The Dudley Group
NHS Foundation Trust

Board of Directors Meeting Public Papers

Thursday 16th September 2021

12:05 – 15:50

The Dudley Group
NHS Foundation Trust

BOARD MEETINGS
PUBLIC INFORMATION SHEET

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

1. Introduction

This sheet provides some information about how Board meetings work.

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

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

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

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2. Board Members' interests

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

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

3. Opportunity for questions

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

4. Debate

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

5. Minutes

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

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

6. Key Contacts

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The Dudley Group
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THE SEVEN PRINCIPLES OF PUBLIC LIFE

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

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

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

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

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

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

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

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

IN PUBLIC

The Dudley Group NHS Foundation Trust

Board of Directors
Thursday 16 September 2021
By MS Teams

AGENDA

	ITEM	PAPER REF	LEAD	PURPOSE	TIME
16	**Chairmans welcome and note of apologies –**		Y Buckland	For noting	12.05
17	**Declarations of Interest** Standing declaration to be reviewed against agenda items.		Y Buckland	For noting	12.05
18	**Minutes of the previous meeting** Thursday 10 June 2021 Action Sheet 10 June 2021	Enclosure 13 Enclosure 14	Y Buckland	For approval	12.05
19	**Chief Executive's Overview**	Enclosure 15	D Wake	For information & assurance	12.10
20	**Chair's update**	Verbal	Y Buckland	For information	12.30
21	**Public Questions**	Enclosure 16	Y Buckland	For information	12.40
22	**Presentation – Safeguarding Team**	Enclosure 17	J Mullis	Presentation	12.45
23	**GOVERNANCE**				
23.1	Acute Collaboration	Enclosure 18	K Sheerin	For assurance	13.15
23.2	Trust Strategy Update	Enclosure 19	K Sheerin	For approval	13.35
24	**QUALITY & SAFETY**				
24.1	Quality and Safety Committee Report	Enclosure 20	E Hughes	For assurance	13.45
24.2	Chief Nurse Report	Enclosure 21	J Wakeman	For assurance	13.55
24.3	Board Assurance Infection Control Framework	Enclosure 22	J Wakeman	For assurance	14.15
24.4	Maternity and Neonatal Safety and Quality Dashboard	Enclosure 23	D Lewis	For assurance	14.25
24.5	EPRR Core Standards	Enclosure 24	C Leach	For assurance	14.35
25	**FINANCE & PERFORMANCE**				
25.1	Finance and Performance Committee Report	Enclosure 25	J Hodgkin	For assurance	14.45

25.2	Integrated Performance Dashboard	Enclosure 26	K Kelly	For assurance	14.55
26	**WORKFORCE**				
26.1	Workforce and Staff Engagement Committee Report	Enclosure 27	J Atkins	For assurance	15.05
26.2	Workforce KPIs	Enclosure 28	J Fleet	For assurance	15.15
27	**DIGITAL AND TECHNOLOGY**				
27.1	Digital and Technology Committee Report	Enclosure 29	C Holland	For assurance	15.35
28	**Any Other Business**	Verbal	All		15.45
29	**Reflection on meeting**	Verbal	All		15.45
30	**Date of next Board of Directors meeting** 14 October 2021				15.50

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

Enclosure 13

The Dudley Group NHS Foundation Trust

Minutes of the Public Board of Directors meeting held on Thursday 10th June 2021, by Remote Attendance

Present:

Yve Buckland, **Chair** (YB)
Diane Wake, Chief Executive (DW)
Liz Hughes, Non-executive Director (LH)
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 Head of Communications (LA)

21/069 Note of Apologies and Welcome

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

Governors

Helen Ashby, public elected Stourbridge

Public

Richard Guttridge (Express and Star)

Ian Franckom, IPSEN and a member of the public

Apologies were received from Jonathan Hodgkin.

21/070 Declarations of Interest

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

21/071 Minutes of the previous meeting held on 13th May 2021

It was **RESOLVED**

- **That the minutes of the meeting of the 13th May 2021 be agreed as a true and accurate record of the meeting.**

The Action log was noted.

21/072 Public Chief Executive Overview Report

DW introduced her report and advised that there were currently four in patients with COVID-19, and one death in the last twenty- four hours. There were currently one to two admissions per day and length of stay was lower than had previously been experienced.

The community rate was currently 25 per 100k. The Trust was planning for a third wave from the end of August and preparations were being made for a third phase of vaccinations from September alongside the flu vaccination programme.

Staff sickness absence was currently at 4.6% and staff numbers with COVID- 19 had reduced to fourteen.

It was noted that COVID variants were now circulating in Dudley and the public were reminded to continue to be vigilant and to observe the “hands, face, space” guidance

The Trust had held its Committed to Excellence awards on 19th May and these had been very well received as an opportunity to celebrate success.

Ted Baker, the CEO of the Care Quality Commission had visited the Trust on the 27th May to see the improvements made in hospital services since the last inspection. The Trust was pleased to receive positive feedback from this and welcomed Professor Baker’s commitment to sponsor work on patient safety.

DW advised that she had received a question from Helen Ashby concerning Changing Places and was pleased to report that work on the facilities for people with disabilities under this programme had begun and was due to complete by the 29th June.

The Board was advised that the Modular Unit would shortly be opened and would be named the Rainbow Unit. This was a much needed facility to help with elective work and the increase in emergency activity.

It was **RESOLVED**

- **That the report be noted**

21/073 Chair's Public Update

The Chair advised that she had been involved in a number of system meetings and had also attended the Committed to Excellence Awards. She had greatly enjoyed delivering the awards to some of the winners and commended the staff for their dedication.

21/074 Public Questions

Fred Allen asked "*I have read on social media (may be fake I don't know). Endoscope Decontamination Process Failure at Corbetts Urology department. Failure led to adverse outcomes. Patients have been identified as developing Pseudomonas infection. The 46 patients involved have instructed Shoosmiths to act on their behalf after undergoing routine Cystosopies. Could I have an update please as I will be unavailable to attend in an observation capacity."*

Karen Kelly responded *"There was a failure of decontamination at Corbett in relation to the Cystoscopy suite. A full RCA process was completed, and changes to the practice were made and revision of some equipment such as the decontamination sink was completed. Since then a full replacement of the decontamination plant on the Corbett site has been completed and the team are moving back in next week (w/c 7/6/21). From a litigation point of view, there have been a small number of individual claims, however I am not aware of a mass claim with Shoosmiths as mentioned below. A small number of patients did come to harm (3) All of which have been informed and treated."*

21/075 Case Study – Conversion of glaucoma pathways to a full virtual service

The Chair welcomed Babar Elahi (BE), Akash Raj and John Barry from the Opthalmology Team who delivered a presentation setting out the challenges in the service and the innovations introduced to deliver a full virtual service option.

The Chair asked whether patients were satisfied with a virtual service and BE advised that the service was additional to other types of consultation, noting that the offer now included, virtual, telephone and face to face consultations.

GB asked if there were any unintended consequences in relation to staff training requirements as a result of the changes in service provision. BE advised that feedback on training had been positive and that teaching using a 3d image was often more effective. Helen Ashby noted that this was an effective way of managing relationships and asked if it could be transferred to other clinical settings. JHO replied that the service offer had to take different forms tailored to patient needs and that the Trust benefitted from clinicians like Mr Elahi who were focussed on continuous service improvement.

The Chair thanked the members of the team who had presented and attended the Board for showcasing the best practice.

21/076 GOVERNANCE

21/076.1 Audit Committee Exception Report

GC summarised the exception report and noted that the Audit Committee meeting had been productive with no areas of concern requiring escalation.

It was **RESOLVED**

- **That the report be noted**

21/076.2 Acute Collaboration

KS summarised the report and advised that the last Programme Board had approved the resource requirements of the programme for the next two years and the arrangements for a Programme Director and project support had also been approved.

Ian Franckom asked about the governance arrangements that would be applicable and KS advised that the governance in all provider organisations would change with the development of Provider Collaboratives.

The Chair stated that the Board needed to see system data and gain an understanding of how key programmes of work would deliver efficiencies in back office, workforce development and efficiency, for example through a Black Country approach to bank staff.

GC noted that the commitment of the Trust to collaborative working was evident from this work and this was to be commended.

It was **RESOLVED**

- **That the report be noted**

21/076.3 Board Assurance Framework

LN summarised the Board Assurance framework, noting that this was a composite report of the various Committee assurance reports. He advised that whilst the underlying risk scores had not changed there were a number of mitigations against each risk that remained above the target score. It was noted that compliance with Access Standards, recruitment, and the position of the Trust within the wider health economy remained the key risks for the Trust and these issues were all matters that were subject to separate agenda items and discussion in the Board meeting.

It was **RESOLVED**

- **That the report be noted**

21/077 QUALITY AND SAFETY

21/077.1 Quality and Safety Committee Report

LH summarised the exception report.

With regard to the increase in the SHMI, JHO advised that there was no single method for reporting mortality and a technical reporting issue had the effect of increasing observed mortality for the Trust. It was understood that from April 2022 there would be a consistent national reporting arrangement which would be an improvement from the current position.

The Chair noted that performance in relation to TIA clinics had a negative assurance and asked for further information on the proposed mitigations. LH advised that the committee noted and accepted that performance standards had inevitably declined during COVID but that these were not now demonstrating the expected improvement. The Committee had requested to see an action plan to achieve pre-pandemic levels of performance.

MS advised that subsequent work in this area had demonstrated full compliance and this would be formally reported back to the committee.

It was **RESOLVED**

- **That the report be noted**

21/077.2 Quality Accounts

MS summarised the report and the draft Quality Accounts it being noted that these had been subject to scrutiny by the Quality and Safety Committee. These had been prepared in accordance with mandated requirements and provided national and local comparative data on the overall performance of the Trust. There had been a striking amount of improvement work undertaken despite the demands of the pandemic and she commended colleagues who had undertaken this work. However, the demands placed on clinical staff were such that the Trust priorities had not been fully met with the two key areas being “partially achieved”

It was **RESOLVED**

- **That the Quality Account 2020/21 be approved and submitted to NHSE/I**

21/077.3 Chief Nurse Report

MS summarised the report and noted the key issues for consideration by the Board.
There were currently challenges around compliance with life support training and a recovery plan was in place to achieve compliance by the end of July

LH commended the work of the Safeguarding Team and the Chair requested that the Board receive a presentation from the team at a future meeting.

The Chair noted the quality of care provided by Susan Whorton of ward C7, as referred to in the report and asked that the thanks of the Board be recorded for the compassion that she had demonstrated.

It was **RESOLVED**

- **That the report be noted**

21/077.4 Board Assurance Infection Control Framework

MS advised that compliance with mandatory training was below the required standard when the paper was drafted but that subsequently this had increased to 91.3%, which demonstrated good progress.

MS stated that she wished to place on record the supportive visit received from regulators on the 6th April. The Board were reminded that this had arisen because of the Klebsiella outbreak previously reported to the Board. An action plan had been discussed and agreed with the regulators and the issues raised had now been addressed. The Trust's PFI partner had been responsive in attending to these concerns. There were some continuing challenges around storage that the Trust was continuing to work on and a recent "Dump the Junk" day had been effective and would be repeated.

CH emphasised the importance of ongoing compliance with PPE amongst staff and the need to role model this for the public. She asked how this would be maintained and MS assured the Board that this was subject to ongoing explanation, challenge and if necessary, in exceptional cases, enforcement.

The Chair asked how the Trust compared with peers in performance in this area and MS advised that the Trust was in the top four for the region for nosocomial infection.

GB noted that some staff had religious or cultural reasons for not shaving and he sought and received assurance that there were sufficient respirator hoods and other devices in these cases.

21/077.5 Maternity and Neonatal Safety and Quality Dashboard

The Board was joined by Dawn Lewis (DL), Head of Midwifery for this item. DL advised that there was a considerable volume of data in the report but that this was a requirement of both CNST and Ockenden.
DL advised that the evidence presented to the Board demonstrated that all ten of the CNST safety standards had been achieved. Specifically, it was noted that all areas on the action plan were now recorded as "green" and all the requirements in the spreadsheet for submission to NHSR had been met.
With regard to perinatal mortality, the quarterly report demonstrated that the Trust compared favourably within the STP.

The Chair noted that the report and supporting evidence was positive and that whilst there were some ongoing challenges with regard to staffing, there were no significant risks presented to the Board. DL agreed and stated that the internal and external evidence supporting this view was consistent and the areas for improvement were subject to an action plan that was subject to governance through the STP and LMS.

GB asked for clarification of steps that were being taken in relation to poor outcomes amongst BAME groups. DL advised that resources had been deployed to areas of high deprivation and ethnicity and there was a plan to increase the resource in the Continuity Teams later in the year but the Trust needed to be staffed to Birth rate Plus levels to achieve this.

JHO added that the Health Inequality Board had undertaken detailed discussions about perinatal mortality which it was noted had a disproportionate impact on BAME communities There was substantial work being done on this across the system.

The Chair stated that the Board should receive a report on the Trust as an anchor institution and its wider role in tackling health inequalities.

It was **RESOLVED**

- **That the Board accept the assurances provided in the report and its appendices demonstrating compliance with the CNST safety standards**
- **That the Board noted the evidence in relation to the Ockenden actions and that the "Minimum evidence" and the local action plan be utilised as a monitoring tool for future Board reports**

21/077.6 Research and Development Bi-Annual Report

JHO summarised the report and advised that there was a good research profile in the Trust as evidenced by the activities summarised in the report, particularly around COVID research, noting that some of the successful COVID therapies had been developed with Trust patients.

GB commended the report and emphasised the importance of future research including subjects that were of specific concern in Dudley, for example mental health, and obesity.

It was **RESOLVED**

- **That the report be noted**

21/077.7 Learning from Deaths

It was noted that the technical issues around the SHMI had been discussed under a previous agenda item.

It was **RESOLVED**

- **That the report be noted**

21/078 FINANCE AND PERFORMANCE

21/078.1 Finance and Performance Committee Report

TJ summarised the report and LW advised the Board that the Committee had discussed the new financial environment that would emerge post -Covid and which would require the Trust to review its delivery model and the strategy which in turn would drive financial planning.

It was **RESOLVED**

- **That the report be noted.**

21/078.2 Integrated Performance Report

KK summarised the report and the Board were advised that;

- In respect of the Emergency Access Standard there had been a 54% increase in type 1 attendances between January and May, with significant increase in attendance at the Urgent Care Centre also.
- Performance in relation to cancer and two week waits was good and hitting trajectory
- RTT was between 77 and 78%

- The Trust was the best performing in the Midlands for 52 week breaches and the number outstanding was currently 196 and reducing

Helen Ashby asked whether the increased demand for emergency and urgent care was likely to be sustained and KK stated that this increase was being seen nationally and there were a number of reasons for it. However, it was not possible to say whether the trend would continue.

It was **RESOLVED**

- **That the report be noted**

21/079 WORKFORCE

21/079.1 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**

21/079.2 Workforce KPI Report

JF summarised the report and advised the Board that twenty diversity champions had recently been appointed. CH challenged how the Trust would monitor their effectiveness. JF advised that the purpose was to provide feedback and support particularly for unsuccessful job candidates from a BAME background

GC noted that there were some key disciplines with significant vacancies and challenged what the strategy was for addressing hard to fill posts.

JF advised that there was substantial recruitment activity including the International Nurse Recruitment Programme.

It was **RESOLVED**
- That the report be noted

21/080 Any Other Business

There was no other business

21/081 Reflections on Meeting

Ian Franckom (a member of the public) thanked the Board for an inclusive environment and an opportunity to ask appropriate questions.

Date for the Next Meeting - 15 July 2021

Signed ……

Date …….....

Enclosure 14

The Dudley Group NHS Foundation Trust

Action Sheet
Minutes of the Board of Directors (Public Session)
Held on 10 June 2021

Item No	Subject	Action	Responsible	Due Date	Comments
21/077.3	Chief Nurse Report	Presentation from Safeguarding Team	MS	September Board	On Agenda

Enclosure 15

e Dudley Group NHS Foundation Trust

Paper for submission to the Board of Directors on 16th September 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
- Acute Provider Collaboration
- Healthcare Heroes
- Changing Places
- Charity Update
- Patient Feedback
- Visits and Events

IMPLICATIONS OF PAPER:

IMPLICATIONS FOR THE CORPORATE RISK REGISTER OR BOARD ASSURANCE FRAMEWORK

RISK	**N**	**Risk Description:**
	Risk Register: N	**Risk Score:**

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

CHIEF EXECUTIVE'S REPORT – PUBLIC BOARD – 16th September 2021

Coronavirus

The rules for healthcare settings did not change on Monday 19th July and anyone visiting our hospital or outpatient centres is still required to wear a surgical face mask, gel their hands and keep socially distanced. Preventing the spread of infection continues to be a priority for the Trust. While patients are complying with mask wearing, some members of the public have been non-compliant. We all have a duty to protect ourselves, each other and our clinically vulnerable patients. We encourage all our staff to test regularly for COVID using the saliva sampling method called LAMP testing. LAMP stands for loop-mediated isothermal amplification and is a weekly test for staff showing no symptoms.

Acute Provider Collaboration

The second Acute Provider Clinical Summit was held on 28th July, at West Bromwich Albion Football Club. 82 people attended in person, with clinicians from 14 specialities across the four Acute Trusts. Clinicians heard from some great national speakers in the morning, including Mrs Melanie Hingorani, Consultant Ophthalmologist and Clinical Lead for the National Eye Care Recovery and Transformation Programme, who talked about clinical leadership and engagement to secure successful service changes in London and nationally.

Clinicians worked together with their specialty colleagues to review information about their services and start to plan how outcomes can be improved by working together. This work is being taken forward over the summer, and will be developed further at the next clinical summit on 24th September. Following this, a clinical strategy will be produced in conjunction with Trust Boards, and all required consultation and engagement undertaken.

National guidance has been issued regarding how Provider Collaboratives will work in new ICS arrangements; the Programme Board will consider this in September to understand how governance arrangements may need to change in future and report back to Boards.

We look forward to bringing our clinical colleagues together again on the 24th September, 2021.

A Cancer Clinical Summit is also taking place on 29th September at West Bromwich Albion Football Club. This will be the first Oncology event of its kind in the Black Country and West Birmingham and we are very excited to explore how we can improve Cancer Services for the benefit of our local patients.

Healthcare Heroes

June Team Award

June's Healthcare Hero team award went to the Cardiology One Stop team. This team was nominated for their drive to seek new ways to improve their service and for going above and beyond for patients. They are a crucial part of our cardiology service and ensure all patients see a nurse consultant or advanced nurse practitioners on the same day they have any relevant tests. This avoids patients having to wait for another appointment. They have recently launched a new HOT clinic that supports patients with chest pain that have been discharged from our Emergency Department. With this new clinic in place, they are able to see those patients within 72 hours of discharge. This significantly improves patient experience which is always at the top of their priority list.

June Individual Award

June's individual Healthcare Hero was Jane Pugh who is a senior emergency care practitioner. She was nominated for her heroic actions that saved a person's life at a local gym when the person went into cardiac arrest. While Jane was off shift, enjoying a swim, someone collapsed at the side of the pool and Jane immediately took control of the situation and commenced CPR. Not only did Jane assist in saving someone's life, but she also went on to support the family member of the individual by getting them a cup of tea to calm them down and give them all the relevant information they would need to know following her care. Jane is hard working member of staff and a great role model to all her peers.

July Team Award

July's Healthcare Hero team award went to the out of hours district nurses. This team goes to extraordinary lengths to ensure patients across the Dudley borough receive exceptional care throughout the evenings whilst day staff are off duty. The team ensures every patient has nothing but the best quality of care. The out of hours district nurses pride themselves on efficiency, professionalism and remarkable teamwork. They continue to have positive impact on the lives of the patients they attend to. Sometimes, bettering their quality of life by giving them the confidence to self-care and giving them their independence back.

July Individual Award

July's Healthcare Heroes individual award went to Sue Hodder who is a neurology nurse specialist. Sue started out as the only MS nurse in the community and has recently celebrated 34 years' service in the NHS. Over the last 12 months, two new members have joined her team. Sue has provided them with first class education and training to ensure they meet their competencies ensuring patients receive the best possible care. Sue always goes above and beyond to provide support to her patients, even if they call out of hours. They are her top priority and that shines through her caring and compassionate persona. She is a well-respected member of The Dudley Group and has inspired many colleagues over the years. (Sue's presentation has not yet taken place).

Changing Places

We are converting one of our standard accessible toilets in the main corridor on the ground floor of Russells Hall Hospital for people with disabilities so they can attend appointments in comfort and safety and help them come to hospital without fear or stress.

Changing Places facility will be easily accessible and clearly signposted. It will be accessed by radar key and can be used by people with profound and multiple learning disabilities, motor neurone disease, multiple sclerosis and cerebral palsy, as well as older people.

Each Changing Places toilet provides a height adjustable, adult-sized changing bench; a tracking hoist system or mobile hoist; space for the disabled person and up to two carers; a centrally places toilet with room either side, and a screen or curtain to allow some privacy. Standard accessible toilets do not provide changing benches or hoists, and most are too small to accommodate more than one person.

Charity Update

New face on Trust fundraising team

We have appointed a new fundraising and community development lead to work alongside our fundraising manager, Karen Phillips. Nithee Kotecha comes from an extensive background in fundraising within the charitable sector having worked for national charities such as Street League and Mencap. She is looking forward to reviewing the Trust's fundraising approach and will be looking to create a new fundraising strategy whilst strengthening internal relationships and networking with new external funders.

We are always overwhelmed by the generosity of those who support our charity in the form of donations, legacies and taking part in fundraising. The charitable donations we receive allow us to provide extra comfort, equipment and facilities that otherwise would not be available. These help to make a real difference to those we care for every day.

On behalf of the Trust's charity, I would like to extend our thanks to everyone who has supported Dudley Group NHS Charity.

Anyone can make a donation using our Just Giving page link www.justgiving/dghc, follow us on Twitter and Facebook @dgnhscharity

People can also go to our Trust website www.dgft.nhs.uk and click on Support Our Charity.

Virtual London Marathon

On Sunday, October 3rd, 2021, 50,000 runners will have the chance to be a part of the biggest marathon ever staged anywhere in the world. The virtual Virgin Money London Marathon will return this year and the Dudley Group NHS Charity was lucky enough to gain five ballot places.

These have been filled by Rajeev Kumar and Andrew Lee both lead pharmacists from the Pharmacy Department; Matthew Welch, a district nurse in Community Services; Sue Hammond, the Datix administrator in the Clinical Governance Department and a long-standing supporter of the Trust Steve Waltho, former Mayor of Dudley. Also, Claire Macdiarmid, matron for the Maternity Unit, who ran the London Marathon in 2019, has won her own ballot place this year.

All the amazing runners are currently fundraising for our charity and have a combined goal of £3,000 to reach and are currently 30 per cent towards reaching this target. The fundraising team are profiling their journeys and supporting them with their fundraising efforts **#TeamDudley**

Glitter Ball

The fundraising team are organising the **Glitter Ball** fundraising event, inviting local businesses across the Black Country to support the Dudley Group NHS Charity. The post COVID celebration event is on the 5th of November 2021 at The Copthorne Hotel Merry Hill, Dudley.

Guests, including staff, will be treated to a wonderful evening of entertainment including welcome drinks and a two-course meal. The funds raised will go towards the charity's current Better Brighter Future Appeal which is aimed at building on the COVID-19 Crisis Appeal to make a better, brighter future for both patients and colleagues.

No Barriers Here

A project funded by NHS Charities Together via the Black Country and West Birmingham STP will improve care at the end of life for people from BAME communities and ensure that palliative care services are accessible for all, with greater awareness of the different cultures and needs within the Black Country.

The Dudley Group NHS Charity is partnering with Mary Stevens Hospice on the project called No Barriers Here.

The two-year project will work with people from a BAME background to develop and deliver art workshops, so they have a greater awareness of culturally sensitive issues. This will feed into future practice and strategies, so services provided are culturally aware.

It is based on a programme the hospice previously ran with people with learning disabilities, to encourage and support advance care planning. A film was created from this project which is now being circulated alongside a series of train the trainer workshops.

Mary Stevens Hospice has taken on an ethnic minority community worker, Elisha Frimpong, who will work alongside partners to reach out and engage with the diverse Dudley community, and raise awareness of palliative and end of life services and the No Barriers Here project.

Patient Feedback

A&E - All the staff including the front desk, nurses in minor, doctors and physios were all on their 'A' game.

A&E - The staff were so pleasant, reassuring and kind. Can't rate them high enough.

ED - Very happy about my experience. Thank you so much to all the staff!

Neurology - I was not kept waiting at all and everything was explained to me. I was put at ease as soon as I entered the scanning area. Nothing could have been better.

C6 - Very professional, polite nurses and staff. Kept up to date. Food good. Clean wards.

B3 - Everything was good, the staff on B3 were fantastic and I can't praise them enough. They get a gold star from me.

C2 - All staff were fantastic. Nothing was too much for them. We really appreciate everything you have done for us.

GI Unit - The staff were very friendly and I was informed about my procedure throughout.

CMAPS - Always empathetic and considerate. Very pleasant.

C1 - It was a pleasure to be looked after by loving, caring staff.

Maternity birth – The staff at Russells Hall maternity unit were absolutely fantastic with me.

B1 - My treatment before and after my operation was amazing. I felt safe the whole time.

Podiatric Surgery - All staff are pleasant and act very professionally.

Intermediate Care Team (Physiotherapy) - Very understanding. Gave me my own time. Made sure I understood and explained everything to me.

C4 (Georgina) - Staff are as always, friendly, efficient and extremely caring. Nothing is too much trouble on C4 Georgina Day Case.

Dietitians - Diabetic clinic called in before appt, thorough consultation without feeling rushed. Very pleasant staff.

Leg Ulcer - From the start I was so well treated and everything was explained with so much detail. I was very impressed with all the staff (so well done). Thank you.

Maternity Antenatal - The midwives are very helpful and explained everything well.

Visits and Events

18th June 2021	**Live Chat**
18th June 2021	**Council of Governors Quarterly Meeting**
21st June 2021	**Trust Management Team**
9th July 2021	**Live Chat**
9th July 2021	**Exec Walkaround- Diane Visiting C7**
14th July 2021	**Ophthalmology meeting- refined models of working**
15th July 2021	**Private Board Meeting.**
15th July 2021	**Board Workshop on ICS/ Acute Collaboration**
19th July 2021	**Kadeer Akhtar shadowing Diane Wake**
19th July 2021	**Trust Team Management**
20th July 2021	**Diane visiting the new AMU**
23rd July 2021	**Live Chat**
26th July 2021	**Maternity Workshop- Maternity and Neonatal Leads across Black Country and West Birmingham**
13th August 2021	**Live Chat**
13th August 2021	**Team Brief**
20th August 2021	**Live Chat**
23rd August 2021	**Trust Team Management**
25th August 2021	**Healthcare Heroes**
26th August 2021	**ICS Development Session**
27th August 2021	**Healthcare Heroes**
27th August 2021	**Live Chat**

8th September 2021	**ICS Next Steps Programme Board**
10th September 2021	**Team Brief**

Enclosure 16

The Dudley Group NHS Foundation Trust

Paper for submission to the Board of Directors
16th September 2021

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

CLINICAL STRATEGIC AIMS

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

ACTION REQUIRED OF COMMITTEE

Decision	Approval	Discussion	Other
		X	X

RECOMMENDATIONS:

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

CORPORATE OBJECTIVE:

All

SUMMARY OF KEY ISSUES:

Public Questions

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

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

Questions received:

Dr Ruth Tapparo, PCN Clinical Director Brierley Hill and Amblecote

Qu. Please can the Board advise how the funds within The Dudley Group NHS Foundation Trust's capital programme will be utilised by the 'local population patients and local health providers.'

As PCN Clinical Director for Brierley Hill and Amblecote, I have contacted Diane Wake to discuss the Corbett Meadow and the potential benefits that the local population and the PCN (as part of the local health system) Unfortunately my request to meet to discuss options has not been taken up.

The Meadow has multiple opportunities which would benefit the health and wellbeing of the local population, my PCN which is exactly the purpose of why the land was gifted originally.

Along with the Action Group, I would like to make an extended invitation to the board to meet to discuss this further.

Judith Davies, Brierley Hill

Qu. As a relative of the late, great John Corbett, I would like to ask a question about the Corbett hospital and its meadowland. Despite making a fortune, John never disowned his roots and sought to enhance the everyday lives of the Black Country working class amongst whom he had grown up. When John gave the Hill estate to the people of Stourbridge and vicinity, his brother, the eminent doctor, Thomas Corbett was one of the original trustees and the deed of trust makes it clear that they wished the grounds to be made available as 'a Public Park', for the benefit of all, not sold off to a privileged few, thus gaining short-term profit at the expense of long-term loss. My question is what makes the present-day trustees think they have the right to over-ride the wishes of the benefactor by seeking to make a deal with a commercial developer? And does it concern them that that the message they are sending to other families who might be considering making a bequest to the Dudley Group NHS Foundation Trust, is to think again as there is no guarantee that any of their wishes will be respected?

Paul Watson, Stourbridge

Qu. Given the Trust's commitment to best practice & innovation, green social prescribing and the well-being of its staff & patients, will it commission a report, to be prepared in liaison with interested parties, which considers the potential for utilising the Meadow at Corbett Hospital for such purposes? and, in the light of that report's findings, review its position that the Meadow is surplus to its requirements?

An. In light of financial challenges that face the NHS we are under a duty to make the best use of our resources and public money. NHS guidance states we should dispose of any surplus assets. We are required to sell the parcel of land we own at the rear of Corbett Outpatient Centre and reinvest the money directly back into patient care for the people of Dudley and surrounding areas. The money will be spent on crucial medical equipment to support the local communities' healthcare. We are therefore in ongoing discussions with a developer regarding the surplus land.

IMPLICATIONS OF PAPER:			
IMPLICATIONS FOR THE CORPORATE RISK REGISTER OR BOARD ASSURANCE FRAMEWORK			
RISK	**N**		**Risk Description**
	Risk Register: N		**Risk Score:**
COMPLIANCE and/or LEGAL REQUIREMENTS	**CQC**	**Y**	**Details:** Well Led
	NHSI	**Y**	**Details:** Well led
	Other	**N**	**Details:**
REPORT DESTINATION	EXECUTIVE DIRECTORS	N	DATE:
	WORKING GROUP	N	DATE:
	COMMITTEE	N	DATE:

Enclosure 17

NHS
The Dudley Group
NHS Foundation Trust

Safeguarding – achievements, challenges and opportunities

Julie Mullis – Head of Safeguarding




Trust Safeguarding Team

The Dudley Group NHS Foundation Trust

Head of Safeguarding

Lead Nurse for Safeguarding

Adult Safeguarding Team – Nurses and Lead Consultant

Children Safeguarding Team – Named Nurses, Midwife and Paediatric Consultant

Lead Nurse for Child Mortality

Safeguarding Administrators

CARE RESPECT RESPONSIBILITY

COVID-19 – Safeguarding Response

The Dudley Group NHS Foundation Trust

- "Business as usual"
- The hidden vulnerable
- Risk assessments
- Every contact counts
- Supervision

CARE RESPECT RESPONSIBILITY

Areas of outstanding practice

The Dudley Group NHS Foundation Trust

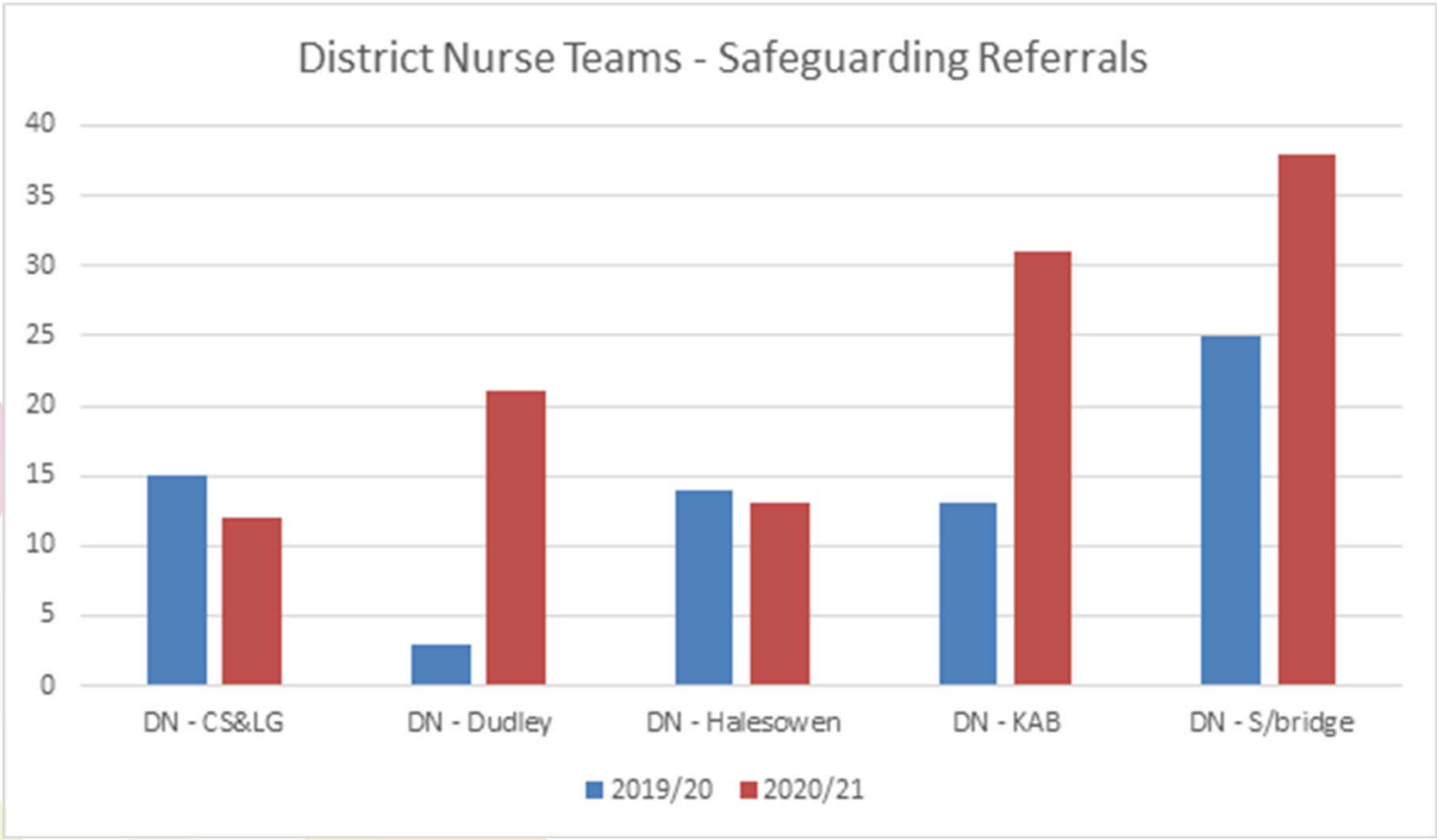
- Community Services

- Neglect/Self-neglect
- Domestic Abuse

- Supervision

CARE RESPECT RESPONSIBILITY

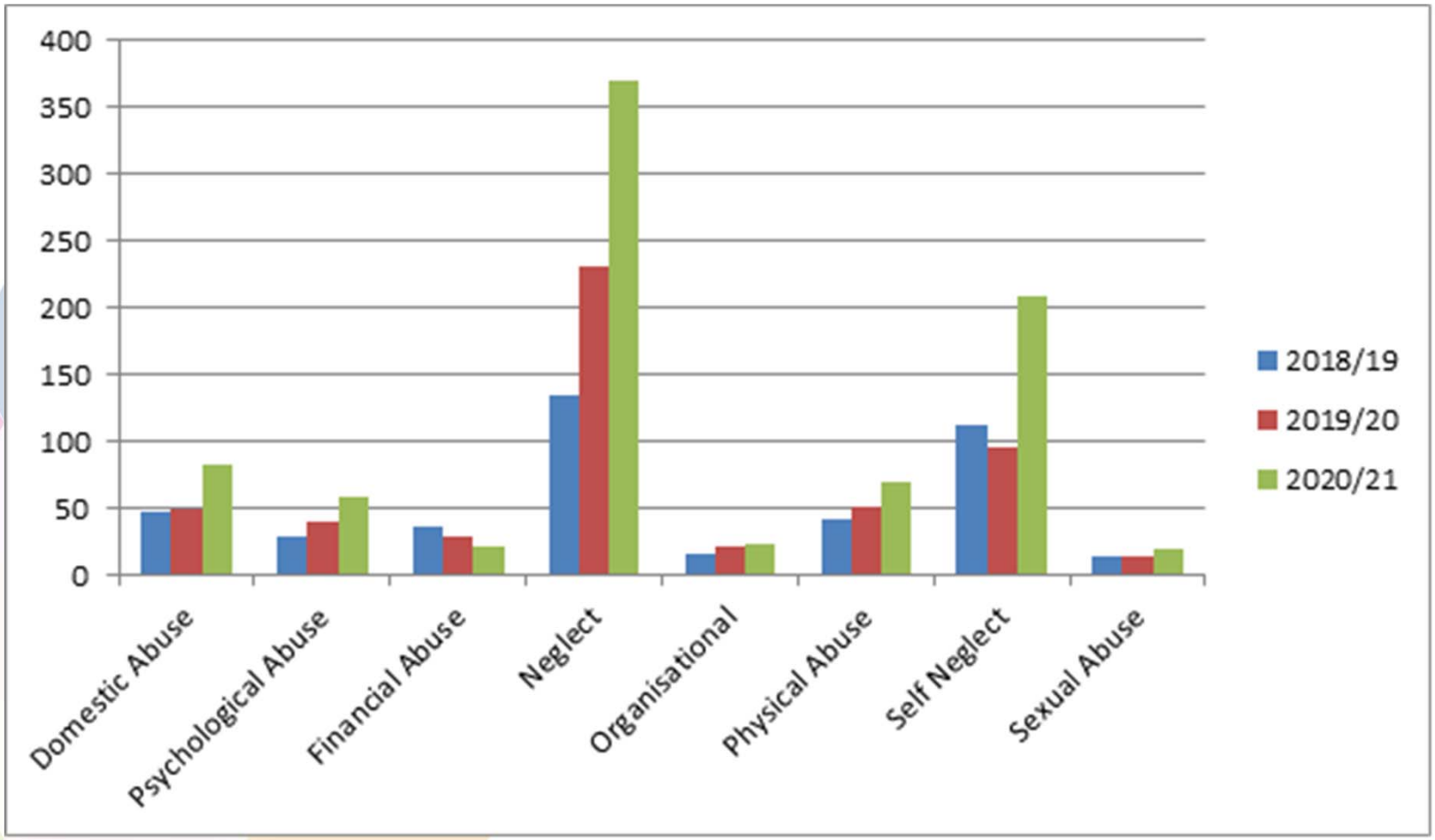
District Nurse Safeguarding Referrals



Source: Datix Reporting System

The Dudley Group
NHS Foundation Trust

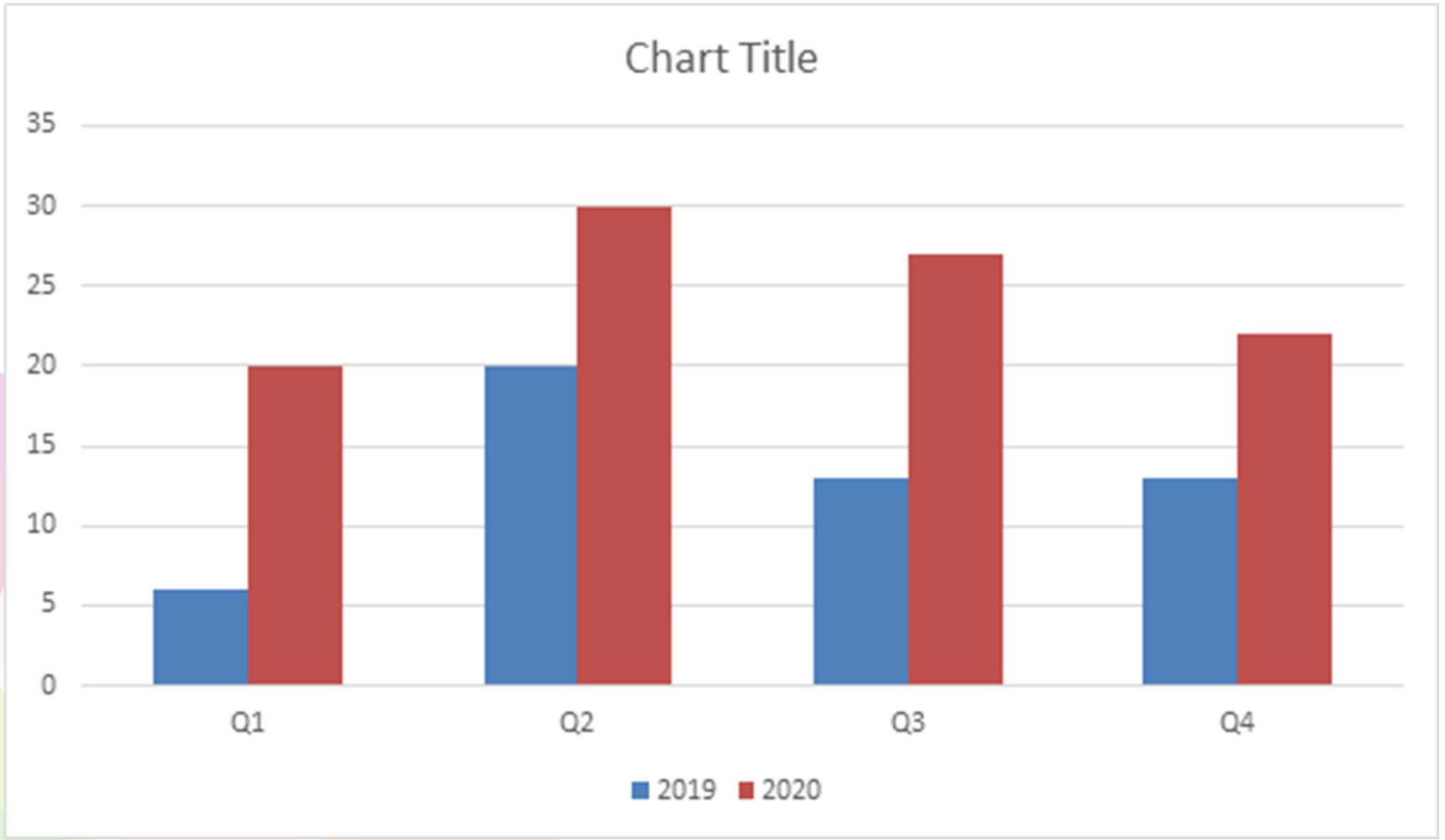
Safeguarding Adult Referrals by Category



Source: Datix Reporting System

CARE RESPECT RESPONSIBILITY

Domestic Abuse - Datix Submitted



Source: Datix Reporting System

Supervision and support

- Accessibility
- Visibility
- Building relationships
- Modelling practice
- Feedback
- Sharing learning

Challenges and Themes

- Liberty Protection Safeguards

- Mental Capacity Assessment

- Domestic Abuse

- Children Young People (CYP) Mental Health, Substance Misuse, Exploitation

LPS – Planning and Implementing
Actions and considerations

The Dudley Group NHS Foundation Trust

- Risk assessment
- Buy in from key internal players
- Staff resources
- Awareness raising and training
- Funding
- IT
- Documentation ?Sunrise
- Partnership working – internal and external
- Monitoring, incident reporting and audit
- Patient experience, patient feedback

CARE RESPECT RESPONSIBILITY

LPS - New roles & responsibilities

The Dudley Group NHS Foundation Trust

Medical staff:-

Assess capacity and mental disorder

Multi-disciplinary professionals:-

Skills and confidence to assess capacity and decide if actions are necessary and proportionate

Pre-authorisation Reviewer:-

Review patient assessments to ensure they meet conditions of LPS

Advanced Mental Capacity Professional:-

Review assessments and meet patient, as required

Responsible Body (The Trust):-

- required to authorise, monitor, report and regulate

The Domestic Abuse Act 2021
The role of Health Organisations and Professionals

The Dudley Group NHS Foundation Trust

- Health settings are trusted environments
- “critical” to ensure awareness about domestic abuse is embedded in the practices of all health settings
- Responsibility to support employees who are either victims or perpetrators of domestic abuse

CARE RESPECT RESPONSIBILITY

The Dudley Group NHS Foundation Trust
Domestic Abuse Strategy 2021 - 2023

The Dudley Group NHS Foundation Trust

Domestic abuse is the abuse of someone within a family or intimate relationship (including ex-partners). It is the repeated, random and habitual use of intimidation to control a person. Domestic abuse can incluse physical, coercive, emotional psychological, harassment and stalking, online/digital, financial, economic or sexual .

Domestic Abuse is one of the 10 Categories of Adult Abuse. Domestic abuse is an important part of the safeguarding work within the Trust and all staff are aware of their safeguarding responsibilities; to protect adults with care and support needs and children and young people from harm and abuse.

Our Vision	**All adults and children experiencing or witnessing domestic abuse will be seen, heard and supported. Everyone will be responded to with sensitivity and respect and care. We will protect dignity and confidentiality at all times.**
Our Principles	**Observe Ask Listen Respect Respond**

CARE RESPECT RESPONSIBILITY

Challenges into opportunities

The Dudley Group NHS Foundation Trust

DGFT Safeguarding Team

Head of Safeguarding

Complex Vulnerabilities Team	**Safeguarding Adults and Children Team**
Lead Nurse for Mental Health and Complex Vulnerabilities	**Lead Nurse for Safeguarding**
Lead Nurse for Learning Disabilities	**Lead Nurse for MCA/LPS complex vulnerabilities**
Learning Disabilities Nurses	**Associate Nurses for Mental Health**
LD and MCA/LPS Admin x 2	**SG and Child Protection/Death Admin x2**

Adult Safeguarding Team

- Named Nurse for Safeguarding Adults
- Domestic Abuse Coordinator
- Associate Nurse for Safeguarding Adults

Safeguarding Children Team

- Named Nurse for Safeguarding Children
- Lead Nurse for Child Mortality
- Named Midwife
- Associate Nurse for Safeguarding Children

Outcomes of re-structured service

- Integrated, flexible and co-ordinated service
- Strengthened accountability, governance and assurance
- Greater accessibility and responsiveness – 7/7
- Professional development, skill mix and succession planning
- Increased opportunities for shared learning and activities

Reachable Moments

The Dudley Group NHS Foundation Trust

- St Giles Charity to provide specialist youth service provision in ED

- **Aims:-**
- To "reach out" to CYP up to age of 25 years
- Identify gang/criminal related behaviour and exploitation
- Impact on mental health, substance misuse and violent injury

CARE RESPECT RESPONSIBILITY

The Future

The Dudley Group
NHS Foundation Trust

- Growing team for a growing safeguarding agenda
- Integrated approach, recognising complexity of patient vulnerabilities
- Responsive and proactive
- Sustaining partnerships
- Keeping Adults and Children safe from harm and abuse

CARE RESPECT RESPONSIBILITY

Enclosure 18

The Dudley Group NHS Foundation Trust

Paper for submission to the Board of Directors on 16th September 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 and decisions taken at the Acute Provider Collaboration Programme Board held on 22th July 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 issues considered and decisions taken by the Programme Board including the approval of a Memorandum of Understanding to support staff working across organisations, and endorsing a standardised rate for Waiting List Initiative payments.

Please note: there was no Board meeting in August 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: 16th September 2021**
	WORKING GROUP	**N**	**DATE: Acute Provider Collaboration Programme Board 22nd July 2021**
	COMMITTEE	**N**	

The Dudley Group NHS Foundation Trust

ACUTE PROVIDER COLLABORATION PROGRAMME

UPDATE TO THE BOARD

16th SEPTEMBER 2021

1. PURPOSE

The purpose of this paper is to provide an update to the Board on the Acute Provider Collaboration Programme.

2. KEY ISSUES AND DECISIONS TAKEN AT THE PROGRAMME BOARD MEETING ON 22ND JULY 2021

Clinical summit

The Programme Board agreed that this should go ahead on 24th July as planned, as a series of 16 concurrent seminars within a clinical summit environment. Please see update from CEO on success of the event.

ICS update

Matt Hartland attended to share progress on the development of the ICS. Programme Board members expressed strong support for place and asked how the CCG was progressing the transfer of staff to support new arrangements at place and in provider collaboratives.

It was suggested that governance around the ICS DOFs group needed to be strengthened and established as the ICS Finance Board. A discussion regarding contracting arrangements followed, with agreement to progress moving away from PBR to cost-based financial arrangements in order to protect provider collaborative from a significant deficit starting point.

Finally, the Board stressed the need to ensure NED engagement in design of future ICS structures and governance arrangements.

'Hot / cold' sites review

It was agreed that a specification should be drafted to bring in expertise to undertake a review of sites, to see what is possible in terms of unplanned / elective consolidation. This will be brought back to the Programme Board and onto to Trust Boards for sign off.

HR workstream

A proposal regarding a consistent approach to payments for Waiting List Initiatives was discussed. It was agreed that each organisation would cost a flat rate of £540 per session and test acceptability with LNCs as required. The next step is to explore locum rates.

An MOU to underpin staff working across different organisations was approved. This is a really positive step forward and will support service changes arising from the clinical and back office discussions.

Governance and implementation

An outline for the NEDs session was agreed. It was advised that this should not be in September; a date for October is being confirmed. The need for joint Executive development was also discussed. A plan will be developed.

It was also suggested that a session involving Health and Wellbeing Board / other Local Authority leads is planned for the New Year.

3. KEY NEXT STEPS

The next Programme Board meeting will be held on 23rd September. This will consider the output from the 2nd Clinical Summit, and a framework for how service changes should be prioritised. This will then enable us to develop a Clinical Strategy and start to engage with partners on the changes required.

The brief to explore 'hot/cold' sites will be presented for discussion. This will then need to be approved by Trust Boards.

The Board will also look at the recently published guidance on Provider Collaboratives, and the impact on the Programme governance.

A report is also due on options for how we work together on procurement, along with updates from all workstreams.

4. RISKS AND MITIGATIONS

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 continues to be committed to ensure its success in accordance with the refreshed Trust strategic plan.

5. RECOMMENDATIONS

To note the key issues discussed and decisions taken at the Acute Provider Collaboration Programme Board held on 22nd July 2021.

KATHERINE SHEERIN
DIRECTOR OF STRATEGY AND TRANSFORMATION
SEPTEMBER 2021

Enclosure 19

The Dudley Group NHS Foundation Trust

Paper for submission to the Board on 16th September 2021

TITLE:	**The Dudley Group NHS Foundation Trust Strategic Plan 2021 – 24: Shaping#OurFuture**		
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		

RECOMMENDATIONS

To approve the Trust's Strategic Plan 2021-24 and to note the details regarding the formal launch.

To note the next steps regarding developing a robust implementation plan and aligning the Board Assurance Framework with the Strategic Plan goals.

CORPORATE OBJECTIVE:

SO1, SO2, SO3, SO4, SO5, SO6

SUMMARY OF KEY ISSUES:

1. **Background**

During the past year, significant work has been undertaken to produce the Trust's new Strategic Plan for 2021-24.

This has taken account of the changing national context in relation to how the NHS will operate as set out in the recent Health and Care Bill, with a new climate of partnership working rather than competition; the impact of Covid in terms of both transformational changes and new challenges in access to care; the need to have a greater focus on addressing health inequalities; the need to ensure we have a happy, well-motivated, secure workforce both now and in the future; the economic outlook.

This involved extensive work with Board members, Governors, the Executive Team, staff, and partners, including the Health and Wellbeing Board and a successful event with local 3rd sector organisations and patient representative groups.

2. Next Steps

Once approved, a formal launch is planned for 4pm, Thursday 30th September 2021. This will be led by the Chief Executive with staff and partners invited. A full communications plan is being produced to include a public facing summary document and video clips for social media platforms etc.

Work is underway to present a detailed implementation plan to the Executive Team and Board in September / October, with clear governance arrangements to ensure that the goals are met and transformation programmes are delivered.

Alongside this, work has commenced to review the Board Assurance Framework. A development session for the Board to work this through is planned for October 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**
	NHSEI	**Y**	**Details:** National Guidance
	Other	**N**	**Details: White Paper / Health and Care Bill / etc**
REPORT DESTINATION	**Board of directors**	**Y**	**DATE: Various**
	WORKING GROUP	**N**	**DATE: Various**
	COMMITTEE	**N**	**DATE:**

NHS
The Dudley Group
NHS Foundation Trust

Shaping #OurFuture

Strategic Plan
2021-2024

Contents

1 Welcome from chairman and chief executive

It is a privilege to lead The Dudley Group NHS Foundation Trust. We have such talented, committed and dedicated staff, delivering incredible care to patients, day after day. We are privileged to serve a wonderful community, whose generosity and support has been more apparent than ever during 2020/2022.

During the three years to 2021, we have seen some fantastic achievements in our Trust. Major investments have been made across the organisation, including in the Emergency Department, at Corbett and Guest outpatient centres and in our digital capacity, and we are proud of the significant improvements to the quality and safety of services which have been delivered. The dedication to continuous improvement is evident in the progress that has been made.

COVID-19 has, of course, impacted all parts of the organisation and continues to do so. Now, more than ever, we need to support our staff and enable them to thrive as members of the team in The Dudley Group. We are committed to ensuring that our services are inclusive and that all people in our communities have good access to care so that we can contribute to improving health outcomes and reducing inequalities.

We welcome the changes to the NHS environment, and will play a major role in collaborating with our partners to deliver the best services both within Dudley, and in the Black Country and West Birmingham and beyond. We are working hard to deliver our responsibilities as an anchor institution, through creating wealth and jobs in the local community.

This three-year Strategic Plan sets out our vision and ambitious goals and describes how we will achieve them. Our actions are driven by our values - care, respect and responsibility.

We are excited by the opportunities for The Dudley Group NHS Foundation Trust – and we believe that with our fantastic teams and wonderful local communities we will achieve so much together.

Dame Yve Buckland
Chairman

Diane Wake
Chief executive

We have such talented, committed and dedicated staff, delivering incredible care to patients, day after day.

2 Introduction

The 18 months from March 2020 were like no other for the world, the country and the NHS. By June 2021, the global pandemic claimed 3.7m lives globally, and 128,000 lives in the UK. The NHS response was fantastic, with staff commitment and expertise shining through. However, the impact of COVID-19 on care for people with other conditions, and the anticipated economic downturn will have a significant impact on the NHS for years to come.

It was a time of great uncertainty in terms of our relationship with Europe and how this will impact on society and public infrastructure. And specific to the NHS, were in a time of changing orthodoxy, with a move away from the competitive market, which has been in place for 30 years, to integration and partnership working across organisations. Locally, this manifests in two significant developments for the Trust – far greater collaboration with other hospitals across the Black Country and West Birmingham, and far greater integration of preventive, primary care, community, hospital and social care services within Dudley.

We now need to look ahead, and to shape how The Dudley Group NHS Foundation Trust moves forward as an organisation.

This strategic plan sets out our vision, values and goals and embeds how we ensure that we are an inclusive organisation, for staff, patients, families and local communities. It recognises the significant role that The Dudley Group can play as an anchor institution, and the benefits this can bring to the local economy and, in turn, to local people. And it puts improving health outcomes and addressing health inequalities at the core of what we do.

This strategic plan gives us a framework for how we will shape our future as an organisation, and best serve our patients, staff and people.

3 About The Dudley Group NHS Foundation Trust

The Dudley Group NHS Foundation Trust (DGFT) provides acute and community services to the population of Dudley and to other parts of the Black Country, West Birmingham, South Staffordshire and North Worcestershire. We also provide a range of specialist services, some of which are accessed by patients from across the UK. These include vascular surgery, endoscopic procedures, stem cell transplants and specialist genitourinary reconstruction.

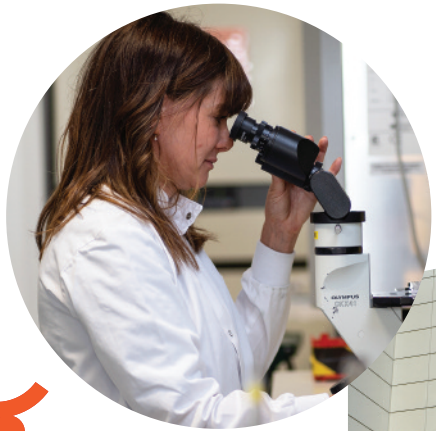
Our staff are our greatest asset. We have a workforce of around 4,400 whole time equivalent (WTE) staff making us the second largest employer in Dudley.

Russells Hall Hospital has more than 650 beds, including intensive care beds and neonatal cots. The hospital provides secondary and tertiary services such as maternity, critical care and outpatients, and an Emergency Department that features a brand new Emergency Treatment Centre.

The Guest Outpatient Centre in Dudley and Corbett Outpatient Centre in Stourbridge provide a range of outpatient and day case services.

We currently provide a full range of community services including adult community nursing, end of life care, podiatry, therapies and outpatient services in people's homes and from a range of community venues across the borough.

We are a designated teaching hospital of the University of Birmingham with more than 100 undergraduate medical students undertaking placements with us. We provide placements for nursing, allied health professionals and technicians from local universities. We have an active research and development team.



A typical day at The Dudley Group

300 people attend the Emergency Department

2,000 people have an outpatient appointment – either in person or via telephone/video

12 babies are born

Over £1m of expenditure, **60%** is our staff

When the NHS was established in 1948, The Dudley, Stourbridge and District Hospital Management Committee was created to oversee the running of all hospitals in the borough. There were hospitals at Wordsley, The Guest, Burton Road and Corbett. Russells Hall Hospital was opened in 1984 by Princess Anne with 400 beds. Following a major re-organisation of the NHS in 1991, The Dudley Group of Hospitals NHS Trust was formed in 1994, managing all acute services in Dudley and Stourbridge. In 1996 plans for the future development of hospital services were approved with an extension of Russells Hall Hospital and the re-distribution of services at Wordsley to Russells Hall Hospital, Guest and Corbett.

By 2005, the new Guest and Corbett Hospital Outpatient Centres along with all phases of the new Russells Hall Hospital were complete. A Clinical Research Unit was opened in 2008 and the Trust became a foundation trust on 1st October 2008. This gave local people the opportunity to become members and have a greater say in the development of local services. In April 2011, more than 500 staff from Dudley Adult Community Services joined the Trust as part of the government's Transforming Community Services programme.

The Trust became the specialist centre for vascular surgery in The Black Country in 2013. In 2018, a brand new Emergency Treatment Centre was opened next to the Emergency Department at Russells Hall Hospital and a new imaging suite was opened at The Guest Outpatient Centre for patients requiring MRI or CT. Our next big development was the opening of a brand new, purpose built Acute Medical Unit in 2021 which offers state of the art care for patients and improved the quality of urgent care for patients in hospital.

The Trust currently has an overall rating of 'Requires Improvement' by the Care Quality Commission (CQC), with a rating of 'Good' for effective and caring and 'Inadequate' for safety. This rating is based on the inspection carried out in Jan/Feb 2019. Routine inspections from CQC were suspended during the COVID pandemic but the Trust did receive a focused inspection of the Emergency Department in February 2021. This resulted in the safe domain being changed from 'Inadequate' to 'Requires Improvement'.

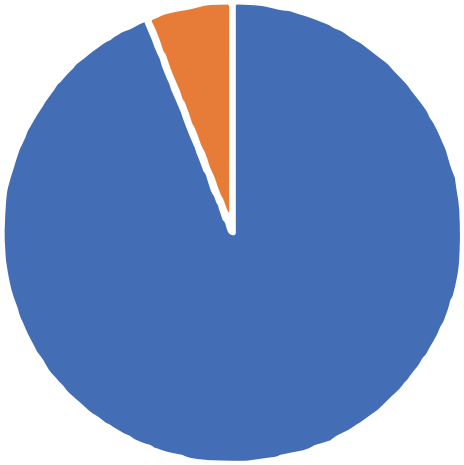
Many staff have been engaged in action to improve compliance against standards. Following the December 2017 inspection, CQC issued four Section 31 enforcement notices although none of these placed any restrictions on the Trust's licence. Due to the efforts of staff, all enforcement notices have now been removed.

The CQC launched its new strategy in June 2021. In the future there will be an increased focus on how services are working together within an integrated system and whether the care provided is improving outcomes for people and reducing inequalities in their care.

The Dudley Group is a combined acute and community trust and is classified by NHS England as a medium acute trust. Income comes mainly from our commissioners (local Clinical Commissioning Groups and NHS England for certain specialised services) but the Trust also earns income from the training of healthcare professionals and from research. Over the last three years, Trust income has been:

2018/19	2019/20	2020/21
£372.7m	£411.9m	£450.4m

Income from hospital and community services



Expected income in 2021/22 is £456.4m. The increase has been due to a number of factors including additional funding provided to manage the COVID pandemic including resources for the vaccination programme.

4 Our context

Over the coming years, the care that we provide and the way that we provide it will continue to be shaped by the national, regional and local factors that impact on us, in particular the on-going impact of COVID-19. Given the uncertainties, we know that circumstances may change and the expectations on us will be different from what they are today. The following section describes the main things that, to the best of our knowledge, will influence the Trust over the next three years.

About Dudley and the Black Country

It is important that we understand the diverse needs and expectations of the local population. Using intelligence from Dudley Metropolitan Borough Council and Public Health England, we have been able to summarise the health status of the communities we serve and how this is predicted to change.

About Dudley:

- The population of the Dudley borough was estimated to be 320,600 (in 2019), with 65,000 people aged over 65 years.[1,2]
- Residents in Dudley are, on average, older than England's population.
- Life expectancy for men in the most deprived areas of Dudley is nine years lower than in the least deprived areas, 7.2 per cent lower for women.[1]
- Almost a third (28%) of the Dudley population live in areas amongst the 20 per cent most deprived in England.[1]
- Levels of GCSE attainment, breast feeding and smoking in pregnancy are worse than the England average.[3]
- The rate of hip fractures in older people (aged 65+) is worse than the England average. The rates of homelessness, under 75 mortality from cancer and employment are worse than the England average.
- Levels of obesity, including child obesity, and physical activity are worse than the England average.[4]
- Figures from Public Health England showed that there were almost 2000 admissions to hospital for alcohol-related conditions. Dudley borough has a higher mortality rate due to alcohol than the England average.[5]
- There is a higher prevalence of hip and knee osteoarthritis than the England average.[6]
- In Dudley, people aged 65 and over are currently in a care home with or without nursing.[6]

How is this expected to change?

- Life expectancy and the number of elderly people will continue to rise. The number of people aged 85 and over in Dudley is expected to increase from 8,300 in 2018 to 9,500 in 2025.[7]
- There will be more people with multiple, complex and long-term health conditions.
- There will be a growth in the number of people with disabilities and mental health issues.
- Following a period that has seen the number of births decrease, this is expected to stabilise and even increase slightly.
- Residents of Sandwell Borough in Rowley Regis and Tipton will continue to make use of our services and even more Sandwell residents may choose us following the opening of the Midland Metropolitan University Hospital in 2022.

The Dudley Health & Wellbeing Board provides leadership for Dudley's health and care system. Using local evidence, it works to identify the needs of local residents, improve efficiency and secure better care to improve health and wellbeing and tackle health inequalities across the borough. The Health and Wellbeing Strategy (2017 – 2022) is about how to make Dudley a place where everyone can live 'longer, safer and healthier lives'. The three goals that have been identified as having the biggest impact on people's health and wellbeing are:

1. **Promoting healthy weight**
2. **Reducing the impact of poverty**
3. **Reducing loneliness and isolation**

We clearly have a role to play in achieving these goals and the steps we plan to take are set out later in this document.

References

1. Dudley Metropolitan Borough Council. Dudley Borough in numbers 2019
2. Dudley Metropolitan Borough Council. Older People in Dudley
3. Dudley Metropolitan Borough Council. Understanding Dudley
4. Public Health England. Local Authority Health profile 2019
5. Public Health England. Local Area Profiles
6. Dudley Metropolitan Borough Council. Older People Market Position Statement 2019 – 2022
7. Office for National Statistics. 2018-based population projections

It is clear that there are significant inequalities faced by the people of Dudley, both between Dudley and the rest of England and within the borough. As a major employer and provider of health care services, we recognise the major role we must play to address these inequalities.

A changing context

The NHS Long Term Plan (published in January 2019) set out a ten-year plan for reform and signalled how the NHS would need to change in response to changing health and care needs. The main areas in which improvements will be delivered were:

- The development of out of hospital care to ensure that more patients can be seen in primary and community care settings.
- A reduction in the pressure on emergency hospital services.
- Delivery of high quality person-centred care with improved outcomes.

Key to the Long Term Plan was the development and implementation of Integrated Care Systems across England. This is where NHS organisations and local authorities work together to meet the needs of the population they serve.

The Government White Paper 'Integration and innovation: working together to improve health and social care for all' (February 2021) sets out proposals for changes in the law that will make this a reality. Integrated Care Systems will replace Clinical Commissioning Groups and new duties will be placed on all NHS organisations to collaborate and deliver the 'triple aim' to support better health and wellbeing for everyone, better quality of health services for all and sustainable use of NHS resources.

For us, this means that we will continue to be an NHS Foundation Trust, delivering services for the people of Dudley and surrounding area and remaining accountable to them through our governors and members. We will still be responsible for the quality of services and the way in which we use our resources. But we will play an increasingly important role in integrating services in our 'place' (Dudley) and our 'system' (The Black Country and West Birmingham), and take more responsibility for ensuring that services across organisations are sustainable and of the highest quality.

Our system

The Black Country and West Birmingham Integrated Care System (ICS) is known as 'Healthier Futures'. Like other ICSs in England, the Black Country and West Birmingham is preparing for the expected legal changes that will enable it to become a statutory organisation from April 2022.

The White Paper makes it clear that all NHS providers are expected to be part of provider collaboratives. This will mean that we will work much more closely with the other acute hospital trusts in the Black Country and with providers in Dudley.

Across the Black Country and West Birmingham, we have some good examples of collaboration already, for example:-

- The Trust has a shared procurement function with Sandwell & West Birmingham Hospitals NHS Trust.
- In 2018, the four acute hospital trusts in the Black Country came together to create The Black Country Pathology Service, hosted by The Royal Wolverhampton Trust. Under this arrangement, staff and resources are managed centrally to give better value for money, reduce duplication and improve both efficiency and quality.
- Working together also helps to address workforce shortages and recruit and retain clinicians with specialist expertise. In several specialties, consultants already work at more than one hospital, ensuring services are available locally. Vascular Surgery is an example of this, where consultants from both Wolverhampton and Walsall provide specialist surgery at Russells Hall Hospital and consultants from Russells Hall provide outpatient clinics at Wolverhampton and Walsall.

Over the coming three years, we expect to see these type of arrangements extended to other services, and we have already started a formal programme of acute collaboration with our neighbouring trusts in the Black Country and West Birmingham.

We recognise that this needs to be clinically-led and demonstrate benefits to patients. At the time of the publication of this strategy, the CQC ratings for hospital trusts in the Black Country show that only one of these (Wolverhampton) was rated Good with the remaining three, including The Dudley Group, as Requires Improvement. Any collaborative effort between the hospital trusts must focus on how this can be improved.

During the lifetime of this strategy, one of the most significant changes to hospital services in our region will be the opening of the Midland Metropolitan University Hospital, managed by Sandwell & West Birmingham Hospitals NHS Trust. The state-of-the art facility in Smethwick will replace many of the inpatient services currently located at Sandwell and City Hospitals, with a scheduled date for opening in 2022. The Dudley Group Trust will need to work closely with Sandwell & West Birmingham Hospitals and the ICS to monitor the impact of this change, particularly for emergency care following the closure of the Emergency Department at Sandwell.

Our place

The direction set out in the White Paper and the NHS Long Term Plan requires all parts of the NHS to work towards better integration of services: integrating primary health care and hospital services, physical and mental health, health and social care. The ICS in the Black Country and West Birmingham identified five 'places' where models of integration are being developed. Each place has developed different approaches to this, with the same ultimate goal in mind.

In Dudley, the local clinical commissioning group and the Dudley Metropolitan Borough Council have commissioned an Integrated Community Provider (ICP) for Dudley. A new NHS trust, Dudley Integrated Health and Care (DIHC), has been formed to provide an organisational home for the ICP.

The Dudley Group is working with DIHC, Black Country Partnerships Mental Health Trust, the local authority and local GPs to take this development forward and to ensure that services are integrated around the needs of patients, regardless of organisational form.

COVID and beyond

The COVID pandemic gave the NHS its greatest challenge in its 73 year history. The NHS was widely praised for its response in managing the pandemic and was able to treat those who needed treatment after becoming seriously ill with COVID-19. This was our experience in Dudley; staff worked incredibly hard and, wherever they were needed, to ensure that care could be provided. But this was achieved by cancelling many routine operations, diagnostic tests and outpatient clinics with many of the latter moving to video or telephone consultations. There was a marked deterioration in waiting times. The Trust worked hard to restore services to restore services within the constraints of social distancing and the additional infection prevention and control measures that were required to keep staff, patients and visitors safe. It was clear from the advice being given to us by national bodies, such as NHS England, and Public Health England, that we will need to learn to live with COVID-19 for some time to come. Whilst we celebrated the rapid development of effective vaccines and the success of the vaccination programme, there were concerns about new variants and the potential for local outbreaks, especially during the winter months.

The COVID pandemic put some of the ambitions in the NHS Long Term Plan into sharper focus. The development of 'out of hospital' options for patients became even more pertinent to minimise the risk of further spreading infection by requiring patients to attend in person.

The more patients we can treat without admitting them to hospital, or with a brief one-day visit, the better. Before the pandemic, the Trust had been allocated £20.3m of capital funding to rebuild the Emergency Department at Russells Hall Hospital to improve patient flow and provide sufficient space for critically ill patients.

Following the government's announcement of additional capital funding to support the NHS manage the pandemic, the Trust received funding to enable the construction of a two-storey modular build at Russells Hall Hospital. This space enables different assessment areas and will enable different assessment areas to be centralised in one place. One of the key service changes envisaged in the NHS Long Term Plan was the expansion of 'Same Day Emergency Care' whereby instead of admitting patients to a hospital ward, patients are assessed in a designated assessment area with rapid access to diagnostic tests if they need them. In many cases, they will be discharged back home with a support package in place. There were a number of assessment areas located on the ground floor of Russells Hall Hospital. The additional space provided by the modular building enabled these assessment areas to be co-located in the same place and to improve the flow of patients through the hospital.

All NHS trusts were asked to create separate zones within their hospitals and other facilities to minimise the risk of patients contracting the virus as a result of attending an appointment for another reason. Increasingly, we will need to think about how we separate planned and emergency care. This includes diagnostic tests such as blood tests, X-rays, MRIs and CTs. We will need to consider how to minimise the number of people coming to Russells Hall Hospital and make greater use of our other facilities and those run by primary care, such as health centres.

The NHS Long Term Plan ambition to reduce the number of face-to-face outpatient attendances by up to 30 per cent by 2023/2024 through the re-design of outpatient pathways and using digital technology was achieved within the space of a few months. By 2021, a third of all outpatient attendances were delivered virtually. Feedback from patients has been positive. They appreciated the convenience and the reduction in the burden placed on those who care for them. There were concerns that some patients may not find it easy to adjust to these new ways of working and that sufficient steps are taken to ensure that no group of patients is disadvantaged.

The NHS Long Term Plan spoke about the need to reduce health inequalities between different populations. The issue of health inequalities was brought to the fore through the global experience of the pandemic. We know that the outcomes for certain ethnic minorities was worse than the general population, although the reasons for this are still be investigated at a national level. Locally, we know that there is notable inequality in health outcomes with those in the most deprived areas of our community, experiencing lower life expectancy than those in the least deprived areas.

The pandemic saw sudden changes to the way in which the Trust is funded. Prior to the pandemic, the Trust was paid by its commissioners based on the amount of patients it saw. During 2020/21 and 2021/22, the Trust was allocated fixed amounts based on historic funding levels and funding to meet the additional costs of managing the pandemic. Whilst the funding arrangements for future years have not yet been finalised, all the indications are that NHS trusts will receive fixed funding amounts and our ability to earn additional income will be limited. This has forced us to look ever more closely at how we can manage our resources. We will need to ensure that patients who can be seen in alternative ways or settings do not take up precious space and resources that are required for the sickest patients.

The experience of managing the pandemic also highlighted the vital role placed by social care in the overall health and care system. The disparity in the public perception between social care and the NHS was thrown into sharp relief, including the low pay for many care workers. There have been calls for a national level funding arrangement for social care accompanied by a long-term plan, similar to that agreed for the NHS. There has, to date, been no public commitment given on social care, and it remains a sensitive political topic. What is clear is that the number of people likely to require social care is expected to grow and the amount of support they require intensify. Any failures of the local social care system will have a direct impact on the NHS through increased pressures on primary care teams, community services and, ultimately, hospitals.

The next section of the document describes how we will respond to this changing and challenging environment. It sets out our vision, values, goals, measures of success and major programmes of work.

Shaping our future

NHS
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Vision

Excellent health care, improved health for all

Values

CARE

RESPECT

RESPONSIBILITY

Goals

Deliver right care every time	To be a brilliant place to work and thrive	Drive sustainability	Build innovative partnerships in Dudley & beyond	Improve health and wellbeing

Measures of success

Care Quality Commission good or outstanding Improve patient experience survey result	Reduce the vacancy rate Improve the staff survey results	Reduce cost per weighted activity Reduce carbon emissions Financial and environment	Increase the proportion of local people employed Increase the number of services jointly delivered across the Black Country	Improve rate of early detection of cancers Increase planned care and screening for the most disadvantaged groups

Programmes

Black Country system service transformation	Local leadership to address health inequalities	Research and development, education and innovation

Dudley Improvement Practice

Our vision

Excellent health care, improved health for all

Our new vision is designed to be simple and memorable. It combines our desire to deliver excellent care for our patients but also recognises the impact that we have on the health of the wider population.

Our values

Our values support our vision and define how the Trust and every member of staff will work to deliver the best care possible. The current values were adopted by the Trust in 2015.

Staff told us that these values helped them during the COVID pandemic, providing a framework for them and what they expected from others.

The values are embedded into our local processes. They form part of the recruitment process and are included in annual appraisals, and this helps to keep them live and relevant.

We, therefore, believe that these values will still be relevant to us as we look ahead over the coming three years.

we provide safe, quality healthcare for every person – every time

we show respect for our patients, our visitors and each other – at all times

we take responsibility for everything we do – every day

Our goals

We have identified five goals, the pursuit of which will guide all that we will do.

Deliver right care every time – our desire to deliver care that is safe and effective. Where mistakes are made, we will learn from these and improve for the future.

Be the best place to work and thrive – we want to be recognised by our staff as the best place to work and to offer them opportunities to grow and develop regardless of who they are.

Drive sustainability – includes financial sustainability in the way in which we use resources and become more productive and environmental sustainability, recognising the responsibility we have in reducing the harmful impact our activities have on the environment.

Build innovative partnerships in Dudley & beyond – includes partnering with other acute trusts in the Black Country, health and social care organisations, the voluntary sector in Dudley, local academic institutions and others who can help us achieve our goals.

Improve health and well-being and reduce inequalities – prioritising investment in areas which are likely to have the biggest impact on health outcomes and reducing health inequalities.

Our measures of success

We will monitor our progress against delivering the goals in this strategy through a small number of measures. In designing these measures, we have adopted the approach used by the Dudley Improvement Practice, namely that our measures should reflect four domains: delivery, quality, cost and morale.

Deliver right care every time	• CQC Good or Outstanding for all services • Improved clinical outcomes / reduced never events
Be the best place to work and thrive	• Vacancy rate • Staff survey results
Drive sustainability	• Cost per weighted activity unit • Carbon emissions
Build innovative partnerships in Dudley and beyond	• Increase the proportion of local people employed • Increase the number of services jointly delivered across the Black Country
Improve health and well-being and reduce inequalities	• Improve rate of early detection of cancers • Increase rate of planned care and screening for the most disadvantaged groups

What we are going to do?

In developing this Strategic Plan, we identified three transformational programmes of work that will help us make progress in achieving our goals.

Programme	Description
Transform the delivery of services	• In the aftermath of COVID, restore activity levels as quickly as possible; recover elective waiting times and diagnostic waiting times in accordance with national standards; embed the changes to services that were made during COVID. • Implement changes to the urgent and emergency care pathway to provide increased capacity to manage peaks in demand and improve flow through the hospital. • Recover cancer waiting times in accordance with national standards; re-design pathways to reduce delays to diagnosis and treatment; provide specialist treatment to patients with skin, breast, colo-rectal and urological cancers. • Deliver effective, accessible and sustainable acute care services for the Black Country and West Birmingham by optimising clinical outcomes, securing sustainable services delivered by a robust workforce, maximising efficiency and addressing inequalities in access and outcomes.
Realising the benefits of being an anchor institution and addressing health inequalities	• Use the Trust's scale, purpose and roots in Dudley to address the challenges faced in addressing the wider determinants of poor health and inequalities, a credible sustainability agenda and the integration of health and care services. • Address health inequalities through embedding a population health approach to service re-design, informed by evidence of local population health needs. Increase the use of population data in decision-making by staff at all levels.
Research and Development, Education and Innovation	• Promote participation in research and education by staff at all levels by developing closer relationships with local universities and colleges; promoting the adoption of innovative treatments and the use of technology to support the delivery of care.

Our underpinning strategies and plans

The Trust has a number of strategic documents that underpin and support the delivery of our vision, values and commitments. We intend to use the development of this Strategic Plan to reduce the number of underpinning strategies, simplify them and ensure that they align to this Strategic Plan.

The Dudley People Plan (our workforce strategy) has five areas of focus:

- A workforce for now and for the future
- A caring, kind and compassionate place
- Equality, fairness and inclusion
- Improvement and development culture
- Using technology to innovate

This plan will evolve in light of the changing national agenda and the expectations of the Integrated Care System (ICS).

Clinical Services Strategy

This strategy sets out how the Trust proposes to develop, organise and deliver its clinical services which will ultimately lead to improved quality, patient access, clinical outcomes and patient experience. The Clinical Services Strategy 2017 – 2020 is due to be revised and further work is needed to set out in more detail how out clinical services will develop. Clinical support services (e.g. pharmacy, imaging, pathology and therapies) will be included in the development of this strategy since they are vital to the development of our clinical services.

The Clinical Services Strategy will be affected by the changes in our local context that have already been discussed. The Integrated Care Provider will impact the provision of community-based services. The development of the Integrated Care System (ICS) in the Black Country and West Birmingham and the Acute Provider Collaboration will affect the services we provide in the future and how these will be managed. There are also national guidelines and changes in healthcare technology that will need to be considered.

Our approach to quality improvement, including the use of the Dudley Improvement Practice, will be included within this strategy. This will update our existing Quality Improvement Strategy and Patient Safety Strategy and will set out how we intend to improve the quality of care and achieve improved ratings on the CQC inspection.

Estates Strategy

The Trust's Estates Strategy 2018 – 2020 is due to be revised. Development of a new strategy will take place during 2021 due to the need to agree the type of clinical services to be provided before decisions can be taken about the estate required to deliver these services. The new strategy for estates will need to align with the ICS Estates Strategy and national plans. It is likely that access to significant capital funding will continue to require agreement across our partners in the ICS.

The key themes of the new Estates Strategy are expected to include:

- Redevelopment of our Emergency Department
- The modular building and co-location of all assessment areas to deliver Same Day Emergency Care
- Development of additional theatre capacity including a hybrid theatre at Russells Hall Hospital
- Maximising the use of Guest and Corbett
- Reconfigure space to meet the requirements for social distancing and designated COVID-free areas
- Reconfigure space used by back-office functions as a result of increased remote-working
- Assessing the impact of the Electronic Patient Record on storage requirements for paper-based patient records
- Development and investment in schemes to de-carbonise our estate
- Maximising our green space to promote biodiversity and enhance patient and staff well-being.
- Aligning our estate to the developments of the ICP and ICS

Digital, data and technology plan

The Trust has recently updated its Digital and Technology Strategy 2019 – 2024 reflecting changes made as a result of managing the pandemic. The Digital Trust vision for 2024 is:

1. To become an interactive digital trust, where citizens have digital access to services, to contribute and participate actively in their health record – so they may better manage their health. In doing so, we will protect privacy and give citizens control of their medical record.
2. To become a digitally enabled organisation, where, as a workforce, we are able to embrace technology to support different ways of working so that we may access the information we need wherever we are.
3. To become a data-driven healthcare partner, where decision support and artificial intelligence (AI) help limit unwarranted variation whilst genomic data, predictive techniques and co-authored care plans enable personalised care.
4. To be known as a responsible digital leader, in our approach to delivering national standards in data security, cybersecurity, interoperability and workforce development.
5. To become a provider that will not need a 'digital strategy', as technology will be adopted as mechanism for innovation to meet the core Trust Strategy.

The three fixed point strategic objectives are:

- **Brilliant Basics** – creating a secure, safe environment where equipment, access and service do not create barriers to care provision
- **Digital First** – creating a place that embraces innovation with a workforce skilled to deliver different ways of working, so that teams can deliver safe, caring efficient services and board development of digital confidence
- **Connected Care** – creating a place where teams across the borough are joined up around our citizens to improve outcomes, prevent ill health and link together as a regional health and care system

Financial Strategy

Stewarding the financial resources that we are responsible for is key to the successful delivery of our strategic commitments and to enable us to operate as a going concern. In the new financial regime we are likely to find ourselves in, we will inevitably need to focus on the elimination of waste. We will need to deepen existing partnership, and develop new ones, in areas such as the purchasing of good and services and developing new workforce models that reduce our dependency on high-cost temporary staffing.

Green Plan

The Trust approved a plan in December 2020 to respond to the ambitions of the NHS to become the world's first net zero carbon health system. The plan sets out actions the Trust plans to take, in conjunction with our PFI partners, who own and manage much of the estate we use, to reduce the carbon emissions associated with our activities.

Given the breadth of this agenda, the Board has requested that for the first two years of the plan, the Trust focuses efforts on energy consumption and the management of waste, including recycling. This includes reviewing the supplies and equipment we purchase with the aim of reducing single-use items.

The plan commits the Trust to provide regular updates on progress and to partner with staff, other NHS organisations in the ICS, the council and others.

Research and Development Strategy

The Trust has a vision to develop, across the Trust, a high-quality research culture where research will be integrated into the routine clinical care of our patients and seen as everybody's business.

The strategy (2018 – 2021) has the following goals:

- Foster a research culture across the whole organisation and in all staff groups
- Become a fully research active organisation
- Optimise research capability and capacity
- Further enhance partnerships between industry, academia and the Trust to improve the delivery of our research portfolio
- Improve patient experience by providing the opportunity and choice to participate in research all possible specialties in our organisation

6 Implementing our Strategic Plan

This Strategic Plan sets out our goals and what we are going to do from 2021 to 2024 at a high level. Our approach will be to create a culture of continuous improvement, known locally as the Dudley Improvement Practice (DIP).

In 2018, we made a long-term commitment to building a system for continuous improvement and were selected by NHS England and Improvement to be part of the first national cohort in the Vital Signs programme. Supported by NHSE&I, eight trusts have co-produced an approach to developing a culture of continuous improvement which is founded on supporting and empowering staff to improve the services they are passionate about.

Strategy deployment

All improvement activity supported by Dudley Improvement Practice (DIP) is aligned to the Trust's vision and goals which describe the state of perfection that we continually strive towards. Each division, department and team will use the vision and goals to guide their improvement efforts by defining breakthrough objectives specific to their work area. Using a structured process (known as A3s) for each project as a standard problem-solving tool, and a ward to board reporting information cascade of virtual or physical improvement boards and team huddles, every member of staff will know how their work is contributing to the strategy.

7 References

The Black Country and West Birmingham STP. 20118. Clinical Strategy Clinical Case for Change.

The Health Foundation. August 2019. Building Healthier Communities: the role of the NHS as an anchor institution.

NHS England. December 2020. Next Steps to building strong and effective integrated care systems in England.

Department for Health and Social Care. February 2021. Integration and innovation: working together to improve health and social care for all.

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Enclosure 20

The Dudley Group NHS Foundation Trust

Paper for Submission to the Board of Directors 16th September 2021

TITLE:	Quality and Safety Committee 27th July 2021 and 24 August 2021		
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:**22/06/21 Quality and Safety Committee

CHAIRS LOG

UPWARD REPORT FROM QUALITY AND SAFETY COMMITTEE

The Dudley Group NHS Foundation Trust

MATTERS OF CONCERN OR KEY RISKS TO ESCALATE	MAJOR ACTIONS COMMISSIONED/WORK UNDERWAY
• In Maternity the challenges in respect of the medical and midwifery workforce and the actions being taken to address. • Challenges in respect of ward rounds being completed earlier in the day to facilitate early discharge for patients. • Challenges across maternity with an increased workload over the previous 2 months with demand. Assurance was received this had not resulted in an increase in patient safety incidents. • Challenges in respect of the increase in admissions of children and young people with mental health needs, the complexity of cases and the impact on length of stay due to non-availability of Tier 4 beds and or social care placements.	• Commissioned a review to be presented to the next Committee detailing the birth outcomes including by ethnicity in maternity
POSITIVE ASSURANCES TO PROVIDE • Positive assurance was received in relation to a part time dedicated individual who is undertaking a full review of the procedural documents. They are driving the removal of obsolete or merging documents where these are duplicated or split. Further assurance was requested from the division for a trajectory of completed procedural document reviews • Positive assurance of a continued reduction of the number of outstanding complaints and the increase in complaints being responded to within the 30 days • Positive assurance was received of a further three wards being accredited for the Gold Standard Framework • Positive assurance of the Trusts completed submission for CNST and the Trust technical compliance to all 10 of the safety actions. Although it was noted this work was ongoing • Positive assurance of ongoing scrutiny, work and further developments to strengthen assurance which will be reflected in the Maternity improvement plan. • Positive assurance of strengthening the maternity workforce with money secured from NHSE/I. This will be for key roles across the directorate with one of these being the appointment of additional	**DECISIONS MADE** • Agreed closure for three corporate risks where all actions had been completed and the risk mitigated • Agreed paper to the next committee regarding performance on stroke indicators • Approved the Paediatric Annual Report • Supported the exploration of the purchase of a digital solutions to support the implementation of the RESPECT process

consultants. This has been supported by the Trust with additional funding given to increase the consultants to 16. • Positive assurance of joint working between maternity and the Maternity Voices Partnership • Positive assurance in regards to the introduction in the surgical division of a 'Preventing Harm' meeting. A dedicated monthly meeting that focusses on Trust and National progress on patient harm such as falls, tissue viability, VTE, complaints, incident investigations etc. Its focus to identify, share and adopt learning and good practice across the Division. • Positive assurance received of the surgical divisions approach to make risk and governance more accessible across the SWC Division. The invite to the Divisional Governance meeting is now open to all staff to attend and participate. • Positive assurance of the actions taken to mitigate the increased demand at the front door which could impact on quality and safety of patient care if this continued to rise. • Positive assurance of the Trusts response to published guidance from NHS England in May 2021 regarding the response to reporting and responding to hospital-onset COVID-19 and COVID-19 deaths. The Trust has set up a Harm Review process which covers quality of care, addresses the issue of avoidability. • Positive assurance of the implementation / go live date of the 4th October 2021 for RESPECT (Recommended Summary Plan for Emergency Care and Treatment) process. A process that creates a summary of personalised recommendations for a person's clinical care in a future emergency in which they do not have the capacity to make or express choices • Positive feedback of the outcome of the local Patient Experience Survey which showed 47% of scores improving since the previous 2019 survey. These related to advice provided, support and explanations provided of possible complications to treatment. • Positive assurance of the 'Home for Lunch' initiative. Although the Trust recognises there is further work to be done to maximise the opportunity to discharge earlier and embed this across the organisation. • Positive assurance received in the Clinical Support Divisions report of improved risk and incident management.	

Enclosure 21

The Dudley Group NHS Foundation Trust

Paper for submission to the Public Trust Board on Thursday 16th September 2021

TITLE:	**Chief Nurse Report**		
AUTHOR:	**Helen Bromage** **Deputy Chief Nurse**	**PRESENTER**	**Helen Bromage** **Deputy 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.

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**	**N**	**Details:**
	NHSI	**N**	**Details:**
	Other	**N**	**Details:**

REPORT DESTINATION	**EXECUTIVE DIRECTORS**	**N**	**DATE:**
	WORKING GROUP	**N**	**DATE:**
	COMMITTEE	**N**	**DATE:**

NHS
The Dudley Group
NHS Foundation Trust

Chief Nurse Report

Trust Board 16th September 2021

Mary Sexton, Chief Nurse



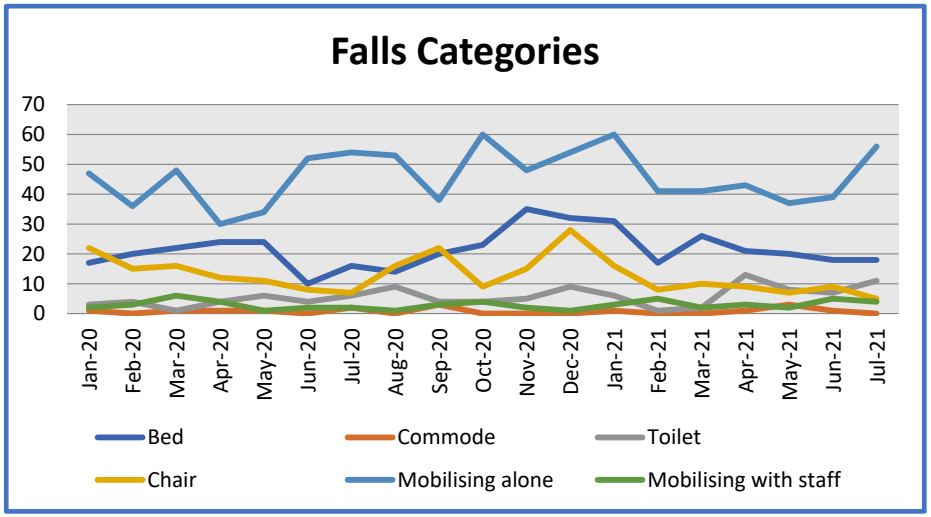

Care - Deliver safe and caring services - Falls

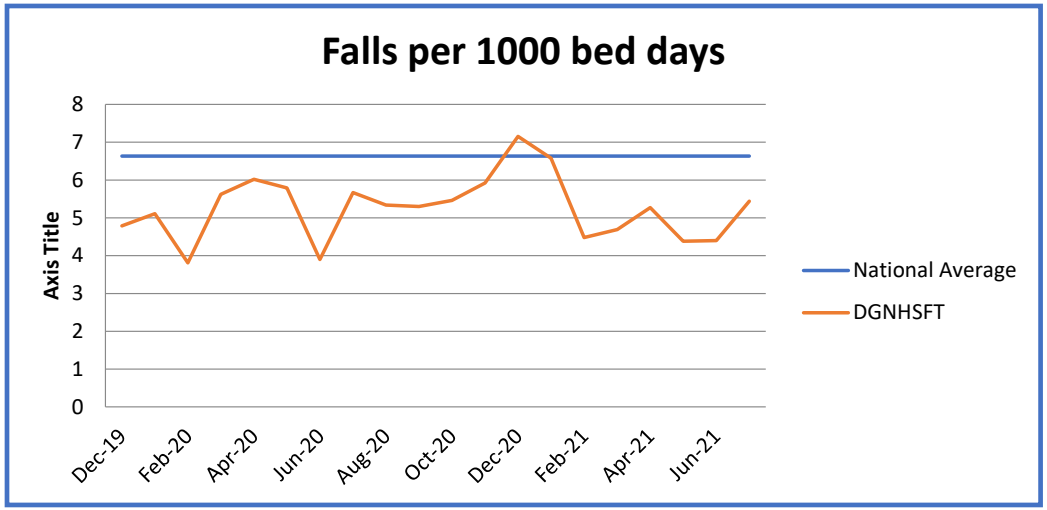
Over the past couple of months we have seen an increase in falls, however based on per thousand bed days we remain below the national average.

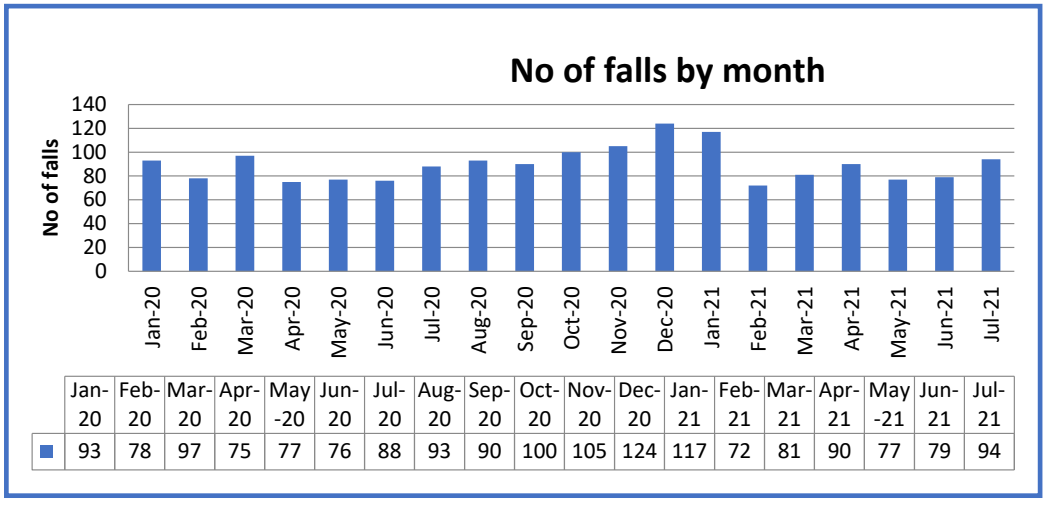
92 of the 94 falls were categorised as no or low harm in July.

Since the last report, we have launched the bespoke falls assessment for our ED team on Sunrise. A review of the data collected within AMaT has been conducted resulting in a revision of questions. These new questions will support with the audit of the documentation and improve fall prevention strategies at the start of the patient journey.

Prevention strategies continue to be an area of focus across the trust, with our use of bed/chair sensors currently being reviewed.







	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	May-21	Jun-21	Jul-21
■	93	78	97	75	77	76	88	93	90	100	105	124	117	72	81	90	77	79	94

Care - Deliver safe and caring services

Safeguarding

A successful bid to the Home Office by West Midlands Violence Reduction Unit for youth workers to be based in ED. The youth workers will identify children and young people attending ED and provide opportunistic support, advice and signposting including following up on the wards if admitted or in the community. The project will cover children and young people up to the age of 25 years with scope to see other ages if they are involved in gang related behaviour or have sustained serious physical injury due to violent crime.

An audit was undertaken to check whether information is shared with partner agencies when an adult with caring responsibilities for children attends ED due to substance misuse, domestic abuse and mental health. The audit identified that the Trust were sharing information in a timely and appropriate manner with partners agencies to ensure the safety of children looked after by parents with vulnerabilities.

Our Safeguarding associate nurse has secured information sharing agreement to work in partnership with Hear4youth to support young people with substance misuse issues this will enable staff to make direct referrals for children and young people and enhance the accessibility of young people to specialist support and advice

Number of referral's in July 164 (56 Adult 108 Child).

Number of Section 42/other enquiries - 1

Gold Standard Framework

We are delighted to announce that the following 3 wards have achieved GSF accreditation – C1a, C4 and B6 which is a fantastic achievement with now 6 wards accredited across the Trust.



Tissue Viability

We have continued to review the tissue injury related incidents across the trust and have reduced the number of delayed reviews. Some have been progressed to serious incident reviews, however the majority have remained with a local investigation. These reviews are supported by our colleagues within the Clinical Commissioning Group (CCG).

Life Support Mandatory Training Compliance

Over the past 3 months we have made improvements in attainment of compliance with Life Support competence. Improvement by 25% has been seen taking overall compliance to 77.8% across the trust.

Compassion - Deliver a great patient experience

Deprivation of Liberty Safeguards (DoLS)

The Trust has submitted applications for DoLS authorisations as follows:

	Supervisory Body							
2021	Dudley	Sandwell	Wolverhampton	Walsall	Worcestershire	Staffordshire	Birmingham	TOTAL
April	8	2	1				1	12
May	4			1	1	1		7
June	7					1		8
July	11	2				1		14

As previously reported, no approved standard authorisations have been received due to a national lack of Supervisory Body assessors. It has been confirmed that there is no requirement for the Trust to resubmit applications every 7 days in the absence of an approved authorisation by the local authority.

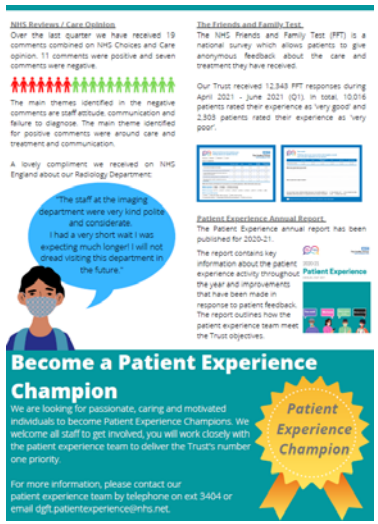
The new national Liberty Protection Safeguards (LPS), which will replace DoLS, are due to be launched nationally in April 2022. This will resolve the delay in approval of authorisations as the Trust will be expected to approve and manage its own authorisations in future. Preparations for this process change are being overseen by the Head of Safeguarding.

Mental Health Act

Eight patients were received in the Trust who were subject to sections of the Mental Health Act. It is noted that where patient presentations were acute and the patients settled post treatment, Consultants revoked sections in a timely manner.

Patient Experience

Issue 2 of the Patient Experience Team Newsletter was disseminated and received positively across the trust and partners.



Competence - Drive service improvement, innovation and transformation

Freedom to Speak Up (FTSU)

Numbers of concerns in 21-22 have remained fairly consistent although the service has been a little quieter during August: this may be due to it being the holiday period.

An in house training video has been filmed to help to raise awareness of the Guardians, champions and Exec/Non exec roles in the organisation:
a shortened version can be seen here:

https://player.vimeo.com/video/546411979

The National Guardian Office has published new guidance for FTSU champion networks and a comparison will be undertaken to assess how compliant we are is, with this guidance, and deadlines will be set for full compliance.

The guardian/champion group has recently undertaken Inclusion training delivered by the Trust Workforce Inclusion and Culture Lead and new champions recruited from the BAME and Disability inclusion networks.

A FTSU patient safety bulletin was published in July 2021 and the service has the support of communications team in planning for national FTSU month (October).

Enhanced knowledge in Trauma and Orthopaedics (New course based within The Dudley Group NHS Trust)

The Midlands Orthopaedic Centre in Collaboration with the University of Wolverhampton will be launching a new clinical course for post registered nurses and allied health care professionals in February 2022 (Degree level 6/7, six months duration, 40 academic credits awarded on completion).

This is an exciting opportunity to share knowledge and experience of the Trauma and orthopaedic patient journey with external and internal students. Research and evidence based practice will be embedded within the programme.

The Course will be lead by Dr Gail Parsons, Nurse Consultant and Deputy Director of Research and Development with Mr. Matthew Waites and Mr. Fouad Chaudhry, both Consultant Orthopaedic Surgeon supporting.

Communication - Make the best of what we have

Changing Places

Work has commenced for a Changing places facility to be installed in the Trust. This much needed provision for our people who use our hospital who may need this facility to ensure their care needs are met.
Changing Places are a national Consortium working to support the rights of people with profound and multiple learning disabilities and/or other physical disabilities. Established in 2005, the Consortium campaigns for Changing Places to be installed in all big public spaces so people can access their community www.changing-places.org

Royal College of Nursing Workforce Standards

In May the Royal College of Nursing published the Nursing Workforce Standards Supporting a safe and effective nursing workforce. The standards apply across all areas of nursing and all sectors within the United Kingdom. The standards are designed to support a safe and effective nursing workforce alongside each nation's legislation.

We have undertaken an initial gap analysis of our position against these standards and an improvement plan is in creation.

Professional Nursing Advocates

Towards the end of the second serge of the pandemic England's Chief Nurse recognised that the Nursing workforce was in desperate need of some restorative support and clinical supervision. The Midwifery model of Professional Advocates was adopted and introduced into Nursing. External funding was available and secured for a variety of staff to undertake the learning programme to undertake this PNA role. We have 15 registered nurses undertaking the academic learning over the next 9 months. Initial work as to what this role will look like and how it will be incorporated into the wider organisation is underway, however the foundations have been brought into nursing form our midwifery colleagues.

Two of our 15 learners have successfully achieved their programme of learning; Congratulations to them both.

Commitment - Be the place that people choose to work

Recruitment Programme

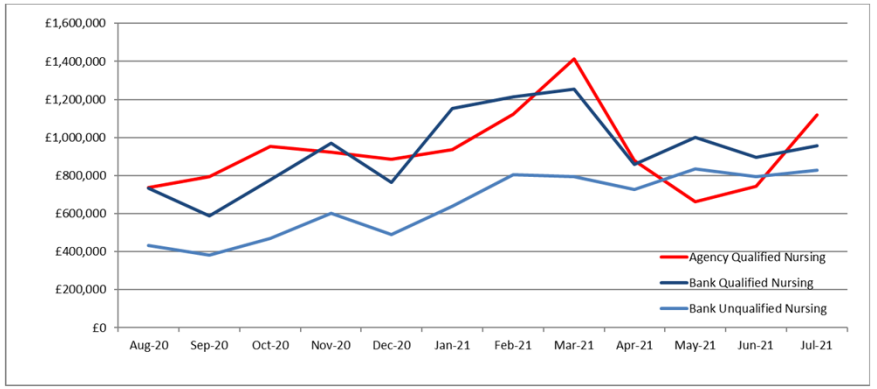
National funding was secured to work in collaboration with the STP and recruit Nurses from abroad. We are delighted that our first 10 recruits have arrived with us and are working to obtain the NMC registration with a further 40 to follow in September and an additional 25 before Christmas 2021.
The joint collaboration has been an initial success so that Nationally there is an ask that we look to recruit internationally for Midwives. We have expressed our interest in this and to continue to work with the STP collaboration.

Building on the fantastic work of the HCSW recruitment work at the start of the year and the great work of the career development programme, we have been offered funding to develop a proportion of the HCSW recruits into Nursing Associates. We have expressed our interest in this and have committed to progressing 15% of our recruits to the Nursing Associate Apprenticeship by December 2021.

The start of the next cohort of the Novice Care Support Worker Programme start date is September This programme will support and develop individuals new to care into our workforce.

We have continued to see an increase in agency and bank usage over the months, in part due to significant pressures on our teams, particularly ED and Critical Care with additional areas opened to cope with the demand and prevent delays. A reinvigoration of the HCA recruitment to bank has been initiated and interviews are underway.

Nursing Bank & Agency spend by month for last calendar year.



July 2021 Vacancies, Bank & Agency spend for top 10 Areas

Area	Vacancy %	Agency Qualified Nursing	Bank Qualified Nursing	Bank Unqualified Nursing	Grand Total
Emergency Department N	5%	£276,869	£43,002	£30,139	£350,010
I.T.U.	7%	£161,631	£41,126	£19,051	£221,809
Acute Med Unit (EAU)	17%	£28,612	£58,000	£33,693	£120,305
Ward C7	18%	£62,715	£19,313	£34,569	£116,597
Ward B3	27%	£62,596	£15,629	£16,896	£95,121
Ward C8	4%	£43,083	£30,789	£15,890	£89,761
Ward B5	-2%	£43,552	£20,281	£9,142	£72,975
Ward C5 Area B	-5%	£38,544	£14,865	£5,496	£58,905
Ward C6	0%	£16,447	£16,160	£24,006	£56,614
Ward C3	7%	£16,608	£12,843	£24,125	£53,576

Commitment - Be the place that people choose to work

Safer Staffing Summary Jul — Days in Month 31

Ward	Day RN Plan	Day RN Actual	Day CSW Plan	Day CSW Actual	Night RN Plan	Night RN Actual	Night CSW Plan	Night CSW Actual	Qual Day	UnQual Day	Qual N	UnQual N	Actual CHPPD Sum 24:00 Occ	Average Occupancy	Registered	Care staff	Total
B1	135	111	101	62	94	72	92	54	82%	62%	77%	59%	459	57%	4.55	2.90	7.46
B2(H)	121	108	192	165	95	86	155	145	90%	86%	91%	93%	718	77%	3.24	5.06	8.30
B2(T)	120	105	133	103	93	85	104	91	88%	78%	91%	88%	702	94%	3.24	3.32	6.56
B3	225	191	186	115	157	152	155	125	85%	62%	97%	81%	950	73%	4.23	3.04	7.27
B4	261	217	268	257	159	137	203	194	83%	96%	86%	96%	1,337	90%	3.10	4.05	7.14
B5	219	204	187	162	232	211	120	105	93%	87%	91%	87%	516	69%	9.85	6.05	15.90
C1	253	230	270	253	186	170	212	185	91%	94%	91%	87%	1,455	98%	3.22	3.62	6.83
C2	287	241	67	59	254	210	64	55	84%	89%	83%	85%	579	62%	9.14	2.31	11.46
C3	248	234	420	398	187	172	387	375	95%	95%	92%	97%	1,593	99%	3.06	5.70	8.76
C4	162	148	68	61	124	95	63	70	92%	91%	77%	111%	521	76%	5.46	2.90	8.36
C5	335	208	260	242	280	192	198	181	62%	93%	69%	91%	1,402	94%	3.46	3.62	7.08
C6	106	98	102	88	92	80	72	68	92%	86%	87%	95%	519	84%	4.03	3.60	7.63
C7	210	197	229	153	171	165	227	150	94%	67%	97%	66%	1,085	97%	3.92	3.35	7.27
C8	292	269	217	187	249	234	186	158	92%	86%	94%	85%	1,305	96%	4.52	3.16	7.68
CCU_PCCU	253	220	66	54	224	184	37	26	87%	82%	82%	70%	662	82%	7.16	1.45	8.61
Critical Care	498	416	183	73	509	436			84%	40%	86%		390	79%	26.22	2.25	28.47
EAU AMU 1	585	401	496	421	501	384	373	314	69%	85%	77%	84%	2,480	98%	3.72	3.55	7.27
Maternity	920	651	349	206	527	420	195	156	71%	59%	80%	80%	786	58%	13.04	5.39	18.43
MHDU	155	125	104	39	156	120	80	37	80%	38%	77%	47%	206	66%	14.24	4.28	18.52
NNU	176	128			149	138			72%		93%		297	53%	10.75	0.00	10.75
TOTAL	**5,561**	**4,502**	**3,896**	**3,099**	**4,439**	**3,743**	**2,922**	**2,487**	**81%**	**80%**	**84%**	**85%**	**17,962**	**84%**	**5.30**	**3.70**	**9.00**

Overall data collection from Allocate for July 2021.

Despite the overall data showing some areas of red, each shift where staffing was not meeting the national ask was dynamically risk assessed at the point in time, and professional judgement used based on patient numbers and acuity.

Courage - Deliver a viable future

Community musculoskeletal assessment and Physiotherapy service

CMAPS has created 2 new clinical leadership posts due to commence in September. These roles demonstrate the services commitment to developing advanced practice and it is fantastic to be able to attract such highly specialist and experienced Physiotherapists to the Trust.

The Parkinson's Disease Specialist Pharmacy Network (PDSPN) has been short listed for a PD UK Excellence award under the Sharing Learning and Education category. They will be notified by October 8th as to whether we have reached the final.

To support the future working we have our first AHP support worker undertaking the senior healthcare support worker apprenticeship and our first physiotherapy student apprenticeship.

ReSPECT

12 months ago funding was received to implement ReSPECT (Recommended Summary Plan for Emergency Care and Treatment). The ReSPECT process creates a summary of personalised recommendations for a person's clinical care in a future emergency in which they do not have capacity to make or express choices.

Here at Dudley the implementation is supported by a project implementation lead and multi-disciplinary key stakeholder steering group. Following on from 6 months of awareness and training on the process, go live date is planned for October 2021.

HEE Workforce Development Funding (WDF) and Continuous Professional Development (CPD) Funding 2021/22

Workforce Development Funding has a different focus to CPD. WDF should be invested in activities which are driven by employer intent, to target the improvement and transformation of care delivery, requiring scale of education and training intervention; CPD is for individual personal and professional development informed by the appraisal process. WDF is to be used for all employees, CPD is for a defined list and is only available for this year and the next.

As with previous years the funding allocated to us does not meet the demand and alternative funding streams are being sourced for some activities. To support a decision making around which requests are approved for funding, a priority matrix has been created and approved by the Executive Team.

	Service Need	Workforce Need	National Guidance	Incidents & learning	Role enhancement
Low	This knowledge/ability required to deliver care to 40% of the patients 80% of the time.	75-100% of the workforce already have the knowledge/ability	This knowledge/ability is required by a regulatory body or to meet recognised & established national standards	Incidents have increased by 20% due to a lack of knowledge/ability. Complaints have increased by 20% due to a lack of knowledge/ability. Specific outcome of learning in 0 x SI	Clearly evidenced in objectives for this year how this knowledge and ability will enhance the role.
Medium	This knowledge/ability required to deliver care to 60% of the patients 80% of the time.	35-74% of the workforce already have the knowledge/ability	This knowledge/ability is not required by a regulatory body or to meet recognised & established national standards	Incidents have increased by 30% due to a lack of knowledge/ability. Complaints have increased by 30% due to a lack of knowledge/ability. Specific outcome of learning in 1 x SI	Clearly evidenced in objectives for this year how this knowledge and ability will enhance the role. Measurable objectives in place for post knowledge/ability outcomes.
High	This knowledge/ability required to deliver care to 80% of the patients 80% of the time.	34% or less of the workforce already have the knowledge/ability	This knowledge/ability is required by a regulatory body or to meet recognised & **new** national standards	Incidents have increased by 40% due to a lack of knowledge/ability. Complaints have increased by 40% due to a lack of knowledge/ability. Specific outcome of learning in 2 x SI	Clearly evidenced in objectives for this year how this knowledge and ability will enhance the role. Measurable objectives in place for post knowledge/ability outcomes. Objectives and outcome measures are clearly lined to the trusts values and strategic direction.

Enclosure 22

The Dudley Group NHS Foundation Trust

Paper for submission to the Trust Board September 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**	**Jo Wakeman - Deputy Chief Nurse**

CLINICAL STRATEGIC AIMS

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

CORPORATE OBJECTIVE: SO2: Safe and Caring Services

SUMMARY OF KEY ISSUES:

This paper is to demonstrate Trust compliance with the Health and social care act 2008 and highlight gaps in assurance for action. In May 2020 NHSI/E requested that the Infection Prevention board assurance framework template is completed and shared with Trust board. One of the key areas to combating the COVID crisis relates to robust infection control standards and practices across the trust. The framework adopts the same headings as the Health and Social Care Act 2008 listing the 10 criterion.
The colour coded matrix over the page (before the detailed IPC BAF) demonstrates the many areas which the trust is able to give assurance as evidence of compliance can be confirmed.

Updates since last report:

- Deputy DIPC appointed due to commence in post 13th September 2021
- Decontamination Lead appointed and commenced in post
- New guidance regarding staff isolation as of 16th August 2021
- IPC mandatory training scores above 90%

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**	**Log**
	Risk Register: Y	**Risk Score:**

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:**

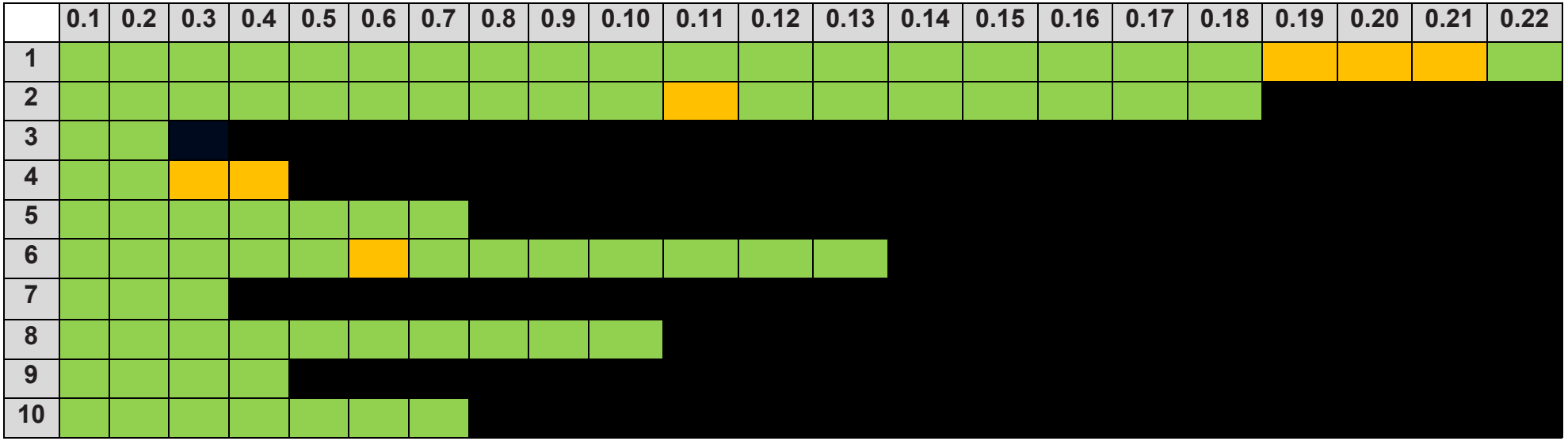
ACTION REQUIRED OF COMMITTEE / GROUP:

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



1	The infection control risk assessment in the admission documentation is limited – IPC tool devised to be amended and shared at Septembers IPC meeting. Estates work remain outstanding
2	The review of the cleaning contract and quality measures should be undertaken as planned in line with the new cleaning standards
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	There is no formal COVID PPE audit.
7	No GAPs identified
8	No GAPs identified
9	No GAPs identified
10	IPC to assist with Vaccination roll out for 2021 for COVID19 and Flu.

Infection Prevention and Control Board Assurance Framework: September 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:				
1.1	• Infection risk is assessed at the front door and this is documented in patient notes	The Trust has policies and procedures in place to identify alert organisms in patients admitted to the Trust.	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	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		
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.	Outpatient flow chart in use. Documentation audits are ongoing monthly. Point of care testing in place within Emergency Department that enables streaming of patients thus preventing	Frequency of moves not routinely monitored. Re-zoning of clinical areas to meet patient demand often compounds frequent	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 with IPC practice	crowding of patients as a direct result of waiting for COVID-19 swabs. Movement of patients restricted to clinical need. Zoning SOP in place - Updated June 2021 Lead nurse sign off for terminal cleaning. Cleaning audits. Senior nurse environmental monthly audits. Outbreak meetings three times a week when an outbreak is open. IPC inspections un announced.	movement of patients. Information not readily 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. IPC team to do trust wide review, to be included work plan. Compliant.	
1.5	• Staff adherence to hand hygiene?	Mandatory training, monthly hand hygiene audits. IPC inspections un announced. 5 moments of Hand Hygiene audit implemented March 2021. Frequency of audit dependant on previous result. <95%Monthly <90%Weekly >90%Daily	N/A		
1.6	• Patients with possible or confirmed COVID-19 are not moved unless this	The Trust has implemented a Zoning system, Green, Yellow and Blue with	N/A		

	is essential to their care or reduces the risk of transmission	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 required. Due to Low numbers of COVID Positive patients any positive patients currently nursed on home ward in side rooms. Zones will be reintroduced as necessary.	IPC ward list not a live document.	Infection control attend the capacity meetings as required	
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	The infection prevention team have the daily ward list which documents the location of COVID 19 patients and their contacts. BI Power Server introduced by Informatics to monitor COVID changes.	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.	Any staff member that becomes positive for COVID-19, are followed up for any breaches in PPE and social distancing. PPE marshals located around the trust. Staff members encouraged to challenge non-compliance of PPE. Available on all entrances to the trust. Staff lateral flow system set up. Staff encouraged to record lateral flow results.	N/A N/A N/A	Compliant. Compliant Complaint	

		Whenever outbreaks are identified, the testing evidence is available. Recorded in outbreak meetings.			
1.9	• Training in IPC standard infection control and transmission-based precautions are provided to all staff	Included in all mandatory training which all staff must complete yearly. Mandatory training is monitored by the learning and development team and reminders sent out when training is due to lapse.	N/A	Complaint	
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	SIITREP data submitted by informatics.	N/A	Complaint	
1.11	• This Board Assurance Framework is reviewed, and evidence of assessments are made available and discussed at Trust board	BAF submitted in timely manner for board review. Updated monthly by IPC, Consultant microbiologist and deputy chief nurse.	N/A	Complaint	
1.12	• Ensure Trust Board have oversight of ongoing outbreaks and action plans	Board updated by DIPC. DIPC chairs outbreak meetings and have updates sent via email by IPC. Minutes of outbreak meeting available as required. Discussed at Quality and safety			

1.13	• There are check and challenge opportunities by the executive/senior leadership teams in both clinical and non-clinical areas.	committee. Via board and Quality and safety committee.			
	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	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.	

		discharge. Prompt now available on sunrise to trigger screening prior to discharge.			
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.	If a patient refuses to wear a Fluid resistant surgical mask then it is documented in the patient notes.		
	Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating**	**R.A.G**

				Actions	
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 and mitigating actions are highlighted	COVID 19 taskforce meeting that reports directly to the Executive Board. – No longer meet July 2021 – Due to COVID-19 surge taskforce meetings recommenced weekly.	N/A	Latest updated PHE/NHS IPC guidance is going through Trust processes currently.	
	Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating**	**R.A.G**

				Actions	
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 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 infection control risk assessment in the admission documentation is limited.	Live link to sunrise system in place, for COVID-19 results Meeting due August 2021 for IPC to discuss with IT the possibility of having an IPC tab on sunrise to document all infectious organisms Risk Assessment has been completed, to be	

		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.		discussed at June IPC Meeting – delayed from last year Following review of IPC Risk assessment at June's IPC meeting amendments required. To be re reviewed at Septembers IPC meeting. 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		All other works identified will be prioritised/RAG rated on a formal action plan with risks mitigated as required and	

		and performance monitored through the PFI contract mechanisms as required. 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:		progress reported through to Corporate level via the IPCG and Quality and Safety Committee Matrons and DIPC emailed on 29/04/2021 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.	

		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. **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		Risk register reviewed at monthly IPCG.	

		Critical Care TAC 1626 – Suboptimal compliance with management of cleanliness of environment & equipment TAC 1615 Medication storage compliance			
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 Group.		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	Lack of accurate data to demonstrate compliance	Now donning and doffing training completed by the IPCT is documented, this	

		assigned to the high COVID areas. IPCT have provided training for Donning and Doffing of PPE, the team commenced in March 2020-but did not capture training attendance until April. IPCT happy to provide any training on Ad hoc basis if required Face fit testing undertaken locally and by the clinical skills team.		is now included in mandatory training Database for fit testing now in use and compliance is being monitored by learning and development.	
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 all facilities staff were/are 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.	N/A		

		The Trust HPV team where possible have completed room disinfections following the standard terminal cleans within isolation rooms, ward bays.	Current HPV service/contract expired June 2021 – extended for a 3 month period whilst options reviewed.		
2.4	Increased frequency, at least twice daily, of cleaning in areas that have higher environmental contamination rates as set out in the PHE and other national guidance attention to the cleaning of toilets/bathrooms, as COVID-19 has frequently been found to contaminate surfaces in these areas cleaning is carried out with neutral detergent, a chlorine-based disinfectant, in the form of a solution at a minimum strength of 1,000ppm available chlorine, as per national guidance. If an alternative disinfectant is used, the local infection prevention and control team (IPCT) should be consulted on this to ensure that this is effective against enveloped viruses manufacturers' guidance and recommended product 'contact time' must be followed for all cleaning/disinfectant solutions/products as per national guidance: 'frequently touched' surfaces, e.g. door/toilet handles, patient call bells, over-bed tables and bed rails, should be decontaminated at least twice daily	COVID additional cleaning documents and cleaning policy remain in place. The Trust facilities team and infection prevention team have reviewed cleaning requirements through the pandemic, assessing cleaning standards through the audit programme and by gaining feedback from clinical teams**.** . Audits against cleaning standards reviewed at the IPC Committee. July 2021 – Meetings currently being held to discuss implantation of new cleaning standards released May 2021. The trust utilises Clinell wipes for	N/A		

	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 must be decontaminated, timed to coincide with periods immediately after PPE removal by groups of staff (at least twice daily.)	decontamination of medical devices and surfaces-Gamma state the wipe are against enveloped viruses and that 60 seconds contact time is required. Sporicdal Wipes were rolled out throughout trust week commencing 9th August to clean commodes and bed pans. These are to be used in the dirty utility only. GAMA healthcare provided training and continue to support. These have been introduced as a additional measure to assist with the prevention of Healthcare associated infections. Touch point cleaning continues; this is reviewed as required by IPC and facilities team. Dedicated staff have been resourced			

	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 includes 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 quarterly IPC environmental audit.	
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 The use of maceratorable products is promoted encouraged.	Due to COVID crisis frequency of audits has been reduced.	IPC environmental audits are completed quarterly.	

2.7	• Reusable equipment is appropriately decontaminated in line with local and PHE and other national policy	Reusable non-invasive medical devices are decontaminated using disinfectant wipes or Chlorine releasing agent in line with Trust policy and/or manufactures instructions. Decontamination and decontamination of medical devices policy available on the HUB. Reports from Medical engineering team that wards are not using correct processes, escalation in place to report noncompliance to improve current practice	I am clean labels in use. Decontamination Lead commenced in post September 2021. Business plan being put forward to review IPC staffing	Reviewed quarterly as part of the IPC environmental audits. Use of Datix system to report non-compliance in place.	
2.8 2.9	• 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	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	N/A Decontamination Lead commenced in post September 2021. Business plan being put forward to	Installation of air conditioning units of which all have a health and safety assessment. Periodic opening of windows to dilute air – monitored by lead nurses and reported on NHSI	

2.10	• monitor adherence to the decontamination of shared equipment with actions in place to mitigate any identified risk	regarding the benefits of periodically opening windows to aid air exchanges within clinical areas. Cleaning Audits submitted monthly Audits, spot auditing. De-contamination certificates.	review IPC staffing	audit tool	
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 in May 2021 Consideration should be given to recording cleanliness as a risk on the risk register. July 2021 – Meetings currently being held to discuss implantation of	

				new cleaning standards released May 2021.	
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 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		To address immediate actions prior to cleaning standards contract review	
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.	Temporary store has been built by ICU and is in use	Estates review to identify areas for appropriate storage.	
2.13	NHSI visit An action plan is required as to how	Schedule of areas to be developed with Mitie to identify specific times for		Feasibility study for additional	

	cleaning standards can be maintained with areas of limited storage space.	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.		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. July 2021 Feasibility Study has been completed and options considered. Business case being developed to construct external bed store and to release current bed stores for clinical storage	
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		Implementation of declutter days and focused work on	

		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.		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 changed from negative pressure to positive pressure.	Following guidance received from NHSi in June 2020, indicating that positive areas should not be converted to negative, following 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		Check governance arrangements around decision making	

		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.			
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 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		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 on engagement between Procurement & departments Review items that can be moved to NHS Supply Chain from direct	

		undertake a full review across the trust		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. All out of date policies up dated and reviewed by IPC Group. Currently with governance awaiting upload to the HUB.	
	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	
	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**	**R.A.G**

				Actions	
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. July 2021 – Visiting has recommenced – patients are allowed one visitor for 45 minutes per day and this must be booked via the on line booking system. The visiting of COVID positive patients remains restricted and must be risk assessed. .	N/A		
4.2	• Areas in which suspected or confirmed COVID-19 patients are where possible being treated in areas clearly marked with appropriate signage and have restricted access	Signage is placed on entrances to wards and other clinical settings stating restricted access. In addition have zoning SOP, zoning notices and poster with PPE requirements for the area.	N/A		

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 confirmed COVID-19 patient needs to be moved	There is a patient transfer checklist which asks-infection type if the patient requires barrier nursing or side room and requests current observations.	Assurance required regarding evidence of completion	To be reviewed as part of the monthly documentation audit.	

		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.			
	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 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	Please refer to section 1. There is the zoning document for in-patient admissions which covers patient placement. ED have a flow chart describing the designated 'red area' which is separate to the rest of ED with dedicated staff for suspected COVID patients. Point of care testing in place in ED.	N/A		

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.. Testing is completed on admission via ED, elective cases before admission. 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.	N/A		
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	N/A		

		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.			
5.4	• Patients that attend for routine appointments who display symptoms of COVID-19 are managed appropriately	Where possible out patients appointments are conducted virtually or by telephone. Some clinics are appointments, before patients attend they are asked if they have symptoms, if patients has symptoms and they have to attend they are asked to wear a surgical mask and decontaminate hands and would be placed last on the list. Phlebotomy clinics have commenced at the main hospital patients have to	N/A		

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

				compliance.	
	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 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 is monitored via the IPC Group bi monthly. Mandatory training scores for the Trust as of 26.08.21 are 90.3% with an objective of 90%.	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	

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 IPC Lead 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. Designated 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.	IPC are in the process of devising a PPE audit.	COVID PPE audit, audit tool in draft Quality Rounds Commenced	
6.7	• Staff regularly undertake hand hygiene and observe standard infection control precautions	The hand hygiene saving lives audits are completed monthly and compliance continues to be monitored. This level of compliance requires an independent review the IPCT carry out unannounced spot checks as required.	Independent review of hand hygiene required	IPC quarterly audit programme has now commenced	
6.8	• 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	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.			

6.9	• Guidance on hand hygiene, including drying, should be clearly displayed in all public toilet areas as well as staff areas				
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 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.	N/A Not monitored.	Compliant. Regular updates provided via 'In The Know' communication daily to all members of staff through email.	

6.13	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 good seal of the mask to the face •	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 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.		Communications to all staff and staffing groups to ensure clear messaging around FFP3 use. Check with the fit test trainers in relation to key messaging. This is monitored through the PPE audit that is in place.	

		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 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			
	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	N/A		

		reviewed 3 times daily at the capacity meetings The infection prevention team have the daily ward list which documents the location of COVID patients and patients with resistant/alert organisms. 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 Actions	R.A.G
8.1	There are systems and processes in place to ensure: • Testing is undertaken by competent and trained individuals	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.	N/A	Matrons informed during Huddles regarding testing required. Information also available on the hub and communications update.	
8.2	• Patient and staff COVID-19 testing is undertaken promptly and in line with PHE and other national guidance	Community staff weekly testing requirement: collaborative approach with CCG and DMBC PH have weekly testing for health care workers who attend care/nursing homes.			
8.3	• Screening for other potential infections takes place	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 Clostridioides difficile tests for patients who have diarrhoea.		Compliant.	

		All other screening has continued as pre COVID crisis.		Compliant.	
8.4	That all emergency patients are tested for COVID-19 on 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.		Dashboard mitigation.	
8.5	• That those inpatients who go on to develop symptoms of COVID-19 after admission are retested at the point symptoms arise	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. Compliant.	

				Compliant.	
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	Prompts on SUNRISE system. Reviewed as part of the outbreak meetings.	Not reported anywhere within the trust.		
8.7	• That sites with high nosocomial rates should consider testing COVID negative patients daily	Trust have reviewed and are unable. Therefore do not have the resources to carry out daily testing of negative patients. Insufficient capacity.			
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	On discharge checklist.		Partial compliance. Divisional chief nurse to report compliance within IPC report.	
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.	Commissioned care home for COVID-19 positive patients.			

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	All elective patients are tested. SOP in place.			
	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,	N/A		

		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)			
9.3	• All clinical waste related to confirmed or suspected COVID-19 cases is handled, stored and managed in accordance with current national guidance	Waste streams on yellow and blue zones are clinical waste: orange bag. Some reports received of improper disposal Interserve have communicated issues to areas concerned. 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	N/A		
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.	N/A		

		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			
	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	N/A	Vulnerable staff may not disclose to employer, therefore all staff to have risk assessment completed	

		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. 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 are 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	Many staff are choosing to be tested via Pillar 2 due to ease of access and convenience.		

		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 IPC contact Tracer 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 apyrexial 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. As of 16th August new guidance was released advising that is you are a	N/A Staff isolation SOP available.		

		household contact regardless of vaccination status you are to continue to refrain from work for 10 days. If the staff member has received a notification via the NHS app or via track and trace a risk assessment must be completed prior to attending to work.			
10.8	• IPC to help in the COVID19 booster and Flu vaccination programme 2021	IPC team members to complete up to date vaccination training and to be part of the vaccination rota.		Programme yet to be rolled out	

Enclosure 23

Paper for submission to the Trust Board 16th September 2021

The Dudley Group NHS Foundation Trust

TITLE:	**Maternity Incentive Scheme and Ockenden Response**		
AUTHOR:	Dawn Lewis Head of Midwifery	**PRESENTER**	Jo Wakeman Deputy 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

- To note the Trust has responded to the first round of submission of Ockenden evidence and external review is awaited.
- The Ockenden response action plan is ongoing and evidences the recognition of gaps.
- To note the fourth year of maternity CNST safety standards and the plan to request project management in order to achieve the required standard.

CORPORATE OBJECTIVE:

SO1, SO2, SO3, SO4, SO5, SO6

SUMMARY OF KEY ISSUES:

- The year 4 CNST maternity safety standards guidance was published on 8th August 2021 and distributed to trusts.
- Project management support has been requested to enable the appropriate timing of evidence to Board.
- The submission of assurance evidence requested for the first round of Ockenden recommendations and the awaited report.
- The ongoing review of assurance evidence.
- Staffing, both midwifery and medical is challenged. Evidence of the actions to address these challenges.

IMPLICATIONS OF PAPER:

IMPLICATIONS FOR THE CORPORATE RISK REGISTER OR BOARD ASSURANCE FRAMEWORK

RISK	**Y**	**Risk Description:** Midwifery staffing is below recommended ratios from Birth rate plus.

	Risk Register: Y		**Risk Score:** 20
COMPLIANCE and/or LEGAL REQUIREMENTS	**CQC**	**Y**	**Details:** Safe, Effective, Caring, Responsive, Well Led
	NHSI	**Y**	**Details:** Maternity Incentive Scheme
	Other	**N**	**Details:**
REPORT DESTINATION	**Board of directors**	**Y**	**DATE:** 16th September 2021
	WORKING GROUP	**N**	**DATE:**
	COMMITTEE	**Y**	**DATE:** 24 August 2021

Maternity CNST and Ockenden Update

Report to Board of Directors 16th September 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 (NHSE/I) in the response following the publication first Ockenden report of services at Shrewsbury and Telford NHS Trust.

The topics covered within this paper include:

- Progress against the CNST Maternity Incentive Scheme
- Perinatal mortality
- Midwifery staffing
- Obstetric staffing
- Ockenden Submission to NHSE/I

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 assurances, 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. This report to committee allows for more detailed discussion of assurances provided, any gaps or omissions and the action plan to address areas that require improvement

2.2 **CNST Maternity Incentive Scheme –NHS Resolution Year 4**

NHS Resolution released the year 4 standards for the CNST Maternity Incentive scheme on 9th August 2021. The subject of each the standards remains the same as previous years, however the technical guidance is extensive and requires production of extensive assurance. There does appear to be some inconsistencies with guidance received following the Ockenden report. These have been noted and forwarded via the Regional Chief Midwife to request clarity. A request has been made for project management support to assist with achieving this.

Standard 8 related to multidisciplinary training is a particular challenge but discussions with the relevant leads are inprogress to ascertain our plan to achieve. The final date for submission in year 4 is 30th June 2022

The Trust awaits the response from NHS Resolution to our Year 3 Board declaration made in July this year.

2.3 Perinatal Mortality.

2.3.1 **Stillbirths** - There has been 1 stillbirth during the month of July
2.3.2 **Early Neonatal Deaths** – There have been 0 neonatal deaths during the month of July
2.3.3 All stillbirths and neontatal deaths are reviewed using the National Perinatal Mortality Review Tool (NPMRT) which includes parent's perspectives and questions as part of the review. The system allows for a report to be produced to cover all aspects required as part of the CNST Safety Action 1.

2.3.4 In addition to the NPMRT database we are required as a Trust to report the following to MBRRACE (UKs surveillance data collection system)

- **Late fetal losses** – the baby is delivered between 22 weeks+0 days and 23 weeks+6 days of gestation (or from 400g where an accurate estimate of gestation is not available) showing no signs of life, irrespective of when the death occurred
- **Stillbirths** – the baby is delivered from 24 weeks+0 days gestation (or from 400g where an accurate estimate of gestation is not available) showing no signs of life, irrespective of when the death occurred
- **Early neonatal deaths** – death of a live born baby (born at 20 weeks+0 days gestation of pregnancy or later or 400g where an accurate estimate of gestation is not available) occurring before 7 completed days after birth
- **Late neonatal deaths** – death of a live born baby (born at 20 weeks+0 days gestation of pregnancy or later or 400g where an accurate estimate of gestation is not available) occurring between 7 and 28 completed days after birth.

  A national report is produced by MBRRACE annually highlighting themes of good practice and reccomendations for changes in practice. Additionally MBRRACE carry out confidential enquiries based on identified themes from their main reports.

2.3.5 Since April 2018 the Healthcare Safety Investigation Branch (HSIB) have been responsible for the investigations into specific maternity incidents. These include;

- Intrapartum stillbirth
- Early neonatal deaths
- Potential severe brain injury
- Maternal deaths

DGFT executive summary from HSIB

Cases to date	
Total referrals	14
Referrals / cases rejected	2 (duplicate entries)
Total investigations to date	12
Total investigations completed	12
Current active cases	0
Exception reporting	Nil

Each of these are treated as RCA investigations in respect of Trust reporting and following receipt of the HSIB report and production of our local action plan the reporting through appropriate governance processes is carried out.

2.4 **Workforce**

2.4.1 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 it is acknowledged nationally that increases in obesity and gestational diabetes along with a number of other co morbidities have increased the acuity of women being cared for. Also, moving to a continuity of care model as the default model of maternity care, it 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.

2.4.2 The Trust is currently undertaking a Birth Rate Plus reassessment with the external assessors.

2.4.3 The 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-19 absence. The recommended ratio based on the previous Birth Rate Plus assessment should be 1:27 this is unlikely to alter significantly during reassessment.

2.4.4 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. Recruitment of our 3rd year students has taken place and we await their start dates in the autumn once they receive their NMC registration.

2.4.5 Additional money for midwives and obstetricians to allow for staffing to birthrate plus and achievement of some of the Ockenden reccomendations was successfully applied for from the national team. We are currently recruiting to these posts also.

2.4.6 The following table outlines percentage midwifery fill rates for the in-patient areas for July.

	Day qualified %	Night qualified%
July 2021	72.7%	80%

2.4.7 Throughout July there have been significant challenges because of midwifery staffing and capacity within maternity. This has been due to a combination of factors. Maternity escalation standard operating procedure has been implemented and Datix reporting as appropriate. In addition the national team have requested daily return of staffing and activity. The returns have been shared across the region and it appears that all maternity units are experiencing similar issues.

2.4.8 Similarly there are gaps within medical rotas and recruitment is ongoing to address gaps both at consultant and middle grade doctor levels. There are two consultant vacancies due to retirement and one due to long term sickness and locum consultants are covering these gaps in the interim. A further four locum consultants will commence in the next two months to address the additional responsibilities required due to the Ockenden report. The additional posts will allow for focus solely on obstetrics for two consultant posts with ambulatory gynaecology for the other two posts.

2.4.9 Recruitment into middle grade doctor posts is also ongoing with a plan to also increase to a 1:16 rota.

2.5 **Ockenden report and submission of assurance**

2.5.1The Trust submitted 298 pieces of evidence to NHS futures platforms providing assurance requested by the NHSE/I to address the Ockenden recommendations. At the time of writing this we are still awaiting the LMNS level report it is promised before the end of August.

2.5.2 The maternity team and Trust governance team members have held a series of meetings to review the gaps in assurance, identify additional assurance that would improve assurance and update the action plan. *Appendix 1*

3. RISKS AND MITIGATIONS

3.1 Midwifery staffing is included on the risk register within the Directorate and discussed at Divisional level on a monthly basis.

3.2 Recruitment to establishment is a challenge. One of the mitigations is submitting an expression of interest for national funds for international recruitment.

4. RECOMMENDATION(S)

4.1 To note the Trust has responded to the first round of submission of Ockenden evidence and external review is awaited.

The Ockenden response action plan is ongoing and evidences the recognition of gaps.

To note the fourth year of maternity CNST safety standards and the plan to request project management in order to achieve the required standard.

4.2 The awaited report on the assurance already submitted to NHSI will be included in the next report to Quality and Safety committee. This will also allow us to update our action plan and identify appropriate timescales.

Dawn Lewis
Head of Midwifery
Report prepared 17th August 2021

APPENDICES:

Appendix 1 Ockenden response action plan

~~Appendix 1~~

Appendix 1

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**	Trust Board
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 received

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	LMNS dashboard in progress however review of this recommendation highlights that Trust dashboard should be shared at LMNS not just an LMNS dashboard. Agreed that this will be process in Q&S work stream moving forward	
		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	Agreed that perinatal mortality review meeting and audit meeting should be separated	
		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	Initial discussion with RWT and with SWBT and agreement reached that midwife representation will attend via teams perinatal mortality meeting at DGFT	
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	June 2021	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 Agreement at LMNS that compliance and Gap analysis related to training will be reported to Q&S work stream and upwards to operational and delivery board.	
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. Midwives, Obstetricians and Anaesthetists have been contacted and reminded of their responsibility to participate.	
		Contact with all required professional groups to remind them of their responsibility to participate	Clinical Director	31March 2021		

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~~ Revised date August 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~~ Revised date August 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~~ Revised date 30 Sept 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 Dedicated midwife for fetal monitoring appointed in June 2021. Awaiting job plan and nominated obstetric lead	

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	Lead midwife fetal monitoring	~~July 2021~~ Revised date	Planning in progress by appointed midwife on track to complete before completion deadline	
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	Full compliance submitted to NHSE in June audit	
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.**					
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	

Action Number	Recommendation / Area for Action Identified	Action Agreed	Lead	Date for Completion	Progress / Assurance	Key
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	Choice and personalisation booklet developed and commenced use with women. Information for women and staff disseminated posters with QR code distributed.	
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.	
		Midwifery Staffing report to be presented to Directors and included in Board Report	HOM	30 April 2021	Midwifery staffing report presented to May Board Birthrate plus reassessment to be completed July 2021. Meeting with Birthrate plus on 16th July 2021	
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	
8.3	Midwifery Workforce to be established to BirthRate+ recommendation	Submission to bid for national funding for Band 5 and 6 midwives to support staffing to Birthrate plus	CD/ HoM/ DM and finance	6 May 2021	Submission made and monies received	

Action Number	Recommendation / Area for Action Identified	Action Agreed	Lead	Date for Completion	Progress / Assurance	Key
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 reported in staffing paper to Trust board June 2021	
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 depends on the needs of each Trust	Review current roles and current requirements	HOM	March 2021	Reviewed as described and additional roles identified. To be included in the staffing report	
		Include specialist midwife staffing requirements in report to Directors and Board	HOM	30 May2021	Included in staffing report and awaiting outcome of funding bid in order to implement	
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						

Action Number	Recommendation / Area for Action Identified	Action Agreed	Lead	Date for Completion	Progress / Assurance	Key
	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~~ Revised date 31 Aug 2021	All senior midwives and obstetricians have access to AMAT the Trust system for review and action of NICE guidance. Discussion with Trust audit team about need for formally recorded audit plan. Current process for NICE guidance leaves gaps and requires review and additional safeguards to avoid omissions.	

Enclosure 24

The Dudley Group NHS Foundation Trust

Paper for submission to Public Board
On 16th September 2021

TITLE:	EPRR Core Standards 2021 Submission		
AUTHOR:	Christopher Leach - EPRR and Business Continuity Manager	**PRESENTER:**	Christopher Leach - EPRR and Business Continuity Manager

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
	Y		

RECOMMENDATIONS

To approve the trusts submission in relation to the NHS Commissioning EPRR Core Standards as issued by NHS England for 2021.

CORPORATE OBJECTIVE:

SO1, SO2, SO3, SO4, SO5, SO6

SUMMARY OF KEY ISSUES:

Annually the trust is expected to submit its Core Standards pertaining to EPRR in order to demonstrate to commissioners and regulators that we have in place suitable and sufficient plans and processes linked to EPRR. These standards are formed from key requirements in relation to the Civil Contingencies Act 2004, Health and Social Care Act 2012 and the EPRR Framework as well as other associated guidance and frameworks.

The trust continually strives to improve its EPRR arrangements ensuring our organisation and staff are suitably prepared for any potential incident(s). For 2021/22 the Corporate Resilience team are pleased to indicate we retain (under self-assessment) our Substantial Compliance status.

It evidences the ongoing work and engagement by the organisation in relation to the EPRR programme of work. There are however a number of standards that were identified in relation to requiring improvement, and therefore were failed this year, these are indicated below:

- Assurance of commissioned providers- this relates to the lack of assurance from Mitie FM in relation to Business Continuity. This has been raised as a risk as indicated below, The Trust Estates team are also working with Summit and Mitie to rectify this. This work will remain on the risk register until suitable assurance is received into the trust as this continues to pose a risk to the organisation
- Business Continuity plans- This relates to the required improvement works that are ongoing in relation to engagement with the business continuity process, there are extensive processes in place in order to complete this programme of work with a final date for completion of the 31st August 2021 when final

areas are due to engage with the programme completing localised planning, this will be noted on our follow up to NHS England anticipated to take place in Autumn 2021

- CBRN Decontamination capability- This is in relation to the training of the ED department in CBRN response. This has unfortunately been adversely affected by the COVID 19 pandemic whereby training was suspended. We have an extensive training programme under way with compliance due to be reached by the e/o 2021. This includes extensive training tools i.e. e-learning, increased trainer availability (x4 due to be trained by WMAS in September 2021), live exercise training, specific training for those in responsibility i.e. supervising decontamination, face to face sessions for suit training including health and safety elements

A deep dive was completed in relation to 2021's core standards this was in relation to medical gases and the compliance tracking required in relation to these key areas resilience as identified during the ongoing response to COVID 19. The areas identified as partially compliant that will require further work over the next 6 months to achieve the standards are:

- DD2- Organisation has robust and tested BC or DR plans for medical gases- Whilst the trust has robust BCPs in place we have yet to be provided the assurance from mitie FM in relation to there own for which medical gases will feature, this will require:
    - Routine BCP EPRR Testing to be implemented for PMGS Joint Trust/Summit/Mitie- this will be lead by the trust EPRR lead once assurance of planning is provided
    - Trust wide compliance with medical gas training needs to be improved- this will be escalated through medical gas group for action by the divisional chief nurses
- DD3- The organisation has used Appendix H to the HTM 0201-part A to support the planning, installing, upgrading of its cryogenic liquid supply system- the trust hasn't been provided by Mitie AO the latest copy of the auditing in relation these systems, to comply this action requires:
    - Authorising Engineer Audit to presented at Medical Gas Committee- this will be led by Summit/Mitie
- DD4- The organisation has reviewed the skills and competencies of identified roles within the HTM and has assurance of resilience for these functions, further training is required for trust staff in relation to this with further cover being requested in relation to APs by Summit/Mitie, to comply this action requires:
    - Ensure all DNO/DMO attend and complete Training- this will be led by the divisional chief nurses
    - Appoint further APs to ensure resilient cover- this will be led by Summit/Mitie
- DD6- Organisation has an accurate and up to date technical file on its oxygen supply system with the relevant instruction for use (IFU) - the trust hasn't been provided by Mitie AO the latest copy of the auditing in relation these systems, to comply this action requires:
    - Authorising Engineer Audit to presented at Medical Gas Committee- this will be led by Summit/Mitie
- DD7- The organisation has undertaken as risk assessment in the development of the medical oxygen installation to produce a safe and practical design and ensure that a safe supply of oxygen is available for patient use at all times as described in Health Technical Memorandum HTM02-01 6.6- the trust hasn't been provided by Mitie AO the latest copy of the auditing in relation these systems, to comply this action requires:

- Authorising Engineer updated system risk assessment to presented at Medical Gas Committee- this will be led by Summit/Mitie

In relation to all standards identified as failed there have been timeframes of no longer than 6 months for them to be rectified and evidence of full compliance provided to the EPRR Assurance Group

The Core Standards status is important to the trust and a programme of work is in place to ensure improvement against those standards as requiring further work.

IMPLICATIONS OF PAPER:

IMPLICATIONS FOR THE CORPORATE RISK REGISTER OR BOARD ASSURANCE FRAMEWORK

RISK	**Y**		**Risk Description:** FE1610 Lack of Business Continuity arrangements for Mitie FM OPS1481 COVID 19 Pandemic OPS1450 No Deal EU Exit could affect supply chain and workforce, affecting the ability to provide safe/effective services
	Risk Register: Y		**Risk Score:** FE1610 Major OPS1481 Major OPS1450 Minor
COMPLIANCE and/or LEGAL REQUIREMENTS	**CQC**	**N**	**Details:**
	NHSI	**Y**	**Details:** NHS England EPRR Core Standards
	Other	**Y**	**Details:** Civil Contingencies Act 2004 EPRR Framework 2015 Health and Social Care Act 2021 NHS Standard Contract Section 46 & 47 ISO 22301 & 22313
REPORT DESTINATION	**Board of Directors**	**Y**	**DATE:**
	Working Group	**N**	**DATE:**
	Committee	**Y**	**DATE:**

Ref	Domain	Standard	Detail	Acute Providers	Evidence - examples listed below	Organisational Evidence	Self assessment RAG Red (not compliant) = Not compliant with the core standard. The organisation's EPRR work programme shows compliance will not be reached within the next 12 months. Amber (partially compliant) = Not compliant with core standard. However, the organisation's EPRR work programme demonstrates sufficient evidence of progress and an action plan to achieve full compliance within the next 12 months. Green (fully compliant) = Fully compliant with core standard.	Action to be taken	Lead	Timescale	Comments
51	Business Continuity	Business Continuity Plans	The organisation has established business continuity plans for the management of incidents. Detailing how it will respond, recover and manage its services during disruptions to: • people • information and data • premises • suppliers and contractors • IT and infrastructure	Y	• Documented evidence that as a minimum the BCP checklist is covered by the various plans of the organisation	The trust has in place a robust process for individual Business Continuity plans by service area. There are a number of areas that are still working on there processes for this year whilst they have existing processes in place they need annual updats and to reflect on learning from the COVID 19 Response so far. This is due to be completed by mid September 2021	Partially compliant	Final areas to meet with EPRR to complete there service level BCPs	Divisional Teams/EPRR/Senior Teams	1 month	
55	Business Continuity	Assurance of commissioned providers / suppliers BCPs	The organisation has in place a system to assess the business continuity plans of commissioned providers or suppliers; and are assured that these providers business continuity arrangements work with their own.	Y	• EPRR policy document or stand alone Business continuity policy • Provider/supplier assurance framework • Provider/supplier business continuity arrangements	This is completed by procurement through request of BC arrangements during contracting, this was assessed during the response and preperation to Brexit and found to be in place. However Mitie have yet to provide an updated BC policy in line with national guidance, this is captured on the trusts risk register and is being managed through the trust estates compliance team	Partially compliant	Mitie to be requested to provide assurance that Business Continuity Plan is in place with a robust testing process having being completed	Trust Estates Compliance Team	1 month	
59	CBRN	Decontamination capability availability 24 /7	The organisation has adequate and appropriate decontamination capability to manage self presenting patients (minimum four patients per hour), 24 hours a day, 7 days a week.	Y	• Rotas of appropriately trained staff availability 24 /7	Due to COVID 19 training for CBRN has been reduced and due to the high turnover of staff and reliance on banklagency there is a reduction in the amount of CBRN trained staff within ED, there are a number of programmes underway to rectify this, increased training sessions, e-learning, live exercise planned for Sept, Consultant engagement training and additional staff outside the ED being identified to be trained in CBRN response	Partially compliant	Increase % compliance in relation to training within the ED	Emergency Department	4 months	

Ref	Domain	Standard	Detail	Evidence - examples listed below	Acute Providers	Organisational Evidence	Self assessment RAG **Red (not compliant) =** Not compliant with the core standard. The organisation's work programme shows compliance will not be reached within the next 12 months. **Amber (partially compliant) =** Not compliant with core standard. However, the organisation's work programme demonstrates sufficient evidence of progress and an action plan to achieve full compliance within the next 12 months. **Green (fully compliant) =** Fully compliant with core standard.	Action to be taken	Lead	Timescale	Comments
Deep Dive - Oxygen Supply **Domain: Oxygen Suuply**											
DD1	**Oxygen Supply**	**Medical gasses - governance**	The organisation has in place an effective Medical Gas Committee as described in Health Technical Memorandum HTM02-01 Part B.	• Committee meets annually as a minimum • Committee has signed off terms of reference • Minutes of Committee meetings are maintained • Actions from the Committee are managed effectively • Committee reports progress and any issues to the Chief Executive • Committee develops and maintains organisational policies and procedures • Committee develops site resilience/contingency plans with related standard operating procedures (SOPs) • Committee escalates risk onto the organisational risk register and Board Assurance Framework where appropriate • The Committee receives Authorising Engineer's annual report and prepares an action plan to address issues, there being evidence that this is reported to the organisation's Board	Y	The Medical Gas & Pipeline Systems Group was set up in 2016 and chaired by the Chief Pharmacist. This is a multidisciplinary group of clinical, operational, technical subject matter experts and the group meets at least quarterly. The Terms of Reference are reviewed biannually and each quarterly meeting is summarised into a highlight report escalating to the Medicines Management Group any areas of success, progress and emerging concern or risk. The Medicines Management Group provides quarterly highlight report on operational delivery, quality improvement, issues and risks to the Quality and Safety Committee, a Trust sub-Board Committee. The Chief Executive is a member of both the Quality & Safety Committee and the Medicines Management Group.	Fully compliant				
DD2	**Oxygen Supply**	**Medical gasses - planning**	The organisation has robust and tested Business Continuity and/or Disaster Recovery plans for medical gases	• The organisation has reviewed and updated the plans and are they available for view • The organisation has assessed its maximum anticipated flow rate using the national toolkit • The organisation has documented plans (agreed with suppliers) to achieve rectification of identified shortfalls in infrastructure capacity requirements. • The organisation has documented a pipework survey that provides assurance of oxygen supply capacity in designated wards across the site • The organisation has clear plans for where oxygen cylinders are used and this has been discussed and there should be an agreement with the supplier to know the location and distribution so they can advise on storage and risk, on delivery times and numbers of cylinders and any escalation procedure in the event of an emergency (e.g. understand if there is a maximum limit to the number of cylinders the supplier has available) • Standard Operating Procedures exist and are available for staff regarding the use, storage and operation of cylinders that meet safety and security policies • The organisation has breaching points available to support access for additional equipment as required • The organisation has a developed plan for ward level education and training on good housekeeping practices • The organisation has available a comprehensive needs assessment to identify training and education requirements for safe management of medical gases	Y	•All Piped Medical Gas Systems and Services are delivered by Summit/Mitie as Part of the Trusts PFI Contract. The PFI contract requires full compliance with all Health Technical Memorandums •Mitie have a BCP for all their services including medical Gases (See attached) •The maximum flow rate on the Piped O2 system is 2,100 L/M •Drawings of the medical gas pipeline systems are available and are up to date •Details of oxygen cylinder storage at ward/department level available (see attached) •NIST connections are installed around the estate •APs not appointed by AE unless appropriate training in place •BCP tested for high flow alarms and escalation •BCP on Twin VIEs is and has been tested as part of routine	Partially compliant	Routine BCP EPRR Testing to be implemented for PMGS Joint Trust/Summit/Mitie Action – Trust wide compliance with medical gas training needs to be improved	Mitie/Summit Divisional Chief Nurses	6 months 6 months	
DD3	**Oxygen Supply**	**Medical gasses - planning**	The organisation has used Appendix H to the HTM 0201 part A to support the planning, installing, upgrading of its cryogenic liquid supply system.	• The organisation has clear guidance that includes delivery frequency for medical gases that identifies key requirements for safe and secure deliveries • The organisation has policy to support consistent calculation for medical gas consumption to support supply mechanisms • The organisation has a policy for the maintenance of pipework and systems that includes regular checking for leaks and having de-icing regimes • Organisation has utilised the checklist retrospectively as part of an assurance or audit process	Y	•All Piped Medical Gas Systems and Services are delivered by Summit/Mitie as Part of the Trusts PFI Contract. The PFI contract requires full compliance with all Health Technical Memorandums •Deliveries to VIE are based upon real time telemetry monitoring by BOC •The system was fully upgraded and extended in compliance with HTM which was completed in 2005 •Routine maintenance in line with HTM in place via Summit/Mitie with specialist contractors •Procedure is in place by Mitie to de-ice the VIE evaporators in line with BOC requirements •Live real time monitoring of Oxygen Flow Rates from Primary VIE in place with alarms at pre agreed levels which are monitored by Mitie 24/7	Partially compliant	Authorising Engineer Audit to presented at Medical Gas Committee	Summit/Mitie	6 months	
DD4	**Oxygen Supply**	**Medical gasses -workforce**	The organisation has reviewed the skills and competencies of identified roles within the HTM and has assurance of resilience for these functions.	• Job descriptions/person specifications are available to cover each identified role • Rotating of staff to ensure staff leave/ shift patterns are planned around availability of key personnel e.g. ensuring QC (MGPS) availability for commissioning upgrade work. • Education and training packages are available for all identified roles and attendance is monitored on compliance to training requirements • Medical gas training forms part of the induction package for all staff.	Y	•All Piped Medical Gas Systems and Services are delivered by Summit/Mitie as Part of the Trusts PFI Contract. The PFI contract requires full compliance with all Health Technical Memorandums •Mitie employ all AEs, APs and CPs as part of their responsibilities under the PFI contract •Roles and responsibilities are clearly detailed in the Medical Gas Policy (2020). (Copy Attached) •APs not appointed by AE unless appropriate training in place •The Trust have a qualified and competent Compliance Manager with a clear job description who oversee the PFI Contract Delivery. •Appointment documentation for AEs and APs in place (See attached), however, further APs required to be appointed	Partially compliant	Ensure all DNO/DMO attend and complete Training Appoint further APs to ensure resilient cover	Divisonal Chief Nurse Summit/Mitie	6 months	
DD5	**Oxygen Supply**	**Oxygen systems - escalation**	The organisation has a clear escalation plan and processes for management of surge in oxygen demand	• SOPs exist, and have been reviewed and updated, for 'stand up' of weekly/ daily multi-disciplinary oxygen rounds • Staff are informed and aware of the requirements for increasing de-icing of vaporisers • SOPs are available for the 'good housekeeping' practices identified during the pandemic surge and include, for example, Medical Director sign off for the use of HFNO	Y	•All Piped Medical Gas Systems and Services are delivered by Summit/Mitie as Part of the Trusts PFI Contract. The PFI contract requires full compliance with all Health Technical Memorandums •A clear escalation plan and action cards are in place (See attached) •Procedure is in place by Mitie to de-ice the VIE evaporators in line with BOC requirements	Fully compliant				
DD6	**Oxygen Supply**	**Oxygen systems**	Organisation has an accurate and up to date technical file on its oxygen supply system with the relevant instruction for use (IFU)	• Reviewed and updated instructions for use (IFU), where required as part of Authorising Engineer's annual verification and report	Y	•All Piped Medical Gas Systems and Services are delivered by Summit/Mitie as Part of the Trusts PFI Contract. The PFI contract requires full compliance with all Health Technical Memorandums •Medical gas Policy in Place (See attached) •Drawings of medical gas pipelines are available and have been updated •Feasibility study undertaken to increase max oxygen flow capacity to 5,000L/M (see attached) •Authorising Engineer undertakes annual audits of medical gas pipeline systems; however, Trust has not been provided with latest copy •Authorising Engineer audit reviewed at Medical Gases Group	Partially compliant	Authorising Engineer Audit to presented at Medical Gas Committee	Summit/Mitie	6 months	
DD7	**Oxygen Supply**	**Oxygen systems**	The organisation has undertaken as risk assessment in the development of the medical oxygen installation to produce a safe and practical design and ensure that a safe supply of oxygen is available for patient use at all times as described in Health Technical Memorandum HTM02-01 6.6	• Organisation has a risk assessment as per section 6.6 of the HTM 02-01 • Organisation has undertaken an annual review of the risk assessment as per section 6.134 of the HTM 02-01 (please indicated in the organisational evidence column the date of your last review)	Y	•All Piped Medical Gas Systems and Services are delivered by Mitie as Part of the Trusts PFI Contract. The PFI contract requires full compliance with all Health Technical Memorandums •The system was fully upgraded and extended in compliance with HTM which was completed in 2005 •Risk basement undertaken on 09/03/2020 regarding clinical impact and mitigation for insufficient Oxygen Supplies to meet demand •Authorising Engineer undertakes annual audits of medical gas pipeline systems; however, Trust has not been provided with latest copy •AE audit reviewed at Medical gases group	Partially compliant	Authorising Engineer Audit including updated system RA to presented at Medical Gas Committee	Summit/Mitie	6 months	

The Dudley Group
NHS Foundation Trust

EPRR ASSURANCE GROUP
ACTION MONITORING SHEET

Action Date	Action	Person Responsible	To be completed by	Progress/Comments
[redacted]	[redacted]	[redacted]	[redacted]	
[redacted]	[redacted]	[redacted]	[redacted]	
[redacted]	[redacted]	[redacted]	[redacted]	
[redacted]	[redacted]	[redacted]	[redacted]	
[redacted]	[redacted]	[redacted]	[redacted]	
[redacted]	[redacted]	[redacted]	[redacted]	
[redacted]	[redacted]	[redacted]	[redacted]	
09/03/2021	Mitie to provide assurance to the trust that they have business continuity arrangements in place	D.Lowe/ L.Garrison	**08/06/2021**	
[redacted]	[redacted]	[redacted]	[redacted]	
[redacted]	[redacted]	[redacted]	[redacted]	
[redacted]	[redacted]	[redacted]	[redacted]	

	[redacted]	[redacted]		
17th August 2021	Completion of Trust Wide Business Continuity Plans	Divisional Directors	**30/09/2021**	01/03/2021- New Template launched following learning from COVID and Incidents. 06/06/2021- Escalation via F&P in relation to compliance of Business Continuity programme 17/08/2021- 14 areas outstanding, 4 clinical, meetings booked with them
17th August 2021	For ED to assure improvement in there CBRN preparedness status (training)	ED PDN team	**24/12/2021**	01/08/2021- Training status standing at 27% compliance 04/08/2021- ED made aware of the availability of the Moodle platform to support training 12/08/2021- x4 DGH staff booked onto WMAS train the trainer for PRPS

The Dudley Group
NHS Foundation Trust

Tel: 01384 321000

Ref: EPRR annual assurance 2021 - 2022

Date: 17th August 2021

Karen Kelly
Chief Operating Officer
Dudley Group NHS FT
Russells Hall Hospital
Pensnett Road
Dudley
West Midlands
DY1 2HQ

Dear Sir/Madam

Re: EPRR annual assurance 2021 - 2022

In accordance with your letter dated 28th July 2021, please find below assurance in relation to DGFT assurance against the EPRR Core Standards Process:

DGFT has maintained its status of ***Substantial compliance*** in relation to the EPRR core standards, with the self assessment attached evidencing the level of compliance.

We have ensured that high standards are maintained in relation to the Civil Contingencies Act 2004, Health and Social Care Act 2012 and the EPRR Framework 2015.

The areas we have identified as requiring further work to allow the trust to attain a full compliance level are indicated with clear objectives in order for us to successfully achieve them, this has also been factored into the trusts EPRR Work Plan for 2021/22.

We hope this letter provides the level of detail required against your letter. However should you require further detail please contact us

Yours Sincerely

Karen Kelly

Karen Kelly
Chief Operating Officer (Accountable Emergency Officer)

Enclosure 25

The Dudley Group NHS Foundation Trust

Paper for submission to the Board of Directors on 16th September 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's held on 29th July and 26th August 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	**Board of Directors**	**Y**	**DATE:** 16 September 2021
	Working Group	**N**	**DATE:**
	Committee	**N**	**DATE:**

NHS
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NHS Foundation Trust

EXCEPTION REPORT FROM FINANCE AND PERFORMANCE COMMITTEE CHAIR

Meeting held on: 29 July 2021

MATTERS OF CONCERN OR KEY RISKS TO ESCALATE	MAJOR ACTIONS COMMISSIONED/WORK UNDERWAY
• EAS 77.6%, lowest level for over a year, due to substantial increase in demand, much of it inappropriate, and staffing pressures • Continued high agency and medical WLI to deal with current pressures and recovery and restoration • Trust will retain its Substantial Compliant status in relation to EPRR Core Standards however we are expected to fail to meet a number due to failure to keep operational business continuity plans, Mitie Business Continuity Plan not being submitted and CBRN Training within the ED, this is closely linked to staffing pressure in some cases and others failure to engage. • Growing concern about financial position in H2, with increase to ERF thresholds, rising non-pay costs and more business cases • Deterioration in PFI performance (cleaning and estates especially) to pre-COVID levels, although early signs that Mitie is willing and able to respond	• Review corporate and strategic risks given growing uncertainties around H2 and 2021/22 • Pursue with NHSI timely payment of Vaccination Workforce Bureau costs • Develop proposals for properly resourcing delivery of the Green Plan
POSITIVE ASSURANCES TO PROVIDE	**DECISIONS MADE**
• Small surplus in June taking Q1 surplus to £1.6m, £0.1m better than plan. Unaccrued ERF in Q1 also slightly ahead	• Approved EPRR Strategy 2021/22 and Business Continuity Policy

• Expect Trust and System to breakeven in H1 • On or ahead of trajectory for cancer, DM01 and RTT, although RTT position likely to deteriorate • Continued good performance of Vaccination Workforce Bureau • Strategy and Workforce are developing a dashboard to track the financial impact of staffing and productivity initiatives. First iteration due September	
• **Chair's comments on the effectiveness of the meeting:** Lengthy discussion of staffing issues and impact on ED, recovery and restoration and financial performance. Keen to highlight to Board (1) the importance of the System working together to communicate clearly to the local population about how best to use the NHS services that are available so as to reduce unnecessary demand on ED and (2) the need for the System to work together in a more mature way, for example around finances, or risk undermining its credibility	

The Dudley Group NHS Foundation Trust

EXCEPTION REPORT FROM FINANCE AND PERFORMANCE COMMITTEE CHAIR

Meeting held on: 26 August 2021

MATTERS OF CONCERN OR KEY RISKS TO ESCALATE

- Deterioration in H1 financial position is leading to increased concern about H2. H1 flexibility of £8m at the start of the year has fallen to £4.5m, principally due to changes to ERF rules and budget pressures in MIC and CSS
- Potential 2022/23 deficit has increased to £20.9m, with further increases likely (see decisions made)
- 2021/22 CIP plans revised down to £2.72m
- EAS remains between 77% and 78% and recovery and restoration of electives is below target
- Modular ward further delayed. Occupation now anticipated 6 October

MAJOR ACTIONS COMMISSIONED/WORK UNDERWAY

- Finance and MIC and CSS divisions to understand in detail the variances from budget and the divisions to develop recovery plans for the next committee meeting
- £20m cost reduction plan for 2022/23 to be presented to January F&P
- As part of the approval below, IT to provide quarterly updates to F&P on the development of Phase II of the Infrastructure Refresh business case, identifying in conjunction with the divisions the scale of, and delivery mechanism for realising, the anticipated benefits

POSITIVE ASSURANCES TO PROVIDE

- Year to date I&E surplus of £1.46m, £0.23m better than phased plan
- System surplus of £0.83m. Currently forecasting H1 deficit (due to WMAS) although in practice expected to break even
- Continued good performance by the vaccination workforce bureau, which is recognised nationally, and assurance received around VFM of Phase 3 plans
- Whilst below target, Cancer, RTT and DM01 performance remains robust

DECISIONS MADE

- Recommended to Board approval of:
  - Phase I of the Infrastructure Refresh business case, but in doing so draws the Board's attention to the fact that on current information Phase II will further increase cost pressures, potentially by up to £2.5m a year
  - The tender awards for Phase 3 of the vaccination workforce bureau
  - The Ligature Points Removal From In-patients Areas business case

	o Approved the Storage Facilities Russells Hall Hospital business case
• **Chair's comments on the effectiveness of the meeting:** Lengthy discussion around medium term financial pressures, which are of mounting concern. Received interesting deep dive presentation from CSS highlighting areas of progress and some areas of concern	

Enclosure 26

The Dudley Group NHS Foundation Trust

Paper for submission to Trust Board

TITLE:	**Integrated Performance Report for Month 4 (July)**		
AUTHOR:	S ILLINGWORTH	**PRESENTER**	K KELLY

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:

Key Areas of Success

- To July the Trust continues to deliver strong performance against the national 2ww standard with many tumour sites delivering 93% month on month against this key target.
- Whilst performance against the 4 hour standard fell short of the target the Trust is one of the stronger performing trusts in the locality. To August the Trust is rated third out of five Trusts
- Diagnostics remains a significant area of success with the Trust performing strongly against both DM01 performance targets and R&R activity targets.
- VTE assessment remains strong and whilst there was a small dip in performance (0.5%) in July across Surgery overall performance against this key quality remains strong month on month.

Key Areas of Concern

- The number of patients waiting over 12 hours (trolley waits) in the ED department has been a concern and the team have worked extremely hard to avoid these occurring. Whilst attendances were high in June and July activity has stabilised and the focus must now shift to discharge. Long waits in ED are primarily now being driven by late discharges on base wards.
- There has been an increase in the number of patients waiting over 104 days for cancer treatment and the cancer team and tumour sites are working hard to bring this number down. Whilst some of these patients are waiting for treatment at tertiary centres, many are waiting for surgical dates at RHH. Additional senior input at the weekly cancer performance meetings will aim to improve oversight of the issues.
- Staffing issues remain a significant challenge across theatres and this has hampered the recovery of elective activity. Over the last month the theatre team have increased the number of Band 7 staff employed and have also agreed to upgrade Band 5 staff to Band 6 to help with retention and increase skill mix available. There has also been a large scale recruitment drive and the team are currently assessing how this will be support filling long standing vacancies. Current plans suggest these staffing challenges will ease in September.

EAS

EAS standards remain a challenge with the Trust again missing the 4 hours standard, delivering 77.4% in July. In addition to 4 hour delays, 12 hour trolley waits have been an issue. The main focus needed to address these problems needs to be on effective discharge from hospital from the base wards. The operational teams are working hard to deploy Home for Lunch scheme and Right to Reside in order to try and improve matters.

Delayed discharges remain a challenge and the discharge team is working with social services and primary care to reduce the number of patients who are Medically Fit for Discharge (MFFD), which at time of writing was over 50 patients.

Cancer

Cancer performance remains generally strong with regards to 2ww while delivery of 62 day standard is more of a challenged (67.9% June). The main factors for this are

- Diagnostic delays both internally and awaiting results from external organisations
- Patients awaiting a treatment date at tertiary centres
- Some delays accessing theatres at RHH due to capacity constraints

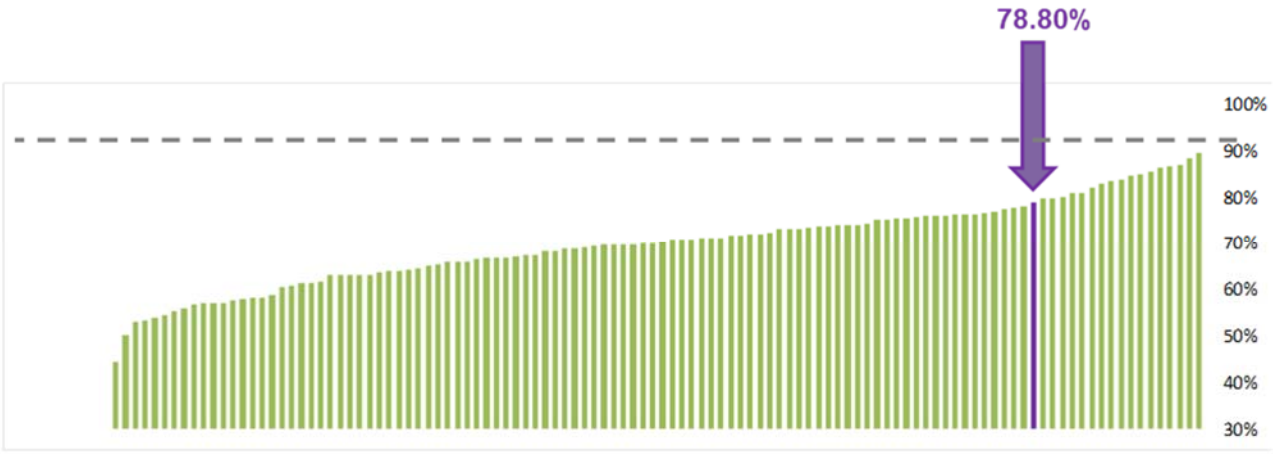
To address this, the team plans to open additional theatres from September and October which should ease the pressure. Increased scrutiny at the weekly cancer performance meetings will ensure that patients are managed in a more timely way.

RTT & 52 week waits

RTT position for July shows that the Trust was one of the strongest performing organisations in the country for performance against the 18 week standard, achieving 78.8%.

Trust Wide RTT Benchmarking

July 2021



Provider Name	Total
NORTHUMBRIA HEALTHCARE NHS FOUNDATION TRUST	89.42%
NORTH TEES AND HARTLEPOOL NHS FOUNDATION TRUST	88.32%
SOUTH TYNESIDE AND SUNDERLAND NHS FOUNDATION TRUST	86.91%
BARNSLEY HOSPITAL NHS FOUNDATION TRUST	86.77%
CROYDON HEALTH SERVICES NHS TRUST	86.46%
NORTH MIDDLESEX UNIVERSITY HOSPITAL NHS TRUST	85.64%
KINGSTON HOSPITAL NHS FOUNDATION TRUST	84.90%
THE ROTHERHAM NHS FOUNDATION TRUST	84.72%
SOUTHPORT AND ORMSKIRK HOSPITAL NHS TRUST	83.76%
SOUTH WARWICKSHIRE NHS FOUNDATION TRUST	83.39%
HOMERTON UNIVERSITY HOSPITAL NHS FOUNDATION TRUST	83.07%
ASHFORD AND ST PETER'S HOSPITALS NHS FOUNDATION TRUST	82.12%
GATESHEAD HEALTH NHS FOUNDATION TRUST	81.07%
SHEFFIELD TEACHING HOSPITALS NHS FOUNDATION TRUST	81.06%
EPSOM AND ST HELIER UNIVERSITY HOSPITALS NHS TRUST	80.22%
EAST SUSSEX HEALTHCARE NHS TRUST	79.78%
LONDON NORTH WEST UNIVERSITY HEALTHCARE NHS TRUST	79.69%
THE DUDLEY GROUP NHS FOUNDATION TRUST	78.80%

There is a growing risk to this position (which is reflected in the slipping position) due to continued challenges opening all available operating theatres. Opening this capacity from September and October is critical.

The national focus remains on the management of long waiting patients (over 104 and 52 weeks) and on the management of patients against their national clinical prioritisation codes (P codes) which does impact on delivery of the 18 week standard. The total number of 52 week waiters at Dudley remains one of the lowest in the region.

DM01

Performance against DM01 standards remains strong (Dudley has one of the best performing diagnostic services in the region) achieving 83.7% against the national standard.

The team are leading the way with the development of the Community Diagnostic Hub (CDH) across the Black Country. Once Phase 1 commences from September 2021 the CDH will provide significant additional capacity to treat Dudley patients as well as those from across the wider STP footprint.

IMPLICATIONS OF PAPER:

IMPLICATIONS FOR THE CORPORATE RISK REGISTER OR BOARD ASSURANCE FRAMEWORK

RISK	**Y**		**Risk** **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 **Description:**
	Risk Register: Y/N		**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:** F & P

Performance KPIs

August 2021 Report (July 2021 Data)

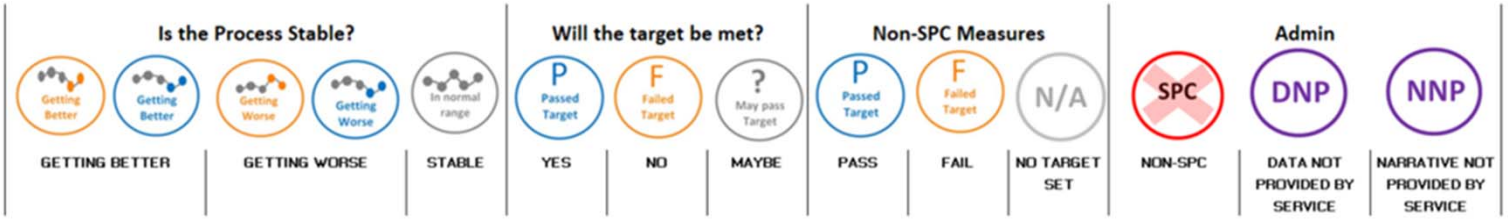
NHS
The Dudley Group
NHS Foundation Trust

Karen Kelly, Chief Operating Officer

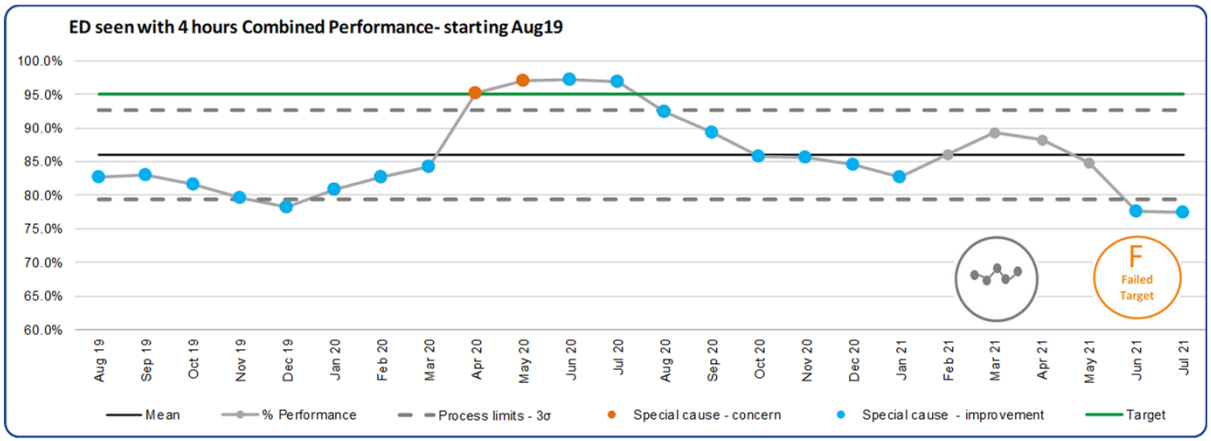



Constitutional Performance

Constitutional Standard and KPI		Target	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Status	
Emergency Access Standard (EAS)	Combined 4hr Performance	95.0%	84.5%	82.7%	86.1%	89.3%	88.2%	84.9%	77.6%	77.4%	In normal range	F Failed Target
Triage	Triage - All	95.0%	95.0%	93.5%	95.0%	93.4%	94.3%	92.3%	89.1%	87.4%	In normal range	F Failed Target
Cancer	Cancer 62 Day - Urgent GP Referral to Treatment	85.0%	60.0%	70.6%	68.5%	55.9%	74.1%	64.9%	79.5%	67.9%	In normal range	F Failed Target
	Cancer 31 Day -	96.0%	95.2%	93.3%	96.3%	96.8%	95.2%	94.3%	95.6%	92.9%	In normal range	F Failed Target
	All Cancer 2 Week Waits	93.0%	94.1%	85.9%	98.0%	96.6%	86.8%	93.9%	92.7%	93.0%	H	F Failed Target
Referral to Treatment (RTT)	RTT Incomplete	92%	83.1%	80.5%	77.8%	77.4%	77.0%	78.4%	79.4%	78.8%	Getting Worse	F Failed Target
Diagnostics	0M01 - Diagnostics achieved within 6 weeks	99%	77.5%	73.5%	78.4%	82.7%	80.4%	83.8%	84.9%	83.7%	In normal range	F Failed Target
VTE	% Assessed on Admission	95%	93.6%	92.1%	95.5%	96.4%	96.1%	96.3%	96.3%	95.7%	H	P Passed Target



ED Performance



77.4%	54	11th
		As at 16/07/21
EAS 4 hour target 95% for Type 1 & 3 attendances (inc of booked appointments)	DTA 12 hour breaches - target zero	DGFT ranking out of 21 Midlands area Trusts

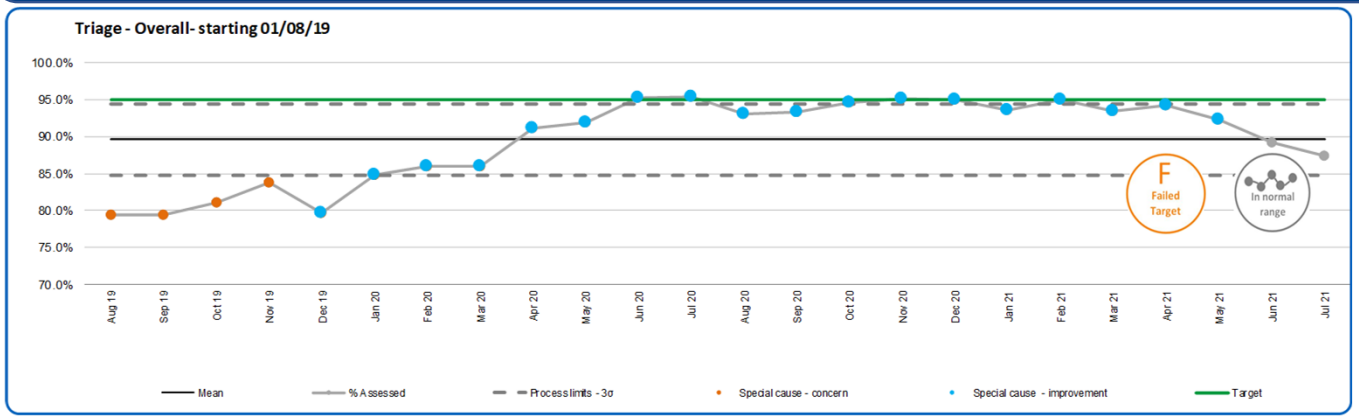
Performance

- Performance against the 4 hour standard continues to struggle against the 95% standard
- Levels of demand within ED were high during June and July in particular, with many days seeing in excess of 350 attenders (with two says seeing in excess of 400). More recently however demand has returned to more predictable levels.
- Total number of 4 hour breaches overall remain generally lower than pre-pandemic levels and continues a downward trajectory. The exception to this being when ED attendances are very high. During this same period however admissions have not been excessive.
- There has been a significant spike in the number of 12 hour trolley waits and this is reflective of higher bed occupancy levels during the same period (June and July), the high numbers of patients who are medically fit for discharge remaining in acute hospital beds and challenges with effective discharge planning
- In July ED performance at Dudley was roughly the middle of the pack for 21 Trusts across the Midlands area. For further context, as at the 11th August, the department was the 3rd best performing ED department out of the 5 Trusts locally.

Action

- ✓ Continued focus on effective discharge planning across all main surgical and emergency wards. Full deployment of Home for Lunch across all wards from September.
- ✓ Working with CCG to ensure that the UCC remains fit for purpose and able to meet the demands of the Trust and users.
- ✓ Re-establishing the Urgent Care Service Improvement Group from August onwards, to oversee improvements in urgent care and flow.
- ✓ Continued development and refinement of the SDEC pathway work in preparation for the opening of the new modular ward in September

ED Triage



87.4%

Triage – target 95%

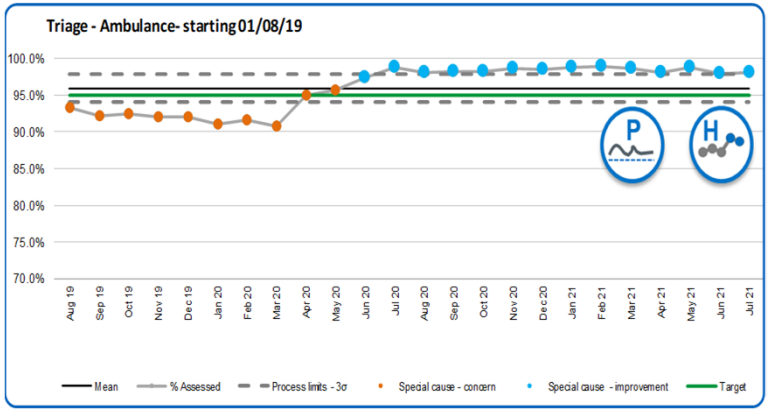
Performance

- Overall ED Triage performance has dipped in recent months, this is reflective of the high levels of demand during June and July
- There was a further reduction in performance between June and July

Action

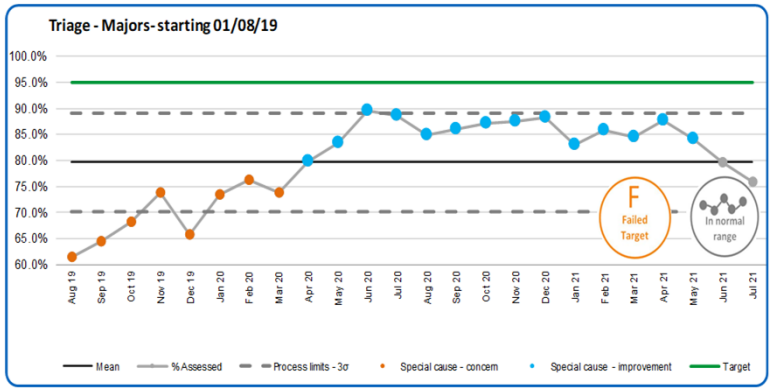
- ✓ Front ED triage reconfigured of space expanding capacity to 10 spaces (from 5)
- ✓ Department continue working on CSW management of bloods, 12l ECG, basic observations, " Meet and great standard"
- ✓ Add additional workstation

ED Triage



July

98.1%



July

75.9%

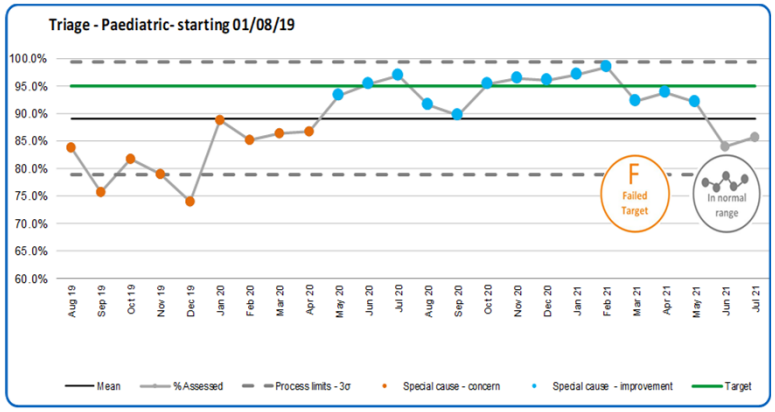
Performance

- Ambulance triage continues to meet the standard month on month
- Challenges remain in Majors, due to high volumes of attendances in June and July

Action

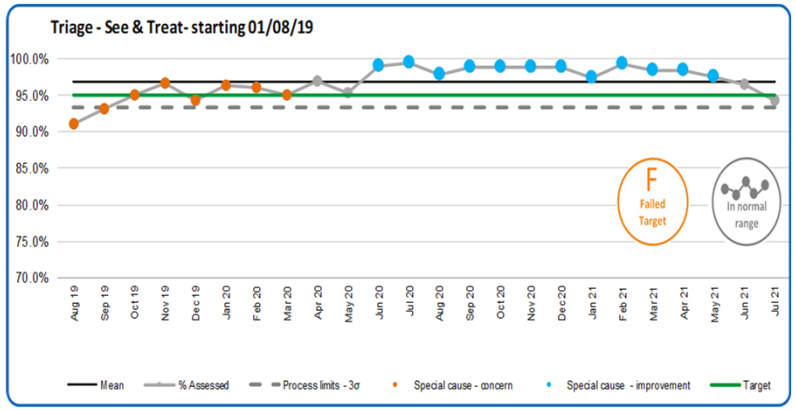
- ✓ Invest in a new communication devices between ED Flow Nurse, Nursing Interventions Classification (NIC) and Emergency Severity Index (ESI) Nurse
- ✓ Improve availability of ESI trained nurses 24/7
- ✓ Rapid Assessment and Treatment (RAT) implementation was delayed –will commence now additional ED Middle Grades commenced
- ✓ RAT Project –ED Consultant Body approved proposal, programme to commence
- ✓ Deployed NIC for facilitating triage across all clinical areas

ED Triage



July

85.7%



July

94.3%

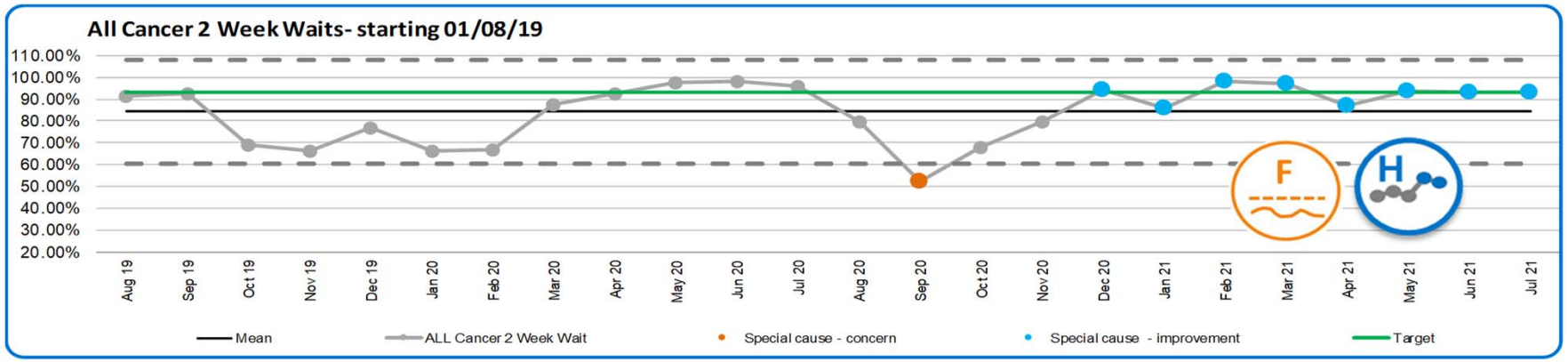
Performance

- "ED Paediatrics" and "See and Treat "performance continues to be validated daily.
- Additional triage facility open to improve falling triage performance on the background of raising attendances
- RSV surge plan agreed and ready for deployment

Action

- ✓ Continue with existing plans for performance improvement
- ✓ Performance expected to improve in coming months

Cancer Performance – 2 Week Wait



93.0%

All cancer 2 week waits – target 93%

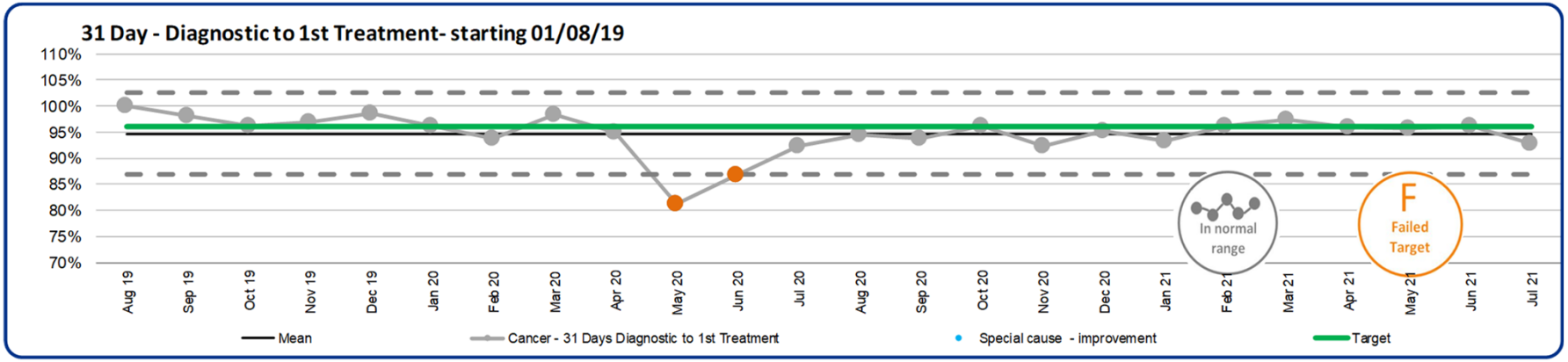
Performance

- 2ww performance at Dudley remains strong and this is reflective of hard work the tumour sites have put into managing and prioritising cancer capacity.
- All tumour sites are delivering strong performance against the 2ww position but Gynaecology and Breast remain the two tumour sites of concern.
- Demand for 2ww is largely back to pre-pandemic levels across all tumour sites
- Colorectal are consistently delivering against the 2ww standard and this is reflective of the new pathways put in place. In addition H&N, Upper GI and Urology are also consistently achieving the 2ww standard.
- Any natural spikes in demand outpatient remain challenging to manage at short notice due to continued to social distancing measures in Outpatients restricting how many patients can be seen.

Action

- ✓ Continue to monitor and maintain performance across all tumour sites via the weekly cancer performance meeting
- ✓ Focus on additional short term capacity solutions in Breast and Gynaecology
- ✓ Engage with system on long term solutions for Breast Services
- ✓ Improve information shared with clinicians on performance in their tumour sites

Cancer Performance – 31 Day



92.9%

Target 96%

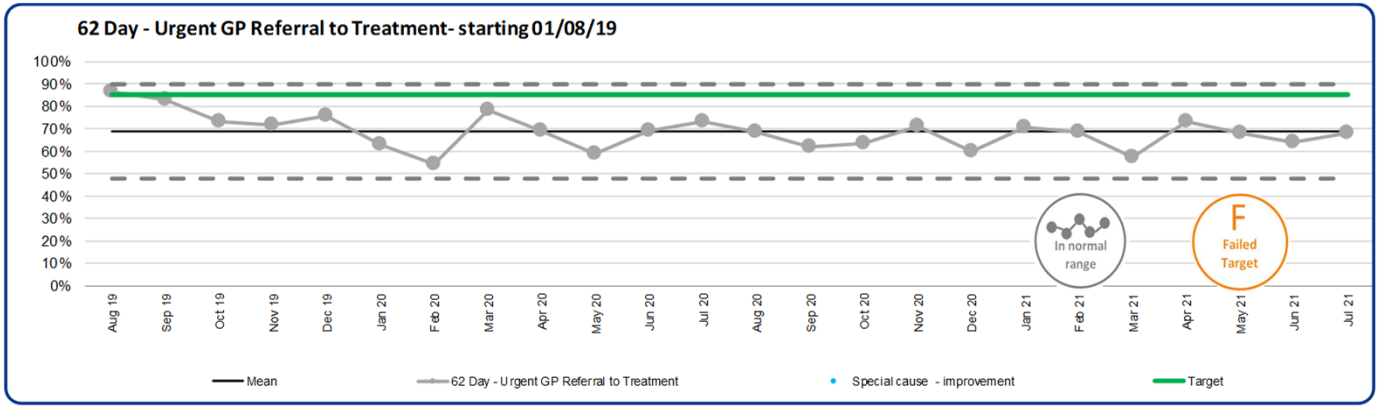
Performance

- Validation of Cancer performance figures run at a 2 month lead time. Therefore latest month position is un-validated .**This report refers to performance in June**.
- Performance against the 31 day standard remains consistent, but falls below the standard of 96% at 92.9% for June
- Key tumour sites which are struggling to meet this standard on a recurrent basis include Colorectal (87% in June) and Gynaecology (78% in June)
- Overall 31 day treatment numbers are low meaning that missed targets (%) are accrued from small numbers (i.e. in Gynaecology there were 2 breaches and 9 treatments in June)
- Issues with meeting this standard including timely diagnostics and access to MDT in a timely way.

Action

- ✓ Ensure effective and timely MDT takes place each week to agree treatment dates
- ✓ Monitor and track diagnostic results and ensure that patients are escalated to operational and BCPS teams as appropriate
- ✓ Ensure that all patients are effectively tracked, every 48 hours, to ensure timely treatment

Cancer Performance – 62 Day



67.9%

Target 85%

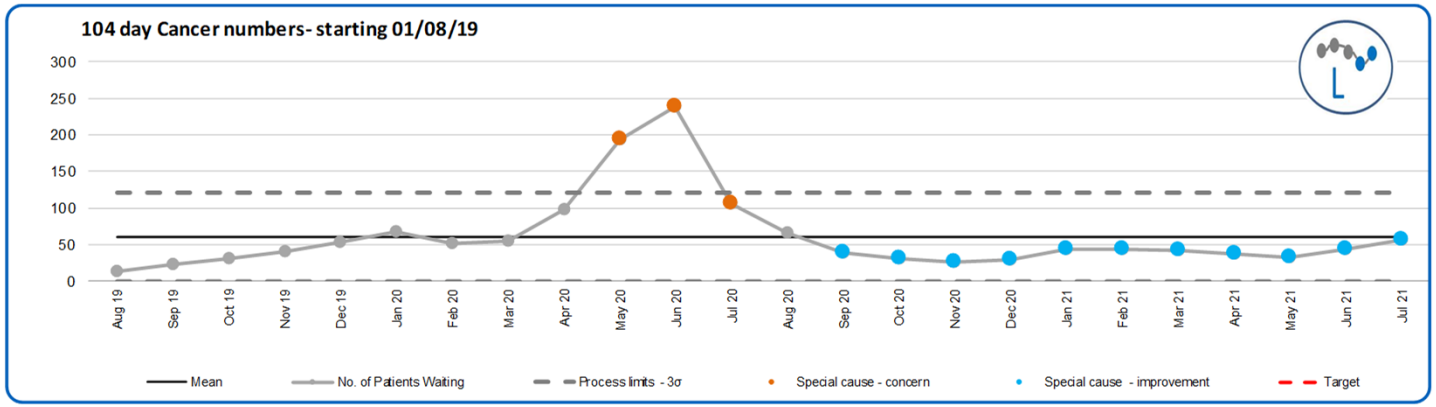
Performance

- Validation of Cancer performance figures run at a 2 month lead time. Therefore latest month position is un-validated. **This report refers to performance in June**.
- The trust remains some way from delivering 85% target against.
- In June there were 76 treatments and 17.5 breaches of the 62 day standard. Key tumour sites which are struggling to deliver the 62 day position include
  - Breast (23 treatments, 5 breaches)
  - Colorectal (5 treatments, 4 breaches)
  - Gynaecology (3 treatments and 3 breaches)
- Only skin is consistently achieving the 62 day standard each month however there was a significant improvement in Urology which also delivered against the 85% standard in June

Action

- ✓ Ensure effective and timely MDT takes place each week to agree treatment dates
- ✓ Monitor and track diagnostic results and ensure that patients are escalated to operational and BCPS teams as appropriate
- ✓ Ensure that all patients are effectively tracked, every 48 hours, to ensure timely treatment
- ✓ Work with BCPS to improve turnaround times
- ✓ Reduce turnaround times for Radiology
- ✓ Ensure that there are robust plans in place to address long waiters and that this is managed via the weekly cancer performance meeting

Cancer Performance – 104 Day



56

As at 31/07/2021

All 104 week waits, target zero

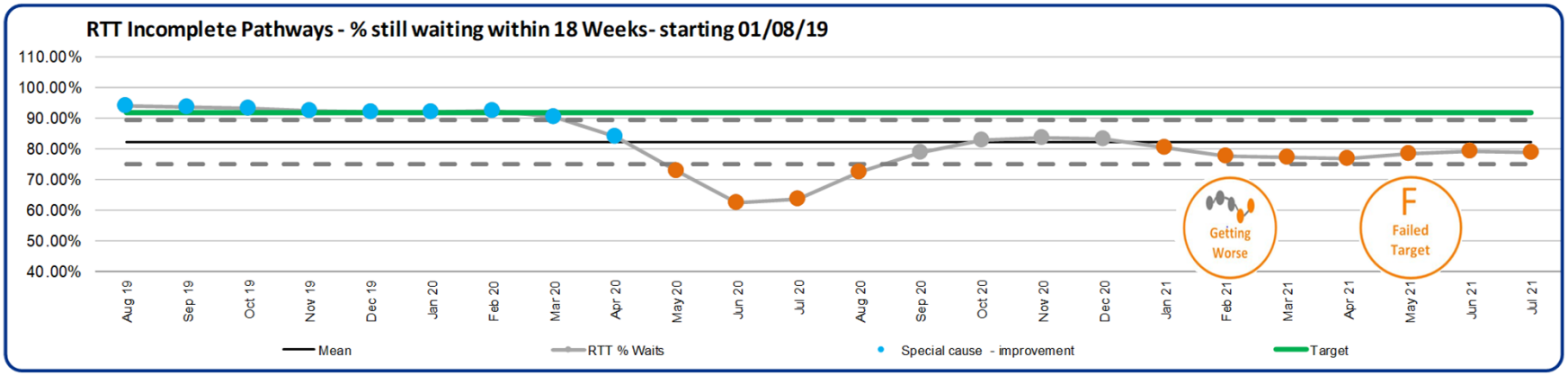
Performance

- There was a very slight increase in patients waiting over 104 days. This includes a combination of patients waiting who have diagnosis and are waiting for treatment and those who do net yet have a confirmed cancer diagnosis.
- There are currently 32 patients waiting over 104 days as at August 2021
- Colorectal (7) and Urology (8) and Gynaecology (5) have the largest numbers of patients waiting
- Numbers of patients waiting over 104 is reflective of the slight increase in the overall numbers of patients on the total cancer PTL
- Reasons for extended waits include diagnostic delays, complex pathways and delays are tertiary centres

Action

- ✓ Additional theatre staff are being sourced via a single agency solution to provide additional theatre capacity to support theatres
- ✓ Focussed intervention in Gynaecology and Urology to drive down total long waiters
- ✓ Detailed breach analysis with Gynaecology and Urology to understand reasons for long waits
- ✓ Ensure that all patients are validated and tracked every 48 hours

RTT Performance



78.8%

RTT Incomplete pathways target 92%

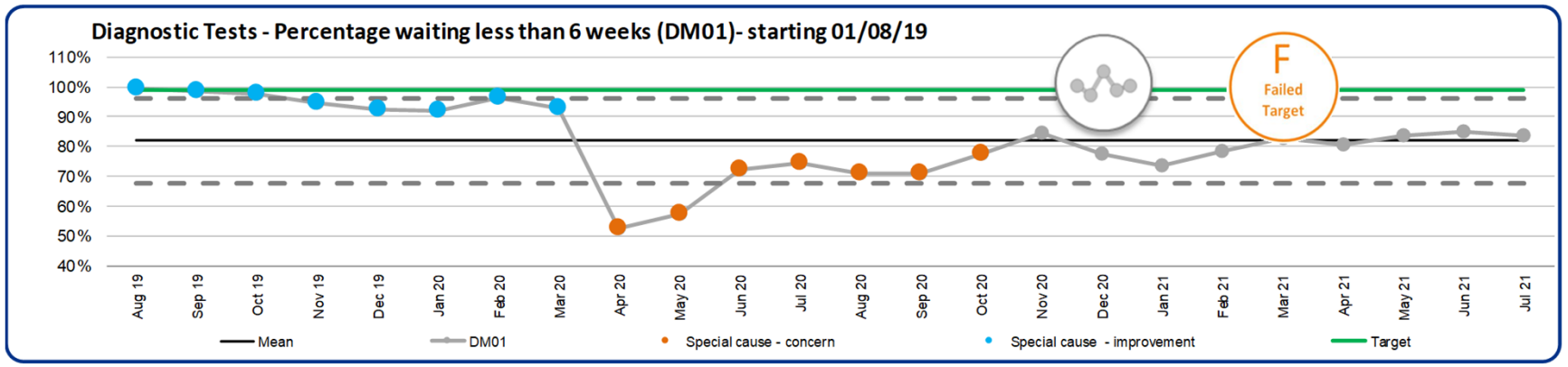
Performance

- RTT performance has stabilised over recent months which reflects the largely unchanged levels of activity versus demand
- National focus remains on covid recovery measures which include managing 52 weeks waiters and P2 (urgents) rather than recovery of the 18 week standard
- Recent challenges have included our inability to restore theatre lists as fully as initially planned due to staffing and recently support for ITU
- The overall shape of the current waiting list suggests that RTT is likely to deteriorate before there is a sustained improvement later this year as the additional theatre capacity comes on line
- To see a sustained improvement in RTT waiting times there is a need to provide additional theatre capacity

Action

- ✓ Additional theatre staff sourced from a single agency to come on line in August and September will provide additional theatre capacity
- ✓ Continued use of the Private sector to treat patients in line with financial arrangements
- ✓ Continued validation to ensure that waiting list is accurate and patients waiting require treatment
- ✓ Continued focus on the national requirements to drive down long waiters (we currently have zero patients waiting over 104 weeks and are in a strong position with regards to 52 week waits) and P2 patients
- ✓ Continue with existing operational plans to see sustained improvement in RTT by March 2022

DM01 Performance



83.7%

DM01 combining 15 modalities - target 99%

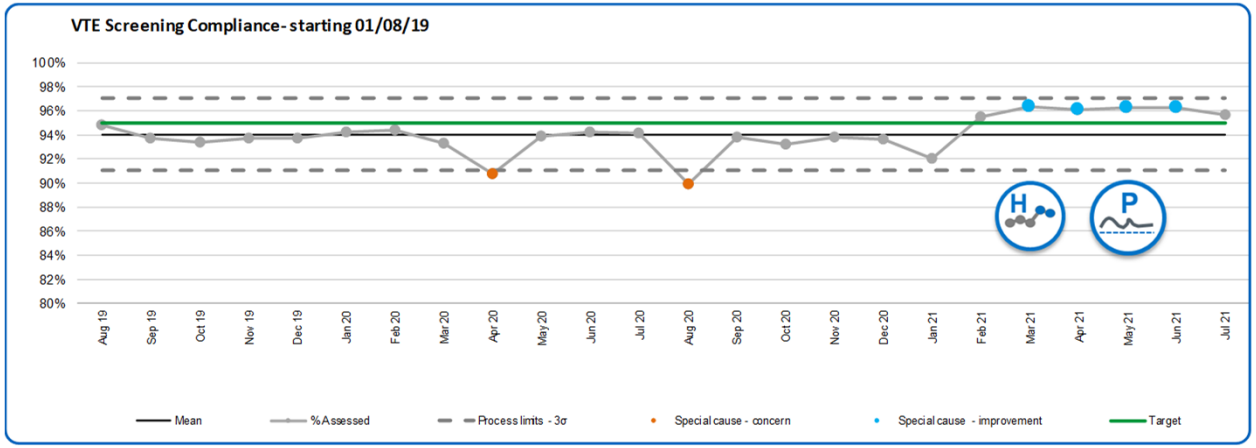
Performance

- Slight deterioration in July's DM01 performance but overall performance remains stable
- Main issue is non-obstetric ultrasound & colonoscopy waits making up over ½ of the overall DM01 breaches
- CT ad DEXA scans are all over performing in terms of activity levels against trust R&R plans

Action

✓ Plan to increase US capacity in September as part of CDH & utilising Ramsay capacity further due to an improved process change

VTE Performance



Trust overall Position	Medicine & IC	Surgery, W & C
95.7%	96.6%	94.4%

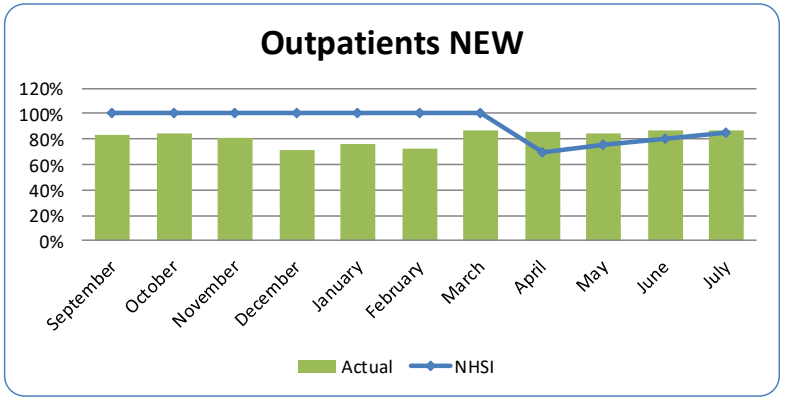
Performance

- VTE performance continues to perform strongly across the Trust
- Clinical teams continue to focus on VTE assessments and this quality measure remains a key focus of governance agenda
- Significant improvements have been seen in surgery although July has dipped slightly to just below the standard (by 0.5%).
- Medicine continues to have strong performance month on month
- Across both medicine and surgery VTE assessments are underperforming against the standard in relation to assessments done at 24 hours but 12 hours is performing well.
- Surgical wards (B2, B4 and B4) are performing very well although some performance areas are Paeds and Surgical Assessment Unit (short stay emergency wards)

Action

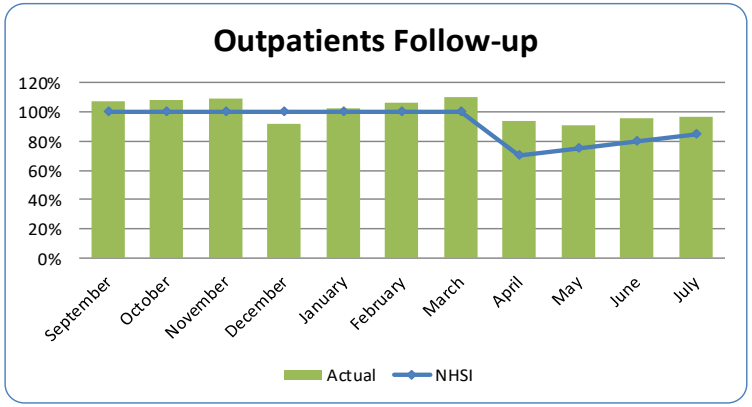
- ✓ Review Surgical Assessment Unit and Paeds (16 year olds) for why there has been a drop in performance in July
- ✓ Review IT solution to prompt for the second assessment across medicine and surgery
- ✓ Continue to monitor via Divisional governance meetings

Recovery and Restoration - Outpatients



July

87%



July

97%

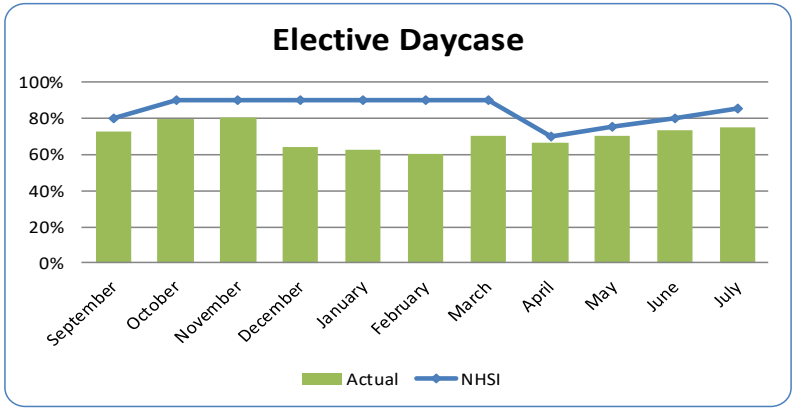
Performance

- Outpatient New and Follow Up Activity continue to over perform against the Trusts R&R activity plan
- Key specialties which are delivering increased levels of outpatient activity include Dermatology, Ophthalmology, and T&O
- Activity includes both virtual and face to face attendances
- Social distancing restrictions are continuing in all outpatient areas, this is restricting the volume of patients we can see face to face although this is offset by a switch to virtual in some cases

Action

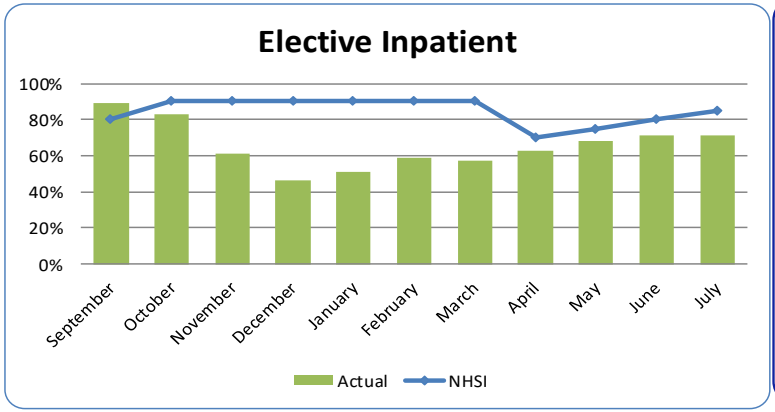
- ✓ Continue to use WLI to put on extra clinics – including face to face clinics and virtual clinics
- ✓ Weekend working in outpatients has now been standardised from a staff perspective. This means weekend working is now supported within existing establishment. Services are being encouraged to book additional weekend clinics

Recovery and Restoration - Electives



July

75%



July

71%

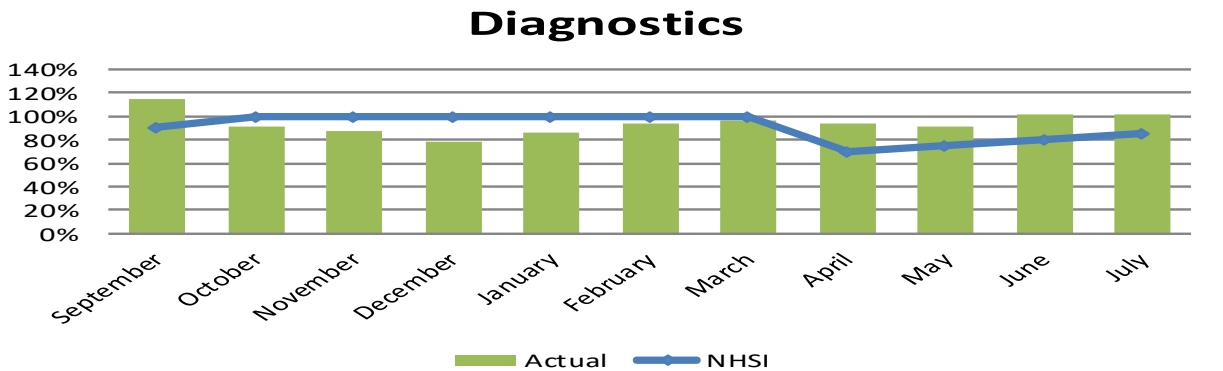
Performance

- Electives inpatient and day cases remains an area of challenge in terms of activity against the R&R plans however day case is performing better than inpatient electives.
- Capacity issues within Theatres remain the key factor in elective activity. Lack of agency to help fill vacancies have exacerbated the problems.
- Trauma and Orthopaedics is one of the services which is below plan and this is reflective of the priority of T&O work using the new national P codes.
- Full use continues to be made of the private sector for Breast and Plastic Surgery
- High volume lists are being planned to include orthopaedic injections and cataracts to help increase overall levels of activity

Action

- ✓ Using single agency supplier for additional theatre staff in order to open up additional theatre capacity is planned from September
- ✓ Ensure effective theatre scheduling
- ✓ Reduce number of cancellations on the day

Recovery and Restoration - Diagnostics



June

101%

Performance

- Diagnostic activity remains strong against the Trust R&R targets
- Dudley Group remains one of the strongest performers in terms of diagnostic R&R activity
- Since April there has been consistent over delivery of activity against R&R targets
- There remains significant over delivery in CT with MRI with non obstetric ultrasound also performing strongly
- MRI, CT, Plain film & US activity expected to continue to increase in Sept 21 as part of CDH.

Action

- ✓ Continue with existing operational plans to maintain activity
- ✓ Continue to develop and work on the CDH model to ensure sustainable additional capacity is available from autumn
- ✓ Continued use of mobile capacity
- ✓ Agency capacity to continue

Enclosure 27

The Dudley Group NHS Foundation Trust

Paper for submission to the Board of Directors on Thursday 16th September 2021

TITLE:	**Summary of Workforce and Staff Engagement Committee meeting on Tuesday 31st August 2021**		
AUTHOR:	**Julian Atkins**	**PRESENTER:**	**Julian Atkins**

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

CORPORATE OBJECTIVE:

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

SUMMARY OF KEY ISSUES:

As detailed in the paper.

IMPLICATIONS OF PAPER:

IMPLICATIONS FOR THE CORPORATE RISK REGISTER OR BOARD ASSURANCE FRAMEWORK

RISK	**N**		**Risk Description:**
	Risk Register: N		**Risk Score:**
COMPLIANCE and/or LEGAL REQUIREMENTS	**CQC**	**Y**	**Details: Well Led**
	NHSI	**Y**	**Details: Annual Business Planning Process**
	Other	**N**	**Details:**
REPORT DESTINATION	**Board of Directors**	**Y**	**DATE: 16/09/2021**
	WORKING GROUP	**N**	**DATE:**
	COMMITTEE	**N**	**DATE:**

CHAIR'S LOG
UPWARD REPORT FROM WORKFORCE & STAFF ENGAGEMENT COMMITTEE
Date Committee last met: 31st August 2021

The Dudley Group NHS Foundation Trust

MATTERS OF CONCERN OR KEY RISKS TO ESCALATE

- KPI's – concerns were raised regarding the level of vacancies and the subsequent impact on agency usage. In addition, the inability to fill all gaps via temporary staffing and agency usage was raised, alongside an increasing sickness absence related to COVID-19 related absence. The Committee were briefed on the range of actions being taken by the Workforce team, Professional Nursing team and the Divisional teams to increase workforce capacity, including; targeted recruitment campaigns, international nursing programme, optimising social media channels/comms, strengthening internal career pathways, Locums Nest and system efforts (collaborative bank).
- Quarter 2 Staff Survey results. The Committee received a detailed report from the recent Pulse staff survey which was undertaken in July and reported back in August. Concern was raised regarding the low response rate. Whilst higher than many peers (@ 28% v peer average of 26%), a focus on increasing participation is required ahead of the upcoming national NHS Staff Survey in October. A robust plan to increase response rates was presented to WSEC which was strongly supported.

MAJOR ACTIONS COMMISSIONED/WORK UNDERWAY

- Karen Brogan, Acting Deputy Chief People Officer, provided an update on the Healthcare Support Worker Recruitment work which has been successful in recruiting 152 HCSW's between November to June. WSEC were also assured that this work continues with further recruitment cohorts, including additional bank HCSW recruitment (40 are being interviewed in September), Novice Clinical Support Worker Apprenticeships (24 offers made), and the setting up of a Clinical Support Worker Training Programme (112 applications).

POSITIVE ASSURANCES TO PROVIDE

- Equality, Diversity & Inclusion (EDI) and Health & Wellbeing Steering Groups were both launched in August which is a positive reflection of the Trust's ambitions in these key areas of the Workforce/People agenda. Both Steering groups are being chaired by NEDs and will formally upward report to WSEC. The ToR's and workplans for these Steering groups were approved and actively supported by WSEC.
- The annual WRES and WDES submissions were presented to the Committee. The Committee was assured that these submissions had been reviewed in detailed by the EDI Steering Group earlier in August. Whilst noting that there is more work and focus required in a number of areas, the

DECISIONS MADE

- The Committee approved the proposed move to Adult Safeguarding Level 3 (triannual requirement for senior staff) from Priority 2 to Priority 1, with staff having received above the standard one year introduction period for subject changes. This will reflect in published reports from end September 2021 onwards.
- The Committee approved the final version of the DIP 3 Year Plan. Peter Lowe presented the final version of the plan, which has been updated to reflect comments and feedback from the July Deep-Dive session. The Committee strongly supports the DIP strategy and the huge opportunity that this represents for the Trust.

Committee were encouraged to note some key improvements in a range of the indicators, which represents a step change from previous WRES and WDES submissions. The Inclusion Network Chairs commented that they are seeing the day-to-day impact of the many improvement interventions that are now in place (ref; Diversity Champions, Mentoring for Inclusion scheme, engagement activities and Inclusion Networks), which was welcomed. • The Committee was pleased to be updated on the recent Talent Inclusion and Diversity Evaluation (TIDE) Report 2021, whereby the Trust increased its previous 2020 score from 36% to 72%. Whilst this is a self-assessment process, Gurjit Bhogal, as chair of the EDI Steering Group provided assurance that the EDI Steering group had reviewed the detail of the assessment and that the Trust's self-assessment was wholly robust and representative. The Committee was also pleased to hear that the Inclusion Networks had been engaged in the scoring process, and the Network Chairs confirmed that they believed the assessment to be reflective of the improvements that have and continue to be delivered in the EDI space.	• The Committee approved the Clinical Skills Training Policy Review.

Chair's comments on the effectiveness of the meeting:

The meeting ran to the timetable which was appreciated. The Committee was pleased to see the positive movements in some key parts of the Trust's performance against the WRES and WDES indicators, whilst recognising that ongoing work is required. Further assurance was provided through triangulation between the improved metrics and the day-to-day experience of the Inclusion Network Chairs and their members. The Committee welcomed the Talent Inclusion and Diversity Evaluation (TIDE) Report 2021 assessment and the plans for further improvement and progress in the next 12 months. It was great to hear that the inaugural meetings of the newly formed EDI and Health and Wellbeing Steering Groups took place in August and to see the ambitious workplans for these groups; this reflects the maturity of the WSEC and the Trust's commitment to dedicating focused time on these key areas of the people agenda. Clearly there is a need to do all we can to encourage better engagement and participation in the upcoming national staff survey and to learn the lessons from the recent quarterly Pulse survey. A robust plan is in place including comms, HR and IT working closely with Divisional, Corporate and professional leaders across the Trust. I thanked everyone for their participation and contribution for developing such high quality papers, I gave a special thank you to Graeme Ratten for the impressive analytics work.

Enclosure 28

The Dudley Group NHS Foundation Trust

Paper for submission to Board 16th September 2021

TITLE:	**Workforce KPIs**		
AUTHOR:	**Greg Ferris** **Karen Brogan - Acting Deputy Chief People Officer**	**PRESENTER:**	**James Fleet - Chief People Officer**

CLINICAL STRATEGIC AIMS

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

ACTION REQUIRED OF COMMITTEE

Decision	Approval	Discussion	Other
	x	x	

RECOMMENDATIONS

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

CORPORATE OBJECTIVE:

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

SUMMARY OF KEY ISSUES:

- Overall Sickness/Absence was 7.04% in July, an increase of 1.7% compared against June.
- C19 absence tracking is now reported daily. The number of people off for a COVID-19 related reason as 8th September is 57, which accounts for 1.04% of absence.
- The total vacancies stand at 707.28 WTE (calculated as the difference between Budgeted WTE and Contracted WTE), this equates to 12% which is a reduction of 1.2% WTE on reported vacancies.
- Contracted WTE staff has increased to 4957.09 WTE in August, increasing by 47.56 from July.
- Bank usage has decreased to 445.40 from 455.10 WTE in July, a decrease of 9.7 WTE, in addition Agency usage has increased to 194.27 WTE an increase of 7.03 WTE.
- Total temporary staffing usage in August is 640 WTE, which has remained stable since July. This remains lower than the total vacancies for July.
- Overall staff turnover is at 8.20% (rolling average 12 months). Excluding Students and Medics, Scientific & Technical, are highest at 10.2%. AHP's at 7.7%, Admin at 6.7%, Additional Clinical Services at 6.8% and Nursing & Midwifery Registered at 3.8%.

- Mandatory Training: overall compliance decreased to 87.58% as of 13th August compared to 88.29% as of 15th July, which is a 0.71% decrease.

- The current caseload is 33, with 'Disciplinary' at 40.6% the highest category, followed by 'Grievance' at 31.3%. There are 3 live suspensions.

IMPLICATIONS OF PAPER:			
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**	**DATE: WSEC 31/08/2021**

Workforce KPI Report

16th September 2021

NHS
The Dudley Group
NHS Foundation Trust

James Fleet, Executive Chief People Officer




Summary 1/3	*Performance*	*Action*
Sickness & Absence	o Overall Sickness/Absence was 7.04% in July, an increase of 1.7% compared against June. o Clinical Support Services is the division with the highest sickness absence rate at 9.21% in July, Corporate has the lowest at 3.83%. o C19 absence tracking is now reported on a daily basis. The number of people off for a Covid related reason as of the 8th September is 57, which accounts for 1.04% of absence. o Discounting Covid-absences, 'Anxiety/stress/depression' is still the most common reason for absence (59 people) followed by musculoskeletal (24)	✓ 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 The COVID vaccination Bank and Agency usage is now excluded from the Trust KPI report (DGFT is the lead employer for BCWB). o Bank usage has decreased to 445.40 from 455.10 WTE in July, a decrease of 9.7WTE., in addition Agency usage has increased to 194.27 WTE an increase of 7.03WTE. o Total temporary staffing usage in August is 640 WTE, which has remained stable since July. This remains lower than the total vacancies for July	✓ 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. ✓ Embedding 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. ✓ A task and finish group has been established to reduce agency usage.
Turnover & Recruitment	o Contracted WTE staff has increased to 4957.09 WTE in August, increasing by 47.56 from July o The total vacancies stands at 707.28 WTE (calculated as the difference between Budgeted WTE and Contracted WTE) This equates to 12% which is a reduction of 1.2% WTE on reported vacancies o Overall staff turnover is at 8.20% (rolling average 12 months). Excluding Students and Medics, Scientific & Technical, are highest at 10.2%. AHP's at 7.7%, Admin at 6.7% , Additional Clinical Services at 6.8% and Nursing & Midwifery Registered at 3.8%.	✓ 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.

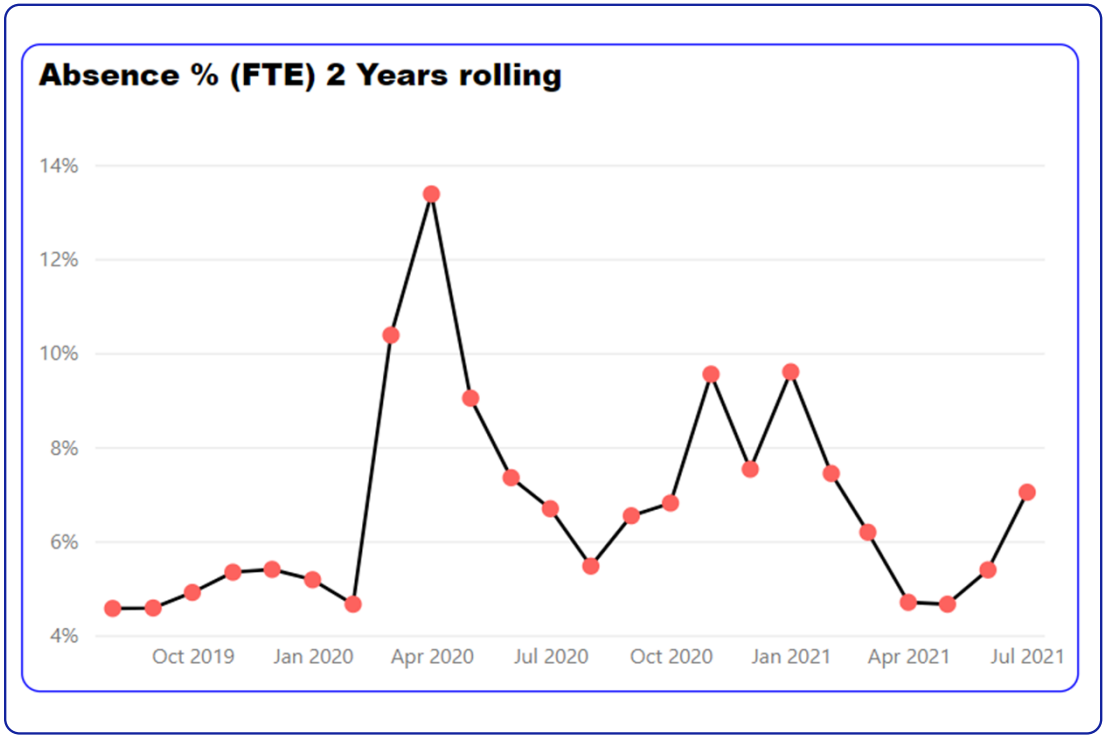
Summary 2/3	*Performance*	*Action*
Mandatory Training	o Mandatory Training: overall compliance decreased to 87.58% as of the 13th August compared to 88.29% as at the 15th July, which is a 0.71% decrease. o The priority areas continue to be Reses (Paeds), Safeguarding Children (level three) Manual Handling (Patient) and Resus Neonatal.	✓ An action plan has been devised along with a trajectory for the Divisions to achieve mandatory training compliance. ✓ Restrictions to the amount of attendees and exploration of adjusted delivery continues, staff absence continued to be a factor. ✓ Meetings held with SMT Lead and Gen Managers for MIC, Surgery, and CSS, with out-of-hours additional sessions run throughout September up to December to capture Clinicians and increase overall compliance.
Equality, Diversity & Inclusion	o BAME staff Trust representation is at 19.36%, down 0.4% from last month. o Disabled staff Trust representation is at 3.7% up 0.2% from the previous month. o LGBTQ+ staff representation is at 1.91%.	✓ The Trust has established 4 Inclusion Networks: BAME, LGBTQ+, Disability and Women's Network. These Networks are growing in membership, with regular meetings and events. Each of these networks has both an Executive Director and Non-Executive Director sponsor. In addition, the Chairs of the networks are attending Board meetings. ✓ A task group has been established, chaired by Catherine Holland (NED) to address the immediate actions arising form a deep-dive into gender equality. ✓ A formal EDI Steering Group is being established, to be chaired by Dr Gurjit Bhogal, to oversee and support the Trust's ambitious EDI strategy for all protected characteristics. ✓ 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

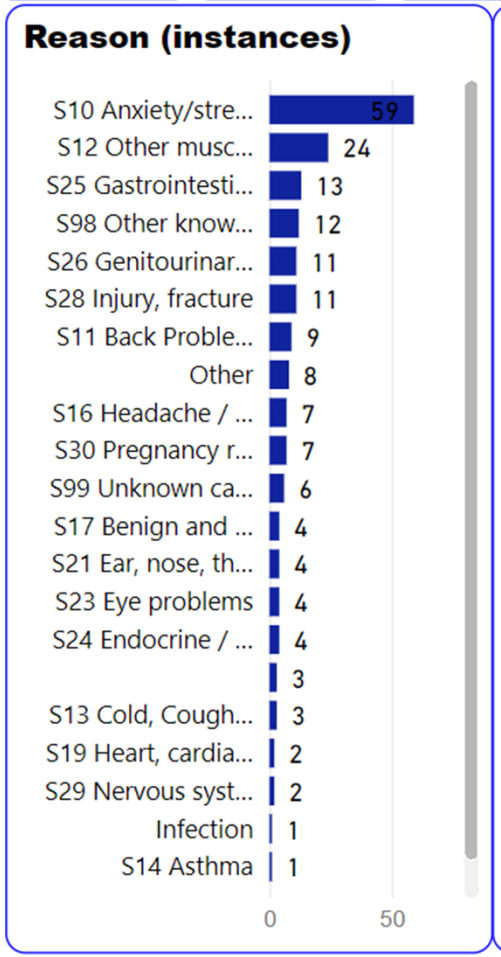
	Performance	*Action*
HR Caseload	o The current caseload is 33, with 'Disciplinary' at 40.6% the highest category, followed by 'Grievance' at 31.3%. o The highest Division is Medicine with 34 open cases. o There are 3 live suspensions. o BAME representation is at 27%, with 9 open cases.	✓ Employee relations 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 are being published w/c 21st June 2021.

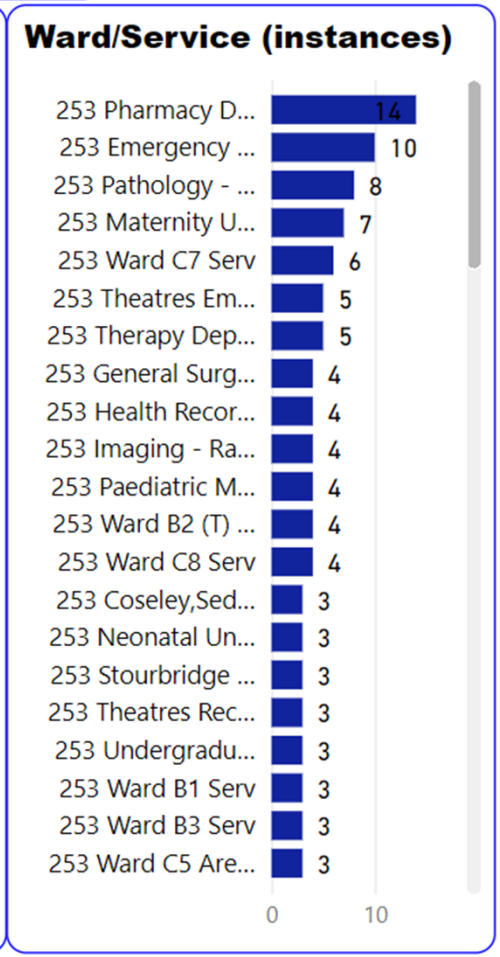
Sickness Absence

- Overall Sickness/Absence was 7.04% in July, an increase of 1.7% compared against June.
- Clinical Support Services is the division with the highest sickness absence rate at 9.21% in July, Corporate has the lowest at 3.83%.
- C19 absence tracking is now reported on a daily basis. The number of people off for a Covid related reason has decreased from 78 to 62 over the last 10 days (to 16/08/21).
- Discounting Covid-absences, 'Anxiety/stress/depression' is still the most common reason for absence (59 people) followed by musculoskeletal (24)



Trust	CS	Corporate	MIC	Surgery
7.04%	9.21%	3.83%	7.01%	7.62%

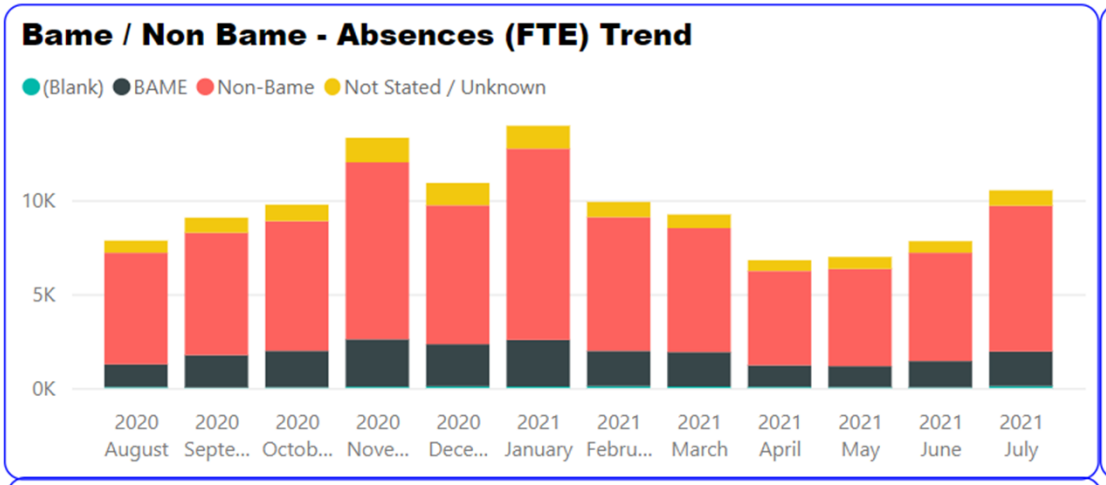


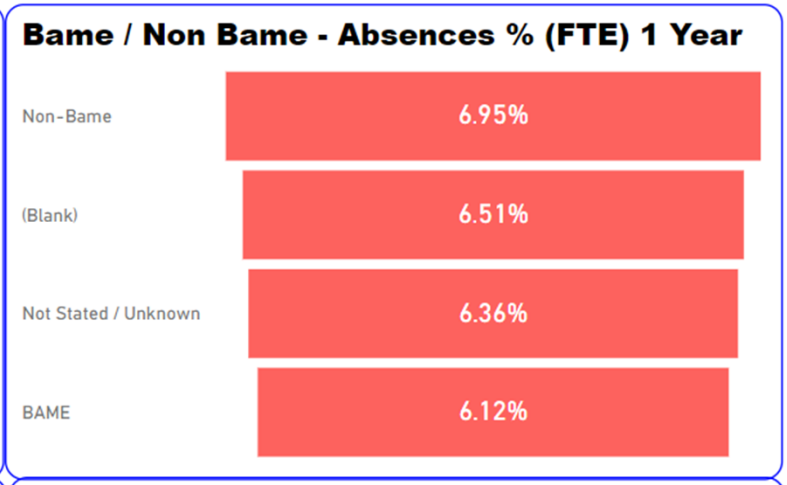


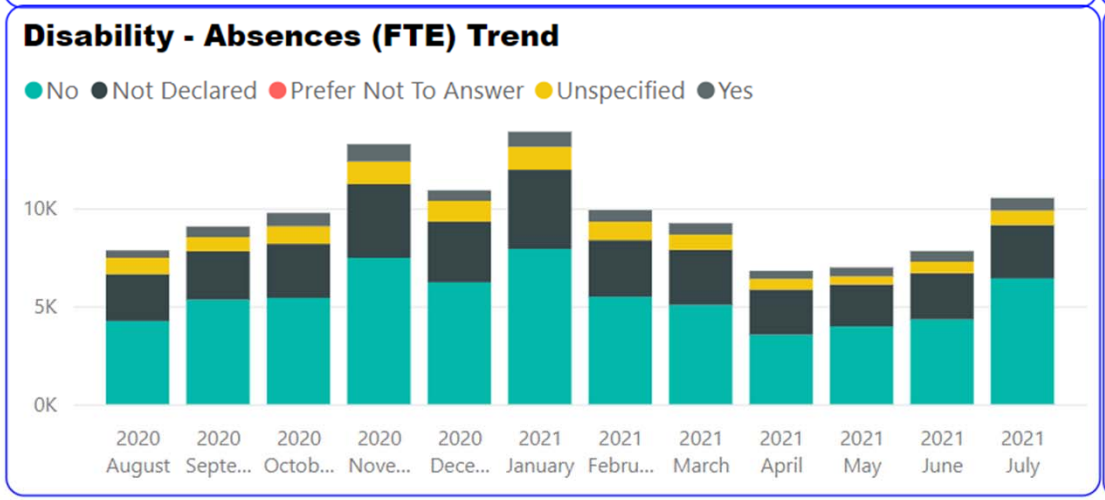
Sickness Absence - Detail

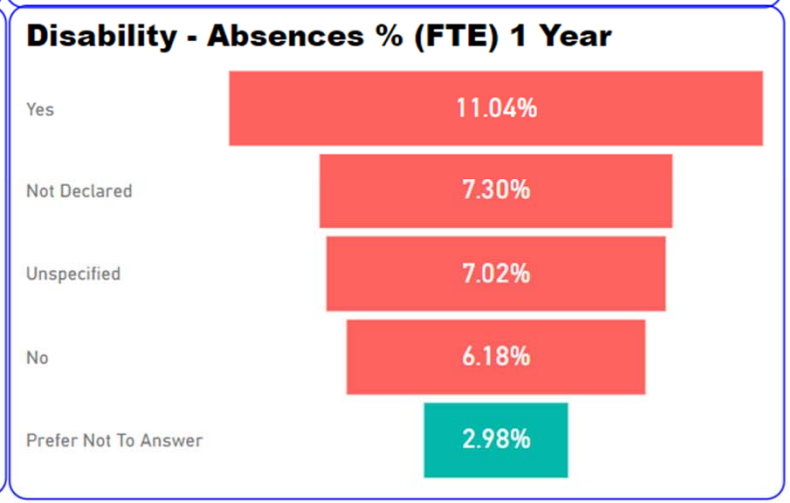
BAME colleagues show absence levels 0.83% lower that non-BAME colleagues.

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





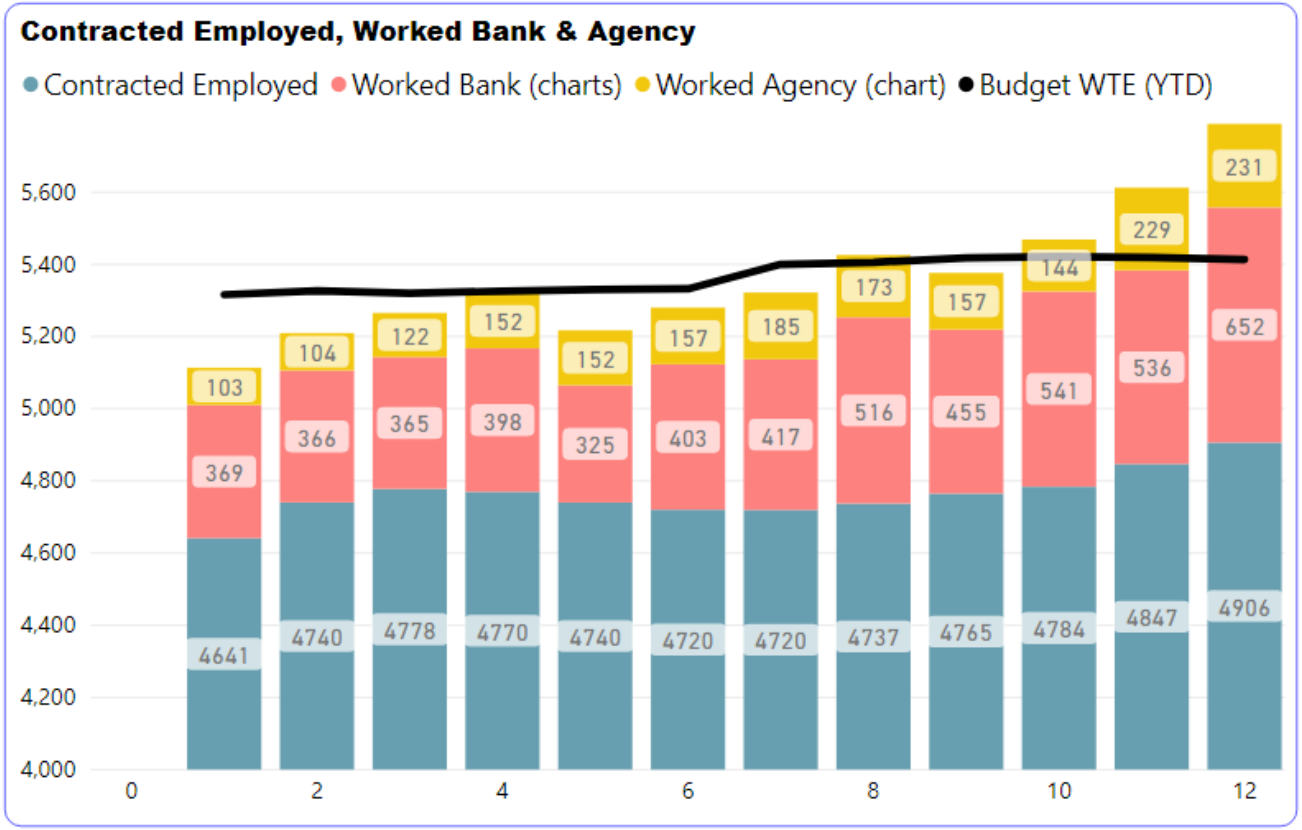


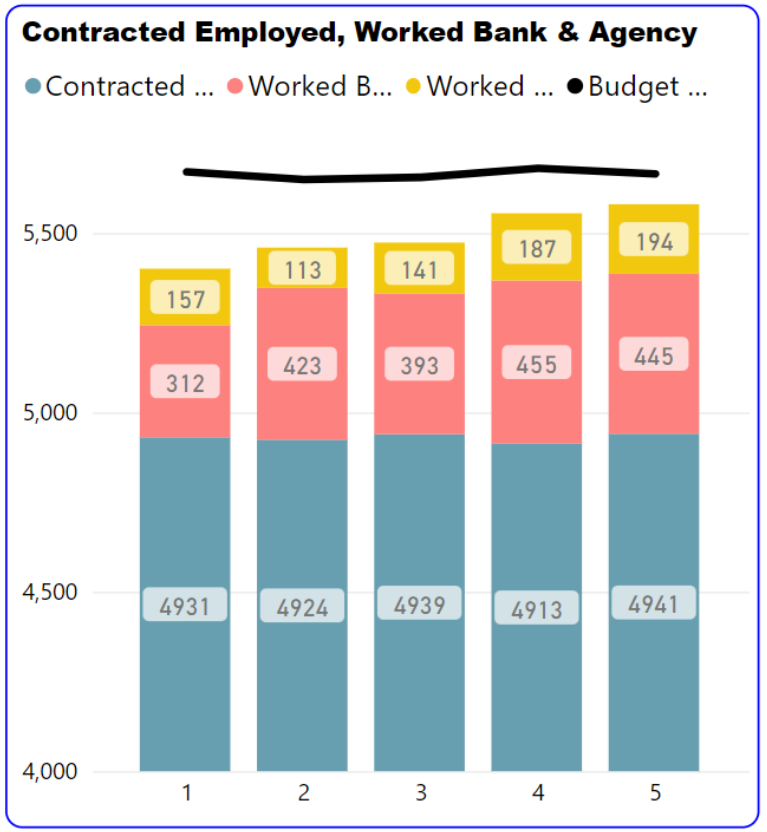


Bank & Agency – Total Trust

- The COVID vaccination Bank and Agency usage is now excluded from the Trust KPI report (DGFT is the lead employer for BCWB).
- Bank usage has decreased to 445.40 from 455.10 WTE in July, a decrease of 9.7WTE., in addition Agency usage has increased to 194.27 WTE an increase of 7.03WTE.

Trust	CS	Corporate	MIC	Surgery
12%	17%	4%	13%	13%



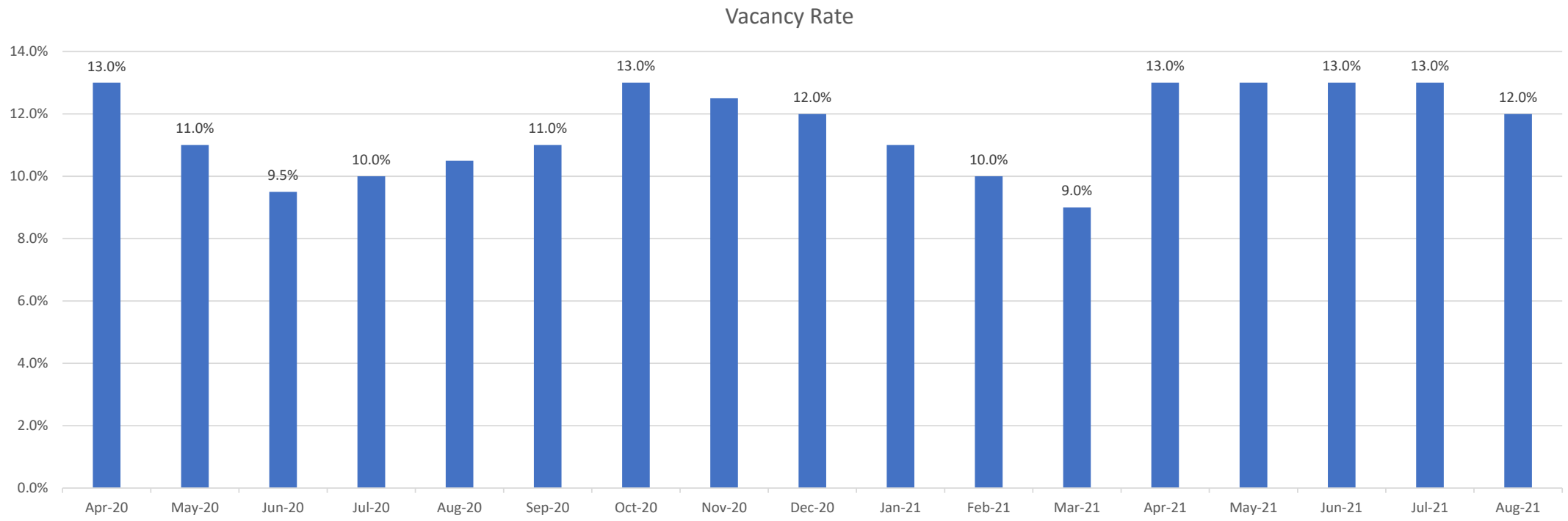


Vacancies – Staff in Post

- Contracted WTE staff has increased to 4957.09 WTE in August, increasing by 47.56 from July
- The total vacancies stands at 707.28 WTE (calculated as the difference between Budgeted WTE and Contracted WTE) This equates to 12% which is a reduction of 1.2% WTE on reported vacancies

Trust	CS	Corporate	MIC	Surgery
12%	17%	4%	13%	13%

July 2021/22



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

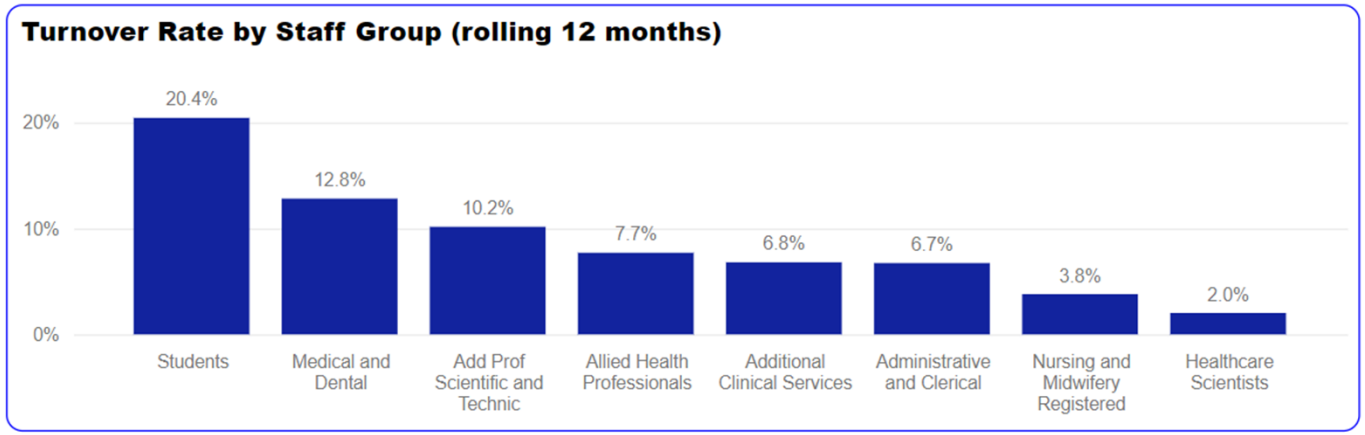
CC1 Desc	Budget WTE	Contracted WTE	Vacancy WTE	Vacancy %	Worked Bank	Bank (£)	Worked Agency	Agency (£)	Bank & Agency
Clinical Support	553.30	460.09	93.21	17%	41.92	£148,505	7.11	£55,310	£203,816
Corporate / Mgt	676.62	649.76	26.86	4%	27.86	£114,032	1.89	£16,671	£130,703
Medicine & Integrated Care	2,477.13	2,148.01	329.12	13%	222.01	£1,276,831	95.15	£710,706	£1,987,537
Surgery	1,958.13	1,700.04	258.09	13%	153.61	£829,720	90.12	£854,490	£1,684,210
Total	**5,665.18**	**4,957.90**	**707.28**	**12%**	**445.40**	**£2,369,088**	**194.27**	**£1,637,177**	**£4,006,265**

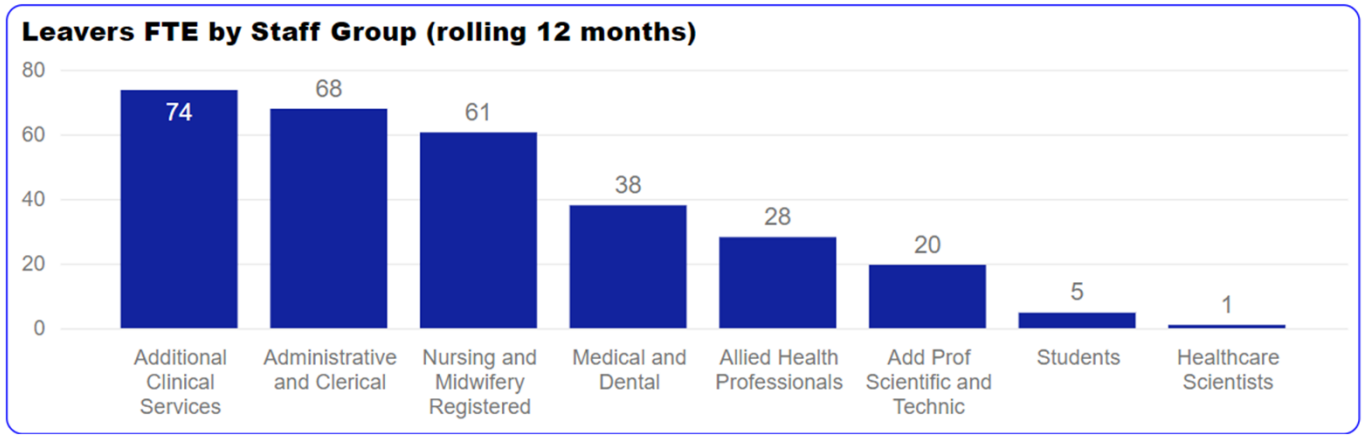
StaffGroup	Budget WTE	Contracted WTE	Vacancy WTE	Vacancy %	Worked Bank	Bank (£)	Worked Agency	Agency (£)	Bank & Agency
⊞ Nursing	1,893.62	1,561.51	332.11	18%	139.60	£706,250	149.72	£1,139,128	£1,845,378
⊞ Admin	1,070.08	973.38	96.70	9%	57.62	£141,765	0.23	£12,966	£154,731
⊞ CSW	911.59	866.76	44.83	5%	147.99	£438,512	9.68	£37,449	£475,961
⊞ Allied Healthcare Professional	846.63	731.61	115.02	14%	29.74	£124,960	13.48	£88,587	£213,547
⊞ Junior Medic	436.05	385.32	50.73	12%	38.86	£415,871	12.65	£173,545	£589,417
⊞ Senior Medic	375.07	310.13	64.94	17%	27.41	£531,652	8.47	£185,347	£716,999
⊞ Prof Tech Scientist	64.40	51.76	12.64	20%	3.91	£11,294	0.00	£0	£11,294
⊞ Other	34.98	40.36	-5.38	-15%	0.12	£333	0.04	£154	£487
Total	**5,665.18**	**4,957.90**	**707.28**	**12%**	**445.40**	**£2,369,088**	**194.27**	**£1,637,177**	**£4,006,265**

Staff Turnover

Overall staff turnover is at 8.20% (rolling average 12 months). Excluding Students and Medics, Scientific & Technical, are highest at 10.2%. AHP's at 7.7%, Admin at 6.7% , Additional Clinical Services at 6.8% and Nursing & Midwifery Registered at 3.8%.

Trust	CS	Corporate	MIC	Surgery
8.2%	10.4%	8.9%	8.8%	6.5%



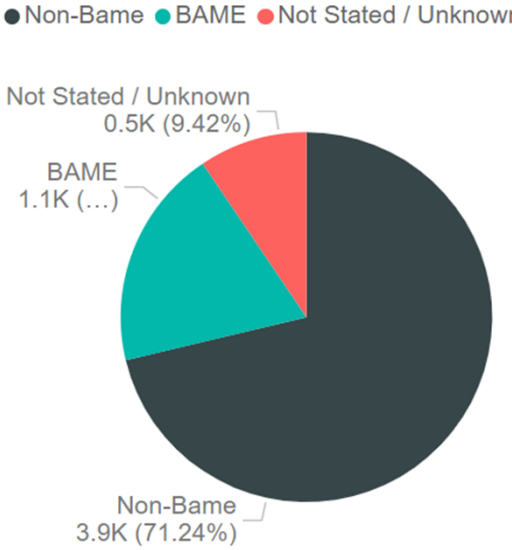


Workforce Profile - Ethnicity – Representation by Division and Grade

BAME staff Trust representation is at 19.36%.

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

Ethnicity Profile



Values between 1-7 have been masked.
Data shows head count, primary assignment only

BAME/Non-BAME by Division

Mapping Org L2	BAME		Non-Bame		Not Stated / Unknown	
	No.	%	No.	%	No.	%
253 Surgery	385	20.2%	1351	70.7%	174	9.1%
253 Medicine & Integrated Care	451	18.9%	1702	71.3%	235	9.8%
253 Corporate / Mgt	82	12.6%	501	76.7%	70	10.7%
253 Clinical Support	141	26.9%	347	66.1%	37	7.0%

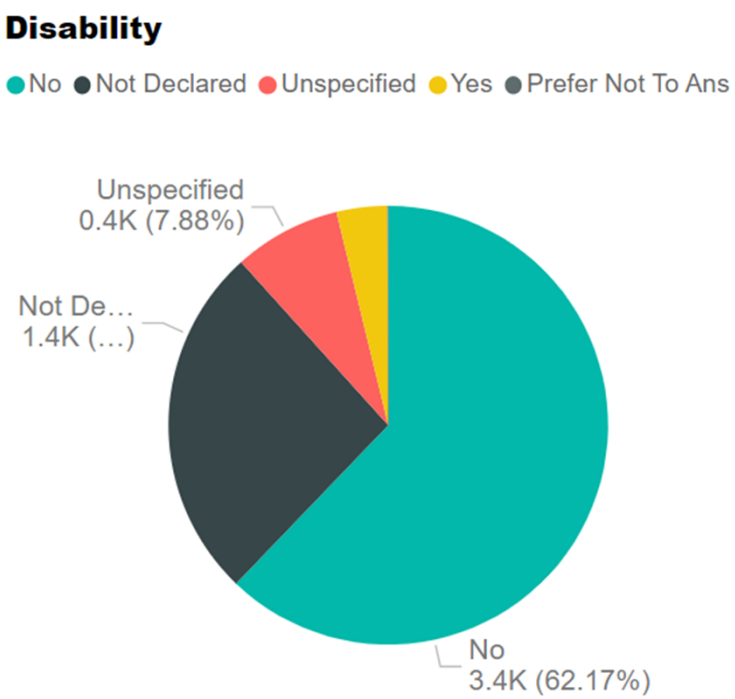
BAME/Non-BAME by Pay Grade (grouped)

Mapping Mapping	BAME		Non-Bame		Not Stated / Unknown	
	No.	%	No.	%	No.	%
Apprentice			35	77.8%		
Band 2	124	9.8%	1017	80.0%	130	10.2%
Band 3	32	8.6%	309	82.8%	32	8.6%
Band 4	48	11.8%	319	78.6%	39	9.6%
Band 5	253	24.8%	659	64.5%	109	10.7%
Band 6	161	16.0%	759	75.2%	89	8.8%
Band 7	55	10.9%	418	83.1%	30	6.0%
Band 8a	39	24.2%	109	67.7%	13	8.1%
Band 8b			41	82.0%		
Band 8c			12	75.0%		
Band 8d			11	100.0%		
Band 9			8	80.0%		
Consultant	116	48.5%	95	39.7%	28	11.7%
Non-Consultant	213	67.2%	80	25.2%	24	7.6%
Trust contract			24	70.6%	8	23.5%
VSM						

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.



Values between 1-7 have been masked.
Data shows head count, primary assignment only

Disability by Division

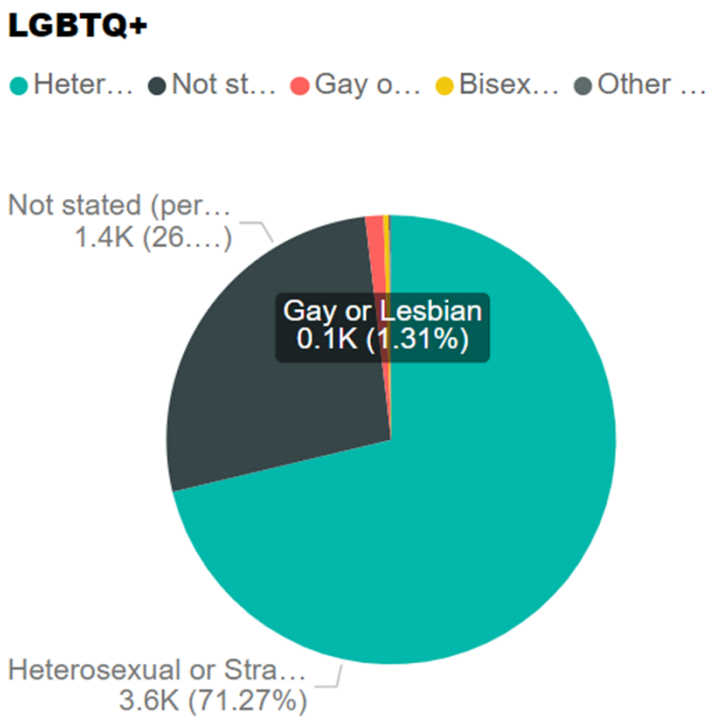
Org L2	No	Not Declared	Prefer Not To Answer	Unspecified	Yes
253 Clinical Support	68.0%	22.3%		6.1%	3.6%
253 Corporate / Mgt	69.3%	19.8%	[redacted]	4.7%	5.9%
253 Medicine & Integrated Care	62.2%	25.5%		8.2%	4.0%
253 Surgery	58.1%	30.2%		9.0%	2.6%
Total	**62.2%**	**26.2%**	**0.1%**	**7.9%**	**3.7%**

Disability by Pay Grade (grouping)

Mapping	No	Not Declared	Prefer Not To Answer	Unspecified	Yes
Apprentice	73.3%	[redacted]		[redacted]	17.8%
Band 2	59.6%	26.5%	[redacted]	11.0%	2.9%
Band 3	62.2%	25.1%		7.1%	5.6%
Band 4	68.5%	21.8%		7.1%	2.7%
Band 5	59.9%	26.2%		9.1%	4.8%
Band 6	63.0%	26.7%		6.7%	3.6%
Band 7	61.9%	30.4%	[redacted]	2.6%	4.9%
Band 8a	68.3%	21.7%		6.2%	[redacted]
Band 8b	64.0%	26.0%		[redacted]	[redacted]
Band 8c	81.3%	[redacted]		[redacted]	
Band 8d	72.7%	[redacted]			
Band 9	90.0%				[redacted]
Consultant	44.2%	46.7%	[redacted]	8.8%	
Non-Consultant	76.8%	13.6%		6.8%	2.8%
Trust contract	61.8%	29.4%		[redacted]	
VSM	[redacted]	[redacted]	[redacted]		[redacted]
Total	**62.2%**	**26.2%**	**0.1%**	**7.9%**	**3.7%**

Workforce Profile – LGBTQ+ – Representation by Division and Grade

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



Values between 1-7 have been masked.
Data shows head count, primary assignment only

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			73.9%	24.7%		
253 Corporate / Mgt			79.6%	19.0%		
253 Medicine & Integrated Care		1.8%	72.0%	25.8%		
253 Surgery	0.4%	1.1%	66.6%	31.7%		
Total	**0.4%**	**1.3%**	**71.3%**	**26.9%**	**0.1%**	**0.0%**

LGBTQ+ by Pay Grade (grouped)

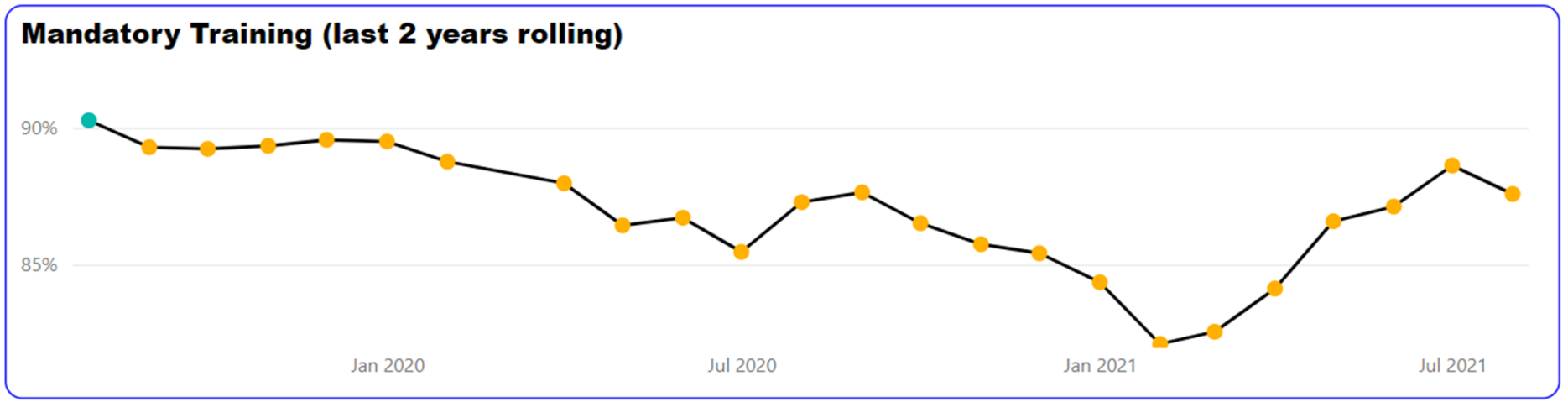
Mapping	Bisexual	Gay or Lesbian	Heterosexual or Straight	Not stated (person asked but declined to provide a response)	Other sexual orientation not listed	Undecided
Apprentice			81.4%			
Band 2		2.1%	70.5%	26.6%		
Band 3			75.9%	23.2%		
Band 4			73.1%	25.3%		
Band 5		1.0%	70.4%	28.2%		
Band 6		1.1%	71.7%	26.6%		
Band 7			69.9%	28.7%		
Band 8a			77.1%	22.2%		
Band 8b			68.1%	27.7%		
Band 8c			78.6%			
Band 8d			72.7%			
Band 9			100.0%			
Consultant			47.5%	51.1%		
Non-Consultant			82.4%	15.0%		
Trust contract			64.5%	35.5%		
VSM			80.0%			
Total	**0.4%**	**1.3%**	**71.3%**	**26.9%**	**0.1%**	**0.0%**

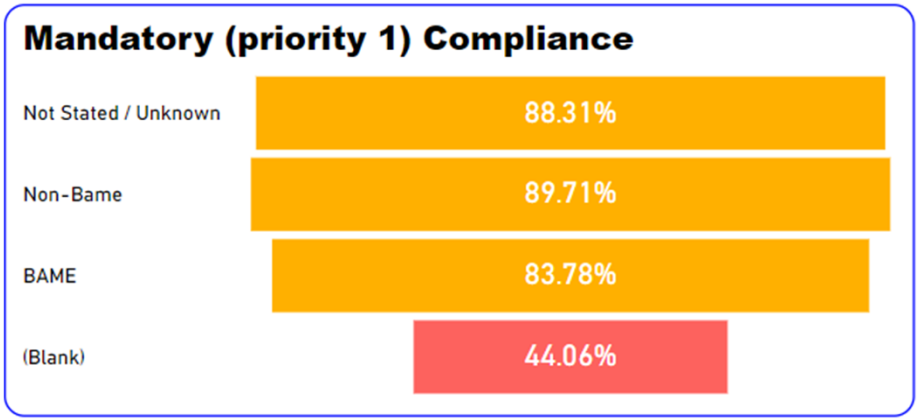
Mandatory Training – Performance Trend

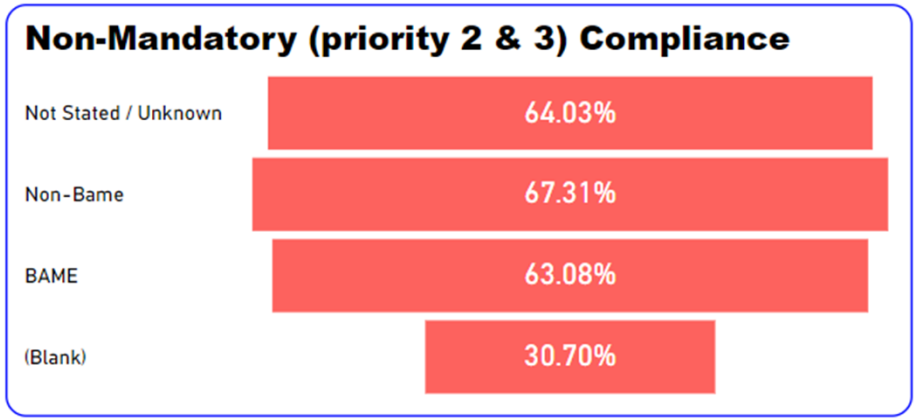
Mandatory Training: overall compliance increased to 87.58% as of the 13th August compared to 88.29% as at the 15th July, which is a 0.71% decrease.

The priority areas continue to be Reses (Paeds), Safeguarding Children (level three) Manual Handling (Patient) and Resus Neonatal. All have improvements on June with the exception of Neonatal Resus which has decreased slightly.

15th July 2021	Trust	CS	Corporate	MIC	Surgery
	87.58%	89.21%	88.01%	88.10%	86.41%







Mandatory Training – Areas of Focus

The priority areas are be:

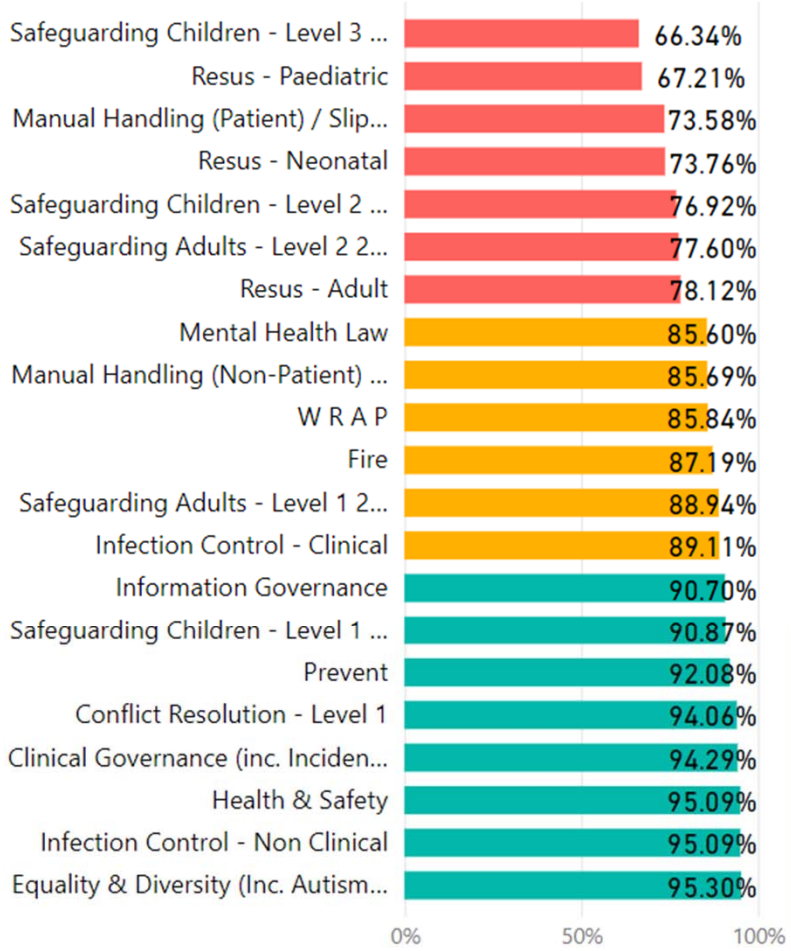
SAFEGUARDING CHILDREN Level 3 – showing a 2.21% increase

RESUS PAEDS – showing a 5.99% increase.

MANUAL HANDLING – showing a 0.39% decrease.

RESUS NEONATAL - showing a 2.39% decrease.

Course Compliance (based on selections)



Ward/Service (based selections)

Group5Description	Actual	No. >90%	%' tage
253 General Surgery Medical Staff Serv	392	253	54.74%
253 Maternity Unit Serv	2,423	131	85.40%
253 Anaesthetics Medical Staff Serv	850	115	79.29%
253 MOC Medical Staff Serv	404	98	72.53%
253 Emergency Dept Nursing Serv	1,813	86	85.96%
253 Medical Staff - EAU Serv	550	71	79.82%
253 Obs.and Gynae. Medical Staff Serv	352	68	75.53%
253 Theatres Recovery & Anaesth Serv	400	68	77.07%
253 Medical Director Serv	55	67	40.74%
253 Medical Staff (Emergency Med) Serv	770	64	83.15%
253 Paediatric Medical Staff Serv	253	63	72.07%
253 Medical Staff Cardiology Serv	185	60	68.01%
253 Medical Staff Renal Serv	88	60	53.65%
253 Pathology - Phlebotomy Serv	465	58	80.03%
253 Ward B5 Serv	892	57	84.62%
253 Medical Staff (Older People) Serv	129	55	63.23%
253 Operations Management Serv	220	52	72.84%
253 Urology Medical Staff Serv	107	51	61.14%
253 Medical Staff - Respiratory Serv	194	50	71.58%
253 Medical Staff Endocrin/Diab Serv	97	50	59.50%
253 Theatres Emergency & Other Serv	572	46	83.38%
253 Information Technology Serv	633	42	84.40%
Total	**58,671**	**1615**	**87.58%**

HR Caseload

The current caseload is 33, with 'Disciplinary' at 40.6% the highest category, followed by 'Grievance' at 31.3%.

The highest Division is Medicine with 34 open cases.

There are 3 live suspensions.

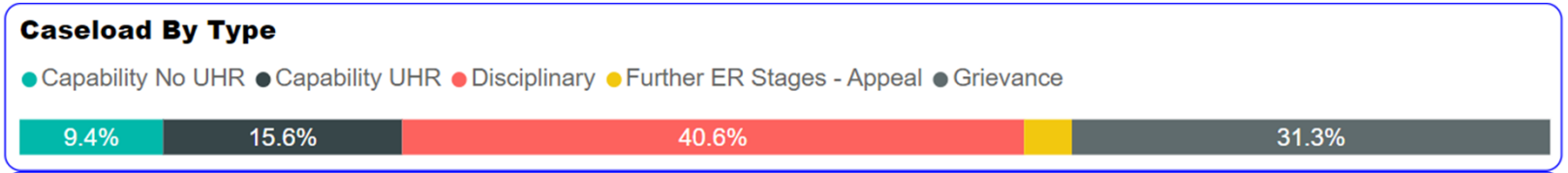
BAME representation is at 27%, with 9 open cases.

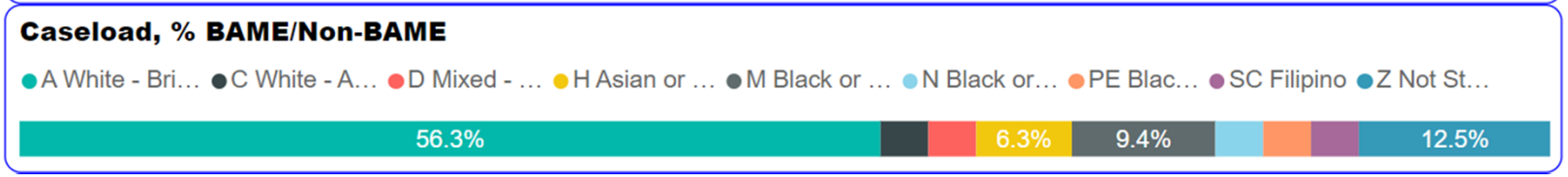
Case start to close performance is at 120 days (for closed cases since January 2020), however the current open cases have a running total average of 127 days. This increase is in part as a result of two separate periods were Employee Relations activity was paused due to COVID.

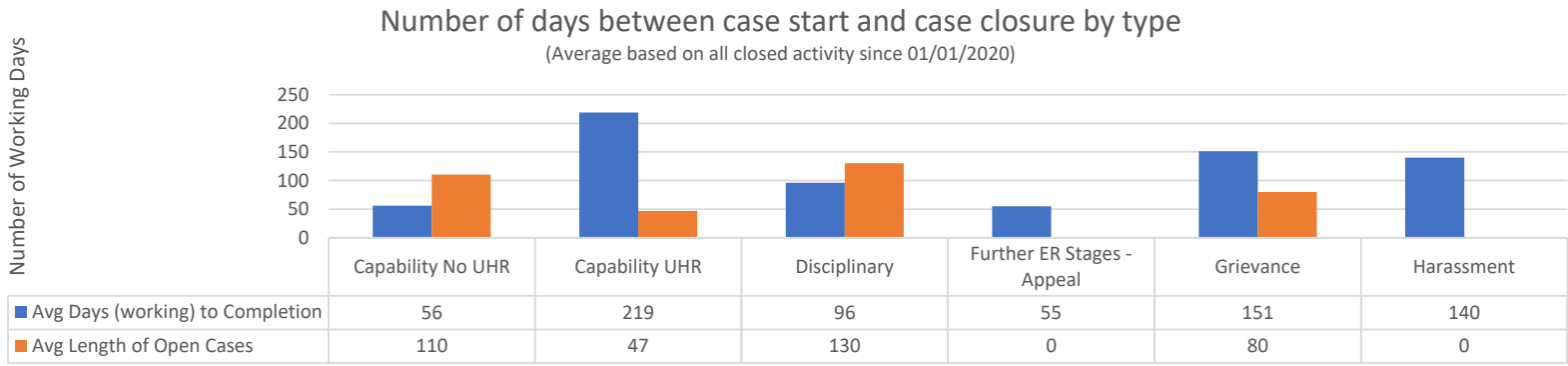
In the chart (bottom right) the blue bars show the average days from open to completed for closed cases. The orange bars show the running total average days the 'live' cases have been open.

Employee Relations Type	Number of Open Cases
Capability No UHR	3
Capability UHR	5
Disciplinary	13
Further ER Stages - Appeal	1
Grievance	11
Grand Total	33

Division	Capability No UHR	Capability UHR	Disciplinary	Further ER Stages - Appeal	Grievance	Grand Total
253 Clinical Support		1	2			3
253 Corporate / Mgt	1		3		3	7
253 Medicine & Integrated Care	1	3	6	1	2	13
253 Surgery	1	1	2		6	10
Grand Total	3	5	13	1	11	33







	Capability No UHR	Capability UHR	Disciplinary	Further ER Stages - Appeal	Grievance	Harassment
Avg Days (working) to Completion	56	219	96	55	151	140
Avg Length of Open Cases	110	47	130	0	80	0

Enclosure 29

The Dudley Group NHS Foundation Trust

Paper for submission to the Board of Directors on 16th September 2021

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

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

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

RECOMMENDATIONS:

Note the report and the significant volume of commissioned work advancing strategic plans.

CORPORATE OBJECTIVE:

SO3, S05, S06

SUMMARY OF KEY ISSUES:

- The committee effectiveness report (delayed report) and Terms of Reference were reviewed, no changes required. The Chair noted that the committee was now becoming well established with a high standard of papers and content and highlighted the need to undertake the planned but delayed "Digital Boards" (HEE, NHSx, NHSp) board development workshop.
- Significant positive assurances in performance and Electronic Prescribing 1 year review
- Recommend strategic support for the IT infrastructure replacement plans and journey to public cloud, to Finance and Performance Committee (August) with attendance of Digital Committee Chair and onward to Trust board (September).
- Cyber-security assurance noting compliant response and closure of High CareCert CC3894

IMPLICATIONS OF PAPER:

BAF 5b – Failure to adopt digital workflows

RISK	**Y**		**Risk Description:** **COR1540** Failure of the IT Infrastructure (compute, storage & backups) would impact on patient safety and performance **COR1083** Risk of cyber a security incident causing widespread impact of Trust operational capability and patient safety
	Risk Register: Y		
COMPLIANCE and/or LEGAL REQUIREMENTS	**Other**	**Y**	**Details:** DCB0160 and DCB0129 clinical risk management standards (HSCA statue 250)
REPORT DESTINATION	**EXECUTIVE DIRECTORS**	**Y/N**	**DATE:**
	COMMITTEE	**Y**	**DATE: 19th August 2021**
	BOARD	**Y**	**DATE: 16th September 2021**

UPWARD REPORT FROM DIGITAL COMMITTEE

The Dudley Group NHS Foundation Trust

Date Committee last met: 19th August 2021

MATTERS OF CONCERN OR KEY RISKS TO ESCALATE	MAJOR ACTIONS COMMISSIONED/WORK UNDERWAY
• Continued challenges in recruiting a Clinical Safety Officer (CSO), Trust remains compliant via CNO, MD reviews. • Corporate risk report noted and triangulated to mitigations in the major commissioned work, including the Infrastructure Replacement business case. • Significant growth in endpoints devices (PCs / Laptops) through Covid response highlighted, noting impact to the existing rolling refresh cycle (linked to a pre-Covid baseline) and future funding requirements. • Microsoft Office N365 upgrade programme in progress but in exception from plan – due to the impact to services / Trust operational pressures, noted low risk and recovery plans.	• Executive summary business case (Green Book 5-case model) for IT infrastructure replacement accordance with the report findings outlining a staged path to cloud. Stage 1 will be 21/22 business case in plan and outline for phase 2 in subsequent years for further development. • Maternity EPR progress excellent, with 'Go-Live' planned for the first week in September 2021, with Training in progress. • Planned upgrade programme of the existing Patient Administration • Planned Microsoft Office N365 roll out ongoing – large project • Windows 10 upgrade project meets National requirement • Medical Devices Group – refresh replacement programme • Medical Devices Group Field Safety Notice actions • Chair commissioned medical device group strategic reporting workplan for review at the next committee.
POSITIVE ASSURANCES TO PROVIDE	**DECISIONS MADE**
• Committee Effectiveness review (delayed report) demonstrates a well-established and maturing committee. • Committee Terms of Reference (ToR) reviewed - no changes recommended. • Cyber-security assurance noting compliant response and closure of High CareCert CC3894 (11th July 2021) • Significant positive external assurance provided by NHSx National Cyber team assessment Trust's performance metrics meeting or exceeding all standards. The Trust is rated as a high performer Nationally across every metric. • TeraFirma, KPIs returning to steady state post Covid surge. • One year review of the electronic prescribing and medicines administration (EPMA) and formation of EPMA user-group, - project has been successful and well adopted. • Patient Administration System – upgraded infrastructure successful	• Recommend strategic support for the IT infrastructure replacement plans and journey to public cloud, to Finance and Performance Committee (August) with attendance of Digital Committee Chair and onward to Trust board (September).

Chair's comments on the effectiveness of the meeting: well-established and maturing committee