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NHS
The Dudley Group
NHS Foundation Trust

Board of Directors Meeting Public Papers

Thursday 21st July 2022 10:15 – 14:00pm

The Dudley Group
NHS Foundation Trust

BOARD MEETINGS
PUBLIC INFORMATION SHEET

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

1. Introduction

This sheet provides some information about how Board meetings work.

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

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

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

Helen Attwood
Executive Officer
The Dudley Group NHS Foundation Trust
DDI: 01384 321012 (Ext. 1012)
Email: helen.attwood3@nhs.net

Helen Board
Deputy Trust Secretary
The Dudley Group NHS Foundation Trust
Tel: 01384 321124 ext 1124
email: helen.board@nhs.net

2. Board Members' interests

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

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

3. Opportunity for questions

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

4. Debate

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

5. Minutes

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

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

6. Key Contacts

Andy Proctor
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The Dudley Group NHS Foundation Trust
Tel: 01384 321114
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THE SEVEN PRINCIPLES OF PUBLIC LIFE

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

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

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

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

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

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

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

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

IN PUBLIC

The Dudley Group NHS Foundation Trust

Board of Directors
Thursday 21st July 2022 at 10:15am
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	10:15
2	**Declarations of Interest** Standing declaration to be reviewed against agenda items.	Enclosure 1	Y Buckland	For noting	10:15
3	**Minutes of the previous meeting** Thursday 18 May 2022 Action Sheet 18 May 2022	Enclosure 2 Enclosure 3	Y Buckland	For approval	10:15
4	**Chief Executive's Overview and Operational Update**	Enclosure 4	D Wake/ Executive Directors	For information & assurance	10:20
5	**Chair's Update**	Verbal	Y Buckland	For information	10:40
6	**Public Questions**	Enclosure 5	Y Buckland	For information	10:50
7	**Patient Story** Paediatric Virtual ward	Verbal	L Rozga	For information	10:55
8	**GOVERNANCE**				
8.1	Audit Committee Report	Enclosure 6	G Crowe	For assurance	11:15
8.2	Board and Committee Effectiveness Review	Enclosure 7	A Proctor	For assurance	11:25
	Comfort Break *(5mins)*				
9	**FINANCE AND PERFORMANCE**				
9.1	Finance and Performance Committee Report	Enclosure 8	J Hodgkin	For assurance	11:40
9.2	Integrated Performance Dashboard	Enclosure 9	S Illingworth	For assurance	11:50
9.3	Charitable Funds Committee Report	Enclosure 10	J Atkins	For assurance	12:00
9.4	7 Day Services Compliance	Enclosure 11	J Hobbs	For assurance	12:05
10	**QUALITY & SAFETY**				
10.1	Quality and Safety Committee Report	Enclosure 12	G Bhogal	For assurance	12:10
10.2	Chief Nurse Report	Enclosure 13	M Sexton	For assurance	12:20
10.3	Board Assurance Infection Control Framework	Enclosure 14	M Sexton	For assurance	12:30

10.4	**Presentation** VTE Assessment Data Presentation	Verbal	M Fusi	For assurance	12:40
10.5	Maternity Report including Neonatal Safety, Quality Dashboard and Ockenden	Enclosure 15	C MacDiarmid /S Bannerjee	For assurance	12:50
Comfort Break *(5mins)*					
11	**WORKFORCE**				
11.1	Workforce and Staff Engagement Committee Report	Enclosure 16	J Atkins	For assurance	13:00
11.2	Workforce KPIs	Enclosure 17	A Duffell	For assurance	13:10
12	**DIGITAL**				
12.1	Digital Trust Technology Committee Report	Enclosure 18	V Randeniya	For assurance	13:40
13	**Any Other Business**	Verbal	All	For noting	13:50
14	**Reflections on meeting**	Verbal	All		
15	**Date of next Board of Directors meeting** Thursday 22 September 2022 (public session)	Verbal			
16	**Meeting close**				14:00

Quorum: One Third of Total Board Members to include One Executive Director and One Non-executive Director
Items marked*: indicates documents included for the purpose of the record as information items and as such, no discussion time has been allocated within the agenda.

Enclosure 1

Register of interests 01/04/2021 - 31/03/2022 Board of Directors

The Dudley Group NHS Foundation Trust

Updated 05/07/2022

Name	Position	Date of interest	Description
Thuvarahan Amuthalingam	Associate Non-Executive Director	01/01/2015	Candesic. Consultant. Strategic consultancy services
Thuvarahan Amuthalingam	Associate Non-Executive Director	01/09/2020	GP Salaried - GP with special interest in dermatology seeing patients on behalf of SWBH and private patients
Thuvarahan Amuthalingam	Associate Non-Executive Director	23/09/2016	Managing director. Medcas Group Limited. Private clinical, training and consultancy services
Thuvarahan Amuthalingam	Associate Non-Executive Director	13/07/2021 - 13/07/2021	Dudley Integrated Health and Care Dinner With Both Medical Directors
Thuvarahan Amuthalingam	Associate Non-Executive Director	01/01/2015	Candesic. Consultant. Strategic consultancy services
Thuvarahan Amuthalingam	Associate Non-Executive Director	01/09/2020	GP Salaried - GP with special interest in dermatology seeing patients on behalf of SWBH and private patients
Thuvarahan Amuthalingam	Associate Non-Executive Director	23/09/2016	Managing director. Medcas Group Limited. Private clinical, training and consultancy services
Julian Atkins	Deputy Chairman	01/06/2004	Board Chair of Coventry and Warwickshire Chamber Training
Julian Atkins	Deputy Chairman	01/09/2021	Non-Executive Director of an organisation called ENTRUST
Gurjit Bhogal	Associate Non-Executive Director	01/10/2015	Aston Villa Football Club, Doctor providing medical care for Aston Villa
Gurjit Bhogal	Associate Non-Executive Director	01/05/2015	Bhogal Medical Services Limited, Doctor, Clinical work - primary care & private MSK work
Gurjit Bhogal	Associate Non-Executive Director	01/09/2015	Royal Orthopaedic Hospital, Consultant in MSK & Sports Medicine. NHS substantive consultant job
Gurjit Bhogal	Associate Non-Executive Director	01/05/2021	Mencap Heart of England. Trustee. Charitable Trustee Role
Gurjit Bhogal	Associate Non-Executive Director	24/08/2021 - 01/12/2021	Co-Chair of the ICC T20 Cricket World Cup Biosecurity Advisory Committee
Yve Buckland	Chairman	01/01/2022	Trustee - national charity for adults with ADHD
Yve Buckland	Chairman	01/04/2020 - 28/02/2022	Trustee Tessa Jowell Foundation ended Feb 2022
Yve Buckland	Chairman	16/01/2021	Independent Chair of Birmingham and Solihull ICS (Integrated Care System)
Yve Buckland	Chairman	01/04/2020	Pro Chancellor Aston University
Gary Crowe	Non-Executive Director	01/09/2019	Independent Member, The Human Tissue Authority
Gary Crowe	Non-Executive Director	01/09/2019	Non Executive Director, University Hospitals of North Midlands NHS Trust
Gary Crowe	Non-Executive Director	01/09/2019	Occasional lecturer, Keele University
Alan Duffell	Chief People Officer (Interim)	20/06/2022	Chief People Officer at The Royal Wolverhampton NHS Trust
James Fleet	Chief People Officer	01/04/2020	Director of Equipped Solutions Ltd. This company provides consultancy services to the NHS.
James Fleet	Chief People Officer	09/03/2020	Appointed Chief People Officer at the Trust
James Fleet	Chief People Officer	01/04/2020	Director of Equipped Solutions Ltd
James Fleet	Chief People Officer	01/04/2020	Director of Equipped Solutions Ltd. This company provides consultancy services to the NHS.
James Fleet	Chief People Officer	09/03/2020	Appointed Chief People Officer at the Trust
James Fleet	Chief People Officer	01/04/2020	Director of Equipped Solutions Ltd
James Fleet	Chief People Officer	01/05/2021	Equipped Solutions Trading Ltd, Company no: 13404935. This company is completely unrelated to healthcare. I am the only Director and own 100% of the shares.
James Fleet	Chief People Officer	01/04/2018	Equipped Solutions Ltd had a commercial relationship with CRF Partnership prior to J Fleet becoming a Trust Director. All relevant disclosures and appropriate actions have been taken in relation to any commercial arrangements arising since that time.
William Hobbs	Medical Director	05/07/2021	Nil
Jonathan Hodgkin	Non-Executive Director	06/03/2019	Director of Dudley Clinical Services Limited which is 100% owned subsidiary of the Trust
Catherine Holland	Senior Independent Director	25/03/2022	Nil
Elizabeth Hughes	Non-Executive Director	01/04/1990	Consultant Chemical Pathologist Sandwell and West Birmingham Hospitals NHS Trust
Elizabeth Hughes	Non-Executive Director	01/10/2012	Deputy Medical Director Health Education England
Elizabeth Hughes	Non-Executive Director	01/04/2018	Director Dinwoodie Charitable Company
Elizabeth Hughes	Non-Executive Director	03/07/2007	Trustee HEARTUK Charity
Elizabeth Hughes	Non-Executive Director	02/08/2021	appointed Honorary Professor at Warwick Medical School
Elizabeth Hughes	Non-Executive Director	01/09/2016	Honorary Professor University of Aston
Elizabeth Hughes	Non-Executive Director	01/07/2008	Honorary Professor University of Birmingham
Elizabeth Hughes	Non-Executive Director	01/03/2017	Honorary Professor University of Worcester
Thomas Jackson	Finance Director	01/02/2017	Chair and Trustee of St. Helens Autism Support registered charity
Thomas Jackson	Finance Director	01/02/2017	Chair Liverpool St. Helens FC CASC registered Rugby Union Club
Thomas Jackson	Finance Director	01/02/2017	Governor Lansbury Bridge Sports College
Karen Kelly	Chief Operating Officer	05/07/2021	Nil
Andrew Proctor	Director of Governance/Board Sec	08/06/2022	Nil
Vijith Randeniya	Non-Executive Director	06/10/2014	Board member of Aston University
Vijith Randeniya	Non-Executive Director	05/10/2020	Chair, Trent Regional Flood and Coastal Committee, DEFRA
Vijith Randeniya	Non-Executive Director	02/06/2014	Vice Chair of Birmingham Women and Children's Hospital
Kat Rose	Director of Strategy & Partnerships	19/04/2022	Nil
Mary Sexton	Chief Nurse	29/09/2021	Nil
Kevin Stringer	Director of Finance (Interim)	14/06/2022	Chief Financial Officer and Deputy Chief Executive The Royal Wolverhampton NHS Trust
Kevin Stringer	Director of Finance (Interim)	14/06/2022	Interim IT Director and SIRO Walsall Healthcare NHS Trust
Adam Thomas	Chief Information Officer	01/07/2019	Director of Dudley Clinical Services Limited which is 100% owned subsidiary of the Trust
Diane Wake	Chief Executive	05/07/2021	Nil
Lowell Williams	Non-Executive Director	01/12/2019	Lowell Williams Consulting Limited
Lowell Williams	Non-Executive Director	01/04/2021	Director of Dudley Clinical Services Limited which is 100% owned subsidiary of the Trust
Lowell Williams	Associate Non-Executive Director	01/12/2019	Lowell Williams Consulting Limited

Enclosure 2

The Dudley Group
NHS Foundation Trust

UNCONFIRMED **Minutes of the Public Board of Directors meeting (Public session)**
held on Wednesday 18th May 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)
Karen Kelly, Chief Operating Officer (KK)
Tom Jackson, Director of Finance (TJ)
Vij Randeniya, Non-Executive Director (VR)
Kat Rose, Director of Strategy & Partnerships
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)
Sudipta Banerjee, Clinical Service Lead, Consultant Obs. & Gynae. (SB) [agenda item 11.4]
Phil Brammer, Deputy Medical Director (PB) [agenda item 7]
Helen Board, Deputy Trust Secretary (Minutes) (HB)
Paul Hudson, Deputy Medical Director (PH) [agenda item 7]
Babar Elahi, Chief of Surgery, Consultant Ophthalmology (BE) [agenda item 11.4]
Claire McDiarmid, Head of Midwifery (CMc) [agenda item 8.4]
Andy Proctor, Director of Governance & Board Secretary [joining the Trust in June 2022]

Apologies
None received

Governors and Members of the Public and External attendees
Helen Ashby, public elected governor, Stourbridge
Cllr Rebbekah Collins, appointed governor, Dudley MBC
Ian Frankom, Ipsen International [part of the meeting]
Emily Townsend, Health Service Journal
Thomas Parker, MNA Media

22/16.0 Note of Apologies and Welcome

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

22/17.0 Declarations of Interest

There were none other than those contained on the Register given as enclosure 1.

22/18.0 Minutes of the previous meeting held on 10th March 2022

It was **RESOLVED**

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

All actions had been completed except for; 21/105 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. 22/08.01 VTE presentation by Junior doctors to be received at July meeting.

22/19.0 Chief Executive's Overview and Operational Update

DW summarised the report given as enclosure 3 and highlighted the arrangements now in place to reflect the recent relaxation of the social distancing guidelines. All clinic templates had been risk assessed and theatre lists reviewed to increase activity to support restoration and recovery and improvement of cancer standards performance. Referrals received across each of the four acute providers in the Black Country had seen a return to pre-COVID levels. Performance was tracked as a System with providers working together to eliminate long waiters. The Trust was meeting the 2 week target across all specialities and had no patients waiting longer than 104 weeks. Mutual aid was being provided to neighbouring trusts to reduce all 104 waiters to zero by the end of June.

The number of inpatients with COVID-19 remained below 30 with 15 reported for that day and noted that one patient was receiving critical care. Community transmission rates had reduced significantly. There was also a significant reduction in staff absence owning to COVID-19 or related reasons with less than 20 off at the time of reporting.

Diagnostic standards performance was also performing well and supported by the recently established Clinical Diagnostic Centres providing additional CT and MRI scanning capacity. This enabled the Trust to see urgent care patients at the Russells Hall Hospital more quickly than before. With uncertainty about what added pressure COVID-19 and flu could place on winter pressures, the Trust applied all effort to increase activity and aspire to 110% activity over the summer period.

LH applauded the progress made on clearing the backlogs and good performance on the cancer pathways and asked if there were barriers impeding further improvement. DW replied that the biggest impact was turnaround on histopathology services where the Trust experienced delays in getting results back. The Black Country Pathology Service had acknowledged the issue and reported on plans to outsource some services and focus on recruitment with an anticipated return to normal service levels by September. Trust action included ensuring that clinicians marked samples correctly and to mark those that are genuinely urgent are marked urgent.

CH commended the performance and asked what the Trust was doing differently that others in our local system could perhaps learn from. She asked about mask wearing compliance for staff and visitors. DW advised that maximising theatre utilisation with seven day working had been a priority to support and maintain elective capacity at 110% compared to the 2019/20 activity levels and strive to maintain it. There were some staffing challenges and had pressed ahead with recruitment and retention plans. The PPE Marshals had been stood down with no appreciable decline in mask wearing.

In response to the query from GB about visiting arrangements DW confirmed that the Trust worked to the national standards and continued to adopt a flexible and humanitarian approach with visitors logged in case they needed to be traced as a result of an outbreak. Optimisation to support elective recovery adopted several approaches and noted the cohesive working of the four acute providers to address including moving towards a central waiting list.

DW noted that urgent and emergency care performance remained a challenge with patient flow a contributing factor and continued to work collaboratively with partners. The Home for Lunch campaign was making some progress to support earlier and better discharges and had adopted a range of initiatives including delivery of TTO (take home medication) to patient's home. VR commented that as the Home for Lunch champion he was disappointed that the perfect fortnight had not gone as well as planned and suggested that this be a deep dive topic at the next board meeting.

Action Home for Lunch deep dive to be added to the agenda of the June Board meeting **Trust Secretary**

DW noted that the Trust had celebrated the day of the midwife in May commending their commitment during COVID-19 and merited their achievements for the Trust.

DW reported the establishment of a Provider Collaboration Board in line with recent guidance issued with Sir David Nicholson appointed as chair. DW provided a summary of the revised governance arrangements and noted the progress made with the formation of clinical networks and the significant work underway improving pathways for our patients, focussing on access to healthcare and reducing inequalities and gave example of urology and colorectal pathways. The system approach aimed to utilise the latest robotic technology.

DW highlighted the national recognition received for the Trust's AAA (abdominal aortic aneurism) screening programme.

GC commended the progress made on elective recovery and the System approach to high volume pathways. He was keen to be assured that lessons learned during the pandemic had not been lost and that innovation at scale was retained. DW highlighted digital solutions as a key enabler and noted some specialities that had successfully retained the Attend Anywhere virtual appointment solution. Patient Initiated Follow Up (PIFU) was being driven nationally and the Trust was a lead performer on this. Mrs Ashby asked if the Trust was collecting data about what patients thought about virtual appointments and noted she had received positive feedback about the asthma clinic that had benefitted the family involved with no travel or parking charges and not split up the family. DW confirmed that this was collected and would be considered System wide. AT commented that in the first year of using virtual consultation, it had saved 2 million health miles in and around Dudley which would bring wider health and environmental benefits.

Freedom of the Borough had been awarded to NHS staff in Dudley. DW had attended the event and had accepted the charter presented by the Mayor on behalf of the NHS in Dudley.

It was **RESOLVED**

- **That the report be noted**

22/20.0 Chair's Update

The chairman provided a verbal update highlighting the recent conclusion of mid-year appraisals for the non-executive directors and the chief executive.

There was a move to bring committee meetings and other board activities back on site and noted that feedback from non-executive quality walk about activity was considered in Private board. Public sessions of board meetings would remain in a virtual format and noted the improved attendance by governors, staff and external guests. Board meetings had moved back to Thursdays having previously moved to Wednesdays to accommodate System matters that had not materialised.

The chair thanked Governors for their participation in the quality and safety reviews that had been resumed. The chair and chief executive had recently hosted an afternoon tea providing an opportunity for both existing and newer governors to meet members of the board in an informal setting.

The chair noted the activity and discussions taking place with the Dudley System partners to shape the future pathways for Dudley Place to realise benefits for patients in line with the triple aims set by the secretary of state for health.

22/20.1 Well-led Review Action Plan

The chair provided a summary and noted that the action plan had been developed to reflect the recommendations of the Well-led Review report and would be monitored at future meetings. All actions were underway.

It was **RESOLVED**

- **That the report be noted**

22/20.2 Enhancing the NED Role – new guidance report

The chair summarised the report that had reflected the review that had been undertaken and mapped against new guidance issued in December 2021 by NHS England. The report would be shared with the Council of Governors to support their role of holding non-executive directors to account. Any changes required will be reflected in the board committee effectiveness reviews.

JA raised a point of clarification that the report should note that he also chaired the Freedom to Speak Up Steering Group.

22/21.0 Public Questions

There had been none submitted.

22/22.0 Presentation – Virtual Ward

JHO merited the innovation and the work undertaken by Dr Brammer, Dr Hudson and the team to establish virtual wards. Following a recent visit by the national team the service had been classed as an exemplar. They had noted the very skilled physicians who were effective at managing risk, utilising and harnessing technology.

Phil Brammer gave context to the term virtual ward as way of supporting discharge and / or avoiding admissions. It had been spearheaded by the respiratory team and designed principally as a secondary care step down model. The format had also been applied and utilised as a frailty virtual ward and a COVID-19 virtual ward with paediatric virtual ward launched in March. He described the next steps to embed the format in other areas of the Trust.

GB acknowledged the many advantages of the virtual approach to clinical care and asked if there had been other consequences of the programme as an approach to addressing health inequalities and supporting staff to work in a different way. Dr Brammer commented there may be some groups of staff and patients where digital proficiency or access was a challenge. The initiative had yet to establish the maximum and optimum number of patients on a virtual ward and achieve the balance of what is effective and provided the patient with appropriate oversight. There was more to do to ensure that Wi-Fi enabled technology was appropriate. There were various apps available that were easy to use. The team were taking decisive but cautious steps to manage the balance between face-to-face versus virtual visits with the focus on improving the patient experience.

In response to a question from Mrs Ashby, there was no significant loss or damage of equipment provided to patients. Compared to hosting a patient in a hospital bed and supporting flow through the hospital it represented a net gain. The service was dependent on dedicated staff to deliver safe and professional services and commended the respiratory teams as a quality team.

In the context of nurses travelling to see patients JA referenced the services provided by cancer services staff travelling to patients' home to administer chemo that was positively received and asked if the virtual ward could share learning. Dr Brammer replied that the respiratory service had offered home visiting services for 18 years and had learned a lot about what patients really value noting that it would be a balance and adopted on a case by case basis. JHO commented that prior to the pandemic, the Trust had a lower length of stay compared to other trusts and had continued to maintain this performance which had been acknowledged by the national team.

The chair commended the innovation that helped to reinforce the role of the Trust as an anchor organisation in the community and the ability to extend our services to the patient's home. She noted that the Trust had shared best practice with a number of London providers as an innovation that had come directly out of COVID-19 and was now building this into business as usual. On behalf of the board she gave thanks to the teams involved.

22/23 STRATEGY

22/23.1 Strategy Progress Report Q4 2021/2022

KR summarised the report given as enclosure seven as the first quarterly report issued since the launch of the Trust's refreshed strategy and highlighted the work around elective care and positive work engaging with the communities to increase access to the breast screening service. She noted the areas where performance and efficiency required improvement such as theatre utilisation. Dudley Improvement Practice were supporting the programme to drive improvement which would be monitored by the Finance & Performance Committee and the Financial Improvement Group.

It was **RESOLVED**

- **That the report be noted**

22/24.0 FINANCE AND PERFORMANCE

22/24.01 Finance & Performance Committee Report

JH summarised the report given as enclosure 8 and noted that that the ethics of international recruitment of nurses would be addressed in the chief nurses' report.

The chair directed a question to TJ who would shortly take up the role of System's Director of Finance about how the resources would be balanced and if the System priorities would contradict those of providers. TJ reported that resource allocations would be subject to a one year planning round and have subsequently broken it down to quarterly planning noting that most of the 42 Integrated Care Systems were struggling to break even. Year-end contingencies would be distributed early with details still to be confirmed. It was anticipated that cash flow would remain a problem and the Trust could expect to have an £8m deficit as a share of current System deficit. Further allocation information was expected in the next few weeks. The focus would remain on performance as a System noting that the CQC regime would inspect on a System basis.

It was **RESOLVED**

- **to note the assurances provided by the Committee, the matters for escalation and the decision made**

22/24.02 Integrated Performance Dashboard

KK summarised the report given as enclosure 9 and highlighted ambulance handover targets had not achieved zero and the Trust continued to work with partners and the ambulance service to ensure that patients remained safe whilst waiting to offload. Targeted actions to increase patient flow had not achieved the required level of improvement and the Trust was now reviewing other options. A short term solution had been to provide extra capacity by opening additional beds. Elective activity was currently at 106% when compared to pre covid levels.

The chair commended the performance on elective recovery and noted the challenges faced by the urgent and emergency care services and asked if ahead of next winter there was more to be done to increase the amount of step down facilities. KK reported that 2021/22 winter planning had been modelled on 40 delayed transfers of care and flagged that the actual position was often in excess of 100 patients who were medically fit for discharge on any given day. KK described the process of assessment that may result in pathway 3 patients being overprescribed for the services they may need at home and suggested a solution that would provide assessment beds or discharge to assess.

Mrs Ashby noted that paediatric triage had performed worse in March owing to nurses being redeployed and asked where they were moved to. KK advised that they had stayed within the department and had reviewed majors triage to ensure that other areas are supported and moved to the area with the greatest need.

It was **RESOLVED**

- **That the report be noted**

22/25.0 WORKFORCE

22/25.1 Workforce and Staff Engagement Committee Report

JA summarised the report of the last meeting that had focussed on a national staff survey deep dive to review the results and considered action plans. The committee had also considered the Trust strategy from the staff perspective with feedback from the inclusion networks and divisions.

It was **RESOLVED**

- **to note the assurances provided by the Committee, the matters for escalation and the decision made**

22/25.2 Workforce KPIs

JF summarised the report given as enclosure 11 and highlighted staff sickness absence had significantly reduced for those off with Covid-19 or Covid-19 related sickness equating to under 7% of sickness overall.

There had been a marginal improvement in the filling of vacancies and an increase in shift fill recognising there was still more to do. The Trust had used more bank and agency than planned that was attributable to some year-end issues.

In response to concerns raised by non-executive colleagues, JF agreed to provide a projection of the planned reduction of bank and agency spend with key milestones. The approval of the

International Nurse recruitment business had been caveated to receive a detailed 'flightpath' which would be submitted to the next meeting of the Finance and Performance Committee.

The chair noted that the Council of Governors has raised concerns about mandatory training compliance and were seeking assurance about recovery on resuscitation and manual handling training. JF confirmed that a formal presentation of an action plan was scheduled to be considered at the next Workforce and Staff Engagement Committee meeting.

It was **RESOLVED**

- **That the report be noted**

22/25.3 National Staff Survey Results

JA highlighted that the Trusts staff survey results compared favourably to our peers and noted the significant increase in the Trusts response rate to 59% compared to 13% increase in the previous year and was more representative of the staff community. The national deterioration in results directly related to staff experience during the pandemic. Whilst the Trusts results had worsened less comparatively, there remained strong challenge from non-executive colleagues to each of the divisions who had presented their detailed action plans.

JF commented that the deep dive activity had supported open and honest discussions about the areas where improvement had been identified. He summarised the report given as enclosure 12 and clarified that the results had been organised under each of the 'People Promises' with a focus on the deterioration where ours has been less than our peers. It was salutary to note that the celebration of improvement was not the focus and guided colleagues to review the divisional summaries where a RAG rating had been applied. Each of the specialities rated with mostly red ratings had been invited to present their improvement plans grouped by division. He highlighted that one key message from the results was staff not feeling recognised within their teams or by their immediate line manager or leadership team.

JH queried the usefulness of the RAG rating when teams were very small and too granular to effect meaningful performance change. GB asked what we could learn from other Trusts who consistently achieved better results. LW noted that the tables had been scrutinised in detail at the deep dive session where the same teams had been in both the top ten and the bottom ten and was encouraged by the identification of quick wins that could be gained from immediate actions.

JF confirmed that data was presented where there were no less than 11 in the respondent group. He noted that the improvement actions identified for the maternity teams was supported by the Dudley Improvement Practice Team. JF commented that those trusts maintaining consistently good results have a rigorous and proactive approach in equipping line managers with the skills that they need and this has impacted positively; recognised to improve patient experience as well as staff experience.

It was **RESOLVED**

- **That the report be noted**

22/25.4 Gender Pay Gap Annual Update

JF summarised the report and highlighted that the pay gap and representation measure different things and noted the Trusts actions underway to improve the position. Substantive issues that drive the gender pay gap at the Trust is the lower number of men employed in lower banded roles and the steps to encourage men into those roles which historically didn't attract men, such as care roles,

would be the focus of discussion at the Workforce Committee and the Equality Diversity Steering Group.

MS advised that a longer term solution was underway with a national campaign to encourage men into nursing and noted the perception within the staff groups that the gender pay gap was simplified as not the same pay for the same role within our organisation.

CH commented that the statistics in gender pay gap charts are illustrative of the time it can take for change to happen. The lived experience of staff that would contribute primarily to positive change and would depend on the perception as a Trust wide approach.

It was **RESOLVED**

- **That the report be noted**

22/25.5 Workforce Race Equality Standard summary for 2021/22 reporting year

JF explained that the report was issued nationally with data drawn from a wide variety of sources and reported that the Trust sat in the middle of the pack overall and within the individual indicators the Trust featured in the higher and lower areas. The results had seen improvement compared to previous years with more work still to. The Equality Diversity Inclusion (EDI) Steering Group oversaw the development of the strategy and delivery of actions.

In response to comments from VR and GC, JF advised the Trust would target resources proportionally to follow the data and as an early adopter of the Race Code had continued to develop initiatives and actions and gave examples. A review of the diversity reporting and potential linkage to bullying and harassment would be considered at the Workforce Committee.

Action National survey - review of the diversity reporting and potential linkage to bullying and harassment to be considered at the Workforce Committee **JA**

It was **RESOLVED**

- **That the report be noted**

22/26.0 QUALITY AND SAFETY

22/26.1 Quality and Safety Committee Report

LH introduced the report given as enclosure 15 and highlighted the positive assurances received relating to improved SSNAP data, improved closure of actions related to serious incidents investigations by the medicine division and the improvement in the VTE performance. The chair merited the work of the junior doctors in resolving the VTE data issue and was supportive of their involvement in other quality improvement projects.

The Committee had ratified the patient safety voice volunteers and patient safety partners framework and policy and approved the Patient Safety Strategy.

It was **RESOLVED**

- **to note the assurances provided by the Committee, the matters for escalation and the decision made**

22/26.2 Chief Nurse Report

MS presented the report and highlighted that the governance responsibility for the vaccination centre sat with the Trust and was in discussion with system colleagues for the facility to be established as business as usual and noted the overwhelmingly positive feedback received from patients.

The increased number of DOLS (deprivation of liberty standards) submissions was reflective of the recent appointment of a mental health lead and awareness raising amongst staff. There had also been a similar increase in the number of a safeguarding concerns being raised. A domestic abuse co-ordinator role had been appointed and would be in place shortly to support clinical teams.

The thematic review of tissue viability was complete and had met with commissioners to strengthen the process and training provided to staff.

The first 75 international nurse recruits had all passed their OSCE (objective structured clinical examination) and would be registered on the NMC register and be counted within our establishment. Support was in place from the professional development team. An additional 53 had arrived at the Trust during March and April of which all had passed their OSCE on the first attempt and reflective of the support they are receiving. It was important to note that many were experienced and transitioning well with two already promoted. Individual career conversations were undertaken to maximise their clinical skills and aspirations. There was an extensive pastoral programme in place to support them with practical issues such as opening bank account and finding accommodation. A celebration event had been held to commend their achievement of their OSCE and arrangements had been put in place with the divisions to place them in small groups within teams and ward areas and support reduction of vacancies. Expectations have been set that those areas will adhere to an agreed reduction in bank and agency usage.

Non-executive colleagues commended the progress made and asked for assurance that the initiative would reduce bank and agency and an effective holding to account mechanism be evident. MS confirmed that a report would be prepared for the June meeting.

It was **RESOLVED**

- **That the report be noted**

Learning disability DNACPR review

MS introduced the report given as enclosure 17 and highlighted the completion of an internal and external review into the DNACPR (do no attempt cardiopulmonary resuscitation) decisions of patients with Learning Disabilities during wave one of the Covid-19 pandemic.

The board were asked to note the scope of the review and the recommendations arising and receive confirmation that the actions had been fully implemented and the report was shared with the Dudley Safeguarding Board.

The identified learning and actions from the reviews had led to the development and implementation of robust systems to review all deaths of patients with LD (Learning Disabilities) and recognise, share, and act upon learning. The process was overseen by the Trust's mortality lead with input from the lead for learning disability and now fully embedded.

The chair noted the importance of the review and the Trusts dedication to being open and how learning from the review would strengthen the quality of care provided.

Mr Ashby commended the review and asked for an update on progress to provide LD liaison staff as a seven day service and what steps were being taken to raise awareness of the service amongst staff. MS confirmed that the recruitment was underway to support a seven day service and will work

towards a 24/7 provision. *Post meeting note: awareness raising on a number of levels undertaken during Learning Disability week that ran from Monday 20th June 2022.*

The chair thanked LH and CH for their contribution to the work of the Ethics Committee.

It was **RESOLVED**

- **That the report be noted**

22/26.3 Maternity Report including Neonatal Safety, Quality Dashboard and Ockenden

MS introduced colleagues Mr Elahi, Chief of Surgery, Ms Banerjee, Clinical Service Lead and Claire MacDiarmid, Head of Midwifery.

Claire MacDiarmid summarised the report given as enclosure 17 and highlighted that during the assessment of the perceived increase in death rates, it had become evident that a backlog in the reviews was contributory and had now assigned a dedicated midwife to coordinate and track all of the reviews and utilise the independent external NPMRT (National Perinatal Mortality Review Tool).

The Continuity of Carer review had concluded with a report to be submitted to the next meeting of the Board.

An Insight Team Visit had taken place on the 20th April comprising colleagues from NHS England, Local Maternity Neonatal System (LMNS) and the Clinical Commissioning Group (CCG) who had used an appreciative enquiry approach to provide assurance against the requirements of the seven immediate and essential actions from the Ockenden report. Positive feedback was received in relation to staff working well together, the implementation of the twice daily ward round, excellent leadership and expertise. The Team had merited the linkage between public health service and the community teams. Recommendations had included improved visibility of senior staff, some re-banding suggestions and robust succession planning. Good comments were also made about midwives and support workers with a recommendation to introduce buddying arrangements to improve health outcomes through shared learning; this would be implemented.

LH confirmed that she was present at the review and noted her participation in monthly walk rounds. Posters had been displayed to raise awareness amongst staff about the maternity safety champions. There was evidence to support significant improvement made and acknowledged there was further work required.

JA commended the report and the detail given had provided assurance that improvements had been made. He asked whether the Trust operated below the recommended ratio of midwives. Claire MacDiarmid confirmed that the Trust ratio is currently 1:31 and were focussing on recruitment.

Mr Elahi commented that an IT Engagement Group had been established and provided a forum to support issues as they arose and collect feedback. He noted progress on embedding the twice daily ward round and improvement made to the visibility of senior staff and safety champions. Ms Banerjee confirmed that recent recruitment activity had resulted in appointments to all vacant senior roles as set out in the Ockenden recommendations.

JHo commended the value of Sunrise as a patient management system and noted that the benefits were not highlighted in the report to support assessment and monitoring of patients and sharing of data.

GC stressed the importance of cross referencing the service improvement programme to the internal audit review and the recommendations arising from the previous year's activity.

AT asked the Board to note that the Trust had been awarded maternity funding for continuing the work to link up maternity systems in the Black Country as well as being an active leader at Place in joining up to the Midlands One Health and Care Record.

The chair noted her appreciation of the attendance of the clinical leadership and thanked them for supporting senior executive to provide assurance over and above the delivery of the report.

Ockenden
MS provided an update on actions taken as recommended in report published 30th March 2022 that contained 15 separate areas of focus that the team were are working through and cross referencing with the existing maternity improvement plan to combine into one plan. The Quality & Safety Committee would consider the plan as a deep dive at its June meeting and report back to the Board in July.

It was **RESOLVED**

- **That the report be noted**

22/27.0 Audit Committee Report

GC summarised the report given as enclosure 18 highlighting that the Trust was on track for a positive outcome for the financial year end and the end of year audit and review. A positive opinion was expected from the auditors in relation to the effectiveness of our internal controls.

It was **RESOLVED**

- **to note the assurances provided by the Committee, the matters for escalation and the decision made**

22/28.0 Charitable Funds Committee Report

JA reported positive assurance in respect of £100k awarded by NHS Charities Together to support the Trusts volunteering service to recruit 10 volunteers to train 100 volunteers and fund administrative support for the initiative. In year, the Trust had received £677k and spent £524k on a variety of schemes large and small. The Committee had approved funding for a portable MRI machine for use with Dudley stroke patients.

He outlined the format of the forthcoming Will fortnight and the progress of the erection of the Rainbow sculpture. Plans were underway to launch a £1m appeal over two years which would be considered at the next meeting.

In response to a question raised by the chair, JA replied that whilst funds had historically been used to fund water fountains there had been no applications more recently. He noted that charitable funding would support the development of staff wellbeing areas.

It was **RESOLVED**

- **to note the assurances provided by the Committee, the matters for escalation and the decision made**

22/29.0 Any other Business

There was none raised.

22/30.0 Reflections on the meeting

Many present indicated that the meeting had benefitted from being held ahead of the private session noting that discussion had been robust with transparency demonstrated in responses that had acknowledged successes and improvements required. The chair thanked governors for their continued support and attendance.

22/31.0 Date of next Board of Directors Meeting

The next meeting would be held on Wednesday 21st July 2022. Via MS Teams.

22/32.0 Meeting Close

The chair declared the meeting closed at 13:13hr.

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Yve Buckland **Chair** Date:

Enclosure 3

The Dudley Group NHS Foundation Trust

Action Sheet
Minutes of the Board of Directors (Public Session)
Held on 18th May 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~~ Date tbc	Request to defer until newly appointed Director in post **Work in progress**
22/08.1	Quality and Safety Committee Report	Junior doctors to present the VTE assessment data capture review report to the Board of Directors	Medical Director	July 2022	**Complete** agenda item for July Board
22/09.1	Finance and Performance Committee	Arrange deep dive session after private board on the transformation agenda for the Trust and System.	Exec directors	Date tbc	Provisionally scheduled to follow board meeting. Date to be confirmed
22/19.0	Chief Executive's Overview and Operational Update	Home for Lunch presentation to review perfect fortnight	Chief Operating Officer	June 2022	**Complete** received
22/25.5	Workforce Race Equality Standard summary for 2020/21 reporting year	National survey - review of the diversity reporting and potential linkage to bullying and harassment to be considered at the Workforce Committee	Workforce Committee Chair	Date tbc	

Enclosure 4

The Dudley Group NHS Foundation Trust

Paper for submission to the Board of Directors on 21st July 2022

Title:	Public Chief Executive's Report
Author:	Diane Wake, Chief Executive
Presenter:	Diane Wake, Chief Executive

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:

- Mask wearing re-introduced
- Committed to Excellence
- Alex Griffiths awarded British Empire Medal
- Charity Update
- Healthcare Heroes
- Patient Feedback
- RACE Equality Code – Quality Mark achievement
- Provider Collaborative
- Restoration and Recovery
- Integrated Care Board
- 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: 21st July 2022
	Other	N	Date:

CHIEF EXECUTIVE'S REPORT – PUBLIC BOARD – 21st July 2022

Mask wearing re-introduced in all Trust areas

Following the national guidance to cease the wearing of face masks in all Trust areas other than those assessed as high risk, we stopped wearing face masks on the 15th June. We closely monitoring the COVID-19 infection rates across the community and our staff and have seen over the last week a marked increase in both rates. We reinstated masks wearing across all Trust premises for our staff and visitors and patients from 11th July. This coincided with a message from NHSE that it would be sensible to reintroduce across all healthcare settings so we are in line with partners locally and nationally.

The Dudley community rate is 195.1 per 100,000 population (w/c 06.07.2022), this is the highest in the Black Country. Our numbers of inpatients is slowly rising however critical care cases remain low.

Masks are available at all hospital entrances and we ask all staff and visitors to wear one when in our buildings.

We also ask visitors to inpatient wards not to visit if they have any flu or cold like symptoms to help us prevent the spread of infection amongst our poorly patients and to help protect our staff.

All Black Country hospital trusts have either reinstated or are about to reinstate mask wearing to help prevent the spread of infection.

We will continue to evaluate mask wearing both in Dudley and with colleagues across the region.

Committed to Excellence

Our annual staff awards Committed to Excellence are now in their 14th year and recognise teams and individuals who go the extra mile for our patients, whether giving direct care or in vital back office supporting roles.

The awards celebrate outstanding care, compassionate staff, team spirit, innovation and those who have made a significant improvement in quality, safety and patient experience. They give staff across the Trust, and from our partner organisations, the opportunity to nominate colleagues in both clinical and non-clinical roles.

Shortlisted finalists will be treated to an awards night in July where the winners will be announced. Finalists can be found here http://www.dgft.nhs.uk/committed-to-excellence/

Alex Griffiths awarded British Empire Medal

Congratulations to clinical support worker Alex Griffiths who has been awarded a British Empire Medal (BEM) in the Queen's birthday honours list.

Alex was recognised for his dedication and commitment to helping COVID patients during the pandemic. He is also a long-term carer having cared for his mother, who has multiple sclerosis, since he was five, and later caring for his grandparents also.

Charity Update

NHS Charities Together Big Tea

Our charity fundraising team organised a day of celebrations across the Trust with several teams and departments getting into the spirit to raise funds for our Trust Charity, through the growing NHS Charities Together Big Tea event. It was a welcome opportunity for our staff to take a break and grab a cuppa and some cake whilst raising vital funds. So far it has raised over £500 and we are yet to receive the donations that our PFI partners Starbucks and our corporate business partner raised.

Wellbeing Hub

Back in November 2021 the charity was successful in being awarded £121,000 of funding from NHS Charities Together. The funding will go towards creating a brand-new staff only wellbeing hub at the Russells Hall Hospital is also being supported by the Trust and our PFI partners.

Three ‘mood’ boards were shared with staff and over 400 people responded to vote for their preferred design style. Nature was the winning theme and designs will now be drawn up for final agreement. It has been great to engage our workforce in designing this much needed relaxation/break out area.

Healthcare Heroes

Medical Engineering Team - June 2022

The team were been nominated for the quality of service they provide to our Trust. No job is too much or too difficult as they ensure all our medical equipment is serviced and repaired properly. They work in the background day and night to keep our equipment running and making sure it is always available for the wards that need it. Their work spans across Russells Hall Hospital, Corbett outpatients, Guest outpatients and our community services to help keep all our sites running smoothly. The team work so hard and with such efficiency, it’s great show them the appreciation that they more than deserve.

Laura McCaffery - May 2022

Laura has received her nomination because of her incredible response when she witnessed a road traffic accident while out visiting patients in the community. She immediately attended the accident where she had to perform CPR which saved the person's life. She also ensured the person in the accident received emergency care and kept them safe. Once the person in the accident was taken to hospital, Laura continued with her daily tasks and saw all her vulnerable patients in their homes.

Patient Feedback

Rheumatology: I would like to give recognition to two of your staff who have helped me through what is an extremely difficult time whilst I wait for a diagnosis which may be unfavourable.

The two individuals I would like to name are both consultant secretaries. The first is Amanda Vaughan (secretary to Dr Erb - Rheumatology) who answers all of my calls, emails and messages professionally, courteously and in a timely manner. She has arranged follow ups and liaised with doctors and specialists alike to ensure that follow up action is taken. I honestly don't know what I would have done during the last few weeks without her help and empathy.

The second is Nicky Davies (secretary to Dr Marwick - Osteoporosis/Rheumatology). I don't know how I would have managed without her help and support. She has contacted other hospitals and units for information on my behalf going over and above her duties. She is a committed, professional individual and if she says she will come back to me by 3pm, I know that she will. In fact, I have nicknamed her "Ronseal" Nicky because she does exactly what it says on the tin. She has helped me maintain a positive, determined attitude when I have felt like giving up.

CAU: The care shown to me in CAU was beyond any of your tick boxes. They were kind and prepared to listen and answer all questions. All worry was taken away from me as if they wrapped me in cotton wool and made me feel secure. Well done everyone.

B1- Excellent care delivered with empathy, support, kindness, knowledge and professionalism to the highest standard. The ward manager and the chief executive should be so proud of all the Trust staff. Nothing could have been better – perfection.

FAA (Frailty Assessment Area): This is my fourth visit and I could not fault the staff, they told me everything that was happening, looked after me well and I also had transport home arranged.

General Outpatients: Staff were polite, professional and supportive. I was dealt with quickly and the aftercare was top notch. NHS never lets me down.

Physiotherapy: Staff were always friendly and helpful. My treatment was explained to me and all my questions were answered. I always received encouragement from the staff in Hydrotherapy.

Respiratory: Everything was great, all the way from coming in the ambulance to discharge. Lovely staff, lovely hospital.

RACE Equality Code – Quality Mark achievement

We are thrilled to have received the RACE Equality Code quality mark in July 2022. The standards we have achieved and been assessed against show our commitment and application of collective efforts to radically move the dial on representation in the boardroom and senior leadership. The quality mark will become synonymous with organisations that are taking a targeted approach in this area, whilst ensuring it forms part of our wider inclusion strategy. The trust has recently developed through wide engagement our Equality, diversity and inclusion strategy, which sets out our overall vision and commitment to an inclusive culture across our organisation. We will be able to use the quality mark on our website and other materials**.**

Provider Collaborative Update

The following is a summary of recent Provider Collaborative activities:

1. **COLLABORATION BOARD**

   The Board met on 28th June under its new arrangements (CEO's and Chairs only). The agenda included:

   a. **SRO update** - A progress update from the SRO, outlining key achievements in Q1, and identification of work that is planned for delivery across the remainder of the year.

   b. **Governance** - An update on the emerging system governance arrangements in addition to sharing the draft Programme Board terms of reference for review and approval.

   c. **Strengthening Collaboration –** some discussion on how the four partners might strengthen collaboration within the BCPC aligned to the forthcoming work on the 'Case for Change'.

   a. **Strategic Developments** – The Board were provided with an update on both the North Hub 'cold site' elective development, and the development of a strategic business case for acquiring / procuring Surgical Robotics for the Black Country system.

   b. **Engagement on Change** – With a clinical & corporate improvement programme being progressed and opportunities for consolidation and specialisation being identified and explored, there is a diverse range of clinical and service change on the horizon, and this paper was presented to help understand the need to comply with the *NHSE Assurance process for service change*, what it means for developments and the engagement activities that will need to be undertaken to satisfactorily comply.

2. COLLABORATION EXECUTIVE

- There was no Collaboration Executive in July, with the next meeting due on 4th August.

3. CLINICAL SUMMIT

- This took place on 11th July at West Bromwich Albion FC.
- Approximately 150 delegates attended and participated in the day sharing progress, learning from each other, and planning for subsequent delivery.

- Objectives for the day were:
  - Support our Clinical Networks in driving delivery across the Black Country
  - Understand the latest developments from Black Country ICB
  - Listen & learn from the national experiences and those of our Clinical Networks
  - Further development of plans which enable delivery
  - Continue to build a culture of trust through relationships, and a collaborative way of working
- The day was co-hosted by Diane Wake and Sir David Nicholson, with a presentation on the emergent ICB from Mark Axcell (ICB CEO), a keynote presentation from Professor Tim Briggs (National Clinical Improvement Director & Lead for GIRFT), and the Clinical Leads for Orthopaedics (Dr Sohail Butt) , Urology (Dr Pete Cooke) and Skin (Dr. James Halpern).
- The afternoon session was dedicated for the Clinical Networks to progress an agenda of their choosing ranging from Clinical Network meetings, to planning for delivery on their priorities.
- The initial feedback from delegates has been very positive and generally the day was well received by all.
- Further specialty away days are planned for Skin (14th July), Gynaecology (22nd July) and a joint away day for Colorectal and Head & Neck on the 9th September.
- The next Clinical Summit has been arranged for Wednesday 19th October, where we hope to hear from more of our Clinical Networks on their progress, in addition to sharing the early thoughts / drafts on our 'Case for Change'.

Restoration and Recovery

The Trust is continuing to focus on treating the most urgent patients first, such as those waiting for cancer treatment, along with those who have waited the longest. There are no patients who have waited over 104 weeks at Dudley which is one of the best positions regionally and the average wait time for outpatient appointments is also one of the best in the region. In recent months the Trust is now also able to offer access to 2 week wait (suspected cancer) appointments within the national target time of 14 days. The next priority is now reduce the number of patients waiting over 52 weeks.

Integrated Care Board (ICB)

The ICB Board met for its inaugural meeting on Friday 1st July, it was a brief first meeting to consider documentation to bring the ICB into force. It was pleasing to note that I had been chosen as Provider Partner member on the Board representing and with the support of Black Country provider organisations. See attached letter from Jonathan Fellows at Appendix 2. Monthly Board meetings are now arranged and I will keep the Board updated on progress.

Visits and Events

16th May 2022	**Trust Team Management**
17th May 2022	**Freedom of the Borough Garden Party**
18th May 2022	**Board of Directors**
20th May 2022	**Team Brief**
23rd May 2022	**Black Country & West Birmingham Orthopaedic Away Day**
23rd May 2022	**Clinical Leads Forum**
9th June 2022	**Black Country Provider Collaborative- Programme Executive**
10th June 2022	**Live Chat**
13th June 2022	**Diane Wake & Yve Buckland Coaching Session with Davo Ruthven-Stuart**
13th June 2022	**DIHC Coaching Session - Marsha/Diane/Davo**
16th June 2022	**Private Board of Directors**
16th June 2022	**Digital Board Workshop- Session 1**
17th June 2022	**Team Brief**
20th June 2022	**Trust Team Management**
20th June 2022	**Full Council of Governance Quarterly Meeting**
21st June 2022	**The Black Country Provider Collaborative Critical Care Away Day**
22nd June 2022	**Place Development Programme**
22nd June 2022	**Digital Board Workshop - Session 2**
23rd June 2022	**Black Country Integrated Care Partnership - Session with Donna Hall**
24th June 2022	**Mark Axcell/Diane Wake/Davo Ruthven-Stuart coaching Session**
24th June 2022	**Live Chat**
28th June 2022	**Black Country Provider Collaborative Board**
29th June 2022	**Healthcare Heroes**
1st July 2022	**Lunch with Sajid Javid & Roy Richardson**

6th July 2022	**Place Development Programme**
8th July 2022	**Live Chat**
11th July 2022	**Black Country Provider Collaborative Clinical Summit**
13th July 2022	**Clinical Leads Forum**
14th July 2022	**Black Country Provider Collaborative Skin Away Day**
18th July 2022	**Trust Team Management**

Enclosure 6

The Dudley Group NHS Foundation Trust

Paper for submission to the Board of Directors on 21 July 2022

Title:	**Exception Report from Audit Committee Chair**
Author:	Alison Fisher, Executive Assistant
Presenter:	Gary Crowe, Audit Committee Chair

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

Recommendations:

The Board is asked to note the issues discussed at the Audit Committee on 23 May 2022 and 15 June 2022.

Summary of Key Issues:

Good assurance received in matters discussed.

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	
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: 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:
	Board of Directors	Y	Date: 16/06/22 and 21/07/22
	Other	N	Date:

The Dudley Group NHS Foundation Trust

EXCEPTION REPORT FROM AUDIT COMMITTEE CHAIR

Meeting held on: 23 May 2022

MATTERS OF CONCERN OR KEY RISKS TO ESCALATE	MAJOR ACTIONS COMMISSIONED/WORK UNDERWAY
• Information Governance mandatory training compliance currently below required 95% • Overall losses for the year were higher than previous year due to two high overseas visitor debts written off	• Board Assurance Framework development continues at pace
POSITIVE ASSURANCES TO PROVIDE	**DECISIONS MADE**
• Clinical effectiveness audits are making good progress and trajectory in place to complete the 2020/21 carried over audits • Excellent progress had been made on implementation of consultant job plans and reconciliation between pay and Allocate • Strong Head of Internal Audit Opinion received for the year and good progress on recent Internal Audit reviews • Implementation on maternity progress governance to be tracked • Local Counter Fraud Specialist Annual Report 2021/22 confirmed satisfactory fraud arrangements are in place • Grant Thornton financial statements audit progressing well. A comprehensive savings plan for Value for Money review will need to be in place and be robust • Good progress made in writing the Trust's Annual Report 2021/22 • Good level of compliance against the declaration of gifts, hospitality and interest policy	• Conduct Policy was ratified subject to minor amendment • NHS Provider License self-certification recommended to the Council of Governors for endorsement
Chair's comments on the effectiveness of the meeting: Good updates provided which gave assurance of good progress being made.	

The Dudley Group NHS Foundation Trust

EXCEPTION REPORT FROM AUDIT COMMITTEE CHAIR

Meeting held on: 15 June 2022

MATTERS OF CONCERN OR KEY RISKS TO ESCALATE	MAJOR ACTIONS COMMISSIONED/WORK UNDERWAY
• None	• None
POSITIVE ASSURANCES TO PROVIDE	**DECISIONS MADE**
• Grant Thornton anticipate issuing an Unmodified audit opinion of the Trust financial statements 2021/22 • Trust Financial statements prepared in accordance with relevant accounts standards and manuals • Trust Annual Report 2021/22 and Annual Governance Statement noted as good quality by Grant Thornton	• Letter of Representation recommended to Board of Directors for approval • Trust Annual Accounts 2021/22 recommended to Board of Directors for approval • Trust Annual Report 2021/22 (including Annual Governance Statement) recommended to Board of Directors for approval • Audit Committee Annual Report 2021/22 recommended to Board of Directors for approval
• **Chair's comments on the effectiveness of the meeting:** Financial working papers of excellent quality and Committee thanked the Finance team for all their hard work. Thanks were also given to Grant Thornton for the professional relationship with Trust finance staff during the audit.	

Enclosure 7

The Dudley Group NHS Foundation Trust

Paper for submission to the Board of Directors 21st July 2022

Title:	Committee Effectiveness Review 2021
Author:	Helen Board, Deputy Trust Secretary
Presenter:	Andy Proctor, Director of Governance/Trust Secretary

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

Recommendations:

- To note that it is best practice to undertake an annual review, by way of self-assessment, of the Board and it sub Committee's effectiveness.
- To receive the attached report that sets out those areas where <10 per cent of responders have identified concerns. There are 12 questions that received a green rating >100% of which nine had improved from the previous year's results.
- That the Board of Directors is encouraged to debate and determine whether any changes to its practices are required arising from the self-assessment responses

Summary of Key Issues:

Committee Effectiveness Review 2021

It is best practice to undertake an annual review, by way of self-assessment, of the Committee's effectiveness. This entails assessment of questionnaire responses completed by committee members in relation to the scope and operation of the committee, and a review of the terms of reference and annual work plan.

A self- assessment questionnaire was sent to 18 Board members and the collated responses from 10 are appended to this report.

The free form comments made by respondents indicated that there was some concern about the quality of information presented to Board related to lack of focus and clarity of the 'ask' for board. Board succession planning opaque. Too much focus on operational vs strategic issues.

The Board is asked to review the responses and determine whether there are any improvements or further steps necessary in relation to the responses.

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)	**x**
Build innovative partnerships in Dudley and beyond	**x**

Improve health and wellbeing	**x**

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: Code of Governance
	Other	N	Details:

Report Journey/ Destination *(if applicable)*	Working / Exec Group	N	Date:
	Committee	N	Date:
	Board of Directors	Y	Date: 21/07/22
	Other	N	Date:

The Dudley Group
NHS Foundation Trust

Annual Review of effectiveness of the Board of Directors 2021-2022
Report to Trust Board on 21st July 2022

1 EXECUTIVE SUMMARY

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

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

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

2 BACKGROUND INFORMATION

2.1 Questionnaire Self-assessment Responses

Reponses were received from 10 members of the board excluding those questions related to chairing, where nine responses were received. See Appendix 1.

There are seven questions where 10% or more of the responders have identified concerns, three of which have seen no improvement from the previous year's results:

- Is the information sufficiently concise?
- Is a Succession Plan in Place?
- Does the Board spend sufficient time discussing the organisation's strategic direction?

- Is information in the right form to enable the Board to make sound decisions?
- Board Committee meetings are held sufficiently far in advance of Board meetings to allow for the resolution of issues?
- Is the Board satisfied that it has identified the strategic risks facing the organisation, and that it has the controls to manage them?
- Is the Board Assurance Framework effective?

Comments received using the free text option included:

Quality of information presented to Board remains a concern - often too much detail with insufficient effort to focus on the key issues and what is required from Board. Succession planning opaque. Too much focus on operational vs strategic issues.

There are 12 questions that received a green rating >100% of which nine had improved from the previous year's results:

- Does the Board receive timely information?
- The Board is the right size to ensure effective decision making?
- Does the Board keep abreast of changes in the external environment and considers their impact on the strategic direction of the Trust?
- Communication between the Board and its Committees is adequate and effective?
- The Board has clearly identified open channels of communication with Staff and external Stakeholders in order to improve patient care?
- The Chair demonstrates good listening skills?
- The Chair operates satisfactorily in terms of promoting effective and efficient meetings, with an appropriate level of involvement outside of the formal meetings?
- Executive and Non-Executive Board members have a frank and open relationship with each other and each Director understands his/her own personal Board level responsibilities?
- All Board members have sufficient time and commitment to fulfil their responsibilities?

2.2 Frequency and Content of Meetings

The Board continues to meet monthly and attendance of Directors is very high with absence being exceptional. See table 1.

Table 1

Board of Directors' attendance

Position	Name	Commencing	End	Board meeting attendance out of 11*
Chief executive	Diane Wake	03/04/17		10
Director of finance	Tom Jackson	01/02/18		11
Chief operating officer	Karen Kelly	02/01/18		9
Medical director	Dr Julian Hobbs	02/10/17		9
Chief nurse	Mary Sexton	29/11/19		10
Chief people officer	James Fleet	10/03/20		10
Director of strategy & transformation	Katherine Sheerin	07/07/20	30/11/21	7/7
Chief information officer	Adam Thomas***	01/09/19		11
Trust secretary	Liam Nevin**	19/08/19	31/10/21	6/6
Chairman	Dame Yve Buckland	20/11/20	31/05/23	10
Non-executive director	Prof Liz Hughes	15/11/19	15/11/22	10
Non-executive director	Julian Atkins	04/01/16	31/05/23	11
Non-executive director	Catherine Holland	01/09/18	31/08/24	10
Non-executive director	Lowell Williams	01/12/19	31/03/23	9
Non-executive director	Prof Gary Crowe	01/07/19	01/07/22	10
Non-executive director	Vij Randeniya	20/11/20	31/03/24	11
Non-executive director	Jonathan Hodgkin	01/04/18	31/03/24	8
Associate non-executive director	Thuvarahan Amuthalingham****	13/05/21	12/05/23	9/10
Associate non-executive director	Gurjit Bhogal****	13/05/21	12/05/23	10/10

*There was no meeting held in August 2021
**non voting
***Became voting effective from 01/01/22
****associate non-executive directors are non voting

There have been periods during the year when as a result of the steps required to address the level 4 status of the pandemic it has been necessary to restrict agendas for committee meetings and to a lesser extent the Board. COVID-19 also had some impact on the capacity to undertake Board development and other informal Board activities such as exec/non-exec walkarounds. From June 2021, public sessions of the Board of Directors meetings were scheduled bi-monthly with 18 held during 2021/22 compared to 25 in the previous year. Committee meetings has increased in 2021/22 to 58 compared to 54 in the previous year.

2.3 On Site Meetings

The Board have met physically in March and November 2021. The Board has kept the option to resume face-to-face meetings under review with private sessions of the Board resuming in a face-to-face format in May 2022. Public session of board has remained in a virtual format and benefitted from improved attendance from governor's, staff and embers of the public. Hybrid working whereby participants can attend face-to-face and via remote was trialled in November 2021 where it as identified that an improved audio visual solution was required. This has subsequently been installed and will see it first use at the July 2022 meeting.

Maintaining face-to-face meetings and other onsite activities will be subject to any conditions that the Director of Infection Control deems necessary.

2.4 Board Development

The Board development programme gained some momentum during the year. In addition to a series of executive away days, the Trust board participated in a series of development sessions during the latter half of 2021 facilitated by Andy and Mike Mullins. The sessions were delivered as part of the NHSI Development Programme comprising the following components:

- Understanding ourselves and the team
- Working well as a team together
- Managing Board effectiveness
- Understanding the role of the Non- Executive Director (NED) and making the best use of their skills and perspective
- Positive influence of the Board
- Influence in the region and nationally

Early in 2022, the Board contributed to and agreed a further series of development and workshop sessions scheduled up to the end of 2022 on the following topics:

April – Patient Safety Specialist
June – HEE Digital Board training
June – Board Assurance Framework Workshop
August – Patient Safety Improvement Framework (PSIF)
October – High Reliability Organisations

Other suggested topics with dates to be confirmed:

Mental Health Act (MHA)/Deprivation of Liberty Standards (DOLS)
Equality, Diversity, Inclusivity (EDI)

2.5 Well-led Developmental review
The Trust commissioned an external developmental well-led review that concluded in December 2021. The report was submitted to the Board of Directors in March 2022 and an action plan developed to reflect the recommendations made.

3 RISKS AND MITIGATIONS

3.1 These are identified in the body of this report

4. RECOMMENDATIONS

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

Andy Proctor
Director of Governance/Trust Secretary
June 2022

Board Effectiveness Annual review 2022

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

Board Effectiveness: Support and Infrastructure

This year's rating			Previous year
Does the Board receive timely information?			
All of the time / Fully satisfactory	0/9	0.0%	
Most of the time / Above average	9/9	100.0%	
Some of the time / Average	0/9	0.0%	
Occasionally / Below average	0/9	0.0%	
Hardly ever / Poor	0/9	0.0%	
N/A	0/9	0.0%	

This year's rating			Previous year
Is the information of the right quality?			
All of the time / Fully satisfactory	0/9	0.0%	
Most of the time / Above average	6/9	66.7%	
Some of the time / Average	3/9	33.3%	
Occasionally / Below average	0/9	0.0%	
Hardly ever / Poor	0/9	0.0%	
N/A	0/9	0.0%	

This year's rating			Previous year
Is the information sufficiently concise?			
All of the time / Fully satisfactory	0/9	0.0%	
Most of the time / Above average	3/9	33.3%	
Some of the time / Average	4/9	44.4%	
Occasionally / Below average	2/9	22.2%	
Hardly ever / Poor	0/9	0.0%	
N/A	0/9	0.0%	

This year's rating			Previous year
Is information in the right form to enable the Board to make sound decisions?			
All of the time / Fully satisfactory	0/9	0.0%	
Most of the time / Above average	7/9	77.8%	
Some of the time / Average	1/9	11.1%	
Occasionally / Below average	1/9	11.1%	
Hardly ever / Poor	0/9	0.0%	
N/A	0/9	0.0%	

This year's rating	Previous year

The number and length of meetings and access to resources is sufficient to allow the Board to fully discharge its duties?			
All of the time / Fully satisfactory	3/9	33.3%	
Most of the time / Above average	4/9	44.4%	
Some of the time / Average	2/9	22.2%	
Occasionally / Below average	0/9	0.0%	
Hardly ever / Poor	0/9	0.0%	
N/A	0/9	0.0%	

This year's rating			Previous year
Is the agenda sufficient to allow the Board to carry out its functions?			
All of the time / Fully satisfactory	6/9	66.7%	
Most of the time / Above average	2/9	22.2%	
Some of the time / Average	1/9	11.1%	
Occasionally / Below average	0/9	0.0%	
Hardly ever / Poor	0/9	0.0%	
N/A	0/9	0.0%	

This year's rating			Previous year
Does the agenda prioritise the right issues?			
All of the time / Fully satisfactory	2/9	22.2%	
Most of the time / Above average	6/9	66.7%	
Some of the time / Average	1/9	11.1%	
Occasionally / Below average	0/9	0.0%	
Hardly ever / Poor	0/9	0.0%	
N/A	0/9	0.0%	

This year's rating			Previous year
Sufficient time is spent on each agenda item?			
All of the time / Fully satisfactory	1/9	11.1%	
Most of the time / Above average	6/9	66.7%	
Some of the time / Average	2/9	22.2%	
Occasionally / Below average	0/9	0.0%	
Hardly ever / Poor	0/9	0.0%	
N/A	0/9	0.0%	

This year's rating			Previous year
The Board receives an appropriate amount of presentations from Clinicians, Managers and others to remain informed?			
All of the time / Fully satisfactory	2/9	22.2%	
Most of the time / Above average	2/9	22.2%	
Some of the time / Average	5/9	55.6%	
Occasionally / Below average	0/9	0.0%	
Hardly ever / Poor	0/9	0.0%	
N/A	0/9	0.0%	

This year's rating	Previous year

Board Committee meetings are held sufficiently far in advance of Board meetings to allow for the resolution of issues?			
All of the time / Fully satisfactory	0/9	0.0%	
Most of the time / Above average	6/9	66.7%	
Some of the time / Average	2/9	22.2%	
Occasionally / Below average	0/9	0.0%	
Hardly ever / Poor	1/9	11.1%	
N/A	0/9	0.0%	

Board Effectiveness: Structure

This year's rating			Previous year
Does the Board have the right balance of skills, knowledge and experience to deal with current and anticipated challenges?			
All of the time / Fully satisfactory	7/9	77.8%	
Most of the time / Above average	2/9	22.2%	
Some of the time / Average	0/9	0.0%	
Occasionally / Below average	0/9	0.0%	
Hardly ever / Poor	0/9	0.0%	
N/A	0/9	0.0%	

This year's rating			Previous year
Board Members are clear on the role of the Board as a whole?			
All of the time / Fully satisfactory	6/9	66.7%	
Most of the time / Above average	3/9	33.3%	
Some of the time / Average	0/9	0.0%	
Occasionally / Below average	0/9	0.0%	
Hardly ever / Poor	0/9	0.0%	
N/A	0/9	0.0%	

This year's rating			Previous year
The Board is clear as to its role in relation to Governance across the Trust?			
All of the time / Fully satisfactory	6/9	66.7%	
Most of the time / Above average	3/9	33.3%	
Some of the time / Average	0/9	0.0%	
Occasionally / Below average	0/9	0.0%	
Hardly ever / Poor	0/9	0.0%	
N/A	0/9	0.0%	

This year's rating			Previous year
The Board is the right size to ensure effective decision making?			
All of the time / Fully satisfactory	7/9	77.8%	
Most of the time / Above average	2/9	22.2%	
Some of the time / Average	0/9	0.0%	
Occasionally / Below average	0/9	0.0%	
Hardly ever / Poor	0/9	0.0%	
N/A	0/9	0.0%	

This year's rating			Previous year
Is a succession plan in place?			
All of the time / Fully satisfactory	0/9	0.0%	
Most of the time / Above average	4/9	44.4%	
Some of the time / Average	3/9	33.3%	
Occasionally / Below average	1/9	11.1%	
Hardly ever / Poor	0/9	0.0%	
N/A	1/9	11.1%	

Board Effectiveness: Leadership

This year's rating			Previous year
Does the Board periodically review organisational culture and plan to maintain a positive culture?			
All of the time / Fully satisfactory	3/9	33.3%	
Most of the time / Above average	3/9	33.3%	
Some of the time / Average	3/9	33.3%	
Occasionally / Below average	0/9	0.0%	
Hardly ever / Poor	0/9	0.0%	
N/A	0/9	0.0%	

This year's rating			Previous year
Does the Board collectively and individually model behaviours consistent with organisational values and culture?			
All of the time / Fully satisfactory	3/9	33.3%	
Most of the time / Above average	5/9	55.6%	
Some of the time / Average	1/9	11.1%	
Occasionally / Below average	0/9	0.0%	
Hardly ever / Poor	0/9	0.0%	
N/A	0/9	0.0%	

This year's rating			Previous year
Does the time spent on strategy result in defined proposals to be incorporated into the business plan?			
All of the time / Fully satisfactory	2/9	22.2%	
Most of the time / Above average	5/9	55.6%	
Some of the time / Average	2/9	22.2%	
Occasionally / Below average	0/9	0.0%	
Hardly ever / Poor	0/9	0.0%	
N/A	0/9	0.0%	

This year's rating	Previous year

Is the Board satisfied that it has identified the strategic risks facing the organisation, and that it has the controls to manage them?			
All of the time / Fully satisfactory	1/9	11.1%	
Most of the time / Above average	6/9	66.7%	
Some of the time / Average	1/9	11.1%	
Occasionally / Below average	1/9	11.1%	
Hardly ever / Poor	0/9	0.0%	
N/A	0/9	0.0%	

This year's rating			Previous year
The Board focuses on the right questions and can challenge effectively?			
All of the time / Fully satisfactory	1/9	11.1%	
Most of the time / Above average	7/9	77.8%	
Some of the time / Average	1/9	11.1%	
Occasionally / Below average	0/9	0.0%	
Hardly ever / Poor	0/9	0.0%	
N/A	0/9	0.0%	

This year's rating			Previous year
Does the Board keep abreast of changes in the external environment and considers their impact on the strategic direction of the Trust?			
All of the time / Fully satisfactory	1/9	11.1%	
Most of the time / Above average	8/9	88.9%	
Some of the time / Average	0/9	0.0%	
Occasionally / Below average	0/9	0.0%	
Hardly ever / Poor	0/9	0.0%	
N/A	0/9	0.0%	

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

Board Effectiveness: Effectiveness

This year's rating	Previous year

The Board assures itself that patient safety and quality issues are being addressed?			
All of the time / Fully satisfactory	4/9	44.4%	
Most of the time / Above average	4/9	44.4%	
Some of the time / Average	1/9	11.1%	
Occasionally / Below average	0/9	0.0%	
Hardly ever / Poor	0/9	0.0%	
N/A	0/9	0.0%	

This year's rating			Previous year
Is the Board Assurance Framework effective?			
All of the time / Fully satisfactory	0/9	0.0%	
Most of the time / Above average	2/9	22.2%	
Some of the time / Average	5/9	55.6%	
Occasionally / Below average	1/9	11.1%	
Hardly ever / Poor	1/9	11.1%	
N/A	0/9	0.0%	

This year's rating			Previous year
Communication between the Board and its Committees is adequate and effective?			
All of the time / Fully satisfactory	3/9	33.3%	
Most of the time / Above average	6/9	66.7%	
Some of the time / Average	0/9	0.0%	
Occasionally / Below average	0/9	0.0%	
Hardly ever / Poor	0/9	0.0%	
N/A	0/9	0.0%	

Board Effectiveness: Stakeholder engagement

This year's rating			Previous year
Does the Board inform and involve key stakeholders in its work and check their views?			
All of the time / Fully satisfactory	0/9	0.0%	
Most of the time / Above average	8/9	88.9%	
Some of the time / Average	1/9	11.1%	
Occasionally / Below average	0/9	0.0%	
Hardly ever / Poor	0/9	0.0%	
N/A	0/9	0.0%	

This year's rating	Previous year
The Board has clearly identified open channels of communication with Staff and external Stakeholders in order to improve patient care?	

All of the time / Fully satisfactory	2/9	22.2%	
Most of the time / Above average	7/9	77.8%	
Some of the time / Average	0/9	0.0%	
Occasionally / Below average	0/9	0.0%	
Hardly ever / Poor	0/9	0.0%	
N/A	0/9	0.0%	

This year's rating			Previous year
Does the Chair ensure that there is sufficient challenge on each issue on the Boards agenda?			
All of the time / Fully satisfactory	5/9	55.6%	
Most of the time / Above average	3/9	33.3%	
Some of the time / Average	1/9	11.1%	
Occasionally / Below average	0/9	0.0%	
Hardly ever / Poor	0/9	0.0%	
N/A	0/9	0.0%	

Board Effectiveness: Behaviours

This year's rating			Previous year
The Chair demonstrates good listening skills?			
All of the time / Fully satisfactory	8/9	88.9%	
Most of the time / Above average	1/9	11.1%	
Some of the time / Average	0/9	0.0%	
Occasionally / Below average	0/9	0.0%	
Hardly ever / Poor	0/9	0.0%	
N/A	0/9	0.0%	

This year's rating			Previous year
Board meetings encourage a high quality of debate with robust and probing discussions?			
All of the time / Fully satisfactory	3/9	33.3%	
Most of the time / Above average	5/9	55.6%	
Some of the time / Average	1/9	11.1%	
Occasionally / Below average	0/9	0.0%	
Hardly ever / Poor	0/9	0.0%	
N/A	0/9	0.0%	

This year's rating			Previous year
The Board responds positively and constructively to bad news in order to encourage future transparency?			
All of the time / Fully satisfactory	3/9	33.3%	

Most of the time / Above average	5/9	55.6%	
Some of the time / Average	1/9	11.1%	
Occasionally / Below average	0/9	0.0%	
Hardly ever / Poor	0/9	0.0%	
N/A	0/9	0.0%	

This year's rating			Previous year
The Chair operates satisfactorily in terms of promoting effective and efficient meetings, with an appropriate level of involvement outside of the formal meetings?			
All of the time / Fully satisfactory	6/9	66.7%	
Most of the time / Above average	3/9	33.3%	
Some of the time / Average	0/9	0.0%	
Occasionally / Below average	0/9	0.0%	
Hardly ever / Poor	0/9	0.0%	
N/A	0/9	0.0%	

This year's rating			Previous year
Executive and Non-Executive Board members have a frank and open relationship with each other and each Director understands his/her own personal Board level responsibilities?			
All of the time / Fully satisfactory	1/9	11.1%	
Most of the time / Above average	8/9	88.9%	
Some of the time / Average	0/9	0.0%	
Occasionally / Below average	0/9	0.0%	
Hardly ever / Poor	0/9	0.0%	
N/A	0/9	0.0%	

This year's rating			Previous year
The Board has a good understanding of key people issues, particularly those regarding Transformation?			
All of the time / Fully satisfactory	1/9	11.1%	
Most of the time / Above average	7/9	77.8%	
Some of the time / Average	1/9	11.1%	
Occasionally / Below average	0/9	0.0%	
Hardly ever / Poor	0/9	0.0%	
N/A	0/9	0.0%	

This year's rating			Previous year
All Board members attend and actively contribute at meetings?			
All of the time / Fully satisfactory	1/9	11.1%	
Most of the time / Above average	7/9	77.8%	
Some of the time / Average	1/9	11.1%	

Occasionally / Below average	0/9	0.0%	
Hardly ever / Poor	0/9	0.0%	
N/A	0/9	0.0%	

This year's rating			Previous year
All Board members have sufficient time and commitment to fulfil their responsibilities?			
All of the time / Fully satisfactory	1/9	11.1%	
Most of the time / Above average	8/9	88.9%	
Some of the time / Average	0/9	0.0%	
Occasionally / Below average	0/9	0.0%	
Hardly ever / Poor	0/9	0.0%	
N/A	0/9	0.0%	

This year's rating			Previous year
Board members undertake ongoing personal development?			
All of the time / Fully satisfactory	3/9	33.3%	
Most of the time / Above average	3/9	33.3%	
Some of the time / Average	3/9	33.3%	
Occasionally / Below average	0/9	0.0%	
Hardly ever / Poor	0/9	0.0%	
N/A	0/9	0.0%	

Enclosure 8

The Dudley Group NHS Foundation Trust

Paper for submission to the Board of Directors on 21 July 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**	Y	**Other**

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 meetings held on 6 June 2022 and 27 June 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	

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NHS Foundation Trust

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: 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:
	Board of Directors	Y	Date: 21/07/22
	Other	N	Date:

The Dudley Group NHS Foundation Trust

EXCEPTION REPORT FROM FINANCE AND PERFORMANCE COMMITTEE CHAIR

Meeting held on: 6 June 2022

MATTERS OF CONCERN OR KEY RISKS TO ESCALATE	MAJOR ACTIONS COMMISSIONED/WORK UNDERWAY
• Flow and bed blocking rainbow unit • ED and AMU staff Chemical, biological, radiological and nuclear (CBRN) training levels low • Nurse staffing levels were not achieved Oct 21 – March 22 • Nurse sickness levels above average • Financial plan not finalised and potential need for increased CIP • Cost Improvement Plans (CIP) level very high over 5% required • Productivity low, but some plans in place for activity improvement • Activity levels below mandated levels • PFI inflation likely to increase in 2023/24	• ED/AMU CBRN training • Black Country comparison to be included in the Integrated Performance Report • Financial plan to be presented to Board prior to System resubmission
POSITIVE ASSURANCES TO PROVIDE	**DECISIONS MADE**
• Good patient responses in Rainbow Unit • Emergency Preparedness, Resilience and Response (EPRR) annual report gave good assurance • Forward assurance that by February 2023; full complement of nursing staff • Recovery performance good assurance • Collaborative operational system working on pressure points • Improve PFI contract performance cleaning and estates • Ahead of internal activity plan for elective surgery	• Business case policy • Vaccination programme contract extension recommended to Board for approval • EPRR annual report
Chair's comments on the effectiveness of the meeting: Good time keeping. Good business and questioning to tease out answers and good summary. Business conducted very well. Thanks to all staff from Committee as financial position and operational pressures are very challenging.	

The Dudley Group NHS Foundation Trust

Meeting held on: 27 June 2022

MATTERS OF CONCERN OR KEY RISKS TO ESCALATE	MAJOR ACTIONS COMMISSIONED/WORK UNDERWAY
• £30m, or 6%, cost improvement target is unrealistic. Even a £24.5M CIP will be a significant challenge whilst maintaining quality and safety. The Integrated Care System (ICS) being pressed to ensure that Cost Improvement Plans (CIP) challenges are distributed fairly across providers • The vast majority of CIP delivery will be in the second half of the year, increasing the risk of under delivery • Year end cash forecast consistent with CIP of £24.5m is £6.8m. Failure to deliver CIP could jeopardise this	• Cash management actions to be prepared in case required later in the year • Consequences of failure to achieve CIP of £24.5m to be included in CIP reporting
POSITIVE ASSURANCES TO PROVIDE	**DECISIONS MADE**
• Good progress against Cancer two week wait targets with performance at 92.5% in May versus target of 93% • Other key metrics stable and below nationally set targets, but performance benchmarks well against regional peers and the Trust is being called on to provide support to others • Divisions committed to delivering CIP plans consistent with overall delivery of £24.5m • Strengthened governance around Financial Improvement Group to ensure delivery of CIP	• none
Chair's comments on the effectiveness of the meeting: Meeting focused largely on scale of CIP challenge. Detailed deep dive into performance and initiatives in Medicine and Integrated Care Division	

Enclosure 9

The Dudley Group NHS Foundation Trust

Paper for submission to Trust Board on 21st July 2022

Title:	IPR Report for May 2022
Author:	Jonathan Boulter, Associate Director of Performance
Presenter:	Simon Illingworth, Deputy Chief Operating Officer

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

Recommendations:

This report summarises the Trust's performance against national standards and local recovery plans for the month of May 2022 (April 2022 for Cancer). The Committee is asked to note performance and next steps.

Summary of Key Issues:

Key Areas of Success

There has been continued improvement against the cancer 2 week wait standard increasing to 86.9% in April. There has been continued improvement into May and June delivering the 93% standard. Five tumour sites achieved the target in April, an improvement on 1 in March. 31-day cancer standard has also seen a month-on-month improvement, increasing to 93%

Ambulance triage continues to perform well against an increase in attendances seen during May. Following strong performance in April, Paediatric ED triage and See and Treat tirage dropped back slightly in May, but performance is showing signs of recovery in late May/early June, returning to above 90%.

The Trust has provided mutual aid to neighbouring Trusts. The Trust also has the 2nd shortest median waiting time for elective waits of the 20 regional acute organisations.

Key Areas of Concern

Performance across all Emergency Access Standards remains largely unchanged in May and continues to be a challenged performance area. Ambulance handover delays of 60 minutes or greater remains a significant performance and quality challenge for the Trust; May saw 13 more delays than April, although this is set against a 6.5% increase in attendances. Patients waiting in the hospital who are Medically Optimised for Discharge (MOFD) remains high and there is significant work going on with colleagues from social and primary care to improve matters, especially with a focus on D2A and Home First.

Delivery against the 62 day cancer standard continues to remain fairly static. The focus remains on clearing those patients waiting over 104 days. At a tumour site level, some progress has been made in Upper GI, Skin and Urology, but all specialities remain below the national standard. Additional weekend theatre lists are being utilised and more are planned for June and July but delays are being seen in all areas and across all pathways including increases in complex pathways and delays at tertiary centres.

The number of patients waiting 52 weeks or longer to commence routine treatment has increased in May and remains behind trajectory. The most challenged specialities with the largest backlogs are those specialties which also have significant cancer demand (for example General Surgery and Skin) however T&O remains a challenged specialty as well. Where specialties have high demand for cancer as well as a backlog of 52 weeks specialties are clearly prioritising capacity towards cancer. Utilising additional capacity at weekends and picking up dropped lists from other specialities are strategies being used to offer additional capacity for routine long waiting patients.

Emergency Access Standards

There remains little noticeable change in performance against the ED 4-hour standard, with a significant number of 12 hour breaches within month. The ED team are refining a single action plan which encompasses all key actions, and which aims to address the ongoing performance issues. Critical to any long-term success will be reductions in the numbers of patients who are Medically Optimised for Discharge (MOFD). The Trust continues to experience increasing number of ED attendances; May saw attendances exceed 9,000, (just short of 10,000 for the third month running), which represents a 6.5% increase on April. Equally, Ambulance conveyances remain high, 2.5% up on April and circa 30% up on February.

Ambulance handover delays of 60 minutes or greater remains a significant quality and performance challenge for the Trust. There were 387 handover delays exceeding 60 minutes in May, which represents a slight increase on the 374 in April, during which there were fewer attendances in total. However, both May and April saw improved performance compared to March. The department continues to use cohorting to mitigate this pressure point.

Cancer (Data to April 2022)

The 2ww standard in April continues to improve. Performance in April attained 86.9%, representing a significant improvement on 76% achieved in March. Recovery plans at a tumour site level are driving this improvement with five tumour sites achieving the 93% standard in April, up from 1 site in March. Urology is a challenged speciality for this standard. Whilst not achieving the target, the tumour site has seen month-on-month improvement over the last 3 months, increasing to 81.16% in April from 67.43% in March. Colorectal are revising their capacity plans to offer additional 2ww slots. By June 2ww delivery has been achieved.

The 31 day standard continues on an improving trajectory. Six of 9 tumour sites achieved the standard in April, up from 5 in March, which represents an overall performance on 93%, just short of the 96% target.

Having seen a continued fall since February in the number of patients waiting over 104 days to commence treatment, this trajectory has remained fairly static for the last 4 weeks and more recently has increased. Colorectal is the main driver of this position as a result of increased referral demand. The speciality is working with Cancer Services to inject additional capacity, reduce DNAs and to better prepare patients for colonoscopies to reduce repeat test rates. Despite a slowdown in the numbers of patients being taken off the 104 day list, the teams aim to maintain steady reductions over the next few months.

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

RTT performance remained static in May at 73.6%. The number of patients waiting in excess of 52 weeks has increased during May. Specialties with high cancer and urgent (P2) workloads are the most challenged areas as they place emphasis on treating their most urgent cohorts as a priority. Plastic Surgery, Urology and General Surgery are the most challenged examples of this. The Division is focusing on productivity gains to improve throughput and has increased from 60% to 68% in 12 weeks.

However, in light of these challenges, progress is being made in some specialities and non-admitted RTT completes is ahead of trajectory for May. Comparing the Trust to its peers, the DGFT has the 7th lowest number of 52 week breaches out of the 20 acute Trusts in the region and 2nd within the ICS. Of the 20 acute regional organisations, the Trust has the 2nd shortest median waiting time of 9.9 weeks and 9th least >104 week breaches, with 14 recorded. The Trust has supported Royal Wolverhampton with mutual aid, treating 13 Urology patients at around 104 weeks and is supporting University Hospitals Leicester in General Surgery and ENT.

DM01

DM01 performance remains below target but has realised an up tick in performance to 81.8% in May from 78% in April. This represents a first improvement in performance since January/February 2022. The key areas of focus for further DM01 performance are cystoscopy, colonoscopy and gastroscopy, all of which currently require additional Endoscopy capacity.

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	

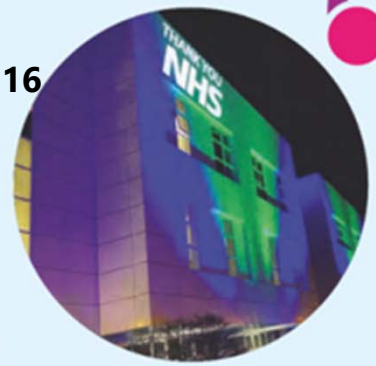
Implications of the Paper: *(complete all sections including the Corporate Risk Register and/or the Board Assurance Framework)*			
Risk	Y	Risk Description: Risk Description: BAF 1b - Failure to meet access standards caused by inability to improve patient flow and work effectively with very local partners 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	N	Details:
Report Journey/ Destination *(if applicable)*	Working / Exec Group	N	Date:
	Committee	Y	Date: Finance & Performance 27/06/2022
	Board of Directors	Y	Date:
	Other	N	Date:

Performance KPIs

June 2022 Report (May 2022 Data)

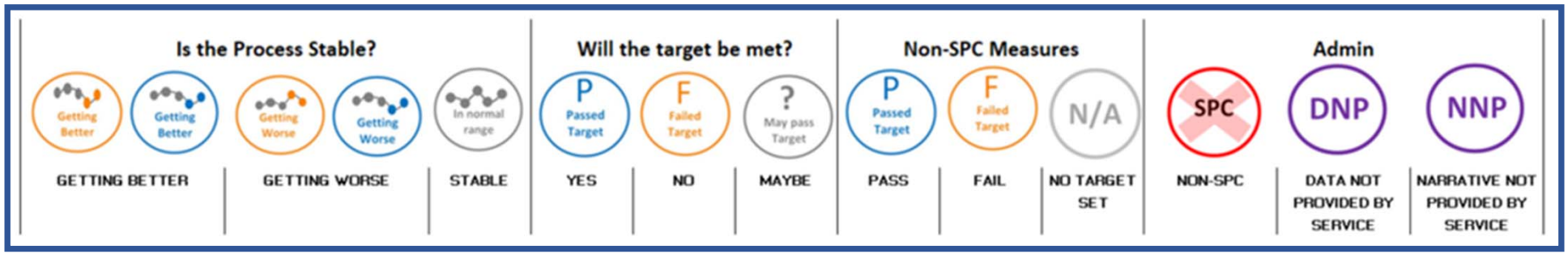
Karen Kelly, Chief Operating Officer

The Dudley Group NHS Foundation Trust

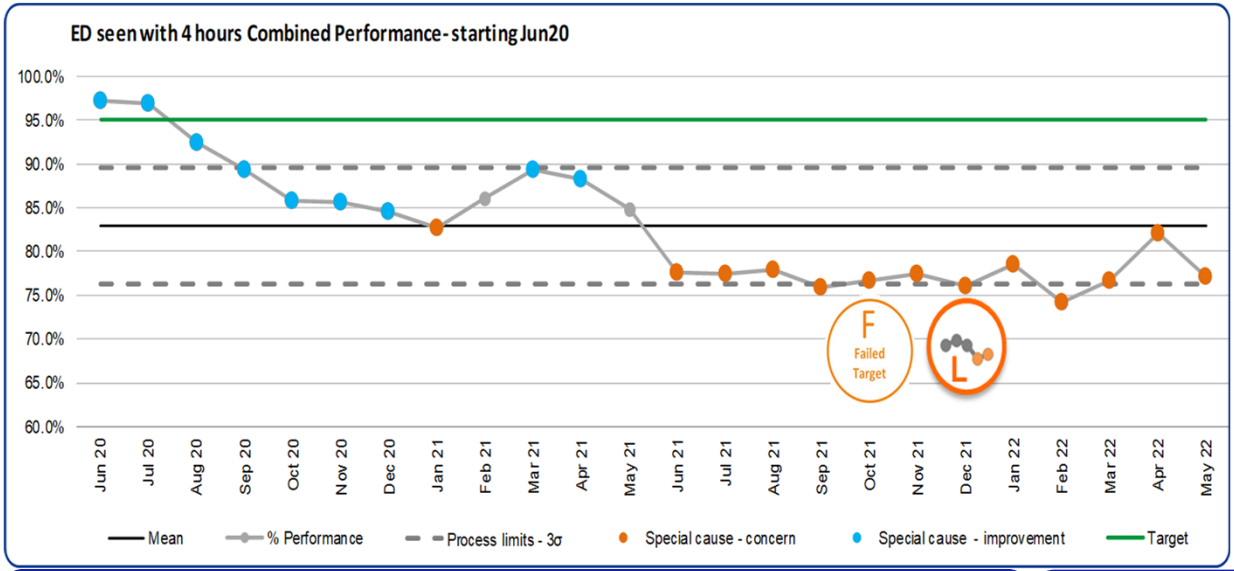


Constitutional Performance

Constitutional Standard and KPI		Target	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-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%	72.3%	74.7%	72.1%	77.1%	L	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%	86.4%	86.1%	90.1%	85.4%	L	F Failed Target
Cancer	Cancer 62 Day - All	85.0%	69.7%	81.9%	75.2%	74.6%	74.2%	77.7%	70.8%	56.2%	73.9%	69.3%	69.7%	69.7%	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%	89.6%	91.5%	92.3%	93.0%	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%	64.6%	78.5%	76.0%	86.9%	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%	72.9%	73.6%	73.3%	73.6%	Getting Worse	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%	82.8%	82.3%	78.1%	81.8%	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%	94.4%	93.5%	94.3%	94.0%	In normal range	F Failed Target



ED Performance



Latest Month	Latest Month	2nd
77.1%	79	For April 22
EAS 4 hour target 95% for Type 1 & 3 attendances	DTA 12 hour breaches - target zero	DGFT ranking out of 13 West Midlands area Trusts

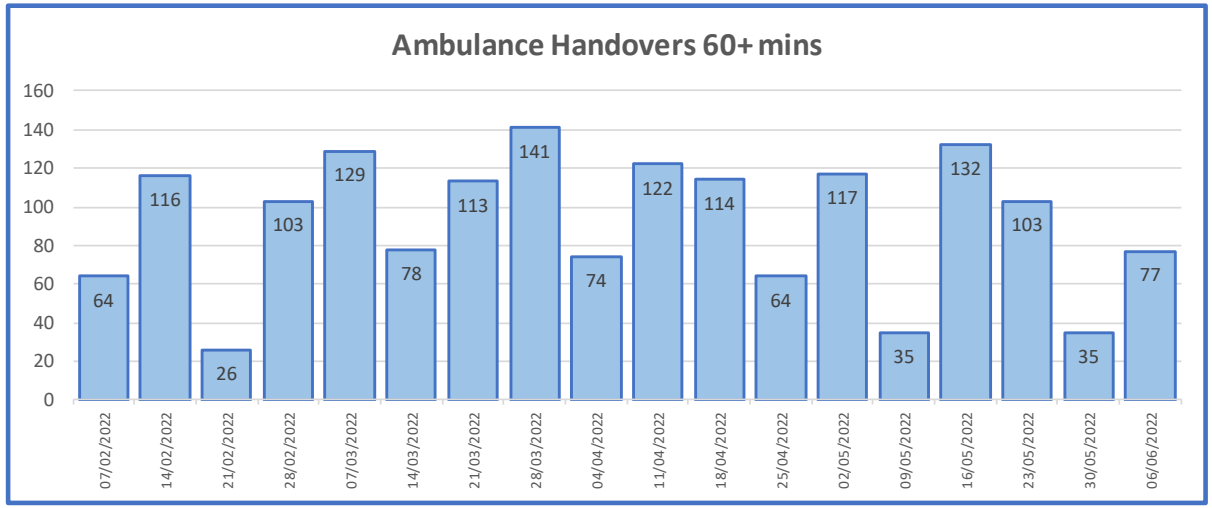
Performance

- Overall ED 4 hour performance remains static, with no improvement
- May saw an increase in the number of 12 hour DTA breaches, having seen a reduction the month before
- ED attendances remain high and saw a 6.5% increase in May compared to June, to just short of 10,000 in month
- Ambulance conveyances remained high in May at 3,230, representing a 2.5% increase on April

Action

- Plans to create a combined Urgent Treatment Centre and ED Triage have been drawn up. Planning meeting with UTC representatives to take place during June. Plan aims to reduce the length of stay for patients in ED
- Trial of dedicated ED phlebotomist service is underway – review pilot and measure impact

Ambulance Handovers 60+ Mins



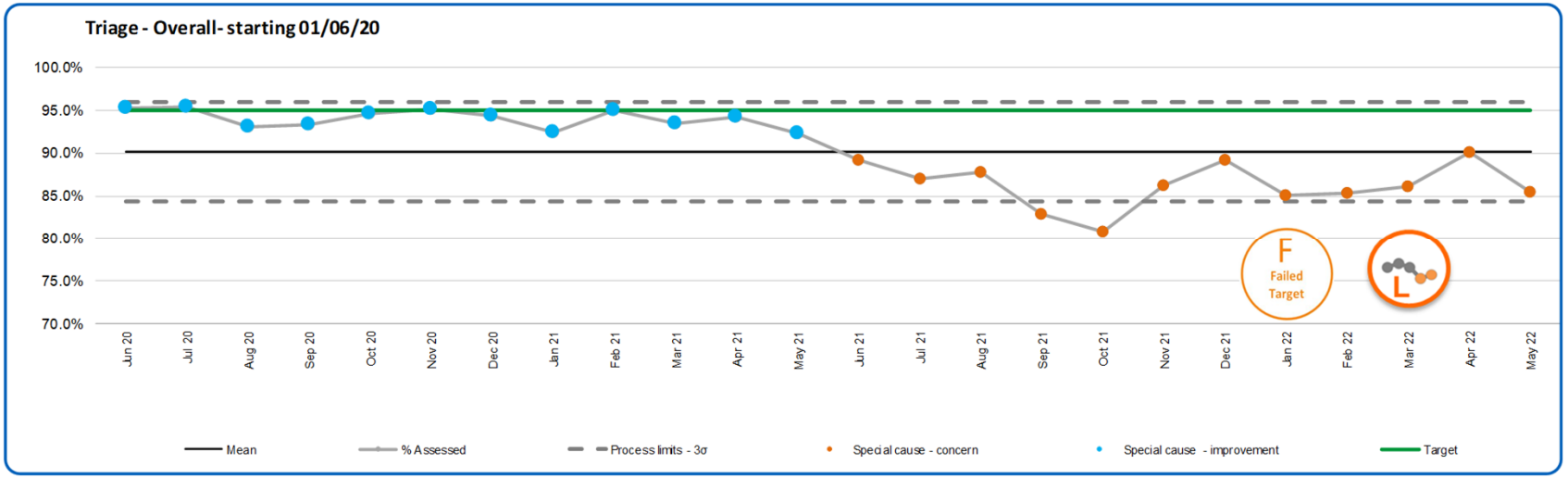
Performance

- Ambulance handover delays of over 60 minutes continues to prove challenging
- There was a small uptick in the number of ambulances waiting 60 minutes or longer to off load in May compared to April, although, both months are an improved position on March
    - *March 22: 461*
    - *April 22: 374*
    - *May 22: 387*
- This issue remains a significant quality and performance challenge

Action

- Continue to utilise cohorting areas within the Emergency Department to allow West Midlands Ambulance Service crews to be released promptly
- Additional assessment area in ‘old minors’ footprint to optimise assessment space to maintain flow

ED Triage



Latest Month

85.4%

Triage – target 95%

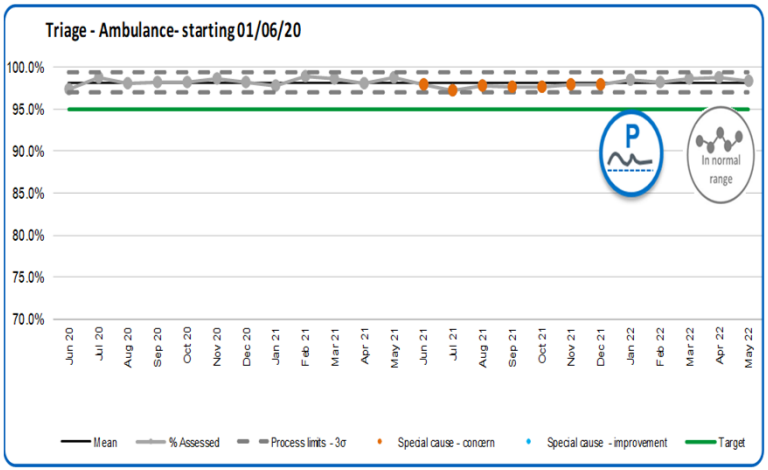
Performance

- Overall ED Triage remains challenging, with May seeing a slight fallback in overall triage performance compared to April

Action

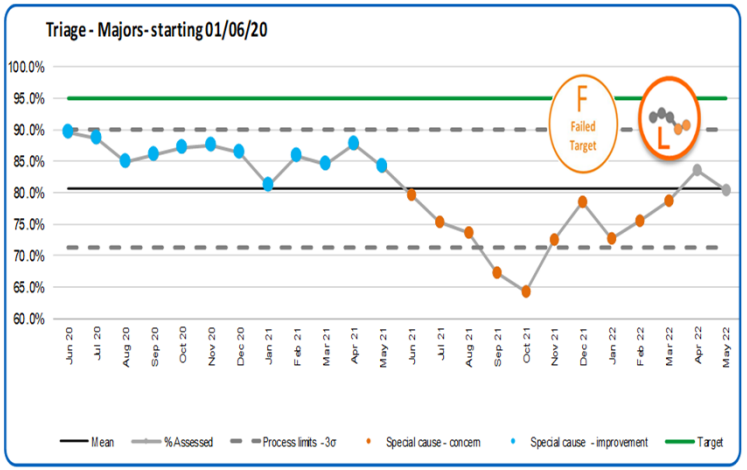
- Plans to increase the number of ESI triage nurses in ED from 1 to 2 per shift are on going
- Training to ESI standards on going with 62/94 staff now trained

ED Triage



Latest Month

98.4%



Latest Month

80.4%

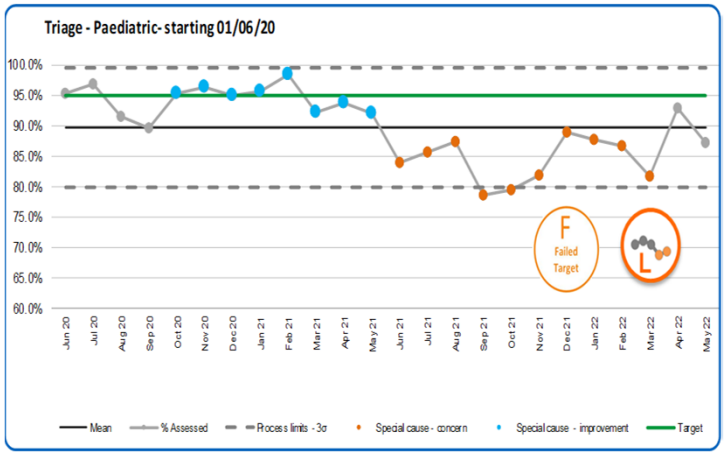
Performance

- Ambulance triage continues to perform well, attaining target in May and delivering improved performance in month compared to April
- The sustained improvement in Majors triage seen during January to April dropped back slightly in May as a result of sustained high attendances and staffing challenges
- However, Majors performance remains at over 80%, which was last realised in June 2021
- May's performance of 80% is ahead of the 12 month rolling figure of 74.19%

Action

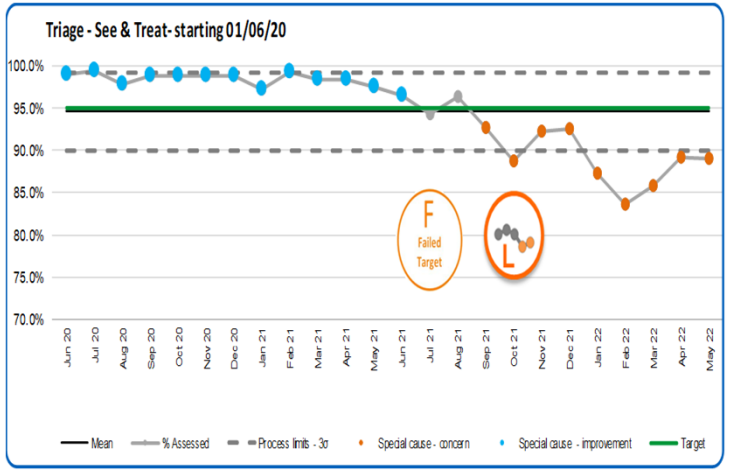
- TAKT time study has taken place during May – plan to review findings
- Continue with optimising nursing workforce staffing plans

ED Triage



Latest Month

87.2%



Latest Month

89.0%

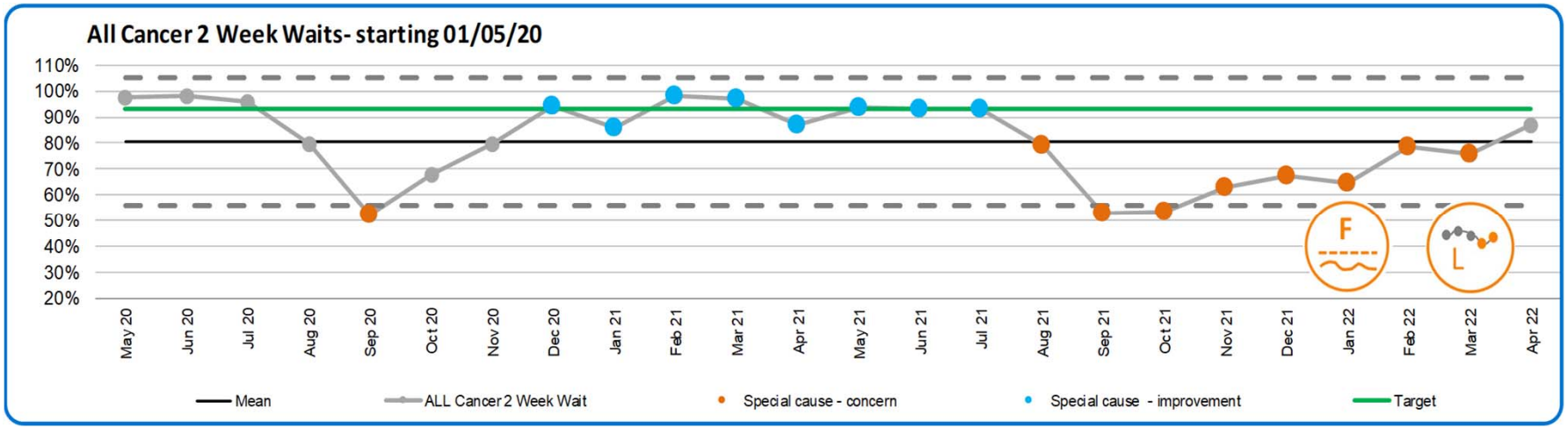
Performance

- Having performed strongly in April, Paediatric triage fell back slightly in May, reducing from 92% to 87.2%
- However, the last week of May and early June are showing signs of recovered performance with these weeks returning to attaining above 90%
- See and Treat performance has seen improved performance in recent months. May's performance is consistent with that achieved in April
- Similar to Paediatric triage, late May and early June have seen further improvement gains with weekly performance exceeing 90%

Action

- Manage staffing within Paeds to reduce need to move staff to other areas
- Use newly installed live data screens to monitor and react to performance

Cancer Performance – 2 Week Wait



Latest Month

86.9%

All cancer 2 week waits – target 93%

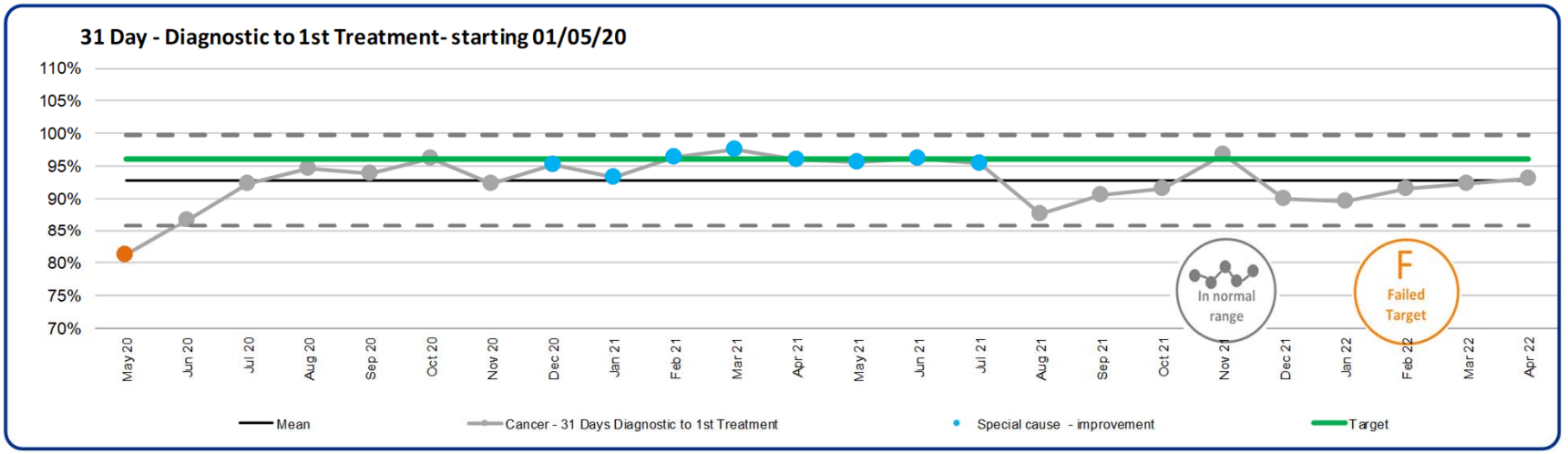
Performance

- All cancer data runs two months behind. Data included within this pack is up to an including April 2022
- 2ww cancer performance attained 86.9% in April representing a significant improvement on the 76.0% achieved in March
- April's performance continues the improving trajectory seen since September 2021. The Trust is now close to achieving the 93% standard for the first time since summer 2021
- 5 tumour sites achieved the 93% target in April, up from 1 tumour site in March
- Whilst not achieving the 93% standard, Urology has seen month-on-month improvement over the last 3 months, increasing to 81.16% in April from 67.43 in March

Action

- As social distancing within outpatient areas is removed, utilise newly released capacity for new cancer appointments
- Continue to monitor clinic template exceptions through the Operational Performance Management Group to ensure full utilisation and return to pre-covid template usage
- Continue with additional clinics to clear remaining backlogs

Cancer Performance – 31 Day



Latest Month

93.0%

Target 96%

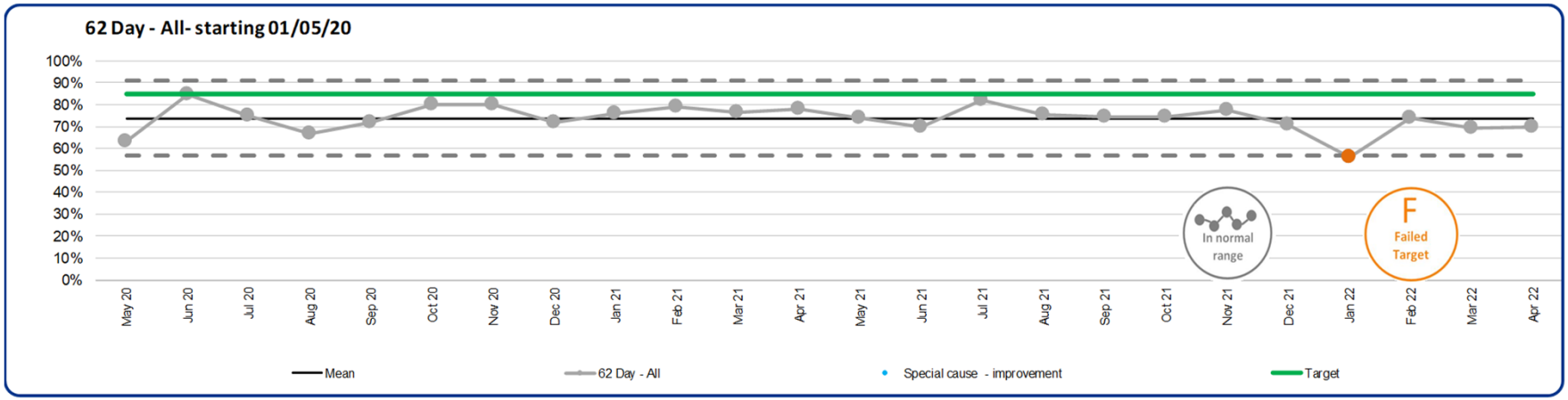
Performance

- April performance was 93% and similar to the 2ww standard, represents an improving trajectory. 93% is a slight increase on the 92.3% seen in March, 91.48% in February and 89.83% in January
- 6 of 9 tumour sites achieved the 31 day standard, up from 5 of 9 in March
- Breast has achieved the largest improvement within month, rising from 87.88% to 96%
- The number of breaches has reduced from 15 in February to 10 in March
- Having seen a significant improvement last month, Skin has maintained this position in April, achieving 93.10%

Action

- Continue emphasis on reducing the number of patients waiting over 104 days, to provide additional capacity to treat patients on a 31 day pathway
- Continue to liaise with BCPN to address pathology turnaround times to further drive an improvement in performance

Cancer Performance – 62 Day - All



Latest Month

69.7%

Target 85%

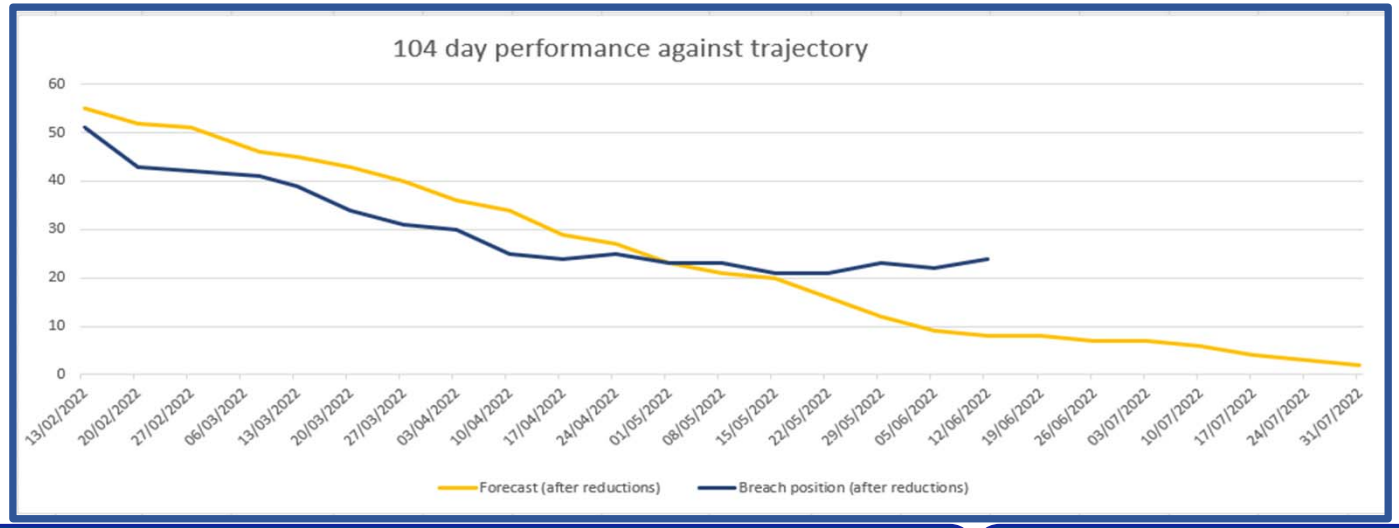
Performance

- Trust-wide, performance against the 62 day standard is fairly static and consistent with past months
- 2 tumour sites (Colorectal and Gynae) achieved the 62 day standard in March, however, both specialties have slipped back in April. This month saw no tumour site meet the 85% target
- Upper GI, Skin and Urology realised some improvement in the month of April, but are still short of the standard
- The total number of breaches in April is fewer than in March and February, but the Trust treated fewer patients on a 62 day pathway last month. (April; 75 compared to 83 in March)

Action

- Continue to prioritise cancer patients (P2) for treatment
- Maintain effective weekly, detailed tracking of each patient on a cancer PTL
- Bring the 104 day reduction trajectory back on track to provide capacity to treat an increasing number of patients on 62 day pathways
- Monitor list utilisation through Theatre productivity meetings to ensure lists are productive
- New 62 day recovery plans have been drawn up for each tumour site
- Continue to work with external partners to improve performance:
  - BCPN to improve histology turnaround times
  - RWH for access to Oncology capacity

Cancer Performance – 104 Day



Latest Week

(12/06/22)

24

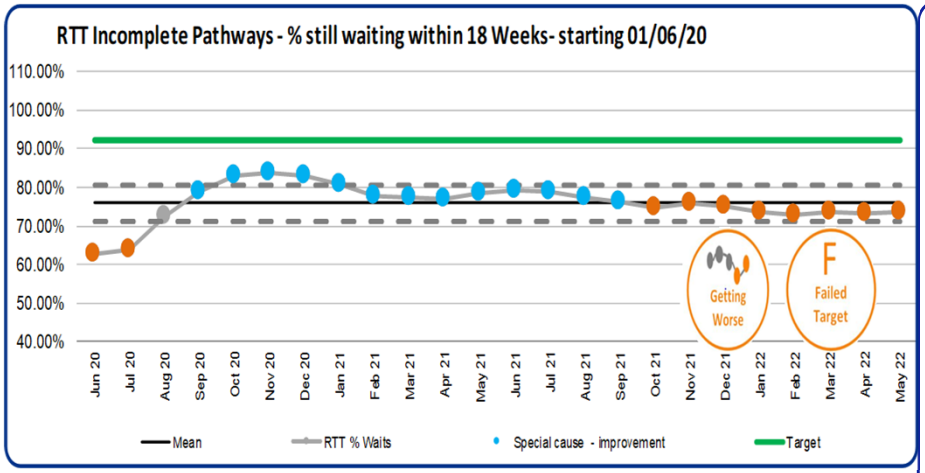
Performance

- Data above runs until early June.
- Having seen a steady reduction since February in the number of patients waiting over 104 days, the total backlog position has remained fairly static for the last circa 4 weeks
- However, the cohort of patients in this category is not static; as patients are treated, new patient have entered this category
- Colorectal is the most challenged tumour site for this standard with demand and histology issues the main drivers for pathway delays

Action

- Prioritise patients waiting over 104 days for access to treatment slots
- Colorectal team are devising plans for short term injection of additional capacity
- Embed 'Care Navigator' in post in Colorectal. Post holder objectives to include reducing DNAs and better preparing patients for colonoscopies to ensure rate of repeat tests is reduced
- Gynae are devising plans to introduce a one-stop clinic to undertaken ultrasound diagnostics in one visit

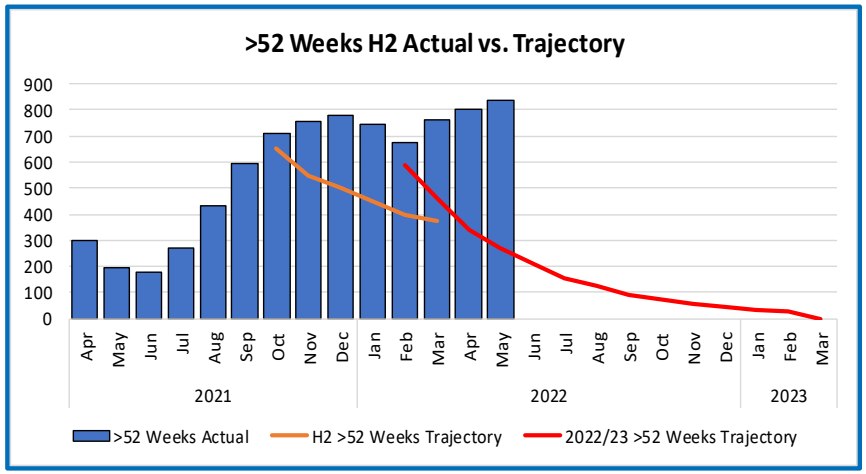
RTT Performance



Latest Month

73.6%

RTT Incomplete pathways target 92%



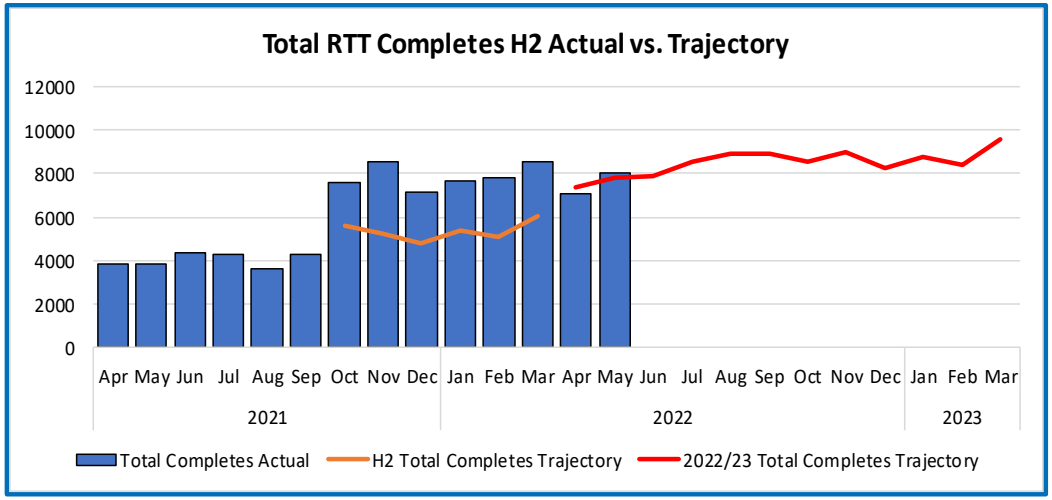
Performance

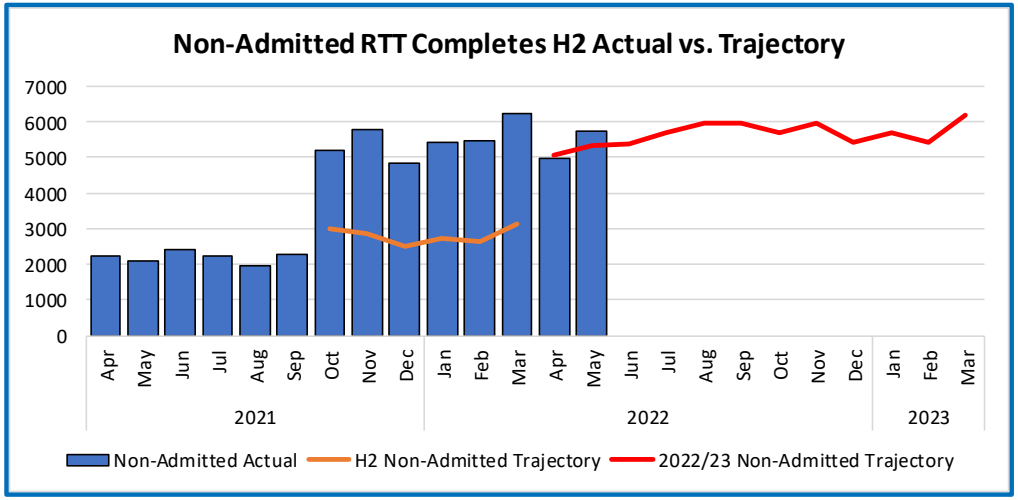
- RTT performance remains static
- Following a steady decrease at the turn of the calendar year, the total number of patients waiting longer than 52 weeks to commence treatment has increased in May
- Specialties with high cancer workload are the most challenged areas as they balance urgent and routine activity; notably General Surgery and Urology, however, both specialities have seen a small recent reduction in long waiting patients

Action

- Surgery continues to aim to utilise up to 50% of theatre list capacity for long waiting patients, although this is impacted by cancer demand, particularly in Plastic Surgery
- Surgery have been targeting productivity gains in recent months and have increased from 60% to 68% within the last 12 weeks
- The Division further aims to improve to 75% by 31st July

Recovery and Restoration – RTT Completes





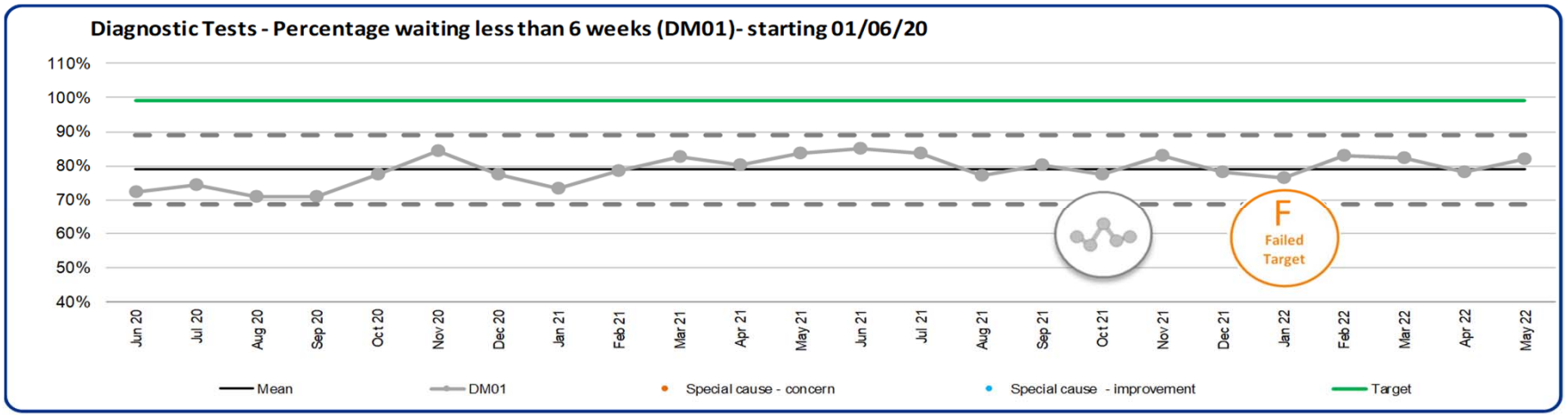
Performance

- RTT completes performed slightly below the new 2022/23 trajectory in May.
- Non admitted RTT completes have increased once more in May and are ahead of the 2022/23 trajectory
- The Trust is 7th lowest number of 52 week breaches out of the 20 acute Trusts in the region and the 4th least >78 week waits
- Of the 20 regional Trusts, DGFT has the 9th least >104 week waits, at 14, and the second shortest median waiting time of 9.9 weeks
- Within the ICS, Walsall has the fewest number of 52 week breaches (767), DGFT (803), SWBH (1,769), RWT (1,738)

Action

- x2 new Minor Procedure Rooms are currently under construction and are due to come online during Summer 2022, providing additional capacity
- To reduce the number of 52 week + waits in Orthopaedics, 2 additional weekend lists have been allocated to the speciality

DM01 Performance



Latest Month

81.8%

DM01 combining 15 modalities - target 99%

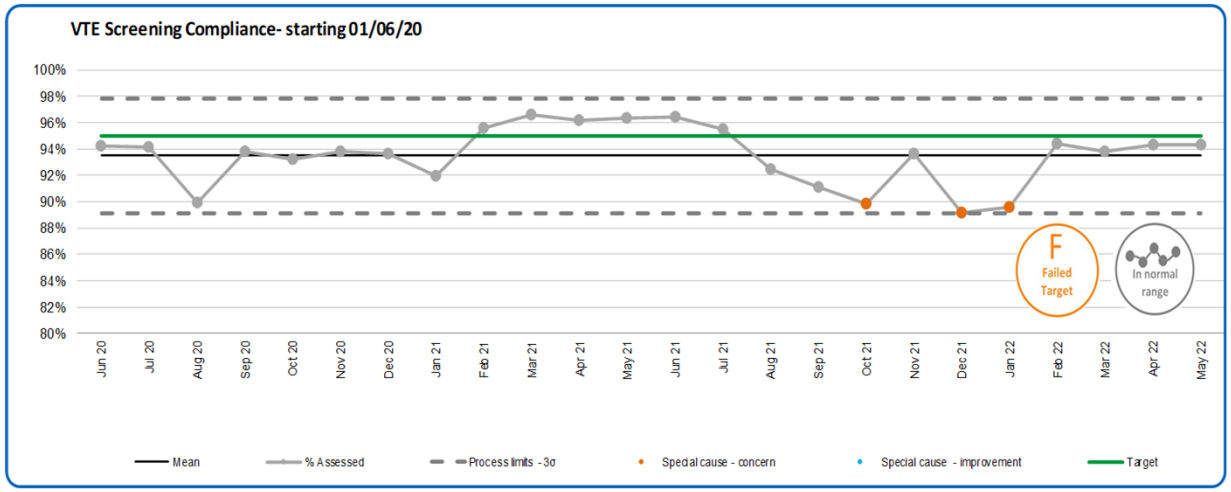
Performance

- DM01 performance remains below target but has realised a slight up tick to 81.8% in May from 78% in April. This represents a first increase in performance since January/February 2022
- A new assurance meeting for DM01 has been launched to drive forward performance
- Sleep Studies project is delivering improvement and is on trajectory

Action

- DM01 remains on track to deliver 95% within 6 weeks by March 2023, as per national requirements
- Performance to be driven via new DM01 assurance meeting

VTE Performance



Latest Month	Latest Month	Latest Month
94.03%	94.09%	93.97%
Trust overall Position	**Medicine & IC**	**Surgery, W & C**

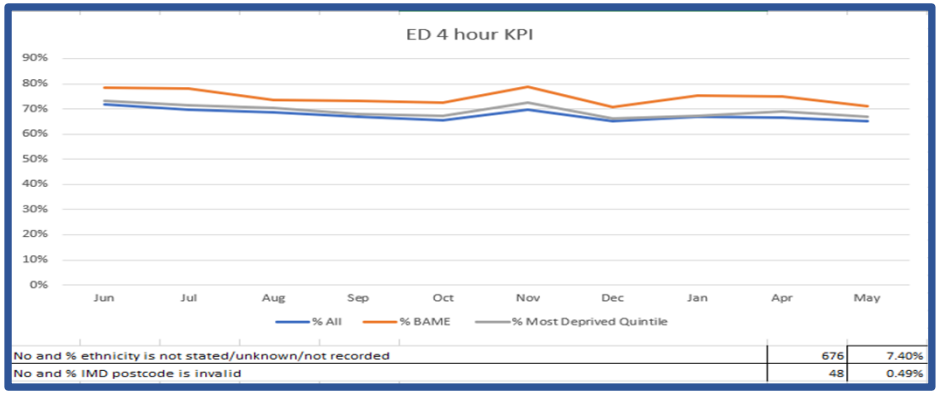
Performance

- Overall, Trust attainment against the VTE standard is consistent with last month
- Surgery is maintaining the performance gains made over the last quarter and Medicine improved on their performance in May
- Overall Trust performance is just short of the required standard

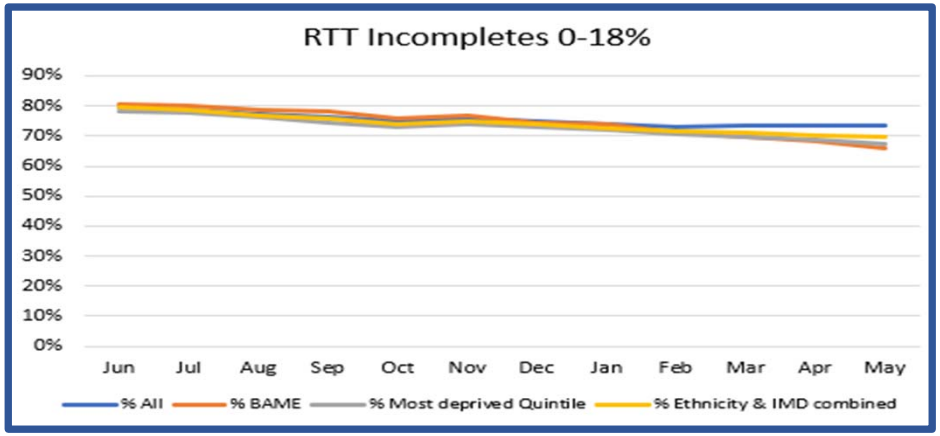
Action

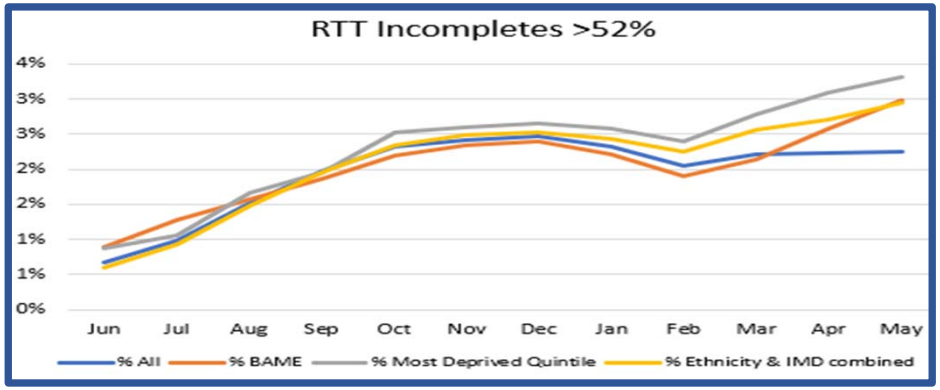
- Emergency Surgical Hub tracker to monitor patients requiring assessment in post
- Surgery have implemented a new checklist to aid completion

Health Inequalities



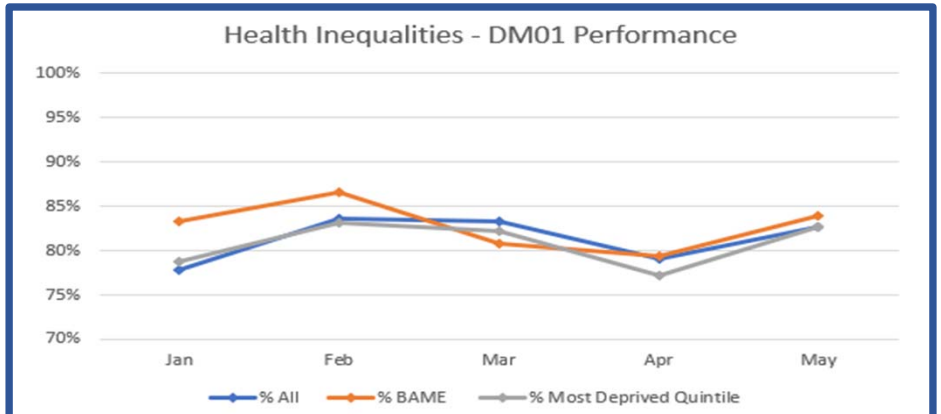
No and % ethnicity is not stated/unknown/not recorded	676	7.40%
No and % IMD postcode is invalid	48	0.49%



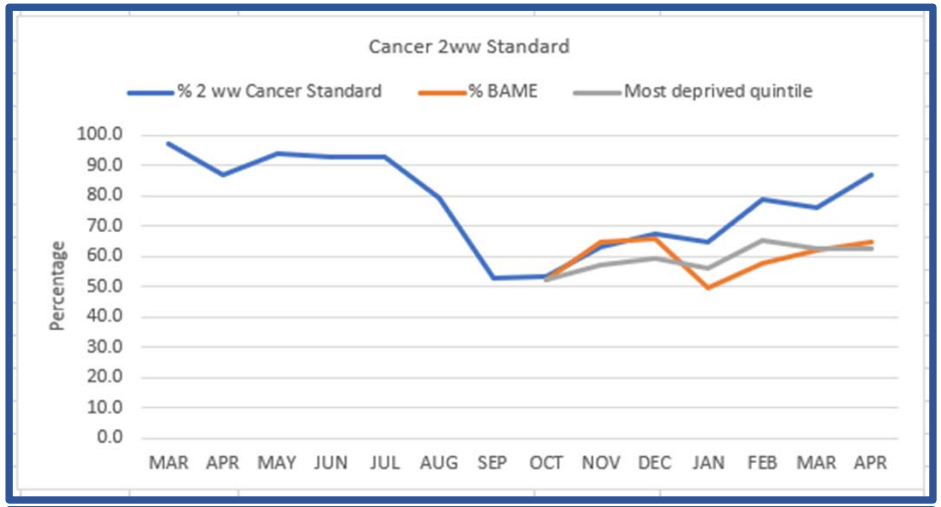


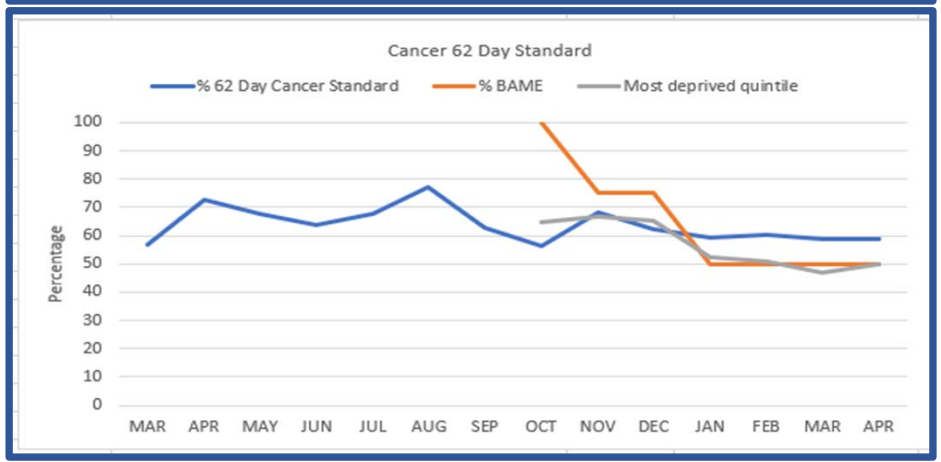
No and % ethnicity is not stated/unknown/not recorded	14822	39.7%
No and % IMD postcode is invalid/missing	10310	27.6%

Please note: As a significant number of missing ethnicity & IMD are for patients currently on ASI or RAS, these will be shorter waits excluded from the "BAME" and "IMD 1&2" figures, causing an downward skew of their performance. The yellow line shows performance for only those RTT waits with both a recorded ethnicity and IMD decile, and is therefore more comparative than the blue line of total waiting list figures.



No and % Ethnicity is not stated/unknown/not recorded	1091	13.92%
No and % IDM postcode is invalid	15	0.19%





Enclosure 10

The Dudley Group NHS Foundation Trust

Paper for submission to the Board of Directors on 21 July 2022

Title:	Charitable Funds Committee Summary Report
Author:	Julian Atkins, Charitable Funds Committee Chair
Presenter:	Julian Atkins, Charitable Funds Committee Chair

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

Recommendations:

The Board is asked to note the contents of the report.

Summary of Key Issues:

Summary of key issues discussed and approved by the Charitable Funds Committee on 27 June 2022

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:
(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	N	Details:
	NHSE/I	N	Details:
	Other	Y	Details: Charity Commission

Report Journey/ Destination *(if applicable)*	Working / Exec Group	N	Date:
	Committee	Y	Date: 27/06/22
	Board of Directors	Y	Date: 21/07/22
	Other	N	Date:

The Dudley Group
NHS Foundation Trust

UPWARD REPORT FROM CHARITABLE FUNDS COMMITTEE

Date Committee met: 27 June 2022

MATTERS OF CONCERN OR KEY RISKS TO ESCALATE	MAJOR ACTIONS COMMISSIONED/WORK UNDERWAY
• There were no matters of concern to escalate.	• Miss S Preston, Directorate Manager, Ophthalmology, presented the plans that the service have to spend the £140k legacy received in late 2021. The business case is to purchase equipment to facilitate the provision of a high volume cataract list and clear the large backlog of cataract operations. The service could also be offered to other local providers. The Committee were supportive of the business case but asked that it was reviewed to ensure that this was the correct use of charitable funds and to understand the revenue consequences. • Miss Kotecha outlined the events that the charity had coming up over the next few months. These were the NHS Big Tea party, the Committed to Excellence Awards, the 'Heroes fun run', the London marathon and the Glitter Ball. She also explained that work is underway to build and strengthen corporate partnerships. • Mrs Abbiss reported that there had been good engagement from staff in respect of the wellbeing hub but that there had been a delay in the build start date. Mr Walker stated that a Board to Board meeting with Summit was being confirmed. • Mrs Abbiss and Miss Kotecha presented the draft three year funding strategy for 2022 to 2025. A one page summary will be developed for staff and the public. The Committee supported the draft strategy proposal.

The Dudley Group
NHS Foundation Trust

POSITIVE ASSURANCES TO PROVIDE	DECISIONS MADE
• Mrs Taylor reported that since 1st April 2022, the Charity had received income of £104,451 while expenditure had been £78,970. Total fund balances had remained at circa £2.5m. • Miss Kotecha will work with the finance team to increase the spending of individual funds or seek agreement for these to be moved to general funds which are currently relatively low. • Mr Walker presented the draft pre-audited charity fund accounts for 2021/22. These were well received by the Committee who recorded their thanks to the Finance team for their work.	• It was agreed that Miss Kotecha should develop an Appeal proposal for presentation initially to the Executive Directors and subsequently the Charitable Funds Committee. • A decision was pending in respect of the purchase of equipment by the Dudley Rehab service from their own funds. A bid had been made from general funds.
Chair's comments on the effectiveness of the meeting: The meeting was quorate and effective.	

Enclosure 11

The Dudley Group NHS Foundation Trust

Paper for submission to the Board of Directors on July 2022

Title:	7 Day Services 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 complaint, 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.

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: July 2022
	Other	N	Date:

The Dudley Group
NHS Foundation Trust

REPORTS FOR ASSURANCE

Report to Board of Directors July 2022

1 EXECUTIVE SUMMARY

The 7 Day Service Standards (7DS) 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 complaint, 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.

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 dependent 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. Whilst we are compliant with the high level target for each standard have segmented our data and looked at the performance of subsets.

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.

Outstanding issues:

Endocrinology

Due to staffing issues the service is partially compliant, with job planned Consultant ward rounds 6 days a week, and reliant on the current consultant body undertaking additional sessions to provide the required cover. A business case has been approved for additional resource but recruitment remains a challenge.

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 June 2022 to develop a consultant of the week model. A demand and capacity exercise was undertaken which revealed that with the current workforce, introduction of the model would adversely impact on provision of clinics, including the lung cancer pathway. Further work is underway to develop a business case for additional resource.

ITU

The job planning consistency panel identified 87% compliance for twice daily consultant review. Work has completed to rationalise the footprint of critical care to establish a combined critical care, surgical high dependency unit and medical high dependency unit. The CSL for Critical Care is now undertaking an audit of 7DS compliance to provide assurance.

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 inpatient CT/MRI/Ultrasound and Interventional Radiology requests. which revealed significant progress made since the launch of the 7DS standards identifying 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 93.8% for all of radiology . Further work is required for compliance against all modalities specifically CT and MRI as significant challenges remain namely:

- Due to staffing and skill mix MRI scans are not available overnight with an SLA in place with UHB for transfer of patients requiring emergency neurological imaging
- Of the 2 CT scanners available on site one is required to be partially utilised for cardiac imaging

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(S)

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
11/7/2022

Enclosure 12

The Dudley Group NHS Foundation Trust

Paper for Submission to the Board of Directors
21st July 2022

Title:	Quality and Safety Committee 25th January 2022
Author:	Amanda Last – 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 is asked 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:

Risk	Y	Risk Description:	
	On Risk Register: Y	Risk Score: Numerous across the Board Assurance Framework, Corporate Risk Register and divisional risk registers	
Compliance and/or Lead Requirements	CQC	Y	Details: All Domains
	NHSE	Y	Details: Governance Framework
	Other	N	Details:
Report Journey/ Destination *(if applicable)*	Working / Exec Group	N	Date:
	Committee	Y	Date: 28/06/22 Quality and Safety Committee
	Board of Directors	Y	Date: 21/07/22
	Other	N	Date:

CHAIRS LOG

UPWARD REPORT FROM QUALITY AND SAFETY COMMITTEE 28 June 2022

The Dudley Group NHS Foundation Trust

MATTERS OF CONCERN OR KEY RISKS TO ESCALATE	MAJOR ACTIONS COMMISSIONED/WORK UNDERWAY
• Concern was raised regarding the use of the Electronic Patient Record in Maternity. Difficulties with document availability which could hinder obtaining a complete clinical picture have been escalated through the Maternity Governance Framework, however additional assurance is required with respect to addressing this safety issue. • The Committee noted the lack of compliance with meeting the internal 30 day response time for complaints. Although process improvements have resulted in some benefit, further assurance was requested. • A Health and Safety risk was acknowledged regarding staff non-compliance with wearing dosimeter badges in Theatres resulting in lack of oversight of exposure to ionising radiation in this area. • There are ongoing challenges meeting cancer targets; the 62 days referral to treatment target was noted as a particular concern. However, the Committee was informed of improvement work in relation to increasing diagnostic capacity and histology case prioritisation processes.	• none
POSITIVE ASSURANCES TO PROVIDE	**DECISIONS MADE**
• Positive assurance was received with respect to the progress made with immediate essential actions within the Ockenden report. • The Perinatal Mortality Review Tool process has been strengthened in line with national requirements; a multi-disciplinary approach has been implemented with clear monitoring processes and the backlog of reviews has been addressed. • Positive assurance has been received regarding work ongoing to improve compliance with evidencing all stages of the Duty of Candour regulation. • Assurance was gained regarding actions to improve the process of managing National Patient Safety Alerts however it was acknowledged that there was risk associated with one alert that was close to breaching timeframes set. • Positive assurance was received regarding Trust research activities and infrastructure, of note the relaunch of the 'Research and Innovation Support Group' has seen good attendance and provides a forum for new ideas sharing. • The extensive portfolio of work undertaken by the Medicines Management Group was acknowledged, noting examples of innovative practice such as the implementation of medication counselling cards. • Positive assurance was received regarding improvements seen in the Imaging Department, e.g., waitlist reduction, improvements in staffing levels and morale.	• The Committee agreed to give more dedicated time to the Ockenden report work in order to gain greater assurance.

Enclosure 13

The Dudley Group NHS Foundation Trust

Paper for submission to the Board of Directors on 21st July 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** Y

Recommendations:

The Board are asked to note the continued excellent work of the Chief Nurse's Office.

Summary of Key Issues:

The Vaccination programme have delivered over 16,000 Covid-19 vaccines in the last six months to people aged 5 – 100+ years. The vaccination sites supported by Russells Hall Hospital have been selected as exemplars of the Making Every Contact Count initiative.

Identification of Deprivation of Liberty Standards continues to be a focus across the Trust and administrative support has been identified to support the tracking of overdue actions and escalations when necessary.

There were five detentions under the Mental Health Act within the Trust in April and May 2022. A service level agreement has now been agreed with Black Country Healthcare to provide Mental Health Act administration to the Trust.

The Trust have successfully bid for funding to ensure that the Independent Domestic Violence Advisor based in the Emergency Department will continue for a further 12 months.

A national programme was launched across the Trust in June to promote techniques to support those caring for children cope with crying. The ICON programme have been launched by members of the safeguarding Team and colleagues from the Trusts STORK team.

There was an increase in the amount of pressure area damage identified in patients on admission in May compared to April 2022. Incidents continue to be monitored at the Pressure Ulcer Scrutiny Group where the majority are found to have no care omissions although there was significant learning in relation to early identification of pressure damage.

There continues to be fluctuation in the number of falls however the Trust remains below the national average. In May and June 2022 there were zero falls categorised as severe harm.

82% of Family and Friends Test respondents rated their experience of Trust services as 'very good/good' in May 2022. Despite the current challenges faced by the Emergency

Department they have seen an improvement of 2% (71%) in very good/good ratings since April.

The development of Paediatric Virtual Ward has allowed children to be cared for in their own home when previously they would be in an acute hospital bed.

The Paediatric Virtual Ward has been identified as a finalist in the **RCN Awards for 2022** in the Child Health category. In addition the Paediatric Virtual Ward are finalists in the **Nursing Times Awards for 2022** in the categories of Children's Services and Data and Technology.

The Trust 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. The deficit in unfilled shifts 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 2022 International recruitment programme is underway and has seen over 60 recruits start with the trust since April. They are currently working towards gaining their NMC registration to work independently.

Impact on the Strategic Goals	
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:			
Risk	Y	Risk Description: BAF & Corporate Risk Register	
	On Risk Register: Y/N	Risk Score: various	
Compliance and/or Lead Requirements	CQC	Y	Details: All domains
	NHSE/I	Y/N	Details:
	Other	N	Details:

Report Journey/ Destination	Working / Exec Group	N	Date:
	Committee	N	Date:
	Board of Directors	Y	Date: 21st July 2022
	Other	N	Date:

Chief Nurse Public Trust Board Report

The Dudley Group NHS Foundation Trust

Thursday 21st July 2022

Mary Sexton – Chief Nurse

Care
Deliver safe and caring services

The Dudley Group NHS Foundation Trust

Vaccination Work

In 6 months 16578 vaccines have been administered to those aged 5 to 100+ years.

Vaccines have been delivered in the vaccination centre, Russell's Hall Hospital and through the Housebound project in collaboration with St. Johns Ambulance service. In that time service user satisfaction has been evaluated as extremely high.

To support the wider Trust and locality work, the Making Every Contact Count (MECC) initiative has been embedded within the service. This has resulted in the sharing of best practice and the sites used as exemplar of the initiative.

The team look forward to what the autumn Covid vaccination campaigns bring and prepare to deliver flu vaccine to the staff and volunteers of DGFT.

CARE RESPECT RESPONSIBILITY

Care
Deliver safe and caring services

The Dudley Group NHS Foundation Trust

22/23	No. DoLs applications	22/23	No. DoLs applications		
April	20	May	44	21/22 total	172

Deprivation of Liberty Safeguards (DoLS)

The DoLS monitoring and tracking process within the Trust is continuously being refined. Administrative support is now in place to support the tracking of overdue applications and escalations where necessary. Identifying DoLS is an on-going concern across the Trust. The Mental Health Team visit wards daily to support the staff to understand when a DoLS needs to be applied for. The reduction of applications in April is attributed to new staff joining the Mental Health Team and the wider training elements required. This has demonstrated that the ward areas require additional support to identify the need for a DoL at the earliest opportunity.

Revised training has commenced and it is hoped once embedded changes in practice should be apparent. An intensive training and awareness campaign with begin shortly on AMU with the support from the Practice Development Nurse and Link Nurses on both MCA assessments and recognising when a deprivation of liberty is occurring. By starting with this ward it should enable the identifying DOLS before being admitted to other areas of the ward.

Mental Health Act

There were 5 Detentions under the Mental Health Act within DGT between April and May. All patients were given their rights and there were no appeal requests. The Service Level Agreement has now been agreed with Black Country Healthcare who will provide Mental Health Act Administration for Dudley Group, to ensure all Mental Health detentions are in line with regulation.

Care
Deliver safe and caring services

The Dudley Group NHS Foundation Trust

Q1 22/23	No. Referrals		No. Referrals		No. Referrals
Adult	161	Child & Young Person	494	Section 42	4

Safeguarding

Following a successful bid, funding for the Independent Domestic Violence Advisor based in the Emergency Department will continue for a further 12 months.

Due to the significant part Domestic abuse features within the work of the Safeguarding team, a coordinator has been appointed to support the embedding of the strategy and the associated work to help protect adults with care and support needs and children and young people from harm and abuse.

A national programme was launched across the trust in June, to promote techniques to support those caring for children cope with crying. It is hoped that the initiative will have a significant impact on the number of head injuries seen in children. The programme have been launched by members of the safeguarding Team and colleagues from the Trusts STORK team. The programme is called ICON (I – Infant crying is normal, C – Comforting methods can help, O – It is OK to walk way, N – Never, ever shake a baby)

The learning disability team held a patient panel in June, inviting previous patients to attend. The event was facilitated by the charity Dudley Voices for Choice self-advocacy. Using an accessible format with tablecloths to write and draw on the tables, people were able to reflect on their experience as a patient and what was 'good' when they came into hospital and 'what could have been better'. The information gleaned at this event will be used to inform the Learning Disability Standards Action Plan.

Care
Deliver safe and caring services

The Dudley Group NHS Foundation Trust

Tissue Viability

Pressure Ulcer incidence across the Trust remains static, though when broken down demonstrates an increase in the amount of pressure damage identified on admission (213 in May vs. 162 in April). The analysis of the figures from May demonstrate that there has been an increase in the number of Grade 3 and Unstageable Pressure Ulcers in the community and a decrease in the number in the hospital setting. Review at the Pressure Ulcer Scrutiny Group (PUSG) is identifying that the majority have no care omissions although there is significant learning in relation to the early identification of pressure damage in the community and domiciliary care settings for which we have requested CCG support.

The Tissue Viability Task & Finish Group continues to meet bi-weekly, currently focusing on the review of the short investigation tool (SIT) in the community. The purpose of this is to reduce the current delays in SITS being completed to bring to the PUSG, whilst this work is ongoing a member of staff has been redeployed to support in their completion. Further work is needed around the harm rating of the pressure ulcers and support has kindly been offered from both the governance and patient safety teams.

CARE RESPECT RESPONSIBILITY

Care
Deliver safe and caring services

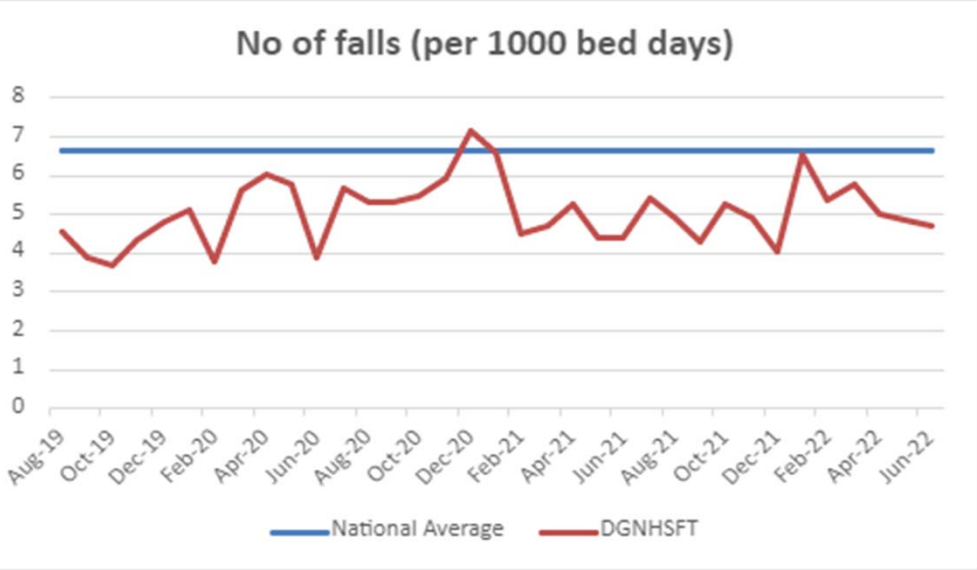
The Dudley Group NHS Foundation Trust

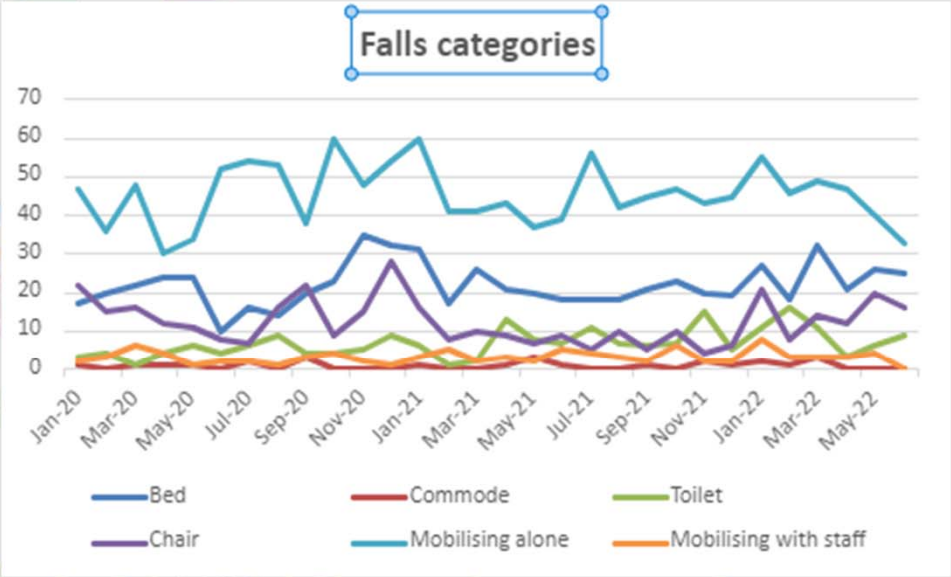
Falls

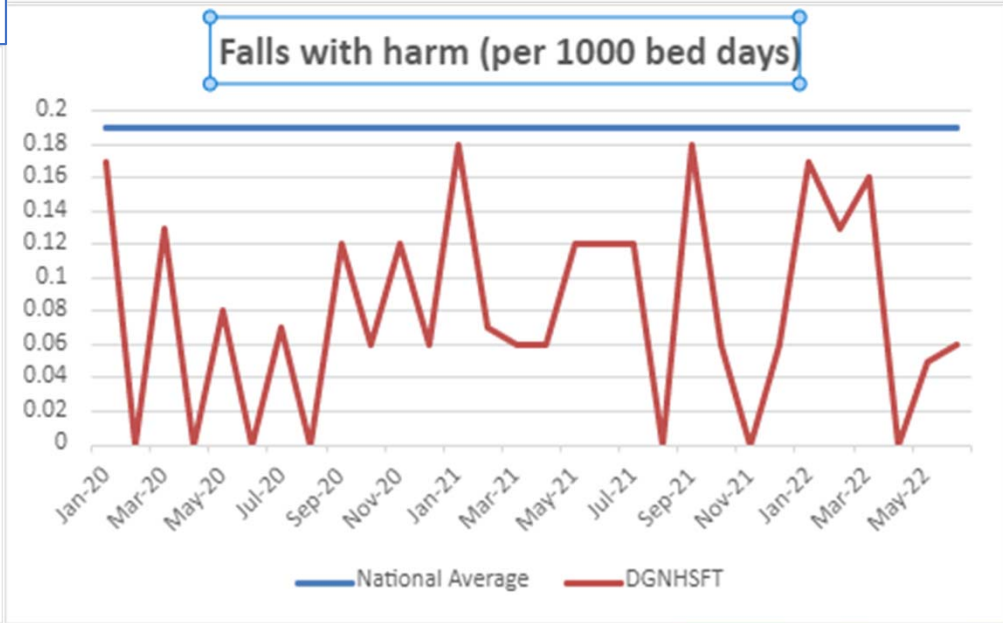
There continues to be fluctuation in the number of falls however the Trust remains below the national average. In May and June there were zero falls categorised as severe harm.

Collaborative working is ongoing with the digital team to create additional recording functionality for lying and standing Blood Pressures. Knowledge sharing on the importance of undertaking both blood pressures is persistent across all professions.

Steady improvement can be seen with falls assessment compliance in ED from 47.8% in Aug 2021 to a current compliance of 72.0% in June 2022.







CARE RESPECT RESPONSIBILITY

Compassion
Deliver a great patient experience

The Dudley Group NHS Foundation Trust

PALS	Concerns	Comments	Signposting contacts	Total
May 2022	322	5	50	377
June 2022	312	4	50	366
	Main concerns relate to appointment delays and cancellations			

Friends and Family Test

82% of respondents rated their experience of Trust services as 'very good/good' in May 2022. 7% of patients rated their experience of Trust services as 'very poor/poor' in May 2022, a 2% increase since April 2022. Despite the current challenges faced by The Emergency Department they have seen an improvement of 2% (71%) in very good/good ratings since April. The Inpatient/Outpatient Department received the highest positive ratings at 87%.

Compliments

The Trust has received 492 compliments in May 2022. Ward C4 received the highest number of compliments (40) in May 2022.

NHS Choices

15 comments were posted on NHS Choices/Patient Opinion during May 2022, an increase since April 2022. Two comments were negative, and 13 comments were positive.

Competence
Drive service improvement, innovation and transformation

The Dudley Group NHS Foundation Trust

Paediatric Virtual Ward

The development of Paediatric Virtual Ward has allowed children to be cared for in their own home when previously they would be in an acute hospital bed.

The provision of the team around the virtual ward has ensured that parents and carers feel fully supported when caring for a sick child at home as they have direct access to children's specialist nurses and doctors.

Paediatric Virtual Ward has been identified as a finalist in the **RCN Awards for 2022** in the Child Health category. This will be announced on 4th October 2022. In addition the Paediatric Virtual Ward are finalists in the **Nursing Times Awards for 2022** in the categories of Children's Services and Data and Technology. The winners will be announced on 26th October 2022. This is a fantastic achievement for the team and testament to the hard work of everyone involved.

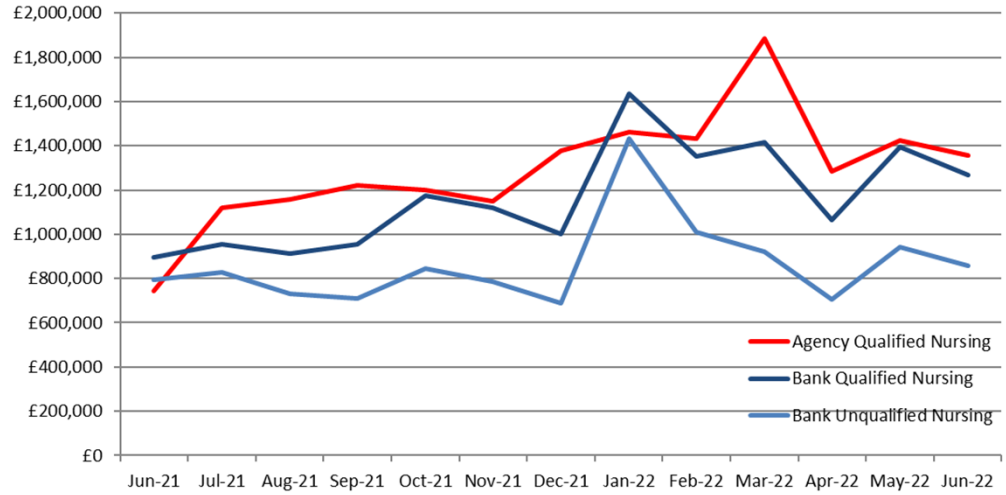
CARE RESPECT RESPONSIBILITY

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. To note there has been a reduction in agency usage. 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. Additional areas to support capacity remain open and are dependent on the use of temporary staff.

The 2022 International recruitment programme is underway and has seen over 60 recruits start with the trust since April. They are currently working towards gaining their NMC registration to work independently.



Area	Vacancy %	Agency Qualified Nursing	Bank Qualified Nursing	Bank Unqualified Nursing	Grand Total
Emergency Department Nursing	35%	£281,477	£36,765	£37,553	£355,795
I.T.U.	30%	£268,339	£48,796	£11,762	£328,898
Ward B4	-2%	£134,015	£40,284	£47,834	£222,133
Acute Med Unit (EAU)	21%	£51,914	£70,925	£52,323	£175,162
Ward B5	10%	£64,763	£37,050	£25,321	£127,135
Ward C7	23%	£48,714	£21,677	£38,788	£109,179
Ward C8	14%	£52,256	£26,718	£25,744	£104,718
Ward B3	6%	£48,267	£29,536	£18,922	£96,726
Ward A2	3%	£25,468	£38,034	£31,668	£95,170
Ward CCU	17%	£68,131	£22,362	£2,627	£93,121

CARE RESPECT RESPONSIBILITY

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The Dudley Group NHS Foundation Trust

Through May we have continued to have had a fluctuating position with regards to our safter staffing return. On average it is recognised that we have overall seen an increase with 89% (up 10%) of the qualified nurse requirements being met for a night shift and 82% (up 4%) for the day requirements.

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.

Safer Staffing Summary Jun — Days in Month 30

	Day RN	Day RN	Day CSW	Day CSW	Night RN	Night RN	Night CSW	Night CSW					Actual CHPPD			
Ward	Plan	Actual	Plan	Actual	Plan	Actual	Plan	Actual	Qual Day	UnQual Day	Qual N	UnQual N	Sum 24:00 Occ	Registered	Care staff	Total
A2	155	138	149	117	153	147	121	114	89%	78%	96%	94%	775	4.32	3.57	7.89
B1	152	131	74	67	86	76	61	50	87%	90%	88%	83%	441	5.34	3.04	8.38
B2(H)	123	118	217	173	92	92	189	157	96%	80%	100%	83%	709	3.55	5.45	9.00
B2(T)	118	108	128	115	91	89	100	88	91%	90%	98%	88%	674	3.50	3.61	7.12
B3	247	221	180	150	194	177	150	136	89%	84%	91%	90%	1,070	4.36	3.21	7.57
B4	105	79	105	94	67	61	108	87	75%	90%	91%	80%	1,243	1.32	1.75	3.06
B5	245	192	160	131	267	220	124	104	78%	82%	82%	84%	522	9.67	5.27	14.94
C1	245	201	265	245	181	178	207	190	82%	92%	98%	92%	1,397	3.18	3.74	6.91
C2	284	201	70	84	250	199	64	77	71%	120%	80%	120%	565	8.33	3.35	11.68
C3	210	174	385	363	181	169	364	355	83%	94%	93%	97%	1,553	2.65	5.43	8.08
C4	202	169	65	62	119	91	60	67	83%	95%	77%	112%	584	5.19	2.54	7.73
C5	318	234	264	242	275	243	203	181	74%	92%	88%	89%	1,401	4.13	3.62	7.75
C6	104	88	109	86	93	88	77	68	84%	79%	95%	88%	538	3.85	3.43	7.28
C7	199	196	204	162	156	154	208	186	99%	79%	99%	89%	1,041	3.94	4.00	7.95
C8	265	213	210	178	228	202	181	168	81%	85%	89%	93%	1,267	3.85	3.27	7.12
CCU_PCCU	255	230	63	60	225	213	34	30	90%	95%	95%	88%	706	7.37	1.53	8.90
Critical Care	565	481	140	89	560	483			85%	64%	86%		463	24.98	2.31	27.29
EAU AMU 1	652	509	513	371	428	461	419	366	78%	72%	108%	87%	2,074	5.49	4.26	9.75
Maternity	906	676	360	240	515	374	210	163	75%	67%	73%	77%	1,336	7.41	3.53	10.93
MHDU	151	132	72	43	151	130	30	-	87%	60%	86%		161	19.52	2.94	22.47
NNU	157	130			143	138			83%		97%		363	8.87	0.00	8.87
TOTAL	**5,657**	**4,621**	**3,731**	**3,071**	**4,454**	**3,985**	**2,911**	**2,585**	**82%**	**82%**	**89%**	**89%**	**18,883**	**5.27**	**3.56**	**8.83**

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Clinical Support Worker (CSW) We have had another CSW training programme advert go live on the 29th June. Due to the increase in vacancy position and the expected development of CSW to NAA an additional CSW training programme will commence in October 2022. Dorin Willetts has joined the team as a Professional Development Higher Clinical Support Worker. There are 2 seconded 12 months posts and will incorporate working across the Patient Experience team and the PD team. To support volunteers with some extended duties, and to provide pastoral 1:1 support to CSWs that may be finding the transition into their new role difficult within the trust.

Nursing Associate Apprentices (NAA) We recruited 18 new starters for the programme- 12 candidates are internal and already working within the trust, and 6 are external and will be new to the organisation. This group will be cohort 11 and the course will commence in September in partnership with Wolverhampton University. Some leads have reached out to the team to request to keep their members of staff who were successful following interview.

International Team We continue to recruit international nurses via the Clinical fellowship programme in partnership with The Royal Wolverhampton Trust. In June we were delighted to welcome our new international nurses via the agency that the trust is supporting to complete their OSCE programme. The international nurses who have achieved their NMC registration, whilst waiting to undertake the graduate programme the team are supporting clinical skills training to aid the nurses to benefit their department with these additional skills. Hopefully this help in the smooth transition onto the graduate programme.

CARE RESPECT RESPONSIBILITY

Parish Notices

The Dudley Group NHS Foundation Trust

To incorporate International day of the Midwife, International Nurses and National ODP day, The Trust celebrated these events with the Launch of #CaringWithPride Week in May. The week saw many activities and celebrations across the Trust, including the return of the bed making competition.

Having submitted an expression of interest the Trust have been awarded the opportunity to appoint two fellows to work with Health Education England (HEE) for a 12 month secondment. The fellows will work with local and national colleagues on two of the main agenda items, Nurse Recruitment and the Maternity Better Births Programme. We are delighted that Nadine Beresford and Dee Wilson are the successful fellows and look forward to seeing the input and the impact of these roles.

Last month saw the successful recruitment into our Core Skill Lead post covering Manual Handling and Medical Devices.

Claire Nash (Trusts Procurement Clinical Specialist) won the most Outstanding Contribution at the Supply Chain Awards. A fantastic achievement and a testament to her dedication.

Gill Hiskett, Tissue Viability Lead has retired from the Trust. The role has been successfully appointed to.

CARE RESPECT RESPONSIBILITY

Enclosure 14

The Dudley Group NHS Foundation Trust

Paper for submission to the Trust Board
21st July 2022

Title:	Infection Prevention and Control Board Assurance Framework
Author:	Liz Watkins – Deputy Director Infection Prevention and Control (DDIPC)
Presenter:	Mary Sexton – Director Infection Prevention and Control (DIPC)

Action Required of Board

Decision	Approval	Discussion	Y	Other

Recommendations:

The Group 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 criterions.

The colour coded matrix over the page (before the detailed IPC BAF) demonstrates the many areas which the trust can give assurance as evidence of compliance can be confirmed.

Updates since last report:

- New version of IPC BAF for 2022/2023
- COVID- 19 Zoning continues

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.

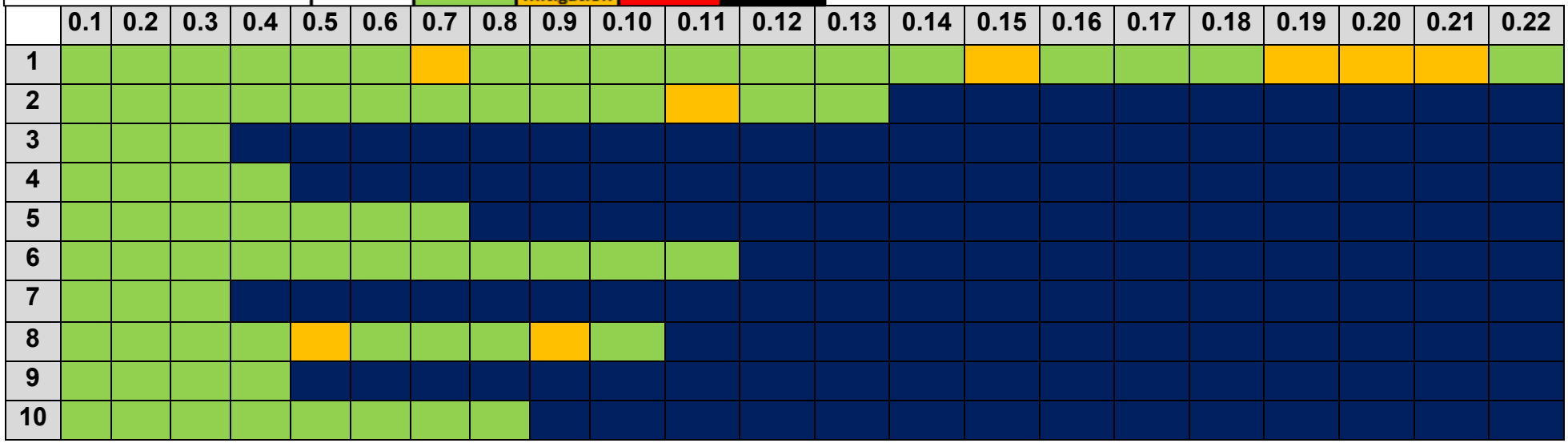
Impact on the Strategic Goals

(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:
	Committee	N	Date:
	Board of Directors	N	Date:
	Other	Y	Date: IPCG Meeting 30/05/2022

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



1	Twice weekly LFD testing remains voluntary. Trust promoting staff testing. IT currently reviewing and updating Sunrise 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	SOP awaiting review and adoption of screening for elective surgery
9	No GAPs identified
10	No GAPs identified

INFECTION PREVENTION AND CONTROL BOARD ASSURANCE FRAMEWORK - APRIL 2022

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.
1.1	Systems and processes are in place to ensure: 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	Point of care testing initiated Feb 2021.	
1.2	There are pathways in place which support minimal or avoid patient bed/ward transfers for duration of admission unless clinically imperative.	Patients with symptoms are assessed by ED and are placed into the RED Cohort area of ED; all admissions via ED are screened	N/A		
1.3	That on occasions when it is necessary to cohort COVID-19 or non-COVID-19 patients, reliable application of IPC measures are implemented and that any vacated areas are cleaned as per guidance.	Outpatient flow chart in use. Zoning and screening SOP in place Documentation audits are ongoing monthly. Merging of contacts guidance circulated COVID-19 contacts isolated for 24 hours on identification. Isolation de-escalated on result if negative.	Frequency of moves not routinely monitored. Re-zoning of clinical areas to meet patient demand often compounds frequent movement of patients.	IPC team monitor movement of any patient positive from COVID-19 and monitor the contacts.	
1.4	Monitoring of IPC practices, ensuring resources are in place to enable compliance with IPC practice.	point of care testing in place within Emergency Department that enables streaming of patients thus preventing crowding of patients as a direct result of waiting for COVID-19 swabs. Movement of patients restricted to clinical need.	Monthly audits reliant on clinical staff assessing their own area. Self-auditing.		

1.5	Staff adherence to hand hygiene?	Mandatory training, monthly hand hygiene audits. Unannounced IPC inspections. 5 moments of Hand Hygiene audit implemented. Frequency of audit dependant on previous result <95% Monthly <90% Weekly >90% Daily			
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 – SOP updated April 2022. The capacity of the Zones is reviewed at the capacity meetings. IPC attend as required. Due to Low numbers of COVID-19 Positive patients any positive patients currently nursed on wards in side rooms. Zoning will be reintroduced, as necessary. Infection control attend the Trust am capacity meetings.	N/A		
1.7	Implementation of twice weekly lateral flow antigen (LFD) 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-19 changes.	LFD is currently voluntary. Not all front facing staff are recording results. Lack of data. Local data compliance is not readily available.	Twice weekly LFD testing continues to be promoted throughout the Trust.	

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/UK HSA/ Public Health team.	Any staff member that becomes positive for COVID-19, are followed up for any breaches in PPE Staff members encouraged to challenge non-compliance of PPE. PPE available on all entrances to the trust. PCR testing available for outbreaks of COVID-19 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 Compliant	
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		
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	Compliant	
1.11	This Board Assurance Framework is reviewed, and evidence of assessments are made available and discussed at Trust board.	IPC BAF submitted in timely manner for board review. Updated monthly by IPC, Consultant Microbiologist and Deputy Chief Nurse.	N/A	Compliant	

1.12	Ensure Trust Board have oversight of ongoing outbreaks and action plans.	Board updated by DIPC. DIPC chairs outbreak meetings and updates sent via email by IPC. Minutes of outbreak meeting available as required. Closure reports are circulated IPC BAF Discussed at Quality and safety Committee.		Compliant	
1.13	There are check and challenge opportunities by the executive/senior leadership teams in both clinical and non-clinical areas.	Via board and Quality and safety Committee.			
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. Zoning and screening policy updated April 2022. COVID-19 results are provided to other care providers on transfer with discharge information. COVID-19 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-19-cases in care/nursing homes to enable follow up of patients. April 2022 Rapid swabs to be used to facilitate rapid discharge to care homes to ensure capacity and safe transfer of care	April 2022 Rapid swabs to be used to facilitate rapid discharge to care homes.		

1.15	Patients and staff are protected with PPE, as per the UK HSA national guidance.	UK HSA guidance in relation to PPE has changed during the COVID-19 pandemic. Staff are updated promptly when new guidance is released via “In the Know” communications. Staff have access to PPE as per UK HSA guidance. Executive oversite of PPE stocks. Patients and visitors are offered type IIR fluid resistant surgical face 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.	Patients, visitors are not always mask compliant.	Patients and visitors to the Trust are challenged if a patient refuses to wear a Fluid resistant surgical mask Non- compliance is documented in the patient notes.	
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-19 and then forward this, on receipt, to all relevant departments. The IPCT review the UK HSA and Gov.uk websites for updated IPC guidance. Changes are communicated to staff via IPCT visiting clinical areas, Matron’s meeting, daily brief, HUB page, COVID-19 emails, and CEO briefing. Daily situations report to UK HSA/NHSI/E.	N/A		

1.17	Changes to guidance are brought to the attention of boards and any risks and mitigating actions are highlighted.	IPC BAF is completed and escalated to the Board. Risk assessments completed. DIPC updates the Exec Team.	N/A		
1.18	Risks are reflected in risk registers and the Board Assurance. Framework where appropriate.	COVID-19 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-19 related risks are documented and reported.			
1.19	Robust IPC risk assessment processes and practices are in place for non-COVID-19 infections and pathogens	Admission assessments include an infection control section which asks if patients have an infection. There are policies and procedures in place to identify alert organisms in admitted patients. These are audited and presented to the Infection Prevention and Control Group for reporting via the governance process. Surveillance of alert organisms is completed by the IPCT utilising ICNet surveillance system and the national MESS database.	The infection control risk assessment in the admission documentation is limited due to its simplicity and does not risk assess against all infections.	Live link to Sunrise system in place, for COVID-19 and other infectious results. Ongoing discussions with IT to the possibility of having an IPC tab on Sunrise to document all infectious organisms.	

		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 reviewed		<u>April 2022</u> IT are developing an IPC section to be included in the documentation section. Risk Assessment has been completed. <u>April 2022</u> Blue tick now on Sunrise	
1.20	NHSE/I visit April 2021 Noted several areas required estates work completing.	Additional Estates focused reactive audits being introduced as of 17/05/2021 to review wards and departments across the sites on a targeted basis. Minor issues that can be dealt with within 24 hours will be followed through to completion and performance monitored through the PFI contract mechanisms as required. All 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:		All other works identified will be prioritised/RAG rated on plan with risks mitigated as required and progress reported through to corporate level via the IPCG and Quality and Safety Committee. a formal action Additional estates reactive auditing to be introduced from 17/05/2021 to review wards and departments across the sites on a targeted basis and to follow through to completion of all issues identified. <u>January 2022</u> Summit and Mitie have confirmed all back log small works are completed and we have reverted to contract e.g., performance	

		Maintenance – Work has commenced on site, orders raised with suppliers. Estimated Date for Completion 30/05/2021 based upon access being available to all required areas Life Cycle – Plans being developed to refurbish identified areas which will be treated as priority. Estimated Date for Completion 30/05/2021 based upon access being available to all required areas. Variations - Variations raised which will be treated as priority. Some items will have a lead time including the new patient kitchen etc. Estimated Date for Completion 30/06/2021 based upon access being available to all required areas.		managed. About the larger life cycle works this remains subject to the Trust providing decant areas April 2022 Additional Resource remains in place coordinating joint audits and following up to ensure reactive works are completed. Any outstanding will be performance managed in line with the PFI contract	
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. Critical Care Risks and actions reviewed on 07/04/2021 & 28/04/2021 TAC1412 – Lack of storage affecting MHDU - 24/07/2021 07/04/2021 – Risks added: TAC 1616 – Lack of Storage in Critical Care TAC 1626 – Suboptimal compliance with management of cleanliness of environment & equipment		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	

		TAC 1615 Medication storage compliance		are being accelerated as quickly as possible so the materials can be ordered. <u>April 2022</u> The construction of the new storage facility has commenced and is due for completion June 2022. On completion the existing bed store will be handed over for clinical storage. <u>June 2022</u> Bed storage facility completed and handed over	
1.22	A respiratory season/winter plan is in place: That includes point of care testing (POCT) methods for seasonal respiratory viruses to support patient triage/placement and safe management according to local needs, prevalence, and care services to enable appropriate segregation of cases depending on the pathogen. Plan for and manage increasing case numbers where they occur. a multidisciplinary team approach is adopted with hospital leadership, estates & facilities, IPC Teams, and	The Dudley Group is part of the winter plan for the Dudley Health Board. Point of care is available in ED for all admissions to test for influenza and COVID-19 this allows for the correct zoning and placing of patients. The Trust Incident Management Team meets once weekly, (and more frequently when required), to review local and National Data allowing for escalation and discharges to be reviewed. An SOP, Risk Matrix and Assessment and is available of the Hub to allow for staff to be brought back in to work if they have positive household contacts.		Compliant Compliant Compliant Compliant	

	clinical staff to assess and plan for creation of adequate isolation rooms/units as part of the Trusts winter plan.				
	Health and care settings continue to apply COVID-19 secure workplace requirements as far as practicable, and that any workplace risk(s) are mitigated for everyone.				
1.23	<u>Care Systems.</u> if the organisation has adopted practices that differ from those recommended/stated in the national guidance a risk assessment has been completed and it has been approved through local governance procedures, for example Integrated Care Systems. Risk assessments are carried out in all areas by a competent person with the skills, knowledge, and experience to be able to recognise the hazards associated with respiratory infectious agents. if an unacceptable risk of transmission remains following the risk assessment, the extended use of Respiratory Protective Equipment (RPE) for patient care in specific situations should be considered.	Zoning policy of Blue, amber, green still is use. Zoning policy April 2022, circulated via Comms and is available on the Hub. Risk assessments are completed and reviewed by Health and Safety and risk advisor. Risk assessment completed and following discussion with IMT and Procurement increased RPE was introduced in January 2022 from IIR to FFP3 or equivalent All IPC policies and SOPS are available via the Hub.		Compliant Compliant Compliant	

	Ensure that patients are not transferred unnecessarily between care areas unless, there is a change in their infectious status, clinical need, or availability of services.	Hand hygiene and environmental audits are undertaken and recorded via AMaT. UK HSA training videos are available on the Hub for donning and doffing.		Compliant	
	resources are in place to implement and measure adherence to good IPC practice. This must include all care areas and all staff (permanent, agency and external contractors).the application of IPC practices within this guidance is monitored, e.g.: hand hygiene. PPE donning and doffing training. cleaning and decontamination.	Fit mask testing is available.		Compliant	
1.24	Organisational /employers risk assessments in the context of managing seasonal respiratory infectious agents are: Based on the measures as prioritised in the hierarchy of controls. including evaluation of the ventilation in the area, operational capacity, and prevalence of infection/new variants of concern in the local area. Applied in order and include elimination; substitution, engineering, administration and PPE/RPE. Communicated to staff.	SOPs are in place for returning to work following positive contact, updated April 2022. Seasonal flu and respiratory screens are available. POC testing is available. In the Know is updated with Comms		Compliant	

	Safe systems of working; including managing the risk associated with infectious agents through the completion of risk assessments have been approved through local	Risk assessments available on the hub for completion			

	governance procedures, for example Integrated. The Trust is not reliant on a particular mask type and ensure that a range of predominantly UK Make FFP3 masks are available to users as required.	The trust has a PPE cell to review different types of masks both available to and used within the Trust. The Trust has access to RPE, JSP ½ masks and FFP3 masks. There is a FFP3 fit testing service available, and staff fit testers in each area.		Compliant	
2	Provide and maintain a clean and appropriate environment in managed premises that facilities the prevention and control of infections.				
	Key lines of enquiry	Evidence	Gaps in Assurance	Mitigating Actions	R.A.G.
2.1	Systems and processes are in place to ensure: Designated teams with appropriate training are assigned to care for and treat patients in COVID-19 isolation or cohort areas.	Staff caring for COVID-19 patients, are supported by Matrons, Consultants and IPCT. The medical rotas were adjusted to ensure that those with respiratory experience were assigned to the high COVID-19 areas. Face fit testing undertaken locally and by the clinical skills team. Donning and doffing training completed by the 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-19 cohort areas. An external cleaning training provider has completed a programme of education. Facilities team report yearly training in line with the trust. IPCT hold regular meetings to ensure facilities resources are focused in risk areas New Decontamination of the Environment Policy in place April 2022	N/A		
2.3	Decontamination and terminal decontamination of isolation rooms or cohort areas is carried out in line with UK HSA and other national guidance	Terminal cleans completed when a COVID-19 patient vacates a bed space or area in none COVID-19 areas. 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 on a rolling 3 monthly basis whilst cleaning and decontamination review takes place			
2.4	Increased frequency of cleaning in areas that have higher environmental contamination rates	COVID-19 additional cleaning documents and cleaning policy remain in place.			

	as set out in the UK HSA and other national guidance attention to the cleaning of toilets/bathrooms, as COVID-19 has frequently been found to contaminate surfaces in these areas cleaning is carried out with neutral detergent, a chlorine-based disinfectant, in the form of a solution at a minimum strength of 1,000ppm available chlorine, as per national guidance. If an alternative disinfectant is used, the local infection prevention and control team (IPCT) should be consulted on this to ensure that this is effective against enveloped viruses manufacturers' guidance and recommended product 'contact time' must be followed for all cleaning/disinfectant solutions/products as per national guidance: 'Frequently touched' surfaces, e.g., door/toilet handles, patient call bells, over-bed tables and bed rails, should be decontaminated at least twice daily and when known to be contaminated with secretions, excretions, or body fluids electronic equipment, e.g., mobile phones, desk phones, tablets, desktops, and keyboards should be cleaned at least twice daily rooms / areas where PPE is removed must be decontaminated, timed to	Touch point cleaning discontinued April 2022 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. The trust utilises Clinell wipes for decontamination of medical devices and surfaces-Gamma state the wipe are against enveloped viruses and that 60 seconds contact time is required. Sporicidal Wipes in use throughout the Trust to clean commodes and bed pans. These were measures to assist with the prevention of Healthcare Associated infections.			

	coincide with periods immediately after PPE removal by groups of staff (at least twice daily.)				
2.5	Linen from possible and confirmed COVID-19 patients is managed in line with UK HSA and other national guidance and the appropriate precautions are taken.	COVID-19 positive linen is managed in line with Elis's policy (placed into alginate bag and the white bag) which is compliant with UK HSA guidance-which is available on the Trust. Standard precaution policy has been updated to include colour coding. Information regarding the correct bagging for linen is 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-19 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 UK HSA and other national policy	Reusable non-invasive medical devices are decontaminated using universal wipes or Chlorine releasing agent in line with Trust policy and/or manufactures instructions.		I am clean decontamination labels in use to identify equipment ready to use	

		I am clean labels in use. 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. Seconded 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	Review and ensure good ventilation in admission and waiting areas to minimize opportunistic airborne transmission.	The Estates department as part of the hot weather plans have been installing where possible portable air conditioning units and have reviewed ventilation at the Trust. The estates team hold details regarding air changes according to site plans. Communications held with matrons regarding the benefits of periodically. opening windows to aid air exchanges within clinical areas.	N/A	Installation of air conditioning units 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.	
2.9	Monitor adherence environmental decontamination with actions in place to mitigate any identified risk.	Cleaning Audits submitted monthly Audits, spot auditing. De-contamination certificates.			
2.10	Monitor adherence to the decontamination of shared equipment with actions in place to mitigate any identified risk.				

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. <u>October 2021</u> – Meetings currently being held to discuss implantation of new cleaning standards released May 2021 and trials of new cleaning products. <u>January 2022</u> Delay escalated to Quality and Safety Committee. <u>March 2022</u> Decontamination of the environment Policy incorporating the new cleaning standards adopted at IPCG. <u>April 2022</u> Cleaning policy ratified and formally sent to Mitie for full	

				implementation by May 2022. In addition to the cleaning review high level cleaning continues to be monitored by the Trust's Audit Team and actioned by Mitie within the contractual response times.	
2.12	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 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 20/04/2021 and an action from this was for additional storage solutions for electrical equipment to be identified.		Feasibility study for additional storage is being tendered with a view to raising order to undertake the feasibility study by 21/05/2021 Temporary storage is being constructed adjacent to critical care unit to improve and declutter the clinical area in the immediate term <u>July 2021</u> 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. <u>November 2021</u>	

				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. <u>April 2022</u> The construction of the new storage facility has commenced and is due for completion June 2022. On completion the existing bed store will be handed over for clinical storage <u>June 2022</u> Bed storage facility completed and handed over.	
2.13	The Trust has a plan in place for the implementation of the National Standards of Healthcare Cleanliness and this plan is monitored at board level.	Decontamination of the Environment Policy adopted at IPCG March 2022 Room definitions FR1 -FR6 are in place.			

	The organisation has systems and processes in place to identify and communicate changes in the functionality of areas/rooms.				
	Cleaning standards and frequencies are monitored in clinical and nonclinical areas with actions in place to resolve issues in maintaining a clean environment. Increased frequency of cleaning should be incorporated into the environmental decontamination schedules for patient isolation rooms and cohort areas. Where patients with respiratory infections are cared for: cleaning and decontamination are carried out with neutral detergent or a combined solution followed by 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) are consulted on this to ensure that this is effective against enveloped viruses	Cleaning audits are undertaken and reported to IPCG. Action plans are developed at the time of audit. Room definitions FR1 -FR6 are in place with frequency of cleaning and frequency of audit. These have been added to the new policy. MITIE undertake terminal cleans HPV fogging is available Cleaning is undertaken by MITIE PFI Partners using Chlorclean. COSHH information and dilution schedules are available in Cleaners Cupboards			

	Manufacturers' guidance and recommended product 'contact time' is followed for all cleaning/ disinfectant solutions/products.				
	A minimum of twice daily cleaning of: - patient isolation rooms. - cohort areas. - Donning & doffing areas - 'Frequently touched' surfaces e.g., door/toilet handles, patient call bells, over bed tables and bed rails. - where there may be higher environmental contamination rates, including: toilets/commodes particularly if patients have diarrhoea. A terminal/deep clean of inpatient rooms is carried out: - following resolutions of symptoms and removal of precautions. - when vacated following discharge or transfer (this includes removal and disposal/or laundering of all - curtains and bed screens). following an AGP if room vacated (clearance of infectious particles after an AGP are dependent on the ventilation and air change within the room).	Terminal cleans are requested via the MITIE help desk.		Compliant Compliant	

	Reusable non-invasive care Equipment is decontaminated: - between each use. after blood and/or body fluid contamination - at regular predefined intervals as part of an equipment cleaning				
	protocol - before inspection, servicing, or repair equipment Compliance with regular cleaning regimes is monitored including that of reusable patient care equipment As part of the Hierarchy of controls assessment: ventilation systems, particularly in, patient care areas (natural or mechanical) meet national recommendations for minimum air changes refer to country specific guidance. In patient Care Health Building Note 04-01: Adult in-patient facilities The assessment is carried out in conjunction with organisational estates teams and or specialist advice from ventilation group and or the organisations, authorised engineer. A systematic review of ventilation and risk assessment is undertaken	A regular cleaning audit schedule is in place and audit scores and stars on the doors are reported to the IPCG bimonthly meeting. Areas scorning 3 stars or lower are re-audited. Trust ventilation meeting meets monthly and includes PFI partners. The Trust has an AE in place.		Compliant Compliant Compliant	

	to support location of patient care areas for respiratory pathways.	All areas are encouraged to open windows to increase ventilation and air changes.			
	Where possible air is diluted by natural ventilation by opening windows and doors where appropriate. Where a clinical space has very low air changes and it is not possible to increase dilution effectively, alternative technologies are considered with Estates/ ventilation group. When considering screens/ partitions in reception/ waiting areas, consult with estates/facilities teams, to ensure that air flow is not affected, and cleaning schedules are in place	IPC and Health and Safety are included in the review for screen purchasing		Compliant	
3	Ensure appropriate antimicrobial use to optimize patient outcomes and to reduce the risk of adverse and antimicrobial				
	Key lines of enquiry	Evidence	Gaps in Assurance	Mitigating Actions	R.A.G.
3.1	Systems and process are in place to ensure: Arrangements around antimicrobial stewardship are maintained.	Antimicrobial Pharmacy referrals in place.		Virtual Antimicrobial stewardship group meetings during pandemic (via email/ teams).	

	Previous antimicrobial history is considered. To reduce inappropriate prescribing.			All clinical Pharmacists actively referring patients to antimicrobial Pharmacist for stewardship queries. Snapshot antimicrobial prescribing audits.	
	To ensure patients with infections are treated promptly with correct antibiotic.			Infection control Nurses to support AMS activity.	
3.2	Mandatory reporting requirements are adhered to, and boards continue to maintain oversight.	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-19 screening to reduce inappropriate prescribing of antimicrobials.	Micro/Antimicrobial Pharmacist ward rounds not happening as often as before Pandemic due to isolations and remote working. Rigorous monitoring not possible currently.	EPMA now in place to allow ongoing monitoring of prescriptions	
3.3	Risk assessments and mitigations are in place to avoid unintended consequences from other pathogens.	Zoning and Swabbing SOP is in place. Specimens are taken as and when required		Compliant	
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: Visits from patient's relatives and/or carers (formal/informal) should be encouraged and supported whilst	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.	N/A	New SOP on the hub for visitors March 2022 2 visitors permitted	

	maintaining the safety and wellbeing of patients, staff, and visitors. Implementation of national guidance on visiting patients in a care setting.	Visiting Policy to be updated to reflect current visiting advice. Information regarding visiting during the COVID-19 crisis is provided via			
	Restrictive visiting may be considered appropriate during outbreaks within inpatient areas This is an organisational decision following a risk assessment	automated message on calling direct to Trust switchboard. March 2022 – Visiting has recommenced. The visiting of COVID-19 positive patients remains restricted and must be risk assessed but the Trust will work with patients and relatives to accommodate patients' needs and wishes			
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. A zoning and screening SOP is in place.	N/A		
4.3	Information and guidance on COVID-19 is available on all Trust websites with easy read versions. Handwashing, wearing of facemask/face covering and physical distancing.	COVID-19 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-19 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. April 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	There is a patient transfer checklist which asks infection type if the patient requires barrier nursing or side room and requests current observations.	Assurance required regarding evidence of completion	October 2021 COVID-19 status on transfer is covered in the monthly documentation	
	confirmed COVID-19 patient needs to be moved. If visitors are attending a care area with infectious patients, they should be made aware of any infection risks and offered appropriate PPE. This would routinely be an FRSM. Visitors with respiratory symptoms should not be permitted to enter a care area. However, if the visit is considered essential for compassionate (end of life) or other care reasons (e.g., parent/child) a risk assessment may be undertaken, and mitigations put in place to support visiting wherever possible.	As previously documented, there is a discharge and transfer checklist (which will be updated to specifically include COVID-19) and COVID-19 status is included in all discharge documentation to all other healthcare providers. COVID-19 test results for intra trust transfers are documented on Sunrise. Visitors' instructions and booking system available on the trust website. Questions and advice regarding visiting with symptoms on booking form. Visitors are advised to contact the ward for instructions if symptomatic Facemasks are compulsory for all visits to healthcare premises		audit completed by all inpatient nursing areas. Compliant Compliant	

	Visitors are not present during AGPs on infectious patients unless they are considered essential following a risk assessment e.g., carer/parent/ guardian.	Visitors are not present during AGP's unless risk assessment completed.		Compliant	

	Implementation of the Supporting excellence in infection prevention and control behaviours Implementation Toolkit has been adopted C1116-Supporting - excellence-in-ipc-behaviours-imp-toolkit.pdf (england.nhs.uk)	Posters and signage in use throughout the Trust			
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-19 patients. Point of care testing in place in ED.			
5.2	Patients with suspected COVID-19 are tested promptly.	As per national guidelines testing for acute admissions is completed on admission to ED (detail included in both zoning SOP and patient flow policies). A process for screening of elective cases is in place. Testing is completed on admission via ED, elective cases before admission.		Compliant	

		Patients in green (non-COVID-19) and yellow zones (awaiting results) are monitored for symptoms of COVID-19 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.			
	Signage is displayed prior to and on entry to all health and care settings instructing patients with respiratory symptoms to inform receiving reception staff, immediately on their arrival. Infection status of the patient is communicated to the receiving organization, department or transferring services, when a possible or confirmed seasonal. Respiratory infection needs to be transferred. Screening for COVID-19 is undertaken prior to attendance wherever possible. To enable early recognition and to clinically assess patients prior to any patient attending a healthcare environment.	Patients are routinely tested on admission day, day 3, day 5, day 7 and day 13 and weekly thereafter. Via discharge summary or handover.		Compliant Compliant	

	Front door areas have appropriate triaging arrangements in place to cohort.	POCT is undertaken in ED. PCR screening in undertaken on the wards or prior to procedure.			
	Patients with possible or confirmed COVID-19 other respiratory infection.	Routine in patient screening for COVID-19 is taken as per SOP.		Compliant	
	Symptoms and segregation of cases to minimise the risk of cross-infection as per national guidance.	Patients are triaged in UCC and ED on arrival.		Compliant	
	Triage is undertaken by clinical staff who are trained and competent in the clinical case definition and patient is allocated appropriate pathway as soon as possible.	Blue zoned areas are in use in ED.		Compliant	
	There is evidence of compliance with routine patient testing protocols in line with trust approved hierarchies of control risk assessment and approved.	Patients are triaged in UCC and ED on arrival.		Compliant	
	Patients with suspected or confirmed respiratory infection are provided with a surgical facemask (Type II or Type IIR) to be worn in multi-bedded bays and communal areas if this can be tolerated.	In patients are tested on admission day, days 3, 5, 7, 13 and weekly.		Compliant	
	Patients with respiratory symptoms are assessed in a segregated area, ideally a single room, and away from	Non-compliance with face mask wearing is documented in patients' notes.			

	other patients pending their test result.				
	Patients with excessive cough and sputum production are prioritised for placement in single rooms whilst awaiting testing.	A zoning system is in place.		Compliant	
	Patients at risk of severe outcomes of respiratory infection receive protective IPC measures depending on their medical condition and treatment whilst receiving healthcare e.g., priority for single room isolation and risk for their families and carers accompanying them for treatments/ procedures must be considered.	Patients are placed in single side rooms, DATIXs are completed if side rooms are not available. Patients are placed inside rooms or co-horted depending on their need			
	Where treatment is not urgent consider delaying this until resolution of symptoms providing this does not impact negatively on patient outcomes.				
	Face masks/coverings are worn by staff and patients in all health and care facilities	All patients are reviewed.		Compliant	
	Where infectious respiratory patients are cared for physical distancing remains at 2 metres distance.				
	Patients, visitors, and staff can maintain 1 metre or greater social &	Social distancing is encouraged between patients.		Compliant	

	physical distancing in all patient care areas; ideally segregation should be with separate spaces, but there is potential to use screens, e.g., to protect reception staff.	Screening is in place at all reception areas and ward nurse stations, but social distancing requirements have been discontinued.		Compliant	
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 Symptomatic patients are treated inside rooms, where possible. Patients in green (non-COVID-19) and yellow zones (awaiting results) are monitored for symptoms of COVID-19 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 IPCT. 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 and monitored for 10 days. Test and trace flow chart in place, which describes the contact tracing risk assessments	N/A		
5.4	Patients that attend for routine appointments who display symptoms of COVID-19 are managed appropriately	Where possible 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	N/A		

		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. Currently all patients attending the OPD are screened via symptom enquiry, 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-19 screening in place Information provided in policies.	Not monitored. Not monitored		
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. Patients' refusal to wear a mask is documented in their noted	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).		Not reported on but non-compliance documented in patients notes. Patients' refusal to wear a mask is documented in their notes		

5.7	There is evidence of compliance with routine patient testing protocols.				
6	Systems to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process pf preventing and controlling infection				
	Key lines of enquiry	Evidence	Gaps in Assurance	Mitigating Actions	R.A.G.
6.1	Systems and processes are in place to ensure: All staff (clinical and non- clinical) have appropriate training, in line with latest UK HSA and other guidance, to ensure their personal safety and working environment is safe.	IPC mandatory training via e learning has continued, face to face recommenced March 2022. Face Fit testing. Training PPE donning and doffing HUB information with inks to UK HSA guidance and videos. The core IPC mandatory training has been updated to include specific COVID-19 training. Face fit testing database now in place – held by clinical skills. Trust reviewing the updated UKHSA/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 have an objective of 90%.			

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.	Donning and doffing is included in IPC Mandatory training. UK HSA 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. Communications via huddles and email to all to remind staff of PPE requirements.	N/A		
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.			
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 / UK HSA guidance for reuse of 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. Staff reminded to report re-use of PPE via Datix. Procurement team monitor stock levels.	N/A		
6.6	Adherence to UK HSA national guidance on the use of PPE is regularly audited.	There is no formal COVID-19 PPE audit. PPE use is included as part of the routine ward audit.			

		PPE is audited Quality Rounds. Datix reports of failure to follow PPE advice are reviewed.			
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. May 2022 Hand Hygiene assessments being introduced throughout the Trust			
6.8	Guidance on hand hygiene, including drying, should be clearly displayed in all public toilet areas as well as staff areas. 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. Appropriate infection prevention education is provided for staff, patients, and visitors. Training in IPC measures is provided to all staff, including: the correct use of PPE including an initial face fit	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. All staff attend mandated IPC training. Face fit testing is available		Compliant Compliant	

6.9	test/and fit check each time when wearing a filtering face piece (FFP3) respirator and the correct technique for putting on and removing (donning/doffing) PPE safely. All staff providing patient care and working within the clinical environment are trained in the selection and use of PPE appropriate for the clinical. Situation and on how to safely put it on and remove it. Adherence to national guidance on the use of PPE is regularly audited with actions in place to mitigate any identified risk. Gloves are worn when exposure to blood and/or other body fluids, non intact skin or mucous membranes is anticipated or in line with SICP's and TBP's.	PPE training is provided, and PPE audits are undertaken. PPE information is provided in "in the Know". PPE compliance is audited. Glove use is risk assessed. Standard Precautions Policy available on the Hub		Compliant Compliant	
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-19 update email. Limited changing room facilities availability across the trust.	N/A		

6.11	All staff understand the symptoms of COVID-19 and take appropriate action in line with UK HSA and other national guidance if they or a member of their household display any of the symptoms.	Staff Huddles completed, information shared via intranet, email, and posters. Sickness is reported and monitored via a dedicated line; staff are aware of isolation procedures in line with UK HSA guidance. Staff are encouraged to undertake twice weekly LFD testing Information available for staff on the Hub.	N/A	Compliant	
	All staff understand the symptoms of COVID-19 and take appropriate action if they or a member of their household display any of the symptoms (even if experiencing mild symptoms) in line with national guidance.	Regular comms “In the know”.		Compliant	
	There is a rapid and continued response to ongoing surveillance of rates of infection transmission within the local population and for hospital/organisation onset cases (staff and patients/individuals).	Data is submitted as requested.			
	Positive cases identified after admission who fit the criteria for investigation should trigger a case investigation.	Outbreaks are monitored and reported to OKTA.			
	Two or more positive cases linked in time and place trigger an outbreak investigation and are reported.	Meetings held both internal and with external partners.		Compliant	

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 April 2022. The infection prevention team have the daily ward list which documents the location of COVID-19 patients and patients with resistant/alert organisms. Zoning SOP available on the HUB.	N/A		
7.2	Areas used to cohort patients with suspected or confirmed COVID-19 are compliant with the environmental requirements set out in the current UK HSA national guidance.	Cohorting of (positive/negative and patients awaiting results) patients into bays, patients must 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.	.	Hospital environment limited Zoning SOP in place	
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, CDI.	N/A	Compliant	

	Clear advice is provided, and monitoring is carried out of inpatients compliance with wearing face masks (particularly when moving around the ward or healthcare facility) providing it can be tolerated and is not detrimental to their (physical or mental) care needs.	All patients are encouraged to wear IIR fluid resistant surgical face masks both in bays and when moving around the hospitals.		Compliant	
	Patients who are known or suspected to be positive with a respiratory pathogen including COVID-19 where their treatment cannot be deferred, their care is provided from services able to operate in a way which minimise the risk of spread of the virus to other patients/individuals.	Clinic times are scheduled	Non-compliance with masks wearing is documented in the patients notes	Compliant	
	Patients are appropriately placed i.e., infectious patients in isolation or cohorts.	Patients are risk assessed.		Compliant	
	Ongoing regular assessments of considering potential increases in staff to patient ratios and equipment needs (dependent on clinical care requirements).			Compliant	
	Standard infection control precautions (SIPC's) are used at point of care for patients who have been screened, triaged, and tested and have a negative result.	Patients are isolated or cohorted if possible, DATIX are completed if there is a delay. Audits are undertaken by IPCT and wards. Audit scores updated to AMaT.			

		Patient's screening continues on admission day 3, 5,7,10 and weekly.		Compliant	
	The principles of SICPs and TBPs continued to be applied when caring for the deceased.	Standard infection prevention and control and transmission-based precautions are followed.		Compliant	
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 shadow and then complete a screen under supervision. Testing of the COVID-19 swabs is undertaken in accredited laboratories.		Matrons informed during Huddles regarding testing required.	
	Testing is undertaken by competent and trained individuals. Patient and staff COVID-19 testing is undertaken promptly and in line with UK HSA and other national guidance	Community staff weekly testing requirement: collaborative approach with CCG and DMBC PH have weekly testing for health care workers who attend care/nursing homes.		Information also available on the hub and communications update.	
	Screening for other potential infections takes place.	Prompt now in place on sunrise system to ensure green patients are retested on day 0, day 3 and day 5, day 7 day 13 and weekly as per national guidance. MRSA screening has continued along with *Clostridioides difficile* tests for patients who have diarrhoea.		Compliant Compliant	

		All other screening has continued as pre COVID-19 crisis.		Compliant	
8.2	That all emergency patients are tested for COVID-19 on admission.	All Patients tested on admission, routine swabbing for asymptomatic patients, admitted to amber bed whilst awaiting swab result which is back normally within 24 hours (not tested on site). Symptomatic patients are swabbed as an emergency and test on site and results available within 4 hours. Isolated until result available.		Dashboard mitigation.	
8.3	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	
8.4	That those emergency admissions who test negative on admission are retested on day 3 of admission, and again between 5-7 days post Admission	Prompts on SUNRISE system. Reviewed as part of the outbreak meetings. Prompt now in place on sunrise system to ensure green patients are retested on day 0, day 3 and day 5, day 7 day 13 and weekly as per national guidance.		Compliant	
8.5	That sites with high nosocomial rates should consider testing COVID-19 negative patients daily.	Trust have reviewed and are unable as they do not have the resources to carry out daily testing of negative patients. Insufficient capacity.	Not reported anywhere within the trust.	Partial compliance. Divisional Chief Nurses to report compliance within IPC reports.	
8.6	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	On discharge checklist.			

	receiving organization prior to discharge.				
8.7	That those being discharged to a care facility within their 14-day isolation period should be discharged to a designated care setting, where they should complete their remaining isolation.	Commissioned care home for COVID-19 positive patients.			
8.8	That all elective patients are tested prior to admission.	All elective patients are tested. SOP in place.	LFDs are in the process of being rolled out for all elective admissions. SOP in process	Letter detailing instructions issued to all pre-op patients. Help line available via consultant secretary or GP Patients are questioned on admission	
8.9	There is an assessment of the need for a negative PCR and 3 days self-isolation before certain elective procedures on selected low risk patients who are fully vaccinated, asymptomatic, and not a contact of case suspected/confirmed case of COVID-19 within the last 10 days. Instead, these patients can take a lateral flow test (LFT) on the day of the procedure as per national guidance	February 2022 A new SOP has been drafted to allow for LFD/rapid PCR testing to be undertaken.	Due to the layout of the hospital, there is insufficient space in theatre reception to undertake LFD and await results. The hospital has no system to upload LFD results to the national systems	A new SOP has been drafted and is under consultation to allow for LFD testing to be undertaken on day of procedure. System wide discussions in progress regarding the uploading of LFD results to the national database	
9	Have and adhere to policies designed for the individuals care and provider organisation 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:		N/A		

	Staff are supported in adhering to all IPC policies, including those for other alert organisms. The application of IPC practices are monitored and that resources are in place to implement and measure adherence to good IPC practice. This must include all care areas and all staff (permanent, agency and external contractors). Staff are supported in adhering to all IPC policies, including those for other alert organisms. Safe spaces for staff break areas/ changing facilities are provided	IPC policy adherence is completed by IPCT visits, training and via Saving Lives audits. IPC polices are in place including IPC in the Built Environment which are all available on the Hub. Staff changing areas are provided.		Compliant	
9.2	Any changes to the UK HSA national guidance on PPE are quickly identified and effectively communicated to staff.	The IPCT receive email alerts from UK HSA which describe any changes in guidance, the IPCT also review the UK HSA 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-19 emails, and CEO briefings.	N/A		
9.3	All clinical waste related to confirmed or suspected COVID-19 cases is handled, stored, and managed in accordance with current national guidance.	Waste streams on yellow and blue zones are clinical waste: orange bag. Some reports received of improper disposal Interserve have communicated issues to areas concerned.	N/A		

		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 and adhere to policies designed for the individuals care and provider organisation that will help to prevent and control infections					
	Key lines of enquiry	Evidence	Gaps in Assurance	Mitigating Actions	R.A.G.
10.1		Staff in the following groups have been identified: • Over 70's • Pregnant Staff • BAME Staff	N/A	Vulnerable staff may not disclose to employer, therefore all staff to have risk assessment completed	

	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 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-19 vaccination programme on 29/12/20 priority is to be given to patients over 80 years and staff with increased risk.			
	Staff seek advice when required from their IPCT/occupational health department/GP or employer as per their local policy. Bank, agency, and locum staff follow the same deployment advice as permanent staff.	SHAW based on site. Page on staff hub with details. Training is available for all staff in donning and doffing. PPE audits including donning and doffing are undertaken.		Compliant	

	Staff understand and are adequately trained in safe systems of working including donning and doffing of PPE.	Fit testing programme is in place. Details available on the staff Hub.		Compliant	
	A fit testing programme is in place for those who may need to wear respiratory protection.	Fit tester in all departments.		Compliant	
	Where there has been a breach in infection control procedures staff are reviewed by occupational health. Who will: • Lead on the implementation of systems to monitor for illness and absence. • Facilitate access of staff to antiviral treatment where necessary and • implement a vaccination programme for the healthcare workforce. •	Staff are reviewed by IPC. Risk assessments are available on the Hub. Staff vaccinations are available through SHAW and COVID-19 /influenza vaccinations via Action Heart gym. Staff sickness is reviewed via HR and SHAW referral.			
	Lead on the implementation of systems to monitor staff illness, absence and vaccination against seasonal influenza and COVID-19	Policy available on the Hub.			
	A discussion is had with employees who are in the at-risk groups, including those who are pregnant and specific ethnic minority groups.	Risk assessments are completed for staff with copies held in personnel files.		Compliant	

	That advice is available to all health and social care staff, including specific advice to those at risk from complications. Bank, agency, and locum staff who fall into these categories should follow the same deployment advice as permanent staff. A risk assessment is required for health and social care staff at high risk of complications, including pregnant staff. Vaccination and testing policies are in place as advised by occupational health/public health.	Vaccination polices and staff testing follows national guidance.			
10.2	Staff required to wear FFP reusable respirators undergo training that is compliant with UK HSA 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	Zoning SOP sets out that staff should not work across areas where possible, although due to patient safety issues movement of staff may occur.	Appropriate workforce numbers to maintain segregation of zones.	Zoning SOP and areas are segregated with staff support.	

	elective care pathways and urgent and emergency care pathways, as per national guidance.	The hospital has limited space to have totally separate services therefore the Trust has segregated areas by utilising pods and physical barriers and one-way systems.			
10.4	Consideration is given to staggering staff breaks to limit the density of healthcare workers in specific areas.	Staff are provided with face masks when they enter the building and can obtain face masks from their manager. The Trust has reviewed staff rest area space as they are currently limited within ward areas-breaks are being staggered. CCG Quality visit completed no issues identified, and embedded processes found.	N/A		
10.5	Staff absence and well-being are monitored and staff who are self-isolating are supported and able to access testing.	All COVID-19 related absence are reported centrally through a COVID-19 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.			

10.6	Staff that test positive have adequate information and support to aid their recovery and return to work.	If the staff member has been swab tested by the Trust, negative results are sent via text and positive results are contacted by IPC contact Tracer. If the staff member has received a test for antibodies by the Trust, test results are given via text message-this service has now ceased. Regarding a positive result staff are advised to stay off work for a minimum of 5 days and can return to work after two negative LFD tests on day 6 and 7 if they are apyrexial for 48 hours, in line with UK HSA guidance. The Trust have increased the Staff Health and Wellbeing provision, including access to an Occupational Health Physician and 24/7 access to personalised, on-demand advice and support from our team of mental health, financial, and legal experts	N/A		
10.7	IPC to help in the COVID-19 booster and Flu vaccination programme 2022.	IPC team members to promote vaccination and training and other opportunities.	Vaccination programme COVID-19 Booster and Influenza vaccination hub now running and accessible for all staff. Walk in appointments available		

Enclosure 15

The Dudley Group NHS Foundation Trust

Paper for submission to The Board of Directors
21st July 2022

Title:	Maternity and Neonatal Safety and Quality Dashboard
Author:	Claire Macdiarmid – Head of Midwifery
Presenter:	Mary Sexton – Chief Nurse

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

Recommendations:

The Board is invited:

- to accept the assurance provided in this report as progress towards compliance with both Clinical Negligence Scheme for Trusts (CNST) requirements, Ockenden recommendations and building blocks towards Maternity Continuity of Carer (MCOC).
- to accept the requirements needed in order to progress delivery of MCoC as given in appendix 1
- to receive an update from the team at the beginning of December 2022 to revise the implementation plan and to gain assurance of safe staffing to begin the roll out of MCoC in March 2023.
- to note that the Service continues to drive improvement across all aspects of Maternity and Neonatal services.

Summary of Key Issues:

There were no still births or neonatal deaths reported during April and May 2022. The Perinatal Mortality Review Tool (PMRT) reviews has recognised a significant delay in post-mortem result being received by families following the death of their baby. The associated risk has been added to the risk register and the bereavement team have informed families of the delay and potential implications.

In May 2022, one serious incident was reported within Maternity, there were no serious incidents reported in April 2022. There were no Coroner Regulation 28 made directly to the Trust for perinatal or maternal deaths in April or May 2022.

The final Ockenden Report was published on the 30th March 2022. 87 actions were identified in the report divided across 15 sections. Seven of the actions require national action and the Trust await guidance on how to progress these.

The final Ockenden Report outlined the rquirement for all trusts to risk assess their ability to safely continue to deliver Continuity of Carer team. We are aware that staffing and workforce are the biggest blocker to us commencing Maternity Continuity of Carer at full scale at the current time; local, regional and national work is underway to rectify this position. Appendix 1 outlines our Maternity Continuity of Carer position.

Midwifery staffing continues to be a risk and remains on the risk register. Recruitment is ongoing and 13 WTE newly qualified midwives are due to commence in September/October 2022. A 'Retention Midwife' has recently commenced to support early career midwives and help staff remain within the Trust.

Impact on the Strategic Goals	
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:			
Risk	Y	Risk Description: BAF, Corporate Risk Register	
	On Risk Register: Y	Risk Score: various	
Compliance and/or Lead Requirements	CQC	Y	Details: All Areas
	NHSE/I	Y	Details: CNST standards
	Other	Y	Details: Ockenden Recommendations

Report Journey/ Destination	Working / Exec Group	N	Date:
	Committee	N	Date:
	Board of Directors	Y	Date: 21st July 2022
	Other	N	Date:

REPORT FOR ASSURANCE

Maternity and Neonatal Safety and Quality Dashboard

Report to Trust Board 21st July 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 Trust board and Local Maternity Neonatal System (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 Ockendon 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 **April and May 2022**, unless otherwise specified throughout.

2 BACKGROUND INFORMATION

2.1 Perinatal Mortality.

Stillbirths – there has been 0 still births during April 2022 and 0 during May 2022.

Early Neonatal Deaths – There has been 0 early neonatal deaths during the month of April 2022 and 0 during May 2022.

Late Neonatal deaths -There have been 0 late neonatal deaths in April and 1 during May 2022.

All stillbirths and neonatal deaths are reviewed using the National Perinatal Mortality Review Tool (NPMRT) which includes parent's perspectives and questions as part of the review. The system allows for a report to be produced 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 Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries (MBRRACE);

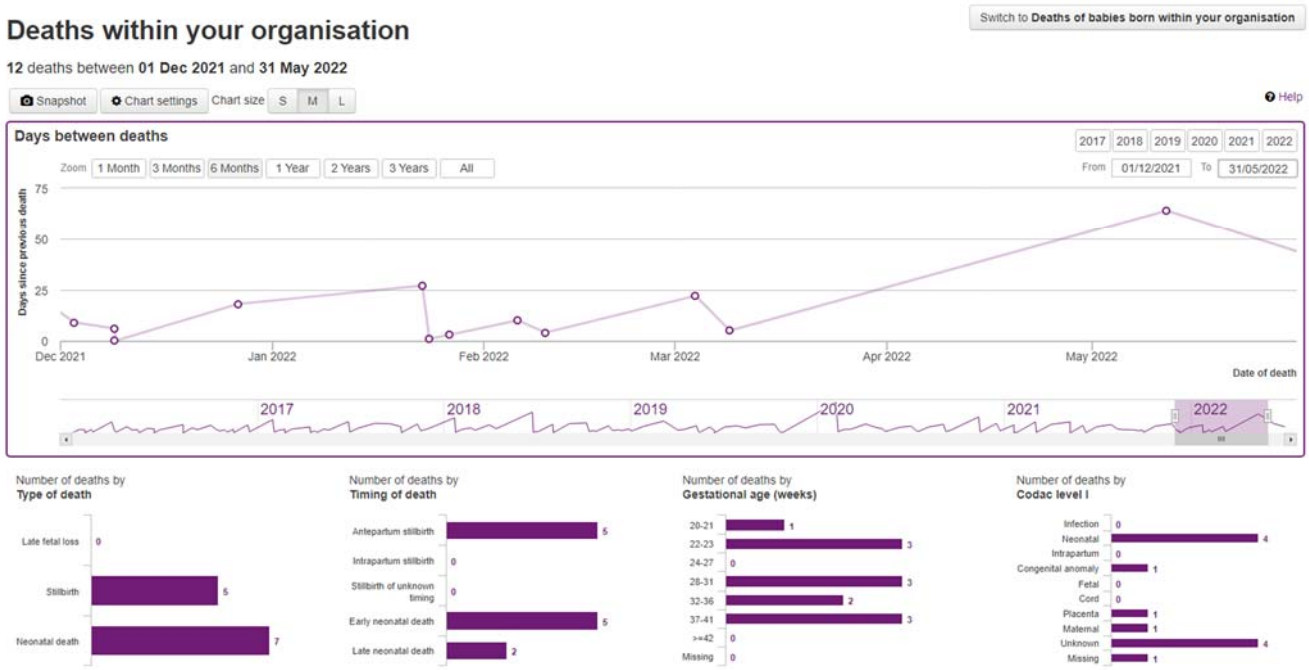
- **Late fetal losses** – the baby is delivered between 22 weeks+0 days and 23 weeks+6 days of gestation (or from 400g where an accurate estimate of gestation is not available) showing no signs of life, irrespective of when the death occurred
- **Stillbirths** – the baby is delivered from 24 weeks+0 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 Perinatal Mortality Review Tool (PMRT) real time data monitoring tool

Six months of data (December 2021 – May 2022) showing deaths of babies who were born within our organisation, including babies who died elsewhere.



The line chart above, shows the number of days between consecutive deaths, to help you identify unusual patterns of deaths; the four bar charts, plot the number of deaths according to various characteristics.

2.1.3 Mortality rates

2022	April 2022	May 2022	National Rate
Crude Stillbirth rate	3.40	3.40	**3.51**
Adjusted Stillbirth rate	2.67	2.67	-
Crude combined neonatal death rate	2.41	2.4	**1.64**
Adjusted combined Neonatal death rate	1.21	1.21	-

*Rate is per 1000 births

The above chart demonstrates the crude and adjusted stillbirth and total neonatal death rates (over a rolling 12 months). It can be seen that when the rate is adjusted there is a 50% decrease in the number of neonatal deaths 01.05.2021 to 30.04.2022.

It is recognised that when babies are born under 27 weeks gestation, this birth should occur in a level 3 unit to increase the chances of survival significantly. Our nearest level 3 unit is Royal Wolverhampton. A piece of investigatory work is being led by the LMNS to scrutinise cases where babies of this gestation are born outside of a level 3 unit, to find any causation, and subsequent preventative action required.

2.1.4 Learning from PMRT reviews

It has been recognised that there is a significant delay in post-mortem results being received by families following the death of their baby. Some cases are taking around 10-12 months. This is a risk given that findings from these reports can show learning for the organisation which will be severely delayed, but most importantly can potentially alter the care required in future pregnancies. This risk has been escalated to our pathology network, added to the risk register and our bereavement team are informing families of the delay and the potential implications for this.

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

The Dudley Group executive summary from HSIB up to 8/7/22

Cases to date	
Total referrals	21
Referrals / cases rejected	3 (duplicate entries)
Total investigations to date	18
Total investigations completed	16
Current active cases	2
Exception reporting	MI-005206

Each of these are treated as Root Cause Analysis (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.

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

2.3 Coroner Regulation 28 made directly to the Trust

There were 0 Coroner Regulation 28 made directly to the Trust in respect of perinatal or maternal deaths in April or May 2022.

2.4 Maternity Serious Incidents

There were 0 serious incidents reported in Maternity during April 2022. There has been 1 serious incident reported within Maternity during May 2022.

2.5 Ockenden Report final

The final Ockenden report was published on the 30th of March 2022. The report was divided into 15 sections, and immediate essential actions (IEA) have been allocated as per findings of the report.

The table below highlight current compliance with the 87 actions, in a red, amber, green rating. Seven of the actions require a national steer before they can be moved on at a Trust level and these are highlighted as grey. The blue category is to show the actions that are already in place with evidence available to support their implementation.

To note, there has been no request from the national team for evidence or submission of this gap analysis, due to the expected publication of the investigation into East Kent NHS trust, which is now due in September 2022 (delayed from June 2022). A joint action plan is expected, following this publication.

	Total actions	Red	Amber	Green	Blue	Grey
IEA1- WF and Planning	11	3	3	1	1	3
IEA2- Safe staffing	10	2	5	2	1	0
IEA3- Escalation and accountability	5	1	3	1	0	0
IEA4- Clinical governance leadership	7	2	4	1	0	0
IEA5- Clinical governance incidents	7	1	5	1	0	0
IEA6- Learning from Maternal deaths	2	1	1	0	0	0
IEA7- MDT Training	7	1	5	1	0	0
IEA8- Complex AN Care	5	0	3	2	0	0
IEA9- Preterm birth	4		2	2	0	0
IEA10- Labour and birth	6	2	3	1	0	0
IEA11- Obstetric anaesthesia	4	0	0	3	0	1
IEA12- Postnatal care	4	0	4	0	0	0
IEA13- Bereavement care	4	0	4	0	0	0
IEA14- Neonatal care	8	1	3	1		3
IEA15- Supporting families	3	2	1	0	0	0
TOTALS	87	16	46	16	2	7

	Limited or non-compliance		Fully compliant
	Partially compliant		Fully compliant- with assurance
	Nationally led actions		

Monthly multi-disciplinary (MDT), Ockenden assurance meetings continue, attended by the multidisciplinary team, each with allocated responsibility for providing assurance of progress on each IEA.

The Quality and Safety committee have discussed the progress against the Ockenden recommendations at its June meeting and a further meeting is planned to undertake a deep dive by the committee to go through the evidence in detail.

2.6 Continuity of Care

Following on from the recommendations of Better Births and the commitments of the NHS long term plan, the ambition for the NHS is for Midwifery Continuity of Care (MCoC) to be the default model of care for the maternity services, and available to all pregnant women – with the rollout prioritised to those most likely to experience poorer outcomes. Where safe staffing allows and building blocks in place, the national timeline for achieving this is by **March 2023.**

The guidance from NHSE Delivering Midwifery Continuity of Care at Full Scale was published at the end of October 2021 to offer guidance on planning implementation and monitoring over the next year. The document supersedes previous guidance and timescale published as part of the maternity Transformation Program.

The Ockenden final report was published on the 30th of March 2022. This clearly outlined the requirement for all trusts to risk asses their ability to safely continue to deliver continuity of carer team. We are aware that staffing and workforce are the biggest blocker to us commencing CoC at full scale at the current time, and local, regional and national work is underway to rectify this position. See Appendix 1) for more details and associated recommendations.

2.7 Saving Babies Lives V2

2.7.1 We are able to evidence compliance for The Saving Babies Lives care bundle version 2 (SBLCBv2) in all five elements of the care bundle. Safety action six of the clinical negligence scheme for trusts is focused on full compliance with each of the five domains.

The improvement in detection rates of babies that are growth restricted has continued to improve and the process is now embedded within the electronic patient record (EPR) system. The recent introduction of the digital maternity growth charts should further improve these rates.

Following the Ockenden Insight visit from NHSE in April 2022, the regional team highlighted the excellent work of the health in pregnancy support service (HPSS) team in reducing smoking in pregnancy and the compliance of Element 1. The LMNS are now looking to roll out the service across the region.

Prevention of Preterm Birth, Element 5, of the care bundle is compliant, however requires further strengthening with additional services for the women and their families. The use of Fetal Fibronectin and the National QUIPP app will give a better predictor of preterm birth and allow for these babies to be diverted to the correct hospital for the appropriate level 3 neonatal care. The Fetal Fibronectin Machine is now in Trust and staff training has begun. We will be due to launch by September once the pathway and guideline has been ratified.

As part of the LMNS Best Starts work stream the LMNS and the ODN are formulating a strategy for women to have prehospital divert to ensure they are seen and deliver in the correct place.

2.8 NHS Resolution Maternity Incentive Scheme CNST

2.8.1 NHS Resolution recommenced year 4 standards for the CNST Maternity Incentive scheme on 6th May 2022 following a pause due to winter wave of the COVID-19 pandemic. Board declarations must be submitted by 5th January 2022 to be eligible for payment under the scheme. Work is ongoing to gain compliance in all areas but progress to date is as follows:

Safety action one	Are you using the National Perinatal Mortality Review Tool to review perinatal deaths to the required standard?	
Safety action two	Are you submitting data to the Maternity Services Data Set (MSDS) to the required standard?	
Safety action three	Can you demonstrate that you have transitional care services in place to minimise separation of mothers and their babies and to support the recommendations made in the Avoiding Term Admissions into Neonatal units Programme.	
Safety action four	Can you demonstrate an effective system of clinical workforce planning to the required standard?	
Safety action five	Can you demonstrate an effective system of midwifery workforce planning to the required standard?	
Safety action six	Can you demonstrate compliance with all five elements of the Saving Babies' Lives care bundle version two?	
Safety action seven	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 (MVP) to coproduce local maternity services?	
Safety action eight	Can you evidence that a local training plan is in place to ensure that all six core modules of the Core Competency Framework will be included in your unit training programme over the next 3 years, starting from the launch of MIS year 4? In addition, can you evidence that at least 90% of each relevant maternity unit staff group has attended an 'in house', one-day, multi-professional training day which includes a selection of maternity emergencies, antenatal and intrapartum fetal surveillance and new-born life support, starting from the launch of MIS year 4?	
Safety action nine	Can you demonstrate that there are robust processes in place to provide assurance to the Board on maternity and neonatal safety and quality issues?	
Safety action ten	Have you reported 100% of qualifying cases to Healthcare Safety Investigation Branch (HSIB) and to NHS Resolution's Early Notification (EN) Scheme from 1 April 2021 to 5 December 2022?	

2.9.2 A suite of role specific mandatory training was rolled out last year, to address the requirements of Maternity Incentive scheme CNST and the 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 the domains of the 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 via the online learning and competency assessment from K2 CTG training. Regular sessions are hosted on delivery suite by the fetal wellbeing team. These have been delayed due to staff absence and high activity within the department.

As of 1st July 2022, 92% of all multidisciplinary maternity staff have completed this training and therefore we are compliant with this part of the CNST safety action 8.

2.10 Safe Maternity Staffing

Organisational requirements for safe midwifery staffing for maternity settings National Institute for Health and Care Excellence (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 was commissioned, and results have been received as follows.

2.10.1 Birthrate plus

Birthrate Plus is a framework for workforce planning and strategic decision-making and has been in variable use in UK maternity units since 1988, with periodic revisions as national maternity policies and guidance are published.

It is based upon an understanding of the total midwifery time required to care for women and on a minimum standard of providing one-to-one midwifery care throughout established labour. The principles underpinning the Birthrate Plus methodology are consistent with recommendations in the NICE safe staffing guideline for midwives in maternity settings and have been endorsed by the Royal College of Midwives (RCM) and Royal College of Obstetricians and Gynaecologists (RCOG).

A Birthrate Plus workforce review was commissioned during the Autumn of 2021 and results were received in May 2022. The data used was related to 2020-21 admissions and acuity, and 2021-22 number of births of 4101 (An increase of around 150 compared to the previous years data).

An uplift of the workforce to 26% was requested due to the increasing training demands within maternity services.

The following points were noted:

- Maternity services at The Dudley Group are currently under funded by 5.04WTE
- 1.47WTE of these should be in specialist Midwifery roles.

The reason for this increase in required midwives, despite a drop in the birth rate since the last assessment is mainly due to:

- Increased acuity of women accessing maternity services
- Increased training requirements sue to CNST and Ockenden requirements.

A business case will be produced to support the requirement for these additional posts.

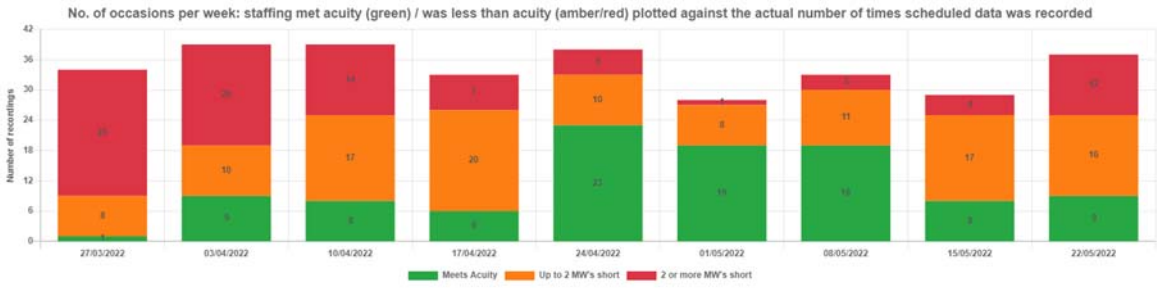
We have successfully been awarded £560k to develop additional new roles within the Trust as per the recommendation of the Ockenden report. This money is for one year of funded roles only. Roles successfully bid for include:

- Digital midwife
- Maternity governance lead
- Consultant midwife
- Additional practice development midwives
- Midwifery clinical skills facilitators

It should be noted that essential action one, from the Ockenden final report, calls for the feasibility and accuracy of the BirthRate Plus tool and associated methodology to be reviewed nationally by all bodies. These bodies must include as a minimum NHSE, RCOG, RCM, RCPCH. We await further information relating to this

2.10.2 Maternity staffing

The Birthrate plus **acuity tool** measures whether there are adequate midwives on shift, in relation to the number of women requiring care, to include the level of care required. Findings for April and May 2022 are as follows:



Compliance for completion of the acuity tool for Delivery suite/midwifery led unit (MLU) is 82% (85% is recognised as providing reliable data) The accuracy of our data is therefore improving. The data highlights that the incidence of red staffing levels decreased drastically since the w/c

27/3/22 and this is due to decreased staff sickness levels, new staff commencing in post as well as a marked decrease in activity.

April and May 2022 have seen challenging staffing levels for all areas of Maternity. This has again been due to high maternity leave rate (14% of qualified midwives) as well as non-covid sickness absence. All staffing shortfalls (red or amber on the acuity tool) have been reported via the Datix system, and each patient assessed as to whether any harm was caused because of these staffing shortfalls. Zero incidents were reported as harm, caused because of delays owing to 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 Operational Pressures Escalation Levels (OPEL) 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 Birthrate Plus acuity scores. It also allows quick reference of neighbouring units with the capacity and ability to support as required. This dashboard is moving to a real-time state so will allow the department to be able to see quickly which local units are able to support when activity is high.

Maternity currently has a vacancy of 24WTE midwives. Recruitment is ongoing and 13WTE newly qualified midwives are due to commence in September/October 2022. Seconded nurse roles have been advertised and filled, to provide backfill until November 2022. An enhanced Band 3 Midwifery support worker role has now launched. This role has also launched in the community setting. A newly created ‘Retention Midwife’ has recently commenced within maternity. The purpose of this role is to support early career midwives (Band 5) to support them to remain within the trust and profession. International midwifery recruitment is also ongoing with 3.0WTE currently commenced in post and undertaking their bootcamp and OSCE.

2.10.3 Obstetric staffing

We currently have 13.6 TE substantive consultants in the post, and 16.0WTE in budget. The demand capacity model has shown requirement for 20.32 WTE consultants. We have appointed one locum consultant in the post. Two posts are waiting to be advertised in August 2022 following royal college approval of the job plans.

We are pleased to inform that most of the lead roles as suggested in Ockenden action have been filled. We have still got a few lead roles unfilled which will be allocated to the vacant post holders.

The newly agreed job plan and new consultant rota is running successfully from 16/5/22. The major change is allocation of separate Obstetrics and Gynaecology consultants during daytime which is supported by Ockenden report.

The middle grade rota is undergoing a major change from September 2022. There has been a need for separate Obstetrics and Gynaecology registrars for a long-time during daytime. This is going to be achieved in the new rota.

We have expanded the middle grade rota by successfully employing two new registrars and two trust doctors. This will help covering gaps in the rota and make it possible to cover most shifts by internal locums. The RCOG staffing guideline supports this change.

All the new doctors including new consultants have a named mentor who will support and guide them in their new role. As per Ockenden action, all middle grade doctors are achieving their sign offs in their portfolio prior to be placed for independent work.

This is providing a safe working environment for the trainee doctors and achieving safe patient care.

There is currently no long-term sickness, however 1.0 WTE consultant is on amended duty.

2.11 Maternity safety champions

A Maternity safety champion meeting took place on the 15th of June 2022 attended by all safety champions for both maternity and neonatal.

Areas of discussion included:

- Footprint of the neonatal unit is a risk; current footprint is insufficient to meet national standards.
- Meetings were held with maternity staff to discuss concerns raised with staff within the unit. A staff engagement and improvement plan is in development to rectify these issues and concerns.
- Lack of staffroom on delivery suite was highlighted as a concern due to delayed building work timescales on the new wellbeing room. This was impacting on clinical work due to lack of space for specialist teams to work. This has now been rectified.

2.12 Service user feedback

“Midwife was amazing and made me feel safe and guided me through my labour and delivered my baby boy safe into the world - forever grateful.”

“The midwives- super workers, doctors, all staff on the maternity and triage ward, so caring in attending to your every needs and made me feel so comfortable. Any problems or concerns that I had, the staff listened and made it easy for me to speak and raise my concerns. All staff are so friendly.“

“The theatre team were amazing, and I felt well looked after – from consent to recovery. The staff in theatre took some amazing photos on my phone that I will treasure forever.”

“Good communication, sonographer was friendly and kept me informed with every check she was doing at scan”

“A bit more time for dads to stop with mum and baby at first to help out please.

“Longer visiting hours and change of visitor. Bigger area on postnatal ward as very cramped and felt claustrophobic. Mental health to be taken more seriously for some staff.”

3 RISKS AND MITIGATIONS

3.1 Midwifery staffing continues to be a risk and remains on the risk register. Significant improvement is required to be able to comply with the continuity of carer requirements. Business case is required to be able to staff as per Birthrate Plus recommendations. 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

4.1 The Board is invited to accept the assurance provided in this report as progress towards compliance with both CNST requirements, Ockenden recommendations and building blocks towards Maternity Continuity of Carer (MCOC).

Claire Macdiarmid
Head of Midwifery
8th July 2022

APPENDIX 1

Delivering Midwifery Continuity of Care at Full Scale

Report to Trust Board July 21st 2022

EXECUTIVE SUMMARY

Following on from the recommendations of Better Births and the commitments of the NHS Long Term Plan, the ambition for the NHS is for Midwifery Continuity of Care (MCoC) to be the default model of care for the maternity services, and available to all pregnant women – with the rollout prioritised to those most likely to experience poorer outcomes. Where safe staffing allows and building blocks in place, this should be achieved by **March 2023.**

The guidance from NHSE Delivering Midwifery Continuity of Care at Full Scale was published at the end of October to offer guidance on planning implementation and monitoring over the next year. The document supersedes previous guidance and timescale published as part of the maternity Transformation Program.

Following on from the Ockenden report regarding MCoC, alternative timescales will be accepted on a case-by-case basis, where it is clear, that full staffing cannot be achieved by March 2023 and there is a credible linked recruitment plan. These revised timescales will be assessed and agreed through regional assurance.

The Trust Board must be sighted on the recommendations and expectations laid out in the new guidance on planning, implementation, and monitoring of delivering Midwifery Continuity of Care (MCOC) at full scale.

The Trust will be required to support both financial and organisational needs to deliver this initiative safely.

BACKGROUND INFORMATION

Timeline

Date	Requirement	RAG
July 2022	Implementation plan developed and agreed by both Trust and LMNS	
March 2023	LMNS and Trust co-producing the building blocks, these will be in place to ensure readiness to implement and sustain MCoC as the default model of care	

December 2022	Recruitment to enable safe midwifery staffing enabling implementation of MCoC	
March 2024	MCoC as default model of care	

An implementation plan has been developed with agreed timeline with the LMNS where building blocks have been identified. This states that each trust within the LMNS will have four operational MCoC teams by March 2024.

Building Blocks

1. Co-designing a plan with local midwives, obstetricians, and service users for implementation and MCoC teams in compliance with national principles and standards. This should be phased alongside the fulfilment of required staffing levels
2. The plan should also recognise the need for staff to recover from the challenges of the pandemic
3. Priority for women who are most likely to experience poorer outcomes including BAME and those from the most deprived areas are placed on a MCoC pathway March 2024
4. The Maternity Service Dataset (MSDS) should be developed to report electronically on these metrics
5. Identify multiple suitable Maternity Community Hubs to act as bases for the MCOC teams across Dudley
6. Development of a Communication and Engagement Strategy

Safe midwifery staffing

The recommended way to identify the midwifery workforce requirements for an individual service is to utilize the Birthrate Plus tool. This is the essential building block to identify any deficits in midwife numbers. Birthrate Plus assessment has been completed and the report has been received.

Currently the Trust's Maternity workforce is not up to the recommended establishment reported by Birthrate Plus and therefore the trust is not able to roll out MCoC safely at present. A continuous workforce assessment will be carried out to establish safe staffing to progress with MCoC, with the aim for MCoC to be the default model of care in March 2024.

The utilisation of the NHSE MCoC staffing planning tool is also essential in helping with the staffing plan for scaled up MCoC.

Workforce strategy has been developed and recruitment to vacancies is ongoing. The additional midwife posts identified by the Birthrate plus assessment will need to be financed and recruited to.

Consistently over the past three years maternity leave has played a significant part in midwifery staffing deficits and it is important that this is considered in order to successfully deliver Continuity of Care as the default model of care. Maternity leave rates are currently 14% within the maternity unit.

The role of a retention Midwife is now in post, to support early career midwives and to support the transition of staff into MCoC. Further support needed to ensure the success of staff retention.

Planning Requirements

It is only possible to deliver MCoC to those women who receive all three parts their maternity care antenatal, intrapartum and postnatal from the same provider.

At The Dudley Group Foundation Trust, we cared for 4150 births in the last financial year although the prediction from bookings and scans had been 4408. The 258 women for whom pregnancy did not continue to a live birth but would have received some antenatal intrapartum and postnatal care and support.

Of these births 2832 were to Dudley women for whom we can provide all three parts of their maternity care.

1223 births are to women who live elsewhere and therefore they would remain in a traditional model of midwifery care.

A much smaller number of approx. 300 women receive antenatal and post-natal care from Dudley Midwives but choose to give birth with other providers.

The MCoC model requires that the ratio of midwife to women is 1 :36 for each full-time midwife caseload and that teams are formed of 7-8 midwives. This allows for the woman to meet and get to know each of the midwives in her team but also allows for just one out of hours session per week

Based on this model 78.6 WTE midwives will be required to provide MCoC to the 2832 women. Equating to 12-14 teams (each team requiring 8 midwives with the minimum of 5.4WTE)

Additionally, there will be a requirement to provide traditional models of staffing including:

65 WTE midwives for delivery suite and triage including supernumerary shift lead, as required by CNST. The staff will be the default carers for those women who only receive intrapartum care from DGFT but also provide the intrapartum care for approx. 20% of the women on MCoC pathway if the on-call midwife is unavailable.

- 7.16 WTE midwives for antenatal clinic and day, assessment unit

- 3.1 WTE midwives for traditional community care

- 23 WTE Midwives for in patient antenatal and postnatal care including induction of labour and examination of the newborn screening.

A total of 176.8 WTE clinical midwives will be required to safely deliver this model

Roll out of the MCoC teams would be phased rather than a big bang approach and can only commence once staffing is optimum.

The roll out should target those likely to experience poor outcomes. Priority should be given to those geographical areas with highest numbers of Black, Asian and minority ethnic women. Together with those women who live in areas of the highest indices of deprivation in Dudley.

Management of change

The move to MCoC requires a wholescale change in midwifery staffing models. Several terms and conditions will change including but not restricted to, on call commitments from all midwives, a non-standardised working week and a requirement to deliver care in all settings.

Within MCoC teams:

- No midwife is expected to work over contracted hours.
- Out of hours sessions are part of the contracted hours, not in addition.
- Flexible working is encouraged with a tally of hours monitored on a weekly and four weekly basis.
- Flexibility and autonomy are encouraged, with a degree of self-management and teamwork.

Support and guidance from the HR team will be essential to deliver the management of change successfully.

Skill mix

It is important that newly qualified and preceptee midwives are included in the MCoC. It is recommended that one preceptee per team is the optimum number and allows for good preceptorship and a healthy skill mix. Newly qualified midwives must have at least 12 months experience before transitioning into a MCoC midwife as recommended following the Ockenden report.

Leadership from band 7 midwives is still vital but one team leader will be able to oversee several teams (maximum of 3 teams)

Another aspect that is essential is the whole service continuity. Each team should have a linked obstetrician. The obstetrician may be linked to more than one team but must be available to the midwifery team and attend team meetings on a regular basis. Further support is needed to ensure engagement with whole MDT.

Training and additional skills

A training needs analysis will be completed identifying the clinical skills that require updating for each midwife.

Preparation for working in a more flexible way, providing care to a set number of women at a time and place that is agreed by the woman and midwife.
Training time must include time for team building to ensure high functioning teams.

Pay

No midwife should be financially disadvantaged for working in a MCoC. The Trust is asked to review and agree pay and conditions utilising the AfC handbook. Consideration of a regular percentage payment for working out of hours rather than an on call and out of hours payments is encouraged. Consider a pay uplift to ensure no midwife is financial disadvantaged.

Estates and equipment

Each team will need to have a base with easy access to other healthcare providers. It can be helpful to be based in a community setting. Maternity will need to work with both Trust estates and other stakeholders to realise this ambition and recommendation.
Maternity Community Hubs will be essential for MCoC to be successful.

Each midwife in a MCoC or traditional community role require some standard items

- ✓ A laptop
- ✓ Mobile Phone
- ✓ Standard midwifery equipment
- ✓ Transport with payment for mileage

These will require costing and procurement.

Data collection and reporting

Recording and reporting of activity in MCoC teams will be required via the MSDS

The Trust should be assured that the maternity information system is able to submit data to the required standards on a monthly basis

The maternity team will be including routine local monitoring and tracking outcomes.

RISKS AND MITIGATIONS

1. Midwifery staffing is a risk and already included on the risk register

2. Funding has been obtained by the LMNS to support a seconded band 7 midwife to lead on the Midwifery Continuity of Care with the support of the senior midwifery team.

RECOMMENDATIONS

- to accept the requirements needed in order to progress delivery of Maternity Continuity of Carer (MCoC) as given in appendix 1
- to receive an update from the team at the beginning of December 2022 to revise the implementation plan and to gain assurance of safe staffing to begin the roll out of MCoC in March 2023.
- to note that the Service continues to drive improvement across all aspects of Maternity and Neonatal services.

Gabriella Garbett, MCoC Lead Midwife
Claire Macdiarmid, Head of Midwifery
8th July 2022

Enclosure 16

The Dudley Group NHS Foundation Trust

Paper for submission to the Board of Directors on 21st July 2022

Title:	Summary of Workforce and Staff Engagement Committee (WSEC) Meeting (Deep Dive into Clinical Support Services (CSS) Division) on Tuesday 31st May 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 Workforce and Staff Engagement Committee (WSEC) meeting on 31st May was a Deep-Dive session, which adopts a different format to the standard Committee business meeting programme. On this basis, the Chair's Upward Report from the May meeting of WSEC is presented in a narrative format, as opposed to using the standard Committee reporting template, which is used for the upward reporting of the WSEC business meetings.

The Board is asked to note the assurances provided by the Committee following the review of detailed workforce information, KPIs and improvement plans/trajectories relating specifically to the Clinical Support Services (CSS) Division. Regular review of performance against the improvement trajectories that were presented by the CSS leadership team will be reported to future WSEC meetings and will be captured in the Committee's upward reporting to the Board.

Whilst workforce capacity and resourcing (driven by; high vacancies/turnover/sickness absence) was highlighted by CSS as the area of greatest risk, the Committee notes that this reflects the severe staffing and skills shortages that are impacting NHS Trusts across the country. The CSS team articulated the range of measures that are in place to mitigate these risks.

Summary of Key Issues:

MAJOR ACTIONS COMMISSIONED/WORK UNDERWAY

- Updates provided on existing workforce KPI's, improvement plans, trajectories and measures for future assurance, including:
  - Sickness absence
  - Vacancies and turnover
  - Bank/agency use
  - Engagement and staff satisfaction
  - Equality, Diversity & Inclusion (EDI)
  - Mandatory training

A full summary is provided within the attached report.

POSITIVE ASSURANCES

- CSS has a fully established Divisional Leadership Team, with a new role, Divisional Chief of AHP (Maria Dance) within the division. The Divisional Leadership Team are working closely with Director of Improvement and Head of Learning and Organisational Development to build a strong, effective and performing Divisional Team.

- Imaging Directorate leadership team is well embedded, and this is demonstrated in the significant improvement on the directorates vacancy rates, improving trends with sickness absence and a positive staff engagement and wellbeing score.
- CSS Division is achieving Statutory and Mandatory Training compliance across the division and managing to sustain this position.
- CSS Division has seen a decrease in its vacancy rate from 18% to 14% with proactive approaches being taken to plan and attract into hard to fill technical posts across several directorates.

DECISIONS MADE

No key decisions were made by the Committee.

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: 31/05/2022
	Board of Directors	Y	Date: 21/07/2022
	Other	N	Date:

INTRODUCTION

The Committee was pleased to hear the results of the Deep-Dive into the people plans and associated improvement trajectories for the Clinical Support Services (CSS) Division. The Deep-Dive session was led by the CSS Leadership team; Amandeep Tung-Nahal (Divisional Director), Elizabeth Rees (Chief of Clinical Support Services) with proactive input from the Directorate Leaderships teams, Rucki Kahlon (Associate Director of Medicines Optimisation and Chief Pharmacist), John Schneider (Assistant Directorate Manager for Cancer Services), Joanne Essex (Programme Manager for Breast Screening), Kelly Taylor (Deputy Director of Operations for CSS), Bill Norton (Head of Imaging and Pamela Beckford (Matron for Imaging), and support from Sherrie Kelly (HR Business Partner) and Michelle Link, and, whilst not in attendance for the session due to annual leave, Amandeep confirmed that Maria Dance (Divisional Chief AHP) had actively contributed to the presentation materials. The Deep-Dive session covered the following areas:

1. Outline of the new CSS Divisional Leadership team
2. Interactive session with the committee on understanding CSS as a division
3. Divisional overview of sickness absence, bank and agency, vacancies, turnover, workforce profile, mandatory training.
4. Pharmacy overview of sickness absence, bank and agency, vacancies, turnover, workforce profile, mandatory training
5. Cancer overview of sickness absence, bank and agency, vacancies, turnover, workforce profile, mandatory training
6. Breast Screening overview of sickness absence, bank and agency, vacancies, turnover, workforce profile, mandatory training
7. Retained Pathology Services overview of sickness absence, bank and agency, vacancies, turnover, workforce profile, mandatory training
8. Imaging overview of sickness absence, bank and agency, vacancies, turnover, workforce profile, mandatory training
9. Improvement Plans

The summary below highlights the key areas of discussion and actions that were agreed.

Sickness Absence:

- The CSS team highlighted that sickness absence was at 5.29% in May 2021 stabilising at 6.98%. Recent short-term spikes in sickness absence have been due to Covid-19.
- 35% of all absences during the reporting period have been related to Covid-19 as being the most common reason for absence, with anxiety/depression and stress as the second reason and MSK as the third.
- The key Hot Spots are in; Retained Services Directorate, specifically Phlebotomy, which has been driven by Anxiety/Stress/Depression as the leading cause.
- **Key improvement actions: review, improve communications/marketing of the Trust wellbeing offer in the division for better prevention (particularly around stress).**

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Vacancy, Turnover & Bank/Agency use:

- CSS has seen vacancy rate decrease from 18% to 14% across the Division. .
- The team reported recent successful recruitment campaigns within Imaging, and whilst there has been an increase in bank agency, this supports the medium to longer term plans of reducing the vacancy factor.
- Cancer Services has reported zero use of bank and agency costs.
- Turnover has been particularly challenging within the Retained Services Directorate, and this is being managed with Divisional support and conclusion of the management of change process.
- There are examples across the Division of the teams investing in training and succession planning to ensure the continued reduction in vacancy rates and sustaining improvement of staff retention.

Engagement & Staff Satisfaction:

- CSS are awaiting official results to inform of progress and action plans, and in the main the initial results are in line with the Trusts indicative results, with some positive progress made across directorates, especially within Imaging.
- CSS are looking to develop health and wellbeing posts across all directorates and review flexible working arrangements.
- To support staff wellbeing, there is a proactive approach being taken to ensure there is investment in services and infrastructure, for example the pharmacy robot replacement and dispensary transformation will support this.

Equality, Diversity & Inclusion:

- The CSS team noted under-representation of BAME staff at senior levels, with the highest population of BAME staff siting in the medical workforce and band 5 groups.
- **CSS outlined a plan to work with the EDI team and the Inclusion Networks to increase reporting of E&D data, with a plan to increase membership in the networks and the number of Inclusion Champions. CSS will continue to actively support Trust-wide interventions and the strategy work for EDI.**

Mandatory Training:

- CSS remains compliant with Mandatory Training KPI's and has an established way of managing this within all directorates.

Chair's comments on the effectiveness of the meeting:

- **Progress made within Imaging was commended.**
- **Acknowledgment of the new Divisional leadership team within CSS**
- **Review of the presentation reporting to ensure consistency across all divisions.**

The Dudley Group NHS Foundation Trust

CHAIR'S LOG
UPWARD REPORT FROM WORKFORCE & STAFF ENGAGEMENT COMMITTEE
Date Committee last met: 31st May 2022

The Deep-Dive session covered the following areas:

- Outline of the new CSS Divisional Leadership team.
- Interactive session with the committee on understanding CSS as a division.
- Divisional overview of sickness absence, bank and agency, vacancies, turnover, workforce profile, mandatory training.
- Pharmacy overview of sickness absence, bank and agency, vacancies, turnover, workforce profile, mandatory training.
- Cancer overview of sickness absence, bank and agency, vacancies, turnover, workforce profile, mandatory training.
- Breast Screening overview of sickness absence, bank and agency, vacancies, turnover, workforce profile, mandatory training.
- Retained Pathology Services overview of sickness absence, bank and agency, vacancies, turnover, workforce profile, mandatory training.
- Imaging overview of sickness absence, bank and agency, vacancies, turnover, workforce profile, mandatory training.
- Improvement Plans.

MATTERS OF CONCERN OR KEY RISKS TO ESCALATE	MAJOR ACTIONS COMMISSIONED/WORK UNDERWAY
• The CSS team highlighted that sickness absence stood at 5.29% in May. • 35% of all absences during the reporting period have been related to COVID-19, (the most common reason for absence), with anxiety/stress/depression (ASD) as the second reason and musculoskeletal (MSK) as the third. • The key hot spots are in; Retained Services Directorate, specifically Phlebotomy, which has been driven by Anxiety/Stress/Depression as the leading cause. • The CSS team noted an under-representation of BAME staff at senior levels, with the highest population of BAME staff siting in the medical workforce and band 5 groups.	• Key improvement actions: review, improve communications/marketing of the Trust wellbeing offer in the division for better prevention (particularly around stress). • Turnover has been particularly challenging within the Retained Services Directorate, and this has been managed with Divisional support. A new Directorate Manager will be in post from 1st August and new management processes will also be in place from that date. These changes should have a positive impact on turnover and will be monitored. • CSS outlined a plan to work with the EDI team and the Inclusion Networks to increase reporting of E&D data, with a plan to increase membership in the networks and the number of Inclusion Champions. CSS will continue to actively support Trust-wide interventions and the strategy work for EDI.

POSITIVE ASSURANCES TO PROVIDE	DECISIONS MADE
• The Committee was pleased to hear the results of the Deep-Dive into the people plans and associated improvement trajectories for the Clinical Support Services (CSS) Division. • CSS has seen vacancy rate decrease from 18% to 14% across the Division. • There are examples across the Division of the teams investing in training and succession planning to ensure the continued reduction in vacancy rates and sustaining improvement of staff retention. • To support staff wellbeing, there is a proactive approach being taken to ensure there is investment in services and infrastructure, for example the pharmacy robot replacement and dispensary transformation will support this. • CSS remains compliant with Mandatory Training KPI's and has an established way of managing this within all directorates.	• There were no key decisions of the Committee at this meeting.

Chair's comments on the effectiveness of the meeting:

The deep dive prompted a good discussion, and it was encouraging to see contributions from across the CSS division. It was pleasing to see collaborative working both across the organisation and division in order to understand the key challenges and to work towards solutions. The progress made within Imaging was commended and the new Divisional leadership team within CSS was acknowledged.

The meeting was well attended and it was encouraging to see the significant progress being made within the division.

The Dudley Group NHS Foundation Trust

Paper for submission to the Board of Directors on 21st July 2022

Title:	Summary of Extraordinary Workforce and Staff Engagement Committee (WSEC) Meeting on Tuesday 28th June 2022
Author:	Karen Brogan - Deputy 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 following the review of the Workforce KPI report, the actions from the Extraordinary WSEC meeting, the Wellbeing and EDI Steering Group updates and Inclusion Network updates.

Summary of Key Issues:

MATTERS OF CONCERN OR KEY RISKS TO ESCALATE

- Bank usage had decreased slightly from 560 WTE in April to 524 WTE in May, but bank costs had increased from £2,752,532 in April to £3,400,806 in May.
- Agency usage had decreased in May but agency spend had increased from £1,720,398 in April to £1,954,736 in May.
- Statutory training compliance had increased slightly to 90.2% overall, just over the organisation's target, however resuscitation, patient moving and handling and safeguarding remained non-compliant.
- There was increased concern around staff wellbeing due to increased presentation of more complex and higher risk mental health wellbeing issues.

MAJOR ACTIONS COMMISSIONED/WORK UNDERWAY

- An extraordinary WSEC meeting was held on 24th June 2022 to examine options for improving mandatory training compliance for resuscitation, moving and handling and safeguarding. Actions included weekly reporting to the Execs weekly meetings, production of reports to establish those who had not yet completed mandatory training and adding these subjects to the monthly WSEC agenda.
- Targeted work on staff health and wellbeing was being undertaken to ensure awareness of and access to support services.

POSITIVE ASSURANCES

- Overall sickness absence decreased in May to 5.08% from 6.82% in April.
- An increase in shift fill was achieve for registered nurses from 81.45% in April to 87.77% in May and for unregistered nurses an increase from 66% in April to 70% in May.
- Positive reports from the Inclusion Network Chairs highlighted their membership growth, progress and plans for the coming months.

- The Committee were pleased to hear about the successful Kickstart programme; out of 24 candidates ten had secured substantive employment with the Trust and one with NHS England. Two further candidates were working in bank roles.

DECISIONS MADE

No key decisions were made by the Committee.

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: 28/06/2022
	Board of Directors	Y	Date: 21/07/2022
	Other	N	Date:

The Dudley Group NHS Foundation Trust

CHAIR'S LOG
UPWARD REPORT FROM THE WORKFORCE & STAFF ENGAGEMENT COMMITTEE
28th June 2022

MATTERS OF CONCERN OR KEY RISKS TO ESCALATE

- Bank usage had decreased slightly from 560 WTE in April to 524 WTE in May; however bank costs had increased from £2,752,532 in April to £3,400,806 in May.
- There had been a decrease in agency usage in May but agency spend had increased from £1,720,398 in April to £1,954,736 in May.
- There had been a slight increase in Statutory Training compliance since the previous report, with overall compliance at 90.2%, just above the organisation's target. However as per previous reports, Resus, Patient Moving & Handling and Safeguarding remained non-compliant.
- There is an increasing concern around staff wellbeing and increased presentation of more complex and higher risk mental wellbeing issues in staff.

MAJOR ACTIONS COMMISSIONED/WORK UNDERWAY

- An Extraordinary WSEC meeting was held on 24th June 2022 to examine options for improving mandatory training compliance for resuscitation, moving and handling and safeguarding. Actions included:
  - producing a breakdown of those who have not completed their mandatory training and ensuring that they are booked on to the training,
  - producing a weekly report on resuscitation, moving and handling and safeguarding for submission to Execs/divisions (for two months initially),
  - ensuring that a monitoring process is in place for those who are non-compliant,
  - including appraisals in the monthly KPI report to enable tracking,
  - setting a realistic training target to support the divisions,
  - discussing the IT infrastructure to address manual processes and the ESR system,
  - adding resuscitation, moving and handling and safeguarding to the regular WSEC agenda.
- Targeted work on staff health and wellbeing is being undertaken to ensure access to support services is shared.

POSITIVE ASSURANCES TO PROVIDE

The Committee was pleased to receive the following updates:

- Overall sickness absence in May was 5.08%, a significant reduction from 6.82% in April.
- There has been an increase in shift fill for registered nurses from 81.45% in April to 87.77% in May and for unregistered nurses, an increase from 66% to 70% respectively.
- The Inclusion Network Chairs provided positive reports on their progress, and plans for the coming months, including membership growth, greater awareness raising, communication plans, and development.

DECISIONS MADE

- There were no key decisions of the Committee at this meeting.

• Rachel Andrew provided an update on the successful Kickstart programme. 24 candidates had enrolled in the programme and ten of those had secured substantive employment with the Trust and one had secured employment with NHS England. Two further candidates were working in bank roles.	

Chair's comments on the effectiveness of the meeting:

The Committee reviewed performance on KPIs and revisited agreed actions from the Extraordinary Committee meeting.
There was a detailed discussion around workforce risks, especially on the impact of ESR on managing employees, providing quality information and its capacity to improve workforce challenges.
There were positive reports regarding Inclusion and Wellbeing from both the respective Steering Groups. This reflects an improving position in both areas with progress made against action plans and an improvement in employee experience.
Rachel Andrew's presentation on the Kickstart programme provided very useful information regarding the positive impact of this work on the candidates and on progress around pre-employment and work experience. It was particularly encouraging to see that so many from the group are now working for the Trust.
Overall, this was an effective meeting with good participation from those attending.

Enclosure 17

The Dudley Group NHS Foundation Trust

Paper for submission to Trust Board on 21st July 2022

Title:	Workforce KPI Report
Author:	Greg Ferris - Senior Information Analyst Karen Brogan - Deputy Chief People Officer
Presenter:	Alan Duffell - Interim Chief People Officer

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

Recommendations:

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

Summary of Key Issues:

- Overall Sickness/Absence was 5.08% in May, a significant reduction from 6.82% in April.

- The total vacancies stand at 841.32 WTE (calculated as the difference between Budgeted WTE and Contracted WTE). This equates to 14%.

- Nursing 20% (393.71)
- Senior Medics 15% (60.19)
- Junior Medics 12% (57.59)
- AHP's 19% (156.58)

- Contracted establishment was 5061.39, in April and is 5105.22 WTE in May, an increase of 43.83 WTE. It should be noted that the budgeted establishment has increased to 5911.57 in April 22, an increase of 34.97.

- Bank usage has decreased slightly from 560.23 WTE in April to 524.84 WTE in May. However, bank costs increased from £2,752,532 in April to £3,400,806 in May.

- Agency usage has decreased from 210.11 WTE in April to 198.60 WTE in May, however agency spend has increased from £1,720,398 in April to £1,954,736.

- The combined spend of temporary staffing in May is £5,355,542 compared to £4,472,930 in April.

- In May the average shift fill rate for registered nurses was 87.77% compared to 81.45% in April, for unregistered nursing this increased from 66%.to 70.1%.

- 6688 registered shifts were requested in May, a decrease from 7773 in April with 932 remaining unfilled. 2847 unregistered shifts were requested in May, a decrease from 4133 in April 1216 remained unfilled.

- Mandatory Training: overall compliance is 87.59% as at 9th June. This is a slight decrease from 87.70% as of 12th May.

- The current caseload is 38 an increase of 1 case since April. Disciplinary accounts for 56.8% with 21 cases, the highest category, followed by Capability (Underlying Health Reason) at 24.3% (9 cases). The division with the highest number of open cases is Medicine and Integrated Care at 16 cases.

WTE = whole time equivalent

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	Risk Description: BAF risks and corporate risks	
	On Risk Register: Y	Risk Score:	
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: 28/06/2022
	Board of Directors	Y	Date: 21/07/2022
	Other	N	Date:

Workforce KPI Report

June 2022

Alan Duffell

Interim Chief People Officer

NHS
The Dudley Group
NHS Foundation Trust

CARE
RESPECT
RESPONSIBILITY

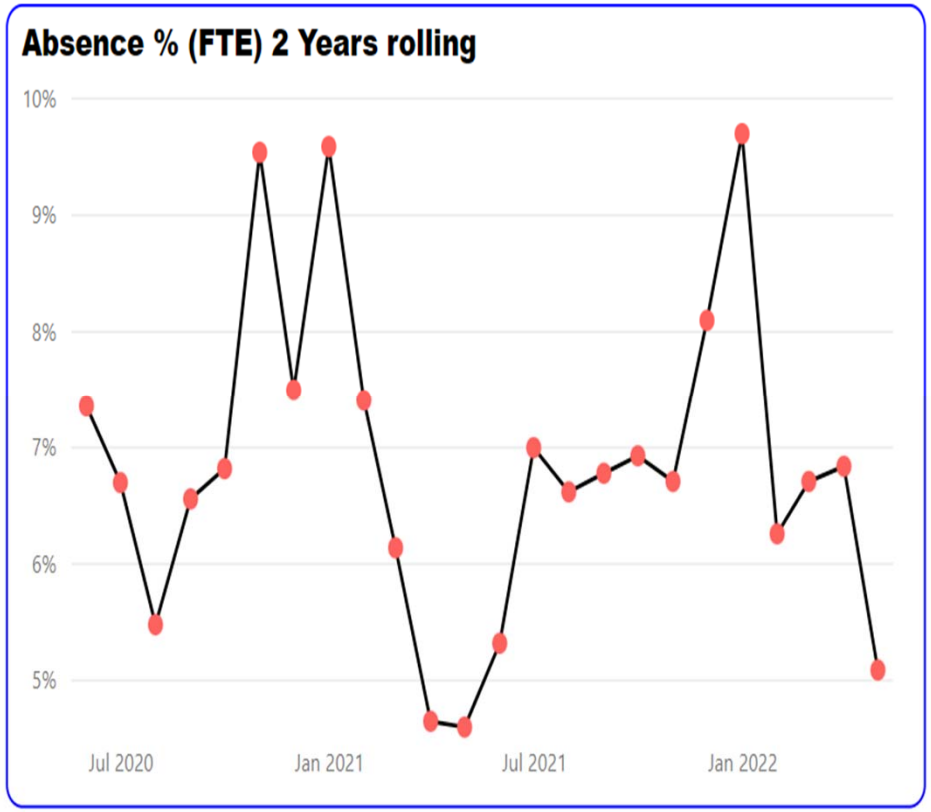
Summary 1/2	*Performance*	*Action*
Sickness & Absence	o Overall Sickness/Absence was 5.08% in May, a significant reduction from 6.82% in April. o Medicine and Integrated Care is the division with the highest sickness absence rate at 6.37% in May, a decrease from 8.09% in April. o Discounting Covid-absences, 'Anxiety/stress/depression' remains the most common reason for absence (74 people) followed by musculoskeletal (32).	✓ 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. ✓ Individual plans in place for all long-term sickness @ 6months+ ✓ Individual plans in place for all short-term persistent absence.
Bank & Agency Usage	o The COVID vaccination Bank and Agency usage is now excluded from the Trust KPI report (DGFT is the lead employer for BCWB). o Bank usage has decreased slightly from 560.23 WTE in April to 524.84 WTE in May. However bank costs increased from £2,752,532 in April to £3,400,806 in May. o Total temporary staffing usage in May is 724 WTE a reduction from 770 WTE in April. This is lower than the total vacancies for May which is 841.32 WTE. o In May the average shift fill rate for registered nurses was 87.77% compared to 81.45% in April, for unregistered nursing this increased from 66% to 70.1%. 6688 registered shifts were requested in May, a decrease from 7773 in April with 932 remaining unfilled. 2847 unregistered shifts were requested in May, a decrease from 4133 in April, 1216 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 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 establishment was 5061.39, in April and is 5105.22 WTE in May, an increase of 43.83 WTE. It should be noted that the budgeted establishment has increased to 5911.57 in April 22, an increase of 34.97. o The total vacancies stands at 841.32 WTE (calculated as the difference between Budgeted WTE and Contracted WTE). This equates to 14%. o Registered Nursing vacancies are at 393.71, an increase of 5.13 since April. Unregistered Nursing vacancies are 49.76 WTE which is consistent with April. o Overall staff turnover is at 11.5% o Excluding Medics, AHP's are the highest group at 10.4%, Admin and Clerical at 10.2%, Additional Professional Scientific & Technical, at 7.9%. Additional Clinical Services at 7.0% and Nursing & Midwifery Registered at 5.3%.	✓ 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.

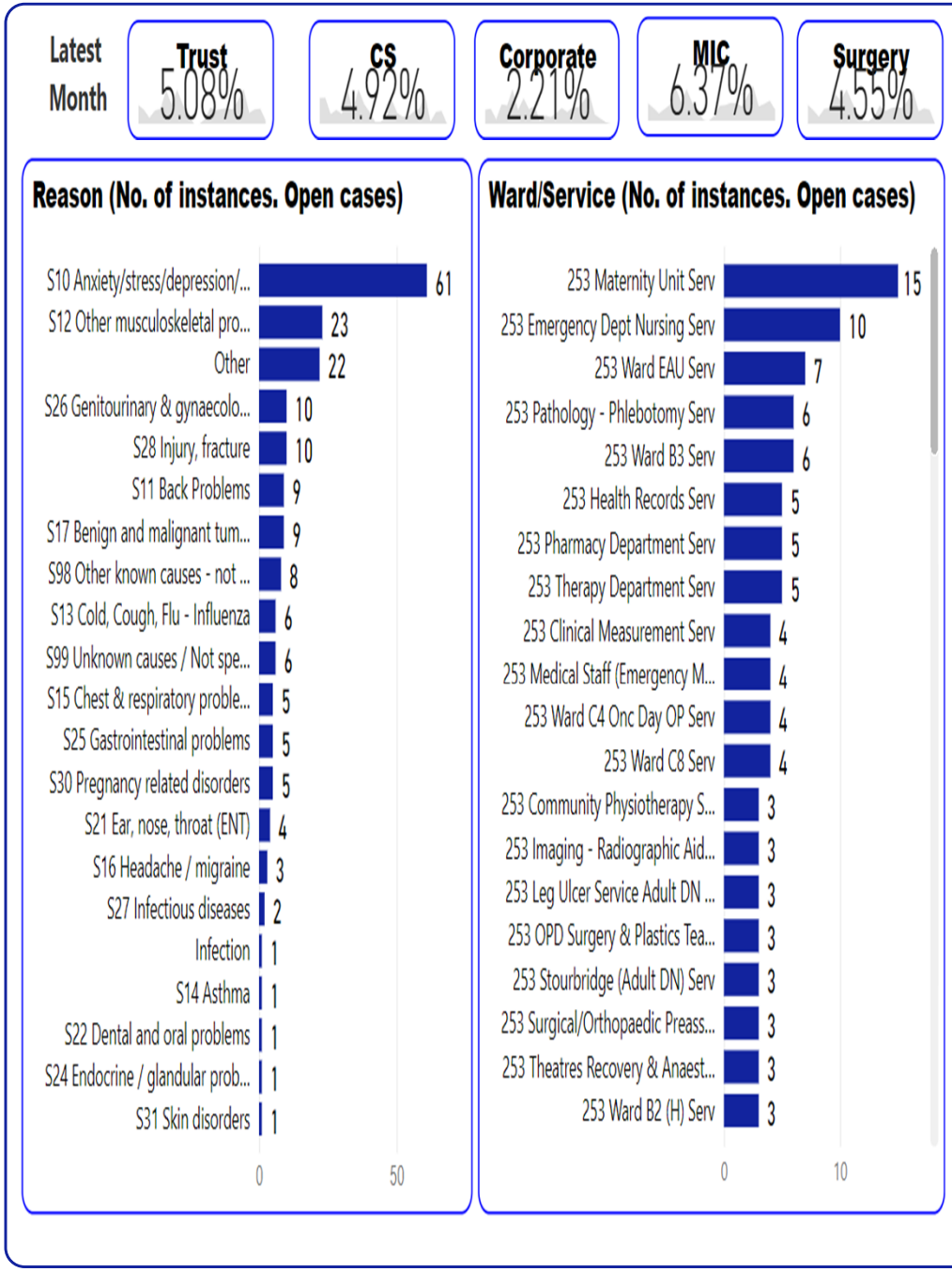
Summary 2/2	*Performance*	*Action*
Mandatory Training	o Mandatory Training: overall compliance is 87.59% as at 9th June. this is a slight decrease from 87.70% as at 12th May o The priority areas continue to be Safeguarding (child and adult), Resus and Manual Handling. o The most challenged staff group 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 running to capture Clinicians and increase overall compliance.
Equality, Diversity & Inclusion	o BAME staff Trust representation is at 21.4%, an increase of 0.4% since April. o Disabled staff Trust representation is at 4%. o LGBTQ+ staff Trust representation is at 1.8%.	✓ 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 38 an increase of 1 case since April. o Disciplinary accounts for 56.8% with 21 cases, the highest category, followed by Capability (Underlying Health Reason) at 24.3% (9 cases). o The division with the highest number of open cases is Medicine and Integrated Care at 16 cases. o BAME representation is at 24.33%, with 9 open cases. o There are currently 3 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	• BHSF RISE activity for Q1 2022 has seen a total of 34 contacts and 140 counselling sessions for staff, which has seen the highest utilisation of the service since figures started to be recorded in Q1 2020/21. • Black Country Healthcare mental health hub referrals has seen 9 staff self-refer in Q1 2022, final figures are still to be confirmed by BCH, so this figure is likely to increase • Via Vita participation has ended due to the end of the contract, however, other utilisation figures are now being recorded and an update to the dashboard is pending as a result of this. • We have seen 22 views of the wellbeing YouTube channel in May (as of 23.05). • REMPLOY utilisation has been monitored since October 21 and to date, 33 staff members have referred themselves to Remploy, which is an increase of 8 staff members since the last steering group in April 22.	✓ 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 5.08% in May, a significant reduction from 6.82% in April
- Medicine and Integrated Care is the division with the highest sickness absence rate at 6.37% in May, a decrease from 8.09% in April.
- Discounting Covid-absences, 'Anxiety/stress/depression' remains the most common reason for absence (61 Episodes) followed by musculoskeletal (23 episodes)



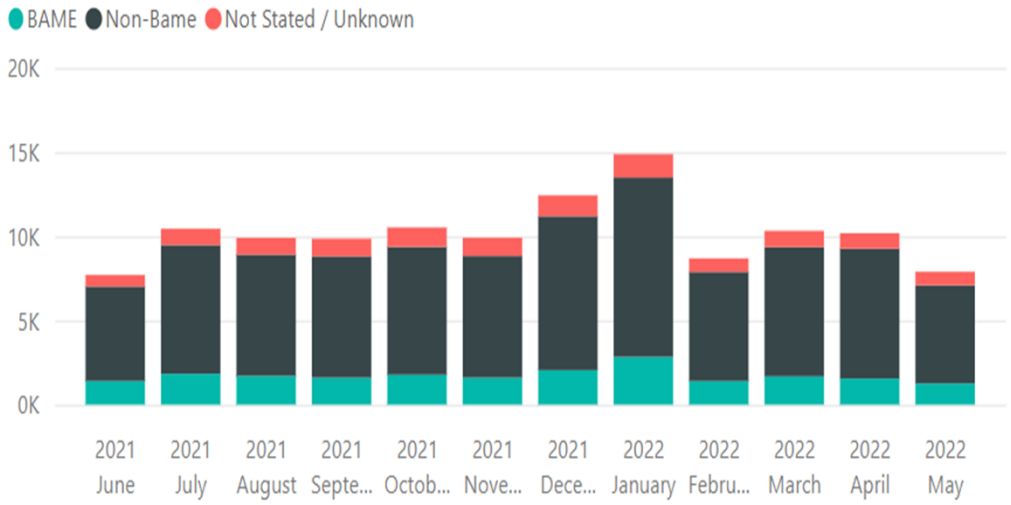


Sickness Absence - Detail

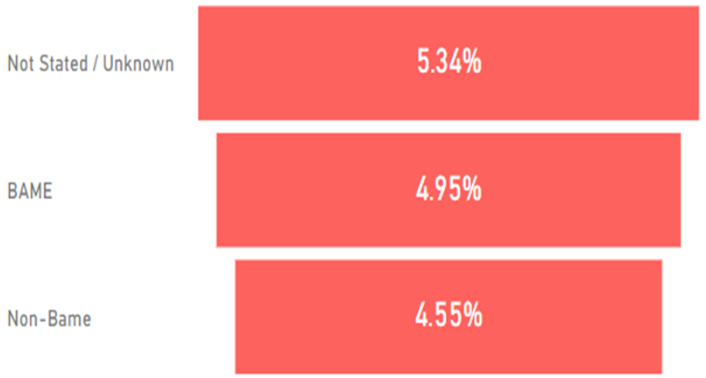
BAME colleagues show absence levels 0.4% higher that non-BAME colleagues.

Colleagues who have declared a disability show absences levels 5.34 % higher than colleagues who have declared that they do not have a disability.

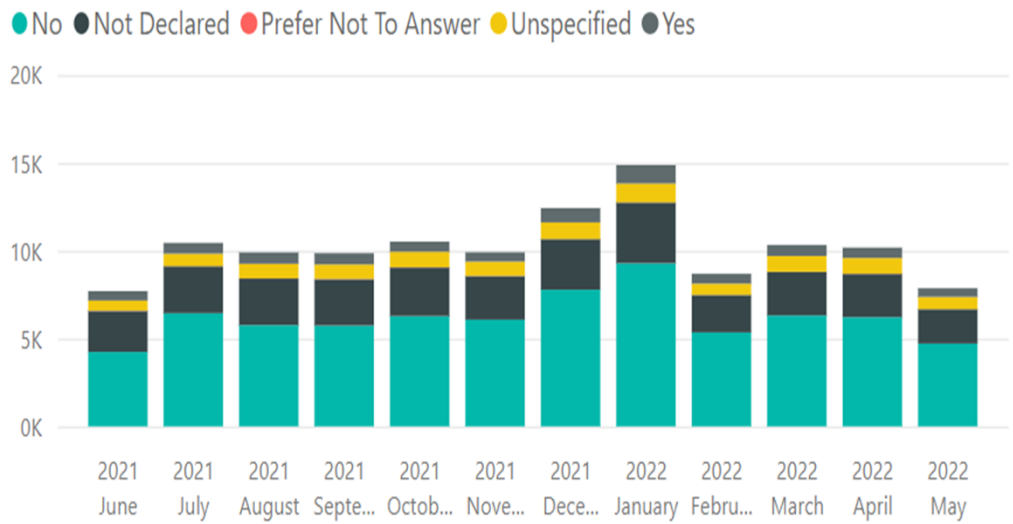
Bame / Non Bame - Absences (FTE) Trend



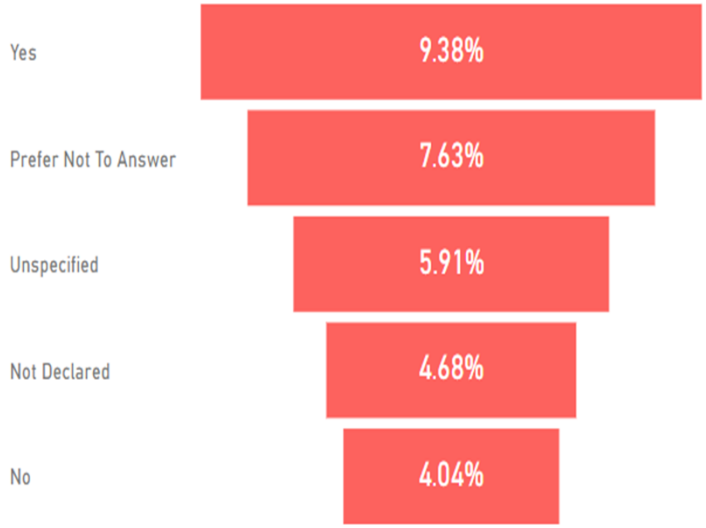
Bame / Non Bame - Absences % (FTE) 1 Year



Disability - Absences (FTE) Trend



Disability - Absences % (FTE) 1 Year



Bank & Agency – Total Trust

Bank usage has decreased slightly from 560.23 WTE in April to 524.84 WTE in May. However bank costs increased from £2,752,532 in April to £3,400,806 in May.

Agency usage has decreased from 210.11 WTE in April to 198.60 WTE in May, however agency spend has increased from £1,720,398 in April to £1,954,736. The combined spend of temporary staffing in May is £5,355,542 compared to £4,472,930 in April.

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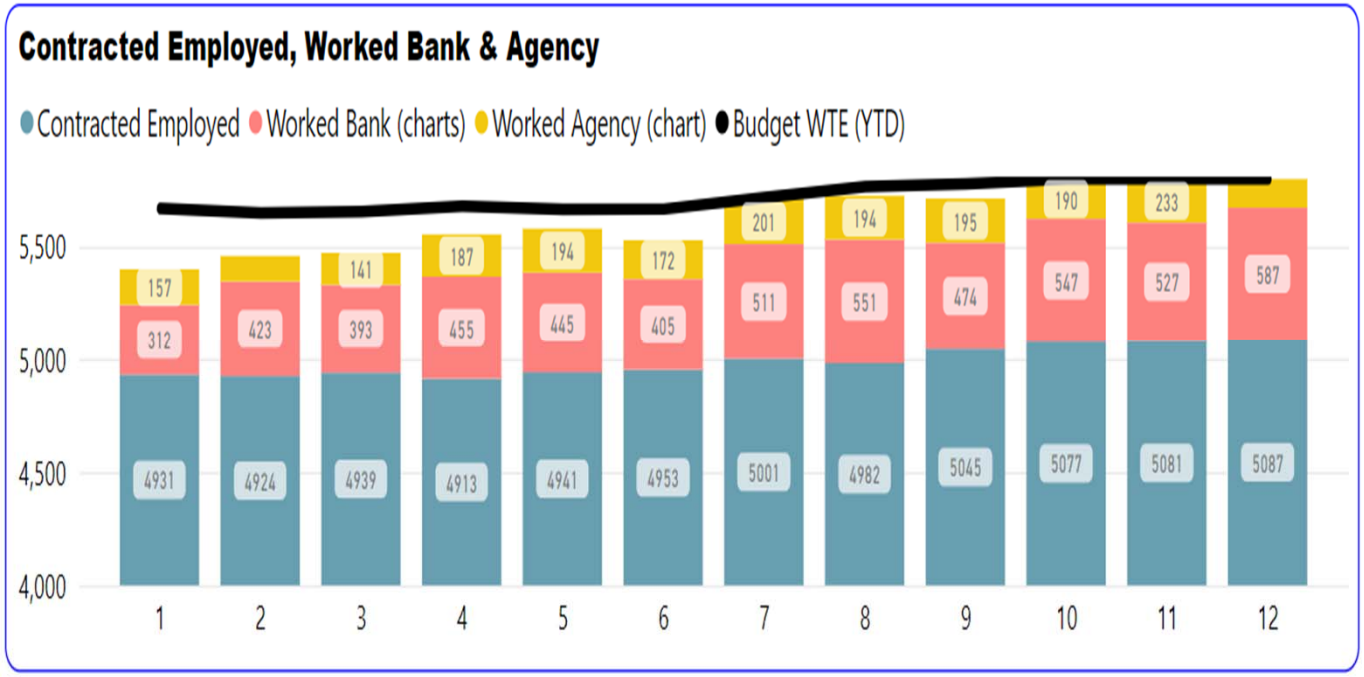
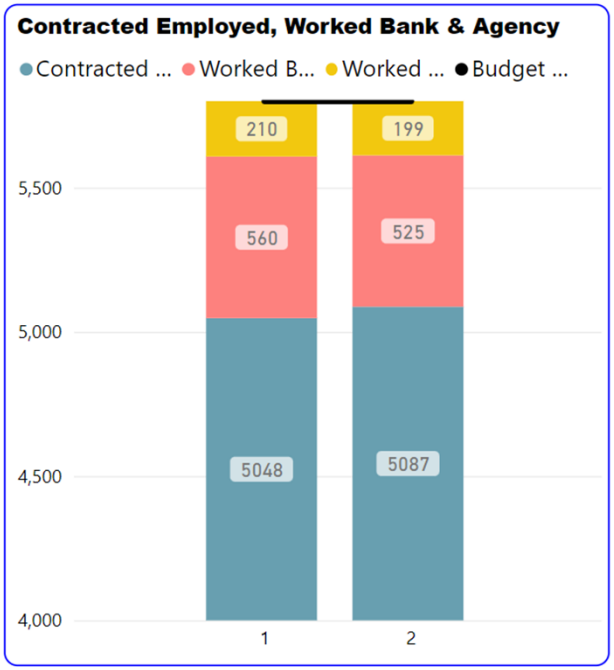




Bank Fill Rate

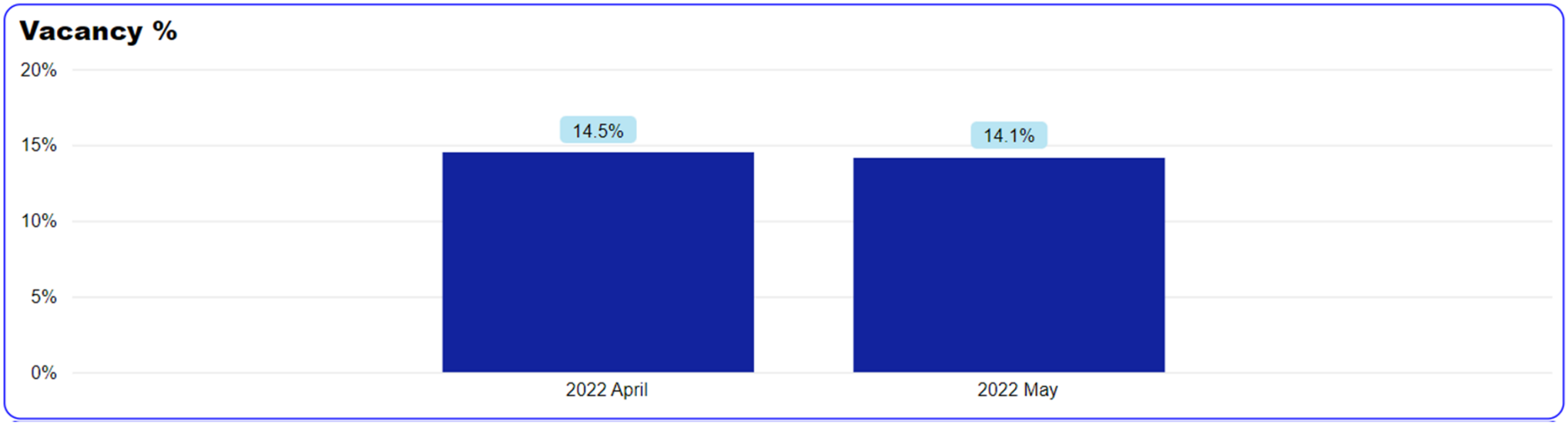
			Bank Filled		Agency Filled		Non-Framework			Unfilled Duties	
Date	Staff Group	Duties Requested	Duties	%	Duties	%	Duties	%	Overall Fill Rate	Duties	%
2nd May - 8th May	Registered	1882	966	**51.3%**	649	**34.5%**	93	**4.9%**	**85.8%**	267	**14.2%**
	Unregistered	981	651	**66.4%**	9	**0.9%**	0	**0.0%**	**67.3%**	321	**32.7%**
9th May - 15th May	Registered	1913	981	**51.3%**	692	**36.2%**	81	**4.2%**	**87.5%**	240	**12.5%**
	Unregistered	961	706	**73.5%**	10	**1.0%**	0	**0.0%**	**74.5%**	245	**25.5%**
16th May - 22nd May	Registered	1887	1132	**60.0%**	667	**35.3%**	77	**4.1%**	**95.3%**	207	**11.0%**
	Unregistered	1036	699	**67.5%**	20	**29.7%**	0	**0.0%**	**69.4%**	317	**30.6%**
23rd May - 29th May	Registered	1938	1015	**52.4%**	705	**36.4%**	79	**4.1%**	**88.8%**	218	**11.2%**
	Unregistered	1085	748	**68.9%**	4	**0.4%**	0	**0.0%**	**69.3%**	333	**30.7%**

Vacancies – Staff in Post

The total vacancies stands at 841.32 WTE (calculated as the difference between Budgeted WTE and Contracted WTE). This equates to 14%.

It should be noted that the budgeted establishment has increased to 5911.57 in April 22, an increase of 34.97, the contracted establishment was 5061.39, in April and is 5105.22 WTE in May, an increase of 43.83 WTE.

Month:	Trust	CS	Corporate	MIC	Surgery
31 May 2022	14%	19%	3%	17%	12%



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	613.60	495.22	118.38	19%	44.78	£185,211	8.73	£74,041	£259,252
Corporate / Mgt	664.91	643.45	21.46	3%	22.36	£683,088	7.61	£158,810	£841,898
Medicine & Integrated Care	2,636.09	2,175.67	460.42	17%	271.33	£1,586,983	77.51	£691,755	£2,278,738
Surgery	2,031.94	1,790.88	241.06	12%	186.37	£945,524	104.75	£1,030,130	£1,975,654
Total	**5,946.54**	**5,105.22**	**841.32**	**14%**	**524.84**	**£3,400,806**	**198.60**	**£1,954,736**	**£5,355,542**

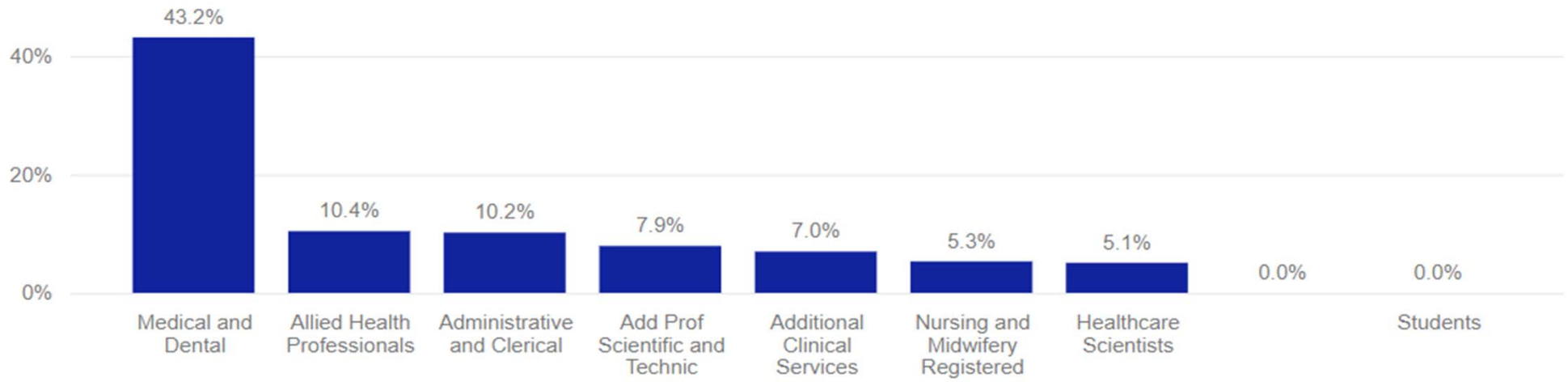
StaffGroup	Budget WTE	Contracted WTE	Vacancy WTE	Vacancy %	Worked Bank	Bank (£)	Worked Agency	Agency (£)	Bank & Agency
⊞ Nursing	1,980.00	1,586.29	393.71	20%	179.25	£1,213,009	162.83	£1,423,437	£2,636,446
⊞ Admin	1,107.16	993.32	113.84	10%	58.77	£153,373	1.67	£24,928	£178,300
⊞ CSW	968.34	918.58	49.76	5%	171.76	£783,719	2.58	£10,112	£793,831
⊞ Allied Healthcare Professional	840.08	683.50	156.58	19%	38.61	£237,081	8.39	£67,936	£305,017
⊞ Junior Medic	464.50	406.91	57.59	12%	38.23	£476,620	12.80	£181,016	£657,636
⊞ Senior Medic	394.16	333.97	60.19	15%	23.37	£483,695	1.67	£89,496	£573,191
⊞ Prof Tech Scientist	131.02	115.98	15.04	11%	15.02	£54,274	2.79	£19,976	£74,250
⊞ Other	27.55	33.65	-6.10	-22%	0.00	£0	0.00	£0	£0
⊞ Senior Manager	23.80	19.16	4.64	19%			5.87	£137,837	£137,837
Total	**5,946.54**	**5,105.22**	**841.32**	**14%**	**524.84**	**£3,400,806**	**198.60**	**£1,954,736**	**£5,355,542**

Staff Turnover

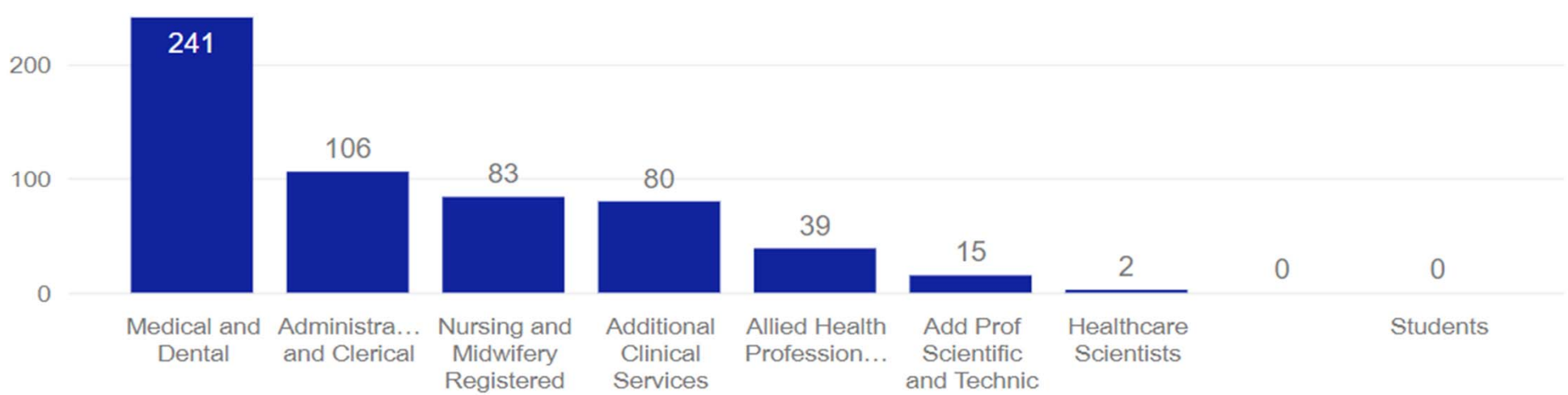
- Overall staff turnover is at 11.5%
- Excluding Medics, AHP's are the highest group at 10.4%, Admin and Clerical at 10.2%, Additional Professional Scientific & Technical, at 7.9%. Additional Clinical Services at 7.0% and Nursing & Midwifery Registered at 5.3%.

Latest Month	Trust	CS	Corporate	MIC	Surgery
	11.5%	12.1%	14.0%	10.8%	11.3%

Turnover Rate by Staff Group (rolling 12 months)



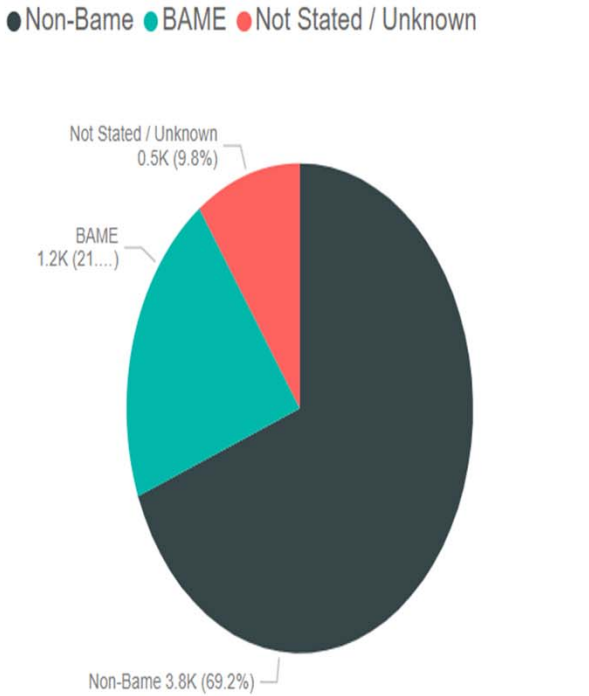
Leavers FTE by Staff Group (rolling 12 months)



Workforce Profile - Ethnicity – Representation by Division and Grade

BAME staff Trust representation is at 21.4%, an increase of 0.4% since April.

Ethnicity Profile



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	435	22.4%	1309	67.4%	197	10.1%
253 Medicine & Integrated Care	494	20.6%	1664	69.3%	243	10.1%
253 Corporate / Mgt	83	12.8%	497	76.6%	69	10.6%
253 Clinical Support	153	27.5%	366	65.8%	37	6.7%

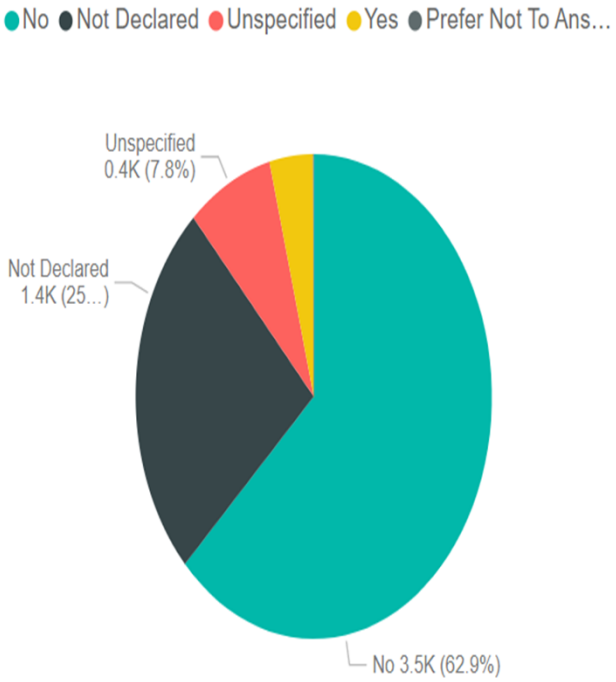
BAME/Non-BAME by Pay Grade (grouped)

Mapping Mapping	BAME No.	BAME %	Non-Bame No.	Non-Bame %	Not Stated / Unknown No.	Not Stated / Unknown %
Apprentice	8	18.2%	33	75.0%		
Band 2	127	10.5%	974	80.2%	114	9.4%
Band 3	72	16.2%	335	75.3%	38	8.5%
Band 4	53	11.9%	355	79.6%	38	8.5%
Band 5	279	28.2%	601	60.8%	108	10.9%
Band 6	195	19.4%	728	72.5%	81	8.1%
Band 7	64	11.9%	442	82.5%	30	5.6%
Band 8a	40	24.0%	115	68.9%	12	7.2%
Band 8b	8	12.9%	48	77.4%	6	9.7%
Band 8c			19	86.4%		
Band 8d			11	84.6%		
Band 9			6	66.7%		
Consultant	122	49.2%	92	37.1%	34	13.7%
Non-Consultant	186	58.7%	59	18.6%	72	22.7%
Trust contract			12	66.7%		
VSM						

Workforce Profile - Disability – Representation by Division and Grade

Disabled staff Trust representation is at 4%

Disability



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	71.5%	18.9%		6.5%	3.2%
253 Corporate / Mgt	67.9%	19.7%		5.0%	7.0%
253 Medicine & Integrated Care	63.2%	24.5%		7.9%	4.3%
253 Surgery	58.3%	30.1%		8.9%	2.7%
Total	**62.9%**	**25.3%**	**0.1%**	**7.8%**	**3.9%**

Disability by Pay Grade (grouping)

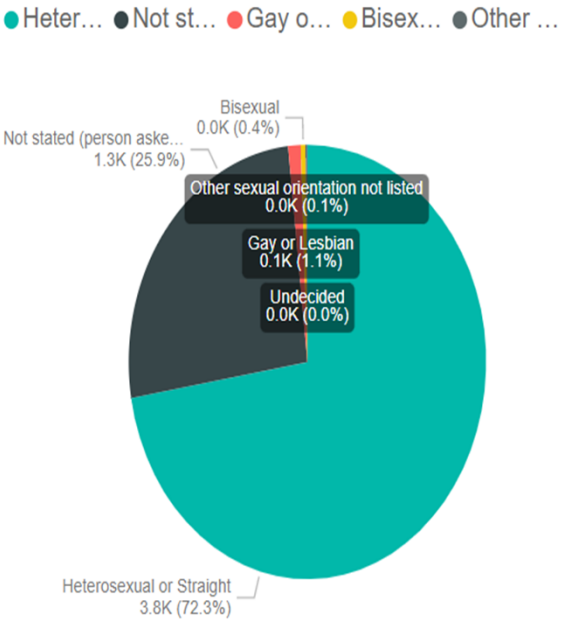
Mapping	No	Not Declared	Prefer Not To Answer	Unspecified	Yes
Apprentice	81.8%				
Band 2	62.6%	24.1%		10.0%	3.3%
Band 3	60.2%	27.2%		7.3%	5.3%
Band 4	70.8%	18.5%		6.9%	3.8%
Band 5	60.7%	25.4%		9.1%	4.8%
Band 6	67.1%	21.8%		6.5%	4.6%
Band 7	65.8%	26.4%		3.3%	4.3%
Band 8a	72.6%	17.9%		4.2%	5.4%
Band 8b	72.6%	19.4%			
Band 8c	77.3%				
Band 8d	76.9%				
Band 9	88.9%				
Consultant	46.2%	45.0%		8.0%	
Non-Consultant	47.9%	39.3%		12.0%	
Trust contract	66.7%				
VSM					
Total	**62.9%**	**25.3%**	**0.1%**	**7.8%**	**3.9%**

Workforce Profile – LGBTQ+ – Representation by Division and Grade

LGBTQ+ staff representation is shown as 1.8%

The numbers are shown as a % since absolute numbers are low.

LGBTQ+



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			77.0%	21.7%		
253 Corporate / Mgt	1.3%	1.1%	79.7%	17.9%		
253 Medicine & Integrated Care	0.4%	1.5%	73.1%	24.9%		
253 Surgery		0.9%	67.5%	31.2%		
Total	**0.4%**	**1.1%**	**72.3%**	**25.9%**	**0.1%**	**0.0%**

LGBTQ+ by Pay Grade (grouped)

Mapping	Bisexual	Gay or Lesbian	Heterosexual or Straight	Not stated (person asked but declined to provide a response)	Other sexual orientation not listed	Undecided
Apprentice			83.7%			
Band 2	0.6%	1.5%	73.1%	24.5%		
Band 3			71.9%	26.7%		
Band 4			77.3%	21.0%		
Band 5			70.3%	29.1%		
Band 6	0.6%	1.4%	74.9%	23.1%		
Band 7			73.3%	25.2%		
Band 8a			77.8%	21.6%		
Band 8b			78.0%	18.6%		
Band 8c			80.0%			
Band 8d			76.9%			
Band 9			100.0%			
Consultant			50.7%	48.0%		
Non-Consultant			69.3%	28.3%		
Trust contract			70.6%			
VSM			80.0%			
Total	**0.4%**	**1.1%**	**72.3%**	**25.9%**	**0.1%**	**0.0%**

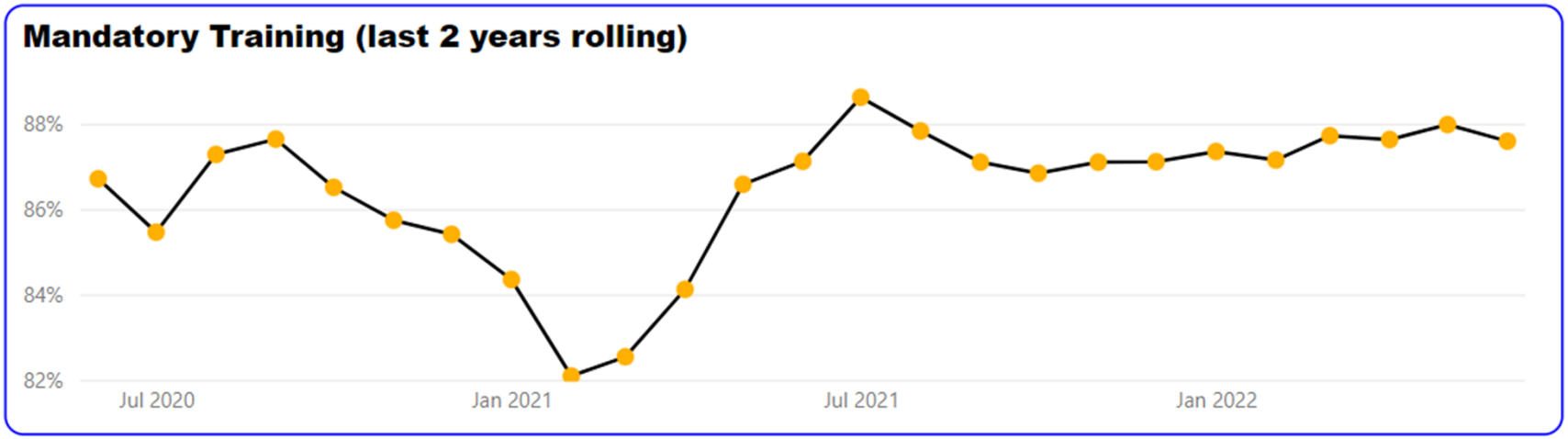
Mandatory Training – Performance Trend

Mandatory Training: overall compliance is 87.59% as at 9th June. this is a slight decrease from 87.70% as at 12th May

10th June 2022

Latest Month

Trust	CS	Corporate	MIC	Surgery
87.59%	90.46%	88.94%	87.30%	86.84%



View Courses | View Specialties | View Directorates

Specialty Table

Group4Description	March 2022	April 2022	May 2022	June 2022
253 AAA Screening Spec	100.00%	100.00%	98.46%	98.46%
253 Acute Medicine - Renal Svcs Spec	80.72%	83.13%	84.70%	86.11%
253 Acute Medicine Respiratory Svc Spec	84.58%	83.81%	83.19%	84.73%
253 Acute Medicine-Cardiology Medics Spec	63.33%	71.93%	67.14%	65.23%
253 Anaesthetics Spec	88.79%	85.07%	84.00%	83.07%
253 Assertive Case Managers Spec	97.98%	99.32%	97.98%	96.64%
253 Blood Borne Virus Spec	88.46%	88.46%	88.46%	94.87%
253 Breast Screening Service Spec	89.73%	92.49%	91.96%	92.35%
253 Brierley Hill (Adult DN) Spec	76.04%	74.37%	74.64%	72.30%
Total	**87.72%**	**87.63%**	**87.98%**	**87.59%**

Mandatory Training – Areas of Focus

The priority areas continue to be:

SAFEGUARDING ADULTS - Level 3

SAFEGUARDING CHILDREN Level 3

RESUS PAEDS

RESUS ADULTS

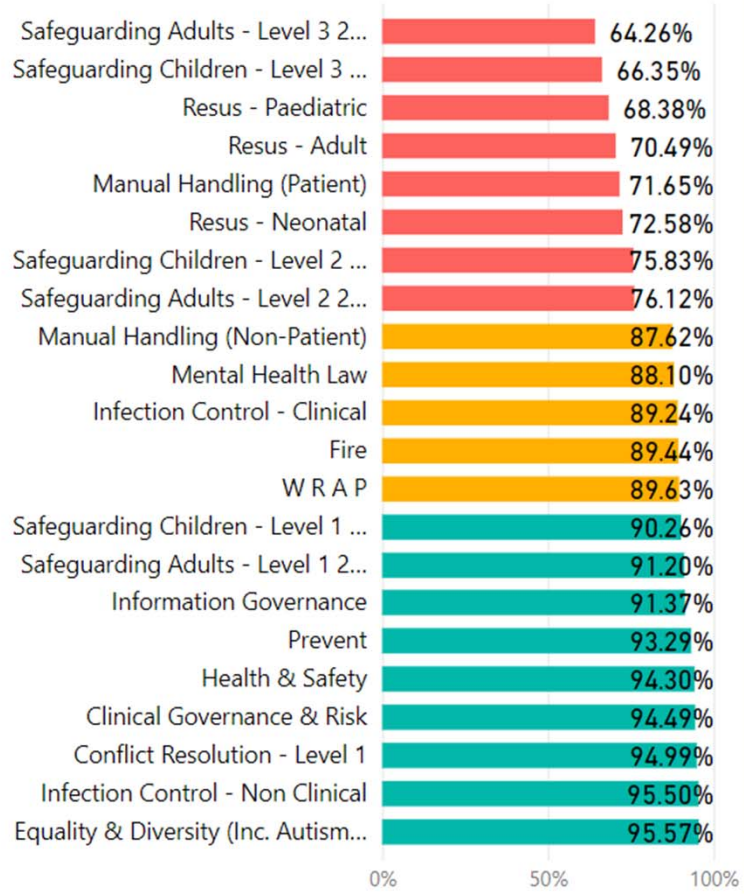
MANUAL HANDLING

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 Emergency Dept Nursing Serv	1,473	231	77.81%
253 General Surgery Medical Staff Serv	412	154	65.60%
253 Maternity Unit Serv	2,270	154	84.29%
253 Theatres Emergency & Other Serv	706	100	78.88%
253 Anaesthetics Medical Staff Serv	972	81	83.07%
253 Medical Staff - EAU Serv	731	76	81.58%
253 Theatres Recovery & Anaesth Serv	595	76	79.86%
253 Paediatric Medical Staff Serv	303	75	72.14%
253 Brierley Hill (Adult DN) Serv	295	73	72.30%
253 Ward B5 Serv	767	72	82.29%
253 Medical Staff (Emergency Med) Serv	732	65	82.71%
253 Medical Staff (Older People) Serv	201	64	68.36%
253 Medical Director Serv	147	61	63.63%
253 Medical Staff - Respiratory Serv	167	59	66.53%
253 Renal Unit Serv	278	55	75.13%
253 Urology Medical Staff Serv	147	54	65.91%
253 Ward B3 Serv	720	54	83.81%
253 Medical Staff Cardiology Serv	137	52	65.23%
253 Ward CCU Serv	598	51	82.94%
253 Ward C8 Serv	886	50	85.19%
253 Clinical Measurement Serv	371	49	79.61%
Total	**61,390**	**1685**	**87.59%**

HR Caseload

- The current caseload is 38 an increase of 1 case since April.
- Disciplinary accounts for 56.8% with 21 cases, the highest category, followed by Capability (Underlying Health Reason) at 24.3% (9 cases).
- The division with the highest number of open cases is Medicine and Integrated Care at 16 cases.
- BAME representation is at 24.33%, with 9 open cases.
- There are currently 3 live suspensions.

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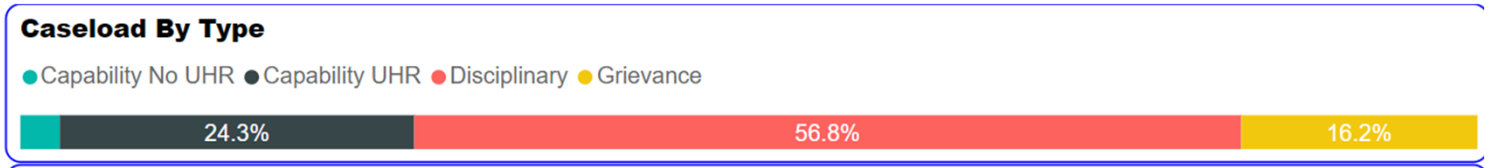
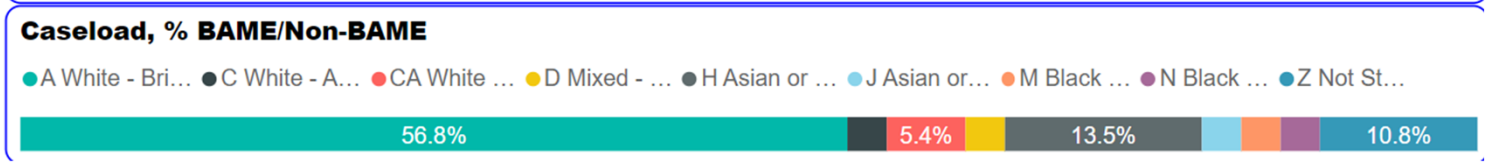
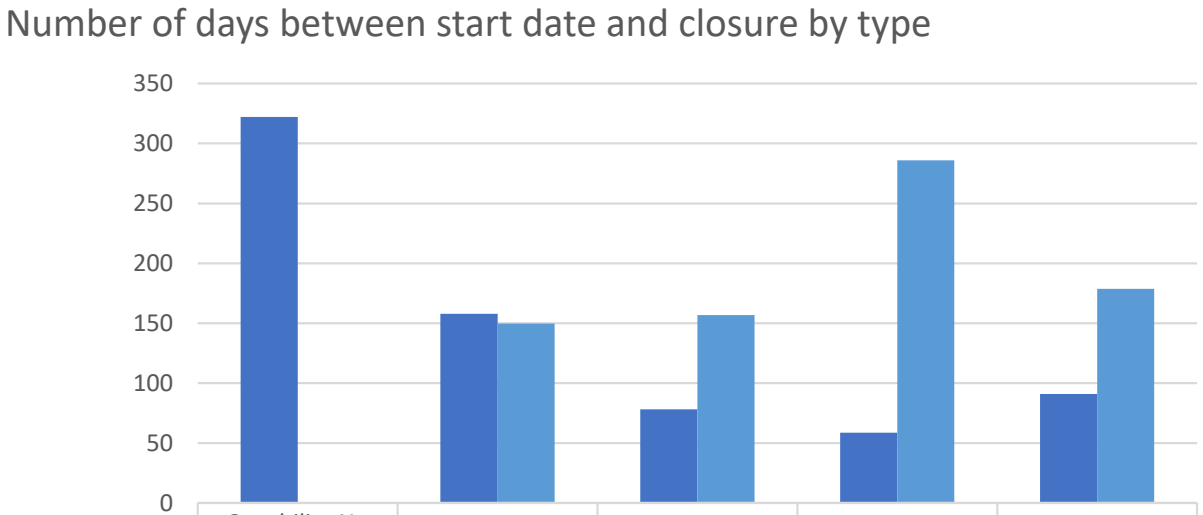
Division	Capability UHR	Disciplinary	Grievance	Grand Total
253 Clinical Support		1		1
253 Corporate / Mgt	4	3	2	9
253 Medicine & Integrated Care	5	8	3	16
253 Surgery	1	9	2	12
Grand Total	10	21	7	38





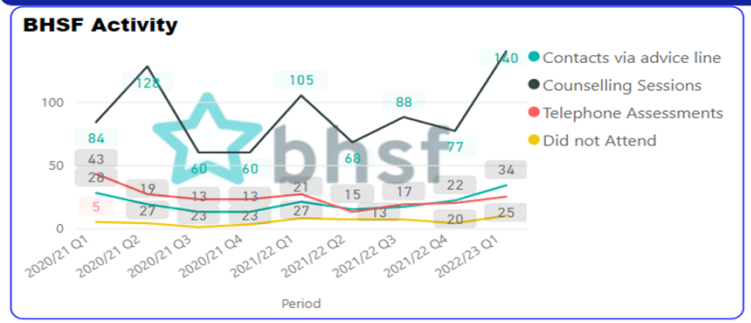


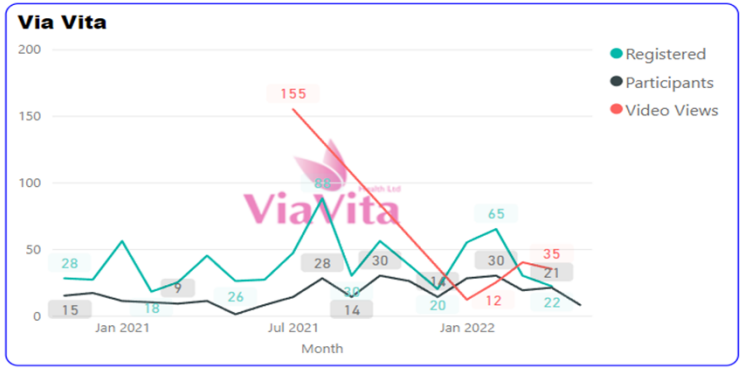
	Capability No UHR	Capability UHR	Disciplinary	Grievance	Grand Total
Average length of days to completion	322	158	78	59	91
Average length of open cases		150	157	286	179

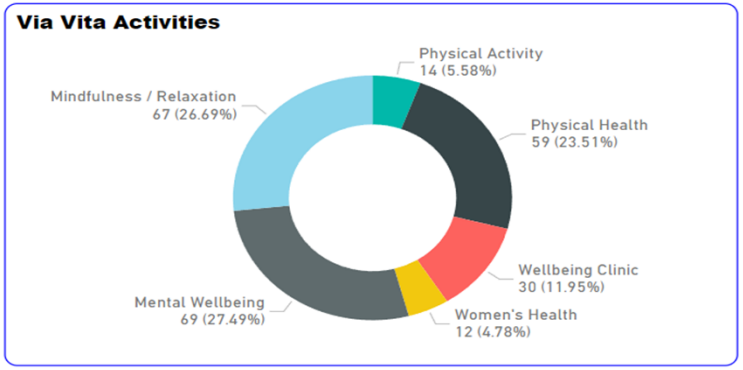
Accessing Support

- BHSF RISE activity for Q1 2022 has seen a total of 34 contacts and 140 counselling sessions for staff, which has seen the highest utilisation of the service since figures started to be recorded in Q1 2020/21.
- Black Country Healthcare mental health hub referrals has seen 9 staff self-refer in Q1 2022, final figures are still to be confirmed by BCH, so this figure is likely to increase
- Via Vita participation has ended due to the end of the contract, however, other utilisation figures are now being recorded and an update to the dashboard is pending as a result of this.
- We have seen 22 views of the wellbeing YouTube channel in May (as of 23.05).
- Wellbeing courses and engagement has continued with the support of the Organisational Development team and the Wellbeing Business Partner, this has seen an additional 21 members of staff join the wellbeing workshops since April 22. We have also seen 34 members of staff engage in additional ad hoc sessions in April and 31 during May 22.
- REMPLOY utilisation has been monitored since October 21 and to date, 33 staff members have referred themselves to Remploy, which is an increase of 8 staff members since the last steering group in April 22.
- The Staff Health and Wellbeing (SHAW) average referrals by reason show the main reason for referral as being 'Ability to perform duties' (60.6%), followed by 'Long-term sickness absence' (23.6%), which is in line with the previous steering group reporting.
- The Staff Health and Wellbeing (SHAW) mean average wait time has increased from just below 22 days in February 22 to just above 37 days in April 22 for the 1st appointment offer to staff.

Accessing Support







Accessing Support

Enclosure 18

The Dudley Group NHS Foundation Trust

Paper for submission to the Board of Directors on 21st July 2022

Title:	**Digital Committee Report – Public Board**
Author:	**Catherine Holland** (Digital Committee Chair)
Presenter:	Vij Randeniya, Non-executive director

Action Required of Committee / Group			
Decision	**Approval**	**Discussion**	**Other** Y
Recommendations: Note the report.			

Summary of Key Issues:

The committee meets bi-monthly. Three updates are provided, the March committee occurred after board, May report missed upward public report in error.

- A critical decision point for the board on the next steps for transition to public cloud is imminent and concerns are recorded in the matrix report. The Chair urges board members to visit the data centre to understand this risk prior to receiving the business case – and commissioned the technical team to support this request.
- Deep dives covered the Cloud Transition Project highlighting risks and plans
- The Digital Portfolio backlog deep dive as per the action from the previous committee meeting
- Ongoing positive assurance is received on the CareCERT process and meeting key performance indicators.
- The levels of capacity within the current digital team is captured as a concern.
- There are several positive or partial assurances captured in the matrix reports
- Committee Effectiveness, structure and Terms of Reference were reviewed in May and recommended for approval.

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			
Implications of the Paper:			
Risk	Y	Risk Description: Failure to successfully adopt digital workflows, due to competing organisation / clinical pressures, availability of resources and change fatigue; results in clinical risk, reputational risk and inefficiency.	
	On Risk Register: BAF Y	Risk Score: Moderate (8)	
Compliance and/or Lead Requirements	CQC	Y	Details: Well Led
	NHSE/I	N	Details:
	Other	Y	Details: DCB0160 and DCB0129 clinical risk management standards (HSCA statue 250)

Report Journey/ Destination	Working / Exec Group	N	Date:
	Committee	N	Date:
	Board of Directors	Y	Date: 21 July 2022
	Other	N	Date:

UPWARD REPORT FROM DIGITAL COMMITEE

Date Committee last met: 6th July 2022

MATTERS OF CONCERN OR KEY RISKS TO ESCALATE

- The committee chair highlights that the board will soon arrive at a critical decision point for the ongoing transition to cloud that will be laid out in the phase 2 final business case. Finance attendee highlighted this case is the most complicated planning exercises the Trust has ever undertaken. Concern is raised of the risk associated with fitting a project to the outline cost forecast vs. funding long-term strategic solutions. The Chair urged board members to visit the Data Centre to better understand the corporate risk. The emotional impact on the technical workforce was noted.
- The Board Assurance Framework (BAF) needs to be reviewed in line with escalating corporate risks to explore a more open risk appetite for digital innovation.
- A deep dive of the current digital portfolio was received. With current levels of resource capacity it will take 6.25 years to deliver if no new requests are made. A workforce plan for capacity & skills change was prepared in accordance with BAF 10 agreed mitigations – but has been suspended due to the current financial position. As such delivery risks remain un-controlled. It was noted that department leads are not validating priority requests, only 4% of priorities have been validated by their named lead.

MAJOR ACTIONS COMMISSIONED/WORK UNDERWAY

- Review and escalate BAF and corporate risks
- As part of the Cloud Transition Project, Executive staff have been encouraged to visit the FMC to have a better understand of the work involved, the risks, and meeting staff that are constantly working under pressure to ensure the smooth running of the hospital with aging and unsupported infrastructure
- Comms will be going out to inform all staff that they are expected to carry out self-service for password reset to free up the service desk capacity for other work.

POSITIVE ASSURANCES TO PROVIDE

- Partial assurance for Admit via issue. There is an ongoing investigation, the supplier Altera (Allscripts) are required to change their software to resolve it. Trust technical and process controls are in place
- Perinatal Institute integration has been delivered in Maternity. Much of the work was carried out by the in-house development team due to the product provided by Altera not being fit for purpose
- N365 has been rolled out across the organisation
- Sunrise GP data load project has been delivered
- The Digital Trust team have been nominated for the Committed to Excellence awards 2022

DECISIONS MADE

- No decision were made. The meeting was not quorate

Chair's comments on the effectiveness of the meeting:

A good meeting - the careful consideration that has been given to preparing well-structured reports and aligning to an overall theme is apparent. Board and Executives to initiate conversation around the opportunities moving forward. There was only one Non-Executive Director.

UPWARD REPORT FROM DIGITAL COMMITEE

Date Committee last met: 25th May 2022

MATTERS OF CONCERN OR KEY RISKS TO ESCALATE

- There is a national skills gap in modern digital skills and high levels of competition in the market. NHS organisations do not have a competitive offer and work is ongoing in national team to address.
- Capacity and skills within the current digital, data and technology team cannot meet the current demand on the service, this is recorded on the Trust's corporate risk register. The Digital portfolio priorities significantly outstrip capacity currently – a deep dive to be undertaken.
- The Trust continues with Phase 1 delivery to plan and Phase 2 planning of the cloud transition project.

MAJOR ACTIONS COMMISSIONED/WORK UNDERWAY

- As part of the NHS Transformation Directorate Year of the Digital Profession 2022 - work has commenced to identify opportunities to support staff in obtaining professional recognition registration, continuing professional development as part of team skills improvement and assessments in 2022.
- A deep dive into the digital portfolio was commissioned for the next meeting
- Development of the Phase 2 business case continue and updates to committee on progress.

POSITIVE ASSURANCES TO PROVIDE

- Continued assurance with compliance on CareCERT Threat Notifications key performance indicators
- Migration to Windows 11 is progressing well and the Trust is ahead of many providers in this requirement.
- Dudley has 100% information governance sign-up to the One Care Record (OCR) programme across the West Midlands which delivers shared care records.
- Data Quality in all Trust data set submissions exceeds the National average, in maternity this currently 99.9%.
- Learning from regional and National IT failures discussed previously embedded into strategic plans to make them more robust.
- The Digital Trust team have been nominated for the Committed to Excellence awards 2022

DECISIONS MADE

- Following the feedback from the Committee Effectiveness review, the Committee agreed to continue with having executive directors within the membership and not make any changes to the current structure of the Committee or its governance at this time
- The committee endorsed the reviewed Terms of Reference for approval.

Chair's comments on the effectiveness of the meeting:

A good meeting - excellent reports, easy to understand and aligning to an overall workplan. The IT Operations Report contained a considerable amount of information and should be split into multiple reports - to include operational performance and strategic project delivery reports

UPWARD REPORT FROM DIGITAL COMMITEE

Date Committee last met: 16th March 2022

MATTERS OF CONCERN OR KEY RISKS TO ESCALATE	MAJOR ACTIONS COMMISSIONED/WORK UNDERWAY
• It was noted that the Trust's main Electronic Record (EPR) supplier has been acquired by another technology company. Early assurances are provided but the committee will receive updates as this progresses. • In reviewing the Board Assurance Framework (BAF) strategic risks two gaps were identified in that; a. inflationary pressures, fuel costs and supply chain disruption all significantly impact technology and b. addition global political uncertainty raises the cybersecurity threat. It was commissioned that corporate risk register and BAF 10 shall reflect this. • Central funding for delivering What Good Looks Like (WGLL) requires detailed work and fund matched committed plans that are yet to be fully developed. • There is a digital portfolio programme backlog as capacity to deliver Trust priorities is limited leading to risk – which is escalated to the corporate register.	• Corporate risk register and BAF to be updated with the details discussed. • The continuation of the strategic infrastructure case and transition to public cloud remains ongoing. • Digital Board Development has been commissioned and will occur in the summer to support the Trust board with confidence in digital strategic decision making pertinent to a number of large pieces of work ongoing.
POSITIVE ASSURANCES TO PROVIDE	**DECISIONS MADE**
• Continued positive assurance with compliance on CareCERT Threat Notifications key performance indicators • Partial assurance that a central fund for addressing a minimal viable product (MVP) Electronic Record (EPR) and driving Minimum Digitisation Foundations (MDF) was welcomed but as yet not fully clear. • Positive assurance on the detailed work in progress to address the strategic issues that the Trust faces. • The work and resources that supported a regional organisation with a major IT failure and root cause analysis was noted and commended.	• No decisions requested or made.
Chair's comments on the effectiveness of the meeting: Excellent meeting. Good assurance, well triangulated and maturing reports, effective challenge. Apologies received from executives due to ASE event in Telfford. Heavy lifting and lots of work underway. A deeper dive on the strategic issues would benefit from wider board input. Future face-2-face meetings may better support strategic discussions.	