Excellent health care, improved health for all

The Dudley Group NHS Foundation Trust

Board of Directors Meeting Public Papers

Thursday 22nd September 2022 10:00 – 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
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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
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2. Board Members' interests

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

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

3. Opportunity for questions

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

4. Debate

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

5. Minutes

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

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

6. Key Contacts

Andy Proctor
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The Dudley Group NHS Foundation Trust

Board of Directors
Thursday 22 September 2022 at 10:00
via MS Teams Video Conference
AGENDA

	ITEM	PAPER REF	LEAD	PURPOSE	TIME
1	**Chairman's welcome and note of apologies**	Verbal	D Nicholson	For noting	10:00
2	**Declarations of Interest** Standing declaration to be reviewed against agenda items.	Enclosure 1	D Nicholson	For noting	10:00
3	**Minutes of the previous meeting** Thursday 21 July 2022 Action Sheet 21 July 2022	Enclosure 2 Enclosure 3	D Nicholson	For approval	10:00
4	**Chief Executive's Overview and Operational Update**	Enclosure 4	D Wake/ Executive Directors	For information & assurance	10:05
5	**Chair's Update**	Verbal	D Nicholson	For information	10:20
6	**Public Questions**	Enclosure 5	D Nicholson	For information	10:30
7	**Presentation –** Ophthalmology first to launch of novel Intra Vitreal injection	Verbal	Mr Shafquat	For information	10:35
8	**GOVERNANCE**				
8.1	Board Assurance Framework	Enclosure 6	A Proctor	For assurance	10:55
8.2	Emergency Planning Core Standards	Enclosure 7	K Kelly	For approval	11:05
8.3	Audit Committee	Enclosure 8	G Crowe	For approval	11:15
8.4	**System updates** Dudley Health & Care Partnership	Enclosure 9	K Rose	For endorsement	11:25
9	**FINANCE & PERFORMANCE**				
9.1	Finance & Performance Committee Report	Enclosure 10	L Williams	For assurance	11:35
9.2	Integrated Performance Dashboard	Enclosure 11	K Kelly	For assurance	11:45
9.3	Trust Strategy Updates	Enclosure 12	K Rose	For assurance	11:55
9.4	Estates Strategy	Enclosure 13	K Stringer	For approval	12:05
	Comfort Break *(5mins)*				

10	**QUALITY & SAFETY**				
10.1	Quality & Safety Committee Report	Enclosure 14	L Hughes	For assurance	12:15
10.2	Chief Nurse Report	Enclosure 15	M Sexton	For assurance	12:25
10.3	Board Assurance Infection Prevention Control (IPC) Framework IPC Annual Report	Enclosure 16 Enclosure 16a	M Sexton L Watkins	For assurance For assurance	12:35
10.4	Maternity Report including Neonatal Safety, Quality Dashboard and Ockenden	Enclosure 17	M Sexton	For assurance	12:45
10.5	Health & Safety Annual Report	Enclosure 18	K Kelly	For approval	12:55
11	**WORKFORCE**				
11.1	Workforce & Staff Engagement Committee Report	Enclosure 19	J Atkins	For assurance	13:00
11.2	Workforce KPIs	Enclosure 20	A Duffell	For assurance	13:10
12	**PATIENT EXPERIENCE**				
12.1	Patient Experience & Complaints Annual Report	Enclosure 21	M Sexton	For assurance	13:20
13	**DIGITAL**				
13.1	Digital Trust Technology Committee Report	Enclosure 22	C Holland	For assurance	13:30
14	**RESEARCH & DEVELOPMENT**				
14.1	Research & Development Report and Strategy	Enclosure 23	G Parsons	For approval	13:40
15	**WINTER PLAN**				
15.1	Winter Plan	Enclosure 24	K Kelly	For approval	13:50
16	**Any Other Business**	Verbal	All	For noting	14:00
17	**Reflections on meeting**	Verbal	All		
18	**Date of next Board of Directors meeting** Thursday 17 November 2022 (public session)	Verbal			
19	**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 14/09/2022

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	01/06/2022	Appointed to the Non-executive role as Chair of the Quality Committee for Birmingham and Solihull ICS
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
David Nicholson	Chairman	01/09/2022	Chair - Sandwell and West Birmingham Hospitals NHS Trust
David Nicholson	Chairman	01/09/2022	Sole Director - David Nicholson Healthcare Solutions
David Nicholson	Chairman	01/09/2022	Director - The Worcestershire Healthcare Education Co Ltd
David Nicholson	Chairman	01/09/2022	Visiting Professor - Global Health Innovation, Imperial College
David Nicholson	Chairman	01/09/2022	Spouse is Chief Executive of Birmingham Women's and Children's NHS Foundation Trust
David Nicholson	Chairman	01/09/2022	Advisor to KPMG Global
David Nicholson	Chairman	01/09/2022	Non-Executive Director – Lifecycle
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 Thursday 21 July 2022 10:15hr
virtually via MS Teams Video Conference

Present
Julian Atkins, Non-executive Director (JA)
Yve Buckland, **Chair**
Gary Crowe, Non-executive Director (GC)
Alan Duffell, Interim Chief People Officer (A*D)*
Julian Hobbs, Medical Director (JHO)
Jonathan Hodgkin, Non-executive Director (JH)
Liz Hughes, Non-executive Director (LH)
Kat Rose, Director of Strategy & Partnerships
Mary Sexton, Chief Nurse (MS)
Kevin Stringer, Interim Director of Finance (KS)
Adam Thomas, Chief Information Officer (AT)
Diane Wake, Chief Executive (DW)
Lowell Williams, Non-executive Director (LW)

In Attendance
Sudipta Banerjee, Clinical Service Lead, Consultant Obs. & Gynae. (SB) *[agenda item 10.5]*
Helen Board, Deputy Trust Secretary (Minutes) (HB)
Karen Brogan, Deputy Chief People Officer (KB)
Mike Fusi, CT1 Core trainee in anaesthetics *[agenda item 10.4]*
Simon Illingworth, Deputy Director of Operations
Claire McDiarmid, Head of Midwifery (CMc) *[agenda item 10.5]*
Andy Proctor, Director of Governance & Trust Secretary
Lucy Rozga, Matron Paediatrics and Neonates *[agenda item 7]*

Apologies
Liz Abbiss, Head of Communications (LA)
Thuvarahan Amuthalingham, Associate Non-executive Director (TA)
Gurjit Bhogal, Associate, Non-executive Director (GB)
Catherine Holland, Non-executive Director (CH)
Karen Kelly, Chief Operating Officer (KK)
Vij Randeniya, Non-Executive Director (VR)

Governors and Members of the Public and External attendees
Alex Giles, Public Elected Governor, Stourbridge
Sandra Harris, Public Elected Governor, Central Dudley
Maria Lodge-Smith, Public Elected Governor, Brierley Hill
Dr Atef Michael, Staff Elected Governor, Medical & Dental
Lizzy Naylor, Public Elected Governor, North Dudley
Thomas Parker, MNA Media / Express & Star
Yvonne Peers, Public Elected Governor, North Dudley
Cllr. Alan Taylor, Appointed Governor, Dudley Metropolitan Borough Council

22/33.0 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.

22/34.0 Declarations of Interest

Professor Elizabeth Hughes declared a new item to add to the register of interests noting she had recently been appointed Non-executive Director (quality) Birmingham and Solihull ICS.

22/35.0 Minutes of the previous meeting held on 18 May 2022

The minutes of the previous meeting were approved subject to the following amendments and clarifications:

- clarification that DW chairs the FTSU steering group
- item 22/25.3 National Staff Survey Results. First sentence should read ...'59% an increase of 13% on the previous year'

It was **RESOLVED**

- **That the minutes of the meeting be agreed subject to amendments given in the preamble to this minute**

All actions had been completed except for the following awaiting dates - 21/105, 22/09.1 and 22/25.5.

22/36.0 Chief Executive's Overview and Operational Update

DW summarised the report given as enclosure four noting that the initial plans to hold the meeting in a hybrid format (a mix of virtual and face-to-face) supported by appropriate technical solution had been reviewed and held in virtual format owing to the rising number of COVID-19 cases.

The number of inpatients with COVID-19 had seen an increase with 85 reported for that day. Community transmission rates had increased to 250/100k and noted that 67 staff were off with COVID-19 or COVID-19 related reasons. Mask wearing was attributed to reducing transmission and had been reintroduced in all areas of the Trust and noted good compliance.

Staff were commended for their resilience during the recent extreme heat wave and put on record her personal thanks for their efforts in continuing to deliver all planed work and providing the best care to all patients. Additional support had been made available to staff with mobile cooling units, regular distribution of bottled water and ice creams frequently made available.

The Trust's Restoration and Recovery activity had consistently achieved steady performance and reported no waiters at 104 weeks with good progress also made with reducing numbers of patients waiting 78 and 52 weeks. Cancer services were achieving the two week standard and noted that the 62 day was on trajectory for achieving target by March 2023. The provider collaborative continued to work very closely together providing mutual aid as needed to ensure that patients received the best care as quickly as possible.

Emergency department attendances had returned to pre-covid levels and presented an increasing challenge to ensure that patients flowed through the system. When the Trust had more than 40 patients classed as delayed transfer of Care (DTOC) this caused exit block and delayed admissions. In the last several months the Trust had more than a hundred DTOC patients daily and had seen some increase in the number of ambulance handover delays. The Trust continued to work closely with system partners to address the challenge and was working to create 'discharge to assess' pathways to reduce discharge delays.

The Trust had held its 14th Committed to Excellence awards to celebrate the achievements and innovations of staff and teams in the organisation and noted the positive media coverage.

Congratulations were noted in respect of Trust 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-19 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.

The Provider Collaborative Board Chaired by Sir David Nicholson continued to meet regularly to support trusts to plan towards working more efficiently. A series of clinical summits had recently been held providing an opportunity to hear from clinicians from each of the four acute providers. The Black Country were leading the way in collaboration to develop and share new ways of working.

Governor Maria Lodge-Smith asked if the new Rainbow Unit was working as planned to accommodate a 24 hr admission, then transfer to appropriate ward / department. DW confirmed that the new unit was supporting improved patient flow and noted that the upstairs areas were quite often holding patients longer that the 24 to 48 hours that the unit was designed for and hoped that there would be a real impact with the introduction of the 'discharge to assess' pathways.

In response the chairs request for clarification DW confirmed that up to one third of the Trust's bed base was occupied by delayed transfer of care (DTOC). The Trust continued to focus on initiatives in collaboration with local health and social partners with every effort made to do what was best for patients. She noted that Sandwell and Walsall had well embedded discharge to assess pathways and working to learn from them. GC commended the collaborative approach taken to share learning.

It was **RESOLVED**

- **That the report be noted**

22/37.0 Chair's Update

The chairman provided a verbal update. She announced that non-executive director (NED) Jonathan Hodgkin was to stand down at the end of July having been appointed in April 2018. She commended his chairing of the Finance and Performance Committee. The chairman extended grateful thanks for his commitment and dedication to the role. Following discussion with the wider NED cohort, Lowell Williams had agreed to chair the Finance and Performance Committee.

The chairman noted her thanks to Governor Mrs Helen Ashby who had stepped down in June 2022. Mr Alex Giles, public elected governor for Stourbridge had agreed to act as the interim lead governor until such time that elections had concluded.

The chairman noted the ongoing work of The Dudley Group within the Black Country ICS and, in particular, supporting activity recovery plans and Acute Collaboration. There was also an ongoing programme to improve integration and collaboration within Dudley Place. She noted the continuing good reputation of the Trust and its strong comparative performance. DW had recently attended a lunch engagement held in the Black Country where the former secretary state for health, Sajid Javid had commended the performance of The Dudley Group and its worthy achievements.

The chairman announced that she would step down from the role at the end of August 2022 and recorded her thanks for the support of the Board of Directors, Council of Governors, all Trust staff and the wider public and noted the achievements during the term of office. DW thanked the chair for her leadership over a difficult few years and commended her work in supporting her as CEO and the board with great leadership. LW noted that the challenge for the Board and Council would be to focus on the work in hand at what could be a vulnerable time when key personnel change.

22/38.0 Public Questions

There had been none submitted.

22/39.0 Patient Story – Paediatric Virtual Ward

The chairman welcomed Lucy Rozga, matron for paediatrics and neonatal. Matron Rozga introduced the presentation and gave context to the paediatric virtual ward and notable achievements of the initiative that included the CO_2 saved, reducing the Trust's the carbon footprint, reducing the patient's length of stay and opportunities to achieve admission avoidance. The presentation included two videos of families sharing their positive experiences of the virtual ward. The initiative was now subject to a rapid assessment by local commissioners to ascertain the learning and the benefits to share with the wider healthcare community which would include exploring its application to support neonatal care.

Those present commended the value of hearing the views of the families involved and noted the tangible benefits of saving time and money for families who now had no need to travel to and from the hospital and reducing pollution that often precipitates respiratory conditions.

LW asked if other trusts had adopted a similar care model and asked for more information at the strategic level and the parameters that had made it work so effectively. Matron Rozga confirmed that The Dudley Group was the first in the country to launch the model of care for paediatrics and were supporting others to set up similar initiatives. The approach would also benefit more widely during the winter months and had taken the time now to embed and use PDSA methodology to refine. Matron Rozga commended the Trusts Community Ward Outreach Team (CWOT) of nurses that had been fundamental to its development noting that the Trust had invested into the team and not all trusts operated a CWOT service.

JHo commented that the Trust had received a visit from the national NHSEI team who have commended the initiative and were keen to learn more about the recipe for success. He merited the IT support coupled with highly skilled clinical staff across acute and community settings that been able to leverage their skills. There was scope to develop this approach for 'step up' as well as a 'step down' initiative across other specialities.

AT observed that adopting digital solutions to support working in a different way was about the convergence of clinical expertise and the vision to design a solution. The Trust was committed to this approach and noted the importance of continual monitoring to support ongoing improvements and to share across the organisation the true value of doing something in a different way for improved patient outcomes.

MS confirmed that the service had worked closely with a lot of families and parents of children who are often well known to us noting the importance of ensuring that they felt safe with any innovation. She had been delighted with the amount of overwhelmingly positive feedback received.

22/40 GOVERNANCE

22/40.1 Audit Committee Report

GC summarised the upward reports from meetings held in May and June 2022. The May meeting had considered the concerns related to mandatory training compliance. There had been scrutiny of the losses that occurred during the year noting that there had been an increase in the final quarter related to the treatment of overseas visitors who had received emergency care and subsequently unable to recover the money. Positive assurances received where the internal Auditors were able

to confirm that the Trust had an adequate range of internal controls and concluded this opinion would be included in the subsequent year-end report.
Positive assurance was received at the June meeting from the external Auditors who had confirmed they would issue an unmodified opinion on the annual report and accounts and were able to report that the end of year accounts and letter representation would be submitted to the Board of Directors. Grant Thornton had gone out of their way to commend the work of the finance team positive noting the professional approach that had not been their experience at other organisations.

In response to the chairman's query whether the write offs were routine or exceptional, GC confirmed this was an unusual occurrence because of treating overseas visitors when it was the right thing to do.

It was **RESOLVED**

- **That the report be noted**

22/40.2 Board and Committee Effectiveness Review

AP summarised the report given as enclosure seven and highlighted the areas that had improved, comments received and the areas identified for improvement. Being new to the Trust, he would take the opportunity to discuss with board and council members to explore improvement opportunities to ensure that the right information is clearly available to support those who work as non-executives and governors.

The chairman noted that the findings would be taken in conjunction with the outcome of the DCO well-led review that provided good opportunities for continual board development.

It was **RESOLVED**

- **That the report be noted**

22/41.0 FINANCE AND PERFORMANCE

22/41.1 Finance and Performance Committee Report

JH summarised the report given as enclosure eight and highlighted the unrealistic cost improvement target that had been set that equated to £30m or 6%. The vast majority of cost improvement (CIP) delivery would occur in the second half of the year, increasing the risk of under delivery. The projected year-end cash forecast of £6.8m was consistent with CIP target of £24.5m and noted with concern that failure to deliver CIP could jeopardise the position. There had been a lack of engagement from facilities partner Mitie and progress on performance was required.

Governor Maria Lodge-Smith asked whether there had been an issue with provision of supplies to wards. She recounted that a patient had approached her about a shortage of ward curtains and subsequent lack of curtain changes. DW replied that there had been a misunderstanding because of a change of management. She added that board to board meetings between the Trust and Mitie had resumed to address several issues. MS commented that there where supplies issues had arisen, the procurements team had a robust system in place to source products aligned to the national procurement strategy.

The chair requested that Executive Directors provide regular updates to Board on progress with Mitie contract performance matters.

Action Executive Directors to provide regular updates to Board on progress with Mitie contract performance **Chief Executive**

Action report on savings attributed to the provider collaboration **Interim Director of Finance**

It was **RESOLVED**

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

22/41.2 Integrated Performance Dashboard

SI summarised the report given as enclosure nine and highlighted that the Trust was performing well with restoration and recovery and supporting other trusts with mutual aid.

DM01 (Diagnostic) performance was an improving picture and was expected to continue an upward trend owing to planned increases in endoscopy capacity. Performance against all emergency access standards remained challenging noting the ambulance handover delays of 60 minutes or greater had increased in May compared to April. There had been a significant increase in the number of patients 'self-presenting' at the emergency department. There was consistent effort by all teams across the Trust to focus on patient flow. Action plans were in place to support a range of initiatives to address the Delayed Transfer of Care issues and noted the development of discharge to assess pathway.

Challenges remained with 52-week recovery and restoration and noted an increase during May of the number of patients waiting more than 52 weeks. The surgery division was focused on productivity gains to improve throughput. Comparatively the Trust has the lowest number of 52 week breaches out of the 20 acute trusts in the region. Information was shared on screen illustrating the Trust's performance compared to other trusts in the midlands and east region. This information would be circulated after the meeting and included in future integrated performance reporting.

LW welcomed the tabular presentation of the comparison data that provided context and from which the board could draw assurance.

In response to the query raised by GC about plans to create a combined triage and Urgent Treatment Centre (UTC) SI advised that the Trust engaged in discussions with the commissioner and other stakeholders on this matter exploring the options for to bring the pathways together to work more effectively system wide.

Governor Alex Giles endorsed governor involvement to help with the patient expectations work relating to Primary Care to help the system level approach.

LH raised a query about how well the system worked as a whole to ensure that patients were directed to the most appropriate settings as per the NHSE guidance e.g., seeking help at a pharmacy and if there was consistent advertising to raise awareness. SI commented that there were both local and national campaigns and described the different streaming options available and the work underway to support the teams who support this.

The chair referenced the recent report about GP access across the country and asked if accessing GP services was an issue for patients in the Black Country. DW commented that Dudley had good primary care access compared to other places in the Black Country. When patients access expectations are not met the outcome was more attendances at emergency and urgent treatment centres.

The Home for Lunch initiative had seen a small number of wards achieving the 30% target set. The executive teamed continued to closely monitor progress. There was full support to maintain a focus on the initiative to build on the performance recognizing it would take time to embed.

It was **RESOLVED**

- **That the report be noted**

22/41.3 Charitable Funds Committee Report

JA provided an update on the work of the Charitable Funds Committee noting that the committee had given its support for a business case to purchase equipment to facilitate high volume cataracts clinics to take place with the potential benefit to support other local trusts. This would be funded by large legacy donation of £140k.

The Committee had agreed to spend charitable funds to support the development of a Well-being Hub for staff. Mrs Abbiss had reported good engagement from staff in respect of the design elements and noted that had been some delay experienced from Mitie. DW commented that the delays with Mitie were being followed up with the board-to-board performance meetings.

Since the 1 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. Individual fund managers were encouraged to spend more from those funds.

It was **RESOLVED**

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

22/41.4 7 Day Services Compliance

SI summarised the report given as enclosure 11 and highlighted Trusts achievements with progress against the prescribed standards.

JHo commented that the Trust continued to report positive outcomes for patients with low rates of mortality, length of stay and noted that readmissions were the lowest in the country. He commended the work completed on job planning to ensure services were robust noting that more to do on some of the diagnostic areas.

It was **RESOLVED**

- **That the report be noted**

22/42.0 QUALITY AND SAFETY

22/42.1 Quality and Safety Committee Report

LH introduced the report given as enclosure 12 and highlighted the positive assurances received related to the Trust's progress with immediate essential actions recommended by the Ockenden report. Improvements to perinatal review tool process were noted to meet the national requirements; the backlog of reviews had been addressed. Assurance received that the Trust remained compliant with duty of candour regulations and the process of managing national patient safety alerts.

The Committee received the Research and Development Annual Report and noted the excellent work at the Trust, the recent relaunch of the Research and Innovations Support Group and ongoing collaboration with Aston University.

Concerns had been considered relating to the challenges of embedding the electronic patient record (EPR) in maternity and noted the escalation steps taken to ensure that any potential safety issues were being addressed. Response times for answering complaints had seen some improvement but continued to miss the 30 days response time target. There was ongoing work to ensure that staff were wearing the radiation badges correctly to ensure safety.

The Committee continued to monitor improvements to pathology and diagnostic services performance. DW commented that there had been little improvement to turn around times from the Black Country Pathology Service (BCPS). The collaborative Cancer Board had requested and awaited a recovery action plan from the pathology service. Sandwell have adopted a good approach to labelling and were working with clinicians at the other three trusts to resolve the labelling of requests. This had been identified as contributing to a reduction in performance figures down. There would be additional clinical resource at BCPS from October and should see improvement.

In response to the concerns raised by the chair about escalation of EPR matters and potential patient safety issues, LH advised that the national team had raised a concern that the Trust was not using Badgernet in line with neighbouring trusts but accepted that he Trust had adopted the Trust wide patient information system for maternity. AT gave context to the issues that had arisen following the introduction of EPR in maternity and confirmed that all actions were complete. He noted that in the most recent meetings held with the department, staff had requested improving accessibility to information rather that a binary change. The patient information solution used by the Trust had received funding to ensure that it connected to other systems to link together. AT stated that he was not aware of any causal issues that could compromise patient safety. Staff were receiving further training. JHo noted the benefit of accessing patient data in a digital format compared to using paper records and noted that the clinicians can provide more support to identify the health information management aspect of the EPR. There was recognised benefits of EPR in relation to improved VTE, Sepsis and diabetes management.

It was **RESOLVED**

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

22/42.2 Chief Nurse Report

MS summarised the report and highlighted the following;

The Vaccination programme had 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 continued 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 had been launched by members of the safeguarding Team and colleagues from the Trust's 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 had seen an improvement of 2% (71%) in very good/good ratings since April.

The Paediatric Virtual Ward had 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 continued to face challenges with the registered nurse workforce vacancies. The current vacancy rates had a direct impact on the use of temporary staffing across the Trust. The deficit in unfilled shifts was routinely 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 was well underway and has seen over 60 recruits start with the Trust since April. They were working towards gaining their NMC registration to work independently.

In response to a question from the chair regarding the Trust's responsibility in running the Black Country BC vaccination programme, MS that it remained an operational area and was listed on the Trust's licence registration. AD commented that more information was expected soon to confirm arrangements about the service transfer to the system later in the year and would report back on progress at the next Board meeting. He confirmed that all staff registered on the vaccination staff bank would be offered the opportunity to join the Trust's staff bank. JH noted that the funding arrangements for the vaccination programme were set to change and could become a potential risk to the Trust and welcomed a timely resolution to the matter.

It was **RESOLVED**

- **That the report be noted**

22/42.3 Board Assurance Infection Control Framework

MS summarised the report given and enclosure 14 and confirmed that the Trust continued to achieve good performance against the required standards and noted there were no area on non-compliance and mitigations in place for those rated amber. Mask wearing had been re-instated and noted there were currently four outbreak areas in the Trust and confirmed that mitigations were in place to prevent transmission. The prevalent variants of COVID-19 are BA4 and BA5 where the latter remained asymptomatic for longer in a greater number of cases. Some challenges remain with the Mitie contract and work continued to work through the actions. Further guidance on the handling of outbreaks was expected with changes to reduce the onerous burden of documenting and investigating.

In response to the question from the chair about visiting arrangements as COVID-19 became more business as usual, MS responded that the Trust adopted a flexible and generous approach to visiting arrangements compared to other trusts and would keep under review.

GC referenced the section in the report relating to the requirements of lateral flow testing (LTF) and acknowledged the difficulty in its administration; he asked whether people were complying. MS replied that most of the public were actively engaging with the requirements noting it was unlikely to be addressed nationally and noted that the Trust kept testing requirements under continual review with the head of services and the Deputy Director of Infection Prevention and Control.

The chair asked if visitors are required to complete a lateral flow test. MS confirmed that they were not required to and only asked them to stay away if they are unwell. There is no national mandate on this. Some visitors were adamantly not wearing a mask and noted that the recent outbreak was linked to a visitor who was unwell and refused to wear a mask.

It was **RESOLVED**

- **That the report be noted**

22/42.4 Presentation – VTE assessment data
12:15 [Babar Elahi and Mike Fusi joined the meeting for this section]

Mr Elahi provided background and context to the requirements for VTE assessments for patients admitted for treatment. Mr Elahi introduced Mr Mike Fusi, CT1 Core trainee in anaesthetics who had led the project.

Mr Fusi provided an informative presentation that noted some challenges in VTE assessment performance where a dip against target had been identified and described the project undertaken to complete a full analysis. The conclusion of the project had identified a combination of issues related to data input, coding and data reporting; all of which had been addressed and noted the plans to re-audit in support continual improvement.

In response the question from Dr Michael about the data issues being limited to one area and not the wider hospital, Mr Fusi noted the affected groups and explained the way that coding of patients had affected the different types and there were certain groups that were targeted. Some of the elective admissions affected had been identified and data anomalies addressed noting they would be subject to future audit.

GC commented that he came from an improvement background and commended the project. On a wider point he queried the lack of evidence that improvement practice formed a key part of medical education and asked about the skills that Mr Fusi had applied to undertake the review and how had he been equipped. Mr Fusi replied that part of modern medical education required trainees to show and evidence skills related to improvement methodologies and noted that the project has honed his analytical capabilities. In response to a further question raised by GC, Mr Elahi replied that in his role as guardian of safe working, the learning had led him to query why the VTE assessment scores differed between surgery and medicine when junior docs rotated through both indicating that ongoing monitoring hoped to reveal causality. There had been no additional resources allocated to the project and gave credit to the junior doctors for their efforts over and above their work commitments. He noted that VTE assessments are a ‘must do’ and took time to describe the data collection issues.

GC asked how the trust might work to enable more projects like this and resource appropriately to support the Trusts aspiration for improvement at scale. AT commented that it had been a good use of clinical informatics and of the educational skills given and applied in a practical sense. He noted

that the reporting tools had been identified at the weak link and the data that was being pulled through.

Maria Lodge Smith emphasised the seriousness of VTE and the life changing outcomes for young and old patients. She asked whether staff still received VTE training. She suggested that the VTE assessment data be printed on the patient's wrist band noting it could easily be reprinted if the status changed during their admission. She noted that maternity patients are VTE assessed from start of pregnancy and reassessed if pregnancy risks change therefore emergency assessment would be a score readjustment and medical management as needed. LH confirmed that the Quality and Safety Committee had retained oversight of the matter and commended the improvement project and noted the assurance received that patients were receiving the appropriate assessments. The Trust was not an outlier on pulmonary embolism and had not represented a safety issue.

JHo affirmed the importance of both the initial assessment and reassessment of VTE and noted it was a dynamic process and he was not supportive printing it on a patient's wristband. The online dashboard showing this information was accessible to all who delivered patient care and was an efficient way of keeping up to date. He added that not all VTE 's were avoidable and assessment does not mitigate them 100%. The Trust compared favourably with most trusts with those in front limited to small specialist low volume, low risk patient cohorts. The Trust participated with Vital Signs initiative and had many junior doctors involved in the AQuA work and the training packages to drive the improvement

YB thanked Mr Fusi and his colleagues meriting it as an example of using data to drive improvement. Important for all trainees from foundation to junior to understand that the board has a keen interest to harness medics to drive improvement in other areas and cited patient flow. To maintain links, the chair extended an invitation to junior doctors to attend meetings of the board and the quality and safety committee.

22/42.5 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 15 and highlighted the progress made with perinatal reviews where the backlog had been cleared. The Trusts stillbirth rate remained below the national average. In respect of the neonatal data, there had been a change to the way data was reported and awaited the new national figures to see where the Trust benchmarked. Data was also awaited from the Local Maternity Neonatal System that would complete a review of where mothers gave birth and assess appropriateness.

Ms Banerjee provided an update on the Trusts progress for the assigned 15 Immediate and Essential Actions (IEA) arising from the Ockenden report. She summarised the seven that applied to the Trust and noted the performance and progress against the action plan. The national Hospital report was due in September and confirmed that the Trust's Ockenden Assurance Committee met monthly to monitor progress against the action plan with regular reports submitted to the Quality and Safety Committee.

Claire MacDiarmid provided an update on the continuity of carer scheme that had paused owing to staffing challenges. The Trust had submitted plans in June setting out the plan for re-establishment and summarised the building blocks given in appendix one of the reports. The plans had been co-produced with community staff and had involved midwives to ensure that allocations and rostering met the needs of service users and staff. Provisional plans were to re-establish the scheme in March 2023 and would await national guidance in light national staffing issues for actual scheduling.

The Trust was able to demonstrate good performance with the Saving babies lives initiative and described some of the ongoing work underway to support the assessment of babies.

A review of the Safe Staffing tool had completed earlier in the year that revealed the Trust was underfunded by 5wte midwives and confirmed that action plans were in place to address the shortfall. More information was given about the acuity tool and how it assessed the maternity resourcing in the unit versus the number of mothers and described the mitigations enacted to ensure patients were kept safe with the use of appropriately skilled nursing staff.

There were ongoing staff challenges owing to sickness absence and 24 WTE vacancies; this would be eased as several new candidates were due to commence in post September 2022.

Ms Banerjee stated that there were 13.6 WTE clinicians in post and reported that one locum had been appointed recently and two posts were to be advertised next month. Most of the lead roles suggested by Ockenden have been filled. She observed that the new job planning rota was running well and updated board on the recruitment processes being followed. All clinicians are adequately mentored to support sign off on competencies. There are no issues with sickness absence. The last assurance meeting was held in June had been attended by maternity safety champions. Issues had been raised relating to the sub-optimal neonatal unit footprint, staffing challenges and the impact of the delayed opening of the new maternity unit at Sandwell. and staff challenges. Maternity user feedback was also considered in respect of opening visiting to more family members.

LH noted her role as maternity champion and added that the meetings were also useful to contemplate any issues raised on the walk arounds she conducted accompanied by the chief nurse. They had become known as the ‘dynamic duo’ and were on a mission to ensure that all staff knew who they were, that they are being heard and any concerns raised are being addressed including those less essential issues that can all add up and affect the team. MS observed a significant step change in the number of staff wanting to have conversations. She noted that the maternity multi-disciplinary team had commended the support of the Dudley Improvement Practice Team in reviewing the induction and neonatal pathways.

JA commended the report given and asked about the impact of improvements to IT in the department. Claire MacDiarmid acknowledged that some of the hardware and Wi-Fi issues had been addressed in a timely manner. Ms Banerjee confirmed that actions to address EPR issues were underway to modify and make it more user friendly. JA commented that the length of time to complete reviews and investigations following a baby bereavement, some taking up to 12 months, was distressing for parents and asked what the Board could do to help. Ms Banerjee described the process and noted that short staffing nationally was the primary and all steps were being taken by the central team to address the backlog. LH concurred adding that the shortage of specialist neonatal pathologists resulted in some areas with no service at all and gave the example of Northern Ireland who were contracting with UK based services for post mortems. The focus was on encouraging staff to go into this very specialist area of medicine and cited several recruitment and retention initiatives.

DW noted that the rollout of the Continuity of Carer scheme remained a concern at national level linked to staffing challenges. She observed that the corporate risk registers would need to reflect the obstetric medical staffing issues and asked that this be addressed. To provide some assurance she requested that the December maternity report include the trajectory and recruitment action plan with clearly stated mitigations.

Action Future Maternity reports to include recruitment action plan and trajectory **CM, SB**

It was **RESOLVED**

- **That the report be noted**

22/43.0 WORKFORCE

22/43.1 Workforce and Staff Engagement Committee Report

JA summarised the report on the last three meetings that had been held in the intervening period. The May meeting had been a deep dive that had focussed on the Clinical Support Services Division. The Division had worked with the Dudley Improvement Practice and the Organisational Development Team and the committee had been pleased to note that they were developing their own leadership style. Positive improvements were reported for the Imaging Department in relation to vacancy rates and sickness levels and good feedback scores from recent surveys.

The had been an extraordinary meeting of the Committee in June to specifically look at three key areas of mandatory training: moving and handling, resuscitation and safeguarding where compliance had been an ongoing matter for concern. Closer scrutiny would be applied until such time that significant improvement was seen.

At main meeting in June it was noted that shift fill rates had improved as had mandatory training compliance. Some concern was expressed about staff wellbeing and assurances were received that staff were being signposted to help that was available. There was a positive report received about the Kickstart programme designed to help young people on universal credit to get into work. The Trust had hosted 24 who had completed a placement of which 10 had got full time employment, 10 had gone on to fulltime education with Health Education England and two had signed up to the Trust's staff bank.

It was **RESOLVED**

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

22/43.2 Workforce KPIs

AD summarised the report given as enclosure 17 and highlighted the following items:

The vacancy rate was currently 14% with all efforts in play to reduce and lessen the impact on service provision and reduce agency/bank use and support wellbeing of staff. The reporting of the metrics and tracking of the trajectory leavers v joiners was under review. There had been a reduction in sickness absence adding that there was significant fluctuation owing to COVID-19.

Bank and agency had reduced with spend increasing indicating that rates had increased. Plans were underway to increase the availability of bank staff.

A National pay award that adopted a tapered approach depending on banding had been announced earlier in the week providing an average of 4-5% uplift backdated to April which would be reflected in the September pay. Confirmation of the consultant award details were awaited.

In response to the chairs request for comparative sickness absence and vacancy rates for the four local providers, AD advised that there were plans to develop a reporting tool to illustrate this. He advised the Royal Wolverhampton carried approximately 7% vacancies that compared well to the average of around 11%. Sickness absence indicated that Dudley was in the middle of the pack.

GC welcomed the opening comment of adding a trajectory to closing the vacancy gap. He asked what the strategic level view of workforce planning at national and trust level. AD commented that nationally there was poor planning and there was a need to understand demand linked to future service provision and what that would look like in 3 - 5 years' time. The default applied currently

locally and nationally was to recruit to what was needed now. He noted that the pathway development work underway across the collaboration should underpin this going forward.

JA recounted that strategic planning had been the central topic of discussion at a recent meeting of the provider collaborative Workforce Committee chairs attended by chief people officer and had identified the key challenges of recruiting to stand still to address turnover, close the vacancy gap and seeing where the service was going strategically and the gap/changes that would bring. The was commitment across the Black Country to work together to work to address this collectively.

Staff Elected Governor Dr Michael asked if the Trust completed an analysis comparison of retention by division to reflect different cultures. AD noted that there was some raw data available that helped to identify hotspots and noted work underway to explore how the ESR system could be developed to produce the accurate data to monitor.

It was **RESOLVED**

- **That the report be noted**

22/44.0 DIGITAL

22/44.1 Digital Trust Technology Committee

Adam summarised the report given as enclosure 18 that highlighted the key items for upward reporting for the meetings held in March, May and July. He highlighted the following.

The Trust's Electronic Patient Record (EPR) had been reviewed to assess against the revised national guidance that had set out a fund matching deal. The Trust had prepared a bid for submission subject to prescribed governance arrangements. Subsequently, the funding had been diverted to support national pay deal. The review had revealed that the Trust was ahead of the pack in terms of updates to software used. There was a full sign up to the shared care record across all providers in the midlands. Public Elected Governor Alex Giles endorsed the consensus amongst the providers to support the shared care record

The Trusts Digital Teams had been nominated and shortlisted for the Committed to Excellence awards taking place later that day. He commended their hard work and noted the staffing challenges faced by the team.

The strategic business case had launched for transition to the public cloud and was monitored by the Committee. The Board would soon be at a critical decision point about the funding for the transition to the cloud and noted the affordability challenge to mitigate.

He was pleased to note a regular attendance at committee meeting by both board and council members. There had been deep dive into the digital portfolio to prioritise the digital project delivery programme.

It was **RESOLVED**

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

22/45.0 Any other Business

There was none raised.

22/46.0 Reflections on the meeting

The meeting had included robust discussions on a range of topics adding to the clarity of understanding of the risks and challenges faced by the Trust. There was also acknowledgement of the achievements to celebrate. The chair thanked governors and the press for their continued support and attendance.

22/47.0 Date of next Board of Directors Meeting

The next meeting would be held on Thursday 22 September 2022.

22/48.0 Meeting Close

The chair declared the meeting closed at 13:55hr.

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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 21 July 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 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**
22/09.1	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
22/25.5	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	October 22	Workforce Inclusion and Culture Lead to prepare in advance of October Workforce meeting
22/41.1	Finance & Performance Committee Report	Executive Directors to provide regular updates to Board on progress with Mitie contract performance	Chief Executive	Ongoing	Included in performance updates via F&P
22/41.1	Finance & Performance Committee Report	Report on savings attributed to the provider collaboration	Interim Director of Finance	November 2022	
22/42.5	Maternity Report	Future Maternity reports to include recruitment action plan and trajectory	MacDiarmid/ S Banerjee	September 2022	Included in report **Complete**

Enclosure 4

The Dudley Group NHS Foundation Trust

Paper for submission to the Board of Directors on 22nd September 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:

- Her Majesty Queen Elizabeth II
- Operational Performance
- Reducing Long Waits
- Covid 19 and Changes to PPE (Mask Wearing)
- Winter vaccines
- New Chairman Starts
- Eye Injection First
- Staff Survey Shortlisted for HSJ Award
- Fraud Culture Survey
- Charity Update
- Healthcare Heroes
- Provider Collaborative
- Dudley Partnership Board Options
- Patient Feedback
- Visits and Events

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

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

Build innovative partnerships in Dudley and beyond	✓
Improve health and wellbeing	✓

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

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

CHIEF EXECUTIVE'S REPORT – PUBLIC BOARD – 22nd September 2022

Her Majesty Queen Elizabeth II

On behalf of The Dudley Group NHS Foundation Trust and our Trust board, I would like to express my heartfelt condolences to the Royal Family on the sad passing of Her Majesty Queen Elizabeth II. Her Majesty was a devoted public servant who acknowledged the importance of our work when she awarded the NHS the George Cross earlier this year. I would like to offer my warmest support to His Majesty King Charles III who has ascended to the throne.

Operational Performance

Elective restoration and recovery remains strong; during August, the Trust continued to deliver against the national requirement to ensure zero 104 week+ breaches for patients waiting for routine procedures, placing the Trust joint 1st among the 20 Midlands Trusts. Reducing the 78+ week plus backlog by March 2023 remains the focus of the operational divisions, with progress being made in August; long waits in this category are down 18% on July 2022 placing the Trust 7th of 20 regional acute Trusts. Ensuring a timely service remains a priority and to this end, the Trust delivered the 4th shortest waiting times in the Midlands region last month. Reducing the number of patients waiting 52-78 weeks remains a challenge, with a small rise in such waits in recent weeks. However, progress is being seen at speciality level, particularly within the large volume speciality of General Surgery. Additional capacity is due to come online in September with the opening of 2 new Minor Procedure Room facilities, which will provide additional capacity to meet elective and cancer demand.

Cancer treatment remains a priority for the organisation; the cancer 2 week wait target was achieved for 2 months this summer. Overall, the number of patients over 62 days remain higher than trajectory, however, 5 tumour sites are performing ahead of their improvement plans. Clearance of patients waiting over 104 days to commence treatment remains the priority. UEC remains under considerable pressure.

Reducing Long Waits

We have received regional recognition for our dedicated commitment and focus for reducing the longest waits for our patients in the Black Country. Through the hard work of our clinical and operational teams, our longest waiting patients are either treated or on a pathway to be treated. Post the COVID pandemic, we continue to work collaboratively with colleagues across the system to support our recovery of elective, cancer and diagnostic services.

Covid 19 and Changes to PPE (Mask Wearing)

As the community rate for COVID has come down, staff, patients and visitors do not routinely need to wear facemasks in non-clinical areas of the Trust including corridors and offices. Mask wearing is still required in all clinical areas, including wards and outpatient areas.

All outpatients attending for lung function tests, respiratory clinic and Same Day Emergency Care (SDEC) with respiratory symptoms will be asked to wear a facemask. All other outpatients are not required to wear a facemask unless this is a personal preference.

Masks also remain available at the entrances to the hospital for those who wish to continue using them. We appreciate the easing of mask wearing requirements marks a significant change for both our staff and our patients and we need to continue to support each other during this time.

Infection prevention and control is a priority at the Trust, and all staff and visitors will be expected to continue to maintain good hand hygiene.

Winter Vaccines

Our winter vaccination programme for staff launched on Monday 12th September with our staff COVID booster programme. This will be an opportunity for all staff to keep their patients, friends and loved ones safe during the coming winter and we are encouraging them all to take the opportunity to get their free booster vaccine early. Our staff flu vaccine will be available at the end of September when staff will be able to have one appointment for both vaccinations if they wish too.

New Chairman Starts

Sir David Nicholson joined the Trust as chairman on 1 September 2022. He is also currently chairman of Sandwell and West Birmingham Hospitals NHS Trust, having taken up his position there in May 2021.

Sir David Nicholson's career in NHS management has spanned more than 40 years and included the most senior posts in the service. He was Chief Executive of the NHS for seven years from 2006-2013 and then, following a major national restructure, became the first Chief Executive of the organisation now known as NHS England from 2013-2014.

Since his retirement from the NHS in 2014, he has taken on a number of international roles providing advice and guidance to governments and organisations focused on improving population health and universal healthcare coverage.

He has worked in China, Brazil, the USA, Europe and the Middle East, independently, and in association with the World Health Organisation, and World Bank. Sir David chaired the State Health Services organisation of the Republic of Cyprus and more recently was also the chair of the Metropolitan Group of Hospitals, Nairobi.

Sir David is Chair of the Universal Health Coverage Forum of the World Innovation Summit for Health. Other roles include adjunct Professor of Global Health at the Institute of Global Health Imperial College, Advisor to the British Association of Physicians of Indian Origin and Lancet Commissioner to Global Surgery.

His contribution to healthcare was recognised by the award of the CBE in 2008, and he was knighted by Her Majesty the Queen in 2010. He lives in Worcestershire with his wife and two children.

Our former chairman Dame Yve Buckland left the Trust to focus on her role as chairman of Birmingham and Solihull Integrated Care Board. I would like to thank Yve for the contributions she has made to the Trust during her three and a half years as chairman.

Eye Injection First

Our consultant ophthalmic surgeon Mr Shahzad Shafquat was pleased to announce the launch of a new drug that helps our retina patients maintain vision with around half of them requiring an injection every four months after a loading dose.

The novel Intra Vitreal injection, Faricimab, is the first Anti-VEGF A plus ANG 2 receptor blocker to be approved by NICE.

It is licensed for use in both Wet Age-related Macular Degeneration (ARMD) and Diabetic Macular Oedema. These two conditions account for around 56 per cent of all blindness and partial sighted registrations in the United Kingdom (340,000 total - RNIB, September 2021).

This comes after Mr Shafquat launched Brolucizumab in April 2021 becoming the first NHS hospital in the East and West Midlands region to offer it as an alternative to conventional therapies.

Staff Survey Shortlisted for HSJ Award

We have been shortlisted for a Health Service Journal (HSJ) NHS Communications Initiative of the Year award for their “Engaging staff for a better future: NHS Staff Survey” project in which volunteers queued for members of staff waiting to be served in the restaurant while they completed their staff survey.

The collaborative Trust-wide project was supported closely by our communications team, HR and Learning and Development colleagues. It enabled the Trust staff survey return rate to go from 46 per cent to our highest ever figure of 59 per cent which is fundamental in ensuring we can make Dudley the very best place to work and thrive.

This incredible 13 per cent rise was one of the largest increases across all 217 NHS trusts involved in the survey and compares to an overall average increase of 2 per cent in response rates.

The HSJ Awards will take place on the 17th November 2022.

Fraud Culture Survey

Fraud is estimated to cost the NHS more than £1 billion each year - enough money to pay for over 40,000 staff nurses, or to purchase over 5,000 frontline ambulances. Many will be shocked to learn that some people, fortunately a small minority, seek to gain by targeting taxpayer funds that are meant for patient care – particularly at a time when NHS resources are under significant pressure. To gain a better insight into our staff’s tolerance to fraud, and how they feel about how the Trust responds to allegations, we asked them to complete a fraud culture survey. We are encouraging as many staff as possible to complete it.

Charity Update

Superhero Run

The Superhero Fun Run is taking place on Sunday 2nd October. The run starts at 11am and those taking part will be joined by some of the Trust’s virtual London marathon runners who will begin their 26.2 miles marathon distance, completing their first 5k at Himley Hall. A local company Collective Fitness will start the day with a warmup session.

We welcome people of all abilities, and anyone is free to either run or walk the event. Tickets are £10 per adult and £5 per child and can be purchased through this link: 5k Superhero Fun Run | Dudley Group NHS Charity (enthuse.com)

London Marathon 2022

Hollie Murphy, deputy matron for surgery, urology and vascular, will be running in person for the Trust charity in London on Sunday 2nd of October 2022. She is aiming to raise £2,000 for the Trust charity.

Our virtual runners are aiming to raise £500 each for the charity. They include medical director Julian Hobbs, community nurse Matthew Welch and therapy lead for musculoskeletal and trauma and orthopaedics lead Louise Brooks. External runners include Connor McManus, founder and head coach from Collective Fitness and Martin Lopez, director of communications, media and marketing from the Windsor Education Trust.

Glitter Ball 2022

Last year the Dudley Group NHS Charity brought together local businesses in a post-COVID celebration and networking event at the Copthorne Hotel in Brierley Hill. The event raised over £10,000 from the sponsorship, table packages, raffle, and auction.

The Glitter Ball is back on 24th November 2022 and businesses from across the Black Country will have the opportunity to hear from some of our staff and network with other like-minded businesses. The event is a great opportunity for them to celebrate Christmas parties this year whilst giving back to our Trust Charity Thank You Appeal.

We are looking for a few last sponsors and companies to take a table at the event. If businesses are interested, please contact Nithee on nithee.kotecha@nhs.net

Healthcare Heroes

Individual Award – June

Simon Gregory was June's individual Healthcare Hero. He has made a great impact on theatres. Since becoming matron, staff morale has gone up. His teamwork and leadership skills are amazing, and he always makes an effort to understand and appreciate the workload of everyone who works in theatres. Simon is a fantastic example of a great manager and an exemplary leader and has made such a positive change to the culture in the department. Simon takes the time to listen to his staff, has an open-door policy and is very approachable. No problem is too small, he treats everyone fairly and takes on board the needs of the staff to make the department a nicer place to work.

Provider Collaboration – Strengthening Collaboration Across the Black Country

Black Country Provider Board's have been asked to receive, note and acknowledge some key strategic work undertaken by the Provider Collaborative on strengthening partnership working across the system. Please see attached at Appendix 1.

Dudley Partnership Board Options

At its July meeting, the Dudley Partnership Board received a copy of the partnership paper for organisation boards, and we are asked to note the contents and endorse the recommendations of the partnership board.

Patient Feedback

B4 - The day-to-day care from nursing and other staff was excellent. The treatment I received was also excellent.

B6 - Staff were very caring and understanding of my mom's dementia. Her dignity was always maintained and staff always kept us well informed. So grateful for all they have done for us and mom.

C4 Oncology- Prompt and courteous service provided by all staff. Lovely surroundings in Georgina Ward. I felt fully informed of all my ongoing treatment and had no concerns about asking questions.

Day Case Unit - All the staff from reception, CSWs, nurses, Drs etc were very friendly and attentive. They made me very comfortable and at ease. I could not have wished for it to go any better! Thank you to you all.

FAA (Frailty Assessment Area)- my grandfather received excellent care on FAA staff were friendly and attentive to his needs and were able to stabilise him during his angina attack, not only supporting him but supporting his family also we cannot thank you all enough for supporting his individual needs and for updating us regularly on his care plan.

General Community: I was seen on time and made to feel very welcome, the treatment I received was conducted in a very professional and friendly manner and would like to thank everyone involved.

GI Unit- An excellent experience, everyone was very kind and friendly. The whole procedure was explained very well. The procedure was painless, and it was very informative to be able to watch the whole procedure on screen which was interpreted for me in a way I could understand. I was given great advice on how to deal with my condition and treated with great respect and dignity throughout. Many thanks.

GUM Clinic: All staff were great as and they provided a private space to wait every time without any indication that it was a problem. Nurses were excellent at taking bloods with tricky veins and they were patient and caring.

Neonatal- Everyone that cared for my daughter has been amazing. They were all very friendly and gave the best care that they could. It was very appreciated. Thank you all :)

Orthopaedics (nurse)- I felt that the clinician really cared about the effects of the operation on me. She was really interested in how I felt about the whole procedure. I was able to reassure her that everything was positive, including the fact that it had certainly improved my quality of life.

Visits and Events

19th July 2022	**King's Fund- Building Collaborative Leadership across Health and Care Organisation**
21st July 2022	**Board of Directors**
21st July 2022	**Committed to Excellence Awards**
27th July 2022	**Trust Management Group**
4th August 2022	**Black Country Provider Collaborative- Executive Meeting – Chaired Meeting**
5th August 2022	**Live Chat**
10th August 2022	**Black Country Provider Collaborative Clinical Leads Meeting – Chaired Meeting**
19th August 2022	**Live Chat**
24th August 2022	**Healthcare Heroes Presentation**
25th August 2022	**Board Visit Pensnett- FMC, Centafile, PNC, and AAA**
26th August 2022	**Healthcare Heroes**
5th September 2022	**Integrated Care Board Development Session, Molineux Stadium**
6th September 2022	**Black Country Provider Collaborative Board – Chaired by Sir David Nicholson**
6th September 2022	**The Dudley Group NHS Foundation Trust: GIRFT Critical Care Deep Dive**
9th September 2022	**Colorectal Away Day**
13th September 2022	**West Midlands Imaging Network Board Away Day, Hagley Gold Club – Deputy Chair**
14th September 2022	**Black Country Quarterly System Review Meeting**
21st September 2022	**High Reliability Actions Board Workshop**

Black Country Provider Collaborative

Report to the Sovereign Boards of the BCPC

Subject: Strengthening Collaboration across the Black Country

Date: 22nd September 2022

Report from: Black Country Provider Collaboration Board

1. PURPOSE

1.1 To share with Board members of the four sovereign Trusts the output of recent discussions on strengthening collaboration and obtain approval from each sovereign Board on the recommendations made by the Black Country Provider Collaborative Board.

2. BACKGROUND

2.1 Our environment is changing and has recently seen the establishment of Integrated Care Systems/ Partnership/ and Board (ICS, ICB & ICP) underpinned by Provider Collaboratives, Place Based Partnerships, Primary Care Networks and more in the new architecture (see appendix A for summary overview).

2.2 The Black Country Provider Collaborative (BCPC) sits as part of the delivery infrastructure of the ICS and the four Acute providers have been working collaboratively on a range of quality and service improvement initiatives since late 2020.

2.3 In building better relationships and trust between the four partners, it is anticipated that the opportunities presented for us to innovate and build on through best practice models in addition to addressing those collective issues (e.g. CQC ratings) with which we are dissatisfied, aligned with our focus on quality and service improvement, will begin to have a natural impact that will lead to questions of form, and whether the existing arrangements (of four independent organisations) remain a 'fit for purpose' vehicle as we move forward.

2.4 Against this context the regulator (NHSE) are paying close attention to the emergent 'target operating models' of the ICB and in turn the PC so that it can understand the implications for service change providing guidance, support, and approval whilst ensuring a level of assurance that is compliant with the NHSE *'Assurance for managing service change'*.

2.5 This interest has led to more frequent inquiries to key leaders within the Black Country Acute care sector on what the vision for a possible 'end-state' for acute care across the Black Country may be, and any short-term steps that may be taken to support the journey and ambition.

2.6 Under normal circumstances, determining form may not be the optimal course to pursue, with 'form' emanating from an understanding of the key drivers for change, current operating model, vision for the future, and the development of a target operating model amongst other processes.

2.7 However, the issue of 'future form' has taken on a level of importance which necessitated the development of a *Discussion Paper* (for the Provider Collaborative Board) focused

solely on this issue, that would in turn be a key foundational component of our forthcoming work on a '*Case for Change'*.

2.8 In short, this *Discussion Paper* described:

a. The background to the establishment of the Black Country Provider Collaborative
b. The positive journey and progressive work that has been undertaken since its establishment in late 2020
c. The recent governance refresh that has been undertaken to ensure it remains current
d. The context behind refreshing the 'case for change' soon
e. Some suggestions on possible options for future form
f. An insight into some key drivers, opportunities, and options for a way forward
g. Recommendations for consideration
h. An outline of a range of imminent engagement activities should the Programme Board deem it necessary.

2.9 Key extracts of this 'Discussion Paper' are provided in Appendix B.

3. PROPOSED WAY FORWARD

3.1 At their recent meeting on the 28th June the Provider Collaborative Board discussed and reviewed the range of issues presented within the paper by the BCPC Senior Responsible Officer (SRO). Amongst the key discussion points were:

- An acknowledgement of the progressive journey that the 4 partners have taken since late 2020.
- Analysis of the Provider Collaborative policy agenda as part of the emerging healthcare architecture with integration and collaboration central facets.
- The recognition of the range of drivers within the healthcare environment that are influencing and shaping the provision of care and how health care provision is optimally organised for the future.
- The important role that acute care will drive to deliver improvements in unwarranted variation, inequalities in health outcomes, access to services and experience.
- The positive focus on Clinical Service Improvement through the Clinical Networks, which will support delivery of access times, opportunities to 'level up', and pursue opportunities for specialisation and consolidation.

3.2 Against this context several options on a vision for 'future acute care form in the Black Country' were presented, discussed, and considered. These included (descriptions of each provided in Appendix B, section 2):

Short to medium term aspirations

a. Consolidating around existing statutory arrangements
b. North & South Black Country system model (retaining Trust Boards)
c. Shared Chair with existing statutory arrangements (retaining Trust Boards)
d. Single Hospital system – across multiple sites
    i. Site Group Model
    ii. Service Group Model

Longer term possible aspirations

e. Black Country system Acute, Mental Health & Learning Disabilities care provider
f. Black Country ACO / Integrated Health organisation

g. Black Country Integrated Health & Social Care Board

3.3 The discussion paper proposed the following:

i. that the BCPC should work towards developing an agreed model that could be implemented over the next 36 months, and possibly focus on Option (b) '***North & South Black Country system model***' in the first instance.

ii. At an appropriate time, in maximising the opportunities afforded by the new Health & Care Act, a longer-term end-state vision for consideration may be that of option (f) an ***'Black Country ACO / Integrated Health Board'*** which could incorporate all types of health providers enabling a more integrated system.

3.4 Discussion by the Black Country Provider Collaboration Board concluded with the following key Agreements:

a. It was agreed that with the current Chair of Dudley due to step down in the summer, a single Chair for DGFT and SWBH would be pursued. This has now been confirmed with Sir David Nicholson being appointed as of the 1st September 2022.

b. It was agreed that a subsequent step would be to pursue a single unified Chair for the Acute sector in the Black Country at the appropriate time, and in establishing this arrangement that 'anchor organisations' at Place would most likely have a 'Deputy Chair' in a Group Model arrangement, a model that is being explored and adopted in many places around the country (see Appendix B, section 3.7).

c. It was agreed that this approach would be articulated in a short paper for presenting to all Board members of the four Acute Providers simultaneously in private prior to presentation at a public board meeting.

d. It was agreed that an engagement plan would be urgently developed, to ensure good communications and engagement with all stakeholders.

3.5 It should be recognised that no changes to Trust Board sovereignty are being proposed, and with 'Place Based Partnerships' being a key vehicle for local delivery, Trusts will retain a very strong local focus in the future healthcare delivery and provision model.

3.6 This is something that we are actively working on with our colleagues in the ICB as part of the work on a future 'target operating model' and will be further expanded upon in our forthcoming work on a 'Case for Change'.

4. RECOMMENDATIONS

4.1 Sovereign Trust Boards are asked to:

a. Note the circumstances which have led to key discussions and this report

b. Receive and note the contents of this report as identified in 3.4 (c) above.

c. Discuss and review at the next sovereign Trust Board, the approach proposed by the Black Country Provider Collaborative Board, outlined at 3.4 and confirm / provide support for this proposal to the Black Country Provider Collaborative SRO and Programme Director

5. CONTACT DETAILS

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BCPC Programme Director
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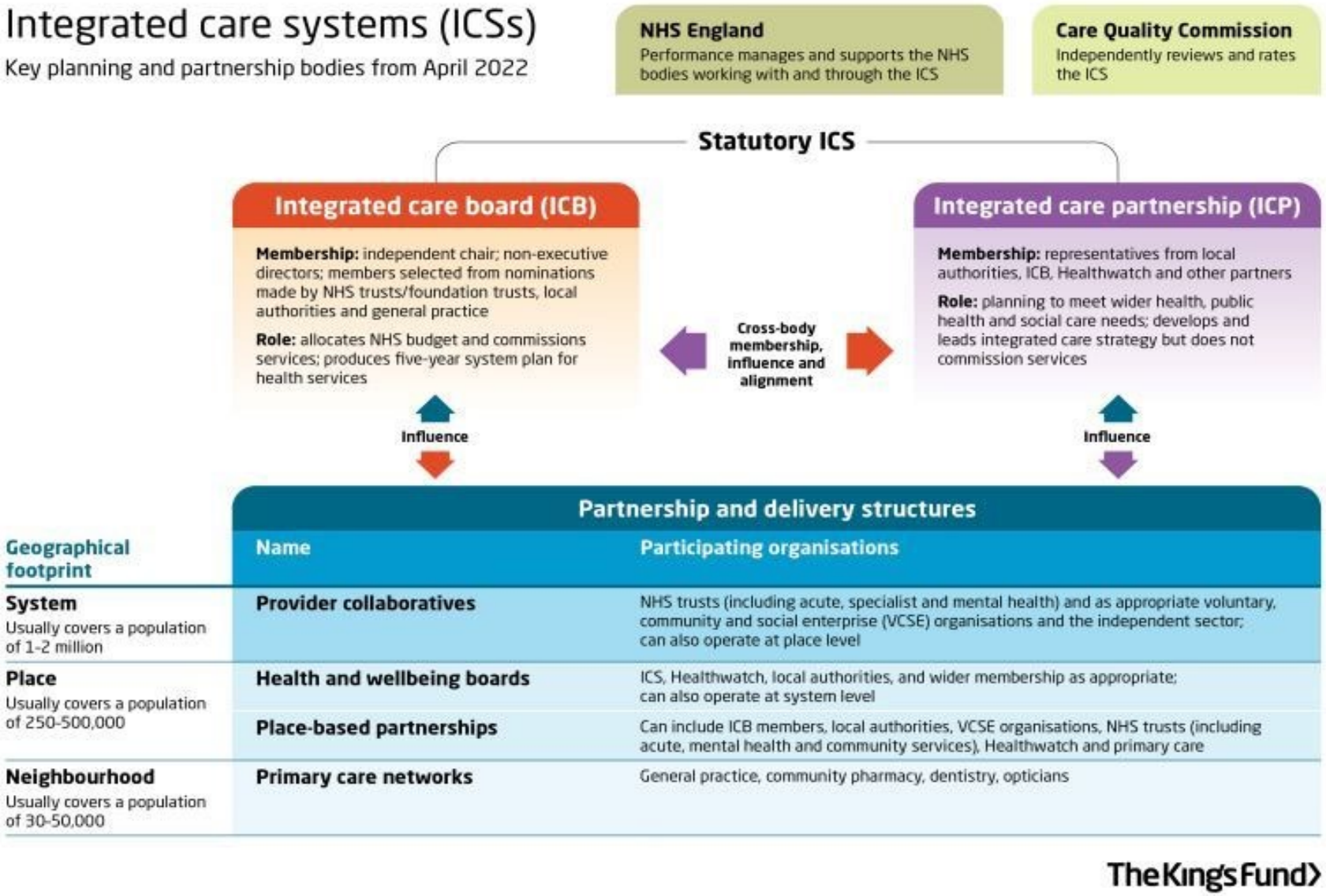
Appendix A – Our changing environment



Appendix B – Key Extracts from the Discussion Paper

1. DEVELOPMENT OF A 'CASE FOR CHANGE'

1.1 At the Collaboration Executive meeting in April a '*Special Governance*' only agenda was formulated seeking legal advice on the form of a Provider Collaborative which was presented by the legal firm Brown & Jacobson and highlighted the need to consider discussions centred around the end state form.

1.2 The guidance was helpful in outlining the 'art of the possible' and shared a model of seven different types of form for a Provider Collaborative (see Appendix C), which at one extreme was a 'loose arrangement' increasing in complexity through 'tight agreements' and at the other extreme 'mergers'.

1.3 Whilst the guidance may have been provided for a variety of Provider Collaborative forums, there are key principles within which are likely to be very relevant to any future organisational form for the Black Country Acute sector, especially as improvements in quality challenge the way in which the Acute sector is currently organised and prompting the question as to whether current form is 'fit for the future'.

1.4 Against the context of the legal advice sought and recent policy guidance (Provider Collaborative Toolkit – which outlines a range of governance models and some broad criteria for establishing a 'case for change'), a significant piece of work that the BCPC is beginning to focus its attention on is the development / refresh of its 'case for change'.

1.5 Our experiences have shown that a mere focus on a 'clinical case for change' will be inadequate for our needs as the impact of pursuing quality, innovation, improvement, and system resilience opportunities will inevitably lead to questions of whether 'organisational form' across the Black Country is 'fit for purpose' as the current form may become both less effective and inefficient to operate (with the current leadership and management arrangements) in an environment which from a clinical service perspective may look considerably different.

1.6 The broader context of the ICS must also not be underestimated as it begins to establish its 'target operating model', within which it will begin to identify its goals and priorities (drawing on NHS Operational delivery standards, and both the CQC and NHS Oversight regulatory frameworks) within a 'mandate' for progression in both the short and longer term.

1.7 In moving forward, it is unlikely that a desired end point form will be settled on within this financial year, but that should not deter partners within the BCPC from at least considering the options, especially considering forthcoming ICS discussions on the development of an 'Operating Model'.

1.8 Experience has also shown that any change journey towards a new 'form' is one which requires maturation over a longer gestational period with socialisation and engagement on the concept and thus worthy of early consideration.

1.9 Consequently, as we begin to build for our refresh of the clinical case for change, we are mindful of the need to also ensure that additional parameters may necessitate a broader 'case for change', something we hope to be guided on by the Collaboration Board and be taking a pro-active approach on over the summer period.

1.10 Any ‘case for change’ will need to navigate several gateways internally within the BCPC including sovereign Boards and the ICB, and there is likely to be a need to navigate the NHSE ‘*Assurance Process for managing service change*’ (May 2022) which will require an extensive range of engagement.

2. SOME POSSIBLE OPTIONS FOR FORM

2.1 Given the context outlined above, there are a number of options that emerge and would warrant more thorough exploration prior to any formality commencing. These include some traditional models such as:

Short-medium term possible aspirations

a. Consolidating around existing statutory arrangements
This would maintain the ‘status quo’ with each of the four acute partner organisations retaining their statutory ‘sovereign’ status, and a firmer Partnership arrangement would be established to ensure more cohesion and common purpose in the collaborative working.

b. North & South Black Country system model *(retain Trust Boards)*
With a joint leadership and governance arrangement in place in the North of the System (RWT and WHT), a similar arrangement could be considered for the South of the BCPC system (DGFT and SWBH), ensuring a better degree of resilience through strengthening leadership arrangements and as a minimum the appointment of a shared Chair.

c. Shared Chair with existing statutory arrangements *(retain Trust Boards)*
A further version of consolidating around existing arrangements may be through a shared Chair that could be appointed by March 2023 to some / all 4 Providers to further develop the cohesion and collaboration, and consistent strategic leadership.

d. Single Hospital system - across multiple sites
An advanced step would be to consolidate into a single hospital organisation across the Black Country, establishing a system leadership team, and with multiple possible options which may include (not an exhaustive list):

i. Site Group Model
A site leadership team led by a Managing Director and a range of directors could be established to ensure that services at the facility level were optimally and effectively run. This essentially would be a ‘vertical’ managerial form.

ii. Service Group Model
A service leadership team led by a number of clinical ‘Chiefs’ (supported by a range of business partners) would work across the multiple sites in a matrix fashion within their Clinical Specialty domain.

This would be a ‘horizontal’ leadership form, and something that is deployed with success where geographies are small, facilities are few, and clinical leadership is the preferred model of operations.

Longer-term possible aspirations

2.2 Subject to further guidance and confirmation of what legislation may allow there are some additional creative and innovative system models which are present and evident

from international healthcare environments over and above the obvious NHS approaches worth exploring more. These would include:

e. Black Country system Acute, Mental Health & Learning Disabilities care provider

In addition to all 4 current Acute providers merging, the possible integration of the Mental Health & Learning Disabilities provider would add a further layer of service integration, and an opportunity to look at a wider range of holistic care.

f. Black Country ACO / Integrated Health Organisation

A vertically integrated healthcare system across the Black Country, which would see all provision from Primary & Community care, through Secondary care (including Tertiary & Quaternary services where appropriate), Ambulance and Mental Health care all under one 'umbrella' organisation.

This is a model that is seen in parts of Scotland, Wales (Health Boards) and Canada (Regional or Provincial Health Authorities), and the emerging environment of Integrated care does lend itself well to this possibility.

g. Black Country Integrated Health & Social Care Board

In addition to the 'Integrated Health Organisation' at point (e) above, there is the possibility of pursuing a total system wide health & social care integration across the Black Country, incorporating both Adult Social Care and Children's Services as a bare minimum.

2.3 Of course, there is not just a linear approach to a future form, and several of these options may be 'stepping-stones' on the journey towards the desired 'end organisational state' with some of these options not yet politically palatable locally. Therefore, an incremental approach over several years may be a necessary consideration.

3. KEY CONSIDERATIONS & OPTIONS FOR A WAY FORWARD

3.1 With the continued interest from our Regulator (NHSE), it is important that the BCPC establishes a vision for a 'future state' identifying any logical and key steps along the way.

3.2 There are a range of drivers and opportunities which may necessitate the serious consideration of the 'future state organisational form', and include (in no particular order):

Drivers

- Diminishing availability of new (& existing) workforce (skill mix) necessitating a consolidation (leading to better service resilience) and specialisation (leading to the development of '*Centres of Excellence*') of services across the Black Country.
- A strong focus on moving away from the long embedded competitive environment to that of a collaborative one, improving relationships and trust across the four providers through partnership working and the pursuit of joint agendas across the established Clinical Networks.
- Building on the positive collaborative working through the pandemic period in addition to supporting each other through such initiatives as 'mutual aid'.
- The pursuit of clinical improvement ('levelling up' and harmonisation) and innovation (new models of care) with the aim to improve equity and reduce health inequalities for our patients through standardisation of care and reduction of unwarranted variance

repositioning the organisation of our services across the four sites more optimally ensuring that the right skill mix is in the right place to deliver the best care for the population, as safe as possible.

- Currently a less than optimal CQC rating at three of the four Acute Providers with a critical mass enabling the pursuit of a higher and consistent rating across the Black Country.
- The development of a 'target operating model' by the ICB in which both Provider Collaboratives and Place Based partnerships are to play an important role, in addition to on-going discussions regarding future delegated responsibilities and resources.
- Greater opportunities for productivity and efficiencies across a range of corporate services, through shared service arrangements (minimising the costs – resource and workforce – across systems and processes).

Opportunities

- Building on the shared leadership and working arrangements currently being pursued between Royal Wolverhampton NHS Trust and Walsall NHS Trust
- Identifying opportunities to consolidate when terms of the Chair and NEDs naturally come to their conclusion
- Consider alternative options when there is a departure (retirements or pastures new) within leadership team especially at the CEO and Executive team level.
- Explore the opportunity to integrate the PBPs' as a vehicle for local delivery within a newly organised provider landscape, where 'provider led commissioning' and 'commissioning led provision' will become a more symbiotic healthcare function.

3.3 A robust range of criteria needs to be utilised within our thinking as we consider this question of form, and may include considerations such as:

- ***Ambition*** - Is our ambition for a future form consistent with those of the BC ICB and aligned with the freedoms of the new H&C Act?
- ***Collaboration*** - Will our way forward enable greater collaboration as opposed to reinforcing the competitive culture that exists?
- ***Integration*** - Does our proposed way forward support better integration?
- ***Scale*** - Are there greater economies of scale?
- ***Best Interests*** - Does our future form act in the best interests for the BC population?
- ***Geography*** - Does our way forward align with or suit our geography?
- ***Resilience*** - Does our preferred way forward sustain service resilience?

3.4 In briefly analysing the range of options presented in section 7, it becomes evident that options (a) and (g) are at opposite ends of the continuum (and possibly the least palatable options), whereas all other options are increasing variants (from b to f) of an integrated form.

3.5 It is therefore proposed that the BCPC should work towards developing an agreed model that could be implemented over the next 36 months, and possibly focus on Option (b) '***North & South Black Country system model***' in the first instance.

3.6 Furthermore, in maximising the opportunities afforded by the new Health & Care Act, a longer-term end-state vision for consideration may be that of option (f) an ***'Black***

Country ACO / Integrated Health Board' which could incorporate all types of health providers enabling a more integrated system.

3.7 In progressing these proposed options, some of the suggested key steps on the journey may include:

Short term (within 12 months)

- Consolidate arrangements at the north end of the Black Country patch by pursuing opportunities to further integrate RWT and WHT.
- With the impending departure of the Chair at DGFT, take the opportunity of appointing a joint chair for the South of the Black Country patch.
- Align 'target operating models' with the ICB to ensure that appropriate responsibilities and mandates are agreed to enable the successful move towards a desired and agreed upon future end-state.
- Engage the regulator (NHSE) to ensure buy in and support for the desired end-state.

Medium term (12 to 24 months)

- Look to review arrangement for a single Chair across the Black Country as current terms come to an end.
- Work through a 'management of change' process which would seek '*Operational Chairs'* for each site together with a localised executive leadership model.
- Commence engagement with PBPs and possibly wider (Primary & Community Care, MH & LD) functions to subsequent integration.

Longer term (25 to 36+ months)

- Work with colleagues in Primary & Community Care and MH&LD organisations to establish an Integrated Health Organisation across the BC ICS.

3.8 It should be recognised that the challenges for both NHS Trusts and NHS Foundation Trusts vary, and legal advice will be required to clarify any disestablishment process in addition to the 'vehicle' within which any new entity is established.

4. COLLABORATION BOARD MEMBERS & KEY CONTRIBUTORS

BCPC Board Members

Sir David Nicholson (CBE), Chair BCPC & SWBH
Dame Yve Buckland, Chair DGFT
Dr. Steve Field, Chair RWT & WHT
Mrs. Diane Wake, SRO BCPC & CEO DGFT
Prof. David Loughton, CEO RWT & WHT
Mr. Richard Beeken, CEO SWBH
Dr. Jonathan Odum, CMO BCPC & RWT
Mr. Sohaib Khalid, Programme Director, BCPC

Key Contributors

Mr. David Baker, Chief Strategy Officer, SWBH NHST
Mr. Simon Evans, Chief Strategy Officer, RWT NHST
Ms. Kat Rose, Director of Strategy & Partnerships, DGFT

GLOSSARY OF TERMS

ACC	Acute Care Collaborative
ACO	Accountable Care Organisation
APC	Acute Provider Collaborative
BCPC	Black Country Provider Collaborative
BCWB	Black Country & West Birmingham
CEO	Chief Executive Officer
CQC	Care Quality Commission
DGFT	Dudley Group NHS Foundation Trust
ED	Emergency Department
FC	Football Club
HOSCs	Health & Overview Scrutiny Committees
HR	Human Resources
ICB	Integrated Care Board
ICP	Integrated Care Partnership
ICS	Integrated Care System
IT	Information Technology
NHS	National Health Service
NHSE / I	National Health Service Executive / Improvement
OD	Organisational Development
PC	Provider Collaborative
PMO	Programme Management Office
RWT	The Royal Wolverhampton NHS Trust
SRO	Senior Responsible Officer
SWBH	Sandwell & West Birmingham NHS Trust
WHT	Walsall NHS Trust

Appendix C – Options for developing provider collaboratives *(Brown & Jacobson)*

Loose Arrangements		Tight Agreements				Merger
Working Group	**Joint Committee**	**Contractual Joint Venture**	**Corporate Joint Venture**	**Lead Provider**	**Shared /Joint Leadership**	**Single Provider/ Merger**
Leadership Board	Leadership Board	JV partnership board	JV corporate board of directors	Main Contract held by lead NHS provider	Shared / Joint leadership structure	Governance and legal advice required to determine feasibility
MoU	MOU / Collaboration Agreement	Contractual JV agreement which mimics corporate joint venture approach	Articles of Assoc / Constitution	Alliance / consortium agreement	Same person or people lead each provider involved	Will need to demonstrate patient benefit
ToR for Board	ToR for joint committee	Services Agreement	Members Agreement	Sub contracts between lead provider and other NHS / non-NHS providers	Boards of NHSTs or FTs appoint same person to multiple posts	Heads of Terms
Individual exercise of delegated authority	Collective exercise of delegated functions	Principally a mechanism for service delivery	Services Agreement	Principally a mechanism for service delivery	Enables aligned or virtual (but not actual) joint decision making	Due Diligence Questionnaire
Shared information to discuss relevant matters.	Shared information to discuss relevant matters.	Can permit joint decision making on JV management	Principally a mechanism for service delivery	Can permit joint decision making on alliance / consortium management		Due Diligence Report
Individuals make decision for their own organisation	Joint decisions by unanimous or majority voting		Can permit joint decision making on JV management			Interim Management Agreement
Aligned decision making but not shared decision making	Shared decision-making for joint approach to collaboration		NB restricted NHS trust powers			Transaction Agreement
						Dissolution Order / Transfer Order

Enclosure 6

The Dudley Group NHS Foundation Trust

Paper for submission to the Board of Directors on 22 September 2022

Title:	**Board Assurance Framework**
Author:	Andy Proctor Trust Secretary
Presenter:	Andy Proctor Trust Secretary

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

The Board is asked to note the current BAF position as set out in the Board Assurance Framework and its current development direction.

Summary of Key Issues:

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

The Board of Directors formally approved the refreshed Trust Strategy during 2021 and a subsequent board development session was held on the 29 June 2022. The proposed development suggestions and direction were discussed and considered which provided the direction of the development of the BAF to its current position.

After further development and due consideration at each of the Board committees with assigned BAF oversight, the attached document provides a summary of the current BAF which went to Audit committee on the 12 September 2022.

Each BAF risk now clearly sets out the inherent risk score, residual risk score and the target risk score. Also key controls, the gaps in those key controls and the mitigating actions for those gaps are clearly articulated now in each BAF risk.

Each committee receives their individual BAF risks scheduled throughout the year tabled by the Executive lead for that risk. The Audit Committee receives all of the BAF risks along with the attached summary BAF high level table showing the current position on one page as it did on 12 September 2022.

As agreed at the last Audit Committee the Committees will now start to articulate their assurance levels for each BAF risk. A risk appetite session is being held in November 2022 to further review and discus the BAF risks and our risk appetite.

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

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

Report Journey/ Destination *(if applicable)*	Working / Exec Group	Y	Date: 08/03/22
	Committee	Y	Date: various dates – Aug/Sept 2022
	Board of Directors	Y	Date: 20/04/22
	Other	N	Date:

Summary Board Assurance Framework (BAF): September 2022

The key elements of the BAF are:

- A description of each Principal (strategic) Risk, that forms the basis of the Trust's risk framework (with corresponding corporate and operational risks defined at a Trust-wide and service level)
- Risk ratings – Inherent, current (residual), and target levels
- A statement of risk appetite for each threat and opportunity, to be defined by the Lead Committee on behalf of the Board

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

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

Likelihood score	**1**	**2**	**3**	**4**	**5**
Descriptor	**Rare**	**Unlikely**	**Possible**	**Likely**	**Almost certain**
Frequency How often might it/does it happen	This will probably never happen/recur	Do not expect it to happen/recur but it is possible it may do so	Might happen or recur occasionally	Will probably happen/recur but it is not a persisting issue	Will undoubtedly happen/recur, possibly frequently

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

Risk scoring = consequence x likelihood (C x L)

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

ID	Area	Risk Description *What might happen if the risk materialises*	Lead Exec	Lead Committee	Last Reviewed	Inherent Risk score *(Consequence x Likelihood)*	Current Residual Risk score *(Consequence x Likelihood)*	Target Risk Score *(Consequence x Likelihood)*	Risk Appetite
1	Patient Outcomes	Systemic failure to deliver safe, effective and high quality care which will impact on patient outcomes and patient Safety Experience	Chief Nurse & Medical Director	Quality and Safety	Aug 2022	**25** (5x5)	**16** (4x4)	**12** (4x3)	**Moderate**
2	Workforce	Failure to increase workforce capacity sufficiently to deliver operational requirements and strategic priorities	Chief People Officer	Workforce & Staff Engagement	Aug 2022	**25** (5x5)	**20** (5x4)	**10** (2 x5)	**Moderate**
3	Staff satisfaction	Failure to improve and sustain staff satisfaction and morale	Chief People Officer	Workforce & Staff Engagement	Aug 2022	**15** (3x5)	**12** (3x4)	**8** (2x4)	**Moderate**
4	Finance	Failure to reduce cost to better than England average	Director of Finance	Finance and Performance	Aug 2022	**20** (4x5)	**20** (4x5)	**12** (4x3)	**Moderate**
5	Environmental	Failure to achieve carbon reduction emissions in line with trajectory	Director of Finance	Finance and Performance	Aug 2022	**25** (5x5)	**16** (4x4)	**8** (2x4)	**Cautious**
6	Partnerships	The Trust fails to deliver on its ambition to build innovative partnerships in Dudley and beyond	Director of Strategy	Finance and Performance	Aug 2022	**16** (4x4)	**12** (3x4)	**8** (2x4)	**Open**
7	Operational Performance	Failure to achieve operational performance requirements and deliver strategic goals	Chief Operating Officer	Finance and Performance	Aug 2022	**25** (5x5)	**20** (5x4)	**12** (4x3)	**Moderate**
8	IT and Digital Infrastructure	IF DGFT does not establish, invest and sustain, the resources, infrastructures, applications and end-user devices for digital innovation THEN the Trust's operational performance and strategic objectives will not be delivered or risk major disruption in the event of a cyber-attack	Chief Information Officer (CIO)	Digital and Technology	Aug 2022	**25** (5x5)	**20** (4x5)	**8** (2x4)	**Moderate**

Enclosure 7

The Dudley Group NHS Foundation Trust

Paper for submission to the Board of Directors on 22nd September 2022

Title:	Emergency Planning Core Standard (EPRR)
Author:	Luke Lewis - Head of Corporate Resilience
Presenter:	Karen Kelly - Chief Operating Officer

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

Recommendations:

To approve the Trusts submission in relation to the NHS Commissioning EPRR Core Standards as issued by NHS England for 2022.

Summary of Key Issues:

Annually the Trust is expected to submit its Core Standards pertaining to EPRR in order to demonstrate to commissioners and regulators that we have in place suitable and sufficient plans and processes linked to EPRR. These standards are formed from key requirements in relation to the Civil Contingencies Act 2004, Health and Social Care Act 2012 and the EPRR Framework as well as other associated guidance and frameworks.
The trust continually strives to improve its EPRR arrangements ensuring our organisation and staff are suitably prepared for any potential incident(s). Due to changes within the team the trust will be reporting a self-assessment of Substantial Compliance for 22/23, the team however has developed a robust workplan to ensure the Trust is fully compliant within 6 months.
It evidences the ongoing work and engagement by the organisation in relation to the EPRR programme of work. There are however several standards that were identified in relation to requiring improvement, and whilst we could not evidence full compliance, these standards had some degree of work and evidence to allow the Trust to score them partially complaint with plans in place to progress, which is indicated below:

- EPRR exercising and testing programme- due to COVID and changes within the team there has not been a tabletop exercise run in the past 12 months at DGH, this will be planned to be completed within 6 months to test the evacuation and shelter plan at the trust. This will be supported with a full training and exercising schedule aligned to the National Occupational Standard

- Decontamination capability availability 24 /7

- Staff training – decontamination

In relation to decontamination capability the follow has been put in place to improve compliance.

- First ED CBRN Awareness Training Session has taken place where 21exisitng members of staff were identified to undertake the training in this first cohort of training, with a plan to capture more ED staff to further increase compliance in a collaboratively coordinated manner with the department.

- 4 members of Corporate Resilience have completed suit training, with a further two members of ED staff. This has increased the number fop train the trainers within the Trust.
- Compliance projected to increase to 59 by end of training of first cohort.
- Live Practical Training Exercises to take place through October with ED and AMU.
- 21 newly recruited members of ED staff have been identified to be trained in CBRN from September onwards once in post.
- Extended CBRN Training to be given by Team to identified International Nurses.
- AMU staff to also undertake further training to increase resilience.

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

The Core Standards status is important to the trust, and a programme of work is in place to ensure improvement against those standards as requiring further work which will be reported to the Finance and Performance Committee to provide assurance.

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)	**N**
Build innovative partnerships in Dudley and beyond	**Y**
Improve health and wellbeing	**Y**

Implications of the Paper:			
Risk	Y	Risk Description: *OPS1481 COVID 19 Pandemic* *OPS1450 No Deal EU Exit could affect supply chain and workforce, affecting the ability to provide safe/effective services*	
	On Risk Register: Y	Risk Score: OPS1481 Major OPS1450 Minor	
Compliance and/or Lead Requirements	CQC	N	Details:
	NHSE/I	Y	Details: NHS England EPRR Core Standards
	Other	Y	Details: Civil Contingencies Act 2004 EPRR Framework 2015 Health and Social Care Act 2021 NHS Standard Contract Section 46 & 47 ISO 22301 & 22313

Report Journey/ Destination *(if applicable)*	Working / Exec Group	N	Date:
	Committee	Y	Date: Quality & Safety Aug 22
	Board of Directors	Y	Date: 22/09/22
	Other	N	Date:

Ref	Domain	Standard name	Standard Detail	Acute Providers	Supporting Information - including examples of evidence
1	**Governance**	**Senior Leadership**	The organisation has appointed an Accountable Emergency Officer (AEO) responsible for Emergency Preparedness Resilience and Response (EPRR). This individual should be a board level director within their individual organisation, and have the appropriate authority, resources and budget to direct the EPRR portfolio.	Y	Evidence • Name and role of appointed individual • AEO responsibilities included in role/job description
2	**Governance**	**EPRR Policy Statement**	The organisation has an overarching EPRR policy or statement of intent. This should take into account the organisation's: • Business objectives and processes • Key suppliers and contractual arrangements • Risk assessment(s) • Functions and / or organisation, structural and staff changes.	Y	The policy should: • Have a review schedule and version control • Use unambiguous terminology • Identify those responsible for ensuring policies and arrangements are updated, distributed and regularly tested and exercised • Include references to other sources of information and supporting documentation. Evidence Up to date EPRR policy or statement of intent that includes: • Resourcing commitment • Access to funds • Commitment to Emergency Planning, Business Continuity, Training, Exercising etc.

Ref	Domain	Standard name	Standard Detail	Acute Providers	Supporting Information - including examples of evidence
3	Governance	EPRR board reports	The Chief Executive Officer ensures that the Accountable Emergency Officer discharges their responsibilities to provide EPRR reports to the Board, no less than annually. The organisation publicly states its readiness and preparedness activities in annual reports within the organisation's own regulatory reporting requirements	Y	These reports should be taken to a public board, and as a minimum, include an overview on: • training and exercises undertaken by the organisation • summary of any business continuity, critical incidents and major incidents experienced by the organisation • lessons identified and learning undertaken from incidents and exercises • the organisation's compliance position in relation to the latest NHS England EPRR assurance process. Evidence • Public Board meeting minutes • Evidence of presenting the results of the annual EPRR assurance process to the Public Board • For those organisations that do not have a public board, a public statement of readiness and preparedness activitites.
4	Governance	EPRR work programme	The organisation has an annual EPRR work programme, informed by: • current guidance and good practice • lessons identified from incidents and exercises • identified risks • outcomes of any assurance and audit processes The work programme should be regularly reported upon and shared with partners where appropriate.	Y	Evidence • Reporting process explicitly described within the EPRR policy statement • Annual work plan
5	Governance	EPRR Resource	The Board / Governing Body is satisfied that the organisation has sufficient and appropriate resource to ensure it can fully discharge its EPRR duties.	Y	Evidence • EPRR Policy identifies resources required to fulfil EPRR function; policy has been signed off by the organisation's Board • Assessment of role / resources • Role description of EPRR Staff/ staff who undertake the EPRR responsibilities • Organisation structure chart • Internal Governance process chart including EPRR group

Ref	Domain	Standard name	Standard Detail	Acute Providers	Supporting Information - including examples of evidence
6	Governance	Continuous improvement	The organisation has clearly defined processes for capturing learning from incidents and exercises to inform the review and embed into EPRR arrangements.	Y	Evidence • Process explicitly described within the EPRR policy statement • Reporting those lessons to the Board/ governing body and where the improvements to plans were made • participation within a regional process for sharing lessons with partner organisations
7	Duty to risk assess	Risk assessment	The organisation has a process in place to regularly assess the risks to the population it serves. This process should consider all relevant risk registers including community and national risk registers.	Y	• Evidence that EPRR risks are regularly considered and recorded • Evidence that EPRR risks are represented and recorded on the organisations corporate risk register • Risk assessments to consider community risk registers and as a core component, include reasonable worst-case scenarios and extreme events for adverse weather
8	Duty to risk assess	Risk Management	The organisation has a robust method of reporting, recording, monitoring, communicating, and escalating EPRR risks internally and externally	Y	Evidence • EPRR risks are considered in the organisation's risk management policy • Reference to EPRR risk management in the organisation's EPRR policy document
9	Duty to maintain plans	Collaborative planning	Plans and arrangements have been developed in collaboration with relevant stakeholders to ensure the whole patient pathway is considered.	Y	Partner organisations collaborated with as part of the planning process are in planning arrangements Evidence • Consultation process in place for plans and arrangements • Changes to arrangements as a result of consultation are recorded
10	Duty to maintain plans	Incident Response	In line with current guidance and legislation, the organisation has effective arrangements in place to define and respond to Critical and Major incidents as defined within the EPRR Framework.	Y	Arrangements should be: • current (reviewed in the last 12 months) • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required

Ref	Domain	Standard name	Standard Detail	Acute Providers	Supporting Information - including examples of evidence
11	Duty to maintain plans	Adverse Weather	In line with current guidance and legislation, the organisation has effective arrangements in place for adverse weather events.	Y	Arrangements should be: • current • in line with current national UK Health Security Agency (UKHSA) & NHS guidance and Met Office or Environment Agency alerts • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required • reflective of climate change risk assessments • cognisant of extreme events e.g. drought, storms (including dust storms), wildfire.
12	Duty to maintain plans	Infectious disease	In line with current guidance and legislation, the organisation has arrangements in place to respond to an infectious disease outbreak within the organisation or the community it serves, covering a range of diseases including High Consequence Infectious Diseases.	Y	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required Acute providers should ensure their arrangements reflect the guidance issued by DHSC in relation to FFP3 Resilience in Acute setting incorporating the FFP3 resilience principles.

Ref	Domain	Standard name	Standard Detail	Acute Providers	Supporting Information - including examples of evidence
13	Duty to maintain plans	New and emerging pandemics	In line with current guidance and legislation and reflecting recent lessons identified, the organisation has arrangements in place to respond to a new and emerging pandemic	Y	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required
14	Duty to maintain plans	Countermeasures	In line with current guidance and legislation, the organisation has arrangements in place to support an incident requiring countermeasures or a mass countermeasure deployment	Y	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required Mass Countermeasure arrangements should include arrangements for administration, reception and distribution of mass prophylaxis and mass vaccination. There may be a requirement for Specialist providers, Community Service Providers, Mental Health and Primary Care services to develop or support Mass Countermeasure distribution arrangements. Organisations should have plans to support patients in their care during activation of mass countermeasure arrangements. Commissioners may be required to commission new services to support mass countermeasure distribution locally, this will be dependant on the incident.

Ref	Domain	Standard name	Standard Detail	Acute Providers	Supporting Information - including examples of evidence
15	Duty to maintain plans	Mass Casualty	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to incidents with mass casualties.	Y	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required Receiving organisations should also include a safe identification system for unidentified patients in an emergency/mass casualty incident where necessary.
16	Duty to maintain plans	Evacuation and shelter	In line with current guidance and legislation, the organisation has arrangements in place to evacuate and shelter patients, staff and visitors.	Y	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required
17	Duty to maintain plans	Lockdown	In line with current guidance, regulation and legislation, the organisation has arrangements in place to control access and egress for patients, staff and visitors to and from the organisation's premises and key assets in an incident.	Y	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required

Ref	Domain	Standard name	Standard Detail	Acute Providers	Supporting Information - including examples of evidence
18	Duty to maintain plans	Protected individuals	In line with current guidance and legislation, the organisation has arrangements in place to respond and manage 'protected individuals' including Very Important Persons (VIPs),high profile patients and visitors to the site.	Y	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required
19	Duty to maintain plans	Excess fatalities	The organisation has contributed to, and understands, its role in the multiagency arrangements for excess deaths and mass fatalities, including mortuary arrangements. This includes arrangements for rising tide and sudden onset events.	Y	Arrangements should be: • current • in line with current national guidance in line with DVI processes • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required
20	Command and control	On-call mechanism	The organisation has resilient and dedicated mechanisms and structures to enable 24/7 receipt and action of incident notifications, internal or external. This should provide the facility to respond to or escalate notifications to an executive level.	Y	• Process explicitly described within the EPRR policy statement • On call Standards and expectations are set out • Add on call processes/handbook available to staff on call • Include 24 hour arrangements for alerting managers and other key staff. • CSUs where they are delivering OOHs business critical services for providers and commissioners

Ref	Domain	Standard name	Standard Detail	Acute Providers	Supporting Information - including examples of evidence
21	Command and control	Trained on-call staff	Trained and up to date staff are available 24/7 to manage escalations, make decisions and identify key actions	Y	• Process explicitly described within the EPRR policy or statement of intent The identified individual: • Should be trained according to the NHS England EPRR competencies (National Minimum Occupational Standards) • Has a specific process to adopt during the decision making • Is aware who should be consulted and informed during decision making • Should ensure appropriate records are maintained throughout. • Trained in accordance with the TNA identified frequency.
22	Training and exercising	EPRR Training	The organisation carries out training in line with a training needs analysis to ensure staff are current in their response role.	Y	Evidence • Process explicitly described within the EPRR policy or statement of intent • Evidence of a training needs analysis • Training records for all staff on call and those performing a role within the ICC • Training materials • Evidence of personal training and exercising portfolios for key staff

Ref	Domain	Standard name	Standard Detail	Acute Providers	Supporting Information - including examples of evidence
23	Training and exercising	EPRR exercising and testing programme	In accordance with the minimum requirements, in line with current guidance, the organisation has an exercising and testing programme to safely* test incident response arrangements, (*no undue risk to exercise players or participants, or those patients in your care)	Y	Organisations should meet the following exercising and testing requirements: • a six-monthly communications test • annual table top exercise • live exercise at least once every three years • command post exercise every three years. The exercising programme must: • identify exercises relevant to local risks • meet the needs of the organisation type and stakeholders • ensure warning and informing arrangements are effective. Lessons identified must be captured, recorded and acted upon as part of continuous improvement. <u>Evidence</u> • Exercising Schedule which includes as a minimum one Business Continuity exercise • Post exercise reports and embedding learning
24	Training and exercising	Responder training	The organisation has the ability to maintain training records and exercise attendance of all staff with key roles for response in accordance with the Minimum Occupational Standards. Individual responders and key decision makers should be supported to maintain a continuous personal development portfolio including involvement in exercising and incident response as well as any training undertaken to fulfil their role	Y	<u>Evidence</u> • Training records • Evidence of personal training and exercising portfolios for key staff

Ref	Domain	Standard name	Standard Detail	Acute Providers	Supporting Information - including examples of evidence
25	Training and exercising	Staff Awareness & Training	There are mechanisms in place to ensure staff are aware of their role in an incident and where to find plans relevant to their area of work or department.	Y	As part of mandatory training Exercise and Training attendance records reported to Board
26	Response	Incident Co-ordination Centre (ICC)	The organisation has in place suitable and sufficient arrangements to effectively coordinate the response to an incident in line with national guidance. ICC arrangements need to be flexible and scalable to cope with a range of incidents and hours of operation required. An ICC must have dedicated business continuity arrangements in place and must be resilient to loss of utilities, including telecommunications, and to external hazards. ICC equipment should be tested in line with national guidance or after a major infrastructure change to ensure functionality and in a state of organisational readiness. Arrangements should be supported with access to documentation for its activation and operation.	Y	• Documented processes for identifying the location and establishing an ICC • Maps and diagrams • A testing schedule • A training schedule • Pre identified roles and responsibilities, with action cards • Demonstration ICC location is resilient to loss of utilities, including telecommunications, and external hazards • Arrangements might include virtual arrangements in addition to physical facilities but must be resilient with alternative contingency solutions.
27	Response	Access to planning arrangements	Version controlled current response documents are available to relevant staff at all times. Staff should be aware of where they are stored and should be easily accessible.	Y	Planning arrangements are easily accessible - both electronically and local copies

Ref	Domain	Standard name	Standard Detail	Acute Providers	Supporting Information - including examples of evidence
28	Response	Management of business continuity incidents	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to a business continuity incident (as defined within the EPRR Framework).	Y	• Business Continuity Response plans • Arrangements in place that mitigate escalation to business continuity incident • Escalation processes
29	Response	Decision Logging	To ensure decisions are recorded during business continuity, critical and major incidents, the organisation must ensure: 1. Key response staff are aware of the need for creating their own personal records and decision logs to the required standards and storing them in accordance with the organisations' records management policy. 2. has 24 hour access to a trained loggist(s) to ensure support to the decision maker	Y	• Documented processes for accessing and utilising loggists • Training records
30	Response	Situation Reports	The organisation has processes in place for receiving, completing, authorising and submitting situation reports (SitReps) and briefings during the response to incidents including bespoke or incident dependent formats.	Y	• Documented processes for completing, quality assuring, signing off and submitting SitReps • Evidence of testing and exercising • The organisation has access to the standard SitRep Template
31	Response	Access to 'Clinical Guidelines for Major Incidents and Mass Casualty events'	Key clinical staff (especially emergency department) have access to the 'Clinical Guidelines for Major Incidents and Mass Casualty events' handbook.	Y	Guidance is available to appropriate staff either electronically or hard copies
32	Response	Access to 'CBRN incident: Clinical Management and health protection'	Clinical staff have access to the 'CBRN incident: Clinical Management and health protection' guidance. (Formerly published by PHE)	Y	Guidance is available to appropriate staff either electronically or hard copies

Ref	Domain	Standard name	Standard Detail	Acute Providers	Supporting Information - including examples of evidence
33	Warning and informing	Warning and informing	The organisation aligns communications planning and activity with the organisation's EPRR planning and activity.	Y	• Awareness within communications team of the organisation's EPRR plan, and how to report potential incidents. • Measures are in place to ensure incidents are appropriately described and declared in line with the NHS EPRR Framework. • Out of hours communication system (24/7, year-round) is in place to allow access to trained comms support for senior leaders during an incident. This should include on call arrangements. • Having a process for being able to log incoming requests, track responses to these requests and to ensure that information related to incidents is stored effectively. This will allow organisations to provide evidence should it be required for an inquiry.
34	Warning and informing	Incident Communication Plan	The organisation has a plan in place for communicating during an incident which can be enacted.	Y	• An incident communications plan has been developed and is available to on call communications staff • The incident communications plan has been tested both in and out of hours • Action cards have been developed for communications roles • A requirement for briefing NHS England regional communications team has been established • The plan has been tested, both in and out of hours as part of an exercise. • Clarity on sign off for communications is included in the plan, noting the need to ensure communications are signed off by incident leads, as well as NHSE (if appropriate).

Ref	Domain	Standard name	Standard Detail	Acute Providers	Supporting Information - including examples of evidence
35	Warning and informing	Communication with partners and stakeholders	The organisation has arrangements in place to communicate with patients, staff, partner organisations, stakeholders, and the public before, during and after a major incident, critical incident or business continuity incident.	Y	• Established means of communicating with staff, at both short notice and for the duration of the incident, including out of hours communications • A developed list of contacts in partner organisations who are key to service delivery (local Council, LRF partners, neighbouring NHS organisations etc) and a means of warning and informing these organisations about an incident as well as sharing communications information with partner organisations to create consistent messages at a local, regional and national level. • A developed list of key local stakeholders (such as local elected officials, unions etc) and an established a process by which to brief local stakeholders during an incident • Appropriate channels for communicating with members of the public that can be used 24/7 if required • Identified sites within the organisation for displaying of important public information (such as main points of access) • Have in place a means of communicating with patients who have appointments booked or are receiving treatment. • Have in place a plan to communicate with inpatients and their families or care givers. • The organisation publicly states its readiness and preparedness activities in annual reports within the organisations own regulatory reporting requirements
36	Warning and informing	Media strategy	The organisation has arrangements in place to enable rapid and structured communication via the media and social media	Y	• Having an agreed media strategy and a plan for how this will be enacted during an incident. This will allow for timely distribution of information to warn and inform the media • Develop a pool of media spokespeople able to represent the organisation to the media at all times. • Social Media policy and monitoring in place to identify and track information on social media relating to incidents. • Setting up protocols for using social media to warn and inform • Specifying advice to senior staff to effectively use social media accounts whilst the organisation is in incident response
37	Cooperation	LHRP Engagement	The Accountable Emergency Officer, or a director level representative with delegated authority (to authorise plans and commit resources on behalf of their organisation) attends Local Health Resilience Partnership (LHRP) meetings.	Y	• Minutes of meetings • Individual members of the LHRP must be authorised by their employing organisation to act in accordance with their organisational governance arrangements and their statutory status and responsibilities.

Ref	Domain	Standard name	Standard Detail	Acute Providers	Supporting Information - including examples of evidence
38	Cooperation	LRF / BRF Engagement	The organisation participates in, contributes to or is adequately represented at Local Resilience Forum (LRF) or Borough Resilience Forum (BRF), demonstrating engagement and co-operation with partner responders.	Y	• Minutes of meetings • A governance agreement is in place if the organisation is represented and feeds back across the system
39	Cooperation	Mutual aid arrangements	The organisation has agreed mutual aid arrangements in place outlining the process for requesting, coordinating and maintaining mutual aid resources. These arrangements may include staff, equipment, services and supplies. In line with current NHS guidance, these arrangements may be formal and should include the process for requesting Military Aid to Civil Authorities (MACA) via NHS England.	Y	• Detailed documentation on the process for requesting, receiving and managing mutual aid requests • Templates and other required documentation is available in ICC or as appendices to IRP • Signed mutual aid agreements where appropriate
43	Cooperation	Information sharing	The organisation has an agreed protocol(s) for sharing appropriate information pertinent to the response with stakeholders and partners, during incidents.	Y	• Documented and signed information sharing protocol • Evidence relevant guidance has been considered, e.g. Freedom of Information Act 2000, General Data Protection Regulation 2016, Caldicott Principles, Safeguarding requirements and the Civil Contingencies Act 2004
44	Business Continuity	BC policy statement	The organisation has in place a policy which includes a statement of intent to undertake business continuity. This includes the commitment to a Business Continuity Management System (BCMS) that aligns to the ISO standard 22301.	Y	The organisation has in place a policy which includes intentions and direction as formally expressed by its top management. The BC Policy should: • Provide the strategic direction from which the business continuity programme is delivered. • Define the way in which the organisation will approach business continuity. • Show evidence of being supported, approved and owned by top management. • Be reflective of the organisation in terms of size, complexity and type of organisation. • Document any standards or guidelines that are used as a benchmark for the BC programme. • Consider short term and long term impacts on the organisation including climate change adaption planning

Ref	Domain	Standard name	Standard Detail	Acute Providers	Supporting Information - including examples of evidence
45	**Business Continuity**	**Business Continuity Management Systems (BCMS) scope and objectives**	The organisation has established the scope and objectives of the BCMS in relation to the organisation, specifying the risk management process and how this will be documented. A definition of the scope of the programme ensures a clear understanding of which areas of the organisation are in and out of scope of the BC programme.	Y	BCMS should detail: • Scope e.g. key products and services within the scope and exclusions from the scope • Objectives of the system • The requirement to undertake BC e.g. Statutory, Regulatory and contractual duties • Specific roles within the BCMS including responsibilities, competencies and authorities. • The risk management processes for the organisation i.e. how risk will be assessed and documented (e.g. Risk Register), the acceptable level of risk and risk review and monitoring process • Resource requirements • Communications strategy with all staff to ensure they are aware of their roles • alignment to the organisations strategy, objectives, operating environment and approach to risk. • the outsourced activities and suppliers of products and suppliers. • how the understanding of BC will be increased in the organisation

Ref	Domain	Standard name	Standard Detail	Acute Providers	Supporting Information - including examples of evidence
46	**Business Continuity**	**Business Impact Analysis/Assessment (BIA)**	The organisation annually assesses and documents the impact of disruption to its services through Business Impact Analysis(es).	Y	The organisation has identified prioritised activities by undertaking a strategic Business Impact Analysis/Assessments. Business Impact Analysis/Assessment is the key first stage in the development of a BCMS and is therefore critical to a business continuity programme. Documented process on how BIA will be conducted, including: • the method to be used • the frequency of review • how the information will be used to inform planning • how RA is used to support. The organisation should undertake a review of its critical function using a Business Impact Analysis/assessment. Without a Business Impact Analysis organisations are not able to assess/assure compliance without it. The following points should be considered when undertaking a BIA: • Determining impacts over time should demonstrate to top management how quickly the organisation needs to respond to a disruption. • A consistent approach to performing the BIA should be used throughout the organisation. • BIA method used should be robust enough to ensure the information is collected consistently and impartially.

Ref	Domain	Standard name	Standard Detail	Acute Providers	Supporting Information - including examples of evidence
47	**Business Continuity**	**Business Continuity Plans (BCP)**	The organisation has business continuity plans for the management of incidents. Detailing how it will respond, recover and manage its services during disruptions to: • people • information and data • premises • suppliers and contractors • IT and infrastructure	Y	Documented evidence that as a minimum the BCP checklist is covered by the various plans of the organisation. Ensure BCPS are Developed using the ISO 22301 and the NHS Toolkit. BC Planning is undertaken by an adequately trained person and contain the following: • Purpose and Scope • Objectives and assumptions • Escalation & Response Structure which is specific to your organisation. • Plan activation criteria, procedures and authorisation. • Response teams roles and responsibilities. • Individual responsibilities and authorities of team members. • Prompts for immediate action and any specific decisions the team may need to make. • Communication requirements and procedures with relevant interested parties. • Internal and external interdependencies. • Summary Information of the organisations prioritised activities. • Decision support checklists • Details of meeting locations • Appendix/Appendices
48	**Business Continuity**	**Testing and Exercising**	The organisation has in place a procedure whereby testing and exercising of Business Continuity plans is undertaken on a yearly basis as a minimum, following organisational change or as a result of learning from other business continuity incidents.	Y	Confirm the type of exercise the organisation has undertaken to meet this sub standard: • Discussion based exercise • Scenario Exercises • Simulation Exercises • Live exercise • Test • Undertake a debrief <u>Evidence</u> Post exercise/ testing reports and action plans

Ref	Domain	Standard name	Standard Detail	Acute Providers	Supporting Information - including examples of evidence
49	Business Continuity	Data Protection and Security Toolkit	Organisation's Information Technology department certify that they are compliant with the Data Protection and Security Toolkit on an annual basis.	Y	Evidence • Statement of compliance • Action plan to obtain compliance if not achieved
50	Business Continuity	BCMS monitoring and evaluation	The organisation's BCMS is monitored, measured and evaluated against established Key Performance Indicators. Reports on these and the outcome of any exercises, and status of any corrective action are annually reported to the board.	Y	• Business continuity policy • BCMS • performance reporting • Board papers
51	Business Continuity	BC audit	The organisation has a process for internal audit, and outcomes are included in the report to the board. The organisation has conducted audits at planned intervals to confirm they are conforming with its own business continuity programme.	Y	• process documented in EPRR policy/Business continuity policy or BCMS aligned to the audit programme for the organisation • Board papers • Audit reports • Remedial action plan that is agreed by top management. • An independent business continuity management audit report. • Internal audits should be undertaken as agreed by the organisation's audit planning schedule on a rolling cycle. • External audits should be undertaken in alignment with the organisations audit programme

Ref	Domain	Standard name	Standard Detail	Acute Providers	Supporting Information - including examples of evidence
52	Business Continuity	BCMS continuous improvement process	There is a process in place to assess the effectiveness of the BCMS and take corrective action to ensure continual improvement to the BCMS.	Y	• process documented in the EPRR policy/Business continuity policy or BCMS • Board papers showing evidence of improvement • Action plans following exercising, training and incidents • Improvement plans following internal or external auditing •Changes to suppliers or contracts following assessment of suitability Continuous Improvement can be identified via the following routes: • Lessons learned through exercising. • Changes to the organisations structure, products and services, infrastructure, processes or activities. • Changes to the environment in which the organisation operates. • A review or audit. • Changes or updates to the business continuity management lifecycle, such as the BIA or continuity solutions. • Self assessment • Quality assurance • Performance appraisal • Supplier performance • Management review • Debriefs • After action reviews • Lessons learned through exercising or live incidents
53	Business Continuity	Assurance of commissioned providers / suppliers BCPs	The organisation has in place a system to assess the business continuity plans of commissioned providers or suppliers; and are assured that these providers business continuity arrangements align and are interoperable with their own.	Y	• EPRR policy/Business continuity policy or BCMS outlines the process to be used and how suppliers will be identified for assurance • Provider/supplier assurance framework • Provider/supplier business continuity arrangements This may be supported by the organisations procurement or commercial teams (where trained in BC) at tender phase and at set intervals for critical and/or high value suppliers
55	CBRN	Telephony advice for CBRN exposure	Key clinical staff have access to telephone advice for managing patients involved in CBRN incidents.	Y	Staff are aware of the number / process to gain access to advice through appropriate planning arrangements

Ref	Domain	Standard name	Standard Detail	Acute Providers	Supporting Information - including examples of evidence
56	**CBRN**	**HAZMAT / CBRN planning arrangement**	There are documented organisation specific HAZMAT/ CBRN response arrangements.	Y	Evidence of: • command and control structures • procedures for activating staff and equipment • pre-determined decontamination locations and access to facilities • management and decontamination processes for contaminated patients and fatalities in line with the latest guidance • interoperability with other relevant agencies • plan to maintain a cordon / access control • arrangements for staff contamination • plans for the management of hazardous waste • stand-down procedures, including debriefing and the process of recovery and returning to (new) normal processes • contact details of key personnel and relevant partner agencies
57	**CBRN**	**HAZMAT / CBRN risk assessments**	HAZMAT/ CBRN decontamination risk assessments are in place appropriate to the organisation. This includes: • Documented systems of work • List of required competencies • Arrangements for the management of hazardous waste.	Y	• Impact assessment of CBRN decontamination on other key facilities
58	**CBRN**	**Decontamination capability availability 24 /7**	The organisation has adequate and appropriate decontamination capability to manage self presenting patients (minimum four patients per hour), 24 hours a day, 7 days a week.	Y	Rotas of appropriately trained staff availability 24 /7

Ref	Domain	Standard name	Standard Detail	Acute Providers	Supporting Information - including examples of evidence
59	CBRN	Equipment and supplies	The organisation holds appropriate equipment to ensure safe decontamination of patients and protection of staff. There is an accurate inventory of equipment required for decontaminating patients. • Acute providers - see Equipment checklist: https://www.england.nhs.uk/ourwork/eprr/hm/ • Community, Mental Health and Specialist service providers - see guidance 'Planning for the management of self-presenting patients in healthcare setting': https://webarchive.nationalarchives.gov.uk/20161104231146/https://www.england.nhs.uk/wp-content/uploads/2015/04/eprr-chemical-incidents.pdf • Initial Operating Response (IOR) DVD and other material: http://www.jesip.org.uk/what-will-jesip-do/training/	Y	Completed equipment inventories; including completion date
60	CBRN	PRPS availability	The organisation has the expected number of PRPS (sealed and in date) available for immediate deployment. There is a plan and finance in place to revalidate (extend) or replace suits that are reaching their expiration date.	Y	Completed equipment inventories; including completion date

Ref	Domain	Standard name	Standard Detail	Acute Providers	Supporting Information - including examples of evidence
61	CBRN	Equipment checks	There are routine checks carried out on the decontamination equipment including: • PRPS Suits • Decontamination structures • Disrobe and rerobe structures • Shower tray pump • RAM GENE (radiation monitor) • Other decontamination equipment. There is a named individual responsible for completing these checks	Y	Record of equipment checks, including date completed and by whom.
62	CBRN	Equipment Preventative Programme of Maintenance	There is a preventative programme of maintenance (PPM) in place for the maintenance, repair, calibration and replacement of out of date decontamination equipment for: • PRPS Suits • Decontamination structures • Disrobe and rerobe structures • Shower tray pump • RAM GENE (radiation monitor) • Other equipment	Y	Completed PPM, including date completed, and by whom
63	CBRN	PPE disposal arrangements	There are effective disposal arrangements in place for PPE no longer required, as indicated by manufacturer / supplier guidance.	Y	Organisational policy
64	CBRN	HAZMAT / CBRN training lead	The current HAZMAT/ CBRN Decontamination training lead is appropriately trained to deliver HAZMAT/ CBRN training	Y	Maintenance of CPD records

Ref	Domain	Standard name	Standard Detail	Acute Providers	Supporting Information - including examples of evidence
65	CBRN	Training programme	Internal training is based upon current good practice and uses material that has been supplied as appropriate. Training programmes should include training for PPE and decontamination.	Y	Evidence training utilises advice within: • Primary Care HAZMAT/ CBRN guidance • Initial Operating Response (IOR) and other material: http://www.jesip.org.uk/what-will-jesip-do/training/ • A range of staff roles are trained in decontamination techniques • Lead identified for training • Established system for refresher training
66	CBRN	HAZMAT / CBRN trained trainers	The organisation has a sufficient number of trained decontamination trainers to fully support its staff HAZMAT/ CBRN training programme.	Y	Maintenance of CPD records
67	CBRN	Staff training - decontamination	Staff who are most likely to come into contact with a patient requiring decontamination understand the requirement to isolate the patient to stop the spread of the contaminant.	Y	Evidence training utilises advice within: • Primary Care HAZMAT/ CBRN guidance • Initial Operating Response (IOR) and other material: http://www.jesip.org.uk/what-will-jesip-do/training/ • Community, Mental Health and Specialist service providers - see Response Box in 'Preparation for Incidents Involving Hazardous Materials - Guidance for Primary and Community Care Facilities' (NHS London, 2011). Found at: http://www.londonccn.nhs.uk/_store/documents/hazardous-material-incident-guidance-for-primary-and-community-care.pdf • A range of staff roles are trained in decontamination technique

Ref	Domain	Standard name	Standard Detail	Acute Providers	Supporting Information - including examples of evidence
68	CBRN	FFP3 access	Organisations must ensure staff who may come into contact with confirmed infectious respiratory viruses have access to, and are trained to use, FFP3 mask protection (or equivalent) 24/7.	Y	

Ref	Domain	Standard	Deep Dive question	Further information	Acute Providers	Specialist Providers	NHS Ambulance Service Providers	Community Service Providers	Patient Transport Services	NHS111	Mental Health Providers	NHS England Region	NHS England National	Integrated Care Boards	Commissioning Support Unit	Primary Care Services - GP, community pharmacy	Other NHS funded organisations	Organisational Evidence - Please provide details of arrangements in order to capture areas of good practice or further development. (Use comment column if required)	Self assessment RAG Red (not compliant) = Not evidenced in evacuation and shelter plans or EPRR arrangements. Amber (partially compliant) = Evidenced in evacuation and shelter plans or EPRR arrangements but requires further development or not tested/exercised. Green (fully compliant) = Evidenced in plans or EPRR arrangements and are tested/exercised as effective.	Action to be taken	Lead	Timescale	Comments
DD1	Evacuation and Shelter	Up to date plans	The organisation has updated its evacuation and shelter arrangements since October 2021, to reflect the latest guidance.	https://www.england.nhs.uk/publication/shelter-and-evacuation-guidance-for-the-nhs-in-england/	Y	Y	Y	Y	Y		Y	Y	Y	Y	Y	Y	Y	Evacuation and Shelters SOP in places. It is in line with national guidance. Is in date. It is available on the trust hub page.	Fully compliant				
DD2	Evacuation and Shelter	Activation	The organisation has defined evacuation activation arrangements, including the decision to evacuate and/or shelter by a nominated individual with the authority of the organisation's chief executive officer.		Y	Y	Y	Y	Y		Y	Y	Y	Y	Y	Y	Y	Evacuation and Shelters SOP in places. It is in line with national guidance. Is in date. It is available on the trust hub page.	Fully compliant				
DD3	Evacuation and Shelter	Incremental planning	The organisation's evacuation and shelter plan clearly defines the incremental stages of an evacuation, including in situ sheltering, horizontal, vertical , full building, full site and off-site evacuation.		Y	Y	Y	Y	Y		Y	Y	Y	Y	Y	Y	Y	Evacuation and Shelters SOP in places. It is in line with national guidance. Is in date. It is available on the trust hub page.	Fully compliant				
DD4	Evacuation and Shelter	Evacuation patient triage	The organisation has a process in place to triage patients in the event of an incident requiring evacuation and/or shelter of patients.		Y	Y	Y	Y			Y						Y	Evacuation and Shelters SOP in places. It is in line with national guidance. Is in date. It is available on the trust hub page.	Fully compliant				
DD5	Evacuation and Shelter	Patient movement	The organisation's arrangements, equipment and training includes the onsite movement of patients required to evacuate and/or shelter.		Y	Y	Y	Y			Y					Y	Y	Evacuation and Shelters SOP in places. It is in line with national guidance. Is in date. It is available on the trust hub page.	Fully compliant				
DD6	Evacuation and Shelter	Patient transportation	The organisation's arrangements, equipment and training includes offsite transportation of patients required to be transferred to another hospital or site.		Y	Y	Y	Y	Y		Y						Y	Evacuation and Shelters SOP in places. It is in line with national guidance. Is in date. It is available on the trust hub page.	Fully compliant				
DD7	Evacuation and Shelter	Patient dispersal and tracking	The organisation has an interoperable patient tracking process in place to safely account for all patients as part of patient dispersal arrangements.		Y	Y	Y	Y	Y		Y						Y	Evacuation and Shelters SOP in places. It is in line with national guidance. Is in date. It is available on the trust hub page.	Fully compliant				
DD8	Evacuation and Shelter	Patient receiving	The organisation has arrangements in place to safely receive patients and staff from the evacuation of another organisations inpatient facility. This could with little advanced notice.		Y	Y		Y			Y						Y	Evacuation and Shelters SOP in places. It is in line with national guidance. Is in date. It is available on the trust hub page.	Fully compliant				
DD9	Evacuation and Shelter	Community Evacuation	The organisation has effective arrangements in place to support partners in a community evacuation, where the population of a large area may need to be displaced.		Y	Y	Y	Y	Y	Y	Y	Y	Y	Y		Y	Y	Evacuation and Shelters SOP in places. It is in line with national guidance. Is in date. It is available on the trust hub page.	Fully compliant				
DD10	Evacuation and Shelter	Partnership working	The organisation's arrangements include effective plans to support partner organisations during incidents requiring their evacuation.		Y	Y	Y	Y	Y		Y	Y		Y		Y	Y	Evacuation and Shelters SOP in places. It is in line with national guidance. Is in date. It is available on the trust hub page.	Fully compliant				
DD11	Evacuation and Shelter	Communications-Warning and informing	The organisation's evacuation and shelter arrangements include resilient mechanisms to communicate with staff, patients, their families and the public, pre, peri and post evacuation.		Y	Y	Y	Y		Y	Y	Y	Y	Y		Y	Y	Evacuation and Shelters SOP in places. It is in line with national guidance. Is in date. It is available on the trust hub page.	Fully compliant				
DD12	Evacuation and Shelter	Equality and Health Inequalities	The organisation has undertaken an Equality and Health Inequalities Impact Assessment of plans to identify the potential impact evacuation and shelter arrangements may have on protected characteristic groups and groups who face health inequalities.		Y	Y	Y	Y	Y		Y	Y		Y		Y	Y	Evacuation and Shelters SOP in places. It is in line with national guidance. Is in date. It is available on the trust hub page.	Fully compliant				
DD13	Evacuation and Shelter	Exercising	The evacuation and shelter arrangements have been exercised in the last 3 year. Where this isn't the case this will be included as part of the organisations EPRR exercise programme for the coming year. Please specify.		Y	Y	Y	Y	Y	Y	Y	Y	Y	Y		Y	Y	Evacuation and Shelters SOP in places. It is in line with national guidance. Is in date. It is available on the trust hub page.	Fully compliant				

Enclosure 8

Paper for submission to the Board of Directors on 22 September 2022

Title:	**Exception Report from Audit Committee Chair**
Author:	Andy Proctor, Director of Governance/Trust Secretary Helen Board, Deputy Trust Secretary
Presenter:	Gary Crowe, Audit Committee Chair

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

Recommendations:

The Board is asked to:

- Note the issues discussed at the Audit Committee on 12 September 2022
- Receive the updated Standing Financial Instructions and Scheme of delegation recommended for approval by the Audit Committee

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	Working / Exec Group	N	Date:
	Committee	Y	Date: 12/09/2022
	Board of Directors	Y	Date: 22/09/2022
	Other	N	Date:

EXCEPTION REPORT FROM AUDIT COMMITTEE CHAIR

Meeting held on: 12 September 2022

MATTERS OF CONCERN OR KEY RISKS TO ESCALATE	MAJOR ACTIONS COMMISSIONED/WORK UNDERWAY
• Matters of significance arising from the Auditor Annual report relating to Financial sustainability for 2022/2023 and re-raised the issue of Dudley Integrated Health and Care Trust as a matter that needs early resolution. • Progress to higher level of HIMMS AMAM (data maturity) requires significant work requiring significant investment	• Internal audit to review Trusts financial sustainability assessment undertaken in line with HFMA checklist Improving NHS Financial Sustainability. Report on finding to be submitted to December meeting of Audit Committee
POSITIVE ASSURANCES TO PROVIDE	**DECISIONS MADE**
• New style of Clinical Effectiveness Report commended. Clinical effectiveness audits continue to make good progress. Noted assurance around trajectory to recover backlog of SJR's. • Grant Thornton presented their Annual report on The Dudley Group noting good financial management noting the 2022/23 challenge due to a change in the funding regime. The Trust had robust governance arrangements in place and that appropriate performance management arrangements are used caveated with a comment that the Trust, like most other trusts, was not yet meeting the national performance standards. • Caldicott & Information Governance Group highlight report noted Information Governance mandatory training has reached > 95% compliance across all areas of the Trust. Noted exemplary achievement of Data Security and Protection Toolkit • Board Assurance Framework refinement phase progressing supported by executive leads to embed as dynamic tool • Implementation of internal audit recommendations developed and monitored closely by the Audit Committee • Local Counter Fraud Specialist update noted with finalisation of practical exercises due for reporting to the next meeting.	• The Trust's Standing Financial Instructions and Scheme of Delegations had been reviewed and were recommended for submission to the Board of Directors for approval. • The Committee received and approved the Grant Thornton external auditors report on The Dudley Group NHS Foundation Trust. Grant Thornton to issue letter of closure of audit and issue Independent auditor's report to the Council of Governors for inclusion in the final version of the Annual Report 2021/2022

Chair's comments on the effectiveness of the meeting: Meeting held in hybrid format with a face to face meeting convened at the Russells Hall site and a number of colleagues joining via MS Teams and. Support for online or virtual as a format for future meetings. The meeting ran to time with effective debate and challenge.

Enclosure 9

The Dudley Group NHS Foundation Trust

Paper for submission to Public Trust Board on 22nd September 2022

Title:	Dudley Health and Care Partnership Update Report
Author:	Kat Rose, Director of Strategy & Partnerships
Presenter:	Kat Rose, Director of Strategy & Partnerships

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

To note the report and the board is asked that the recommendations that were approved by Dudley Partnership Board at the meeting on 13th July 2022, be endorsed.

Summary of Key Issues:

On the 13th of July 2022 the NHS Directors of Strategy for Dudley presented the enclosed report to Dudley Partnership Board. The report:

1. summarises key national documents including examples and learning from other parts of the country;
2. outline the current status of place-based partnerships in Dudley;
3. bring together outputs from various workstreams that have been taking place within Dudley; and
4. present options and make recommendations on the partnership's governance arrangements.

Dudley Partnership Board confirmed:

- The Partnership Board will continue with a rotating chair between the two Dudley NHS providers.
- The role of a 'single accountable person' will be determined over time when guidance and governance becomes clearer but is not being instigated at this point in time.

The following recommendations were approved:

1. Partnership Board is renamed Dudley Health and Care Partnership Board and that the revised terms of reference in Appendix A were approved.
2. Partnership Board moves towards operating as a Joint committee. But this will be considered further in light of the evolving ICB operating model.
3. Option 1 was approved as the preferred governance structure for Dudley. During the transition period the Chief Executives and Chairs will continue to meet on a short-term basis. It is envisaged that at the appropriate time this group will be stood down and replaced with a meeting of the Chief Executives of the Dudley system.

4. An Executive Team is established to support the Dudley Health and Care Partnership Board and the Terms of Reference in Appendix B were approved.
5. Partnership Board supported the establishment of the Integrated Model of Care Implementation Group and ratified the Terms of Reference in Appendix C and approved it formally reporting into the Dudley Health and Care Partnership Board.
6. To appoint a short-term Independent Chair for the Integrated Model of Care Implementation Group.
7. The Partnership Executive Team to consider the appointment of a new Programme Director who will be responsible for driving forward integration and collaboration in Health and Social Care within Dudley who would report to the Chair of the Partnership Board.
8. Further consideration to be given to commissioning arrangements following receipt of the paper developed through ICB Governance Workstream
9. This paper is shared with partner boards in September.

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	
	On Risk Register: Y	Risk Score: see BAF	
Compliance and/or Lead Requirements	CQC	Y	Details: Safe, Effective, Caring, Responsive, Well Led
	NHSE/I	N	Details: annual planning is an NHSEI requirement
	Other	N	Details:

Report Journey/ Destination *(if applicable)*	Working / Exec Group	Y	Date: 17.05.22
	Committee	N	Date:
	Board of Directors	Y	Date: 22.08.22
	Other	Y	Date: 13.07.22

Dudley Partnership

A Discussion Paper

July 2022

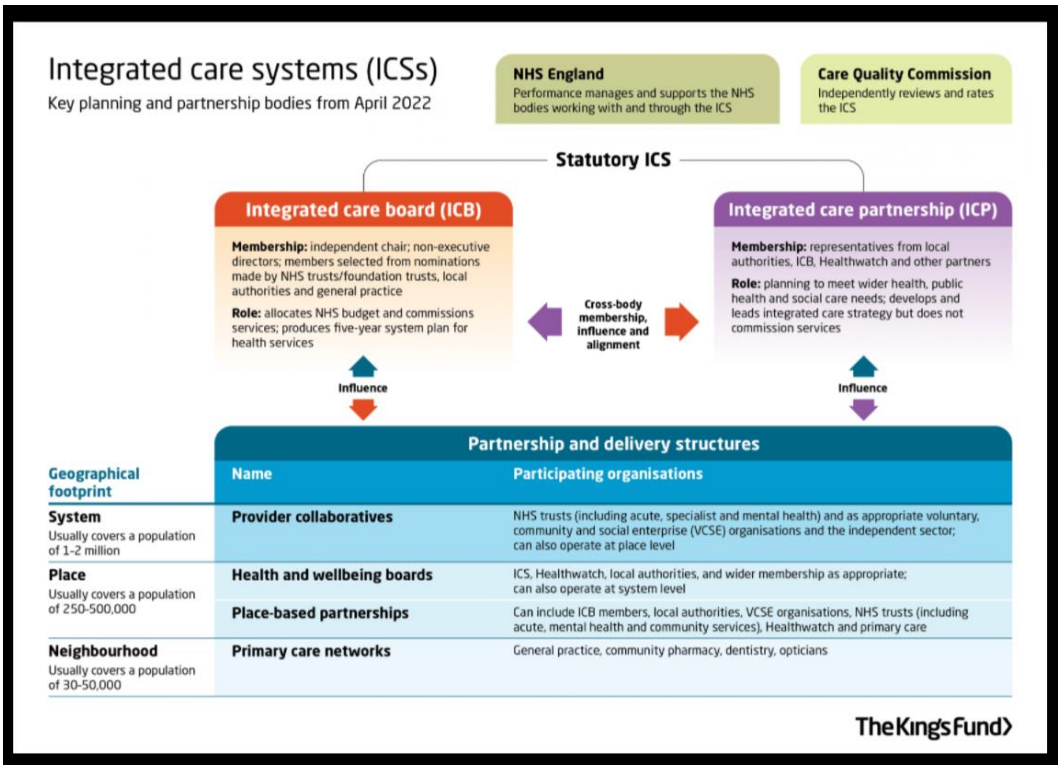
1. Purpose

Place-based partnerships are one of the main pieces of architecture within the new NHS structure in England. The purpose of this paper is to:

1. summarise key national documents including examples and learning from other parts of the country;
2. outline the current status of place-based partnerships in Dudley;
3. bring together outputs from various workstreams that have been taking place within Dudley; and
4. present options and make recommendations on the partnership's governance arrangements.

2. Background

Integrated Care Systems (ICS) were put on a statutory footing on 1st July 2022 following the passing of the Health and Care Act 2022. Place, covering populations in the range 250 – 500,000, is one of the main pieces of the new architecture as illustrated in the graphic below. Health & Wellbeing Boards, which were created following the 2012 Act, remain as do Primary Care Networks (PCN'S).



Guidance from NHS England and NHS Improvement and the Local Government Association has identified the following guiding principles for Place-based Partnerships:

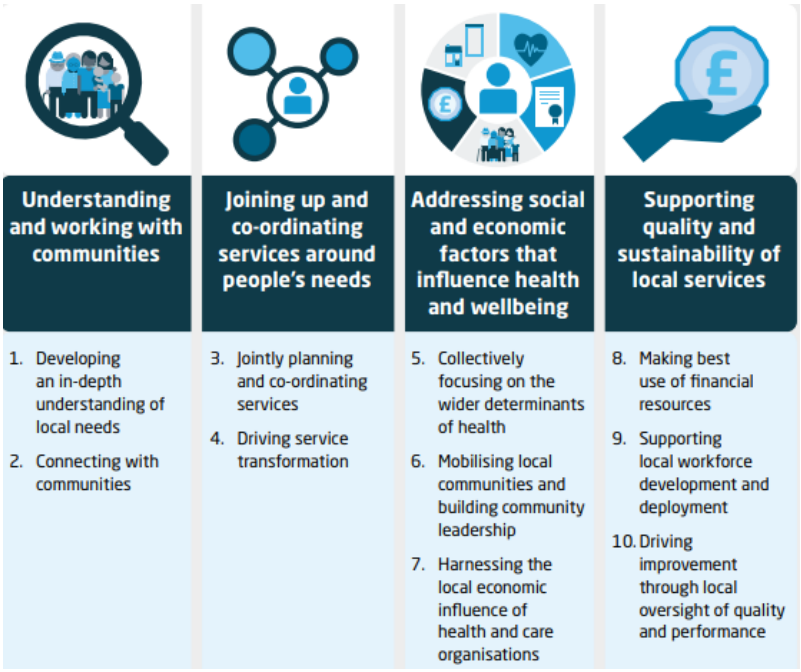
- Place-based Partnerships should start from understanding people and communities and agreeing shared purpose before defining structures.
- Effective partnerships are often built ‘by doing’ – acting together and building collaborative arrangements to support this action as it evolves.
- Governance arrangements must develop over time, with the potential to develop into more formal arrangements as working relationships and trust increase.
- Partnerships should be built on an ethos of equal partnership across sectors, organisations, professionals and communities.
- Partners should consider how they develop the culture and behaviors that reflect their shared values and sustain open, respectful and trusting working relationships supported by clearly defined mechanisms to support public accountability and transparency.

The guidance gives a number of different options for governance at place:

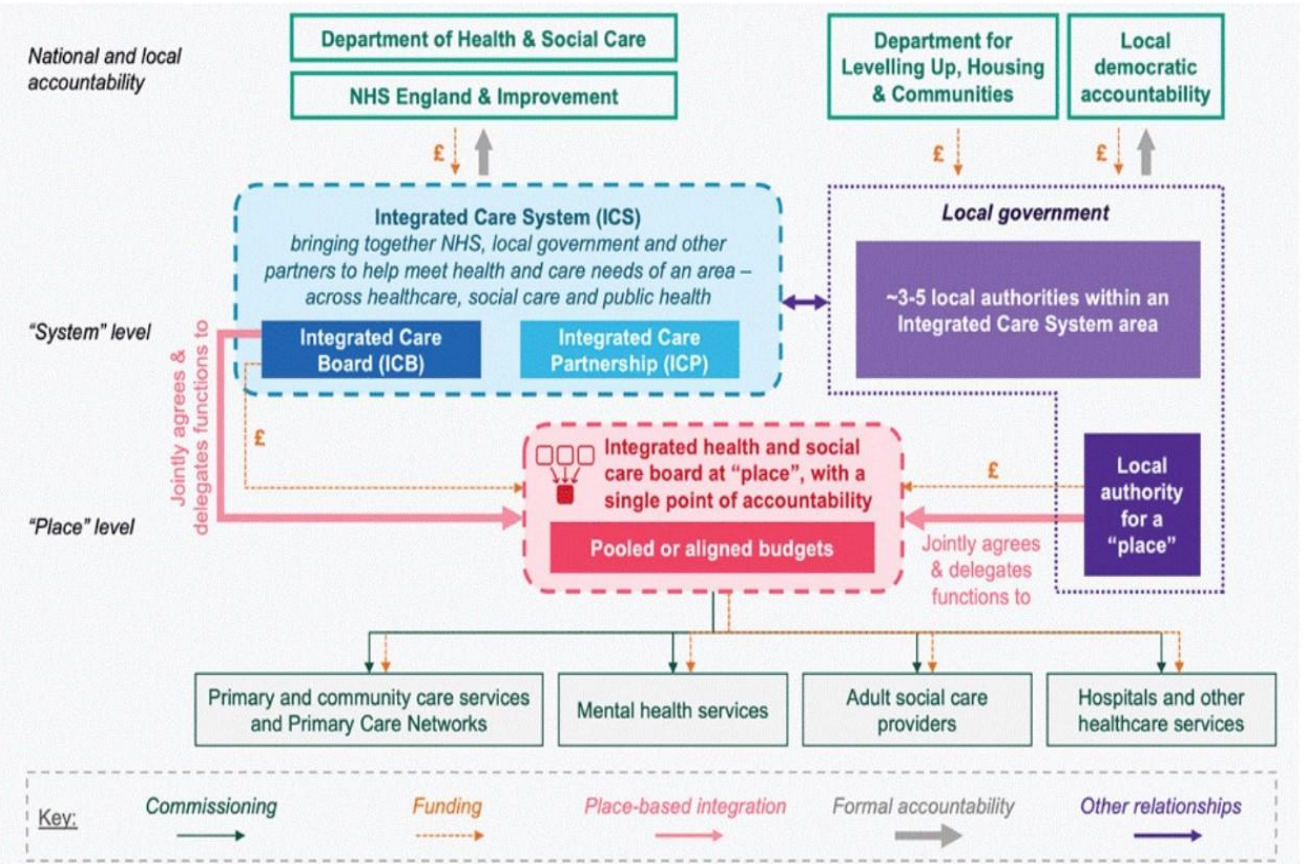
Consultative forum	A collaborative forum to inform and align decisions by relevant statutory bodies, such as the ICB or local authorities, in an advisory role. In this arrangement, the decisions of statutory bodies should be informed by the consultative forum.
Individual executives or staff	Statutory bodies may agree to delegate functions to individual members of staff to exercise delegated functions, and they may convene a committee to support them, with membership that includes representatives from other organisations
Committee of a statutory body	A committee provided with delegated authority to make decisions about the use of resources. The terms of references and scope are set by the statutory body and agreed to by the committee members. A delegated budget can be set to describe the level of resources available to cover the remit of the committee.
Joint committee	A committee established between partner organisations, such as the ICB, local authorities, statutory NHS providers or NHS England and NHS Improvement. The relevant statutory bodies can agree to delegate defined decision-making functions to the joint committee in accordance with their respective schemes of delegation. A budget may be defined by the bodies delegating statutory functions to the joint committee, to provide visibility of the resources available to deliver the committee’s remit
Lead provider	A led provider manages resources and delivery at place-level, as part of a provider partnership, under a contract with the ICB and/or local government, having lead responsibility for delivering the agreed outcomes for the place (including national standards and priorities) for the defined set of services.

Previous discussions at Partnership Board have identified that a joint committee was the preferred way forward for Dudley at the appropriate point in time.

The Kings Fund have outlined 10 key functions that place based partnerships should perform:



The recently-published white paper 'Joining up care for people, places and populations' (February 2022) gives a further potential governance arrangement.



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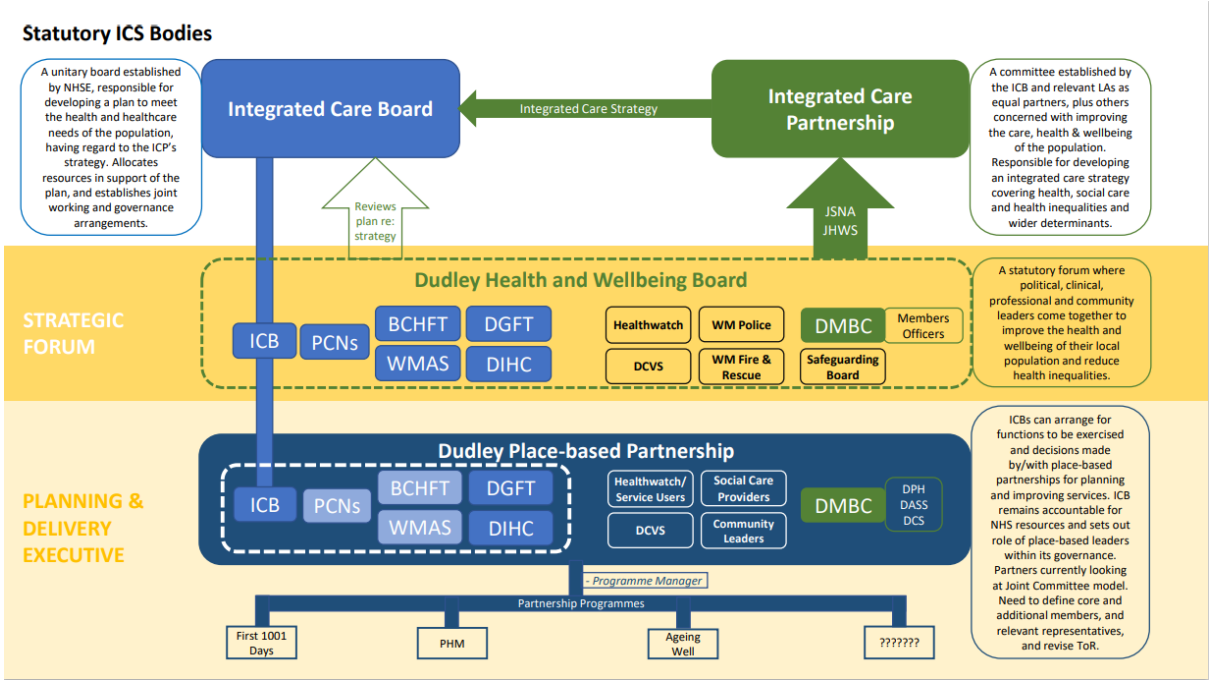


The Partnership Board consists of representation from all key health & care partners working in Dudley, Dudley CVS and patient representatives. It meets monthly and is supported by a part-time Programme Manager. Work has already started to identify priorities and demonstrate progress against these.

3. Dudley Health & Care Development

Over the last few months members of Dudley Partnership Board have been involved in a number of workstreams that have been supporting the development of how we work within Dudley these include:

- Place Development Programme (Four Modules focusing on: Vision & Leadership, Governance and Finance, Population Health and Digital);
- Development of the integrated model of care with support of Capgemini;
- Undertaking development activities linked to the guiding principles outlined within Thriving Places: Guidance on the development of place-based partnerships as part of statutory integrated care systems published in 2021;
- ICS reset programme which is leading on the design and development of the ICS 'operating model'. This has established the following workstreams: Governance, Outcomes framework, strategic commissioning/delivery & assurance, Place Action Learning Set (ALS) supported by David Frith from the Strategy Unit PBP ALS, readiness to operate and financial framework.

The discussions and outputs from all these workstreams have been utilised to develop the options for the future of the Partnership Board that have been outlined in the following section.

At the Partnership Board in June 2022 an update on the progress that has been made by the place development programme was given. This programme is due to finish in July 2022. As a result of the vision and leadership module a set of values for the Partnership Board have been agreed and are described below. There is unanimous support for these values to be adopted by the transformation groups that have been established to implement the integrated model of integrated care who have a developed the following vision statement '***Happy and Healthy***

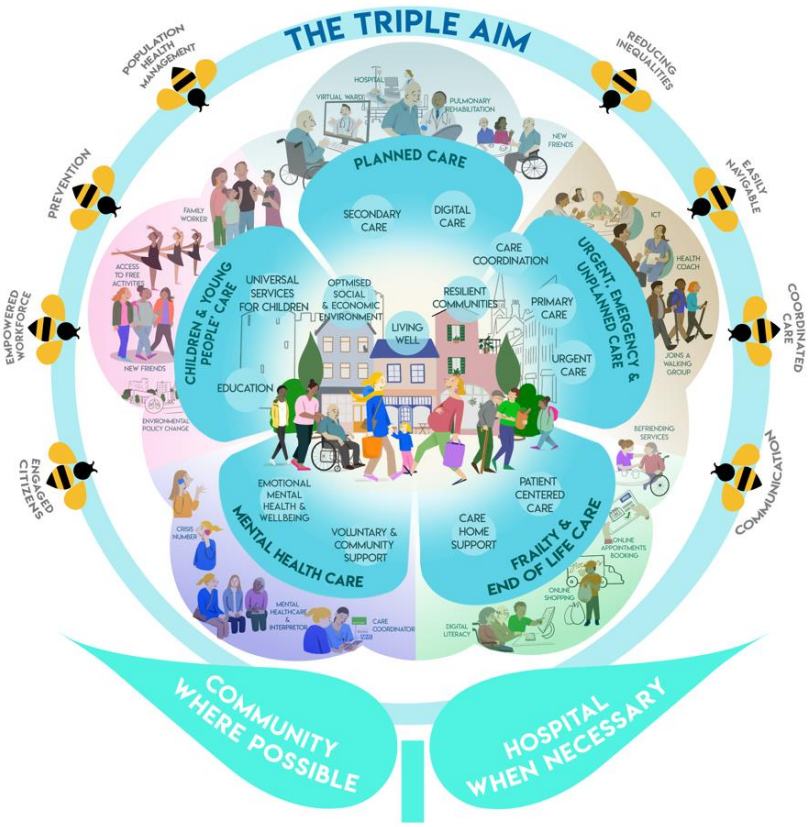
Communities… Community where possible, Hospital when necessary.' The Dudley system, through the Vision and Leadership module of the Place Based Development Programme and the Accelerated Solutions Environment events that have taken place to develop the new integrated model of care, have agreed to adopt the vision statement above and the values below in all of their communications across the system.

With the support of Capgemini, the Accelerated Solutions Events (ASE) focussed on developing a new integrated model of care for the citizens of Dudley. Over 80 individuals participated in two, two-day ASEs, (15-16 March and 10-11 May). Most of the participants were clinicians from across the Dudley system. The events collectively developed consensus on a high-level model of integrated health and care for the population of Dudley consisting of number of key components, enablers and strategies built around addressing the needs of people. The second event focused on specific challenges and issues and tested the outline model from the first event.

As a result of these events the following graphics have been developed to illustrate the model of care. These graphics are intended to show a blurring of the organisational lines between primary, community, secondary health and care exhibited in previous graphics to attempt to remove the concept of 'referral' and replace it with 'coordination', and `care by conversation not by correspondence'. At the core is the local community with Health and Social care services wrapped around the local community. With five key principles running through everything we do:

- Ease of Navigation
- Co-ordinated Care
- Prevention
- Empowered Workforce
- Engaged Citizens

The final iteration of the Model of Care will be developed with the Capgemini Team and consulted on prior to a coordinate dissemination via a system wide communication plan.



Following the ASE events an Integrated Model of Care Implementation Group has been established and initial priority Transformation Groups have been set up. It is proposed that the Integrated Model of Care Implementation Group will report into the Dudley Health & Care Board. The terms of reference for this group are in Appendix A.

Each Transformation Group has an identified SRO who will report into the Integrated Model of Care Implementation group, and they will complete a PID and Problem and Opportunity Statement that will be agreed by the Integrated Model of Care Implementation Group, to ensure clarity of scope and purpose. Other groups will be established as the model develops and consideration will be given to both widening the membership of the groups, and how the voice of the community is built into this.

Integrated Model of Care Implementation Group

Clinical Hub	ICT/CC Integrated Care Teams/Care Coordination	Mental Health	Childrens
SRO : Julian Hobbs Members: Beccy Willetts, Dr Murali, Dr Hudson, Steve Mann, Will Overfield, Simon Hughes, Bianca Mascarenhas, Richard Bramble	**SRO : Richard Bramble** Members: Sarah Knight, Zoe Dixon, Karen Lewis, Bianca Mascarenhas, Kate Keeling, Duncan Jenkins, Jo Taylor, Mayada Abuaffan, Simon Hughes, Kuli Kaur Wilson, Ann Bevington, Wendy Malpass, Marie Spittle	**SRO : Sharada Abilash / Kuli Kaur-Wilson** Members: Simon Hughes, Laura Brookes, Phillip King, Muhammed Iqbal/ Vanathi Kennedy, Melvena Anderson, Becci Lewis, Piotr Gass, Jill Edwards (when required: - Jim Cole, Andy Gray)	**SRO : Angela Cartwright/ Lydia Jones** Members: Sue Nicholls, Sarah Hogan, Dr Muthu Yeshwanth, Karen Anderson, Linda Cropper, Sally Cornfield

A prioritised work plan is being developed by the Integrated Model of Care Implementation group. As the work plan for this and the other place workstreams are developed, a resource plan to support this will need to be agreed to ensure there is sufficient capacity to deliver.

4. Options for the future

When considering the options for the future arrangements for Dudley we need to consider getting the right balance between what is undertaken at a System level and what takes place at Place and that we maximise the best use of resources at these levels.

The ultimate aim will be to develop place-based structures within the Black Country ICS, that mean pooled budgets are created within each of the 4 Partnerships with a set of outcomes and milestones that can be monitored in order to measure progress and delivery. This will require resources with the capacity and capability to lead and deliver the Partnership priorities with a focus on integration and collaboration.

Currently the Partnership Board is being supported by a part time Programme Manager as it was recognised that to deliver the priorities at place some dedicated resources will be required. The Programme Manager has helped drive forward actions within one of the Partnership Boards priorities the first 1001 days. However as we mature and the role of the System and Place becomes clearer there will be a need to have a full time dedicated resource to focus on providing direction to the 'engine room' team that needs to be established and supporting the Board to hold partners to account for implementing integration and collaboration within Dudley's health and social care services.

In other places within the system, they have recognised this and have jointly recruited a Programme Director or equivalent post. It is therefore recommended that the Board supports the appointment of a Programme Director who is given responsibility to drive forward the integration of health and social care within Dudley and to support all system partners in that agenda.

Moving forward there may be other resources required to support the 'engine room' for example in Sandwell the partners have locally funded the following resources – Communication Lead, Business Intelligence Lead, 7 x Programme Managers, Joint Analyst and Head of Programme Management.

Structures at Place will need to consider those developed as part of the provider collaboratives and at ICB system level. The ICB will require assurance that the limited resources across the system are directed in the right place to ensure effective use of resource. The NHS Oversight Framework 2022/2023 published in June 2022 says the system Memorandum of Understanding (MoU) must cover "The role of place-based partnerships and provider collaboratives in delivering the NHS priorities set out in the 2022/23 priorities and operational planning guidance."

Structures need to support decision making as close as possible to the local communities but consider activities that should be led at scale where a critical mass may get the best outcomes and reduces variations and provides opportunity to share best practice where common issues need to be tackled across the system.

Given the constraints of resources and capacity it is vital that duplication is avoided wherever possible and that the system and place activities are aligned and coordinated and that they develop in a planned way. The capacity does not exist to support any duplication or even much double running of this whilst it develops.

There are a number of areas where there is going to be overlap and interface between system and place. The table below outlines how this could be achieved through clear high-level principles alongside specific service areas clarifications.

System Role	Area	Dudley's Role
Create system-wide strategies for: (not an exhaustive list) • System Finance Strategy • System Digital Strategy • Workforce Strategy • ICP Integrated Care Strategy	**Set Strategy**	**Create Dudley strategies for:** • Health and Well Being strategy • Neighbourhood/PCN level strategies for population health management and reducing health inequalities. • Workforce Development
Determine and set the priority areas of focus for System and Place.	**Determine Priorities**	Develop the delivery plan to address the agreed priorities Develop plans for local "bottom-up" PHM initiatives. Publish the Joint Strategic Needs Assessment
Strategic allocation of resources between system and place and determine place-level allocations.	**Allocate Resources**	Tactical distribution of delegated resources to support the delivery of place priorities.
Strategic level commissioning where consistency of access and equality of outcome are paramount.	**Develop Commissioning / Access Policies**	Tactical level commissioning where variations in local infrastructure or organisation may prevent a single system solution and to support transformation
Programme leadership in national priority areas.	**Ensure Delivery**	Local delivery resources aligned to priority areas.
Set strategic outcomes for Place to aim for in their delivery plan and define the proxy performance measures to assess progress.	**Outcomes**	Report progress against the outcomes and proxy performance measures.
Oversee performance across System and Place priorities. Manage reporting relationship with NHSE region and national. Assure actions to address areas of concern.	**Performance**	Monitor detailed performance at local level. Report to ICB on exceptions against agreed standards.

There are four places in the Black Country ICS aligned to the four local authorities. Different approaches to the development of Place-based Partnerships are in evidence. In preparation for the transition to becoming an ICS, the ICS as part of the Reset Governance Workstream has developed a discussion paper to describe how it will discharge its responsibilities. This paper will be shared with the Dudley Health & Care Board once approval at the Reset Board.

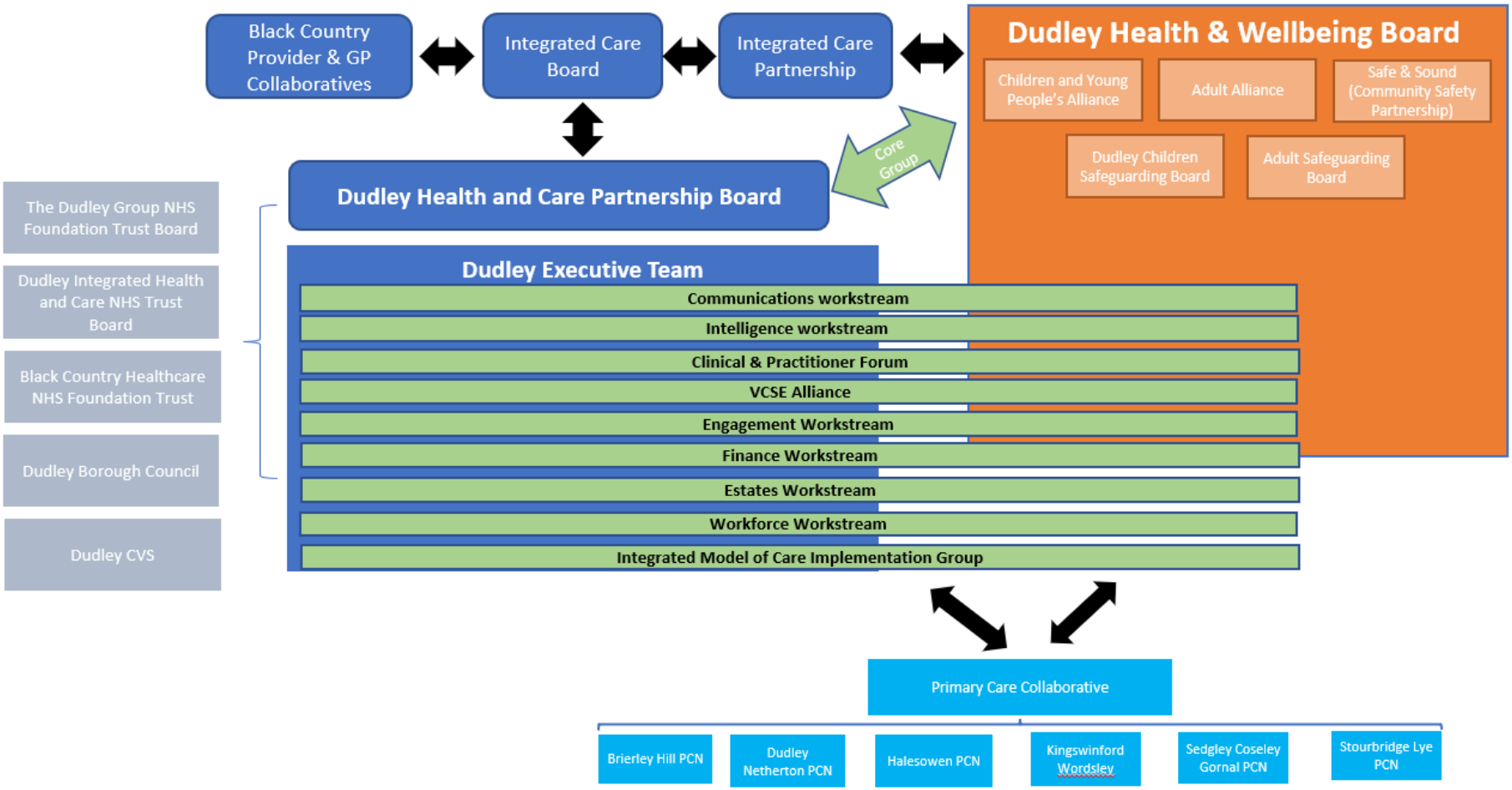
Following a review of existing and emerging models of place-based partnerships the following three options, have been developed by the Directors of Strategy within Dudley, for further discussion by the Board.

For each of the options partners should consider the ability to:

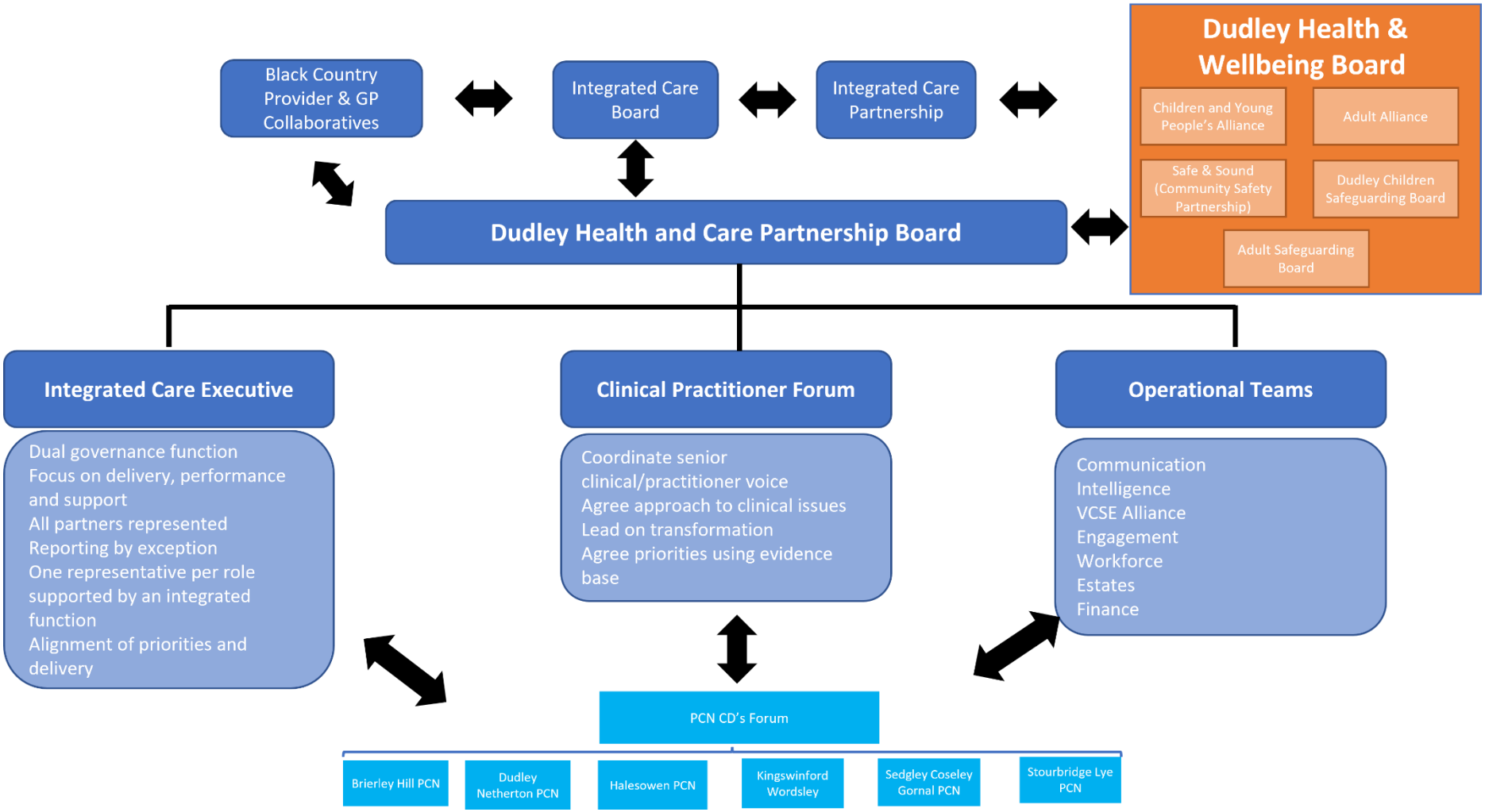
- make timely, effective, high-quality and enduring decisions;
- be accountable for the most effective use of very significant taxpayer funding;
- enable joined-up decision-making and delivery across the range of services meeting immediate care and support needs;

- support safe and effective delivery of ICB functions and responsibilities alongside wider functions of the partnership;
- take on executive responsibility for functions delegated by the ICS or local authority;
- enable non-statutory partners to play an appropriate role in decision-making
- support the exercise of primary care leadership, including through leadership and operational support.

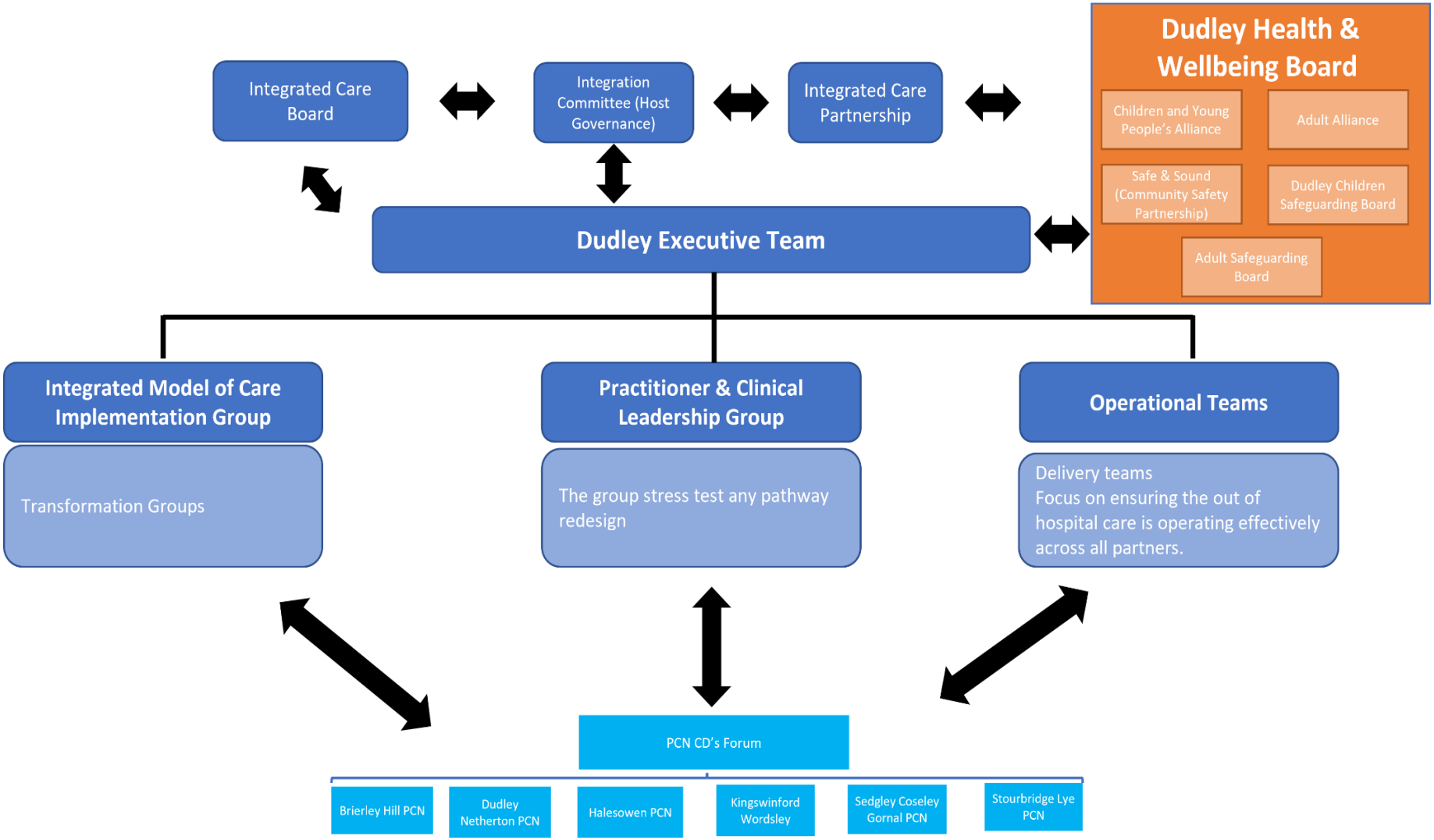
Option 1 – This option shows the establishment of the Dudley Health & Care Partnership Executive Team which would oversee the delivery of all of the various workstreams that would be established and would provide assurance to the Health & Care Partnership Board. The Health & Care Partnership Board will in time operate as a Joint Committee.



Option 2 – In this option the Health & Care Partnership Board still operates as a Joint committee, but the Dudley Health & Care Partnership Executive Team is only responsible for the delivery of the integrated care model and the other workstreams report directly into the Partnership Board.



Option 3 - This option is based on the Sandwell/Walsall model where the Health & Care Partnership Board/Integration Committee is hosted by the Acute NHS Trust and then underneath that sits the Health & Care Partnership Executive Team that the other workstreams feed into.



The Directors of Strategy have discussed and considered the options outlined and would recommend that we proceed with option 1 at this stage and later look to review the options again as we mature as a partnership.

It is felt that option 1 provides the next logical step in development and reflects the discussions that have taken place through Governance Module B of the place-based development programme and would allow the Executive Group to be established and allow it to act as a coherent and effective engine room for the next phase of the Dudley Health and Care Partnership Board's development.

In all three options there is some form of Partnership Executive Team that sits below the Board which would act as an 'engine room'. Terms of reference for this group have been drafted and can be found in Appendix B. It is recommended that this group is established and that it meets monthly prior to Board and that the Chair rotates in line the Chair of the Health & Care Partnership Board.

To reflect the establishment of the Partnership Executive Team the Board terms of reference have also been reviewed and updated and can be found in Appendix A. We are recommending that this is now called the Dudley Health and Care Partnership Board. These will need to be further reviewed when the ICB confirm the detail of what will be delegated to the Boards.

All three options include some form of Clinical Leadership and Practitioner Forum:

- Alongside patients, service users and carers, the CLPF places clinicians and practitioners at centre of place developments.
- Place takes 'problems to be solved' to CLPF
- Drives innovation and transformation at place
- Provides clinical oversight of development of place plan
- Takes a JSNA / business intelligence, service and population lens
- Support Directors of Nursing and Medical Directors to formulate a place plan that will improve patient outcomes and reduce inequalities
- Clinical assurance of place strategies.

5. Confirmation from Partnership Board Held on July 13th 2022

- The Partnership Board will continue with a rotating chair between the two Dudley NHS providers.
- The role of a 'single accountable person' will be determined over time when guidance and governance become clearer but is not being instigated now.

6. Recommendations

1. Partnership Board is renamed Dudley Health and Care Partnership Board and that the revised terms of reference in Appendix A have been approved.
2. Partnership Board moves towards operating as a Joint committee. Will be considered further in light of ICB delegation.
3. Option 1 is approved as the preferred governance structure for Dudley. During the transition period the Chief Executives and Chairs will continue to meet on a short-term basis. It is envisaged that at the appropriate time this group will be stood down and replaced with a meeting of the Chief Executives of the Dudley system.

4. An Executive Team is established to support the Dudley Health and Care Partnership Board and the Terms of Reference in Appendix B are approved.
5. Partnership Board supports the establishment of the Integrated Model of Care Implementation Group and ratifies the Terms of Reference in Appendix C and approves it formally reporting into the Dudley Health and Care Partnership Board.
6. To appoint a short-term Independent Chair for the Integrated Model of Care Implementation Group.
7. The Partnership Executive Team to consider the appointment of a new Programme Director who will be responsible for driving forward integration and collaboration in Health and Social Care within Dudley who would report to the Chair of the Partnership Board.
8. Further consideration to be given to commissioning arrangements following receipt of the paper developed through ICB Governance Workstream
9. This paper is shared with partner boards in September.

Appendix A

Dudley Health & Care Partnership Board

Terms of Reference: June 2022

1. PRIMARY PURPOSE/S

1.1 The Dudley Health & Care Board (DHCPB) brings together all health and care partners across the Dudley place to support and ensure the delivery of an integrated health and care system to make sure that everyone gets the right care in the right place at the right time, to achieve better health and care outcomes.

1.2 The DHCPB will be responsible for:

- Developing a 'blueprint' for Dudley services which are integrated across prevention, primary, community, social and secondary care which improves outcomes and reduce inequalities.
- Implementing the Department of Health and Social Care White Paper "Integration and innovation: working together to improve health and social care for all".
- Facilitating the required collaboration and coordination necessary to develop a full integrated Dudley health & care system, with a care model for planned/urgent care alongside the model for 'out of hospital' primary & community services.
- Responsible setting strategic direction and outcomes for integration in Dudley with due regard to ICB/ICP/HWB strategies and plans'.
- Overseeing an agreed system level integrated care risk register;
- Contribute to the final iteration of the Better Care Fund Plan as developed by the Integrated Commissioning Executive.
- Reporting to the Health and Wellbeing Board on opportunities for and progress with the integration of health and care services, whilst ensuring the local integrated health and care system maintains a focus prevention and on identifying and addressing health inequalities. The JSNA/JHWS will be integral to the development of plans.
- Horizon scanning – reviewing demographic, political, social and technological trends, assessing their impact and advising other relevant bodies on their significance
- Preparing an annual "State of the System" report for partners and other local partnerships.
- Providing the main place-based link to the Black Country Integrated Care Board (ICB) and the Black Country Integrated Care Partnership (ICP) and overseeing local implementation of ICS initiatives;
- Ensuring systems and processes are in place so that the ICB, local authority and/or other partners can delegate responsibilities to the partnership.
- Governance of agreed workstreams and Boards

2. ACCOUNTABILITY

2.1 Key decisions made on behalf of the Board may require separate approval by the Boards of individual organisations prior to final agreement.

2.2 The Health & Care Partnership Board will report directly to the ICB for those matters delegated to it by the ICB and to the ICP for those matters related to the Black Country Integrated Care Plan. All work streams will report into Health & Care Board.

2.3 The Health & Care Board has no executive powers, other than those specifically delegated to it by the ICB and set out in the ICB's scheme of delegation.

3. SCOPE

3.1 Will be delegated by the ICB

4. LEAD OFFICER

4.1 The Chair for the Health & Care Partnership Board will rotate amongst the CEO's in Dudley Group, DIHC and Dudley MBC and will be supported by the Programme Manager for the Health & Care Partnership Board in administratively managing the work programme agenda.

4.2 A suitable Vice Chair will be selected by the Chair in their absence.

5. SERVICED BY

5.1 The Health and Care Partnership Board will be serviced by the Programme Manager.

5.2 The process for developing the agenda will be coordinated through the Dudley Executive Team and the final agenda will be signed off by the Chair of the Health and Care Partnership Board. A forward plan of agenda items will be maintained.

5.3 Every effort will be made to compile and circulate the agenda and associated papers at least 5 working days prior to each meeting.

6. COMPOSITION & MEMBERSHIP

6.1 As the Health & Care Partnership Board is focused on the delivery of an integrated health and care system, the Board will comprise of the following members from partner organisations. All organisations will be 'core' members of the Health and Care Partnership Board and will be required to attend all meetings.

- CEO (DG NHSFT)
- CEO (DIHC NHST)
- CEO (BCH NHSFT)
- CEO (Dudley MBC)
- Director of Strategy (DG NHSFT)
- Director of Strategy (DIHC NHST)
- Director of Strategy (BCH NHSFT)
- Director of Public Health (Dudley MBC)
- Director of Adult Social Care
- Director of Children's Services
- Managing Director (Black Country ICB)

- Representative, Dudley Council for Voluntary Service
- Representative, Dudley Healthwatch
- Representative, PCNs
- Representative, West Midlands Ambulance Service University NHSFT
- Programme Manager, Health & Care Partnership Board*non-voting capacity

6.2 Any other lead executives from any of the work streams may also be required to attend the Health & Care Partnership Board to present items under consideration such as Independent Chair of the Dudley Integrated Model of Care Implementation Group, Chair of the Commissioning Board.

6.3 In addition to the 'core' members, other partners may be in invited to attend the Health & Care Partnership Board and support the programme of work in a non-voting capacity

7. FREQUENCY OF MEETINGS

7.1 Meetings shall be held monthly.

8. QUORACY & DECISION MAKING

8.1 As a minimum, the following people must be in attendance for the Board to be quorate: -

- Chair or nominated Vice Chair.
- CEO or nominated Executive Director lead for each partner organisation.

8.2 All key decisions of the Health & Care Partnership Board will be made through consensus* unless an alternative decision-making procedure has been agreed in advance.

8.3 It is recognised that each of the partners has their own regulatory and statutory responsibilities and partners have their own internal governance arrangements. There may be some matters where partners' respective Boards/Governing Bodies need to approve a decision(s).*

*Details are to be confirmed dependent upon the delegation of duties agreed.

9. REPORTING ARRANGEMENTS

9.1 The Board will provide a quarterly report to each organisation's Board detailing the key decisions and progress made within the reporting period.

9.2 Routine reporting will be provided through to the ICB. *

*Details are to be confirmed dependent upon the delegation of duties agreed.

10. REVIEW DATE

10.1 Membership and terms of reference will be reviewed every six months from the date of commencement or when the ICB scheme of delegation is agreed whichever is earliest.

10.2 Membership will be reviewed when the function of the Single Accountable Officer is clear

11. DATE APPROVED

11.1 July 2022

Appendix B

Dudley Health & Care Partnership Executive Team

Terms of Reference – August 2022

1. PRIMARY PURPOSE/S

1.1 The primary purposes for the Dudley Health & Care Partnership Executive Team (DPET) are outlined as follows:

1.2

a. To advise the Dudley Health & Care Partnership Board as the main decision-making body for the health and care system issues on the exercise of any of the delegated powers.

b. To recommend the scope and priorities of the Dudley Health & Care Partnership Board and ensuring they are fully aligned to other priorities and plans.

c. To manage and implement the programmes of work of the Dudley Health & Care Partnership Board.

d. To develop, establish, and manage the 'blueprint' for the Dudley Health & Care Partnership Board, providing a consistent agreed upon strategic direction of travel.

e. To develop, coordinate and manage the delivery of the system priorities for the Dudley Health & Care Partnership Board.

f. To act collaboratively to make best use of scarce resources and skills.

g. To ensure effective communication across the internal and external interfaces.

h. To manage and mitigate risks to the delivery of the programme.

i. Responsible for drafting the Dudley Health & Care Partnership Board Agenda.

2. ACCOUNTABILITY

2.1 Through its Chair, the DPET will be accountable for delivery of its work to the Dudley Health & Care Partnership Board.

2.2 In addition, and through its constituent membership, each member will be responsible for communicating key messages to their own organisation as is appropriate.

3. SCOPE & BOUNDARIES

3.1 The DPET incorporates representatives from across partners within the Dudley place. These are:

- The Black Country ICB
- The Dudley Group NHSFT
- Dudley Integrated Health & Care NHST
- Black Country Healthcare NHSFT
- Dudley Primary Care Networks
- Dudley Metropolitan Borough Council

- Dudley Council for Voluntary Service
- Dudley Healthwatch

4. LEAD OFFICER

4.1 The lead officer for the DPET is the Chair who will be nominated from within the group and will be supported by the Programme Manager for the Health & Care Partnership Board in administratively managing the work programme agenda.

5. SERVICED BY

5.1 The DPET will be serviced by the administration from the Programme Manager.

5.2 The process for developing the agenda will be coordinated through the Programme Manager. A forward plan of agenda items will be maintained, but in addition to this the admin from the Programme Manager will seek agenda items from members two weeks in advance of the meeting.

5.3 Every effort will be made to compile and circulate the agenda and associated papers at least 5 working days prior to each meeting.

6. COMPOSITION & MEMBERSHIP

6.1 The DPET will comprise of the following core members:

- Programme Director for Dudley Health & Care Partnership Board
- Managing Director (Dudley), Black Country ICB
- Nominated representative from Public Health, Dudley Borough Council
- Nominated representative from Adult Social Care
- Nominated representative from Children's Services
- 3x Directors of Strategy – (DGFT, DIHC, BCHC)
- 3x Chief Operating Officers (DGFT, DIHC, BCHC)
- Nominated representative from Dudley Council for Voluntary Service
- Programme Manager, Health & Care Partnership Board

6.2 The DPET core membership will comprise these 9 members.

6.3 The Chair for the DPET will be nominated from the group and may rotate as appropriate. A suitable deputy chair will be selected for deputising in their absence if appropriate.

7. RESPONSIBILITIES

7.1 The duties and responsibilities of the DPET are consistent with its primary purposes, with specific duties to include:

Strategic Developments & Planning

a. Responsibility for developing and establishing the full Placed Based programme and the identified benefits, which maximise the opportunities at the Dudley place engaging stakeholders wherever appropriate.

b. Responsibility for ensuring that strategic developments are incorporated and aligned to the Health & Care Partnership Board plans and priorities.

c. Responsibility for directing the development of and receiving for review, recommendation and approval, all business cases related to the integration of health & care.

d. Responsibility for ensuring that plans align to ICS and ICB priorities and plans, with interdependencies managed.

e. Responsibility for ensuring that place based partner organisations individual plans align and support the delivery of Dudley's Priorities.

f. Monitoring and review of key interdependencies between workstreams to ensure that benefits of the new model of care is fully realised for the benefit of patients, carers and their families.

Governance

g. Responsible for the appropriate governance to provide assurance to sovereign Boards on the delivery of Dudley Health & Care Partnership vision and identified benefits

h. Overseeing an agreed place level integrated care risk register

Performance

i. To work together to manage the key agreed performance metrics holding to account all Senior Responsible Officer's (SROs) or work program leads for agreed delivery of priorities.

Resource management

j. Provide oversight for the management of the place based programme budget ensuring that it is appropriately focused to delivering agreed priorities.

k. Provide direction to the work of the Programme Manager and the leads for any group or workstream that reports into the Health & Care Partnership Board.

l. Ensure that opportunities from shared efficiency and infrastructure are explored, planned, resourced, and delivered.

m. To provide assurance that needs of the community and patients are best serviced by the proposed partnering arrangements.

Workforce, HR & OD

n. Routinely identify workforce requirements and where possible seek to manage through the redeployment of workforce across place, through secondments or repurposing of roles (when primary role is no longer required), as opposed to seeking additional resources.

Communication & Engagement

o. Responsibility for directing the communication and engagement activities with stakeholders which promote and inform key developments associated with the programme.

p. To establish meaningful patient and public engagement in planning for the future.

Risk Management

q. Consider the assessment of identified risks to achievement of the plans and review and assure the adequacy of associated mitigation plans.

Others

r. Receive and consider reports from directors / managers concerning any exceptional issues affecting the implementation of the plans

s. Agree and propose to the Board for its approval any significant changes to the agreed plans or terms of reference.

8. RESOURCES

8.1 The Place Executive will, through the office of the Programme Manager, have access to sufficient resources in order to carry out its duties in delivering the agreed priorities.

8.2 Core resources are currently provided by the CCG (soon to be ICB) and are to be complemented on an equal 'fair share' basis by each of the full member trusts, should there be a shortfall in available resources.

9. FREQUENCY OF MEETINGS

9.1 The DPET will convene monthly, two weeks prior to Health & Care Partnership Board.

10. QUORACY

10.1 At least four organisations must be represented for the meeting to proceed. No decisions can be taken about organisations not present without prior consent.

11. VOTING RIGHTS

11.1 The work of the PET is centred around information sharing and strategic service problem solving, arriving at recommendations for management to consider.

11.2 Thus, as the focus will be on consensus, it is not anticipated that any voting rights will be required as PET will make recommendations to the Health & Care Partnership Board for progression.

12. REPORTING ARRANGEMENT & ESCALATION

12.1 The DPET will report to the Health & Care Partnership Board and escalate all appropriate matters through the Chair.

13. MINUTES CIRCULATION

13.1 Action notes will be circulated to all members within one week of the meeting taking place.

13.2 Members should ensure that key messages are cascaded widely, both within their own organisation and beyond where appropriate to ensure both delivery and effective communication.

14. REVIEW DATE

14.1 Membership and terms of reference will initially be reviewed at 3 months are thereafter every 6 months from the date of commencement.

15. DATE APPROVED

15.1 August 2022.

Appendix C

INTEGRATED MODEL OF CARE IMPLEMENTATION GROUP
Terms of Reference June 2022

1. PURPOSE & DUTIES

1.1. The purpose of the Team Dudley Integrated Model of Care Implementation Group is to provide clinical and strategic leadership to implement the newly designed integrated model of care for the Dudley population.

1.2. The work of the Implementation Group will be organised into the following priorities for moving at pace in implementing the model of care:

1.2.1. Clinical Hub
1.2.2. Integrated Care Teams (including the role of care co-ordination)
1.2.3. Mental Health
1.2.4. Children's services

These priorities will be added to as agreed by the Implementation Group throughout the model implementation phase.

1.3. The functions of the Implementation Group are to:

1.3.1. Ensure the model is finalised sufficiently, working with the Capgemini team and the system Chairs and Chief Executive Officers, to enable pace of implementation of the model of care.
1.3.2. Motivate, drive and keep pace on the implementation of the model of care agreed through the Accelerated Solutions Environment events in Dudley.
1.3.3. Monitor progress of the priority workstreams.
1.3.4. Agree terms of reference for the priority workstream groups.
1.3.5. Commit to unblock any barriers that may be being experienced in progressing implementation of priorities.
1.3.6. Ensure any priorities agreed and recommended by the Dudley Health and Care Partnership Board are included in the implementation work programme.
1.3.7. Report into the Dudley Health and Care Partnership Board on progress with implementation of the new model of care.
1.3.8. Ensure mutual accountability to deliver the new model of care.
1.3.9. Ensure that appropriate patient and community engagement takes place on the implementation of the model of care and any proposed service changes/improvements.
1.3.10. Report accordingly with appropriate supporting rationale to the system Chairs and Chief Executives Group on any transformational areas where transfers of services are recommended.

2. MEMBERSHIP

2.1. The Implementation Group membership will consist of clinical and strategic leaders from across the partner organisations as follows:

- Medical Director of The Dudley Group NHS Foundation Trust
- Deputy Medical Director of The Dudley Group NHS Foundation Trust
- Medical Director of Dudley Integrated Health and Care NHS Trust

- Senior Clinical Lead from Dudley Integrated Health and Care NHS Trust
- Medical Director of Black Country Healthcare NHS Foundation Trust
- Deputy Medical Director of Black Country Healthcare NHS Foundation Trust
- Director of Strategy for The Dudley Group NHS Foundation Trust
- Director of Strategy, People and Partnerships for Dudley Integrated Health and Care NHS Trust
- Chief Strategy Officer for Black Country Healthcare NHS Foundation Trust
- Dudley Managing Director, Black Country Integrated Care Board
- Chair of Dudley Local Commissioning Board
- Programme Manager for Dudley Partnership Board
- PCN Clinical Director
- Director of Public Health for Dudley Metropolitan Borough Council
- Consultant in Public Health for Dudley Metropolitan Borough Council

2.2. The Chair of the meeting will be an independent clinical expert. In the absence of the Chair the Programme Manager will facilitate discussion.

3. ATTENDEES

3.1. Other professional/clinical leaders from across the partnership should be invited to attend, particularly when the Group is discussing areas pertinent to the expertise or specialism of that professional/clinician.

4. ATTENDANCE

4.1. Members are expected to attend all meetings.

4.2. If members of the group are unable to attend a meeting they will be requested to send a nominated deputy.

5. QUORUM

5.1. At least one representative from each organisation should be present at the meeting.

5.2. Decisions about services for organisations that are not represented cannot be made by the group; however this will not preclude the group from discussing the pertinent issues.

6. FREQUENCY OF MEETINGS

6.1. The Group will meet on a fortnightly basis and for a minimum of 24 times a year. Additional meetings of the group can be put in place as and when required.

7. REVIEW AND REVISION

7.1. The Terms of Reference will be reviewed on a three monthly basis throughout the life of the implementation programme.

8. ADMINISTRATIVE ARRANGEMENTS

8.1.1 The Implementation Group will be supported administratively by the Programme Manager. The duties will include:

- Agreement of agenda with Chair and attendees and collation of papers;
- Taking the action notes;
- Keeping a record of matters arising and issues to be carried forward;
- Advising the Implementation Group on pertinent issues/areas.

8.1. All papers presented to the Implementation Group should be prefaced by a summary of key issues and clear recommendations setting out what is required.

9. REPORTING ARRANGEMENTS

9.1. The Implementation Group will provide a highlight report monthly to the Dudley Health and Care Partnership Board outlining key actions taken, assurances given and areas of risk.

9.2. The Implementation Group will make recommendations to the Dudley Health and Care Partnership Board on alignment of programmes for the implementation of the new model of care.

10. Date Approved

10.1 June 2022

Enclosure 10

Paper for submission to the Board of Directors on 22 September 2022

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

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

Recommendations:

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

Summary of Key Issues:

Summary from the Finance and Performance Committee meeting held on 22 August 2022.

Impact on the Strategic Goals	
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	

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: 22nd September 2022
	Other	N	Date:

EXCEPTION REPORT FROM FINANCE AND PERFORMANCE COMMITTEE CHAIR

Meeting held on: 22 August 2022

MATTERS OF CONCERN OR KEY RISKS TO ESCALATE	MAJOR ACTIONS COMMISSIONED/WORK UNDERWAY
• Underperformance against elective recovery fund targets (although no claw back anticipated in H1 of 22/23). • CIPs shortfall against target anticipated at £11.5m. • Inevitable overspend by year end predicted at £15.3m reducing cash position to £3.5m at year end. • Emerging evidence of system overspend - £27.2m year to date. • Overspends in medical and surgery, in part due to COVID legacy issues. • Weakness of digital infrastructure not being addressed at pace due to restricted capital and revenue funds in system. • Achieving emergency access standard is a continued challenge impacted adversely by flow thorough hospital. • Potential new financial risk if Black Country Workforce Bureau/Hub is not transferred to another provider or remodelled with the support of the ICS. • Potential claim of up to £627k (unbudgeted) for holiday pay not correctly identified on pay slips for locum doctors. • Inflationary pressure on PFI contract for next financial year and significant energies required by Trust staff to ensure contract operates effectively.	• Include return on investment analysis into procurement report. • Ensure update actions are reported to Committee secretariat before meeting, to be included on action sheet issued with agenda and papers.
POSITIVE ASSURANCES TO PROVIDE	**DECISIONS MADE**
• Whilst below target significant CIP projects of £13m are underway with 65% of savings forecast as recurrent. • Recognition of opportunities for further productivity of existing services. • On-going positive refinement of the board assurance framework.	• Recommended to Board approval of 4-year contract to the stated supplier • Recommended to Board approval of Cloud Transition Year 2 business case.

• Strong performance against cancer two week wait target, improvement in emergency department tirage, diagnostics, and referral to treatment performance. • On target to substantively achieve enhanced 52-week treatment target (March 2023) except for surgery and ear, nose and throat. • Positive performance by clinical support services in areas including imagery, breast screening and pharmacy. • Ambitious plans for development of community diagnostic centres. • Excellent outcome of Human Tissue authority assessment. • Trust's procurement practices benchmark well against national comparators.	• Recommended to Board reporting of anticipated £15.3m year end overspend and escalation of this position to system.
Chair's comments on the effectiveness of the meeting: Revised approach to presentation of the forecast financial outturn and the impact of CIPs improved accessibility of information. Concise and well-presented deep dive into Clinical Services enhanced the meeting. Shortage of NEDs compromised the quoracy of the meeting at later stages requiring items for approval to be taken earlier and the agenda to be re-ordered. Some frank and useful discussion.	

Enclosure 11

Paper for submission to Board of Directors on 22nd September 2022

Title:	IPR Report for July 2022
Author:	Jonathan Boulter, Associate Director of Performance
Presenter:	Karen Kelly, 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 July 2022 (June 2022 for Cancer). The Board is asked to note performance and next steps.

Summary of Key Issues:

Summary: Key Areas of Success

Having attained the 2 week wait cancer standard in May, the Trust achieved this target for the second consecutive month in June, delivering 93.1%. This performance places DGFT 2nd of the 4 Black Country and West Birmingham ICS acute Trusts and is set against the overall performance for England of 77%.

ED triage saw some improvement in July with 3 of the 4 triage areas realising increases in performance. Overall, ED triage rose to 86.1% last month, with Ambulance triage performing the best of the 4 triage areas at 98.6%. Performance against the 4 hour ED target also increased in July, rising by 4% on June's performance.

DM01 performance achieved an improvement for the third month running, attaining 84.1%. Of the DM01 modalities, there has been considerable improvement in Imaging and CT and the Sleep Studies recovery plan in on course deliver, having increased from 39% in March to 98.93% in July.

During July, the Trust delivered the 3rd best RTT performance compared to the 20 Midlands acute Trusts, as well as having the 6th fewest number of patient waits in excess of 78 weeks for routine treatment, with 73 of the 19,746 breaches in the Region. The Trust also has the 5th shortest median waiting time of the 20 regional acute organisations.

Summary: Key Areas of Concern

The majority of Emergency Access Standards continue to be a challenged performance area for the Trust. Ambulance handover delays of 60 minutes or more represents a significant performance and quality challenge for the Trust. This position worsened during July, exceeding the previous peak seen in April.

62 day cancer performance remained consistent last month and below target. However, despite overall Trust performance being static, gains were realised at a tumour site level; June saw an increase in the number of tumour sites achieving the target but set against a larger number of breaches in higher volume specialities. Additional weekend theatre lists have been offered in July and August for areas of concern.

The number of patients waiting 52 weeks or longer to commence routine treatment has increased in July to over 1,000. However, the Trust accounts for 0.36% of all 78 week plus breaches for the 20 Midlands acute Trusts.

Emergency Access Standards

July saw a reversal in the downward trend seen for 3 months against the 4 hour ED target. Performance increased by 4% during the month, placing the Trust 5th of the 13 West Midlands Trusts. Despite an increase in 4 hour performance, the number of 12 hour DTA breaches increased by 18 in July, compared to June. Ambulance handover delays in excess of 60 minutes increased in July, within the context of a 9.6% rise in ambulance conveyances to the Trust compared June. July's conveyances were consistent with those seen in May.

ED triage saw gains in improvement last month; 3 of the 4 areas realised improvement; of note, having fallen back in May and June, Majors increased by 4% and Paediatrics rose to just short of 90%. However, See and Treat saw a significant decline. Workforce challenges are significant contributing factors. The ED department are continuing to implement its workforce plan that seeks to resolve performance and substantive/agency imbalance. 13 new Band 5 recruits are due to commence in the autumn and flexible working has been implemented between Majors and See and Treat to support with triaging during times of surge.

Cancer (Data to June 2022)

The improvements seen with regards to the 2ww cancer standard in recent months has culminated in the Trust achieving the standard for the second consecutive month in June. This has been driven by an increase in performance in the larger volume speciates. Of note, Gynaecology did not achieve the standard in May, but made significant gains in June to deliver 94%.

Performance against the 31 day standard improved slightly in June, rising to 93.2% against a target of 96%, placing the Trust 1st out of the 4 Black Country and West Birmingham ICS acute Trusts, and marginally better than the overall England performance of 91%. 62 day performance remained static and consistent with May's figures, however, June saw an increase in the number of tumour sites attaining the standard. Delivery against the new tumour site 62 day recovery plans and reducing the number of patients waiting over 104 days are key actions to improve both the 31 and 62 day metrics. Last month, 5 of 9 tumour sites performed better than their 62 day trajectories.

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

RTT performance declined to 69.3% in July, down from 70% in June but the Trust delivered the 3rd best RTT performance when compared to the 20 Midlands Trusts within the month.

The number of patients waiting in excess of 52 weeks for routine procedures has also increased last month, rising to over 1,000. This increase has mainly been driven by Orthopaedics and specialties with high cancer workloads. Modelling has been undertaken on a speciality basis to ascertain the proportion of theatre lists that can be allocated to routine work, which has fed into a revised 52 week trajectory that has been developed by the Surgical Division. Within the Midlands Region of 20 acute Trusts, DGFT is placed 7th for the number of 104 week breaches (with 3 of the 2,190 total). The Trust also has the 6th fewest number of 78 week breeches, with 73 of the 19,746 within Region.

Progress is being made from an RTT restoration and recovery perspective; non admitted RTT completes performed just below the trajectory despite the planned new MPR facilities being delayed. These are now due to come online in September, providing the additional capacity that is reflected in the trajectory.

Impact on the Strategic Goals	
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:			
Risk	Y	Risk Description: BAF 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	Working / Exec Group	N	Date:
	Committee	Y	Date: F&P 22/08/2022
	Board of Directors	Y	Date: 22/09/2022
	Other	N	Date:

Performance KPIs

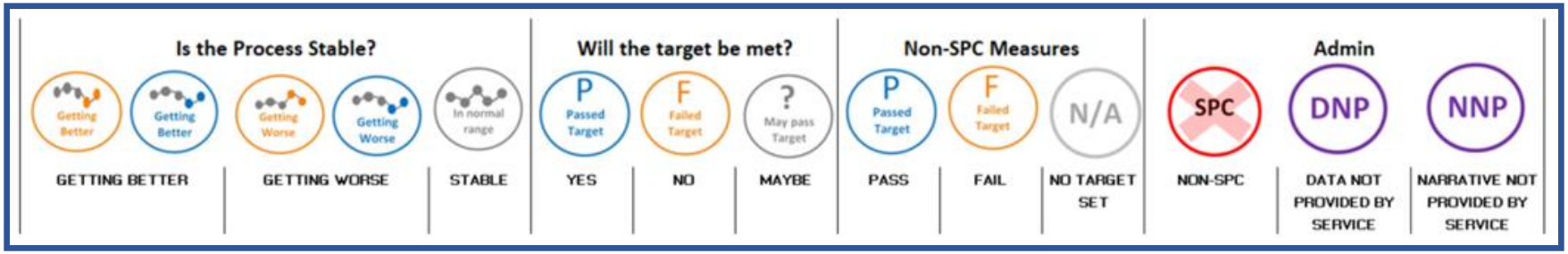
(July 2022 Data; June 2022 Data for Cancer)

Karen Kelly, Chief Operating Officer

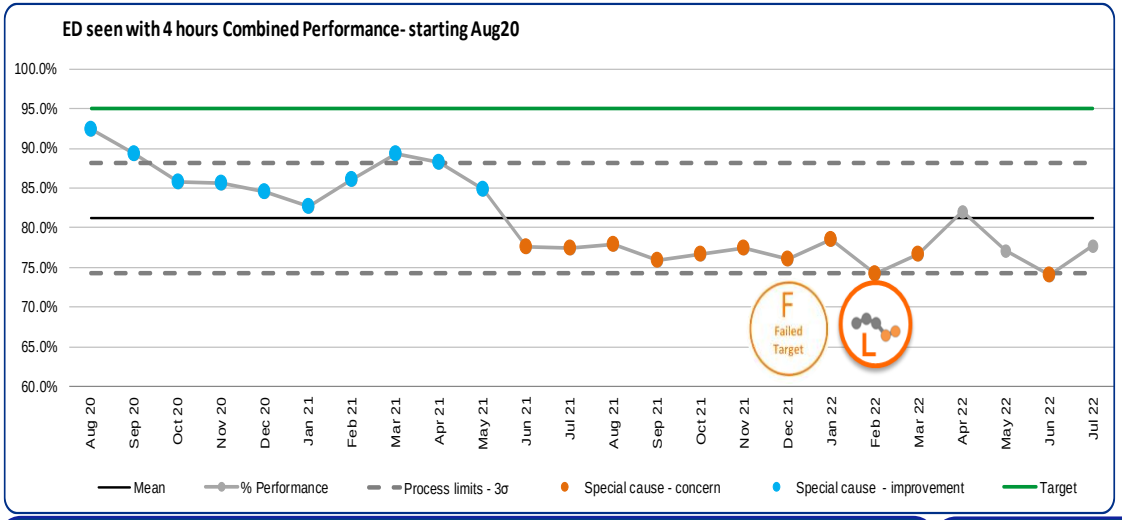
NHS
The Dudley Group
NHS Foundation Trust

Constitutional Performance

Constitutional Standard and KPI		Target	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Status	
Emergency Access Standard (EAS)	Combined 4hr Performance	95.0%	77.9%	75.9%	76.7%	77.4%	76.1%	76.7%	72.3%	74.7%	72.1%	77.1%	74.0%	77.8%	L	F
Triage	Triage - All	95.0%	87.8%	83.0%	80.9%	86.9%	89.2%	88.2%	86.4%	86.1%	90.1%	85.4%	84.8%	86.1%	In normal range	F
Cancer	Cancer 62 Day - All	85.0%	74.6%	74.2%	77.7%	70.8%	56.2%	73.9%	56.2%	73.9%	69.3%	69.7%	69.7%	N/A	In normal range	F
	Cancer 31 Day -	96.0%	86.6%	87.8%	91.5%	96.8%	90.0%	89.6%	91.5%	92.3%	93.0%	92.6%	93.2%	N/A	Getting Worse	F
	All Cancer 2 Week Waits	93.0%	78.9%	52.3%	53.2%	63.0%	67.4%	64.6%	78.5%	76.0%	86.9%	96.1%	93.1%	N/A	In normal range	F
Referral to Treatment (RTT)	RTT Incomplete	92%	77.3%	76.1%	75.9%	75.9%	74.9%	73.7%	72.9%	73.6%	73.3%	73.6%	71.0%	69.3%	Getting Worse	F
Diagnostics	DM01 - Diagnostics achieved within 6 weeks	99%	77.0%	80.2%	77.4%	83.0%	78.1%	76.5%	82.8%	82.3%	78.1%	81.8%	83.1%	84.2%	In normal range	F
VTE	% Assessed on Admission	95%	92.1%	90.9%	89.7%	93.7%	89.5%	89.6%	94.1%	93.7%	93.6%	94.1%	93.7%	93.4%	In normal range	F



ED Performance



Latest Month	Latest Month	5th
77.8%	67	For June 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

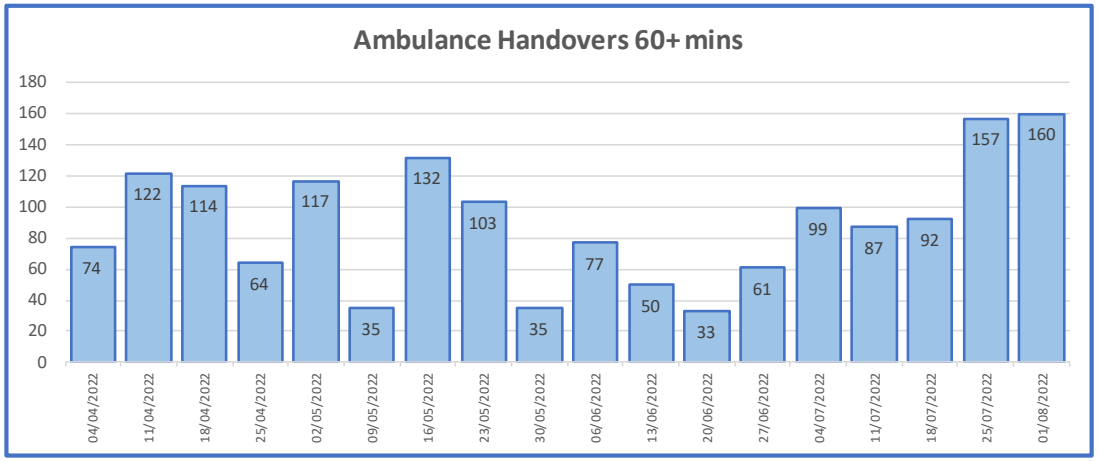
Performance

- Overall, ED 4 hour performance realised an almost 4% increase in July, compared to June
- This performance, places the Trust 5th of the 13 West Midlands Trusts, consistent with last month
- Despite the improvement in 4 hour performance the number of 12 hour DTA breaches increased by 18 in July, compared to June
- Substantive workforce challenges are a contributing factor in performance. Short term sickness reported last month due to Covid eased slightly in July

Action

- To continue to operationalise workforce plan. Next milestones:
  - X13 new Band 5 starters due in September/October
  - X3 new Band 2 starters due in September
  - Commence recruitment process for 2.0 WTE Band 6's
- Recruitment is on track to deliver increase in Band 5s by the autumn

Ambulance Handovers 60+ Mins



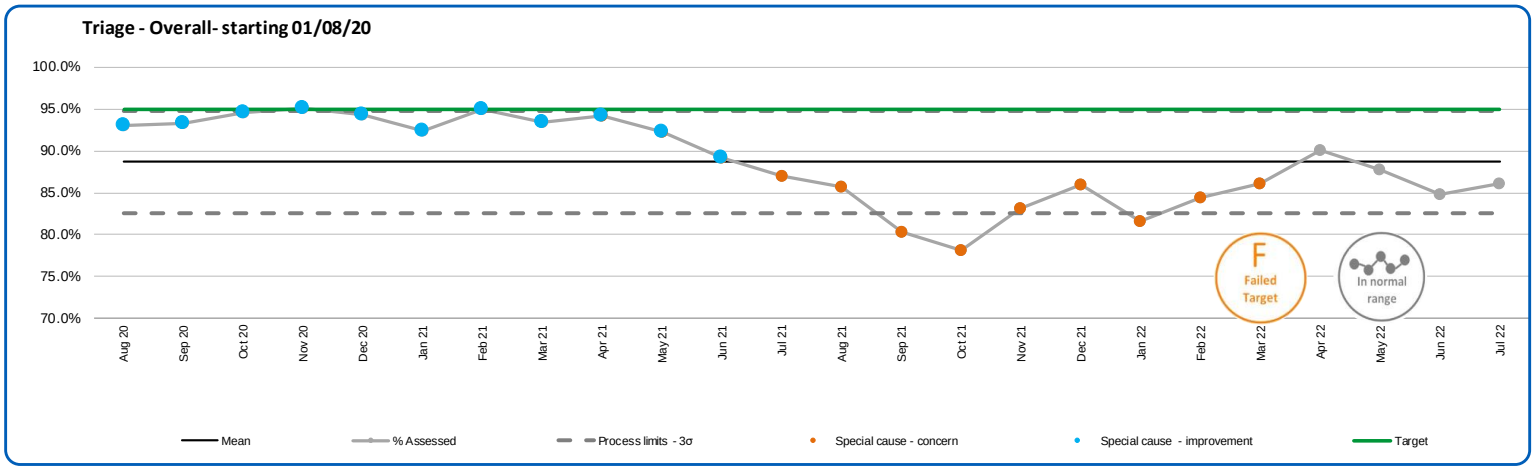
Performance

- Ambulance handover delays of over 60 minutes continues to be a challenged area for the Trust
- Recent weeks have seen a rise in the number of delayed ambulance crews waiting over one hour, exceeding the previous peaks seen in April
- Ambulance conveyances to the Trust increased by 9.6% in July compared to June, returning to levels last seen in May

Action

- Operational focus on attaining early discharges to continue – the last 4 weeks have seen a week-on-week increase in discharge lounge usage
- Continue to support a cohorting facility within ED, to release West Midlands Ambulance Service crews earlier

ED Triage



Latest Month

86.1%

Triage – target 95%

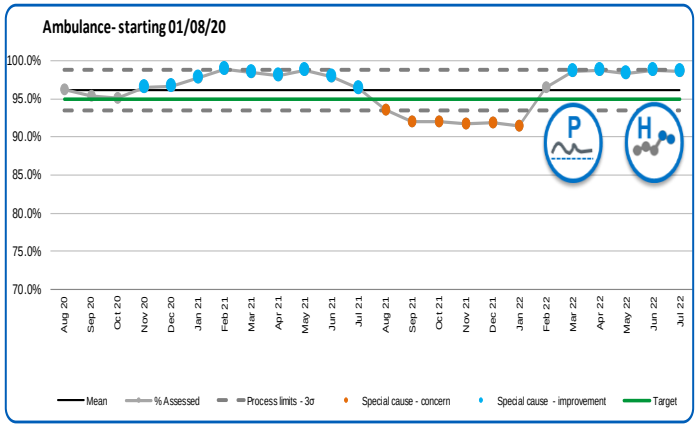
Performance

- Overall ED triage compliance improved in July, increasing to 86.1%, up from 84% in June
- Improvement was realised in 3 of the 4 triage areas, however, See and Treat saw a marked decline in performance

Action

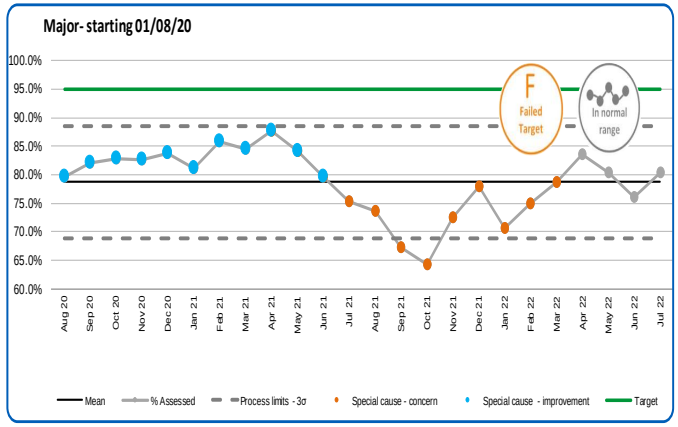
- Overall, to continue to implement workforce plan that seeks to resolve performance and substantive/agency imbalance. During July, on average, 47% of staff on day shifts and 55% on night shifts within ED were agency workers

ED Triage



Latest Month

98.6%



Latest Month

80.4%

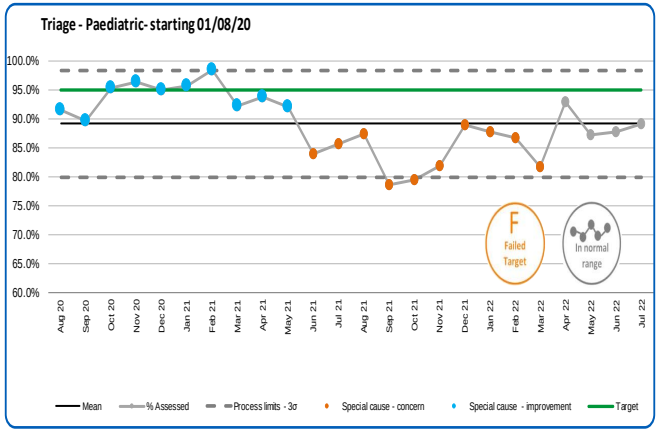
Performance

- Ambulance triage continues to perform well, achieving the standard in July
- Having fallen back in May and June, Majors triage has started to reverse this tend, increasing by 4% in July to 80.4%

Action

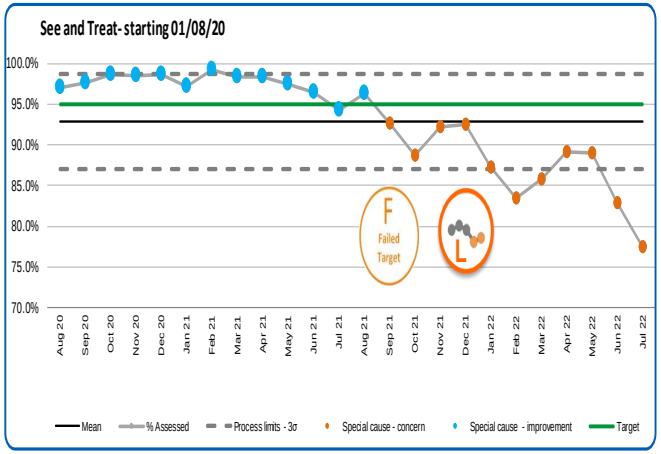
- Continue to utilise flexile workforce between See and Treat and Majors to support each other during times of surge, when capacity allows
- 13 new Band 5 recruits are due to commence in September/October. These staff are a mixture of graduate nurses who have been based within ED during their last academic year, international recruits and experienced external staff

ED Triage



Latest Month

89.2%



Latest Month

77.4%

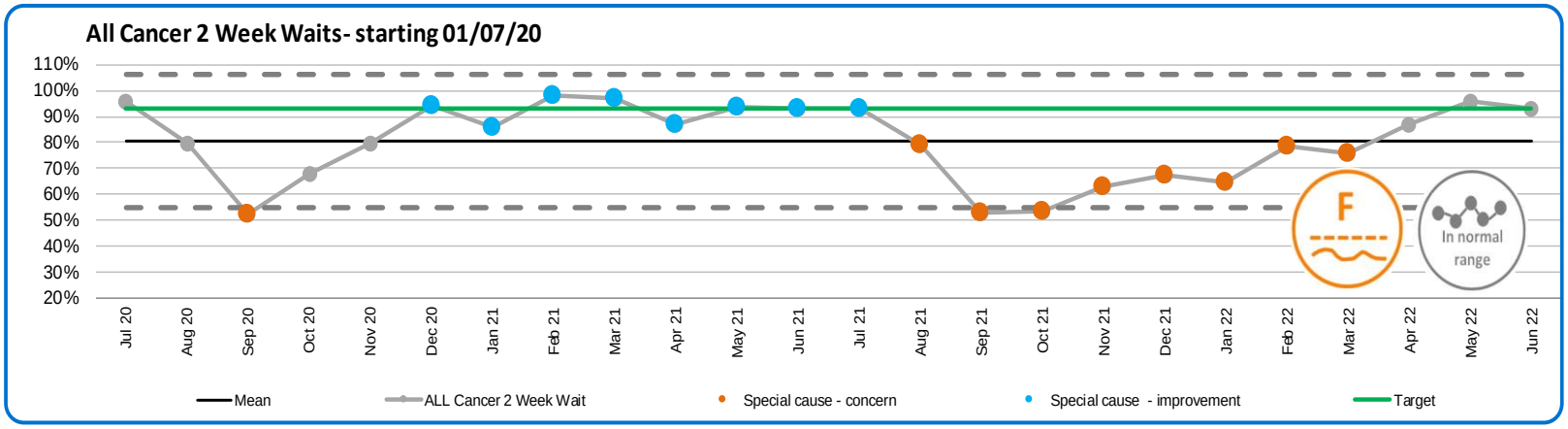
Performance

- Paediatric triage also saw small gains in July, increasing to just short of 90%, which represents a month-on-month improvement for 3 months
- See and Treat saw a significant decline in performance in July, despite an uptick in performance in the first week of the month when compared to June. Performance can be attributed to workforce challenges

Action

- Introduction of a Helicopter Band 7 coordination role - due to be launched at the end of August

Cancer Performance – 2 Week Wait



Latest Month

93.1%

All cancer 2 week waits – target 93%

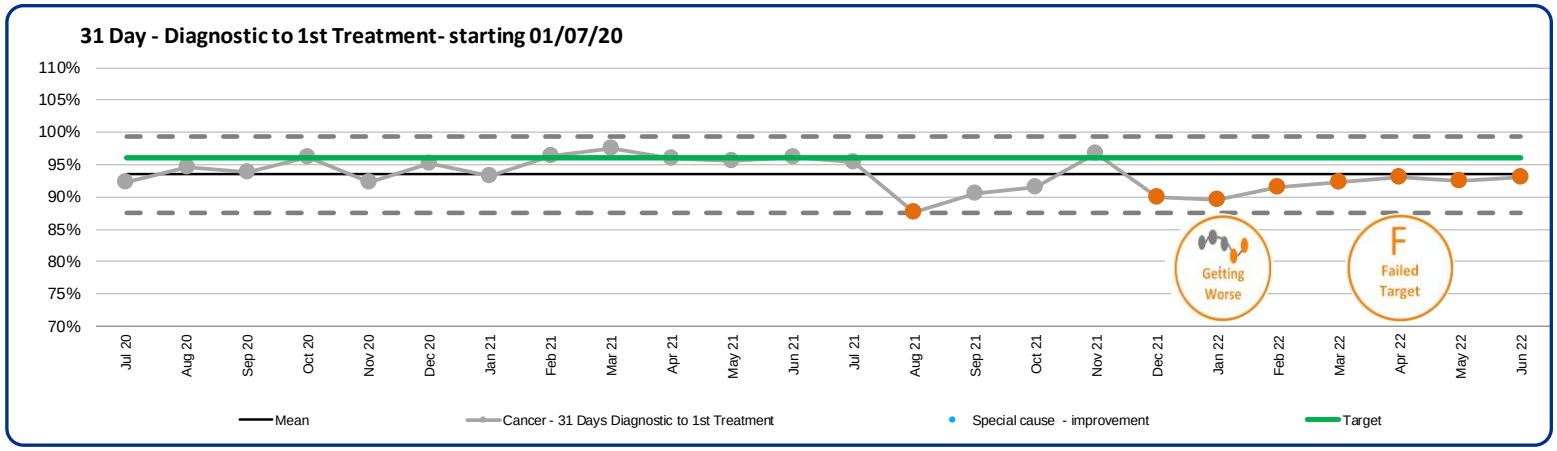
Performance

- All cancer data runs two months behind. Data included within this pack is up to and including June 2022
- Having attained the standard in May for the first time since July 2021, the Trust achieved the required performance for the second month running in June
- This position places the Trust 2nd out of the 4 Black Country and West Birmingham ICS acute Trusts
- DGFT performance of 93.1% is within the context of the total England performance of 77%
- At a tumour site level, Gynaecology did not achieve 93% in last months report, but made significant improvements in June to attain 94%

Action

- Continue to monitor clinic template exceptions though the Operational Performance Management Group to ensure full clinic utilisation
- Conduct a demand and capacity modelling exercise to ascertain whether any additional capacity that has been utilised to achieve the target, needs to be included within baseline clinic templates in the future to maintain performance

Cancer Performance – 31 Day



Latest Month

93.2%

Target 96%

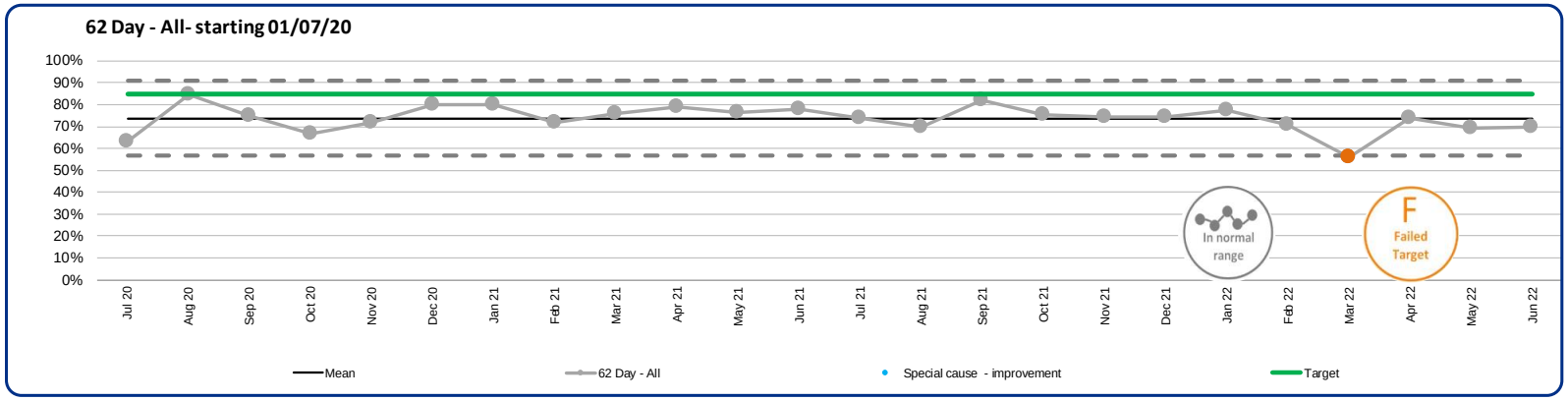
Performance

- June's performance against the 31 day standard saw a small uptick on May, rising to 93.2%
- There was an increase in the number of tumour sites achieving the standard in June: 5 of 9 tumour sites attained the target
- Notable performance improvement was realised in Upper GI and Urology in June: both specialities achieved 93% within the month
- The number of breaches within June fell by 3 compared to May, down to a total of 10
- Trust performance of 93.2% places DGFT 1st of the 4 Black Country and West Birmingham ICS acute Trusts. This is set against an all England provider performance of 91%

Action

- Focus remains on reducing the backlog of 104 day waits further, in order to release treatment capacity for 31 days

Cancer Performance – 62 Day - All



Latest Month

69.7%

Target 85%

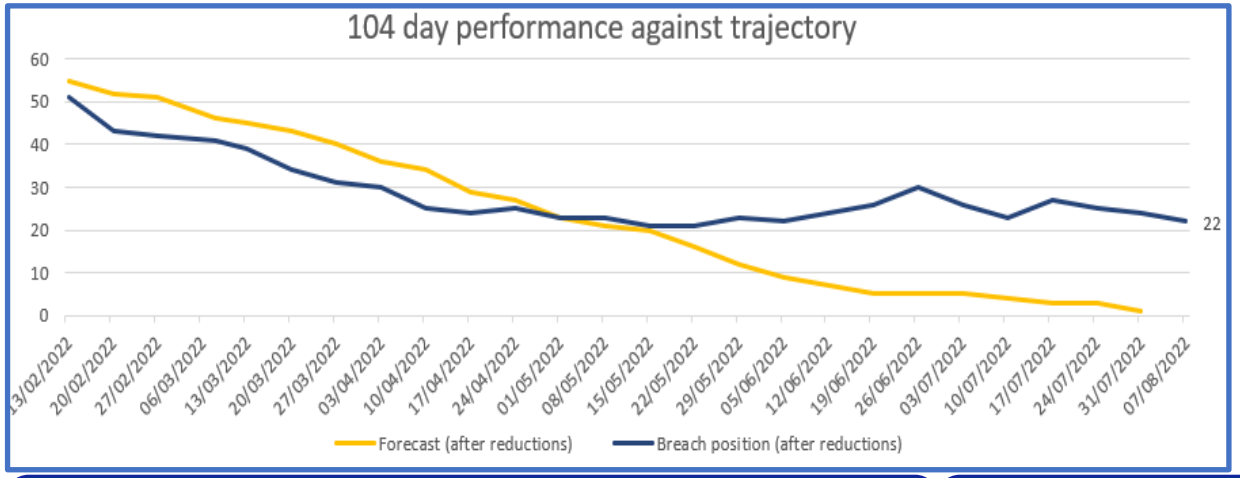
Performance

- June's performance for 62 day standard for first definitive treatment matched May's performance at 69.7%
- Despite overall Trust performance remaining static, June saw an increase in the number of tumour sites achieving the target
- At a tumour site level, Skin has continued its month on month improvement in performance, attaining the standard in June

Action

- Continue to prioritise theatre list access in Surgery to P2 cancer patients
- Monitor performance on a weekly basis against the 62 day recovery plans for each tumour site that were developed last month. 5 of 9 tumour sites performed better than their trajectory in June
- The Clinical Support Services Division continues to work closely with external partners involved in delivering 62 day pathways such as BPCN to improve histology turnaround times (largely pertinent to Skin) and RWH for access to Oncology capacity

Cancer Performance – 104 Day



Source: Weekly Cancer Performance

Latest Week

(07/08/22)

22

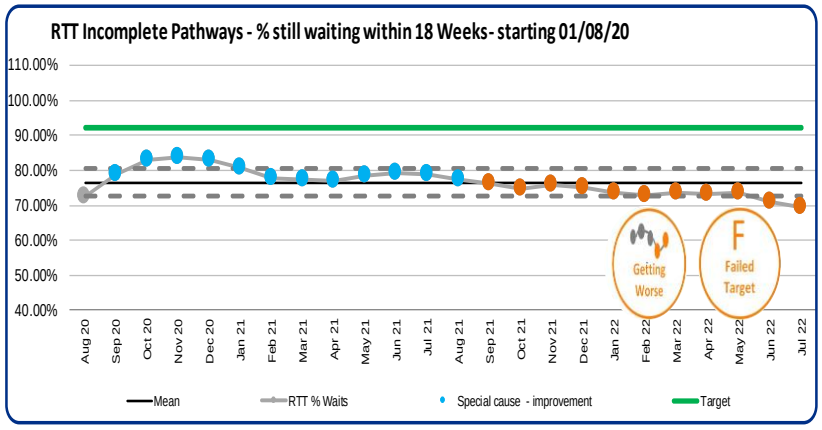
Performance

- Data for 104 day performance runs until early August
- The recent uptick seen in the 104 day backlog has started to steadily reduce in over the last 4 weeks
- The recent increase in the backlog has largely been driven by Colorectal, Gynae and Skin. Of these tumour sites, Colorectal has halved the number of patients waiting over 104 days since July's IPR report and Skin has reduced its backlog to just 3 patients

Action

- Continue with additional, temporary capacity in tumour site such as Colorectal
- Workforce gaps in Skin are being temporarily resolved through locum support, to bring the backlog down further and to maintain service provision
- Enhanced PTL tracking at a patient level for patients waiting over 104 days and patients who are at risk of tipping over into 104 days

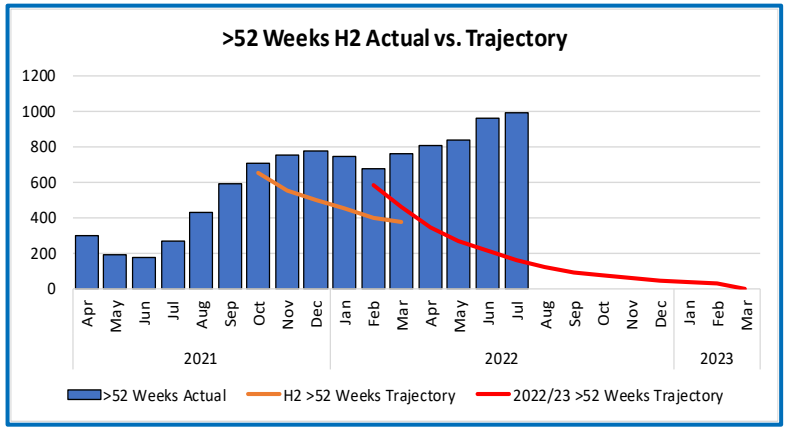
RTT Performance



Latest Month

69.3%

RTT Incomplete pathways target 92%



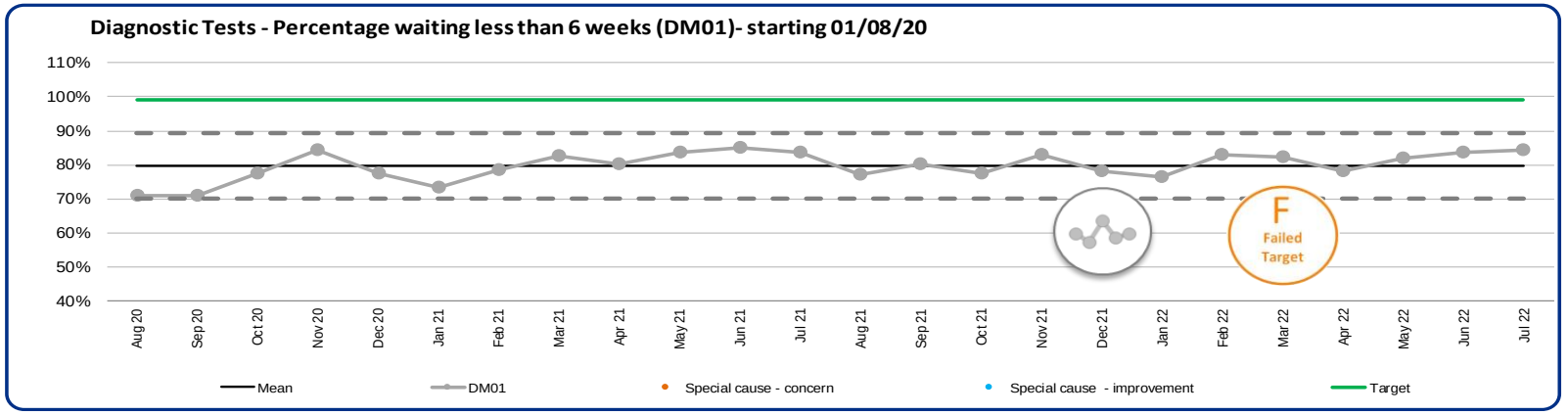
Performance

- RTT performance declined in July compared to June, to 69.3%
- The number of patients waiting over 52 weeks to commence routine treatment has increased to over 1,000. This position is being driven by General Surgery, Urology, T&O, Gynae, Plastic Surgery and ENT
- The Trust is placed 7th of 20 Midlands acute Trusts for the number of 104 week breaches (with just 3). There are 2,190 104 week breaches across the 20 Midlands organisations
- Specialties with a large cancer workload are some the most challenged areas as they balance cancer and routine demand. For example, Plastics have only been able to use 10% of their theatre lists for routine activity, with the remaining 90% being utilised for skin cancer cases

Action

- Modelling has been undertaken on a speciality basis to ascertain the proportion of theatre lists can be realistically allocated to routine work
- Surgery is leading on productivity gains to support greater throughput of activity
- The most challenged specialties are being prioritised for additional weekend theatre lists
- A revised trajectory for the reduction of 52 + weeks backlog has been devised by the SWC Division, which is being tabled separately at Finance & Performance Committee

DM01 Performance



Latest Month

84.2%

DM01 combining 15 modalities - target 99%

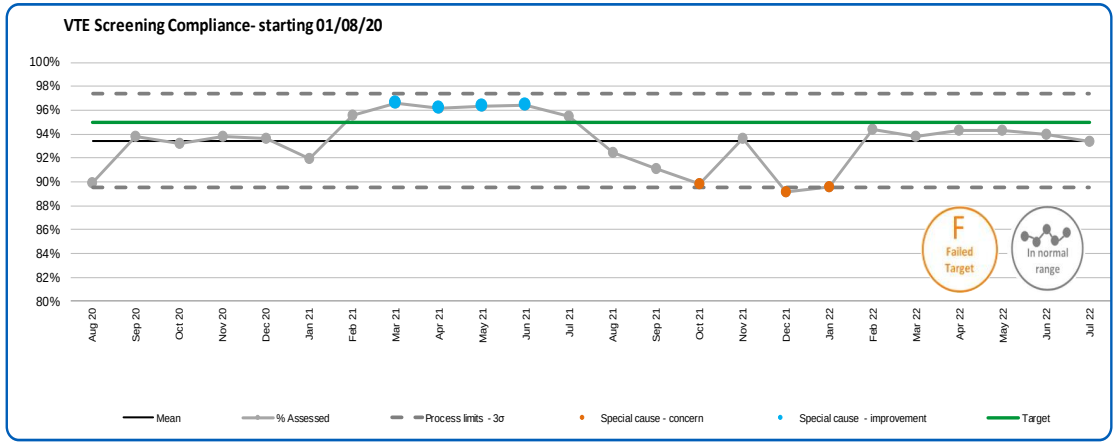
Performance

- DM01 performance remains below target but has realised a small improvement in overall performance for the third consecutive month
- There has been a considerable increase in performance in Imaging and CT
- The Sleep Studies recovery plan is on course to deliver, increasing to 98.93% in July, up from 39% in March

Action

- DM01 is on track to deliver 95% within 6 weeks by March 2023, as per national requirements
- Performance seen in some modalities has been driven by a new assurance meeting
- Improvement is to be focused on endoscopy

VTE Performance



Latest Month	Latest Month	Latest Month
93.4%	93.5%	93.2%
Trust overall Position	**Medicine & IC**	**Surgery, W & C**

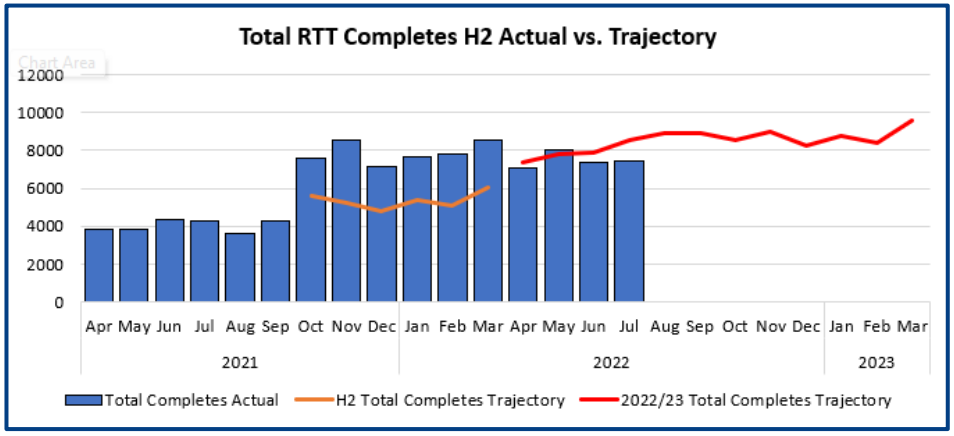
Performance

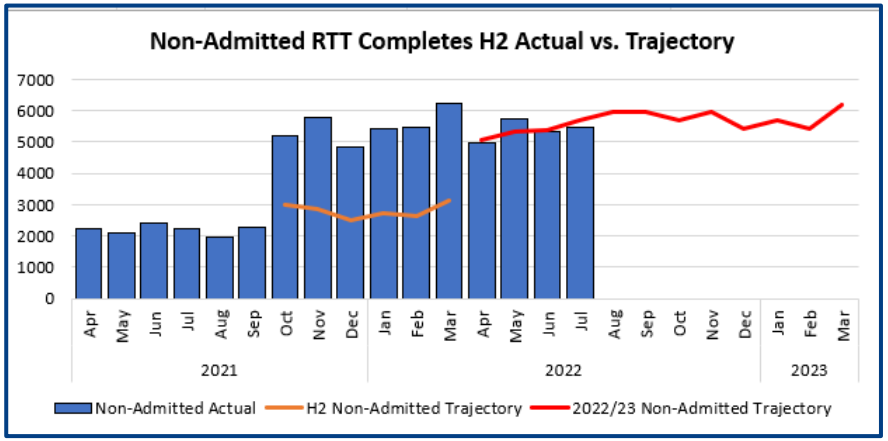
- VTE performance fell slightly during June, to 93.4% from 93.7%.
- Surgery remained static at 93.2%, while Medicine fell from 94.1% to 93.5%
- Overall Trust performance remains just short of the required standard

Action

- Surgery continue to monitor completion of their new checklist, which has been a key influence in significantly improving its performance in recent months

Recovery and Restoration – RTT Completes





Performance

- RTT completes fell slightly below trajectory in June
- This can be partially attributed to the delayed opening of the two new MPR facilities – the annual plan and trajectory planned for this additional capacity, and associated activity, to become available in June
- Non admitted RTT completes performed just below trajectory in June
- The Trust has the 6th fewest number of 78 week plus breaches, compared to the 20 Midlands acute Trusts with 73 of the 19,746 total breaches for the 20 Trusts in the Region
- DGFT has the 5th shortest median waiting time of the 20 Midlands acute Trusts

Action

- X2 new MPR facilities, that have been delayed, are now planned to be operational in early September, providing additional capacity
- Additional theatre provision is to be allocated to specialties with the highest number of patients over 78 weeks
- Continue to focus on irradiating 78 week breaches by March 2023, as per national requirements

RTT Restoration and Recovery – Trust Comparisons

0-18 Week RTT Performance (Midlands Region): 3rd

Region Code	Provider Code	Provider Name	Total number of incomplete pathways	Total within 18 weeks	% within 18 weeks
Y60	RJC	SOUTH WARWICKSHIRE NHS FOUNDATION TRUST	27,354	20,143	73.6%
Y60	RK5	SHERWOOD FOREST HOSPITALS NHS FOUNDATION TRUST	43,008	30,874	71.8%
Y60	RNA	THE DUDLEY GROUP NHS FOUNDATION TRUST	38,942	27,663	71.0%
Y60	RLT	GEORGE ELIOT HOSPITAL NHS TRUST	14,128	9,806	69.4%
Y60	RNQ	KETTERING GENERAL HOSPITAL NHS FOUNDATION TRUST	26,316	18,254	69.4%
Y60	RXK	SANDWELL AND WEST BIRMINGHAM HOSPITALS NHS TRUST	62,400	40,710	65.2%
Y60	RL4	THE ROYAL WOLVERHAMPTON NHS TRUST	65,310	41,787	64.0%
Y60	RLQ	WYE VALLEY NHS TRUST	19,038	12,040	63.2%
Y60	RFS	CHESTERFIELD ROYAL HOSPITAL NHS FOUNDATION TRUST	23,103	14,583	63.1%
Y60	RX1	NOTTINGHAM UNIVERSITY HOSPITALS NHS TRUST	69,711	43,945	63.0%
Y60	RBK	WALSALL HEALTHCARE NHS TRUST	31,447	19,457	61.9%
Y60	RTG	UNIVERSITY HOSPITALS OF DERBY AND BURTON NHS FOUNDATION TRUST	100,185	58,848	58.7%
Y60	RXW	THE SHREWSBURY AND TELFORD HOSPITAL NHS TRUST	35,250	20,227	57.4%
Y60	RJE	UNIVERSITY HOSPITALS OF NORTH MIDLANDS NHS TRUST	76,651	42,093	54.9%
Y60	RWD	UNITED LINCOLNSHIRE HOSPITALS NHS TRUST	68,137	34,610	50.8%
Y60	RWE	UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST	123,182	60,654	49.2%
Y60	RWP	WORCESTERSHIRE ACUTE HOSPITALS NHS TRUST	63,319	31,144	49.2%
Y60	RRK	UNIVERSITY HOSPITALS BIRMINGHAM NHS FOUNDATION TRUST	161,794	67,276	41.6%
Y60	RKB	UNIVERSITY HOSPITALS COVENTRY AND WARWICKSHIRE NHS TRUST	62,827		
Y60	RNS	NORTHAMPTON GENERAL HOSPITAL NHS TRUST	29,783		

RTT Restoration and Recovery – Trust Comparisons

Number of Patients Waiting 78+ Weeks for Routine Treatment (Midlands Region): 6th

Region Code	Provider Code	Provider Name	Total 78 plus weeks
Y60	RLT	GEORGE ELIOT HOSPITAL NHS TRUST	-
Y60	RNQ	KETTERING GENERAL HOSPITAL NHS FOUNDATION TRUST	15
Y60	RNS	NORTHAMPTON GENERAL HOSPITAL NHS TRUST	18
Y60	RJC	SOUTH WARWICKSHIRE NHS FOUNDATION TRUST	27
Y60	RK5	SHERWOOD FOREST HOSPITALS NHS FOUNDATION TRUST	72
Y60	RNA	THE DUDLEY GROUP NHS FOUNDATION TRUST	73
Y60	RBK	WALSALL HEALTHCARE NHS TRUST	132
Y60	RLQ	WYE VALLEY NHS TRUST	143
Y60	RXK	SANDWELL AND WEST BIRMINGHAM HOSPITALS NHS TRUST	201
Y60	RWD	UNITED LINCOLNSHIRE HOSPITALS NHS TRUST	208
Y60	RFS	CHESTERFIELD ROYAL HOSPITAL NHS FOUNDATION TRUST	230
Y60	RKB	UNIVERSITY HOSPITALS COVENTRY AND WARWICKSHIRE NHS TRUST	286
Y60	RXW	THE SHREWSBURY AND TELFORD HOSPITAL NHS TRUST	354
Y60	RL4	THE ROYAL WOLVERHAMPTON NHS TRUST	360
Y60	RX1	NOTTINGHAM UNIVERSITY HOSPITALS NHS TRUST	924
Y60	RTG	UNIVERSITY HOSPITALS OF DERBY AND BURTON NHS FOUNDATION TRUST	943
Y60	RJE	UNIVERSITY HOSPITALS OF NORTH MIDLANDS NHS TRUST	1,021
Y60	RWP	WORCESTERSHIRE ACUTE HOSPITALS NHS TRUST	1,644
Y60	RWE	UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST	3,717
Y60	RRK	UNIVERSITY HOSPITALS BIRMINGHAM NHS FOUNDATION TRUST	9,377

RTT Restoration and Recovery – Trust Comparisons

Number of 104 Week Breaches (Midlands Region): 7th

Region Code	Provider Code	Provider Name	104 plus
Y60	RJC	SOUTH WARWICKSHIRE NHS FOUNDATION TRUST	-
Y60	RLT	GEORGE ELIOT HOSPITAL NHS TRUST	-
Y60	RKB	UNIVERSITY HOSPITALS COVENTRY AND WARWICKSHIRE NHS TRUST	-
Y60	RK5	SHERWOOD FOREST HOSPITALS NHS FOUNDATION TRUST	1
Y60	RXK	SANDWELL AND WEST BIRMINGHAM HOSPITALS NHS TRUST	1
Y60	RBK	WALSALL HEALTHCARE NHS TRUST	1
Y60	RNA	THE DUDLEY GROUP NHS FOUNDATION TRUST	3
Y60	RWD	UNITED LINCOLNSHIRE HOSPITALS NHS TRUST	6
Y60	RNQ	KETTERING GENERAL HOSPITAL NHS FOUNDATION TRUST	9
Y60	RNS	NORTHAMPTON GENERAL HOSPITAL NHS TRUST	12
Y60	RLQ	WYE VALLEY NHS TRUST	21
Y60	RFS	CHESTERFIELD ROYAL HOSPITAL NHS FOUNDATION TRUST	33
Y60	RXW	THE SHREWSBURY AND TELFORD HOSPITAL NHS TRUST	40
Y60	RL4	THE ROYAL WOLVERHAMPTON NHS TRUST	57
Y60	RTG	UNIVERSITY HOSPITALS OF DERBY AND BURTON NHS FOUNDATION TRUST	146
Y60	RJE	UNIVERSITY HOSPITALS OF NORTH MIDLANDS NHS TRUST	157
Y60	RWP	WORCESTERSHIRE ACUTE HOSPITALS NHS TRUST	161
Y60	RX1	NOTTINGHAM UNIVERSITY HOSPITALS NHS TRUST	162
Y60	RRK	UNIVERSITY HOSPITALS BIRMINGHAM NHS FOUNDATION TRUST	539
Y60	RWE	UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST	544

RTT Restoration and Recovery – Trust Comparisons

Median Waiting Time (Midlands Region): 5th Shortest

Region Code	Provider Code	Provider Name	Average (median) waiting time (in weeks)
Y60	RJC	SOUTH WARWICKSHIRE NHS FOUNDATION TRUST	9.8
Y60	RK5	SHERWOOD FOREST HOSPITALS NHS FOUNDATION TRUST	9.9
Y60	RNS	NORTHAMPTON GENERAL HOSPITAL NHS TRUST	10.0
Y60	RLT	GEORGE ELIOT HOSPITAL NHS TRUST	11.2
Y60	RNA	THE DUDLEY GROUP NHS FOUNDATION TRUST	11.3
Y60	RNQ	KETTERING GENERAL HOSPITAL NHS FOUNDATION TRUST	11.8
Y60	RL4	THE ROYAL WOLVERHAMPTON NHS TRUST	12.7
Y60	RXK	SANDWELL AND WEST BIRMINGHAM HOSPITALS NHS TRUST	12.8
Y60	RX1	NOTTINGHAM UNIVERSITY HOSPITALS NHS TRUST	12.9
Y60	RFS	CHESTERFIELD ROYAL HOSPITAL NHS FOUNDATION TRUST	13.0
Y60	RLQ	WYE VALLEY NHS TRUST	13.2
Y60	RBK	WALSALL HEALTHCARE NHS TRUST	13.4
Y60	RTG	UNIVERSITY HOSPITALS OF DERBY AND BURTON NHS FOUNDATION TRUST	14.6
Y60	RXW	THE SHREWSBURY AND TELFORD HOSPITAL NHS TRUST	15.0
Y60	RJE	UNIVERSITY HOSPITALS OF NORTH MIDLANDS NHS TRUST	15.8
Y60	RKB	UNIVERSITY HOSPITALS COVENTRY AND WARWICKSHIRE NHS TRUST	15.8
Y60	RWD	UNITED LINCOLNSHIRE HOSPITALS NHS TRUST	17.6
Y60	RWE	UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST	18.4
Y60	RWP	WORCESTERSHIRE ACUTE HOSPITALS NHS TRUST	18.4
Y60	RRK	UNIVERSITY HOSPITALS BIRMINGHAM NHS FOUNDATION TRUST	23.1

Cancer Restoration and Recovery – Trust Comparisons

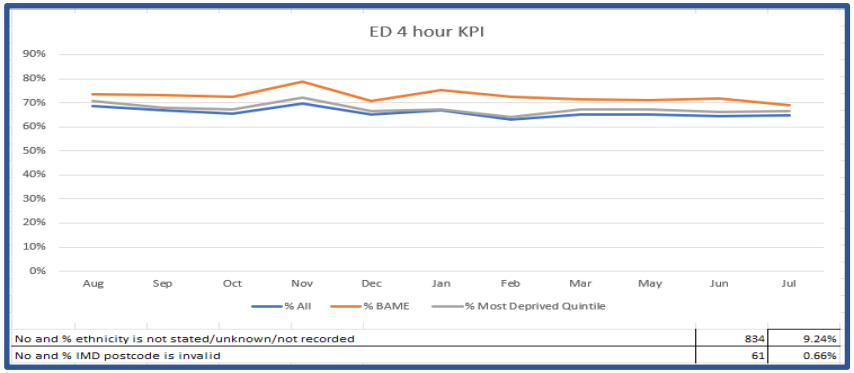
2 Week Wait: 2nd ICS

ACCOUNTABLE PROVIDER	PERCENTAGE SEEN WITHIN 14 DAYS
SANDWELL AND WEST BIRMINGHAM HOSPITALS NHS TRUST	94.72%
THE DUDLEY GROUP NHS FOUNDATION TRUST	93.08%
THE ROYAL WOLVERHAMPTON NHS TRUST	91.05%
WALSALL HEALTHCARE NHS TRUST	79.98%
ALL ENGLISH PROVIDERS	**77.71%**

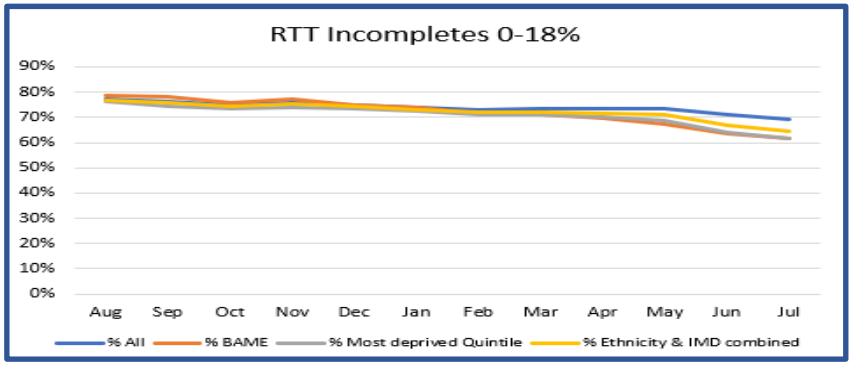
31 Day 2st Treatment: 1st ICS

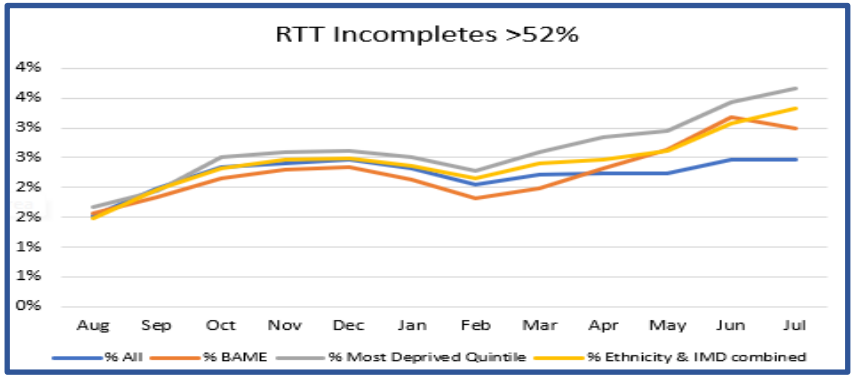
ACCOUNTABLE PROVIDER	PERCENTAGE TREATED WITHIN 31 DAYS
THE DUDLEY GROUP NHS FOUNDATION TRUST	93.15%
WALSALL HEALTHCARE NHS TRUST	90.14%
SANDWELL AND WEST BIRMINGHAM HOSPITALS NHS TRUST	89.39%
THE ROYAL WOLVERHAMPTON NHS TRUST	73.97%
ALL ENGLISH PROVIDERS	**91.83%**

Health Inequalities



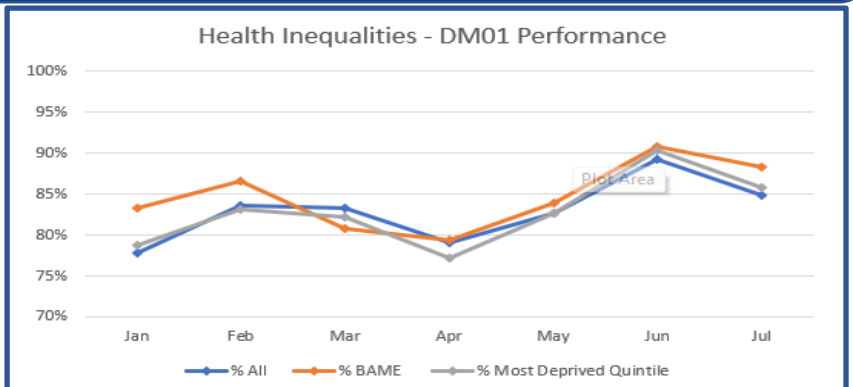
No and % ethnicity is not stated/unknown/not recorded	834	9.24%
No and % IMD postcode is invalid	61	0.66%



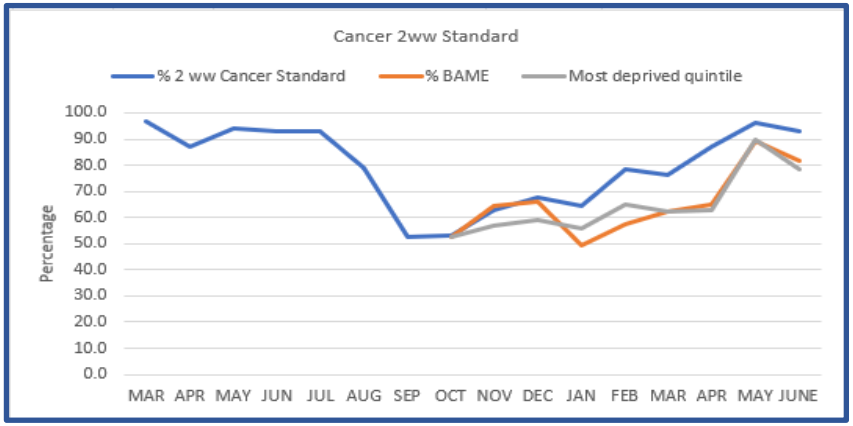


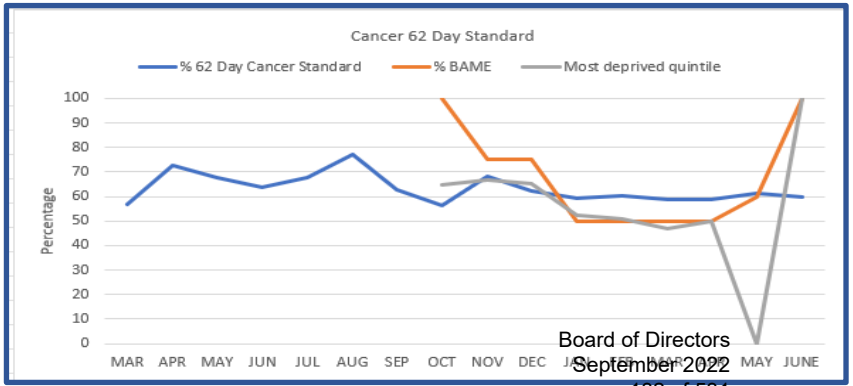
No and % ethnicity is not stated/unknown/not recorded	16750	41.5%
No and % IMD postcode is invalid/missing	12064	29.9%

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	1068	13.81%
No and % IDM postcode is invalid	18	0.22%





0 = no BAME patients identified in this months data

Enclosure 12

The Dudley Group NHS Foundation Trust

Paper for submission to Board of Directors on 22nd September 2022

Title:	Strategy progress report – Q1 2022/23
Author:	Ian Chadwell, Senior Strategy Development Lead
Presenter:	Kat Rose, Director of Strategy & Partnerships

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

Recommendations:

- To note the strategy progress report for Q1 2022/23

Summary of Key Issues:

A report to cover Q1 (Apr-Jun) was compiled with input from the different lead Executives and their respective teams. The report shows a summary against the twelve measures of success, narrative summarising progress against each goal and progress for the three transformation programmes in the strategic plan.

Relevant content from the report was presented to Finance & Performance, Quality & Safety and Workforce & Staff Engagement Committees in July and has been reviewed at each committee.

Compared to the previous quarter, one measure of success (reduce cost per weighted activity) has moved from amber to red given the high medical and nursing staff costs per weighted activity and the challenges of identifying efficiency savings. One measure of success (improve rate of early detection of cancers) has been moved from red to amber following improvement in the completion of cancer staging data and progression of plans to implement a tobacco treatment service.

Given the time delay between the production of the report and its approval at the July committees, some of the information contained within the report may be outdated by the time of the September Board.

Throughout September, a series of walkabouts have been planned to talk with staff about the strategy and their role in delivering it. These will cover all Trust areas and include Executive Directors, other senior staff and in some cases Non-executive Directors. Themes emerging from the walkabouts will be captured and feedback provided at the Board/Council of Governors Trust Strategy Review on 29th September 2022.

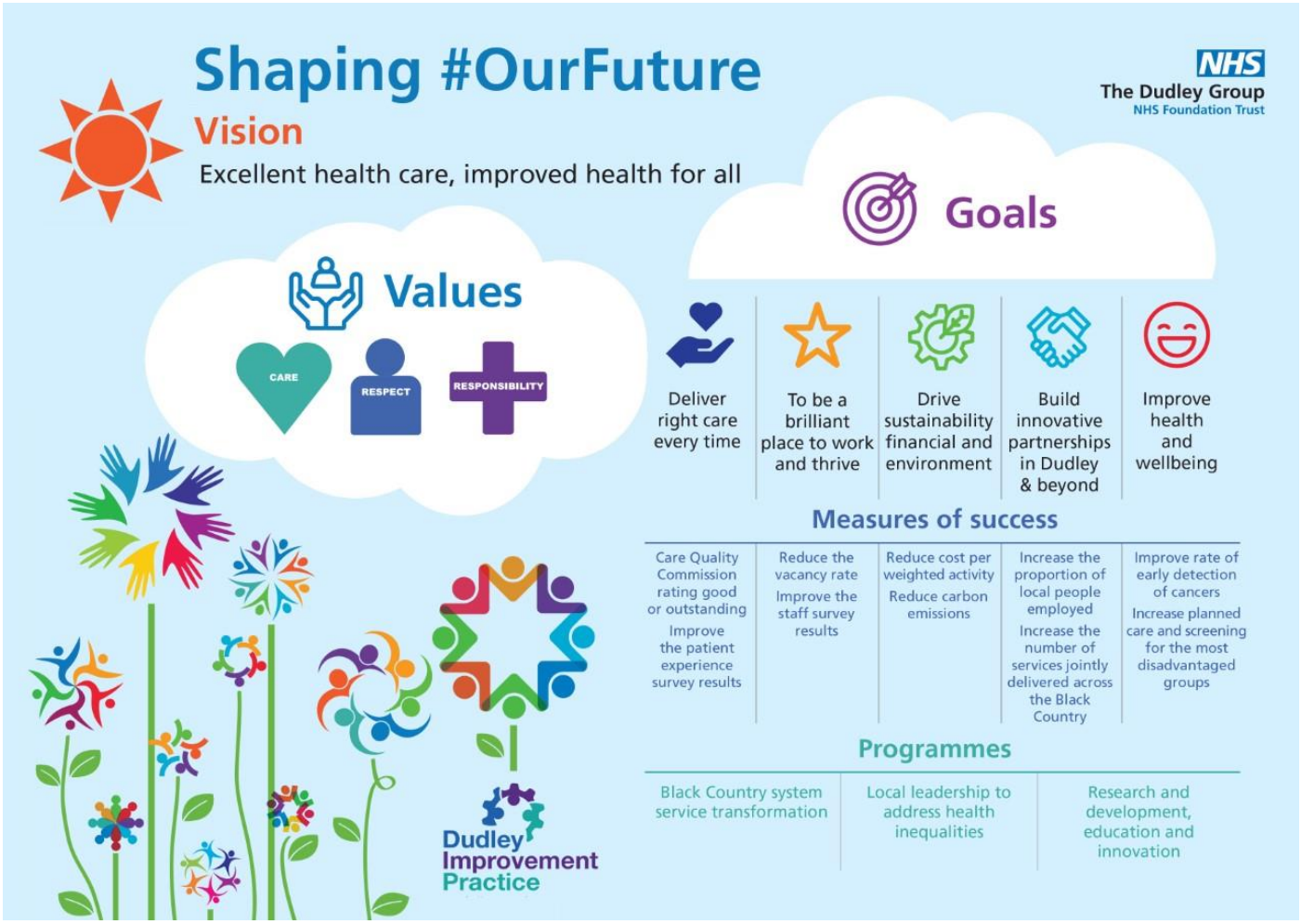
Impact on the Strategic Goals	
Deliver right care every time	✓
Be a brilliant place to work and thrive	✓
Drive sustainability (financial and environmental)	✓
Build innovative partnerships in Dudley and beyond	✓
Improve health and wellbeing	✓

Implications of the Paper:			
Risk	Y/N	Risk Description: *Inc risk ref number*	
	On Risk Register: Y/N	Risk Score:	
Compliance and/or Lead Requirements	CQC	Y	Details: well-led
	NHSE/I	N	Details:
	Other	N	Details:

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

Implementing our strategic plan Shaping #OurFuture

Quarterly Report April - June 2022



This report provides an update on implementation of the strategic plan 2021 – 2024 in two parts:

Part 1 – a summary of the status of each of the measures of success

Part 2 – progress against each of the five goals with updates on the measures of success

Part 3 – progress against each of the three transformation programmes that will help make progress against the goals

Progress has been RAG rated where:

	Actions are on track
	Actions started but not yet completed
	Actions not started or at risk of not achieving

Part 1 – Summary of status for measures of success

			RAG rating	
Goal	**Measure of Success**	**Current status**	**this quarter**	**Last quarter**
Deliver right care every time	CQC good or outstanding	All outstanding actions from 2108 CQC action plan closed; Quality & Safety reviews showing 2/13 services satisfactory and 10/13 working towards satisfactory		
	Improve the patient experience results	All FFT percentage very good/good scores are below the national average for all departments		
Be a brilliant place to work and thrive	Reduce the vacancy rate	Current vacancy rate is 14%; international nurse recruitment has started		
	Improve the staff survey results	Steering Groups for Health & Wellbeing and EDI fully established; Divisional engagement plans in place		
Drive sustainability	Reduce cost per weighted activity	Recently refreshed Model Hospital metrics continued to show medical and nursing staff costs in highest quartile; challenges to identify schemes to cover required CIP target		
	Reduce carbon emissions	Successful recruitment for dedicated sustainability lead; outstanding problems with obtaining baseline information		
Build innovative partnerships in Dudley and beyond	Increase the proportion of local people employed	Current proportion of staff who live locally unchanged at 65%; plans to develop closer partnership with local schools progressed		
	Increase the number of services jointly delivered across the Black Country	Leadership and active engagement by Trust in the Black Country Provider Collaborative; governance arrangements refreshed to align with statutory ICS		
Improve health & wellbeing	Improve rate of early detection of cancers	Some improvement in cancer staging data especially for lung; plans to introduce tobacco treatment service progressing		
	Increased planned care and screening for the most disadvantaged groups	Proactive actions being taken by breast screening service to improve uptake by disadvantaged groups; audit under way to better understand reasons for patients who DNA appointments		

Part 2 – Goals and measures of success

<table>
<tr><th colspan="2">Goal: Deliver right care every time</th><th colspan="2">Executive lead: Medical Director / Chief Nurse</th></tr>
<tr><th colspan="4">Metric: CQC good or outstanding</th></tr>
<tr><th>Workstreams</th><th>Current status</th><th>Summary of progress this quarter</th><th>Actions planned for next quarter</th></tr>
<tr><td>Compliance</td><td>4 outstanding actions from 2018 CQC action plan closed as 2 now included on 2021 action plan and remaining 2 on risk register and monitored through the governance framework.</td><td>All actions closed and ongoing monitoring in place and reported via Quality and Safety Group and Quality and Safety Committee</td><td>Monitoring will continue via Divisional Leads</td></tr>
<tr><td>Quality & Safety Reviews</td><td>15 reviews in Quarter 1 2022/23.

Of these the report and ratings have been completed for 13.

Collated themes for improvement are;

Medicine Management
Documentation
Infection Control & Environment
Safeguarding (relates to training figures)
Learning from incidents
Mandatory training</td><td>
<table>
<tr><th>Ratings</th><th>Number of areas</th><th>Ward/Department</th></tr>
<tr><td>Satisfactory</td><td>2</td><td>C4
Elective Medical Unit</td></tr>
<tr><td>Working towards satisfactory</td><td>10</td><td>A2/Discharge Lounge
B4 A/B
B6
C2
C6
Corbett Hospital Endoscopy
ED – Adults
T+O Outpatients (RHH)
Renal Unit</td></tr>
<tr><td>Unsatisfactory</td><td>1</td><td>ED - Paediatrics</td></tr>
</table>

The review at Corbett Hospital included the following departments;

Phlebotomy, Dudley Rehab Service, Physiotherapy, Dermatology OPD, T+O OPD, Medicine/Surgery OPD, Ophthalmology OPD, Day Case Unit, Imaging, Gynaecology and Urology OPD

ED Paediatrics – Improvement required related to; Mandatory training, Infection Control, Awareness of risks, Completion and recording of safety checks.</td><td>The Quality Review and Improvement Lead is leaving her post of the 19th of July 2022. The role acts as the Lead Reviewer for each Quality and Safety Review.

Discussions are currently ongoing to ensure continuation of the reviews, as the role is not being replaced.</td></tr>
<tr><td>Deteriorating patient</td><td>Education programme in place for all clinical staff</td><td>Education programme operational. 50 staff have completed Bronze and 18 completed gold as of 4/7/22
Launch events held and 1st presentation of awards via Grand Round</td><td>Completion and launch of Gold level award
Ongoing celebration events</td></tr>
</table>

	Deteriorating patient dashboard in use		
Metric: Improve the patient experience survey results			
National CQC Patient Experience Surveys	2021 Maternity Survey results were published on the CQC website on 10 February 2022. The Trust performed 'about the same' as other trust for 46 questions, two were better than expected and one was 'somewhat worse than expected'.	An action plan is in progress to address areas for improvement and was presented to the Patient Experience Group in May 2022. The Trust performed worse than other hospitals regarding visiting, although the Trust followed national guidance throughout the pandemic. To address this action the Trust are allowing two birth partners during labour and five hours per bed space alternatively. Visiting was not restricted for parents on the Neonatal Unit throughout the pandemic although other restrictions applied. Mental health support for women and staff creating a comfortable environment during labour and birth were highlighted as areas of concern. Mental health support is being offered with increased capacity to those who are suffering with problems during pregnancy and during bereavement. Charitable funds are being used to improve the atmosphere during labour including the purchasing of a second birthing pool. Having two birthing partners present will also improve the atmosphere and make patients feel more comfortable during labour. Women felt that they did not receive enough information from the doctor or midwife on where to have their baby and did not feel involved in decisions about their care during labour and birth. A leaflet has been created for patients outlining pros and cons of delivery location to help the patient make informed decisions. A Pregnancy and Birth Choices, Personalised Care and Support Plan document is available to women, and midwives are encouraged to discuss this with women. A birth preferences document is available for completion by women on their patient portal.	An update on progress against the actions to be addressed is to be presented at the August 22nd Patient Experience Group.
Friends and Family Test	Percentage Very Good/Good scores have seen a small increase in Q1	Percentage very good/good scores have seen small increase in Q1 (82% in May 2022 in comparison to 82% in April 2022). A total of 7% of patients rated their experience of Trust services as 'very poor/poor' in May 2022, an increase since April 2022 (5%). In May 2022, A&E received the lowest percentage scores for patients rating their overall experience as 'very good/good' at 71%, an improvement since April 2022 (69%). The percentage very poor/poor scores for A&E remain the highest of all departments at 15% but this	FFT scores and patient comments are monitored through divisional updates at the Patient Experience Group. Patient's responses and feedback are shared with teams for learning and service improvement. Comments and scores are sent to

		score has seen an improvement since April 2022 (17%). All FFT percentage very good/good scores are below the national average for all departments.	all members of staff and discussed in the daily huddles and You Said We Have actions are reported to the Patient Experience Team.

Goal: Be a brilliant place to work and thrive		**Executive lead: Chief People Officer**	
Metric: Reduce the vacancy rate			
Workstreams	**Current status**	**Summary of progress this quarter**	**Actions planned for next quarter**
Reduce the vacancy rate	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) The budgeted establishment reported in February 2022 was 5806.14, in May 2022 this was reported as 5911.57 an increase in budgeted establishment of 105.43 WTE. The contracted establishment reported in February 2022 was 5097.20, in May 2022 this was reported as 5105.22 WTE, a nominal increase	<u>Healthcare Support Worker</u> • Healthcare support worker recruitment campaign 138 were recruited from April 21 to April 22 45 will be progressing onto Nurse Associate training in September 22 47 recruits in pipeline 7 campaigns planned with target of 35 per cohort <u>Nursing</u> • 44 international nurses and 3 international midwives commenced employment with The Dudley Group • Targeted Divisional recruitment plans (i.e., theatre/critical care), • Imaging Review/Community Diagnostic Hub • ICS collaborative recruitment initiatives • Clearer internal career pathways • Vaccination programme retention initiative • Recruitment and retention steering group established to provide oversight and effective coordination of local, regional, and national programmes of work	Robust workforce capacity plans for each division – September 22 Clear career pathways – July 22 Healthcare support worker recruitment campaign Bank recruitment campaign

International nurse recruitment	As of 30th June 2022, we have recruited 140 international nurses and 3 international midwives, all these nurses & midwives have arrived in the UK and commenced employment with The Dudley Group	In quarter 1 of 2022 from 1st April 2022 to 30th June 2022, we had 44 international nurses and 3 international midwives (of the planned 320 international staff) arrive in the UK and commence employment with The Dudley Group	In quarter 2 of 2022 from 1st July to 30th September, we are scheduled to have 100 international nurses and 2 international midwives arrive in the UK and take up employment with the Dudley Group. They are scheduled to arrive as follows: 18/7/22 – 20 nurses, 8/8/22 – 30 nurses and 2 midwives, 22/8/22 – 20 nurses and 19/9/22 – 30 nurses.
Metric: Improve the staff survey results			
Improve and sustain staff satisfaction & morale	**Staff Survey:** 3185 Responses – 59% return rate • The Trust is performing around the benchmark average for all of the of the 9 main themes (most equal to benchmark average, 3 slightly below). We can compare 56 of the questions to last year – which helps us get a sense of what's happening at Dudley. Of those 56 questions: • 2 are significantly better • 42 show no significant change • 12 are significantly worse No further data update until Q4 as Staff Survey is annual.	Action continues to target poorest performing directorates with support; monitored through WSEC. The engagement model continues to be developed with engagement and wellbeing activities across divisions to support morale and engagement scores. Continued focus on Manager's Essentials to improve manager delivery of team working measures including team effectiveness and objectives. • DGFT Workforce H&WB plan in place for 12 months. • EAP provision has been procured and will support a core service with targeted additional activity including better training and access to mental health first aid training and critical incident de-brief training. • H&WB Steering Group now fully established and upward reporting through to WSEC • Recruitment and training of wellbeing champions to support local wellbeing promotion and embedding activities in teams • EDI Steering group now fully established and upward reporting through to WSEC • Continued triumvirate divisional engagement activities (HR/DIP/OD&LD) with the 11 areas that identified as most challenged – a range of support is being delivered • Divisional Engagement plans in place and updates through WSEC • Significant progress made in adopting the RACE Code action plan and single Equality Strategy and ENEI assessment.	Champion Flexible Working Recruit and embed Wellbeing Champions Increase attendance at Managers Essentials. Further expansion of development available Policy development to include the development of training packages and toolkits, this includes refreshing the behaviour framework Continuing progress against Divisional Engagement plans presented at WSEC in April. Review of progress at WSEC in Q2.

	The Quarterly People Pulse provides a more frequent check of engagement and morale. Results due August.	• Development of policies and processes to incorporate Just and Learning culture • Development of a new Flexible working policy, toolkit and training and the completion of 6 awareness sessions.	

Goal: Drive sustainability		**Executive lead: Director of Finance**	
		Metric: Reduce the cost per weighted activity	
Workstreams	**Current status**	**Summary of progress this quarter**	**Actions planned for next quarter**
Cost Improvement Programme	In order to submit a balanced financial plan across the system, the trust CIP has risen to £29m which is 6% of expenditure. The Trust has formally written to ICS highlighting the risks to delivery. Internally the Trust is working to the original target of £24.5m. There is some balance sheet flexibility that can be used to offset the requirement. The plans so far have identified £12.9m to £18.9m with varying levels of risk around delivery. The gap is currently between £5.4m and £11.5m to reach the internal £24.5m target.	• CEO resumed chair of Financial Improvement Group which has been stepped up to twice a month to provide greater scrutiny • Workstreams have been developed to provide more detailed focus on key delivery elements such as workforce, productivity, income recovery and acute collaboration. Each workstream will concentrate on specific sub-projects such as reducing bank and agency, delivery of ERF, removing Covid Costs, improving and reducing sickness absence etc. • Corporate budget holders have had their budgets reviewed and have identified £900k of CIP opportunity which will be phased across the remainder of the year. • Deep dives are underway across Medicine and Integrated Care to understand DNA's and cancellations on the day and what is driving these. Also investigating and ensuring that all clinical templates are back to 2019/20 levels and then adjusted to reflect virtual clinics, 25% reduction in follow ups and utilising Patient Initiated Follow Up (PIFU) methodologies	• Monitor progress of schemes identified and continue to identify new schemes. • Support Divisions to manage within assigned budget envelopes. • Prioritise both the workforce and productivity workstreams to release savings as well as alternative ways of working. • Continue with providing assurance to Financial and Performance Committee (F&P) around gap closure plans.
Improving productivity	Model Hospital productivity metrics for 2020/21 have recently been made available. Whilst showing a slight improvement in the Trust position for overall	Planned Care Improvement Programme workstreams to address productivity in theatres and outpatients. Developing plans for introducing routine HVLC in a number of specialties, focusing initially on cataracts.	Maximise use of MPR to support HVLC lists once they are opened

	cost per weighted activity unit (WAU), the Trust remains in the highest quartile for medical and nursing staff costs, clustered around services that have high use of temporary staffing including premium rate WLI sessions. There have been no further publications of the NHS productivity metric comparing 2021/22 with 2019/20.	Outpatient clinic templates returned to pre-COVID levels following risk assessment and relaxation of social distancing rules. Being monitored through Operational Performance Management Group on a weekly basis Further development work on internal productivity dashboard to enable services to track their unit cost	Continued weekly monitoring Presentation to stakeholders at FIG on 8th July
Metric: Reduce carbon emissions			
Governance	Green Plan Working Group met in April and June and reports to F&P quarterly Interim arrangements in place until substantive Director of Finance appointed	Recruitment process for appointing Sustainability Lead run for second time after first attempt unsuccessful. Offer has been made and person expected to join Trust in October Progress against deliverables continues to be monitored via the Working Group and reported to F&P Events held in the Health Hub at Russells Hall and Corbett to celebrate NHS Sustainability Day on 8th June. Re-usable cutlery distributed to staff and awareness conversations held	Prepare orientation and training programme for new lead Escalate concerns where progress falling behind that require input from Summit/Mitie
Estates and facilities	Sub-group set-up to focus on estates contribution to delivering net zero In process of establishing baselines for key metrics	Sub-group has not met this quarter No further progress with proposals to introduce better recycling facilities into theatres Following relaxation of infection control measures, on-site catering facilities now able to accept re-useable cups	Escalate with Summit/Mitie Promote re-useable cups in catering outlets
Travel and transport	4 electric vehicle charging points installed in staff multi-storey car park Secure cycling facilities available at Russells Hall	Plans to introduce car sharing app progressed Discussions with NX Bus have resulted in new discount offers becoming available for staff, patients and visitors. Staff discounts are being promoted via the Hub and at induction	Launch and promote the use of car sharing app Provide information on patient & visitor discounts

	Discounted bus travel available to staff through National Express		
Supply chain and procurement	Establishing baselines for commonly used items Exploring with clinical teams where re-usable items can replace single-use	Agreement in principle to pilot re-usable theatre hats with laundry at home Supplier of recycled paper invited to trust to address concerns which have now been resolved	Develop Standard Operating Procedure for use of re-usable hats Participate in meet the buyer event in Black Country on 14th July

Goal: Build innovative partnerships in Dudley and beyond		**Executive lead: Director of Strategy & Partnerships**	
Metric: Increase the proportion of local people employed			
Workstreams	**Current status**	**Summary of progress this quarter**	**Actions planned for next quarter**
Apprenticeships and work experience	Proportion of substantive staff who live in Dudley and Tipton/Rowley is 65% (census taken April 2022) with 3599 employed substantively	Target for apprenticeship sign-ups in 2022/23 is 129. Q1 - Confirmed 13, possible total 18 (waiting on confirmation of 5 sign ups). Kickstart – 21 complete at end of May – 2 left on programme completing end of July 22. On target for 23 completions in total. Out of completions so far - 11 have joined staff bank, and 8 have gained substantive employment with the Trust. Work Experience re-opened for department-led placements for Age 16+ from May. 99 interest forms received which have been passed on to departments. Due to high volumes of interest candidates contact departments directly. Quarterly meetings with all departments who have signed up. Spring Pod virtual work experience programme – bespoke to The Dudley Group - in final stages of development, application open online	Continue to promote opportunities that apprenticeships can offer to teams around development and workforce planning Secure cover for coordinator. Fixed term advert to go out during July Working with Informatics to advertise New L4 Data Analyst Apprenticeship Vacancy – event at Dudley Institute of Technology Commence 1st Spring pod virtual work experience programme (25th July)

		Attendance at Skills Shop – Programme for those aged 19+ who are receiving Universal Credit who are interested in NHS Careers. Dudley Ambassadors attended the 2 sessions (April & May). June session cancelled due to not enough interest	Engagement with Youth Network. Continued engagement with Skills Shop
Anchor Network Development	A pilot project in Pensnett to support local people into entry level jobs is being considered by the Partnership Board Partnership opportunities with Dudley Institute of Technology and local schools being explored	Visit to Dudley Institute of Technology and St James Academy to explore opportunities for working with local schools on 13th June Mapping current offer to schools by the Trust undertaken Assessment of capacity of what Trust can do to support local schools Attendance at 'Friends Reunited' and poverty challenge summit organised by Dudley CVS	Collaborative planning meeting with Dudley Academy Trust school around engagement, work experience and ambassadors 18th July Continue to build relationships with local voluntary organisations and connect them with relevant trusts services
Metric: Increase the number of services jointly delivered across the Black Country			
Black Country Provider Collaborative (BCPC)	Services already provided via formal collaboration across Black Country Trusts are: vascular surgery, ENT, cardiology, oncology. Urology delivered via the emerging Urology Area Network (UAN) Programme Director in post Clinical leads for 9 services appointed including 2 from the Trust (Ophthalmology and Orthopaedics) The System is developing a case to increase access to Robotic Surgery in the Black Country. The intention is that this will improve cancer waits across the system, while	Consolidation and organisation of a Clinical Improvement Programme, which through the Clinical Leads / Networks have identified a range of 'quick win' and longer term 'strategic' priorities. The work been undertaken through the Collaborative has been showcased through Regional GIRFT reviews, Clinical Awaydays, monthly Newsletters, and specialty specific 'away days'. There has been ongoing work on the development of the provider collaborative governance which has resulted in some new committees, refreshed and new terms of references, more permanent leadership, and active dialogue on the development of future 'target operating model' work both for the BCPC and the ICS.	Manage the delivery of the Clinical Improvement Programme priorities to ensure progress is being made and contributing towards delivery of operational requirements. Clinical Summit scheduled for 11th July Seek to make progress with the '*Digital Passport'* as a solution for staff working across the system. Driving the development of the '*Case for Change*' including options for future end state acute care form within the Black Country. Develop an engagement plan for key stakeholders.

	improving quality both through a reduction in open surgery and a system network of subspecialist centres of excellence		Working with ICS colleagues, to develop an optimal '*target operating model'* for the acute care system and consider alignment / integration of '*Place Based Partnerships'* as local delivery vehicles.

Goal: Improve health and wellbeing		**Executive lead: Chief Operating Officer**	
Metric: Improve rate of early detection of cancers			
Workstreams	**Current status**	**Summary of progress this quarter**	**Actions planned for next quarter**
Understanding the data	Most recent period for which data is available is Q4 21/22. Analysis of locally held data shows 35% not staged for Q4 21/22 which is a marked improvement on the previous quarter (46%) Data held by Cancer Outcomes and Services Dataset (COSD) for Q4 21/22 staging completeness was 82.2%, the third best in the West Midlands Cancer Alliance but this does not reconcile with what is held locally	• Data completeness improvement work has taken place with staging data improvement from 40% to now being at 82% • Discrepancy in data completeness caused by further staging information being added to the dataset after submission • Process for ensuring alignment between data sets has been developed	Continue to monitor and improve data quality Initial focus on lung cancer will continue Remaining tumour sites will now undergo the same improvement work, in order to make internal monitoring correlate to national reports Present data to Health Inequalities Working Group 12th July

Lung cancer	NHS Long Term Plan ambition is 75% of all cancers to be diagnosed at stage I&II by 2028 Locally held data shows early staging (I,II) at 25% in Q4 2021/22 The Faster Diagnosis Standard (28 days) performance for lung cancer is as follows: - April 22 at 63.16% - May 22 at 60.00%	Data completeness improvement work has taken place with staging data improvement Active participation in Tobacco treatment group as ICS, developing plans to receive targeted funds to establish smoking cessation service in house Completed operational readiness assessment and submitted to ICS. Identified a service lead within respiratory department Preparation of project plan for tobacco treatment	Faster diagnosis of lung cancer – implementation of 'straight to CT' pathway Submit project plan to ICS to secure funds Engagement with partners building the case for establishing Healthy lung checks in Dudley
Metric: Increased planned care and screening for the most disadvantaged groups			
Breast screening	Currently setting up the reintroduction of Cancer Champions with CCG & Macmillan Face-to-face events are back, positive events for engagements, really good feedback on videos, especially from the Deaf Community. 80% ethnicity recorded, investigate recording ethnicity of those who are not attending.	• Hearing video for the general population • Animated video particularly for ethnic minatory communities • Video of signs & Symptoms for the Deaf Community • Video for the Deaf Community of a mammogram • Meeting with BAME Network • Early Detection of Breast Cancer in African and Caribbean Women	• Get 'Chatbot' back up and running • Re-launch leaflet aimed at ethnic minority communities • Work on keeping the Gulshan Radio engagement • Find funding to update screening website • Going out into Wolverhampton Food Banks • Outreach into blind and visually challenged community • Outreach into Roma and South Asian community in Lye
Planned care	Presentation of constitutional targets such as waiting lists now being shown by ethnicity and deprivation	Audit begun into the reasons why patients "Do Not Attend" following conversation with Dudley CVS at event in Nov-21. The aim is to collect data on a minimum of 100 patients before the data is anonymised and analysed by ethnicity and deprivation.	Analyse results of audit and develop action plan

	Evidence to show that patients who were from deprived backgrounds were more likely not to attend appointments, which contributed to their having longer planned care pathways		

Part 3 – Transformation Programmes

Programme: Black Country system service transformation		**Executive lead: Chief Operating Officer / Director of Strategy & Partnerships**	
Workstream	**RAG**	**Summary of progress this quarter**	**Actions planned for next quarter**
Urgent and Emergency Care		Discussion with CCG around UTC and improved joint working between trust and Malling Health Piloted the use of dedicated phlebotomist in ED Urgent and Emergency Care Wellbeing Event held at end of April as a follow-up to the first VSA event in February. Away days for UEC leadership and triumvirates to progress actions agreed at the February event. Some reduction in sickness absence in ED has been observed. Getting it Right First Time visit to Acute & General Medicine service on 17th June. Positive feedback about the transformational changes that have taken place since the opening of the Rainbow Unit	Agree way forward and progress plans Measure impact of pilot Improvement Event in SDEC scheduled for 18th July External consultant will support AMU and SDEC around improvement work particularly length of stay, discharge rates, destination and streaming Creation of tranquillity room in ED Review recommendations following GIRFT visit and agree action plan
Restoration of Elective services		Construction work for the additional Minor Procedure Rooms has continued Allocation of 2 additional weekend lists to orthopaedics to reduce 52+ week waiters Aim to utilise half of theatre capacity for long waiting patients although cancer demand (especially for plastic surgery) affects this Theatre utilisation has improved from 60% to 68% Continued use of private sector capacity at Ramsay New meeting for provide assurance around delivery of diagnostic waiting standard (DM01)	Open new rooms in July 2022 Focus efforts on improved productivity aiming to return to pre-COVID levels Refresh theatre capacity review first undertaken in 2021 and paused due to COVID Optimise use of Ramsay

		Development of 5-year business case for Community Diagnostic Centre as part of national programme	Business case will now be submitted in July 2022, later than the original timetable. Approval expected by end of July Continued preparation to open phlebotomy hub in September
Cancer services redesign		Operational Performance Management Group reviews clinic utilisation with a view to ensuring a return to pre-COVID levels. April performance for 2 week wait (86.9%) continues the improving trajectory since September 2021. April performance for 31-day was 93% demonstrating an improving trajectory but still short of the 96% target. Weekly detailed tracking of each patient on the cancer PTL Recovery plans have been drawn up for each tumour site Embed 'care navigator' for patients on colorectal pathway. This will ensure patients are better prepared for colonoscopy and reduce DNAs	Utilise newly released capacity for new cancer appointments 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 BCPS to address pathology turnaround times Improve delivery of 62-day target from September 2022 and ensure sustainable delivery from March 2023 Continue to maintain 2 week wait performance One-stop clinic in gynaecology for diagnostic ultrasounds Work with Imaging to reduce reporting times for CT to 7 days or less Prepare case for additional endoscopy staffing following successful bid for regional capital funds which have been approved
Black Country Provider Collaborative (BCPC)		Consolidation and organisation of a Clinical Improvement Programme, which through the Clinical Leads / Networks have identified a range of 'quick win' and longer term 'strategic' priorities. The work been undertaken through the Collaborative has been showcased through Regional GIRFT reviews, Clinical Awaydays, monthly Newsletters, and specialty specific 'away days'.	Manage the delivery of the Clinical Improvement Programme priorities to ensure progress is being made and contributing towards delivery of operational requirements. Clinical Summit scheduled for 11th July Seek to make progress with the '*Digital Passport'* as a solution for staff working across the system.

		There has been ongoing work on the development of the provider collaborative governance which has resulted in some new committees, refreshed and new terms of references, more permanent leadership, and active dialogue on the development of future 'target operating model' work both for the BCPC and the ICS. The System is developing a case to increase access to Robotic Surgery in the Black Country. The intention is that this will improve cancer waits across the system, while improving quality both through a reduction in open surgery and a system network of subspecialist centres of excellence	Driving the development of the '*Case for Change*' including options for future end state acute care form within the Black Country. Develop an engagement plan for key stakeholders. Working with ICS colleagues, to develop an optimal '*target operating model'* for the acute care system and consider alignment / integration of '*Place Based Partnerships'* as local delivery vehicles.

Programme: Local Leadership to address health inequalities		Executive lead: Medical Director / Director of Strategy & Partnerships	
Workstream	**RAG**	**Summary of progress this quarter**	**Actions planned for next quarter**
Leading as an anchor institution in Dudley		Working Group met in June (re-scheduled from May) and reviewed work programme Visit to Dudley IoT and St James Academy to explore opportunities for working with local schools on 13th June Mapping current offer to schools by the Trust undertaken Assessment of capacity of what Trust can do to support local schools Attendance at 'Friends Reunited' and poverty challenge summit organised by Dudley CVS	Invite local school principals to discuss options and understand what would work best for them Continue to build relationships with local voluntary organisations and connect them with relevant trusts services
Addressing health inequalities		Health Inequalities dashboard has continued to be included in the monthly Integrated Performance Report Material for the public website to make it easier to access services and the support available drafted and passed to Communications team to upload Audit begun into the reasons why patients "Do Not Attend" following conversation with Dudley CVS at event in Nov-21. The aim is to collect data on a minimum of 100 patients before the data is anonymised and analysed by ethnicity and deprivation. Approached West Midlands Cancer Alliance concerning the roll-out of the Healthy Lung Checks programme. Aim is for the Trust to actively develop a proposal for when funding becomes available for this in light of local mortality and morbidity	Continue to develop metrics Complete refresh of relevant pages on Trust website Analyse results of audit and develop action plan Develop proposal for Healthy Lung Checks in Dudley

Programme: Research & Development, Education and innovation		Executive lead: Medical Director	
Workstream	**RAG**	**Summary of progress this quarter**	**Actions planned for next quarter**
Research & Development		New Director of Research & Development appointed	Recruit Deputy Director

		Draft MoU for future co-operation between the Trust and Aston University received and further discussions around collaboration held Further drafting of R&D strategy, shared with Aston University for comments Research and Innovation Support Group has re-started, to encourage staff develop research ideas Compilation of a list of trust staff (medical and non-medical) with research experience and intention to become involved in research Establish task & finish group to look at standards that need to be met to achieve university hospital status	Sign MoU Ratify R&D Strategy at Board Continue meeting monthly Group to meet and establish gap analysis
Education		Library strategy ratified Self-service in library operational from May. 24/7 service now available Lead faculty to liaise with Aston students appointed Workshop on improving feedback from post graduate students focusing on induction held Draft Medical Education and Training strategy out for consultation Discussions held with Three Counties Medical School (University of Worcester) concerning potential to host medical students from 2023 Proposal to provide additional teaching facilities (modular building) currently on hold as company the Trust was working with has gone out of business	Prepare for Aston intake from September Develop action plan University will respond with specific requests for placements Re-evaluate options for providing modular building
Innovation		No progress on arranging a date with West Midlands AHSN to help trust develop a process for promoting and supporting innovation amongst clinical teams QI notify app was presented at NHSE Midlands Quality Board and West Midlands AHSN Showcase event in June. Specification for making this a 'platform solution' sharable across the NHS has been submitted to software developer for quote	Meeting scheduled for 12th July Source funding to enable development

Enclosure 13

The Dudley Group NHS Foundation Trust

Paper for submission to the Board of Directors 22nd September 2022

Title:	Estates Strategy
Author:	Chris Walker - Deputy Director of Finance – Financial Reporting
Presenter:	Kevin Stringer – Interim Director of Finance

Action Required of Board			
Decision	**Approval**	**Discussion**	**Other**
N	**Y**	N	N

Recommendations:

To approve the Estates Strategy.

Summary of Key Issues:

The Trust is required to have an Estates Strategy that is updated on a periodic basis. The strategy also informs the System estates strategy as well as being a formal requirement by NHSI. If the Trust bids for external capital investment, then an up-to-date estates strategy must be in place.

The Estates Strategy has been prepared in a standard format that the Black Country ICS has requested. This allows each providers strategy to be consolidated to form the system estates strategy that will need to be in place by early 2023.

The Chief Operating Officer and the three Directors of Operations have been consulted closely during the production of the strategy. All sections relating to clinical development priorities that have an estates impact have been established via these work groups. There is no doubt that the strategy will evolve over the coming three years as both the Dudley Health Economy and the Black Country ICS move forward with the changing clinical strategy.

To aid the reader of the document a two-page summary of the strategy is provided.

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

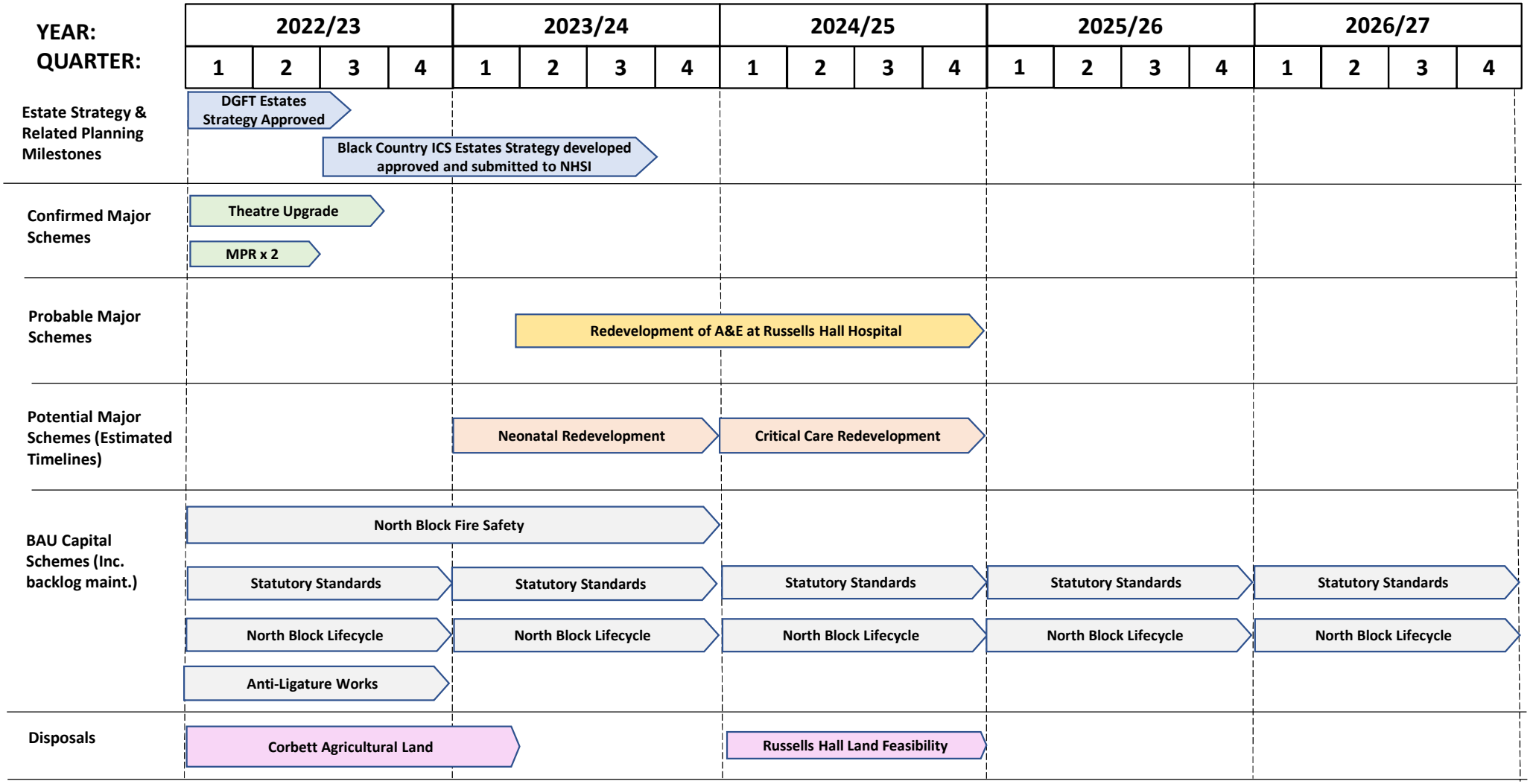
Improve health and wellbeing	**X**

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

Report Journey/ Destination *(if applicable)*	Working / Exec Group	Y	Date: 2nd August 2022
	Committee		Date:
	Board of Directors	Y	Date: 22nd September 2022
	Other	N	Date:

Dudley Group NHS Foundation Trust Estates Strategy priorities & milestones 2022-27

Shown below is a summary road map of our estates strategy key priorities & milestones.



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Dudley Group NHS FT Estates Strategy priorities & milestones 2022-27 (Continued)

Top 5 Clinical/Service Priorities and/or Developments with estate implications or opportunities

1. Emergency Care – Emergency Department redevelopment.
2. Neonatal Redevelopment.
3. Critical Care Redevelopment
4. Peri-Operative Hub.
5. Community Diagnostic Centres.

Estates Operational Challenges for the Trust

1. Poor performance of the PFI FM provider and the contract management resource required to ensure services are delivered.
2. Collaboration of system partners to drive forward the future system estates agenda.
3. Taking forward the sustainability and energy efficiency agenda.

Plans/initiatives to improve utilisation and/or rationalisation of estate

1. Space utilisation group established and operating.
2. Disposal of Corbett agricultural land.
3. Review of RHH land and better use of staff accommodation through PFI.
4. Rationalisation of community estate.

Estimated housing units (inc. affordable housing in brackets) arising from disposals and/or other land opportunities

1. Corbett agricultural land 84 units (21 units).

Top 5 Risks & Issues

1. Capital funding – Trust is in a challenging financial environment. Operational capital is allocated on a system basis and as a PFI Trust our allocation will be minimal.
2. System & NHSI capital bids – if unsuccessful then large capital schemes will not be able to progress.
3. PFI – the Trust is predominantly PFI and is therefore constrained in terms of development of the site.
4. MCP clinical Strategy – the development of the MCP clinical strategy needs to progress to allow the Trust's estates strategy to move forward.
5. System clinical strategy – the lack of a joined up System clinical strategy will impede any System wide estates strategy development.

Top 5 Interdependencies with – and opportunities for joint working with - LEF/System/other partners

1. MCP – development of community estates strategy in Dudley and impact on Trust buildings.
2. Dudley Health Economy joint working to rationalise community estate to progress building/land disposals.
3. Local Authority – use of Local Authority buildings to assist in the rationalisation of the estate and assistance in disposing of surplus land.
4. System – cooperation around System capital allocation and the prioritisation process.
5. Accessing CIL and S106 funding through the Dudley local health economy.

Potential External Capital Bids

1. NHSI PDC funds including CDC, Endoscopy and general diagnostics.
2. Public Sector Decarbonisation Scheme.
3. Targeted Investment Fund for Elective Recovery.

Other comments (add as necessary)

The future estates strategy needs to be driven by both Dudley Health Economy and System clinical strategies to ensure system capital funds are invested in the right place for the benefit of patients.

The Dudley Group
NHS Foundation Trust

Estate Strategy

September 2022

Review September 2027

Document control

Version	Date	Amendment description	Circulation	Author
V0.1	19/04/2022	Initial restructuring and drafting		S Maleham
V0.2	29/04/2022	Updated draft		S Maleham / Chris Walker
V0.3	04/07/2022	Updated draft		S Maleham / Chris Walker
V0.4	14/07/2022	Final Draft		S Maleham / Chris Walker

Formal Approvals

Version	Date	Submitted to	Outcome
V0.4	02/08/2022	Executive Directors	Approved subject to minor changes which have been actioned.

Table of Contents

1 Executive Summary

1.1 Introduction

This Estate Strategy sets out a high-level overview of the current and future estate for Dudley Group NHS Foundation Trust (DGNHSFT). The estate strategy indicates the direction of travel for further development of what is a complex and varied estate, but one which is critical to the overall success of the Trust's aims, ambitions and objectives.

Changes in the way NHS services are provided both locally and nationally will ultimately reshape this strategy with heightened focus on improvements to patient care, greater reliance on technology, the 'Green' agenda and the way in which services are accessed and delivered in the future.

The Estates Strategy reflects the changing ways of delivering healthcare and the part we will play in the new Integrated Care System (ICS).

1.2 Context and Strategic Direction

The National Context

The key national drivers, policies and guidance underpinning the Trust's Operating Plan in service delivery and supporting safe practices are:

- **The NHS Long Term Plan** (2019)
- **The People Plan** (2020)
- The latest **Planning and Priorities Guidance** (2022/23)

The key national estates drivers, policies and guidance underpinning the Estates Strategy are:

- **The Carter Report** (February 2016)
- **The Naylor Report** (March 2017)
- **The NHS Health Infrastructure Plan** (September 2019)
- **Delivering a net zero NHS** (October 2020)

Regional and Local Context

ICS's led by their Integrated Care Boards (ICBs) are a new collaboration of health and social care organisations who retain their individual responsibility and decision-making powers but recognise the benefits of working together for people who use local health and care services. Within the Black Country, the ICS Partnership is called 'Healthier Futures' with the newly established ICB becoming operational on 1st July 2022.

Multi-Specialty Provider Model of Care

A product of the New Care Models (NCM) national programme, Dudley has a Multi-Specialty Community Provider - Dudley Integrated Health and Care NHS Trust (DIHC) – which operates a range of community services and is actively supporting local Primary Care Networks (PCNs).

The Trust is committed to working in partnership as DIHC develops and to actively contribute to supporting the achievement of the intended benefits of the MCP model as it is fully rolled out.

1.3 Overview of the Trust and the Estate

Based in the heart of the Black Country, DGNHSFT is the main provider of hospital and adult community services to the populations of Dudley, significant parts of the Sandwell borough and growing communities in South Staffordshire and Wyre Forest.

The Trust, with a workforce of more than 6,000 WTE staff and an annual income of more than £520m serves a population of around 450,000 people from three hospital sites and more than 40 local centres.

The Trusts' service portfolio currently includes:

- Adult community services including community nursing, end of life care, podiatry, therapies and outpatient services from a range of community venues across the borough.
- Russells Hall Hospital in Dudley, which has more than 650 beds, including intensive care beds and neonatal cots, provides secondary and tertiary services such as maternity, critical care and outpatients, and an Emergency Department (ED) with Emergency Treatment Centre.
- The Guest Outpatient Centre in Dudley and Corbett Outpatient Centre in Stourbridge provide a range of diagnostic, outpatient, therapy and day case services.
- The Trust is also the vascular services hub for the Black Country and has an active research and development team.

The Trust is a designated teaching hospital of the University of Birmingham with large cohorts of undergraduate students. The Trust also has an active research and development team.

The Vision

The Trust approved a new strategic plan covering the period 2021 - 2024 in September 2021. The key elements of the strategic plan include:

Trust vision: Excellent health care, improved health for all

Values: Care – respect – responsibility

Goals:

- Delivering right care every time
- Being the best place to work and thrive
- Driving sustainability
- Building innovative partnerships in place and system
- Improving health and wellbeing

A working framework for a new clinical services strategy has been developed and is intended to align with the emerging clinical strategy for the Black Country ICS being developed as part of the Acute Provider Collaboration. The key themes within the new clinical service strategy include:

Elective care

- Strengthening the Midlands Orthopaedic Centre
- Establishing a first-class peri-operative hub
- Increasing theatre capacity and performing more surgery in outpatient settings
- Maintaining short waiting times

Urgent and acute care

- Delivering Same Emergency Care (SDEC) in dedicated facilities
- Strengthening links with community services in the community to avoid hospital admission and reduce length of stay
- Improve flow through a re-designed Emergency Department
- Increase the number of beds available to treat patients and improve flow

Cancer

- Streamline pathways to achieve earlier diagnosis
- Provide specialist surgical treatment for skin, colo-rectal, breast and renal cancers
- Expand the provision of home chemotherapy services
- Improved co-ordination with tertiary centres

Diagnostics

- Establishing a Community Diagnostic Hub (CDH)
- Separation of acute and elective diagnostic pathways

The Challenges

In developing the direction for the future of the estate, the following challenges are considered:

- Issues of safety and compliance have been prioritised according to the level of risk to patients, staff and the continued delivery of clinical services.
- Revenue budgets will remain flat in real terms and will be expected to flex in line with increases or reductions to clinical activity in response to local ICS priorities.
- Internally generated capital investment will be restricted to within system capital allocations meaning investment programmes will be risk based and will remain flat in real terms.

The Estate

Most of the estate, the three main hospital sites, form part of a Private Finance Initiative (PFI) contract with Summit Healthcare (Dudley) Limited and its appointed service provider Mitie. Within the PFI estates footprint there are also three elements that are retained estate being North Block, The Rainbow Unit and the Multi-Storey Car Park. The remaining estate is leasehold delivering adult community services including community nurse bases, podiatry, physiotherapy and sexual health and support services at the following locations:

CHP	NHS PS	
• Brierley Hill Health & Social Care Centre • Stourbridge Health & Social Care Centre	• Central Clinic • Cross Street Clinic • Halesowen Health Centre • Kingswinford Medical Practice • Lower Gornal Health Centre	• Netherton Health Centre • Sedgley Health Library & Social Care Centre • St James Medical Practice • Wordsley Green Health Centre

The Trust also leases the FM Centre which is the Trust's IT data centre and IT staff base and (via the PFI contract) operates from Centafile, a warehouse holding patient records and the booking offices.

Management of the Estate

Under the PFI contract the Trust has been able to reduce from four sites to three with the demolition of much of the aged estate and centralising acute services at Russell's Hall Hospital, plus the creation of two new ambulatory care centres at the Corbett and Guest Hospital sites. The PFI contract, which includes the provision of both hard and soft FM services, is performance managed by the Trust's Estates and Facilities Contract Team. The contract is due to expire in 2041.

Estates Performance

Occupancy Costs

In 2021-22 the occupancy cost of the PFI estate was £47,839,251 of which £42,578,600 was the unitary payment with the remainder variations and energy costs. In addition, the Trust leases several other sites for community led services at an annual cost of £2,631,445, together totalling annual expenditure of £50,470,696 to operate the estate.

The Trust uses 'Model Hospital' to benchmark against a peer group of acute Trusts of similar size and scale. Based on model hospital reporting (March 2022), the Trust is in the upper quartile with regard overall occupancy cost for the PFI estate per m^2, paying £509/m^2 against a peer group benchmark value of £408/m2. However, not all Trusts pay for the same range of services within the unitary

payment. Nevertheless, when Hard FM costs are compared '*like for like*', the Trust remains above the benchmark with a cost of £122 per m2 compared with peer group benchmark cost of £102 per m2.

Metric	Trust position	Peer Group median
Hard FM cost per square metre	£122	£102
Soft FM cost per square metre	£147	£138
Amount of non-clinical space	28%	28%
Total energy cost per m2	£34.39	£27.93
Linen & Laundry productivity (items per WAU)	34.26	£33.65
Cleaning productivity (m2 per WTE)	326	572
Inpatient food service productivity (means per bed day)	2.23	2.75
Backlog Maintenance (£ per m2)	£2	£305

Backlog maintenance liability is very low relative to other peer group Trusts, reflecting the large proportion of the estate that is within the PFI contract and therefore maintained to condition B.

The Trust is in the upper percentile for energy costs reflecting high levels of consumption of electricity, gas and oil. The PFI provider takes the risk on energy usage so while this is not a financial risk for the Trust there is a commitment to work with the PFI provider to reduce energy consumption.

Asset Value

Total asset value of the PFI sites as at 31st March 2022 is £152,506,000 valued under the alternative site valuation methodology. The non-PFI estate (North Block, Rainbow Ward, MSCP) has a combined value of £30,562,618, giving a total asset valuation as at March 2022 of £183,068,747

Valuation as at March 2022	
Land	£13,120,000
RHH	£126,861,823
Corbett	£10,140,175
Guest	£2,384,131
North Block	£9,182,461
Rainbow Ward	£11,511,344
MSCP	£9,868,813
Total	**£183,068,747**

Capital Investment and PFI Lifecycle Costs

The Trust carries out capital enhancement works to the PFI building through a variation to the PFI contract. This involves a 'bullet payment' to the PFI company for the capital works and is funded from the Trusts capital resources. Any impact on the PFI lifecycle process is reviewed as part of the variation and a refund agreed offset against the capital variation payable by the Trust.

Capital Programme 2022-2027

	2022-23		2023-24		2024-25		2025-26		2026-27
Scheme	**£000's**		**£000's**		**£000's**		**£000's**		**£000's**
Operational									
Replacement Medical Equipment	1,932		3,000		3,000		3,000		3,000
Imaging Enabling Work	0		250		250		500		500
North Wing Lifecycle	110		250		750		750		750
Statutory Standards/Minor Works	513		859		600		1,000		1,000
IT PC Replacement Programme	0		600		600		600		600
North Block Fire Works	690		460		0		0		0
Temperature Monitoring Medcine Rooms	447		446		0		0		0
Anti-Ligature Works	595		0		0		0		0
Pharmacy Robot Replacement	832		0		0		0		0
Replacement Training Simultors	66		0		0		0		0
Relocation of Breast Service	0		500		0		0		0
Vascular x2 outpatient US Machine Sonosite	0		150		0		0		0
3rd CT Scanner RHH	0		0		2,000		0		0
Pathology Laboratory Move	0		200		0		0		0
Community network/WiFi replacement	50		0		0		0		0
IT Other BAU	534		0		0		0		0
IT Infrastructure/Cloud Stage 1	248		0		0		0		0
IT Infrastructure/Cloud Stage 2	908		620		275		0		0
Self-Financed Capital	**6,925**		**7,335**		**7,475**		**5,850**		**5,850**
ED Development RHH	0		13,267		3,708		0		0
PDC Financed Capital	**0**		**13,267**		**3,708**		**0**		**0**
PFI Lifecycle	2,601		1,979		2,928		3,456		3,277
PFI MTS Equipment	1,408		805		490		2,570		926
PFI Capital	**4,009**		**2,784**		**3,418**		**6,026**		**4,203**
Total	**10,934**		**23,386**		**14,601**		**11,876**		**10,053**

In addition to capital enhancements initiated by the Trust, the SPV (Summit Healthcare) has an obligation to maintain the buildings at Condition B through a planned preventative maintenance and lifecycle replacement programme. The SPV provides the Trust each year with a forward profile showing their proposed planned life cycle investment programme to address routine backlog and planned preventative maintenance for the next six years. The current Lifecycle programme represents a planned investment of more than £13.6m over the period.

Commercial/3rd Party Income arrangements

The PFI contract financial model operates so that the base 3rd party income within the original PFI agreement is inflated in line with the contractual RPI increase each year and deducted from the service payment. This means that the SPV takes the risk and reward of increases or decreases to 3rd party income over the contract period. 3rd party income includes patient and visitor car parking, commercial catering, residences income, payphone income and commercial rent on site.

PLACE Assessment

National PLACE assessments were suspended during 2020 or 2021 due to the pandemic however, there is an expectation that there will be a renewed national assessment during late 2022. In the interim, NHS digital launched PLACE-Lite where Trusts determine the frequency of assessments and have freedom to choose the categories and areas to be assessed.

The PLACE-Lite programme will continue to run through the Spring/Summer of 2022 and further guidance is awaited with regards to the expectations of national PLACE happening later in the year.

Financial Standing

The COVID-19 pandemic resulted in a significant change to the financial arrangements for 20/21 as resources were focused on dealing with the crisis and additional funding support was made available nationally to ensure each organisation achieved a breakeven position. Financial management across the system and the deployment of a risk sharing scheme ensured that all organisations within the system delivered a surplus amounting to £2.2m. The Dudley Group end of year position for performance management purposes amounted to £0.2m, the second consecutive year of achieving a positive financial outcome. The numbers presented below relate to The Dudley Group financial performance, not including the Charity.

	2020-21			2019-20	
	PLAN £000	ACTUAL £000	VARIANCE £000	PLAN £000	ACTUAL £000
INCOME	£419,964	£450,449	£30,485	£382,327	£411,900
PAY	-£261,884	-£281,534	-£19,650	-£238,106	-£249,923
NON PAY	-£136,922	-£144,392	-£7,470	-£117,837	-£136,061
EBITDA	**£21,158**	**£24,523**	**£3,365**	**£26,384**	**£25,916**
DEPRECIATION & FINANCE COSTS*	-£23,199	-£22,822	£377	-£18,412	-£22,395
NET SURPLUS/(DEFICIT)	**-£2,041**	**£1,701**	**£3,742**	**£7,972**	**£3,521**
Technical Adjustments	£41	-£1,502	-£1,543	£85	(£317)
FINAL SURPLUS/(DEFICIT)	**-£2,000**	**£199**	**£2,199**	**£8,055**	**£3,204**

* Figure includes impairment of £0.028m in 19/20

1.4 Our Future Priorities

The key estates priorities within this Estates Strategy include:

New or substantially reconfigured estate:

- Development of additional theatre capacity including a hybrid theatre at Russells Hall Hospital

- Redevelopment of our Emergency Department
- Neonatal Unit
- Critical Care
- Peri-operative Hub

Estate efficiency and optimisation:

- Optimising the use of our existing estate
- Improving the performance of our PFI service provider (via the helpdesk)
- Reconfigure space used by back-office functions because of increased remote-working
- Assessing the impact of the Electronic Patient Record on storage requirements for paper-based patient records
- Development and investment in schemes to de-carbonise our estate
- Maximising our green space to promote biodiversity and enhance patient and staff well-being.
- Aligning our estate to the developments of the ICP and ICS

Our Priority Schemes

Theatres

A new Hybrid Theatre and two new Minor Procedure Rooms are due for completion later this year. The Hybrid Theatre will provide modern state-of-the art facilities to strengthen our position as the arterial centre for the Black Country Vascular Centre, extending the range of procedures offered, and improving outcomes for patients across the region. This is due for completion in September 2022.

The following projects are priorities for the Trust but are classified as **'Pipeline Schemes'** pending business case approval by NHSE&I and/or funding routes identified:

ED Redesign

There is currently significant demand on the existing emergency care facilities at RHH. Over the last 3 financial years there has been an average annual growth in activity of 3.8%. Capacity modelling for resuscitation facilities indicates 7 spaces are required immediately for the current demand, current resus accommodates 4 spaces with no segregation for paediatrics & adults. The pandemic has further highlighted the need for improved isolation facilities.

A new build and refurbishment scheme has been developed to provide additional capacity to the resuscitation area to provide an expanded and fit for purpose twelve bay resuscitation facility

including bays for bariatric patients, isolation and aerosol-generating procedures (AGP) bays and simulation training facilities for the ED department.

An ICS Wave 4 capital bid has been made for £16.9m and a construction period of 13 months is envisaged.

Neonatal Unit

The current neonatal unit is no longer fit for purpose, being cramped and cluttered, with limited storage and the facilities for parents, carers and families are inadequate. The space for each cot does not meet the current Health Building Note (HBN) recommendations. Reconfiguring the Neonatal Unit would allow the neonatal service to achieve the required standards. This would ensure that parents and carers have the facilities to allow full implementation if the Family Integrated Care principles and allow improved flow by supporting the transfer of babies back from Level 3 units. The redesign and expansion of the Unit would ensure that the neonatal service is able to function more effectively as part of the West Midlands Neonatal Operational Delivery Network (WMNODN).

Critical Care

The current Critical Care estates template is non-compliant with national General Provision of Intensive Care Standards (GPICS), both in terms of the physical bed spaces and general environment. A feasibility study is planned to assess estates options available to accommodate a Critical Care Unit that achieves the building requirements set out in the NHSE Health Building Note – 'Guidance on designing Critical Care Units'. This would improved patient safety and management of infection prevention and control and provide a better working environment for staff.

Peri-Operative Hub

Our ability to increase pre-operative assessment capacity has been constrained by lack of space within the Outpatient Department. A priority for 2022/23 will be to identify capacity to allow expansion of the service to meet the demands associated with restoration and recovery. A Peri-Operative Hub strategy is being developed, which will set out future plans for a wider multi-disciplinary Peri-Operative Hub, which will have further estates requirements to accommodate additional services. As well as providing space for expansion of activity, the Peri-Operative Hub will provide holistic input to improve outcomes after surgery and reduce length of stay through enhanced care planning and early intervention to address risk factors

1.5 Optimising the Estate

The Trust are almost a wholly PFI based estate and any reconfiguration required across their current estate will come with increased charges because of having to progress any design and associated alterations through their PFI partner. There are however a number of areas which could be interrogated further to identify opportunities to optimise the estate and how it is utilised, including:

- The PFI Estate
- The Trust Retained Estate
- The Leased Estate

- Residencies & Car Parking
- Opportunities for Site Rationalisation
- Off Site Options/Solutions

Estate Utilisation

Through the PFI partner the Trust is clear about the condition of the estate, featuring in routine reporting. However, information detailing the utilisation of the estate is not fully available.

Key to unlocking the Trust's mainly PFI estate to better service the organisation's clinical needs is to fully understand how the estate is being used, by who and when. A detailed utilisation study will provide this information and is key to being able to strategically reconfigure any current areas that constrain clinical services from changing their operational requirements. Alternative options available to free up space in the highly utilised and clinical areas of the estate are moving non-clinical and less utilised services either elsewhere or off site.

To inform a better understanding of space utilisation, the SPV (Summit) have proposed 'Activeplan', a web based application which ensures that any changes to the estate is captured and reflected in 'on demand' reports. Area reports for each of the facilities can be created and the latest base drawings that reflect the current facilities layout can be downloaded. Activeplan ensures that any area changes due to variations undertaken within the facilities are reflected in the drawings and data presented.

PFI Service Provider Performance

Following a period of poor performance by Mitie (the PFI FM service provider) a review of the contractual requirements for response times has been undertaken. Mitie are working to develop their reporting to ensure that the initial Service Response Time and the final Turnaround times are presented. With jobs are being logged more quickly.

Under the terms of the PFI Project Agreement, 'the Rectification Period' commences from the earlier of notification of the Non-Compliant Incident to the helpdesk and Mitie becoming aware. Mitie are working to develop a proposal that will ensure jobs are logged when they are notified (or that their system will be adapted to back-date the job commencement time if not logged on the same day).

Community Health Partnerships

A total of 72% of the Trust's leasehold budget is spent on two CHP properties, Brierley Hill and Stourbridge Health and Social Care Centres. This equates to annual occupancy costs of £1,864,178 for just two properties out of a total annual occupancy cost budget of £2,631,745. The Naylor report recommends that Trusts should pay no more than £350/m2 on leasehold space and The Trust is paying the following on these two CHP properties:

Site	Total Annual Occupancy Costs	Cost per m^2	Annual Cost above Naylor Recommendation
Brierley Hill Health & Social Care Centre	£1,157,452	£388.06	£113,508
Stourbridge Health & Social Care Centre	£706,725	£447.26	£188,446

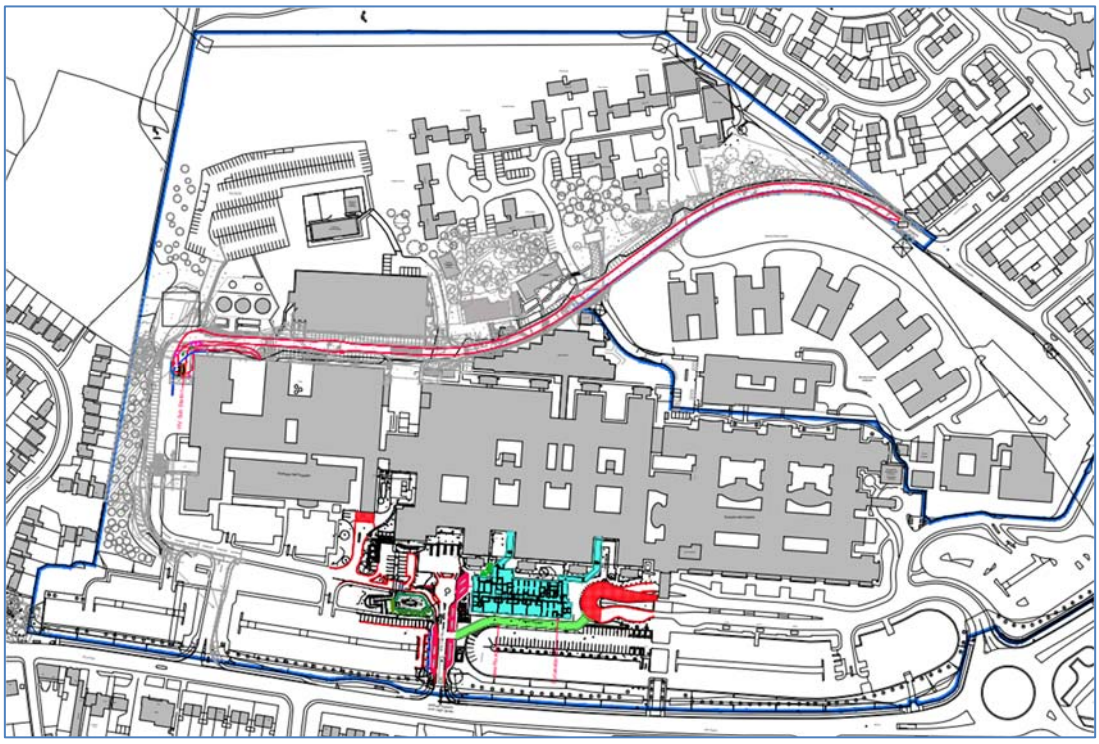
At present there are no lease arrangements agreed between CHP and the Trust. However, while the occupancy costs are more than the Naylor Report recommendation, there would be no financial benefit for the Trust in renegotiating a lower cost due to the structure of the charging mechanism in place. A whole system approach regarding rental agreements and occupancy costs would have a more successful and financially advantageous outcome.

Residences and Car Parking

Under the PFI agreement Summit own the buildings and lease the land from the Trust over the term of the contract, except for the retained estate (highlighted within the red boundary on the following site plan). At the end of the PFI Contract the ownership of the buildings will revert to the Trust.

The largest plot of land available at the back of the residential block form part of a nature reserve and would be difficult to develop due to environmental constraints. The only real requirement the Trust currently has for redevelopment would be to create additional staff car parking. The Trust currently manages and receives an income from the existing staff car parking. All other visitor and patient car parking is owned and managed by Summit Healthcare who receives an income from these facilities.

Summit Healthcare also own the twelve residential blocks (including Esk House which is being used by the Trust for office accommodation) at the rear of Russell's Hall Hospital. The residential blocks, and their supporting accommodation e.g., laundry, garages, are managed by Mitie.



Digitisation of Patient Records

The Trust is currently leasing Centafile to store patient records. The business case for the Trust's new Electronic Patient Record (E.P.R.) system identified a savings benefit of £194k in relation to the current health records storage which was the lease of Centafile. To date the requirement for storage of paper records has not gone away and the Trust has extended the lease to 5th July 2024.

Opportunities for Site Rationalisation

In line with current NHS policy all NHS bodies are required to review their surplus assets and dispose of these assets if there are no plans for future operational use.

The Trust owns a parcel of land which adjoins the Corbett Ambulatory Centre in Stourbridge. Over the last 4 years, the Trust has initiated various approaches to the market and held negotiations with a number of developers. In April 2021 a further approach to the market was concluded and a preferred developer chosen. Following their detailed due diligence work, a contract of sale, subject to planning permission, was finally signed in January 2022. The developer is currently working through the planning application and public consultation with a possible final disposal in 2023-24.

Off-site / Commercial / Back Office Functions

The NHS response to the Covid pandemic has transformed some of the working practices including virtual consultation, mobile working and home working. This has demonstrated opportunities to free up non-clinical space for the delivery of clinical services.

The Trust has been working for some time with Acute Collaboration and ICS partners to assess the feasibility and potential benefits of how certain back office functions such as payroll, support staff, procurement, HR and legal services could be reconfigured to provide a streamlined and efficient yet cost effective coordinated service across the ICS. The Trust would benefit from the economies of scale this would realise in recurrent savings. There is also an argument that current Trust back office functions occupy expensive PFI estate that if vacated into off site private and cheaper accommodation, could be better utilised by clinical services.

1.6 Funding Options

Capital funding in the NHS is now allocated on an Integrated Care System (ICS) basis. The ICS receives an annual operational capital allocation based on a formulaic calculation. The ICS then allocates operational capital to providers. This is done through a risk-based prioritisation process which works through individual provider governance processes up into the ICS. Each provider is then expected to manage within the operational capital allocation. Other central capital allocations from the Department of Health are available in any given financial year, these are in the form of PDC which provides cash funding for a specific capital project. More recently these are in relation to current high priority operational objectives including elective recovery and diagnostics. Providers are required to submit business cases through the system to bid for this funding.

Other sources of capital include 'sustainability' capital funding from Government Grants or other external sources, investment opportunities with Local Authorities or Higher Education and donations

1.7 Sustainability and energy efficiency

Under the PFI contract the SPV takes the responsibility and risk for energy usage while the Trust takes on tariff risk. This is managed through an 'Energy Tariff Adjuster' mechanism which is adjusted for tariff increases every year based on a base usage. A fixed tariff price is entered into by the SPV each February and this is the basis of the charge made to the Trust each year against the base consumption. The Trust and SPV entered into a variation to the 'Energy Tariff Adjuster' mechanism a number of years ago. This allowed the SPV to pool all the PFI building energy into a national energy market arrangement and forward buy energy. Gains from this process in relation to tariff reduction from the fixed position is shared 60/40 by the Trust/SPV based on a reconciliation each month.

Summit are members of the Trust's Estates and Energy Sub-committee and there is an opportunity for collaborative working to try to reduce energy consumption through engaging with staff, visitors and patients with regard changing behaviours and culture and also through planned investment e.g. procuring more energy efficient products when replacement is necessary. Through this collaboration the Trust can negotiate with the PFI provider as to a possible gain/share on any savings made.

Decarbonisation – towards net zero

The Trust has ambitious plans for a pathway towards Net Zero Green House Gas emissions. In 2021, an Energy and Estates Sub-group was established with representatives from the Trust, Mitie and Summit. This group reports to the Green Plan Working Group looking at a range of subjects including Travel and Transport, Supply Chain and Procurement, Digital Transformation and Food and Nutrition.

1.8 Summary and Conclusions

Through the implementation of this Estates Strategy, tangible benefits for patients, staff, visitors, commissioners and the wider health and social care economy should be derived including:

- An estate that better meets the current and future needs of the population served
- Demonstrable improvements in quality and patient experience
- Improved environmental performance (including carbon reduction)
- Improved flexibility to respond to new service developments or activity retractions

More particularly, a full understanding of the current space utilisation of the estate would enable:

- Additional income (through increased elective recovery activity) from services which can expand within the existing footprint, plus income generation from new services which are not currently delivered by the Trust
- Savings from maximising the use of currently unused space or optimising the use of clinical and non-clinical space
- Reduction in footprint and associated costs by relinquishing properties which no longer serve the Trusts' need e.g., storage of patient records
- Longer term savings through more efficient energy procurement and usage

2 Introduction

This Estates Strategy has been developed to provide an integrated approach to The Dudley Group NHS Foundation Trust's (hereafter referred to as 'DGNHSFT' or 'the Trust') estate, relative to current and proposed service models, aligned to both national and local plans including the emerging ICS strategy.

This Estate Strategy aims to set out a high-level overview of the current estate as at March 2022 and indicate the direction of travel for further development of what is a complex and varied estate, but one which is critical to the overall success of the Trust's ambitions and objectives. This document will remain fluid given the national and local context and will need to be read in a spirit of flexibility to permit meeting the needs of the Trust going forward.

Changes in the way NHS services are provided both locally and nationally will ultimately reshape this strategy with heightened focus on improvements to patient care, greater reliance on technology, the Green agenda and the way in which services are accessed and delivered in the future. The integration of various NHS Service providers, the introduction of service networks and acute collaboration activities will all influence the ways in which an effective estate can offer and deliver cost effective support to clinical services.

3 Developing the Estate Strategy

The emphasis may be on buildings and land, but in practice having a clear strategic vision, and considering 'how' estates use can be optimised to achieve this, benefits from considering a variety of approaches including:

- Developing an understanding and categorising the current estate, including its performance, using robust data
- Assessment of future needs/where do we want to be? – requiring input from a wide range of stakeholders. As above, this should begin with the strategic vision and be driven by the clinical strategy. It should also involve developing performance criteria
- An analysis of the gap between current and required provision – this will help identify key priorities for change and determine a plan for investment/ disinvestment
- Identification of options for delivering on key priority areas. These should be assessed to determine their viability, fit with overarching Trust objectives, as well as the financial implications

3.1 Flexibility

The Estate Strategy document covers those developments being considered by the Trust which will make both improvements to the estate performance and provide the appropriate built environment for the effective delivery of services. The Trust is mindful that this document will need to remain flexible to the changing needs of developing services requirements, changing emphasis on patient care for commissioning bodies and also the long-term condition of the Estate.

3.2 Responsibilities

NHS bodies have a statutory responsibility for the good management of their assets and a robust Estates Strategy is an essential component of that process. The Estates Strategy sets out the long-term direction for managing the estate in an optimum way in relation to the service and business needs of the Trust but also identifies some short-term goals. In developing the strategy, it is helpful to recognise the wide-ranging influence that the estate has across the Trust which includes:

- Safety
- Infection prevention
- Fire precautions
- Physical environment (internal and external)
- Environmental conditions (energy/emissions/sustainability)
- Access, transportation / car parking
- Aid to healing
- Recruitment and retention of staff

The Estates Strategy, therefore, reflects the changing ways of delivering healthcare, the part we will play in the Integrated Care System (ICS) plans, the opportunities to integrate community and primary care services and sets out the key issues around the backlog maintenance requirements of the Estate.

3.3 Internal Analysis (SWOT)

Looking inwards and learning from past practices and behaviours, we have used embedded industry tools to help to set out how we can develop our direction. In adopting a SWOT analysis, we find the following high level outputs:

SWOT	Theme	DGFT Characteristic
Strengths	Leadership and Governance	Strong Executive Team committed to ensuring the patient remains at the heart of decision making
		Strong governance process of effective reviewing of all business cases via challenge processes for requested investment across the estate.
	Estates technical and professional expertise	The Trust team have an established estates and contract management function, technically skilled across a broad spectrum of building types across clinical and non-clinical areas.
Weaknesses	Trust Estates Team capacity	The Trusts in-house Estates and facilities team is smaller than a comparable Trust without such a large PFI portfolio and has a strong focus around PFI contract management
	Estates constraints due to PFI commitments	The PFI estate results in lower backlog maintenance than comparable acute Trusts, but the PFI contract can make it difficult to add additional capacity or adapt space for alternative use
	Trust access to capital	The Trusts access to capital is restricted by the balance sheet treatment of the PFI investment. Nationally the capital allocations are managed at system (rather than Trust) level.
Opportunities	Partnership Working	Externally, we are working closer with other healthcare providers across the Black County. The Trusts' involvement as an active participant of the ICS and the Dudley health economy, together with productive relationships with NHE&I are likely to yield opportunities in the future
Threats	Left shift of Outpatient activity	Proposals to move a proportion of outpatient activity into a primary and community setting could

		potentially destabilise the Trusts estate portfolio and increase the costs of weighted activity units (WAU)
	Inflation and Supply Chain issues	Increase costs of energy and building related supplies could suppress the ability for the Trust to deliver all of its estates priorities

3.4 External Analysis (PESTLE)

In adopting a PESTLE analysis, we find the following high level outputs:

PESTLE	Theme	Potential Impact on DGFT
Political	Brexit	Mover away from UE standards and more focus on BS (British Standards) Procurement and supply issues may prevail while new arrangements are embedded
		Labour Market may be adversely impacted
	Hospital Car Parking	Management of car parking for staff and patients can be emotive and politically influenced
	HTMs	Changes in HTMs and NHS specific law could create operational issues for the Trust
	Health & Safety	Grenfell Tower - redefining of the management of project risks together with increased levels of certification
Economic	Staffing levels NHS Funding R&D	Staff attrition and retention problems may lead to restrictions on delivery of services Capital Funding may be more constrained given the challenges facing UK PLC R&D (including Clinical Trials) funding may receive more support as a response to the Covid pandemic
Social	Infection Prevention and Control Place Based Care	The experience of the SARS Virus and more recently the Covid pandemic may require additional pressures of testing zones, quarantine zones, isolation units which may impact on BAU service delivery, such as additional cleaning regimes. Move towards de- centralisation and enhanced teams (including PCNs) in the community, via HUB's twinned with the relocation of services may bring challenges to acquire such spaces for delivery of services
Societal	Equalities Access to Services	Potential impact on the design of the healthcare estate Our population may increasingly expect more accessible services including evening/ weekend/ 24hr access to services

	Flexible working arrangements	Society is changing its views on flexible working arrangements and agile working and the NHS needs to harness this going forward, particularly with back office functions.
Technology	Mobile technology and remote working	new Technology Platforms that can provide remote consultations with doctors and health care professionals via text and video messaging through mobile applications.
Legal	The built environment	Work related stress, seasonal affected disorders (SAD) and other factors affected by human interaction with their working environments with employee claims against their employers on the rise.
Environmental	Green and Net Zero ambitions Global warming	Trust will have ambitious carbon reduction targets to achieve net zero carbon targets and will require input and support from our PFI partners Increasing frequency of adverse weather events may periodically impact on the estate and operational services

3.5 Triangulation and Iteration – Keeping it aligned

At each stage, reference is made to the supporting strategies and plans of the Trust, to ensure the strategy aligns to outcomes with maximum benefit. The Estates Strategy is designed to fit as part of a suite of documents, with strong reference across each whilst avoiding duplication.

3.6 Review Process

Throughout the development of the Estates Strategy, the position of reference data and the targets developed are reviewed alongside a 'sense check' regarding the emerging options for reconfiguration to ensure they are prudent, operationally sound and based upon firm foundations. It is essential that such key proposals are also discussed with senior colleagues and stakeholders, ensuring a shared understanding of the drivers, priorities and rationale behind them.

3.7 Risk

The NHS has been traditionally seen as risk adverse with policy initiatives and financial pressures encouraging the rationalisation of estates with increasing pressure to identify surplus land for sale. Although relatively low risk this may offer poor value both in terms of capital release and long-term value. However, the 'do nothing' approach and delaying reconfiguration of the estate will most likely worsen the current financial situation of the Trust and therefore the Trust has to have an appetite to take on this risk in order to be able to continually provide, safe, effective and sustainable services.

3.8 Governance

The Estate Strategy should be developed and held accountable at the highest level ensuring that the estate strategy reflects local and organisational needs. Implementation of the Estate Strategy should have its own governance structure ensuring that a phased programme of works is developed to deliver the identified benefits and successful outcomes.

4 Context and Strategic Direction

4.1 The National Context

The key national drivers, policies and guidance underpinning the Trust's Operating Plan in service delivery and supporting safe practice are:

NHS Long Term Plan (2019)	The 10 year plan which sets out: • How the NHS will move to a new service model in which patients get more options, better support, and properly joined-up care at the right time in the optimal care setting. • New, funded, action the NHS will take to strengthen its contribution to prevention and health inequalities • The NHS's priorities for care quality and outcomes improvement for the decade ahead • How current workforce pressures will be tackled, and staff supported. • A wide-ranging and funded programme to upgrade technology and digitally enabled care across the NHS
The People Plan (2020/21)	The workforce strategy for delivering the Long Term Plan for the NHS. The People Plan sets out a range of actions organised around four pillars: • Looking after our people – with quality health and wellbeing support for everyone • Belonging in the NHS – with a particular focus on tackling the discrimination that some staff face • New ways of working and delivering care – making effective use of the full range of our people's skills and experience • Growing for the future – how we recruit and keep our people, and welcome back colleagues who want to return
2022/23 Priorities and Operational Planning Guidance	• accelerate plans to grow the substantive workforce and work differently as we keep our focus on the health, wellbeing and safety of our staff • use what we have learnt through the pandemic to rapidly and consistently adopt new models of care that exploit the full potential of digital technologies • work in partnership as systems to make the most effective use of the resources available to us across acute, community, primary and social care settings, to get above pre-pandemic levels of productivity as the context allows • use the additional funding government has made available to us to increase our capacity and invest in our buildings and equipment to support staff to deliver safe, effective and efficient care

4.2 The National Estate Context

The key national estates drivers, policies and guidance underpinning the Trust Estates Strategy are as follows:

- **The Carter Report** (February 2016) provided an independent review of NHS property and estates and recommends how to make best use of the buildings and land that the NHS possesses/occupies. Although mainly relevant to acute trusts, a number of the report's findings

are pertinent to the wider NHS estate, including recommendations as to the proportion of space that should be associated with non-clinical activities, maximum levels of unoccupied space and occupancy costs per square metre.

- The Naylor Report (March 2017) which calls for the NHS, through the STP process to rapidly develop robust capital plans which are aligned with clinical strategies, maximise value for money (including through land sales) and address backlog maintenance.
- The NHS Health Infrastructure Plan (September 2019) sets Government's strategy in respect of Healthcare infrastructure, the principles behind a rolling five-year programme of investment in health infrastructure, and a new capital regime managed through STPs and ICSs.
- Delivering a net zero NHS (October 2020) provides a detailed account of the NHS' modelling and analytics underpinning the latest NHS carbon footprint, trajectories to net zero and the interventions required to achieve that ambition. It lays out the direction, scale and pace of change. It describes an iterative and adaptive approach, which will periodically review progress and aims to increase the level of ambition over time

4.3 Regional Context

The Black Country & West Birmingham health and care system faces significant challenges. Some of these challenges are through changes in population need; others are a through the way services are organised and provided; others grow from the way patients and the public are engaged with. As a result, gaps in care quality, health outcomes and financial sustainability have emerged.

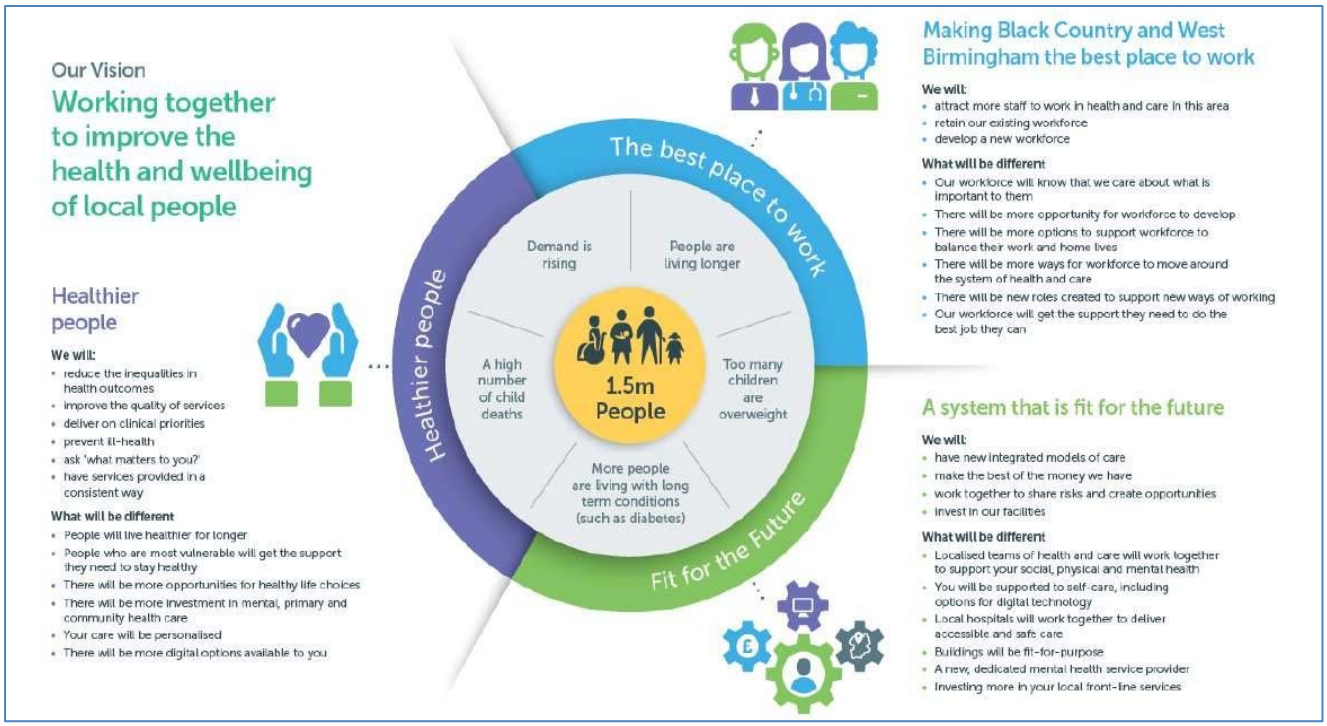
Following the publication of the NHS Long Term Plan in 2019, there was a national requirement to develop long term Sustainability and Transformation Partnerships (STP) covering all areas of NHS spending in England and linking with all national strategic priorities for health. These are now known as Integrated Care Systems (ICS).

The ICS is a collaboration of organisations across primary care, community services, social care, mental health and acute and specialised services across the Black Country and the west of Birmingham. These organisations retain their individual responsibility and decision-making powers but recognise the opportunity and benefits of coming together for people who use our health and care services. The ICS is not a statutory body, but the Health and Social Care Bill currently going through parliament will enable them to become statutory bodies. This is expected to take place from July 2022.

ICSs offer a new way of working for health and social care services locally, focusing on delivering health and care services defined by local area boundaries, not by local organisational boundaries. The aims are to:

- Improve the health and wellbeing of local people
- Improve the quality of local health and care services
- Deliver financial stability and efficiencies throughout the local health care system

Locally the ICS Partnership is called 'Healthier Futures' and the summary Strategic Plan 2019-2024 is set out in the figure below.



A map showing the coverage of the ICS is shown below.

The partners currently involved in the Healthier Futures ICS are:

- Black Country and West Birmingham Clinical Commissioning Group
- Dudley Metropolitan Borough Council
- DIHC – Dudley Integrated Health and Care NHS Trust
- The Dudley Group NHS Foundation Trust
- City of Wolverhampton Council
- The Royal Wolverhampton NHS Trust

- West Midlands Ambulance Service
- NHS England and Improvement
- Black Country Healthcare NHS Foundation Trust
- Birmingham Community Healthcare NHS Trust
- Birmingham City Council
- Sandwell and West Birmingham Hospitals NHS Trust
- Sandwell Metropolitan Borough Council
- Walsall Metropolitan Borough Council
- Walsall Healthcare NHS Trust

Note: ICS membership is set to change as West Birmingham is due to move into BSOL as part of new ICB/ICS arrangements from July 2022

ICS Priorities and Principles

To deliver the ICS's system priorities, five system principles have been developed that will support and guide the approach of the system. These principles are set out in the table below:

Principle	Description
Focus on long term collaboration	Changing how we work, for example, acting in collaboration rather than competition across providers, requires us to focus on transforming the culture of our organisations more than their structures. We see our role as protecting the resources we have – people, economic, environmental – and ensuring that we provide the taxpayer with the maximum value for their investment.
Health and Social Care act as one	Patients should not be impacted when crossing from NHS services to council services. Health and social care will work together to design services at regional, system and place levels to deliver person-centred care.
All Providers will work as a network around an identified need	We will be clear on the scope of our activities for a particular condition or population and how our activity adds value to the treatment people receive. This will create networks of providers around an identified need, working together towards an agreed set of outcomes and objectives. Together, the networks will be responsible for how resources are invested, for reducing duplication and getting the most value from services.
Ensure each individual makes decisions to optimise personal value	In the NHS Long Term Plan, there is considerable focus on personalised care and prevention. We will make sure that services are set up so that individuals can make decisions that allow them to get the most value from that service and can make decisions that keep them healthier for longer.
We will take collective responsibility for our success and failures	System working means collective responsibility across all areas of service delivery. Our system governance enables shared decision-making, so the outcomes of our decisions will also be shared. Our approach will be centred around a culture of transparency and learning

4.4 Multi-Specialty Provider Model of Care

The former Dudley CCG, as an NHS Vanguard, was a member of the Five Year Forward View New Models of Care Programme. Central to their plans was a new model of care – the Multi-Specialty Provider (MCP), designed to deliver population health and wellbeing based on the principles of shared ownership, shared responsibility and shared benefits.

The focus on the proposed new model of care builds on a joined-up network of GP-led, community-based Multi-Disciplinary Teams (MDTs) which enable staff from health, social care and the voluntary sector to work better together in the MCP.

The current status of the MCP initiative as at March 2022 is:

- The MCP Trust has been established – Dudley Integrated Health and Care NHS Trust (DIHC)
- Several services have been transferred into DIHC including Continuing Healthcare, School Nursing, Talking Therapies (IAPT), Primary Care Mental Health and Pharmaceutical Needs Assessment. The Trust are also actively supporting local Primary Care Networks (PCNs)
- The business case is being reviewed by NHSE&I as a local service initiative within the context of evolving national policy and planning guidance
- Work is continuing within Dudley and NHSE&I to finalise the business case and service / contractual matters to allow the MCP process to become fully established

The Trust is committed to working in partnership as DIHC develops and to actively contribute to supporting the achievement of intended benefits of the MCP model as it is fully rolled out.

5 Overview of the Trust and the Estate

5.1 The Dudley Group NHS Foundation Trust

Based in the heart of the Black Country, the Trust is the main provider of hospital and adult community services to the populations of Dudley, significant parts of the Sandwell borough and smaller, but growing, communities in South Staffordshire and Wyre Forest.

The Trust was the first hospital Trust in the area to be awarded coveted Foundation Trust status in 2008 and provides a wide range of medical, surgical and rehabilitation services. It serves a population of around 450,000 people from three hospital sites at Russell's Hall Hospital, Guest Outpatient Centre in Dudley and Corbett Outpatient Centre in Stourbridge.

The Trust provides the full range of secondary care services and some specialist services for the wider populations of the Black Country and West Midlands region. The Trust also provides specialist adult community based care in patients' homes and in more than 40 centres in the Dudley Metropolitan Borough Council community.

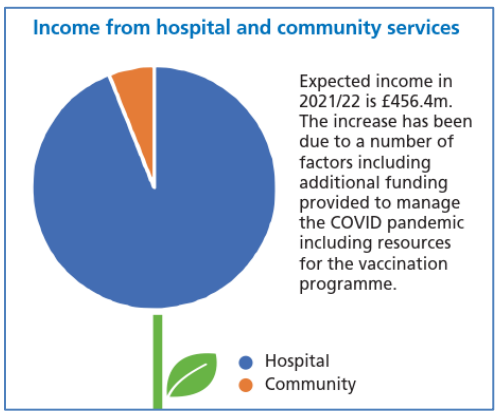
The Trust has a workforce of around 6,000 whole-time equivalent staff, it provides a range of secondary and tertiary services:

- Adult community services including community nursing, end of life care, podiatry, therapies and outpatient services from a range of community venues across the borough
- Russells Hall Hospital in Dudley, which has more than 650 beds, including intensive care beds and neonatal cots, provides secondary and tertiary services such as maternity, critical care and outpatients, and an Emergency Department (ED) with Emergency Treatment Centre
- The Guest Outpatient Centre in Dudley and Corbett Outpatient Centre in Stourbridge provide a range of outpatient, therapy and day-case services
- The Trust is also the vascular services hub for the Black Country and has an active research and development team

The Trust is a designated teaching hospital of the University of Birmingham with large cohorts of undergraduate students. The Trust has an active research and development team.

Income comes mainly from our commissioners (local Clinical Commissioning Groups and NHS England for certain specialised services) but the Trust also earns income from the training of healthcare professionals and from research. Over the last three years, Trust income has been:

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



5.2 The Vision

The Trust approved a new strategic plan covering the period 2021 - 2024 in September 2021. The plan has been developed at a time of great change and uncertainty in the NHS as the service continues to manage the global pandemic and prepares to implement the proposed legislative changes contained in the new Health and Social Care Act.

Trust vision: Excellent health care, improved health for all

Values: Care – respect – responsibility

Goals:

- Delivering right care every time
- Being the best place to work and thrive
- Driving sustainability
- Building innovative partnerships in place and system
- Improving health and wellbeing

At the same time the Trust is developing a new Clinical Services Strategy that will describe the services that we plan to deliver over the coming period considering the changes we expect to see in terms of service delivery. An understanding of this is critical, since it is impossible to describe the type of facilities that will be needed to deliver clinical services until the nature of those clinical services have been described.

A working framework for the clinical services strategy is shown below although this framework is unlikely to be ratified until after March 2022 to align with the clinical strategy for the Black Country ICS being developed as part of the Acute Provider Collaboration.

Elective care

- Strengthening the Midlands Orthopaedic Centre
- Establishing a first-class peri-operative hub
- Increasing theatre capacity and performing more surgery in outpatient settings
- Maintaining short waiting times

Urgent and acute care

- Delivering Same Emergency Care (SDEC) in dedicated facilities
- Strengthening links with community services in the community to avoid hospital admission and reduce LoS
- Improve flow through a re-designed Emergency Department
- Increase the number of beds available to treat patients and improve flow

Cancer

- Streamline pathways to achieve earlier diagnosis
- Continue to provide specialist surgical treatment for skin, colo-rectal, breast and renal cancers
- Expand the provision of home chemotherapy services
- Improved co-ordination with tertiary centres

Diagnostics

- Establishing a Community Diagnostic Hub (CDH)
- Separation of acute and elective diagnostic pathways

5.3 Considerations and Timeframes

This Estates Strategy looks to set out high level aims in support of meeting the strategic needs of the Trust and aims to look at the five-year period from 2022. Given the extended timescales taken to realise building and development programs, it is essential that consideration is given to the strategic risks and opportunities over the longer term. There are many competing and complex factors which will impact on the effectiveness of this strategy; however, there are several specific aspects which this strategy will seek to address:

- Alignment with and enabling the delivery of the Trust Strategy
- Recognising the very constrained financial environment
- Enabling opportunities which emerge from moving towards an Integrated Care System
- Enabling clinical change programmes
- Enabling changes to working practices
- Developing sustainable and environmental initiatives
- Delivering ongoing programmes to maintain and improve the existing Estate

The core objective is always to deliver and operate an Estate that is safe, sustainable and fit for purpose to meet the changing needs of patients. The financial constraints within which the NHS must operate however heightens the importance of ensuring the use of a robust and transparent system for risk-based decision making and investment prioritisation.

5.4 The Challenges

One of the most significant challenges facing the Estate both historically, and in going forward, is ensuring an appropriate balance of investment between the desire for new developments against the funding of maintaining the existing estate. Both issues carry significant risk if they are not funded appropriately, and it is a significant challenge to ensure the right balance in the allocation of capital resources and associated on-going costs. The strategic risk register plays an important part in this aspect, identifying the specific issues that the Trust faces from a service/operational delivery perspective and their relative priority.

In developing the direction for the future of the estate it is likely that the following parameters will be foremost:

- Issues of safety and compliance have been prioritised according to the level of risk to patients, staff and the continued delivery of clinical services.
- Revenue budgets will remain flat in real terms and will be expected to flex in line with increases or reductions to clinical activity in response to Integrated Care Systems.
- Internally generated capital investment will be restricted to operate within system capital allocations meaning investment programmes will be risk based. Capital budgets will remain flat in real terms.

5.5 Overview of the Estate

The Trust serves a large population from three hospital sites at Russell's Hall Hospital, Guest Outpatient Centre in Dudley and Corbett Outpatient Centre in Stourbridge. This provides inpatient facilities covering a total area of 125,197m2 (Russell's Hall – 99,799m2, Corbett Hospital – 5,481m2 and Guest Hospital – 1,170m2).

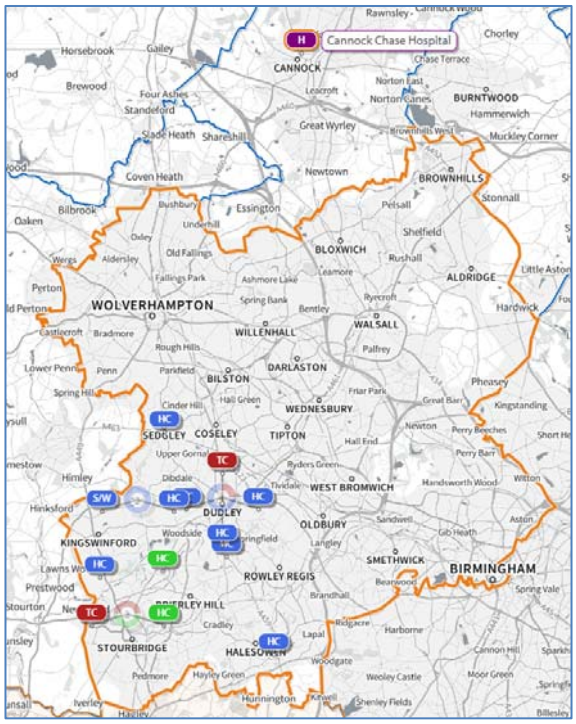
Most of the estate, the three main hospital sites, form part of a Private Finance Initiative (PFI) contract with Summit Healthcare and its appointed service providers, Mitie. The remaining estate is leasehold delivering adult community services including community nurse bases, podiatry, physiotherapy and sexual health and support services at the following locations:

CHP	NHS PS	
• Brierley Hill Health & Social Care Centre • Stourbridge Health & Social Care Centre	• Central Clinic • Cross Street Clinic • Halesowen Health Centre • Kingswinford Medical Practice • Lower Gornal Health Centre	• Netherton Health Centre • Sedgley Health Library & Social Care Centre • St James Medical Practice • Wordsley Green Health Centre

The Trust also leases the Facilities Management Centre (FMC) which is the Trust's IT data centre and IT staff base and through the PFI contract operates from Centafile, a warehouse which holds patient records and is the location for the booking offices.

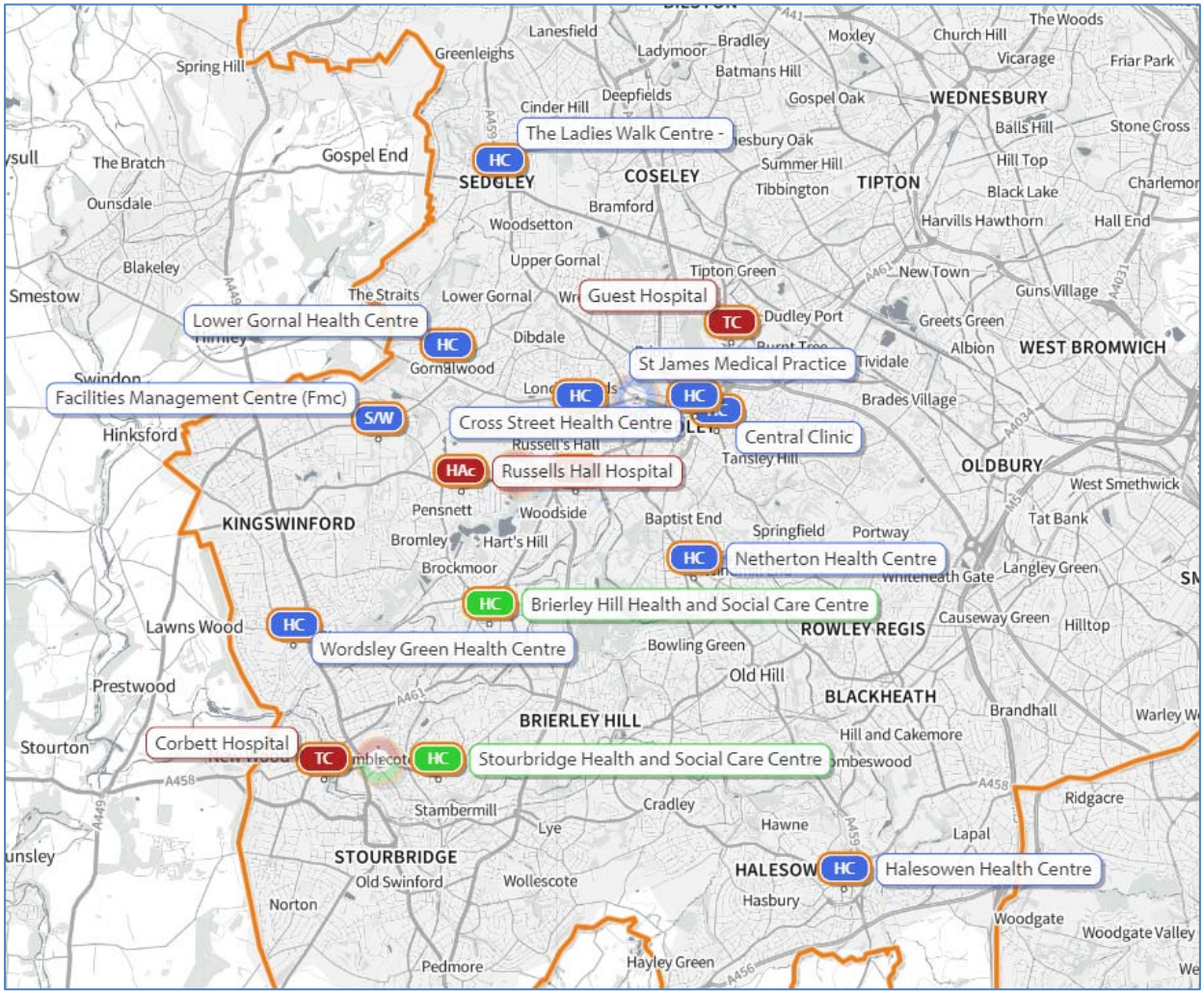
There are currently no signed lease agreements in place with CHP and NHSPS which is a situation which is recognised nationally. The Trust does have a signed lease directly with London and Cambridge Properties Limited for the FMC and leases accommodation at Cannock Chase Hospital for a breast screening service (the lease is with Royal Wolverhampton NHS Trust).

The map below indicates the location of properties and their tenure.



Key

- PFI
- Leasehold - NHSPS
- Leasehold - CHP
- Leasehold – Other



An Estates Terrier has been developed which lists all known details about each property the Trust occupies. The terrier also acts as a gap analysis and can be used to inform the Trust regarding decisions around the most effective use of the estate. The Estates Terrier identifies data which is currently outstanding, or which is out of date and needs to be refreshed.

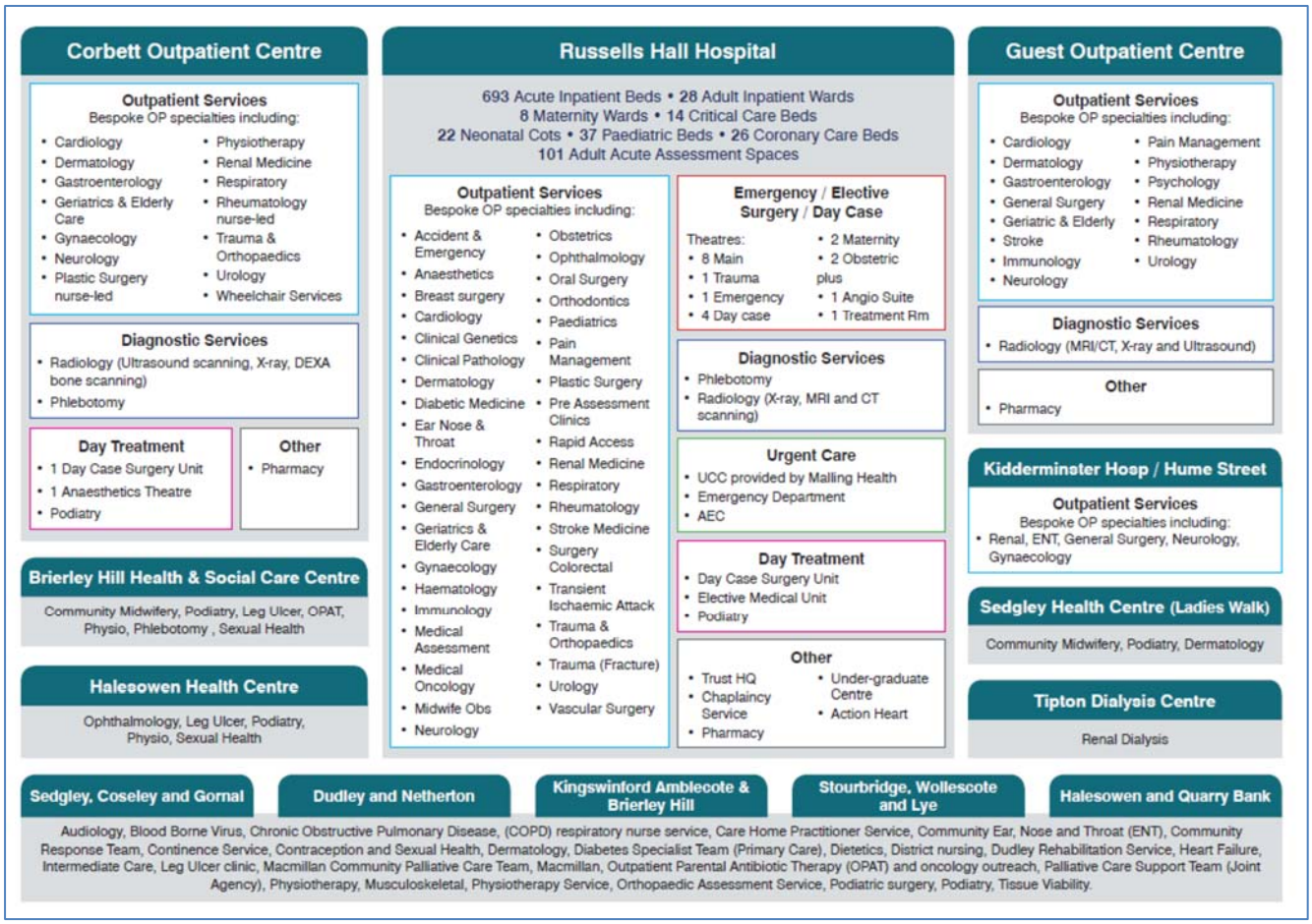
Summit Healthcare provide the Trust with condition reports which details the physical condition and statutory compliance of the PFI estate. The Trust also has condition reports on the retained estate and that which is leased from CHP and NHSPS.

Backlog costs including Risk Adjusted Backlog Maintenance (e.g., those safety critical items which need to be addressed immediately) are assessed by the Trust annually for retained estate and investment to rectify these items forms part of the annual capital programme.

The Trust works with the PFI provider to ensure data is collected in the appropriate format and to agreed standards and definitions to ensure that data is accurate and kept up to date. The Trust gathers assurance for this through management of the PFI contract and through a rolling programme of estates compliance audits. The information maintained by the PFI provider has greatly improved over the past few years, but further work is still required. The Trust continues to work with the PFI provider to shape the information provided and the tools used to produce and hold the information.

The Trust is restricted in terms of estate expansion on the current PFI sites. Space is fully utilised within all buildings but not necessarily in the most effective way. A space utilisation group continually reviews how we maximise the space available for clinical use.

The following diagram indicates the services provided at each location.



It is also worth understanding the ratio between clinical and non-clinical space use. The Trust is currently within the Carter Review recommendation of less than 35% non-clinical space (at 28%). However, in comparison with other peer PFI Hospitals Russell's Hall Hospital ranks in the medium percentile and was just below the average of 30.61% with the highest percentage of non-clinical space being 45.11% and the lowest being 16.30%. It can therefore be assumed that the Trust should be able to improve on this ratio.

5.6 Management of the Estate

In April 2000, Summit Healthcare (a consortium of Interserve plc, Halifax, Bank of Scotland and Sir Robert McAlpine) was appointed as the preferred bidder for the Trust's Private Finance Initiative (PFI). The Trust's estate was reduced from four sites to three with the demolition of much of the aged estate centralising services at Russell's Hall Hospital. It also saw the creation of two new ambulatory care centres at the Corbett and Guest Hospital sites.

The contract is performance managed by the Trust's Estates and Facilities Contract Team. This is managed through a governance structure with monthly performance meetings formally reviewing the performance of each service within the contract. This enables the Trust to oversee the performance of the services against the contract service specifications and apply any performance deductions and deficiency points in line with the contract.

The contract is due to expire in 2041 therefore the Trust is contractually obliged to the use of the PFI buildings, and its occupancy costs for the next 19 years. The PFI contract includes the provision of both hard and soft Facility Management services.

5.7 Key Sites

The following section sets out the Trust's key sites.

Russell's Hall Hospital

Russell's Hall Hospital is the largest of the three hospitals (total GIA of 99,799m2) and is the Trust's centre for inpatient care. Bushey Fields Hospital, a mental health inpatient facility managed Black Country Healthcare NHS Foundation Trust, is situated directly behind the hospital.

Nearly 50% of the Russell's Hall Hospital site formed part of the PFI and is therefore just over 15 years old. A further 38% of the site was built between 1995 and 2004 leaving only 15% of Russell's Hall Hospital being over 40 years old.

The main hospital is split into the following six blocks or wings:

- Block A – East Wing
- Block B – West Wing
- Block C – South Wing
- Block D
- Rainbow Ward
- North Block

The following table sets out the services delivered from Russell's Hall Hospital.

Block A – East Wing	• Anticoagulation • Chapel • Critical Care • Hydrotherapy • Intensive Care • Maternity Unit		• Renal Unit • Same Day Emergency Care • Site Management/Capacity Team • Therapy Services

	• Midlands Orthopaedic Centre: Ward B1 Ward B2 - Trauma Ward B2 - Hip Suite • Neonatal Unit • Operating Theatres • Orthotics		• Vascular Specialist Care Unit - B3 • Ward A2 & Discharge Lounge • Ward C1 – Renal • Ward C2 - Childrens • Ward C3 – Elderly Care • Women's & Children's OPD
Block B - West Wing	• Acute Stroke Unit • Acute Medical Unit(Rainbow Unit) • Clinical Management Offices • Clinical Measurement • Coronary Care/Post Coronary Care Unit • Day Theatres • Dietetics • EBME Library • Emergency Department • Emergency Surgical Hub	• GI Unit • High Dependency Unit • Lung Function Unit • Medical Photography • Mortuary • Outpatient Department • Pathology • Pharmacy • Imaging & main X-Ray • Reception & General Office • Urgent Care Centre	• Ward A4 – Medical Day Case Unit • Ward B4 - Surgical • Ward B6 – Medical • Ward C4 – Oncology • Ward C5 – Respiratory • Ward C6 – Urology • Ward C7 – Gastroenterology • Ward C8 - Stroke
Block C – South Wing	• Action Heart • Education Department	• Staff Facilities • Trust Offices	
Block D	• IT department • FM Estates Offices	• Main Kitchen • Stores	
Rainbow Ward	•	•	
North Block	• Clinical Offices • Diabetes & Endocrine Centre • GUM • Ophthalmology	• Research & Development • Simulation Training Centre • Undergraduate Medical Centre • Vascular Lab	

North Block and the Rainbow Ward are the only retained estate on the Russell's Hall Hospital site.

In addition, there are 11 accommodation blocks behind Russell's Hall Hospital which provide residential accommodation with four supporting garage blocks and a residences laundry:

- Avon House
- Brent House
- Cam House
- Dee House
- Frome House
- Glen House
- Humber House
- Isis House
- John House
- Kennett House
- Lee House

Summit Healthcare own the blocks and Mitie manage the accommodation which is occupied by doctors, nurses and, at times, other members of the public. The Trust has no direct involvement in these residential flats. A twelfth block, Esk House, is being used as office/training facility for the Trust as part of the PFI contract.

There is parking on site which includes a mix of land parking and a multi-storey car park. All car parking is managed and maintained by Summit Healthcare who also manage and receive the income from all patient and visitor car parking. The Trust, however, manages and receives income from staff car parking.

Corbett Hospital Outpatient Centre (Stourbridge)

Corbett Hospital Outpatient Centre is located in Stourbridge and has a GIA of 5,481m2. The following clinical services are delivered from this facility:

- Day Surgery
- Imaging
- Outpatient Department
- Pharmacy
- Therapy Services

Surplus land on the estate, currently used as grazing land, has been identified as surplus.

Guest Hospital (Dudley)

The smallest of the three PFI hospital sites, Guest Hospital was built in 2003. It has a GIA of 1,170m^2 and provides the following services to the local community:

- Imaging
- Outpatient Department
- Pharmacy
- Therapy Departments

Guest Hospital is 3.4 miles distance from Russell's Hall Hospital and 6.1 miles from Corbett Hospital. Guest Hospital had significant capital investment in 2017-18 to create an imaging hub on the site.

5.8 Estates Performance

Occupancy Costs

In 2021-22 the occupancy cost of the PFI estate was £47,839,251 of which £42,578,600 was the unitary payment with the remainder variations and energy costs.

In addition, the Trust leases several outpatient sites for community led services at an annual cost of £2,631,445. Together this totals annual expenditure of £50,470,696 to operate a safe and fit for purpose estate.

Based on model hospital reporting (MARCH 2022), in comparison with peer Trusts, DGNHSFT is in the upper quartile with regard overall occupancy cost for the PFI estate per m^2, paying £509/m^2 against a peer group benchmark value of £408/m2. However, not all Trusts pay for the same services within the unitary payment e.g. energy, waste, sewage, EBME or soft FM costs. Nevertheless, when Hard FM costs are compared '*like for like*', the Trust remains above the peer group benchmark with a cost of £122 per m2 compared with peer group benchmark cost of £102 per m2.

It must be noted that of the leased properties, 72% of the occupancy costs (£1,864,177) relate to two CHP properties, Brierley Hill Health and Social Care Centre (£1,157,452) and Stourbridge Health and Social Care Centre (£706,725). Whilst these properties should also be maintained at Estatecode B with regard to physical condition all of the other properties where facet surveys have been undertaken are also deemed Estatecode B or B/C and yet the occupancy costs for these properties are significantly lower.

Asset Value

Total asset value of the PFI site as at 31st March 2022 is £152,506,000 valued under the alternative site valuation methodology.

The non-PFI estate (North Block, Rainbow Ward, MSCP) has a combined value of £30,562,618, giving a total asset valuation as at March 2022 of £183,068,747

Valuation as at March 2022	
	£
Land	13,120,000
RHH	126,861,823
Corbett	10,140,175
Guest	2,384,131
North Block	9,182,461
Rainbow Ward	11,511,344
MSCP	9,868,813
Total	**183,068,747**

Capital Investment

The Trust's 5 year capital programme is shown below.

	2022-23		2023-24		2024-25		2025-26		2026-27
Scheme	**£000's**		**£000's**		**£000's**		**£000's**		**£000's**
Operational									
Replacement Medical Equipment	1,932		3,000		3,000		3,000		3,000
Imaging Enabling Work	0		250		250		500		500
North Wing Lifecycle	110		250		750		750		750
Statutory Standards/Minor Works	513		859		600		1,000		1,000
IT PC Replacement Programme	0		600		600		600		600
North Block Fire Works	690		460		0		0		0
Temperature Monitoring Medcine Rooms	447		446		0		0		0
Anti-Ligature Works	595		0		0		0		0
Pharmacy Robot Replacement	832		0		0		0		0
Replacement Training Simultors	66		0		0		0		0
Relocation of Breast Service	0		500		0		0		0
Vascular x2 outpatient US Machine Sonosite	0		150		0		0		0
3rd CT Scanner RHH	0		0		2,000		0		0
Pathology Laboratory Move	0		200		0		0		0
Community network/WiFi replacement	50		0		0		0		0
IT Other BAU	534		0		0		0		0
IT Infrastructure/Cloud Stage 1	248		0		0		0		0
IT Infrastructure/Cloud Stage 2	908		620		275		0		0
Self-Financed Capital	**6,925**		**7,335**		**7,475**		**5,850**		**5,850**
ED Development RHH	0		13,267		3,708		0		0
PDC Financed Capital	**0**		**13,267**		**3,708**		**0**		**0**
PFI Lifecycle	2,601		1,979		2,928		3,456		3,277
PFI MTS Equipment	1,408		805		490		2,570		926
PFI Capital	**4,009**		**2,784**		**3,418**		**6,026**		**4,203**
Total	**10,934**		**23,386**		**14,601**		**11,876**		**10,053**

The Trust carries out capital enhancement works to the PFI building through a variation to the PFI contract. This involves a 'bullet payment' to the PFI company for the capital works and is funded from the Trusts capital resources. Any impact on the PFI lifecycle process is reviewed as part of the variation and a refund agreed offset against the capital variation payable by the Trust.

PFI Life Cycle Costs

Following a recent condition survey the subsequent Lifecycle reprofiled spend has been proposed by the Project Company (the SPV) for review by the Trust who have suggested the possibility of decanting wards on a station by station basis. The Project Company are currently pulling together a draft proposal that is being finalised for consideration by the Trust.

The following shows the Trust's PFI Provider's planned life cycle investment which will address routine backlog maintenance for the next six years.

Building	2022	2023	2024	2025	2026	2027
Block A	Yr 1	Yr 2	Yr 3	Yr 4	Yr 5	Yr 6
Block B	£ 175,549	£ 26,732	£ 151,435	£ 156,951	£ 101,383	£1,045,910
Block C	£ 537,063	£ 231,624	£ 200,946	£ 147,137	£ 363,626	£ 584,929
Block D	£ 113,558	£ -	£ 442,050	£ 442,050	£ 546,266	£ 148,209
Externals	£ 3,397	£ 200,430	£ 271,875	£ 140,721	£ 181,227	£ 125,427
Avon	£ 75,189	£ 5,711	£ 5,711	£ 5,711	£ 19,488	£ 40,097
Brent	£ 2,154	£ 2,385	£ 4,125	£ 48,862	£ 97,717	£ 12,965
Cam	£ 997	£ 15,582	£ 9,906	£ 30,969	£ 103,941	£ 1,420
Corbett	£ -	£ 4,005	£ 19,781	£ 35,913	£ 65,392	£ 14,385
Dee	£ 14,739	£ 15,579	£ 11,100	£ 11,100	£ 18,454	£ 193,681
Esk	£ -	£ 5,743	£ 21,482	£ 31,200	£ 62,182	£ 14,385
Frome	£ 498	£ 10,541	£ 13,660	£ 48,391	£ 162,652	£ 30,506
Glen	£ -	£ 5,182	£ 1,389	£ 39,386	£ 81,067	£ 12,965
Guest	£ -	£ 1,080	£ 5,854	£ 30,096	£ 50,507	£ 14,385
Humber	£ -	£ 25,624	£ 13,695	£ 60,012	£ 163,573	£ 59,733
Isis	£ -	£ -	£ 5,524	£ 65,962	£ 40,392	£ 7,718
John	£ -	£ 540	£ 1,389	£ 36,769	£ 51,927	£ 12,965
Kenneth	£ -	£ 4,502	£ 5,854	£ 26,778	£ 84,697	£ 12,965
Lea	£ -	£ 1,080	£ 4,572	£ 34,492	£ 50,512	£ 14,385
	£ -	£ -	£ 4,371	£ 63,014	£ 53,312	£ 9,138
Telecomms						
EBME SERVICES AGREEMENT						£ 143,985
Renal Dialysis machines	£ 17,322	£ 17,322	£ 17,322	£ 17,322	£ 17,322	£ 17,322
FF&E	£ 98,000	£ 112,105	£ -	£ -	£ -	£ -
Blocks Redecoration	£ 522,000	£ 522,000	£ 522,000	£ 522,000	£ 522,000	£ 522,000
Residential Redecoration	£ 179,000	£ 179,000	£ 179,000	£ 179,000	£ 179,000	£ 179,000
	£ 13,425	£ 13,425	£ 13,425	£ 13,425	£ 13,425	£ 13,425
Model Total						
Total	£1,752,889	£1,400,192	£1,926,467	£2,187,259	£3,030,064	£3,231,901

Commercial/3rd Party Income arrangements

The PFI contract financial model operates so that the base 3rd party income within the original PFI agreement is inflated in line with the contractual RPI increase each year and deducted from the service payment. This means that the SPV takes the risk and reward of increases or decreases to 3rd party income over the contract period. 3rd party income includes patient and visitor car parking, commercial catering, residences income, payphone income and commercial rent on site.

Estate Performance

The Trust uses 'Model Hospital' to benchmark against a peer group of acute hospital Trusts of similar size and scale.

Model Health System

Dudley Group NHS Foundation Trust

Estates & Facilities

The peer group members are shown below:

Peer group members

Mid Essex Hospital Services NHS Foundation Trust	Whittington Health NHS Trust
Surrey and Sussex Healthcare NHS Trust	Taunton and Somerset NHS Foundation Trust
University Hospitals of Morecambe Bay NHS Foundation Trust	West Hertfordshire Hospitals NHS Trust
Wrightington, Wigan and Leigh NHS Foundation Trust	Walsall Healthcare NHS Trust
Frimley Health NHS Foundation Trust	Bolton NHS Foundation Trust
Basildon and Thurrock University Hospitals NHS Foundation Trust	Great Western Hospitals NHS Foundation Trust
East Suffolk and North Essex NHS Foundation Trust	Ipswich Hospital NHS Trust
Ashford and St Peter's Hospitals NHS Foundation Trust	Northampton General Hospital NHS Trust
Rotherham NHS Foundation Trust	Dudley Group NHS Foundation Trust
Stockport NHS Foundation Trust	North Tees and Hartlepool NHS Foundation Trust
Torbay and South Devon NHS Foundation Trust	Croydon Health Services NHS Trust
Sherwood Forest Hospitals NHS Foundation Trust	Royal United Hospitals Bath NHS Foundation Trust
Royal Surrey NHS Foundation Trust	The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust
Homerton University Hospital NHS Foundation Trust	Medway NHS Foundation Trust

The table below shows a summary of the Trust's estate portfolio:

Trust Summary metrics	Data period	Provider value	Performance band description	Peer median	Benchmark value
Total number of sites (No.)	2020/21	17	Below the benchmark (blue)	20	20
• Number of sites reported (No.)	2020/21	12	Above the benchmark (blue)	12	12
• Number of sites not reported (No.)	2020/21	5	Above the benchmark (blue)	3	3
Gross internal area (m2)	2020/21	109.31k	Above the benchmark (blue)	99,272	99,272
PFI Occupied floor area (m2)	2020/21	85,307	Above the benchmark (blue)	47,701	47,701
• Percentage PFI occupied floor area (%)	2020/21	93.7%	Above the benchmark (blue)	61.8%	61.8%
Occupied floor area (m2)	2020/21	91,059	Above the benchmark (blue)	91,059	91,059

The data provided within Model Hospital enables the analysis of Estates and Facilities information from NHS Trusts in England however it must be noted that the accuracy and completeness of the information is the responsibility of the reporting organisation.

Metric	Trust position	Peer Group median
Hard FM cost per sq metre	£122	£102
Soft FM cost per sq metre	£147	£138
Amount of non clinical space	28%	28%
Total energy cost per m2	£34.39	£27.93
Linen & Laundry productivity (items per WAU)	34.26	£33.65
Cleaning productivity (m2 per WTE)	326	572
Inpatient food service productivity (means per bed day)	2.23	2.75
Backlog Maintenance (£ per m2)	£2	£305

Backlog maintenance liability it very low relative to other peer group Trusts, reflecting the large proportion of the estate footprint that is within the PFI contract and therefore maintained to condition B. It can therefore be assumed that other Trusts have a larger element of retained estate which requires ongoing capital investment to maintain the estate at Estatecode B.

The Carter Review, 'Operational Productivity and Performance in English NHS Acute Hospitals: Unwarranted Variations', published in February 2016, recommended that,

'Trusts should operate at or above the benchmarks agreed by NHS Improvement for the operational management of their estates and facilities functions by April 2017, with all trusts (where appropriate) having a plan to operate with a maximum of 35% of non-clinical floor space and 2.5% of unoccupied or under-used space so that estates and facilities resources are used in a cost effective manner'. With regard to GIA being used as non-clinical space, at 28% DGFT is well within the recommended guidance.

The Trust is in the upper percentile for energy costs which may be explained by the high levels of consumption of electricity, gas and oil. In addition, the Trust is also using the most water in comparison to peer Trusts. The PFI Provider takes the risk on energy usage.

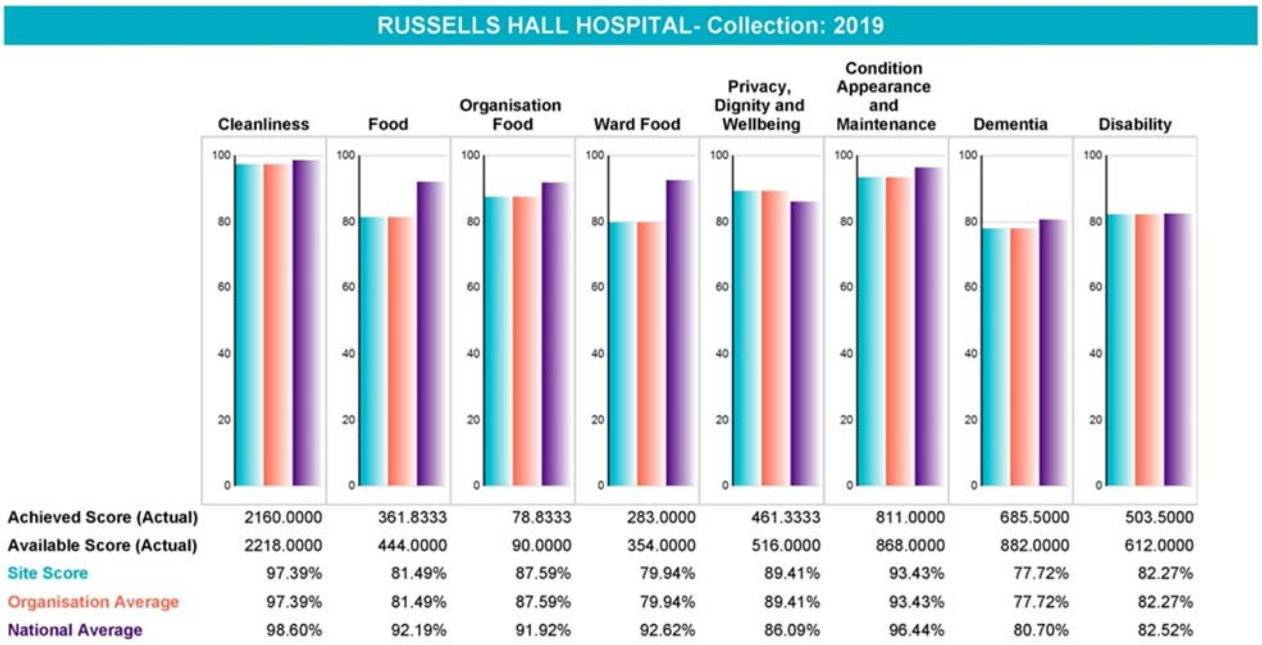
PLACE Assessment

The introduction of PLACE (Patient Led Assessment of the Care Environment) in 2013 whereby the environment is assessed with regard to privacy and dignity, food, cleanliness, general building maintenance and more recently the extent to which the environment is able to support the care of patients with dementia and also in relation to access for those with disabilities provides a clear message, directly from patients, about how the environment or services might be enhanced.

The last national PLACE assessment took place at Russells Hall Hospital on Tuesday 12 November 2019. National PLACE assessments were suspended during 2020 or 2021 due to the pandemic however, there is an expectation that there will be a national assessment during 2022 although this is yet to be finalised.

Several domains are assessed, as shown below, including; Cleanliness, Food, Condition Appearance & Maintenance, Disability, Privacy, Dignity & Wellbeing, as well as Dementia, the results of which were published in Q1 2020. On this occasion, it was not possible to compare previous results with this year due to the number of changes in questions following a national review

The 2019 PLACE Scores for Russell's Hall Hospital are shown below:



	Cleanliness	Food	Organisation Food	Ward Food	Privacy, Dignity and Wellbeing	Condition Appearance and Maintenance	Dementia	Disability
Achieved Score (Actual)	2160.0000	361.8333	78.8333	283.0000	461.3333	811.0000	685.5000	503.5000
Available Score (Actual)	2218.0000	444.0000	90.0000	354.0000	516.0000	868.0000	882.0000	612.0000
Site Score	97.39%	81.49%	87.59%	79.94%	89.41%	93.43%	77.72%	82.27%
Organisation Average	97.39%	81.49%	87.59%	79.94%	89.41%	93.43%	77.72%	82.27%
National Average	98.60%	92.19%	91.92%	92.62%	86.09%	96.44%	80.70%	82.52%

NHS digital launched PLACE-Lite and Trusts are being encouraged to carry out these assessments as it is felt that it is particularly important to consider the environment for patients and get a sense of how COVID-19 has impacted on the environment. Trusts determine the frequency of assessments and have freedom to choose the categories and areas to be assessed

Attendance at these environmental audits has included a member from the Trust's IPC team, a clinical lead, representatives from Mitie (the FM contractor) and the Trust's Facilities Contract Manager. In addition, hospital Governors and Healthwatch are also supporting this process.

The PLACE-Lite results are recorded on the NHS Digital platform, like national PLACE, but this information is not shared with other Trust's and no benchmarking takes place as with national PLACE. An action plan is produced and monitored via the Patient Experience Group (PEG), chaired by the Chief Nurse. Areas that have been assessed under the PLACE-Lite regime, which commenced in October 21 include the following wards: B5, C1, B1, C6 and AMU. In addition, Communal Areas, Women and Children's OPD and Imaging have also been assessed.

A series of PLACE meal-time assessments have also taken place with feedback being provided to the lead nurses and matrons on improvements that could be made. Follow-up visits to areas are also being scheduled.

An external assessors training session was carried out during February 2022 for Healthwatch so that that could provide support to the process and Healthwatch members have attended both the March and April 2022 assessments. Their support is very much welcomed.

The PLACE-Lite programme will continue to run through the Spring/Summer of 2022 and further guidance is awaited with regards to the expectations of national PLACE happening later in the year.

Financial Standing

The Trust's three hospitals form part of a Private Finance Initiative (PFI) with Summit Healthcare and its appointed service provider Mitie. This means that the Trust has three new hospitals, and a project

agreement that should maintain the buildings and infrastructure in good condition until 2041 (for the next 19 years), via a fixed unitary payment.

The onset of the COVID-19 pandemic resulted in a significant change to the financial arrangements for 20/21 as resources were focused on dealing with the crisis and additional funding support was made available nationally to ensure each organisation achieved a breakeven position. Financial management across the system and the deployment of a risk sharing scheme ensured that all organisations within the system delivered a surplus amounting to £2.2m. The Dudley Group end of year position for performance management purposes amounted to £0.2m, the second consecutive year of achieving a positive financial outcome.

It should be noted that there are significant adverse variances against pay and non-pay more than offset by a positive variance on income. The Trust accepted the role of lead employer for the COVID-19 vaccination programme during the year which involved providing staff for the vaccination centres across the Black Country & West Birmingham with costs incurred being fully reimbursed. In addition, consumables and equipment provided for the fight against COVID were effectively fully funded. Both of these two factors are the main reason for the distortion of the figures. The numbers presented below relate to The Dudley Group financial performance, not including the Charity.

	2020-21			2019-20	
	PLAN £000	ACTUAL £000	VARIANCE £000	PLAN £000	ACTUAL £000
INCOME	£419,964	£450,449	£30,485	£382,327	£411,900
PAY	-£261,884	-£281,534	-£19,650	-£238,106	-£249,923
NON PAY	-£136,922	-£144,392	-£7,470	-£117,837	-£136,061
EBITDA	**£21,158**	**£24,523**	**£3,365**	**£26,384**	**£25,916**
DEPRECIATION & FINANCE COSTS*	-£23,199	-£22,822	£377	-£18,412	-£22,395
NET SURPLUS/(DEFICIT)	**-£2,041**	**£1,701**	**£3,742**	**£7,972**	**£3,521**
Technical Adjustments	£41	-£1,502	-£1,543	£85	(£317)
FINAL SURPLUS/(DEFICIT)	**-£2,000**	**£199**	**£2,199**	**£8,055**	**£3,204**

* Figure includes impairment of £0.028m in 19/20

6 Our Future Priorities

6.1 Organisational objectives

At the heart of everything DGNHSFT does are its patients – and one of the Trust's most important aims is to provide the best possible patient experience. To do that DGNHSFT wants to create an environment that encourages a passionate workforce to get things right for every patient, every time.

To deliver the vision and become a highly regarded healthcare provider for the Black Country and West Midlands the Trust has established a clearly defined vision, objectives and goals

Trust Vision

The Trust's Vision, Values and Goals are set out in the table below:

Trust Vision	Trust Values
Our new vision is designed to be simple and memorable. It combines our desire to deliver excellent care for our patients but also recognises the impact that we have on the health of the wider population.	• We provide safe, quality **care** for every person – every time • We show **respect** for our patients, our visitors and each other – at all times • We take **responsibility** for everything we do – every day
Trust Strategic Objectives	
1. Deliver a great patient experience 2. Deliver safe and caring services 3. Drive service improvement, innovation and transformation 4. Be the place people choose to work 5. Make the best use of what we have 6. Deliver a viable future. **These objectives are underpinned by three clinical aims:** • Develop integrated care provided locally to enable people to stay at home or be treated as close to home as possible. • Strengthen hospital-based care to ensure high-quality hospital services are provided in the most effective and efficient way. • Provide specialist services to patients from the Black Country and further afield	

6.2 Underpinning Strategies, Plans and Programmes

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

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

- A workforce for now and for the future

- A caring, kind and compassionate place
- Equality, fairness and inclusion
- Improvement and development culture
- Using technology to innovate

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

Clinical Services Strategy

Trust is developing a new Clinical Services Strategy that will describe the services that we plan to deliver over the coming period considering the changes we expect to see in terms of service delivery. An understanding of this is critical, since it is impossible to describe the type of facilities that will be needed to deliver clinical services until the nature of those clinical services have been described.

A working framework for the clinical services strategy is shown below although this framework is unlikely to be ratified until after March 2022 to align with the clinical strategy for the Black Country ICS being developed as part of the Acute Provider Collaboration.

Elective care

- Strengthening the Midlands Orthopaedic Centre
- Establishing a first-class peri-operative hub
- Increasing theatre capacity and performing more surgery in outpatient settings
- Maintaining short waiting times

Urgent and acute care

- Delivering Same Emergency Care (SDEC) in dedicated facilities
- Strengthening links with community services in the community to avoid hospital admission and reduce LoS
- Improve flow through a re-designed Emergency Department
- Increase the number of beds available to treat patients and improve flow

Cancer

- Streamline pathways to achieve earlier diagnosis
- Continue to provide specialist surgical treatment for skin, colo-rectal, breast and renal cancers
- Expand the provision of home chemotherapy services
- Improved co-ordination with tertiary centres

Diagnostics

- Establishing a Community Diagnostic Hub (CDH)
- Separation of acute and elective diagnostic pathways

Digital, data and technology

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

1) To become an interactive digital trust, where citizens have digital access to services, to contribute and participate actively in their health record – so they may better manage their health. In doing so, we will protect privacy and give citizens control of their medical record.
2) To become a digitally enabled organisation, where, as a workforce, we are able to embrace technology to support different ways of working so that we may access the information we need wherever we are.

3) To become a data-driven healthcare partner, where decision support and artificial intelligence (AI) help limit unwarranted variation whilst genomic data, predictive techniques and co-authored care plans enable personalised care.
4) To be known as a responsible digital leader, in our approach to delivering national standards in data security, cybersecurity, interoperability and workforce development.
5) To become a provider that will not need a 'digital strategy', as technology will be adopted as mechanism for innovation to meet the core Trust Strategy.

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

The three fixed point strategic objectives are:

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

Financial Strategy

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

Green Plan

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

6.3 Estate Priorities

The strategic aims of the Trust in relation to the built environment are centred around Compliance, Capacity and Sustainability.

Compliance and backlog	Capacity and resilience	Modernity and sustainability
Our estate is appropriate and safe and meets the expectations of patients, visitors and staff	Our estate is adequate and supports the needs of clinical services, with the capacity to meet demand for healthcare in the right place	We offer 21st Century healthcare and have flexibility to respond to the requirements of commissioners and ICS plans in the long term.

The key estates priorities within this Estates Strategy include:

New or substantially reconfigured estate:

- Development of additional theatre capacity including a hybrid theatre at Russells Hall Hospital
- Redevelopment of our Emergency Department
- Neonatal Unit
- Critical Care
- Peri-operative Hub

Estate efficiency and optimisation:

- Optimising the use of our existing estate
- Improving the performance of our PFI service provider (via the helpdesk)

  Reconfigure space used by back-office functions as a result of increased remote-working
- Assessing the impact of the Electronic Patient Record on storage requirements for paper-based patient records
- Development and investment in schemes to de-carbonise our estate
- Maximising our green space to promote biodiversity and enhance patient and staff well-being.
- Aligning our estate to the developments of the ICP and ICS

6.4 Our Priority Schemes

Theatres

A new Hybrid Theatre and two new Minor Procedure Rooms due for completion later this year. The Hybrid Theatre will provide modern state-of-the art facilities to strengthen our position as the arterial centre for the Black Country Vascular Centre, extending the range of procedures offered, and improving outcomes for patients across the region. This is due for completion in September 2022. The two new Minor Procedure Rooms will provide additional capacity to support waiting list backlog clearance both within the Trust, and across the ICS. These rooms are fundamental in achieving our goal to deliver all care in the most appropriate care setting, with main theatre and day-case capacity being released for

higher acuity cases. Additional work is planned to improve the environment within main recovery and increase storage within the Anaesthetic Rooms to support achievement of key national standards.

The following projects are priorities for the Trust but are classified as 'Pipeline Schemes' pending business case approval by NHSE&I and/or funding routes identified:

ED Redesign

There is currently significant demand on the existing emergency care facilities at RHH. Over the last 3 financial years there has been an average annual growth in activity of 3.8%. Capacity modelling for resuscitation facilities indicates 7 spaces are required immediately for the current demand, current resus accommodates 4 spaces with no segregation for paediatrics & adults. The pandemic has further highlighted the need for improved isolation facilities resulting in a resus facility.

A new build and refurbishment scheme has been developed to provide additional capacity to the Resuscitation area to provide an expanded and fit for purpose twelve bay resuscitation facility including bays for bariatric patients, isolation and aerosol-generating procedures (AGP) bays and simulation training facilities for the ED department. Further elements of the scope of the scheme are:

- An improved bereavement suite to include two viewing rooms and improved relatives' facilities.
- A reconfigured relocated & improved ambulance triage area.
- An improved Majors area to include resizing of cubicles, improved drug preparation & supporting facilities.
- A reconfigured See and Treat area that is located close to the front door and diagnostic facilities.
- An improved decontamination area for staff.
- Extension to current staff area to provide staff change & rest areas, training facilities and office accommodation management suite and staff rest area.
- Resus will decant into space within the new Rainbow Unit – works required to facilitate this decant

In addition, a request has been made via the Trusts capital programme for a corridor to be created through the current ambulance triage & ED Paediatric area. This will provide access from the new Rainbow Unit to the main hospital street and ease the traffic on the corridor that runs through ED Xray. In addition, it will provide 2 x 4 bed bays that during the works will temporarily accommodate Ambulance Triage.

An STP/ICS Wave 4 capital bid has been made for £16.9m and a construction period of 13 months is envisaged.

Neonatal Unit

The current neonatal unit is no longer fit for purpose, being cramped and cluttered, with limited storage and the facilities for parents, carers and families are inadequate. The space for each cot does not meet the current Health Building Note recommendations. Reconfiguring the Neonatal Unit would allow the

neonatal service to achieve the required standards. This would ensure that parents and carers have the facilities to allow full implementation if the Family Integrated Care principles, allow improved flow by supporting the transfer of babies back from Level 3 units. The redesign and expansion of the Unit would ensure that the neonatal service is able to function more effectively as part of the West Midlands Neonatal Operational Delivery Network (WMNODN).

Critical Care

The current Critical Care estates template is non-compliant with national General Provision of Intensive Care Standards (GPICS), both in terms of the physical bed spaces and general environment. A feasibility study is planned for 2022/23 to assess the estates options available to accommodate a Critical Care Unit that achieves the building requirements set out in the NHSE Health Building Note – 'Guidance on designing Critical Care Units'. This would allow us to improve patient safety and management of infection prevention and control, as well as improve staff morale through an improved working environment.

Peri-Operative Hub

Our ability to increase pre-operative assessment capacity has been constrained by lack of space within the Outpatient Department. A priority for 2022/23 will be to identify capacity to allow expansion of the service to meet the demands associated with restoration and recovery. A Peri-Operative Hub strategy is being developed, which will set out future plans for a wider multi-disciplinary Peri-Operative Hub, which will have further estates requirements to accommodate additional services. As well as providing space for expansion of activity, the Peri-Operative Hub will provide holistic input to improve outcomes after surgery and reduce length of stay through enhanced care planning and early intervention to address risk factors

6.5 Optimising the Estate

DGNHSFT is not in the position of other NHS organisations where they have a number of options available to them to either reconfigure the estate (should they wish to do so), and/or have ease of access to capital monies to progress capital schemes to reflect any strategic change in clinical operational delivery. The Trust are almost a wholly PFI based estate and any reconfiguration required across their current estate will come with increased charges as a result of having to progress any design and associated alterations through their PFI partner. As a consequence, the Trust's estate is currently acting as a part barrier to change rather than a wholly enabling entity.

Although any output as a result of further review will be limited, there are a number of areas which could be interrogated further to fully understand what could help deliver future strategic plans. These are as follows:

- The PFI Estate
- The Trust Retained Estate
- The Leased Estate
- Residencies & Car Parking
- Opportunities for Site Rationalisation
- Off Site Options/Solutions

The above areas are discussed in more detail below with regard how each could potentially inform any future estate reconfiguration and/or strategic thinking to enable future clinical operational service change.

The Trust needs to be able to flex the estate to its maximum without incurring unnecessary charges, and to do there is a need to understand exactly how the existing estate is being utilised. The Trust particularly wishes to maintain a range of hospital based services and expand those in which the Trust excels and has a competitive advantage. Through their PFI partner the Trust is clear about the condition of the estate as such information underpins the monthly unitary charge, however, information detailing the utilisation of the estate is not currently available.

This information is essential to understand how the estate is currently being used, and once validated will inform any future strategic thinking and option appraisal regards potential clinical and non-clinical service moves to maximise the productivity of the estate without fundamentally changing the internal fabric of the PFI owned buildings and associated infrastructure. Without such information to hand it is impossible that any informed decisions can be made regards the possible future reconfiguration of space.

Whilst the actual space utilisation is not fully understood it is estimated that potentially up to 30% of the outpatients from services which are currently delivered from Russell's Hall Hospital could be relocated in the community equating to approximately 700 appointments per week.

Utilisation Survey & Strategy

Key to unlocking the Trust's mainly PFI estate to better service the organisation's clinical needs is to fully understand how the estate is being used, by who and when. A detailed utilisation study will provide this information and is key to being able to strategically reconfigure any current areas that constrain clinical services from changing their operational requirements. Alternative options available to free up space in the highly utilised and clinical areas of the estate by moving non clinical and less utilised services either elsewhere or off site could be highlighted.

To inform a better understanding of space utilisation, the SPV (Summit) were requested to provide a solution to the data management statistics that Mitie (the FM service provider) and the Trust need to collate to satisfy the various auditors. Summit have proposed 'Activeplan', a web based application which ensures that any changes to the estate that affect the Gross internal floor (GIA) area of the specified facilities is captured and reflected in 'on demand' reports. Area reports for each of the facilities can be created. The latest base drawings that reflect the current facilities layout can be available for download from the application. Going forward, Activeplan will ensure that any area changes due to variations undertaken within the facilities, will be reflected in the data presented.

PFI Service Provider Performance

Following a period of poor performance of FM Co estates department there is a plan to undertake a full review of the Joint Audit Regime and associated helpdesk logging. A review of the contractual requirements for response times has been completed. It is felt that Mitie need to develop their reporting to ensure that the initial Service Response Time and the final Turnaround times are presented. Summit are investing in improvements to the functionality and performance of the FM Helpdesk, Mitie (the service provider) will need to ensure that jobs are being logged more quickly as currently many are being logged sometime after the actual audit was issued to the help desk. Under the terms of the PFI Project Agreement, 'the Rectification Period commences from the earlier of notification of the Non-Compliant Incident to the helpdesk and Project Co [FM Co] becoming aware. Mitie are working to develop a proposal that sets out how they will ensure jobs are logged when they are notified of them – or that their system will be adapted to back-date the job commencement time

if these are not logged on the same day. It is proposed that a Memorandum of Understanding is drafted to bring structure to the Helpdesk purpose and assist with the correct categorisation and response times.

The Trust Retained Estate

The Trust's estate is almost wholly PFI except for North Block, Rainbow Ward, the multi-storey car park and a parcel of land at the back of Corbett Hospital. Occupants of North Block include Ophthalmology, Microbiology, Chiropody, Nursing and Orthoptics. Similarly, with the PFI estate the Trust needs to explore the current level of Space Utilisation within this block to determine room for expansion or reconfiguration. To do this the Trust has already established a Space Utilisation Group chaired by the Chief Operating Officer to pull together this information.

The MCP Model of Care

Work is continuing within Dudley and NHSE&I to finalise the business case and service / contractual matters to allow the MCP process to become fully established. The Trust is committed to working in partnership as DIHC develops and to actively contribute to supporting the achievement of intended benefits of the MCP model as it is fully rolled out.

Once the Dudley MCP procurement process has been finalised then decisions regarding which services could transfer into the community can be made, which would then feed the next iteration of this Estate Strategy document by informing options on any potential reconfiguration and/or use of vacated space.

Community Health Partnerships

72% of the Trust's leasehold budget is spent on two CHP properties, Brierley Hill and Stourbridge Health and Social Care Centres. This equates to annual occupancy costs of £1,864,178 for just two properties out of a total annual occupancy cost budget of £2,631,745.

The Naylor report recommends that Trusts should pay no more than £350/m2 on leasehold space and DGNHSFT is paying the following on these two CHP properties:

Site	Total Annual Occupancy Costs	Cost per m^2	Annual Cost paid over & above Naylor Recommendation
Brierley Hill Health & Social Care Centre	£1,157,452	£388.06	£113,508
Stourbridge Health & Social Care Centre	£706,725	£447.26	£188,446

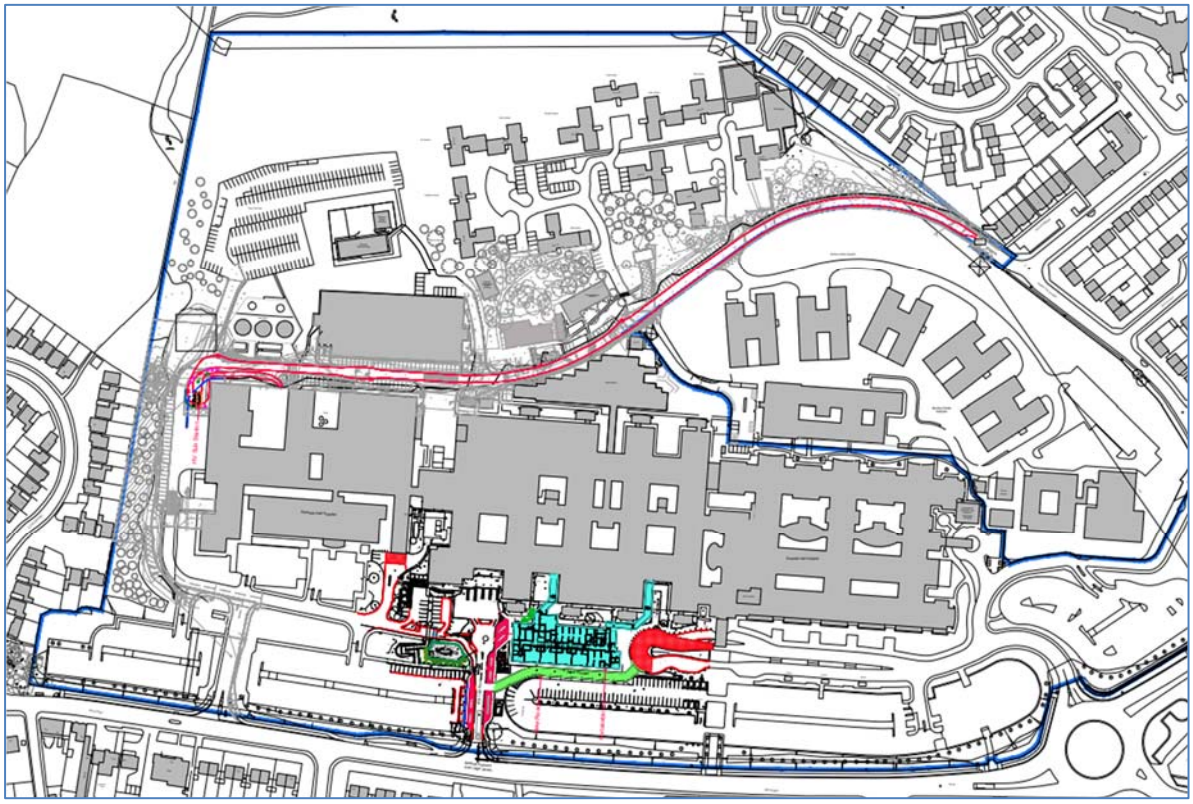
At present there are no lease arrangements agreed between CHP and DGNHSFT. However, while the occupancy costs are more than the Naylor Report recommendation, there would be no financial benefit for the Trust in renegotiating a lower cost due to the structure of the charging mechanism in place. It is believed that a whole system approach with regard rental agreements and occupancy costs would have a more successful and financially advantageous outcome.

Residences and Car Parking

Under the PFI agreement Summit Healthcare own the buildings and lease the land from the Trust over the term of the contract, except for the retained estate which is highlighted within the red boundary on the following site plan. At the end of the PFI Contract the ownership of the buildings will revert to the Trust. The largest plot of land available at the back of the residential blocks forms part of a nature reserve and would be difficult to develop due to environmental constraints. It should also be noted that the only real requirement the Trust currently has for redevelopment in this area would be to create additional staff car parking. The Trust currently manages and receives an income from the existing staff car parking. Should the Trust build additional car parking due to the current parking issues no additional income would be forthcoming.

All other visitor and patient car parking is owned and managed by Summit Healthcare who receives an income from these facilities.

Summit Healthcare also own the twelve residential blocks (including Esk House which is being leased by the Trust for office accommodation) at the rear of Russell's Hall Hospital. The residential blocks, and their supporting accommodation e.g. laundry, garages, are managed by Interserve.



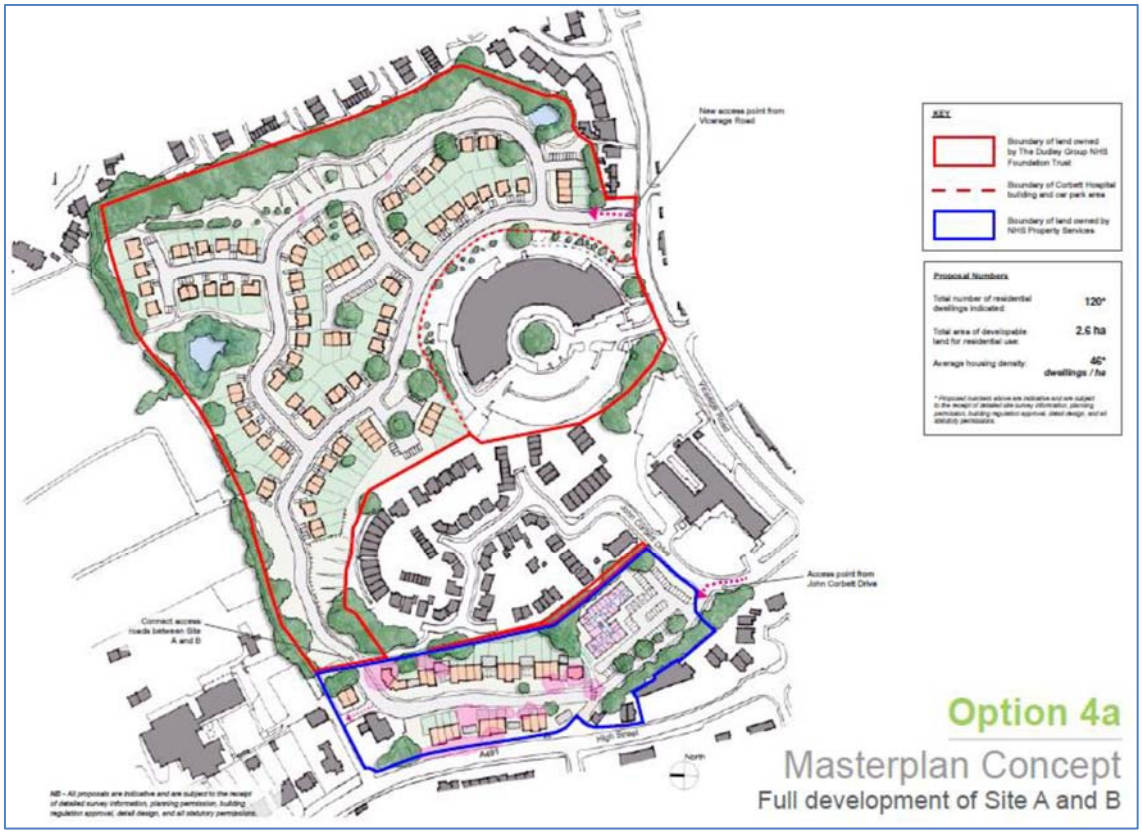
Digitisation of Patient Records

The Trust is currently leasing Centafile to store patient records. The business case for the Trust's new Electronic Patient Record (E.P.R.) system identified a savings benefit of £194k in relation to the current health records storage which was the lease of Centafile. To date the requirement for storage of paper records has not gone away and the Trust has extended the lease to 5th July 2024.

6.6 Opportunities for Site Rationalisation

In line with current NHS policy all NHS bodies are required to review their surplus assets and dispose of these assets if there are no plans for future operational use.

The Trust owns a parcel of land which adjoins the Corbett Ambulatory Centre in Stourbridge. Since the 1980's this land has been leased to a local farmer for agricultural use at a nominal rent. Historically the land had a covenant imposed on it by the local authority that restricted its use for agricultural purposes only. In early 2017 the Trust approached the local authority to discuss the removal of the covenant especially as central Government pressure was being put on local authorities to increase housing. The local authority agreed to remove the covenant and the Trust has since worked with the Department of Health, disposal advisors and development partners to dispose of the land.



The Trust first went to the open market with the land in 2017 and worked with a chosen developer through to 2018 when unfortunately, the developer pulled out of the contract. Following a second market process a further developer was chosen, however due to COVID-19 and changes in the market the developer pulled out of the contract. In April 2021, a further approach to the market was concluded and third developer was chosen, following their detailed due diligence work a contract of sale, subject to planning permission was finally signed in January 2022. The developer is currently working through the planning application and public consultation with a possible final disposal in 2023-24.

6.7 Off-site / Commercial / Back Office Functions

The NHS response to the Covid pandemic has transformed some of the working practices including virtual consultation, mobile working and home working. This has demonstrated opportunities to free up non-clinical space for the delivery of clinical services.

The Trust has been working for some time with Acute Collaboration and ICS partners to assess the feasibility and potential benefits of how certain back office functions such as payroll, support staff, procurement, HR and legal services could be reconfigured to provide a streamlined and efficient yet cost effective coordinated service across the ICS. The Trust would benefit from the economies of scale this would realise in recurrent savings. There is also an argument that current Trust back office functions occupy expensive PFI estate that if vacated into off site private and cheaper accommodation, could be better utilised by clinical services.

6.8 Funding Options

Capital funding in the NHS is now allocated on an Integrated Care System (ICS) basis. The ICS receives an annual operational capital allocation based on a formulaic calculation. The ICS will then allocate operational capital to providers. This is done through a risk-based prioritisation process which works through individual provider governance processes up into the ICS. Each provider is then expected to manage within the operational capital allocation. Other central capital allocations from the Department of Health are available in any given financial year, these are in the form of PDC which provides cash funding for a specific capital project. More recently these are in relation to current high priority operational objectives including elective recovery and diagnostics. Providers are required to submit business cases through the system to bid for this funding.

Other external sources of capital funding include 'sustainability' capital funding from Government Grants or other external sources, investment opportunities with Local Authorities or Higher Education and donations

6.9 Sustainability and energy efficiency

Under the PFI contract the SPV takes the responsibility and risk for energy usage while the Trust takes on tariff risk. This is managed through an 'Energy Tariff Adjuster' mechanism which is adjusted for tariff increases every financial year based on a base usage. A fixed tariff price is entered into by the SPV each February and the this is the basis of the charge made to the Trust each year against the base consumption. The Trust and the SPV entered into a variation to the 'Energy Tariff Adjuster' mechanism a number of years ago. This allowed the SPV to pool all the PFI building energy into a national energy market arrangement and forward buy energy. Any gains from this process in relation to tariff reduction from the fixed position is shared 60/40 by the Trust/SPV based on a reconciliation each month.

The Trust is in the highest percentile with regard energy efficiency cost and consumption and Lord Carter's review states that investment in schemes such as LED lighting and smart energy management systems could significantly contribute to a reduction in costs. Funding for these schemes can be sought through 'invest to save energy efficiency funds' provided through the Department of Health.

Summit Healthcare are members of the Trust's Energy Group and it is believed that there is an opportunity for Summit Healthcare and the Trust to work together to try to reduce energy consumption through engaging with staff, visitors and patients with regard changing behaviours and culture and also through planned investment e.g., procuring more energy efficient products when replacement is necessary.

An initial exercise is worthwhile to fully understand the current level of consumption and expenditure and to monitor this over time in order to identify areas which could be focused on with regard energy efficiency. Although the Trust may have to invest a small amount of capital on top of their annual unitary payment for lifecycle maintenance payback is becoming increasingly reduced with new products on the market.

Through this collaboration the Trust can negotiate with the PFI provider as to a possible gain/share on any savings made. It should be noted, however, that a conservative estimate on the level of income saved through this exercise should be made at this time.

Decarbonisation – towards net zero

The Dudley Group NHS Foundation Trust have ambitious plans to put them on the pathway to Net Zero Green House Gas emissions as a Trust. In 2021 an Energy and Estates Sub-committee was established and this has led to the establishment of the Green Plan Working Group looking at a range of subjects including:

- Travel and Transport
- Supply Chain and Procurement
- Digital Transformation
- Medicines, and
- Food and Nutrition

These committees are made up of representatives from the Trust, Mitie FM Ltd and the Summit Healthcare Project team. Mitie and Summit will work with the Project Team to agree baseline Net Zero and Energy goals for the Project and assist in scoping of specific related actions and work packages. Draft target actions include:

- Assessment of the Asset GHG baseline. This will include the aspects that Summit is responsible for and not the operational NHS aspects, based on known data in Scope 1 & 2, and limited aspects of Scope. These aspects will be agreed with Summit
- Develop the NZ curve against Science based targets
- Draft a tender for the review of the Lifecycle and Condition reports from Aecom, (specialist consultancy) with regards to low carbon and energy efficient alternatives
- Draft a tender for the development of the EV charging strategy / road map and opportunities.
- Continue discussion with Mitie/Summit to investigate potential for installing Renewable Energy generation (behind the meter)

7 Summary and Conclusions

Through the implementation of this Estates Strategy, several tangible benefits for patients, staff, visitors, commissioners and the wider health and social care economy should be derived including:

- Demonstrable improvements in quality and patient experience
- A reduction in the frequency and severity of adverse incidents
- Alignment with the expectation of regulators e.g., Monitor, CQC, HSE
- Improved environmental performance (including carbon reduction)
- An estate that better meets the current and future needs of the population served
- Improved flexibility to respond to new service developments or minimise the impact of service or activity retractions

More particularly, a full understanding of the current space utilisation of the estate would enable:

- Additional income (elective recovery growth) from services which can expand within the existing footprint, plus income generation from new services which are not currently delivered by the Trust

  - Savings from maximising the use of currently unused space or optimising the use of clinical and non-clinical space
- Potential capital release from the sale of land adjacent to Corbett Hospital
- Reduction in footprint and associated costs with regard relinquishing properties which no longer serve the Trusts e.g., storage of patient records
- Longer term savings through more efficient energy use through consumption and agreement

Enclosure 14

The Dudley Group NHS Foundation Trust

Paper for Submission to the Board of Directors on the 22nd September 2022

Title:	Quality and Safety Committee 26th July and 23rd August 2022
Author:	Amanda Last – Deputy Director of Governance
Presenter:	Liz Hughes – Non Executive Director

Action Required of Committee / Group

Decision		Approval	Y	Discussion	Y	Other

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: Numerous as indicated below	
	On Risk Register: Y	Risk Score: Numerous across the BAF, CRR and divisional risk registers	
Compliance and/or Lead Requirements	CQC	Y	Details: All Domains
	NHSE/I	Y	Details: Governance Framework
	Other	N	Details:
Report Journey/ Destination *(if applicable)*	Working / Exec Group	N	Date:
	Committee	Y	Date: 26/08/22 & 23/08/22 Quality and Safety Committee
	Board of Directors	N	Date:
	Other	N	Date:

CHAIRS LOG

UPWARD REPORT FROM QUALITY AND SAFETY COMMITTEE
July and August 2022

The Dudley Group NHS Foundation Trust

MATTERS OF CONCERN OR KEY RISKS TO ESCALATE	MAJOR ACTIONS COMMISSIONED/WORK UNDERWAY
The Committee noted the ongoing lack of compliance with meeting the internal 30 day response time for complaints and requested a trajectory for improvement be brought to the September Committee meeting. The Committee noted that the delay in complaint response times has been added to the risk register.	
POSITIVE ASSURANCES TO PROVIDE Positive assurance was received with respect to the progress made with closing serious incident action plans. The Committee acknowledged there was further improvement work to do but were assured by the plans in place to strengthen the process. Positive assurance was received regarding the Medical Division's progress made with mandatory training compliance, complaint responses and procedural document reviews. In addition, the positive impact of the RADAR (Recognise Acute Deterioration, Action & ReSPECT) programme on the quality of care delivered was highlighted and the Committee were assured by the plans for further roll out. The Committee were informed of a peer review that took place in the Emergency Department (ED) which was led by the Black Country Integrated Care System. A key focus for the review team was patient flow across the system. ED received positive feedback regarding escalation processes, ongoing improvement work and noted a motivated and competent workforce. Positive discussion regarding actions to improve patient flow and collaboration work were noted. The Trust are particularly highly performing in the use of antibiotics and antimicrobial stewardship compared to peer organisations Positive assurances were received around the IPC Board Assurance Framework	**DECISIONS MADE** The Committee approved the Neonatal Annual Report commending the service delivered and the good practice showcased however noted the workforce challenges particularly regarding Allied Health Professional roles. The Paediatric Annual Report was approved. The Committee acknowledged good examples of innovation and transformation; for example the development of the virtual ward and the youth forum. The Incident Management Annual Report was approved noting good levels of assurance. The Committee noted the work planned to implement the new Patient Safety Incident Response Framework. The Terms of Reference for the End of Life Working Group were approved with one minor amendment requested. The Committee approved the Infection Prevention and Control, Medicines Management, Health and Safety, and the Patient Experience and Complaints Annual Reports, noting the good work carried out by all teams. The Terms of Reference for several reporting groups were approved The new Board Assurance Framework was received and the risk agreed as moderate.

Enclosure 15

The Dudley Group NHS Foundation Trust

Paper for submission to the Board of Directors on

Thursday 22nd September 2022

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

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

Recommendations:

For the Board of Directors to note and discuss the key workstreams of the Chief Nurses' Office with a particular focus in this report on the work of the professional development team.

Summary of Key Issues:

The Trust launched its Autumn Vaccination for staff campaign for SARS-CoV-2 virus on Monday 12th September 2022.

Continued focused work continues with strengthening out practice relating to the Deprivation of Liberty standards and the mental capacity act compliance across all inpatient teams. There were nine detentions under the Mental Health Act in this reporting period.

Reduction in falls is evident in this month's data and we continue to be below the national average. There were zero falls categorised as severe harm. Falls assessment in ED shows improvement to 76.5%

Workforce challenges remain with mitigations and incentives in place to support. To date, 131 international nurses and midwives have joined the Trust as part of our 2022 programme. We have also appointed six international recruits who are undertaking the paediatric route to NMC registration.

The first cohort of wards have successfully completed their RADAR – Recognising Acute Deterioration, Action & ReSPECT programme with positive impacts across all three ward areas.

Preceptorship offer has been reviewed and the new multi-professional programme and competency framework will launch in September.

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	N	Risk Description:	
	On Risk Register: N	Risk Score:	
Compliance and/or Lead Requirements	CQC	Y	Details: All domains
	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: 22nd September 2022
	Other	N	Date:

Chief Nurse Public Trust Board Report

Thursday 20th September 2022

Mary Sexton – Chief Nurse

The Dudley Group NHS Foundation Trust

Care
Deliver safe and caring services

The Dudley Group NHS Foundation Trust

Vaccination Work

To date Saltwells have delivered circa 20,000 vaccines to the Dudley population. This includes using outreach models for the most vulnerable and supporting our wider healthcare partners such as Bushy fields.

The Autumn/Winter Vaccination programme went live on September 12th which will deliver Covid 19 boosters to the population of Dudley. The Vaccine which will be delivered here is the bivalent vaccine. Bivalent vaccines protect against two different strains of the SARS-CoV-2 virus.

The Hospital vaccine hub will be housed in the Clinical Education Centre. This hub will deliver Covid 19 boosters and the Flu vaccination for the workforce of the Dudley Group.

We are expecting our delivery of the flu vaccine by the 26th September and will commence our staff vaccination as soon as the vaccine has been received.

Care
Deliver safe and caring services

The Dudley Group NHS Foundation Trust

22/23	No DoLs applications	22/23	No DoLs applications		
June	25	July	31	22/23 total	120

Deprivation of Liberty Safeguards (DoLS)

There is an array of training on offer within the Trust for MCA, from basic awareness, practical application to advanced and ward specific. There are some challenges in releasing staff to undertake the training due to staffing, capacity, and demand within clinical teams. Understanding the full MCA process is important in identifying and applying for a DOLS. The Mental Health team currently monitor and track all DOLS raised across the trust. This is a labour intensive process. Since beginning this process, the Trust has had 4 DOLS authorised by the Supervisory Body. Prior to this, over the past year, no DOLS authorisations had been received. This reflects increased awareness amongst our staff and impact of the Mental Health lead.

The Advanced Mental Capacity Act Level 3 training takes place twice a month. So far the feedback from these sessions has been positive and attendance is increasing.

Mental Health Act

There were 9 Detentions under the Mental Health Act within the Trust between June and July. Of these detentions all patients were given their rights and there were no appeal requests. The mental health lead is working with the head of patient access and discharge to formalise a centralised reporting system within the trust to facilitate a more accurate digital monitoring and recording system.

Care
Deliver safe and caring services

The Dudley Group NHS Foundation Trust

Tissue Viability

Pressure Ulcer prevalence remains static in the most recent reporting period. The Pressure Ulcer Scrutiny Group continues to meet weekly to review all Category 3, 4 and Unstageable Hospital or Community Acquired Ulcers and there is a reduction evident in the number that are found to have any care omissions. Issues are still identified with the lack of escalation for early signs of pressure damage from domiciliary care; in order to mitigate this the TV team have provided some additional training sessions to care providers and more are planned. The team are attending the BCWB care home conference in September to share more training with this sector.

The new Pressure Ulcer Prevention documentation which includes a non-concordance procedure will be launched during ward visits during September.

Care
Deliver safe and caring services

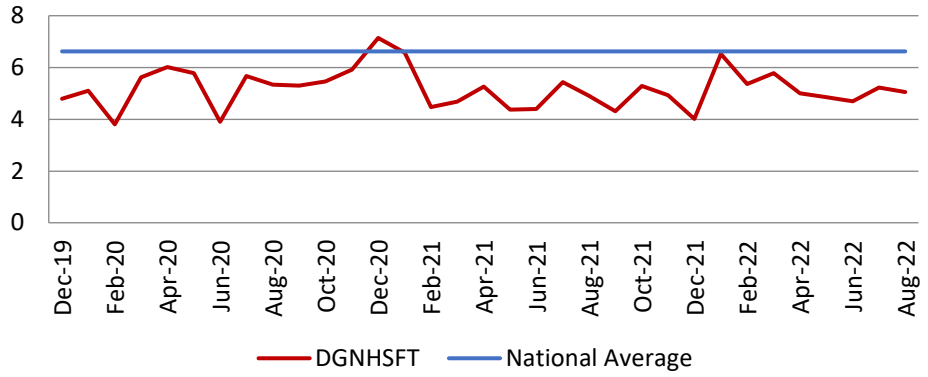
The Dudley Group NHS Foundation Trust

There continues to be fluctuation in the number of falls however the Trust remains below the national average target. In July & August there were zero falls categorised as severe harm.

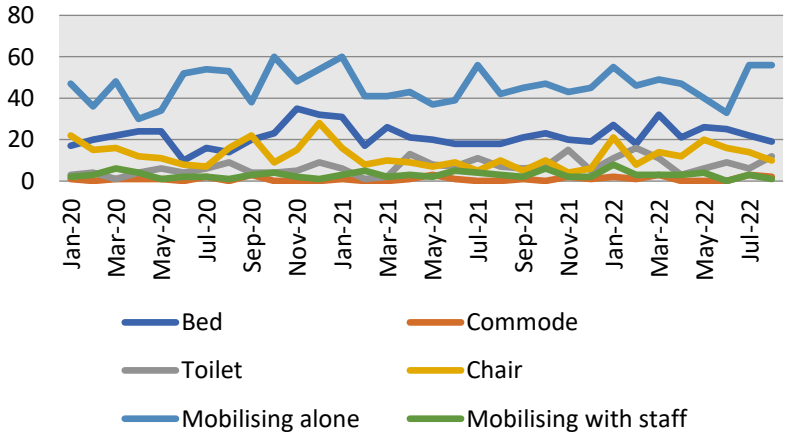
Collaborative working is ongoing with the digital team to create additional recording functionality for post fall lying and standing Blood Pressures. Knowledge sharing on the importance of undertaking both blood pressures is embedded across all professions.

Steady improvement continues to be seen with falls assessment compliance in ED from 47.8% in Aug 2021 to a current compliance of 76.5.0% in August 2022.

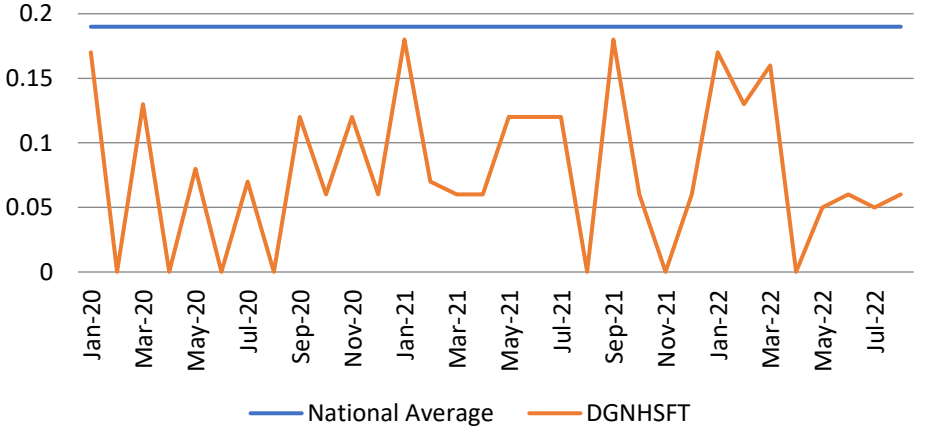
Falls per 1000 bed days



Falls Categories



Falls with harm (per 1000 bed days)



Compassion
Deliver a great patient experience

The Dudley Group NHS Foundation Trust

PALS	Concerns	Comments	Signposting contacts	Total
June 2022	312	4	50	366
July 2022	309	6	41	356
	Main concerns relate to appointment delays and cancellations			

Friends and Family Test

A total of 4473 responses were received in July 2022 in comparison to 4379 in June 2022. Overall, 81% of respondents have rated their experience of Trust services as 'very good/good' in July 2022, a small decline since June 2022 (82%). A total of 8% of patients rated their experience of Trust services as 'very poor/poor' in July 2022, a 1% decline since June 2022. The Maternity Department have seen the biggest increase in the number of patients who rated their overall experience as 'very poor/poor' at 12% in July 2022 in comparison to 4% in June 22, and the received the lowest score for the patients rating their experience as Very good/good at 50% (although there were only 22 responses received and half of the respondents rated their experience as 'don't know'). The Inpatient Department received the highest positive score at 88%. Community received the lowest number of patients who rated their overall experience as 'very poor/poor' at 3% and the A&E Department received the highest negative score at 16%.The main themes for improvement focussed on poor communication, delayed waiting times on the day of attending, waiting times for medication and admission to the wards. Patients were positive about the care and treatment received and regarding the attitude of staff involved in their care, a recurring theme each month.

Compliments

The number of compliments received has increased in July 2022. The Trust received 460 compliments in July 2022 compared to 435 compliments in June 2022. Maternity received the highest number of compliments (67) in July 2022.

NHS Choices

Seven comments were posted on NHS Choices/Patient Opinion during July 2022, a decrease since June 2022. Six comments were positive, and one comment was negative. The theme for the negative comment was around care and treatment within the Emergency Department.

Competence
Drive service improvement, innovation and transformation

The Dudley Group NHS Foundation Trust

Core Skills – Medical Device and Manual Handling Training

With the introduction of the team leader role, the core skills team are working to improve access and availability of training across al clinical and non-clinical staff.

The manual handling training offer has been increased and the use of champions to support with training at the point of care has increased. Due to the health and safety legislation, it has been challenging to recognise prior learning for our many international recruits which has had an overall negative effect on the compliance figures for the Trust this is being addressed.

Our medical device training offer has been reviewed. This continues to evolve and looks to enhance the support to the clinical teams.

Competence
Drive service improvement, innovation and transformation

The Dudley Group NHS Foundation Trust

At the end of August the Deteriorating Patient Team, held their first awards ceremony for the Recognise Acute Deterioration, Action & ReSPECT (RADAR) Programme.

The RADAR programme is an innovative 12 week programme aimed to make an impact on key areas linked to the Deteriorating Patient Team

C5, C7 and B2 were the first areas to go through the programme with great achievements made and positively effecting patient care and safety.

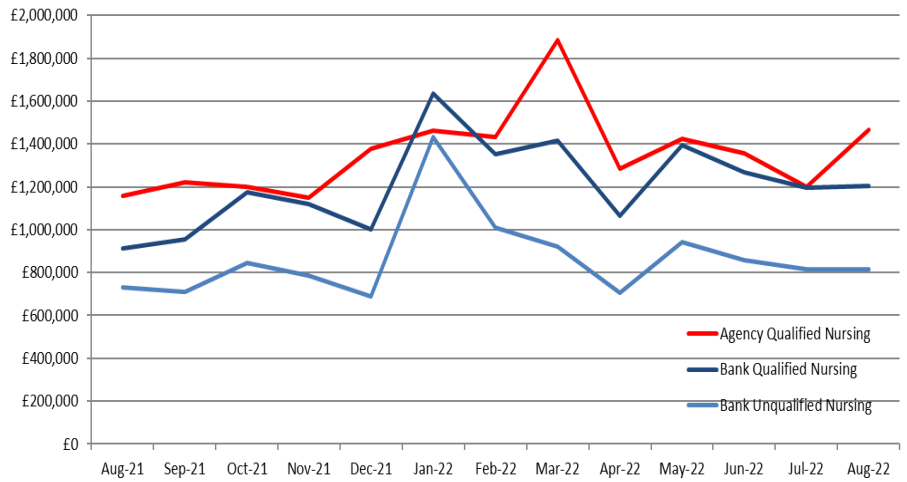
The programme has now moved to another 3 wards and we hope for the same success.

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. It is pleasing 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.

The 2022 International recruitment programme is underway has seen over 130 recruits start with the trust since April and 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	36%	£279,810	£36,251	£41,431	£357,492
I.T.U.	18%	£284,177	£31,947	£6,988	£323,112
Acute Med Unit (EAU)	22%	£63,919	£46,245	£58,403	£168,566
Ward B5	9%	£71,493	£29,824	£21,205	£122,523
Ward C8	13%	£68,677	£26,113	£22,941	£117,731
Ward C7	25%	£54,878	£21,375	£34,682	£110,934
Ward B3	5%	£61,027	£23,913	£24,862	£109,801
Ward B4	-7%	£51,793	£27,439	£30,300	£109,533
Ward A2	-19%	£28,986	£37,354	£28,722	£95,062
Ward C3	24%	£16,504	£14,888	£35,977	£67,370

Commitment
Be the place that people choose to work

The Dudley Group NHS Foundation Trust

We have continue 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 in qualified nurse requirements being met.

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 **Aug** Days in Month 31

	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	95	72	14	12	-	-	-	-	75%	83%			761	1.08	0.19	1.27
B1	159	127	68	69	104	77	62	54	80%	102%	74%	87%	438	5.31	3.21	8.52
B2(H)	125	110	201	158	106	95	161	155	88%	78%	90%	96%	725	3.39	5.08	8.46
B2(T)	122	103	160	123	95	90	135	120	84%	77%	95%	89%	716	3.23	4.08	7.32
B3	209	197	165	132	216	187	134	129	94%	79%	87%	96%	1,094	4.12	2.86	6.98
B4	226	168	248	204	157	142	201	192	74%	82%	90%	96%	1,290	2.82	3.68	6.50
B5	245	195	163	150	266	216	125	104	79%	92%	81%	83%	577	8.72	5.14	13.86
C1	253	211	254	234	189	172	192	160	83%	92%	91%	84%	1,474	3.05	3.21	6.26
C2	285	220	68	62	250	199	65	57	77%	91%	80%	88%	492	10.00	2.83	12.83
C3	218	186	397	368	192	173	379	372	85%	93%	90%	98%	1,583	2.72	5.50	8.21
C4	210	164	68	61	124	94	61	78	78%	90%	76%	127%	615	4.90	2.61	7.51
C5	304	215	260	227	253	231	196	199	71%	87%	91%	101%	1,458	3.71	3.51	7.22
C6	102	92	104	86	95	92	78	75	90%	82%	97%	96%	557	3.88	3.46	7.34
C7	199	165	203	165	156	151	201	187	83%	81%	97%	93%	1,096	3.38	3.85	7.23
C8	269	202	217	171	227	205	186	153	75%	79%	90%	82%	1,310	3.65	2.97	6.61
CCU_PCCU	255	227	73	69	221	213	42	34	89%	95%	97%	81%	698	7.41	1.77	9.18
Critical Care	575	446	136	95	569	443			78%	70%	78%		391	27.29	2.91	30.20
EAU AMU 1	678	510	534	425	438	455	442	376	75%	80%	104%	85%	2,210	5.13	4.35	9.47
Matemity	1,038	657	371	218	564	431	218	161	63%	59%	76%	74%	1,348	7.73	3.29	11.02
MHDU	155	128	107	59	155	131			83%	55%	84%		194	16.02	3.37	19.39
NNU	160	123			149	139			77%		94%		430	7.33	0.00	7.33
TOTAL	**5,883**	**4,518**	**3,810**	**3,086**	**4,525**	**3,935**	**2,879**	**2,606**	**77%**	**81%**	**87%**	**91%**	**19,457**	**5.02**	**3.48**	**8.50**

Commitment
Be the place that people choose to work

The Dudley Group NHS Foundation Trust

Since the last Chief Nurse report many pieces of work have come to fruition for the Practice development team. This in part is due to the academic calendar and the rapidly approach start of the next academic year.

Support staff team have completed the AHP support staff care certificate training. The feedback has been positive, and staff have reported that the sessions were relevant and gave the underpinning theory required to undertake the practical skill safely and competently. The support team have worked with the Lead Support Worker for AHP's and now offered further spaces for the October Fundamentals Programme, further AHP support staff fundamental programmes have been scheduled for January April 2023.

Nursing Associate Apprentices 18 new starters have been recruited for the programme - 12 candidates are internal and already working within the trust, and 6 are external and will be new to the organisation. The team are currently finalising the details of their timetable with planned trust study days etc. This group will be cohort 11 and the course will be completed in partnership with Wolverhampton University.

Pre-registration Team have revived the challenge day for our third-year students. It was a successful day and the students gained a lot from the day in particular what knowledge they already have!

At the start of the previous academic year, funding was received to increase student placement's across the professional groups. This programme has now come to an end with over 140 additional placement opportunities identified across Trust teams.

As we move to the next academic year, we are looking forward to welcoming the first year students from all professions and specialties into he Trust. This is an exciting time for all as they transition into the Dudley Group.

Commitment
Be the place that people choose to work

The Dudley Group NHS Foundation Trust

Post Registration team. Due to the great achievements of the recruitment programme and the many new recruits who are joining the Trust, it has been timely to review the Preceptorship programme and the outcomes of this, The new multi professional programme and competency document will launch September.

The team are working with our academic partners to ensure access to the academic programmes available are timely for the registrants and meet the need of the patient, the staff member and the service.

Due to the success of the transfer window concept which was launched in March 2022 another Transfer window opened in September 2022. The Transfer window allows staff across the trust op request a transfer to other areas without having to go through the formal recruitment process. The initial window had over 10 requests with all transferring and remaining in that area.

International recruitment Team continue to welcome internationally educated (IE) nurses and midwives to Dudley Group. To date the 2022 programme has welcomed 131 IEN & M's to the trust and are working with them to attain NMC registration. Work continues to welcome the remaining 169 over the coming months. We have been extremely fortunate to have attracted 6 IEN's who are undertaking the Paediatric route to gain NMC registration as a children's nurse.

To support the IE nurses in their pastoral care an evening social event was held. The nurse's and midwives bought food dishes from their home countries for everyone to try. The event was a huge success with over 50 people attending. Another has been planned over the next month.

Along with the wider Black Country Collaboration, The Trust has recently secured funding for internationally recruiting AHP's into the workforce. This is another exciting venture which we anticipate will come to fruition later in the year.

Parish Notices

The Dudley Group NHS Foundation Trust

Working collaboratively with the Learning and organisational development team, we have created a Clinical Leaders Programme. This programme is based on the recently relaunched Matron's Handbook, with key adaptations for all professional groups within Dudley. Nominations are open for candidates for the initial cohort commencing in October.

This continued collaborative working has facilitated the conception of an accredited train the trainer course, for all current and aspiring trainers. This will be delivered in partnership with Dudley College and will result in a formal academic qualification. Nominations are open and the first cohort will commence in October too.

The nutritional team are currently working with the ICB to look at the creation of the first nutritional Virtual Ward for Dudley patients. Yet another example of clinically led innovation to further improve patient outcomes and their experience.

Enclosure 16

The Dudley Group NHS Foundation Trust

Paper for submission to the Trust Board Meeting

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 Committee / Group							
Decision	N	**Approval**	N	**Discussion**	Y	**Other**	N

Recommendations:

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

Summary of Key Issues:

This paper is to demonstrate Trust compliance with the Health and Social Care Act 2008 (updated 2015) and highlight gaps in assurance for action. In May 2020 NHSE/I requested that the Infection Prevention Board Assurance Framework template is completed and shared with Trust board.

One of the key areas to combating the COVID-19 pandemic relates to robust infection prevention and control standards and practices across the Trust.

The framework adopts the same headings as the Health and Social Care Act 2008 (updated 2015) listing the 10 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
- Zoning continues

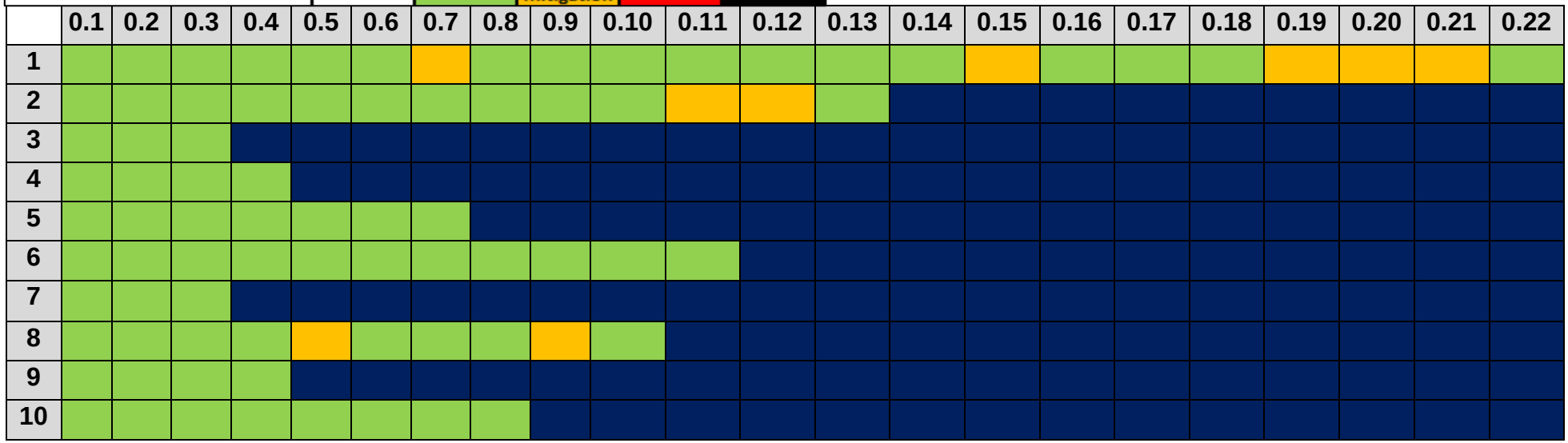
There are no red non-compliant areas, there are amber areas with mitigations in place, the IPC Group and wider Trust team continue to progress this work stream.

Impact on the Strategic Goals	
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
	Other	N	Details:

Report Journey / Destination *(if applicable)*	Working / Exec Group	Y	Date: IPCG 25/07/22
	Committee	Y	Date: Q & S Committee 26/07/22
	Board of Directors	Y	Date: 22/09/2022
	Other	N	Date:

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



	0.1	0.2	0.3	0.4	0.5	0.6	0.7	0.8	0.9	0.10	0.11	0.12	0.13	0.14	0.15	0.16	0.17	0.18	0.19	0.20	0.21	0.22
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1	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	The Trust does not have the capacity to test all high-risk patients daily.
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.	
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 clinical staff to assess and plan for creation of adequate isolation rooms/units as part of the Trusts winter plan.	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	

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

	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	
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. The organisation has systems and processes in place to identify and communicate changes in the functionality of areas/rooms.	Decontamination of the Environment Policy adopted at IPCG March 2022 Room definitions FR1 -FR6 are in place.			

	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 Manufacturers' guidance and recommended product 'contact time' is followed for all cleaning/ disinfectant solutions/products.	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			

	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	
	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			Compliant	

	protocol - before inspection, servicing, or repair equipment				
	Compliance with regular cleaning regimes is monitored including that of reusable patient care equipment	A regular cleaning audit schedule is in place and audit scores and stars on the doors are reported to the IPCG bimonthly meeting.		Compliant	
	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.	Areas scorning 3 stars or lower are re-audited.		Compliant	
	In patient Care Health Building Note 04-01: Adult in-patient facilities	Trust ventilation meeting meets monthly and includes PFI partners.			
	The assessment is carried out in conjunction with organisational estates teams and or specialist advice from ventilation group and or the organisations, authorised engineer.	The Trust has an AE in place.		Compliant	
	A systematic review of ventilation and risk assessment is undertaken 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. Previous antimicrobial history is considered. To reduce inappropriate prescribing.	Antimicrobial Pharmacy referrals in place.		Virtual Antimicrobial stewardship group meetings during pandemic (via email/ teams). All clinical Pharmacists actively referring patients to antimicrobial Pharmacist for stewardship queries. Snapshot antimicrobial prescribing audits.	

	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 maintaining the safety and wellbeing of patients, staff, and visitors. Implementation of national guidance on visiting patients in a care setting.	Visitors are to wear PPE when visiting. This has been communicated by nursing staff to patients and visitors, via social media, switch board and posters as pictured around the hospital. Visiting Policy to be updated to reflect current visiting advice. Information regarding visiting during the COVID-19 crisis is provided via	N/A	New SOP on the hub for visitors March 2022 2 visitors permitted	

	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.	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.		audit completed by all inpatient nursing areas. Compliant	
	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' 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		Compliant	
	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.	Facemasks are compulsory for all visits to healthcare premises		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.			

	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. 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. 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 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 &	A zoning system is in place. 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 All patients are reviewed. Social distancing is encouraged between patients.		Compliant Compliant 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 nurse to report compliance within IPC report.	
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	

	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 16a

The Dudley Group NHS Foundation Trust

Paper for submission to the Trust Board.

Title:	Infection Prevention and Control Annual Report 2021-2022
Author:	Liz Watkins - DDIPC
Presenter:	Mary Sexton - DIPC

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

Recommendations:

The Group is asked to review and note the contents of the Infection prevention and control Annual Report in ensuring compliance with the Health and Social Care Act (2008, updated 2015)

Summary of Key Issues:

The purpose of the Infection Prevention and Control Annual Report is to outline the activities relating to infection prevention and control for the year from April 2021 to March 2022. To discuss the arrangements The Dudley Group NHS Foundation Trust (DGFT) have in place to reduce the spread of infections and to demonstrate Trust compliance with the Health and Social Care Act 2008 (updated 2015) adopting the same headings, listing the 10 criterions.

The report reviews our accountability arrangements, policies, and procedures relating to infection prevention and control, audit, and the education necessary in order to support prevention and control of infection.

Our key achievements were:

- 18 Clostridiodes difficile infections attributable to DGFT against a threshold of no more than 40.
- Mandatory Infection Prevention and Control training completed by 90.3% of clinical staff.
- 94.6% of non-clinical staff up to date with IPC e-learning.
- Response to the challenges arising from COVID-19.
- The IPC Team received a Trust committed to excellence team award for Outstanding Achievement

- Recruitment to the IPC team under very challenging circumstances
- Decontamination Lead for the Trust has been appointed and started in September 2021
- Deputy Director For Infection Prevention and Control commenced employment in September 2021
- IPC promotional activities included IPC week and World Health Organisation Clean Your Hands Day.

The Coronavirus pandemic has significantly impacted on the trust further highlighting the role of infection prevention and control has in keeping our patients and staff safe.

Impact on the Strategic Goals:	
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		Risk Description: *Inc risk ref number*	
	On Risk Register: N	Risk Score:	
Compliance and/or Lead Requirements	CQC	Y	Details: Safe, Effective, Well-led
	NHSE	Y	Details: Compliance with Health and Social Care Act 2008 (updated 2015)
	Other	N	Details:

Report Journey / Destination *(if applicable)*	Working / Exec Group	Y	Date:
	Committee	Y/N	Date: Quality and Safety Committee on 26/07/2022

	Board of Directors	Y/N	Date:
	Other	Y	Date: IPC Group Meeting 25/07/2022

Director of Infection Prevention and Control Annual Report 2021/2022

Contents

i. Executive introduction from the Chief Nurse and Director of Infection Prevention and Control

Dear Staff, Patients, Carers, Service Users and Partners,

Firstly, a huge thank you to you all for all your positive endeavours and in particular in dealing with an unprecedented pandemic. Special thanks go to our staff, both those in clinical practice front facing roles and to those support staff behind the scenes, for their commitment to provide the best possible response to the new challenges and ways of working resulting from these demanding times.

Welcome to The Dudley Group NHS foundation Trust (DGFT) Infection Prevention and Control Annual Report which has been developed in collaboration with the Deputy Director for Infection Prevention and Control and the Infection Prevention and Control Team.

As the Director of the Trusts' Infection Prevention and Control I am proud to be able to present the Annual Infection Prevention and Control Report for 2021/22. The purpose of this report is to outline the activities relating to infection prevention and control for the year from April 2021 to March 2022 and to discuss the arrangements DGFT have in place to reduce the spread of infections. It reviews our accountability arrangements, policies and procedures relating to infection prevention and control, audit, and the education necessary in order to support prevention and control of infection.

Our key achievements were:

- 1*8 Clostridium difficile infections attributable to DGFT against a threshold of no more than 40.*
- *Mandatory Infection Prevention and Control training completed by 90.3% of clinical staff.*
- *94.6% of non-clinical staff up to date with IPC e-learning.*
- *Response to the challenges arising from COVID-19.*
- *The IPC Team received a Trust committed to excellence team award for Outstanding Achievement*
- *Recruitment to the IPC team under very challenging circumstances*
- *Decontamination Lead for the Trust has been appointed and started in September 2021*
- *Deputy Director For Infection Prevention and Control commenced employment in September 2021*
- *IPC promotional activities included IPC week and World Health Organisation Clean Your Hands Day.*

The Coronavirus pandemic has significantly impacted on the trust further highlighting the role of infection prevention and control has in keeping our patients and staff safe. I want to formally acknowledge and thank all trust teams for their commitment during the last year.

Looking forward to 2022/23, the IPC team and all DGFT staff will continue to work towards the prevention of all healthcare acquired infections.

Mary Sexton

Table 1: The requirements of the Health and Social Care Act (2008: revised 2015)

Compliance criterion	What the registered provider will need to demonstrate
1	Systems to manage and monitor the prevention and control of infection. These systems use risk assessments and consider how susceptible service users are and any risks that their environment and other users may pose to them.
2	Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections.
3	Ensure appropriate antimicrobial use to optimise patient outcomes and reduce the risk of adverse events and antimicrobial resistance.
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.
5	Ensure prompt identification of people who have or are at risk of developing so that they receive timely and appropriate treatment to reduce the risk of transmitting the infection to other people.
6	Systems to ensure that all care workers (including contractors, volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection.
7	Provide or secure adequate isolation facilities.
8	Secure adequate access to laboratory support as appropriate.
9	Have and adhere to policies, designed for the individual's care and provider organisations that will help to prevent and control infections.
10	Providers have a system in place to manage the occupational health needs and obligations in relation to infection.

ii. List of Abbreviations

ACP	Advanced Care Practitioner
AER	Automated Endoscope Reprocessor. A specialised machine for washing and disinfecting endoscopes
AHP	Allied Health Professional
AmpC beta lactamases producing Enterobacteriaceae	Produce enzymes which mediate resistance to a wide variety of B-lactam antibiotics e.g., amoxicillin
AMS	Antimicrobial Stewardship
ASG	Antimicrobial Stewardship Group
Bacteraemia	A bloodstream infection
BBFE	Blood and Bodily Fluids Exposure
BCPS	Black Country Pathology Services
BCWB	Black Country and West Birmingham
BSI	Bloodstream Infection
CCGs	Clinical Commissioning Groups.
CD	Contact Dermatitis
CDI	*Clostridioides difficile infection.* *Clostridioides difficile* is a bacterium which lives harmlessly in the intestines of many people. *Clostridioides difficile* infection most commonly occurs in people who have recently had a course of antibiotics. Symptoms can range from mild diarrhoea to a life-threatening inflammation of the bowel.
CE	Chief Executive
CMT	Certified Medication Technician
COHA	Community Onset Healthcare Acquired
COVID-19	Coronavirus disease
CPA/ UKAS	Clinical Pathology Accreditation (CPA UK) is a subsidiary of United Kingdom Accreditation Service (UKAS)
CPE	Carbapenemase-producing Enterobacteriaceae. Enterobacteriaceae are a large family of bacteria that usually live harmlessly in the gut of all humans and animals. They are also some of the most common causes of opportunistic urinary tract infections, intra-abdominal and bloodstream infections. Carbapenemases are enzymes that destroy carbapenem antibiotics, conferring resistance.
CQC	Care Quality Commission
CQUIN	Commissioning for Quality and Innovation (CQUIN) payment framework
CSSD	Central Sterile Services Division
CSU	Catheter Specimen of Urine
D&V	Diarrhoea and vomiting

Datix	Patient safety organisation that produces web-based incident reporting and risk management software for healthcare and social care organisations.
DDIPC	Deputy Director of Infection Prevention & Control
DGFT	The Dudley Group NHS Foundation Trust
DH	Department of Health
DIPC	Director of Infection Prevention & Control
DMC	Dudley Metropolitan Council
E.coli	*Escherichia coli. E. coli* is the name of a type of bacteria that lives in the intestines of humans and animals.
ENT	Ear, Nose and Throat
EPMA	Electronic Prescribing and Medicines Administration
ESBL	Extended-Spectrum Beta-Lactamases are enzymes that can be produced by bacteria making them resistant to many of the commonly prescribed antibiotics.
ESR	Electronic Staff Record
GNBSI	Gram-negative bacteraemia (GNBSI), including *Escherichia coli*, Klebsiella and Pseudomonas.
GRE/VRE	Glycopeptide-Resistant Enterococci/Vancomycin Resistant Enterococci. Enterococci are bacteria that are commonly found in the bowels/gut of most humans. There are many different species of enterococci but only a few that have the potential to cause infections in humans and have become resistant to a group of antibiotics known as Glycopeptides; these include Vancomycin.
HCAI	Healthcare Associated Infection
HII	High Impact Interventions
HOHA	Hospital Onset Healthcare Associated
HR	Human Resources Department
HSDU	Healthcare Sterilisation Decontamination Unit
HSE	Health and Safety Executive
IC NET	IPC Surveillance software and database
ICS	Integrated Care System
IPC	Infection Prevention and Control
IPC BAF	Infection Prevention and Control Board Assurance Framework
IPCG	Infection Prevention and Control Group Meeting
IPCT	IPC Team
IPMO PLG	Integrating Pharmacy and Medicines Optimisation Pharmacy Leadership Group
IPS	Infection Prevention Society
IV	Intravenous
KPI	Key Performance Indicator
LFD	Lateral Flow Device
LHE	Local Health Economy

MHRA	Medicines and Healthcare Products Regulatory Agency
MRSA	Meticillin Resistant *Staphylococcus aureus.* Any strain of *Staphylococcus aureus* that has developed resistance to some antibiotics, thus making it more difficult to treat.
MSSA	Meticillin Sensitive *Staphylococcus aureus. Staphylococcus aureus* is a bacterium that commonly colonises human skin and mucosa (e.g., inside the nose) without causing any problems. It most commonly causes skin and wound infections.
NED	Non-Executive Director
NEWS 2	The latest version of the National Early Warning Score (NEWS), which advocates a system to standardise the assessment and response to acute illness.
NHS	National Health Service
NHSE/I	NHS England and NHS Improvement
NICE	National Institute for Health and Care Excellence
NITCAR	National infections team's collaborative for audit and research
NNU	Neonatal Unit
Norovirus	Norovirus is a major cause of acute gastroenteritis and diarrhoea in children and adults.
OH	Occupational Health
Outbreak	One or more persons with the same signs, symptoms in time place and space.
OPAT	Out-patient parenteral antimicrobial therapy
OPD	Outpatients Department
PEG	Patient Experience Group
PFI	Private Finance Initiative
PGD	Patient Group Direction
PHE	Public Health England now UK HSA
PII	Period of Increased Incidence
PIR	Post Infection Review
PLACE	Patient Led Assessment of the Care Environment
PPE	Personal Protective Equipment e.g., gloves, aprons, and goggles
QSC	Quality and Safety Committee
QSG	Quality and Safety Group
RCA	Root Cause Analysis
RCN	Royal College of Nurses
RIDDOR	Reporting of Injuries, Diseases and Dangerous Occurrences Regulations
SARS-CoV-2	COVID-19
SENDS	Safety engineered needleless device systems
SEPSIS	A potentially life-threatening condition caused by the body's response to an infection.
SEQOHS	Safe, Effective, and Quality Occupational Health Service
SHAW	Staff Health and Wellbeing Service

SIGHTED	Suspect, Isolate, Gloves and Aprons, Hand washing, Test for Toxins, Educate, Document
SIP	Service Improvement Plan
SLA	Service Level Agreement
SOP	Standard Operating Procedure
SSI	Surgical Site Surveillance
TDM	Therapeutic Drug Monitoring
The HUB	Staff Intranet Site
TOR	Terms of Reference
UK HSA	UK Health Security Agency formally Public Health England (UK HSA)
UTI	Urinary Tract Infection
WHO	World Health Organisation
WSG	Water Safety Group

Section One: Introduction

The purpose of this report is to provide assurance to The Dudley Group NHS Foundation Trust (DGFT) Board of Directors, Governors and the public for the reporting period 1 April 2021-31 March 2022 regarding the Infection Prevention and Control (IPC) activity including compliance with the Health and Social Care Act 2008: Code of Practice on the prevention and control of infections and related guidance (Revised July 2015) (commonly known as The Hygiene Code) and also with regard to appropriate National Institute for Health and Clinical Excellence (NICE) guidance.

This annual report fulfils the Trusts' statutory requirements under the Health and Social Care Act 2008: Code of Practice on the prevention and control of infections and related guidance (Revised July 2015), which sets out 10 compliance criteria against which a registered provider will be judged on how it complies with the registration requirements for cleanliness and infection prevention and control. It sets the basis of our annual programme which is monitored at the DGFT bimonthly Infection Prevention and Control (IPC) Group meeting. Infection prevention and control is the responsibility of everyone in our healthcare community and is only truly successful when everyone works together. The aim of the IPC team is to increase organisational focus and collaborative working so to ensure continued compliance and quality improvement

DGFT is registered with the Care Quality Commission (CQC) and declared full compliance with the ten compliance criteria as detailed in Table 1.

Compliance criterion	What the registered provider will need to demonstrate
1	Systems to manage and monitor the prevention and control of infection. These systems use risk assessments and consider how susceptible service users are and any risks that their environment and other users may pose to them.
2	Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections.
3	Ensure appropriate antimicrobial use to optimise patient outcomes and reduce the risk of adverse events and antimicrobial resistance.
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.
5	Ensure prompt identification of people who have or are at risk of developing so that they receive timely and appropriate treatment to reduce the risk of transmitting the infection to other people.
6	Systems to ensure that all care workers (including contractors, volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection.
7	Provide or secure adequate isolation facilities.
8	Secure adequate access to laboratory support as appropriate.

9	Have and adhere to policies, designed for the individual's care and provider organisations that will help to prevent and control infections.
10	Providers have a system in place to manage the occupational health needs and obligations in relation to infection.

Infection Prevention and Control is a scientific approach and practical solution designed to prevent harm caused by infection to patients and health care workers (WHO) it is essential to ensure that the safety and quality of care for our patients can be provided. At The Dudley Group NHS Foundation Trust Infection Prevention and Control (DGFT) is a key priority.

Our Trust is committed to delivering the highest infection prevention and control standards to prevent avoidable harm to patients, visitors and staff from healthcare associated infection. It is a key priority to ensure that a robust infection prevention and control function operates and is embedded within all clinical areas of the organisation. Effective prevention and control of infection is embedded as part of everyday practice and applied consistently by everyone at all times.

The infection prevention and control agenda faces many challenges including the ever-increasing threat from emerging diseases, antimicrobial resistant micro-organisms, growing service development in addition to national targets and outcomes. The Trust Infection Prevention and Control Team experienced a number of changes in personnel over the last year and recruitment into the team has been challenging. This has resulted in periods of reduced staffing levels and reduction in the service provided to clinical teams.

The Board of Directors and ultimately the Chief Executive, as the accountable officer, carries responsibility for IPC throughout the Trust and it is a vital component of Quality and Safety. The day-to-day management is delegated to the Director of Infection Prevention and Control (DIPC). All managers and clinicians ensure that the management of IPC risks is one of their fundamental duties. Every clinical member of staff demonstrates commitment to reducing the risk of Healthcare Associated Infections (HCAI) through standard infection prevention and control measures. The IPC team endeavours to provide a comprehensive proactive service, which is responsive to the needs of staff and public alike and is committed to the promotion of excellence within everyday practice of IPC.

As with the previous year, the 2021/22 NHS Outcomes Framework included reducing the incidence of HCAIs, in particular Meticillin Resistant *Staphylococcus aureus* (MRSA) Bacteraemia and *Clostridium difficile* infection (CDI) as areas for improvement. Within Domain 5: Treating and caring for people in a safe environment and protecting them from avoidable harm of the Outcomes Framework reducing all HCAIs remained a priority.

As previously reported, the extension to the mandatory surveillance to include Meticillin Sensitive *Staphylococcus aureus* (MSSA) and *Escherichia coli* (*E.coli*) Bacteraemia infections since 2011 together with the MRSA Bacteraemia and CDI national reduction thresholds set for Acute and Clinical Commissioning Groups (CCGs) reflects the zero-tolerance approach for all avoidable HCAIs.

This report will provide information of the activities and performance of Key Performance Indicators (KPI) for IPC during the period 1 April 2021-31 March 2022 by DGFT. The report is aligned to the 2021/22 IPC Programme, informing progress against the objectives set and outlines performance of DGFT against the MRSA Bacteraemia and CDI reduction thresholds.

In addition, the report aims to reassure the public that reducing the risk of infection through robust infection prevention and control practice is a key priority for DGFT and supports the provision of high-quality services for patients and a safe working environment for staff.

Section Two: Who are we, our duties, arrangements, and assurance

2.1 Who Are We?

As a Trust, the Dudley Group provides health services to around 450,000 people in Dudley. These include for example three hospital sites, Russell's Hall, Corbet and Guest Hospitals and community nursing services.

In a year we…

- deliver 4,700 babies
- see around 500,000 outpatients
- treat almost 100,000 patients in our emergency department
- maintain our 13,000 Public Members

Our PFI partners

- dispose of approximately 900 tonnes of clinical waste
- sterilise 630,000 clinical instruments
- undertake 100,000 portering moves
- recycle approximately 120 tonnes of cardboard

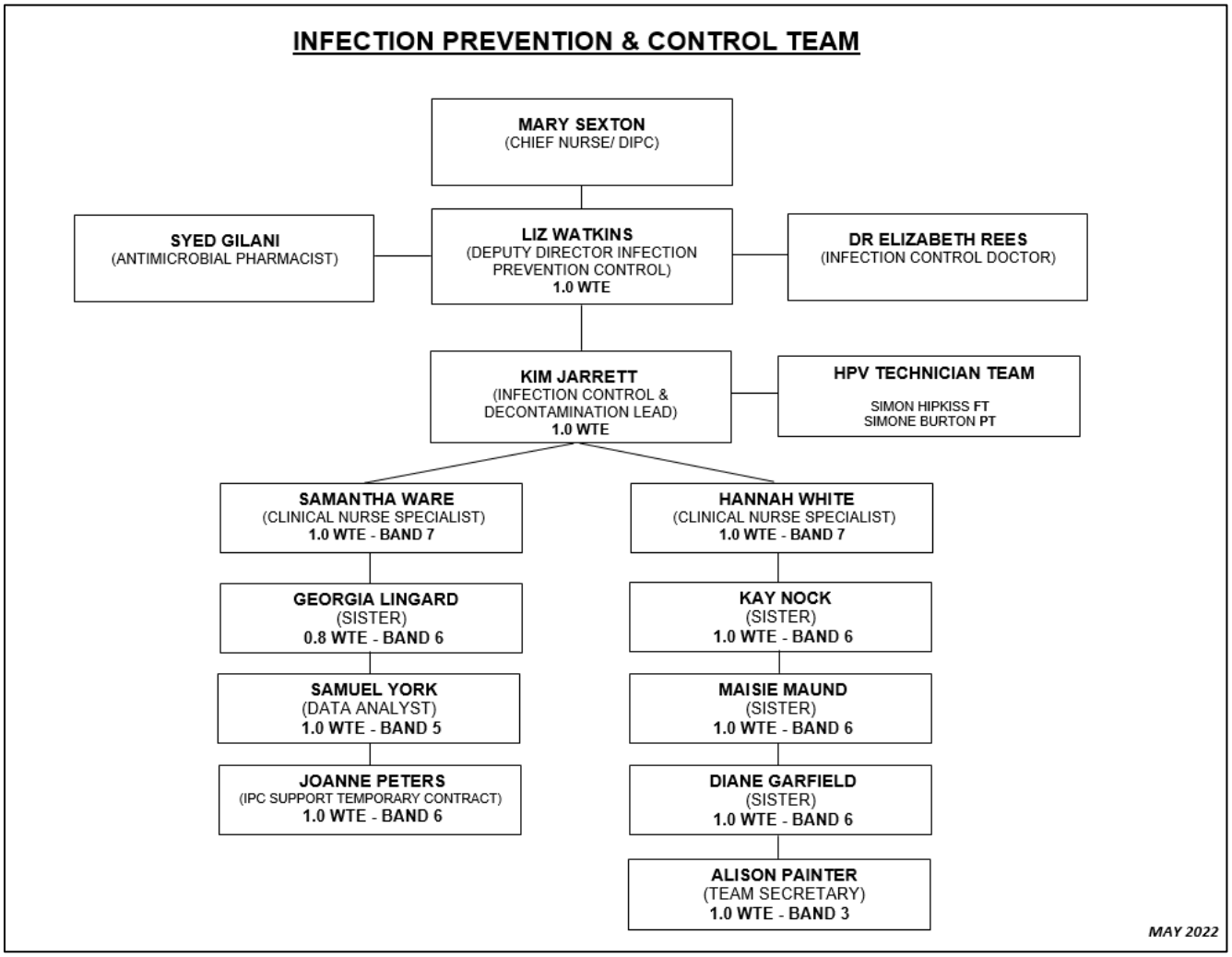
DGFT has a committed IPC team that is very clear on the actions necessary to deliver and maintain patient safety. Equally, it is recognised that infection prevention and control is the responsibility of every member of staff and must remain a high priority for all to ensure the best outcome for patients. The IPC team utilises a proactive approach with the emphasis on being visible so making their accessibility for guidance and advice a priority. This in turn has led to an improved IPC team image i.e., being a regular familiar friendly face rather than only visiting to audit or when there are outbreaks of infections or problems.

Looking forward, it is critical that DGFT maintain this level of commitment. As in previous years, we will continue to work closely with our partner organisations Clinical Commissioning Group, and the Local Health Economy (LHE) as well as experts in other organisations, UK Health Security Agency (UK HSA) and NHS England and NHS Improvement (NHSE/I).

Our Duties and Arrangements

Infection Prevention and Control Service:

- Director for Infection Prevention and Control (also chief Nurse)
- Deputy Director for Infection Prevention and Control (commenced in post September 2021)
- Decontamination Lead (Seconded to post September 2021)
- Infection Prevention and Control Nurse Specialists
- Infection Prevention and Control Nurses
- Data Analyst
- HPV Technicians
- Infection Prevention and Control Team Secretary



2.2 Director of Infection Prevention and Control – Mary Sexton (Chief Nurse)

The Director of Infection Prevention and Control (DIPC) is a role (whether by that name or another) required by all registered NHS care providers under current legislation (The Health and Social Care Act2008, updated 2015). The DIPC will have the executive authority and responsibilities for ensuring strategies are implemented to prevent avoidable HCAIs at all levels within the organisation.

The DIPC will be the public face of IPC and will be responsible for the Trust's annual report, providing

details on the organisations IPC programme and publication of HCAI data for the organisation.

The DIPC will lead the commitment to quality and patient safety, good communication and ensure robust reporting channels and access to a group of staff with expert prevention and control knowledge, able to offer advice and support. The role and function of the IPC Service is to provide specialist knowledge, advice and education for staff, service users and visitors. Additional support is provided by the antimicrobial pharmacists and Lead Nurse for Infection Prevention and Control. All work undertaken by the service supports the Trust with the full implementation of and on-going compliance to the Hygiene Code.

At the Dudley Group, the Chief Nurse holds the role of DIPC.

2.3 The Infection Prevention and Control Team

The IPC Team is led by the DDIPC for IPC and is supported by Infection Prevention Nurse Specialists, Infection Prevention Sisters, Data Analyst and Team Secretary.

The IPC service is provided through a structured annual programme of works which includes expert advice, education, audit, policy development and review and service development. DGFT has a Service Level Agreement with Royal Wolverhampton Trust for specialist support from a Consultant Microbiologist. Medical microbiology support is provided 24 hours a day, 365 days a year.

The DIPC has overall responsibility for the IPC Team. The IPC Team works collaboratively alongside clinical leaders at the Trust.

A workforce review of the IPC Team has been undertaken and an IPC business case has been developed as one of the lessons learnt from the COVID-19 pandemic. This review will be presented to the trust executive team. The review will look at the service being provided over a 7-day period while putting in a sustainable model to future proof the team and the service.

The IPC team devises and implements a robust Annual Programme of Work to reduce HCAIs. This is achieved by working in collaboration with all SCHT services and staff. The IPC team perform a number of activities that minimise the risk of infection to patients, staff and visitors including advice on all aspects of infection prevention and control; education and training; audit; formulating policies and procedures; interpreting and implementing national guidance at local level; alert organisms' surveillance and managing outbreaks of infection.

The IPC Team has re-introduced IPC Link staff which was suspended due to COVID-19.

2.4 Committee Structures and Reporting Processes

2.5 Trust Board

The Code of Practice requires that the Trust Board has a collective agreement recognising its responsibilities for IPC. The Chief Executive (CE) has overall accountability for the control of infection at DGFT and any IPC matters across the trust.
DCFT's performance against National and local thresholds are included in Performance Report and Quality and Safety Reports which are presented at DGFT Board meetings.

2.6 Quality and Safety Committee

Bimonthly IPC reports, the IPC Board Assurance Frameworks and the IPC Annual report are presented to the Quality and Safety Committee (QSC) meetings. The QSC is chaired by a Non - Executive Director (NED), it is a sub- committee of the Trust Board which meets monthly. The purpose of the QSC is to provide oversight and scrutiny of infection control standards and practices and seeking assurance that IPC Standards are being met.

The QSC will provide assurance to the Trust Board around the DGFT's arrangements for protecting and improving the quality and safety of patient-centered healthcare, thus improving the experience for all people that come into contact with the services at DGFT.

2.7 Quality and Safety Group

Bimonthly IPC reports are presented to the Quality and Safety Delivery Group meetings. The Quality and Safety Group (QSG), chaired by the Chief Nurse/ DIPC, meets monthly and is responsible for ensuring that there are processes in place for ensuring patient safety and continuous monitoring and improvement in relation to key areas including IPC, but also covers subdivisions of the trust as well as other specialties. The QSG receives assurance from the IPC that adequate and effective policies, processes and systems are in place. This assurance is provided through a regular process of reporting. The IPC Team provide a bi-monthly report to the Group covering the full aspects of the hygiene code.

2.8 Infection Prevention and Control Group (IPCG) Meeting

The membership is multi-disciplinary and includes representation from the divisions, operations and quality directorates, estates department, antimicrobial pharmacists, and Consultant Microbiologist. Additional members are representatives from UK HSA, Dudley Metropolitan Borough Council, CCG and Private finance Initiative (PFI) partners. The meeting is chaired by the DIPC and meets bimonthly. The Terms of Reference (TOR) and membership are reviewed annually to ensure responsibility for IPC continues to be embedded across the organisation. This meeting monitors the progress of the annual IPC programme, approves IPC policies and monitors compliance with them.

The purpose of this meeting is to oversee compliance against the Health and Social Care Act (2008, updated 2015) and to provide assurance that risks are appropriately managed and that appropriate arrangements are in place to provide safe, clinical environments for patients, visitors, and staff.

The IPC Governance Meeting is responsible for:

- Reviewing and monitoring the progress of the annual programme and assisting and affecting implementation.
- Reviewing, developing, and adopting relevant policies, procedures, care pathways and guidelines and standard operating procedures.
- Assessing the impact of all existing and new relevant plans and policies on infection prevention and control and make recommendations for change.
- Ensuring, through the DIPC, the Chief Executive, associated Committees and the Trust Board are informed of any significant infection prevention and control concerns.
- To receive, review and endorse the publication of the Infection Prevention and Control Annual Report.
- To ensure that the wider aspects of maintaining IPC are reported and reviewed within the IPC group these include Health and Safety, Estates, Water Safety, Antimicrobial stewardship and Staff Health and Wellbeing Service (SHAW).

2.8.1 DGFT Water Safety Group –

The membership is multi-disciplinary and has representatives from PFI Partners and an Authorising Engineer. The Group continues to monitor water risk assessments especially around Legionella, flushing regimens, annual disinfection, Automated Endoscope Reprocessor (AER) and capital developments.

2.8.2 Decontamination Group –

This was established in January 2022 by the Trusts new Decontamination lead, the group monitors, challenges, reviews, and where appropriate takes action in response to presented assurances to ensure that the trust is demonstrating compliance against regulatory standards. The aim of the group is to identify any risk factors in relation to decontamination, to identify any trust strategies for the safe decontamination of medical devices in accordance with national and local guidelines with particular reference to HTM 01-01 and 01-06, Decontamination policies, Health, and Social Care Act 2008 (updated 2015), MHRA guidelines, NICE IPG 196 Guidance – replaced with IPG 666 2020 and Care quality commission. The group receives reports from Endoscopy services, Outpatients and Specialist Surgery, Sterile Services (CSSD), theatres and Imaging with the group meeting bimonthly. A Terms of Reference and Governance structure was developed and is reviewed by the Decontamination Group annually. The Group reports to the IPCG Meeting.

2.8.3 Ventilation Group Meeting –

The membership is multi-disciplinary and has representatives from PFI Partners and an Authorising Engineer. The Group continues to monitor ventilation risk assessments especially around air handling units, air extraction and capital developments.

2.8.4 DIPC, DDIPC and Consultant Microbiologist –

The IPC nurses meet weekly to offer a supportive environment within which clinical issues are discussed and a consensus obtained.

2.8.5 Infection Prevention and Control Link Staff –

The aim of our IPC link staff is to enhance the IPC knowledge of healthcare professionals working within DGFT, ensuring the delivery of high standards of quality and patient safety in relation to IPC. Our IPC link staff are responsible for arranging for IPC audits and self-audits to be undertaken where required and for disseminating IPC information to colleagues.

2.8.6 Divisional Leads, Matrons and Ward Managers, Sisters, Charge Nurses, and Team Leaders –

Divisional leads, Ward Managers, Sisters, Charge Nurses, and Team Leaders are responsible for ensuring that their work environments are maintained at high levels of cleanliness. Monthly cleanliness audits are undertaken with staff. These audits are reported in the Divisional Leads and Estates reports to the IPCG meeting. The Sisters, Charge Nurses, Ward Managers and Team Leaders are responsible for ensuring the link staff are supported in performing their role and have appropriate time and resources to do this effectively. Self-audit scores and on-going work undertaken by the link staff is also included in Managers reports submitted to the IPCG meeting.

2.8.7 Learning and Development Team –

Arrangements are in place for staff to attend corporate induction and complete mandatory training programmes which includes IPC. Due to COVID-19 this has been now delivered virtually. Arrangements are in place for staff training to be effectively recorded and maintained in staff

records. Alerts inform managers of their staff's non-compliance with mandatory training. Training compliance is reported monthly to the Quality and Safety Committee.

2.8.8 Roles and Responsibilities of all Staff –
All staff in both clinical and non-clinical roles within the Trust are responsible for ensuring that they follow the standard IPC precautions at all times and are familiar with IPC policies, procedures, and guidance relevant to their area of work. All staff have a duty of care to report any non-compliance and take action as appropriate. All IPC policies and procedures are available on the staff intranet site, The Hub.

Section Three: Position in Relation to Health Care Associated Infections

3.1 Surveillance of Healthcare Associated Infection

Surveillance is undertaken within DGFT on a number of alert organisms and mandatory reporting to UK HSA is undertaken via the HealthCare Associated Infection Data Capture System. Performance is monitored by both Dudley Clinical Commissioning Group (CCG) and the Dudley Metropolitan Borough Council (DMC).

3.2 Surgical Site Surveillance

Surgical Site Infection (SSI)

Surgical Site Infections are a particularly important Healthcare-associated Infection (HCAI) because they can increase a patient's length of stay in hospital and are associated with considerable morbidity. It has been reported that over one-third of postoperative deaths are related, at least in part, to SSI.

However, it is important to recognise that SSIs can range from a relatively trivial wound discharge with no other complications to a life- threatening condition" National Institute for Health and Clinical excellence (NICE) (2008).

Guidelines for the prevention of SSI were issued by NICE in the UK, updated in 2013, and accompanied by a High Impact Intervention (HII) from the Department of Health.

Mandatory surveillance of infections, in the following procedures, started in April 2004 specifying that each trust should conduct surveillance for at least 1 orthopaedic category for 1 period in the financial year. This surveillance helps hospitals, in England, to review or change practice, as necessary.

- Hip replacement
- Knee replacement
- Repair of neck of femur
- Reduction of long bone fracture

For the period relating to this report the IPC Team undertook one quarter of mandatory orthopaedic surveillance focusing on knee replacement surgery. One case of patient reported surgical site infection was identified during this period which equates to 1.3% of the total operations included within the surveillance. This is compared to 0.8% over the last four periods

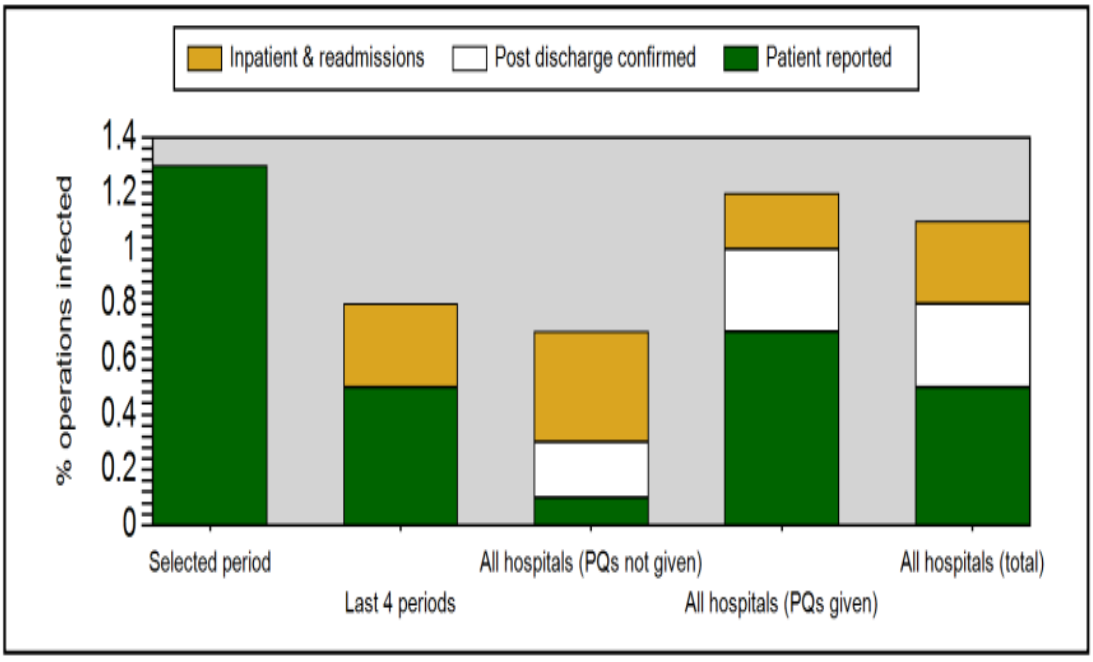
of surveillance completed. Previous surveillance completed did capture a smaller patient group due to pressure related to COVID-19 and. Therefore, this surveillance period for this quarter of surveillance was a larger sample size.

Knee replacement October - December 2021

Table 1: No. of operations and completed post-discharge questionnaires with rates of SSI by selected period (Oct-Dec 2021) and the last 4 periods for which data are available (Oct-Dec 2021, Apr-Jun 2019, Apr-Jun 2018, Jan-Mar 2018) at your hospital.

Operations & surgical site infections		Your hospital	
		Selected period	Last 4 periods
Operations	Total no.	79	369
	No. with PQ given	79	368
	% PQ completed	62.0%	55.7%
Surgical Site Infection	No. inpatient/readmission	0	1
	% infected	0.0%	0.3%
	No. post-discharge confirmed	0	0
	% infected	0.0%	0.0%
	No. patient reported	1	2
	% infected	1.3%	0.5%
	All SSI	1	3
	% infected	1.3%	0.8%

Figure 1: Rates of SSI by inpatient/readmission, post-discharge confirmed and patient reported SSIs for the selected period (Oct-Dec 2021) and last 4 periods compared to all hospitals* for the previous 5 years available (Jan-Mar 2017 to Oct-Dec 2021).



Note: a more precise estimate of the incidence of SSI can be made by cumulating data over several surveillance periods

The mandatory surveillance for 2022/23 is to commence shortly and will be shared once surveillance completed and reconciled.

2022/2023

The IPCT have registered to undertake an additional surveillance category.

Four further members of the IPC team have completed the Surgical Site Surveillance course (2 clinical, 2 nonclinical) with further team members booked on the course. With this in mind the team are hoping to be able to not only complete the Mandatory modules for 2022/2023 but also some voluntary ones. The Voluntary Surgical Site Infections Surveillance module that we hope to undertake will focus on Caesarean Sections. This will take place from 01.10.2022 – 31.12.2022

3.3 Methicillin Resistant *Staphylococcus aureus* Blood Stream Infections (MRSA)

Staphylococcus aureus is an organism harmlessly carried on the skin by around 1 in 30 of the healthy population and remains endemic in many UK hospitals. The transmission of MRSA and the risk of MRSA infection (including MRSA Bacteraemia) can only be addressed effectively if measures are taken to identify MRSA carriers as potential sources of infection and treating them to reduce the risk of transmission. Guidance is in place regarding the screening of our patients for MRSA for both emergency and elective admissions at DGFT. In addition, DGFT have processes in place to ensure isolation of patients colonised with MRSA, following the national guidance.

Infection associated with indwelling medical devices, particularly intravascular devices, is a major cause of morbidity and occasionally, mortality.

The DGFT comply with national guidance to reduce the risk of blood stream infection and have systems in place for:

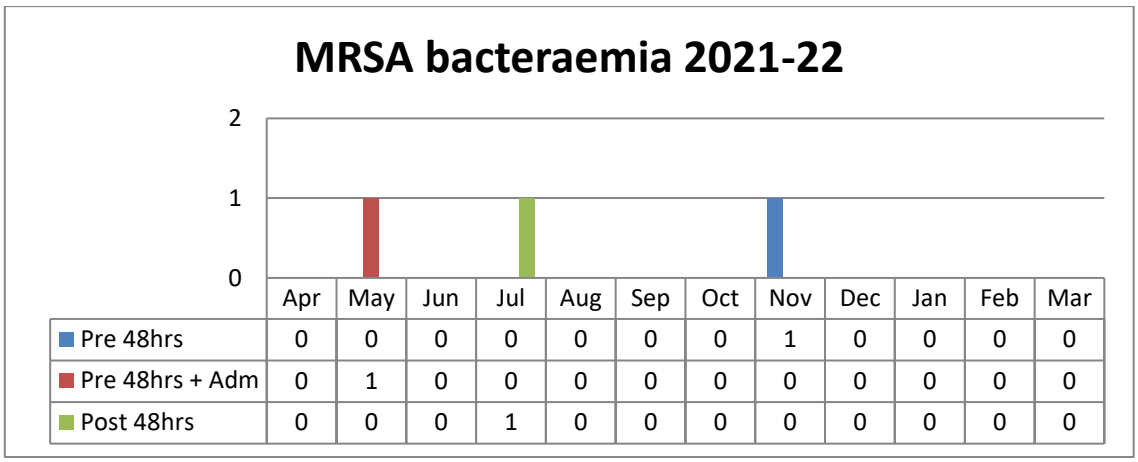
- The management and care of devices
- Antimicrobial prophylaxis
- Compliance with national guidance

There have been three case of MRSA bacteraemia identified in total in the local Health Economy. For the cases that were identified as pre-48-hour cases, (Admitted within 48 hours of the positive result being identified), investigations were carried out by the CCG and DMC and actions identified. For the period covered by this annual report there has been one case of post 48-hour MRSA bacteraemia, identified in July 2021. A Post infection review (PIR) was carried out and the investigation concluded that there were missed opportunities in obtaining swabs and cultures and delays identified in reporting the results. Actions from the PIR were identified and disseminated to staff.

MRSA compliance is monitored against the monthly ward compliance for MRSA in order to identify any missed screening opportunities and investigate reasons for this occurrence. The areas with the lowest screening compliance are identified as areas where a small number of screens have been completed.

Cannulation training continues to be provided via the clinical skills nursing team with competency assessments carried out on ward areas. Saving lives scores are undertaken by link workers on the ward areas with some peer reviews in operation in order to cross reference locally reported scores to ensure assurance.

Actions from the RCA's are completed and monitored through the division and Governance forums.



	Trust Apportioned > 48 hours	Health Economy Total
April 2021	0	0
May 2021	0	1
June 2021	0	0
July 2021	1	1
August 2021	0	0
September 2021	0	0
October 2021	0	0
November 2021	0	1
December 2021	0	0
January 2022	0	0
February 2022	0	0
March 2022	0	0
Yearly Total to Date	1	3

Epidemiological analyses of *Staphylococcus aureus* bacteraemia data

Figure 4a. Quarterly rates of all reported MRSA bacteraemia: April to June 2007, to October to December 2021

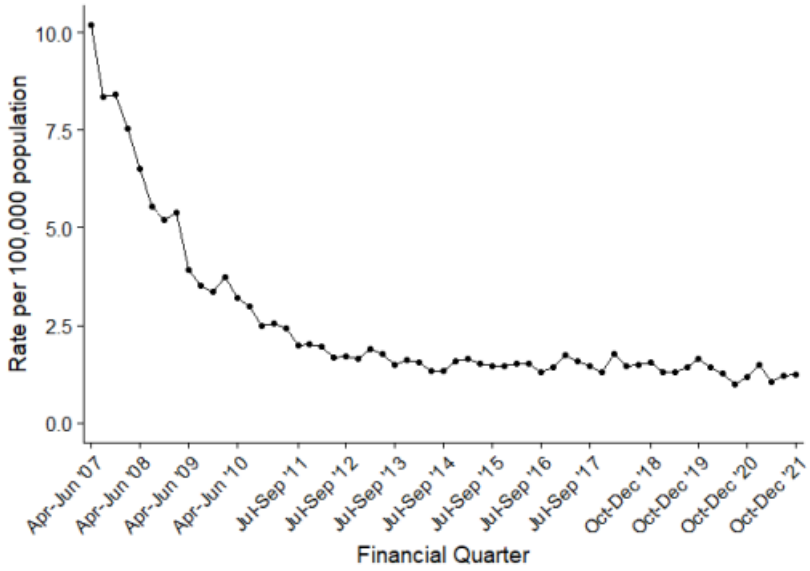
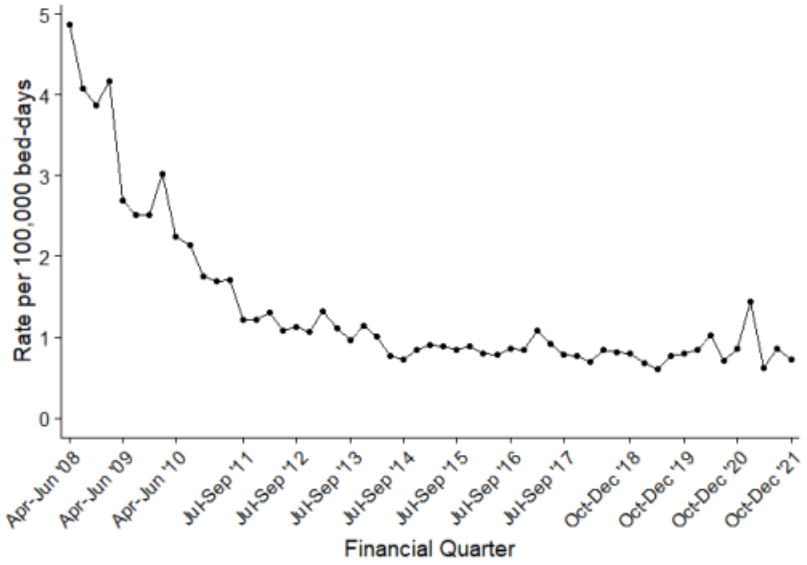


Figure 4b. Quarterly rates of hospital-onset MRSA bacteraemia: April to June 2008, to October to December 2021



DGFT is in line with the national performance when compared to peers across England.

There has been a considerable decrease in the incidence rate of all reported MRSA bacteraemia since the enhanced mandatory surveillance of MRSA bacteraemia began in April 2007.

Rates of MSSA bacteraemia continued to increase moderately from April 2011 to March 2012 when the surveillance was introduced. However, the rate decreased from 21.7 cases per 100,000 population in April 2019 to March 2020 to 20.8 per 100,000 population in April 2020 to March 2021.

At its peak (2007/2008) MRSA bacteraemia's accounted for approximately 40% of all *Staphylococcus aureus* bacteraemia cases in England.

The objective to achieve at DGFT is a target of zero cases of post 48-hour MRSA bacteraemia cases.

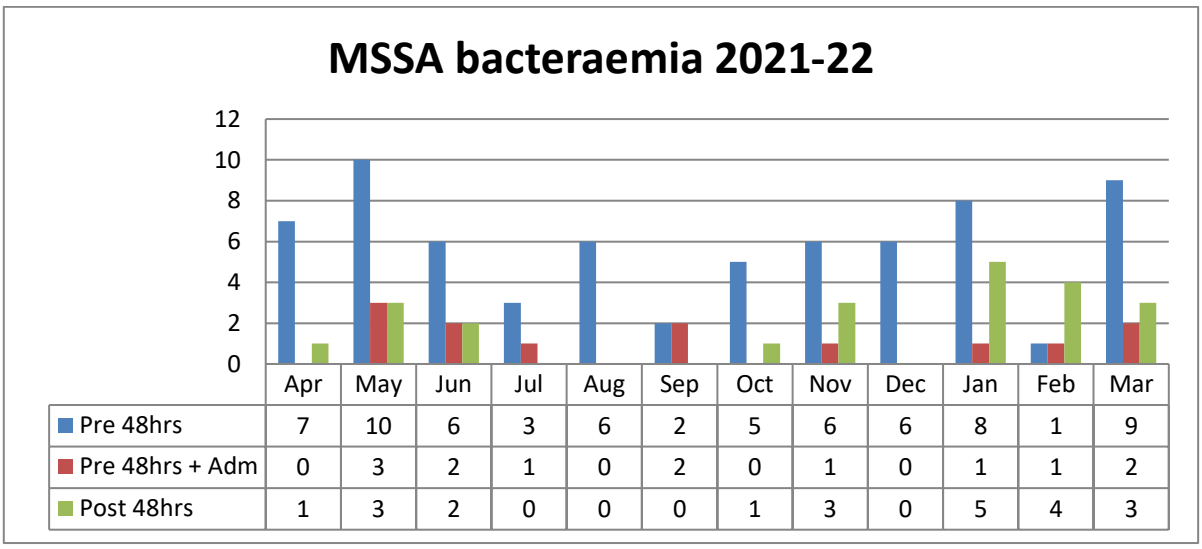
3.4 Methicillin Sensitive *Staphylococcus aureus* Blood Stream Infections (MSSA)

Meticillin-sensitive *Staphylococcus aureus* (MSSA) is a type of bacterium which lives harmlessly on the skin and in the noses, in one third of people. People who have MSSA on their bodies or in their noses are said to be colonised.

MSSA colonisation usually causes no problems but can cause an infection when it enters into the body. This is more likely to happen in people who are already unwell. MSSA can cause local infections such as abscesses or boils and it can infect any wound that has caused a break in the skin e.g., Grazes, surgical wounds.

MSSA can cause serious infections called septicaemia (blood poisoning) or a blood stream infection where it gets into the bloodstream.

Following a Secretary of State announcement on 5 October 2010, there was a mandatory requirement for all NHS acute trusts to report MSSA bacteraemia. This applied to all cases diagnosed after 1 January 2011.



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Pre 48hrs	7	10	6	3	6	2	5	6	6	8	1	9
Pre 48hrs + Adm	0	3	2	1	0	2	0	1	0	1	1	2
Post 48hrs	1	3	2	0	0	0	1	3	0	5	4	3

Meticillin Resistant *Staphylococcus Aureus* Infections

	Trust Apportioned > 48 hours	Health Economy Total
April 2021	1	8
May 2021	3	16
June 2021	2	10
July 2021	0	4
August 2021	0	6
September 2021	0	4
October 2021	1	6
November 2021	3	10
December 2021	0	6
January 2022	5	14
February 2022	4	6
March 2022	3	14
Yearly Total to Date	22	104

Common themes identified following patient review include chronic leg ulcers, infective endocarditis. Lower respiratory tract infections and infective dermatitis with many of the cases identified having underlying disease prior to admission. MRSA screening compliance, including

wounds is discussed through the divisions monthly in order to review missed screening compliance and identify any gaps in compliance.

3.5 *Clostridioides difficile* (Previously Referred to as *Clostridium* difficile Infection) (CDI)

*Clostridioides difficile (*CDI) reporting since 2019/20 year has aligned the UK definitions with international descriptions of disease.

These changes meant that additional patients would be included in the group of patients that the trust is required to investigate. The patients who will be included are categorised in the following groups:

1. Hospital Onset Healthcare Associated (**HOHA**): cases that are detected in the hospital two or more days after admission

2. Community Onset Healthcare Associated (**COHA**): cases that occur in the community or within two days of hospital admission when the patient has been an inpatient in the Trust reporting the case, within the previous 4 weeks

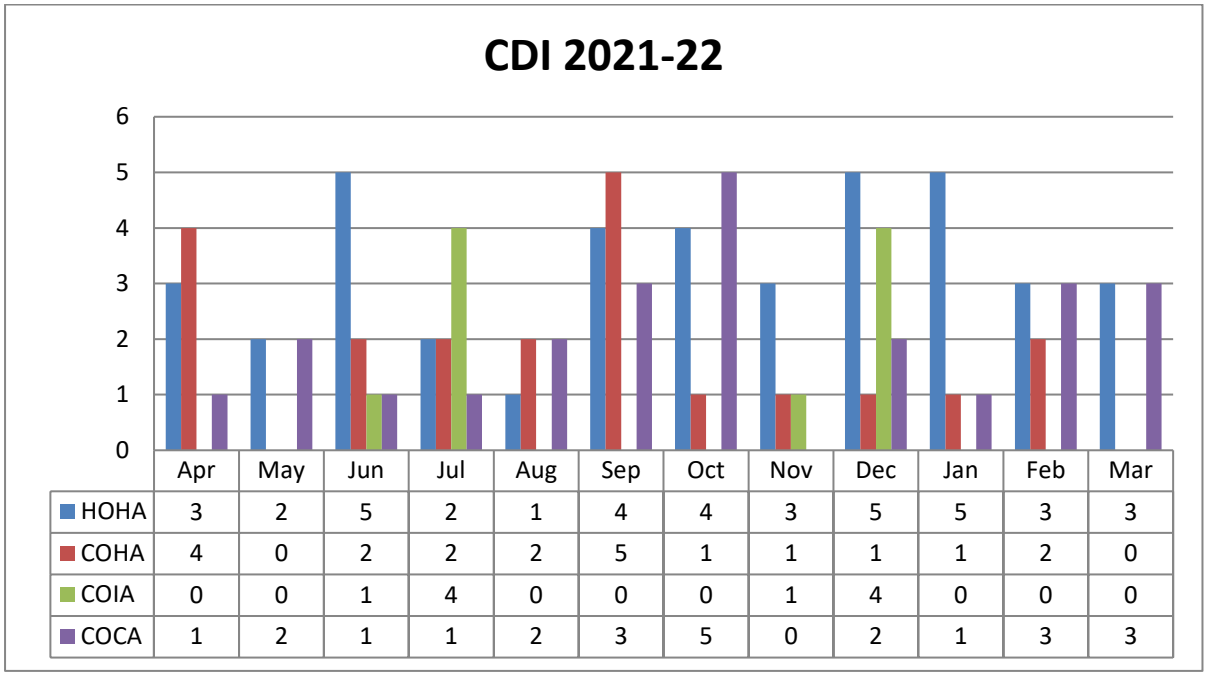
For patients in group 2 (COHA), diagnosed in the community or on admission to DGFT but with a previous admission the Infection Control Team will lead the RCA.
Patients in group 1(HOHA) will be investigated by the local clinical team.

During 2021/2022, the number of cases that occurred were:

- 18 Hospital Onset Healthcare Associated (HOHA)
- 24 Community Onset Healthcare Associated (COHA)

Cases were discussed across the Health Economy using the national apportionment tool.
Due to the COVID-19-19 pandemic several RCA meetings did not go ahead as planned as they were not quorate due to the increased work commitments across the trust by all parties. In order to address issues that were identified, the clinical teams were required to develop action plans which were then monitored locally and via reports submitted by the divisions to the Infection Prevention and Control Group. The RCA meetings have now recommenced with the introduction of a scrutiny panel held internally to review each case.

CDI Apportionment Decisions to Date Hospital onset healthcare associated – April 2021 to March 2022



	Trust Apportioned > 48 hours	Health Economy Total
April 2021	2	8
May 2021	2	4
June 2021	3	9
July 2021	2	9
August 2021	1	5
September 2021	1	12
October 2021	2	10
November 2021	2	5
December 2021	0	12
January 2022	1	7
February 2022	1	8
March 2022	1	6
Yearly Total to Date	18	95

There have been 40 post 48-hour cases identified in 2021/2022; of these cases 18 have been associated with having a lapse in care. The common themes identified have been antimicrobial stewardship and issues relating to mandatory training compliance and samples not being obtained in a timely manner. To assist with the improvement of antimicrobial prescribing, several actions have been initiated to include:

- Executive level reporting to influence change.
- Antibiotic awareness week campaign.
- NICE guidance baseline assessment completed.
- Patient safety bulletin published online and sent to all staff.
- Hub communication/ screen saver produced to raise awareness.
- Junior Dr antimicrobial prescribing teaching sessions completed.
- Antimicrobial stewardship section in Trust wide Governance newsletter.
- Feedback to the divisions provided via ASG.
- Monthly Antimicrobial stewardship report provided monthly to Infection Prevention and Control Group, Drugs and Therapeutics Group &Medicines Management Group.

Further details related to antimicrobial stewardship can be located in the relevant section of this report.

Reduced compliance of infection control mandatory training was noted during 2021/2022; the trust was under immense pressure due to COVID-19 and associated workforce challenges. Face to face teaching sessions were suspended due to social distancing measures this impacted on training compliance across the Trust however, IPC induction training for new starters was delivered face to face observing social distancing requirements.
In order to ensure we have systems in place to increase the compliance across the trust there is a direct link to enable staff to complete the training via the DGFT intranet page, making it easier for staff to access e learning.

The face-to-face training sessions for IPC Training have now been re- introduced.

Epidemiological analyses of *Clostridiodes difficile* infection data (England)

Since the initiation of C. difficile (CDI) surveillance in April 2007, there has been an overall decrease in the count and incidence rate of both all-reported and hospital-onset cases of CDI.

A large part of the decrease in the incidence rate occurred between April to June 2007 and January to March 2012, with a 78.0% decrease in all-reported cases of CDI from 16,864 to 3,711 cases and an associated 78.8% reduction in incidence rate from 131.6 cases per 100,000 population to 27.9 cases per 100,000 population.

Subsequently, between January to March 2012 and October to December 2021, the count of all-reported cases decreased by 5.3% from 3,711 to 3,516 cases, with the incidence rate reduced by 11.3% from 27.9 to 24.7 cases per 100,000 population.

Figure 6a. Quarterly rates of all reported *C. difficile*: April to June 2007, to October to December 2021

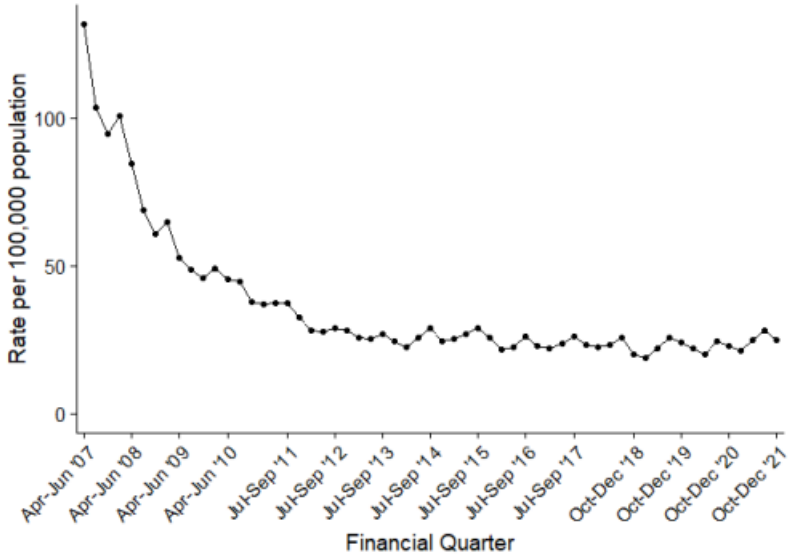
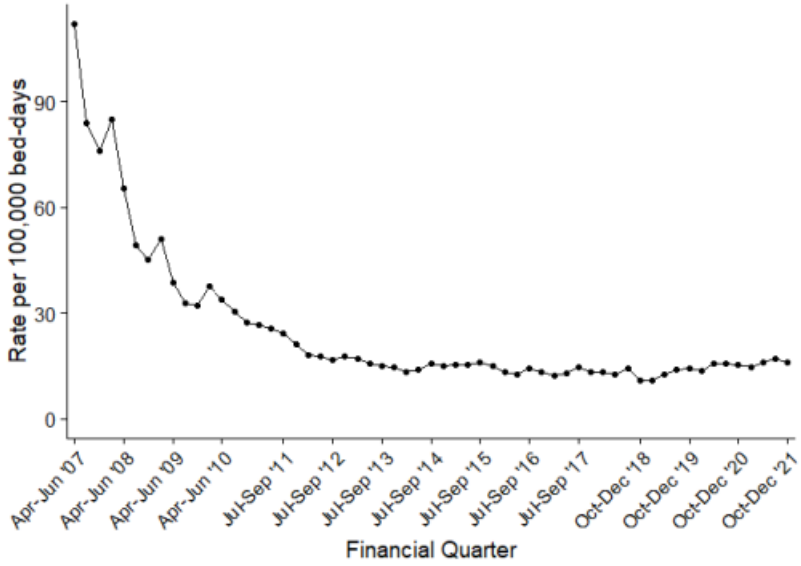


Figure 6b. Quarterly rates of hospital-onset *C. difficile*: April to June 2007, to October to December 2021



The division of cases into hospital-onset and community-onset cases does not take into account any patient who may have been admitted into healthcare within the previous twenty-eight days leading up to the positive CDI result. Patients who have received previous inpatient care may be at increased risk of developing CDI. For this reason, reporting of information prior to trust exposure to healthcare facilities was introduced in April 2017.

3.6 CDI Root Cause Analysis and Investigation

Preventing and controlling the spread of CDI is a vital part of the Trust's quality and safety agenda by a multifaceted approach and the proactive element of early recognition and isolation of CDI toxin positive cases and of those cases that are CDI carriers (GDH positive).

In all cases control measures are instigated immediately. Each HOHA and COHA CDI's have a Root cause analysis completed.

The HOHA cases undergo an RCA scrutiny panel to establish root cause of the infection and any learning outcomes identified. Following this process and review by the CCG/ Dudley Health Board

each case is apportioned to identify if any lapses or no lapses in care can be identified. The lapses in care are then plotted against the trust objective for CDI for that year. This is then feedback via reporting mechanisms to the IPCG. An improvement has been noted throughout this year in comparison to the previous year with a reduction of HOHA cases identified.

Lessons Learnt

Following review of all of the Root Cause analysis completed some common themes have been identified. These include antimicrobial stewardship and appropriateness of antimicrobial prescribing in line with Trust guidelines, Environmental Cleaning scores below an overall compliance of 95% and IPC Mandatory training compliance falling below the Trust objective of 90% compliance. All RCA's have an action plan completed with objectives to achieve and a timeframe for completion with all having a matron sign off to ensure this has senior level review. Many of the actions are addressed through divisional governance meetings or teams' meetings with minutes being taken as well as daily staff reminders on the ward in the form of huddle board meetings. Action plans and compliance are then monitored through the divisions.

DGFT closely monitors periods of increased incidents (PII) of patients with evidence of toxigenic *Clostridioides difficile* in any ward or area. The definition of a PII is 2 or more patients identified with evidence of toxigenic *Clostridioides difficile* within a period of 28 days and associated with stay in the same ward or area, each case is reviewed to establish if they can be linked by time and place and identify any common themes. Should this occur samples are obtained and submitted to Public Health England for ribotyping. This helps to identify wards or areas where patient to patient transmission is likely to have occurred, with enhanced focus on control measures and increased cleaning of the patient areas if necessary.

The terminology of *Clostridioides difficile* is not commonly used, therefore further work in terms of communication of this is required to filter down to the wider organisation.

There were three incidents identified with two cases of CDI which did meet the criteria for a period of increased incidence. All cases were reviewed. Two cases could be linked by time and location on the Ward. Both cases were sent to Public Health England for ribotyping which confirmed both samples were the same but both patients were independent, self-caring and mobile and had loose stools prior to admission. It was agreed that although there was a link between the patients the CDI infection could not be linked. Following the RCA process there were no links established between the other cases.

An additional scrutiny panel has been introduced to discuss all cases of CDI internally with ward representatives, microbiologist, antimicrobial pharmacist, and IPC Team. This allows oversight and challenge against each case identified, to identify any learning and agree action plans prior to the RCA panel discussion with external colleagues.

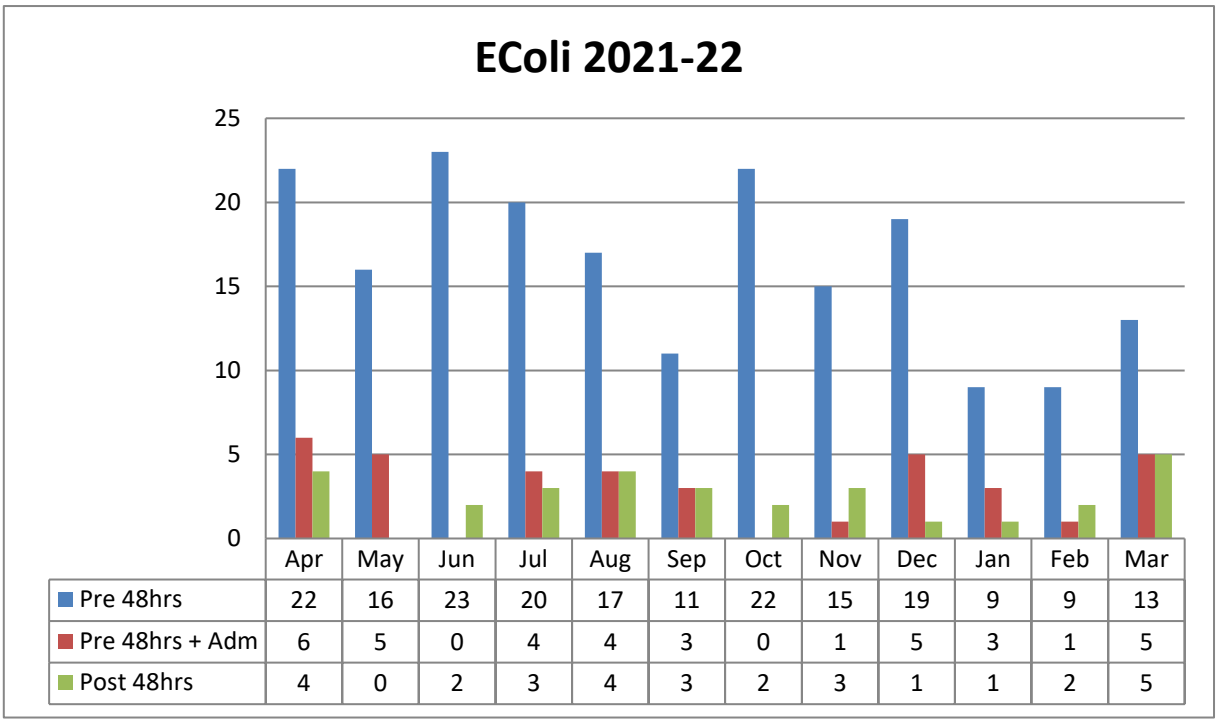
3.7 Gram Negative Blood Stream Infections – *Escherichia coli (E. coli)*

Escherichia coli (E. coli) bacteria are frequently found in the intestines of humans and animals. There are many different types of E. coli, and while some live in the intestine quite harmlessly, others may cause a variety of diseases. The bacterium is found in faeces and can survive in the environment. E. coli bacteria can cause a range of infections including urinary tract infection, cystitis (infection of the bladder), and intestinal infection. E. coli BSI may be caused by primary infections spreading to the blood.

The Secretary of State for Health in 2017 launched an ambition to reduce healthcare associated GN bloodstream infections (BSIs) by 50% by 2021.

Enhanced surveillance of E. coli BSI has been mandatory for NHS acute trusts since June 2011 and is reported monthly to UK HSA. This is to ascertain themes and trends associated with E.coli bacteraemia within the acute Trust to see where lessons may be learnt. There is work ongoing that is part of the national agenda for health and social care economies to reduce the number of Gram-negative bloodstream infections (BSIs) with an initial focus on Escherichia coli (E.coli). To date this has focused on the management of patients with long term urinary catheters and a catheter passport was introduced in conjunction with the CCG and used across Birmingham and the Black Country.

As detailed in the graphs below 263 E. coli infections have been identified with 30 classified as post 48-hour cases. Each post 48-hour case will be reviewed by the IPCT to establish the potential source of the bacteraemia.



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Pre 48hrs	22	16	23	20	17	11	22	15	19	9	9	13
Pre 48hrs + Adm	6	5	0	4	4	3	0	1	5	3	1	5
Post 48hrs	4	0	2	3	4	3	2	3	1	1	2	5

	Trust Apportioned > 48 hours	Health Economy Total
April 2021	4	32
May 2021	0	21
June 2021	2	25
July 2021	3	27
August 2021	4	25
September 2021	3	17
October 2021	2	24
November 2021	3	19
December 2021	1	25
January 2022	1	13
February 2022	2	12
March 2022	5	23
Yearly Total to Date	30	263

Epidemiological analyses of Gram- negative bacteraemia data (England)

***E. coli* bacteraemia**

The incidence rate of all reported E. coli bacteraemia increased each year between the initiation of

the mandatory surveillance of E. coli bacteraemia in July 2011 and the start of the COVID-19 pandemic (January to March 2020). This increase was primarily driven by community-onset cases. The number and incidence rates of all reported and community-onset cases declined after the start of the pandemic but remain higher than observed at the start of E. coli surveillance.

In contrast, the incidence rate of hospital-onset cases remained relatively stable during the same period, except for a sharp reduction observed in April to June 2021. Between July to September 2011 and October to December 2021, the count, and the incidence rate of all reported cases of E. coli bacteraemia increased by 10.8% from 8,275 cases to 9,166 and from 61.8 to 64.5 cases per 100,000 population, respectively.

Similarly, over the same period, the count of community-onset cases increased by 16.3% from 6,279 to 7,300, while the incidence rate increased by 9.5% from 46.9 to 51.4 cases per 100,000 population. Concurrently, the count of hospital-onset cases decreased by 6.5% from 1,996 to 1,866 cases. This corresponded to a decrease in the incidence rate of hospital-onset cases by 6.2% from 23.6 per 100,000 bed-days to 22.1 per 100,000 bed-days.

Figure 1a. Quarterly rates of all reported *E. coli* bacteraemia: July to September 2011, to October to December 2021

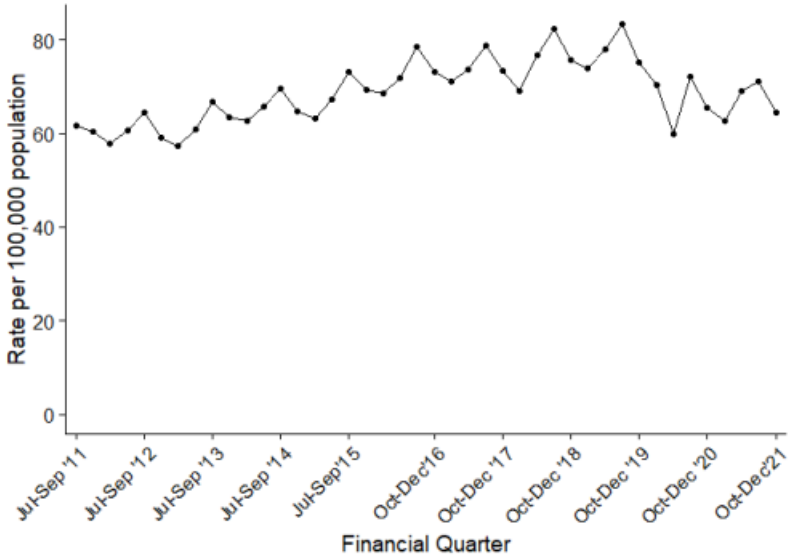
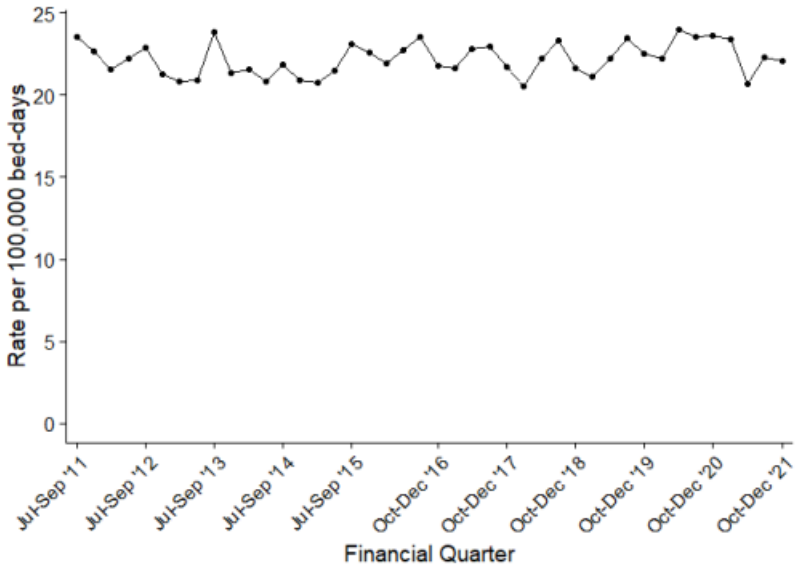


Figure 1b. Quarterly rates of hospital-onset *E. coli* bacteraemia: July to September 2011, to October to December 2021



Further work is needed in order to reduce the number of cases reported within DGFT and examples of these include a catheter passport which was introduced across Birmingham and the Black Country which due to issues associated with the COVID-19 pandemic the embedding of this has been fragmented.

A simplified algorithm was introduced associated with Urinary tract infections in over 65s within ED and in agreement with the ED lead. Teaching sessions completed for all Pharmacists on management of simple Urinary Tract Infections (UTI)s.

3.8 Vancomycin/Glycopeptide Resistant Enterococci (VRE/GRE)

Enterococci are part of the normal bowel flora and can cause urinary tract and blood stream infections.

Vancomycin resistant enterococci (VRE) and Glycopeptide resistant enterococci (GRE) may be found in the healthy population thought to reflect inappropriate use of antibiotics in farming.

Mandatory surveillance was discontinued in 2013.

3.9 Carbapenemase Producing Enterobacteriaceae

The Enterobacteriaceae are a large family of Gram-negative bacteria including species such as E. coli, Klebsiella sp., Proteus sp., and Enterobacter sp. They live usually harmlessly in the guts of both humans and animals. They are opportunistic pathogens, capable of causing urinary tract infections, abdominal infections, and bloodstream infections (UK HSA 2013).

Some of these bacteria develop resistance to antibiotics through various mechanisms, one of them being the ability to produce an enzyme called Carbapenemase which is capable of destroying the β-lactam ring, an essential component of β-lactam antibiotics. The Carbapenemase enzyme makes these organisms resistant to multiple antibiotics, hence the options of treating infections caused by CPE is limited. Antibiotic resistance is a major Public Health concern and stringent Infection Prevention, and Control precautions need to be instigated and maintained to reduce the spread of these organisms.

UK HSA published a toolkit in 2013 to control the spread in healthcare and onwards in the community.

DGFT did not identify any cases of CPE during the time period covered by the report

3.10 Norovirus

Norovirus is defined as an abrupt explosive onset of profuse watery diarrhoea which may be accompanied by projectile or violent vomiting. Several cases may occur on the ward within hours. If this occurs the ward must gather information about the patient's affected, this infection is known to be highly infectious. The virus is easily transmitted through contact with infected individuals from one person to another or environmental contamination. In hospital this environmental risk is considerable, and outbreaks are common.

Management relies on prompt recognition of symptoms, robust isolation, and IPC procedures as well as enhanced environmental cleaning within the area affected.

For the period covered in this report DGFT had no confirmed cases of Norovirus.

3.11 COVID-19 Pandemic

The World Health Organisation (WHO) issued a press release (Thursday 9 January 2020) announcing the discovery of novel virus identified in China and called for more research. In January 2019 Public Health England declared a National Incident following a preliminary determination of a novel (or new) coronavirus by officials in Wuhan, China.

The Department of Health and Social Care also declared an incident and established an incident team. As human-to-human transmission escalated globally numerous countries declared outbreaks with increasing pressures on healthcare systems. On the 12 March 2020 WHO declared a global pandemic of COVID-19.

Background

Coronaviruses are a large family of viruses with some causing less-severe disease, such as the common cold, and others more severe disease such as MERS and SARS. Some transmit easily from person to person, while others do not. A novel coronavirus is a new strain that has not been previously identified in humans. The virus was named as SARS-CoV-2 and the infection caused by the virus named as COVID-19.

The Trust has implemented the requirements as identified by NHS England in order to manage the additional pressures on healthcare systems. A COVID-19 planning team was established and comprises of all key partners that are required within trust to ensure all aspects of COVID-19 are considered and planned for. The Trust is well engaged with all local arrangements and national planning. This work is ongoing and subject to change as national guidance is updated.

Significant changes have been made to how the Trust operates during the COVID-19 pandemic to keep patients' staff and visitors safe; face to face training, consultations and meetings were suspended or held virtually to ensure social distancing.

Hospital Acquired COVID-19 Definitions

- **Admission –** defined as day 0
- **Community-Onset (CO) -** Positive specimen date less than or equal to 2 days after hospital admission or hospital attendance.
- **Hospital-Onset Indeterminate Healthcare-Associated (HOHA)** – defined as positive result within 3-7 days after hospital admission.
- **Hospital-Onset Probable Healthcare-Associated (HOHA) –** defined as positive result within 8-14 days after the hospital admission.
- **Hospital-Onset Definite Healthcare-Associated (HOHA) –** defined as positive result within 15 days or more of the hospital admission

A **probable** or **definite** hospital-onset healthcare associated COVID-19 infection is a **patient safety incident** and should be reported and responded to according to the trust's existing policies.

A probable or definite hospital-onset healthcare associated COVID-19 infection **death** is defined as.

- The death of a patient who has a positive specimen result where the swab was taken within 28 days of death and/or COVID-19 is cited on either Part 1 or Part 2 of the death certificate

(i.e., the death resulted from a COVID-19 clinically compatible illness with no period of complete recovery between the illness and death).
- The COVID-19 infection is linked to the death which meets the definition of 'probable' or 'definite' hospital-onset healthcare associated infection (see above).

In instances where a patient has had a positive test result and the swab date was more than 28 days prior to death, this death would not be considered a COVID-19 death unless COVID-19 is cited in part 1 or part 2 of the death certificate.

Similarly, the death is not considered a COVID-19 death if there is a clear alternative cause of death that cannot be related to COVID-19 disease (e.g., trauma) and so COVID-19 is not cited in part 1 or 2 of the death certificate.
Public Health England / Reporting, reviewing, and investigating hospital-onset COVID-19 cases and COVID-19 deaths (February 2021)

Hospital Acquired COVID-19 Data.

3103 individuals were tested positive for COVID-19 from 1st March 2020 to the 12 April 2021 at The Dudley Group.

In November 2020 UK HSA/NHSI/E requested that each acute Trust submit a daily return identifying confirming positive cases and at which point during the patients stay did they become positive. Below is the available data

Critical Care Data - 1st March 2020 12th April 2021

370 patients were admitted to Critical Care of which 114 patients sadly died. 301 of the 370 patients (89.85%) were community onset against the criteria.

There was no evidence of 36 patients having had a COVID-19–19 positive screen. However, these patients may have been treated clinically for signs of COVID-19.

There are 69 patients within the Critical Care data set that will require a review as part of a harm review process. NHSE/I and UK HSA recommend any patient that requires level 2 or level 3 care as part of a hospital acquired COVID-19 positive pathway must be assessed for harm and long-term health needs. A harm review will be completed and will be reported in subsequent report.

Level 2 care is defined as patient who requires support for one organ failure.
Level 3 care is patients who require support for two or more organs that are failing.

Contact Tracing Evidence

Whilst the IPC team and Staff Health and Wellbeing (SHAW) undertook some limited staff contact tracing during the first wave, it was recognised during the second wave that a bespoke team was required to meet the national guidance the Chief Nurse supported resourcing a contact tracing service for staff which came into service in November 2020.

COVID-19 positive staff members have been contact traced (this includes all members of the MDT and PFI staff). This information is fed into the outbreak meetings so that data can be triangulated establishing any potential breaches in the use of Personal Protective Equipment (PPE) or behaviour aspects that may have contributed to the outbreak.

Key themes identified from staff contract tracing have included:

- Breaching PPE – face mask compliance
- Car Sharing
- Sociaising outside of work areas
- Communial break areas – Doctors Mess, canteen

In line with trust policy all patients who test positive for COVID-19 are informed if appropriate. All cases are investigated and contact tracing undertaken this includes notifying any potential contacts of exposure to isolate as per national guidance.

All patient contact information is stored on a newly created patient database. Information regarding positive patient/s and contacts are detailed within the file and discussed as part of the outbreak meetings held internally. This system provides assurance and oversight for any patient and staff member that recieves a positive result for COVID-19, allowing triangulation of data and the monitoring of any potential outbreaks across the Trust. This early detection and any remedial action taken to prevent further transmission.

COVID-19 Outbreaks

Outbreaks as defined by UK HSA (08.2020) two or more cases linked by time and place. Outbreak meetings were established in line with best practice toolkit from NHSI/E.

Each outbreak has an individual timeline where all information regarding these patients are collated and reviewed.

These meetings are recorded and minuted, detailing all attendee discusions and findings. Once this information has been signed off by Chief Nurse/DIPC or her deputy the information is shared with partners via the Outbreak System.

Since April 2021 there have been a total of 88 outbreak areas relating to COVID-19 within the Trust where 2 or more cases tested positive on the same ward or area that can be linked by time and place.

Once the outbreak areas have been identified within the trust, reviews are undertaken to find potential themes/issues behind the outbreak occurring. Outbreak meetings are arranged with external partners and actions identified where necessary. Closure reports are issued after 28 days and the outbreaks are recorded on the NHSE/I database,

The Dudley Group NHS Foundation Trust COVID-19 Outbreak Overview:

DGFT Outbreak Data - 31/03/22	
Total Outbreaks	**88**
Total Outbreak Areas	**38**
Total COVID-19 Positives	**1044**
Total Patients	**562**
Total Staff	**482**

Review of Outbreak Areas – Action Plans

Once outbreak areas have been identified within the trust, reviews are undertaken to find potential themes/issues behind the outbreak occurring. Audits are undertaken by a member of the IPC team to identify compliance and where necessary action plans are devised to prevent any further occurrences. Our Estates departments have been responsive in enabling the zoning of departments within wards in response to demand to enable segregation of patients.

Clinical practice audits including hand hygiene, Matron peer review and Environmental audits are completed and compliance scores for each ward are collated. Where improvements are required, advice is provided by the IPC team to the wards to facilitate an improvement in their overall compliance. By reviewing areas, risks and non-compliance can be identified to limit the potential of outbreaks occurring within the trust.

Specialist audits have been devised and implemented for specific visits to off-site areas such as the new vaccination centre at Saltwells Centre, in Dudley.

Recommendations from the COVID-19 Pandemic

- Ensure all patients identified as potential harm via a Structured Judgement Review are referred to the Weekly meeting of harm and a datix completed.
- To set up a harm review panel to discuss level 2 and level 3 patients to review potential harm as a direct consequence of contracting COVID-19 whilst in our care.
- Work with our PFI partners to review the cleaning specification in line with the new cleaning standards.

Dissemination of the learning is disseminated through the divisions and shared with all Trust teams.

3.12 Audit Programme

The DGFT has a programme of audits in place undertaken on all clinical areas and outpatients' departments. The IPC Team provide assurance against consistent compliance with evidence-based practice and policies. Each audit completed creates an action plan for review and completion by the ward teams.

These audits are undertaken quarterly to ensure all wards and departments receive monitoring to provide assurance that improvements are being made.

Where a period of increased incidence (PII) occurs, risks are identified and the IPC Team undertakes additional audits in accordance with risk requirement, this will be daily initially with an increase to weekly once an improvement and consistency in scores has been identified.

Action plans are developed by the clinical areas, and these are managed and monitored within the divisions and escalated to IPCG and upwardly reported through the DGFT Governance structure.

High Impact Interventions

High Impact Interventions relate to key clinical procedures or care processes based on evidence-based approach.

The High Impact Interventions are:

- HII 1 – Ventilator Associated Pneumonia
- HII 2a – Peripheral Vascular Access Devices (Insertion)
- HII 2b – Peripheral Vascular Access Devices (Ongoing Care)
- HII 3a – Central Venous Access Devices (Insertion)
- HII 3b – Central Venous Access Devices (Ongoing Care)
- HII 4a – Surgical Site Infection Prevention (Preoperative)
- HII 4b – Surgical Site Infection Prevention (Intraoperative Actions)
- HII 5 – Infection Prevention in Chronic Wounds
- HII 6a – Urinary Catheter (Insertion)
- HII 6b – Urinary Catheter (Maintenance and Assessment)

The clinical nursing team's complete self-assessment practice audits across each ward area and look at the elements of the high impact interventions applicable to their area. Below is an outline of the performance broken down by month for each of the elements highlighted.

DGFT OVERALL SCORES 2021-22

Interventions		Quarter 1			Quarter 2			Quarter 3			Quarter 4		
		4-21	5-21	6-21	7-21	8-21	9-21	10-21	11-20	12-21	1-22	2-22	3-22
HII 1:	Ventilator Associated Pneumonia	100.0%	100.0%	100.0%	90.0%	100.0%	90.0%	90.0%	100.0%	80.0%	90.0%	100.0%	85.7%
HII 2a:	Peripheral Vascular Access Devices - Insertion	99.0%	91.2%	95.9%	98.1%	97.2%	96.2%	96.6%	100.0%	98.8%	100.0%	95.2%	95.8%
HII 2b:	Peripheral Vascular Access Devices - Ongoing care	97.0%	92.9%	96.6%	94.7%	98.6%	97.1%	98.7%	99.3%	98.4%	99.2%	97.9%	95.7%
HII 3a:	Central Venous Access Devices - Insertion	100.0%	100.0%	100.0%	100.0%	100.0%	90.9%	100.0%	100.0%	100.0%	95.0%	94.7%	100.0%
HII 3b:	Central Venous Access Devices - Ongoing Care	100.0%	95.0%	100.0%	100.0%	100.0%	94.7%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
HII 4a:	Surgical Site Infection Prevention - Preoperative	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	88.9%	100.0%	100.0%	100.0%	100.0%
HII 5:	Infection Prevention in Chronic Wounds	95.0%	92.0%	100.0%	100.0%	100.0%	95.9%	97.6%	100.0%	97.4%	100.0%	100.0%	100.0%
HII 6a:	Urinary Catheter - Insertion	100.0%	100.0%	95.2%	100.0%	91.7%	100.0%	96.2%	100.0%	98.3%	100.0%	97.6%	99.2%
HII 6b:	Urinary Catheter - Maintenance & Assessment	96.0%	94.8%	96.9%	94.4%	94.8%	95.7%	97.5%	97.9%	95.7%	98.3%	97.1%	97.1%
High Impact Interventions Monthly Overall		98.6%	96.2%	98.3%	97.5%	98.0%	95.6%	97.4%	98.5%	96.5%	98.1%	98.1%	97.1%
Hand Hygiene		97.0%	94.9%	98.5%	98.7%	99.4%	98.7%	98.6%	98.6%	97.8%	98.9%	99.2%	99.2%
Commode Audits		99.0%	98.7%	98.1%	98.0%	98.1%	88.0%	98.5%	98.1%	98.0%	98.9%	97.4%	99.0%
Cleaning Scores		94.0%	94.0%	94.3%	93.3%	93.5%	93.4%	92.8%	92.8%	95.0%	94.7%	94.8%	94.7%

Clinical practice audits have been commenced by the IPC Team to monitor compliance of key infection control issues across the wards and departments such as environmental cleanliness, hand hygiene compliance, equipment monitoring and sharps compliance.

3.13 Hand Hygiene Audits

Hand hygiene continues to be included in the audit programme. An environmental hand hygiene audit was in place throughout a large part of the year which includes environmental elements. Due to the COVID-19 pandemic some of the Hand hygiene scores were not uploaded and there were some gaps in submission, therefore the figures in the chart below indicate compliance based on the data submitted.

The DGFT introduced the 5 moments of hand hygiene tool in March 2021 which focuses on opportunities and performance of hand hygiene across a variety of staff groups on each area. This is completed in conjunction with an environmental hand hygiene audit and the hand hygiene audits completed as part of the ward environmental audit programme.

Hand hygiene continues to be audited across all wards and departments, on a monthly basis, this now includes monthly compliance following the WHO 5 Moments of Hand Hygiene tool and an example of the 5 moments of hand hygiene tool can be found below:

Patients, visitors, and staff are encouraged to challenge staff if they have any concerns about hand hygiene and in cases of repeated non-compliance, concerns are raised divisionally. This is across all staff groups including nurses, medical staff, AHP's and our PFI partners.

Raising awareness of hand hygiene and the 'Bare below the elbow' are consistently monitored throughout the year.

3.14 Mandatory Training

The revised mandatory requirement is to update Infection Control training annually for clinical staff.

The following measures have been introduced to achieve compliance of 90% of clinical staff.

Reduced compliance of infection control training was noted during COVID-19; the trust was under immense pressure due to COVID-19 and associated workforce challenges. Face to face teaching sessions were suspended due to social distancing measures this has impacted training compliance across the Trust. In order to ensure we have systems in place to increase the compliance across the trust:

- There is a direct link for the mandatory IPC training on the staff intranet (The HUB) making it easier for staff to access e-learning.

- Face to face sessions have now been re-introduced with a reduced capacity to ensure compliance with social distancing requirements.

As of March 2022, the trust total is 90.3% (Clinical) & 94.6% (non-Clinical). This data is based upon an annual cycle. The reduction in compliance is in part due to the cancellation of several face-to-face training sessions due to COVID-19. The IPC Training compliance is managed by the divisions and is discussed monthly at divisional meetings. This is then fed through the IPC Group with actions being taken to improve compliance and discuss current progress.

Infection Control – Clinical %				
Month	**Corporate / Management**	**Medicine/ Integrated Care**	**Surgery**	**Clinical Support**
April 2021	85.61	89.17	88.51	85.85
May 2021	87.59	91.89	91.91	88.12
June 2021	81.25	90.39	91.17	86.15
July 2021	85.71	92.32	91.91	89.23

August 2021	78.57	91.75	89.38	90.99
September 2021	81.87	91.50	88.20	92.37
October 2021	81.98	90.57	87.65	92.55
November 2021	87.89	92.91	88.21	94.20
December 2021	88.27	92.04	86.40	94.63
January 2022	88.12	92.10	87.66	94.44
February 2022	87.73	90.85	88.91	93.98
March 2022	88.19	90.64	90.22	92.05

Infection Control – Non-Clinical %				
Month	**Corporate / Management**	**Medicine/ Integrated Care**	**Surgery**	**Clinical Support**
April 2021	90.86	95.04	94.66	97.43
May 2021	92.00	95.12	95.63	98.71
June 2021	92.76	96.67	93.85	96.29
July 2021	93.64	96.95	96.03	97.36
August 2021	93.47	96.97	96.02	94.80
September 2021	93.90	95.37	96.03	94.87
October 2021	93.69	96.35	96.66	93.58
November 2021	94.10	95.69	96.01	91.76
December 2021	93.81	96.64	96.40	94.11
January 2022	94.44	96.02	96.44	93.10
February 2022	93.56	93.83	97.73	96.55
March 2022	94.34	95.37	95.42	95.29

3.15 Influenza Vaccination Programme

There are 4 types of seasonal influenza viruses, types A, B, C and D. Influenza A and B viruses circulate and cause seasonal epidemics of disease.

Seasonal influenza is characterized by a sudden onset of fever, cough, headache, muscle and joint pain, severe malaise, sore throat, and a runny nose. The cough can be severe and can last 2 or more weeks.

Illnesses range from mild to severe and even death. Hospitalization and death occur mainly among high-risk groups. Worldwide, these annual epidemics are estimated to result in about 3 to 5 million cases of severe illness, and about 290 000 to 650 000 respiratory deaths. (WHO, 2018)

The most effective way to prevent the disease is vaccination. Immunity from vaccination wanes over time so annual vaccination is recommended to protect against influenza.

(WHO, 2018)

The Dudley Group held an influenza flu campaign running from August 2021. The campaign included:

- Peer vaccinators across the trust assigned with an online flu competency to be completed.
- Flu posters created and distributed across the trust, via the trust website and on social media.
- New strapline for the year introduced which was added to t shirts and sashes for peer vaccinators to wear and it was used in all communications on the trust intranet and on social media
- A screensaver was developed prior to the launch to display across trust computers
- Ward based vaccinators were recruited as well as sessional vaccination sessions at the hospital vaccination hub
- Staff health and wellbeing provided advice and guidance for staff that had underlying conditions or allergies.

At the end of March 2022 65.5% of the DGFT staff had received their influenzas vaccine. This percentage is a reflection of substantive staff that have been corroborated against Electronic Staff Record (ESR). It was noted that PFI colleagues and volunteers were not included in this percentage.

3.16 Link Worker Programme

The IPCT continues to provide the Infection Prevention and Control Link Nurse programme.

Link Worker sessions recommenced in March 2022, and it is proposed they run every second month to provide education support and act as an IPC resource for the link staff to maintain their enthusiasm and commitment to IPC.

The aim of these sessions is to update on any new guidance / policies and to increase the flow of Infection Prevention and Control communications There is a link worker in every department both inpatient and community areas and they are key in undertaking monthly audits of practice.

Throughout this year several face-to-face link worker sessions were cancelled due to the COVID-19 pandemic. Audit work was continued by the link workers.

3.17 Incidents and Outbreaks

Neonatal Enterobacter

In June 2021 it was identified that two babies had recently tested positive within a 28-day period for *Enterobacter Cloacae* from eye swabs. Following the trust investigations, we were unable to identify a source for the outbreak. No areas of cross contamination were identified. This was possibly an incidental finding of a common organism.

Following the investigation, the Neonatal unit (NNU) have updated the cleaning schedule to identify clear roles and responsibilities and the IPC standards expected within the unit.

As a direct result of this incident The Infection Prevention and Control Team identified gaps in identifying outbreaks of sensitive organisms due to only monitoring resistant organisms on the daily IPCT Ward List. Following this the IPCT have made the decision to input all results received via ICNET (result system) on to the ward list for 28 days.

The NNU allocated members of the medical workforce to work with the already identified ward IPC link workers to improve and promote good infection control practices and carry out local audits. The main issue identified was the lack of knowledge around the 5 moments. Hand Hygiene training was completed with all staff this was also extended to parents. All parents are taught hand washing techniques on admission to the unit.

Period of increased incidence *Serratia marcescens*

In October 2021, two *Serratia marcescens* results were identified in two patients on Critical Care area A. No other patients in the area had positive results.

All patients in Critical Care area A were re-screened for Serratia. Screens were collected from throat, groin, and axilla and also from any lines, invasive devices etc. depending on the patient.

Environmental surface swabs were obtained prior to a deep clean of the area. 24 environmental swabs were collected comprising of the arterial blood gas machine, patient ventilator, sinks and taps, patient bed side screens, bed frames, bed side lockers, linen trollies, bed side computers, nursing station, telephones. No positive swab results were received.

Following a discussion with the microbiology consultant advice was given that no further Serratia swabs were needed from patients or the environment. It was discussed that ribotyping of the results was not advised as both Serratia results have a similar sensitivity pattern therefore no definitive proof of a link and this event should be classed as a Period of increased incidence.

There have been no further Serratia positive results in Critical Area A to date.

Giardia lamblia

Six cases were identified in the Trust during the period September 2021 to November 2021. These were reviewed by UK HSA, but no links were established between the patients.

Section Four: Progress against 2021/2022 Infection Prevention and Control Programme

4.1 Criterion 1

Systems to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of service users and any risk that their environment and other users may pose to them.

- Infection Prevention and Control Arrangements and Responsibilities policy reviewed to reflect management and reporting structure of DGFT, outlining its collective responsibility for IPC and demonstrating responsibilities are devolved to all staff/groups in the organisation.
- IPCG meeting Terms of Reference (TOR) and membership reviewed annually.
- Head of IPC has provided quarterly reports to Quality and Safety Committee including thresholds, risks, and progress against objectives.
- Head of IPC has provided bi-monthly reports to Quality and Safety Delivery Group.

- The Annual IPC Report is produced and presented to the public board.
- The Annual IPC Report is made available for public viewing via the DGFT website.
- IPC Board Assurance Frameworks were developed, updated as required and presented to the Quality and Safety Delivery Groups, quality, and Safety Committees and the DGFT Public Board
- Risks associated with infection have been entered on the DGFT risk register and reviewed monthly.
- The IPC team continued to identify IPC risks and areas of weakness in policy and practice though audit and surveillance.
- CQC Provider Compliance Assessments completed.

- IPC Team has worked alongside clinical staff in the hospitals as a mechanism to deliver teaching and education to staff.
- All infection outbreaks reviewed, and service improvement plans developed so that relevant learning was appropriately communicated and acted upon.
- RCA/CCRs were completed for all patients who developed a CDI tabled at the IPCG meeting.
- PIRs were completed when required.
- Alerts are added to patients' sunrise records to highlight risk of infection.
- New electronic patient record alerts have been developed to reflect COVID-19, supported by informatics reports to support national reporting requirements.
- The IPC Annual Audit Programme was reduced following an increase in COVID-19 , winter pressures and staff sickness and vacancies within the IPC Team
- IPC audit tools adapted in 2011/12 from the Department of Health (DH) /Infection Prevention Society Quality Improvement Tools and DH Saving Lives care bundles have been revised and updated to incorporate new guidance. These are reviewed and updated annually.
- Due to COVID-19 IPC training is delivered via E-learning.
- IPC Induction training is delivered face to face

4.2 Criterion 2
Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections

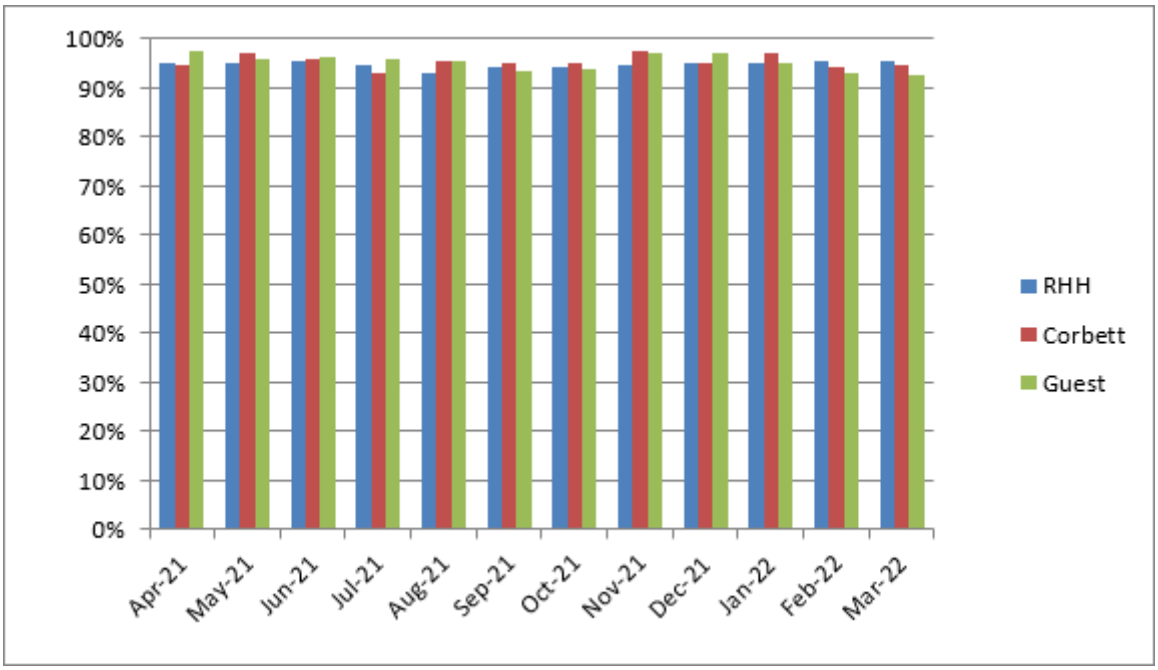
4.2.1 Estates and Facilities

The section below in italics has been completed by Jannine Dyke, Soft Services contract Manager.

Environmental Audits

The Trust recognises its duty to provide safe and clean environments where patients, staff and visitors can expect to be protected from the risk of infection. The environmental cleaning service is provided by Mitie Facilities Management as part of the Trusts PFI contract with Summit Healthcare (Dudley) Ltd (Summit). The contract is managed by the Trust's Facilities and Property Development Team. Environmental audits are undertaken by the Trust Auditors in partnership with Mitie and clinical staff where possible across its sites.

The table below outlines the technical audit cleaning scores against the national 49 cleaning elements, as well as the PFI service level for the Trust, for this reporting period April 21 to March 22.



Cleaning scores across the Trust have continued to plateau over the past 12 months. In the main, Russell's Hall Hospital, Guest and Corbett Out-Patient Centres continue to achieve an overall monthly score above the 95% threshold on a monthly basis.

Although the number of monthly audits during the COVID-19 phases were reduced, an average of 199 audits per month were carried out during the Apr 21-Mar 22 period. Areas were audited in line with the Trust's Cleaning and Disinfection Policy and the Trust continued to apply the performance management mechanisms within the PFI contract throughout this period. Additional Touchpoint cleaning was also carried out across all sites during this time and Trust's Facilities team and Infection Prevention and Control team worked closely with Mitie and Summit in order for this to take place. Staffing provided many challenges during this time, but all parties recognised the need to maintain cleanliness within the hospitals.

Technical audits are carried out by the Trust's audit team, with Mitie attendance but more frequent attendance by the clinical team continues to be encouraged. Access to rooms can sometimes be denied at the time of the audit but as many rooms as possible are audited at each session. A minimum of 50% of each area is audited in one session making the audit representative of the whole area, but on the majority of occasions 80% of more of the area is audited especially in clinical areas. At the end of the audit the auditor liaises with a senior member of the clinical team to advise of the audit outcome and point out any significant areas of concern.

During the technical cleaning audit, items of environmental maintenance may also be identified, and the electronic audit tool has also been used to capture these items, and for these to be followed through to close out.

High level cleaning has been of concern, this has been monitored via the Trust's audit team and a close eye kept on this element by the Cleaning Operations and Monitoring Group. High level cleaning failures raised on audits have reduced over recent months.

The Trust implemented cleanliness star ratings during quarter 3 in line with the National Standards for Healthcare Cleanliness 2021 and will be fully implementing these cleaning standards in May 2022.

Patient Led Assessment of the Care Environment (PLACE)

PLACE is the national system which focuses exclusively on the environment in which care is delivered; it does not cover the clinical care provision. PLACE was last carried out at Dudley Group Foundation Trust on Tuesday 12 November 2019. Several domains are assessed, as per below, including Cleanliness, Food, Condition Appearance & Maintenance, Disability, Privacy, Dignity & Wellbeing, as well as Dementia, the results of which were published in Q1 2020. On this occasion, it was not possible to compare previous results with this year due to the number of changes in questions following a national review.

National PLACE assessments were suspended during 2020 or 2021 due to the pandemic however, there is an expectation that there will be a national assessment during 2022 although this is yet to be finalised.

NHS digital launched PLACE-Lite and Trusts are being encouraged to carry out these out as it is felt that it is particularly important to consider the environment for patients and get a sense of how COVID-19 has impacted on the environment. Trusts determine the frequency of assessments and have freedom to choose the categories and areas assessed, although all domains continue to be assessed. The Trust commenced PLACE-Lite in October 2021 and attendance has included a member from the Trust's IPC team, a clinical lead, Mitie, and the Trust's Facilities Contract Manager. In addition, hospital Governors and Healthwatch are also supporting this process. The PLACE-Lite results are recorded on the NHS Digital platform, similar to national PLACE, but this information is not shared with other Trust's and no benchmarking takes place as with national PLACE. An action plan is produced and monitored via the Patient Experience Group (PEG), chaired by the Chief Nurse.

Areas that have been assessed under the PLACE-Lite regime, which commenced in October 21 include the following wards: B5, C1, B1, C6 and AMU. In addition, Communal Areas, Women and Children's Outpatients Department and Imaging have also been assessed.

A series of PLACE meal-time assessments have also taken place, 14 to-date, with feedback being provided to the lead nurses and matrons on any improvements. Follow-up visits to areas are also being scheduled.

An external assessors training session was carried out during February 2022 for Healthwatch so that that could provide support to the process and Healthwatch members have attended both the March and April 2022 assessments. Their support is very much welcomed.

The PLACE-Lite programme will continue to run through the Spring/Summer of 2022 and further guidance is awaited with regards to the expectations of national PLACE later in the year.

4.2.2 Water Systems Management

The Water Safety Group (WSG) oversees all aspects of water safety for the PFI Estate. The Group is chaired by Summit Healthcare Limited who are the owners of the PFI Estate. The members of the group included:

- Assistant General Manager (Summit)(Chair)
- Responsible Person for Water Safety (Mitie)
- Authorising Engineer for Water Safety (Mitie)
- Estates Manager (Mitie)
- Technical Compliance Manager (Trust)
- Consultant Microbiologist (Trust)
- Infection Prevention and Control (Trust)
- Authorising Engineer for Safety

A regime of regular water quality testing is in place across the PFI estate which has been agreed by the Water Safety Group. The tests include legionella and *Pseudomonas Aeruginosa*. As previously reported, no issues of significance have been identified in the past 12 months.

The Authorising Engineer (AE) for Water Safety has completed the required Audit on the arrangements in place. The outcome of the audit was described by the AE as site inspections suggest that the system is mostly well managed and maintained with only minor issues identified which are being actioned.

Flushing of underused outlets has been on agenda of the Water safety Group on many occasions as there are over 400 outlets being flushed twice weekly.

Pseudomonas risk assessments have been carried out by the Authorising Engineer, which are awaiting ratification by end users and the WSG.

Ventilation

During early stages of COVID-19 wave 1, mechanical ventilation serving Main Theatres, ICU and other COVID-19 cohort areas were converted to negative pressure. This was at the request of Clinicians to contain, dilute and remove potential contaminants within the space, avoiding overspill into adjacent areas. This was also endorsed by the DIPC. Following guidance received from NHSE/I in June 2020, indicating that positive areas should not be converted to negative, the modified systems were converted back to their positive pressures as per design and HTM, providing greater dilution of any airborne virus particles with fresh air changes.

Where ventilation systems were modified, performance verification was carried out by skilled and experienced Technicians. When converted back to their design parameters, the systems were verified by third party specialists.

In COVID-19 Blue areas (C5 and B3) To supplement ventilation in patient bedded areas, which only have natural ventilation in the form of opening windows, extractor fans were installed into fixed pane window frames. This also aided with reducing oxygen enrichment from patients receiving high flow oxygen treatment.

As per the latest HTM 03 requirement, critical ventilation systems including ICU, MHDU, Renal, Theatres, CCU, Lung Function, Endoscopy, Mortuary etc (as defined in HTM 03-01 Part B - 4.7) are annually verified for system performance is in accordance with HTM 03-01, design, and room data sheet (RDS) requirements. Although the ventilation systems serving noncritical areas, which were designed and installed to HTM2025 are inspected in accordance with HTM 03, there is

currently no requirement for systems to be checked for performance at the grilles. The Trust will instruct Mitie FM to routinely check and confirm system performance of all non-critical ventilation systems are in accordance with original design and RDS.

4.2.3 Management of Decontamination

The section below in italics has been completed by Kim Jarrett, the Trusts Decontamination Lead.

DGFT appointed to a 12-month seconded Decontamination Lead post which commenced in September 2021. The Decontamination Leads Roles and Responsibilities Course at Eastwood Park was completed in February 2022.

Since the introduction of the new role there have been a variety of implementations key to providing assurance to the trust in relation to decontamination:

- *A New decontamination Group has been launched which requests reports from a variety of key areas, this meets bimonthly and there is an upward reporting structure to the IPCG.*
- *In order to be able to correctly identify decontamination incidents that occur across the trust a section specifically created for decontamination has been added onto the datix reporting system.*
- *All existing decontamination policies are being reviewed including neonatal and children's services Standard Operating Procedures (SOP)'s which are being amalgamated into one decontamination policy.*
- *National Standards of Healthcare Cleanliness 2021 have been released and the trust are currently working in conjunction with our PFI partners to ensure the required level of cleanliness is reflected in our practice and delivery of services. Decontamination lead has been involved in the implementation of these standards, including being an active member of the Cleaning Working group and have looked through the 6 categories which form part of the cleaning standards which are FR1 through to FR6. A review of all the 50 functional risk areas and cleaning responsibilities for each element have been completed.*
- *An audit of the hospital laundry was reviewed as part of this process due to the laundering of hospital laundry, including reusable microfiber products utilised in the trials for assurance of correct transfer to the laundry, decontamination processes and transfer back to wards and departments.*
- *There has been a review of current track and traceability across the trust. The aim is that all areas where semi critical (high level disinfection) or critical (Sterilization) equipment which is used across the trust must have a track and traceability system available. Changes have been made in cardiology where the introduction of the healthedge system was implemented meaning all equipment can now be linked to individual patients.*
- *Work is ongoing within the imaging department to ensure all invasive probes used within the area have a form of traceability. Trials have taken place and department are working towards implementing this system of decontamination. As an interim measure all probes that are used on individual patients are*

manually recorded to ensure each probe can be traced to each patient. Tristel duo is being utilised currently providing high level decontamination.

- *The nasendoscope which is available in Ear, Nose and Throat (ENT) outpatients is periodically used by ophthalmology. There were some gaps in the process when returning the scope from ophthalmology back to ENT outpatients. Following a review with the departmental managers, the risks associated with decontamination was discussed and new process implemented within the department. Bespoke training is being arranged by the ophthalmology department to ensure staff follow the process and a traceable decontamination system is being used to enable each scope to be traced back to individual patients.*
- *It was identified that ENT outpatients had one sterile tray which equipment for clinics was taken off throughout the day. Decontamination lead discussed with Clinical Nurse Specialist for the area, and this was ceased immediately. Following this discussion, the decision was made to revert to all single use equipment.*
- *Any medical device non-compliance with the Decontamination Policy to be logged via datix*
- *An authorising engineer for decontamination had been identified*

Decontamination Plan for the next 12 months

Over the next 12 months there are a number of key things planned to further strengthen decontamination processes across DGFT. The aim of the next 12 months will be:

- *Completion and final ratification of the decontamination policy and ensure its implementation across DGFT.*
- *A bespoke decontamination audit programme is being planned for the upcoming year which will provide specific focus to decontamination processes undertaken. Audit tool is currently being developed which will provide further assurance to the trust.*
- *To continue to review each area across the trust to assess what equipment is used and what decontamination methods are required. All equipment that requires high level disinfection or sterilisation will be reviewed to ensure there is a form of track and traceability associated with each device for each area.*

4.3 Criterion 3
Ensure appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance

The section below in italics has been completed by Syed Gilani, Syed Gilani, Principal Pharmacist Antimicrobial Therapy for the Trust.

Antimicrobial steering Group at The Dudley Group NHS Foundation Trust is the subgroup of Drugs which reports to quality and safety committee via medicines management group

Antimicrobial Stewardship Annual Report 2021-22

This paper provides an update and an assurance of compliance with standards set out by Health and Social care IPC code of practice for antimicrobial stewardship, Department of Health "Start Smart then Focus" and NICE NG15 (2015) Antimicrobial Stewardship: systems and processes for effective antimicrobial medicines use.

All national CQUINs were suspended for 2021/2022 due to pandemic.

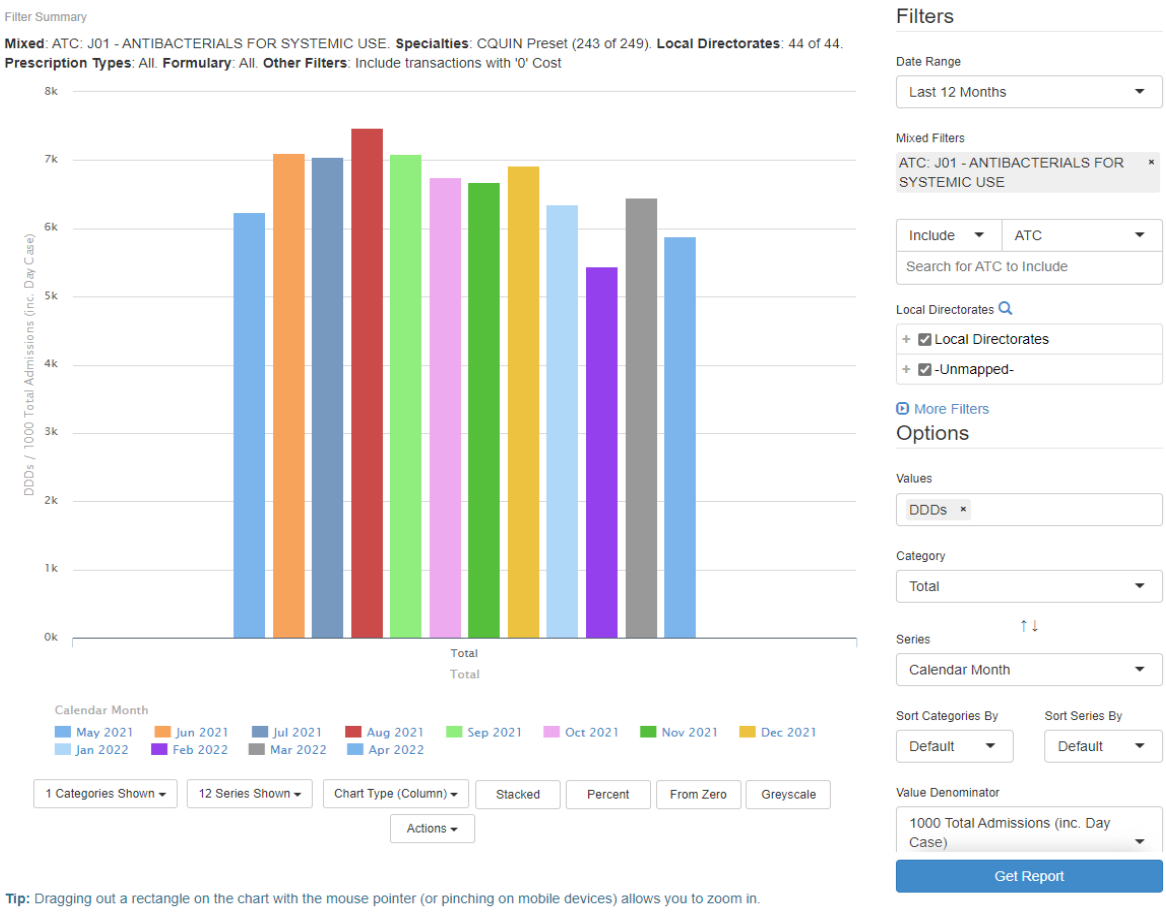
Antimicrobial Consumption

The unprecedented times have fluctuated antimicrobial use significantly.

Total Consumption

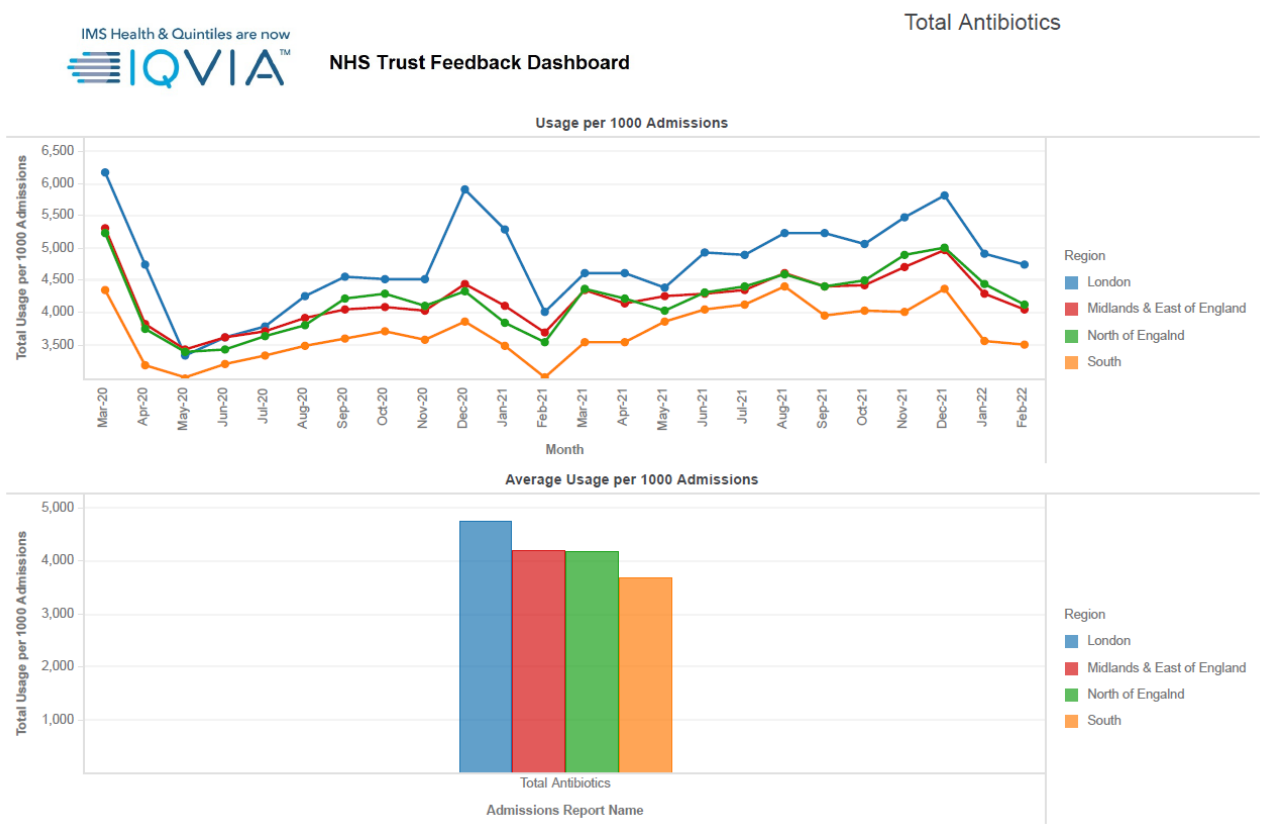
Consumption during COVID-19 Pandemic (2021-2022)

Consumption of antibiotics data including day case admission data



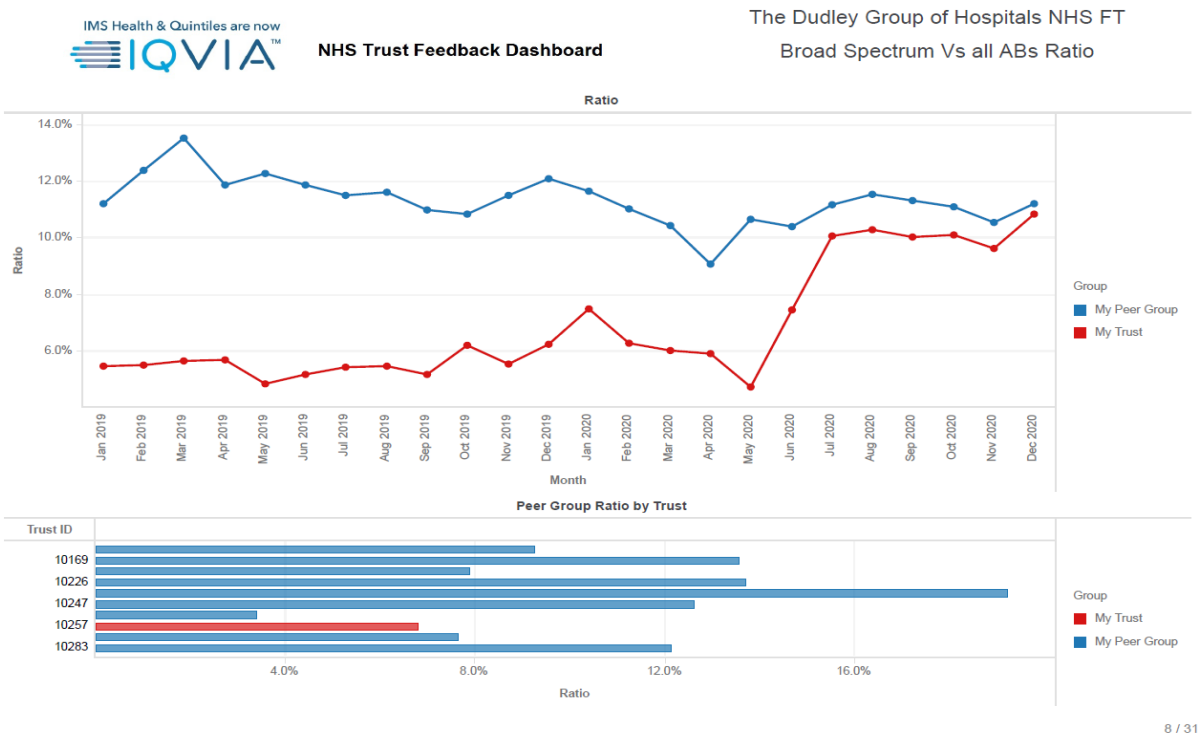
Consumption of antibiotics data excluding day case admission data

National antibiotic consumption per 1000 admissions

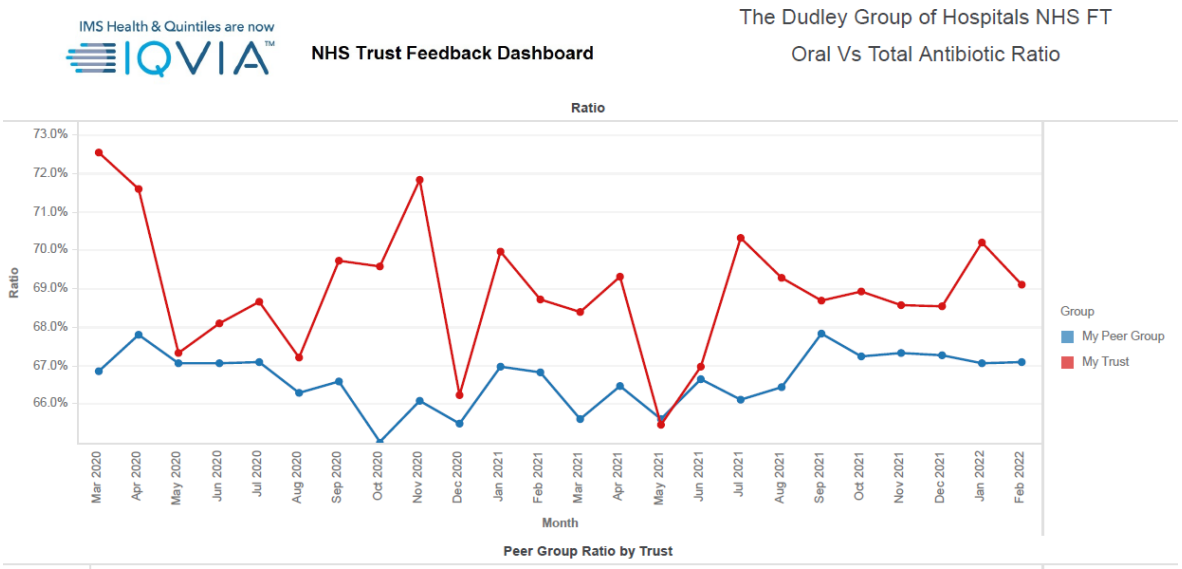


Ratio of Oral vs IV antibiotics

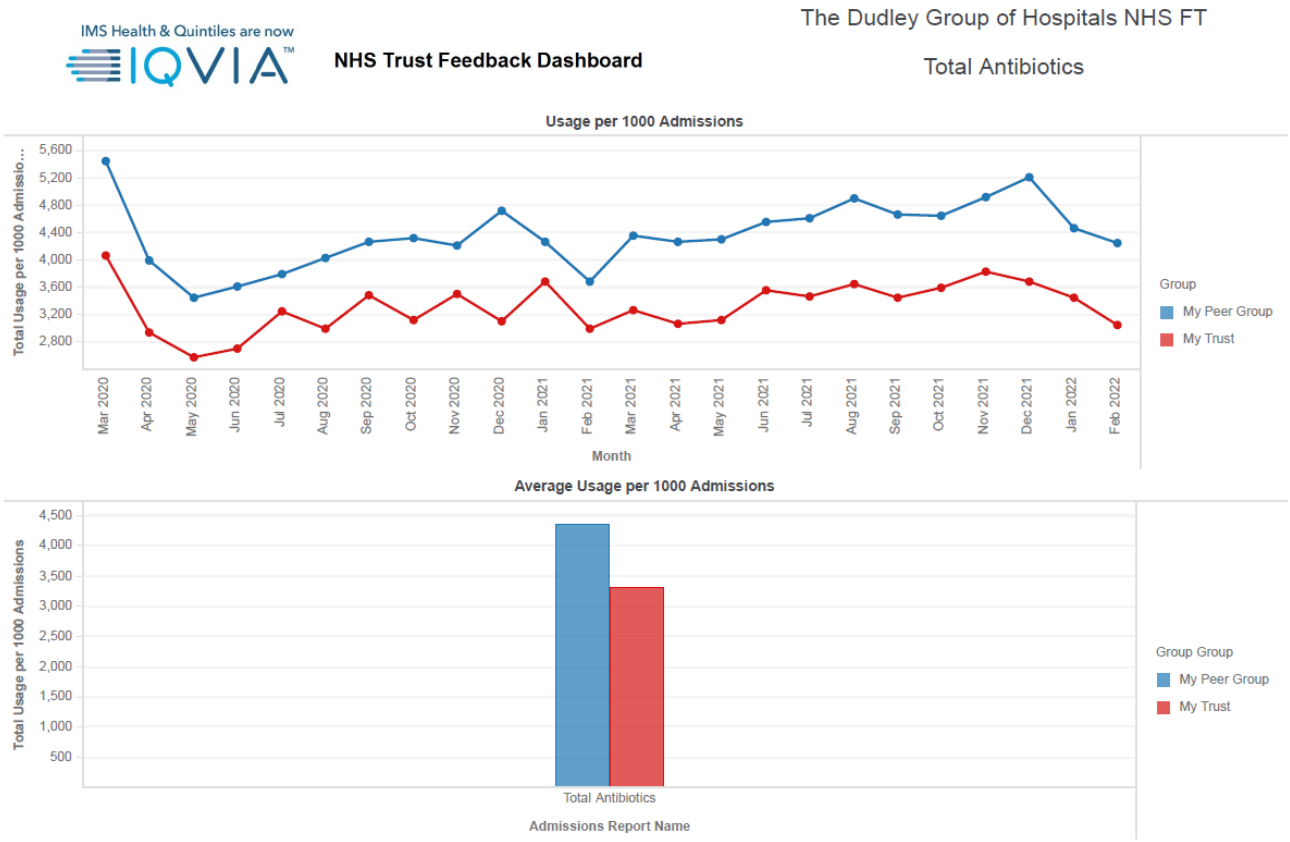
Data suggest Dudley group is performing better compared to its peers.



Oral vs Total antibiotics Ratio of the Dudley Group



Total antibiotics consumption The Dudley Group compared to peers



The Dudley Group NHS Foundation Trust is among the best quantile in England for using access list antibiotics.

Proportion of Access, Watch and Reserve list of antibiotics (Last 12 months)

Access = Narrow spectrum (list provided by NHSE/I and UK HSA)
Watch = Broader spectrum (list provided by NHSE/I and UK HSA)
Reserve = Broader spectrum last line antibiotics (list provided by NHSE/I and UK HSA)

For financial year 2021/2022 the proportion of access list antibiotics used at DGFT was 57%.

Antimicrobial Prescribing snapshot audit

Dudley Group NHS Foundation Trust - Snap shot audit			
		Percentage	Regional target
Number of patients audited	562	100.0	
Allergy Status recorded on chart (NKDA, Yes, No)	562	100.0	> 98%
Number of patients with an allergy who have the nature of the allergy documented	75	45.0	> 98%
Number of patients on Antibiotics	221	39.3	
Number of Patients on intravenous antibiotics	128	22.8	
Number of patients on intravenous antibiotics over 48 hours (>72hrs Jan 2013)	48	37.5	
Number of patients where total course over 5 days (>7days Jan 2013)	30	13.6	
Number of patients where stop / review date documented on the prescription chart	221	100.0	> 70%
Has the indication been documented on the chart/notes?	219	99.1	> 70%
Is patient on Meropenem/Ertapenem? (Of those patients on an IV abx)	10	7.8	< 10%

All the results from the snapshot audits carried out over the last year shows significant improvements, the recurrent issue identified is type of allergic reaction documentation, and discussions have been started with EPMA team to explore a potential solution for it.

Medicines Division Data

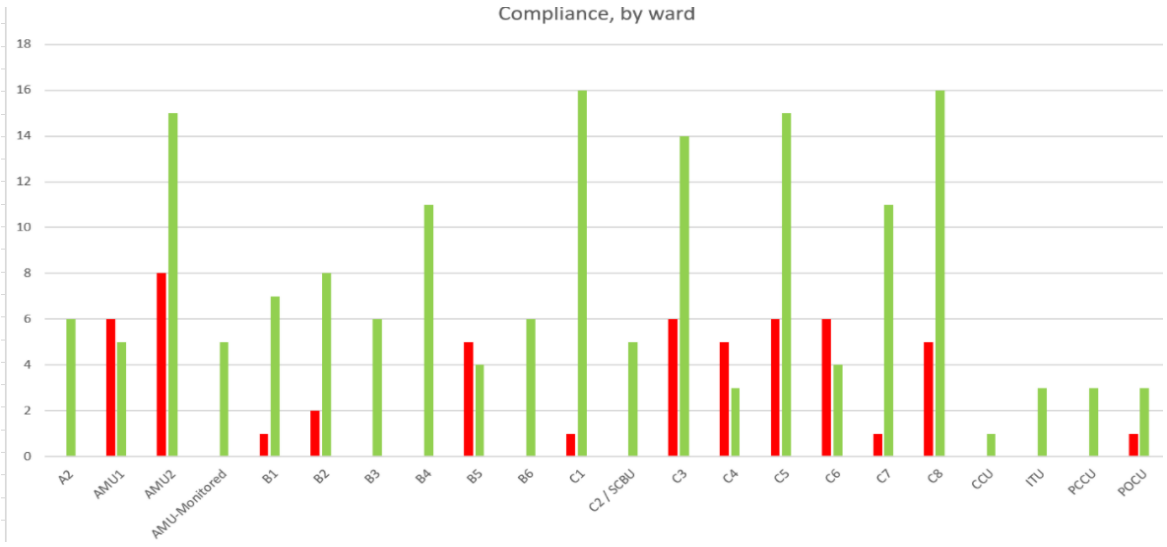
Medicine Divison - Snap shot audit			
		Percentage	Trust target
Number of occupied beds	343	100.0	
Allergy Status recorded on chart (NKDA, Yes, No)	343	100%	> 98%
Number of patients with an allergy who have the nature of the allergy documented	58	46%	> 98%
Number of patients on Antibiotics	163	47.5	
Number of Patients on intravenous antibiotics	86	25.1	
Number of patients on intravenous antibiotics over 48 hours (>72hrs Jan 2013)	33	38.4	
Number of patients where total course over 5 days (>7days Jan 2013)	21	12.9	
Number of patients where stop / review date documented on the prescription chart	163	100.0	> 70%
Has the indication been documented on the chart?	161	98.8	> 70%
Is patient on Meropenem/Ertapenem? (Out of those on an IV abx)	6	7.0	< 10%

Surgical Division Data

Surgical Divison - Snap shot audit			
		Percentage	Trust target
Number of occupied beds	219	100.0	
Allergy Status recorded on chart (NKDA, Yes, No)	219	100.0	> 98%
Number of patients with an allergy who have the nature of the allergy documented	15	39.5	> 98%
Number of patients on Antibiotics	58	26.5	
Number of Patients on intravenous antibiotics	42	19.2	
Number of patients on intravenous antibiotics over 48 hours (>72hrs Jan 2013)	15	35.7	
Number of patients where total course over 5 days (>7days Jan 2013)	9	15.5	
Number of patients where stop / review date documented on the prescription chart	58	100.0	> 70%
Has the indication been documented on the chart?	58	100.0	> 70%
Is patient on Meropenem/Ertapenem? (Out of those on an IV abx)	4	9.5	< 10%

Compliance by ward

Compliance by ward was fed back to respective directorate Pharmacists who then took the data to respective directorates for reporting and improvement plans.



Current data shows:

- *A reduction in the proportion of patients on antibiotics*
- *A reduction in the nature of allergy documentation*
- *An increase in the relative proportion of patients on a carbapenem*
- *Reviews not documented (EPMA might help in improving)*

- *Allergy nature*
- *Documentation is limited and potential solutions are being looked at with EPMA team.*
- *Currently working on an IT solution for easy data collection moving forward.*

The documentation of stop/review date seems low however, data collected within the snapshot audit is limited to active prescriptions and does not include documentation of stop/review in the medical notes.

Patients on restricted antibiotics e.g., meropenem & piperacillin/tazobactam (which are not recommended in the Trust guidelines or approved by microbiology) are referred to the antimicrobial pharmacists.

The pharmacy team monitor and raise awareness at ward level on how to correctly document allergy status on prescribing system.

OPAT data 2021/2022

Bed Days Saved by Type

01/03/2021-28/02/2022

Type	Episodes	Treatment Days Saved
Admission Avoidance	90	1260
Early Discharge	86	2212

From the selected records this shows the total episode count and number of bed days saved (ie Opat Stop Date - Opat Start Date) by OPAT Type.

Interventions over past 12 months to improve Antimicrobial Stewardship at DGFT

The targets were achieved with the help of multiple initiatives i.e.

- *Executive level reporting to influence change.*
- *Project group formed including medical director, chief pharmacist, AMS team, Sepsis leads and service improvement.*
- *Antibiotic awareness week campaign (completed).*
- *Multiple guidelines updated and published on microguide through the year.*
- *NICE guidance baseline assessment completed.*
- *Audit tool designing for antimicrobial prescribing on EPMA in progress.*
- *Antimicrobial usage during surge is being analysed locally and nationally. Report suggest surge in use (admission data might have affected)*
- *COVID-19 therapeutics guidelines added to Microguide for easy access*
- *EPMA antimicrobial prescribing TDM modules are being tweaked to improve them further.*
- *EPMA antimicrobial prescribing module in place so far no major issues, work being carried out to increase clinicians' awareness on ward level.*
- *Patient safety bulletin published online and sent to all staff.*
- *Hub communication/ screen saver produced to raise awareness.*
- *Discussed and shared plans at West midlands Antimicrobial Pharmacists Group.*
- *Junior Dr antimicrobial prescribing teaching sessions completed.*

- *Teaching session completed for all Pharmacists on AMS principles.*
- *Antimicrobial stewardship section in Trust wide Governance newsletter.*
- *Acute medicine Junior Drs are involved for assisting in data collection.*
- *Antimicrobial stewardship session delivered to community team.*
- *Feedback to the divisions provided via Antimicrobial Stewardship Group (ASG).*
- *OPAT virtual ward rounds started (Antimicrobial Pharmacist, Microbiologist, and In-charge OPAT Nurse).*
- *Monthly Antimicrobial stewardship report provided monthly to Infection Prevention and Control Group, Drugs and Therapeutics Group &Medicines Management Group.*
- *C diff ward rounds started once a week the team include an antimicrobial Pharmacist and an IPC Nurse.*
- *DGFT (antimicrobial stewardship (AMS)) team has led on the development of COVID-19 therapeutic pathways which were accepted and adapted by the Black Country and West Birmingham (BCWB) system.*
- *DGFT AMS team also heavily contributed to the national COVID-19 vaccination program and provided senior leadership and clinical expertise.*
- *Pelvic inflammatory disease antibiotic guidelines are updated, (awaiting publishing).*
- *Orbital cellulitis guidelines are agreed.*
- *CQUIN 2022 target and action plan agreed.*
- *Bronchiectasis guidelines are agreed after looking at the local antimicrobial resistance trend.*

COVID-19 therapeutics

COVID-19 treatment algorithms are developed by The Dudley Group which were approved and shared across Black Country and West Birmingham (BCWB) Integrated Care system (ICS). The algorithms were aimed to simplify the available treatment options for Clinical teams.

ICS AMS Group

The Dudley Group AMS team took the initiative to establish an ICS wide AMS group. The ICS AMS group reports to Clinical leadership group via the IPMO PLG group. The group is looking into all the sectors across the system.

Education and Training

Mandatory training for clinicians in antimicrobial prescribing and stewardship continues to take place. All doctors new to the Trust are provided with antimicrobial training at induction. Better Training Better Care for FY1 and FY2 doctors in Antimicrobial Prescribing received excellent feedback from the participants. Additional training sessions have also been carried out through the year when guideline changes have occurred.
Teaching sessions for CMTs are delivered around antimicrobial stewardship and infection management.
Grand rounds around CQUINs and antimicrobial stewardship is delivered whenever required.

Pharmacists receive regular feedback on antimicrobial prescribing in their clinical areas after the snapshot audits, pharmacist prescribers' complete online modules on antimicrobial prescribing.

Feedback is provided to clinicians after every RCA for C. diff infections.
Teaching/training sessions are delivered to primary care teams of Dudley to improve health economy wide antimicrobial stewardship that include primary care and CCG pharmacists and community/district Nurses and ACPs.

Research

AMS team is always looking for research opportunities and is involved in all the studies carried out in Trust around infection management.

AMS team completed a study in collaboration with Acute medical team around prevalence of increasing beta lactam resistance in gram negative organisms at DGFT which has been published.

AMS team also contributed to the development of national guidelines for treatment of CPE infections.

An undergraduate final year Pharmacy research project was completed on "Impact of pandemic on antibiotic consumption and C diff rates at Russell's Hall hospital," in collaboration with Birmingham University.

An undergraduate final year Pharmacy research project was completed on "resistance patterns of E coli blood culture isolates at Russell's Hall hospital" in collaboration with Aston University.

The AMS team enrolled and took part in the national quality improvement project around Gentamicin prescribing and monitoring "Co-Gent" which is run by the NITCAR (National infections teams collaborative for audit and research).

Current Challenges

- *COVID-19 has presented unprecedented challenges currently the national target of reduction in total consumption of antibiotics (Watch and Reserve list) seems unrealistic to achieve within the timeframe specified.*
- *Encouraging already stretched clinicians to represent their areas at ASG meetings.*
- *Capacity of AMS team is limited therefore ward presence is low. Currently 1 x Consultant Microbiologist vacancy with one substantive and one Locum in post. This limits pro-active monitoring through limited ward visits.*
- *Antibiotic shortages are unpredictable and require frequent guidance changes leading to prescriber confusion.*
- *Lack of e-PMA solution for capturing prescribing data at present is making the snapshot audits laborious (IT is developing a solution for it).*

Plans for 2022/2023

- *Assess the impact of COVID-19 on antimicrobial stewardship and consumption after the pandemic ends.*
- *Review guidelines in view of new NICE guidance issued in coming months.*
- *Continue working as a part of sepsis work streams: created "Sepsis team" (4x sepsis nurse practitioners' band 7s + 2 x antimicrobial pharmacists+ Consultant Physician)*
- *Focus on drive for IV2PO switch – septic patients flagged to antimicrobial team. Reinforce the need for a high standard antimicrobial stewardship at pharmacist clinical huddles. IV2PO switch has been set as a high priority item on national agenda for AMR.*
- *Training sessions with all pharmacists to highlight the changes and rationale.*
- *Engage clinicians from medical and surgical divisions to attend ASG meetings and feedback to respective directorates.*
- *Regular snapshot audits to assess antimicrobial prescribing.*

- *Increase the frequency of AMS ward rounds currently 3 days a week on critical care, 2 day a week on Medical HDU and 1 days a week on acute medical wards.*
- *Regular communication in the form of patient safety alerts, screen savers, trust wide communication emails on changes in processes and guidance.*

- *Scope further expansion of antifungal stewardship.*
- *Support postgraduate diploma pharmacists in conducting clinical audits as part of their infectious disease module.*
- *Support 2022/23 pre-registration pharmacists with antimicrobial audits and teaching if required.*
- *Patient safety bulletins around arising issues over the year.*
- *Organise and promote Antibiotic awareness week 2022.*
- *Identify opportunities for research and development around antimicrobial stewardship.*

Syed Gilani,
Principal Pharmacist Antimicrobial Therapy

4.4 Criterion 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

- DGFT has a dedicated communication team. In cases of outbreaks where there may be interest from the media, the Communications Team are invited to meetings and their support and guidance on preparing Press statements is sought.

- Communication boards are located across the Trust providing patients and visitors of key communication

- The IPC Team have a page on the Trust intranet page which provides information to staff. The external Trust website also has key messages relating to infection control.

- The Trust Intranet promotes infection prevention issues and guides users to information on specific alert organisms such as MRSA and *Clostridioides difficile* as well as key organisms that may be of particular concern seasonally.

In January 2022, the IPC Team produced a newsletter for staff called “We’ve gone Viral” which provides updates to staff on current IPC matters. This newsletter will be published on a bi-monthly basis.

  - IPC produced an annual report covering the organisation’s approach to prevention and control of infections for publication on the DGFT website.
  - Hand hygiene included in patient/visitor/volunteer/staff/agency staff and visiting health
  - professionals’ information leaflets.
  - Strategically placed hand hygiene products available with information on how to use.

- Continued to encourage patient and public involvement in hand hygiene and cleanliness campaigns and services' Quality Review process, satisfaction surveys and PLACE inspections.
- Polices related to specific organisms and care pathways remind staff of the need to give affected patients and relatives leaflets about the infection.
- Information leaflets revised and placed on the DGFT public facing website informing patient/public on specific infections and hygiene measures they can adopt to reduce the risk of infection.
- The IPC team and other members of staff continue to respond to ad hoc requests for information related to IPC under the Freedom of Information Act.
- IPC requirements are included in the health economy transfer/discharge form.
- IPC team share infection rates and outbreak information with appropriate services based upon local, regional, and national surveillance.
- Alert organism surveillance by the IPC team.

- IPC policies available.
  - MRSA screening compliance shared.

4.5 Criterion 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.

The IPC Arrangements and Responsibilities policy reflects the management and reporting structure of SCHT outlining its collective responsibility for IPC and demonstrating responsibilities are disseminated to all staff/groups in the organisation.

- Responsibilities of groups and staff included in IPC policies.
- Support provided by IPC team included visits and telephone contact.
- Continued to develop link staff and support their role.
- Continued to audit compliance with IPC polices and care pathways.
- IPC team access to IC NET Laboratory IT systems allowed enhanced alert organism surveillance.
- IPC team reported outbreaks and incidents of infection to the CCG, UK HSA and NHSE/I. Outbreak of infection meeting are held with external partners and agencies to ensure transparency and that any lessons learnt are disseminated throughout the organisation
- IPC received notification of outbreaks of infection within the local health economy.
- IPC specific organism policies available e.g., MRSA, CDI, VRE/GRE.
- Patients are screened for MRSA on admission.
- Patients are screened for COVID-19 on admission.
- Blue, Amber, Green clinical pathways available to aid correct patient placement

- Twice weekly COVID-19 Lateral Flow Testing (LFT) was introduced to all patient facing staff in November 2020 this was offered to all staff in February 2021 and continues to be recommended. Weekly LAMP testing was discontinued in February 2022
- Antibiotic policy available to all clinicians.
- PIRs will be undertaken on all MRSA Bacteraemias.
- Use of SIGHTED mnemonic (see images 3 and 4 referred to earlier).
- Ward staff advised to use isolation checklist to ensure compliance with isolation policy.

4.6 Criterion 6
Systems to ensure that all care workers (including contractors and volunteers) are aware of their responsibilities in the process of preventing and controlling infection.

At DGFT infection prevention is of paramount importance and everyone's responsibility, it is included in all job descriptions across the Trust.

All clinical staff receive training and education in infection prevention and control practices during their induction and mandatory training sessions. Additional bespoke training is provided to wards and departments as necessary and in response to shared learning.

The graph below identifies the compliance of mandatory IPC Training throughout the year. For each month compliance has been above 80%, however due to the COVID-19 pandemic these scores were not achieving the required objective of 90% compliance. Scores started to improve at the end of the financial year and following divisional escalation IPC Training continues to be a key priority in order to ensure the Trust reaches this objective with improvements in compliance being observed.

- Continued to work with NHS providers and facilitated by the LHE group, to aim to reduce all avoidable infections including MRSA Bacteraemia and CDI.
- Alerts are added to sunrise to highlight risk of infection.
- Compliance with MRSA screening policy audited monthly, and findings shared.
- As appropriate, joint investigations and reviews held between local partners and the acute trust on cases of MRSA Bacteraemia and CDI.
- To assist staff with managing outbreaks,
- Bespoke IPC Training is delivered if need identified.
- IPC team supported the development of DGFT clinical policies/procedures and Standard Operating Procedures (SOPs).
- Infection Prevention and Control Standard Operating Procedure for Building, Construction, Renovation and Refurbishment Projects in available for all contractors working in DGFT.
- Lateral flow testing is recommended to be undertaken twice weekly. Weekly LAMP testing was discontinued in February 2022

4.7 Criterion 7
Provide or secure adequate isolation facilities

Spread of infection in healthcare facilities may be prevented by isolation or other barrier procedures, which may vary, according to the nature of the infection. Isolation may involve either source isolation, whereby infected patients are nursed with precautions necessary to prevent the spread of infection to others, or protective isolation, which is used for patients at special risk of acquiring infection such as haematology or oncology patients.

There is a policy in place which has been updated in 2022 to ensure that patients are isolated appropriately.

The decision to isolate a patient should be based on a risk assessment with regular assessments taking place to ensure the most appropriate use of the isolation facilities. 25% of the inpatient beds at Russell's Hall Hospital take the form of single ensuite rooms which are prioritised for patients with either confirmed or developing signs of infection.

In addition to the Isolation policy a Zoning Standard Operating Procedure (SOP) was developed in March 2020 due to COVID-19 which identified that for the duration of the COVID-19 clinical facilities at DGFT will be segregated into differing zones. Patients will be admitted in to or moved between the different zones dependent on their COVID-19 status. All patients admitted to an inpatient bed will be swabbed for COVID-19 on admissions, day 3, day 5, day 7, day 13 and weekly regardless of whether they display any signs or symptoms of the disease. The zoning introduced was:

- Green zone – proven COVID-19 negative
- Yellow zone – admissions where COVID-19 test results are still awaited
- Blue zone – confirmed COVID-19 positive or very high clinical suspicion of COVID-19 infection who have had a negative test, -these patients are to be placed into a side room within a blue area.

This SOP has been updated regularly due to changes in National Guidance.

- IPC Isolation Policy in place to support staff.
- Isolation Policy updated in 2020/21 to include COVID-19
- Isolation Risk matrix developed to aid patient placement
- Risk assessments performed by ward staff with support from the IPC team when insufficient isolation facilities were available to meet demand.
- Cohort approach taken as necessary within DGFT during outbreaks of diarrhoea and vomiting.
- All episodes where staff are unable to isolate patients are reported to Risk Management via Datix.

4.8 Criterion 8
Adequate access to laboratory support as appropriate

The IPC Team work closely with the clinical microbiology department which provides comprehensive microbiology advice. The laboratory forms part of the Black Country Pathology Services (BCPS) which covers 4 hospital sites to include The Royal Wolverhampton NHS Trust, The Dudley Group NHS Foundation Trust, Sandwell and West Birmingham NHS Trust and Walsall Healthcare NHS Trust.

The trust has access to a CPA/UKAS accredited laboratory. The clinical microbiology departments provide support to the IPC Team through reporting of results, processing of clinical samples and provision of expert microbiological advice as required. Electronic systems are available for the reporting of alert organisms. Out of hours, the on-call duty microbiologists will provide Infection Prevention and Control advice for the Trust. Funding has been secured for upgrading the current IC Net system in June 2022.

- Continuation of rapid testing for *Clostridium difficile* and use of typing to search for clusters and linked cases.
- Continuation of local test for Norovirus to speed up diagnosis and outbreak management of patients with infection.
- Continuation of local test for influenza to speed up diagnosis and outbreak management of patients with infection.
- Local testing for COVID-19.
- Pint of Care testing available in Emergency Department for COVID-19
- Adequate resources available in laboratory for MRSA screening in line with national guidance.
- Mandatory surveillance also included MSSA, *E.coli* , pseudomonas Bacteraemia infections.
- Consultant Microbiologist at DGFT's is SCHT's IPC Doctor.
- Medical microbiology support provided by DGFT 24 hours a day 365 days a year.

4.9 Criterion 9
Have and adhere to policies, designed for the individual's care and provider organisations that help to prevent and control infections

All IPC policies, guidelines and SOPs are available for staff to view on the Trust Intranet site, the HUB. Access to these are clearly displayed under the documents section and there is a link on the IPC page for ease of use. A formal Governance structure is in place for the development, reviewing and ratifying such documents and is monitored via the IPC Group meeting.

- Rolling programme of policy / SOP review continued.
- Published evidence reviewed whenever policies were developed or reviewed on publication of new national guidance to ensure they reflect up to date, evidence based, best practice national guidance.
- New policies developed as need identified.
- In collaboration with Medicines Management team, commenced work to implement the relevant recommendations of the Tackling Antimicrobial Resistance 2019-2024, the UK's five-year national action plan.

Below is a list of all of the policies which relate to IPC and the date of review:

Title	Review Date
Policy	
IPC Peripheral Venous Catheters Policy	31/07/2021
Control of Infections with Specific Organisms Policy	31/12/2021
Infection Control in the Built Environment Policy	31/05/2022
Hand Hygiene Policy	31/05/2022
Diarrhoea Management of Patients and Staff Policy	31/05/2022
Glove Policy	31/08/2022
Infection Control General and Medical Devices Decontamination Policy	31/10/2022
MRSA Screening Policy	30/11/2022
Isolation of Patients policy	31/07/2024
Standard (Universal) Infection Control Precautions Policy	31/07/2024
Infection Control Precautions in Pandemic Flu Policy	31/07/2024
Infection Control Precautions for Extended Spectrum Beta Lactamase (ESBL) and AMPC Producing Organisms Policy	31/07/2024
Control of an Outbreak of Infection in Hospital Policy	31/07/2024
Cleaning and Disinfection Policy	31/07/2024
Carbapenemase Producing Enterobacteriacea (CPE) Screening, Management and Prevention of the Spread Policy	31/07/2024
Reporting Infections to Public Health England and Local authority Policy	31/11/2024
Scabies	31/01/2025
Group A Strep Policy	31/01/2025
Transmissible Spongiform Encephalopathies (TSEs) Policy	31/03/2025
HCAI Surveillance Policy	31/03/2025
Clostridium difficile Policy	31/03/2025

Compliance with policies was audited locally through the hand hygiene, cleanliness and IPC audit tools/checklists, specific competency tools and peer assessments. Specific audits undertaken by the IPC team as part of their annual programme, clinical incident reporting and root cause analysis of infections including debrief meetings were also used to monitor compliance.

4.10 Criterion 10
Providers have a system in place to manage the occupational health needs of staff in relation to infection

4.10.1 Staff Health and Wellbeing (SHAW)

The section below in italics has been completed Karl Brookes MSc.BN(Hons)RGN FRSPH Occupational Health Service Lead and Carl Banks DIP HE & BSC (Hon's) RGN & RSCN Snr Occupational Health Nurse Advisor.

Staff Health and Wellbeing (SHAW) offer a wide range of services aimed at reducing ill health at work and supporting those at work with health problems and disabilities. Below, is a list of the services provided within Staff Health and Wellbeing at the Trust:

- *New employee health assessments where necessarily with pre-existing conditions, all new employees have immunisation screening*
- *Crisis support post incident or ill health (duty line)*
- *Immunisations (Hepatitis, MMR, Flu, pertussis)*
- *Screening for immunity to blood borne viruses*
- *Manage needle stick/ splash/ contamination incidents for staff*
- *Management referrals in order to assist with sickness management.*
- *Health and lifestyle advice*
- *Work related health surveillance-Covid exposure health risk assessments*
- *NHS Health Checks*

- *Skin Assessments*
- *Long Covid clinic via self-referral and management referral*

The below table shows the activity levels for the SHAW service for 2021/22

SHAW Activity 2021/22	Total
Blood Test	129
Counselling	376
Covid 19 Assessment	14
Long Covid Review and Support	81
Immunisations / Immunisation Review	2150
Lung Function Test	16
Management Referral	672
Mantoux Test / Results	74
Needlestick Injury / Follow up	233
Pre-Employment	440
Self-Referral Meeting / General Advice	228
Skin Assessment	143
Grand Total	4556
The above categories includes both telephone, email & face to face meetings.	

As well as the 'in-house' Occupational Health Provision the Trust has an external Employee Assistance Programme (EAP) through BHSF RISE who provide the Trust with free and confidential help and advice 24 hours a day 7 days a week. Within this provision is a staff counselling service.

4.10.2 Health and Safety

The section below in italics has been completed by Jody Griffin, the Trusts Health, and Safety Advisor.

The Health & Safety team have carried out several IPC related audit and projects in the year April 2021 to March 2022.

These audits/projects have included:

- *Social distancing Audit*
- *Sharps Audit*

1. Social distancing Audit

The Dudley Group Foundation Trust has a legal obligation to protect employees at work, in accordance with the Health and Safety at Work Act 1974. Since the outbreak of SARS-COV-2, a respiratory disease, in December 2019 in China, and here in the UK in February 2020, social distancing measures have been implemented across the trust to limit the transmission of the virus within the workplace.

Several measures were implemented across the trust to aid social distancing in non- clinical areas such as breakrooms, changing facilities and offices.

An initial audit was carried out in December 2020 to determine the level of compliance across the trust. The audit was carried out again in April, June, and September 2021 to ensure that there is ongoing compliance and that risk assessments remain suitable and sufficient in line with emerging government guidance.

The social distancing audit checklist (fig. 1) evolved from the original checklist but is more robust. The audit now incorporates checking ventilation and that face fit testing records are stored appropriately. The results are then added to a compliance dashboard (appx.1) to show which departments are fully, partially, or non-compliant and in what areas. More departments have been included in the new audit to ensure that all areas are included.

Fig.1. Social distancing checklist

NHS
The Dudley Group
NHS Foundation Trust

Social Distancing Audit check list

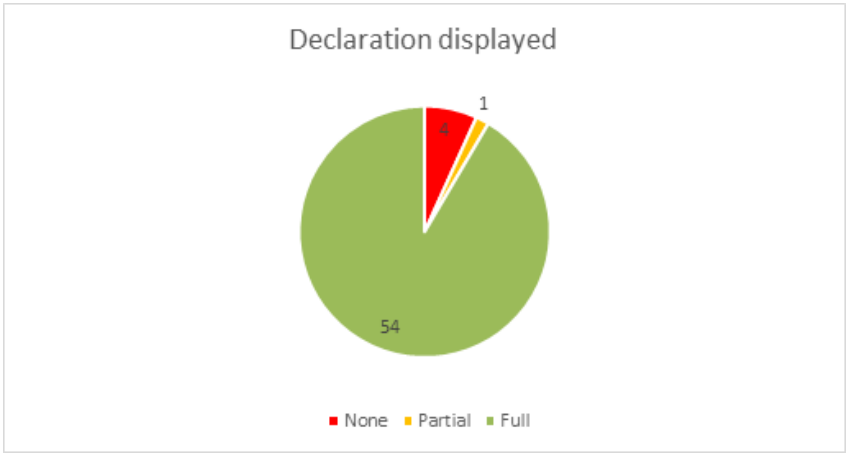
Department: Site: Date:

Measures	Yes/No	Comment
• Social distancing RA in place? • Evidence of review? • Suitable and Sufficient?		
Covid secure declaration in place?		
Max occupancy displayed: • Break rooms • Changing rooms • Offices/ Meeting rooms		
Clinell wipes available?		
Masks being worn when appropriate? Are face fit testing records available (for FFP3 and respirators)? Are they also stored in personnel files?		
Alc gel/ hand washing facilities available?		
Ventilation (Natural/ Mechanical) windows open, air change units?		

Compliance has been split in to full, partial and none. Full compliance shows that all criteria has been met across the whole department, partial shows that criteria has been met across most of the department (may have one or two rooms without occupancy displayed for example) and none means the department is unable to demonstrate the criteria in across any of the department/ward. A further audit was also carried out on the risk assessments sent from each department (December 2020) for social distancing in non-clinical areas. The aim of the audit was to check that the risk assessments were suitable and sufficient and contained key information around ventilation, face masks/coverings, staff Covid testing and hand hygiene facilities as well as other measures such as sneeze screens, temperature checking and staff vaccination (appx. 2). The risk assessments were then reviewed again in June 2021.

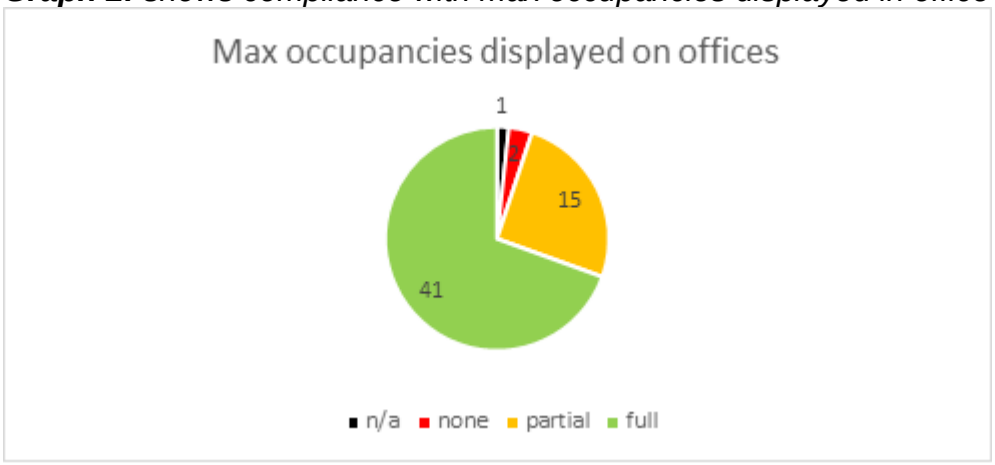
Results:

Graph1 *shows the compliance for Covid secure declarations across the trust for the areas audited*



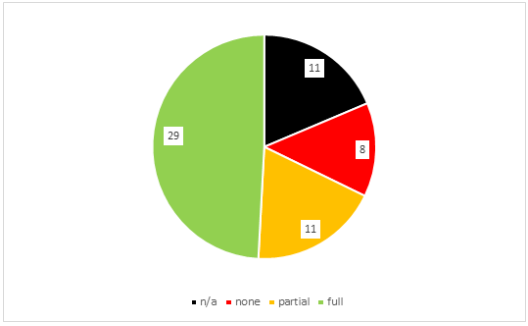
91.5% of departments audited were full compliant with displaying the Covid secure declarations, 1.7% were partially compliant and 6.8% were noncompliant. The full compliance has dropped by 4% since the last audit in June 2021.

***Graph 2:** shows compliance with max occupancies displayed in office areas across the trust*



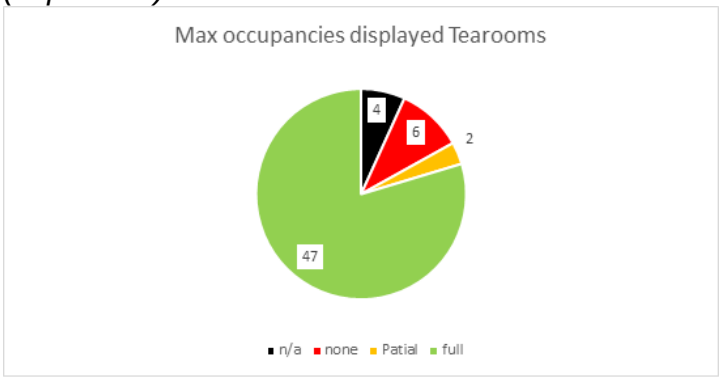
The graph shows that 69.5% of departments were fully compliant in Sept 2021: a drop of 20% since the last audit in June 2021.

***Graph 3** showing the compliance rates for max occupancies displayed on changing rooms (Sept 2021).*



Full compliance for max occupancies displayed on changing rooms sits at 49%, partial 18.6% and noncompliance 13.6%, the other departments do not have changing rooms.

***Graph 4** showing the compliance rates for max occupancies displayed on tea/break/staff rooms (sept 2021)*



Departments that were fully compliant sits at 79.6% , with partial being 3.4% and noncompliant being 10.2% with the remainder of the departments not having a tea/break room.

Graph 5: *Showing ventilation in each department and hand hygiene facilities as a percentage as of Sept 2021.*

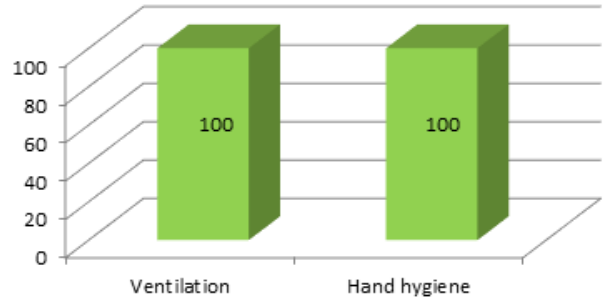


Table 3: *Showing the results from the social distancing risk assessment audit as of June 2021.*

Risk assessments available to audit	Percentage Reviewed	Percentage of RA s where ventilation is considered	Percentage of RAs where lateral/Lamp testing is considered?	Percentage risk assessments where vaccinations are mentioned?
72%	100%	96.5%	98.2 %	96.2%

Findings:

The social distancing audit has shown a reduction in compliance from the original audit across the board. This may be due to more departments being audited in this audit from the first one. Covid declarations have been removed due to either infection control guidance or painting work and not put back up. These departments have been re-audited to ensure that these signs have been replaced as advised by the auditor. The main finding was that max occupancy was not displayed on changing areas doors. Some areas may have the signage inside the changing rooms, but the auditor was not able to access these due to key code lock restrictions.

There is a new social distancing risk assessment template available on the Health & Safety hub page to guide departments to write a suitable and sufficient risk assessment. This template is more comprehensive and includes ventilation, staff testing, PPE and other measures implemented. The template can be edited to reflect the departments control measures. Risk assessments were requested to be submitted again to the health & safety team in June 2021.

The June audit of the social distancing risk assessments saw 72% of departments send in the risk assessments for review. Of the risk assessments reviewed, 96.5% mentioned ventilation and just over 96% mentioned staff testing. This is an improvement since the last audit (December 2020) with increases of 80% and 90% respectively.

2. Sharps Audit

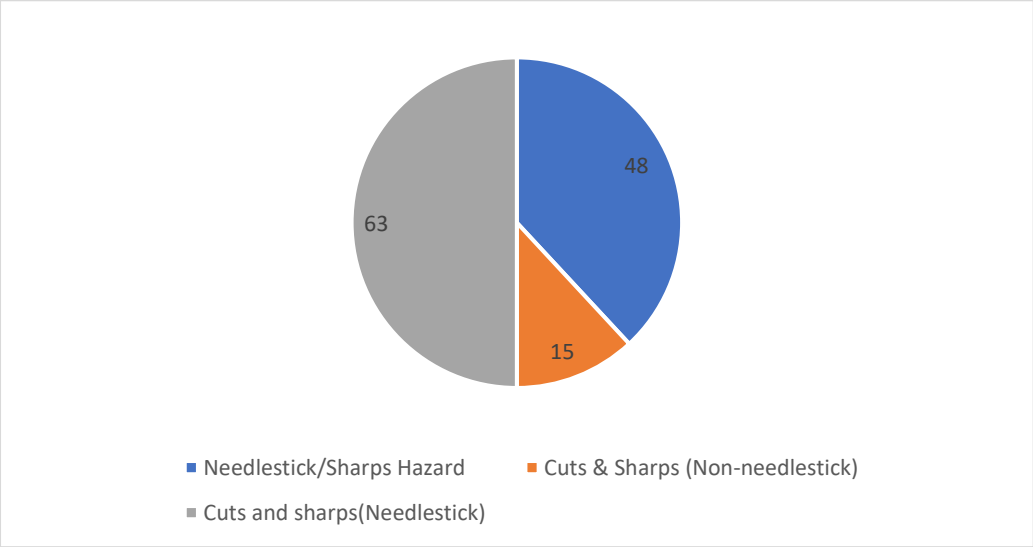
Correlation of sharps incidents with non-safe sharps (needles) use

Introduction:

The purpose of this paper is to look at the correlation of needlestick sharps incidents. Please note non-needlestick related devices such as scalpels, and mucocutaneous exposures, have not been included in this report as non-needlestick injuries are infrequently reported.

As a Trust, a large proportion of incidences reported via the Datix reporting system are sharps injuries. These can be broken down into Sharps/Needle stick or Sharps/ Non-needle stick. For the last years (1st April 2021- 31st March 2022) sharps incidents have accounted for over 42% of all reported incidents or near misses with 125 sharps incidents reported. The pie graph below shows the breakdown of Sharps category for these incidents.

***Graph 1**: Showing breakdown of Sharps Incident by type for incidents reported between 1st April 2021- 31st March 2022*



Graph showing over 88% of Sharps injuries reported between 1st April 2012-31st March 2022 were needlestick injuries, with less than 12% cuts/sharps injuries from non-needle devices.

***Table 1**: Level of harm for Sharps incidents reported between April 1st, 2021, and March 31st, 2022.*

Level of Harm	Number of incidents
No harm	60
Near miss	0
Low	50

Of these incidents, 3 have been reported to the HSE (Health & Safety Executive) under RIDDOR (Reporting of Injuries, Diseases and Dangerous Occurrences Regulations) as they have involved sharps that have been used on known patients with blood borne viruses. One incident, reported in October 2021, was picked up by the HSE and further information was requested in relation to the Trusts Safer Sharps Policy.

Using the Datix system, the number of sharps incidents was gathered for the period 1st April 2021-31st March 2022 and broken down by department. The procurement team gathered a list of departments ordering non-safety needle devices. The data was then compared to see if the

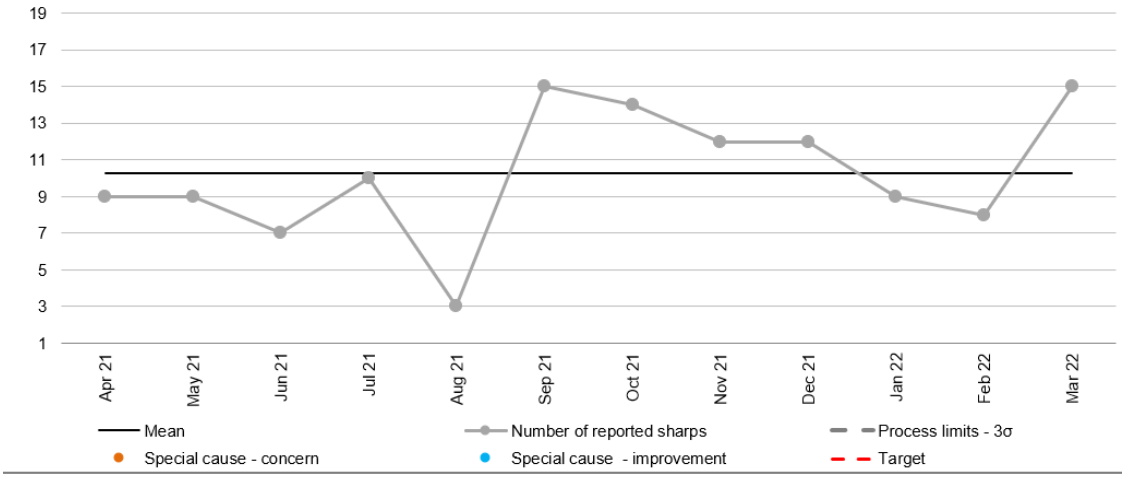
departments reporting the higher number of sharps incidents are those ordering non-safety needle devices.

***Table 2**: Departments reporting highest numbers of Sharps injuries between 1st April 2021-31st March 2022.*

Department	Sharps incidents	Percentage
A&E	16	12.80%
Theatres (Main)	11	8.80%
Maternity (Obstetrics)	9	7.20%
AMU 1	7	5.60%
C2	4	3.20%
C8	4	3.20%

The table shows that A&E has the highest number of sharps incidents reported within the specified timeframe, followed by Theatres and Maternity (Obstetrics). A&E accounts for over 12% of the 125 sharps incidents reported between 1st April 2021-31st March 2022.

Graph 2: Plot the dots graph showing the trend of sharps incidents between April 1st 2021-March 31st 2022



Graph 1 showing the number of sharps incidents reported on Datix each month from 1st April 2021- 31st March 2022. The spikes evident in September 2021 and March 2022, cannot be determined from a single cause.

A Sharps Task and Finish group has now been established to look at the sharp's devices in use across the Trust to try to reduce the number of Sharps incidents. Trends will continue to be monitored.

Section Five: Looking Forward to 2022/2023

5.1 An Overview of Infection Prevention and Control Programme 2022/23

This section gives an oversight of the work planned to prevent and control infections in 2022/23 and to achieve external thresholds and comply with the Code of Practice on the prevention and control of infections. It is designed to reflect DGFT's Quality Strategy to deliver care that is clinically effective; care that is safe; and care that provides as positive an experience for patients as possible.

The key aims in 2022/23 will be to build on the work that has been done in previous years to prevent HCAIs and improve the lives of the people who come into contact with DGFT services. Patient safety is at the heart of IPC, and to ensure our work is sustainable, DGFT promotes that every member of staff takes responsibility for IPC in order that that **no person is harmed by a preventable infection.**

Infection Control Strategy focus for the upcoming year are:

- Minimise the risk to patients from healthcare-associated infection and prevent all avoidable HCAI's
- Maintain compliance with all requirements of the Code of Practice for Health and Adult Social Care on the Prevention and Control of Infections and related guidance 2015
- Continued commitment to working in partnership with other healthcare providers and the multidisciplinary team
- Continued delivery of education and training on prevention and control of infection so that staff understands their responsibilities and action to take
- Review and improve internal processes and systems related to infection control and PFI partners
- Enhanced surveillance of infections and learning through actions
- Support proactive antimicrobial stewardship within the Trust
- Ensure appropriate information relating to infection risks is communicated to relevant parties.
- Ensure collaborative working within the Trust to ensure the maintenance of a clean and appropriate environment.
- Ensure policies are in place and reviewed to ensure they fully reflect and meet the regulatory standard.
- Continued commitment to an approach whereby prevention and control of infection is viewed as integral to service delivery and development.
- Enhance patient and public involvement in infection prevention and control in order to improve patient experience and reduce risk to the public.
- Develop a programme of quality improvement to underpin the delivery of high-quality infection prevention practice with the potential to foster improvements in experience, safety, and effectiveness of patient care

- Team members will be supported to develop their skills and knowledge within the field of infection prevention and control ensuring that the quality of service provided by all the members of the team is robust and of high standard

What are the key challenges?

- Level of hospital activity and service capacity
- Prioritising resources to deliver the Strategy within the current financial climate
- Emerging infections, resistance patterns and new strains of microorganisms
- Limited isolation facilities
- Ensuring a clean fit for purpose environment
- Meeting regulatory HCAI targets
- Educating workforce, patients and public
- Engaging with key stakeholders and external agencies
- Providing assurance that there is continued compliance with Infection Control policy and standards
- Releasing staff to undertake training

5.2 2022/23 Local Infection Prevention and Control Objectives as agreed with Commissioners

5.2.1 2022/23 Infection Thresholds

- Zero tolerance MRSA bacteraemia will continue in 2022/23 and reduction targets will be set for *Clostridium difficile* infection and Gram-negative bacteraemia (GNBSI), including *Escherichia coli*, Klebsiella and Pseudomonas. 2022/23 NHS Standard Contract
- Financial sanctions relating to MRSA bacteraemia and *Clostridium difficile* infection have been removed from the 2022/23 NHS Standard Contract and sanctions will not apply in relation to the new GNBSI targets

5.2.2 2022/23 IPC Key Performance Indicator (KPI)

DGFT will continue to undertake MRSA screening for all relevant elective and emergency admissions.

5.3 Conclusion

The elimination of avoidable healthcare associated infections continues to be a priority for the Trust, patients and the wider public. In response, a robust annual programme of work has been implemented by the Trust over the last year which has been led by an experienced and highly motivated Infection Prevention and Control Team and supported by colleagues at all levels of the organisation. The successes over the last year have only been possible due to the commitment for infection prevention and control that is demonstrated at all levels within the Trust. High standards of infection prevention and control and antimicrobial stewardship will remain crucial to minimise the risk of infection and limit the emergence and spread of multi-drug resistant organisms.

Section Six: Acknowledgements and further information

Thank you for reading the IPC Annual Report for 2021/22.

If you require any further information about IPC in DGFT please email the team at dgft.infection.control@nhs.net or visit our webpage at Infection control - The Dudley Group NHS Foundation Trust (dgft.nhs.uk)

This report was prepared by DGFT's IPC team:

Mary Sexton – Chief Nurse and DIPC,

Liz Watkins – Deputy DIPC (from September 2021)

Kim Jarrett – Trust Decontamination Lead (from September 2021)

Hannah White – IPC Clinical Nurse Specialist

Samantha Ware – IPC Clinical Nurse Specialist

Timea Vig – IPC Clinical Nurse Specialist (until September 2021)

Kay Nock - IPC Nurse

Diane Garfield – IPC Nurse

Simone Stellian - IPC Nurse (until October 2021)

Sam York – IPC Data Analyst

Simone Burton – HPV Technician

Simon Hipkiss – HPV Technician

Alison Painter – IPC Team Secretary

Jo Peters – COVID-19 Bank Nurse Contact Tracer

In conjunction with:

Syed Gilani – Principal Pharmacist Antimicrobial Therapy

Jodie Griffin – Health and Safety Advisor

Karl Brookes – Staff Health and Wellbeing

Jannine Dyke – Soft Services Contract Manager

Enclosure 17

The Dudley Group NHS Foundation Trust

Paper for submission to the Board of Directors 22nd September 2022

Title:	Maternity and Neonatal Safety and Quality Dashboard
Author:	Claire Macdiarmid – Head of Midwifery, Sudipta Bannerjee- Clinical director for Obstetrics
Presenter:	Mary Sexton – Chief Nurse

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

Recommendations:

The Board is invited to accept the assurance provided in this report as progress towards compliance with both CNST requirements, Ockenden recommendations and plans to rectify current Midwifery and obstetric vacancies.

The Service continues to drive Improvement actions all aspects of Maternity and Neonatal services.

Summary of Key Issues:

There was one still births reported during June and July, and one neonatal death. The stillbirth rate remains below the national rate. Neonatal death rates remain above the national rate- but work is ongoing to review cases by use of the Perinatal mortality review tool (PMRT) in a timely manner to ensure learning is highlighted, and acted upon.

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

The final Ockenden Report was published on the 30th March 2022. 87 actions were identified in the report divided across 15 sections. Review of current position has highlighted a positive shift with an increase in the number of green and blue compliant actions, and a reduction in amber and red.

CNST 10 safety actions are ongoing to achieve compliance before January 2023. Highlights of key issues include Neonatal resuscitation training rates, and data collection issues for the Maternity services data set (MSDS).

Midwifery staffing continues to be a risk and the risk score has been increased due to a declining position and increased vacancy. A workforce plan is contained to outline actions being taken to rectify the staffing position in both midwifery and obstetrics.

Impact on the Strategic Goals

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

Deliver right care every time	**X**

Be a brilliant place to work and thrive	**X**
Drive sustainability (financial and environmental)	
Build innovative partnerships in Dudley and beyond	**X**
Improve health and wellbeing	**X**

Implications of the Paper:			
Risk	Y	Risk Description: Various as detailed in the h report	
	On Risk Register: Y	Risk Score: 9	
Compliance and/or Lead Requirements	CQC	Y	Details: All Areas
	NHSE/I	Y	Details: CNST standards
	Other	Y	Details: Ockenden Recommendations

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

Maternity and Neonatal Safety and Quality Dashboard

Report to Trust Board 22nd September 2022

1 EXECUTIVE SUMMARY

1.1 This report outlines locally and nationally agreed measures to monitor maternity and neonatal safety as outlined in the NHSEI document "Implementing a revised perinatal quality surveillance model" (December 2020). The purpose of the report is to inform the Trust board and LMNS board of present or emerging safety concerns or activity to ensure safety with a two-way reflection of ward to board insight across the multidisciplinary multi professional maternity and neonatal service teams. The information within the report will reflect actions in line with 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 **June and July 2022**, unless otherwise specified throughout.

2 BACKGROUND INFORMATION

2.1 Perinatal Mortality.

Stillbirths -There has been 1 still births during June 2022 and 0 during July 2022

Early Neonatal Deaths – There has been 0 early neonatal deaths during the month of June 2022 and 1 during July 2022.

Late Neonatal deaths -There have been 0 late neonatal deaths in June and 1 during July 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.

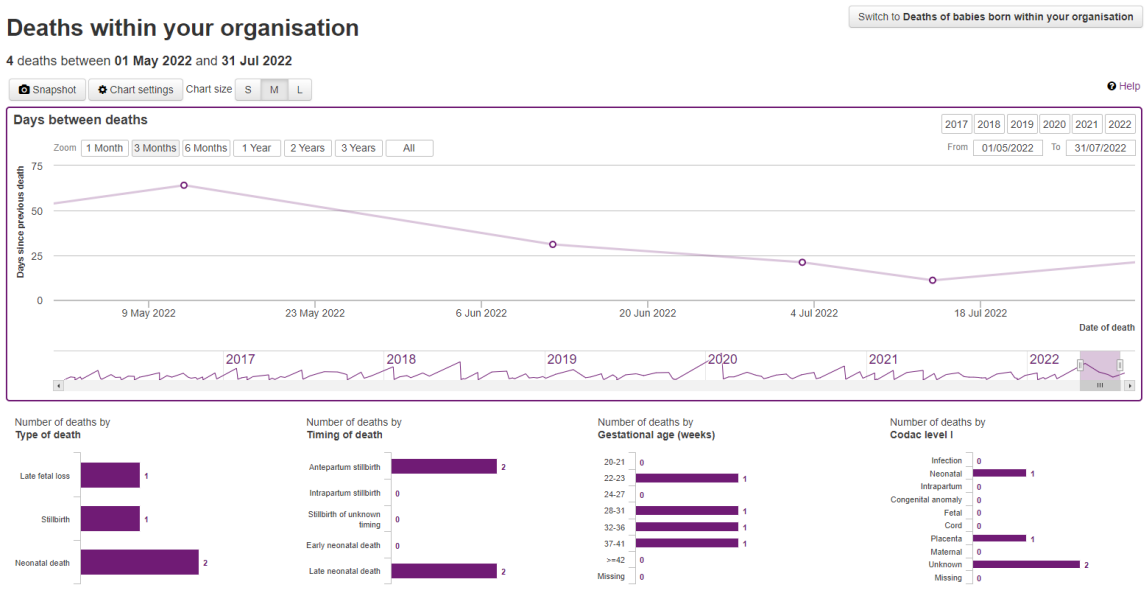
In addition to the NPMRT database we are required as a Trust to report the following to MBRRACE

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

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

2.1.2 PMRT real time data monitoring tool

3 months of data (May, June and July 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

Per 1000 births	June	July	National rate
Stillbirth rate (Crude)	3.17	3.15	3.35
Stillbirth rate adjusted	2.69	2.67	-
Early neonatal death rate (Crude)	1.71	1.94	1.08
Early neonatal death rate (Adjusted)	0.73	0.97	-
Late neonatal death rate (crude)	0.73	0.97	0.54
Combined neonatal death rate (crude)	2.45	2.92	1.62
Combined neonatal death rate (adjusted)	1.71	1.94	-

DGFT remain below the national stillbirth rate. It should be noted that there were 13 stillbirths from 01.08.2021 to 31.07.2022 and of these, 2 had known congenital anomalies.

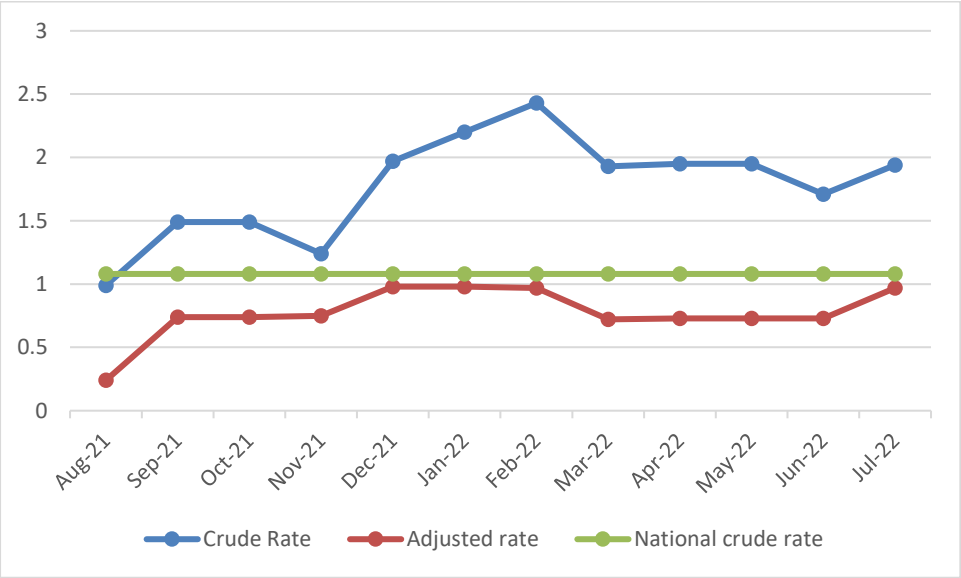
DGFT Early neonatal death rate (crude) rate remains above the national rate.

It should be noted that there were 8 early neonatal deaths from 01.08.2021 to 31.07.2022 and that 4 of the deaths (50%) were between 20- and 24-weeks' gestation.

The national rate for Late Neonatal Deaths is 0.54 (MBRRACE 2021) and it can be seen DGFT are above the national rate.

It should be noted that there were 4 late neonatal deaths from 01.08.2021 to 31.07.2022, 3 of these cases were sudden infant deaths and 2 of these case received Maternity care at a neighbouring Trust.

The Women and Children's service continues to report perinatal mortality rates through Divisional Governance each month and into the Trusts Mortality Surveillance Group.



The above chart details how the crude early neonatal death rate has been consistently higher than the National rate of 1.08 (MBRRACE 2021) during the last 12 months, but it should be noted that 50% of these cases were babies born between 20 and 24 weeks gestation.

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 (up to 42 days postnatal).

As of April 2023, HSIB will split into two organisations and the **Maternity and Newborn Safety Investigations Special Health Authority** (MNSI) will be responsible for Maternity and Neonatal investigations as specified above.

2.2.1 Investigation progress update

DGFT executive summary from HSIB up to 2/9/22

Cases to date	
Total referrals	22
Referrals / cases rejected	3 (duplicate entries) 1 rejected lack of family consent
Total investigations to date	18
Total investigations completed	17
Current active cases	1

Exception reporting	Nil

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

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 June or July 2022.

2.4 Maternity Serious Incidents

There were 0 serious incidents reported in Maternity during June 2022.

There has been 1 serious incidents reported within Maternity during July 2022 (INC112612). This incident related to a baby that was transferred out to a tertiary unit for therapeutic cooling therapy.

2.5 Maternity action plans

2.5.1 Ockenden Report final

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

Below is a table highlighting current compliance with the 87 actions in a red, amber, green rating. It shows an overall improving situation with an increase in green and blue compliance, and a reduction in the amber and red categories. Work is ongoing to further improve this situation. Monthly multi-disciplinary, Ockenden assurance meetings continue, attended by the multidisciplinary team, each with allocated responsibility for providing assurance of progress on each IEA.

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.

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.

Date of assessment	Total actions					
July 2022	87	19%	53%	18%	2%	8%
September 2022	87	13%	48%	24%	9%	6%

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

2.6 Saving Babies Lives V2

2.6.1 We are able to evidence compliance for The Saving Babies Lives care bundle version 2 (SBLCBv2) in all 5 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 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 the regional team highlighted the excellent work of the HPSS team (health in pregnancy support service) 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 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.

2.7 NHS Resolution Maternity Incentive Scheme CNST

2.7.1 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 newborn 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?	

2.7.2 Safety action two relating to the Maternity services dataset (MSDS) has faced challenges with compliance. The informatics team have had to overcome challenges in relation to data errors coming from the maternity electronic patient record (EPR). They are now on-track to be compliant by the end of September 2022.

2.7.3 A suite of role specific mandatory training was rolled out last year, to address the requirements of Maternity Incentive scheme CNST **safety action eight** 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.

Outstanding action for safety action 8 include compliance of 90% with neonatal resuscitation. Compliance is currently at 63%. All staff have been booked onto training sessions and have a midwife to backfill for their allocated training time. The trajectory will ensure 90% compliance before the 30th November 2022 as per table below.

	Current compliance	RAG Rating	Rectification plans
Multi-Professional Emergency Training/Skills Drills	91%		New starters to undertake training in November 2022 to ensure compliance remains above 90%. New year of training to commence January 2023
CTG/ fetal Monitoring Training	91%		New starters to undertake training in November 2022 to ensure compliance remains above 90%. New year of training to commence January 2023
Neonatal resuscitation	63%		All staff that are non-compliant have been allocated a time to attend training- back fill midwife will cover their clinical duties whilst they update.
Adult resuscitation	63.2%		All staff that are non-compliant have been allocated a time to attend training- back fill midwife will cover their clinical duties whilst they update.

2.8 Maternity staffing

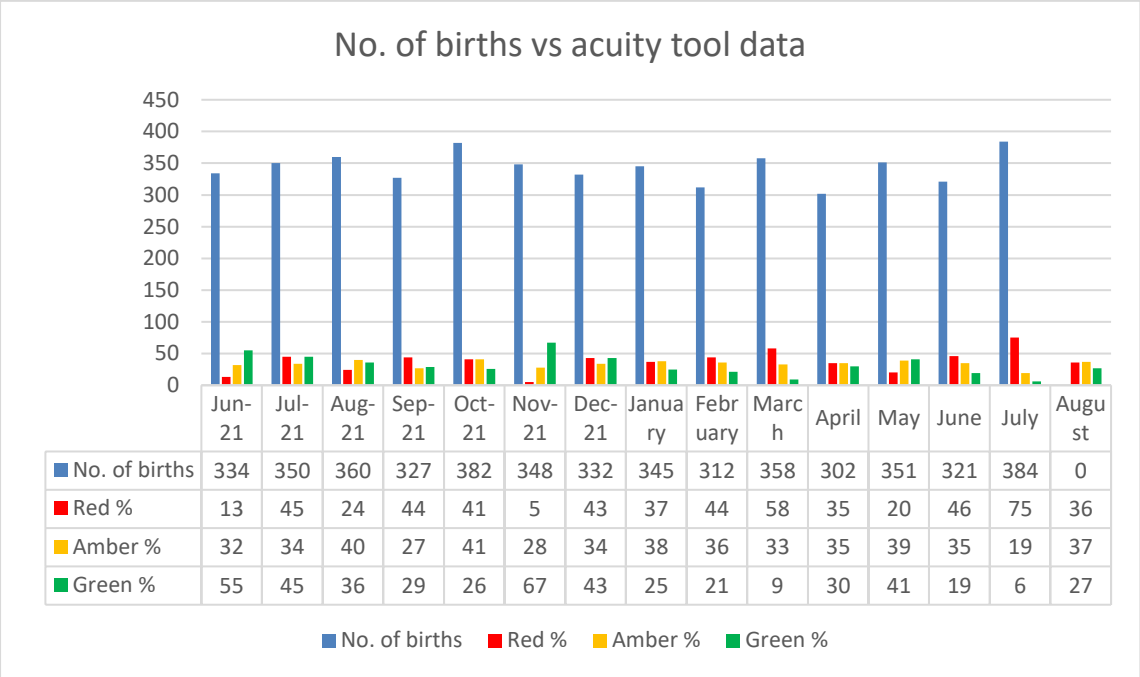
Fill rates for midwifery staffing in inpatient areas:

Fill rate	Day	Night
June 2022	66%	73%
July 2022	60%	77%

Mitigation for the lower staffing numbers throughout the day that are not included within these figures are the ward managers undertaking clinical duties, and a rota for the specialist midwives to be pulled to work clinically during days of higher activity. Acuity is measured alongside this via the Birthrate acuity tool. **Appendix one** shows the details of the workforce plan to rectify the vacancy rate currently held within the midwifery workforce.

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

The table below shows the number of births per month, related to the number of hours at red, amber and green staffing levels as a percentage (delivery suite only).



	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	January	February	March	April	May	June	July	August
No. of births	334	350	360	327	382	348	332	345	312	358	302	351	321	384	0
Red %	13	45	24	44	41	5	43	37	44	58	35	20	46	75	36
Amber %	32	34	40	27	41	28	34	38	36	33	35	39	35	19	37
Green %	55	45	36	29	26	67	43	25	21	9	30	41	19	6	27

Red shifts demonstrate a shortage of more than 2 midwives compared to the acuity of the department.

Amber shifts demonstrate a shortage of less than 2 midwives compared to the acuity of the department.

Green shifts show we have appropriate staffing for the acuity of the department.

2.8.1 Obstetric staffing

See appendix one for an update on Obstetric workforce planning.

2.9 Maternity safety champions

A Maternity safety champion meeting occurred on the 5th September 2022 attended by safety champions for both maternity and neonatal. Areas of discussion were:

- Obstetric job roles remaining unfilled and plans to mitigate this.
- Progress with maternity action plans including Ockenden and CNST
- Follow up from maternity safety walkaround actions
- Workforce plans
- Neonatal update.

A more detailed report from this group is presented at Quality and safety committee.

2.10 Service user feedback

Emma was lovely gave me all the information I needed and listened to questions that I had a great experience nothing was rushed.

My midwife who helped me through the labour was most amazing calm way being a first time mom, the whole team was incredible and the aftercare was amazing.

All staff welcoming and knowledgeable and offer reassurance and consider well-being and safety above all they do.

Although busy and visibly battling political cuts and underfunding (such as having to share equipment between rooms etc), a team effort and high morale can be sensed throughout the whole department with a work ethic of hard work and high expectations.

This service cannot be faulted and all staff should be held in high regard for the job they perform under pressure.

Just the team being stretched on a Saturday, I was left waiting for over 24 hours for staff and a room become available to induce labour this is nothing to do with the amazing team, just the staffing.

Despite no smoking signs people were smoking right by the entrance. My midwife told me that passive smoking is just as bad for the baby as smoking yourself. So it was horrible and worrying having to walk through clouds of smoke to enter the building.

3 RISKS AND MITIGATIONS

3.1 Midwifery staffing continues to be a risk and remains on the risk register- the score has been increased to reflect the increasing vacancy that we have seen over the course of 2022. Significant improvement is required in order to be able to comply with the continuity of carer

requirements as outlines in pubic board July 2022. A business case is required to be able to staff as per Birthrate plus recommendations. Ongoing midwifery recruitment including international recruitment is in progress as per workforce plan.

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

4. RECOMMENDATION(S)

4.1 The Board is invited to accept the assurance provided in this report as progress towards compliance with both CNST requirements, saving babies lives V2 and Ockenden recommendations

Name of Author: Claire Macdiarmid/Dr.Sudipta Bannerjee
Title of Author Head of Midwifery/ Clinical Director for Obstetrics
September 13th 2022

APPENDIX ONE

Maternity services Workforce action plan 2022

Manager/Lead	Sudipta Banerjee/ Claire Macdiarmid		
Associated Staff	Jo Malpass/ Katie Philpott/ Amanda Clayton		
Actions Identified	August 2022		
Date Action Plan agreed	September 2022	**Deadline for all actions**	31/3/23

Action not started	**Action underway**	**Action completed and full assurance received**

No	Recommendation	Actions Required	By whom	Progress to date	Agreed Completion Date	RAG Rating
1.	Recruitment into vacant midwifery posts has been unsuccessful on multiple occasions due to a national shortage of Midwives in the UK. **Midwifery vacancy as of September 2022 25.5WTE**	Recruitment of newly qualified student midwives, internally and externally trained.	**Matron Katie Philpott**	13 Midwives (10.4WTE) recruited to commence October 2022	November 2022	
		Recruitment of internationally trained midwives as part of collaborative with RWT	**Claire Macdiarmid**	5 WTE commenced in post July 2022. None have passed their OSCE to date and further actions required to ensure they are competent in all areas of midwifery practice even after receiving NMC Pin number. NMC informed of the issues faced. Further 20 WTE IR Midwives being recruited.	March 2023	
		Recruitment of Newly qualified internal and externally trained Midwives, due to qualify February and March 2023	**Matron Katie Philpott**	Posts currently advertised on TRAC. Local universities contacted to disseminate opportunities at Dudley to NQRM.	March 2023	
		Events hosted to ensure ongoing communication with all individuals offered jobs.	**Courtnay Hynes- retention Midwife**	First face to face visit June 2022. Second event September 2022. Regular contact maintained with candidates. Full induction week planned for essential skills before commencing supernumerary shifts.	September 2022	

		Extended roles advertised to try and attract external experienced midwives such as: 1. Elective caesarean section Midwife 2. Enhanced maternal care 3. Telephone triage 4. Community only contract 5. Joint in and outpatient contracts	**Matrons Katie Philpott and Amanda Clayton**	Job roles advertised on TRAC. All candidates were internal	August 2022	
		Flexible working available to all staff to include return from maternity leaves.	**Deputy Matrons Katy Penn and Donna Cox.**	All flexible working applications considered and processed.	Completed	
2.	Actions taken to mitigate the risk associated with a shortage of Midwives	Risk already on risk register regarding compromised midwifery staffing (WC1290),	**Claire Macdiarmid**	Risk reviewed and increased to reflect the increasing number of vacancies due to retirements, reduction in hours, and leavers.	September 2022	
		Nurse secondments advertised and recruited to cover the short-term reduction in qualified workforce (5WTE)	**Matron Katie Philpott**	Nurse role defined and disseminated to lead midwives. 2 x candidates unable to be released from wards until September 2022. 2 x gained promotions elsewhere in trust and declined job offers. 1 x theatre recovery nurse in post.	November 2022	
		Retention midwifery post funded for one year.	**Claire Macdiarmid**	Post filled June 2022 Work ongoing with LMNS as a collaborative to reduce attrition rates and improve staff experience.	June 2022	
		Increased student numbers at both universities	**Julie Ruff- Lead practice development Midwife**	Meetings held with University of Wolverhampton and University of Worcester and agreement to increase the number of students by 6 students per year with immediate effect (Long and short course) Meetings held with University of Birmingham to accept shortened midwifery student cohort (MSc)	September 2022	

		Work experience to be recommenced to encourage school and college aged people, to aspire for a career in midwifery	**Katy Penn/ Donna Cox – Deputy Matrons**	Contact made with work experience team to ensure this process is managed in a timely manner.	December 2022	
		Enhanced band 3 midwifery support worker roles developed to be able to assist midwives with increased levels of work.	**Matrons Katie Philpott/Amanda Clayton**	Roles now operational	April 2022	
		Bid submitted to fund practice development hours to assist with Midwifery support worker (MSW) development and retention	**Claire Macdiarmid**	Awaiting outcome of bid.	October 2022	
3.	**Recruitment to additional roles funded by LMNS following the publication of the final Ockenden report.**	All posts are funded for 12 months, therefore likely to be filled by internal candidates. This would further deplete the midwifery workforce. Unable to fill all posts until Midwifery vacancy is in an improved position.	**Claire Macdiarmid**	Plan to advertise all posts on a staggered basis, in priority order. Remainder of posts to be advertised once vacancy position improves.		
4.	**Midwifery staffing to be as per Birthrate plus recommendations (May 2022 paper)**	To submit business case for 4.0WTE additional midwives to the workforce	**Claire Macdiarmid/ Jo Malpass**	Birth rate plus results returned. Business case to be submitted	October 2022	
5.	**Create a stable and substantive medical workforce**	Fill vacant consultant posts in Obstetrics and Gynaecology Medical Staffing to 16.0 WTE Complete job plans and advertise posts to recruit to 2.4 WTE consultant vacancies and upcoming 1.0 vacancy due to become vacant. Posts to be dual O&G posts with job planning biased towards	**Sudipta Banerjee/ Uzma Zafar/Joanne Malpass**	Job plans to be drafted to support recruitment.	February 2023	

		Obstetrics and a mainly Gynaecology post.				
		Cover 6 month sabbatical for consultant	**Sudipta Banerjee/ Uzma Zafar/Joanne Malpass**	Trust locum recruited to 6 month post, appointed consultant awaiting confirmation from recruitment. Will need to give 3 month's notice.	December 2022	
		Ensure a full complement of tier 1 and tier 2 medical staff		Monthly meetings with medical workforce to plan ahead for any deanery gaps Review current establishment with finance to identify gaps Advert out for registrar's posts, interviews to be arranged for mid October. Plan to implement 16 person reg rota March 23 2 x MTI doctors to join.	February 2022	
		Job Planning	**Sudipta Banerjee/ Uzma Zafar/Joanne Malpass**	Job planning under review again for coming year to include specialist and educational supervisor roles	October 2022	
6.	**Allocate PAs to lead roles in Obstetrics to meet Ockenden standards**	Review Job Plans Governance role to be allocated 2.0 PAs (1.0 PA role currently in position) Clinical Director role to be allocated 3.0 PAs (2.0 PA role in place for Obstetric CD)	**Sudipta Banerjee and Uzma Zafar** **Babar Elahi**	Allocated roles review against Ockenden recommendations Additional PA to be identified and allocated to Governance role Applied for funding from NHSE for 1.0 PA to support leadership within obstetrics	November 2022	

7.	**Allocate the additional roles required in Gynaecology**	Early Pregnancy Lead, Ambulatory Gynaecology Lead required.	**Sudipta Banerjee and Uzma Zafar**	Roles to be included in job plans and allocated on appointment of consultants	February 2023	
8.	**Separate Obstetrics and Gynaecology workforce as per Ockenden Recommendations**	Proposal for a 24 hour 7 day a week separate Obstetrics and Gynaecology workforce Recruit additional medical staff to support rotas	**Sudipta Banerjee/ Uzma Zafar/Joanne Malpass**	Consultant team has met to discuss recommendations Team to pull together proposal Present to exec team Recruit to posts	October 2022 March 2023	
9.	**Reduce agency locum spend**	Recruit to vacant posts. Utilise internal locums/bank where possible. Cover on call commitments for consultant on amended duties until Oct 2023	**Joanne Malpass**	Trust locum post recruited to, 12 month fixed term post. Waiting for recruitment to confirm with applicant, requires 3 month notice period.	December 2023	
10.	**Scope additional non medical roles**	Physician assistants to support maternity	**Joanne Malpass**	Business case completed, sitting with finance. To be submitted September DMT.	February 2023	

Enclosure 18

The Dudley Group NHS Foundation Trust

Paper for submission to the Board of Directors on 22 September 2022

Title:	Health & Safety Annual Report
Author:	Jodi Griffin- **Health & Safety Advisor** Jo Garett- **Fire Safety Advisor**
Presenter:	Karen Kelly -**Chief Operating Officer**

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

Recommendations:

To approve the trusts annual report submission in relation to the Health and Safety and Fire Safety work streams and plans for 2021/2022.

Summary of Key Issues:

Annually the Trust is expected to submit its annual report pertaining to Health, Safety and Fire in order to demonstrate compliance with the Health and Safety at Work Act 1974, the Management of Health & Safety in the workplace Regulations 1999 and the Regulatory Reform (Fire Safety) Order 2005, as well as the other regulations that sit under these specialities.
The Trust continually strives to reduce health & safety incidents including ensuring our organisation and staff are suitably prepared for any potential fire incidents and evacuations through training and assessment of risk.

Health and Safety annual report summary.

- Sharps/ Needlestick incidents were the highest reported Health & Safety related incident of the financial year 2021/22. This was an increase of 9.6% compared to 2020/21 (up from 114 to 124)
  The Trust is actively raising awareness regarding needle stick injuries by reporting at each divisional meetings and working with departments to implement safer sharps, including collaboration with Staff Health and Wellbeing to ensure that RIDDOR reportable incidents are not being under reported.
- The number of incidents and near misses reported on Datix in relation to Health & Safety have increased by 19.1% compared to 2020/21 (up from 313 to 373 reports). In response to this, the Trust have now made the workplace safety inspection checklist monthly on AMaT for departments to complete, giving us real time information for potential hazards and trends. The team have created a health & safety newsletter that covers a different topic each quarter and is sent out to all the leads to share with staff.
- Collisions and contacts incident reports have increased by 35.5% compared to 2020/21. Most of these incidents related to staff walking into furniture or other stationary objects.
- Exposure to hazardous substance incidents have increased by 59.6% compared to 2020/21. The increase in incidents relates to an increase of samples being sent to microbiology incorrectly labelled or packaged which exposes the lab staff to potential infectious agents.

The Trust plan to reduce exposure to hazardous substances incidents by rolling out spillage training to those areas identified as requiring the training, promoting the laboratory user guide so staff are appropriately labelling, and packaging samples submitted to the laboratories. We have also set up monthly meetings with Royal Wolverhampton Health & Safety team and the BCPS head of service for spoke labs (including those based at RHH) to ensure incidents are reported and investigated in a timely manner to protect both DGFT and RWT staff.

- Comparable number of RIDDORS reported this financial year with 13 reported this financial year compared to 14 for 2020/21.

Key Priority's for 2022/23 for Health and Safety include:

- Policy Development and Review
- Promote health & safety training and increase uptake. We are offering a range of training for staff to attend and have developed a new Health & Safety for Managers workshop for staff to attend. The training covers a range of health & safety topics from roles and responsibilities, legislation, risk assessment and accident investigation.
- Lone worker devices business case. Following a HSE surveillance visit last October (2021), it was recommended the Trust look at purchasing lone worker devices, particularly for the community staff who are more vulnerable to incidents of violence and aggression

Fire Safety annual report summary.

- 127 fire leads have been trained across the hospital to spot fire hazards, with 80% of departments now having a trained Fire Lead.
- Evacuation mat training has commenced with sessions being run monthly, as well as being offered to all staff on wards with a high percentage of highly dependent patients.
- Fire risk assessment compliance is at 100% for RHH, Guest and Corbett sites. Community fire risk assessments have been impacted severely by Covid-19. A new workplan has been created to address this.
- An increase in fire alarm activations is being in 2022 compared to 2021, with 32 so far YTD. The data shows that the vast majority were accidental activation of a manual call point. A project has commenced to review signage at all exit points of departments to standardise signage.
- At the time of this report, Fire Prevention and Safety training compliance is at 91.7%. Extra sessions have been added to increase compliance from the previous year. As well as offering Teams training, and face to face training on evenings and weekends.

Key Priority's for 2022/23 for Fire include:

- Policy development and review of all policies and SOPs due in the year, including fire safety in the community.
- Creation of a Trust wide audit of fire safety, benchmarking against relevant legislation and Government guidance, with actions feeding into the Fire Safety Team workplan for 2023.
- Increase compliance scores for mandatory fire safety training,and see continued and sustained improvement across the year. This includes the provision of training for Mitie staff. A recorded version of the training has been created to support in the backlog of fire training for Mitie, as well as offering evening and weekend training to Trust staff.
- Introduce department specific Fire Manuals to all areas of RHH, Guest and Corbett. This will be an invaluable tool for Trust staff and to support the West Midlands Fire & Rescue Service in the event of a real fire. The manual will contain specific plans and drawings,

policies and procedures for fire safety, and a reminder of the fire risk assessments and action plans for the department.
- Re-introduce a robust fire drill programme across the Trust, which had been suspended due to Covid-19 pressures. This will test the Trust's response to a fire within departments, and ensure all staff are able to effectively deal with a fire situation. Higher risk areas are being prioritised, and Critical Care will be the first to run through a desktop drill.
- All Community buildings will be fire risk assessed in line with Trust policy, which had been impacted by the Covid-19 pandemic.

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)	**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	N	Details:
	NHSE/I	N	Details:
	Other	Y	Details: Health & Safety at Work Act 1974 Regulatory Reform (Fire Safety) Order 2005 Management of Health & Safety at Work Regulations 1999

Report Journey/ Destination	Working / Exec Group	Y/	Date:
	Committee	Y	Date: Quality & Safety Aug 22
	Board of Directors	Y	Date: 22/09/22
	Other	N	Date:

The Dudley Group
NHS Foundation Trust

HEALTH, SAFETY AND FIRE ANNUAL REPORT 2021/2022

Contents

Abbreviations

COMAH	Control of Major Accidents and Hazards
COSHH	Control of Substances Hazardous to Health
DSE	Display Screen Equipment
HSE	Health and Safety Executive
PAT	Portable Appliance Testing
PPE	Personal Protective Equipment
RIDDOR	Reporting of Injuries, Diseases and Dangerous Occurrences Regulations
HSFAG	Health, Safety and Fire Assurance Group

1.0 Executive Summary

All employers have a legal responsibility under the Health and Safety at Work Act 1974 (HASAW Act) and associated statutory legislation to ensure it has in place suitable arrangements for the management of health and safety. Legislation sets minimum standards for these arrangements and the requirement for organisations to identify, manage and mitigate risks. Failure to comply with these arrangements may result in the potential harm to the Trust's patients, staff and others to whom it owes a duty of care, with the possibility of criminal proceedings or other enforcement action. In addition, there is the potential of further actions being taken for none compliance and breaches to regulatory requirements by the Care Quality Commission (CQC), NHS Resolution, the Health and Safety Executive (HSE), NHS England, NHS Improvement and local commissioners.

This report is therefore produced to provide assurance to the boards that the Trust:

- Is compliant with legislation and policies
- Has an appropriate governance structure
- Has in place suitable and sufficient arrangements to ensure that Trust reports and learns from reported incidents
- has taken reasonable steps to ensure that that health, safety and welfare of staff, patients, visitors or anyone who may be affected by our work into consideration and mitigating measures and processes have been followed and embedded to ensure compliance.

The fire elements of this report are intended to provide assurance in relation to the Trust's statutory responsibilities with regards to compliance with The Regulatory Reform (Fire Safety) Order 2005 (RR(FS)O).

The boards expectation of an organisation with a good safety culture is a high number of incidents reported with no harm. Learning from incidents and the delivery and embedding of robust actions is essential to mitigate risk.

The annual report for 2021/2022 will continue to progress Management of Health & Safety across the Trust, with particular focus on:

- Working with Mitie and Summit to ensure adequate arrangements are in place to assess, monitor and provide assurance that the premises are fit for purpose
- Ensure that trend analysis in adverse event reporting continues, an any resulting actions are identified and implemented
- Raising the level of mandatory Fire Safety training attendance
- Raising the level of COSHH, Risk assessment and DSE training for staff identified as requiring the training

2. Health & Safety Requirements

Under both the Health & Safety at Work Act 1974 (HSAWA) and the Management of Health & safety at Work Regulations 1999 (MHSAWR), there is a requirement to proactively manage and control risks. Based on the HSG65 (Health & Safety Executives "Successful Health & Safety Management", the Trusts approach is based on the "Plan-Do-Check-Act" approach.

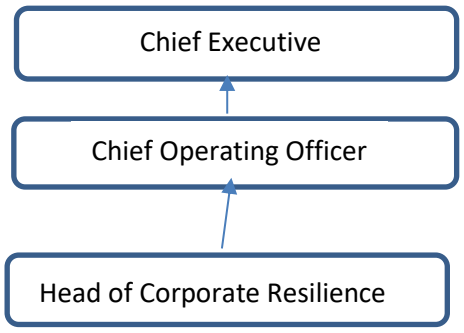
HSG65 Requirement	DGNHSFT Evidence monitored by HSFAG (Health, Safety and Fire assurance Group)
PLAN	The Health & Safety policy previously approved by the board remains in place (Reviewed Sept 2021). The following policies have been reviewed and approved in this period (2021/22): • Control of Substances Hazardous to Health Policy • Slips, trips and Falls Policy • Working from Height Policy • Sharps selection, handling, and disposal policy
DO	The HSFAG meet quarterly to provide assurance via the Trusts Quality and Safety Committee in the form of a report to the chair following each meeting. The Executive Lead is the Chief Operating Officer and the Chair the Deputy Chief Operating Officer. The Group triangulates data, receives assurance, challenges, and identifies gaps and risks. It is ultimately accountable to the Board and the Chief Executive of the organisation and reports directly to the Quality and Safety Committee, a designated committee of the board and through that committee up to Board It is supported by specific subgroups including: • Divisional representation • PFI partners • Medical Gases • Security liaison • Radiation protection • Medical devices • Infection Prevention and Control • Estates and Facilities Compliance has reduced during 2021/2022 due to covid-19. More fire sessions have been put on both face to face and online to increase compliance Mandatory and local training are provided for the following subjects on a monthly basis (with the exception of fire which runs more sessions per month):

	• Mandatory Fire Safety training • Fire leads training • COSHH workshops • Risk Assessment workshops • Health & Safety awareness sessions • Display Screen Equipment Assessor workshops To minimise hazards and reduce risk, an effective Health and safety management system is required. Risk assessments using the Trusts templates and process, supports this approach. Full site risk assessments were completed for: • Social distancing in non-clinical areas • Fire • Sharps • Lone working Each department has access on the Hub, to a full risk assessment template for their areas. The template should be edited to reflect local controls if different from the templated. These assessments cover: • Slips, trips and falls • Work related stress • Violence and aggression • Manual handling (general) • Display screen equipment • Sharps • COSHH Most departments across the Trust have been audited for risk assessment compliance (80%) and compliance has improved since the last report (2020/21). Social distancing audits were carried out across the Trust on a quarterly basis to ensure compliance with social distancing measures including mask wearing, maximum occupancies being displayed and adhere to in non-clinical settings and adequate ventilation.
CHECK	Proactive monitoring assesses the achievement s of plans and the extent of compliance with standards: • Compliance audit of health & Safety documentation such as risk assessments and COSHH assessments • Environmental audits to identify any potential hazards such as slips and trips and report them to the PFI partners • Dissemination of relevant safety alerts from organisations such as National Patient Safety Agency or Central Alerting System. • Monitoring of actions plans from each group reporting to the HSFAG Reactive systems monitor accidents, ill health and incidents: • Near misses and incidents are reported on the Datix system. These incidents are reviewed weekly by the health & safety advisor and any investigations are then carried out.

	• Data from incidents and near misses are reported at the HSFAG and at monthly divisional meetings. Further bespoke reports are produced with a summary of the data for 2021/22 presented in section 6.
Act	Period reviews, investigations, review of policies with subject matter experts and inspections are undertaken to provide assurance that performance is consistent across the Trust and meets annual objectives. DGNHSFT ensures, by regular reporting to HSFAG that we: • Continue to monitor and Improve performance • Learn from experience • Respond to change • Develop and improve the Health & Safety management system

3 Reporting Lines for Health, Safety and Fire

Health, Safety and Fire is ultimately the responsibility of the Chief Executive, this is however delegated to an accountable executive (Chief Operating Officer) who is responsible for the delivery of the Health, Safety and Fire portfolio. The Trust, to ensure it meets its legal obligation has in post a Head of Corporate Resilience as an expert in these fields ensuring the trust remains compliant to relevant legislation and guidance.



4 Progress against 2020/21 objectives

Several objectives were set for 2021/22 of which the following table provides a summary, evidence of progress and actions outstanding for completion:

Objective	Outcomes	Action outstanding
Health & safety		
Policy Development and Review	Review of all health, safety and fire documents, encompassing a holistic review of process in place currently to ensure fit for purpose	None
So far as reasonably practicable, ensure health, safety and welfare in response to COVID-19	❖ Continued involvement in the response to COVID 19 specifically around PPE requirements and face fit testing, this is ongoing throughout the pandemic ❖ To ensure that the Trust is in a prepared state to deal with further COVID-19 outbreak, this will be in relation to supporting other departments such as Infection control, staff health and wellbeing, HR and the clinical departments and continue to support the incident control room	None
Raise awareness in regards to needle stick injuries and work with departments to implement safer sharps	❖ Development and implementation of communications plan to raise awareness ❖ Review sharps data and audit departments reporting higher number of sharps injuries	None
Assurance of Trust Wide Air Monitoring across the organisation to identify potential areas for review	❖ Formalin monitoring systems in pathology, handheld monitoring devices within Trust which are used in areas such as GI and Mortuary. ❖ Areas identified for requiring air monitoring ❖ Companies have been contacted in relation to quotes for air monitoring	Implement appropriate air monitoring systems in identified areas with assurance to be provided if gaps identified- Pathology have now left leaving a gap in compliance for the monitoring of formalin
Reduce exposure to hazardous substances incidents	Full review of COSHH assessments across the Trust including the Guest and Corbett Outpatient Centres, implement a COSHH go to page on the hub with readily available COSHH assessments	Spillage train the trainer to be booked once payment has been completed.

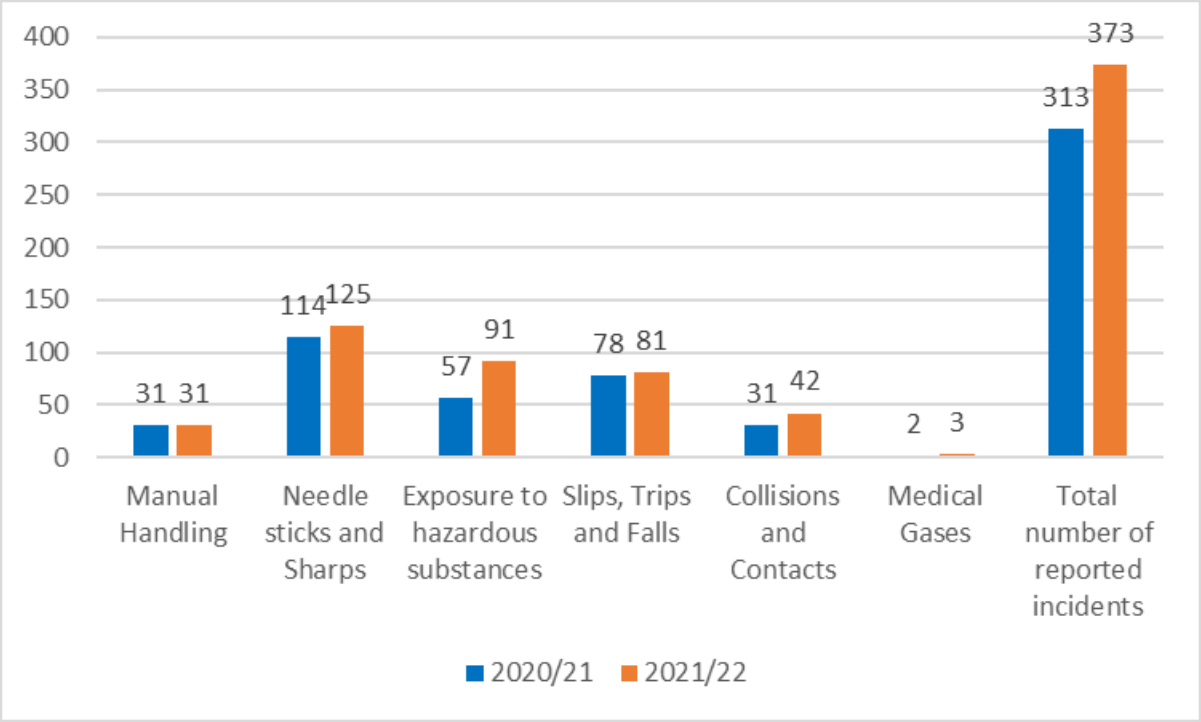
Objective	Outcomes	Action outstanding
Development of robust risk assessment and auditing inspection framework (Stress risk assessment) and embed an audit and inspection framework across the organisation for COSHH and DSE risk assessments)	To ensure monitoring processes are in place and embedded to ensure oversight of compliance levels across the organisation for all areas covered by health, safety, and fire by July 2021.	None
Objective	**Outcomes**	**Action outstanding**
Fire		
Monitor the North Block fire engineering works over the three year works programme.	Continue to support the Estates team to understand the works being undertaken and ensure that they are being carried out as agreed. Engage with West Midlands Fire & Service should any deviations and issue arise.	On going
Increase mandatory fire training compliance to a minimum of 90%.	Undertake a full review of training processes across the Trust ensuring they are fit for purpose and accessible to all staff. Offer a selection of training opportunities to maximise attendance, to include lecture theatre training, on ward, online and Teams training. Ensure Mitie compliance to mandatory annual fire safety training is increased.	On going
Reduce unwanted false fire alarms across the Trust.	Liaise with West Midlands Fire & Rescue Service on the changes to response to automatic fire alarms. Review fire alarms across the Trust in order to reduce the number of activations to as low as possible by putting preventative measures in place.	On Going

5 Incident Reporting and Analysis

The following table provides an overview of the total number of incidents affecting staff reported over the financial year 2021/22 in comparison to the previous year.

	2020/21	2021/22
Manual Handling	31	31
Needle sticks and Sharps	114	125
Exposure to hazardous substances	57	91
Slips, Trips and Falls	78	81
Collisions and Contacts	31	42
Medical Gases	2	3
Total number of reported incidents	**313**	**373**

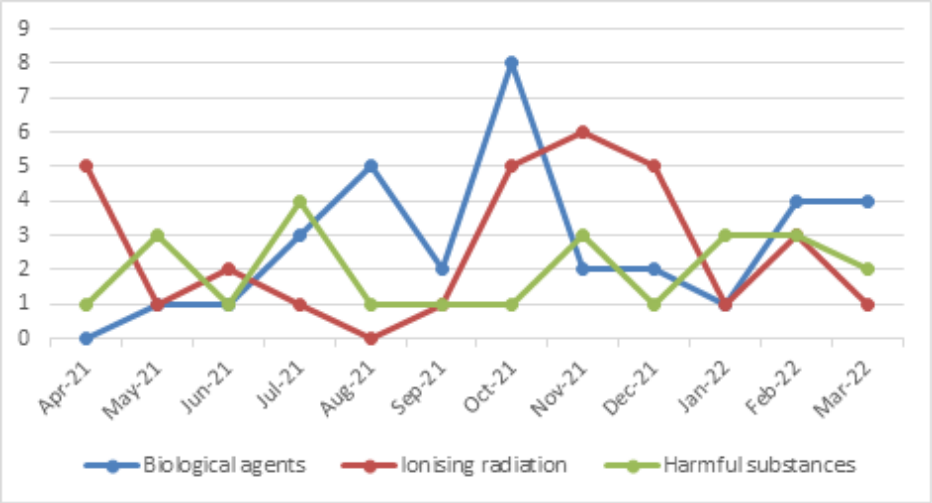
Graph 1 showing the number of incidents reported by incident type across the Trust in 2021/22 compared to 2020/21



Graph showing the number of incidents reported for this year (1st April 21-31st March 22) compared to the previous year. There were increases in sharps of 9.6% (11 more than last year), exposure to hazardous substances increased by 59%,(up 34 on last year) and contracts and collisions increased by 13% (up 11 on last year). Manual handling incidents decreased by 3% and incidents involving medical gases decreased by 66% (down from 3 to 2).

The main increase in near miss incidents relates to Exposure to Hazardous substances from 11 reported near miss incidents in 2020/21. The increase in Exposure to hazardous substances has been driven by the Microbiology Department reporting the number of specimens sent to the laboratory either incorrectly packaged or missing/ incomplete mandatory information. Reporting of Exposure to Hazardous substances incidents has increased by 59% (an increase of 34 incidents) compared to 2020/21.

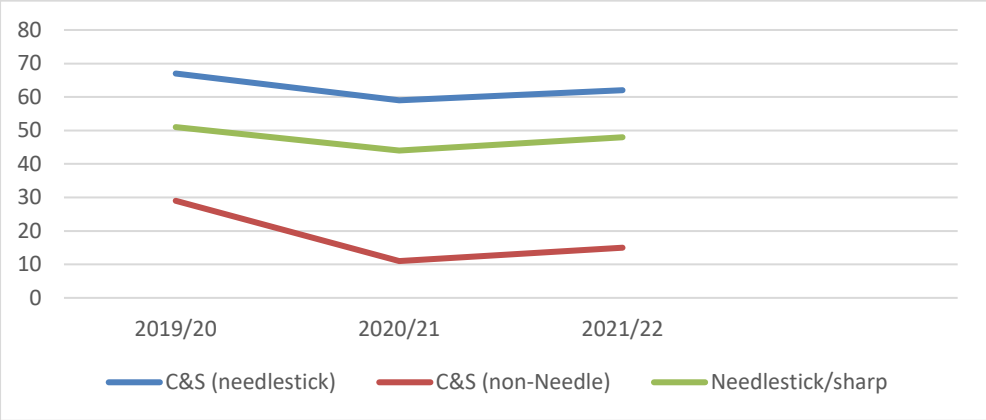
Graph 2 showing the breakdown of incidents reported under the Exposure to hazardous substances between April 21-March 22.



The graph shows a peak in the number of incidents reported for Exposure to Hazardous substances between September and November 2021.

Sharps injuries including needlesticks, remain the highest reported health and safety incident at the organisation and the Trust recognise this as a priority for the following year. This has again increased from the previous year from 114 in 2020/21 to 125 in 2021/22. The increase regarding needle stick is positive assurance as it demonstrates an increase in health and safety awareness and the necessity of reporting near misses.

Graph 3 showing the trends for sharps incidents reported for the last 3 years from 2019 to 2022.



The graph shows a drop in incident from 2019/20 to 2020/21 but these figures have started to increase again in 2021/22, with Cuts & Sharps (needlesticks) being the most reported category in the last 3 years.

The Dudley Group have introduced a safer sharps policy which continues to be promoted throughout the Trust, the product evaluation group continue to engage clinicians throughout the Trust to promote safer sharps. An audit of non-safe sharps use has been carried out across the Trust to look at the rationale behind their use and to ensure risk assessments are in place for their use. The result of this audit is being monitored by the Quality and Safety Assurance group.

The table below provides a breakdown of the number of incidents reported as near miss and no harm.

Reporting year	Total number of incidents	Number of reported near misses	% of near misses	Number reported of actual harm	% of actual harm
2018/19	360	69	19.2%	56	15.6%
2019/20	396	60	15.2%	126	31.8%
2020/21	313	46	14.7%	102	32.5%
2021/22	373	60	16.1%	128	34.3%

The number of near miss incidents reported has increased from 46 to 60 in the reporting period 2021/22 but is consistent with the figures from the years 2018/19 and 2019/20.

Whereas over the comparison period the number of incidents reported as resulting in harm has increased slightly by 1.8% compared to the same review period last year. This is largely due to raised awareness of incident reporting through health and safety training resulting in an increase in overall reported incidents, which shows that staff are using the DATIX system more widely. There are no identified trends or systemic failures.

6 RIDDOR Data

The Health and Safety team reviews all the health and safety incidents. Where there are identifiable failings in equipment, procedure or infrastructure immediate actions are taken to mitigate the risk of further occurrence. These incidents relate to all staff, patients and visitors as the Trust has a duty of care to staff, patients and to anyone who may be harmed by its actions. These then undergo a full investigation, recommendations and action plans where appropriate. Any incidents which meet the RIDDOR reportable criteria are reported by the health and safety team externally to the Health and Safety Executive (HSE).

The following table/chart provides an overview of the total number of RIDDOR reportable incidents reported each year for the preceding four years (staff and patients). The number reported during 2021/22 is comparable to the previous year. The last 2 years have seen higher than previous years reports under RIDDOR compared to 2018/19 and 2019/20. This may be done to a more robust procedure for identifying RIDDOR reportable incidents.

Incident Category	Incidents During 2017/18	Incidents During 2018/19	Incidents During 2019/20	Incidents During 2020/21	Incidents During 2021/22
Over seven day injury	8	0	1	6	7
Dangerous Occurrence	2	2	3	6	3

Disease	0	0	1	0	0
Major Injury	2	5	2	3	3
Total	**12**	**7**	**7**	**14**	**13**

The data shows that the category for dangerous occurrence has decreased by 50% (decrease from 6 to 3). However dangerous injury (over 7 days) has increased by 16.6% (increase from 6 to 7) from the previous year. Review of the increase showed no relative theme or systemic failure.

The low numbers of incidents reported to the HSE in respect to the Diseases is a concern as the Trust has only reported 1 case over the last few years. This may be a gap in assurance where further investigation is required together with Staff Health & Wellbeing to identify any potential occupational diseases such as occupational dermatitis.

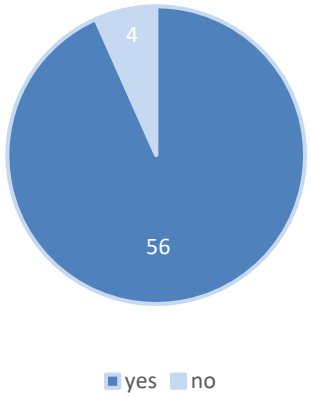
All health and safety incidents are reviewed in DATIX to determine if they are potentially RIDDOR reportable. The Trust is not assured that there are no potential gaps to staff reporting the incidents or if the low numbers are due to improved changes in practice mitigating the risks. This will be taken forward as an objective for the financial year 2022/23.

7 Health and Safety Compliance

Risk Assessment

The Health & Safety document compliance audit is a rolling audit to audit all departments across the trust, with each department being audited every 3 years. To date, 60 departments across the Trust have been audited for risk assessment compliance. Compliance is split to compliant or non-compliant and is demonstrated in the graph below.

Graph 4 showing compliance for risk assessment across the Trust 2021/22.

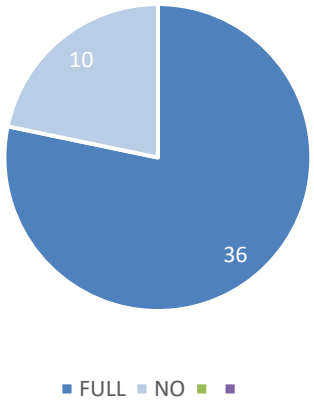


The graph shows that 93% of departments audited are now compliant with risk assessments after a campaign to support departments with risk assessment compliance.

COSHH compliance

COSHH compliance has dropped in the last year as the COSHH assessments completed by the external auditor have no passed their review dates and with increased capacity due to covid pressures in this period (2021/22) .

Graph 5 showing COSHH compliance across the Trust 2021/22



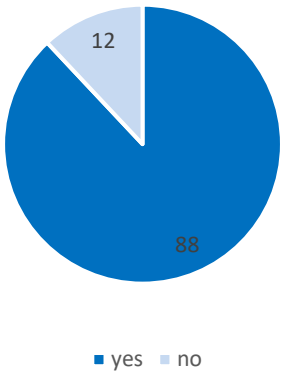
COVID-19 – Social Distancing Audit

The Health, Safety and Fire Team have been involved in the response to COVID-19 since the identification of the Pandemic in early 2020. This has involved interpretation and implementation of guidance around PPE and social distancing as well as coordinating the fit testing response to ensure compliance with the Personal Protective Equipment at Work Regulations 1992.

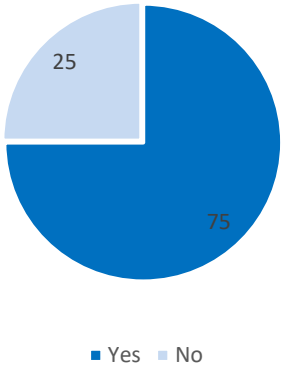
Whilst this response has taken capacity away from the Health, Safety and Fire Team it have continued to ensure compliance with legislation and where possible begin to drive improvements.

Social distancing audits were carried out across the Trust on 4 separate occasions. The final compliance for the audits is demonstrated in the graphs below.

Graph 6 showing compliance with covid declarations being displayed (Sept 2021)



Graph 7 showing compliance with max occupancies displayed on offices.



Fire Safety

During 2020/21 the Fire Lead training programme has been reviewed and refreshed. A total of 127 fire leads trained to spot fire safety hazards and completely monthly checklists across the main Russells Hall site. This is an increase of 95% in trained Fire Leads, with 80% of all departments having at least 1 Fire Lead. They are the key links between the trust fire team and the clinical teams on the ground.

Fire Risk Assessment Compliance

Fire risk assessment compliance is at 100% for all Trust premises including Guest and Corbett Outpatient Centres for 2020/21. Some fire risk assessments have been combined together, e.g. 6 separate fire risk assessments for the hospital streets in east and west wing have been combined into one assessment to reduce duplication. Non-Trust premises (those that have our staff in them but are not our owned buildings) i.e. Brierley Hill Health and Social Care Centre (BHSCC) are inspected every 2 years.

Trust Fire Risk Assessments	
Total Trust premises to inspect	74
Trust premises - Total inspected	74
Trust premises - Percentage complete	100%
Non-Trust Fire Risk Assessments	
Total non-Trust premises to inspect	30
Non-Trust premises - Total inspected	20
Non-Trust premises - Percentage completed	67%

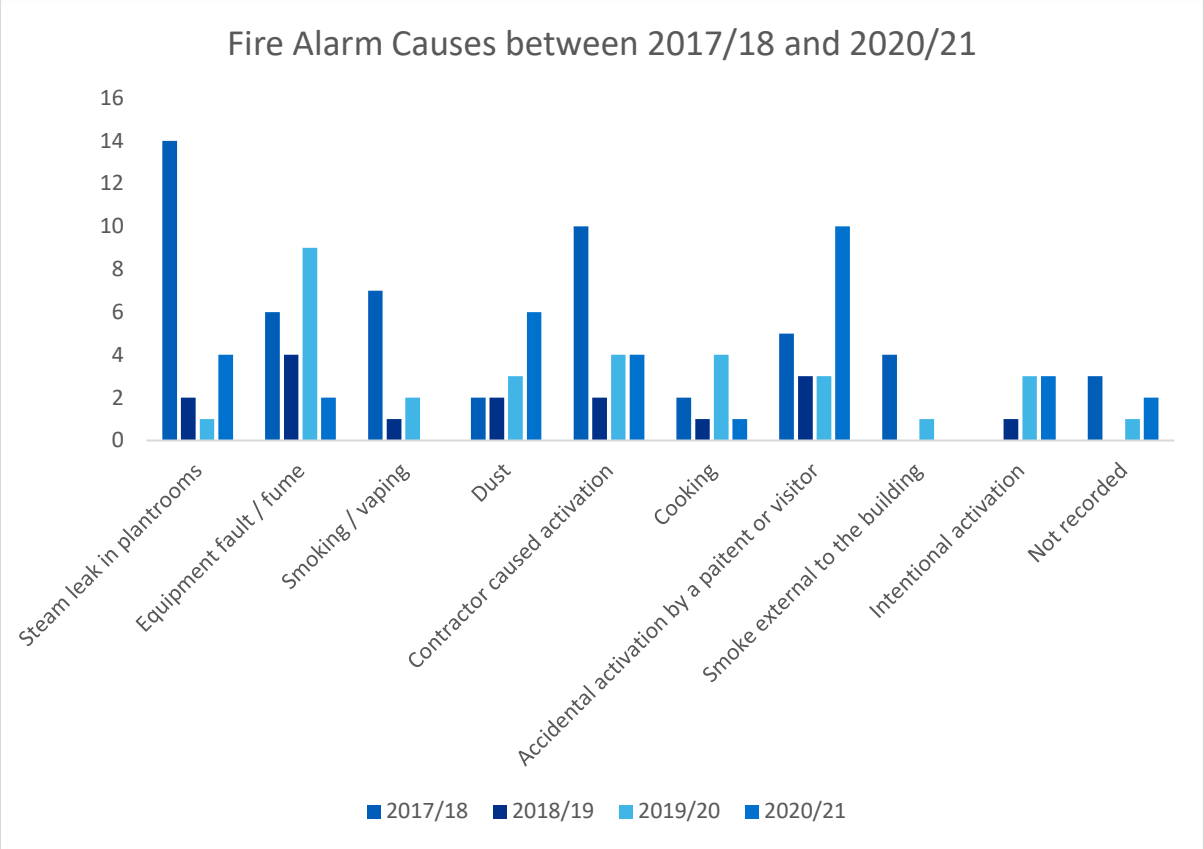
The Community fire risk assessment programme has been impacted severely by Covid-19. A programme to complete all fire risk assessments is in place for the current year.

Fire Incidents

There were a total of 32 fire alarm activations in 2020/21, this includes the Guest and Corbett Outpatient Centres. This is an increase of 7% since 2020/21.

Below is a table detailing the causations for the false alarms experienced on site, comparative for the previous years:

Activation Type	2017/18	2018/19	2019/20	2020/21
Steam leak in plantrooms	14	2	1	4
Equipment fault / fume	6	4	9	2
Smoking / vaping	7	1	2	0
Dust	2	2	3	6
Contractor caused activation	10	2	4	4
Cooking	2	1	4	1
Accidental activation of a manual call point	5	3	3	10
Smoke external to the building	4	0	1	0
Intentional activation	0	1	3	3
Not recorded	3	0	1	2
TOTAL	**53**	**16**	**30**	**32**



Of the 32 fire alarms in 2020/21, the highest causation was accidental activation of a manual call point by a patient or visitor. This is a 233% increase on the previous year. False fire alarms are reviewed in each departments fire risk assessment, and actions are put in place to reduce these occurrences, including adding alarm boxes to the call points themselves.

The West Midlands Fire & Rescue Service will be placing more focus on 'call challenge' during 2021/22, and full training to the change in response to fire alarm activations is being provided by the service to key Trust staff.

The Trust has seen one potential arson attempt that did not result in a fire alarm activation. A waste bin in a toilet on the hospital street, ground floor, was set on fire. This was very quickly carried outside by Mitie staff and extinguished by a Trust member of staff.

8 Fire and Health and Safety Training

The Trust delivered a number of training packages throughout 2021/22 with total numbers of staff trained by type below:

Type	Number
Health and Safety	94.3% (5005 of 5303)
Fire Safety and Prevention	90.1% (4781 of 5303)
Figures taken from 31/03/2022 training report	

Fire training compliance scores have suffered during the pandemic, but with multiple routes to complete the training offered, including face to face in the lecture theatre, and in wards,

and online training via e-learning and Teams, the compliance score is now above the 90% target. Continued focus is being placed on training Mitie staff, to ensure all staff are able to support the reduction of fire risk across the hospital.

Health and Safety Policies and Standard Operating Procedures (SOPs)

During 2021/22 all polices and SOPs due for review were updated, in line with the identified Health, Safety and Fire procedural documents review schedule. Where required documents have been updated to ensure they reflect current legislation and practice. Documents due for review in 2022 are on schedule.

This has included:

	When Last Done?	Next Required
Policy		
Control Of Substances Hazardous To Health (COSHH) Policy	05/2021	05/2024
Display Screen Equipment Policy	11/2019	11/2022
First Aid at Work Policy	11/2019	11/2022
Health and Safety Policy	09/2021	09/2024
Health and Safety Risk Assessment Templates Policy	11/2021	07/2022
Latex Policy	12/2019	12/2022
PAT Testing and Extension Lead Policy	08/2019	08/2022
RIDDOR Policy	11/2019	08/2022
Selection Handling and Disposal of Sharps Policy	09/2021	09/2024
Slips Trips and Falls Policy	11/2021	11/2024
Stress Management and Risk Assessment Policy	11/2021	07/2022
Work at Height Policy	11/2021	11/2024
Fire Safety Management in the Community Policy	12/2019	12/2022
Fire Safety Policy	12/2019	12/2022
Standard Operating Procedure (SOP)		
Fire Safety Procedure, Russells Hall Hospital Standard Operating Procedure	12/2019	12/2022
Monthly Fire Inspections SOP	09/2020	09/2022
Permit to Breach Compartmentation Walls Standard Operating Procedure	12/2019	12/2022
Social Distancing for Clinical Areas and Community Care SOP	06/2020	06/2023
Social Distancing Office Space Standard Operating Procedure	06/2020	06/2023
Water Cooler Dispenser Management Standard Operating Procedure	12/2019	12/2022

16.0 Enforcement Authority Interest in the Trust

During the reporting period the Trust has maintained contact with West Midlands Fire & Service in relation to North Block improvement works. These visits will continue to ensure that the Fire Service is fully engaged and briefed on the development of the fire rectification works on the North Block building.

The Trust were visited by the HSE (Health & Safety Executive) as part of a routine surveillance visit in October 2021. The visit from the inspectors lasted 3 days and looked at Violence and Aggression, Social distancing and covid measures and manual handling. The visit went very well, and the inspectors commended the face fit testing process the Trust has in place. A report will be sent to the Trust at the end of the year when the HSE have completed their round of NHS surveillance visits.

The HSE have also contacted the Trust in relation to two incidents reported under RIDDOR these were:

- **Sharps incident**- Registrar in Interventional Radiology received a needlestick injury from a needle used on a Hep C patient. The needle was placed in a plastic cup, rather than in sharps stop device. The needle had perforated the side of the cup and the needlestick occurred when the registrar picked up the cup to dispose of the sharps.
  The HSE requested the Trusts safer sharps policy and no further action has been taken to date.
- **Slip incident**- Staff member on B4 slipped on a wet floor fracturing her wrist and ankle. The wet vax had been used to clean up a spillage and left a trail of water on taking the vax away. The HSE have requested more information on this incident and have asked for MITIE's policy in relation to responsibilities and communications when clean up spillages.

17.0 Forward Plan and Priorities for Health, Safety and Fire for 2022/23

Priorities	Plan
Policy Development and Review	Review of all health, safety, and fire documents, encompassing a holistic review of process in place currently to ensure fit for purpose
Raise awareness regarding needle stick injuries and work with departments to implement safer sharps	Audit of departments reporting higher rates of needlesticks injuries to look at patterns and trends including any non-safety devices in use. Drive the use of safer sharp alternatives across the Board and where not possible, ensure that a robust risk assessment with suitable controls are in place.
Reduce exposure to Hazardous substances incidents	Review of incidents to identify trends. Spillage training to be rolled out to departments identified as requiring the training. Information on correct packaging and transportation of specimens to the lab to be developed and communicated including mandatory information on the forms.
Ensure Health Surveillance compliance is being adhered to	Work with the staff health and wellbeing team to collate the data from the mandatory appraisal staff meetings and ensure that any health surveillance queries are being dealt with accordingly. Work with SHAW to identify any possible RIDDOR reportable incidents or diseases such as Occupational dermatitis, Carpal tunnel syndrome or potential contamination from high risk needlesticks or splashes.
Increase uptake of non-mandatory Health & Safety training	Identify Health & Safety leads that have not yet undertaken the required Health & safety training such as risk assessment, COSHH and Display Screen Assessor training.
COSHH audit	Full review of COSHH assessments, substances and storage across the Trust including identification of areas requiring spillage training

Priorities	Plan
Monitor the North Block fire engineering works over the three year works programme	Attend the North Block fire engineering works meetings to understand the works being undertaken and ensure that they are being carried out as agreed, if there are any deviations from the original works then work with the design team and estates to ensure that safety is not compromised and continued safe usage of the building Engage with West Midlands Fire Service should any deviations and issue arise.

Enclosure 19

The Dudley Group NHS Foundation Trust

Paper for submission to the Board of Directors on 22nd September 2022

Title:	Summary of Workforce & Staff Engagement Committee (WSEC) Meeting (Deep Dive into Dudley Improvement Practice (DIP) on 26th July 2022
Author:	Alan Duffell - Interim Chief People Officer/ Julian Atkins - Non-executive Director
Presenter:	Julian Atkins - Non-executive Director

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

Recommendations:

This upward report is presented to the Board for information.

Summary of Key Issues:

The enclosed is an upward report from the Workforce & Staff Engagement Committee (WSEC) held on 26th July 2022.

The Committee received an update on the Trust's strategy progress in relation to the strategic goal of being a brilliant place to work and thrive. The KPI report was presented and the Committee agreed a new format was required from September 2022 onwards with some additional metrics to be included around vacancies and appraisals.

A report was presented detailing the current position of mandatory training compliance, which has made a significant improvement in June, but noted there was still some work to do around Resus, Manual Handling and Safeguarding training compliance.

The Committee approved the WRES and WDES reports on behalf of the Board with one minor amendment to the action around talent pools.

The Committee received a deep dive presentation and discussion regarding the Dudley Improvement Practice.

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

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

Report Journey/ Destination	Working / Exec Group	N	Date:
	Committee	Y	Date: WSEC 26/07/2022
	Board of Directors	Y	Date: 22/09/2022
	Other	N	Date:

The Dudley Group NHS Foundation Trust

CHAIR'S LOG
UPWARD REPORT FROM WORKFORCE & STAFF ENGAGEMENT COMMITTEE
Date Committee last met: 26th July 2022

The Deep-Dive session covered the following areas:

- **Dudley Improvement Practice (DIP)** – a walk though of the independent learning review and discussion on the five key opportunities identified; 1) Divisional Leadership 2) Communities of Practice 3) Governance and supporting processes to create autonomous improvement capability across the Trust 4) Strategy deployment 5) ICP collaboration

MATTERS OF CONCERN OR KEY RISKS TO ESCALATE	MAJOR ACTIONS COMMISSIONED/WORK UNDERWAY
• Vacancy rates remain an area of concern particularly the accuracy of the reported figures. • Retention needs to be a key area of focus in accordance with the Trust's strategic priority of being a brilliant place to work and thrive. • Mandatory Training - Resus, Manual Handling and Safeguarding are being monitored to ensure increased compliance and sustained rates of compliance.	• For September 2022 the KPI report will be reviewed and presented in a new format, with the following amendments: appraisal compliance rates shown, Nursing separated from Midwifery in the vacancy figures, areas with highest vacancy levels shown, lowest vacancy levels displayed together with a mean average vacancy rate per ward/team.
POSITIVE ASSURANCES TO PROVIDE	**DECISIONS MADE**
• Long-term sickness absence was noted as showing a downwards trend highlighting effective management of cases. • Mandatory Training compliance rates have made a significant improvement from the previous month (note see above concern).	• Decision made to approve the Workforce RACE Equality Standard (WRES) and the Workforce Disability Equality Standard (WDES) 2022 reports, subject to a minor amendment to update the talent pool actions.

Chair's comments on the effectiveness of the meeting:

The meeting was quorate and, although it ran slightly over time, was an effective meeting with some useful discussions on workforce strategy, the further developments around the workforce KPI report (with good suggestions from nursing on how to improve the vacancy data), and the improvements in mandatory training. The Committee were pleased to approve the WRES/WDES submission subject to one small amendment prior to Board submission for approval. The deep dive presentation from the Dudley Improvement Practice team highlighted the ongoing improvements made as a result of their support. Quarterly updates will continue to be provided at WSEC and Trust Management Group meetings.

The Dudley Group NHS Foundation Trust

Paper for submission to the Board of Directors on 22nd September 2022

Title:	Summary of Workforce & Staff Engagement Committee (WSEC) Meeting on 30th August 2022
Author:	Alan Duffell - Interim Chief People Officer/ Julian Atkins - Non-executive Director
Presenter:	Julian Atkins - Non-executive Director

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

Recommendations:

This upward report is presented to the Board for information.

Summary of Key Issues:

The enclosed is an upward report from the Workforce & Staff Engagement Committee (WSEC) held on 30th August 2022. Key points:-

MATTERS OF CONCERN OR KEY RISKS TO ESCALATE

- The Electronic Staff Record (ESR) was discussed. There was increasing concern on the deployment of ESR and the Committee concluded that, providing the costs are not prohibitive, the Trust should enlist the help of a specialist to enable better use of the ESR system.
- Mandatory Training - Resus, Manual Handling and Safeguarding compliance continues to show slow progress.

POSITIVE ASSURANCES TO PROVIDE

- The Committee noted the improvements that have been made in the Workforce KPI report so far. There is further work to be done and this should be completed by October.
- The improvements in the statutory and mandatory training statistics were noted.
- The Divisional Directors for Medicine, Surgery Women & Children and Clinical Support Services gave their updates about the transformational work being done in respect of new roles at the Trust.

MAJOR ACTIONS COMMISSIONED/WORK UNDERWAY

- There was a good discussion around the Equality, Diversity and Improvement (EDI) draft strategy, with a suggestion that this is called a plan, journey or approach. The Committee's contributions will be incorporated and brought back to the Committee once it has been to Execs.
- The meeting was the first since the sad loss of Andrew Boswell. The Committee gave thanks to Andrew for his tremendous contribution to statutory and mandatory training which had enabled the Trust to improve its compliance rates.

DECISIONS MADE

- No key decisions were made.

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)	**X**
Build innovative partnerships in Dudley and beyond	
Improve health and wellbeing	

Implications of the Paper:			
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	N	Details:

Report Journey/ Destination *(if applicable)*	Working / Exec Group	N	Date:
	Committee	Y	Date: WSEC 30/08/2022
	Board of Directors	N	Date: 22/09/2022
	Other	N	Date:

The Dudley Group NHS Foundation Trust

CHAIR'S LOG
UPWARD REPORT FROM WORKFORCE & STAFF ENGAGEMENT COMMITTEE
Date Committee last met: 30th August 2022

MATTERS OF CONCERN OR KEY RISKS TO ESCALATE	MAJOR ACTIONS COMMISSIONED/WORK UNDERWAY
• Increasing concern on the deployment of ESR and it was agreed that, providing costs are not prohibitive, the Trust should enlist the help of a specialist to help us make better use of the Electronic Staff Record (ESR) system. • Mandatory Training - Resus, Manual Handling and Safeguarding continue to show slow progress.	• There was good discussion around the Equality, Diversity, and Improvement (EDI) draft strategy, with a suggestion that this is a plan, journey, or an approach rather than a strategy. The Committee's contributions will be incorporated and brought back to the Committee once it has been to the Executive Committee. .
POSITIVE ASSURANCES TO PROVIDE	**DECISIONS MADE**
• The Committee noted the improvements that have been made in the Workforce KPI report so far and noted that there was further work to do. • The improvements in the overall statutory and mandatory training statistics were noted. • The Divisional Directors for Medicine, Surgery Women & Children and Clinical Support Services gave updates and prompted a good discussion about the transformational work on new roles at the Trust.	• There were no key decisions of the Committee at this meeting.

Chair's comments on the effectiveness of the meeting:

The meeting ran to time. This was the first meeting since the sad loss of Andrew Boswell and his tremendous contribution to statutory and mandatory training was noted, with the work he undertook enabling the Trust to achieve increased compliance rates.
The Committee reviewed performance on KPIs and there was a detailed discussion on workforce risks, especially on the impact of ESR on managing employees, providing quality information and its capacity to improve workforce challenges.
Overall, this was an effective meeting with good participation from those attending.

Enclosure 20

The Dudley Group NHS Foundation Trust

Paper for submission to the Board of Directors on 22nd September 2022

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

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

Recommendations:

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

Summary of Key Issues:

Sickness Absence

- In month sickness absence has continued to rise from 5.59% in June to 6.61% in July, which correlates with an increase in COVID-19 cases.
- The rolling 12-month absence remains consistent at 6.73% as a result of increased absence due to COVID-19 being represented across the full year figure.

Vacancies

- The total vacancies stand at 798.38 WTE, a reduction from 881.43 in June, this equates to 13%.
- There are recruitment offers in place for 435.96 WTE of the vacancies and recruitment activity for a further 244.36 WTE.

Turnover

- Overall staff turnover (rolling 12 months average) is at 10.9%.
- Excluding Students and Medics, Admin & Clerical are the highest at 10.2%.
- Since September 2021 the number if starters have exceeded the leavers.

Bank & Agency Usage

- Bank usage has increased from 552 WTE in June to 580 in July, bank costs increased marginally from £3,224,018 in June to £3,294,608 in July. Agency usage has decreased from 258.28 WTE in June to 195.02 in July, with agency costs reducing from £1,801,870 in June to £1,589,817 in July.
- The combined spend of temporary staffing in July is £4,884,425 compared to £5,355,542 in June. Combined bank and agency usage is 774.62 WTE which is below the total vacancies, which are 798.38 WTE.

Mandatory Training
• Mandatory Training: overall compliance is at 89.29 as at 11th August.

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 and corporate	
	On Risk Register: Y	Risk Score: various	
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: 30/08/2022
	Board of Directors	Y	Date: 22/09/2022
	Other	Y/N	Date:

Workforce KPI Report

July 2022

Karen Brogan

Deputy Chief People Officer

NHS
The Dudley Group
NHS Foundation Trust

Executive Summary

The Dudley Group NHS Foundation Trust

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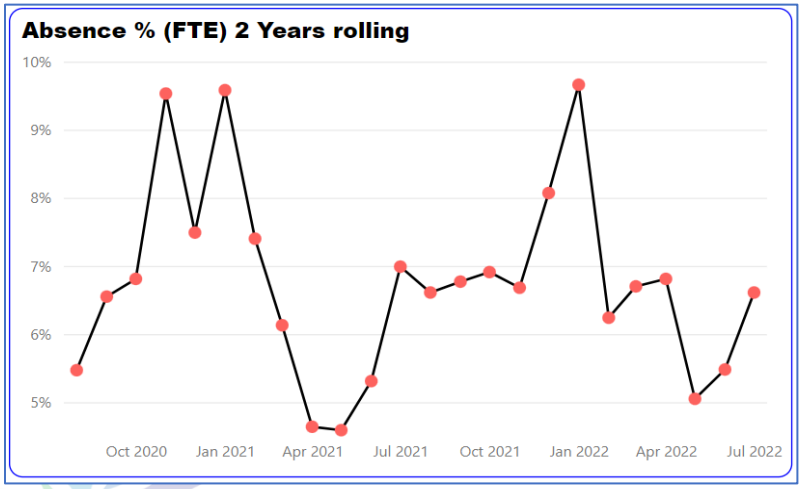
- **Mandatory Training**

- Mandatory Training: overall compliance is at 89.29 as at 11th August.

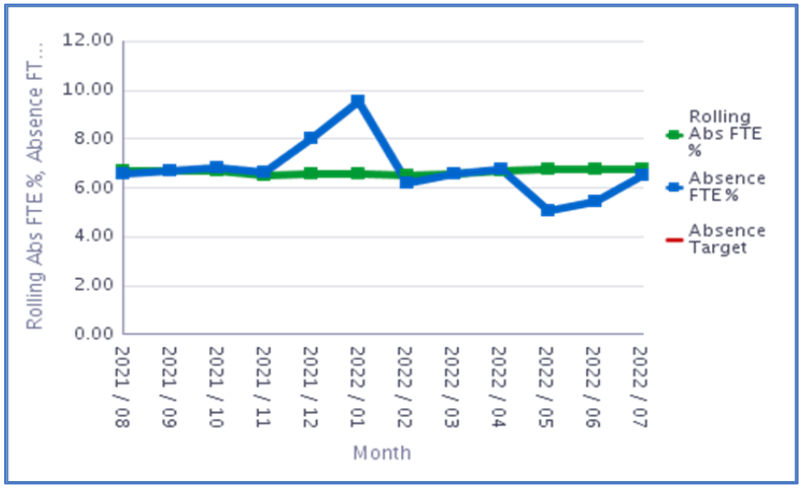
Sickness Absence

The Dudley Group NHS Foundation Trust

Trust Sickness Absence in Month



Trust Sickness Absence – Rolling



Performance:

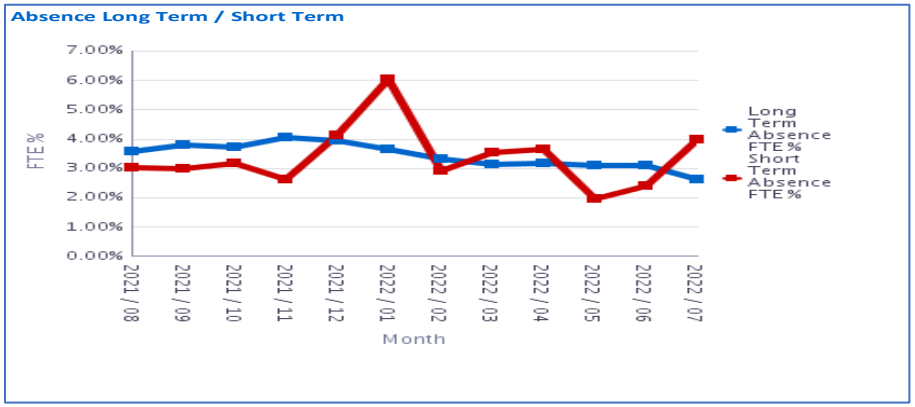
- In month sickness absence has continued to rise from 5.59% in June to 6.61% in July, which correlates with an increase in COVID-19 cases.
- The rolling 12 month absence remains consistent at 6.73% as a result of increased absence due to COVID-19 being represented across the full year figure.

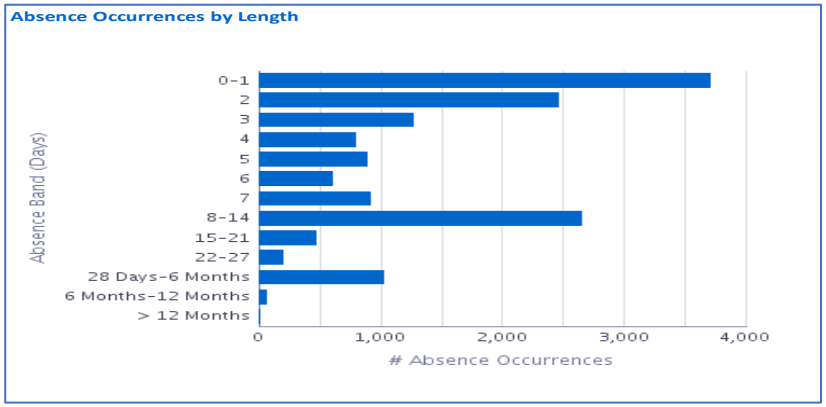
Assurance:

- All COVID-related absence is reviewed and supported by the operational HR teams.
- The HR team continue to sensitively support the management of long and short-term absence cases as appropriate.

Sickness Absence (2)

The Dudley Group NHS Foundation Trust





Performance:

- In July short-term absence accounted for 87.02% of all sickness absence episodes, with long-term absence (28 days +) accounting for 12.98% of absence episodes. However long-term absence accounted for 71.65% of all FTE lost, compared to 28.35% for short-term absence.
- There is a steady slight decline in long-term absence, short-term absence has some sharp peaks and troughs directly correlated to Covid-19.
- Over the last rolling 12 months the highest incidences of absence are 0-1 days, 2 days and 8-14 days.

Assurance

- Individual plans in place for all long-term sickness @ 6months+.
- Individual plans in place for all short-term persistent absence.

Sickness Absence (3)

The Dudley Group NHS Foundation Trust

Absence Reason	Headcount	Abs Occurren	FTE Days Lost	%
S25 Gastrointestinal problems	224	231	776.87	11.6
S10 Anxiety/stress/depression/other psychiatric illnesses	140	151	1,950.73	29.1
S13 Cold, Cough, Flu - Influenza	113	120	315.71	4.7
S16 Headache / migraine	74	79	229.26	3.4
S12 Other musculoskeletal problems	68	74	685.03	10.2
S99 Unknown causes / Not specified	54	55	344.26	5.1
S30 Pregnancy related disorders	47	52	374.56	5.6

- In July Gastrointestinal problems is the highest reason of absence (231) (excluding COVID) followed by Anxiety, Stress and Depression (140), further work is being undertaken review this as this presents as an outlier.

Org L5	FTE Days Lost
253 Emergency Service Spec	6,463.91
253 Maternity Unit Spec	5,976.65
253 Short Stay Spec	5,774.52
253 Imaging Spec	4,992.51
253 Therapy Department Spec	4,533.80

Absence % (FTE) - Drill Down

Month	May 2022		June 2022		July 2022	
Division	FTE	Rate	FTE	Rate	FTE	Rate
⊞ 253 Clinical Support	789.51	5.09%	855.40	5.68%	1,223.97	7.85%
⊞ 253 Corporate / Mgt	469.43	2.47%	556.68	3.05%	808.24	4.33%
⊞ 253 Medicine & Integrated Care	4,143.92	6.27%	4,076.66	6.31%	4,925.83	7.39%
⊞ 253 Surgery	2,414.96	4.45%	2,788.31	5.26%	3,353.36	6.08%
Total	**7,817.82**	**5.05%**	**8,277.05**	**5.48%**	**10,311.41**	**6.61%**

Performance

- There have been increases in July across all areas, which correlates with an increase in Covid-19 cases.
- Clinical Support Services are the division with the highest sickness absence rate at 7.85% in July, an increase of 2.17% on June.

Assurance

- Divisional focus on addressing sickness absence by HR Business Partners and leadership teams.

Vacancies

Month: 31 July 2022	Trust 13%	CS 18%	Corporate 5%	MIC 17%	Surgery 10%

The Dudley Group NHS Foundation Trust

StaffGroup	Budget WTE	Contracted WTE	Vacancy WTE	Vacancy %	Bank	Agency	Bank & Agency	Future Leavers	Leavers (Internal)	Auth	Advt	S List	Intview	Offer	Starting (Internal)	Starting (Fm Bank)	Starting (External)	Total
Senior Manager	22.80	17.76	5.04	22%		£138,674	£138,674	-0.40						1.00			1.00	2.00
Nursing	2,043.85	1,657.43	386.42	19%	£1,090,959	£1,201,087	£2,292,046	-32.09	-8.24	16.48	19.98	11.56	12.56	58.50	8.24	6.88	16.24	150.44
Allied Healthcare Professional	842.25	687.12	155.13	18%	£219,492	-£24,020	£195,472	-4.04	-6.90	4.00	20.80	5.00	15.40	41.48	6.90	4.00	24.64	122.22
Junior Medic	466.30	397.63	68.67	15%	£571,109	£149,071	£720,180	-12.00	-1.00	6.00	1.00		6.00	30.00	1.00		17.00	61.00
Senior Medic	403.66	352.66	51.00	13%	£482,453	£108,791	£591,244	-4.00	-1.00	2.00	5.00	2.00	3.00	14.25	1.00	1.00	2.00	30.25
Admin	1,109.60	996.18	113.42	10%	£194,962	£11,982	£206,944	-8.60	-2.86	5.60	19.81	27.03	16.37	29.53	2.86	5.00	12.44	118.64
Prof Tech Scientist	129.98	121.59	8.39	6%	£67,454	£1,463	£68,917	-4.00		1.00	8.00			6.80			11.00	26.80
Other	28.06	27.34	0.72	3%	£0	£0	£0	-0.67		4.00	1.00		2.00	6.00			2.00	15.00
CSW	907.03	897.44	9.59	1%	£668,179	£2,767	£670,946	-12.52	-11.96	9.80	1.57	9.60	7.80	63.40	11.96		49.84	153.97
Total	**5,953.53**	**5,155.15**	**798.38**	**13%**	**£3,294,608**	**£1,589,817**	**£4,884,42**	**-78.32**	**-31.96**	**48.88**	**77.16**	**55.19**	**63.13**	**250.96**	**31.96**	**16.88**	**136.16**	**680.32**

	May Vacancy WTE	May Vacancy WTE	June Vacancy WTE	June Vacancy %	July Vacancy WTE	July Vacancy %
Nursing	406.18	20%	404.6	20%	386.42	19%
Admin	113.84	10%	114.8	10%	113.42	10%
CSW	37.29	4%	11.6	1%	9.59	1%
AHP	156.58	19%	155.37	18%	155.13	18%
Junior Medics	57.59	12%	63.14	14%	68.67	15%
Senior Medics	56.31	14%	54.43	14%	51	13%
Prof Tech Scientist	15.04	11%	12.27	9%	8.39	6%
Other	-6.15	-22%	-4.19	-15%	0.72	3%
Senior Manager	4.64	19%	6.31	2800%	5.04	22%
Total	841.32	14%	818.33	14%	798.38	13%

Assurance:

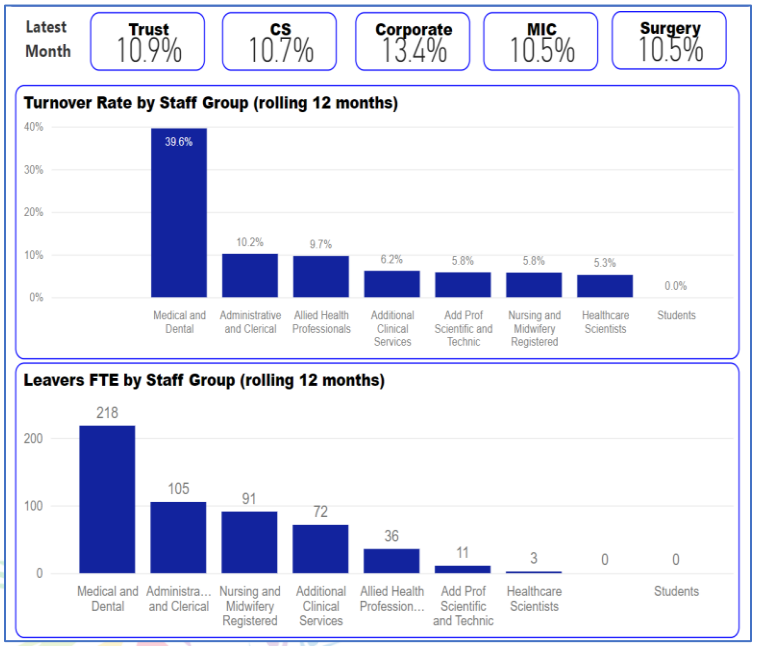
- International Nurse recruitment programme
- HCSW recruitment campaign
- Targeted Divisional recruitment plans (i.e., theatre/critical care),
- Imaging Review/Community Diagnostic Hub.
- ICS collaborative recruitment initiatives

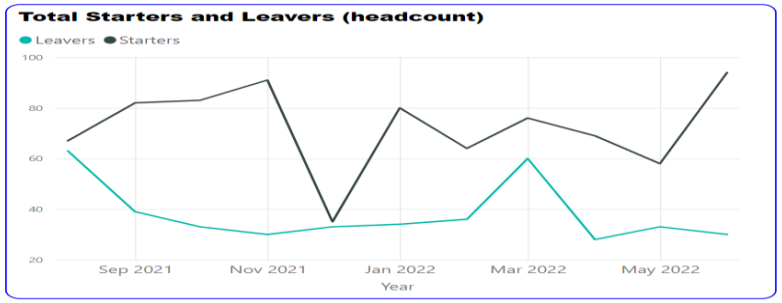
Performance:

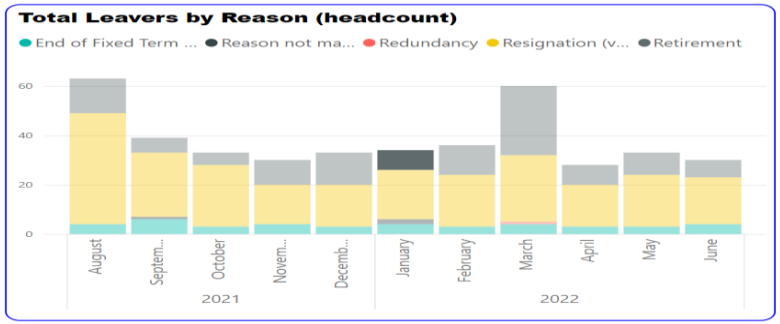
- Contracted WTE staff has increased from 5131.95 in June to 5155.15 in July.
- The total vacancies stands a 798.38 WTE, a reduction from 881.43 in June, this equates to 13%.
- There are recruitment offers in place for 435.96 WTE of the vacancies and recruitment activity for a further 244.36 WTE
- Registered Nursing vacancies are at 386.42, with 150.44 WTE in the recruitment pipeline (this does not include the international recruitment pipeline).

Turnover

The Dudley Group NHS Foundation Trust







Performance:

- Overall staff turnover (rolling 12 months average) is at 10.9%
- Excluding Students and Medics, Admin & Clerical are the highest at 10.2%, AHP's at 9.7% and Nursing & Midwifery Registered at 5.8%.
- Since September 2021 the number of starters has exceeded the leavers.

Assurance:

- International Nurse recruitment programme
- HCSW recruitment campaign
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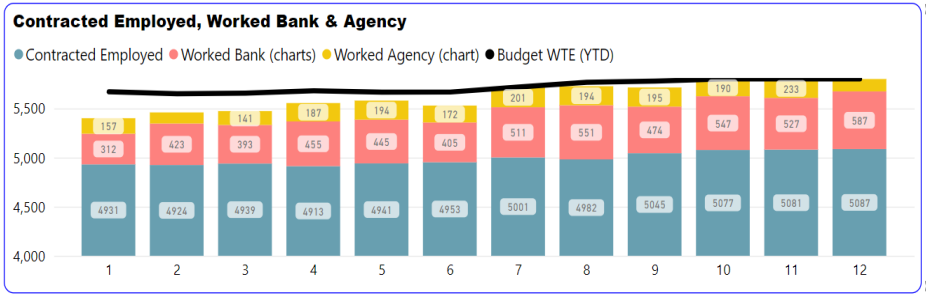
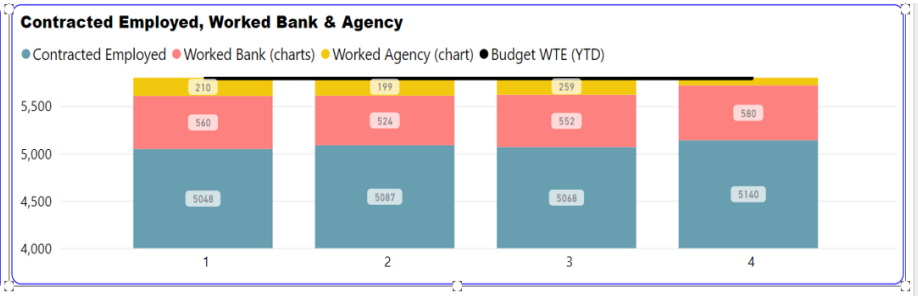
Bank & Agency Usage (1)

The Dudley Group
NHS Foundation Trust

CC1 Desc	Budget WTE	Contracted WTE	Vacancy WTE	Vacancy %	Worked Bank	Bank (£)	Worked Agency	Agency (£)	Bank & Agency
Medicine & Integrated Care	2,636.73	2,192.30	444.43	17%	290.39	£1,694,773	97.31	£766,417	£2,461,189
Surgery	2,033.74	1,828.63	205.11	10%	201.22	£1,040,868	83.84	£656,778	£1,697,646
Clinical Support	616.36	503.03	113.33	18%	56.21	£219,581	6.26	£26,507	£246,088
Corporate / Mgt	666.70	631.19	35.51	5%	31.78	£339,387	7.61	£140,114	£479,501
Total	**5,953.53**	**5,155.15**	**798.38**	**13%**	**579.60**	**£3,294,608**	**195.02**	**£1,589,817**	**£4,884,425**





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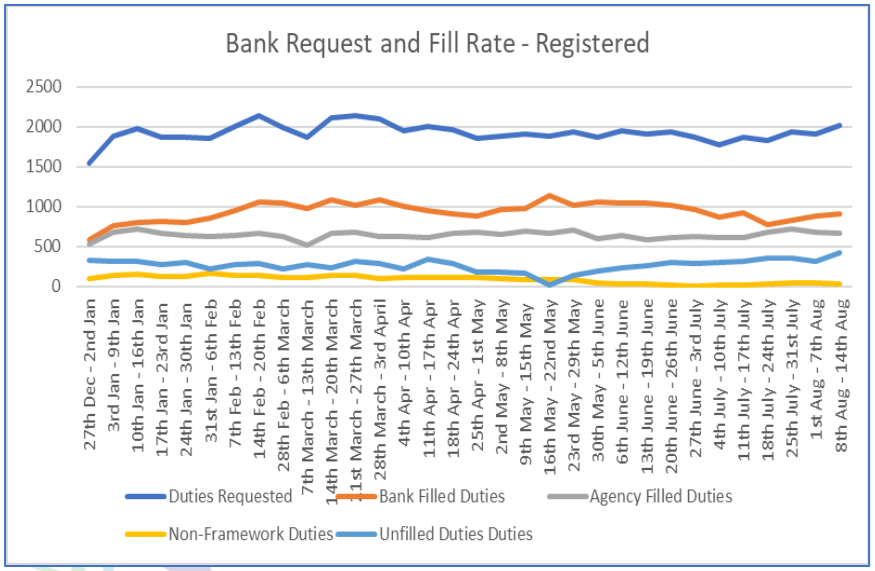
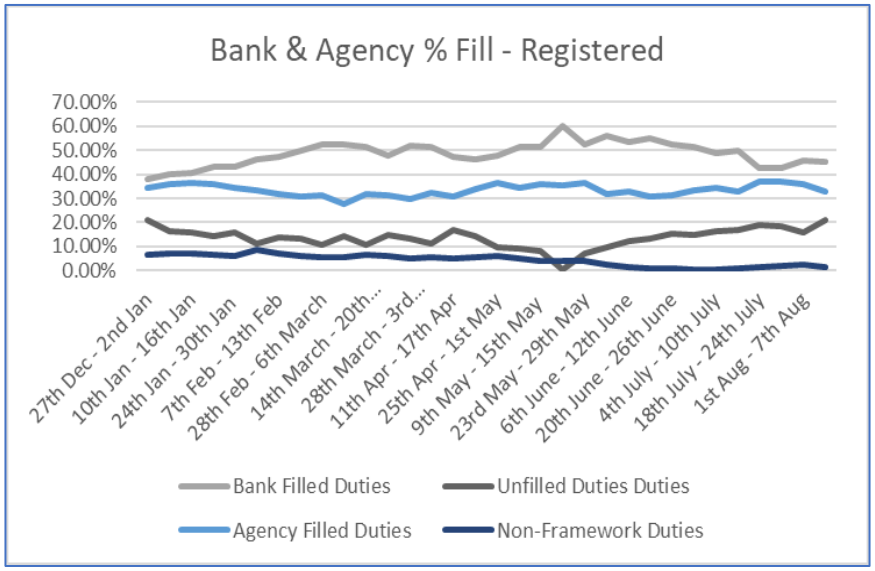
Bank & Agency Usage (1)

The Dudley Group
NHS Foundation Trust



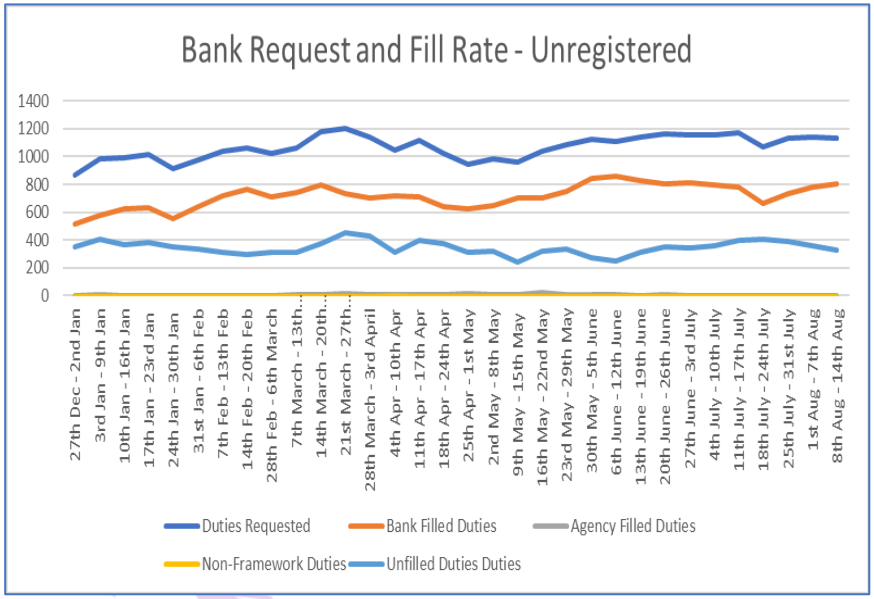


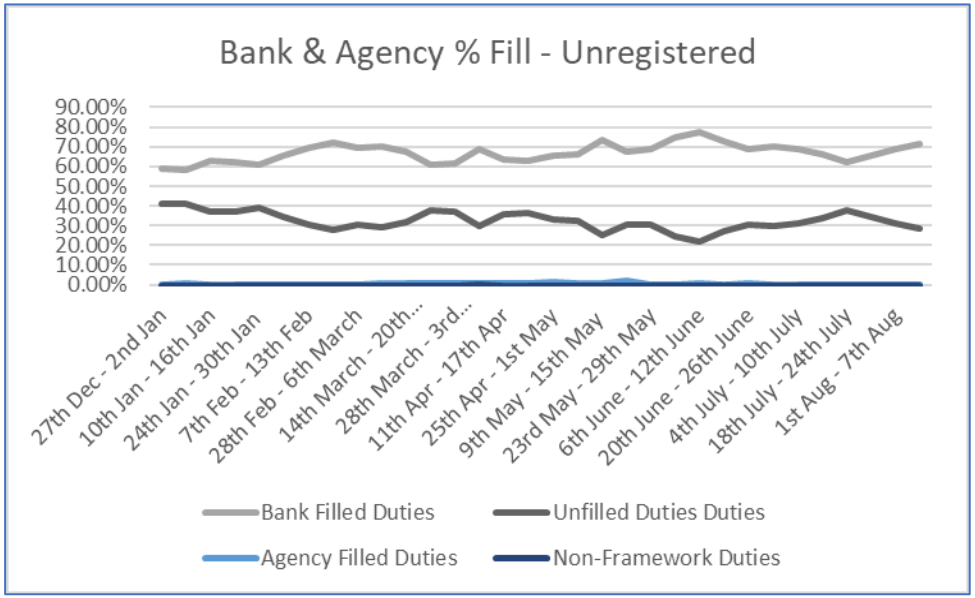
Performance:

- In July the average bank shift fill rate for registered nurses was 68.59% compared to 53% in June.
- 7405 registered shifts were requested July compared to in 9540 in June, 3393 shifts were filled by bank, 2607 by agency, 90 by non-framework agency and 1315 remained unfilled.

Bank & Agency Usage (2)

The Dudley Group
NHS Foundation Trust



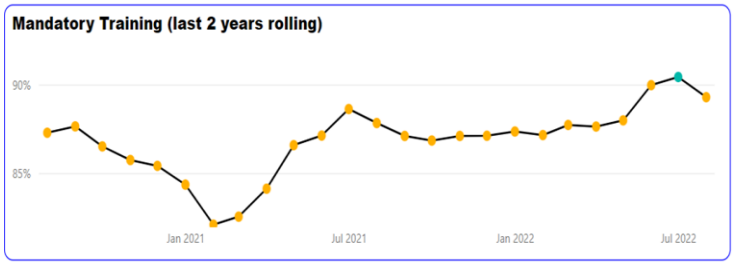


Performance:

- In July the average bank shift fill rate for unregistered nursing was 65.63% compared to 72.34 in June.
- 4525 unregistered shifts were requested July compared to in 5690 in June, 2973 shifts were filled by bank, 2 by agency (incorrectly coded), 1551 remained unfilled.

Mandatory Training (1)

Latest Month	Trust	CS	Corporate	MIC	Surgery
	89.29%	92.58%	90.46%	88.81%	88.68%



The Dudley Group
NHS Foundation Trust

Ward/Service (based selections)

Group5Description	Actual	No. >90%	%' tage
253 General Surgery Medical Staff Serv	373	205	58.09%
253 Emergency Dept Nursing Serv	1,506	159	81.44%
253 Maternity Unit Serv	2,224	108	85.83%
253 Critical Care Serv	1,358	88	84.55%
253 Medical Staff (Emergency Med) Serv	697	86	80.11%
253 Medical Staff - EAU Serv	660	84	79.90%
253 Theatres Recovery & Anaesth Serv	614	71	80.68%
253 Medical Staff - Respiratory Serv	183	69	65.59%
253 Medical Staff Cardiology Serv	125	64	59.52%
253 Theatres Emergency & Other Serv	729	63	82.84%
253 Urology Medical Staff Serv	152	62	64.13%
253 Anaesthetics Medical Staff Serv	951	60	84.68%
253 Paediatric Medical Staff Serv	318	60	75.71%

Group6Description	April 2022	May 2022	June 2022	July 2022	August 2022
Clinical Governance & Risk	93.62%	94.61%	96.11%	95.63%	93.30%
Conflict Resolution - Level 1	94.08%	94.48%	96.49%	96.23%	94.91%
Equality & Diversity (Inc. Autism Awareness)	94.93%	95.54%	96.85%	96.37%	94.90%
Fire	89.63%	90.60%	92.56%	92.06%	91.41%
Health & Safety	94.07%	94.55%	96.21%	95.69%	94.26%
Infection Control - Clinical	88.58%	89.72%	92.30%	91.10%	90.49%
Infection Control - Non Clinical	94.07%	95.07%	96.88%	96.62%	96.36%
Information Governance	92.01%	92.35%	96.27%	94.80%	93.64%
Manual Handling (Non-Patient)	87.68%	87.32%	90.60%	90.78%	86.20%
Manual Handling (Patient)	75.11%	73.89%	77.23%	91.50%	91.30%
Mental Health Law	85.80%	87.43%	88.94%	89.08%	87.53%
Prevent	92.11%	92.75%	94.43%	94.03%	93.96%
Resus - Adult	76.90%	73.30%	73.31%	77.84%	77.44%
Resus - Neonatal	71.21%	73.35%	75.50%	77.68%	76.28%
Resus - Paediatric	77.05%	71.75%	71.10%	70.61%	72.87%
Safeguarding Adults - Level 1 2020	90.54%	91.37%	93.23%	92.91%	92.65%
Safeguarding Adults - Level 2 2020	75.56%	76.25%	78.79%	78.49%	76.20%
Safeguarding Adults - Level 3 2020	63.85%	63.52%	66.14%	68.04%	69.30%
Safeguarding Children - Level 1 2020	90.38%	90.95%	92.62%	93.01%	92.75%
Safeguarding Children - Level 2 2020	75.57%	76.07%	78.44%	78.31%	76.15%
Safeguarding Children - Level 3 2020	61.70%	65.42%	68.44%	68.50%	68.18%
W R A P	88.21%	89.35%	90.56%	89.81%	89.64%
Total	**87.63%**	**87.98%**	**89.97%**	**90.43%**	**89.29%**

Performance:

- Mandatory Training: overall compliance is at 89.29 as at 11th August.

The areas of low compliance continue to be the priority areas of:
Safeguarding adults & Safeguarding Children - level 3
Resus paeds
Resus adults
Manual handling
Safeguarding adults & children - level 2
RESUS neonatal

Recruitment

The Dudley Group
NHS Foundation Trust

Year	2021					2022				
Measure	Aug 21	Sep 21	Oct 21	Nov 21	Dec 21	Feb 22	Mar 22	Apr 22	May 22	Jun 22
Authorisation Stage (% vacancies approved within 8 days)	92.71%	82.11%	92.22%	90.09%	83.13%	87.38%	88.78%	90.43%	87.50%	86.81%
Advert Stage (% vacancies advertised within 7 days)	100.34%	87.91%	92.71%	96.23%	91.75%	92.23%	96.72%	92.96%	91.67%	83.84%
Interview Stage (% of interviews held within 7 days)	75.00%	77.16%	77.45%	81.28%	77.78%	80.84%	84.14%	79.82%	68.70%	80.53%
Interview stage (% of vacancies invites sent for within 2 days)	98.51%	94.29%	94.85%	92.37%	100.00%	97.83%	84.89%	93.00%	99.17%	99.09%
Offer stage (% of vacancies offered within 2 days)	55.71%	52.37%	63.70%	78.67%	85.85%	65.19%	61.80%	69.42%	84.30%	66.67%
Employment Checks Stage (% of conditional offers sent within 2 days)	69.89%	66.91%	56.02%	93.84%	72.67%	73.75%	70.82%	56.77%	83.97%	56.10%
Employment Checks Stage (% of employment checks completed from offer sent to checks OK within 25 days)	60.00%	71.97%	67.52%	75.19%	79.53%	72.79%	86.76%	87.29%	74.81%	74.36%
Employment Checks Stage (% of ID appt to check OK within 15 days)	51.61%	48.28%	58.62%	70.00%	50.00%	57.28%	71.01%	58.33%	60.66%	48.00%

Staff Group	Average of Wait in Workings (advertising start date to Conditional offer made on)	Average of Wait in Working Days (advertising start date to ALL employment checks completed)
Non-Medical and Dental	30	55
Medical and Dental	39	86
Grand Total	**31**	**61**

Performance:

The recruitment KPI is 50 working days from advert to unconditional offer, with the average wait currently at 61 working days. Medical recruitment is currently a significant outlier.

Assurance:

A piece of work is currently underway to review the KPI and develop an action plan to reduce the current wait, with a key focus on areas such as line manager responsiveness and candidate interaction.

Enclosure 21

The Dudley Group NHS Foundation Trust

Paper for Submission to the Board of Directors 22 September 2022

Title:	**Patient Experience Annual Report 2021/2022** **Annual Learning from Complaints Report 2021-22**
Author:	Jill Faulkner, head of patient experience Lara Fullwood, complaints & PALS manager
Presenter:	Mary Sexton, chief nurse

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

Recommendations:

- To receive the patient experience annual report
- To receive the content of the 'Annual Learning from Complaints Report 2021/22'.
- To review the assurances presented in how feedback is used and learning from complaints is implemented.

Summary of Key Issues:

Patient Advice Liaison Service (PALS)	The Trust received 3,715 informal concerns and comments (PALS) in 2021/22 which is an increase from the previous year (2020/21) of 3,362. This is an increase of 353 cases (10.5%) which is a significantly less increase than 2019/20 to 2020/21 which was 32%.
Complaints	The key data for 2021/22 is as follows: • 935 complaints received. • 975 complaints closed. • 100% of complaints (935) were acknowledged within three working days of receipt. • 31.9% of complaints (311) received had a response within 30 working days. • 59% of complaints closed (576) were upheld/partially upheld. • 12.7% of complaints closed (124) were reopened. • Three new complaints were investigated by the Parliamentary Health Service Ombudsman (PHSO). • One complaint was referred to the Local Government Ombudsman (LGO).

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	
Improve health and wellbeing	**X**

Implications of the Paper:			
Risk	N	Risk Description: *N/A*	
	On Risk Register: N	Risk Score:	
Compliance and/or Lead Requirements	CQC	Y	Details: *Effective, caring, responsive*
	NHSE/I	Y	Details: *Compliance with statutory duties*
	Other	Y	Details: *discharging responsibilities as set out in the Health and Social Care Act 2012*

Report Journey/ Destination *(if applicable)*	Working / Exec Group	N	Date:
	Committee	Y	Date: Quality & Safety August 2022
	Board of Directors	Y	Date: 22/09/22
	Other	N	Date:

Annual Learning from Complaints Report 2021 - 22

NHS
The Dudley Group
NHS Foundation Trust

1. Introduction

This report summarises the complaints and Patient Advice Liaison Service (PALS) activity and performance at The Dudley Group NHS Foundation Trust (DGFT) for the year 1 April 2021 to 31 March 2022. The report is written in line with the Local Authority Social Services and National Health Service Complaints (England) Regulations 2009 whereby the Trust must prepare an 'annual learning from complaints' reports each year.

The report includes details of the number of complaints and PALS received during the year, our performance in responding to complaints, Parliamentary Health Service Ombudsman (PHSO) and Local Government Ombudsman (LGO) investigations, and the actions taken by the Trust in response to the feedback and concerns raised.

Our arrangements for receiving and investigating complaints is just one element of a wide range of feedback methods which we use to ensure that we listen to and learn from the experiences of the patients and their families who use our services.

The Trusts number one strategic objective is 'to deliver a great patient experience.' The Trust has a strong focus on improving patient experience and is continuing to develop and evolve robust systems and processes to support our staff to do this.

Patient complaints and PALS concerns are reported to the Trust Board on a quarterly basis within the Complaints, Litigation, Incident and PALS (CLIP) report. Monthly patient experience reports integrating complaints data with feedback from PALS, national surveys, Friends, and Family Test (FFT), NHS Choices and compliments, are submitted to the Patient Experience Group and thereafter to the Quality and Safety Committee (a delegated committee) of the Trust Board.

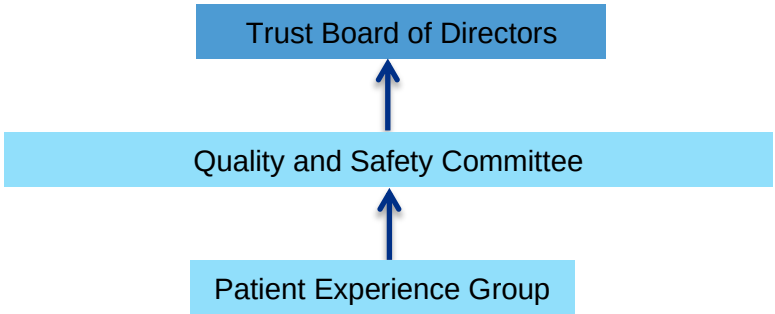
Since April 2019, the Trust holds a quarterly 'Learning by Experience' event which is attended by staff across the Trust as well as members of the public to talk about their experience of making a complaint and resolution, promoting, and encouraging staff members to learn from other experiences. The impact of the COVID-19 pandemic has meant that the 'Learning by Experience' event has not been able to be held in all of the quarters this financial year.

The COVID-19 pandemic has impacted on complaints within the Trust; initially in 2020-21 financial year seeing a decrease in the number of complaints received at the start of the first wave of the pandemic and a national pause on the complaints process. This increased following the first wave and has continued to increase into this financial year. We have found that complainants initially delayed in raising a complaint during the first wave/part of 2020-21. We have also found the frustrations caused by the COVID-19 pandemic (restrictions on visiting, slow recovery of services, delays to procedures/surgeries) had added to the increase on complaints being raised.

The ability to investigate concerns raised has been impacted by COVID-19 as staff both clinically and non-clinically were redeployed to areas during more recent waves of the pandemic resulting in a delay in responding to complaints within the local timeframe of 30 working days.

Local resolution meetings (LRM) have also been placed on hold twice during 2020-21 to allow staff to prioritise clinical work and restrict visiting to the Trust, this was particularly when there was a new variant of COVID-19, Omicron.

The Trust assurance framework as of 31 March 2022 is as follows:



Key points to note for 2021/22:

- 935 complaints received.
- 975 complaints closed.
- 100% of complaints (935) were acknowledged within three working days of receipt.
- 31.9% of complaints (311) received had a response within 30 working days.
- 59% of complaints closed (576) were upheld/partially upheld.
- 12.7% of complaints closed (124) were reopened.
- 3 new complaints were investigated by the Parliamentary Health Service Ombudsman (PHSO).
- One complaint was referred to the Local Government Ombudsman (LGO).

2. Definitions

Throughout this report the term '*complaints*' is used to describe formal complaints requiring a response from the Chief Executive. All formal complaints are managed through the Trust complaints process and are reported to NHS Digital by KO41 (formally the Health and Social Care Information Centre) on a quarterly basis.

The term '*concerns*' is used to describe informal contact with PALS which requires a faster resolution to issues that may be resolved in real time. These are usually concerns, queries, or requests for information which do not require a detailed and formal investigation, but which may require guidance, signposting, or information.

Staff are encouraged to try and resolve complaints at ward and/or local departmental level. Where required the lead nurses, matrons and divisional chief nurses will be involved in resolving the concerns as quickly as possible. Where this is not possible, they can direct patient/families/carers to the PALS and complaints team. A dedicated email address and telephone number is available for both PALS and complaints.

3. Complaints

The Trust investigates complaints in a manner appropriate to the issues raised and where appropriate we may seek and obtain consent for an independent review. We aim to resolve all complaints as quickly as possible and keep the complainant informed as far as reasonably practicable as to the progress of the investigation and the rationale for any delays.

Each complaint is triaged by the head of patient experience and supported by the complaints and PALS manager. This ensures a consistent approach and an independent view of the issues raised.

All complaints are expected to be acknowledged within three working days from receipt. A timescale is identified in line with the Trust policy of 30 working days or where necessary negotiated with the complainant as part of the process at the start of the investigation. This is intended to ensure a realistic timescale is given in the context of the anticipated investigation.

Learning from patient/family feedback and using it to drive service improvement is fundamental to our Trust to ensure service improvement and support the continued journey working towards improving a person's experience of care.

4. Activity & Performance

This section provides an overview and detailed breakdown of key performance and activity data for 2021/22. It includes the number of complaints received, the number of complaints closed, response times and a breakdown of the subjects raised in complaints.

4.1 Complaints as a proportion of our activity

Table 1 details the number of complaints received in each quarter in comparison to patient activity. The percentage of complaints received has risen from 0.06% to 0.078%.

Table 1

ACTIVITY	TOTAL Year ending 19/20	TOTAL Year Ending 20/21	Total Q1 ending 30/6/21	Total Q2 ending 30/09/21	Total Q3 ending 31/12/21	Total Q4 ending 31/03/22	TOTAL year ending 21/22
Total patient activity	**1,231,181**	**1,041,474**	296,153	294,608	307,666	**291,125	****1,189,552**
% Complaints against activity	**0.05%**	**0.06%**	0.07%	0.08%	0.08%	**0.07%	****0.078%**

**at the time of reporting not all data had been submitted to CSDS as the National deadlines so it is anticipated that the community patient activity for this period will be slightly higher.

Table 2: Activity and Performance Data

Table 2	2019/20	2020/21	2021/22
Number of complaints received	678	711	935
Number of complaints closed	775	811	975
Number of concerns received	2,546	3,362	3,715
Complaints investigated by the PHSO	2	4	3
Complaints investigated by the LGO	0	0	1

There was an increase in activity from 2020/21 (711) to 2021/22 (935), (increase of 31.5%). It is believed the COVID-19 pandemic impacted on the number of complaints received during April 2020 to June 2020 when the anticipated figure was lower than expected. There was an increase of 19.8% for the number of complaints received from 2018/19 to 2019/20 and therefore the increase of 4.86% for 2020/21 was lower than anticipated. If 2020/21 had seen an increase of around 19.8% from 2019/20, then the total of complaints received for 2020/21 would have been in the region of 812. The percentage increase between 2020/21 (say 812) to 2021/22 (935) would then have been around 15.1%, which is more in keeping with the yearly increase as opposed to the sudden increase to 31.5% for 2021/22. The focus remains on responsiveness, engaging with users and proactively encouraging patients and their families to give feedback.

To understand if this increase of activity is reflected nationally, we would usually compare such data with neighbouring trusts, but this is not available on NHS Digital at the time of writing this report. The impact of the COVID-19 pandemic has previously postponed the submitting of this data. When this data becomes available, we will benchmark our activity and report any variance to the Trust's Quality and Safety Committee.

The Trust received 3,715 informal concerns and comments (PALS) in 2021/22 which is an increase from the previous year (2020/21) of 3,362. This is an increase of 353 cases (10.5%) which is a significantly less increase than 2019/20 to 2020/21 which was 32%. This increase is a reflection on the restrictions to visiting to the Trust during the COVID-19 pandemic. Relatives were contacting PALS to assist in communicating with their loved ones who were inpatients.

The Trust is keen to address concerns as soon as possible and provide swift action and resolution to the individual highlighting the concern.

4.2 Complaints and Concerns Received

Table 3 shows the number of concerns and complaints received during 2021/22. This demonstrates the fluctuations which can occur between each quarter. The table illustrates an increased number of PALS concerns and comments received during 2021/22 which reflects the number of concerns increasing due to

visitor restrictions under the COVID-19 pandemic. Both complaints and PALS concerns have increased during 2020/21 and generally show an increasing trend quarter on quarter.

Table 3

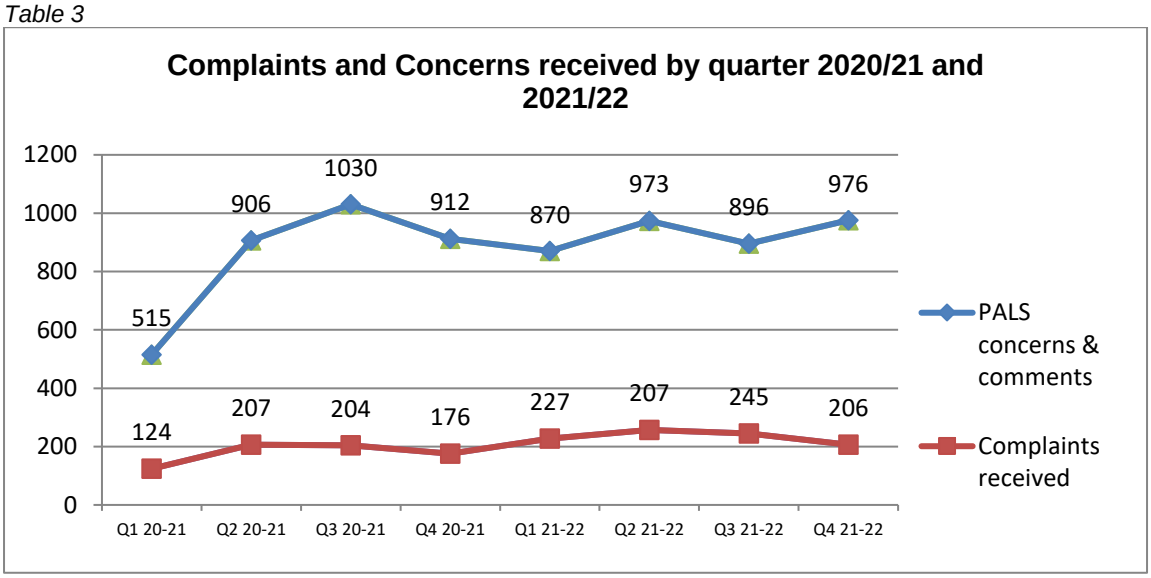


Table 4 details the number of complaints received in each division during 2021/22. The Medicine and Integrated Care Division received the most complaints (457) followed by the Surgery Division (395).

Table 4

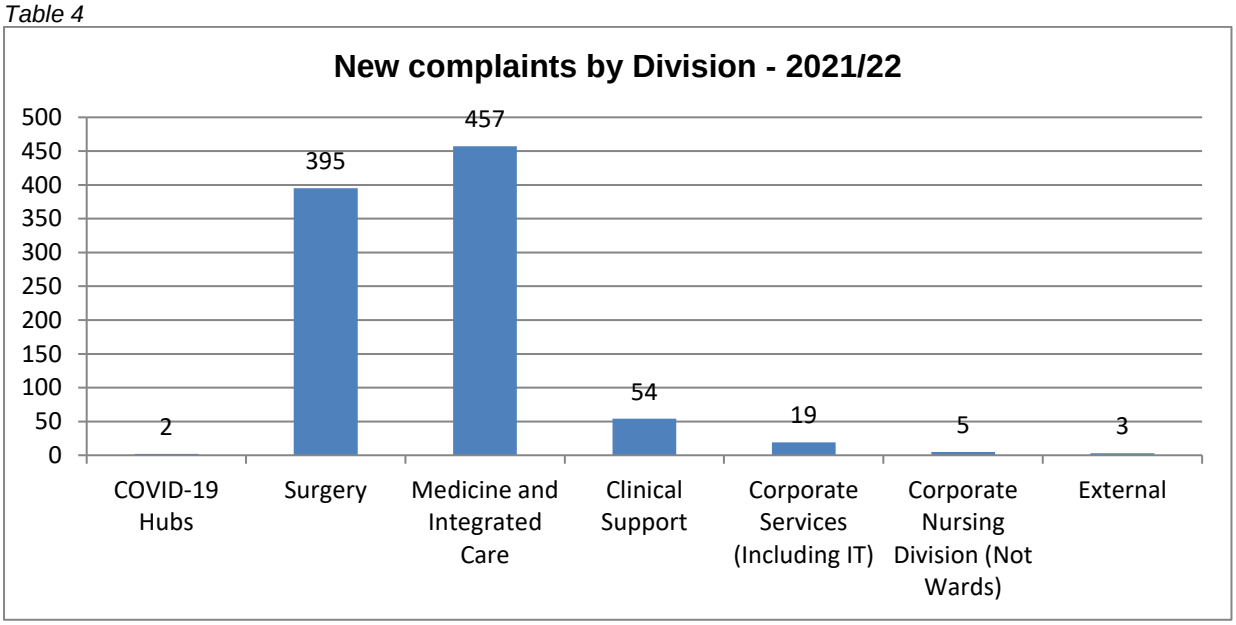
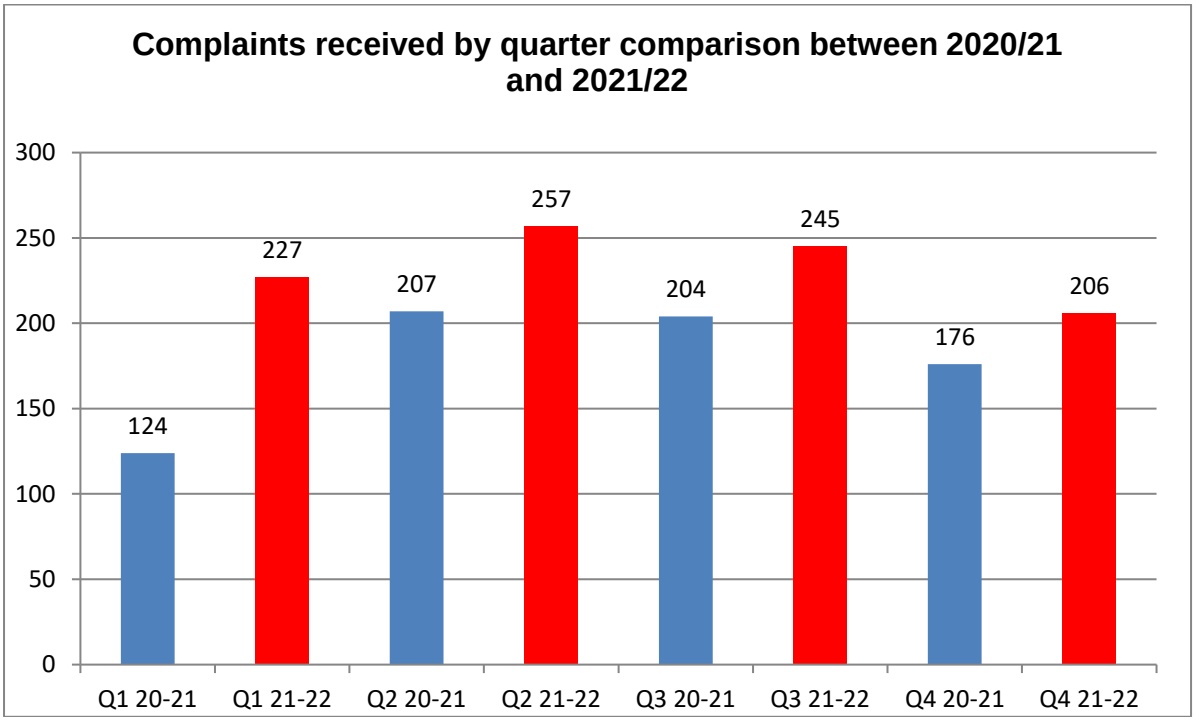


Table 5 represents complaints received by quarter during 2020/21 and 2021/22. Q2, 2021/22 received the most complaints similarly to Q2 2020-21 which also received the most complaints. With Q3 for both 2020/21 and 2021/22 received a higher number of complaints than Q1 and Q4. The number of complaints for 2021/22 has significantly increased compared to 2020/21.

Table 5



4.3 Complaints received by method

Complaints are received by various methods, face to face, email, telephone, and letter. Staff are available to meet at any time during office hours, between 9.00am and 5.00pm, Monday to Friday. Complaints received in this way are minimal but remain a fundamental part of the service available and have required COVID-19 safety measures to maintain patient safety.

4.4 Complaints by subject by quarter

Table 6 shows the top themes of complaints received by quarter during the year. The themes of complaints we receive remain similar from year to year, reflecting the importance that patients place on communication, values and behaviour, effective treatment, timely appointments, discharge, and transfers.

Table 6

Quarter 1, 2021/22	Quarter 2, 2021/22	Quarter 3, 2021/22	Quarter 4, 2021/22
Communications	Communications	Communications	Communications
Values and Behaviours (Staff)	Values and Behaviours (Staff)	Clinical Treatment - Surgical Group	Patient Care including Nutrition and Hydration
Patient Care including Nutrition and Hydration	Admissions, discharges, and transfers (excluding delayed discharge due to absence of package of care)	Patient Care including Nutrition and Hydration	Values and Behaviours (Staff)
Clinical Treatment - Surgical Group	Clinical Treatment - Surgical Group	Values and Behaviours (Staff)	Admissions, discharges, and transfers (excluding delayed discharge due to absence of package of care)

Admissions, discharges, and transfers (excluding delayed discharge due to absence of package of care)	Patient Care including Nutrition and Hydration	Appointments including delays and cancellations	Clinical Treatment - Surgical Group

Surgery, Women & Children's Division

- Clinical treatment including failure to diagnose appropriately, and lack of care and treatment were the most common themes throughout the year.
- Delay with surgery/appointments due to the impact of the COVID-19 pandemic increasing waiting times.

Medicine and Integrated Care Division

- Poor communication with patients due to the COVID-19 restrictions on visiting for relatives and difficulty for relatives to get through by telephone to wards during the height of COVID-19 pandemic.
- Clinical assessment and treatment within the Emergency Department particularly querying diagnoses, lack of investigations and inappropriate/too early discharges.

Clinical Support Division

- Issues regarding booking appointments with the phlebotomy service.
- Concerns raised regarding staff behaviour towards patients.

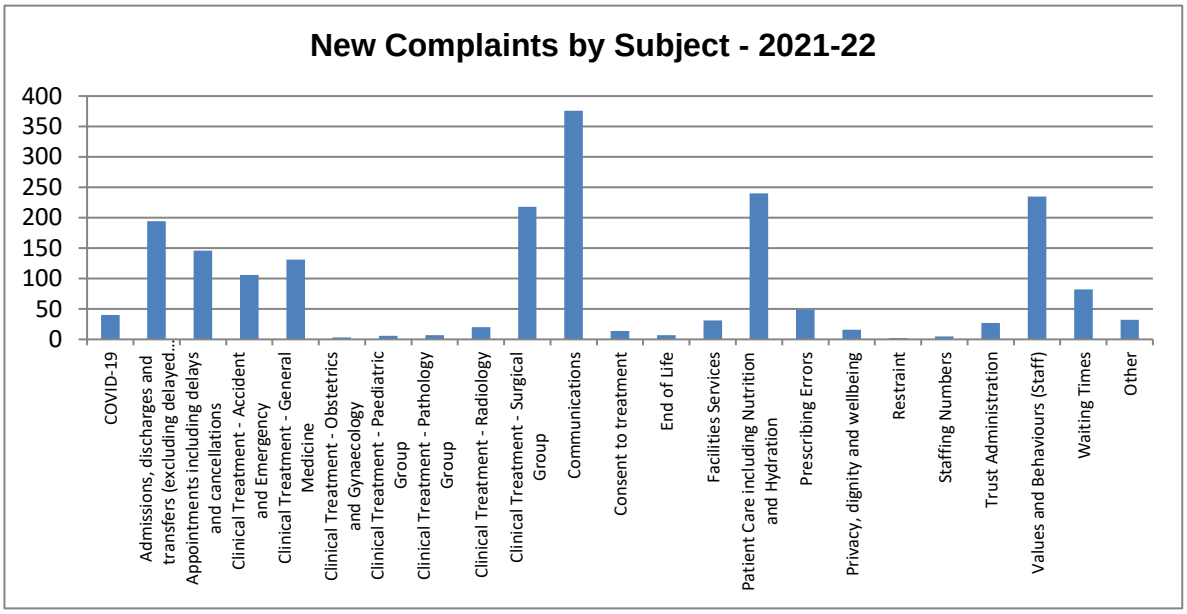
Corporate Nursing

- Concerns regarding infection control measures (face mask wearing) not being followed.

Corporate Services (including IT)

- Poor communication/lack of communication from the discharge team to relatives in respect of discharge arrangements of their loved ones.
- Concerns raised regarding inappropriate discharge (discharged too early).

Table 7



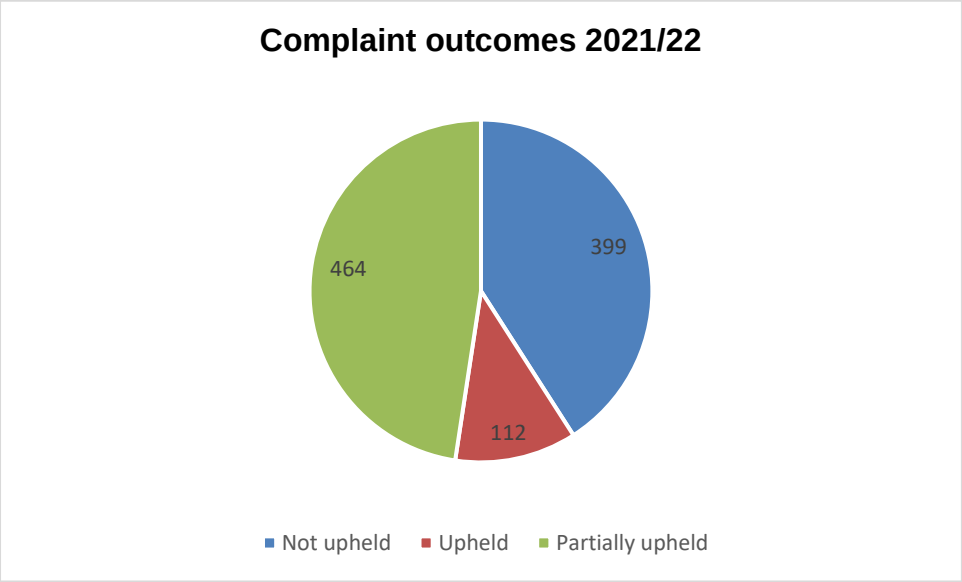
4.5 Complaint outcomes

Upheld	Complaints in which the main or majority of concerns were found to be correct on investigation and an apology given.
Partially Upheld	Complaints in which, on investigation, the main concerns were not found to be upheld, however some of the concerns or issues raised by the complainant were found to be correct and an apology given.
Not Upheld	Complaints in which the main or majority of concerns were not found to be upheld on investigation. If a complaint is not upheld, we still recognise the validity of the concern to that complainant and we acknowledge that we have failed to meet the complainant's expectations.

The total number of upheld/partially upheld complaints for 2021/22 was 576 out of a total 975 closed complaints (59%). This is an increase on the previous year (2020/21) whereby 57.4% of all formal complaints were upheld or partially upheld.

It is of note that upheld complaints are an objective viewpoint by the investigator and the threshold for partially upheld/upheld complaints may vary from trust to trust and thus cannot be used as a benchmark.

Table 8



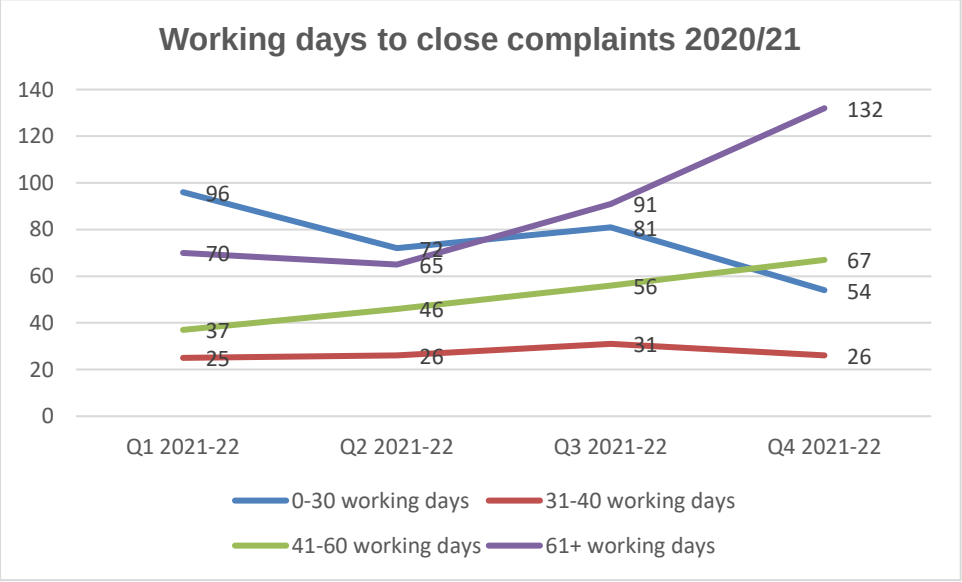
4.6 Response times

Table 9 details the performance for responding to formal complaints. For 2021/22 there were 975 complaints closed with appropriate apologies offered in the letter of response from the Chief Executive or within an LRM. Divisions are required to take action and demonstrate learning from complaints. Complaints are discussed and progressed through the Divisional Governance arrangements.

Performance in responding to complaints within the agreed timeframe is variable but is slowly and steadily improving. All complainants are contacted to advise of any delay to their complaint and a new timeframe is given and agreed.

The COVID-19 pandemic impacted on the response times with LRMs being temporarily placed on hold for periods of 2021/22 to allow staff to work clinically. This also impacted on staff administration time to investigate complaints. The Trust has worked at decreasing the backlog of complaints and this can be seen during Q3 and Q4 2021/22 with such high number of responses (91 and 132 responses respectively for those quarters). There does appear to be fewer complaints closed doing 31 to 40 working days and the complaints team continue to encourage responses in a timely manner. This is discussed at governance meetings and regular correspondence with staff when complaints are due to breach 30 working days.

Table 9



5. Parliamentary Health Service Ombudsman (PHSO) / Local Government Ombudsman (LGO)

The PHSO and LGO represent the second and final stage of the complaints process.

During 2021/22 there has been one new LGO case involving the local council (social care package delay) and the Trust's discharge process. This case is currently under investigation.

During the latter end of the 2020/21, the PHSO began to take a different approach to resolution, returning to the Trust to attempt mediation/local resolution at Trust level by offering an apology and/or financial remedy. This PHSO stated the following about this approach:

"We have decided we should focus on the more serious complaints about health services in which people may have faced a more significant impact and where we can make the biggest difference.

For other complaints where someone has faced less of an impact, we will consider whether there is anything we can do to help resolve things quickly, but if not, we will close the complaint.

This will allow us to help complainants who have faced a significant impact more promptly than would otherwise be possible."

The below information summarises the cases for local resolution/mediation brought to our attention by the PHSO and the remedy suggested by them without them carrying out a formal investigation:

Local resolution cases

The Trust received no new matters for local resolution during 2021/22. There were five cases for local resolution carried over from 2020/21 and one carried over from 2019/20 and five were closed during 2021/22 with the following outcomes:

- A payment of £2,000 for lost property (jewellery), closed in July 2021.
- A payment of £450 for delay with complaint response, closed April 2021.
- A letter of apology given, closed October 2021.
- A payment of £750 for distress caused, a letter of apology and confirmed systemic improvements made, closed April 2021.
- A payment of £250 for lost property, closed May 2021.

The remaining local resolution matter has now been closed (as of April 2022) with an apology given and financial remedy of £500.

Mediation/Dispute resolution

The Trust received one case for mediation/dispute resolution (in November 2021), and this is currently ongoing with mediation meetings recently taking place and further actions identified for the Trust.

Under investigation

The Trust carried over four cases under investigation from 2020/21 and one case from 2019/20. The case from 2019/20 has now been closed (closed in December 2021) being partially upheld, an apology given, and an action plan created and implemented.

Of the four cases carried over from 2020/21, two have been closed with the following outcomes:

- Not upheld
- Upheld- apology and financial remedy of £450

Two remain under investigation.

Three new matters were received during 2021/22 and these remain under investigation.

In summary, there are no new local resolution matters for 2021/22 and no carried forward from 2020/21 are open. There is one mediation matter open and still under investigation with actions identified and there are five cases currently under investigation by PHSO (two carried dover from 2020/21 and three new cases for 2021/22). There is one LGO cases under investigation.

6. Learning from complaints

The Trust has made a number of changes and improvements in response to patient complaints. Listening to patient feedback and engaging with the experiences of patients through meetings, patient stories and focus groups supports our staff to improve the standard of care and service provided.

The Trust continues to provide training as part of the Nurse Graduate Training Programme, the Inter Professional Education Programme, managing complaint training and corporate induction for all new employees. Complaints are viewed as extremely important pieces of valuable information without which we would not be given the opportunity to learn from errors and improve care and safety for others.

Complaints are reviewed on a monthly basis to identify themes and trends across the Trust. These are then shared with the divisions. Improvement actions and learning is put into practice and reported to the Patient Experience Group, the Quality and Safety Committee and the Trust Board.

The divisions have provided the following examples of learning from complaints in 2021/22. These aim to improve the process and the opportunity to change. It is recognised that the focus must be on the actions taken as a direct result of complaints to improve the care we deliver.

Privacy & Dignity **Complaint description:** As part of a wider complaint received this month a concern was raised regarding wait to be transferred from ambulance to the Emergency Department and having to wait for pain relief. The complainant advised that a male member of staff came to the ambulance but did not introduce himself and when asked for pain relief informed her that he was not qualified to give her any medications, which made her feel unsafe. Pain relief was given within a reasonable time frame, however, the complainant described being given a suppository and having to administer it herself in front of male staff.
Learning & action taken: The Trust apologised for the delay in transfer from the ambulance to the department. Staff reminded to always introduce themselves at point of contact with patient. **Change & impact:** The Matron for the department shared this incident anonymously with staff to remind them that privacy and dignity must always be observed. Staff were also reminded that communication is paramount with patients at all times but especially in times of extremis. The department also works closely with the hospital liaison officer to ensure good communication with WMAS.
Staff attitude, lack of compassion **Complaint description:** Patient described that she had been previously independent on the ward, on this night she was attached to a drip, which was alarming, but no one came to see what the problem was. The patient then needed the toilet but had not got her buzzer to hand and needed help to move whilst being attached to the drip. The patient opposite used the buzzer, but still no one came. The patient struggled to the door as she was 'desperate' when the nurse saw her by the door, she was sharp with the patient, chastising the patient for not using the call bell. The patient describes the nurse's attitude as 'vindictive'.
Learning & action taken: The Trust apologised for the poor experience. The nurse involved also offered a sincere apology to the patient about the events that took place that night, stating that she would never have intentionally meant to upset the patient. **Change & impact:** The Division used this complaint as a learning tool to be shared not only with those immediately involved but also on a wider basis during mandatory training sessions, ward, and departmental meetings, so that staff can reflect, learn, and make improvements to practice if appropriate. The staff involved and the wider team have also been reminded of the Trust behaviour charter
Clinical Care

Complaint description: Patient fell at home and fractured cervical spine. Brace was not fitted correctly, also not documented who fitted the brace. Was changed from large to medium but needed extra small. No-one noticed that it was too big; it is thought that it may not have been noticeable when lying down. Consultant advised the patient's son that, despite the ill-fitting collar, it is extremely unlikely that his mother would have regained much of the movement in her neck post injury.

Learning & action taken: Staff involved have completed competencies for fitting of collars and all staff are to receive the training to support staff fitting of collars but also identifying when they do not fit correctly.

Patient Care

Complaint description: The patient stated that staff transferred them from the bed to a chair without use of manual handling equipment, patient advised staff to use this, but they refused, and he subsequently fell.

Learning & action taken: Unfortunately, this incident was not documented at the time and no Datix completed. The Lead Nurse advised that there were two agency nurses on duty when the incident took place. There was documentation four days later regarding the fall and the patient told the staff that he had pain in his right shoulder and thumb following a fall the previous week. The documentation confirmed that the patient had asked for a stand turner to be used but this was not used.

Change & impact: The complaint has been shared anonymously to immediate staff and to wider teams. The lead nurse for the ward offered the following assurances, all staff, including bank and agency are now reminded twice daily at the ward huddle, that any incident relating a patient which occurs must always generate an incident report on Datix. Staff have also been reminded to always follow therapy instruction on the 'behind the bed board' to ensure patient safety. The ward has also developed a new falls action plan which incorporates actions from recent falls which have been investigated by the patient harm team, which in turn have been approved by Deputy Chief Nurse.

Complaint description: Complaint received from patient, who advised that pain relief was not managed during sickle cell crisis. Patient has also attended a local resolution meeting with the team involved in the care. The patient felt that staff attitude was that she was 'being a nuisance'.

Learning and action taken: The Trust has apologised for shortfalls in observation, there were two episodes whereby checks were not documented. The patient was also given the timeline of the medications and times given whilst in our care. Staff involved were asked to provide reflections and give assurance that practice will be improved in the future.
Change and Impact: The Trust pain specialist nurse has engaged with the team and given insight and process to care for patients in sickle cell crisis. In addition, staff have been advised the referral process for the pain team in and out of hours to ensure there is contact with staff that have ah specialist training in managing patients in acute pain.

Lost property

Complaint description: Patient's next of kin (NOK) informed the Trust that dentures had been lost whilst in hospital. Patient was taken to the Emergency Department with them insitu; this is confirmed by WMAS documentation.

Learning & action taken: The Trust apologised for the loss of the patient's dentures. The patient's property was logged and documented in the property book on transfer from ED, however, it was not custom at that time to check for and document if the patients have dentures. The ward was not therefore able to ascertain if the patient had them at the point of transfer. The ward was searched but the staff were unable to locate the missing items.

Change & impact: The Matron for the department shared this incident anonymously with staff and practice has changed as a result. All patients are now asked and checked to ascertain if they have dentures insitu. This is now documented on the property list. In addition, as there has been an increase in patient lot property across the division, this complaint is shared not only with those immediately involved but also on a wider basis, to ensure staff can reflect, learn, and make improvements to practice.

Communication

Complaint description: Complaint related to poor communication across wards C3 & B2 (Hip). Also concerns regarding discharge team in relation to discharge planning.

Learning & action taken: Regrettable, once again, there is an evident gap in the evidence to support comprehensive communication with NOK (in relation to ongoing care needs & dietary intake). Discussed with lead nurse, recognition of the need to improve communication (even more pertinent with restricted visiting). LN identified that some staff were particularly proficient at communicating with patients and relatives whilst some did appear reluctant to offer more than very basic information. On further discussion it was apparent that some of the more junior or inexperienced staff were unsure as to how much information they were able to provide and as such offered very little. The ward has one sister who has completed their customer care ambassador training and it was agreed that the LN would utilise these skills and those of a couple of other ward staff to create a simple training programme for all staff to undertake, as there is

no similar training currently being provided by the Trust. LN is liaising with the learning and development team to support the staff in creating the training programme. LN has discussed the complaint anonymously at the daily huddle on several occasions and emphasised the importance of providing adequate communication.

Change & impact: Increased awareness. Training package being developed.

Communication

Complaint description: Follow up complaint as a result of a full yellow investigation into the death of patient being sent out without any explanatory notes.

Learning and action taken: The plan to include the complete investigation paperwork with the complaint was not communicated to those signing off the complaint response as part of the approval process. This caused additional distress to the family. Approving managers to be made aware of any documentation planned to be included in the complaint response envelope.

Change and Impact: Any investigation paper should be sent separately to a complaint response. Communication with families in relation to investigations is being completed separately to complaints.

Communication

Complaint description: Patient had, regrettably, passed away post discharge. Met with his daughters, who had several concerns around communication (across all disciplines); patient was registered blind & deaf.

Learning & action taken: Assurance given that patient was assisted with taking his medication as he also had limited function in his hands.
Staff attempted to communicate with patient by writing him questions/notes etc on a piece of paper, however family state that he would not have been able to read them due to his limited vision.
Therapy assessment was completed prior to discharge however family felt that this did not provide a true reflection of their father's condition on discharge. Feedback has been provided to team leader.
Antibiotic was not dispensed from the ward although prescribed on the TTO. It is evident that the checking process was not robust as this should have been identified when checking the TTOs.

No recognition of patient's condition being End of Life. Advised that this was not the assessment of nursing staff (patient had only been on the ward for 2 days).
It was identified that there was a need to reinforce the Trust Patient Information Policy which complies with the Accessible Information Standard with all colleagues: nursing/med/therapy. Matron will share documentation with lead nurses & professional colleagues to disseminate to all staff.

Change and impact: To ensure all staff undertake an existing Auditory & Visual Awareness session to enhance their appreciation of the difficulties encountered by patients with these impairments. Matron has been liaising with the leads for these sessions to arrange suitable dates for staff training.

Waiting times, social distancing (COVID-19)

Complaint description: Concerns raised with phlebotomy service regards to waiting times, social distancing and overall a poor patient experience.

Learning and action taken: At present, the shared outpatient area for pre-assessment and phlebotomy is causing many issues due to the volume of patients that go through there in a single day. The complaint has also identified process issues that can be improved.
From the beginning of September, all patients who are having a virtual outpatient appointment and requiring bloods will be required to book a blood test online using the same online system that GP (General Practitioner) patients use. This will reduce unplanned busy periods by helping organise patient attendances, without patients having to make multiple visits to the hospital. From December, the intention is to go to a fully bookable system and open more phlebotomy services in the community, at Brierley Hill & Stourbridge Health and Social Care Centres. This will reduce waiting times and improve patient experience.

Change and Impact: Issues have been identified and once in place, the impact on patient experience will be considered. It is anticipated that this will improve patient experience and there will be no further concerns of this nature.

7. Conclusion

We are committed to ensuring that we make it easy for patients, relatives, and carers to make a complaint or raise a concern and encourage feedback in various ways. We continue to focus on learning and actions from the complaints and feedback received.

Jill Faulkner
Head of Patient Experience
August 2022

Patient Experience Annual Report 2021 - 22

NHS
The Dudley Group
NHS Foundation Trust

Patient Experience Annual Report 2021/2022

1.0 Introduction

The Dudley Group NHS Foundation Trust's strategic vision is 'to deliver excellent healthcare, improved health for all'. Our aim is to provide an excellent patient experience alongside effective and safe care that results in positive health and wellbeing outcomes.

Putting patients first and working together to deliver exceptional care, each and every time is paramount. This report sets out our achievements and ongoing work to ensure that patient experience is prioritised and underpins everything we do.

The 'Patient Experience Annual Report 2021/22' provides an overview of how we have gathered feedback from our patients on their experience of care, our achievements, what patient experience feedback tells us, and our plans for the coming year for patient experience.

Our Trust collects patient experience feedback from multiple sources and works in partnership with patients, carers, the wider public and local partners to ensure that the services are representative of our population. In accordance with our 'Patient Experience Strategy 2021-2023' we are committed to actively engaging and involving patients, their relatives, and carers in order to listen and to act on feedback to ensure the continuous improvement in the patient experience and the overall quality of care that is provided.

Our 'Patient Experience Strategy' was developed to embrace the aims and objectives set out in the Trust's Quality Priorities and The Dudley Group NHS Foundation Trust Strategy to deliver 'excellent health care, improved health for all'. The aim of the strategy is to ensure that all patients, relatives, carers and visitors have a positive experience in our care, ensuring their emotional and physical needs and expectations are met. The Trust's values (care, respect, and responsibility) underpin everything we do, and we expect our staff to work to these values in the delivery of safe, consistent, and high-quality patient care.

The Patient Experience Group (PEG) oversees the operational implementation of this strategy to ensure the outcomes improve service quality and further meet the needs of patients.

The patient experience strategy is intrinsically linked to various other strategies within the Trust who all work together to promote the services we provide and to meet the needs of the communities we serve:

The Trust's values underpin everything we do:

Our values are: C*are, Respect and Responsibility*

Our values are about us all helping each other to deliver a great patient experience more consistently involving people who use our services, their relatives, carers, staff and partners in continuing to improve the care we deliver.

We have had a great year working together in partnership with our patients, carers, staff and partner organisations to help patient and carer experience become an integral part of our culture and everyday thinking, and to enable us to establish a set of priorities and actions that can be collectively delivered together.

Our annual report provides a summary of the patient experience from different sources, taking into consideration feedback that was reported directly to the Trust, and other feedback received via Healthwatch, Care Opinion and NHS Choices:

- National surveys
- Local surveys
- Website Feedback
- Friends and Family Test (FFT)
- Comment cards
- Patient panel/Feedback Friday
- Listening into Action
- Service Improvement projects
- Compliments

2.0 Our Priorities

Patient experience is a key quality priority and specific targets have been set on each of the quality priorities. These are:

Priority 1 of 2021/22: Patient experience
1. Improve the way we communicate and engage with patients a. 'Do staff treating and examining you introduce themselves?' (National baseline Maternity 2019 99%, Children 2018 93% with the aim being 95% overall) b. 'Have you been told what is going to happen to you today (tests etc.)?' (Local survey baseline 59% with suggested improvement to 95%) c. Hold a quarterly forum/focus group with each prioritising two key planned actions and undertaking those actions and measuring the success. d. Hold the newly developed Patient Panel at least quarterly (this may be more frequent depending on the views of the attendees at the first meeting). e. Establish a group of Expert Volunteers to ensure we raise the patient voice so that services are delivered compassionately.

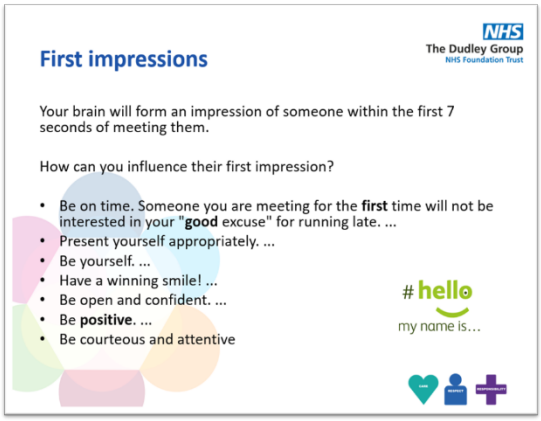
We have included a number of specific examples of the quality initiatives our staff are undertaking across the Trust and what patients have said about the care they have received from us. Developments we have taken to improve our overall scores can be found in section 2.1 below.

a) Do staff treating and examining you introduce themselves?

The monthly patient audit demonstrates that we achieved 98.1% (numerator 2747/denominator 2798) compliance against patients reporting that staff members introduced themselves. The results from the 2021 Maternity survey (published February 2022) show that 88% of women felt that the staff treating and examining them introduced themselves, which is slightly below the national average of 89% of Trusts surveyed in the 2021 Maternity Survey. The Children and Young people 2022 survey is due to take place in January 2023 with the results to be published in November 2023.

To ensure there is improvement and achievement against this priority we have delivered and supported a number of initiatives with a focus on how we improve the way we communicate and engage with patients. We have continued to deliver patient panels throughout the year to capture people's views and experience of our services.

To further address this priority, action and learning plans are shared in the patient experience monthly reports, quarterly reports, at governance meetings and during training with Trust staff. The 'Hello My Name is' campaign is presented to new employees at Trust induction. In partnership with the professional development team we continue to deliver customer care training to newly qualified nurses, international nurses and other staff within the Trust.



b) Have you been told what is going to happen to you today?

Our monthly audits demonstrate that we achieved 90.5% (numerator 1398/denominator 1545) compliance against patients reporting that they knew what was going to happen to them each day.

From April 2021 and March 2022, a total of 1358 inpatients completed the face-to-face real-time survey and overall, 64% stated that they had been told what is going to happen to them each day. Ward reports are sent to Matrons on a monthly basis and patient experience activity is presented through divisional updates at the quarterly Patient Experience Group meeting. The monthly patient experience report is presented to the Quality and Safety Committee for assurance of recommendations having been completed and improvements made.

The 2020 Children and Young People Survey (published December 2021) asks parents if hospital staff kept them informed about was happening whilst their child was in hospital. The score for this question was 88% and is performing 'about the same' as other trusts but is below the 95% target.

The Urgent and Emergency Care Survey 2020 (published September 2021) includes the question 'did the doctor or nurse explain what was going to happen next. The

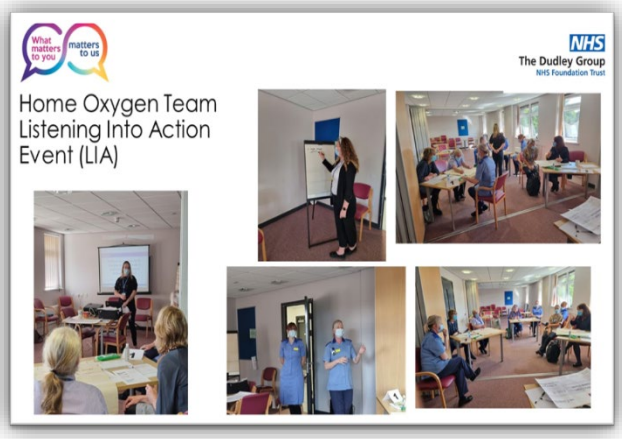
Trust score was 73% and is performing ‘about the same’ as other Trusts nationally but is below the 95% Trust target.

The results from the CQC surveys have been shared with directors, matrons and leads and presented to the Quality and Safety Committee. Action plans are submitted to the Patient Experience Group meeting for monitoring and assurance. Real-time survey feedback is shared with Divisional leadership teams and included the monthly patient experience report for action planning and learning.

To ensure there is improvement and achievement against this priority Customer Care training has been implemented in partnership with the Professional Development team and all staff can book on to the training which is currently delivered to newly qualified nurses, international nurses, and other staff.

c) Hold a quarterly forum/focus group with each prioritising two key planned actions and undertaking those actions and measuring the success.

Most departments and teams within the Trust have now booked an LIA event and several teams have already hosted these events (Cancer Services, Home Oxygen Team). Some events were postponed due to lack of patient attendance or the cancellation of non-essential meetings due the pandemic.



The Home Oxygen Team LIA was held on 1 October 2021. Patients were very complimentary about the service and the support received, although they felt that the service needed more staff as there are currently only two nurses for the whole of the service. A suggestion for improvement was more support for families from the Home Oxygen Team when a patient is approaching end of life rather than passing them on to the palliative care team. Improvements to the service have been made and the team now ensure they are informed of when the patient is end-of-life so that they can be reviewed on a more regular basis, and the team only refer onto palliative care the patient requires more assistance symptom management. The Home Oxygen team have liaised with the palliative care team to improve and expand their knowledge on symptom management in palliative care. This will enable an improved service for the patients.

The Cancer Service held an LIA 20 October 2021. The main themes for improvement identified by patient were around communication, the impact on emotional wellbeing, staffing, including GPs and nursing, waiting times and training. To address the concerns raised, cancer services have implemented the role of the cancer navigator for communication and to provide more patient feedback. They will be able to address waiting times for investigations and results. There is Living with and Beyond Cancer team to signpost to counselling services and psychological referral for emotional impact. To improve staffing, they have recruited to a Macmillan Oncology Clinical Nurse Specialist, awaiting start date, and now have an oncology dietitian.

Patient experience activity is presented through divisional updates at the quarterly Patient Experience Group meeting and the monthly patient experience report to the Quality and Safety Committee for assurance of recommendations having been completed and improvements made.

d) Hold the newly developed Patient Panel at least quarterly (this may be more frequent depending on the views of the attendees at the first meeting).

To help us shape future service planning and the development of services. we hosted a number of virtual panels throughout 2020/21. In April 2021 our panel focused on ‘Communication’. We asked attendees if the doctor/nurse introduce themselves, if they felt comfortable to ask any questions about their care or treatment, and if the doctor/nurse communicate in a way that was suitable for your needs. The feedback demonstrated that staff do not always introduce themselves, and communication with staff is often difficult, particularly if the patient has certain communication needs and patients/relatives do not always feel able to ask questions.

To address the concerns raised we have now we have now implemented customer care training (as discussed above). We have developed local survey feedback through virtual methods, to improve accessibility and we are encouraging patients and carers to use online communication channels such as NHS Choices, Patient Opinion to raise concerns and give feedback about their experiences of the services.

In July 2021, the theme of our Patient Panel was 'general' and attendees were able to share their views on their experience of our hospital, and discuss their thoughts on how we can improve our services. The main themes were around communication and delays in the Emergency Department. The feedback was shared with matron leads for action planning and learning.

Our new Patient Experience Strategy for 2021-2023 has been developed to embrace the aims and objectives set out in the Trust's Quality Priorities and the vision to deliver 'excellent health care, improved health for all'. The aim of the strategy is to ensure that all patients, relatives, carers and visitors have a positive experience in our care, ensuring their emotional and physical needs and expectations are met. We want to listen to our patients, families, and carers to understand what is important to them, to value their ideas and learn from and act on the feedback we receive. We will monitor our progress against delivering the objectives in this strategy through a set of key performance indicators that will measure the impact of the processes in place for improving patient experience and engagement. We will know we are successful when we have evidence that our processes for improving patient experience and engagement are reliable and are making an impact on outcomes for patients demonstrated by increased patient experience scores.

We held our People's Panel in March 2022 to ascertain the views and ideas of patients accessing Pharmacy services:

- Have you used our home delivery medication service?
- How can we improve medicine supply for outpatients?
- How was your overall experience with pharmacy?
- Have you had a recent inpatient stay? How was your pharmacy experience?

Attendees stated that they were unaware of the home delivery service and raised concerns about using medication and equipment after discharge and that a discharge telephone helpline would be useful to be able ask any questions and obtain advice. Attendees felt that waiting times for mediation need to be improved. In response to this the pharmacy team advised that a tracking system has been installed for inpatients. This allows ward staff to follow the journey of the medication and track where it is. An action plan is being developed to identify any improvements to the service.

e) stablish a group of expert volunteers to ensure we raise the patient voice so that services are delivered compassionately.

In partnership with the Governance team, we have produced a policy that provides a framework that details the recruitment, support and governance arrangements in place to ensure 'Patient Voice Volunteers' and 'Patient Safety Partners' are safely introduced, monitored and effective in their roles. This includes patients, carers, families and other members of the public who use their experiences of services to inform and influence the delivery, planning, quality and safety of services we provide.

The Patient Voice Volunteer policy has now been ratified and a plan is in place for recruitment of the volunteers. A 'Meet and Greet' took place to promote the role and gauge interest from patients and members of the public.

A job description has been developed and a recruitment plan in place to recruit patient voice volunteers (PVV) to use their experiences of services to inform and influence the delivery, planning and quality of services we provide.

2.1 Developments that occurred in 2021/2022 to improve the experience of patients:

- To improve the accessibility of giving feedback in maternity services for the FFT we have designed a business card/sticker with online links and QR codes for many wards and departments.
- We have hosted a number of virtual Patient Panels and supported several departments and teams to deliver into Action evets throughout the year to capture people's views and experiences
- Increased the availability of the FFT survey via online/QR codes and promoted more widely.
- We hold monthly 'Feedback Fridays' to obtain feedback from patients/carers.
- Our 'What Matters to You' campaign continues to be implemented throughout the Trust to promote the accessibility of giving feedback and to raise the profile of patient experience.
- We have continued to work in partnership with other organisations to benefit our patients. For example, working in partnership with Healthwatch Dudley to capture the views and experience of our local community.
- We have continued to deliver customer care training to newly qualified nurses and other staff within the Trust to raise the profile of patient experience and to highlight the importance of what matters most to patients.

- We have implemented the Patient Experience Champion role within teams and departments who will promote patient experience within their areas to help to drive trust-wide improvements, share good practice and provide the best patient experience and care.
- We set up the 'Staying Connected' initiative which allows relatives to send 'a letter to a loved one' and 'virtual flowers' to patients on the wards, due to visiting restrictions.
- Local surveys have been set up online to allow patients to provide feedback on their experience of services and implemented across the trust.

2.0 Patient Experience Feedback

The Trust actively encourages feedback to help us ensure we meet the needs and expectations of our patients, their families and carers, our staff and our stakeholders. This section provides a summary of how we gather feedback from patients on their experience of care and what the feedback tells us. We gather feedback in a number of ways:

- FFT
- Real-time surveys (face-to-face surveys)
- Local surveys
- PREMS
- NHS Choices and Patient Opinion online reviews
- National surveys including the national inpatient survey
- Listening events and focus groups
- Feedback Friday
- Compliments

The examples detailed below demonstrate the quantity of feedback received during 2021/2022 and more detailed information about some of the methods. These methods alone highlight more than **47,548** opportunities for us to listen to our patients' views.

Method	Total	Method	Total
FFT – Inpatient (Inc. day case)	**14,851**	NHS Choices/Patient Opinion	**87**
FFT – Emergency department	**12,235**	National surveys - Maternity 2021 (published Feb 22)	**130**
FFT – Maternity	**934**	National surveys - Adult Inpatient 2020 (published Oct 21)	**490**
FFT – Community	**4130**	National surveys - Urgent and Emergency Care 2020 (published Sept 21)	**341**
FFT – Outpatients	**12,357**	National surveys - Children and Young People 2020 (published Dec 21)	**113**

Community patient survey	**0**	Cancer Patient Experience 2021 (local survey)	**50**
Real-time surveys	**1358**	Other local/department surveys	**472**

3.1 Friends and Family Test (FFT)

The FFT is made up of a single mandatory question (overall, how was your experience of our service?') followed by two free-text questions to drive service improvement. Following feedback from patients and staff the Trust have chosen to use two free-text questions to enable people to tell us more about their experience in their own words questions below:

1. What was good about your visit?
2. What could have made it better?

There are no longer targets set for response rates and NHS guidance states that reporting should focus on what feedback has been collected and what has been done with it, rather than 'response rates' and 'scores'. However, the Trust continues to monitor how many surveys are completed for each service/department to ensure that the process is being followed. The results are published on the national NHS England website. The scores, which are updated monthly, are displayed on our website and prominently in our wards/departments for all patients, staff and visitors to see.

The FFT survey provides valuable data to inform local actions to improve the patient experience. FFT is firmly embedded within the Trust with all patients given the opportunity to complete the survey after each episode of care and treatment in all areas of the organisation. Feedback is captured through a variety of methods (SMS and online once the patient is home).

We monitor our performance compared to that of our neighbours in the Black Country. We submit our date NHS England and Improvement on monthly for national benchmarking to monitor performance against the national average.

FFT activity is presented through divisional updates at the quarterly Patient Experience Group meeting and the monthly patient experience report to the Quality and Safety Committee for assurance of recommendations having been completed and improvements made.

Percentage very good/good FFT Scores (April 2021 to March 2022)

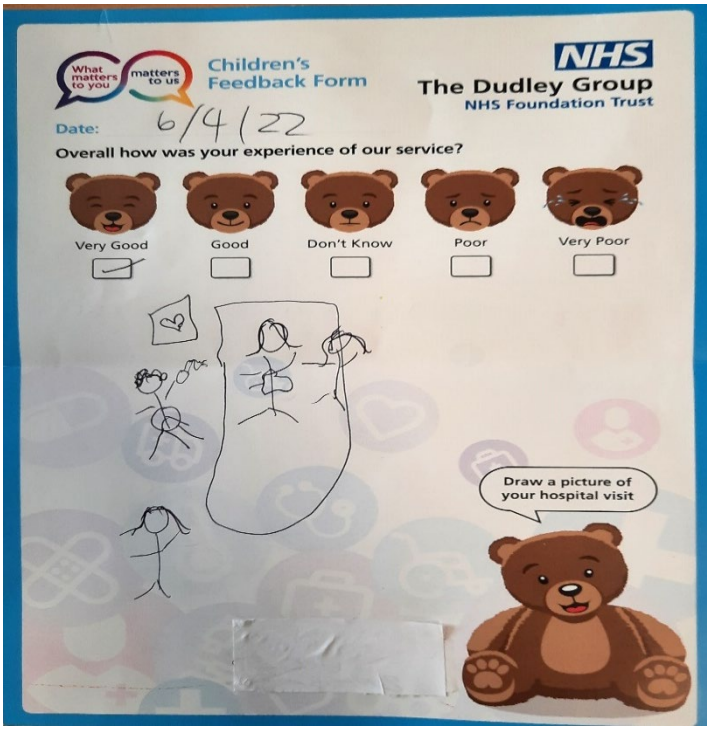
Percentage very good/good FFT Scores	April 21	May 21	June 21	July 21	Aug 21	Sept 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	March 22
Inpatient (Including day case)	**88%**	**90%**	**87%**	**88%**	**83%**	**85%**	**86%**	**89%**	**89%**	**90%**	**87%**	**87%**
National	95%	95%	95%	94%	94%	94%	94%	94%	94%	94%	94%	**
A & E	**80%**	**73%**	**70%**	**65%**	**73%**	**68%**	**66%**	**69%**	**72%**	**71%**	**65%**	**70%**
National	82%	80%	79%	76%	77%	72%	75%	76%	79%	81%	77%	**
Maternity Antenatal	**100%**	**87%**	**82%**	**56%**	**0%**	**33%**	**100%**	**0%**	**0%**	**0%**	**92%**	**85%**
National	90%	91%	91%	91%	90%	87%	85%	91%	92%	91%	90%	**
Maternity Birth	**92%**	**92%**	**94%**	**74%**	**0%**	**78%**	**71%**	**0%**	**0%**	**0%**	**0%**	**0%**
National	96%	95%	95%	93%	93%	92%	93%	95%	94%	94%	94%	**
Maternity Postnatal Ward	**80%**	**92%**	**88%**	**74%**	**0%**	**70%**	**71%**	**0%**	**100%**	**0%**	**0%**	**0%**
National	94%	94%	93%	91%	92%	91%	89%	91%	90%	93%	92%	**
Maternity Postnatal Community	**93%**	**75%**	**56%**	**73%**	**0%**	**0%**	**50%**	**0%**	**0%**	**0%**	**0%**	**0%**
National	89%	94%	90%	91%	90%	91%	90%	90%	89%	92%	91%	**
Community	**87%**	**86%**	**84%**	**85%**	**87%**	**87%**	**88%**	**86%**	**86%**	**86%**	**85%**	**88%**
National	95%	82%	95%	94%	95%	94%	93%	94%	94%	94%	94%	**
Outpatients	**85%**	**85%**	**83%**	**81%**	**81%**	**81%**	**78%**	**80%**	**84%**	**81%**	**84%**	**84%**
National	93%	91%	91%	93%	93%	92%	92%	93%	93%	93%	93%	**

In 2022, the number of patients rating their overall experience of their care and treatment as ‘Very Good/Good’ was 80% in comparison to 82% in 2020/2021. The number of people rating their experience as ‘very poor/poor’ has increased to 7% in comparison to 5% in 2020/2021. The Outpatient Department received the highest number of responses at 12,357 throughout the year. The Inpatient Department received the highest number of positive scores with 88% of patients rating their overall experience of our services at ‘Very Good/Good’ in 2021/2022.

Total number of responses April 2021 to March 2022	
FFT – Inpatient (Inc. day case)	**14,851**
FFT – Emergency Department	**12,235**
FFT – Maternity	**934**
FFT – Community	**4130**
FFT – Outpatients	**12,357**

The Trust received a total of 44,507 responses from FFT during 2021/2022 (in comparison to 35,423 during 2020/2021) and over 32,276 comments from patients and their relatives. The patient experience team has ensured that every part of our community is able to provide feedback about their experience of care received from the Trust.

An example of the FFT card for Children and Young people's:



Examples of patient/carer comments from the Friends and Family Test:

Ward B1

"Very good, professional, and caring staff. Everything was explained carefully and concisely. I felt extremely safe and well protected. It was clear that my welfare was at the heart of everything. I was extremely impressed with the staff on all levels".

AMU

"I was delighted with my emergency stay in Russells Hall. The attention I received from surgical, medical, and nursing staff was beyond outstanding. I cannot fault it at all. From reception to discharge the service was brilliant. Even the meals were of a very high standard. What more can I say?"

Intermediate Care Team (Occupational Therapy)

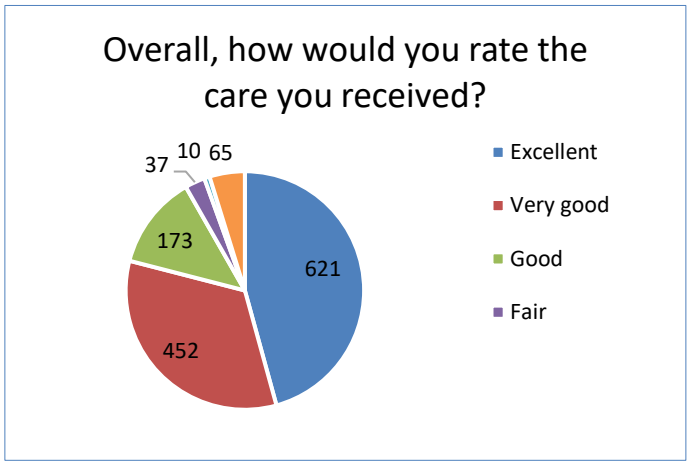
"Very nice staff, friendly and I could talk to them about anything, and they would try to help me"

Ophthalmology

"Very clear & concise information - polite and punctual with appointment time very caring and understanding with my needs overall good service"

3.2 Real-time Surveys

1358 surveys were completed face-to-face with patients on our wards from April 2021 to March 2022. The results were very positive 91% of patients feeling that they were treated with dignity and respect while they were in hospital. Patient were complimentary about their experience of being admitted to the ward, for having confidence and trust in the doctors and nurses and for their overall rating of care (see graph below).



Patients (83%) felt that they were always offered a choice of food and where applicable, their dietary needs were met, and they were assisted by staff to eat their meals.

Areas for improvement focus on communication. Over half of the patients surveyed stated that they were not given a welcome booklet on arrival to the ward. Scores were less positive for patients being spoken to about a plan to get well enough to home and for being told what is going to happen to them on the day.

Examples of comments received from our patients:

"The communication is brilliant"

"The food is very good, all things considered, and compared to other hospitals"

"Everything explained fully"

"The nurses are brilliant and have compassion"

3.3 Local Surveys

We have designed and facilitated a number of local surveys via online links and QR codes to improve the accessibility of giving feedback to allow patients to provide feedback on their experience of services. These are promoted on the new patient experience boards and tablets.

- We designed and delivered surveys for the Dudley Rehabilitation Service (Stroke Pathway, Early Supported Discharge, Speech and Language and Neurology teams).
- We have designed a survey for Asthma Service, Anaesthesia Post-Operative service.
- We have supported the design of a patient survey for the Breast Screening Service, Dietetics Outpatient Service, Birth Reflection Clinic and a Diabetes survey for children.
- We have created posters and business card to promote the survey and ensure it is accessible.

Examples of patient experience local survey feedback 2021/2022:

Local Cancer Patient Experience Survey 2021

The National Cancer Patient Experience Survey (CPES) 2020 was cancelled due to COVID pandemic. We facilitated a local survey to obtain patient views on their experience of care and to identify areas of good practice and highlight themes for improvement as a number of scores fell below the national average following the 2019 CPES.

We sent out a survey out in March 2021 to 40 patients who had been seen in September 2020 (response rate 40%) and 61 December 2020 (response rate 56%).

September Results

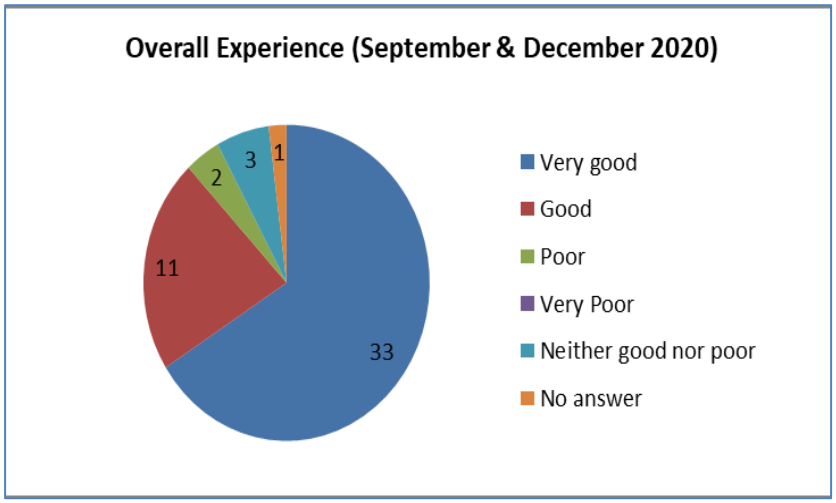
The results were very positive in particular for patients being given the name of a Clinical Nurse Specialist who would support them, for side effects about treatment being explained in a way they could understand and for being given enough privacy to discuss their condition and treatment, where these scores were below the expected range in the 2019 CPES. Scores were less positive for patients feeling they were given enough information about whether their chemotherapy was working in a way they could understand, after their treatment had started with only 31% stating 'yes' to this question (CPES 2019 score was 58% for the Trust compared to the national average of 68% national average), demonstrating a theme for improvement. A high number of patients felt that they did not receive enough support from health and social care services during their treatment, which is below the 2019 CPES expected range. Overall, 81% of patients felt they were treated with dignity and respect while they were in hospital.

December Survey

The scores for the December demonstrate some improvements against the CPES scores that were below the expected range. Patients were positive about feeling involved as in decisions about their care and treatment (85% stated 'yes' to this question in comparison to 81% national average and 76% 2019 CPES score for the Trust). Patients were also positive about being called by their preferred name while in hospital and for having confidence in the doctors treating them. Lower scores were received for patients being given the name of a Clinical Nurse Specialist, being given information about whether their chemotherapy was working in a way they could understand and for having someone at the hospital staff to talk to about their worries and fears. Overall, 89% rated their overall experience as 'very good/good'.

All comments are shared with the teams to highlight areas of good practice and to ensure any areas for improvement are actioned as required. They will be monitored through the quarterly Patient Experience Group meeting and the Quality and Safety Committee looking at recurrent themes, gaps and assurance of recommendations having been completed and embedded and if these have resulted in improvement.

Overall Experience



Overall, 88% rated their overall experience as 'very good/good' in September and December 2020, when combing the scores.

The overall experience score has improved since the 2019 CPES and is in line with the National Average score:

Patient's average rating of care scored from very poor to very good	Sep-20	Dec-20	Trust 2019 score	National Score 2019
	8.8	8.8	8.6	8.8

A thematic review of the free-text comments shows that patients were positive about the care and treatment received, particularly regarding the kind, caring staff involved in their care. The comments highlight that patient's felt that staff were helpful and supportive, and they were treated with kindness, understanding and compassion:

- *"My CNS (Gynaecology) has been invaluable to me from my diagnosis, whilst waiting for surgery & through to the present time. She always returns my calls as soon as she can & is always helpful. Don't know what I would have done without her".*
- *"I am very happy with my treatment and the kindness of all the staff".*
- *"All staff, through very busy were very good and helpful, couldn't be more attentive and reassuring when necessary".*
- *"I have been treated very well by all staff. The breast care nurses, and the chemotherapy nurses are so caring. I cannot fault anything. I am so grateful to NHS".*
- *"The care provided by the breast cancer team was exceptional. Extremely caring and considerate. I cannot fault them. My only recommendation is a private room to talk - had a conversation with my oncology in a corridor which was very busy*

Local Survey - The Dudley Rehabilitation Service

A number of surveys have been completed by patients accessing the Dudley Rehabilitation Service, including Speech and Language Therapy, the Stroke Early Supported Pathway, Neurology, the Neuro-Hydro Service and the Rehabilitation Service. The results were very positive with patients feeling that the therapy and support they received was 'just right', for goals being clearly set out and jointly discussed and that their experience of the Dudley Rehabilitation Service was a positive one. The free-text comments showed that patients felt staff were friendly, professional, understanding, and supportive:

"Excellent team should be commended for their work"

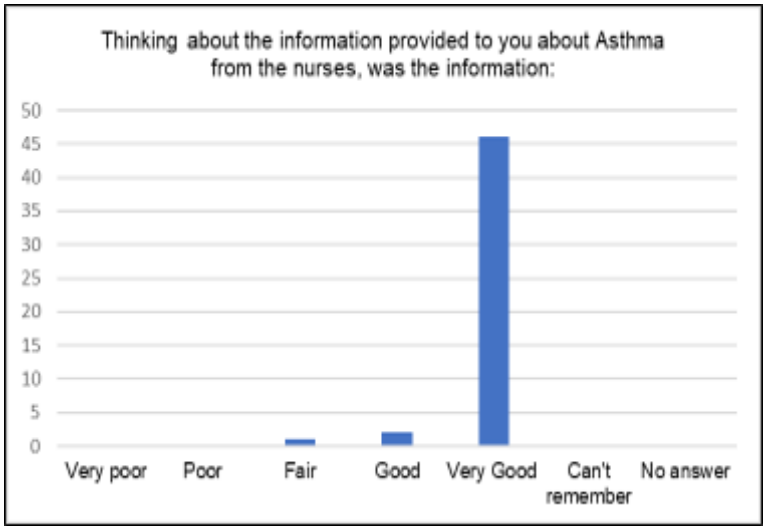
"All I can say they have been really good with me and understanding."

Specialist Adult Asthma Patient Satisfaction Survey

49 surveys were received in Quarter 3, 2021-2022 from patients accessing the Specialist Adult Asthma Service.

The results from the survey were extremely positive with all respondents stating that they felt that they were treated with dignity and respect by the asthma nurses, which is strongly reflected in the free-text comments. Patients felt that the nurses were kind, informative, caring, and always there to provide support when needed. When asked about the asthma nurses that they have seen 100% of patients felt that they were given enough time to discuss their health problems.

94% of respondents felt that the information provided by the asthma nurses was 'very good'. 96% felt that the nurses provided explanations about their condition and the reasons for their treatment in a way they could understand. The information provided was clear, concise and the nurses were extremely knowledgeable.

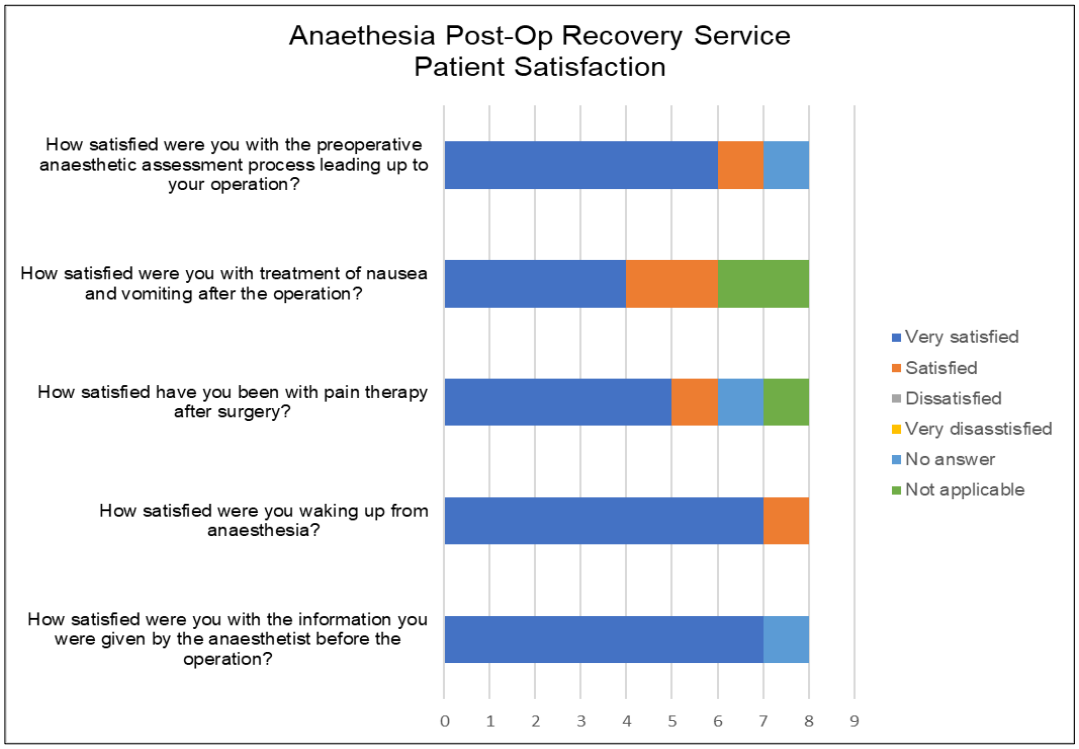


Respondents were extremely positive about the ease of attending appointments, with 92% stating that they found it easy to attend their appointments at the clinic. The free-text comments show that the main reasons for patients finding it difficult to attend the clinic is due to parking at the hospital and mobility issues.

Almost all survey respondents felt they were involved as much as they wanted to be in decisions about their asthma care and treatment and that appointments are convenient for them. The comments show that patients feel that staff are very accommodating if they are not able to attend an appointment, and that staff take the time to explain, listen and provide reassurance.

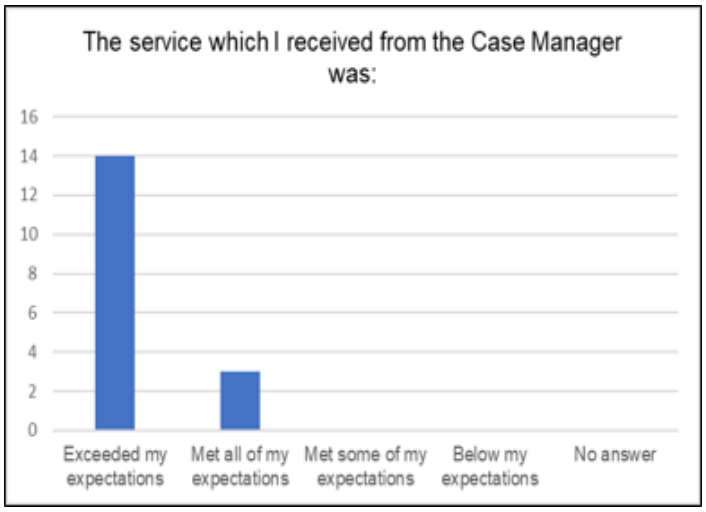
Anaesthesia Post-Op Recovery Service Survey January 2022

The results were positive with all patients stating that they would recommend the service to friends and family. Respondents were very satisfied with the information provided and regarding waking up from the anaesthesia. All patients were very satisfied/satisfied with the preoperative anaesthetic process leading up to their operation. Fewer patients rated their treatment of nausea and vomiting after the operation as 'very satisfied', although there were no patients who were very dissatisfied/dissatisfied.



Dudley Rehabilitation Service – Case Manager Survey

The results were very positive with all respondents who answered the question feeling that their experience with the case manager was a positive one. 82% of patients felt that the service they received exceeded their expectations.



- Support provided by the case manager included help with finance /benefits advice, self-management and assistance with maintaining health and wellbeing. A number of patients stated that the case manager assisted them with emotional support, family/carer support and specialised equipment.

- The benefits of the help and support given to patients is reflected in the free text comments. Patients stated that their case managers have been supportive, helpful, caring and listened to their concerns. The assistance provided has improved the quality of life for the patients accessing the service, such as help with moving to a new house, enabling them to receive support when they did not know where to go and providing a listening ear and regular contact when it was needed

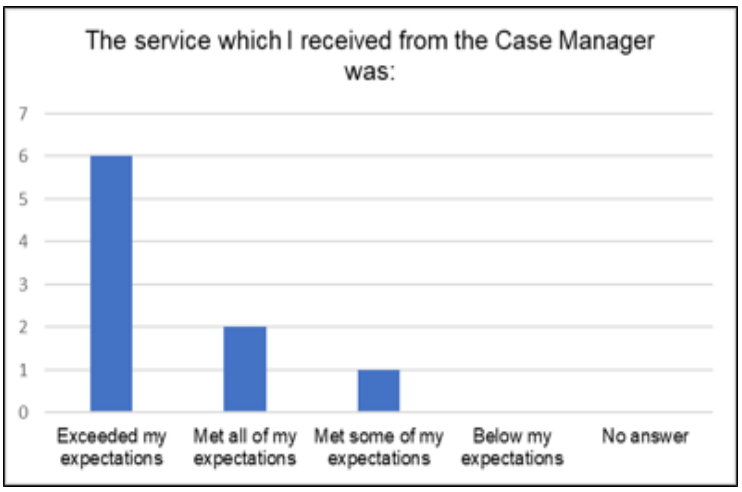
Some examples of positive comments (no negative comments were received):

Everyone who has been to my home has been very helpful and kind and so supportive thank you to them all. I could not function without the help I have been given

Would not have been able to cope with everything if it wasn't for my case manager. I am grateful for the help and support

Dudley Rehabilitation Service – ABI Case Manager Survey

- The results were very positive with 8 out of 9 patients stating that their experience with the case manager was a positive one. 67% felt that the service they received from the case managers exceeded their expectations. One person felt that the service received met some of their expectations.



- Support provided by the case manager included help with finance/benefits advice, self-management, family/carer support, emotional support and assistance with maintaining health and wellbeing. A number of patients also stated that they assisted them with accessing community or vocational activities, relationship advice, housing, advice with parenting and specialised equipment.

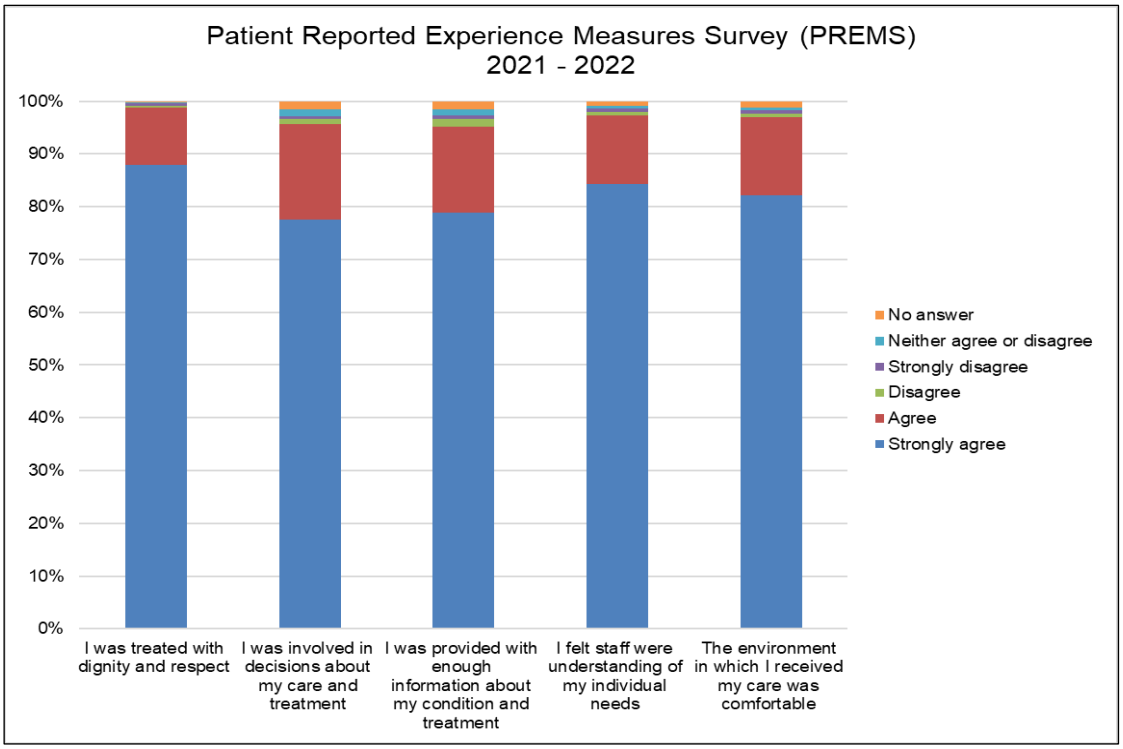
- The free-text comments also demonstrate that patients/carers feel that the ABI case managers have been supportive, helpful, and caring.

3.4 Patient Reported Experience Measures Survey (PREMS)

Patient Reported Experience Measure (PREM) survey aim to capture, understand, and use patient experience in a consistent way, cross referencing the findings with the FFT (included on the back), as an overall satisfaction score.

A total of **8,365** patients/carers responded to the PREM survey in 2021/22 in comparison to 2,993 in 2020/21. As shown in the graph below, the findings were very positive with 97% of respondents receiving a positive experience in terms of being treated with dignity and respect, feeling involved and informed and feeling that the care environment was comfortable. Overall, only 1.4% of patients strongly disagreed/disagreed with the questions.

Patient Reported Experience Measures Survey (PREMS) Totals scores April 2021 to March 2022



As shown in the table below, Day case received the highest number of responses and the highest number of positive scores and the lowest number of patients who strongly disagreed/disagreed with the questions which demonstrates a positive patient experience overall. Patients were less positive about their experience of the A&E Department.

Number of positive/negative responses by Department April 2021 – March 2022

Department	Total Responses	% Strongly Agree/Agree	% Strongly Disagree/Disagree
Inpatients	3052	97%	1.7%
Outpatients	1585	96%	0.8%
Community	665	97%	0.7%
A&E	375	87%	9.3%
Day Case	2050	99%	0.1%
Maternity	638	95%	1.8%

As shown in the graph above, all respondents were positive about being treated with dignity and respect by staff involved in their care and treatment and felt that staff were understanding of their individual needs, demonstrating that the Trust is particularly 'caring' and 'responsive', these were highest scoring questions for all departments. The lowest scoring questions were for patients being given enough information about their condition and treatment, and for feeling involved in decision about their care and treatment. highlighting an area for improvement.

Results are shared with teams to highlight areas of good practice and to ensure any areas for improvement are actioned as required. They are monitored through divisional updates at the quarterly PEG.

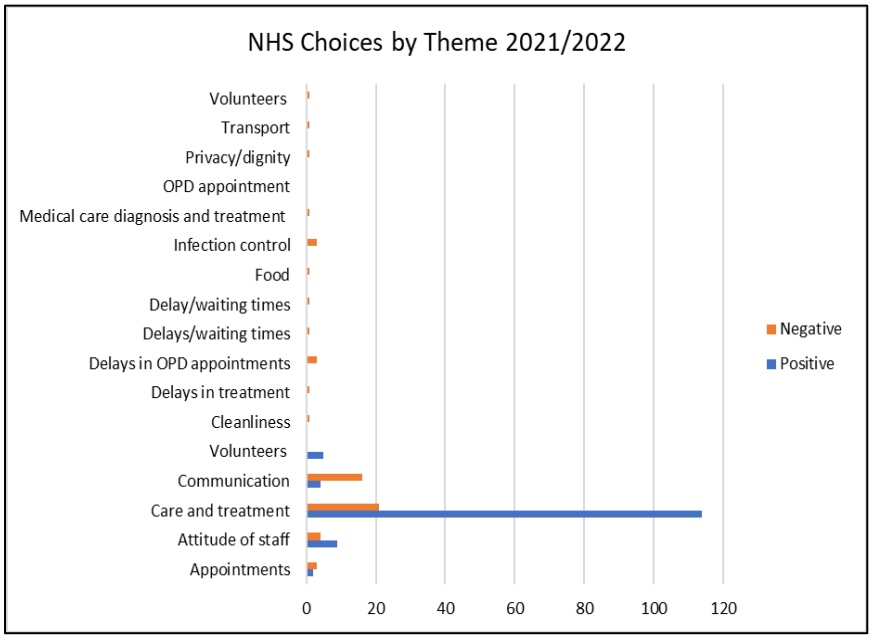
3.5 NHS Choices and Patient Opinion online reviews

Patients, relatives and carers can provide feedback about their experience of any of our services on the NHS Choices and Care Opinion websites. Comments can be posted anonymously, or individuals can choose to give their name. All comments are responded to online within 48 hours. In the year 2021/22 the Trust received 193 pieces of feedback via NHS Choices. 134 comments were positive and 59 were negative.

As shown in the graph below, patients were positive about their care and treatment and the attitude of staff involved in their care. The main themes for improvement focussed on communication and a small percentage (11%) on care and treatment.

Lead nurses are asked to respond to patient comments for their ward and to use this as learning for staff to improve our services. Changes implemented as a result of patient feedback are captured and reported through our 'You Said We Have' process.

Themes identified from April 2021 to March 2022:



Emergency Dept/CAU

"Today my father came into the Emergency Department with chest pain. The care and kindness he was shown by all staff has been all he has talked about all day. He then attended the Cardiac Assessment Unit and again was treated with the utmost respect and care. The staff went above and beyond to ensure he was comfortable, fed and hydrated and kept in constant communication with his treatment plan. Well done everyone...and thank you for continuing to provide a service as

Phlebotomy

"This department is extremely slow. Spent hour and half waiting for a blood test. On one visit I was the only one there and I was still left waiting,"

3.4 National surveys including the National Inpatient Survey

In 2021/22, the Trust participated in the Care Quality Commission (CQC) national surveys programme with the following national patient surveys published during the period.

Survey name	Survey sample month	Trust response rate	National average response rate
2020 Adult Inpatient (published October 2021)	**November 2020**	**42%**	**46%**
2021 Women's Experiences of Maternity Services (published February 2022)	**February 2021**	**43%**	**53%**
2020 Children and Young People Survey (published December 2021)	**November – December 2020**	**20%**	**24%**
2020 Urgent and Emergency Care Survey (published September 2021)	**September 2020**	**27%**	**31%**

Participants for all national surveys are selected against the sampling guidance issued by the Care Quality Commission (CQC) for the months indicated in the table below:

What the results of the surveys told us

Adult Inpatient Survey 2019

The results of the 2020 Adult Inpatient survey were published on the CQC website on 19 October 2021 and overall show an improved picture when compared to our previous year's performance.

The Trust is ranked 115 out of 137 Trusts that participated in the survey (compared to 117 out of 143 trusts in 2019) based on the Overall Patient Experience Score (OPES). The OPES ranged from the lowest score in England of 7.5 to the highest trust score in England of 9.5. The Trust score is 8.1 in comparison to 7.8 in 2019 and is performing 'about the same' when compared to all other trusts.

Between January and May 2021, a questionnaire was sent to 1,250 recent inpatients at each trust. Responses were received from 490 patients at The Dudley Group NHS Foundation Trust (42%). This compares with an average response rate of 46%.

9 out of the 10 sections were performing 'about the same' as other trusts nationally. One section (nurses) scored 'somewhat worse'.

The Trust scored 9.1 out of 10 for patients feeling that they were treated with dignity and respect while they were in the hospital, and this was the highest scoring section in the survey. Patients were also positive about the doctors who treated them with this section scoring 8.7 in comparison to the 8.9 national average score.

Overall, people were most positive about being treated with dignity and respect while in hospital which is in line with the key findings for England. Patients reported less positive experiences around communication regarding medication and further support after they hospital.

Women's Experiences of Maternity Services 2021

The results of the 2021 Maternity survey were published on the CQC website on 10 February 2022. Women who gave birth between 1 and 28 February 2021 (and January if a trust did not have a minimum of 300 eligible births in February) were invited to take part in the survey.

Responses were received from 130 patients at The Dudley Group NHS Foundation Trust (43%). This compares with an average response rate of 53%. The response rate for the Trust has also seen an improvement since the 2019 survey (28%).

Antenatal Care - 3 out of 3 sections are performing 'about the same' as most other Trusts. One question regarding antenatal check-ups is 'somewhat worse' (during your antenatal check-ups did your midwife listen to you?). Antenatal Care was the lowest scoring section overall in comparison to the national average, with care at the start of pregnancy being the lowest scoring area within this section (4.9).

Labour and Birth – 3 out of 3 sections are performing 'about the same' when compared to the average of Trusts surveyed. Staff care is the highest scoring area within this section (8.4).

Postnatal Care – 3 out of 3 sections are performing about the same as the national average. One question is 'much better' (when you were home after the birth of your baby, did you have a phone number for a midwifery or health visiting team that you could contact?) and two questions are performing 'better' than most other Trusts (if you contacted a midwifery or health visiting team, were you given the help you needed and did you have confidence and trust in the midwife or midwifery team you saw or spoke to after going home?). Postnatal Care is the highest scoring section overall and questions about feeding baby are the highest scoring areas in this section.

Overall, 33 out of 43 questions have seen a decline since the 2019 survey. The Labour and Birth section has seen the biggest decline in scores. There are 7 questions where scores have improved in 2021, with Postnatal Care receiving the highest number of increased scores in comparison to the 2019 survey. Patients were positive about the advice given about feeding their baby, being given support and information after birth, feeling that they were treated with kindness and understanding and having confidence in their midwife. Areas for improvement focussed on being given support for mental health during birth, being given enough support and time to ask questions during antenatal check-ups and being given information about where to have their baby.

Children and Young People (CYP) Survey 2020

Between March and July 2021, a questionnaire was sent to 583 recent patients. Responses were received from 113 patients at The Dudley Group NHS Foundation Trust (20%). This compares with an average response rate of 24%

Most questions are performing 'about the same' as the other trusts. There are a small number of questions that are performing better than other Trusts; for staff being friendly and spending time playing with the children during their stay in hospital. Questions about the quality of the WIFI, noise levels on the ward and for the ward being suitable for the age of the child scored worse/somewhat worse than expected.

Historically, thirteen scores have seen a significant increase since the previous survey. Section scores have improved for 'The Hospital Ward', 'Hospital Staff' 'Leaving Hospital' and 'Overall'. The questions about Hospital Staff have seen the biggest improvement since the 2018 survey. The scores for overall care and treatment have seen an increase since the previous survey; for the parent/carer feeling that they were well looked after by hospital staff (8.5 in 2020 in comparison to 7.4 in 2018), parents feeling listened to, feeling that staff were friendly and that their child was well looked after by staff (9.4 in 2020 in comparison to 8.3 in 2018).

The national picture shows that most children and young people, and their parents, continue to report positive experiences about many important aspects of care and treatment. Many children and young people felt that overall, they were treated well by staff, that staff were friendly and gave them privacy during treatment. Most children felt that staff always answered their questions and listened to what they had to say. These findings are in line with the results for the Trust.

Children were less positive about feeling involved in decisions about their care and knowing what was going to happen next with after leaving hospital. Some children and young people reported poorer experiences around having enough to do in the hospital or being played with. This is not in line with the findings for the Trust, where scores are higher than the national average for children feeling informed and involved and being played with in the hospital.

Urgent and Emergency Care Survey 2020

The results of the 2020 Urgent and Emergency Care survey were published on the CQC website on 15 September 2021. The results show an overall improved picture when compared to our previous year's performance.

The Trust is ranked 83 out of 126 Trusts that participated in the survey based on the 'Overall Patient Experience Score' (OPES). The OPES ranged from the lowest score in England of 7.4 to the highest trust score in England of 8.9. The Trust score is 8.2.

8 out of the 9 sections are performing 'about the same' as other trusts nationally and one section (doctors and nurses) is performing 'worse' when compared to most other trusts that took part in the survey. The lowest scoring question in this section was for patients feeling that were given clear explanations about their condition and treatment.

Scores for ‘Tests’ (answered by those who had tests) have declined since the previous survey in 2018. In the ‘Leaving A&E’ section lower scores were received for patients being told about possible medication side effects to watch out for at 4.8 out of 10, this score is in line with the national average.

Since the previous survey in 2018 we have maintained ‘about the same’ in several sections for 2020. The mean average scores have improved for 5 out of 9 sections in comparison to the 2018 survey. Scores for ‘Leaving A&E’ have seen the biggest improvement at 6.9 out of 10, in comparison to 5.6 in 2018 where the trust performed ‘worse’ for that section compared to most other trusts that took part in the survey.

The mean average scores for patients feeling that they were treated with dignity and respect and for overall experience have also seen an improvement since 2018. The Trust score for ‘Overall Experience’ in 2020 is 8.2 compared to 7.7 in 2018.

Our results reflect the patients views and opinions of other trusts that took part in the survey. Nationally, most people surveyed were positive about many important aspects of their urgent and emergency care. The majority of people said that they were treated with respect and dignity, had confidence and trust in the people that treated and examined them and rated their overall experience positively.

Survey findings were less positive, however, for areas of care including people’s perceptions of pain management, emotional support, the availability of staff when they felt they needed attention and information provided during discharge.

3.5 Listening events and focus groups

The patient experience team captures patient experience feedback using a wide range of mechanisms and is responsible for reporting on this activity and facilitating organisational learning and improvement.

To build on existing patient experience mechanisms and provide wider interaction with patients, their families and carers we deliver regular ‘listening into action’ events which are about engaging all the right people to deliver better outcomes for our patients, our staff and our Trust to ensure we continually seek feedback and review and improve services.

The Trust has continued to support a growing number of listening events and focus groups hosted by departments and teams across the organisation. This enables the individual areas to use triangulated performance and feedback information to raise awareness with a focused group of patients, their carers and families. The feedback from these events and the suggestions for improvement are used to develop action plans that provide a continual improvement approach to the patient experience.

During 2021/22 the Trust has hosted events with the following departments and teams: Cancer Services and the Home Oxygen Team. Further detail on findings and action taken can be found in section 2.0 above.

Some examples of action taken following the Cancer LIA:

We have hosted a number of patient panels throughout the year to capture people's views on their experience of our services. The panels are open to all patients, relatives, and the general public. In 2021/2022 we hosted a number of patient panels focussing on communication, general feedback about patient experience of their care and treatment and pharmacy services.

The events were well attended, and action and learning has been implemented following the panels (see section 2.0 above).

Communication was a recurring theme highlighted by all attendees who attended our panels. Our strategic objectives have been developed to ensure that all patients receive care in a way that respects what is important to them and that patients are informed and involved in decisions affecting their future and that of the Trust. Customer care training has also been established throughout the Trust and is available for all members of staff to book onto.

3.6 Feedback Friday

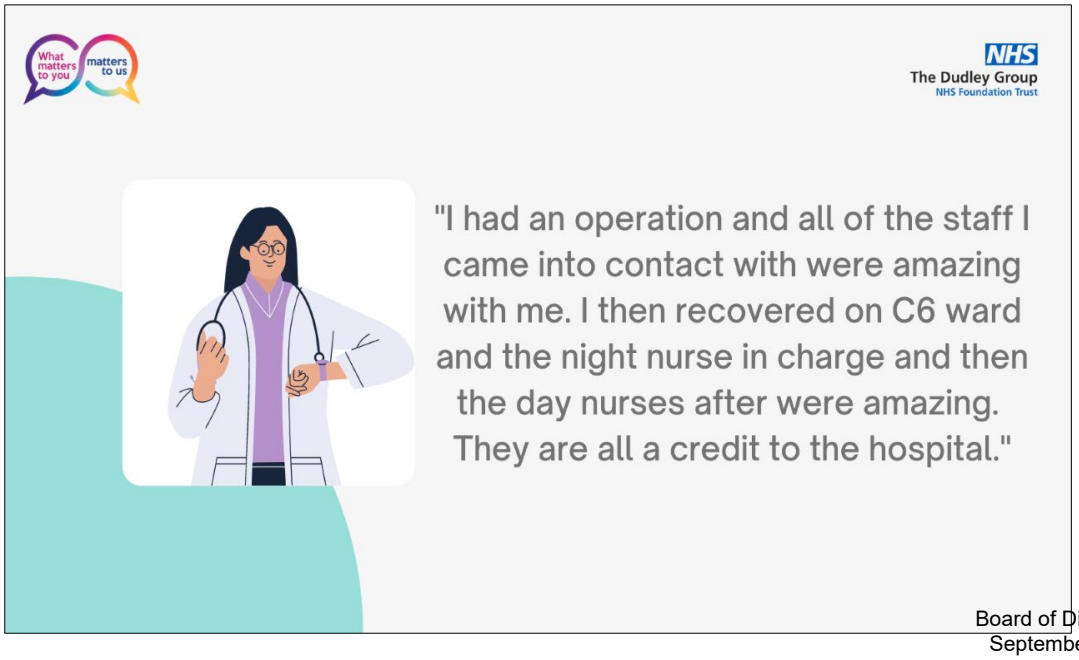
The Trust hosts a 'Feedback Friday' event every month to gather feedback from people who use services and the public, to gather patient thoughts and implement changes to improve the services that we offer. Our 'Feedback Friday' sessions have been held virtually at the end of each month. To build on our engagement activities we promote national awareness days and campaigns to highlight and raise awareness of specific health conditions to improve the health and wellbeing of our local communities.

3.7 Compliments

The total number of compliments received during the period April 2021 to March 2022 has increased compared with previous years as detailed in the table below. The Trust received over **4,980** compliments during the year. Ward C4 received the highest number of compliments throughout the year with 391 compliments. All compliment letters received by the chief executive and chief nurse are personally acknowledged and shared directly with the individual and teams as appropriate, accompanied with a personal letter of thanks.

Compliments are shared on our social media and will be displayed on our new 'What Matters to You' patient experience boards.

An example of the feedback can be found below:



3.8 'What Matters to You' Campaign

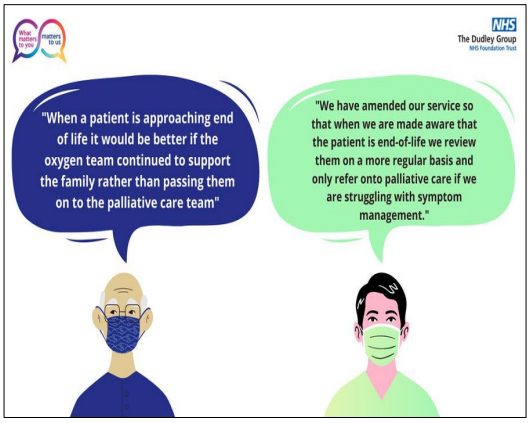
We share feedback via our 'what matters to you' campaign across the Trust through social media channels and internal communications. This campaign aims to raise the profile of patient experience across the Trust, capture feedback and share successes to confirm that we listen, respond and embed lessons learned.

4.0 Improvements in patient experience

A priority of the patient experience team over the last year, and a continuing focus, is to enable and encourage more people to give feedback and to use the intelligence this generates to make changes that improve people's experience.

4.1 Acting on feedback received

Every month the patient experience team sends out reports with patient comments/scores from FFT and real-time surveys. The 'you said' comments received form part of the patient experience reports, which are emailed to matrons and leads on a monthly basis. All managers are required to respond back with their 'we have' actions.



'You Said We Have' feedback highlights the impact patient feedback has across the Trust in real patient-led change. We work alongside frontline staff to translate feedback into local actions and ensure that the quality of care and patient experience improves:

We continue to use the feedback from national and local surveys to improve patient experience. Below are some examples of actions taken as a result of patient feedback throughout the year:

Division/Dept.	You Said	We Have
Surgery	I want more information about my hip and knee operation before I'm admitted.	Uploaded videos on the website with useful information which gives the patient a chance to ask questions before admission
Ward B3	I want to be discharged quicker	Introduced a "Home for Lunch" initiative which aims to get patients discharged before 12:00.
C6 Urology	As a female patient, I would feel more comfortable staying on the Urology ward around females	Introduced an additional seven beds for female patients on the Urology Ward

Neonatal Unit	I want more information about how to look after my premature baby	We have developed information packs for parents of premature babies
Children Outpatients	I feel nervous bringing my child into the hospital due to COVID-19	Ensured that a day before any children's outpatient appointment, a nurse contacts the parents and explains the procedures that are in place within the department to offer reassurance.
Community Musculoskeletal Assessment & Physiotherapy service (CMAPS)	I feel there could have been more information provided about how to access the building on a Sunday (front doors locked and no signposting) and clearer guidance on not needing to find a receptionist to log your arrival. For people with anxiety issues, this is quite important to note.	We have asked our secretary to email the whole admin team to ask them to ensure patients are aware that the front doors are locked and how to access alternative doors on their arrival.
Pharmacy	Waiting times for medication are too long	A tracking board has been installed in the Pharmacy waiting room to show patients their position in the queue.
Paediatrics	I want more support with mental health	A safe room for Child and Adolescent Mental Health Services (CAMHS) on ward C2 has officially launched to support patients with mental health issues.
Paediatrics	I want staff to communicate with me and my child in MAKATON	75% of staff are trained in MAKATON level one for beginners.
Radiology	When I try to make an appointment, the phoneline consistently rings and nobody answers	Appointment lines in Radiology have been upgraded with Direct Dial In (DDI) which means the phonelines will dial or show as engaged.
Rheumatology Outpatients	I was struggling with the chair in outpatient waiting area as it was too low due to additional needs that I have	We have purchased a bariatric chair for the waiting room to support patients with additional needs, in order to protect patient's dignity
Medicine Division	Waiting times for medication are too long	A 'To take out' (TTO) delivery service is available for some patients to reduce waiting times
Community Services	Access to water in the waiting rooms would be appreciated	Installed a water dispenser in the OPAT waiting area

5.0 Our Achievements

The Trust has made several changes and improvements in response to patient feedback. Patient experience data is reviewed monthly to identify themes and trends across the Trust. This is then shared with the divisions and improvement actions and learning is put into practice and reported to the Patient Experience Group, the Quality and Safety Committee and the Trust board. Many of the achievements have already been reported on this report but to add to those:

- **Patient Experience social media**

We have continued to share patient experience via our twitter page/patient experience boards and our newsletter to share feedback from our patients to highlight the importance of what matters most to patients, and to celebrate successes to demonstrate gratitude and appreciation of our staff. We post compliments, patient poems, examples from our 'You Said We Have' feedback to highlight the impact patient feedback has across the Trust in real patient-led change. Our twitter account remains very active with increased engagement and numbers of followers are increasing each month. We currently have 490 followers in comparison to 337 in 2020/21.

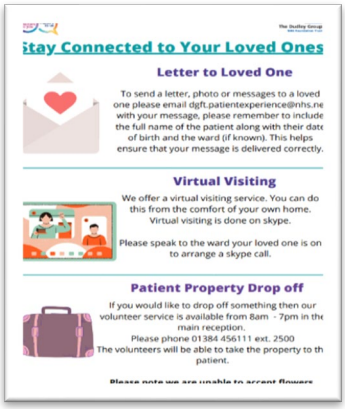
- **Training**

We have continued to deliver customer care training to newly qualified nurses and other staff within the Trust to raise the profile of patient experience and to highlight the importance of what matters most to patients.

- **Compliments Process**

We have reviewed our compliments process and built this into the Datix system so that staff can access compliments by division/departments to highlight trends and themes for sharing good practice and reporting to the Patient Experience Group.

- **Staying Connected**


Stay Connected to Your Loved Ones

Letter to Loved One

To send a letter, photo or messages to a loved one please email dgft.patientexperience@nhs.ne with your message, please remember to include the full name of the patient along with their date of birth and the ward (if known). This helps ensure that your message is delivered correctly.

Virtual Visiting

We offer a virtual visiting service. You can do this from the comfort of your own home. Virtual visiting is done on skype.

Please speak to the ward your loved one is on to arrange a skype call.

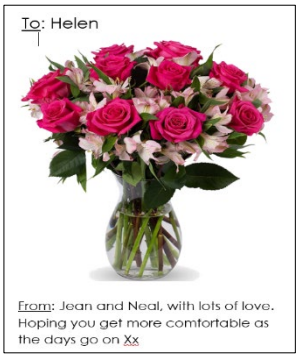
Patient Property Drop off

If you would like to drop off something then our volunteer service is available from 8am - 7pm in the main reception.

Please phone 01384 456111 ext. 2500

The volunteers will be able to take the property to th patient.

We set up the Staying Connected initiative which allows relatives to send 'a letter to a loved one' and 'virtual flowers' to patients on the wards, due to visiting restrictions. Staying Connected posters are displayed on the Patient Experience boards throughout the Trust and have been promoted through the Trust's internal communications for staff and on the external website for patients to be able to stay in connect with their loved one during the pandemic.



Our 'virtual flowers' and the 'letter to a loved one' service has been extremely successful, and many patients have benefitted from the service. Relatives email a message to the Patient Experience team, who print a picture of flowers/a letter template with the message from the patient's loved one and deliver it directly to the patient on the ward. This intends to brighten their day and ensure they are able to stay in contact with the people they care about.

- **Encouraging patient feedback and sharing success**

Our feedback is received via a number of mechanisms that have been designed to enhance the patient experience and improve learning, including complaints, PALS, national and local surveys, focus groups and listening into action events, and the friends and family test. Throughout 2021/2022 we have continued to build on our 'what matters to you' campaign across the Trust and via social media channels. This campaign aims to raise the profile of patient experience across the Trust, capture feedback and share successes

- **Patient Experience Group (PEG) Reporting Structure**

We have reviewed and revised the divisional reporting structure for the Patient Experience meeting. Divisions are required to report on PALS/complaints data, compliments, friends and family test data, updates on local and national surveys, action taken and patient experience initiative. This aims to improve triangulation to highlight key themes and trends for improve and to highlight good practice that can be shared across divisions/departments.

- **Patient Experience Newsletter and Communication Channels**

We send out a quarterly newsletter to or staff which is shared through the Trust's weekly 'In the Know' bulletin. The newsletter aims to raise the profile of patient experience, share successes and encourage staff to promote and share improvements made to services to enhance the patient experience and highlight the impact patient feedback has across the Trust.

We update our 'What Matters to You' boards to display good news, You Said We Have examples and other information to encourage patient engagement and enhance reputation of the Trust.

- **Virtual/Online surveys**

We developed QR codes/online survey to enable patients to send feedback via online channels. These have been promoted on the new patient experience boards, business cards and tablets to improve accessibility.

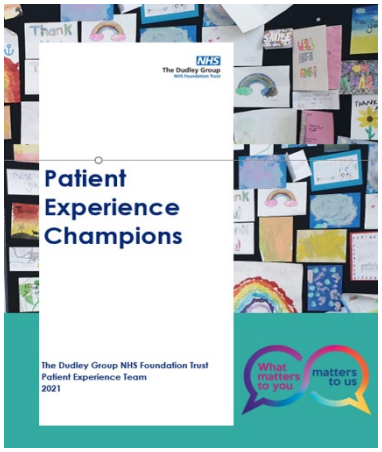
- **Weddings and additional support to teams**

The patient experience team have arranged and supported a number of weddings on the wards for end-of-life patients. We contacted the registrar and chaplains, made decorations, and facilitated the events to ensure the patient and their partners were able to celebrate this special occasion at such a difficult time.

We have continued to work with each division to ensure that all action plans are monitored on a monthly basis, and these are reported to the PEG to share learning to improve the patient experience and to highlight good practice and ideas.

- **Patient Experience Champions**

We have implemented the Patient Experience Champions role within the Trust and teams have identified a Patient Experience Champion for their area. The champions will promote patient experience within their areas to help to drive trust-wide improvements, share good practice and provide the best patient experience and care. We hosted a number of workshops for the champions to learn more about the role and how we can support them to develop patient experience initiatives.



6.0 Patient Experience Strategic Objectives

The Patient Experience strategy 2021-2023 is a two-year plan which builds on the work we have been undertaking with our patients, their relatives, and carers. We are committed to actively engaging and involving patients, their relatives, and carers to listen and act on the information we receive. This strategy will promote working together and will set out how we will do this to ensure maximum involvement and engagement. The aim of the strategy is to ensure that all patients, relatives, carers and visitors have a positive experience in our care, ensuring their emotional and physical needs and expectations are met.

Our Trust's patient experience strategic objectives for 2021/2023 are to:

1. Improve communication between our staff and patients
2. Build innovative partnerships for better health outcomes for our patients
3. Enhance our listening and responding to what people say

A thematic review of our patient feedback shows that communication is a continuous recurring concern identified by our patients, for all departments and teams and consequently demonstrates an area for improvement. Our strategic objectives have been developed to ensure that all patients receive care in a way that respects what is important to them and that patients are informed and involved in decisions affecting their future and that of the Trust.

Our 2021-2023 strategy focusses on increased engagement activity for the next year through partnership working with our stakeholders, local Healthwatch and voluntary and community groups and organisations.

The Trust's focus for 'excellent health care, improved health for all' is reflected in our objectives through building relationships, improving communication, listening, learning, and putting patients, families, and communities at the centre of healthcare. The strategy encourages people to speak up about what is important to them and for staff to listen, learn, and respond to what our patients are saying to enable them to have better understanding of what matters to them.

6.1 Future Plans 2022-2023

- **Patient Panels**

We will continue to deliver our patient panels to give patients/carers and members of the public the opportunity to have their say on how our services are run and proposals for future service redesign. We will identify improvement projects within the Trust for theme/focus for our panels.

- **Patient Voice Volunteers (PVV)**

We will have a number PVV recruited in the Trust in 2022. The PVV's will use their experiences of services to inform and influence the delivery, planning and quality of services we provide. The PVV's will also represent the interests and views of local people in Dudley with the overall aim of improving the experiences of people who use our services.

- **Raising the profile of patient experience**

We will continue to implement and develop our 'What Matters to You' campaign to raise the profile of patient experience across the Trust, to capture feedback and share successes.

- **Engagement Strategy and Tool Kit**

We currently engage with a number of groups, however we have identified a gap in the process around engaging with the wider community, in particular BME groups to ensure our services are representative of our communities. In order to achieve the objectives highlighted in the patient experience strategy, to improve the way we communicate with patients, their GP's and between different services within the Trust, we are developing an Engagement Strategy to reflect our Trust value 'to improve the patient experience' and to strengthen patient and public engagement across the organisation.

We aim to equip staff with the tools that they will need to successfully engage patients to ensure they play an integral role in the improvement of quality and safety. This will include resources and ideas for engaging with patients, a guide to working with patient voice volunteers and representatives, patient and carer engagement policy, sample consent forms and 'ground rules', and guidance on methods of engagement e.g. focus groups.

- **Continue to support staff and teams with the development of specific patient engagement projects**

The Patient Experience Department will continue to support teams to obtain feedback on their services to highlight areas of good practice and themes for improvement through Listening into Action events, forums and focus groups and patient panels to ensure patients are involved in service development and this can be evidenced by our quality priorities for 2022/23.

- **Build on working relationships with our partners and networks, and departments within the Trust**

In line with our Patient Experience Strategy, we will build on our links with local groups and services. We will establish relationships and collaborative working with internal departments within the Trust such as Dudley improvement practice, the patient safety team and clinical governance to work together to enhance service improvement.

- **Monitoring of action plans to drive service improvement**

We will continue to work with each division to ensure that all action plans are monitored on a monthly basis and these are reported to the PEG to share learning to improve the patient's experience, and to highlight good practice and ideas. The patient experience team will work alongside frontline staff to translate feedback into local actions for the following patient experience surveys:

- National Cancer Experience Survey
- Maternity
- Adult Inpatient
- Emergency Department
- Children and Young People

- **Making sense of information**

We will continue to monitor patient feedback, with a focus on overall rating of our services and supporting teams with action plans and analysis of feedback and development of the 'You Said, We Have' process. This will ensure actions are being reported and patients are being given the opportunity to share their experiences. We will carry out analysis and investigation of feedback that is received and assess whether actions have prevented further occurrence or have affected a more positive patient experience through triangulation and cross-referencing of all sources of patient feedback. Improvements made to services will be monitored and reported through divisional updates at the quarterly PEG. The measurement of patient experience at an organisational level will demonstrate improvements in positive experience.

7.0 In Conclusion

This annual report reflects the significant focus given to improving the experiences of our patients, their families and carers. All Trust teams are committed to complying with this active engagement to ensure 'our patient views' are kept at the heart of what we do.

Enclosure 22

The Dudley Group NHS Foundation Trust

Paper for submission to the Board of Directors on 22nd September 2022

Title:	**Digital Trust Technology Committee Report – Public Board**
Author:	**Catherine Holland** (Digital Committee Chair)
Presenter:	**Catherine Holland** (Digital Committee Chair)

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

Summary of Key Issues:

- The strategic outline for the 3 Year Digital Plan was approved in principle, so that the full business case can be developed with centrally funded contract expertise.
- It is recommended that the Digital Portfolio – Backlog Deep Dive work is presented to the Board
- Partial assurance of Maternity Service data quality for Clinical Negligence Scheme for Trusts (CNST) submission was noted, four items for service improvement in record keeping are being developed with the department.

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: **BAF 8:** ***IF*** *DGFT does not establish, invest and sustain, the resources, infrastructures, applications and end-user devices for digital innovation* ***THEN*** *the Trust's operational performance and strategic objectives will not be delivered or risk major disruption in the event of a cyber-attack.* ***COR1540*** *- Failure of the IT Infrastructure (compute, storage & backups) would impact on patient safety and performance.* ***COR1083*** *Risk of a Cyber Security incident causing widespread impact on Trust operational capability* ***COR1865*** *Geopolitical instability, leads to economic uncertainty, effecting supply chain resilience which leads to inflationary rises, presenting a risk of increasing costs to the Trust and our workforce*	
	On Risk Register: BAF Y	Risk Score: COR1540 (20), COR1083 (20) COR1865 (20). BAF 8 (20) inherent risk (25)	
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: 22nd September 2022
	Other	N	Date:

The Dudley Group NHS Foundation Trust

UPWARD REPORT FROM DIGITAL TRUST TECHNOLOGY COMMITEE

Date Committee last met: 7th September 2022

MATTERS OF CONCERN OR KEY RISKS TO ESCALATE	MAJOR ACTIONS COMMISSIONED/WORK UNDERWAY
• Gaps in recording four discrete items within the clinical record is impacting the Maternity Clinical Negligence Scheme for Trusts (CNST) submission data quality. This has been shared with the department. Clear operational plans are being developed to improve record keeping compliance to resolve this. An update will be provided to the next committee.	• Work to pilot a Same Sign solution to harmonise computer log-on passwords with NHSMail passwords is underway. This will allow self-service password reset via the NHSMail portal initially and eventually lead to a secure single password access to all systems. This work is part of a wider project to better support the workforce in the black country provider collaborative. Following the pilot, Same Sign On will be rolled out Trust wide to simply log-in management and support the reduction in number of calls to the IT Service Desk, so that this team can deal with higher priority calls. A template for this work will be shared with provider partners. • BAF risks under continued review along with the significant risks which filter into the BAF to articulate the digital and technology risks. BAF will be reviewed at next committee
POSITIVE ASSURANCES TO PROVIDE	**DECISIONS MADE**
• Positive assurance provided by the ongoing CareCERT management process • The Data Quality Maturity Index scoring remains higher than national average across all individual datasets •	• Agreed in principle to approve the strategic outline case for a 3-year digital plan, that will be developed into a full business case through centrally funded resources.
Chair's comments on the effectiveness of the meeting: A good meeting, kept to time. Agenda timings gave the opportunity for good discussion.	

Enclosure 23

The Dudley Group NHS Foundation Trust

Paper for submission to the Board of Directors on 22nd September 2022

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

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

Recommendations:

- Approval of Research & Development strategy content, dated Final Draft v4 September 2022 (appendix 1)
- Acknowledge report

Summary of Key Issues:

Understand the full research activity across the Trust (including 2021/22 year performance)
Outline of activity for University Hospital Status application
Review and approval of revised R&D Strategy

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	M1938	Risk Description: The uncertainty of being able to increase research activity due to unsuccessful external funding bids	
	On Risk Register: Y	Risk Score: 12	
Compliance and/or Lead Requirements	CQC	Y	Details: safe, effective, caring, Responsive & Well-led
	NHSE/I	Y	Details: R&D activity included in Trust annual report
	Other	Y	Details: Recruitment and performance activity is monitored by CRN;WM, NIHR & DHSC.
Report Journey/ Destination *(if applicable)*	Working / Exec Group	Y	Date: August 2022 Research Education Innovation Committee
	Committee	Y	Date: June 2022 Quality & Safety Committee
	Board of Directors	Y	Date: September 2022
	Other	N	Date:

INTRODUCTION

Research awareness across the Trust has significantly improved because of COVID 19, both for the wider public as well as staff. We have also completed a considerable amount of work to promote more widely and support anyone with an interest in research. In the last 6 months, we have ultimately, seen an increase in staff wishing to participate in studies, or require support to develop their own home-grown studies. With the launch of the HEE AHP Research and Innovation Strategy 2022, we have seen an increase specifically, in this staff group reaching out for support from the R&D department.

Work is well under way to support the University Hospital status application, with regular meetings with Aston University. We have established a Research Working Group to implement action plans to co-ordinate activity to support the application.

R&D STRATEGY

The revised five-year R&D Strategy is included with this report for Trust Board approval. The strategy encompasses the Trust aim of achieving University Hospital status.

The strategy covers our 5-year plan to obtain University Hospital status. We are currently developing a pipeline plan, which is currently under review. In summary, as part of pour strategy, we aim to increase the number of non-medical and medical Principal Investigators (PI's), to develop into Senior Investigators, increase research activity in those areas that are not currently active or have very little activity and increase R&D income overall. We will work towards research becoming fully embedded across the organisation. The R&D Strategy is attached to this report: Appendix 1.

CURRENT ACTIVITY

Summary Of Urgent Public Health Research (UPH):

We are still recruiting into UPH studies, however due to the success of the COVID 19 vaccination programme, in-patient numbers are decreasing. This has enabled the team to re-open paused non-COVID studies. We have been able to concentrate on opening more studies to improve treatment options for our patients, moving forward and getting back to business as usual. We will, however, keep COVID-19 studies running, as per sponsor requirements, so there are treatment options for COVID patients should numbers rise during the proposed winter pressures.

We have condensed the UPH studies into a table below as full details were included in the last report.

STUDY NAME	PRINICPAL INVESTIGATOR	RECRUITMENT TARGET	TOTAL RECRUITED	RECRUITMENT END DATE
ISARIC	Dr Paraiso	1	2094	on-going
SIREN	Dr Ashby	200	425	31/03/2021
RECOVERY	Dr Ashby	1	244	30/11/2022
REMAP-CAP	Dr Reay	30	183	30/06/2022
CCP CANCER UK	RN Watts	1	86	17/05/2022

GenOMICC	Dr Anumakonda	40	61	31/03/2022
COVIP	Dr Reay	13	25	30/09/2021
COPCOV	Dr Paraiso	400	13	31/03/2021 (closed early)

Non-COVID research:

Most non-covid studies have now re-opened (a couple of studies were closed by the sponsors during COVID).

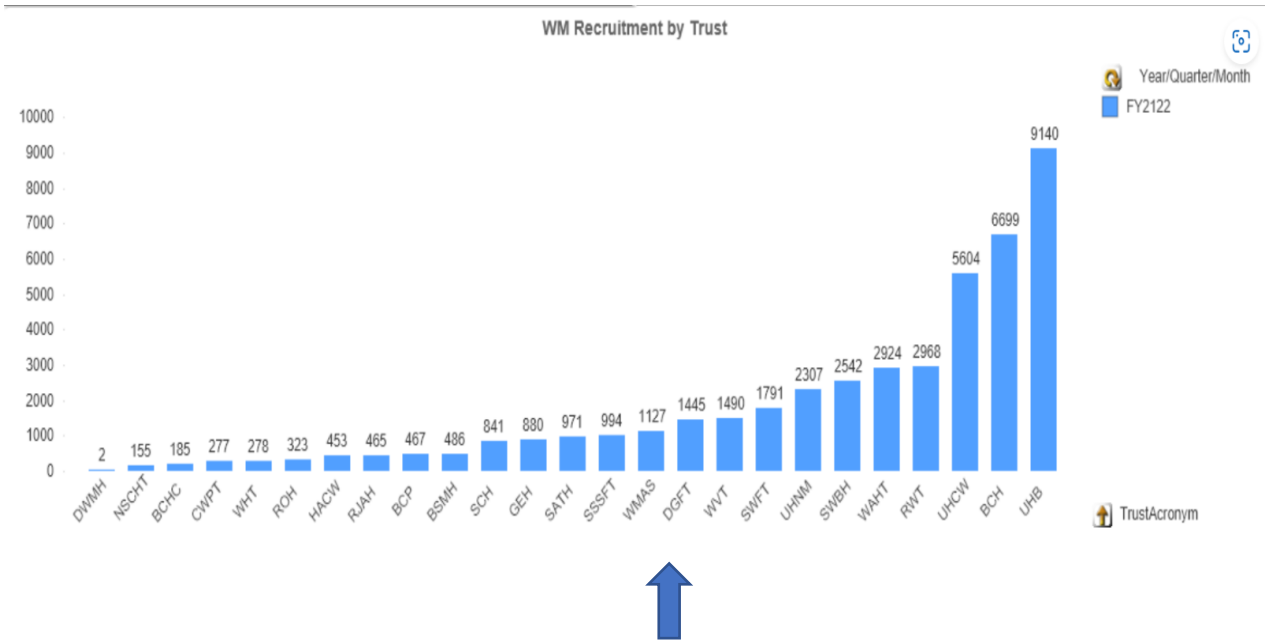
To date we have 27 studies in set-up throughout our portfolio of specialities. Current participant recruitment stands at 142 participants in CRN portfolio adopted studies with an additional 98 participants recruited to non-portfolio studies. Our 2021-22 year-end recruitment activity is shown below in Graph 1 and 2. Individual specialty recruitment is attached as Appendix 1.

The CRN/NIHR managed recovery programme ended 31st March 2022 Vascular surgery, cardiology, cancer and critical care specialties continue to be very research active, with some recruitment in dermatology, metabolic medicine, stroke, gastro, musculoskeletal and diabetes also.

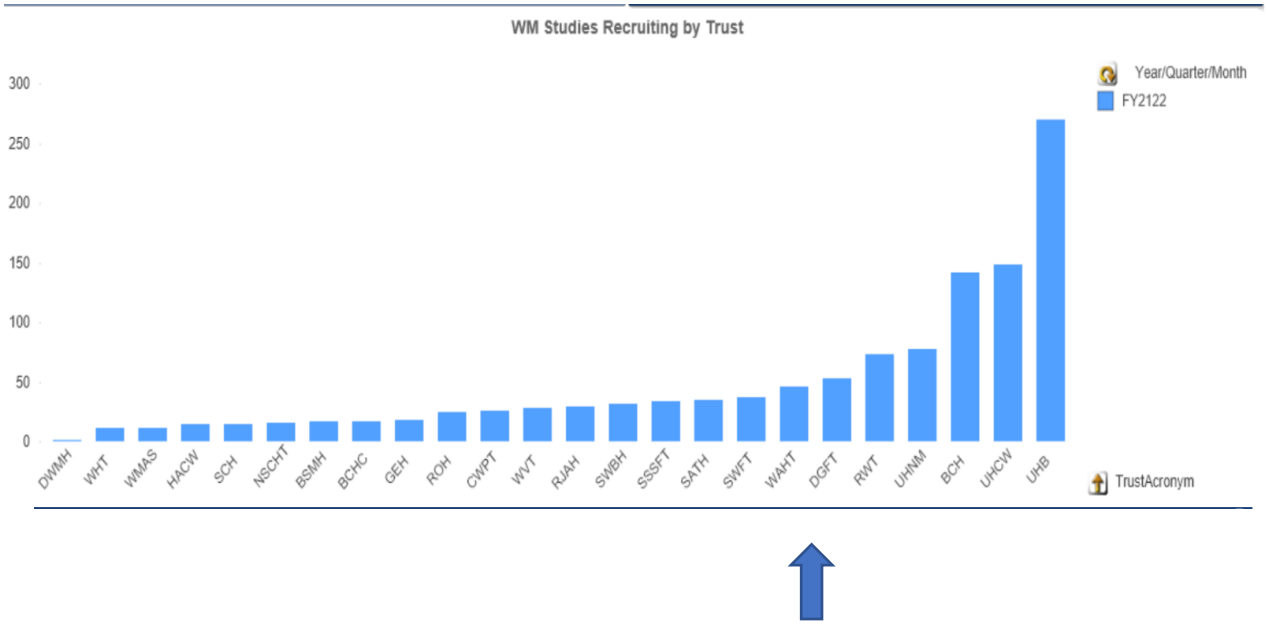
We are currently setting up a study with our Community Respiratory team - the IMPROVE trial: *Improving completion of Pulmonary Rehabilitation via lay health workers to improve life quality in COPD.* This is a new area for research, so we are excited to build on this collaboration to open more studies in future with the Community teams as well as this disease area.

We have other emerging specialties such as Palliative Care, Surgery and Ophthalmology that are showing an interest in research, with some submitting NIHR expressions of interest to participate in trials.

Graph 1 – Participant Recruitment Numbers across West Midlands Trusts for April 2021-March 22



Graph 2 – Number of CRN Portfolio studies across West Midlands Trusts



Enhancing research capability and collaborative working

Aston University – A Memorandum of Understanding (MoU) has been developed and signed off by Dr Julian Hobbs, pending Aston University approval. Collaborations with Aston University currently include Statistician Support (provided by Aston University) has now been confirmed. Peer review for grant applications prior to submission to increase success rate has also been confirmed by Aston University.

In the last few months there has been an increase in staff contacts that are interested in becoming involved in research, some wanting to develop their own projects and others wanting to participate in commercial or academic trials. This is very encouraging for us, and we are keeping a record of this activity and outcomes from staff enquiries. This activity is also supported by our Research & Innovation Support Meetings that are held monthly.

Research Scholarships and Fellowships

Mr Mike Wall (Consultant Vascular Surgeon) has been awarded funds from the West Midlands Vascular Research & Innovation Consortium (VARICS) to support Vascular research at the Trust. An exciting appointment has been made for a Senior Lecturer post in vascular surgery, with a start date to be confirmed. The VARICS funds will go to support a band 5/6 Nurse to work on current and up-coming Vascular studies. They have also appointed a Vascular Research Fellow who started in August. This should improve recruitment to the studies and assist with visits for those in follow-up.

Dr Sally Fenton, an affiliated academic staff member, has been successful in gaining a 5-year NIHR Senior Fellowship for a project entitles MISSION-RA. Russell's Hall will be the main recruiting site, with Sandwell & West Birmingham, as a second site. This programme will pan three studies, with the first due to commence in early 2023.

Student Placements

R&D will continue to host a rotation of Physiotherapy AHP students from Wolverhampton and Birmingham Universities from September 2022. We also have placements available for student nurses from Wolverhampton & Birmingham Universities.

Grant Funding Applications

DuPARDS study **(Infra-red intervention trial)**, Mr Mike Reay; unfortunately, our NIHR Grant application was unsuccessful, June 2022. We have received feedback and are now preparing to submit a second application via a different NIHR funding stream.

Dr Gail Parsons is preparing an NIHR funding application to support her home-grown study: *exploring lived experiences of individuals with severe osteoarthritis (OA) of hip or knee, whilst waiting for joint replacement; the effect of the pandemic'*. This study will be in collaboration with Professors at Aston University and a local Dudley GP, Dr Lucy Martins.

Vascular Surgery successful NIHR and Black Country VARICS funding for posts, as described above, to expand their research portfolio.

Home-Grown research

We have a number of exciting 'home-grown' research projects running and under development:

Mr A Akingboye, Consultant Surgeon, study - Colorectal cancer biomarker, proof of concept study, has commenced., The team in the Research Laboratory are now processing samples supplied by Arden Tissue Bank. This project is in collaboration with colleagues at Aston University

Mr Michael Wall, Vascular Surgeon, started his OBVIOUS 2 study which is a questionnaire-based study to gather patient's feedback on their vascular disease from a weight loss clinic. The study is running well and has recruited 64 participants to date.

Dr Dijon Millette, Dermatology Research Fellow & Trust Grade Registrar, has been supported with submitting an application for his own study "Feasibility Studies for an RCT in Anogenital Psoriasis". This has been sent for ethics review and is pending outcome.

Dr Helena Wells, Dermatology Registrar. The prevalence and impact of dermatoses in an in-hospital palliative care population in the UK: A prospective study. This has been sent for ethics review and is pending the outcome.

Dr Gail Parsons, Nurse Consultant & R&D Director. Currently working on the study design for OA project. An application for funding will be made October 2022.

Lisa Tanner-Byles, Advanced Nurse Practitioner, patient discussion group arranged to inform project design around Oxford Hip and Knee Score tool.

Yunzheng Jiao – Clinical Trials Pharmacist, received ethics approval for project looking at pharmacist involvement in trials.

Ruth Hopper (Dudley Continence Team Leader) and Yesudas Joseph (Senior Physiotherapist), designing a project entitled *'the effectiveness of pre-operative rehabilitation in women undergoing elective/emergency C section or normal birth'*.

Staffing

We have our Band 5 Clinical Research Practitioner replaced with a Band 3 Clinical Research Assistant to cover some of her duties during the maternity leave (commenced August 2022). We have appointed a Band 3 Pharmacy Assistant, to replace a band 6 Pharmacy Technician. One of our band 7 Research Nurses is also retiring September 2022, for which an internal replacement has been appointed.

Patient & Public Involvement Experience

We have a patient representative identified, that is assisting us within the R&D department with our NIHR National Patient Research Experience Survey (PRES) and attending some of our meetings.

We held a successful LIA event early August 2022 and captured some really good ideas to improve patients experience in research. Report and action plan is currently in development.

Future developments and opportunities

The use of technology with remote participant appointments and video calls will be incorporated into future studies as it was recognised as a positive future choice for participants wishing to be involved. Capturing participants across our diverse population where there maybe communication barriers, is an area of focus for studies.

We aim to obtain funding to support a part time Research Midwife post, to enable the delivery of important national trials such as GBS3 trial (looking at whether testing pregnant women for Group B Streptococcus reduces the risk of infection in new-born babies compared to the current strategy in place in the UK). We have tried previously to enable these types of studies; however, it hasn't been very successful and has highlighted that protected funded time is needed to take on these studies. We have approached the CRN; WM for funding and are currently awaiting their response.

Our recently appointed Principal Research Pharmacist has received formal confirmation that he was successful at interview and offered a place to join East Midlands - Leicester Central REC, (specialised in reviewing studies involving CTIMPs). This is a great opportunity for him and will be a fantastic support for our researchers when developing their projects, to be able to obtain that perspective.

We will be rolling out a patient and staff survey looking at awareness of research across the Trust, to provide us with suggestions and feedback.

Publications

Please see appendix 3 for research publications list from January 2022 to August 2022.

Summary

Name of Authors: Dr Gail Parsons, Professor George Kitas; Claire Phillips, Helen Hollis.

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

Date report prepared 09/09/2022

APPENDICES:

Appendix 1 – Research, Development & Innovation Strategy, Final Draft v4, September 2022

Appendix 2 - Trust Specialty Participant Recruitment Report - DGNHSFT

Appendix 2 – Research Publications – January 2022 – August 2022

Appendix 1 Research, Development & Innovation Strategy, Final Draft v4 Sept 2022

Appendix 2

Table 1 –Year 2021-22 Participant Recruitment, Study Type and Specialty Data

Studies Recruiting: 53 Recruitment: 1,445

Study Category	Studies Recruiting	Recruitment
Commercial	10	43
Interventional	25	185
Large Scale	9	1143
Observational	9	74

Commercial/Academic	**Managing Specialty**	**Number of Studies Recruiting**	**Numbers of participants**
Commercial	Cancer	1	1
	Cardiovascular Disease	4	31
	Dermatology	3	3
	Diabetes	1	7
	Gastroenterology	1	1
	Total	10	43
Non-Commercial	Anaesthesia	4	92
	Cancer	8	32
	Cardiovascular Disease	2	6
	Children	1	4
	Critical Care	6	73
	Dementias and Neurodegeneration	1	3
	Dermatology	2	4

	Diabetes	3	14
	Gastroenterology	2	6
	Haematology	1	3
	Infection	2	1066
	Musculoskeletal Disorders	6	25
	Stroke	1	1
	Surgery	3	68
	Trauma and Emergency Care	1	5
	Total	43	1402
Overall Total (all studies)		53	1445

Appendix 3 Published research - January to August 2022

1. ADIKARI, M., C. KOUTSIANAS, H. JOHN and R. KLOCKE. Comparative Utility of UltrasoundAnonymous *Known Vs Query New Inflammatory Arthritis - a Retrospective Case-Note Audit*, 2022.
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CHANGE HISTORY

(Put document title here) STRATEGY

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The electronic version of this document is the definitive version	

Version	Date	Reason

2.0	May 2022	This document has been reviewed and replaces Research Strategy 2018-2021.

A translation service is available for this document. The Interpretation/Translation Policy, Guidance for Staff is located on the intranet under Trust-wide Policies.

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Contents

THE DUDLEY GROUP NHS FOUNDATION TRUST

RESEARCH, INNOVATION & DEVELOPMENT STRATEGY

1 INTRODUCTION

The unprecedented global and local research response to the COVID-19 pandemic has brought the importance of clinical research to the forefront, and significantly increased interest and awareness in this important area[1,2].

Research, Development and Innovation are essential to the development of world-leading excellence in clinical care. It is now well recognised that a research-active culture can contribute to improved overall Trust performance[3], better clinical care, improved patient outcomes[4,5] and enhanced patient experience. In addition, this can result in increased staff satisfaction and additional opportunities for staff development, which in turn will benefit staff recruitment and retention.

The Dudley Group NHS Foundation Trust (DGNHSFT) Research & Development Strategy will form the basis of a five-year plan that builds on our previous successes in research within the trust. This success has historically been based around a number of core specialities and therefore our mission is to embed research across the Trust, and scope of our clinical services, by embracing and embedding research in our Dudley Hospitals to create a better future for our patients, our staff and wider populations.

2 STATEMENT OF INTENT/PURPOSE

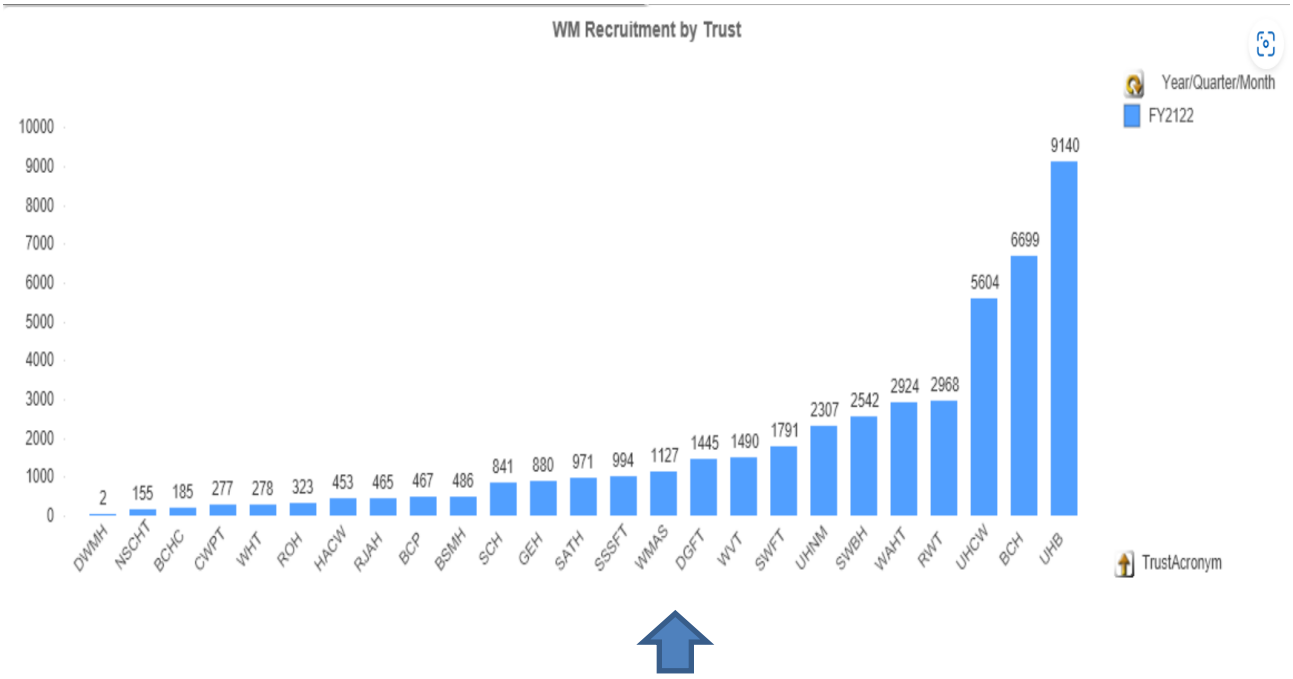
Research and Innovation are an integral component of our Trust strategy; constantly to improve and offer better care for our patients and attract and retain staff. We aim to deliver excellent, innovative clinical services, underpinned by excellent research and teaching. The Trust's vision to become a University Hospital incorporates research, innovation and education, therefore our fundamental principles are to contribute to this goal. By developing and delivering this research strategy, we will also contribute to the other Trust strategic priorities.

This detailed five-year plan will take into account the overall Trust strategic direction, along with regional and national strategies. It is based on consultation with the relevant stakeholders and reflects the aims, objectives and needs of The Dudley Group NHS Foundation Trust. Working with our partners in academia, patient representative groups, NHS and Industry to realise the research potential in all areas

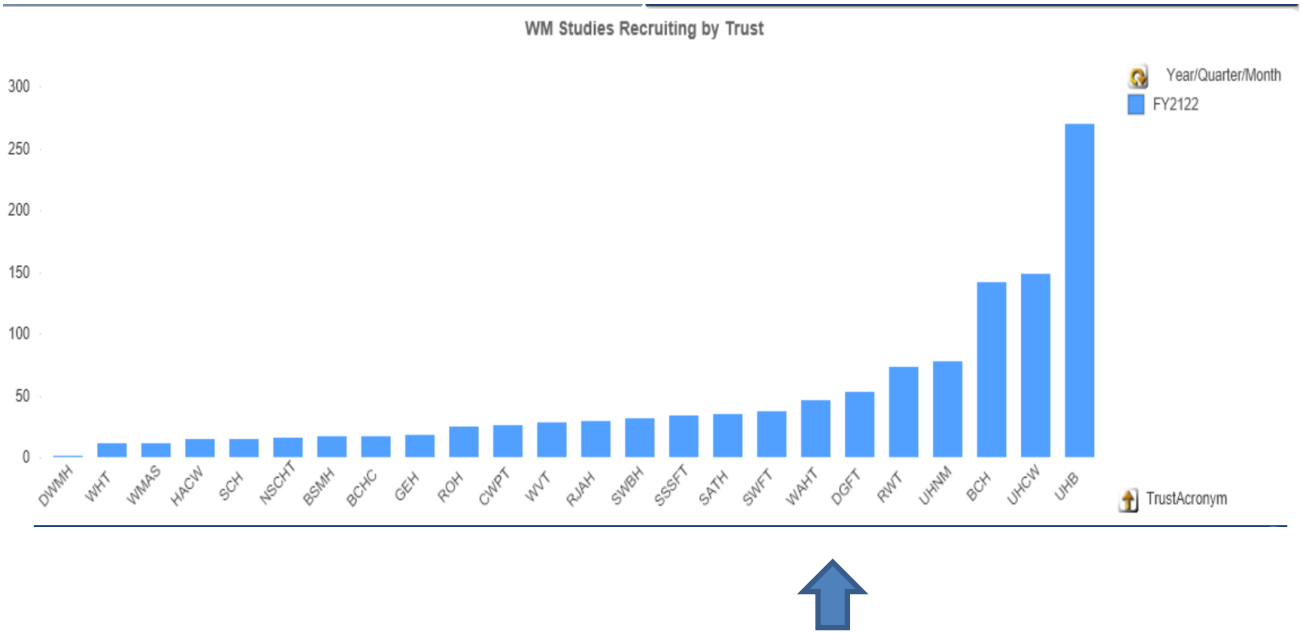
of our hospitals, to be able to offer every patient and member of staff the opportunity to be part of research.

We currently perform well with our current research activity across the region in comparison with local Trusts (abbreviation DGFT) (see graphs 1 and 2 below).

Graph 1 – Participant Recruitment Numbers across West Midlands Trusts for April 2021- March 22 (Open Data Platform, CRN West Midlands, Trust Reports FY2122)



Graph 2 – Number of CRN Portfolio studies across West Midlands Trusts (Open Data Platform, CRN West Midlands, Trust Reports FY2122)



We aim to expand this further, by increasing research activity across the organisation and beyond, increasing the number of studies available to our patients and increasing the number of participants involved in studies. This activity will include embedding research from staff recruitment and induction, staff training and student placements, access to research for all, to research results and patient/public involvement. We will increase collaborations to enable further research for our local population and thus resulting in increasing research income to support growth and sustainability.

We have a strong history of publications, with an annual average of 160 plus publications accepted into high impact British, European and International journals.

3 DEFINITIONS

AHSN	Allied Health Science Network
CI	Chief Investigator (national lead for study)
CRN WM	Clinical Research Network West Midlands
DGNHSFT	Dudley Group NHS Foundation Trust
EPR	Electronic Patient Record
GCP	Good Clinical Practice
GLP	Good Laboratory Practice
PI	Principal Investigator (lead at Trust/Site)
R&D	Research and Development

4 PROCESS

We are building on an already established, strong foundation of research delivery at DGNHSFT, with currently evident activity within these areas:

Anaesthesia/Critical Care
Cardiology
Dermatology
Diabetes
Haematology
Metabolic Medicine
Oncology
Orthopaedics
Rheumatology
Vascular Surgery

We aim to expand research delivery across the Trust and become a centre of clinical academic excellence, specifically in Palliative Care, Rheumatology, Urology and Vascular Surgery where new treatments are discovered, new healthcare professionals are trained, and innovative developments are put into practice.

We will review previous years research activity and performance, to measure success across our 5-year strategy plan. Table 1 below shows a summary of the number of recruiting studies and participant recruitment numbers for year 2021-22. Table 2 gives more detail of which specialties were actively recruiting in year 2021-22 and the number of participants recruited at the end of 2021-22.

Table 1 –Year 2021-22 Participant Recruitment, Study Type and Specialty Data (CRN:WM, DGFT Trust Google Sheet Yr2122)

Studies Recruiting: 53 Recruitment: 1,445

Study Category	Studies Recruiting	Recruitment
Commercial	10	43
Interventional	25	185
Large Scale	9	1143
Observational	9	74

Table 2: Number of studies recruiting, and participants recruited for each research active specialty within the Trust for year 2021-22

Study type	Managing Specialty	Studies Recruiting	Recruitment
Commercial	Cancer	1	1
	Cardiovascular Disease	4	31
	Dermatology	3	3
	Diabetes	1	7
	Gastroenterology	1	1
	Total	**10**	**43**
Non-Commercial	Anaesthesia	4	92
	Cancer	8	32
	Cardiovascular Disease	2	6
	Children	1	4
	Critical Care	6	73
	Dementias and Neurodegeneration	1	3
	Dermatology	2	4
	Diabetes	3	14
	Gastroenterology	2	6
	Haematology	1	3
	Infection	2	1066
	Musculoskeletal Disorders	6	25
	Stroke	1	1
	Surgery	3	68
	Trauma and Emergency Care	1	5
	Total	**43**	**1402**
Total (all studies)		53	1445

Research, Development & Innovation Vision

High quality, research and innovation will be fully embedded across all staff groups within the Trust, as part of our vision to deliver high quality, patient-centred care.

To realise our vision, we will need to deliver the following goals:

1. Embed a research culture across the whole organisation and in all staff groups, to become a fully research active organisation.
2. Optimise research capability and capacity.
3. To further enhance partnership between industry, academia, AHSN and other NHS organisations to improve delivery of our research portfolio.
4. Improve patient experience by providing opportunity and choice to participate in research across all possible specialities in our organisation.

5. Deliver high quality research through excellence in research governance.
6. Disseminate research findings though quality publications and ensure research impact is rapidly integrated into clinical care for our patients.

Further detail around these goals is presented below.

Goal 1: Embedding a research culture across the organisation and in all staff groups, to become a fully research active organisation.

Our **aim** is to facilitate a research-positive culture in all areas of DGNHSFT, not just the current areas of activity, empowering colleagues to lead, support and become involved in research. These could be locally trained principal investigators (PIs) from nursing, midwifery, pharmacy, allied health professional, health care scientists, as well as the more traditional medical backgrounds. Operational leaders will be aware of, and value research undertaken in their areas and by their staff, as it will be a marker of quality, of patient-centred care.

Our **aim** is to increase the number of specialities/areas of the Trust that are engaged in research, so that it is visible in all aspects of the day-to-day business of the Trust. Trust senior leaders will encourage specialties be research active, so that encouragement to do research comes from multiple directions and not just from the R&D Department.

Our relationships with our academic partners are an indicator of our success in creating a research culture. Our research managers will be well linked and working towards common goals and to achieve clinical research strategic aspirations. Partnerships will develop between academics and Trust staff, to increase joint academic roles, to set up and deliver academic research initiatives in a streamline way. Collaborations with a primary University, alongside additional university collaborations, will be critical to achieving our Trust ambition of becoming a University Hospital Teaching Trust.

We will use a variety of media and events to raise the profile and visibility of research, so that staff will seek and ask about research opportunities, and well as being approached by R&D staff. This will include annual events, open days, and Trust research awards.

Support services, such as radiology and pathology, will be aware of the crucial role that they play in ensuring the success of the research agenda and will be supported to facilitate this.

1. An increase in the number of PIs from non-medical disciplines.
2. An increase in PIs from medical backgrounds and non-consultant grades.
3. Wider celebration of success of local researchers.

4. Engagement of all corporate directorates to include research in all DGNHSFT strategies.
5. Research being considered in the recruitment of all senior staff – clinical and non-clinical.
6. Creation of an operational research reporting mechanism that demonstrates the benefits of research, to each section of the organisation.
7. Greater visibility of research activity in clinical areas.
8. An increase in the number of specialties offering research at DGNHSFT.

Table 3 below represents the number of principal investigators since 2018-2021 and whether these were from a medical or non-medical background. This will be useful in comparing success of increasing the number if PI's over our 5-year plan.

Table 3: Number of Principal Investigators (PIs) in previous years (EDGE PI Report, August 2022)

Medical PIs	*Number*
2018	**52**
2019	**56**
2020	**59**
2021	**57**
Non-Medical PIs	
2018	**3**
2019	**4**
2020	**6**
2021	**3**

Goal 2: Optimise research capacity and capability

Our aim is to increase, as far as possible the research capacity and capability across the Trust. We will invest in our people, by increasing and promoting research training, and provide support to those who are capable of becoming chief investigators, to enable us to grow our own research. We will implement support/funding programmes for those staff actively participating in research to promote further, future research. We will work with our academic partners to support joint clinical academic posts, to further grow our capacity and capability for research.

This will need to be supported by an effective and efficient research administration function capable of supporting individuals within the trust. We will streamline our study set up processes in collaboration with our Partners to support quick and efficient study set-up across sites.

Our **success** will be measured by

1. An increase the number of Chief Investigators/Senior Investigators, up to the level required for University Hospital status.
2. An increase in the number of specialties involved in ‘home-grown’ research.
3. An increase in the number of specialities that are involved in CRN research.
4. An increase in research training uptake and/or educational projects supported by R&D
5. Primary care and community disciplines becoming involved in research activity.
6. An increase in the number of R&D funded projects/research programmes
7. Improved study set-up performance metrics across commercial, non-commercial studies and home-grown studies.

Goal 3: To further enhance partnership between industry, academia, AHSN and other NHS organisations to improve delivery of our research portfolio.

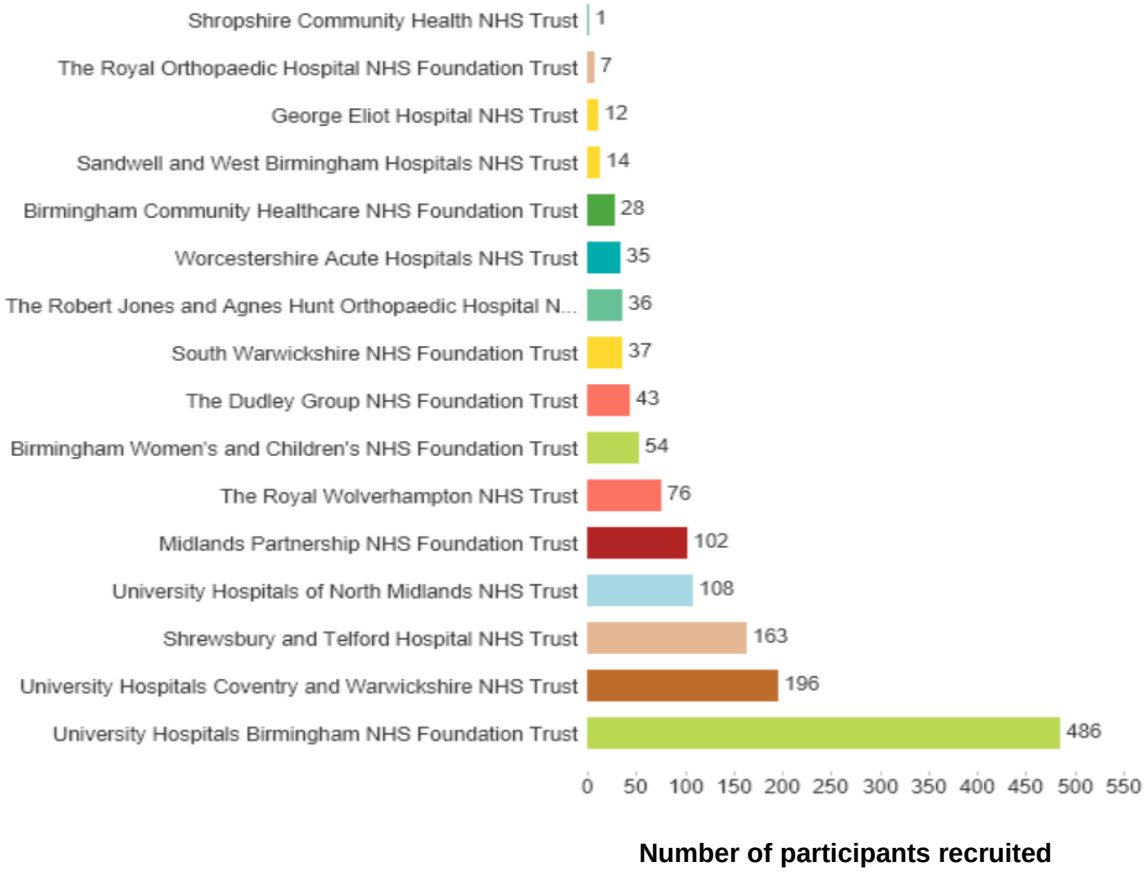
Our **aim** is to enhance further our links with all our partners in order to increase the number of studies we can offer our patients. This will involve strengthening involvement in specialties that are currently participating in research and engaging those specialties that do not have any research activity. We also aim to optimise our links with academic institutions to further our research activity, by using existing links and forging new ones as opportunities arise.

Our **success** will be measured by

1. An increase in the number of patients recruited into commercial studies
2. An increase in the number of commercial studies offered at DHNHSFT
3. An increase in commercial income
4. Evidence of collaboration with a primary University and other local Universities resulting in increased research activity.
5. An increase in the number of innovation projects and intellectual property
6. Collaboration with Integrated Care System and other NHS Trusts, to increase successfully access and deliver research for our local population

Graph 3 below shows our current recruitment to commercial studies, compared to other Trusts in the region.

Graph 3 – West Midlands NHS Trusts – Commercial study recruitment for April 2021-March 2022 (Open Data Platform, CRN West Midlands, Trust Reports FY2122)



Goal 4: Improve patient experience by providing opportunity and choice to participate in research across all possible specialities in our organisation.

Our **aim** is to improve our patients' experience by offering the choice of contributing to research and obtain their feedback on their experience of both being invited to become involved and the involvement itself. While there is evidence of better outcomes from involvement in research[2,3], patients' research experience is an under-researched area, and it is not known if involvement in research results in a better experience compared to patients who are not involved. We will strive to capture our patient's experience of research in order to improve it and explore further research into this topic.

We will use a variety of media and events to raise the profile and visibility of research, so that patients will ask about research opportunities, and well as being approached by our own staff.

Our **success** will be measured by

1. Evidence of surveys/events of patient's experience of research and actions resulting from these, utilising available Trust and CRN resources.
2. Evidence of participation in research into patients' experience of research.
3. Acknowledge and share any positive patient experience feedback

Goal 5: Deliver high quality research through excellence in research governance.

Our **aim** is to be a beacon of excellence in research governance. We have a high performing administrative team that meet efficiency performance metrics across all study types. We have robust systems in place to support collaborative study set up and closedown. Our innovative use of the EDGE system has already been recognised through a CRN West Midlands award and national conferences. EDGE is the electronic system that is used across the regions to report research activity externally and that can generate internal reports about research activity. Meticulous research governance helps imbed a culture of thoroughness that is essential for the delivery of GCP. Table 4 below shows our median R&D set-up days for commercial and non-commercial studies compared with other Trusts within the West Midlands region.

Table 4 – demonstrates our current study set up metrics.
(CRN;WM DGFT Google Sheet Report June 2022)

Study Start-up Performance, measured from 'Date site selected' to 'Date of 1st patient recruit'. The table shows the West Midlands performance (all studies).				
	Commercial Studies, Target Median 80 days		Non-Commercial Studies, Target Median 60 days	
	Studies	Median days	Studies	Median days
DGNHSFT	6	40	22	64
Network Wide	138	203	479	111.5
DGNHSFT is in the top 3 West Midlands Trusts for efficient study start-up performance.				

One of our unique points, is that we have a Good Laboratory Practice Accredited Research Laboratory located on our Russell's Hall Hospital site (see photo 1below). This is the only one in the Midlands area. Due to the high-quality expectations this promotes, we attract a number of commercial study sponsors and non-commercial sponsors to participate in their trials where laboratory activities are required. We will utilise marketing strategies, to promote this, to increase further activity in next five years.

Photo 1: GLP Accredited Research Laboratory

Our **success** will be measured by

1. Continued delivery of GCP and PI training locally
2. Increased profile of R&D across the trust through a R&D portal on the trust hub that will provide resource, governance and training information.
3. The existence of a transparent support mechanism for support services to enable their engagement with research activities.
4. Evidence that research requirements are integrated into the new EPR
5. Increased and improved use of data/digital technologies available
6. Being a beacon in the use of research EDGE system.

Goal 6: Disseminate research findings though quality publications and ensure research impact is rapidly integrated into clinical care for our patients.

Patients should benefit as soon as possible from interventions that research shows, improve their care and/or their outcomes.

We will explore how R&D can provide assistance to deliver this.

Our **success** will be measured by

1. Evidence of review of the trust mechanism for ensuring the adoption of interventions proven to improve care/outcomes.
2. Participant feedback on outcomes and information sharing of studies (during their participation)
3. Trust Research Awards, to celebrate successes
4. Number of quality publications per year

5 TRAINING/SUPPORT

GCP online training is available for all staff wanting to undertake research, renewable every two years. Training is logged on our electronic research database and reminders sent to staff when renewal is required

Patient Research Ambassador training for any patient/public volunteers is currently available from CRN WM

PI and CI training is available locally within the Trust and externally from CRN WM.

R&D is included in Corporate Trust Induction and Junior Doctors Induction.

We currently provide placements within the R&D Department, for student nurses and Allied Health Professionals.

We hold a Research and Innovation Support Group, on a monthly basis (with additional sessions if required), for anyone undertaking research or education with a research element attached.

We have access to the Research Design Service (hosted by University of Birmingham), to assist with study design and grant applications. We have close collaboration with our primary University partner to also provide statistician support and peer review.

6 PROCESS FOR MONITORING COMPLIANCE

This strategy will be delivered through annual department action plans incorporating quarterly review points to monitor progress and evaluate success of outcomes. Each Operational Action will have an identified lead and a delivery lead for each project. These will report regularly to the senior responsible officer (R&D Director).
The department action plans will be reviewed quarterly in consultation with stakeholders and are presented to the Research, Education, and Innovation Committee & Trust Board.

Monitoring of Compliance Chart

	Lead	Tool	Frequency	Reporting arrangements	Acting on recommendations and Lead(s)	Change in practice and lessons to be shared
Examples of key aspects to include are given below:						
Operational Action Logs Training Student Feedback	R&D Director and R&D Manager	Database reporting system (EDGE) Action Log tool	Quarterly	Trust Board,6 monthly reports Quality & Safety Committee, quarterly Research, Education & Innovation Committee, monthly	Identify trends and actions, delegate individual to take forward;	Communication/ information sharing via The Hub, R&D quarterly newsletters (shared with partners and stakeholders, as well as Trust staff), Department and Directorate meetings, training sessions; regular AHSN meetings; regular University partner meetings

7 EQUALITY

The Dudley Group NHS Foundation Trust is committed to ensuring that, as far as is reasonably practicable the way we provide services to the public and the way we treat our staff reflects their individual needs and does not discriminate against individuals or groups on any grounds.

8 REFERENCES

1. National Institute for Health and Care Research. (2021). NIHR's response to COVID-19. NIHR's response to COVID-19 | NIHR (accessed 16th May 2022)
2. Jonker L, S J Fisher, Dagnan D. Patients admitted to more research-active hospitals have more confidence in staff and are better informed about their condition and medication: Results from a retrospective cross-sectional study. 2019 Journal of Evaluation in Clinical Practice. https://doi.org/10.1111/jep.13118

3. Hanney S, Boaz A, Jones T, Soper B. Engagement in research: an innovative three-stage review of the benefits for health-care performance. Health Serv and Deliv Res. 2013;1(8).
4. Ozdemir BA, Karthikesalingam A, Sinha S, Poloniecki JD, Hinchliffe RJ, et al. (2015) Research Activity and the Association with Mortality. PLOS ONE 10(2): e0118253. https://doi.org/10.1371/journal.pone.0118253
5. Downing A, et al. High hospital research participation and improved colorectal cancer survival outcomes: a population-based study. Gut 2016;0:1–8. doi:10.1136/gutjnl-2015-311308

9 APPENDICES

None

Strategy Consultation Form

(This page to be deleted from the document prior to adding to HUB Trust Central document page)

Please ensure that you receive either a confirmation or comments from a stakeholder (via an email) before you add their details to the consultation section on the procedural document

During the development or review of the Strategy, consideration must be given to the actual or potential impact on equality. Due care is given to ensure that they do not contravene the article of the Human Rights Act or could be interpreted as containing any matters of a discriminatory nature, including but not limited to age, disability, sex, race, religion or belief, gender reassignment, marriage or civil partnership, pregnancy or maternity.

What is the title of the document:			
RESEARCH, DEVELOPMENT & INNOVATION STRATEGY			
Date of Submission:		**Author**	**Claire Phillips**
Is there a similar/same document already in existence? Please state which document this will replace. If the document has a different title or has been merged with another document, please provide details of relevant documents.			
R&D Strategy 2018-2021			
Please detail under which folder on the Procedural Documents Hub Page that the document is to be stored. Procedural documents can only be stored on the central procedural documents page. If you require the document link to be stored on another page outside of this, please contact IT and ask them to put a link on.			

Consultation: Please list the stakeholders who have been consulted in the development of this document and the date they confirmed agreement of its content. This is any member of staff/groups who will be part of or affected by this. If this was a group please list attendees:

Name	Designation	Date confirmed agreement (mm/yy)
R&D Department Staff	All staff	R&D Away Day (03/22) First draft review (05/22)
Professor Chris Langley	Professor of Pharmacy Law and Practice Deputy Dean (External)	09/22

	College of Health and Life Sciences, Aston University	
Professor Elizabeth Hughes	Non-executive Director, DGNHSFT	05/22
Professor Gary Crowe	Non-Executive Director, DGNHSFT	05/22
Dr Julian Hobbs	Medical Director, DGNHSFT	09/22
Rebecca Edwards	Directorate Manager, Medical Directors Office, DGNHSFT	09/22
Dr Jeff Neilson	Consultant Haematologist (R&D Director until 31.03.22), DGNHSFT	03/22
Faye Steadman, Black Country Pathology	Chief Biomedical Scientist, Research Lab, Russell's Hall Hospital	03/22 & 05/22
Claire Roberts, Black Country Pathology	Chief Biomedical Scientist, Research Lab, Russell's Hall Hospital	03/22 & 05/22

Check List

(This page to be deleted from the document prior to adding to HUB Trust Central document page)

Prior to submission of the Strategy please ensure you can answer yes to all of the questions below.

	Yes/No
1. Title	
Is the title clear and unambiguous?	Y
2. Front Sheet Completion	
Is the colour banding strip purple?	Y
Is the Author identified (name and designation)?	Y
Is the Director Lead identified?	Y
Is the target audience identified?	Y
Is the document version controlled?	Y
Have the people contributing to the document been identified on the Front cover Sheet as per designation and not individual names?	Y
Have the CQC registration requirement outcomes been recorded?	Y
Have relevant documents/legislation standards been recorded if applicable?	Y
Have the identified contributors been documented?	Y
Has the change history been fully completed?	Y
3. Body of the document	
Has the contents page been fully completed and the numbering reflects the document content pages?	Y

Is there a footer on each page recording; document title, date of issue, version number, page number and total number of pages?	Y
Is the document written in Arial 12pt font?	Y
Does the document contain individual designations and NOT names?	Y
Does the numbering run in sequence?	Y
Does the document follow trust format of; Introduction, Statement of Intent/Purpose, Definitions, Process, Training/Support, Monitoring, Equality and References for the main body?	Y
The meaning for any definitions or abbreviations used is clearly stated?	Y
Is there identified training or support which includes the process for follow up of non-compliance clearly cited?	Y
Are procedural documents relating/supporting this document hyperlinked?	Y
Is the table for Monitoring Compliance fully completed?	Y
Are references cited in full and comply with the Harvard referencing?	Y
Does the document require changes to clinical documentation?	N
If yes, has the digital Trust Clinical Approvals Group been informed?	NA
4. Consultation	
Is the consultation form completed?	Y
If the document includes prescribing or administering of medicines, has pharmacy been consulted?	NA
Has the Director Lead been consulted and accepted the document?	Y

Enclosure 24

Paper for submission to Board of Directors

22 September 2022

Title:	Winter Plan
Author:	Simon Illingworth,
Presenter:	Karen Kelly, Chief Operating Officer

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

Recommendations:

Note and agree the plan for Winter

Summary of Key Issues:

This paper aims to set the themes for this year's winter plan.

1. Continuing focus on discharge improvement as core strategy including development of D2A and improved discharge planning on admission, which will encompass the requirements in the national 100-day discharge challenge
2. Renewed effort around Urgent and Emergency Care (UEC) especially in relation to improvements in AMU 1 and AMU 2 LOS, discharge home and discharges per day
3. Additional physical capacity, both funded and unfunded, to close the gap in expected bed demand
4. Continued to support from social care and community partners

The Winter plan sets out the key strategies for dealing with winter pressures during 2022/23. Demand for beds was slightly lower than predicted via the system bed modelling plan last winter but despite this there remained significant operational pressure, particularly across the UEC footprint - with increased ambulance off loads issue. COVID-19 played a part in this and the impact of COVID-19 on operations this year is, as yet, not fully known although an increase in COVID cases is expected as are additional incidences of normal flu and winter colds which will undoubtedly cause pressures across all areas.

The plan has modelled the predicted number of acute bed required between 1st November and 1st May (Max 651 mid-January) against a baseline number of beds (580) available, which is similar worst case scenario gap to last year. The plans set out the Trusts intentions to mitigate this gap, including additional funded and unfunded capacity along with discharge and UEC work and virtual wards.

The plan also includes strategies identified by partner organisations across health and social care, expected increases in nurse staffing resulting from previous and ongoing

international recruitment and how these increases in staffing are phased over the coming months. The national requirements to address the actions set out in the 100-day discharge plan are largely being delivered via the Discharge on Admission project and support via the 100-day discharge challenge working group being led on a ICB basis.

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	

Implications of the Paper:			
Risk	Y	Risk Description: BAF 7: Failure to achieve operational performance requirements and deliver strategic goals	
	On Risk Register: Y	Risk Score: 20	
Compliance and/or Lead Requirements	CQC	Y	Details: Safe, Effective, Caring, Responsive, Well Led
	NHSE/I	Y	Details: performance standards
	Other	N	Details:
Report Journey/ Destination *(if applicable)*	Working / Exec Group	N	Date:
	Committee	N	Date:
	Board of Directors	Y	Date: 22/09/22
	Other	N	Date:

DGHFT WINTER PLAN SUMMARY 2022/23

DRAFT 1.1

The Dudley Group NHS Foundation Trust

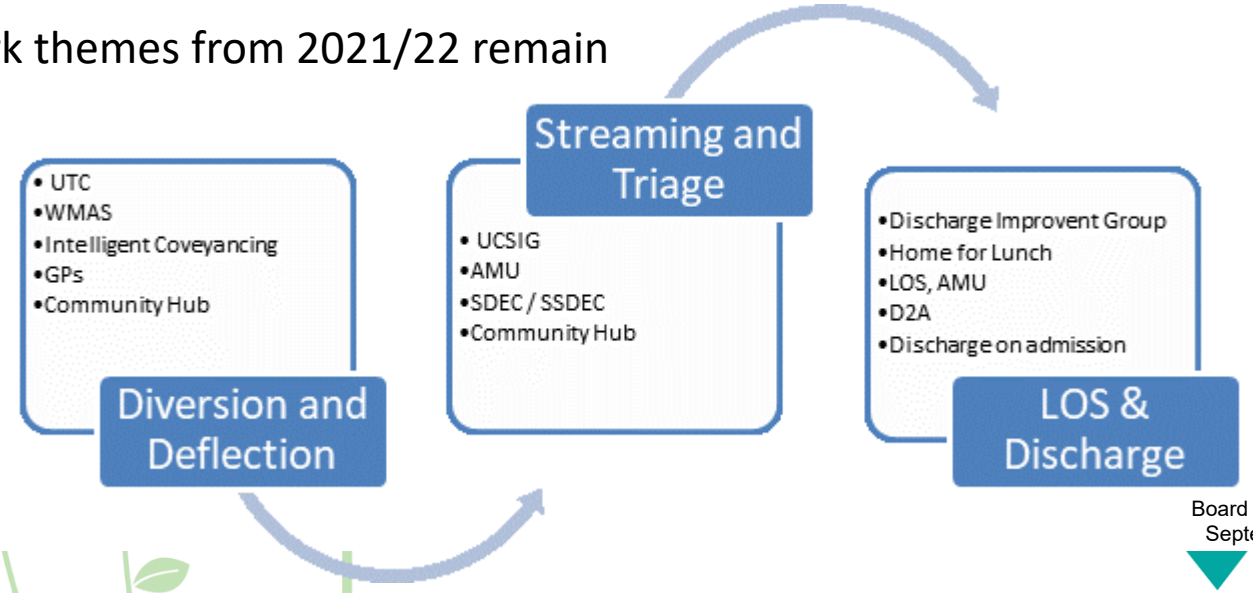
Contents

The Dudley Group NHS Foundation Trust

1. Background
2. Review of 2022/23
3. Key Risks
4. Bed Modelling
   - Closing gap
5. Key Mitigation Strategies
   - Discharge Plans
   - Urgent and Emergency Care Plans
   - Dudley Community, DIHC
   - Local Authority and Black Country Healthcare
6. Summary

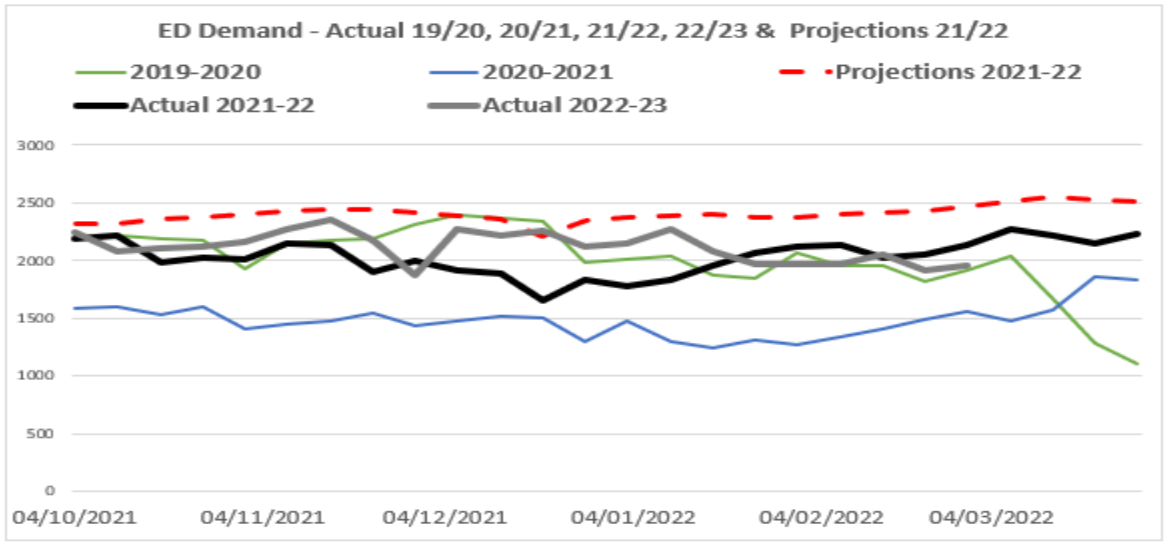
Background

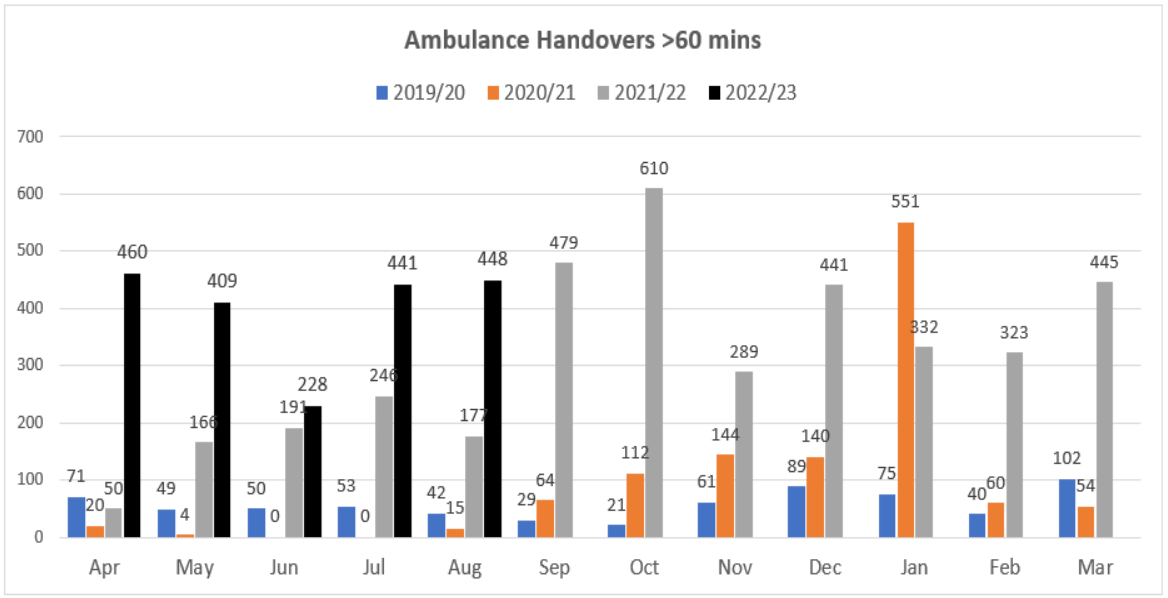
- COVID-19 remains a pressure, full impact unknown for this year
- Staffing continues to pose challenges, international recruitment plans in place
- Focus on improving discharge remains a key priority
  - Reducing MOFD is key area
  - Discharge to Assess
- Focus on Urgent and Emergency Care Improvement
  - SDEC benefits
  - AMU flow
- Work building community and primary care input / relationships
- Three key work themes from 2021/22 remain



Review of 2021/22 Data

The Dudley Group NHS Foundation Trust





Actual ED demand was lower in winter 2021/22 than expected

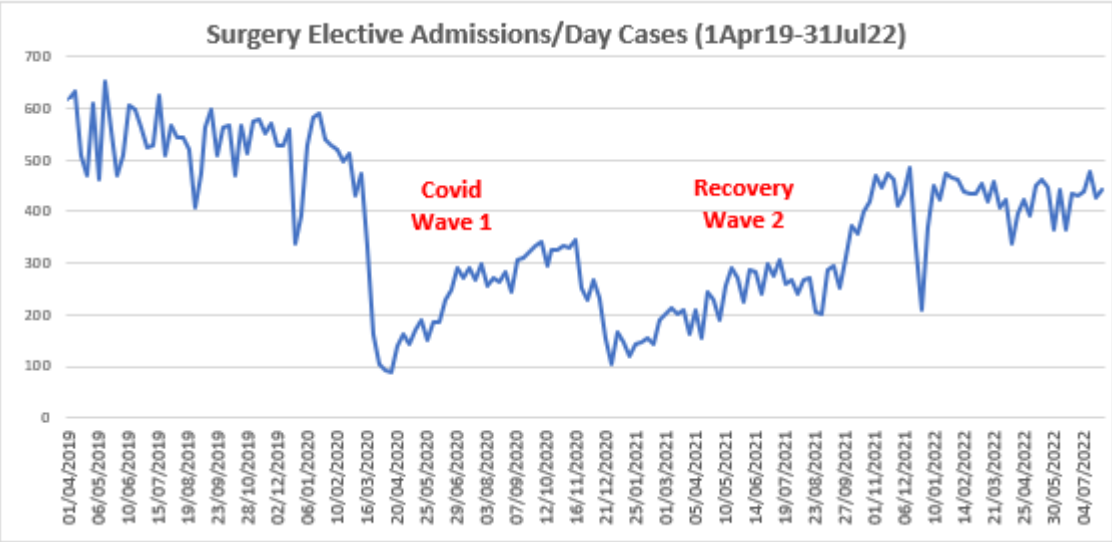
ED activity has been higher than previous 12 months, increases seen in self presenters

Projections for 2022/23 continue same trend

Ambulance handover delays have been worse this year YTD compared to last year

Review of 2021/22 Data

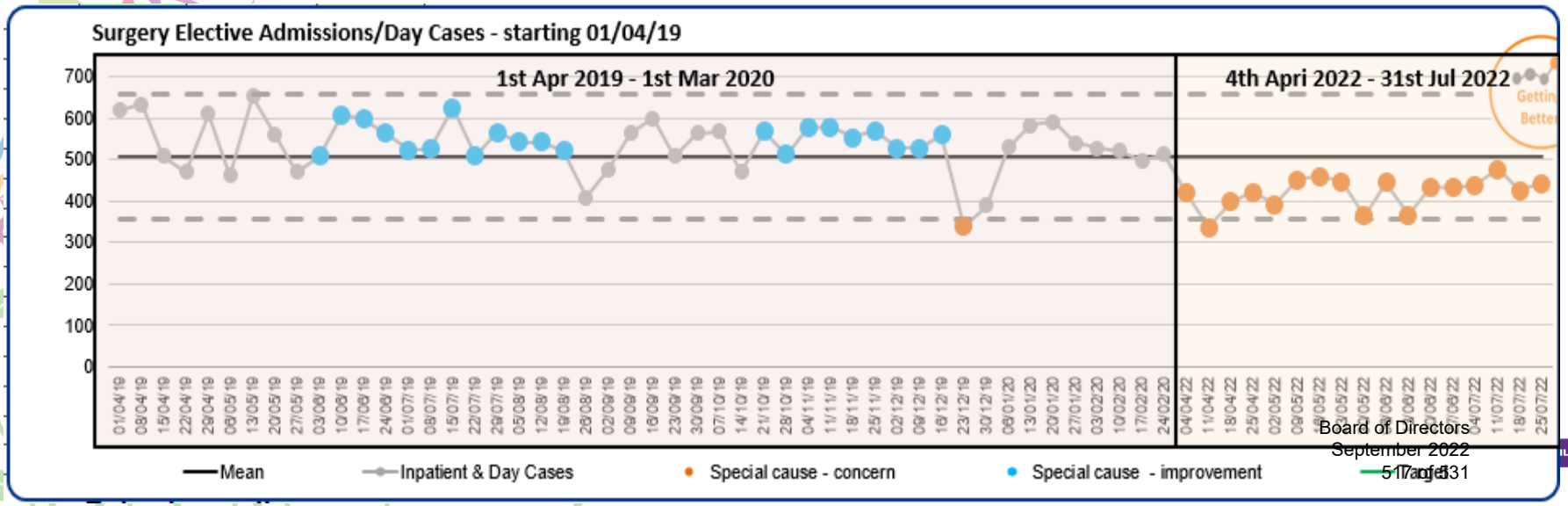
The Dudley Group
NHS Foundation Trust



Trust has struggled to recover elective activity to pre-covid levels. Substantial backlogs remain

During winter we must maintain and increase elective programme

Day case opportunity (HVLC)



Key Risks for 2022/23

The Dudley Group NHS Foundation Trust

- Staffing
  - Nurse vacancies
- Covid-19
  - Uncertain prevalence / impact
  - Normal winter respiratory illness impact to be considered
  - Staffing / sickness – flu / covid / winter colds
- Community / Primary Care
  - Social Care Resource
    - Lack of robust D2A for pathways 1 discharges
    - Continuing High rates of MOFD
- Elective Backlog – Maintaining activity
  - Long Waiters (52 and 78 weeks)
  - Cancer Recovery

Bed Modelling – 2022/23

The Dudley Group NHS Foundation Trust

- Baseline 580 G&A beds
- Flex / additional modelled capacity
  - ICB funded beds – 26
  - Plus MOFD reduction, SDEC &Virtual Wards
- Total available beds 606
  - A2- Requires funding from ICB winter money
- Peak demand expected mid January
- Other areas identified (unfunded)
  - A4 (12 beds)
  - Discharge Lounge (12 beds)

Bed Demand (G&A)

The Dudley Group
NHS Foundation Trust

Predicted Peak Demand	**651**
Baseline	580
ICB Funded (RHH or Rowley)	26
Virtual Ward	9
SDEC/UTC	3
MOFD Reductions	8
Unfunded Super Surge - Medical	12
Unfunded Super Surge - Discharge Lounge	12
Total	650
Gap	-1

Discharge Focus

The Dudley Group
NHS Foundation Trust

- Five key discharge projects underway within the Trust
  - Discharge to Assess (D2A)
  - Discharge on Admission (project to deliver 100 day discharge challenge, inc. planning discharge on day of admission / EDD)
  - Perfect Discharge Lounge (30 pts per day through lounge)
  - Perfect Discharge Team (30 discharges per day)
  - Home for Lunch (30% before noon)
- Discharge promotion "*Deconditioning Games", ending deconditioning of patients on wards;*
  - *Already in place across East of England, to be deployed across West Mids.*
  - NHS England — East of England » East of England's Deconditioning Games
- 100 day discharge challenge
  - Objectives delivered via Discharge Planning on Admission project

Discharge Strategy

The Dudley Group NHS Foundation Trust

Discharge Improvement Group

Discharge to Assess Helen Mallard	Perfect Discharge Lounge Rita Rai	Perfect Discharge Team Antionette Cummings Bianca Mascarenhas	Discharge Planning on Admission Amandeep Tung	Home for Lunch Anita Cupper & Jonathan Boulter
Patients Assessed in own home as primary goal Reducing numbers of patients, particularly on pathway 1, waiting for discharge **Key Measures** • Reduction in total no. MOFD patients on pathway 1 • Reduction in ALOS between pts becoming MOFD and Discharge date for pathways 1-3 • Patients using D2A pathway every day	Discharge Lounge open Monday to Friday (+ plan for weekends) Pull models in place from ward **Key Measures** • 30 pts per day through lounge Monday to Friday • Improvement in HFL rate before 5pm • Improve of discharges from wards before noon	Effective discharge team, integrated with community & therapy services, **Key Measures** • 30 discharges per day from MOFD list • Every patient with a pathway allocated • Reduction in total patients MOFD at 9am • Reduction in out of area delays	Effective process in place for planning discharge within 48 hours of admission Links to single management of Community, Discharge and Therapies Teams **Key Measures** • Everyone with an EDD within 24/48 hrs of admission • Everyone with pathway allocated within 24/48 hrs of admission • Standard discharge planning	HFL now BAU Provide weekly performance metrics to Divisions by Ward Require HFL reporting from DM and Matrons monthly at HFL mgt. **Target** • 30% of patients HFL on each ward • Increase in discharges earlier in the day (before 5pm)
August to December	**September to November**	**September to March**	**September to March**	**Ongoing BAU**

Improvements ahead of winter - Discharge

The Dudley Group
NHS Foundation Trust

	Apr	May	Jun	Jul	Aug
B1	13%	14%	15%	12%	11%
B2 HIP	33%	6%	25%	22%	6%
B2 TRAUMA	17%	18%	12%	13%	19%
B3	17%	22%	12%	23%	20%
B4	22%	21%	18%	18%	19%
C6	12%	10%	12%	14%	9%

Surgery

Medicine

	Apr	May	Jun	Jul	Aug
AMU 2	8%	11%	10%	9%	11%
B6 FRAILTY	25%	16%	16%	10%	22%
C1 A	29%	23%	22%	27%	27%
C1 B	14%	10%	13%	25%	25%
FMNU	39%	26%	13%	18%	25%
C4	20%	24%	18%	17%	24%
C5 A	7%	12%	12%	9%	24%
C5 B	18%	10%	8%	15%	17%
C7	24%	12%	10%	11%	18%
C8 ASU	24%	11%	4%	27%	25%
C8 ASU	14%	8%	9%	6%	6%
C8 STROKE	10%	23%	9%	22%	22%

Mitigate risks – UEC

The Dudley Group NHS Foundation Trust

Delivered via Urgent Care Service Improvement Group (UCSIG)

- 5 key areas of focus and metrics

1. AMU 1 and 2: Length of stay, discharges per day, discharges home, effective ward rounds
2. SDEC: proportion pts referred home / % not admitted
3. Clinical Hub: deflections from ED, calls from Care Homes, calls from WMAS
4. ED: reduction in long waits, reduction in referrals not admitted, reduction in off loads
5. Surgical SDEC: Length of stay, discharges per day, discharges home, effective ward rounds
6. Urgent Treatment Centre Review

UEC - Urgent Care Service Improvement Group (UCSIG) and Metrics

The Dudley Group NHS Foundation Trust

Urgent Care Service Improvement Group

AMU Chris Leach	SDEC Jean Pegg	ED Phil Atkins	Community Hub Bianca Mascarenhas	Surgical SDEC Nat Hill
Ensure the Modular Ward (AMU1 and AMU2) are working effectively as per business case Key Measures • LOS on AMU1 >12hrs • LOS AMU2 >72 hrs • Discharges per day from AMU2 – 10 • % Discharges home	Reduce demand on ED through effective use of SDEC services • Referrals to SDEC from ED • % of SDEC attendances sent home 85-90% • % of SDEC attendances admitted onwards into Trust – 10-15%	Reduction in long waits in ED and improvement in ambulance handovers • Reduction in the % of patients waiting over 12 hours in ED • Average LOS in ED (admitted and non-admitted) • Ambulance handovers	Increase number of patients triaged by hub and deflected from ED • % Patients attendances to ED triaged by Hub • Number of calls made via Hub • SPA development • Step Up capacity • Discharge Team	Reduce demand on ED through effective use of surgical SDEC services • Referrals to SDEC from ED • % of SDEC attendances sent home 85-90% • % of SDEC attendances admitted onwards into Trust – 10-15%

Support for these three workstreams is being given by external clinical consultant Dr. Shaun Nakash

Improvements ahead of Winter: UCSIG

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Streaming:

- SDEC is discharging majority 85%+ of patients home on the same day
- Clinical Hub is increasing volume of calls sent via Hub to improve streaming
- Increasing calls via Hub from WMAS, esp. care homes attendances
- Category 5 Diversions from ED – est. 830 Adults and 1085 Paeds between April to August

Areas of work LOS and Discharge from Assessment / SS areas:

- AMU 1 and 2 (LOS, discharges, and discharges home)
- Increase number of Discharges per day from AMU to 10

Dudley Clinical Hub / Community

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1. From 1st of October SDEC referrals from Lion Health and Summerhill GP practices (highest referrers) to be accepted electronically to release phone lines for UCR calls.
2. From 1st of October IV Iron pathway to be set up to support iron infusion for patients in OPAT clinic or at home.
3. HALO to be based in the HUB with access to live CAD system- working with Phil to trial this asap.
4. Care Co-ordinator in ED to support discharges 7 days a week
5. OBI to hold 1 appt for D2A pathway patient daily
6. Deteriorating patients across community services to be managed by daily escalation plans to prevent unnecessary conveyances to hospital.
7. Top 21 care homes to be proactively visited by the Enhanced Care Home team to identify and manage deteriorating patients at home.
8. Care Co-ordinator in the HUB to contact patients on LTC caseload pro-actively to identify early deterioration.

Primary Care and DIHC

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Primary Care

- To explore the use of ARRs monies to ensure it is maximised for this financial year and explore the opportunities to use ARRs posts at scale over the winter period to support flow. Specific areas to be explored further are therapy support and pharmacy support to support flow.
- Advised group of enhanced access DES commencing on October 1st and provision associated with this.
- Primary care looking to optimise opportunities of using support/signposting services rather than trying to increase capacity.

DIHC

- Revising tiggers, escalations and actions and will link in with RCMT re automated emails for triggers.
- Reviewing classification of triggers to identify what could be earlier in escalation to try and deflect increasing pressures.
- Looking at opportunities to increase capacity in bed based services particularly around the provision of Saltwells.
- Continued development of the brokerage service to access both a bed base and support LA with packages of care.
- A physical presence with DGFT to support discharge planning
- Ongoing conversations with LA around admission prevention support.

Local Authority & Black Country HC

Local Authority

- Revising tiggers, escalations and actions and will link in with RCMT re automated emails for triggers.
- Work ongoing with DIHC to develop a more robust admission avoidance process
- D2A for pathway 1
- Key partners in further development of the discharge to assess model for pathway 1.Physical presence with DGFT to support discharge planning
- Launching a carers HUB on the ground floor of DGFT to support carers and families and to answer queries and questions.

Black Country Healthcare

- Revising tiggers, escalations and actions and will link in with RCMT re automated emails for triggers.
- Re-visiting and reviewing escalation process with DGFT for mental health patients within the ED department.
- To commence a discussion/develop a plan for those more complex mental health patients who are low in numbers but high in resource required to facilitate transfer

DGHFT Nurse staffing

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- Nursing staff vacancies caused significant pressures during winter 2021/22
- Successful international recruitment strategy planned during 2022 to mitigate risks
- 131 staff (registered and non registered) have started since April 2022
- Further 169 staff to commence between August and December 2022
  - 31 September
  - 70 October
  - 25 November
  - 43 December
- Grades 5-6. Some staff will take 12 weeks to gain NMC registration and will work as HCA
- Staffing deployed to call key areas inc. base ward, theatres etc

Summary key winter plan actions

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- Predicted demand for winter 2021/22 did not materialise as planned, but increased demand still expected
- ICB funded capacity will provide 26 beds
- Major focus on discharge including implementing a D2A Pathway, to commence in pilot form September
- Urgent Care Improvement strategy including expanding SDEC and improving AMU flow
- Urgent Treatment Centre – scoping opportunities to expand ambulance off load areas
- Virtual Wards
- Unfunded capacity identified to be used in extremis
- Increase in nurse staffing through international recruitment programme to support additional areas