Excellent health care, improved health for all

The Dudley Group
NHS Foundation Trust

Board of Directors Meeting Public Papers

Thursday 10th March 2022, 10:00 – 13:25pm

The Dudley Group
NHS Foundation Trust

BOARD MEETINGS
PUBLIC INFORMATION SHEET

The Dudley Group's Board of Directors meet 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 the 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 the (confidential/private) meeting.

Copies of the agenda and papers for the public meeting are available at the meetings, and on the Trust website www.dgft.nhs.uk or may be obtained in advance from the following key contacts:

Helen Benbow
Executive Officer
The Dudley Group NHS Foundation Trust
Tel: 01384 321012 (direct dial) / 01384 456111 ext. 1012
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Helen Board
Deputy Trust Secretary
The Dudley Group NHS Foundation Trust
Tel: 01384 321114 ext 1124
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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 of Interests. If you would like to see the register, please contact the trust secretary or visit our website www.dgft.nhs.uk.

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

The chairman will endeavour to respond to questions from the public on agenda items, where time permits. Members of the public, should raise any questions directly related to an agenda item with the chair.

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 a 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 Board of Directors for approval, are added to the website at the same time as the papers for that meeting.

6. Future meeting dates

For details of future Board of Directors meetings, please visit the Trust's website www.dgft.nhs.uk

7. Accessibility

If you would like this information in an alternative format, for example in large print, please call us on 0800 073 0510 or email dgft.pals@nhs.net

The Dudley Group
NHS Foundation Trust

THE SEVEN PRINCIPLES OF PUBLIC LIFE

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

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

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

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

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

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

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

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

IN PUBLIC

The Dudley Group NHS Foundation Trust

Board of Directors
Thursday 10 March 2022 at 10.00am
via MS Teams Video Conference
AGENDA

	ITEM	PAPER REF	LEAD	PURPOSE	TIME
1	**Chairman's welcome and note of apologies**	Verbal	Y Buckland	For noting	10.00
2	**Declarations of Interest** Standing declaration to be reviewed against agenda items.	Verbal	Y Buckland	For noting	
3	**Minutes of the previous meeting** Thursday 13 January 2022 Action Sheet 13 January 2022	Enclosure 1 Enclosure 2	Y Buckland	For approval	
4	**Chief Executive's Overview and Operational Update**	Enclosure 3	K Kelly / Executive Directors	For information & assurance	10.05
5	**Chair's Update**	Verbal	Y Buckland	For information	10.20
6	**Public Questions**	Enclosure 4	Y Buckland	For information	10.30
7	**GOVERNANCE**				
7.1	Well-Led External Review Report	Enclosure 5	Giles Peel, DCO Partners Ltd	For approval	10.35
7.3	Board Assurance Framework Development – Update	Enclosure 6	T Jackson	For assurance	10.50
8	**QUALITY & SAFETY**				
8.1	Quality and Safety Committee Report	Enclosure 7	E Hughes	For assurance	10.55
8.2	Chief Nurse Report	Enclosure 8	M Sexton	For assurance	11.05
8.3	Infection, Prevention and Control Board Assurance Framework	Enclosure 9	M Sexton	For assurance	11.10
8.4	Maternity and Neonatal Safety and Quality Dashboard	Enclosure 10	M Sexton	For assurance	11.15
8.5	Learning from Deaths (Quarterly Report)	Enclosure 11	J Hobbs	For assurance	11.25
8.6	Research & Development Report	Enclosure 12	J Nielson	For assurance	11.35
	COMFORT BREAK				

9	**FINANCE & PERFORMANCE**				
9.1	Finance and Performance Committee Report	Enclosure 13	J Hodgkin	For assurance	11.45
9.2	7 Day Services Compliance	Enclosure 14	K Kelly	For assurance	11.50
9.3	Integrated Performance Dashboard	Enclosure 15	K Kelly	For assurance	12.05
10	**WORKFORCE**				
10.1	Workforce and Staff Engagement Committee Report	Enclosure 16	J Atkins	For assurance	12.20
10.2	Workforce KPIs	Enclosure 17	J Fleet	For assurance	12.30
10.3	Freedom to Speak Up Report	Enclosure 18	R Plant	For assurance	12.40
10.3	Guardian of Safe Working	Enclosure 19	B Elahi	For assurance	12.50
11	**DIGITAL TRUST TECHNOLOGY**				
11.1	Cloud Transition Programme Plan Update Report	Enclosure 20	A Thomas	For assurance	13.00
12	**Any Other Business**	Verbal	All	For noting	13.10
13	**Reflections on meeting**	Verbal	All		13.15
14	**Date of next Board of Directors meeting** 18 May 2022 via MS Teams	Verbal			
15	**Meeting close**				13.25

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

Enclosure 1

The Dudley Group
NHS Foundation Trust

DRAFT **Minutes of the Public Board of Directors meeting**
(Public session)
held on Thursday 13th January 2022
virtually via MS Teams Video Conference

Present
Thuvarahan Amuthalingham, Associate Non-executive Director (TA)
Julian Atkins, Non-executive Director (JA)
Gurjit Bhogal, Associate, Non-executive Director (GB)
Yve Buckland, **Chair**
Gary Crowe, Non-executive Director (GC)
James Fleet, Chief People Officer (JF)
Julian Hobbs, Medical Director (JHO)
Catherine Holland, Non-executive Director (CH)
Jonathan Hodgkin, Non-executive Director (JH)
Liz Hughes, Non-executive Director (LH)
Tom Jackson, Director of Finance (TJ)
Vij Randeniya, Non-Executive Director (VR)
Mary Sexton, Chief Nurse (MS)
Adam Thomas, Chief Information Officer (AT)
Diane Wake, Chief Executive (DW)
Lowell Williams, Associate Non-executive Director (LW)

In Attendance
Liz Abbiss, Head of Communications (LA)
Helen Board, Deputy Trust Secretary (Minutes) (HB)
Simon Illingworth, Deputy Chief Operating Officer *[deputising for Karen Kelly]* (SI)
Becky Plant, Freedom to Speak Up Guardian *[attended for agenda item 24.2 that was subsequently deferred to the March 2022 meeting]*

Apologies
Ian Chadwell, Senior Strategy & Development Lead (IC)
Julie Dawes, Interim Trust Secretary (JD)
Karen Kelly, Chief Operating Officer (KK)

Governors and Members of the Public in attendance
Helen Ashby, public elected governor, Stourbridge
Alex Giles, public elected governor, Stourbridge
Hilary Lumsden, public elected governor, Halesowen
Maria Lodge-Smith, public elected governor, Brierley Hill
Lizzy Naylor, public elected governor, North Dudley
Suraj Parikh, rehabilitation registrar *[guest of G Bhogal]*
Louise Smith, staff elected governor, Nursing & Midwifery

21/111 Note of Apologies and Welcome

The chair opened the meeting and welcomed board colleagues, governors, and members of the public in attendance. Apologies were listed as given above.

The chair advised that in response to the current period of National Level 4 Incident escalation, NHSE/I guidance had been issued to all Trusts updating the position on reducing the governance burden to release capacity to manage the COVID-19 pandemic. The board meeting agenda had been streamlined to focus on key pandemic matters.

21/112 Declarations of Interest

There were none other than those contained on the Register.

21/113 Minutes of the previous meeting held on 11th November 2021

It was **RESOLVED**

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

There were no outstanding actions on the Action Log.

21/114 Public Chief Executive Overview Report

DW summarised her report given as enclosure 9 and highlighted the following items:

Between 14 and 20 COVID-19 cases were being admitted daily. Community transmission rates were just below 2000 per 100k and of the 81 inpatients, eight were being cared for by the critical care team; the majority of which were unvaccinated. DW encouraged all to take up the vaccine offer. Data modelling indicated a super surge in the coming weeks and planning was underway to manage patients safely. Staff absence had seen a reduction in the last week and was now 7.5% and noted the forthcoming change in testing and isolation guidance reducing the length of required isolation for those with COVID-19 to five days. Non-clinical staff has been identified and deployed to the ward areas and a small number of military personnel were expected on site in the coming week.

Mandatory staff vaccinations would come into effect from April 2022. The Trust was presently validating the vaccination status of all staff and preparing redeployment options for those who chose not to have the vaccine or were medically exempt.

The Black Country and West Birmingham ICS had established two COVID-19 medicines delivery units (CMDUs) located at Sandwell NHS Trust and the Royal Wolverhampton NHS Trust. From the middle of December, eligible Dudley patients had been triaged and treated with n-mab (neutralising monoclonal antibody) at Sandwell. The current surge and the national digital algorithm used to identify high risk patients had increased the number of referrals that led to Dudley sharing the workload. Great clinical leadership was recognised; namely led by Dr Holly John, and a growing number of clinicians providing clinical triage to support Sandwell colleagues to manage and support the care of our patients. Should numbers continue to surge, expansion plans were being developed to enable Dudley to deliver the n-mab therapy.

GC commended recent positive press engagement. In response to his challenge about the risk associated with high staff absences and whether the trust would declare a major incident, DW advised that the daily Gold command call kept this matter under close review. Consensus in the local system was to continue to work closely to support each other and gave the example of intelligent conveyancing enacted by the West Midlands Ambulance Service. MS confirmed there were robust processes in place to manage staff absences and described how staff had been moved around to ensure safe staffing. In partnership with workforce colleagues, absent staff received appropriate support to return them to work as soon and safely as possible.

DW noted her concern for the growing number of patients medically fit for discharge (MFFD) in the bed base; 128 reported on the day of the meeting and the highest within the Black Country System. The recent closures of local nursing and care homes owing to COVID-19 outbreaks was a key factor and noted the increased level of support from the Integrated Care System supporting infection control training and PPE. The Trust was working closely with all health economy partners and out of area options also explored. The impact was felt across the hospital, ED, and ambulance handovers.

All trusts would be subject to a nationally mandated peer review undertaken by a senior nursing and medical team who were expected to visit the Trust the following week. All trusts are to host a Multi-agency discharge event to clear the bed base in anticipation of the surge. DW described the many initiatives already in place.

[Helen Ashby joined the meeting]

Staff were commended for their dedication, resilience and working above and beyond to support surgical and elective work to address the backlog. Staff health and wellbeing remained paramount with the latest initiatives including supporting staff to take their birthday day off. Regular updates on the health and wellbeing offerings available to staff were listed on the Hub and In the Know daily newsletter for staff.

The chair asked to formally put on record the gratitude of the Board for all those involved with the new COVID-19 treatment drugs supporting great innovation and, all staff for doing their best to keep services running during difficult times.

It was **RESOLVED**

- **That the report be noted**

21/115 Chair's Public Update

The chairman provided a verbal update which she opened by acknowledging that all trust chairs had been asked to ensure that their respective boards were fully briefed on the mandatory vaccination matter and system wide operational pressures; Boards were asked to be able to assure themselves that all efforts were being made in supporting effective patient discharge. Initiatives to improve patient flow had been robustly challenged at the private session of the board earlier that day.

The chair announced that following consideration by the Council of Governors in December 2021, Lowell Williams was formally appointed as voting non-executive Director with effect from 1st January 2022. Adam Thomas, Chief Information Officer was appointed as a voting director of the Board of Directors with effect from 1st January 2022. The recent appointments would bring the voting composition of the Board to eight voting NEDs (including the chair) and seven executive directors.

21/116 Public Questions

Mike Heaton, Public Elected Governor: Brierley Hill asked:
Qu. Due to the enormous house building in our area and due to Dudley Council granting building permission for 1500 houses in the Kingswinford area alone, this extra equates to approx. 5000 head of people in this area alone. What are the Board's plans, if any, for the extension of buildings and medical services at the Dudley Group?

An. The recent opening of the new Rainbow unit has provided additional capacity within the footprint of the Russells Hall Hospital and a key component of improving the flow of patients throughout the hospital. The Trust is proactively supporting the establishment of the local Integrated Care System and the development of acute collaboration programmes to underpin the effective use of resources.

In line with the NHS long term plan, the Trust will continue to support the delivery of the appropriate care in the appropriate setting, reducing health equalities and improving access to diagnostic and community services. The Trust has successfully bid for funds to establish a Community Diagnostic Centre to increase access to diagnostic tests. Initially the additional capacity will be based at the Corbett Outpatient Centre with plans to provide at additional locations in the near future. Increased capacity is planned with funding recently approved to develop additional endoscopy facilities and

two further minor procedure rooms at Russells Hall Hospital which will increase our capacity to treat patients in the future.

The chair thanked Mr Heaton for raising the query and confirmed that a copy of the response would be provided.

Action Public questions response to be sent to Mr Heaton. **Trust Secretary**

21/117 GOVERNANCE

21/117.1 Audit Committee Quarterly Report

GC summarised report given as enclosure 11 and highlighted the outcome of the recent internal audit review that attributed partial assurance to the process of payment arrangements for temporary staffing contracts that had supported the vaccination programme during its initial establishment and noted the substantial work undertaken to ensure that robust the processes were now in place.

Work to refresh the Board Assurance Framework (BAF) was currently behind plan (as referenced in enclosure 23) and additional resource would be applied to recover the situation.

It was **RESOLVED**

- **That the report be noted**

21/117.2 Charitable Funds Committee Report

JA introduced the report given as enclosure 12 that highlighted the key items considered at the last meeting held on 13th December 2021.

Plans to develop staff only restaurant facilities were underway as were plans to upgrade the maternity staff rest room that had recently been approved. It was envisaged that a standard style would be developed for use across other staff rest rooms at all Trust locations. In response to concerns raised by Governor Lodge-Smith, MS confirmed that staff changing rooms were provided across the Trust.

In response to the chairs' query, JA advised that the staff restaurant facilities would utilise some existing outdoor spaces providing food outlets across the estate. DW noted that redevelopment plans would include the existing canteen spaces to create/update facilities. A selection of healthy food was available 24 hours a day for staff and visitors.

It was **RESOLVED**

- **That the report be noted**

21/118 QUALITY AND SAFETY

21/118.1 Quality and Safety Committee Report

LH summarised the exception report given as enclosure 13 and noted the positive assurances reported to the Committee:

- 100% compliance for TIA (transient ischemic attack) patients now seen within 24 hours
- Procedural documents process now supporting timely review
- Commended staff for their work to keep elective services running

- HSE (Health & Safety Executive) report following compliance visit noted robust systems and processes.
- Received positive feedback on radiology performance and improvements to workforce delivering a high quality service

LH noted concerns that related to timely access to the stroke unit for stroke patients, delayed discharges, two maternity incidents that had been reported to HSIB (Healthcare Safety Investigation Branch) and quoracy issues at the Medicines Management Group where it was noted an action plan was in place to address. JHO added that the Trusts mortality data gave stroke as a reason for death was substantially lower that the national position.

In response to a query from the chair, LH advised that all serious incidents were subject to the HSIB process regardless of department or the status of any Trust investigation that may be underway. Any outcomes and learning from the HSIB reporting process were incorporated with the Trusts established governance process.

It was **RESOLVED**

- **That the report be noted**

21/118.2 Chief Nurse Report

MS introduced the report given as enclosure 14 and highlighted the very positive feedback received in respect of the Trust's involvement with the fast track set up of the vaccination centres delivering COVID-19 boosters.

Proposed changes to the liberty protection standards in April 2022 would be deferred and dependent on the finalisation of the code of practice that was still awaiting publication. Assurance was provided that the Trust had appointed a member of staff to lead implementation of the required changes.

International nurses had responded well to the support given with 75 now on site. The Trust was an early adopter of London Critical Care Passport supporting clinical staff with the requisite skills to redeploy to critical care if needed. Nurse associate trainees were now working alongside qualified nursing staff equating to an extra 40 staff working towards their nursing registration. Five staff had completed level 7 to become nurse advocates and support staff in CCU initially, ahead of a Trust wide roll out.

In response to the chair's query, MS advised that there had been a slight increase in *c. difficile* infections, along with norovirus, MRSA and E. coli; these were reported monthly to the Quality and Safety Committee. MS reported a significant increase in Omicron related outbreaks for staff and patients, reflective of the high community transmission rates reported earlier.

It was **RESOLVED**

- **That the report be noted**

21/118.3 Maternity and Neonatal Safety and Quality Dashboard

MS summarised the report given as enclosure 15 and noted that Dawn Lewis had retired from the post of Head of Midwifery on Christmas Eve and gave grateful thanks for her dedication to the role. She was delighted to report that Claire MacDiarmid had been appointed as her successor.

There had been one still birth reported in December and two serious incidents reported in November relating to babies that required cooling and three active cases awaiting outcomes from HSIB (Healthcare Safety Investigation Branch).

Good progress was being made to deliver actions as per the Ockenden recommendations with compliance now 77%. In response to query from TJ, the Trust was not an outlier with a level of compliance that was middle of the pack for the local area.

Maternity staffing remained a challenge owing to COVID-19 related and other sickness absences. Steps to address had included pausing the continuity of care initiative and bringing in some staff from other clinical areas to maintain patient safety; the situation was monitored many times daily. Successful appointments had been made to four of the six consultant vacancies.

Recent CQC engagement activity had been attended by a large number of clinicians and feedback had reflected positively on the progress made within the department. A daily sitrep had been introduced regionwide providing key data enabling the system partners to work together effectively.

In response to a question raised by GC, the chief nurse confirmed that unlike the main inpatient wards where visiting had been paused, there had been no changes to visiting and access arrangements for both the antenatal and post-natal areas.

In response to the questions raised by VJ, international recruitment would continue for the next 18 months to 2 years. There had been a significant increase in UCAS applications for health related courses with any appreciable impact only being felt in four to five years.

It was **RESOLVED**

- **That the report be noted**

21/119 FINANCE AND PERFORMANCE

21/119.1 Finance and Performance Committee Chair

LW presented the report given as enclosure 16 and highlighted the following key points:

Concerns were noted regarding the continued pressure on ambulance handover times, and the risk of staff sickness potentially impacting patient care in some areas.

Positive assurance was received relating to improved performance in emergency department triage sepsis compliance, referral to treatment times and diagnostic waiting times. The Trust had received excellent feedback following a recent Care Quality Commission (CQC) visit to the emergency department, acute medicine (AMU) and same day emergency care (SDEC). The committee had received a deep dive into ED, AMU and SDEC which had highlighted increased collaboration both internally and externally to the Trust.

The Trusts underlying financial position was reasonably stable with the matter of high bank and agency staff rates to be resolved.

The Committee had approved the Terms of Reference for the Trust's Financial Improvement Group.

It was **RESOLVED**

- **That the report be noted**

21/119.2 Integrated Performance Dashboard

SI presented the report given as enclosure 17 and summarised the Trust's performance against national standards and local recovery plans for the month of November 2021. The Board drew some assurance from areas of success in relation to performance against the national ED 4 hour standard that compared favourably to other trusts in the West Midlands. Compliance against the VTE standards had improved across both medicine and surgery but recognised there was still more work to do. In response to the challenge from JA about the recent poor triage performance, SI noted that overcrowding in ED and staffing levels had contributed to a decline. Assurance was given that the situation had subsequently recovered with performance regularly in the higher 90%.

All Trust theatre capacity was open with very few cancellations and was supporting large scale elective recovery work that was on trajectory. Diagnostic standards continued to perform well; 96% waiting less than six weeks supported by increased capacity provided by the community diagnostic centres.

In response to a question raised by GB, the Rainbow Unit continued to work as planned with patients moving through in a timely manner. VJ noted the positive impact of the Home for Lunch initiative and challenged whether there was more that could be done to improve patient discharge. SI commented the length of stay performance compared well to other trusts and some of the challenges around discharging patients earlier in the day were linked to ward processes and all efforts were being made to refocus staff.

In response to a question from Governor Ashby, the challenge to discharge medically fit patients to a care home setting was currently problematic and the Trust was working closely with social care partners to resolve.

It was **RESOLVED**

- **That the report be noted**

21/120 WORKFORCE

21/120.1 Workforce and Staff Engagement Committee Report

JA summarised the report given as enclosure 18 and highlighted the ongoing concern about nursing vacancies and acknowledged it was reflective of the national challenges. Overall mandatory training rates were 87% and assurances were received that flexible training options were available to support staff to achieve greater compliance. Shift fill rates remained consistent and noted the significant increase in demand for bank shifts during December 2021.

The Committee had received positive upward reports from the recently established EDI Steering Group and the Health and Wellbeing Group detailing the significant programmes of work underway. The Committee had received an outline of the revised health and wellbeing offer for staff and the implementation plan for 2022 and beyond.

The Committee heard that the Trust had been awarded the Workforce Disability Equality Standard innovation fund award from NHSE/I and a draft programme of work was presented which the Committee was pleased to support.

It was **RESOLVED**

- **That the report be noted**

21/120.2 Freedom to Speak up Report

This item was deferred to the next board meeting in public session scheduled for March 2022.

It was **RESOLVED**

- **That the report be deferred to the next meeting of the board in public session**

21/121 INFORMATION ITEMS

In response to NHSEI guidance issued on 24 December 2021, a more streamlined agenda has been adopted for the meeting. The following documents were accordingly distributed separately to board members via email and were included in the meeting pack for the purpose of the record as information items given and as such, no discussion time had been allocated within the agenda.

- Enclosure 20 - Reducing the burden of reporting and releasing the capacity to manage the COVID-19 pandemic – Proposed Interim Governance Arrangements
- Enclosure 21 – Workforce KPIs
- Enclosure 22 – Statutory Mandatory training
- Enclosure 23 – Board Assurance Framework

The chair invited any question or comments arising. There were none.

It was **RESOLVED**

- **That the above reports listed in the preamble to this minute be noted for information**

21/122 Any Other Business

There was no other business.

21/123 Reflections on Meeting

The meeting had overrun the allocated time and noted that preparation of future agendas would have regard to increased time allocations.

The chair declared the meeting closed at 15.27hr

Date of the Next Board of Directors Meeting: Thursday 10th March 2022 via MS Teams.

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Yve Buckland
Chair Date: 13th January 2022

Enclosure 2

The Dudley Group
NHS Foundation Trust

Action Sheet
Minutes of the Board of Directors (Public Session)
Held on 13th January 2022

Item No	Subject	Action	Responsible	Due Date	Comments
21/105.1	Quality and Safety Committee Report	The role of the Trust as an anchor organisation and its place in addressing health inequalities to be covered in more detail at a future meeting	Director of Strategy & Transformation	~~March~~ May 2022	Request to defer until May for newly appointed Director in post **Work in progress**
21/116	Public questions	Public questions response to be sent to governor, Mr Heaton	Trust Secretary	January 2022	**Complete**

Enclosure 3

The Dudley Group NHS Foundation Trust

Paper for submission to the Board of Directors on 10th March 2022

Title:	Public Chief Executive's Report
Author:	Diane Wake, Chief Executive
Presenter:	Karen Kelly, Chief Operating Officer

Action Required of Committee / Group			
Decision	**Approval**	**Discussion**	**Other**
		X	

Recommendations:

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

Summary of Key Issues:

- Living with COVID
- Vaccination
- Climate Debate at Windsor Castle
- New Appointment for Finance Director
- Charity Update
- Healthcare Heroes
- Improvement Practice Update
- Draft Black Country ICB Constitution and Draft Function and Decision Map
- Patient Feedback
- Visits and Events

Impact on the Strategic Goals *(indicate which of the Trust's strategic goals are impacted by this report)*	
Deliver right care every time	✓
Be a brilliant place to work and thrive	✓
Drive sustainability (financial and environmental)	✓
Build innovative partnerships in Dudley and beyond	✓
Improve health and wellbeing	✓

Implications of the Paper: *(complete all sections including the Corporate Risk Register and/or the Board Assurance Framework)*			
Risk	N	Risk Description	
	On Risk Register: N	Risk Score:	
Compliance and/or Lead Requirements	CQC	Y	Details: Safe, Effective, Caring, Responsive, Well Led
	NHSE/I	N	Details:
	Other	N	Details:

Report Journey/ Destination *(if applicable)*	Working / Exec Group	N	Date:
	Committee	N	Date:
	Board of Directors	Y	Date: 10th March 2022
	Other	N	Date:

CHIEF EXECUTIVE'S REPORT – PUBLIC BOARD – 10th March 2022

Living with COVID

Last month the Prime Minister outlined a plan for Living with COVID-19. There are currently no changes to the COVID-19 guidance for healthcare staff and anyone who visits our hospital sites are still required to wear a surgical mask, wash hands and keep socially distant.

Vaccination

Getting vaccinated is an evergreen offer and having the COVID vaccine is the best way to protect ourselves and those around us. All Trust staff are encouraged to drop into our vaccination hub at Russells Hall Hospital to protect themselves, patients, colleagues, friends and family.

Climate Debate at Windsor Castle

Clare Nash, our Procurement Head of Clinical Products, represented nursing and the Midlands at Windsor Castle to join the conversation on public health and the climate emergency. Of 29 contributors at the consultation, Clare was the only registered nurse, alongside industry experts, professors in climate science and doctors representing their Royal Colleges. The event, held in St George's House, was a call to action to build a Collaborative Leadership Group with a shared strategy.

The Dudley Group is proud to get behind Healthier Planet, Healthier People – the NHS's eco campaign. We approved our own Green Plan in December 2020 and we are working with our PFI partners to reduce our carbon footprint. This includes switching to power from renewable resources, a clear focus on moving towards more environmentally sustainable clinical products, reducing single use plastics, installing electric car charging points, renewed focus on recycling and a number of initiatives on individual wards.

The Trust has a lively and active Green Team, of which Claire Nash is a member, which meets monthly. There is overwhelming support for action on climate change across the NHS workforce. Even small differences to the way we all work can make a big difference to the future of our world and its climate.

New Appointment for Finance Director

Congratulations to our Director of Finance Tom Jackson who has been appointed Chief Finance Officer for the Black Country Integrated Care Board. Tom will be leaving his role of Finance Director at The Dudley Group. In his new role he will continue to support the development of health and care across the Black Country.

It has been a pleasure working with Tom who has been a very supportive colleague. I want to thank him for everything he has brought to the Trust, and for managing our finances so well during the pandemic. We wish him well in his new role.

Tom said, "It has been an honour to serve our community and a privilege to work with so many committed clinicians, officers and Board members. I would like to thank my amazing staff who work tirelessly and effectively to support the delivery of our services and who have made my job that much easier. Also, my gratitude to Diane, Yve and other Board members who have been beyond supportive to me personally during the last four years."

Charity Update

Staff Wellbeing Hub Development

As part of our commitment to developing our staff wellbeing offer, exciting times are ahead of us with the build of a brand-new staff only wellbeing hub at Russells Hall Hospital. The hub will provide staff a safe space to rest and recuperate overall improving their health and wellbeing. The build is a joint funded project by the Trust Charity and NHS Charities Together the independent national charity caring for the NHS initially set up by the incredible donations of Captain Sir Tom Moore. Initial proposed ideas of what this area could look include kitchenette facilities, large seating area, breakfast bar area and a separate breakout area.

Success in Volunteering Futures Fund

The Dudley Group NHS Charity was successful in receiving a grant of £97,047 from NHS Charities Together and Department for Digital, Culture, Media, and Sport (DCMS) for a 15-month Young People Volunteering Programme that will build on our volunteering service's existing student volunteering programme. We will recruit and train 10 of our existing young volunteers as mentors and best practice assessors to support 150 new young volunteers who are currently experiencing barriers to volunteering in Dudley.

#WithAllOurHearts

NHS Charities Together has launched a national campaign, #WithAllOurHearts, to highlight the continuing need to support NHS staff and remind the public that NHS charities are there for them when they need it most. Our Trust charity would also like to promote our Dudley Group Thank You Appeal 2022 - JustGiving with a call for the public to demonstrate their support for NHS staff by donating. We have asked Trust staff, their families and friends to add a blue heart 💙 to their social media profiles (Twitter/Facebook/LinkedIn etc.).

Healthcare Heroes

February – Individual
Hayley Pardoe, a sister specialising in mental health, was the February individual Healthcare Hero.
Hayley is a champion for our patients living with dementia, using her font of knowledge about the condition to see and review our patients with dementia each month. Despite being advised to shield during the worst of the pandemic, Hayley's passion and care for her patients meant she continued to work regardless.

February – Team
Our February Team Healthcare Heroes award winners were the Dudley Respiratory Assessment Service (DRAS). Even with the additional pressures of the pandemic that this team has faced, they have continued to work extremely hard to help their patients cope with their recovery from COVID when they return home. The DRAS team has been at the forefront of the pandemic, providing care and treatment to COVID patients and offering support under the difficult circumstances, both on the ward and in the community

Improvement Practice Update

Dudley Improvement Practice update

2021 Gastro Pathway

Last year DIP supported departments and services along the upper and lower gastro pathways. This included the Endoscopy Unit and the Imaging department which has now become a positive case study for the recent staff survey results. The gastro ward (C7) designed and set up a new day case unit for which the last part of the estates work is currently being completed. This will save unnecessary overnight stays for patients who will be able to have their procedures carried out in the new Assessment & Intervention Room (AIR). An event took place to progress plans and referral processes for a Perioperative Hub; by optimising patients before surgery, evidence shows that there is a faster recovery and less readmission to hospital. And recruitment is almost complete to staff a new Drug and Alcohol Liaison Service which is being called the Dudley Integrated Liver Service (DILS). An event is due to be held in Spring to design the processes and launch this service. Something Dudley has never had before and which will provide access to a range of appropriate services more quickly and by dedicated specialist staff.

2022 Urgent & Emergency Care + Women's and Children's pathways

Senior leaders from the Medicine and Integrated Care division defined three true norths for Urgent and Emergency Care (UEC). These will be used to guide all improvement work throughout 2022.

Collaboration – improving working between staff groups across Acute Medicine, Same Day Emergency Care and the Emergency Department. This will reduce the number of patients at our ED front door as well as the time patients spend in ED by ensuring they are seen in the most appropriate department first time and reduce admission to the wards.

Flow – working to improve triage and streaming of patients, forecasting and responding to changes in demand to avoid bottlenecks and waiting at various stages of the patient journey.

Staff Wellbeing – it is well known that staff wellbeing results in improved patient care and experience and can produce a virtuous circle of staff recruitment and retention, reduce sickness absence and use of bank and agency staff. The ambition is to replicate the staff survey success seen in Imaging over the last year and continue to build on the improvements already made in UEC.

In March, multidisciplinary teams from Maternity, Neonates and Paediatrics will be taking part in an initial event to design and plan a whole year of focussed improvement across these services. Several patient journeys will be used to identify opportunities for change in areas such as antenatal clinics, maternity diabetes and neuro speciality. There will be a series of implementation events and projects taking place throughout the year to provide our mums, babies and children with outstanding care and experience**.**

Reflection extracts

We have had some 'passionate' debate at times and occasionally we've had to remind ourselves about respect for one another and the impact on people it has when we dismiss other's thoughts.

But this week has really given us hope that behaviour and habits that create culture can change if we all work at it together with respect and grace.

Rachel Wakeman, ED Matron

I truly now understand the value of the 5 day improvement event. I feel inspired and more confident to run improvement projects within our clinical areas.

Dr Murali Veerabahu

"Staff have a real sense of pride and are excited to return to work to implement their ideas."

Anon.

"I enjoyed that everyone had a say and were able to voice their opinions no matter what job role or banding you are."

Terri-leigh Partridge, ED Clinical Support Worker

"This is a great step forward for us to build happy working relationships."

Jayne Woodcock, ED Lead Radiographer

"Open & honest approach by all teams. Everyone's voice has been heard in a safe environment. Positive vibe throughout the week with everyone recognising the need for change & improvements. Brilliant collaboration from everyone"

Debra Vasey, Acute Medicine Matron

"It was wonderful to know other people shared similar frustrations about processes and it was incredible we were able to work out solutions without blaming/finding fault with individual teams/members"

Anon.

"Interaction with other teams (even though daunting at times) and finding my voice to actually make a valued contribution."

Lyndsey Taylor, Acute Medicine Senior Nurse

"Communication is key! Collaboration is essential! Workforce is paramount!"

Karen Hanson, Director of Operations for Medicine and Integrated Care

"The theories and techniques have been interesting as well allowing the team to feel empowered to make effective change. It has also allowed the team UEC to work closer together building bridges to allow effective working."

Chris Leach, Acute Medicine Directorate Manager

“Attending the DIP VSA week has been an eye-opening experience for me. To be able to see how all areas of the UEC work along side each other, I feel, has enabled us to identify ways we can work more collaboratively. I have felt a sense of pride knowing that the work we have produced will allow us to implement change for UEC and ultimately improve our patient experiences. I am looking forward to the future we have created for the UEC and am excited to share these opportunities with my fellow colleagues.”

Olivia Grange, ED Senior Nurse

“I have been really encouraged by the attitude of individuals to take away the ideas and begin implementation. However, some key hurdles remain after the event as they did before and these attitudes and resistance will require further cracking before sustained improvement or change can be achieved.”

Phil Atkins, ED Directorate Manager

“This week has been an eye-opener on how much we can improve now with little changes that would reduce our wasted time.”

Charlotte Corfield, ED Clinical Support Worker

- Outcome driven with personal commitments.
- Accountability and transparency of what each commitment stands for.
- Supporting each other.

Dr Mo Wani

“Everyone had a single aim – ensuring that the patient is well looked after, and care is given to the best standard possible. I feel really proud of how the urgent care team currently views pharmacy and its service.”

Aminah Ibrahim, SDEC Pharmacist

“Structured; engaging; practical experiences; sharing views; active participation; my viewpoint is a lot clearer in a few areas.”

Dr Ahmed Ismail

“Excellent experience, pleasant gathering, teamwork, practical experience, active participation.”

Dr Shaukat Ali

“We can build a better workplace and working relationship with others.”

Anon.

Draft Black Country ICB Constitution and Draft Function and Decision Map

The draft Black Country ICB Constitution was received on 18th February 2022 and has been shared with the Board for comments.

On the Board Composition, Jonathan Fellows has been recruited as Independent Chair and Mark Axcell as Interim CEO Designate. 5 NEDs have been recruited (Audit and Governance, Remuneration and People, Quality and Safety, Finance Performance and Digital and a NED to oversee work on reducing Health Inequalities and Innovation). In addition, the ICB have appointed to the 3 mandated Executive Roles of Chief Finance Officer, Chief Medical Officer and Chief Nursing Officer. There will be further adverts out later this month for the remaining 3 executive roles of Chief People Office, Chief Inequality and Innovation Officer and Chief Operating Officer.

Conversations are ongoing with partners about the number and perspectives the Board requires for the partner members. Secondary legislation is due which will provide clarity on 'eligibility to nominate'/be nominated for these positions and the Board expects to be in a position to run a nomination and selection process in mid/late May-early June. The timetable for the sign off of the final constitution and 'function and decision map' is not until late May.

The draft Function and Decision Map setting out at high level the Committee Structure of the Board is attached at Appendix one.

Patient Feedback

- **B1** - Staff were absolutely brilliant. Surgeons, doctors, nurses and all auxiliary staff made me feel confident and comfortable at all times. Can't thank everyone enough.
- **C2** - The staff are lovely, treatment pathway and reasoning were explained, so that I understood. The rooms were comfortable.

- **C5:** The staff were amazing and very calming. As a member of staff myself, I was very uneasy about being an inpatient, but they explained everything and made me feel at ease about what was going on. From CSWs all the way to my consultant they are worth their weight in gold. I am very pleased and happy now I have a diagnosis.
- **Community Musculoskeletal Assessment & Physiotherapy service (CMAPS)** - I thought the staff were very helpful and caring and it was very organised, and the equipment was very good and it was all explained to us.
- **Day Case, Corbett** - The staff are lovely and kept me informed about what was going to happen with the surgery, treated really well from the time that I came in until the time I was discharged. Couldn't fault anything.
- **Emergency Department** - Everyone was very helpful, friendly and very professional. Everything was explained to me so I could easily understand the care plan. Very pleased.
- **Maternity (Labour)** - All staff were amazing and could not have been more helpful. As a first-time mom, they made me feel so welcome and at ease. Thank you so much to all the team.
- **Neonatal –** The team were amazing, every single person on this fantastic team.
- **Safeguarding Team** - Thank you to everyone for your support in this matter. It is a great example of multi-agency working for the good of the people we strive to support.
- **Oral Surgery** - Staff were compassionate, supportive and caring. I am very grateful to all staff involved in caring for me.
- **Own Bed Instead (OBI) team:** I firmly believe that without the help of this wonderful team, my mother-in-law would not have been able to come home from hospital when she did, and I am also sure that without Ruth Dugmore's professional, committed and caring nature she would still be "sofa sleeping" and her mental wellbeing would have suffered. Ruth has been a ray of sunshine in my mother-in-law's life when she needed it most. You are all so caring and committed in getting people back into their Own Bed Instead. Wonderful service, long may it continue so that others can benefit from the rapid response and excellent care.

Visits and Events

14th January 2022	**Team Brief**
21st January 2022	**VMI Transformation Guiding Board (TGB)**
9th February 2022	**Place Development Programme - DUDLEY | Joint 'start well' session**
9th February 2022	**ICS Development – Developing the Architecture for Our Integrated Care System**
10th February 2022	**Private Board of Directors**
10th February 2022	**Board Development Session on ICB/ICS**
11th February 2022	**Team Brief**
14th February 2022	**Live Chat**
17th February 2022	**Provider Collaborative Board Meeting**
18th February 2022	**Healthcare Heroes**
23rd February 2022	**Visit to the Black Country & Marches Institute of Technology**
24th February 2022	**Healthcare Heroes**
25th February 2022	**Live Chat**
2nd March 2022	**Diagnostic Workforce Workshop**
7th March 2022	**Black Country Collaboration Clinical Summit**

Appendix 1

DRAFT Functions and Decisions Map

NHS Black Country – Functions and Decisions Map (DRAFT)

Black County Integrated Care Partnership (ICP) is a statutory joint committee between the ICB and Dudley, Sandwell, Walsall and Wolverhampton Councils.

The ICP prepares an **Integrated Care Strategy** setting out how the assessed health, social care and public health needs of people living in the Black Country are to be met by the Integrated Care System.

Health and Wellbeing Boards are statutory committees of the four Local Authorities, with statutory ICB membership.

The Boards discharge the ICB and Local Authorities' joint duties to:

- Prepare **Joint Strategic Needs Assessments** (JSNAs) for the Local Authority areas.
- Prepare **Joint Local Health and Wellbeing Strategies** that set out how the Local Authority, ICB and NHS England will meet the assessed needs in the Local Authority areas.

West Midlands Integrated Commissioning Committee is a joint committee between NHS England and the ICBs in the West Midlands.

The Committee:

- Arranges for the provision of specialised services – acute and pharmacy services, and specialised mental health, learning disabilities, and autism services.
- *Arranges for the provision of 111 and 999 services*

NHS Black Country Integrated Care Board (ICB) is a statutory NHS organisation.

The ICB is responsible for:

- Preparing a **five-year forward plan** with partner NHS Trusts and Foundation Trusts to meet the health needs of people living in the Black Country.
- **Allocating resources and arranging for the provision of health services** across the system to deliver the five-year forward plan including preparing a **joint capital resource use plan** with partner NHS Trusts and NHS Foundation Trusts.
- Establishing **joint working arrangements** with partners to deliver the priorities within the five-year forward plan.
- Establishing **governance arrangements** to support collective accountability for whole-system delivery.
- Leading system implementation of the **People Plan,** system-wide action on **data and digital** and drives joint work on **estates, procurement, supply chain and commercial strategies** as key enablers for delivery of the five-year plan.
- **Plans for, responds to, and leads recovery from incidents** (EPRR).

The ICB has established the Committees below to support it in delivering these functions and developed a Scheme of Reservation and Delegation which provides detailed information on the functions and decisions that are reserved to the ICB's Board and those that are delegated to the Board's committees, sub-committees and to ICB employees. It also sets out any ICB functions delegated to other bodies or to joint committees with other bodies, and how functions delegated to the ICB will be exercised.

Audit and Governance Committee

Responsible for Assurance on Internal Control, Audit arrangements, Governance and Statutory functions

Remuneration Committee

Responsible for setting Pay and Conditions for ICB Staff and Board Members

Finance, Performance & Digital Committee

Responsible for assurance on financial duties, system performance and digital strategy and delivery

Quality & Safety Committee

Responsible for quality surveillance and improvement across the system and oversight of safeguarding , CHC and Medicines

People Committee

Responsible for Development of People Strategy, Assurance on workforce development

System Development Committee

Responsible for supporting the development of the system operating model and provider collaboratives , primary care collaborative and Place based partnerships

Strategic Commissioning Committee

Responsible for developing plans for health services for the population, including the commissioning of Primary Care

Mental Health Joint Committee

Responsible Joint oversight of the work of the Mental Health Lead Provider with the Black Country Healthcare Trust

The Black Country area has four **Place-based Partnerships (PBPs)** that bring together the NHS, local councils, community and voluntary organisations, and citizens in each of the four Boroughs.

The PBPs:

- Develop Primary Care Networks (PCNs) within their localities and implement national PCN requirements.
- Provide operational support for General Practice and interface with the wider neighbourhood-level teams.
- Deliver local service development and improvement.
- Deliver medicines optimisation.
- Design, plan and implement specified programmes of work in line with local priority areas.

Running costs and programme budgets are delegated as part of the ICB's annual budget setting arrangements to enable delivery of ICB functions.

Acute Provider Collaborative for the Black Country is a collaborative comprised of providers across the Black Country.

The Provider Collaborative:

- Enables accelerates post-pandemic recovery of elective services, addressing inequalities in access and outcomes.
- Maximises the collective impact of the three organisations as anchor institutions (e.g. purchasing more locally, reducing environment impact, supporting local recruitment, etc).

West Midlands Joint Commissioning Committee

The arrangements for the Joint Commissioning Committee are:

The Joint Commissioning Committee has the following functions:

1.
2.
3.
4.
5.

This means that the Joint Committee is responsible for making the following decisions:

1.
2.
3.
4.
5

NHS Black Country Integrated Care Board (ICB)

- The ICB is chaired by Jonathan Fellows
- The ICB meets on a *Bi-monthly* basis with the meeting held in public (the public may be excluded from certain items where there is confidential .
- Meeting dates and papers for the meeting can be found on the following link:

The ICB has the following functions:

- Duty to produce and revise 5 year forward plan with partner trusts and NHS foundation trusts
- Power to arrange for the provision of such services or facilities as it considers appropriate for the purposes of the health service including conducting procurements
- Determine Arrangements for discharging statutory commissioning duties
- ICB may arrange for any functions exercisable by it to be exercised by or jointly with a relevant body, local authority or combined authority.
- ICB may set up a joint committee and establish and maintain a pooled fund in respect of jointly managed functions.
- ICBs and each responsible local authority is to establish an ICP. The ICP must include members appointed by the ICB and each relevant authority.
- Allocation of budgets / resource and agree Joint Capital Resource Plan
- System incentive re-alignment
- Duties to have regard to:
    - all likely effects of decisions on the health and well-being of the people of England, the quality of services provided or arranged and the efficiency and sustainability of resources used.
    - assessments and strategies
    - NHS guidance concerning joint working and delegation arrangements.
- Oversight of:
    - Clinical Leadership Arrangements
    - Internal and External Communications and Media relations
    - Strategic partnership management
    - Engagement, Involvement & Consultation including Political and Clinical and professional engagement
    - Corporate Governance
    - Performance of functions outside England
    - Engagement with Health Overview and Scrutiny Committees
    - National Programme
- Powers to do anything calculated to facilitate, conducive or incidental to another function.
- Respond to NHSEI Consultation on any Directions it intends to issue
- ICBs are permitted to disclose information it has obtained in the exercise of its functions in certain circumstances
- Refer a dispute concerning an NHS contract to the Secretary of State
- Make arrangements with the Secretary of State in respect of the exercise of public health functions
- Power to agree arrangements for support with the Secretary of State
- Exercise power to apply to become a Care Trust

Audit and Governance Committee

The Committee acts as the ICB's statutory Audit committee is responsible for overseeing the work of both internal and external audit, as well as other key systems of internal control including counter fraud, risk management and compliance with financial governance arrangements. The Committee will support the ICB in preparing its Annual Report and Accounts and oversee compliance with key statutory responsibilities including Emergency Planning and Information Governance along with the wider Governance Framework.

The Audit and Governance Committee has the following functions:

- Support the preparation and publish the Annual reports and accounts
- Appointment of internal and external auditors
- Monitoring Compliance with standing orders
- Monitoring Counter fraud and security arrangements
- Monitor internal/external audit function
- ICB duties as category 1 responders including assessing the risk of an emergency occurring and to maintain plans for the purposes of responding to an emergency
- Support the Development of the ICB constitution, including applications for updates and variations.
- Support the development of other Governance documents (e.g. Governance Handbook)
- Determine the ICB's Risk Management arrangements, including ensuring they work effectively
- Developing proposals for audit activity at a system level to ensure assurance and learning is effectively shared with all partners
- Oversight of the following Corporate Functions:-
    - Information governance arrangements
    - Records management
    - FOI
    - Intellectual Property
    - Corporate Affairs (including PMO, Business and Executive Support)
    - Emergency Planning / business continuity
    - Conflicts of interest management
    - Health and Safety
    - Equality & Diversity
    - Litigation (including Corporate Manslaughter claims etc.)

Remuneration Committee

The Statutory Committee responsible for agreeing pay and conditions for the ICB and its employees. This includes agreeing the overall pay policy and the specific arrangements for employees not on Agenda for Change Contracts and for Non-Executive ordinary Members of the Board. The Membership of the Committee includes independent Non-Executive Representatives to enable it to be quorate when decisions are made about ICB Non-Executive pay.

The Remuneration Committee has the following functions:

- Arrangements for remuneration and allowances for Employees and relevant Board Members
- Arrangements for payment of allowance to other persons
- Following guidance issued by NHS England concerning joint appointments between relevant NHS commissioners, relevant NHS commissioners and local authorities and relevant NHS commissioners and Combined Authorities.
- Determine the ICB pay policy (including the adoption of pay frameworks such as Agenda for Change);
- Oversee contractual arrangements;
- Determine the arrangements for termination payments and any special payments following scrutiny of their proper calculation and taking account of such national guidance as appropriate.

People Committee

The People Committee is responsible for supporting the ICB in meeting its responsibilities for leading the People agenda across the system. This includes oversight of the development of strategic workforce plans, monitoring workforce issues across the system and actions to address them. The committee will also have oversight of the ICB's own HR arrangements including agreeing HR Policies for ICB employees.:

The People Committee has the following functions:

- Supporting the ICB in meeting its responsibility to lead the delivery of the People Plan for the system
- Arrangements for discharging statutory duties as an employer
- Following guidance issued by NHS England concerning joint appointments between relevant NHS commissioners, relevant NHS commissioners and local authorities and relevant NHS commissioners and Combined Authorities.
- Compliance with duty to make available facilities to university medical or dental schools for the purposes of clinical teaching and research
- Responsibilities in respect of Whistleblowing Legislation
- Developing a Workforce strategy and vision
- Developing a System Workforce Plan
- Agreeing appropriate Employment policies
- Oversight of the ICBs Human Resources function including:-
    - Recruitment
    - Payroll
    - Workforce Performance
    - Organisation development
    - Workforce System Management
    - Strategic HR Advice
    - HR Policy Development
    - General Health and Safety duties as an employer

Finance, Performance and Digital Committee

The Finance, Performance and Digital Committee is Responsible for supporting the ICB in ensuring it meets its financial responsibilities, leads on the digital and data agenda across the system and providing assurance that performance is being managed across the system to deliver ICB strategy and plans. This includes developing financial strategies (including the overall system financial and capital plans) and monitoring performance to ensure the system collectively achieve financial balance. The committee will also support the development of strategies for estates, digital and data as key strategic enablers for overall ICS plans and provide assurance to the ICB that delivery against them is on track and sustainable.

The Finance, Performance and Digital Committee has the following functions:

- Arrangements for discharging statutory financial duties including responsibility for payments to providers and operation within resource limits.
- Supporting the ICB, its partner NHS trusts and NHS foundation trusts to prepare the capital resource plan.
- Agreeing to make facilities available to providers, local authorities or eligible voluntary organisations
- Agreeing arrangements to make grants or loans, subject to such conditions as the ICB deems appropriate, to NHS, trusts, NHS foundation trusts, or voluntary organisations that provide or arrange for the provision of services similar to the services of which ICB has functions.
- Agreeing arrangements for budgetary control
- Agreeing arrangements for the ICB are required to use banking facilities as specified by the SoS.
- Monitoring Compliance with Duty as to effectiveness, efficiency etc
- Supporting the establishment of pooled funds
- Power of CCGs to make payments towards expenditure incurred by local authorities on social care functions
- ICB may be required to provide NHS England with any necessary documents or other information.
- Supporting the ICB in complying with NHS England financial requirements relating to management or use of financial or other resources.
- Development of Capital and Investment Strategy
- Development and Monitoring of Data and digital strategy arrangements
- Development and Monitoring of Estates Strategy Development
- Supporting Duty to publish details of how it has spent a quality payment from NHS England
- Power to recover any reduction, remission or repayment which was not due to a person as a civil debt
- Approving any arrangements for raising additional income (the initial decision to raise individual income should be reserved to the CCG but ongoing use of this power could be done via a joint committee)
- Complying with NHSE requirements on ICBs in order to raise money for investment in Special Administration Funds.
- If required by regulations, each ICB may be required to pay charges in the context of NHSE's functions relating to securing continued provision of health care services for the purposes of the NHS.
- Power to make arrangements for the purposes of furthering sustainable development in countries outside the United Kingdom with the consent of the SoS.
- Oversight of:-
    - Financial Performance
    - Financial Reporting
    - Financial Contract Support
    - Prescribing Budget
    - Financial framework improvement
    - Acute Contract Management
    - Financial planning and management
    - Non-Clinical Contract Management
    - Capital expenditure / capital scheme
    - Performance Management
    - Financial planning
    - Strategic IT
    - Supply chain management
    - Programme Delivery
    - QIPP and other cost reduction and demand management arrangements
    - Facilities management
    - Financial Control
    - Operational Estates Support - Primary Care
    - Operational Estates Support – Corporate
    - Environment and environmental sustainability

Quality and Safety Committee

The Quality and Safety Committee is responsible for supporting the ICB in ensuring it meets its responsibilities to ensure that there is a focus on continuously improving quality across the services in the system. This includes maintaining an oversight of quality issues across the system to provide assurance to the ICB and escalating any issues as appropriate. The committee will also maintain an oversight of arrangements to ensure the ICB continues to meet its statutory responsibilities in relation to safeguarding vulnerable adults and children and young people, working with Local Authorities to support people with Special Educational Needs and Disabilities, continuing health care and medicines management.

The Quality and Safety Committee has the following functions:

- Strategic quality assurance including development and monitoring of Quality improvement strategy to secure continuous quality improvement
- Measures to secure the continued provision or commissioner requested services
- Quality Improvement Analysis
- Supporting the ICB in meeting its duties to:-
    - promote NHS Constitution
    - secure improvement in quality of services
    - to promote research, education and training
- Developing and monitoring arrangements for Patient safety improvement
- Arrangements for the discharge of the ICB's power to appoint Medical Examiners.
- Comply with NHSE directions following investigations of failure to establish measures to allow patient choice
- Ensuring the ICB Cooperates with HSSIB when carrying out an investigation into the same or related incident
- Ensuring the ICB cooperates with the CQC in its role as a regulator.
- Oversight of ICB Duties in respect of Continuing Healthcare
- Oversight of ICB Duties in respect of Safeguarding Vulnerable Adults and Children and Young People
- Oversight of ICB Duties in respect of SEND
- Oversight of ICB Duties in respect of Individual Funding Requests
- Oversight of Quality in respect of the following:-
    - Medicines Management and Optimisation
    - 111/999 Quality Management
    - Serious incident management
    - Health Prevention Protection and Improvement
    - PPE
    - Infection control
    - Access and Response
    - Care Home Quality and Safety

Strategic Commissioning Committee

The Strategic Commissioning Committee is responsible for supporting the ICB in its responsibility to arrange services for the population it serves. This includes reviewing the arrangements for meeting a number of statutory duties (including complying with relevant standing rules and guidance, promoting the NHS Constitution and around patient choice). The Committee will oversee the work of collaborative forums across the system that are developing clinical contributions to strategic plans and setting shared priorities for delivery. The committee is also responsible for exercising the powers delegated to the ICB by NHS England in relation to Primary Medical Services and the preparation for further delegation of responsibilities related to Pharmacy, Ophthalmology and Dentistry.

The Strategic Commissioning Committee has the following functions:

- Supporting the ICB to ensure that the services it is responsible for arranging comply with the following statutory duties:-
    - ensure persons are offered a choice of health service provider
    - publicise and promote information about patient choice
    - meet the maximum waiting times standard (the essence of this duty is to hold providers to account for their performance against waiting times)
    - offer an alternative provider
    - make arrangements to provide an appointment with a specialist for those patients urgently referred for treatment for suspected cancer
    - offer alternative provider for treatment for suspected cancer
    - offer assistance re waiting times
    - Duty to promote the NHS Constitution
    - Duty as to reducing inequalities
    - Duty to promote involvement of each patient
    - Duty as to patient choice
    - Duty to obtain appropriate advice
    - Duty to promote innovation
    - Duty to promote integration
    - Duty to have regard to guidance on commissioning published by NHS England
    - Duty to cooperate with other NHS bodies and Local Authorities
    - Duty in respect of research
    - Duty to promote education and training
    - Public sector equality duty
    - Comply with "standing rules" including those in relation to Patient Choice
- Oversight of Collaborative Forums that contribute to the development of strategic planning and setting shared for priorities operational delivery
- Exercising functions delegated by NHS England in relation to Primary Medical Services
- Overseeing the preparation for the delegation of Primary dental and ophthalmology
- Overseeing the preparation for the delegation of specialised services and other NHSEI commissioning responsibilities
- Oversight of the following activities conducted in relation to services the ICB is responsible for arranging:-
    - Research projects
    - Public Involvement Consultation about plans
    - Compliance with regulations made by the SoS in relation to the procurement of health care services.
    - ICBs and local authorities are to have regard to the joint strategic needs assessment, integrated care strategy and joint local health and wellbeing strategy when exercising their functions.
    - Insight, Intelligence & System Analysis
    - Evidence based protocols and pathways
    - Service design and development
    - Service and care coordination
    - Place based planning
    - Strategic market shaping
    - Clinical Policy Development
    - Responding to requests for information made by the Local Healthwatch organisation and dealing with their reports or recommendations.

System Development Committee

This Committee is time limited and will support the ICB in developing proposals for the further development of the operating model across the system. This includes oversight of the development of Place Based Partnerships, Provider Collaboratives, Primary Care Networks and Collaboratives and the overall strategy for clinical leadership across the system. The committee will also develop proposals for governance arrangements that will enable mutual leadership and accountability across the system that facilitates appropriate delegation of decision making across the system in line with the principle of subsidiarity.

The Strategic Development Committee has the following functions:

- Oversight of the development of the operating model for the system, including the contributions made to this by:-
  - Place based Partnerships
  - Provider Collaboratives
  - Primary Care Networks and Primary Care Collaboratives
- Develop proposals for future Governance and oversight arrangements for the system in line with the operating model
- Oversight of the ICBs relationship with Local Authorities including
  - Cooperation with Public Health
  - Duty to prepare a JSNA along with the local authority
  - Co-operating generally with local authorities in relation to adults with needs for care and support, and carers
  - Local Health and Wellbeing Strategy (JSHW)
  - Approving arrangements for pooled budgets and ensuring monies designated for integration for that purpose - aka Better Care Fund
  - Comply with requirements in relation to Review and scrutiny by local authorities.
  - Each ICB must appoint a person to represent it on its relevant Health and Wellbeing Board.
  - Each ICB has a duty to cooperate with its HWB in relation to the discharge of the HWB's functions.
  - Assist Local Authorities in the discharge of their relevant functions

Mental Health Joint Committee

The Mental Health Joint Committee is responsible for ensuring that the ICB and Mental Health Lead Provider are able to jointly oversee the work of the lead provider and ensure that the activities undertaken are delivered within the agreed financial envelope and in line with the ICB's statutory responsibilities relating to the quality of services. This will include decision making in relation to resource allocation within the identified financial envelope and joint oversight of delivery in line with the contract for the lead provider programme.

The Mental Health Joint Committee has the following functions:

- Oversight of the Work of the Mental Health Lead Provider Arrangements, including its contributions to:-
  - Mental health - Wellbeing and Prevention
  - CAMHS
  - Mental health - S117 Aftercare
  - Mental health - Crisis & acute
  - Mental health - Community
  - Mental health - Integration with primary, secondary, acute and community
  - Learning Disabilities and Autism
- Oversight of the following activities conducted by the Mental Health Lead Provider:-
  - Research projects
  - Public Involvement Consultation about plans
  - Compliance with regulations made by the SoS in relation to the procurement of health care services.
  - Service planned at place including Long term conditions, rehabilitation, recovery, Provision of vehicles for disabled people
  - ICBs and local authorities are to have regard to the joint strategic needs assessment, integrated care strategy and joint local health and wellbeing strategy when exercising their functions.
  - Insight, Intelligence & System Analysis
  - Evidence based protocols and pathways
  - Service design and development
  - Service and care coordination
  - Strategic planning
  - Strategic market shaping
  - Responding to requests for information made by the Local Healthwatch organisation and dealing with their reports or recommendations.
  - Clinical Policy Development
- Supporting the ICB of the delivery of the following Statutory Duties in respect of services planned and delivered at by the Mental Health Lead Provider:-
  - Duty to promote the NHS Constitution
  - Duty as to reducing inequalities
  - Duty to promote involvement of each patient
  - Duty as to patient choice
  - Duty to obtain appropriate advice
  - Duty to promote innovation
  - Duty to promote integration
  - Duty to have regard to guidance on commissioning published by NHS England
  - Duty to cooperate with other NHS bodies and Local Authorities
  - Duty in respect of research
  - Duty to promote education and training
  - Public sector equality duty
  - Comply with "standing rules" including those in relation to Patient Choice

Provider Collaboratives - PLACEHOLDER

The arrangements for Provider Collaboratives in the ICB are……
The provider collaborative is chaired by X

Provider collaboratives have the following functions:

- To enable two or more NHS Providers to come together with a shared purpose and effective decision-making arrangements, to:
    - reduce unwarranted variation and inequality in health outcomes, access to services and experience
    - improve resilience by, for example, providing mutual aid
    - ensure that specialisation and consolidation occur where this will provide better outcomes and value.

This means that decisions relating to these functions are made by:

1.
2.
3.
4.
5

Place Based Partnership (PBP) - PLACEHOLDER

The arrangements for the place based partnership in the ICB are……
The Place Based Partnership is chaired by X

The PBP has the following functions:

- To bring partners in each place together to develop shared objectives, built on a mutual understanding of the population and a shared vision for the place focussed on improving the health and wellbeing outcomes for the population, preventing ill health and addressing health inequalities.
- To agree objectives to support this vision including goals to:-
    - Improving the quality, co-ordination and accessibility of health and care services to better meet the needs of people and communities.
    - Build coalitions across a range of community partners.
    - Reflect the priorities that are most important to their partnership and to their communities.
- Agree actions the partnership will undertake together, and the capabilities required to support the vision and goal.
- To support the agreement of shared priorities for the wider system, which will include working with at-scale provider collaboratives, where they have taken on responsibility for the delivery of certain services at-scale, to ensure this meets the needs of communities in their place and to avoid the duplication of activities.
- To consider different approaches to take locally to support providers of different types and from different sectors to work together to co-ordinate care and integrate services in their locality.
- Oversight of the following functions agreed for delivery through the partnership:-
    - Health and Care Strategy and Planning
    - Service Planning
    - Service delivery and transformation
    - Population Health Management
    - Connect support in the community
    - Promote Health and Wellbeing
    - Align Management Support

Integrated Care Partnership (ICP) - PLACEHOLDER

- The Black Country ICP is chaired by X
- The ICP meets on a x basis with the meeting held in public.
- Meeting dates and papers for the meeting can be found on the following link:

The ICB has the following functions:

- To operate as a forum to bring partners across local government, NHS and others to align purpose and ambitions with plans to integrate care and improve health and wellbeing outcomes for the population.
- To facilitate joint action to improve health and care services and to influence the wider determinants of health and broader social and economic development.
- To develop an 'integrated care strategy' for the whole population that will:-
    - Use best available evidence and data, covering health and social care (both children's and adult's social care).
    - Address the wider determinants of health and wellbeing.
    - Be built bottom-up from local assessments of needs and assets identified at place level, based on Joint Strategic Needs Assessments.
    - Be focused on improving health and care outcomes, reducing inequalities and addressing the consequences of the pandemic for communities.
- To champion inclusion and transparency and to challenge all partners to demonstrate progress in reducing inequalities and improving outcomes.

Enclosure 4

The Dudley Group
NHS Foundation Trust

Paper for submission to the Board of Directors on 10th March 2022

Title:	Public Questions
Author:	Helen Board, Deputy Trust Secretary
Presenter:	Yve Buckland, Trust Chair

Action Required of Committee / Group			
Decision	**Approval**	**Discussion**	**Other** Y
The Board is asked to note the questions raised by the Council of Governors and the public where indicated.			

Summary of Key Issues:

Public Questions

The Trust Board will continue to invite governors and members of the public to attend 'virtually' 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

Question/s received:

Mike Heaton, Public Elected Governor: Brierley Hill
Q. In light of the Liverpool bombing in November 2021, what steps has the Trust taken to tighten security and have security staff more visible to prevent a similar type of attack at one of its sites. He raises particular concerns about: large bags (used my reps for example) not being checked when visiting departments and wards. Staff ID badges not worn correctly to display the persons name and photo and or being illegible.

A. Following the Liverpool incident, several measures were adopted by the Trusts facilities partners Mitie who provide the security services.

- Increase in presence in main reception and around the boulevard, back of house.
- Increased physical patrols in and around site, with special focus around entrances/ exits, GAS stores, BOC supply and other High risk areas.
- CCTV spot monitors reconfigured to keeps entrance exits on main monitors.
- Security Training revisited to ensure Counter Terrorism Training was updated to ensure 100% compliance. Including all Trust Mandatory training.
- Increased enforcement of and ticketing of vehicles parked on the red route.

- Toolbox talks sent out to Mitie Managers and toolbox talks conducted with security staff around suspicious items, activity and reporting.
  - Increase in security bank staff and confirmed with local agency that they are able to provide a minimum of 5 officers with immediate effect, should an urgent call be made at any time of the day.

Staff are advised to update their ID badges following faded images. Trust communicates the need to follow good identification processes throughout the year to all staff through a variety of methods. The Trust also adopted a risk based approach to any events of gathering of people outside main entrances.

Impact on the Strategic Goals *(indicate which of the Trust's strategic goals are impacted by this report)*	
 **Deliver right care every time**	**Y**
 **Be a brilliant place to work and thrive**	
 **Drive sustainability (financial and environmental)**	**Y**
 **Build innovative partnerships in Dudley and beyond**	**Y**
 **Improve health and wellbeing**	**Y**

Implications of the Paper:			
Risk	N	Risk Description:	
	On Risk Register: N	Risk Score:	
Compliance and/or Lead Requirements	CQC	Y	Details: Well led
	NHSE/I	N	Details:
	Other	N	Details:

Report Journey/ Destination *(if applicable)*	Working / Exec Group	N	Date:
	Committee	N	Date:
	Board of Directors	Y	Date: 10/03/2022
	Other	N	Date:

Enclosure 5

The Dudley Group
NHS Foundation Trust

Paper for submission to the Board of Directors on 10th March 2022

Title:	**Well-Led External Review Report**
Author:	Helen Board, Deputy Trust Secretary
Presenter:	Giles Peel, DCO Partners Ltd

Action Required of Committee / Group			
Decision	**Approval** Y	**Discussion**	**Other** Y

The Board is asked to:

- Receive the report provided by DCO Partner following the conclusion of an independent governance review under NHS Improvement's Well-Led framework
- To note the development of the action plan that is underway developed to reflect the review findings and recommendations. To be submitted to April Board for approval.

Summary of Key Issues:

Background
The boards of NHS foundation trusts and NHS trusts are responsible for all aspects of the leadership of their organisations. NHS Improvement (NHSI) support in-depth, regular and externally facilitated developmental reviews of leadership and governance. Reviews should identify the areas of leadership and governance that would benefit from further targeted development work to secure and sustain future performance.

The external input is vital to safeguard against the optimism bias and group think to which even the best organisations may be susceptible. NHSI strongly encourage all providers to carry out externally facilitated, developmental reviews of their leadership and governance using the well-led framework every three to five years, according to their circumstances.

The Review
Following a competitive tender process, DCO Partners Ltd were commissioned to undertake a Well-led Developmental Review to provide an independent review of the Trust's governance against certain of the NHS Improvement Well-Led Framework's Key Lines of Enquiry (KLOEs). The review, led by Giles Peel and Mike Bewick, was conducted between October 2021 and January 2022. Issues raised in the final report (Appendix 1) were identified during the review.

Next steps
Findings of the review have been prioritised and an action plan development is underway to reflect the recommendations as set out in the report. The Board will receive the action plan at their April 2022 meeting and receive regular updates to maintain oversight of the plan.

Appendix: 1
DCO Partners Ltd Report January 2022

Impact on the Strategic Goals *(indicate which of the Trust's strategic goals are impacted by this report)*	
Deliver right care every time	**Y**
Be a brilliant place to work and thrive	**Y**
Drive sustainability (financial and environmental)	**Y**
Build innovative partnerships in Dudley and beyond	**Y**
Improve health and wellbeing	**Y**

Implications of the Paper:			
Risk	N	Risk Description:	
	On Risk Register: N	Risk Score:	
Compliance and/or Lead Requirements	CQC	Y	Details: Well led
	NHSE/I	Y	Details: Well-Led Guidance Publication CG32/17
	Other	N	Details:

Report Journey/ Destination *(if applicable)*	Working / Exec Group	Y	Date: 01/03/22
	Committee	N	Date:
	Board of Directors	Y	Date: 10/03/22
	Other	N	Date:

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The Dudley Group NHS FT Well-Led Developmental Review

This report is intended to provide an independent review of the Trust's governance against certain of the NHS Improvement (NHSI) Well-Led Framework's Key Lines of Enquiry (KLOE). The review was conducted between October 2021 and January 2022. Issues raised in this report were identified in course of our review, but they may not represent the totality of the position currently faced by the Trust. This report is addressed to the Trust's Board; the contents may not be shared with any third party without the express permission of DCO Partners Ltd.

Contents

Overall impressions of the Trust

From a position of historical underperformance and poor external assessments of its service, DGFT has improved its service delivery and stabilised the organisation. Many of these achievements resulted from significant changes made in the turbulent period 2017-19 but the last two years has seen further improvement – a step change – in leadership at many levels. There is demonstrably more ambition and increased pride at the Trust. Key to this has been the Board's focus on engagement with its staff and especially its clinicians. The organisation has progressed significantly in clinical leadership – the Trust used to be better known for being operationally led - and the new Executive team are forming better relationships with external players. The Trust is well-placed to play a vital role in partnerships and in terms of acute collaboration. The next step is to build on these successes to become more self-confident, which means that Dudley can grow as an anchor organisation. A vigorous focus on Dudley's role within the health and social system, as both a large provider, and as a significant leader for change across the geographical footprint, is the next step. This will also continue to change external perceptions of the Trust.

Scope and approach

After an initial scoping meeting with the Chair and Chief Executive, we began a four-phase approach. Phase 1 was a documentary review, lasting some three weeks. We then started Phase 2 which consisted of a series of one-to-one interviews with members of the Board, as well as with three external interviewees representing various parts of the regional health system. We then observed a number of key meetings in Phase 3 before producing this report as the first stage of Phase 4. As the final element, we will present this report to the Board and facilitate a discussion on actions arising.

Documentary review

As part of the review, we were supplied with a sample of documents (84 in total) covering the period between January and August 2021. We received a wide range, covering meetings for the Board and Committees, policies, risk papers, planning, and strategy. These were supplied by means of an e-portal and we then rearranged the information into more accessible sections. We strongly recommend that the Trust now does the same, so that this can then be used as a database on which to build a portfolio for a Well-Led Review. Ideally, Board members and senior management should have rapid access to the same repository, ordered by KLOE, where examples of documents are stored and can also be presented as evidence to the CQC.

The overall quality of paperwork was good, and clearly much work goes into preparation. Of particular note is the way the Trust cross-refers most papers to its risk framework, making analysis simple and effective. We make comments elsewhere on the suitability of detail for certain papers, and we also question gently, how far documentary records reflect the levels of challenge that actually take place.

Meeting observations

We observed a wide range of Trust meetings in the period October to December 2021, both virtually and in person. A full list is shown at Appendix A.

The meetings observed were well attended by the Executive team, who tend to stick mainly to their respective subject expertise, but there were some absences from the NEDs. Overall, the committees receive very detailed papers (often too detailed) and we observed good levels of scrutiny from the NEDs. As stated earlier, the minutes of these meetings sometimes give a false impression that there is not much debate, an issue that we go into in more detail at Appendix B.

On more than one occasion we saw less than the full number of NEDs attend the meeting. Further examination of the committee TORs (QSC, Audit, FPC, Workforce and DTTC) showed that, unusually, Dudley includes both NEDs and EDs as committee members, and in all but one meeting (the Audit Committee), EDs are included in the quorum. We feel that this should be revised such that the Board's committees are comprised only of NEDs, with any EDs attending the meetings rather than being there as voting members.

At both the QSC and WSEC committees there was excellent clinical input. The in-depth review of differential outcomes in maternity care for BAME/Caucasian populations was an excellent example of where future risk could be identified and managed. This was also true in the divisional deep dive presented at the WSEC where improvement targets were set for clinicians as well as managers. At the latter there was significant challenge from NEDs. These were excellent examples of where Board members could challenge clinicians as well as support them at a time of considerable pandemic pressures.

Observations at the private section of the Trust Board also demonstrated the contribution of clinicians in responding to the challenges identified in the consolidated performance review. We observed a mature conversation where risk was appreciated, shared and owned by the Executive Directors and senior clinicians. An example was the joint approach in implementing and assessing the new arrangements at the recently launched front of house assessment unit in the Emergency Department.

The Council of Governors demonstrated a warm relationship between the Board and Council, with strong levels of information circulated and a demonstrable desire to keep Governors informed. In contrast, the response from Governors could be more robust (except for some staff governors who did probe on trust performance). It would be good to see more challenge encouraged, and training given where necessary, so that the NEDs are, and seen to be, held to account.

Interviews

A full list is shown at Appendix A. We interviewed all Board members, one Associate NED and three external representatives from the local health economy. The internal team all interviewed well and were both confident and highly knowledgeable about their Trust. We found strong consistency in the descriptions of the main risks faced by the Trust, and all were able to describe the journey that Dudley has been on in recent years, as well as the progress made. The continuity of the challenges that the Trust faces suggests to us that the Board is well informed about the running of the Trust and its key areas of concern, especially clinical. There was less consistency in answering how the newly developed strategy would be implemented, but we acknowledge that this strategy is at an early stage of development. We also received several NED comments about the levels of detail and complexity of financial reports, which are not always clearly interpreted.

All those we spoke to from the Trust were enthusiastic about the tasks ahead and very proud to be part of the Dudley Group – they were a pleasure to interview.

Ward to Board reporting arrangements

As part of this review, we were asked specifically to assess the effectiveness of reporting from 'ward to board', in other words from operational clinical services, rising through the governance structure, and ending at the board. Whilst our observations elsewhere in this report are arranged principally by KLOE, these ward to board reporting arrangements span KLOEs 4, 5 and 6, so we have produced Appendix B to address this specific aspect of our brief. For a Well-Led Review, KLOE 4 is where this aspect is considered primarily by the CQC, and NHSE uses the words 'board to front line to board' in its guidance.

We believe that significant efforts have been made by the clinical leadership to address the reporting mechanisms, however these are not the finished article and there is too much variability between the Divisional reports. This presents itself in either too complex or over-simplified summaries, making it hard for the NEDs in the committees to assess problems and therefore to challenge Executive management, as well as to identify, commend and disseminate successes. A standard reporting process would help greatly here. Furthermore, the documentary evidence that we were given reinforces this point and presents a potentially confusing picture on some issues.

External views of the Trust

During our review on 30 November, the Trust received the welcome news that NHSI was removing its enforcement of undertakings, thereby restoring the Trust's reputation and regulatory status in some key areas. We interviewed some external officials at around the same time and found a consistent set of themes, namely that Dudley Group is a positive system partner, led by a CEO who is prominent in her collaborative roles (including as SRO for Cancer and Elective Recovery).

The one area which remains of concern is around the community interaction and in particular, the Trust's relationships with local GPs (and linked to the observation made at KLOE 2 below on Primary and Secondary care visions differing). Interviewees were anxious to make the point that this is a separate issue from DIHC, and one that the Trust needs to work on with more energy, as it detracts from the otherwise good and still improving reputation.

Observations by KLOE

The following sections contain a summary of our observations, grouped into each KLOE area. The observations are a mixture of areas we thought stood out as examples of good practice, together with those which we felt needed further work to improve the standard of Well-Led performance in the Trust.

KLOE 1: "Is there the leadership capacity and capability to deliver high quality, sustainable care?"

- The CEO enjoys good profile with staff, holding regular "Meet the CEO" style meetings which are well attended. The Chair leads the Board in a most effective manner, confidently raising issues and encouraging debate amongst the Board team, as well as with the Council of Governors
- We encountered a team of effective, conscientious NEDs that understand their roles and bring to the Trust wide experience
- We observed that some EDs tend to focus on their own areas of responsibility in meetings and debate, and contribute less to the overall discussions of the Board
- Mature clinical leadership is evident but with variable reporting from divisions
- Senior medical leadership are more engaged with a renewed focus on service improvement
- New blood on board is a good sign and attracting clinicians from other areas and specialities as A/NEDs is innovative
- There is an active plan to develop talent and nurture more local leaders across senior management and clinicians.
- There is a parallel stream looking towards local as well as wider national recruitment for future ED/NED roles. The recent resignation of the company secretary and director of strategy for career reasons is a signal that succession planning should be a priority and without it the sustainability of the current leadership is always under threat

KLOE 2: "Is there a clear vision and credible strategy to deliver high quality, sustainable care to people, and robust plans to deliver?"

- The Trust needs to develop its own narrative to change the existing assumptions that remain in the system, and which are based on the "old Dudley Group"
- The Trust is determined to contribute to system working across the region, this is most obvious in the roles of CEO and her team, as well as the NEDs. This area has received particular praise from our external interviewees and externally the Trust is seen as playing an increasingly positive role in the development of the ICS and the provider collaborative
- There is also good evidence of a collaborative attitude amongst the NEDs – some are already involved in meeting their counterparts in other Trusts across the region. This is an excellent base upon which to build further change
- We found plenty of good examples of strategy development, and the process for this has been thorough and wide ranging, including evidence of work with patients as well as the Council of Governors
- There remains an imbalance between the Primary and Secondary care visions for the future of integrated care – the Trust cannot control all this, but it remains part of the relationship issues described by us elsewhere in this review

KLOE 3: "Is there a culture of high quality, sustainable care?"

- The new divisional structure is well embedded but there are still improvements to be made in reporting concerns and specific areas of clinical performance
- Less than optimal co-operation across professions can be seen in some areas such as ED/Maternity
- The emphasis for change in the Trust has tended to be focused on the CMO's responsibilities, but the Trust needs to recognise that Nursing must also be considered similarly for clinical leadership development to avoid an imbalance in terms of oversight of care
- Clinical leadership is maturing but still provides inconsistent information when reporting through the governance structure – working with divisional leaders, the Board should define its requirements here
- The consultant body remains a powerful part of the cultural fabric of Dudley, and it will need continued strong leadership and support at all levels
- Poor relationships with some GPs risk lessening the quality of overall care for patients; however, the Trust is making significant efforts to engage local GPs to reduce this negative impact with some success
- We were presented with strong evidence of EDI development – Dudley is determined to turn this into an area of strength for its clinicians and staff and this is worth shouting about

- Building on the current effective clinical governance processes, the Trust has developed very effective reviews of mortality and has rapidly grown expertise in the new medical examiner processes. There is thus an opportunity to link this with its audit processes. This would allow the Trust to describe how an integrated set of governance tools could assist both within the organisation, and system wide, as well as showing how continuous quality improvement can be implemented across clinical pathways and services. This will be especially important where the Trust's developing leadership role within the ICS requires a more rigorous and accountable governance structure

KLOE 4: "Are there clear responsibilities, roles and systems of accountability to support good governance and management?"

- Ward to Board – this reporting process suffers from significant variation in the quantity and quality of data which is passed upwards, and often in non-standard form – one Divisional report can look very different in shape and size from another. More consistency of reporting is needed, and the Board (especially the NEDs) need to say what they want in terms of management information to be able to generate assurance
- We were concerned that the Board's Committees included Executive Directors as voting members and, in the quorum, – this risks a dominance of executive thinking in the scrutiny role of these committees
- The meetings that we observed were a mixed bag. There was good oversight from the NEDs and the EDs always attend in numbers, responding to questions with candour. Some meetings were not quorate however, due to NED absences
- Many agendas were complex, and the Board should continue to review the distribution of content between the public and private agendas, keeping as much in the public domain as practicable
- Holding the Part 2 meeting of the Board first risks encouraging bad habits – all the major discussions took place here which can result in a lack of transparency at the public meeting. It is more common to hold the meeting in public first and have only contentious or sensitive items in the subsequent Part 2 meeting

KLOE 5: "Are there clear and effective processes for managing risks, issues and performance?"

- There is a short-term issue over the development of strategic risks to accompany the strategic objectives that were agreed by the Board in October. Agreement on the risks is three months behind schedule and the Trust remains slightly exposed on this – it is accepted best practice that the BAF is usually produced with matching strategic risks and objectives in the same timeframe
- The Workforce's sustainability is a commonly reported risk, and while the deep dive observed at the WSEC was an excellent piece of work, there is no Trust-wide plan for a sustainable workforce
- We saw little evidence of awareness of risk appetite within the Board's deliberations, leading to some lengthy discussions in committee about priorities – the Board should form an overall view of where it wants to invest in risk mitigation
- We were concerned that Serious Incident follow-up Actions were significantly behind schedule. This makes quantification of risk in this area very difficult

KLOE 6: Is appropriate and accurate information being effectively processed, challenged and acted on?"

- Our documentary review suggested inconsistency in the Divisional information presented to the QSC and FPC (see Appendix B recommendations)
- Allied to this, there is plenty of complexity in systems of clinical reporting, resulting from the many initiatives that the Medical Director has introduced. This will need rationalisation to provide a clearer overall picture for the Board in terms of quality improvement
- We noted that some board papers were also not classified properly, risking inappropriate disclosure

KLOE 7: "Are the people who use services, the public, staff and external partners engaged and involved to support high quality, sustainable services?"

- We observed a close relationship between the Board and its Governors at the Council meeting on 20 December. They are kept well informed and enjoy detailed access to information which is provided enthusiastically by the Board members who attend
- The Governors seem to be less confident about challenge and assurance – the exception to this are the staff governors who seek answers to questions of risk and quality with confidence
- We received strong feedback from external interviewees, who consistently praised the Trust's efforts to play a major role in system development and collaboration. However, Community relationships are described as "up and down"– another area for new focus?
- The Executive team is regarded as a group of individuals who defend their turf appropriately, but who recognise the importance of system working
- GP relationships still need work and investment of time to make them improve – this is a major priority
- DIHC remains a sensitive topic at the Dudley Group, but the Trust recognises that it has made its case and that the ICS will now resolve the situation in due course. It is a truism that whilst many of the relationship problems are not of the current team's making, they have nevertheless not been able to resolve them completely

KLOE 8: "Are there robust systems and processes for learning, continuous improvement and innovation?"

- There is strong leadership by Executive Directors in information and digital innovation, this is a useful conduit for improving stakeholder and partner engagement
- The deep dive approach at the WSEC meeting was an example of good practice - a broader understanding was gained of the fundamental problems and how the required mitigations could be delivered
- We observed plenty of examples of excellent innovation (the "Queue for you" initiative for staff surveys in the canteen, the new educational app in the Emergency Department, the Orthopaedic Academy, the virtual Glaucoma clinics and transformation to digitally driven Outpatient clinics are good examples) – the challenge now is to ensure that these are understood and appreciated more widely by staff and patients

Recommendations

1. External relationships still need work by the Trust to improve, especially with the Dudley GPs. The roles of the CEO and Chair are increasingly pivotal in enhancing system-wide development and their engagement will need further support from the rest of the Board
2. Financial reporting and strategy need to become more consistent and simpler to be comprehended more fully by the NEDs
3. Concerted effort is needed for the Trust to own its narrative and thereby improve the Trust's reputation by means of systematic and consistent (i.e., planned) external engagement to change perceptions
4. There is good evidence of innovation, but this may not be widely recognised across all staff. The recent development of a supportive App for education and operational performance in the Emergency Department being good examples which should be publicised more internally
5. Executive Directors should not be voting members of Board Committees – these should be non-executive only - with every effort made to ensure that these meetings are always quorate so that their agendas can be delivered
6. The Board would benefit from conducting a risk appetite exercise to confirm its view of how risk should be managed
7. The Serious Incident (SI) actions backlog needs to be addressed – what patterns or trends are the Board unsighted on because of the inherent complexities and delays in the current system of responses to SIs?
8. The clinical governance and audit processes across the Trust should be linked to create an integrated set of governance tools
9. Succession planning for the Board is an area for development which needs to be addressed quickly, especially given predicted turnover in the next 2/3 years
10. Management information is very detailed (in the case of clinical performance data, sometimes too complicated) and would benefit from benchmarking to give an indication of Dudley's performance nationally and to set a common standard for ward to board reporting (see also Appendix B)
11. Better management information co-ordination is required to enable the QSC and FPC to function at their best, as well as complement each other
12. Workforce needs to be represented on the Quality and Safety Committee and key areas of concern prioritised by the ED for people to support high risk specialities
13. The Governors are well informed and enthusiastic but need to be encouraged further to challenge the Board and seek assurance on the full range of issues facing the Trust – a training package might help here

Giles Peel FCG and Professor Mike Bewick FRCP FRCGP MICP

DCO PARTNERS, January 2022

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Appendix A
List of interviewees

We observed Trust Board meetings in private and public on 11 November.

We observed meetings of the following committees:

- Quality and Safety Committee – 26 October and 23 November
- Digital Technology Committee – 18 November
- Workforce and Staff Engagement Committee – 23 November
- Finance and Performance – 25 November
- Audit – 13 December
- Council of Governors – 20 December

We interviewed the following:

Chairman – Dame Yve Buckland

Professor Liz Hughes MBE (Chair of QSC)

Gary Crowe (Chair of Audit Committee)

Lowell Williams

Catherine Holland (Chair of DTTC)

Jonathan Hodgkin (Chair of FPC)

Julian Atkins (Chair of WSEC)

Vij Randeniya

Dr Gurjit Bhogal (Associate NED)

CEO – Diane Wake

Medical Director – Dr Julian Hobbs

Chief Operating Officer – Karen Kelly

Chief Nursing Officer – Mary Sexton

Director of Finance – Tom Jackson

Chief People Officer – James Fleet

Director of Strategy – Katherine Sheerin

Chief Information Officer – Adam Thomas

Matt Hartland - Deputy CEO Black Country and West Birmingham CCG

Alastair McIntyre – Deputy SRO for the Black Country ICS

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Appendix B
Detailed recommendations on ward to board reporting

KLOE 4 makes it clear that the Trust should have in place "a clear organisational structure that cascades responsibility for delivering quality, operational and financial performance from 'board to front line to board'". KLOEs 4, 5 and 6 go on to include a range of related requirements.

We were told (and we have seen meeting papers to confirm) that the Trust has in place processes for the three clinical divisions – Medicine and Integrated Care (MIC); Surgery, Women and Children (SWC); and Clinical Support Services (CSS) – to report to the executive and to the Finance and Performance Committee (FPC) and the Quality and Safety Committee (QSC). We understand that the executive directors meet with each divisional management team every month to review performance. In addition, the workplan for the FPC shows that every two months it will receive a report from one of the divisions (so each division reports twice per year to the FPC). We understand that this arrangement has been disrupted and curtailed during the Trust's response to the Covid-19 pandemic and we note that over the period from May to September 2021 the FPC received a report from only one division, CSS, at its meeting in August. We have not seen a workplan for the QSC but its meeting papers for the period June to August 2021 show that it received a divisional report at each of those meetings. We were told that the QSC's meetings were not affected by the pandemic response (other than being moved to take place by videoconference).

We observed considerable variation in the quantity and quality of information which the three divisions present to the committees, particularly the QSC. For example, the MIC report to the QSC in June 2021 runs to 156 pages; by comparison the SWC report to the QSC in July 2021 is seven pages in length. The MIC report in June 2021 contains several papers which were prepared for the division's internal governance meeting and therefore it contains excessive detail. All the divisions' reports to the QSC focus upon quality governance which is appropriate to the role of the QSC – for example, clinical incidents, complaints, and compliance with NICE requirements – but they provide mainly data and contain relatively little analysis to inform the QSC.

The minutes of the QSC's meetings in June, July and August 2021 all show some discussion of the divisions' reports, with focus on clinical safety issues but we note relatively little debate about division-specific themes, trends, or quality priorities (though we note that at other times the QSC reviews progress against quality account priorities). The minutes of the QSC's meeting in August 2021 record almost no discussion of the CSS report that was received, other than that the report was "well written and easy to read and follow". As we note above, we have seen only one divisional report to the FPC – a presentation from the CSS division in August 2021, so no paper was available – but here too the minutes record relatively little debate.

In this section we have so far considered only the three operating divisions of the Trust, MIC, SWC and CSS. We note that the Trust provides community services in patients' homes and in 40 other locations (as described on the Trust's website). We have seen in the FPC and QSC papers no substantial reference to the performance of these services, though the FPC papers do contain some references to the financial position and operational activity.

We know from our brief that the Trust is keen to have robust reporting from ward to board so that challenges, risks and successes and good practice are escalated to senior managers, executives, and board members, as envisaged by the KLOEs. This enables challenges to be addressed and for successes to be recognised and disseminated (for implementation elsewhere as appropriate). In our view it is unlikely that this is being achieved through the reporting arrangements as they stand at present. The structure which the Trust has in place, monthly executive reviews of the divisions' performance, coupled with reports to the QSC and the FPC, provides the basis for 'ward to board' reporting but in our view, there are several aspects of the arrangements which require development.

We would recommend the following actions:

1. The Trust should develop and improve the performance information which is made available throughout the governance structure. The information should be specific to the remit of each committee or group, with increasing levels of aggregation as reporting moves upward towards the QSC and the FPC (whilst ensuring that board members have information about specific operational, ward-level issues where necessary). Each committee or group should agree for itself the information that it requires, recognising that this is likely to develop over time.
2. Whilst it is appropriate for the QSC and FPC to receive divisional reports in this way the Trust should consider the means by which the whole board is briefed on key issues within the divisions. Such briefings could supplement the committee chairs' existing reports to the board, which we have seen and consider to be good practice. This ensures that non-executive directors (in particular) who are not members of the QSC, for example, understand the key issues reported by divisions to that committee.

3. The information should be truly integrated so that each committee or group can take a whole view of the divisions' performance, encompassing quality, activity, finance, workforce, risk, and estates matters (where relevant). It should comprise an appropriate mix of qualitative and quantitative information, including analysis of the data presented.
4. The Trust should utilise the existing monthly executive reviews of the divisions' performance such that the outcomes from these meetings inform reports to the QSC and FPC.
5. It would be preferable for each division to report quarterly to the QSC and FPC, with information appropriate to their remits. However, where a quality-of-care challenge that is reported to the QSC is influenced by activity levels that are considered by the FPC, this should be made clear to both committees.
6. The Trust should consider introducing similar performance reporting arrangements for its community services, appropriate to their scale and risk profile.
7. The arrangements we recommend here should encourage and enable debate at the QSC and FPC, focusing on specific issues (which should include successes and good practice as well as challenges) as highlighted in the data and analyses presented to the committees.
8. This approach to divisional or ward to board reporting should be discussed and agreed among divisional management teams, senior managers, and executive and non-executive directors, and should be defined in a performance framework or similar. This should ensure that there is consistency among the divisions and that all managers involved understand the aims and objectives of the arrangements. In developing them the Trust may wish to draw upon experience from other NHS organisations locally or elsewhere (this approach being increasingly common in the NHS).
9. The arrangements should be kept under regular review to ensure that, over time, the board and the QSC and FPC achieve the 'ward to board' reporting that they aim for.

Graham Lawrence FCG
DCO Partners

Enclosure 6

The Dudley Group
NHS Foundation Trust

Paper for submission to the Board of Directors on 10th March 2022

Title:	**Board Assurance Framework 2021/22 – revised timeline**
Author:	Helen Board, Deputy Trust Secretary
Presenter:	Tom Jackson, Director of Finance

Action Required of Committee / Group			
Decision	**Approval**	**Discussion**	**Other** Y

The Board is asked to note the revised timeline for the development and approval of the Board Assurance Framework for the year ending 31st March 2022.

Summary of Key Issues:

The Board Assurance Framework (BAF) provides a structure and process to enable the Board to focus on the key risks that might compromise the achievement of the Trust's strategic goals.

The Board of Directors formally approved the refreshed Trust Strategy in September 2021 and a subsequent board development session was held in October 2021 at which the proposed strategic risks were considered. On 13th January, the Board was briefed by the then interim trust secretary, that the BAF for the third quarter ending 31st December 2021 would be updated to reflect the recently approached strategic goals.

Subsequently, the timeline for the preparation of the BAF has been reviewed and following individual discussions with executive leads and non-executive committee chairs, the BAF for the fourth quarter ending 31st March 2021 would be updated to reflect the year end position. Recognising the need to provide additional resource to support the finalisation of the Board Assurance Framework, the Trust has commissioned external consultancy services MIAA.

At the request of the Chair of the Audit Committee, it was agreed that given its importance from a governance perspective, the Board would be provided with the revised timeline for the completion of this work to meet the usual year end requirements.

Date	Action
March 2022	Revised BAF to Board Committees to review and approve their section of BAF for the assigned strategic risks that they have overall responsibility: • Digital Trust Technology Committee • Quality & Safety Committee • Workforce & Staff Engagement Committee • Finance & Performance Committee
April 2022	Final version of the BAF to Board of Directors

Reporting on the progress against the Strategic goals

To ensure reporting alignment, an update on the progress against the Trust's strategic goals will accompany the BAF report provided to the April meeting of the Board of Directors and quarterly thereafter.

Impact on the Strategic Goals *(indicate which of the Trust's strategic goals are impacted by this report)*	
Deliver right care every time	**Y**
Be a brilliant place to work and thrive	**Y**
Drive sustainability (financial and environmental)	**Y**
Build innovative partnerships in Dudley and beyond	**Y**
Improve health and wellbeing	**Y**

Implications of the Paper:			
Risk	N	Risk Description:	
	On Risk Register: N	Risk Score:	
Compliance and/or Lead Requirements	CQC	Y	Details: Well led
	NHSE/I	Y	Details: Publication approval ref: C1518
	Other	N	Details:

Report Journey/ Destination *(if applicable)*	Working / Exec Group	Y	Date: 08/03/22
	Committee	Y	Date: various dates - March 2022
	Board of Directors	Y	Date: 10/03/22
	Other	N	Date:

Enclosure 7

The Dudley Group NHS Foundation Trust

Paper for Submission to the Board of Directors 10th March 2022

Title:	Quality and Safety Committee 22nd February 2022
Author:	Sharon Phillips – Deputy Director of Governance
Presenter:	Liz Hughes – Non-Executive Director

Action Required of Committee / Group

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

Recommendations:

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

Summary of Key Issues:

The key issues are identified in the attached report.

Impact on the Strategic Goals
(indicate which of the Trust's strategic goals are impacted by this report)

Deliver right care every time	**YES**
Be a brilliant place to work and thrive	**YES**
Drive sustainability (financial and environmental)	
Build innovative partnerships in Dudley and beyond	**YES**
Improve health and wellbeing	**YES**

Implications of the Paper:
(complete all sections including the Corporate Risk Register and/or the Board Assurance Framework)

Risk	Y	Risk Description: *Inc risk ref number*	
	On Risk Register: Y	Risk Score: Numerous across the BAF, CRR and divisional risk registers	
Compliance and/or Lead Requirements	CQC	Y	Details: All Domains
	NHSE/I	Y	Details: Governance Framework
	Other	N	Details:
Report Journey/ Destination *(if applicable)*	Working / Exec Group	N	Date:
	Committee	Y	Date: 22/02/22 Q & S Committee
	Board of Directors	N	Date:
	Other	N	Date:

CHAIRS LOG

UPWARD REPORT FROM QUALITY AND SAFETY COMMITTEE

MATTERS OF CONCERN OR KEY RISKS TO ESCALATE	MAJOR ACTIONS COMMISSIONED/WORK UNDERWAY
• Challenges at divisional level to review procedural documents in agreed timescales.	
POSITIVE ASSURANCES TO PROVIDE • Positive assurance of the Trust having for the last two reporting periods a decrease in SHMI with the latest value of 1.12. In addition, the work being taken forward with the ICS to look at a standardised approach to the use of SHMI across the system. • Significant assurance of excellent work completed in surgery to undertake an in-depth review of VTE and determination of areas of concern for compliance and data quality. The review identified challenges in informatics accurately capturing data and the alerts to complete not consistently triggered. A manual review of data identified positive compliance (94%) supported by VTE assessment inclusion in preoperative checklists. Positive assurance received of patient outcomes • Positive assurance presented in the Surgery Woman and Childrens governance report across key quality indicators.	**DECISIONS MADE** • Ratification of Patient Experience Strategy • Ratification of Learning Disability Strategy

Enclosure 8

The Dudley Group
NHS Foundation Trust

Paper for submission to the Board of Directors on

Thursday 10th January 2022

Title:	Chief Nurse Report
Author:	Helen Bromage - Deputy Chief Nurse
Presenter:	Mary Sexton - Chief Nurse

Action Required of Committee / Group				
Decision	**Approval**	**Discussion**	Y	**Other**

Recommendations:

For the board to note and discuss the excellent work of the Chief Nurses' Office with a particular focus on the vaccination programme work currently underway.

Summary of Key Issues:

Excellent work surrounding the national vaccination programme and the progress made with the introduction of an additional site at Saltwells.

Focused work continues with the Deprivation of Liberty standards and the mental act compliance.

Reduction in falls is evident in this month's data and we continue to be below the national average.

Workforce challenges remain with mitigations and incentives in place to support. The international recruitment programme is developing, and fruition is starting to be seen. Over 60 internationally recruited nurses are in post. A more favourable position is reported within the safer staffing data as on average we have 88% of our registered nurse requirements covered in the day and 86% at night.

The Trust has become an early adopter of the London Critical Care Passport. The programme has been created and trialled in the Capital following on from the extensive workforce challenges face at the start of the pandemic and the response required supporting enhanced care requirements.

Impact on the Strategic Goals

(indicate which of the Trust's strategic goals are impacted by this report)	
Deliver right care every time	✓
Be a brilliant place to work and thrive	✓
Drive sustainability (financial and environmental)	✓
Build innovative partnerships in Dudley and beyond	✓
Improve health and wellbeing	✓

Implications of the Paper: *(complete all sections including the Corporate Risk Register and/or the Board Assurance Framework)*			
Risk	Y/N	Risk Description: *Inc risk ref number*	
	On Risk Register: Y/N	Risk Score:	
Compliance and/or Lead Requirements	CQC	Y/N	Details:
	NHSE/I	Y/N	Details:
	Other	Y/N	Details:

Report Journey/ Destination *(if applicable)*	Working / Exec Group	Y/N	Date:
	Committee	Y/N	Date:
	Board of Directors	Y/N	Date:
	Other	Y/N	Date:

Chief Nurse Public Trust Board Report

Thursday 10th March 2022

Mary Sexton – Chief Nurse

The Dudley Group NHS Foundation Trust

CARE

RESPECT

RESPONSIBILITY

Care
Deliver safe and caring services

The Dudley Group NHS Foundation Trust

Vaccination Programme

Action Heart VC – Continues to provide COVID 19 vaccines to all staff and vulnerable patients. At the time of this report 78.54% of staff have received a COVID vaccination and 65.5 % of staff have received a flu vaccine. This data only reflects substantive staff who have an ESR number and does not include staff who may have had their vaccines outside of the Trust and our Mitie team. The numbers of staff still requiring the vaccine have reduced significantly, the Trust plans to close this vaccine hub by the 1st April 2022.

The Saltwells Vaccination Centre (SVC) opened its doors on 29 December 2021 to respond to the increasing capacity to deliver Covid-19 vaccinations. SVC has undertaken a review of compliance against CQC Regulatory Standards with evidence to support performance across all elements. The Team at SVC keep these under review to maintain compliance.

Since opening additional workstreams have been added to the portfolio, these include vaccinations for the vulnerable 5-11 year olds. 3rd and 4th doses for those who are clinically vulnerable and the addition of bespoke clinics such as women only, promoting the uptake of the vaccination for those groups which do not wish to mix. Work is ongoing for the site to be able to validate credentials for international/overseas citizens to enable access to the vaccine.

Example of the feedback received at Saltwells.

CARE RESPECT RESPONSIBILITY

Care
Deliver safe and caring services

The Dudley Group NHS Foundation Trust

Deprivation of Liberty Safeguards (DoLS)

- DoLS applications are showing a marked increase. This is due to the appointment of a new Clinical Lead for Mental Health who is visiting wards daily to educate staff in the correct use of DoLS for their patient group. Partial month figures for February 2022 have been added to indicate the rapid increase in DoLS reporting. This also reflects the increase in vulnerable patients requiring inpatient care.

- As previously reported, the Interim Lead for the Liberty Protection Safeguards (LPS) had identified that the Trust was not recognising all of the patients who are deprived of their liberty. When compared with Wigan NHS Trust, a Trust of similar size to DGHFT, Wigan were averaging 130 DoLS applications per month, so the rise seen at DGHFT is not unexpected.

- Education of ward based staff by the Mental Health Team is continuing to embed DoLS knowledge in the practice setting and this work will continue across all clinical teams

Mental Health Act

- 4 patients have been sectioned in January 2022. All cases were reviewed by the Mental Health Team and appropriately managed.

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	No DoLs applications
Q1	27
Q2	23
Q3	20
Q4 (To date)	69

CARE RESPECT RESPONSIBILITY

Care
Deliver safe and caring services

The Dudley Group NHS Foundation Trust

Safeguarding

An audit was completed and this demonstrated a positive picture of staff knowledge regarding Female Genital Mutilation (FGM). Further actions are planned to build on this knowledge base and ensure staff across the Trust know the signs of FGM and work proactively to prevent it, or report as required.

Commencement of ICON training in the Trust to relevant staff to equip them with knowledge and skills to support parents and raise awareness of how to care for a crying baby. This initiative is in support of reducing the number of head injuries in children which can occur due to parents not coping or having the skills to care for a crying baby. ICON is all about helping people who care for babies to cope with crying. ICON stands for

I – Infant crying is normal

C –Comforting methods can help

O – It's OK to walk away

N – Never, ever shake a baby

Our Learning Disability Strategy has been updated and approves the Quality and Safety Committee, clearly sets out the Trusts vision and commitment to providing high quality, responsive services to patients with learning disabilities

Praise was received from the CCG and Dudley Adult Social Care regarding the response of the safeguarding team and their effective partnership working to ensure the safety of a patient with complex vulnerabilities who attended ED

Positive feedback has been received from partner agencies for the Safeguarding Associate Nurse for Children regarding her input into Dudley work around children and young people at risk of exploitation

	No Referrals
Adult	46
Child & Young Person	131
Section 42	3

CARE RESPECT RESPONSIBILITY

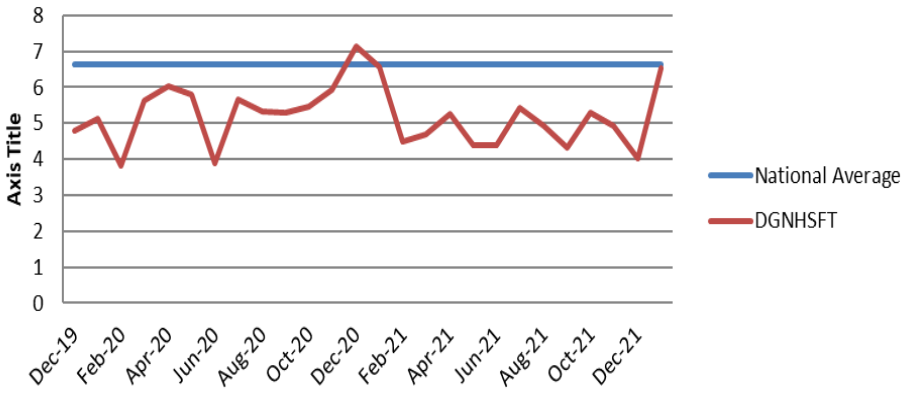
Care
Deliver safe and caring services

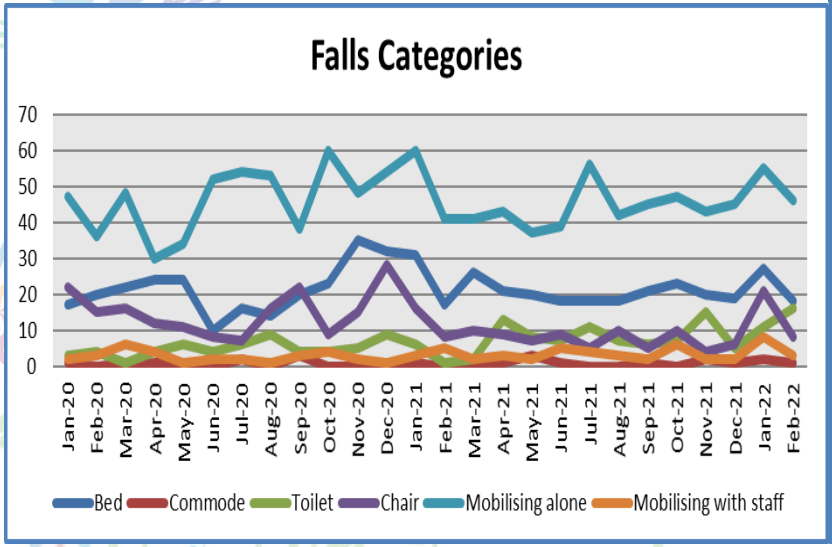
The Dudley Group NHS Foundation Trust

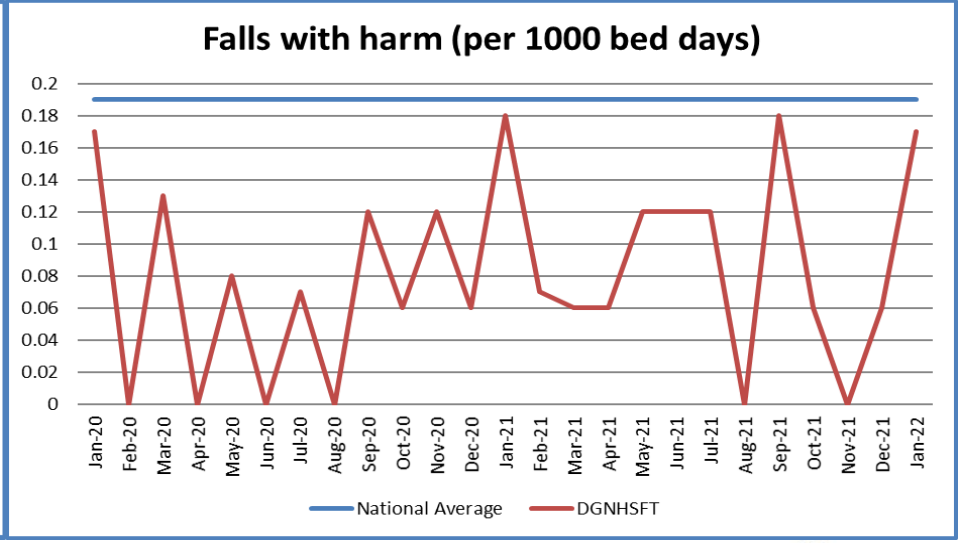
The previous overall increase in falls we have seen has started to reduce over the past couple of months, however we have seen an increase in falls with harm, with 3 serious incidents have been reported in January.

Collaborative working is ongoing with the digital team to create additional recording functionality for lying and standing Blood Pressures.

Prevention strategies continue to be an area of focus across the trust with ED having focused support regarding falls assessments.







CARE RESPECT RESPONSIBILITY

Compassion
Deliver a great patient experience

The Dudley Group NHS Foundation Trust

- **Complaints**

During January 2022, the Trust received 63 new complaints compared to 66 for December 2021. In February 2022, the Trust received 60 new complaints.

In February 2022, the Trust closed 105 complaints which demonstrates the actions taken by the teams, to close the complaints. Of the 105 complaints. 17 were closed within 30 working days (16.2%) with the focus being on closing those that have breached the 30-working day timescale. Local resolution meetings are now being held and these are being arranged.

- **PALS**

In January 2022, PALS received 294 concerns, eight comments and 49 signposting contacts (signposting includes letters/emails/telephone calls/face-to-face enquiries) totalling 351. In February 2022, PALS received 313 concerns, seven comments and 44 signposting contacts totalling 364.

The most frequent 'type' of concerns received are regarding queries relating to appointments including delays and cancellations and this remains the same for February 2022. The operational team have been asked to review their communication with patients when there is a need to amend their appointments.

- **Friends and Family Test**

A total of 3979 responses were received in January 2022 in comparison to 3337 in December 2021. Overall, 82% of respondents have rated their experience of Trust services as 'very good/good' in January 2022,. A total of 6% of patients rated their experience of Trust services as 'very poor/poor', no change since the previous month (6%).

In January 202, A&E received the lowest percentage scores for patients rating their overall experience as 'very good/good' at 71%. The percentage very poor/poor scores for A&E remain the highest of all departments at 15%. The Inpatient wards received the highest positive ratings again this month at 90% and the lowest number of patients who rated their overall experience as 'very poor/poor'.

- **Compliments**

The Trust received 351 compliments in January 2022. Ward C8 received the highest number of compliments (51) in January 2022. These are shared with the matron/lead nurses and promoted via our 'What Matters to You' campaign.

Competence
Drive service improvement, innovation and transformation

The Dudley Group NHS Foundation Trust

- We have been awarded the incredible £97,047 from the Volunteering Futures funding to NHS Charities Together for our Youth Volunteering Project! This is an incredible outcome only 15 NHS Charities would have been chosen for this with a very tight turnaround time line. The monies will be used to support our volunteers with training and pastoral support.

- February saw The Audiology service maintaining their UKAS accreditation for 2022 following evidence submission, on-site assessment and successful clearing of mandatory findings.

CARE RESPECT RESPONSIBILITY

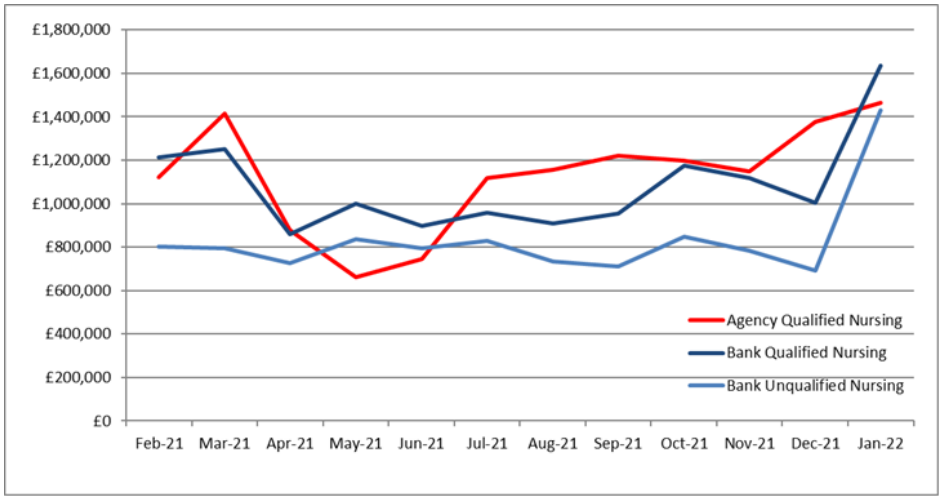
Commitment
Be the place that people choose to work

The Dudley Group NHS Foundation Trust

We continue to face challenges with the registered nurse workforce vacancies. The current vacancy rates have a direct impact on the use of temporary staffing across the trust.

There continues to be a significant amount of unfilled shifts. This deficit is routinely being reviewed by the senior nursing leadership for the area and mitigations enacted upon where possible to maintain patient safety and staff support.

The 2021 international recruitment programme has come to an end with 75 registrants joining the workforce. Over half have gained NMC registration, the others are awaiting OSCE results or a date to undertake the OSCE.



Area	Vacancy %	Agency Qualified Nursing	Bank Qualified Nursing	Bank Unqualified Nursing	Grand Total
I.T.U.	8%	£495,341	£48,512	£27,414	£571,267
Emergency Department Nursing	16%	£267,821	£53,175	£36,760	£357,757
Acute Med Unit (EAU)	23%	£55,161	£64,186	£49,593	£168,940
Ward B3	13%	£63,648	£23,095	£20,963	£107,706
Ward C7	13%	£36,745	£20,641	£40,356	£97,743
Ward B5	14%	£47,741	£24,250	£19,751	£91,742
Ward C8	14%	£35,603	£31,380	£20,130	£87,114
Ward C6	29%	£20,342	£25,144	£31,105	£76,591
Ward A2	47%	£21,755	£29,785	£21,304	£72,844
Ward CCU	25%	£40,253	£24,741	£4,647	£69,641

CARE RESPECT RESPONSIBILITY

Commitment
Be the place that people choose to work

The Dudley Group NHS Foundation Trust

Throughout December, January and February we have had a fluctuating position with regards to our safter staffing return. On average for January we have had 76% of our registered nurse/midwife requirements covered during the day with 86% overnight. Staffing absence increased in January due to the Omicron wave.

It is recognised that dynamic risk assessments are undertaken by the ward leadership team and mitigations are put in place however some of those mitigations are not clearly evident in the data sets.

Jan			Days in Month	31										
Day RN	Day CSW	Day CSW	Night RN	Night RN	Night CSW	Night CSW								
Actual	Plan	Actual	Plan	Actual	Plan	Actual	Qual Day	UnQual Day	Qual N	UnQual N	Sum 24:00 Occ	Average Occupancy	Regist
137	147	88	118	145	124	68	110%	60%	123%	55%	774	96%	4
106	101	64	94	79	94	56	78%	64%	84%	60%	487	60%	4
102	194	141	94	90	159	136	82%	73%	96%	86%	709	76%	3
97	128	117	93	85	96	90	80%	92%	91%	94%	718	97%	3
192	186	120	254	203	155	119	59%	64%	80%	77%	970	75%	4
202	261	219	175	150	226	186	78%	84%	86%	82%	1,346	90%	3
179	162	122	216	176	126	95	74%	76%	82%	75%	573	77%	7
204	269	247	186	174	212	189	80%	92%	93%	89%	1,438	97%	3
229	68	80	247	195	69	62	80%	118%	79%	90%	558	60%	8
194	398	392	187	179	366	343	91%	98%	96%	94%	1,546	96%	2
146	68	64	124	94	62	65	71%	94%	76%	104%	604	89%	4
204	254	260	286	233	196	177	62%	102%	81%	90%	1,344	90%	3
96	95	83	95	87	65	60	89%	87%	91%	93%	546	88%	3
149	225	177	159	143	221	169	76%	79%	90%	77%	1,093	98%	3
223	219	179	251	224	187	132	77%	82%	89%	71%	1,302	95%	4
215	72	65	232	214	37	30	81%	90%	92%	81%	692	86%	7
564	174	98	699	572			82%	56%	82%		520	105%	26
512	623	454	441	431	440	334	71%	73%	98%	76%	2,059	81%	5
679	321	174	527	406	163	133	74%	54%	77%	82%	845	62%	12
114	117	53	189	119	72	22	59%	45%	63%	31%	120	39%	23
123			148	133			76%		90%		435	78%	7
4,664	4,080	3,196	4,815	4,131	3,071	2,467	76%	78%	86%	80%	18,679	87%	5

CARE RESPECT RESPONSIBILITY

Courage
Deliver a viable future

The Dudley Group NHS Foundation Trust

- **Tissue Viability:**

We have an improving picture with the number of outstanding incidents to review. A close down thematic review of all incidents prior to January 2022 is planned and will take place on 24th and 25th March 2022.

A trial of Hybrid mattresses will take place on ward B3 to look at the impact of pressure ulcer prevention in one of the high risk areas – A procurement exercise is being completed and the trial should go live in March. An evaluation criteria has been established. If this trial is successful we will then move to a full procurement exercise with multiple tenders in line with our procurement framework.

A meeting is to take place with the CCG to look at reimplementation of 'React to Red' – this is reported to have been trialled at the trust before with little impact so we are going to look at how it can have more impact if we reintroduce across al inpatient areas.

Courage
Deliver a viable future

The Dudley Group NHS Foundation Trust

The Trust has signed-up to the Power of Youth Charter to empower more children and young people to be active citizens. The pledges show how committed we are to improving experiences and providing worthwhile opportunities for our young people. This public commitment shows our dedication to empowering young people to make positive differences on issues that affect their lives, communities, and the broader society. Signing up to the charter, allows us access to new ideas and perspectives that will enhance our organisation's work and impact, Strengthens our organisation's relationship with our younger stakeholders by showing them that we care about their views and impact The Charter sets an example to other organisations within and beyond our sector to encourage them to embrace and grow the power of youth This has also facilitated access to networks and resources through the #iwill Partnership that help us to deliver our charter commitments. The Trust Board has endorsed The Power of Youth Charter and staff from children's services will be visiting areas across the Trust to discuss how departments can take part in engaging young people in the development of services. Promotional materials will be placed around the hospital explaining our commitment to staff and to the public.

Paediatric Virtual Ward

Working in collaboration with the Integrated Care System, Children's Services will go live with a paediatric virtual ward on 1st March 2022. Whilst this is an established development for adult services this new innovation for paediatrics is being driven to better enable children and young people to recover from illness in their home. This will support admission avoidance and reduced length of stay. The virtual ward will be supported by the expert children's ward community outreach team with remote monitoring equipment. Parents and carers will receive training to allow them to use specialist equipment to monitor vital signs which will be shared with the team via virtual platforms.

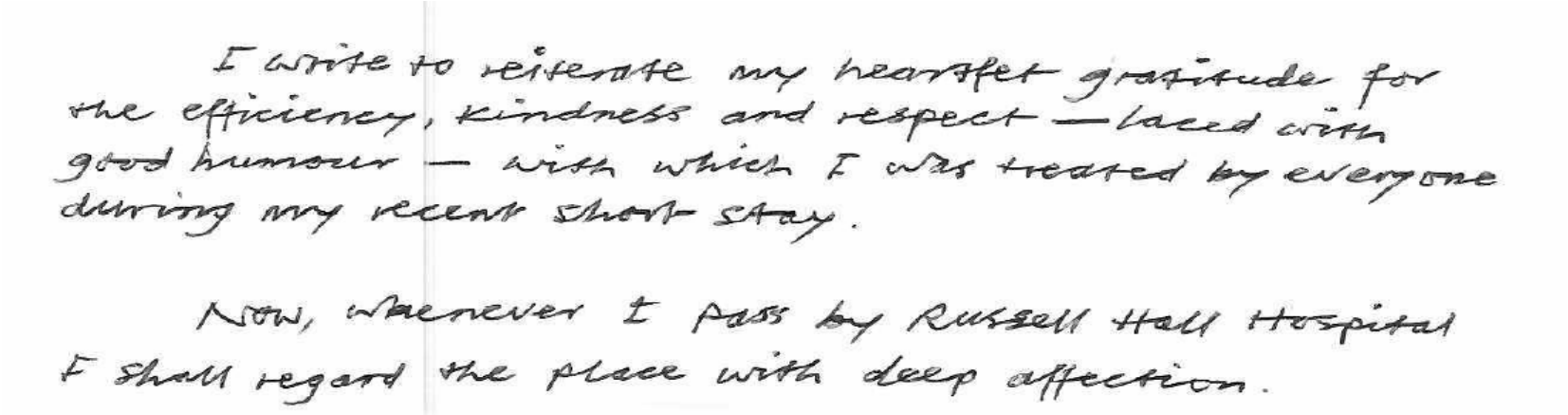
Family Integrated Care

The Neonatal Service is currently undertaking a process of self-assessment against the Family Integrated Care Framework for Practice. Collaborative care between parents / carers and health professionals is essential and this self-assessment allows the service to measure current state and what is required to achieve best practice. There are undoubtedly some challenges around achieving this in respect of the facilities that are available to parent and carers however a wider project is running in parallel to ascertain the feasibility of expanding the Neonatal Unit to address gaps.

CARE RESPECT RESPONSIBILITY

Some of the compliments received by the teams.

The Dudley Group
NHS Foundation Trust



I write to reiterate my heartfelt gratitude for the efficiency, kindness and respect — laced with good humour — with which I was treated by everyone during my recent short stay.

Now, whenever I pass by Russell Hall Hospital I shall regard the place with deep affection.

I just wanted to drop a quick message about how well my 14-year-old daughter was looked after when she came for Day surgery.

From the moment she came for her first outpatient appointment with Rachel Willetts, to having the lump in her breast removed by Mr Stonelake, she has been treated with respect and integrity by all the staff we have encountered.

They have all done a fantastic job and put us at ease every step of the way.

I know RHH have had alot of bad press and have been criticised for patient care and treatment and have got it wrong in some cases, however I just wanted you and the wonderful doctor and nursing team to know they all got it 100% right that night, exceptional care, thought and treatment throughout , I must also extend our thanks also to C2 ward and the HDU unit she was transfered to my son and daughterinlaw said the excellent care and treatment contiued there too.

This experience has changed our entire opinion on this hospital and also the opinion of our friends and extended family members too.

CARE RESPECT RESPONSIBILITY

Parish Notice News

The Dudley Group NHS Foundation Trust

Since the last report there has been some changes in the Chief Nurse Leadership Team.

Dawn Lewis retired from her role as the Head of Midwifery in December. Claire MacDiarmid has been appointed to the Head of Midwifery role and commenced in post in January 2022

Justine Edwards retired from her role as the Patient Safety Manager for the Trust. Jodie Conlon has been appointed.

Beth Farney (Critical Care) has received her Professional Nurse Advocate certificate after successful completion of the course. We are looking forward to many more receiving their certificates having successful completed the course.

February we were joined by colleagues from the Royal Air Force who were deployed to support the workforce. They were welcomed with open arms and integrated with the teams well.
Many thanks to them for their valuable contribution to the care of our patients.

CARE RESPECT RESPONSIBILITY

Enclosure 9

The Dudley Group
NHS Foundation Trust

Paper for submission to the Board of Directors on 10th March 2022

Title:	Infection Prevention and Control (IPC) Board Assurance Framework
Author:	Liz Watkins Deputy Director Infection, Prevention & Control (DDIPC)
Presenter:	Mary Sexton Chief Nurse/ DIPC

Action Required of Committee / Group							
Decision	N	**Approval**	N	**Discussion**	Y	**Other**	N

Recommendations:

The Board is asked to review and note the contents of the IPC Board Assurance Framework in providing assurance of the continued actions within the IPC BAF ensuring compliance with the Health and Social Care Act (2008, updated 2015)

Summary of Key Issues:

This paper is to demonstrate Trust compliance with the Health and Social Care Act 2008 (updated 2015) and highlight gaps in assurance for action. In May 2020 NHSE/I 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-19 pandemic relates to robust infection prevention and control standards and practices across the Trust.
The framework adopts the same headings as the Health and Social Care Act 2008 (updated 2015) 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 Director IPC commenced in post 13th September 2021
- Decontamination Lead appointed in post
- New guidance regarding staff isolation as of 16th August 2021 updated January 2022
- IPC mandatory training scores above 90%

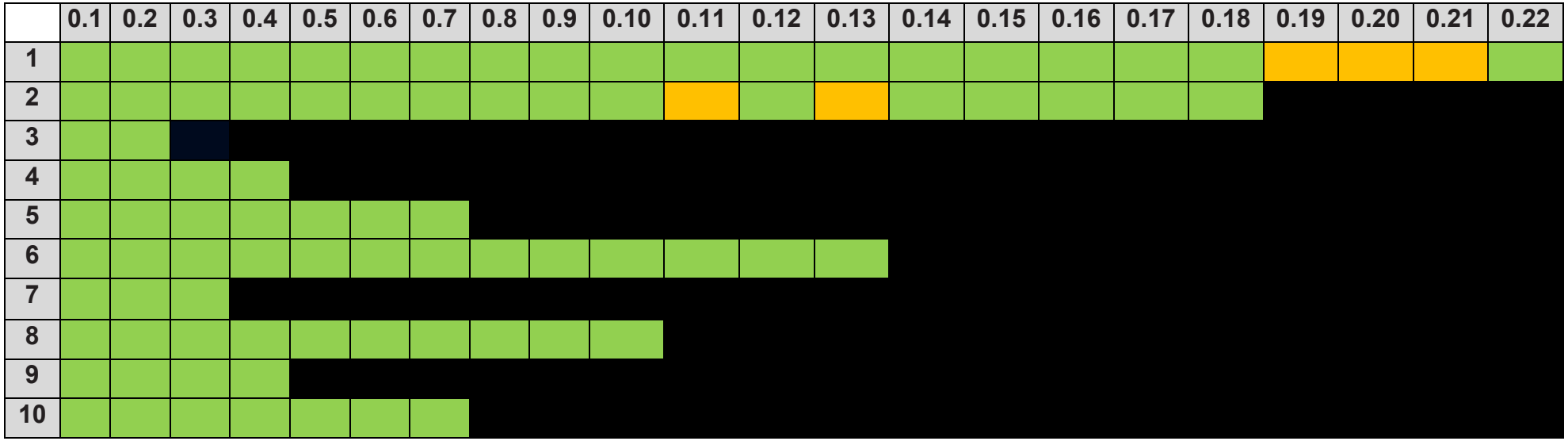
There are no red non-compliant areas, there are amber areas with mitigations in place, the IPC Group and wider Trust team continue to progress this work stream.

Impact on the Strategic Goals *(indicate which of the Trust's strategic goals are impacted by this report)*	
Deliver right care every time	**Y**
Be a brilliant place to work and thrive	
Drive sustainability (financial and environmental)	**Y**
Build innovative partnerships in Dudley and beyond	
Improve health and wellbeing	**Y**

Implications of the Paper:				
Risk		N	Risk Description:	
	On Risk Register:	N	Risk Score:	
Compliance and/or Lead Requirements	CQC		Y	Details: Safe, Effective, Well-led
	NHSE/I		Y	Details: The IPC BAF was requested by NHSE/I
	Other		N	Details:

Report Journey/ Destination *(if applicable)*	Working / Exec Group	Y	Date: Infection, Prevention Control Group (IPCG) 21.01.22
	Committee	N	Date:
	Board of Directors	Y	Date: 10/02/2022
	Other	Y/N	Date:

BAF Compliance Matrix	KEY	No Gaps	Gaps Identified with mitigation	Gap No Mitigation	No line of enquiry



	0.1	0.2	0.3	0.4	0.5	0.6	0.7	0.8	0.9	0.10	0.11	0.12	0.13	0.14	0.15	0.16	0.17	0.18	0.19	0.20	0.21	0.22
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1	The infection control risk assessment in the admission documentation is limited – IPC tool devised to be amended and shared at January's IPC meeting. Estate's work remains 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	No GAPs identified
5	No GAPs identified
6	No GAPs identified
7	No GAPs identified
8	No GAPs identified
9	No GAPs identified
10	No GAPs identified

	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	IPC team monitor movement of any patient positive from COVID and monitor the contacts. Report to be presented at IPC with recommendations for improvement.	
1.3	• 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		

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 nurses 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 unannounced.	compounds frequent 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 unannounced. 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 is essential to their care or reduces the risk of transmission	The Trust has implemented a Zoning system, Green, Yellow and Blue with SOP in place (this is in line with	N/A		

		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 inside 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. Whenever outbreaks are identified, the testing evidence is available. Recorded in outbreak meetings.	N/A N/A N/A	Compliant. Compliant Complaint	

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 committee.			
1.13	• There are check and challenge opportunities by the executive/senior	Via board and Quality and safety committee.			

	leadership teams in both clinical and non-clinical areas.				
	Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	**R.A.G**
1.14	• Compliance with the national guidance around discharge or transfer of COVID-19 positive patients	Patients who are to be discharged to another care facility (Nursing/Care/LD Home) are screened for COVID 19 as per national guidance. Policy completed to be added to the hub. COVID results are provided to other care providers on transfer with discharge information. COVID status will be added as a separate item on the discharge and transfer information. Where tests are processed in house DMBC PH are informed of any COVID cases in care/nursing homes to enable follow up of patients. Completed. 01/12/20 –meeting held for Sunrise prompt care/nursing home patients to be tested for COVID before discharge. Prompt now available on sunrise to trigger screening prior to discharge.	This process is awaiting audit, as some gaps have been identified by stakeholders, whereby patients have been discharged to a home without being tested.	Where a patient has been missed, the ward is contacted to make them aware. Discharge check lists to be updated.	

1.15	• Patients and staff are protected with PPE, as per the PHE national guidance	PHE guidance in relation to PPE has changed during the COVID pandemic. Staff are updated promptly when new guidance is released via the daily communications. Staff have access to PPE as per PHE guidance. PPE Marshalls are in place, there are posters stating PPE requirements in each of the zones. Executive oversite of PPE stocks. Patients are offered surgical mask upon entry to the hospital. In-Patients are to be offered face masks if they are placed in waiting area, or bay with other patients. All patients are encouraged to wear surgical masks at all times except overnight.	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 Actions**	**R.A.G**
1.16	• National IPC guidance is regularly checked for updates and any changes are effectively communicated to staff in a timely way	The Incident Room, established in response to the pandemic receives all internal and external information in relation to COVID and then forward this, on a daily basis, to all relevant departments. The IPCT review the PHE website daily for updated PPE and infection control guidance. Changes are communicated to staff via IPCT visiting clinical areas, Matron's	N/A		

		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).			
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 Actions**	**R.A.G**
1.18	• Risks are reflected in risk registers and the Board Assurance Framework where appropriate	COVID Operational risks are contained within the corporate and divisional risk registers. The infection prevention framework document will be presented to Board for suggestion of inclusion on the corporate risk register. Risk registers reviewed to ensure all COVID related risks are documented and reported.			
1.19	• Robust IPC risk assessment processes and practices are in place	Admission assessments include an infection control section which asks if patients have an infection. There	The infection control risk assessment in the admission documentation is limited due	Live link to sunrise system in place, for COVID-	

	for non COVID-19 infections and pathogens	are policies and procedures in place to identify alert organisms in admitted patients. These are audited and presented to the Infection Prevention and Control Group for reporting up through the organisation. Surveillance of alert organisms is completed by the IPCT utilising ICNet surveillance system and the national MESS database. Any positive results are reported via sunrise system to inform clinical teams. The PAS is updated with significant infection risks as per policy. Sepsis screens are completed via sunrise. IPC admission risk assessment document to be revisited.	to its simplicity and does not risk assess against all infections.	19 and other infectious 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 October 2021 Discussions took place in Aug and IT are developing an IPC section to be included in the documentation section Risk Assessment has been completed	
1.20	NHSE/I visit Noted several areas required estates work completing.	Additional Estates focused reactive audits being introduced as of 17th May 2021 to review wards and departments across the sites on a targeted basis. Minor issues that can be dealt with within 24 hours will be followed through to completion and performance monitored through		All other works identified will be prioritised/RAG rated on a formal action plan with risks mitigated as required and progress reported	

		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: **Maintenance** – Work has commenced on site, orders raised with suppliers. Estimated Date for		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. January 2022 Summit and Mitie have confirmed all back log small works are completed and we have reverted to contract e.g., performance managed. About	

		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.		the larger life cycle works this remains subject to the Trust providing decant areas	
1.21	NHSE/I review Risks outlined, a full review and escalation of risks on the risk register should be carried out as well as a full review of the current IPC risk register.	Risk register reviewed at IPC group agreed risks appropriately reflect the risks. <u>Critical Care</u> Risks and actions reviewed on 7.4.21 & 28.4.21 TAC1412 – Lack of storage affecting MHDU - 24.7.20 7.4.21 – Risks added: TAC 1616 – Lack of Storage in Critical Care TAC 1626 – Suboptimal compliance with management of cleanliness of environment & equipment TAC 1615 Medication storage compliance		Risk register reviewed at bi-monthly IPCG. **November 2021** The design of the new storage facility is well advanced. The main risk with the project at present is the availability of construction materials including the steel work which are	

				being quoted as approximately on a 12-week lead time. Designs are being accelerated as quickly as possible so the materials can be ordered	
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 expectation, 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	Staff caring for COVID patients, are supported by Matrons, Consultants and IPCT. The medical rotas were	Lack of accurate data to demonstrate compliance	Now donning and doffing training completed by the	

	treat patients in COVID-19 isolation or cohort areas	adjusted to ensure that those with respiratory experience were assigned to the high COVID areas. IPCT have provided training for Donning and Doffing of PPE, the team commenced in March 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.		IPCT is documented, this 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	Terminal cleans completed when a COVID patient vacates a bed space or area in none COVID areas.	N/A		

	with PHE and other national guidance	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 and when known to be contaminated	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 decontamination of medical devices	N/A		

	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.)	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 an 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's 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	I am clean labels in use.	Reviewed quarterly as part of the IPC environmental audits.	

		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	Decontamination Lead commenced in post September 2021. Business plan being put forward to review IPC staffing	Use of Datix system to report non-compliance in place.	
2.8 2.9 2.10	• Review and ensure good ventilation in admission and waiting areas to minimize opportunistic airborne transmission • Monitor adherence environmental decontamination with actions in place to mitigate any identified risk • monitor adherence to the decontamination of shared equipment with actions in place to mitigate any identified risk	The Estates department as part of the hot weather plans have been installing where possible portable air conditioning units and have reviewed ventilation at the Trust. The estates team hold details regarding air changes according to site plans. Communications held with matrons regarding the benefits of periodically opening windows to aid air exchanges within clinical areas. Cleaning Audits submitted monthly Audits, spot auditing. De-contamination certificates.	N/A Decontamination Lead commenced in post September 2021. Business plan being put forward to review IPC staffing	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 audit tool	

2.11	NHSE/I 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. October 2021 – Meetings currently being held to discuss implantation of new cleaning standards released May 2021 and trials of new cleaning products	

				January 2022 Delay escalated to Quality and Safety Committee	
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	NHSE/I visit An action plan is required as to how cleaning standards can be maintained with areas of limited storage space.	Schedule of areas to be developed with Mitie to identify specific times for difficult to access areas to be		Feasibility study for additional storage is being tendered with a	

		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.		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 **November 2021** The design of the new storage facility is well advanced. The main risk with the project at present	

				is the availability of construction materials including the steel work which are being quoted as approximately on a 12-week lead time. Designs are being accelerated as quickly as possible so the materials can be ordered.	
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 decluttering days are to be adopted and a meeting with Estates to assist with removal of waste is to be planned. Reminder included in Medicine Achieving Excellence newsletter this was circulated to divisional colleagues and will be monitored during monthly environment audits.		Implementation of declutter days and focused work on decluttering to improve storage.	
2.15	NHSI visit It was noted throughout critical care and the emergency department there were consumable items which had been taken out of their packaging and set up.	.4.21 Consumables removed from all equipment 8.4.21 Equipment covered in plastic to prevent contamination 21.4.21 2 x emergency ventilators set up – 1 for Area A & 1 x Area B – risk assessment in place		All consumable items should be stored in their sealed, sterile, original packaging with the equipment, so they are ready to set up but	

				maintaining sterility	
2.16	NHSI visit Positive pressure in ITU: The air pressures in “ITU A”, which is the designated COVID-19 area, have been changed from negative pressure to positive pressure.	Following guidance received from NHSE/I 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 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.		Check governance arrangements around decision making	
2.17	NHSI visit Requested Materials Management – stock control	• Meeting between Jack Richards, Steph Thompson, Tracey Price, Paul Mellor, Kirstin Taylor and Clare Nash occurred 20/04/21 with key actions identified below • Historically ITU have ordered many items directly from suppliers rather than through NHS Supply Chain, meaning		Meeting to discuss the Materials Management service in ITU and how this can be optimised. The Materials Management service is continually under	

		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 undertake a full review across the trust		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 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 updated 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 Snapshot 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. Snapshot antimicrobial prescribing audits. Infection control Nurses to support AMS activity.	

				EPMA now in place to allow ongoing monitoring of prescriptions	
	4 Provide suitable accurate information on infections to service users, their visitors and any person concerned with providing further support or nursing/ medical care in a timely fashion				
	Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	**R.A.G**
4.1	Systems and processes are in place to ensure: • Implementation of national guidance on visiting patients in a care setting	The trust currently has restricted visiting in place due to social distancing and government essential travel restrictions. Visitors are to wear PPE when visiting. This has been communicated by nursing staff to patients and visitors, via social media, switch board and posters as pictured around the hospital. Visiting Policy to be updated to reflect current visiting advice. Information regarding visiting during the COVID crisis is provided via automated message on calling direct to Trust switchboard. July 2021 – Visiting has recommenced – patients are allowed one visitor for 45 minutes per day and this must be booked via the online booking system. The visiting of COVID positive patients remains	N/A		

		restricted and must be risk assessed. .			
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 October 2021 Currently working with Communication team to produce information in different formats. Formats available on NHS and Government websites January 2022. Leaflets available for download from .GOV.uk website.	
4.4	• Infection status is communicated to the receiving organisation or department when a possible or confirmed COVID-19 patient needs to be moved	There is a patient transfer checklist which asks-infection type if the patient requires barrier nursing or side room and requests current observations. As previously documented, there is a discharge and transfer checklist (which will be updated to specifically include COVID) and COVID status is included in all discharge documentation to all other healthcare providers. COVID test results for intra trust transfers are documented on Sunrise.	Assurance required regarding evidence of completion	October 2021 Covid status on transfer is covered in the monthly documentation audit completed by all inpatient nursing areas	

	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.	N/A		

		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 are triggered. Requests are made via the Sunrise system; the results are reported via this system also.			
5.3	• Patients that test negative but display or go on to develop symptoms of COVID-19 are segregated, tested and instigation of contract tracing as soon as possible	As described in the zoning SOP and draft COVID policy. Symptomatic patients are treated inside rooms where possible. Patients in green (non COVID) and yellow zones (awaiting results) are monitored for symptoms of COVID and are rescreened if required. Patients' observations are input into sunrise which will set an alert when news scores are 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.	N/A		

		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 outpatients' appointments are conducted virtually or by telephone. Some clinics are appointments, before patients attend, they are asked if they have symptoms, if patients have symptoms and they have to attend they are asked to wear a surgical mask and decontaminate hands and would be placed last on the list. Phlebotomy clinics have commenced at the main hospital patients have to book appointments and social distancing is in place. Currently all patients attending the OPD are screened via symptom enquiry and temperature check, if necessary, asked to decontaminate hands and wear a face mask. The majority of OPD appointments are being conducted virtually or by telephone. OPD flow chart for COVID screening in place.	N/A Not monitored. Not monitored.		

		Information provided in policies.			
5.5	• Face masks are available for all patients, and they are always advised to wear them	Patients are requested to wear a face mask at all times 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.	
5.6	• Monitoring of Inpatients compliance with wearing face masks particularly when moving around the ward (if clinically ok to do so)				
5.7	• There is evidence of compliance with routine patient testing protocols			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**
	Systems and processes are in place to ensure:				
6.1	• All staff (clinical and non- clinical) have appropriate training, in line with latest PHE and other guidance, to ensure their personal safety and working environment is safe	IPC mandatory training via e learning has continued, face to face training was suspended during March 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.	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 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 bimonthly. Mandatory training scores for the Trust as of 26.08.21 are 90.3% with an objective of 90%.		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.	October 2021 PPE is audited Quality Rounds.	
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. This is monitored through the completion of the PPE audit in the Divisions		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 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 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	N/A		

		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:	Staff that are obtaining swab samples are trained to do so. A training package has been devised; staff have the opportunity to	N/A	Matrons informed during Huddles regarding testing required.	

8.2 8.3	• Testing is undertaken by competent and trained individuals • Patient and staff COVID-19 testing is undertaken promptly and in line with PHE and other national guidance • Screening for other potential infections takes place	shadow and then complete a screen under supervision. Testing of the COVID swabs is undertaken in accredited laboratories. Community staff weekly testing requirement: collaborative approach with CCG and DMBC PH have weekly testing for health care workers who attend care/nursing homes. Prompt now in place on sunrise system to ensure green patients are retested on day 0, day 3 and day 5 as per national guidance Lateral flow testing commenced W/C 23/11/2020. All clinical and non-clinical staff. MRSA screening has continued along with Clostridioides difficile tests for patients who have diarrhoea. All other screening has continued as pre COVID crisis.		Information also available on the hub and communications update. Compliant. 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.	
				Non-compliant.	
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 onsite test and results back within 4 hours		Compliant.	
				Compliant.	
8.6	• That those emergency admissions who test negative on admission are retested on day 3 of admission, and	Prompts on SUNRISE system. Reviewed as part of the outbreak meetings.	Not reported anywhere within the trust.		

8.7 8.8 8.9 8.10 	again between 5-7 days post admission • That sites with high nosocomial rates should consider testing COVID negative patients daily • 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 • 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. • 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	Trust have reviewed and are unable. Therefore, do not have the resources to carry out daily testing of negative patients. Insufficient capacity. On discharge checklist. Commissioned care home for COVID-19 positive patients. All elective patients are tested. SOP in place.		Partial compliance. Divisional chief nurse to report compliance within IPC report.	

	9 Have and adhere to policies designed for the individual's care and provider organisations that will help to prevent and control infections				
	Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	**R.A.G**
9.1	Systems and processes are in place to ensure that: • Staff are supported in adhering to all IPC policies, including those for other alert organisms	IPC policy adherence is completed by IPCT visits, training and via Saving Lives audits.	N/A		
9.2	• Any changes to the PHE national guidance on PPE are quickly identified and effectively communicated to staff	The IPCT receive email alerts from PHE which describe any changes in guidance, the IPCT also review the PHE website daily for updated PPE and infection control guidance. Changes are communicated to staff via IPCT visiting clinical areas, Matron's meeting, daily brief, HUB page, COVID emails and CEO briefings. (See previous information regarding Incident Room cascading all relevant COVID information throughout the Trust)	N/A		
9.3	• All clinical waste related to confirmed or suspected COVID-19 cases is handled, stored and managed in	Waste streams on yellow and blue zones are clinical waste: orange bag. Some reports received of improper disposal Interserve have	N/A		

	accordance with current national guidance	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 into the domestic waste stream. Tiger stripe clinical waste stream has been implemented across the wards- when a case has been identified then orange waste stream is used			
9.4	• PPE stock is appropriately stored and accessible to staff who require it	A central store is maintained by procurement, who distribute PPE according to need to ensure adequate stocks, there is out of hours access. On entrance to clinical areas there is available stock of PPE. Staff obtain replacement stock directly from procurement. IPCT sit on PPE Cell meetings with Health and Safety, Procurement and clinical skills. Half face respirators have been purchased and distributed by the trust	N/A		
	10 Have a system in place to manage the occupational health needs and obligations of staff in relation to infection				

	Key lines of enquiry	Evidence	Gaps in Assurance	Mitigating Actions	R.A.G
10.1	Appropriate systems and processes are in place to ensure: • Staff in 'at-risk' groups are identified and managed appropriately including ensuring their physical and psychological wellbeing is supported	Staff in the following groups have been identified: • Over 70's • Pregnant Staff • BAME Staff • Staff with underlying conditions Line managers of 'at-risk' groups have been tasked with completing risk assessments to identify risks and consider adjustments where appropriate with the support of Staff Health & Wellbeing and HR. Staff members identified as vulnerable are being supported appropriately to ensure both their physical and psychological wellbeing is supported. There has been an active programme of undertaking risk assessments for all staff, this is an on-going process which line managers will review appropriately. The risk assessment process is ongoing and returns continue to be monitored. The Trust commenced COVID vaccination programme on 29/12/20	N/A	Vulnerable staff may not disclose to employer, therefore all staff to have risk assessment completed	

		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 at 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	Appropriate workforce numbers to maintain segregation of zones.	Zoning SOP and areas are segregated with one-way systems	

		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. .			
10.4 10.5	• All staff adhere to national guidance on social distancing (2 metres) wherever possible, particularly if not wearing a facemask and in non-clinical areas • Consideration is given to staggering staff breaks to limit the density of healthcare workers in specific areas	The Trust has provided staff with detailed guidance with regards of social distancing a standard 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	N/A		

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

		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 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.	Staff isolation SOP available.		
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.	IPC Team not required to be part of the vaccination programme COVID-19 Booster and Influenza vaccination hub now running and accessible for all staff. Walk in appointments available		

Enclosure 10

The Dudley Group NHS Foundation Trust

Paper for submission to the Board of Directors 10th March 2022

Title:	Maternity and Neonatal Safety and Quality Dashboard
Author:	Clare MacDiarmid, Head of Midwifery
Presenter:	Mary Sexton, Chief Nurse

Action Required of Committee / Group							
Decision	N	**Approval**	N	**Discussion**	Y	**Other**	N

Recommendations:

- The Board is invited to accept the assurance provided in this report as progress towards compliance with both CNST requirements and Ockenden recommendations.
- The Board is invited to review the reassessment against the 7 IEA of the Ockenden report as well as the recommendation of the Kirkup report of 2015.

Summary of Key Issues:

The report provides an overview of the current position within Maternity Unit including our position against Saving Babies Lives, CNST standards, Ockenden recommendations, and perinatal mortality.

The Maternity service continues to experience significant peaks in activity and challenges regarding workforce numbers.

There have been two serious incidents in maternity during December and one during January 2022. All have been referred to HSIB.

CNST Maternity Incentive Standards Year 4 standards published in August 2021 were paused by the national team in January 2022. We await updated technical guidance and technical data for the amended timescales for Year 4.
Work continues to progress the safety actions.

Birth-rate plus assessment for maternity staffing is in progress and the outcome will be reported to a future Board meeting.

We have been successful in appointing 3.6 WTE consultant staff due to commence from May 2022.

Significant progress has been made against the Ockenden IEA. A full reassessment of our progress against both Ockenden recommendations and the Kirkup report (2015) has been completed and detailed is Section 2.10. There is a

robust framework in place to oversee the further improvements required and ensure we have robust evidence and assurance.

Maternity safety walkaround was undertaken by the Executive and Non-Executive safety champions on 22nd February 2022.

Impact on the Strategic Goals *(indicate which of the Trust's strategic goals are impacted by this report)*	
Deliver right care every time	**X**
Be a brilliant place to work and thrive	**X**
Drive sustainability (financial and environmental)	
Build innovative partnerships in Dudley and beyond	**X**
Improve health and wellbeing	**X**

Implications of the Paper: *(complete all sections including the Corporate Risk Register and/or the Board Assurance Framework)*			
Risk	N	Risk Description:	
	On Risk Register: N	Risk Score:	
Compliance and/or Lead Requirements	CQC	Y	Details: All areas
	NHSE/I	Y/N	Details:
	Other	Y	Details: CNST Standards Ockenden Recommendations Kirkup report (2015) recommendations

Report Journey/ Destination *(if applicable)*			
	Working / Exec Group	N	Date:
	Committee	Y	Date:
	Board of Directors	Y	Date: 10th March 2022
	Other	Y/N	Date:

Maternity and Neonatal Safety and Quality Dashboard

Report to Trust Board 10th March 2022.

1 EXECUTIVE SUMMARY

1.1 This report outlines locally and nationally agreed measures to monitor maternity and neonatal safety as outlined in the NHSEI document "Implementing a revised perinatal quality surveillance model" (December 2020). The purpose of the report is to inform the Trust Board and LMNS board of present or emerging safety concerns or activity to ensure safety with a two-way reflection of ward to board insight across the multidisciplinary multi professional maternity and neonatal service teams. The information within the report will reflect actions in line with Ockenden and progress made in response to any identified concerns at provider level.

1.2 In line with the perinatal surveillance model, we are required to report the information outlined in the data measures proforma monthly to the trust board. Data contained within this report is for December 2021 and January 2022.

The report will provide an update regarding NHS resolutions maternity incentive scheme year four.

2 BACKGROUND INFORMATION

2.1 Perinatal Mortality.

Stillbirths -There has been 2 stillbirths during the month of December and 2 stillbirths during the month of January 2022 (Rate adjusted to 1 as this was a twin pregnancy).

Early Neonatal Deaths – There have been 1 early neonatal death during the month of December 2021 and 1 during January 2022.

Late Neonatal deaths -There have been 0 late neonatal deaths in December 2021 or January 2002.

All stillbirths and neonatal deaths are reviewed using the National Perinatal Mortality Review Tool (NPMRT) which includes the parent's perspectives and questions as part of the review. The system in place allows for a report to be produced covering all aspects required as part of the CNST Safety Action 1.

In addition to the NPMRT database we are required as a Trust to report the following to MBRRACE

- **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 recommendations for changes in practice. Additionally, MBRRACE carry out confidential enquiries based on identified themes from their main reports.

2.1.2 PMRT real time data monitoring tool

Mortality rates

2.1.3

	December	January
Crude Stillbirth rate	3.43	3.16
Adjusted Stillbirth rate	3.19	2.68
Crude neonatal death rate (early)	1.97	2.20
Adjusted Neonatal death rate (early)	0.98	0.98

*Rate is per 1000 births

2.1.4 Learning from PMRT reviews

All learning is now shared across the Black Country and West Birmingham LMNS on a monthly basis via the quality and safety workstream.

2.2 Healthcare Safety Investigation Branch HSIB and Maternity Serious Incidents SIs

Since April 2018 the Healthcare Safety Investigation Branch HSIB has been responsible for the investigations into specific maternity incidents. These include:

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

2.2.2 Investigation progress update

DGFT executive summary from HSIB up to February 20th, 2022.

Cases to date	
Total referrals	20
Referrals / cases rejected	3 (duplicate entries)
Total investigations to date	17
Total investigations completed	13
Current active cases	4
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.

2.3 Coroner Ref 28 made directly to the Trust

There were no Coroner reg 28 made directly to the Trust in respect of perinatal or maternal deaths in December 2021 or January 2022

2.4 Maternity Serious Incidents

There were 2 serious incidents reported in Maternity during December 2021.

There have been 1 serious incident in maternity in January, the incident has been referred to HSIB maternity for investigation as per national guidance.

	Maternity	Incident number
RCA in progress	5	INC95167 INC95610 INC99624 INC98391 INC100740
RCA submitted to CCG and awaiting closure	0	
RCA breached submission to CCG	0	
RCA CCG queries received by Trust	0	
RCA closed by the CCG/NHSE outstanding actions in action plans	4	INC85471 INC82171 INC86371 INC89708
Serious incident closures	0	

2.5 Continuity of Care

There have been no changes since the last report in relation to progress against continuity of carer within Maternity Services at Dudley. CoC is currently paused due to inadequate staffing to facilitate safe deployment of the transformation. An action plan is due to be commenced over the coming months, with a plan of how to restart the continuity of carer model at Dudley, however we recognise that this is based upon receipt and acceptance of the Birthrate plus workforce analysis, and successful recruitment into vacant posts.

2.6 Training related to core competency framework

2.6.1 A suite of role specific mandatory training is planned for the next year to address the requirements of Maternity Incentive scheme CNST and the ongoing requirements of the Ockenden recommendations.

These include:

- Multidisciplinary skills drills training to include obstetric, midwifery, theatre and anaesthetic staff along with the neonatal team.
- GAP/GROW training online to address the fetal growth restriction domain of Saving Babies Lives.
- A new session delivered by the specialist midwife that addresses all of the domains of the Saving Babies Lives Care Bundle version 2 (SBLCBv2).
- Fetal monitoring competencies are going to be assessed in two ways. This will include face to face teaching followed by a short test of competency and also via the online learning and competency assessment from K2 CTG training. Regular sessions had commenced on delivery suite, hosted by the fetal wellbeing team. These have been delayed due to staff absence and high activity within the department.

2.7 Saving Babies Lives V2

2.7.1 The saving babies lives care bundle version 2 (SBLCBv2) continues to make excellent progress towards full implementation. Safety action six of the clinical negligence scheme for trusts is focused on full compliance with each of the five domains of the care bundle.

Improvement in detection rates of babies that are growth restricted continues due to collaborative working between the digital midwife, SBLV2 specialist Midwife and the obstetric sonography team in their efforts to ensure full and accurate data is being produced and calculated within the EPR. Work is ongoing with the Perinatal Institute to further improve detection rates. Introduction of the digital maternity growth charts should further improve these rates. This is due to go live within the next 6 weeks, following completion of full staff training for all relevant clinicians.

2.8 NHS Resolution Maternity Incentive Scheme CNST

2.8.1 NHS Resolution released the year 4 standards for the CNST Maternity Incentive scheme on 9th August 2021. In January 2022 it was announced that the scheme would be paused for 3 months due to the ongoing efforts of the current wave of the COVID-19 pandemic. There was a reported revision of guidance in October 2021 related to a number of the safety actions In November has been a further revision of the guidance related to safety action 2 which is the MSDS compliance. This brings the safety action in line with NHS Digital requirements and timescales. We await updated guidance and technical data for the amended timescales for year 4.

2.8.2 Each of the safety actions has been allocated a lead, and monthly meetings continue. There has been resolution of the difficulties related to action 1; we now have independent attendance at the perinatal mortality review meeting. Improvement continues with gaps in data entry to ensure we can provide the MSDS as required.

2.8.3 The Trust still awaits the response from NHS Resolution to our Year 3 Board declaration made in July this year. A further declaration was requested by NHSE following conflicting information requested via an FOI by Baby life line during May 2021.

2.8.4 Progress towards achieving all of the safety actions for year 4 continues despite the pause announced.

2.9 Safe Maternity Staffing

Organisational requirements for safe midwifery staffing for maternity settings NICE (2017) states that Trusts develop procedures to ensure that a systematic process is used to set the midwifery staffing establishment to maintain continuity of maternity services and to always provide safe care to women and babies in all settings. Midwifery staffing is reported biannually to Trust board. NICE (2017) recommend that a Birth rate plus assessment is carried out every three years. An assessment has been commissioned and is in progress. The assessment is currently with Birth rate plus and the results of this will be published in the next maternity report to board.

2.9.1 Midwifery Staffing

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

Midwifery shift fill rates for December and January planned v actual staffing:

	Day qualified %	Night qualified%
December 2021	65%	77%
January 2022	65%	79.5%

December and January have seen challenging staffing levels for all areas of Maternity. This has been due to covid absence, high maternity leave rates as well as non-covid sickness absence. All staffing shortfalls have been reported via the datix system, and each patient assessed as to whether any harm was caused as a result of these staffing shortfalls. 0 incidents were reported as harm caused due to delays caused by staffing shortages. 1:1 care in labour was also reported as 100% throughout.

The regional Midwifery sitrep is completed Monday to Friday, which allows declaration of OPAL status to the region. It collects data relating to workload and any delays associated. It collates some data relating to acuity of the department and links to birth-rate plus acuity scores. It also allows quick reference of neighbouring units with the capacity and ability to support as required.

2.9.2 Community Midwifery

Staff survey results published in 2019 and 2020 showed a downward trend in relation to the scores of the whole maternity unit. An area of particular concerns was shown to be community Midwifery. The Chief people officer and Chief executive undertook meetings with this group of staff to highlight concerns and issues they were facing, that may have affected these scores/answers.

Work has been undertaken since this time to improve the working lives of the community midwifery team and ongoing work includes the following:

Twice daily, Microsoft teams ‘Check ins’ by lead midwives to their teams to ensure wellbeing of staff.

Smartphones ordered for each community midwife to make communication with women and their teams easier.

Clear guidance regarding on calls and safeguarded areas to work when staff are called in, where staff feel confident and competent

Protected rest time following on-calls, if called out during the night.

Weekly recorded huddles introduced

PMA places allocated for community staff to enhance pastoral support.

Away day/coaching sessions arranged for May 2022

Introduction of one band 3 MSW, per team to support daily workload

Meetings with Head of Midwifery to voice concerns and make suggestions for improvements

SMT exploring potential venues for community hubs for each team.

A deep dive into the culture of the whole maternity workforce has been commissioned, to commence April/May 2022.

2.9.3 Obstetric staffing

Over the last six to nine months, we have identified a shortfall in our medical workforce and taken steps to provide a safe and high-quality service as well as to meet the requirements of Ockenden. In addition to this, pre-existing vacancies have also been addressed. A workforce demand and capacity review is under way that will ultimately demonstrate the medical staff numbers required for our service at all grades. In the meantime, several newly funded posts have been financially approved and recruited to address the gaps identified.

We have successfully recruited to consultant posts in O&G to cover our vacancies as well as towards an additional 4.0WTE posts to further develop and meet Ockenden requirements. Substantive consultants (3.6 WTE) have been appointed with most having commenced work – final new colleague starting in March 2022. We have also appointed a Trust Locum Consultant with start date TBC. The remaining 1.4 WTE vacancy will be covered by agency locums with a plan to further recruit to a Trust Locum post in due course. These 16 Consultants will join a re-designed job plan template in May 2022. Current job plans are all signed off and new plans will reflect key clinical lead roles to meet Ockenden requirements.

We have recruited 2.0 WTE SHO (Senior House Officer) and 4.0 WTE registrars into fixed term posts to cover gaps in deanery doctors with start dates to be confirmed. We have increased the number of registrar doctors from 14 to 16 WTEs. Vacancies are being covered by bank and agency workers. 2.0 MTIs recruited will be supernumerary, both are awaiting visas. We are recruiting to the bank at all levels to decrease the locum agency spend. This expansion will allow long standing gaps in cover (e.g., additional twilight shift on Delivery Suite) to be covered.

Throughout January and December, we have had high levels of sickness, 2.0 WTE consultants on LTS (1 RTW 28.2.22), and short-term sickness related to COVID. This has increased the need for agency medical staff which we are hoping to reduce as soon as safely possible.

2.10 Maternity Service Improvement Plans

2.10.1 The initial feedback from the Ockenden assurance process was received from NHSE/I by the Trust and the LMNS at the end of October The Head of Midwifery met with the Regional Chief midwife to challenge that some evidence provided had not been acknowledged.

2.11.2 The trust received a letter dated the 25th January from NHSE requesting progress with implementation of the 7 IEAs outlined in the Ockenden report and the plan to ensure full compliance as well as consideration against the Morecambe Bay (Kirkup report, 2015).

Update re self-assessment against the Ockenden report and Kirkup Report (2015)
Appendix 1

Progress since December 2021 is as follows:

IEA	December 2021	March 2022
1	88%	100%
2	71%	94%
3	67%	100%
4	93%	100%
5	87%	100%
6	56%	100%
7	93%	100%
WF	60%	100%

2.11.2 Good progress has been noted in compliance with the 7 IEA in areas including:

The Maternity EPR allowing rapid access to data/audits, and the ability to ensure appropriate conversations with women are being prompted/documented.

Safety champion walk rounds and evidences associated with this.

Fetal monitoring lead obstetrician now in post and engaging with review of incidents and subsequent learning.

Dudley MVP is now being managed by 'Gateway' who will present a paper to board directly.

2.11.3 Areas of concerns and challenge are noted to be:

Evidences relating to board level safety champion bimonthly meeting.

Recruitment and retention strategy required for Maternity/Obstetrics.

Named consultant for Saving babies lives care bundle V2, not currently in post.

2.11.4 A 'blue' category is to be added to the assessment, to reflect assurance that the action is embedded and evidenced. This is as per guidance from the regional Midwifery team.

2.11.5 Monthly Ockenden assurance meetings are now being held in Maternity, attended by the multidisciplinary team, each with allocated responsibility for providing assurance of progress on each IEA.

2.12 Staff feedback from frontline champions and walk about.

A safety walkaround was undertaken on the 22nd February 2022. The main actions identified are below. A full action log is completed during each walkaround.

Concerns	Actions
Booking process for all elective caesarean sections requires review to ensure process	Team to consider appointment of a booking clerk

is fit for purpose and reduce delays for women	
Improvements required to staff facilities in all areas including shower facilities and rest rooms.	Ongoing work to Maternity unit staff wellbeing room. Estates issues escalated to Mitie.

2.13 Service user feedback

Antenatal - We would like to pass a huge compliment to Rachel Greene - midwife - who was incredible too. She started my partner, Cara's induction and explained every step of the way.

Maternity Delivery suite- – 'Cory was amazing, very confident, I couldn't have done it without you. I will never forget you!'

Delivery Suite Midwife Natalie Mallett was nominated for a healthcare hero award by the Chaplaincy team for the care and compassion she showed whilst caring for a bereaved family. 'Nat came in on her day off to continue the care that she had started, supporting mom through giving birth and giving the mom and dad so much love and attention as they came to terms with their loss. She was visibly moved by the tragic circumstances but always maintained a high standard of professionalism'.

3 RISKS AND MITIGATIONS

3.2 Midwifery staffing continues to be a risk and remains on the risk register. Significant improvement is required in order to be able to comply with the continuity of carer requirements. Ongoing midwifery recruitment including international recruitment is in progress.

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

4. RECOMMENDATION(S)

4.1 The Board is invited to accept the assurance provided in this report as progress towards compliance with both CNST requirements and Ockenden recommendations.

4.2 The Board is invited to review the reassessment against the 7 IEA of the Ockenden report as well as the recommendation of the Kirkup report of 2015.

Name of Author: Claire Macdiarmid
Title of Author Head of Midwifery
Date report prepared 27th February 2022.

APPENDICES:

Appendix 1 – Ockenden Kirkup Return template March 2022

Appendix 1 - Ockenden Kirkup Return template March 2022

Ockenden Initial report recommendations
Results of Regional
Update January 22

IEA	Question	Action	Evidence Required	THE DUDLEY GROUP
IEA1	Q1	Maternity Dashboard to LMS every 3 months	Dashboard to be shared as evidence.	100%
			Minutes and agendas to identify regular review and use of common data dashboards and the response / actions taken.	100%
			SOP required which demonstrates how the trust reports this both internally and externally through the LMS.	100%
			Submission of minutes and organogram, that shows how this takes place.	100%
		Maternity Dashboard to LMS every 3 months Total		**100%**
	Q2	External clinical specialist opinion for cases of intrapartum fetal death, maternal death, neonatal brain injury and neonatal death	Audit to demonstrate this takes place.	100%

		Policy or SOP which is in place for involving external clinical specialists in reviews.	100%
	External clinical specialist opinion for cases of intrapartum fetal death, maternal death, neonatal brain injury and neonatal death Total		**100%**
Q3	Maternity SI's to Trust Board & LMS every 3 months	Individual SI's, overall summary of case, key learning, recommendations made, and actions taken to address with clear timescales for completion	100%
		Submission of private trust board minutes as a minimum every three months with highlighted areas where SI's discussed	100%
		Submit SOP	100%
	Maternity SI's to Trust Board & LMS every 3 months Total		**100%**
Q4	Using the National Perinatal Mortality Review Tool to review perinatal deaths	Audit of 100% of PMRT completed demonstrating meeting the required standard including parents notified as a minimum and external review.	100%
		Local PMRT report. PMRT trust board report. Submission of a SOP that describes how parents and women are involved in the PMRT process as per the PMRT guidance.	100%
	Using the National Perinatal Mortality Review Tool to review perinatal deaths Total		**100%**

	Q5	Submitting data to the Maternity Services Dataset to the required standard	Evidence of a plan for implementing the full MSDS requirements with clear timescales aligned to NHSR requirements within MIS.	100%
		Submitting data to the Maternity Services Dataset to the required standard Total		**100%**
	Q6	Reported 100% of qualifying cases to HSIB / NHS Resolution's Early Notification scheme	Audit showing compliance of 100% reporting to both HSIB and NHSR Early Notification Scheme.	100%
		Reported 100% of qualifying cases to HSIB / NHS Resolution's Early Notification scheme Total		**100%**
	Q7	Plan to implement the Perinatal Clinical Quality Surveillance Model	Full evidence of full implementation of the perinatal surveillance framework by June 2021.	100%
			LMS SOP and minutes that describe how this is embedded in the ICS governance structure and signed off by the ICS.	100%
			Submit SOP and minutes and organogram of organisations involved that will support the above from the trust, signed of via the trust governance structure.	100%
		Plan to implement the Perinatal Clinical Quality Surveillance Model Total		**100%**
IEA1 Total				**100%**
IEA2	Q11	Non-executive director who has oversight of maternity services	Evidence of how all voices are represented:	100%
			Evidence of link in to MVP; any other mechanisms	100%
			Evidence of NED sitting at trust board meetings, minutes of trust board where NED has contributed	100%

		Evidence of ward to board and board to ward activities e.g. NED walk arounds and subsequent actions	100%
		Name of NED and date of appointment	100%
		NED JD	100%
	Non-executive director who has oversight of maternity services Total		**100%**
	Demonstrate mechanism for gathering service user feedback, and work with service users through Maternity Voices Partnership to coproduce local maternity services	Clear co-produced plan, with MVP's that demonstrate that co production and co-design of service improvements, changes and developments will be in place and will be embedded by December 2021.	100%
		Evidence of service user feedback being used to support improvement in maternity services (E.G you said, we did, FFT, 15 Steps)	100%
Q13		Please upload your CNST evidence of co-production. If utilised then upload completed templates for providers to successfully achieve maternity safety action 7. CNST templates to be signed off by the MVP.	100%
	Demonstrate mechanism for gathering service user feedback, and work with service users through Maternity Voices Partnership to coproduce local maternity services Total		**100%**
	Trust safety champions meeting bimonthly with Board level champions	Action log and actions taken.	100%
Q14		Log of attendees and core membership.	100%
		Minutes of the meeting and minutes of the LMS meeting where this is discussed.	0%

			SOP that includes role descriptors for all key members who attend by-monthly safety meetings.	100%
		Trust safety champions meeting bimonthly with Board level champions Total		**75%**
	Q15	Evidence that you have a robust mechanism for gathering service user feedback, and that you work with service users through your Maternity Voices Partnership (MVP) to coproduce local maternity services.	Clear co produced plan, with MVP's that demonstrate that co-production and co-design of all service improvements, changes and developments will be in place and will be embedded by December 2021.	100%
		Evidence that you have a robust mechanism for gathering service user feedback, and that you work with service users through your Maternity Voices Partnership (MVP) to coproduce local maternity services. Total		**100%**
	Q16	Non-executive director support the Board maternity safety champion	Evidence of participation and collaboration between ED, NED and Maternity Safety Champion, e.g. evidence of raising issues at trust board, minutes of trust board and evidence of actions taken	100%
			Name of ED and date of appointment	100%
			Role descriptors	100%
		Non-executive director support the Board maternity safety champion Total		**100%**
IEA2 Total				**94%**

IEA3		Multidisciplinary training and working occurs. Evidence must be externally validated through the LMS, 3 times a year.	A clear trajectory in place to meet and maintain compliance as articulated in the TNA.	100%
	Q17		LMS reports showing regular review of training data (attendance, compliance coverage) and training needs assessment that demonstrates validation describes as checking the accuracy of the data.	100%
			Submit evidence of training sessions being attended, with clear evidence that all MDT members are represented for each session.	100%
			Submit training needs analysis (TNA) that clearly articulates the expectation of all professional groups in attendance at all MDT training and core competency training. Also aligned to NHSR requirements.	100%
			Where inaccurate or not meeting planned target what actions and what risk reduction mitigations have been put in place.	100%
		Multidisciplinary training and working occurs. Evidence must be externally validated through the LMS, 3 times a year. Total		**100%**
	Q18	Twice daily consultant-led and present multidisciplinary ward rounds on the labour ward.	Evidence of scheduled MDT ward rounds taking place since December, twice a day, day & night. 7 days a week (e.g. audit of compliance with SOP)	100%
			SOP created for consultant led ward rounds.	100%
		Twice daily consultant-led and present multidisciplinary ward rounds on the labour ward. Total		**100%**

Q19	External funding allocated for the training of maternity staff, is ring-fenced and used for this purpose only	Confirmation from Directors of Finance	100%
		Evidence from Budget statements.	100%
		Evidence of funding received and spent.	100%
		Evidence that additional external funding has been spent on funding including staff can attend training in work time.	100%
		MTP spend reports to LMS	100%
	External funding allocated for the training of maternity staff, is ring-fenced and used for this purpose only Total		**100%**
Q21	90% of each maternity unit staff group have attended an 'in-house' multi-professional maternity emergencies training session	A clear trajectory in place to meet and maintain compliance as articulated in the TNA.	100%
		Attendance records - summarised	100%
		LMS reports showing regular review of training data (attendance, compliance coverage) and training needs assessment that demonstrates validation describes as checking the accuracy of the data. Where inaccurate or not meeting planned target what actions and what risk reduction mitigations have been put in place.	100%
	90% of each maternity unit staff group have attended an 'in-house' multi-professional maternity emergencies training session Total		**100%**

	Q22	Implement consultant led labour ward rounds twice daily (over 24 hours) and 7 days per week.	Evidence of scheduled MDT ward rounds taking place since December 2020 twice a day, day & night; 7 days a week (E.G audit of compliance with SOP)	100%
		Implement consultant led labour ward rounds twice daily (over 24 hours) and 7 days per week. Total		**100%**
	Q23	The report is clear that joint multi-disciplinary training is vital, and therefore we will be publishing further guidance shortly which must be implemented. In the meantime we are seeking assurance that a MDT training schedule is in place	A clear trajectory in place to meet and maintain compliance as articulated in the TNA.	100%
			LMS reports showing regular review of training data (attendance, compliance coverage) and training needs assessment that demonstrates validation described as checking the accuracy of the data.	100%
		The report is clear that joint multi-disciplinary training is vital, and therefore we will be publishing further guidance shortly which must be implemented. In the meantime we are seeking assurance that a MDT training schedule is in place Total		**100%**
IEA3 Total				**100%**

IEA4		Links with the tertiary level Maternal Medicine Centre & agreement reached on the criteria for those cases to be discussed and /or referred to a maternal medicine specialist centre	Audit that demonstrates referral against criteria has been implemented that there is a named consultant lead, and early specialist involvement and that a Management plan that has been agreed between the women and clinicians	100%
	Q24		SOP that clearly demonstrates the current maternal medicine pathways that includes: agreed criteria for referral to the maternal medicine centre pathway.	100%
		Links with the tertiary level Maternal Medicine Centre & agreement reached on the criteria for those cases to be discussed and /or referred to a maternal medicine specialist centre Total		**100%**
		Women with complex pregnancies must have a named consultant lead	Audit of 1% of notes, where all women have complex pregnancies to demonstrate the woman has a named consultant lead.	100%
	Q25		SOP that states that both women with complex pregnancies who require referral to maternal medicine networks and women with complex pregnancies but who do not require referral to maternal medicine network must have a named consultant lead.	100%
		Women with complex pregnancies must have a named consultant lead Total		**100%**
	Q26	Complex pregnancies have early specialist involvement and management plans agreed	Audit of 1% of notes, where women have complex pregnancies to ensure women have early specialist involvement and management plans are developed by the clinical team in consultation with the woman.	100%

		SOP that identifies where a complex pregnancy is identified, there must be early specialist involvement and management plans agreed between the woman and the teams.	100%
	Complex pregnancies have early specialist involvement and management plans agreed Total		**100%**
Q27	Compliance with all five elements of the Saving Babies' Lives care bundle Version 2	Audits for each element.	100%
		Guidelines with evidence for each pathway	100%
		SOP's	100%
	Compliance with all five elements of the Saving Babies' Lives care bundle Version 2 Total		**100%**
Q28	All women with complex pregnancy must have a named consultant lead, and mechanisms to regularly audit compliance must be in place.	SOP that states women with complex pregnancies must have a named consultant lead.	100%
		Submission of an audit plan to regularly audit compliance	100%
	All women with complex pregnancy must have a named consultant lead, and mechanisms to regularly audit compliance must be in place. Total		**100%**

		Understand what further steps are required by your organisation to support the development of maternal medicine specialist centres	Agreed pathways	100%
			Criteria for referrals to MMC	100%
	Q29		The maternity services involved in the establishment of maternal medicine networks evidenced by notes of meetings, agendas, action logs.	100%
		Understand what further steps are required by your organisation to support the development of maternal medicine specialist centres Total		**100%**
IEA4 Total				**100%**
IEA5	**Q30**	All women must be formally risk assessed at every antenatal contact so that they have continued access to care provision by the most appropriately trained professional	How this is achieved within the organisation.	100%
			Personal Care and Support plans are in place and an ongoing audit of 1% of records that demonstrates compliance of the above.	100%
			Review and discussed and documented intended place of birth at every visit.	100%
			SOP that includes definition of antenatal risk assessment as per NICE guidance.	100%
			What is being risk assessed.	100%

	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 Total		**100%**
Q31	Risk assessment must include ongoing review of the intended place of birth, based on the developing clinical picture.	Evidence of referral to birth options clinics	100%
		Out with guidance pathway.	100%
		Personal Care and Support plans are in place and an ongoing audit of 1% of records that demonstrates compliance of the above.	100%
		SOP that includes review of intended place of birth.	100%
	Risk assessment must include ongoing review of the intended place of birth, based on the developing clinical picture. Total		**100%**
Q33	A risk assessment at every contact. Include ongoing review and discussion of intended place of birth. This is a key element of the Personalised Care and Support Plan (PCSP). Regular audit mechanisms are in place to assess PCSP compliance.	Example submission of a Personalised Care and Support Plan (It is important that we recognise that PCSP will be variable in how they are presented from each trust)	100%
		How this is achieved in the organisation	100%
		Personal Care and Support plans are in place and an ongoing audit of 5% of records that demonstrates compliance of the above.	100%

			Review and discussed and documented intended place of birth at every visit.	100%
			SOP to describe risk assessment being undertaken at every contact.	100%
			What is being risk assessed.	100%
		A risk assessment at every contact. Include ongoing review and discussion of intended place of birth. This is a key element of the Personalised Care and Support Plan (PCSP). Regular audit mechanisms are in place to assess PCSP compliance. Total		**100%**
IEA5 Total				**100%**
IEA6	**Q34**	Appoint a dedicated Lead Midwife and Lead Obstetrician both with demonstrated expertise to focus on and champion best practice in fetal monitoring	Copies of rotas / off duties to demonstrate they are given dedicated time.	100%
			Examples of what the leads do with the dedicated time E.G attendance at external fetal wellbeing event, involvement with training, meeting minutes and action logs.	100%
			Incident investigations and reviews	100%
			Name of dedicated Lead Midwife and Lead Obstetrician	100%

	Appoint a dedicated Lead Midwife and Lead Obstetrician both with demonstrated expertise to focus on and champion best practice in fetal monitoring Total		**100%**
Q35	The Leads must be of sufficient seniority and demonstrated expertise to ensure they are able to effectively lead on elements of fetal health	Consolidating existing knowledge of monitoring fetal wellbeing	100%
		Ensuring that colleagues engaged in fetal wellbeing monitoring are adequately supported e.g clinical supervision	100%
		Improving the practice & raising the profile of fetal wellbeing monitoring	100%
		Interface with external units and agencies to learn about and keep abreast of developments in the field, and to track and introduce best practice.	100%
		Job Description which has in the criteria as a minimum for both roles and confirmation that roles are in post	100%
		Keeping abreast of developments in the field	100%
		Lead on the review of cases of adverse outcome involving poor FHR interpretation and practice.	100%
		Plan and run regular departmental fetal heart rate (FHR) monitoring meetings and training.	100%
	The Leads must be of sufficient seniority and demonstrated expertise to ensure they are able to effectively lead on elements of fetal health Total		**100%**

	Q36	Can you demonstrate compliance with all five elements of the Saving Babies' Lives care bundle Version 2?	Audits for each element	100%
			Guidelines with evidence for each pathway	100%
			SOP's	100%
		Can you demonstrate compliance with all five elements of the Saving Babies' Lives care bundle Version 2? Total		**100%**
	Q37	Can you evidence that at least 90% of each maternity unit staff group have attended an 'in-house' multi-professional maternity emergencies training session since the launch of MIS year three in December 2019?	A clear trajectory in place to meet and maintain compliance as articulated in the TNA.	100%
			Attendance records - summarised	100%
			Submit training needs analysis (TNA) that clearly articulates the expectation of all professional groups in attendance at all MDT training and core competency training. Also aligned to NHSR requirements.	100%
		Can you evidence that at least 90% of each maternity unit staff group have attended an 'in-house' multi-professional maternity emergencies training session since the launch of MIS year three in December 2019? Total		**100%**
IEA6 Total				**100%**

IEA7		Trusts 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	Information on maternal choice including choice for caesarean delivery.	100%
	Q39		Submission from MVP chair rating trust information in terms of: accessibility (navigation, language etc) quality of info (clear language, all/minimum topic covered) other evidence could include patient information leaflets, apps, websites.	100%
		Trusts 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 Total		**100%**
		Women must be enabled to participate equally in all decision-making processes	An audit of 1% of notes demonstrating compliance.	100%
			CQC survey and associated action plans	100%
	Q41		SOP which shows how women are enabled to participate equally in all decision making processes and to make informed choices about their care. And where that is recorded.	100%
		Women must be enabled to participate equally in all decision-making processes Total		**100%**

Q42	Women's choices following a shared and informed decision-making process must be respected	An audit of 5% of notes demonstrating compliance, this should include women who have specifically requested a care pathway which may differ from that recommended by the clinician during the antenatal period, and also a selection of women who request a caesarean section during labour or induction.	100%
		SOP to demonstrate how women's choices are respected and how this is evidenced following a shared and informed decision-making process, and where that is recorded.	100%
	Women's choices following a shared and informed decision-making process must be respected Total		**100%**
Q43	Can you demonstrate that you have a mechanism for gathering service user feedback, and that you work with service users through your Maternity Voices Partnership to coproduce local maternity services?	Clear co produced plan, with MVP's that demonstrate that co production and co-design of all service improvements, changes and developments will be in place and will be embedded by December 2021.	100%
		Evidence of service user feedback being used to support improvement in maternity services (E.G you said, we did, FFT, 15 Steps)	100%
		Please upload your CNST evidence of co-production. If utilised then upload completed templates for providers to successfully achieve maternity safety action 7. CNST templates to be signed off by the MVP.	100%

		Can you demonstrate that you have a mechanism for gathering service user feedback, and that you work with service users through your Maternity Voices Partnership to coproduce local maternity services? Total		**100%**
	Q44	Pathways of care clearly described, in written information in formats consistent with NHS policy and posted on the trust website.	Co-produced action plan to address gaps identified	100%
			Gap analysis of website against Chelsea & Westminster conducted by the MVP	100%
			Information on maternal choice including choice for caesarean delivery.	100%
			Submission from MVP chair rating trust information in terms of: accessibility (navigation, language etc) quality of info (clear language, all/minimum topic covered) other evidence could include patient information leaflets, apps, websites.	100%
		Pathways of care clearly described, in written information in formats consistent with NHS policy and posted on the trust website. Total		**100%**
IEA7 Total				**100%**
WF	**Q45**	Demonstrate an effective system of clinical workforce planning to the required standard	Consider evidence of workforce planning at LMS/ICS level given this is the direction of travel of the people plan	100%
			Evidence of reviews 6 monthly for all staff groups and evidence considered at board level.	100%

		Most recent BR+ report and board minutes agreeing to fund.	100%
	Demonstrate an effective system of clinical workforce planning to the required standard Total		**100%**
Q46	Demonstrate an effective system of midwifery workforce planning to the required standard?	Most recent BR+ report and board minutes agreeing to fund.	100%
	Demonstrate an effective system of midwifery workforce planning to the required standard? Total		**100%**
Q47	Director/Head of Midwifery is responsible and accountable to an executive director	HoM/DoM Job Description with explicit signposting to responsibility and accountability to an executive director	100%
	Director/Head of Midwifery is responsible and accountable to an executive director Total		**100%**
Q48	Describe how your organisation meets the maternity leadership requirements set out by the Royal College of Midwives in Strengthening midwifery leadership: a manifesto for better maternity care:	Action plan where manifesto is not met	100%
		Gap analysis completed against the RCM strengthening midwifery leadership: a manifesto for better maternity care	100%

		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: Total		**100%**
		Providers to review their approach to NICE guidelines in maternity and provide assurance that these are assessed and implemented where appropriate.	Audit to demonstrate all guidelines are in date.	100%
			Evidence of risk assessment where guidance is not implemented.	100%
	Q49		SOP in place for all guidelines with a demonstrable process for ongoing review.	100%
		Providers to review their approach to NICE guidelines in maternity and provide assurance that these are assessed and implemented where appropriate. Total		**100%**
WF Total				**100%**

Regional Update 31st December 2021

Those that are greyed out are superseded by Ockenden and do not need completing on this tab.

Kirkup Action no.	Relating to Kirkup Recommendation (see Kirkup Recommendations tab for further information)	Action	Suggested documents that may support Trust assurance.	THE DUDLEY GROUP
1	R1, R13, R24	Ensure that an open and honest approach is taken to any incident	Critical friend is allocated for every level 4/ 5 incident (SI's)	
			Women and their families are kept informed of the progress of the investigation	
			Women and their families are invited to contribute to the investigation process	
			Offering an apology	
			Ensure that all nurses and midwives are aware of their responsibilities in relation to the duty of Candour and their NMC Code	
2	R1, R13	Review the current processes for obtaining feedback from the public to increase the information received	Offering women and their families the opportunity to make suggestions e.g., "You said… we did…."	
			Ensuring that national/ local awareness opportunities are utilised effectively e.g. international day of the midwife/ nurse. Breastfeeding week	
			Continue to support the LSA in the feedback mechanism to staff from service users regarding our service	

			Share patient stories	
3	**R2**	Review the current skills and drills programme across the directorate to ensure that a wide range of scenarios are included across all clinical settings, including bespoke skills drills for different clinical areas	Ensure a high quality training scheme is delivered	
4		Foster a culture of shared learning between clinical departments that supports effective communication and practice development	Minutes of meetings showing MDT working	
5	**R2**	Review the current preceptorship programme	Midwives/ Nurses are allocated a buddy in each clinical area and that this is supported by the clinical team.	Green
			The buddy midwife is allocated time to support the preceptee	Green
			Midwives are supported throughout the programme, progress is monitored and there is a clear plan developed for any midwife that is struggling to attain certain clinical skills	Green
			Midwives are confident and competent to go through the gateway within the agreed timeframe	Green
6	**R2**	Obtain feedback from midwives and nurses who have recently completed a preceptorship programme to identify any improvements that can be made to the programme	Utilise PMA feedback	Green
7	**R2, R3**	Review the skills of Band 6 midwives to identify and address any training needs to ensure a competent and motivated workforce	Develop a robust support package for new band 6 midwives	Green
			Completion of the Mentoring module	Green
			Suturing competency	Green
			IV therapy competency	Green

			Care of women choosing epidural anaesthesia.	Green
8		Review the current induction and orientation process for midwives and nurses joining the organisation at Band 6 to ensure they are competent and confident to provide care	Practice educator reports and feedback	Green
9	**R2**	Review the current induction programme for locum doctors	Locum policies	Amber
10		Review the current provision of education and training for locum doctors with the aim of introducing streamlined bespoke training for this group.		Amber
11	**R2**	Review the provision of maternal AIMS courses and ensure that all places are allocated appropriately and staff attend the session.	Practice educator meeting notes, discussion with DoMS/HoMs	Red
12	**R2**	Review the educational opportunities available for staff working in postnatal areas to increase their understanding of the compromised neonate, including consideration of bespoke educational sessions and HEI courses e.g. Care of the compromised baby module at University of Salford	Practice educator reports and feedback	Green
13	**R2**	Improve staff knowledge, response time and escalation processes in relation to a woman's deteriorating condition	Incident review and feedback, related lessons learnt, training opportunities	Green

14	**R2**	Implement a process for cascading learning points generated from incidents or risk management in each clinical area e.g. email to staff, noticeboard, themed week / message of the week, core huddles, NICU news		Green
15	**R3**	Review the current process for staff rotation to ensure that a competent workforce is maintained in all clinical areas.		Green
16	**R2, R3, R4**	Review and update the Education Strategy		
17	**R3**	Review the support provided when staff are allocated to a new clinical area and what supernumerary actually means in order to manage staff expectations		Green
18	**R3**	Offer opportunities to other heads of service for staff from other trusts to broaden their experience by secondment or supernumerary status		
19	**R5**	Develop a list of current MDT meetings and events and share with staff across the directorate		
20	**R8**	Develop and implement a recruitment and retention strategy specifically for the obstetric directorate		Amber
21		Review the current midwifery staffing establishment to ensure		

		appropriate staffing levels in all clinical areas		
22		Ensure that all staff who leave are offered an exit interview with a senior member of staff and use the information gained from these interviews to inform changes aimed at improving retention		Green
23		Provide Staff Forum meetings where staff are encouraged to attend and discuss concerns		Green
24	**Only applicable to multi-site trusts.**	Improve working relationships between the different sites located geographically apart but under the same organization.		
25	**R9**	Reiterate to all staff via email and team meetings the roles and responsibilities of the consultant obstetrician carrying the hot week bleep.		
26	**R11, R12**	Ensure that staff receive education during their induction regarding the incident reporting process including the process for reporting incidents, the incidents that should be reported and the rationale for learning from incidents.		Amber
27	**R11, R12**	Including a review of the processes for disseminating and learning from incidents		
28		Ensure that staff undertaking incident investigations have received	All consultants to have completed RCA training	
			Identified midwives to have completed RCA training	

		appropriate education and training to undertake this effectively	Staff who have completed RCA training undertake an investigation within 1 year and regularly thereafter in order to maintain their skills	
			Develop a local record of staff who have completed RCA training and the investigations undertaken (including dates)	
29	**R12**	Ensure that the details regarding staff debriefing and support are completed on the Trust incident reporting system for all level 4 and 5 incidents		
30	**R12**	Ensure that all Serious Incidents (SI's)are fedback to the staff		
31	**R12**	Identify ways of improving attendance of midwives at SI's feedback sessions		
32	**R13**	Maternity Services Liaison Committee involvement in complaints	Collation of complaints reports	
33	**R14**	Review the current obstetric clinical lead structure		
34	**R15**	Review past SI's and map common themes	Thematic reviews	
35	**R23**	Ensure that maternal deaths, late and intrapartum stillbirths and unexpected neonatal deaths are reported, reviewed and an investigation undertaken where appropriate	Maternal deaths, stillbirths and early neonatal deaths reports	
36	**R26**	Ensure that all staff are aware of how to raise concerns	Whistle blowing staff policy	Green
37	**R31**	Provide evidence of how we deal with complaints		Green

38	**R31**	Educate staff regarding the process for local resolution and support staff to undertake this process in their clinical area	Identifying situations where local resolution is required	Green
39	**R32**	Develop a plan to maintain a supervision system beyond the decommissioning of the LSAs once national recommendations have been agreed.	Implementation of the A-AQUIP model	
40	**R38**	Ensure that all perinatal deaths are recorded appropriately	Sending the completed form to the Deputy Director of Nursing/ Head of Midwifery and the Divisional Clinical Effectiveness Manager	
41	**R39**	Ensure that Confidential Enquiry reports are reviewed following publication and that an action plan is developed and monitored to ensure that high standards of care are maintained	MBRRACE action plan	Green

Recommendations from the published Kirkup report

1	The University Hospitals of Morecambe Bay NHS Foundation Trust should formally admit the extent and nature of the problems that have previously occurred, and should apologise to those patients and relatives affected, not only for the avoidable damage caused but also for the length of time it has taken to bring them to light and the previous failures to act. This should begin immediately with the response to this Report.
2	The University Hospitals of Morecambe Bay NHS Foundation Trust should review the skills, knowledge, competencies and professional duties of care of all obstetric, paediatric, midwifery and neonatal nursing staff, and other staff caring for critically ill patients in anaesthetics and intensive and high dependency care, against all relevant guidance from professional and regulatory bodies. This review will be completed by June 2015, and identify requirements for additional training, development and, where necessary, a period of experience elsewhere if applicable
3	The University Hospitals of Morecambe Bay NHS Foundation Trust should draw up plans to deliver the training and development of staff identified as a result of the review of maternity, neonatal and other staff, and should identify opportunities to broaden staff experience in other units, including by secondment and by supernumerary practice. These should be in place in time for June 2015.
4	Following completion of additional training or experience where necessary, the University Hospitals of Morecambe Bay NHS Foundation Trust should identify requirements for continuing professional development of staff and link this explicitly with professional requirements including revalidation. This should be completed by September 2015.
5	The University Hospitals of Morecambe Bay NHS Foundation Trust should identify and develop measures that will promote effective multidisciplinary team-working, in particular between paediatricians, obstetricians, midwives and neonatal staff. These measures should include, but not be limited to, joint training sessions, clinical, policy and management meetings and staff development activities. Attendance at designated events must be compulsory within terms of employment. These measures should be identified by April 2015 and begun by June 2015.
6	The University Hospitals of Morecambe Bay NHS Foundation Trust should draw up a protocol for risk assessment in maternity services, setting out clearly: who should be offered the option of delivery at Furness General Hospital and who should not; who will carry out this assessment against which criteria; and how this will be discussed with pregnant women and families. The protocol should involve all relevant staff groups, including midwives, paediatricians, obstetricians and those in the receiving units within the region. The Trust should ensure that individual decisions on delivery are clearly recorded as part of the plan of care, including what risk factors may trigger escalation of care, and that all Trust staff are aware that they should not vary decisions without a documented risk assessment. This should be completed by June 2015.
7	The University Hospitals of Morecambe Bay NHS Foundation Trust should audit the operation of maternity and paediatric services, to ensure that they follow risk assessment protocols on place of delivery, transfers and management of care, and that effective multidisciplinary care operates without inflexible demarcations between professional groups. This should be in place by September 2015.

8	The University Hospitals of Morecambe Bay NHS Foundation Trust should identify a recruitment and retention strategy aimed at achieving a balanced and sustainable workforce with the requisite skills and experience. This should include, but not be limited to, seeking links with one or more other centre(s) to encourage development of specialist and/or academic practice whilst offering opportunities in generalist practice in the Trust; in addition, opportunities for flexible working to maximise the advantages of close proximity to South Lakeland should be sought. Development of the strategy should be completed by January 2016.
9	The University Hospitals of Morecambe Bay NHS Foundation Trust should identify an approach to developing better joint working between its main hospital sites, including the development and operation of common policies, systems and standards. Whilst we do not believe that the introduction of extensive split-site responsibilities for clinical staff will do much other than lead to time wasted in travelling, we do consider that, as part of this approach, flexibility should be built into working responsibilities to provide temporary solutions to short-term staffing problems. This approach should be begun by September 2015.
10	The University Hospitals of Morecambe Bay NHS Foundation Trust should seek to forge links with a partner Trust, so that both can benefit from opportunities for learning, mentoring, secondment, staff development and sharing approaches to problems. This arrangement is promoted and sometimes facilitated by Monitor as 'buddying' and we endorse the approach under these circumstances. This could involve the same centre identified as part of the recruitment and retention strategy. If a suitable partner is forthcoming, this arrangement should be begun by September 2015.
11	The University Hospitals of Morecambe Bay NHS Foundation Trust should identify and implement a programme to raise awareness of incident reporting, including requirements, benefits and processes. The Trust should also review its policy of openness and honesty in line with the duty of candour of professional staff, and incorporate into the programme compliance with the refreshed policy.
12	The University Hospitals of Morecambe Bay NHS Foundation Trust should review the structures, processes and staff involved in investigating incidents, carrying out root cause analyses, reporting results and disseminating learning from incidents, identifying any residual conflicts of interest and requirements for additional training. The Trust should ensure that robust documentation is used, based on a recognised system, and that Board reports include details of how services have been improved in response. The review should include the provision of appropriate arrangements for staff debriefing and support following a serious incident. This should be begun with maternity units by April 2015 and rolled out across the Trust by April 2016.
13	The University Hospitals of Morecambe Bay NHS Foundation Trust should review the structures, processes and staff involved in responding to complaints, and introduce measures to promote the use of complaints as a source of improvement and reduce defensive 'closed' responses to complainants. The Trust should increase public and patient involvement in resolving complaints, in the case of maternity services through the Maternity Services Liaison Committee. This should be completed, and the improvements demonstrated at an open Board meeting, by December 2015.

14	The University Hospitals of Morecambe Bay NHS Foundation Trust should review arrangements for clinical leadership in obstetrics, paediatrics and midwifery, to ensure that the right people are in place with appropriate skills and support. The Trust has implemented change at executive level, but this needs to be carried through to the levels below. All staff with defined responsibilities for clinical leadership should show evidence of attendance at appropriate training and development events. This review should be commenced by April 2015.
15	The University Hospitals of Morecambe Bay NHS Foundation Trust should continue to prioritise the work commenced in response to the review of governance systems already carried out, including clinical governance, so that the Board has adequate assurance of the quality of care provided by the Trust's services. This work is already underway with the facilitation of Monitor, and we would not seek to vary or add to it, which would serve only to detract from implementation. We do, however, recommend that a full audit of implementation be undertaken before this is signed off as completed.
16	As part of the governance systems work, we consider that the University Hospitals of Morecambe Bay NHS Foundation Trust should ensure that middle managers, senior managers and non-executives have the requisite clarity over roles and responsibilities in relation to quality, and it should provide appropriate guidance and where necessary training. This should be completed by December 2015.
17 & 18	The University Hospitals of Morecambe Bay NHS Foundation Trust should identify options, with a view to implementation as soon as practicable, to improve the physical environment of the delivery suite at Furness General Hospital, including particularly access to operating theatres, an improved ability to observe and respond to all women in labour and en suite facilities; arrangements for post-operative care of women also need to be reviewed. Plans should be in place by December 2015 and completed by December 2017. 18. All of the previous recommendations should be implemented with the involvement of Clinical Commissioning Groups, and where necessary, the Care Quality Commission and Monitor. In the particular circumstances surrounding the University Hospitals of Morecambe Bay NHS Foundation Trust, NHS England should oversee the process, provide the necessary support, and ensure that all parties remain committed to the outcome, through an agreed plan with the Care Quality Commission, Monitor and the Clinical Commissioning Groups.
Recommendations for the wider NHS	
19	In light of the evidence we have heard during the Investigation, we consider that the professional regulatory bodies should review the findings of this Report in detail with a view to investigating further the conduct of registrants involved in the care of patients during the time period of this Investigation. Action: the General Medical Council, the Nursing and Midwifery Council.
20	There should be a national review of the provision of maternity care and paediatrics in challenging circumstances, including areas that are rural, difficult to recruit to, or isolated. This should identify the requirements to sustain safe services under these conditions. In conjunction, a national protocol should be drawn up that defines the types of unit required in different settings and the levels of care that it is appropriate to offer in them. Action: NHS England, the Care Quality Commission, the Royal College of Obstetricians and Gynaecologists, the Royal College of Midwives, the Royal College of Paediatrics and Child Health, the National Institute for Health and Care Excellence.

21	The challenge of providing healthcare in areas that are rural, difficult to recruit to or isolated is not restricted to maternity care and paediatrics. We recommend that NHS England consider the wisdom of extending the review of requirements to sustain safe provision to other services. This is an area lacking in good-quality research yet it affects many regions of England, Wales and Scotland. This should be seen as providing an opportunity to develop and promote a positive way of working in remote and rural environments. Action: NHS England.
22	We believe that the educational opportunities afforded by smaller units, particularly in delivering a broad range of care with a high personal level of responsibility, have been insufficiently recognised and exploited. We recommend that a review be carried out of the opportunities and challenges to assist such units in promoting services and the benefits to larger units of linking with them. Action: Health Education England, the Royal College of Obstetricians and Gynaecologists, the Royal College of Paediatrics and Child Health, the Royal College of Midwives.
23	Clear standards should be drawn up for incident reporting and investigation in maternity services. These should include the mandatory reporting and investigation as serious incidents of maternal deaths, late and intrapartum stillbirths and unexpected neonatal deaths. We believe that there is a strong case to include a requirement that investigation of these incidents be subject to a standardised process, which includes input from and feedback to families, and independent, multidisciplinary peer review, and should certainly be framed to exclude conflicts of interest between staff. We recommend that this build on national work already begun on how such a process would work. Action: the Care Quality Commission, NHS England, the Department of Health.
24	We commend the introduction of the duty of candour for all NHS professionals. This should be extended to include the involvement of patients and relatives in the investigation of serious incidents, both to provide evidence that may otherwise be lacking and to receive personal feedback on the results. Action: the Care Quality Commission, NHS England.
25	We recommend that a duty should be placed on all NHS Boards to report openly the findings of any external investigation into clinical services, governance or other aspects of the operation of the Trust, including prompt notification of relevant external bodies such as the Care Quality Commission and Monitor. The Care Quality Commission should develop a system to disseminate learning from investigations to other Trusts. Action: the Department of Health, the Care Quality Commission
26	We commend the introduction of a clear national policy on whistleblowing. As well as protecting the interests of whistleblowers, we recommend that this is implemented in a way that ensures that a systematic and proportionate response is made by Trusts to concerns identified. Action: the Department of Health.
27	Professional regulatory bodies should clarify and reinforce the duty of professional staff to report concerns about clinical services, particularly where these relate to patient safety, and the mechanism to do so. Failure to report concerns should be regarded as a lapse from professional standards. Action: the General Medical Council, the Nursing and Midwifery Council, the Professional Standards Authority for Health and Social Care.
28	Clear national standards should be drawn up setting out the professional duties and expectations of clinical leads at all levels, including, but not limited to, clinical directors, clinical leads, heads of service, medical directors, nurse directors. Trusts should provide evidence to the Care Quality Commission, as part of their processes, of appropriate policies and training to ensure that standards are met. Action: NHS England, the Care Quality Commission, the General Medical Council, the Nursing and Midwifery Council, all Trusts.

29	Clear national standards should be drawn up setting out the responsibilities for clinical quality of other managers, including executive directors, middle managers and non-executives. All Trusts should provide evidence to the Care Quality Commission, as part of their processes, of appropriate policies and training to ensure that standards are met. Action: NHS England, the Care Quality Commission, all Trusts.
30	A national protocol should be drawn up setting out the duties of all Trusts and their staff in relation to inquests. This should include, but not be limited to, the avoidance of attempts to 'fend off' inquests, a mandatory requirement not to coach staff or provide 'model answers', the need to avoid collusion between staff on lines to take, and the inappropriateness of relying on coronial processes or expert opinions provided to coroners to substitute for incident investigation. Action: NHS England, the Care Quality Commission.
31	The NHS complaints system in the University Hospitals of Morecambe Bay NHS Foundation Trust failed relatives at almost every turn. Although it was not within our remit to examine the operation of the NHS complaints system nationally, both the nature of the failures and persistent comment from elsewhere lead us to suppose that this is not unique to this Trust. We believe that a fundamental review of the NHS complaints system is required, with particular reference to strengthening local resolution and improving its timeliness, introducing external scrutiny of local resolution and reducing reliance on the Parliamentary and Health Service Ombudsman to intervene in unresolved complaints. Action: the Department of Health, NHS England, the Care Quality Commission, the Parliamentary and Health Service Ombudsman.
32	The Local Supervising Authority system for midwives was ineffectual at detecting manifest problems at the University Hospitals of Morecambe Bay NHS Foundation Trust, not only in individual failures of care but also with the systems to investigate them. As with complaints, our remit was not to examine the operation of the system nationally; however, the nature of the failures and the recent King's Fund review (*Midwifery regulation in the United Kingdom*) lead us to suppose that this is not unique to this Trust, although there were specific problems there that exacerbated the more systematic concern. We believe that an urgent response is required to the King's Fund findings, with effective reform of the system. Action: the Department of Health, NHS England, the Nursing and Midwifery Council.
33	We considered carefully the effectiveness of separating organisationally the regulation of quality by the Care Quality Commission from the regulation of finance and performance by Monitor, given the close inter-relationship between Trust decisions in each area. However, we were persuaded that there is more to be gained than lost by keeping regulation separated in this way, not least that decisions on safety are not perceived to be biased by their financial implications. The close links, however, require a carefully coordinated approach, and we recommend that the organisations draw up a memorandum of understanding specifying roles, relationships and communication. Action: Monitor, the Care Quality Commission, the Department of Health.
34	The relationship between the investigation of individual complaints and the investigation of the systemic problems that they exemplify gave us cause for concern, in particular the breakdown in communication between the Care Quality Commission and the Parliamentary and Health Service Ombudsman over necessary action and follow-up. We recommend that a memorandum of understanding be drawn up clearly specifying roles, responsibilities, communication and follow-up, including explicitly agreed actions where issues overlap. Action: the Care Quality Commission, the Parliamentary and Health Service Ombudsman.

35	The division of responsibilities between the Care Quality Commission and other parts of the NHS for oversight of service quality and the implementation of measures to correct patient safety failures was not clear, and we are concerned that potential ambiguity persists. We recommend that NHS England draw up a protocol that clearly sets out the responsibilities for all parts of the oversight system, including itself, in conjunction with the other relevant bodies; the starting point should be that one body, the Care Quality Commission, takes prime responsibility. Action: the Care Quality Commission, NHS England, Monitor, the Department of Health.
36	The cumulative impact of new policies and processes, particularly the perceived pressure to achieve Foundation Trust status, together with organisational reconfiguration, placed significant pressure on the management capacity of the University Hospitals of Morecambe Bay NHS Foundation Trust to deliver against changing requirements whilst maintaining day-to-day needs, including safeguarding patient safety. Whilst we do not absolve Trusts from responsibility for prioritising limited capability safely and effectively, we recommend that the Department of Health should review how it carries out impact assessments of new policies to identify the risks as well as the resources and time required. Action: the Department of Health.
37	Organisational change that alters or transfers responsibilities and accountability carries significant risk, which can be mitigated only if well managed. We recommend that an explicit protocol be drawn up setting out how such processes will be managed in future. This must include systems to secure retention of both electronic and paper documents against future need, as well as ensuring a clearly defined transition of responsibilities and accountability. Action: the Department of Health.
38	Mortality recording of perinatal deaths is not sufficiently systematic, with failures to record properly at individual unit level and to account routinely for neonatal deaths of transferred babies by place of birth. This is of added significance when maternity units rely inappropriately on headline mortality figures to reassure others that all is well. We recommend that recording systems are reviewed and plans brought forward to improve systematic recording and tracking of perinatal deaths. This should build on the work of national audits such as MBRRACE-UK, and include the provision of comparative information to Trusts. Action: NHS England.
39	There is no mechanism to scrutinise perinatal deaths or maternal deaths independently, to identify patient safety concerns and to provide early warning of adverse trends. This shortcoming has been clearly identified in relation to adult deaths by Dame Janet Smith in her review of the Shipman deaths, but is in our view no less applicable to maternal and perinatal deaths, and should have raised concerns in the University Hospitals of Morecambe Bay NHS Foundation Trust before they eventually became evident. Legislative preparations have already been made to implement a system based on medical examiners, as effectively used in other countries, and pilot schemes have apparently proved effective. We cannot understand why this has not already been implemented in full, and recommend that steps are taken to do so without delay. Action: the Department of Health.
40	Given that the systematic review of deaths by medical examiners should be in place, as above, we recommend that this system be extended to stillbirths as well as neonatal deaths, thereby ensuring that appropriate recommendations are made to coroners concerning the occasional need for inquests in individual cases, including deaths following neonatal transfer. Action: the Department of Health

41	We were concerned by the ad hoc nature and variable quality of the numerous external reviews of services that were carried out at the University Hospitals of Morecambe Bay NHS Foundation Trust. We recommend that systematic guidance be drawn up setting out an appropriate framework for external reviews and professional responsibilities in undertaking them. Action: the Academy of Medical Royal Colleges, the Royal College of Nursing, the Royal College of Midwives.
42	We further recommend that all external reviews of suspected service failures be registered with the Care Quality Commission and Monitor, and that the Care Quality Commission develops a system to collate learning from reviews and disseminate it to other Trusts. Action: the Care Quality Commission, Monitor.
43	We strongly endorse the emphasis placed on the quality of NHS services that began with the Darzi review, *High Quality Care for All*, and gathered importance with the response to the events at the Mid Staffordshire NHS Foundation Trust. Our findings confirm that this was necessary and must not be lost. We are concerned that the scale of recent NHS reconfiguration could result in new organisations and post-holders losing the focus on this priority. We recommend that the importance of putting quality first is re-emphasised and local arrangements reviewed to identify any need for personal or organisational development, including amongst clinical leadership in commissioning organisations. Action: NHS England, the Department of Health.
44	This Investigation was hampered at the outset by the lack of an established framework covering such matters as access to documents, the duty of staff and former staff to cooperate, and the legal basis for handling evidence. These obstacles were overcome, but the need to do this from scratch each time an investigation of this format is set up is unnecessarily time-consuming. We believe that this is an effective investigation format that is capable of getting to the bottom of significant service and organisational problems without the need for a much more expensive, time-consuming and disruptive public inquiry. This being so, we believe that there is considerable merit in establishing a proper framework, if necessary statutory, on which future investigations could be promptly established. This would include setting out the arrangements necessary to maintain independence and work effectively and efficiently, as well as clarifying responsibilities of current

Enclosure 11

The Dudley Group NHS Foundation Trust

Paper for submission to Trust Board

March 2022

Title:	**Learning from Deaths**
Author:	Dr Philip Brammer, Deputy Medical Director
Presenter:	Dr Julian Hobbs, Medical Director

Action Required of Committee / Group							
Decision	N	**Approval**	Y	**Discussion**	Y	**Other**	N

Recommendations:

This paper is to update the committee on current learning from deaths occurring within the Trust.

Summary of Key Issues:

The Trust has recorded a decrease in SHMI (Summary Hospital-level Mortality Indicator) the last two reporting periods with the latest value of 1.12.

The Trust current diagnosis specific reports are detailed below show a risk regarding mortality related to respiratory illness. This recorded on the Trust risk register ASM1633 and the support of AQuA is in place.

Structured Judgement Reviews (SJR) continue with the biggest source of referral from the Medical Examiner Service.

COVID-19 Harm Review panel outcomes were sent for external review and have identified learning around a number of issues including delays in ED, equipment shortages and DNACPR decisions. The full review is included as an appendix.

Notable developments relating to the mortality review process within the Trust are the rollout of a new mortality tracking module via AMAT in January 2022 and the expansion of the medical examiners service.

Impact on the Strategic Goals
(indicate which of the Trust's strategic goals are impacted by this report)

Deliver right care every time	**X**
Be a brilliant place to work and thrive	
Drive sustainability (financial and environmental)	

Build innovative partnerships in Dudley and beyond	
Improve health and wellbeing	

Implications of the Paper:			
Risk	Y	Risk Description: 1. COR1015 Compliance to the identification and action of all deteriorating patient groups 2. ASM1633 Identified as outlier for COPD and Pneumonia mortality	
	On Risk Register: Y	Risk Score: 1. COR1015 - 15 2. ASM1633 - 16	
Compliance and/or Lead Requirements	CQC	N	Details:
	NHSE/I	N	Details:
	Other	N	Details:

Report Journey/ Destination *(if applicable)*	Working / Exec Group	N	Date:
	Committee	Y	Date: Feb 2022
	Board of Directors	Y	Date: 10th March 2022
	Other	N	Date:

MORTALITY ASSURANCE

Report to Trust Board

1 EXECUTIVE SUMMARY

The Trust has recorded a decrease in SHMI (Summary Hospital-level Mortality Indicator) in the last two reporting periods with the latest value of 1.12.

The Trust's current diagnosis specific reports are detailed below show a risk regarding mortality related to respiratory illness. This is recorded on the Trust risk register ASM1633 and the support of AQuA is in place.

COVID-19 Harm Review panels are continuing with the first 123 completed and cases with harm sent for external review. The external reviewer has made a series of recommendations in relation to delays in ED, equipment supplies, improving decision making and clarification of documentation of the detail of ceiling of care decisions once DNAR orders are in place.

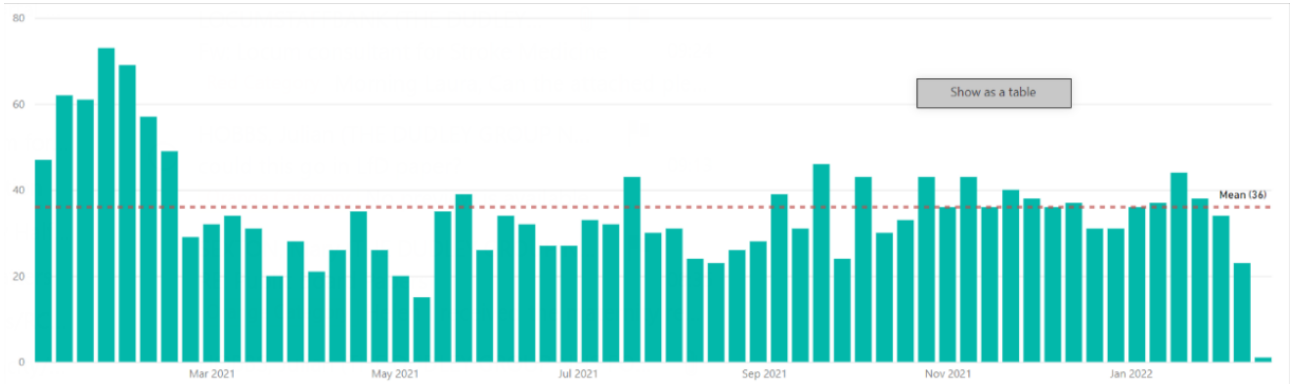
Notable developments relating to the mortality process within the Trust are the rollout of a new mortality tracking module via AMaT in January 2022 and the expansion of the medical examiners service to include scrutiny of community deaths from April 2022.

2 BACKGROUND INFORMATION

2.1 Overall Standardised Mortality indices

The latest recorded SHMI for the Trust up to September 2021 is 1.12 a progressive fall over 2 quarters.

The Trust has recognised the challenges of reducing numbers of recorded admissions since 2017 when SHMI started to rise. It was anticipated that a national move to recording Same Day Emergency Care (SDEC) would negate the effect of local changes, but this change has continued to be delayed and the Trust thus still remains as an outlier. There is variation across the Black Country with Wolverhampton and Walsall recording admission data differently from Sandwell/West Birmingham and Dudley. The Trust is progressing a return to the original methods of coding admissions. At the current time no work to standardise reporting across the ICS is in progress.



2.2 Specific Mortality Alerts

The Trust has significantly improved mortality outcomes in relation to pneumonia, sepsis, acute kidney injury and pulmonary embolism outcomes post discharge.

This is positively correlated with the introduction of electronic alerting tools and the implementation of urgent CXR with a report to treating clinicians. We continue to work with our improvement partners AQuA in relation to the improvement in care bundle delivery and have seen incremental compliance over the last quarter.

Areas of focus

1. Fluid and electrolyte disorders.

This has been a previous alert for the trust. Our initial work has focused on palliative care coding due to the opportunity to improve in this area. No specific concerns related to clinical care have been raised.

2. Acute liver disease and COPD.

Both areas have improved their compliance with the care bundles. The introduction of comprehensive clinical notes in March 2022 on the Trusts EPR and the more structured use of the deteriorating patient dashboard will allow real time intervention and oversight of the treatment bundles.

Additional in reach from alcohol liaison and respiratory teams is in place following successful recruitment to additional posts.

2.3 Learning from Case Note Review

2.3.1 COVID-19 Harm Review

Multi-disciplinary COVID-19 Harm Review panels have continued to be held to review 123 deaths that were deemed to be hospital acquired (COVID+ 8 days post admission).

- All cases have been reviewed. Ie. It was noted by the panel that many of these cases were frail and elderly and often at end of life prior to contacting the virus. However, it was clear that for many delays in packages of care may have contributed to the prolonged risk of potential exposure. The 15 cases were deemed to have moderate levels of harm with one case deemed to have severe harm caused. All 16 cases were sent for external moderation along with a further sample.

In summary the report identified that half the cases of the cohort presented to and were cared for within the Emergency department and the assessor felt that ED notes demonstrated real improvements in clinical care compared 2017-2018 as well as a very clear improvement in the quality and structure of documentation.

There were still some patients who spent “long periods of time” being cared for within the ED setting, but there was no evidence that this adversely affected outcome in the sample of cases reviewed.

The quality of care delivered within the inpatient services was felt to be of a high standard, with 88% of all scores allocated equating to good or excellent care, and similarly overall care and record keeping being judged as good or excellent in 88% of cases.

Shortages of equipment that materially altered medical care were noted in several cases, and although Datix reporting in general was good it was not clear that these were centrally recorded, and this may be worth tracking in more detail on a prospective basis.

The recommendations from the review are being monitored via Mortality Surveillance Group and there is initial conversation to undertake some Black Country wide comparative reviews for further learning.

2.3.2 General Case Note review

There continues to be a high standard of care in most cases where review has been undertaken.

A number of themes continue to emerge:

- Strengthening of Advanced Care Plan or DNA CPR to establish ceilings of care and appropriate care settings.
- A gap in updating GSF for patients when they begin to deteriorate. Overall end of life care is good within the trust.
- Delays in implementation of best supportive care may occur when decisions are awaited from tertiary centres. Such delays may prevent a transfer home or to a hospice at an appropriate time.
- EMLAP and NELA data are above the national average but with opportunities to further improve performance with multi-departmental working.
- Learning disability reviews - care was appropriate although there are some questions raised over appropriateness of wording on MCCD and DNA CPR. LD team are currently auditing DNA CPR for presentation at MSG.

The Trust and community teams are implementing the RESPECT document which may help to minimise unnecessary admissions at end of life. Similarly, the Palliative Care teams are working to highlight such issues and to improve discharge planning for such patients.

2.4 Deteriorating Patient Pathways

The committee previously received details of snapshot audits completed for the following conditions.

- COPD
- Pneumonia

- Sepsis
- DLD (Decompensated liver disease)
- AKI (Acute Kidney Injury)

AKI and DLD work continues with AQuA and Clinical Teams to improve clinical engagement. The electronic patient record has been modified to allow requests of order sets to facilitate completion of the bundles.

The pathways have been further described to the Digital Trust to determine implementation to support uptake and work is progressing at pace to digitalise this work.

2.5 Medical Examiner Service

The Medical Examiner service has expanded to prepare for the scrutiny of community deaths. An additional 0.5 wte Medical Examiner have been appointed and will be supported by 3 wte Medical Examiner Officers.

3 RISKS AND MITIGATIONS

3.1 The following associated risks are live on the Risk Register

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

4. RECOMMENDATION(S)

4.1 The Board is asked to note the decrease in SHMI during the last two reporting periods.

4.2 The progress against mortality related actions is reported via Quarterly Learning from Deaths reports submitted to Quality and Safety Committee and Trust Board.

Dr Philip Brammer, Deputy Medical Director
28/2/22

Enclosure 12

The Dudley Group NHS Foundation Trust

Paper for submission to Board of Directors on 10th March 2022

Title:	Research & Development 6 Monthly Report
Author:	Dr Jeff Neilson, Director of R&D; Prof George Kitas, Director of R&D Academic Affairs; Dr Gail Parsons, Deputy Director of R&D (Nursing); Claire Phillips, R&D Manager; Helen Hollis, Deputy R&D Manager
Presenter:	Dr Jeff Neilson, Director of R&D

Action Required of Committee / Group			
Decision	**Approval**	**Discussion**	**Other**
		Y	

Recommendations:

For the Board to:

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

Summary of Key Issues:

COVID-19 related Urgent Public Health and Non-urgent Public Health research activity.

Impact on the Strategic Goals	
Deliver right care every time	**Y**
Be a brilliant place to work and thrive	**Y**
Drive sustainability (financial and environmental)	**Y**
Build innovative partnerships in Dudley and beyond	**Y**
Improve health and wellbeing	**Y**

Implications of the Paper:			
Risk	Y	Risk Description: Reduction in annual funding from Clinical Research Network. Lack of space for archiving study documents (up to 25 yrs) - pending works to be carried out to convert space.	
	On Risk Register: Y	Risk score: 12	
Compliance and/or Lead Requirements	CQC	Y	Details: Safe, Effective, Caring, Responsive, Well Led - The leadership, management and governance of the organisation assures the delivery of high quality person-centred care, supports learning and innovation, and promotes an open and fair culture
	NHSE/I	Y	Details: R&D activity included in the Annual Report
	Other	Y	Details: Recruitment activity is monitored by CRN:WM, NIHR, DHSC.

Report Journey/ Destination *(if applicable)*	Working / Exec Group	Y/N	Date:
	Committee	Y	Date:
	Board of Directors	Y	Date: 10/03/2022
	Other	Y/N	Date:

Research & Development 6 Monthly Report

We have continued to prioritise Urgent Public Health Studies, and despite some staff shortages due to covid, plus other sickness absences and staff vacancies we have re-opened almost all other non-urgent public health studies.

The Urgent Public Health studies which are ongoing are listed below with number of recruits into each with a brief description of the study purpose, and where available, results of the studies so far. These provide a clear example of how research can be integrated into clinical practice, contribute to improving outcomes and become business as usual.

URGENT PUBLIC HEALTH RESEARCH:

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

2094 recruiting

The primary objectives include describing the clinical features, response to treatment, pathogen and host factors that relate to disease severity and immune response. We are part of Tier 0 in this study and as such this is a study that involves collecting clinical data only. This study closed to recruitment 28th February 2022, with data lock 29th April 2022.

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

425 recruited (closed to recruitment 31.03.21)

This aims to establish whether staff working in healthcare organisations who have evidence of prior COVID-19, detected by antibody assays (positive antibody tests), are protected from future episodes of infection compared to those who do not have evidence of prior infection (negative antibody tests). This study is also exploring both short and long-term effectiveness of a vaccine against infection and immunological response to a vaccine. Participants complete short questionnaires and have COVID PCR tests fortnightly and antibody tests every four weeks. Follow-up will continue for one year (minimum) with an optional extension to 24 month follow-up from recruitment. 332 members of staff are currently in follow-up.

There has been a lot of positive feedback from staff recruited who appreciate the regular testing and who receive the antibody test results via text. On request, they can obtain their antibody levels too. This is the only large study that involves frequent follow-up visits.

Randomised Evaluation of COVID-19 therapy (RECOVERY)

244 recruited to date

This is a randomised trial for patients hospitalised with COVID-19. All eligible patients are randomly allocated between several treatment arms, each to be given in addition to the usual standard of care in the participating hospital. The RECOVERY trial has so far recruited over 39,000 patients and is currently investigating baricitinib, di-methyl fumarate, and high vs low dose corticosteroids.

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

184 recruited to date

This study was devised before the pandemic to explore interventions in an intensive care unit setting to improve outcomes of patients with community acquired pneumonia from any cause – most are bacterial in adults. As the pandemic took off, the trial was essentially re-purposed as a COVID study using the same structure which is similar to RECOVERY which allows for multiple interventions to examined both sequentially and simultaneously.

CCP Cancer UK - Clinical Characterisation Protocol for Severe Emerging Infections in the UK (CCP-UK) – a prospective companion study for patients with Cancer and COVID-19

75 recruited to date

Patients with cancer are considered a high-risk group given the significant concerns regarding the potential risks of acquiring SARS-CoV-2. CCP-Cancer UK is a companion study to the Clinical Characterisation Protocol for Severe Emerging Infections (CCP-UK) study. This is the largest study in the world of the effects of COVID-19 on patients with cancer.

Genetics of susceptibility and mortality in critical care (GenOMICC)

57 recruited to date

This study aims to sequence the genomes of 20,000 people who are severely ill with COVID-19, and a further 15,000 individuals with mild symptoms. The data will help scientists better understand the varied effects that the virus has on people and will support the search for treatments, to respond to the global crisis.

UKOSS: Pandemic Influenza in Pregnancy

41 recruited to date

This study is a national study of women hospitalised with confirmed COVID-19 in pregnancy. The information will be analysed to inform ongoing guidance for women and maternity staff as we respond to the pandemic. Specifically, the study will describe incidence, management and outcomes of COVID-19 in pregnancy and identify factors associated with better outcomes for women and their babies.

COVIP - COVID-19 in very old intensive care patients

25 recruited (closed to recruitment Sept 2021)

A prospective, multicentre, international observational study of Clinical course and prognostic factors of COVID-19 infection in very old intensive care patients

Non-COVID research

Majority of non-covid studies have now re-opened with just five studies still 'on hold' due to study sponsors decision. Recruitment into these studies remains slow, affected both by new ways of working where fewer patients attend the hospital for appointments, and many patients still fear attending hospital. We have recruited 37 patients into non-COVID studies since 1st April 2021 with surgery and critical care specialties dominating, with some recruitment in cardiology, musculoskeletal and diabetes also. We will continue to focus on improving this, whilst also continuing with Urgent Public Health studies.

R&D Strategy

We are currently revising our R&D Strategy document. We are reviewing to what degree we have met previous strategic goals, to establish our goals for the future, in line with the Trust strategy and Clinical Research Network West Midlands (CRN WM) over the next three to five years. We had a successful away day session on 3rd March 2022, whereby relevant clinicians, service leads and R&D staff attended to develop our draft plan. This will be brought to Trust Board later in the 2022.

We aim to continue to increase the number of non-medical Principal Investigators (PI) and build on the opportunities for the development of staff to full fill this role, and this will remain as a key objective for the department and Trust. We currently have six non-medical PIs within the Trust. One AHP is due to complete MRES, with a second Clinical Nurse Specialist due to commence next year (funded by R&D).

We continue with PI Essentials training for current and potential PIs (medical and non-medical) within the Trust. The training aims to inform the PIs of their role and responsibilities in the study and what support they can expect from R&D.

Research Scholarships and Fellowships

Mr Mike Wall (Consultant Vascular Surgeon) has now commenced his CRN Research Scholarship, allowing one (funded) day per week for two years, to facilitate his advancement towards becoming a chief investigator (lead researcher in a multi-centre research study). He has two projects, whereby he is Chief Investigator, currently under review to open March 2022.

A previous successful applicant, Dr Steve Jenkins (Consultant Haematologist) has opened his first clinical trial study as a chief investigator – REPAIR-MDS, which is a phase II trial of drug therapy for patients with low risk myelodysplasia. Recruitment is going well and has already met the recruitment target, with a further 18 months to go.

Sally Fenton, an affiliated academic staff member, has been successful in gaining a 5-year NIHR Senior Fellowship for a project entitles MISSION-RA. Russell's Hall will be the main recruiting site, with Sandwell & West Birmingham, as a second site. This programme will pan three studies, with the first due to commence June 2022.

The CRN scholarship awards 2022, have just closed to applicants, where we have had increased interest with three applications submitted, of which two applicants shortlisted to stage 2, with interviews arranged for March 2022. The third applicant was praised for their passion and current research work and support from CRN WM to submit project via an alternative funding stream. We have interest from two local General Practitioners, to

collaborate on this qualitative research project, along with Aston University. Initial discussions have taken place, and we look forward to working with them.

National Developments and Performance Management

The number of patients receiving health services provided or sub-contracted by the Trust in 2020/21 that were recruited during that period to participate in research approved by a Research Ethics Committee was 914 (NIHR portfolio research and non-portfolio research). Please see appendix 1 for our activity compared to other West Midlands Trusts (this report shows NIHR portfolio research only).

Dr Adrian Jennings and the FLO-ELA team (FLuid Optimisation in Emergency LAparotomy) have been listed as top recruiters for the study, with a total of 284 patients.

ROSSINI 2 study (Reduction Of Surgical Site Infection using several Novel Interventions) –Mr Mike Wall and the team have exceeded their recruitment target of 60 patients, with a total of 96 recruits so far. The team have been named the best opening site and top recruiting site for the study.

Dr Craig Barr and his research nurses recruited 13 patients, reaching recruitment target in two clinic days for the First Kind Geko Pacemaker Interaction Trial.

The median days for study set up is 40 days for commercial studies and 21 days for non-commercial studies.

Enhancing research capability and collaborative working

Aston University - Dr Julian Hobbs and R&D are leading the Trust in an exciting collaboration with Aston University, seeking to promote, extend and grow research across the Trust. First talks have taken place between both organisations, to discuss how we can work together. A second visit to ASTON University has been arranged for 15th March 2022.

AHP Student Placements - Since the beginning of November 2021, R&D have been host to a rotation of Physiotherapy AHP students from Wolverhampton and Birmingham Universities. Research nurses (Kath Harrow and Karen Pearson) designed a 2-week training programme for students, to develop their knowledge and understanding of clinical research. Appendix 2 shows some of the excellent feedback we have received from the students.

Funding Bids - We were unsuccessful in our CRN WM Innovation & Improvement Strategic funding bid (to enhance research capability in general practice by enabling two GP trainees to undertake a Masters in Research (MRes) degree)

Home-Grown research - We have a number of exciting 'home-grown' research projects in the pipeline:

- **Colorectal cancer biomarker**, proof of concept study, due to commence 2022, Mr A Akinboye (pending laboratory equipment to arrive).
- **Infra-red intervention trial**, Mr M Reay, currently developing protocol, entitled DuPARDS. Grant application March 2022.
- **OBVIOUS 2, Mr Michael Wall,** a questionnaire-based study to gather patient's feedback on their vascular disease from a weight loss clinic.

Staffing - We have appointed a full time 8b Clinical Trials Pharmacist (due to commence April 2022), to manage and facilitate all pharmacy related trials. This is a development opportunity to become Consultant Pharmacist, to enable pharmacy-led trials in the future. The infrastructure within the department has undergone review and, as a result of adapting to new ways of working, the Clinical Research Assistant (CRA) role has been introduced and proven successful with the SIREN study and will become embedded within the new department structure (two vacancies currently awaiting interview); Three Research Nurses vacancies (one appointed to, two out to advert currently)

Publications

Please see appendix 3 for research publications list from January 2021 to December 2021.

Summary

Research awareness across the Trust has significantly improved because of COVID 19, both for the wider public as well as staff. This response may influence future participation in research studies. The commitment and determination from staff within the department enabled us to adapt quickly and effectively in the implementation of COVID 19 studies.

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

Name of Authors: Dr Jeff Neilson, Dr Gail Parsons, Claire Phillips, Helen Hollis.

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

Date report prepared 17/02/2022

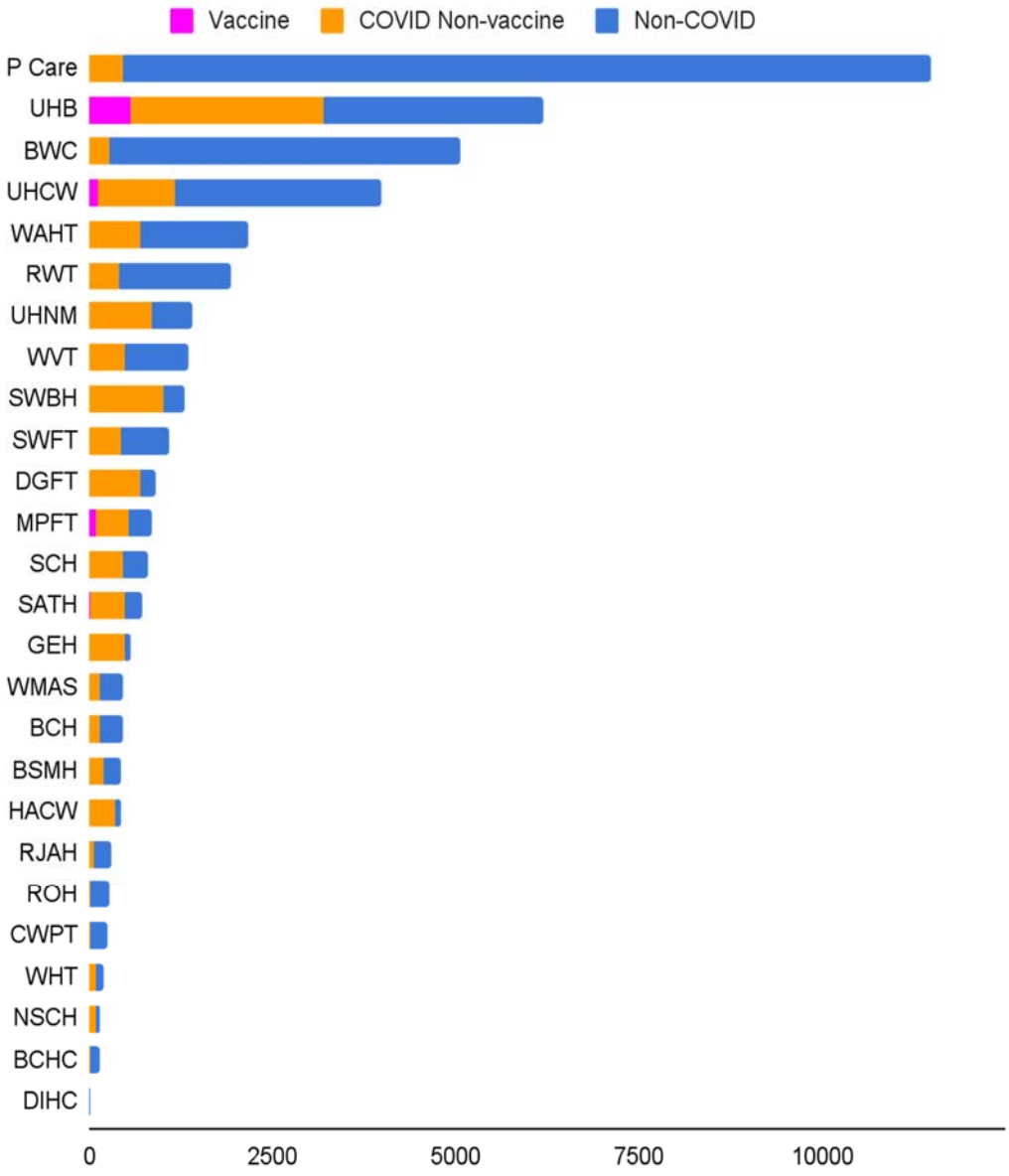
APPENDICES:

Appendix 1 – Trust Reports compared to WM Trusts

Appendix 2 - Physiotherapy Student R&D Placement Feeback

Appendix 3 – Research Publications – January 2021 – December 2021

Appendix 1 - Trust Reports compared to WM Trusts



Appendix 2 - Physiotherapy Student R&D Placement Feedback

The Dudley Group
NHS Foundation Trust

Appendix 3
Published research - January to December 2021

1. Abdullah, M. (2021). "Does ultrasound quantification of suspicious axillary nodes correlate with pathological results?" British Journal of Surgery **108**.

2. Abdullah, M., et al. (2021). "Does 'fast - track' axillary node clearance following positive core biopsy lead to overtreatment of axilla?" The surgeon : journal of the Royal Colleges of Surgeons of Edinburgh and Ireland **19**(3): 135-141.

3. Agarwal, M., et al. (2021). "Wilson disease tissue classification and characterization using seven artificial intelligence models embedded with 3D optimization paradigm on a weak training brain magnetic resonance imaging datasets: a supercomputer application." Medical and Biological Engineering and Computing **59**(3): 511-533.

4. Agrawal, S. and C. Sellahewa (2021). "Evaluating the impact of COVID-19 on the trend of emergency laparoscopic cholecystectomy." British Journal of Surgery **108**.

5. Ahmad, A. N., et al. (2021). "Identifying the barriers and the solutions to surgical endoscopy training. A national online survey of UK trainee experience." Colorectal Disease **23**: 66-67.

6. Ahmad, A. N., et al. (2021). "Is it feasible for Surgical Trainees to acquire JAG endoscopy accreditation by CCT? A national online survey of UK trainee experience." Colorectal Disease **23**: 66.

7. Ahmad, N. Z., et al. (2021). "A Meta-analysis of Transanal Endoscopic Microsurgery versus Total Mesorectal Excision in the Treatment of Rectal Cancer." Surgery journal (New York, N.Y.) **7**(3): e241-e250.

8. Ahmad, W., et al. (2021). "Acute Cholestatic Liver Injury Due to Ciprofloxacin in a Young Healthy Adult." Cureus **13**(2): e13340.

9. Ahmed, I. S. H., et al. (2021). "The Postnatal Growth and Retinopathy of Prematurity Model: A Multi-institutional Validation Study." Ophthalmic Epidemiology: 1-6.

10. Ahmed, M., et al. (2021). "Colocutaneous fistula following Clostridioides difficile infection managed as an a autocolostomy': A novel approach to a recognised complication." BMJ Case Reports **14**(4).

11. Ahmed, S., et al. (2021). "Comorbidities in rheumatic diseases need special consideration during the COVID-19 pandemic." Rheumatology International **41**(2): 243-256.

12. Ahmed, S., et al. (2021). "COVID-19 and the clinical course of rheumatic manifestations." Clinical Rheumatology.

13. Ahmed, Z. S., et al. (2021). "De Garengeot's hernia in an elderly woman as a diagnostic challenge: A review of literature." BMJ Case Reports **14**(1).

14. Akingboye, A. and A. Chaudhuri (2021). "A Dedicated Lightweight Titanized Mesh Prevents Incisional Hernias After Open Abdominal Aortic Aneurysm (AAA) Repair: Results of an Initial Prospective Cohort Study." Cureus **13**(5): e14821.

15. Akingboye, A. and F. Mahmood (2021). "Intracorporeal stapled ileocolic anastomosis with mechanical closure of the enterotomy after laparoscopic right colectomy for cancer: Keep it Simpler." Updates in surgery **73**(1): 357-358.

16. Akingboye, A., et al. (2021). "Outcomes From Routine Use of Intraoperative Cholangiogram in Laparoscopic Cholecystectomy: Factors Predicting Benefit From Selective Cholangiography." Cureus **13**(1): e12555.

OBJ

17. Akingboye, A., et al. (2021). "Increased risk of COVID-19-related admissions in patients with active solid organ cancer in the West Midlands region of the UK: A retrospective cohort study." BMJ Open **11**(12).

18. Akingboye, A., et al. (2021). "Effect of low-pressure pneumoperitoneum on cardio-respiratory physiology during elective Laparoscopic Colorectal surgery (ELCS) in facilitating ERAS during the COVID19 Pandemic." Colorectal Disease **23**: 132.

19. Akingboye, A. A., et al. (2021). "Risk of COVID-19 related admissions in cancer patients in a UK metropolitan region." Colorectal Disease **23**: 113.

20. Akingboye, A. A., et al. (2021). "Early versus delayed (interval) appendicectomy for the management of appendicular abscess and phlegmon: a systematic review and meta-analysis." Langenbeck's Archives of Surgery.

21. Al-Najjar, Y., et al. (2021). "Three changes to reduce the loss of dual degree trainees from OMFS national specialty selection in the UK: evidence based proposals." British Journal of Oral and Maxillofacial Surgery.

22. Albéniz, E., et al. (2021). "Cricopharyngeal peroral endoscopic myotomy for achalasia of the cricopharynx: "to do or not to do"." Endoscopy.

23. Albeniz, E., et al. (2021). "Cricopharyngeal peroral endoscopic myotomy for achalasia of the cricopharynx: To do or not to do." Endoscopy.

24. Ali, S. A., et al. (2021). "A Pattern of Antibiotic Resistance in Gram-Negative Rods Causing Urinary Tract Infection in Adults." Cureus **13**(1): e12977.

25. Alnajjar, F. A. (2021). "The expression and function of metastases associated lung adenocarcinoma transcript-1 long non-coding RNA in subchondral bone and osteoblasts in osteoarthritis patients." Osteoarthritis and Cartilage **29**.

26. Anyfanti, P., et al. (2021). "Monitoring and Managing Cardiovascular Risk in Immune Mediated Inflammatory Diseases." Journal of Inflammation Research **14**: 6893-6906.

27. Arshad, F., et al. (2021). "Orthopaedic Trauma Theatre Efficiency in the COVID-19 Pandemic: Are We Returning to Normality?" Cureus **13**(2): e13221.

28. Arvanitaki, A., et al. (2021). "Nailfold videocapillaroscopy: a novel possible surrogate marker for the evaluation of peripheral microangiopathy in pulmonary arterial hypertension." Scandinavian Journal of Rheumatology **50**(2): 85-94.

29. Asselta, R., et al. (2021). "X Chromosome Contribution to the Genetic Architecture of Primary Biliary Cholangitis." Gastroenterology **160**(7): 2483.

30. Awasthi, A., et al. "Enhanced neoplasia detection in chronic ulcerative colitis: the ENDCaP-C diagnostic accuracy study."

31. Bechman, K., et al. (2021). "Nonserious Infections in Patients With Rheumatoid Arthritis: Results From the British Society for Rheumatology Biologics Register for Rheumatoid Arthritis." Arthritis and Rheumatology **73**(10): 1800-1809.

32. Bendall, O., et al. (2021). "Delayed Bleeding After Endoscopic Resection of Colorectal Polyps: Identifying High-Risk Patients." Clinical and Experimental Gastroenterology **14**: 477-492.

33. Bhamra, N., et al. (2021). "The impact of coronavirus disease 2019 on suspected head and neck cancer two-week-wait referrals." Journal of Laryngology and Otology.

34. Bhojwani, A., et al. (2021). "Challenges in the management of lower gastrointestinal bleeding in general surgery: Developing consistent practice and application of BSG guidelines." British Journal of Surgery **108**.

OBJ

35. Bhojwani, A., et al. (2021). "Implementing European Randomised Study of Screening for Prostate Cancer Risk calculator 3 (ERSPC RC3): A comparative study of cognitive, fusion and template prostate biopsy in the UK." Journal of Clinical Urology **14**(1): 6-7.

36. Bhojwani, A., et al. (2021). "Comparison of magnetic resonance imaging cognitive prostate biopsy versus magnetic resonance imaging-ultrasound fusion prostate biopsy in the detection of prostate cancer." British Journal of Surgery **108**.

37. Biswas, M., et al. (2021). "A Review on Joint Carotid Intima-Media Thickness and Plaque Area Measurement in Ultrasound for Cardiovascular/Stroke Risk Monitoring: Artificial Intelligence Framework." Journal of digital imaging **34**(3): 581-604.

38. Boger, P., et al. (2021). "Endoscopic full thickness resection in the colo-rectum: Outcomes from the UK Registry." European Journal of Gastroenterology and Hepatology: 852-858.

39. Bowen, J., et al. (2021). "The impact of whole hospital gsf implementation at the dudley group nhs foundation trust during covid." Palliative Medicine **35**(1): 173.

40. Brady, S. M., et al. (2021). "Different types of physical activity are positively associated with indicators of mental health and psychological wellbeing in rheumatoid arthritis during COVID-19." Rheumatology International **41**(2): 335-344.

41. Bravo, L., et al. (2021). "Machine learning risk prediction of mortality for patients undergoing surgery with perioperative SARS-CoV-2: The COVIDSurg mortality score." British Journal of Surgery **19**(4).

42. Bruce, A., et al. (2021). "Safety and Efficacy of Bipolar Transurethral Resection of the Prostate vs Monopolar Transurethral Resection of Prostate in the Treatment of Moderate-Large Volume Prostatic Hyperplasia: A Systematic Review and Meta-Analysis." Journal of Endourology **35**(5): 663-673.

43. Bud, E. S., et al. (2021). "Observational Study Regarding Possible Side Effects of Miniscrew-Assisted Rapid Palatal Expander (MARPE) with or without the Use of Corticopuncture Therapy." Biology **10**(3).

44. Calcara, C., et al. (2021). "Water immersion sigmoidoscopy versus standard insufflation for colorectal cancer screening: A cohort study." Saudi journal of gastroenterology : official journal of the Saudi Gastroenterology Association.

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46. Chan, A., et al. (2021). "Seven-day clinical standards and ultrasound in emergency gynaecology-are we achieving the target?" BJOG: An International Journal of Obstetrics and Gynaecology **128**: 122.

47. Chan, A. K. Y., et al. (2021). "Transvaginal Evisceration of the Small Bowel More Than 15 Years After Abdominal Hysterectomy and Vaginal Surgery." Cureus **13**(3): e13955.

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Enclosure 13

The Dudley Group NHS Foundation Trust

Paper for submission to the Board of Directors on 10 March 2022

Title:	**Exception Report from the Finance and Performance Committee Chair**
Author:	Jonathan Hodgkin, Non-executive Director
Presenter:	Jonathan Hodgkin, Non-executive Director

Action Required of Committee / Group			
Decision	**Approval**	**Discussion**	**Other**
N	N	Y	N

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.

Summary of Key Issues:

Summary from the Finance and Performance Committee meeting held on 28 February 2022.

Impact on the Strategic Goals *(indicate which of the Trust's strategic goals are impacted by this report)*	
Deliver right care every time	
Be a brilliant place to work and thrive	
Drive sustainability (financial and environmental)	**Y**
Build innovative partnerships in Dudley and beyond	
Improve health and wellbeing	

The Dudley Group
NHS Foundation Trust

Implications of the Paper: *(complete all sections including the Corporate Risk Register and/or the Board Assurance Framework)*			
Risk	N	Risk Description:	
	On Risk Register: N	Risk Score:	
Compliance and/or Lead Requirements	CQC	Y	Details: Well Led
	NHSE/I	Y	Details: Achievement of financial and performance targets
	Other	Y	Details: Value for money

Report Journey/ Destination *(if applicable)*	Working / Exec Group	N	Date:
	Committee	N	Date: 28/02/22
	Board of Directors	Y	Date: 10/03/22
	Other	N	Date:

EXCEPTION REPORT FROM FINANCE AND PERFORMANCE COMMITTEE CHAIR

The Dudley Group NHS Foundation Trust

Meeting held on: 28 February 2022

MATTERS OF CONCERN OR KEY RISKS TO ESCALATE	MAJOR ACTIONS COMMISSIONED/WORK UNDERWAY
• Continued high agency spend – highest to date – of which 75% qualified nursing. Bank also high, but distorted by bonus payments • Concern raised about the reliability and accuracy of our vacancy data and mismatch between ledger information and the Electronic Staff Record • Significant potential deficit in 2022/23 of the order of £20m, highlighting the need to reduce the cost base • Triage remains challenging and there is insufficient assurance around performance • Breast 2WW is the main area of concern for cancer	• James Fleet and Adam Thomas to revert to the Executive with a costed plan for how to progress with the Electronic Staff Record • Richard Price to draft template to be attached to business cases
POSITIVE ASSURANCES TO PROVIDE	**DECISIONS MADE**
• Excluding the impairment in relation to the asset value of the Rainbow Unit, remain on plan with a cumulative surplus of £42k • System reforecast has identified £23.3m surplus, of which our share is £3.8m which will be delivered following receipt of a similar amount from the CCG • £8m received for ERF performance in H2, plus additional payments in relation to untaken leave and international nurse recruitment • Trust has fully met the CNST targets resulting in a £871k rebate • Following additional allocations from CCG year end cash forecast has improved by £15m to £25m	• Recommended to Board for approval: o Extension of the mobile CT/MRI scanner contracts at a maximum revenue cost of £2.72m, financed externally o The Trust's year 2 to 5 plans for the Community Diagnostics Centre and associated bid for external funding o Pharmacy robot replacement at a capital cost of £1.125m o £1.3m increase in the cost of the North Block fire protection works o Nursing and midwifery international recruitment business case with a non-recurrent cost of £3m generating savings of £1m a year from 2023/24, subject to the provision of clear, monitored and delivered targets for the reduction and the elimination of agency and clarifying our vacancy position

Chair's comments on the effectiveness of the meeting: Efficient meeting but concerns raised again by NEDs about the quality of business cases and the length and complexity of papers

Enclosure 14

The Dudley Group NHS Foundation Trust

Paper for submission to the Board of Directors on 10th March 2022

Title:	7DS Update
Author:	Dr Paul Hudson, Deputy Medical Director
Presenter:	Dr Julian Hobbs, Medical Director

Action Required of Committee				
Decision	**Approval**	**Discussion**	Y	**Other**

Recommendations:

The board is asked to note the progress to embed 7 Day Service standards across the Trust and the use of the job planning governance framework to seek assurance on the standards.

Summary of Key Issues:

The 7 Day Service Standards were first introduced in 2013 by NHS Improvement as 10 standards of which four were identified as clinical priorities in 2016 based on their potential to positively affect patient outcomes. It is against these which the Trust has previously been assessed through a Board Assurance Framework (BAF). This process was stood down during the pandemic, however we continue to monitor the progress as part of our quality standards. There is no requirement to report formally externally.

The Trust is compliant with a small number of specialities (Endocrinology, Respiratory and Critical Care) working to achieve daily consultant review standards. The Trust job planning governance framework has been utilised to provide assurance of compliance. Radiology standards are compliant, although further work is required to ensure compliance with standard 5 for all modalities specifically CT and MRI.

Impact on the Strategic Goals

(indicate which of the Trust's strategic goals are impacted by this report)

Deliver right care every time	**x**
Be a brilliant place to work and thrive	
Drive sustainability (financial and environmental)	
Build innovative partnerships in Dudley and beyond	

Improve health and wellbeing	

Implications of the Paper: *(complete all sections including the Corporate Risk Register and/or the Board Assurance Framework)*			
Risk	N	Risk Description: *Inc risk ref number*	
	On Risk Register: N	Risk Score:	
Compliance and/or Lead Requirements	CQC	Y	Details: Safe
	NHSE/I	N	Details:
	Other	N	Details:

Report Journey/ Destination *(if applicable)*	Working / Exec Group	N	Date:
	Committee	N	Date:
	Board of Directors	Y	Date: March 2022
	Other	N	Date:

REPORTS FOR ASSURANCE

Report to Board of Directors March 2022

1 EXECUTIVE SUMMARY

The 7 Day Service Standards were first introduced in 2013 by NHS Improvement as 10 standards of which four were identified as clinical priorities in 2016 based on their potential to positively affect patient outcomes. It is against these which the Trust has previously been assessed through a Board Assurance Framework (BAF). This process was stood down during the pandemic, however we continue to monitor the progress as part of our quality standards. There is no requirement to report formally externally.

The Trust is compliant with a small number of specialities (Endocrinology, Respiratory and Critical Care) working to achieve daily consultant review standards. The Trust job planning governance framework has been utilised to provide assurance of compliance. Radiology standards are complaint, although further work is required to ensure compliance with standard 5 for all modalities specifically CT and MRI.

This paper will outline progress made to date and will update on progress to embed the standards.

2 BACKGROUND INFORMATION

The 7DS programme aim is to provide a standard of consultant led care to all patients presenting urgently or as an emergency such that their outcomes are optimised and there is equity of access nationwide but also outcomes are not dependant on the time of day or day of the week patients present.

The Four Priority Clinical Standards

Standard 2 - Time to first Consultant review- within 14 hours of admission for all non-elective patients

Standard 5 - Access to diagnostic tests - ultrasound, computerised tomography (CT), magnetic resonance imaging (MRI), echocardiography, endoscopy, and microbiology.

- Within 1 hour for critical patients
- Within 12 hours for urgent patients
- Within 24 hours for non-urgent patients

Standard 6 - Access to consultant directed interventions - Critical Care, Interventional Radiology, Interventional Endoscopy, Emergency Surgery, Emergency Renal Replacement Therapy, Urgent Radiotherapy, Stroke Thrombolysis, Percutaneous Coronary Intervention and Stroke Thrombolysis

Standard 8 - Ongoing review by consultant twice daily if high dependency patients, daily for others

Summary of results

By March 2020 NHS England expected all Trusts in the country to be 90% compliant with the 4 clinical standards. The Trust reported in June 2020 that these standards had been achieved.

Assurance of these standards is now sought from the Trust job planning governance framework. To date 95% of specialities have presented their current job plans to a consistency panel where the provision of 7-day service standards is assessed. Compliance is required for plans to be formally signed off.

Standard 2 and Standard 8

We have achieved 92% for standard 2 and for standard 8 94% for once daily review and 87% for twice daily reviews. These results reflect data prior to Covid-19 so will have improved now due to the change in the ED pathway to ensure all patients are seen by a Medical Consultant prior to admission.

Outstanding issues:

Endocrinology

Due to staffing issues the service is partially compliant and are reliant on the current consultant body undertaking additional sessions to provide the required cover. A business case has been approved for additional resource.

Respiratory

Compliance has been impacted by changes in the workforce and the disproportionate burden on the service during the pandemic. A team job planning meeting was held in February 2022 to develop a consultant of the week model and posts to support this are currently out to advert.

ITU

The job planning consistency panel identified 87% compliance for twice daily consultant review. Work is underway to rationalise the footprint of critical care to achieve compliance with a combined critical care, surgical high dependency unit and medical high dependency unit in one footprint**.**

Standard 5 and 6

Full compliance with standard 6 has always been achieved.

A further audit of standards 5 and 6 was undertaken in Autumn 2020 reviewing all inpatient CT/MRI/Ultrasound and Interventional Radiology requests throughout August 2020. It should be noted that significant progress has been made since the launch of the 7DS standards and this audit identified 76% of urgent inpatient CT scans were undertaken and reported in 24 hours and 98% of all CT scans (routine and urgent) completed in 48 hours. 2 out of 3

patients requiring urgent MRI scans were competed in 48 hours. A high level of compliance was reported in the audit with a requirement for additional scanning capacity to further enhance the performance against the standards.

The Trust sought further assurance on compliance through internal audit with the report providing partial assurance against the standards and highlighted Priority Standard 5 (Diagnostics) as reflecting the availability of services and not the delivery of reporting within the set timescales. Considerable work has been undertaken and compliance against standard 5 is monitored and reported in real time via a power BI report and via the Medical Directors dashboard. At the time of writing current compliance is 92.4% for all of radiology . Further work is required for compliance against all modalities specifically CT and MRI.

All actions recommended by RSM have been completed and closed.

3 RISKS AND MITIGATIONS

As identified in this paper, compliance in a small number of specialities is being monitored with plans in place to address the risk to compliance. This will continue to be monitored via the job planning process.

4 RECOMMENDATION

The board is asked to note the progress to embed 7 Day Service standards across the Trust and the use of the job planning governance framework to seek assurance on the standards.

Dr Paul Hudson
Deputy Medical Director
02/03/22

Enclosure 15

The Dudley Group NHS Foundation Trust

Paper for submission to Trust Board on 10th March 2022

Title:	IPR Report for January 2022
Author:	Simon Illingworth, Deputy Chief Operating Officer
Presenter:	Karen Kelly, Chief Operating Officer

Action Required of Committee / Group			
Decision	**Approval**	**Discussion**	**Other**
		x	

Recommendations:

This report summarises the Trusts performance against national standards and local recovery plans for the month of January 2022.

The Committee is asked to note performance and next steps

Summary of Key Issues:

Key Areas of Success

Performance has remained stable across a number of key metrics. Whilst maintaining performance is not our ambition (we want to improve delivery against current standards) the Trusts ability to maintain service delivery despite challenging environmental factors should be seen as positive. We have maintained a strong position with regards to ED 4 hours compared to our regional peers and our delivery of the DM01 standards remains strong.

Breast services have remained under considerable pressure. Despite more patients waiting longer than we would like for their 2ww appointment, over 85% of patients received their treatment within 62 days in December. The number of patients waiting over 104 days at Dudley for cancer treatment has also fallen, ahead of trajectory.

Surgery Women and Children's Division have struggled to improve VTE performance but a recent audit, presented at Quality and Safety Committee in February, suggests that performance against the 12 hour VTE standard has reached 95% following a detailed review of the data being used to monitor this metric.

Key Areas of Concern

ED Triage across both Majors and Paeds remains below standard. Despite variation week to week improvements are not being sustained over the month leading to poor performance. The Executive Team continue to receive weekly assurance reports and the operational teams from ED are now attending Weekly Operations Meeting to provide updates on progress with greater oversight. There is a trajectory for improvement between now and end of April 2022. In addition the Matron and Deputy Matron have now taken direct control for improvement.

Ambulance handovers continue to affect the Trust. Improvements remain inconsistent with high variation in performance day to day. There are particular problems overnight and in the early evening around 6pm. There is a strong focus on improving handover delays at all Trusts in England and plans at Dudley remain focussed Home for Lunch as well as utilisation of Same Day Emergency Care (SDEC).

Emergency Access Standard (EAS)

Delivery of the four hour standard remains stable, with little material change on previous months. Dudley remains 5th across the West Midlands for delivery against the 4 hour standard.

There have been nineteen 12 hour breaches in January. This is down from 28 in December but remains disappointing given the hard work of the team to improve matters. The team have a strong commitment to eradicating all 12 hour trolley waits but, as with ambulance delays, performance improvements are inconsistent so we need to strengthen those actions being taken. New ED performance measures are expected to come into force from April and a renewed focus will be required on waits in ED.

Cancer

There has been a reduction in the number of patients waiting over 104 days for treatment at Dudley and Skin 2ww compliance has significantly improved over recent weeks. Breast 2ww remains the most significant area of concern although recent changes to IPC standards means that capacity can be increased in Breast outpatients.

Delivery of the 62 day treatment standard was achieved in Breast and was very nearly delivered in Skin despite performance around 2ww. Key tumour sites for 62 day improvement are Colorectal and Urology. All tumour sites have received a pathway review and are having 121 meetings to agree improvement trajectories.

Referral to Treatment (RTT), Clock Stops & 52 Weeks

There continues to be a reduction in the number of patients waiting over 52 weeks and while this is not as fast as the trajectory, looking into February there were 660 patients waiting over 52 weeks down from over 800 in the middle of January.

The number of clock stops continues ahead of trajectory, largely driven by data validation but with continued strong performance through admitted clock stops, reflecting the high volume of elective work which we have continued to deliver during Winter.

DM01

DM01 continues to perform well, across all main Radiology modalities. Sleep Studies remains the most significant area of concern and there is an action plan, which requires additional kit to be installed, in place to correct performance from April onwards.

Impact on the Strategic Goals *(indicate which of the Trust's strategic goals are impacted by this report)*	
Deliver right care every time	**X**
Be a brilliant place to work and thrive	
Drive sustainability (financial and environmental)	**X**
Build innovative partnerships in Dudley and beyond	
Improve health and wellbeing	

Implications of the Paper: *(complete all sections including the Corporate Risk Register and/or the Board Assurance Framework)*			
Risk	Y	Risk Description: 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	
	On Risk Register: Y	Risk Score: 15	
Compliance and/or Lead Requirements	CQC	Y	Details: Compliance with Quality Standards for safe & effective care
	NHSE/I	Y	Details: Achievement of National Performance and Recovery targets
	Other	Y	Details:

Report Journey/ Destination *(if applicable)*	Working / Exec Group	N	Date:
	Committee	Y	Date: F&P 28/02/22
	Board of Directors	Y	Date: 10/03/22
	Other	N	Date:

Performance KPIs

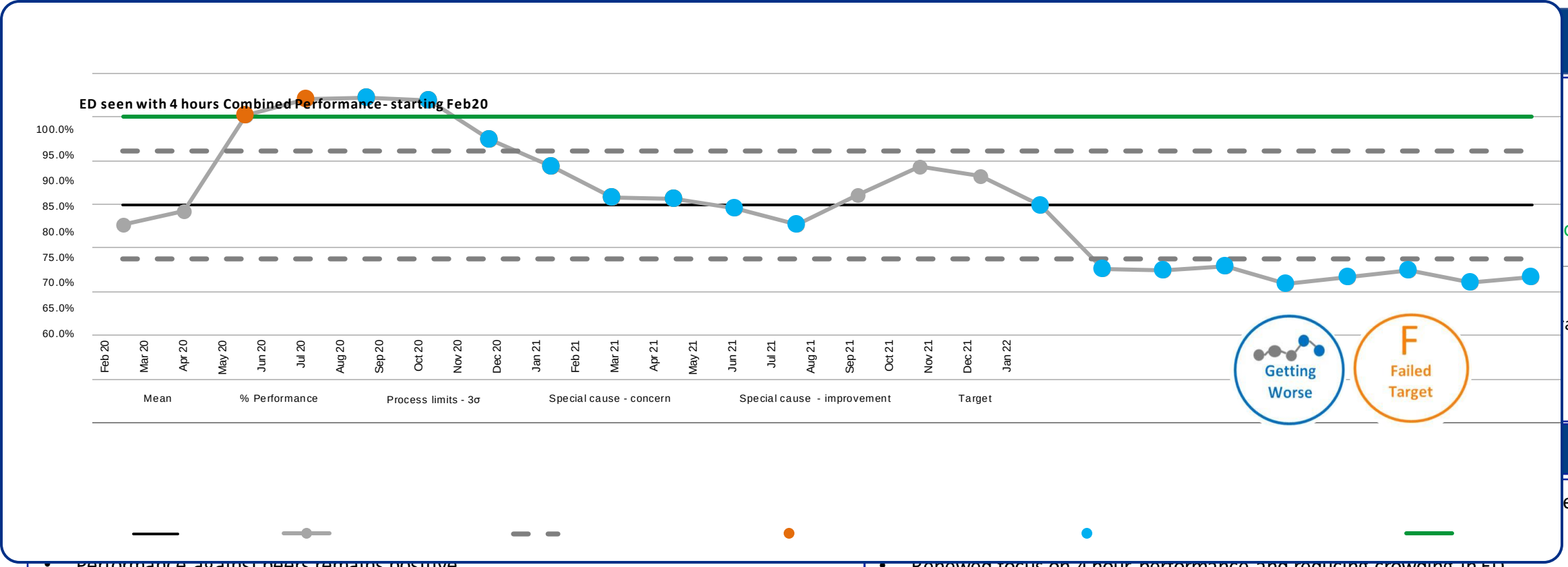
February 2022 Report (January 2022 Data)

Karen Kelly, Chief Operating Officer

NHS
The Dudley Group
NHS Foundation Trust

Constitutional Performance

Constitutional Standard and KPI		Target	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Status	
Emergency Access Standard (EAS)	Combined 4hr Performance	95.0%	84.9%	77.6%	77.4%	77.9%	75.9%	76.7%	77.4%	76.1%	76.7%	Getting Worse	F Failed Target
Triage	Triage - All	95.0%	92.3%	89.1%	87.4%	87.8%	83.0%	80.9%	86.9%	89.2%	88.2%	L	F Failed Target
Cancer	Cancer 62 Day - Urgent GP Referral to Treatment	85.0%	64.9%	79.5%	67.9%	80.8%	64.4%	56.2%	68.1%	62.1%	N/A	In normal range	F Failed Target
	Cancer 31 Day -	96.0%	94.3%	95.6%	92.9%	86.6%	87.8%	91.5%	96.8%	90.0%	N/A	In normal range	F Failed Target
	All Cancer 2 Week Waits	93.0%	93.9%	92.7%	93.0%	78.9%	52.3%	53.2%	63.0%	67.4%	N/A	L	F Failed Target
Referral to Treatment (RTT)	RTT Incomplete	92%	78.4%	79.4%	78.8%	77.3%	76.1%	75.9%	75.9%	74.9%	73.7%	In normal range	F Failed Target
Diagnostics	DM01 - Diagnostics achieved within 6 weeks	99%	83.8%	84.9%	83.7%	77.0%	80.2%	77.4%	83.0%	78.1%	76.5%	In normal range	F Failed Target
VTE	% Assessed on Admission	95%	96.3%	96.3%	95.7%	92.1%	90.9%	89.7%	93.7%	89.5%	89.6%	L	F Failed Target



5th

or Jan 22

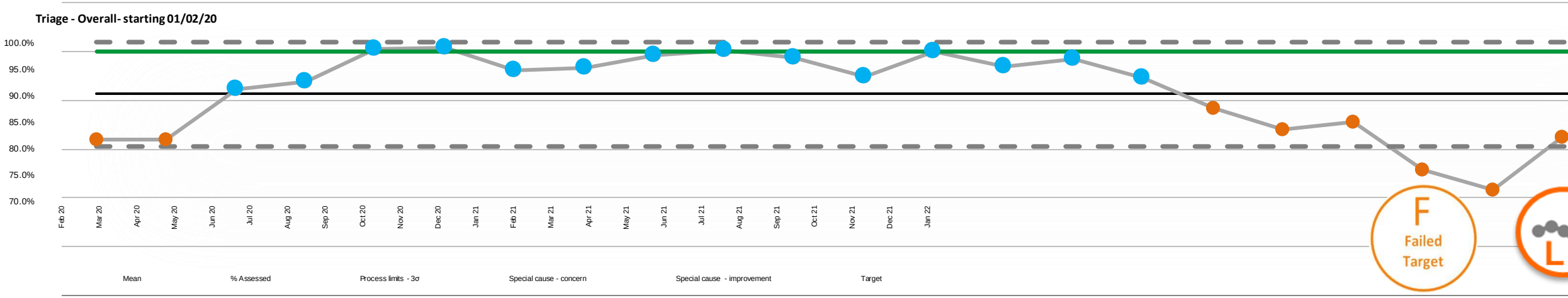
anking out of 13 Midlands area Trusts

eekly ops to

- Performance against peers remains positive
- Attendances in ED remain below pre-pandemic levels
- Ambulance conveyances remain slightly below pre-pandemic demand
- UTC demand remains stable

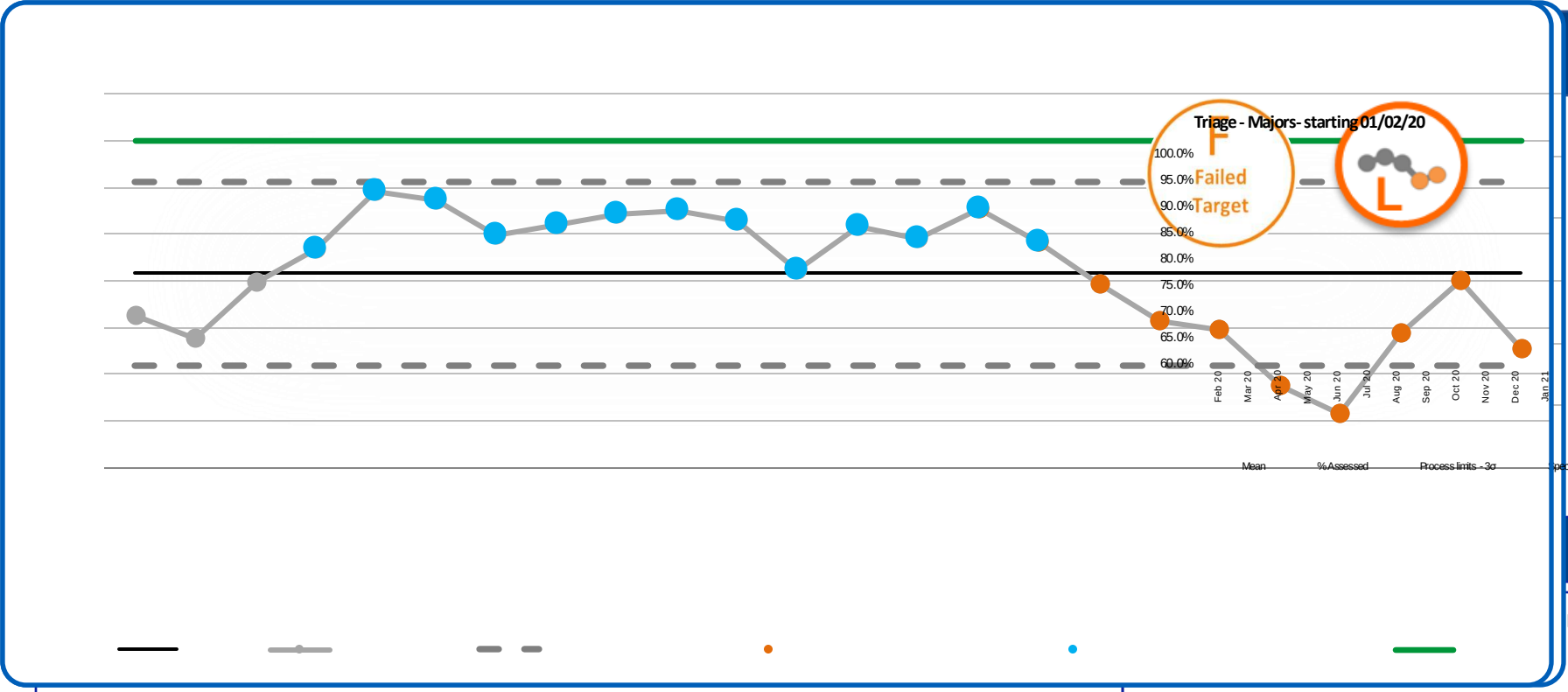
Expected New ED measures for 2022
- Ambulance Handovers within 15 minutes
- Time to initial assessment
- Total time in the department (admitted and non admitted)
- 12 Hours in department
- Clinically ready to proceed

- Renewed focus on 4 hour performance and reducing crowding in ED
- Launch new reporting measures in Trust IPR when they have been confirmed nationally
- External improvement support in place to review referrals to medicine and discharges from ED
- DIP event recommendations to be implemented



- ED triage remains a concern across all areas except ambulance triage which is performing well
- While there has been a gradual improvement across all measure delivery remains inconsistent especially in Major and Paeds
- The team remain committed to improve triage performance across all domains and intend to see rapid improvement March, reaching the 90% for majors by middle of March and 95% by start of April

- Weekly reporting remains in place with Execs
- Reinforce with teams that triage can be completed quickly to prevent delays
- Regular Focus Groups with Nursing & Medics Focusing on Roles & Responsibilities
- Review & Monitor Triage time (time spent with Triage Nurse)
- ESI training and Continue with staff development
- Review UCC Streaming Model to ensure that the right patients are being streamed to ED



Latest Month

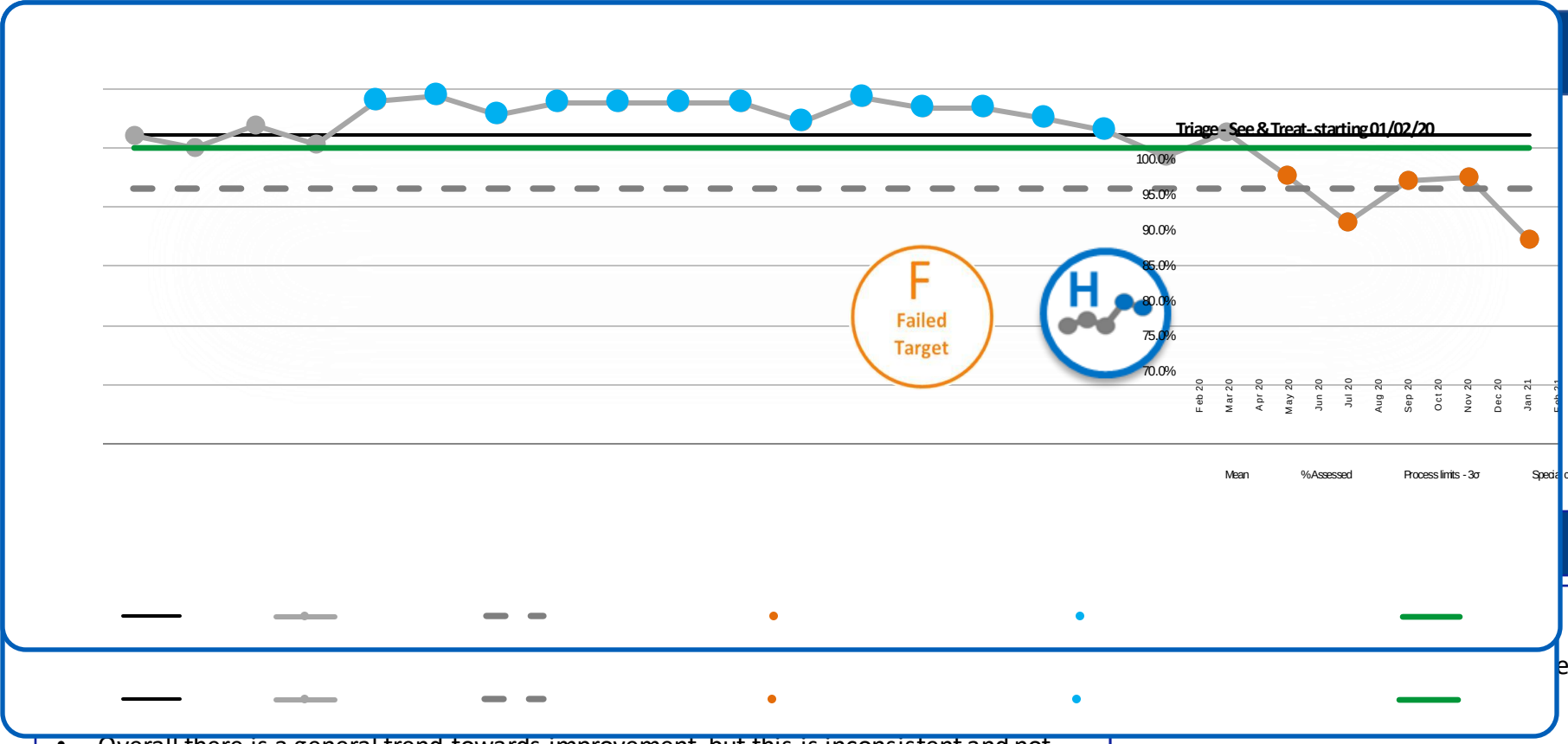
72.7%

- Ambulance triage remains stable and above the required threshold
- Staff availability resulting from sickness and recruitment have caused some issues with compliance

Action

major back up to required 95% standard as soon as

- Matron and Deputy Matron now taking ownership of improvement actions
- Increased scrutiny with ED team reporting directly to Senior Ops Team weekly operations meeting
- Reinforce that triage can be completed quickly to prevent delays
- Identify and provide assurance around utilising alternative pathways
- New Layout to be agreed and implemented in Majors Triage
- Regular Focus Groups with Nursing & Medics Focusing on Roles & Responsibilities
- Review & Monitor Triage time (time spent with Triage Nurse)
- Ad hoc allocate staff to support away from other tasks as necessary



Latest Month

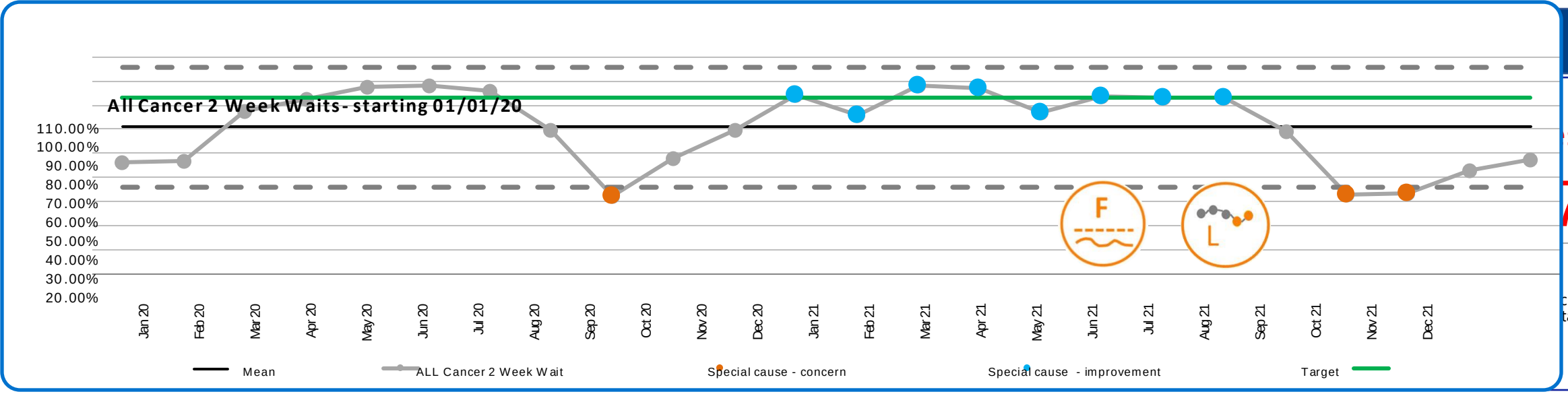
87.3%

Action

e completed quickly to prevent delays

- Overall there is a general trend towards improvement but this is inconsistent and not sufficient to meet the standard

- New Layout to be agreed and implemented in Majors Triage
- Regular Focus Groups with Nursing & Medics Focusing on Roles & Responsibilities
- Review & Monitor Triage time (time spent with Triage Nurse)



st Month

7.4%

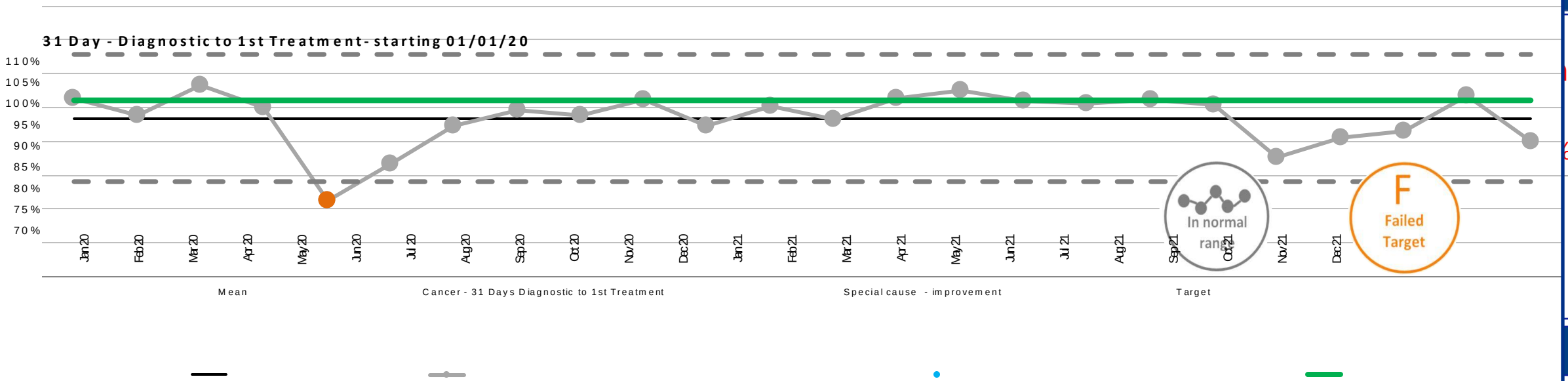
cer 2 week waits – target 93%

Performance

- Slight improvement in 2ww performance in December
- January remained challenged in terms of performance but month to date in February is looking more promising
- Improvement into February is being driven by significant in Skin pathway
- Breast remains challenged but schemes are being worked up to increase capacity including implementation of under 40s pathway
- While 2ww waiting times for breast remain below the standard, delivery of 62 day standard (which is the time that patients actually receive their first treatment) remains strong, achieving 85.7% in December which is above the national standard of 85%
- Urology is also seeing capacity challenges for 2ww and routine capacity is being converted to 2ww

Action

- The Trust remains committed to delivering strong 2ww performance and will plan to deliver 2ww standard across all tumour sites, with the exception of Breast by April 2022.
- Breast is likely to remain challenged until such time as social distancing limits on capacity might be able to be lifted, however additional actions to increase capacity will be implemented including
  - Under 40's pathways
  - Patients waiting in their cars while they wait for their appointment. This has been successfully implemented at other Trusts
  - Additional mutual aid for Breast from across the region
- Current plans are for performance improvements to be seen in Breast by May 2022
- Recent agreement to increase capacity in Breast OPD through relaxation of IPC rules will assist backlog clearance

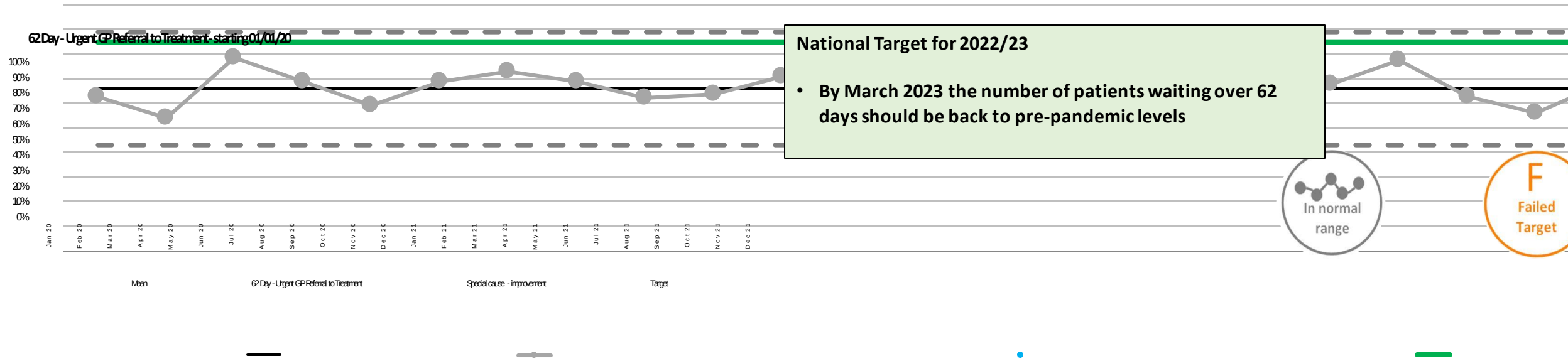


for December 2021

- Performance dipped in December following a period of improvement in the preceding 3 months, down to 90% from circa 96% in November.
- Key tumour sites with longer than desired waits include Skin, Colorectal and Gynaecology.
- January remains challenged with early performance suggesting performance have remained at around 90%
- 15 patients out of 114 waited longer than the standard for this measure during December
- FDS data – performance in this area is related to missing data. Cancer team have been inputting missing data to improve data completeness standards

day pathway

- ✓ Diagnostic and particularly pathology turnaround times to improve to drive performance
- ✓ Maintain cancer PTL
- ✓ Ensure patients are escalated effectively at weekly PTL Meeting



National Target for 2022/23

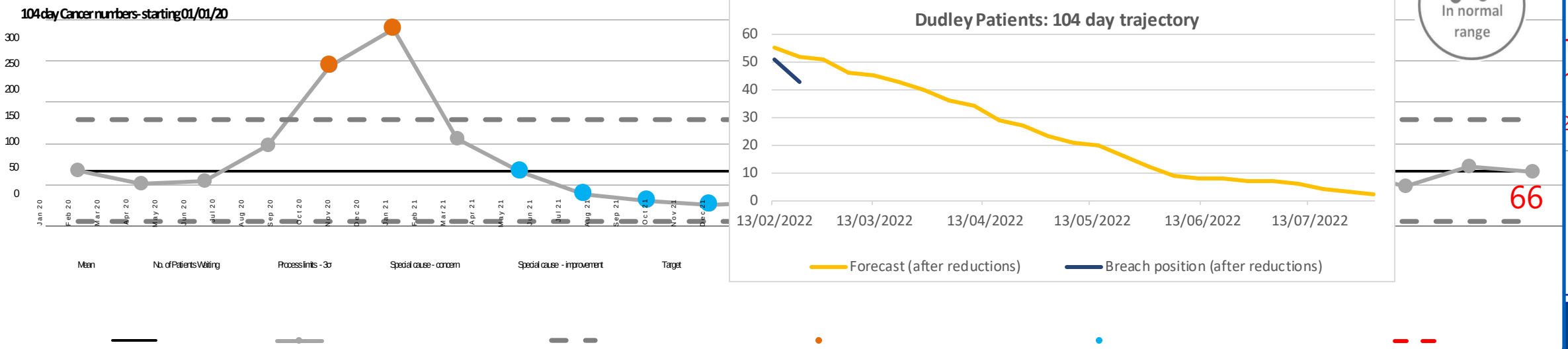
- **By March 2023 the number of patients waiting over 62 days should be back to pre-pandemic levels**

In normal range

F
Failed Target

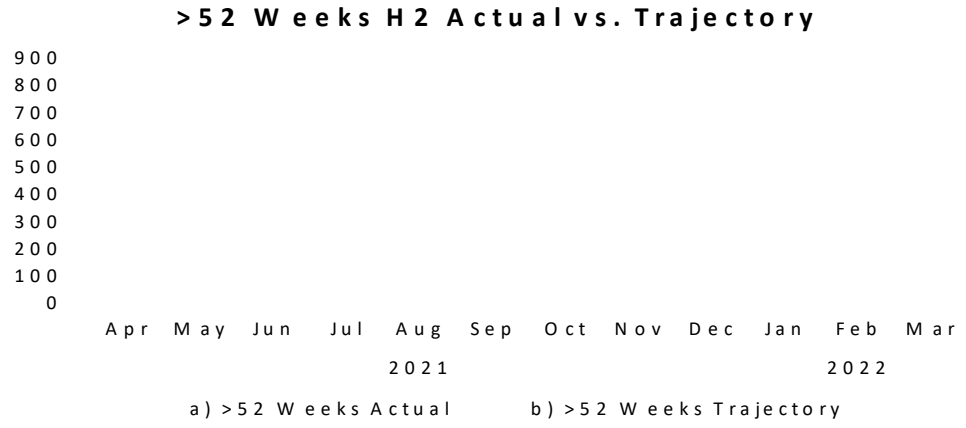
- Validation of Cancer performance figures run at a 2 month lead time. Latest position for December 2021.
- Delivery against the 62 day remains frustratingly static. To improve performance the primary focus must be to reduce the numbers on the 104 day list
- Strongest delivery against for 62 day performance in December was in Breast and Skin (note: these are two of the most challenged tumour sites in regards to 2ww)
- Colorectal and Upper GI had the poorest performance. Colorectal and Upper GI was primarily around access to Endoscopy
- Improvements in Pathology turnaround times is also required

- ✓ The 2022/23 planning guidance's is to reduce the number of patients waiting over 62 days back to pre-pandemic levels by March 2023
- ✓ The ambition for Dudley patients is to move faster on this and, along with the aim to clear to all 104+ days waits by the end of July, we begin delivering against the 62 day standard for all Dudley treatments from September 2022 onwards
- ✓ To deliver this we will
  - Reduce 104 days
  - Continue to maximise capacity in theatres for cancer treatments
  - Reduce length of time from diagnosis and confirmation of cancer to TCI date being given



- Validation of Cancer performance figures run at a 2 month lead time. Graph shows the latest validated month (December 2021) at 66
- Total number of patients waiting over 104 days as set out in this report includes both patients waiting at Dudley as well as those referred from Dudley to tertiary centres.
- As at February 2022 there were 77 patients waiting over 104 days – of which 43 patients are at Dudley and 43 patients are at Tertiary Centres. This is an improvement in those waiting for treatment at Dudley
- Once a patient has been referred to the tertiary centre there is very little that the Trust can do to expedite treatment, but the patient remains on both Trusts PTL.
- The largest volumes of waiters are in Colorectal, Gynaecology and Skin
- The ambition remains to clear all patients waiting for treatment at Dudley with delays over 104 days by July 2022

- ✓ Requirement to reduce numbers waiting over 104 days immediately
- ✓ Action plan in place with clearance / reduction targets agreed at tumour site level
- ✓ Ensure there is separation in counting between those waiting for treatment at Dudley Group and those referred to tertiary centres for treatment and that this is reflected in the trajectory

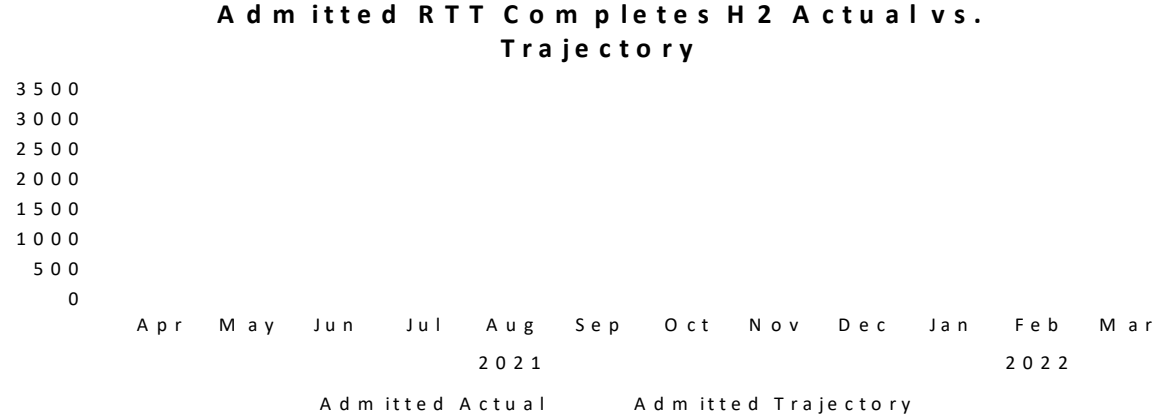


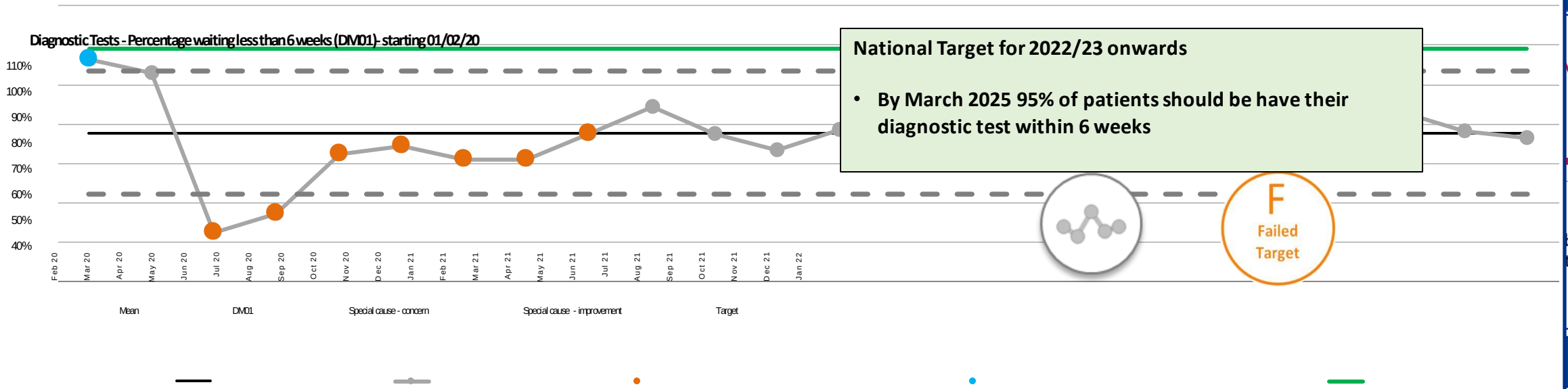
- RTT performance remains stable, although there remains no noticeable improvement in performance
- There recent growth in the overall waiting list has stabilised, suggesting that performance has now turned a corner however the overall waiting list remains significantly higher than pre-pandemic levels so improvement will be marginal initially
- The number of 52 week waiters continues to fall, albeit much more slowly than planned. Ambition is that all 52 week waits will be cleared by summer 2022. This is 30 months ahead of the national requirement of 2025.

National Targets for 2022 onwards for elective care are set out below

- July 2022 : no one will wait more than 2 years
- April 2023: to over 18 month waits
- March 2024: No over 65 week waits
- March 2025: No over 52 week waits
- Delivery between 104% and 110% of pre-pandemic elective activity levels

- Continue to monitor plans against the trajectory
- Increase rate of clearance for 52 week waits now and between now and April
- Ensure private sector capacity continues to be used and efficiencies are realised from theatres
- Trust on course and with plans to deliver all elective targets ahead of schedule
- Only 1 patient has so far waited more 104 weeks and this was in ENT.


Admitted RTT Completes H2 Actual vs. Trajectory
3500
3000
2500
2000
1500
1000
500
0
Apr
May
Jun
Jul
Aug
Sep
Oct
Nov
Dec
Jan
Feb
Mar
2021
2022
Admitted Actual
Admitted Trajectory



National Target for 2022/23 onwards

- **By March 2025 95% of patients should be have their diagnostic test within 6 weeks**

F
Failed Target

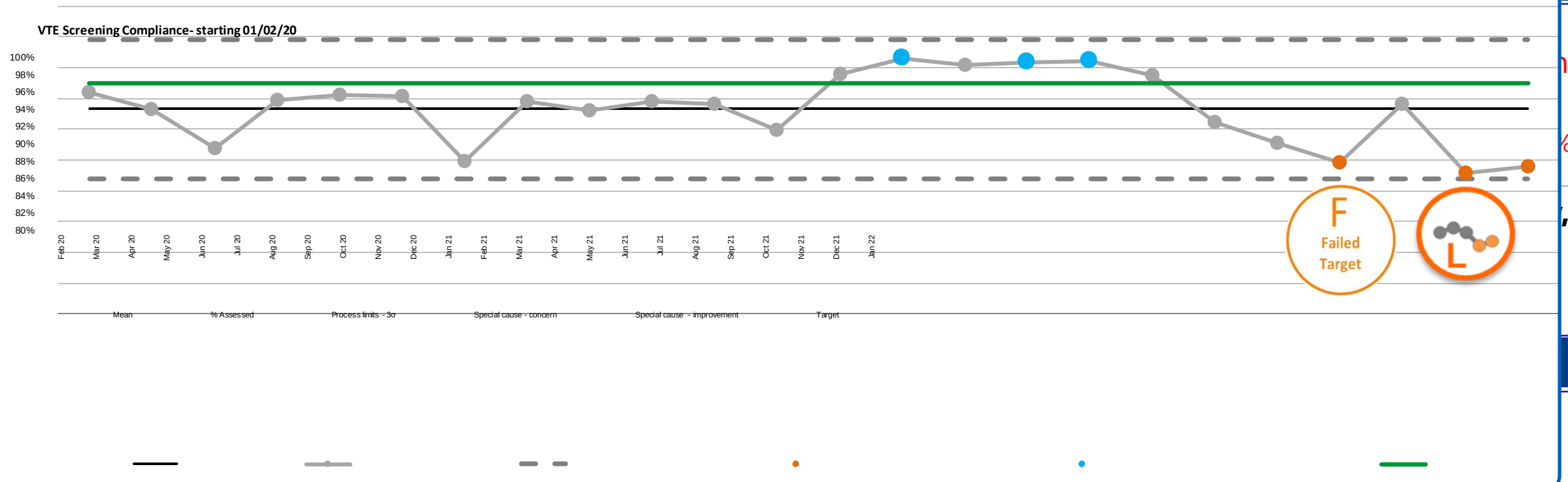
Month

.5%

oining 15
target 99%

- Performance remains steady although still below the existing 99% standard
- Key areas of concern include sleep studies and cardiology remain the key areas of concern.
- There are recovery plans in place for both sleep studies and cardiology and improvement in these two areas will be seen from April
- All other major modalities are delivering strong performance including Ultrasound and MRI
- CT has seen particularly strong improvement in performance in recent months

- ✓ Deliver against the sleep studies and cardiology improvement plan
- ✓ Maintain levels of performance in major Radiology modalities including MRI, US and CT
- ✓ Delivery revised *95% 6 week* standard by summer 2022, head of the national requirement of March 2025



significant amount of data error in the SWC data with large volumes of incorrectly coded data.

- A recent audit suggests performance is closer to 95% - presented at Quality and Safety Committee
- This will be confirmed and reflected in next months data

Summary of new performance measures for 2022

Domain	Current Measure	New Measures	National Target date	DGH Planned Delivery Date
RTT	18 weeks	Zero over 104 weeks	June 2022	Immediately
	Zero over 52 weeks	Zero over 18 months by April 2023	April 2023	March 2023
		Zero over 65 weeks by March 2024	March 2024	March 2023
		Zero over 52 weeks by March 2025	March 2025	March 2023
Diagnostics	99% within 6 weeks	95% within 6 weeks	March 2025	March 2023
Cancer 62 day	85% Treatment within 62 days	62 day Performance back to pre-pandemic levels by March 2023	March 2023	Immediately
EAS	4 hours (Core)	Ambulance Handover in 15 minutes	Month on Month	From commencement of nee national standards, TBC
	12 hour trolley waits (Core)	Time to initial assessment	Month on Month	
	*Handover 15 minutes **	Average time in the department (non admitted) NEW	Month on Month	
	*Time to initial assessment **	Average time in the department (admitted) NEW	Month on Month	
	*Clinically Ready to Proceed **	Clinically ready to proceed	Month on Month	
		Patients spending 12 hours in ED (total time) NEW	Month on Month	

*** these measures are currently monitored as part of the new 4 hour / 12 hour trolley wait standard pathway*
All cancer targets remain the same
Next months IPR report will show current performance against new standards

Enclosure 16

The Dudley Group NHS Foundation Trust

Paper for submission to the Board of Directors on 10th March 2022

Title:	Summary of Workforce and Staff Engagement Committee (WSEC) Meeting on Tuesday 22nd February 2022
Author:	James Fleet Chief People Officer/Julian Atkins Non-executive Director
Presenter:	Julian Atkins - Non-executive Director

Action Required of Committee / Group			
Decision	**Approval**	**Discussion**	**Other**
		Y	Y

Recommendations:
The Board is asked to note the assurances provided by the Committee as follows:-

Summary of Key Issues:

MATTERS OF CONCERN OR KEY RISKS TO ESCALATE

- The Committee noted the increase in sickness absence of 1.9% in January to 10.06%, (from December 8.16%) which was principally due to high levels of COVID absence, however this had decreased significantly during February, falling to 37 as at 21st February.
- The Committee discussed the ongoing challenge regarding statutory training compliance for Adult, Paediatric, and Neonatal Resuscitation; Adult and Child Safeguarding Levels 2 and 3; and Patient Moving and Handling. A specific piece of work was commissioned to address this (see Major Actions Commissioned/Work Underway), which will be brought back to March Committee.

MAJOR ACTIONS COMMISSIONED/WORK UNDERWAY

- The Committee commissioned a review of options to address the Trust's continued failure to achieve compliance for Resuscitation (Adult, Paediatric, and Neonatal), Patient Moving and Handling, and Safeguarding Adults and Children Levels 2 and 3. Andrew Boswell confirmed that alternative means of completion for Levels 2 and 3 will be implemented and Helen Bromage confirmed that successful completion of Resuscitation at previous Trusts should be honoured by the Resuscitation Department. The Committee also considered the need to address compliance for Patient Moving and Handling, given the incidence of musculoskeletal injuries amongst the workforce. Andrew Boswell and Helen Bromage will bring a paper outlining the options to the March Committee meeting.
- Julian Atkins updated the Committee from the recent 'Connecting Workforce Chairs' meeting held on 27th January 2022 and explained the key purpose of this forum was to connect the Workforce Chairs from the partner organisations across the system. The forthcoming March meeting will focus on system-wide recruitment and retention activities. The aim will be to agree deliverable actions which benefit the whole system.
- As part of the ESR Optimisation meetings, a focused L&D function meeting is scheduled for March 2022, to identify the potential benefits of ESR Employee Self-Service. Findings will be shared with the Committee.

POSITIVE ASSURANCES

- Total vacancies had reduced by 5.03 WTE in January from December.

- Bank usage increased in January by 73.10 WTE, whilst agency usage decreased by 10.84 WTE, with an associated improvement in average shift fill rate for registered nurses (77% compared to 74% in December), unregistered nursing shift fill remained static at 61%.
- A slight improvement was noted in Statutory Training compliance of 0.3% since the previous report, with three further subjects also moving into green and therefore above the Trust target.
- Gurjit Bhogal (Chair EDI Steering Group) gave an update on the February EDI Steering Group meeting, which demonstrated the progress being made, which was commended by the Committee. The update included the work on the ethnicity and disability gender pay gap and an update on the development of an integrated Trust EDI Strategy. James Fleet updated on the work that is being taken forward to develop a System EDI Strategy.
- Vij Randeniya (Chair Wellbeing Steering Group) provided an update on the February meeting of the Wellbeing Steering Group, which is also making strong progress. The update included the ongoing work to develop a broader and more inclusive range of wellbeing options for staff, the positive feedback from the Staff Survey regarding staff experience of wellbeing support within the Trust, particularly during such a challenging and pressured time. Paige Massey (Trust Wellbeing Lead) has begun work on a health and wellbeing training package with the OD team. A further update will be provided to the Committee meeting in April.

DECISIONS MADE

- The Committee moved the planned presentation of the Patient Safety Strategy by Patient Safety Lead to the March Committee.
- To enable sufficient time for consideration and discussion the Committee moved the planned update on the Trust's OD workplan forward to the March Committee meeting.

Impact on the Strategic Goals	
Deliver right care every time	**Yes**
Be a brilliant place to work and thrive	**Yes**
Drive sustainability (financial and environmental)	
Build innovative partnerships in Dudley and beyond	**Yes**
Improve health and wellbeing	**Yes**

Implications of the Paper:			
Risk	Y	Risk Description: As described in Board Assurance Framework 4a, 4b, 4c.	
	On Risk Register: Y	Risk Score: Seven, scored moderate and major.	
Compliance and/or Lead Requirements	CQC	Y	Details: Well-led
	NHSE/I	Y	Details: NHS People Plan
	Other	N	Details:

Report Journey/ Destination *(if applicable)*	Working / Exec Group	N	Date:
	Committee	Y	Date: WSEC 22/02/2022
	Board of Directors	Y	Date: 10/03/2022
	Other	N	Date:

The Dudley Group NHS Foundation Trust

CHAIR'S LOG
UPWARD REPORT FROM WORKFORCE & STAFF ENGAGEMENT COMMITTEE
Date Committee last met: 22nd February 2022

MATTERS OF CONCERN OR KEY RISKS TO ESCALATE	MAJOR ACTIONS COMMISSIONED/WORK UNDERWAY
• Whilst the Committee noted the increase in sickness absence of 1.9% in January (10.06%) from December (8.16%), which was principally due to high levels of COVID absence (347 at the highest point in January), James Fleet advised that the number of staff absent from work for COVID related reasons has decreased significantly during February, falling to 37 as at 21st February. • The Committee discussed the ongoing challenge regarding statutory training compliance for Adult, Paediatric, and Neonatal Resuscitation; Adult and Child Safeguarding Levels 2 and 3; and Patient Moving and Handling. A specific piece of work was commissioned to address this (see Major Actions Commissioned/Work Underway).	• The Committee commissioned a review of options to address the Trust's continued failure to achieve compliance for Resuscitation (Adult, Paediatric, and Neonatal), Patient Moving and Handling, and Safeguarding Adults and Children Levels 2 and 3. Andrew Boswell (Mandatory Training Manager) confirmed that alternative means of completion for Level 2 and 3 will be implemented, subject to approval by the Trust's Internal Safeguarding Board. Andrew Boswell and Helen Bromage (Deputy Chief Nurse) also confirmed that successful completion of Resuscitation at previous Trusts should be honoured by the Resuscitation Department, particularly for clinicians who may rotate up to six-monthly, given the standardised national algorithm for life support. The Committee also considered the need to address compliance for Patient Moving and Handling, given incidence of musculoskeletal injuries amongst the workforce. The Committee have asked Helen Bromage and Andrew Boswell to bring a paper to the March Committee meeting for discussion, consideration and action. • Julian Atkins updated the Committee from the recent 'Connecting Workforce Chairs' meeting which was held on 27th January 2022. The key purpose of this forum is to connect the Workforce Chairs from the partner organisations across the system. Following the inaugural meeting in November 2021, the decision was taken to invite the Chief People Officers (CPOs). Julian updated that there was strong attendance at this meeting by both Chairs and CPOs, as well as consensus that this forum will provide a valuable platform to, enhance collaboration in the people agenda across the system and review and challenge the progress being made across key workforce initiatives and work programmes. This forum will also provide the opportunity for NEDs to contribute to the agenda and workforce programme of the People Board, as well as provide independent 'check and challenge'. Julian advised that the next meeting in March will focus on system-wide recruitment activities. Future meetings will address, workforce retention, workforce technology, equality and inclusion and talent management. There will be a focus on agreeing deliverable actions which benefit the whole system.

	• As part of the ESR Optimisation meetings, a focused L&D function meeting is scheduled for March 2022 to identify the potential benefits of ESR Employee Self-Service. Findings will be shared with the Committee.
POSITIVE ASSURANCES TO PROVIDE The Committee was pleased to receive the following updates: • The total vacancies reduced by 5.03 WTE in January from December. • Bank usage increased in January by 73.10 WTE, whilst agency usage decreased by 10.84 WTE, with an associated improvement in the average shift fill rate for registered nurses (77% compared to 74% in December), unregistered nursing shift fill remained static at 61%. • There had been a slight improvement in Statutory Training compliance since the previous report (0.3%), with three further subjects also moving into green and therefore above the Trust target. • There was a positive report from Gurjit Bhogal (Chair EDI Steering Group) which demonstrated the progress that this group is making, which was commended by the Committee. The update included work on the ethnicity and disability gender pay gap and an update on the development of an integrated Trust EDI Strategy. James Fleet updated on the work that is being taken forward to develop a System EDI Strategy. • Vij Randeniya (Chair Wellbeing Steering Group) provided an update on the February meeting of the Wellbeing Steering Group, which is also making strong progress. Vij updated the Committee on the work that is being undertaken to develop a broader and more inclusive range of wellbeing options for staff. Vij also highlighted the positive feedback from the Staff Survey regarding staff experience of wellbeing support within the Trust, particularly during such a challenging and pressured time. Vij also fed back that Paige Massey (Trust Wellbeing Lead) has begun work on a health and wellbeing training package with the OD team. Wellbeing conversations have started to happen. The recruitment of Wellbeing Champions is taking place during the next couple of months. A further update will be provided to the Committee meeting in April.	**DECISIONS MADE** • The Committee moved the planned presentation of the Patient Safety strategy, by Patient Safety Lead, to the March Committee. • To enable sufficient time for consideration and discussion, the Committee moved the planned update on the Trust's OD workplan forward to the March Committee meeting.

Chair's comments on the effectiveness of the meeting:

Despite being a short meeting (given the Trust's level 4 status), there were several positive updates, including feedback from the Health & Wellbeing and EDI Steering Groups which have built a strong momentum across their work programmes. The February Workforce KPI report also provided some assurances that the range of initiatives that are being deployed to increase recruitment is having an impact in reducing the overall vacancy factor. It was also good to note that COVID related absence has reduced significantly since its most recent peak in January. The Committee had a constructive discussion regarding opportunities to increase the accessibility of mandatory training, through more flexible approach; the Committee has commissioned a report with recommendations to be presented to the March meeting.

Enclosure 17

The Dudley Group NHS Foundation Trust

Paper for submission to Board of Directors on 10th March 2022

Title:	Workforce KPI Report
Author:	Greg Ferris - Senior Information Analyst Karen Brogan - Deputy Chief People Officer
Presenter:	James Fleet - Chief People Officer

Action Required of Committee / Group			
Decision	**Approval**	**Discussion**	**Other**
N	N	Y	N

Recommendations:

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

Summary of Key Issues:

- Overall sickness/absence was 10.06% (FTE lost) for January, an increase of 1.9% compared against December 2021, which was 8.16%. This was principally due to high levels of COVID absence. The number of staff absent from work for COVID related reasons has decreased significantly during February.

- COVID-19 absence tracking continues to be reported daily. The number of people off for a COVID related reason has reduced to 35 and currently accounts for 0.62% of sickness absence (to 25/02/22). It should be noted that this ranged from 250 staff absent early January, through to 347 at its peak and reducing to 100 staff per day by the end of January.

- Discounting COVID-19 absences, 'Anxiety/stress/depression' remains the most common reason for absence (74 people) followed by musculoskeletal (32).

- The total vacancies stand at 710.63 WTE (calculated as the difference between Budgeted WTE and Contracted WTE), this equates to 12%. The number of vacancies has decreased by 5.03 WTE since December because of sustained recruitment activity.

- Nursing 18% (343.69)
- Senior Medics 16% (59.81)
- Junior Medics 13% (59.04)
- AHP's 12% (94.12)

- Bank usage has increased from 474.04 in December to 547.14 in January, an increase of 73.10 WTE. Agency usage has decreased to 184.25 from 195.09 WTE a decrease of 10.84 WTE.

- In January the average shift fill rate for registered nurses was 77% compared to 74% in December, for unregistered nursing this remained static at 61%.

- 7,593 registered shifts were requested in January, an increase from 6,994 in December, with 1,715 remaining unfilled. 3,897 unregistered shifts were requested in January which is consistent with December 1,501 remained unfilled.

- Mandatory Training: overall compliance is 86.91% as of 3rd February, this is a decrease from 87.11% on 13th January.

- The current caseload is 40, a decrease of four cases since December 2021. Disciplinary accounts for 52.6% with 21 cases, the highest category, followed by 'Grievance' at 23.7% (10 cases).

Impact on the Strategic Goals	
Deliver right care every time	**Y**
Be a brilliant place to work and thrive	**Y**
Drive sustainability (financial and environmental)	
Build innovative partnerships in Dudley and beyond	
Improve health and wellbeing	**Y**

Implications of the Paper:			
Risk	Y	BAF 4a, 4b, COR1537, COR1489, COR1538, COR1789, COR1791	
	On Risk Register: Y		
Compliance and/or Lead Requirements	CQC	Y/N	Details:
	NHSE/I	Y/N	Details:
	Other	Y/N	Details:

Report Journey/ Destination *(if applicable)*	Working / Exec Group	Y/N	Date:
	Committee	Y	Date: 22/02/2022
	Board of Directors	Y	Date: 10/03/2022
	Other	Y/N	Date:

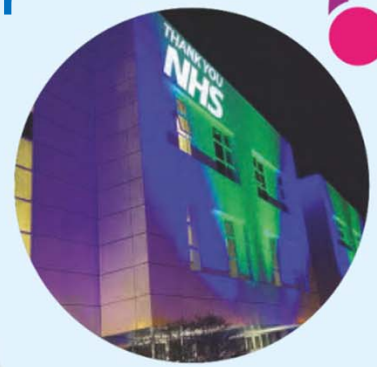
Workforce KPI Report

February 2022

James Fleet,

Executive Chief People Officer

NHS
The Dudley Group
NHS Foundation Trust



CARE
RESPECT
RESPONSIBILITY

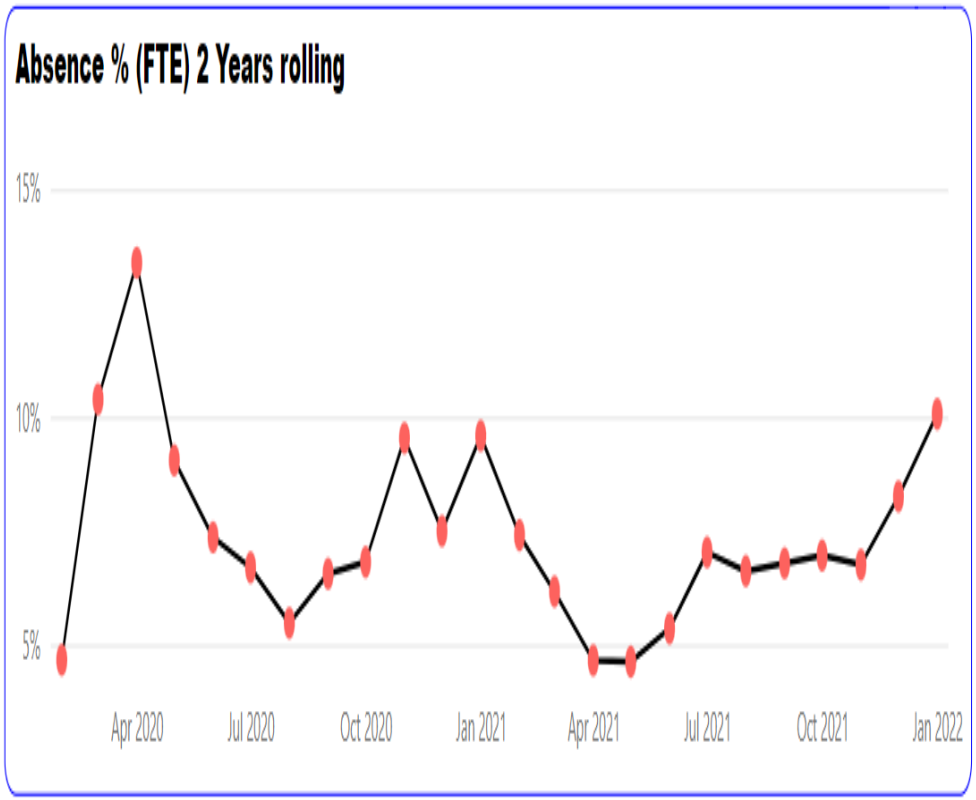
Summary 1/2	*Performance*	*Action*
Sickness & Absence	o Overall Sickness/Absence was 10.06% in January, a increase of 1.9% compared against December 2021, which was 8.16% o Medicine and Integrated Care is the division with the highest sickness absence rate at 10.75% in January, an increase of 1.84% on December. o COVID-19 absence tracking continues to be reported on a daily basis. The number of people off for a COVID related reason has reduced to 35 and currently accounts for 0.62% of sickness absence (to 25/02/22). It should be noted that this ranged from 250 staff absent early January, through to 347 at its peak and reducing to 100 staff per day by the end of January. o Discounting COVID absences, 'Anxiety/stress/depression' remains the most common reason for absence (74 people) followed by musculoskeletal (32).	✓ 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 increased from 474.04 in December to 547.14 in January, an increase of 73.10 WTE. In addition Agency usage has decreased to 184.25 from 195.09 WTE an decrease of 10.84 WTE. o Total temporary staffing usage in January is 731.39 September is an increase from 669.14 WTE in December . This is higher than the total vacancies for January which is 710.63 WTE o In January the average shift fill rate for registered nurses was 77% compared to 74% in December, for unregistered nursing this remained static at 61%. 7593 registered shifts were requested in January, an increase from 6994 in December, with 1715 remaining unfilled. 3897 unregistered shifts were requested in January which is consistent with December, 1501 remained unfilled.	✓ 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 taken in relation to vacancies, retention and bank and agency usage. ✓ A task and finish group has been established to reduce agency usage. ✓ Introduction of NHSP national bank service (planning to mobilise Nov) to support shift fill.
Turnover & Recruitment	o Contracted WTE staff has increased from 5062.65 in December to 5094.77 in January, an increase of 32.12 WTE. o The total vacancies stand at 710.63 WTE (calculated as the difference between Budgeted WTE and Contracted WTE) This equates to 12%. The number of vacancies have decreased by 5.03 WTE since December. o Registered Nursing vacancies are at 350.96, an increase of 7.27 WTE from December. Unregistered Nursing vacancies are 51.34 WTE, an increase of 3.2 since December. o Overall staff turnover is at 7.3% (rolling average 12 months this discounts rotational posts). o Excluding Students and Medics, Additional Professional Scientific & Technical, are highest at 9.2%. Admin at 8.4% AHP's at 8.0%,, Additional Clinical Services at 7.5% and Nursing & Midwifery Registered at 5.1%.	✓ The HR Business Partners will be supporting the Divisional Directors to ensure the development and implementation of workforce planning, that understands staffing capacity, establishments, and skill & experience requirements and incorporates into service design to ensure roles are fit for purpose and add value. ✓ A methodology is being developed that will examine trends on planned versus actual staffing levels, triangulated with key quality and outcome measures, including exit interviews and stay interviews. ✓ An action plan has been developed to prioritise recruitment and retention, concentrating specifically on HCSW's and Registered Nurses, including international nurse recruitment.

Summary 2/2	*Performance*	*Action*
Mandatory Training	o Mandatory Training: overall compliance is 86.91% as at 3rd February, this is a decrease from 87.11% on 13th January. o The priority areas continue to be Safeguarding (Child and Adult), Resus and Manual Handling. o The most challenged staff group is Medical and Dental staff.	✓ An action plan has been devised along with a trajectory for the Divisions to achieve mandatory training compliance. ✓ Restrictions to the amount of attendees and exploration of adjusted delivery continues, staff absence continued to be a factor. ✓ Meetings held with SMT Lead and Gen Managers for MIC, Surgery, and CSS, with out-of-hours additional sessions run throughout September up to December to capture Clinicians and increase overall compliance.
Equality, Diversity & Inclusion	o BAME staff Trust representation is at 20.4%, an increase of 0.1% since December o Disabled staff Trust representation is at 3.9%. o LGBTQ+ staff Trust representation is at 1.9%.	✓ 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.
HR Caseload	o The current caseload is 40 a decrease of 4 cases since December 21. o Disciplinary accounts for 52.6% with 21 cases, the highest category, followed by 'Grievance' at 23.7% (10 cases). o The division with the highest number of open cases is Medicine and Integrated Care at 19 cases. o BAME representation is at 30%, with 12 open cases. o There are currently 2 live suspensions.	✓ Employee relations cases continue to be proactively managed and supported by the implementation and maintenance of a case tracker. ✓ There is a focus on the Just Culture framework, with shared learning and early resolution where possible. ✓ 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.

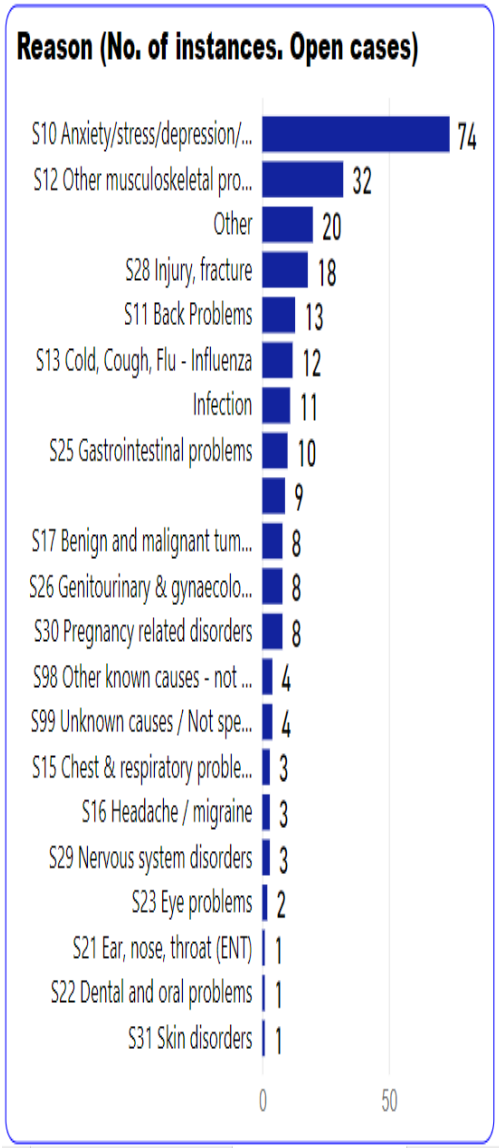
Summary 3/3	*Performance*	*Action*
Staff Health & Wellbeing	• We continue to see the development of wellbeing metrics, which are displayed for information and continued to be developed. • BHSF RISE activity reduced slightly in Q4, when compared to Q3. • Black Country Mental Health hub referrals have totalled 10 self-referrals between May 21-January 22. • Via Vita participation has increased. • REMPLOY access has totalled 17 self-referrals between October 21-December 21	✓ A review of Staff Health & Wellbeing service has been undertaken and we are currently recruiting to the new structure. ✓ A Wellbeing Business Partner has been appointed and is in post and a Wellbeing Steering Group has been established which will report upwards to WSEC.

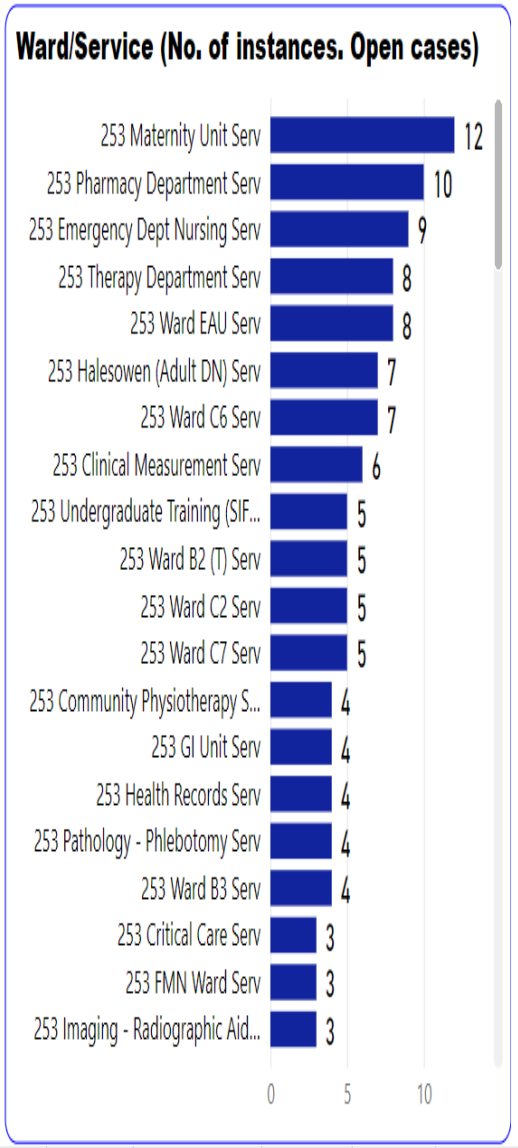
Sickness Absence

- Overall Sickness/Absence was 10.06% in January, a increase of 1.9% compared against December 2021, which was 8.16%
- Medicine and Integrated Care is the division with the highest sickness absence rate at 10.75% in January, an increase of 1.84% on December.
- COVID-19 absence tracking continues to be reported on a daily basis. The number of people off for a COVID related reason remains consistent at an average of 75 and currently accounts for 1.33% of sickness absence (to 10/02/22). It should be noted that this ranged from 250 staff absent early January, through to 347 at its peak and reducing to 100 staff per day by the end of January.
- Discounting COVID-absences, 'Anxiety/stress/depression' remains the most common reason for absence (74 people) followed by musculoskeletal (32)



Latest Month	Trust	CS	Corporate	MIC	Surgery
	10.06%	11.42%	5.63%	10.75%	10.36%



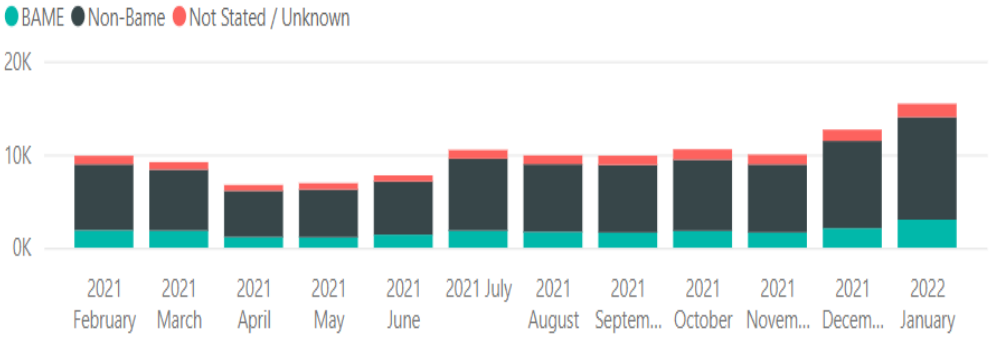


Sickness Absence - Detail

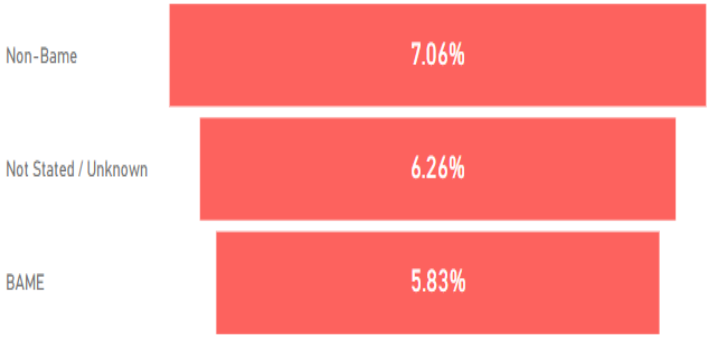
BAME colleagues show absence levels 1.23% lower that non-BAME colleagues.

In terms of disability, the chart to the right highlights the absence levels of disabled colleagues (for the 12 months to January 2022, including the COVID effect).

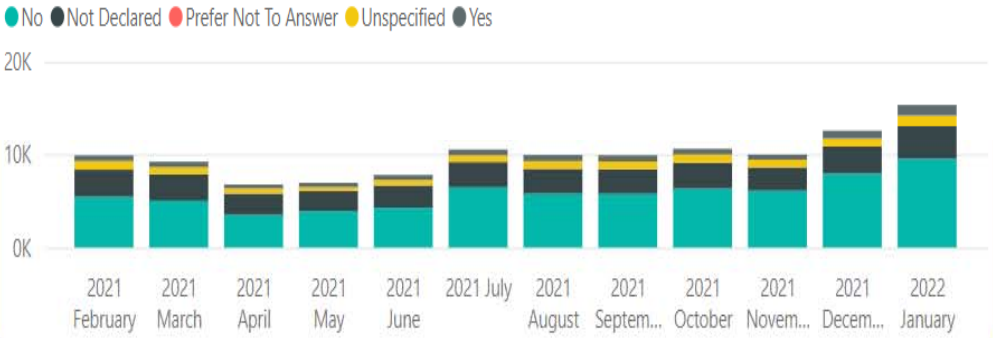
Bame / Non Bame - Absences (FTE) Trend



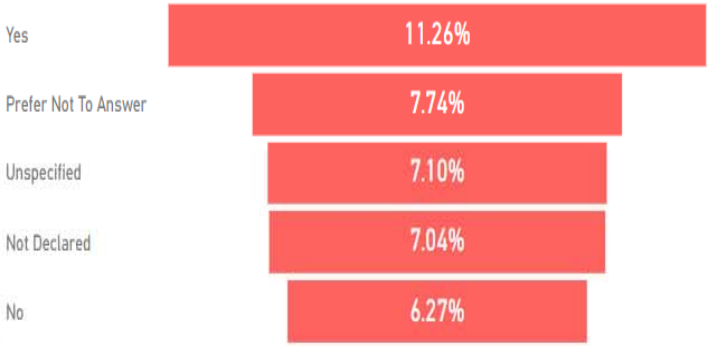
Bame / Non Bame - Absences % (FTE) 1 Year



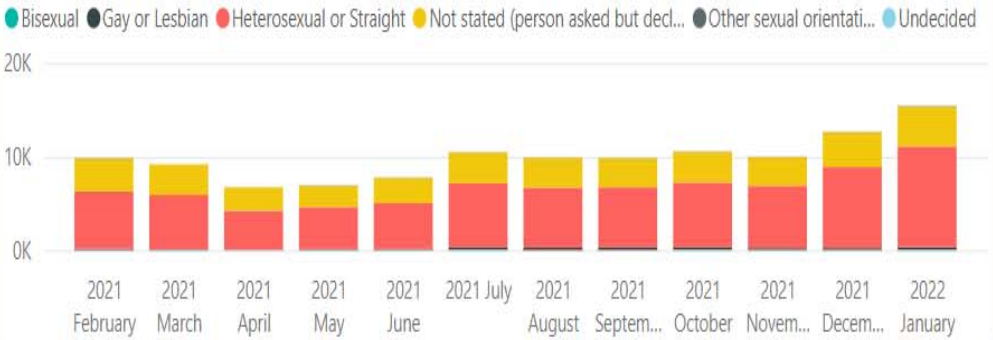
Disability - Absences (FTE) Trend



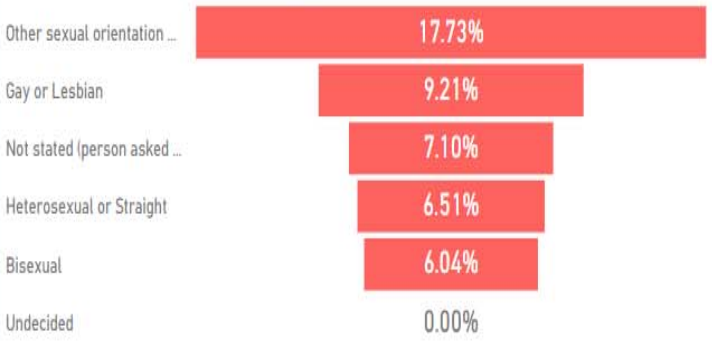
Disability - Absences % (FTE) 1 Year



LGBTQ+ - Absences (FTE) Trend



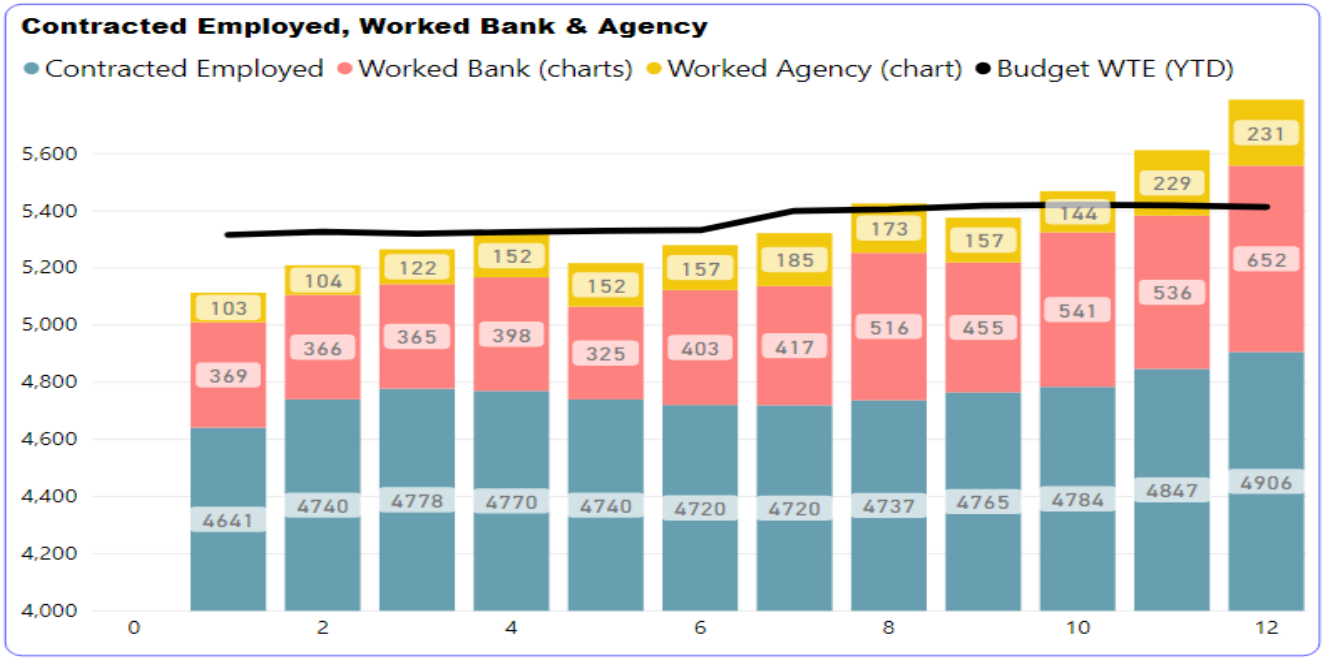
LGBTQ+ - Absences % (FTE) 1 Year

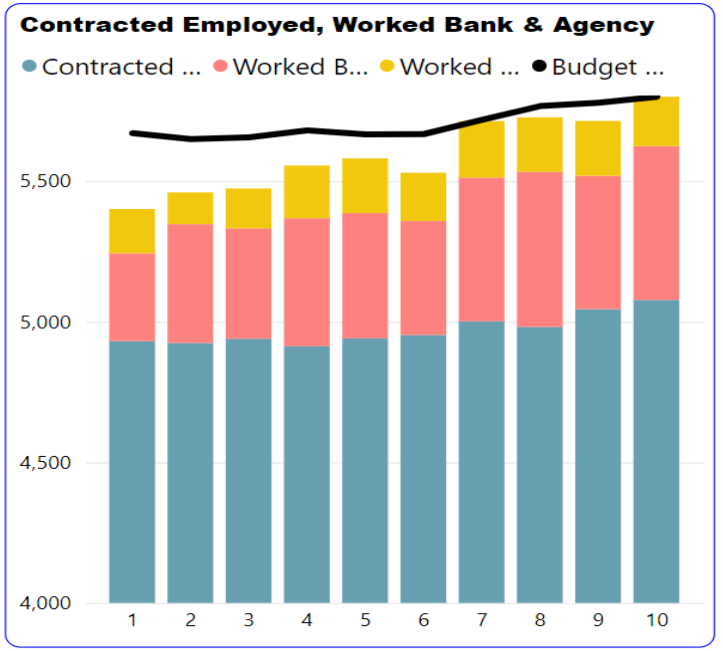


Bank & Agency – Total Trust

Bank usage has increased from 474.04 in December to 547.14 in January, an increase of 73.10 WTE. In addition Agency usage has decreased to 184.25 from 195.09 WTE an decrease of 10.84 WTE. In January the average shift fill rate for registered nurses was 77% compared to 74% in December, for unregistered nursing this remained static at 61%. 7,593 registered shifts were requested in January, an increase from 6,994 in December, with 1,715 remaining unfilled. 3,897 unregistered shifts were requested in January which is consistent with December, 1,501 remained unfilled.

The COVID vaccination Bank and Agency usage is now excluded from the Trust KPI report (DGFT is the lead employer for BCWB).





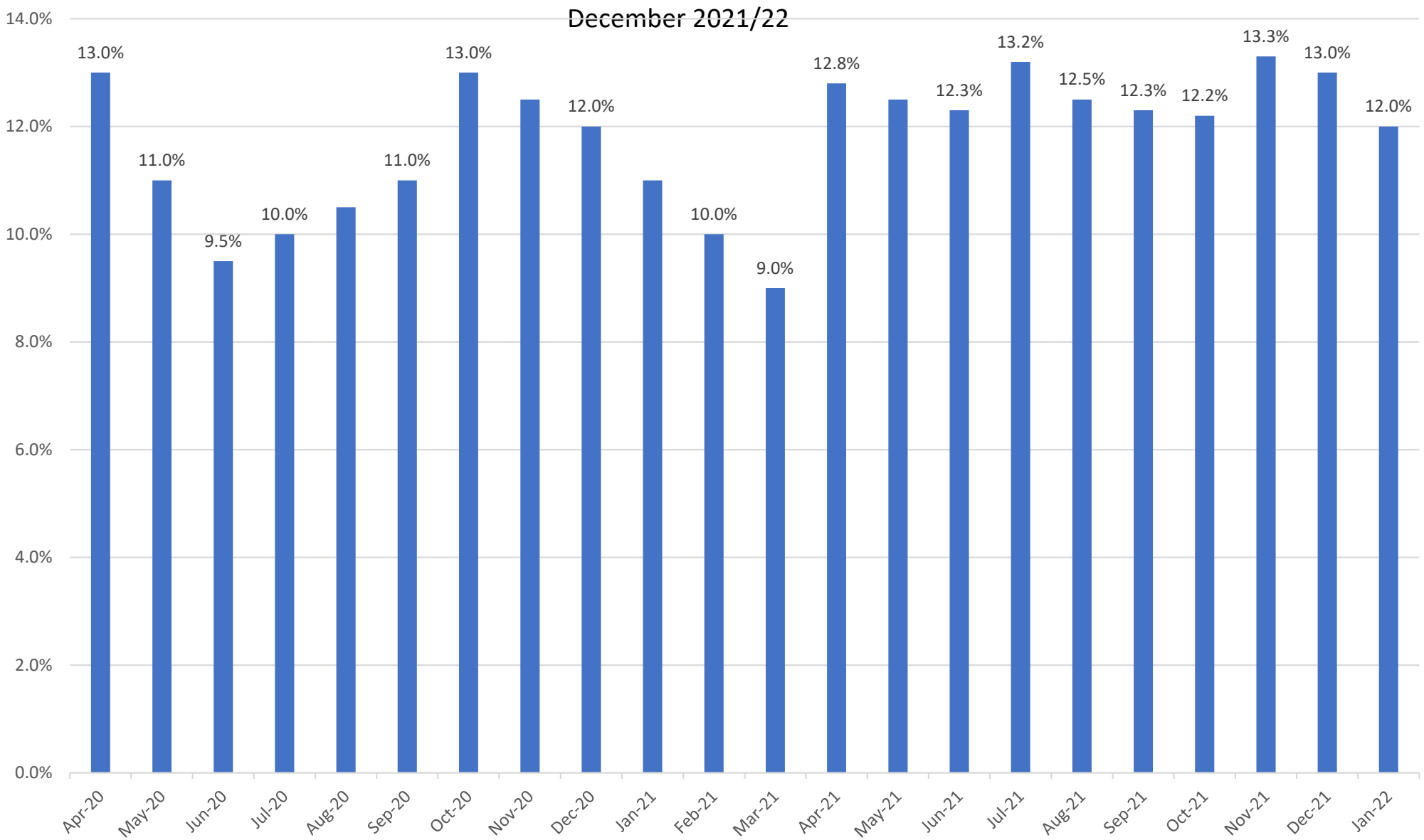
Bank Fill Rate

			Bank Filled		Agency Filled		Non-Framework			Unfilled Duties	
Date	Staff Group	Duties Requested	Duties	%	Duties	%	Duties	%	Overall Fill Rate	Duties	%
3rd Jan - 9th Jan	Registered	1883	758	**40.3%**	681	**36.2%**	138	**7.3%**	**76.4%**	444	**23.6%**
	Unregistered	984	576	**58.5%**	4	**0.4%**	0	**0.0%**	**58.9%**	404	**41.0%**
10th Jan - 16th Jan	Registered	1978	797	**40.3%**	720	**36.4%**	144	**7.3%**	**76.7%**	461	**23.3%**
	Unregistered	989	625	**63.2%**	0	**0.0%**	0	**0.0%**	**63.2%**	364	**36.8%**
17th Jan - 23rd Jan	Registered	1868	806	**43.1%**	668	**35.8%**	122	**6.5%**	**79.0%**	394	**21.1%**
	Unregistered	1014	634	**62.5%**	1	**0.0%**	0	**0.0%**	**62.6%**	379	**37.4%**
24th Jan - 30th Jan	Registered	1864	805	**43.2%**	643	**34.5%**	118	**6.3%**	**77.7%**	416	**22.3%**
	Unregistered	910	553	**60.8%**	3	**0.3%**	0	**0.0%**	**61.1%**	354	**38.9%**

Vacancies – Staff in Post

The total vacancies stands at 710.63 WTE (calculated as the difference between Budgeted WTE and Contracted WTE). This equates to 12%. The number of vacancies has decreased by 5.03 WTE since December.

Month:	Trust	CS	Corporate	MIC	Surgery
31 January 2022	12%	14%	5%	14%	11%



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	572.15	492.22	79.93	14%	43.46	£194,485	6.79	£64,968	£259,453
Corporate / Mgt	678.59	642.65	35.94	5%	36.11	£991,762	0.30	£33,603	£1,025,365
Medicine & Integrated Care	2,564.98	2,196.18	368.80	14%	285.86	£1,665,284	80.91	£721,827	£2,387,110
Surgery	1,989.68	1,763.72	225.96	11%	181.71	£812,536	96.25	£1,113,316	£1,925,852
Total	**5,805.40**	**5,094.77**	**710.63**	**12%**	**547.14**	**£3,664,067**	**184.25**	**£1,933,714**	**£5,597,781**

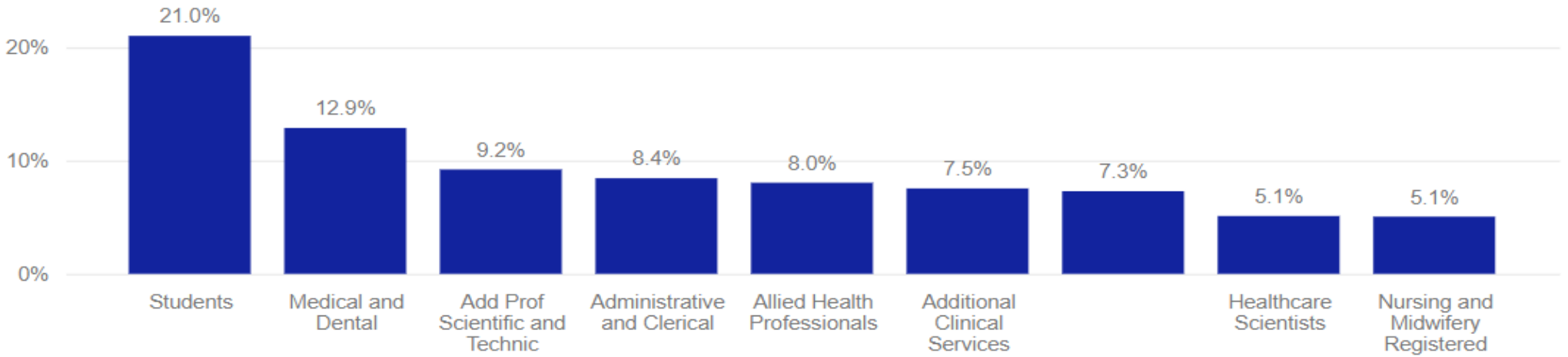
StaffGroup	Budget WTE	Contracted WTE	Vacancy WTE	Vacancy %	Worked Bank	Bank (£)	Worked Agency	Agency (£)	Bank & Agency
Nursing	1,933.75	1,582.79	350.96	18%	173.37	£1,330,277	154.72	£1,457,262	£2,787,539
Admin	1,082.77	992.50	90.27	8%	69.50	£190,734	0.15	£3,921	£194,655
CSW	957.72	906.38	51.34	5%	185.45	£975,745	0.02	-£66	£975,679
Allied Healthcare Professional	801.80	705.60	96.20	12%	40.43	£243,360	9.29	£71,071	£314,431
Junior Medic	448.85	392.35	56.50	13%	48.06	£542,124	12.43	£199,651	£741,776
Senior Medic	379.04	323.66	55.38	15%	21.46	£378,913	7.25	£164,464	£543,377
Prof Tech Scientist	134.64	116.04	18.60	14%	8.04	£1,631	0.18	£29,829	£31,459
Other	33.50	45.39	-11.89	-35%	0.23	£435	0.02	£112	£547
Senior Manager	23.80	18.76	5.04	21%			0.19	£7,470	£7,470
Total	**5,805.40**	**5,094.77**	**710.63**	**12%**	**547.14**	**£3,664,067**	**184.25**	**£1,933,714**	**£5,597,781**

Staff Turnover

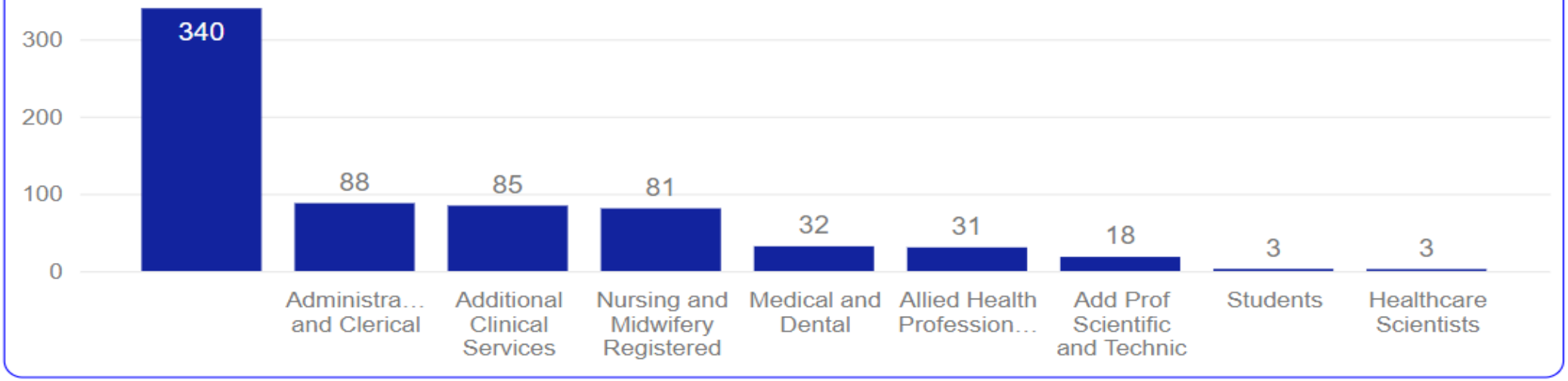
- Overall staff turnover is at 7.3% (rolling average 12 months - this discounts rotational posts).
- Excluding Students and Medics, Additional Professional Scientific & Technical, are highest at 9.2%. Admin at 8.4% AHP's at 8.0%, Additional Clinical Services at 7.5% and Nursing & Midwifery Registered at 5.1%.

Latest Month	Trust	CS	Corporate	MIC	Surgery
	7.3%	9.4%	11.5%	7.0%	5.5%

Turnover Rate by Staff Group (rolling 12 months)



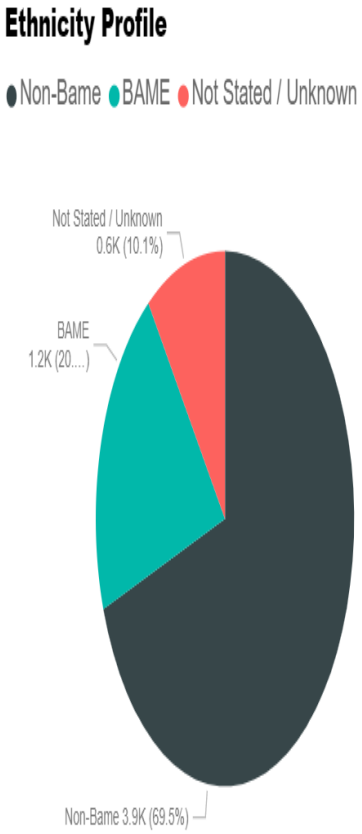
Leavers FTE by Staff Group (rolling 12 months)



Workforce Profile - Ethnicity – Representation by Division and Grade

BAME staff Trust representation is at 20.4%, an increase of 0.1% since December

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



Values between 1-5 (inclusive) have been masked.

Data shows head count, primary assignment only

BAME/Non-BAME by Division

Mapping Org L2	BAME No.	BAME %	Non-Bame No.	Non-Bame %	Not Stated / Unknown No.	Not Stated / Unknown %
253 Surgery	425	21.5%	1350	68.3%	203	10.3%
253 Medicine & Integrated Care	489	19.9%	1718	70.0%	249	10.1%
253 Corporate / Mgt	86	12.8%	509	75.5%	79	11.7%
253 Clinical Support	157	27.4%	372	65.0%	43	7.5%

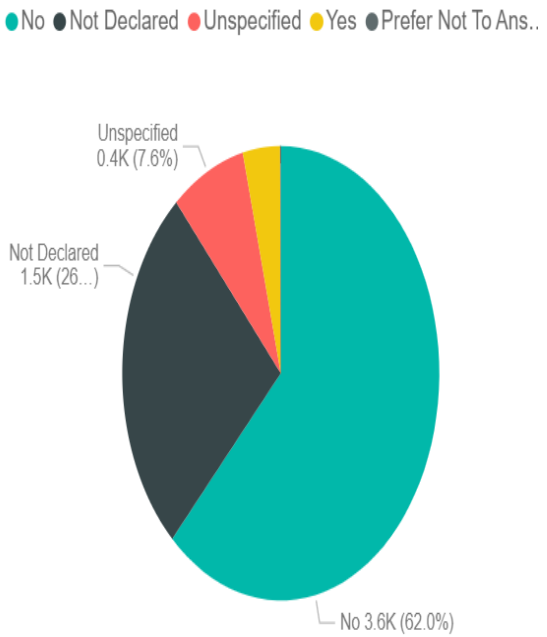
BAME/Non-BAME by Pay Grade (grouped)

Mapping Mapping	BAME No.	BAME %	Non-Bame No.	Non-Bame %	Not Stated / Unknown No.	Not Stated / Unknown %
Apprentice	11	18.0%	45	73.8%		
Band 2	119	9.6%	998	80.7%	120	9.7%
Band 3	65	15.4%	316	74.9%	41	9.7%
Band 4	53	11.9%	351	79.1%	40	9.0%
Band 5	274	26.8%	634	62.0%	115	11.2%
Band 6	193	18.5%	768	73.5%	84	8.0%
Band 7	66	12.4%	434	81.4%	33	6.2%
Band 8a	43	23.8%	125	69.1%	13	7.2%
Band 8b	6	10.2%	47	79.7%	6	10.2%
Band 8c			20	83.3%		
Band 8d			11	91.7%		
Band 9			7	70.0%		
Consultant	136	49.5%	107	38.9%	32	11.6%
Non-Consultant	182	56.5%	66	20.5%	74	23.0%
Trust contract			14	73.7%		
VSM						

Workforce Profile - Disability – Representation by Division and Grade

Disabled staff Trust representation is at 3.9%.

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



Values between 1-5 (inclusive) have been masked.
Data shows head count, primary assignment only

Disability by Division

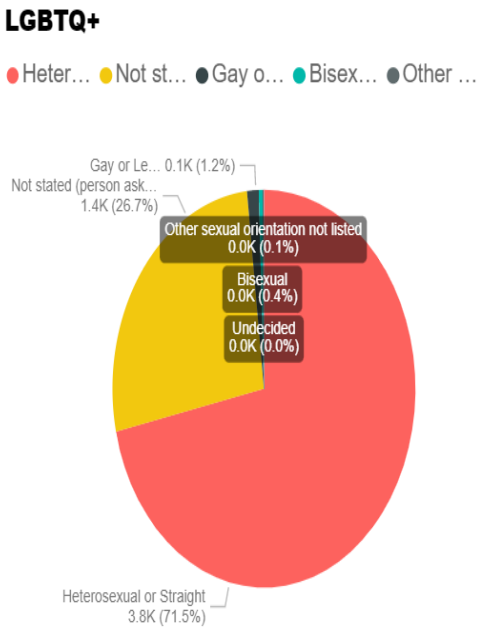
Org L2	No	Not Declared	Prefer Not To Answer	Unspecified	Yes
253 Clinical Support	70.9%	19.7%		6.1%	3.3%
253 Corporate / Mgt	67.4%	21.3%		4.7%	6.3%
253 Medicine & Integrated Care	62.5%	25.7%		7.7%	4.1%
253 Surgery	57.1%	31.4%		8.9%	2.7%
Total	**62.0%**	**26.5%**	**0.1%**	**7.6%**	**3.8%**

Disability by Pay Grade (grouping)

Mapping	No	Not Declared	Prefer Not To Answer	Unspecified	Yes
Apprentice	82.0%				11.5%
Band 2	61.4%	25.0%		10.2%	3.3%
Band 3	60.7%	25.7%		8.4%	5.1%
Band 4	70.2%	20.4%		6.3%	3.1%
Band 5	60.7%	25.6%		9.2%	4.5%
Band 6	65.0%	24.7%		6.1%	4.2%
Band 7	64.0%	27.4%		3.7%	4.7%
Band 8a	72.0%	18.1%		4.4%	5.5%
Band 8b	72.9%	18.6%			
Band 8c	75.0%				
Band 8d	75.0%				
Band 9	90.0%				
Consultant	45.3%	46.7%		7.6%	
Non-Consultant	48.3%	42.6%		7.9%	
Trust contract	57.9%	36.8%			
VSM					
Total	**62.0%**	**26.5%**	**0.1%**	**7.6%**	**3.8%**

Workforce Profile – LGBTQ+ – Representation by Division and Grade

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



Values between 1-5 (inclusive) 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			76.1%	22.8%		
253 Corporate / Mgt	1.1%	1.2%	78.5%	19.1%		
253 Medicine & Integrated Care	0.4%	1.7%	72.5%	25.3%		
253 Surgery		0.9%	66.6%	32.1%		
Total	**0.4%**	**1.2%**	**71.5%**	**26.7%**	**0.1%**	**0.0%**

LGBTQ+ by Pay Grade (grouped)

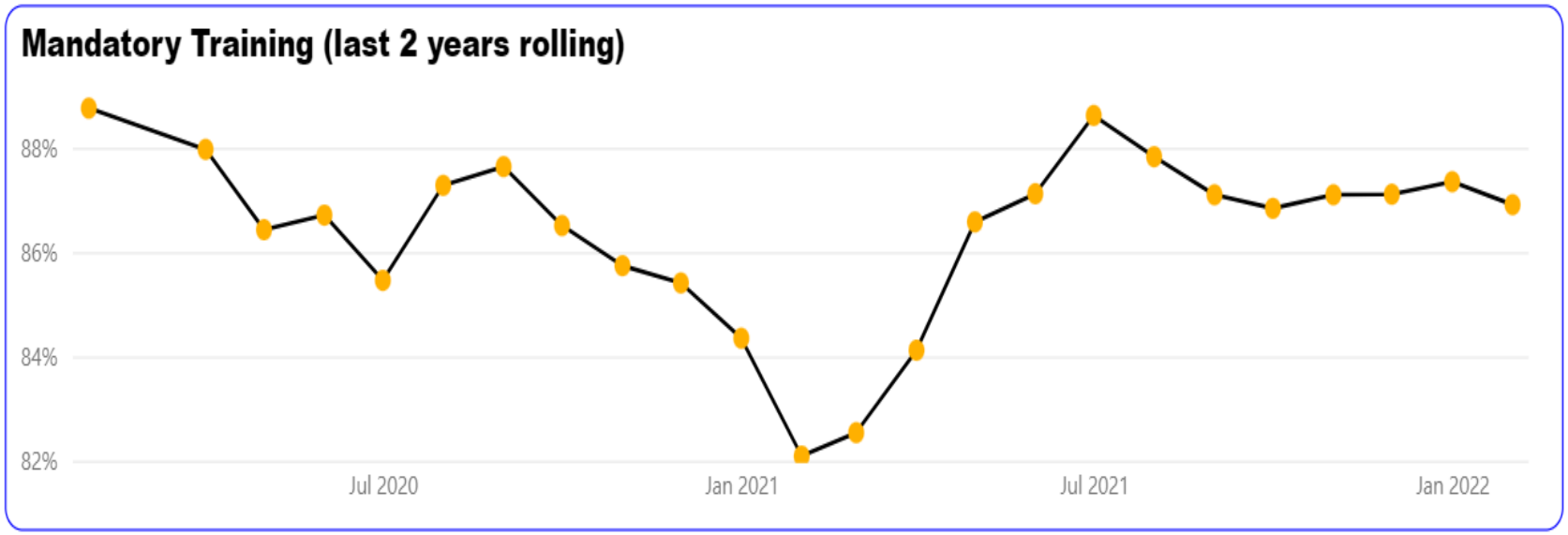
Mapping	Bisexual	Gay or Lesbian	Heterosexual or Straight	Not stated (person asked but declined to provide a response)	Other sexual orientation not listed	Undecided
Apprentice			85.0%			
Band 2	0.6%	1.7%	71.9%	25.6%		
Band 3			72.3%	26.4%		
Band 4		1.4%	75.8%	22.2%		
Band 5			70.9%	28.3%		
Band 6		1.2%	73.7%	24.7%		
Band 7			71.5%	27.2%		
Band 8a			78.9%	20.0%		
Band 8b			75.4%	17.5%		
Band 8c			77.3%			
Band 8d			75.0%			
Band 9			100.0%			
Consultant			49.6%	49.2%		
Non-Consultant			68.8%	28.2%		
Trust contract			61.1%	38.9%		
VSM			80.0%			
Total	**0.4%**	**1.2%**	**71.5%**	**26.7%**	**0.1%**	**0.0%**

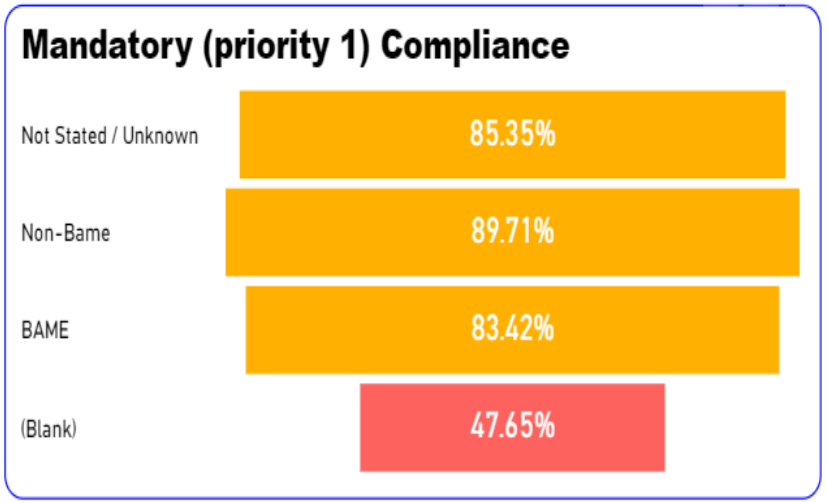
Mandatory Training – Performance Trend

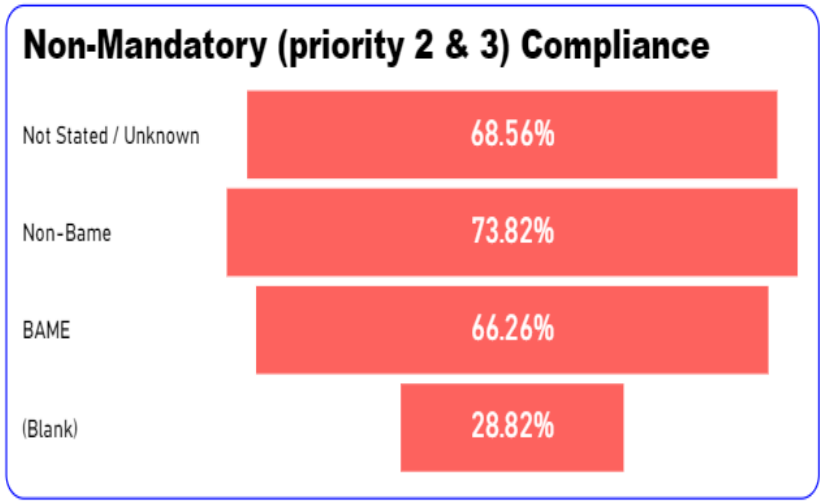
Mandatory Training: overall compliance is 86.91% as at 3rd February, this is a decrease from 87.11% on 13th January

3rd February 2022

Trust	CS	Corporate	MIC	Surgery
86.91%	89.75%	88.16%	87.89%	84.61%







Mandatory Training – Areas of Focus

The priority areas continue to be:

SAFEGUARDING ADULTS - Level 3

SAFEGUARDING CHILDREN - Level 3

RESUS PAEDS

RESUS ADULTS

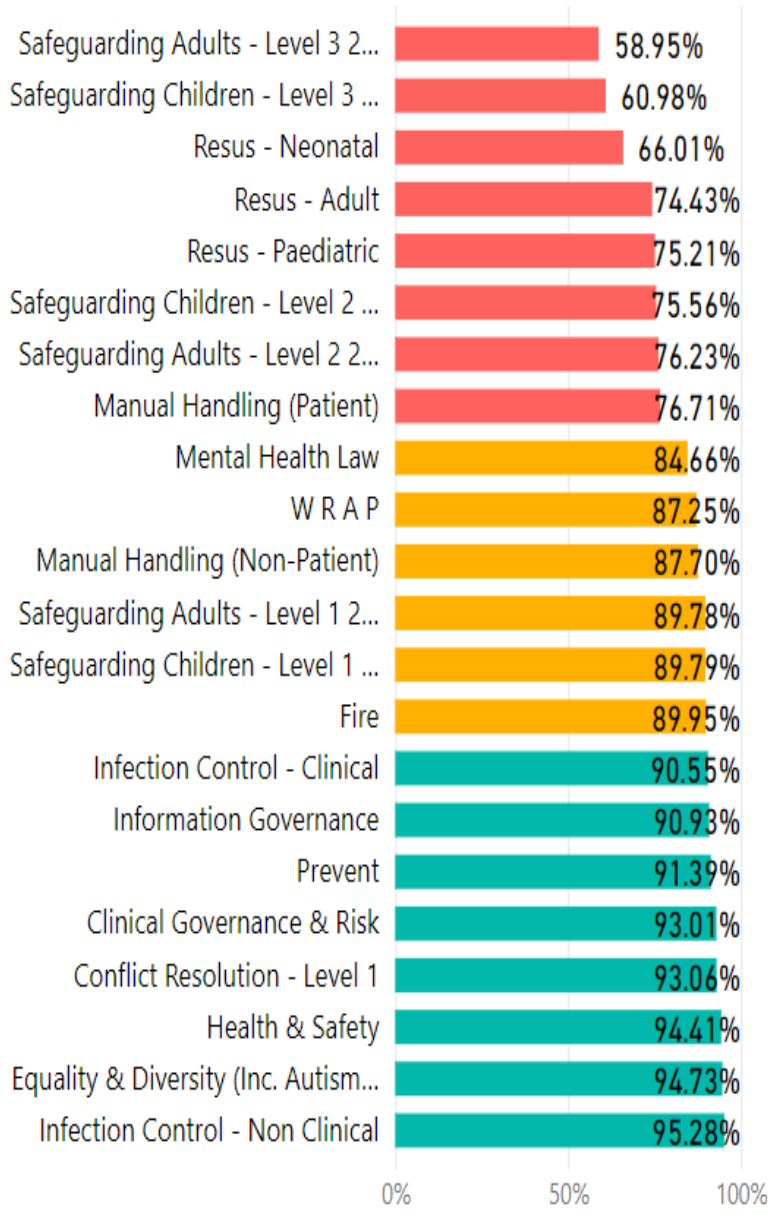
MANUAL HANDLING

SAFEGUARDING CHILDREN - Level 2

SAFEGUARDING ADULTS - Level 2

RESUS Neonatal

Course Compliance (based on selections)



Ward/Service (based selections)

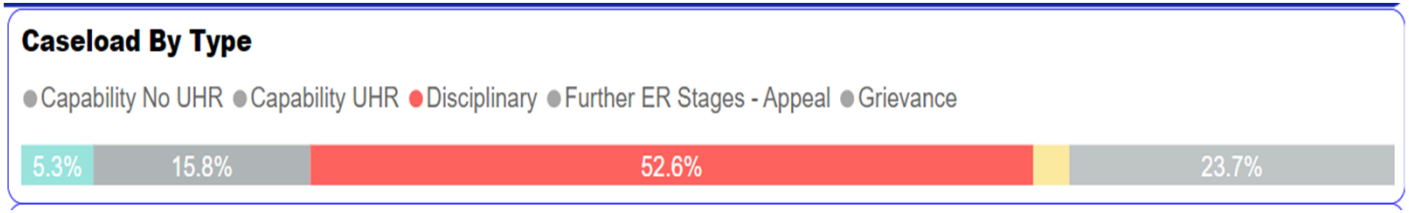
Group5Description	Actual	No. >90%	%' tage
253 Ward B3 Serv	656	193	69.56%
253 Maternity Unit Serv	2,241	155	84.18%
253 Theatres Recovery & Anaesth Serv	527	133	71.89%
253 General Surgery Medical Staff Serv	446	120	71.01%
253 Critical Care Serv	1,046	118	80.89%
253 Emergency Dept Nursing Serv	1,629	117	83.96%
253 Theatres Emergency & Other Serv	634	83	79.64%
253 Ward B1 Serv	332	79	72.80%
253 Medical Discharge Ward Serv	263	78	69.57%
253 Ward B5 Serv	800	77	82.13%
253 Medical Staff - Respiratory Serv	176	76	63.08%
253 Medical Staff Cardiology Serv	136	66	60.71%
253 Paediatric Medical Staff Serv	314	64	74.76%
253 Brierley Hill (Adult DN) Serv	342	63	76.00%
253 Urology Medical Staff Serv	143	58	64.12%
253 Ward C5 Area B Serv	412	55	79.53%
253 Medical Director Serv	85	54	55.19%
253 Medical Staff - EAU Serv	590	53	82.63%
253 MOC Medical Staff Serv	436	53	80.29%
253 Ward C5 Area A Serv	466	53	80.90%
253 Ward C6 Serv	283	52	76.07%
253 Ward B4b Serv	479	51	81.46%
253 Medical Staff (Older People) Serv	190	50	71.42%
Total	**60,906**	**1842**	**87.35%**

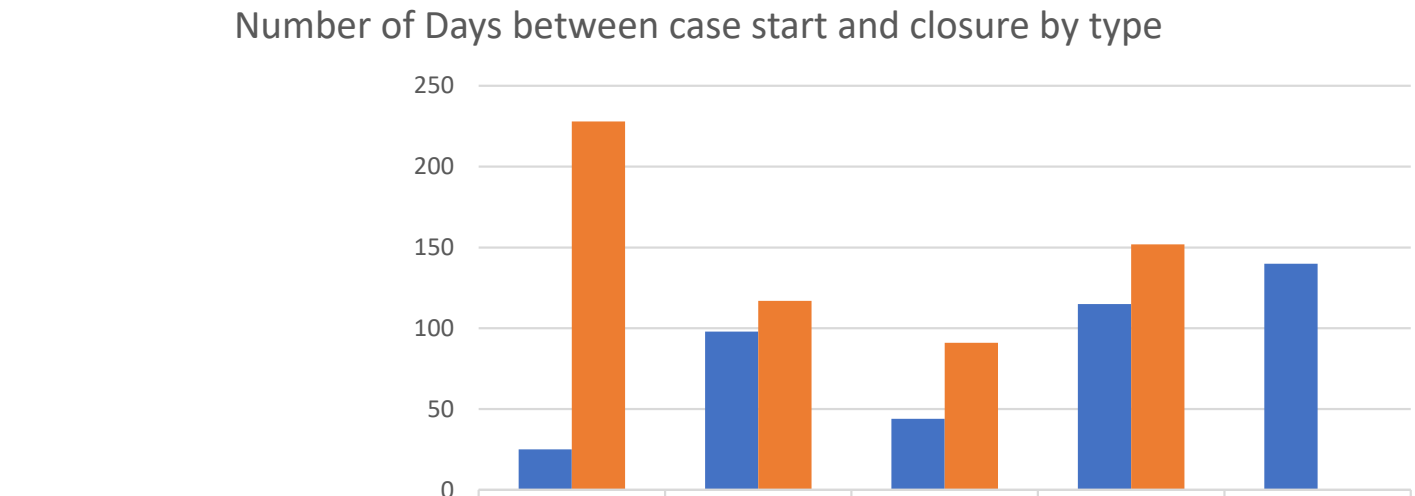
HR Caseload

- The current caseload is 40, a decrease of 4 cases since December 21.
- Disciplinary accounts for 52.6% with 21 cases, the highest category, followed by ‘Grievance’ at 23.7% (10 cases).
- The division with the highest number of open cases is Medicine and Integrated Care at 19 cases.
- BAME representation is at 30%, with 12 open cases.
- There are currently 2 live suspensions.
- In the chart (bottom right) the blue bars show the average days from open to completed for closed cases. The green bars show the running total average days the ‘live’ cases have been open.
- There were also two separate periods where Employee Relations activity was paused due to COVID.

Division	Grand Total
253 Clinical Support	2
253 Corporate / Mgt	8
253 Medicine & Integrated Care	19
253 Surgery	10
Grand Total	40

Division	Capability No UHR	Capability UHR	Disciplinary	Further ER Stages - Appeal	Grievance	Grand Total
253 Clinical Support			1		1	2
253 Corporate / Mgt			4	1	3	8
253 Medicine & Integrated Care	1	5	9		4	19
253 Surgery	1	1	7		2	10
Grand Total	2	6	21	1	10	40

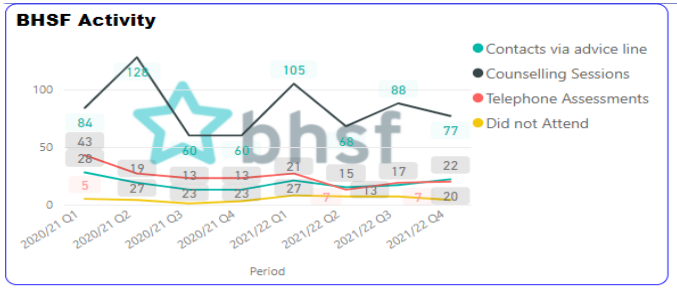


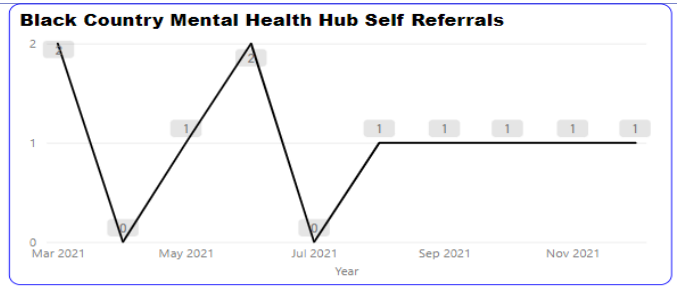


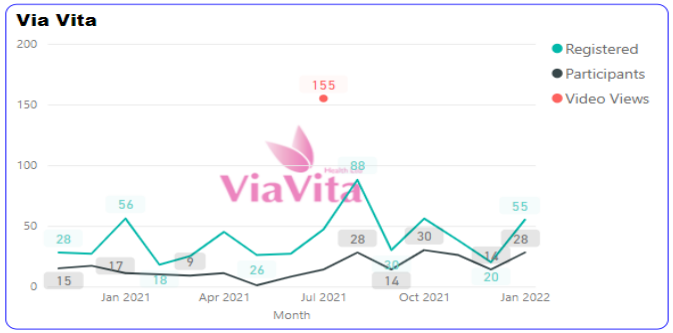
	Capability - NO UHR	Capability UHR	Further ER Stages - Appeal	Grievance	Harassment
Average length of days to completion working days)	25	98	44	115	140
Average length of open cases (working days)	228	117	91	152	

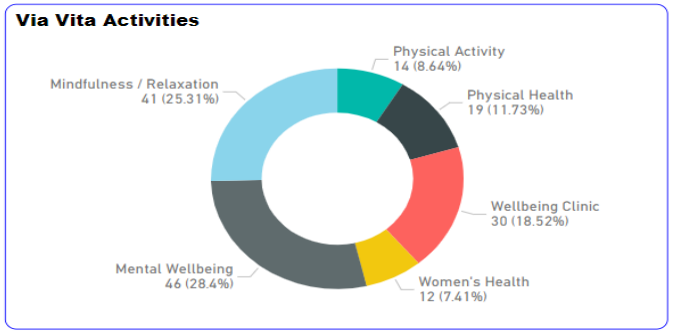
Accessing Support

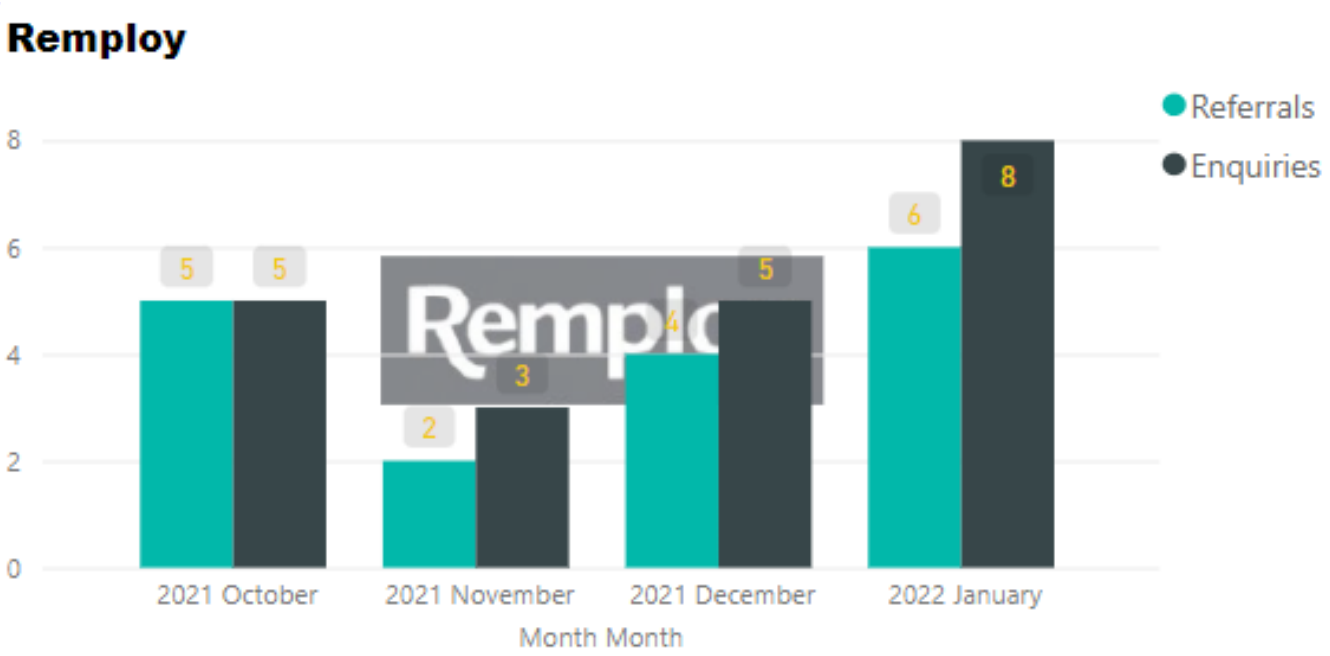
- We continue to see the development of wellbeing metrics, which are displayed for information and continued to be developed.
- BHSF RISE activity reduced slightly in Q4, when compared to Q3.
- Black Country Mental Health hub referrals have totalled 10 self-referrals between May 21-January 22.
- Via Vita participation has increased.
- REMPLOY access has totalled 17 self-referrals between October 21-December 21











Enclosure 18

The Dudley Group NHS Foundation Trust

Paper for submission to the Board of Directors on 10th March 2022

Title:	Freedom to Speak up overview 2021-2022 Q1 - Q3
Author:	Rebekah Plant – Freedom to Speak up Guardian
Presenter:	Rebekah Plant – Freedom to Speak up Guardian

Action Required of Committee / Group			
Decision ~~Y~~/N	**Approval** ~~Y~~/N	**Discussion** ~~Y~~/N	**Other** Y/~~N~~
Recommendations: The Board is asked to please note the content of this report.			

Summary of Key Issues:

This report contains an overview of Freedom to Speak up for Q1 – Q3 2021 – 2022 including recent activities and numbers/themes of concerns. The service last reported to the Workforce Committee in November 2021.

Impact on the Strategic Goals *(indicate which of the Trust's strategic goals are impacted by this report)*	
Deliver right care every time	✓
Be a brilliant place to work and thrive	✓
Improve health and wellbeing	✓

Implications of the Paper:			
Risk	N	Risk Description:	
	On Risk Register: N	Risk Score:	
Compliance and/or Lead Requirements	CQC	Y	Details: Well Led
	NHSE/I	Y	Details: Review completed 2020
	Other	N	Details:

Report Journey/ Destination *(if applicable)*	Working / Exec Group	N	Date:
	Committee	N	Date:
	Board of Directors	Y	Date: 10th March 2022
	Other	N	Date:

Freedom to Speak Up service overview 2021- 2022, Q1 - Q3

The Freedom to Speak up service in DGFT aims to provide all staff (including non-substantive) with a safe route to raise concerns in the workplace. Concerns can be raised confidentially with the FTSU team who will listen and offer support and signposting as well as escalating appropriately as/when necessary. The service is represented as follows:

- Diane Wake - CEO and Executive Lead for Freedom to Speak up.
- Julian Atkins – Non-executive Lead for Freedom to Speak up.
- Rebekah Plant – Lead Freedom to Speak up Guardian.
- Philippa Brazier – Freedom to Speak up Guardian.
- Lesley Bucknall – Freedom to Speak up champion and administrative support.

Those wishing to raise concerns can contact the team directly, by phone, in person or by emailing (either individually or to our generic mailbox dgft.raising.concerns@nhs.net).

Information and contact details for the service can be found on the Trust intranet and on posters displayed around the Trust sites.

Governance arrangements

The FTSU steering group (meets quarterly) includes representation from Human Resources, Staff side and Communications. The group reports in to the Workforce Committee and to Trust Board as required.

The Lead Guardian participates in twice monthly informal meetings with other FTSU Guardians in our region: best practice and new initiatives are shared in this way.

In line with the National Guardian office (NGO)'s guidance the Trust submits anonymised data, about the numbers and types of concerns received, to their online portal on a quarterly basis. These submissions are analysed using the model hospital system and can be compared to local and national Trusts.

Strategy

The 2021 FTSU strategy set the following priorities for achievement:

- Staff irrespective of role, from any area and any background feel safe to raise valid concerns about their workplace and their experience.
- Managers and Senior Leaders approach the resolution of concerns in a structured manner which supports and reinforces the values and benefits of a speaking up culture
- All levels of the organisation are aware of the FTSU service and view it as a credible independent and objective support service.

To achieve the priorities the service strives to continuously improve – an ongoing action plan is in place which is based on an independent NHSI review of our FTSU arrangements in late 2020. Actions from a review by our internal auditors (2020) have also been implemented.

Champions

In order to maximise the accessibility of the FTSU service we have a network of 22 champions across the Trust in various roles including administrative, medical, nursing and AHP. Their role is a combined FTSU and patient safety role and the team are there primarily to listen and signpost: champions do not usually handle concerns themselves.

The Trust adheres to the NGO ‘Guidance for developing a champion network’ (2021) and champions undertake training on induction which is refreshed annually thereafter. Champion group meetings are held (mixture of face to face and virtually for our community staff) on a quarterly basis in addition to 1:1 ‘catch ups’ with the Guardians.

Inclusion

It is widely acknowledged that some staff groups may experience barriers to speaking up/raising concerns and the FTSU team are committed to working towards removing these barriers: the champion network includes representation from BAME, LGBTQ+ and Disability staff groups.

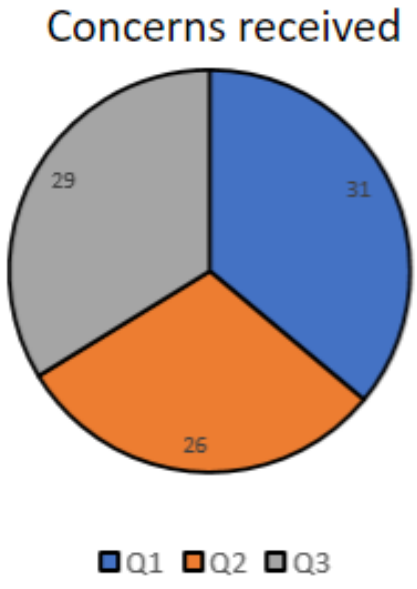
The Lead Guardian is a member the of the Equality, Diversity and Inclusion steering group and a member of each of the Trust inclusion networks: in October 2021 the Lead Guardian was nominated as ‘White Ally of the Year Award during Covid 19’, as part of the Black Country and West Birmingham NHS Trust Collaborative Black History Month event.

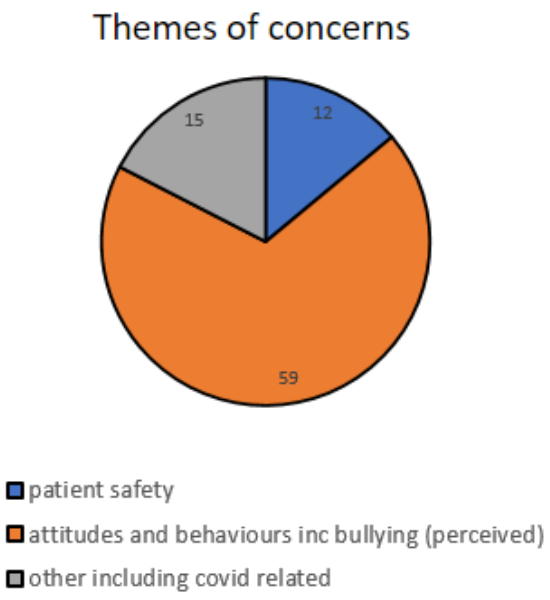
Recent activities

For ‘Speak up’ month 2021 (October) the Exec and non Exec team supported FTSU with a series of ‘walkrounds’ around the Trust sites to talk staff about the service.

The Executive and Non-executive Leads for FTSU were profiled on Twitter along with the Guardians and Champions and the hospital was lit up, in green, in honour of Freedom to Speak up.

Summary of anonymised concerns





Current projects

- The NGO have recently provided a service 'Gap Analysis' template based on recent reviews undertaken in various Trusts around the country and this is currently being used to internally review our own service.
- The Lead Guardian has recently participated in a meeting with other Guardians, in our system, which has made recommendations for the Black Country and West Birmingham STP Leadership and Culture Group Freedom to Speak Up Project.

Feedback recently received:

'I do feel much better for talking it out with you (thank you)'

'Thank you for meeting with us today and for all your support.'

Becky Plant
Freedom to Speak up Guardian
February 2022

Enclosure 19

The Dudley Group
NHS Foundation Trust

Paper for submission to the Board of Directors
10th March 2022

Title:	**Guardian of safe working report**
Author:	Mr Babar Elahi – Guardian of safe Working Hours
Presenter:	Mr Babar Elahi – Guardian of safe Working Hours

Action Required of Committee / Group			
Decision	**Approval**	**Discussion**	**Other**
		Y	Y

The Board is asked to note the actions taken by the Trust and its appointed guardian of safe working.

Summary of Key Issues:

Executive Summary:

The purpose of this report is to give assurance to the Trust Board that Junior Doctors in Training (JDT) are safely rostered, and their working hours are compliant with the Terms and Conditions of Service for NHS Doctors and Dentists in Training (England) 2016 (TCS).

This paper provides a summary of the following areas related to JDT and the 2016 TCS:

- Challenges
- Exception reports
- Vacancies (data provided by Medical Work Force Department)

Background Information:

The role of Guardian of Safe Working Hours (GSW) is to:

- Ensure the confidence of doctors that their concerns will be addressed
- Ensure improvements in working hours and work schedules for JDTs
- Provide Board with assurance that junior medical staff are safe and able to work, identifying risks and advising Board on the required response
- Ensure fair distribution of any financial penalty income, to the benefit of JDTs.

This is the 18th GSW report and covers the period from 10th February 2021 to 26th February 2022. The Guardian has been working closely with colleagues from medical staffing and rostering, post graduate medical education staff, human resources and finance to establish his role in the Trust and build relationships.

Risks and Mitigations:

Exception Reports by Department – 10th February 2021 – 26th February 2022 total = 51

Number of exceptions carried over	Number of exceptions raised	Number of exceptions closed	Number of exceptions outstanding	Specialty
0	51	44	7	12 - Gen medicine 13 – Gen surg 12 – Paediatrics 6 – Vascular 3 – Acute medicine 1 – Diabetes and endocrine 3 – T&O 1 – Urology

Exception Reports by Grade

Grade	Addressed within 48 hours	Addressed within 7 days	Addressed in longer than 7 days	Still open –
24 – FY1 6 – FY2 5 – CT1 16 - ST	14	14	16	7

Exception Reports and Fines:

- No fines submitted
- 7 exception reports still pending

Total number of Doctors in training	**224**

Department	DOCTORS IN TRAINING				Total
	FY1	FY2	ST Lower (CT, CMT, GPST	ST Higher	
AMU				2	**2**
ANAESTHETICS					**0**
CARDIOLOGY					**0**
DERMATOLOGY					**0**
DIABETES					**0**
ELDERLY CARE			1	2	**3**
EMERGENCY			2		**2**
ENT			1		**1**
GASTROENTEROLOGY				1	**1**
HAEMATOLOGY					**0**
MAX FAC			2	1	**3**
OBS & GYNAE			1		**1**
ONCOLOGY					**0**
OPHTHALMOLOGY					**0**

PAEDIATRICS			1		**1**
PAIN MANAGEMENT					**0**
RADIOLOGY					**0**
RENAL			1		**1**
RESPIRATORY					**0**
RHEUMATOLOGY					**0**
STROKE					**0**
SURGERY (GENERAL)					**0**
TRAUMA & ORTHOPAEDICS					**0**
UROLOGY					**0**
VASCULAR				2	**2**
Total	**0**	**0**	**8**	**4**	**12**

Mitigations:

Engagement with the junior doctor workforce continues to improve. The Guardian is following his strategy to engage with the junior doctors, which involves:

Engagement with the junior doctor workforce continues to improve. The Guardian is following his strategy to engage with the junior doctors, which involves:

- The Junior Doctor Forum and Guardian of Safe Working forum have been merged into one afternoon session every 2 months to maximise junior doctors' contribution.

- The Guardian has been communicating with junior doctors through electronic newsletter. This newsletter is focusing on the health and wellbeing of junior doctors.

- Guardian is aware of low number of exception reporting during this quarter and has engaged with the junior doctors through the above mentioned engagement strategy. The Guardian has been reassured through all these forums and meetings that the junior doctors are aware of the exception reporting process and are encouraged to submit one if they feel necessary.

- Junior doctors have been conveyed by the Guardian through above mentioned engagement strategy that the Trust promotes a culture of safe working and high standard of learning opportunity.

Conclusion

Guardian can give assurance to the Trust Board that Junior Doctors in Training (JDT) are safely rostered and their working hours are compliant with the Terms and Conditions of Service for NHS Doctors and Dentists in Training (England) 2016 (TCS).

Impact on the Strategic Goals	
Deliver right care every time	**Y**
Be a brilliant place to work and thrive	**Y**
Drive sustainability (financial and environmental)	
Build innovative partnerships in Dudley and beyond	**Y**
Improve health and wellbeing	**Y**

Implications of the Paper:			
Risk	Y	Risk Description: Risk Description: Implementation of revised JD contract may adversely impact on rotas	
	On Risk Register: Y	Risk Score: COR102 score 16	
Compliance and/or Lead Requirements	CQC	Y	Details: links to safe, caring and well led domains
	NHSE/I	N	Details:
	Other	Y	Details: national requirement for effective guardian role

Report Journey/ Destination *(if applicable)*	Working / Exec Group	N	Date:
	Committee	N	Date:
	Board of Directors	Y	Date: 10/03/22
	Other	N	Date:

Enclosure 20

The Dudley Group NHS Foundation Trust

Paper for submission to Trust Board on 10th March 2022

Title:	Cloud Transition Update Paper – Phase 1
Author:	Sarah Ellis – IT Operations Director
Presenter:	Adam Thomas – Chief Information Officer

Action Required of Committee / Group			
Decision	**Approval**	**Discussion**	**Other**
N	N	N	Noting

Recommendations:
Note the report and Phase 1 Cloud Transition progress update.
Note the analysis for future stages in developing the phase 2 business case in line with the identified capital and revenue.

Summary of Key Issues:

1. Phase 1 work is rated 'green' overall. All work remains on track and broadly on budget.
2. Detailed planning and analysis for phase 2 is underway working with vendors.
3. Work is in place to address intial quotes that are over the approved cost envelope for network links (amber status).
4. Recent 3rd party supplier actions occurring after approval and lessons learned from other organisations, challenge the cost and timeframews of the approved November business. This is due to the following reasons discussed in detail within the paper:
   - Allscripts Sunrise Upgrade
   - Vendor Neutral Archive (VNA) (accessed via Sunrise to view images, reports and documents)
   - Renal Service
   - Backups
5. Quartlery progress reporting will continue.

Impact on the Strategic Goals *(indicate which of the Trust's strategic goals are impacted by this report)*	
Deliver right care every time	
Be a brilliant place to work and thrive	**Y**
Drive sustainability (financial and environmental)	**Y**
Build innovative partnerships in Dudley and beyond	**Y**
Improve health and wellbeing	

Implications of the Paper: *(complete all sections including the Corporate Risk Register and/or the Board Assurance Framework)*			
Risk		Risk Description: Risk Description: COR1540 Failure of the IT Infrastructure (compute, storage & backups) would impact on patient safety and performance	
	On Risk Register: Y	Risk Score:20	
Compliance and/or Lead Requirements	CQC	N	Details:
	NHSE/I	N	Details:
	Other	N	Details:

Report Journey/ Destination *(if applicable)*	Working / Exec Group	Y	Date: February 2022
	Committee	Y	Date: F&P 28th February 2022
	Board of Directors	Y	Date:10th March 2022
	Other	N	Date:

The Dudley Group
NHS Foundation Trust

REPORTS FOR ASSURANCE

Report to Trust Board on 10th March 2022,

Cloud Transition – Summary status Update Report

1 EXECUTIVE SUMMARY

1.1 This paper identifies the progress to date and current status of the approved Infrastructure Business Phase 1. It also provides details of the recent challenges for the next proposed phase of the Cloud Transition.

1.2 Trust Board should be sighted on the status of the approved phase 1 infrastructure programme of work progessing well. External factors beyond the control of the Trust, have resulted in a rephasing of the future proposed Cloud Transition which will be fully described in the business case to follow. These changes will have a financial impact, exceeding the previous forecast of capital and revenue and a corresponding improvement on the speed of accessing benefits. This is being analysed in detail.

1.3 In response to recent 3rd party supplier actions, the proposed Cloud transition phasing over a 4 year period that was included within the approved November business case is now under challenge. This is due to the following reasons:-

- **Sunrise**. Allscripts have announced that the software version in use is now unsupported. They have identified that new infrastructure hardware will be required to enable the software upgrade to take place. This has triggered a review of options to respond to this challenge. Allscripts have also communicated that the annual maintenance and support costs will increase significantly until the Trust upgrades. This is currently under negotiation. An overview of the options available are included in this paper and will be fully described in the business case to follow. The Sunrise application makes up approximately a quarter of the overall onsite data centre footprint.
- **Vendor Neutral Archive (VNA) (accessed via Sunrise to view images, reports and documents)** Elements of the VNA infrastructure exceed extended support in June. The current supplier will not offer any further extended support due to the high risk of failure and reduced likelihood of being able to resolve technical issues. There are complex interdependencies between the VNA and Sunrise infrastructure.
- **Renal.** The current Renal application has been in operational use at the Trust for circa 10 years. Due to an acquisition, the incumbent supplier also has a much-improved solution that is web based and offered as a fully managed service. As the first customer to move from the legacy solution to the replacement system a heavily discounted offer has been made to migrate from the current solution to the fully managed service.
- **Backups.** Establishing backups within the Cloud will be essential to support the decant of the onsite data centres and to shrink from two data centres to 1 and then

none. The recent events of another NHS organisation has resulted in a system failure and has led to systems outages causing significant business and patient impact. A review of options including an accelerated approach of including backups within Cloud will be identified within the Cloud Transition Business Case FY 22/23, to follow.

Sunrise, VNA and Backups were included in the transition to Cloud in 2024 however, due to the supplier responses recently received, the transition phasing has bought these forward to 2022/23. This will introduce a cost in 22/23 for Cloud or to purchase additional hardware onsite.

2 BACKGROUND INFORMATION

Due to the age of the hardware within the 2 data centres onsite at Russells Hall Hospital and the Facilities Management Centre a corporate risk has been identified with a risk score of 20 (CE1540).

Trust Board approved the Infrastructure Phase 1 business case in November which started the journey to Cloud by moving IT systems used for testing from the onsite data centres to Microsoft Azure public Cloud and the investment in hardware for the onsite data centres to provide some mitigation, enabling a reduction of the risk score to 16 when in place.

The journey to the Cloud is a highly complex programme of work spanning multiple years, offering financial, security, operational and system wide benefits whilst heavily supporting the Green Plan.

A business case is in progress which will identify the proposed next phase of the transition to Cloud, setting out the plan for Financial Year 22/23. The case will include a comparison of the costs of operating fully within the Cloud compared to the costs of remaining within onsite data centres with the associated benefits and risk profile.

Trust Board should be sighted on the progress of delivery within the approved scope of Phase 1 transition to the Cloud and the further analysis that has been carried out supporting the proposed future long-term programme of work to fully migrate to the Cloud**.** Phase 1 is currently on schedule and working within the forecast budget.

2.1 Phase 1 Hardware

Due to the risk of hardware failure, phase 1 included the procurement of additional hardware to be used onsite. This will provide limited risk mitigation until furter progress is made to decant from the onsite data centres to Cloud or significant capital investment is made to replace onsite hardware.

Hardware	Delivery	Comments	Budget
Additional server blades		Order placed and due to arrive in May	
Additional Storage		Goods received and implemented	
Additional network hardware		Order can now be raised due to Cloud design complete. Initial quotes are over budget but negotiations	

		are underway to recover this	

2.2 Cloud Landing Zone

The Cloud landing Zone was procure to enable the Trust to make its initial steps into the Cloud technology environment by migrating systems used for testing.

Cloud Elements	Delivery	Comments	Budget
Cloud Network Links		Order raised and work in progress	
Cloud Landing Zone		High and low level design complete, work on track	
Professional Services		Professional services to support the data warehouse are in progress with operational meetings in place including finance	

2.3 Data Warehouse

Phase 1 of the infrastructure business case included the migration of the data warehouse into a Microsoft Azure environment. Future requirements are being scoped to be included within next business case for the migration to Cloud

Data Warehouse Elements	Delivery	Comments	Budget
Data Warehouse design		High level design signed off but Low level design is work in progress.	
Cloud Landing Zone		High and low level design complete, work on track	
Professional Services		Professional services to support the data warehouse are in progress with operational meetings in place including finance	

2.4 Next stage

2.4.1 Hardware

- Negotiation of the costs of the additional network will progress and on conclusion the order will be placed to secure the earliest delivery date.
- On receipt of the additional 5 server blades, these will be added into the resource pool. Delivery dates are anticipated in May

2.4.2 Professional Services

- Working with our established partnered suppliers for the Cloud Landing Zone and data Warehouse will progress via the operational meetings in place to remain on track with the project deliverables.

3 RISKS AND MITIGATIONS

3.1 The impact of 3rd party supplier decisions has resulted in a rephasing of the future transition to cloud which will exceed forecasted capital and revenue spend. A review of this impact and options are currently under analysis and will be included in the Cloud Transition business case to follow. IT are also reaching out to NHS Digital to explore options available to assess and support the challenges faced.

3.2 The aged infrastructure remains as a risk of failure which is recorded as a corporate risk with a score of 20.

4. RECOMMENDATION(S)

4.1 The Trust board are assured that the approved Phase 1 programme of work to migrate test systems and the Data Warehouse to the Cloud is on track in terms of delivery and budget. Partnership working between the Dudley Group and the awarded specialists is progressing well to develop skills and experience as

4.2 Status update reports will be provided to Trust Board for quarterly upward reporting.

Name of Sarah Ellis
Title of IT Operations Director
Date report prepared 2nd March 2022

APPENDICES:

Appendix 1 – None