PUBLIC SESSION

The Dudley Group NHS Foundation Trust

Board of Directors
Thursday 11 July at 10:00am
Clinical Education Centre, South Block, Russells Hall Hospital, Dudley, DY1 2HQ
AGENDA

	ITEM	PAPER REF	LEAD	PURPOSE	TIME
1	**Chairman's welcome and note of apologies**	Verbal	Chair	For noting	10:00
2	**Staff & Patient Story – Renal Services** Introduced by M Morris, Chief Nurse				
3	**Declarations of Interest**	Enclosure 1	Chair	For noting	10:20
4	**Minutes of the previous meeting** Thursday 9 May 2024 Action Sheet 9 May 2024	Enclosure 2 All complete	Chair	For approval	
5	**Chief Executive's Overview**	Enclosure 3	D Wake	For information & assurance	
6	**Chair's Update**	Verbal	Chair	For information	
7	**Drive sustainability financial and environment** Reduce the cost per weighted activity | Reduce carbon emissions				10:45
7.1	Finance & Productivity matters • Committee upward assurance report • Finance report Month 2 (May '24)	Enclosure 4 Enclosure 5	L Williams C Walker	For approval	
7.2	Cost Improvement Programme Update	Enclosure 6	A Thomas	For discussion	
7.3	Black Country Finance Undertakings	Enclosure 7	C Walker	For approval	
8	**Build Innovative Partnerships in Dudley & beyond** Increase the proportion of local people employed | Increase the number of services jointly across the Black Country				11:10
8.1	Integrated Performance Dashboard *Full report in further reading pack*	Enclosure 8	K Kelly	For assurance	
	Comfort break (10 mins)				
9	**Deliver right care every time** CQC rating good or outstanding | Improve the patient experience survey results				11:30
9.1	Quality Committee upward assurance report	Enclosure 9	E Hughes	For approval	
9.2	Chief Nurse & Medical Director report	Enclosure 10	M Morris/ J Hobbs	For assurance	
9.3	Perinatal Clinical Quality Surveillance (maternity and neonatal dashboard) - Maternity Incentive Scheme year 6 Workforce review	Enclosure 11 Enclosure 12	C Macdiarmid / S Muammar	For assurance	

9.4	Complaints Annual Report *Full report in further reading pack*	Enclosure 13	M Morris	For assurance	
9.5	Safeguarding & Complex Vulnerabilities - Safeguarding Annual Report - Complex vulnerabilities Annual Report *Full reports in further reading pack*	Enclosure 14 Enclosure 15	M Morris	For assurance	
10	**To be a brilliant place to work and thrive** Reduce the vacancy rate | Improve the staff survey results				12:00
10.1	People Committee - upward assurance report - Workforce key performance indicators	Enclosure 16 Enclosure 17	C Holland K Brogan	For approval	
10.2	Public Sector Equality Duty (PSED) Annual Report *Full report in further reading pack*	Enclosure 18	P Singh	For approval	
10.3	Guardian of Safe Working	Enclosure 19	F Chaudhry	For approval	
10.4	Freedom to Speak up Guardian update	Enclosure 20	A Burrows / C Holland	For assurance	
11	**GOVERNANCE**				12:25
11.1	Committee upward assurance reports - Audit Committee - Integration Committee - Joint Provider Committee - Charity Committee - Digital Committee close out	Enclosure 21 Enclosure 22 Enclosure 23 Enclosure 24 Enclosure 25	J Hanley V Randeniya D Nicholson G Crowe C Holland	For approval	
11.2	Board Assurance Framework	Enclosure 26	H Board	For approval	
12	**Any Other Business** - Public questions		All	For noting	
13	**Date of next Board of Directors meeting** (public session) Thursday 12 September 2024				
14	**Meeting close**				13:00

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. Access to report information as guidance.

Enclosure 1

Register of interests 01/04/2024 - 30/06/2024

Name	Position	Date of interest	Description	Value	Was Accepted	Percentage Of Shareholding	Staff Group
Elizabeth Abbiss	Director of Communications	26/06/2023	Nil				Board Member
Elizabeth Abbiss	Director of Communications	05/06/2023	Commenced work at Sandwell & West Birmingham NHS Hospitals Trust one day				Board Member
Elizabeth Abbiss	Director of Communications	05/06/2023	Commenced work at Sandwell & West Birmingham NHS Hospitals Trust one day				Board Member
Karen Brogan	Interim Chief People Officer	01/05/2024	Nil				Board Member
Gary Crowe	Deputy Chair	01/09/2019	Independent Member, The Human Tissue Authority				Board Member
Gary Crowe	Deputy Chair	01/09/2019	Non Executive Director, University Hospitals of North Midlands NHS Trust				Board Member
Gary Crowe	Deputy Chair	01/09/2019	Occasional lecturer, Keele University				Board Member
Peter Featherstone	Non-Executive Director	01/11/2018	NED, Shropshire Community Health NHS Trust				Board Member
Peter Featherstone	Non-Executive Director	01/02/2024	NED, Dudly Integrated Health and Care NHS Trust				Board Member
Peter Featherstone	Non-Executive Director	01/10/2023	Associate consultant, Commercially Public Ltd, management consultant to local authorities				Board Member
Peter Featherstone	Non-Executive Director	10/07/2008	Featherstone Management Consultancy Ltd, Managing director and company				Board Member
Joanne Hanley	Non-Executive Director	01/01/2004	Executive employment with Lloyds Banking Group				Board member
Anthony Hilton	Associate Non-Executive Director	01/03/2020	Aston University - Pro-vice Chancellor and Executive Dean				Board member
Anthony Hilton	Associate Non-Executive Director	01/01/2010	Director, Microbiology Consulting Limited				Board member
William Hobbs	Medical Director - Operations	26/06/2023	Nil				Board Member
Catherine Holland	Senior Independent Director	26/06/2023	Nil				Board member
Elizabeth Hughes	Non-Executive Director	03/09/2021	Medical Director NHS England (formerly Health Education England)				Board Member
Elizabeth Hughes	Non-Executive Director	02/08/2021	Appointed Honorary Professor at Warwick Medical School				Board Member
Elizabeth Hughes	Non-Executive Director	01/04/1990	Consultant Chemical Pathologist Sandwell and West Birmingham Hospitals NHS				Board Member
Elizabeth Hughes	Non-Executive Director	20/06/2021	Development of educational material for Novartis				Board Member
Elizabeth Hughes	Non-Executive Director	01/04/2018	Director Dinwoodie Charitable Company				Board Member
Elizabeth Hughes	Non-Executive Director	26/11/2021	Educational Speaker for Amgen				Board Member
Elizabeth Hughes	Non-Executive Director	08/05/2021	Educational Speaker for Sobi educational material preparation				Board Member
Elizabeth Hughes	Non-Executive Director	06/10/2020	Educational Speakers Bureau Daiichyi Sankyo -occasional lecture				Board Member
Elizabeth Hughes	Non-Executive Director	01/09/2016	Honorary Professor University of Aston				Board Member
Elizabeth Hughes	Non-Executive Director	01/07/2008	Honorary Professor University of Birmingham				Board Member
Elizabeth Hughes	Non-Executive Director	01/03/2017	Honorary Professor University of Worcester				Board Member
Elizabeth Hughes	Non-Executive Director	01/06/2022	Non-executive Director - chair of Quality Committee for Birmingham and Solihull				Board Member
Elizabeth Hughes	Non-Executive Director	01/01/2022	Professor of General Practice University of Bolton				Board Member
Elizabeth Hughes	Non-Executive Director	01/04/2022	Speakers Bureau Amarin occasional lecture				Board Member
Elizabeth Hughes	Non-Executive Director	03/07/2007	Trustee HEARTUK charity				Board Member
Elizabeth Hughes	Non-Executive Director	08/03/2023	Honorary Professor (Vice Chancellor) University of Coventry				Board Member
Elizabeth Hughes	Non-Executive Director	01/12/2023	Sponsorship of community lipid clinics				Board Member
Elizabeth Hughes	Non-Executive Director	01/12/2023	Sponsorship of nursing and admin staff for community lipid clinics within sandwell				Board Member
Karen Kelly	Chief Operating Officer	26/06/2023	Nil				Board Member
Mohit Mandiratta	Non-Executive Director	2018	GP Partner at Feldon Practice, Halesowen				Board Member
Mohit Mandiratta	Non-Executive Director	2016	Chair Dudley Prescribing and Medicines Optimisation Sub-committee (DIHC)				Board Member
Mohit Mandiratta	Non-Executive Director	2021	GP on BBC Breakfast -				Board Member
Mohit Mandiratta	Non-Executive Director	01/06/2024	Futureproof Health - Practive based shareholding				Board Member
Anne-Maria Newham	Non-Executive Director	01/07/2023	Chair of small Ltd compnay called Nuture Care Ltd				Board Member

Martina Morris	Chief Nurse	01/03/2024	Nil				Board Member
David Nicholson	Chairman	01/09/2022	Senior Operating Partner for Healfund (investor in healthcare Africa)				Board Member
David Nicholson	Chairman	01/04/2023	Chair - Royal Wolverhampton NHS Trust and Walsall Healthcare NHS Trust				Board Member
David Nicholson	Chairman	01/09/2022	Chair - Sandwell and West Birmingham Hospitals NHS Trust				Board Member
David Nicholson	Chairman	01/09/2022 - 30/06/2023	Former Advisor to KPMG Global				Board Member
David Nicholson	Chairman	01/09/2022 - 30/06/2023	Former Non-Executive Director – Lifecycle				Board Member
David Nicholson	Chairman	01/09/2022	Visiting Professor - Global Health Innovation, Imperial College				Board Member
David Nicholson	Chairman	01/09/2022 - 30/06/2023	Sole Director - David Nicholson Healthcare Solutions. Voluntary liquidation requested.			100	Board Member
David Nicholson	Chairman	01/09/2022 - 30/06/2023	Former Member - IPPR Health Advisory Committee				Board Member
David Nicholson	Chairman	01/09/2022 - 30/06/2023	Former Senior Operating Partner for Healfund (investor in healthcare Africa)				Board Member
David Nicholson	Chairman	01/01/2023	Spouse appointed National Director of Urgent and Emergency Care and Deputy				Board Member
Ita O'Donovan	Associate non-executive Director	2010	Managing director - Beechgrove Associates LTD. Own company, consultancy in local government				Board Member
Andrew Proctor	Director of Governance	26/06/2023	Nil				Board Member
Vijith Randeniya	Non-Executive Director	06/10/2014	Board member of Aston University				Board Member
Vijith Randeniya	Non-Executive Director	05/10/2020	Chair, Trent Regional Flood and Coastal Committee, DEFRA				Board Member
Vijith Randeniya	Non-Executive Director	02/06/2014 - 30/04/2023	Vice Chair of Birmingham Women and Children's Hospital				Board Member
Vijith Randeniya	Non-Executive Director	06/02/2024	Commissioner for South Wales Fire and Rescue Service.				Board Member
Vijith Randeniya	Non-Executive Director	06/10/2014	Board member of Aston University				Board Member
Vijith Randeniya	Non-Executive Director	01/05/2023	Chair of Birmingham Women and Childrens facilities management company called				Board Member
Vijith Randeniya	Non-Executive Director	05/10/2020	Chair, Trent Regional Flood and Coastal Committee, DEFRA				Board Member
Vijith Randeniya	Non-Executive Director	02/06/2014 - 30/04/2023	Vice Chair of Birmingham Women and Children's Hospital				Board Member
Vijith Randeniya	Non-Executive Director	01/08/2022	Director of Dudley Clinical Services Limited which is 100% owned subsidiary of the			o	Board Member
Kathleen Rose	Director of Integration	26/06/2023	Nil				Board Member
Adam Thomas	Chief Strategy and Digital Officer	01/07/2019	Director of Dudley Clinical Services Limited which is 100% owned subsidiary of the			0	Board Member
Diane Wake	Chief Executive	04/07/2022	Provider CEO member on the BC ICB Board				Board Member
Diane Wake	Chief Executive	01/03/2023	Spouse: Peter Williams, appointed non-executive director at University Hospitals				Board Member
Chris Walker	Interim Chief Fianance Officer	01/01/2024	Director of Dudley Clinical Services Limited which is 100% owned subsidiary of the				Board Member
Lowell Williams	Non-Executive Director	01/08/2017	Chair, Dudley Academies Trust				Board Member
Lowell Williams	Non-Executive Director	01/01/2023 - 30/10/2023	Principal & CEO National College for Advanced Transport & Infrastructure				Board Member
Lowell Williams	Non-Executive Director	01/04/2021	Director of Dudley Clinical Services Limited which is 100% owned subsidiary of the			0	Board Member
Lowell Williams	Non-Executive Director	01/12/2019	Lowell Williams Consulting Limited			100	Board Member
Lowell Williams	Non-Executive Director	24/10/2023	Registered as Director at NCHSR Limited. National College for High Speed Rail			0	Board Member
Lowell Williams	Non-Executive Director	01/04/2022	Director - Transformational Technologies Partnership Ltd (which oversees the				Board Member
Lowell Williams	Non-Executive Director	04/05/2023	Elected as a Councillor to Warwick District Council on behalf of the Green Party				Board Member

Enclosure 2

The Dudley Group
NHS Foundation Trust

UNCONFIRMED **Minutes of the Public Board of Directors meeting (Public session)**
held on Thursday 9th May 2024 10:00hr
in the Board Room, Brierley Hill Health and Social Care Centre

Present:
Liz Abbiss, Director of Communications (LA)
Thuvarahan Amuthalingam, Associate Non-executive Director (TA)
Julian Atkins, Non-executive Director (JA)
Alan Duffell, Chief People Officer (AD)
Joanne Hanley, Non-executive Director (JHa)
Anthony Hilton, Associate Non-executive Director (AH)
Julian Hobbs, Medical Director (JHo)
Liz Hughes, Non-executive Director (LH)
Catherine Holland, Non-executive Director (CH)
Karen Kelly, Chief Operating Officer/Deputy Chief Executive (KK)
Martina Morris, Chief Nurse (MM)
Sir David Nicholson (SDN) **Chair**
Andy Proctor, Director of Governance (AP)
Kat Rose, Director of Integration (KR)
Adam Thomas, Chief Strategy and Digital Officer (CSDO)/Deputy Chief Executive (AT)
Diane Wake, Chief Executive (DW)
Chris Walker, Interim Director of Finance (CW)
Lowell Williams, Non-executive Director (LW)

In Attendance:
Helen Attwood, Directorate Manager (Minutes) (HA)
Helen Board, Board Secretary (HB)
Ruth Delves, Audiology Manager (RD)
Nuala Hadley, Mortality Co-ordinator (NH)
Claire Macdiarmid, Head of Midwifery (CM) [for Maternity and Neonatal Dashboard]
Madhuri Mascarenhas, Governance Admin. Lead (MM)
Claire McCafferty, Transition Coordinator for Children and Young People (CMc) [for Youth Worker Service]
Luke Purdy, Youth Worker (LP) [for Youth Worker Service]
Mr Sohail Quraishi, Consultant Orthopaedic Surgeon (SQ) [for Patient Story]
Jack Richards, Director of Operations – Surgery, Women and Children (JR) [for Paediatric Audiology Report]
Paul Singh, Head of Equality, Diversity and Inclusion (PS) [for WRES and WDES Report]
Nasreen Syeda (NS) [for Maternity and Neonatal Dashboard]
Hannah White, Head of People (HW) [for Karen Brogan]

Apologies
Gurjit Bhogal, Non-executive Director
Karen Brogan, Interim Chief People Officer
Gary Crowe, Deputy Chair
Vij Randeniya, Non-executive Director

Governors and Members of the Public and External attendees
Sandra Harris, Public Governor, Central Dudley
Katricia Hill [for Patient Story]

24/43 Note of Apologies and Welcome

The Chair welcomed Board colleagues, Governors, members of the public and external attendees. Apologies were noted as listed above.

The Chair confirmed that Gurjit Bhogal, Non-Executive Director, would be leaving the Trust and wished him well and thanked him for his support during his term as Non-Executive Director. The Board also heard that Julian Atkins, Non-Executive Director would be leaving the Trust in May, at the end of his term and thanked Julian for his support as the longest serving NED and previous Deputy Chair. Presentations were made by the Board.

24/44 Staff and Patient Story – Mako Robot

MM introduced the Patient Story. The meeting was joined by Mr Quraishi, Consultant Orthopaedic Surgeon and KH, the patient.

KH worked as a teacher and had taken time away from school to join the meeting and share her experience. In August 2023 the Board supported a paper to introduce Robotic Arthroplasty (knee and hip replacement) at the Dudley Group on a one year trial basis. The robot, named a MAKO, was loaned to the Trust by Stryker for the year, along with a recurrent discount on theatre kit worth £500,000, as part of Dudley joining a collaborative Volume Purchase Agreement along with Trusts from the Black Country and Shropshire. The aim of Robotic Arthroplasty was, by way of uploading a CT image into the robot itself, to vastly improve surgical accuracy leading to better surgical outcomes and shorter hospital stays for the patients, thereby further reducing the risk of infection.

Since the Robot was delivered in October 2023, five Consultants and ten Theatre staff have been trained to deliver Robotic Arthroplasty, and with the fantastic support of the Radiology and Theatres departments, the Dudley Midlands Orthopaedic Centre has now delivered fifty Robotic Arthroplasties and has begun work on the next one hundred patients.

DW asked about impact on length of stay. SQ confirmed that many patients were sent home the same day. DW asked about the cost of a MAKO robot and SQ confirmed that to purchase they are £1m.

The Chair asked how long KH had to wait for surgery and she confirmed that this was around 52 weeks. She had been suffering with severe knee pain for over five years.

JA asked which patients were chosen for the robotic surgery and the criteria applied. SQ confirmed that it was appropriate for all patients.

TA asked if medical trainees had welcomed the robot. SQ confirmed that fellowship doctors were being trained in use of the robot.

JHa asked about the lead time for training. SQ confirmed that this was 100 hours and then it would be used under supervision.

It was **RESOLVED** to

- Note the patient story

24/45 Declarations of Interest

The Chair declared that he was the shared Chair of Sandwell and West Birmingham NHS Hospitals Trust, Royal Wolverhampton NHS Trust and Walsall Healthcare Trust.

24/46 Minutes of the previous meeting held on 14th March 2024

The minutes of the previous meeting were approved as a correct record.

It was **RESOLVED** to

- approve the minutes of the last meeting

Action Sheet of 14th March 2024

All actions were noted to be complete.

24/47 Chief Executive's Overview and Operational Update

The meeting was joined by LP, Youth Worker and CMc, Transition Coordinator, to update the Board on LPs role and the impact it was having on patients.

CMc described the work of Transition Coordinators and the importance of general hospitals appointing youth workers to support the transition service. LP had been appointed on a one year trial service basis.

LP described the important role of a hospital youth worker. He had a current caseload of around 30 patients and meets with each patient every two weeks. A large part of LPs role was meeting with young people in the community and at their schools. LP supports young people between the ages of 13 to 25.

DW thanked LP for his presentation and commented on the importance of finding the funding to continue the service. LW thanked LP for his work and commented on the link between attendance at school and young people being able to manage their condition. He agreed it was important to continue to fund the service.

DW summarised the report given as enclosure three and highlighted the following:

Emergency 4 hour performance was good and the Trust was continuing to sustain this performance although during recent weeks it was noted that there had been some challenges around ambulance handover delays and the trust was working with partners to address.

All mandated targets for elective recovery were consistently achieved with resultant reduction in waiting lists.

Cancer service performance was performing extremely well and delivering above all standards with very few patients waiting over 62 and 104 days for cancer treatment.

The Black Country Provider Collaborative continued to work well to deliver key targets across the system and working together to share good practice and learning. A key area of focus was Getting it Right First Time and there were reviews underway for every specialty.

The Trust had invested in surgical robots 18 months ago and this was a real advancement for patients. Work to make improvements to the Urology cancer pathway involved Dudley working with Wolverhampton to undertake Urology work. Dudley would become a renal centre for the system.

Further work around clinical transformation would be shared with the Board. Work on corporate improvement programmes was also underway and progress would be shared with all four Black

Country Trust Boards. Joint Board meetings were being held to share challenges and how each organisation plans address these and how we can work together as a system.

In 2023 there was a Sexual Safety Charter launched by NHS England. The Trust had signed up to the Charter in October 2023 and was committed to keeping its workforce safe.

Russells Hall had launched its memory tree and this is a poignant reminder for staff and patients.

A superhero fun run was taking place on Sunday 9th June at Himley Hall and staff, patients and visitors were encouraged to join and raise valuable funds for the Trust charity.

Three Healthcare Hero awards were presented in March to Danny Taylor for the Volunteer award, an individual awards to Heather Bowen and Scott Murray. DW commended these staff members for their efforts.

It was **RESOLVED**

- Note the important role of Dudley youth workers and note the chief executives report and take it for assurance

23/48 Chair's Update

No further items to add.

24/49 Drive Sustainability Financial and Environmental

24/49.1 Finance and Productivity Matters

24/49.1.1 Committee Upward Assurance Report

LW summarised the reports from previous Committee meetings held on 28th March and 25th April 2024, given as enclosure four, and thanked all contributors to the meetings and for allowing clarity around the Trusts finance and performance.

The Committee had considered and robustly discussed all matters relating to financial challenges, focused on performance against related targets and reviewed the workforce plan and related productivity.

LW commented on the number of positive items included in the report. Positive assurance was noted around consistency in 'grip and control in a challenging environment and LW thanked DW and CW and their teams for their excellent work. The number of assurances around performance metrics were also noted.

Decisions made around contracts and the Committee considered the Board Assurance Framework and were anticipating an ongoing reduction of some risk scores.

Areas of concern remained around the sub optimal Black Country Pathology Service performance and the redesign of ED project, where there were system challenges.

It was **RESOLVED**

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

24/49.1.2 Finance Report Month 12 (March 2024)

CW presented the Month 12 (March 2024) Finance Report given as enclosure five.

The Board noted the Month 12 Trust financial position. After technical changes the March cumulative position was a £6.807m surplus; £2.388m better than the updated phased plan submitted to NHSE.

The plan had been updated by NHSE to include the non-recurrent cash support income of £23.6m provided to the Trust in January. The Trust has submitted its draft accounts to NHSE and the audit of the accounts began at the end of April.

The Board was asked to note the Black Country System March 2024 financial position. The System submitted a revised forecast position to NHSE in early December of a £90m deficit (£21m adverse to planned deficit). In January a revised deficit of £101.0m was reported to take into consideration industrial action costs. The System had now been funded for industrial action costs and received non-recurrent cash funding of £68.8m. The System therefore was required to achieve a position of a £21.2m deficit (being the £90m deficit position in December less the £68.8m non-recurrent funding). The System was reporting achievement of this position for the 2023/24 financial year.

CW commented on the hard work of the whole Trust for achieving the excellent year end position.

The Chair commented on the importance of delivering what we set out to do and the need to look at lessons and learning to take forward. He also passed on the thanks of the Board for the excellent performance.

It was **RESOLVED** to

- approve the financial performance for Month 12 (March 24)

24/49.1.3 Cost Improvement Programme (CIP) Update

AT presented the CIP Update Report given as enclosure six. The Board noted the status of the 2023/24 Cost Improvement Programme (CIP) following the last report on 28th March when a £762k over performance was forecast. The Board received positive assurance that the Cost Improvement Programme for 2023/24 was now closed and had delivered a year-end total of £27.05m against a year end plan of £26.23m. This resulted in a final over delivery of £850k and noted that 51% of the programme was recurrent in nature.

Work continued across all divisions to meet the 2024/25 assigned CIP programme targets. The Trust is currently working towards a 5.2% expectation in line with the Financial Recovery Programme (FRP). This equated to a CIP Programme value of £28.69m. To date the Trust had identified c.£21.24m made up of £8.97m of CIP plus a further £12.27m in workforce savings. The current gap was £7.45m with approximately 70% of the current programme plan as recurrent savings. It was noted that the workforce figure was yet to be divisionally phased and would also go through the Quality Improvement Assessment process. AT added that it was key not to lose sight of the importance of delivering a high quality, safe level of care for our patients.

It was **RESOLVED** to

- Note the current status of the Cost Improvement Programme, its identified and non-identified values including any risks identified

24/50 Build Innovative Partnerships in Dudley and Beyond

24/50.1 Integrated Performance Dashboard

KK presented the Integrated Performance Report (IPR) for March 2024 given as enclosure seven. The full IPR was included in the reading pack. The Board noted the following key highlights:

The Trust was performing well on mandated targets. Specific actions were taking place in ED and Medicine were highlighted in the report. The ED build was scheduled to be complete in October 2025.

The Trust was ahead of trajectory for diagnostic and cancer performance with Dudley supporting partners in the Black Country with investigations and procedures.

The report detailed the improvement in ED Paediatrics and Minors performance.

The Board was asked to note the work with the ED resuscitation build and the impact of the Midland Metropolitan University Hospital opening with more impact and mitigation details to be presented to Board.

JA asked about VTE performance. KK and LH confirmed that the Trust is performing very well.

LW confirmed that the Finance Committee had commissioned a report to look at the impact of the opening of the Midland Met. He also asked about targets and performance and asked that as performance continued to improve, stretch targets to be introduced to ensure that patients received the best care possible.

The Chair added that the work undertaken in the Community and Primary Care would be an important aspect moving forward and would need to consider how those KPIs were incorporated into integrated performance reporting. DW confirmed that metrics for Community Services were due to be launched. She added that the ED Resus build would take out 6 cubicles in ED at a time when two EDs merge into one in Birmingham and this would mean increased footfall into ED in Dudley. The Trust would be working with local partners to free up beds and work with Community Services to keep patients in their own homes where possible.

MM agreed that there would be many opportunities in relation to Community Services.

KR confirmed that the Integration Committee had undertaken a deep dive into Community Services.

It was **RESOLVED** to

- note the Trust's performance against national standards and local recovery plans for the month of March 2024

[short comfort break]

24/51 Deliver Right Care Every Time

24/51.1 Quality Committee Upward Assurance Report

LH summarised the upward report from the Committee meetings held on 26th March and 30th April 2024, given as enclosure eight. The paper outlined the key points of assurance and escalation at the Quality Committee meetings and work commissioned as result of discussions held and any decisions made.

No concerns to note from the March meeting. There was much positive work to note from both meetings related to patient safety and the culture of the organisation. Patient Safety partners had been appointed and were now well embedded.

LH gave thanks to the Trust volunteers for their work. Assurance was provided around the implementation of Matha's rule.

At the April meeting the Committee received positive assurance around Paediatric Audiology and Maternity CNST year 5. LH was pleased to report the improvement to complaints responses and congratulated Pharmacy for the reduction in the use of IV antibiotics.

Safeguarding level 3 training was noted to be a concern. All staff needed to complete Level 1 Oliver McGowan training. The Committee had identified issues with recording of training on ESR and a high level data cleanse was required. There continued to be issues around the effectiveness of cleaning and the Committee asked that the Board's attention was drawn to the responsible clinical and mental health administrator concern. EH also commented on the huge lead in time for staff to be supplied with a uniform.

In response to JA question related to the Neonatal Unit, EH and MM confirmed that there was much focus on Neonatal staffing and care and many actions had been put in place with improvement seen. There had been a very positive Local Maternity and Neonatal System (LMNS) peer review held the previous day. JHo commented on the strong leadership and improvement seen in the area. Junior Doctors had feedback on the change and were now training in Paediatrics. DW echoed these comments and the focus would remain on the QIS standard.

In response to the Chairs query related to mandatory training, LH confirmed that Safeguarding level 3 training was a long set of modules and there was an issue with releasing staff noting it was a fundamental part of health care delivery and would be prioritised. JA confirmed that the issue had been recognised at the People Committee.

It was **RESOLVED** to

- note the report, the assurances provided by the Committee, the matters for escalation and the decisions made

24/51.2 Chief Nurse and Medical Director Report

MM and JHo presented the first combined Chief Nurse and Medical Director Report given as enclosure nine, focussing on the quality metrics,.

The report provided an overview of key quality, safety and professional matters from a multiprofessional perspective, to demonstrate how multiprofessional teams worked collaboratively to positively influence everyday practice and focus on improving quality outcomes and patient experience, presented in an assure, advise and alert format. The Board noted the following key issues:

Assure
The Summary Hospital-level Mortality Indicator (SHMI) and Hospital Standardised Mortality Ratio (HSMR) continued to reduce and there is ongoing focus on improving safety and quality of care.

Improvements with the senior clinical reviews as part of the deteriorating patient pathway (DPP) continue to be evidenced.

The latest structured judgement reviews carried out by the Medical Examiner indicate predominantly good quality of care provided, with low levels of harm reported.

Responsiveness to complaints and their closure continues to improve as a result of the improvement interventions implemented.

As of 6th April 2024, a new visiting regulation has been introduced, which made visiting a legal requirement. The Trust had undertaken a scoping exercise and was compliant with the associated requirements.

Advise
Ongoing safer staffing (Nursing and Midwifery) oversight continues. A safer staffing review would be carried out in June 2024 and the outcome to be reported to the Quality Committee in July/August 2024.

Priority 1 audits were introduced in March 2024 and the Chief Nurse's team continued to work with Information Technology colleagues to develop a heat map to include key metrics such as harm and workforce information to enable triangulation of data and inform any interventions required.

Objectives have been agreed for 2024/25 as part of the Nursing, Midwifery and AHP strategy, which complemented the quality priorities and wider nursing, midwifery and AHP agendas.

The Complex Nutrition service and Nutrition Virtual Ward had been very successful, resulting in improved patient experience and quality of care and generating financial savings for the Trust due to admission avoidance.

The Speech and Language Therapy team's capacity continues to be challenged, due to reduced staffing. A business continuity plan is in place, including mitigations to ensure that priority patients are seen. A deep dive is being undertaken that will inform additional actions required to improve the position.

The International Day of the Midwife was on 5th May and International Nurses Day was on 12th May 2024, to pause and celebrate the immense contribution our nursing and midwifery professions make across the NHS and globally. Nursing and midwifery colleagues at the Trust would hold a joint celebration on 9th May, via a variety of local and Trust wide recognition events.

Alert
The Tissue Viability team's capacity remained challenged due to staffing reductions, and this had further deteriorated during March/April 2024. Mitigations were in place to ensure essential support is provided and a review will be undertaken during May 2024 to determine what establishment is required to ensure the team is able to meet the increasing demand.

JHo recognised the work of N Hadley who had joined the meeting.

In response to the question raised by LW about ventilator acquired pneumonia, MM confirmed that audits had not taken place for some time. There were no issues with care but the results related to an audit of documentation. The Chair noted that there was no underlying issue. JHo confirmed that outcomes were improving. DW added that the Infection Control Committee agenda had not been focussed on some key items.

JA asked about pressure ulcer reporting. MM confirmed that reporting had been combined to allow for clarity from the data. The Strategic Pressure Ulcer Group would scrutinise the data.

The Chair welcomed the new report format.

It was **RESOLVED** to

- Acknowledge the work undertaken by the Chief Nurse and Medical Director's office to drive continuous improvements in the provision of high quality of care and patient experience and contribute to the successful achievement of the Trust Strategic objectives

24/51.3 Perinatal Clinical Quality Surveillance (Maternity and Neonatal Dashboard)

CM presented the Perinatal Clinical Quality Surveillance (Maternity and Neonatal Dashboard) given as enclosure 10. CM was joined by Mrs Gupta and Ms Hadley from the specialty.

It was noted that the increase in the stillbirth rate was due to a cluster of incidents during March 2024. All of which would be reviewed via the perinatal mortality review tool (PMRT) in the Clinical Negligence Scheme for Trusts (CNST) expected timescale of four months.

There were no Maternity Newborn Safety Investigation (MNSI) cases open in February or March 2024 and 1 PSII case had been opened.

The Trust has received confirmation of successfully meeting all 10 safety actions and therefore securing funds associated with Maternity Incentive Scheme year 5.

Maternity Incentive Scheme year 6 had launched, and a gap analysis undertaken showing that the Trust had the opportunity to be compliant with all 10 safety actions as per the current position. The forward workplan was contained in Appendix 1 of the papers.

Information on current homebirth service provision was provided, including when the service was not possible to offer due to staffing challenges. Mitigations were in place to further reduce any instances of service unavailability.

There had been an increase in the number of completed actions, and progress is being made on all remining amber actions within the 3 year delivery plan. The Regional Maternity Heatmap was included for information.

In response to the query from AT about the home birth service, CM confirmed that there was a disparity across the system.

It was **RESOLVED** to

- Accept the assurance of progress made with the three year delivery plan and the assurance on the initial position with the MIS year six plan for compliance

24/51.4 Paediatric Audiology Report

JR presented the Paediatric Audiology Report given as enclosure 11. JR was joined by audiology Manager, Ruth Delves.

The Board noted that the Audiology Service was not yet achieving 'Improving Quality in Physiological Services Accreditation (IQIPS)' accreditation and was working towards its attainment.

An external review of the service had identified no significant concerns. The areas that were identified for action have been addressed subsequent to the review.

LW asked why we did not have the standard. JR confirmed that it had not previously been a requirement.

In response to a question from AH about the likelihood of achievement, JR and RD confirmed accreditation would be achieved once the required work was completed. LW asked if there were issues with other pieces of equipment across the Trust. KK confirmed that within clinical areas there was regular testing by medical engineering. AT agreed that there were quality management systems in place. There would be some cost associated with achieving the accreditation. AH offered support from Aston University if required.

It was **RESOLVED** that the Board:

- Acknowledged the current status of the Audiology Service and supported the investment in the required funds to achieve accreditation

24/51.5 7 Day Services

JHo presented the 7 Day Services Report given as enclosure 12.

The 7 Day Service (7DS) programme's aim is to provide a standard of Consultant led care to patients presenting urgently or as an emergency to ensure outcomes are optimised and there was equity of access nationwide. Until 2020 the Trust was required to complete a Board Assurance Framework return to NHS England.

The paper outlined compliance against all standards (4 priority) with evidence to suggest compliance amongst all standards. A number of standards had not been formally tested and were included in the 2024/25 audit plan.

The paper also provided a detailed review of Respiratory and Endocrinology services following the 2022/23 Job Planning round which highlighted non-compliance. Respiratory were now compliant and Endocrinology were providing cover utilising the existing consultant workforce. A snapshot audit has provided assurance that 95% of patients were seen within the recommended time frames set out by NHS England. 100% of patients had a management plan in place and documented discussions with the patient, relative or carers and had a Consultant review on admission. There was an opportunity to improve senior reviews for medically unwell patients on subsequent days.

The overall Trust SHMI and HSMR had reduced with no weekend effect evident. There was also no increase in length of stay for those patients admitted at weekends.

The Trust Job Planning governance would continue to monitor 7 day service compliance with additional assurance sought via the audit plan

It was **RESOLVED** that the Board:

- Noted the assurance provided against the standards, progress to embed 7DS standards across the Trust with assurance now received in Critical Care and Respiratory. Supported the use of the Job Planning Governance Framework and Trust audit cycle to seek continual assurance on the standards

24/51.6 Learning from Deaths

JHo presented the Learning from Deaths Report given as enclosure 13.

The paper provided an update on the 12 month rolling Summary Hospital-level Mortality Indicator (SHMI) 100.66 and the Hospital Standardised Mortality Ratio (HSMR) 85.95 which have both continued to fall.

Following a change in coding in October 2022, SHMI had fallen within the expected range and HSMR performance was amongst the lowest in the region.

The Medical Examiner (ME) Service continued to be the largest source of referrals for Structured Judgement Review (SJR). Completed SJRs show a high quality of care and low level of avoidability. An action from a previous report on death certification was included in the report, outlining the core staffing of the Dudley ME service.

LW reflected on the previous position. JHo agreed that we do need to reflect and note the better processes, improvement in culture and the impact of improvement methodologies. The Trust had seen a shift from being a 'Keogh' trust to being a national positive outlier and attributable to the improved quality of data, focus on the deteriorating patient and evidence based care needs to be delivered in a timely way.

It was **RESOLVED** that the Board:

- Noted the assurance of decreased SHMI and HSMR over the last 12 months and noted the staffing in place within the Dudley Examiner Service

24/52 To be a Brilliant Place to Work and Thrive

24/52.1 People Committee Upward Assurance Report

JA summarised the report given as enclosure fourteen relating to the Committee meetings held on 26th March and 30th April 2024.

March 2024

Matters of concern/key risks to escalate noted as follows:

Mandatory training had decreased slightly to 92.37%. Compliancy concerns with specific modules (Safeguarding and Resus) were noted, hotspot areas would be reviewed. The rolling twelve-month absence rate had slightly increased to 5.02% in February. Turnover (all terminations) had increased minimally to 8.46%, normalised turnover (voluntary resignations) had increased from 3.96% to 3.98%.

Positive assurances noted as follows:

Sickness absence analysis data gave assurance of robust management. The Trust's Baby Loss and Flexible Working Policies were in line with the national policies. Staff costs were within plan with staff numbers slightly ahead of plan due to strike action and winter pressures. The success of the Psychological Wellbeing Practitioner role was reported.

Major actions commissioned/underway were noted as follows:

The national staff survey 2023 results were more positive than 2022 with a benchmark average response rate of 45% and improved performance across most promises and individual questions. Workforce numbers and staffing costs were included in the workforce KPI report.

Decisions made were noted as follows:

BAF Risks 2 and 3 remained unchanged as positive assurance.

April 2024

Matters of concern/key risks to escalate were noted as follows:

Turnover had increased from 8.46% in February to 8.55% in March. Mandatory training compliance had slightly decreased to 91.59% but remained above the 90%target.

Positive assurances were noted as follows:

Positive results from the National Education and Training Survey were received. Positive update received from the Freedom to Speak Up Guardian. The workforce KPI report presented positive assurance against metrics, sickness absence and normalised turnover reductions in March, with positive performance against the workforce plan. Mandatory training remained above the 90% target. Manager's Essentials training had led to positive benefits to managers' personal development and their ability to provide improved engagement with their direct reports. Positive reports were received from the Wellbeing and Equality, Diversity & Inclusion Steering Groups. CCCS presented a deep dive into their division, which gave good assurance to the Committee that the appropriate people issues were being addressed. The Committee Effectiveness Review of People Committee had been carried out and positive feedback received.

Major actions commissioned/underway were noted as follows:

Updated Staff Survey action plans were presented by MIC, SWC and CCCS. An update was given on the Dudley Improvement Practice's Strategic Workstream a summary of leadership development opportunities for clinical colleagues was presented. Updates on the ICan Programme and Apprenticeship offer were given by Rachel Andrew.

Decisions made were noted as follows:

The following items were approved: the Strategy progress report for Q4 2023/24, workforce thresholds and targets for 2024/25, the Safe Staffing Policy, the Workforce RACE Equality Standard (WRES) and 2024 Workforce Disability Equality Standard (WDES) Summary reports. BAF Risks 2 and 3 remained unchanged as positive assurance.

CH welcomed the appointment of the Psychological Wellbeing Practitioner and the positive impact they were having within the organisation.

It was **RESOLVED** to

- note the report, the assurances provided by the Committee, the matters for escalation and the decisions made

24/52.2 Workforce KPIs

HW summarised the report given as enclosure 15 and highlighted the following key areas for noting:

The Committee noted and discussed the key areas highlighted and the mitigating actions presented. The three key areas highlighted were:

- Mandatory Training

- Sickness Absence
- Vacancies/ Turnover and performance against plan

Workforce growth was noted to be 0.3% across year with a 0.5% variance against plan.

It was **RESOLVED** to

- note the report for assurance

24/52.3 Workforce Race Equality Standard (WRES)

PS presented the WRES Report given as enclosure 16 and highlighted the following key areas:

The Board were asked to approve the Workforce Race Equality Standard (WRES) data summary for 2024 prior to external submission to NHSE by 31st May 2024.

A report must be published on the Trust's external website by 31st October 2024, and this was currently being completed to ensure compliancy with corporate branding.

The Workforce Race Equality Standards (WRES) has a set of nine specific measures which enabled NHS organisations to compare the experiences of different staff groups.

The WRES compares the experience of ethnically diverse staff with white staff.

The ethnically diverse representation in the Trust had increased from 25% in March 2023 to 28%. Although, overall, ethnically diverse representation within the Trust had increased, the Board membership was reporting as less ethnically diverse (16.7% to 15%).

Improvement had been seen in recruitment practices, career progression or promotion. There had been a Trust, regional and national decline of our ethnically diverse employees who have experienced bullying, harassment, and discrimination.

Ethnically diverse staff were more likely to enter a formal disciplinary process and were less likely to access non-mandatory training and professional development.

The data indicated a requirement to improve across a number of the WRES indicators, these align to the actions set out in the Trust's EDI Journey and in the Trust's commitment to becoming an anti-racist organisation. The areas for improvement align to key priorities set out in the Trust's EDI Journey, which had a key focus on recruitment, development and addressing bullying and harassment. The Journey sought to make further improvements which would enhance culture and leadership within the Trust.

TA welcomed the data and looked forward to improving outcomes. The Chair asked for PS's thoughts on performance. PS confirmed that there was more work to do and was moving in the right direction. The Chair asked about a person from a different backgrounds' experience of working at the Trust. PS confirmed that experiences were very different and varied across areas. The Chair then asked about the disciplinary element. PS confirmed that this was being reviewed. HW confirmed that a deep dive would be undertaken at the People Committee in May.

In response to a suggestion from AH that the Trust might use reverse mentoring, DW confirmed that it was actively undertaken at the Trust. CH was supportive of the approach of reviewing our process before we moved forward.

In response to the comment from JHa about using data from Freedom to Speak Up activity, PS confirmed that the data was reviewed and triangulated with other feedback and metrics.

KR added that an international doctor had recently given very positive feedback of his experiences at the Trust.

It was **RESOLVED** to

- Approve the WRES data summary for submission to NHS England and Note the work ongoing to complete publication to the Trust's external website by 31st October 2024

24/52.4 Workforce Disability Equality Standard (WRES)

PS presented the WDES Report given as enclosure seventeen and highlighted the following key areas:

The Board were asked to approve the Workforce Disability Equality Standard (WDES) data summary for 2024 prior to external submission to NHSE by 31st May 2024.

A report must be published on the Trust's external website by 31st October 2024 and this was currently being completed to ensure it was compliant with corporate branding.

The WDES has a set of specific measures which enable NHS organisations to compare the experiences of different staff groups. The WDES compares the experience of staff with and without a disability.

The Trust had seen improvements with WDES Indicators that cover workforce representation, recruitment, staff experience, provision of reasonable adjustments and engagement.

The WDES indicators that remained a challenge for the Trust were staff experiences i.e. bullying and harassment, equal opportunities in career progression or promotion and presenteeism.

This year there are fewer disabled colleagues represented at Board level.

The report evidenced that the Trust had made good progress in bridging the gap between disabled and non-disabled staff experience, however, clear areas for improvement remained.

Actions to further improve the Trust's WDES performance were aligned with the Trust's strategic ambitions and priorities, in particular making Dudley Group a brilliant place to work and thrive. To meet this goal the Trust has continued to implement the EDI Journey and has committed to improve practices for disabled staff by continued engagement, supporting with reasonable adjustments and supporting inclusive recruitment.

LH asked how we could accelerate improvements. PS confirmed that there were continuous engagement initiatives that would showing results

It was **RESOLVED** to

- Approve the WDES data summary for submission to NHS England and Note the work ongoing to complete publication to the Trust's external website by 31st October 2024. The organisation will consider how to increase numbers

24/52.5 National Education and Training (NETS) Survey Report

JHo presented the NETS Survey Report given as enclosure 18 and highlighted the following key areas:

The Board noted that a review of NETs Survey results showed that improvements were linked to increased staffing.

Specialties for close monitoring included Obstetrics & Gynaecology, Paediatrics and Foundation Training in Medicine.

Additional areas of focus include workload, culture and communications, sick leave and academic success.

It was **RESOLVED** to

- note the assurance that the National Education and Training survey results were being monitored through the Education Team quality assurance processes. Action plans/Improvement plans would be put in place as a continuing process of managing medical quality assurance of training and education in the Trust, led by the Director of Medical Education

24/53 Build Innovative Partnerships in Dudley and Beyond

24/52.1 Audit Committee Upward Assurance Report

JHa summarised the report given as enclosure 19 relating to the Committee meeting held on 18th March 2024. The Board noted the following key highlights:

External Audit saw the commencement of audits for annual financial accounts and VfM. For internal audit good progress was noted on plans. Audit plans had provided good assurance. Cyber Security was noted to have partial assurance but with a path to green. The Internal Audit and Counter Fraud plans were approved. IFRS adjustment was noted and assurance provided that actions were in line with national guidance.

Items for the Board to note include: the BAF would continue to be embedded and evolve and the 2024/25 planning process would surface any new risks. Discussion around discharge management and partial assurance would continue and would be an area of focus.

It was **RESOLVED** to

- note the report, the assurances provided by the Committee, the matters for escalation and the decisions made

24/52.2 Integration Committee Upward Assurance Report

KR summarised the report given as enclosure 20 relating to the Committee meetings held on 28th March and 24th April 2024. The Board noted the following key highlights:

At the meeting in March, the Committee received an update on the programme of work on the Dudley Community Information Directory (DCID). Sarah Owens from the Public Health team at the Dudley Council joined the Committee to share an update, raising the profile of the directory, this is something that all system partners can participate in. The Committee supported the directory and

will promote it amongst health care practitioners and consider how staff can be involved to shape the service specification.

The Committee also received an update on Health and Care Partnerships, an update on the DIHC Transaction was noted with supporting documents such as Communications and Engagement Plan, benefits realisation, Implementation plan, risk register, reporting structures and self-certification template. The Committee approved and agreed the recommendations, noting positive assurance with the comprehensive plan, noting the identified risks, and ongoing work with the staff engagement and cultural communication plan.

The Committee also received a Terms of Reference review where the changes were approved.

The BAF risk 6 was noted to remain unchanged. The Chair shared the Committee Effectiveness Review with the group for consideration asking for feedback.

The meeting in April was the Committees first face to face visit to the Community and Voluntary sector. The meeting had taken place at The White House Cancer Support Unit.

BAF risk 6 was reviewed and noted to remain unchanged and it was agreed to amend the frequency in which the BAF is reviewed to every other month.

The Committee received an update on Community Services and noted positive assurance on the work undertaken since the last meeting.

The Dudley Integrated Health and Care DIHC Transaction update was noted along with the positive feedback received from DIHC staff, inviting them to attend the next Leadership Conference.

The Committee also noted an update on Health and Care Partnerships.

A quarterly strategy report was presented to the committee. The updated Committee workplan was shared and agreed.

It was **RESOLVED** to

- note the report, the assurances provided by the Committee, the matters for escalation and the decisions made

24/52.3 Joint Provider Committee Upward Report

The Chair summarised the report given as enclosure 21 relating to the Joint Provider Committee meeting held on 15th March 2024. Key discussion points included:

An update from the Black County Provider Collaborative CEO Lead on progress against the range of activities being progressed in delivering the agreed work plan.

The approval of the Collaborative Executive recommendation for the pursuit of a scoping exercise on PACs/RIS.

A refocus of the 2024/25 BCPC workplan required in light of recent regional and national reviews of the Systems' Financial Recovery Plan (FRP). An active discussion on the recent FRP developments with proposed plans for a way forward took place.

The Committee received the proposed new schedules and revisions for the Collaboration Agreement.

An update was received on corporate services consolidation, with request to progress work at pace.

The Board noted the work underway at Walsall and Wolverhampton to bring both Board's together as a joint Board. They would hold their final individual Board meetings the following week.

It was important for the Committee to make a judgement on what work can be undertaken individually and that work required to be undertaken as a System.

In response to a question from LW about the makeup of the RWT/WHT joint Board, the Chair described how the new joint Board Committee would improve decision making.

It was **RESOLVED** to

- note the report, the assurances provided by the Committee, the matters for escalation and the decisions made

24/52.4 Charitable Funds Committee Upward Report

JA summarised the report given as enclosure 22 relating to the committee meeting held on 15th April 2024. Key discussion points included:

There were no matters of concern. Positive assurance regarding Charities Together had agreed money could be used to upgrade staff wellbeing rooms. Local solicitors had raised £6k for the charity. It was positive to note that the Charity had spent more money than it had received.

The Committee noted that Heather Taylor would retire at the end of June and thanked her for her dedicated support over many years.

The Charity rebranding exercise was well received by the Committee. LA commented on the rebranding and the Board noted that the funding had been via a development grant from NHS Charities Together.

There were two new grant applications underway and a work experience programme has been established.

GC would become the Committee Chair and would lead a review of the Charity Strategy.

Two new bids were approved.

The Trust was reviewing prospective investment managers to replace the current incumbent.

LW asked whether it might be possible for the charity to support youth work. DW confirmed that this could potentially be supported by the charity.

It was **RESOLVED** to

- note the report, the assurances provided by the Committee, the matters for escalation and the decisions made

23/53 GOVERNANCE

23/53.1 Trust Strategy Update Q4

AT presented the Trust Strategy update for Quarter 4 given as enclosure 23.

The report summarised progress against the goals and measures of success in the Trust's strategic plan 'Shaping #OurFuture'. Detailed progress updates were made to Executive Directors and the relevant Board sub-Committees during April. The Committees received the reports as being a comprehensive reflection.

Only one measure of success had changed its RAG ratings this quarter:

- Increase planned care and screening for the most disadvantaged groups. The (unvalidated) figure for breast screening for Q3 which is the most recent data (68%) is below the acceptable uptake rate (70%). All other RAG ratings remain unchanged.

A full copy of the quarterly report with the content that went to Committees was included in the reading pack.

It was **RESOLVED** to

- To note the strategy progress report for Q4 2023/24

24/53.2 Digital Committee Upward Assurance Report

CH presented the upward report from the previous Committee meeting held on 20th March 2024, given as enclosure 24, including the following key highlights:

Positive assurance was noted in terms of the risk associated with the ongoing infrastructure project and on cybersecurity CareCert. The Digital Team had been successful in achieving Gold Partner status with the British Computer Society (BCS) and was awarded a HTN award for the development and deployment of an alternative approach to Maternity Services.

The BAF assurance rating remained positive. The Committee agreed the work plan and Steering Group Terms of Reference. The Committee recommended final assurance on ongoing corporate governance arrangements are presented to the final Committee meeting in May.

The Committee noted that the recommendation for the dissolution of the Digital Committee was approved at the June meeting of Board (private session).

It was **RESOLVED** to

- note the report, the assurances provided by the Committee, the matters for escalation and the decisions made

24/53.3 Board Assurance Framework

HB presented the Board Assurance Framework (BAF) given as enclosure 25. The Board noted the following key highlights:

Of the nine risks listed, Committee assurance ratings had changed from the previous summary report:

- Eight (was six) was assigned a ‘positive’ rating
- One (was three) was assigned an ‘inconclusive’ rating
- No risks were assigned with a ‘negative’ rating

The Board noted that further Board development workshop activities were being scheduled for 2024/2025.

It was **RESOLVED** to

- Approve the update made since the last meeting and note the ongoing work to embed effective risk management with further Board development workshop activity being scheduled for 2024/2025, actions arising from the audit activity and review work underway ahead of 2024/25

24/54 Any other Business

There was none raised.

24/55 Date of next Board of Directors Meeting

The next meeting would be held on Thursday 11th July 2024.

24/56 Meeting Close

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

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Sir David Nicholson **Chair** Date:

Enclosure 3

The Dudley Group NHS Foundation Trust

Paper for submission to the Board of Directors on 11 July 2024

Report Title	Public Chief Executive Report
Sponsoring Executive & Presenter	Diane Wake, Chief Executive
Report Author	Alison Fisher, Executive Officer

1.	**Suggested discussion points**

- Operational Performance
- Junior Doctors Industrial Action
- Black Country Provider Collaborative
- Charity Update
- Healthcare Heroes
- Patient Feedback
- Awards
- Visits and Events

2.	**Alignment to our Vision**									
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

2.	**Report journey**
Board of Directors	

3.	**Recommendation**
The Public Trust Board is asked to:	
a.	**Note** and discuss the contents of the report

4.	**Impact**							
Board Assurance Framework Risk 1.1	x	Deliver high quality, safe person centred care and treatment						
Board Assurance Framework Risk 1.2	x	Achieve outstanding CQC rating.						
Board Assurance Framework Risk 3.0	x	Improve and sustain staff satisfaction and morale						
Board Assurance Framework Risk 4.0	x	Remain financially sustainable in 2023/24 and beyond						
Board Assurance Framework Risk 6.0	x	Deliver on its ambition to building innovative partnerships in Dudley and beyond						
Board Assurance Framework Risk 7.0	x	Achieve operational performance requirements						
Board Assurance Framework Risk 8.0	x	Establish, invest and sustain the infrastructures, applications and end-user devices for digital innovation						
Corporate Risk Register	Y	Various						
Equality Impact Assessment	Is this required?		Y		N	x	If 'Y' date completed	
Quality Impact Assessment	Is this required?		Y		N	x	If 'Y' date completed	

CHIEF EXECUTIVE'S REPORT – PUBLIC BOARD – 11 JULY 2024

Operational Performance

National focus remains on reducing long waits to routine treatment. The focus is now moving away from 78 weeks and towards 65 weeks, though the target for this was March 2024 this has nationally been stretched to the end of Q1 due to the impact of industrial action earlier in the last financial year not allowing the required number of patients to be treated.

Junior Doctors Industrial Action

The latest industrial action by Junior Doctors took place 27 June to 2 July 2024. A brief overview is below and a full debrief report will be written following Trust debrief on Friday 5th July and circulated to Board members.

- Patient safety and safe staffing levels were maintained throughout the strike period.
- Where necessary, consultants acted down to cover staffing gaps.
- Small number of unexpected resident doctor gaps arose over the weekend of the strike, however these were escalated appropriately and cover was swiftly found on site.
- A significant level of elective inpatient, day case, and outpatient activity was rescheduled due to the strike. However, there were no impacts to cancer and long-waiter activity, and very minimal impacts to diagnostic activity. Final cancellation numbers will be included in the debrief report.
- The Finance and Productivity Committee continue to monitor the cost impact of industrial action.
- Further information regarding impacts to MET calls, mortality, patient flow, and any identified areas for improvement ahead of future strikes will be included in the debrief report.

Black Country Provider Collaborative

The following are the key messages from the 10th June 2024 Black Country Provider Collaborative Executive meeting and formed the basis of the Chief Executive Officer Highlight report to the Black Country Provider Collaborative Joint Provider Committee on the 21st June 2024.

a. Improvement

- **Breast Service Proposals –** The Collaborative Executive received three proposals from the Breast Service Clinical Network, which were reviewed and approved for progression. They included the following:
  - Breast Radiology Alliance – Received an update on the resilience and variable standards of radiology provision across the Black Country system, which would benefit from the establishment of a system wide Alliance. Black Country Provider Collaborative partners have agreed to support further work in developing this Alliance arrangement ensuring all partners identify local leadership / representative.
  - Breast Unit Review – Received a current state analysis agreeing commitment from all partners to proceed with a full cost analysis of options identified. Output to be received by Collaborative Executive for a decision on a way forward.
  - DIEP (deep inferior epigastric perforator) Breast Reconstruction service - Received a current state analysis which identified that there is no provision of DIEP (deep inferior epigastric perforator) reconstructive breast surgery provided by any of the four partners in the Black Country, with inequitable access for the Black Country population. Agreed to review options and undertake detailed cost analysis to determine a preferred option for delivery.

- **Pharmacy Asceptics** – A detailed report was received from the Clinical Leads for Pharmacy on the state of the provision of Aseptic services across the Black Country. With impending aseptic service rule changes, it is unlikely that the current facilities will comply with requirements, with a

plan required for a way forward. It was agreed that the Pharmacy Clinical Network would be supported to develop a feasibility report on options for a way forward, and in the interim consider options for mitigation.

- **Networked Service Solutions Stroke Services –** An update was received on the potential use of beds at Rowley Regis for Acute Stroke rehabilitation, with costs being finalised. Subject to successful Midland Met University Hospital transition, and the option being cost neutral Dudley Group Foundation Trust should establish an equitable service for the Dudley population in the south of the Black Country prior to the winter season.

  Following successful implementation of the acute stroke rehabilitation service, work will commence on the development of a suitable community stroke rehab offer for both the north and south of the Black country system alongside a focus on improving the Single Nucleotide Polymorphisms data and provision of Transient Ischemic Attack services.

- **Urology public involvement exercise –** The Collaborative Executive received a summary report from the lead for Communications & Engagement on the recently concluded public involvement exercise required for the urological cancer transformation work.

  Key finding generally revolved around transportation and familiarity with a new hospital site. A range of mitigations have been identified and will be developed further. A briefing paper for the HOSCs (Health Overview Scrutiny Committee) is now being developed with a view to securing support for the proposed transformation and enable the business case to be signed off by the Black Country Integrated Care Board.

b. Transformation

- **Corporate Services Transformation update –** The Collaborative Executive received a brief update from the Black Country Provider Collaborative Managing Director and the Corporate Services Transformation Senior Responsible Officer on current progress. Recruitment has been commenced, governance arrangements are being put in place and nominees from each partner Trust have been requested.

  The Black Country Integrated Care Board and BCH Chief Executive Officers have also been communicated with to request confirmation of their participation and appropriate nominations for inclusion within the Corporate Services Transformation Programme Delivery Group.

c. Strategic & Enabling Priorities

- **Allocate proposal –** The Collaborative Executive approved a proposal received by RLDatix (Allocate)centred around the 'Allocate' e-rostering system. This will be cost neutral to the four BCPC partners with a RLDatix commitment equivalent to approximately £100k.

  The key aims of this work will be:
  - To gain greater use of the systems we currently purchase
  - Provide greater alignment in the utilisation between the 4 Trusts
  - Demonstrate a potential for greater productivity.

- **Memorandum Of Understanding 2 –** The Collaborative Executive received and approved an updated Memorandum Of Understanding 2 for use by the four Black Country Provider Collaborative partners across the Black Country system.

Charity Update

Trust charity rebrand

The Dudley Group NHS Charity received a development grant from NHS Charities Together to rebrand its marketing materials and brand and today we are very excited to share its new look and logo.

The charity engaged with many different stakeholders through the development phase of the brand to ensure it reflected a diverse range of views and ideas from fundraisers and businesses to members and staff. This will help with its recognition and strength as we launch the new brand.

The new brand concept is **"Smiles"**, to reflect how the charity strives to bring happiness to patients and staff and this is reflected in the new logo.

The new strapline for the charity is '**Making every day better'**, as the charity's aim is to support the wellbeing and experience of patients, visitors, and staff. By providing services and facilities over and above what our Trust and the NHS can provide, they are making every day better for everyone in our community.

The development grant also included a new charity website and mascot, and these will be launched in September.

As part of the rebrand, the Trust charity also has new branding guidelines and guidance around the use of their new logo. Please contact dgft.fundraising@nhs.net if you would like to know more.

Superhero Fun Run and Family Fun Day

The Dudley Group NHS Charity's third annual 5K Superhero Fun Run and Family Day took place on June 9th, raising funds for their Children's Appeal, which supports children's services across Russells Hall Hospital and community sites in Dudley.

Over 250 people from across the Black Country region arrived at Himley Hall and Park for the event dressed in an array of costumes.

125 people took part in the 5K fun run itself and participants included executives and staff members, who took to the starting line along with adults and children of all ages.

Participants could walk or run the route, which consisted of three laps around the lake in Himley Park and were awarded with a medal for their efforts. Afterwards, participants were free to enjoy the family fun day, with 35 stall holders including food stalls, health activities and a children's funfair.

The clinical nurse specialist teams from across children's services were in attendance on the day, running a stall where they gave advice and guidance to families on the day on a range of issues, including epilepsy and diabetes awareness.

The event was sponsored by Grosvenor Interiors and the Juice Bar, it was a great success and has raised over £4,249 from the race entrants, donations from stall holders and a raffle held. The funds raised will go towards improving the women and children's outpatients area in Russells Hall Hospital.

This was the third 5K Superhero Fun Run and Family Day the charity has held, and they hope to bring it back next year, bigger and better, so please look out for the 2025 event.




Charity Abseil

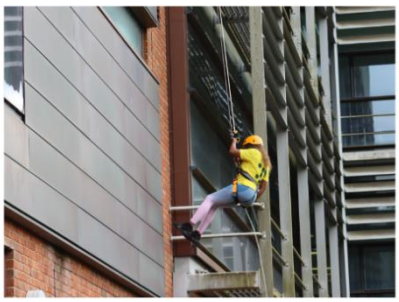
A daring group of fundraisers scaled new heights to raise almost £1,032 to support Dudley Group NHS Charity. Seven brave members of staff took part in a charity abseil from the rooftop of Dudley College's Evolve building, into the Coronation Gardens on June 20th. The daredevils dropped 60ft from the building to support their local NHS charity alongside Dudley College staff members.

One of the staff members who took part was Louise Brookes from therapy services, who said: “What a privilege to be able to take part in the abseil for the Dudley Group NHS Charity at Dudley College. We had a great team from the Trust who bonded and supported each other.

"It was an amazing experience and a huge leap of faith to climb up and over the edge. It didn't look so high from the ground but when you are up there kneeling on a small ledge and climbing over, it was certainly quite daunting!





"The team were very reassuring and put me at ease each step of the way. A great personal achievement and a real exciting opportunity for each one of us and we are all up for the next challenge! Thank you to the charity for giving us the opportunity to take part."

If anyone would like to express their interest in future events, please email dgft.fundraising@nhs.net.

Healthcare Heroes

Individual awards

Scott Peters

Scott is the Trust's Service Operations Centre Manager; he is responsible for overseeing and managing the Trust cybersecurity program. He plays a key role in protecting the Trust information assets, systems, and networks from cyber threats and attacks. Scott has worked in this role for just over 4 years and has transformed the way the trust monitor and action any cyber threats.

Team awards

Our **Urology** team at Corbett Hospital is a small but mighty team who cover a full service of Urology treatments and diagnostic tests and treat all patients with care, respect and dignity at all times, especially due to the nature of the service the patients sing highly of them all and show gratitude to staff on a daily basis.

The **Inflammatory Bowel Disease Nursing team** was nominated by a patient and their relative for being consistently friendly, empathetic, understanding, and unwavering in their knowledge and support given to them. Any questions they had were answered and all care received has been 10/10. The patient had a rough few years with his illness but dealing with such an exceptional team has made things easier.

Volunteer awards

Derek Gregory was the proud recipient of our volunteer healthcare hero award. Derek was nominated by a patient's son who said that he had noticed his mother struggling to get from the carpark to the hospital. Derek approached them with a wheelchair and transported her to the appointment. Not only was Derek helpful and kind-hearted, but he was delighted to chat with them, and they were grateful for all the useful advice he gave them.

Patient Feedback

Acute Medical Unit - Staff are friendly, caring, kind and considerate with excellent communication. They all work well together, and I am happy with the care provided for my dad.

Dermatology Day Case - All of the staff at Corbett Hospital were exceptional and explained the procedure in detail. They were very caring and thoughtful.

Ward B5 - All the staff were very helpful, they really looked after me. It's always difficult being in hospital but they all made me feel like I was in good hands.

General Community - The oncology nurses at the Brierley Hill health centre were so lovely with me during my first visit, they put me at ease and explained everything, such lovely ladies.

Neonatal - Such lovely caring staff. A real team of first-class professionals. Always kept informed.

Ophthalmology - I was seen quickly and efficiently. The nurse who attended to me was lovely, kind, answered my questions and very polite.

Intermediate Care Team (Physiotherapy) - Everything has been good. My mobility is much better now. I could hardly walk when I arrived, and I am now independent with a walking stick.

C2 (Children's) - We were seen quickly, and staff were friendly and attentive, and my daughter was given colours while waiting. The play team were amazing. Very satisfied.

Ward C6 - Staff were excellent. I cannot praise the staff on C6 enough. Professional, happy, courteous, cheeky and a huge can-do attitude. Made recovery so much easier.

Own Bed Instead - The therapist was a complete professional and a joy to work with. Things were well explained, and exercises demonstrated. I was never put in a situation where I was feeling unsafe.

Daycase Unit, Russells Hall- Everyone treated me with such a high level of care and thoughtfulness. I could not have asked for a higher level of care. Everything was perfect, thank you so much.

Awards

Congratulations to our chief pharmacist Ruckie Kahlon who has been designated as a Fellow of the Royal Pharmaceutical Society for distinction in the profession of Pharmacy.

The Fellowship is awarded to members who have made an outstanding original contribution to the advancement of pharmaceutical knowledge or attained distinction in the science, practice, profession, or history of pharmacy.

Ruckie told us: “I’ve been practicing as a pharmacist for over 33 years, all of this in secondary care and my role as chief pharmacist has been instrumental in collaborating with system, regional and national partners to lead and enable service transformation. I am privileged to have a seat at a national advisory panel and chair a regional network, all these experiences enrich the work I do locally.

“Our progressive approach at the Trust has led in the improvement of a wide range of pharmacy services, that are supporting safe patient centred care. We have transformed our clinical pharmacy practice that supports our ward teams and patient flow, embedded pharmacists into clinical teams, undertaken dispensing service transformation, enabled medicines optimisation with clinical speciality leads, driving digital medicines delivery, develop non-medical prescribing and supporting cancer services through our aseptic dispensing provision.

“It’s an honour, privilege and truly humbling to be recognised for my contribution to the profession.”

Committed to Excellence 2024

Thursday 27 June saw us award some well-deserved winners at our Committed to Excellence Awards. Winners included:

Improvement Practice Award – Joanne Hules and Carrie Westwood
Unsung Hero Non-clinical award – Gina Vowles
Healthcare Hero Individual Award - George Adetunji
Unsung Hero Clinical – Dr Min Yen Wong
Chief Executive Award – Surgical Operational Management Team
Chief Nurse Award – Amy Sargent
Medical Director Award - Indre Verpetinske
Outstanding Achievement Individual Award – Raj Uppal
Excellence in Patient Care Award – Joanne Bowen
The Steve Ford Volunteer Award – George Hodson and Carol Harris
Outstanding Achievement Team Award – Pulmonary Rehab

Best Use of Charitable Funds Award – Forget-me-not-Unit
Healthcare Hero Team Award – Alcohol Care Team
Sustainability Award – Sustainable Medicines Project
Outstanding Achievement Award – Breast Care Nursing Team
Team Excellence Award – Nutrition Team
Chair's Lifetime Achievement Award – Professor Sauid Ishaq

Congratulations to all!

Visits and Events

1 May	NHS Leadership Event
1 May	Black Country Integrated Care Board Extra-ordinary Private Board
2 May	Dudley Group Board of Director Extra-ordinary Private Board
9 May	Dudley Group Board of Directors Public and Private Board
13 May	Black Country Provider Collaborative Executive meeting
13 May	Black Country Integrated Card Board Chair appointment external stakeholder panel
14 May	Community Nurses Engagement Event
15 May	Dudley Group Non-Executive appointment interviews
17 May	Black Country Joint Providers Committee
20 May	NHSE/Integrated Care System Oversight and Assurance meeting
21 May	Black Country System Chief Executive Officers meeting
22 May	Black Country Financial Recovery System Oversight meeting
4 June	Black Country System Chief Executive Officers meeting
5 June	Black Country Elective and Diagnostic Strategic Board
6 June	Black Country Integrated Care Board Development session
10 June	Black Country Provider Collaborative Executive meeting
13 June	Dudley Group Private Board of Directors
13 June	Dudley Group Board Development workshop
19 June	Black Country Integrated Care Board Chief Executive Officers round table meeting with Midlands Regional Executive Team
20 June	Dudley Group Council of Governors meeting
21 June	Black Country Joint Providers Committee
21 June	Black Country Financial Recovery System Oversight Group
24 June	Dudley Group Audit Committee
25 June	Midlands Regional Access Board
26 June	Black Country Elective and Diagnostic Strategic Board
27 June	Dudley Group Finance and Productivity Committee
27 June	Dudley Group Committed to Excellence staff awards

Enclosure 4

The Dudley Group NHS Foundation Trust

Paper for submission to the Board of Directors on 11th July 2024

Report title	Finance and Productivity Committee Upward Assurance Report
Sponsoring executive	Lowell Williams, Non-executive Director
Report author	Zoe Harris, Executive Assistant to Interim Director of Finance

1. Suggested discussion points

The committee has considered and robustly discussed all matters relating to financial challenges, focused on performance against related targets and reviewed the Workforce Plan and related productivity. Points to highlight from the Finance and Productivity Committee meetings held on 30th May and 27th June 2024 include:

- Continued sub optimal performance of the Black Country Pathology Services
- Impact of the opening of the Midland Metropolitan University Hospital on the Trusts emergency department capacity
- Ongoing strong operational performance noted

2. Alignment to our Vision

Deliver right care every time		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	

3. Report journey

Board of Directors – 11th July 2024

4. Recommendation

The Public Trust Board is asked to:

a. Note the contents of the report and in particular the items referred to the Board for decision or action.

5. Impact

Board Assurance Framework Risk 1.1	X	Deliver high quality, safe person centred care and treatment					
Board Assurance Framework Risk 2.0	X	Address critical shortage of workforce capacity					
Board Assurance Framework Risk 4.0	X	Remain financially sustainable in 2023/24 and beyond					
Board Assurance Framework Risk 5.0	X	Achieve carbon reduction ambitions in line with NHS England Net Zero targets					
Board Assurance Framework Risk 7.0	X	Achieve operational performance requirements					
Board Assurance Framework Risk 8.0	X	Establish, invest and sustain the infrastructures, applications and end-user devices for digital innovation					
Corporate Risk Register							
Equality Impact Assessment	Is this required?			N	X	If 'Y' date completed	
Quality Impact Assessment	Is this required?			N	X	If 'Y' date completed	

The Dudley Group NHS Foundation Trust

EXCEPTION REPORT FROM FINANCE AND PRODUCTIVITY COMMITTEE CHAIR

Meeting held on: 30th May 2024

MATTERS OF CONCERN OR KEY RISKS TO ESCALATE	MAJOR ACTIONS COMMISSIONED/WORK UNDERWAY
• The ongoing underperformance of the Black Country Pathology Service (BCPS) would be rereferred to Board. • There was a concern regarding the impact of the opening of the Midland Metropolitan University Hospital on the Trusts emergency department capacity, with a potential financial pressure of c£15m. • The delivery of the remaining £10m unidentified CIP was a concern. • The levels of cleanliness from the PFI provider Mitie was being monitored.	• There were no actions commissioned.
POSITIVE ASSURANCES TO PROVIDE	**DECISIONS MADE**
• High levels of operational performance were seen for ED, Cancer Diagnostics and 78 week waits. • The committee saw a positive deep dive into medicine and integrated care. • There were continued strong procurement performance practices.	• The committee approved the Emergency Preparedness Resilience and Response (EPRR) annual report for 2023/24. • The committee approved the four year managed service contract for provision of CT and MRI scanning with staffing at Corbett to Cobalt Health. • The extension of the contract to Cobalt Health for June and July for mobile CT and MRI scanners was approved. • The pacing tender was recommended to Board for approval. • The operating tables contact award was recommended to Board for approval. • The committee agreed to reduce the BAF risk 7 score to 16. • The committee agreed formal recognition of all the hard work of the teams.
Chair's comments on the effectiveness of the meeting: The meeting was good with good challenges. Mr Atkins noted that this reflected the success of the Trust. The Trust was in very good hands with an excellent executive director team and strong group of non-executive directors. Miss Rose agreed, adding that it had been a really good meeting with a good balance between performance. She recognised the work done to get to the month one position from all of the teams and divisions.	

The Dudley Group NHS Foundation Trust

EXCEPTION REPORT FROM FINANCE AND PRODUCTIVITY COMMITTEE CHAIR

Meeting held on: 27th June 2024

MATTERS OF CONCERN OR KEY RISKS TO ESCALATE	MAJOR ACTIONS COMMISSIONED/WORK UNDERWAY
• There is a concern that weighted full time equivalents are currently higher than planned. • There is a reduced capital allocation of £6m to the System with a potential impact on the Trust's capital programme.	• No actions were commissioned.
POSITIVE ASSURANCES TO PROVIDE	**DECISIONS MADE**
• There is an ongoing and strong operational performance including, emergency, cancer, diagnostic, and clinical hubs. • Community with Core Clinical Services presented a positive and comprehensive deep dive into the division. • The committee received a positive review of the impact of Patient Initiated Follow Up (PIFU), noting further developmental opportunities. • The Trust is currently forecasting to deliver its financial plan, subject to the achievement of unidentified Cost Improvement Programmes (CIP).	• The committee approved the transformation business case. • The integration of the CIP report into the finance report was agreed with a stronger future focus on the risks associated with the implementation of CIPs.
Chair's comments on the effectiveness of the meeting: It was a good meeting, with attendees reporting that it was well chaired. Members noted that the quality of committee reports is strong and continues to improve. Mrs Morris liked the triangulation of quality, safety and finance and the impact that this has.	

Enclosure 5

The Dudley Group NHS Foundation Trust

Paper for submission to the Board of Directors on 11th July 2024

Report title	Month 2 Financial Position
Sponsoring executive	Chris Walker, Interim Director of Finance
Report author	Chris Walker, Interim Director of Finance

1. Suggested discussion points

The Board is asked to note the Month 2 (May 2024) Trust financial position. After technical changes the May cumulative position is a £6.578m deficit. This position is £0.294m better than the updated phased plan submitted to NHSE in June. The plan has been updated for the final June submission to include the latest Cost Improvement Programme (CIP) phasing and the improved position of identified CIP. The Trust is forecasting that we will achieve our 2024/25 financial year planned deficit of £32.565m after technical adjustments.

The Board is asked to note the Black Country Integrated Care System May 2024 financial position and year end deficit plan of £119.2m. The System did not change the overall deficit plan for the final submission in June remaining at the £119.2m deficit. NHSE had previously set the System a control total of a £90m deficit for 2024/25. At the time of writing this report the System had not received formal notification from NHSE acknowledging the deficit of £119.2m in the final submission.

2. Alignment to our Vision

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	

3. Report journey

Month 2 (May 2024) detailed finance report presented to the Finance and Productivity Committee on the 27th June 2024. Summary Month 2 financial report presented to Executive Directors on 12th June 2024.

4. Recommendation(s)

The Public Trust Board is asked to:

a.	Note the financial performance for the month of May 2024.
b.	Note the reported Trust and System 2024/25 financial year end position.

5. Impact

Board Assurance Framework Risk 1.1	X	Deliver high quality, safe person centred care and treatment
Board Assurance Framework Risk 1.2	X	Achieve outstanding CQC rating.
Board Assurance Framework Risk 2.0	X	Address critical shortage of workforce capacity
Board Assurance Framework Risk 3.0	X	Improve and sustain staff satisfaction and morale
Board Assurance Framework Risk 4.0	X	Remain financially sustainable in 2023/24 and beyond
Board Assurance Framework Risk 8.0	x	Establish, invest and sustain the infrastructures, applications and end-user devices for digital innovation
Corporate Risk Register		*[Give risk Nos]*

Equality Impact Assessment	Is this required?			N		If 'Y' date completed	
Quality Impact Assessment	Is this required?			N		If 'Y' date completed	

REPORTS FOR ASSURANCE AND DECISION

FINANCE REPORT

REPORT TO PUBLIC BOARD OF DIRECTORS ON 11 JULY 2024

1. EXECUTIVE SUMMARY

1.1 After technical changes the **May cumulative position is a £6.578m deficit.** This position is £0.294m better than the phased plan submitted to NHSE as part of the June plan resubmission.

1.2 The plan has been updated for the final June submission to include the latest Cost Improvement Programme (CIP) phasing and the improved position of identified CIP. This actual position in May is slightly better than the revised plan. Over achievement on income predominantly Elective Recovery Fund overperformance is offset by non-pay overspend relating to CIP underachieved against the phased CIP plan, drug overspends and a general non-pay increase against plan.

1.3 Performance against the Elective Recovery Fund continued to be positive in May. Early estimates for May activity show a predicted over performance of £1.507m against the assumed Elective Recovery Fund NHSE target. This is also £0.798m higher than the Trust internal plan which includes Elective Recovery Fund CIP schemes.

1.4 The May pay costs showed an underspend of £331k against plan. The majority of this relates to pay awards funded in the plan versus actual and accrued costs in the year-to-date position. Bank expenditure remains under plan, but the underspend has reduced in May to £0.332m compared to £0.411m reported for April. Agency usage remains very low with only medical staff being used in May.

1.5 Non pay spend continued to exceed the budget in May. This was partly attributable to ICB passthrough drugs within the block contract, general drugs, and other consumables plus a level of unidentified CIP.

1.6 The Trust financial forecast for the 2024/25 financial year remains in line with plan at a £32.565m deficit. Good progress has been made on the cost Improvement Programme with only £3.9m now remaining unidentified. The risk is now the delivery of the programme, especially the workforce related elements and cost pressures not included in the plan.

1.7 The Integrated Care System reported an actual aggregate £40.924m deficit for May. The System has reported the financial position against the original May plan which shows an overspend from plan of £4.284m. All providers have submitted revised plans in June which will contain revised phasing.

1.8 The System did not change the overall deficit plan for the final submission in June remaining at the £119.2m deficit. NHSE had previously set the System a control total of a £90m deficit for 2024/25. At the time of writing this report the System had not received formal notification from NHSE acknowledging the deficit of £119.2m in the final submission.

2. INCOME AND EXPENDITURE (APPENDIX 1)

2.1 After technical changes the **May cumulative position is a £6.578m deficit.** This position is £0.294m better than the phased plan submitted to NHSE as part of the June plan resubmission.

2.2 The Trust submitted a revised plan in June which didn't change the overall financial plan value of a £32.565m deficit but did update the phasing of the plan. The changes were predominantly around the phasing of the Cost Improvement Programme and the inclusion of an updated position on the Trusts

identified schemes and the timing of their planned delivery.

2.3 The actual position in May is slightly better than the revised plan. Over achievement on income predominantly Elective Recovery Fund overperformance is offset by non-pay overspend relating to Cost Improvement Programme underachieved against the phased Cost Improvement Programme plan, drug overspends and a general non-pay increase against plan.

2.4 Performance against the Elective Recovery Fund continued to be positive in May. Early estimates for May activity show a predicted over performance of £1.507m against the assumed Elective Recovery Fund NHSE target. This is also £0.798m higher than the Trust internal plan which includes Elective Recovery Fund CIP schemes.

2.5 Substantive staff are 17.45 Whole Time Equivalents (WTE) behind target in May (April 4.75 WTE better than target). Allowing for increased Deanery and externally funded posts reduces the shortfall to 8.20 WTE. Despite the adverse position, the finance position is £331k better than plan. This is largely due to pay awards funded in the plan versus actual and accrued costs in the year-to-date position.

2.6 Bank has increased in May and is over target by 27.52 Whole Time Equivalents (WTE) (April 44.83 WTE better than target). This is in line with expectations as the Trust was required to open 30 extra surge beds to cope with emergency pressures. Much of the increase related to Clinical Support Workers. There remains a cumulative saving of £0.332m but this has reduced from the £0.411m reported for April.

2.7 Agency usage remains very low with only medical staff being used in May. This equated to an improvement against the target of 4.10 WTE in May, resulting in a cumulative saving of £38k.

2.8 Non pay spend continued to exceed the budget in May. This was partly attributable to ICB passthrough drugs included in the block contract, general drugs, other consumables plus an amount of the Cost Improvement Programme that had not delivered against the plan.

3. CAPITAL AND CASH

3.1 The cash position at the end of May was £2.780m higher than the previous month's forecast. Receipts were £1.330m above the forecast position in May. Non-patient income receipts were £1.103m above forecast. This related to year end invoices being paid earlier than planned and receipt of the 2023/24 consultant pay award funding not included in forecast. Payments were £0.825m lower than the forecast in May. Payments to suppliers were £0.869m lower than forecast. This related to old invoices that were forecast to be paid in May that remain with disputes unresolved.

3.2 The cash forecast for the financial year remains as per plan after Month 2 (£2.964m). The plan and forecast assume £14m of revenue cash support from NHSE. This will commence in August following agreement with the ICB to pay an element of contract income a month in advance for July. The System will receive deficit revenue funding as in 2023/24 and this will remove the need to borrow cash. However, the timing of this is yet to be confirmed by NHSE. Cash downside modelling currently shows the Trust running out of cash in November, but this would mean additional revenue cash support would be required.

3.3 Compliance with the Better Practice Payment Code was 95.6% in terms of number of invoices paid to non-NHS suppliers and 93.4% for NHS suppliers as at 31st May 2024.

3.4 In month 2 there was capital expenditure of £1.341m against a planned spend of £1.341m. Work is on-going to review capital plans in all providers to ensure System remains within allocation. This will include a review of the Dudley ED scheme and how the funding is managed across the two financial years with the System.

4. INTEGRATED CARE SYSTEM (ICS) AND SYSTEM WORKING.

4.1 The Integrated Care System reported an actual aggregate £40.924m deficit for May. The System has reported the financial position against the original May plan which shows an overspend from plan of £4.284m. All providers have submitted revised plans in June which will contain revised phasing.

4.2 The System did not change the overall deficit plan for the final submission in June remaining at the £119.2m deficit. NHSE had previously set the System a control total of a £90m deficit for 2024/25. At the time of writing this report the System had not received formal notification from NHSE acknowledging the deficit of £119.2m in the final submission.

5. RECOMMENDATIONS

5.1 The Trust Board is asked to note the financial performance for the month of May 2024.

Chris Walker
Interim Director of Finance
27th June 2024

Enclosure 6

The Dudley Group NHS Foundation Trust

Paper for submission to the Trust Board of Directors on 11th July 2024.

Report title	CIP Update on the progress to date of the 2024/25 Programme
Sponsoring executive/ presenter	Adam Thomas – Chief Strategy and Digital Officer / Deputy CEO
Report author	Dara Bradbury – Senior Transformation Programme Lead

1. Suggested discussion points

- The committee is asked to note the status of the 2024/25 Cost Improvement Programme since our last report on 30th May 2024 and our progression in closing the unidentified gap.
- Reduced gap in unidentified CIP since last report – specific areas identified
- 84% of identified CIP is recurrent saving
- 57% of programme has now completed Quality Impact Assessment process
- Note schemes with high risk to delivery (table 5)
- Agreed at Exec and F&P that future CIP reporting will be streamlined and included in the financial report.

2. Alignment to our Vision

Deliver right care every time		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	

2. Report journey

Executive Directors on 18th June.
Financial Improvement Group on Thursday 20th June 2024.
Finance & Productivity Committee 27th June 2024.
Trust Board of Directors 11th July 2024

3. Recommendation

The Public Trust Board is asked to:

a. Note the current status of the Cost Improvement Programme, its identified and non-identified values including any risks identified.

4. Impact

Board Assurance Framework Risk 4.0	X	Remain financially sustainable in 2024/25 and beyond					
Corporate Risk Register	X	COR2166					
Equality Impact Assessment	Is this required?			N		If 'Y' date completed	
Quality Impact Assessment	Is this required?			Y		If 'Y' date completed	Per scheme

Report Title: Cost Improvement Programme Update

Report to: Trust Board of Directors

Report Date: 27th June 2024.

1. EXECUTIVE SUMMARY

1.1 The committee is asked to note the status of the 2024/25 Cost Improvement Programme since our last report on 30th May 2024 when we reported an identified savings value of £21.8m, of which £18.2m was recurrent.

1.2 The CIP Programme target currently remains at £31.9m and the Trust is therefore working towards a 5.2% expectation in line with the Financial Recovery Programme (FRP).

1.3 We can now report that £27.9m of savings has been identified of which £23.5m is recurrent in nature. This equates to 84% of the identified savings to date being recurrent. The unidentified programme gap has significantly reduced to £3.9m.

1.4 The largest values in additional savings have come from:

- £2.3m in PFI energy costs due to realignment of cost per unit/budget allocation
- A forecast overperformance of £2.6m in ERF from the Medicine and Integrated Care division
- The inclusion of £691k of CNST year 5 in the 2024/25 income for Surgery Women and Children's division
- Realignment of various activity within community worth c. £400k from Community with Core Clinical Services division.

1.5 If NHS England continues to advocate for a system deficit to be less than £120m then a potential for further distribution of system financial risk to providers exists. This would increase the currently unidentified CIP gap of c.£45.2m across the system to around £75m.

2. PROGRESS OF 2024/25 CIP PROGRAMME

2.1 A total of £27.9m has been identified to date. This consists of £15.5m of traditional CIP plus a potential £12.4m in workforce savings to meet the required 4% reduction in Pay. The Trust has identified 96 schemes of which 84% is recurrent. The unidentified gap in traditional CIP spread across the divisions as per table 1 below.

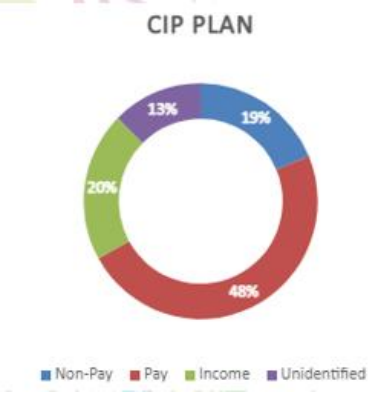
Table 1

2.2

DIVISIONAL PERFORMANCE v TARGET	£	£	£	£
	Target	Identified	(Of which is Recurrent)	Unidentified Gap
Corporate	£6,779,000	£5,438,936	£3,614,012	£1,252,386
Community & Core Clinical Services	£5,547,000	£3,731,000	£3,197,808	£1,815,990
Medicine	£9,862,000	£9,949,678	£8,958,436	£0
Surgery, Women & Children	£9,708,000	£8,778,602	£7,727,207	£929,398
Total	£31,896,000	£27,898,226	£23,497,463	£3,997,774

The Savings Category Split is shown in table 2 with most of the savings currently identified through savings in Pay budgets, generating 48% of the overall £27.98m value.

Table 2



Pay Non Pay Income split

Savings Categc	Plan Total	% of Plan
Non-Pay	£5,980,762	19%
Pay	£15,369,289	48%
Income	£6,548,175	21%
Unidentified	£3,997,774	13%
Total	**£31,896,000**	**100%**

2.3 The recurrent to non-recurrent split is shown in table 3 with 74% of the identified savings to date being recurrent in nature. That is £23.5m of the total £31.9m Programme (including the unidentified gap).

Table 3

Recurrent Non Recurrent split

R/NR	Plan Total	% of Plan
Recurrent	£23,497,463	74%
Non-Recurrent	£4,400,763	14%
Unidentified	£3,997,774	13%
Total	**£31,896,000**	**100%**

2.4 The identified CIP has been aligned against the PA Consulting Pillar categories as shown in table 4 with the most financial opportunity continuing to fall under Workforce.

Table 4

	Corporate Estates & Commercial	Operational and Clinical Productivity	Workforce	Share of System Wide Solutions	Unidentified (Yet to be categorised)
Corporate	26	0	0	0	0
CCCS	0	15	2	1	0
MIC	0	16	4	0	3
SWC	0	25	3	0	1
Number of Schemes	**26**	**56**	**9**	**1**	**4**
Total Value	**£5.439m**	**£8.066m**	**£13.183m**	**£0.583m**	**£0.627m**

3. RISKS TO THE 2024/25 CIP PROGRAMME

3.1 The currently identified programme has 4 Recurrent 'Pay and Establishment Review" related schemes which total £11.9m. These now require detail on plans for delivery and impact on workforce. Table 5 provides detail on the values.

Table 5

Reference	Description	R/NR	Scheme Type (NHSE)	Risk Rating	Plan Total
MIC-2425-039	4% Reduction in Actually Employed WTE in post|MIC	Recurrent	Pay - Establishment reviews	High	£4,339,364
CCS-2425-3MV	4% Reduction in Actually Employed WTE in post|CCS	Recurrent	Pay - Establishment reviews	High	£1,675,141
SWC-2425-4Pc	4% Reduction in Actually Employed WTE in post|SWC	Recurrent	Pay - Establishment reviews	High	£5,155,433
CRP-2425-014	4% Reduction in Actually Employed WTE in post|CRP	Recurrent	Pay - Establishment reviews	High	£731,062
					£11,901,000

4. QIA Approvals

4.1 A paper was presented to the Quality Committee on 28th May 2024 where assurance was provided that the QIA process was working in line with its Trust procedure.

4.2 We now have 55 schemes gone through the QIA process or 57% of the programme.

5. NEXT STEPS FOR GAP CLOSURE 2024/25 CIP PROGRAMME

5.1 Continued effort to be made across all divisions to reduce their existing unidentified CIP gap further through recurrent CIP where possible.

5.2 Workforce Workstream project meetings set up to bring additional grip and control to the following. Financial leads are part of the group and will support the identification of any savings:

- Sickness and Absence
- Rostering
- Bank
- Medical Bank and Extra Contractual

5.4 Continue work to identify themes and reduce DNAs, ensuring OPD clinic slots are utilised fully and increase the number of patients suitable for PIFU pathways.

6. RECOMMENDATION

6.1 The Board is asked to note the progress to date of the 2024/25 CIP programme and risks identified.

Enclosure 7

The Dudley Group NHS Foundation Trust

Paper for submission to the Board of Directors on 11th July 2024

Report title	Black Country Finance Undertakings
Sponsoring executive/ presenter	Chris Walker, Interim Director of Finance
Report author	Chris Walker, Interim Director of Finance

1. Suggested discussion points

The Trust Board received the draft undertakings proposed by NHS England at its meeting held on 11th April 2024. The Trust has subsequently reviewed the draft undertakings and responded to NHS England with comments and matters of accuracy. The Trust has now received the final agreed undertakings back from NHS England.

The undertakings fall under the following categories and the details of each one are stated on page 7 of the NHS England letter attached to this report:

- Financial Governance
  - Recovery Plan
  - Financial Controls
- Funding Conditions and Spending Approvals
- Programme Management
- Meetings and Reports

The Trust Board is requested to discuss these final agreed undertakings with the Trust Board formally accepting the undertakings. The Trust is then required to return a counter-signed copy to NHS England by 12th July 2024.

NHS England will then publish the undertakings on their website and agree a reactive media handling plan should there be any contact from media outlets or other stakeholders about the undertakings.

Oversight arrangements between NHS England and the system in 2024/25 are to be agreed with the Black Country ICB, including the oversight of the Trust's progress with these undertakings. Further confirmation is awaited from NHS England as to the process of how the Trust removes itself from the undertakings and the timescales involved.

2. Alignment to our Vision

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	

3. Report journey

April 2024 Private Board discussed the draft undertakings. June 2024 Executive Directors discussed the final agreed undertakings.

4. Recommendation(s)

The Public Trust Board is asked to:

a.	**Accept** the final agreed undertakings from NHS England.
b.	**Authorise** the Chair or Chief Executive to sign the undertakings.

5.	**Impact**							
Board Assurance Framework Risk 1.1	X	Deliver high quality, safe person centred care and treatment						
Board Assurance Framework Risk 1.2	X	Achieve outstanding CQC rating.						
Board Assurance Framework Risk 2.0	X	Address critical shortage of workforce capacity						
Board Assurance Framework Risk 3.0	X	Improve and sustain staff satisfaction and morale						
Board Assurance Framework Risk 4.0	X	Remain financially sustainable in 2023/24 and beyond						
Board Assurance Framework Risk 8.0	x	Establish, invest and sustain the infrastructures, applications and end-user devices for digital innovation						
Corporate Risk Register		*[Give risk Nos]*						
Equality Impact Assessment	Is this required?			N		If 'Y' date completed		
Quality Impact Assessment	Is this required?			N		If 'Y' date completed		

NHS England Midlands

Diane Wake - Chief Executive
Sir David Nicholson - Chair
The Dudley Group NHS Foundation Trust

Rebecca Farmer
Director of System Co-ordination and Oversight
West Midlands
Wellington House
133-155 Waterloo Road
London
SE1 8UG

T: 07703 695814
E: Rebecca.farmer14@nhs.net
W: www.england.nhs.uk

13 June 2024

Dear Diane and Sir David,

The Dudley Group NHS Foundation Trust: Enforcement Action under the Health and Social Care Act 2012

The Black Country system has faced significant challenges over the last 12 months to recover performance whilst balancing financial recovery and sustainability. Despite this, the system met key milestones by the end of 2023/24, such as reducing the cancer backlog to below the fair shares value, achieving over 75% for the Faster Diagnosis Standard, achieving over 76% for the Emergency Access Standard and significantly reducing the number of patients waiting over 13 weeks for a Diagnostic test. In addition, we recognise the progress that has been made through the System Operating Model work to set the strategic vision for the system, including developing new integrated models of care and in particular the significant work undertaken by the Trust regarding the Dudley Integrated Health and Care NHS Trust transaction.

However, the Trust and system overall remain an outlier for financial performance, with a £119m deficit forecast for 2024/25 and a system Financial Recovery Plan that does not forecast returning to a breakeven position until 2027/28. Whilst we do not underestimate the complexity of reducing the underlying financial deficit and recognise that difficult decisions balancing quality and safety with financial performance have already been made, we believe that further work is required across the system to improve financial governance and controls.

We previously notified you of our conclusion that the Trust should be allocated to segment 3 of the NHS Oversight Framework (NOF). As you will be aware, we have continued to monitor the position, considering the views and concerns of the Black Country Integrated Care Board (ICB) (which now has a key role in the oversight of providers), and the approach being taken elsewhere in the country.

NHS England Midlands has concluded that, given the scale of financial challenge within the system, it is important to place a common and consistent set of expectations on all key NHS partners in the ICS. As you are aware our regulatory mechanism to do this via agreement of undertakings[1].

[1] Where NHS England has reasonable grounds to suspect a potential failure or is concerned that a provider is at risk of failing to discharge its functions, NHS England may accept undertakings from that provider. By offering and agreeing undertakings, the Trust gives a commitment that it will comply and carry out the relevant actions.

Therefore, we had previously advised the system of this position and shared the proposed undertakings we are prepared to accept with the ICB and each provider. It is important to note that this approach is being replicated with all NOF 3 organisations in the Black Country system, except for Dudley Integrated Health and Care NHS Trust. As noted above, we have agreed this approach as a way of setting clear and consistent expectations for all parties on key improvement actions. This is in line with NHS England's approach to other providers and ICBs across the country where we have similar concerns and has been agreed through our regional governance.

Thank you for providing feedback on the proposed undertakings. We have amended these to reflect the reported position at Month 12 2023/24 and to correct any other factual accuracy points raised. A detailed response to your other comments is provided in Annex A. In Annex B, I now enclose a copy signed by NHS England which reflects these agreed amendments.

Next steps

We expect that the Trust will discuss these final agreed undertakings with the Trust Board as soon as is practically possible. You should then return a counter-signed copy to Katrina Boffey. If you foresee any difficulty with achieving this **by 12 July** you should let us know so we can review and consider if an extension to this deadline is appropriate.

We will then publish the undertakings on our website and can agree a reactive media handling plan should there be any contact from media outlets or other stakeholders about the undertakings.

We are in discussion with Black Country ICB to agree oversight arrangements between NHS England and the system in 2024/25, including the oversight of the Trust's progress with these undertakings. We have agreed the principle that existing oversight arrangements will be utilised, to allow organisations to focus on the improvements outlined in the undertakings, as far as possible.

If you have any questions in relation to the matters set out in this letter, please contact either me or Katrina Boffey.

Yours sincerely,

Rebecca Farmer
Director of System Co-ordination and Oversight, West Midlands

cc. Mark Axcell – Chief Executive
Tom Jackson – Chief Finance Officer
Black Country ICB

Katrina Boffey, John Bailey
NHS England - Midlands

NHS England Midlands

ANNEX A
Response to feedback received from The Dudley Group NHS Foundation Trust

Feedback received	NHS England response
Feedback is not balanced and doesn't reflect that Trust has achieved financial targets in 22/23 and 23/24 in the context of strong operational delivery.	For the purposes of the legal undertakings documents, broader context is not permissible or appropriate. However, this has been recognised in this covering letter to the trust.
Section 1.2.1 Realistically this means we need to have all CIP recurrent from day 1. Whilst there is a fundamental issue with feasibility to meet this requirement in full, the Trust has defined plans to transition to recurrent measures to lead into the 24/25 FY.	The same wording has been applied across all undertakings and is consistent with the requirements set for other organisations with financial undertakings.
Section 2.2.2 This should read: "Work to review the underlying financial position of the Black Country system and individual providers was completed in January 2024. As part of this exercise the Licensee reported a £53.2m underlying deficit in line with the medium risk scenario accepted by the Black Country system."	The lowest risk scenario (including the impact of MMUH) was included across all undertakings in the Black Country for consistency, so will not be amended.
Section 2.2.3 This section is not a fair and reasonable comment and needs to be challenged. The Trust has overachieved on its CIP plans for 2023/24 and improved its financial position 'net' from the agreed plan. There needs to be recognition of the DIHC transaction and safe landing process that is being proactively managed in addressing historical challenges in integrated models of care that is not a reflective position. The second paragraph needs updating to the latest position which would read "*The Licensee at month 11 was forecasting to deliver £26.995m of efficiencies, £762 above their plan. 67% of the CIP is on a recurrent basis*." The final paragraph is also not a fair and reasonable statement given that we have 2/3rds of the CIP now recurrent. "This failure to deliver recurrent efficiency savings gives NHS England reasonable grounds to suspect the Licensee has breached its duty to operate efficiently, economically and effectively (NHS2(5)) and to, when making decisions in relation to its functions, have regard to likely effects in relation to the sustainable and efficient use of resources by NHS bodies (WS2(4)(c))."	The numerical values included in the undertakings were accurate at the time of writing, however have now been updated in line with the Month 12 position across all organisations. This includes an updated position on CIP recurrency. For the purposes of the legal undertakings documents, broader context is not permissible or appropriate. We have recognised the work progressed in 2023/24 to develop future integrated models of care and the significant work regarding DIHC in the covering letter to the undertakings.
Section 2.3 There are two issues – the first is an assertion that the above unreasonable statements are fact and the second relates to the management of material risks over the period defined around compliance with our general	We recognise the importance of making decisions in line with the triple aim. However, the grounds for the undertakings on financial

duties and CQC regulation. As we found yesterday in the review of the main areas of growth, they were where there were substantial safety concerns and pursuant of national guidance (such as CNST). The general duties of the license include the triple aim – but the statement choose to take that view that only 1 part of the triple is valid when dealing with material risks.	governance is the reason for the focus on finances in this instance.

ANNEX B

ENFORCEMENT UNDERTAKINGS

LICENSEE

The Dudley Group NHS Foundation Trust
Trust Headquarters,
Russells Hall Hospital,
Dudley,
West Midlands,
DY1 2HQ

DECISION

NHS England, on the basis of the grounds set out below, and having regard to its Enforcement Guidance, has decided to accept from the Licensee the enforcement undertakings specified below pursuant to its powers under section 106 of the Health and Social Care Act 2012 ("the Act").

BACKGROUND

Given the grounds set out below are linked to the broader management of financial risk across the system, NHS England has also decided to accept undertakings from the Black Country Integrated Care Board (ICB), pursuant to its powers under the National Health Service Act 2006 as amended (NHS Act 2006), and several individual NHS Trusts and Foundation Trusts across the Black Country system.

These provider specific undertakings are intended to support the delivery of system undertakings.

GROUNDS

1. Licence

1.1. The Licensee is the holder of a licence granted under section 87 of the Act.

BREACHES

2. Financial governance

2.1. NHS England has reasonable grounds to suspect that the Licensee has provided and is providing healthcare services for the purposes of the NHS in breach of the following conditions of its licence:

2.1.1. The Licensee shall establish and effectively implement systems and/or processes (NHS2(5)):

2.1.1.1. to ensure compliance with the Licensee's duty to operate efficiently, economically and effectively (NHS2(5)(a)).

2.1.2. When making decisions in the exercise of its functions which relate to the provision of health care for the purposes of the NHS, the Licensee shall comply with its duty relating to the triple aim (WS2), including:

2.1.2.1. more sustainable and efficient use of resources by NHS bodies (WS2(4)(c))

2.2. In particular:

2.2.1. In May 2023, the ICB submitted a 2023/24 ICS financial plan with a deficit of £68.801m, which it deemed to be achievable. This deficit is a significant forecast overspend when compared to other systems across the Midlands and nationally.

In December 2023 as part of the H2 planning process, the ICB submitted a revised ICS deficit position for 2023/24 of £90.01m.

The 2023/24 outturn for performance measurement purposes of the ICS (ICB and Partner Trusts) was a £90.0m deficit. Following the national technical adjustment to fund the plan deficit, the outturn for annual accounts purposes was a £21.2m deficit.

2.2.2. The Licensee delivered a £16.8m deficit in 2023/24, for financial performance purposes, which was an improvement of £2.4m on the H2 plan (£19.2m).

2.2.3. Work to review the underlying financial position of the Black Country system and individual providers was completed in January 2024. As part of this exercise the Licensee reported a £59.6m underlying deficit (in the lowest risk scenario, including the impact of Midland Metropolitan University Hospital (MMUH)).

2.2.4. Although external support has been procured by the ICB and progressed in-year to develop schemes that will deliver recurrent efficiency savings for the system, these are not due to begin implementation until 2024/25.

The Licensee at month 12 had delivered £27m of efficiencies, £0.8m above their plan, but only 51% on a recurrent basis.

This failure to deliver recurrent efficiency savings gives NHS England reasonable grounds to suspect the Licensee has breached its duty to operate efficiently, economically and effectively (NHS2(5)) and to, when making decisions in relation to its functions, have regard to likely effects in relation to the sustainable and efficient use of resources by NHS bodies (WS2(4)(c)).

2.2.5. There has been a significant growth in workforce since 2019/20, with an increase of 16.5% from month 12 2019/20 to month 12 2023/24. The Licensee has delivered the workforce plan in 2023/24, ending month 12 31 WTE (0.5%) below plan. However, the trend level of growth is not financially affordable and has not been subject to sufficient scrutiny by the Licensee ahead of mandated controls being placed on the Licensee by NHS England.

This gives NHS England reasonable grounds to suspect the Licensee has

breached its duty to operate efficiently, economically and effectively (NHS2(5)) and to deliver more sustainable and efficient use of resources by NHS bodies (WS2(4)(c)).

2.3. These failings by the Licensee demonstrate a failure of financial governance arrangements including, in particular, a failure to establish and effectively implement systems or processes to identify and manage material risks to compliance with the Licensee's general duties.

2.4. Need for action

NHS England believes that the action, which the Licensee has undertaken to take pursuant to these undertakings, is action to secure that the breaches in question do not continue or recur.

3. Appropriateness of Undertaking

In considering the appropriateness of accepting in this case the undertakings set out below, NHS England has taken into account the matters set out in its Enforcement Guidance.

UNDERTAKINGS

NHS England has agreed to accept, and the Licensee has agreed to give the following undertakings, pursuant to section 106 of the Act:

1. Financial governance

1.1. Recovery Plan

1.1.1. The Licensee will work with its partner NHS Trusts, NHS Foundation Trusts (system Trusts) and ICB to develop a single ICS Recovery Plan that brings together the ICB, provider and additional system wide recovery initiatives. The plan should:

1.1.1.1. Reflect NHS England planning guidance for 2024/25;

1.1.1.2. Demonstrate recurrent financial improvement to the Licensee and ICS underlying deficit, reduce the Licensee and ICS monthly deficit run-rate, preserve cash and minimise the deficit;

1.1.1.3. Provide a high-level milestone plan to address the key financial issues (including actions to deliver efficiency plans) for the ICB and system Trusts to return to a breakeven financial position in accordance with timeframes agreed with NHS England;

1.1.1.4. Establish immediate financial and operational grip and control actions, followed by transformational initiatives and options such as financially sustainable clinical services, clinical support services and corporate services;

1.1.1.5. Include details of how the ICB and system Trusts will deploy sufficient resources to ensure implementation of the Recovery Plan;

1.1.1.6. Provide a description of systems and processes the system will use to gain assurance on the delivery of the Recovery Plan and with governance arrangements for approval and delivery of the Recovery Plan.

1.1.2. When developing the plan, the Licensee will, working with the ICB and other system Trusts, engage effectively with key stakeholders, including commissioners, and will reflect their views appropriately in the Plan.

1.1.3. The Licensee will, working with the ICB and other system Trusts, ensure the system demonstrates to NHS England a period of successful implementation of the Recovery Plan and assurance of continued focus, capability and capacity to sustainably maintain financial recovery and deliver the Recovery Plan.

1.1.4. The board of the Licensee will, working with the ICB and the boards of the other system Trusts, keep the Recovery Plan under continuous review and will update it as required. Any proposed updates will be subject to the review and approval by NHS England.

1.2. Financial Controls

1.2.1. The Licensee commits to recurrent delivery of efficiency schemes from quarter 1 to achieve a full year effect in 2024/25 to compensate for any non-recurrent measures required to achieve the 2023/24 plans.

1.2.2. The Licensee will fully engage in national pay and non-pay savings initiatives, in particular around national agreements for medicines and other non-pay purchasing.

1.2.3. The Licensee will monitor agency usage and compliance with usage and rate limits.

1.2.4. Any Licensee revenue consultancy spend above £50,000 and non-clinical agency usage continues to require prior approval from the NHS England regional team based on the agreed regional process.

1.2.5. The Licensee must have robust financial controls and processes and reporting must be in place and overseen through appropriate financial governance procedures and a track record of identifying and addressing financial issues when they arise.

1.2.6. The Licensee must be able to demonstrate internal capabilities around finance resource management (grip and control).

2. Funding conditions and spending approvals

2.1. Where interim support financing or planned term support financing is provided by the Secretary of State for Health to the Licensee pursuant to section 40 of

the NHS Act 2006, the Licensee will comply with any terms and conditions which attach to the financing.

2.2. The Licensee will comply with any reporting requests made by NHS England in relation to any financing to be provided to the Licensee by the Secretary of State for Health pursuant to section 40 of the NHS Act 2006.

2.3. The Licensee will comply with any spending approvals processes that are deemed necessary by NHS England.

3. Programme management

3.1. The Licensee will, with the ICB and system Trusts, implement sufficient programme management and governance arrangements to enable delivery of these undertakings. Such programme management and governance arrangements must enable the board to:

3.1.1. obtain clear oversight over the process in delivering these undertakings;

3.1.2. obtain an understanding of the risks to the successful achievement of the undertakings and ensure appropriate mitigation; and

3.1.3. hold individuals to account for the delivery of the undertakings.

4. Meetings and reports

4.1. In conjunction with the ICB and system Trusts, the Licensee will provide quarterly reports to NHS England on its progress in complying with the undertakings set out above.

4.2. The Licensee will attend meetings or, if NHS England stipulates, conference calls, at such times and places, and with such attendees, as may be required by NHS England. These meetings will take place once a month unless NHS England otherwise stipulates, at a time and place to be specified by NHS England and with attendees specified by NHS England.

4.3. Upon request, the Licensee (in conjunction with the ICB and system Trusts) will provide NHS England with the evidence, reports or other information relied on by its Board in relation to assessing its progress in delivering these undertakings.

4.4. The Licensee will comply with any additional reporting or information requests made by NHS England.

The undertakings set out above are without prejudice to the requirement on the Licensee to ensure that it is compliant with all the conditions of its licence, including any additional licence condition imposed under section 111 of the Act and those conditions relating to:

- compliance with the health care standards binding on the Licensee; and
- compliance with all requirements concerning quality of care.

Any failure to comply with the above undertakings will render the Licensee liable to further formal action by NHS England. This could include the imposition of discretionary requirements under section 105 of the Act in respect of the breach in respect of which the undertakings were given and/or revocation of the licence pursuant to section 89 of the Act.

Where NHS England is satisfied that the Licensee has given inaccurate, misleading or incomplete information in relation to the undertakings: (i) NHS England may treat the Licensee as having failed to comply with the undertakings; and (ii) if NHS England decides so to treat the Licensee, NHS England must by notice revoke any compliance certificate given to the Licensee in respect of compliance with the relevant undertakings.

LICENSEE

Signed

Name:

Chair / Chief Executive of Licensee, The Dudley Group NHS Foundation Trust

Dated:

NHS ENGLAND

Signed

Name: Rebecca Farmer

Director of System Co-ordination and Oversight (West Midlands) and member of the Regional Support Group (Midlands)

Dated: 13 June 2024

Enclosure 8

The Dudley Group NHS Foundation Trust

Paper for submission to Board of Directors July 2024

Report title	Integrated Performance Report for May 2024
Sponsoring executive	Karen Kelly, Chief Operating Officer
Report author	Jack Richards, Director of Operations - Surgery, Women and Childrens. Amandeep Tung-Nahal, Director of Operations - Community with Core Clinical Services. Rory McMahon, Director of Operations - Medicine and Integrated Care.

1. Suggested discussion points

This report summarises the Trust's performance against the national standards and local recovery plans for the month of May 2024 (April 2024 for Cancer and VTE).

The Committee is asked to note performance and next steps against the below national standards.

Emergency Performance

In May ED 4 hour performance increased to 81.2%, meaning the trust exceeded the 78% target mandated for April. This is the highest performance in a year.

On going focus on:

- GP letter patients straight to SDEC/Surgical SDEC.
- Agree new streaming template with UCC for patients with letters to go direct to Speciality.
- Re-run of heat mapping exercise for nurses and medics in ED.
- Joint working with Surgery to ensure proactivity to take patients from ED even when full.
- Organizational agreement that specialties must take patients directly and not wait to assess them in ED.
- Extra Validation resource.

Cancer Performance

The 28 day Faster Diagnostic Standard (FDS) achieved 78.3% (April 24 validated) against the constitutional standard of 75%. NHSE have revised this target to 77% by March 2025.

31-day combined decision to treat performance achieved 91.6% in April against the national target of 96%. This is mainly driven by surgical capacity.

Performance against the 62 Day combined target achieved 71.9% in April against the national target of 85%. NHSE have revised this target to 70% by March 2025.

DM01 Performance

May's DM01 performance achieved 88.38%. Diagnostic wait trajectories for each modality have been submitted to ICB to deliver 95% NHSE target by end of March 2025.

Clinical Hub Performance

April Urgent Community Response (UCR) performance reported was 89% against a target of 70%.

Elective Restoration & Recovery

National focus remains on reducing long waits to routine treatment. The focus is now moving away from 78 weeks and towards 65 weeks, though the target for this was March 2024 this has nationally been stretched to the end of Q1 due to the impact of industrial action earlier in the last financial year not allowing the required number of patients to be treated.

There were zero 78 week breaches in the month of May, and the Trust is on track to deliver this again in the month of June. July looks to be a challenging month and the impact of the industrial action at the beginning of July is unlikely to be completely mitigated meaning further catch up work over the remainder of the month.

Our June position for patients treated within 65 weeks has deteriorated slightly, but this is as a result of the upcoming industrial action and the need to prioritise patients waiting 78 weeks in addition to ensuring that the urgent and cancer patients are treated as a priority.

Particular recognition goes to Gynaecology who have ensured that all of their patients have now been offered an appointment if waiting over 65 weeks, this is a significant improvement on their position last month.

The full data pack associated with this report is located in the further reading room.

2. Alignment to our Vision

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	

3. Report journey

The Integrated Performance Report will be going to the Board of Directors July 2024.

4. Recommendation

The Public Board of Directors is asked to:

a. Receive the report as assurance of Trust performance

5. Impact

Board Assurance Framework Risk 1.1	X	Deliver high quality, safe person centred care and treatment
Board Assurance Framework Risk 1.2	X	Achieve outstanding CQC rating.
Board Assurance Framework Risk 6.0	X	Deliver on its ambition to building innovative partnerships in Dudley and beyond
Board Assurance Framework Risk 7.0	X	Achieve operational performance requirements
Corporate Risk Register	X	BAF 1b - Failure to meet access standards caused by inability to improve patient flow and work effectively with local partners will result in an adverse outcome for the patient. Risk Score: 15

Equality Impact Assessment	Is this required?	Y		N	x	If 'Y' date completed	
Quality Impact Assessment	Is this required?	Y		N	x	If 'Y' date completed	

Summary: Key Areas of Concern

ED Triage
May Overall Triage position 80.57% vs 95% national target.

Triage nurses are now in post within minors to improve triage performance and waiting times. We have since seen an improvement in triage performance within See and Treat.

Ambulance Handover
There has been a decrease in performance in ambulance handover for both >30 mins and handovers >60mins. This contributes to the trust been over prediction for ambulance arrivals on multiple days in May along with acuity of patients. 22 out of the 31 days we have seen >300 patients attend ED. 7 out of those 22 days ED saw >240 patients. May saw an >6% increase in attendance numbers compared to April. May has also seen the highest number of attendances when compared to the last 12 months.

In terms of capacity the trust continues to be impacted by medically optimised for discharge patients, which is further exacerbating flow issues and leading to pressure at both the front and back door.

Cancer (Data to March)
Since October 2023 National Cancer Constitutional standards now monitor against 28 day Faster Diagnostic Standard (FDS), 31-day combined decision to treat, and 62 days combined referral to treatment. NHSE have revised the new March 2025 targets for the 28-day FDS and 62-day to change to 77% and 70% respectively.

The 28 day Faster Diagnostic Standards (FDS) achieved 78.3% (April 24 validated) against the constitutional standard of 75%.

31-day combined decision to treat performance achieved 91.6% in April against the national target of 96%. This is mainly driven by surgical capacity.

Performance against the 62 Day combined target achieved 71.9% in April against the national target of 85%. NHSE have revised this target to 70% by March 2025.

There is also robust monitoring of patients over 104 days, reported externally for any potential harm reviews. The total number of patients over 104 days is at 26 of these 10 have treatment plans. Several of the patients waiting over 104 days are late tertiary referrals or patient comorbidities.

DM01
May's DM01 performance achieved 88.38%

Both Cardiology and Endoscopy are performing well and achieved 94.67% and 96.56%, respectively. MRI has seen an improvement from 87.59% last month to 91.12% in May. CT and Dexa continue to exceed 90%.

NOUS has seen an increase in 6 week breaches. Reduced staffing impacted performance and recruitment is now underway. ENT has the largest backlog and additional specialist capacity has been identified to support. Further expansion of CDC during July 2024. System mutual aid continues to be offered to SWBH and will be regularly reviewed.

Sleep studies achieved 58.45% for May and is an area of focus. Equipment issues have impacted on performance and the team are working through options to address this.

13-week diagnostic breaches and route to zero are monitored weekly by NHSE. Areas of focus for further reduction are NOUS and MRI with plan to clear 13 week waits by August and September respectively.

Elective Restoration & Recovery

National focus remains on reducing long waits to routine treatment. The focus is now moving away from 78 weeks and towards 65 weeks, though the target for this was March 2024 this has nationally been stretched to the end of Q1 due to the impact of industrial action earlier in the last financial year not allowing the required number of patients to be treated.

Elective Recovery Programme Performance Report – Regional Midlands 14.06.24

Black Country ICB Performance Summary – Completed Pathways to 09.06.24

Elective Recovery | Performance Summary

Activity Metrics

Region	Value Weighted Activity 05-May-24		Completed Pathways 09-Jun-24	
MIDLANDS	107.5%	▲	128.9%	▲
BIRMINGHAM AND SOLIHULL ICB	107.7%	▲	143.1%	▲
BLACK COUNTRY ICB	112.1%	▲	112.1%	▲
COVENTRY AND WARWICKSHIRE ICB	108.2%	▲	123.4%	▼
DERBY AND DERBYSHIRE ICB	109.8%	▲	119.9%	▼
HEREFORDSHIRE AND WORCESTERSHIRE ICB	99.4%	▲	136.6%	▲
LEICESTER, LEICESTERSHIRE AND RUTLAND ICB	107.1%	▲	142.5%	▲
LINCOLNSHIRE ICB	98.6%	▼	109.6%	▲
NORTHAMPTONSHIRE ICB	107.1%	▼	152.7%	▲
NOTTINGHAM AND NOTTINGHAMSHIRE ICB	120.1%	▲	119.9%	▼
SHROPSHIRE, TELFORD AND WREKIN ICB	85.0%	▼	192.8%	▼
STAFFORDSHIRE AND STOKE-ON-TRENT ICB	102.7%	▲	108.5%	▲

Published Performance Figures

Region	RTT		Cancer Activity		FDS		DM01	
	Latest Published Data April 24							
MIDLANDS	55.6%	▲	61.3%	▶	74.9%	▼	26.2%	▲
BIRMINGHAM AND SOLIHULL ICB	52.3%	▲	55.5%	▼	75.4%	▼	31.3%	▼
BLACK COUNTRY ICB	55.4%	▲	60.2%	▼	77.9%	▼	25.9%	▼
COVENTRY AND WARWICKSHIRE ICB	56.6%	▲	61.1%	▲	69.4%	▼	17.2%	▲
DERBY AND DERBYSHIRE ICB	56.1%	▲	64.4%	▼	71.8%	▼	28.0%	▲
HEREFORDSHIRE AND WORCESTERSHIRE ICB	55.7%	▲	63.1%	▲	74.9%	▼	25.8%	▲
LEICESTER, LEICESTERSHIRE AND RUTLAND ICB	57.8%	▲	57.5%	▲	77.7%	▼	25.7%	▲
LINCOLNSHIRE ICB	52.7%	▲	64.2%	▲	73.9%	▼	28.5%	▲
NORTHAMPTONSHIRE ICB	62.0%	▲	60.9%	▼	82.3%	▼	15.6%	▼
NOTTINGHAM AND NOTTINGHAMSHIRE ICB	57.5%	▼	64.1%	▲	77.1%	▼	31.2%	▲
SHROPSHIRE, TELFORD AND WREKIN ICB	51.9%	▲	58.5%	▼	74.5%	▼	26.9%	▲
STAFFORDSHIRE AND STOKE-ON-TRENT ICB	55.9%	▲	68.1%	▲	72.1%	▼	26.8%	▲

Waiting List Metrics

	104+		78w+		65w+		>49ww Cohort (Sep 2024 65ww)		52w+		Total List		<18ww performance	
Region	w-e 09 Jun 24 (un-published)													
MIDLANDS	8	▼	229	▲	8,231	▲	75,281	▼	53,346	▼	1,276,394	▲	54.7%	▲
BIRMINGHAM AND SOLIHULL ICB	0	▶	0	▶	432	▲	11,882	▼	7,843	▼	165,734	▼	50.0%	▼
BLACK COUNTRY ICB	1	▶	31	▲	1,163	▼	13,264	▼	8,840	▼	246,959	▲	54.9%	▲
COVENTRY AND WARWICKSHIRE ICB	0	▼	27	▼	559	▲	5,554	▼	3,805	▲	119,456	▲	55.4%	▲
DERBY AND DERBYSHIRE ICB	0	▶	51	▲	1,412	▶	9,216	▼	6,638	▶	137,286	▲	53.2%	▲
HEREFORDSHIRE AND WORCESTERSHIRE ICB	1	▶	26	▲	608	▼	4,366	▼	3,274	▼	86,471	▲	53.9%	▲
LEICESTER, LEICESTERSHIRE AND RUTLAND ICB	0	▶	10	▲	200	▼	3,553	▼	2,355	▲	108,885	▲	59.0%	▼
LINCOLNSHIRE ICB	0	▶	4	▶	412	▲	4,805	▼	3,527	▼	72,083	▲	50.4%	▲
NORTHAMPTONSHIRE ICB	0	▶	7	▲	322	▲	2,666	▼	1,857	▲	71,181	▼	64.1%	▲
NOTTINGHAM AND NOTTINGHAMSHIRE ICB	0	▶	8	▲	582	▼	6,936	▼	4,937	▲	127,595	▼	58.6%	▼
SHROPSHIRE, TELFORD AND WREKIN ICB	0	▼	23	▲	1,248	▲	6,389	▼	4,902	▲	62,420	▲	51.2%	▼
STAFFORDSHIRE AND STOKE-ON-TRENT ICB	6	▼	42	▼	1,293	▲	6,648	▼	5,368	▼	78,324	▼	52.5%	▲

Elective Recovery | Recovery and Performance

Source: Faster SUS / RTT Monthly / WLMDS / Weekly Cancer PTL

3

*VWA is calculated using the new methodology in place for 2023/24. Weekly data excluded Outpatient Follow Up activity.

The trust continues to drive the GIRFT Further Faster Programme, as well as, Specialty GIRFT Meetings since July 2023, with key priorities delivering on Outpatients Pre-Appointments / Reducing and managing DNAs / Remote Appointments / Outpatient throughput / Patient Initiative Follow Ups across 17 core outpatient services. Improving Pathways through:- Diagnostics / Surgical Pathways / Theatres.

Enclosure 9

The Dudley Group NHS Foundation Trust

Paper for submission to the Board of Directors on 11th July 2024

Report title	Quality Committee 28th May, 24th and 25th June and 4th July: Chair's Report.
Sponsoring non-executive / presenter	Professor Liz Hughes
Report author	Amanda Vaughan, PA to Corporate Nursing team Martina Morris, Chief Nurse

1. Suggested discussion points

This paper outlines the key points of assurance and escalation form the Quality Committee meetings that took place on 28th May, 24th & 25th June and 4th July 2024. The report details work commissioned as result of discussions held and any decisions made.

To highlight, there were the following concerns raised related to:

- Level 3 Children Safeguarding training compliance.
- Staffing challenges within the Tissue Viability Service.
- Maternity Incentive Scheme Year 2 resubmission of additional information.
- Digital related matters, which featured as a theme in the annual reports.
- Maternity workforce paper highlighting the current budgeted midwifery establishment gap, which requires rectification to avoid the risk of MIS year 6 non-compliance and wider regulatory impact.

2. Alignment to our Vision

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	

2. Report journey

Quality Committee 28/05/2024, 24/06/2024, 25/06/2024 and 04/07/2024.

3. Recommendation(s)

The Public Trust Board is asked to:

a. Note the assurances provided by the Committee, the matters for escalation and the decisions made by the Committee.

4. Impact

Board Assurance Framework Risk 1.1	X	Deliver high quality, safe person-centred care and treatment					
Board Assurance Framework Risk 1.2	X	Achieve outstanding CQC rating.					
Corporate Risk Register							
Equality Impact Assessment	Is this required?	N		N		If 'Y' date completed	
Quality Impact Assessment	Is this required?	N		N		If 'Y' date completed	

UPWARD REPORT FROM THE QUALITY COMMITTEE Date Committee last met: 28 May 2024

MATTERS OF CONCERN OR KEY RISKS TO ESCALATE	MAJOR ACTIONS COMMISSIONED/WORK UNDERWAY
• Ongoing concerns relating to the assurance of Level 3 Children Safeguarding training compliance. An update has been requested for the June 2024 Quality Committee. • Staffing challenges within the Tissue Viability Service continue. Discussions are taking place with the ICB around support for community areas. • Maternity Incentive Scheme Year 2 resubmission of additional information.	• None identified.
POSITIVE ASSURANCES TO PROVIDE	**DECISIONS MADE**
• Excellent assurance received from an unannounced mortuary inspection. Verbal feedback received that the mortuary had an excellent cohesive team and patients were well cared for. The team were commended for their good practice and inspectors were keen to share the patient passport with other organisations as an exemplary document. • Assurance was provided that SHMI and HMSR reductions had been sustained. • Improved position on procedural documents overdue review within the Surgery, Women and Children, Community and Core Clinical Services Divisions was noted. • The Committee discussed the impact of opening of MMUH, the options for packages of care and mitigations. • Assurance was received that the workforce headcount reduction and effect on performance indicators M1 position was under plan (trajectory ceiling) in relation to Bank and agency staff. • Good assurance was received around complaints responsiveness improvement and better signposting to appropriate responsive options e.g. PALS. Appreciation was given to the commitment of staff to make improvements. • Research and Innovation were commended for winning West Midlands Network award.	• The assurance level for BAF Risk 1.1 remains as inconclusive. • The assurance level for BAF Risk 1.2 remains as positive. • The Committee reviewed, discussed, and approved the following reports. ○ Provision of PEP Policy approved.

UPWARD REPORT FROM THE QUALITY COMMITTEE Date Committee last met: 24th and 25th June and 4th July 2024

MATTERS OF CONCERN OR KEY RISKS TO ESCALATE	MAJOR ACTIONS COMMISSIONED/WORK UNDERWAY
25th June meeting: • No additional concerns identified to those that have been previously escalated such as the outstanding Responsible Clinician contract and MHA administrator contract. 24th June meeting (annual reports presentations): • Neonates EPR, the lack of space and issues this is causing and the suggestion to relocate PAU & Paediatrics ED to improve patient journey. • The CAHMS service which has seen a 40% reduction in admissions and look at preventing the funding being discontinued. • Supporting the implementation of digital medicines cabinets. • All groups have brought to the committee's attention the improvements that could be achieved with the correct digital systems and support across the organisation.	• An extraordinary meeting was conducted on 4th July 2024, to review the Maternity workforce paper. The key points of note include: ○ Current budgeted midwifery establishment is below the BR+ recommended levels due to the previously temporary funded roles coming to an end. ○ The Maternity unit is over established with Registered Midwives at the current time which is ensuring that quality and safety is maintained. ○ A business case will be developed for consideration to rectify the funding gap and avoid the risk of MIS year 6 non-compliance and wider regulatory impact.
POSITIVE ASSURANCES TO PROVIDE	**DECISIONS MADE**
• Level 3 Safeguarding for Adults training was above 90% for the first time. Level 3 Children Safeguarding training was at 85% and has an improvement plan in place. • Award achieved by the Complex Nutrition Team for the virtual ward. • Stroke SSNAP performance has shown improvement. • VTE performance had been above 90% for 12 months on the first VTE assessment. Work remains in progress on the second VTE assessment. • Improvement in the perinatal data with neonatal death rates now at 1.67 with the national benchmark being 1.65. This is the lowest the rate has been for over the last 12 months. • Good assurance around R&I report. Board and external R&D governance. • A variety of annual reports were received, providing assurance on the wide breath of work and achievements during 2023/24, including risks, mitigations and priorities for 2024/25.	• The assurance level for BAF Risk 1.1 remains as inconclusive. • The assurance level for BAF Risk 1.2 remains as positive. • The Committee reviewed, discussed, and approved the following documents: ○ Terms of Reference - Risk & Assurance Group ○ Terms of Reference - Quality Committee ○ Terms of Reference - Patient Experience Group ○ Terms of Reference - Mortality Surveillance Group ○ Terms of Reference - Quality & Safety Group ○ Terms of Reference - Internal Safeguarding Group ○ Terms of Reference – Maternity Safety Champions Group • The following Terms of reference were not approved: ○ Terms of Reference Health, Safety & Fire Assurance Group – not approved, amendments requested and to be brought back to July's meeting. ○ Terms of Reference End-of-Life Working Group – not approved, amendments requested and to be brought back to July's meeting.

Enclosure 10

The Dudley Group NHS Foundation Trust

Paper for submission to Trust Board on 11th July 2024

Report Title	Chief Nurse and Medical Director's Report.
Sponsoring Executive / presenters	Martina Morris, Chief Nurse and Dr Julian Hobbs, Medical Director
Report Author	Jo Wakeman, Deputy Chief Nurse in collaboration with Specialty Leads.

1. Suggested discussion points

This report provides an overview of key quality, safety and professional matters from a multiprofessional perspective, to demonstrate how multiprofessional teams work collaboratively to positively influence everyday practice and focus on improving quality outcomes and patient experience.

Assure

- Reduction in SHMI (99.7) and HSMR (84.95) has been sustained.
- Staff training for Safer Staffing reviews has commenced. Inpatient adult wards, Adult Acute Assessment Units, Children and Young Person inpatients and Emergency Department commenced data collection on 1st June 2024. The Trust is utilising the licensed national acuity tools for these reviews and will mirror the approach to safer staffing reviews across the Integrated Care System and nationally. An overarching improvement plan has been developed to assist the Trust being fully compliant with safer staffing guidance and workforce safeguards.
- Back to the Floor of our Senior Nurses and AHPs continues, with positive feedback received from our clinical teams.
- Saving Lives 1: Ventilator associated pneumonia audit. Cuff pressures were not being recorded as expected. Latest audit shows a 100% compliance for the second month running.
- 89% of our consultant job plans have been signed off in May 2024. AHP job planning continues.
- The Complex Nutrition Team are undertaking three research studies and have conducted a small research study which has been accepted by The European Society for Clinical Nutrition and Metabolism. The team are also applying for a HSJ award in June 2024 as the first Complex Nutrition virtual ward in the country. The service now runs 7 days with 95% of patients within 24 hours of referral.
- Work towards the University Hospital Status continues with medical students from Three Counties Medical School joining the Trust in May 2024.
- Five key workstreams have taken place in May 2024 to improve our infection control practices: gloves awareness, bare below the elbows, surgical site surveillance knees and caesarean sections, and commode cleaning.

Advise

- The Infection Prevention and Control Board Assurance Framework is enclosed for information as Appendix 1 to demonstrate The Trust's current position. The Trust is compliant with all the requirement apart from 3, with mitigations in place.
- Supervision for community midwives is challenging with compliance achieving 80%, an increase on the previous month.
- The Quality Dashboard outlines findings from Matron and Lead Nurse audits, highlighting areas for improvement. Key themes indicate poor documentation and the findings have been shared with the Divisional teams for action.
- There were 3 Section 42 enquiries against the Trust during May 2024, relating to 1 case of neglect and act of omission and 2 unsafe discharges. These are currently under review by the Lead Nurses.
- There is a proposed plan to review all pharmacy audits completed on wards/departments to facilitate improved audit with involvement of nursing and pharmacy teams working collaboratively. Formal approval is being sought from Senior Leads and the Medicines Management Group.
- There continues to be a higher proportion of pressure ulcers per 1000 patients in District Nursing caseload within community settings compared to the acute setting. The Trust wide improvement plan as part of the thematic reviews continues to be progressed.
- The number of inpatient falls has decreased by 11% compared to the previous months. Similarly, the number of falls resulting in harm has decreased significantly compared to April. There were 2 After Action Reviews (AARs) completed in May 2024.
- There has been an increase in Bank usage during May 2024, although this remains lower than previous years. Usage of Nursing and Midwifery agency staff remains low.
- 46.4% of complaints received were closed within 30 days, a slight decrease on April's performance.

Alert

- The Tissue Viability team's capacity remains challenged due to staffing reductions. Mitigations are in place to ensure essential support is provided. A conversation with ICB colleague is scheduled to determine what other support may be available, especially to support the community areas.
- The Speech and Language Therapy capacity continues to be challenged, due to workforce reductions. A business continuity plan is in place, including mitigations to ensure that priority patients are seen. A plan is being developed by the Division to address the current challenges.

2.	**Alignment to our Vision**										
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			

2.	Report journey
Trust Management Group – June 2024. Quality Committee – June 2024. IPC BAF – Infection Prevention and Control Group – June 2024.	

3.	
The Trust Board is asked to:	
a.	Acknowledge the work undertaken by the Chief Nurse and Medical Director's office, to drive continuous improvements in the provision of high quality of care and patient experience and contribute to the successful achievement of the Trust Strategy's objectives.
b.	Note the IPC BAF in Appendix 1.

4.	Impact							
Board Assurance Framework Risk 1.1	x	Deliver high quality, safe person-centred care and treatment						
Board Assurance Framework Risk 2.0	x	Address critical shortage of workforce capacity						
Board Assurance Framework Risk 3.0	x	Improve and sustain staff satisfaction and morale						
Board Assurance Framework Risk 4.0	x	Remain financially sustainable in 2023/24 and beyond						
Board Assurance Framework Risk 6.0	x	Deliver on its ambition to building innovative partnerships in Dudley and beyond						
Corporate Risk Register								
Equality Impact Assessment	Is this required?			N		If 'Y' date completed		
Quality Impact Assessment	Is this required?			N		If 'Y' date completed		

Trust Strategy - Deliver the right care every time

Links to Delivering the fundamentals of care every time and patient safety and improved quality and care outcomes in the Nursing, Midwifery and Allied Health Professionals strategy.

Deteriorating Patient Pathway

Deteriorating patient pathway (DPP)

The deteriorating patient pathway consists of 3 elements: an escalation document, a senior clinical review document and the sepsis screen, there are always more patients triggering the DPP versus those that require a sepsis screen as the DPP may retrigger if the patient has deteriorated significantly as indicated by their early warning score. In May, 165 more patients triggered the DPP (1533) than in April, therefore although there was a slight decrease in escalation documents completed by % (from 59.5% to 58.2%) in absolute numbers we increased the number completed. The number of senior clinical reviews completed on the DPP within 60 mins of deterioration also increased from 45.6% to 45.9%. Patients being screened for sepsis following a trigger increased from 83.3% to 84.1%. Of those patients who were screened 12.7% were deemed as requiring treatment for sepsis and 70% received the IV antibiotics within 60 minutes of their trigger. The other patients who triggered the DPP were treated for other non-sepsis related reasons, outcome data suggests less patients who have triggered have been admitted to critical care or deceased in the last 4 weeks compared to the 3-month averages. See table below showing escalation and senior review of DPP episodes.

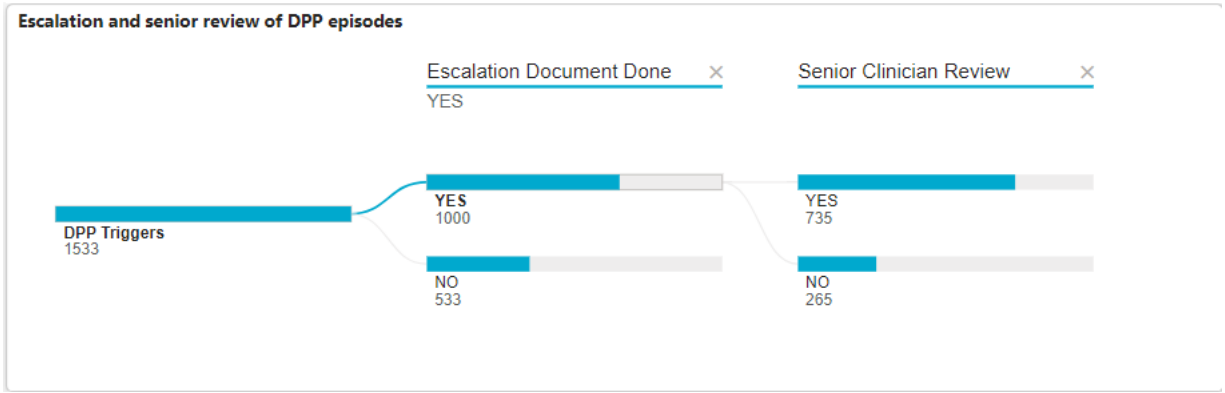


Figure 1 escalation and senior review of DPP episodes.

% Deceased		% Admitted to a Critical Care Ward		LOS Excluding the Last 4 Weeks (hrs)	
Over Last 4 Weeks	Over Last 3 Months	Over Last 4 Weeks	Over last 3 Months	Average Over Last 3 Months	Median Over Last 3 Months
6.53	9.10	3.21	4.03	189	79

Mortality

The Summary Hospital-level Mortality Indicator (SHMI) is 99.7 and the Hospital Standardised Mortality Ratio (HSMR) 84.95 and they have both continued to reduce. The Medical Examiner Service continues to be the largest source of referrals for Structured Judgement Reviews (SJRs). Completed SJRs demonstrate predominantly a high quality of care and low level of avoidability. The Dudley Medical Examiner Service is continuing to increase community referrals ahead of the statutory requirement for all deaths to receive a proportionate review. 100% of acute deaths are routinely reviewed.

Safeguarding

There were 3 Section 42 enquiries against the Trust during May 2024, relating to 1 case of neglect and act of omission and 2 unsafe discharges. These are currently under review by the Lead Nurses.

All Midwives and Paediatric Nurses are required to be in receipt of regular safeguarding supervision. The latest compliance with supervision is as follows: Maternity - 89%, Community MW - 80%, NNU - 100%, Paediatrics - 90%. Supervision to community midwives is a challenge due to capacity issues within the service.

Safeguarding Training

Safeguarding Adults L1	95%
Safeguarding Adults L2	81%
Safeguarding Adults L3	91%
Safeguarding CYP L1	95%
Safeguarding CYP L2	86%
Safeguarding CYP L3	86%
Prevent	95%
WRAP	94%

Safeguarding Adults Level 3 is above 90% for the first time since it was introduced in 2018.

Deprivation of Liberty Safeguards (DoLS)
In April 2024, there were 335 DoLS applications. This is below the number expected and may reflect the challenge for the dementia and delirium team to support wards with recognising deprivation of liberty due to vacancies within the team.

Mental Health Act (MHA)
There are gaps in ward staff reporting to the Site Coordinator that a patient has been admitted on a Section of the MHA or have been detained under the MHA whilst an in-patient. The Trust must be able to identify all patients that are subject to a detention within our care. There are plans underway for Black Country Healthcare to provide a Mental Health Act Administrator who will support with this process and should improve the consistency of data collection and handling of MHA paperwork.

Nursing Quality Dashboard
Work continues within the informatics team to address the differing audit/reporting systems interfaces that are currently preventing all required dashboard metrics to be visible on one spreadsheet. Additional information requested by the Chief Nurse is in the process of being assessed to ensure relevant data can be extracted to appear on the dashboard.

There is a proposed plan to review pharmacy audits completed on wards/departments to facilitate improved audit, and to provide ward and departments leads with the autonomy to continue audit/demonstrate improvements with the 6 monthly joint nursing and pharmacy audits. Formal agreement with this process is in the process of being sought via Senior Leaders and the Medicines Management Group.

The current Trust quality dashboard is illustrated below.

KPI_DESCRIPTION	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24	Apr 24	May 24
Tissue Viability SKIN audit (CQUIN 12)	0.00	93.29	94.81	95.87	93.58	98.22	97.97	96.80	96.06	96.29	97.73	96.67
Standard of Documentation Audit 2024	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	95.83	95.93	96.45	96.48
Saving Lives HII No 5 - Infection Prevention in Chronic Wounds	100.00	87.50	94.12	97.22	100.00	94.74	100.00	100.00	96.97	95.83	92.54	97.87
Saving Lives HII No 4b - Surgical site infection prevention - Intraoperative	100.00	100.00	96.97	0.00	100.00	96.67	100.00	100.00	100.00	100.00	100.00	100.00
Saving Lives HII No 4a - Surgical site infection prevention - Preoperative	94.12	94.74	100.00	100.00	100.00	100.00	100.00	88.89	100.00	100.00	100.00	92.86
Saving Lives HII No 3b - Central Venous Access Devices - Ongoing Care	100.00	100.00	94.74	100.00	100.00	100.00	100.00	100.00	100.00	97.06	100.00	100.00
Saving Lives HII No 3a - Central Venous Access Devices - Insertion	66.67	100.00	100.00	100.00	100.00	100.00	100.00	100.00	100.00	100.00	100.00	100.00
Saving Lives HII No 1 - Ventilator Associated Pneumonia	100.00	90.00	75.00	60.00	80.00	75.00	80.00	100.00	90.00	83.33	100.00	100.00
Matron In Patient Audit	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	85.97	87.90	85.54	88.13
Lead Nurse In Patient Audit January 2024	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	84.18	93.69	92.84	93.77
Hand Hygiene 5 moments audit (v2)	98.96	97.95	99.11	98.46	99.39	98.96	98.80	96.52	97.83	98.62	98.70	98.24
Hand Hygiene - environment audit (v1)	99.16	98.50	97.97	97.14	99.03	98.93	99.16	99.04	99.03	98.90	0.00	0.00

Themes noted for areas rated Amber or Red ratings:

Saving Lives No 1:

- Cuff pressures were not being recorded as expected. The Matron and Deputy Matron were aware of this issue, and actions have been taken to rectify this, resulting in 100% compliance for the second month running. This will continue to be monitored monthly.

Saving Lives No 4a:

- Although an Amber score, this relates to incorrect formatting of question 5 response within AMaT. This has been amended.

Matron in patient audit - key themes:

- Nursing admission inpatient document not completed within 6 hours of admission.
- Care not planned in accordance with assessment outcomes.
- Care not reviewed each shift by a Registered Nurse (RN).
- Single sex accommodation not complied with due to capacity challenges.
- Ward areas cluttered.
- Notice boards out of date.

- Not all required AMaT audits completed in last month (although improvement from last month 75% (Red) to 94.4% (Amber) this month is noted - not far off 95% Green RAG rating).
- Action plans missing for AMaT audits.
- Staffing: Red flags present at time of review, however the next question asking if Red flags were addressed is RAG rated Green, confirming action had been taken to address staffing requirements.
- Mandatory training only up to date in 22% of staff.

Lead nurse in patient audit - key themes:

- Patient disclaimer forms not completed.
- Urinalysis not completed.
- Where dementia is identified, no referral to dementia team or completion of dementia bundle on admission.
- MUST not completed on admission.
- Lying and standing BP not recorded on admission.
- Care plans not evaluated.
- Nursing quality review sheet not completed each shift.
- MUST and falls risk not reassessed every 7 days.
- Cannula VIP scores not completed.
- Cannula removal not documented.
- Urinary catheter insertion document not completed.
- Matron not always being asked to be involved with difficult patient discharge processes.

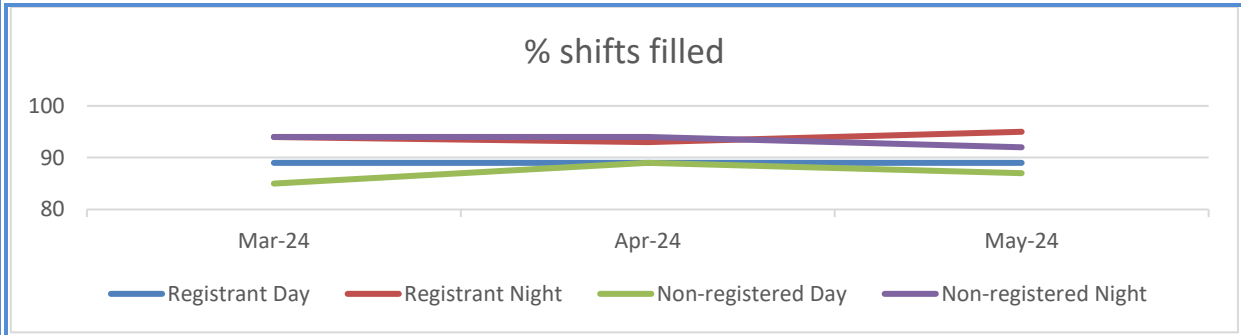
Divisional Chief Nurses, Matrons and Lead Nurses are aware of these findings and are ensuring actions are in place to address the themes identified.

The Chief Nurse, Deputy Chief Nurses/AHP, Divisional Chief Nurses/AHP, Deputy Divisional Chief Nurses and other senior nursing/midwifery staff are completing quality visits and Back to the Floor shifts in clinical areas and they will use the opportunity to review the themes identified during these visits. This includes rostered periodic night visits with a clinical half day per week as a minimum. A report summarising findings will be provided for each quarter going forward.

Safer Nursing and Midwifery staffing May 2024

Safer Staffing Summary **May** Days in Month 31

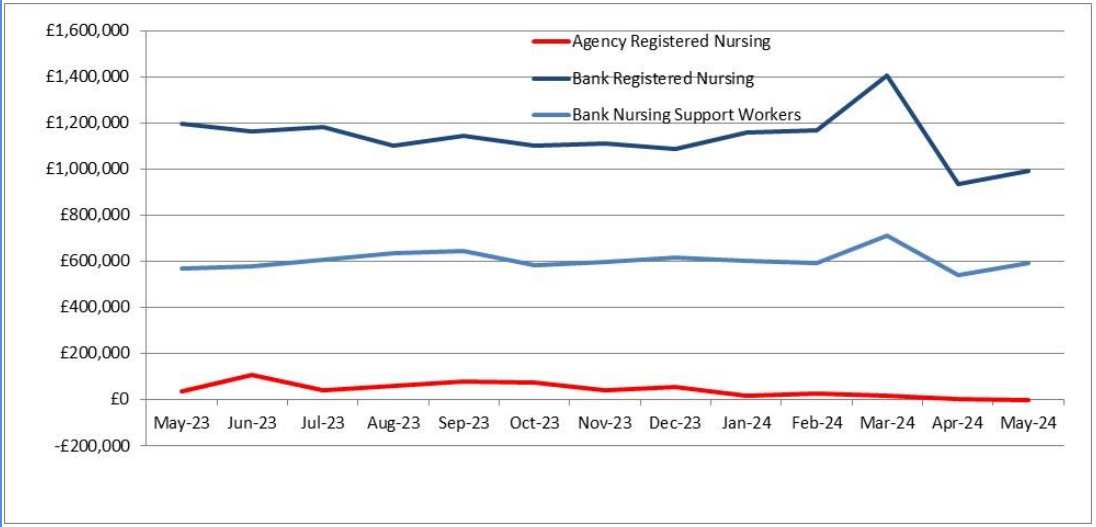
Ward	Day RN Plan	Day RN Actual	Day CSW Plan	Day CSW Actual	Night RN Plan	Night RN Actual	Night CSW Plan	Night CSW Actual	RN Day %	CSW Day %	RN N %	CSW N %	Sum 24:00 Occ	Actual CHPPD Registered	Care staff	Total
A2 /A4	97	85	66	60	62	62	62	62	87%	91%	100%	100%	369	4.65	3.96	8.61
B1	126	114	55	62	63	63	48	45	91%	114%	100%	94%	471	4.27	2.60	6.87
B2(H)	124	98	194	185	93	89	171	168	79%	95%	96%	98%	716	3.14	5.78	8.93
B2(T)	124	104	132	129	93	88	109	103	84%	97%	95%	95%	712	3.24	3.90	7.14
B3	188	192	234	174	180	185	229	191	102%	74%	103%	83%	1,165	3.80	3.76	7.56
B4	226	186	251	214	186	177	199	192	82%	85%	95%	96%	1,298	3.28	3.75	7.04
B5	248	196	162	154	238	223	96	88	79%	95%	94%	92%	928	5.53	3.05	8.58
C1	253	236	251	234	186	183	199	188	93%	93%	98%	95%	1,475	3.33	3.43	6.76
C2	284	243	65	63	250	235	64	61	86%	97%	94%	95%	635	8.84	2.29	11.13
C3	217	217	394	361	186	173	381	365	100%	92%	93%	96%	1,606	2.91	5.31	8.22
C4	209	176	68	74	124	100	62	79	84%	110%	81%	127%	674	4.79	2.61	7.40
C5	269	250	255	231	251	247	198	187	93%	90%	99%	94%	1,478	4.08	3.39	7.48
C6	98	94	93	89	93	87	65	65	96%	96%	94%	99%	572	3.72	3.23	6.95
C7	218	170	186	176	155	146	163	154	78%	94%	94%	94%	1,103	3.36	3.58	6.95
C8	259	234	217	183	217	207	186	178	90%	84%	95%	95%	1,330	3.89	3.25	7.14
CCU_PCCU	251	238	62	60	220	219	31	28	95%	96%	100%	91%	762	7.04	1.39	8.42
Critical Care	526	410	125	86	527	429			78%	69%	81%		439	22.94	2.34	25.28
EAU AMU	485	492	414	364	405	434	414	382	101%	88%	107%	92%	2,309	4.71	3.88	8.58
Maternity	863	814	373	221	527	508	217	143	94%	59%	96%	66%	1,365	9.23	3.12	12.35
MECU	93	93	34	34	92	92			100%	100%	100%		222	10.00	1.68	11.68
NNU	338	264			224	221			78%		99%		458	12.67	0.00	12.67
TOTAL	**5,497**	**4,907**	**3,629**	**3,152**	**4,371**	**4,168**	**2,895**	**2,677**	**89%**	**87%**	**95%**	**92%**	**20,087**	**5.20**	**3.45**	**8.65**



Our registrant staffing has either remained the same as April or has increased, whilst our non-registrant staffing has decreased.

Multiple application in practice sessions have been facilitated throughout May to support with the data collection for the staffing review.

Bank and Agency usage



Agency use continues to be extremely low. Bank use has increased throughout May but has remained lower than the previous 12 months.

Complaints

New Complaints

The Trust received 87 new complaints in May 2024 compared to 83 in April 2024. Of the 87 complaints received, all were acknowledged within 3 working days. The main theme for complaints for May 2024 was regarding communication.

Closed complaints

In May 2024, the Trust closed 82 complaints compared to 75 in April 2024. Of those 82 closed, 33 (40.2%) were closed within 30 working days. Not including re-opened complaints and Ombudsman cases, there were 71 complaints closed (first response) and of those 71 complaints, 33 were within 30 working days (46.4%)., which is a decrease on last month's response rate of 61%.

Reopened Complaints

There has been a decrease of reopened complaints (12) for May 2024 compared to 13 for April 2024. There are currently 31 reopened complaints in total under investigation.

Outstanding complaints

Position as of 31 May 2024 was as follows:

- Outstanding for all complaints (including new, reopened and ombudsman cases) = 176
- Outstanding complaints (excluding reopened and excluding Ombudsman cases) = 139

Concerted efforts and strengthened escalation processes remain in place to drive improvements in complaint responsiveness.

Nursing, Midwifery and AHP presence within clinical areas

The 'Back to the Floor' presence of Nurses, Midwives and AHPs continues to be embedded across the organisation.

Challenged service provision

The Tissue Viability team's capacity remains challenged due to staffing reductions. Mitigations are in place to ensure essential support is provided. A conversation with ICB colleague is scheduled to determine what other support may be available, especially to support the community areas.

The Speech and Language Therapy capacity continues to be challenged, due to workforce reductions. A business continuity plan is in place, including mitigations to ensure that priority patients are seen. A plan is being developed by the Division to address the current challenges.

Trust Strategy - To be a brilliant place to work Links to compassionate and strong leadership, Developing the Nursing, Midwifery and AHP workforce and sustainability and growth in the Nursing, Midwifery and Allied Health Professionals strategy	Call for Concern has gone live across the Trust in. There will be regular evaluations and reviews of the process and the contact rates which will be regularly reports through the Deteriorating Patient Group and the Critical Care governance routes. The Professional Development Team has been working in collaboration with the Divisions to commence training to support the use of the National Critical Care Skills Passport within the ward areas. This learning will increase the knowledge and skills of a key group of nursing staff based within our enhanced care areas. It is a tri-fold programme encompassing eLearning theory, practical simulation sessions and practice competencies within the clinical areas. Over the next 6 months it is anticipated that we will have 6 cohorts of 10 candidates who will go through the programme. To save confusion, this programme has been renamed to the Clinical Skills passport. **Job Planning (Medical)** Medical job plans were open for editing between January-March 2024. As of 07/06/2024, 89% of Consultants are signed off or in the sign off process. SAS Doctors are being supported to complete job planning currently. Consistency panels have been held during June 2024 and show high levels of alignment across the workforce. There were no Red rated specialities with most rated as Amber due to the lack of personal objectives included. This will be picked up via Job Planning Steering Group. The outcome of an internal RSM led audit is due in July and will be reported via People Committee. **Job Planning (AHPs)** AHP job planning opened on 01 April 2024 and appropriate support will be provided to teams to populate signs for sign off.
Trust Strategy - Drive sustainability and financial environment Links to sustainability and growth.	**Complex Nutrition** The team is now fully established in clinical staff to support a 7-day service on the virtual ward and complex nutrition. This had led to improvement from time of referral to time of review, with 95% of patient being seen within 24 hours. Following appraisals a training needs analysis has been completed for 2024 to focus on team development. This includes planning for a commencement of PhD, completion of ACP MSc and standalone modules in clinical care therefore funding and support opportunities are currently being explored. This is working towards being a fully Nurse-Led service. **Clinical** Parenteral Nutrition (PN) bags are being reassessed in line with National standards and new evidence around protein requirements in Critical Care patient. A new initiative has been launched to assess the change of supplier and types of PN bags stored in pharmacy. Due to the audit of safety and effectiveness of PN prescribing an initiative has been launched to change PN prescriptions from paper to electronic. Collaboration with pharmacy has been started this month. This will lead to increases in proficiency and safety of adult PN prescribing.

Percutaneous endoscopic colostomy tubes are a new initiative launched 2 years ago, the nutrition team has been the nursing support pre during and post procedure. A new audit has been launched to confirm safety and effectiveness of these tubes.
Work and audit on the effectiveness of the team's care is ongoing with a focus on evidencing the appropriateness of complex nutritional interventions. The project will look at how many unnecessary have been prevented with the use of alternative strategies. This will evidence benefits to patients, Staff and organisation.

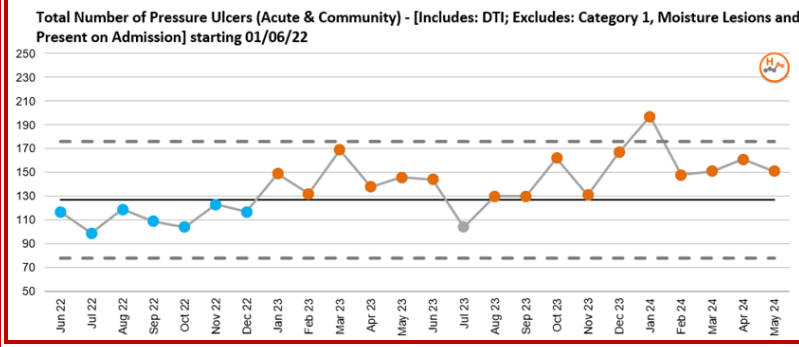
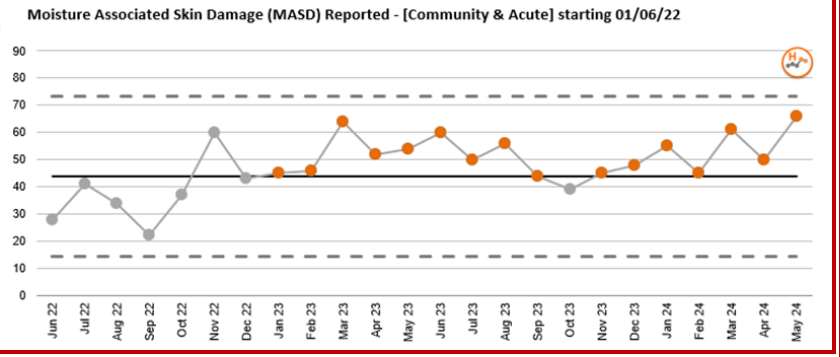
Research
A primary research project poster completed by Izzie Gibson (ACP) has been accepted for presentation at the European Society of Parenteral and Enteral Nutrition (ESPEN) to increase international the profile of the complex Nutrition Team and organisation across Europe. The study concluded that patient that require a best interest decision for insertion of PEG following a Stroke have a shorter length of survival when compared to consented. Changes in the approach to best interest decisions has been implemented because of this research and it has been presented to Gastroenterology and Stroke services. A further 5 posters have been created based on both the work of the Complex Nutrition inpatient service and virtual ward. They are all finalists at the regional #weresearch awards at the end of June.

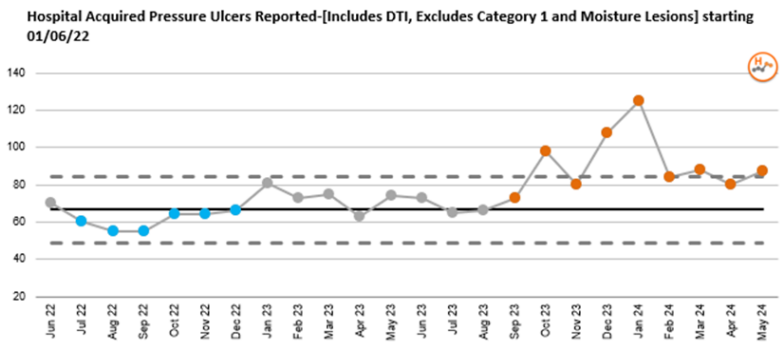
Nasogastric tube safety
A new audit system has been designed with the clinical skills team to capture the entire pathway of NG tube gastric confirmation. This audit will be launched in July.

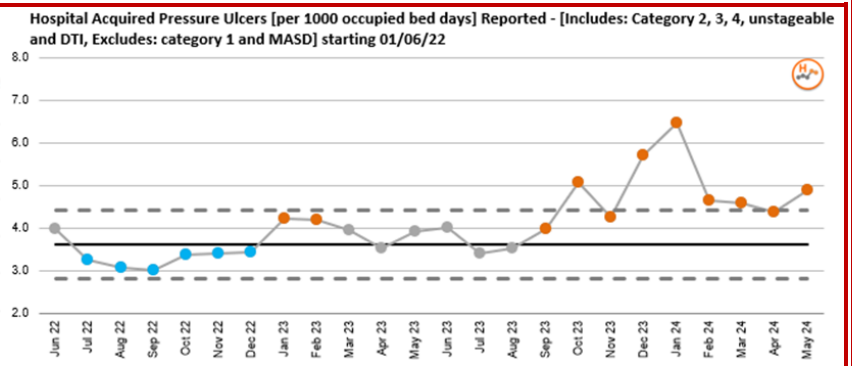
Celebrations:

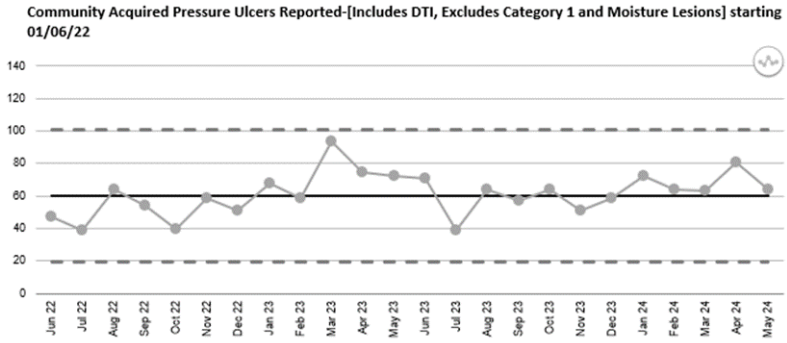
- Dr Falks nurse innovation award won.
- Finalists in Trust's Committed to Excellence Awards.
- Research accepted at ESPEN.
- Finalists for poster presentations x 5 at regional #weresearch.
- Nomination for parliamentary award.
- Application to HSJ virtual award.
- Collaboration with research design service and future grant applications as hosts.
- Successful completion of academic qualifications.

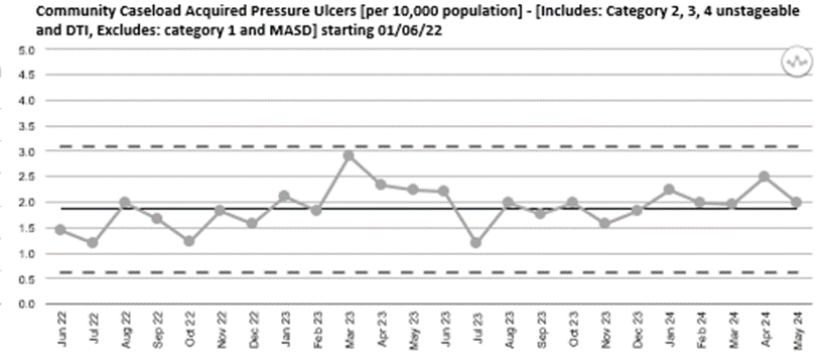
Trust Strategy - Build innovative partnerships in Dudley & beyond Links to Developing the Nursing, Midwifery and AHP workforce, Patient safety and improved quality and care outcomes and sustainability and growth in the Nursing, Midwifery and Allied Health Professionals strategy.	**Education** The NMC are to relaunch the new title of the Trainee Nursing Associate to student Nursing Associate, as they have audited trusts nationally and identified that the title varies from trust to trust. As a Trust we will be using the new terminology as guided by the NMC, and this change will be effective from 1st June 2024 in partnership with our local HEI's. **Dementia and Delirium** The Trust is working on developing an Admiral Nursing Service, which will promote links with Dementia UK and offer opportunities for service improvement and development. **University Hospital Status** Work to establish academic contracts is a focus for the working group with our partners at Aston University as a core component of the UHS application process. Medical Students from Three Counties Medical School commenced placements in the Trust during May 2024, joining undergraduate students from Birmingham and Aston Universities. Work continues to establish a provision for students from St Mary's University.
Trust Strategy - Improve health and wellbeing	**Infection Prevention and Control** The Trust has not received the trajectories for 2024/25 and has reported on those set out for 2023/24. The trajectories for 2024/25 are due to be issued in June 2024. The Trust has a zero tolerance for MRSA Bacteraemia and has reported zero MRSA bacteraemia for April 2024. Following a review of the Trust's Infection Prevention and Control Group, the Chief Nurse has requested for the group to increase the frequency of its meetings from May to monthly. This will reduce the length of the meetings but will allow for a more in-depth review and discussion of the reports.

Links to listening and learning for improvement in the Nursing, Midwifery and Allied Health Professionals strategy.	The IPC Annual programme has been drafted for approval at the Infection Prevention and Control Group. The annual programme of work has amalgamated the *Clostridiodes difficile* improvement plan, the NNU service improvement plan and the IPC annual plan of work into one document. There are 5 key workstream themes for 2024/25: • 'Are you gloves aware?' • Bare Below the elbow - 5 moments of Hand Hygiene. • Surgical Site Surveillance (SSISS) for Knees and Caesarean sections. • Commode Cleaning. • IPC Link Worker attendance. The latest version of the IPC Board Assurance Framework is enclosed as Appendix 1 for Trust Board's awareness. The Trust is currently fully compliant with all the requirements, apart from 3 which are partially compliant. These related to the Post Exposure Prophylaxis Policy not in date although it is being reviewed and two requirements for CPE screening not following the latest Department of Health guidance. This been raised with the Integrated Care System and recorded as a risk on their risk register (this action requires resolutions from the Black Country Pathology System). **Pressure Ulcers (PUs)** In May 2024, there were 151 PUs (category 2, 3, 4, unstageable and DTIs) reported (Trust acquired and patients admitted with a pressure ulcer). From this number, 68 were category 2 and 36 were reported as category 3,4 and unstageable pressure damage.  









*(*Please note that figures provided for May 24, are not fully validated and may slightly change in future reports)*

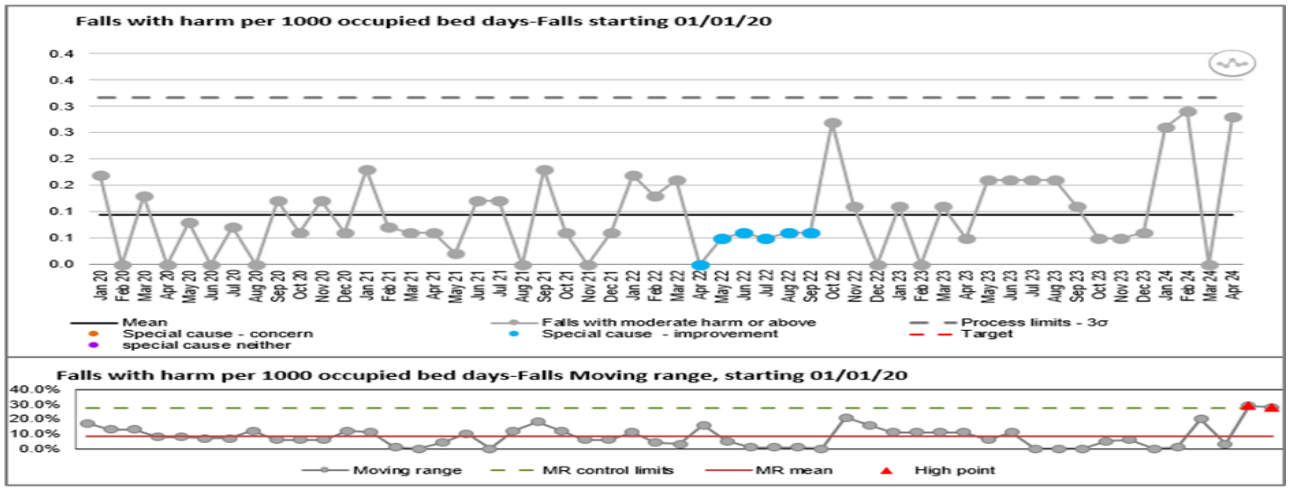
As part of the wider PSIRF work, a Trust improvement plan is in place and continues to be progressed to ensure learning from incidents and improve practice to prevent pressure ulcers. In addition to ongoing staff training, the TVN team continue to pilot the blue pillows on B2 and CCU. The team are also working with ED as a high reporter of pressure ulcers with the introduction of repro mattresses specifically designed for ED trollies.

Falls May 2024

May- 2024 falls data	
Inpatient falls	103
Outpatient/Community falls	1
Repeat fallers	8
AAR	2 incidents C5b – Awaiting on SJR C7 - Neck of Femur Fracture

The number of inpatient falls has decreased by 11% compared to the previous months. Similarly, the number of falls resulting in harm has decreased significantly compared to April. There were 2 AAR incidents reported in May 2024.

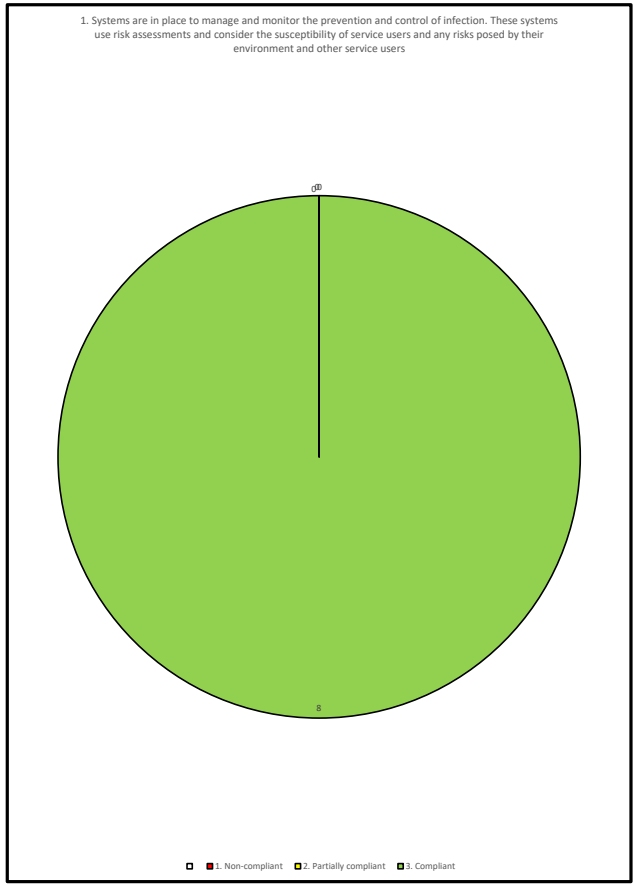
The Trust remains below the national average for falls per 1000 occupied bed days.



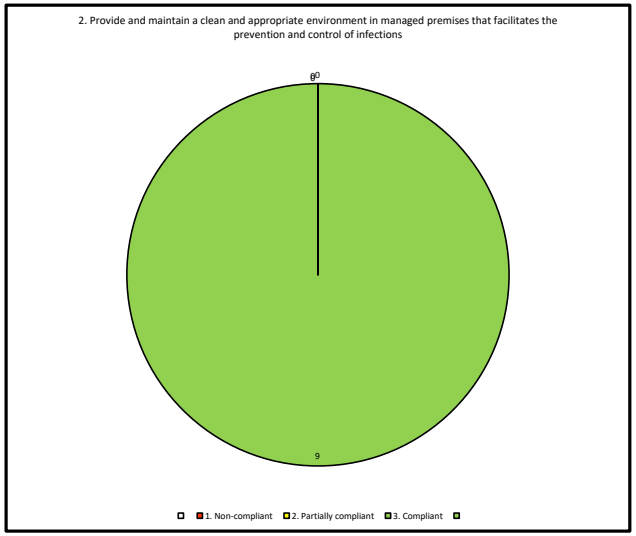
	The national average for the number of falls with moderate harm or above per 1000 occupied bed days was 0.19. The Dudley Group remains below the national average at 0.11. Similarly, this figure is associated with falls with harm which impacts hospital stay. The Falls After Action Review (AAR) pilot study will be relaunched in July 2024, which will be extended across all Divisions. The population for the Pilot study will include Staff and Patient Safety Partners. The Patient and Public Involvement (PPI) from the Patient Safety Partners will enhance Equality, Diversity, and Inclusion. Improvement actions include: • The 1st thematic review and Single Improvement Plan have been completed. • The 2nd thematic review is currently in the early stages of data sampling and coding of themes, to be presented in August 2024 • Focus support continues for the ward areas with the high rate of falls. • To enhance the effective utilisation of the community falls pathway and continuity of care at the point of discharge, local partners are in the process of organising a session with the Acute Medicine Consultants.

Infection Prevention and Control board assurance framework v0.1

	Key Lines of Enquiry	Evidence	Gaps in Assurance	Mitigating Actions	Comments	Compliance rating
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 risks their environment and other users may pose to them						
Organisational or board systems and process should be in place to ensure that:						
1.1	There is a governance structure, which as a minimum should include an IPC committee or equivalent, including a Director of Infection Prevention and Control (DIPC) and an IPC lead, ensuring roles and responsibilities are clearly defined with clear lines of accountability to the IPC team.	The Trust has both a DIPC and Deputy DIPC in post. There is an IPC and Decontamination Lead in post. There is a clearly defined structure with clear accountability IPCG meeting meetings quarterly with TOR agreed annually.				3. Compliant
1.2	There is monitoring and reporting of infections with appropriate governance structures to mitigate the risk of infection transmission.	HCAI data is reported to IPCG, Quality Committee, CQRM and IPR. Divisions report into IPCG All outbreaks are reported internally and externally to UK HSA, ICB, and NSHE There is an IPC Governance structure in place from IPCG Meeting to Public Board via Quality Committee. HCAI data is presented to external partners e.g. UK HSA, ICB, Dudley Place, Walsall Place and Dudley Metropolitan Council.				3. Compliant
1.3	That there is a culture that promotes incident reporting, including near misses, while focusing on improving systemic failures and encouraging safe working practices, that is, that any workplace risk(s) are mitigated maximally for everyone.	DATIX reporting is encouraged. There is a Freedom to Speak up Guardian in place. There are separate DATIX streams for IPC and Decontamination incidents to be reported and actioned. Decontamination incidents are raised at the Sterile Services and Decontamination Meetings. Meeting minutes available. Incidents are included in IPCG reporting.				3. Compliant
1.4	They implement, monitor, and report adherence to the NIPCM.	An IPC programme of audit is detailed in the IPC Annual Programme. Audits are recorded on AMaT and monitored via the IPCG meeting. IPC Audit tools are fluid documents and are reviewed annually and updated as required. IPCG minutes detail audit scores. Meeting minutes are available				3. Compliant
1.5	They undertake surveillance (mandatory infectious agents as a minimum) to ensure identification, monitoring, and reporting of incidents/outbreaks with an associated action plan agreed at or with oversight at board level.	HCAI data is reported to IPCG, CQRM, Quality Committee and IPR. Divisions report into IPCG All outbreaks are reported internally and externally to UK HSA, ICB and NSHE. There is an IPC Governance structure in place from IPCG Meeting to Public Board via Quality Committee SSI data is recorded and uploaded to UK HSA				3. Compliant
1.6	Systems and resources are available to implement and monitor compliance with infection prevention and control as outlined in the responsibilities section of the NIPCM.	An IPC programme of audit is detailed in the IPC Annual Programme. Audits are recorded on AMaT. Audit scores are monitored via the IPCG meeting reports.				3. Compliant
1.7	All staff receive the required training commensurate with their duties to minimise the risks of infection transmission.	IPC Training for both clinical and non clinical staff is available via e-learning following the Health Education England programme. IPC induction training is delivered face to face. Bespoke training is delivered where required. IPC mandatory training data is reported via IPCG meetings and divisional reports.				3. Compliant

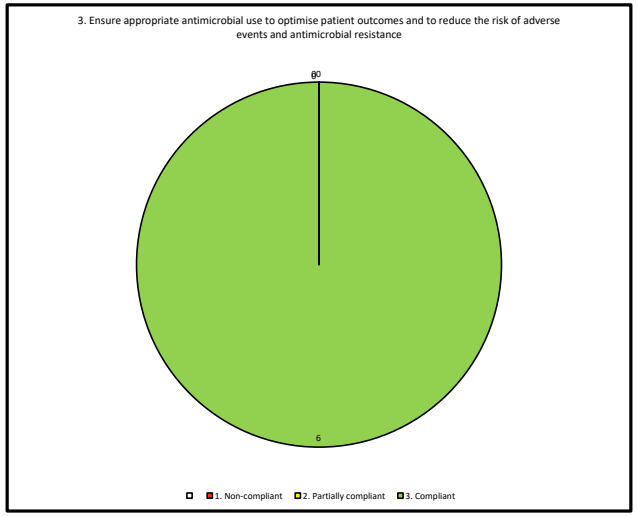


1.8	There is support in clinical areas to undertake a local dynamic risk assessment based on the hierarchy of controls to prevent/reduce or control infection transmission and provide mitigations. (primary care, community care and outpatient settings, acute inpatient areas, and primary and community care dental settings)	Risk assessments are available for use. Policies and procedures are developed to facilitate autonomy. IPC Doctor is on call out of ours for advice and support. IPC team attends site capacity at 9am and when required. A weekend plan with IPC is developed on a Friday and available to site and capacity A winter plan has been developed				3. Compliant
2. Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections						
System and process are in place to ensure that:						
2.1	There is evidence of compliance with National cleanliness standards including monitoring and mitigations **(excludes some settings e.g. ambulance, primary care/dental unless part of the NHS standard contract** these setting will have locally agreed processes in place).	Decontamination of the Environment Policy incorporating the National standards of Cleanliness adopted April 2022 Cleanliness audits completed and presented at IPCG Stars on the doors are displayed on the entrances to area There is a Minuted Cleaning meeting with PFI partners Cleaning is increased during an outbreak of infection				3. Compliant
2.2	There is an annual programme of Patient-Led Assessments of the Care Environment (PLACE) visits and completion of action plans monitored by the board.	IPC audits and Quality walk rounds are recorded on AMAT. PLACE and PLACE Lite visits undertaken				3. Compliant
2.3	There are clear guidelines to identify roles and responsibilities for maintaining a clean environment (including patient care equipment) in line with the national cleanliness standards.	Cleaning is outsourced to PFI partners. Cleanliness audits and scores on the doors are produced Mitie follow the Trust's Decontamination of the Environment policy Joint Terminal cleaning SOP available for use Cleaning schedules are available in clinical areas				3. Compliant
2.4	There is monitoring and reporting of water and ventilation safety, this must include a water and ventilation safety group and plan. **2.4.1** Ventilation systems are appropriate and evidence of regular ventilation assessments in compliance with the regulations set out in HTM:03-01. **2.4.2** Water safety plans are in place for addressing all actions highlighted from water safety risk assessments in compliance with the regulations set out in HTM:04-01.	Ventilation The Trust has a ventilation group with PFI partners Mitie has an appointed authorising engineer for Ventilation Mitie undertake PPM and ventilation audits which are reported to the Ventilation Group Water The Trust has a Water Safety Plan, policies and procedures The Trust has a water safety group with PFI partners Mitie has an appointed authorising engineer for water Flushing, sampling regimes and results are reported to the Water Safety group The Trust has an authorising engineer for decontamination. Both above meetings report to IPCG				3. Compliant

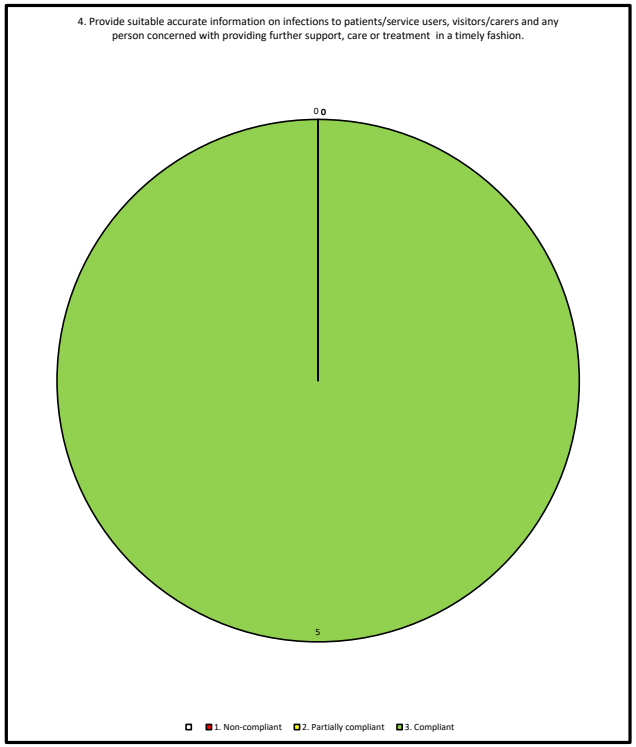


2.5	There is evidence of a programme of planned preventative maintenance for buildings and care environments and IPC involvement in the development new builds or refurbishments to ensure the estate is fit for purpose in compliance with the recommendations set out in HBN:00-09	**Maintenance Controls** 1. 1 year and 5 year Maintenance Programme issued annually 2. Asset condition survey 3. Trust Helpdesk for reporting issues 4. Monthly Report to demonstrate compliance 5. Trust Monitoring Team for compliance **Maintenance Improvements** 1. Mitie/Summit to revisit asset lists 2. New CAFM system being implemented 3. Improved self reporting for non performance of PPMs **IPC Capital Schemes Controls** 1. Trust interface for small works and capital projects 2. Trust Policy for IPC in capital schemes 3. Schemes shared with IPC for comment (Larger schemes) **IPC Capital Schemes improvements** 1. Full implementation of IPC policy for capital schemes 2. Trust to gain IPC sign off for designs 3. Trust to develop a Capital Works Policy 4. AE Water and Ventilation to sign off design and commissioning				3. Compliant
2.6	The storage, supply and provision of linen and laundry are appropriate for the level and type of care delivered and compliant with the recommendations set out in HTM:01-04 and the NIPCM.	Linen and laundry are supplied by Mitie via a PFI contract. Laundry is supplied and processed via a contract with Elis and assurance visits are undertaken with the Trust and Mitie. Items are also laundered on site in a laundry operated by Mitie with is regularly audited but the Trust. There is a system in place for the return of damaged linen. Microbiological sampling on the laundry is also undertaken. These are reported to IPCG for assurance.				3. Compliant
2.7	The classification, segregation, storage etc of healthcare waste is consistent with HTM:07:01 which contains the regulatory waste management guidance for all health and care settings (NHS and non-NHS) in England and Wales including waste classification, segregation, storage, packaging, transport, treatment, and disposal.	Healthcare waste and the segregation of waste is provided by our PFI partner Mitie. A PFI partner waste group meets monthly. Correct procedure for Waste segregation is included on the IPC induction and IPC training programmes. Waste is included on the estates report to IPCG Duty of Care visits are undertaken with the Trust and PFI partners to outside contractors including Tradebe and Sharpsmart. A "correct waste stream"quiz is available on the hub.				3. Compliant

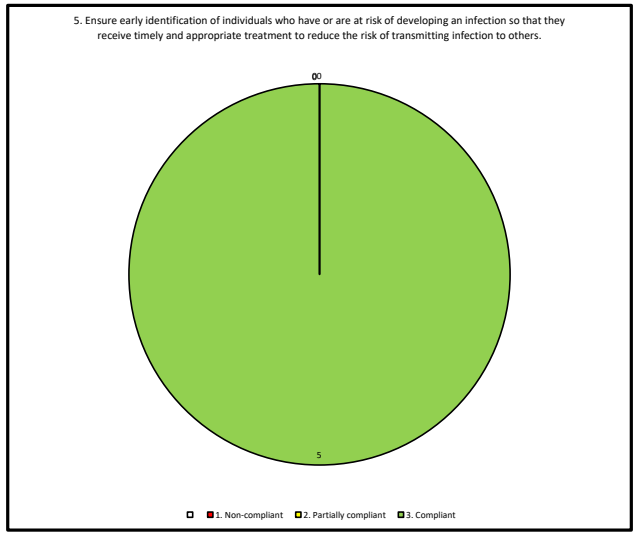
2.8	There is evidence of compliance and monitoring of decontamination processes for reusable devices/surgical instruments as set out in HTM:01-01, HTM:01-05, and HTM:01-06.	Standard infection precautions policy available on the Hub I am clean stickers are in use throughout the Trust Decontamination policy updated February 2024 available on the Hub Reusable non-invasive medical devices are decontaminated using Clinell universal wipes or Chlorine releasing agent in line with Trust policy and/or manufactures instructions. Sterile Services follow the HTM 01-01 guidelines. Sterile Services polices and procedures are audited internally and then followed through with our External Approved Body SGS annually. Decontamination audit programme in place. PAQ enquiries are completed with Procurement, EBME and the IPC teams prior to the purchasing of equipment to ensure it can be decontaminated EBME department on site The trust employs a Decontamination Authorizing engineer Certificated and recorded specialised decontamination training and competencies for specific items or services are in place. Bi-monthy decontamination meeting held with PFI partners Sterile Services meeting held monthly.				3. Compliant
2.9	Food hygiene training is commensurate with the duties of staff **as per food hygiene regulations**. If food is brought into the care setting by a patient/service user, family/carer or staff this must be stored in line with food hygiene regulations.	Food hygiene training is undertaken by staff and recorded in ESR. Trust Staff have access to Food Hygiene Basics for Nursing and core staff. Food hygiene regulations. Food hygiene slide incorporated in IPC mandatory training				3. Compliant
3. Ensure appropriate antimicrobial stewardship to optimise service user outcomes and to reduce the risk of adverse events and antimicrobial resistance						
Systems and process are in place to ensure that:						
3.1	If antimicrobial prescribing is indicated, arrangements for antimicrobial stewardship (AMS) are maintained and where appropriate a formal lead for AMS is nominated.	AMS Group in place with AMS lead for the Trust and antimicrobial stewardship principles are implemented throughout the Trust.				3. Compliant
3.2	The board receives a formal report on antimicrobial stewardship activities annually which includes the organisation's progress with achieving the UK AMR National Action Plan goals.	A formal report goes to board via medicines management group which covers AMS activities, achievements and risks. It is also included in annual IPC report to the board. Pharmacy formally report into IPCG and attend the IPCG meeting.				3. Compliant
3.3	There is an executive on the board with responsibility for antimicrobial stewardship (AMS), as set out in the UK AMR National Action Plan.	Chief Nurse is the executive on the board with responsibility for AMS. Chief Nurse is also the Director of infection Prevention and Control.				3. Compliant
3.4	NICE Guideline NG15 'Antimicrobial Stewardship: systems and processes for effective antimicrobial medicine use' or Treat Antibiotics Responsibly, Guidance, Education, Tools [TARGET] are implemented and adherence to the use of antimicrobials is managed and monitored: • To optimise patient outcomes. • To minimise inappropriate prescribing. • To ensure the principles of Start Smart, Then Focus are followed.	The principles of Antimicrobial stewardship are embedded and tools, processes and support is available for effective antimicrobial use. NICE NG15 baseline assessment completed. AMS ward rounds across identified areas for support. AMS teaching sessions to Pharmacists, Drs and Nurses. AMS quality improvement projects. And effective monitoring system around antimicrobial consumption as a whole.				3. Compliant
3.5	Contractual reporting requirements are adhered to, progress with incentive and performance improvement schemes relating to AMR are reported to the board where relevant, and boards continue to maintain oversight of key performance indicators for prescribing, including: • Total antimicrobial prescribing. • Broad-spectrum prescribing. • Intravenous route prescribing. • Treatment course length.	All contractual reporting requirements are met and reports sent to Drugs and therapeutics Group, Medicines management Group and IPC Group which are then sent to Quality Committee and highlights presented to board.				3. Compliant

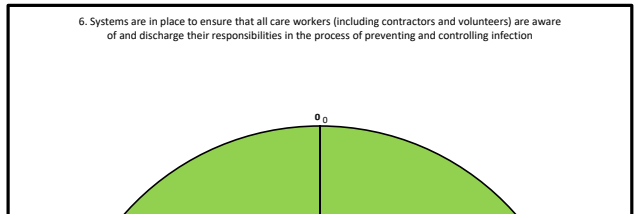


3.6	Resources are in place to support and measure adherence to good practice and quality improvement in AMS. This must include all care areas and staff (permanent, flexible, agency, and external contractors)	AMS team. Electronic prescribing aids (72 hours review) Microguide (Trusts antibiotic guidelines) and induction sessions on antimicrobial stewardship. AMS day in November is supported by Pharmacy and the IPC Team				3. Compliant
4. Provide suitable accurate information on infections to patients/service users, visitors/carers and any person concerned with providing further support, care or treatment nursing/medical in a timely fashion						
Systems and processes are in place to ensure that:						
4.1	Information is developed with local service-user representative organisations, which should recognise and reflect local population demographics, diversity, inclusion, and health and care needs.	Patient facing information available on the Trust web site Patient leaflets available on the Trust website, different languages are available Interpreter service available DDIPC attends Dudley Health Board and Walsall Place IPC and Health promotion and protection meetings DDIPC attends system IPC meetings chaired by the ICB DDIPC attended system health protection and promotion meetings with Walsall Place Updates and alerts received from NHSE, UK HSA are disseminated				3. Compliant
4.2	Information is appropriate to the target audience, remains accurate and up to date, is provided in a timely manner and is easily accessible in a range of formats (e.g. digital and paper) and platforms, taking account of the communication needs of the patient/service user/care giver/visitor/advocate.	Leaflets are reviewed annually and when guidance changes Paper and digital information is available Interpreter service is available PALS service available				3. Compliant
4.3	The provision of information includes and supports general principles on the prevention and control of infection and antimicrobial resistance, setting out expectations and key aspects of the registered provider's policies on IPC and AMR.	Information is available on IPC and AMR. Information days are held at the Health Hub to promote AMR, Hand Hygiene and IPC weeks. Prescribing information available Micrguide is available to all staff IPC Policies and procedures available on the Hub CDI ward round held weekly with IPC and Pharmacy External partner CDI meetings held weekly. Antimicrobial pharmacist attends IPCG AMR Systems meetings attended by IPC				3. Compliant
4.4	Roles and responsibilities of specific individuals, carers, visitors, and advocates when attending with or visiting patients/service users in care settings, are clearly outlined to support good standards of IPC and AMR and include: •Hand hygiene, respiratory hygiene, PPE (mask use if applicable) •Supporting patients/service users' awareness and involvement in the safe provision of care in relation to IPC (e.g. cleanliness) •Explanations of infections such as incident/outbreak management and action taken to prevent recurrence. •Provide published materials from national/local public health campaigns (e.g. AMR awareness/vaccination programmes/seasonal and respiratory infections) should be utilised to inform and improve the knowledge of patients/service users, care givers, visitors and advocates to minimise the risk of transmission of infections.	Supporting information available for visitors, patients and relatives, Patient leaflets and information available in paper or digital form. Interpreter available Information available on hand hygiene, specific micro-organisms Hand hygiene provision at the entrance at the hospital and ward entrances, Information banners on entry to the building Information days are held at the Health Hub to promote AMR, Hand Hygiene and IPC weeks. Information aviable on fluid resistant surgical masks Clinical information given to patients documented in the patients notes or Sunrise				3. Compliant

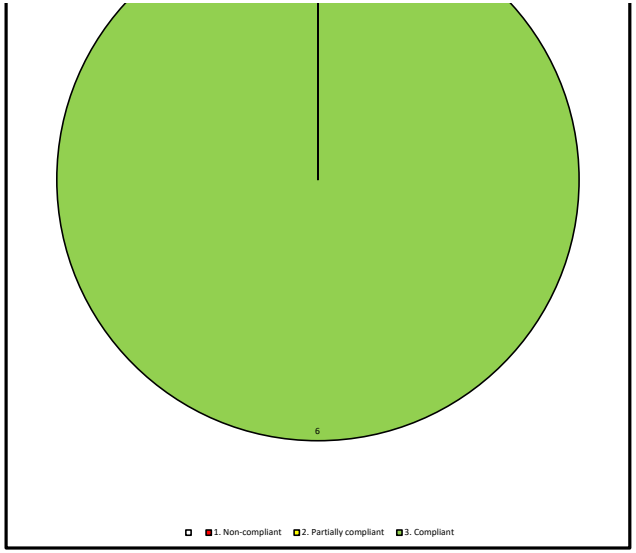


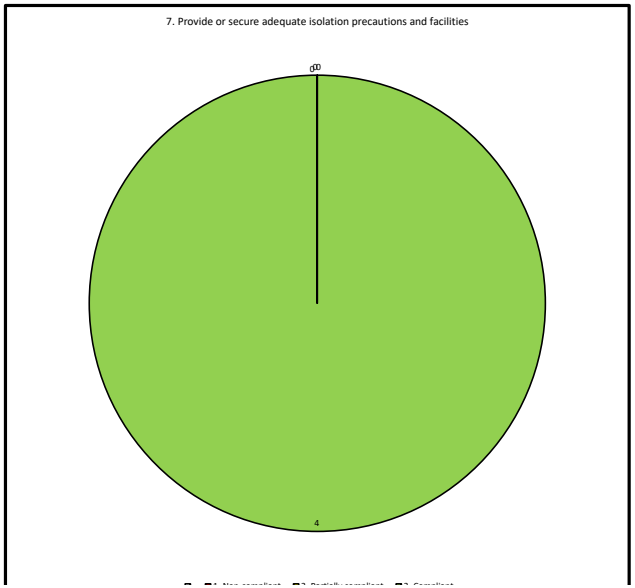
4.5	Relevant information, including infectious status, invasive device passports/care plans, is provided across organisation boundaries to support safe and appropriate management of patients/service users.	Discharge documentation is completed Patients information is given on a need to know basis in line with IG procedures and governance External partners attend CDI and BSI meetings				3. Compliant
5.	**Ensure early identification of individuals 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 others.**					
Systems and processes are in place to ensure that patient placement decisions are in line with the NIPCM:						
5.1	All patients/individuals are promptly assessed for infection and/or colonisation risk on arrival/transfer at the care area. Those who have, or are at risk of developing, an infection receive timely and appropriate treatment to reduce the risk of infection transmission.	As per policy patients are screened on admission or pre-admission and placed accordingly. Nursing documentation is completed on Sunrise	Trust does not always have side rooms available Datix is completed if source isolation cannot be accommodated Patient is isolated in the bay until suitable placement can be arranged.	Datix is completed if a patient cannot be isolated with 2 hours. Side room requests are escalated to site.		3. Compliant
5.2	Patients' infectious status should be continuously reviewed throughout their **stay/period of care**. This assessment should influence placement decisions in accordance with clinical/care need(s). If required, the patient is placed /isolated or cohorted accordingly whilst awaiting test results and documented in the patient's notes.	Patient is nursed in most appropriate place. If the patient cannot be nursed in isolation then this is risk assessed and documented on Sunrise Isolation signs are available for protected and Source isolation Nursing notes are documented on Sunrise.				3. Compliant
5.3	The infection status of the patient is communicated prior to transfer to the receiving organisation, department, or transferring services ensuring correct management/placement.	Discharge documentation is completed Patients information is given on a need to know basis in line with IG procedures and governance				3. Compliant
5.4	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.	Notice and floor length banners are available at entrances to educate and remind patients and visitors. Source Isolation and Protective isolation door mounted signs available on each ward for use.				3. Compliant
5.5	Two or more infection cases (or a single case of serious infection) linked by time, place, and person triggers an incident/outbreak investigation and this must be reported via governance reporting structures.	Outbreak policy available on the Hub Micro-organism polices available on the Hub Outbreak criteria reviewed and all potential outbreaks reviewed All outbreaks reported externally. Outbreaks reported to external partners including, UK HSA and ICB Outbreak meetings held, if required and minutes circulated External partners invited to outbreak meetings Outbreak information reported to IPCG and CQRM and IPR data			Outbreak of infection policy due for review July 2025.	3. Compliant
6.	**Systems are in place to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection**					
Systems and processes are in place to ensure:						
6.1	Induction and mandatory training on IPC includes the key criteria (SICPs/TBPs) for preventing and controlling infection within the context of the care setting.	IPC induction training is face to face and includes information on HCAI, SIPC, PPE donning and doffing, single use and is community and acute focused. IPC training is developed to the Skills for Care Level 2 standard and includes waste, sharps and decontamination.				3. Compliant
6.2	The workforce is competent in IPC commensurate with roles and responsibilities.	Polices and procedures are available on the IPC page on the Hub IPC is included in staff job descriptions IPC training is mandatory Data is reported by Divisions to IPCG meeting				3. Compliant



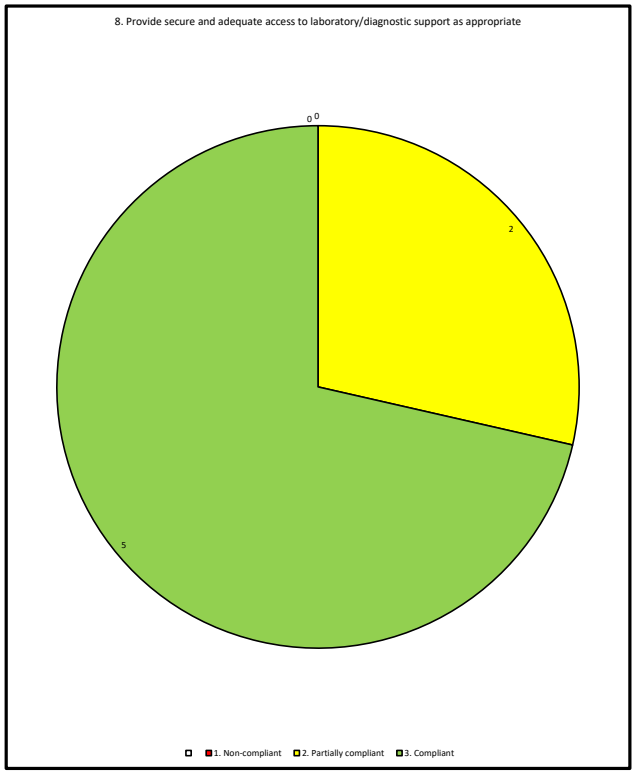


6.3	Monitoring compliance and update IPC training programs as required.	Training presentation are reviewed and amended at least annually and when information and policies and procedures change IPC competencies are recorded and monitored by the Learning and Development Team. PFI partners also have to complete IPC training. Details of compliance are recorded in IPCG Estates Reports. Mitie IPC training and IPC competencies developed with DDIPC in Aug 2023.				3. Compliant
6.4	All identified staff are trained in the selection and use of personal protective equipment / respiratory protective equipment (PPE/RPE) appropriate for their place of work including how to safely put on and remove (donning and doffing) PPE and RPE.	PPE and Donning and doffing is included in mandatory face to face induction training. Information is available on the hub including NHSE/ UK HSA Donning and doffing video IPC information is provided to contractors attending site to undertake work prior to the commencement of work An onsite induction is provided by Mitie				3. Compliant
6.5	That all identified staff are fit-tested as per Health and Safety Executive requirements and that a record is kept.	All staff who are required to wear FFP3 masks are fit tested every 2 years or when required, if sooner. Records are held by the Health and Safety Department				3. Compliant
6.6	If clinical staff undertake procedures that require additional clinical skills, for example, medical device insertion, there is evidence staff are trained to an agreed standard and the staff member has completed a competency assessment which is recorded in their records before being allowed to undertake the procedures independently.	Competencies completed and additional training is provided for specific clinical procedures e.g. venepuncture, catheterisation.				3. Compliant
7. Provide or secure adequate isolation precautions and facilities						
Systems and processes are in place in line with the NIPCM to ensure that:						
7.1	Patients that are known or suspected to be infectious as per criterion 5 are individually clinically risk assessed for infectious status when entering a care facility. The result of individual clinical assessments should determine patient placement decisions and the required IPC precautions. Clinical care should not be delayed based on infectious status.	As per IPC policies patients are screened on admission or pre-admission and placed accordingly.	Side rooms are not always available immediately	Datix is completed Patient is isolated in the bay until suitable placement can be arranged. Site team are notified if side room is required		3. Compliant
7.2	Isolation facilities are prioritised, depending on the known or suspected infectious agent and all decisions made are clearly documented in the patient's notes. Patients can be cohorted together if: • Single rooms are in short supply and if there are two or more patients with the same confirmed infection. • There are situations of service pressure, for example, winter, and patients may have different or multiple infections. In these situations, a preparedness plan must be in place ensuring that organisation/board level assurance on IPC systems and processes are in place to mitigate risk.	Isolation facilities' in side rooms are provided Isolation matrix available to aid clinical placement Patients are cohorted, if appropriate Flu pandemic plan available IPC Business continuity plan available IPC Team attends capacity daily and more frequently when required Weekend plan produced Winter plan produced				3. Compliant
7.3	Transmission based precautions (TBPs) in conjunction with SICPs are applied and monitored and there is clear signage where isolation is in progress, outlining the precautions required.	SICP policy available on the Hub PPE readily available Source isolation and protective isolation signage available for use Floor mounted banners advising of IPC precautions available for use.				3. Compliant

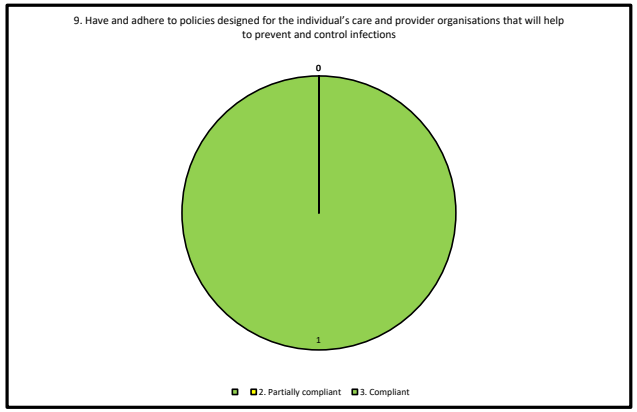


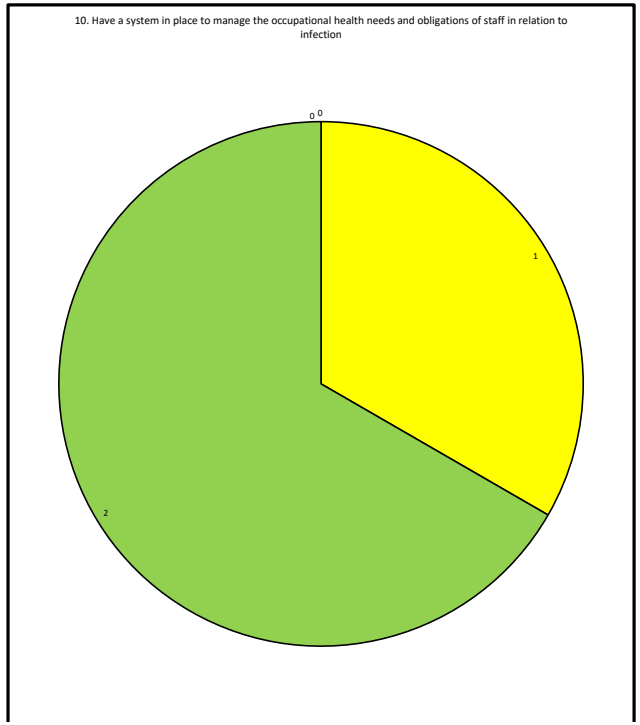


7.4	Infectious patients should only be transferred if clinically necessary. The receiving area (ward, hospital, care home etc.) must be made aware of the required precautions.	All infectious patients are reviewed by the IPC team prior to relocation or transfer. Patients are transferred when clinically appropriate.				3. Compliant
8.0	**Provide secure and adequate access to laboratory/diagnostic support as appropriate**					
Systems and processes to ensure that pathogen-specific guidance and testing in line with UKHSA are in place:						
8.1	Patient/service user testing for infectious agents is undertaken by competent and trained individuals and meet the standards required within a nationally recognised accreditation system.	All swabs are sent to BCPS accredited lab at Royal Wolverhampton Hospital. POC testing in ED is undertaken by trained competent staff				3. Compliant
8.2	Early identification and reporting of the infectious agent using the relevant test is required with reporting structures in place to escalate the result if necessary.	Trust has access to IC NET laboratory reporting system All results are pulled through onto the Trusts Sunrise system	Screening for CPE following the latest Department of Health guidance. Awaiting outcome of review from ICB and BCPS for funding to meet the new guidance	Trust has an in date CPE policy based on the previous Department for Health guidance All in patients who meet the criteria and are high risk are screened for CPE on admission Rectal and faecal screening for CPE can be provided A new CPE policy following the new guidance has been drafted and approved. Adoption of the policy is awaiting a decision from BCPS and the ICB This is recorded as a risk on the IPC risk register and ICB risk register	CPE screening not following the latest Department of Health guidance has been raised with the ICB and has been recorded as a risk on their risk register.	2. Partially compliant
8.3	Protocols/service contracts for testing and reporting laboratory/pathology results, including turnaround times, should be in place. These should be agreed and monitored with relevant service users as part of contract monitoring and laboratory accreditation systems.	Policies and procedures in place. Agreed with Black County Pathology Services.	Screening for CPE as discussed in section 8.2	Trust has an in date CPE policy based on the previous Department for Health guidance All in patients who meet the criteria and are high risk are screened for CPE on admission Rectal screening for CPE can be provided A new CPE policy following the new guidance has been drafted and	CPE screening not following the latest Department of Health guidance has been raised with the ICB and has been recorded as a risk on their risk register.	2. Partially compliant
8.4	Patient/service user testing on admission, transfer, and discharge should be in line with national guidance, local protocols and results should be communicated to the relevant organisation.	Polices, procedures and SOPs in place for testing for infections pre admission, admission and discharge. COVID_19 staff and screening policy in place COVID-19 rapid swabs available on request The trust follows national guidance on testing for MRSA, BBV screening for renal patients., Clostidiodes difficile etc The Trust has policies and procedures for guidance based on national polices for screening and testing for infections.		All in patients who meet the criteria and are high risk are screened for CPE on admission		3. Compliant
8.5	Patients/service users who develops symptom of infection are tested / retested at the point symptoms arise and in line with national guidance and local protocols.	PCR testing is available for symptomatic in patients for COVID-19 Patients for all other infections are tested at the point symptoms arise. POCT is available in ED Testing and retesting are available for all patients who require testing. The trust follows national guidance on testing for MRSA, BBV screening for renal patients, clostridiodes difficile etc. The Trust has policies and procedures for guidance based on national polices for screening and testing for infections.				3. Compliant
8.6	There should be protocols agreed between laboratory services and the service user organisations for laboratory support during outbreak investigation and management of known/ emerging/novel and high-risk pathogens.	Polices and procedures are in place with BCPS for outbreak investigation and high risk pathogens		A new CPE policy following the new guidance has been drafted and approved.		3. Compliant



8.7	There should be protocols agreed between laboratory services and service user organisations for the transportation of specimens including routine/ novel/ emerging/high risk pathogens. This protocol should be regularly tested to ensure compliance.	Policies and procedures are in place for the transportations of specimens to the laboratory in RWT.		This is recorded as a risk on the IPC risk register and ICB risk register		3. Compliant
9. Have and adhere to policies designed for the individual's care and provider organisations that will help to prevent and control infections						
9.1	Systems and processes are in place to ensure that guidance for the management of specific infectious agents is followed (as per UKHSA, A to Z pathogen resource, and the NIPCM). Policies and procedures are in place for the identification of and management of outbreaks/incidence of infection. This includes monitoring, recording, escalation and reporting of an outbreak/incident by the registered provider.	Polices, procedures and SOPS are in place for specific micro-organisms Outbreak and isolation policies are available All polices, procedures and SOPS are in date and available on the Trusts Hub. There is a CDI Improvement plan in place The Trust has access to IC NET All outbreaks are reported to NHSE, UK HSA and reported to external partners HCAI data is recorded and reported externally both and nationally. External partners attend BSI and CDI meetings when required Outbreak meetings are held when required Specimens are sent for Ribotyping when required The Trust is adopting the PSIRF directive				3. Compliant
10. Have a system in place to manage the occupational health needs and obligations of staff in relation to infection						
Systems and processes are in place to ensure that any workplace risk(s) are mitigated maximally for everyone. This includes access to an occupational health or an equivalent service to ensure:						
10.1	Staff who may be at high risk of complications from infection (including pregnancy) have an individual risk assessment.	risk assessments are completed for staff who are at risk of complications form infection. Risk assessments are kept in staffs' personal file Staff have access to the Staff Health and Wellbeing Service (SHAW)				3. Compliant
10.2	Staff who have had an occupational exposure are referred promptly to the relevant agency, for example, GP, occupational health, or accident and emergency, and understand immediate actions, for example, first aid, following an occupational exposure including process for reporting.	The Trust has a Sharps Injury Policy and have access to a 24 hour Emergency Department on Site. A HIV PEP service is available A Datix system is available to all staff and there is a joined up service between Health and Safety and SHAW for the monitoring and reporting of Sharps Injuries All injuries are reported via the IPCG meeting A sharps flow chart is available for staff to follow in the event of an injury Sharps handing and injuries are covered in IPC mandatory face to face training. The Trust has a sharps safety task and finish group Safer sharps are promoted Vaccinations are given as required. Seasonal flu and COVID vaccination service provided in house.	The PeP policy is out of date and is currently under review.	Pep is provided by SHAW and out of Hours be ED although this process needs formally adopting.	The PeP policy is about of date and is currently under review. To be adopted at the IPCG meeting in April 2024	2. Partially compliant
10.3	Staff have had the required health checks, immunisations and clearance undertaken by a competent advisor (including those undertaking exposure prone procedures (EPPs).	Pre employment checks for all staff are completed via the Staff Health and Wellbeing Service.				3. Compliant





Enclosure 11

The Dudley Group NHS Foundation Trust

Paper for submission to the Public Board of Directors on 11th July 2024

Report title	**Perinatal Clinical Quality Surveillance**
Sponsoring executive	Martina Morris - Chief Nurse
Report author /presenter	Claire Macdiarmid - Head of Midwifery

1. Suggested discussion points

Perinatal mortality data has shown an improvement with the stillbirth rate, neonatal death rate and total mortality death rates all reducing. Neonatal death rates are now at 1.67 with the national benchmark being 1.65. This is the lowest the rate has been for over 12 months.

There have been no cases referred to the Maternity and Newborn Safety Investigations (MNSI) during April and May 2024. There has been 1 new Patient Safety Incident Investigation (PSII) commenced during April and May 2024, which relates to missed administration of Anti D and has been reported to Serious Hazards of Transfusion (SHOT). There has been 2 PSII and 3 MNSI cases concluded during April and May 2024.

Maternity services have improved scoring on the regional heatmap to a green score of 25, compared to a red score of 38 in November 2023. Work is underway to improve this score further.

PERIPrem data is included for information on progress since its launch in November 2023. 5 elements are fully achieved and 5 require further action to ensure full consistent compliance.

Maternity incentive scheme year 6 commenced in April 2024 and all actions are in an amber position with a trajectory for full compliance by the completion date of the 30th November 2024.

Maternity safety champions and safety walkarounds continue to meet bimonthly. Staff from Maternity and Neonatal have the opportunity to raise concerns at a session hosted by non-executive director Dr Liz Hughes and Board level safety champions Martina Morris (Chief Nurse) and Dr Julian Hobbs (Medical Director) planned for July 2024.

2. Alignment to our Vision *[indicate with an **'X'** which Strategic Objective[s] this paper supports]*

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

3. Report journey

Quality Committee
LMNS Quality and Safety
Maternity Governance Group
Mortality Surveillance Group (perinatal mortality data)

4.	Recommendation(s)
The Quality Committee is asked to:	
a.	Accept assurance of progress made with 3-year delivery plan.
b.	Accept assurance of current position with MIS year 6.
c.	

5	Impact							
Board Assurance Framework Risk 1.1		x	Deliver high quality, safe person-centred care and treatment					
Board Assurance Framework Risk 1.2		x	Achieve outstanding CQC rating.					
Board Assurance Framework Risk 3.0		x	Improve and sustain staff satisfaction and morale					
Corporate Risk Register			*[Give risk Nos]*					
Equality Impact Assessment	Is this required?		Y		N		If 'Y' date completed	
Quality Impact Assessment	Is this required?		Y		N		If 'Y' date completed	

REPORT FOR ASSURANCE

Perinatal Clinical Quality Surveillance

Report to Public Board of Directors 11th July 2024

1 EXECUTIVE SUMMARY

1.1 This report outlines locally and nationally agreed measures to monitor maternity and neonatal safety as outlined in the NHS England/Improvement (NHSEI) document "Implementing a revised perinatal quality surveillance model" (December 2020). The purpose of the report is to inform the Quality Committee, Trust Board and Local Maternity and Neonatal System (LMNS) board of present or emerging safety concerns or activity to ensure safety with a two-way reflection of ward to board insight across the multidisciplinary multi professional maternity and neonatal service teams. The information within the report will reflect actions in line with Ockenden and 3-year delivery plan and progress made in response to any identified concerns at provider level.

1.2 In line with the perinatal surveillance model, the Trust is required to report the information outlined in the data measures proforma monthly to the trust board. Data contained within this report is for **April and May 2024**, unless otherwise specified throughout.

2. BACKGROUND INFORMATION

2.1 Perinatal Mortality Overview

Stillbirth: A baby born at or after 24 completed weeks gestational age showing no signs of life, irrespective of when the death occurred

Neonatal death: A baby born at any time during the pregnancy who lives, even briefly, but dies within four weeks of being born.

Perinatal mortality rate: Stillbirth and neonatal deathrates combined.

*Please note that MBRRACE have changed the way they report Neonatal deaths to total number of deaths, compared to their previously split between early and late neonatal deaths.

Table 1: Perinatal Safety data including mortality and serious incidents

2024

The MAT should be viewed in conjunction with the Maternity Dashboard and the Head of Midwifery report

	CQC Maternity Inspection April 2023 (safe and Well Led) (Previous rating from 2019)	Safe	Effective	Caring	Well-Led	Responsive	
		Good	Good	Good	Good	Good	
		2024 Jan	**2024 Feb**	**2024 March**	**2024 Apr**	**2024 May**	**2024 Jun**
PMRT	Perinatal Mortality Review Tool cases opened in month	1	0	4	1	1	
	PMRT reviewed in month	2	1	2	2	2	
HSIB/ MNSI	Number of cases referred to and accepted by MNSI (with 72 hr review)	0	0	0	0	0	
	Reports received from MNSI	0	0	0	1	2	
	MNSI investigations ongoing	4	4	4	3	1	
	MNSI open action plans	0	0	0	1	1	
PSIRF	The number of incidents logged as moderate or above:	1	0	1	0	0	
	PSII Reported	0	1	0	0	0	
	PSII Completed	0	0	0	2	0	
	PSII Ongoing	2	2	2	0	0	
	Oustanding Investigation Actions - overdue	7	3	3	5		
	Oustanding Investigation Actions - open			6	7		
	Maternity Incidents Improvement Plan - overdue actions					12	
	Maternity Incidents Improvement Plan - open actions					13	
Clinical Outcome measures	Stillbirth rate (National crude rate 3.54 per 1000 births)	2.44	2.43	3.4	2.9	2.62	
	Neonatal Death Rate 1.65 (> 22+0 - up to 28 days post delivery)	2.44	2.19	2.19	2.18	1.67	
	Neonatal death rate only including babies born over 24/40			1.21	1.21	0.96	
	Total Perinatal Mortality Rate (MBRRACE figure 5.19 per 1000 births)	4.88	4.62	5.59	5.08	4.29	
	Avoidable term admission to NNU (reported quarterly)		3				
Appraisals	All Maternity staff (90%)						
Midwifery Training	Fetal Monitoring Training (90%)*	99.00%%	97.00%	98.00%	96.00%	96.00%	
	Obstetric Emergency Simulation Training (PROMPT) (90%)*	99.00%%	97.00%	96.00%	96.00%	98.00%	
	Safeguarding (level 3) Adult (90%)	84.00%	83.00%	77.00%	70.00%	83.00%	
	Safeguarding (level 3) Children (90%)	78.00%	79.00%	82.00%	79.00%	83.00%	
	Neonatal Resusitation (90-95%)*	93.00%	92.00%	90.00%	86.00%	90.00%	
	Adult Resusitation (90 - 95%)*	94.00%	93.00%	91.00%	86.00%	84.00%	
Obstetrics Training	Fetal Monitoring Training (90%)*	97%	100.00%	100.00%	95.00%	95.00%	
	Obstetric Emergency Simulation Training (PROMPT) (90%)*	92%	97.00%	97.00%	95.00%	100.00%	
	Safeguarding (level 3) Adult (90%)	81.00%	73.00%	73.00%	80.00%	80.00%	
	Safeguarding (level 3) Children (90%)	68.00%	68.00%	71.00%	72.00%	80.00%	
	Neonatal Resusitation (90-95%)*	86.00%	85.00%	80.00%	90.00%	92.00%	
	Adult Resusitation (90 - 95%)*	86.00%	85.00%	91.00%	88.00%	90.00%	
						*Element 4 and 5 of CCFv2 as included in other training days	
Safe staffing	Obstetric consultant cover on delivery suite	91	91	91	91	91	
	Vacancies midwifery (WTE)	0	0	0	0	0	
	Obstetric Consultant vacancies (WTE)	0	0	0	0	0	
	Total Red flag data: Total number of red flags (As per acuity tool)	5	1	0	14	14	
	Shift Leader supernumuary: % of time	100%	100%	100%	100%	100%	
	1:1 care in labour achieved	100%	100%	100%	100%	100%	
	Birth Before Arrival (BBA)	2	1	1	3	2	
Service user feedback	MVP (Quarterly)	.	.	6.3.24	.	.	~~6.6.24~~
	MNVP Extraordinary meetings* Bereavement / Neonatal / EDI	.	.	21.3.24	25.4.24	-	
Engagement	Response Rate (%)	7.00%	11.00%	25.00%	33.00%	17.00%	
	Recommendation Response Rate (Good/ Very Good %)	17.00%	86.00%	81.00%	82.00%	77%	
	PALS	3	9	5	3	1	
	Complaints	5	5	3	6	4	
	Compliments	71	65	70	72	67	
Safety Champion	Maternity Safety champions walk- about	None	Cancelled	None	none	13.5.24	
	Maternity and Neonatal Safety Champion Meeting	None	28/2/24	None	24.4.24		26.6.24
	Maternity Quad	None	None	None	25.4.24	Kornferry	
External	MNSI/NHSR/CQC or other organisation with a concern or request for action made directly with the trust	0	0	0	0	0	
Legal	Legal cases (Maternity only- Including Coroners cases and ENS claims)	1 closed	0	0	3	0	

Annual Response	Proportion of Midwives responding with 'Agree' or 'Strongly Agree' on whether they would recommend their trust as a place to work or receive treatment	60.60%
	Proportion of all doctors responding with 'excellent or good' on how they would rate the quality of clincial supervision out of hours	57.10%
	Speciality OBS/Gynae with 'Good' or 'Excellent' for support	Awaiting

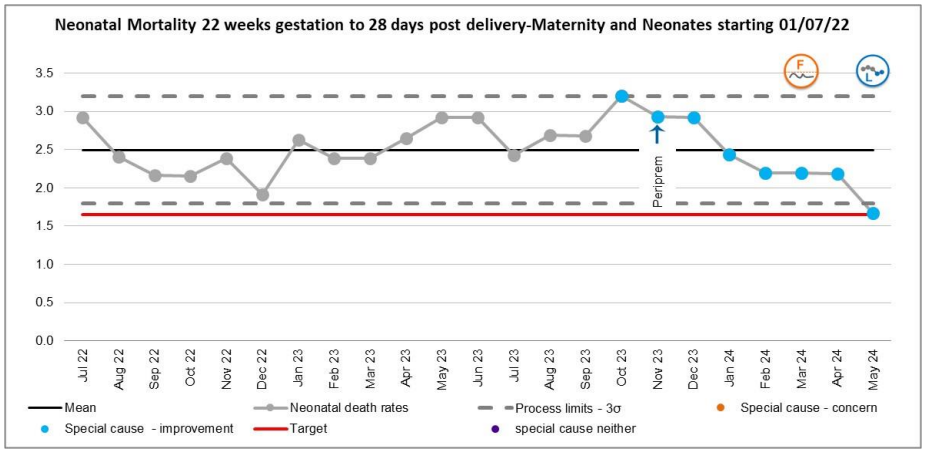
2.2 Perinatal Mortality overview (table 1)

The Women and Children's service continues to report perinatal mortality rates through Divisional Governance each month and into the Trusts Mortality Surveillance Group. Quarterly reports will be reported via the Private Board of Directors.

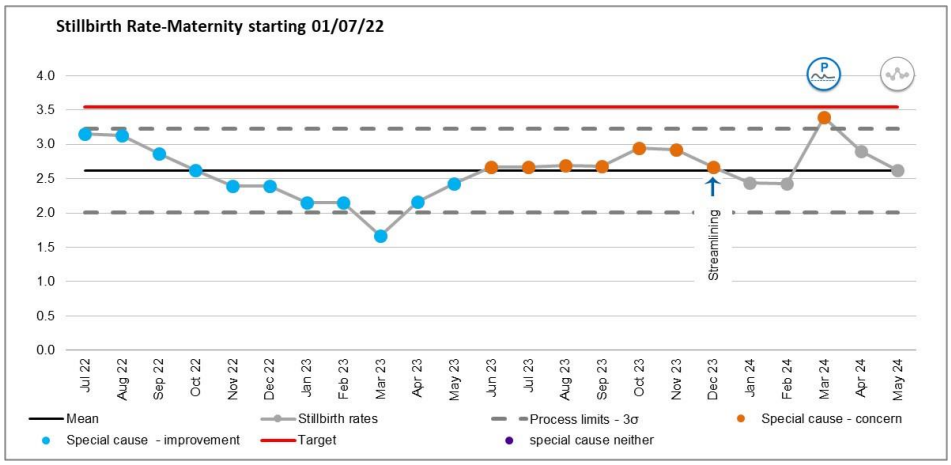
A thematic review has been undertaken into Neonatal deaths due to the rate being persistently above the National average rate (note the change in rate as per MBRRACE January 2024). MBRRACE now report neonatal deaths as one figure, compared to the early and late death rates previously featured.

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 Maternity incentive scheme (MIS) Safety Action 1.

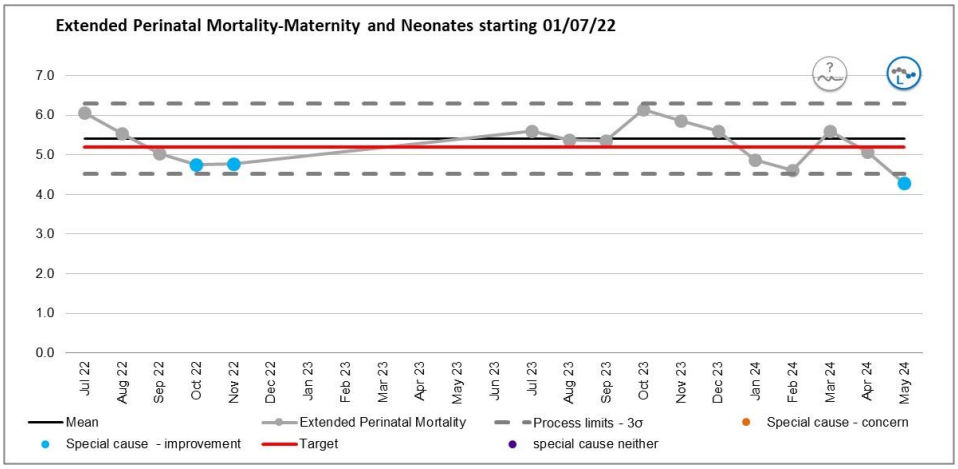
The neonatal death rate has decreased significantly as per SPC chart below. There has been a month-on-month reduction over the last 7 months. The Trust rate is now at 1.67, the national rate is 1.65 per 1000 births. PERIPrem was introduced in November 2023 and results of this intervention are discussed below.



The Trust stillbirth rate peaked above the national rate of 3.54 in March 2024, however, has now returned to a rate of 2.62 per 1000 births.



Extended Trust perinatal mortality rate is now at 4.29, below the national rate of 5.19 per 1000 births.



There has been 1 stillbirth during April and May 2024.

There has been 1 neonatal death during April and May 2024.

2.3 Serious incidents and Maternity and Newborn investigations

There have been no cases referred to the Maternity and Newborn Safety Investigations (MNSI) during April and May 2024.

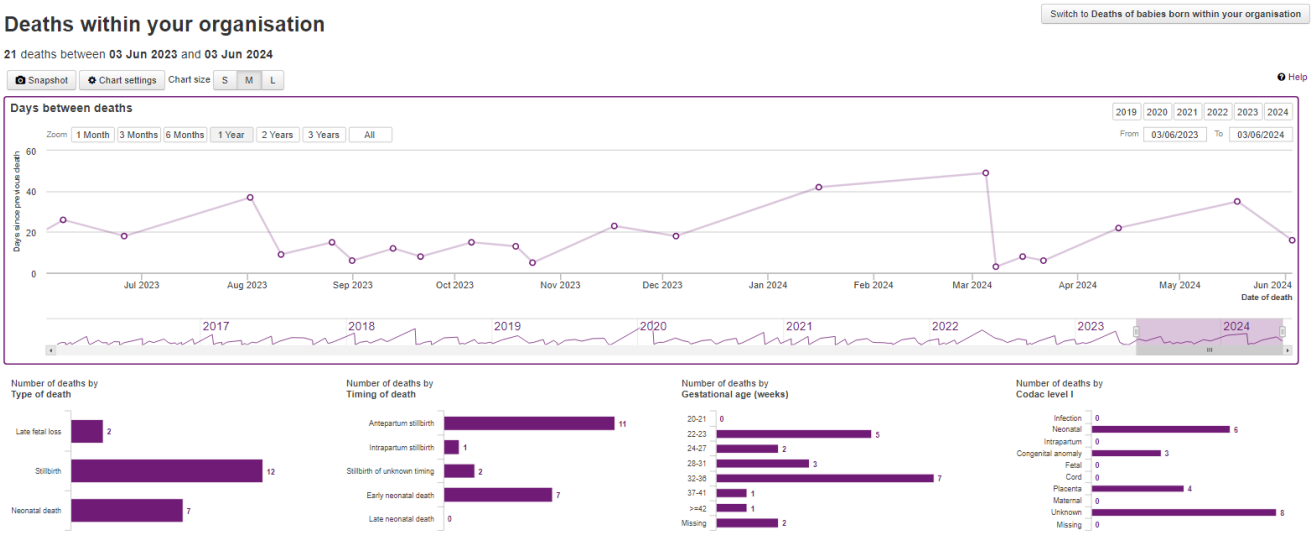
There has been 1 new Patient Safety Incident Investigation (PSII) commenced during April and May 2024, which relates to missed administration of Anti D and has been reported to Serious Hazards of Transfusion (SHOT).

There has been 2 PSII and 3 MNSI cases concluded during April and May 2024. A summary of cases was discusses at the Quality committee (June 2024).

2.4 Perinatal Mortality Review tool (PMRT)

2.4.1 PMRT real time data monitoring tool

12 months of data showing deaths of babies who were born within our organisation, including babies who died elsewhere but were born at the trust.



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.

2.5 Coroner Regulation 28 made directly to the Trust

There were 0 Coroner regulation 28 made directly to the Trust in respect of perinatal or maternal deaths in April or May 2024

2.6 Maternity safety champions

Maternity safety champions met on the 24th April 2024. Issues discussed were:

- New safety dashboard development.
- MIS year 2 resubmission of evidence.
- Update on the CQC Maternity survey action plan and comparison within the Black country.
- ATTAIN report and action plan review.
- Saving babies lives version 3 update.
- Freedom to speak up and speak up from safety champion session held.
- Single delivery plan.

A subsequent meeting was held on the 26th June 2024.

A maternity safety walkaround occurred on the 13th May 2024, but due to capacity challenges this was only attended by the Chief Nurse. No major issues were identified. Ward to board walk arounds on maternity continue and are logged as part of the minutes of the safety champions. A session to allow staff to vocalise and raise any concerns is being held in July 2024. Staff from maternity and neonates are encouraged to attend. This is being hosted by Non-executive Director Dr Liz Hughes and Executive level safety champions Martina Morris (Chief Nurse) and Dr Julain Hobbs (Medical Director).

2.7 Saving Babies Lives

As part of the Three year delivery plan for maternity and neonatal services, NHS trusts are responsible for implementing SBLCBv3 by March 2024 and integrated care boards (ICBs) / Local Maternity and Neonatal Systems (LMNS) are responsible for agreeing a local

improvement trajectory with providers, along with overseeing, supporting, and challenging local delivery. Providers are required to demonstrate 50% compliance with each element of the care bundle, with a minimum of 70% compliance overall.

Compliance as of LMNS review on 06/12/23:

Implementation Progress

Intervention Elements	Description	Element Progress Status (Self assessment)	% of Interventions Fully Implemented (Self assessment)	Element Progress Status (LMNS Validated)	% of Interventions Fully Implemented (LMNS Validated)	NHS Resolution Maternity Incentive Scheme
Element 1	Smoking in pregnancy	Partially implemented	80%	Partially implemented	70%	CNST Met
Element 2	Fetal growth restriction	Fully implemented	100%	Partially implemented	85%	CNST Met
Element 3	Reduced fetal movements	Fully implemented	100%	Partially implemented	50%	CNST Met
Element 4	Fetal monitoring in labour	Partially implemented	80%	Partially implemented	60%	CNST Met
Element 5	Preterm birth	Partially implemented	93%	Partially implemented	81%	CNST Met
Element 6	Diabetes	Fully implemented	100%	Fully implemented	100%	CNST Met
All Elements	TOTAL	Partially implemented	93%	Partially implemented	80%	CNST Met

Self-assessed compliance is currently 93% following the addition of extra evidence. A touchpoint meeting with the LMNS is scheduled for late July 2024. Progress with full implementation is on trajectory to achieve the required standard for MIS year 6.

2.8 Maternity and Perinatal incentive scheme (MIS) year 6

MIS year 6 launched on the 2nd April 2024, outlining the requirements of the scheme. The trust undertook a gap analysis which was discussed in the Quality Committee in April. Progress with compliance is ongoing and papers are being submitted to relevant committees and Board to provide assurance. All safety actions are on trajectory for full compliance by the completion date of 30th November 2024. Deadline for submission of the of the self-certification declaration from the Trust Board to NHS resolution (NHSR) is 3rd March 2025. NHS R have launched an audit compliance tool on the futures platform that allows trusts to monitor their progress and compliance status against all 10 safety actions. This tool will be completed and presented to the August 2024 Quality committee.

Trust Current position MIS year 6

Safety Action	Safety Action Title Theme	RAG rating as of June 2024.
1	Perinatal Mortality review tool	
2	Maternity Services Dataset (MSDS)	
3	Transitional Care and and Quality improvement	
4	Clinical Workforce	
5	Midwifery Workforce	
6	Saving Babies Lives	
7	Listen to women, parents and families using maternity and neonatal services and coproduce services with users.	
8	Training	

9	Board Assurance	
10	Maternity and Neonatal Safety Investigations and Early Notification Scheme	

2.9 Maternity action plans

3-year delivery plan NHS England » Three year delivery plan for maternity and neonatal services

The three-year delivery plan for maternity and neonates was launched in March 2023, and sets out four high levels themes that will enhance choice and safety within perinatal services. The responsibility within each theme is shared between NHS trusts, Integrated care boards and NHS England with each having to implement key targets within the next 3 years.

Appendix 3 outlines a summary highlight of current position with the plan. NHS England have recently launched a compliance tool on the futures platform to allow trusts and systems to monitor compliance. Quarterly updates will be presented to the quality committee. committee.

2.10 Neonatal update

The PERIPrem care bundle - Health Innovation West of England (healthinnowest.net)

PERIPrem (Perinatal Excellence to Reduce Injury in Premature Birth) is a unique perinatal care bundle of 11 interventions that demonstrate a significant impact on brain injury and mortality rates amongst babies born prematurely. PERIPrem also forges new ways of working, where clinicians from obstetrics, midwifery and neonatal join together to drive forward and revolutionise care for pre-term babies.

PERIPrem was launched at the Dudley Group in November 2023 and results from the first two quarters of data can be found in appendix 2. Six elements are fully compliant, and five require further work. This includes steroids and magnesium sulphate administration, birth in the right place, early breast milk administration delayed cord clamping. The team are committed to improving outcomes and work remains ongoing with all elements. Some require support from external agencies and the team are involved in supporting all working groups within the LMNS.

*The data is currently displayed in a standardised format as recommended by the PERIPrem team. We plan to display this data in an SPC chart format once enough data has been gathered later this year.

2.11 Maternity Regional Heatmap (Table 2)

Table 2 demonstrates trusts current position with the regional Maternity heat map. The lower the score, the less the number of concerns have been raised about the Trust. Dudley is achieving a green score of 25. Areas to highlight are a score of 2 for ethnicity data quality. This issue has been highlighted by the digital midwife and rectifications are in place. The CQC maternity survey scores 4 due to being a negative outlier and work remains ongoing in improving this. This score cannot improve until publication of this year's results. Senior leadership remains a score of 5 due to no Director of Midwifery role at the Trust and this is being rectified by the division and HR. To note our neonatal death rate has reduced to a score of 1 due to its persistent decline towards the national rate.

2.12 Service user feedback

The Maternity and neonatal voices partnership (MNVP) meeting scheduled for the 6th June, had to be postponed due to the upcoming general election. This will be rescheduled for after July 2024. The MNVP are invited to many elements of maternity services governance processes such as governance meetings, regular catch ups with the Head of Midwifery and soon this will include PMRT.

2.12.1 Service user feedback- Friends and Family results April and May 2024

“We had a male midwife who was very attentive and professional. All midwives read and understand our preference sheets. The theatre team were amazing at making us feel comfortable especially our anaesthetist.”

“Midwife Lucy on maternity was so calming. She really helped. Edele who delivered the baby was also amazing - really calming and listened to what I wanted. “

“Midwife Salina made me feel like I was in safe hands. Had a bad experience last year. She was very helpful and I had a very good experience this time. Could not thank her enough.”

“Staff co-operative.”
“Everyone was very nice and everyone explained everything very well.”
“The whole team was very nice.”

“The staff are amazing and caring they work as a team.”

“When given lots of information - could do with written down as its easy to forget.”

“More info and support as I was a first time mom.”

“During induction. Night staff just popping in checking a little more.”

“The waiting list was long (For labour induction).”

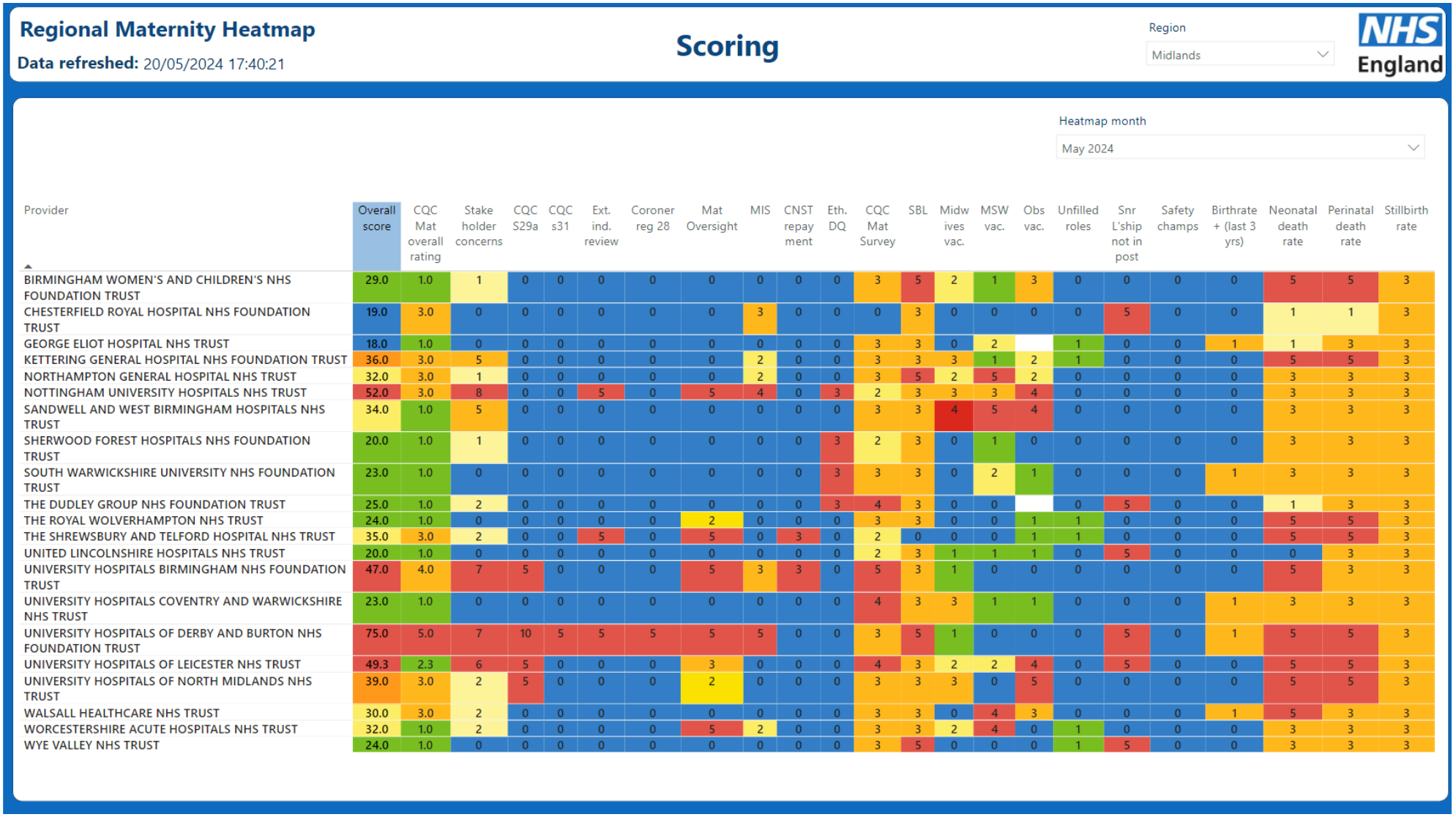
3. RECOMMENDATION(S)

3.1 The Board is invited to accept the assurance provided in this report as current position with perinatal mortality, Serious incidents and learning, 3-year delivery plan, Regional Maternity heatmap scoring, and progress with MIS year 6.

Name of Authors: Claire Macdiarmid
Title of Author Head of Midwifery

Date 1st July 2024

Appendix 1: Regional maternity Heatmap



Regional Maternity Heatmap

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Scoring

Region: Midlands

NHS England

Heatmap month: May 2024

Provider	Overall score	CQC Mat overall rating	Stake holder concerns	CQC S29a	CQC s31	Ext. ind. review	Coroner reg 28	Mat Oversight	MIS	CNST repay ment	Eth. DQ	CQC Mat Survey	SBL	Midw ives vac.	MSW vac.	Obs vac.	Unfilled roles	Snr L'ship not in post	Safety champs	Birthrate + (last 3 yrs)	Neonatal death rate	Perinatal death rate	Stillbirth rate
BIRMINGHAM WOMEN'S AND CHILDREN'S NHS FOUNDATION TRUST	29.0	1.0	1	0	0	0	0	0	0	0	0	3	5	2	1	3	0	0	0	0	5	5	3
CHESTERFIELD ROYAL HOSPITAL NHS FOUNDATION TRUST	19.0	3.0	0	0	0	0	0	0	3	0	0	0	3	0	0	0	0	5	0	0	1	1	3
GEORGE ELIOT HOSPITAL NHS TRUST	18.0	1.0	0	0	0	0	0	0	0	0	0	3	3	0	2		1	0	0	1	1	3	3
KETTERING GENERAL HOSPITAL NHS FOUNDATION TRUST	36.0	3.0	5	0	0	0	0	0	2	0	0	3	3	3	1	2	1	0	0	0	5	5	3
NORTHAMPTON GENERAL HOSPITAL NHS TRUST	32.0	3.0	1	0	0	0	0	0	2	0	0	3	5	2	5	2	0	0	0	0	3	3	3
NOTTINGHAM UNIVERSITY HOSPITALS NHS TRUST	52.0	3.0	8	0	0	5	0	5	4	0	3	2	3	3	3	4	0	0	0	0	3	3	3
SANDWELL AND WEST BIRMINGHAM HOSPITALS NHS TRUST	34.0	1.0	5	0	0	0	0	0	0	0	0	3	3	4	5	4	0	0	0	0	3	3	3
SHERWOOD FOREST HOSPITALS NHS FOUNDATION TRUST	20.0	1.0	1	0	0	0	0	0	0	0	3	2	3	0	1	0	0	0	0	0	3	3	3
SOUTH WARWICKSHIRE UNIVERSITY NHS FOUNDATION TRUST	23.0	1.0	0	0	0	0	0	0	0	0	3	3	3	0	2	1	0	0	0	1	3	3	3
THE DUDLEY GROUP NHS FOUNDATION TRUST	25.0	1.0	2	0	0	0	0	0	0	0	3	4	3	0	0		0	5	0	0	1	3	3
THE ROYAL WOLVERHAMPTON NHS TRUST	24.0	1.0	0	0	0	0	0	2	0	0	0	3	3	0	0	1	1	0	0	0	5	5	3
THE SHREWSBURY AND TELFORD HOSPITAL NHS TRUST	35.0	3.0	2	0	0	5	0	5	0	3	0	2	0	0	0	1	1	0	0	0	5	5	3
UNITED LINCOLNSHIRE HOSPITALS NHS TRUST	20.0	1.0	0	0	0	0	0	0	0	0	0	2	3	1	1	1	0	5	0	0	0	3	3
UNIVERSITY HOSPITALS BIRMINGHAM NHS FOUNDATION TRUST	47.0	4.0	7	5	0	0	0	5	3	3	0	5	3	1	0	0	0	0	0	0	5	3	3
UNIVERSITY HOSPITALS COVENTRY AND WARWICKSHIRE NHS TRUST	23.0	1.0	0	0	0	0	0	0	0	0	0	4	3	3	1	1	0	0	0	1	3	3	3
UNIVERSITY HOSPITALS OF DERBY AND BURTON NHS FOUNDATION TRUST	75.0	5.0	7	10	5	5	5	5	5	0	0	3	5	1	0	0	0	5	0	1	5	5	3
UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST	49.3	2.3	6	5	0	0	0	3	0	0	0	4	3	2	2	4	0	5	0	0	5	5	3
UNIVERSITY HOSPITALS OF NORTH MIDLANDS NHS TRUST	39.0	3.0	2	5	0	0	0	2	0	0	0	3	3	3	0	5	0	0	0	0	5	5	3
WALSALL HEALTHCARE NHS TRUST	30.0	3.0	2	0	0	0	0	0	0	0	0	3	3	0	4	3	0	0	0	1	5	3	3
WORCESTERSHIRE ACUTE HOSPITALS NHS TRUST	32.0	1.0	2	0	0	0	0	5	2	0	0	3	3	2	4	0	1	0	0	0	3	3	3
WYE VALLEY NHS TRUST	24.0	1.0	0	0	0	0	0	0	0	0	0	3	5	0	0	0	1	5	0	0	3	3	3

Regional Maternity Heatmap

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Provider Scoring Summary

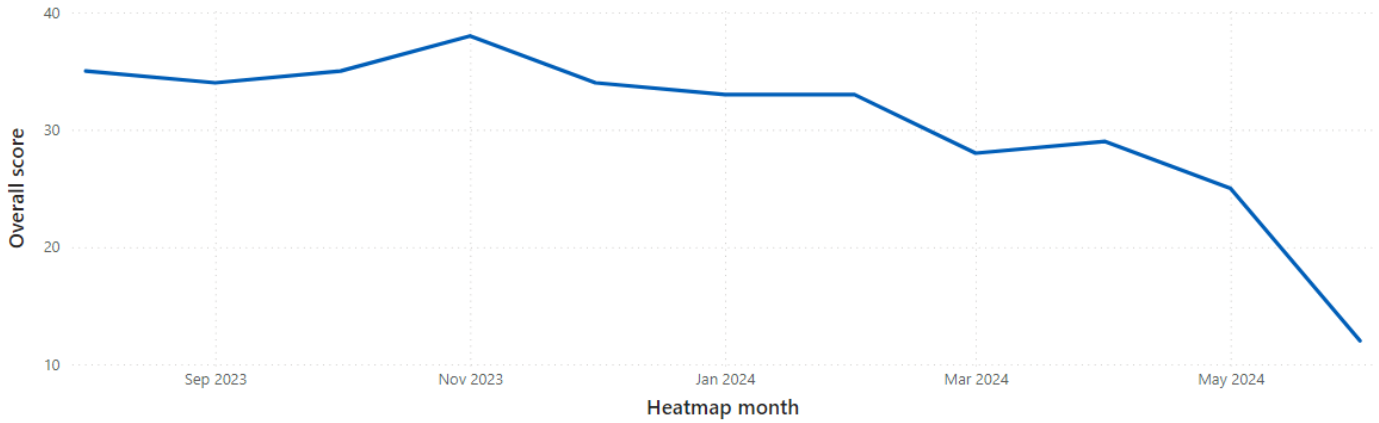
Region: Midlands

NHS England

Select a trust

THE DUDLEY GROUP NHS FOUNDATION TRUST

Overall heatmap score by month



Heatmap month	Overall score	CQC Mat overall rating	Stake holder concerns	CQC S29a	CQC s31	Ext. ind. review	Coroner reg 28	Mat Oversight	MIS	CNST repayment	Eth. DQ	CQC Mat Survey	SBL	Midwives vac.	MSW vac.	Obs vac.	Unfilled roles	Snr L'ship not in post	Safety champs	Birthrate + (last 3 yrs)	Neonatal death rate	Perinatal death rate	Stillbirth rate
June 2024	12.0	1.0							0	0		4									1	3	3
May 2024	25.0	1.0	2	0	0	0	0	0	0	0	3	4	3	0	0		0	5	0	0	1	3	3
April 2024	29.0	1.0	3	0	0	0	0	0	3	0	3	4	3	0	0		0	5	0	0	1	3	3
March 2024	28.0	1.0	2	0	0	0	0	0	3	0	3	4	3	0	0		0	5	0	0	1	3	3
February 2024	33.0	1.0	2	0	0	0	0	0	3	0	3	5	3	0	0		0	5	0	0	5	3	3
January 2024	33.0	1.0	5	0	0	0	0	0	3	0	0	5	3	0	0		0	5	0	0	5	3	3
December 2023	34.0	1.0	5	0	0	0	0	0	3	0	0	5	3	0	1		0	5	0	0	5	3	3
November 2023	38.0	1.0	5	0	0	0	0	0	3	0	3	5	5	0	0		0	5	0	0	5	3	3
October 2023	35.0	1.0	5	0	0	0		0	3	0	3	5		0	1		1	5	0	0	5	3	3
September 2023	34.0	1.0	4	0	0	0		0	3	0	3	5		0	1		1	5	0	0	5	3	3

Appendix 2: Periprem bundle Data Q4 2024

PERIPRem Bundle: Unit Snapshot Tool

Trust: Dudley **Team:** Neonatal/Maternity - Lisa Gough **Date:** Quarter 4

Bundle Element	Current or past QI work in this area	Where are we now? include baseline data / known barriers and facilitators to improvement	Is this an area of expertise / innovation or difficulty for us?
Birth in the right place 	Previous deepdive (LMNS) 2022 that determined that 6 babies delivered at RHH could have been transfered out to deliver at level 3. All babies out of pathway have MDT review within 1 week.	Quarter 3 - 1 baby out of pathway. Jan - 2 Babies out of pathway Feb - 2 Babies out of pathway March - 100% compliance	Compliance NOT ACHIEVED in Jan and Feb. All babies reviewed at MDT WIRMS - none of the mothers could be transfered before delivery to level 3.
Antenatal Steroids 	Improvement from 2022 = 23% Quarter 3 - 44%	Jan - 66% Feb - 42% March - 30% = 43% total	We are below standard of 90%. NOT ACHIEVED Obs team to formulate an action plan. This is a challenge for all units in LMNS City 51%, NX 45%, Walsall 40%
Magnesium Sulphate 	Quarter 3 83% 4 babies delivering quickly out of pathway has effected this quarters figures.	Jan - 100% Feb - 33% March - 100% = 66%	We exceeded compliance of 85% in Jan and March. We had 33% compliance in Feb. NOT ACHIEVED Our compliance has dropped from Q3.
Early Breast Milk 	Quarter 3 27% AMAT critical action plan in place. Train CSW, prescribe colostrum, targetted teaching for staff. STORK practitioners now in place.	Jan - 57% Feb - 50% March - 33% = 44%	Below compliance of 85% however greatly increased from Q3. NOT ACHIEVED
Delayed Cord Clamping (DCC) 	Quarter 3 86% AMAT critical action plan to be devised Lifestart training for staff, targetted awareness for new medics.	Jan - 55% Feb - 50% March - 58% = 55%	Below compliance of 85%. NOT ACHIEVED

PERIPRem Bundle: Unit Snapshot Tool

Trust: Dudley **Team:** Neonatal/Maternity - Lisa Gough **Date:** Quarter 4

Bundle Element	Current or past QI work in this area	Where are we now? include baseline data / known barriers and facilitators to improvement	Is this an area of expertise / innovation or difficulty for us?
Thermal Care 	Quarter 3 = 97% Previous sucessful QI project, ATAIN training for staff. Neonatal nurse at preterm deliveries.	Jan - 77% Feb - 75% March - 100% = 86%	Close to target of 90%, Second highest in West Midlands. ACHIEVED
Caffeine 	Quarter 3 = 100%	Jan - 100% Feb - 100% March - 100% = 100%	Exceeding target of 85% This is well embedded in practice. ACHIEVED
Probiotics 	Quarter 3 = 100% Launched June 2023. NNU/Maternity teaching prior to launch.	Jan - 100% Feb - 100% March - 100% = 100%	We are exceeding target of 85% ACHIEVED
Volume guaranteed ventilation 	Quarter 3 = 100% Attendance of medics and nurses at various study days and inhouse training to increase staff knowledge of targetted ventilation.	Jan - 100% Feb - 100% March - 100% = 100%	100% compliance ACHIEVED
Prophylactic hydrocortisone 	Quarter 3 = 100% Launched in Oct with PERIPrem, PERIPrem promotion board on NNU, newly developed monograph by ANNP/Pharmacist	Jan - 100% Feb - 100% March - 100%	We are exceeding target of 85% ACHIEVED

Appendix 4: 3 year delivery plan summary

The Dudley Group NHS Foundation Trust

3 year Delivery Plan Progress Update – The Dudley Group NHS Foundation Trust May 2024

Year 1 Trust Objectives:

1. **Listening to and working with families with compassion**

EDI Lead Midwife recruited to ensure equalities remain a top priority for the service

MNVP Included in governance processes
Action plan coproduced for 2023-2024.

2. **Growing, retaining and supporting our workforce**

Continue to monitor the midwifery workforce every 6 months and report via Board.

Retention midwife to remain in post

TNA completed for year 1

3. **Developing and sustaining a culture of safety, learning, and support**

Perinatal quad to prioritise attendance at the Perinatal culture and leadership program.

Implementation of the Each baby counts toolkit

Recruitment of a Maternity patient safety specialist.

4. **Standards and structures that underpin safer, more personalised, and more equitable care**

Implementation of Saving babies lives V3 by 31/3/24.

Year 2 Trust Objectives:

1. **Listening to and working with families with compassion**

Recruitment of a Consultant midwife to ensure all women have choice in the planning of their care and birth.

Thematic review of morality undertaken to ensure an increased number of equalities are being considered and therefore actioned.

2. **Growing, retaining and supporting our workforce**

All labour ward leads to attend LMNS run labour ward leaders course

Continued review of the preceptorship program- in line with LMNS.

PROMPT implemented- now standardised training across the LMNS

3. **Developing and sustaining a culture of safety, learning, and support**

Undertaking full maternity and neonatal review of culture using the SCORE survey.

Strengthen the opportunities for staff and families to speak up via different routes- FTSU, Maternity safety champions.

Year 3 Trust Objectives:

1. **Listening to and working with families with compassion**

Continuity of Carer consideration of prioritisation of those families in areas of highest deprivation in the borough in line with LMNS CoC forward plan.

Strengthen audits and feedback on personalised care

2. **Growing, retaining and supporting our workforce**

Review administrative support required for the service to include screening failsafe officer.

Ensure anti-racism is a priority- to be led by the EDI Lead Midwife.

Succession planning to be reviewed as part of career MOT days and appraisals.

3. **Developing and sustaining a culture of safety, learning, and support**

Review of perinatal Safety dashboard to ensure data is clear and and safety concerns can be easily identified

To develop links between complaints and MNVP to ensure complaint responses are easy to understand for families.

Monitoring and targeted improvements relating to term admissions to the neonatal unit Completion of digital maturity assessment. EPR System in place- ongoing developments.	Implementation of PSIRF Formalise pathways for babies at risk of being born under 27 week gestation to ensure they are born in level 3 Neonatal units. **4. Standards and structures that underpin safer, more personalised, and more equitable care** Establish impact of deprivation on community maternity services on workforce and identify areas of inequality ie Digital and travel. Review and revise Perinatal safety dataset to highlight areas of concern Continue to use feedback from families to enhance digital communication to them	Act upon findings and recommendations of the SCORE culture survey results. **4. Standards and structures that underpin safer, more personalised, and more equitable care** Implementation of NEWTT-2 by 2025 Strengthen families access to their records by way of enhanced maternity portal (digital app)

RAG Status of Activities

Total Number of Green Activities:	34
Total Number of Amber Activities:	10
Total Number of Red Activities:	0
Actions in Place to Address Red Activities:	No actions are rated as red.
Please indicate any blockers to achieving outcomes planned and any support required:	Funding for development of enhanced Maternity portal. Funding for any changes to working practices such as CoC. Unknown resources required for actions taken post SCORE survey results/action plan development. Trusts financial position has the potential to negatively impacting on new activity/initiatives.

Enclosure 12

The Dudley Group NHS Foundation Trust

Paper for submission to the Public Board of Directors 11th July 2024

Report title	**Maternity and Obstetric Workforce paper**
Sponsoring executive	Martina Morris - Chief Nurse
Report author /presenter	Claire Macdiarmid - Head of Midwifery

1. Suggested discussion points

The number of births has remained consistent over the last 5 years and is currently at 4144 for 2023/24.

Acuity for shifts in inpatient areas is demonstrated via the RAG rating from the Birthrate plus acuity tool. There has been a decline in the number of green rated shifts over the last 4 months.

1:1 care in labour and Supernumerary shift lead is at 100% compliant, as per MIS year 6 requirements.

Birthrate plus (BR+) workforce calculation was undertaken and published in 2022, confirming that 178.96 WTE Registered Midwives (RMs) were required to safely staff the maternity service.

Due to the temporary funding coming to an end, we are now funded for 167.8 RMs and have 179.6 in post. Qualified band 3 Midwifery support workers (MSW) can form a small proportion of the midwifery workforce, in postnatal areas of the service only. It is a requirement of the MIS year 6 to ensure that Midwifery staffing budget fully reflects the establishment as calculated by BR+. A business case will be developed for consideration to rectify this position and mitigate the risk of MIS year 6 non-compliance.

It is recognised maternity specific training requires 34 hours per year per midwife, in additional to Trust mandatory training and this is impacting on an increase in the unavailability within the department.

Fill rates for inpatient and community midwifery have improved and are at between 94-100% for maternity inpatients and 87-96% for Community Midwifery.

The Obstetric consultant workforce has been over established this year due to a prolonged absence. Gaps in the on-call rota are currently being filled with Agency/Locum.

Training compliance in all areas of the Core competency framework V2 (CCFV2) are on track for above 90% by the end of the MIS period. This will be monitored via the Quality Committee.

2. Alignment to our Vision

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	X

3.	**Report journey**

4.	**Recommendations**
The Quality Committee is asked to:	
a.	Note the current position with Maternity staffing, including BR+ requirement.
b.	Note and agree the recommendations and next steps outlined within the paper pertaining to staffing Midwifery staffing and current mitigations.

5	**Impact**							
Board Assurance Framework Risk 1.1		x	Deliver high quality, safe person-centred care and treatment					
Board Assurance Framework Risk 1.2		x	Achieve outstanding CQC rating.					
Board Assurance Framework Risk 2.0		x	Address critical shortage of workforce capacity					
Board Assurance Framework Risk 3.0		x	Improve and sustain staff satisfaction and morale					
Corporate Risk Register			*[Give risk Nos]*					
Equality Impact Assessment	Is this required?		Y		N		If 'Y' date completed	
Quality Impact Assessment	Is this required?		Y		N		If 'Y' date completed	

Maternity and Obstetric Workforce Report – considered at an Extraordinary Quality Committee 4th July 2024.

Supporting compliance with MIS year 6

1 EXECUTIVE SUMMARY

This report outlines the current position with Maternity department staffing, to include Midwives and Obstetricians. This is in line with the recommendations published in the Ockenden report (2020 and 2022) and to support MIS year 6 requirements.

2. BACKGROUND INFORMATION

The aim of this report is to provide assurance to the Trust Board that there is an effective system of Midwifery and Obstetric workforce planning and monitoring of safe staffing levels. This is a requirement of the Maternity Incentive Scheme Year 6- safety action 6. The report provides an accurate account of the current workforce status.

Table 1

Number of births at Dudley Group by month Dec 23 - May 24:

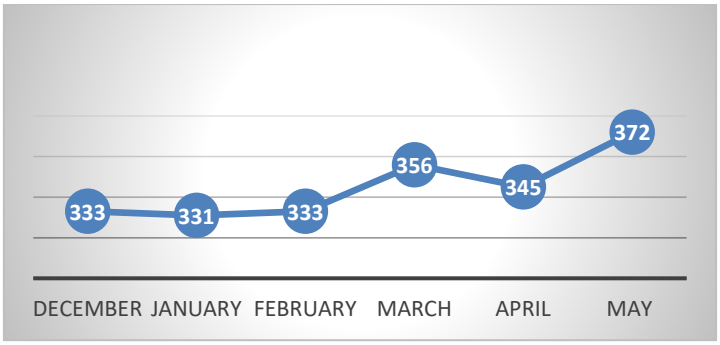


Table 1 highlights the number of births at the Trust by month. There were 4060 babies born at the Trust during the 2023/24 financial year. This number remains similar to previous years as shown below:

Table 1

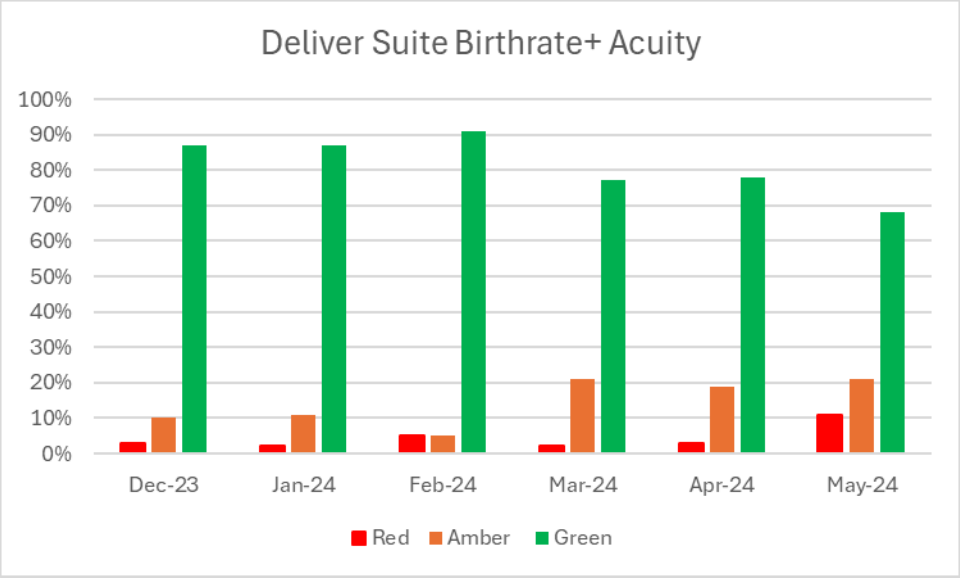
Year	Number of births	% of non-Dudley Births
2019/20	4144	29%
2020/21	4055	30%
2021/22	4156	29%
2022/23	4158	29%
2023/24	4060	28%

Table 2 provides the staffing position on the high-risk Delivery suite over the last 6 months using scoring from the Birthrate acuity tool, which is completed in real time by the shift leader on the Delivery suite and the Maternity ward, every 6 hours.

The green bar demonstrates the number of times the Maternity unit has had the correct number of staff for the number of patients and the complexity of their health needs. The amber bar evidences

the percentage of shifts that were short staffed by up to 2 Midwives, with the red bar evidencing the percentage of shifts that were over 2 Midwives short.

Table 2



Red Flags

A midwifery red flag event is a warning sign that there may be concerns with midwifery staffing. If a midwifery red flag event occurs, the Midwife in charge of the service should be notified. The Midwife in charge should determine whether midwifery staffing is the cause, and the action that is required. The classification of a midwifery red flag is as follows:

- Delayed or cancelled time-critical activity.
- Missed or delayed care (for example, delay of 60 minutes or more in washing and suturing (due to lack of midwifery staffing).
- Missed medication during an admission to hospital or midwifery-led unit (for example, diabetes medication).
- Delay of more than 30 minutes in providing pain relief.
- Delay of 30 minutes or more between presentation and triage.
- Full clinical examination not carried out when presenting in labour.
- Delay of 2 hours or more between admission for induction and beginning of process.
- Delayed recognition of and action on abnormal vital signs (for example, sepsis or urine output).
- Any occasion when 1 midwife is not able to provide continuous one-to-one care and support to a woman during established labour.
- Other midwifery red flags may be agreed locally.

Table 3

Table 3 demonstrates that red flags increased in April and May 2024, all were classified as delays in care. The majority of these were due to the number of induction of labour cases awaiting progression when the Delivery suite was already at capacity. The matrons are undertaking a further piece of work to identify any potential changes that could prevent these delays occurring in the future. None of these delays impacted on patient safety or led to a clinical incident.

Month (2023/24)	Total number of red flags	1:1 care in labour not met	Coordinator not supernumerary

December	0	0	0
January	0	0	0
February	1	0	0
March	0	0	0
April	14	0	0
May	14	0	0

There had been 0 occasions between 1st December 2023 and 31st May 2024 when 1:1 care in labour has not been achieved.

There had been 0 occasions between 1st December 2023 and 31st May 2024 when the band 7 shift leader had not worked in a supernumerary capacity.

Midwifery Recruitment

Due to the non-recurrent funding coming to an end, there is now a shortfall between the BR+ recommendations and the budgeted establishment in Maternity services.

In addition, **4.36 WTE** midwives have resigned from their posts or have reduced their hours, which will be reflected in the workforce figures by the 31/7/24.

Birthrate plus staffing inclusive of the 22% uplift: (Calculations were also undertaken at 26% uplift at the time)

Clinical WTE required as per Birthrate plus calculations.		**In post – May 2024**	**Budget**	**Difference budget vs birthrate +**
Delivery Suite: • Births • A/N cases • IOLs • P/N readmissions • Non-viable pregnancies • Escorted transfers out	51.13WTE RMs	124.35 WTE RMs 4.4 WTE Band 3 (6.6 are qualified but can only count 4.4 in the numbers)	19.38 WTE B5 73.38 WTE Band 6 12.13 WTE Band 7 4.4 WTE of total band 3	
Triage - BSOTS Model	10.93 WTE RMs**			
Birth Centre • Births & postnatal care • Births only • Transfers to Delivery Suite • Triage cases	10.93 WTE (2 RMs Minimum staffing)			
Maternity Ward • A/N Admissions • Inductions of Labour • Postnatal women • NIPE • Extra Care Babies • Postnatal readmissions	44.40 WTE RMs and 1 MSW per shift. (40 RM and 4.4 band 3 MSW)			
Total Maternity inpatients	**117.39WTE**	**128.75 WTE**	**109.29 WTE**	**-8.1 WTE**
Outpatients Services • Fetal Medicine clinics • Specialist midwife clinics • Midwifery led clinics • Obstetric clinics • Specialist Obstetric clinics	6.19 WTE RMs	9.06 WTE	8.99 WTE	

• DAU	4.95 WTE RMs			
Total Maternity OP	11.14 WTE			-2.15 WTE
Community Services: • Home births • Community AN & PN care • Attrition • Additional safeguarding	34.16 WTE RMs (30.74 RM and 3.4 Band 3 MSW)	24.76 plus 1.59 WTE qualified 3 MSW	3.4 Community MSW 25.48 WTE Band 6 4.0 WTE Band 7 Total 29.48 WTE	
Total Community clinical WTE		26.35 WTE	32.88 WTE	-1.28 WTE
Total Clinical WTE	**162.69 WTE RMs & PN MSWs**	**158.17 WTE RM and 5.99 WTE Band 3 MSW = 164.16 WTE**	**151.16 WTE**	**-11.53 WTE**
Specialist Midwives roles and management NICE recommended 9-11%	16.27 WTE	15.44 WTE	16.64 WTE	1.2 WTE
Grand total	**178.96**	**179.60**	**167.8**	**-11.16 WTE**

*Once the clinical 'midwifery' establishment has been calculated using the ratios, a skill mix % can be applied to the total clinical WTE to work out what of the total clinical 'midwifery' WTE can be suitably qualified support staff, namely MSWs Band 3. Nursery Nurses and Registered Nurses working in postnatal services only. This means that 7.8 WTE of the workforce could be band 3 MSW, but currently only 5.99 WTE are suitably qualified.

**Triage BSOTS has required an increase in midwifery staffing by 2.73 WTE to cover a 9-21.30 dedicated telephone triage service.

The Governance and Quality lead cannot be counted in these numbers as they are not a Registered Midwife.

The full BR+ calculations are due to be repeated during Q4 of 2024/25, to be published in May 2025.

The Midwife to birth ratio by month:

December 2024	1:27
January 2024	1:26
February 2024	1:26
March 2024	1:26
April 2024	1:25
May 2024	1:26

These ratios are within the acceptable range for safe staffing.

Midwifery fixed term posts:

	Band	Funded by	Post remit and to continue
Digital Midwife	**7**	Historic IT bid (2021) and LMNS jointly from Ockenden 2	The digital midwife is part of a team that leads on Saving babies' lives (data element). This forms part of compliance with MIS SA2. They also lead the digital agenda for maternity as per the 3-year delivery plan - theme 4 and objective 12.
Governance Lead	**8a**	LMNS from Ockenden 2 *Added to funded establishment from 24/25	In post due to the complexity of maternity services governance processes and the levels of assurance required. Governance leadership features heavily throughout the Ockenden report (2022). All trusts must ensure that those individuals leading maternity governance teams are trained in human factors, causal analysis and family engagement.
Consultant Midwife	**8b**	LMNS from Ockenden 2 *Added to funded establishment from 24/25	The national recommendation remains that midwifery-led units (MLU) have one full-time Consultant Midwife post and obstetric-led units have one additional full-time Consultant Midwife post to every 900 births, based on 60 per cent low risk women receiving midwifery-led care. The requirement for a Consultant Midwife also forms part of the outcome of regional heatmap.
Clinical skills facilitator	**6**		To be absorbed into establishment and the role to continue.
EDI Lead Midwife	**8a**	LMNS Standard funding	Implementing the LMNS Equality action plan. Contributing to the quality of data collection for SA2. Contributing to the leadership and roll out of continuity of carer as per the NHS long term plan. Completion of the maternity WRES.
Patient safety lead	**7**	LMNS from Ockenden 2 Added to funded establishment from 24/25	Ockenden (2022) recommendation: EA4: Every trust must ensure they have a patient safety specialist, specifically dedicated to maternity services.

Table 5: Fill rates for maternity inpatients

Fill rates for maternity inpatients	December 2023	January 2024	February 2024	March 2024	April 2024	May 2024
Day	94%	97%	95%	97%	96%	95%
Night	97%	99%	97%	98%	100%	97%

Table 6: Fill rates for community midwifery

Fill rates for community Midwifery	December 2023	January 2024	February 2024	March 2024	April 2024	May 2024
	87%	96%	91%	94%	94%	96%

Table 5 and 6 evidence the improvement in fill rates of Midwifery shifts in both inpatient and community areas. Community midwifery is currently under established; however, secondment of inpatient staff are due to commence during the summer to reduce this gap and the associated risk. The current gap has been filled by using Bank staff.

Turnover by staff group

Table 7

Staff group	Percentage leavers rolling 12 months	WTE
Midwifery	2.9%	4.1 WTE
Additional clinical services	5%	2.5WTE

Unavailability

Table 8

	Q4 23/24	Q1 24/25
Maternity leave*	3.6%	3.9%
Sickness absence- Midwifery and support team	6.47%	4.3%
Obstetric Team Sickness absence	6.35%	2.42%

*Midwives only

Line managers have been working with Human Resources (HR) to support staff following sickness absence to return to work in a supportive way. This has resulted in a significant decrease in sickness absence rates across Midwifery and support staff. Maternity leave has returned to a lower rate after an elevated 2 years of maternity leave absence. **To note, maternity leave for 24/25 Q2**

is due to significantly increase due to the number of staff currently pregnant and yet to commence their leave.

Homebirth provision

A homebirth service is offered at the Trust to allow women and birthing people the option to be able to birth their baby at home, if they choose to do so. There has been local and national scrutiny around provision of homebirth services. Table 9 shows the number of times the Trust's homebirth service has been postponed during the last 6 months, due to lack of Midwifery availability. The service is only able to operate when two Registered Midwives are available to attend for labour and birth. There has been a decrease in the number of times the service is suspended.

The on-call maternity manager rota has been amended to facilitate an increase the number of midwives on the on-call rota. The number of times community midwives are called into the unit has decreased significantly over the last 9 months, which in turn increases the number of hours the Homebirth service is operational for.

Table 9

	Non-operation of Homebirth service		
	Number of episodes	Number of hours	Total percentage of time
December 2023	8	128	17%
January 2024	3	48	6.5%
February	6	96	13.8%
March	4	64	8.6%
April	3	48	6.6%
May	2	32	4%

Obstetric staffing

Consultant workforce has been over established this year due to a prolonged absence. This contract was terminated in April 2024.

There are three gaps in the out of hours rota due to sickness and ill health amendments (one long term adjustment), currently filled with locum/agency. Plans are in place to recruit a further substantive Urogynaecologist and utilise a small vacancy from a consultant who is LTFT and WLI funding to fund a locum post to backfill thus reducing agency/bank spend.

A new Clinical Director is in post and both CSL post are filled, stabilising our senior clinical leadership team.

The team has successfully established the tier 2 (registrar) workforce. The recruits are currently working supernumerary therefore improvements have not yet been realised. There remain concerns regarding the skill sets of doctors recruited from abroad, clear objectives have been set to ensure these doctors achieve competency within 6 months of the start date. This issue is mainly due to other countries not performing instrumental deliveries. The Trust has a very few of these procedures to support training, but it is an essential skill to support out of hours. Simulation training and step-up programmes are being utilised to support training. Trust grades are currently fixed term and there is a plan to recruit to these posts substantively and recruit a further SAS doctor to ensure that the skill gaps are filled. 1.0 WTE clinical fellow recruited yet to start. 1.0 WTE MTI has stepped up to tier 2 rota. Gaps have been filled by bank staff; agency are only used where we are unable to fill internally. We have built up our own Bank of medical staff to reduce variance. The locums used meet the Royal College of Obstetricians and Gynaecologists (RCOG) locums guidance.

There will be 2.2 WTE tier 1 Deanery gaps from August 24 onwards. Fixed term Trust grade doctors are being extended to cover the gaps.

A Health Education England (NHS England) action plan has been submitted regarding training. The tier 1 rota has been increased to 1:12 to cover separate obstetrics and gynaecology SHOs overnight. The tier 2 rota is to be increased to 1:16 to cover twilights in gynaecology and DAU-this is dependent on the tier 2 doctors achieving competencies and is being reviewed weekly. Further work is being undertaken by Mitie on the maternity unit to provide a suitable area for Gynaecology handover and junior doctor workspace.
External consultant has been sourced to support culture work alongside the ongoing perinatal programme.

Summary:

- Tier 3: 0.4 WTE vacancy (1 consultant LTFT).
- Tier 2: Fully established; ongoing skills gap, training and plans in place.
- Tier 1: 1:12 rota. From August, 2.2 WTE vacancies from The Deanery. Gaps filled by Trust grades/MTIs.

Mandatory and Maternity specific training

The maternity, obstetric, and neonatal teams are currently above 90% compliance for all training required under the Core competency framework V2 published May 2023.

Table 10

	Consultant obstetricians - current	ST1-7 current	Anaesthetic consultants	Anaesthetic registrar (that cover obstetrics) current
PROMPT	100%	100%	100%	100%
Fetal monitoring	94%	100%		
Neonatal resuscitation	93%	88%		
Adult resuscitation	87%	88%		
Saving babies Lives	94%	100%		

	Midwives current	MSW current
PROMPT	98%	93%
Fetal monitoring	96%	
Neonatal resuscitation	90%	
Adult resuscitation	84%	94%
Saving babies Lives	96%	

	Neonatal consultants	Neonatal ST1-7	Neonatal nurses (all bands)	ANNP
Neonatal Resuscitation	100%	80%*	92%	100%

*Neonatal ST1-7 is 8/10 compliance with the two remaining outstanding booked for WC 1/7/24.

Table 10 demonstrates current position with maternity specific mandatory training, which forms the core competency framework V2, as part of compliance with the Maternity incentive scheme year 6. The service is currently compliant, with a robust plan in place to maintain compliance above 90%. The scheme requires 90% attendance of relevant staff groups by the end of the 12-month period at:

1. Fetal monitoring training

2. Multi-professional maternity Emergencies training /PROMPT

3. Neonatal Life Support Training

*PROMPT is Practical Obstetric Multi-Professional Training.

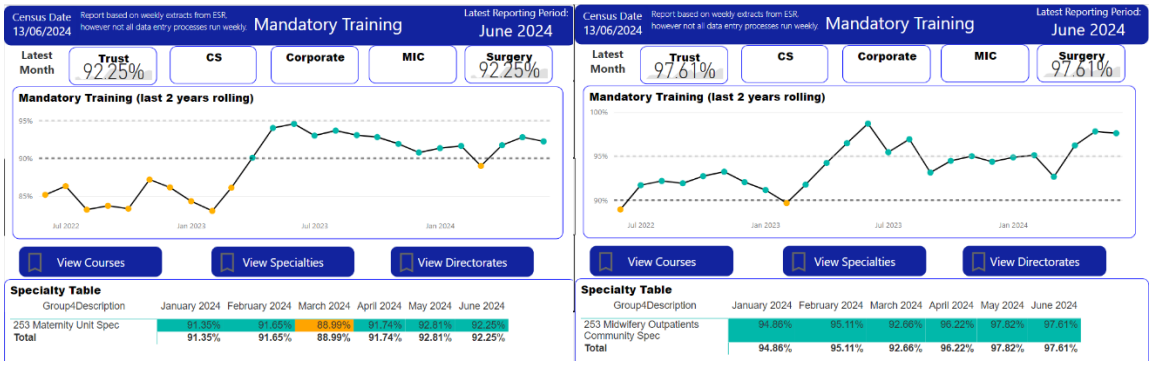
Maternity Specific mandatory training

The requirement for maternity specific training has increased significantly since the introduction of the Maternity incentive scheme and the Ockenden report 2020. The Core competency framework V2 was published in 2023 outlining 6 modules of education that form part of the maternity incentive scheme. Registered midwives must attend the following training, in addition to the trusts mandatory training requirements:

Name of training	Frequency	Length of training
PROMPT	Annually	7.5 hours
Saving babies lives	Annually	7.5 hours
Fetal Monitoring	Annually	7.5 hours (Inc to 9 hrs from 24/25)
Midwifery mandatory training	Annually	7.5 hours
GAP (fetal growth training)	Annually	2 hours
NIPE (Newborn examination)	Annually	2 hours
Anti- D training	3 yearly	30 minutes
ICON	Once only	1 hour
ATTAIN	Once only	5 hours

Midwives have to attend 34 hours of additional training annually to ensure compliance with the recommendation of the Ockenden report, Maternity incentive scheme and the Core competency framework V2.

Maternity Trust mandatory training: Table 11



Obstetric Mandatory training: Table 12

Midwifery mandatory training compliance remains above 90% at the current time. The obstetric team compliance is below 90%. The Division has a rectification plan in place.

3.0 RISKS AND MITIGATIONS

The requirements for evidence for Ockenden, Maternity incentive scheme and the perinatal quality surveillance model for assurance are very specific, and significant in its amount. The Board is required to receive and minute detailed information particularly in relation to Maternity workforce current position and plans to mitigate risks.

The current risks are as follows:

- Current budgeted midwifery establishment is below the BR+ recommended levels due to the previously temporary funded roles coming to an end.
- The Maternity unit has a number of temporary funded specialist roles that are no longer being funded by the LMNS. These roles are fundamental to the safe running of the Maternity unit.
- Should the Midwifery staffing budget not fully reflect the establishment as calculated by BR+ this will create a risk of MIS year 6 non-compliance and a rectification plan will be required.
- Maternity specific training requires 34 additional hours of training to be attended by all registered midwives to remain compliant with MIS year 6 and the CCFV2. This has led to an increase in study leave requirements.
- There is no Director of Midwifery (DoM) in post. However, the Trust employs a Head of Midwifery, who is working at the DoM level. The Executive team has agreed for the job title to be changed to reflect the requirements and supporting structures reviewed and managed within the allocated financial envelope.

The mitigations are as follows:

- The Maternity unit is over established with Registered Midwives at the current time which is ensuring that quality and safety is maintained.
- A business case will be developed for consideration to rectify the funding gap.
- The Trust is supporting the development of a Director of Midwifery role and work is in progress between the Division and Human Resources to rectify this position.

4. RECOMMENDATIONS

The Quality Committee is asked to accept this paper as assurance of current position with Midwifery and obstetric staffing and to note current mitigations to maintain safety and the plans in place moving forward to ensure the staffing budget matches BR+ recommendations.

Name of Author: Claire Macdiarmid and Jo Malpass.

Title of Author: Head of Midwifery and Directorate Manager for Women's services.

Date: 03/07/2024

Enclosure 13

The Dudley Group NHS Foundation Trust

Paper for submission to the Trust Board on 11th July 2024

Report title	Annual Learning from Complaints Report 2023/24
Sponsoring executive/ presenter	Martina Morris, Chief Nurse
Report author	Jill Faulkner, Head of Patient Experience Lara Fullwood, PALS & Complaints coordinator

1. Suggested discussion points

Why are the board seeing this report and what next. The summary of key statistics, achievements, challenges and opportunities are as follows:

PALS:

The Trust received 4144 informal concerns and comments and 998 signposting contacts (in total 5142 cases/activity) to the Patient Advice and Liaison Service (PALS) in 2023/2024, which is an increase from the previous year's (2022/23) data of 4110 in total (3547 informal concerns and comments and 563 signposting contacts). This is an increase of 1032 total cases/activity (25.1%).

The main theme for PALS concerns was regarding appointments (delays and cancellations).

Complaints:

- The number of complaints received in 2023/24 was 956.
- 1059 complaints were closed.
- 100% of complaints (956) were acknowledged within three working days of receipt.
- 42.8% of complaints received a response within 30 working days.
- 54% of complaints were closed (571) were upheld/partially upheld.
- 14% of complaints were closed (133) were reopened.
- There were 98 complaints under the early resolution process with 86 of the 98 complaints (88%) responded to within 30 working days.
- The Division of Surgery received the most complaints at 442 for 2023/24.
- The complaint activity versus the patient activity for the Trust was 0.07%.
- The Parliamentary Health Service Ombudsman (PHSO) formally investigated five cases, one for mediation and two for local resolution. Three formal investigation cases were carried over from the previous years, with two now closed. One received during 2023/24 was closed, leaving four under investigation from 2023/24 and one from previous year. This remains similar to the previous year.
- No complaints were formally investigated by the Local Government Ombudsman (LGO) during the year.

The main theme for complaints was poor communication with patients and relatives.

Achievements:

- There was a decrease in the number of new complaints received by 7.9% from 2022/23. This is the first decrease the Trust has seen in the number of complaints received for several years.
- The team closed 1059 complaints.
- All new complaints were acknowledged within three working days.
- 42.8% of complaints received a response within 30 working days. An improvement from 2022/23 which had a response rate of 35.9%.
- There were 98 complaints under the early resolution process with 86 of the 98 complaints (88%) responded to within 30 working days.
- There has been a decrease in the number of complaints upheld/partially upheld in 2023/24 to 54% when compared to 2022/23 of 64%.
- The complaint activity versus the patient activity for the Trust has decreased from 0.08% to 0.07% for 2023/24.

- No complaints were formally investigated by the Local Government Ombudsman (LGO) during the year.

Challenges and opportunities:

- The response rate continues to be below the 90% KPI.
- The complaints backlog continues to be challenging with the number of new complaints received versus dealing with complaints over 30 working days as the workload is unpredictable.

Actions taken to overcome challenges and maximise opportunities:

- A new escalation process was introduced in January 2024, with a further amendment in March/April 2024, to improve responsiveness from the Divisions.
- Online complaints training is available and accessible via the Complaints Department Hub page for all staff who require training on how to investigate complaints and write responses.
- The Complaints team will offer an informal approach (PALS route) to address concerns where applicable. This has been in operation since January 2024.
- Focus on reducing the backlog of complaints (those over 30 working days) by ensuring escalation plan strictly followed.
- A Back to the Floor initiative was introduced in April 2004, to further increase the senior nursing, midwifery and Allied Health Professionals (AHPs) presence within clinical areas and to provide more time for engagement with patients and their loved ones.

2.											
Deliver right care every time	x	Be a brilliant place to work and thrive		Drive sustainability (financial and environmental)		Build innovative partnerships in Dudley and beyond		Improve health and wellbeing			

3.	**Report journey**
The Patient Experience Group (PEG) – May 2024. Quality Committee – June 2024.	

4.	**Recommendations**
The Trust Board is asked to:	
a.	• Note the complaints and PALS activity in 2023/24. • Note how the learning from complaints and PALS feedback is being implemented, the challenges faced, and improvement actions taken.

5	**Impact**							
Board Assurance Framework Risk 1.1			X	Deliver high quality, safe person-centred care and treatment				
Board Assurance Framework Risk 1.2			X	Achieve outstanding CQC rating.				
Board Assurance Framework Risk 6.0			X	Deliver on its ambition to building innovative partnerships in Dudley and beyond				
Corporate Risk Register								
Equality Impact Assessment	Is this required?	Y		N	X	If 'Y' date completed		
Quality Impact Assessment	Is this required?	Y		N	X	If 'Y' date completed		

Executive summary

The annual report summarises the complaints and Patient Advice Liaison Service (PALS) activity and performance at The Dudley Group NHS Foundation Trust (The Trust) for the year 1 April 2023 to 31 March 2024. 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 used to ensure that we listen to and learn from the experiences of the patients, their families and carers who use our services.

Patient complaints and PALS concerns are reported to the Patient Experience Group, and thereafter to the Quality Committee (a delegated committee) of the Trust Board, on a quarterly basis within the patient experience report which integrates complaints data and PALS activity along with national surveys, Friends, and Family Test (FFT), NHS Choices and compliments.

Since April 2019, the Trust has been holding 'Learning by Experience' events which are 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.

In April 2023, The NHS Complaints Standards 2023 were created and implemented to provide a consistent approach to complaints handling for trusts. These Standards have highlighted the importance of good complaints handling in a healthcare setting and learning from these to improve patient care and safety going forward. The Standards set out the need to involve complainants from the outset, focusing on early resolution, and for trusts to embed learning to improve services. The Trust has implemented these Standards within the existing complaints process and has supported staff through training and 'how to guides' in putting these Standards into practice. Where applicable, the early resolution process is working well.

Key points to note for 2023/24:

- 956 complaints were received.
- 1059 complaints were closed.
- 100% of complaints (956) were acknowledged within three working days of receipt.
- 42.8% of complaints were received a response within 30 working days.
- 54% of complaints closed (571) were upheld/partially upheld.
- 14% of complaints closed (133) were reopened.
- There were 98 complaints under the early resolution process with 86 of the 98 complaints (88%) responded to within 30 working days.
- The Parliamentary Health Service Ombudsman (PHSO) formally investigated five cases, in addition to one for mediation and two for local resolution.
- No complaints were formally investigated by the Local Government Ombudsman (LGO) during the year.

The full annual report is enclosed the further reading pack associated with this meeting for information and has been reviewed in detail by the Quality Committee in June 2024.

Martina Morris
Chief Nurse
June 2024

Enclosure 14

The Dudley Group NHS Foundation Trust

Paper for submission to Trust Board on 11th July 2024

Report title	Safeguarding Annual Report.
Sponsoring executive / presenter	Martina Morris – Chief Nurse
Report author	Julie Mullis - Head of Safeguarding

1. Suggested discussion points

During 2023/24, there was an exponential growth of safeguarding activity within the Trust. Despite this, teams across the organisation worked collaboratively to ensure that our patients and their families are safeguarded, ensure that cases of abuse and identified and responded to promptly and embed any learning from safeguarding incidents and reviews. The Safeguarding team have been pivotal in providing leadership, guidance and facilitating multidisciplinary and multi-agency engagement.

Achievements:

- High level of multi-agency partnership work undertaken by the Trust to ensure our legal and statutory responsibilities are met and patients are kept safe from harm and abuse.
- The Trust has a Named Doctor for Safeguarding Children and Lead Consultant for Safeguarding Adults and meets the statutory requirements set out in the NHS Safeguarding Assurance and Accountability Framework.
- An Internal Safeguarding Board remains well established, which meets quarterly (the frequency of these meetings will increase in 2024/25) and oversees the safeguarding and complex vulnerabilities agendas. The Group is chaired by the Chief Nurse, who is the executive lead for safeguarding.
- Improved reporting, monitoring and governance around management of allegations with a high level of transparency and accountability.
- Safeguarding training and supervision provision is highly accessible, reflects current learning and the face-to-face learning receives positive feedback.
- Highly visible and responsive Safeguarding team who offer advice, support and raise awareness of safeguarding through a variety of communications and via Trust committees and groups.

Challenges and opportunities:

- Impact of the increase in the safeguarding activity on the Safeguarding team.
- Ensuring a skilled and competent workforce.
- Complexity of safeguarding where patients are subject to multiple categories of abuse which may be hidden and requires deeper understanding of vulnerabilities.
- Evidencing that learning is embedded and having a positive impact.
- Ensuring safeguarding continues to be a priority for the Trust during times of increasing workforce and capacity challenges.

Actions taken to overcome challenges and maximise opportunities:

- Review and develop the safeguarding service to re-focus activity towards promoting awareness and learning, with the aim of preventing abuse.
- Work with Black Country health providers to review and align safeguarding training and consider collaborative and consistent approach to training across the system.
- Use of role modelling, supervision, incident feedback and awareness raising events to supplement training opportunities.
- Continue to work in partnership with the Complex Vulnerabilities team and Divisions to support a workforce that can think critically, challenge assumptions and can have difficult conversations about abuse across the lifespan, to identify hidden harm and abuse.
- Maintain a highly visible and proactive safeguarding service which seeks to engage with Divisional leadership teams in methods to improve the sharing of learning and monitoring of how

learning is embedded. This includes awareness raising via a variety of communications and increased presence at Divisional operational and governance meetings.

2.	Alignment to our Vision										
Deliver right care every time	X	Be a brilliant place to work and thrive		Drive sustainability (financial and environmental)		Build innovative partnerships in Dudley and beyond	X	Improve health and wellbeing	

3.	Report journey
Internal Safeguarding Board – June 2024. Quality Committee – June 2024.	

4.	Recommendations
The Trust Board is asked to:	
a.	Note the information provided regarding trends, themes, achievements, and challenges in safeguarding during 1st April 2023 to 31st March 2024.
b.	To gain assurance with respect to compliance with statutory responsibilities and contractual standards.

5	Impact	
Board Assurance Framework Risk 1.1	X	Deliver high quality, safe person-centred care and treatment
Board Assurance Framework Risk 1.2	X	Achieve outstanding CQC rating.
Board Assurance Framework Risk 6.0	X	Deliver on its ambition to building innovative partnerships in Dudley and beyond
Corporate Risk Register		

Equality Impact Assessment	Is this required ?	Y		N	X	If 'Y' date completed	
Quality Impact Assessment	Is this required ?	Y		N	X	If 'Y' date completed	

Report to Board of Directors

EXECUTIVE SUMMARY

The Trust Safeguarding Annual Report has been developed to provide assurance to the Board that the Trust is compliant with their statutory responsibilities under the legislative frameworks relevant to protecting people from abuse and neglect.

The report:

- Demonstrates the exponential growth of safeguarding activity, celebrating the achievements of staff Trust wide in recognising, and referring safeguarding concerns and the impact of this on capacity of safeguarding team.
- Acknowledges the complexities of safeguarding cases where patients are often subject to multiple categories of abuse which requires additional support from the safeguarding team and robust partnership working with other agencies.
- Provides a picture of strong compliance with statutory responsibilities including robust governance processes and acknowledges the work that is required to improve the Trust's ability to demonstrate learning from internal and external incidents.
- Demonstrates the progress of the managing of allegations against staff process which is providing increased assurance that where allegations arise these are responded to in a timely manner, with clear and transparent decision making and partnership working.
- Highlights the safeguarding team's commitment to providing accessible and relevant training with continuing challenges around compliance.
- Evidences the breadth and depth of partnership work undertaken by the safeguarding team to offer assurance to the Safeguarding Partnership and influence multi-agency actions and services in line with the needs of patients within the Trust are heard.
- Highlights the proactive work undertaken by the children's safeguarding team by their visibility within the Emergency Department and paediatrics and the systems and processes they are implementing to support staff in their safeguarding role.
- Outlines the future objectives of the team during the year 2024-2025 to support the priorities of the Trust and the Dudley People's Partnership priorities in delivering right care every time and protecting patients across the lifespan from abuse and neglect.

The full annual report is enclosed the further reading pack associated with this meeting and has been reviewed in detail by the Quality Committee in June 2024.

Martina Morris
Chief Nurse
June 2024

Enclosure 15

The Dudley Group NHS Foundation Trust

Paper for submission to Trust Board held on 11th July 2024

Report title	Complex Vulnerabilities Annual Report.
Sponsoring executive/presenter	Martina Morris – Chief Nurse
Report author	Joanne Day – Lead for Mental Health and Complex Vulnerabilities

1. Suggested discussion points

During 2023/24, the team have worked relentlessly to ensure that patients with complex vulnerabilities receive the additional support they require throughout their patient journey, ensuring that they feel safe, listened to, and have confidence in the knowledge and skills of our staff.

The Dementia and Delirium team assists in recognising and identifying early diagnosis for patient with cognitive concerns and working with partner agencies to support safe discharge and ongoing support. With leadership from the Mental Health Lead, they maintain oversight of mental health act activity within the Trust. They also support the work of the Mental Capacity Lead in ensuring patients' rights are upheld and the Trust is working within the legal frameworks when restrictive practices are used.

The Mental Health and Complex Vulnerabilities Lead is a demanding and challenging role with both operational and strategic responsibilities. The subject matter expertise offered to the Trust has been invaluable in ensuring we recognise and carry out our statutory duties under the Mental Health Act.

The Learning Disability Team are recognised within Trust and across the system as a leading example of liaison work to ensure learning disabled patients are supported and inequalities in access to health care are addressed. The team have started to develop a pathway for supporting patients with Autism.

Achievements:

- Processes in place to ensure Trust is compliant with statutory responsibilities under the Mental Health Act and Mental Capacity Act. Gap analysis and audits have evidenced improvements in compliance and implementation.
- Training and risk assessments implemented in the Emergency Department (ED) to support staff that are caring for increasing numbers of patients attending with mental health conditions.
- Progressive work around management of restraint, including partnerships with Mitie Security staff and Patient Safety Team.
- Development of a pathway to support patients with Autism, concentrating on those that present with Autism and complex vulnerabilities due to cognitive or communication challenges.
- Successful proposal to introduce an Admiral Nursing Service into the Trust to support improvements in care to patients living with Dementia.

Challenges and opportunities:

- Strengthen governance around use of chemical restraint and PRN (as required) sedation.
- Strengthen process of Mental Health Act detentions.
- Improve monitoring and oversight of LeDeR learning actions.

- Embedding of the digital Learning Disability Reasonable Adjustment Flag process.
- Direction and focus on care of patients with Dementia.
- Ensure that the Mental Health Act Administrator and Responsible Clinician contracts are implemented, which are currently in the final stages of being available.

Actions taken to overcome challenges and maximise opportunities:

- The Restrictive Intervention Group meets monthly and is working to engage key stakeholders within the Trust to improve reporting, reviewing and monitoring of chemical restraint. This is a risk on the safeguarding risk register and is being monitored via the Internal Safeguarding Group.
- A gap analysis has identified gaps in compliance in Mental Health Act processes. Actions are underway to improve Information Technology (IT) structures and address staff knowledge.
- Development of a Learning from Deaths – people with a learning disability and autistic people (LeDeR) action tracker which will be overseen by a newly established learning disability steering group and progress reported to Internal Safeguarding Group.
- An analysis has identified gaps around embedding of the digital reasonable adjustment process. The learning disability team will work with partners across the system to support embedding of the process.
- Introduction of Admiral Nursing Service with support from Dementia UK will support engagement with internal and external key stakeholders to give direction and priority to improvements in Dementia care.

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

3.	**Report journey**
Internal Safeguarding Board – 20th June 2024. Quality Committee – 24th June 2024.	

4.	**Recommendation(s)**
The Trust Board is asked to:	
a.	Note the information provided regarding trends, themes, achievements, and challenges in the work supporting patients with complex vulnerabilities during 1st April 2023 to 31st March 2024.
b.	To gain assurance with respect to compliance with statutory responsibilities and contractual standards.

5	**Impact**	
Board Assurance Framework Risk 1.1	X	Deliver high quality, safe person-centred care and treatment
Board Assurance Framework Risk 1.2	X	Achieve outstanding CQC rating.
Board Assurance Framework Risk 6.0	X	Deliver on its ambition to building innovative partnerships in Dudley and beyond
Corporate Risk Register		

Equality Impact Assessment	Is this required?	Y		N	X	If 'Y' date completed	
Quality Impact Assessment	Is this required?	Y		N	X	If 'Y' date completed	

Report to Board of Directors, July 2024

EXECUTIVE SUMMARY

The Trust Complex Vulnerabilities Annual Report has been developed to provide assurance to the Board that the Trust is compliant with their statutory responsibilities under the legislative frameworks relevant to ensuring safe and accessible care for patients with Learning Disabilities, Dementia, mental capacity issues and Mental health conditions.

The report:

- Demonstrates the breadth and depth of the work undertaken by the Complex Vulnerabilities Team to ensure our most vulnerable patients receive high quality care.
- Acknowledges the complexity of needs of this cohort of patients who require the skills and expertise of Complex Vulnerabilities Team to ensure equality, accessibility and patient centred care.
- Demonstrates the progress in ensuring compliance with statutory responsibilities and highlights gaps and risks where improvements are required.
- Outlines the future objectives of the team during the year 2024-2025 to support the priorities of the Trust priorities in delivering right care every time.

The full annual report is enclosed the further reading pack associated with this meeting for information and has been reviewed in detail by the Quality Committee in June 2024.

Martina Morris
Chief Nurse
June 2024

Enclosure 16

The Dudley Group NHS Foundation Trust

Paper for submission to the Board of Directors Thursday 11th July 2024

Report title	Upward Report from the People Committee Meetings held on 28th May and 25th June 2024
Sponsoring executive	Karen Brogan - Interim Chief People Officer
Report author **Report presenter**	Karen Brogan - Interim Chief People Officer Catherine Holland - Non-executive Director

1. Suggested discussion points

May 2024

Matters of concern/key risks to escalate

- Implications of the new Midland Met Hospital and mitigations put in place regarding some of the key issues which could arise, the impact on workforce requirements was unknown. There could be a risk regarding turnover and retention once the new site is opened.

Positive assurances

- The KPI report gave positive assurance against sickness absence and mandatory training and the new workforce plan showed monthly performance against the plan, triangulated with operational, workforce and quality performance indicators.

Major actions commissioned/underway

- An update on the progress made on the NHS Rainbow Badge Assessment was given, a further progress report would be given in July.
- A deep dive into employee relations was presented, which demonstrated the benefits of the new database which had logged 248 cases since April 2023, as a full year's data was available for analysis.
- The Medicine & Integrated Care division presented a deep dive into their division.

Decisions made

- The proposals and recommendations for the Nursing & Midwifery workforce pipeline and associated financial benefits were approved.
- The Public Sector Equality Duty (PSED) report was noted and approved.
- BAF Risks 2 and 3 remained unchanged as positive assurance.

June 2024

Matters of concern/key risks to escalate

- An update was given on the Sexual Safety Charter and the sexual safety survey results.
- Performance against the workforce plan had slipped, but a longer-term trend was required to fully understand the position.

Positive assurances

- The workforce KPI report presented positive assurance against all measures, particularly sickness absence which was demonstrating a longer-term positive trend.
- Mandatory training compliance had improved with sustained performance above target since Q2 2023/24.
- Good progress had been made on apprenticeships.
- Positive reports were received from the Wellbeing and Equality, Diversity & Inclusion Steering Groups.
- Disability Confident Leader Status had been maintained.
- SWC presented a deep dive into their division, which gave good assurance to the Committee of a good grasp of the issues and demonstrated effective leadership and management.

Major actions commissioned/underway

- Positive report received regarding job planning and progress towards the national levels of attainment; work underway to improve the process and link it with appraisals.

Decisions made
- BAF Risks 2 and 3 remained unchanged as positive assurance.

2.	Alignment to our Vision								
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	X

3.	Report Journey
The Board of Directors.	

4.	Recommendation(s)
The Public Trust Board is asked to:	
a.	Approve the upward report for assurance

5.	Impact						
Board Assurance Framework Risk 2.0	X	Address critical shortage of workforce capacity					
Board Assurance Framework Risk 3.0	X	Improve and sustain staff satisfaction and morale					
Corporate Risk Register		*[Give risk Nos]*					
Equality Impact Assessment	Is this required?	Y		N		If 'Y' date completed	
Quality Impact Assessment	Is this required?	Y		N		If 'Y' date completed	

The Dudley Group
NHS Foundation Trust

CHAIR'S LOG
UPWARD REPORT FROM PEOPLE COMMITTEE
Date Committee last met: 25th June 2024

MATTERS OF CONCERN OR KEY RISKS TO ESCALATE	MAJOR ACTIONS COMMISSIONED/WORK UNDERWAY
• Paul Singh updated the Committee on the Sexual Safety Charter. The sexual safety survey highlighted some concerning (but expected) issues, assurance provided that DGFT have signed the Sexual Safety Charter and that actions were underway, but this was a significant culture issue which required active leadership from everyone. • Performance against the workforce plan was presented, which showed performance in May had slipped; the variance against the forecasted month 2 position was 40.87 WTE over plan (31.63 WTE when Deanery/income-backed posts were removed). However, there was a good grasp of the drivers, and it was felt that a longer-term trend was required to fully understand the position.	• A positive report was received regarding job planning and progress towards the national levels of attainment, it was noted that there is still work underway to improve the job planning process and to link it with appraisals.
POSITIVE ASSURANCES TO PROVIDE	**DECISIONS MADE**
• The KPI report presented positive assurance against all measures, particularly sickness absence which was a demonstrating a longer-term positive trend. • Mandatory training compliance had improved, with sustained performance at above target since Q2 23/24. A discussion took place regarding its effectiveness and impact, and it was noted that further work was underway. • Good progress had been made on apprenticeships. • Positive reports given on the Wellbeing and EDI Steering Groups. • Disability Confident Leader status had been maintained. • SWC presented a deep dive into their division, which highlighted leaders had a good grasp of issues and were demonstrating effective leadership and management.	• The Committee reviewed the assurance level of the two BAF risks overseen by the Committee and agreed that the assurance level would remain unchanged as positive assurance.
Chair's comments on the meeting - It was good to hear some fresh voices, CH thanked Mo M Mandiratta for attending. The meeting finished ahead of time.	

The Dudley Group
NHS Foundation Trust

CHAIR'S LOG
UPWARD REPORT FROM PEOPLE COMMITTEE
Date Committee last met: 28th May 2024

MATTERS OF CONCERN OR KEY RISKS TO ESCALATE	MAJOR ACTIONS COMMISSIONED/WORK UNDERWAY
• A paper was received on the implications of the new Midland Met Hospital and mitigations put in place regarding some of the key issues we perceive may arise. The impact on workforce requirements was unknown and have not been included in the workforce plan. Once known there would be a system narrative. It was also noted that there may be a risk regarding turnover and retention once the new site is opened	• An update was given on the progress made on the NHS Rainbow Badge Assessment; an update would be given to the Committee in July. • A deep dive into employee relations was given. A new database to record casework had been implemented in April 2023, a full year's data was available which showed 248 cases (formal and informal) were logged across the categories of disciplinary, grievance, bullying and harassment, hearings, appeals and employment tribunals). Areas for continuous improvement were KPI timescales for bullying and harassment, hearings, and the disproportionate likelihood of individuals with protected characteristics being subject to employee relations casework, with actions developed to address these.
POSITIVE ASSURANCES TO PROVIDE	**DECISIONS MADE**
• The KPI report presented positive assurance against particularly sickness absence (both in-month and twelve-month) which had reduced in April and were RAG rated green. Mandatory training had increased to 92.39% There had been sustained performance at above target since Q2 23/24. There had been an ongoing decline throughout the winter period although it had remained above target each month. There had been increased activity in April and May. • The new workforce plan was presented, which showed performance against the plan month by month, triangulated with operational, workforce and quality performance indicators. Performance in April was positive; variance against the forecasted month 1 position was -51.47 WTE (under plan). The Committee thought this was a good addition to the agenda and would be presented monthly. • MIC presented a deep dive into their division, three key services that would benefit from targeted support were Cardiac Assessment, AMU	• The proposals and recommendations for the Nursing & Midwifery workforce pipeline with associated financial benefits were approved. • The Public Sector Equality Duty (PSED) report was noted and approved. • The Committee reviewed the assurance level of the two BAF risks overseen by the Committee and agreed that the assurance level would remain unchanged as positive assurance.

and B6, action plans had been developed. The Committee was assured that positive progress was being made.	

Chair's comments on the meeting

The meeting finished ahead of time. The Chair thanked everyone for their support in his tenure as Chair of the People Committee, everyone expressed their thanks to him for his service to the Committee.

Enclosure 17

The Dudley Group NHS Foundation Trust

Paper for submission to the Board of Directors on 11th July 2024

Report title	Workforce KPI Report
Report author /presenter	Karen Brogan, Interim Chief People Officer

1. Suggested discussion points

Analysis of the report workforce KPI's shows overall positive assurance with six of the eight reported metrics performing at or better than target.

The Committee is asked to note the following positive assurance and areas of challenge:

- Sickness Absence
  The rolling 12-month absence has seen a reducing trend since March 2023 and is now sitting below target, this is supported by a reducing trend across both short and long-term sickness absence. In May there were 103 long-term absences open across the Trust 87 (85%) cases are between 28 days and six months in length.

- Retention
  The retention rate is relatively stable and has been since September 2023.

- Agency Usage
  Agency remains very low, with only Medical & Dental agency being utilised. There is no off-framework agency usage.

- Mandatory Training
  Performance against target remains above 90% for the month. This is an ongoing sustained performance at above target since Q2 23/24. The overall position is stable with variations in staff groups (medical staff) and subjects (Paediatric Resus). Whilst performing above target cumulatively, eight individual subjects remain under target – these include manual handling, safeguarding and resus. The corporate nursing and HR teams are supporting the divisions to address this.

- Turnover
  Turnover has been just above Trust target since August 2023 but is still below the industry average. This is an area of focus through the 'being a brilliant place to work and thrive' group.

- Bank Usage
  There has been a general increase in clinical bank use this month, specifically within the Additional Clinical Services staff group. This is paired with an increase in requests for registered nursing but a lower fill rate than the previous month. Admin & Clerical requests and actual use have reduced for the third consecutive month.

2. Alignment to our Vision

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	

3. Report journey

People Committee Public Trust Board

4.	**Recommendation(s)**
The Public Trust Board is asked to:	
a.	**ASSURANCE:** Receive the report for assurance.

5. Impact		
Board Assurance Framework Risk 1.1	X	Deliver high quality, safe person-centred care, and treatment
Board Assurance Framework Risk 1.2	X	Achieve outstanding CQC rating.
Board Assurance Framework Risk 2.0	X	Effectively manage workforce demand and capacity
Board Assurance Framework Risk 3.0	X	Ensure Dudley is a brilliant place to work
Board Assurance Framework Risk 4.0	X	Remain financially sustainable in 2023/24 and beyond
Board Assurance Framework Risk 7.0	X	Achieve operational performance requirements
Corporate Risk Register	Y	COR1433 - Ability to deliver an effective staff health and wellbeing service to support staff wellbeing. COR1538 - Lack of sufficient clinical workforce capacity to deliver safe and effective services and support staff wellbeing. COR1789 - Non-compliance with statutory and mandatory training requirements with potential risk to provision and performance. COR1303 - There is a risk of low Staff engagement and Morale impacting on Absence, Turnover and Retention COR1791 - High Levels of Staff Absence could result in the inability to maintain safe and effective services.
Equality Impact Assessment	Is this required? N If 'Y' date completed	
Quality Impact Assessment	Is this required? N If 'Y' date completed	

Workforce KPI Report
Reporting on May 2024

The Dudley Group
NHS Foundation Trust

Karen Brogan
Interim Chief People Officer

CARE RESPECT RESPONSIBILITY

Summary

NHS
The Dudley Group
NHS Foundation Trust

Metric	Rate	Target	Trend	
Absence – In Month	4.74%	<=5%	↑	**Sickness Absence** In-month sickness absence for May 2024 is 4.74% a slight increase from 4.67% in April 2024.
Absence - 12m Rolling	4.96%	<=5%	↓	The rolling 12-month absence has decreased to 4.96% in May 2024 from 4.97% in April 2024.
Turnover	8.25%	<=8%	↓	**Turnover** Turnover (all terminations) has decreased from 8.35% in April 2024 to 8.25% in May 2024.
Normalised Turnover	3.64%	<=5%	↓	Normalised Turnover has decreased from 3.71% in April 2024 to 3.64% in May 2024. Turnover (all terminations) is all terminations from the organisation. Normalised Turnover focuses on voluntary resignations and excludes dismissals, fixed-term contracts, redundancy, retirement and rotations.
Retention (12 month)	91.5%	>=80%	↑	**Retention** The 12-month retention rate has increased slightly to 91.5% in May 2024 from 91.4% in April 2024.
Vacancy Rate	6%	<=7%	↔	**Vacancy Rate** The vacancy rate has remained static at 6%
Mandatory Training	92.65%	>=90%	↑	**Mandatory Training** Statutory Training increased to 92.44% in May 2024 from 92.39% in April 2024. Overall, it has remained above 90% target for a sustained period. As at 28th June Mandatory training was 92.65%.
Appraisals	85%	>=90%	↑	**Appraisals** • The appraisal rate is currently 85% • The Appraisal window will close on the 14th July 2024

Summary

The Dudley Group NHS Foundation Trust

SUMMARY	
Positive Assurance	
Sickness Absence	The rolling 12-month absence has seen a reducing trend since March 2023 and is now sitting below target, this is support by a reducing trend across both short and long-term sickness absence. In May there were 103 long-term absences open across the Trust 87 (85%) cases are between 28 days and 6 months in length.
Retention	The retention rate is relatively stable and has been since September 2023.
Agency Usage	Agency remains very low – with only Medical & Dental agency being utilised. There is no off-framework agency usage
Mandatory Training	Performance against target remains above 90% for the month. This is an ongoing sustained performance at above target since Q2 23/24. The overall position is stable with variations in staff groups (medical staff) and subjects (Paediatric Resus).
Negative Assurance	
Turnover	Turnover has been just above Trust target since August 2023 but is still below the industry average. This is an area of focus through the 'being a brilliant place to work and thrive' group.
Bank Usage	There has been a general increase in clinical bank use this month, specifically within in Additional Clinical Services staff group. This is paired with an increase in requests for registered nursing but a lower fill rate than the previous month. Admin & Clerical requests and actual use have reduced for the third consecutive month.
Mandatory Training	Whilst performing above target cumulatively, 8 individual subjects remain under target – these include manual handling, safeguarding and resus. The corporate nursing and HR team are supporting the divisions to address this.

Exceptions/Improvement/Actions

The Dudley Group
NHS Foundation Trust

METRIC	SUMMARY
Mandatory Training	Performance remains above target for mandatory training, and this has been a sustained above target position since Q2 23/24. There remain areas of challenge in individual subjects and there remain a focus of action on these alongside divisions. The Divisional picture is varied and there have been prompts to maintain focus on compliance across the suite of training – with a specific focus on resuscitation and safeguarding training as areas of concern. Safeguarding Children Level 3 has begun to increase this month. Only Paediatric resus is red - being 0.3% below 80%. Oliver McGowan training has been added to reports as a new subject and is now at 23.76 % for the e-learning. The subject will be added to the Priority 1 dashboard when it reaches 60%. Further training is required for all staff, and this will be promoted once available.
Leadership and Culture	Work continues to promote update of Manager's Essentials and to embed the Induction for new Managers to ensure this provides a strong introduction to expectations. Courses in the latest month have seen increased attendance and forthcoming courses are also booked to capacity each month. Completion of Manager's Essentials has been included in divisional action plans and work is underway to produce a compliance report of the current state for review. The broader leadership programme is currently being reviewed with an additional layer of training for leaders to support confidence and skills being launched in Quarter 2. This will enable leaders to consolidate learning from Manager's Essentials and add to their skills and knowledge through a portfolio approach on 'Leading Now'. Developing Leaders will then re-launch as a stretch programme in Quarter 3. Being a Brilliant Place to Work Make it happen rounds planned at the start of Quarter 1 have focused on cascading information about the People Plan and associated Journeys. This work to promote and embed the Plan, Journeys and Behaviour Framework will continue throughout the year. The annual review window opened on 1st April and compliance is now at 58.6% overall. Medicine Division is currently the highest performer at 65.5%.

CARE RESPECT RESPONSIBILITY

Enclosure 18

The Dudley Group NHS Foundation Trust

Paper for submission to Trust Board on 11th July 2024

Report title	Public Sector Equality Duty (PSED) Annual Report 2024
Sponsoring executive	Karen Brogan, Interim Chief People Officer
Report author / presenter	Paul Singh, Head of Equality, Diversity, Inclusion & Workforce Wellbeing

1. Suggested discussion points

The purpose of the annual Public Sector Equality Duty (PSED) report is to provide an overview with progress towards creating an inclusive workplace where all employees are treated fairly and with respect. It outlines the strategies/approaches, initiatives, and actions taken and planned by the Trust over the last twelve months to promote equality, diversity, and inclusion.

The PSED report is the second one produced by Dudley Group, the first being produced in 2023. The Trust Board are required to provide final sign off of the PSED annual report for assurance. The report serves as a tool for transparency and accountability, as it communicates the Trust's commitment to equality, diversity, and inclusion, and its progress in this area alongside internal and external stakeholders.

The full PSED report is enclosed within the further reading pack associated with this meeting for information and has been reviewed by the Executive Directors Committee and the People Committee. Both committees have confirmed approval of this year's PSED compliance submission report.

The PSED annual report will be published onto the Trust internal and external websites as required.

2. Alignment to our Vision

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	X

3. Report

People Committee – 28.05.24
Executive Committee – 18.06.24

4. Recommendation

The Public Trust Board is asked to:

a. **Approve** annual progress on Public Sector Equality Duty (PSED).

5. Impact

Board Assurance Framework Risk 1.1	X	Deliver high quality, safe person centred care and treatment
Board Assurance Framework Risk 3.0	X	Improve and sustain staff satisfaction and morale
Board Assurance Framework Risk 4.0		Remain financially sustainable in 2023/24 and beyond
Corporate Risk Register		*[Give risk Nos]*

Equality Impact Assessment	Is this required?			N	X	If 'Y' date completed	
Quality Impact Assessment	Is this required?			N	X	If 'Y' date completed	

REPORTS FOR DECISION

Summary of the Annual EDI Public Sector Equality Duty (PSED) Report

Report to Trust Board on 11th July 2024

1. EXECUTIVE SUMMARY

The Trust has a legal requirement to meet the Public Sector Equality Duty (PSED) under the Equality 2010.

The annual PSED report serves as a tool for transparency and accountability, as it communicates the Trust's commitment to equality, diversity, and inclusion, its progress in this area alongside internal and external stakeholders.

The Trust Board are required to provide final sign off of the PSED annual report for assurance. The full PSED report is enclosed within the further reading pack associated with this meeting for information and has been reviewed by the Executive Directors Committee and the People Committee. Both committees have confirmed approval of this years PSED compliance submission report.

The report includes details of how the Trust is meeting the key drivers for EDI, such as the: Workforce Race Equality Standard (WRES), Workforce Disability Equality Standard (WDES), Gender Pay Gap (GPG) reporting, Equality Delivery System (EDS), NHS England EDI Improvement Plan 23/24 (High Impact actions), Dudley People Plan – EDI Journey, EDI Journey Equality Objectives, Race Code, ENEI TIDE, Rainbow Badge and Staff Network work programmes.

Our equality objectives are contained within our Equality, Diversity, and Inclusion Journey, Trust Strategy, and translated into deliverables in line with the NHS People Promise, Our Dudley People Plan, WRES, WDES metrics, EDS assessment and NHS Improvement High Impact Actions.

The report brings together all EDI activity in one place. Progress, challenges, areas of good practice and actions against each of the drivers above are highlighted in detail within the report. It is to be noted that all EDI drivers are monitored through the EDI Steering group and upward reported to the People Committee.

Overall, there has been good progress made over the last twelve months. Key points to note:

- The report highlights areas of good practice such as becoming an anti-racist Trust, inclusive recruitment and supporting staff declaring a disability/ long term condition with reasonable adjustments.
- Continued to grow our current staff networks to enhance staff voice and introduced 2 new networks, namely a carers and armed forces network - the Trust are proud to have been awarded the Veterans Aware Kite mark in December 2023.
- Introduced a standardised anti-discriminatory statement into all relevant workforce policies.
- Increased staff engagement through ward rounds and divisional meetings

- Developed SMART EDI objectives for the Chair, Chief Executive and Board members.
- Developing EDI data packs and objectives for divisional teams – addressing workforce challenges such as career progression and professional development.
- Career fairs introduced targeting women in areas where the Gender Pay Gap exists.
- Implementation of the EDS has highlighted good progress on staff and health & wellbeing and developing inclusive leadership across the Trust.

The equalities and wellbeing team have been recognised throughout 2023/24 for their contribution to the equality, diversity, and inclusion agenda, locally, across the ICB and regionally being awarded with accolades.

The data within the report also outlines areas of challenges for the Trust. There are clear areas where improvement is needed such as experiences around bullying, harassment and discrimination, the likelihood of entering a formal disciplinary process, access non-mandatory training and professional development and diversity of the Trust Board. Challenges will be mitigated through actions set out in the Trust's EDI Journey and through the Trust's commitment to address unwarranted differences in staff experience.

Through the EDS and Rainbow badge accreditation, gaps have identified with EDI and patient experience/engagement. A working group with key stakeholders has now been developed and an initial gap analysis is being carried out to address these issues..

2. CONCLUSION

There have been significant improvements made within the Trust over the year and the main area of focus for the next 12 months is to strive to maintain and improve performance across all areas of EDI.

The Trust's EDI Journey action plan and corresponding EDI work programmes identify the key EDI objectives and main priorities for action.

The PSED annual report will be published onto the Trust internal and external websites as required.

3. RISKS AND MITIGATIONS

a. This work relates to BAF risks around staff engagement and retention.
b. Failure to effectively deliver actions associated with this work programme will continue to limit the scope and pace of improvement against the legal stator requirement under the Equality Act 2010

4. RECOMMENDATIONS

Note and approve the annual EDI Public Sector Equality Duty Report.

Enclosure 19

The Dudley Group NHS Foundation Trust

Paper for submission to the Board of Directors on 11th July 2024

Report title	Guardian of Safe working
Sponsoring executive/ presenter	Dr Julian Hobbs, Medical Director
Report author	Mr Fouad Chaudhry, Guardian of Safe Working

1. Suggested discussion points

The Board is asked to note that the purpose of this report is to give assurance to the Trust Board that Junior Doctors in Training (JDT) are safely rostered, and their working hours are compliant with the Terms and Conditions of Service for NHS Doctors and Dentists in Training (England) 2016 (TCS).

This paper provides a summary of the following areas related to JDT and the 2016 TCS:

- Challenges
- Exception reports
- Vacancies (data provided by Medical Work Force Department)

To note the mitigations to support effective engagement with the Junior doctors.

2. Alignment to our Vision

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

2. Report journey

3. Recommendation

The Public Trust Board is asked to:

a. **Note** the assurance

4. Impact

Board Assurance Framework Risk 1.1	x	Deliver high quality, safe person centred care and treatment
Board Assurance Framework Risk 1.2	x	Achieve outstanding CQC rating.
Board Assurance Framework Risk 2.0	x	Address critical shortage of workforce capacity
Board Assurance Framework Risk 3.0	x	Improve and sustain staff satisfaction and morale
Corporate Risk Register		

Equality Impact Assessment	Is this required?			N		If 'Y' date completed	
Quality Impact Assessment	Is this required?			N		If 'Y' date completed	

REPORTS FOR ASSURANCE

Guardian of Safe working Report

Report to Trust Board July 2024

1 EXECUTIVE SUMMARY

This is the 6th report from the Guardian of safe working (GOSW) and covers the period between 05 March 2024 and 01 July 2024.

There have been **7** exception reports raised in the period. 7 were carried forward from the previous report. 13 have been fully closed. Outcome of ER is combination of TOIL and payment. 1 ER is pending. A reminder e-mail has been sent to the educational supervisor to arrange the meeting with the trainee.

No fines have been issued in this reporting period. There are currently **42** vacancies in the junior workforce.

2 BACKGROUND INFORMATION

The purpose of this report is to give assurance to the Trust Board that Junior Doctors in Training (JDT) are safely rostered, and their working hours are compliant with the Terms and Conditions of Service for NHS Doctors and Dentists in Training (England) 2016 (TCS).

This paper provides a summary of the following areas related to JDT and the 2016 TCS:

- Challenges
- Exception reports
- Vacancies (data provided by Medical Work Force Department)

The role of Guardian of Safe Working Hours (GSW) is to:

- Ensure the confidence of doctors that their concerns will be addressed.
- Ensure improvements in working hours and work schedules for JDTs.
- Provide Board with assurance that junior medical staff are safe and able to work, identifying risks and advising Board on the required response.
- Ensure fair distribution of any financial penalty income, to the benefit of JDTs.

This is the 24th GSW report and covers the period from 05 March 2024 to 01 July 2024. This is the sixth report from the current guardian (Fouad Chaudhry). The Guardian has been working closely with colleagues from medical staffing and rostering, post graduate medical education staff, human resources, and finance to establish his role in the Trust and build relationships.

Exception Reports– 05-03-2024 till 01-07-2024 total = 13

Exception Reports (ER) over past quarter	
Reference period of report	05/03/24 - 01/07/24
Total number of exception reports received	7
Number relating to immediate patient safety issues	0
Number relating to hours of working	6
Number relating to pattern of work	1
Number relating to educational opportunities	0
Number relating to service support available to the doctor	0

Reasons for ER over last quarter by specialty & grade						
ER relating to:	Specialty	Grade	No. ERs carried over from last report	No. ERs raised	No. ERs closed	No. ERs outstanding
Immediate patient safety issues	General medicine	FY1	1	0	1	0
Total			**1**	**0**	**1**	**0**
No. relating to hours/pattern	Cardiology	FY1	0	1	1	0
	General Medicine	ST2	7	2	9	0
	Paediatrics	FY1	0	4	3	0
Total			**7**	**7**	**13**	**1**
No. relating to educational opportunities	General medicine	FY1	1	0	1	0
Total			**1**	**0**	**1**	**0**
No. relating to service support available						
Total			**0**	**0**	**0**	**0**

ER by Month

Month	Number of Doctors	Number of reports
March 2024	0	0
April 2024	2	2
May 2024	4	2
June 2024	1	1

Historic Data

Year	Total Exception Reports
2018	55
2019	103
2020	60
2021	44
2022	72
2023	69

Exception Reports and Fines.

- No fines submitted.

Medical Vacancies – Training

Medical Vacancy - Doctors in training: 42
Total number of doctors in training: 252

Department	DOCTORS IN TRAINING				Total
	F2	LT	GPST	ST Higher	
Acute Medicine	0	5	2	1	8

Anaesthetics	0	1	0	0	1
Cardiology	0	1	2	1	4
Emergency Medicine	0	0	6	0	6
Endo/Diabetics	0	2	0	0	2
ENT	0	2	0	0	2
Gastro	0	1	1	0	2
Max/Fac	0	1	0	1	2
MOC	0	2	0	0	2
Obs/Gyane	0	0	1	0	1
Older People	0	1	2	0	3
Pain Relief	0	0	0	1	1
Psychiatry	2	0	0	0	2
Renal	0	1	0	0	1
Respiratory	0	2	0	0	2
Stroke	0	0	1	0	1
Surgery	1	1	0	0	2
Total	**3**	**20**	**15**	**4**	**42**

Mitigations:

Engagement with the junior doctor workforce continues to improve. The Guardian is following his strategy to engage with the junior doctors, which involves:

- The Junior Doctor Forum and Guardian of Safe Working forum have been merged into one afternoon session every 2 months to maximise junior doctors' contribution. In the last JDF once again the trainee doctors were encouraged to do the exceptional report if they work beyond their contracted hours. The JDF was reassured that ER is the right of every trainee if they work beyond their contracted hours.

- The number of exception reports during the reporting period is 7. Guardian has engaged with the junior doctors through the above-mentioned engagement strategy. The guardian has also met with the BMA trainee rep in Russell Hall hospital Dudley and highlighted the importance of ER to improve working pattern. The trainees were also encouraged to do ER if they are denied of attending training opportunities.

- One of the ER from the previous report was due to trainee not been able to attend the teaching session. The concerned department has agreed to make necessary arrangements in advance and all FY teaching sessions are being covered.

- The Guardian has been reassured through all these forums and meetings that the junior doctors are aware of the exception reporting process and are encouraged to submit one if they feel necessary.

- A constant reminder has been sent to the trainees from the junior doctor representative and the Guardian.

- Reminder emails are sent to the educational supervisors about the process. They are encouraged to arrange the meeting at the earliest with the trainee, once the exceptional report is submitted.

- Junior doctors have been conveyed by the Guardian through above mentioned engagement strategy that the Trust promotes a culture of safe working and high standard of learning opportunity.

Fouad Chaudhry
Guardian of Safe Working
July 2024

Enclosure 20

The Dudley Group NHS Foundation Trust

Paper for submission to the Board of Directors on 11th July 2024

Report title	Freedom to Speak Up Report
Sponsoring executive	Diane Wake, chief executive
Report author /presenter	April Burrows, Freedom to Speak Up Guardian

1. Suggested discussion points

This report has been prepared by the Trust's Freedom to Speak Up (FTSU) Guardian and provides an update on the FTSU activity.

There are presently 20 trained multi professional and diverse FTSU champions providing a network of support across our acute and community sites which provides greater accessibility to the service. The service is supported by named executive and non-executive directors. Catherine Holland is our newly assigned non- executive Director.

E-Learning for health completed training data shows 37 staff members have completed the Speak Up training module, with 20 members of staff completed the Listen up module and finally only 6 members of staff have completed the follow up module for senior leads.

In the past three months the Dudley Group Freedom to Speak Up service handled 25 concerns brought by 25 members of staff (some people prefer to raise concerns in small groups). One concern has been raised anonymously. Forty per cent of concerns are from the medicine division with the staff wellbeing equating to 28% and is the highest reoccurring theme.

2. Alignment to our Vision

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	

3. Report journey

People Committee, Trust Board, FTSU Steering group

4. Recommendation(s)

The Public Trust Board is asked to note:

a.	E-Learning for health completed training data
b.	The NGO will release the updated strategy on the 8th July 2024

5 Impact

Board Assurance Framework Risk 3.0	X	Ensure Dudley is a brilliant place to work					
Corporate Risk Register		*[Give risk Nos]*					
Equality Impact Assessment	Is this required?	Y		N		If 'Y' date completed	
Quality Impact Assessment	Is this required?	Y		N		If 'Y' date completed	

Freedom to Speak Up Report – July 2024

1. Executive Summary

The Freedom to Speak Up (FTSU) service provides an independent and impartial source of advice to staff who wish to raise a concern within the workplace, which may include issues around: unsafe patient care, unsafe working conditions, inadequate induction or training for staff, suspicions of fraud and bullying/concerns with attitudes and behaviours of other.

25,382 cases were raised nationally through FTSU services from 1st April 2022 to 31st March 2023. Due to the National Election the data from 2023 to 2024 has been delayed.

At present there is one full-time lead FTSU Guardian in place supported by a second Guardian who fulfils the role in addition to their substantive post. There will be a 3rd Guardian joining the team with the transfer of Dudley Integrated Health and Care NHS staff later in the year. This arrangement is in line with the National Guardian Office (NGO – oversees the network of FTSU Guardians) recommendation that guardians are allocated enough ring-fenced time to provide optimum service.

20 trained multi professional and diverse FTSU champions provide a network of support across our acute and community sites which provides greater accessibility to the service. Champions listen, advise and signpost but do not routinely handle cases themselves as their role is voluntary and in addition to their substantive posts.

The FTSU service is supported by named executive and non-Executive Directors. Catherine Holland is our newly assigned non-executive Director.

Governance arrangements include a quarterly steering group which reports to the People Committee and to the Trust Board on a regular basis.

Anonymized records of cases are maintained for thematic analysis and this information is shared with the NGO on a quarterly basis in line with their reporting requirements.

The lead guardian regularly attends regional FTSU meetings to share learning and best practice and meets separately with other guardians in our system to discuss local themes and trends.

The service works in partnership with the equality, diversity, and inclusion team (and networks), staff well-being, organisational development, human resources, communications, and patient safety. Work is also carried out with the compliance team where FSTU representation joins regular walk rounds to raise awareness and gain feedback on the service from staff.

The National Guardian Office Freedom to Speak Up training is available across the organization through e-learning for healthcare:

- 'Speak up' (for all staff) can be accessed via trust intranet.
- 'Listen up' (for managers) is promoted via the trust internal training program 'Manager's essentials'.
- Follow up (for senior leaders) is available to all Executive and Non-executive directors via our Executive Lead for FTSU and bespoke face-to-face training is also provided for our governors.
- FTSU awareness is part of Induction for all new starters and students.

E-Learning for health completed training data shows.

FTSU e-learning for healthcare module	**Number of staff complete across the organization**
'Speak up' (for all staff)	37
'Listen up' (for managers)	20
Follow up (for senior leaders)	6

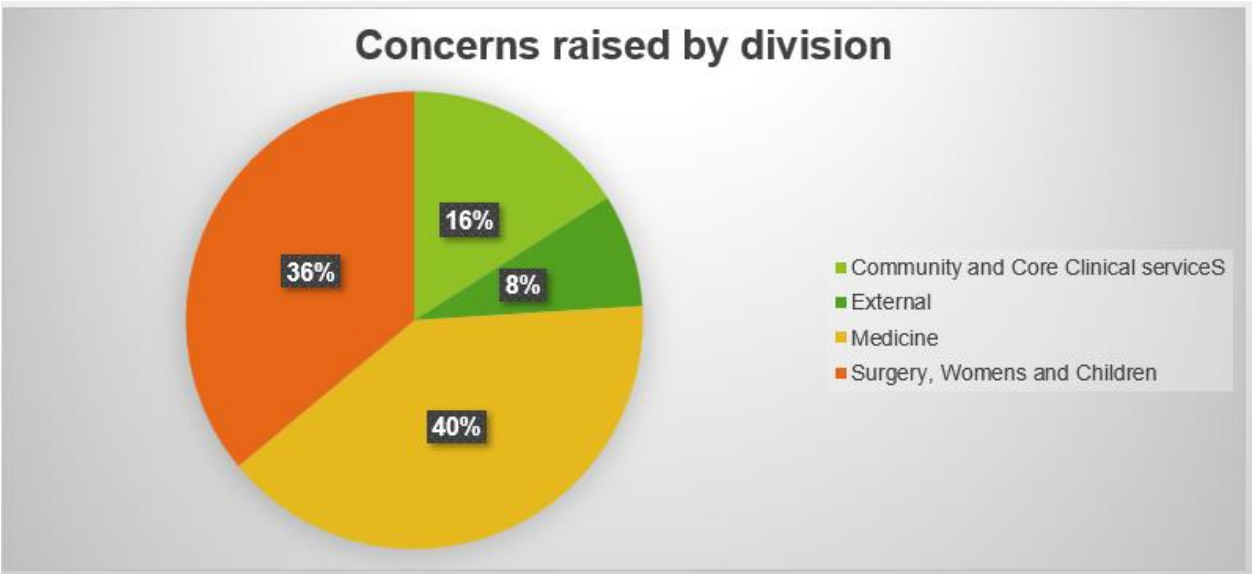
The NGO Freedom to Speak Up training is not part of the Mandatory training for the trust.

2. Update on national guidance/recent publications.

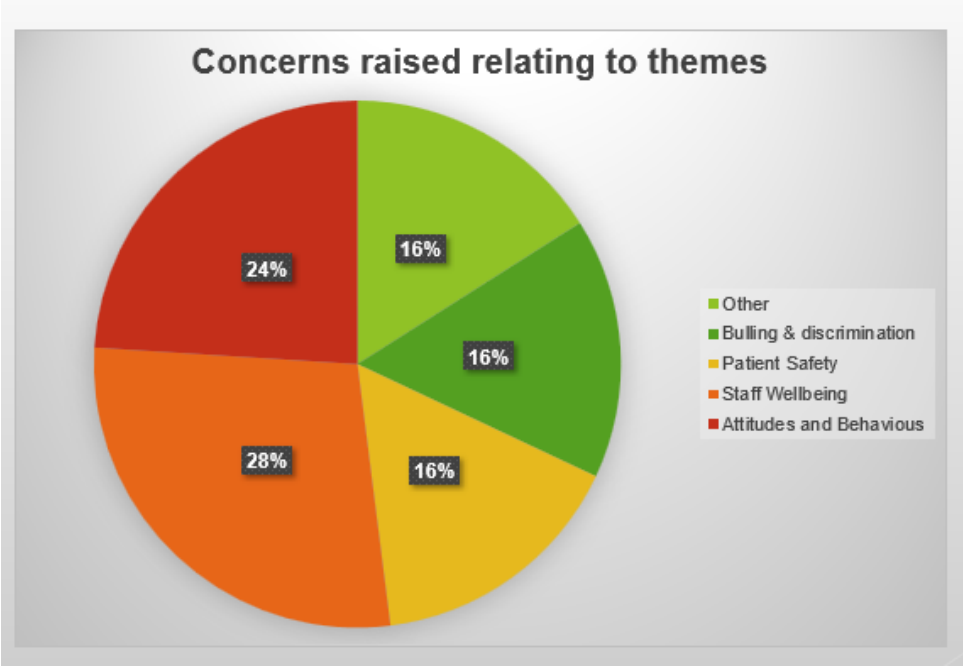
The National Guardian Office (NGO) updated strategy has been delayed following the announcement of a general election taking place on Thursday 4th July. The NGO will release the updated strategy on the 8th of July and a virtual engagement session with Freedom to Speak Up guardians on 9th July.

3. Numbers and Themes of concerns raised.

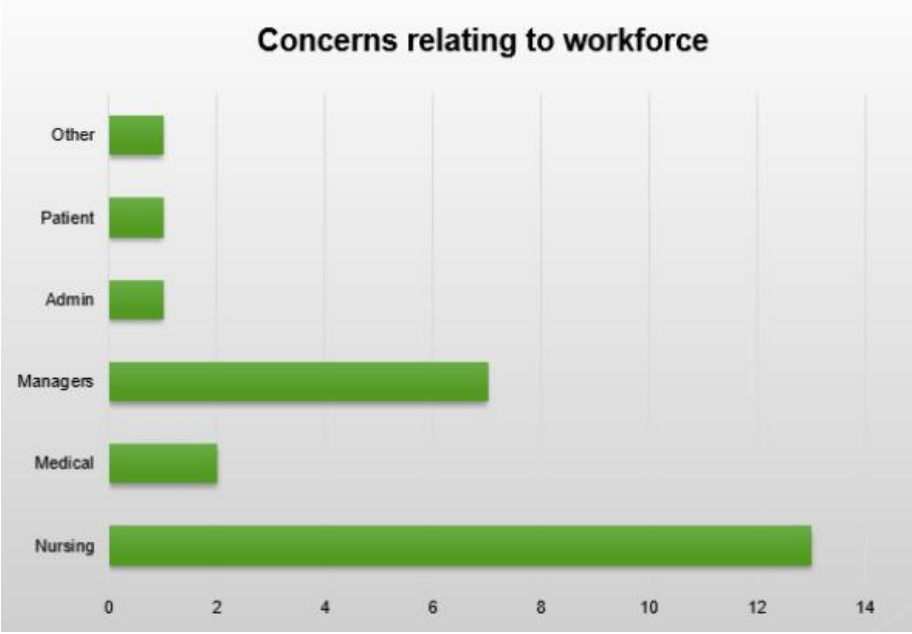
In the past three months the DGFT Freedom to Speak Up service handled 25 concerns brought by 25 members of staff (some people prefer to raise concerns in small groups). One concern has been raised anonymously.



Medicine had the greatest number of concerns followed by Surgery, Women's, and Children division.



Staff wellbeing equate to 28% and is the highest reoccurring theme followed by Staff Wellbeing 24%



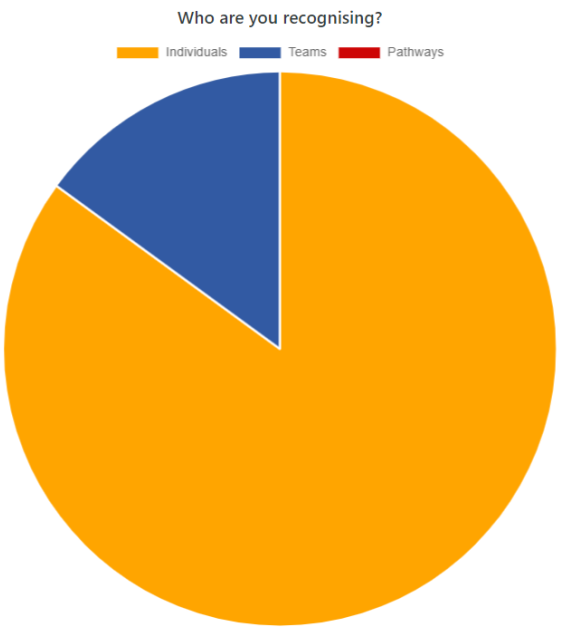
52% of concerns were relating to the Nursing workforce followed by Managers with27%.

3. Greatix

The Greatix continues to be actioned due to the transitional period between the FTSU Guardian and Patient safety lead. The Being a Brilliant Place To Work Group are working together to drive the Greatix system forward and share learning from excellence.

The aim of the Greatix system is to identify, appreciate, study, and learn from episodes of excellence. This has the dual benefit of improving patient care and boosting staff morale by recognising when people have given that bit extra to ensure our patients are receiving the best care we can provide in The Dudley Group NHS Foundation Trust.

Since the creation of the Greatix system there has been 3965 submitted, with 1143 Greatix completed in the last financial year.



Enclosure 21

The Dudley Group NHS Foundation Trust

Paper for submission to the Board of Directors on 11th July 2024

Report title	Upward Assurance Report from Audit Committee
Sponsoring executive / presenter	Joanne Hanley, Audit Committee Chair
Report author	Zoe Harris, Executive Assistant to Interim Director of Finance

1. Suggested discussion points

The Audit Committee met on the 24th June 2024 and discussed key matters. A number of items were approved including:

- The Audit Committee Terms of Reference (TOR) were reviewed and agreed as a recommendation to Board for endorsement – appendix 1.
- Under delegated authority from the chair, the Trust Annual Accounts for 2023/24 were approved.
- The committee approved the Trust Annual Report and Annual Governance Statement for 2023/24.
- The committee approved the Grant Thornton letter of representation.

2. Alignment to our Vision

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	

3. Report journey

Board of Directors – 11th July 2024

4. Recommendation(s)

The Public Trust Board is asked to:

a.	Approve and note the contents of the report.
b.	Endorse the Audit Committee Terms of Reference

5. Impact

Board Assurance Framework Risk 1.1	x	Deliver high quality, safe person centred care and treatment
Board Assurance Framework Risk 3.0	x	Improve and sustain staff satisfaction and morale
Board Assurance Framework Risk 4.0	x	Remain financially sustainable in 2023/24 and beyond
Board Assurance Framework Risk 5.0	x	Achieve carbon reduction ambitions in line with NHS England Net Zero targets
Corporate Risk Register		

Equality Impact Assessment	Is this required?			N		If 'Y' date completed	
Quality Impact Assessment	Is this required?			N		If 'Y' date completed	

UPWARD REPORT FROM AUDIT COMMITTEE
Date Committee met: 24th June 2024

MATTERS OF CONCERN OR KEY RISKS TO ESCALATE	**MAJOR ACTIONS COMMISSIONED/WORK UNDERWAY**
• There were no matters of concern to escalate.	• The charitable funds audit plan was approved for the audit work to commence. • Chair to work with Audit Committee members on actions arising from the Annual Effectiveness Review including specific annual objectives/mission to supplement workplan and consider how interact and work with the wider System.
POSITIVE ASSURANCES TO PROVIDE	**DECISIONS MADE**
• Positive assurances were received throughout the audit reports particularly around the annual accounts, the valuation of land and properties and the changing of valuer and the PFI IFRS16 application. • The committee noted the Data Security Toolkits assessments, giving the committee assurance, whilst recognising that there are a number of actions to have the right level of evidence going forwards. • External Audit Annual report, including Value for Money, noted with no significant findings to report and provided assurance around the quality of the Trust Accounts Production and the way the Trust is governed.	• The Audit Committee Terms of Reference (TOR) were reviewed and agreed as a recommendation to Board for endorsement. • The committee effectiveness review was approved with the workplan to be noted by Board. • Under delegated authority from the chair, the Trust Annual Accounts for 2023/24 were approved. • The committee approved the Trust Annual Report and Annual Governance Statement for 2023/24. • The Charitable Funds audit plan and fees for 2023/24 were approved. • The committee approved the Grant Thornton letter of representation.
Chair's comments on the effectiveness of the meeting: Committee ran to time whilst effectively covering a number of key items. Committee reflected that the meeting was well Chaired	

UPWARD REPORT FROM AUDIT COMMITTEE
Date Committee met: 20th May 2024

MATTERS OF CONCERN OR KEY RISKS TO ESCALATE	**MAJOR ACTIONS COMMISSIONED/WORK UNDERWAY**
• An increase in serious data breaches had been seen across the Trust.	• The business plan for the committee must be synchronised with the latest version of the HFMA Audit Committee handbook. • A revised plan of the Audit Committee workplan with the work that falls into the Audit Committee remit would be revised and approved at the next committee meeting following the disbanding of the Digital Committee. • The data collected as part of the Annual Committee Effectiveness Review would be finalised at the June committee meeting. • It was asked to ensure that the approach to quality impact assessment and cross committee escalation was implemented and effective within reporting. • Two reports were commissioned from pharmacy outlining the management of drugs within the department and appropriate management of stock within pharmacy.
POSITIVE ASSURANCES TO PROVIDE	**DECISIONS MADE**
• The Head of Internal Audit opinion was a positive, above the line opinion with an adequate and effective framework for risk management, governance and internal control. Enhancements to the framework of control had been agreed with management. • There were no overdue internal audit actions. • The draft Trust Annual Report and Accounts 2023/24 were on track. • The Audit Committee were satisfied with the process laid out in the Clinical Effectiveness Plan.	• The committee approved and supported the land and buildings valuation. • The committee received and approved variations to the internal audit plan. • It was agreed to have an offline discussion around linking the strategy, risk management and risk management practice to ensure there was a robust roadmap to refreshing the strategic risks and the approach to the BAF development. • The committee acknowledged the Chairs request to delegate the approval of the 2023/24 Annual Report and Accounts.
Chair's comments on the effectiveness of the meeting:	

The Dudley Group
NHS Foundation Trust

AUDIT COMMITTEE

TERMS OF REFERENCE

1. Constitution

1.1 The Board of Directors resolves to establish a Committee of the Board to be known as the Audit Committee. The Audit Committee in its workings will be required to adhere to the Constitution of The Dudley Group NHS Foundation Trust, the Terms of Authorisation and Code of Governance issued by the Independent Regulator for NHS Foundation Trusts. As a committee of the Board of Directors, the Standing Orders of the Trust shall apply to the conduct of the working of the Audit Committee. The Committee is a non-executive committee of the Board and has no executive powers, other than those specifically delegated in these Terms of Reference.

2. Membership

The Committee shall be appointed by the Board from amongst the Non-executive directors of the Trust and shall consist of not less than three members. One of the members will be appointed Chair of the Committee by the Board (the chair of this committee will have relevant financial experience). The Chair/deputy chair of the Trust shall not be a member of the Committee.

3. Attendance

3.1 The following members of staff and partners would usually be in attendance at every meeting:

Director of Finance
Trust Secretary
Internal Auditors
External Auditors

Representatives of Internal and External Audit shall have the right of direct access to the Committee Chair. Attendance at the Committee will be monitored and reported in the Annual Report.

3.2 The Chief Executive should be invited to attend and should discuss at least annually with the Audit Committee, the process for assurance that supports the Annual Governance Statement. They should also attend when the Committee considers the draft Internal Audit Plan and the Annual Accounts. All other Executive Directors should be invited to attend, particularly when the Committee is discussing areas of risk or operation that are the responsibility of that director.

3.3 Other managers/staff may be invited to attend meetings depending upon issues under discussion. The Committee has the power to co-opt, or to require to attend, any member of Trust staff, as felt necessary.

3.4 The Committee will exclude the Director of Finance and any other Trust employee from its meeting with Internal and External Auditors for a minimum of one meeting per year.

3.5 The Trust Secretary will ensure that an efficient secretariat service is provided to the Committee.

4. Quorum

4.1 A quorum shall be two Non-executive Directors.

5. Frequency of meetings

5.1 The Committee will meet at least four times per year. The agenda will be circulated with papers seven days before the meeting.

5.2 Ad hoc meetings can be called by the Chair or as a result of a request from at least two members of the Committee. The request is to be made to the Chair. Ad hoc meetings will be arranged within 28 days of the Chair's decision or the request from at least two members of the Committee. Additional meetings may be held at the discretion of the Chair of the Committee.

6. Authority

6.1 The Committee is authorised by the Board of Directors to investigate any activity within its Terms of Reference. It is authorised to seek any information it requires from any employee and all employees are directed to co-operate with any request made by the Committee. The Committee is authorised by the Board to obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers this necessary.

7. Duties

The duties of the Committee can be categorised as follows:

7.1 Governance Risk Management and Internal Control

7.1.1 The Committee will review the establishment and maintenance of an effective system of integrated governance, risk management and internal control, across the whole of the organisation's activities (both clinical and non-clinical), that supports the achievement of the organisation's objectives.

In particular, the Committee will review the adequacy and effectiveness of:

- all risk and control-related disclosure statements (in particular the Annual Governance Statement), together with an accompanying Head of Internal Audit statement, External Audit Opinion or other appropriate independent assurances, prior to endorsement by the Board of Directors.

- The underlying assurance processes that indicate the degree of achievement of corporate objectives, the effectiveness of the management of principal risks and the appropriateness of the above disclosure statements.

- The policies for ensuring compliance with relevant regulatory, legal and code of conduct requirements and related reporting and self-certification. The policies and procedures for all work related to fraud and corruption as set out in Secretary of State's Directions and as required by the NHS Counter Fraud Authority (formally NHS Protect).

In carrying out this work the Committee will primarily utilise the work of Internal Audit, External Audit and other assurance functions, but will not be limited to these sources. It will also seek reports and assurances from directors and managers as appropriate, concentrating on the over-arching systems of integrated governance, risk management and internal control, together with indicators of their effectiveness. This will be evidenced through the Committee's use of an

effective Assurance Framework to guide its work and that of the audit and assurance functions that report to it.

7.2 Internal Audit

7.2.1 The Committee shall ensure that there is an effective Internal Audit function that meets Government Internal Audit Standards and provide appropriate independent assurance to the Audit Committee, Chief Executive and Board. This will be achieved by:

- consideration of the provision of the Internal Audit service, the cost of the audit and any questions of resignation and dismissal.
- Review and approval of the Internal Audit Strategy, Operational Plan and more detailed programme of work, ensuring that this is consistent with the audit needs of the Trust as identified in the Assurance Framework.
- Considering the major findings of Internal Audit work (and management's response) and ensuring co-ordination between the Internal and External Auditors to optimise audit resources.
- Ensuring that the Internal Audit function is adequately resourced and has appropriate standing within the organisation.
- An annual review of the effectiveness of Internal Audit.

7.3 External Audit

7.3.1 The Committee shall review the work and findings of the External Auditors and consider the implications and management's responses to their work. This will be achieved by:

- Consideration of the appointment and performance of the external auditors, as far as the rules governing the appointment permit.
- Discussion and agreement with the external auditors, before the audit commences, of the nature and scope of the audit as set out in the Annual Plan, and ensuring co-ordination, as appropriate, with other external auditors in the local health economy.
- Discussion with the external auditors of their local evaluation of audit risks and assessment of the Trust and associated impact on the audit fee
- Review of all external audit reports, including the Report to those charged with Governance and any work undertaken outside the Annual Audit Plan, together with the appropriateness of management responses.
- Review of the report on Quality Accounts.

7.4 Other Assurance Functions

7.4.1 The Audit Committee shall review the findings of other significant assurance functions, both internal and external to the Trust and consider the implications for the governance of the organisation.

7.4.2 These will include, but will not be limited to, any reviews by Department of Health arm's length bodies or regulators/inspectors (for example, NHS England , the Care Quality Commission, NHS Resolution (formerly NHSLA) etc.) and professional bodies with responsibility for the performance of staff or functions (for example, Royal Colleges, accreditation bodies etc.).

In addition, the Committee will review the work of other committees within the Trust whose work can provide assurance to the Audit Committee's own scope of work. In particular, this will include the Quality Committee and risk management groups established as reporting groups at 8.6 below.

7.5 Counter Fraud

7.5.1 The Committee shall satisfy itself that the organisation has adequate arrangements in place for countering fraud and shall review the outcomes of counter fraud work.

7.6 Management

7.6.1 The Committee shall request and review reports and positive assurances from directors and managers on the overall arrangements for governance, risk management and internal control.

7.6.2 The Committee may also request specific reports from individual functions within the organisation (for example, clinical audit, Freedom to Speak Up (whistleblowing)) as they may be appropriate to the overall arrangements.

7.7 Financial Reporting

7.7.1 The Audit Committee shall monitor the integrity of the financial statements of the Trust and any formal announcements relating to the Trust's financial performance.

7.7.2 The Committee should ensure that the systems for financial reporting to the Board, including those of budgetary control, are subject to review as to completeness and accuracy of the information provided to the Board.

7.7.3 The Audit Committee shall review the Annual Report, Quality Accounts and financial statements before submission to the Board, focusing particularly on:

- The wording in the Annual Governance Statement and other disclosures relevant to the terms of reference of the Committee.
- Changes in, and compliance with, accounting policies, practices and estimation techniques.
- Unadjusted misstatements in the financial statements.
- Significant judgements in preparation of the financial statements.
- Significant adjustments resulting from the audit.
- Letter of representation.
- Qualitative aspects of financial reporting.
- Contents of Quality Accounts.

8. Reporting

8.1 The Audit Committee reports to the Board of Directors. The minutes of Audit Committee meetings shall be formally recorded and a summary of key issues, and if required, the minutes, submitted to the Board. The Chair of the Committee shall draw to the attention of the Board any issues that require disclosure to the full Board or require executive action.

8.2 The Committee will report to the Board at least annually on its work in support of the Annual Governance Statement, specifically commenting on the fitness for purpose of the Assurance Framework, the completeness and 'embeddedness' of risk management in the organisation, the integration of governance arrangements, the appropriateness of the evidence compiled to demonstrate fitness to register with the Care Quality Commission and the robustness of the processes behind the Quality Accounts.

8.3 The Committee will review the work of other committees/groups within the Trust whose work can provide assurance to the Audit Committee's own scope of work. In particular this will include the Board Committees. In reviewing the work of these Committees and issues around clinical risk management, the Audit Committee will wish to satisfy itself on the assurance that can be gained from the Clinical Audit function.

8.4 The Committee will approve the Clinical Audit Annual Plan and will receive verbal reports by exception on audit activity via a member of the Quality Committee at each meeting. An annual Clinical Audit and Effectiveness Report to be presented to Audit Committee, for transparency.

8.5 An annual Data Quality and Standards Report to be presented to Audit Committee, for transparency (provided by the Data Quality and Standards Group via the Digital Trust Steering Group). Items will be raised to the Committee on an ad hoc basis as appropriate outside of the annual reporting cycle.

8.6 The following group reports directly into this Committee:

- Caldicott and Information Governance Group

Ad hoc reports also received from the following groups that report directly to the Quality Committee:

- Research Education and Innovation Group
- Risk and Assurance Group relating to the Risk Management Strategy review at least every three years

Ad hoc reports also received from the following groups that report directly to the Digital Trust Steering Group:

- Data Quality and Standards Group

9. Policies

The Committee will approve policies on subjects related to the Committee Terms of Reference on recommendation from time to time.

10. Review

10.1 The Committee shall formally consider its effectiveness utilising any tools within the HFMA NHS Audit Committee handbook.

10.2 The Terms of Reference of the Committee shall be reviewed by the Board of Directors at least annually.

Enclosure 22

The Dudley Group NHS Foundation Trust

Paper for submission to the Board of Directors on 11th July 2024

Report title	**Integration Committee Upwards Report**
Sponsoring executive	Kat Rose, Director of Integration
Report author	Vij Randeniya, Non-Executive Director (Integration Committee Chair)

1. Suggested discussion points

Two formal Integration Committee meetings took place on the 29th of May and 26th June 2024.

In the meeting in May, the committee received an update on Health and Care Partnerships, which the committee noted. An update was given on the DIHC transaction and approved the post transaction implementation plan, as the general election had been called for 4th July 2024, discussions were ongoing to understand the impact on the 1st of July transfer date, as this was subject to sign-off by the Secretary of State. The first update was received on the University Hospital Trust Application. Positive assurance was received within three deep dive presentations on Procurement, Abdominal Aortic Aneurysm (AAA) and Breast Screening Service (BSS). The committee received an update on the impact and mitigations on the Midland Met University Hospital (MMUH), which the committee noted. It was agreed that the assurance level of the BAF Risk 6 risk would remain unchanged.

The meeting in June, the committee received an update on DIHC Transaction, where it was noted that no decisions on a revised date of transaction this will be agreed until after the general election. Positive assurance was given through the update on the Dudley Health and Care Partnership. The committee received its first update on Targeted Lung Health Check Programme, where positive assurance was received, noting the update is to be added onto the committee workplan and update every quarter. A Memorandum of Understanding (MoU) between the Trust and Dudley Academies Trust was supported by the committee. The committee also supported a proposal of neighbourhood working to improve relationships with Primary Care, a working group will be set up to look at implementing shadowing between primary and secondary care clinicians. Positive assurance was received from the two-prevention programme deep dives that were presented within the Alcohol and Tobacco Care teams, both having actions to feedback on at future committees.

2. Alignment to our Vision

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

3.	Report journey
This report is an upwards report following the Integration Committee Meetings.	

4.	Recommendation(s)
The Board (public) is asked to:	
a.	To note the upward report from two Integration Committee's held in 2024.

5.	Impact							
Board Assurance Framework Risk 6.0	**X**	Deliver on its ambition to building innovative partnerships in Dudley and beyond						
Corporate Risk Register		*[Give risk Nos]*						
Equality Impact Assessment	Is this required?	Y		N	**X**	If 'Y' date completed		
Quality Impact Assessment	Is this required?	Y		N	**X**	If 'Y' date completed		

UPWARD REPORT FROM INTEGRATION COMMITTEE

MATTERS OF CONCERN OR KEY RISKS TO ESCALATE

29th May 2024

- A key risk to escalate following the DIHC transaction update, was that the general election had been called for 4th July, discussions were ongoing to understand the impact on the 1st of July date, as this was subject to sign-off by the Secretary of State.

26th June 2024

- A matter of concern to escalate is the DIHC Transaction date will be finalised after the general election.

MAJOR ACTIONS COMMISSIONED/WORK UNDERWAY

29th May 2024

- Dr Hobbs presented the first update on the University Hospital Trust application. A five-year trajectory was in place which would focus on: - increasing research capability funding (RCF) grant applications (250k over 2 consecutive years required), research excellence framework (REF) all research to be REF returnable substantive contract with a university and securing clinical academic contracts. Dr Hobbs highlighted a funding gap in terms of the criteria for NHIL related studies which had been reported to Quality Committee on 28/05/24 and several individuals who could make a credible application for an academic appointment at Aston had been identified and these would be progressed.
- The impact and mitigations on the Midland Met University Hospital (MMUH) were reported to the Committee, the paper was noted.

26th June 2024

- To commission the creation of a development presentation on the operating model for primary care and GP practices, to be shared with Board and its committees.
- Dr Balraj Mavi shared a proposal of neighbourhood working to improve relationships between primary and secondary care clinicians which the committee supported. A working group will be set up to look at implementing this.

POSITIVE ASSURANCES TO PROVIDE

29th May 2024

- Positive assurance was received throughout the update on the ongoing work of the Dudley Health and Care Partnership.
- Paul Mellor gave a deep dive on procurement and the four pillars of integration: social value, sustainability, local procurement and equality, diversity, and inclusion in the supply chain. Clare Nash (Head of Clinical

DECISIONS MADE

29th May 2024

- The Committee reviewed the assurance level of the BAF risk overseen by the Committee and agreed that the assurance level would remain unchanged.

Products Management at SWBH) joined the meeting to explain the methods used to achieve sustainability and reduce the Trust's carbon footprint. • A deep dive was given on the Abdominal Aortic Aneurysm (AAA) Screening programme. A structured plan was now in place to target deprived areas and links had been established with the ICB. Annual data would be available in July for comparison with previous data to analyse the impact of the actions taken. • A deep dive into the Breast Screening Service (BSS) was given which highlighted the various initiatives to increase uptake in Dudley & Netherton PCN (lowest performer for breast screening services across Dudley, Wolverhampton and Southwest Staffordshire which had pockets of high deprivation) and reach women with learning disabilities, Black African and Caribbean Women and people with mental health issues. **26th June 2024** • Liz Abbiss updated the committee on the stakeholder mapping exercise, positive assurance was received on the work ongoing to undertake the exercise. • Positive assurance was received following the update on Dudley Health and Care Partnerships, noting the positive integrated work, which is ongoing, • Elaine Gilliland presented an update on Targeted Lung Health Check, which received positive assurance on the work ongoing to detect lung cancer earlier, • Positive assurance was received from the prevention programme deep dives within the Alcohol Care Team and Tobacco Care Team, both teams have actions to feedback on at future committees.	**26th June 2024** • Following the update on Dudley Health and Care Partnerships, it was agreed the project lead for the 'life in Lye' will be invited to a future committee to give further insight to the programme. • The committee reviewed the assurance level of BAF risk 6, noting the changes made, it was agreed that the assurance level would remain unchanged. • The committee supported the Memorandum of Understanding between The Dudley Group NHS Foundation Trust and Dudley Academies Trust.

Chair's comments on the effectiveness of the meeting:
Good, detailed discussions within the committee meeting, with actions to report back on at future meetings.

Black Country Provider Collaborative

Enclosure 23

NHS

Joint Provider Committee – Report to Trust Boards

Date: 21st June 2024

Agenda item: TBC

TITLE OF REPORT:	Report to Trust Boards from the 21st of June 2024 JPC meeting.
PURPOSE OF REPORT:	To provide all partner Trust Boards with a summary of key messages from the 21st of June 2024 Joint Provider Committee.
AUTHOR(S) OF REPORT:	Sohaib Khalid, *BCPC Managing Director*
MANAGEMENT LEAD/SIGNED OFF BY:	Sir David Nicholson - *Chair of BC JPC & Group Chair of DGFT, SWBH, RWT, & WHT* Diane Wake - *CEO Lead of the BCPC*
KEY POINTS:	The Joint Provider Committee (JPC) was held, and was quorate with attendance by the Chair, all four Deputy Chairs, and two CEO's. Key discussion points included: a. A progress update from the BCPC CEO Lead with a particular focus on Breast and Pharmacy Clinical Network developments. b. Review of the updates and revisions to the draft Collaboration Agreement, highlighting the key changes that have been made c. Update on the preparations being made to progress with the Corporate Services Transformation work, which will proceed with greater pace following the General Election.
RECOMMENDATION(S):	The partner Trust Boards are asked to: a) **RECEIVE** this report as a summary update of key discussions on the 21st of June 2024 JPC meeting. b) **NOTE** the key messages, agreements, and actions in section 2 of the report.
CONFLICTS OF INTEREST:	There were no declarations of interest.
DELIVERY OF WHICH BCPC WORK PLAN PRIORITY:	The Joint Provider Committee oversees and assures progress against the agreed BCPC annual Work Plan, as outlined in schedule 3 of the Collaboration Agreement.
ACTION REQUIRED:	☒ Assurance ☐ Endorsement / Support ☒ Approval ☒ For Information
Possible implications identified in the paper:	
Financial	N/A
Risk Assurance Framework	The following agenda items have a potential risk implication: ▪ Corporate Services Transformation – require a clear plan of planned efficiency savings, productivity improvement, and resilience.
Policy and Legal Obligations	N/A
Health Inequalities	N/A
Workforce Inequalities	N/A
Governance	The following agenda item has a potential health inequalities implication: ▪ Collaboration Agreement – will require all partner Trusts to amend their Scheme of Reservation & Delegations (SORD) in due course.
Other Implications (e.g. HR, Estates, IT, Quality)	N/A

Black Country Provider Collaborative

NHS

1. PURPOSE

1.1 To provide all partner Trust Boards with a summary of key messages from the 21st June 2024 Joint Provider Committee.

2. SUMMARY

2.1 The Joint Provider Committee was held on the 21st of June 2024. The meeting was quorate with attendance by the Chair, two CEO's and all four of the Deputy Chairs.

2.2 The minutes of the previous meeting were accepted as an accurate record. The Action Log was reviewed, with a short discussion on better understanding preparation plans for the forthcoming MMUH opening. A focus on this item has been requested for the next JPC meeting.

2.3 The following is a summary of discussions with agreements noted:

a) **Items for Approval / Noting**

- **CEO Leads update report** – The JPC received an update report from the Chair of the Collaborative Executive, which highlighted:
  - Three proposals received from the Breast Clinical Network, which were reviewed and supported for progression. They will focus on progressing feasibility / option appraisals for a BC Radiology Alliance, Consolidation of Breast Units, and the establishment of a BC Breast Reconstruction Service, over the remainder of the 24/25 financial year.
  - The change in Pharmacy Aseptic regulations which will have a significant impact for Aseptic services across the Black Country. The Collaborative Executive supported some further feasibility work to present a proposed way forward for the Collaborative Executives consideration.

b) **Items for Discussion**

- **Collaboration Agreement** – The JPC received a draft of the revised and updated Collaboration Agreement. A number of additional schedules have now been incorporated with appropriate adjustments made to the main document.

  The JPC approved the changes subject to agreement by the Collaborative Executive at its next meeting. A short paper for all Trust Boards will be established highlighting the key updates and revisions and seek formal delegation approval through use of Annex A in Part 1 of Schedule 5.

- **Corporate Services Transformation** – The JPC received a further progress update on organising for delivery, with recruitment underway, programme delivery group meetings being established, benchmarking work being undertaken, and a general engagement presentation being developed. Work will proceed at pace following the 'purdah' period of the General Election, with JPC committed to the pursuit of a 'radical' approach to transformation, with all BCPC partner Trusts agreeing to a way forward.

c) Any Other Business

- There was no A.O.B.

3. REQUIRED ACTIONS

3.1 The partner Trust Boards are asked to:

a. **RECEIVE** this report as a summary update of key discussions at the 21st June 2024 JPC meeting.

b. **NOTE** the key messages, agreements, and actions in section 2 of the above report.

Joint Provider Committee – Report to Trust Boards

Date: 17th May 2024

Agenda item: TBC

TITLE OF REPORT:	Report to Trust Boards from the 17th of May 2024 JPC meeting.
PURPOSE OF REPORT:	To provide all partner Trust Boards with a summary of key messages from the 15th of March 2024 Joint Provider Committee.
AUTHOR(S) OF REPORT:	Sohaib Khalid, *BCPC Managing Director*
MANAGEMENT LEAD/SIGNED OFF BY:	Sir David Nicholson - *Chair of BC JPC & Group Chair of DGFT, SWBH, RWT, & WHT* Diane Wake - *CEO Lead of the BCPC*
KEY POINTS:	The Joint Provider Committee (JPC) was held, and was quorate with attendance by the Chair, two Deputy Chairs, and the three CEO's. Key discussion points included: a. The Chair led a reflective discussion on some key perceptions and presumptions being made about the BCPC, with a view to dispelling myths and portraying a united front. b. An update from the BCPC CEO Lead on progress against the range of activities being progressed in delivering the agreed work plan. c. An update was provided on the governance and planning arrangements for work on a robust approach to Corporate Services Transformation. A small budget request was approved to support and enable its delivery. d. A current position on the BCPC partner Trusts plans to support financial recovery was presented and supported. e. The key priorities for the 24/25 BCPC workplan was presented together with the annual budget required to support delivery. Both were approved. f. The JPC received clarification on the range of delegations being sought in line with key provisions of the Collaboration Agreement. These were approved.
RECOMMENDATION(S):	The partner Trust Boards are asked to: a) **RECEIVE** this report as a summary update of key discussions at the17th May 2024 JPC meeting. b) **NOTE** the key messages, agreements, and actions in section 2 of the report.
CONFLICTS OF INTEREST:	There were no declarations of interest.
DELIVERY OF WHICH BCPC WORK PLAN PRIORITY:	The Joint Provider Committee oversees and assures progress against the agreed BCPC annual Work Plan, as outlined in schedule 3 of the Collaboration Agreement.
ACTION REQUIRED:	☒ Assurance ☐ Endorsement / Support ☒ Approval ☒ For Information

Possible implications identified in the paper:	
Financial	The following agenda items have a potential financial implication: ▪ Financial Recovery Plan – delivery against target and trajectories ▪ The BCPC 24 / 25 annual workplan – budget required for delivery which will be apportioned to each of the four partner Trusts ▪ Corporate Services Transformation programme of work, which will require a small support budget incorporated in the annual workplan request.
Risk Assurance Framework	The following agenda items have a potential risk implication: ▪ Financial Recovery Plan – mitigations are being identified ▪ The BCPC 24 / 25 annual workplan – capacity and capability to deliver the agreed workplan. ▪ Corporate Services Transformation – require a clear plan of planned efficiency savings, productivity improvement, and resilience.
Policy and Legal Obligations	N/A
Health Inequalities	The following agenda item has a potential health inequalities implication: ▪ Financial Recovery Plan – delivery against target and trajectories
Workforce Inequalities	The following agenda item has a potential health inequalities implication: ▪ Financial Recovery Plan – potential workforce reductions may impact on health inequalities
Governance	The following agenda item has a potential health inequalities implication: ▪ Corporate Services Transformation – decision making may have potential governance implications for sovereign Trusts.
Other Implications (e.g. HR, Estates, IT, Quality)	N/A

Black Country Provider Collaborative

NHS

1. PURPOSE

1.1 To provide all partner Trust Boards with a summary of key messages from the 17th of May 2024 Joint Provider Committee.

2. SUMMARY

2.1 The Joint Provider Committee was held on the 17th of March 2024. The meeting was quorate with attendance by the Chair, all three CEO's and two of the four Deputy Chairs.

2.2 The minutes of the previous meeting were accepted as an accurate record. The Action Log was reviewed, with updates received for three items to the JPC's satisfaction.

2.3 The JPC meeting commenced with a reflective discussion led by the Chair following a range of recent system and national wide interactions. The Chair highlighted the following:

a) **A perception that the Black Country was a "dysfunctional system", which has the worst financial position in the West Midlands, and a core reason for this is because the partners do not get on well with one another**.

JPC members discussed this set of presumptions and highlighted the need to address these perceptions, citing the many examples of positive work that have been progressed over the last several years, building trust and relationships through the work of the BCPC.

Such examples have included the establishment of Clinical Networks that have pursued work to reduce unwarranted variance, build resilience and transform our services to provide better, faster, and safer care for our population (e.g. Urology, Breast, ENT, Orthopaedic, and Ophthalmology transformation, in addition to Networked Service Solutions for Stroke, and national initiatives such as 'Further Faster').

More recently, there has been strong collaborative and partnership working on the financial challenge with the re-distribution of resources to level out an efficiency request across all four partners, a further and strong indication of how relationships have matured in recent times.

b) **A perception from some partner Boards that the BCPC had a performance management role for its partner Trusts**.

It was re-iterated that whilst the BCPC (through delegations to the JPC) retained some performance oversight, it was not a core role of the BCPC to performance manage partner NHS Trusts. This remains the statutory responsibility of the NHS ICB and NHSE as outlined in the 2022 NHS Health & Care Act.

c) **A recognition that the emerging arrangements for managing delivery of the system finance deficit may focus on scrutinising the BCPC**.

To this end (and the previous point above), the importance of standardising data and information received by the BC ICB Financial Recovery Oversight Group was recognised to ensure that a consistent message was communicated and that all partners remained positive about one another. The Executive System Finance Lead will seek to work with partner Trust Directors of Finance to improve the quality of data / information submitted, enhancing the profile and visibility of partnership working.

2.4 The following is a summary of discussions with agreements noted:

a) **Items for Approval / Noting**

- **CEO Leads update report** – The JPC received an update report from the Chair of the Collaborative Executive, which highlighted:

- the positive progress being made in key clinical areas (e.g. Urology transformation, Stroke rehabilitation services, ENT, Breast service developments). Work also continues to refocus the work of the Clinical Leads on quality and productivity activities which will support the systems work on financial recovery.
- the steady progress with existing priorities (e.g. payroll and procurement, with a pause on MAST) and the re-launch of a robust Corporate Services Transformation programme of work to commence shortly.
- A range of strategic activities including early work on 'estates review / rationalisation' and joint working with both the Mental Health and Primary Care Collaboratives initiated by our external partners.

b) **Items for Discussion**

- **Corporate Services Transformation** – The JPC was provided with an update on developments to re-launch a 'Corporate Services Transformation Programme'. Draft terms of reference have been established, and it was agreed that all three CEO's would provide leadership for an SRO and Programme Lead in driving forward an agreed programme of work.

  The JPC approved the budget request of c£350k, and in addition to a comms & engagement plan, have requested the presentation of a short-, medium- and long-term plan for delivering a combination of efficiencies, improvement / productivity, and service resilience as quickly as possible.

- **Financial Recovery Plan** – The Executive System Finance Lead provided a summary of the latest position on the BCPC partner Trusts contribution to the systems financial recovery. Key highlights included:
  - System financial position deteriorated – BCPC contribution is now **£172m.**
  - Partner Trusts – have currently identified local CIP schemes to a value of **£127m.**
  - It was proposed (and agreed) that partner Trusts remain responsible and accountable for delivery through identified internal capacity.
  - Remaining shortfall – assumed a shared responsibility with system financial improvement director and the BCPC … subject to resource to support delivery.
  - Range of opportunities from:
    - Further review of FRP opportunities – PA Consulting
    - Specialty specific modernisation & transformation e.g. Urology cancer
    - Operational productivity and / or efficiencies
    - Estates rationalisation
    - Corporate services transformation
    - Clinical service improvement & transformation

  The JPC approved the '*Efficiency Recommendations*' that were presented.

- **BCPC24/25 Workplan** – The BCPC Managing Director shared an updated workplan centred around three themes and eight priorities which was reviewed and considered by the JPC.

  The priorities built on a foundation of CIP delivery (locally) that supports financial recovery, and outlined a range of priorities that would be best undertaken at scale highlighting the proposed level of responsibility for delivery (see Appendix A).

Discussion identified a range of clinical areas in which improvement and transformation work is currently being progressed e.g. Urology Cancer Care, ENT, Breast Services, Bariatric Surgery (General Surgery), Ophthalmology, Orthopaedics, SKIN, and Stroke Rehabilitation services.

It was acknowledged that in order to deliver meaningful efficiencies (and improvement) in subsequent years a programme of clinical improvement and transformation on a far bigger scale maybe required, for which the development of a **clinical strategy** and accompanying **clinical services strategic plan** would need to be established prior to considering options for support through an appropriate external delivery partner.

The JPC approved the proposed priorities with a view to the workplan (presented in March 2024) being updated. The JPC also approved the (full year effect) budget request of c.£2m for 24/25 (and 25/26 given the unlikely ability to recruit for short term contracts).

- **24/25 Delegations to the JPC** – In accordance with the key provisions of the Collaboration Agreement, and in particular section 3.11, 3.23, and 3.24, JPC agreed the following delegations to be received from partner Trusts:

  a) **APPROVED** the BCPC priorities and delegation for delivery of the BCPC workplan under scope (a) of the terms of reference.

  b) **APPROVED** the continued delegation of the three key areas (Strategic & Capital Planning, Performance Oversight, and System Business Cases) identified under scope (b) of the JPC terms of reference.

  c) **APPROVED** the continued delegation of scope (c) of the terms of reference in light of continued work by the ICB on its 'Operating Model' BUT noted that this is unlikely to be actioned / used given national guidance within in 24/25.

  d) **APPROVED** the (full year effect) budget request of **c.£2m** for 24/25 and committed to a similar range for the following year (25/26) to enable appropriate recruitment of competent and capable capacity to support delivery of the agreed BCPC workplan.

- **Joint Board Development Workshops** – The JPC reflected on a positive Joint Board Development Workshop held on the 19th of April 2024 at the GTG Centre.

  Early thoughts on the next development workshop scheduled for 23rd of August 2024 centre around 'taking stock of progress' in addition to the sharing of good practice around community services and hospital utilisation, and some dedicated time for joint learning.

  The Trust Board Secretaries and Governance leads will work with the Deputy Chairs and BCPC CEO lead to develop a draft programme for review at a forthcoming JPC.

c) Any Other Business

- There was no A.O.B.

3. REQUIRED ACTIONS

3.1 The partner Trust Boards are asked to:

a. **RECEIVE** this report as a summary update of key discussions at the 17th of May 2024 JPC meeting.

b. **NOTE** the key messages, agreements, and actions in section 2 of the above report.

Black Country Provider Collaborative

NHS

Appendix A - Delivery Overview

PRIORITY	PARTNER TRUST		BLACK COUNTRY PROVIDER COLLABORATIVE	
	Delivery	Comment	Delivery	Comment
IMPROVEMENT				
Clinical & Operational Productivity ▪ *Identified CIP schemes totalling* ***£127m***	✓	Partner Trusts to be accountable for delivery, utilising the defined internal capacity.	✘	Oversight role through the BCPC Executive Finance Lead (EFL) and monitored at the Collaborative Executive / JPC.
Clinical & Operational Productivity ▪ *Unidentified Gap totalling c.* ***£45m***	✘	Leadership will be left to the BCPC, BUT when agreed, delivery may be at a local partner Trust level.	✓	The BCPC Executive to take a leadership role in exploring and developing plans for delivery through the BCPC EFL, MD, and CMO
Quality (reduce variation) – *protocols, pathways, standards*	✓	Some local developments which would feed into system wide work.	✓	Clinical Networks to lead the development and implementation of work at a system level.
Service Productivity – *GIRFT, & Further Faster 40*	✓	Partner Trusts will actively contribute to the delivery of best practice through these national initiatives	✓	BCPC will coordinate the delivery at a system level working with and through any ICS programme Boards
Service Change & Transformation – *Better organisation through new models of care (e.g. Urology, ENT, Breast, Networked Service Solutions)*	✘	Partner Trusts will continue to be engaged in the development of new models of care.	✓	BCPC Clinical Leads & Networks will drive the review and development of ways in which to deliver new models of care.
TRANSFORMATION				
Corporate Services Transformation Programme	✘	Partner Trusts will delegate to the BCPC Executive through the workplan and be active through the established Programme Board.	✓	Delivered at a system level through a Programme Board to be established by the BCPC Executive.
Clinical Services Transformation & Reconfiguration	✘	Partner Trusts will delegate to the BCPC Executive through the workplan and be active through the established Programme Board.	✓	Delivered at a system level through a Programme Board to be established by the BCPC Executive.
STRATEGIC & ENABLING PRIORITIES				
Governance – *Pursuit of integration at the 'North' and 'South of the Black Country ICS*	✓	Arrangements yet to be determined. 'North' option maybe undertaken by partner Trusts with 'South' managed by the BCPC.	✓	Arrangements yet to be determined. 'North' option maybe undertaken by partner Trusts with 'South' managed by the BCPC.
Planning Guidance – *support delivery of the key enabling priorities outlined in the 24/25 Planning Guidance (Comms & Engagement, DDaT, Service Change, Workforce)*	✓	All partner Trusts are responsible for delivering the requirements of the annual Planning Guidance.	✓	The BCPC will work with partner Trusts to identify areas which are best progressed at scale once.

Black Country
Provider Collaborative

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Enclosure 24

The Dudley Group NHS Foundation Trust

Paper for submission to the Board of Directors on 11th July 2024

Report title	Charity Committee Upward Assurance Report
Sponsoring executive	Gary Crowe, Charity Committee Chair
Report author	Zoe Harris, Executive Assistant to Interim Director of Finance

1. Suggested discussion points

The Charity Committee met on 27th June 2024 and was chaired for the first time by Gary Crowe. A range of matters were considered and should be noted:

- The Staff Wellbeing Working Group has been established to deploy the NHS charities grant £121k held to renovate rest areas. The committee agreed to target at least 10 rooms/areas for improvement.
- Four general fund requests for funding were received and approved.
- Brewin Dolphin had been appointed as the new investment manager (£2.5m investable funds held, investment approach to be agreed).
- The charity had been through its rebranding and was launched internally. 3 yearly Strategy refresh work has commenced.

Positive assurance reported here to Board.

2. Alignment to our Vision

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

3. Report journey

Board of Directors – 11th July 2024

4. Recommendation(s)

The Public Trust Board is asked to:

a. Note the contents of the report.

5. Impact

Board Assurance Framework Risk 1.1	x	Deliver high quality, safe person centred care and treatment
Board Assurance Framework Risk 3.0	x	Improve and sustain staff satisfaction and morale
Board Assurance Framework Risk 4.0	x	Remain financially sustainable in 2023/24 and beyond
Board Assurance Framework Risk 5.0	x	Achieve carbon reduction ambitions in line with NHS England Net Zero targets
Corporate Risk Register		

Equality Impact Assessment	Is this required?			N		If 'Y' date completed	
Quality Impact Assessment	Is this required?			N		If 'Y' date completed	

UPWARD REPORT FROM THE CHARITY COMMITTEE
Date Committee met: 27th June 2024

MATTERS OF CONCERN OR KEY RISKS TO ESCALATE	**MAJOR ACTIONS COMMISSIONED/WORK UNDERWAY**
• There were no matters of concern to escalate.	• The committee was happy for the fundraising team to look at ways to access unrestricted funds. • The Charity strategy was due to run out in 2025, therefore the committee would refresh this in parallel with the spending strategy. • Work was underway on the new charity website, the timeframe for launch was September 2024.
POSITIVE ASSURANCES TO PROVIDE • The Charity Fun Run took place on the 9th June, raising £4k for the Childrens Appeal. • The Staff Wellbeing Working Group had been set up, it was agreed to renovate at least 10 rooms for staff. Mitie had donated £30k towards the project. • The Charity rebranding had gone live internally and would be launched externally following the general election. • Since 1 April the charity has received £82,033 income with the majority coming from donations, investment income and activities to generate funds. For the same period expenditure of £73,778 has been made, giving an increase in fund balances of £8,256. Total fund balances remained at £2.5m. • Brewin Dolphin had been appointed as the new investment manager following meetings with the Head of Financial Services, the Charity Committee chair and the Interim Director of Finance.	**DECISIONS MADE** • Four requests for funding were received and approved:- - Inpatient welcome booklets (£1,669) - Part funding for the RITA system (£2,123.84) - World Patient Safety Day promotional items (£1,669) with the caveat that this is done in partnership with the communications team. - Patient Safety Incident Response materials (£1,970)
Chair's comments on the effectiveness of the meeting: The meeting was quorate and effective.	

Enclosure 25

The Dudley Group NHS Foundation Trust

Paper for submission to the Board of Directors on 11th July 2024

Report title	Digital Committee Upward Report – Closure Report
Sponsoring executive / presenter	Catherine Holland (Digital Committee Chair)
Report author /presenter	Catherine Holland (Digital Committee Chair)

1. Suggested discussion points

- Digital Committee will be disestablished as of the 22nd May 2024 with Digital Trust Steering Group (DTSG) reporting direct to Trust Management Group, Executive Directors, Committees and Trust Board as required
- BAF 8 met its interim in year target risk score of 16
- BAF 8 assurance reporting will continue bi monthly via Finance and Procurement (F&P) – starting July 2024
- The Digital Trust Steering Group (DTSG) revised Terms of Reference were approved
- The proposed governance reporting recommendations for Digital post disestablishment of the Digital Committee were approved – see Appendix 1
- Positive assurance in terms of the risk associated with the ongoing infrastructure project
- Positive assurance on the ongoing CareCERT – Respond to a Cyber Alert management process
- The Trust Non-Executive Champion for Security (including Cyber) moving forward will be Lowell Williams

2. Alignment to our Vision

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	

3. Report journey

Board of Directors

4. Recommendation(s)

The Public Trust Board is asked to:

a.	The Board is asked to note the report, and confirm that the arrangements for the transfer of the committees business are satisfactory

5 Impact

Board Assurance Framework Risk 8.0	X	Establish, invest and sustain the infrastructures, applications and end-user devices for digital innovation						
Corporate Risk Register		*COR1083, COR1540, COR1843*						
Equality Impact Assessment	Is this required?			N		If 'Y' date completed		
Quality Impact Assessment	Is this required?			N		If 'Y' date completed		

The Dudley Group NHS Foundation Trust

UPWARD REPORT FROM THE DIGITAL COMMITTEE

Date Committee last met: 22nd May 2024

MATTERS OF CONCERN OR KEY RISKS TO ESCALATE	**MAJOR ACTIONS COMMISSIONED/WORK UNDERWAY**
•	• Work is underway in collaboration with NHS England to establish a Digital Clinical Network • Further work on benefits realisation continues with the national and regional frontline digitisation teams
POSITIVE ASSURANCES TO PROVIDE • Positive assurance on the management of the risks associated with the infrastructure project • Positive assurance provided by the ongoing CareCERT management process • BAF 8 has met its interim in year target risk score of 16 • The Trust Non-Executive Champion for Security (including Cyber) moving forward will be Lowell Williams	**DECISIONS MADE** • As of the 22nd May 2024, the Digital Committee has been disestablished • The proposed governance reporting recommendations for Digital were approved • BAF 8 assurance reporting will continue bi monthly via Finance and Procurement (F&P) – starting July 2024 • The three year digital plan benefits realisation reporting will continue via Finance and Procurement • The Digital Trust Steering Group (DTSG) revised Terms of Reference were approved • DTSG will produce a quarterly consolidated assurance report for the following Committees; Finance & Productivity, Audit, Integration, People
Chair's comments on the effectiveness of the meeting: Good meeting keeping to the agenda and report timings Good work on wider benefits realisation as a result of digital implementations	

Appendix 1 – Approved Governance Reporting Routes post disestablishment of Digital Committee

Item	Report Name	Frequency	Governance Groups
CareCERT "high" statutory assurance report, by exception to board in month	Cyber High Report	Monthly	DTSG
			Finance & Productivity
			Board
ISO27001 ISMS Annual Report	ISO27001 ISMS Annual Report	Annual	DTSG
			Exec
Internal Audit Report - Cyber	Internal Audit Report - Cyber	Annual	CIGG
			DTSG
			Exec
			Audit Committee
Internal Audit Report - DSPT	Internal Audit Report - DSPT	Annual	CIGG
			DTSG
			Exec
			Audit Committee
Digital Strategy (inc. 3 year Plan)	3 year Digital Plan	Quarterly	DTSG
			Exec
Digial Maturity Assessment (DMA) Report	Digial Maturity Assessment (DMA) Report	Semi-annually	DTSG
			Exec
Data Quality & Standards Group Report	Data Quality & Standards Group Report	Quarterly	DTSG
		Annually	Audit Committee
Infrastructure Plan Progress	DTSG Consolidated Report	Quarterly	TMG
Demand/Capacity Go Live Report			Exec
Frontline Digitisation Fund Assurance Report			Finance & Productivity
Clinical Safety Report (DCB0160/0129) Assurance			Quality Committee
Infrastructure Compliance Assurance			People Committee
Service Desk Performance Report			Integration Committee
Medical Devices Group Report (by exception)			
Quarterly Review of DTSG Workplan			
Corporate Risk Report	Corporate Risk Report	Bi Monthly	DTSG
			Risk & Assurance
BAF Review & Assurance	BAF Review & Assurance Report	Bi Monthly	TMG
			Finance & Productivity
Terms of Reference Review	DTSG Consolidated Report	Annually	TMG

The Dudley Group NHS Foundation Trust

Paper for submission to the Board of Directors 11th July 2024

Report title	Board Assurance Framework
Sponsoring executive	Diane Wake, Chief Executive
Report author / presenter	Helen Board, Board Secretary

1. Suggested discussion points

Background

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 Assurance Framework Report provides the Board of Directors with a summary view on the status of progress towards the achievement of its agreed strategic goals and the Trust objectives supporting each of them. This includes the risks, controls and gaps in controls, assurances, and mitigations associated with each.

Each committee receives their individual BAF risks scheduled throughout the year tabled by the Executive lead for that risk; the date of most recent meeting is indicated. The Board of Directors receive a one page summary of the BAF at its public meetings, given in appendix 1.

All BAF risks reflect audit recommendations issued in quarter 4 and have been subject to a review and reset for 2024/25. Further BAF refresh work will proceed as part of the strategy refresh activity later in the year.

Summary of changes since the last report – March 2024

Each of the Committees articulate their assurance levels for each BAF risk for which they have oversight. This approach informs the agenda and regular management information received by the lead committee.

Of the nine risks listed, committee assurance ratings have changed from the previous summary report:

- Eight (was six) assigned a 'positive' rating
- One (was three) assigned an 'inconclusive' rating
- None assigned a 'negative' rating

Responding to the request for increased cross committee oversight of risks, each BAF risk is summarised in this document for the reporting period as follows:

BAF Risk 1.1: Quality: Safe, High-Quality Care There is a risk that the Trust fails to deliver high quality, safe, person centred care and treatment resulting in incidents of avoidable harm and poor clinical outcomes

Overseen by Quality Committee, last reviewed 25/06/24 and assigned an 'inconclusive' committee assurance level and noted the need to clearly articulate the exit criteria to support movement of overall score.

The current risk score Q4, 23/24 is 12 (3x4) as there is a variation in ownership and embedding of key actions and learning. The Q4 2024/25 target score is 9 (3x3). The target is to reduce the likelihood score to 'possible' whilst the impact remains major. Note: Quality and Safety links to patient flow articulated in BAF 7.

The links to risks that are held on Trust risk registers have been updated to reflect the current situation as of May 2024.

BAF Risk 1.2: Compliance and Regulatory Failure to achieve Outstanding CQC rating and comply with external quality reviews, reports, and inspections could result in regulatory action.

Overseen by Quality Committee, last reviewed 30/04/24 and agree to retain a 'positive' committee assurance level.

The current risk score is 9 (3x3) last updated November 2023 with no further changes.

The risk appetite is defined as Open. Committee assurance level rating was last reviewed in May 2024 and remained as positive.

Items to note

Key controls expanded to set out the new process standardised across the Black Country provider Collaborative for 24/25 with a breakdown of self-assessment timeline to support delivery and track progress.

BAF Risk 2 – Failure to increase workforce capacity If the Trust fails to effectively plan for, recruit and retain people with the right skills, this may adversely impact on the Trust's ability to deliver the Trust's strategy and to deliver safe and effective care.

Current risk score is 9 (3x3) (Moderate x Possible). This is because the Trust requires sufficient workforce capacity to deliver safe services. This score has been reviewed in line with the levers in the Risk Management Strategy, the rationale is that there are still key performance indicators above Trust target (turnover, absence).

Whilst there are existing staffing challenges, normalised vacancy levels are low, retention remains high. There has been a decrease in turnover. There is however a continuation of medical industrial action and a national shortage in some professions such as Allied Health Professionals (Radiographers).

There remain challenges around data quality, impacting on workforce planning for current and future workforce requirements (including number of staff, skill-mix, and training) which may lead to impaired ability to deliver the quantity of healthcare services to the required standards of quality; and inability to achieve the business plan and strategic objectives.

Target score 9 (3x3) (Moderate x Possible). The target risk will remain under consideration given the detailed workforce plan and potential risk.

To note that the People Committee assigned a 'positive' Committee level assurance rating at its last meeting. Links to the Trust's Risk register have been updated to reflect those risks that are scored 20 or above.

BAF Risk 3:

If issues affecting staff experience are not addressed, this will adversely impact on staff motivation, engagement and satisfaction and consequently could impact turnover, retention, and absence.

Overseen by People Committee, last reviewed 25/06/24 and retained a 'positive' committee assurance level.

The current risk score is 12 (3x4). Given the improvements in key indicators of staff satisfaction the likelihood is deemed to be 'Possible' The impact of this risk, should it be realised, would be

'Major.' There are a range of mitigating actions in place, which will reduce the risk score (Post Mitigation Risk Score) to 6 (Minor/Possible) during 2024/25.

Whilst there has been improved staff retention and reduced vacancy levels and stable sickness absence, the Trust has remained stable in terms of staff survey results, with scores performing around benchmark position for all people promises and staff engagement and morale themes.

For 2023, the Trust remains at benchmark average performance across all themes and promises. There are slight differences with four promises almost the same as benchmark, four slightly lower than benchmark (by 0.1) and one slightly above. Between 2022 and 2023, performance across the nine promises and themes has remained the same for three out of the nine indicators. We have improved in six out of the nine. In terms of scores, these are small changes (0.1-0.2).

Failure to maintain a coherent and co-ordinated structure and approach to succession planning, organisational development and leadership development may jeopardise: the development of robust clinical and non-clinical leadership to support service delivery and change; the Trust becoming a clinically led organisation; staff being supported in their career development and to maintain competencies and training attendance; staff retention; and the Trust being a "well-led" organisation under the CQC domain.

A failure to develop and maintain our culture in line with the Trust values and the NHS People Promise (which includes being compassionate and inclusive, recognition and reward, having a voice that counts, health, safety, and wellbeing of staff, working flexibly, supporting learning and development, promoting equality, diversity and inclusivity and fostering a team culture) could result in; harm to staff; an inability to recruit and retain staff; a workforce which does not reflect Trust and NHS values; and poorer service delivery.

To support the Trust's financial plan, the workforce plan assumes a 4% reduction of substantive workforce and a 25% bank and agency reduction. The delivery of the above presents risks around the ability to recruit to persistent vacancies or to retain staff which could lead to the quality and quantity of healthcare being impaired; pressure on existing staff and decreased resilience, health & wellbeing, and staff morale and loss of the Trust's reputation as an employer of choice. Mitigating actions are in place, i.e. delivery of the people plans and associated actions.

Increased financial scrutiny and additional restrictions to support delivery of the financial recovery plan are likely to negatively impact staff engagement and morale. The transfer in of DHIC staff is an unknown impact on engagement and this will need to be closely monitored to support proactive action.

The target score is 6 (2x3), The aim is to move the likelihood to 'Possible,' whilst the impact of the risk will be Minor.

Links to the Trust's Risk register have been updated to reflect those risks that are scored 20 or above.

BAF Risk 4 – Financial Sustainability

Overseen by Finance & Productivity Committee, last reviewed 227/06/24 and received a 'positive' committee assurance level.

The current risk score is 20 (5x4) based on an almost certain and major impact assessment. The Trust has set a deficit plan of £32.6m which is extremely challenging. To achieve this plan the Trust is required to deliver £31.9m CIP. The Trust will need revenue cash support of £16m from NHSE in 2024/25. The medium-term financial plan requires further work at a system level to substantiate future years efficiency plans.

The target risk score is 12 (4x3). This is based on a reduction in likelihood (from 4 to 3) but unchanged impact. This reflects the Trust having a fully identified CIP plan for 2024/25 and a clear medium-term plan showing financial sustainability.

BAF Risk 5 – Carbon Emissions Reduction

Failure to successfully adapt and reduce carbon emissions due to competing organisational and PFI pressures and availability of resources, resulting in a failure to meet targets set by NHSE and outlined within the Health and Social Care Act (2022). The resulting impact will cause risk in the following areas: regulatory, financial, workforce, patient safety, and increased health inequalities.

Overseen by Finance & Productivity Committee, last reviewed 25/04/24 and received a 'positive' committee assurance level.

The current risk score is 12 (3x4). This is because we still developing our understanding of what actions will have the biggest change on carbon emissions. A baseline has been published but actions particularly around decarbonisation of the estate will only demonstrate impact over a longer time frame. The impacts of climate change are here now, and the Trust needs to adapt to ensure risk and impact are mitigated. The target score is 8 (4x2). The Trust needs to develop appropriate plans to ensure that this is unlikely, whilst the impact would remain major.

The Committee agreed to receive an update every six months with the next report due October 2024.

BAF Risk 6 – Build Partnerships

Failure to successfully build innovative partnerships due to competing organisation pressures, priorities and historic actions results in the Trust being unable to transform clinical services, improve the outcomes of our local population and develop our future workforce. The resulting impact will cause a risk to the following areas: regulatory, financial, workforce, patient outcomes, operational performance, and Trust reputation.

Overseen by Integration Committee, last reviewed 26/06/24 and retained a 'positive' committee assurance level.

To note that BAF 6 residual score for is 12 (3x4). This is based on a possible and major impact assessment. The impact is assessed as major as the health outcomes of our population will not improve without us working in partnership to deliver transformation. There will also be an impact on our reputation.

BAF Risk 7 – Achieve Operational Performance/Strategic goals

Failure to achieve operational performance requirements and deliver strategic goals and potential to be subject to regulatory action.

Overseen by Finance & Productivity Committee, last reviewed 27/06/24 and received a 'positive' committee assurance level.

The current risk score remains 20 (5x4). This is on the basis that the current likelihood is "almost certain". The impact of this risk, should it be realised, for the Trust's services, is 'major'. The target score is 12 (3x4). The aim is to reduce the likelihood to "possible", whilst the impact would remain 'major'.

BAF Risk 8 – IT & 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.

Overseen by Digital Committee, last reviewed 22/05/24 and retained a 'positive' committee assurance level.

The current risk is The current Digital, Data and Technology (DDaT) capacity is already exceeded. The pace of digital solution delivery is managed by strict priority criteria due to capacity constraints. This is rate-limiting the Trust's delivery of strategic objectives. Executive Leads have identified issues as a result of this, therefore the consequent risks are highly likely to manifest.

Analytics, IT capacity and technology requirements of all strategic goals are identified as underpinning major dependent strategic consequences

Items to note

The Committee met for the final time on 22 May 2024 where agreement was sought for reassignment of BAF risk 8 to the Finance & Productivity Committee ahead of it remapping as part of the strategy refresh and the concurrent review of BAF risks.

Next Steps

To note that the Trust's Risk Management Strategy has been reviewed and will shortly be circulated. There will be further Board development workshop activity being scheduled for 2024/2025.

2. Alignment to our Vision

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	X		

3. Report journey

Audit Committee received full BAF documents – March 2023

4. Recommendations

The Public Trust Board is asked to:

a.	**Approve** the updates made since the last meeting
b.	**Note** ongoing work embed effective risk management with further Board development workshop activity being scheduled for 2024/2025

5 Impact

Board Assurance Framework Risk 1.1	X	Deliver high quality, safe person centred care and treatment
Board Assurance Framework Risk 1.2	X	Achieve outstanding CQC rating.
Board Assurance Framework Risk 2.0	X	Address critical shortage of workforce capacity
Board Assurance Framework Risk 3.0	X	Improve and sustain staff satisfaction and morale
Board Assurance Framework Risk 4.0	X	Remain financially sustainable in 2023/24 and beyond
Board Assurance Framework Risk 5.0	X	Achieve carbon reduction ambitions in line with NHS England Net Zero targets
Board Assurance Framework Risk 6.0	X	Deliver on its ambition to building innovative partnerships in Dudley and beyond
Board Assurance Framework Risk 7.0	X	Achieve operational performance requirements
Board Assurance Framework Risk 8.0	X	Establish, invest and sustain the infrastructures, applications and end-user devices for digital innovation

Equality impact Assessment	Is this required?	Y		N	X	If 'Y' date completed	
Quality Impact Assessment	Is this required?	Y		N	X	If 'Y' date completed	

Summary Board Assurance Framework (BAF): June 2024 update

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 (Consequence x Likelihood)
- A statement of risk appetite for each threat and opportunity, to be defined by the Lead Committee on behalf of the Board

Tables relating to scoring and ratings are given on page 2. *'No move indicates no change from last report'*

					Ratings as reported at June 2024				
ID	**Area**	**Risk Description**	**Lead Exec**	**Lead Committee**	**Inherent Risk score**	**Current Residual Risk score**	**Target Risk Score**	**Risk Appetite**	**Committee Assurance Rating/** last reviewed
1.1	Quality: Safe, High-Quality Care	Failure to deliver high quality, safe, person centred care and treatment resulting in incidents of avoidable harm and poor clinical outcomes.	Medical Director Chief Operating Officer Chief Nurse	Quality	**20** (4x5)	**12** (3x4)	**9** (3x3)	**Cautious**	**Inconclusive** *25/06/24*
1.2	Compliance and Regulation	Failure to achieve Outstanding CQC rating and comply with external quality reviews, reports, and inspections could result in regulatory action	Director of Governance	Quality	**20** (4x5)	**9** (3x3)	**9** (3x3)	**Open**	**Positive** *25/06/24*
2	Workforce	Failure to effectively manage workforce demand and capacity to deliver Trust Strategic Objectives	Chief People Officer	People	**20** (4x5)	**9** (3x3)	**9** (3x3)	**Seek**	**Positive** *25/06/24*
3	Staff satisfaction	Failure to ensure Dudley is a brilliant place to work and thrive will impact turnover, retention, and absence.	Chief People Officer	People	**15** (3x5)	**12** (3x4)	**6** (2x3)	**Open**	**Positive** *25/06/24*
4	Finance	Failure to remain financially sustainable in 2023/24 and beyond	Director of Finance	Finance and Productivity	**20** (4x5)	**20** (5x4)	**12** (4x3)	**Open**	**Positive** *27/06/24*
5	Environmental	Failure to achieve carbon reduction emissions in line with NHS England Net Zero targets	Director of Finance	Finance and Productivity	**16** (4x4)	**12** (3x4)	**8** (4x2)	**Open**	**Positive** *25/04/24*
6	Partnerships	Failure to deliver on its ambition to build innovative partnerships in Dudley and beyond	Director of Integration	Integration Committee	**16** (4x4)	**12** (3x4)	**8** (2x4)	**Open**	**Positive** *26/06/24*
7	Operational Performance	Failure to achieve operational performance requirements and deliver strategic goals	Chief Operating Officer	Finance and Productivity	**20** (4x5)	**16** (4x4)	**12** (3x4)	**Open**	**Positive** *27/06/24*
8	IT and Digital Infrastructure	Failure to establish, invest and sustain, the resources, infrastructures, applications and end-user devices for digital innovation	Executive Chief Strategy & Digital Officer	Digital until May 2024	**25** (5x5)	**16** (4x4)	**16** (4x4)	**Open**	**Positive** *22/05/24*

Risk Scoring Levels

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

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

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

Risk Scoring =Consequence x Likelihood (C x L)

Committee Assurance Level *descriptors updated March '23*

Positive	The committee is satisfied that the current approach to managing this strategic risk is appropriate and effective. Prompt and proportionate action is being taken to close any gaps in control or assurance, providing confidence that we can reduce the risk to its target score within twelve months.
Inconclusive	Progress is being made to close gaps in controls and assurance but not all actions have been completed on time or have yet had the desired impact. It is uncertain whether the current approach to managing this strategic risk will be sufficient to reduce the level of the risk to the target score within twelve months.
Negative	There has been a lack of progress with the actions necessary to manage this risk. The level of risk may also have increased significantly since the risk was originally assessed, due to factors outside of the trust's direct control. The current approach to managing this strategic risk is unlikely to be effective and requires major revision

This approach informs the agenda and regular management information received by the relevant lead committees, to enable them to make informed judgements as to the level of assurance that they can take, and which can then be provided to the Board in relation to each Principal Risk and also to identify any further action required to improve the management of those risks.

Risk Appetite	Descriptor
None	Avoidance of Risk is a key organisational objective
Minimal	Preference for very safe delivery options that have a low degree of inherent risk and only a limited reward potential
Cautious	Preference for safe delivery options that have a low degree of residual risk and only a limited reward potential
Open	Willing to consider all potential delivery options and choose whilst also providing an acceptable level of reward
Seek	Eager to be innovative and to choose options offering higher business rewards (despite greater inherent risk)
Significant	Confident in setting high levels of risk appetite because controls, forward scanning and responsive systems are robust

Performance KPIs

June 2024 Report (May 2024 Data & April 2024 Data for Cancer & VTE)

The Dudley Group NHS Foundation Trust

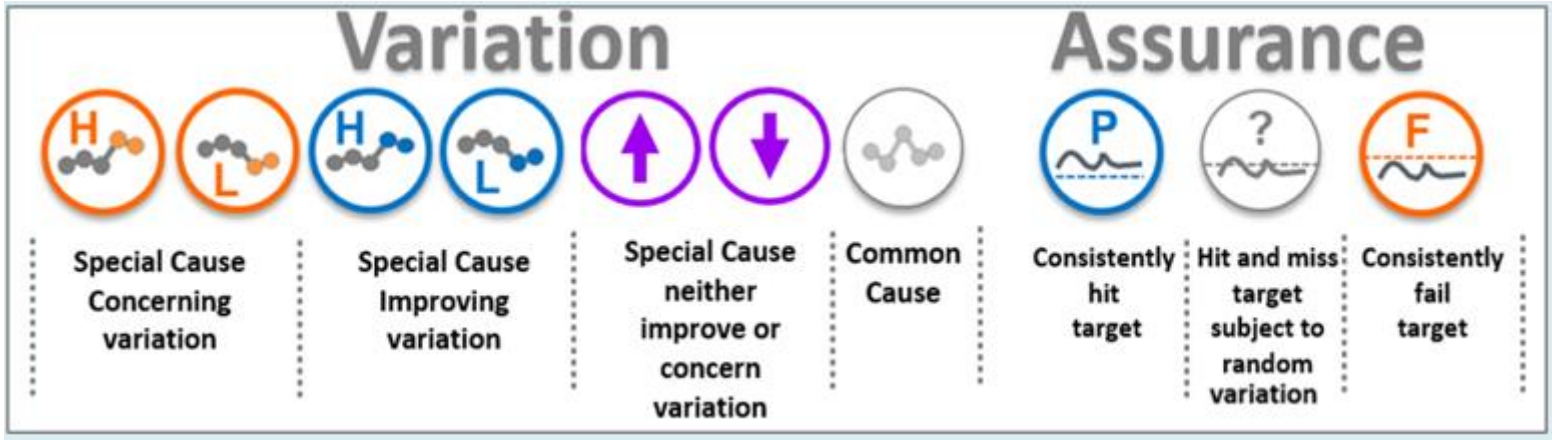
Karen Kelly, Chief Operating Officer

Constitutional Targets Summary	Page 2
ED Performance	Pages 3-10
Cancer Performance	Pages 11-13
RTT Performance	Page 14-15
DM01 Performance	Page 16-17
VTE	Page 18
Screening Programmes	Page 19
Kitemark Explanation	Page 20

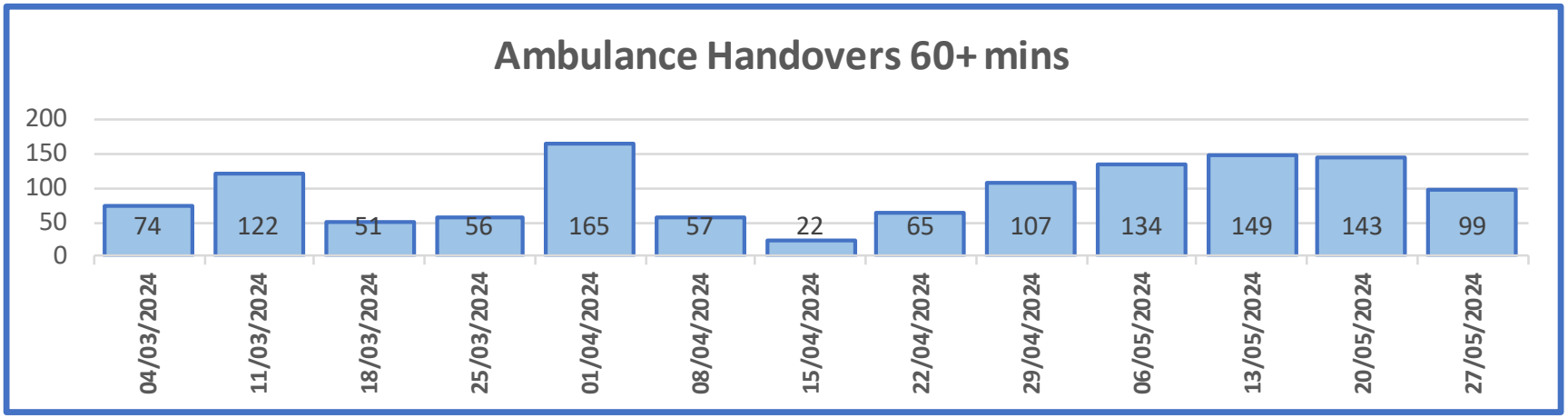
CARE RESPECT RESPONSIBILITY

Constitutional Performance

Constitutional Standard and KPI		Target	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24		
Emergency Access Standard (EAS)	Combined 4hr Performance	78.0%	73.4%	72.9%	74.5%	72.8%	74.1%	72.5%	72.9%	71.5%	71.9%	73.8%	78.7%	80.3%	81.2%	H	?
Triage	Triage - All	95.0%	80.7%	74.2%	79.5%	80.2%	73.3%	71.0%	74.0%	78.0%	84.3%	80.6%	80.6%	80.6%	80.6%		F
Referral to Treatment (RTT)	RTT Incomplete	92%	58.0%	58.3%	56.7%	55.6%	55.6%	55.5%	55.0%	55.2%	55.8%	56.2%	56.5%	57.8%	58.2%	L	F
Diagnostics	DM01 - Diagnostics achieved within 6 weeks	85%	68.7%	68.7%	67.4%	64.4%	66.6%	68.9%	70.3%	71.5%	79.7%	90.6%	91.3%	89.6%	88.4%	H	F
VTE	% Assessed on Admission	95%	95.1%	97.4%	98.3%	99.1%	99.0%	98.9%	98.9%	99.1%	99.1%	99.3%	99.3%	98.9%	N/a	H	P



Ambulance Handovers 60+ Mins



Performance

There has been a decrease in performance in ambulance handover for both >30 mins and handovers >60mins. This contributes to the trust been over prediction for ambulance arrivals on multiple days in May along with acuity of patients.

22 out of the 31 days we have seen >300 patients attend ED. 7 out of those 22 days ED saw >240 patients. May saw an >6% increase in attendance numbers compared to April. May has also seen the highest number of attendances when compared to the last 12 months.

Utilisation of pathways remains negligible with most days recording single figures of calls to Hub from WMAS and the proposed call before convey scheme did not start as planned.

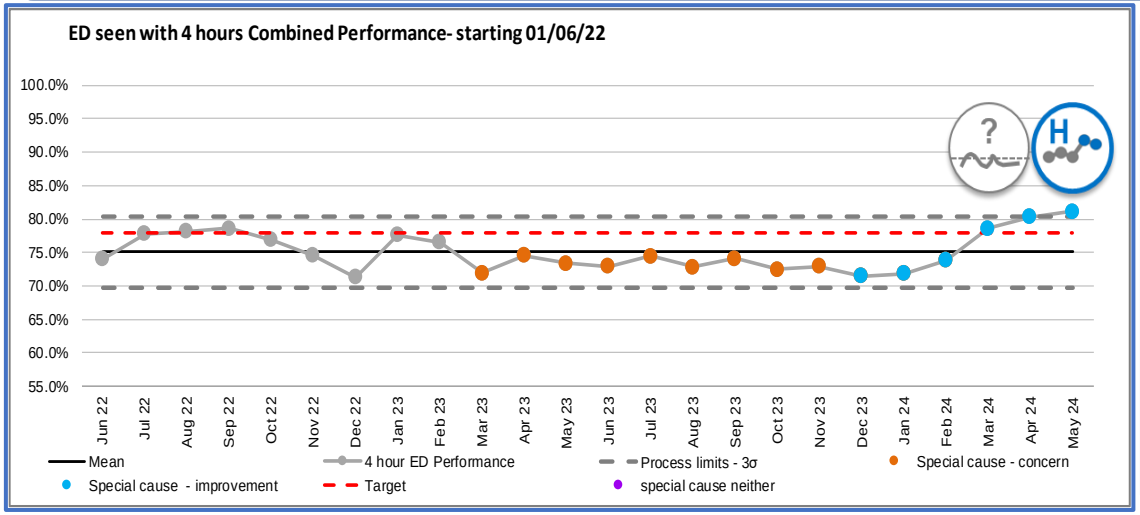
Call before you convey is having little difference on the number of ambulances arriving at ED and this has been flagged to the wider ICS & WMAS.

Initial RAT Data shows significant falls in LoS in RAT cubicles and quicker access to antibiotics, fluids and analgesia. RAT is continuing through to March before a decision is made at F&P about long term funding.

Action

- Continue to use RAT for all ambulance patients to ensure assessment, treatment and medication are given quickly.
- Escalation of ambulances without a plan to offload at 30mins to Site Team with additional role cards to link AMU & Site teams based on the Kings College Model.
- Additional trolley capacity now in place to ensure offloads can happen promptly at the ambulance entrance.
- Streamers and triage nurses continue to utilise pathways as early as possible and sit out suitable patients to free up ambulance.
- Designated ED Tracker monitoring ambulance offloads/pinning. Regular escalation to both halo, site, ops management and NIC
- ED operational escalation bleep initiated through office hours and point of contact for urgent escalations

ED Performance



Latest Month	Latest Month	1st
81.2%	238	For May 24
EAS 4 hour target 78% for Type 1 & 3 attendances	DTA 12 hour breaches - target zero	DGFT ranking out of 13 West Midlands area Trusts

Performance

This month ED performance increased to 81.2%, meaning the trust exceeded the 78% target mandated for April. This is the highest performance in a year.

Last months data have allowed for identification of themes and increased focus on these have been:

- GP letter patients straight to SDEC/Surgical SDEC.
- Agree new streaming template with UCC for patients with letters to go direct to Speciality.
- Re-run of heat mapping exercise for nurses and medics in ED.
- Joint working with Surgery to ensure proactivity to take patients from ED even when full.
- Organizational agreement that specialties must take patients directly and not wait to assess them in ED.
- Extra Validation resource.

Action

- Deputy Matrons are further highlighting 4h performance whilst on clinical floor to teams.
- Continued scrutiny that GP letters are being directly streamed to appropriate area to avoid being booked into ED.
- Focus now on NHSE's 5 priority ED improvement initiatives
  - Streaming & Redirection
  - Rapid Assessment & Treatment
  - Maximising UTC use
  - Improving Ambulance Handover process
  - Reducing the time in department

ED 4 Hour Waits Benchmarking

National 4 hour EAS Target Comparison

This is based on trust activity for the following:
Inclusion of Type 1-4
Inclusion of 111 booked activity for all types

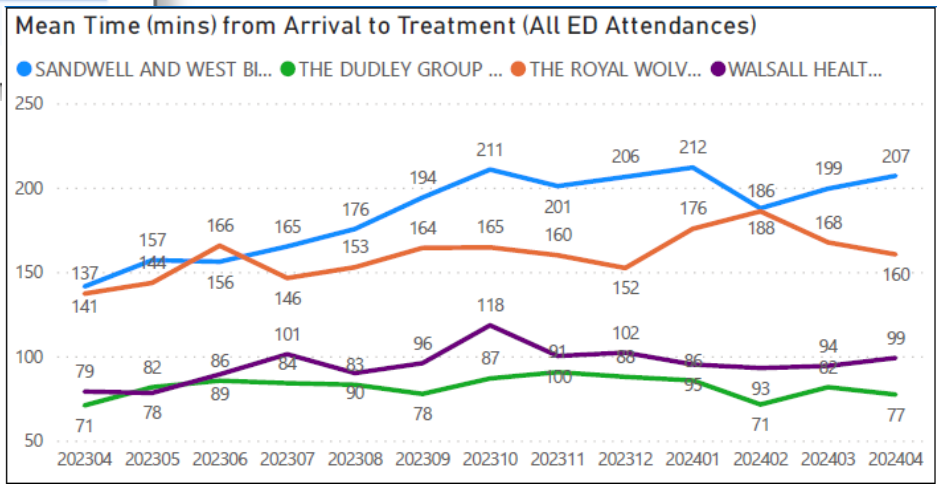
May 2024

Name	Value	RANK
The Dudley Group NHS Foundation Trust	81.18%	16
The Royal Wolverhampton NHS Trust	81.12%	18
Birmingham Women's And Children's NHS Foundation Trust	78.31%	42
Walsall Healthcare NHS Trust	77.62%	48
George Eliot Hospital NHS Trust	75.32%	74
South Warwickshire NHS Foundation Trust	72.43%	110
University Hospitals Coventry And Warwickshire NHS Trust	71.73%	122
University Hospitals Of North Midlands NHS Trust	71.46%	130
Sandwell And West Birmingham Hospitals NHS Trust	69.88%	144
Wye Valley NHS Trust	68.08%	164
Worcestershire Acute Hospitals NHS Trust	66.05%	180
University Hospitals Birmingham NHS Foundation Trust	59.00%	232
The Shrewsbury And Telford Hospital NHS Trust	48.44%	

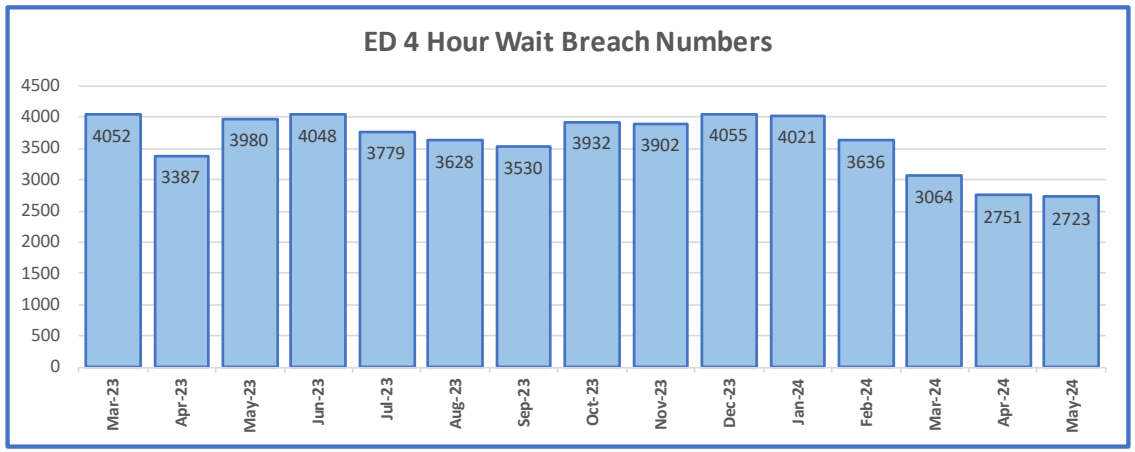
DGH

Ranking out of 122 Trusts

Source: [Daily EAS - Power BI]



ED 4 Hour Wait Number of Breaches

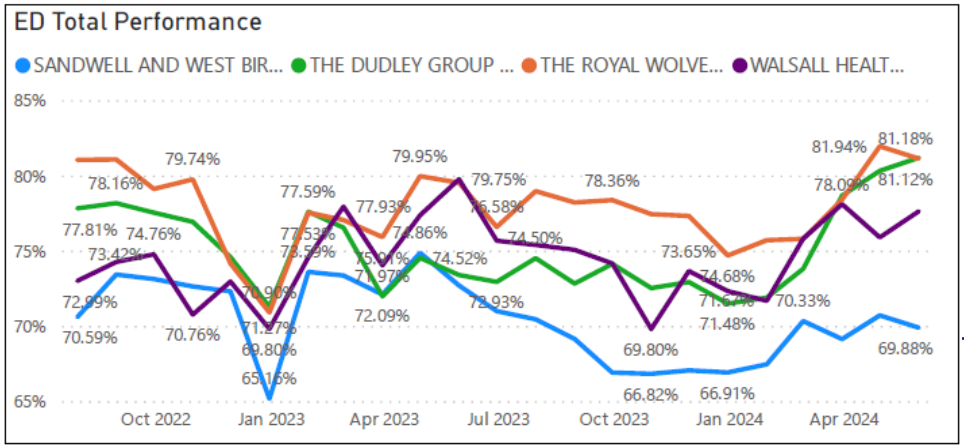


Date	No Breaches
Mar-23	4052
Apr-23	3387
May-23	3980
Jun-23	4048
Jul-23	3779
Aug-23	3628
Sep-23	3530
Oct-23	3932
Nov-23	3902
Dec-23	4055
Jan-24	4021
Feb-24	3636
Mar-24	3064
Apr-24	2751
May-24	2723

Performance

Majority of performance increase is from our non-admitted patients. ED has reached optimum performance level and without further improvement in the flow out of ED for patients awaiting admission 4h performance improvements will stall and begin to flatten out.

Currently patients waiting for admission on average in excess of 7hours, compared to just over 3hours for those being treated and discharged.

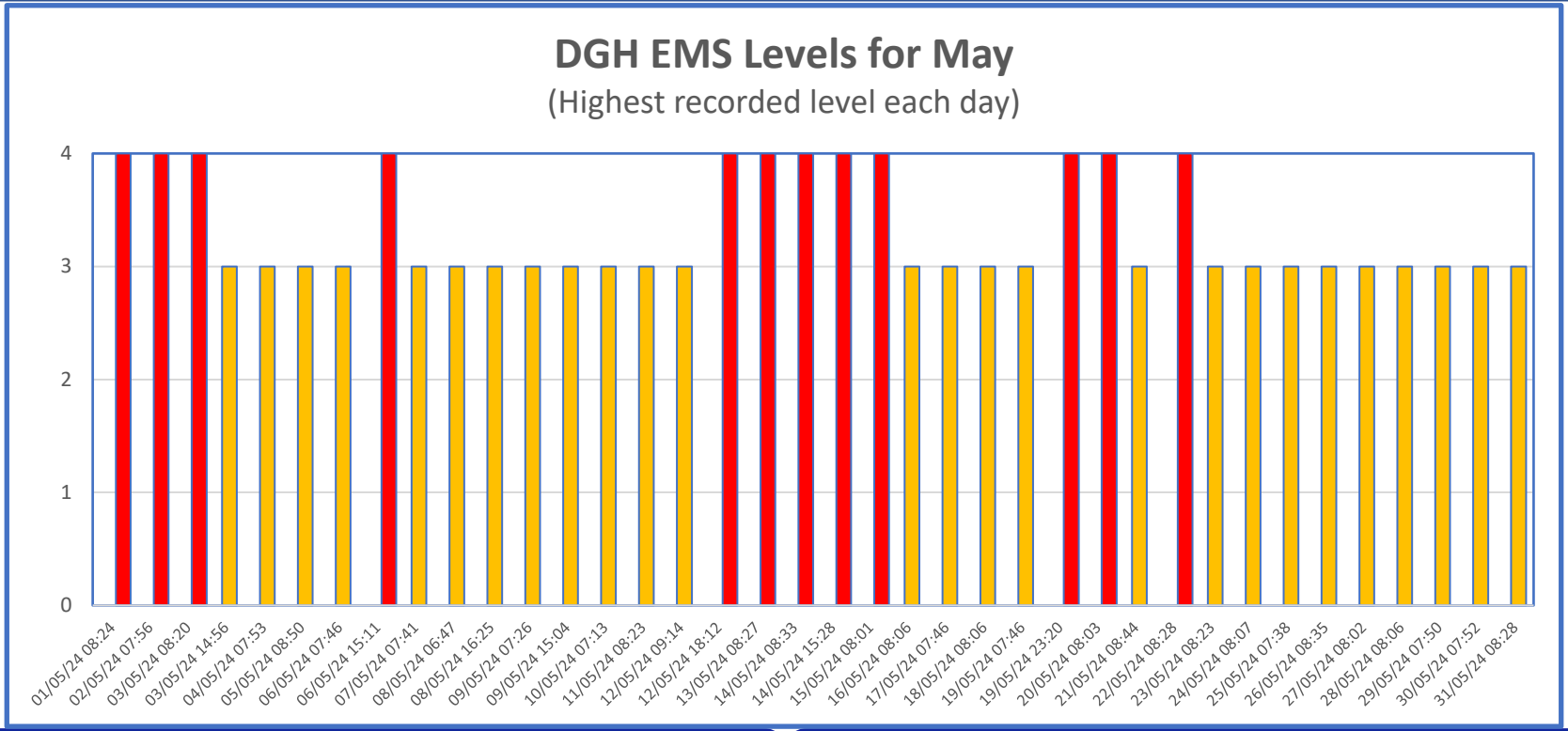


Action

- This month ED performance increased to 81.2%, meaning the trust exceeded the 78% target mandated for April. This is the highest performance in a year.
- Last months data have allowed for identification of themes and increased focus on these have been:

- GP letter patients straight to SDEC/Surgical SDEC.
- Agree new streaming template with UCC for patients with letters to go direct to Speciality.
- Re-run of heat mapping exercise for nurses and medics in ED.
- Joint working with Surgery to ensure proactivity to take patients from ED even when full.
- Organizational agreement that specialties must take patients directly and not wait to assess them in ED.
- Extra Validation resource.

EMS Level for last month



Performance

EMS Levels 3/4 during May.

There has been a decrease in performance in ambulance handover for both >30 mins and handovers >60mins. This contributes to the trust been over prediction for ambulance arrivals on multiple days in May along with acuity of patients.

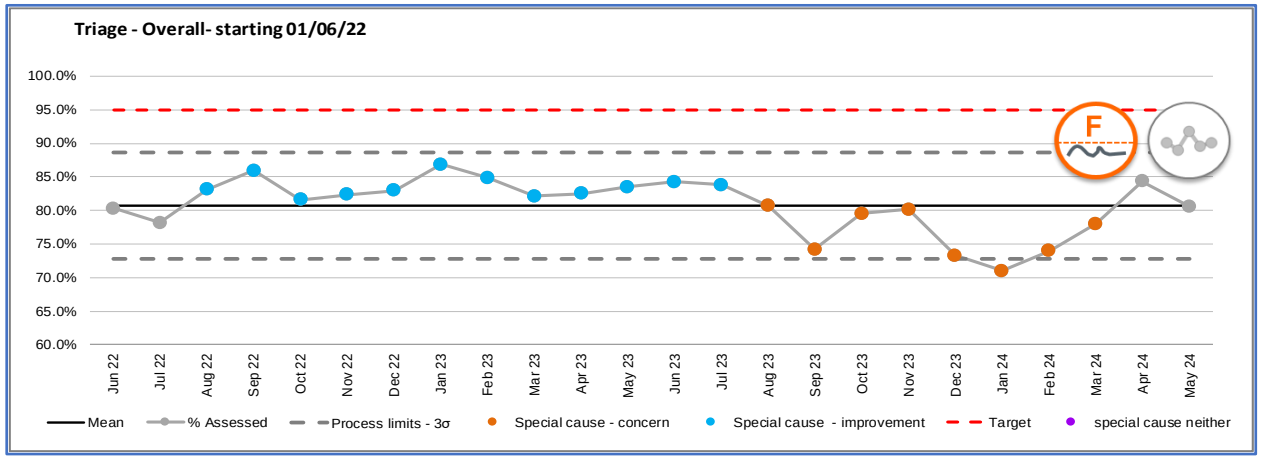
22 out of the 31 days we have seen >300 patients attend ED. 7 out of those 22 days ED saw >240 patients.

In terms of capacity the trust continues to be impacted by medically optimised for discharge patients, which is further exacerbating flow issues and leading to pressure at both the front and back door.

Action

- To continue to utilise non-admitted pathways wherever possible.
- Maintain step downs from acute areas to ensure provision available for the highest acuity patients.
- Focus now on NHSE's 5 priority ED improvement initiatives
  - Streaming & Redirection
  - Rapid Assessment & Treatment
  - Maximising UTC use
  - Improving Ambulance Handover process
  - Reducing the time in department

ED Triage



Latest Month

80.57%

Triage – target 95%

Performance

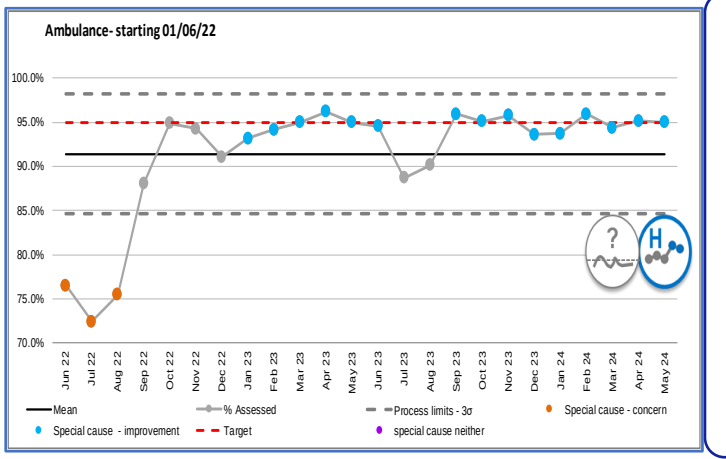
May Overall Triage position 80.57% vs 95% national target.

Triage nurses now in post within minors to improve triage performance and waiting times. We have since seen an improvement in triage performance within see and treat.

Action

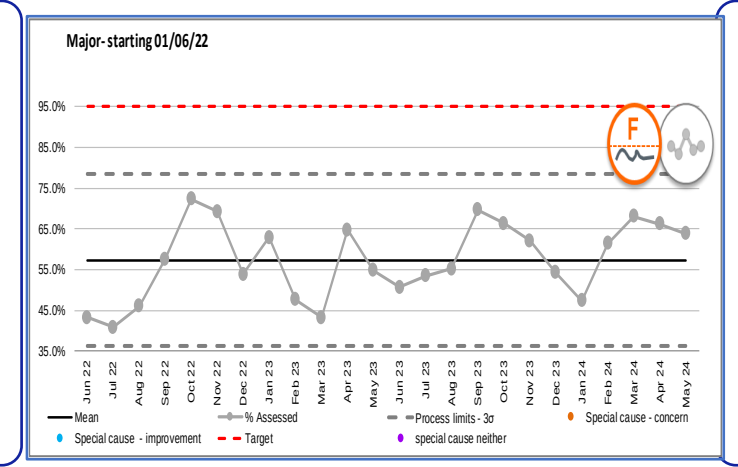
- Deputy Matron now leading on Triage improvement from October.
- Triage project has completed, and assurance report was submitted and presented to the execs with positive feedback.
- ED assurance report now submitted monthly to Execs.
- Daily triage continues to be monitored by the Deputy Matron.
- Front door triage demand continues to be higher than the available capacity of area and staff.
- New lead nurse for both majors and paediatrics have commenced in post from Monday 18th March.
- More nurses have received their ESI training with additional codes which have been purchased.

ED Triage



Latest Month

95.0%



Latest Month

63.8%

Performance

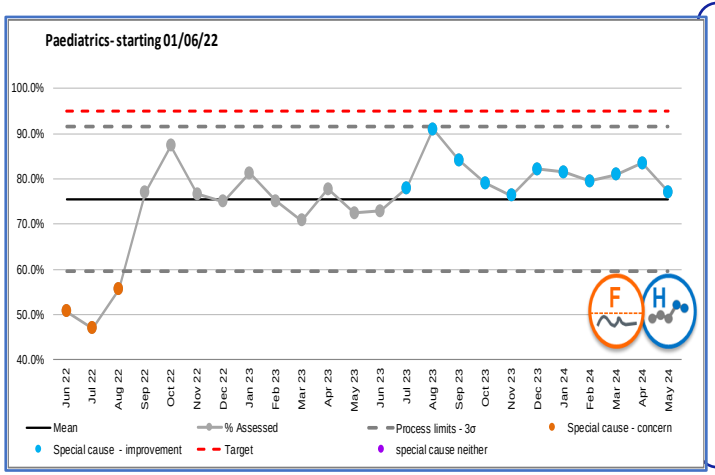
Majors continues to perform higher than our neighbours despite staffing issues this month in both paeds and minors resulting in triage staff having to be bolstered from Majors.

Ambulance triage has seen a positive increase in performance over the past several months. As roles and responsibility of the ED trackers assigned to ambulances along with RAT, this has improved communication and flow into cubicles.

Action

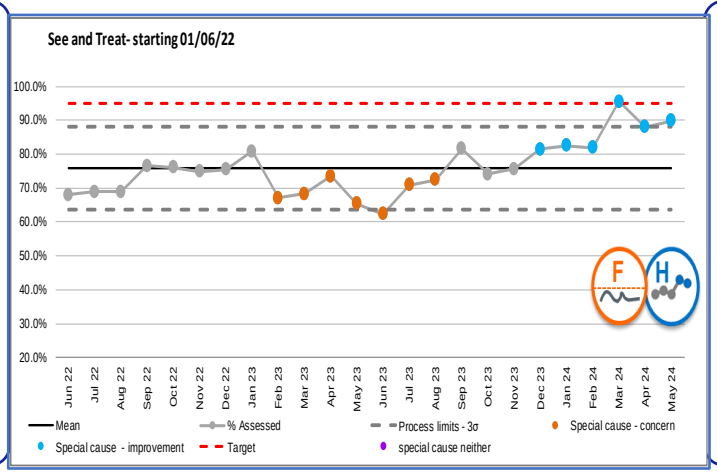
- Time spent in triage continues to be monitored
- Increased focus in direct to speciality patients being sent from UCC rather than being triaged in ED

ED Triage



Latest Month

77.1%



Latest Month

89.9%

Performance

Paediatrics triage performance was at 77.1% May.

Minors has struggled this month with staff shortages and has often had to have their patients triaged in majors, this has contributed to the lower performance this month but remains on an upward overall trend.

Triage nurses, when available for triage have seen 6 days of 100% performance & 15 days above 95%

Action

- Paeds daily huddles have restarted to good effect and triage performance and escalations are discussed.
- Paediatric Lead nurse commenced in post from 18th March.
- Develop process for quickly monitoring and altering when minor's patients need to begin having early "eyes on" assessments rather than just seeing and treating patients all in one go – this is being developed and supported by Nurse/ENP/Medical teams.
- New minors Nursing role (band 6) focused on triage and treatments have commenced in post and actively working on increasing performance.
- ACP trial to commence from Monday 25th march increasing the scope of injuries which can be treated in minors.

Cancer

	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24
28 Day Combined (75%)	73.2%	76.5%	83.6%	80.1%	76.9%	81.9%	87.2%	82.4%	82.5%	87.6%	81.2%	78.3%
31 Day Combined (96%)	84.9%	85.2%	84.6%	86.9%	85.0%	86.9%	81.4%	87.6%	81.1%	89.8%	86.7%	91.6%
62 Day Combined (85%)	71.4%	61.3%	69.5%	70.5%	67.1%	67.1%	68.1%	68.0%	58.3%	67.7%	71.5%	71.9%

Latest Month	Latest Month	Latest Month
78.3%	91.6%	71.9%
All cancer 28 Day FDS waits – target 75%	31 day Combined Target 96%	62 Day Combined Target 85%

Performance

*All cancer data reports two months behind. Data included is up to and including April 2024:

<u>28-day Faster Diagnosis Standard (FDS)</u>

- Performance achieved 78.3% which is above the constitutional target standard of 75%.

<u>31 day combined</u>

- Performance shows an improvement achieving 91.6% compared to the previous month at 89.8%. One of the main challenges is surgical capacity.

<u>62 day combined</u>

- Performance has improved to 71.9% compared to the previous month against the national target of 85%. NHSE target is to achieve 70% by the end of March 2025. (This target does not supersede the 85% constitutional standard but set to support tiering measures for cancer performance)

Action

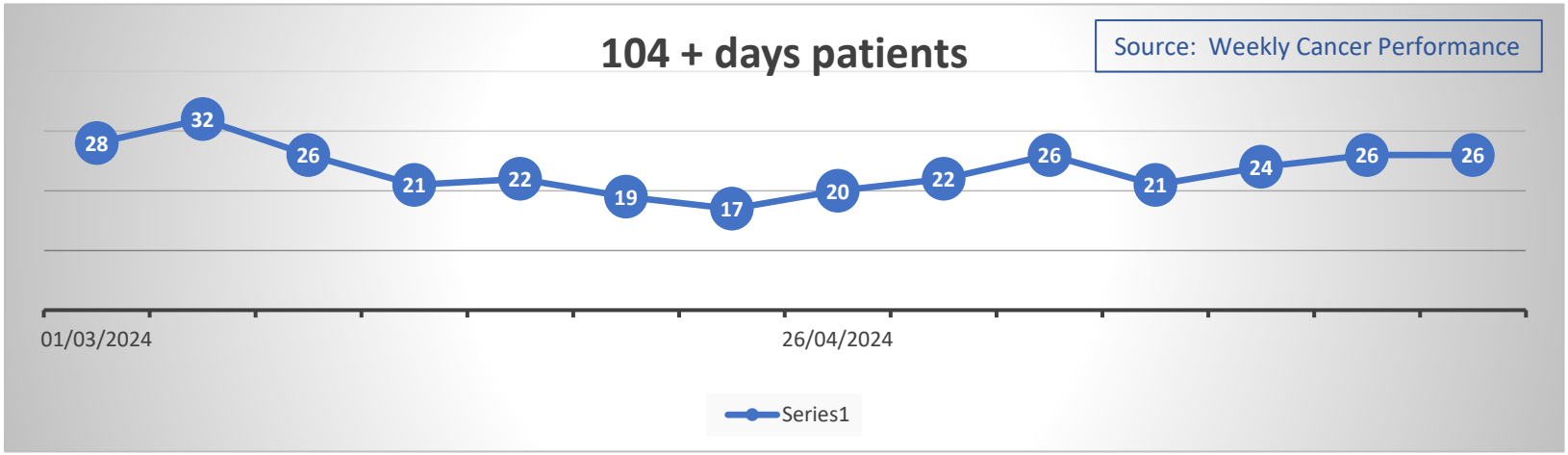
<u>28-day FDS</u>

- To sustain performance
- New FDS target for March 2025 is 77% and this will be focused on

<u>31 day combined & 62 combined</u>

- Increased focus on the 31-day target when escalating for treatments going forward and ensuring data validation is undertaken monthly.
- Weekly PTL meetings to incorporate 31-day decision to treat date in addition to 62-day decision to treat date.
- CDC Dermoscopy service has commenced, this is to support dermatology referrals for suspected cancers. Patients to receive imaging in the community setting to support robust triage of referrals to ensure that we utilise rapid access capacity appropriately. Only 50% of patients currently get on a rapid access appointment.
- New 62 Day target for March 2025 will be 70% and this will be focused on

Cancer Performance – 104 Day – Harm Review



Latest Week

(07/06/24)

26

All 104 week waits, target 10 Patients

Performance

Of the 26 over 104 days patients, urology remains the most challenged pathway with 14 patients waiting over 104 days.

12 of the 26 104+ day patients are tertiary referrals from other Trusts for Urology (Robotic Renal work).

10 of 22 breaches have treatment plans / treatment dates. Those without treatment plans were awaiting surgery dates, best interest meetings or further investigations.

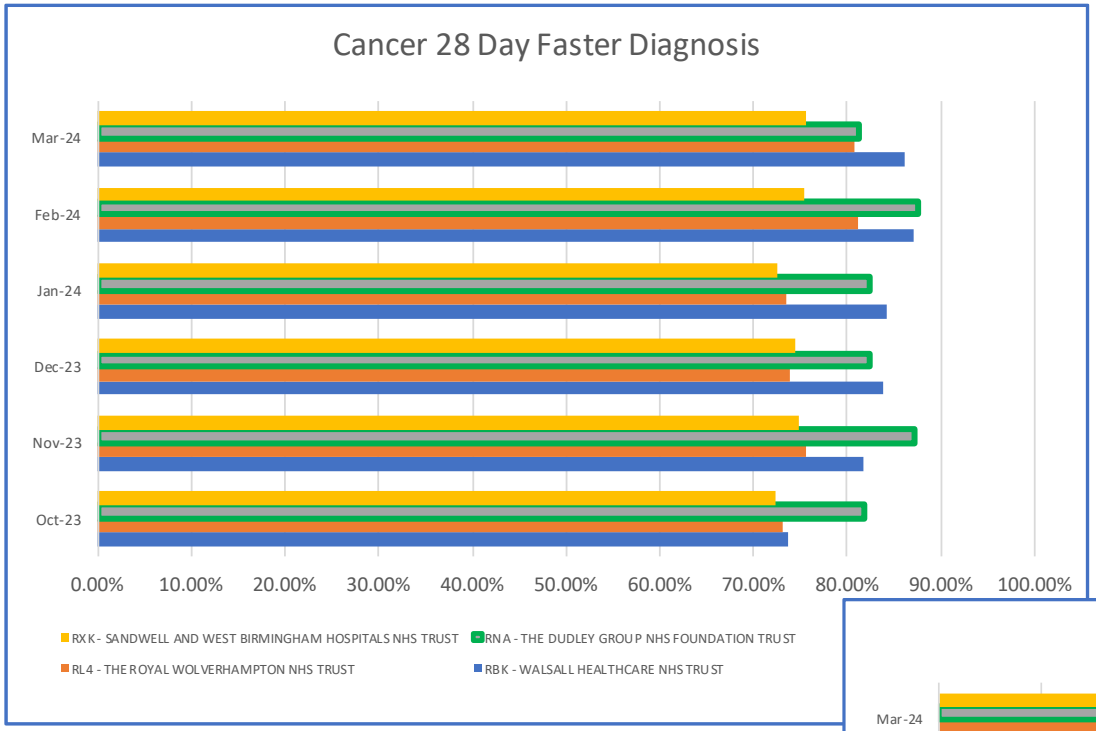
Following harm review, there were 0 patients for April (reported 2 months in arrears).

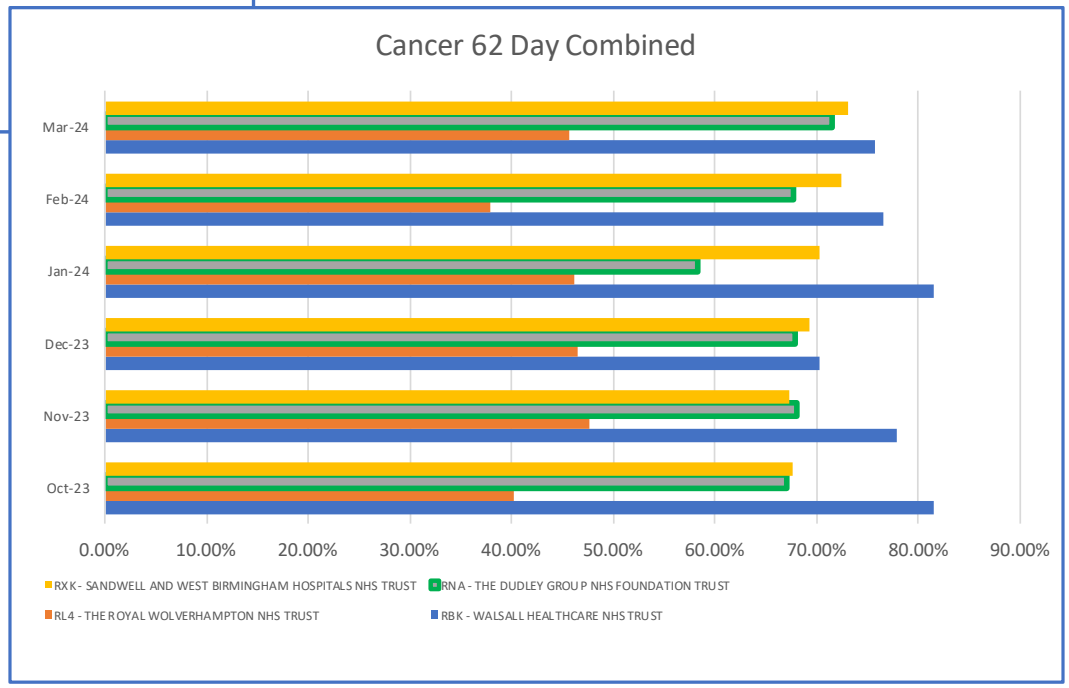
May reported 22 patients waiting over 104 days.

Action

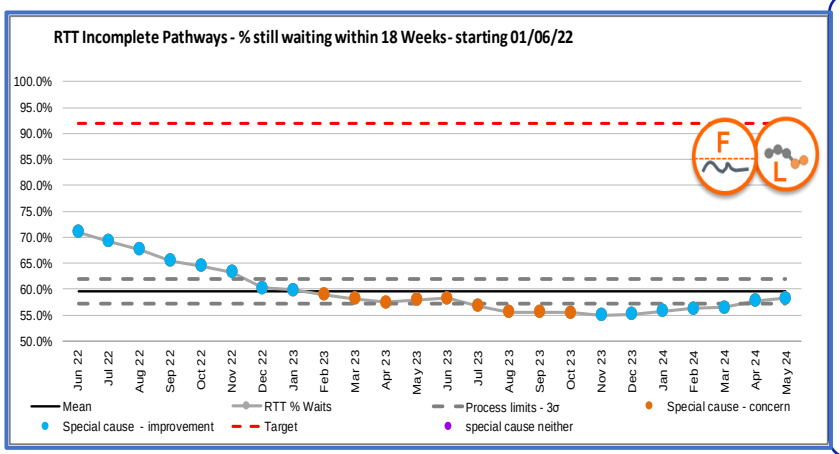
- Monthly harm review undertaken for patients waiting over 104 days on the cancer pathway. No harms identified for March.
- Focus on reducing the backlog of 104 day waits to release treatment capacity for 31 day and 62-day targets continues. Improve patient engagement earlier in the pathway.
- It is anticipated that actions taken to improve combined 62-day performance will support the reduction of patients waiting over 104 days.

Cancer Benchmarking





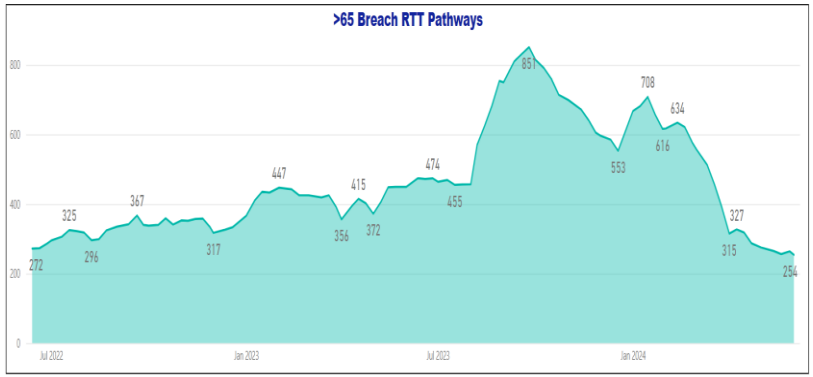
RTT Performance



Latest Month

58.2%

RTT Incomplete pathways target 92%



Taken from: [RTT Incompletes - Post Validation Analysis - Power BI Report Server]

Performance

There has been a continuous slight improvement in the number of completed RTT pathways within 18 weeks in May. That said, this continues to not be monitored with the key focus being on ensuring that we are clearing the longest waiting patients from our waiting list.

The trust continues to perform well against both the 78- and 65-week targets for both elective and outpatient procedures, acknowledging challenges particularly in General Surgery, Pain and Chemical Pathology.

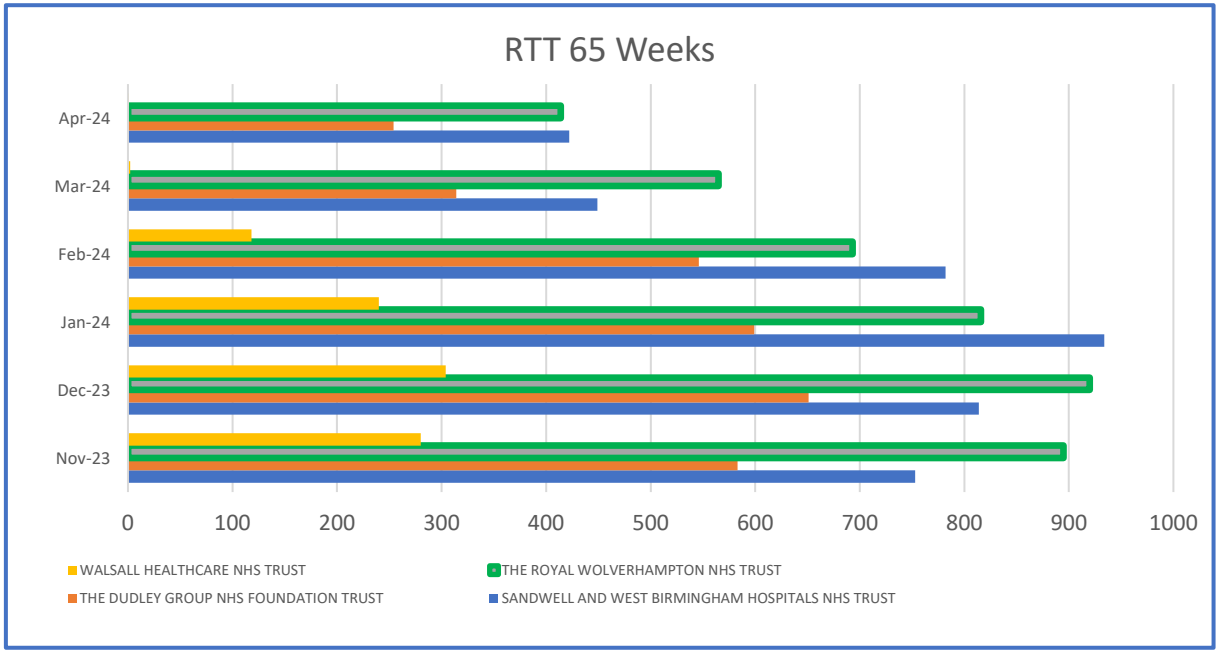
The trust is participating in the GIRFT led Further Faster Programme with all specialities having been issued with the national handbook on how to improve productivity in the outpatient setting.

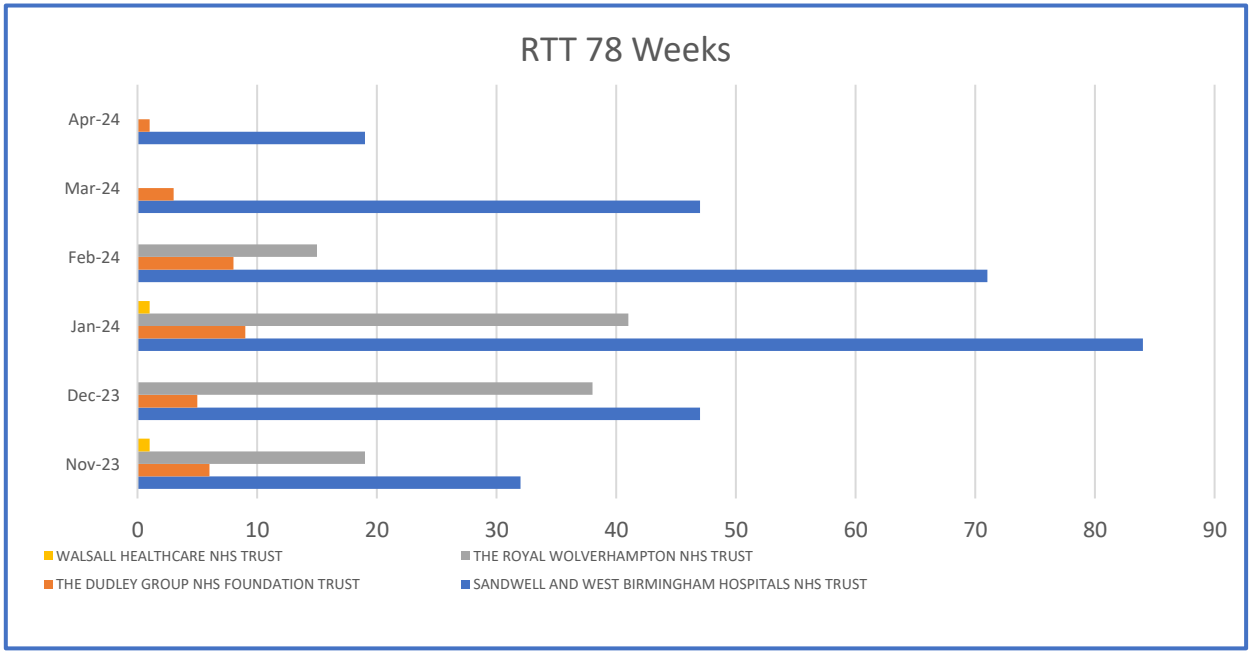
May RTT position 58.2% vs 92% national target.

Action

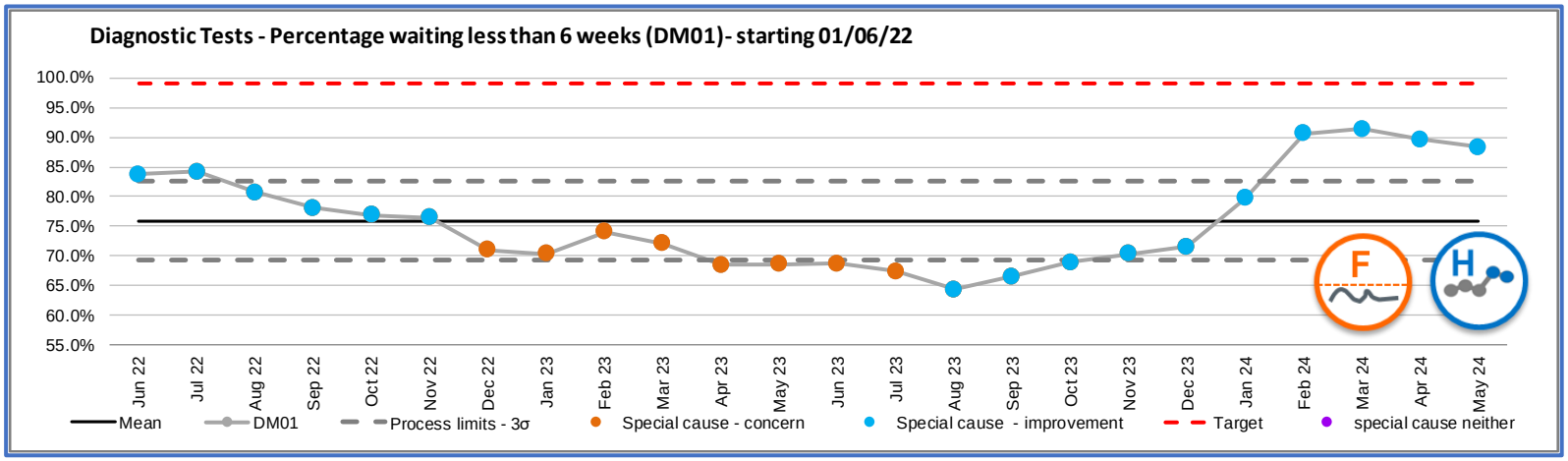
- Outsourcing to support Neurology, Dermatology & Gynaecology long waiters which is proving effective. Though a number of patients have now been returned from our Gynaecology outsourcing provider that require further treatment.
- Continue to engage with the Further Faster Programme.
- PIFU rates are improving and are now above 2.9%, improvements have been made particularly in therapies and T&O.
- 65 week 1st OPA target continues to be challenging, Pain is on track to clear by the end of July and trajectories for Dermatology and Chemical Pathology are being prepared.

RTT Benchmarking





DM01 Performance



Latest Month

88.4%

DM01 combining 15 modalities - target 85%

Performance

May's DM01 performance achieved 88.4%

Both Cardiology and Endoscopy are performing well and achieved 94.67% and 96.56%, respectively. MRI has seen an improvement from 87.59% last month to 91.12% in May. CT and Dexa continue to exceed 90%..

Non-Obstetric Ultrasound (NOUS) has seen an increase in 6 week breaches. Reduced staffing impacted performance and there are resource challenges for ENT, paediatric and specialist consultant scans. NOUS mutual aid continues to be provided to the system.

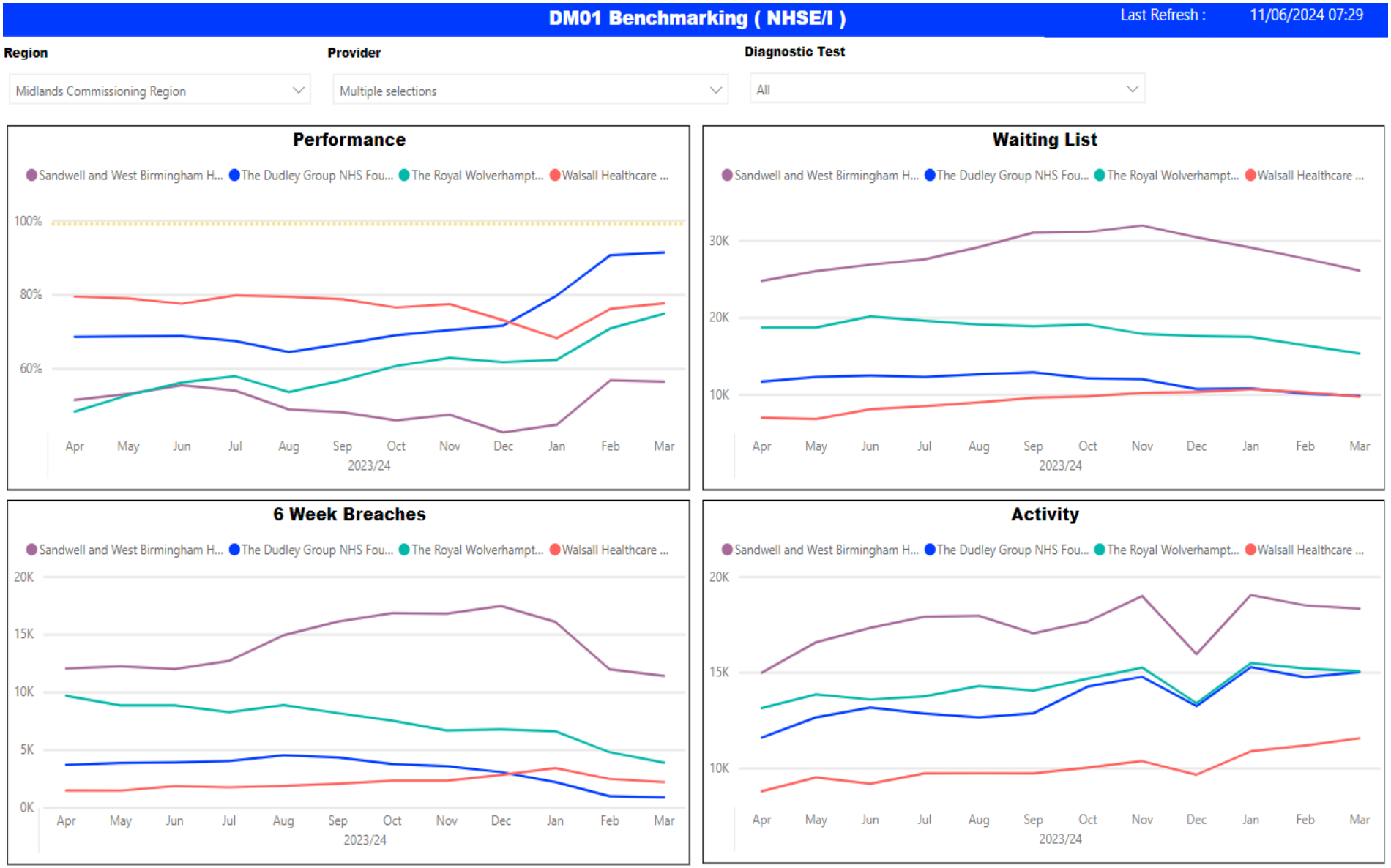
Sleep studies achieved 58.45% for May and is an area of focus. Equipment issues have impacted on performance and the team are working through options to address this. MRI has seen an improvement over the last month. CT and Dexa continue to perform well.

13-week diagnostic breaches and route to zero are monitored weekly by NHSE. Areas of focus for further reduction are NOUS and MRI with plan to clear 13 week waits by August and September respectively.

Action

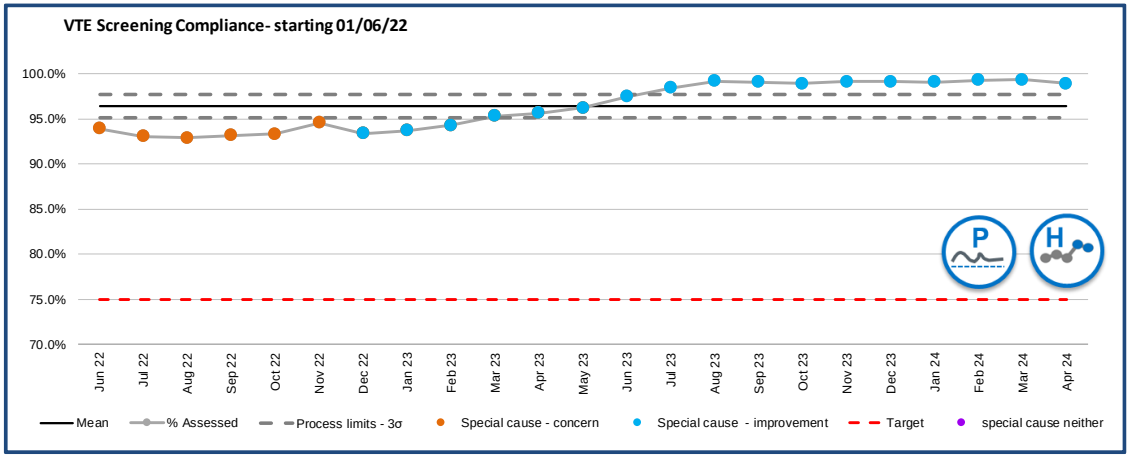
- Recruitment is underway to address NOUS staffing challenges. Additional specialist capacity has been identified to support ENT backlog. System mutual aid is provided to SWBH (600 slots a month) and remains under review.
- Recovery plan with timescales is in development to address equipment issues for sleep studies.
- Diagnostic performance is reviewed fortnightly at system tiering calls with NHSE.

DM01 Benchmarking



Source: [Imaging Cardiology CRIS Dashboard - Power BI Report Server (wmids.nhs.uk)]

VTE Performance Please note: VTE figures now run 1 month in arrears



Latest Month	Latest Month	Latest Month
98.9%	99.2%	98.6%
Trust overall Position	**Medicine & IC**	**Surgery, W & C**

Performance

VTE performance sustained above the standard of compliance in consecutive months since March 2023.

Action

Ward level reporting is available, and this is being monitored as part of the ward performance reviews.

Screening Programmes

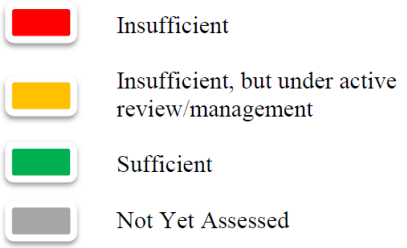
Screening Programme Performance for IPR (F&P)

Description	Comments	Reference	Target	Q1	Q2
NHS Abdominal Aortic Aneurysm Screening Programme (AAA) 2023/24 (@ ICB level)	Percentage of abnormal screens reviewed ≤ 21 days of the initial screen date within the reporting period.	AAA-S12	Acceptable: ≥60.0% Achievable : ≥95.0%	16.67%	29.41%
NHS Breast Screening Programme 2023/24 (@ ICB level)	The proportion of eligible women who have a technically adequate screen less than or equal to 6 months from date of first offered appointment	BSP-S03a	Acceptable: ≥70.0% Achievable : ≥80.0%	69.00%	77.00%
NHS Colposcopy Intervention/treatment 6 week appointment 2023/24	Proportion of women who are offered a colposcopy within 6 weeks of referral due to a positive HR-HPV test and negative cytology OR borderline changes or low-grade dyskaryosis.	CSP-S11	>=99% Green <99% Red	87.00%	100.00%
NHS FASP Trisomy screening 2023/24	Indequate samples for Downs/Edwards/Patau screening a) Combined samples	FA4	To be Set	0.70%	1.20%
NHS FASP Trisomy screening 2023/25	Indequate samples for Downs/Edwards/Patau screening a) Quadruple samples	FA4	To be Set	0.70%	2.00%
NHS Infectious Diseases in Pregnancy Screening 2023/24	The proportion of pregnant women eligible for human immunodeficiency virus (HIV) screening for whom a confirmed screening result is available at the day of report	ID1(IDPS-S01)	>=99% Green 95%-99% Amber <95% Red	99.80%	99.90%
NHS Infectious Diseases in Pregnancy Screening 2023/24	The proportion of pregnant women eligible for hepatitis B screening for whom a confirmed screening result is available at the day of report	ID3(IDPS-S02)	>=99% Green 95%-99% Amber <95% Red	99.80%	99.90%
NHS Infectious Diseases in Pregnancy Screening 2023/24	The proportion of pregnant women eligible for syphilis screening for whom a confirmed screening result is available at the day of report	ID4(IDPS-S03)	>=99% Green 95%-99% Amber <95% Red	99.80%	99.90%
NHS FASP Fetal Anomaly scan 2023/24	The proportion of pregnant women eligible for NIPT screening for whom a conclusive screening result is available at the day of report.	FASP NIPT-S01	Thresholds are not set for this metric	81.00%	80.00%
NHS Sickle Cell and Thalassaemia screening 2023/24	The proportion of pregnant women having antenatal sickle cell and thalassaemia screening for whom a screening result is available ≤10 weeks + 0 days gestation	ST2	>=75% Green 50%-75% Amber <50% Red	43.20%	50.10%
NHS Newborn Blood Spot screening 2023/24	The proportion of first blood spot samples that require repeating due to an avoidable failure in the sampling process	NB2 (NBS-S06)	<=1% 1%-2% Amber >=2% Red	0.80%	1.00%
NHS Newborn Hearing Screening 2023/24	Coverage	NHSP-S01 & KPI NH1	>=99.5% Green 98%-99.5% Amber <98% Red	98.50%	Not Yet Available
NHS Newborn and Infant Physical Examination screening 2023/24	Coverage	ANNB NIPE NP1	>=97.5% Green 95%-97.5% Amber <95% Red	96.60%	95.90%
NHS Newborn and Infant Physical Examination screening 2023/24	Timeliness	ANNB NIPE NP3	>=95% Green 90%-95% Amber <90% Red	85.20%	91.40%
Child Vision screening commenced in September				Not Yet Avaialble	

Kitemark Explanation

Element	Definition
Timeliness	The time taken between the end of the data period and when the information can be produced and reviewed. The acceptable data lag will be different for different performance indicators. Data should be captured as quickly as possible after the event or activity and must be available for the intended use within a reasonable time period. Data must be available quickly and frequently enough to support information needs and to influence the appropriate level of service or management decisions.
Monitoring	The degree to which the trust can drill down into data in order to review and understand operational performance. The level to which the trust needs to drill down into the data will vary for different performance indicators. Some information should always be available at patient level for performance monitoring purposes. Whereas some information may be sufficient if it is available at speciality level for all specialties or even trust level for performance monitoring purposes
Completeness	The extent to which all of the expected attributes of the data are populated but also the extent to which all of the records for the relevant population are provided.
Validation	The extent to which the data has been validated to ensure it is accurate and in compliance with relevant requirements. For example, correct application of rules and definitions. The level of validation required will vary from indicator-to-indicator and will depend on the level of data quality risk. Final validation is classified as sufficient where validation has been completed and where the indicator has received final approval from responsible individuals.
Audit	The extent to which the integrity of data (completeness, accuracy, validity, reliability, relevance, and timeliness) has been audited by someone independent of the KPI owner (for example, Internal Audit, External Audit, Clinical Audit or Peer Review) and the extent to which the assurance provided from the audit is positive.

Element	Definition
Reliability	The extent to which the data is generated by a computerised system, with automated IT controls, or a manual process. It also relates to the degree of documentation outlining the data flow, i.e. documented process with controls and data flows mapped. Data should reflect stable and consistent data collection processes across collection points and over time, whether using manual or computer-based systems or a combination. Managers and stakeholders should be confident that progress toward performance targets reflects real changes rather than variations in data collection approaches or methods.
Relevance	The extent to which the data is captured for the purposes for which it is used. This entails periodic review of the selection of key performance indicators to reflect changing needs, such as new strategic objectives. For example, is this indicator the right indicator by which to measure performance against a strategic objective. Strategic objectives will be defined within the scoping document for proposed new measures.



Click HERE for full kitemark explanation & policy

NHS
The Dudley Group
NHS Foundation Trust

1. Introduction

This annual report summarises the complaints and Patient Advice Liaison Service (PALS) activity and performance at The Dudley Group NHS Foundation Trust (The Trust) for the year 1 April 2023 to 31 March 2024. 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' report 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 used to ensure that we listen to and learn from the experiences of the patients, their families and carers who use our services.

The Trusts strategic vision is to deliver 'excellent healthcare, improved health for all.' The Trust has a strong focus on improving patient experience.

Patient complaints and PALS concerns are reported to the Patient Experience Group, and thereafter to the Quality Committee (a delegated committee) of the Trust Board, on a quarterly basis within the patient experience report which integrates complaints data and PALS activity along with national surveys, Friends, and Family Test (FFT), NHS Choices and compliments.

Since April 2019, the Trust holds 'Learning by Experience' events 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.

In April 2023, The NHS Complaints Standards 2023 were created and implemented to provide a consistent approach to complaints handling for trusts. These Standards have highlighted the importance of good complaints handling in a healthcare setting and learning from these to improve patient care and safety going forward.

The Standards set out the need to involve complainants from the outset, focusing on early resolution, and for trusts to embed learning to improve services. The Standards support organisations to provide a quicker, simpler, and more streamlined complaint handling service. The Trust has implemented these Standards within the existing complaints process and has supported staff through training and 'how to guides' in putting these Standards into practice. Where applicable, the early resolution process is working well.

Key points to note for 2023/24:

- 956 complaints received.
- 1059 complaints closed.

- 100% of complaints (956) were acknowledged within three working days of receipt.
- 42.8% of complaints received a response within 30 working days.
- 54% of complaints closed (571) were upheld/partially upheld.
- 14% of complaints closed (133) were reopened.
- There were 98 complaints under the early resolution process with 86 of the 98 complaints (88%) responded to within 30 working days.
- The Parliamentary Health Service Ombudsman (PHSO) formally investigated five cases, in addition to one for mediation and two for local resolution.
- No complaints were formally investigated by the Local Government Ombudsman (LGO) during the year.

2. Definitions

Throughout this report the term '*complaints*' is used to describe formal complaints requiring a response from the Chief Executive (or the delegated executive director in their absence). All formal complaints are managed through the Trust's complaints process and are reported to NHS Digital by KO41 (formally the Health and Social Care Information Centre) on an annual basis.

The term *'early resolution complaints'* is used to describe complaints that involve one service and/or one complaint theme (such as waiting times, values and behaviours of staff, etc) that may be capable of being resolved by early contact from the service involved. Early resolution complaints aim to be resolved promptly with early contact by the service within three working days with a written response to follow.

The term *'reopened complaint'* refers to a complaint that has already been investigated and a response has been shared with the complainant as part of the first stage of the complaints process (local resolution). The complainant has returned to the Trust either dissatisfied with the response or they are seeking further clarification, asking further questions or they wish to meet with Trust staff to understand the investigation outcome (these meetings are known as local resolution meetings). Where possible the Trust will try to resolve any concerns raised as a complaint in order to achieve local resolution for the complainant. Where local resolution is not possible and several responses may have been shared with the complainant, the Trust will direct the complainant to the PHSO as part of the second stage of the complaints process.

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 clinical teams will be involved in resolving the concerns as quickly as possible. Where this is not possible, they can direct the patient/families/carers to the PALS and complaints team. A dedicated email address and telephone number is available for both PALS and complaints and the Trust is currently developing an online enquiry form that complainants can use in the first instance.

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. This is also a key area under the new NHS Complaints Standards 2023.

4. Activity & Performance

This section provides an overview and detailed breakdown of key performance and activity data for 2023/24. 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 decreased from 0.08% to 0.07%.

Table 1

ACTIVITY	TOTAL year ending 22/23	Total Q1 ending 30/6/23	Total Q2 ending 30/09/23	Total Q3 ending 31/12/23	Total Q4 ending 31/03/24	TOTAL year ending 23/24
Total patient activity	**1,183,002**	308,805	319,262	322,134	321,548	****1,271,749**
% Complaints against activity	**0.08%**	0.08%	0.07%	0.07%	0.07%**	**0.07%****

**at the time of reporting not all data had been submitted to Community Services Data Set (CSDS) for the National deadlines so it is anticipated the patient activity data for quarter 4 (Q4) 2023/24 may be slightly higher.

Table 2: Activity and Performance Data

Activity and performance data	2020/21	2021/22	2022/23	2023/34
Number of complaints received *(not including reopened complaints)*	711	935	1038	956
Number of complaints closed	811	975	1132	1059
Number of reopened complaints	96	124	118	133
Number of total PALS received (including signposting contacts)	3929	4329	4110	5142
Number of PALS concerns and comment received	3362	3715	3547	4144
Complaints formally investigated by the PHSO	4	3	4	5
Complaints investigated by the LGO	0	1	0	0

As mentioned, the NHS Complaints Standards 2023 came into effect in April 2023. These Standards encouraged 'early resolution' where possible. Over the course of 2023/24, 98 complaints proceeded under the early resolution process, with 86 of those 98 complaints (88%) responded to within 30 working days.

There was a decrease in complaints activity from 2023/2024 (956) from 2022/23 (1038) by 7.9%.

To understand if the decrease in complaint 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. When this data becomes available, we will benchmark our activity and report any variance to the Trust's Quality Committee.

The Trust received 4144 informal concerns and comments and 998 signposting contacts (in total 5142 cases/activity) to the Patient Advice and Liaison Service (PALS) in 2023/2024, which is an increase from the previous year (2022/23) figures of 4110 in total (3547 informal concerns and comments and 563 signposting contacts). This is an increase of 1032 total cases/activity (25.1 per cent).

The decrease in the number of complaints received and the increase in the number of PALS concerns received links in with the Patient Experience Strategy 2024-2027. The strategy plans to reduce the number of recorded complaints by 25% each month by signposting to a more responsive option such as PALS where suitable. The complaints and PALS teams have been carefully triaging concerns/complaints in this way since January 2024.

Patients have highlighted (both through PALS concerns and complaints) their frustrations in delays with appointments, procedures and treatment as services continue to recovery post COVID-19 pandemic.

Complaints and concerns are reviewed monthly to identify themes and trends across the Trust. These are shared with the divisions each month at their divisional

governance meetings. Improvement actions and learning is put into practice and reported to the Patient Experience Group, the Quality Group/Committee and the Board of Directors. Learning is shared through 'Learning from Experience' events held during the financial year.

4.2 Complaints and Concerns Received

Table 3 shows the number of concerns and complaints received during 2023/24. This demonstrates the fluctuations which can occur between each quarter. For complaints, there was an increase in Q1, 2023/24 when compared to Q1, 2022/23, however, Q2, Q3 and Q4 of 2023/24 showed a decrease when compared to the previous year's quarters. The number of PALS concerns have increased each quarter when compared to 2022/23 quarters showing an increasing trend.

Table 3

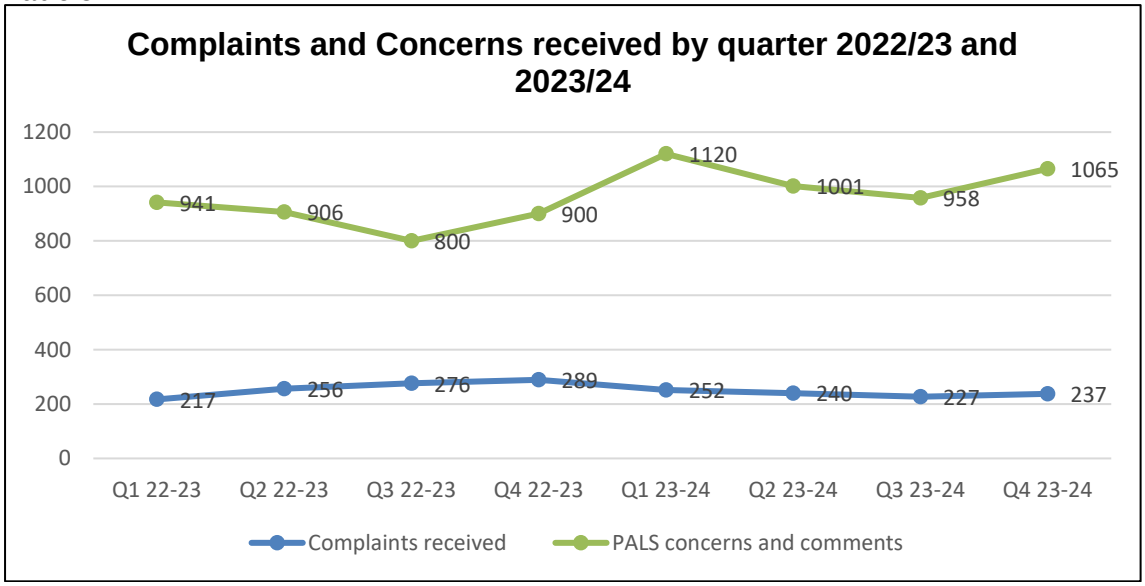
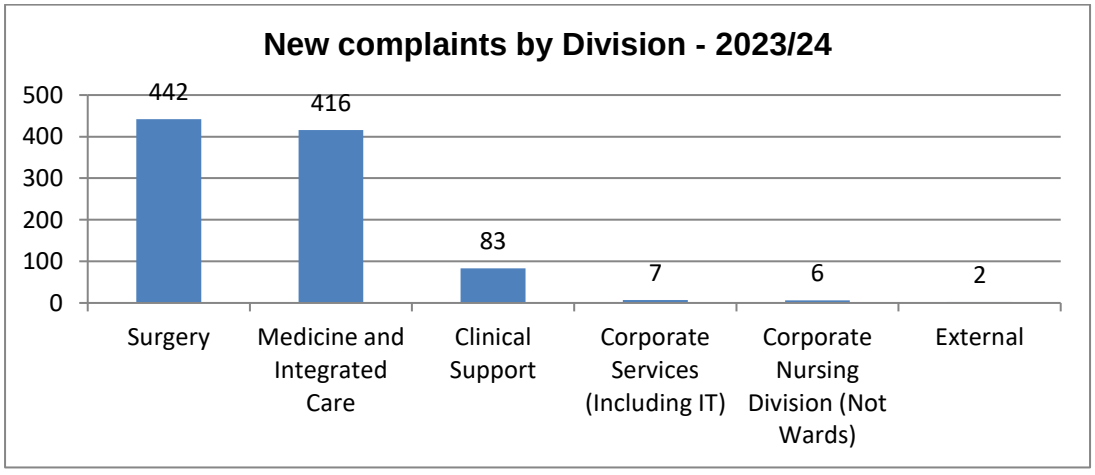


Table 4 details the number of complaints received in each division during 2023/24. The Surgery Division received the most complaints (442) followed by the Medicine and Integrated Care Division (416).

Table 4



4.3 Complaints received by method

Complaints are received by various methods including 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. The Trust is currently developing an online enquiry form accessible 24/7 via the Trust's website.

4.4 Complaints by subject by quarter

Table 5 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 5

Quarter 1, 2023/24	Quarter 2, 2023/24	Quarter 3, 2023/24	Quarter 4, 2023/24
Communications	Patient Care including Nutrition and Hydration	Communications	Communications
Patient Care including Nutrition and Hydration	Communications	Patient Care including Nutrition and Hydration	Patient Care including Nutrition and Hydration
Clinical Treatment - Surgical Group	Clinical Treatment - Surgical Group	Values and Behaviours (Staff)	Values and Behaviours (Staff)
Values and Behaviours (Staff)	Values and Behaviours (Staff)	Clinical Treatment - Surgical Group	Clinical Treatment - Surgical Group
Admissions, discharges, and transfers (excluding delayed discharge due to absence of package of care)	Appointments including delays and cancellations	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)

Table 6 below shows the main themes for each division

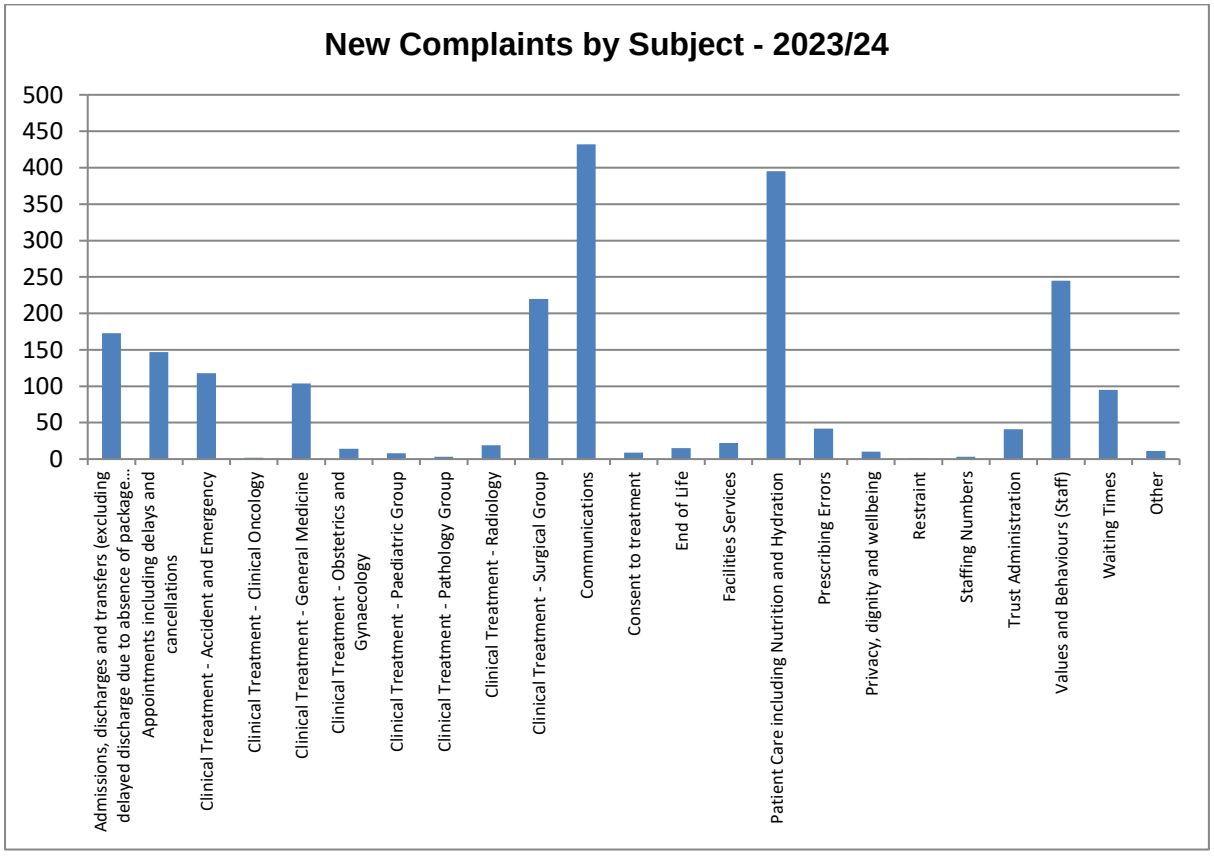
Table 6

Surgery, Women & Children's Division
• Clinical treatment including failure to diagnose appropriately, and lack of care and treatment
• Delay with surgery/appointments.
Medicine and Integrated Care Division
• Poor communication with patients and relatives.

• Clinical treatment in the Emergency Department including failure to diagnose, carry out tests/investigations and discharging too soon.
• Poor nursing care (patient care).
Community with Core Clinical Services (CCCS)
• Concerns raised regarding staff behaviour towards patients.
• Delay with appointments.
• Concerns raised regarding inappropriate discharge (discharged too early).
Corporate Nursing
• Poor communication.
Corporate Services (including IT)
• Lack of parking facilities.

Table 7 shows the themes for new complaints received during 2023/24.

Table 7



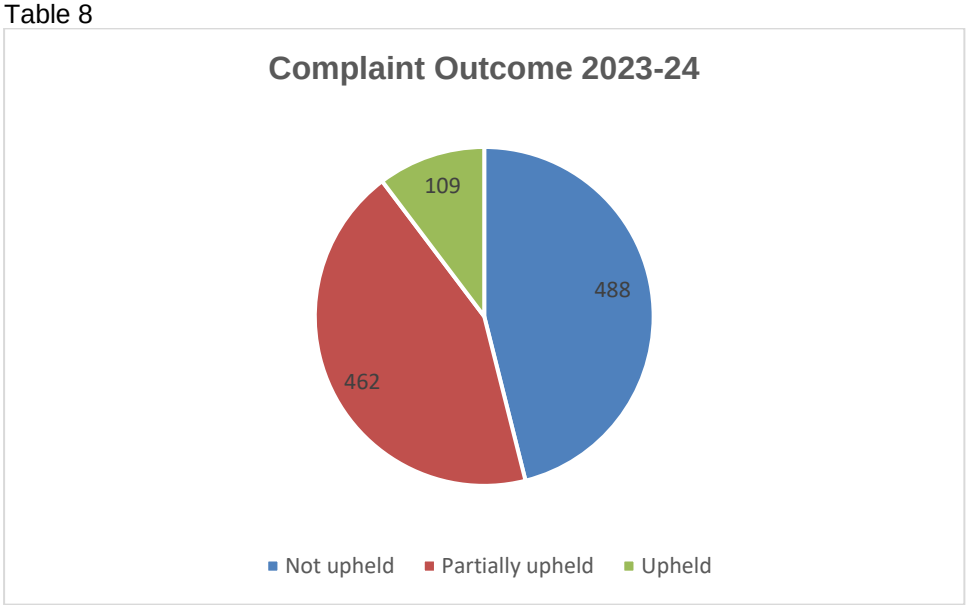
4.5 Complaint outcomes

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 is 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 2023/24 was 571 out of a total 1059 closed complaints (54%). This is a decrease on the previous year (2022/23) whereby 64% of all formal complaints were upheld or partially upheld.

It is of note that upheld complaints are a subjective 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 2023/24 there were 1059 complaints closed with appropriate apologies offered in the letter of response from the Chief Executive or within a local resolution meeting. Divisions are required to take action and demonstrate learning from complaints. Complaints are discussed and progressed through the divisional governance arrangements.

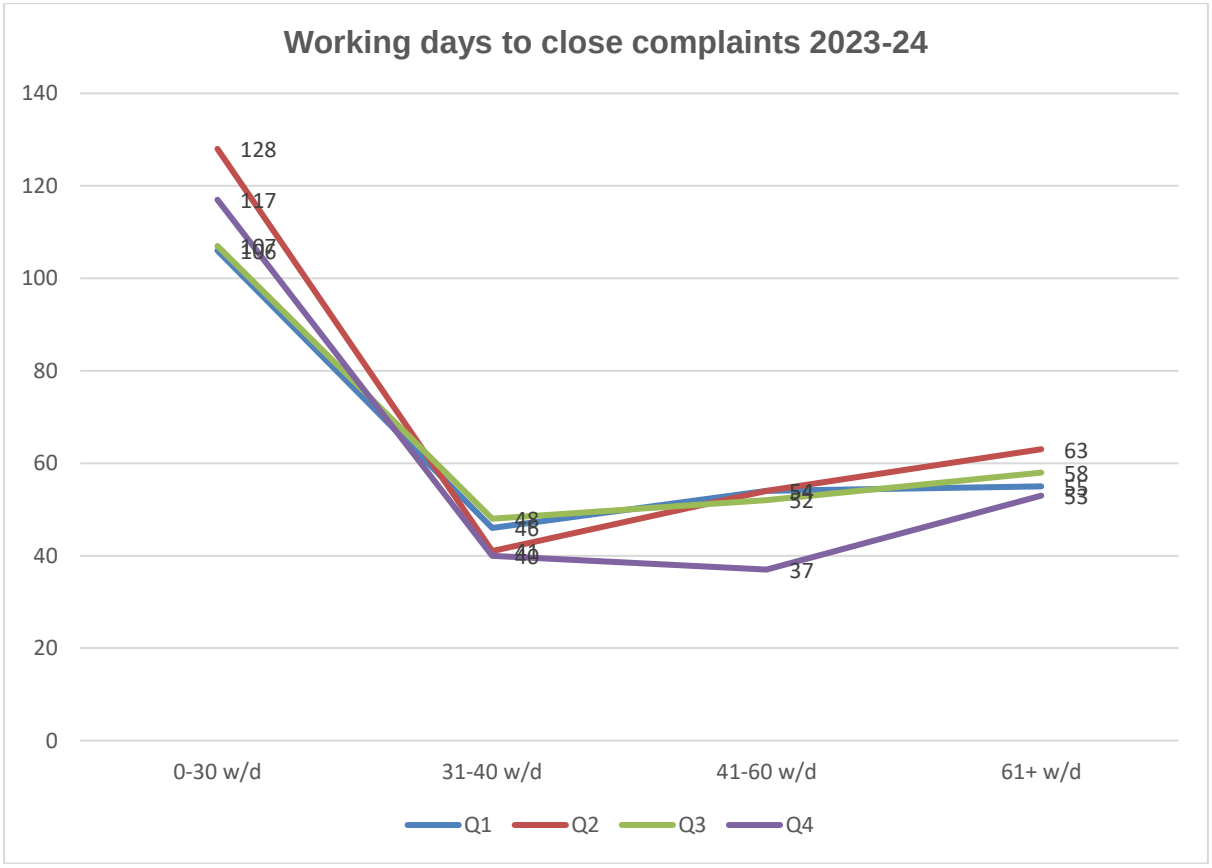
Performance in responding to complaints within the agreed timeframe is variable but is slowly and steadily improving. All complainants are contacted to advise of any delay to their complaint and a new timeframe is given and agreed.

The Trust has worked at decreasing the backlog of complaints along with responding within 30 working days and the response rate has improved since 2022/23 from 35.9% to 42.8% for 2023/24. Timescales are discussed at governance meetings and regular correspondence with staff when complaints are due to breach 30 working days and an escalation process to encourage prompt responses.

Table 9

	0-30 w/d	31-40 w/d	41-60 w/d	61+ w/d
Q1	106	46	54	55
Q2	128	41	54	63
Q3	107	48	52	58
Q4	117	40	37	53

Table 10



5. Parliamentary Health Service Ombudsman (PHSO) / Local Government Ombudsman (LGO)

The PHSO and LGO represent the second stage of the complaints process.

5.1 Parliamentary Health Service Ombudsman (PHSO) cases

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.

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 two new cases for local resolution during 2023/24 with no cases carried over from the previous year. The outcome of these are as follows:

- An apology, payment of £1200 and action plan, received in March 2024 with the action plan to be completed by June 2024. This has been carried over in 2024/25 (Datix 10362).
- Request for further response to concerns raised in February 2024 and response provided in March 2024.

Mediation/Dispute resolution

The Trust received one case for mediation/dispute resolution. (A mediation meeting with the complainant has been held by the PHSO along with a separate meeting with the PHSO and Trust staff. Arrangements are now being made for a final meeting to be held with the complainant, Trust staff and PHSO present. This has been carried over in to 2024/25.

Formal PHSO investigation

One formal investigation case was carried over for 2021/22 and remains under investigation awaiting the final PHSO report.

There were five new cases for 2023/24. Of these five cases, three are under investigation one is awaiting final report, and one has been closed.

Closed formal investigation cases

Of the PHSO cases carried over from previous years, two have now been closed.

- Carried over from 2021/22 and closed in April 2023 once the action plan was completed and shared with the PHSO. This case was partially upheld. The PHSO found that although a continence assessment was completed whilst

the patient was an in-patient at Russells Hall Hospital, this assessment was not felt appropriate and in line with the relevant NICE (National Institute for Health and Care Excellence) guidance. In view of this failing, they considered the impact to the patient was likely to be a loss of dignity, independence and self-esteem, and ongoing unmanaged incontinence whilst an in-patient. An apology was recommended along with an action plan which was completed at the end of April 2023.

- Carried over from 2022/23 and closed October 2023 once a letter of apology was given. Whilst the PHSO found the Trust had acknowledged its poor communication in its responses to the complaint and during a local resolution meeting, they did not feel the Trust had apologised for this and the impact this had on the patient and daughter (complainant). In line with this, the PHSO partially upheld the complaint and recommended that within four weeks of the date of their final report, the Trust write to the complainant to apologise for its poor communication and the impact that this had on the family.

Of the PHSO cases received in 2023/24, one case has been closed.

- Received in 2023/24, The PHSO found the Trust did not follow relevant guidelines when making decisions about the complainant's pregnancy care. However, although the Trust got this wrong the PHSO did not consider the Trust missed the opportunity to diagnose one of the complainant's son's conditions before he was born. However, the PHSO acknowledged that the failing did cause some of the distress the complainant experienced by not knowing if her son's condition could have been diagnosed during her pregnancy. The PHSO found the Trust had not acknowledged this failing or reflected on the distressing impact it had on the complainant during their investigation.

  The PHSO found the Trust's actions fell short of NHS guidance in relation to arranging a specialist review and weekly scans when the complainant's babies' weight difference went above 25%. The PHSO recommended the Trust write to the complainant to acknowledge the failings identified in their report and apologise for the distress caused and complete an action plan to address the failings identified in their report (completed March 2024).

5.2 Local Government Ombudsman (LGO) cases

During 2023/24 there were no LGO cases carried forward from 2022/23 and no new LGO cases.

6. Learning from complaints

The Trust has made several changes and improvements in response to formal complaints. Listening to patient/relative/carer 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 which includes the Trust Induction training for all new employees, the Nurse Graduate Training Programme, the Inter Professional Education Programme, and additional managing complaint training. 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 clinical teams and services. Improvement actions and learning is put into practice and reported to the Patient Experience Group, the Quality Committee and the Trust Board.

The divisions have provided the following examples of learning from complaints in 2023/24. 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.

Table 11

Communication **Complaint Description:** Concerns raised regarding patient care and lack of communication, and decision making with relatives during the (Gold Standard Framework) GSF discussions.
Learning and action taken: That patient and/or family should always be involved in decisions when and where possible and that any decisions made are always discussed with the patient/and or NOK especially when decisions are being made on the patients GSF status. During the daily ward rounds and regular huddle boards discussions of patients takes place with the MDT and nurses to encourage open and transparent discussions and decisions. That can be relayed back to the patient and family. **Change and impact:** The lack of communication regarding GSF status has been discussed with nursing staff on twice daily huddle meetings and with medics on MDT board rounds and will continue to be discussed/encouraged.
Patient Experience **Complaint description:** Patient was sensitive to light and sound and whilst initially could be placed in a side room, the patient did have to be removed. The patient asked for ear defenders, as to which the Trust do not have a supply.
Learning and action taken: The ward did not have a learning disability link nurse. The ward identified a member of staff to take on the role of learning disabilities link nurse to help vulnerable patients who are admitted into the ward's care. It is hoped that this will improve the patient experience going forward.

Change and impact:
The link nurse has developed a learning disability board signposting staff to the resources available improving the patient experience.

The complaint has been shared as a wider division between lead nurses to help to identify ways to promote the best experience for our most vulnerable patients.

Clinical Treatment

Complaint Description: The complainant believed their fracture was missed whilst in our care.

Learning and action taken:
The team confirmed that the patient had a fall and saw the general practitioner (GP) who referred them for an X-ray. Then the X-ray department referred the patient to the Emergency Department (ED) following the X-ray.

An Emergency Nurse Practitioner (ENP) was concerned about a scaphoid (thumb side of the carpal (wrist) bone) fracture and requested scaphoid views. The ENP documented that there was no obvious fracture seen but had treated the patient as per trauma and orthopaedic (T&O) protocol for scaphoid injuries.

The ENP gave the patient a wrist splint and documented that they were to be seen by T&O following the magnetic resonance imaging (MRI) scan. On review, it has been confirmed that the patient was treated correctly at the time for a scaphoid injury.

The patient went on to be reviewed in the virtual fracture clinic (VFC). T&O consultant has confirmed that there was no convincing evidence of a fracture. There were some degenerative changes in the carpometacarpal (CMC) joint and the correct treatment of a wrist splint was applied and the plan was to review in the face-to-face clinic in two weeks' time.

The team were able to reiterate to the patient that they were reviewed in the fracture clinic following the symptoms not settling, therefore that is why the patient was offered a cast for three weeks. The team explained to the patient that the reason for giving the cast was for pain relief and to rest the soft tissues. It was suggested that the patient may have some flare up of arthritis or micro trabecular fracture (bone bruises) of the carpal bone. It is a common practice to offer cast for few weeks after the injury if the symptoms are not settling.

The cast was removed some weeks later and the patient was advised to start mobilising their wrist. It is documented that as the patient had arthritis, for that they were advised to consult the hand consultant if symptoms did not improve.

Some months later the patient was reviewed again in the clinic. This time they had some features of tenosynovitis (inflammation and swelling of the tendon) and so the patient was referred to a hand consultant and to a hand therapist.

It was noted with physiotherapy in a months' time that the wrist pain was improving.

However now there was pain in the right shoulder. It was suggested that the patient may have an Un displaced fracture of the scapula (shoulder blade) and so was referred to physiotherapy for the shoulder pain.

The patient was reviewed over the telephone by T&O sometime later. There was some improvement in the symptoms, although not fully settled. The patient was given a further clinic appointment.

Change and impact:
The complainant was assured that their concerns and the issues they raised have been taken very seriously.

The trauma consultant was able to articulate to the patient that he understood that the patient was given different opinions during their clinic appointments for which he apologised for any confusion. Upon review, the consultant confirmed that the MRI did report microfracture and bone marrow oedema (build-up of fluid inside the bone marrow) of the lunate (central wrist) bone. These are microfractures and the treatment is splintage, rest and physiotherapy, all of which were offered to the patient.

Regarding the shoulder injury, it was reported there was no fracture around the shoulder region. However, on reviewing the X-rays the consultant noted that there was a small cortical break around the scapular neck, hence the registrar doctor who saw the patient stated that there may be a small fracture there. The treatment for that, again is physiotherapy to improve the pain which is why a referral was made to them.

It was recognised that communication needed to be clearer, and this has been fed back to the team.

Delay with medication

Complaint description:
Long delays waiting for pain killers, worse at night and a failure to initially consider the patients underlying medical history, knowing that mild to moderate painkillers would not be effective for patient. Further delay in then prescribing opioid painkillers (controlled drug).

Learning and action taken:
Recognised that patients requiring controlled drugs require a two Registered Nurse check and cannot wait until after a medication round as this may delay administration for up to two hours.

Change and impact:
The ward is looking at a better way to ensure that controlled drugs are given at the point when needed by the patient by asking the patients prior to commencing the medication round if they want it then or can wait until end of medication round.

Appointments

Complaint description:
Concerns raised regarding issues with booking appointments.

Learning and action taken:
The previous supplier of the online booking system pulled their service on 31 March 2023 and declined our offer to extend for another month. The procurement exercise for new supplier has taken longer than expected and therefore online booking has been suspended. A manual process was put in place and additional staff have been allocated to the call centre.

Communication has been shared on Trust's website booking page and to GPs, however the communications should have been shared sooner and the message needed to be clearer. Going forward planning and communication needs to be better before any supplier change and service to work closer with procurement team. Risk going forward will be low once new online booking is live.

Patient contacted by telephone and apology offered and explanation given.

Change and impact:
New booking system now in place. Temporary disruption while the new system was installed and now resolved.

Injury sustained

Complaint description:
Concerns raised regarding potential harm caused following cannula being put in hand.

Learning and action taken:
Communication could have been better. We have learnt that when given verbal information post scans, patients do not always retain what to do when they get home following a scan. Implemented a patient information booklet to advise patients who to contact and what to do if they have any concerns when they get home.

Change and impact:
Improved patient information.

Lack of access to service

Complaint description:
Patient waited five hours in ED and three hours on ESH to be told she had suffered a miscarriage. No access to EPAC on a weekend.

Learning and action taken:
The team are working hard to offer a weekend / out of hours service. The compliant has reconfirmed what the team already know that the services for patients who have suffered an early pregnancy loss are in adequate and do not meet the needs of the patient.

Fortnightly gynaecology assessment unit meetings are held with the director of operations and divisional chief nurse to prioritise the gynaecology services.

Listening into Action event previously held; the team are planning to re-invite patients back for an update on the improvement event.

Change and impact:

- Appointment of an outpatient gynaecology matron who has oversight of the gynaecology team working closely alongside ESH.
- Two senior gynaecology experienced staff released from ESH to support EPAC and gynaecology OPA.
- Upskilling current workforce in EPAC with the successful appointment of an EPAC lead nurse.
- 24/7 EPAC service required, and the matron is scoping this.
- Action plan in progress with working solutions to improve patient access to gynaecology services. This has been reported to the patient experience group and to the Integrated Care Board.
- Planned allocated female only station on ESH 2 (improve flow and allow for gynaecology to have an `identified` area within the organisation for inpatients and those attending for assessment.
- Developing a `virtual` ward for EPAC patients to be monitored – bridging the gap in communication and allowing patients to have a point of access.

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.

The Dudley Group
NHS Foundation Trust

Safeguarding Annual Report

2023-2024

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1.0 Foreword

The Dudley Group NHS Foundation Trust (DGFT) recognises that everybody has the right to be safe, free from abuse and protected from harm, no matter who they are, or what their circumstances. The term 'safeguarding' encompasses all activities to assist children, young people, and adults to live a life that is free from abuse and neglect and to enable independence, wellbeing, dignity and choice. Safeguarding includes the early identification and/or prevention of harm, exploitation, and abuse by using national guidelines, local multi-agency procedures and by disseminating 'lessons learnt' and promoting best practice from serious incidents to improve future service development for patients and staff.

Safeguarding means protecting a citizen's health, wellbeing and human rights; enabling them to live free from harm, abuse and neglect. It is an integral part of providing high-quality health care. Safeguarding children, young people and adults is a collective responsibility – NHSE

2.0 Introduction

This annual report reflects the arrangements to safeguard and promote the welfare of children, young people and adults at risk within Dudley Group NHS Foundation Trust for the period April 2023 to March 2024.

The report highlights areas of priority and activity and those areas requiring further focus and development to strengthen the safeguarding processes and ensure the Trust is working within legal frameworks to protect children and adults from harm. The report demonstrates the Trust's commitment to work in an honest, open and transparent manner with our commissioners and partner agencies.

3.0 National and local safeguarding Context, Guidance and Key Legislation

Safeguarding is an increasingly complex and challenging environment. For vulnerable adults there is the need to balance the rights and choices of an individual with the Trust's duty to act in their best interest and protect them from harm. Children and young people continue to experience abuse from within and outside their families, including criminal and sexual exploitation, gang related abuse and on-line harm. These are areas of multi-faceted abuse which are often hidden and can be difficult to identify and monitor. As a Trust we have recognised that specific groups of adults and children present with complex vulnerabilities which can leave them at increased risk of harm and we have been responsive to this by establishing an integrated safeguarding and complex vulnerabilities service.

3.1 Dudley Safeguarding People's Partnership Board (DSPPB)

Dudley Safeguarding People's Partnership has embraced a life course approach to their arrangements, with a focus on an integrated adult and children's agenda and emphasis on transitional arrangements to ensure young people reaching adulthood continue to receive the care and support they need.

The priorities 2022-2024 for the Partnership are: -

- Neglect
- Exploitation
- Think Family

The safeguarding team has reflected these priorities via training, learning events, supervision and audit.

The Trust has been involved in the planning and development of the partnership arrangements for services for children and adults in Dudley. The Trust is represented at the DSPPB sub-groups and is an integral decision maker in the development and progression of the local safeguarding agendas. The Trust representatives play a key role in informing the multi-agency board on the development of safeguarding initiatives specifically related to health.

The Dudley Group NHS Foundation Trust recognises that safeguarding children, young people and adults with complex vulnerabilities cannot be done in isolation; it is only truly effective when we work collaboratively and restoratively with partner agencies to "Think Family" and protect all those at risk of harm, abuse or neglect. The Safeguarding team represent the Trust at the partnership working and planning groups and provide a commitment to work with partners to ensure the best outcomes for children and adults at risk of harm.

3.2 *Key Legislation*

- Children Act 1989
- Human Rights Act 1998
- Sexual Offences Act 2003
- Female Genital Mutilation Act 2003
- Data Protection Act 2018
- United Nations Conventions on the rights of the child 1990
- Children Act 2004
- Children and Social Work Act 2017
- Mental Health Act 1983
- Human Rights Act 1998
- Article 5 - Right to Liberty and Security
- Article 8 - Respect for Private and Family Life
- Article 14 - Prohibition of Discrimination
- Mental Capacity Act 2005 and Mental Capacity Amendment Act 2019
- Health & Social Care Act 2008
- Deprivation of Liberty Safeguards 2009
- Care Act 2014
- Counter Terrorism and Security Act 2015
- Serious Crime Act 2015
- Modern Slavery Act 2015
- Domestic Abuse Act 2021

3.3 *National Guidance*

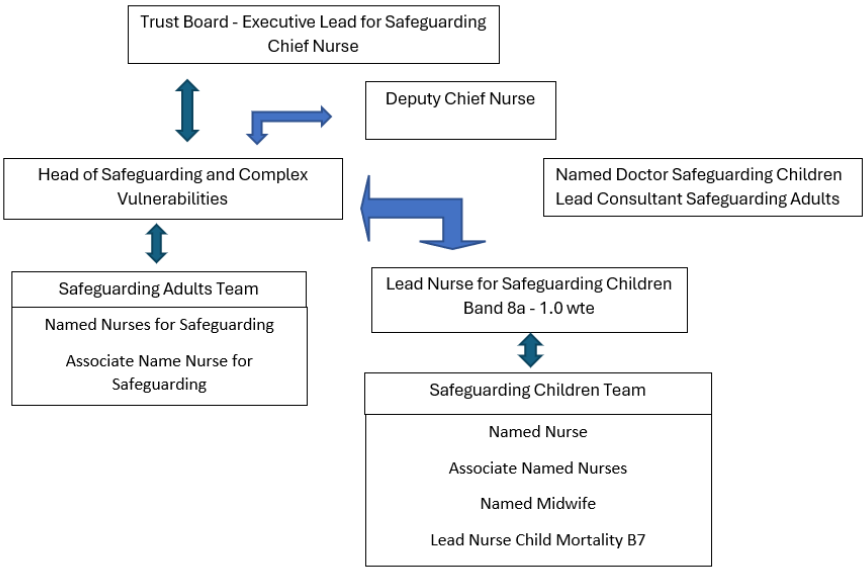
- Working Together to Safeguard Children 2018
- PREVENT Duty Guidance 2015
- CQC Fundamental Standards Statement on CQC's Roles and Responsibilities For Safeguarding Children and Adults June 2015
- FGM Enhanced Data Set 2015
- RCN 2018 Intercollegiate Document - Safeguarding Adults: Roles and Competencies for Healthcare Staff
- Child Death Review - Statutory and Operational Guidance 2018
- RCN 2019 Intercollegiate Document Safeguarding Children and Young People: Roles and Competencies for Health Care Staff
- NHS England Safeguarding Children, Young People and Adults at Risk in the NHS: Accountability and Assurance Framework updated in 2023.

4.0 <u>The Dudley Group NHS Foundation Trust Safeguarding Team</u>

Safeguarding Team - April 2023 – March 2024

The Safeguarding Team is made up of a diverse and multi-professional team who provide specialist and expert training, advice, support and supervision to all Trust employees to enable them to fulfil their safeguarding responsibilities and provide high quality care. This includes the use of appropriate legal frameworks which protect the rights and dignity of our patients, and that patients at risk of harm always remain in our 'line of sight', that we 'hear their voice' and that they remain at the centre of all we do.

Safeguarding Team Structure



5.0 *Governance*

The Safeguarding Team is led by the Head of Safeguarding and Complex Vulnerabilities, and the Chief Nurse is the Trust Executive Lead for Safeguarding, providing Board oversight of safeguarding arrangements. The Deputy Chief Nurse holds Safeguarding the services within their portfolio.

The Named Professionals provide the organisation with operational advice, support and input. The professionals are committed to supporting the workforce in understanding safeguarding, embedding it into 'everyday business' and improving outcomes.

The Trust oversees the governance arrangements through the quarterly Internal Safeguarding Board (ISB), which is chaired by the Chief Nurse. Following review by the newly appointed Chief Nurse, the Safeguarding Board will be held bi-monthly with effect from June 2024. The ISB gains assurance on behalf of the Trust Board that its legal and statutory duties are met in relation to safeguarding of adults, young people and children. The ISB is attended by a safeguarding representative from the Designated Nurse Team in the Integrated Care Board (ICB) and senior leaders of Trust departments whose role is to offer scrutiny and challenge and cascade learning to their areas. Areas for escalation from the ISB are reported to the Trust Quality Committee. The Internal Safeguarding Board monitors progress against the:

- Annual work and audit plan
- CCG key performance indicators and contractual standards
- Risk register
- Incident reporting
- Local and National learning from Domestic Homicide Reviews, Safeguarding Adult Reviews and Child Safeguarding Practice Reviews
- Performance against statutory standards

5.1 Risk Register Review

A robust Risk Register is required to ensure safe, effective and comprehensive management of risks in relation to safeguarding of children, young people and adults. The identification of risks to the Trust in being able to provide their statutory safeguarding duties, is fundamental to ensuring appropriate mitigations are in place and actions are taken for continued improvement of safeguarding practice.

There has been 1 key area of risk associated with the safeguarding adult and children's agendas during the last 12 months:

- Non-accidental injuries to non-mobile children

There has been a considerable amount work undertaken by the safeguarding team to ensure that staff are aware of the identification and action required when non-mobile infants present with injuries or bruises. The risk matrix currently scores as 9 Moderate which is a decrease in risk from 16 Major when the risk was added in October 2022. It is anticipated that all actions to mitigate this risk will be completed by the end of Q2 during 2024-2025.

*5.*2 Partnership working

During 2023/24 the Trust has contributed to engagement and effective partnership working with agencies across Dudley and the wider Black Country footprint.

Dudley Safeguarding People's Partnership Board (DSPPB) oversees the safeguarding arrangements for Dudley. The Head of Safeguarding attends the Dudley Safeguarding Adult Group. The Children Group is attended by the Designate Nurses for the Integrated Care Board (ICB) and report back to Trust Head of Safeguarding via the Safeguarding Quarterly Review Meeting (SQRM). The Adult and Children Group report to the Executive Board of the DSPPB. Trust representation at the DSPPB four subgroups around operational systems, learning and improvement and exploitation (children's and adults).

The safeguarding team participate in Multi-Agency Audit Case Files for children on a quarterly basis.

The Trust are also represented by the Safeguarding Team at the Dudley Domestic Abuse Local Partnership Board, DHR Governance Group, DHR Panel Meetings, Violence Against Women and Girls (VAWG) Strategic Group and VAWG Forum which are led by Dudley's Community Safety Partnership- Safe and Sound.

The Trust is a virtual member of the Multi Agency Safeguarding Hub [MASH] for adults & children. This process is for the multi-agency sharing of information where a safeguarding concern arises and facilitates effective collaboration.

The safeguarding team also actively contribute to Dudley Safeguarding Adult Reviews, Domestic Homicide Reviews and Child Safeguarding Practice Reviews, both in terms of scoping, Individual Management Reviews and Panel procedures.

The safeguarding team share information with the Multi-Agency Risk Assessment Conference (MARAC) to work in partnership with other agencies to protect people at risk from domestic abuse.

The Named Nurses for Children and Adults also attend:

- Child Exploitation Partnership Group.
- Exploitation Panel Meeting
- Local and regional PREVENT partnership events to ensure the Trust has robust and up to date systems in place to report issues around radicalisation. The Executive Lead role for the Trust is held by the Deputy Chief Operations Officer.
- Health Practitioners Care Home Forum – This forum is attended by one of the Safeguarding Adults nurses. It is an informal meeting chaired by the Designated Safeguarding Adults Lead in the CCG. The forum aims to identify and address low level concerns in care homes before they meet the safeguarding threshold. Where there are concerns, professionals are identified to engage and support the care homes.
- Safeguarding Children and Adult MASH Operational and Strategic Forums
- Safeguarding in Suicide Working Group
- Serious Violence Duty Steering Group

5.2.1 Trust activity contributing to DSPPB Priorities for Dudley 2022-2024

Priority	Target Area	Action Taken
Neglect	Training	Advanced MCA training initiated Targeted Mental Capacity Act training provided to District Nurses Level 3 safeguarding children topic - discusses learning from Child Z and Child Y
	Audit	Audit around use of Mental Capacity Assessments and Best Interest Decisions Snapshot audit of staff knowledge of child neglect and self-neglect - results and analysis pending Was not brought audit completed for paediatrics Review of following Did Not Wait process DSPPB Multi-Agency audit re Self-Neglect
	Raising awareness	Neglect Roadshow Safer7 child neglect and self-neglect put in all staff areas in departments across the hospital Safeguarding supervision - discuss of neglect, completing clutter image rating tools for community partitioners and documenting pets in the home.
Exploitation	Training	Exploitation is a topic in Level 2 and Level 3 safeguarding training Exploitation is discussed at all supervision sessions including use of the screening tool
	Raising awareness	Learning of Child F CSPR published on the safeguarding hub page and in the know to all staff via communications Raising awareness of the role of St Giles in the Trust for staff to make referrals for violence reduction

	Partnership working	Attendance at CPEG Attendance at exploitation panel weekly Attendance at exploitation health forum
	Identification	Daily review of report for 16-17 year olds admitted in adult areas to ensure appropriate safeguarding concerns are identified and prevent adultification
Think Family	Training	Think family is included in all levels of safeguarding training and domestic abuse training
	Awareness Raising	Think family themes discussed in supervision sessions Safeguarding supervision extended to staff working with vulnerable adults; alcohol care team, palliative care team, TB nurses to explore impacts upon children and adults with care and support needs in their care Violence against women and children roadshow completed
	Identification	Mandatory questioning in A&E for all adult attendances if they have caring responsibilities Development of First Contact form to identify key family members and significant others who may impact on the care of the child. Carer, parental responsibly and siblings recorded on admission to the children's ward and neonatal unit as part of admission Paediatric A&E triage includes who has attended with the child and their relationship and staff are required to document who else cares for the child

5.3 ***Safeguarding Training***

Safeguarding Training Compliance (end of Q4)

Topic/Level	CCG Contractual Compliance Standard	Compliance % Q4 Q4 2021/22	Compliance % Q4 2022/23	Compliance % Q4 2023/24
Children Level 1	**90%**	**90%**	**92%**	**93%**
Children Level 2	**90%**	**76%**	**76%**	**83%**
Children Level 3	**90%**	**60%**	**83%**	**75%**

Children Level 4	**90%**	**100%**	**100%**	**100%**
Adults Level 1	**90%**	**90%**	**92%**	**91%**
Adults Level 2	**90%**	**75%**	**78%**	**84%**
Adults Level 3	**90%**	**61%**	**80%**	**87%**
Adults Level 4	**90%**	**100%**	**100%**	**100%**
Prevent Basic Awareness	**90%**	**92%**	**91%**	**94%**
Prevent WRAP	**90%**	**87%**	**88%**	**94%**

Compliance with safeguarding training continues to be a challenge. Both Level 2 and Level 3 training is now offered as both face to face and e-learning. This offer has improved compliance with Level 2 training as some staff in this cohort were struggling to get access to a computer to complete the e-learning packages. Feedback from the face to face training is excellent. Many staff report that the training is thought provoking, relevant to their practice and interesting.

The poor compliance for Level 3 Safeguarding Children is of particular concern. It is likely that this is due to achange from being a 3 yearly compliance to being an annual compliance. This change was made in response to staff feedback. The Intercollegiate document guidance states that staff should be complete a minimum 8 hours of training over 3 years and staff advised that it was difficult for them to take a whole day out of practice to complete this. The annual compliance means that staff must complete 2-3 hours per year of training, making it easier for Them to accommodate this alongside their clinical responsibilities. However, staff are failing to book onto face to training or complete the eLearning in a timely fashion, meaning they are non-compliant before they think about rebooking. In addition to the regular monthly provision of face-to-face training, the safeguarding team provides 2 episodes each financial year of intensive training. This is 60 hours of additional safeguarding training Over 4 weeks.

The Divisional leadership team are responsible for ensuring their staff understand their responsibilities in completing their mandatory training and holding staff to account for failure to complete the training in a timely manner.

5.4 Audit and benchmarking

5.4.1 Single Agency Audits

Title	Purpose	Positive	Improvements Required	Actions Taken
Professional Curiosity Audit in ED x 3	To identify if staff in ED are using professional curiosity in their assessments of children and young people	Improvement in staff asking more questions and speaking to the child alone to identify concerns	Completion of the Medical safeguarding checklist	Separate audit of the medical safeguarding checklist
Case file audit of safeguarding documentation on C2 (include voice of the child)	Assess quality of documentation of safeguarding concerns	Voice of the child evident in documentation including interaction with carers Key family members recorded Good discharge planning and communication of discharge with partner agencies	Documentation of contact details of professionals involved to improve consistency of communication	Audit of safeguarding documentation to be included in departmental audits

Audit of quality of information in ED discharge letters	Identify if information is communicated with health partners where patients "did not wait" to be seen in ED	90% of discharge letter contained the information where patients did not wait to be seen		Shared with Department
Maternity safeguarding documentation audit	Ascertain if there is sufficient information being shared with partners where there is shared care between the Trust and Sandwell Hospital and Children's Services	Safeguarding concerns identified and referrals appropriate due to level of professional curiosity from the midwives Good documentation of safeguarding concerns on discharge letters	Poor documentation of safeguarding concerns resulting in limited detail being shared with partners	Awaiting development of a safeguarding tab onto woman's patient electronic records
Was Not Brought Audit	Assess staff knowledge of the was not brought process	Overall staff knowledge of was not brought process was good – most staff could recall various elements of the pathway	Recognising the impact of the child not being brought on their health and development Checking patient alert flags on Patient Electronic Record	Patient safety bulletin Flowchart in other areas of Trust where children are seen Divisional outpatient areas to re-audit
Safeguarding Medical Checklist Audit	Ascertain quality of completion of the safeguarding checklist by doctors in ED	The information on the checklist did not always reflect the child's presentation of the documentation within the medical assessment 6% of the checklists audited were not completed at all 17% of the checklists stated that CP-IS was not checked even though it had been	There was evidence in the notes that medics were speaking to child alone despite this not being transferred to the checklist	Continue to raise awareness in huddles, supervision and when observing practice Results to be shared and cascaded Present results of audit to ED Operational Group
Non-Accidental Injury Audit	Ascertain ED staff awareness and knowledge of management of non-accidental injuries in non-mobile children			

Neglect/Self-Neglect Audit	Assess staff knowledge of key themes relating to child neglect and adult neglect and self-neglect	Good recognition of the signs of physical and emotional neglect 91% of staff asked would contact SG team for advice and 91% would submit a safeguarding referral	Poor recognition of "was not brought" to appointments as sign of neglect	Share results with senior leaders for cascading WNB bulletin and awareness raising

5.4.2 DSPP Section 11 Audit completed in August 2023

Areas of audit	Overall Rating Children	Overall Rating Adults	Identified Areas for Improvement	Progress	RAG
Leadership and Accountability					
Commissioning					
Quality Assurance			Completion of audits in line with annual audit plan and to demonstrate impact of learning from local and national statutory reviews	The DSPP has introduced multi-agency case file audits for adults. The safeguarding team are introducing spot check audits to check staff knowledge of key themes of abuse	
Policies and Procedures					
Safer Recruitment					
Training and Supervision			Adult safeguarding supervision offer requires review	Review undertaken of staff requiring supervision. Supervision offered as per Safeguarding supervision Policy	
Complaints, Allegations and Whistleblowing			Staff require training on how to deal with allegations of abuse	Head of Safeguarding has met with Matrons to raise awareness of managing allegations. Discussion with HR regarding provision of this training within the Employee Relations training which is currently being reviewed	
Information Sharing					
Listening to Children and Young People					

5.4.3 Multi-Agency Case File Audit (MACFA)

Title	**Purpose**	**Positive**	**Improvements Required**	**Actions Taken**
Children in Care Mental Health	Have appropriate multi-agency safeguarding actions been taken in response to children experiencing mental health concerns	Child in care alerts in place on the children's records. Was Not Brought (WNB) letters sent to the GP	No evidence that the WNB process was followed in relation to discussion with the social worker	Safeguarding team review a monthly report of children with a child protection/child in care flag who have not been brought to

		Voice of the child evident in the Emergency Department records Paediatric Liaison process was followed		appointments and notify the clinician of current policy and action required First Contact Form introduced in Children's Outpatients Department
Neglect	Have appropriate multi-agency safeguarding actions been taken in response to children experiencing neglect	Good multi-agency communication evidenced in the child's records Professional curiosity evident Consent gained for a safeguarding referral to be completed Body map completed on admission and daily throughout the child's stay	No learning identified for the Trust	
Exploitation	Have appropriate multi-agency safeguarding actions been taken in response to children experiencing exploitation	Paediatric Liaison Notification completed and sent to school nurse Safeguarding referrals completed Voice of the child evident in records Thorough documentation in ED triage	Completion of child exploitation screening tools Speaking to children alone Adultification Referral to St Giles Trust for support.	Awareness raising within the ED around the importance of completing screening tools Awareness raising of St Giles within the ED.

5.5 Assurance visits and external peer reviews

Assurance to Black Country Integrated Care Board

The Head of Safeguarding provides an exception report to the bi-monthly Safeguarding Quarterly Review Meeting (SQRM), led by the ICB Dudley Place designate nursing team. These reports provide an opportunity to share achievements of safeguarding practice in the Trust as well as identifying our challenges, actions, and requests for support from the ICB and other partners. The Team continues to receive positive feedback regarding the depth, breadth and transparency of the information provided.

Reports and action plans are also shared with the ICB via the Contractual Quarterly Review Meetings.

Assurance to the Dudley Safeguarding People's Partnership

The Head of Safeguarding has presented assurance reports to both the DSPP Children's Quality and Performance sub-group and the DSPP Safeguarding Children Board in respect of progress on the action plan developed in response to the CQC inspection of paediatrics in ED in February 2023. The partnership was satisfied that the actions were complete, and the Trust was able to demonstrate a positive impact from these actions.

An additional assurance progress paper was reported to the DSPP Children's and Adult's Quality and Performance Sub-Groups which demonstrated that the Trust is monitoring the quality and performance of safeguarding activity effectively in relation to audits.

Joint Targeted Area Inspection (JTAI)

JTAIs are joint inspections carried out by Ofsted, the Care Quality Commission (CQC), Her Majesty's Inspectorate of Constabulary and Fire and Rescue Services (HMICFRS) and Her Majesty's Inspectorate of Probation.

The inspectorates jointly assess how local authorities, police, health, probation and youth offending services are working together in an area to identify, support and protect vulnerable children and young people.

The scope of a JTAI is to look at multi-agency arrangements, including the quality and timeliness of assessments, and to carry out a 'deep dive' investigation of the response to specific children and young people (usually described as the 'theme' of the inspections).

The on-site inspection will take 5 working days (following a notice period of 9 working days). The Trust will be required to provide key information relating to safeguarding practice around individual children and be able to demonstrate how we work with our partners to protect children and young people from harm.

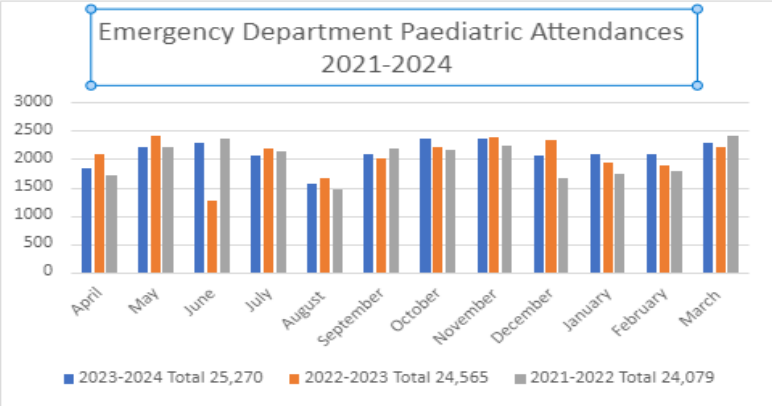
The Trust has undertaken work with partner agencies this year to prepare for a JTAI inspection. These include our ability to access and provide information required around all areas of governance and partnership working. This preparatory work will continue.

<u>Safeguarding Activity and Performance for 2023/24</u>

Safeguarding activity across the Trust has continued to intensify in volume and complexity which is reflected both nationally and regionally. Safeguarding referrals for children and adults and the number of Safeguarding Datix™ submitted, has increased for the fourth year in a row.

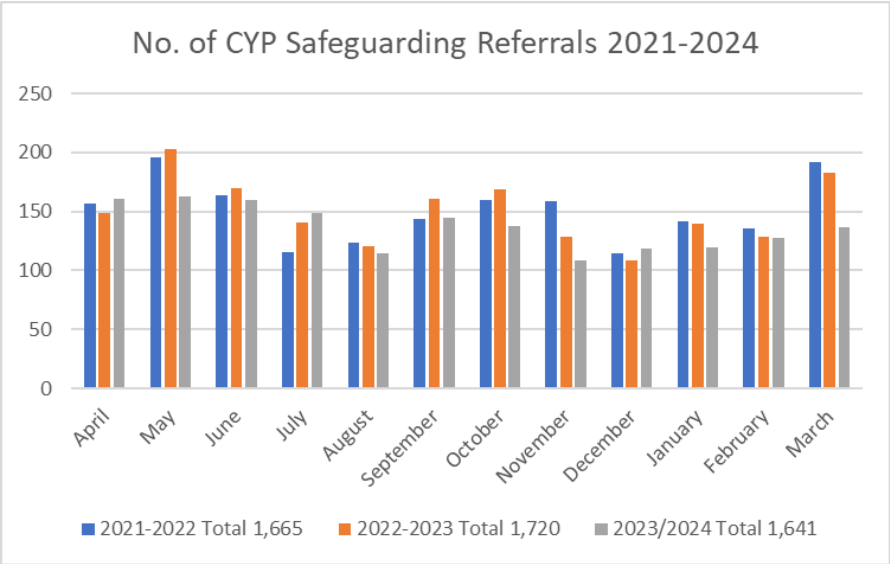
6.0 <u>Safeguarding Children Activity 2023/24</u>

Emergency Department Paediatric Attendances



Source Trust Safeguarding Dashboard

No. of CYP safeguarding referrals



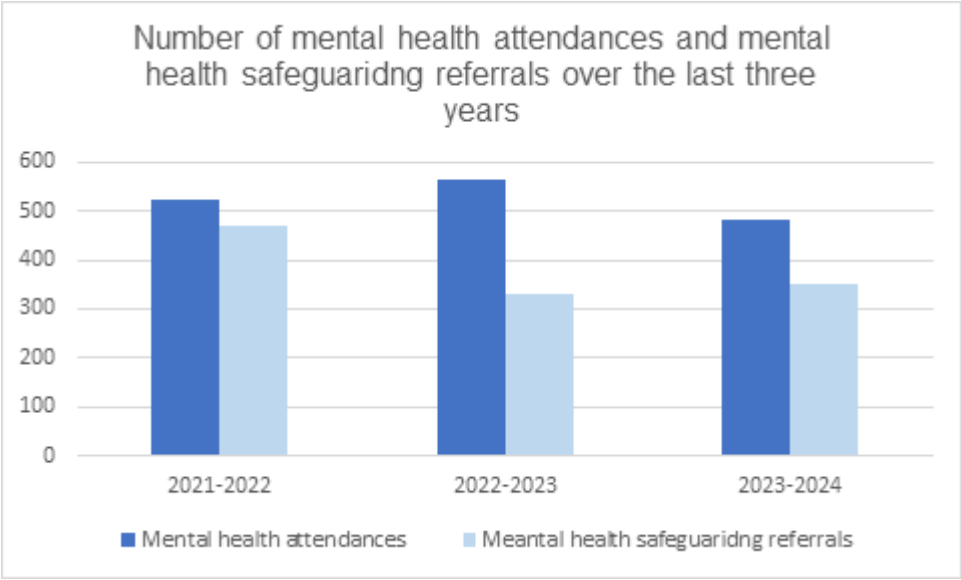
Source: Trust Safeguarding Dashboard

Safeguarding referrals for children and young people have remained consistent over the last 3 years, with an average of 6.5% of attendances requiring a safeguarding referral.

6.1 Themes and trends

Mental Health

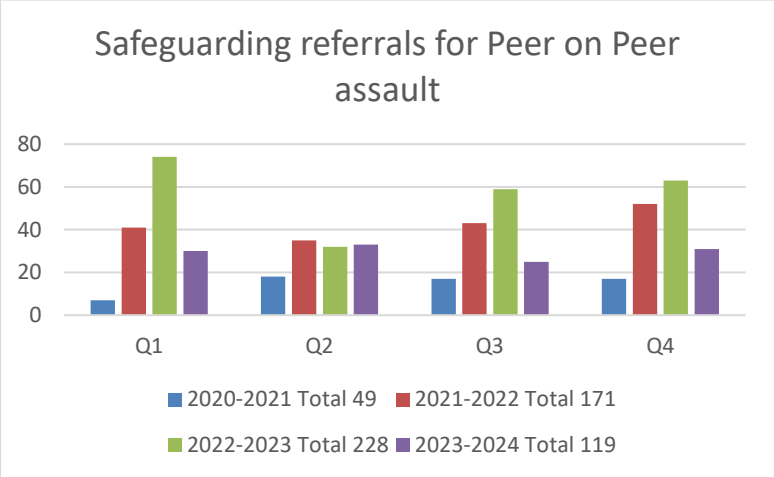
Attendance to ED with mental health concerns has been of significant concern over the last three years. Despite the number of attendances for mental health concerns decreasing since the peak of the post covid-19 pandemic, the proportion of safeguarding referrals submitted for mental health concerns has increased, suggesting presentations are of a more concerning level of harm. The 2 years during and post covid-19 pandemic saw only 59% of mental health attendances requiring a safeguarding referral. As opposed to 72% in the last year.



The Named Nurse has developed a pathway to support ED practitioners' decision making about when to refer a child attending ED with Mental Health concerns to Children's Social Care. This ensures that referrals are being made

appropriately and reduce the number of "no further action" referrals being submitted. The pathway was introduced in Q2 of this year and whilst the effectiveness of the pathway cannot be evidence in this year's data, feedback from Dudley "Front Door" Children's Social Care has been extremely positive and has reduced unnecessary work associated with inappropriate referrals, and ensured those children and young people at risk of harm are assessed and supported by children's services.

Peer Assault

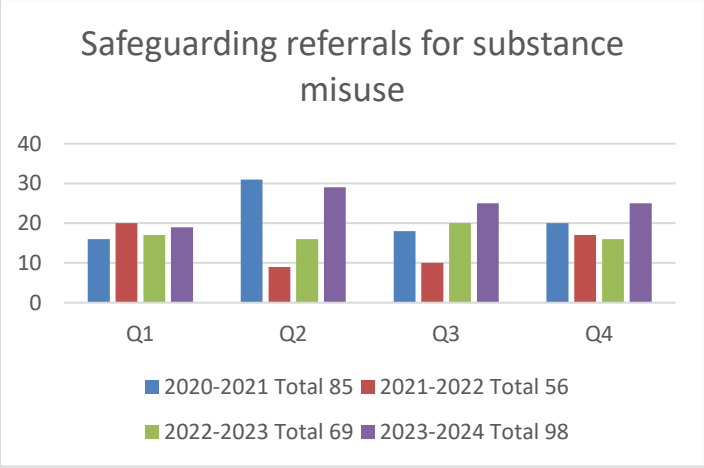


Safeguarding Dashboard

Peer on peer assaults can indicate signs of exploitation. Safeguarding referrals for peer-on-peer assaults reduced this year as staff are gaining more confident in risk assessing through questioning and probing to ascertain if there are elements of potential abuse connected with exploitation.

Substance Misuse

The number of children who attended ED due to substance misuse has increased this year by nearly 10% compared to 2022/24 and by 14% compared to 2021/22. The safeguarding team raised this with partners at the ICB Safeguarding Quarterly Review Meetings and this trend was acknowledged by Public Health colleagues who have subsequently liaised with schools to review current provision of PHSE sessions which include substance misuse. All children who attend ED following incidents of substance misuse automatically receive a safeguarding referral to Children's Social Care.

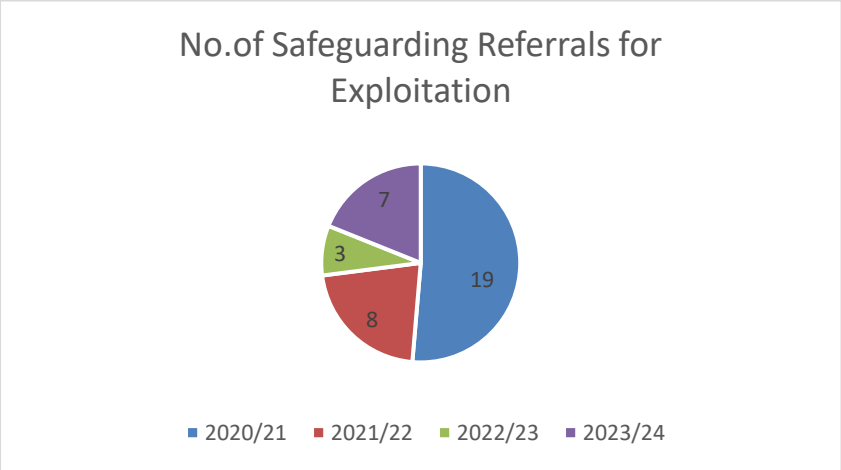


Safeguarding Dashboard

Child Exploitation

Child exploitation is when someone uses a child for financial gain, sexual gratification, labour or personal advantage (Home Office, 2022). Children are often coerced and groomed by the giving of gifts, treats including the use of

alcohol or other illicit substances. Signs and indicators of exploitation include self-harm, poor mental health, substance misuse and being subject to physical harm and abuse. Adult perpetrators of childhood exploitation will often use children to recruit their peers or to punish their peers. Therefore, peer on peer assault can be another indicator of abuse.



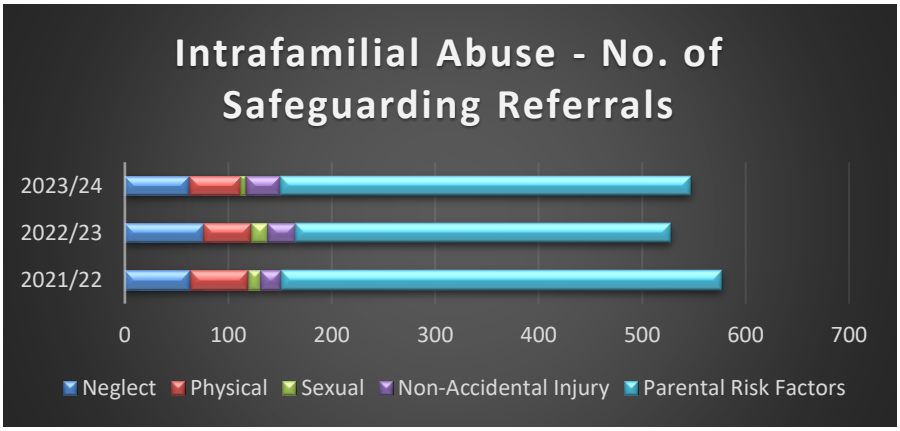
Safeguarding Dashboard

The number of potential victims of exploitation being identified within the Trust is below what would be expected given the numbers of children attending due to peer on peer assault, mental health concerns and substance misuse. Currently safeguarding referrals are categorised by the safeguarding team and recorded on the Safeguarding Dashboard. Referrals are categorised by their primary reason for attendance, therefore it's possible that exploitation is being identified for these cohorts of children but not being captured in the data. Going forward, additional joint categories will be added to capture this, and a retrospective audit will be undertaken to ascertain a clearer picture of children being identified and responded to as victims of exploitation.

The work that the safeguarding team have completed around exploitation this year can be found in Section 5.2.1

Intra-familial abuse

Intrafamilial abuse is the term given to maltreatment of children within a family unit or setting. It is a broad term that can incorporate many different forms of abuse including sexual, physical and emotional abuse, domestic violence - including the effects of a child witnessing it - and neglect linked to parental social and health problems. The graph below shows the incidents of reporting these categories of abuse over the last 4 years. The identification of parental risk factors is key to early prevention of abuse within the home. Some of these risk factors are parental mental health, substance misuse and domestic abuse, known as the trio of vulnerabilities, these risk factors are known to be present in over 60% of child abuse cases which have led to serious injury or death.



Source: Safeguarding Dashboard

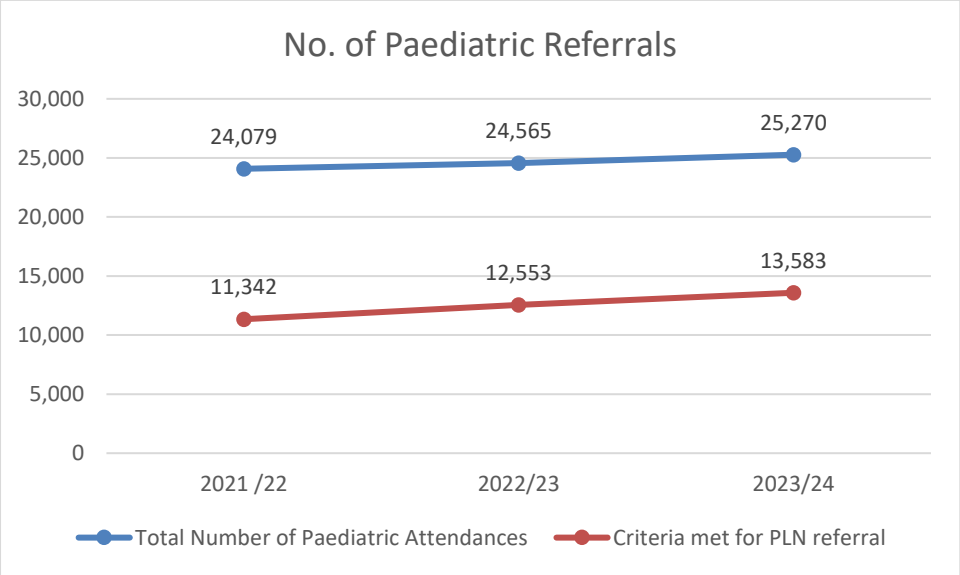
6.2 Paediatric Liaison

Safeguarding liaison between acute and community healthcare settings has been identified as playing an important part in protecting children and young people from harm. Following the Laming Inquiry into the death of Victoria Climbie (DOH 2003) recommendations were made that information relating to a child's attendance at the Emergency Department, discharge from hospital and follow up appointments should be shared with primary care and community services to ensure an effective handover of care and provision of services.

To ensure there is a robust link between the Trust and community and primary care services, information is shared daily with our partners regarding the attendance of children and young people to the Trust Emergency Department. There is also a daily review of all adults with caring responsibilities who attend the ED due to either mental health or substance misuse issues or domestic abuse, in recognition that this may impact on their caring abilities.

The Trust Safeguarding Children's Team review attendances to the Emergency Department via a comprehensive daily report taken from the ED electronic system, Sunrise. The attendances are checked against a set criteria and relevant information is sent to health partners.

Paediatric attendances between April 2021 and March 2024

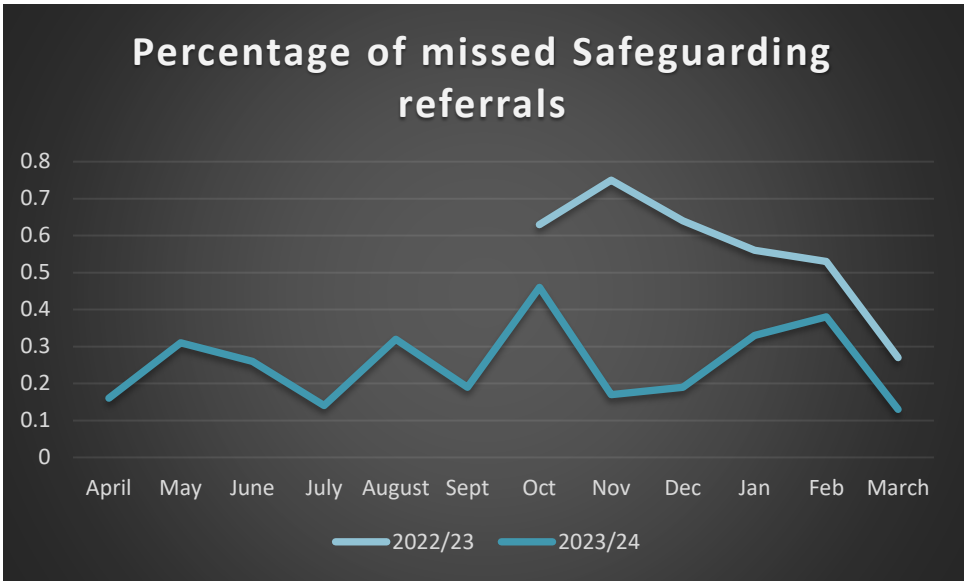


Safeguarding Dashboard

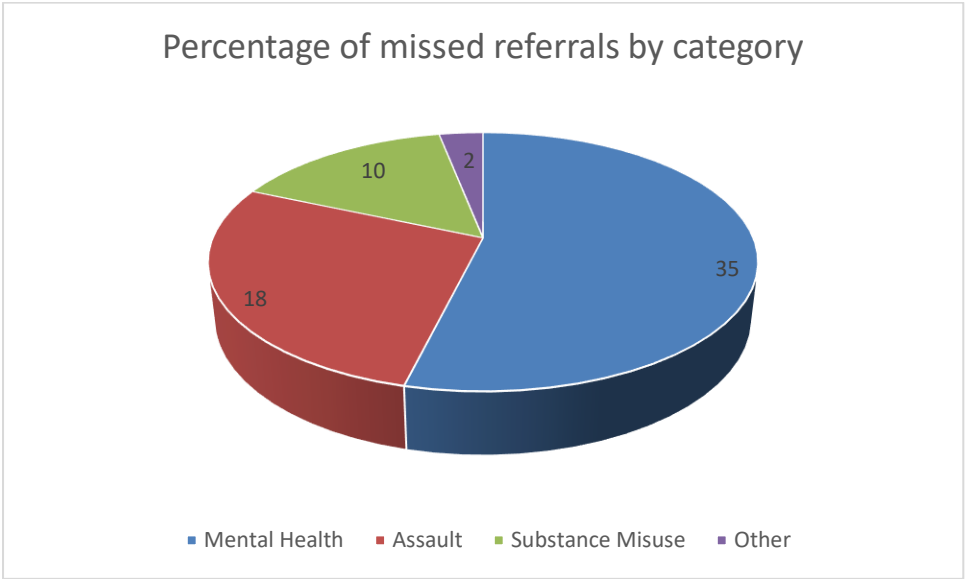
There is a year-on-year increase in the percentage of attendances which meet the criteria for a PLN.

A secondary role of the PLN process is to provide monitoring and scrutiny of safeguarding practice within the ED. This allows the safeguarding team to review attendances which meet the criteria for sharing information and ensure the correct safeguards have been put in place. The recent professional curiosity audit identified that of the 5 cases where there were missed opportunities to safeguarding children, every case was picked up by PLN and the correct action was taken to safeguard the children involved. The safeguarding team provide feedback and allocate actions to the staff in ED to ensure practice is improved and lessons learnt.

Since October 2022, the safeguarding team have been monitoring the number of missed opportunities to safeguard, that the PLN process has identified and subsequently actioned. The graph below shows the percentage of cases where the attendance met the criteria for a paediatric liaison and there was a missed opportunity to make a safeguarding referral

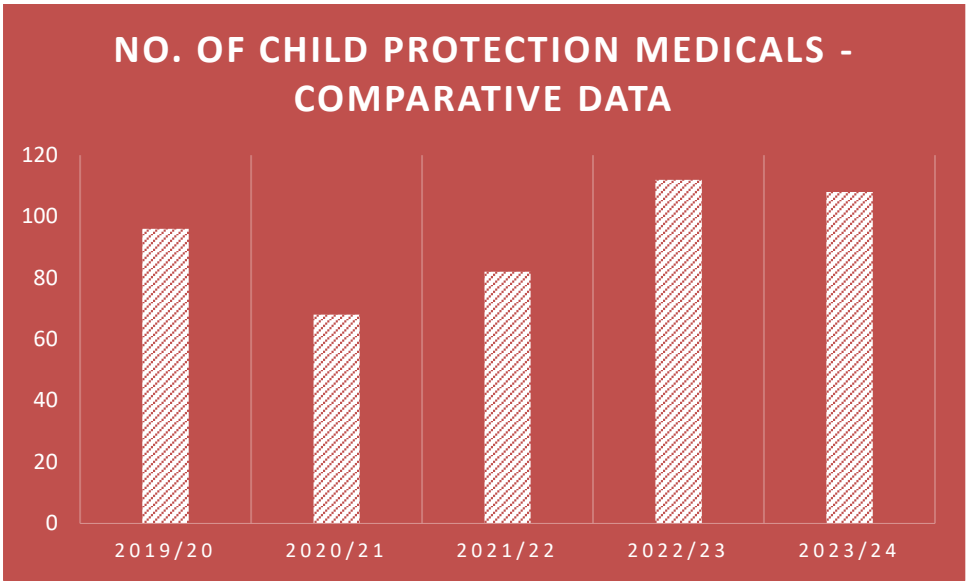


The chart below shows the category of referrals which are being missed.



These categories of abuse will require questioning and analysis to ensure the correct information is gained as part of the safeguarding risk assessment. Over 50% of these missed referrals occurred in ED Majors for young people aged 16 and 17 years. A recent Child Safeguarding Practice Review that the Trust have contributed to, identified learning for the Trust around the adultification of children aged 16 and 17 years who are predominantly seen in adult services. The safeguarding team are in receipt of a daily report informing them where 16- and 17-year-olds have been admitted to adult wards, the team contact the wards to provide any support and advise about possible signs of abuse to consider and be aware of. Safeguarding of 16- and 17-year-olds across the Trust continues to be a priority of the team.

6.3 Child Protection Medicals – 2019 – 2024



Source: Trust Safeguarding Dashboard

The number of Child Protection Medicals carried out in the Trust this year has remained stable following a significant increase the previous year. As with previous years, most of the medicals are undertaken in response to concerns regarding non-accidental injuries and physical abuse.

The Named Doctor for Safeguarding reviews all Child Protection Medical reports completed by members of the Paediatric Doctors to ensure quality and that clear medical opinion is given regarding likelihood of abuse as part of the report. The Trust has signed up to a National Audit around child protection medicals, this is an audit requested by the Royal College of Paediatricians regarding the 12 standards for Child Protection Medicals. Participation in the audit will help the Trust identify any gaps against the standards and drive improvement across the Trust.

6.4 Safeguarding Supervision

The Trust is committed to ensuring that all staff have access to advice and support from competent safeguarding professionals. Safeguarding Supervision is mandatory for all registered clinical staff working directly with children and adults at risk of harm

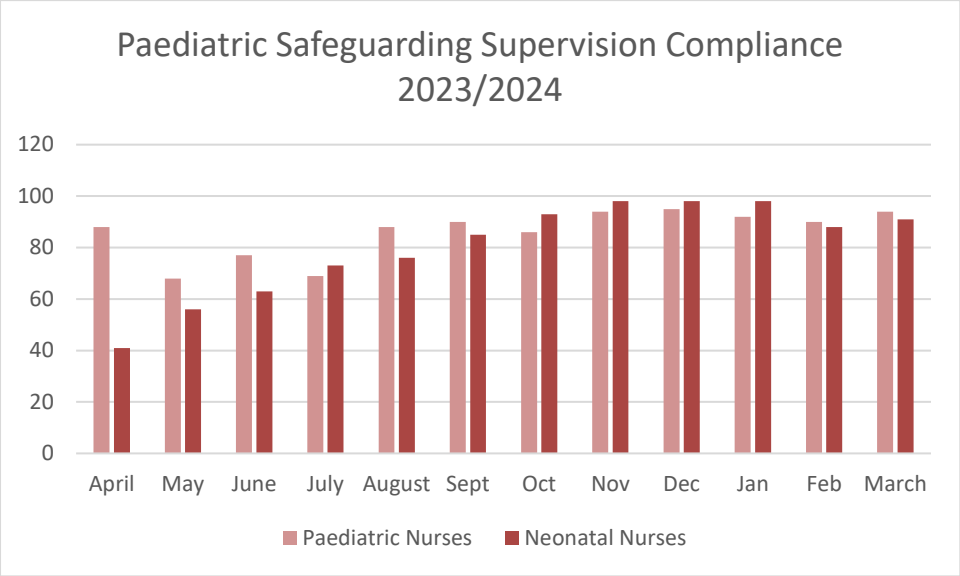
"It is important that staff working with children and families are effectively supervised to support them and to promote good standards of practice in safeguarding children. In line with Working Together, supervision should include reflecting on, scrutinising and evaluating the work carried out, assessing the strengths and weaknesses of the member of staff and providing coaching, development and support" CQC 2009

Supervision can also be accessed in group sessions or on an ad-hoc basis. One-to-one safeguarding supervision is offered for Community midwives and is a mandatory requirement for them to attend quarterly.

Paediatric Nurses - Safeguarding Supervision

Nursing staff in the Neonatal Unit, ED, OPD, Learning Disabilities and C2 receive quarterly group supervision. Specialist paediatric nurses receive one to one supervision due to the complexity of the caseloads they hold.
in receipt of safeguarding children supervision are made up of staff from:

- ED
- C2
- Children's OPD
- Learning Disability Nurses
- Specialist Paediatric Nurses



Safeguarding supervision provides an opportunity for key messages and learning to be shared with staff. Staff are asked to bring case studies to discuss and analyse. The safeguarding nurses encourage discussion, reflection, and peer support. Supervision offers an alternative provision of learning which means staff keep up to date with key themes between their mandatory training sessions.

6.5 Safeguarding Children Case Study

The story has been shared for learning purposes internally but removed from this public facing document to protect patient confidentiality.

6.6 Children Safeguarding Practice Reviews (CSPRs)

The Children and Social Work Act 2017 introduced a new legal framework in respect of local safeguarding arrangements for children. Responsibility of how a system learns lessons from serious child safeguarding incidents now rests with the new National Child Safeguarding Practice Review Panel and the three Safeguarding Partners (Local Authorities, Police and Clinical Commissioning Groups).

Over the past 12 months the Trust has participated in 1 rapid review which progressed to a Local CSPR. There is one outstanding Health Single Agency Review from 2023 that has not yet been signed off by the partnership. 2 Local CSPRs have been published by the DSPPB this year and learning briefings shared across the Trust via Communications, during supervision and via the Trust Internal Safeguarding Board.

Learning/recommendations from the rapid review and published CSPRs for the Trust:

Learning theme	Action
Raise awareness of the Was Not Brought process	• Previous 'Was Not Brought' themed month. Posters of the was not brought process were circulated in staff areas in all departments across the trust. • Flowcharts of the was not brought process were displayed in all outpatient areas across the trust as prompts for staff. • Was not brought is included in level 3 Childrens safeguarding training packages

	for neglect and adverse childhood experiences (think family). • A was not brought audit is completed monthly by the associate nurse for safeguarding children to ensure the process has been followed for all children on a current child protection plan or child in care status as a safety net. • All new employees must attend a safeguarding awareness session as part of induction training where WNB process is discussed. • An audit of staff knowledge in relation to the Was Not Brought pathway completed.
Fathers' mental health and parenting capacity	• Safeguarding level 2 training includes Think Family and parental risk factors including mental health. Safeguarding level 3 training- learning from CSPRs- includes adult mental health and the impact on children. • NSPCC 'Summary of risk factors and learning for improved practice around parental mental health and child welfare' (April 2023) has been distributed to staff via the Trust newsletter. • Parental mental health, parenting capacity, mental health support services for signposting, voice of the child and lived experiences, information sharing, and professional curiosity and challenge discussed in safeguarding supervision as per learning points in the NSPCC document. • 'Think family' is included in safeguarding supervision with staff working with adults and children who meet the requirements for safeguarding supervision.
Caring responsibilities of adults with children	• All admission documents for children and young people require obtaining information including; parental reasonability, parents' details, carers details and who lives within the home. • Mandatory questions for paediatric attendances to the Emergency Department includes who attends with the child and adults are asked if they have caring responsibilities. The completion of these

	questions is audited regularly as part of the professional curiosity audits in A&E. • A First Contact Sheet has been introduced in Children's Outpatients Department which includes parental responsibility and who lives in the household.
Information sharing	• Paediatric liaison service shares information of relevant Emergency Department attendances to community professionals and safety nets opportunities to safeguard children. • A discharge checklist has been implemented on the paediatric ward to ensure information sharing with the relevant professionals on discharge from hospital. • Records are reviewed daily for children with safeguarding concerns admitted to hospital by the safeguarding team who devise a plan of care including information sharing. • Information sharing is discussed in safeguarding supervision.

7.0 Maternity Annual Safeguarding Report – 2022-2014

The Named Midwife supports the Head of Safeguarding in providing assurance that the Trust is meeting its statutory safeguarding duties set out in The Children Act 2004, Working Together to Safeguarding Children 2018 and the Care Quality Commission Core Standards.

They provide specialist advice, training and supervision to staff within the maternity services and work closely with the Safeguarding Adults and Children's Named Nurse Team to ensure there is an effective and robust interface between unborn and neo-natal babies, children and adult safeguarding. Their work includes driving forward recommendations, actions and learning from internal and external reviews in relation to maternity and neo-natal services, ensuring they are promoted and embedded within the Trust through fostering close working relationships with senior staff, and partner agencies from across region.

The Named Midwife provides daily attendance to the maternity and neo-natal units, attendance at training events and via one-to-one supervision, the role has had a positive impact on midwives and the neo-natal team in recognising safeguarding concerns and taking responsibility for making referrals.

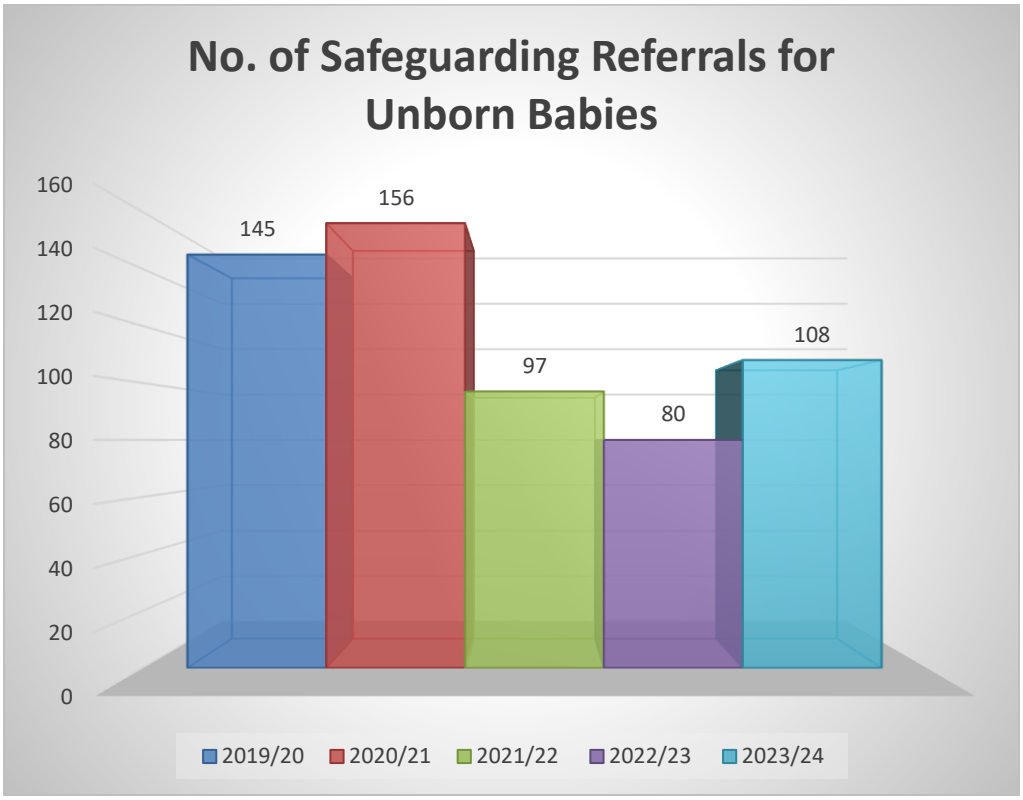
Maternity staffing remains a significant issue particularly regarding the consistency of care provided in the community. The Named Midwife works alongside the Team Leaders and Community Matron to ensure safeguarding activity is covered.

7.1 Maternity Safeguarding Activity

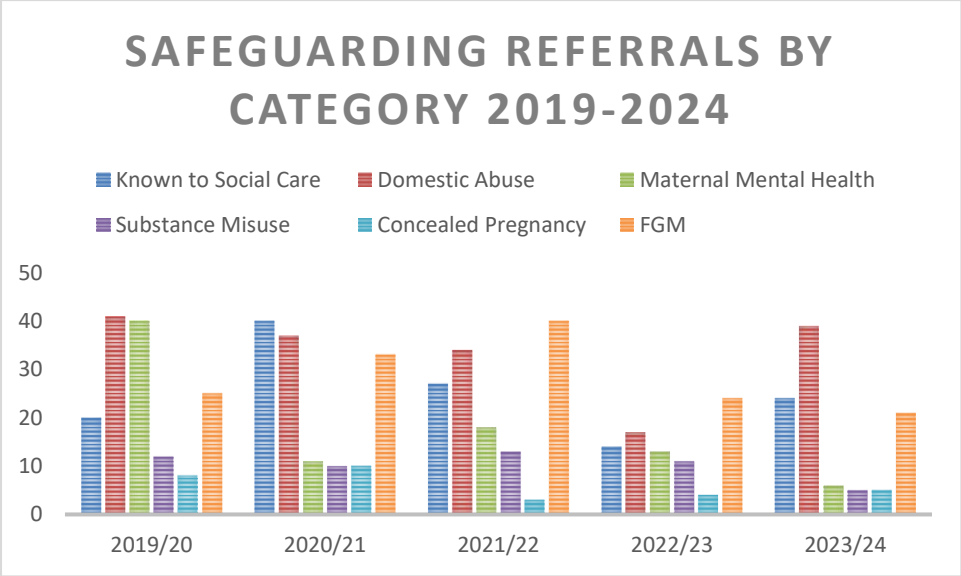
Supporting Vulnerable Families – Incident Reporting

Recognising potential safeguarding concerns and additional support requirements for families is a vital part of a midwife's role. Appropriate referral to other agencies, including Children's Social Care ensures an early response to risk assessment and meeting the needs of babies and families.

Number of Safeguarding Referrals – comparative data



There has been a slight increase in referrals in comparison to the previous two years, however, referral numbers have declined since before the Covid-19 Pandemic and during its height. An increase in referrals during the pandemic may have been due to women being seen on their own, away from partners, which could have increased disclosure of mental health, substance misuse and domestic abuse. Referrals for domestic abuse decreased significantly last year, and it is positive to see that identification and referrals have increased this year meaning women and unborn babies are more likely to receive the correct support. The data is reliant on midwives internally reporting their referrals via Datix. There is some evidence to suggest that this has not been happening. The Named Midwife has carried out awareness raising, training and supervision around the importance of submitting a Datix when making a safeguarding referral and as an immediate response the number of safeguarding referrals evidenced via Datix increased by 68%, with a significant increase in referrals for domestic abuse. This trend will continue to be monitored.



Safeguarding Dashboard

Mental Health and Substance Misuse are two of the trio of vulnerabilities which research evidence as being present in over 60% of child safeguarding practice reviews where children die or are seriously harmed as a result of abuse. The trend for reduction in referrals around maternal mental health and substance misuse over the last two years requires further exploration with the Specialist Vulnerability Midwives who support this cohort of women.

7.2 Training

Safeguarding training compliance has been below contractual standards throughout the year in maternity services. The Named Midwife commenced face to face hour long training sessions in the maternity mandatory days to support compliance. Midwives who were out of date with their training were targeted and allocated on to the level 3 safeguarding sessions by the professional development team. The 4-week intensive adult and children safeguarding level 3 courses during March also supported the increase in compliance.

7.3 Maternity Supervision

All midwives are required to receive safeguarding supervision. All Community Midwives and Specialist Vulnerability Midwives receive quarterly supervision with the Named Midwife on a 1 to 1 basis and all other midwives receive group supervision twice a year. Compliance for supervision has been a challenge due to ongoing capacity issues within the Maternity service. There have been some positive improvements towards the end of the year and the named midwife will continue to work with the senior leadership team to ensure compliance:

	Q1	Q2	Q3	Q4
Maternity	36%	48%	68%	79%
Community Midwives	84%	85%	50%	75%

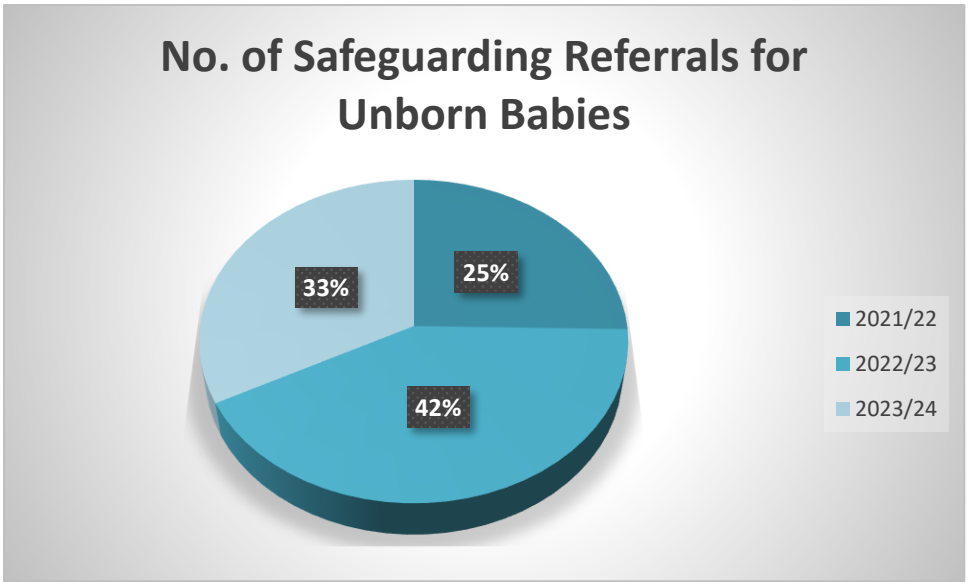
7.4 Unborn Baby Network

The Unborn Baby Network is a multi-agency forum to discuss child protection and safeguarding concerns and referrals for the unborn and new-born child. Its aim is to ensure:

- Good communication and information sharing between agencies
- That appropriate plans are in place to protect vulnerable women and children
- Safeguarding risks are assessed and reviewed, and action plans are implemented to reduce/ eliminate risk factors

The meeting which is chaired by the Named Midwife is held monthly within the Trust with representation from a range of partner agencies including mental health, social care and substance misuse services.

Referrals into Unborn Baby Network are received from a variety of health professionals, with the majority being received from Community Midwives.



During 2023-24 there has been a decrease in referrals to the network in comparison to last year but an increase in the number of referrals from midwives who are recognising the supportive element of the network in ensuring early help Is provided to families. Next year there will be a full review of the scope of the Unborn Baby Network, including criteria for referral, terms of reference and agreements around information sharing between agencies.

7.5 Information Sharing

In the year 2023/2024 there were a total of 5184 maternity bookings to DGFT. Of these, 1464 were bookings for women who lived outside of the Dudley borough representing 28% of the total, an increase of 4% compared to last year. For women who book at the Trust outside of the Dudley borough, the need for information sharing between the areas and the NHS providers is imperative.

The named midwife for safeguarding for the Trust attends fortnightly pre-birth meetings with Sandwell Children's Services to review individual child protection and child in need plans for unborn babies. This has ensured that appropriate multi-agency safety plans are in place before the birth of a child and has improved the co-ordinated response to the birth of a child who is deemed at risk of harm, ensuring parents are informed and prepared and that safe discharge plans are in place. The Named Midwife does not access any pre-birth meetings with Dudley Children's Services and therefore a system is in place to monitor the review of pre-birth plans for unborn babies residing in Dudley, which should take place at Child Protection Core Groups and Child in Need meetings. If there is evidence of drift or delay in pre-birth plans, the Named Midwife will escalate via the appropriate channels, seeking to secure improved information sharing with the Local Authority.

The sharing of information between Sandwell Children's Services and Dudley Group Maternity Services has made an improvement in reducing the barriers presented by working across geographical boundaries. An audit was carried out in Q4 which demonstrated that there has been an improvement in information sharing with Sandwell services although there were recommendations highlighted and shared with Midwives, for further improvement.

7.6 Maternity Safeguarding Case

The story has been shared for learning purposes internally but removed from this public facing document to protect patient confidentiality.

8.0 Child Death Review 2023/24

The collection and analysis of information about every child death is a statutory function and within the Black Country there is a Child Death Overview Panel (CDOP) which is responsible for ensuring the statutory functions are completed. This CDOP consists of paediatricians and professionals with a role that includes child death responsibilities.

The death of any child is a tragedy and deserves to be treated sensitively. Parents and carers will seek answers to why their child died which cannot always be provided but a review will be as thorough as it can be and involve those who knew the child and provided care prior to the death. In some circumstances the death is expected and in others it is not. Where a death is unexpected there is a Sudden Unexpected Death in Infancy or Childhood process to follow (SUDI/C), this requires a multi-agency joint agency response (JAR) with a health representative for advice and support and to assist with a home visit where needed.

The SUDI/C process is initiated when a death: -

- is sudden and there is no confirmed cause allowing a death certificate to be issued
- is, or could be, due to external causes
- occurs in custody or when detained under the Mental Health Act 2007
- occurs where the initial circumstances raise any suspicion that the death may not have been natural
- is that of a preterm infant who could have been born alive, regardless of the gestation, where no healthcare professional is in attendance.

The process is also started in part or fully when a child has collapsed but has successfully been resuscitated, for example a home visit may prove useful; especially where the child goes on to die sometime later.

8.1 Joint Agency Response for Unexpected Child Death

An unexpected death is defined as the death of a child that was not anticipated as a significant possibility 24 hours before their death or where there was a similarly unexpected collapse leading to or precipitating the events that led to the death.

Representation for Joint Agency Response (JAR) is provided by the Lead Nurse for Child Mortality or members of the Safeguarding Team and the Paediatrician on call. Provision is between 9 am -5 pm every day including Bank Holidays and weekends.

8.2 Number of deaths reviewed

Child Death Reviews within a CDOP should take place as soon as is practically possible, ideally within six months of the death, although this can be delayed due to: -

- serious incident investigations
- criminal proceedings
- coronial processes
- serious case reviews/child safeguarding practice reviews
- Length of time it takes to receive, Perinatal Mortality Review Tool (PMRT) reports and final post-mortem reports.

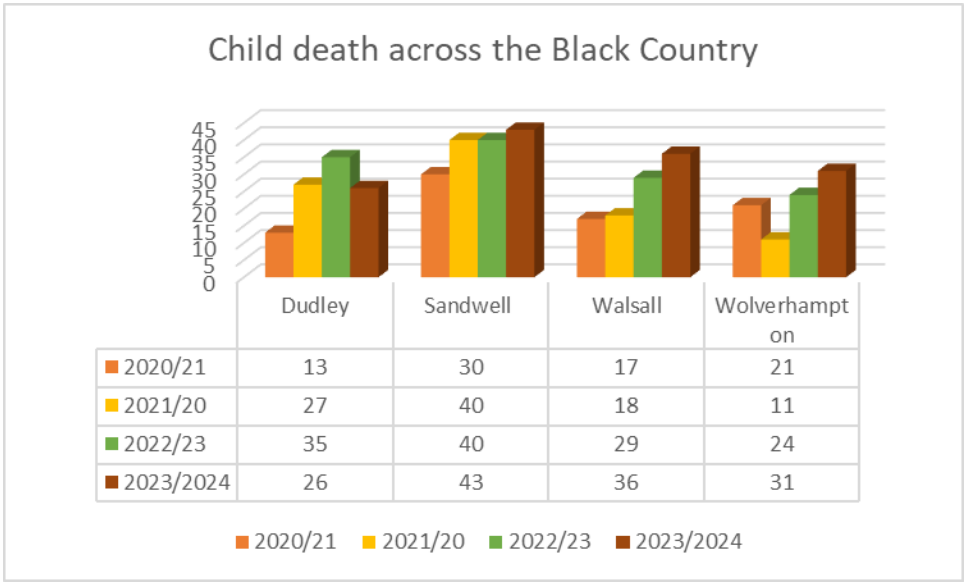
- Some deaths are submitted for HSIB review and cannot be reviewed until that has been completed,
- Where there is a complaint in progress it is usual to wait for the complaint to be completed before the CDOP review.

In 2023/24 there were 26 deaths, a decrease of 9 from the previous year. Dudley has 23 open cases being reviewed and have closed 37 cases in 12 months. Of the 23 that remain open: -

- 5 further cases with open police investigations.
- 2 Serious Incidents awaiting completion
- 4 cases remain with coroner
- 2 have safeguarding practice reviews
- 5 cases have exceeded the 6-month time frame due to delayed post-mortem (PM) / external PMRT reports
- 2 cases still have outstanding PMRT reports but remain within the 6-month timeframe
- 3 cases are relatively recent

8.3 The Dudley Child Mortality Team

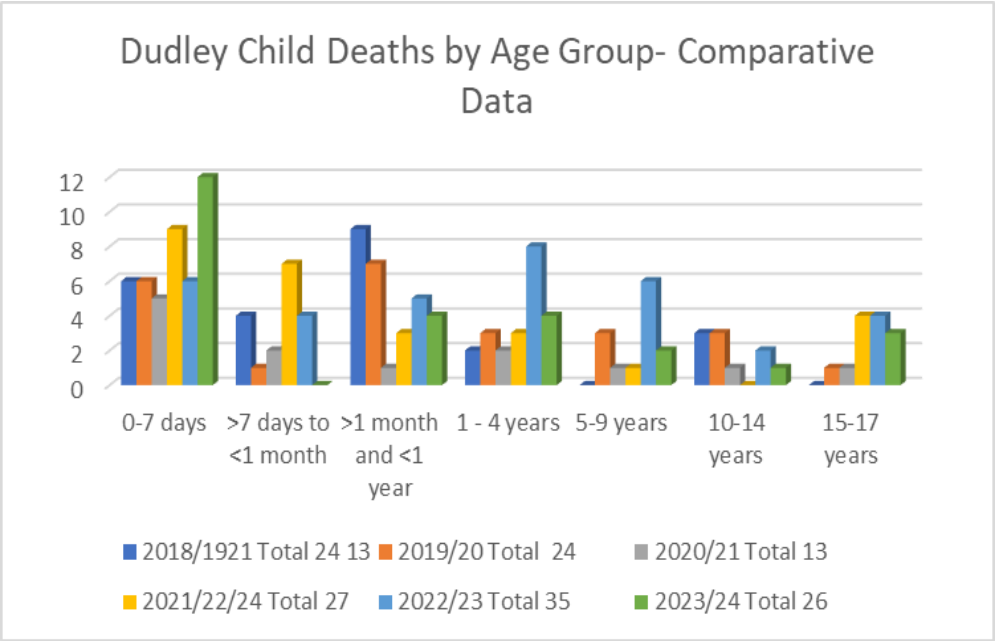
The lead professionals for the review of child mortality in Dudley are the Designated Doctor and the Lead Nurse for Child Mortality and are assisted by the Administrator for Child Protection and Child Death. The safeguarding team provide a 7 day a week on-call service in response to child deaths within the Dudley locality. These professionals handle the local response to child deaths, gathering information, reviewing cases through a Child Death Review Meeting (CDRM) prior to presenting cases to CDOP following which the information is submitted to the National Child Mortality Database. During this process trends in child deaths may be shown and lessons to be learned identified both locally and nationally. Being part of a Black Country wide group enables comparison with other local areas and access to an electronic system, eCDOP, which supports notification of deaths and collection of information.



	Dudley	Sandwell	Walsall	Wolverhampton
2020/21	13	30	17	21
2021/20	27	40	18	11
2022/23	35	40	29	24
2023/2024	26	43	36	31

Source: ECOP system

Dudley Child Deaths by Age Group 2018-2024

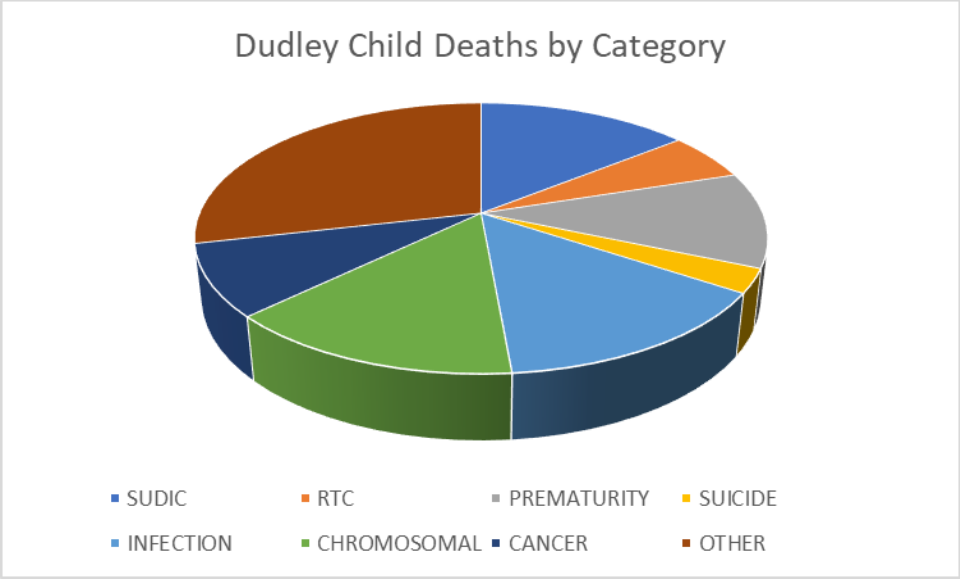


Source: ECOP system

Deaths of babies below 7 days of age have increased this year. It has been identified that of the 12 deaths in this age group all were below the 24 week gestational age, where there a significant incidence of early neonatal death due to complications of extreme prematurity. These cases mothers had spontaneously laboured and delivered despite medical intervention and active resuscitation where appropriate.

There have been no deaths in the age range 7 days to 1 month. Deaths in 1 year to 4 years have halved and deaths in the 5-to-9-year age have reduced by two thirds

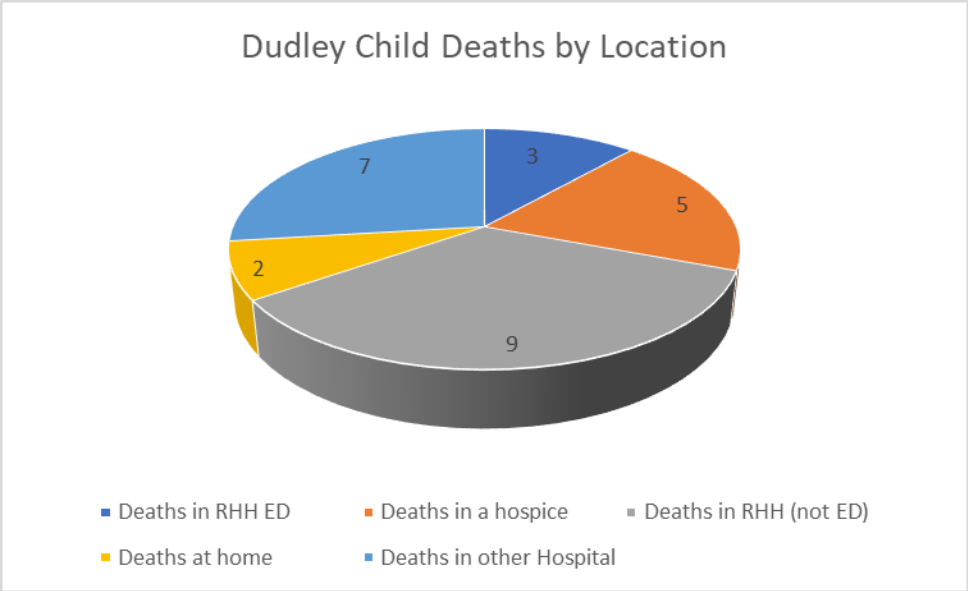
Dudley Child Deaths by Category



Source: ECOP system

Of the 26 deaths, 14 had an identified medical condition.

Dudley Child Deaths by Location



Source: ECOP system

SUDIC - Deaths of Children

During 2023-2024 there have been 6 deaths who have been subject to SUDI/C procedures.

- 2 infants died because of unsafe sleep practice
- 2 deaths were unexplained following postmortem
- 2 had underlying medical conditions

Learning themes identified through the child death review process have been:-

- Failure to adhere to 'Was not brought' guidelines resulting in missed opportunities
- Co-sleeping (some with a combination of mental health and substance misuse)
- Unknown males where the use of substances or mental health concerns have not been known
- Neonatal care – Missed opportunities in the first 24 hours of care, importance of clear, informed and prompt decisions about care, training for staff, importance of monitoring. Lack of leadership during neonatal resuscitation
- Paediatric Palliative care – inconsistent commissioning of services, importance of involving all professionals in a debrief, end of life care and Advanced Care Plans (ACP)

Staff Support

When a child death occurs, support is offered in the form of debrief sessions and these are available throughout the Trust. The Designated Consultant supplies feedback to medical colleagues through their regular departmental safeguarding meetings and attending other department meetings as requested. Supervision and debrief following deaths are provided by the Lead Nurse and Designated Consultant. The Chaplaincy team are also, available for support of staff and families.

9.0 Adult Safeguarding Activity 2022/23

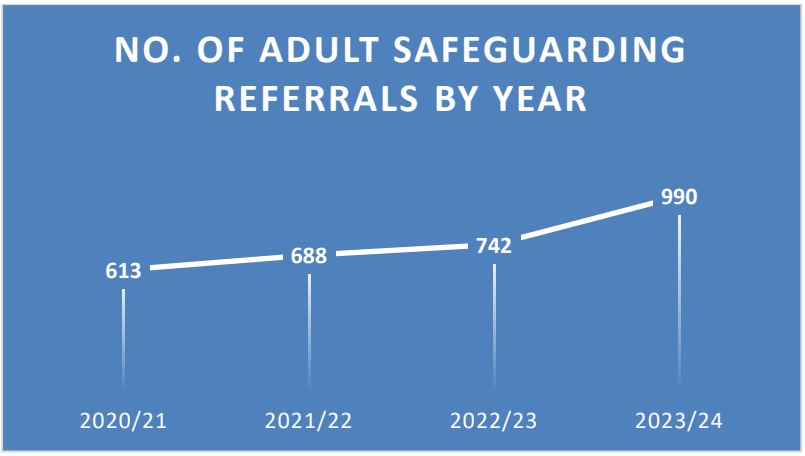
This year has again seen an increase on previous years in the number of safeguarding referrals, internal reporting of safeguarding concerns and completion of MASH questionnaires

Safeguarding Dashboard

Adult Safeguarding Referrals and Internal Reporting – Comparative Data

The chart below demonstrates the exponential growth of safeguarding referrals being made by Trust staff, with the number of referrals increased by 33% since last year.

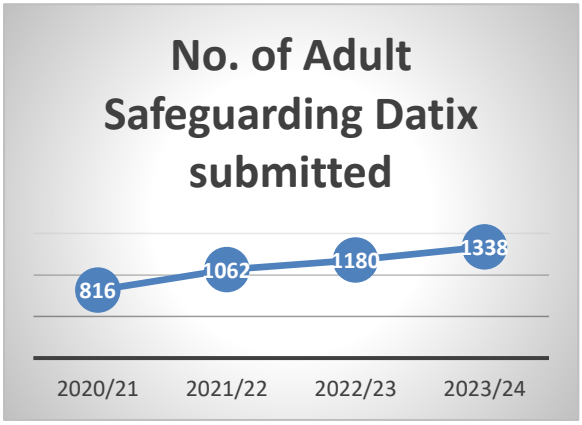
Safeguarding Adult Referrals



Source: Safeguarding Dashboard

Safeguarding Adults Internal Reporting

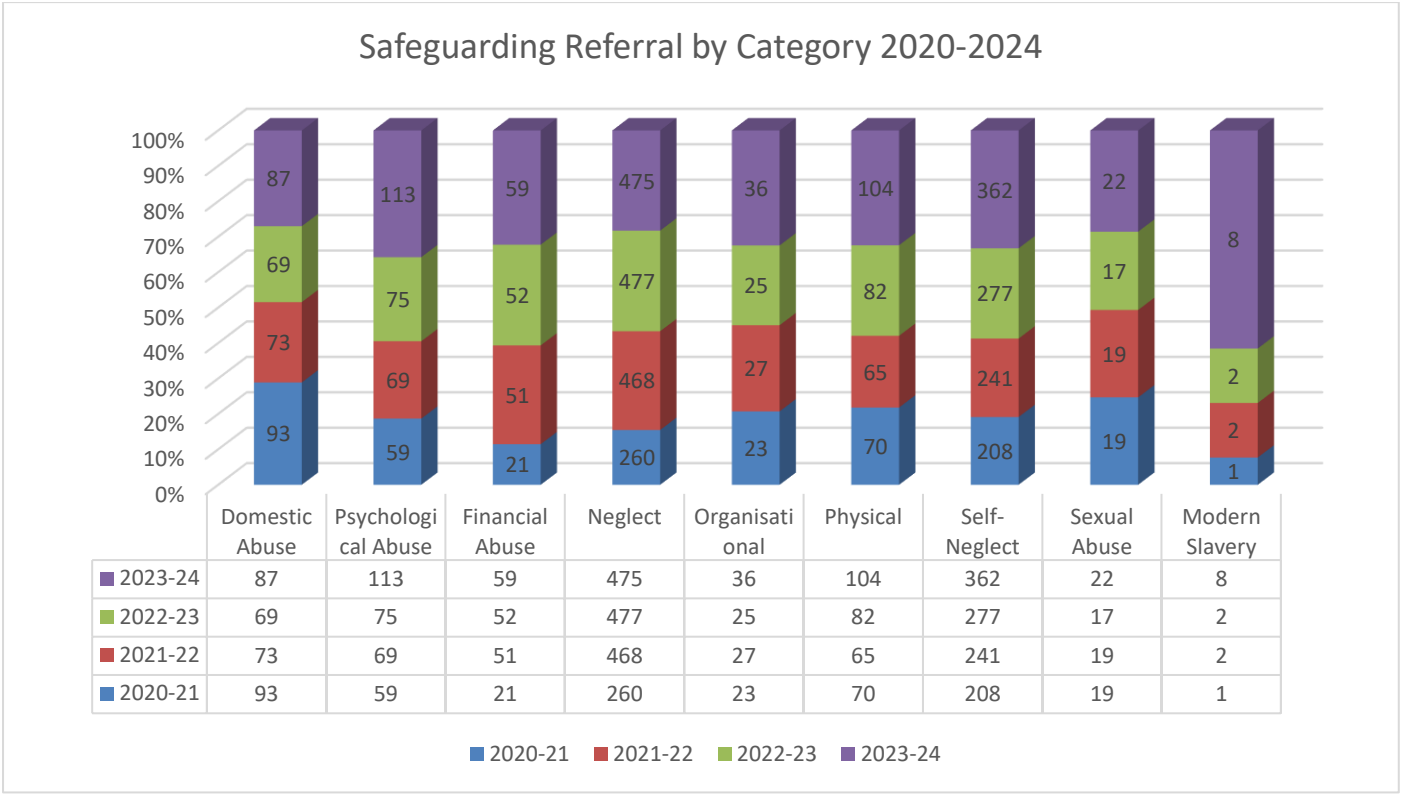
The numbers of adult safeguarding referrals alone do not give a complete picture of safeguarding activity in the Trust. Staff submit a Datix™ for all safeguarding concerns, whether they result in a safeguarding referral or not. Other risk management activities may take place in conjunction with the views and wishes of the patient that may prevent the need for a safeguarding referral to be made. Therefore, analysis of Datix reporting alongside the number of safeguarding referrals provides a more comprehensive view of safeguarding within the Trust and the level of response and scrutiny the safeguarding team will provide in ensuring all appropriate actions have been taken. The graph below shows the number of internal incidents submitted by year



Again, the number of safeguarding adult incidents reported have increased. They have more than doubled over the last 4 years and increased by 13% since last year. It is not just the quantity of referrals and incidents that have increased. The complexity of the safeguarding cases has also increased. Many patients experiencing abuse, experience multi-faceted categories of abuse that requires extensive liaison with other agencies, in-depth assessments around mental capacity alongside consideration of human rights, and comprehensive and dynamic risk management. The staff in the Trust often require the specialist knowledge of the safeguarding team to support them with this work. The capacity of the safeguarding team to meet the increased demand from the increased quantity and complexity of the work is challenging and can mean that the more proactive areas of work such as awareness raising, and visibility of the team is neglected.

Themes and Trends

The graph below demonstrates the most prevalent safeguarding categories that are reported via Datix™ from services across the Trust. The graph supports the narrative that the safeguarding work across the Trust is growing in number and complexity. Every category of abuse has seen an increase. Neglect and Self-Neglect continue to be the biggest reasons for safeguarding, and these are the cases that bring the most complexity to managing and negating risk. The safeguarding team have provided considerable support around these categories. Staff are also identifying the less visible categories of abuse such as psychological abuse and modern slavery. Referrals for psychological abuse has almost doubled over the last 4 years and increased by 50% since last year. Recognising psychological abuse requires staff to ask questions and observe interactions which can sometimes be subtle. This is a reassuring picture of staff employing critical thinking when caring for patients. This awareness is also demonstrated in the increase in referrals around modern slavery. This has increased by 75% since last year.



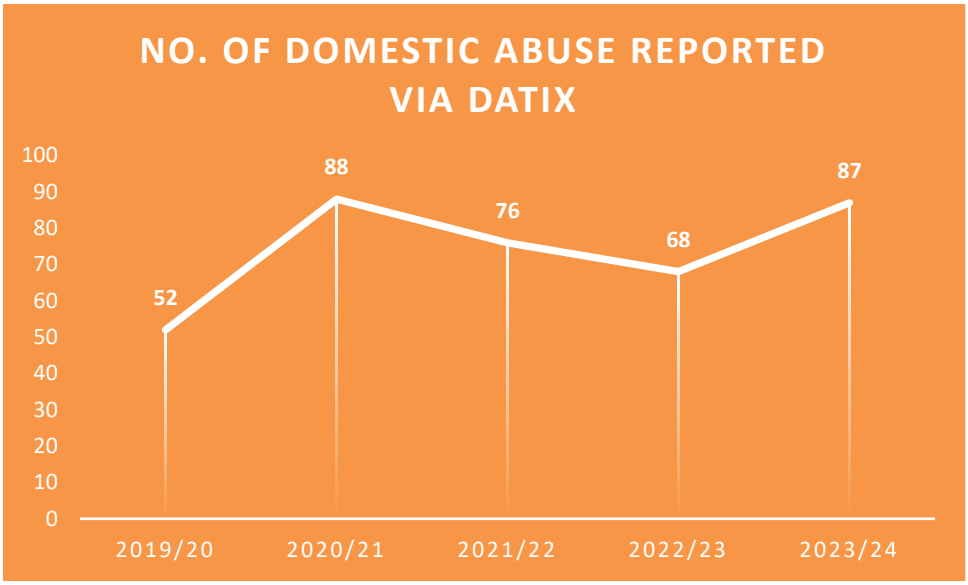
	Domestic Abuse	Psychological Abuse	Financial Abuse	Neglect	Organisational	Physical	Self-Neglect	Sexual Abuse	Modern Slavery
2023-24	87	113	59	475	36	104	362	22	8
2022-23	69	75	52	477	25	82	277	17	2
2021-22	73	69	51	468	27	65	241	19	2
2020-21	93	59	21	260	23	70	208	19	1

Domestic Abuse

"Domestic abuse is a public health epidemic and health must be part of the solution. We must meet victims where they are. We know four of five victims do not call the police. We have to go to them: where they feel supported, where they feel safe and free from stigma." Safe Lives: A Cry for Health, 2016

Domestic violence now has a statutory definition enshrined in the Domestic Abuse Act 2021 and increasing prominence in national and regional strategy. The Domestic Abuse Commissioner, Nicole Jacobs, has said that health must be central to strategic thinking, noting that health settings are trusted environments which can reach people "from every background and walk of life subjected to domestic abuse". It is therefore "critical" to ensure awareness about domestic abuse is embedded in the practices of all health settings.

Reporting



Reporting of domestic abuse via internal reporting increased by 28% from last year's data but the number of identified cases of domestic abuse are still extremely low considering that 1 in 4 women and 1 in 6 men are known to experience domestic abuse.

On average 250 patients attend the Trust Emergency Department each month due to mental health concerns. SafeLives, the UK-wide charity dedicated to ending domestic abuse, states that over 50% of victims report having mental health issues and that 7% of victims report that they have considered or attempted suicide as a result of the abuse, and 17% report self-harming. Considering these figures, it would be expected that staff would be identifying many more cases of domestic abuse. An audit undertaken this year, identified that where victims directly disclose that they are a victim of domestic abuse, staff act appropriately, referring to specialist support services. However, an increase in professional curiosity, and increased confident in direct questioning about domestic abuse is required to identify and support more victims.

Trust Independent Domestic Violence Advocate

The Independent Domestic Violence Advocate (IDVA) is based within the Emergency Department. They primarily see victims who present to the Emergency Department but will see anyone across the Trust who makes a disclosure if required. The IDVA provides specialist support to victims/survivors of domestic abuse which is tailored to their needs. They help with risk assessments, safety planning, referrals to MARAC and help to understand the criminal justice process. In 2023/24 the IDVA received 139 referrals from staff across the Trust, predominantly from the ED but also included self-referrals from staff and referrals from other wards and departments.

Staff as victims of Domestic Abuse

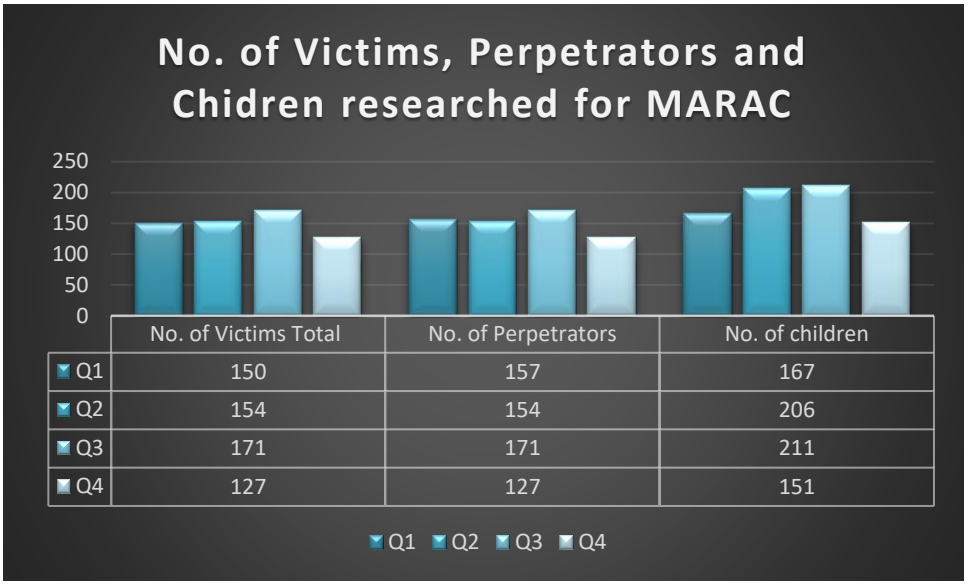
The safeguarding team also support line managers whose staff are disclosing to them that they are victims of domestic abuse. Anecdotally, these requests for support appear to increase each year. We do not currently hold data around this. However, a report by the Cavell Trust in 2016 revealed that nurses, midwives and healthcare assistants are three times more likely to have experienced domestic abuse by a partner or ex-partner in the last year than the average person. The Trust Workplace Domestic Abuse Policy has been updated and the safeguarding team work closely with Human Resources and the Trust IDVA to ensure staff are supported. This includes risk assessment of their work area and implementation of adjustments to ensure their safety whilst at work. This is in line with our responsibility as employers under the Domestic Abuse Act 2021.

Training

Domestic abuse training is within both level 2 and level 3 adults and children safeguarding training. Level 3 training now utilises a DHR as a learning case and the feedback from staff has been positive with some good examples given of how they will utilise their training in their practice.

Multi-Agency Risk Assessment Conference (MARAC)

MARAC is a local, multi-agency victim-focused meeting where information is shared on the highest risk cases of domestic violence and abuse between different statutory and voluntary sector agencies. MARAC is held twice monthly, and the safeguarding team undertake research on the victims, perpetrators and children heard at each meeting to support the multi-agency risk assessment.



The preparation and research for these meeting requires a significant amount of named nurse time. On average the team research 162 patients each month, 38 patients each week to provide information to MARAC. Whilst not all patients are known to the Trust, many are, and the research takes at least 7.5 hours of named nurse time every fortnight. The pressure of this workload has been raised during the Safeguarding Quarterly Review Meetings with the BCICB.

Section 42/Enquiry Requests

The Care Act 2014 (Section 42), Care & Support Statutory Guidance Chapter 14 and the Adult Safeguarding Multi-Agency Policy and Procedures for the Protection of Adults with Care and Support Needs state that a local authority can ask any agency to undertake a Safeguarding Adults Enquiry – Section 42/Other Enquiry – on its behalf. The local authority and other partners must co-operate with each other to ensure the effective safeguarding of the adult experiencing or at risk of abuse or neglect.

The table below indicates how many Enquiries the Trust has been asked to complete in respect of care provided to patients, for the period 2019 to 2024. There has been an increase of 28% in Section 42 enquiries involving the Trust this year compared to last year.

Safeguarding Enquiries completed by Trust 2019-2023

Month	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	TOTAL
2019/20	1	2	1	0	2	2	0	1	1	1	1	0	12
2020/21	2	0	1	4	1	2	0	5	2	1	0	0	18
2021/22	0	3	4	1	1	0	3	2	1	4	8	3	30
2022/23	2	2	0	1	2	0	1	3	2	3	5	0	21
2023/24	1	3	5	4	0	3	2	1	2	4	2	0	27

Categories of concerns

	2021/22	2022/23	2023/24
Pressure area care	7	2	4
Discharge	9	10	11
Neglect (not PU or Discharge)	9	5	10

Sexual	0	1	2
Physical	3	3	1

The increase in this year's number of Section 42 Enquiries comes from an increase in concerns around allegations of neglect by the Trust.

Themes within these categories:

- Poor documentation
- Not completing body map on discharge
- Equipment not in place on discharge
- Communication
- Checking and understanding safeguarding flags/alerts for new and junior staff
- Identification and classification of wounds
- Mental Capacity Assessments

Physical Abuse
This allegation came 2 months after the patient had left the hospital. The patient had a diagnosis of dementia. They were unable to give specific details, including dates or names/descriptions of staff. There were no physical signs of assault on the patient from the body map completed on the ward during her stay or on discharge. There was no evidence available to uphold the allegation. The Managing Allegations Against Staff Policy was followed.

Sexual Abuse
Both allegations were unsubstantiated due to lack of identification of a potential perpetrator of the abuse. Statements were taken from staff, CCTV recordings checked, notes reviewed for both cases but there was no evidence of the assaults. Police were informed and investigated in both cases and the Managing Allegations Against Staff Policy was followed.

Hospital Acquired Pressure Ulcers
The Safeguarding Team are a core member of the Pressure Ulcer Scrutiny group. This has enabled independent scrutiny of the level of investigation of hospital and community caseload acquired pressure ulcers. Following the establishment of this scrutiny group, the Safeguarding Team have been able to provide assurances to the Local Authority regarding the scrutiny and quality of internal investigation when a safeguarding has been raised by external agencies in relation to a pressure ulcer that has developed in Trust.

Unsafe Discharges
This remains the highest category of concern. Enquiries have been investigated by the Trust and there is a pattern of poor communication, documentation, and information sharing. Concerns around discharges received via Section 42 enquiries are shared with the relevant matrons for oversight and action. Where there has been identification of a "hot spot" for poor discharges, the safeguarding team have worked with the Matrons and Lead Nurses to address the concerns.

Neglect
Of the 10 cases of concerns re neglect/acts of omission, 3 of these were not upheld and no learning identified for the Trust. The remaining 7 cases identified the following learning:

- Risk assessing patients at risk of self-harming in ED
- Earlier recognition of deprivation of liberty
- Improved communication with relatives
- Use of body maps on discharge
- Improved recognition and referral of self-neglect
- Ensuring referrals to district nurses
- Ensuring hygiene needs are met prior to discharge

- Ensuring oral hydration
- Completion of bowel charts

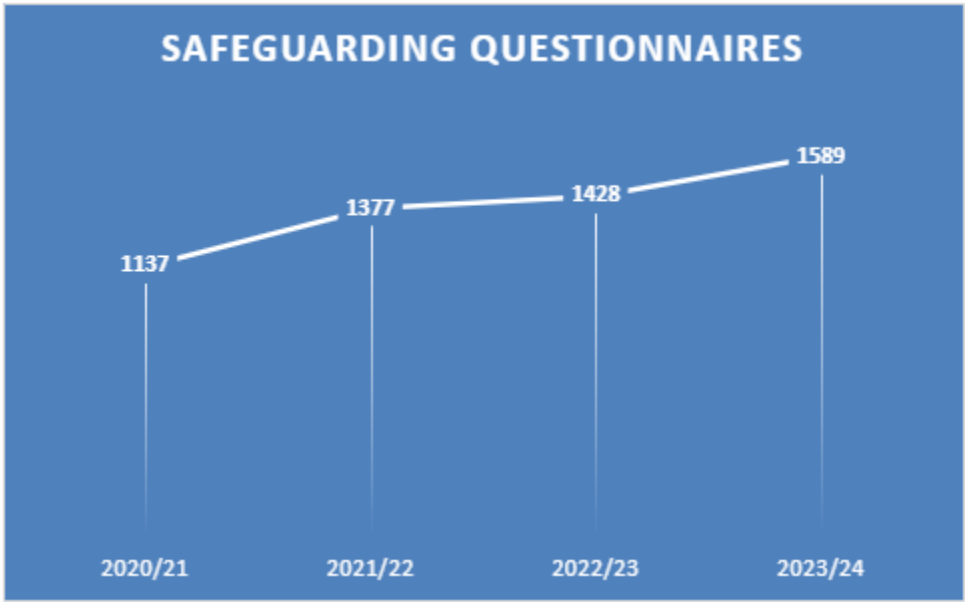
All actions to address learning have been completed. All Section 42 enquiries are monitored via the Trust internal reporting system and reported to the Trust Internal Safeguarding Board

Multi-Agency Adult Safeguarding Hub (MASH) Questionnaires

MASH electronic questionnaires are sent out to Partner Agencies who do not have a 'physical' presence in the Hub. The questionnaire is a means of gathering information to inform the local authority whether a safeguarding concern meets the threshold for a Planning meeting and/or an investigation is required.

Questionnaires are RAG rated in the MASH based on the level of concern and perceived risk to a person.

RED	-	4 working hour response – immediate/substantial risk identified
AMBER	-	8 working hour response – potential section 42 enquiries where further information is required from partners to accurately determine level of risk
GREEN	-	72 hour response – non section 42 "other" enquiries where low/managed risk is identified



No. of MASH questionnaires – comparative data

The table above shows the continuing increase year on year of MASH questionnaires that the Trust safeguarding Team must respond to.

The number of adult safeguarding questionnaires requiring completion has risen exponentially by 30% in the last 4 years and by 11% in the last year. Whilst some questionnaires are relatively quick to complete, some can take significantly longer. The essence of the MASH questionnaire is to support the local authority in deciding whether a referral reaches the threshold for a safeguarding enquiry. However, increasingly, the information being requested by the local authority is becoming more complex. Many questionnaires are taking approximately 40 minutes to complete, some longer. This means that 3 days per week is taken by completing safeguarding questionnaires which is a significant demand on the capacity of the safeguarding adult team and leaves limited time for proactive work and supporting teams and departments to embed learning. Concerns around the level of information sharing the local authority are requesting has been escalated to the ICB who are reviewing the process.

Safeguarding Adult Reviews (SARs)

The Care Act 2014 (section 44) requires Safeguarding Adults Boards to arrange Safeguarding Adults Reviews (previously known as Serious Case Reviews) if there are concerns that agencies could have worked more effectively to protect an adult from serious harm or abuse; whether the adult has died or not.

The purpose of a Safeguarding Adults Review is to establish whether lessons can be learnt from the circumstances of a case that may improve practice or the way in which agencies and professionals work together to safeguard vulnerable adults.

There are currently 8 open SARs which the Trust are participating in, 5 of these are SARs opened during this current year.

During 2023/22 The DSPP have published 1 SAR. The learning themes for the Trust are: -

Theme	Recommendation
High-Intensity Users	The Trust are required to establish policy and process to manage and respond to the associated risks posed to "High Incident" users of its emergency departments

Action Taken

A High Intensity User is someone who presents multiple times to ED with issues that do not require medical treatment, or could be treated elsewhere and are often concerns such as mental health conditions, health anxiety, substance misuse, isolation, potential self-neglect or domestic abuse and often they are people will have a distrust of professionals and not engage with support services.

Partnership Working

Integrated Plus is a social prescribing support service delivered by Dudley CVS and funded by Dudley Clinical Commissioning Group as part of Dudley's integrated care model.

Integrated Plus provide 2 key workers to support and manage HIUs attending ED in the Trust. They provide holistic, non-medical support to people aged 16 years and over, supporting them to become less reliant on medical services and encourage them to connect with wellbeing services and activities in the community.

The service coordinates the referrals that come through to them, lead on the monthly core group meetings and provide support to the Trust HIUs. Each worker carries a caseload of approximately 20 patients each

The criteria for referral to Integrated Plus is 5 attendances to ED in 3 months where there was no requirement for medical intervention.

Identification

- The Trust now employ 2 In-Reach Care Co-ordinators who identify HIUs via a list generated daily from ED attendances and which is reviewed by the In-Reach Care Coordinators each day
- Patients must be 18-75 years of age and be registered with a Dudley GP
- Information on HIUs is shared by the In-Reach Coordinators with the Trust Safeguarding Team for cross referencing.

Risk Management and Referrals

- A monthly core group meeting is held at the Trust, chaired by Integrated Plus
- The Core Group is attended by local agencies included police, the Trust safeguarding Team, Substance Misuse Services, Homeless Team.
- The Group share information around the HIU which aids risk assessments and decisions on

appropriateness of Integrated Plus to approach and offer support

- There are separate meetings held to discuss complex and high-risk cases
- Integrated Plus will share progress of work with HIUs on their caseload and shared decision making and management plans will be completed

Communication

- Following each Core Group, the In-Reach Coordinators will update the patient records and share relevant information with the Community Partnership Care Coordinators across the 6 PCNs covering Dudley and work to ensure a joined-up approach for HIUs between GPs, Community Services and GPs.

Domestic Homicide Reviews (DHR)

The purpose of a Domestic Homicide Review is to establish what lessons are to be learnt from a domestic homicide regarding the way in which local professionals and organisations work individually and together to safeguard victims.

There are 5 ongoing DHRs that the Trust is currently contributing towards, one is currently on hold due to parallel investigation and 4 are new DHRs this year.

Emerging Themes

The 4 new DHRs are in relation to completed suicides where there is a long history of domestic abuse.

Good Practice Identified

There has been no identified learning for the Trust and the initial scoping information provided has evidenced good practice.

- Referrals made to the ED IDVA
- Safeguarding adult referrals completed
- 'Think Family' approach was utilised and safeguarding referrals were completed for the children in the family
- Mental health assessments completed
- Referrals offered for substance misuse/alcohol services

Adult Safeguarding Patient Story

The story has been shared for learning purposes internally but removed from this public facing document to protect patient confidentiality.

10.0 Person in Position of Trust (PiPoT)

The PiPoT framework and process applies to concerns and allegations about:

- a person who works with adults with care and support needs in a position of trust, whether an employee, volunteer, or student (paid or unpaid); and
- where those concerns or allegations indicate the person in a position of trust poses a risk of harm to adults with care and support needs.

These concerns or allegations could include, for example, that the person in a position of trust has:

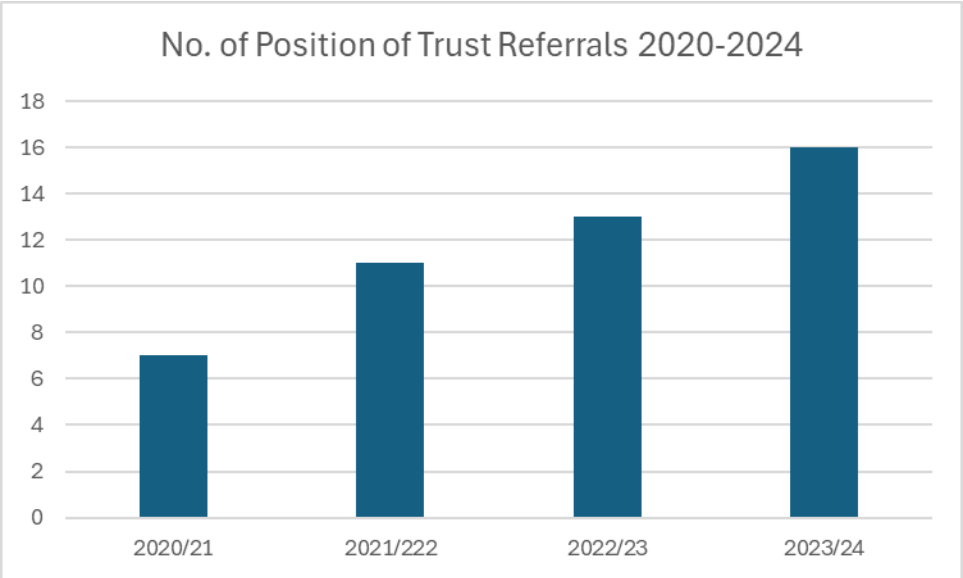
- behaved in a way that has harmed or may have harmed an adult or child.
- possibly committed a criminal offence against, or related to, an adult or child.
- Behaved towards an adult or child in a way that indicates they may pose a risk of harm to adults with care and support needs.

Number of Position of Trust referrals made to the Local Authority

Managing safeguarding allegations against staff working with children and adults with care needs is required under the Children Act (1989/2004) and the Care Act (2014). Working Together to Safeguard Children and Young People (2015) and the Safeguarding Accountability and Assurance Framework (2019) set out expectations that all statutory organisations will have a procedure for managing allegations against staff

Where an allegation is made against a member of staff, the Trust follow the Managing Allegations Against Staff Policy which is informed by the West Midlands Adult Position of Trust Framework and Local Authority Designated Office (LADO) Procedures.

Since the introduction of the Managing Allegations Policy in 2020 the number of referrals has increased by 56%



- 1 referral was in respect of allegations of abuse against children, the remaining referrals were in respect of allegations of abuse against adults
- 2 referrals were in relation to staff activities outside of the workplace
- 1 case was referred to the staff member's professional body
- 5 allegations were not upheld
- 3 cases were unsubstantiated
- 1 bank staff member dismissed
- 1 substantive staff member has been moved to non-patient facing role
- 1 staff member received a written warning
- 1 DBS referral made

The Managing Allegations against Staff Policy has been reviewed and updated. A Decision-Making Group (DMG) has been introduced to tighten governance and actions around managing allegations. A DMG is initiated at the outset of the allegation. This is chaired by the Divisional Chief Nurse/AHP responsible for the staff member and is attended by HR, the Head of Safeguarding and other relevant staff. Information regarding the allegation is bought to the meeting and decision are made on actions to be taken. This has proved an effective way of overseeing allegations and ensuring robust risk assessment and decision making.

In all the above cases, investigations were undertaken in line with Trust procedures, referrals were made to appropriate partner agencies and steps taken in line with guidance from the Dudley Safeguarding People's Partnership to ensure the immediate and ongoing safety of patients, staff, visitors and the wider public. The Head of Safeguarding works closely with Human Resources and the Chief Nurse/Divisional Chief Nurses to ensure all appropriate investigations and assessments are completed.

11.0 The Counter Terrorism and Security Act 2015

The Trust recognises that all members of staff have a duty under the Counter Terrorism and Security Act (2015) to have due regard to the need to prevent people being drawn into terrorism and to act positively to report concerns.

11.1 Prevent Activity 2024-24

There has been 1 Prevent referral this year relating to a person voicing a desire to take revenge on the police and who was known to be a victim of exploitation. A referral was completed by the Safeguarding Team as per local policy to the local Counter Terrorism Unit. There has been no feedback to date

The Named Nurse for Safeguarding Adults is the Prevent Lead with Deputy Chief of Operations being Executive Lead. The safeguarding team attend the Dudley Prevent Delivery Group and receive Local intelligence from the Counter Terrorism Unit Officer via the Safe and Sound community forum. Local mandatory training is updated as required to reflect new information.

12.0 Conclusion

This year has continued to see a rise in both the number and complexity of safeguarding work for children, adults, and unborn babies. The safeguarding team strive to provide a supportive and responsive service to support staff in fulfilling their safeguarding responsibilities. The Safeguarding Children team have a daily presence in Paediatric ED and on the Children's Ward. This supports proactive work with opportunities to provide ad hoc supervision, teaching and role-modelling. There is more work to be done around ensuring staff on adult wards, caring for 16 and 17 year olds, understand the safeguarding children agenda and are equipped to identify and support young people at risk of or experiencing abuse. Safeguarding of unborn babies is a priority for the Named Midwife, but the pressures facing community midwives due to recruitment issues, provides challenges in ensuring these cases have the appropriate management and oversight. This is an acknowledged risk by the Head of Maternity Services and is evidenced on their local risk register.

The adult safeguarding team have a wider footprint to cover in terms of visibility in the hospital and community. The year-on-year increase in the number of referrals demonstrates that staff recognise and act on their safeguarding concerns, but it is the complexity of these cases that provide the biggest challenge for the safeguarding team. Patients are presenting with multi-faceted categories of abuse which require intense and prolonged periods of multi-agency work and risk assessment. Coupled with the increase in demand and expected detail of information sharing around safeguarding MASH questionnaires, the safeguarding team struggle to undertake more proactive actions and service development is negatively affected.

The safeguarding team continue to work closely with their colleagues in the Complex Vulnerability Team as many patients at risk of abuse have additional vulnerabilities associated with capacity issues such as learning disabilities and dementia. The integrated team work together to resolve complex safeguarding and vulnerability issues providing a co-ordinated and collective approach to offer protection from harm and abuse.

12.1 Key objectives for 2024-2025

Areas for focus and improvements	How?
Increase visibility and proactive work of the safeguarding team	Review safeguarding workstreams, roles and responsibilities Complete a "Stop, Start, Continue" review Work with partners to streamline MASH lateral checks Develop a programme of awareness raising events and quality review visits to the wards and departments
Ensuring a skilled and competent workforce	Work with Black Country Partners to review and align safeguarding training and consider collaborative and consistent approach to training across the system. Use of role modelling, supervision, incident feedback and awareness raising events to supplement training opportunities
Managing complex safeguarding cases where patients are subject to multiple categories of abuse which impact on a person's ability to stay safe from abuse and neglect.	Work in partnership with staff to develop pathways and processes that support critical analysis, assessment and management of risk, understanding the impact of trauma on behaviours and the use of legal frameworks to uphold human rights.
Support identification of hidden harm	Support staff to question and challenge assumptions, and enable difficult conversations about abuse across the lifespan
Evidence learning from internal and external reviews	Maintain a highly visible and proactive safeguarding service which seeks to engage with Divisional leadership teams in methods to improve the sharing of learning and monitoring of how learning is embedded and impacting on patient care

The Dudley Group
NHS Foundation Trust

Complex Vulnerabilities Annual Report 2023-2024

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1.0 Forward

The Dudley Group NHS Foundation Trust is committed to ensuring that Patients with Complex Vulnerabilities receive the additional support they require throughout their patient journey, ensuring that they feel safe, listened to, and have confidence in the knowledge and skills of our staff. The Trust supports highly challenging and complex cases, including assessing mental capacity of the patient concerned to make best interest decisions about their care, treatment and safe discharge whilst ensuring least restrictive interventions are maintained throughout. The Team is committed to ensuring that all services are equally accessible to everyone.

The Complex Vulnerabilities Team has a shared vision to support the needs and best interests of the patients, with co-production at its core to support high quality delivery and improvements. The team provide specialist and expert training, advice, support, and supervision to all Trust employees to enable them to fulfil their statutory responsibilities and provide high quality care.

Every adult, whatever their disability, has the right to make their own decisions wherever possible. People should always support a person to make their own decisions if they can - MCA (2005)

2.0 Introduction

This is the second annual report for the newly integrated Complex Vulnerabilities Team, for Dudley Group NHS Foundation Trust which focuses on the period April 2023 to March 2024. It highlights some of our key achievements, giving us the opportunity to reflect on some of our challenges, looking at our ambitions for the future and ensuring the Trust are in line with key statutory requirements:

- The Equality Act (2010)
- Care Act 2014
- The Mental Health Act 1983
- The Human Rights Act 1998
- The Mental Capacity Act 2005 (amendment 2019)

In addition, the Trust, as a registered provider with the Care Quality Commission (CQC), must have regard for the Regulations as established under the Health and Social Care Act (2008). In relation to providing a regulated activity, this includes the assessment or medical treatment for persons detained under the Mental Health Act 1983.

The report provides an overview of the key priorities and activity as well as areas requiring further focus and development to strengthen processes. This is to ensure the Trust is working within legal frameworks to protect against harm and abuse, and ensure vulnerable patients are supported with decision making. This annual report will provide oversight of the key themes and work streams around the Mental Health Act 1983 and the Mental Capacity Act 2005.

3.0 National Guidance and Key Legislation

People with Complex Vulnerabilities are at greater risk of experiencing worsening physical health alongside mental health conditions. Evidence supports that people with a Learning Disability have considerable and often multiple, physical, and mental health conditions and experience high levels of health inequalities. As a Trust we have also identified how the Covid- pandemic has had an impact on the mental health of children and young people and are working in partnership with local Mental Health trusts to bridge the gap between services. Alongside this the Trust have recognised the unprecedented demand on services and the increase in attendance at Emergency departments for patients with a Mental Health Concern.

3.1 Key Legislation

- Childrens Act 1989
- Human Rights Act 1998 (Article 5- Right to liberty and security, Article 8 - Respect for private and family life, Article 14- Prohibition of Discrimination)
- Childrens Act 2004
- Mental Health Act 1983
- Mental Capacity 2005 and Mental Capacity Amendment Act 2019
- Health and Social Care Act 2008
- Deprivation of Liberty Safeguards 2009
- Care Act 2014
- Autism Act 2009

3.2 National Guidance

- The Learning Disability improvement standards for NHS Trusts
- Royal College of Emergency Medicine:
  Mental Health in the ED
  The patient who absconds guideline
- Achieving Better Access to 24/7 Urgent and Mental Health Care
- The Dementia Care Pathway
- Care quality commission (CQC) Guide to Assessing Mental Health Care in the Emergency Department.
- Care Quality Commission Monitoring the Mental Health Act 2022/2023
- Care Quality Commission: Care of children in unsuitable hospital settings
- Healthcare for All 2008
- Meeting the health needs for people with Learning Disabilities (2011)
- NICE guideline NG97: Dementia: Assessment, management and support for people living with dementia and their carers (2018)
- NICE guideline CG103: Delirium: prevention, diagnosis and management in hospital and long-term care (2010)
- NICE guideline (NG10): Violence and aggression: short-term management in mental health, health and community settings (2015)
- NICE (NG96): Care and support of people growing older with learning disabilities (2018)

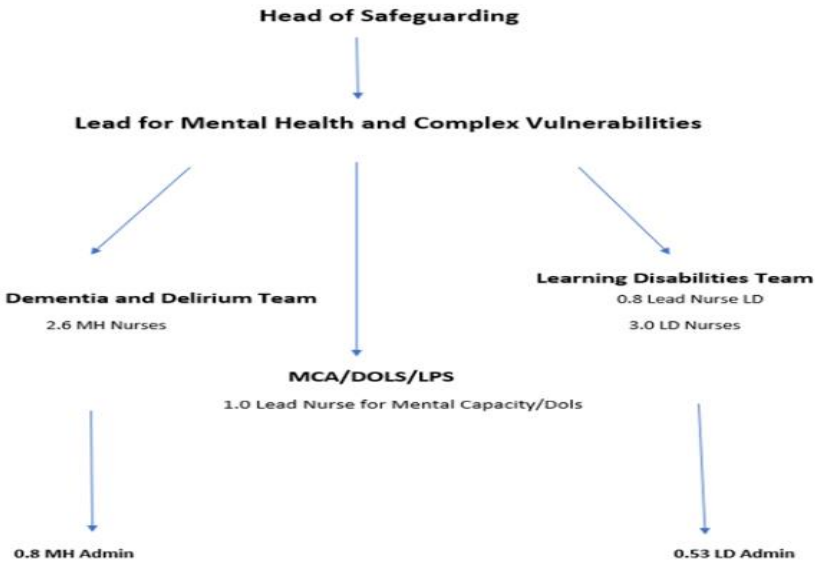
4.0 The Dudley Group NHS Foundation Trust Complex Vulnerabilities Team

The Complex Vulnerabilities team is an integration of the Dementia and Delirium and Learning Disabilities teams. It includes the Trust Lead Nurse for the Mental Capacity Act. This integrated team recognises the additional vulnerabilities of this group of people and the frequent overlap of mental health, learning disabilities and mental capacity issues. The Complex Vulnerabilities Team was developed in 2022/2023 and functions as part of the Trust Safeguarding Team, collaborating closely with the safeguarding nurses. Governance and monitoring are provided by the Trust Internal Safeguarding Board (ISB).

The specialist Dementia and Delirium Team, work 5 days per week and focuses on supporting patients with Dementia and Delirium. The team assists in recognising and identifying early diagnosis for patients with cognitive concerns and referring for further follow-up on discharge. The team supports the wards in recognising and managing restrictive practices, including quality assuring Deprivation of Liberty Safeguards (DoLS) applications and submission to the Local Authority. The team supports and advises family and carers of patients who have a diagnosis of dementia/cognitive deficits and supports the wards concerning management of behaviours that challenge for patients with dementia and delirium. The team also maintains an oversight of mental health activity within the Trust.

The Dementia and Delirium team work closely with the Black Country Healthcare NHS Trust (BCH) Mental Health Liaison Service (MHLS) to improve care delivery and ensure clearly defined roles and responsibilities. MHLS provides support for patients under 65 within their core 24 service, all referrals for patients over 65 with a functional Mental Illness are also referred to MHLS. The Dementia and Delirium team is the first point of call for patients with complex vulnerabilities, such as Dementia, Delirium, Korsakoff's and behaviours that challenge to offer support and advice.

4.1 Team Structure



4.2 Dementia and Delirium Team

The team consists of 2.6 wte Registered Mental Health Nurses (RMN) over a 5-day period. There have been longstanding recruitment challenges in the team, resulting in the service not being fully staffed since Q4 of 2022. The lead for Mental Health has supported with cover but this impacts on the priorities for this role. Due to the Dementia and Delirium Team not having the resources to provide the right support to this client group, this has been placed on the Trust Risk Register.

There has been interim support by a Registered General Nurse who has experience with working with people with Dementia and colleagues that that have left the team working bank shifts to maximise service cover, but this has not been sustainable.

The Lead for Mental Health and Complex Vulnerabilities supports the operational, clinical, and strategic role for Mental Health within the Trust. Capacity and workload are affected due to support that is required as the subject matter expert for the Trust, along with managing the operational issues within the team.

The Trust has agreed a proposal for an Admiral Nurse to be recruited into the Dementia and Delirium Team. The post will be supported by Dementia UK. This will provide leadership and expertise within the team to support their role in delivering a dementia and delirium service based on best practice. The team are also considering alternative resources to replace the longstanding vacancy of a 0.6 wte band 6 Registered Nurse.

4.3 Learning Disabilities Team

The provision in Trust of one specialist Nurse Band 7 for people with a learning disability was implemented in July 2013 and developed in 2019 with an additional two Band 6 registered learning disability nurses and a part time clerical officer. In 2022 an additional part time post was established with the additional expectation of establishing a pathway to support autistic people in Trust.

The Trust continue to celebrate that the Trust are above the national average for nursing staff working within the learning disability team, with the employment of four registered learning disability nurses whose role is to address the identified health care needs of people with a learning disability. As the Trusts provision includes working with children, this provides patients and their families with reassurance when they attend hospital and when transitioning into adult healthcare services.

5.0 Governance

The Complex Vulnerabilities team is led by the Lead for Mental Health and Complex Vulnerabilities with oversight from the Head of Safeguarding. The Deputy Chief Nurse holds the services within the Complex Vulnerabilities within their portfolio, and the Chief Nurse provides Board oversight as the Executive Lead. The Trust oversees the governance arrangements through the quarterly Internal Safeguarding Board (ISB), which is chaired by the Chief Nurse. Following review by the newly appointed Chief Nurse, the Safeguarding Board will be held bi-monthly. The ISB gains assurance on behalf of the Trust Board that it's legal and statutory duties are met in relation to monitoring of the Mental Health Act, Deprivation of Liberty Safeguards, and restrictive interventions. Areas for escalation from the ISB are reported to the Trust Quality Committee.

6.0 Mental Health

The mental health needs of patients who are treated for emergency or elective treatment of physical health conditions, within Dudley Group must always be taken into consideration. All staff must ensure patients are treated lawfully when subject to the Mental Health Act 1983. The Mental Health Act 1983 (MHA) sets out the duties and powers that detaining authorities have regarding the assessment and treatment of people with a Mental Health Disorder.

The main purpose of the Mental Health Act is to allow compulsory action to be taken where necessary to ensure that people with mental health problems receive the care and treatment they need for their own health and safety and for the protection of other people. The MHA Code of Practice 1983 identifies standards that mental health service providers should meet when they perform their responsibilities under the Act.

6.1 Monitoring of the Mental Health Act

The Trust is registered with the Care Quality Commission (CQC) to provide regulated activity. This includes the assessment or medical treatment for persons detained under the Mental Health Act 1983. To ensure compliance, there needs to be clear governance processes for the administration of all Mental Health Act paperwork. The CQC notes the administration of paperwork in relation to the MHA is usually conducted by the Mental Health Trust, via a service level agreement. This allows for the more complex elements such as Managers Hearings and Tribunals in relation to patients appealing against their detention to be supported.

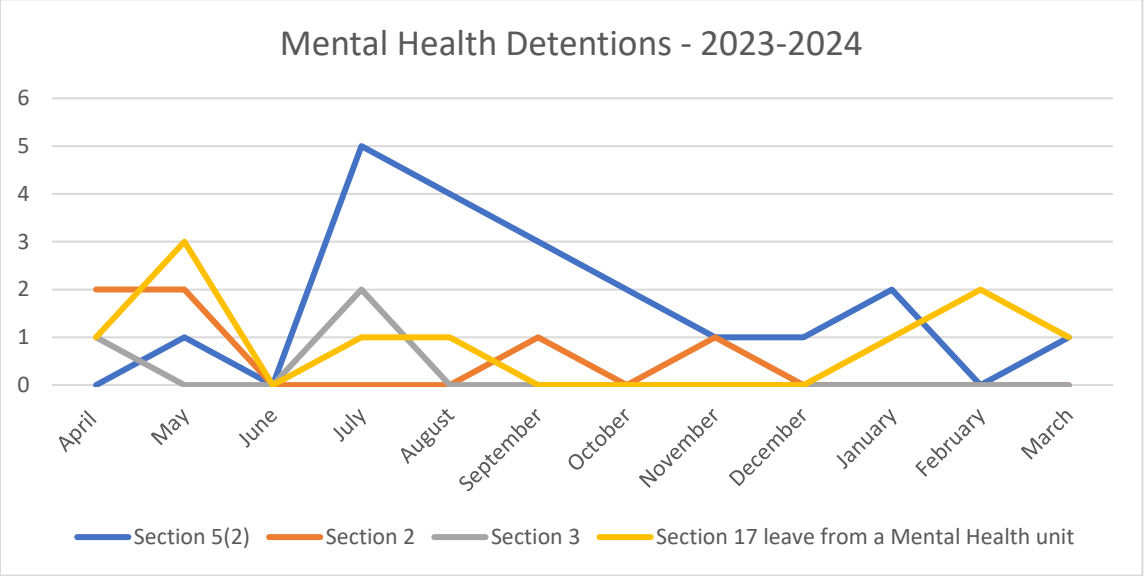
The processes that have been implemented across the Trust remain in place concerning the Site Team now having 24/7 oversight of all Mental Health Act patients within the hospital. Site managers are responsible for receipt of the paperwork on behalf of the Trust. This allows for a centralised monitoring system 24/7 and active follow up of the patient's pathway. It allows for the Trust to have oversight of where the most vulnerable patients are within the hospital for risk management purposes. This process is now embedded.

Work needs to be completed with regards to IT and informatics to produce a live reporting system of Mental Health Act detentions within the hospital. This is inputted through the Sunrise system but is still in its infancy.

A Memorandum of Understanding has been agreed and ready for sign off, for Black Country Healthcare Trust to provide a Responsible Clinician (RC). This is to ensure that there is an approved clinician with overall responsibility for the patient's care and treatment for mental disorder to be given under the direction of a consultant psychiatrist from a mental health unit. There are still ongoing discussions with Black Country Healthcare regarding the implementation of Mental Health Act administration, but it is anticipated this will be in place by the end of Q1 next year. This provision would provide greater assurance for processing of Mental Health Act detentions and upholding each patients' rights to be upheld including their right to appeal.

The absence of final approval for implementation of an RC and decision making for Mental Health Act Administration sits on the Trust risk register.

The chart below details the number of patients subject to the Mental Health Act over the past 12 months. This is broken down into patients detained to the Trust and patients who are under Section 17 leave due to their detention being implemented at another Mental Health Unit:

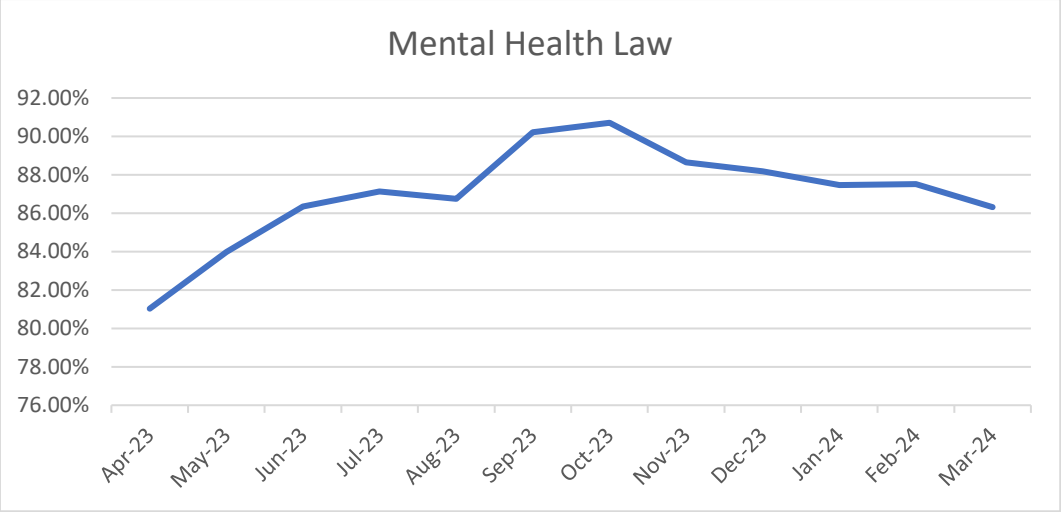


The mean number of detentions per month is 3, which is on a par with the previous year of 3.1. It should be noted that gaps in detentions being reported to the site management team by the inpatient wards have been identified. This could impact on recorded data. Greater scrutiny of Mental Health Act detentions and provision of a patients' rights and restrictions through a formal Mental Health Administration Team would see an increase in reporting and improved monitoring, as has been cited in other Trusts.

6.2 Training

There are 2 tiers to the Mental Health Law training. The basic training is provided at Trust Induction. The enhanced training is attended by all nurses and AHPs of Band 6 and above and all Consultants and Registrars. The advanced training is provided via face to face/MS Teams sessions by the MCA Lead and incorporates a more in-depth view of implementing the Mental Capacity Act. By the end of quarter 4 compliance levels were 50% below the initially agreed target of 60%, agreed as a reasonable target for a newly introduced subject. It is anticipated that the 60% compliance target will be achieved by the end of June 2024. This will require a Trust wide push to improve compliance and will be escalated and monitored via the Trust ISB.

The table below demonstrates Trust compliance with the basic awareness Mental Health Law Training



6.3 Inspections and Reviews

The CQC carried out an unannounced focused inspection of the Emergency Department in April 2023. This was in relation to concerns about care following a serious incident regarding a patient with a mental health concern.

The CQC inspectors noted that the service did not always follow the Trust's Care of the Patient Requiring Close Observation policy and that information about serious incidents, and subsequent learning, was not always shared with partner services.

They noted that Mental Health training completion rates in the Emergency Department at the time of inspection were 81% for nursing staff, and 71% for medical staff. This was below the Trust's compliance target of 90%. However, several staff members were booked to receive training in May 2023.

The inspectors reviewed the contents of a new mental health training package for Emergency Department staff which had been developed by the lead nurse for mental health and complex vulnerabilities. The package included training on mental health triage, understanding and managing behaviours.

It was noted that a KPI in the Mental Health Liaison Service's Standard Operating Procedure is that patients in the emergency department should be assessed within 1 hour of referral, however, this does not always happen. This is largely due to the high demand for a small service. The ED Leadership Team and Lead for Mental Health meet with MHLS monthly to review response times and address arising concerns. This has proved to be successful in improving partnership working and responding to patient's needs.

The CQC were made aware of a clear internal escalation procedure in flowchart form when patient delays were experienced, up to service director level for the most severe delays.

The CQC inspectors saw evidence of the renewed focus on the assessment and management of risk in patients presenting with mental health concerns and reviewed the ligature light cubicles.

A Mental Health Risk Assessment is now in place in Triage to ensure that patients are located in the right area to manage risk and are provided with the appropriate level of observation and support.

6.3 Trust Mental Health Strategy

The Mental Health Strategy that was implemented 2022-2023 continues to be an active strategy, of which the Trust are now in year 2. The 3-year strategy sets out plans to ensure that patients with mental health conditions attending the Trust receive the additional support they require throughout their patient journey, ensuring that they feel safe, listened to, and have confidence in the knowledge and skills of our staff. The aim of the Mental Health Strategy is to improve the experience, quality, and effectiveness of care received by adults with a mental health condition and that our staff can identify the mental health needs of all patients and ensure the correct support pathways are provided. The achieved elements of the strategy are detailed within this report.

Vision of the Mental Health strategy

Staff within Dudley Group Foundation Trust will have the skills and understanding to support, identify and provide care for patients with a mental illness. The Trust will promote a positive Mental Health Culture, reducing barriers and inequalities and ensure the mental health of patients are given equal priority to their physical needs.

6.4 New processes

Emergency Department Mental Health Risk Assessment

In response to a serious incident, the former Mental Health Lead developed a Mental Health Risk Assessment Tool for use in ED triage. The risk assessment tool is used for all patients with suspected mental health related problems and includes reviewing their presentation regarding capacity / co-operation / agitation / abscond risk, review of suicide risk, possession of weapons, and immediate triage plan resulting from these details. This is a rapid assessment based on available data.

Right Care Right Person

Right Care, Right Person (RCRP) has been introduced within the West Midlands via West Midlands Police in collaboration with local stakeholders. The RCRP provides a threshold to assist police in making decisions about when it is appropriate for them to respond to incidents, including those which relate to people with health and social care needs as well as mental health needs. The first stage of Right Care, Right Person was introduced on 5.2.24 and is now live in relation to cases around welfare checks, attending to absconding patients and patients with mental health conditions.

Guidance is in place and has been shared within the Trust to complete a Due Diligence Checklist to identify whether the situation involves a high-risk patient that requires a response from the Police. There is an escalation process for staff to follow if they feel the police response is not adequate and they are concerned that the patient is at immediate risk of harm. The escalation needs to be completed by a senior nurse / manager. There have been minimal concerns raised following this process becoming live.

Joint working is taking place to develop a Memorandum of Understanding to further develop management of RCRP. The Trust is collaborating with local stakeholders.

Stage 2 is planned for October 2024 with changes to police response to conveying and handing over patients subject to S136/135 of the MHA. It is anticipated that this will impact on the Trust as there will be strict criteria for the Police to hand over any patients detained on Section 136 of the Mental Health Act within one hour of attendance to ED. This will also impact on Mitie Security Staff who may

be called on more frequently to manage Physical Restrictive Intervention of patients when Police have left the department. There is a West Midlands wide multi-agency working group who will be planning this, to which the Mental Health Lead and Head of Safeguarding are members.

6.5 Ligature cutters/Ligature Light Rooms

In line with reducing ligature risks within ED, ligature reduction works have taken place within ED in line with Estates works. This has taken place in cubicles C, F, 12 and 14, the Sunflower room and patient toilet. Patients at high risk of ligature would still require observation for maintaining safety, but the environmental risks have been reduced. Accessing the ligature light cubicles is directed by the risk assessment. These elements are detailed within a Mental Health SOP to support the process.

Barrington Ligature Cutters are being introduced into the ED and Critical Care Outreach Team to respond to incidents involving ligatures. Four staff from ED and two staff from the Critical Care Outreach Team (CCOT) have received training to enable them to train their colleagues in the use of the Barrington Ligature Cutters. The Mental Health Lead will monitor use of the Barrington Ligature Cutters and provide support as required. The Standard Operating Procedure for use of the Barrington Ligature Cutters has been agreed and ratified.

Bespoke training has taken place within ED concerning the management of patients that attend with self-harm and suicidal intent and how to support the risks within the department. A video format of this training has been formulated to ensure that all ED staff have access to the training.

7.0 Dementia and Delirium

Dementia is an umbrella term for a range of progressive conditions that affect the brain. NHS England reports that dementia is a growing challenge. As the population ages and people live for longer, it has become one of the most important health and care issues facing the world. In England it is estimated that around 676,000 people have dementia. In the whole of the UK, the number of people with dementia is estimated at 850,000.

Dementia mainly affects older people, and after the age of 65, the likelihood of developing dementia roughly doubles every five years. There are around 540,000 carers of people with dementia in England. It is estimated that one in three people will care for a person with dementia in their lifetime.

7.1 National data collection

The Trust is required to complete a retired CQUIN indicator which has been retained in the standard contract as a mandatory, Burden Advice and Assessment Service (BAAS) approved data submission for all acute providers. It aims to maintain the identification of patients with dementia and delirium at a high level, to prompt appropriate referral and follow up after they leave hospital and to ensure that hospitals deliver high quality care to people with dementia.

There are three separate stages sought by this indicator which are identified as “FAIR”:

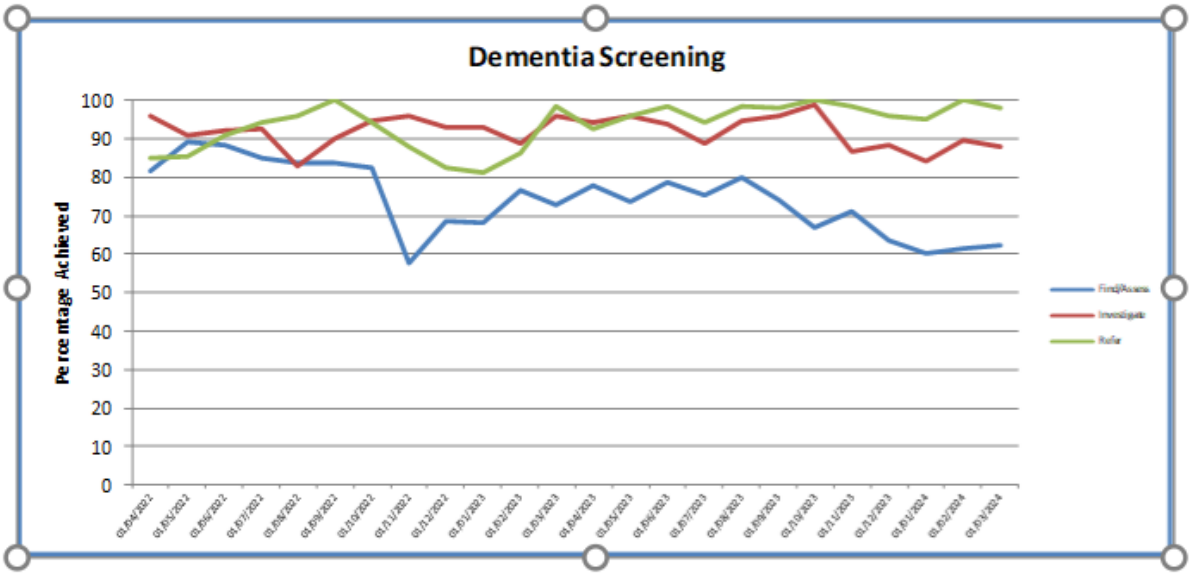
Find - The case finding of at least 90% of all patients aged 75 and over following emergency admission to hospital, using the dementia case finding question and identifying all those with delirium and dementia. This must be completed within 72 hours of admission.

Assess and Investigate - The diagnostic assessment and investigation of at least 90% of those patients who have been assessed as at risk of dementia from the dementia case finding question and/or presence of delirium. The Trust should conduct a diagnostic assessment including investigations to

determine whether the presence of dementia is possible**.** If a patient fails the AMT-4 screening, nursing staff make a referral to the Dementia and Delirium Team to undertake an AMT-10 assessment and make appropriate referrals based on the outcome of this assessment.

Refer - The referral of at least 90 per cent of clinically appropriate cases for specialist diagnosis of dementia and appropriate follow up, in accordance with local pathways. This may include referral to an old age psychiatry liaison team, with the person assessed in hospital, or it could be referral to a memory clinic or to the GP to alert that an assessment had raised the possibility of the presence of dementia.

The chart below demonstrates that since March 2023, there has been a fluctuating pattern concerning the "Find" element with response rates consistently below 80%:



Reviewing the data with Informatics has identified that there are a couple of factors that could be contributing to this, including the transition to digitalisation of admission documentation taking place within the last 12-months. It has also been identified that there is duplication of the AMT-4 within the inpatient documentation that is not pulled through on informatics, only the specific AMT-4 document. This is currently under review. It should also be noted that the data reflects interventions for patients aged 75 and older but it does not record other work completed, particularly as the Dementia and Delirium Team support patients from 65 years of age.

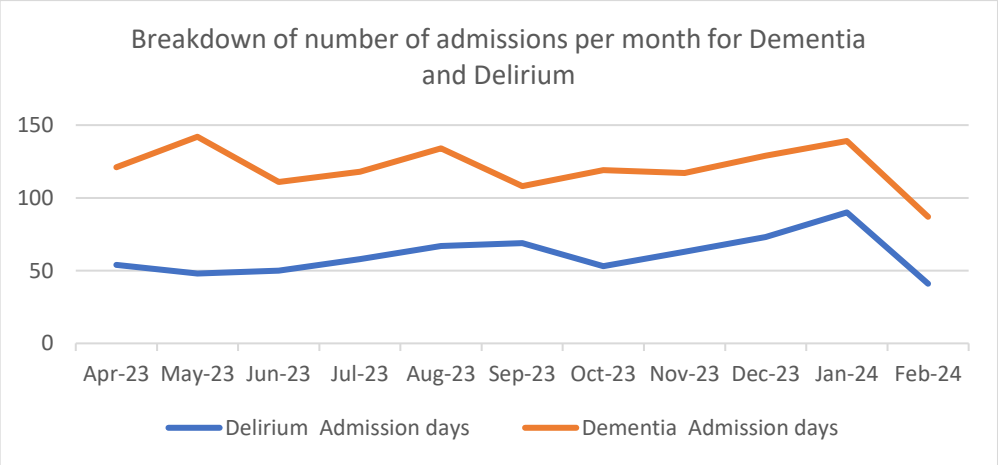
The use of the AMT-4 screening tool has been discussed with the Clinical and Nursing leads for elderly care and frailty unit and it has been agreed that the current threshold for referral to the Dementia and Delirium Team is too low. A proposal has been agreed to change the initial screening tool from the AMT-4 to 6-CIT to ensure that the correct referrals for additional support from the Dementia and Delirium Team are made. The Six-Item Cognitive Impairment Test is accurate in diagnosing cognitive impairment in secondary care settings and has more accuracy that the AMT-4. It is not possible to change this screening tool until the freeze on additions to Sunrise ends in November 2024.

Current completion of the AMT10 tool by the Dementia and Delirium Team has fallen below the 90% threshold with a performance of 84.15%. This action is the Assessment part of "FAIR". This is despite the reduced AMT-4 referrals and a reduced workforce due to staff vacancies. It should be noted that

the Referral part of “FAIR” is also audited, and the rate of the team is 94.92% and so exceeding the KPI target.

There have been 2700 patients with a diagnosis of Dementia admitted to the Trust in the past 12 months, with an average of 120 admissions per months that were admitted longer than 72 hours.

The below chart identifies the breakdown of admissions per month of patients with a secondary diagnosis of Dementia and Delirium. March data is not yet included due to Clinical Coding delay of approximately 6 weeks. This data is for all ages. This highlights the high level of need within the Trust and the importance of service provision for this group of patients.



There has been consistent high contact with the Dementia and Delirium Team outside of AMT-4 referrals, with the team asked to provide support over a range of matters from ED support, DoLS support and guidance, providing support to family members and asking for advice and support with patient care and treatment.

NICE guidelines define delirium as a common clinical syndrome characterised by disturbed consciousness, cognitive function or perception, which has an acute onset and fluctuating course. It usually develops over 1-2 days. It is a serious condition that may be associated with poor outcomes such as increased risk of dementia and/or death and, for people in hospital, may increase their length of stay in hospital and their risk of new admission to long-term care. However, it can be prevented and treated if dealt with urgently.

Data collated identifies that there were 938 patients admitted between 1.4.23 and 31.3.24 with delirium and an average of 61 patients per month admitted for over 72 hours with a diagnosis of delirium.

Within the Trust, management of delirium requires improvement around identification, differentiation between delirium and acute mental illness and clear treatment pathways. Currently staff are contacting the Mental Health Liaison Services requesting they assess patients because they are failing to identify that the patient has a delirium rather than a mental health condition. A clearer understanding and earlier identification of delirium would promote patient recovery through prompt and multicomponent intervention package, reduced length of admission and better patient outcomes. A clinical specialist allocated to support with early identification and treatment of delirium would promote this area.

7.2 Audit and Improvements

Readmission data

A review took place of 50 people with a confirmed diagnosis of Dementia that were readmitted to Russells Hall Hospital within 30 days of discharge over a 3-month period. The most common reasons for people to be readmitted (12%) during this period was "no reason/null/social admission" affecting 6 out of 50 people in the 30-day period and being highly suggestive of failed discharges**.** Failed discharges are the most common cause of the Trust being subject to Section 42 Safeguarding Enquiries under the Care Act 2014.

Other concerns relate to readmission of patients with dementia due to:

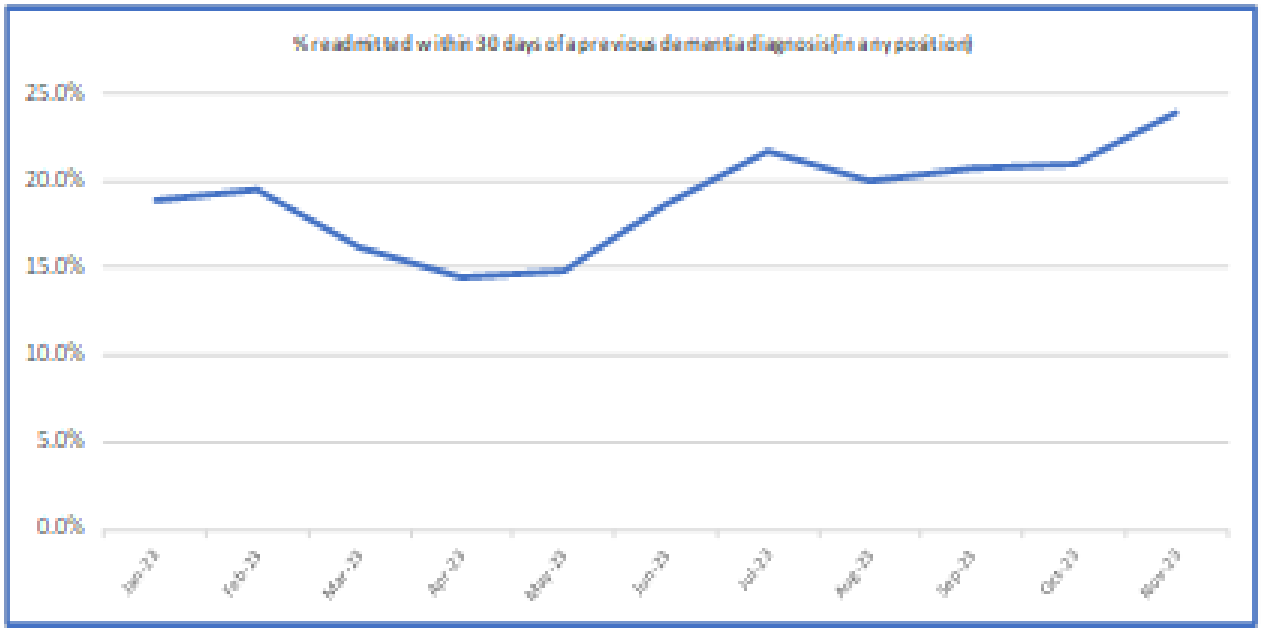
- Constipation and UTI – could be suggestive of dehydration and raises questions regarding management in the community.
- Pneumonitis due to food and vomit
- Delirium –long-term effective treatment of delirium in the community and could be linked to dehydration in the community.

Long-term length of stay in hospital is counterproductive for symptoms of dementia and impacts on recovery and ability to return to preadmission functioning. Delays in discharge are commonly related to delays in requiring suitable packages of care.

The Healthcare Evaluation Data (HED) system identifies that for readmissions of patients from elderly medicine, Russells Hall Hospital sits 27% above the national average for readmission, sitting 107 out of 109 hospitals for poor readmission rates. The detail of this data needs to be explored as this is a very broad area. Readmissions are not exclusively counting patients with a primary and/or secondary diagnosis of dementia. The data covers the whole spectrum of elderly care. It should also be noted that this data covers planned readmissions for investigations or care from a virtual ward.

The below chart demonstrates that the number of readmissions has steadily risen since January 2023, but remains under 25%:

Chart: Percentage of readmission within 30 days of previous dementia diagnosis



A more in-depth review of the reasons for re-admission is planned for Q1 of 2024/25.

National Audit for dementia round 5

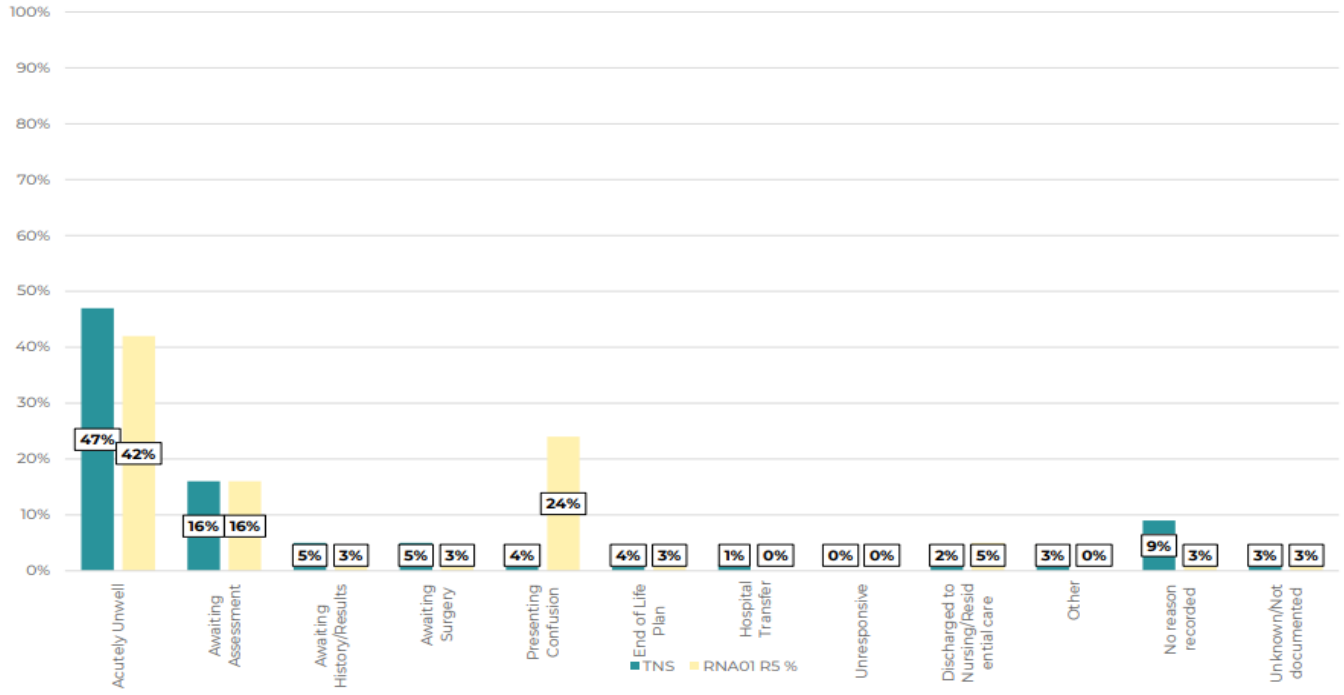
The National Audit for Dementia examines aspects of care received by people with dementia in general hospitals in England and Wales. The audit is commissioned by the Healthcare Quality Improvement Partnership on behalf of NHS England/NHS Improvement. Round 5 collection took place between September 2002 -January 2023. Local reports were then developed with comparisons against national data during the following 12-months.

The report for Russells Hall Hospital reviewed 75 samples from 84 patients and identified the following:

Key Metrics	National R5	RNA01 R5
% Delirium screen (inc. noted on admission)	87%	99%
% Pain assessment	92%	97%
% Pain reassessment	92%	90%
% Pain tool – question only	61%	96%
% Initiation of discharge plan in first 24 hours*	45%	4%
Carer rating overall care quality	66%	75%
Carer rating communication	60%	72%
Summary Data	**National R5**	**RNA01 R5**
% People with dementia admitted to hospital over previous year	Range between 0.1% - 15% Median: 3%	2%
% People with personal information document at bedside	46%	Unknown
Number of Lead Nurse for dementia in post	Ranged between 0 - 6	2
% Staff with Tier 1 training	86%	73.7%
% Staff with Tier 2 training	45%	0%

The data reveals that in most areas, the Trust are comparable or above national data. Key areas of performance to improve are commencing discharge planning within the first 24 hours. The below chart reveals valid rational for delays:

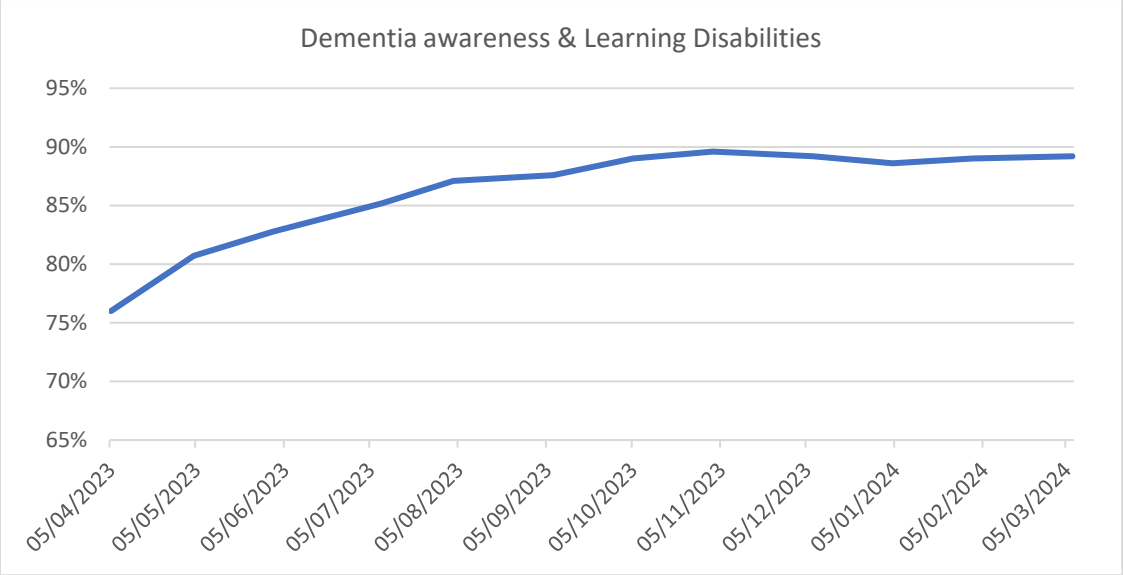
National Audit for Dementia Report: Reasons discharge planning was not initiated within 24 hours of admission



The Trust also need to develop tier 2 training for dementia which is not currently an active programme and review personalised and accessible support plans for inpatients. The Trust are currently in the process of developing a programme based on the audit recommendations.

7.3 Training

Level 3 priority training compliance for Dementia, Delirium and Learning Disabilities Awareness, has consistently remained below the 90% expected Target, but rates have improved. Compliance rates are reported through the Internal Safeguarding Board. Extra sessions have been provided and held within ward areas on weekends and evenings to help support with compliance.



Patient story

The story has been shared for learning purposes internally but removed from this public facing document to protect patient confidentiality.

8.0 Mental Capacity Act 2005

The Mental Capacity Act (MCA) established in 2005 provides a statutory framework for decision-making on behalf of people who are unable to make decisions for themselves. It defines when and how decisions can be made on behalf of others. There is a duty on all health and social care practitioners to follow this framework when providing care and treatment for vulnerable people.

Poor compliance with the MCA is currently on the corporate risk register. The Trust are at risk of regulatory, civil, and criminal actions by failing to follow the safeguards and processes set out in the MCA.

The MCA is central to good quality care and improvement, ensuring care is delivered in a person-centred approach and patients voices are heard. MCA is being embedded throughout the Trust through intense training packages, an array of practical support, governance, and assurance.

The Trust have an MCA Lead Nurse in post to support staff with this process. This report details some of the work that has been undertaken this past year.

8.1 Training and Support

Unique to the Trust is the advanced MCA training course that is mandatory for all Doctors, Consultants, band 6 and above Nurses and AHPs. The training consists of theoretical and practical application of the MCA including Deprivation of Liberties Safeguards (DOLS) and the interface with the Mental Health Act (2007). The training includes scenario-based group work relevant to the Dudley Group Trust. This

helps to enhance skills and knowledge in relation to complex MCA issues and allows the opportunity to share common MCA problems. Approximately 900 staff have so far received this training.

Other training offered:

- Basic Mental Health Law training - this mandatory for all patient facing staff.
- Bespoke MCA training for specialist areas – this is available upon request and aims to be delivered as flexible as possible and incorporates issues specific to that area. This has included:
    - Community audiologists
    - Community ENT
    - Community Nurses - both advanced and basic, across 2 different sites
    - Hospital Radiologists
    - Surgical teams - advanced
    - Extra DOLS training for C3, FMNU, C1, B3, B2 and AMU
    - Security
    - AAA Screening services community
    - Discharge assessment and best interest for hospital physiotherapists and Occupational Therapists
    - Mental Health Law - ED
- Ward based DOLS training – available upon requests, designed to be flexible and focused on all issues around DOL.
- Practice Development Nurse Training – PDN can receive training to allow then to become Basic Mental Health Law trainers to allow them to deliver this to their areas. So far, 5 PDNs have received this training, and 3 more to be arranged.

Feedback from the advanced MCA training has been positive, with staff reporting the sessions to be informative, improving staff confidence about using the MCA and DoLS processes and appreciating the scenario-based elements to enhance learning and linking to daily practice. Staff have noted the importance of this training and have even noted that they would like a longer teaching session to allow more detail to be provided.

As awareness of MCA is growing, so is the request for support on the application of it. The Trust provides this support in numerous ways, including:

- Expert staff in MCA based at RHH, who regularly visit ward areas, outpatients and/or patients and can offer advice, including -
    - The MCA Lead Nurse.
    - The Dementia and Delirium team.
    - The Learning Disabilities team.
- A Mental Capacity Hub page detailing useful information including past caselaw to help shape how we use the MCA in practice.
- Regular information given out through Trust publications such as ‘In the Know’ and patient Health and Safety Bulletin.
- Physical and electronic packs of good example MCA assessments, Best Interest decisions and DOLS applications.
- Target support to clinicians when poor MCA application has been raised.

Despite this support, some staff still feel completing MCA assessments and best interests requires a specialist team. Changing this view is a slow process and requires not only a bottom-up approach in relation to training and support but a top-down approach with senior management promoting the importance of compliancy with this Act.

8.2 Governance and Assurance

The Trust have several policies and guidance's directly relating to MCA, these that have all recently been reviewed and updated, along with this staff are provided tools to help support them in this process. These include:

- MCA Policy
- Deprivation of Liberties Policy
- Best Interest Meeting template
- Advanced Care Planning Policy
- Independent Mental Capacity Advocate Policy
- MCA assessment recording tool available on Sunrise and the Hub
- MCA Best Interest decision-making record tool on Sunrise and the Hub.
- Form 1 Deprivation of Liberties urgent authorisation/standard application available on the hub.
- New E-Consent programme with mandatory MCA assessment and Best Interest recording tool.

Audits completed this year to measure MCA compliance have included MCA assessments, NICE Guidance and DOLS. This has helped gain a baseline so further audits can be completed to measure changes against. Audits do show some improvement is required and there are gaps in both understanding and applying the Act. A repeat of these audits is planned for next year.

Implementation of the Mental Capacity Act is a risk on the Safeguarding Risk Register. There has been a full review of the risk, which was first recorded in June 2021. The risk score has reduced from 16 Major to 9 Moderate over the last 3 years.

Summary of 2023 MCA Audit:

In July and August 2023: 417 MCA Assessment Recording Tools were completed on Sunrise.

- 194 patients were found to have mental capacity to make the decision – 47%
- 179 Discharge/self-discharge decisions - 42%
- 72 decisions in relation to restrictions and confinements.
- More than half decisions in relation to patients refusing care and treatment.
- Highest number of nursing intervention for NG tubes by nutritional nurses.

This audit demonstrated an increased use of the MCA in practice. It highlighted good practical use of the MCA in areas such discharge decisions, carried out mainly by Occupational Therapist and Physiotherapists; decisions to remain in hospital for care and treatment for the purpose of DoLS; and nutritional nurses' decisions around NG tubes. It also highlighted gaps in the formal use of the MCA in some areas such as medical and surgical procedures.

Early indications show an increase of MCA assessments being carried out each month: In July and August 2023, 417 had been completed compared to January and February 2024 where 566 had been completed. This is a positive sign that awareness of the MCA is increasing. The next step will be working on the quality of these assessments.

The Trust is also part of the Birmingham and Black Country Integrated Care Board MCA Forum and regional NHS England MCA steering committee. Information is fed to and from these groups to share good practice, embed consistency with our neighbouring Trusts, offer assurances to commissioning bodies and gain up to date information on case law and Government updates.

8.3 Consent Programme

The E-consent programme has gone live across the Trust on the 19th March 2024 after being trialled by General Surgery late last year. This is a digital consent application provided by Concentric Health. This is for all patients requiring a consent form for medical treatment, investigations, examinations, or procedures. This application will eventually replace all paper versions of consent forms.

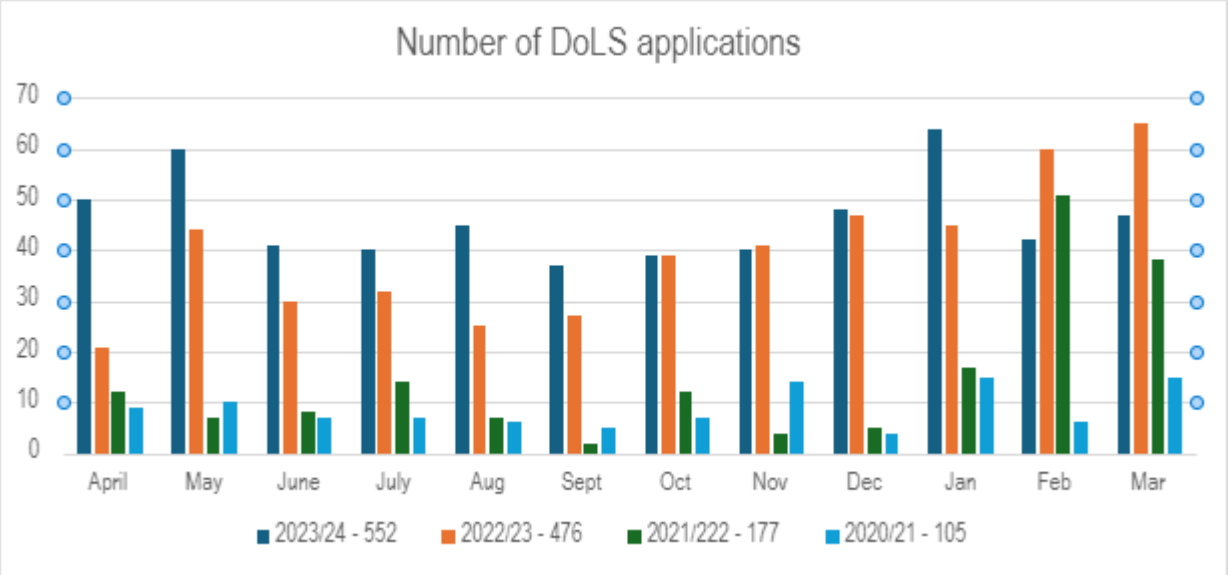
Within this programme, there is a mental capacity assessment and best interest recording tools for all patients who may require consent form 4 (patients who do not have mental capacity to consent themselves). These tools are compulsory and must be completed before the consent form 4 can be completed. Overall, this is an excellent programme to ensure compliancy with MCA as it mandates the use of it.

There have been some minor teething issues with the system that are being addressed in relation to MCA assessments and best interest decisions. Work is being carried out by the Trust with Concentric on this.

8.4 Deprivation of Liberties

Deprivation of Liberties Safeguards (DOLS) are part of the MCA (2005). DOLS ensure people who cannot consent to their care and treatment arrangements in hospital are protected if those arrangements deprive them of their liberty.

The number of DOLS applications is consistent month to month. Wards receive a great deal of support to help them recognise when they are depriving someone of their liberty. The Dementia and Delirium team visit the wards every day and monitor a daily enhanced observation ward list. The Dementia and Delirium team also support the centralised system for DOLS. This is to check the quality of DOLS and ensure they are processed and managed correctly.



Whilst the number of DoLS applications are remaining consistent (with only a slight increase from last year) the Trust still sees a decline in DOLS if wards are not prompted for them. It is thought this is due to ward staff not fully understanding the need for them or the benefit to patients. As a legal obligation, work will continue to raise this issue within the Trust.

Out of 552 DoLS applications sent in 2023/24 only 3 received a standard authorisation from the Local Authority. This is due to how the DoLS standard applications are processed and prioritised by the Local Authorities who receive them. Many of our patients are unlawfully deprived of their liberty while waiting for a standard authorisation to be completed. This is a national challenge and one which was intended to be rectified by the introduction of Liberty Protection Safeguards. Any patients who are considered by the Trust as a high priority - patients with high level and/or long-term frequent restrictions in place - will be highlighted to the Local Authorities who will ensure the relevant assessments for a standard authorisation are completed swiftly.

8.5 Liberty Protection Safeguards

In May 2019, amendments were made to the MCA through Parliament. This introduced Liberty Protection Safeguards (LPS), a new process for authorising deprivation of liberties. The LPS should eventually replace the current Deprivation of Liberties Safeguard (DOLS). Implementation of LPS was planned for April 2022 but was delayed due to the COVID pandemic. In March 2022, a draft new Code of Practice was published by the Government, including guidance on LPS, for a consultation period. The response to the consultation has still not yet been published.

Unfortunately, the implementation of LPS has been delayed further as the Government recently announced it would not come into force during the lifetime of the current parliament as reforms to the social care system are being prioritised. It is not clear when LPS will be implemented. In preparation, the Government are still advising that work to raise awareness of MCA and identifying deprivation of liberties should continue.

Patient story

The story has been shared for learning purposes internally but removed from this public facing document to protect patient confidentiality.

9.0 Learning Disabilities

A learning disability is different for everyone. The degree of disability can vary greatly, being classified as mild, moderate, severe or profound. In all cases, a learning disability is a lifelong condition and cannot be cured.

A learning disability is different to a learning difficulty, which is a reduced intellectual ability for a specific form of learning and includes conditions such as dyslexia (reading), dyspraxia (affecting physical co-ordination) and attention deficit hyperactivity disorder (ADHD). A person with a learning disability may also have one or more learning difficulties.

Additionally, there are several conditions and neurological disorders that often involve or cause some type of learning disability, including Down's syndrome, autism, meningitis, epilepsy, or cerebral palsy.

9.1 Learning Disabilities Team

The Trust continue to celebrate that Dudley Group are above the national average for nursing staff working within the learning disability team, with the employment of four registered learning disability nurses, who have the support of a part time clerical officer. Their role is to address the identified health care needs of people with a learning disability and as the Trusts provision includes working with children, providing younger patients and their families with reassurance both when they attend hospital and when transitioning into adult healthcare services.

9.2 Vision of the Learning Disability strategy

The Strategy represents the commitment of Dudley Group NHS Foundation Trust to improving the care and treatment of people with Learning Disabilities when accessing Trust services. It is designed to support all hospital staff in delivering high quality, person centred, and safe acute hospital services for people with learning disabilities. It references the Key Strategy Principles, of Choice, Rights, Independence and Inclusion, detailing what the organisation wants to achieve and what patients can expect both now and into the future, taking into consideration both professional and national standards.

9.3 Learning Disabilities

There are approximately 1.3 million people with a learning disability in England, including over 950,000 adults aged 18 or over. These figures reflect the most up-to-date data from Mencap and have been calculated using learning disability prevalence rates from Public Health England (2016) and population data (2020) from the Office for National Statistics (ONS).

The number of people with a learning disability recorded in health and welfare systems is much lower. Those known to learning disability services are likely to be people with a more significant learning disability.

A learning disability is defined by the Department of Health and Social Care (DHSC) (2001) as: a significantly reduced ability to understand new or complex information, to learn new skills (impaired intelligence), with a reduced ability to cope independently (impaired social functioning), which started before adulthood.

A learning disability is different to a learning difficulty, which is a reduced intellectual ability for a specific form of learning and includes conditions such as dyslexia (reading), dyspraxia (affecting physical co-ordination) and attention deficit hyperactivity disorder (ADHD). A person with a learning disability may also have one or more learning difficulties.

People with a learning disability have worse physical and mental health than people without a learning disability. On average, women with a learning disability die **23 years younger** than women in the general population. On average, men with a learning disability die **19 years younger** than men in the general population (LeDeR, 2023; ONS, 2022).

9. 4 Learning Disability Mortality Review (LeDeR)

National Context

The Learning Disabilities Mortality Review programme (LeDeR) was established to support local areas across England to review the deaths of people with a learning disability, to draw out learning from those deaths and to put that learning into practice. People who have a diagnosis of autism without a learning disability have been eligible for a review under the Learning Disability Mortality Review programme (LeDeR) since June 2021

ICB LeDeR Steering Group

LeDeR steering groups are part of the ICB quality governance structures.

The role of the LeDeR Steering Group is to:

- view reports of completed reviews presented by the reviewers or Local Area Contact (anonymised)
- support the identification and sharing of best practice in the review process.
- monitor actions and outcomes.
- respond to recommendations to improve service provision and reduce likelihood of premature deaths.
- recognise and share best practice and innovation.
- demonstrate the impact of changes.

The lead nurse and the Head of Safeguarding attend this quarterly steering group to ensure that the Trust is linked into the learning that may be appropriate for the organisation. On a local level there will be a requirement from each provider organisation to identify actions from the reviews and demonstrate how learning is embedded into the organisation. The steering group will hold a dashboard of thematic analysis to allow for assurance and accountability.

Local LeDeR panel

The lead nurse is a member of the Dudley LeDeR review panel. This is usually a bimonthly panel which reviews the outcomes of the Dudley LeDeR reviews and monitors trends. The panel makes recommendations and shares learning across the local health economy. During this year, the lead nurse has attended 12 of the 15 panel meetings called. There are recommendations from each death, they are monitored via an Action Plan which is developed by the LeDeR manager.

Outcomes are reported into the LeDeR steering group, any recommendations for Dudley Group are taken by the Lead Nurse and reported via ISB.

The lead nurse has undertaken an audit of the Trust compliance with the Trusts Learning from Deaths Policy with regards to patients who have died in Trust who had a learning disability.

Learning from lives and deaths - People with a learning disability and autistic people (LeDeR) National Action from learning report 2022/23

The following information consists of findings in the 2022/23 National LeDer report – learning from lives and deaths of people with a learning disability and autistic people. The National LeDer team have made the following recommendations:

- Further in-depth investigation of the LeDeR dataset could be undertaken to investigate specific areas of problems with care and to suggest areas for improvement, for example, where are delays in care most likely to occur and how can they be minimised?
- The implementation of the Reasonable Adjustments Flag should be monitored, and research conducted to consider how it is used to guide adaptations to care, and whether this can be improved.
- What resources are needed for training or support to ensure all clinical staff consistently apply the MCA correctly?
- How can we ensure that people with a learning disability who have multiple long-term conditions receive an individualised management plan and what mechanisms can be used to best co-ordinate care for people who are involved with different health professionals?
- For autistic adults with a learning disability, there are specific needs and considerations that need to be considered that differ from those of autistic adults without a learning disability. Awareness of this and factoring in the specific needs of the person in any care plan, should continue to be a priority.
- The limited analysis possibly suggests a high rate of deaths by suicide for autistic adults without a learning disability in this dataset. This is concerning and requires ongoing attention through further data collection. Preliminary emergent thematic analysis suggests that to address this, services need to ensure a good understanding by staff of the needs of autistic people to identify those at risk, ensure adequate provision of support tailored to the needs of the person, and provide personalised crisis plans.

These recommendations will be included in the Learning Disability Standards actions plan, reporting to Internal Safeguarding Board and to the Trust Mortality Surveillance group.

9.5 Transition Clinic 18-25 Service

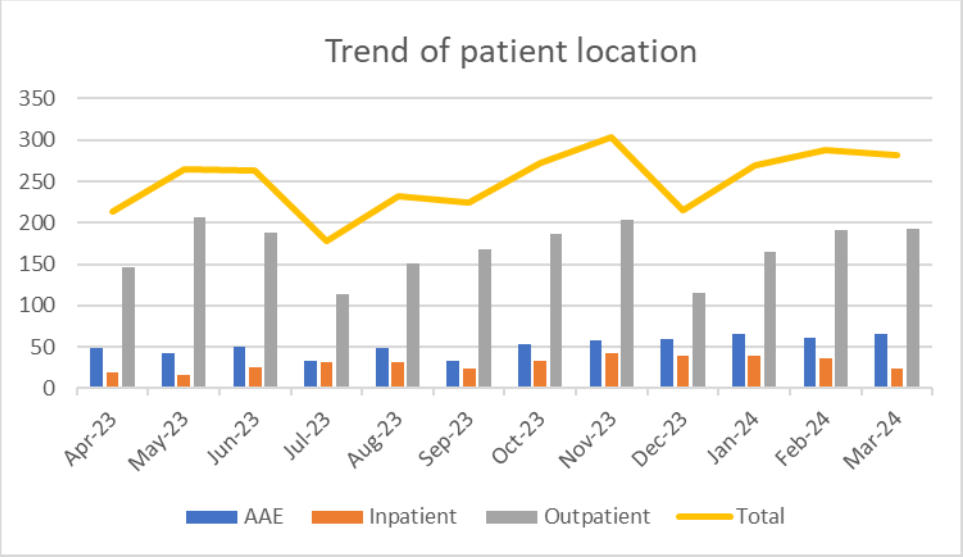
The adult learning disability transition clinic for young people aged 18-25 years who have been known to paediatric services neuro disability service has continued this year, with 8 telephone clinics being held and 23 young people welcomed to the ‘hello to adult services’ element of this clinic.

This nurse led telephone clinic is held monthly by the lead nurse to support the health care transition process, beginning at 18 years, and continuing until the young person is 25 years old.

The clinics have been running for 4 years and have given the young people opportunity to develop a health transition plan and offer information about adult services. The transition clinics enable and encourage the young person to self-manage their ongoing medical condition and has introduced them to adult services. For those who require additional support, it will also help the parents/carers to establish links within the adult services.

9.6 Activity and Performance 2023/24

The activity and performance of the learning disability team is shown in the tables below, highlighting referral source and patient location. The flagging system in Trust remains the highest referral source, this is linked to the PAS system in Trust for admission. Internal referrals are received from ward areas, imaging departments, consultants, consultant secretaries and outpatient booking teams. The learning disability team engage in complex admissions, outpatient appointments and emergency department attendances to ensure person centred care is given and reasonable adjustments are made to meet assessed need.



Date of referral	AAE	Inpatient	Outpatient	Total
Apr-23	48	19	146	213
May-23	42	16	207	265
Jun-23	50	25	188	263
Jul-23	34	31	113	178
Aug-23	49	32	151	232
Sep-23	33	24	168	225
Oct-23	54	33	186	273
Nov-23	58	43	203	304
Dec-23	59	40	116	215

Jan-24	65	39	165	269
Feb-24	61	36	191	288
Mar-24	65	24	193	282
Total	618	362	2027	3007

The referral rate has increased by 18% from 2022/23 records, with the most significant rise in referrals to the team from within the outpatients' departments – a rise of 451 referrals. This can be attributed to the learning disability team implementation of a robust reviewing process last year and the increased capacity of the team following successful recruitment into 2 vacant posts.

9.7 Good news and achievements

The learning disability team received a donation from the niece of one of our patients who sadly died last year. His family and friends were very complimentary of the support their uncle received from the learning disability team. They wanted to help other people with a learning disability when they must come into hospital, so asked if they could take a collection at his funeral in lieu of flowers. His niece came to the team office to present the team with a cheque for £700. Their generosity will enable the team to purchase sensory and activity equipment to support people with a learning disability when in hospital.

9.8 Patient XY – 'That's my brother' Charter *(patient's initials have been changed to protect their confidentiality)*

XY was a gentleman who died at Russells Hall Hospital. After he died, his sister contacted the learning disability team to ask if the team could meet with XY's family to talk about the circumstances around his death. Their aim was to use their experiences to make things better for people with a learning disability when they need to stay in hospital. From our meetings, the team have developed the XY Charter, the aim of this charter is to encourage staff teams to think 'that's my brother' and to consider what would make the hospital experience of their patients with a learning disability more person centred to meet each individual's needs. Each ward and department will sign up to the principles of the XY 'That's my brother 'Charter and display the Charter for all patients and their families to see.

The Trust promise that we will:

- listen to what the person in our care says and help them to have the support they need
- provide information that is accessible for people with a learning disability
- listen to, respect and involve families and carers
- provide practical support and information to families and carers

- appoint a learning disability champion on our ward or in our department
- make sure we get in touch with the Learning Disability Team in Trust for advice and support
- make sure that hospital /health passports are available and used
- make sure that all our staff understand and apply the principles of mental capacity laws
- provide ongoing learning disability awareness training for all staff

The Trust will develop a set of core skills and competencies within the charter, which wards will demonstrate and adopt to ensure the needs of people with a learning disability, who they are caring for, are met.

9.9 Trust Priorities – for learning disabilities 2024/25 and Future plans

***The Oliver McGowan mandatory training on learning disability and autism*.**

The training is named after Oliver McGowan. Oliver was a young man whose death shone a light on the need for health and social care staff to have better skills, knowledge and understanding of the needs for autistic people and people with a learning disability.

The Government has introduced a requirement for Care Quality Commission (CQC) registered service providers to ensure their employees receive learning disability and autism training appropriate to their role. This requirement is set out in the Health and Care Act 2022.

Locally and in Trust

The e learning course is now available via the Mandatory platform in Trust provided by elFH. From 1st April 2024 all Trust staff will be required to complete the eLearning.

The HUB page has been set up where the link and any guidance will be found and can be shared: Learning & Development – Oliver McGowan.

Next Steps:

There will be an additional Tier 1 or Tier 2 training which staff will need to complete in addition to the e-learning to be fully compliant with the Oliver McGowen mandatory training. This Tier 1 training will be face to face, this is now available and provided by Dudley Voices for Choice Self Advocacy charity. The cohort for Tier 1 requires has been set out by the Learning Disabilities Team and is awaiting confirmation and agreement via the Workforce Development Committee.

The learning disability improvement standards for NHS trusts – NHS Improvements 2022/23

National Context

Registrations for the sixth year of these has been completed for Dudley Group. The Learning Disability Improvement Standards are a central part of the NHS Long Term Plan, with providers expected to deliver services in line with the guiding principles outlined in the Improvement Standards.

Local Context

There is a Trust action plan following the results of the 2021/22 benchmarking of the standards for Dudley Group, this was presented at Patient Experience Group with the recommendation that a working party is established to drive this agenda forward within the organisation. A steering group has been established to identify priorities within the Action Plan before a working party is established. The

priority of the steering group is to present a position report to map the gaps in Trust compliance with the standards to the Internal Safeguarding Board.

Autism pathway

There has been some initial process mapping undertaken in terms of the provision for autistic people in Trust. An autism flag has been created for use within the PAS system. A suite of resources has been developed by the nurses in the learning disability team to support autistic people when they need to use the hospital services. There are several potential pathways which could be made available to autistic people; agreement of these will come from the members of the Internal Safeguarding Board.

9.10 Reasonable Adjustment Flags

Under the Equality Act 2010, organisations have a legal duty to make changes in their approach or provision to ensure that services are as accessible to people with disabilities as they are for everybody else. These changes are called reasonable adjustments.

The legal duty of reasonable adjustments means that adjustments should be made prior to a person presenting for care at any service.

The Reasonable Adjustment Flag was developed by NHS England in the NHS Spine to enable health and care workers to record, share and view details of reasonable adjustments across the NHS, wherever the person is treated.

The Learning Disability team have only recently acquired the ability to flag reasonable adjustments onto the digital platform. The team already use the digital platform to check whether patients do already have a reasonable adjustment flag to support the Trust reasonable adjustment plan. This is put in place for all patients with a learning disability alongside the development, by the team, of a one-page profile.

The learning disability team will include adding the reasonable adjustment flag using the agreed SNOMED codes to the team's admission process.

For the 6 months between September 2023 and March 2024, the team provided a 7 day a week service to support people with a learning disability when needing to use the services of the Trust. An evaluation of the provision was undertaken in March 2024.The SWOT analysis identified that there was a perceived risk to the effective delivery of care to patients with a learning disability due to both staff availability during the busiest periods of the working week and the opportunity for the lead nurse to deliver the national agenda priorities due to capacity of the team. It was recommended that the team return to 5 day working pattern in April 2024.

10.0 Restrictive Interventions

10.1 Restrictive Interventions

Restrictive intervention are clinical interventions that restrict or limit what a patient can do or where they can go in order to protect themselves and/or others from harm. These can include physical, mechanical, or chemical restraints.

All forms of restrictive interventions must be reported via the Trust internal reporting system to ensure that the incident is evaluated for effectiveness and to identify if alternatives to the restrictions

could have been utilised. The Dementia and Delirium team raise awareness of this during their walkabouts and via attendance at divisional governance meetings and will continue to support this intervention.

The Trust Restrictive Intervention Group which has been in place over 18 months. The purpose of the Group is to ensure there is effective monitoring and review of incidents of restrictive interventions and that these practices are safe, proportionate and within legal frameworks and follow Trust Restrictive Practice polices. The Group reports into the Trust Internal Safeguarding Board.

Following requests from the former Chief Nurse for a deeper analysis of episodes of restraint, it became clear that staff are not reporting incidents of restraint. This means that the Trust has no means of monitoring, reviewing and learning from episodes of patient restraint. The Trust cannot be assured that patients are not coming to harm, that least restrictive options are being considered and that staff are receiving the appropriate support and debrief. There are no opportunities for identifying learning or further actions and that the appropriate legal frameworks have been used to protect staff and patients from harm. In addition, where chemical restraint is used, the Trust Restrictive Intervention Policy is not being followed by consultants who should be reviewing and providing feedback for all episodes of chemical restraint for patients in their care.

A risk has been added to the Safeguarding Risk Register in relation to concerns regarding the reporting, monitoring and governance around the use of restraint, including chemical restraint.

Due to the gap in internal incident reporting, the Dementia and Delirium team were tasked with triangulating information from Datix and the Mitie Security Call Log and compiling a monthly report of episodes of violence and aggression and restraint. This information was provided to the Divisions for them to oversee and provide feedback. This was a labour-intensive activity, requiring 3-4 days a month of a nurse time to produce this report. This was considered unsustainable and that the focus should be on engaging nursing and clinical staff to ensure they are following policy and reporting all incidents of restraint via Datix.

A new section has been added to Datix reporting, whereby any incident reported under the category of violence and aggression opens a section asking the reporter if any restraint has been used and asks for information including issues around capacity, least restrictive options, documentation. This information will be audited and reviewed to scrutinise and monitor practice. It's recognised that not all forms of restraint are in response to violence and aggression, and this may mislead practitioners when they are incident reporting. The Patient Safety Team are reviewing this with a view to provide clearer categorisation and aid compliance with reporting.

Actions for the coming year include ensuring Consultants use the Datix system to respond to episodes of chemical restraint. Currently where chemical restraint is used, there is poor response from consultants in reviewing the episode and providing feedback to identify whether the restraint was appropriate, safe and if any learning from the incident can be identified.

Use of PRN Sedation

Chemical restraint is not always an unplanned event, some patients are prescribed sedation to be used on an "as required basis." Anecdotal information from the walkabouts made by the Dementia and Delirium teams has highlighted that it is not aways clear why PRN sedation has been prescribed or that it has been administered appropriately. The lack of governance, scrutiny and monitoring around the use of PRN sedation is a risk on the Trust Safeguarding Risk Register. An audit of the use of PRN

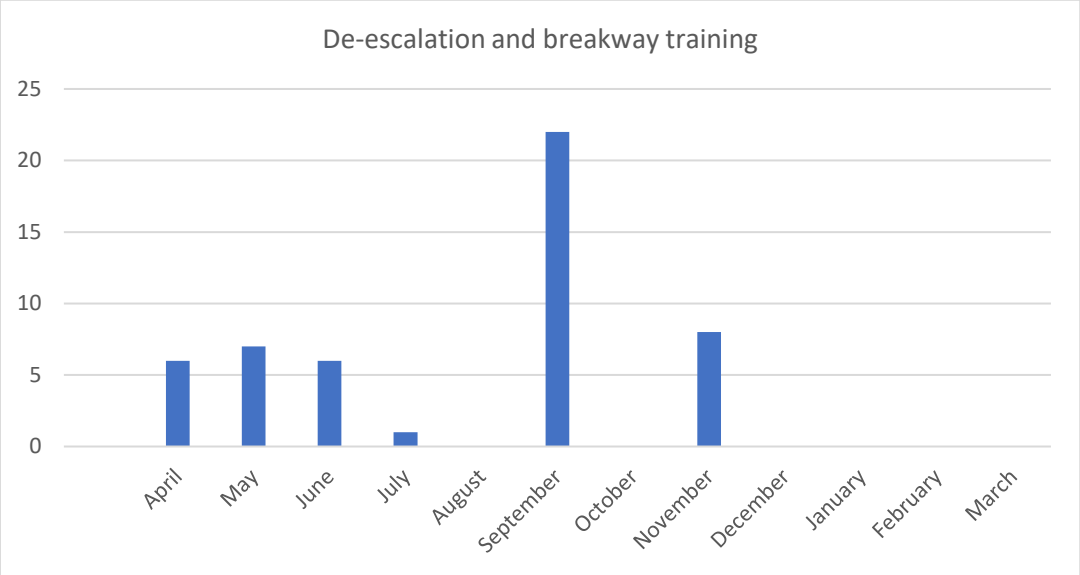
sedation is planned for Q1 of 2024/25 to identify the prescribing and administration and to inform actions moving forward to improve monitoring and evidence of best practice.

10.2 Training

Conflict resolution

Conflict resolution training is via e-learning and is Trust wide and consistently achieves compliance levels.

In addition to this, the Trust provides de-escalation and breakaway training as per the following chart:



Staff attendance is very low, but this course is not mandatory and so does not have the priority or exposure to improve uptake along with staff not having the availability to be released to take part. Staff are required to undertake where they: -

- Work in area of high risk to violence and aggression e.g. ED, Community
- Have been involved in an incident of violence and aggression from a patient/relative

In addition, the training is open to all staff in the Trust. Management of attendance sits within the Divisions.

The training is delivered by 6 members of staff who have undertaken the "train the trainer" training. It has been a challenge this year for staff to be released from their clinical commitments to provide the training.

Plans have been made for members of the CCS Division and Midwifery to be trained to deliver the training for those staff lone working in the Community.

10.3 Audits

Following an incident raising concerns over the governance and standards of security implementing high level physical interventions on site at the Dudley Group, there is agreement for an audit of security body camera footage. The SOP has been ratified by the Internal Safeguarding Board and there is agreement from Mitie, the external provider of Trust security services for this to take place and have access to their security body camera footage.

The audit will review high and medium level restrictive intervention incidents that have required body worn camera activation. The audit is to identify 5% of footage relating to generic violence and aggression incidents and high-level restraint over a variety shifts throughout the day.

The Lead for Mental Health and Complex Vulnerabilities has completed the formal training with MAYBO alongside security. This will ensure that footage reviewed can be identified as taught techniques, alongside proportionate response, least restrictive and de-escalation interventions. MAYBO is Restraint Reduction Network accredited restrictive intervention training.

11.0 Achievements

• A Memorandum of Understanding has been agreed for Black Country Healthcare to provide a Responsible Clinician
• Embedded processes in place for MHA 1983 use within the Trust
• Development of ED Mental Health Risk Assessment Tool
• Right Care, Right Person implementation is in process and creating close working relationships with local Trusts.
• Joint Training alongside security on Managing conflict and challenging behaviour.
• Standard operating procedure for Ligature Cutters is in process.
• Ligature cutter training and access down in place
• ED Bespoke Mental Health training has been rolled out
• Agreement for new assessment tool for assessing dementia and delirium
• Audit of readmission data to influence best practice

• Restrictive intervention group embedded to review practice
• Chemical restraint is a priority for review to improve care standards
• Embedded LD team with increased staffing provision
• Autism Pathway developed
• Attendance at LeDeR steering group and local panel to support improving practice
• LD team have had increased referrals and engagement
• Patient XY Charter in development to improve patient care
• LD Team continues to develop close links with local patient base and their wider connections
• Digital Reasonable adjustment flag implemented
• Patient safety Bulletin shared within Trust regarding “Was not bought” policy
• Advanced MCA training continues with positive feedback
• Bespoke Mental Capacity Act training for specialist areas
• Ward based DoLS training
• Increasing awareness of Mental Capacity Act within the Trust
• Experts in Mental Capacity Act available to offer Trust wide support
• New e-consent programme to streamline mental capacity process
• Audit of Mental Capacity documentation to monitor compliance
• Patient Safety Bulletin shared with the Trust concerning Mental Capacity Assessments and Best Interests decision making.

12.0 Conclusion

There remains ongoing focus to improve the quality and standard of patient care for patients with dementia and delirium. This focuses on support to patients, their families as well as staff. This will link in with the National Audit of Dementia outcomes to ensure evidence-based practice and quality improvement.

There continues to be a drive to improve the standards of recording and monitoring patients detained under the Mental Health Act on a local level and partnership working with Black Country Healthcare. Local education will remain an ongoing area of work.

Staffing of the Dementia and Delirium team remains an area of difficulty but plans to consider all options including the addition of an Admiral Nurse will create an adaptive and responsive team to patient needs and workforce pressures.

Reporting on incidents around restrictive interventions continues to require improvement.

The Learning Disability team have continued to strive towards providing a service which addresses and meets the needs of people with a learning disability when they access hospital services. The team remain committed to continue to embed changes in Trust and continue with the progress noted in the report. With the successful recruitment to vacant posts, the team have demonstrated their ability to increase their episodes of care with people who have a learning disability, and to develop new and exciting initiatives to add to the teams' portfolio to address the health inequalities experienced by the patient group.

The advanced Mental Capacity Act training continues to have positive outcomes and feedback and the MCA Lead will continue to work to increase compliance with this training and maintain high visibility across the Trust.

The Complex Vulnerabilities Team will ensure the Trust appropriately support the most vulnerable patient group, and the Trust are committed to supporting our colleagues to be part of a culture change which sees compassionate and equitable care at its core.

13.0 Key objectives for 2024/25

Key objectives for 2024-2025

Areas for focus and improvements	How?
Strengthen process of Mental Health detentions	• Secure access to Mental Health Act Administrator • Raise awareness in wards and departments • Resolve IT/Sunrise issues around data collection and access • Partnership work with Dudley AMHP
Workforce development	• Compliance with Oliver McGowan Training • Implementation of TNA for MCA Advanced training to support review of gaps and focus training. • Compliance with Advanced MCA Training • Bitesize training on Dementia Care • Training video around use of Section 5(2) • Review staff training options concerning conflict resolution and de-escalation training
Strengthen governance around Restraint	• Communications and awareness raising around use of Datix for reporting and monitoring chemical restraint • Commence monthly audits of high-level restraints captured on body worn camera footage

	• Completion of PRN sedation audit with outcomes to inform practice.
Learning Disabilities Service Improvement	• Development of Learning Disability Champions across the Trust to support the Learning Disability agenda. • Embed the Learning Disability steering group with divisional representation to review Learning disability Standards within the Trust and addressing gaps. • Commence action tracker for LeDeR learning – to be reported and monitored via ISB • Review mobile resources for Learning Disability patients that can be made available for those patients that require them. • Development of Robins Charter**.** • Development of the Autism Pathway. • Reasonable Adjustment flag recording process for patients with a Learning Disability to be embedded.
Dementia Service Improvements	• Review the National Audit for Dementia and implementing outcomes for DGNHSFT. • Implementation of an Admiral Nurse into the Dementia and Delirium Team • Review and update Trust Dementia Strategy • Set up Trust Dementia Steering Group • Review of referral criteria to Trust Dementia and Delirium Team • Review and update of dementia screening pathway and data collection

Workforce KPI Report - Reporting on May 2024
Additional Data
Karen Brogan
Interim Chief People Officer

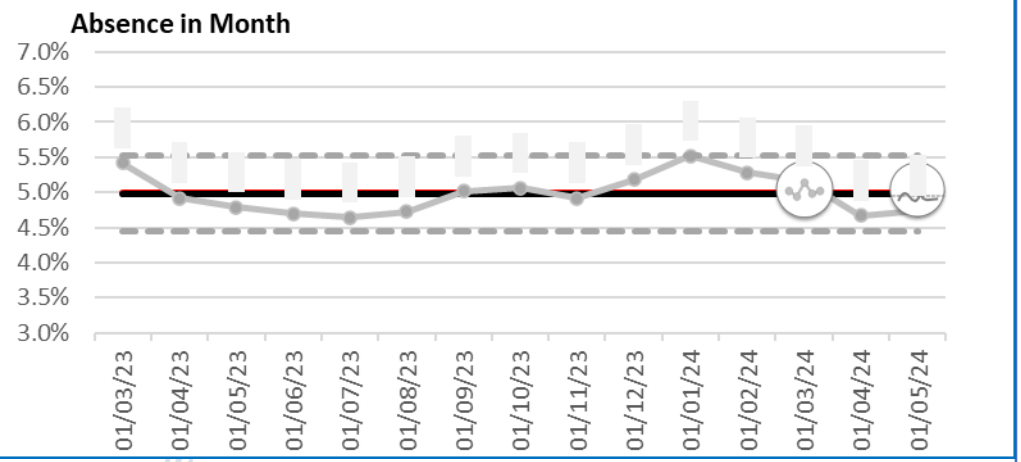
The Dudley Group
NHS Foundation Trust

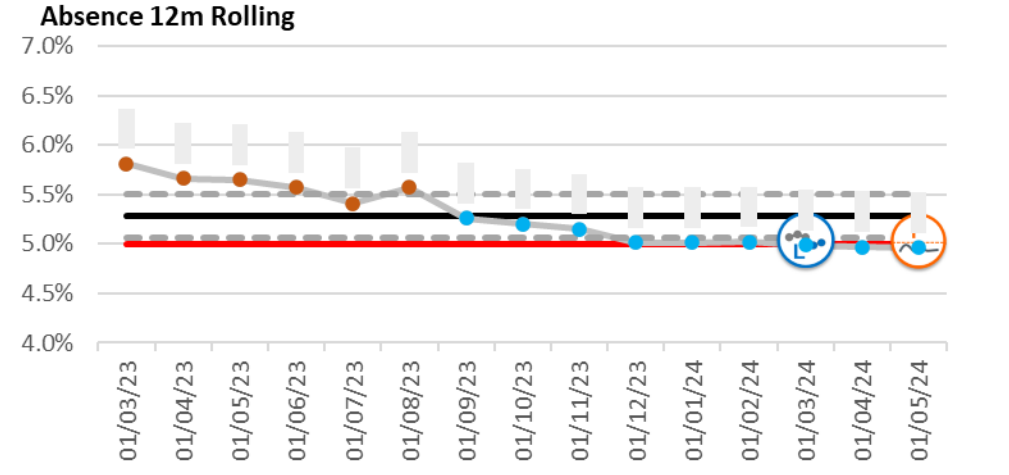


CARE
RESPECT
RESPONSIBILITY

Sickness Absence

The Dudley Group NHS Foundation Trust





In-Month Sickness Absence

In-month sickness absence for May 2024 is 4.74% an increase from 4.67% in April 2024.

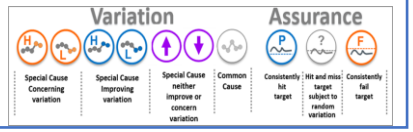
Rolling 12 M Sickness Absence

The rolling 12-month absence has decreased slightly to 4.96% in May 2024 from 4.97% in April 2024. Across the last 12 months this has been reducing but has levelled out over the last few months.

Assurance

Reducing the length of absence is key, to support this we are reviewing how we can support overall wellbeing for our staff members, including the development of a wellbeing strategy.

The main objective is to avoid absences and, where absences do occur, reduce their length, so early intervention is key and is supported by the following discrete pieces of work:

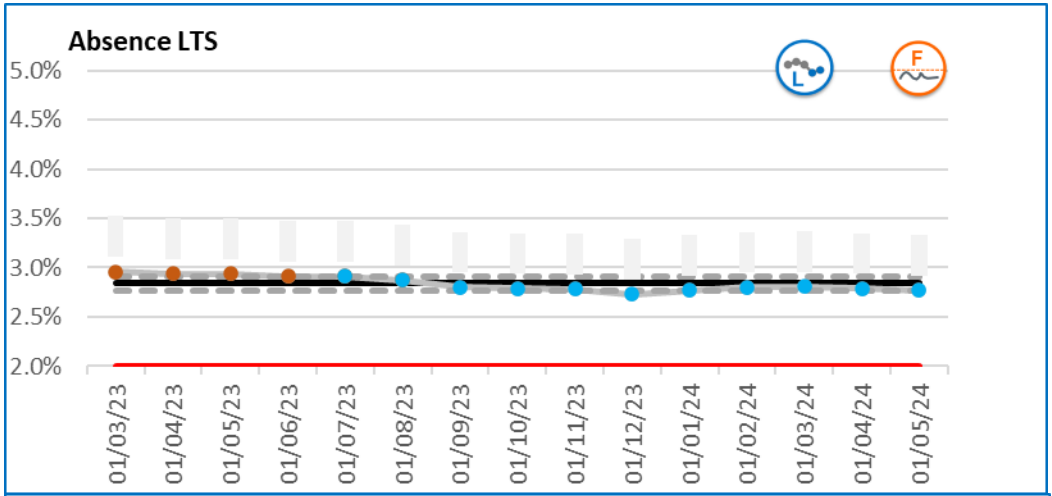


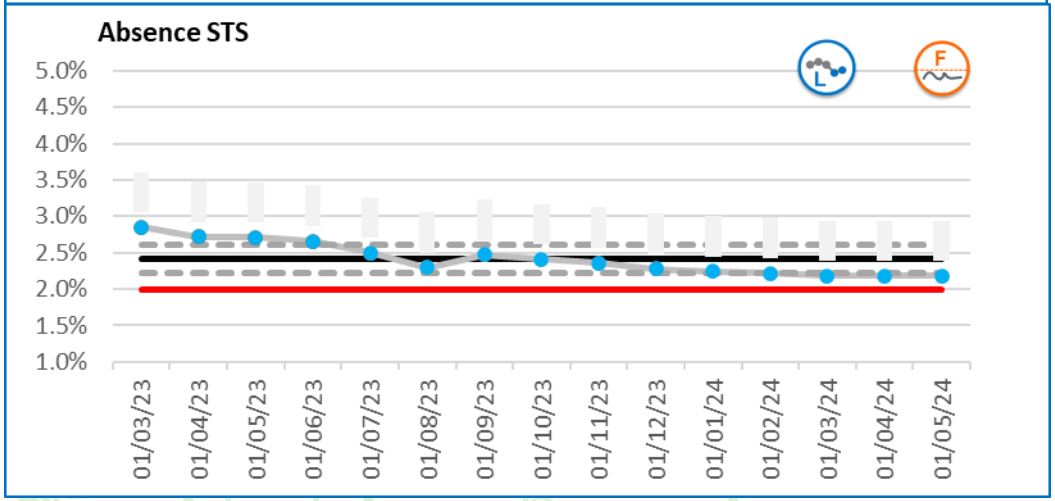
	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24
Absence in Month	4.69%	4.64%	4.72%	5.02%	5.06%	4.92%	5.18%	5.52%	5.28%	5.16%	4.67%	4.74%
Absence 12m Rolling	5.57%	5.41%	5.57%	5.26%	5.20%	5.15%	5.01%	5.01%	5.02%	4.99%	4.97%	4.96%

CARE RESPECT RESPONSIBILITY

Long-Term and Short-Term Absence

The Dudley Group NHS Foundation Trust





Long-Term and Short-Term Sickness Absence

In May 2024 long-term absence has marginally decreased to 2.77% from 2.79% in April 2024. Short-term sickness has remained static at 2.18%.

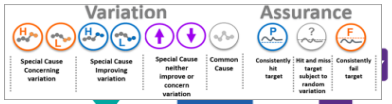
In May 2024 short-term absence accounted for 85% of all sickness absence episodes, with long-term absence (28 days +) accounting for 15% of absence episodes. Long-term absence accounted for 52% of all FTE days lost, compared to 48% for short-term absence.

As at 31st May 2024 there were 103 long-term absences open across the Trust.
87 cases are between 28 days and 6 months
13 cases between 6 months and 12 months
3 cases over 12 months in length

Assurance

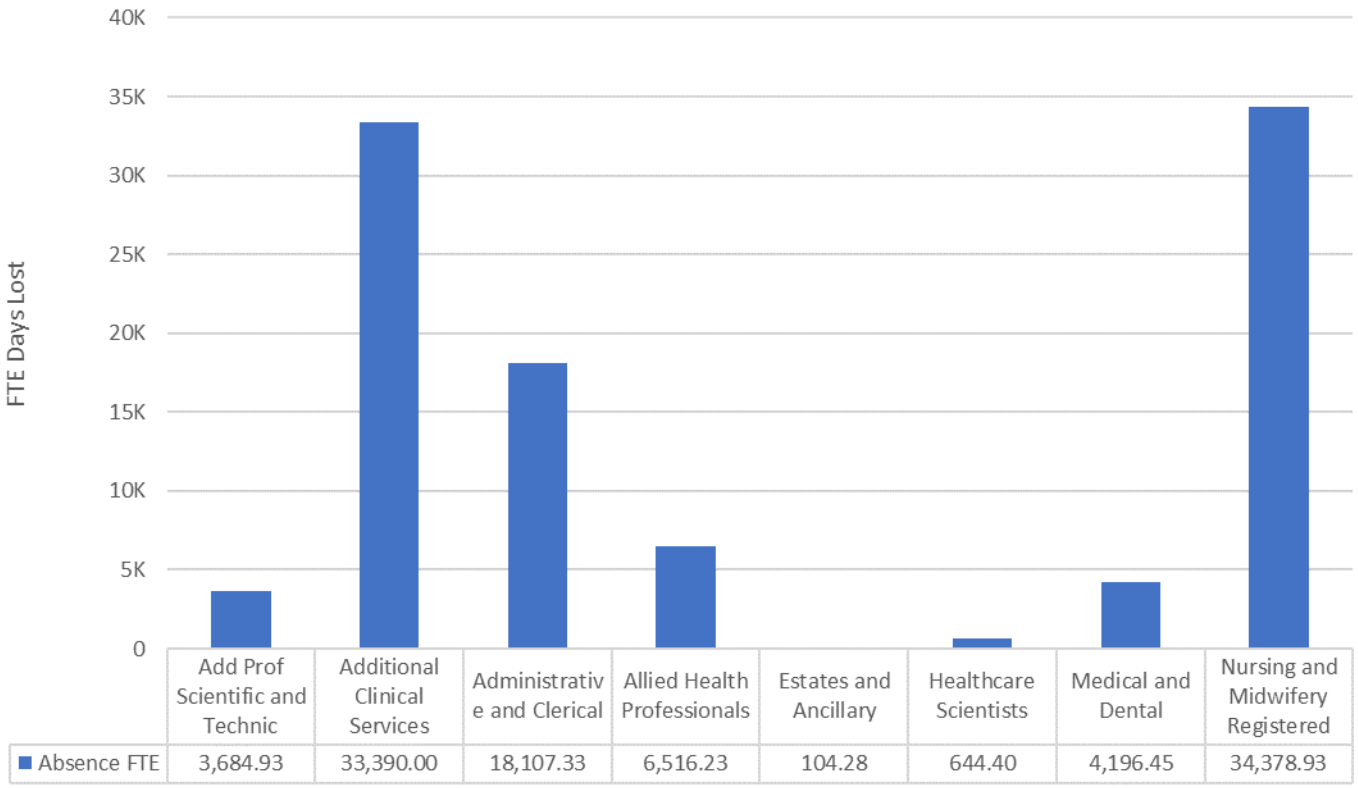
The HR Business Partners continue to support divisions to review both short-term absence and long-term absence and to review the plans in place to ensure that all long-term sickness at 6 months+ and for all short-term persistent absence is being managed robustly.

	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24
Absence LTS	2.91%	2.91%	2.87%	2.80%	2.79%	2.78%	2.73%	2.77%	2.80%	2.81%	2.79%	2.77%
Absence STS	2.66%	2.50%	2.30%	2.47%	2.41%	2.36%	2.28%	2.24%	2.22%	2.18%	2.18%	2.18%



Sickness Absence- Staff Groups

The Dudley Group
NHS Foundation Trust



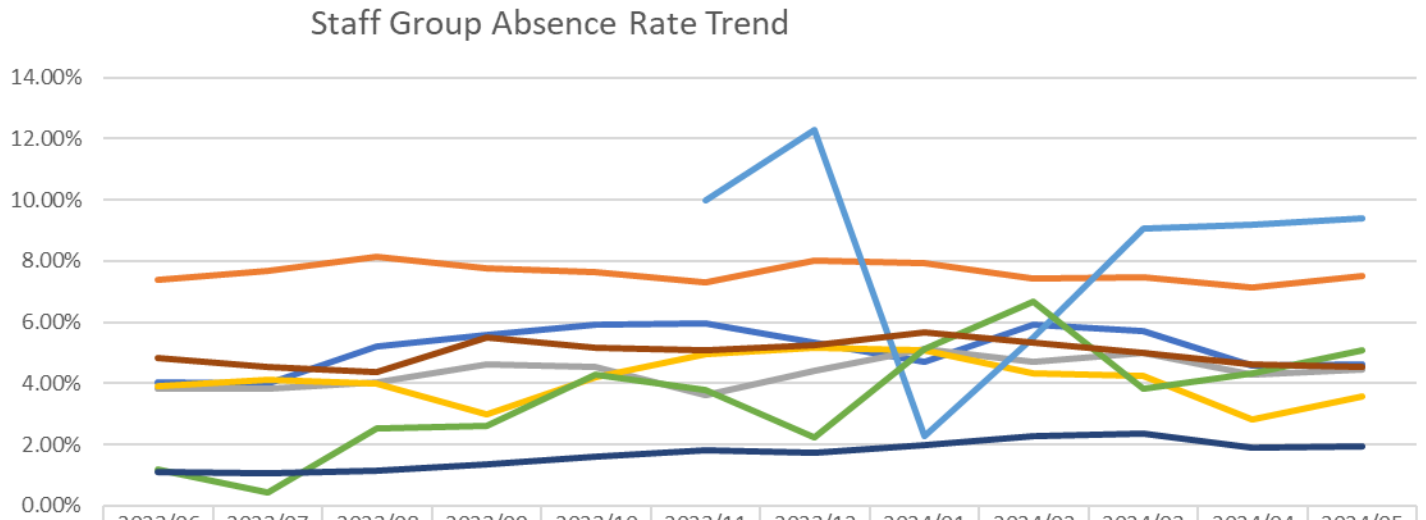
	Add Prof Scientific and Technic	Additional Clinical Services	Administrative and Clerical	Allied Health Professionals	Estates and Ancillary	Healthcare Scientists	Medical and Dental	Nursing and Midwifery Registered
Absence FTE	3,684.93	33,390.00	18,107.33	6,516.23	104.28	644.40	4,196.45	34,378.93

Year to date Nursing and Midwifery and Additional Clinical Services have lost the most FTE days as a result of sickness absence. This is proportionate to the headcount employed within these staff groups.

CARE RESPECT RESPONSIBILITY

Sickness Absence- Staff Groups

The Dudley Group NHS Foundation Trust



	2023/06	2023/07	2023/08	2023/09	2023/10	2023/11	2023/12	2024/01	2024/02	2024/03	2024/04	2024/05
Add Prof Scientific and Technic	4.03%	3.99%	5.19%	5.59%	5.91%	5.95%	5.33%	4.70%	5.92%	5.71%	4.58%	4.64%
Additional Clinical Services	7.38%	7.66%	8.13%	7.78%	7.65%	7.29%	8.01%	7.94%	7.41%	7.45%	7.14%	7.50%
Administrative and Clerical	3.81%	3.82%	4.03%	4.64%	4.55%	3.61%	4.41%	5.12%	4.71%	4.98%	4.29%	4.43%
Allied Health Professionals	3.90%	4.11%	3.97%	3.00%	4.19%	4.95%	5.17%	5.09%	4.31%	4.26%	2.81%	3.59%
Estates and Ancillary						10.00%	12.28%	2.28%	5.52%	9.06%	9.19%	9.38%
Healthcare Scientists	1.17%	0.42%	2.51%	2.62%	4.27%	3.78%	2.24%	5.14%	6.68%	3.82%	4.34%	5.09%
Medical and Dental	1.09%	1.07%	1.13%	1.35%	1.62%	1.80%	1.74%	1.98%	2.28%	2.38%	1.90%	1.95%
Nursing and Midwifery Registered	4.85%	4.54%	4.37%	5.50%	5.18%	5.09%	5.26%	5.67%	5.35%	4.98%	4.61%	4.52%

Estates and Ancillary appears to be the staff group with the highest percentage of absence. Additional Clinical is the second highest. Both are over the Trust target of 5%.

Absence for all staff groups has increased from April, except for Nursing and Midwifery where there has been a slight decline.

Divisional HR Teams are working closely with medical workforce to review processes for managing Medical and Dental sickness absence.

Sickness Absence

The Dudley Group NHS Foundation Trust

Top 10 Departments By Time Lost (May)

Department	Absence FTE	Available FTE	Absence FTE %
253 Pharmacy Department Serv	341.06	4,983.48	6.84%
253 Pathology - Phlebotomy Serv	318.44	1,824.39	17.45%
253 Maternity Unit Serv	274.57	6,334.71	4.33%
253 Critical Care Serv	238.20	4,195.40	5.68%
253 Emergency Dept Nursing Serv	213.04	3,662.08	5.82%
253 Ward C7 Serv	187.32	1,929.88	9.71%
253 Ward B4 Serv	183.28	2,390.72	7.67%
253 Therapy Department Serv	181.66	4,255.43	4.27%
253 Imaging - Radiographic Aides Serv	145.29	1,530.27	9.49%
253 Ward B2 (H) Serv	138.40	1,487.08	9.31%

Top 10 Departments By Absence Rate (May)

Department	Absence FTE	Available FTE	Absence FTE %
253 IBD Nurses Serv	26.45	83.91	31.53%
253 Med Secs Emergency Medicine Serv	24.00	85.15	28.19%
253 Community Dietetics Report Serv	53.33	230.23	23.17%
253 Emergency Minor Injuries Area Serv	118.72	532.37	22.30%
253 Income and Contracting Serv	17.00	80.85	21.03%
253 Med Secs - Neurology Serv	24.00	116.15	20.66%
253 Eye Dept Serv	130.96	673.32	19.45%
253 Pathology - Phlebotomy Serv	318.44	1,824.39	17.45%
253 Community End of Life Nursing Serv	35.80	206.67	17.32%
253 Medical Staff (Medical Oncology) Serv	9.60	55.80	17.20%

Top 10 Absence Reasons By FTE Days Lost (12m)

Absence Reason	Headcount	Abs Occurrences	FTE Days Lost	%
S10 Anxiety/stress/depression/other psychiatric illnesses	719	974	22,315.41	22.1
S13 Cold, Cough, Flu - Influenza	2240	2,945	10,158.63	10.1
S12 Other musculoskeletal problems	552	660	10,088.00	10.0
S25 Gastrointestinal problems	1996	2,689	9,450.22	9.4
S30 Pregnancy related disorders	282	792	5,533.06	5.5
S28 Injury, fracture	213	231	5,410.35	5.4
S99 Unknown causes / Not specified	582	695	5,041.28	5.0
S26 Genitourinary & gynaecological disorders	345	440	4,346.94	4.3
S98 Other known causes - not elsewhere classified	301	423	3,782.46	3.7
S11 Back Problems	280	329	3,402.25	3.4

Top 10 Absence Reasons By Absence Days Lost (12m)

Absence Reason	Headcount	Abs Occurrences	Abs Days	Abs Estimated Cost	%
S10 Anxiety/stress/depression/other psychiatric illnesses	719	974	26,582	£2,297,222.80	22.5
S12 Other musculoskeletal problems	552	660	12,077	£893,782.94	10.2
S13 Cold, Cough, Flu - Influenza	2240	2,945	11,514	£1,119,903.07	9.8
S25 Gastrointestinal problems	1996	2,689	10,779	£919,373.15	9.1
S28 Injury, fracture	213	231	6,312	£618,219.88	5.3
S30 Pregnancy related disorders	282	792	6,224	£547,348.59	5.3
S99 Unknown causes / Not specified	582	695	5,968	£514,527.88	5.1
S26 Genitourinary & gynaecological disorders	345	440	5,266	£350,741.16	4.5
S11 Back Problems	280	329	4,234	£340,939.91	3.6
S98 Other known causes - not elsewhere classified	301	423	4,056	£587,520.38	3.4

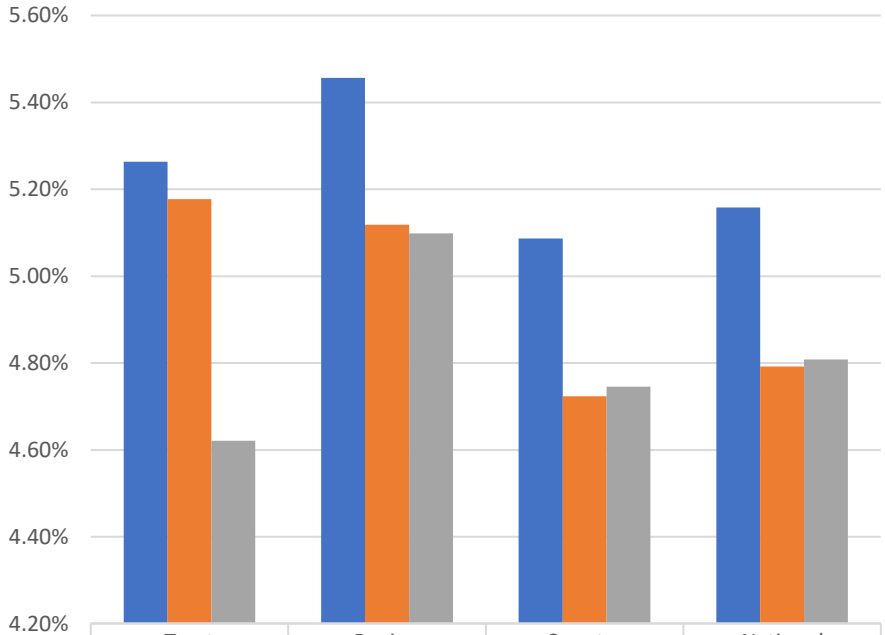
Absence Reasons

- The most common reasons for absence are Anxiety, Stress, and Depression (ASD), Musculoskeletal and Cough, Cold and Flu.
- The departments ranked absence by time lost will be the focus for the HR Business Partners.

CARE RESPECT RESPONSIBILITY

Absence Benchmarking

The Dudley Group NHS Foundation Trust



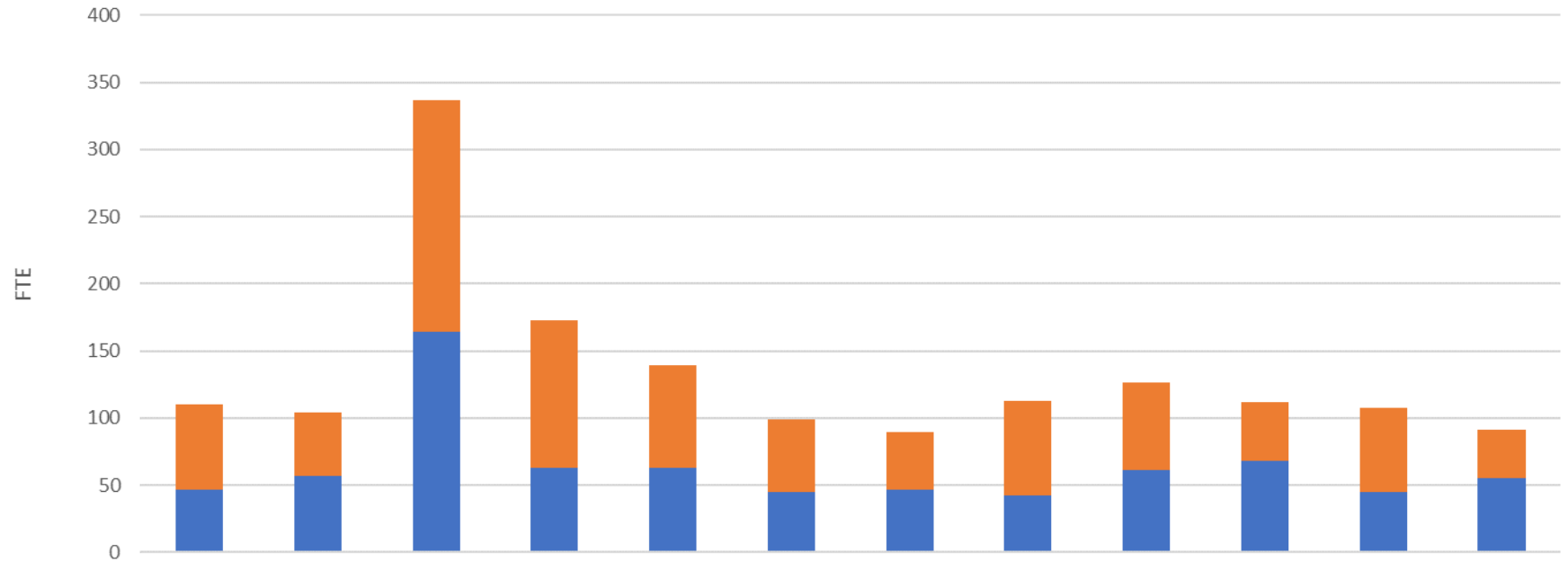
	Trust	Region	Country	National
MO11	5.26%	5.46%	5.09%	5.16%
MO12	5.18%	5.12%	4.72%	4.79%
MO1	4.62%	5.10%	4.75%	4.81%

- National and Regional benchmarking data is only available until end of April 2024.
- Due to local differences in timeframes and methods used for recording sickness absences, national and regional comparative data is subject to change. DGFT absence includes COVID related absences and is refreshed each month twelve months in arrears.
- In April 2024 (M01), the Trust's sickness absence rate was significantly lower than the Region, Country and National reported figures.

CARE RESPECT RESPONSIBILITY

Starters and Leavers

The Dudley Group



	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24
Starters FTE	63.5	47.56	172.18	109.84	76.71	54.58	43.14	70.67	65.39	43.48	62.83	35.54
Leavers FTE	46.58	56.66	164.49	62.96	62.53	44.71	46.14	42.08	60.87	68.38	44.5	55.34

Starters vs Leavers

- This month we have seen more leavers than starters in May 2024.

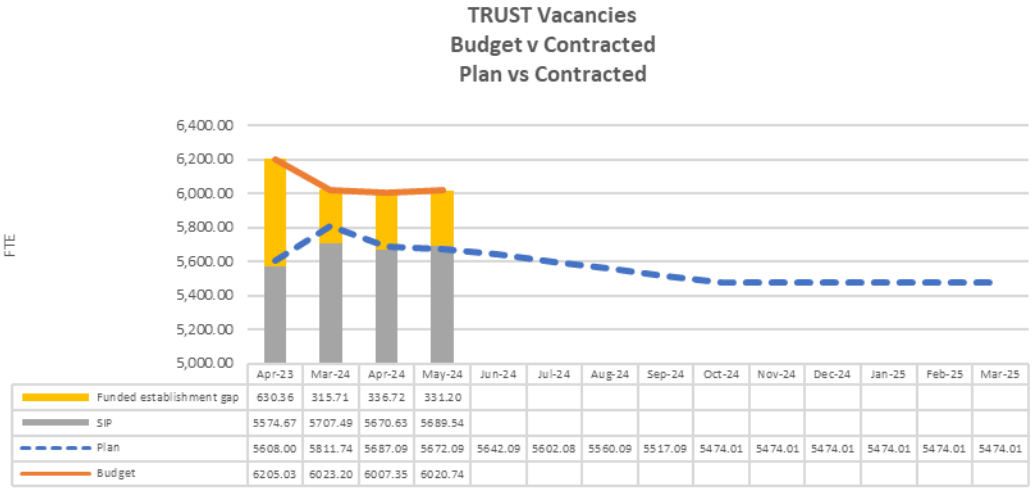
Assurance

- Trust's recruitment and retention journey is now ratified and will be socialised through a new sub-group of People Committee.

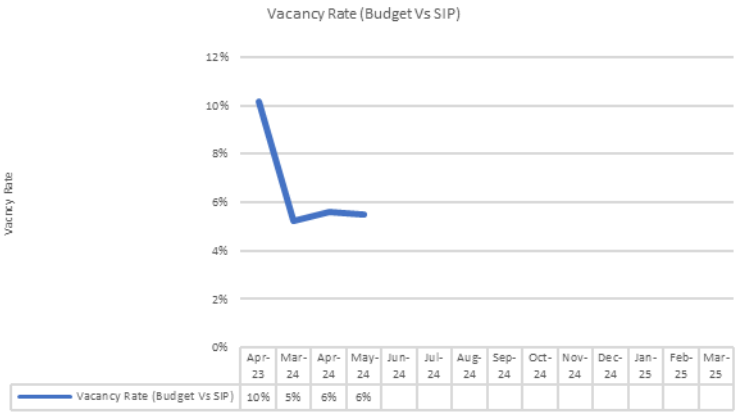
CARE RESPECT RESPONSIBILITY

Recruitment/Vacancies/Turnover - TRUST

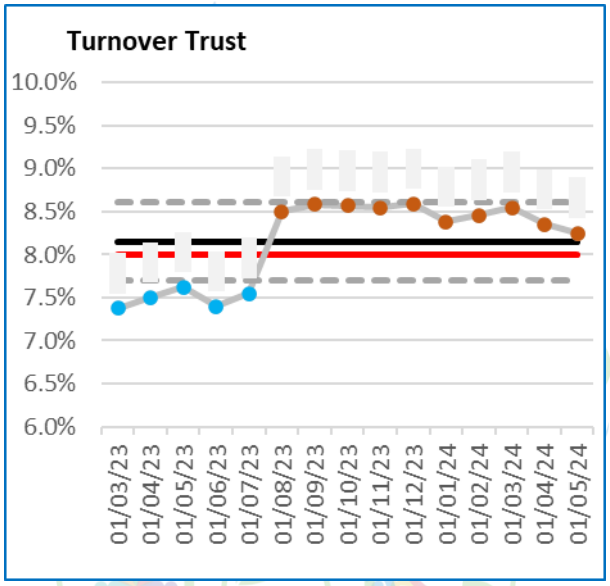
The Dudley Group
NHS Foundation Trust

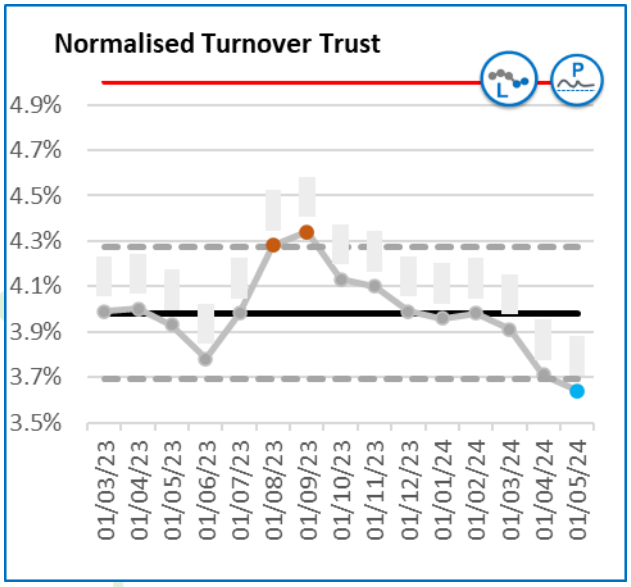


	Apr-23	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25
Funded establishment gap	630.36	315.71	336.72	331.20										
SIP	5574.67	5707.49	5670.63	5689.54										
Plan	5608.00	5811.74	5687.09	5672.09	5642.09	5602.08	5560.09	5517.09	5474.01	5474.01	5474.01	5474.01	5474.01	5474.01
Budget	6205.03	6023.20	6007.35	6020.74										



	Apr-23	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25
Vacancy Rate (Budget Vs SIP)	10%	5%	6%	6%										





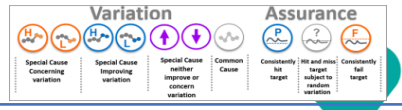
Contracted WTE staff has increased from 5670.63 in April 2024 to 5689.54 in May 2024.

For substantive staff this is 17.45 WTE above the workforce plan.

Total vacancies stand at 331.20 WTE in May 2024. This equates to a vacancy rate of 6%.

Overall staff turnover (rolling twelve months average) is at 8.25% with normalised turnover at 3.64% in May 2024. Both of which are decreases from April 2024.

	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24
Trust Turnover	7.40%	7.55%	8.50%	8.58%	8.57%	8.55%	8.59%	8.38%	8.46%	8.55%	8.35%	8.25%
Trust Normalised Turnover	3.78%	3.98%	4.28%	4.34%	4.13%	4.10%	3.99%	3.96%	3.98%	3.91%	3.71%	3.64%



RESPECT
RESPONSIBILITY

Top 5 Departments - High Vacancies

The Dudley Group
NHS Foundation Trust

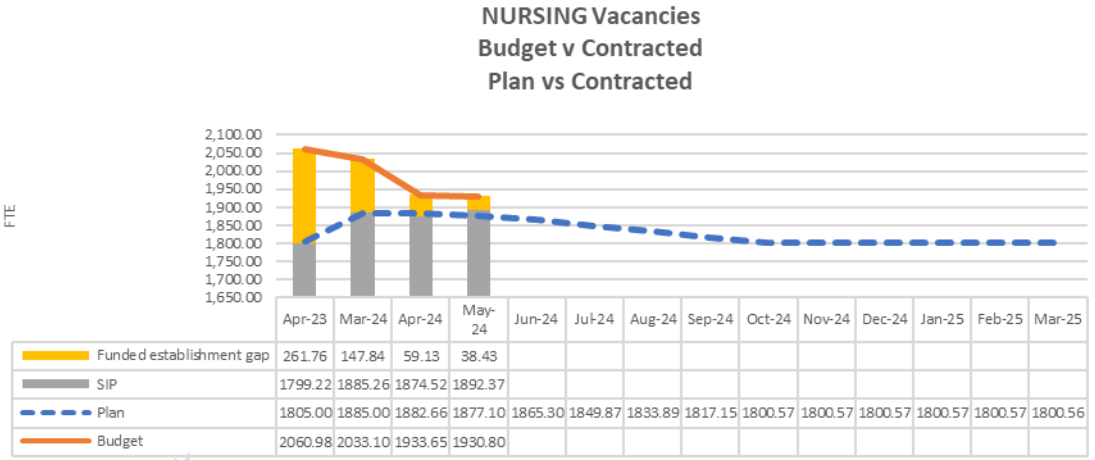
Cost Centre Description	Budget	Contra	Vacanc	Vacanc
Pharmacy Department	187.44	161.2	26.24	14%
Emergency Department Nursing	139.85	117.84	22.01	16%
Breast Screening Mobile	50.8	37.29	13.51	27%
Ward B3	67.49	54.4	13.09	19%
Emergency Dept Paeds Nursing	32.63	21.24	11.39	35%

Pharmacy has the highest WTE vacancies in May 2024 with 26.24 WTE which equates to a 14% vacancy rate.

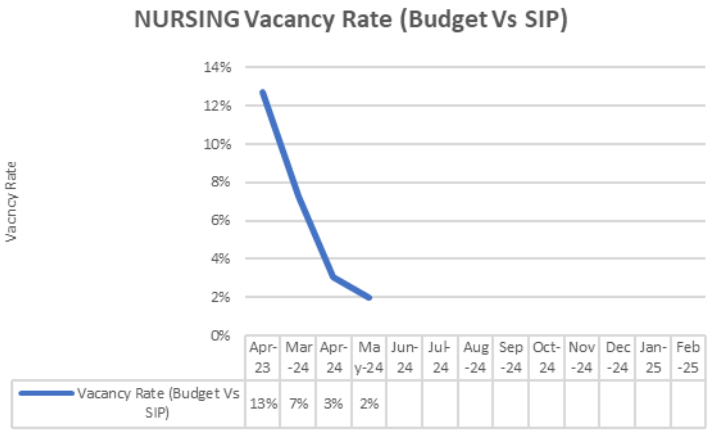
CARE RESPECT RESPONSIBILITY

Recruitment/Vacancies/Turnover - Registered Nursing & Midwifery

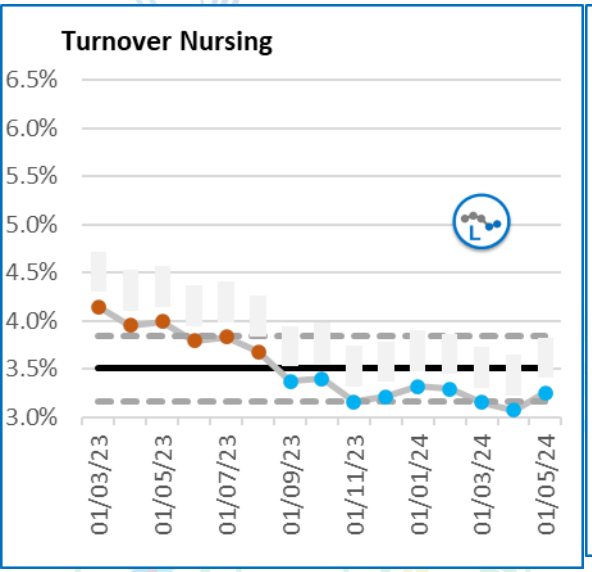
The Dudley Group NHS Foundation Trust

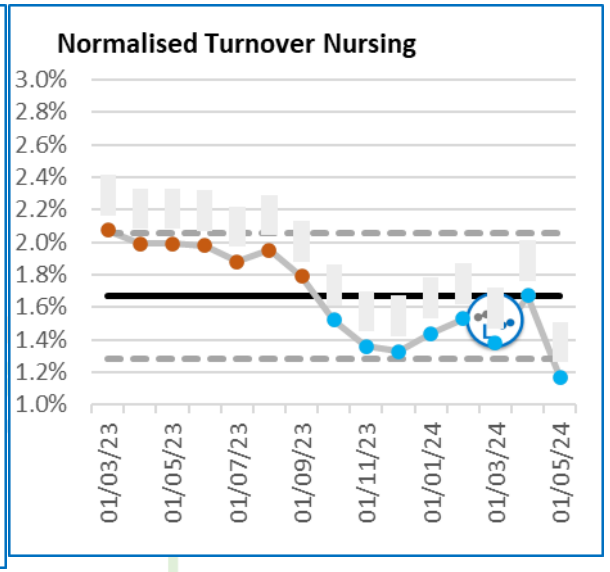


	Apr-23	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25
Funded establishment gap	261.76	147.84	59.13	38.43										
SIP	1799.22	1885.26	1874.52	1892.37										
Plan	1805.00	1885.00	1882.66	1877.10	1865.30	1849.87	1833.89	1817.15	1800.57	1800.57	1800.57	1800.57	1800.57	1800.56
Budget	2060.98	2033.10	1933.65	1930.80										



	Apr-23	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25
Vacancy Rate (Budget Vs SIP)	13%	7%	3%	2%									





Contracted WTE for nursing and midwifery staff has increased from 1874.52 WTE in April 2024 to 1892.37 WTE in May 2024.

This is 15.27 WTE above the workforce plan.

The total nursing and midwifery vacancies reported stands at 38.43 WTE, which equates to a vacancy rate of 2%.

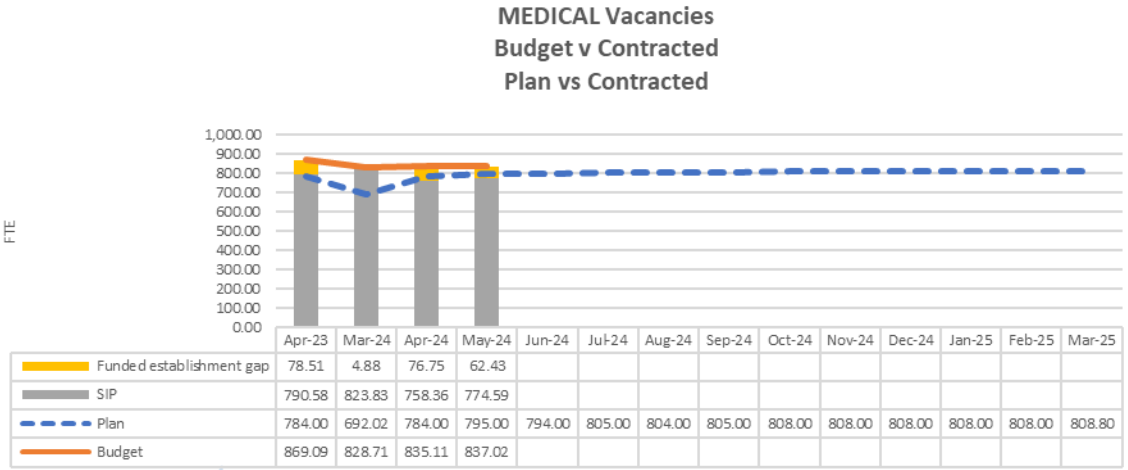
Staff turnover for nursing (rolling 12 months average) is at 3.25%, with normalised turnover at 1.17% in May 2024. Turnover has increased in May 2024 but normalised turnover has decreased.

	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24
Nursing Turnover	3.79%	3.83%	3.68%	3.37%	3.40%	3.16%	3.21%	3.32%	3.29%	3.15%	3.07%	3.25%
Nursing Normalised Turnover	1.98%	1.88%	1.95%	1.79%	1.52%	1.36%	1.33%	1.44%	1.53%	1.38%	1.67%	1.17%

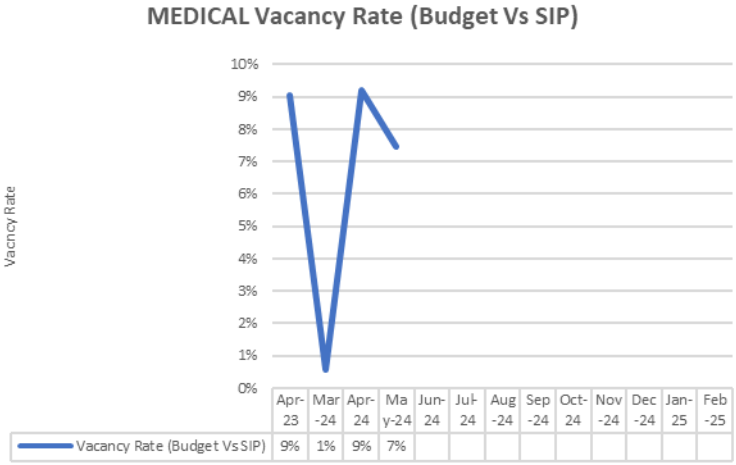
CARE RESPECT RESPONSIBILITY

Recruitment/Vacancies/Turnover - Medical & Dental

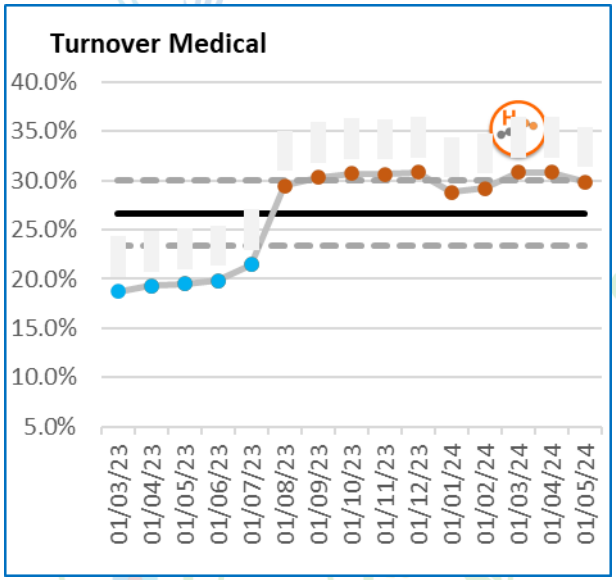
The Dudley Group NHS Foundation Trust

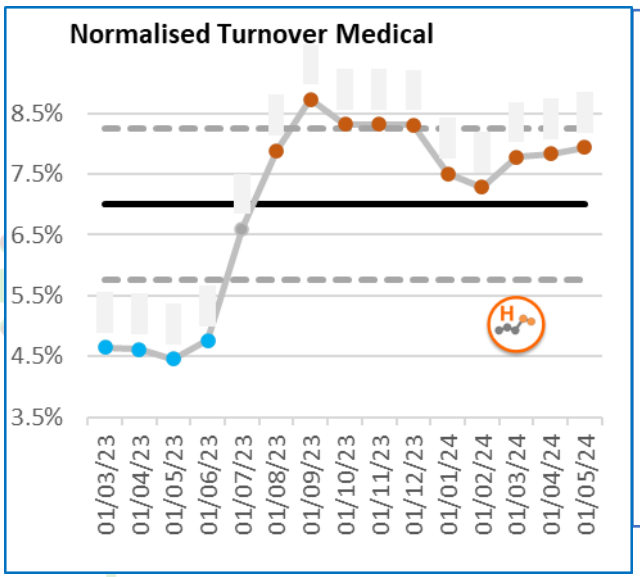


	Apr-23	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25
Funded establishment gap	78.51	4.88	76.75	62.43										
SIP	790.58	823.83	758.36	774.59										
Plan	784.00	692.02	784.00	795.00	794.00	805.00	804.00	805.00	808.00	808.00	808.00	808.00	808.00	808.80
Budget	869.09	828.71	835.11	837.02										



	Apr-23	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25
Vacancy Rate (Budget Vs SIP)	9%	1%	9%	7%									





Contracted WTE for medical and dental staff has increased from 758.36 WTE in April 2024 to 774.59 WTE in May 2024. This is 20.41 WTE below plan.

The total medical and dental vacancies stands at 62.43 WTE. The vacancy rate is 7%.

Staff turnover for medical and dental (rolling 12 months average) is 29.83% with normalised turnover at 7.94%. Turnover decreased but normalised turnover increased. It should be noted that Deanery rotations are included in the turnover.

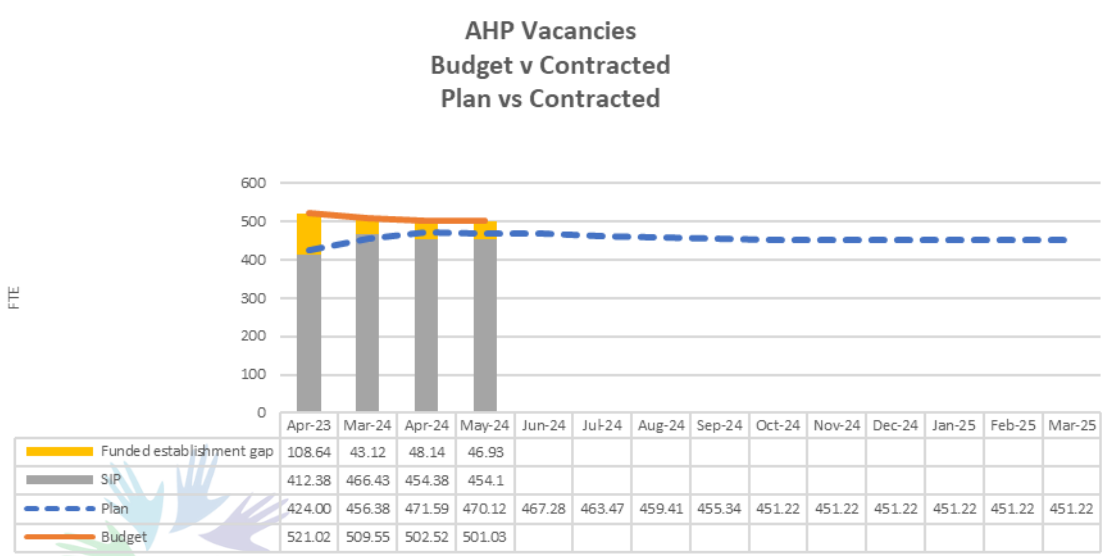
	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24
M&D Turnover	19.82%	21.45%	29.45%	30.34%	30.71%	30.63%	30.82%	28.79%	29.19%	30.86%	30.86%	29.83%
M&D Normalised Turnover	4.76%	6.60%	7.89%	8.73%	8.32%	8.32%	8.31%	7.51%	7.29%	7.78%	7.83%	7.94%

RESPECT

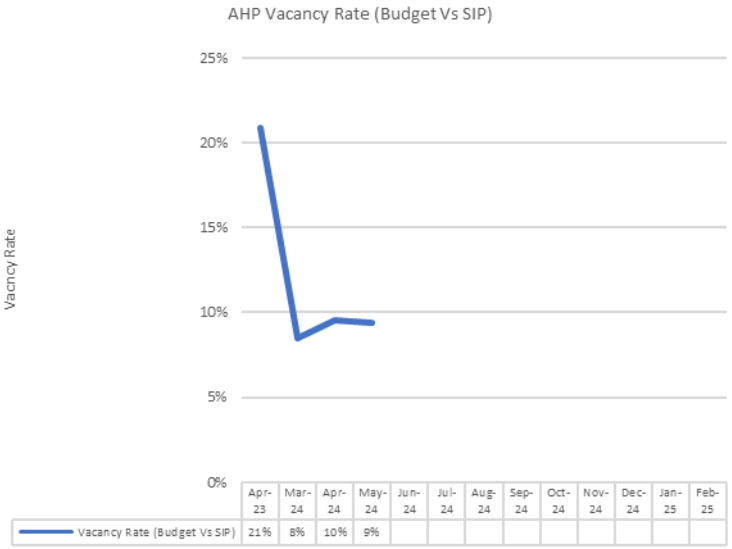
RESPONSIBILITY

Recruitment/Vacancies/Turnover - Allied Health Professional

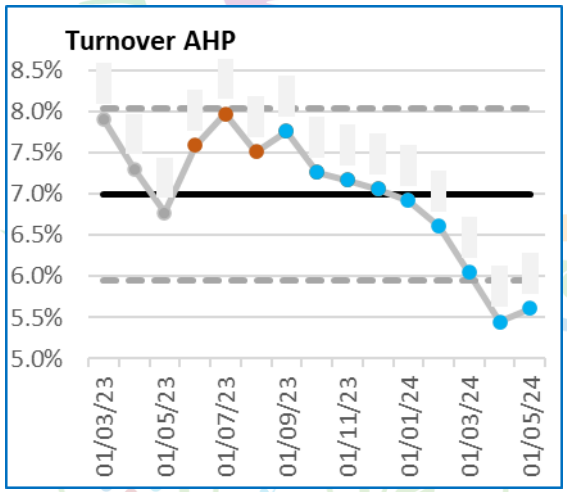
The Dudley Group NHS Foundation Trust

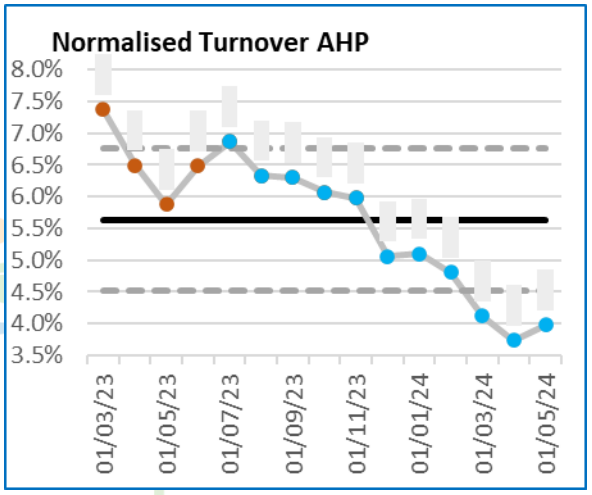


	Apr-23	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25
Funded establishment gap	108.64	43.12	48.14	46.93										
SIP	412.38	466.43	454.38	454.1										
Plan	424.00	456.38	471.59	470.12	467.28	463.47	459.41	455.34	451.22	451.22	451.22	451.22	451.22	451.22
Budget	521.02	509.55	502.52	501.03										



	Apr-23	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25
Vacancy Rate (Budget Vs SIP)	21%	8%	10%	9%									





Contracted WTE for AHP's has decreased from 454.28 WTE in April 2024 to 454.1

This is 16.02 WTE below the workforce plan.

The total AHP vacancies in May 2024 are 46.93, this is a vacancy rate of 9%.

Staff turnover for AHP's (rolling 12 months average) is 5.61%, the normalised turnover is 3.98%. Both of which have increased from the previous month.

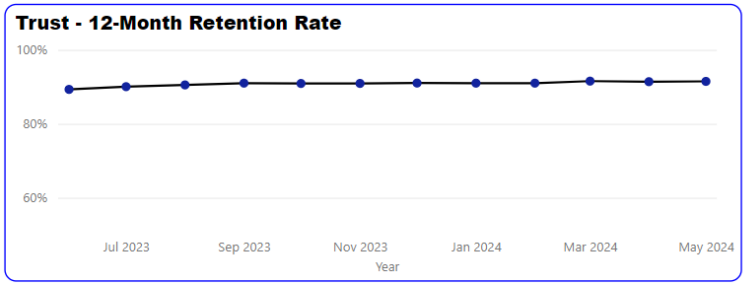
	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24
AHP Turnover	7.59%	7.97%	7.51%	7.76%	7.26%	7.17%	7.06%	6.92%	6.61%	6.05%	5.45%	5.61%
AHP Normalised Turnover	6.48%	6.87%	6.33%	6.30%	6.07%	5.98%	5.06%	5.10%	4.81%	4.12%	3.74%	3.98%

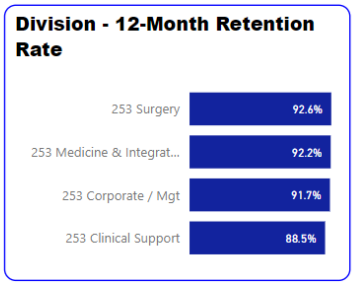
RESPECT

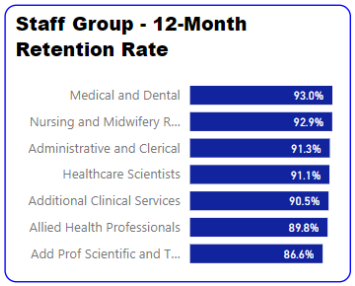
RESPONSIBILITY

Retention

The Dudley Group NHS Foundation Trust

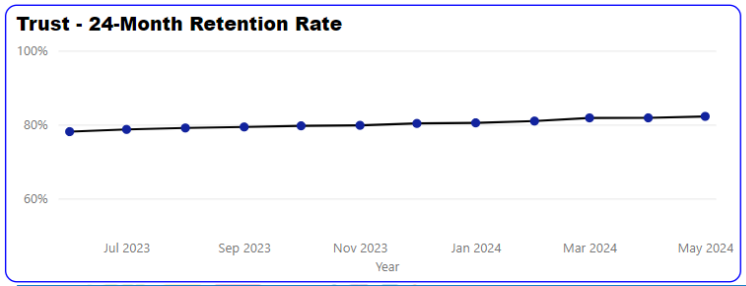


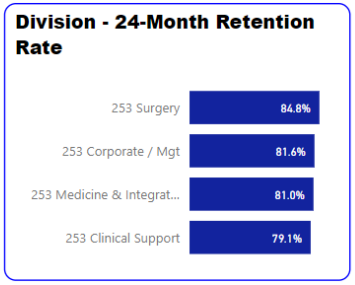


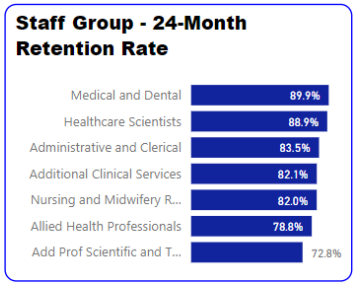


May 2024

12-Month Trust 91.5%



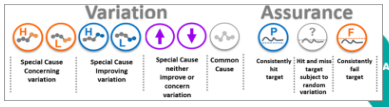




24-Month Trust 82.2%

The retention rate is relatively stable and has been since September 2023. There has been a very slight increase in the 12-month retention rate in May to 91.5% from 91.4% in April 2024.

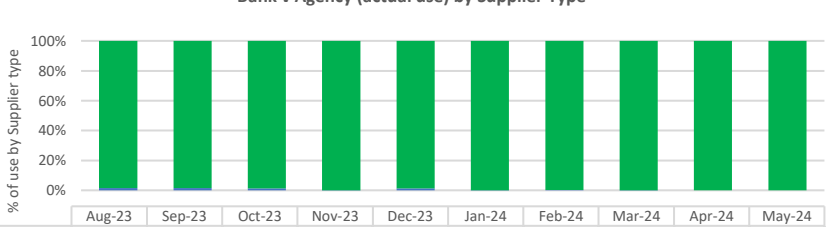
The division with the lowest 24-month retention rate is CCCS at 79.1% ; both Additional Professional, Scientific and Technical staff and Allied Health Professionals are two staff groups that lower retention rates.



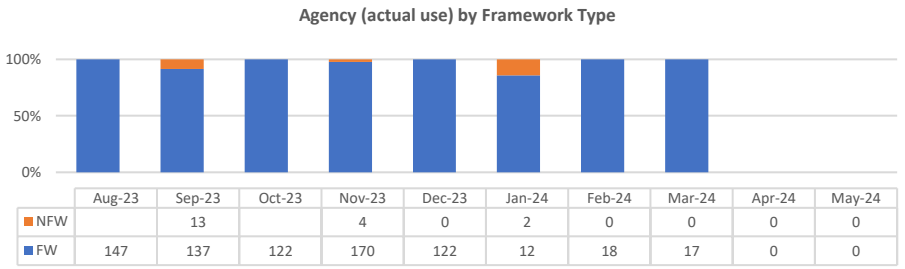
CARE RESPECT RESPONSIBILITY

Bank and Agency Usage

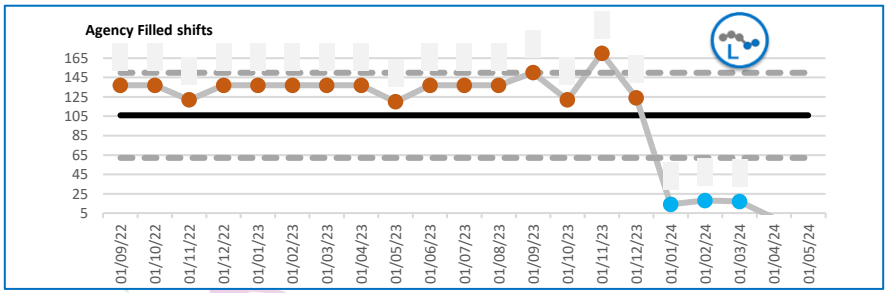
The Dudley Group NHS Foundation Trust

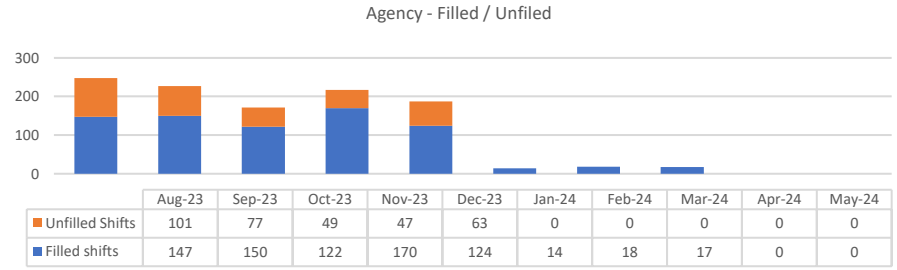


	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24
Bank	98.53%	98.43%	98.78%	98.26	98.64%	99.87%	99.82%	99.87%	100.00%	100.00%
Agency	1.47%	1.57%	1.22%	1.74%	1.36%	0.13%	0.18%	0.13%	0.00%	0.00%

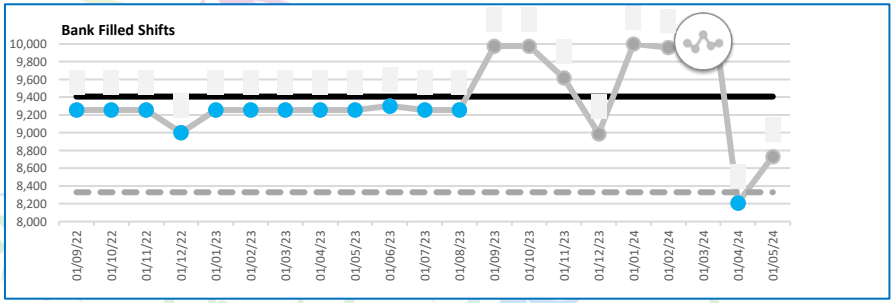


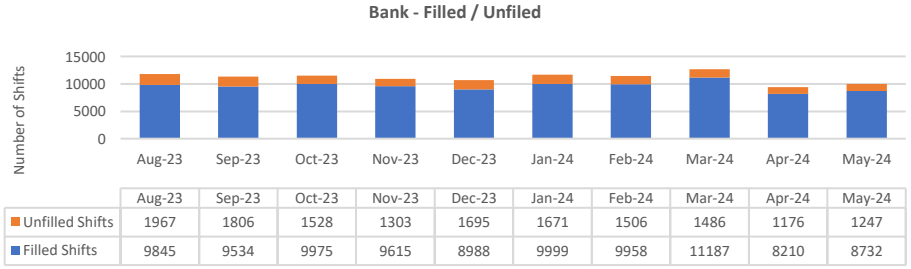
	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24
NFW		13		4	0	2	0	0	0	0
FW	147	137	122	170	122	12	18	17	0	0





	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24
Unfilled Shifts	101	77	49	47	63	0	0	0	0	0
Filled shifts	147	150	122	170	124	14	18	17	0	0





	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24
Unfilled Shifts	1967	1806	1528	1303	1695	1671	1506	1486	1176	1247
Filled Shifts	9845	9534	9975	9615	8988	9999	9958	11187	8210	8732

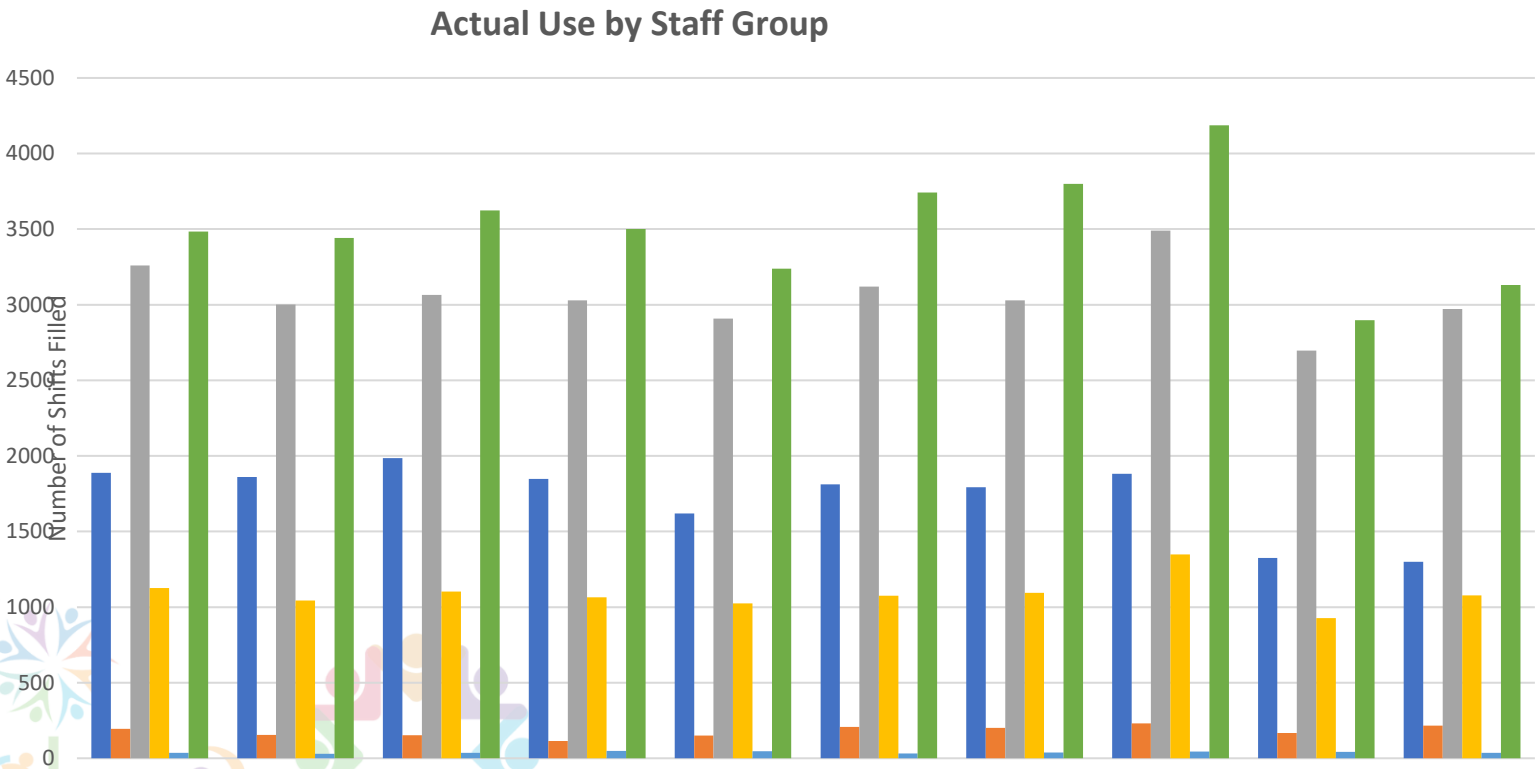
Non-medical agency use remains at zero use. Bank fill rates are 87.5% in May 2024.

There has been a general increase in clinical bank use this month, specifically within in Additional Clinical Services staff group. This is paired with an increase in requests for registered nursing but a lower fill rate than the previous month.

Admin & Clerical requests and actual use have reduced for the third consecutive month.

Bank Usage by Staff Group

The Dudley Group NHS Foundation Trust



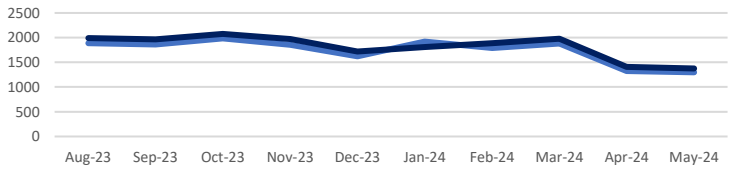
	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24
A&C	1888	1860	1985	1848	1619	1812	1793	1881	1324	1299
Add Prof Scientific and Technic	195	155	152	115	150	208	201	230	168	215
Additional Clinical Services	3259	3001	3065	3028	2907	3120	3028	3490	2696	2972
AHP	1125	1044	1103	1065	1024	1076	1094	1348	926	1078
Healthcare Scientists	35	30	35	48	47	32	38	44	43	36
Nursing & Midwifery Registered	3484	3442	3623	3500	3239	3743	3799	4186	2898	3131

CARE RESPECT RESPONSIBILITY

Bank Fill Rates

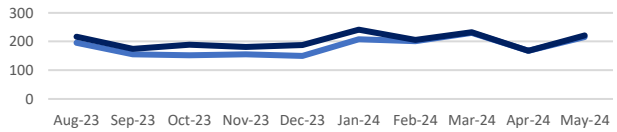
The Dudley Group
NHS Foundation Trust

Bank A&C Filled / Requested



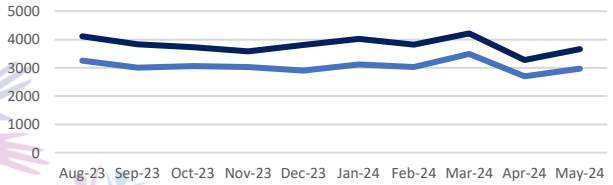
	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24
A&C Filled	1888	1860	1985	1852	1619	1919	1793	1881	1324	1299
Total Request	1994	1965	2074	1971	1717	1812	1885	1977	1406	1377

Bank Add Prof Scientific and Technic Filled / Requested



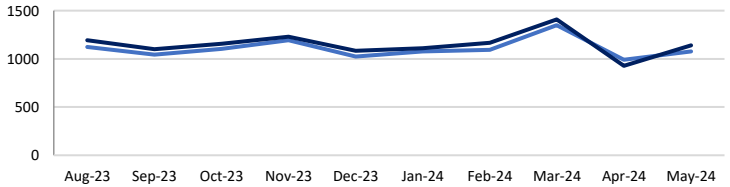
	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24
Add Prof Scientific and Technic Filled	195	155	152	155	150	208	201	230	168	215
Total Request	217	174	189	181	187	241	205	232	168	221

Additional Clinical Services Filled / Requested



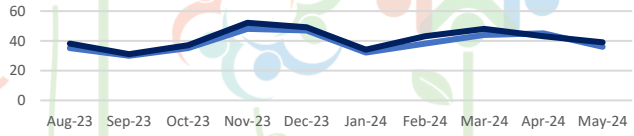
	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24
Additional Clinical Services Filled	3259	3001	3065	3028	2907	3120	3028	3490	2696	2972
Total Request	4116	3831	3733	3581	3812	4027	3819	4211	3278	3667

AHP - Filled / Requested



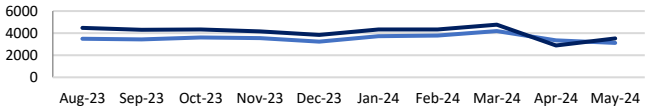
	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24
Filled AHP Filled	1125	1044	1103	1193	1024	1076	1094	1348	990	1078
Filled Total Request	1193	1100	1155	1231	1083	1109	1165	1410	926	1140

Healthcare Scientists Filled / Requested



	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24
Healthcare Scientists Filled	35	30	35	48	47	32	38	44	45	36
Total Request	38	31	37	52	49	34	43	48	43	39

Registered Filled / Requested

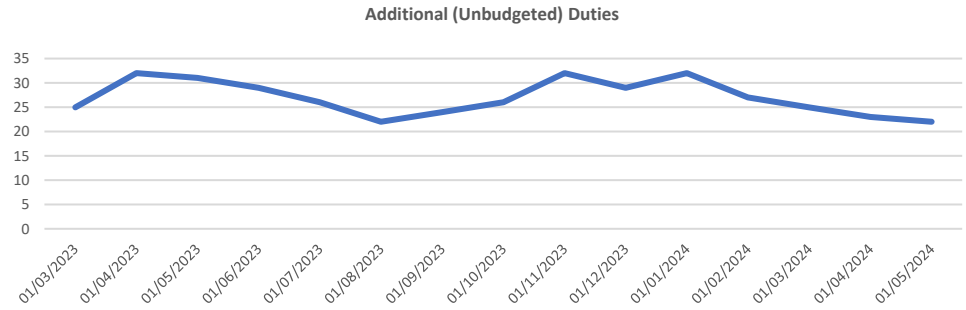


	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24
Nursing & Midwifery Registered Filled	3484	3442	3623	3550	3239	3743	3799	4186	3339	3131
Total Request	4493	4311	4349	4163	3832	4330	4342	4787	2898	3534

CARE RESPECT RESPONSIBILITY

Rostering KPI

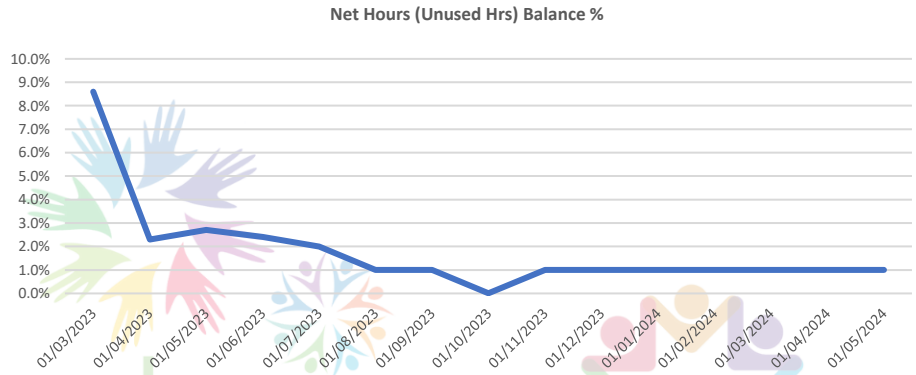
The Dudley Group
NHS Foundation Trust



Average number of assigned unbudgeted shifts per department. These are in addition to the agreed budgeted establishment.

Registered 58%, Unregistered 42%

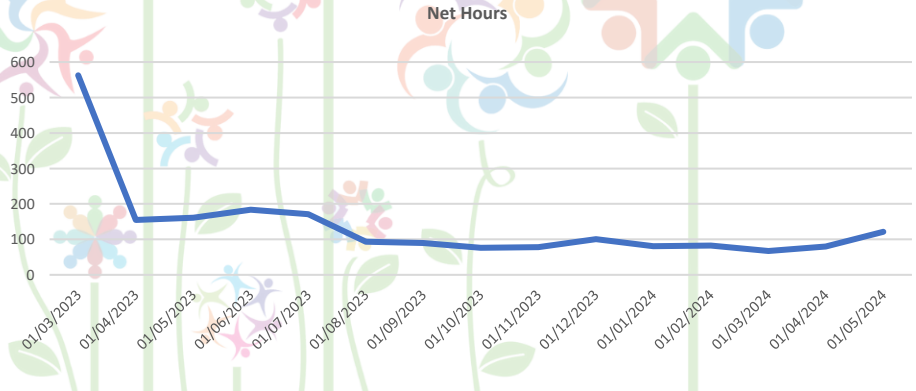
Top departments are Discharge Lounge, Neonatal & Theatres. Top reasons are



Percentage of unused hours at the end of the roster period.

Target – Below 2%

Outreach work by the rostering team helped departments tidy up their rosters so we could report more accurately from April 2023. This metric is monitored during confirm & challenge meetings to ensure departments keep on top of time owing and make up shifts.

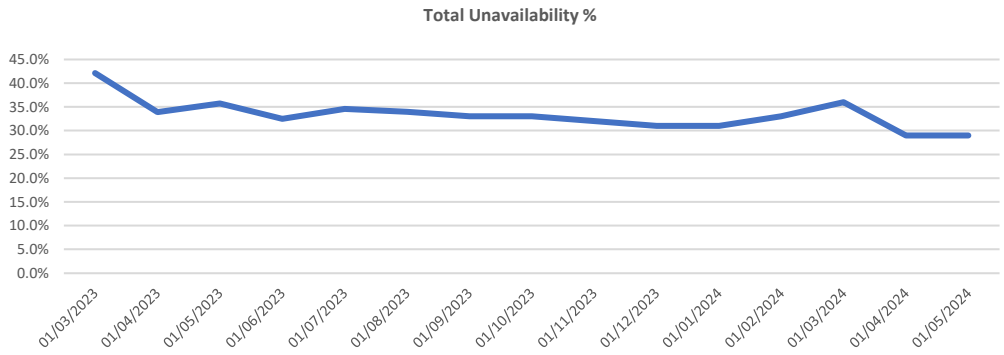


Average number of Divisional unused hours at the end of the roster period.

CARE RESPECT RESPONSIBILITY

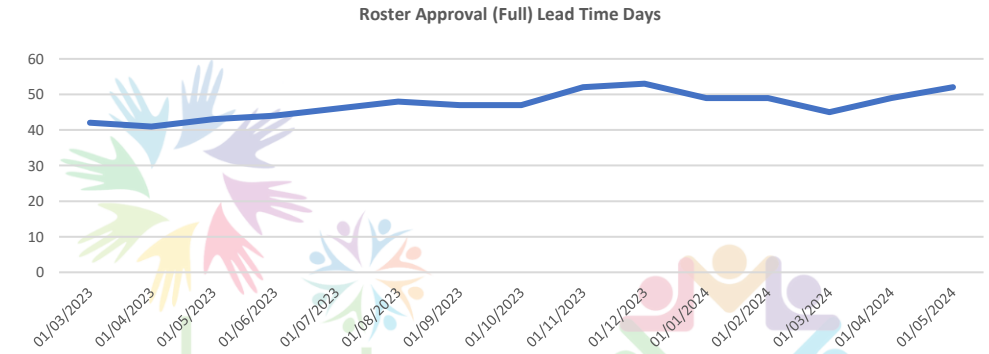
Rostering KPI

The Dudley Group
NHS Foundation Trust



The percentage of staff hours marked as unavailable. Made up of Annual Leave 11%, Sickness 7%, Parenting 4% , Other Leave 1%, Study Day 2% & Working Day 4%.

Headroom percentage built into budgets is 22%.



The average amount of days the 4-week roster has been visible for staff to view before the first day of the roster period.

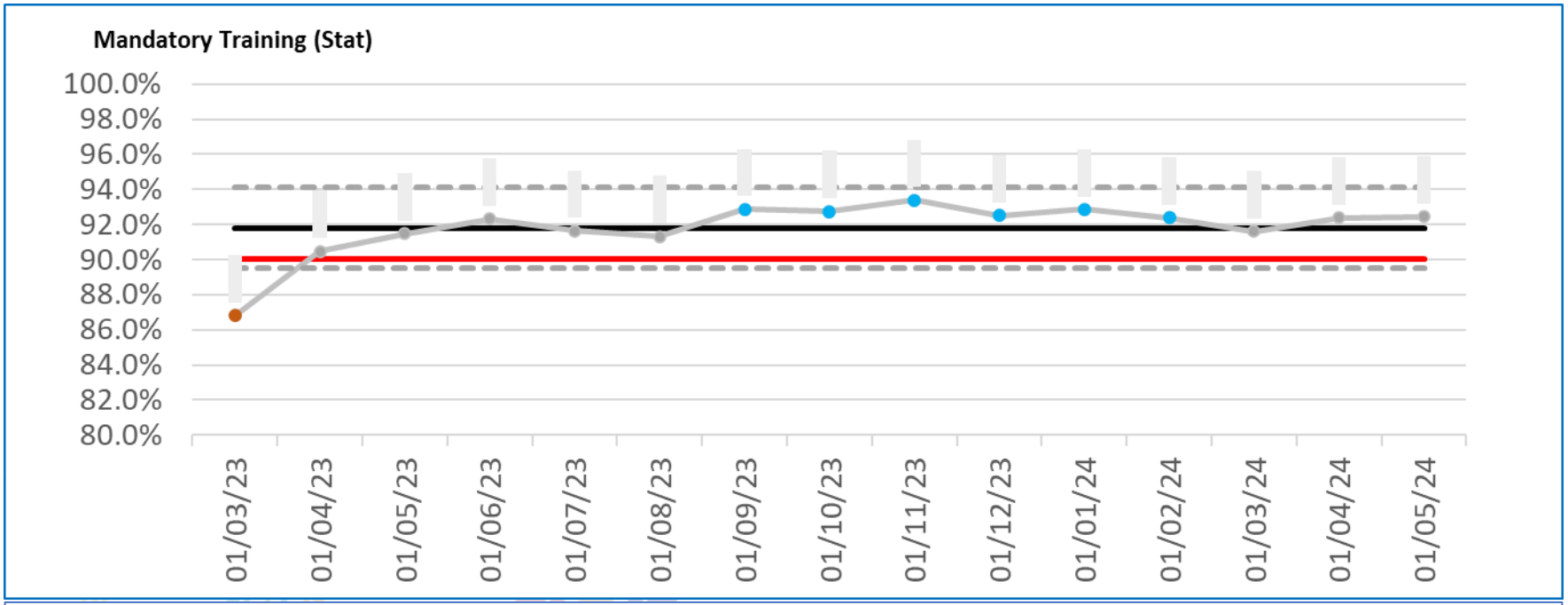
Trust target is 55 days. NHSE minimum is 42 days.

This is trending in the right direction. Confirm & Challenge meetings along with frequent e-mail notifications now being used to improve compliance.

CARE RESPECT RESPONSIBILITY

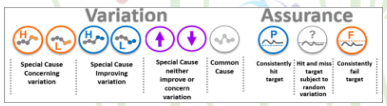
Mandatory Training

The Dudley Group NHS Foundation Trust



Performance against target remains above 90% for the month. This is an ongoing sustained performance at above target since Q2 23/24. The overall position is stable with variations in staff groups (medical staff) and subjects (Paediatric Resus).

	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24
Mandatory Training (Stat)	92.30%	91.63%	91.32%	92.86%	92.74%	93.38%	92.52%	92.85%	92.37%	91.59%	92.39%	92.44%



CARE RESPECT RESPONSIBILITY

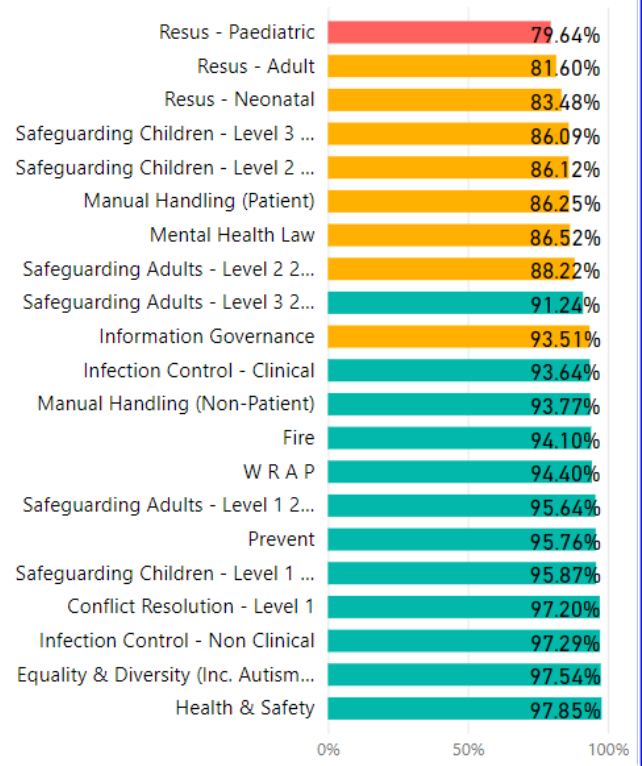
Mandatory Training – Priority 1

The Dudley Group
NHS Foundation Trust

Month: May 2024	Trust	CS	Corporate	MIC	Surgery
	92.44%	94.21%	95.59%	92.20%	90.77%

Course Compliance

Course Compliance (based on selections)



Depts by no. required to achieve 90%

Ward/Service (based selections)

Group5Description	Actual	No. to Target	%' tage
253 Medical Staff - Acute Medicine Serv	909	85	82.33%
253 Theatres Recovery & Anaesth Serv	535	83	77.98%
253 Main Theatre Other Specialities Serv	395	48	80.28%
253 Paediatric Medical Staff Serv	393	48	80.20%
253 Medical Staff (Older People) Serv	235	46	75.32%
253 Medical Staff - GI Serv	204	41	75.00%
253 MOC Medical Staff Serv	416	36	82.86%
253 Theatres Emergency & Other Serv	466	36	83.66%
253 Cardiology Clinical Measurement Serv	444	33	83.93%
253 Medical Staff Cardiology Serv	239	31	79.93%
253 RHH Day Case Theat&Recov Serv	658	28	86.35%
253 Maxillofacial Surgery Medical Staff Serv	68	26	65.38%
253 Ward C8 Serv	831	26	87.28%
253 Medical Staff Stroke Serv	115	25	74.19%
253 Medical Staff - Respiratory Serv	282	22	83.67%
253 Urology Medical Staff Serv	166	21	80.19%
253 Ward C2 Serv	665	21	87.27%
253 General Surgery Medical Staff Serv	484	18	86.89%
253 Medical Staff (Vascular) Serv	134	18	79.76%
253 Mgmt Team Theatres Serv	179	18	82.11%
Total	**66,712**	**-1764**	**92.44%**

The Surgery Division is the lowest performing Division currently.

Statutory Training remains above target across all divisions.

The five subjects requiring most improvement are Resuscitation Adult, Paediatrics and Neonatal, Safeguarding Children Level 2 and Level 3.
Paediatric Resus is only marginally below 80%.

Work continues with Divisions to focus on improvements to these core areas.

CARE RESPECT RESPONSIBILITY

Work Experience and Widening Participation

The Dudley Group NHS Foundation Trust

Work Experience

5 face to face department-led placements (3 clinical, 2 non-clinical; 3 to support access to higher education/training including medical school, and 2 as part of organised work experience through college).
New Centralised WEx programme commenced in May 2024 for College Students in Year 12 & 13, This was a specific programme for those interested in careers in Nursing, Midwifery, and AHPs. The programme consisted of 2 classroom days, and 3 individual student placement days. The classroom days were run by Professional Development and WEx team and took place at the IOT.
24 people applied and 22 were shortlisted and offered. 8 students dropped out for various reasons including exams and no-longer being interested. 14 students attended the programme.

Work Related Learning

Behind the Scenes – Behind the Scenes – No Behind the Scenes Events took place during May. Next event planned for 4th July.

Ambassadors

79 ambassadors currently registered.

Careers Education Information Advice and Guidance (CEIAG)

35 contacts were recorded during May (this comprised of employer talks and a career fair).

Ambassadors - May			
Breakdown	Total number of active ambassadors on record	New active	Number requested to be removed due to time commitments, retirement and leaving the trust
Q1	79	0	0

Employability Programmes

ICAN is a collaborative approach to pre-employment, widening participation and support into employment for people in Dudley. It is a developing programme of work and, currently, connects the Local Council, NHS Acute Trust, and Dudley College. There are three key workstreams currently:

'I CAN Get Started' is a paid work experience programme for people facing significant barriers to employment. The programme commenced in quarter 4 with 10 candidates commencing 6-month placements - 5 at Dudley Group and 5 at Dudley Council. A mid-placement event for Dudley Group placements, ran on 22nd May, with the aim of supporting programme evaluation and to support the candidates on their journey so far.

'Into Employment' Programme – In January 2024 we launched our first Into Employment Programme in collaboration with the Regeneration and Enterprise Adult Learning team (DMBC). This is a 4-week pre-employment programme for unemployed local residents and is designed to fill employability gaps by giving additional skills, knowledge, and building confidence to motivate and prepare candidates for paid work in health and/or social care. The programme culminates in a guaranteed interview for vacancies in our partner organisations, subject to meeting the essential criteria. We are currently running the 4th cohort of the Programme, with 19 people attending the course, and 39 people attending cohorts 1-3.

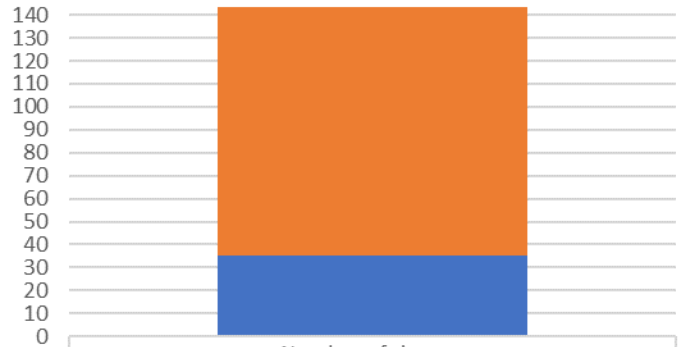
Healthcare Support Worker Novice Programme: The Trust has created a 12-week healthcare support worker training programme, which combines on-the-job experience whilst undertaking the Care Certificate; candidates have been recruited from the Into Employment programme. Following this programme candidates will be eligible to be slotted into support worker vacancies or joining the DGFT CSW bank. The first cohort of the Novice CSW programme commenced on 3rd June with 5 learners, being supported by Professional Development. A further 5 are in the pipeline, having met the criteria and passing the interview for the programme, subject to employment checks. We will interview a further 10 prospective candidates next week to join the second cohort.

Apprenticeships

The Dudley Group
NHS Foundation Trust

Apprenticeships - as of May 24

Number of Signups against year plan (146)



	Number of signups
Remaining signups	111
Sign ups	35

Total Active Apprenticeships **322**	
Apprenticeship Levy	£
Expired Levy April 24	£25,738
Expired Levy May 24	£0

Sign ups for this month include 2 Occupational Therapy Degree apprenticeships. Development work continues for AHP professions from levels 3 to 6.

Target for 2023/24 was not achieved – this was due to a range of factors including:

Expected recruitment activity was not able to go ahead as planned for the novice apprenticeship programme in January and nursing associate programme in March due to lack of available posts.
Cohorts planned in Q4 for the 4th CMI level 5 cohort and Senior Health Care Support Worker Level 3 have been moved to April due to capacity and availability of resources at the College.

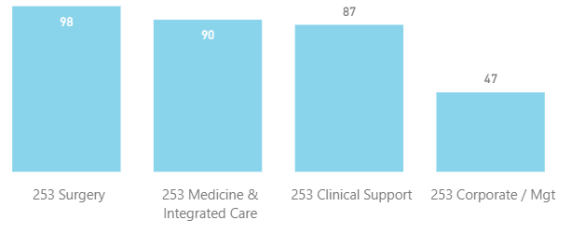
Sign-up activity has included:

31 degree / master level apprenticeships including Chartered Manager, Senior Leader, Operating Department Practitioner, Occupational Therapy, Physiotherapy and Registered Nurse.
Continuation of Business Administration, Medical Administration, Pharmacy programmes and the 3rd CMI level 5 in July.
Introduction of IT programmes at level 4 and 6.
Introduction of Dietetic Masters level 7.

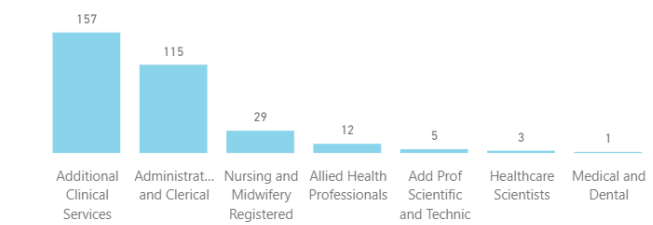
Work continues to promote internal apprenticeship opportunities in order to compensate for the lack of new apprentice opportunities.

Active Apprenticeships breakdown

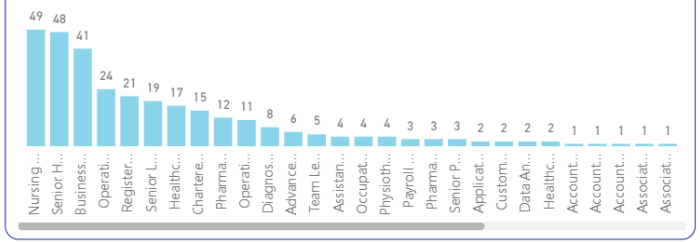
Division



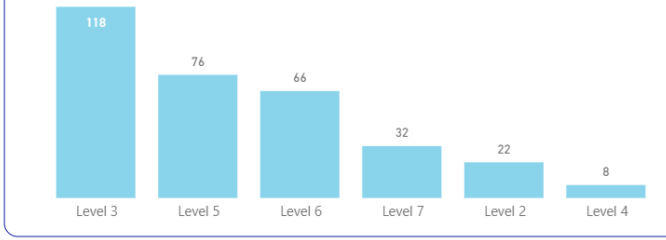
Staff Group



Programme



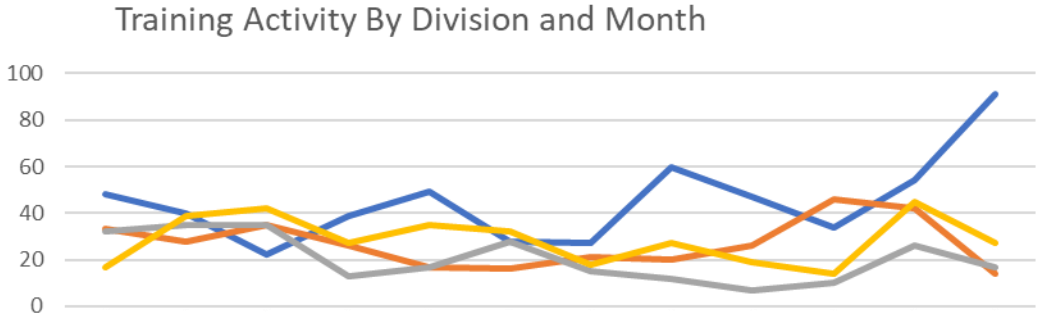
Apprenticeship Level



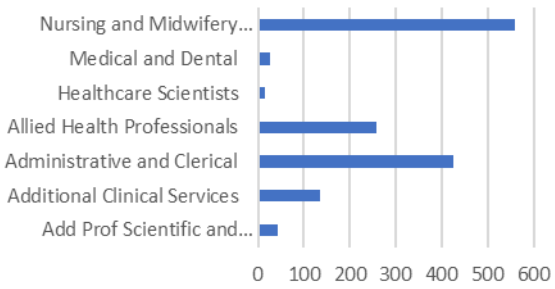
CARE RESPECT RESPONSIBILITY

Organisational Development

The Dudley Group
NHS Foundation Trust



	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24
253 Clinical Support	48	40	22	39	49	28	27	60	47	34	54	91
253 Corporate / Mgt	33	28	35	26	17	16	21	20	26	46	42	14
253 Medicine & Integrated Care	32	35	35	13	17	28	15	12	7	10	26	17
253 Surgery	17	39	42	27	35	32	18	27	19	14	45	27



Course	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Grand Total
253 Admin Essentials							8				12		20
253 Annual Review Training	34	1								12	45	44	136
253 Bespoke Training												21	21
253 Coaching		7			2					5			14
253 Communications 1	3	13	12	8	13	18	24		5	10	6		112
253 Communications 2								10	13		3		26
253 Developing Leaders				6									14
253 Leading People at Dudley								5		8	13	8	34
253 Living The Values	21	12	5	10	37	13		31	21	11	32	12	205
253 Local Induction Training	30	12	7	7		2		6		2		10	76
253 Managers Essentials	22	20	18	25	30	34	20	26	24	23	28	26	296
253 Welcome 2 Dudley Induction	9	10	12	11	18	10	9	20	17	14	9	15	154
253 Wellbeing 1	8	11	24	18		16	14	12	12	7	13	8	143
253 Wellbeing 2	3	5	8	9	11	11	6	9	7	6	3	5	83
253 Wellbeing Adhoc		41	48										89
253 Wellbeing Champions		10		11	7					6	3		37
Grand Total	**130**	**142**	**134**	**105**	**118**	**104**	**81**	**119**	**99**	**104**	**167**	**149**	**1460**

Training activity has increased in April due to the launch of annual review training. Demand for Living the Values training continues to increase alongside increased participation in Manager's Essentials. Promotion continues across the organisation to ensure effective utilisation of training.

CARE RESPECT RESPONSIBILITY

The Dudley Group
NHS Foundation Trust

Public Sector Equality Duty (PSED) Annual Report 2024

Equality, Diversity and Inclusion (EDI) is enshrined in our vision and through our values of care, respect and responsibility that underpin the day-to-day activities and diverse communities of the Trust. We are committed to being a more inclusive organisation, ensuring equal opportunity and celebrating diversity. Encouraging and supporting the workforce we employ to reach their potential. This will support our goal to be a brilliant place to work and thrive.

Publication of Information
May 2024

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1. Introduction

We are continuing with our ambition to embed equality, diversity, and inclusion as a golden thread into everything that we do. We believe it's the right thing to do and we are passionate about doing it. Our workforce is a rich mix of ethnicities, cultures, religions, faiths, beliefs, ages, and identities that come together. Making it imperative that our ambition is advanced through this golden inclusion thread. We want every person who comes through our doors, to feel safe and included, as their authentic self and able to access our services freely and safely, for the right treatment at the right time.

We are committed to creating an inclusive culture where people feel that they belong. We are passionate about this, because it benefits our staff, patients, visitors, service users and the community that we serve. Developing an inclusive environment supports us to comply with our legal and statutory obligations, for example, through the workforce race equality standard (WRES), workforce disability equality standard (WDES), Equality Delivery System (EDS) and the gender pay gap reporting (GPG).

Our aim is to create a culture of inclusion where everyone feels valued and respected for who they are and what they bring to our organisation. Our equality, diversity and inclusion activity is linked to the NHS People Plan, the Trust's Dudley People Plan and our strategic objectives.

The purpose of this annual Public Sector Equality Duty (PSED) report is to provide an overview with progress towards creating an inclusive workplace where all employees are treated fairly and with respect. It outlines the strategies/approaches, initiatives, and actions planned and taken by the Trust to promote equality, diversity, and inclusion.

This report serves as a tool for transparency and accountability, as it communicates the Trust's commitment to equality, diversity, and inclusion, its progress in this area alongside internal and external stakeholders.

2. Our Duties and Responsibilities

Our vision statement is '*Excellent healthcare, improved health for all'* and we are a values-based, aspiring for excellence organisation. We intend to build on and uphold our pledge to become a more inclusive organisation.

At The Dudley Group, we want to ensure all colleagues, patients and visitors are, respected and included in decisions that affect them. Our staff must feel safe and confident to be themselves at work and develop their skills as part of a great team. Embracing our diverse cultures and inspiring collaboration is critical to the success of the Trust.

The care of our patients is strengthened through the diversity of thought, approach and culture delivered by staff from rich and different backgrounds. Embedding an environment of equality and inclusion is a pivotal pillar of the Dudley People Plan, which has the full support and championship of the Trust board.

The Equality Act 2010 introduced a general equality duty requiring organisations to have due regard in the exercising of their functions. These are to:

- Eliminate discrimination, harassment, and victimisation.
- Advance equality of opportunity between people who share a protected characteristic and people who do not.
- Foster good relations between people who share a protected characteristic and those who do not.

We are required to do this by:

- Removing or minimising disadvantages suffered by people due to their protected characteristic.
- Taking steps to meet the needs of people from protected groups where these are different from the needs of other people.
- Encouraging people from protected groups to participate in public life or in other activities where their participation is disproportionately low.
- The steps involved in meeting the needs of disabled persons that are different from the needs of persons who are not disabled include steps to take account of disabled person's disabilities.
- Having due regard to the need to foster good relations between persons who share a relevant protected characteristic and persons who do not share it involves having due regard to the need to tackle prejudice and promote understanding.

The Protected Characteristics covered by the Equality Act 2010 are:

3. Our Commitment

We are committed to being a more inclusive organisation where equality, diversity, and inclusion are a golden thread running through everything we do. The equalities and wellbeing team have been focused on delivering the objectives detailed in our Equality, Diversity, and Inclusion Journey (our strategic plan) since its launch in 2023. The team is dedicated to ensuring equal opportunity for everyone, celebrating staff differences, and encouraging the workforce to reach their potential.

Connecting our strategic objectives to enhancing equality, diversity, and inclusion:

- Deliver right care every time.
- Build innovative partnerships in Dudley and beyond.
- To be a brilliant place to work and thrive.
- Drive Sustainability and financial environment.
- Improve health & well-being and reduce inequalities.

4. Compliance Drivers

In support of the effective delivery of the equality duties of the Equality Act 2010 and the Public Sector Equality Duties (PSED), there are other mandatory requirements for the Trust as an NHS organisation. These include:

- NHS Standard Contract (SC13 Equity of Access, Equality and Non-Discrimination) compliance of which is regulated and monitored by the Care Quality Commission (CQC)
- Workforce Race Equality Standard (WRES)
- Workforce Disability Equality Standard (WDES)
- Gender Pay Gap (GPG) reporting.
- Equality Delivery System (EDS)
- NHS England EDI Improvement Plan 23/24 (High Impact actions).
- Accessible Information Standard (AIS)
- Sexual Orientation Monitoring Standard (SOMS)

5. The Dudley People Plan

The Trust published its Shaping #Our Future in 2022, developed through engagement with staff, patients, and partner organisations. Through a clear vision, set of strategic priorities and refreshed values, it places staff at the heart of what we do as they are central to the success of the organisation. The successful delivery of the Trust's vision 'Excellent health care, improved health for all' requires a motivated and skilled workforce.

We recognise the contribution made by every member of staff and the important role they play, each day, in delivering safe, effective, high quality patient care, whilst role modelling our values

Our People Plan recognises the value of our people and the link that exists between an engaged, happy workforce who feel valued and the quality and efficiency of the care they can provide.

The Dudley people Plan should be read in conjunction with the organisational strategy Shaping #Our Future and the 5 key people journeys as they reflect what matters to our people in its delivery. It is recognised that not all staff provide direct patient care but that we all have a key role in the patient journey. All staff should feel supported and valued in their development to ensure they are able to progress as far as possible in their careers.

The Dudley People Plan covers a three-year period from 2023-2025. The Dudley People Plan summarises the work that our people can expect embedded in our 5 People Journey:

1. Equality, Inclusion and Diversity
2. Organisational Development
3. Wellbeing
4. Recruitment and Retention
5. Continuous Improvement

People Journeys				
Equality, Diversity & Inclusions	**Organisational Development**	**Wellbeing**	**Recruit & Retain**	**Continuous Improvement**
We will create an inclusive organisation that ensures equal opportunity and celebrates diversity	We offer support and growth for you to develop your potential. There are opportunities for everyone	We support staff to be safe and healthy and have access to professional support when needed	Dudley is the place people want to work. We make it easy to work at Dudley	We engage, empower, and enable everyone to continuously improve their work
Measures of Success				
1. Sustain an expand membership of induvial diversity networks. 2. Improve reported position on WRES and WDES metrics around progression, development, and leadership representation.	1. 100% of managers have completed Managers Essentials 2. 95% compliance for Annual Reviews to be achieved from 2023 onwards, with quality audits demonstrating reviews meets standards.	1. Wellbeing Staff Survey scores improve annually with the goal of achieving the top quartile by 2025. 2. Fully embed Wellbeing Champions with a gaol of one active champion for each team/service.	1. Vacancy rate below 7% 2. Turnover Rate below 8%	1. The proportion of employees engaged in improvement activity is above 50%. 2. DGFT's culture of continuous improvement as measured by a subset of staff survey questions is in the top quartile of Acute and Community trusts.
Enablers				
Digital We use digital tools to deliver our plans	Communication We listen and learn from our people to inform what we do		Engagement We involve our people in our work	
Organisational Culture				

To develop each of the journeys, it was important to understand the employee lifecycle, a model that identifies and describes all the various stages an employee experiences with an employer. It starts from the pre-inception stage of knowing the employer but not yet working for them, to the last lap stage of post-employment.

A Positive employee experience is at the heart of our strategy, this brings employee life cycle model at the forefront of developing our journeys, it provides a model for managing every interaction between employee and employer at various points of their timespan brings many advantages, including:

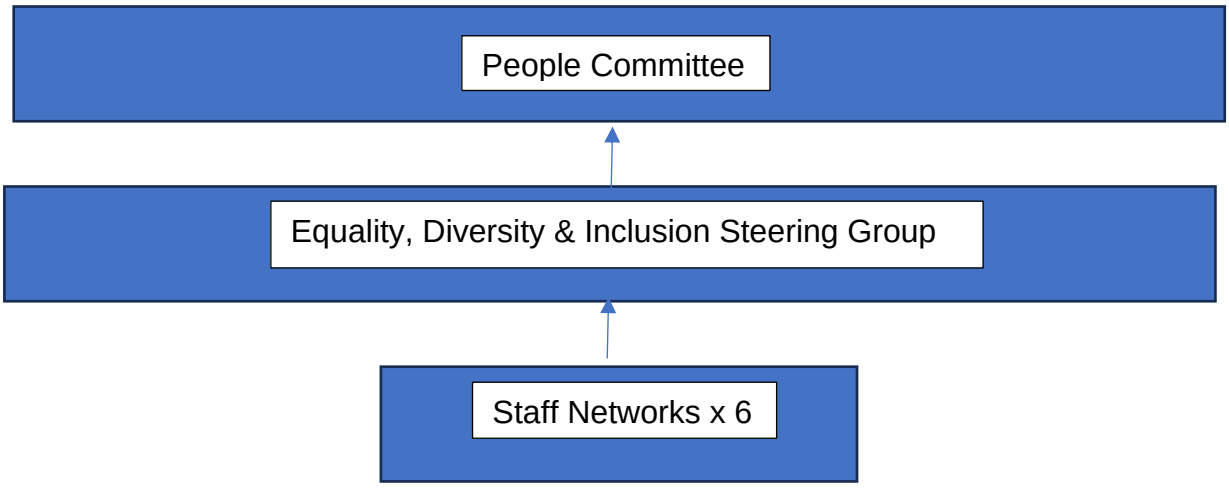
- Engaging with employees at each level:
  Adopting the employment life cycle model and working towards improving each stage of employee experience helps deepen employee engagement. This, in return, helps increase productivity with a happier and engaged workforce.

- Optimising employee experience:
  The model also helps in maximising employee experience, which helps in the building of happier and stronger team with better cohesion.

- Low turnover and higher retention rates:
  Employees find themselves more appreciated and tend to remain with the organisation for longer periods. This helps the business save on hiring costs in the longer term.

6. Trust Equality, Diversity, and Inclusion (EDI) Governance

Our EDI Governance structure is built on the principle of leadership and inclusion This approach will engage with staff from all communities, professions, and protected characteristics to improve the experience for everyone working at The Dudley Group.



People Committee

The People Committee is a sub-committee of the Trusts' board of directors which overseas workforce and has an overview of equality, diversity and inclusion work plans and receives updates from the EDI Steering Group.

Equality, Diversity, and Inclusion (EDI) Steering Group

The steering group is responsible for the co-ordination and strategic leadership of all aspects of the inclusion agenda and upward reports into the People Committee and to the Trust board.

Membership of the steering group and the committee includes key representatives from each of the departments and divisions. The Terms of Reference of the group has now been revised and membership has grown.

Staff Network Groups

The Trust has six staff network groups, which are pivotal to our success in promoting equality, celebrating diversity, and achieving inclusion across our organisation. The staff network leads are members of the EDI Steering Group and the People Committee.

7. The Trust's Equality, Diversity & Inclusion (EDI) strategic Journey

The Trust's Equality, Diversity and Inclusion (EDI) strategic journey was launched in May 2023. The journey outlines our commitments for the next few years in becoming a more inclusive organisation and ensuring equality, diversity and inclusion are enshrined in our values. The journey is built on six building blocks i.e. the employee life cycle.

Each building block illustrates our goals, key focus on what we want to achieve and clear indicators on how we will measure success.

The full Equality, Diversity and Inclusion ourney can be accessed via the Trust website: [Equality, Diversity, and Inclusion - The Dudley Group NHS Foundation Trust (dgft.nhs.uk)]

8. Equality Diversity and Inclusion Strategic Journey Objectives 2023/24

The setting, monitoring, and delivery of equality objectives form part of our Public Sector Equality Duty. Our equality objectives are contained within our Equality, Diversity, and Inclusion Journey, Trust Strategy, and translated into deliverables in line with the NHS People Promise, Our Dudley People Plan, WRES, WDES metrics, EDS assessment and NHS Improvement High Impact Actions.

Equality, Diversity, Diversity & Inclusion Journey (Strategy): ACTION PLAN 2023 /24

Vision	Trust Priority	Goal	Objective	Expected Outputs	Measures
Equality, diversity and inclusion (EDI) is enshrined in our vision and through our values of care, respect and responsibility that underpin the day to-day activities and diverse communities of the Trust. We are committed to being a more inclusive organisation, ensuring equal opportunity and celebrating diversity. Encouraging and supporting the workforce we employ to reach their potential. This will support our ultimate goal to be a brilliant place to work and thrive.	ATTRACT	Be an appealing inclusive employer.	Develop an employer brand that puts inclusion at its core by attracting people tojoin the organisation through the information potential candidates hear about us and can find out about us	• Increase ethnically diverse staff levels to 23 %. • Increase ethnically diverse senior leadership to 1 0% (Model Employer Target) • To ensur e EDI statements are visible on all external and internal communication channels. • Implement and monitor Reasonable Adjustment passport. • Collaborative working with Community and Voluntary sector organisations.	• Workforce Race & Disability Equality Standard metric 1 & 2 (Workforce Representation & Recruitment). • Employ ers Network for Equality and Inclusion (enei). • Disability Leader Lev el 3: Disability ConfidentLeader accreditation.
	RECRUIT	Enable talent to successfully apply for career opportunities	Overhaul recruitment practices. Ensuring people are trained on inclusive recruitment.	• Dev elop and Promote a refreshed inclusiv e recruitmenttraining programme. • Refreshthe behav iour framework, ensuring a clear stance on unacceptable behav iour towards people with protected characteristics. • Equality Impactassess our recruitmentpractices and related policies. • ImplementInclusiv e Recruitment Guidelines .	• Workforce Race & Disability Equality Standard metric 1 & 2 (Workforce Representation & Recruitment). • Employers Network for Equality and Inclusion (enei). • Disability Leader Level 3: Disability Confident Leader. • Race Code (Results for recruitment).

Equality, Diversity, Diversity & Inclusion Journey (Strategy): ACTION PLAN 2023 / 24

Vision	Trust Priority	EDI goal	EDI Objective	Expected Outputs	Measures
Equality, diversity and inclusion (EDI) is enshrined in our vision and through our values of care, respect and responsibility that underpin the day to-day activities and diverse communities of the Trust. We are committed to being a more inclusive organisation, ensuring equal opportunity and celebrating diversity. Encouraging and supporting the workforce we employ to reach their potential. This will support our ultimate goal to be a brilliant place to work and thrive.	WELCOME	Ensure all talent is understood and all staff are inducted and trained.	Ensure there is an inclusiv e induction process forall new recruits promoting ED&I and Trust v alues. Dev elop a bespoke mandatory EDI training module encompassing liv ed experience.	• Simplify and use inclusive language across the Trust. • Continue to grow staff networks to enhance staff voice. • Evaluate mandatory training offer and incorporate lived experience. • Increase declaration rates for staff with protected characteristics. • Create and develop equality and inclusion induction resources.	• Culture dashboard– Welcome to Dudley Induction numbers & Training metrics. • Increase of Staff Network membership. • Declaration rate increase for disability and sexual orientation. • Race Codemetrics • WRES & WDES metrics.
	DEVELOP & SUPPORT	Talent is consistently represented and inclusive.	All learning and development activity has diverse candidates and specific opportunities are available foreveryone where appropriate. Work allocation, performance and progression support for all staff should be consistent with plentiful equal opportunities for everyone to reach their potential.	• Support development of cultural ambassadors programme with HR access and support. • Continue to develop and improve all training programmes- EDI as a golden thread. • Increase females into senior roles and decrease pay gap to 31%. • Line managers to have EDI objectives as part of their annual appraisals. • Produce managers guide for EDI appraisal objectives. • Review of secondment, stretch assignments and talent management process for internal staff. . • Develop a Shadow Board.	• Culture dashboard performance– Training metrics & representation. • Staff Network priorities progress. • Staff Surv ey Metrics on support and dev elopment. • Equality Deliv ery Sy stem Assessments. • WRES & WDES metrics. • Gender Pay Gap metrics.

9. Progress with EDI objectives and Key achievements 2023/24

- ✓ Increased ethnically diverse staff levels to 28%.
- ✓ Increased Disability disclosure rates to 6%
- ✓ EDI statements are visible on all external and internal communication channels.
- ✓ Implemented Centralised Reasonable Adjustment project.
- ✓ Refreshed inclusive recruitment training programme.
- ✓ Refreshed the behaviour framework, ensuring a clear stance on unacceptable behaviour towards people with protected characteristics.
- ✓ Equality impact assessed recruitment practices and related policies.
- ✓ Continued to grow our current staff networks to enhance staff voice and introduced 2 new networks; a carers and armed forces.
- ✓ Evaluated mandatory training offer and incorporate lived experience.
- ✓ In process of developing a Shadow Board.
- ✓ Introduced a standardised anti-discriminatory statement into all relevant workforce polcies.
- ✓ Continued to monitor culture dashboard and incidents of discrimination and abuse.
- ✓ Developed a prospectus supporting staff from all backgrounds to reach their potential, Increasing training and development activities.
- ✓ Increased staff engagement through ward rounds and divisional meetings
- ✓ Developed SMART EDI objectives for the Chair, Chief Executive and Board members.
- ✓ Undertaken career conversations with women from areas where we have a Gender Pay Gap and ethnically diverse nurses to improve career progression.
- ✓ Implemented Equality Delivery System domains 1,2 and 3 evaluation.
- ✓ Launched Neurodiversity toolkit and training for staff and managers.

- ✓ Maintained gold level award from the Employers Network for Equality and Inclusion (enei) in our Talent Inclusion and Diversity evaluation (TIDE) •
- ✓ Launched Trust wide Anti-racism and Anti-Discrimination statement.
- ✓ Launched Cultural Awareness training.
- ✓ Launched Transgender Awareness training.
- ✓ Launched Allyship training.
- ✓ Developing EDI data packs and objectives for divisional teams
- ✓ Continued implementation of the RACE Code Kite mark and have a clear set of actions to support our organisation to improve Race equality.
- ✓ Reviewed and refreshed Equality Impact Analysis / Health Equality Assessments process and governance.
- ✓ Completed the Rainbow Badge Phase II Assessment and developed a set of robust actions to improve equality and inclusion for our LGBTQ+ workforce and patients.
- ✓ The equalities and wellbeing team have been recognised throughout 2023/24 for their contribution to the equality, diversity, and inclusion agenda.

10. Implementation of the Equality Delivery System (EDS)

The EDS is the foundation of equality improvement within the NHS. It is an accountable improvement tool for NHS organisations in England. It supports active conversations with patients, public, staff, staff networks and trade unions, to review and develop services, workforces, and leadership. It is driven by evidence and insight.

The EDS comprises of eleven outcomes spread across three Domains, which are:

- Domain 1: Commissioned or provided services
- Domain 2: Workforce health and well-being
- Domain 3: Inclusive leadership.

The outcomes are evaluated, scored, and rated using available evidence and insight. It is these ratings that provide assurance or point to the need for improvement.

Under Domain 1 Patient Experience was chosen and this was assessed at an organisational and system level. For Domains 2 and 3, a Trust wide review was undertaken.

It is a requirement that each Domain is independently reviewed, and all three Domains were peer-reviewed by Coventry & Warwickshire Partnership NHS Trust.

Overall, the Trust was given a score of 17 and a rating of Developing. The Domain grading results were:

Domain 1: The overall score was 4.
Domain 2: The overall score was 8.
Domain 3: The overall score was 5.

To determine the overall rating, scores provided by graders were averaged for each outcome (rounding to the nearest whole number). The average scores across each outcome were then totalled, and a corresponding grade was given as per the EDS guidance.

The full EDS evaluation report can be accessed via the Trust website: Publications - The Dudley Group NHS Foundation Trust (dgft.nhs.uk)

11. Implementation of the Gender Pay Gap (GPG)

The data shows a mean gender pay gap of 39.5% in March 2023, representing a 6.9 percentage points increase since March 2022, when the gap was 32.6%. The Median gender pay gap was 23.4% in March 2023, representing a decrease since March 2022 of 1.5 percentage points, when the gap was 24.9%.

Although some improvements have been made in the median gap, the data presents an increase in the mean gender pay gap within our organisation. The difference between the mean and median pay supports the organisation in understanding what is driving the gap. The presence of low earners can make the mean smaller than the median. However, high earners can increase the mean to be larger than the median. The following pages set out the analysis of the pay gap and the drivers for the gender pay gap.

Overall gender representation across the staff groups is 81% female and 19% male; however, in the lowest-paid staff group, females are overrepresented at 87%. In the highest-paid staff group, males are significantly overrepresented at 36%. This imbalance alone accounts for the majority of the GPG favouring males.

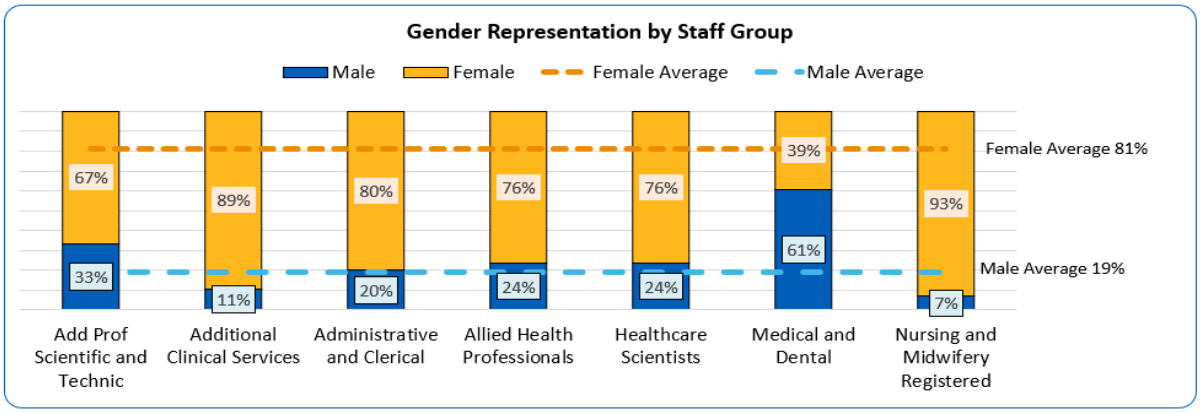
The Highest-paid staff group contains:

- **48% of all male employees**
- **20% of all female employees**

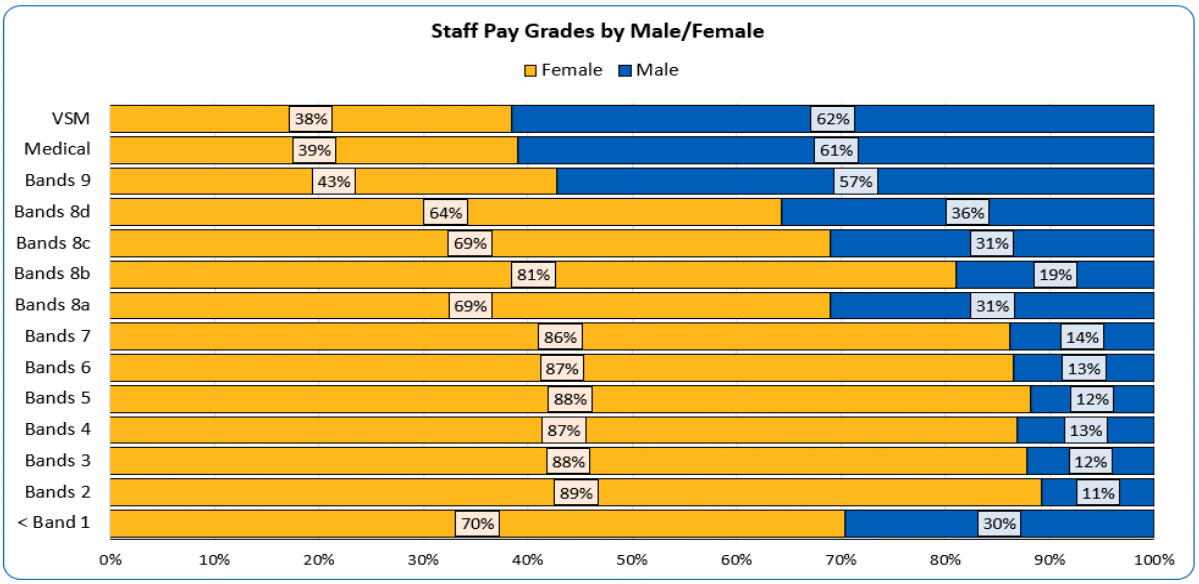
The lowest-paid staff group contains:

- **27% of all female employees**
- **18% of all male employees**

The table below illustrates the proportion of males and females in each staff group compared to the overall average; males are represented in grey and females in green.



The table below illustrates the proportion of males and females in each pay band.



VSM = Very Senior Manager; Band 1 is our Apprentices.

	Female Staff	% Female
Band 2-7	4265	88%
Band 8a and above	227	69%
Band 8a and above, and Medical & Dental	484	49%

We continue to review and implement actions that will support the organisation in reducing our pay gap:

- Career fairs introduced targeting women in areas where the Gender Pay Gap is driven, such as medical and dental.
- Continue promoting policies such as Flexible Working, Shared Parental Leave and Remote Working.
- Launch of a working group focused on the talent and promotional processes and improving career conversation as part of the appraisal process.
- Career conversations continue with women across the Trust, supporting us in understanding lived experience and implementing recommended actions.

The full Gender Pay Gap report can be accessed via the Trust website: Publications - The Dudley Group NHS Foundation Trust (dgft.nhs.uk)

12. Implementation of the Race Equality Code

Implementing the RACE Equality Code (REC) is a significant step towards ensuring our organisation operates according to best practices. This code provides comprehensive guidance on what is expected from us by our sector, regulator, and stakeholders, and how we can effectively meet these expectations. By adhering to the RACE Equality Code 2020, stakeholders can be assured of our commitment to diversity and equality.

The RACE Equality Code is not just a set of rules, but a framework designed to foster a culture of diversity and equality within our organisation. It challenges our managers to identify and implement strategies that improve diversity and race equality within our services. This, in turn, ensures that our staff and service users feel not just valued, but also understood. The Code is a three-year accreditation, and our Trust was awarded the kite mark in 2021, marking our progress in this journey.

The Code is based on the following four themes:

1. **REPORTING:** A clear commitment to transparency—reporting on equality data/information to all stakeholders (internal and external) demonstrates openness and transparency.
2. **ACTION:** Organisations must have a list of the measurable actions and outcomes that contribute to and enable a shift in their approach to delivering positive and sustainable change in race equity and equality.
3. **COMPOSITION:** A set of key indicators that create tangible differences in race diversity across all levels of the organisation. The narrative around what is acceptable will need to change through dialogue and data, leading to challenging conversations that will lead to necessary decisions that the organisation is committed to making.
4. **EDUCATION**: A robust organisational framework that develops the ethical, moral, social, and business reasoning for race diversity at all levels.

REC initially tested Dudley Group's governance through a pre-assessment process, governance assessment, and self-assessment. The assessment's provisions are divided into three categories: must, Should, and Could.

There were twelve Must actions, the Trust is required to comply with all. The Should and Could sections make up a further 31 actions. At the progress meeting in November 2023, the Trust demonstrated its progress against all actions. Here are some of the achievements over the last 18 months:

- The Trust produced, analysed, and published the Ethnicity Pay Gap Report (EPG)
- We produced and published our Anti-racism stance and continue with a project of work to embed this into our culture.
- We have strengthened our review and reporting mechanisms using tools such as the Equality Delivery System (EDS), The Employers Network for Equality and Inclusion (enei), Talent Inclusion Diversity Evaluation (TIDE) and Workforce Race Equality Standard (WRES) Reporting.
- Increased the training available to staff and managers by introducing Allyship training, 5 Anti-racism e-learning modules, new candidate-focused recruitment training and divisional sessions focusing on metrics and actions.

Signing up for the Race Code has supported the organisation in developing an Equality, Diversity, and Inclusion (EDI) strategic Journey with a robust set of actions; we have focused on the MUST actions over the past 18 months and have seen improvement in our data and staff survey results.

The EmbRACE staff network is fully involved and supports the actions and process. Together, the Trust and the networks have used the RACE code as a lever and a supportive mechanism to drive change. Our Workforce Race Equality Standards results have improved year after year; our representation has improved by focusing on the actions and drastically improving access and intelligence from our data. We have produced and published our first ethnicity-gender pay gap report, leading the way in our system.

13. Rainbow Badge Accreditation Phase II

In 2020, the Trust set up the first phase of the NHS Rainbow Badge scheme. The Rainbow Badge was developed and led by Evelina London Children’s Hospital and community services, part of Guy’s and St Thomas’ NHS Foundation Trust. The initiative was created to be a way for NHS staff to demonstrate that they are aware of the issues that LGBTQ+ people can face when accessing healthcare.

The original model emphasised that wearing a badge is a responsibility. It provides basic education and access to resources for the staff who want to sign up. The information provided highlighted the challenges LGBTQ+ people can face in

accessing healthcare and the degree of negative attitudes still found towards LGBTQ+ people.

NHS England commissioned the LGBT Foundation, Stonewall, the LGBT Consortium, Switchboard, and GLADD to collaborate on delivering phase II of the Rainbow Badge scheme. This phase has moved to an assessment and accreditation model. It allows Trusts to demonstrate their commitment to reducing barriers in healthcare for LGBTQ+ people while evidencing the excellent work already undertaken. The phase II programme used focus groups in consultation with patients and professionals to build the assessment and was piloted within 10 NHS Trusts.

The Trust entered Phase II of the Rainbow Badge scheme in March 2023. The assessment focuses on 5 areas: a policy review, a staff survey, a patient survey, a services survey, and a workforce assessment. Each area is assessed and awarded points based on evidence and survey responses. The points are then displayed as a grade, either initial stage, bronze, silver, or gold.

The Trust achieved an initial stage grade and has developed a robust action plan to address improvement areas. This assessment has enabled the Trust to understand the requirement to improve inclusive practice through the lens of the LGBTQ+ community. The assessment has been thorough, and the actions highlighted will enable the Trust to improve and support our EDI journey objectives and deliver on the Public Sector Equality Duties.

14. Implementation of the Workforce Race Equality Standard (WRES)

The Workforce Race Equality Standards (WRES) launched with the aim of improving the workplace and career experiences of our ethnically diverse staff. It has a set of nine specific measures which enable NHS organisations to compare the experiences of different staff groups. The WRES compares the experience of ethnically diverse staff with white staff.

WRES Summary

	WRES Indicator		Reporting Year 2020	2021	2022	2023	2024	Trend
1	Percentage of black and minority ethnic (BME) staff	Overall	18%	20%	20%	25%	28%	
2	Relative likelihood of white applicants being appointed from shortlisting across all posts compared to BME applicants		2.58	1.95	1.49	1.54	1.41	
3	Relative likelihood of BME staff entering the formal disciplinary process compared to white staff		0.9	1.1	1.1	0.79	1.59	
4	Relative likelihood of white staff accessing non mandatory training and continuous		1.52	1.17	1.95	1.02	1.24	
5	Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months*	BME	31.2%	27.1%	27.7%	26.2%	27.3%	
		White	31.6%	25.6%	25.5%	24.8%	25.7%	
6	Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months*	BME	33.0%	32.8%	26.8%	28.8%	31.7%	
		White	28.4%	25.7%	19.7%	20.3%	22.1%	
7	Percentage of staff believing that trust provides equal opportunities for career progression or promotion*	BME	42.9%	44.2%	45.5%	47.2%	51.7%	
		White	56.5%	61.8%	61.2%	63.2%	63.1%	
8	Percentage of staff personally experiencing discrimination at work from a manager/team leader or other colleagues*	BME	17.4%	17.5%	16.3%	16.4%	18.8%	
		White	6.3%	6.0%	5.1%	5.3%	6.3%	
9	BME board membership **	Overall		5.6%	16.7%	16.7%	15.0%	

** Staff survey from previous year*

***Total board members*

National team reviewing data

WRES Key findings:

- The ethnically diverse representation in the Trust has increased from 25% in March 2023 to 28%.
- In March 2024, 28% (1737) of the workforce across Dudley Group were from a diverse ethnic background (black and minority ethnic, BME background). This is an increase from 25% (1515) from March 2023.
- In March 2024, 15% of all board members were from a diverse ethnic background, this compares to 16.7% in March-23
- In 2023/24, the relative likelihood of white applicants being appointed from shortlisting across all posts, when compared to colleagues from a diverse ethnic background is 1.41. this is an improvement on last year's report of 1.54.
- In 2023/24, the relative likelihood of staff from a diverse ethnic background entering the formal disciplinary process compared to white staff is 1.59.
- In 2023/24, the relative likelihood of white staff accessing non-mandatory training and continuous professional development CPD compared to staff from a diverse ethnic background is 1.24. This compares to a value of 1.02 in 2022/23.
- In the 2023 survey, a lower percentage of staff from an ethnically diverse background (51.7%) when compared to white staff (63.1%) felt that the Trust provides equal opportunities for career progression or promotion (source indicator 7). This measure for ethnically diverse staff has improved from last year from 47.2% (an improvement of 4.5%) and for white staff the measure has remained the same.

The full WRES report can be accessed via the Trust website: [Publications - The Dudley Group NHS Foundation Trust (dgft.nhs.uk)]

15. Implementation of the Workforce Disability Equality Standard (WDES)

The Workforce Disability Equality Standards (WDES) was launched with the aim of improving the workplace and career experiences of our ethnically diverse staff and staff with a disability in the NHS. The WDES has a set of specific measures which enable NHS organisations to compare the experiences of different staff groups. The WDES compares the experience of staff with and without a disability.

WDES Summary

WDES Indicator			Reporting Year 2020	2021	2022	2023	2024	Trend
1 Percentage of Disabled staff*		Overall		4%	4%	5%	6%	
2 Relative likelihood of non-disabled staff applicants being appointed from shortlisting across all posts compared to Disabled staff.			2.15	1.09	0.87	1.34	1.16	
3 Relative likelihood of Disabled staff entering the formal capability process (performance management rather than ill health) compared to non-disabled staff.**				1.75	6.34	0		
4 Percentage of staff experiencing harassment, bullying or abuse in the last 12 months ***	From Managers	Staff with a long lasting health condition or illness	21.7%	21.1%	14.5%	17.2%	17.1%	
		Staff without a long lasting condition or illness	15.8%	13.0%	8.7%	8.8%	9.5%	
	From Other Colleagues	Staff with a long lasting health condition or illness	28.0%	29.4%	23.3%	25.3%	25.9%	
		Staff without a long lasting condition or illness	19.4%	18.4%	14.3%	15.0%	16.6%	
	From Patients / Public	Staff with a long lasting health condition or illness	37.9%	32.3%	29.7%	33.0%	31.0%	
		Staff without a long lasting condition or illness	30.3%	24.4%	24.7%	22.6%	24.6%	
5 Percentage of staff believing that trust provides equal opportunities for career progression or promotion ***		Staff with a long lasting health condition or illness	46.1%	54.8%	51.9%	55.3%	55.5%	
		Staff without a long lasting condition or illness	56.1%	59.6%	60.3%	61.1%	61.6%	
6 Percentage of staff saying that they have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties ***		Staff with a long lasting health condition or illness	35.8%	33.1%	33.1%	28.3%	32.0%	
		Staff without a long lasting condition or illness	24.7%	28.7%	26.0%	20.4%	19.4%	
7 Percentage of staff saying that they are satisfied with the extent to which their organisation values their work ***		Staff with a long lasting health condition or illness	30.0%	35.2%	31.5%	29.3%	36.2%	
		Staff without a long lasting condition or illness	39.6%	44.2%	39.1%	42.6%	45.5%	
8 Percentage of Disabled staff saying that their employer has made adequate adjustment(s) to enable them to carry out their work ***		Staff with a long lasting health condition or illness				66.7%	72.4%	
9a Staff engagement score (a composite of nine questions) ***		Staff with a long lasting health condition or illness	6.3	6.5	6.4	6.3	6.5	
		Staff without a long lasting condition or illness	6.8	6.9	6.8	6.9	7.0	
9b Percentage of trusts that facilitate the voices of Disabled staff to be heard within the organisation.				Yes	Yes	Yes	Yes	
10 Percentage of Disabled staff on Boards ****		Overall			6%	11%	5%	

** non-executive directors excluded from 2023 data*
*** 23/24 data*
**** Staff survey from previous year*
*****Total board members*
National team reviewing data

WDES Key findings:

- 6% (384) of the workforce across Dudley Group have a long-term condition or illness, this is an increase from 5% (329)
- The relative likelihood of an applicant with a long-term condition or illness being appointed through shortlisting has improved from 1.34 in 2022/23 to 1.16 in 2023/24.
- This year 36.2% of staff with a disability reported that they felt valued for their contribution.
- 55.5% of staff with a long-term condition or illness believed they had equal opportunities for career progression or promotion. This is in-line with the previous year (source indicator 5).
- 32% of staff with a long-term condition or illness experienced presenteeism, this is higher than the previous year, 28.3%.
- 36.2% of staff with a long-term condition or illness reported that they felt valued for their contribution, this is an improvement on the previous year of 29.3%.
- 72.4% of staff with a long-term condition or illness reported they had the reasonable adjustment(s) required to perform their duties. This is an improvement on the previous year of 66.7%.

16. Implementation of the Employers Network for Equality and Inclusion (enei)Talent Inclusion & Diversity Evaluation (TIDE) Mark

The enei TIDE Mark is a benchmarking tool developed by the Employers Network for Equality & Inclusion (enei) to assess organisational performance and progress with diversity and inclusion. TIDE measures the organisation against eight different areas of diversity and inclusion practice and then benchmarks them against their peers. The Trust has been awarded a gold award for the second year running in December 2023, scoring 87% in our assessment. The Dudley Group is the only Trust to be awarded Gold in the West Midlands.

17. Staff Networks

It is recognised that staff equality networks are an excellent mechanism through which the general duties of the Equality Act 2010 can be supported in relation to staff from the protected groups and other groups at potential risk of inequality.
The Trust now has six staff networks, namely EmbRACE, LGBTQ+, Disability & Long-term Conditions, Women's, Armed Forces and Carers networks. The networks have focused on growing their membership over the past year to strengthen the voices of colleagues. They work closely together, supporting each other with their priorities and driving improvements alongside the Equalities and Wellbeing Team.

Disability Network

This network has gone from strength to strength, growing in numbers and visibility across the Trust. The network has co-produced supportive guidance for managers and staff and this year launched a neurodiversity toolkit – a guide to raise awareness of different neurodiverse conditions.

The network has continued with its work to improve the disability declaration rate and it now stands at over 6%, with 28% of people choosing not to say. The staff survey completion results for 2023 have also significantly increased by 47%.

The network has been instrumental in launching a new project 'Centralising Reasonable Adjustments' which supports staff with advice and guidance about adjustments in the workplace and applications for Access to Work. The project has now supported 7 people to gain their equipment from Access to Work with another 11 staff members either with applications pending or having received relevant advice.

The network has also marked Disability History month, Eating Disorders Awareness week and a joint collaboration with the other networks for Neurodiversity Celebration week.

Embrace Network

This network has helped the Trust to launch a vital piece of work; the Trust's anti-racism statement which includes the Trust's commitments and how to report racism if you are a member of staff or a patient. This statement, which is intended for both staff and patients has a prominent place on the public website and has been sponsored by the whole Trust Board as part of the journey to becoming an anti-racist Trust.

The Network continues to raise awareness of anti-racism learning and staff well-being by promoting anti-racism e-learning modules to all staff and was instrumental in launching allyship training within Black History month as part of the celebrations.

The network has marked Black History Month and Race Equality week as well as the joint collaboration with the other networks for Neurodiversity Celebration week.

LGBTQ+ Network

The LGBTQ+ network achieved Initial Stage for Rainbow Badge Phase II and are now in the process of reviewing actions that were recommended by LGBT Foundation to increase the level to Bronze, Silver or Gold. This involves working with many departments across the Trust to implement change.

The network has also rolled out LGBTQ+ Awareness Training and delivering this to departments around the Trust. Once a staff member has completed this, they will receive a rainbow pin badge as a visual to show they are an ally to both patients and staff.

The network has celebrated LGBT+ History month, will be taking part in Birmingham Pride and collaborated for neurodiversity celebration week.

Women's Network

The network has been instrumental in supporting those affected by the menopause and to provide advice and guidance to all staff about this important topic. A working group, in conjunction with Wellbeing, meets on a bi-monthly basis and support

session every 3 months offer the opportunity for staff to network and listen to guest speakers.

The network has also collaborated with the medical workforce to start a monthly lunch and learn ‘ Women at Work’ which looks at different topics which affect women at the Dudley Group including recruitment, flexible working and neurodiversity.

The network has celebrated Women’s History month, incorporating International Women’s Day and a Let’s Talk month which discussed pregnancy loss, fertility awareness, menstrual health and the menopause with external guest speakers.

Armed Forces Staff Network

The Armed Forces is newly formed and is for all staff who have an interest in the Armed Forces Community (this includes veterans, members of the reserve and cadet forces, along with their families).

The aim of the Network is to promote a better understanding of the Armed Forces Community, thereby creating a more supportive and inclusive working environment.

The main objectives of the Network are:

- To provide an arena where issues can be openly discussed and signposts to external services or staff side representatives.
- To influence policy making and monitor existing policies to ensure that equality is proactively considered.
- To co-ordinate internal events and initiatives to promote the Armed Forces Network.
- To support local and national Armed Forces events and initiatives
- To raise the profile of the Armed Forces Community.
- To promotes opportunities for social networking.

The Group have been supporting the Veterans Aware accreditation and the Trust are proud to have been awarded the Veterans Aware Kite mark in December 2023.

Carers Staff Network

The Staff Carer Network is newly formed. The network supports employees who are Carers. It is a source of information for Carers as well as a way to improve the wellbeing of staff and provide an opportunity for peer support.

The main objectives of the Network is:

- To help reduce the isolation that can be felt by staff carers.
- To raise carer awareness across the Trust.
- To signpost and refer carers to additional support provided both internally and externally.
- To influence policy making and monitor existing policies to ensure that equality is proactively considered.
- To co-ordinate internal events and initiatives to promote the Network.
- To support local and national Carers events and initiatives.
- To collaborate with the EmbRACE, Disability, Women's, Armed Forces & Veterans and LGBTQ+ Staff Networks to promote intersectionality and provide peer support.

A key priority for the network is to develop a Carers policy and Carers support passport.

18. **Launch of the Trust Anti-Racist statement**

The Trust launched its Anti-racist statement in October 2023 during Black History Month.

At The Dudley Group, we want to ensure all colleagues, patients and visitors are, respected and included in decisions that affect them. Our staff must feel safe and confident to be themselves at work and develop their skills as part of a great team.

Embedding an environment of Equality and Inclusion is a pivotal pillar of the Dudley People Plan, which has the full support and championship of the Trust Board.

Embracing our diverse cultures and inspiring collaboration is critical to the success of the Trust. The care of our patients is strengthened through the diversity of thought, approach and culture delivered by staff from diverse backgrounds.

We know that we have not made as much progress as we should have on all race-related issues. The statistics continue to speak for themselves. Anti-racism means actively identifying and opposing racism. It is rooted in action. It is not enough to be "non-racist." We must unapologetically and purposefully tackle structural and personalised racism and its impact on our organisation and people.

The Dudley Group NHS Foundation Trust is striving to become an anti-racist organisation. The Trust has a number of internal programmes of work on anti-racism that our equality networks have codesigned. This has formed the basis for a series of open, honest, and challenging discussions at all levels of the organisation, which has led to the production of an Equality, Diversity, and Inclusion Strategic Journey.

We have signed up to the National RACE Equality Code. The RACE Equality Code allows us to use a robust and comprehensive framework of measures and a methodology for the transparent implementation of actions to which an organisation can demonstrate accountability. We will continue to work to reduce health inequalities faced by our ethnically diverse communities. We will contribute to public discussions about our duty in the services we provide.

We are all responsible for eliminating all forms of racism; we must challenge ourselves and challenge others with care and compassion. We need to ensure our behaviours are shaped by living our values of care, respect and responsibility.

The Trust is committed to taking proactive steps to confront and address the effects of existing ingrained racism in all its forms, within our organisation and in our work, to make meaningful and sustainable change. Our senior leaders will act as role models, always showing positive and assertive behaviours while striving to create inclusive, antiracist environments. This is more than just a statement of intent as we drive a wide range of actions.

Our commitments:

1. We will work to reduce workforce inequalities through our Equality, Diversity, and Inclusion Journey and our People Plan.
2. We will develop local and national partnerships with organisations that work with and represent Black, Asian, and other ethnically diverse

communities so that we can learn from them and support their service delivery to these communities.

3. We will speak out about racism and inequality where we see it and support the voices of people from Black, Asian, and other ethnically diverse communities.
4. We will ensure we drive our agenda of becoming an anti-racist Trust by improving co-production with our ethnically diverse staff, strengthening the voice of our staff networks, supporting staff well-being, and enabling staff groups to influence strategy and actions.
5. We will use the Workforce Race Equality Standards (WRES), the NHS Staff Survey measures, and other local assessments to assess the effectiveness of our actions.
6. We will strive for a better understanding of the systems and structures we work in and how they may perpetuate forms of racial discrimination against the disadvantaged population we serve.
7. We will be inclusive in our approach and be proud to oppose racism.
8. Continue our efforts, taking a data-driven and evidence-based approach, including Workforce Race Equality Standards (WRES) and Medical Workforce Race Equality Standards (MWRES) in campaigns and policies.

19. Accessible Information Standard

The Trust has an Accessible Communications Policy which describes the actions that will be taken to ensure that the Trust is compliant with the accessible information standard.

A summary statement outlining the Trust's commitment to meeting the standard is available on the Trust's website at: Accessible Information Standard – The Dudley Group NHS Foundation Trust (dgft.nhs.uk)

How to access interpreting services including British Sign Language is available on the public website: Interpreting service – The Dudley Group NHS Foundation Trust (dgft.nhs.uk)

Website accessibility statement: Accessibility statement – The Dudley Group NHS Foundation Trust (dgft.nhs.uk)

The Trust is committed to monitoring compliance against the accessible information standard and will be working on strengthening monitoring arrangements in the future, this includes integration of the standard in the Trust's IT systems to support patients and service users in accessing care services appropriate to their communication requirements.

20. Provision of Interpreting and Translation service

The Dudley Group NHS Foundation Trust is committed to providing excellent public services to all our patients, service users, carers, relatives and or their representatives through effective communication, thus improving the overall experience of the service they receive. This includes those where English is not their

first language or who are visually impaired, hard of hearing or have speech impairment.

The Trust is commitment to:

- Providing communication support to patients whose first language is not English, or have hearing impairment/ loss or other perceptual impairment and to make every effort to remove any barriers to communication.
- Making every effort to provide all patient and carer information in their first language, when requested, through an interpreter or by providing translated written or electronic information.
- Communicating our interpreting and translation service to staff.
- Ensuring that frontline staff are aware of how to access interpreting services or who to contact for the provision of translated information.

The information below provides key information on the provision of interpreting and translation services over the last twelve months.

A total number of 4,566 bookings were processed, with a request of 62 different languages. An increase

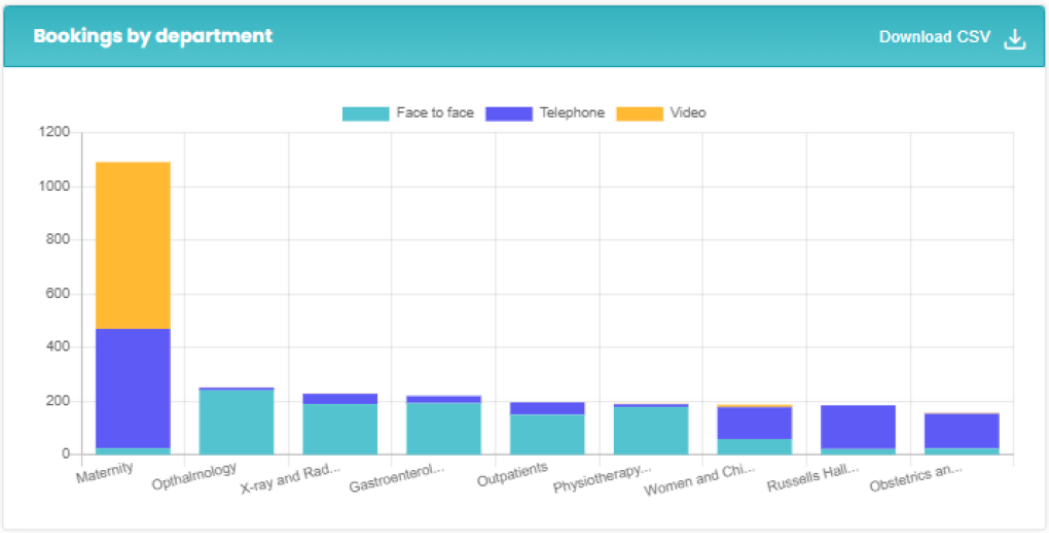
- **130** cancelled bookings ↓ (from 352 in the previous year)
- 44 out of 4566 bookings were rejected resulting in **99.8% coverage**
- **48.5%** of all requests were completed by remote interpreting (25.5% by telephone and 13% by video interpreting services)

Language Usage

Top 20 Languages

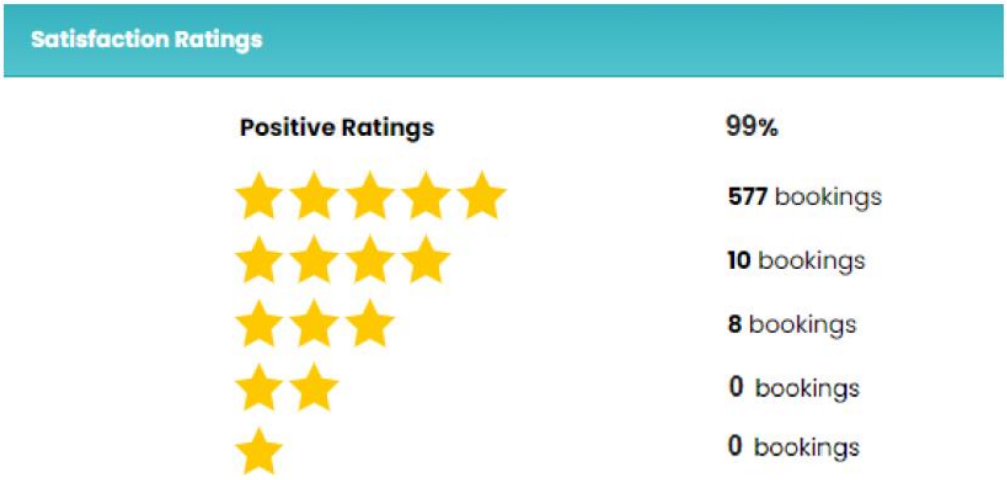
Language	Face to Face	Telephone	Video	All Services
Urdu	402	172	90	664
Punjabi	444	117	64	625
Arabic	188	163	75	426
Polish	228	144	28	400
Romanian	112	183	71	366
British Sign Language (BSL)	325	0	14	339
Albanian	31	101	44	176
Kurdish	69	67	35	171
Mandarin	108	48	4	160
Kurdish - Sorani	22	67	31	120
Bengali	42	39	39	120
Farsi	56	30	3	89
Russian	61	27	0	88
Cantonese	59	24	0	83
Portuguese	15	17	33	65
Pashto	13	31	20	64
Dari	12	46	5	63
Tigrigna	8	36	14	58
Spanish	15	24	16	55
French	18	22	12	52

Usage by Department



- Highest use department was Maternity with 24% of bookings (↑ from 19% in the previous year)

Feedback



21. Provision of Chaplaincy and Spiritual Care

The Dudley Group NHS Foundation Trust (the 'Trust') recognises the importance of the spiritual dimension of care. It appreciates that a patient's faith or belief can make a contribution to a patient's recovery and sense of wellbeing, and that a patient may view their illness or condition in a way that goes beyond a biomedical approach.

As part of the commitment in the NHS Constitution to value every person, it is important that the NHS supports patients with any spiritual, pastoral or religious needs they may have in relation to their care. Further, universal human existential needs such as finding hope and creating meaning in difficult experienced can be critical at times of ill-health, trauma and bereavement.

The chaplaincy department's purpose is to provide high-quality, person-centered spiritual care to anyone connected with the Trust. This includes all patients, their family/visitors, and staff employed by the Trust irrespective of the site they work at. Spiritual care in this policy encompasses pastoral, religious, cultural, and existential support.

It is the responsibility of the department to champion faith and belief in the organisation. We contribute extensively to Equality, Diversity and Inclusion by promoting faith, cultural and secular events throughout the calendar year.

The work of the chaplaincy team supports the delivery of the Trust's strategic objective 'excellent healthcare, improved health for all'.

The team is a small team with a big impact. We have a total of 3.3 WTE substantive chaplains that cover the whole Trust, which is below the recommended staffing levels for chaplaincy teams according to NHS Guidelines. Despite this the team continue to meet the increasing demand for chaplaincy services and to develop more efficient ways of working. We also have focused on volunteer recruitment this year, which enhances what we are able to offer and the diversity of the team.

Bank/ad-hoc chaplains perform specific religious rites and can be called upon when requested by a patient. There is a regional network of honorary chaplaincy staff across the Birmingham and Black Country Chaplaincy Collaborative who offer advice and guidance from a Sikh, Hindu, Buddhist, Pagan, Bahai'I and Jewish perspective as required.

The essence of chaplaincy is to offer religious, pastoral and existential care to all members of the hospital community. This is known as “spiritual care” and is founded on the values of compassion and respect for all that makes us human.

- All our chaplains offer compassionate pastoral care to everyone – patients, their visitors and staff. Anyone can expect compassionate pastoral care from any member of the team.
- All our chaplains are specially trained to offer existential and spiritual care to everyone who wants to explore issues around meaning, purpose, hope, healing and death. Anyone can expect specialist existential and spiritual care from any member of the substantive staff team.
- All our substantive chaplains are authorised/licensed to offer religious care to specific people or groups on request. People who belong to a specific religious or cultural group can expect their request to be met by a member of the team or by bank/honorary staff.
- We responded to a total of 567 routine referrals this year. This excludes baby bereavement, routine visits where we speak to every patient on the ward, and staff referrals, all of which are counted separately. The graph below demonstrates our referral figures per month for this year.

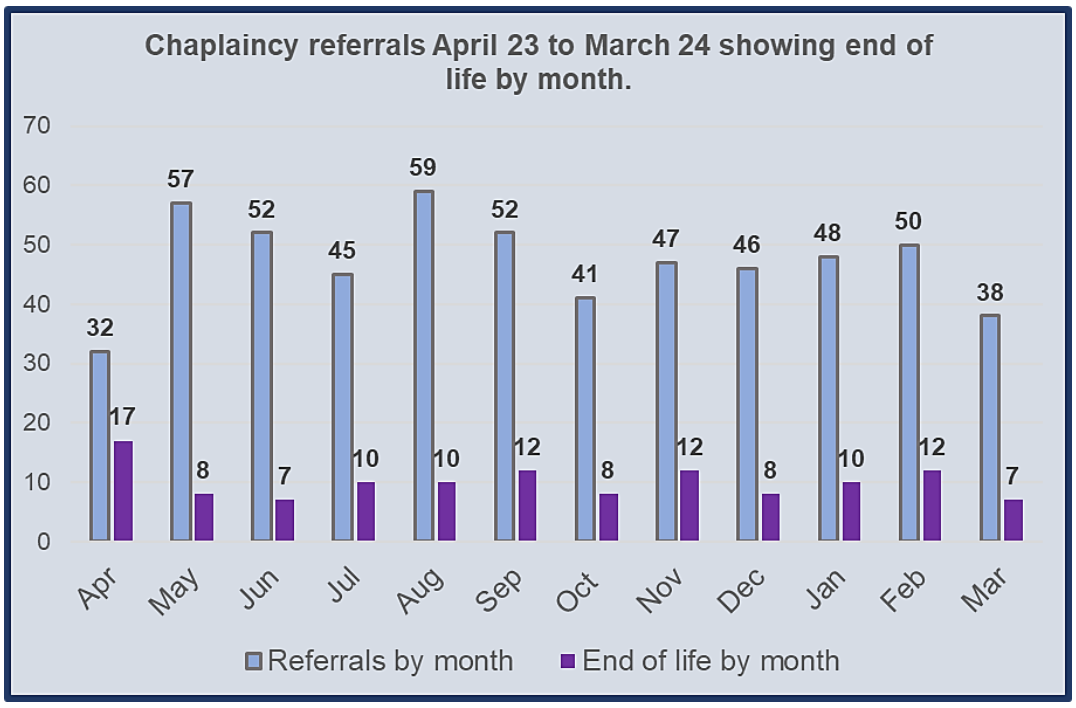


Fig.1 Number of referrals received by month, with second data range showing how many of these referrals were for end-of-life spiritual care.

The number of referrals this year is a 33% increase on last year when we received 404 referrals. The graph (figure one) also shows the number of referrals that were for end-of-life support within this total. Of the 567 formal referrals we responded to, 121 (21%) of them were to attend to a dying patient and their family.

Referrals are usually made by ward staff at the request of the family, or through the End-of-Life care nurses. We provide appropriate and culturally sensitive multi-faith/no faith rituals and rites for the end of life. We utilise our community-based faith leaders and priests to conduct some of these visits where appropriate/requested.

We gather data on the faith affiliation of patients. The majority of people referred to our service report that they have a Christian faith (with a significant number qualifying this by describing themselves as a particular type of Christian – Roman Catholic). 25% of our referrals are for Muslims and 17% are for non-religious people (figure two) Our substantive staff profile reflects the demographic of patients we serve.

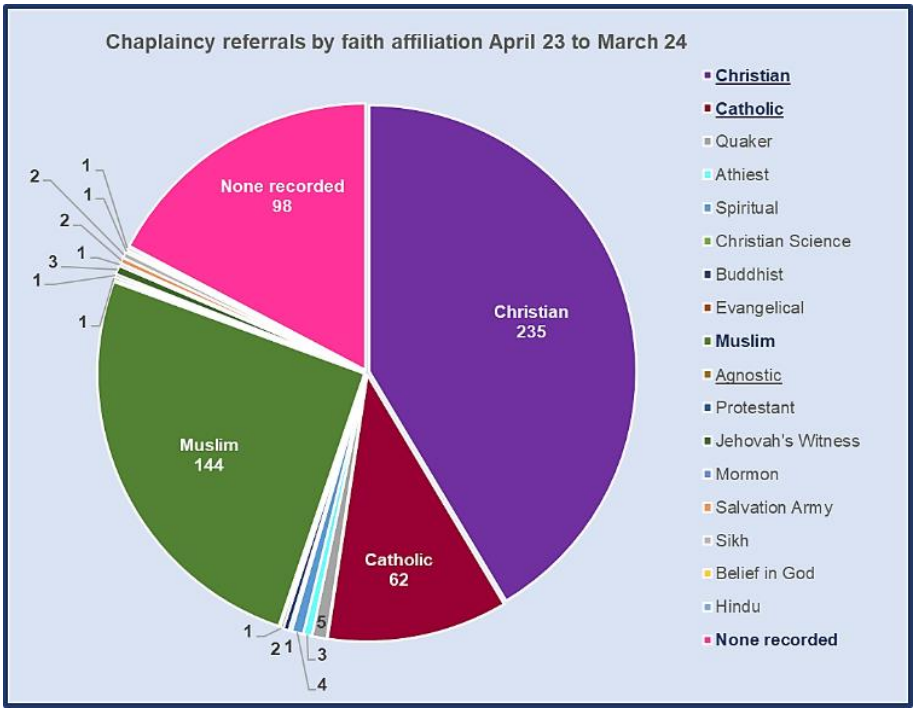
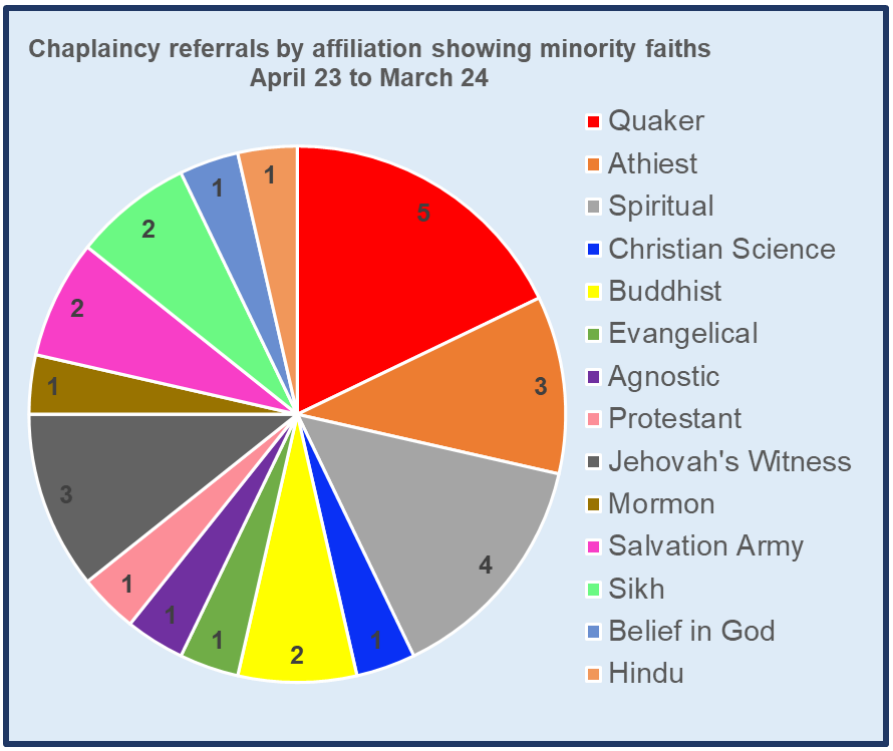


Fig. 2 above – Chart showing the breakdown of referrals according to religious affiliation.

Fig 3 below – Chart showing the breakdown of referrals by faith affiliation after 'Christian', 'Muslim' and 'no faith' have been removed.



When analysing the data we took a closer look at the faith affiliation for people who reported themselves as something other than Christian, Muslim or no faith.

The graph above (figure three) demonstrates the broad range of faiths the chaplaincy service are able to support, either through sourcing a bank/volunteer chaplain or by responding to the person as a fellow human being.

The full Chaplaincy annual report can be accessed via the Trust website.

22. Equality Impact Assessments (EqiA's) and Health Equality Assessments (HEAT)

Equality analysis is the mechanism through which the Trust is able to demonstrate 'due regard' to the Equality Act 2010 and the meeting of its equality duties in relation to all Trust business and activity. Equality analysis ensures that all protected characteristics and other groups at potential risk of health inequality are proactively considered in the Trust's services and business.

The EqIA process has been improved and forms part of the new procedural documents framework. EqIA's are required to be completed for all workforce related policies. The equalities team review and provide scrutiny prior to sign off. Regular reports will be provided to the EDI Steering Committee.

The Trust has made some progress to ensuring that Health Equity Assessments (HEAT) are conducted when planning new services or service redesign. 18 staff members have now been trained on HEAT assessments, increasing the pool of

HEAT facilitators. Resources including training and completed HEAT forms are now uploaded on our Strategy and Transformation pages.

23. Addressing Health Inequalities

The NHS has adopted a national approach to tackling inequalities in healthcare. Inequalities are unfair differences relating to where we are born, live, work and age. The approach defines a target population – the 'Core20PLUS' – and identifies five clinical areas requiring accelerated improvement.

The Trust has been monitoring the recording of ethnicity status for the services it provides as demonstrated in the tables below:

The tables below highlights ethnicity coding for 2023/24.

Ethnicity Status by Age Banding

Ethnicity AgeBanding	Ethnicity Recorded Count	Not Stated Count	NULL Count	**Total Count**	**Total %Recorded**
00-15 Years	96041	12839	1293	**110173**	**87%**
16-24 Years	60414	7276	894	**68584**	**88%**
25-34 Years	127527	18009	4708	**150244**	**85%**
35-44 Years	111199	13724	4014	**128937**	**86%**
45-54 Years	115476	11089	6019	**132584**	**87%**
55-64 Years	170500	14423	11758	**196681**	**87%**
65-74 Years	187549	14664	13260	**215473**	**87%**
75-84 Years	238482	16890	15495	**270867**	**88%**
85+ Years	164665	10162	8778	**183605**	**90%**
Total	**1271853**	**119076**	**66219**	**1457148**	**87%**

Ethnicity Status by DataSource

Ethnicity DataSource	Ethnicity Recorded Count	Not Stated Count	NULL Count	**Total Count**	**Total %Recorded**
APC	144883	13761	6591	**165235**	**88%**
COM	323543	17039	19727	**360309**	**90%**
EMC	100005	7310	3376	**110691**	**90%**
OPA	703422	80966	36525	**820913**	**86%**
Total	**1271853**	**119076**	**66219**	**1457148**	**87%**

This represents a slight deterioration (87% versus 89%) on completeness of coding the previous year across all data sets and underlines the need to ensure completeness of recording is emphasised to staff.

The Trust is working with partners in the Dudley Health & Care Partnership including Dudley Council for Voluntary Services and different community groups to better understand the barriers to accessing healthcare and learn how we can ensure our services reach and benefit everyone.

In 2023/24, a new sub-committee of the Board was established called the Integration Committee which focuses on the actions the trust is taking to build partnerships and improve overall health and wellbeing in the population and this includes work to address health inequalities. The committee receives regular updates from preventative services and the actions being taken to address inequalities.

We have formed a Health Inequalities Core Group which reports to the Integration Committee. This core group has resulted in a better understanding of the available metrics. Relevant reports on health inequalities have been reviewed and recommendations shared with service leads. A proposal has been developed for 'poverty proofing' of paediatric outpatient services by provision of free bus passes and it is hoped to measure the impact of this on the non-attendance rates.

24. Widening participation

As an anchor institution (one whose long-term sustainability is tied to the wellbeing of our local community), we seek to improve and increase entry routes for staff from diverse backgrounds, to facilitate better access to development and career opportunities. In 2023 The Trust appointed to the role of Workforce Development and Widening Participation Business Partner. Current projects include:

ICAN Dudley is a partnership approach with Dudley Council to reduce barriers into employment for local people, to increase the proportion of local people employed in health and social care and council jobs, upskill the local population and reduce healthcare inequalities. We are working together as partners to deliver new ways of working funded by Commonwealth Games Legacy Funds.

This is a new way to recruit at grass roots level for both partner organisations, aiming to change traditional methods of recruitment.

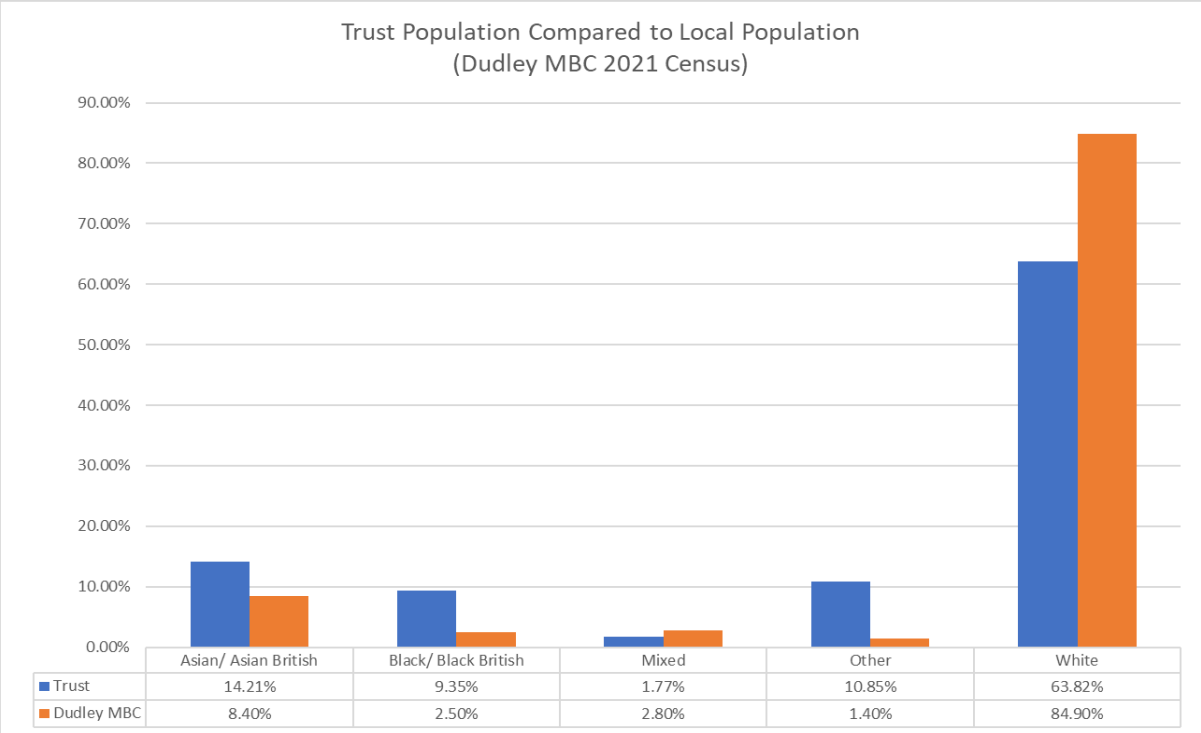
Under "I Can" we provide paid work experience which allows for job carving to design internships that align to the skills, interests and needs of the candidates, allowing them to develop their skill set and employability whilst receiving a wage. This allows us to better support the needs of target groups such as people with SEND, neurodivergent conditions, and Care Experienced young people. It also supports improved recruitment and workplace support. We have 5 paid work experience placements at Dudley Group currently, and plan for a further 10 this year. Dudley Council are supporting 6 placements currently, with another 10 in the pipeline for this year.

Another I Can scheme, “Into Employment” offers a 4-week sector-based work programme that prepares unemployed people for work and culminates in a guaranteed interview. We are utilising this programme to support recruitment onto the Clinical Support Worker temporary staffing bank, and to support an in-house training and competency package to enable recruits to be work-ready. We have supported three cohorts of Into Employment since January, and the first cohort of Novice CSWs commence their training in June.

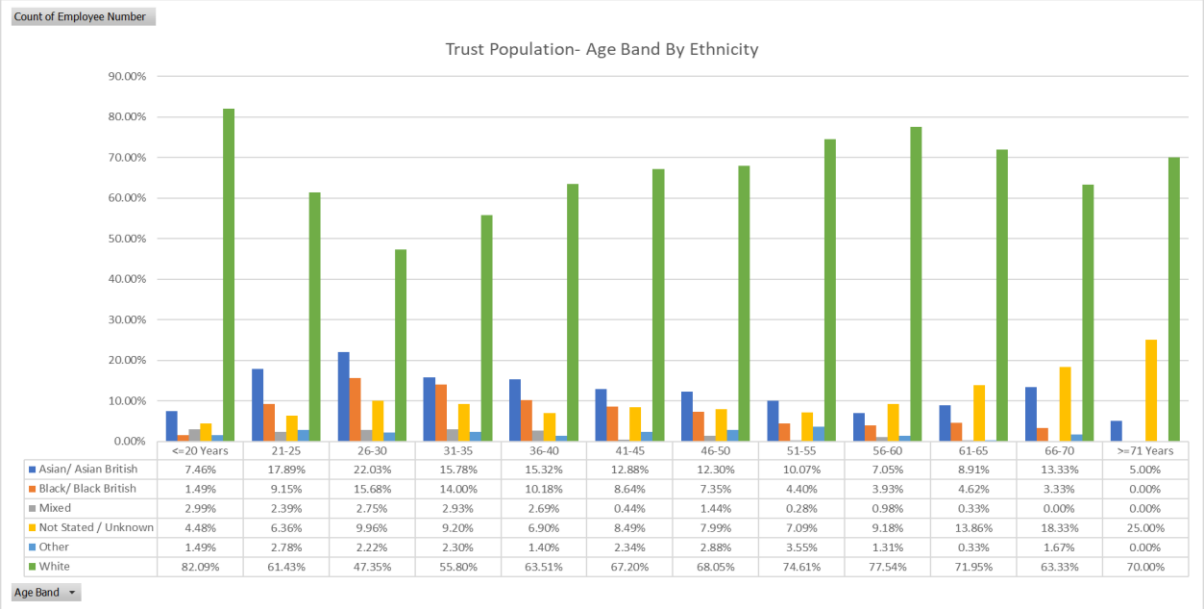
Beyond “I Can”, we are seeking to develop our work experience and schools engagement programme, by targeting interventions to schools and young people that need it the most. Work is underway to develop an in-person careers event in partnership with Dudley College that will be delivered to schools in the Dudley Academies Trust and diversified to include young people with SEND.

25. Population and Workforce Profiles

Population profiles:



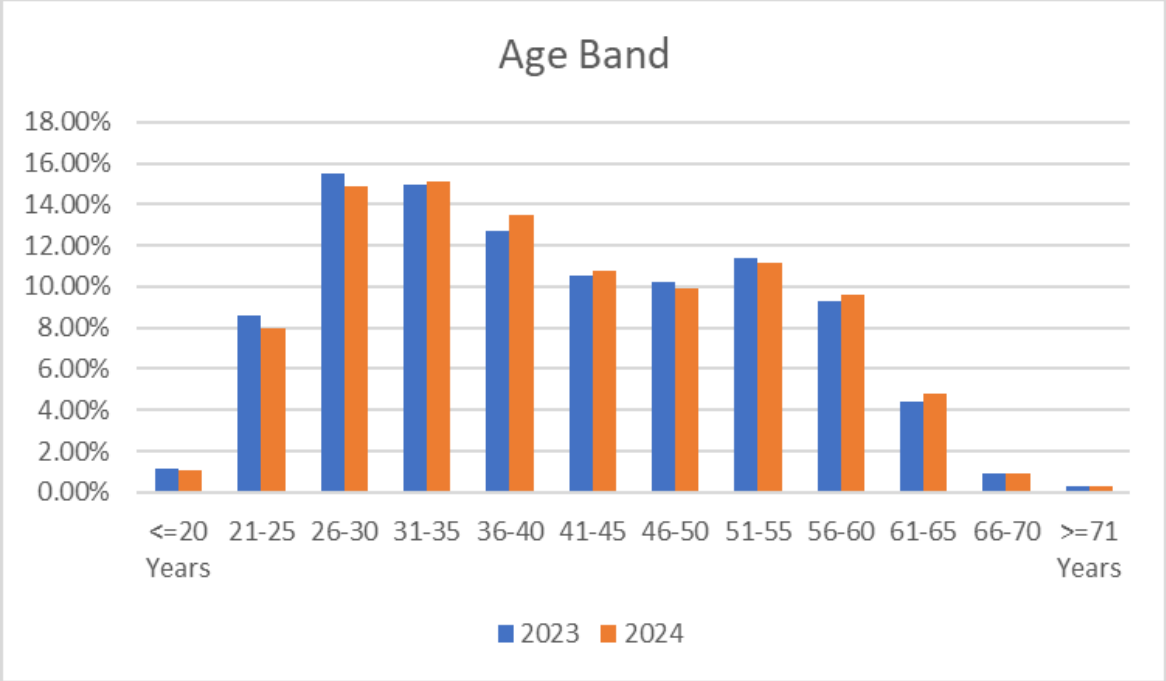
	Asian/ Asian British	Black/ Black British	Mixed	Other	White
Trust	14.21%	9.35%	1.77%	10.85%	63.82%
Dudley MBC	8.40%	2.50%	2.80%	1.40%	84.90%

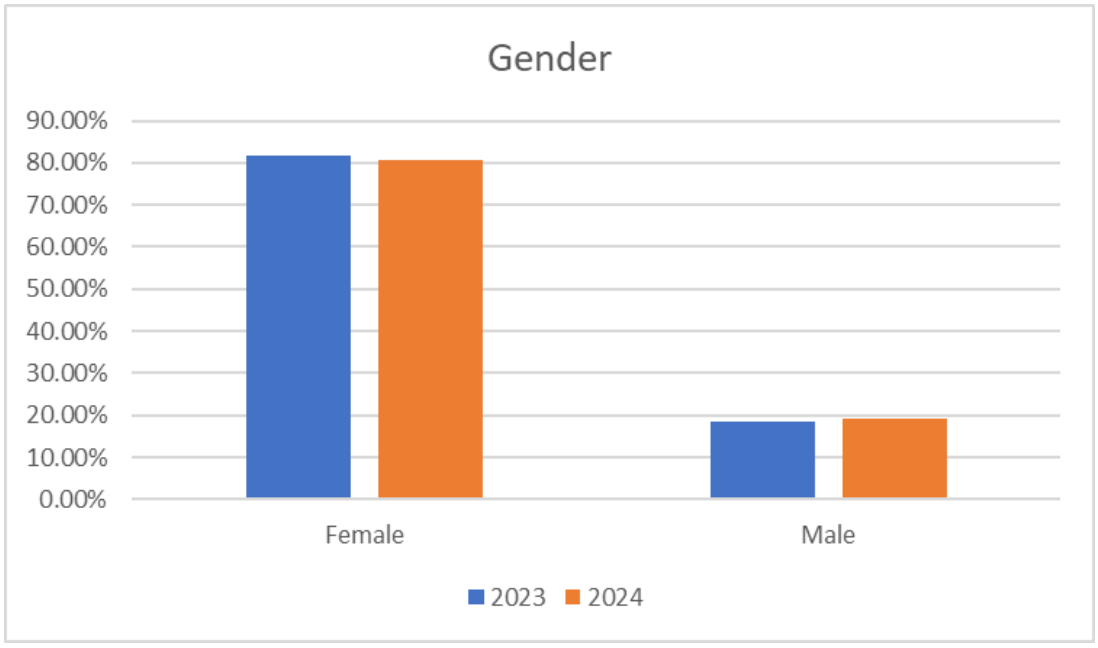


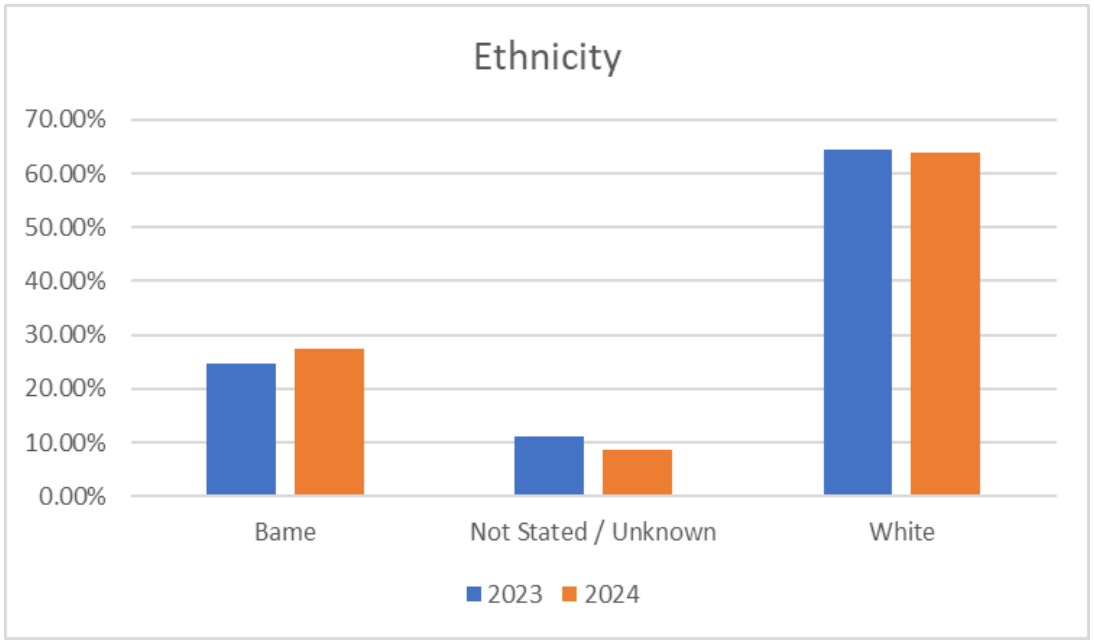
	<=20 Years	21-25	26-30	31-35	36-40	41-45	46-50	51-55	56-60	61-65	66-70	>=71 Years
Asian/ Asian British	7.46%	17.89%	22.03%	15.78%	15.32%	12.88%	12.30%	10.07%	7.05%	8.91%	13.33%	5.00%
Black/ Black British	1.49%	9.15%	15.68%	14.00%	10.18%	8.64%	7.35%	4.40%	3.93%	4.62%	3.33%	0.00%
Mixed	2.99%	2.39%	2.75%	2.93%	2.69%	0.44%	1.44%	0.28%	0.98%	0.33%	0.00%	0.00%
Not Stated / Unknown	4.48%	6.36%	9.96%	9.20%	6.90%	8.49%	7.99%	7.09%	9.18%	13.86%	18.33%	25.00%
Other	1.49%	2.78%	2.22%	2.30%	1.40%	2.34%	2.88%	3.55%	1.31%	0.33%	1.67%	0.00%
White	82.09%	61.43%	47.35%	55.80%	63.51%	67.20%	68.05%	74.61%	77.54%	71.95%	63.33%	70.00%

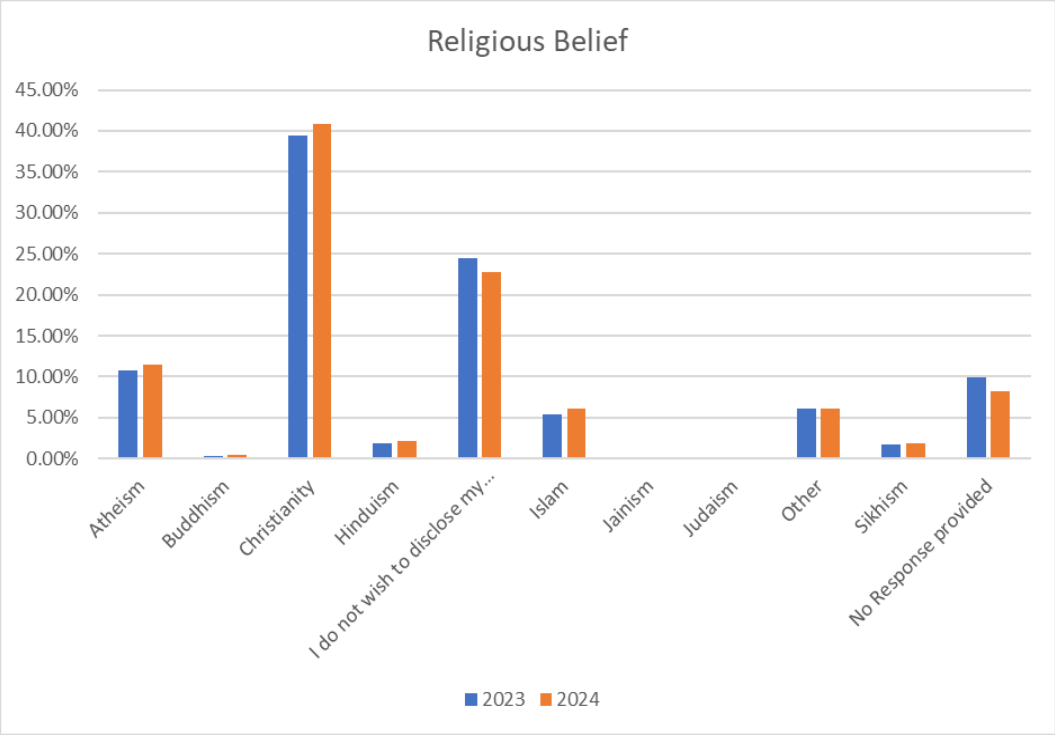
ss

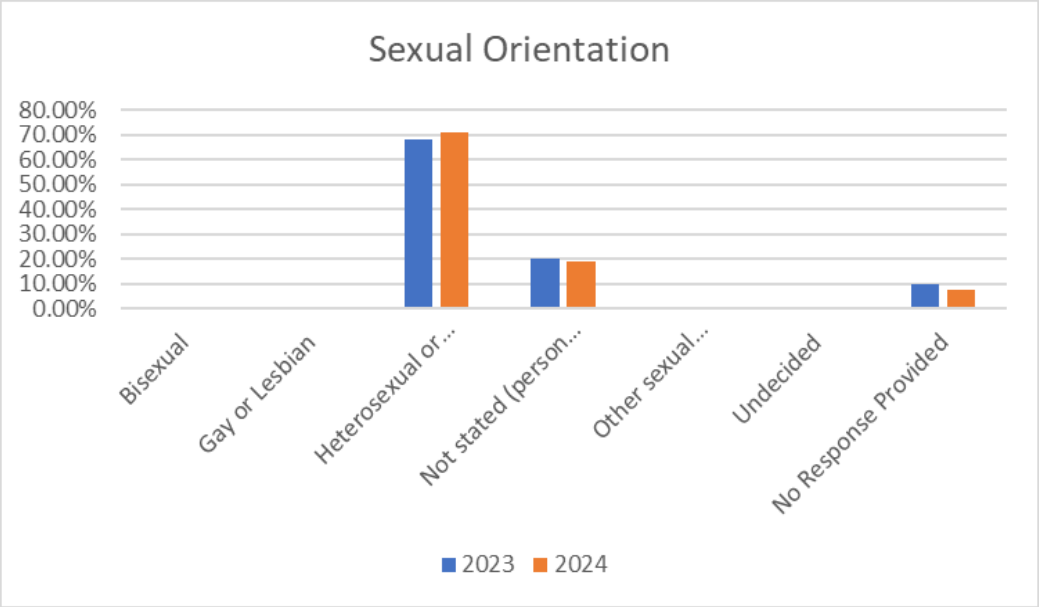
Workforce profiles:




Gender
90.00%
80.00%
70.00%
60.00%
50.00%
40.00%
30.00%
20.00%
10.00%
0.00%
Female
Male
2023
2024


Ethnicity
70.00%
60.00%
50.00%
40.00%
30.00%
20.00%
10.00%
0.00%
Bame
Not Stated / Unknown
White
2023
2024





26. Conclusion

At the Trust we are committed to providing equal opportunities to all of our staff patients and stakeholders. We recognise and value the diversity of our workforce and communities we serve. Our goal is to create a culture of inclusion and respect that enables everybody to achieve their full potential regardless of their background.

We believe that the wealth of information contained within this annual report demonstrates the significant progress made by the Trust on implementing the Public Sector Equality Duty requirements.

Our commitment to equality., diversity, and inclusion is reflected in our policies procedures and practices. We are striving to create an environment where everyone

feels respected, valued, and supported. We work to eliminate all forms of discrimination harassment and bullying and promote a positive and inclusive culture.