situation

- Pre-Covid pathways for glaucoma patients involved multiple face to face attendances, combined with visits that were lengthy in duration
- Glaucoma patients need to be followed up on frequent basis, requiring many hospital attendances per year
- Patients would attend for diagnostic tests such as vision, fields, pressure checks, for example
- Following these tests, they were required to wait to see a consultant for a face to face appointment
- During the clinician appointment, physical examinations would occur
- Large backlogs of patients overdue their follow up appointments were common place

Our Response

- As the pandemic hit, last year, the glaucoma team revised their pathways.
- Reasons for adapting these pathways for this cohort of patients were several fold:
- To ensure that patients still received potentially sight saving reviews
- To ensure that appointments were value-adding and meaningful

Improve the patient experience in the long term and post pandemic

- Reducing the number of face to face attendances
- Reducing the length of time a patient is required to be on site
- Increase the clinic throughput
- Offering additional appointments
- Shorter waits for patients

Virtual Glaucoma Clinic at Corbett Hospital

Detailed history taking

All visits recorded on EPR - Medisight

Eye Pressure Checked

Visual Fields

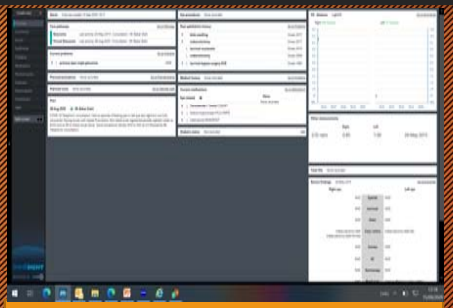
Optic Nerve scans

3D image of Optic Nerve

Virtual Glaucoma Clinic at Corbett Hospital

- Patient attends our off-site diagnostics hub, where they will undergo all diagnostics tests requested by their consultant including 3D imaging of the eye, OCT of the Optic Nerve and anterior segment of the eye and automated Visual fields testing.
- Diagnostic test results are uploaded to the new electronic MediSight system, rather than purely being written in physical notes
- Consultants will conduct a virtual review with the patient utilising the diagnostic data stored on MediSight
- This pathway makes use of a newly purchased 3D camera that takes improved images of the eye. Previous to the use of the 3D camera, physical examination of the eye was required by the clinician

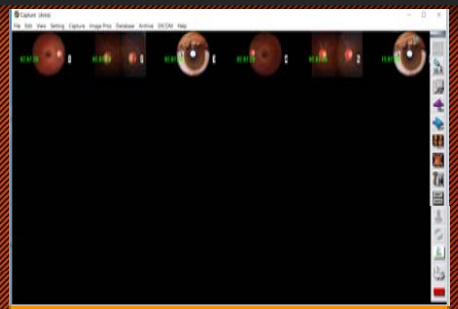
Virtual Glaucoma Clinic at Corbett Hospital



EPR - Medisight

Zeiss Forum
Visual Fields and Scan

Telephonic
Consultation



Kowa 3D Images

bigHand
Get more done

Big Hand –
Communication to GPs
and patients

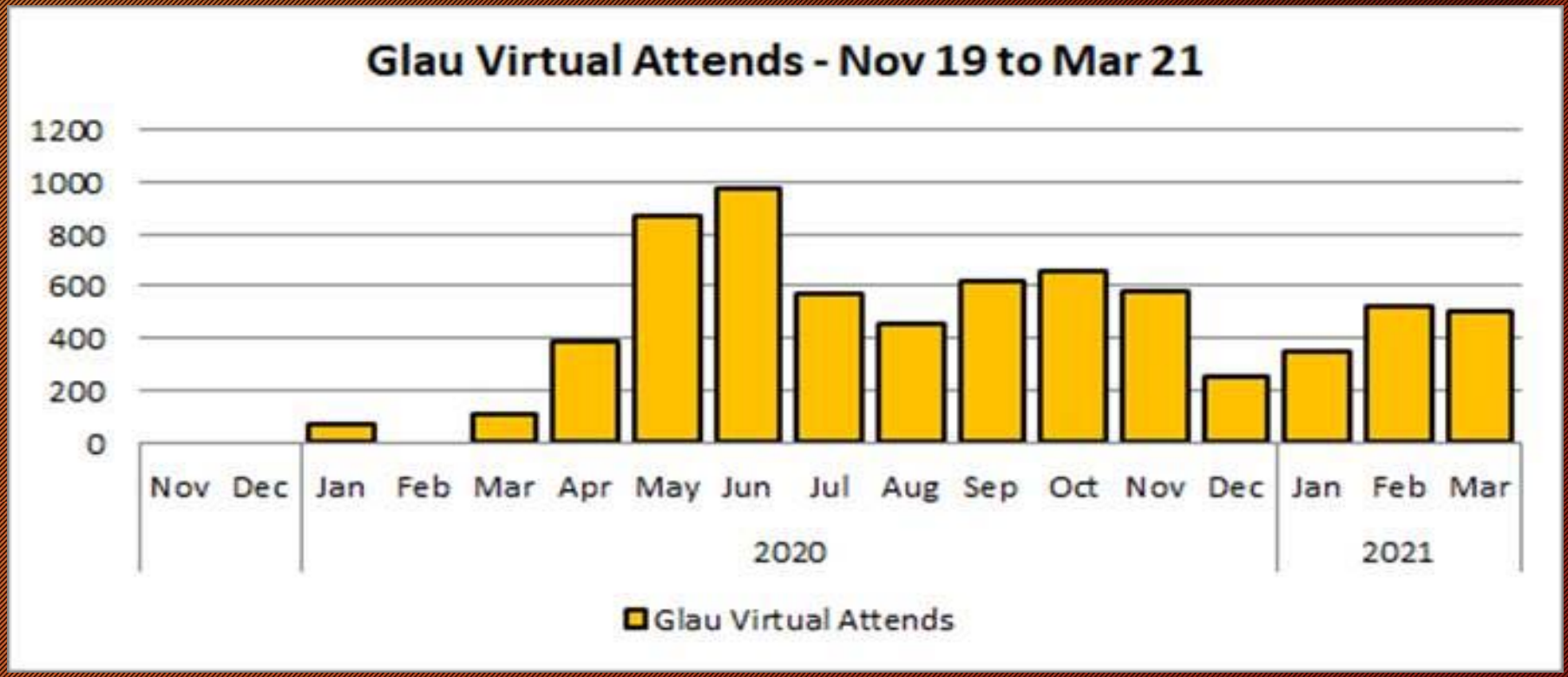
Benefits of this new pathway

- Patients do not have to attend a busy acute site that was at the heart of the covid response, but instead attend an offsite, non-acute outpatients centre for all diagnostics
- All required diagnostics are taken in one attendance
- Patients do not need to attend the hospital for their review with the consultant. This now takes place by telephone or video consultation
- Appointment times are shorter given the use of the 3D camera, which benefits the patient and also allows for greater number of appointments in a single clinic, thereby reducing the follow up backlog for consultant appointments

Benefits of this new pathway

- The time patients are required to be on site is reduced – average time for diagnostics is less than 30 minutes.
- Previously diagnostics took longer, plus waiting time to see the clinician, plus a longer time in the consultation (use of the 3D camera supports clinician decision making that previously would have been conducted by the clinician and physical examination)
- Reduction in patients waiting for a consultant appointment
- The chart below shows the increase in the number of virtual glaucoma appointments since the start of the pandemic.

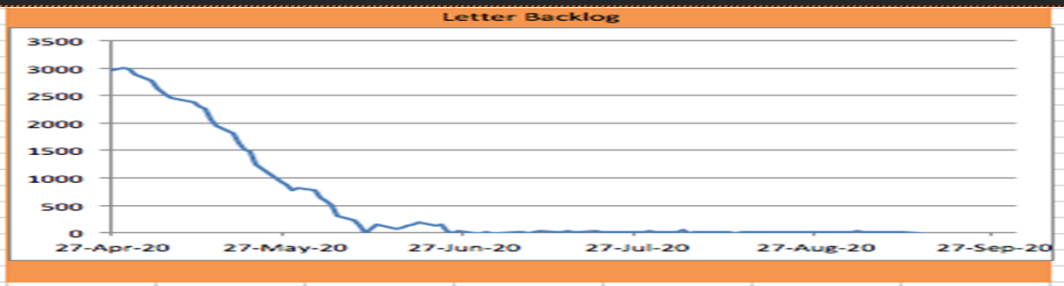
Dudley Ophthalmic Diagnostic HUB

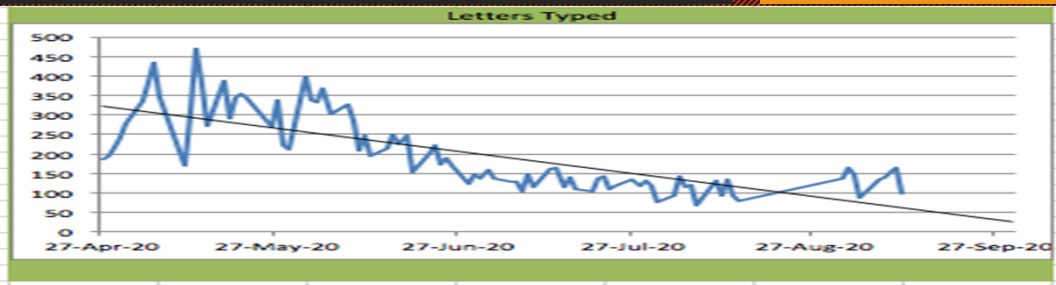


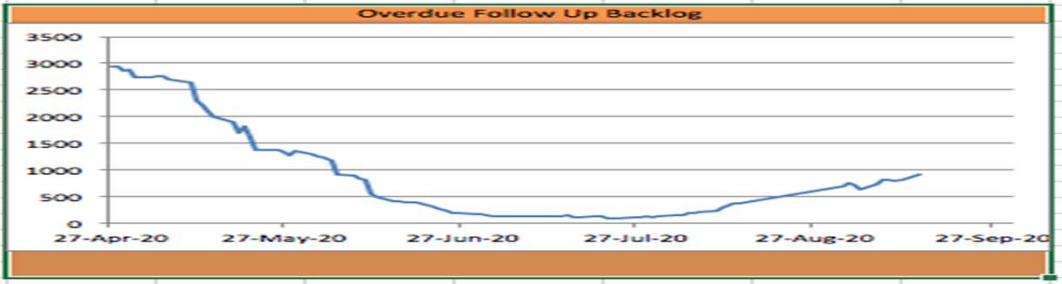
Dudley Ophthalmic Diagnostic HUB

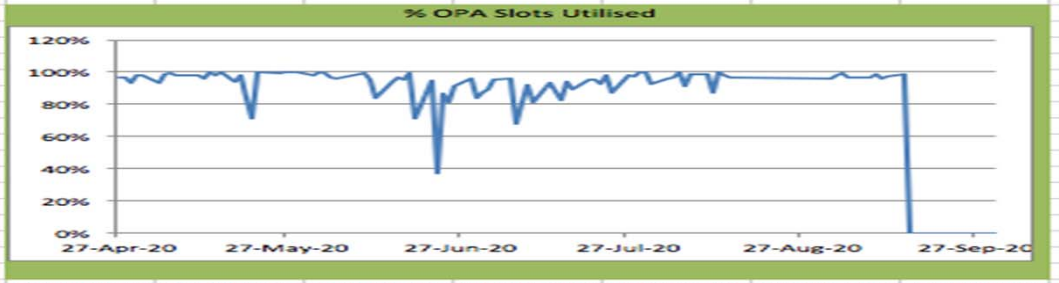
- The new pathway generated a greater number of appointment slots compared to the tradition pathway
- Therefore, greater throughput of patients was enabled and patients who were overdue a follow up appointment were brought forward
- As theatre lists were suspended, additional virtual clinics were conducted in this job planned time, providing an increase in appointment slots
- The department is now seeing circa 400-600 attendances per month (both diagnostics and clinician appointments)

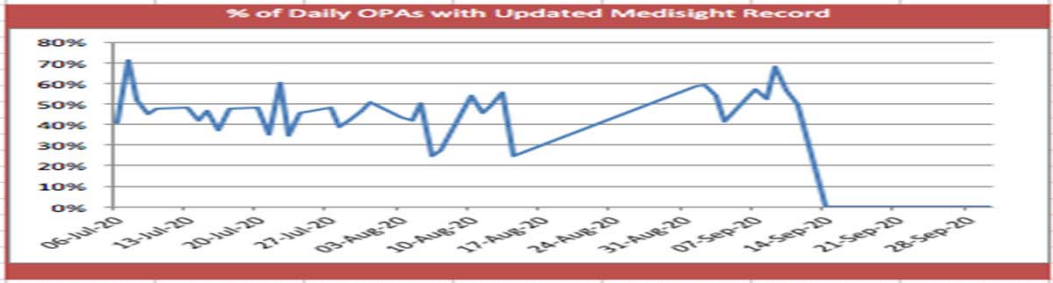
The COVID-19 pandemic has redefined the future delivery of Ophthalmology











Thank you to the Ophthalmology Team and the Division Management Team for this achievement

Enclosure 18

The Dudley Group NHS Foundation Trust

Paper for submission to the Private Board of Directors on 10 June 2021

TITLE:	**Audit Committee Meeting – 20 May 2021**		
AUTHOR:	Liam Nevin Trust Secretary	**PRESENTER**	Gary Crowe Audit 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:

To note the issues discussed at the Audit Committee on 20 May 2021.

CORPORATE OBJECTIVE:

SO3: Drive service improvements, innovation and transformation
SO5: Make the best use of what we have
SO6: Deliver a viable future

SUMMARY OF KEY ISSUES:

Good assurance received in matters discussed, with no areas of concern requiring escalation.

IMPLICATIONS OF PAPER:

IMPLICATIONS FOR THE CORPORATE RISK REGISTER OR BOARD ASSURANCE FRAMEWORK

RISK	**N**		**Risk Description:**
	Risk Register: N		**Risk Score:**
COMPLIANCE and/or LEGAL REQUIREMENTS	**CQC**	**Y**	**Details:** Well Led
	NHSI	**N**	**Details:**
	Other	**Y**	**Details:** Good Governance
REPORT DESTINATION	**EXECUTIVE DIRECTORS**	**N**	**DATE:**
	WORKING GROUP	**N**	**DATE:**
	BOARD OF DIRECTORS	**Y**	**DATE:** 10 June 2021

The Dudley Group NHS Foundation Trust

UPWARD REPORT FROM AUDIT COMMITTEE

Date Committee last met: 20 May 2021

MATTERS OF CONCERN OR KEY RISKS TO ESCALATE • None	**MAJOR ACTIONS COMMISSIONED/WORK UNDERWAY** • Trust Annual Report 2020/21 in draft format and work taking place with External Audit to finalise • External audit of the Trust's financial accounts is underway and is expected to be completed on time • Action plan in place to improve GDPR compliance
POSITIVE ASSURANCES TO PROVIDE • Good progress with clinical effectiveness audits • Positive progress made for consultant job planning • Completion of 2020/21 Internal Audit Plan • Positive Head of Internal Audit Opinion given for 2020/21 • Good progress made in taking forward and closing down Internal Audit management actiona with currently none overdue • Assurance received that there was a strong anti-fraud culture in place across the Trust • Losses and special payments were within acceptable levels and assurance that processes are in place to capture loss	**DECISIONS MADE** • Recommended approval of the NHS Provider License Self-Certification Declaration to Board of Directors and Council of Governors • Approved the Local Counter Fraud Specialist 2020/21 Annual Report • Approved the Audit Committee Annual Report subject to update in relation to internal and external audit opinions
Chair's comments on the effectiveness of the meeting: good areas of assurance received with no areas of concern requiring escalation	

Enclosure 19

The Dudley Group NHS Foundation Trust

Paper for submission to the Board of Directors on 10 June 2021

TITLE:	**Update from the Black Country and West Birmingham Acute Provider Collaboration Programme**		
AUTHOR:	**Katherine Sheerin**	**PRESENTER**	**Katherine Sheerin**

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

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

RECOMMENDATIONS

The Board is asked to note the key issues discussed at the Acute Provider Collaboration Programme Boards held on 18th March, 22nd April and 20th May 2021.

CORPORATE OBJECTIVE:

SO1, SO2, SO3, SO4, SO5, SO6

SUMMARY OF KEY ISSUES:

This paper provides an update on the progress of the programme. It highlights the key governance documents which have been previously approved by the Board in private session, and outlines the key issues discussed at the provide Programme Boards which have taken place in March, April and May 2021.

IMPLICATIONS OF PAPER:

IMPLICATIONS FOR THE CORPORATE RISK REGISTER OR BOARD ASSURANCE FRAMEWORK

RISK	**Y**	**Risk Description:** **BAF 6a: Deliver a viable future**

	BAF: Y		**Risk Score: 16**
COMPLIANCE and/or LEGAL REQUIREMENTS	**CQC**	**Y**	**Details: Safe, Effective, Caring, Responsive, Well Led**
	NHSI	**Y**	**Details:** Correspondence from NHSEI; direction of travel set out in NHSEI guidance 'Integrating Care in England' (Dec 2020); White Paper 'Working Together to Improve Health and Social Care for All'
	Other	**N**	**Details:**
REPORT DESTINATION	**Board of directors**	**Y**	**DATE: [INSERT DATE] 2021**
	WORKING GROUP	**N**	**DATE: Acute Provider Collaboration Programme Board 20th May 2021**
	COMMITTEE	**N**	**DATE:**

The Dudley Group
NHS Foundation Trust

ACUTE PROVIDER COLLABORATION PROGRAMME

UPDATE TO THE BOARD

10TH JUNE 2021

1. PURPOSE

The purpose of this paper is to provide an update to the Board on the Acute Provider Collaboration Programme and note the key governance documents which have been approved in private board sessions (see below).

2. BACKGROUND

This is an update on the progress of the Acute Provider Collaboration since the previous report to the Board in February 2021. At that time there was some uncertainty relating to potential organisational form changes to deliver acute collaboration across the Black Country and West Birmingham. As previously reported, the consensus across all four acute provider Trusts in the region was to establish a clinically led programme which focuses on services where quality and outcomes can be improved with no imminent change in organisational leadership arrangements. This has now been accepted as the most appropriate route to realising the benefits of collaboration.

Work on programme started after a request from NHSEI that the four acute providers in the Black Country work together on a plan for collaboration. Each trust Board agreed to the establishment of a clinical driven change programme (Dec 2020).

During January and February 2021, Directors of Strategy at the four Trusts began the work to establish the programme, including revising the case for change, scoping out Terms of Reference for the programme board and outlining the programme. A meeting was held with Trust Chairs and Chief Executives to share this output in order to ensure on-going alignment across organisations in advance of the first meeting of the programme board.

Since then, the Acute Provider Collaboration Programme Board has met on three occasions, most recently 20th May 2021, attended by the Chairs and CEOs of each Trust, Directors of Strategy and other leads.

The meetings have been positive and action focused, with good debate and commitment to moving the programme forward successfully.

3. KEY ISSUES AND DECISIONS TAKEN AT THE FIRST PROGRAMME BOARD MEETINGS (MARCH AND APRIL 2021)

The Programme Board recommended the following governance documents for approval by each Board, and these have been approved in private session whilst purdah was in place:

a. Programme Board Terms of Reference

b. The Case for Change.

The Programme Board also considered the following documents:

c. The high-level timeline. An additional workstream was added to the programme in May 2021, Digital, Data and Technology the timeline for which is not yet complete. The workstream leads have prepared and shared overview documents that summarise the objectives and desired outcomes from their work.

d. The approach to developing the intelligence to support decision making which was agreed.

e. A proposal for significant clinical engagement to commence in Quarter 2 with a series of full day events to bring clinical leaders together from across the 4 trusts. They will review the intelligence gathered and agree priorities areas for collaborative models.

f. A risk register highlighting the current risk profile was agreed.

g. The Programme Board also agreed to focus on the following 'quick wins':

- Progression of a Urology Network
- Formalisation of critical care support arrangements established to deal with impact of Covid-19
- Alignment of waiting list initiative payment rates
- Repatriation of vascular services
- Acceleration of staff passporting
- Development of back office synergies, and
- Commitment to share consistent performance dashboards

4. PROGRESS AT THE LATEST PROGRAMME BOARD – 20TH MAY 2021

The programme's focus on two delivery workstreams – clinical projects and back office efficiency - together with the structure of the six enabling workstreams, which now includes a Digital, Data and Technology stream.
The Programme Board reviewed and noted the progress made by each workstream, including:

- The **resource requirements** for the programme. An initial estimate of resources required to deliver the programme has been prepared. This indicates resources totalling £2.8m per annum for the first 2 years will be required, the majority of which will come from existing

Trust resources. Discussions are on-going with the ICS / CCG regarding how existing staff are utilised and what further resources will be available as they transition to support the new NHS architecture. The CCG has committed £600k non-recurrently for 21/22.

- Scheduling and agreeing an agenda for the first of a series of **clinical engagement events** which will ensure clinical ownership of the plans that emerge to improve outcomes in the region through collaboration;
- The approach to refreshing **Model Hospital data** to understand the latest performance of the Trusts' back office and the engagement process needed to explore quality focused back office efficiency improvement;
- Understanding the approach to **information gathering** to provide the programme with robust data to drive decision making;
- Setting out the approach to **Communication and Engagement**;
- Understanding areas of potential collaboration to improve the **flexibility of staff movement** between providers;
- Establishing a **digital, data and technology workstream** to assess and implement the necessary changes that will enable the effective collaborative services, and
- Agreeing to **review the quick wins** previously agreed to confirm that they remain appropriate.

6. NEXT STEPS

Programme Board meetings will be held monthly, in the 3rd week of the month in order that issues and decisions can then be taken to Boards early the following month.

Key actions for the next month include:-

- Finalise the programme for the first clinical engagement event on 29th June 2021 and ensure appropriate representation from each specialty / trust
- Ensure back-up plan for virtual event is in place
- Begin active communications with all staff across the four organisations regarding the programme
- Take forward the sustainability reviews of each service

5. RISKS AND MITIGATIONS

As noted above, a risk register for the programme was shared at the programme board.

The only 'red' risk (16) on the programme risk register relates to programme resourcing. The CCG has recently committed £600k non-recurrent funding to support the programme in 21/22. Directors of Strategy are preparing a spending plan for this, and will advise the Board on whether this will reduce the likelihood of this risk materialising in the short term.

In relation to DGFT's strategic risks, this programme is a key part of addressing the Trust's strategic risk 6A – 'Failure of the Trust to influence the local and wider evolving health economy due to a lack of engagement and poor performance undermining our credibility means our clinical and financial viability is undermined as we lose key high value services and opportunities for profitable growth.' As such, significant executive and clinical leadership time is being committed to ensure its success, which is a clear part of the refreshed Trust strategy.

RECOMMENDATION

To note the key issues discussed and decisions taken at the Acute Provider Collaboration Programme Board held on 20th May 2021.

KATHERINE SHEERIN
DIRECTOR OF STRATEGY AND TRANSFORMATION
JUNE 2021

Enclosure 20

The Dudley Group NHS Foundation Trust

Paper for submission to the Board of Directors on 10th June 2021

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

CLINICAL STRATEGIC AIMS

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

ACTION REQUIRED OF COMMITTEE

Decision	Approval	Discussion	Other
		Y	

RECOMMENDATIONS

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

CORPORATE OBJECTIVE:

All

SUMMARY OF KEY ISSUES:

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

IMPLICATIONS OF PAPER:

IMPLICATIONS FOR THE CORPORATE RISK REGISTER OR BOARD ASSURANCE FRAMEWORK

The report is directly concerned with the Board Assurance Framework

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

REPORT DESTINATION	**EXECUTIVE DIRECTORS**	**N**	**DATE:**
	WORKING GROUP	**N**	**DATE:**
	COMMITTEE	**Y**	**DATE: Quality and Safety Committee 25.5.21 Workforce Committee 25.5.21, Finance and Performance Committee 3.6.21,** **Board of Directors 10 June 2021**

1. EXECUTIVE SUMMARY

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

2. BACKGROUND

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

Strategic Objective 1 – Deliver a Great Patient Experience

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

There are three new controls since the last reporting period (reporting from the Learning Experience Group, You Said We Did Boards, and complaints monitoring and challenge through Divisional Performance Review meetings.) Each of these are reported as positive assurances. However, the number of outstanding complaints continues to be high.

There are three actions awaiting implementation and a further three that are ongoing actions subject to continuous evaluation.

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

Corporate Risk Register

There is one corporate risk that addresses strategic objective 1 which is overseen by the Quality and Safety Committee. Corporate risk 1010 (*failure to comply with local and statutory provisions for complaints management*) has reduced from 9 to 6 since the last BAF report, and subsequently closed.

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

There are significant positive assurances since the last reporting period which reflects the shift in focus from COVID-19 to Restoration and Recovery. This includes the introduction of a robust Restoration and Recovery plan, strong performance on 52 week waits, and progress with service recommencement and collaborative working across the STP. However, capacity restrictions continue, and pathway waiting times remain challenging. The introduction of the Modular Build in June 2021 is a significant mitigating action.

The net risk score remains at 20 and there is a significant difference between the level of risk currently being carried and the target risk score of 8.

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

Strategic Objective 2 – Safe and Caring Services

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

The control weaknesses have been updated to increased demand and ambulance arrivals (capacity).

There are seven actions that have been completed since the last review period and three actions remaining to be completed. The introduction of the modular build is also a key mitigating action in respect of this risk.

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

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

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

Six actions have been implemented since the last review and these have provided two additional positive assurances (Medical Engagement score, and PAs in job plans for new appointments)

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

Corporate Risk Register

There are nine corporate risks that address strategic objective 2 that are overseen by Quality and Safety Committee. A number of these risks have arisen from operational areas and are sufficiently serious as to directly impact on corporate aims (1015 *Deteriorating Patient Groups*, 896 *Temperatures in Medicine Storage Rooms*, 1185 *review of radiological investigations, 1422 process for review of results of pathology investigations*, *1449 acting on clinical effectiveness reports*). No risk scores have increased since the last reporting period, and three have reduced.

Strategic Objective 3 – Drive Service Improvements, Innovation and Transformation

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

There are no changes since the last review period. The net risk score remains at 8 and is consistent with the target risk score.

Strategic Objective 4 – Be the Place People Choose to Work

BAF 4A – Be the place people choose to work

Two actions have been implemented since the last review period including the initiation of the international nursing recruitment programme. This is an incremental programme, pending recruitment in August, September and December and therefore it does not present positive assurance at this point.

There are a further nine actions planned including four that have slipped by six months (now with October completion dates). These actions can be broadly categorised as strategy development, planning, and targeted recruitment programmes, with three of the actions being co-dependent on STP partners reflecting the systemic nature of this risk.

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

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

Three additional controls have been added to the reporting framework but each is reported to be currently too immature to identify positive assurance that they are effective.

Six actions have been implemented since the last review period. Four of these actions which represent ongoing programmes or pathways are reporting positive feedback which in due course, if sustained, will feed into assurances against key controls.

There are a further seven planned actions, with three of these having slipped by 2-3 months from the last reporting period. As a result, all of these actions are now due for completion between May and August 2021.

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

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

There is an additional control reported relating to the implementation of the divisional engagement forums. However, the effectiveness of the assurance of this is currently subject to review.

Seven actions have been implemented since the last review. Five of these are not recording positive assurance at this point with the reasons being no impact/delayed impact/low take up/awaiting further data. Two actions are reporting positive impact (increased engagement during COVID, and the relaunch of the DIP).

A further eight actions are planned, two of which have been completed since the last review. There is slippage of one month on the review of effectiveness of the engagement forums. A positive outcome to this review will validate the additional control referred to above.

The net risk score remains at 12 and is now aligned with the target risk score.

In summary, there is no movement on the net risk scores for the three risks over the reporting period. A significant number of actions have been implemented since the last review, but these have had limited impact on the control environment at this point for the reasons set out above. There has also been slippage in relation to some actions, and a high proportion of outstanding actions are now due for completion before the end of August.

None of the three risks have more than 1/3 of controls as operational (and therefore not subject to some form of validation outside of the service).

Corporate Risk Register

There are four corporate risks that relate to strategic objective 4. The BAF risks are concerned with recruitment, training and development and engagement, whilst the Corporate risks being managed by the Committee concern staff absence (981), and staff engagement and morale (1303), and the ability to develop a diverse workforce (1537). High corporate risk scores on sickness and staff morale and the development of a diverse workforce will influence the strategic BAF risk as they may impact on the place people choose to work (strategic objective 4).

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

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

The risk cause has been amended to reflect the uncertainty of the allocation for the second half of 2021/22 and the reliance on ICS partners reflecting the extent to which the risk is increasingly systemic.

There are seven actions that have been implemented since the last review which have had a positive impact on the Trust's cash position and system wide risk sharing. However, improving the net risk position is dependent upon external factors including the allocation for the second half of 2021/22 and the remodelling of the underlying financial position is an action flowing from that.

The net risk score has remained at 12.

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

Risk 5B is to be reviewed at the June Digital and Technology Committee and therefore the scores remain as reported in the last BAF update.

Strategic Objective 6 – Deliver a Viable Future

BAF 6A – Failure of the Trust to influence the local and wider evolving health economy due to a lack of engagement and poor performance undermining our credibility means our clinical

and financial viability is undermined as we lose key high value services and opportunities for profitable growth

The Key controls have been updated to reflect partial or negative assurance around the clinical engagement arrangements across primary and secondary care in relation to integration. Three actions have been implemented around the establishment of engagement meetings and fora since the last review, but these require a review of effectiveness.

In relation to the ICP the actions implemented reflect the activities previously reported to the Board in respect of the further negotiations with regard to the form and scope of the potential ICP and the role that the Trust is willing to play in that.

Significant progress is reported on acute collaboration and the Trust's strategy refresh.

There are nine actions pending all of which are due for completion by the end of July.

The net risk score remains at 16 but there is a clear demarcation of progress in relation to risk in respect of the strategy and acute collaboration where a number of positive actions are reported, as compared to GP engagement and the resolution of the MCP (Integrated Care Provider) where there is less assurance around the measures implemented and the degree of outstanding risk.

None of the three risks have more than 1/3 of controls as operational (and therefore not subject to some form of validation outside of the service).

Corporate Risk Register

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

3. RISKS AND MITIGATIONS

Based on the following criterion:

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

The failure to meet access standards (1A), Recruitment (4A) and the position of the Trust in the wider health economy (6A) remain the highest risks for the Trust. This is consistent with the last reporting period. The mitigations for these risks are set out in the BAF itself.

4. RECOMMENDATIONS

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

Liam Nevin

Trust Secretary May 2021

Board Assurance Framework –April 2021

KEY

RISK SCORE

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

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

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

Key to Control Levels

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

Board Risk Appetite

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

RISK PERFORMANCE

Scores calculated: Likelihood x Impact

BAF Risks	CURRENT RISK SCORE	PREVIOUS RISK SCORE	BOARD RISK APPETITE	TARGET RISK SCORE
BAF 1A - We don't always effectively engage with patients in their care or involve them in service improvement as a result we fail to communicate with them effectively resulting in a poor patient experience which means patient's will not see us as a provider of choice	9	9	Cautious 4-6	6
BAF 1B - Failure to meet access standards caused by inability to improve patient flow and work effectively with very local partners will result in an adverse outcome for the patient	20	20	Cautious 4-6	8
BAF 2A - If we do not achieve and demonstrate a good or outstanding rating with CQC and other regulatory standards we may be unable to achieve the level of quality of care and subsequently our reputation may be damaged	9	9	Cautious 4-6	4
BAF 2B - Insufficient effective leadership and capacity may result in the trust being unable to efficiently manage and deliver safe services for our patients	8	8	Cautious 4-6	8
BAF 3A - The Dudley Improvement Strategy may not be delivered due to insufficient transformational leadership capability and capacity, resulting in a lack of innovation and a failure to improve services	8	8	Moderate 8-12	8
BAF 4A - An inability to recruit sufficient numbers of appropriately trained staff due to national and local staff shortages may impact on being unable to meet service demand or provide safe, high quality services resulting in increased temporary workforce spend	16	16	Moderate 8-12	12

BAF Risks	CURRENT RISK SCORE	PREVIOUS RISK SCORE	BOARD RISK APPETITE	TARGET RISK SCORE
BAF 4B - If we fail to train and develop our workforce to have the right skills to enable the delivery of our clinical strategy, due to inadequate career development, talent management and leadership development, this may result in poor retention rates, difficulties recruiting and a failure to maximise the capabilities of staff	12	12	Moderate 8-12	8
BAF 4C - Failure to effectively engage and involve our workforce by not listening, innovating and acting on their feedback and communicating effectively could lead to an inability to positively improve culture	12	12	Moderate 8-12	12
BAF 5A - Failure to recognise the importance and impact of our constrained financial position due to a lack of understanding, engagement and financial discipline mean we miss key financial targets, run out of cash and come under greater regulatory scrutiny	12	12	Moderate 8-12	10
BAF 5B - Failure to successfully adopt digital workflows, due to competing organisation / clinical pressures, availability of resources and change fatigue; results in clinical risk, reputational risk and inefficiency	8	8	Moderate 8-12	12
BAF 6A - Failure of the Trust to influence the local and wider evolving health economy due to a lack of engagement and poor performance undermining our credibility means our clinical and financial viability is undermined as we lose key high value services and opportunities for profitable growth	16	16	Moderate 8-12	12

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

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

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

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

KEY CONTROLS IN PLACE	ASSURANCE THAT CONTROLS ARE EFFECTIVE [Yes / No (if no what action needs to be taken)]	LEVEL of CONTROL 1 = Operational 2 = Committee 3 = External
Patient experience strategy	Yes	2
Quality priorities focussed on reducing harm	Yes	2
Pt feedback actions sought via FFT, patient surveys, feedback Fridays	Yes – now being done virtually/electronically	3
Complaints process and reporting	Yes – in place and routinely reported at team/ divisional level	1
PALS Reports	Yes	1
AMAT quality metrics	Yes	1

Quality priorities metrics reported via IPR	Yes	2
Learning from Experience group and reports to PEG	Yes	2
CLIP report	Yes	
Patient Experience group and associated work plan	Yes	2
Patient Experience improvement work streams across all services	Yes	1
LIA in place to capture and respond to feedback	Yes	2
Participation in annual patient surveys	Yes	3
Patient Panels	Yes – being held virtually reported through Patient Experience Group	3
You said we did boards in place across the organisation which are regularly updated	Yes	2
Complaints monitored and challenged through divisional performance meetings and governance meetings	Yes	2

ACTIONS IMPLEMENTED SINCE LAST REVIEW	IMPACT OF CONTROLS AND ACTIONS ON RISK/ASSURANCE
• To embed a framework of actions shared from feedback received on the You Said We Did boards	**Positive Assurance** • You Said We Did Boards across the Trust and updated with patient feedback • Recruitment for volunteer experts by experience has been recommenced. • Panels continue to occur via Teams. • Response rates to respond to complaints in the 30 working day deadline is gradually improving with the Trust now achieving 31% • The organisation of Local Resolution Meeting which had been stopped during the COVID-19 pandemic have recommenced • The number of volunteers active in the organisation had reduced due to Covid 19. This is due to restrictions around social distancing and risks for vulnerable groups who act as volunteers. The position is improving with active recruitment being undertaken by the Trust. **Negative Assurance** • Of the 86 complaints closed in March 2021 only 37 (43%) were closed within 30 working days.

	• There are 30 Local resolution meetings to be organised of these 12 have had dates confirmed • The Trust received 62 new complaints in March 2021. In comparison, 52 complaints were opened for February 2021 and 71 opened for January 2021. There was an increase in activity from 2019/20 (678) to 2020/21 (722), (increase of 6.5%). • PALS received 339 concerns, 15 comments and 44 signposting contacts (signposting includes letters/emails/telephone calls/face-to-face enquiries) totalling 398 in March 2021 compared to 322 in February 2021. The number of PALS concerns and contacts has risen for March 2021. Due to capacity these are taking longer than 5 working days to complete. • As of 15 April 2021, there are a total of 150 complaints open including the reopened. There are 120 complaints awaiting a written response from divisions • A 1 month Pilot of tablets by each bedside was to commence January 2021. The tablets have been sourced and are with IT but due to capacity IT have not been able to upload the information to commence the project

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

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

	Action completion date delayed and has been extended due to impact of COVID restricting access to clinical areas – although attempts are to be made to recruit virtually	March 2021	
	Set up Patient Panels	March 2020 Completed	Jill Faulkner
	Development and delivery of a patient experience trolley to be taken to the wards	August 2020 Completed	Jill Faulkner
	Recruitment drive for volunteers	June 2021	Jill Faulkner
	1 month Pilot of tablets by each bedside which will contain welcome booklets, FFT, surveys, menus, Trust Website Etc	January 2021	Jill Faulkner

Strategic Objective		**SO1 Deliver a great patient experience**				**Committee**	**Exec Lead**	
						Quality and Safety Committee	Chief Operating Officer	
Strategic Risk No	BAF 1b	**Pre Mitigations Risk Score**	L xC 5x4 (20)	**Post Mitigations Current Risk Score**	L x C 5x4 (20)	**Board Risk Appetite** Cautious	**Target Score**	L x C 3x4 (12)
RISK: Failure to meet access standards by Mar 2021 which includes RTT / DMO1 /Cancer/EAS. Restoration and Recovery baseline activity targets set at 70% April rising to 85% from July								

Cause	Impact of the Risk
• Reduced outpatient, diagnostic and treatment capacity due to COVID-19 • Clinicians re-deployed to support other pathways, including emergency to support response to COVID-19 • Reduced patient contact for patient requiring routine consultations, investigations and treatment to reduce infection rate of COVID-19 • Measures and precautions put in place in line with national guidance to support response to COVID-19, including social distancing measures • Reduction in patients willing to come into hospital for treatment and requesting to delay their appointments in fear of contracting COVID-19. • National RTT guidance released specifically for COVID-19, does not allow RTT clocks to be stopped as a result of patient initiated delays for COVID-19 reasons. • Priority has been clinically urgent (including cancer) patients with what operational capacity has been available. Increase referrals over coming months as primary care restarts will increase the likelihood of worsening performance as the denominator of the waiting lists across all statutory targets reduces.	• Harm to patients as a result of waiting times • Failure to achieve 92% RTT incomplete standard • Increased risk of 52 week breaches • Failure to meet DMO1 standard • Failure to meet 62 day cancer standard • Poor patient experience • Delayed patient care potential poorer outcome • Poor Trust reputation • Future financial impact • Staff morale

Quarters – Change in Post Mitigation Scores	Q1	Q2	Q3	Q4
	20	15	20	20

KEY CONTROLS IN PLACE	ASSURANCE THAT CONTROLS ARE EFFECTIVE [Yes / No (if no what action is being taken)	LEVEL of CONTROL 1 = Operational 2 = Committee 3 = External
Weekly Trust Operational Group	Yes	1
Weekly Trust RTT Meeting	Yes	1
Outpatient Taskforce Meeting	Yes	1
COVID Taskforce Meeting	Yes	1
Theatres Restoration and Recovery Meeting	Yes	1

Access Policy Review & Training in line with national guidance	Yes	1
Weekly Independent Sector Meeting	Yes	3
Weekly Cancer PTL meeting	Yes	1
Monthly Cancer steering group	Yes	2
Monitoring tool to robustly report & monitor activity & performance	Yes	1
Weekly operational restoration & recovery meeting	Yes	1
Interim Cancer manager in post	Yes	1
Weekly Executive meeting	Yes	1
Finance and Performance Committee	Yes	2
STP Restoration and Recovery	Yes	1

ACTIONS IMPLEMENTED SINCE LAST REVIEW	IMPACT OF CONTROLS AND ACTIONS ON RISK/ASSURANCE
This BAF has been refreshed to in its entirety to reflect the Trusts post c-19 position	Positive Assurance • Re-introduced weekly Trust RTT and Cancer PTL meeting • Trust is fully engaged in national priority categorisation using P values to aid immediate recovery in line with national requirements • Robust restoration and recovery plan in place with good performance against the agreed trajectories • Independent sector being fully utilised • One of the best 52 week wait positions in the country and improvements in line with local trajectory • Overall patient waiting list has reduced by circa 1000 patients compared to pre-COVID • Dedicated cancer informatics / business analyst in post • 77% reduction in patients over 104 days cancer on track to deliver agreed activity levels • Continue to deliver virtual appointments • Increase in face to face appointments where required

	• Nearly all services have now recommenced at least some routine elements of delivery • Excellent STP engagement and working with partner Trusts around elective programme and restoration and recovery <u>Negative Assurance</u> • Productivity and activity levels affected due to social distancing measures • Some reduced activity due to limited operational capacity available • GP referrals are increasing back towards pre-COVID levels resulting in risks to growth in waiting list size • Theatre capacity not at pre-Covid levels as yet

SPECIFIC GAPS IN CONTROL / ASSURANCE	**ACTIONS**	**Completed**	**In progress**	**Outstanding (beyond completion date)**
The main areas of weakness which result in ineffective or absent controls / assurance	*Actions required to mitigate the weaknesses*			*Date for completion*
• Services and staff deployed to Wave 2 C19 response • Gradual opening of theatres in line with Restoration and Recovery plans • Routine Outpatient activity is being delivered but capacity restrictions still in place due to social distancing. Continued effective use of virtual clinics still in place • Diagnostic waits have improved but overall pathway waiting times remain a challenge especially in cancer • Reduced productivity across all pathways due to social distancing and COVID-19 precautions	Independent sector theatre capacity available to Dudley Group would need to treble to increase activity levels to required level			Completed
	Extend one theatre each day into the evening			Completed
	Run four all day elective lists each weekend. Elective activity now suspended due to wave 2 C-19			December 2021
	Increase outpatient levels to pre-COVID state			December 2021

• GP referrals -returning to pre-covid levels • High proportion of waits over 18 weeks and ability to treat more patients that are waiting over 18 weeks versus the number that are added each week is not possible at present • Adoption of national P categorises does not facilitate rapid improvement in 18 week RTT target • Staff fatigue and availability to support increase in capacity out of hours • DM01 performance has improved and independent sector capacity has been used for MRI and CT	Restoration and Recovery Plan March 2021 Trajectory	
	Reduce diagnostic waits to within re-baselined DM01 standards through provision of additional internal and independent sector capacity.	Completed
	4th endoscopy room in place	Completed
	Have in place dedicated cancer informatics / business analyst	Completed
	Modular build in place to increase capacity. Delay with introduction of Modular build due to issues outside the control of the Trust. Completion date revised	31 May 2021

Strategic Objective		**SO2 Safe and Caring services**				**Committee**	**Exec Lead**	
						Quality and Safety Committee	Chief Operating Officer	
Strategic Risk No	BAF 2a	**Pre Mitigations Risk Score**	4X4 (16)	**Post Mitigations Current Risk Score**	3x3 (9)	**Board Risk Appetite** Cautious	**Target Score**	1X4 (4)
RISK: If we do not achieve and demonstrate a good or outstanding rating with CQC and other regulatory standards we may be unable to achieve the level of quality of care and subsequently our reputation may be damaged								
Cause / Effect • Failure to demonstrate we deliver care in line with regulatory standards • Perceived reputational damage • Risk of harm to patients as statutory standards not met						**Impact of the Risk** • Reduced influence with external organisations e.g. NHSI, CCG • Potential impact on ability to recruit staff particularly to senior management positions		

• Impact on staff morale • Impact on recruitment and retention • Increased scrutiny resulting in clinicians potentially being diverted from direct patient care	• Reduced ability of the Trust to take independent decisions • Staff become disengaged • Increased vacancies and over reliance on agency staff • Increased sickness • Staff wellbeing is affected • Patients at risk of not receiving timely interventions • Poor overall patient/family experience			
Quarters - Change in Post Mitigation Scores	**Q1**	**Q2**	**Q3**	**Q4**
	9	9	9	9

KEY CONTROLS IN PLACE	ASSURANCE THAT CONTROLS ARE EFFECTIVE	LEVEL of CONTROL 1 = Operational 2 = Committee 3 = External
Schedule of positive press releases/media campaigns	Yes	3
Collaborative working with NHSI	Yes	3
Collaborative working with neighbouring trusts as appropriate	Yes	3
Weekly Operational meeting to monitor performance against key regulatory standards	Yes	1
Divisional Performance Meetings	Yes	2
IPR report to Q and S, F&P & Board	Yes	3
Cancer Alliance Meetings	Yes	3
Quality review visits against each domain	Yes	1
Perfect ward tool to drive local understanding and improvement	Yes	1
Skill mix review undertaken	Yes	1
Nursing & Midwifery strategy	Yes	1
Mortality Review process	Yes	1
Nurse recruitment Lead	Yes	1
Corporate & bespoke recruitment events	Yes	1
MTI Programme	Yes - delayed	3
Workforce Strategy	Yes	1

Developing Leaders Programme	Yes	2
Staff engagement indicators	Yes	2
National staff survey & FFT results	Yes	3
Board, Executive and senior management development programmes	Yes	2
Urgent Care Service Improvement Group	Yes	2

ACTIONS IMPLEMENTED SINCE LAST REVIEW	IMPACT OF CONTROLS AND ACTIONS ON RISK/ASSURANCE
• Trust fully engaged in STP and clinical area and cancer networks to aid system working • Collaborative working in place with other Trusts, supporting via mutual aid as part of restoration and recovery • Additional senior doctor input to Mortality Process recruited and in post • Revised TOR and meeting structure to include speciality level input for MSG • Managers Essentials course have recommenced for senior managers • Divisional performance meetings have recommenced • Comprehensive divisional staff engagement plans in place, reporting via WSEC • Care bundles implemented for AKI/ALD/Sepsis and Pneumonia	MTI Programme – delayed as a result of the pandemic. Work is now re-starting but date for completion extended to allow time to seek the required authorisations, advertise and recruit and taking into account current travel restrictions.

SPECIFIC GAPS IN CONTROL / ASSURANCE	ACTIONS	STATUS: COMPLETE	STATUS: IN PROGRESS	STATUS: OUTSTANDING (BEYOND COMPLETION DATE)	
The main areas of weakness which result in ineffective or absent controls / assurance	*Actions required to mitigate the weaknesses*		*Date for completion*		*Action Lead*
• RWT challenged capacity for robotic surgeries for Urology – the Trust is now taking a lead in BC Urology Area Network group.	Plan for CT refit commencing June		Completed		P Karanjit
• Increased demand and ambulance arrivals	Business Case to redesign & enhance cancer tracking team		July 2020		P Karanjit

• DM01 – increase in demand overall, and on the day diagnostics, diagnostic capacity is especially important for achieving cancer standards • Mortality reviews not sufficiently robust in providing learning that is shared across the trust • Assessment & analysis of recruitment events to inform where to concentrate resources • Expansion of the MTI programme to more countries – current programme is going well with specific recruitment in Peads/Gynae Obs and ED but this cannot be expanded to other countries due to Covid • Disjointed approach to staff education, development & education • Leadership Programme –-Trust OD department is developing a CD and CSL development programme • Step up to Care programme only provides development at corporate level associated to management development and needs to be broadened to capture other staff development.	EAS System Improvement Plan	Closed	K Kelly
	Review of Mortality meetings & processes	Completed	P Brammer
	MTI programme to be developed alongside one other country and managed effectively within Medical Management fortnightly meetings.	~~Oct 2019~~ Oct 2021	Hassan Paraiso/Jess Haycock
	Review areas of further collaboration across education and training providers under the remit of the Workforce Group	Complete - BAU	Rachel Andrew, Helen BROMAGE-and Atiq Rehman
	Undertake review and audit of data collection systems that record training information to determine what changes can be made to provide better level of detailed analysis and information.	Closed	Becky Cooke
	The introduction of the 'Make it Happen' OD programme supported with the Staff Engagement plan, the behavioural framework and the anti-bullying campaign.	Completed	Rachel Andrew
	Plan to support detailed preparation for the forthcoming Staff Survey in 2019.	Completed	Rachel Andrew
	Development programme to include skills associated to engagement and support for staff and colleagues. This will also be supported by the introduction of anti-bullying campaign	Completed	Rachel Andrew & Becky Cooke
	Modular build to increase capacity. Business case approved and build underway.	31/05/21	Qadar Zada

	Completion date revised based on contractual feedback		
	Further IT input required to develop electronic order sets for deteriorating patient pathways.	31/03/21	Adrian Jennings

Strategic Objective		**SO2 Safe and Caring services**				**Committee**	**Exec Lead**	
						Quality and Safety Committee	Medical Director	
Strategic Risk No	BAF 2b	**Pre Mitigations Risk Score**	L x I 4X4 (16)	**Post Mitigations Current Risk Score**	L x I 2X4 (8)	**Board Risk Appetite** **Cautious**	**Target Score**	L x I 2X4 (8)
Insufficient effective leadership and capacity may result in the trust being unable to efficiently manage and deliver safe services for our patients								
Cause • Insufficient time allocated to leadership roles • Operational demands conflict with leadership roles related to governance and engagement. • Staff lack understanding of the potential of leadership to deliver service improvement • No shared vision for the organization						**Impact of the Risk** • Quality improvement work not undertaken or is ineffective - Mortality reduction not achieved or maintained - CIP not delivered - EAS, cancer and diagnostic waiting times not achieved • Reduced staff morale and engagement • Negative impact on reputation • Poor recruitment and retention		

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

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

ACTIONS IMPLEMENTED SINCE LAST REVIEW	IMPACT OF CONTROLS AND ACTIONS ON RISK/ASSURANCE
Chief Registrar programme applications received SAS Development plan going including appointment of CESR leads Managers Essentials Enrolment ongoing Virtual Clinical Summit held May 2021. Attended by 50+ clinicians from across disciplines. Focused on wellbeing and development of clinical strategy. AQuA continuing to support with QI skill development for clinical and support teams through AQ programme 4 additional Hospital at Night Practitioner posts recruited to, to increase senior clinical leadership on site 24/7 Clinical Directors Leadership Programme established Funding of Kings Fund courses for Clinical Leaders	• Positive assurance - External LfD report completed • Positive Assurance – SAS actions delivering including appointment of SAS doctor to ME role and allocation of Job Planning licences for SAS workforce • Positive assurance – Improved Medical Engagement Scale • Positive Assurance – All new medical leadership appointments have PAs allocated in job plan as opposed to responsibility payments.

SPECIFIC GAPS IN CONTROL / ASSURANCE	ACTIONS	STATUS:		
		COMPLETE	IN PROGRESS	OUTSTANDING (BEYOND

				COMPLETION DATE
The main areas of weakness which result in ineffective or absent controls / assurance	*Actions required to mitigate the weaknesses*		*Date for completion*	*Action Lead*
Assessment of effectiveness.	Staff survey MES		April 21	HRD
Earned autonomy /Competency framework	Develop earned autonomy framework		Dec 19	CofMed / CofSur
Participation in Chief Registrar Programme	Applications for 2021 programme due to open December 2020 – applications received		April 21	Director of Medical Education

Strategic Objective		**SO3 Drive Service improvements, innovation and transformation**				**Committee**	**Exec Lead**	
						Finance & Performance	Medical Director	
Strategic Risk No	BAF 3a	**Pre Mitigations Risk Score**	L x C 4X4 (16)	**Post Mitigations Current Risk Score**	L x C 2X4 (8)	**Board Risk Appetite** **Moderate**	**Target Score**	L x C 2X4 (8)
RISK: The Dudley Improvement Strategy may not be delivered due to insufficient transformational leadership capability and capacity, resulting in a lack of innovation and a failure to improve services								
Cause • If the Improvement Practice Programme is discontinued due to lack of leadership support and commitment, the trust would need to find an alternative approach to continuous quality improvement.					**Impact of the Risk** • Cost of an alternative programme is likely to be in excess of £0.5m and would take at least 1 year to establish. • Without a standard approach to improvement, there could be a slow decline in the quality and cost of services.			
Quarters – Change in Post Mitigation Scores			**Q1**	**Q2**	**Q3**	**Q4**		
			8	**8**	**8**	**8**		

KEY CONTROLS IN PLACE	ASSURANCE THAT CONTROLS ARE EFFECTIVE [Yes / No (if no what action is being taken)	LEVEL of CONTROL 1 = Operational 2 = Committee 3 = External
Contract with NHSI/E until June 2021 provides support from an Improvement consultant for 2 days per week and an executive coach for 8 days per annum	Yes	3
Training at three levels of competency is in place and currently being undertaken by the exec team	Yes	1
The Improvement Practice team has a total of four members of staff and 3 additional posts have been approved from April 2021, bringing the team capacity in line with the national average for the Vital Signs cohort of 8 trusts.	Yes	2

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

	part of the large leadership development programme which commenced in October 2020.

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

Strategic Objective	**SO4 Be the place people choose to work**	**Committee**	**Exec Lead**
		Workforce and Development Committee	Chief People Officer

Strategic Risk No	BAF 4a	Pre Mitigations Risk Score	L x C 4X4 (16)	Post Mitigations Current Risk Score	L x C 4X4 (16)	Board Risk Appetite: Moderate	Target Score	L x C 3X4 (12)

RISK: An inability to recruit sufficient numbers of appropriately trained clinical staff due to national and local staff shortages may impact our ability to meet service demand and/or provide safe, high quality services resulting in enhanced pay arrangements and/or increased temporary workforce spend

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

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

KEY CONTROLS IN PLACE	ASSURANCE THAT CONTROLS ARE EFFECTIVE [Yes / No (if no what action is being taken)]	LEVEL of CONTROL 1 = Operational 2 = Committee 3 = External
Nurse recruitment lead established to work alongside departments in order to support innovative ways to recruit new nursing staff. Collaborative working with HR/Recruitment team.	Y	1/2
Corporate recruitment events alongside bespoke recruitment events for areas with high levels of vacancies as well as participating in external recruitment events, working in collaboration with Professional Development and HR.	Y	2
Development of local sustainable workforce through extension of the Nursing Associate Programme (band 4). Work undertaken to profile the nurse workforce, to identify the maximum opportunity to utilise Nursing Associates (Band 4) in ward areas.	This is medium term strategy.	1

Development of MTI workforce between the Trust and Pakistan.	Y	1
Explore opportunities for international recruitment as part of the short term strategy to fill nursing posts alongside longer term strategy of growing our own	Y	2
Robust recruitment KPI reporting	Y	2

ACTIONS IMPLEMENTED SINCE LAST REVIEW	**IMPACT OF CONTROLS AND ACTIONS ON RISK AND ASSURANCE**
Dudley Chief People Officer has been appointed as the STP lead for the Collaborative Bank programme for the system. This work programme will deliver a detailed implementation plan, with costed benefits (financial/non-financial) by March 2021.	Greater transparency and insight into workforce issues, including recruitment. Strengthened governance.
Implemented more detailed workforce reporting on recruitment activity, for all staff groups to the Workforce Committee through the monthly Workforce KPIs	It is estimated that there is a large no of nurses who work bank shifts on a full time basis within the system. Dudley doesn't current have access to this resource but would through collaborative bank arrangements. Once implemented, a system wide collaborative bank would provide economy of scale and reduce the reliance on agency staff
Major recruitment campaign launched to recruit HCSW's.	Plan to 'over recruit' recognising nurse staffing challenges and a plan to reduce the existing nursing staffing pressures. 200+ applications have been received for HCSW posts, 33 staff have commenced in post, 18 have agreed commencement dates and a further 101 offers of employment have been made.
Registered Nurse recruitment campaign launched	Generic band 5 and band 6 vacancies advertised, supported by a social media campaign, in which the hospital façade displays "We are Recruiting" and a Radio media campaign. This is not only targeted at improving registered nurse recruitment, but also on raising our profile as a local employer.
Extended nurse bank enhancements.	Incentivised bank fill rates, though further consideration required due to low fill levels.
Recruitment to COVID vaccine workforce has increased local profile	STP Workforce Bureau (Vaccination Recruitment) has increased local profile and reputation of the Dudley Group. All staff recruited is hosted by the Dudley Group Staff Bank, with potential to convert the vaccine workforce into both bank assignments within the trust; and to develop links with other candidates for the permanent workforce. Engaging students is building positive relationships with universities for both medical and nursing students.

Recruitment to COVID vaccine workforce has enabled review of recruitment processes and improvements to candidate journey are underway	The STP Workforce Bureau has recruited circa 500 bank staff across a range of roles, mass recruitment has provided the opportunity to improve the recruitment processes, including the use of editable PDF documents and the development of an on-line portal, ensuring the candidate journey is simple and easy to navigate and allowing the Recruitment team to be more responsive. The Trust have committed to participating in the Digital Passport scheme which allows staff to transition between Trusts. The on-boarding process has been reviewed to ensure a warm welcome is provided, improving our reputation as an employer. The Impact is yet to be seen as this work is in its infancy
Revision of Bank Rates – removal of bonus and introduction of a higher base rate	Following several forums with bank users it was established that the previous system of a shift bonus was confusing and viewed as inequitable. Revised higher bates rate will be implemented on the 3rd May 2021, with the aim of introducing transparency and equity in addition to ensuring we remain competitive across the STP.
Engagement in the STP international nursing programme	The Trust is engaging and supporting a collaborative system wide international nurse recruitment initiative, being led by Wolverhampton, to bid for central money/resource that is being made available to support international nurse recruitment. Working in collaboration with RWT to access international nursing cohorts, 3 planned cohorts in August, October and December. Each cohort will consist of 25 nurses.

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

The Nursing Associate Programme is a longer-term strategy that will realise benefits over the next 1-4 years. A fresh approach to new and alternative roles and new ways of working is required to fill some of the longstanding medical vacancies. This requires a focus on workforce transformation. The lack of a comprehensive workforce planning tool to plot the workforce supply and demand over the next 5 years. Inefficiency within the recruitment process still exists and new processes not yet bedded in. E-rostering not optimised across clinical workforce groups, low level of attainment Limited substantive bank only workforce to meet short term supply issues. Low bank fill rates by substantive staff. Clinical staff have been significantly impacted by COVID since Waves 1-3 and winter pressures have exacerbated existing issues with staffing, rest and wellbeing. Impact of winter and COVID pressures likely to result in earlier than planned exits; potential moves from areas/change of focus for staff and ongoing staff sickness.	Development and embedding of a consistent approach to workforce planning including an agreed Dudley Workforce Planning tool.	October 2021	Deputy Chief People Officer
	The Trust is engaging and supporting a collaborative system wide international nurse recruitment initiative, being led by Wolverhampton, to bid for central money/resource that is being made available to support international nurse recruitment.	March 2021	Chief People Officer/Chief Nurse
	Establish a more dynamic approach to recruitment advertising, including social media use, cohorting adverts, selling Dudley/Black Country as well as the Trust, STP collaboration and introducing a one-stop-shop approach to recruiting multiple posts.	February 2021	Resourcing and Planning Lead
	Establish an optimal future staff bank model and implement, in conjunction with STP collaborative bank programme	October 2021	Chief People Officer
	To significantly increase the population of bank only nursing and AHP staff.	October 2021	Resourcing and Planning Lead
	Mobilise the Workforce Transformation – new ways of working programme, which was approved by the Workforce Committee at its January meeting. This work is being supported by Health Education England (HEE), to focus on implementing new roles/ways of working.	May 2021	Chief People Officer
	Develop and implement a comprehensive Nurse Resource Strategy, to include: o Over recruiting CSW's	June 2021	Chief People Officer

	o Strengthening the comms channels used to recruit (i.e. social media) o Refreshing the recruitment offer/marketing, greater focus on development/career progression offer o Exploring local Partnerships, inc Dudley College o Exploring alternative staff bank options, including outsource and technology options o Optimising e-rostering to utilise all available clinical workforce capacity to best effect, include bidding for capital being made available centrally o Explore immediate fixed term enhancements to pay rates/reward to secure greater uptake of bank shifts		
	Develop clear timeline and actions for workforce transformation and new ways of working; supported by HEE.	May 2021	Chief People Officer
	Focused work with BAME nurses to address barriers to career progression.	October 2021	Chief people Officer/Chief Nurse
	Well-being strategy launched – requires ongoing review of effectiveness and impact on staff. 4 month review planned.	May 2021	Chief People Officer

Strategic Objective		**Committee**	**Exec Lead**

	SO4 Be the place people choose to work				Workforce and Development Committee		Chief People Officer	
Strategic Risk No	BAF 4b	**Pre Mitigations Risk Score**	L x C 4X4 (16)	**Post Mitigations Current Risk Score**	L x C 3X4 (12)	**Board Risk Appetite** **Moderate**	**Target Score**	L x C 2X4 (8)

RISK: Failure to train and develop our workforce, maximising their capabilities so they have the right skills to enable the delivery of our clinical strategy, may impact our ability to recruit and retain due to the lack of/inadequate career/leadership development, succession planning and talent management

Cause	**Impact of the Risk**
• Historic lack of investment and prioritisation of staff development, particularly professional and management development. • Vacancy factor, as well as significant operational pressures making it difficult for staff to be released for training and development opportunities • Sickness absence levels making it difficult for staff to be released for training and development opportunities • Recent impact of COVID on availability of staff to be released for development/training • Limited ability to deliver training / impact of paused activity due to physical distancing restrictions	• High turnover, particularly in clinical posts • High vacancy rates • Increased sickness absence, particularly relating to stress • Low morale amongst staff • Dependency on agency workforce at premium cost • Insufficient support for management development has caused poor management of staff resulting in an impact of delivery against objectives • Failure to deliver the quantity and quality of management and leadership development required • Senior staff acting down to provide disproportionate levels of support, therefore, effecting the impact they have on the organisation • Reputational and operational performance issues.

Quarters – Changes in Post Mitigation Risk Scores	**Q1**	**Q2**	**Q3**	**Q4**
	12	12	12	12

KEY CONTROLS IN PLACE	**ASSURANCE THAT CONTROLS ARE EFFECTIVE [Yes / No (if no what action is being taken)**	**LEVEL of CONTROL 1 = Operational 2 = Committee 3 = External**
• The revised Dudley People Plan provides a greater focus on staff development • Trust Board supportive of a learning culture being further developed within the Trust	N – Delivery of the outcomes is at an early stage as the Dudley People Plan is currently undergoing an update/relaunch with actions linked to the NHS People Plan.	1/2

• 'Improvement and Development Culture' in the Dudley People Plan provides the basis for supporting further staff development in the Trust.		
• The introduction of additional development activity including the Developing Leaders Programme, Evolve and Improving Professional practice programmes. • Further plans for additional development programmes are underway to expand the offer for 2021 and beyond.	Y – in part this provided access to development in a tactical approach. Further work required on strategic approach to learning and development.	2/3
• Manager's Essentials programme launched to provide clear support for leadership for all leaders – across all disciplines. Programme running weekly from March 2021	N – impact is too early to measure as programme and accreditation are not yet at critical mass. Initial feedback from participants is positive.	
• Promotion of access to CPD fund for registered health professionals	N – impact is too early to measure; although there has been increased access to development activity	
• Promotion of access to Apprenticeships for enhanced career development and professional development of leaderships skills	N – impact is too early to measure; although there has been increased access to development activity	
• Career Development Framework for AHPs and Nurses published	N – impact is too early to measure. Work underway to promote and increase take-up of development opportunities	

ACTIONS IMPLEMENTED SINCE LAST REVIEW	**IMPACT OF CONTROLS AND ACTIONS ON RISK/ASSURANCE**
Reinstated delivery of Manager's Essentials and launch of accreditation programme to support a supportive management culture including personal and team development	Positive impact of course on participants and teams; developing a more supportive management culture. Increased attendance with managers developing and implementing service actions to improve access to development in their teams.
Results published from National Staff Survey delivered and participation increased for 2020. Data indicates positive scores in relation to development for 2020.	Detailed findings not yet available. Increased participation is indicative of increased engagement in the staff survey. and negative assurance.
Re-instated Action Learning sets for Directorate Managers across all Divisions to provide better peer support; developed model for Assistant Directorate Managers.	Improve working relationships and support for middle-leaders; positive feedback from participants which improves the staff experience in these roles.
Mentoring for inclusion programme has launched with initial small number of matches/conversations	Positive impact on engagement and experience of leaders; especially those with protected characteristics. Further roll-out required to share and spread as a development programme and to impact more widely on inclusive leadership.

Career Pathway document published outlining development opportunities and pathways through from Band 2 roles to senior leadership.	Provides a summary of development opportunities available. Positive feedback from new job applicants. Further work to do to share opportunities within the organisation
Revised Appraisal Framework published for 2021 with a focus on wellbeing and development	Framework will provide focus for development conversations at an individual level. Potential for variable quality of conversations/planning and access to development

SPECIFIC GAPS IN CONTROL / ASSURANCE	**ACTIONS**	**STATUS:**		
		COMPLETE	**IN PROGRESS**	**OUTSTANDING (BEYOND COMPLETION DATE**
The main areas of weakness which result in ineffective or absent controls / assurance	*Actions required to mitigate the weaknesses*		*Date for completion*	*Action Lead*
• Delays in development and delivery of a robust OD and leadership strategy • Engagement across the organisation with manager's essentials programme and accreditation may limit impact where this is not widespread. • Further work is required to enable equitable access and utilisation of the CPD budget for registered staff to ensure this is effective and supports their CPD and identified learning needs • People Plan and Recruitment plans identified key outcomes and streams of work but have been delayed in implementation due to COVID work pressures – amended timescales are being developed as part of the relaunch of the People Plan • Gaps in identifying training needs from appraisals	Delivery of outline OD and Leadership Strategy (including Talent) as part of the WSEC Deep Dive in May.		June 2021	Head of OD & Culture
	Further development of learning activity for 2021/22 to ensure a full programme of activity meets the needs and requests of staff across all parts of the organisation. Draft in development for 2021.		May 2021	Head of OD & Culture
	Report on take-up and access to Manager's Essentials once programme has relaunched in Feb/March to ensure engagement from across the organisation and mitigate any risks of poor engagement and target appropriately		June 2021	Head of OD & Culture
	Promotion of access to CPD funding including link to organisational priorities and individual personal development plans as part of appraisal discussions and recruitment plans		July 2021	Deputy Chief Nurse

	Promotion of Nursing and AHP career pathways from entry to Chief Nurse. Embed and share across whole organisation. Undertake career conversations to support promotion of pathways. Include as part of Induction and appraisal conversations	May-July 2021	Deputy Chief Nurse
	Review of People Plan and Recruitment plan outcomes and timescales in line with period of suspended activities and to re-focus delivery during 2021/22	April 2021 Activities range from July – Dec 2021	Chief People Officer
	Targeted information gathering from Appraisal process to inform training needs	July/August 2021	Head of People – OD/ Learning Deputy Chief Nurse

Strategic Objective		**SO4 Be the place people choose to work**				**Committee**	**Exec Lead**	
						Workforce and Development Committee	Chief People Officer	
Strategic Risk No	BAF 4c	**Pre Mitigations Risk Score**	L x C 4X4 (16)	**Post Mitigations Current Risk Score**	L x C 3X4 (12)	**Board Risk Appetite** **Moderate**	**Target Score**	L x C 3X4 (12)
RISK: Failure to effectively engage and involve our workforce by not actively listening, innovating and acting on their feedback and communicating effectively could lead to an inability to positively improve culture								
Cause					**Impact of the Risk** • High levels of sickness			

• Insufficient awareness and use of formal and informal mechanisms in place to engage meaningfully with staff at all levels, and across all groups. • Insufficient investment of resource, focus and capacity to implement a structured and far-reaching staff engagement programme. • Failure to address matters locally resulting in escalation to inappropriate levels in order to solve staff issues/concerns • Lack of awareness of the changes that happen as a result of staff feedback	• Low morale • Increased employee relations issues • Inability to fulfil the aims of the Trust to the standards expected. • Lack of trust in managers to respond to staff concerns • Instability in leadership arrangements creating unnecessary workloads • Turnover of staff in management/leadership roles due to role dissatisfaction/disempowerment • Reputation damage caused by low morale leading to recruitment challenges • Decrease in engagement metrics in both staff FFT and survey			
Quarters – Change in Post Mitigation Scores	**Q1**	**Q2**	**Q3**	**Q4**
	16	12	12	12

KEY CONTROLS IN PLACE	ASSURANCE THAT CONTROLS ARE EFFECTIVE [Yes / No (if no what action is being taken)	LEVEL of CONTROL 1 = Operational 2 = Committee 3 = External
Collection of staff engagement indicators that are published within the workforce KPIs report for Committees	Y	2
Feedback from the national staff survey and FFT results introduced on the basis on 'you said, we did'	Y	2/3
Board, Executive and senior management development programmes provide better understanding of role and responsibility and impact of positive engagement and impact of behaviours	Y – further roll-out of 360 feedback and leadership development throughout 2021 underway.	3
Annual staff survey process in place	Participation increased in 2020 and is in line with benchmark group. Positive improvement in scores across most categories/dimensions reported through Board which provides	1

	an indication of change. Requires further monitoring to understanding whether indicative of positive trend.	
Engagement plans developed at a divisional level to respond to themes/issues identified in Staff Survey 2019 and 2020. Regular engagement forums in place for all 3 divisions.	Actions were limited in delivery and impact during 2019/20; forums are now active across all divisions and working on actions plans for 2021 impact. Reporting through to WSEC.	1/2

ACTIONS IMPLEMENTED SINCE LAST REVIEW	**IMPACT OF CONTROLS AND ACTIONS ON RISK/ASSURANCE**
Staff Survey results published and cascaded throughout the organisation through Chief Exec briefings and Divisional engagement forums.	Results for 2020 indicate positive improvement across the range of indicators. If sustained, this would improve the risk score and provide assurance. This will need to wait for additional 2021 data. Pulse surveys and implementation of the engagement app will provide additional evidence.
Managers Essentials programme is back running following a pause due to the pandemic. It is running weekly; although still limited to social distancing/room limits. This provides support to improvement in line managers and subsequent team engagement.	Delayed positive impact of training as spread has been slower than planned. Increased capacity during 2021/22 to support planned delivery timescale.
Divisional Staff Engagement Forums are running across all divisions alongside AHP forum running quarterly. Inclusion networks meet monthly and provide additional opportunities to identify and resolve issues for staff. Action plans reported to Workforce Committee.	Clear plans in place to deliver prioritised staff engagement improvement actions. More active staff engagement and participation under development.
Continued engagement and communication activity such as additional team briefs, daily briefings (face to face) and daily update	Positive feedback on increased engagement during COVID wave 1-3. This is identified as an area to continue activity in which will reduce risk/increase assurance of engagement with staff.
Work underway to launch pulse survey across pilot areas in early 2021 to provide additional intelligence more frequently on areas of engaged and disengaged staff.	No impact seen as this is yet to be launched – planned actions will positively impact engagement and reduce risk by being able to more quickly target areas for improvement and celebrate areas of good practice
SHAW provision and capacity has been bolstered including purchase of an extended Employee Assistance Programme, ad hoc support for areas of increased need, Staff Wellbeing steering group and Wellbeing activities to support staff	Greater support is in place for staff. Take up is increasing but remains low in comparison to the workforce numbers. Increased demand for more complex needs of staff.
Re-launch of Dudley Improvement Practice pathway events	Teams/services engaged in events develop skills/tools to change services, improve and develop. Measures for areas who have participated demonstrate positive change in relation to culture/leadership and team.

SPECIFIC GAPS IN CONTROL / ASSURANCE	ACTIONS	STATUS:		
		COMPLETE	IN PROGRESS	OUTSTANDING (BEYOND COMPLETION DATE
The main areas of weakness which result in ineffective or absent controls / assurance	*Actions required to mitigate the weaknesses*		*Date for completion*	*Action Lead*
• Engagement Forums remain under development across all divisions with further opportunity to support the review of Staff Survey 2020 results. There is a need to increase the level of engagement, particularly for front line staff in future engagement forums; ensure that actions from 2019 have been completed and identify process for 2020 actions. • SHAW services remain under review and whilst temporarily, capacity has been bolstered there is still significant work required to provide a consistent, high quality, responsive service which meets the needs of staff on a permanent basis following a period of turnover and poor leadership within the service. A new service operating model is required. • Wellbeing and EAP services were commissioned for COVID Phase 1 and are still developing; uptake amongst staff is increasing but remains low. • Local, regular staff feedback is not robustly collected. The launch of departmental Pulse Surveys will provide additional insight and intelligence to enable better and quicker responses to staff feedback.	Engagement forums to be reviewed by Divisional Directors to ensure they are running effectively alongside efforts to support higher levels of participation by front line staff. Enhancing participation levels will deliver more robust plans/actions and priorities.		April 2021 Ongoing	Head of Communications/ Divisional Directors
	Engagement plans to be improved and regularly reviewed through WSEC.			April 2021	Head of Communications/Deputy Chief People Officer
	Staff Survey results for 2020 to be analysed and shared with staff, engagement and inclusion forums and outline responses developed to link with People Plan and other planned activity.			Complete	Head of OD, Culture and Learning/Head of Communications/
	SHAW review and proposal for future operating model to be presented to WSEC			April 2021	Deputy Chief People Officer
	Wellbeing and EAP services to be reviewed and evaluated and EAP service to be re-provided for 2021/22.			April 2021 Complete	Deputy Chief People Officer
	Pulse Survey to be piloted in initial team and a further roll out plan for 2021 to be developed			April 2021	Chief People Officer/Head of Communications/ Divisional Directors
	Implement national Quarterly Pulse Survey to support national Staff Survey			July 2021	Head of OD, Culture and Learning/Head of Communications

	Delivery of actions within Dudley People Plan will support staff engagement and involvement including enhanced development, improvement activities and exit/stay information gathering.	October 2021	Head of OD, Culture and Learning/Head of People HR, Wellbeing and Workforce

Strategic Objective		**SO5 Make the best use of what we have**				**Committee**	**Exec Lead**	
						Finance & Performance	Director of Finance	
Strategic Risk No	BAF 5a	**Pre Mitigations Risk Score**	L x C 4X5 (20)	**Post Mitigations Current Risk Score**	L x C 3X4(12)	**Board Risk Appetite** **Moderate**	**Target Score**	L x C 2X5 (10)

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

Cause	**Impact of the Risk**
• Failure to fully understand the actual, forecast and underlying financial Income and Expenditure and cash position can lead to a lack of financial discipline and awareness. • The risk score has been updated to reflect the uncertainty that exists in the 2021/22 allocation of resources and the ability of the Trust to fund ongoing costs and agreed developments eg Modular Build. • Reliance on ICS partners to deliver financial balance and enhanced activity plans to secure baseline and additional activity income. • The separation of funding streams so that allocations for the second half of 2021/22 and beyond remain unknown.	• Poor decision making and a weakened ability to manage a deteriorating financial position such as when to seek support for the cash position, budget holders uncertain of resource availability, efficient use of resources and reputation.

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

KEY CONTROLS IN PLACE	ASSURANCE THAT CONTROLS ARE EFFECTIVE [Yes / No (if no what action is being taken)	LEVEL of CONTROL 1 = Operational 2 = Committee 3 = External
Financial Management, Control and Planning Policies	Yes	2
Business Case Process	Yes	2
Financial Improvement Programme	No - improving as we move out of a COVID environment and return to BAU	1
Budget Holder Training	Yes	1
SFI's	Yes	2
Scheme of Delegation	Yes	2

ACTIONS IMPLEMENTED SINCE LAST REVIEW	IMPACT OF CONTROLS AND ACTIONS ON RISK/ASSURANCE
• Additional Covid funds of just over £2m agreed in 2019/20. • Significant additional resources in the first 6 months of 2020/21. • One month's contract payments made in advance during 2020/21. • The full years financial framework for 2020/21 has been received and additional resources allocated to a value of £3m. • A financial risk share arrangement has been agreed across the STP organisations. • Successful submission of returns to fully cover the costs of a Black Country wide vaccination programme. • The development of a multi-year financial plan.	• Successful delivery of control total • Full PSF earned of £6.462m in 2019/20 • Surplus achieved of £3.521m in 2019/20 • No requirement to borrow cash and an enhanced cash position • Public Sector Payment Policy targets have improved significantly • Delivery of the planned financial position and a small surplus for 2020/21 for both the Trust and the STP. • Effective creation and operation of a system wide financial risk share for 2020/21.

SPECIFIC GAPS IN CONTROL / ASSURANCE	ACTIONS	STATUS:		
		COMPLETE	IN PROGRESS	OUTSTANDING (BEYOND COMPLETION DATE

The main areas of weakness which result in ineffective or absent controls / assurance	*Actions required to mitigate the weaknesses*	*Date for completion*	*Action Lead*
• Understanding the Underlying Position, adherence to policies • Adherence to Business Case processes, link to affordability • Adherence to Resources to deliver • Adherence to Budget Holder Training • Adherence to Scheme of Delegation • Benchmarking	Audit of Financial Controls Significant assurance received for internal audits in the year to January 2021	Mar 2021	Chris Walker
	Multi Year Financial Plan reviewed by Finance and Performance Committee Regular benchmarking of income and spend trends reviewed by Finance and Performance Committee	Mar 2021	Richard Price
	Development of full year (2021/22) plans for activity, finance, workforce and performance	June 2021	Richard Price
	Remodelling of the underlying financial position based on future published allocations	Sept 2021	Richard Price

Strategic Objective		**SO5 Make the best use of what we have**				**Committee**	**Exec Lead**	
						Digital Trust Technology committee (DTTC) Sub working group: Digital Steering Group	Chief Information Officer	
Strategic Risk No	BAF 5b	**Pre Mitigations Risk Score**	L x C 3X5 (15)	**Post Mitigations Current Risk Score**	L x C 2X4 (8)	**Board Risk Appetite** **Moderate**	**Target Score**	L x C 3X4 (12)
RISK: Failure to successfully adopt digital workflows, due to competing organisation / clinical pressures, availability of resources and change fatigue; results in clinical risk, reputational risk and inefficiency								
Cause Staff Engagement:					**Impact of the Risk** • Failure to deliver improved efficiencies and patient outcomes			

• Competing organisational priorities / change fatigue – failure to adapt new work flows and system Business Risk / Reputational Risk • Operational / clinical pressures – delayed roll out leading to risk of legacy system failing with no strategic mitigation • Cyberthreats and major failure of legacy systems / infrastructure impact staff adoption of digital workflows and Trust reputation • Failure to deliver infrastructure for interoperable digital workflows impact DGNHSFT sustainability / STP goals Clinical Risk • Not delivering maintains current levels of clinical risk with no systematic mitigation • Lack of resources caused by delayed roll outs – leads to insufficient go-live support	• Increased clinical risk or sustained current state clinical risk • Failure to meet NHS standard contract terms • Fail NHS Long term-plan / Personalised Health and Care 2020 vision and objectives • Adverse impact on patient outcomes or delays to patient care • Failure to deliver sustainability in a future platform for strategic objective 'SO3 Drive Service improvements, innovation and transformation' for future years transformation plans • Failure to support new models of care and future adoption of digital workflows • Inability to attract clinical work in the region • Inability to meet increasing demands for data returns in short timescales (remaining manual) • Loss of revenue • Trust reputation damaged

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

KEY CONTROLS IN PLACE	**ASSURANCE THAT CONTROLS ARE EFFECTIVE [Yes / No (if no what action is being taken)**	**LEVEL of CONTROL 1 = Operational 2 = Committee 3 = External**
Deployment of new workflows and enhancement of existing functionality follows clinically / operationally led design, process mapping and acceptance testing – with directorate / divisional operational ownership. Major commissioned work go-lives run through an operational Go/No-Go process and link to associated governance groups	Y	1
There are a number of forums where the wider the workforce can contribute to ongoing quality improvement. This includes transparently displaying you said we did on the digital trust intranet pages for reference and regularly updated training support content.	Y	1
Interlinked Corporate risk COR1083 - Risk of cyber a security incident causing widespread impact of Trust operational capability and patient safety	Y – controls are dynamically updated in the Corp risk register. Whilst cyber-awareness in the organisation is one part of the	1

COR1081 - Failure of the IT infrastructure would impact on patient safety and performance – dynamically address ongoing operational response to the risk environment, with controls in place	overall cybersecurity risk, there are a number of other key factors including ongoing investments in technology, as well as the increased UK cyber-threat level due to Covid-19.	
The Digital Steering Group will provide clinical governance and workforce engagement and is authorised by the Digital Trust technology Committee to investigate any activity within its terms of reference to deploy technology to meet the trusts prevailing policies, within financial budgets to meet clinical and operational needs.	Y	2
DGNHFT currently manage the clinical risk management standard DCB0160 by exception through the roles of the medical director and chief nurse (in accordance with the provisions in the statute). There is currently no designated clinical safety officer (CSO) in post CCIO and CSO roles report to MD clinical executive. CNIO reports to CN clinical executive	Currently no CSO or CNIO in place. The Trust is meeting the DBC0160 clinical risk management statue through the CCIO clinical safety review process with oversight of the Medical Director and Chief Nurse as defined in the act as "Top management".	2
Board level involvement in ICP programme, including awareness of risks linked to shared digital workflows across the Dudley health care system. In dependent due-diligence reports assess the position of digitally supported clinical pathways.	Y	3
Trust engaged with Black Country Pathology Service (BCPS) on infrastructure to deliver shared digital workflows	Y	3
Trust engaged with STP and new Midlands regional digital boards including priority setting, of local health care records (LHCR), the Black Country Local Maternity System (LMS) integration, and national procurements for virtualised of digital workflows	Y	3
Infrastructure is managed through TeraFirma IT to provide a state-of-the-art infrastructure to support the delivery of shared records population health platform between GPs and DGNHSFT (formally BAF 599)	Y	3
Allscripts are compliant with DCB0129 – clinical risk management and have a designated clinical safety officer (CSO) Dr Anna Bayes	Y	3

ACTIONS IMPLEMENTED SINCE LAST REVIEW	**IMPACT OF CONTROLS AND ACTIONS ON RISK/ASSURANCE**

Bespoke Allscripts enhancements for the Trust for our recent Electronic Prescribing and Medicines Administration (EPMA) solution deployed (Point Release 32) Adoption of eDocuments; Medical patient review and Ward Round clinical documentation to facilitate regular daily patient reviews (replacement of paper) Adoption of eDocument for Treatment Escalation Plan and Resuscitation Status with population level sharing (across place). Data Service model using new Data Relationship Manager roles embedded in Trust Site Office and corporate services to provide insight / oversight dashboards and visualisations. Proactive implantation and adoption of data visualisations used to target discharge and flow. Solution upgrades to Radiology solutions and Intensive Care electronic records delivered. In response to COVID: • Provision of virtual wards in Sunrise and clinical documentation to support • Mandated patient scores and vital signs • Oxygen updates to improve recording of vital signs • Work package 1 (of 4) of the Deteriorating Patient pathway to support vital signs • Digital delivery of Dudley vaccination centre, PCN sites, roving teams and hospital hub d being used as a blue-print to support other boroughs. • Lateral flow testing portal rapidly mobilised using in-house team to capture and report lateral flow testing of the workforce Trust is preparing to undertake its project to build digital maturity in e-Rostering across wider staff groups (to included AHPs) after successfully securing National funding. Network re-fresh delivering the platform for further, future digital innovation continues to deliver	<u>Positive Assurance</u> L1 Positive assurance – ongoing use of video conferencing solution *Attend Anywhere* within outpatient workflows - 600% increase in virtual appointments (170,000 from April to Dec 2020). L1 Positive assurance – significant use of video conferencing's, collaborative productivity tools and up to a third of staff on shift working remotely each day. L2 Positive assurance – digital committee re-cast technology BAF against the refreshed Trust strategy as adoption of what we have improves – provision of digital service transformation is required. L3 Positive assurance Positive assurance, all devices use Advanced Threat Protection to safeguard. L3 Positive assurance – delivery of digital workflow for vaccination centres widely credited. <u>Negative Assurance</u> L2 Negative assurance – current risk level maintained below board appetite. Digital investment decisions to transform need to risk more for greater reward. L2 Negative assurance - Clinical Safety Officer post vacant. MD – advertising, await post fill. L2 Negative assurance - Chief Nursing Information Officer vacant post - CN / CCIO review L3 Negative assurance - National funding and central contract for the currently free-of-charge Attend Anywhere solution has been extended to March 31st

Patient Administration System (PAS) and Oracle infrastructure refresh business case, transitions into delivery to ensure ongoing stable technology platforms for core business solutions.	2020, at which point it will cease. Memorandum of understanding being reviewed for extending for one year at same time as investigating if Microsoft Teams could replace. Procurement work progressing – no concluded. L3 Negative assurance - Lack of clarity on DIHC technology proposal and plans and ICP full busines case / subcontract position, leads to uncertainty and lack of technology provision for community teams.

SPECIFIC GAPS IN CONTROL / ASSURANCE	**ACTIONS**	**STATUS:**		
		COMPLETE	**IN PROGRESS**	**OUTSTANDING (BEYOND COMPLETION DATE**
The main areas of weakness which result in ineffective or absent controls / assurance	*Actions required to mitigate the weaknesses*		*Date for completion*	*Action Lead*
~~1. Dissemination of clear messages into wider clinical community by members of the CAG do not always occur / inconsistent leading to disenfranchised staff.~~ 2. Staff with high levels of digital engagement, leaving a gap to those less eager. ~~3. Original strategy launched under different executive / senior leadership teams leaving an awareness Gap~~ ~~4. Risk appetite lower than current risk level – leading to avoidance disruption / go-live~~ 5. Lack of Staff engagement – creates a block to adopting change 6. Speed of mobilisation and operational readiness leading to lag-time 7. On-going system support, by skilled staff 8. Revenue to recruit and retain adequate skills to deliver projects of this scale 9. New initiatives divert resources away from core project activity	~~Embedding of Digital Transformation through clinically led Board committee's (CQPSE) and groups to ensure that digital first forms part of a reasonable assurance processes and avoids false assurances.~~ Digital committee reinstated, bi-monthly. Committee work plan has been devised such that in the non-meeting months members will support the Digital Steering Group undertaking quality reviews / deep-dives in key areas around the Trust to support the quality committee in establishing clear action plans.		Jul 19	Max Hodges (CCIO)
	Digital strategy re-launched in Board away day. Trust board January 2020 agreed to reinstate committee level oversight, with revised digital / medical devices steering groups. Agreed Digital Trust Technology Committee Terms of		Mar 20	Adam Thomas (CIO)

~~10. Lack of clarity on HSLI Pop Health fund matching (approved case in 18/19 funding held back) carrying forward into 19/20~~ ~~11. Clarity on MCP strategic formation~~ ~~12. Changes in BCPS priorities and co-dependent risk (transferred Corp risk CE008)~~ ~~13. Failure of existing EPR (Soarian) may mean electronic record is irrecoverable. Sunrise Go-live is only mitigation (Corp Risk CE009 / COR091)~~ ~~14. Operational No-Go decision protracts existing higher levels of clinical risk / dual systems of work and chance of Soarian failure.~~ 15. Current levels of organisational-wide clinical risk in practice are poorly understood by the workforce, so that something new seems more risk than something familiar. 16. Digital Trust programme perceived as a technology / IT project rather than clinical transformation (see item 1).	Reference and Digital Steering Group ToR in February 2020 Board.		
	Increase exposure of all clinical groups to independent clinical safety review (CSR) of each project roll out, driving digital skills within the wider clinical workforce and better understanding of clinical risk at an organisational level.	Sept 19 continual process	Clinical Safety Officer / Max Hodges (CCIO)

Strategic Objective		**SO6 Deliver a viable future**				**Committee**	**Exec Lead**	
						Finance & Performance	Director of Strategy and Business Development	
Strategic Risk No	BAF 6a	**Pre Mitigations Risk Score**	L x C 5X4 (20)	**Post Mitigations Current Risk Score**	**L x C 4X4 (16)**	**Board Risk Appetite**	**Target Score**	L x C 3X4 (12)
						Moderate		

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

Causes **Relationships**	**Impact of the Risk**

• Challenged relationship with main commissioner • Lack of engagement with GP practices to jointly develop new service models • Lack of profile of the Trust as an anchor institution in the community **Competition** • A number of acute Trusts within a small geographical area providing similar services. • Private provider in Birmingham for Ophthalmology offering low waiting times • Sandwell & West Birmingham Hospitals integrated with a PCN since Apr-20 which is a significant user of our services **Policy direction** • Implementation of Integrated Care Partnerships at 'place' level has locally been interpreted as the establishment of new organisation (DIHC Integrated Care **Provider**) to deliver and sub-contract for range of services currently provided by DGFT. Could result in significant loss of services. • Development of Integrated Care Systems are predicated on greater provider collaboration, with local drive towards shared leadership / group models; this could result in loss of autonomy. • Block contract arrangements for 20/21 affect ability to income generate; arrangements for 21/22 not yet fully known.	• Loss of activity and associated income may destabilise some services impacting on continued provision • Loss of ability to income generate resulting in CIPs being more focused on cuts to services. • Fragile and fragmented clinical services which become unsafe • Financial losses that threaten the sustainability of the Trust

Quarters – Change in Post Mitigation Scores	Q1	Q2	Q3	Q4
	20	20	16	16

KEY CONTROLS IN PLACE	ASSURANCE THAT CONTROLS ARE EFFECTIVE [Yes / No (if no what action is being taken)	LEVEL of CONTROL 1 = Operational 2 = Committee 3 = External
Weekly operational meetings initiated to ensure good communication throughout COVID waves2 and 3. These have transitioned into fortnightly meetings which ensure alignment across primary / community / secondary care pathway developments, taking forward actions from the monthly engagement meetings and can quickly pick up any operational issues.	Partial – need to confirm terms of reference for clinical integration meeting.	1
Monthly GP / DGFT clinician engagement still taking place, attended by 50 – 70 people.	No – need to review effectiveness.	1
Dedicated Executive support in place to work through the development of the Integrated Care **Provider** in order to ensure risks to DGFT are mitigated.	Yes	2,3
The Integrated Care **Provider** development is scrutinised by the Board directly with approval sought at each gateway.	Yes	2, 3
The Integrated Care Provider development is subject to a national assurance process overseen by NHSEI.	Yes	3
DGFT is an active member of Dudley Partnership Board which will has been reconstituted to become the vehicle for the Integrated Care **Partnership** for Dudley.	No – consideration needs to be given to how the Board has oversight of this.	1
A comparative analysis of performance is presented to F&P Committee every six months with an evolving range of measures discussed to highlight the Trust's strengths and weaknesses. This includes market share analysis to identify changes in referral patterns	Yes	2
Director of Strategy and Transformation part of STP team to develop the case for change, options appraisal and implementation plan for acute collaboration, reporting to Chairs and CEOs.	Yes	3
Board and Governors to have full oversight of proposals for acute collaboration and are required to approve any changes in governance.	Yes	2

ACTIONS IMPLEMENTED SINCE LAST REVIEW	**IMPACT OF CONTROLS AND ACTIONS ON RISK/ASSURANCE**	
GP Engagement • Clinical engagement meetings now established between DGFT and primary care, with sub-group working on developing shared agenda, ensuring actions are followed through, etc. • Weekly operational meetings established between DGFT, DIHC, CCG and PCN leadership to ensure good communication regarding pressures arising from Covid and any services changes required to be made. • Currently exploring establishment of a forum to ensure coherence across primary / community / secondary care pathways. **Procurement of Integrated Care Provider** • Following full analysis of the Full Business Case and intensive negotiations to attempt to resolve outstanding issues and risks, report was presented to DGFT Board in Oct 2020 recommending that the Board do not support the FBC. • National review of FBC has not been progressed given the clinical and financial risks inherent within the Business Case and the poor relationships in the system. • Position statement and way forward jointly agreed by the 3 key providers (DGFT / DIHC / BCP) and confirmed at meeting with NHSEI on 1/4/2021. • As part of this, work has commenced to review the transfer of a range of community services, led by DGFT clinicians in the first stage. • The way forward also confirms that there will be no subcontract in place between DIHC and DGFT for outpatients / emergency admissions / other services and that these will now be commissioned directly by the CCG.	<u>Positive Assurance</u> Risks in the Full Business Case identified and articulated. NHSEI verbal confirmation that risks are too great for transaction to proceed at this time and for local partners to agree the way forward. Written statement setting out the way forward agreed by the provider trusts. <u>Negative Assurance</u> Still a level of uncertainty regarding the full range of community services originally in the scope of the procurement and / or that the commissioiner may push for an alternative arrangement to the sub-contract which is not acceptable to DGFT in order that the original procurement can be delivered.	

Development of Integrated Care Partnership

- Terms of Reference for Dudley Partnership Board refreshed to reflect emerging role as the vehicle as the Integrated Care **Partnership** (rather than, as previously, a board to oversee implementation of the Integrated Care **Provider**).
- A series of developmental workshops have been held to explore the role of the Partnership Board and how it can add value. The initial focus has been on improving children's health. DGFT actively involved in planning and participating in these workshops at Director level.
- Active participation in CCG-led work regarding scope of services to be 'managed' at place level as part of future ICS arrangements.

Acute Collaboration

- Following agreement by all four Trust Boards in December 2021, the Acute Provider Collaboration Programme has now been initiated. The programme board has met twice, signing off the case for change, programme plan, terms of reference and some quick wins. It also approved a series of significant clinical engagement events over the summer to ensure changes are clinical designed and led.
- DGFT CEO is joint SRO for the programme; Director of Strategy and Transformation is the lead for governance and implementation; Director of Finance is lead for back office efficiencies and financial modelling workstreams.

Strategy Refresh

- Refresh of strategy has commenced to provide framework for how the organisation develops over the next 3 – 5 years, including in its role as an anchor institution.

• Two Board development sessions held to further develop the strategy. • Consideration of national context and changing NHS architecture resulted in decision to produce a 3 year strategic plan. • Board agreement to vision, values, goals and big programmes of work. • Strategic Plan on course to be finalised for July Board.	

SPECIFIC GAPS IN CONTROL / ASSURANCE	**ACTIONS**	**STATUS:**		
		COMPLETE	**IN PROGRESS**	**OUTSTANDING (BEYOND COMPLETION DATE**
The main areas of weakness which result in ineffective or absent controls / assurance	*Actions required to mitigate the weaknesses*		*Date for completion*	*Action Lead*
• Integrated Care **Provider** – lack of formally agreed way forward.	Pragmatic way forward to be developed and proposed.		Apr 2021	Tom Jackson
• Trust's existing strategy reliant on income growth in time of greater collaboration.	Board development session to refresh strategy and ensure alignment with changing NHS architecture and financial environment.		Feb 2021	Katherine Sheerin
	Draft strategy to be presented to Board in Apr 2021		June 2021	Katherine Sheerin

SPECIFIC GAPS IN CONTROL / ASSURANCE	ACTIONS	STATUS:		
		COMPLETE	IN PROGRESS	OUTSTANDING (BEYOND COMPLETION DATE
The main areas of weakness which result in ineffective or absent controls / assurance	*Actions required to mitigate the weaknesses*		*Date for completion*	*Action Lead*
	Stakeholder analysis and action plan to be produced to underpin the strategy		Jun 2021	Liz Abbiss
• Terms of reference for fortnightly clinical engagement meetings not confirmed.	TOR and work plan to be confirmed.		Jun 2021	Katherine Sheerin
	Review of monthly GP / DGFT engagement meetings to be undertaken.		July 2021	Katherine Sheerin
	Routine relationship meetings to be set up with other key partners, including commissioners, LA, etc		Apr 2021	Katherine Sheerin
• Limited involvement by Trust staff in the different work streams of the STP / ICS	Strengthen engagement with the work streams of the STP by being clear on where DGFT input is on the work streams and identifying any gaps in engagement /involvement across the Programme. Co-ordinate a regular update to Exec Directors.		May 2021	Katherine Sheerin
	Programme Board for acute collaboration to be established.		March 2021	Katherine Sheerin

Enclosure 21

Paper for Submission to the Board of Directors 10th June 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:

The key issues are identified in the attached report.

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	**Y**	**DATE:**25/05/21 Quality and Safety Committee

CHAIRS LOG

UPWARD REPORT FROM QUALITY AND SAFETY COMMITTEE

Date Committee last met: 25th May 2021

MATTERS OF CONCERN OR KEY RISKS TO ESCALATE	MAJOR ACTIONS COMMISSIONED/WORK UNDERWAY
• The Committee received an overview report and action plan to address the risks and gaps identified. Limited assurance was received regarding the oversight of the pressure ulcer incident management framework and subsequent data accuracy. The Trust has completed a full review and is actively delivering its action plan at pace. • Assurance received of the provision of internal and external support provided to clinical leaders in the emergency department since 2017. The recognition that further work was required in relation to psychological safety between teams. Interventions had been identified to deliver a clear and agreed method of promoting and escalating concerns from the multidisciplinary team. • Limited assurance received in relation to a month on month increase of the number of procedural documents exceeding their review date. The framework had been reviewed and actions identified/being delivered for improvement. • Negative assurance received in relation to one of the four Stroke metrics not meeting the required standard of compliance for TIA. Actions have been implemented to address this further decline. • The Trust had recorded an increase in SHMI (standardised Hospital Mortality Indicator) for the last two reporting periods with the latest value of 1.19. The SHMI denominator has reduced disproportionately to impact significantly on overall SHMI. • The number of serious incident actions outstanding.	• Wrong blood in Tube report to come back to the Committee following a further deep dive across the Trust and assurance of actions taken in response to the review actions reported to the committee. • Stroke Services trajectory and action plan for recovery to be brought back to the July 2021 Committee
POSITIVE ASSURANCES TO PROVIDE	**DECISIONS MADE**
• Positive assurance received in relation to the NORSE pathway. All actions had been delivered and the first of two audits showed times had significantly improved, there had been a decrease in incidents reported over the previous 12 months and no harm incidents	• Approved the Quality and Safety Account for submission to the Board for approval

• Positive assurance received in relation to wrong blood in tube. Following the introduction of measures put in place in the Emergency Departments there had been a reduction in incidents. Further work was being under taken across the Trust to roll this out • Positive assurance of a detailed and comprehensive action plan developed and being delivered by the Trust in response to the IPC peer review carried out by NHSI/E on the 6th April 2021.	

Enclosure 22

The Dudley Group NHS Foundation Trust

Paper for submission to the Board on 10th June 2021

TITLE:	**Quality Account – 2020/2021**		
AUTHOR:	Natalie Launchbury Compliance Manager Sharon Phillip	**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 BOARD

Decision	Approval	Discussion	Other
	√	√	

RECOMMENDATIONS

- To approve the Quality Report 2020/21 for external submission to NHSE/I

CORPORATE OBJECTIVE:

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

SUMMARY OF KEY ISSUES:

The attached Quality Report has been compiled and contains all the national mandated requirements. Some national and local comparative data has not been made available, due to the Covid 19 Pandemic.

NHSI has announced for the second consecutive year that the annual Quality Report and Account of Foundation Trusts does not require an external audit review. Please note the Trust was informed by NHSE/I on the 30th April 2021 the submission of the Quality Account was the 30th June 2021, an extension due to the pandemic had not been offered as it was the previous year. The report is presently out for comment with our partners namely the Trust Council of Governors, the Dudley Clinical Commissioning Group and Healthwatch Dudley; their statements will be added to the report prior to publication.

The Board is asked for comment and to approve the submission to NHSE/I to meet the June 30th 2021 timeline.

IMPLICATIONS OF PAPER:

IMPLICATIONS FOR THE CORPORATE RISK REGISTER OR BOARD ASSURANCE FRAMEWORK None

RISK	**N**		**Risk Description:**
	Risk Register: N		**Risk Score:**
COMPLIANCE and/or LEGAL REQUIREMENTS	**CQC**	**N**	**Details:**
	NHSI	**Y**	**Details:** As per Quality Account requirements

	Other	**Y**	**Details:** As per DoH Quality Report requirements
REPORT DESTINATION	**EXECUTIVE DIRECTORS**	**N**	**DATE:**
	WORKING GROUP	**N**	**DATE:**
	COMMITTEE	**Y**	**DATE: 25/05/21 Quality and Safety Committee**

Enclosure 23

The Dudley Group NHS Foundation Trust

Paper for submission to the Public Trust Board on Thursday 10th January 2021

TITLE:	**Chief Nurse Report**		
AUTHOR:	**Helen Bromage** **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 ongoing work of the Chief Nurses' teams.

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:

Dynamic ongoing work by the Chief Nurses' teams to ensure a safe workforce with patient care and safety at the centre.

The author has faced challenges this month with incomplete data sets being made available due to the timing of the meeting and the paper submission dates the complete data set will be included in the next month's report.

IMPLICATIONS OF PAPER:

IMPLICATIONS FOR THE CORPORATE RISK REGISTER OR BOARD ASSURANCE FRAMEWORK

RISK	**Y/N**		**Risk Description:**
	Risk Register: Y/N		**Risk Score:**
COMPLIANCE	**CQC**	**Y/N**	**Details:**

and/or LEGAL REQUIREMENTS	**NHSI**	**Y/N**	**Details:**
	Other	**Y/N**	**Details:**
REPORT DESTINATION	**EXECUTIVE DIRECTORS**	**Y/N**	**DATE:**
	WORKING GROUP	**Y/N**	**DATE:**
	COMMITTEE	**Y/N**	**DATE:**

NHS
The Dudley Group
NHS Foundation Trust

Chief Nurse Report

Trust Board 10th June 2021

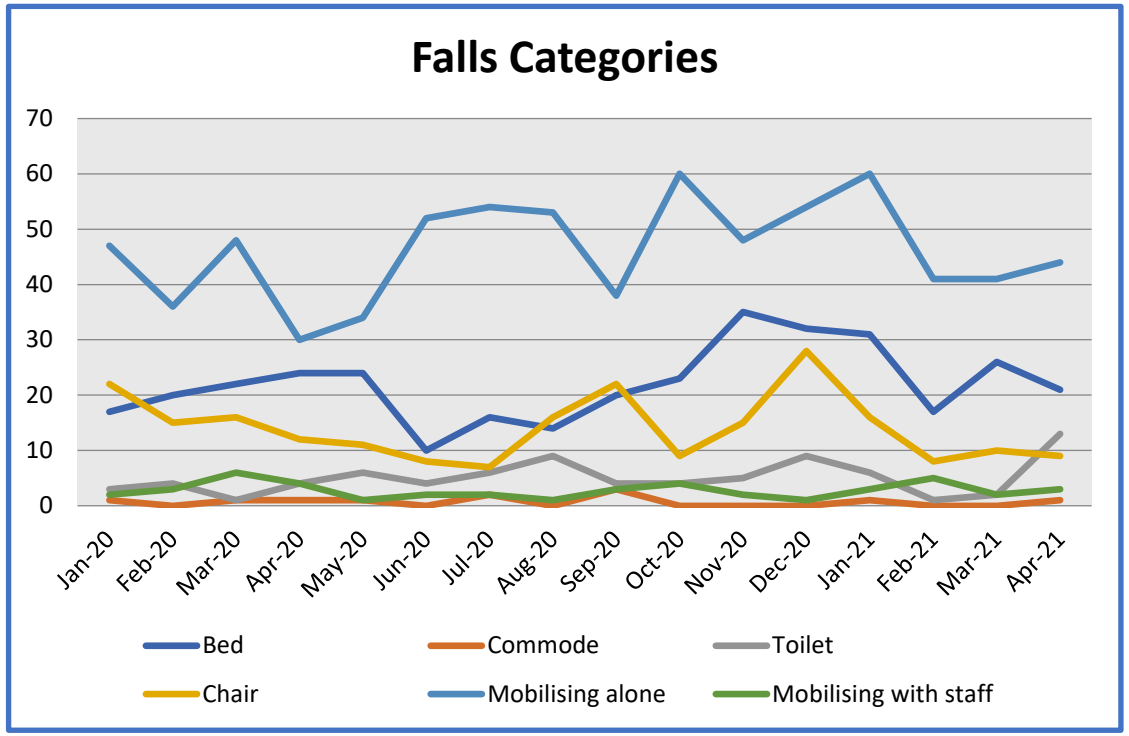
Mary Sexton, Chief Nurse

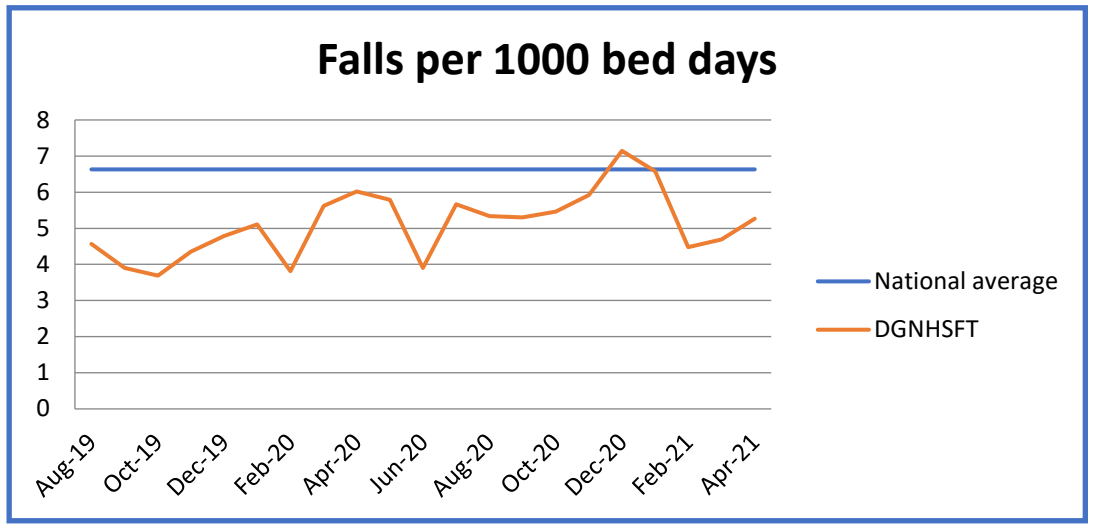


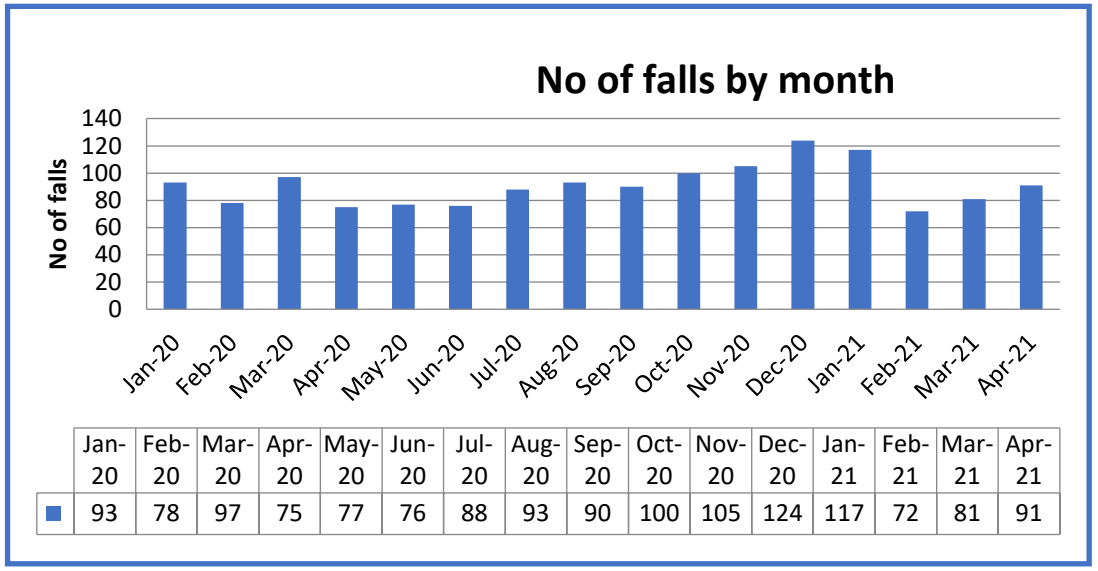

Care - Deliver safe and caring services - Falls

Falls –

May is expected to see an overall reduction in falls, however 2 of those falls been identified to have caused severe harm and are under investigation.







	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

Paediatric Services – CN update

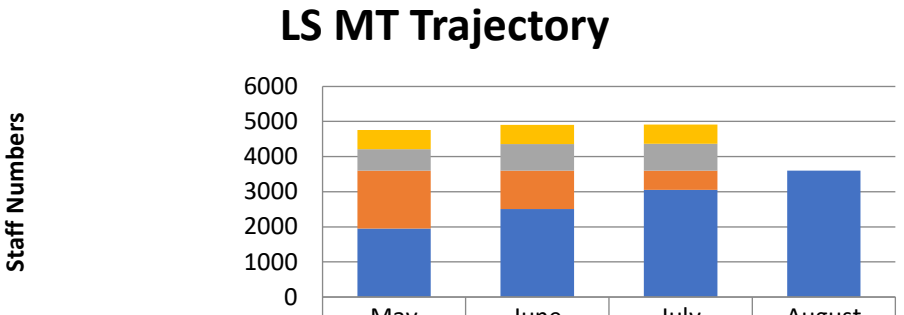
- **Practice Educators**
- In order to support education and clinical skills development Children's Services have recruited Practice Educators for the Neonatal and Paediatric areas. The Educators are taking the lead in ensuring that the teams are addressing outstanding mandatory training. In addition they are facilitating the delivery of cannulation and venepuncture training for neonatal and paediatric nurses. They have secured training to promote inclusivity of vulnerable and minority groups, such as LBGTQ+ and Makaton training.

- **Health Passports**

- A health passport has been developed by a working group of children's professional leads from Black Country Healthcare Foundation Trust and the Dudley Group NHS Trust. Building on the existing 'hospital' passport the health passport is an adapted version that is applicable for use in all settings such as school, primary care and community health services. The passport will be completed by the child, young person and their parents and carers and will be a holistic record of needs. The passport can then be brought to appointments and will facilitate good communication with having to retell their story. The passport will be issued by a healthcare professional and will subject to ongoing review.

Life Support Mandatory Training Compliance

LS compliance has had a significant decline over the past 6 months, which has been hampered by the pandemic response and the need for suspending training. The DP&R Team have moved to assessment of compliance only in an attempt to facilitate rapid attainment of compliance.



	May	June	July	August
Expected use of places	549	548	548	
Min places available in month	612	760	766	
Number outstanding	1645	1096	548	0
Trained at Start of month	1955	2504	3052	3600

Compassion - Deliver a great patient experience

- **Deprivation of Liberty Safeguards (DoLS)**

The Trust has submitted applications for 7 DoLs throughout out May.

No approved standard authorisations have been received due to lack of Supervisory Body assessors; this is a known national issue. The Mental Health Team have been informed that as long as patients are reviewed daily by the team to ensure DoLS remains appropriate, the DoLS can remain in place. There is not a requirement for the Trust to resubmit applications.

The new national DoLs procedure, due to be launched nationally in 2022, will resolve this issue as the Trust will be expected to approve and manage its own DoLs authorisations. Preparations for this are being overseen by the Head of Safeguarding.

A total of 4 patients remain in Trust who are subject to DoLS restrictions at the end May 2021.

New restrictive intervention related questions have been added to all Datix reports in the categories of 'violence and aggression' and 'absconding patients'. This is to ensure staff consider requesting a DoLS application, if not already in place.

- **Mental Health Act**

In April 2021, 1 patient from AMU was issued with a section 5 (2) within the Trust. This patient was transferred to Penn Hospital for further care on the same day as section was applied.

In May 2021, 1 patient from B3 was issued with a section 2. Patient is awaiting an out of area bed and has security and a Registered Mental Health Nurse present 24/7 to manage patient's condition.

Competence - Drive service improvement, innovation and transformation

Professional Development

Recruitment

Since December 2020 until March 2021 we have recruited over 150 new CSW's and have all placed in our clinical areas. This has made a significant impact on CSW vacancies. This excellent work has been recognised by NHS England and Improvement with positive praise and showcasing of the work both regionally and nationally.

With a combination of national funds matched by the trust we have entered into partnership with Royal Wolverhampton Trust (RWT) to recruit 75 international nurses and to support them through the RWT established clinical fellowship programme in collaboration with the University of Wolverhampton. The first cohort of 25 are expected into he trust towards the end of July.

Career Development Launch

Following the publication of the Trust Career Development Guidelines for Nursing, Midwifery and AHP staff in September 2020, a formal launch took place on 26 and 27 May 2021. One event was face to face, the other a virtual session. Both sessions were well received with staff commenting they were not aware of the many and varied opportunities for development of their careers within Dudley.

The virtual session was recorded and will be loaded onto the Hub for staff to access, with further interactive sessions planned for 23 and 24 June; 21 and 22 July. All sessions were planned to tie in with the new appraisal documentation; assisting with the career development discussions during the May – July 2021

Freedom to speak up (FtSu)

Activity in May has included the finalising of the in house mandatory training for all staff on FTSU - this is a 10 minute video which will be slotted in to the Equality and Diversity session; this will go live in the next week or two.

Deteriorating Patient and Resuscitation Team (DP&RT).

DP&RT have taken steps to support with rapid attainment of compliance for life support training and have move to assessment of competence without training. This has been successful with over 700 members of staff being assessed as competent throughout May.

The introduction of cascade assessors is planned for June at the request of the divisions to support with further rapid achievement of attainment.

Communication - Make the best of what we have

Committed to Excellence Awards.

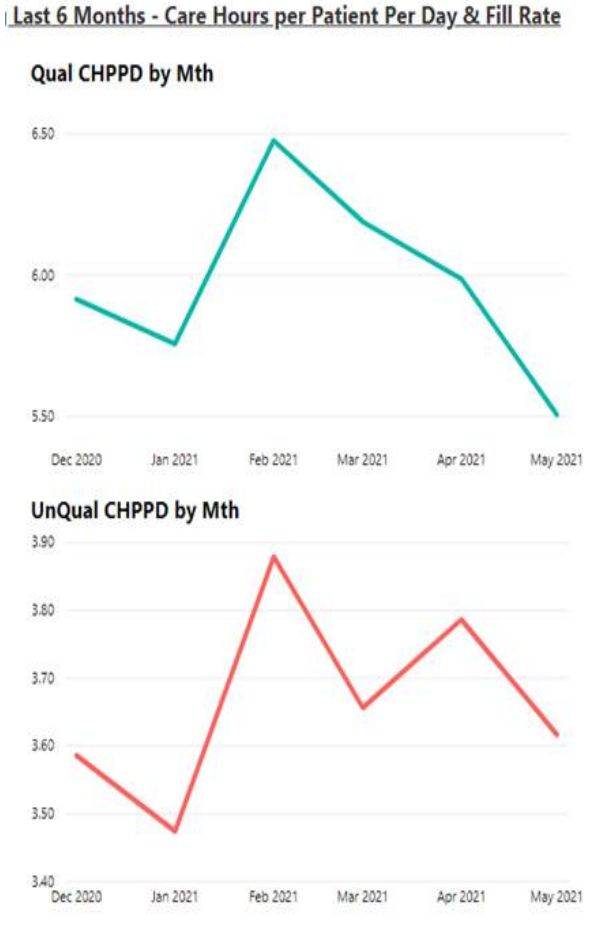
The annual ceremony this year took a different turn with numerous individuals and teams being nominated for Covid-19 Special awards. Multiple members of the Nursing, Midwifery and Allied Health Professions were nominated and awarded awards. A truly memorable night celebrating the dedicated staff of our Trust.

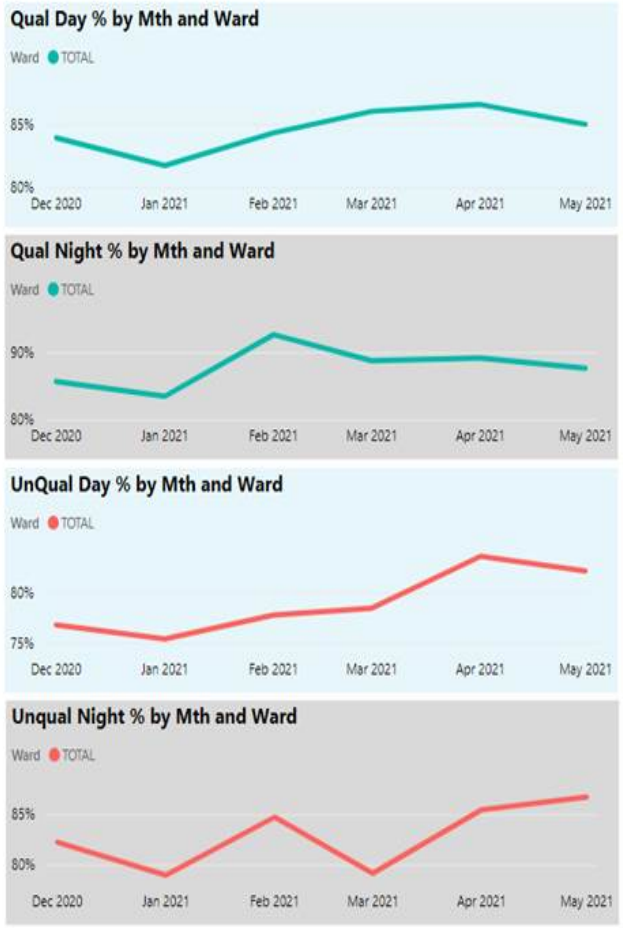
- **Relative feedback about Susan Whorton – Clinical Support Worker Ward C7**

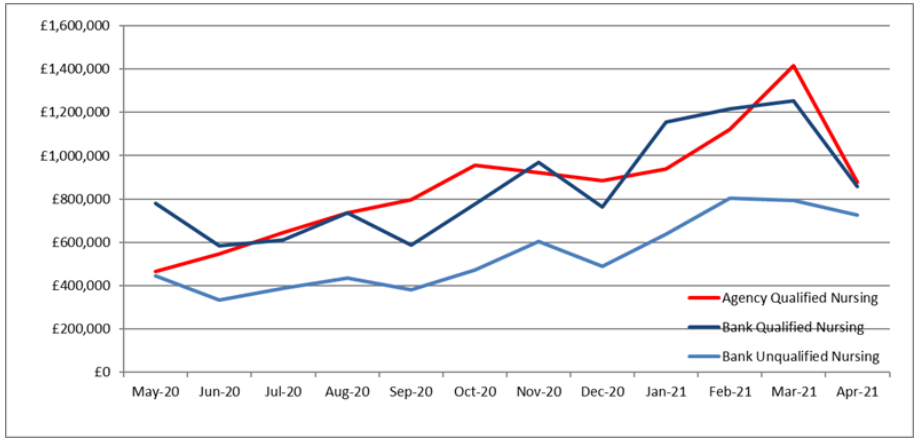
I would just like to thank, a member of your nursing team on c7. Her name is Sue. During the early hrs of Monday morning (2.15 am) I called the ward as my brother is a patient on there, he'd called my mobile he wasn't feeling too good, I telephoned the ward a lady named Sue picked up the call, I was very upset, and stressed about my brother, he's been in hospital a month so I haven't seen him due to covid restrictions she was so kind and reassuring to both myself and the patient.

She managed to sort the situation. Then called me back half later to reassure me, I can't tell you how much I valued that call, and the fact that she went to care for my brother straight way. She was so caring and kind, what a credit to the NHS, please pass on my message of gratitude to her, she'll never realise how much her compassion meant to me that night, especially in these difficult times. Thank you so much

Commitment - Be the place that people choose to work







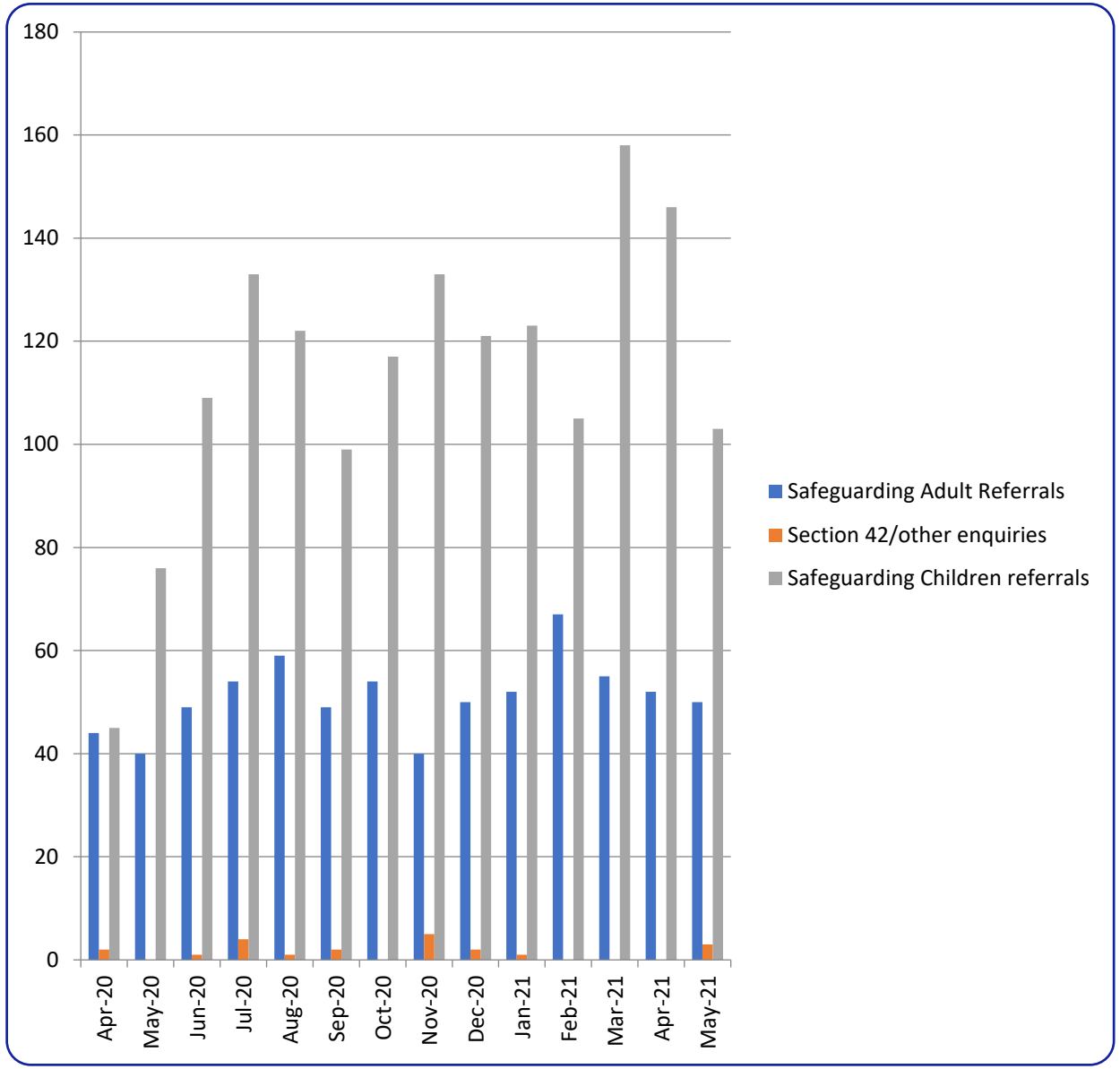
Area	Vacancy %	Agency Qualified Nursing	Bank Qualified Nursing	Bank Unqualified Nursing	Grand Total
I.T.U.	1%	£298,649	£51,342	£9,216	£359,207
Emergency Department Nursing	-3%	£122,594	£43,557	£34,924	£201,075
Acute Med Unit (EAU)	18%	£32,169	£52,955	£26,279	£111,403
Ward C8	-4%	£58,329	£22,709	£17,504	£98,542
Ward C7	7%	£52,865	£12,755	£26,973	£92,592
Ward B3	29%	£57,206	£16,225	£12,111	£85,543
Ward C5 Area B	-14%	£48,954	£10,881	£8,115	£67,950
Ward C5 Area A	-11%	£49,935	£8,112	£4,824	£62,871
Ward B5	-3%	£18,081	£21,868	£13,760	£53,709
Ward C3	4%	£9,550	£12,065	£25,996	£47,611

Agency spend has reduced in April compared to Feb& Mar; there are still pockets of high usage such as critical care but that is based on substantive staff taking their leave where possible.

Courage - Deliver a viable future

Safeguarding

- Referral made to DSPPB for Child Safeguarding Practice and Safeguarding Adult Review
- Helpful Safeguarding Adult Report completed for Sandwell Safeguarding Partnership
- Patient story presented at DSPPB – Adults Group
- Positive feedback received from Designated Nurse at CCG regarding development in Safeguarding during last 12 months
- Trust Domestic Abuse Strategy to be adopted as Dudley Health DA Strategy
- Named Midwife has taken part in filming for the roll out of Graded Care Profile Assessment 2a – tool for midwives
- Named Midwife attending pre-birth panel meetings with Sandwell Children's Trust
- Associate nurse has secured information sharing agreement to work in partnership with Hear4youth to support young people with substance misuse issues
- Team walkabouts commenced to include monthly focus – May: Was Not Brought
- Trust Safeguarding posters with information for visitors and patients distributed across the Trust
- "Reachable Moments" project – plans continue with potential of additional funding from The St Giles Project



Enclosure 24

The Dudley Group NHS Foundation Trust

Paper for submission to the Trust Board June 2021

TITLE:	**Infection Prevention and Control Board Assurance Frame Work**		
AUTHOR:	**Jo Wakeman – Deputy Chief Nurse** **Hannah White and Kim Jarrett Infection Prevention Clinical Nurse Specialists**	**PRESENTER**	**Mary Sexton – Chief Nurse and Director of Infection, Prevention and control**

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 demonstrates the Trust compliance with the Health and Social Care act 2008 and highlights the gaps in assurance for action. In May 2020 NHSI/E requested that the Infection Prevention board assurance framework template is completed and shared with the Trust board . One of the key areas to combating the COVID pandemic 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 the last report:

- IPC training at the time of this report continues to be below target, recovery plans have been agreed with each of the Divisions to achieve the required compliance
- NHSI/E visit was conducted on 16th April. Following the external review the BAF has been updated to include the following recommendations:
- Across all areas that were visited there were repairs required to the estate, plans of work are in progress to address these concerns.
- Environmental cleaning was below target in some areas, with high level dust identified in almost all areas visited.
- There is limited storage on all ward areas. Additional storage units have been brought on site.
- An action plan has been developed to address concerns monitored by the DIPC.
- Introduction of 'Dump the junk' days to assist with the decluttering of our clinical areas.
- Staff were observed to be wearing their FFP3 facemasks when they had facial hair, this is not in line with the HSE guidance around fit testing which advises that "facial hair – stubble and beards – makes it impossible to get a good seal of the mask to the face, this has been addressed at individual levels via line mahagers.
- Throughout critical care and the emergency department there were consumable

items which had been taken out of their packaging and set up.

- The air pressures in "ITU A", which is the designated COVID-19 area, have been changed from negative pressure to positive pressure following a risk assessment.
- A full review of the IPC risk register has been completed.
- Strengthen staff awareness in terms of roles and responsibilities in relation to decontamination of equipment and infection prevention and control. Each IPC policy includes detail of roles and responsibilities for all staff.
- Materials Management – stock control. For review of items that can be moved to NHS Supply Chain from direct supply – bringing them into the Materials Management service. Continue to monitor national stock position for changes to current disrupted stock lines.
- Documentation – For review of all IPC policies.

An action plan has been developed in order to address the issues identified following the visit. This willl be monitored via the Infection control goup and will be upwardly reported to the Trusts Quality and Safety Committee.

There are no red non-compliant areas without mitigation, there are 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: The IPC Board Assurance frame work was requested by NHS/I**
	Other	**N**	**Details:**

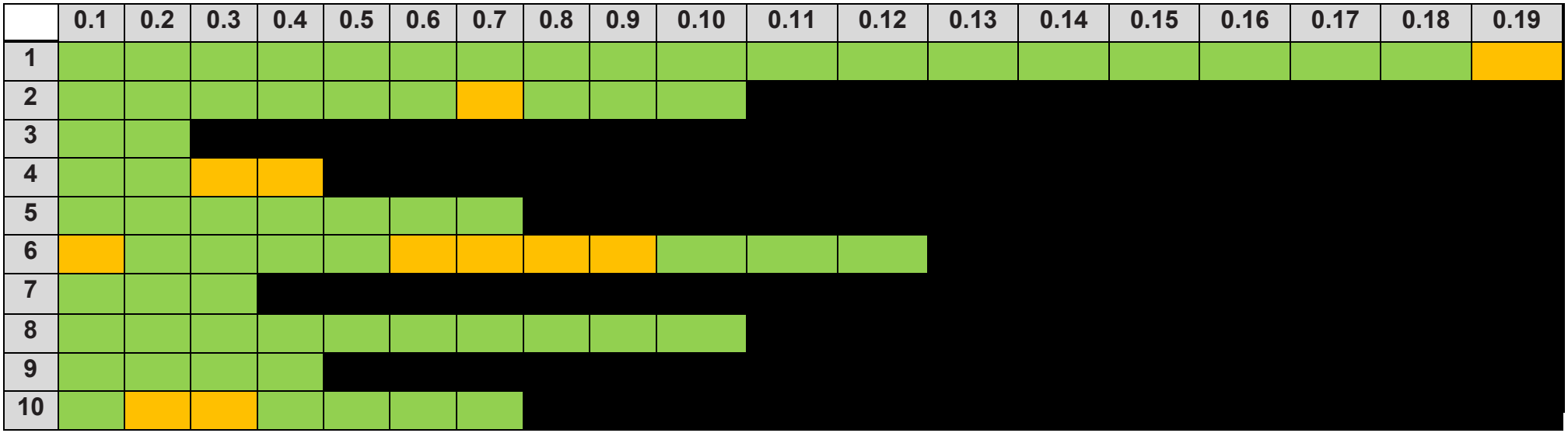
ACTION REQUIRED OF COMMITTEE / GROUP:

Decision	Approval	Discussion	Other
		✓	

RECOMMENDATIONS FOR THE BOARD /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	
1.20	NHSI visit Noted several areas required estates work completing.	Additional Estates focused reactive audits being introduced as of 17th May 2021 to review wards and departments across the sites on a targeted basis. Minor issues that can be dealt with within 24 hours will be followed through to completion and performance monitored through the PFI contract mechanisms as required.		All other works identified will be prioritised/RAG rated on a formal action plan with risks mitigated as required and progress reported through to Corporate level via the IPCF and Quality and Safety Committee	

		All ward and department staff to be reminded of the requirement to report all estates reactive works to the MITIE help desk and to escalate any that are not completed in the required response times to the Trust PFI contract management team. Full review of Critical Care Unit undertaken in conjunction with Lead Nurse, Summit Healthcare Ltd and Mitie. Action plan agreed covering three categories: **Maintenance** – Work has commenced on site, orders raised with suppliers. Estimated Date for Completion 30/05/2021 based upon access being available to all required areas.		Matrons and DIPC emailed on29/04/2021 requesting clinical representation at Trust Audits Additional estates reactive auditing to be introduced from 17th May 2021 to review wards and departments across the sites on a targeted basis and to follow through to completion of all issues identified.	

		Life Cycle – Plans being developed to refurbish identified areas which will be treated as priority. Estimated Date for Completion 30/05/2021 based upon access being available to all required areas. **Variations** - Variations raised which will be treated as priority. Some items will have a lead time including the new patient kitchen etc. Estimated Date for Completion 30/06/2021 based upon access being available to all required areas.			
1.21	NHSI review Risks outlined, a full review and escalation of risks on the risk register should be carried out as well as a full review of the current IPC risk register.	Risk register reviewed at IPC group agreed risks appropriately reflect the risks. <u>Critical Care</u> Risks and actions reviewed on 7.4.21 & 28.4.21 TAC1412 – Lack of storage affecting MHDU - 24.7.20 7.4.21 – Risks added: TAC 1616 – Lack of Storage in Critical Care TAC 1626 – Suboptimal compliance with management of cleanliness of environment & equipment TAC 1615 Medication storage compliance		Risk register reviewed at monthly IPCG.	

1.22	NHSI visit Requirement to strengthen staff awareness in terms of roles and responsibilities in relation to decontamination of equipment and infection prevention and control.	Divisional Chief Nurse held 2 discussion forums 7th and 8th April with lead nurse, senior nurses and matrons which included roles and responsibilities related to IP&C. This was followed up in an email listing expectations, copy of communication placed in personal file and discussed as an objective during appraisal. Summary of findings discussed at Divisional Risk and Governance meeting with a request to Chief of medicine for medical representation to take the lead for IP&C and attend IP&C forum		Formal notification to all Lead nurses, Divisional Leads accountable for maintaining IPC standards.	

	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 assigned to the high COVID areas. IPCT have provided training for Donning and Doffing of PPE, the team commenced in March-but did	Lack of accurate data to demonstrate compliance Robust process required for managing yearly face fit testing requirements.	Now donning and doffing training completed by the IPCT is documented, going forward this will be included in mandatory training Database for fit testing now in use	

		not capture training attendance until April. Face fit testing undertaken locally and by the clinical skills team.		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 following the standard terminal cleans within isolation rooms, ward bays.	N/A		
2.4	Increased frequency, at least twice daily, of cleaning in areas that have higher environmental contamination	COVID additional cleaning documents and cleaning policy remain in place.	N/A		

	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 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	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. Touch point cleaning continues; this			

	must be decontaminated, timed to coincide with periods immediately after PPE removal by groups of staff (at least twice daily.)	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	Evidence of application of policy required	Ensure audits continue as planned via the annual audit programme.	

		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	Nominated Decontamination Lead required-include on risk log.	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 equipment with actions in place to mitigate any identified risk	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. Cleaning Audits submitted monthly	N/A Trust do not currently have a de-contamination lead. Highlighted on risk register.	Installation of air conditioning units. Periodic opening of windows to dilute air.	

		Audits, spot auditing. De-contamination certificates.			
2.11	NHSI visit Identified environmental cleaning was poor in some areas, with high level dust identified in almost all areas visited.	Cleaning review agreed with Summit and Mite. Multidisciplinary team to be engaged with within Trust including DIPC, Matrons, IPCT etc. Review to included: • PFI Project Agreement • PFI Output Specification • PFI Method Statements • PFI Performance Standards and Performance Management Schedule • The National Standards of Healthcare Cleanliness 2021 • Hydrogen Peroxide Vapour Decontamination • Discharge Cleaning • Terminal Cleaning • New Technology • Cleaning Materials and Products		The review of the cleaning contract and quality measures should be undertaken as planned in line with the new cleaning standards, these were released on 27 April 2021 Consideration should be given to recording cleanliness as a risk on your risk register.	
2.12	NHSI visit Identified high levels of dust noted during the review.	Issue raised with Summit Healthcare. Reinforce with Trust Audit team to ensure close monitoring of high level dusting within site is undertaken and any		To address immediate actions prior to cleaning standards contract review	

		issues are performance managed. Ad hoq inspection by Trusts Soft Services Manager undertaken in ED. No issues identified Matrons and DIPC emailed on29/04/2021 requesting clinical representation at Trust Audits All ward and department staff to be reminded of the requirement to report all estates reactive works to the MITIE help desk and to escalate any that are not completed in the required response times to the Trust PFI contract management			
2.13	NHSI visit There is limited storage on all ward areas.	A walk around with the Deputy Director of Finance was completed on 20th April, and an action from this was for additional storage solutions for electrical equipment to be identified.		Estates review to identify areas for appropriate storage.	
2.13	NHSI visit An action plan is required as to how cleaning standards can be maintained with areas of limited storage space.	Schedule of areas to be developed with Mitie to identify specific times for difficult to access areas to be cleaned in liaison with Trust. This will form part of the cleaning review A walk around with the Deputy Director of Finance was completed on 20th April, and an action from this was for additional storage solutions for electrical equipment to be identified.		Feasibility study for additional storage is being tendered with a view to raising order to undertake the feasibility study by 21/05/2021 Temporary storage is being constructed	

				adjacent to critical care unit to improve and declutter the clinical area in the immediate term.	
2.14	NHSI Visit Requirement to ensure how we declutter our clinical areas.	A significant declutter in ITU has already taken place and this will be continued. The idea of declutter days are to be adopted and a meeting with Estates to assist with removal of waste is to be planned. Reminder included in Medicine Achieving Excellence newsletter this was circulated to divisional colleagues and will be monitored during monthly environment audits.		Implementation of declutter days and focused work on decluttering to improve storage.	
2.15	NHSI visit It was noted throughout critical care and the emergency department there were consumable items which had been taken out of their packaging and set up.	.4.21 Consumables removed from all equipment 8.4.21 Equipment covered in plastic to prevent contamination 21.4.21 2 x emergency ventilators set up – 1 for Area A & 1 x Area B – risk assessment in place		All consumable items should be stored in their sealed, sterile, original packaging with the equipment, so they are ready to set up but maintaining sterility	
2.16	**NHSI visit** **Positive pressure in ITU:** The air pressures in “ITU A”, which is the designated COVID-19 area, have been	Following guidance received from NHSi in June 2020, indicating that positive areas should not be converted to negative, following		Check governance arrangements around decision	

	changed from negative pressure to positive pressure.	clinical approval, the modified systems were converted back to their positive pressures as per design and HTM, providing greater dilution of any airborne virus particles with fresh air changes. Where ventilation systems were modified, performance verification was carried out by skilled and experienced Technicians. When converted back to their design parameters, the systems were verified by third party specialists. The decision to remain positive pressure has been subject to a risk assessment agreed and approved by Trust Clinical and Estates Managers. Reviewed following NHSI/E visit.		making	
2.17	NHSI visit Requested Materials Management – stock control	• Meeting between Jack Richards, Steph Thompson, Tracey Price, Paul Mellor, Kirstin Taylor and Clare Nash occurred 20/04/21 with key actions identified below • Historically ITU have ordered many items directly from suppliers rather than through NHS Supply Chain, meaning they don't fall within the Materials Management service. Despite this MM still manage 374 product lines weekly for ITU, which is above average		Meeting to discuss the Materials Management service in ITU and how this can be optimised. The Materials Management service is continually under review by staff with item range and quantities changing frequently based	

		A review of direct items has taken place and to date circa 20 additional products have been added to the MM service. This will continue to be reviewed and updated, with the benefit of reducing ITU involvement in stock-management for each item transferred. Procurement are also working with NHS Supply Chain to undertake a full review across the trust		on engagement between Procurement & departments Review items that can be moved to NHS Supply Chain from direct supply – bringing them into the Materials Management service. Continue to monitor national stock position for changes to current disrupted stock lines	
2.18	NHSI visit Request for review of documentation – Review of all IPC policies	All out of date policies to be reviewed and circulated prior to May 2021 IPC meeting ready for comments/approval		IPC policies to be reviewed to ensure they reflect the new IPC structure and current national guidance.	
	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 shot audits. • Procalcitonin testing introduced as part of covid screening to reduce inappropriate prescribing of antimicrobials.	• Antimicrobial stewardship group meetings. • Micro/Antimicrobial Pharmacist ward rounds not happening as often as before Pandemic due to isolations and remote working. • Rigorous monitoring not possible currently.	Virtual Antimicrobial stewardship group meetings during pandemic (via email/ teams). All clinical Pharmacists actively referring patients to antimicrobial Pharmacist for stewardship queries. Snap shot antimicrobial prescribing audits. Infection control Nurses to support AMS activity. EPMA now in place to allow ongoing monitoring of prescriptions	
3.4	NHSI visit Staff were observed to be wearing their FFP3 facemasks when they had facial hair, this is not in line with the HSE guidance around fit testing which advises that “facial hair – stubble and beards – makes it impossible to get a	Key trainers have received document HSG53 from HSE. They have also been trained Face to Face which covers both theoretical and practical elements that includes this issue relating to FFP3 facemasks not to be worn with facial hair		Communications to all staff and staffing groups to ensure clear messaging around FFP3 use. Check with the fit	

	good seal of the mask to the face	Any new information from H&S is forwarded on to the face fit testers. • Statement for 'In The Know' bulletin to cover action agreed for all staff. • Email to be sent to fit test trainers and Leads, to ensure key message is understood and disseminated. All key trainers are requested to attend an update training session every two years, to maintain and update knowledge, this is recorded on ESR. This is monitored through the completion of the PPE audit in the Divisions This is monitored through the completion of the PPE audit in the Division Chief of medicine sent email communication to teams Item included in Medicine Achieving Excellence newsletter this was circulated to divisional colleagues. Any staff observed not to be		test trainers in relation to key messaging. This is monitored through the PPE audit that is in place.	

		compliant will be immediately challenged. Summary of findings discussed at Divisional Risk and Governance meeting with a request to Chief of medicine for medical representation to take the lead for IP&C and attend IP&C forum			
	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 confirmed COVID-19 patients are where possible being treated in	Signage is placed on entrances to wards and other clinical settings stating restricted access. In addition	N/A		

	areas clearly marked with appropriate signage and have restricted access	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 the receiving organisation or department when a possible or	There is a patient transfer checklist which asks-infection type if the patient requires barrier nursing or	Assurance required regarding evidence of completion	To be reviewed as part of the monthly	

	confirmed COVID-19 patient needs to be moved	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.		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**
5.1	Systems and processes are in place to ensure: • Front door areas have appropriate triaging arrangements in place to	Please refer to section 1. There is the zoning document for in-patient admissions which covers	N/A		

	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	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. Patients' observations are input into sunrise which will set an alert when	N/A		

		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	Where possible out patients appointments are conducted virtually	N/A		

	of COVID-19 are managed appropriately	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.			
5.5	• Face masks are available for all patients and they are always advised to wear them	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.	Not monitored.	Patient information, staff encouraging	
5.6	• Monitoring of Inpatients compliance with wearing face masks particularly when moving around the ward (if clinically ok to do so)	The majority of OPD appointments are being conducted virtually or by telephone. OPD flow chart for COVID screening in place.	Not monitored.	patients to wear face masks within the day. Public notices, posters.	
5.7	• There is evidence of compliance with routine patient testing protocols	Information provided in policies. Patients are requested to wear a face mask at all time other than	Data not gathered and reported on.	Dashboard required to monitor compliance.	

		when asleep. Manual process as part of the outbreak meetings that take place three times a week.			
	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 guidance and videos	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 clinical skills	

		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%			
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	
	There are systems and processes in place to ensure:	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.	
8.1	• Testing is undertaken by competent and trained individuals				
8.2	• Patient and staff COVID-19 testing is undertaken promptly and in line with PHE and other national guidance				
8.3	• Screening for other potential infections takes place				
8.4	• That all emergency patients are tested for COVID-19 on admission				
8.5	• That those inpatients who go on to develop symptoms of COVID-19 after admission are retested at the				

	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.		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	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		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 25

The Dudley Group NHS Foundation Trust

Paper for submission to the Board of Directors on 10th June 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 and to complete the Board document for submission to NHS Resolution before midday 15th July 2021.

The Board is invited to review the minimum evidence requirements for the Ockenden actions, particularly the level of detail stated for inclusion in maternity Board reports.

Trust Board utilise the minimum evidence document and local action plan as a monitoring tool for the service in future reports

CORPORATE OBJECTIVE:

SO1, SO2, SO3, SO4, SO5, SO6

SUMMARY OF KEY ISSUES:

- Assurance provided for achievement of CNST Maternity Incentive Scheme 10 safety actions . Inclusion of Board sign off document that is required to be submitted to NHS Resolution before midday 15th July 2021
- Perinatal mortality information including the quarterly perinatal mortality report for quarter4
- Midwifery staffing paper
- Staff engagement
- Minimum assurance required for submission to NHSE/I in respect of Ockenden response
- Progress on local actions in response to Ockenden recommendations

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 10th June 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 and details of the Trust Board sign off document required to be completed and submitted by midday 15th July 2021
- Perinatal mortality
- Maternity Improvement Plan
- Service User Feedback
- Midwifery staffing report for quarter 3 and 4 of 2020/21
- 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 the incentive scheme on 4th February 2020. Since then the scheme has been updated and relaunched in 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 compliant with timescales. This is monitored monthly and learning from the reviews are included in the quarterly perinatal mortality report and widely disseminated. During the timescales identified by NHS Resolution 30 perinatal losses were identified. These include, stillbirths, late fetal losses, neonatal deaths and post neonatal deaths. 13 reviews have been completed and 7 are ongoing but within all time frames required.	June 2021
2	Are you submitting data to the Maternity Services Data Set to the required standard?		The December data achieved the required standard as has the January data however significant additional workaround has to be done each month 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. Ongoing audit is in place and will be reported via usual governance structures.	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 obstetrics and gynaecology trainees who responded 'Disagreed or Strongly disagreed to the 2019 GMC National Trainees Survey question 'In my current post,	June 2021

			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 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 Birth Rate plus assessment was carried out in 2017. A table top Birth Rate assessment has been carried out on a 6 monthly basis since then and a formal Birth Rate Plus assessment has been requested in line with the NICE guideline Safe midwifery staffing for maternity settings. This is expected in July 2021 Attached to this report is **Appendix 3** that includes all elements of midwifery workforce review required in the CNST standard	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. Completion of the quarterly audit has been submitted evidencing compliance	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. A business case is being submitted to the Black Country and West Birmingham CCG to fund overarching management support for each of the MVPs	
8	Can you evidence that the maternity unit staff groups have attended an 'in-house' multi-professional maternity emergencies training session since the launch of MIS year three in December 2019?		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. **Appendix 4** evidences the compliance for each group of staff.	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.. 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 the majority of women. Changes have been made to the national requirements with specific targets removed.	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

2.2.5 NHS Resolution requires the Trust Board to complete and submit the declaration spreadsheet **Appendix 1** by midday July 15th in order to notify compliance with all 10 safety actions. Additionally the Trust is submitting the evidence to the portal opened on 18th May 2021 for assurance of IEAs from the First Ockenden report. Many of these relate back to the 10 safety actions.

2.3 Perinatal Mortality.

2.3.1 **Stillbirths** - There have been 0 stillbirths during the month of May.

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

2.3.4 **Late fetal loss non-viable** there were 5 late non-viable fetal losses in May

2.3.3 The quarterly mortality report for quarter 4 is attached at Appendix 2.

2.4 Serious Incidents

2.4.1 There have been 0 serious incidents in maternity reported in May 2021

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 Dudley 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 were 25% of all women booked onto a continuity of carer pathway at the end of March 2021 National targets have been altered to removed specific percentages but replaced with an expectation that continuity of care model will become the default pathway for most women in pregnancy.

2.5.4 The maternity team is working closely 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 virtually however there has been a delay to the next meeting as the chair of the MVP recently gave birth here at the Trust

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..

2.6.5 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.

2.6.6 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-about**

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 continue to be the main themes raised. On 5th May the Trust celebrated International Day of the Midwife, the unit received many visitors including the Chief Nurse, Medical Director and Divisional Director of Operations all bearing gifts that were much appreciated.

2.7.2 Staff feedback is encouraged and attendance at the virtual staff forum continues to be good with healthy discussion and suggestions for improvements to the service.

2.7.3 Representatives for all areas of maternity have started to work on the actions generated as a result of the Staff survey and the engagement sessions that followed.

2.8 **Workforce**

2.8.1 The last Birth Rate 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 birth rate has decreased by approximately 300 births per year. However moving to a continuity of care model as the default model of maternity care is likely to require additional midwifery staffing in order to achieve continuity throughout the whole pathway and provide a midwife known to the woman to provide care in labour.

2.8.2 Funding has been secured from the Black Country and West Birmingham LMNS to carry out a Birth Rate Plus review based on current birth rate this is awaited..

2.8.4 Based on the external Birth Rate plus assessment a submission has been made for national funds to support staffing to Birth Rate plus, we await the decision on this which has been delayed.

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 Birth Rate Plus assessment should be 1:27

2.8.5 There are vacancies in both community midwifery and in patient areas within the current funded work force of 13.1wte and recruitment to this is ongoing.

2.8.6 The following table outlines percentage midwifery fill rates for the in-patient areas for May.

	Day qualified %	Night qualified%
May 2021	84.3%	88.6%

2.9 **Progress against the Ockenden Recommendations and action plan**

2.9.1The Assurance and assessment tool that NHSE/I requested from all trusts outlining compliance with the 7 Immediate Essential Actions (IEA's) and 12 clinical priorities has now been populated into a local gap analysis and action plan (**Appendix 5**).

2.9.2 Progress has been made with local actions. The directorate is on track in terms of their implementation strategy regarding the recommendations and locally set timescales. Trusts have now received the Ockenden minimum evidence requirements (**Appendix 6**).

2.9.3 The evidence portal will be open for 1 year with review periods of 1 month initially. The portal opened for the first submissions on the 18th May 2021. The portal will close on the 30th of June and a report will follow outlining an individual trust level compliance report.

- Evidence portal open for submissions 18 May – 30 June 2021
- QA of evidence to commence 31 May - 30 June 2021
- Regional and national reports finalised 5 July 2021
- Undertake prioritisation schedule for QA visits From 14 July 2021

2.9.4 Maternity services that are not able to provide evidence of assurance with the 7 IEA's will be offered support from the Maternity Improvement Advisory team. The minimum data set for evidence submission set against the Immediate and Essential Actions (IEA's) is the document that the Trust will be monitored against by NHSE/I in terms of its Ockenden response and assurance.

2.9.5 Therefore the directorate proposal is that the document **Appendix 6** is presented with the local action plan and should be used as a monitoring tool for Trust Board in future.

3 RISKS AND MITIGATIONS

3.2 Midwifery staffing requires significant investment in order to achieve Birth Rate plus recommended levels and also achieve all aspects of the requirements for the Ockenden assurance.

3.2 The requirements for evidence of assurance is very specific, and significant in its amount. The Trust Board is required to receive and minute detailed information particularly in relation to serious incidents, perinatal mortality and safety champion engagement.

4. RECOMMENDATION(S)

4.1 The Board is invited to accept the assurance provided in this report and to complete the Board document for submission to NHS Resolution before midday 15th July 2021.

4.2 The Board is invited to review the minimum evidence requirements for the Ockenden actions, particularly the level of detail stated for inclusion in maternity Board reports.

4.3 Trust Board utilise the minimum evidence document and local action plan as a monitoring tool for the service in future reports.

Name of Author Dawn Lewis
Title of Author Head of Midwifery
Date report prepared 2.6.2021

Appendix 2

Women and Children's Perinatal Mortality Report Q4:
1st January 2021 to 31st March 2021

RATIONAL:

The national maternity review 'Better Births' report outlined a vision for maternity services across England to become safer, more personalised, kinder, professional and more family friendly. The Long-Term Plan committed the NHS to accelerate action to achieve the national maternity safety ambition of 50% reductions in stillbirth, maternal mortality, neonatal mortality and serious brain injury by 2025. The focus is to measure progress in reducing the rate of stillbirths and neonatal deaths against the trajectory towards the 2025 ambition. The number of stillbirths and neonatal deaths are influenced by a number of factors, including the quality of care delivered to the mother and baby and appropriate surveillance for all women.

All cases of stillbirth and neonatal death are reported to Mothers and Babies Reducing Risk through Audit and Confidential Enquiry (MBRRACE). This is a data collection system for the national surveillance of late fetal losses, stillbirths, infant deaths and maternal deaths. In addition all cases of intrapartum stillbirth and neonatal death are reported via the Each Baby Counts platform hosted by the RCOG. All perinatal mortality rates from 22 weeks gestational age onwards are reported to MBRRACE as recommended by the World Health Organisation (WHO) in order that UK rates can be compared internationally. However only the perinatal mortality rates for babies born at 24 weeks gestational age or later, excluding termination of pregnancy, are included within this report and used by MBRRACE when making comparisons with similar Trusts, Health Boards and the UK average.

The MBRRACE-UK Perinatal Mortality Surveillance Report – UK Perinatal deaths for births from January to December 2018, published in December 2020 provided an overview of a continued downward trend of the baby deaths in the UK giving a national picture for 2018. The continued downward trend in perinatal deaths across the four nations of the UK reflects the impact of a range of national initiatives to address safety in maternity and neonatal care. Compared with 2013, there were 670 fewer baby deaths in 2018.

Highlights of the report evidence inequalities in health and survival for babies with Black and Black British, and Asian and Asian British babies are up to twice as likely to be stillborn or die in the neonatal period. Rates of death are falling more slowly among these babies compared with White babies, suggesting national safety initiatives are failing to reach many women from higher risk ethnicities. The connection between risk and poverty is also clear, with women living in the most deprived areas at an 80% higher risk of their baby dying.

The fall in the number and rates of deaths overall is mainly among babies in late pregnancy. NHS interventions to improve safety in maternity initially focused on term babies because of the option to deliver the baby safely. Yet three out of four babies who died in 2018 were born before 37 week and UK pre-term birth rates are higher than for similar European countries. It is concerning that neonatal deaths continue to fall more slowly than stillbirths. The significant difference in survival rates of newborn babies between units offering the most specialist neonatal care, suggests there is more to do to understand where improvements in neonatal care could prevent newborns from dying. In 2019, the second iteration of the Saving Babies Lives Care Bundle in England introduced guidance on preterm and neonatal babies. Units need to be supported to embrace this and other safety programmes across all four nations, monitoring the impact of these improvements to care to understand if and how they are working.

1. Definitions

Late fetal death: A baby delivered between 22+0 and 23+6 weeks gestational age showing no signs of life, irrespective of when the death occurred.

Stillbirths: A baby delivered at or after 24+0 weeks gestational age showing no signs of life, irrespective of when the death occurred.

- ***Antepartum stillbirth***
    - *A baby delivered at or after 24+0 weeks gestational age showing no signs of life and known to have died before the onset of care in labour.*

- ***Intrapartum stillbirth***
    - *A baby delivered at or after 24+0 weeks gestational age showing no signs of life and known to have been alive at the onset of care in labour.*

Neonatal death: A live born baby (born at 20+0 weeks gestational age or later, or with a birth weight of 400g or more where an accurate estimate of gestation is not available who died *before* 28 completed days after birth.

- ***Early neonatal death***
    - *A liveborn baby (born at 20+0 weeks gestational age or later, or with a birth weight of 400g or more where an accurate estimate of gestation is not available) who died before 7 completed days after birth.*

- ***Late neonatal death***
    - *A liveborn baby (born at 20+0 weeks gestational age or later, or with a birth weight of 400g or more where an accurate estimate of gestation is not available) who died after 7 completed days but before 28 completed days after birth.*

Perinatal death: A stillbirth or early neonatal death.

Extended perinatal death: A stillbirth or neonatal death.
Termination of pregnancy: The deliberate ending of a pregnancy, normally carried out before the embryo or fetus is capable of independent life.

2. Rates

Rates in this report relate to women who received care from the maternity services at the Dudley Group NHS Foundation Trust (DGFT). The total number of births is provided by the Trust Information Officer.

Calculations: All rates are expressed as per 1000 births which is the nationally recognised and expected methodology.

Crude stillbirth rates: Calculated from the total number of stillbirths for the period divided by number of births within the period multiplied by 1,000.

Adjusted stillbirth rates: Calculated from the total number stillbirths for the period less: Multiple pregnancy when one or more fetus has demised preterm but delivered post 24 weeks gestation, Fetal anomalies (incompatible with life) where termination of pregnancy has been declined but delivered a stillbirth. Then divided by number of babies born for the period and multiplied by 1,000

Crude neonatal death rates – Calculated from the total number of neonatal deaths divided by number of live births multiplied by 1,000.

Adjusted neonatal death rates- Calculated from the total number of neonatal deaths less: Babies delivered prior to 24 weeks gestation or with known congenital anomalies, then divided by the number of live births for the period and multiplied by 1,000.

Combined perinatal mortality rates – Calculated by adding the total number of stillbirths and the total number or neonatal deaths for the period, divided by the total number of births within the period multiplied by 1,000.

3. Mothers and Babies: Reducing Risk through Audit and Confidential Enquiries (MBRRACE) across the UK Perinatal Surveillance Report of perinatal deaths for births from January to December 2018 (MBRRACE 2020) rates per 1,000 births.

Sustainability and Transformation Partnerships (STP's) are local partnerships between care providers and organisations providing the funding for care, loosely based on groups of CCGs.

- **Mortality rates for individual Trusts and Health Boards**
- **Mortality rates by sustainability and transformation partnerships**

2018	Crude stillbirth rate	Adjusted stillbirth rate
UK	3.51	No adjusted figures for UK available on MBRRACE
The Dudley Group NHS FT	2.96	2.22
Sandwell & West Birmingham CCG	5.45	3.44
The Black Country sustainability and transformation partnerships	4.55	3.88

The above rates were launched by MBRRACE in the Perinatal Surveillance report 2018, published December 2020. In order to compare Trusts and Health Boards more fairly, stabilised & adjusted mortality rates are calculated. Where there is only a small number of births in an organisation it is difficult in any one year to be sure that any extreme value seen for the crude mortality rate is real and not just a chance finding. A stabilised rate allows for the effects of chance variation due to small numbers. The mortality rates are also adjusted to account for key factors which are known to increase the risk of perinatal mortality. The extent of the adjustment is limited to those factors that are collected for all births across the whole of the UK: mother's age; socio-economic deprivation based on the mother's residence; baby's ethnicity; baby's sex; whether they are from a multiple birth; and gestational age at birth (neonatal deaths only).

4. Dudley Group NHS Foundation Trust rolling annual stillbirth rate for babies born within the organisation of Russell Hall hospital

Births for period 1/4/20 – 31/03/21 = 4054

Rolling annual period 01/4/20 – 31/03/21	Crude stillbirth total number	Crude stillbirth rate	Once adjusted stillbirth total number *(3 cases adjusted)*	Crude stillbirth adjusted rate
Stillbirths	13	3.20	10	2.46
Twin death	1			
Fetal anomaly but declined TOP	1			
Anhydramnious	1			
Undiagnosed congenital anomaly	0			
Hydrops fetalis	0			

Appendix 2

Dudley Group NHS Foundation Trust Quarter 4 stillbirth rates

Births for Q4 period 01/1/21 – 31/03/21 = 938

Quarterly period Q4 01/01/21 – 31/03/21	Total number for period	Total stillbirth rate for period	Once adjusted stillbirth total number	Once adjusted stillbirth rate for period
Stillbirths	3	3.20	3	3.20
Twin death	0			
Anhydramnious	0			
Fetal anomalies but declined TOP	0			
Undiagnosed congenital anomaly	0			
Hydrops fetalis	0			

5. Reporting and escalation-

Monthly stillbirth rates are reported on the maternity clinical dashboard which is reviewed within the monthly Maternity Governance Meeting and Maternity Quality and Governance Meeting and quarterly mortality reports are reviewed at the Governance Assurance Meeting (GAMe) meeting. During the Coronavirus pandemic these meeting were initially suspended and then conducted via Microsoft Teams.

All stillbirths and neonatal deaths are reported through the Trust Datix platform. These incidents are reviewed at a weekly Maternity risk meeting where the case notes are reviewed by the multidisciplinary team to determine any care delivery or service issues that have caused harm.

All stillbirths and neonatal deaths are reported via MBRRACE, each baby counts and reviewed via the National Perinatal Mortality Review Tool (PMRT) which supports high quality standardised perinatal reviews on the principle of 'review once, review well'.

The Health Safety Investigation Board (HSIB) will undertake any maternity investigation which meets the Each Baby Counts (EBC) criteria. These include term deliveries greater or equal to 37 weeks gestation where a baby was thought to be alive at the start of labour and resulted in an intrapartum stillbirth or early neonatal death (NND).

If harm is identified the incident is reported to the NHS Midlands and East via the Strategic Executive Information System (STEIS). The RCA is submitted via Trust Governance to the Central Support Unit (CSU), who receives these on behalf of the Clinical Commissioning Group (CCG). A review is undertaken for all cases. The Trust will report the incident to Each Baby Counts and NHS Resolution Early notification scheme as required.

Where no harm is identified gestation determines the level of investigation performed and subsequent escalation pathway:

22-28 weeks gestation:

- Review by MDT at WIRMS Meeting
- Complete a green DATIX investigation
- Reported & reviewed by Perinatal Mortality review Tool (PMRT)
- Reported to MBRRACE
- Presented at Women's & Children's Perinatal Audit Meeting (unless the MDT on review at WIRMS and the PMRT identify no issues in care and as such there is no learning to share)

28 weeks to Term gestation:

Review by MDT at WIRMS Meeting

- Complete a Level Yellow investigation (unless the MDT agreed at WIRMS that all care was appropriate the incident can be downgraded to a green incident).
- Reported & reviewed by Perinatal Mortality review Tool (PMRT)
- Reported to MBRRACE
- Presented at Women's & Children's Perinatal Audit Meeting

If Harm is identified:

- MDT review at 48 hour round table meeting or ASAP.
- Establish if harm has been identified - If yes – STEIS report
- Complete RCA Investigation
- Perform Duty of Candour with 10 days of the incident

6. Neonatal deaths (early 0-7 days of age)

Mothers and Babies: Reducing Risk through Audit and Confidential Enquiries (MBRRACE) across the UK Perinatal Surveillance Report of Perinatal deaths for births from January to December 2018 (MBRRACE 2020) rates per 1,000 births.

MBBRACE within the 2020 report have reported for The Dudley Group NHS Foundation Trust, the UK rates and Network Trust of Sandwell are included for comparison.

2018	Neonatal death rates	Adjusted neonatal death rates
UK	1.64	No adjusted figures for UK available on MBRRACE
The Dudley Group NHS FT	1.86	1.39
Sandwell & West Birmingham	2.56	1.64
The Black Country sustainability and transformation plans (STP) footprint	3.33	2.89

The above rates were published by MBRRACE in the Perinatal Surveillance report 2018, published December 2020. MBRRACE risk-adjustment factors take into account the mothers age, child poverty (low income families), baby's ethnicity, baby's sex, multiple birth, interaction between child poverty and baby's ethnicity, interaction between child poverty and mother's age and gestation age at birth for neonatal death rates (24+0 to 27+6 weeks, 28+0 to 31+6 week, 32+0 to 33+6 weeks, 34+0 to 36+6 weeks, 37+0 to 41+6 weeks and greater or equal to 42+0 weeks). MBRRACE organisational-level factor for each organisation responsible for delivering maternity care takes into account the availability of a level 3 NICU and neonatal surgery, the availability of a level 3 NICU, 4,000 or more births per annum at 24 weeks or later, 2,000 -3,999 births per annum at 24 weeks or later and under 2,000 births per annum at 24 weeks or later.

7. Dudley Group NHS Foundation Trust Rolling Annual Neonatal Death (early and late) rates for babies born within the organisation of Russell Hall hospital

Total live births for the period 01/04/20– 31/03/21 = 4042

Rolling annual period 01/04/20 – 31/03/21	Neonatal deaths for period	Total neonatal deaths for period	Crude neonatal death rate	Once adjusted Neonatal Death total number *(5 cases adjusted)*	Total Adjusted neonatal death rate for period
Neonatal Deaths	**8**	8	1.97	3	0.74
Early Neonatal Deaths	7				
Late Neonatal Deaths	1				
Abnormalities	0				
Pre-viable	4				

Expected death significant intraventricular haemorrhage	1

8. Dudley Group NHS Foundation Trust Quarter 4 Neonatal Death rates (early and late).

Total live births for period Q4 - 01/01/21 – 31/03/21 = **935**

Quarterly period Q4 - 01/01/21 – 31/03/21	**Neonatal deaths for period**	**Total neonatal deaths for period**	**Neonatal Death Rate Q4**	**Once adjusted total number** *(1 case can be adjusted)*	**Adjusted Neonatal Death Rate**
Early Neonatal Deaths	2	2	2.13	1	1.07
Late Neonatal Deaths	0				
Congenital Abnormality	0				
Pre-viable	1				

There have been 2 early neonatal deaths and 0 late neonatal deaths during this quarter: Q4

9. MBRRACE 2018 Extended Perinatal Mortality Rates as published December 2020.

2018	**Crude mortality rate – extended** (stillbirths and neonatal deaths combined)	**Adjusted mortality rate**
UK	5.13	No adjusted figures for UK available on MBRRACE
The Dudley Group NHS FT	5.09	4.70
Sandwell & West Birmingham	8	5.04
The Black Country sustainability and	7.87	6.74

transformation plans (STP) footprint		

The above rates were launched by MBRRACE in the Perinatal Surveillance report 2018, published December 2020.

10. Dudley Group NHS Foundation Trust Perinatal combined mortality rates (combined stillbirth and neonatal deaths).

	Total births for period	**Total combined Crude mortality rate** (stillbirths and neonatal deaths combined)	**Total combined Adjusted mortality Rate**
Rolling annual rate: **01/04/20 - 31/03/21**	4054	5.18	3.20
Quarter 4 rate: 01/01/21 – 31/03/21	938	5.33	4.26
Quarter 3 rate: 01/10/20 - 31/12/20	998	3.00	2.00
Quarter 2 rate: 01/07/20 – 31/09/20	1071	5.61	2.81
Quarter 1 rate: 01/04/20 - 30/06/20	1047	5.73	2.87

11. Conclusion

The crude annual stillbirth rate for Dudley Group Foundation Trust has been calculated at 3.20 which compares favourably to the UK rate of 3.51 reported through MBRRACE (2020). This figure can be adjusted to reduce further to 2.46 due to considerations of a twin demise and fetal anomaly declining TOP and Anhydramnious. There are no adjusted figures supplied by MBBRRACE for comparison.

The Quarter 4 stillbirth rate has been calculated at 3.20 which compares favourably to the UK rate of 3.51 reported through MBRRACE (2020).

The crude annual neonatal death rate for Dudley Group NHS Foundation Trust has been calculated at 1.97 which compares unfavourably to the UK rate of 1.64 as reported through MBRRACE (2020). This figure however can be significantly reduced when adjusted, to 0.74 due to considerations of pre-viability and expected death due to significant intraventricular haemorrhage.

The Quarter 4 early and late neonatal death rate is 2.13 which compares unfavourably to the UK rate of 1.64 reported through MBRRACE (2020). The figure can be adjusted to 1.07 due to pre-viability, twin demise or fetal anomaly.

The combined crude mortality rate for the rolling annual period is 5.18 this compares unfavourably above the UK rate of 5.09. However the figure can be reduced when adjusted to 3.20 due to considerations of twin demise, known congenital abnormalities declining TOP and pre-viability.

The Quarter 4 combined mortality rate is 5.33 this compares unfavourably at 0.20 higher than the UK rate of 5.13. However the adjusted rate is 4.26 which is 0.87 lower than the UK rate when considerations of twin demise, known fetal anomaly declining TOP and anhydramnious are taken into account.

The crude stillbirth rate is a calculation of all stillbirths including multiple pregnancies, where one fetus has died or where fetal anomaly has been diagnosed and a termination of pregnancy has been declined but a stillbirth ensues. **The adjusted stillbirth rate gives a more meaningful rate than the crude stillbirth rate by excluding these factors.**

All stillbirths and neonatal deaths are reported through the Trust DATIX platform. These incidents are reviewed at the Weekly Incident Review meetings (WIRMS) where the perinatal mortality review tool (PMRT) is updated/completed. The case notes are reviewed by the multidisciplinary team to determine any care delivery or service issues that have caused harm and any incidental learning that can improve practice.

The Trust use the National Perinatal Mortality Review Tool (NPMRT) to further review the information collected about these cases. The review is wholly integrated within the MBRRACE-UK programme of work. It was introduced to support standardised perinatal mortality reviews across NHS maternity and neonatal units in England, Scotland and Wales to provide systematic, multidisciplinary, high quality reviews of circumstances and care leading up to and surrounding each stillbirth, neonatal death and deaths of babies who die in the post-neonatal period having received neonatal care.

The NPMRT facilitates:

- Comprehensive and robust review of all perinatal deaths from 22+0 gestation to 28 days after birth as well as babies who die after 28 days following neonatal care; excludes terminations and babies with a birth weight of <500g
- Standardised high quality review with grading of quality care linked to outcomes.
- Multidisciplinary group review of care with allocated time to do so
- Inclusion of parents' perspectives in the process and consideration of any concerns they may have about their care
- Internal and external peer review of cases
- Generation of action plans which must be implemented and monitored
- Trust/Health Board level reporting and demonstration of organisational learning
- Regional and national benchmarking and learning through publication of annual reports

PMRT REPORT

This report has been generated following mortality reviews which were carried out using the national Perinatal Mortality Review Tool - The Dudley Group NHS Foundation Trust

Report of perinatal mortality reviews completed for deaths which occurred in the period:

Appendix 2

1/4/2020 to 31/3/2021

Summary of perinatal deaths*

Total perinatal* deaths reported to the MBRRACE-UK perinatal mortality surveillance in this period: 23

Summary of reviews**

Stillbirths and late fetal losses				
Number of stillbirths and late fetal losses reported	Not supported for Review	Reviews in progress	Reviews completed ***	Grading of care: number of stillbirths and late fetal losses with issues with care likely to have made a difference to the outcome for the baby
20	5	6	9	0

Neonatal and post-neonatal deaths				
Number of neonatal and post-neonatal deaths reported	Not supported for Review	Reviews in progress	Reviews completed ***	Grading of care: number of neonatal and post-neonatal deaths with issues with care likely to have made a difference to the outcome for the baby
8	0	4	4	0

*Late fetal losses, stillbirths and neonatal deaths (does not include post-neonatal deaths which are not eligible for MBRRACE-UK surveillance) – these are the total deaths reported and may not be all deaths which occurred in the reporting period if notification to MBRRACE-UK is delayed. Deaths following termination of pregnancy are excluded.

There are 5 cases (3 stillbirths and 2 NND) for Q4 which meets the PMRT reportable criteria. The full details of the cases have been discussed earlier within this report. These cases have or will be reported, all issues raised by the MDT or the PMRT have been detailed as above or will be addressed asap as necessary and any identified learning will be actioned . All cases that are reported via the PMRT are reviewed at several stages; any new learning which is identified during these reviews will also be actioned as appropriate and the learning disseminated.

When harm is identified the incidents are reported to the NHS Midlands and East via the Strategic Executive Information System (STEIS). The RCA is submitted via Trust Governance to the Central Support Unit (CSU), who receives these on behalf of the Clinical Commissioning Group (CCG).

The healthcare safety investigation branch (HSIB) is a further initiative to improve safety in maternity care following recommendations from a government inquiry into clinical incident investigations and commenced in February 2019. HSIB is made up of multi-disciplinary professionals who all have investigation experience. HSIB will conduct maternity investigations for all incidents that fit the criteria of the 'Each Baby Counts' programme, the criteria includes intrapartum stillbirth and early neonatal death (died in the first week of life). HSIB investigations replace the Trust investigations for these cases. If the incident meets the criteria of a Serious Incident (SI) in accordance with the

Serious Incident Framework (2015) the Trust will still be responsible for undertaking Duty of Candour, 48 hour reporting and reporting to the Strategic Executive Information System (STEIS). The Trust will report the incident to Each Baby Counts and NHS Resolution Early notification scheme as required. At present reported to NHS Resolution Early notification scheme has been suspended during the Coronavirus Pandemic. Where cases meet the criteria for reporting to the PMRT this will also be completed by the Trust and then also HSIB once the investigation is complete. HSIB will work with women and their families, the maternity unit that cares for them and also the risk and safety teams at the Trust. The purpose of HSIB is to conduct effective investigations, share learning to improve patient safety, raise standards and support learning across the healthcare system in England.

It is usual process for all cases where harm has been identified to have an action plan is formulated and the completion of all actions are monitored through DATIX and the maternity weekly incident review meeting, the weekly meeting of HARM and presented at the Women and Children's Perinatal Audit meeting to the multidisciplinary team to inform and share any learning outcomes. This report is also presented and discussed at the regional Maternity Quality and Governance meeting and at the divisional Governance assurance meeting (GAMe) by the Senior Management team.

Q4 Mortality Report compiled by:
Holly Haden
Specialist Midwife Bereavement Lead

Reviewed and endorsed by the HOM. Date: 30th April 2021

The Dudley Group NHS Foundation Trust

REPORTS FOR ASSURANCE

Midwifery Staffing Report Q3 and Q4

Report to Trust Board on 10TH June 2021

1 EXECUTIVE SUMMARY

1.1 This report gives a summary of all measures in place to ensure safe midwifery staffing; including workforce planning, planned versus actual midwifery staffing levels, the midwife to birth ratio, specialist hours, compliance with supernumerary labour ward coordinator, one to one care in labour and red flag incidents as required for CNST maternity incentive scheme

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2 BACKGROUND INFORMATION

2.1 It is a requirement that as NHS providers we continue to have the right people with the right skills in the right place at the right time to achieve safer nursing and midwifery staffing in line with the National Quality Board (NQB) requirements.

Organisational requirements for safe midwifery staffing for maternity settings (NICE 2017) states that midwifery staffing establishments develop procedures to ensure that a systematic process is used to set the midwifery staffing establishment to maintain continuity of maternity services and to provide safe care at all times to women and babies in all settings.

2.2 Midwifery staffing data is included in the nurse staffing paper, however, to provide evidence for NHS Resolution Maternity CNST Incentive Scheme, a separate paper is also provided.

2.3 Safety action number 5 of the Maternity Incentive Scheme asks: **Can you demonstrate an effective system of midwifery workforce planning to the required standard**? The required standard for this is detailed below: a) A systematic, evidence-based process to calculate midwifery staffing establishment is complete. b) The midwifery coordinator in charge of labour ward must have supernumerary status; (defined as having no caseload of their own during their shift) to ensure there is an oversight of all birth activity within the service c) All women in active labour receive one-to-one midwifery care d) Submit a bi-annual midwifery staffing oversight report that covers staffing/safety issues to the Board. The minimal evidential requirements for this standard are:

The bi-annual report submitted will comprise evidence to support a, b and c progress or achievement. It should include:

• A clear breakdown of BirthRate+ or equivalent calculations to demonstrate how the required establishment has been calculated.

• Details of planned versus actual midwifery staffing levels.

- Include evidence of mitigation/escalation for managing a shortfall in staffing.

• An action plan to address the findings from the full audit or table-top exercise of BirthRate+ or equivalent undertaken, where deficits in staffing levels have been identified.

• Maternity services should detail progress against the action plan to demonstrate an increase in staffing levels and any mitigation to cover any shortfalls.

• The midwife: birth ratio.

• The percentage of specialist midwives employed and mitigation to cover any inconsistencies. Birth Rate plus accounts for 8-10% of the establishment, which are not included in clinical numbers. This includes those in management positions and specialist midwives.

• Evidence from an acuity tool (may be locally developed), local audit, and/or local dashboard figures demonstrating 100% compliance with supernumerary labour ward co-ordinator status and the provision of one-to-one care in active labour. Must include plan for mitigation/escalation to cover any shortfalls. The year 2 standard also included information regarding red flags which have been omitted from year 3 but due to the importance of noting and acting upon these they have been reported in this paper.

2.4 Birth Rate Plus

A formal Birth Rate Plus assessment was completed and report received in 2018, which reviewed the acuity of women who used maternity services together with activity in all maternity settings.
This review recommended a birth to midwife ratio of 1:27 across the Trust. The report from this assessment was received in Trust in February 2018.

NICE (2017) recommend that an assessment is carried out every three years. The Trust has received funding via the Black Country and West Birmingham Local Maternity and Neonatal System – BCWBLMNS to carry out a further assessment. We do not have a specific date from Birth Rate Plus but have been advised that it is likely to be sometime in July 2021.

The first Ockenden report has requested all Trust Boards to provide assurance that they will support midwifery staffing to achieve Birth Rate Plus recommendations. The assurance for this was requested and given at Trust board in January 2021. The trust is awaiting the decision from the national team on the submission for national funding to achieve the required Birth Rate Plus ratios. Request for national funding could only be made for band 5 and 6 midwifery posts. A number of leadership and management posts are also required in order to fully achieve the staffing recommendations set out in the RCM midwifery staffing manifesto.

2.5 Planned Versus Actual Midwifery Staffing Levels

The following table outlines percentage fill rates for the inpatient areas by month and includes delivery suite, maternity ward, maternity triage and midwifery led unit.

	%
October2020	85%
November 2020	88%

December 2020	88%
January 2021	88%
February 2021	87%
March 2021	89%

A daily staffing review meeting is held each morning and is attended by the head of midwifery, maternity matrons band 7 lead midwives from all areas including community midwifery and maternity OPD. Staffing is reviewed against activity for all areas for the seven days ahead. If midwifery staffing is below optimum plans are made to cover any shortfall by utilising bank midwives or bank registered nurses. In periods of high activity or short notice shortfall in midwifery staff in the escalation standard operating procedure is instigated. This includes:

- Requesting midwives in specialist or management roles to work clinically
- Elective workload is prioritised to maximise available staffing
- Relocate staffing to ensure one to one care in labour and supernumerary status for the labour ward lead midwife is maintained.
- Activate the on call midwives in community midwifery to support delivery suite or the midwifery led unit.
- Out of hours request additional support from the on call midwifery manager
- Liaise with neighbouring maternity units to manage and move capacity as required.

2.6 Birth to Midwife Ratio

Currently the birth to midwife ratio is 1:30.7 based on the birth rates at the end of 2020/2021 financial year. This is below the recommended ratio of 1:27 determined in last external Birth Rate Plus assessment. The reasons for this are primarily vacancies, which are in the process of recruitment. The table below indicates the midwifery staffing requirement based on the current workload and also working a very traditional way. Since December 2020 continuity of care teams have been established in order to achieve the national ambition of continuity of care for the majority of women. This involves a small team of midwives providing care throughout antenatal, birth and postnatal periods, for a small caseload of women. The Birth Rate Plus reassessment in July may indicate that additional midwifery staff are required to achieve this. The birth to midwife ratio is also included in the maternity dashboard each month

APPENDIX 3

Calculations based on births 2020/2021					
Methodology Birthrate Plus (Ball & Washbrook)					
Guidance RCM Staffing Standard 2009					
Trust nam	Dudley Group NHS FT		**Differentiated ratios**		
			Tertiary		
Service Type			DGH > 50% categiores IV & V		01:27
			DGH < 50% categiores IV & V		
		Community excluding home and stand alone mlu births			
		Home and stand alone mlu births			
Leave allowance (%)					22%
Budgeted establishment clinical midwives and clinical element managers/specialists					144.1
Existing establishment clinical midwives and clinical element managers/specialists					130.12
Exisiting establishment non clinical managers/specialist elements					13.6
Percentage of non clinical managers/specialist elements (should be 9%)					9.2%
Existing establishment band 3 and above *currently* included in 10% skill mix					4.98
(those with appropriate qualifications, skills and competency used currently to replace midwifery times, includes nursery nurses, RGN's, MSWs)					
			Birth here - AN/PN elsewhere	Birth elsewhere - AN/PN care here	
Case Mix Ratio	No. Hospital Births	Home Births & Stand Alone MLU Births	Exports	Imports	
	3977	20	1223	322	
Hospital Midwives					
(no of hospital births / differentiated ratio)				A	113.62
Community Care				B	31.4
(No of hospital births - exports + imports /98)					
Home Births & Stand Alone MLU births				C	0.6
(No of births/35)					
Total Clinical Midwives Required					
(A + B + C)				D	145.62
Assessed Ratio					26.6
(Total births/ clinical midwives required)					
Additional number of band 3 and above required to deliver 10% skill mix					9.58
Current ratio					
Total Birth/clinical midwives in post					30.7wte

2.7 Specialist Midwives

Birth Rate Plus recommends that 8-10% of the total establishment are excluded from the clinical numbers. This includes specialist midwives and midwifery management roles. We continue to review maternity services to ensure the appropriate level of manager and specialist midwives are not included in the midwifery numbers, however during the COVID-19 period a number of manager and specialist midwives were required to work clinically to support safe care provision.

Specialist midwives currently in post include

- Bereavement
- Infant feeding
- Risk / governance
- Practice development
- Substance misuse
- Vulnerable Women
- Antenatal and Newborn Screening
- Long Term Conditions

Currently the percentage is calculated as 9.2% however this may change following the reassessment July and the planned leadership posts required to achieve all of the Ockenden staffing recommendations. These include a consultant midwife, an additional deputy matron and a senior midwifery lead for maternity governance and risk.

2.8 Birth Rate Plus Live Acuity Tool

The Birth Plus live acuity toll was introduced in the intrapartum areas in Q3 of 2018 and followed a year later by the introduction of the tool for the other in patient areas.
It is a tool for midwives to assess their real time workload arising from the number of women needing care and their condition on admission and during the processes of labour, delivery and postnatally. It is a measure of acuity and the system is based on an adaption of the same clinical indicators used in the well-established workforce planning system, Birth Rate Plus. A positive acuity scores means that the midwifery staffing is adequate for the level of acuity of the women being cared for on DS at that time. A negative acuity score means that there may not be an adequate number of midwives to provide safe care to all women on the DS at the time. In addition the tool collects data such as red flags which are defined as a “warning sign that something may be wrong with midwifery staffing” (NICE 2015).
The tool is completed on a four hourly basis by the delivery suite lead midwife and an assessment is produced of the number of midwives needed in each area to meet the needs of the activity, based on the minimum standards of one to one care in labour for all women and increased ratios of midwifery time for women with higher needs.
The tool provides a visual indication of staffing requirements and also allows evidence of actions taken at times of high acuity and escalation is required.

2.9 Supernumerary status of Delivery Suite Co-ordinator

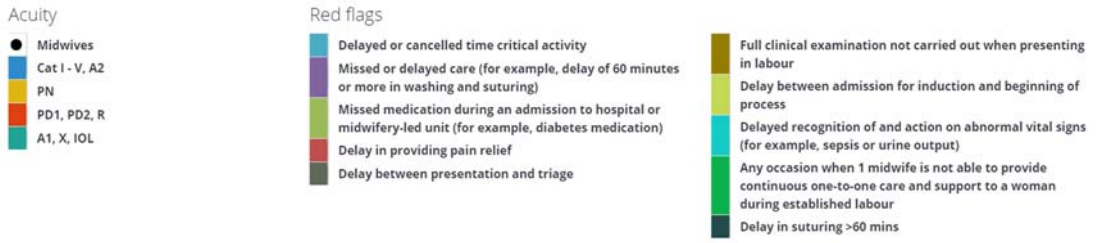
Supernumerary status of the coordinator is defined as the coordinator not having a caseload. The acuity tool has time built in for the coordinator to be supernumerary when it is recorded. In addition to the acuity tool a Datix is submitted to assist with identification of themes and

trends. During this reporting period supernumerary status of the delivery suite coordinator was maintained 100% of the time.

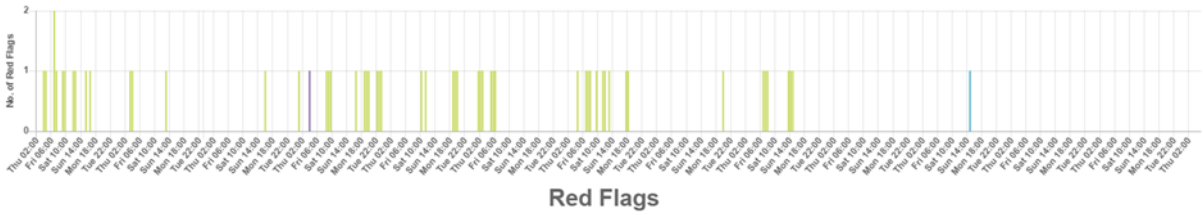
2.10 One to One Care in Established Labour

One to One care is defined as “care provided for the woman throughout labour exclusively by a midwife solely dedicated to her care (not necessarily the same midwife for the whole of labour” (NICE 2015). During this reporting period one to one care was provided for 100% of women.

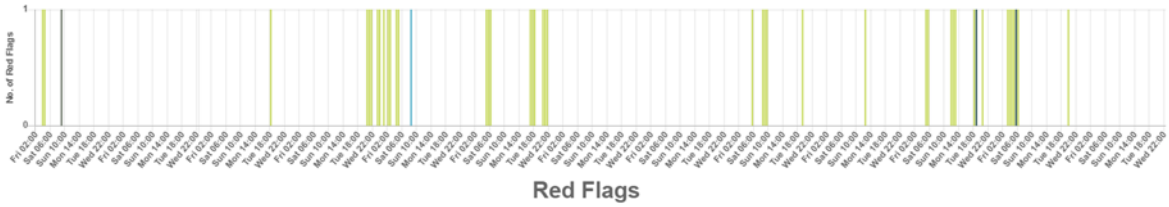
2.11 Red Flag Incidents



56 red flags in Q3 the vast majority were delayed induction of labour



48 Red flags in Q4 again the vast majority were delayed induction of labour.



A multidisciplinary task and finish group are reviewing the induction of labour processes and also completing an audit of compliance with national guidance.

3 RISKS AND MITIGATIONS

3.1 Midwifery staffing is identified as a risk and is included in the directorate risk register

3.2 By exception, summarise the risks, the actions taken to mitigate the risks, and the movement since the last reporting period.

4. RECOMMENDATION(S)

4.1 The National Institute for Health and Care Excellence (NICE) published the report Safe midwifery staffing for maternity settings in 2015, updated in 2019. This guideline aims to improve maternity care by giving advice on monitoring staffing levels and actions to take if there are not enough midwives to meet the needs of women and babies in the service. The guidance was produced in response to previous reports such as the Francis report (2013).

APPENDIX 3

The Maternity Incentive Scheme operated by NHS resolution asks whether the service can demonstrate an effective system of midwifery workforce planning to the required standard

.This report provides the detail of the minimum evidential requirements to Trust Board which are required for this standard including:

- Birth Rate plus assessment
- Midwife to Birth ratio
- Actions to achieve appropriate staffing levels
- Red flags
- The provision of 1:1 care in labour and a supernumerary coordinator on each Delivery Suite (DS) shift
- Details of the specialist midwives employed

Name of Author Dawn Lewis
Title of Author Head of Midwifery
Date report prepared 31st May 2021

Appendix 4

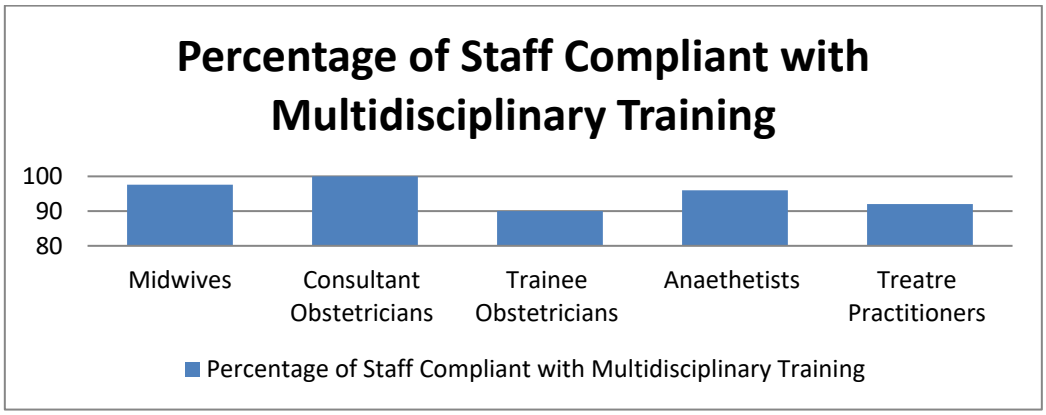
CNST Training Compliance Safety Action 8

Safety action 8: Can you evidence that the maternity unit staff groups have attended an 'in-house' multi-professional maternity emergencies training session since the launch of MIS year three in December 2019?

In February 2020 Multidisciplinary Simulation Training was launched within Maternity that fulfilled the requirements of CNST Safety Action 8. It ran very successfully for 2 months and then was paused due to Covid 19.

In October 2020 we relaunched the multidisciplinary training in line with the new requirements that were released from CNST on 1st October 2020. The training was provided as a live virtual training session via Microsoft Teams. The groups included Midwives, Anaesthetists, Obstetricians of all grades and theatre practitioners. The virtual sessions were facilitated by the practice development team and medical staff (Obstetric and Anaesthetic) and consisted of all the elements requested by CNST. The use of PROMPT training video's allowed for enhanced learning and the introduction of new topics such as Covid 19 and the care of a critically ill woman. All aspects of the requirements were covered during the virtual session and staff engagement was required to obtain completion. Registers from the sessions were completed to evidence completion and certificates were sent to the staff members following the session.

The following graphs show % completion for each staff group. All staff groups achieved above the 90% compliance target



Neonatal Resuscitation Element

Our current neonatal resuscitation training consists of a 20 minute 1:1 session with an NLS instructor encompassing an airway assessment. At the end of May 2021 our compliance figures are 86%, however there is a further training session that is being held on 24th June that will increase compliance to 95%

We currently have Neonatal nursing compliance of 90% at the end of May with a further training session also due to June. The Neonatal Medical Compliance is currently 100%.

Appendix 5

THE DUDLEY GROUP NHS FOUNDATION TRUST
OCKENDEN RESPONSE MATERNITY ASSURANCE ACTION PLAN

Source of Action Plan	Ockenden Report Emerging Findings and Recommendations	**Oversight Committee**	Quality and Safety Committee
Action plan prepared and lead by	Dawn Lewis – Head of Midwifery	**Action plan signed off by**	
Date presented to Div Gov Meeting		**Anticipated date for completion**	September 2021

KEY	Completed and Assurance Received	Action commenced but not yet completed	Action Overdue not completed in agreed time sclaes or at significant risk of note achieving time scales	Assurance recieved

Action Number	Recommendation / Area for Action Identified	Action Agreed	Lead	Date for Completion	Progress / Assurance	Key
1	**ENHANCED SAFETY** **Safety in maternity units across England must be strengthened by increasing partnerships between Trusts and within local networks.** **Neighbouring Trusts must work collaboratively to ensure that local investigations into Serious Incidents (SIs) have regional and Local Maternity System (LMS) oversight**.					
1.1	Clinical change where required must be embedded across trusts with regional clinical oversight in a timely way. Trusts must be able to provide evidence of this through structured reporting mechanisms e.g. through maternity dashboards. This	1.LMNS have agreed that national dashboard does not meet all requirements. Therefore development of LMNS dashboard continues.	Head of Midwifery	30 June 2021	Discussion in progress with LMNS timetable of presentation at LMNS quality and safety meeting	
		2.Local Trust maternity dashboard to be reviewed	Head of Midwifery	30 April June 2021	Additional items forwarded to informatics lead	

Action Number	Recommendation / Area for Action Identified	Action Agreed	Lead	Date for Completion	Progress / Assurance	Key
	must be a formal item on LMS agendas at least every 3 months	3 Ensure development of EPR within Trust includes all required data items.	Maternity SME	31 March 2021		
1.2	External clinical specialist opinion from outside the Trust (but from within the region), must be mandated for cases of intrapartum fetal death, maternal death, neonatal brain injury and neonatal death	Review process for both weekly review and 6 weekly perinatal audit	Deputy Matron	30 June 2021	SOP in development	
		Forward dates of perinatal audit to governance lead at SWBT	Deputy Matron	30 June 2021		
		Discuss with other Trusts within LMNS to gauge a standardised approach moving forward	HOM	31 May 2021	Meeting held with LMNS partners. SWBT have offered to attend perinatal audit meetings as external reviewer	
2	**Maternity services must ensure that women and their families are listened to with their voices heard.**					
2.1	Trusts must create an independent senior advocate role which reports to both the Trust and the LMS Boards	**Await further guidance from NHSE /NHSI on the expectation for this recommendation**				
2.2	The advocate must be available to families attending follow up meetings with clinicians where concerns about maternity or neonatal care are discussed, particularly where there has been an adverse outcome.	**Await further guidance from NHSE /NHSI on the expectation for this recommendation**				

Action Number	Recommendation / Area for Action Identified	Action Agreed	Lead	Date for Completion	Progress / Assurance	Key
2.3	Each Trust Board must identify a non-executive director who has oversight of maternity services, with specific responsibility for ensuring that women and family voices across the Trust are represented at Board level. They must work collaboratively with their maternity Safety Champions			Complete	Currently we have identified Liz Hughes as our NED with oversight for maternity issues.	
3	**Staff who work together must train together**					

Action Number	Recommendation / Area for Action Identified	Action Agreed	Lead	Date for Completion	Progress / Assurance	Key
3.1	Trusts must ensure that multidisciplinary training and working occurs and must provide evidence of it. This evidence must be externally validated through the LMS, 3 times a year	Process to be agreed within the BC & WB LMNS utilising any national guidance produced.	Head of Midwifery	June2021	An MDT training schedule is in place. Human factors are part of the training DGFT have monthly PROMPT training with a fully trained faculty (with the exception that during COVID this was paused). DGFT have just introduced PROMPT at home so that staff can access training remotely. This will require constant review in line with pandemic restrictions. Robust monitoring is in place re: compliance and this is routinely reported via the agreed Departmental and divisional governance framework Discussion at LMNS on programme of presentations.	
3.2	Multidisciplinary training and working together must always include twice daily (day and night through the 7-day week) consultant-led and present multidisciplinary ward rounds on the labour ward	Formalise the ward round process via SOP to avoid inconsistency	Clinical Director	31 March 2021	Multidisciplinary ward rounds are in place. Currently consultant led ward round takes place twice daily, however there have been some inconsistency in MDT attendance.	
		Contact with all required professional groups to remind them of their responsibility to participate	Clinical Director	31March 2021	Midwives, Obstetricians and Anaesthetists have been contacted and reminded of their responsibility to participate.	

Action Number	Recommendation / Area for Action Identified	Action Agreed	Lead	Date for Completion	Progress / Assurance	Key
3.3	Trusts must ensure that any external funding allocated for the training of maternity staff, is ring-fenced and used for this purpose only	Seek clarity about use of CNST MIS Refund	Financial Director	31 Jan 2021	All training funds received via NHSE/I and LMNS have been ring fenced There is also ring fenced funding available through LBR to support CPD for Midwifery staff. The CNST MIS monies have not been used exclusively for maternity safety but utilised as CIP	
4	**There must be robust pathways in place for managing women with complex pregnancies** **Through the development of links with the tertiary level Maternal Medicine Centre there must be agreement reached on the criteria for those cases to be discussed and /or referred to a maternal medicine specialist centre.**					
4.1	Women with complex pregnancies must have a named consultant lead.	Audit to be conducted to provide assurance of the pathway and process	Obstetric Audit Lead	30 June 2021	Risk assessments based on NICE guidance and MBRRACE report guidance are in place. High risk women are assigned a named lead consultant dependent on their risk assessment. Specialist advice is sought via the local network	
4.2	Where a complex pregnancy is identified, there must be early specialist involvement and management plans agreed between the woman and the team.	Audit to be conducted to provide assurance of the pathway and process	Obstetric Audit Lead	30 June 2021	Risk assessments based on NICE guidance and MBRRACE report guidance are in place. High risk women are assigned a named lead consultant dependent on their risk assessment. Specialist advice is sought via the local network	

Action Number	Recommendation / Area for Action Identified	Action Agreed	Lead	Date for Completion	Progress / Assurance	Key
4.3	The development of maternal medicine specialist centres as a regional hub and spoke model must be an urgent national priority to allow early discussion of complex maternity cases with expert clinicians.				This is in development and ongoing discussions are taking place throughout the Maternal clinical network and LMNS. We are engaged at a network level for the development of the maternal medicine networks working towards a tiered specialists centre system. Nationally 18 maternal medicine networks will be announced shortly	
4.4	This must also include regional integration of maternal mental health services				Maternal mental health services are regionally integrated and liaise via the LMNS	
5. Staff must ensure that women undergo a risk assessment at each contact throughout the pregnancy pathway.						

Action Number	Recommendation / Area for Action Identified	Action Agreed	Lead	Date for Completion	Progress / Assurance	Key
5.1	All women must be formally risk assessed at every antenatal contact so that they have continued access to care provision by the most appropriately trained professional Risk assessment must include ongoing review of the intended place of birth, based on the developing clinical picture.	Additional audits of compliance with risk assessment at each antenatal contact to be added and completed in the monthly audits. These will provide assurance of process	Matron ANC/ CMW	30 April 2021	Risk assessments are completed at booking and a pathway of care is recorded. Currently DGFT are using perinatal institute paper notes, these include an antenatal assessment at each appointment with the review and changes in care and or medical management clearly documented within the record.. . Audits are in place to monitor the initial risk assessments.	
5.2	Risk assessment must include ongoing review of the intended place of birth, based on the developing clinical picture.	Ensure audit results are available for	Matron ANC/ CMW	30 April 2021	Currently discussed at booking and birth plan visit	
6	**All maternity services must appoint a dedicated Lead Midwife and Lead Obstetrician both with demonstrated expertise to focus on and champion best practice in fetal monitoring**.					

Action Number	Recommendation / Area for Action Identified	Action Agreed	Lead	Date for Completion	Progress / Assurance	Key
6.1	The Leads must be of sufficient seniority and demonstrated expertise to ensure they are able to effectively lead on: - Improving the practice of monitoring fetal wellbeing - Consolidating existing knowledge of monitoring fetal wellbeing - Keeping abreast of developments in the field - Raising the profile of fetal wellbeing monitoring - Ensuring that colleagues engaged in fetal wellbeing monitoring are adequately supported - Interfacing with external units and agencies to learn about and keep abreast of developments in the field, and to track and introduce best practice.	Appointment of fetal wellbeing lead midwife and consultant obstetrician	HOM	30 June 2021	Secondment opportunity for midwife on NHS Jobs. Included permanent midwifery post in the staffing review. Included obstetrician post in the bid for additional funding for staff. Interviews for midwife organised for w/b 7th June	

Action Number	Recommendation / Area for Action Identified	Action Agreed	Lead	Date for Completion	Progress / Assurance	Key
6.2	The Leads must plan and run regular departmental fetal heart rate (FHR) monitoring meetings and cascade training. They should also lead on the review of cases of adverse outcome involving poor FHR interpretation and practice	Priority action as described in recommendation for successful midwife and consultant		July 2021	Recruitment in progress	
6.3	The Leads must ensure that their maternity service is compliant with the recommendations of Saving Babies Lives Care Bundle 2 and subsequent national guidelines.	Priority action as described in recommendation for successful midwife and consultant		June 2021		
7	**All Trusts must ensure women have ready access to accurate information to enable their informed choice of intended place of birth and mode of birth, including maternal choice for caesarean delivery.**					

Action Number	Recommendation / Area for Action Identified	Action Agreed	Lead	Date for Completion	Progress / Assurance	Key
7.1	All maternity services must ensure the provision to women of accurate and contemporaneous evidence-based information as per national guidance. This must include all aspects of maternity care throughout the antenatal, intrapartum and postnatal periods of care	Production of Choice and personalisation booklet and replicate within the developing EPR	Sp MW COC	30 April	Booklet received from printers. Distribution to community midwives planned with education on how to be used. Discussion on audit of compliance	
7.2	Women must be enabled to participate equally in all decision making processes and to make informed choices about their care	Education and development of staff Audit of choice and personalisation booklet completion	Matron OPD and CMW	June 2021	Education programme in development with continuity of care lead	
7.3	Women's choices following a shared and informed decision making process must be respected.	Audit to be developed and completed to access information sharing , choices offered and communication throughout pregnancy journey	Matrons	September 2021		
8. MATERNITY WORKFORCE PLANNING						
8.1	Midwifery Workforce to be established to BirthRate+ recommendation.	Request funding from LMNS to carry out Birthrate plus reassessment	HOM	February 2021	Completed and funding received. Confirmation from Birthrate plus that review will be carried out in either June or July	
		Request made to Birthrate Plus for assessment	HOM	February 2021	Request made, awaiting date.	

Action Number	Recommendation / Area for Action Identified	Action Agreed	Lead	Date for Completion	Progress / Assurance	Key
		Midwifery Staffing report to be presented to Directors and included in Board Report	HOM	30 April 2021	Included in June Board papers	
8.2	Demonstrate an effective medical workforce plan to required standards	Medical staffing paper to be presented to Directors	Clinical Director	30 April 2021	Discussed with Executive team and support for additional posts agreed	
9. MIDWIFERY LEADERSHIP **Confirm that the Director of Midwifery is responsible and accountable to an executive director and describe how your organisation meets the maternity leadership requirements set out by the Royal College of Midwives in** Strengthening midwifery leadership: a manifesto for better maternity care						
9.1	Each Trust or Health Board should have a director of midwifery. The director of midwifery should be responsible and accountable to an Executive Director.	Discuss requirements with Chief Nurse. Include requirement in Staffing paper to Directors and Board	HOM	31 May2021	Staffing plan agreed with Chief nurse and to take to Trust board in June 2021 paper.	
9.2	There should be at least one consultant midwife in each Trust	Include requirement in staffing report to Directors and then to Board	HOM	31 May 2021	Included in staffing paper and funding based on successful bid for band 5 and 6 midwifery staff	
9.3	There should be a range of specialist midwives in each Trust. The type roles required	Review current roles and current requirements	HOM	March 2021	Reviewed as described and additional roles identified. To be included in the staffing report	

Action Number	Recommendation / Area for Action Identified	Action Agreed	Lead	Date for Completion	Progress / Assurance	Key
	depends on the needs of each Trust	Include specialist midwife staffing requirements in report to Directors and Board	HOM	30 May2021	Included in midwifery staffing paper June board	
9.4	A commitment to fund ongoing midwifery leadership development	Ensure leadership development is included in learning beyond registration requests annually	HOM	30 April 2021	Currently supporting 2 midwives to complete Masters level apprenticeship in leadership.	
10. NICE GUIDANCE RELATED TO MATERNITY						
	Review the Trust approach to NICE guidelines in maternity and provide assurance that these are assessed and implemented where appropriate. Where non-evidenced based guidelines are utilised, the trust must undertake a robust assessment process before implementation and ensure that the decision is clinically justified.	Meet with Trust lead for NICE guidance and audit, to identify any gaps in process. Ensure that all NICE guidance has been assessed and implemented.	HOM & Clinical Director	30 June 2021	All senior midwives and obstetricians have access to AMAT the Trust system for review and action of NICE guidance	

Ockenden - Minimum evidence requirements

				SECTION 1: Immediate and Essential Actions 1 to 7	Assessment Criteria	Minimum Evidence Requirements
Immediate and Essential Action 1: Enhanced Safety						
IEA 1	Q1			Clinical change where required must be embedded across trusts with regional clinical oversight in a timely way. Trusts must be able to provide evidence of this through structured reporting mechanisms e.g. through maternity dashboards. This must be a formal item on LMS agendas at least every 3 months.	**Confirmation of a Maternity Services Dashboard** **Confirmation this is seen by the LMNS at least Quarterly**	• SOP required which demonstrates how the trust reports this both internally and externally through the LMS. • Submission of minutes and organogram, that shows how this takes place. • Minutes and agendas to identify regular review and use of common data dashboards and the response / actions taken. • Dashboard to be shared as evidence.
	Q2			External clinical specialist opinion from outside the Trust (but from within the region), must be mandated for cases of intrapartum fetal death, maternal death, neonatal brain injury and neonatal death.	**Confirmation of external specialist opinion on reviews**	• Policy or SOP which is in place for involving external clinical specialists in reviews. • Audit to demonstrate this takes place.
	Q3			All maternity SI reports (and a summary of the key issues) must be sent to the Trust Board and at the same time to the local LMS for scrutiny, oversight and transparency. This must be done at least every 3 months	Confirmation that SI **GO TO Trust Board** (nab not a sub group of board such as Quality group) Confirmation that a *SUMMARY* of SI key issues goes to Trust Board Confirmation that SI **GO TO LMNS Board** Confirmation that a **SUMMARY** of SI key issues goes to LMNS Board Each of the above happen **quarterly**	• Submit SOP • Submission of private trust board minutes as a minimum every three months with highlighted areas where SI's discussed • Individual SI's, overall summary of case, key learning, recommendations made, and actions taken to address with clear timescales for completion
Link to Maternity Safety actions:						
IEA 1	Q4	Action 1		Are you using the National Perinatal Mortality Review Tool to review perinatal deaths to the required standard?	**Confirmation that PMRT is undertaken** see PMRT Tab	• Local PMRT report. PMRT trust board report. Submission of a SOP that describes how parents and women are involved in the PMRT process as per the PMRT guidance. • Audit of 100% of PMRT completed demonstrating meeting the required standard including parents notified as a minimum and external review.
	Q5	Action 2		Are you submitting data to the Maternity Services Dataset to the required standard?	**Confirmation that Monthly score card completed** (13 mandatory criteria)	• Evidence of a plan for implementing the full MSDS requirements with clear timescales aligned to NHSR requirements within MIS.
	Q6	Action 10		Have you reported 100% of qualifying cases to HSIB and (for 2019/20 births only) reported to NHS Resolution's Early Notification scheme?	Confirmation that **100% of** cases are reported to HSIB & NHS Resolution	• Audit showing compliance of 100% reporting to both HSIB and NHSR Early Notification Scheme.
Link to urgent clinical priorities:						
IEA 1	Q7		(a)	A plan to implement the Perinatal Clinical Quality Surveillance Model	Confirmation that Trust / LMNS / ICS responsibilities of the model are implemented	• Full evidence of full implementation of the perinatal surveillance framework by June 2021. • Submit SOP and minutes and organogram of organisations involved that will support the above from the trust, signed of via the trust governance structure. • LMS SOP and minutes that describe how this is embedded in the ICS governance structure and signed off by the ICS.
	Q8		(b)	All maternity SIs are shared with Trust boards at least monthly and the LMS, in addition to reporting as required to HSIB	Confirmation that SI go to Trust Board (nab not a sub group of board such as Quality group) **Confirmation that SI go to LMNS Board** **Each of the above happen Monthly**	• Submit SOP • Submission of private trust board minutes as a minimum every three months with highlighted areas where SI's discussed • Individual SI's, overall summary of case, key learning, recommendations made, and actions taken to address with clear timescales for completion
Immediate and Essential Action 2: Listening to Women and Families						
IEA 2	Q9			Trusts must create an independent senior advocate role which reports to both the Trust and the LMS Boards.	No expectation that this action is met - national guidance awaited	
	Q10			The advocate must be available to families attending follow up meetings with clinicians where concerns about maternity or neonatal care are discussed, particularly where there has been an adverse outcome.	No expectation that this action is met - national guidance awaited	
	Q11			Each Trust Board must identify a non-executive director who has oversight of maternity services, with specific responsibility for ensuring that women and family voices across the Trust are represented at Board level. They must work collaboratively with their maternity Safety Champions.	Confirmation of an identified Trust Board Non Exec	• Name of NED and date of appointment • Evidence of ward to board and board to ward activities e.g. NED walk arounds and subsequent actions • Evidence of NED sitting at trust board meetings, minutes of trust board where NED has contributed • Evidence of how all voices are represented: • Evidence of link in to MVP; any other mechanisms • NED JD
Link to Maternity Safety actions:						
IEA 2	Q12	Action 1		Are you using the National Perinatal Mortality Review Tool to review perinatal deaths to the required standard?	Confirmation that PMRT is undertaken Confirmation that Parents are involved	• Local PMRT report. • PMRT trust board report. • Submission of a SOP that describes how parents and women are involved in the PMRT process as per the PMRT guidance. • Audit of 100% of PMRT completed demonstrating meeting the required standard including parents notified as a minimum and external review.
	Q13	Action 7		Can you demonstrate that you have a mechanism for gathering service user feedback, and that you work with service users through your Maternity Voices Partnership to coproduce local maternity services?	Confirmation of approach to gathering Service User feedback (i.e. 15 steps / FFT / You Said We Did) **AND** MVP in place that **COPRODUCES** services	• Please upload your CNST evidence of co-production. If utilised then upload completed templates for providers to successfully achieve maternity safety action 7. CNST templates to be signed off by the MVP. • Evidence of service user feedback being used to support improvement in maternity services (E.G you said, we did, FFT, 15 Steps) • Clear co-produced plan, with MVP's that demonstrate that co production and co-design of service improvements, changes and developments will be in place and will be embedded by December 2021.
	Q14	Action 9		Can you demonstrate that the Trust safety champions (obstetrician and midwife) are meeting bimonthly with Board level champions to escalate locally identified issues?	Identified Safety Champions **WORKING WITH** Exec and Non Exec Board Leads for Maternity	• SOP that includes role descriptors for all key members who attend by-monthly safety meetings. • Log of attendees and core membership. • Action log and actions taken. • Minutes of the meeting and minutes of the LMS meeting where this is discussed.
Link to urgent clinical priorities						
IEA 2	Q15	A		Evidence that you have a robust mechanism for gathering service user feedback, and that you work with service users through your Maternity Voices Partnership (MVP) to coproduce local maternity services.	Same score as Q13	• Please upload your CNST evidence of co-production. If utilised then upload completed templates for providers to successfully achieve maternity safety action 7. CNST templates to be signed off by the MVP. • Evidence of service user feedback being used to support improvement in maternity services (E.G you said, we did, FFT, 15 Steps) • Clear co produced plan, with MVP's that demonstrate that co-production and co-design of all service improvements, changes and developments will be in place and will be embedded by December 2021.
	Q16	B		In addition to the identification of an Executive Director with specific responsibility for maternity services, confirmation of a named non-executive director who will support the Board maternity safety champion bringing a degree of independent challenge to the oversight of maternity and neonatal services and ensuring that the voices of service users and staff are heard.	Confirmation of an identified Trust Board Executive Director **AND** a Non Executive Director	• Name of ED and date of appointment • Name of NED and date of appointment • Evidence of participation and collaboration between ED, NED and Maternity Safety Champion, e.g. evidence of raising issues at trust board, minutes of trust board and evidence of actions taken Role descriptors
Immediate and essential action 3: Staff Training and Working Together						
IEA 3	Q17			Trusts must ensure that multidisciplinary training and working occurs and must provide evidence of it. This evidence must be externally validated through the LMS, 3 times a year.	**Training together:** Confirmation of MDT training **AND** this is validated through the LMNS x 3 per year	• Submit training needs analysis (TNA) that clearly articulates the expectation of all professional groups in attendance at all MDT training and core competency training. Also aligned to NHSR requirements. • Submit evidence of training sessions being attended, with clear evidence that all MDT members are represented for each session. • LMS reports showing regular review of training data (attendance, compliance coverage) and training needs assessment that demonstrates validation describes as checking the accuracy of the data. • Where inaccurate or not meeting planned target what actions and what risk reduction mitigations have been put in place. • A clear trajectory in place to meet and maintain compliance as articulated in the TNA.
	Q18			Multidisciplinary training and working together must always include twice daily (day and night through the 7-day week) consultant-led and present multidisciplinary ward rounds on the labour ward.	**Working together:** Confirmation of **ALL** criteria requested	• SOP created for consultant led ward rounds. • Evidence of scheduled MDT ward rounds taking place since December, twice a day, day & night. 7 days a week (e.g. audit of compliance with SOP)
	Q19			Trusts must ensure that any external funding allocated for the training of maternity staff, is ring-fenced and used for this purpose only (e.g. Maternity Safety Fund, Charities monies, MPET/SLA monies etc that is specifically given for training)	Confirmation of ring fenced Maternity training budget	• Evidence that additional external funding has been spent on funding including staff can attend training in work time. • Evidence of funding received and spent. • Confirmation from Directors of Finance • Evidence from Budget statements. • MTP spend reports to LMS
Link to Maternity Safety actions:						
	Q20	Action 4		Can you demonstrate an effective system of clinical workforce planning to the required standard?	See Section 2	**See section 2**

IEA 3	**Q21**	Action 8	Can you evidence that at least 90% of each maternity unit staff group have attended an 'in-house' multi-professional maternity emergencies training session since the launch of MIS year three in December 2019?	90% achieved on MDT training of all Staff groups (Obstetrics / Anaesthetists / Maternity / Neonates / Support Workers)	• Submit training needs analysis (TNA) that clearly articulates the expectation of all professional groups in attendance at all MDT training and core competency training. Also aligned to NHSR requirements. • Submit evidence of training sessions being attended, with clear evidence that all MDT members are represented for each session. • LMS reports showing regular review of training data (attendance, compliance coverage) and training needs assessment that demonstrates validation describes as checking the accuracy of the data. Where inaccurate or not meeting planned target what actions and what risk reduction mitigations have been put in place. • A clear trajectory in place to meet and maintain compliance as articulated in the TNA. • Attendance records - summarised
Link to urgent clinical priorities					
IEA 3	**Q22**		Implement consultant led labour ward rounds twice daily (over 24 hours) and 7 days per week.	See Q18	• SOP created for consultant led ward rounds. • Evidence of scheduled MDT ward rounds taking place since December 2020 twice a day, day & night, 7 days a week (E.G audit of compliance with SOP)
	Q23		The report is clear that joint multi-disciplinary training is vital, and therefore we will be publishing further guidance shortly which must be implemented. In the meantime we are seeking assurance that a MDT training schedule is in place	See Q17	• Submit training needs analysis (TNA) that clearly articulates the expectation of all professional groups in attendance at all MDT training and core competency training. Also aligned to NHSR requirements. • Submit evidence of training sessions being attended, with clear evidence that all MDT members are represented for each session. • LMS reports showing regular review of training data (attendance, compliance coverage) and training needs assessment that demonstrates validation described as checking the accuracy of the data. • Where inaccurate or not meeting planned target what actions and what risk reduction mitigations have been put in place. • A clear trajectory in place to meet and maintain compliance as articulated in the TNA.
Immediate and essential action 4: Managing Complex Pregnancy					
IEA 4	**Q24**		Through the development of links with the tertiary level Maternal Medicine Centre there must be agreement reached on the criteria for those cases to be discussed and /or referred to a maternal medicine specialist centre.	Agreement reached on Criteria for referral to Mat Med Specialist Centre	• SOP that clearly demonstrates the current maternal medicine pathways that includes: agreed criteria for referral to the maternal medicine centre pathway. • Audit that demonstrates referral against criteria has been implemented that there is a named consultant lead, and early specialist involvement and that a Management plan that has been agreed between the women and clinicians
	Q25		Women with complex pregnancies must have a named consultant lead	Named consultant lead for all women identified = Yes	• SOP that states that both women with complex pregnancies who require referral to maternal medicine networks and women with complex pregnances but who do not require referral to maternal medicine network must have a named consultant lead. • Audit of 1% of notes, where all women have complex pregnancies to demonstrate the woman has a named consultant lead.
	Q26		Where a complex pregnancy is identified, there must be early specialist involvement and management plans agreed between the woman and the team	Referenced to specialist involvement AND management plans developed	• SOP that identifies where a complex pregnancy is identified, there must be early specialist involvement and management plans agreed between the woman and the teams. • Audit of 1% of notes, where women have complex pregnancies to ensure women have early specialist involvement and management plans are devloped by the cinical team in consulation with the woman.
Link to Maternity Safety actions:					
IEA 4	**Q27**	Action 6	Can you demonstrate compliance with all five elements of the Saving Babies' Lives care bundle Version 2?	Confirmation of compliance with **ALL** elements	• SOP's • Audits for each element. • Guidelines with evidence for each pathway
Link to urgent clinical priorities:					
IEA 4	**Q28**	A	All women with complex pregnancy must have a named consultant lead, and mechanisms to regularly audit compliance must be in place.	Confirmation of consultant lead **AND** regular Audit of Compliance in place	• SOP that states women with complex pregnancies must have a named consultant lead. • Submission of an audit plan to regularly audit compliance
	Q29	B	Understand what further steps are required by your organisation to support the development of maternal medicine specialist centres	Confirmation that Trust is developing their local actions as part of an agreed Network approach	• The maternity services involved in the establishment of maternal medicine networks evidenced by notes of meetings, agendas, action logs. • Criteria for referrals to MMC • Agreed pathways
Immediate and essential action 5: Risk Assessment Throughout Pregnancy					
IEA 5	**Q30**		All women must be formally risk assessed at every antenatal contact so that they have continued access to care provision by the most appropriately trained professional	Risk Assessment at **EVERY** AN Contact	• SOP that includes definition of antenatal risk assessment as per NICE guidance. • How this is achieved within the organisation. • What is being risk assessed. • Review and discussed and documented intended place of birth at every visit. • Personal Care and Support plans are in place and an ongoing audit of 1% of records that demonstrates compliance of the above.
	Q31		Risk assessment must include ongoing review of the intended place of birth, based on the developing clinical picture.	Review of place of birth in risk assessment at **ALL** AN contacts	• SOP that includes review of intended place of birth. • Personal Care and Support plans are in place and an ongoing audit of 1% of records that demonstrates compliance of the above. • Out with guidance pathway. • Evidence of referral to birth options clinics
Link to Maternity Safety actions:					
IEA 5	**Q32**	Action 6	Can you demonstrate compliance with all five elements of the Saving Babies' Lives care bundle Version 2?	See Q27	• SOP's • Audits for each element • Guidelines with evidence for each pathway
Link to urgent clinical priorities:					
IEA 5	**Q33**		A risk assessment must be completed and recorded at every contact. This must also include ongoing review and discussion of intended place of birth. This is a key element of the Personalised Care and Support Plan (PSCP). Regular audit mechanisms are in place to assess PCSP compliance.	Are PCSPs in place **AND** are they audited	• SOP to describe risk assesement being undertaken at every contact. • What is being risk assessed. • How this is achieved in the organisation. • Review and discussed and documented intended place of birth at every visit. • Personal Care and Support plans are in place and an ongoing audit of 5% of records that demonstrates compliance of the above. • Example submission of a Personalised Care and Support Plan (It is important that we recognise that PCSP will be variable in how they are presented from each trust)
Immediate and essential action 6: Monitoring Fetal Wellbeing					
IEA 6	**Q34**		All maternity services must appoint a dedicated Lead Midwife and Lead Obstetrician both with demonstrated expertise to focus on and champion best practice in fetal wellbeing.	**BOTH** MW and Obstetrician in place	• Name of dedicated Lead Midwife and Lead Obstetrician • Copies of rotas / off duties to demonstrate they are given dedicated time. • Examples of what the leads do with the dedicated time E.G attendance at external fetal wellbeing event, involvement with training, meeting minutes and action logs. • Incident investigations and reviews
	Q35		The Leads must be of sufficient seniority and demonstrated expertise to ensure they are able to effectively lead on: - Improving the practice of monitoring fetal wellbeing - Consolidating existing knowledge of monitoring fetal wellbeing - Keeping abreast of developments in the field - Raising the profile of fetal wellbeing monitoring - Ensuring that colleagues engaged in fetal wellbeing monitoring are adequately supported - Interfacing with external units and agencies to learn about and keep abreast of developments in the field, and to track and introduce best practice. - The Leads must plan and run regular departmental fetal heart rate (FHR) monitoring meetings and cascade training. - They should also lead on the review of cases of adverse outcome involving poor FHR interpretation and practice. - The Leads must ensure that their maternity service is compliant with the recommendations of Saving Babies Lives Care Bundle 2 and subsequent national guidelines.	JD fulfils **ALL** criteria	• Job Description which has in the criteria as a minimum for both roles and confirmation that roles are in post • Improving the practice & raising the profile of fetal wellbeing monitoring • Consolidating existing knowledge of monitoring fetal wellbeing • Keeping abreast of developments in the field • Ensuring that colleagues engaged in fetal wellbeing monitoring are adequately supported e.g clinical supervision • Interface with external units and agencies to learn about and keep abreast of developments in the field, and to track and introduce best practice. • Plan and run regular departmental fetal heart rate (FHR) monitoring meetings and training. • Lead on the review of cases of adverse outcome involving poor FHR interpretation and practice.
Link to Maternity Safety actions:					
IEA 6	**Q36**	Action 6	Can you demonstrate compliance with all five elements of the Saving Babies' Lives care bundle Version 2?	See Q27	• SOP's • Audits for each element • Guidelines with evidence for each pathway
	Q37	Action 8	Can you evidence that at least 90% of each maternity unit staff group have attended an 'in-house' multi-professional maternity emergencies training session since the launch of MIS year three in December 2019?	See Q21	• Submit training needs analysis (TNA) that clearly articulates the expectation of all professional groups in attendance at all MDT training and core competency training. Also aligned to NHSR requirements. Submit evidence of training sessions being attended, with clear evidence that all MDT members are represented for each session. • LMS reports showing regular review of training data (attendance, compliance coverage) and training needs assessment that demonstrates validation describes as checking the accuracy of the data. • Where inaccurate or not meeting planned target what actions and what risk reduction mitigations have been put in place. • A clear trajectory in place to meet and maintain compliance as articulated in the TNA. • Attendance records - summarised
IEA 6					
	Q38		Implement the saving babies lives bundle. Element 4 already states there needs to be one lead. We are now asking that a second lead is identified so that every unit has a lead midwife and a lead obstetrician in place to lead best practice, learning and support. This will include regular training sessions, review of cases and ensuring compliance with saving babies lives care bundle 2 and national guidelines.	See Q34	• Name of dedicated Lead Midwife and Lead Obstetrician • Copies of rotas / off duties to demonstrate they are given dedicated time. Examples of what the leads do with the dedicated time E.G attendance at external fetal wellbeing event, involvement with training, meeting minutes and action logs. • Incident investigations and reviews
Immediate and essential action 7: Informed Consent					

IEA 7	**Q39**	All Trusts must ensure women have ready access to accurate information to enable their informed choice of intended place of birth and mode of birth, including maternal choice for caesarean delivery.	**ALL** place of birth information easily accessible	• Information on maternal choice including choice for caesarean delivery. • Submission from MVP chair rating trust information in terms of: accessibility (navigation, language etc) quality of info (clear language, all/minimum topic covered) other evidence could include patient information leaflets, apps, websites.
	Q40	All maternity services must ensure the provision to women of accurate and contemporaneous evidence-based information as per national guidance. This must include all aspects of maternity care throughout the antenatal, intrapartum and postnatal periods of care	**ALL** information is easily accessible	• Information on maternal choice including choice for caesarean delivery. • Submission from MVP chair rating trust information in terms of: accessibility (navigation, language etc) quality of info (clear language, all/minimum topic covered) other evidence could include patient information leaflets, apps, websites.
	Q41	Women must be enabled to participate equally in all decision-making processes and to make informed choices about their care	Confirmation that trust **HAS** a method of recording decision making processes that includes women's participation & informed choice	• SOP which shows how women are enabled to participate equally in all decision making processes and to make informed choices about their care. And where that is recorded. • An audit of 1% of notes demonstrating compliance. • CQC survey and associated action plans
	Q42	Women's choices following a shared and informed decision-making process must be respected	Reference made to how Women's choices are respected and evidenced	• SOP to demonstrate how women's choices are respected and how this is evidenced following a shared and informed decision-making process, and where that is recorded. • An audit of 5% of notes demonstrating compliance, this should include women who have specifically requested a care pathway which may differ from that recommended by the clinician during the antenatal period, and also a selection of women who request a caesarean section during labour or induction. • CQC survey and associated action plans
Link to Maternity Safety actions:				
IEA 7	**Q43**	Action 7	Can you demonstrate that you have a mechanism for gathering service user feedback, and that you work with service users through your Maternity Voices Partnership to coproduce local maternity services?	See Q13	• Please upload your CNST evidence of co-production. If utilised then upload completed templates for providers to successfully achieve maternity safety action 7. CNST templates to be signed off by the MVP. • Evidence of service user feedback being used to support improvement in maternity services (E.G you said, we did, FFT, 15 Steps) • Clear co produced plan, with MVP's that demonstrate that co production and co-design of all service improvements, changes and developments will be in place and will be embedded by December 2021.
Link to urgent clinical priorities:				
IEA 7	**Q44**	Every trust should have the pathways of care clearly described, in written information in formats consistent with NHS policy and posted on the trust website. An example of good practice is available on the Chelsea and Westminster website.	All information **ON** trust website	• Gap analysis of website against Chelsea & Westminster conducted by the MVP • Co-produced action plan to address gaps identified • Information on maternal choice including choice for caesarean delivery. • Submission from MVP chair rating trust information in terms of: accessibility (navigation, language etc) quality of info (clear language, all/minimum topic covered) other evidence could include patient information leaflets, apps, websites.

SECTION 2: WORFORCE PLANNING			Assessment Criteria	Minimum evidence requirements
Link to Maternity Safety Actions				
Q45	Action 4	Can you demonstrate an effective system of clinical workforce planning to the required standard	Midwifery workforce planning system **in PLACE**	• Most recent BR+ report and board minutes agreeing to fund. • Evidence of reviews 6 monthly for all staff groups and evidence considered at board level. • Consider evidence of workforce planning at LMS/ICS level given this is the direction of travel of the people plan
Q46	Action 5	Can you demonstrate an effective system of midwifery workforce planning to the required standard?	Confirmation of a maternity workforce gap analysis **AND** a plan in place (with confirmed timescales) to meet BR+ standards	• Most recent BR+ report and board minutes agreeing to fund.
Midwifery Leadership				
Q47	Please confirm that your Director/Head of Midwifery is responsible and accountable to an executive director		Evidence the Director/Head of Midwifery responsible and accountable to an executive Director	• HoM/DoM Job Description with explicit signposting to responsibility and accountability to an executive director
Q48	Describe how your organisation meets the maternity leadership requirements set out by the Royal College of Midwives in Strengthening midwifery leadership: a manifesto for better maternity care: 1. A Director of Midwifery in every trust and health board, and more Heads of Midwifery across the service 2. A lead midwife at a senior level in all parts of the NHS, both nationally and regionally 3. More Consultant midwives 4. Specialist midwives in every trust and health board 5. Strengthening and supporting sustainable midwifery leadership in education and research 6. A commitment to fund ongoing midwifery leadership development 7. Professional input into the appointment of midwife leaders		**Meets ALL** that apply **Note - Trusts would not lead on actioning all seven steps**	• Gap analysis completed against the RCM strengthening midwifery leadership: a manifesto for better maternity care • Action plan where manifesto is not met
NICE Guidance related to maternity				
Q49	We are asking providers to review their approach to NICE guidelines in maternity and provide assurance that these are assessed and implemented where appropriate. Where non-evidenced based guidelines are utilised, the trust must undertake a robust assessment process before implementation and ensure that the decision is clinically justified.		**ALL** guidance assessed & implemented = Yes (GREEN)	• SOP in place for all guidelines with a demonstrable process for ongoing review. • Audit to demonstrate all guidelines are in date. • Evidence of risk assessment where guidance is not implemented.

Enclosure 26

The Dudley Group NHS
NHS Foundation Trust

Paper for submission to the Board of Directors on 10th June 2021

TITLE:	**Research & Development 6- monthly Report**		
AUTHOR:	**Dr Jeff Neilson, Director of R&D; Prof George Kitas, Director of R&D Academic Affairs; Dr Gail Parsons, Deputy Director of R&D (Nursing); Helen Hollis, Support R&D Manager**	**PRESENTER**	**Dr Jeff Neilson, Director of R&D**

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

- Acknowledge the report
- Understand the activity and results thus far of Urgent Public Health Research and other COVID studies.

CORPORATE OBJECTIVE:

SO1, SO2, SO3, SO4, SO5, SO6

SUMMARY OF KEY ISSUES:

- COVID related Urgent Public Health and Non-urgent Public Health research activity

IMPLICATIONS OF PAPER:			
IMPLICATIONS FOR THE CORPORATE RISK REGISTER OR BOARD ASSURANCE FRAMEWORK			
RISK	**N**		**Risk Description:** reduction in annual funding from Clinical Research Network
	Risk Register:		**Risk Score:** 12
	N		**Risk Description:** lack of space for archiving study documents (up to 25 yrs)
	Risk Register: Y		**Risk Score:** 12
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:**

IMPLICATIONS OF PAPER:			
RISK	**Y**		**Risk Description:**
	Risk Register: N		**Risk Score:**
	Y		**Risk Description:**
	Risk Register: Y		**Risk Score:** 12
COMPLIANCE and/or LEGAL REQUIREMENTS	**CQC**	**Y**	**Details:** Well Led The leadership, management and governance of the organisation assures the delivery of high quality person-centred care, supports learning and innovation, and promotes an open and fair culture
	NHSI	**Y**	**Details:** R&D activity included in the Annual Report
	Other	**Y**	**Details:** Recruitment activity is monitored by CRN:WM, NIHR, DHSC.

In March 2020 as the COVID19 pandemic was taking hold, the majority of studies were paused and the department focussed on the delivery of Urgent Public Health Studies. These studies are described here in order of number of recruits into each with a brief description of the study purpose, and where available, results of the studies so far. These provide a clear example of how research can be integrated into clinical practice, contribute to improving outcomes and become business as usual.

ISARIC/WHO Clinical Characterisation Protocol for Severe Emerging Infections in the UK (CCP-UK)

1277 recruited

This is a standardized generic protocol for the rapid, coordinated clinical investigation of severe or potentially severe acute infections by pathogens of public health interest. The primary objectives include describing the clinical features, response to treatment, pathogen and host factors that relate to disease severity and immune response. Also to inform policy makers of epidemiological factors that can modify clinical guidance. We are part of Tier 0 in this study and as such this is a study that involves collecting clinical data only.

SIREN: The impact of detectable anti SARS-CoV-2 antibody on the incidence of COVID-19 in healthcare workers

425 recruited

This is a prospective longitudinal cohort study of staff working in healthcare organisations within the UK. It aims to find out whether staff working in healthcare organisations who have evidence of prior COVID-19, detected by antibody assays (positive antibody tests), are protected from future episodes of infection compared to those who do not have evidence of prior infection (negative antibody tests). With the introduction of COVID-19 vaccinations for healthcare workers from December 2020, this study will also examine immunity acquired by a vaccine and obtain early estimates of vaccine effectiveness. It will explore both short and long-term effectiveness of a vaccine against infection and immunological response to a vaccine, including potential differences in response associated with factors such as prior exposure and antibody status. Participants complete short questionnaires and have COVID PCR tests fortnightly and antibody tests every four weeks. Follow-up will continue for one year (minimum) from recruitment.

There has been a lot of positive feedback from staff recruited who appreciate the regular testing and who receive the antibody test results via text. On request, they can obtain their antibody levels too. It also has put a different kind of strain on the R&D logistics, since this is the only large study that involves frequent follow-up visits. Results from the study after 7 months follow up were published in the Lancet (https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(21)00675-9/fulltext) and concluded with: 'This study supports the hypothesis that primary infection with SARS-CoV-2 provides a high degree of immunity to repeat infection in the short to medium term; with similar levels of prevention of symptomatic infection as the new licenced vaccines for working-age adults.' It is likely that future publication will include information on vaccine effectiveness within the study participant group. In February 2021 we received a letter from the trial centre indicating that we were one of the most successful recruiters (appendix 1).

Randomised Evaluation of COVID-19 therapy (RECOVERY)

223 recruited to date

This is a randomised trial for patients hospitalised with COVID-19. All eligible patients are randomly allocated between several treatment arms, each to be given in addition to the usual standard of care in the participating hospital. At the outset, there were no known treatments for this new disease but 'The UK New and Emerging Respiratory Virus Threats Advisory Group' (NERVTAG) advised that several possible treatments should be evaluated, including Lopinavir-Ritonavir, low-dose corticosteroids, and Hydroxychloroquine. These formed the basis of the trial when it opened to recruitment here in early April 2020. The trial changed continually as treatments were either found to improve outcome and were adopted as standard of care – e.g. dexamethasone, or more often, did not show any benefit, when they dropped off and were replaced by alternatives. To add another layer of complexity, not all treatments were available at all centres. The trial was designed to be inclusive and encouraged all doctors who were managing patients with COVID to be part of the recruitment drive, to assist a link is still on the hub to RECOVERY signposting to a short training resource. A small cohort of research nurses were involved in facilitating trial entry, helping patients to understand the study, ensuring all trial procedures were followed and, for some drugs/treatments, actually delivering the intervention. In the latter quarter of 2020, there was a drive from the CRN to target 10% of total COVID patients enter RECOVERY, we were one of 3 trusts in the West Midlands that was recognised as achieving this at the last formal Partnership Group Meeting.

To date RECOVERY has provided evidence of survival benefit with dexamethasone – deaths were reduced by one third in ventilated patients and one fifth in those requiring oxygen. It is now part of standard treatment. Tocilizumab also improves survival with an absolute reduction of 4% in all hospitalised patients, and is now standard of care. The following interventions have failed to show benefit and have been removed from the study: azithromycin, colchicine, convalescent plasma, hydroxychloroquine, and lopinavir-retinvir. The RECOVERY trial has so far recruited over 39,000 patients and is currently investigating baricitinib, di-methyl fumarate, and high vs low dose corticosteroids.

Randomised, embedded, multifactorial platform trial for community-acquired pneumonia (REMAP-CAP)

173 recruited

This study was devised before the pandemic to explore interventions in an intensive care unit setting to improve outcomes of patients with community acquired pneumonia from any cause – most are bacterial in adults. As the pandemic took off, the trial was essentially re-purposed as a COVID study using the same structure which is similar to RECOVERY which allows for multiple interventions to examined both sequentially and simultaneously. It also subsequently allowed entry to COVID patients not in ICU. Interventions have included therapeutic anticoagulation, corticosteroids, simvastatin, convalescent plasma and interleukin-6 blockade (tocilizumab, sarilumab), interleukin-1 blockade (anakinra), hydroxychloroquine, lopinavir-retinvir, aspirin/P2Y12 inhibitors, ACE-II

inhibitors. Again a small team of research nurses worked with critical care staff to recruit patients. When the first REMAP-CAP Newsletter was published in November 2020 (Appendix 2), we were the top recruiting site in the UK.

The RECOVERY trial result with dexamethasone resulted in the corticosteroid part of the study being halted, at the time of stopping there was a trend towards benefit and the data was used a subsequent meta-analysis to bolster the benefit of steroids. The trial showed that patients treated with tocilizumab were more likely to improve compared to those not and subsequently that sarilumab has an equivalent effect to tocilizumab. Early in the pandemic, there was a lot of opinion that more anticoagulation was needed as it was noted that thrombosis was a frequent complication of COVID. The trial showed no difference in outcome in the ITU setting for therapeutic anticoagulation compared to prophylaxis, but, later, the reverse for those not requiring organ support. The latter awaits final publication. Like RECOVERY, this trial did not show any benefit for convalescent plasma.

impaCt of bioLogic therApy on saRs-cov-2 Infection and immuniTY (CLARITY)

52 recruited

The study involves patients with inflammatory bowel disease who have received immunomodulatory therapy. It is known that these patients respond less well to vaccines. It was at first examining the seroprevalence of COVID19 and whether there was a difference between patients treated with two specified drugs. Subsequently it became a vehicle for looking at vaccine responses.

The first results were recently published (https://www.clarityibd.org/). These show that, firstly, fewer than half of people with IBD who were treated with infliximab had detectable antibodies after SARS-CoV-2 infection, the coronavirus that causes COVID-19. After a single dose of vaccine, only about one third of participants (103 of 328) treated exclusively with infliximab generated adequate levels of antibodies to the virus for the vaccine to be considered effective. However, in a sub-group of people who had previously been infected with COVID-19, and also in the few patients studied who had already had a second dose of vaccine, the vaccine-triggered antibody responses rose significantly, indicating an effective response after two exposures.

Outcomes and prognostic factors in coronavirus disease (COVID-19) in very old intensive care patients (COVIP)

25 recruited

This study was designed to study the relationship between age, co-morbidities, pretreatment, frailty, and outcomes prospectively in a group of elderly patients receiving critical care for COVID-19. It is an international study involving patient aged 70 and over. The study involved collecting data only.

Results published thus far show that frailty provides relevant prognostic information in elderly COVID-19 patients in addition to age and comorbidities and that a frailty assessment could be usefully included in the holistic assessment of patients (https://ccforum.biomedcentral.com/articles/10.1186/s13054-021-03551-3).

Chloroquine/ hydroxychloroquine prevention of coronavirus disease (COVID-19) in the healthcare setting; a randomised, placebo-controlled prophylaxis study (COPCOV)

15 recruited

The primary objectives of the study were to determine if prophylactic chloroquine or hydroxychloroquine prevents symptomatic COVID-19 illness in healthcare workers. The secondary objectives included whether clinical severity of COVID-19 infections is attenuated, whether asymptomatic COVID-19 can be prevented and whether symptomatic all-cause acute respiratory infections (ARI) can be prevented. At the time of design, choroquine and hydroxychloroquine were thought to have anti-viral properties. By the time the study was opened here (November 2020), data was had emerged that hydroxychlororquine had no benefit in the treatment of COVID-19, which is likely to have affected the recruitment figures. Recruitment has stopped and we were one of ten trusts who contributed to the total recruitment of 226 participants in the UK. No results have been published to date.

Respiratory Support : Respiratory Strategies in COVID-19; CPAP, High-flow, and standard care (RECOVERY-RS)

12 recruited

This study is an off-shoot of the RECOVERY trial concentrating on respiratory support. In this trust, the approach to this evolved through the pandemic based on experience. This study was set up to provide opportunity to get high quality evidence to establish the best way to provide respiratory support. So far the study has recruited 1278 patients across 75 sites. No results have been published to date.

A Phase II, randomised, double-blind, placebo-controlled clinical trial to assess the safety and efficacy of AZD1656 in diabetic patients hospitalised with suspected or confirmed COVID-19. (The ARCADIA Trial)

9 recruited

Diabetic patients with COVID-19 show abnormal variation in blood glucose levels. This study examines whether this can be improved using a new agent AZD1656. This agent also has effects on T lymphocytes. The study is designed to determine if AZD1656 will improve clinical outcomes for diabetic patients. 156 patients have been recruited across approximately 15 sites in the UK. No results have yet been published.

Non-COVID research

After the first peak of COVID in 2020, we concentrated effort on re-opening the studies and were progressing well before the second peak hit and we effectively closed studies again. Recruitment into our usual studies has been slow. This is hampered by new ways of working where fewer patients attend the hospital for appointments, and many patients fear attending hospital still. It is hoped this will improve with the success of the vaccination programme. We have recruited 42 patients into non-COVID studies since 1st April 2021 with surgery and critical care dominating. Our current focus is on improving this once normal service is resumed within the Trust.

R&D Strategy

The current strategy document covers 2018-2021 and is thus approaching renewal. Over the next six months we will reflect on to what degree we have met strategic goals against the pre-determined measures outlined in the document. This will form the basis of a look forward to our goals for the next three years. We will also reflect on how the pandemic has helped and hindered our strategy. We will also review the strategic investment paper in the light and shape of the peri-COVID world.

We are feeling the impact of Brexit in mainline academic and commercial funding. Our ability to attract Research Fellows from EU countries, a model that we have been running extremely successfully for two decades in several specialities (Rheumatology, Cardiology and Dermatology) has been compromised due to travel restrictions. Commercial sponsors are cautious selecting the UK to participate in studies, which is affecting all CRNs and Trusts.

The number of non-medical PIs to be increased and the opportunities for the development of staff to full fill this role will be a key objective for the department. Funding has been awarded from R&D for MRes for nurses/AHP's (currently two individual members of staff participating in this programme). We currently have five non-medical PIs within the Trust.

We have rolled out PI Essentials training for current and potential PIs within the Trust. This was paused during the lockdown, however has recommenced with a very good attendance record. The training aims to inform the PIs of their role and responsibilities in the study and what support they can expect from R&D. The training is available to all staff – medical and non-medical.

Research Scholarships and Fellowships

Mr Mike Wall (Consultant Vascular Surgeon) has been successful I the latest round of CRN Research Scholarship awards. The award funds a day a week for two years at one of the local clinical trial units to facilitate his advancement towards becoming a chief investigator (lead researcher in a multi-centre research study).

A previous successful applicant, Dr Steve Jenkins (Consultant Haematologist) is in the process of opening his first clinical trial study as a chief investigator – REPAIR-MDS.

Sally Fenton, an affiliated academic staff member, has been shortlisted for a 5-year NIHR Senior Fellowship with the outcome pending, due July 2021.

National Developments and Performance Management

The number of patients receiving health services provided or sub-contracted by the Trust in 2020/21 that were recruited during that period to participate in research approved by a Research Ethics Committee was 2067 (NIHR portfolio research and non-portfolio research). Please see appendix 3 for our activity compared to other West Midlands Trusts.

Publications

Please see appendix 4 for publications since previous report.

Summary

Research awareness has significantly improved because of COVID 19, both for the wider public as well as staff within the Trust. This response may influence future participation in research studies. The commitment and determination from staff within the department enabled us to adapt quickly and effectively in the implementation of COVID 19 studies. The infrastructure within the department is currently under review and, as a result of adapting to new ways of working, the Clinical Support Worker (CSW) role has been introduced and proven successful with the SIREN study and will become embedded within the new department structure.

With new challenges ahead, involving Re-start of paused studies, introduction of new studies and on-going follow-up of COVID 19 participants, the welfare and wellbeing of staff is paramount to ensure the department is successful in achieving their overall objectives. The use of technology with remote participant appointments and video calls will be incorporated into future studies as it was recognised as a positive future choice for participants wishing to be involved.

The impact of COVID 19 has allowed time through the pausity of active research, to publish a very large number of papers in 2020 (in Rheumatology the second highest ever at 43) from legacy studies, however we are already experiencing in 2021 the negative impact of being unable to generate new data.

Name of Authors: Dr Jeff Neilson, Prof George Kitas, Dr Gail Parsons, Helen Hollis.

Title of Authors: Director of R&D, Deputy Director of R&D (Nursing), Director of R&D Academic Affairs, Support R&D manager.

Date report prepared 01/06/2021

APPENDICES:

Appendix 1 – Letter from SIREN study

Appendix 2 – REMAPCAP Newsletter

Appendix 3 – Trust Reports compared to WM Trusts

Appendix 4 - Research Publications -January 2020 -May 2021

Enclosure 27

The Dudley Group
NHS Foundation Trust

Paper for submission to the Board of Directors on 10 June 2021

TITLE:	**Learning from Deaths**		
AUTHOR:	**Dr P Brammer, Deputy MD**	**PRESENTER**	**Dr J Hobbs, MD**

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 increase in SHMI during the last two reporting periods and known issues relating to the Trust denominator for SHMI due to the removal of a large patient cohort in 2017.
- The progress against actions detailed below will be provided via Quarterly Learning from Deaths reports submitted to Quality and Safety and Trust Board:
- Review of SHMI data with NHSI to consider rebasing of data to reflect reduced recorded activity
- Specific audits of COPD with planned review with Dr Martin Allen (National Respiratory Lead for GIRFT) to provide assurance
- Continued review of coding accuracy
- Review of deaths recorded within SHMI that occur outside hospital within 30 days of discharge to identify case mix, diagnosis and palliative care

CORPORATE OBJECTIVE:

SO2, SO3,

SUMMARY OF KEY ISSUES:

The Trust has recorded an increase in SHMI for the last 2 reporting periods with the latest value of 1.19

The SHMI denominator has reduced disproportionately to impact significantly on overall SHMI.

The Trust has a number of measures in place to deliver specific care bundles which have been shown to deliver reductions in mortality in other Trusts. These commenced in March 2020.

An update on COVID mortality and assurance is provided detailing 87 reviews undertaken since September 2020.

IMPLICATIONS OF PAPER:

IMPLICATIONS FOR THE CORPORATE RISK REGISTER OR BOARD ASSURANCE FRAMEWORK

	Y		**Risk Description: COR1015/ASM1633**
	Risk Register: Y		**Risk Score: 15/16**
COMPLIANCE and/or LEGAL REQUIREMENTS	**CQC**	**Y**	**Details: Safe**
	NHSI	**N**	**Details:**
	Other	**N**	**Details:**
REPORT DESTINATION	**Board of directors**	**Y**	**DATE: 10th June 2021**
	WORKING GROUP	**N**	**DATE:**
	COMMITTEE	**Y**	**DATE: Quality and Safety Committee 25th May 2021**

The Dudley Group
NHS Foundation Trust

MORTALITY ASSURANCE

Report to Trust Board

1 EXECUTIVE SUMMARY

The Trust has recorded an increase in SHMI for the last 2 reporting periods with the latest value of 1.19

The SHMI denominator has reduced disproportionately to impact significantly on overall SHMI. Much of this increase has occurred since the introduction of the new admissions model of recording. This has also impacted on SHMI for specific diagnosis groups.

The Trust has a number of measures in place to deliver specific care bundles which have been shown to deliver reductions in mortality in other Trusts. These commenced in March 2020

The paper is presented:

- To update the Board on current mortality statistics within the Trust.
- To provide clarity on the increase in SHMI from recent data.
- Provide assurance on COVID mortality with an update on Structured Judgement Reviews completed since September 2021.
- To update the committee on existing measures to address mortality alerts and to provide assurance on additional measures to reduce mortality and improve monitoring.

2 BACKGROUND INFORMATION

2.1 Overall Standardised Mortality indices

The Trust has noted increasing mortality indicators since the reporting period Jan to Dec 2017 when the Summary Hospital-level Mortality Indicator (SHMI) increased from 1 to 1.04 and subsequently to 1.11. Further increases were noted thereafter to a SHMI of 1.18 in October 17- Sep 18. The value fell to 1.11 in Oct 18-Sep19 but has thereafter slowly climbed.

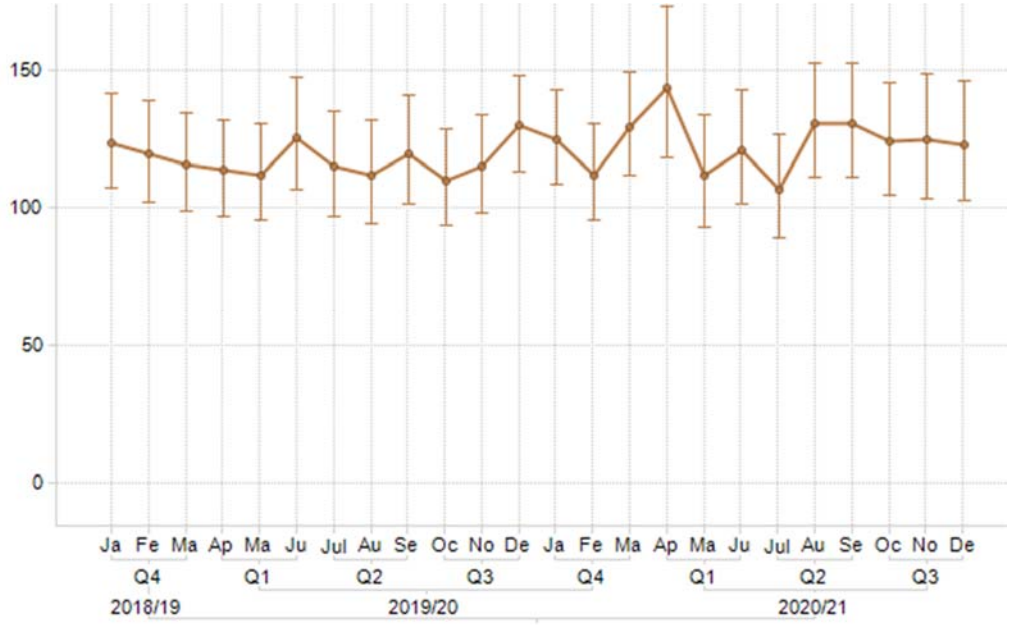
The SHMI is the ratio of the number of observed deaths to expected deaths. SHMI reflects deaths in hospitals but also includes those deaths that occur within 30 days post discharge from hospital. The expected number of deaths is derived by examining the cumulative risk of dying during an admission for all admissions excluding day cases and routine attendance. The risk is derived statistically through a case mix adjustment model, taking into account factors such as age, sex method of admission, primary diagnosis and secondary diagnoses recorded on admission. The expected number of deaths is also very much dependent on the numbers of patients.

In September 2017, Dudley Group made a change to admissions criteria after discussion with the CCG such that patients admitted and discharged on the same day (Same Day Emergency Care (SDEC)) were no longer recorded as formal admissions and were coded on an outpatient tariff. This resulted in a reduction in recorded discharges from 79,461 for the period just prior to the change to a minimum of 61,076. The figure in the 12 months prior to March 2020 was 62,685. This figure represents cases prior to the COVID pandemic.

COVID -19 activity is now excluded from SHMI data as the SHMI modelling does not allow for pandemic activity and clearly not all Trusts have been affected similarly to allow for meaningful comparisons. This alteration has further affected our recorded discharges to reduce values to 56,965. Thus recorded activity has fallen by a maximum of 22, 465. This has an impact on expected number of deaths with a reduction from 2441 to 1990. Observed numbers of deaths have remained stable over the whole period with perhaps a slight reduction on more recent values (2435 reducing to 2320).

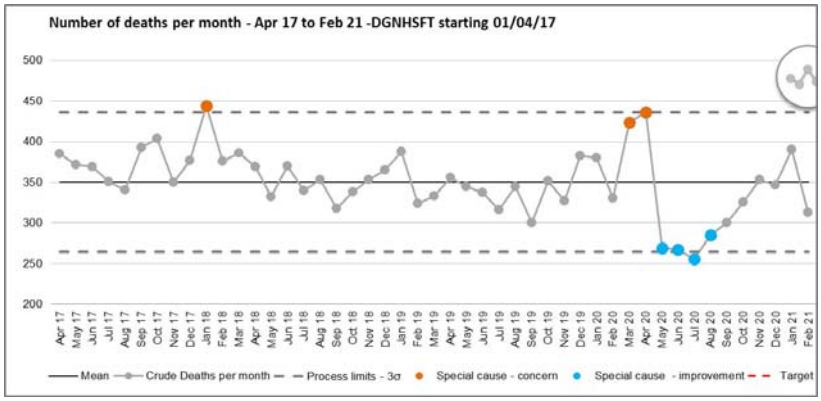
In summary, the SHMI denominator has reduced disproportionately to impact significantly on overall SHMI. Much of this increase has occurred since the introduction of the new admissions model of recording. This has also impacted on SHMI for specific diagnosis groups.

Trend of SHMI Data 2018 onwards



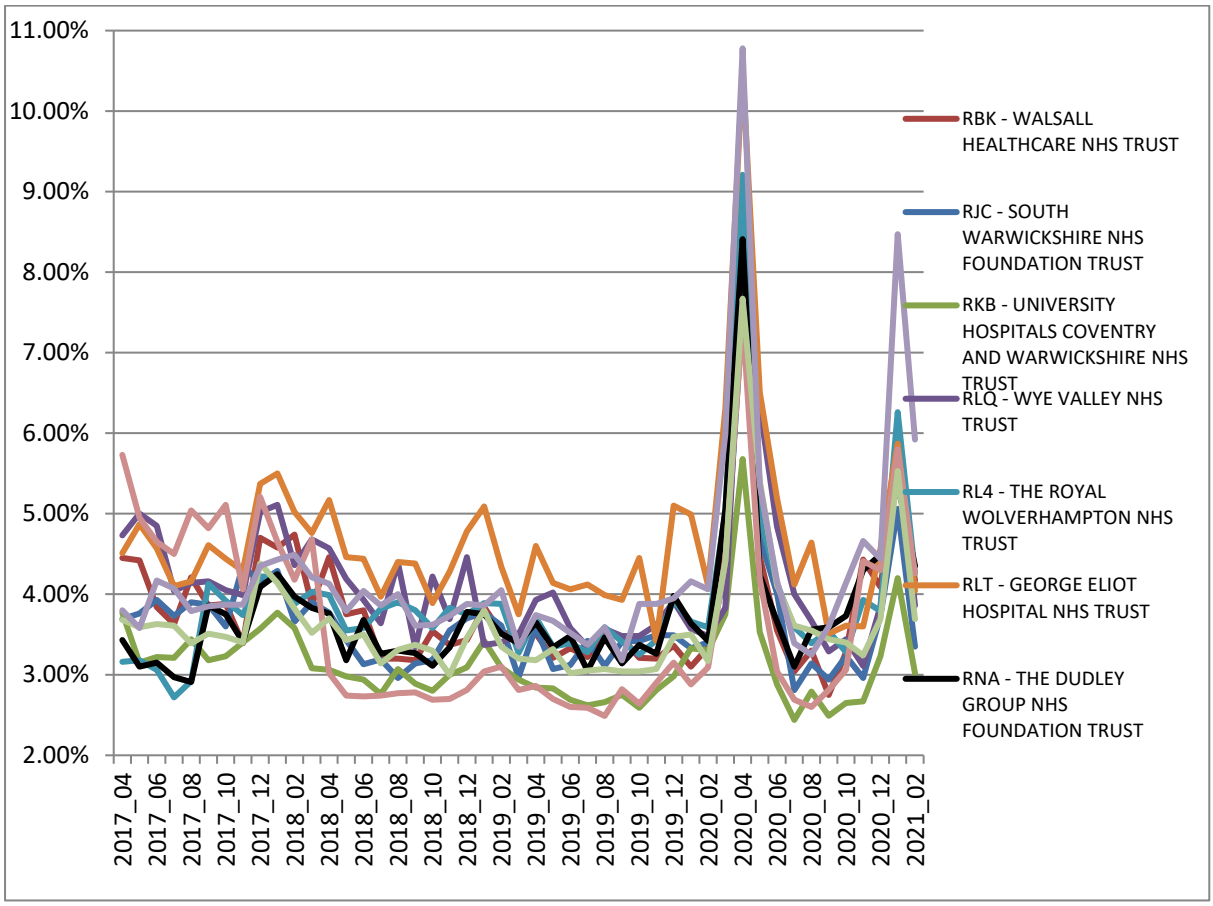
Hospital Standardised Mortality Ratio (HSMR) has similarly been affected. However, there is an additional impact as HSMR is affected by rates of palliative care coding. Whilst the Trust has a highly rated palliative care service and a well-developed ward based palliative care system, this is not reflected in levels of palliative care coding which remain lower than many Trusts.

2.2 Crude Mortality Rates



Despite the concerns of increasing SHMI, the above chart does show that the number of deaths remains within the process limits. We clearly see a spike in deaths March- April 2020 but this coincides with the onset of the COVID pandemic. The subsequent reduction is perhaps a reflection of the case mix admitted to hospital following the first wave of COVID but the activity thereafter matches previous periods.

The chart below demonstrates crude mortality rates for the Trust compared with other Trusts across the West Midlands. The data suggests that crude mortality data in Dudley is comparable to other Trusts.



2.3 Specific Diagnosis Alerts

There have been a number of previous mortality alerts for specific diagnostic coding. Alcoholic liver disease, acute bronchitis and acute unspecified renal failure had triggered alerts and formal audits were undertaken in 2019 and responses submitted to CQC.

The Trust has continued to closely monitor mortality statistics and has noted areas of higher mortality. However, NHS digital data does not show any specific higher than expected diagnostic codes for any group at this point.

Currently, we note high values based on absolute numbers for the following conditions on latest values:

- Pneumonia
- COPD
- UTI
- Acute cerebrovascular disease
- Aspiration pneumonitis

COPD and UTI currently carry high SHMI values>130. UTI has been audited before but, of note, only 49.7% of deaths occur within hospital, the remainder being deaths occurring within the 30 days post discharge. COPD is currently being audited as the recorded

mortality has increased over several recording periods. 29% of deaths occur outside hospital within 30 days post discharge. Both groups have high levels of comorbidities.

It should be noted that the Trust has a very effective respiratory service (Dudley respiratory assessment service (DRAS)). This service provides an early discharge scheme as well as admission avoidance. As a consequence of an effective respiratory admission avoidance service, this in turn reduces the denominator for SHMI in respiratory disease.

A recent audit of a sample of pneumonia cases has shown significant comorbidities in a frail group of patients often at end of life and with underlying malignancy. There was good evidence of compliance with the pneumonia admission bundle. Within the aspiration pneumonia code, 8.4% of cases had a palliative care coding (note previous comment on low frequency of overall palliative care coding).

It should also be noted that Pneumonia, UTI and aspiration pneumonia occur at a high frequency in those patients admitted from nursing homes. Further review of this data is planned.

AKI is subject to ongoing improvement work with AQUA (Advancing Quality Alliance). The AKI admission bundle has already been implemented and we have not seen recent alerts in this area.

Alcoholic liver disease (ALD) has also been subject to quality review work with AQUA including the admission bundle based on the British Society of Gastroenterology (BSG) bundle. A recent audit showed good compliance with the quality standards including treatment criteria and gastroenterology consultant review.

2.4 Rebasing SHMI Data -NHSi date and plan

The current mortality data and SHMI values appear to be distorted by the significant reduction in recorded emergency admissions since September 2017. As mentioned previously, this is as a result of non-recording of same day emergency care (SDEC) as an acute admission and instead recording this under an outpatient tariff. There is a national undertaking to increase SDEC and to standardise all Trusts using the SDEC model. This was planned for April 2020 but has been deferred until 2022.

This will result in the Trust continuing to appear as a mortality outlier and may make recommendations following mortality alerts less certain. We have previously done some work with NHSI on recalculating/ rebasing our mortality figures based on the levels of activity recorded prior to September 2017. In practice, whilst we have seen a reduction in recorded admissions, we have seen a significant increase in SDEC cases and the acute physicians undertake a large amount of early review and discharge within the Emergency Department which again is not reflected in any emergency medical admission data. We are therefore working with NHSI to further review our SDEC activity and arrange a further rebasing exercise.

2.5 COVID-19 hospital deaths

The Trust has received guidance in relation to COVID-19 hospital deaths and the requirements for review and duty of candour relating to this patient cohort. The NHS defines a COVID-19 hospital death as the death of a patient in hospital who has a positive specimen result where the swab was taken within 28 days of death **and/or** COVID-19 is cited on either Part 1 or Part 2 of the death certificate (i.e., the death resulted from a COVID-19 clinically compatible illness with no period of complete recovery between the illness and death). COVID-19 hospital deaths are could be reported to the Covid Patient Notification System (CPNS).

A Harm Review process is underway with the outcome to be reported to Trust Board. The review has commenced with scrutiny of deaths meeting the criteria above and will progress to review patients meeting this criteria who progressed to level 2 or 3 care. The review will determine if serious incidents should be declared and if duty of candour is required. The guidance states that;

Organisations should consider declaring a serious incident for a non-fatal probable and/or definite hospital onset healthcare-associated COVID-19 infection where:

• *There is reason to believe the patient(s) will suffer long-term or permanent harm (if the patient makes a full recovery, the StEIS record can be amended);*

• *There was a need to undertake lifesaving intervention such as CPR;*

• *There is reason to believe that close examination of what led up to the infection will provide significant additional insight that will help prevent future infections or help improve care; or*

• *The patient, their family/carers or members of staff are very concerned about the care and are asking for an investigation.*

We continue to undertake regular mortality case note review and a summary of COVID specific reviews (87 in total) since September 2020 is included as Appendix 1.

2.6 Review of Mortality Data from HED Data/ NHS Digital

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

We have continued to undertake regular audits to proactively respond to any apparent mortality spikes in condition specific cases.

2.7 Actions already undertaken as part of the Mortality Surveillance Process and DPG

- Care Bundle Implementation and Ongoing work with AQUA in quality improvement
    - Acute Kidney Injury

    - Alcoholic Liver Disease
    - Community Acquired Pneumonia
- Work on developing electronic support for completion of the care bundles
- Deteriorating Patient Dashboard on Sunrise continues to be developed with broader use and awareness across the Trust
- Monitoring of CXR performance within 4 hours of admission to comply with pneumonia and COPD admission guidelines
- Review of sepsis cases and timeliness of antibiotic administration
- Investment to Hospital at Night team to 10 ACPs (2 per duty)
- Implementation of Sepsis Dashboard
- Improved CXR reproting

2.8 Review of Coding Data

Reviews of Case specific coding have been undertaken to determine the following:

- accuracy of the coding
- accuracy of clinicians in determining the primary diagnosis and recording of comorbidities

A number of meetings have occurred with the acute physicians to describe the need for diagnostic detail and clear documentation to enable accurate coding. This will be a continued quality improvement process to optimise accuracy of data.

Increased use of electronic documentation within the Sunrise system has improved documentation, especially of comorbidities, primary ongoing diagnosis and GSF/ palliative care planning. Further development of the electronic record is due to be implementated which will enable clearer recording of previous comorbidities and diagnoses.

3 RISKS AND MITIGATIONS

3.1 The following associated risks are live on the Risk Register

Risk	Current Rating	Latest Update
COR1015 Compliance to the identification and action of all deteriorating patient groups	15	21.4.21 We are widening access to the deteriorating patient list on SUNRISE. There is continuing work with AQUA to audit and improve clinical pathways specifically related to pneumonia, AKI, sepsis and alcoholic liver disease.
ASM1633 Identified as outlier for COPD and Pneumonia mortality	16	New Risk - Meeting has occurred with all relevant clinicians and senior nursing staff and managers to implement the following improvement practice: - COPD care bundles - COPD admission bundle - Pneumonia bundle

		- Urgent audit of COPD admissions to review care

4. RECOMMENDATION(S)

4.1 The Board is asked to note the increase in SHMI during the last two reporting periods and known issues relating to the Trust denominator for SHMI due to the removal of a large patient cohort in 2017.

4.2 The progress against actions detailed below will be provided via Quarterly Learning from Deaths reports submitted to Quality and Safety and Trust Board.

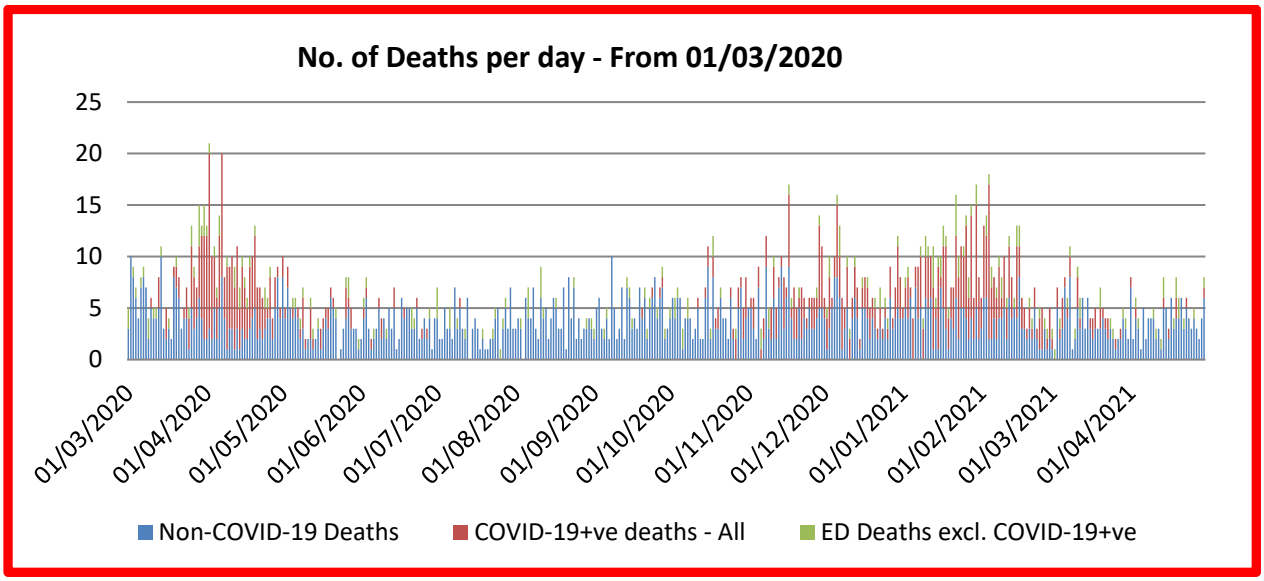
- Review of SHMI data with NHSI has been undertaken but no rebasing of figures is possible. Other external review has been requested to seek further assurance that reduced patient numbers are having an adverse effect on SHMI.
- Specific audits of COPD with planned review with Dr Martin Allen (National Respiratory Lead for GIRFT) to provide assurance
- Continued review of coding accuracy
- Review of deaths recorded within SHMI that occur outside hospital within 30 days of discharge to identify case mix, diagnosis and palliative care

Dr Philip Brammer , Deputy Medical Director

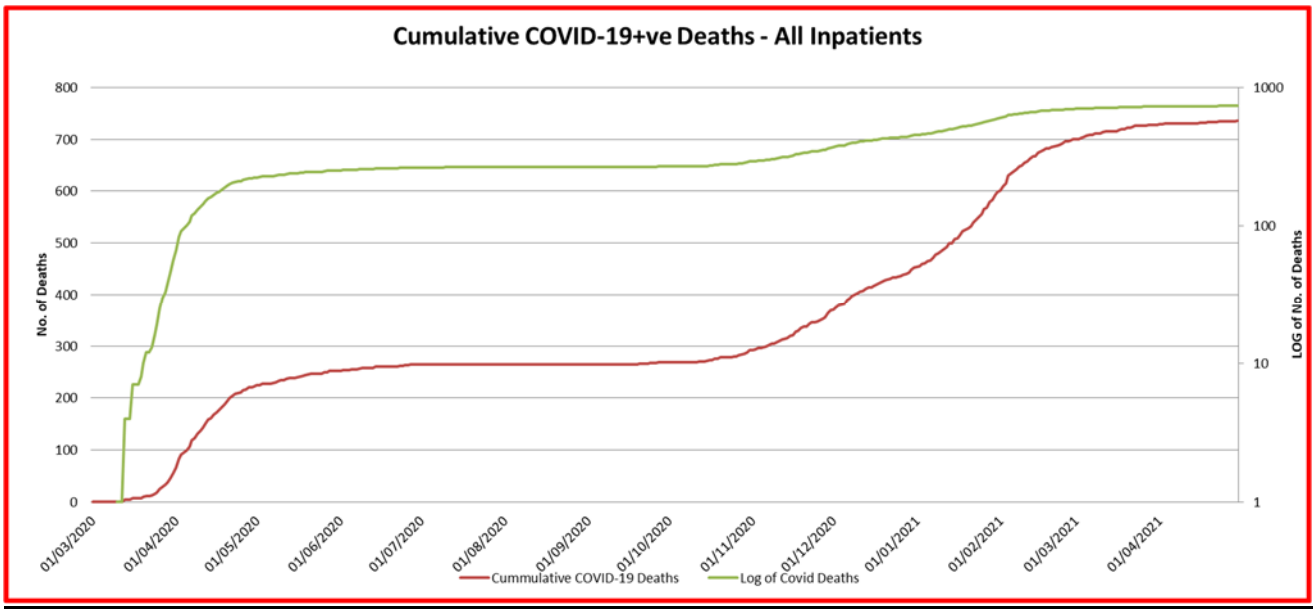
15/05/2021

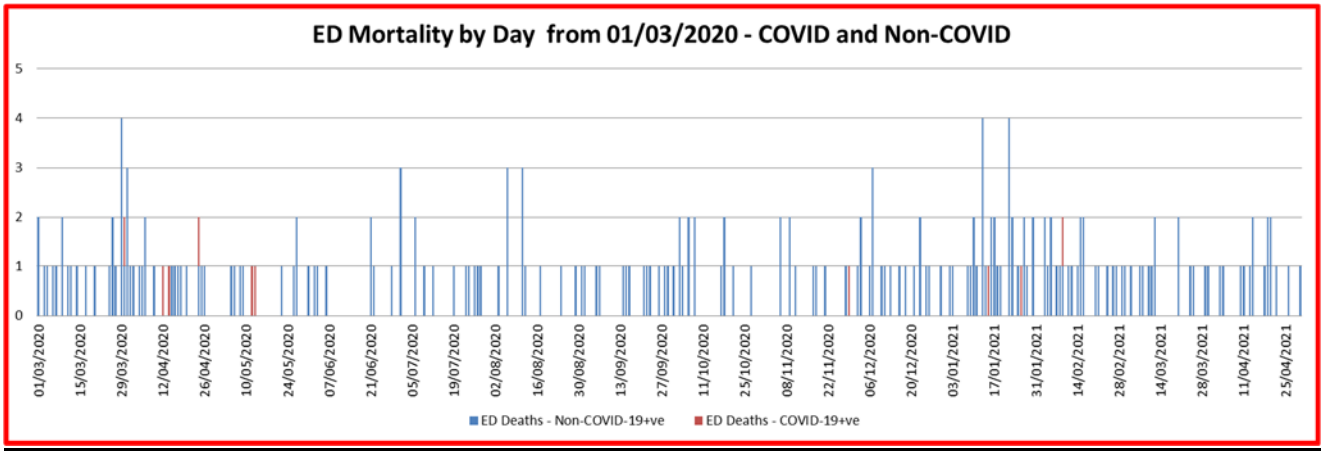
Appendix 1 : **COVID Mortality Assurance**

Since 1/3/20 a total of 757 patients have died with a positive COVID diagnosis.



COVID-10 Deaths - 2
Cumulative Inpatient Mortality since 01/03 showing logarythmic & cumulative deaths





SJR reviews

A total of 87 SJRs have been completed for COVID positive patient deaths since September 2020 (Wave 2).

64 deaths required no further action. Of the remaining deaths the following issues were identified and action has been completed.

1 death had a high level of avoidability and has been discussed at weekly meeting of harm and has been reported at Trust board via LfD paper.

Concern	Action taken
1 x clerking issues	Letter to consultant
1 x no ACP from NH	Letter to NH
1 x delay in End of Life diagnosis	Letter to consultant
1 x Inappropriate admission	Letter to WMAS
1 x COVID infection at Residential Home (Learning Disability)	Letter to CCG
1 x COVID infection at Residential Home (Learning Disability)	Letter to Public Health
1 x completed for Governance as incident investigation	Report to Governance
1 x tissue viability reassurance	Letter to Tissue Viability Team
1 x prolonged stay	Letter to consultant
1 x issues with nerve centre	Letter to Nerve Centre co-ordinators
1 x lack of use of escalation plan and proforma	Letter to consultant
12 x ?nosocomial infection	Letters to Infection Control and Prevention

The Dudley Group NHS Foundation Trust

Paper for submission to the Board of Directors on 10th June 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 3 June 2021.

IMPLICATIONS OF PAPER:

IMPLICATIONS FOR THE CORPORATE RISK REGISTER OR BOARD ASSURANCE FRAMEWORK

RISK	**N**		**Risk Description:**
	Risk Register: N		**Risk Score:**
COMPLIANCE and/or LEGAL REQUIREMENTS	**CQC**	**Y**	**Details:** Well Led
	NHSI	**Y**	**Details:** 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: 3rd June 2021

MATTERS OF CONCERN OR KEY RISKS TO ESCALATE	MAJOR ACTIONS COMMISSIONED/WORK UNDERWAY
• Continued high pay costs, especially for qualified nursing • Significant financial challenge expected in second half of 2021/22 requiring additional cost savings to be identified • Further slippage of the modular ward handover date to July	• Long term financial model to be updated and discussed at next F&P • Update on programme of work to address temporary staffing as a key driver of unsatisfactory staff costs per Weighted Activity Unit at next F&P
POSITIVE ASSURANCES TO PROVIDE	**DECISIONS MADE**
• £0.3m surplus reported for April • STP contract value for Dudley Group set at £176.6m for first half of 2020/21. High degree of confidence this will be sufficient • Continued robust operational performance and on or ahead of trajectory for restoration and recovery activity levels and delivery of mandated targets	• Approved EPRR Annual Report for 2020/21 • Recommend to Board approval of: o Revenue and capital budgets for the first half of 2020/21 o Trust wide medicines treatment room cooling and temperature monitoring business case o Going concern statement
• **Chair's comments on the effectiveness of the meeting:** Large agenda, efficient and productive supported by clear papers, good discussion around financial strategy	

Enclosure 29

The Dudley Group NHS Foundation Trust

Paper for submission to the Board of Directors, 10 June 2021

TITLE:	**Integrated Performance Report for Month 1 (April 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:

Members of the Board are asked to note the contents of the report and next steps.

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

- The number of patients waiting over 104 days on cancer pathways continues to reduce and performance against the 62 day standard has improved significantly during April.
- 52 week waits continue to reduce ahead of trajectory down to 301 from 457 at the end of March and the Trust continues to be the best performing trust locally for RTT performance and 11th nationally.
- Outpatient activity has exceeded the 85% April recovery target for both new and follow up appointments.
- The VTE assessment target of 95% has been met by both Medical and Surgical Divisions.

Key Areas of Concern

- There is a continued increase in ED attendances.
- Staffing absence and estates work continues to impact on Theatre activity and capacity, this has been highlighted to executives.

- Breast and Breast symptomatic services continue to have a capacity shortfall due to social distancing precautions; this coupled with increased referrals is impacting on performance across all cancer pathways.

- Referral rates are increasing which may impact on waiting times with continued social distancing precautions.

EAS

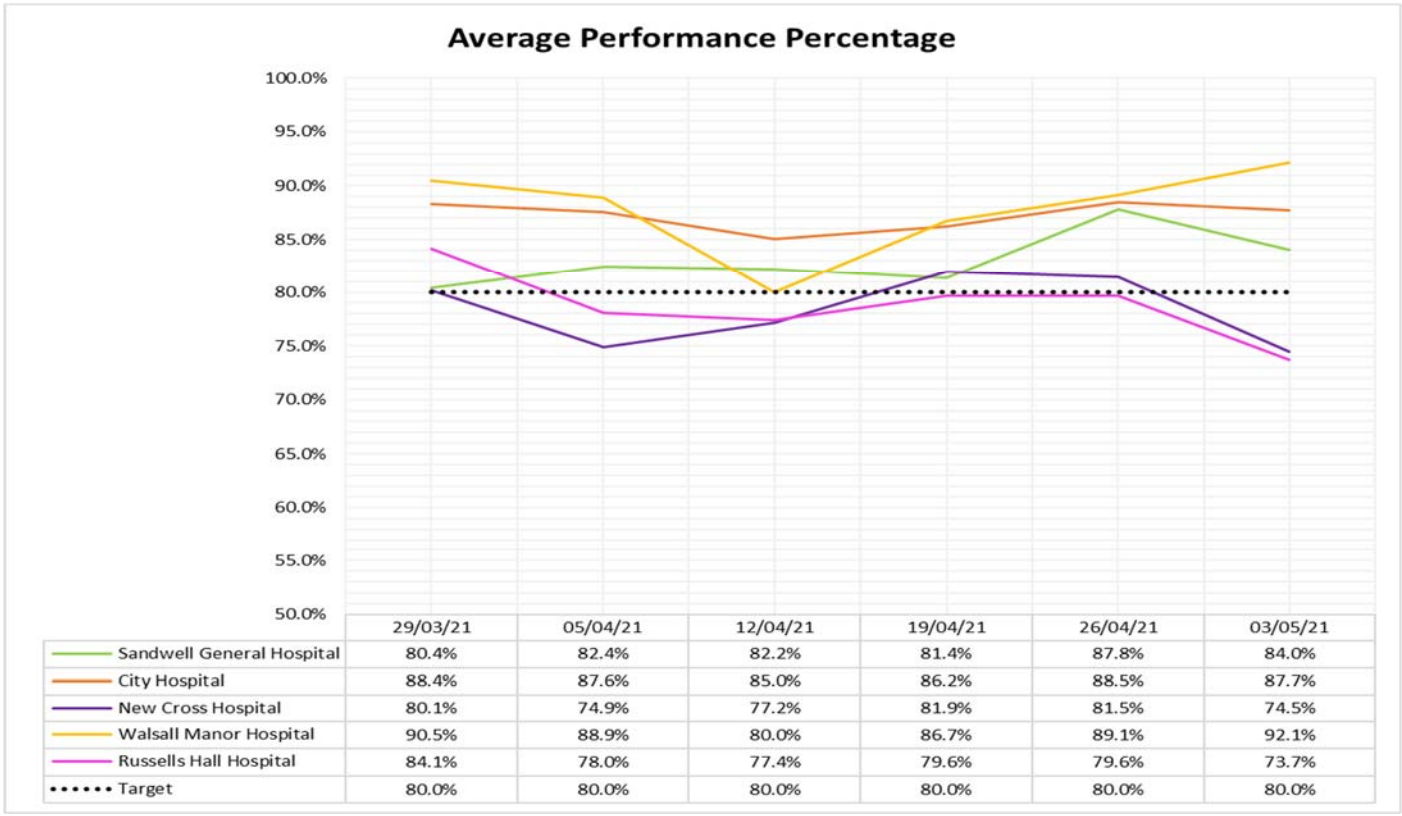
- The April position for performance remains below the expected Emergency Access Standard of 95%, the Trust has achieved a combined performance of 88.2% with the Trust being nationally ranked 7th out of 19 Midlands area Trusts.

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

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

- A continuing increase in attendances for both types.

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



	29/03/21	05/04/21	12/04/21	19/04/21	26/04/21	03/05/21
Sandwell General Hospital	80.4%	82.4%	82.2%	81.4%	87.8%	84.0%
City Hospital	88.4%	87.6%	85.0%	86.2%	88.5%	87.7%
New Cross Hospital	80.1%	74.9%	77.2%	81.9%	81.5%	74.5%
Walsall Manor Hospital	90.5%	88.9%	80.0%	86.7%	89.1%	92.1%
Russells Hall Hospital	84.1%	78.0%	77.4%	79.6%	79.6%	73.7%
Target	80.0%	80.0%	80.0%	80.0%	80.0%	80.0%

CANCER

All cancer performance figures have a 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:

- 2ww & 31 day achievement remains stable.
- 62 day achievement has improved significantly during April to 74.1% increased from 55.9% in March.

The number of patients waiting over 104 days continues to reduce down to 37 at the end of April.

Covid-19 pressures continue to affect all cancer pathways due to patient reluctance to attend, reduction of capacity due to social distancing and to the reduction of diagnostic capacity.

Current 62 day performance is in line with the recovery trajectory submitted for the 62 day pathway to NHSE in August 2020 outlining an expected position with aim of full recovery by Mar-22.

RTT

The RTT position continues to be adversely affected by Covid-19 and remains static at around 75-77%. P2 & P3 category waits are being prioritised in line with 21/22 planning guidance. DGFT continues to compare well with peers for both RTT performance remaining 11th Nationally & the best locally. The number of 52 week breaches continues to reduce ahead of trajectory with 301 at the end of April.

Elective Theatre activity continues to recommence in line with the roadmap agreed with executives.

DM01

The Trust achievement 80.4% of diagnostic tests carried out within 6 weeks during April, against the national operational standard of 99%. Based on DM01 national benchmarking for March 21 the Trust continues to be positioned in the third upper quartile.

The number waiting over 6 weeks during April increased to 1720 up from 1412 at the end of March. 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, 10 June 2021**

Performance KPIs

May 2021 Report (April 2021 Data)

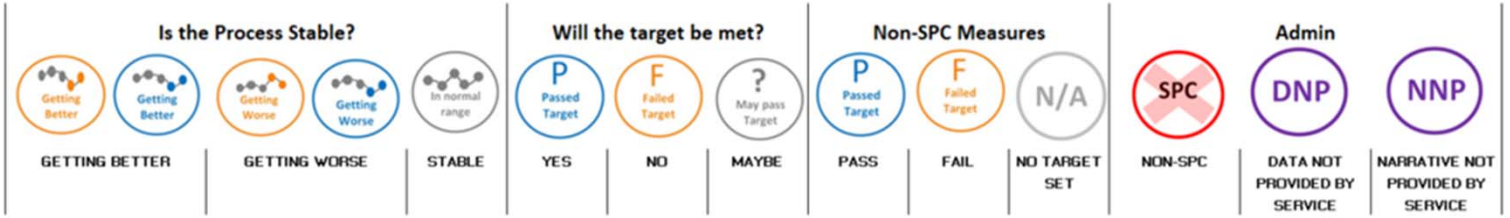
NHS
The Dudley Group
NHS Foundation Trust

Karen Kelly, Chief Operating Officer

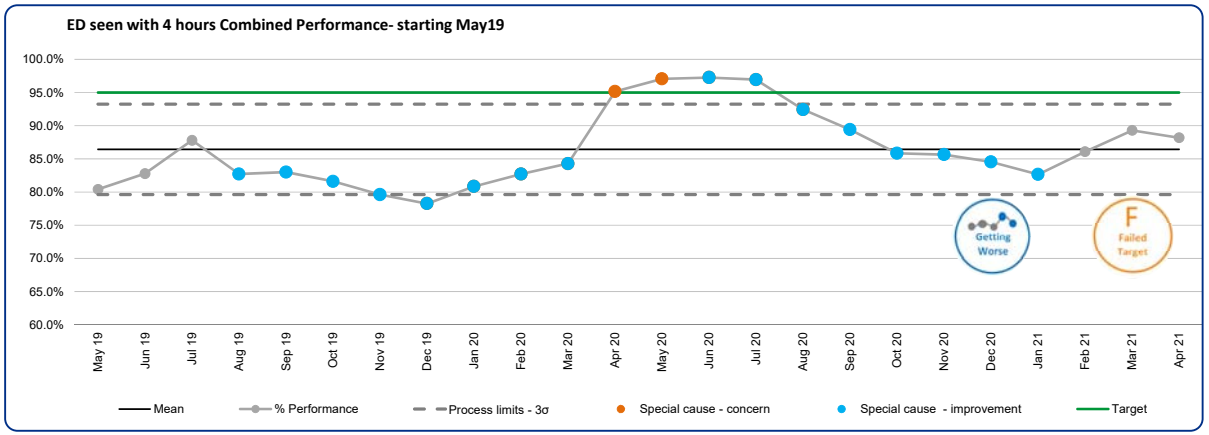



Constitutional Performance

Constitutional Standard and KPI		Target	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	Status	
Emergency Access Standard (EAS)	Combined 4hr Performance	95.0%	85.8%	85.7%	84.5%	82.7%	86.1%	89.3%	88.2%	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%	74.1%	In normal range	F Failed Target
	Cancer 31 Day -	96.0%	96.2%	92.2%	95.2%	93.3%	96.3%	96.8%	95.2%	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%	86.8%	In normal range	F Failed Target
Referral to Treatment (RTT)	RTT Incomplete	92%	82.8%	83.9%	83.1%	80.5%	77.8%	77.4%	77.0%	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%	80.4%	Getting Better	F Failed Target
VTE	% Assessed on Admission	95%	93.2%	93.8%	93.6%	92.1%	95.5%	96.4%	96.1%	In normal range	P Passed Target



ED Performance April'21



88.2%	0	7th th As at 17/05/21
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

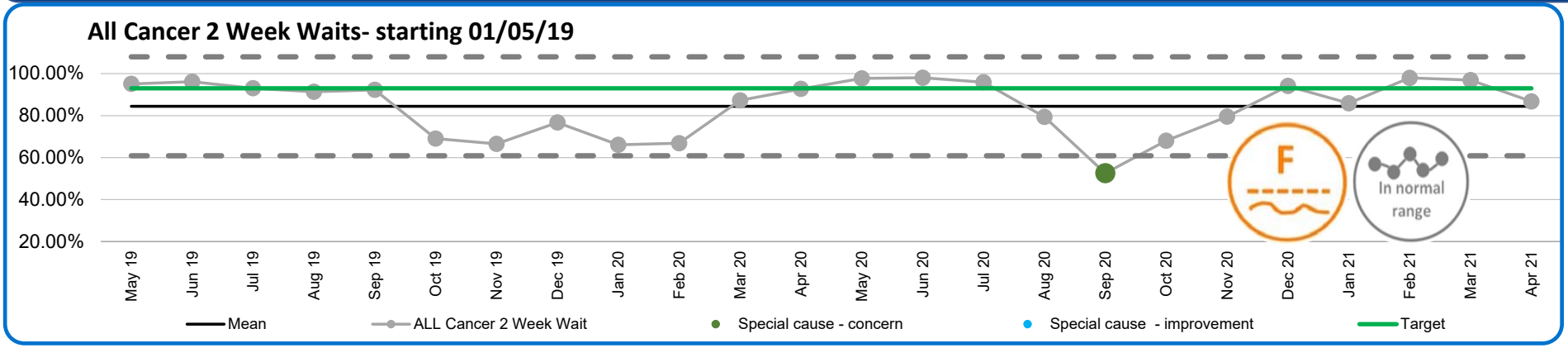
Performance

- During April'21 the Trust achieved 88.2% of ED & UCC Combined attendances being seen in 4 hrs, this represents a reduction on March which was 89.3% and remains below the target of 95% which has not been met since July 20. RHH is ranked 7th out of 19 Midlands area trusts.
- Breach analysis 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 after 16.30 o'clock, lack of space to treat patients and challenging flow to specialty wards there has been a further increase in EAS breaches during April'21 due to delayed Senior Clinical Decision by an ED Doctor or ACP/ENP.
- There has been a significant increase in attendances overall to 8309 for April'21 , both type 1 & 3 attendances have increased to 13402
- April'21 saw "0" 12 hour DTA breaches following a decision to be admitted (DTA) compared to February'21, 8, january'21, 86.
- Delays WMAS handover >60 min = 44 with an increase in WMAS conveyancing to 3530 during April'21.

Action

- HALO contract has been renewed and RHH will have 75hrs available per week at the .busiest time 12.00-24.00 hrs mainly
- 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 still has not got access to Discharge Lounge as ED Patients are Amber
- COVID19 testing at nigh continues by utilising 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 and pathology would like to handover management of POCT COVID19 to be funded within ED
- RAT will commence in ED Ambulance triage from 01/06/2021.

Cancer Performance – 2 Week Wait



86.8%

All cancer 2 week waits – target 93%

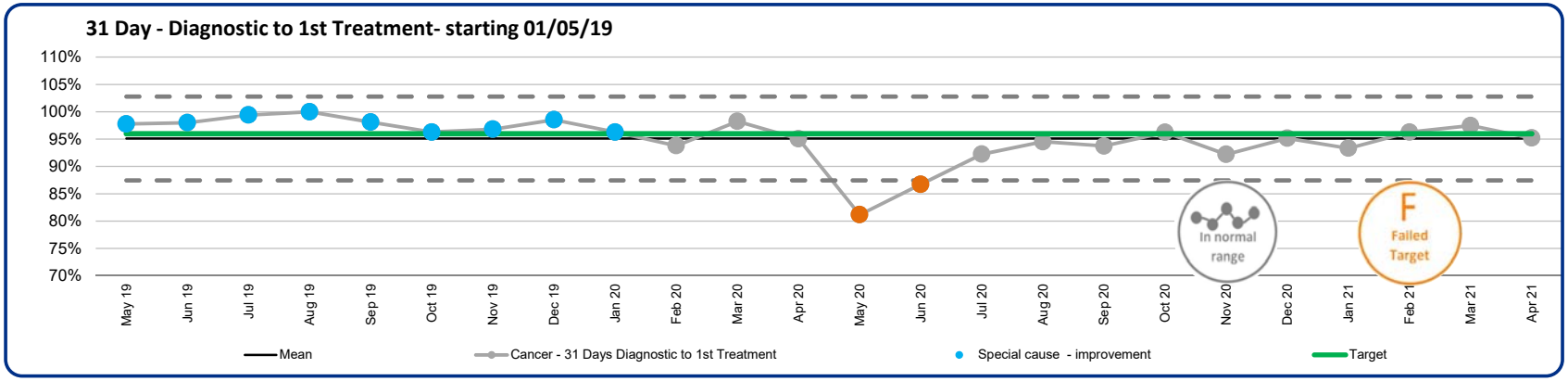
Performance

- Validation of Cancer performance figures run at a 2 month lead time. Therefore the latest month position is un-validated.
- Achievement against the 2ww target remains within normal limits but has reduced to 86.8% meaning that the target of 93% was not achieved for April.
- April performance has reduced due to an increase referrals from primary care towards the latter end of March which impacted on April capacity.
- 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 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.
- ✓ Super weekends and additional clinics continue to support capacity in Breast and Breast Symptomatic .

Cancer Performance – 31 Day



95.2%

31 day waits – target 96%

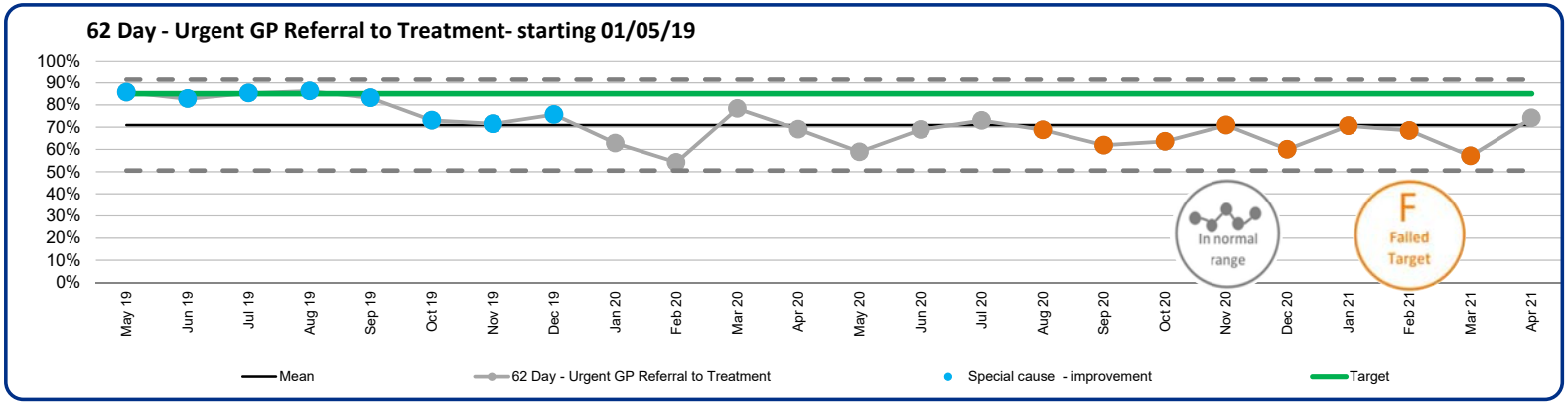
Performance

- Validation of Cancer performance figures run at a 2 month lead time. Therefore latest month position is un-validated.
- Currently Apr-21 performance is at 95.2% against a target of 96% and is within normal limits, with 7 out of 149 patients breaching the 31 day decision to treat to treatment start date.

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



74.1%

All cancer 62 day waits – target 85%

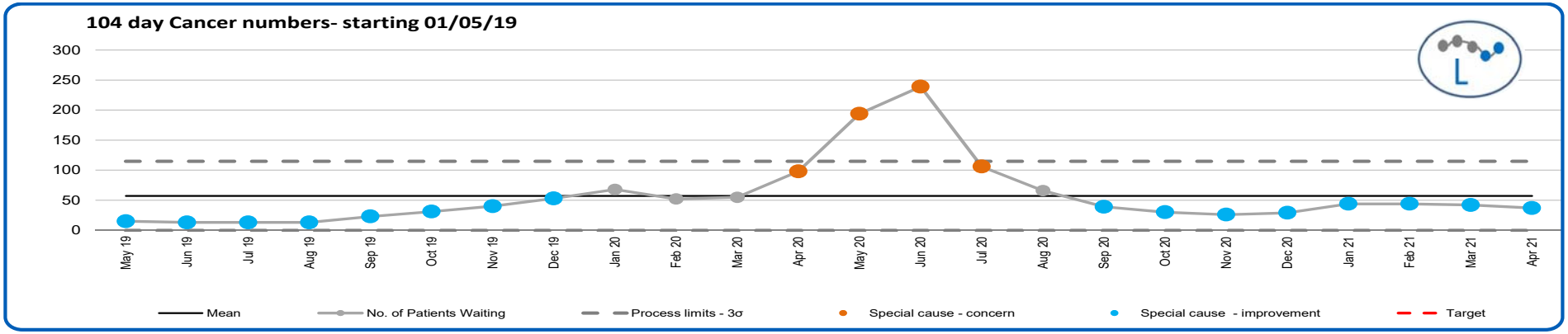
Performance

- Performance remains within normal limits but has improved during April, however the target of 85% has not been achieved target since October 19.
- 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 and this 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.
- 62 Day performance is on track with the trajectory submitted to the STP.
- In April-21we treated 5 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,performance is in line with the agreed trajectory.
- ✓ A revised assurance process with weekly escalations to Medicine, Surgery and CSS, has been re-introduced, with positive feedback received, targeting potential breaches and mitigating performance risk.

Cancer Performance – 104 Day



37

As at 30/04/2021

All 104 week waits, target zero

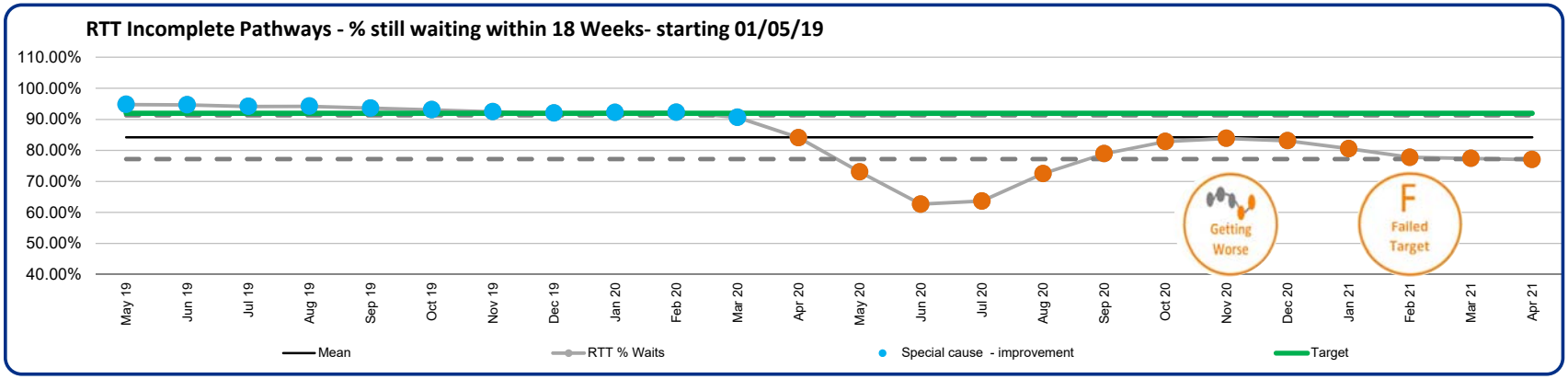
Performance

- As of 19/05/2021, the number of patients waiting 104 days stood at 30 :
  - 62 Day Traditional pathway : 12
  - 62 Day Upgrade/Screening Pathway: 18
- At the end of June 2020 the Trust had >200 patients waiting over 104 days, this number has consistently reduced.

Action

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

RTT Performance



77.0%

RTT Incomplete pathways target 92%

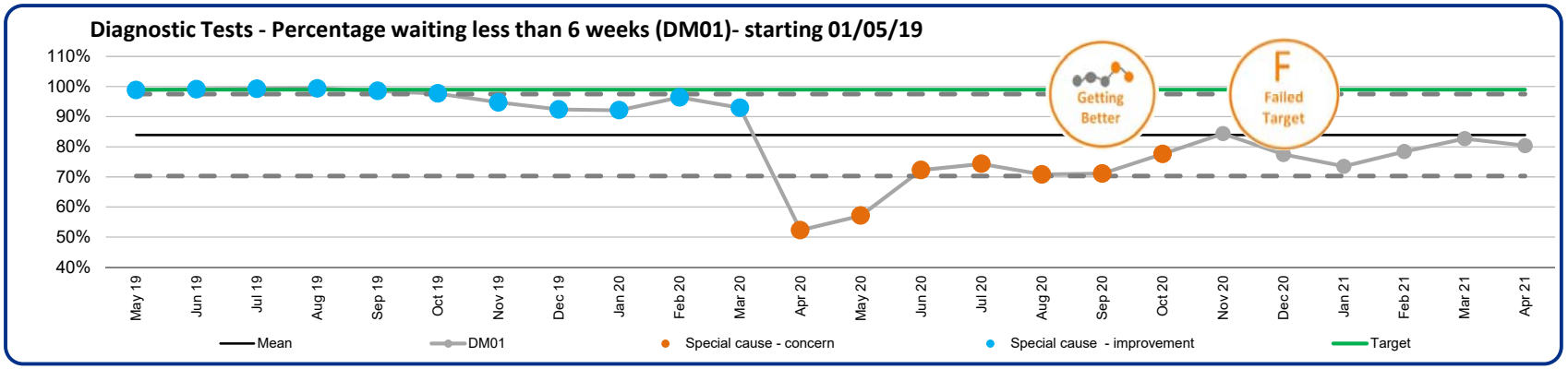
Performance

- RTT Performance has remained static around 77.5% with fluctuation between 75.5% and 77.5% in Month.
- February national data – 77.8% saw the Trust perform 11th best nationally and best regionally.
- 52 week breaches have reduced in April to 301 down from 457 in March. We remain on Trajectory to continue to reduce 52 week breaches in May with view to clear them by the end of June.
- Performance is predicated on reduced elective activity.
- Referrals have increased in some specialities such as plastics & Gynae & ENT
- Workforce shortages mean capacity is reduced

Action

- ✓ Increased theatre activity continuing as per roadmap presented at Execs.
- ✓ Additional Theatre activity is online from w.c 19th April
- ✓ Additional capacity put into BCWB R+R bid which if approved would include Vanguard Theatre.
- ✓ Continued validation of P2/P3 categories, P2/P3 categories are being Prioritised over long waiters as per planning guidance.
- ✓ Increased additional clinics being organised
- ✓ Strengthen the nursing workforce to support capacity
- ✓ Utilise agency doctors where possible
- ✓ Gastroenterology templates reduced to align with clinical guidelines

DM01 Performance



80.4%

DM01 combining 15 modalities - target 99%

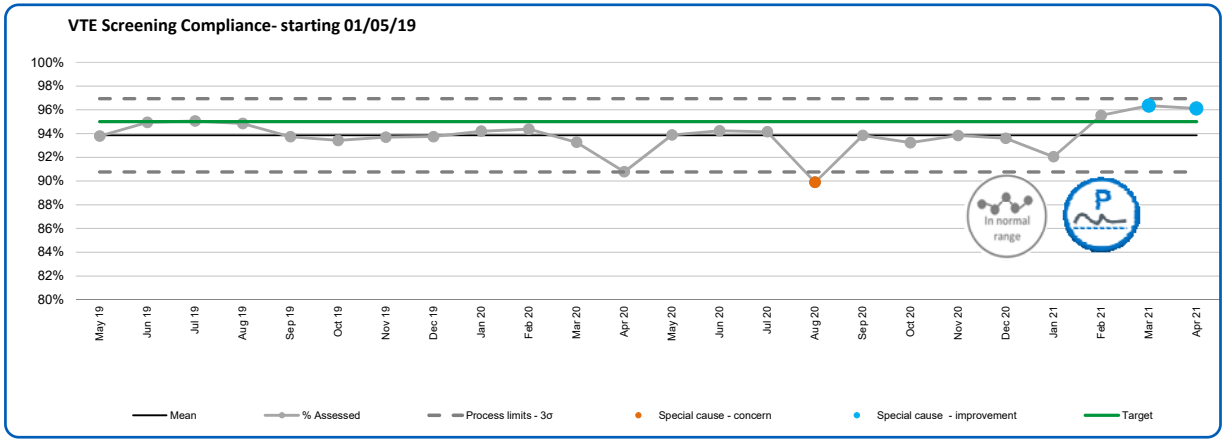
Performance

- In April 2021 the Trust achieved 80.4% of diagnostic tests carried out within 6 weeks against the national operational standard of 99%.
- Based on DM01 national benchmarking for March 2021 the Trust is positioned in the third upper quartile.
- The number of patients waiting over 6 weeks increased in April 2021 from 1412 to 1720
- Non-obstetric ultrasound (NOU), Cardiac CT (CTCA) and Colonoscopy contributed to low performance in April.
- There is increased demand for CT & for US in particular with the lifting of Covid restrictions
- There is a shortage of radiologists to perform some tests such as Head & Neck scans which s limiting capacity.
- Overall DM01 recovery is forecast for March 2022.

Action

- ✓ **CT:** A Mobile CT scanner is on site between 24th and 30th April and will continue during Spring/Summer to support and maintain cancer treatment and reduce the CT waiting list. A Plan is in development to reduce the current Cardiac CT backlog. Additional WLI's will be held on weekend mornings and will commence in May. There is potential for additional capacity at Nuffield Wolverhampton and Spire Little Aston from June onwards.
- ✓ **Non-obstetric ultrasound**: Activity is outsourced on weekends, additional WLI's are being undertaken and Ramsay Healthcare are providing additional capacity from 1st April 2021. 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 for those whose surveillance interval could be extended.

VTE Performance



96.1%	96.6%	95.7%
Trust overall Position	**Medicine & IC**	**Surgery, W & C**

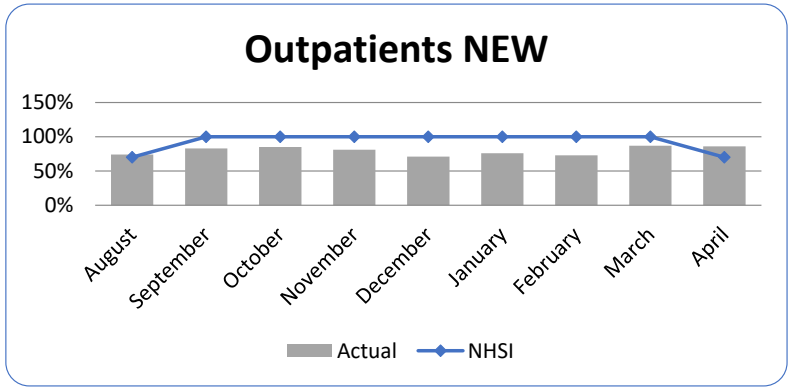
Performance

- VTE performance for April is un-validated and therefore subject to change.
- VTE assessment overall has met the target of 95% for the 3rd Month running, and the target has been met by both Divisions during April.
- Performance is expected to be maintained if not improved further for the end of May.

Action

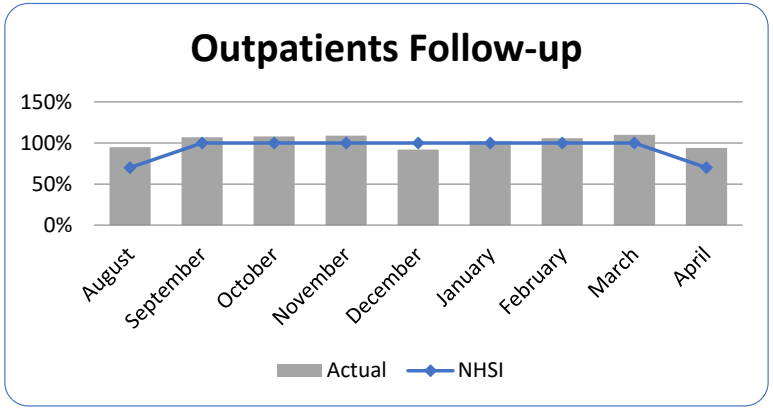
- There has been a lot of good work with our teams in Surgery and this is shown in the steady improvement in the level of VTE assessment as evident in the monthly report.
- Continued improvement is being seen within surgery, compliance is monitored and is shared at regular 'town hall' meetings.

Recovery and Restoration - Outpatients



April

86%



April

94%

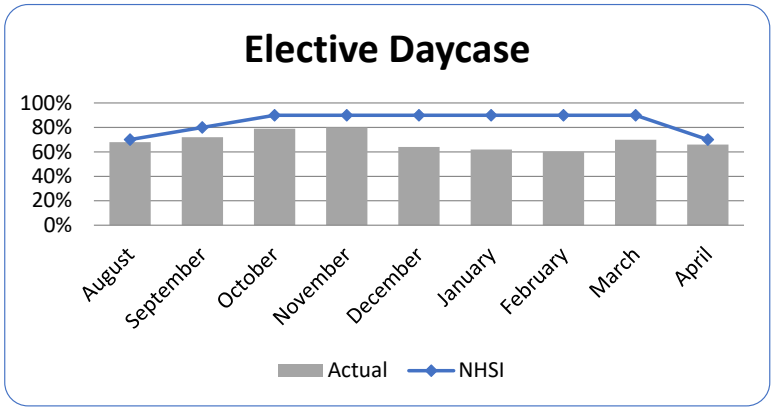
Performance

- Both new and follow up outpatient activity has met the April target of 70% for recovery and has also exceeded the 85% target, attracting additional funding above tariff from Elective recovery funding (ERF).
- Virtual outpatient activity is being maintained at 33% overall for April with 1st virtual appointments at 30% and Follow up at 35%.
- Elective recovery funding achieved is being calculated and will be provided in future narrative in line with financial reporting schedules.

Action

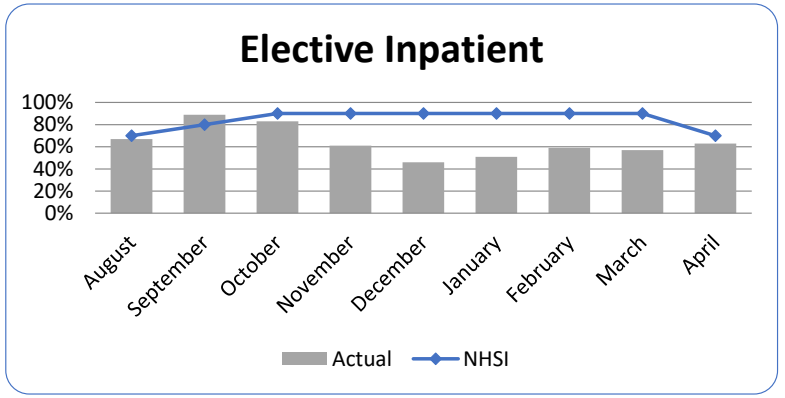
- The outpatient steering group continue to monitor delivery of virtual appointments.
- The Maintenance of social distancing in OP department is being reviewed by IPC.
- OP templates have been reviewed by the OP triumvirate and fed back into the OP Steering Group.
- Overdue follow ups are being validated and monitored through the OP steering group.
- Patient initiated Follow up (PIFU) specialties have gone live in April and further specialities will go live in May 2021 with the opportunity to convert overdue follow up direct to PIFU.

Recovery and Restoration - Electives



April

66%



October

63%

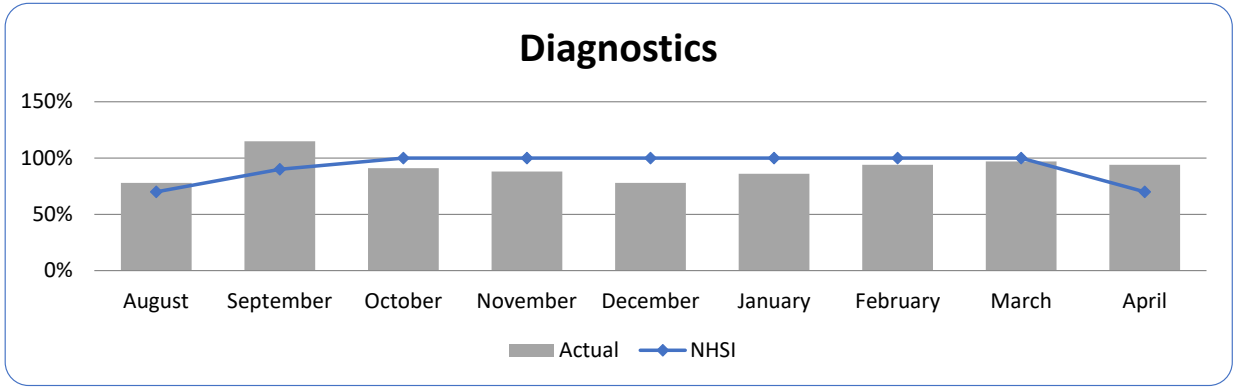
Performance

- The 70% recovery target for April has not been met for daycase or inpatient elective activity.
- Elective inpatient activity has increased during April.
- Extensive estates work happening to IR, Obstetrics and Corbett Theatre reducing ability to further release further theatre capacity.
- Staffing shortages are also impacting theatre activity as highlighted in paper to execs.
- Staff are still supporting additional critical care areas, Area A, B and C are still operational.

Action

- Recruitment and retention strategy under development to fill staffing gaps in theatre.
- Staff to be encouraged to take annual leave to support wellbeing as per planning guidance and operational plan.
- Further theatres will be online as per roadmap presented to Execs on w.c 19th April with a plan for all theatres to be operational from 1st September.
- Use of new bank rates for staffing weekend and evening theatres.
- B1 is being used as green elective zone as required by planning guidance.
- Discussions ongoing with estates to complete Theatre work early

Recovery and Restoration - Diagnostics



April

94%

Performance

- Diagnostics achievement of pre COVID activity was 94% during April 2021 above the local & national target of 70%.
- Pressure on inpatient services has caused reduced outpatient capacity and longer waits. Turnaround times for Rapid Assessment and urgent imaging were maintained as far as possible.
- Appointment slots are reduced due to social distancing and IPC measures.
- Extra CT capacity has been made available to support acute services. Cardiac CT wait times have increased along with an increase in demand for inpatient non-obstetric ultrasound tests and MRI inpatient scans.
- Endoscopy was impacted due to COVID demand. Inpatient capacity during afternoon sessions extended to a whole day session to accommodate a dedicated 'blue' room.
- Endoscopy downtime between procedures reduced but adherence to infection control measures have been maintained.

Action

- ✓ There is a Mobile CT scanner on site between 24th and 30th April 2021 and this will continue during Spring/Summer to support and maintain cancer treatment and reduce the CT waiting list. A Plan is being developed to reduce the current Cardiac CT backlog.
- ✓ Additional CT WLI's will be commenced in May and there is potential for additional capacity at Nuffield Wolverhampton and Spire Little Aston from June onwards
- ✓ Recruitment of bank sonographers is almost complete. Ramsay Healthcare are providing additional capacity for US.
- ✓ The '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.
- ✓ Diagnostic recovery plans include utilisation of the independent sector, additional capacity through internal WLI (extended evenings and weekends) and in sourcing activity.

Enclosure 30

Paper for submission to the Board on 10th June 2021

TITLE:	**Private Workforce and Staff Engagement Committee Report**		
AUTHOR:	**James Fleet** **Chief People Officer**	**PRESENTER**	**Julian Atkins** **NED & Chair WSEC**

CLINICAL STRATEGIC AIMS		
Develop integrated care provided locally to enable people to stay at home or be treated as close to home as possible.	*Strengthen hospital-based care to ensure high quality hospital services provided in the most effective and efficient way.*	*Provide specialist services to patients from the Black Country and further afield.*
SO1: Deliver a great patient experience **SO4: Be the place people choose to work**		

SUMMARY OF KEY ISSUES:

The Workforce and Staff Engagement Committee convened a Deep-Dive session, focusing on Organisational Development and Leadership, on 25th May.

Objectives for the session were:

- To undertake an objective and critical review of the pre-COVID OD/development offer and service delivery model
- Identify and highlight gaps, risks, and concerns
- Present and discuss:
  - Recent improvements to the service offer
  - OD approach to **Creating a Compassionate Culture**
  - Emergent model for **Improving and Developing Teams**
  - Confirm next steps and regular reporting to WSEC on delivery

Overview - Key Actions, Decisions and Updates:

- The Deep-Dive session was a well-attended session, with strong engagement and participation from attendees.
- I was encouraged by the calibre of the discussions, the focus and evident commitment by attendees that development, especially around the welcome to the trust and enabling growth of talent and succession, is a high priority for the Trust. A series of well-articulated principles for strategic development were presented through summary reports and a presentation on the bespoke team offer was delivered.
- The format for the deep dive reflected the approach taken for previous topics. This includes a review of data/metrics to provide a foundation for discussion and critical review of issues and solutions. In relation to development data, the analysis provided a partial position for this review as the capture of data has not been robust before 2021. This means that not all training activity is accessible within ESR (the workforce data system) and some training records are held only in local excel files. This limits the KPI and metrics able to be reported on in relation to training and development. The information provided gave a summary position of an increase in development activity at pace, until 2020 when cessation of activity due to the pandemic impacted progress made. Whilst recognising that the gap in data and effective metrics means that both participation and impact of training are difficult to measure, that activity is now underway to remedy this position for training in place – and planned for future delivery.

Identifying appropriate metrics for regular reporting to Committee was a key output of the discussion.

- This baseline position gave a foundation for an enthusiastic discussion amongst members on the key areas for development moving forward to embed a culture of learning and development and priorities for the year ahead. This included a commitment to continuing the successful Developing Leader's and Manager's Essentials programmes. Members also identified several themes for further work including a development offer for support workers, systems leadership skills and competencies and multidisciplinary learning opportunities to strengthen the leadership conversations between non-clinical managers and clinical leaders in medical, nursing and AHP staff. There was a keenness amongst members to ensure that the management development programmes were reaching all the leaders and managers, in areas where leadership and management has been identified as an improvement goal. The Head of OD explained that although initially the programmes had been advertised and open to all nominees, the approach moving forward is to ensure effective targeting across the trust to prioritise: those teams/services with lower take-up; staff who declare a disability or are from a BAME background; areas already identified for support as a result of staff survey responses; linking with HR and other teams to use informal and formal feedback to identify those staff who may benefit from attending alongside early adopters.
- A summary report was presented which outlined a series of engagement workshops undertaken with some of the Executive Directors during 2020 to provide an outline of priorities to develop a Leadership Strategy for the trust. The committee was grateful for the commitment of the Chief Nurse, Medical Director, Chief Operating Officer and HR Director in giving their time to support this work. As a result, several areas of work for future development were identified which included:
    - Induction, our welcome to the trust and developing learning and improvement mind-set at the start to ensure people choose and stay at Dudley
    - Talent and succession plans and programmes to ensure we provide opportunities for people to grow, develop and thrive
    - Support to improve workplace behaviours linked to bullying and harassment and civility and respect as these have been cultural issues for several years
    - High performing teams
- This provided a foundation for discussions around future programmes and activities for the organisational development team, and the founding principles for an outline OD and Leadership Strategy. There were four key work activities highlighted with a summary of planned work, alongside the invitation for the Committee to comment and influence the development of the strategy principles.
- Induction – Welcome to the Trust was the first area for discussion. An outline plan for the welcome to the trust presented a pathway for new staff from recruitment through to their first year in post. Members of the committee shared their personal experiences of their own induction and identified several important elements to include going forward. This was focussed around: supporting new line managers to be up and running in their new role with the tools to lead their team and service; ensuring that we help people new to the NHS navigate a new system and language from the start; getting our housekeeping elements ready for day 1 including ID badges which are central to belonging; having a flexible but consistent offer for different staff needs; having regular touchpoints and buddies to support alongside line managers.
- A DRAFT programme for Development activities for 2021/22 was presented which outlined additional programmes and learning activities planned for the year. This includes expanding

current programmes (Manager's Essentials and Developing Leaders) and additional workshops, learning opportunities and targeted development work. Committee members were pleased to see an expanded offer, especially in meeting gaps already identified in opportunities for support workers, newly qualified staff, emerging leaders, and clinical leaders. There was a keenness to include skills around system leadership – to support our staff to develop their connections and networks outside the organisation. In addition, identifying that team working and communication skill development remains a core priority. The programme will be developed into a published prospectus by July 2021 to support personal development plans in Appraisals.

- The item on succession planning and talent generated a detailed discussion around ambition, opportunities and how the organisation should structure a programme. There was recognition that this is a huge piece of development work to embed and that this should form a topic for a future deep dive later in the year. In the meantime, a pragmatic approach was agreed which would allow for:
  - Developing elements of a formal programme over time to support a strategic approach to talent management and succession planning which includes identifying talent-maps for senior posts in the short term, moving towards all leadership posts over the next 12 months
  - Creating an internal development scheme for talent which enables staff to experience growth opportunities/projects across the whole organisations (rather than within a specific discipline or division)
  - Focussing on the short term (next 3 months) on identifying talent through known networks and setting up initial talent escalators with those individuals around personal development and growth plans, mentors, and future career conversations
  - Implementing talent and potential conversations
  - Developing leadership competencies for generic and specific roles
  - Identifying barriers to progression in response to concerns about readiness and confidence to progress so that talented leaders are enabled to move safely and with support to do so
- There was a high level of enthusiasm and excitement about the potential in this work and working in a multidisciplinary way. Rachel Andrew, Karen Brogan Helen Bromage and Karen Lewis reported that they are commencing conversations about this as part of the recruitment and retention action plans to escalate progress quickly.
- There was a commitment to continue to provide assurance on this item and to undertake a review of progress on initial actions and a detailed proposal for a trust Talent and Assessment Board as a subject for a further Deep Dive before the end of 2021.
- The final element presented was a summary of planned activity during 2021 to review the purpose, structure and supporting framework for the delivery of appraisal conversations. There was a discussion around the importance of line manager conversations with their team members, identifying development needs and career conversations. This linked to expectations around appraisals meeting several expectations – and a review of focus for 2022. This will include engagement with staff and ensuring that although medical staff have a separate revalidation expectation, that there is an opportunity to link career, wellbeing, and strategy conversations to their appraisals also.
- In summary, the OD and Leadership team described several programmes and development activities already underway. They gave an update on the investment posts approved during 2020 with 3 additional trainers now in post and developing and delivering new programmes. The engagement activity with executives had identified key priorities and the discussion at the committee has provided a secure framework for a transformational Organisational Development

and Leadership Strategy, as well as delivery of an improved scale and scope of activity across the portfolio. The strategy will return for ratification in August.

- The final item was a presentation on bespoke development – focussed on how the HR, Improvement and OD teams are collaborating to improve and develop operational teams across the Trust. Peter Lowe, Karen Brogan and Rachel Andrew described how they have established a business partner model to deliver this work, identifying a team member in each of their teams to form a team working triumvirate for each division. They described that they had recognised that HR, OD, and Improvement teams were working on bespoke responses in isolation or with limited collaboration because people would request help from who they knew rather than an understanding of what they can help with. The support required often bridges across more than one function. e.g. structural and people challenges, systems and processes causing frustration. Karen, Peter and Rachel described the initial diagnostic to assess the understanding of the problem and to identify potential metrics and agreed to implement triumvirate teams across HR, OD and Improvement for this work – allocating teams to each division to enable consistency in the approach, individuals and teams to develop relationships and understanding of their division, which enables sustained changes to be made and embedded.

- These triumvirates are now working within each division to map areas of concern, any existing requests for help and combining informal and formal intelligence to identify those areas that would benefit from support for improvement. The team are applying a standard risk assessment to enable prioritising of teams which pose the greatest risk. This will enable resources to be allocated on a quantifiable basis and will consider workforce measures alongside service performance. The next steps are the design and delivery of activities to support teams which include small team work to large service support, targeted development work with groups or full teams, improvement workshops, reviews of structures/job roles

- This is an area already highlighted by peers as innovative practice and has the potential to support resolution for areas of concern to improve more quickly by focussing a shared improvement and development approach and sustained, embedded changes. There will be regular reporting through to the Workforce Committee on interventions and progress and there are strong links to the Staff Survey engagement and improvement activity within the triumvirates.

The following documents were received for information/assurance:

- Workforce KPI Report
- Resus Plan which provided significant assurance and an amended training approach to support compliance against target. The quality of the report and approach was commended by the committee.
- Board Assurance Framework Report
- Corporate & Significant Risk Report

The next Workforce and Staff Engagement Committee Deep-dive session is planned for 27th July and will focus on Dudley Improvement Practice.

IMPLICATIONS OF PAPER:			
RISK	**Y**		**Risk Description: corporate risk register engagement and retention of staff**
	Risk Register: Y		**Risk Score:**
COMPLIANCE	**CQC**	**Y**	**Details: Caring, Well Led**

and/or LEGAL REQUIREMENTS	**NHSI**	**Y**	**Details:**
	Other	**N**	**Details:**

ACTION REQUIRED OF COMMITTEE :

Decision	Approval	Discussion	Other
	√	√	

RECOMMENDATIONS FOR COMMITTEE:

Note and support the key developments, actions and decisions.

Enclosure 31

The Dudley Group NHS Foundation Trust

Paper for submission to Board on 10th June 2021

TITLE:	**Workforce KPIs**		
AUTHOR:	**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	x	

RECOMMENDATIONS

For the Committee 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 4.64% in April, a slight reduction from 4.98% in March. CSS continues to be the highest at 5.4%, although this is a reduction of from 6.47% in March. The highest absence category is Anxiety/Stress/Depression. Phlebotomy is the department with the highest incidence of sickness in April, there is a reduction in cases by 3 in comparison to March
- DGFT excluding vax rollout: Bank = 302 WTE, and Agency = 182 WTE. COVID vax programme Bank= 320 WTE, £1,677K, AGENCY = £425k (WTE not available)
- Contracted WTE staff has increased to 4,932 WTE in April, up 20 from March. The Budgeted WTE for April has increased to 5,666 (up 252 WTE from March). The increase is largely due to the modular build including extra wards and treatment areas. Staff are now being recruited into these posts. The effect has been to increase the vacancy factor from 9% in March to 13% in April.
- Overall staff turnover is at 7.8%. Excluding Students and Medics, AHPs are highest at 11.6%, Nursing &Midwifery Registered at 4.5%, and Healthcare Scientists lowest at 2.1%.
- Mandatory Training: overall compliance increased in April to 84.12%, up from 82.54% in March.
- It should be noted there have been two separate periods of time since February 2020 where mandatory training has been paused. Surgery is the lowest division at 82.35%. The priority areas continue to be RESUS and SAFEGUARDING. The most challenged service is Medical Staff (Orthodontics).
- HR caseload is at 40, with 'Disciplinary' at 40% the highest category, followed by 'Grievance' at 35%. The highest Division is Medicine and Integrated Care with 17 open cases. The average length of cases is 117 working days, 160 for disciplinary and 90 days for grievance cases. It should be noted that between March 2020 and July 2020 and again between October 2020 and February

2021 Employee Relations cases were paused where appropriate to support the response to the pandemic. BAME representation is at 40%, with 16 open cases. Within disciplinary cases BAE representation is 18.75% and 57.14% within grievance.

- Staff Health & Wellbeing referrals for May is at 63, The largest category is 'Ability to perform duties' at 57% and the average days from referral to appointment was 15 days in May, which is at the target of 15 days

IMPLICATIONS FOR THE CORPORATE RISK REGISTER OR BOARD ASSURANCE FRAMEWORK

RISK	**N**		**Risk Description:**
	Risk Register: Y/N		**Risk Score:**
COMPLIANCE and/or LEGAL REQUIREMENTS	**CQC**	**N**	**Details:**
	NHSI	**N**	**Details:**
	Other	**Y**	**Details:** *in accordance with Trust policies and procedures developed and maintained to comply with prevailing legislation as required.*
REPORT DESTINATION	**EXECUTIVE DIRECTORS**	**Y/N**	**DATE:**
	WORKING GROUP	**Y/N**	**DATE:**
	COMMITTEE	**Y/N**	**DATE:**

NHS
The Dudley Group
NHS Foundation Trust

Workforce KPI Report

10th June 2021

James Fleet, Executive Chief People Officer




Summary 1/3

	Performance	*Action*
Sickness & Absence	o Overall Sickness/Absence was 4.64% in April, a slight reduction from 4.98% in March. CSS continues to be the highest at 5.4%, although this is a reduction from 6.47% in March. o Daily absence tracking shows C19 absence tracking is now weekly, and is currently at 0.2% (12 staff). o The highest absence category is Anxiety/Stress/Depression. o Phlebotomy is the department with the highest incidence of sickness in April, there is a reduction in cases by 3 in comparison to March	✓ 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 DGFT excluding vax rollout: Bank = 302 WTE, and Agency 182 WTE o COVID vax programme Bank= 320 WTE, £1,677K, AGENCY = (data quality, no number value available) WTE £425k	✓ 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 4,932 WTE in April, up 20 from March. o The Budgeted WTE for April has increased to 5,666 (up 252 WTE from March). The increase is largely due to the modular build including extra wards and treatment areas. Staff are now being recruited into these posts. o The effect has been to increase the vacancy factor from 9% in March to 13% in April. o Overall staff turnover is at 7.8%. Excluding Students and Medics, AHPs are highest at 11.6%, Nursing &Midwifery Registered at 4.5%, and Healthcare Scientists lowest at 2.1%.	✓ 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 April to 84.12%, up from 82.54% in March. o It should be noted there have been two separate periods of time since February 2020 where mandatory training has been paused. o Surgery is the lowest division at 82.35% o The priority areas continue to be RESUS and SAFEGUARDING. o The most challenged services is Medical Staff (Orthodontics).	✓ A detailed action plan to achieve compliance for RESUS has been developed and presented to WSEC in May by the Deputy Chief Nurse. Divisional updates will be provided to WSEC each month.
Equality, Diversity & Inclusion	o BAME staff Trust representation is at 19.4%. o Disabled staff Trust representation is at 3.7%. o LGBTQ+ staff representation is 1.7%	✓ The Trust continues to develop and embed 3 existing Staff Inclusion Networks: BAME, LGBTQ+, and Disability. A Women's Network is being launched in June. The BAME, and LGBTQ+ Networks have a growing membership, with regular meetings and events. ✓ Each of these networks has 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.

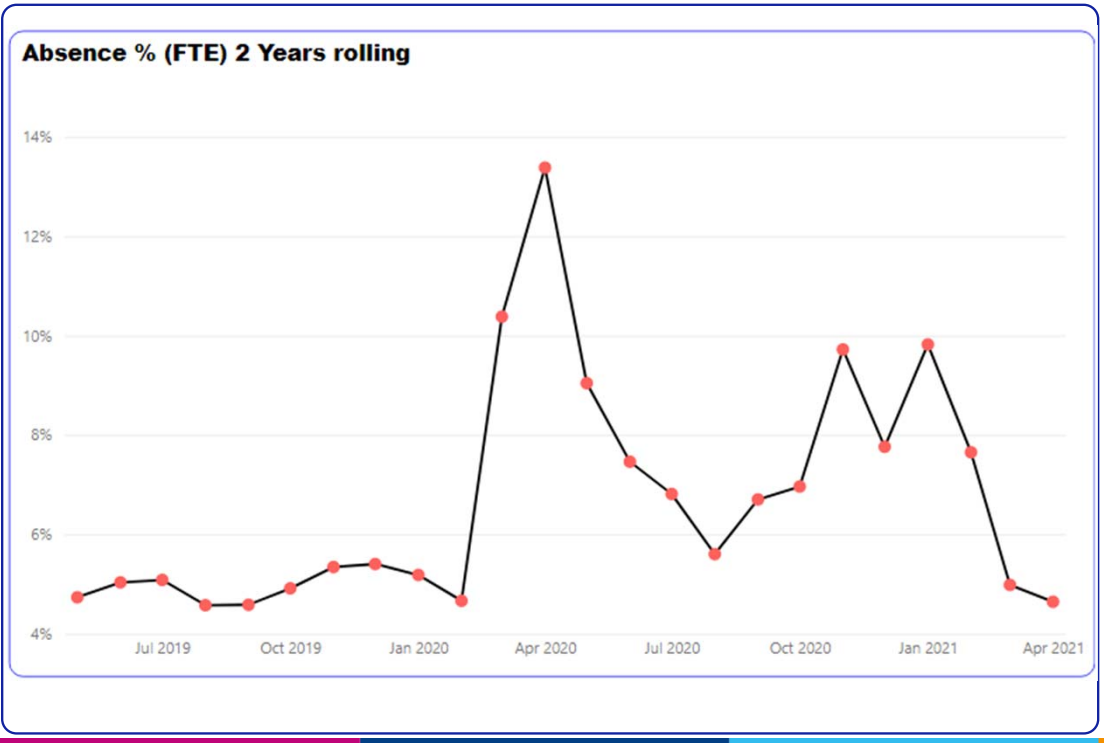
Summary 3/3	*Performance*	*Action*
Staff Health & Wellbeing	o Referrals received in May reduced to 63. o The largest category is 'Ability to perform duties' at 57%. o The average days from referral to appointment was 15 days in May, which is at the target of 15 days.	✓ Review of Staff Health & Wellbeing has been completed. Improvements to the SHAW operation and service model are being implemented currently, along with the creation of a service performance dashboard to capture; capacity, performance and management metrics. ✓ Additional investment has been approved for SHAW, to include appointing a new leader for the service asap. ✓ The new role – Health & Wellbeing Lead has now been appointed to. This role will focus on developing a comprehensive health and wellbeing offer for the workforce. A NED Wellbeing Guardian has also been appointed.
HR Caseload	o The current caseload is 40, with 'Disciplinary' at 40% the highest category, followed by 'Grievance' at 35%. o The highest Division is Medicine & Integrated Care with 17 open cases. o The average length of cases is 117 working days, 160 for disciplinary and 90 days for grievance cases. It should be noted that between March 2020 and July 2020 and again between October 2020 and February 2021 Employee Relations cases were paused where appropriate to support the response to the pandemic. o BAME representation is at 40%, with 16 open cases. Within disciplinary cases BAE representation is 18.75% and 57.14% within grievance.	✓ 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

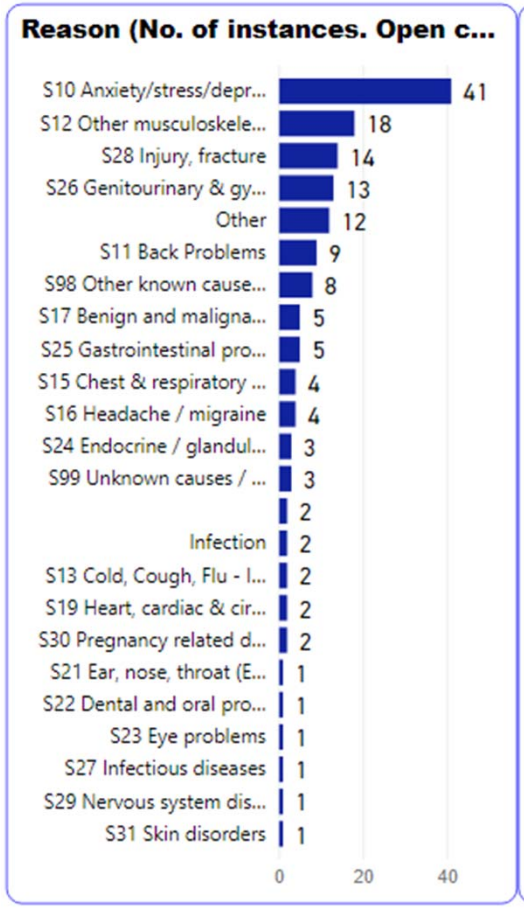
Overall Sickness/Absence was 4.64% in April, a slight reduction from 4.98% in March. CSS continues to be the highest at 5.4%%.

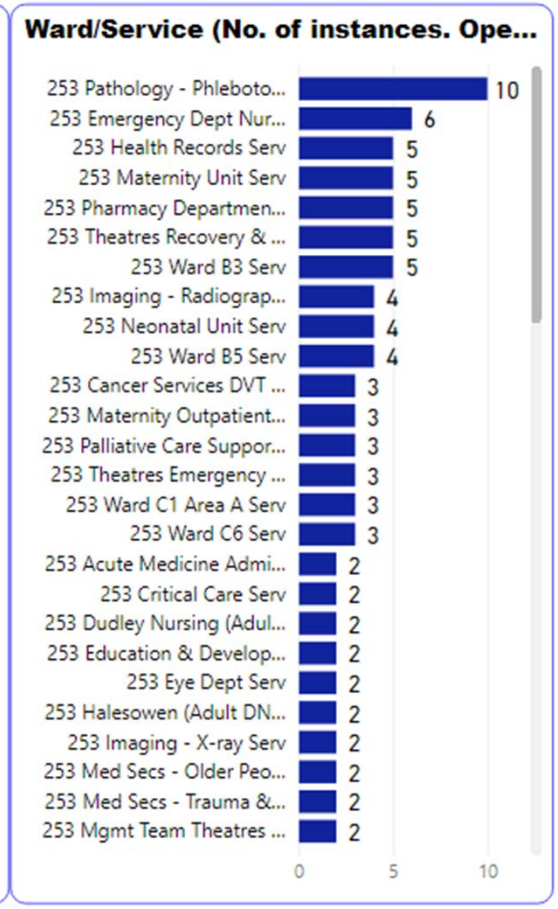
Daily absence tracking shows C19 absence tracking is now weekly, and is currently at 0.2% (12 staff).

The highest absence category is Anxiety/Stress/Depression. Phlebotomy is the department with the highest incidence of sickness in April.



Trust	CS	Corporate	MIC	Surgery
4.64%	5.40%	2.01%	4.76%	5.18%

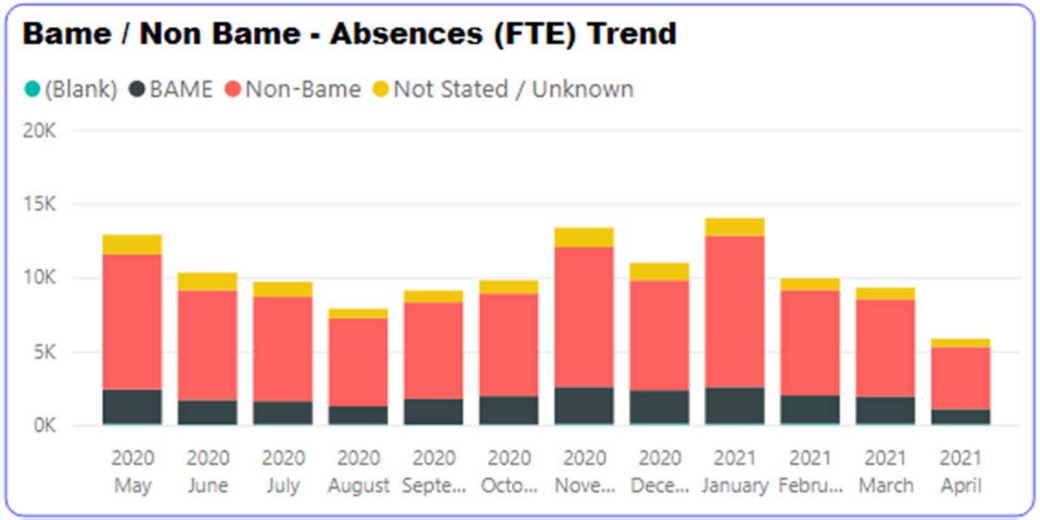


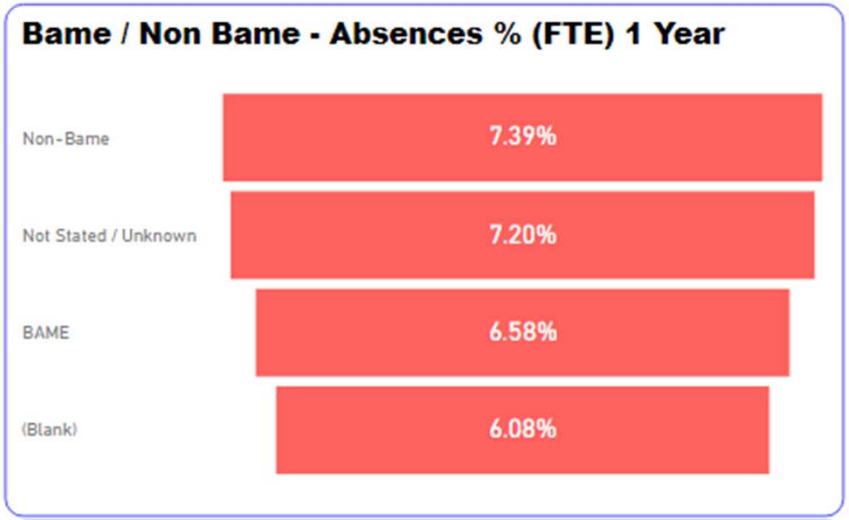


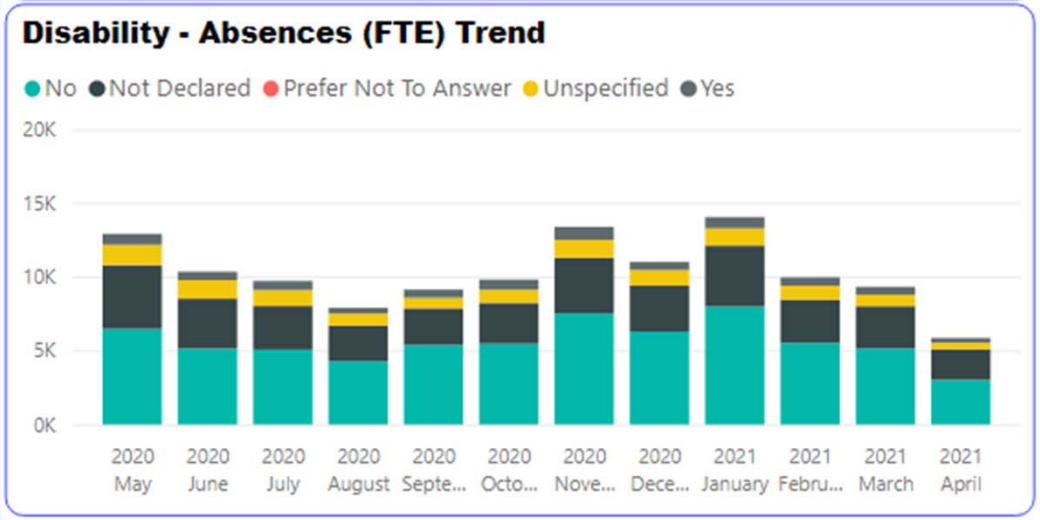
Sickness Absence - Detail

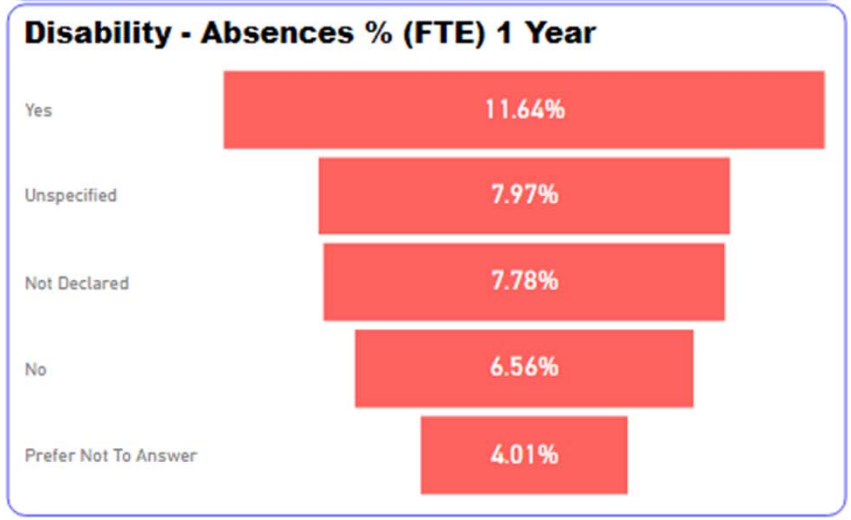
BAME colleagues show absence levels 0.81% lower that white colleagues.

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









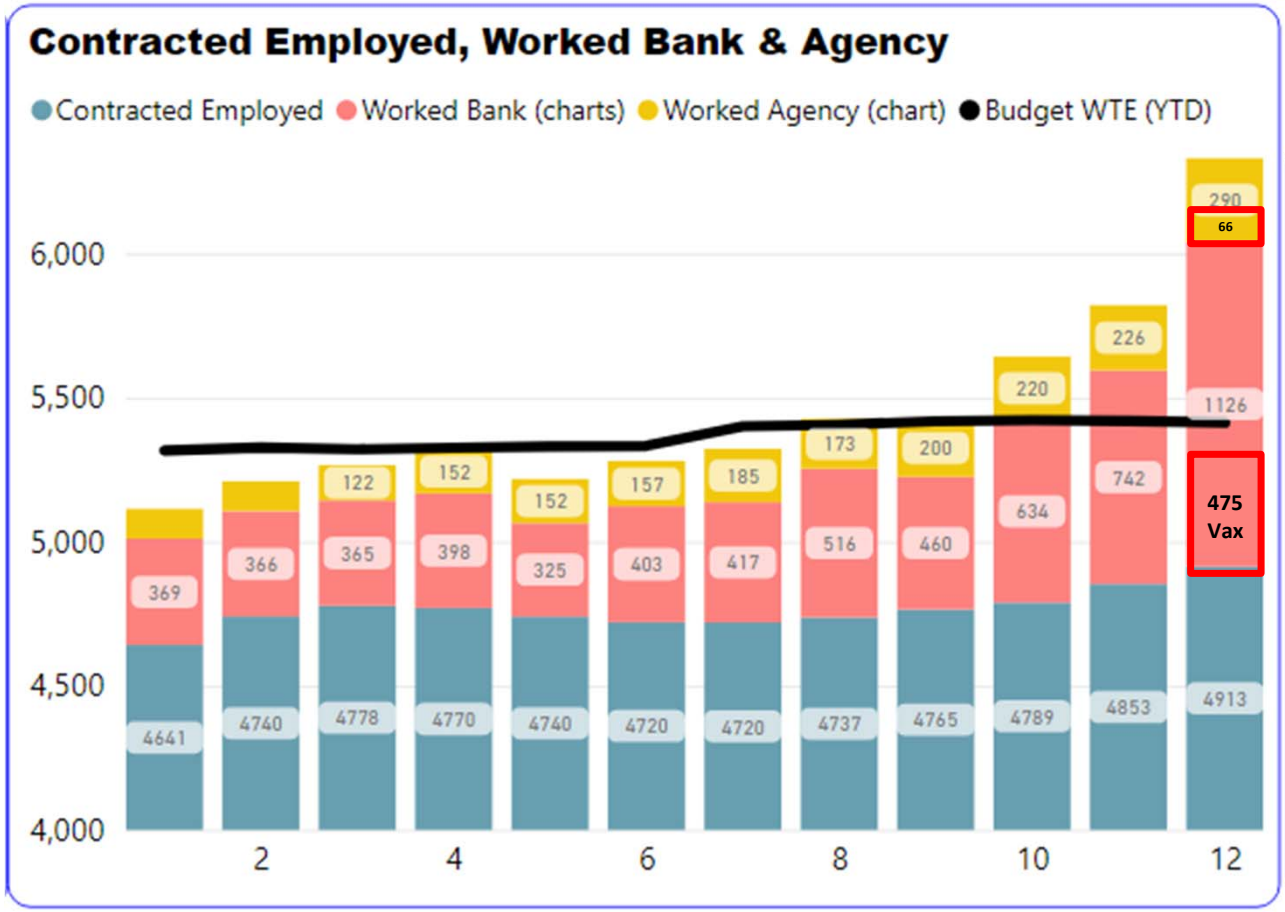
Bank & Agency – Total Trust

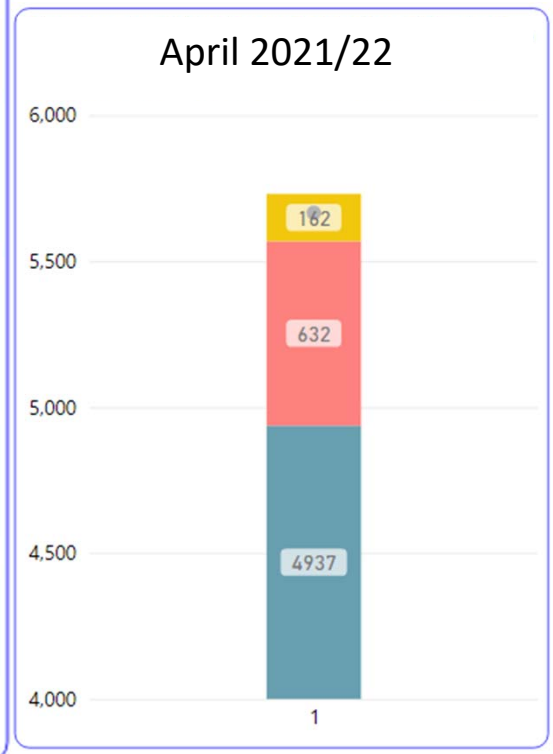
The COVID vaccination rollout numbers are included in the total figure (DGFT is the lead employer for BCWB).

DGFT excluding vax rollout: BANK = 302 WTE, and Agency 182 WTE

COVID vax programme BANK = 320 WTE, £1,677K, AGENCY = (wte not available) £425k

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





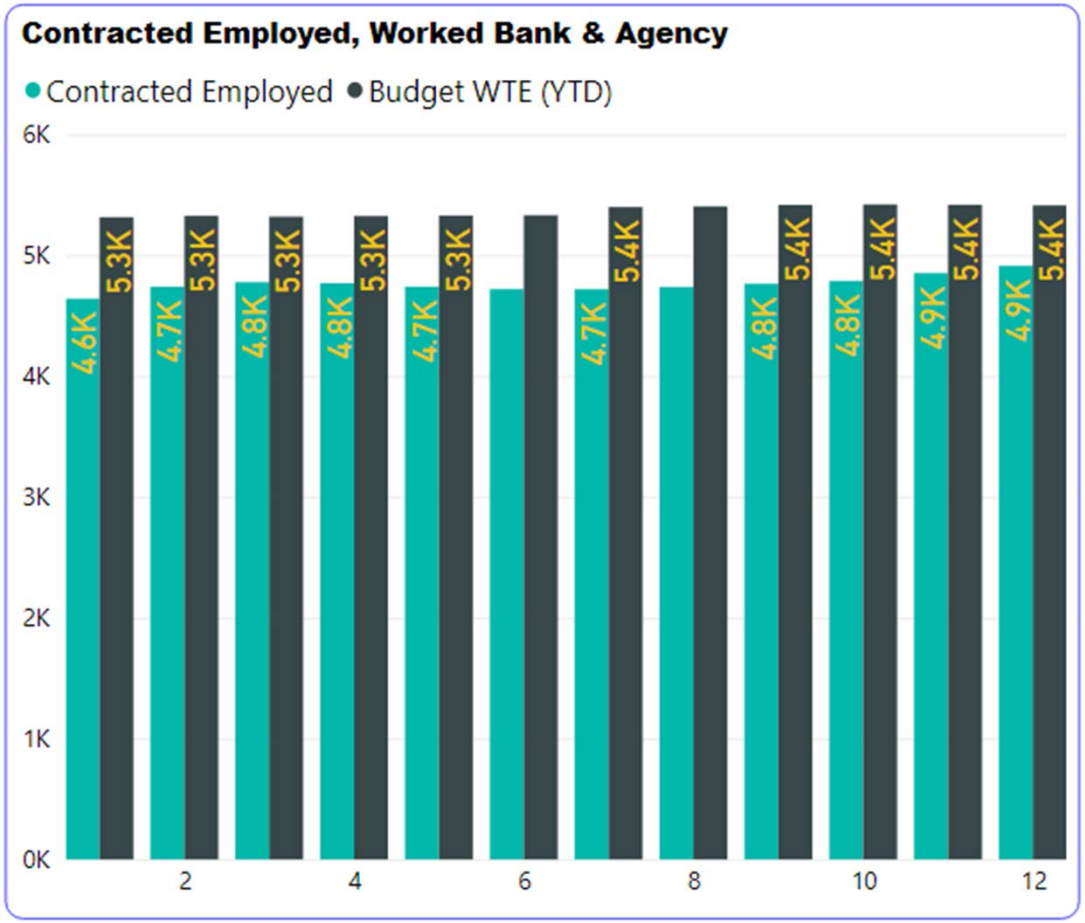
Vacancies – Staff in Post

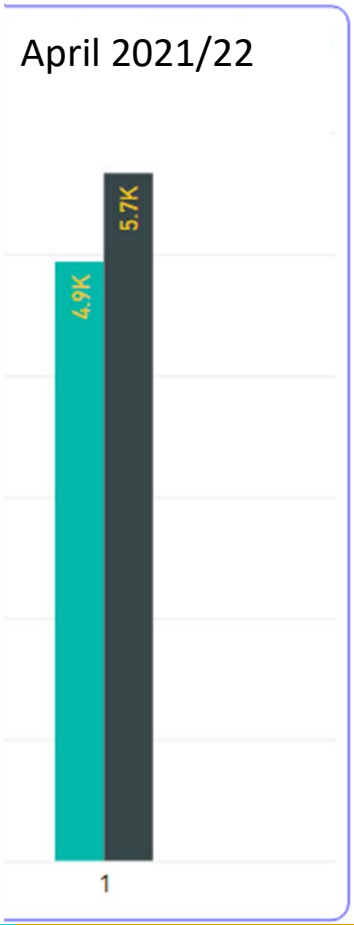
Contracted WTE staff has increased to 4,932 WTE in April, up 20 from March.

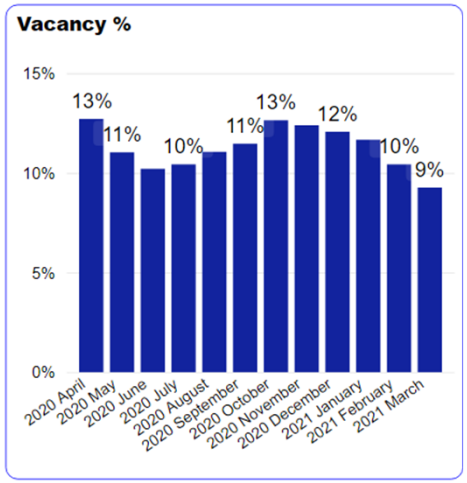
The Budgeted WTE for April has increased to 5,666 (up 252 WTE from March). The increase is largely due to the modular build including extra wards and treatment areas. Staff are now being recruited into these posts.

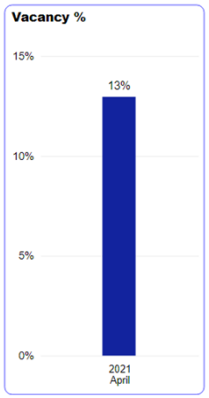
The effect has been to increase the vacancy factor from 9% in March to 13% in April.

Trust	CS	Corporate	MIC	Surgery
13%	19%	7%	13%	14%









Vacancies – Total Trust + Bank & Agency Spend – detail by division and Monitor pay group

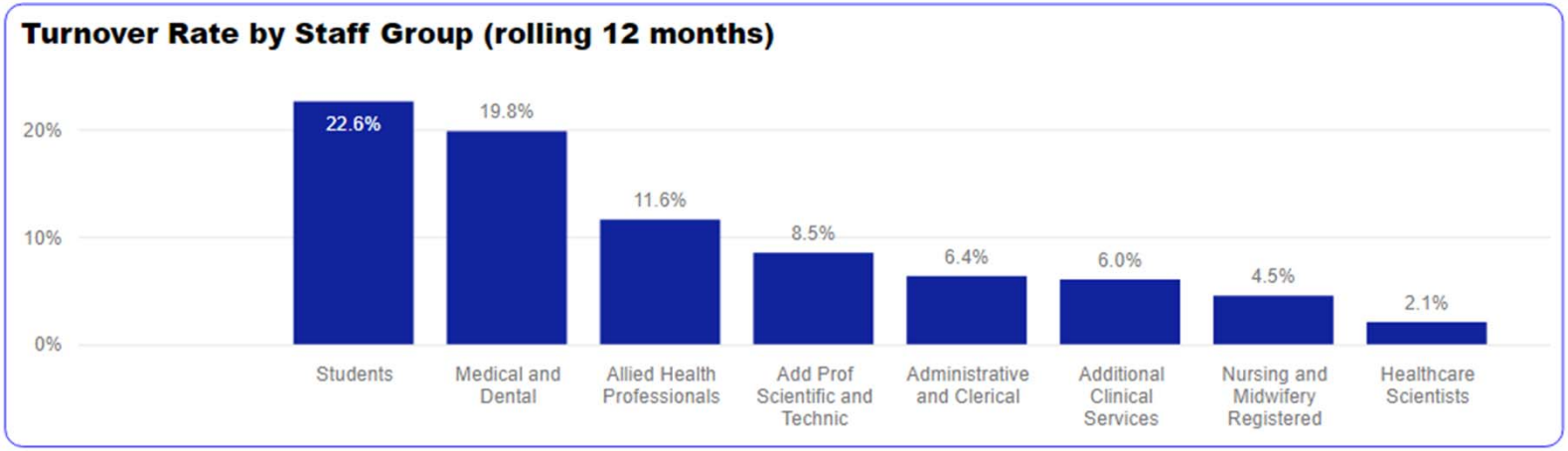
CC1 Desc	Budget WTE	Contracted WTE	Vacancy WTE	Vacancy %	Worked Bank	Bank (£)	Worked Agency	Agency (£)	Bank & Agency
Clinical Support	551.39	446.82	104.57	19%	22.61	£103,900	9.35	£70,796	£174,696
Corporate / Mgt	662.51	615.54	46.97	7%	336.07	£1,761,791	7.91	£465,415	£2,227,206
Medicine & Integrated Care	2,492.40	2,176.48	315.92	13%	163.39	£1,160,909	66.18	£567,775	£1,728,684
Surgery	1,959.79	1,692.84	266.95	14%	110.03	£675,169	78.41	£653,960	£1,329,128
Total	**5,666.09**	**4,931.68**	**734.41**	**13%**	**632.10**	**£3,701,768**	**161.85**	**£1,757,946**	**£5,459,714**

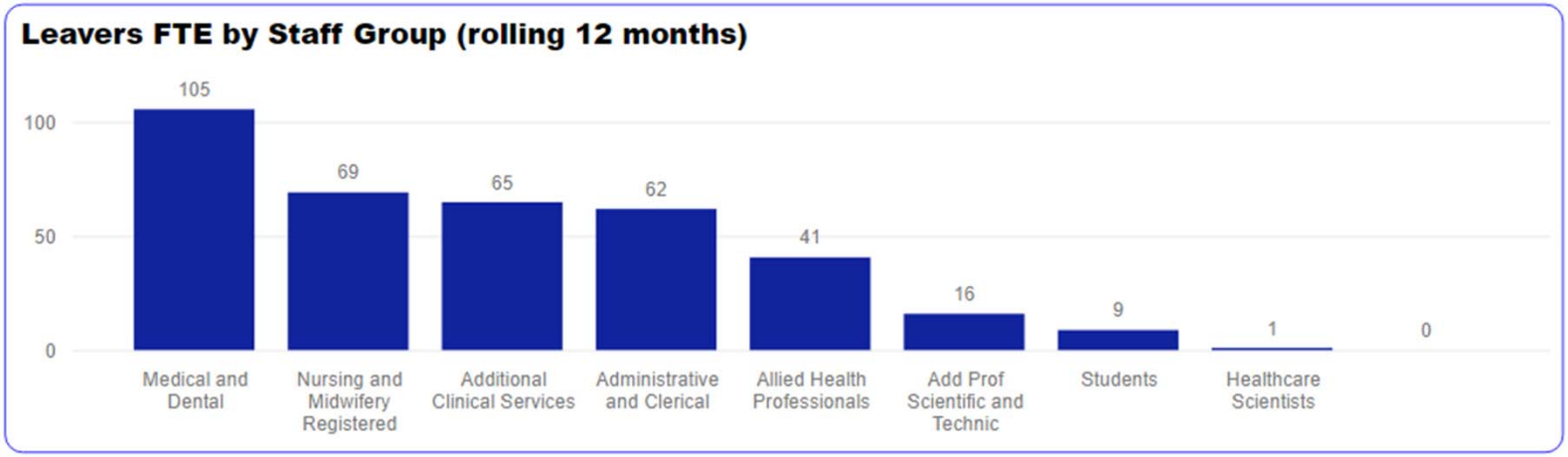
EH4 Description	Budget WTE	Contracted WTE	Vacancy WTE	Vacancy %	Worked Bank	Bank (£)	Worked Agency	Agency (£)	Bank & Agency
Qualified Nursing	1,900.81	1,560.88	339.93	18%	143.07	£857,643	118.70	£932,758	£1,790,401
Administration Staff	1,067.27	946.49	120.78	11%	119.57	£414,250	2.28	£25,022	£439,272
Unqualified Nursing	925.17	887.47	37.70	4%	193.40	£727,023	8.66	£3,635	£730,658
Junior Medical Staff	436.06	388.70	47.36	11%	31.21	£368,782	6.50	£113,173	£481,955
Senior Medical Staff	372.55	312.09	60.46	16%	22.08	£436,252	6.86	£141,615	£577,867
Technical Staff	250.20	213.48	36.72	15%	6.45	£38,159	1.94	£15,938	£54,097
Radiographer	214.53	165.14	49.39	23%	8.78	£32,498	8.01	£59,266	£91,764
Physiotherapists	155.34	144.47	10.87	7%	5.20	£28,010	0.96	£6,731	£34,741
[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
Total	**5,666.09**	**4,931.68**	**734.41**	**13%**	**632.10**	**£3,701,768**	**161.85**	**£1,757,946**	**£5,459,714**

Staff Turnover

Overall staff turnover is at 7.8% (rolling average 12 months). High turnover is expected within the Student and Medical & Dental staff groups. Of the remainder, AHPs are highest at 11.6%, Nursing &Midwifery Registered at 4.5%, and Healthcare Scientists lowest at 2.1%.

Trust	CS	Corporate	MIC	Surgery
7.8%	8.6%	9.0%	8.4%	6.3%





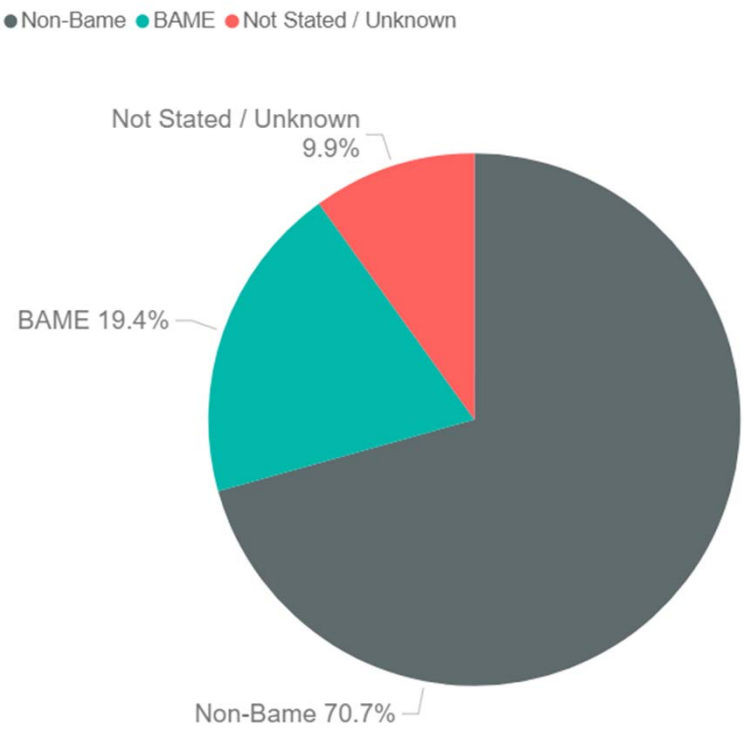
Workforce Profile - Ethnicity – Representation by Division and Grade

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)

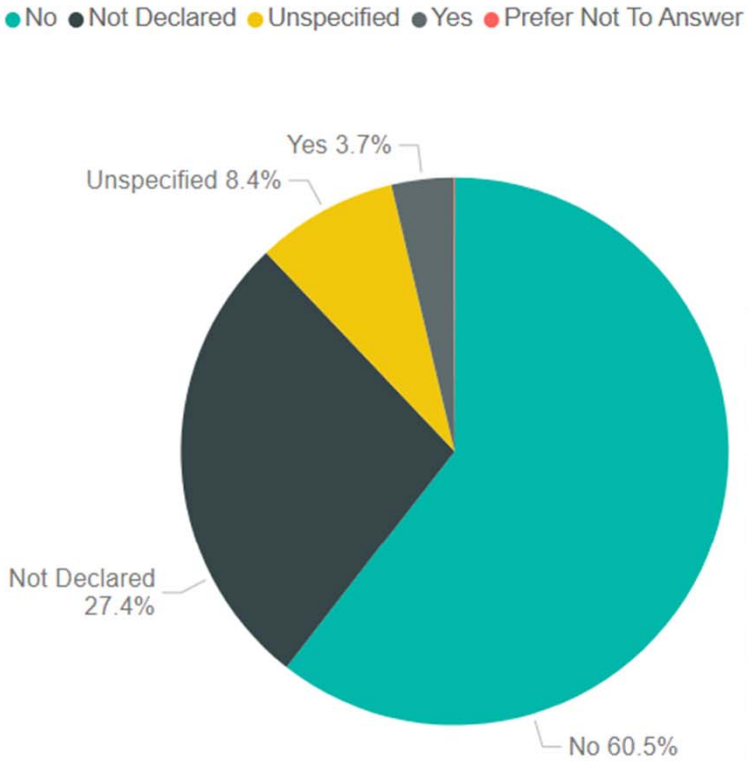
Mapping Mapping	BAME No.	BAME %	Non-Bame No.	Non-Bame %	Not Stated / Unknown No.	Not Stated / Unknown %	Total No.	Total %
Ad Hoc			1	100.0%			1	100.0%
Apprentice	8	13.1%	50	82.0%	3	4.9%	61	100.0%
Band 2	124	10.1%	971	79.1%	133	10.8%	1228	100.0%
Band 3	28	7.8%	290	81.0%	40	11.2%	358	100.0%
Band 4	50	11.9%	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%**

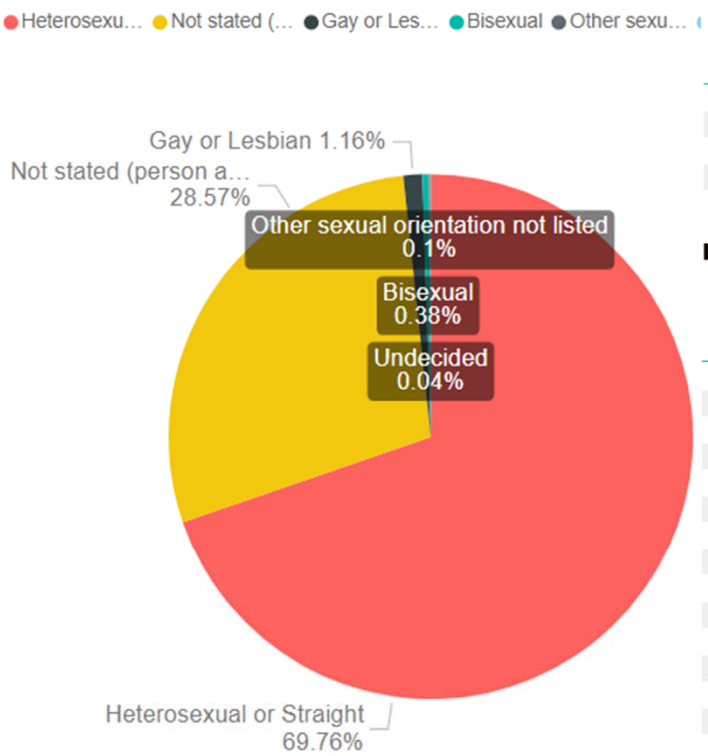
Disability by Pay Grade (grouping)

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%**

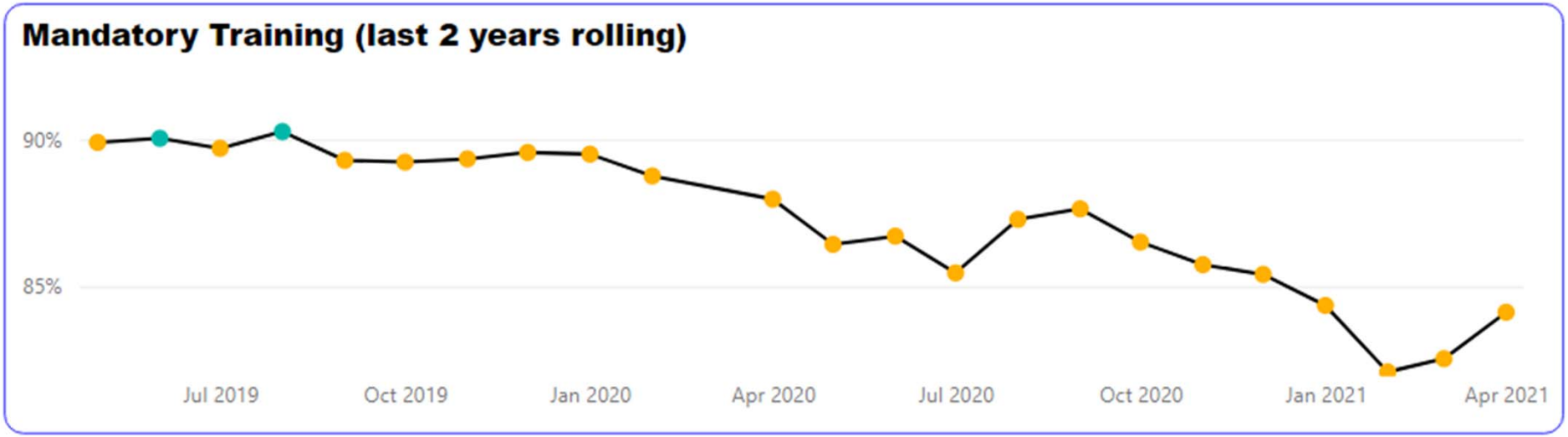
Mandatory Training – Performance Trend

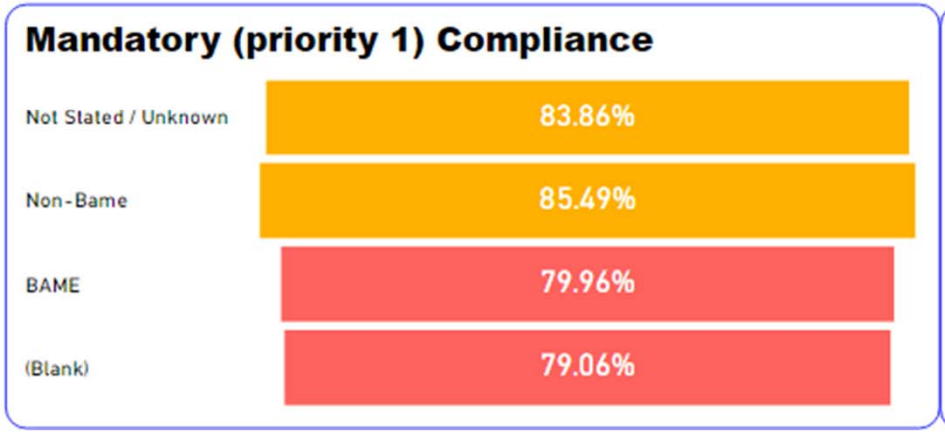
Mandatory Training: overall compliance increased in April to 84.12%, up from 82.54% in March.

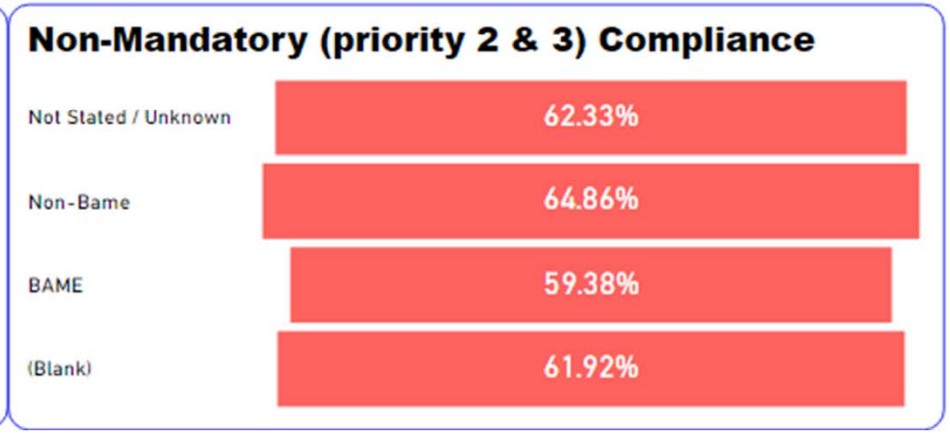
Surgery is the lowest division at 82.35%

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

Trust	CS	Corporate	MIC	Surgery
84.12%	87.64%	85.81%	84.43%	82.35%





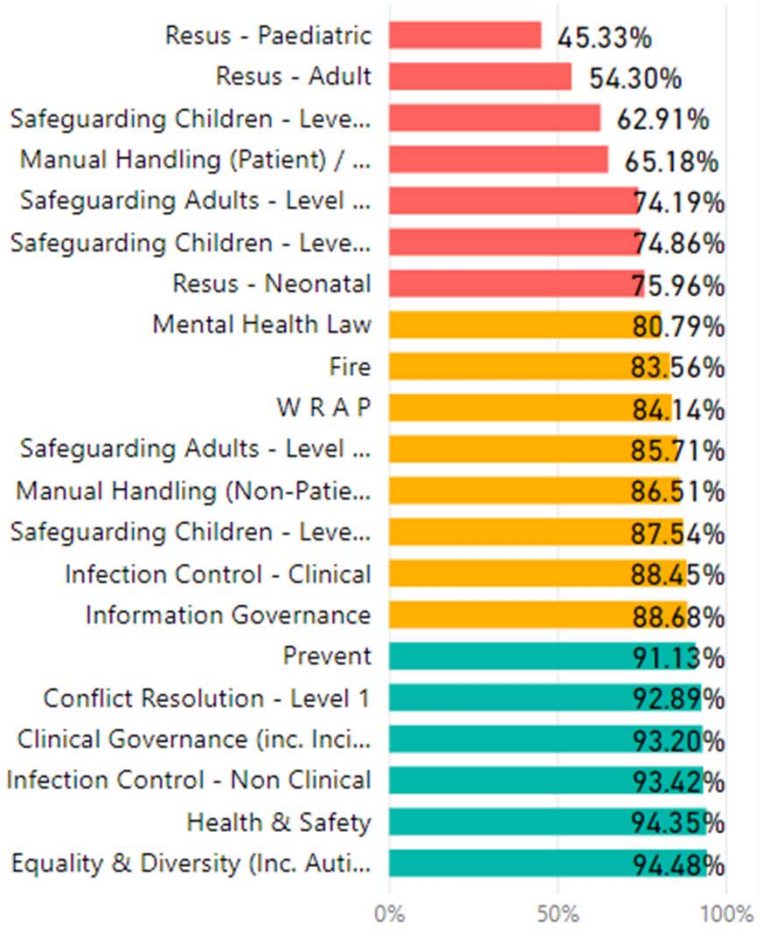


Mandatory Training – Areas of Focus

The priority areas continue to be RESUS and SAFEGUARDING.

The most challenged services is Medical Staff (Orthodontics).

Course Compliance (based on selections)



Ward/Service (based selections)

Group5Description	Actual	No. >90%	%' tage
253 Medical Staff (Orthodontics) Serv	4	8	30.76%
253 HR Director Serv	20	26	39.21%
253 Dudley Improvement Practice Serv	21	24	42.00%
253 Psychiatry Medics Rechg PCT Serv	8	9	44.44%
253 Macmillan Specialist Nurse Serv	13	13	46.42%
253 Medical Staff (Medical Oncology) Serv	13	13	46.42%
253 Covid Vaccination Programme Mgt Serv	10	8	50.00%
253 Integrated Living Team Serv	14	12	50.00%
253 Medical Staff Stroke Serv	71	39	58.19%
253 Medical Director Serv	40	21	59.70%
253 General Surgery Medical Staff Serv	355	163	61.73%
253 Medics - Biochemistry 2 Serv	35	16	62.50%
253 Med Secs Emergency Medicine Serv	19	8	63.33%
253 Operations Management Serv	186	77	63.69%
253 Medical Staff Renal Serv	96	39	64.00%
253 Medical Staff (Older People) Serv	134	51	65.36%
253 Trust Capacity Management Serv	117	44	65.73%
253 CNS Colorectal Serv	78	29	66.10%
253 Urology Medical Staff Serv	108	37	67.08%
253 Paediatric Medical Staff Serv	188	61	68.11%
253 HR Occupational Health Serv	35	10	70.00%
253 Plastic Surgery Medical Staff Serv	94	27	70.14%
Total	**56,117**	**3922**	**84.12%**

HR Caseload

The current caseload is 40, with 'Disciplinary' at 40% the highest category, followed by 'Grievance' at 35%.

The highest Division is Medicine & Integrated Care with 17 open cases.

BAME representation is at 40%, with 16 open cases. Within disciplinary cases BAE representation is 18.75% and 57.14% within grievance.

The average length of cases is 117 working days, 160 for disciplinary and 90 days for grievance cases. It should be noted that between March 2020 and July 2020 and again between October 2020 and February 2021 Employee Relations cases were paused where appropriate to support the response to the pandemic

Employee Relations Type	Clinical Support	Corporate/Mgt	Medicine & Integrated Care	Surgery, Women's & Children's	Total	%
Capability No UHR	1		1	1	3	7.5
Capability UHR			5	1	6	15
Disciplinary	3		7	6	16	40
Further ER Stages - Appeal	1				1	2.5
Grievance		5	4	5	14	35
Total	5	5	17	13	40	100

Employee Relations Type	Clinical Support	Corporate / Mgt	Medicine & Integrated Care	Surgery	Grand Total
Capability No UHR	112		179	96	129
Capability UHR			36	71	42
Disciplinary	204		93	216	160
Further ER Stages - Appeal	223				223
Grievance		114	50	98	90
Grand Total	190	114	71	150	117

Staff Group	Capability No UHR		Capability UHR		Disciplinary		Further ER Stages - Appeal		Grievance		Total	%
	No. of cases	%	No. of cases	%	No. of cases	%	No. of cases	%	No. of cases	%		
Additional Clinical Services		0.00%	2	33.33%	4	25.00%		0.00%	3	21.43%	9	22.50%
Administrative and Clerical	1	33.33%	2	33.33%	5	31.25%	1	100.00%	3	21.43%	12	30.00%
Allied Health Professionals		0.00%		0.00%	2	12.50%		0.00%	1	7.14%	3	7.50%
Medical and Dental		0.00%		0.00%	1	6.25%		0.00%	4	28.57%	5	12.50%
Nursing and Midwifery Registered	2	66.67%	2	33.33%	4	25.00%		0.00%	3	21.43%	11	27.50%
Grand Total	3		6		16		1		14		40	

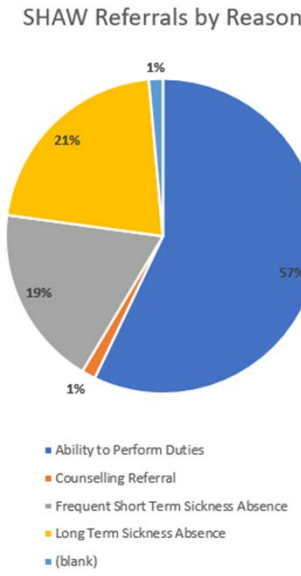
Ethnicity	Capability No UHR		Capability UHR		Disciplinary		Further ER Stages - Appeal		Grievance		Total Count of Random	Total Sum of Random
	No. of cases	%	No. of cases	%	No. of cases	%	No. of cases	%	No. of cases	%		
Bame Staff Members	2	66.67%	3	50.00%	3	18.75%			8	57.14%	16	40.00%
Non Bame Staff Members	1	33.33%	3	50.00%	13	81.25%	1	100.00%	6	42.86%	24	60.00%

Staff Health & Wellbeing – SHAW Service – Manager Referrals

Referrals received in May reduced to 63.

The largest category is 'Ability to perform duties' at 57%.

The average days from referral to appointment was 15 days in May, which is at the target of 15 days.



SHAW Average wait (weekdays. Based on Referral to 1st Appointment Offer)