Our Patients
Our People
Our Place

NHS
The Dudley Group
NHS Foundation Trust

Board of Directors Meeting Public Papers

Thursday 11th September 2025 10:00 – 13:40

Room7/8 Clinical Education Centre, South Block, Russells hall Hospital, Dudley, DY1 2HQ

Health Minister Visit / Volunteer winning CTE Award/ Chief Nurse Fellowship Programme

The Dudley Group
NHS Foundation Trust

BOARD MEETINGS
PUBLIC INFORMATION SHEET

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

1. Introduction

This sheet provides some information about how Board meetings work.

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

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

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

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2. Board Members' interests

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

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

3. Opportunity for questions

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

4. Debate

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

5. Minutes

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

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

6. Key Contacts

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The Dudley Group NHS Foundation Trust

PUBLIC SESSION

Board of Directors
Thursday 11th September 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 –** ENT head and neck Faster Diagnosis Standard (FDS) pathway update Introduced by M Morris, Chief Nurse				
3	**Declarations of Interest** Click here for Register of Interests		Chair	For noting	10:25
4	**Minutes of the previous meeting** Thursday 10 July 2025 Action Sheet 10 July 2025	Enclosure 1 Enclosure 1a	Chair	For approval	
5	**Chief Executive's Overview**	Enclosure 2	D Wake	For information & assurance	
6	**Chair's Update** • Public questions (as submitted) • Journey to a single board	Verbal / enclosure 3	Chair	For information	
6.1	Integrated Committee upward assurance report - *Finance & Productivity, Quality, People, Infrastructure and Integration Committee quadrants in further reading pack*	Enclosure 4	G Crowe & Non-executive committee chairs	For approval	
6.2	Finance report Month 4 (July '25) inc. Cost Improvement update	Enclosure 5	C Walker	For approval	
7	**Our Place** Build Innovative partnerships to improve the health of our communities				11:30
7.1	Dudley's approach to Neighbourhood Health *Additional information in the further reading pack*	Enclosure 6	K Rose / S Cornfield	For assurance	

	Comfort break (10 mins)				
8.	**Our Patients** Deliver right care, in the right place, at the right time				11:50
8.1	Chief Nurse & Medical Director report	Enclosure 7	J Odum M Morris	For assurance	
8.2	Integrated Quality & Operational Performance Report (IQ &OPR) inc. IPC BAF and Safer Staffing *Full reports in further reading pack*	Enclosure 8	J Odum K Kelly M Morris	For assurance	
8.3	Perinatal Quality Surveillance Dashboard *Additional information in the further reading pack*	Enclosure 9	C Macdiarmid	For approval	
8.4	Learning from Deaths *Additional information in the further reading pack*	Enclosure 10	J Odum	For assurance	

8.5	Winter Plan 2025/26 Board Assurance Statements *Full Plan in the further reading pack*	Enclosure 11	K Kelly	For approval	
9	**Our People** Be a brilliant place to work & thrive				12:40
9.1	Workforce Key Performance indicators* *Full report in further reading pack*	Enclosure 12	J Fleet	For noting	
9.2	Performance Against Workforce Forecast* *Full report in further reading pack*	Enclosure 13	J Fleet	For assurance	
9.3	Workforce Race Equality Standard and Workforce Disability Equality Standard	Enclosure 14	J Fleet	For approval	
9.4	Freedom to Speak up	Enclosure 15	A Burrows	For assurance	
9.5	Guardian of Safe Working	Enclosure 16	F Chaudhry	For assurance	
10	**Governance**				12:55
10.1	The Green Plan	Enclosure 17	R Barlow	For approval	13:10
10.2	Board of Directors and Committee effectiveness report	Enclosure 18	H Board	For approval	13:25
10.3	Quarterly Trust strategy and annual plan progress report April – June 2025	Enclosure 19	A Thomas	For approval	
10.4	Board Assurance Framework	Enclosure 20	H Board	For approval	
11	**Any Other Business**				
12	**Date of next Board of Directors meeting** (public session) Thursday 13th November 2025				
13	**Meeting close**				13:40

Quorum: One Third of Total Board Members to include One Executive Director and One Non-executive Director
Items marked *: for noting and no time allowed on the agenda

The Dudley Group
NHS Foundation Trust

Unconfirmed Minutes of the Board of Directors meeting (Public session)
held on Thursday 10th July 2025 10:00hr
Stourbridge Health and Social Care Centre, Vicarage Road, Stourbridge, DY8 4JB

Present:
Laura Broster, Group Director of Communications and Engagement (LB)
Gary Crowe, Deputy Chair (GC) **Chair**
Peter Featherstone, Non-executive Director (PF)
James Fleet, Group Chief People Officer (JF)
Joanne Hanley, Non-executive Director (JHa)
Anthony Hilton, Associate Non-executive Director (AH)
Julian Hobbs, Medical Director (JHo)
Liz Hughes, Non-executive Director (LH)
Karen Kelly, Chief Operating Officer/Deputy Chief Executive (KK)
Mohit Mandiratta, Non-executive Director (MMa)
Martina Morris, Chief Nurse (MM)
Jonathan Odum, Interim Medical Director (JO)
Vij Randeniya, Non-executive Director (VR)
Kat Rose, Chief Integration Officer (KR)
Adam Thomas, Group Chief Strategy & Digital Officer (AT)
Diane Wake, Chief Executive Officer (DW)
Chris Walker, Interim Director of Finance (CW)
Lowell Williams, Non-executive Director (LW)

In Attendance:
Helen Board, Board Secretary (HB)
Ian Chadwell, Deputy Director of Strategy
Mazhar Chaudri, Consultant (MC)
Sally Cornfield, Programme Director for Dudley Health Care Partnership Board (SC)
Alison Fisher, Directorate Manager (Minutes) (AF)
Elaine Gilliland, Programme Lead for Diagnostics (EG)
Madhuri Mascarenhas, Governance Administration Lead (MMas)
Rory McMahon, Director of Ops, Medicine & Integrated Care Division (RMc)
Jack Richards, Deputy Chief Operating Officer (JR)
Dellesa Robinson, Pharmacist (DR)
Amandeep Tung-Nahal, Director of Ops, Community with Core Clinical Services Division (ATN)
Jo Wakeman, Deputy Chief Nurse (JW)

Apologies
Rachel Barlow, Group Chief Development Officer (RB)
Catherine Holland, Non-executive Director (CH)
Mick Laverty, Associate Non-executive Director (ML)
Anne-Maria Newham, Non-executive Director (AMN)
Sir David Nicholson (SDN)
Lowell Williams, Non-executive Director (LW)

Governors and Members of the Public and External attendees
Alex Giles, Public Elected Governor, Stourbridge
Michael Higgs, Patient story (MH)
Nandi Shelambe, member of the public

25/47 Note of Apologies and Welcome

The Chair welcomed all to the meeting. Apologies were noted as listed above.

25/48 Staff and Patient Story – Targeted Lung Health Screening

MM introduced the patient story.

The lung cancer screening programme was an outstanding programme to improve early detection of lung cancer in Dudley.

The programme was meeting and exceeding its targets for lung cancer screening in Dudley. The programme was a vital step in diagnosing lung cancer early to give patients the best chance of a positive outcome.

Mr Higgs joined the Board to share his journey from screening, diagnosis and treatment. His patient journey has had a positive outcome and he was very complementary of the screening. He had no symptoms of lung cancer and couldn't thank the programme enough for detecting his lung cancer early. The only delay in his pathway had been waiting for results of a scan on his non-cancerous lung and JHo agreed to look into this pathway to ensure there were no ongoing reporting delays.

Action: investigate reporting pathway of the lung cancer screening programme to ensure there are no delays with reporting of scan results. **Medical Director**

EG shared that patients were being recalled on a regular basis to help alleviate anxiety following their lung cancer diagnosis and treatment. The screening programme offered easy access with the screening unit being sited in local community sites. It was a very personal and explementary service, leading the way across the Country. Some excellent results were being seen and conditions beyond cancer were being diagnosed. It was an innovative programme and would continue to evolve and develop.

The Board thanked Mr Chadwell and Ms Gilliland for the work they undertook with primary care to ensure the screening programme was established.

EG commented that the programme was collaborative and worked closely with both primary and secondary care.

MC was very complimentary of the screening programme and the sea change it had brought to the early diagnosis of lung cancer.

Within Dudley 14,000 patients had been contacted and had a 97% response rate and 57% conversion rate. Both rates were above national average.

CW commented that smokers were the main criteria for patients who were contacted and asked if there was a plan to widen the criteria. EG commented that in order to ensure the programme was successful the criteria was currently limited, but it was hoped to broaden the criteria as the programme became more established.

LH asked when the programme would become business as usual and where it would sit. EG stated that the plan was to incorporate within the community diagnostic centres (CDC).

In response to a further question from LH about what steps were taken to ensure patients were not missed, EG replied that the programme makes every effort to ensure all patients matching the criteria were contacted and worked very closely with primary care to identify patients.

PF asked what the future ambitions were for the service. EG replied there was ongoing work with the programme manager to review readiness checklists along with how all elements could be brought in house. The initial timeframe was to bring both the programmes for Sandwell and Dudley inhouse as part of the 2026/27 CDC programme noting that reporting was the only area that would lack capacity and would need to stay external at present.
The Board thanked Mr Higgs for sharing his story who confirmed that he would be happy to participate in any promotional material for the programme to encourage others to participate.

Action: Patient story video to be made to highlight the programme and encourage take up of the lung screening. **Group Director of Communications**

It was **RESOLVED** to

- Note the patient story

25/49 Declarations of Interest

The Declarations of Interest Register was available on the Trust website.

25/50 Minutes of the previous meeting held on 08th May 2025

The minutes of the previous meeting were approved as a true and accurate record.

It was **RESOLVED** to

- Approve the minutes of the last meeting

Action Sheet of 8th May 2025

One action was still open.
25/40.2 – Integrated Quality and Operational Performance Report
- Explore support from Aston University for cardiac MRI and sleep lab diagnostic facilities. – AH and KK were discussing how Aston University facilities could be used.

25/51 Chief Executive's Overview

DW summarised the Chief Executive's report given as enclosure two. She highlighted three publications that had been released over the last week.

Fit for the Future: 10 year Health Plan for England that had been launched in the previous week and gave an overview of how the plan aspired to create an NHS fit for the future. There were three key areas of focus – hospital to community; analogue to digital and sickness to prevention. DW was disappointed with the timescales within the 10 year plan as she felt it needed to be more ambitious in the change required. The challenge was for the Trust to bring the strategy to life and bring some of the timescales forward where possible adding that the recently refreshed Trust's Strategy was aligned with the NHS 10 year plan.

NHS Oversight Framework – all Providers would be assigned a segmentation rating where 1 being the best to 5 where intervention would be required. The assessment process measured each provider across six domains – access, effectiveness and experience of care; patient safety; people and

workforce; finance and productivity and ICB system performance. The Trust had been assigned segmentation 3 noting this could not be improved owing to a financial deficit. League tables would be published next week and would be ranked out of the 150 Trusts noting that The Dudley Group would be ranked 60. Work would ensue to ensure what was within the segmentation was included within the Trust's performance metrics for monitoring and understanding.

Dr Penny Dash report – noting that in future, patient experience outcomes would feed into income received. There were clear recommendations for organisations and noted that the report highlighted that the Board would need to be focused on quality and safety.

Operational performance at the Trust remained good. Flow and urgent and emergency care were the two areas were the most challenged areas within the organisation and required daily focus.

Chief Nurses at both The Dudley Group and Sandwell West Birmingham Trust have been successful in being selected to join the national Chief Nurse Strategic Advisory Group which would provide an opportunity to input into the development of national policies and influence practice and decision making.

Following concerns relating to the Black Country Pathology Service (which the Board had previously been sighted on) an external review had been commissioned to review the performance of the service.

The BMA had notified the Trust that Junior doctors strike action had been called and reassured the Board that the Trust had a good track record of planning which would be enacted and focus to ensure patient safety was maintained.

In response to a question from PF related to maturity of relationships with key stakeholders in support of the Trust to maintain flow within the urgent and emergency care pathways, DW confirmed that partners did help and was working closely to review what additional partnership support could involve in strengthening processes.

JH asked who saw the National Oversight Framework league table and whether it had a financial impact on where funding would go. DW confirmed that it would be shared with the public next week and reputation was the main area of risk. Organisations in segmentation 4 and 5 would have greater scrutiny and intervention noting that the Segmentation assigned was linked to executive leadership pay/pay awards.

GC stated that there needed to be alignment to strategy and ensure there was a trajectory to demonstrate confidence that strategy was being delivered and build confidence with the public.

It was **RESOLVED**

- To note the report and assurances provided

25/52 Chair's Update

Public Questions

There had been no public questions received.

GC reported that he had attended the attended the Black Country Leadership Freedom To Speak Up FTSU) event. He commented that it had been a sobering event as stories were heard from staff who had first-hand experience of events that fell within the remit of FTSU. He reminded Board members to always demonstrate the FTSU principles and encouraged Board members to undertake ward to board activity and listen to staff. It was going to be especially important that board members were visible to staff and connect with them as the challenging period of change was navigated.

25/52.1 Integrated Committee Upward Assurance Report

The Chair introduced the report given as enclosure four including upward assurance from each of the Committees; Finance & Productivity, Quality, People, Integration and Charity. Non-executive Committee Chairs were invited to raise any particular items for escalation to the Board.

GC highlighted that the perinatal quality and workforce summaries included as an Appendix of the Quality Committee upward report were important for the board to note. Key points included the following:

Assure

- Perinatal Mortality data remains in a stable position; all rates remain below the national rates.
- Maternity and Neonatal services undertook a 15 steps event on the 20th May that was well attended by families that had used our services. Formal feedback will follow once collated by the Maternity and Neonatal Voices Partnership (MNVP) but overall, the visit was positive, welcomed by the families in attendance and lots of lovely feedback for the teams.

Advise

- Midlands Maternity Heatmap score has increased to 32 for June 2025. This increase is reflective of the vacancy currently within the Midwifery and Maternity support worker workforce. Rectification plans are in place for this.
- There were 2 new cases referred to the Maternity and Newborn Safety Investigations (MNSI) during April and May 2025, by the Trust. 1 case has been rejected due to lack of family engagement. There has been 1 new incident response commenced during April and May 2025. There was 1 incident response concluded during April and May 2025.
- APPENDIX 3 demonstrated the current Midwifery workforce position, presented to the Quality Committee and Board Bi-annually to comply with requirements of the Maternity Incentive Scheme year 7. Main highlights show that the Maternity unit has funded establishment in line with Birthrate plus requirements. There is however a vacancy in the Midwifery workforce of 12.68 WTE and Midwifery Support Workers of 9.6 WTE. All posts have been recruited in to; the majority of these people will commence employment September/October 2025. Most of this RM vacancy is within the Community Midwifery department, with mitigations in place. Despite the vacancy challenges: The Midwife to birth ratio for April is 1:29, this is within acceptable levels. Maternity specific multidisciplinary training compliance remains above 90%. There have been 0 instances where the shift leader has not been supernumerary, or when a woman has not been provided with 1:1 care in labour. This is a requirement of the Maternity Incentive Scheme year 7.

Alert

- Safeguarding level 3 children training compliance within the midwifery and obstetric teams has reduced to 66% in May, from 80% in April for Midwives, and 79% to 58% in

Boards would need to prepare for enhanced governance and patient experience expectations. A detailed review of maternity and neonatal services will be undertaken in ten trusts nationally that had yet to be announced.

JHa highlighted her concerns to the Board in relation to the ability of the Trust to deliver the required CIP savings within the timescales required to deliver the financial plan. She raised the question of whether there was enough capacity and capabilities within the organisation to deliver the CIP programme.

GC highlighted the persistent use of temporary escalation areas as an area of concern for the Board. LH confirmed that the Quality Committee had reviewed this in detail and confirmed that reporting was in place and risk assessments undertaken adding that whilst there were more incidents being raised in these areas, better reporting was in place to ensure the Trust was able to use these areas in a safe way. MM confirmed that these were incidents confirming when the TES areas were open, rather than patient safety incidents and oversight of quality was paramount to maintain patient safety. The data will be published by NHSE in the future. The Trust was working to eliminate the use of temporary escalation areas, unless in exceptional circumstances.

The Joint Provider Collaborative had been positive about the level of clinical service transformation taking place with partners to enhance services across the Black Country organisations.

JF highlighted that corporate service transformation working was live and the programme was split into two phases. A more detailed update will come to Board at the next meeting. **Action: Detailed update on corporate service transformation to be presented at the next meeting**

It was **RESOLVED** to

- to approve and note the report of assurances provided by the Committees upward reports, the matters for escalation and the decisions made

25/52.2 Finance Report Month 2 (May 2025) including Cost Improvement Update

CW presented the Month 2 (May 2025) Finance Report given as enclosure five. The Board noted the following key highlights:

At the end of May 2025 the financial plan was on plan and in a good position. Small increases had been seen in the run rate and was being monitored. There was a positive position on pay and work was underway to look at bringing some of the identified CIP forward. Income was on plan, but ERF was starting to overachieve and this is being seen across the system. CW reminded the board of the risk of non-payment of ERF income. ERF activity to achieve constitutional standards was likely to be paid with a risk of non-payment for ERF activity outside of this scope.

Pay was a positive position overall. Substantive pay was positive and the impact of the previous vacancy freeze was being seen. Capitalisation of some IT posts had taken place reducing pay spend. Bank had seen an increase in WTE and was over target. Due to the reduction in bank rates, the financial position relating to bank remained on plan, but the number of WTE was off plan. Bank spend would need close monitoring to bring it back into plan.

There had been non-pay slippage due to additional activity, but pay benefits had offset this.

The forecast was for the Trust to achieve its breakeven financial plan, but current financial risk was high. CW highlighted that System funding would only be received if the whole System plan was delivered. Delivery of CIP savings represented the largest risk (£13m unidentified) to achievement of financial plan. Contracts for 2025/26 continued to be agreed and only one contract at risk.

The cash position was as expected and the cash forecast had been reduced due to capital payments.

The capital programme was slightly behind plan but expected to catch up.

The forecast was based on the current financial plan and did not include any costs relating to corporate transformation programme or any industrial action.

The Cost Improvement Progamme was hitting target at the end of May adding the importance of identifying transformational schemes to deliver the level of savings required to give the organisation financial sustainability going forward.

The System was on plan at the end of May and confirmation of Q1 deficit funding from NHSE had been received. Quarter two tranche was expected to be received, but organisations across the ICS had started to go off their financial plans.

Divisional plans were forecasting a shortfall. Capacity of staff to drive transformational scheme was an issue and discussions had been taking place with potential external support. Pace was required to deliver the level of savings required and review of what actions could be taken to urgently deliver savings; both short term and long term.

DW commented that actions would be required to deliver financial plan and that external support would be required due to lack of capacity of staff within the organisation.

VR highlighted concerns on the lead up time to CIP schemes and it being behind the plan, and the potential impact of a junior doctors strike on delivery of services. He asked if there would be allowances for this. CW assured that strike planning within the Trust was particularly good and last strike resulted in little impact; plan would be to continue all elective work.

AT commented that divisions were working hard on the CIP in-year plan. As part of the NHS 10 year plan, the Trust would be required to submit a three year plan by the end of December 2025. An immense amount of planning would be required to deliver this during the September – December period noting that the move to a sustainable three year plan would be positive.

JHa commented that whilst the wider System looked positive at end of Q1, two providers were not achieving their financial plan, putting the whole System at risk. GC felt it important for the Board to maintain strong reporting/monitoring of the System financial position to give early sight of any impact on the Trust.

DW commented that the long awaited NHSE voluntary redundancy scheme for workforce reduction had still not materialised. The MARS scheme had launched and was unfunded and a consequence would create a cost pressure in 2025/26.

It was **RESOLVED** to

- Note the financial performance for Month 2 (May 25).

25/52.3 Emergency Preparedness, Resilience and Response (EPRR) Annual Report

KK presented the Emergency Preparedness, Resilience and Response (EPRR) Annual Report given as enclosure six. The Board noted the key areas of the report. The full report was available in the reading pack.

It was **RESOLVED** to

- To approve the content of the Emergency Preparedness, Resilience and Response Annual Report

25/53 Our Place – Build Innovative partnerships to improve the health of our communities

25/53.1 Dudley Health and Care Partnership Update

SC joined the Board to give a full update on work underway within the Dudley Health and Care Partnership (DHCP). Full staff engagement was taking place to update the strategy and a final version would be available in December.

SC highlighted the increase in demand for services and the detailed look at the response which had taken place and alignment with NHS 10 year plan, to drive activity into the community and away from the acute setting. A detailed look at the Dudley population was taking place to ensure services were in the right areas for patients. There was a high prevalence of diabetes in Dudley and work was underway to move into prevention pathways.

Focus on four areas of transformation within Dudley – life expectancy, poor housing, educational attainment and deprivation. Interventions were being made in these areas to benefit residents.

Dudley Improvement Practice Community First value workstream had taken place which was helping to develop future strategy. Eleven programmes had been identified during the event which were being developed.

Good assurance was evidenced in the actions already taken and future initiatives to improve population health for Dudley.

A Care Navigation Centre business case had been developed and would be presented to the Finance and Productivity Committee in July; a positive step forward.

Working closely with local providers and partners to collaborate on community services. ICan initiative was an excellent programme working in conjunction with Dudley Health and Dudley Council to support underrepresented local residents into paid work placements. The Board noted that the programme had won an award that week.

VR commented that some partners were not as engaged; moving forward it would be a step change and a positive move to integration.

MM highlighted the positive community partnership teams with lots of work undertaken within the Trust over the last 24 months. SC highlighted that the Care Home Charter was for all care homes. DHCP would engage with all patients, especially hard to reach patients.

LB reported that work was underway to bring positive stories to share initiatives and changes that had taken place. Positive to build relationships with all communities to gain their trust to help build healthy communities.

VR asked if there was further scope to move to community. DW stated that investment into Community was required. Challenge was for investment within acute services to move community and map this. A focus would be on ensuring that it aligned to the NHS 10 year plan and noted that the plan to move to community services would be overseen by the Integration Committee.

It was **RESOLVED** to

- Note the contents of the report and that the hospital to community plan would be overseen by the Integration Committee

[There was a short comfort break]

25/54 Our Patients - Deliver Right Care, in the Right Place, at the Right Time

25/54.1 Chief Nurse and Medical Director Report

MM and JHo presented the combined Chief Nurse and Medical Director Report given as enclosure eight. The Board noted the following key highlights:

JHo commented that workforce has been receiving focus with a review on how to develop the workforce to ensure we achieved the best out of our staff and recruitment aligned to establishing a workforce fit for the needs of the Trust. It was recognised that staff wellbeing would need to be supported to ensure optimum delivery and maximum output; it would align to NHS 10 year plan. He noted the excellent work taking place within the Trust to support that vision.

MM had been examining key areas of pressure within the organisation to develop those requiring focus. GC asked what had gone through senior leadership to embrace it. JHo stated that the vision was developed taking views of leadership throughout the Trust. GC asked if it would be used to inform workforce planning within the winter plan. JHo described a positive route to success, which included addressing some of the root causes of staff absence. JF stated that actions underway align with staff wellbeing. Absence rates within the Trust overall was 5% noting some challenged areas with high rates would be supported by HR to improve absence rates. It needed full accountability by all leaders to support improvement.

GC suggested that the Trust needed to move to a triangulated report to bring all areas together to give meaningful usable data. JF commented that the pulse survey was live and would help develop a heatmap of the data. JHo commented that CQC reports, patient and staff survey results would provide the triangulation data required.

The Chair thanked JHo and MM for their comprehensive report.

It was **RESOLVED** to

- Note the ongoing work and recommended actions to support staff health and wellbeing.

25/54.2. Integrated Quality and Operational Performance Report

JHo, KK and MM presented the Integrated Quality and Operational Performance Report given as enclosure nine. The Board was assured that the performance reports had been considered in detail at the respective Committees prior to submission to the Board of Directors.

The report summarised the Trust's Quality and Performance data for the month of May 2025 (March/April 2025 for Cancer and VTE). The Board noted that the associated data pack was included in the reading room.

MM highlighted the good areas of work underway to improve patient experience. Further work was being undertaken within the complaints team to improve a timely response rate.

She stated that the focus on the safe staffing agenda has been heightened and it was especially important for the Board to have oversight of the matter, given safe staffing is the responsibility of the whole Board. Monthly planned versus actual staffing levels are being shared with Board members to give assurance via the IQPR. The Trust has recently completed a gap analysis for nursing, midwifery and AHPs, against the Developing Workforce Safeguards and will ensure this is taken via the relevant governance routes, including the resultant action plan. The analysis and plan have already been discussed at a recent Executive team meeting.

MM stated that there had been an increase in the number of midwifery vacancies. All registered midwifery vacancies have been recruited to, mainly by appointing newly qualified midwives who are due to start in September/October time. Dome of the Midwifery Support Worker vacancies have also been recruited into, with further recruitment activity planned. The community midwifery service has experienced some vacancy and broader challenges, with support provided by the acute midwifery staff, as necessary.

As already noted, MM highlighted the national maternity and neonatal review that would be undertaken and described the two elements of the review; firstly, maternity and neonatal services at ten trusts would be reviewed (awaiting Terms of Reference) and also a taskforce would also be set up (Term of Reference also awaited). The notification letter has already been shared with the Board. In the meantime, all trust boards have been reminded to:

- Focus on tackling inappropriate and poor behaviours
- Listening directly to families who have experienced harm
- Importance of setting the right culture
- Focus on using data correctly and proactively
- Retaining laser sharp focus on equality and tackling inequalities

The Trust would collaborate with staff on these focus area to gain good engagement and assessments against these requirements would be presented to Quality Committee in July 2025.

Jho commented that the CN and MD report would be used to scope support for workforce.

JHo reported that several AQuA areas had been nominated for awards. The AQuA data delivers clinical reliability and drives improvement in adult and neonatal mortality and provides assurance to the Board.

JHo highlighted the good performance in the timelessness of certification of death. The Dudley Group was considered 'best performing' with a recent e mail form the Islamic centre thanking the service for its responsiveness.

MM reported that the Trust was seeing a higher level of complex safeguarding cases. Any missed opportunities were raised with clinical teams to ensure learning was ensured and noted 84.3% compliance for safeguarding training which was an improving picture. The Quality Community focussed on areas of low compliance.

KK reported that the Trust was on track to achieve it trajectories for mandatory performance standard targets. Focus was on improving ambulance handover. She reported that 45 minute ambulance handover and 4 hour ED would be included in the national standards adding that the Team were working through trajectory for these areas to deliver standards.

DW highlighted the positive reduction in pressure ulcers and thanked the teams for their work in this area. She commented that the low vital signs compliance was disappointing; it remained an important element of care and required focus to improve. LH agreed and confirmed that a taskforce was in place and needed a cultural change to gain any traction. MM gave reassurance that focus was on this area and a pilot was underway on four wards to improve compliance, with positive results.

DW stated that the Trust has a 4 hour lag in validation of bed management data and would need to greatly improve as we are behind and noted the negative impact on flow throughout the organisation.

DW commented that whilst a decrease had been seen in delayed ambulance handover (12% down from 16%) the tolerance should be 0%. GC commented on the extremely challenging position with urgent and emergency care and that sustained focus to improve performance was vital.

It was **RESOLVED** to

- receive the report and draw assurance on oversight of quality, safety and operational performance

25/54.3 7 Day Services

JHo presented the 7 Day Services Report given as enclosure 10 and slides that had been shared on the day. He highlighted key elements.

The Length of Staff (LoS) data demonstrated a difference in week and weekend performance.

Overall job planning compliance was improving. Team job planning within surgery was good and more challenging in medicine. A new job planning cycle would commence in September 2025 and 7 day services would be clear and included in new job plans. He noted that the Diabetes service was moving to provide a 7 day service and that negotiations continued on weekend working in this speciality. He was able to give full assurance for surgery and partial assurance in medicine.

GC commented that assurance was required that interventions were in place in areas that need support. JHo stated that incremental improvements were taking place using the GiRFT metrics. Interventions to improve safety had been successful and next steps have been highlighted.

VR asked if 7 days working was really being undertaken noting that the Trust was achieving targets and asked if it was really a 7 day service. JHo agreed that whilst improved, services are still different on a weekend and the data supported this. GC stated that the Board's aspiration would be to move to full 7 days.

DW supported this aim with analysis needed to gain a view on the success in delivering a true 7 day working.

It was **RESOLVED** to

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

25/54.4 Winter Plan 2025/2026

KK presented the Winter Plan 2025/2026 report, given as enclosure 11. The Board noted that the full winter plan document was included in the reading room. The Board noted the following key highlights.

JR reported that this was an integrated plan that had been developed with key stakeholders. The National Urgent and Emergency Care planning guidance had been released of which the key elements would be included within winter plan. NHSE asked for submission by 25th July noting the plan would be evaluated over September. Challenged remained with ambulance handover. Key learning from 2024/25 would be to stick to plan.

There was a robust set of mitigations developed and scenario planning also developed. Care Navigation Centre (CNC) operation and rapid discharge was showing improvement and Trust would use the next 80 days to reset and improve. The plan identified a shortfall of 95 beds, plus a 5 bed buffer giving a shortage of 100 beds. Mitigation schemes developed to free up 101 beds. Also the improved CNC and work to avoid admissions would assist improving LoS. Working closely with primary care. Cost out schemes need to be delivered. Must not move into surge areas. Staff

wellbeing over winter period was in place to support staff. A targeted public communications plan was in place to share throughout the community. Detailed infection, prevention and control in place. Mitigations include increasing the use of virtual wards, community services increase and adopt daily huddles to review performance. The approach would be to adopt a 'Live plan' which could be updated and flexed where pressures are seen.

GC acknowledged the work undertaken to develop plan and felt it was a much clearer and in-depth plan this year.

LH agreed the plan was more in-depth this year. She commented that a lot of delays were due to lack of communication with family/careers and need to have early discussions with them to enable discharge as planned. JR agreed that there was a need to set expectations early in the patient journey with family/carers and work with partners (i.e. ref. care package) to support post discharge. An effective discharge hub was key to work with patients and families to enable and support post discharge.

MMa commented that discharge support key and the need to learn from the previous year and give assurance to stick to plan. JR collaborating with partners would be key to ensure that no teams worked by themselves to ensure any changes required are agreed. ATN learning and understanding was vital to succeed aligned with a robust internal communications plan to ensure all services understood the part they played in the discharge process linked to a system wide improvement approach.

JH commented that the discharge improvement work and delivering the UEC improvement was key adding that the Trust was challenged in that area and struggling to deliver the Urgent and Emergency Care improvement workstream and asked what was needed to make the plan work. JR agreed that key workstreams need to be delivering now and urgent change was required. KK stated that closure of all escalation beds would take place by October. GC stated that for the Board to approve the plan assurance was needed that plan can be delivered within the next 80 days. JR additional beds needed to be closed, adding that there was no trajectory to close beds.

PF commented on the positive reference to local authority (LA) involvement and asked if they would deliver their actions and did they have a winter plan that was aligned with the Trust's plan; what would be different. JR stated that the CNC is the main difference and they would access this. There were also different ways of accessing LA elements of support for patients that the Trust were not accessing before. The local authority were working more collaboratively and had been pro-active in the design of the winter plan.

CW highlighted the financial risk to non-delivery of the CIP. There were costs included within the plan that were not included within financial plan. KR commented that there are some better care funds available and highlighted that the LA approach was different this year acknowledging themselves they were working in a challenging environment. There had been lots of leadership changes at the LA which were still embedding. DW felt that Board could support the draft in its current format, but rapid work was required to stabilise the use of additional areas. The Trust needed greater ambition in areas of 7 day working and needed further engagement with LA to get the granular detail resolved. Rapid work required to stabilise the plan. VR supported engagement with key stakeholders throughout the year to harness relationships.

GC agreed that it was a good start to plan, but needs further work to ensure the elements that need contingencies have been delivered. The Board thanked the team for the work undertaken to develop the plan and that the final plan would be presented to the September Board meeting.

It was **RESOLVED** to

- Note the progress made so far on the development of the plan

25/55 Our People - Be a Brilliant Place to Work and Thrive

25/55.1 Workforce Key Performance Indicators (KPIs)

JF presented the Workforce KPI Report given as enclosure 12 for noting and advised the Board that the full data pack was included in the reading room.

JF highlighted the key performance indicators and performance against them commenting that on the whole were rated green and that work was in place to address improvement where necessary.

It was **RESOLVED** to

- Note the Workforce KPI Report

25/55.2 Performance Against Workforce Forecast

JF presented the Performance Against Workforce Forecast report given as enclosure 13 and advised the Board that the full data pack was included in the reading room.

There was still a positive variation to plan, but it had reduced. Adverse position for bank in May and has continued to increase in June to – 32. A detailed review of bank usage had been undertaken with further work to be undertaken to cease bank during July. The month 4 plan had reduced further so challenging position moving forward. GC commented that the Board would be reliant on assurance from executive colleagues and the Committees.

It was **RESOLVED** to

- Receive the report for assurance

25/56 Governance

25/56.1 Annual Report and Accounts

DW presented the Annual Report and Accounts, given as enclosure 14 for assurance. The Board noted that the full report was included in the reading room.

It was **RESOLVED** to

- To note the Annual report in its final basic form ahead of final proof reading and design and the addition of the annual accounts to form one document ready for laying before Parliament and publishing

25/56.2 Trust Strategy 2025 – 2028

AT presented the Trust Strategy 2025 – 2028 Report given as enclosure 15 for approval. The Board noted that the full strategy document was included in the reading room.

The Board thanked IC and communications team for the work to finalise the Strategy document.

It was **RESOLVED** to

- To approve the Trust Strategy document on the understanding that it would be updated following publication of the 10-year health plan

25/56.3 Board Assurance Framework

HB presented the Board Assurance Framework (BAF) given as enclosure 16.

GC commented on the new format and need to ensure Committees use it to move towards target, ensure actions were in place and within trajectory to be achieved.

PF highlighted that there is a governance reputational risk going forward and asked if this had been fully captured. HB trajectory to bring committees together and each committee will be reviewed. Additional risks 5 and 6 capture this.

JH commented that the integration governance needs to be reviewed and required thought.

It was **RESOLVED** to

- Approve the reviewed and reset Board Assurance Framework.

25/56.4 New Joint Board Committee's Report

The Chair presented the New Joint Board Committee's Report given as enclosure 17 for approval.

It was **RESOLVED** to

- Approve the Joint Infrastructure Committee Terms of Reference

25/57 Any other Business

25/58 Date of next Board of Directors Meeting

The next meeting would be held on Thursday 11th September 2025.

25/59 Meeting Close

The Chair declared the meeting closed at 13:45 hr.

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Gary Crowe

Chair Date: at the next meeting

Enclosure 1a

The Dudley Group
NHS Foundation Trust

Action Sheet
Board of Directors Held 10th July 2025
PUBLIC SESSION

Item No	Subject	Action	Responsible	Due Date	Comments
25/52.1	Integrated Committee Upward Assurance Report	Detailed update on corporate service transformation to be presented at the next meeting	JF	~~Sept '25~~ Nov'25	28/8 update JF – will be reported to Board November following October JPC
25/48	Staff and Patient Story – Targeted Lung Health Screening	Patient story video to be made to highlight the programme and encourage take up of the lung screening	LB	August '25	**Complete**. We have permission to use on Trust social media accounts.
25/48	Staff and Patient Story – Targeted Lung Health Screening	investigate reporting pathway of the lung cancer screening programme to ensure there are no delays with reporting of scan results	JO	Sept'25	In progress with update to come to next meeting
25/40.2	Integrated Quality and Operational Performance Report	Explore support from Aston University for cardiac MRI and sleep lab diagnostic facilities	KK	August '25	29/8 Update KK – Director of Ops, MIC exploring options with no activity moved to date

Paper for submission to the Board of Directors on 11 September 2025

Report title:	Public Chief Executive Report
Sponsoring executive / Presenter:	Diane Wake, Group Chief Executive
Report author:	Alison Fisher, Directorate Manager CEO Office

1. Summary of key issues

Assure

Advise

- Community Frailty Intervention Team (C-FIT)
- Operational Performance
- NHS Planning Framework
- NHS Oversight Framework
- Provider Capability
- Q2 Pulse Survey
- Block Contracts
- Get It Right First Time – Urology
- Physician Associates – The Leng Review
- Black Country Provider Collaborative
- Update on University Hospital Status and Proposed Name Changes
- Charity Update
- Healthcare Heroes
- Patient Feedback
- Awards
- Visits and Events

Alert

- British Medical Association Ballot

2. Alignment to our Vision

Patients: Deliver right care, in the right place, at the right time	**X**
People: Be a brilliant place to work and thrive	**X**
Place: Build innovative partnerships to improve the health of our communities	**X**

3. Report journey

Board of Directors

4. Recommendations

The Board is asked to

a) Note and discuss the contents of the report

b) Approve the change of name as follows:

From: The Dudley Group NHS Foundation Trust
To: **Dudley Group University NHS Foundation Trust**
Site name:
From: Russells Hall Hospital
To: **Russells Hall University Hospital**

5. Impact reflected in our Board Assurance Framework (BAF)		
BAF Risk 1.0		Failure to deliver the right care, in the right place every time
BAF Risk 2.0		Failure to ensure Dudley is a brilliant place to work and thrive
BAF Risk 3.0		Failure to build innovative partnerships to improve the health of our communities
BAF Risk 4.0		Failure to remain financially sustainable in 2025/26 and beyond
BAF Risk 5.0		Failure to achieve operational performance requirements & deliver strategic objectives
BAF Risk 6.0		Failure to take sustained action on infrastructures that enables strategic objectives

Community Frailty Intervention Team (C-FIT) update

This year's Community First and Frailty Value Stream Analysis events both identified a community frailty hub (modelled on Hull's Jean Bishop Centre) as a shared priority. During the week of 7th July 2025, Dudley Improvement Practice therefore facilitated a strategic implementation event centred around a preventative approach to community frailty.

Service overview

The event developed a pilot of the Community Frailty Intervention Team (C-FIT), aimed at testing a community-based, holistic and preventative model of care. It will proactively identify patients who would benefit from the completion of a Comprehensive Geriatric Assessment (CGA) and personalised care plan.

Vision: Wouldn't it be great if there was a collaborative approach to frailty, empowering people to live well in their communities for longer. Consistently delivering easily accessible services, built around what matters to the person.

Aim: By 30th April 2026, the Community Frailty Intervention team (C-FIT) will identify, assess, treat and refer on to partners, enabling people to live well with frailty and reduce avoidable frailty hospital attendances and unnecessary GP visits.

The C-FIT multi-disciplinary team is comprised of a long-term conditions nurse, therapist/therapy assistant, pharmacist and social prescriber/care co-ordinator. After each clinic, when CGAs are complete, the team meet to confirm outcomes, agree plans and make referrals, with GP oversight and medication reviews included.

Benefits to **patients**:

- Early identification of frailty risk through CGAs
- Safer medication use by rationalising long lists of prescribed medicines, with deprescription wherever possible
- Reduction in need for GP appointments and hospital attendances

Benefits to the **Trust**:

- Reduced ED attendances by proactively addressing frailty risks
- Reduced unplanned hospital admissions through proactive medication reviews and therapy support
- Better use of staff time as MDT approach reduces duplication across services

Pilot scope and timeline

A pilot for the C-FIT model began on 6th August 2025, with the first of 6 "pop up" clinics at High Oak Surgery. After this time, it will move to St James' Medical Practice for another 6 weeks. Attendance is by invitation only, with targeted patients being identified through EMIS searches at participating practices (initially High Oak and Eve Hill) using agreed criteria: aged over 73, not housebound or in care homes, and taking eight or more medications (excluding dressings). Currently, the service can assess up to 6 patients in each clinic. From January 2025 alone, on average 2136 patients over the age of 73 have attended ED each month. This represents a significant demand on acute services. A preventative service such as C-FIT could redirect a substantial portion of these visits, creating both cost savings and efficiency gains.

Early progress and highlights

The team delivered the pilot service just one month after planning began, working collaboratively and at pace to launch successfully. Early feedback from patients has been positive—they valued the invitation, felt listened to, and had concerns addressed during the visit. The wider C-FIT team meets weekly to review clinic operations and adjust as needed, including refining invitation criteria to target the right patient demographic. In week 3, they added ED attendances within the last year to the selection criteria. Parking spaces at Brierley Hill Health and Social Care Centre have also been secured to improve ease of patient access and improve visit experience.

Next steps

- Transition to Phase 2 at St James' Medical Practice (targeting Eve Hill patient cohort)
- Complete 30-day review of patient outcomes (attendance, CGAs completed, deprescription, referrals made)
- Track ED admissions, hospital attendances and GP attendances for targeted patient cohort
- Continue to review invitation criteria to ensure the patient cohort with the greatest opportunity is identified
- Agree decision point for scaling/expanding the model beyond initial pilot.

Operational Performance

Performance against the 18-week Referral To Treatment standard has shown continued improvement, with 62.9% of patients treated within 18 weeks. This position is 1.4% ahead of trajectory.

Restoration and Recovery

Performance against the 18-week Referal To Treatment (RTT) standard has shown continued improvement, with 62.9% of patients treated within 18 weeks. This position is 1.4% ahead of trajectory.

Participation in the NHSE validation sprint (Sprint 2, commenced 7th July) continues to deliver positive results. The Trust is already 3,800 clock stops ahead of its baseline position, with £33 received per additional clock stop. The sprint has now been extended into September 2025

Ambulance Handover Delays

In July 25, activity saw 10,333 attendances. This has increased when compared to the previous month of June with 9,917. 11 out of the 31 days saw >350 patients, with 1 of those days reaching >400.

3,231 patients arrived by ambulance; this shows an increase from the 2,904 ambulances that attended last month.

469 of these offloads took >1hr (14%). This is a decrease in our performance when compared with last month's performance of 11%.

Over the month, the average length of stay in Emergency Department was 206 mins for non-admitted patients and 409 mins for those waiting for a bed following a decision to admit. This represents a decrease in performance when compared to last month where the length of stay was 196 and 373 mins, respectively.

NHS Planning Framework

Following publication of the spending review in June 2025 and the 10 year Health Plan for England: fit for the future in July 2025, the conditions are in place to support multi-year planning over the medium term. NHS England has published a planning framework setting out the expectations on Integrated Care Boards and provider trusts to produce multi-year plans by the end of December 2025. Working in conjunction with Sandwell & West Birmingham NHS Trust, the Trust has produced a timeline which will deliver the plan within the required timeline. This timeline will require a concentrated effort from staff across the trusts. The Board will need dedicated time to discuss the plan at future development sessions and board meetings.
Detailed planning guidance and financial allocations are expected by the end of September/early October.

NHS Oversight Framework

The new framework describes a consistent and transparent approach to assessing integrated care boards (Integrated Care Boards) and NHS trusts and foundation trusts, ensuring public accountability for performance and providing a foundation for how NHS England works with systems and providers to support improvement.

The 1-year framework sets out how NHS England will assess providers and Integrated Care Boards, alongside a range of agreed metrics, promoting improvement while helping to quickly identify where organisations need support.

The framework is supported by a focused set of national priorities, including those set out in the planning guidance for 2025/26, aiming to strengthen local autonomy. These are presented alongside wider contextual metrics that reflect medium-term goals in areas such as inequalities and outcomes.

Their assessment will be the starting point for how they work with organisations throughout the year and will help them determine how they can support them to improve. They will do this by considering an organisation's segment score, as set out in the framework, and leadership capability.

The framework will be reviewed in 2026/27 to incorporate work to implement the Integrated Care Board operating model and to take account of the ambitions and priorities in the 10 Year Health Plan.

Methodology, latest segmentation and scoring results

The NHS Oversight Framework sets out how NHS trusts and foundation trusts are automatically allocated to a segment (1 to 4) based on performance, with full details set out in the methodology manual. A dashboard and downloadable file with segmentation results, supporting data, and league table comparisons will be published shortly.

The framework sets out how the Recovery Support Programme will be replaced by the Provider Improvement Programme with the most challenged organisations placed into a new segment 5.

Performance improvement

They will use segmentation and our assessment of capability to determine how they will support providers to improve. They plan to finalise their approach to the assessment of provider capability and issue guidance during Q2.

NHS England will align any targeted improvement support offer to organisational delivery scores. Regional teams will coordinate the response to segmentation working with NHS England national teams and wider system partners.

Where performance falls below an acceptable standard and/or has governance concerns that may lead NHS England to step in and use our regulatory powers to secure improvement.

The Trust has been notified of its average metric score, segment and league table position.

The Dudley Group NHS FT		
Average Metric Score	Segment	League table position (*out of 134*)
2.01	**3**	**36**

Provider Capability

The Provider Capability Evidence Dashboard and Self-Assessment Process is an annual requirement by NHS England for all NHS trusts. This process involves evaluating organisational capability across six domains: strategy, leadership and planning; quality of care; people and culture;

access and delivery of services; productivity and value for money; and financial performance and oversight. The Corporate Governance Team will coordinate the process, with executives leading specific domains aligned to their portfolios. They will ensure the evidence presented is accurate and up to date, identifying any areas where assurance is weak or incomplete.

A draft self-assessment will be prepared using the populated dashboard, including proposed confidence ratings and supporting narratives. The Executive Team will review the draft before presenting it to the Boards, ensuring alignment across portfolios and consistency of messaging. The Boards will engage in testing and shaping the final self-assessment during the October Joint Board Development Day, discussing areas of strength and risk. The Executive Team is asked to endorse this approach and provide evidence within the required timeframe, with the Corporate Governance team maintaining oversight and coordinating Board reporting.

Q2 Pulse Survey

We received positive feedback from the Q2 Pulse Survey which was undertaken during July. Not only did we see a significant increase in the response rate for Dudley, from 15% in the Q1 Survey in April to 26% for the Q2 survey; we also saw an improvement in our overall engagement score. This feedback is vital to enabling the Trust to continue to improve the working environment and experience of our staff. I have shared the results with all staff and thanked all for the participation and their commitment. We are now preparing for the 2025 annual staff survey which launches in October and runs through to the end of November.

Block Contracts

There is a national exercise that has commenced to review the current block contracts in order to determine whether Trusts are being under or over paid.

Whilst there is no impact on the current financial year, the outcome of this exercise will be used to shape the financial framework from 2026/27.

The Integrated Care Board are responsible for completing the submission and need to work together with Trusts to populate the NHSE template.

The draft submission is due on 28 August with a final submission required for 24^{t} September. The Trust is working on an updated analysis based on the guidance. This will be submitted to the Integrated Care Board on or before 22 August.

Further updates will be provided to Executive Directors prior to submission, setting out the potential impact on the Trust.

British Medical Association Ballot

The British Medical Association have notified the Trust that they intend to hold a ballot for Industrial Action for all their Foundation Year one members. The ballot papers will be dispatched on 8 September 2025. The British Medical Association state the ballot is in relation to the trade dispute in respect of the lack of an acceptable pay offer for resident doctors in England for the 2025/26 pay round and insufficient provision of training places. For Dudley Group this relates to 43 Foundation Year 1 doctors.

Get It Right First Time Review – Urology

The Get it Right First Time review of the Urology service was completed on 23 July 2025 and overall feedback was very positive. Key strengths and recommendations are outlined below, with a full report to follow.

Key Strengths Identified:

1. Strong teamwork and collaborative working across the service.
2. An integrated service model focused on efficiency and streamlined pathways.
3. Excellent theatre utilisation, currently at 90%.
4. Standardised clinic templates, including the addition of 84 appointments per year, highlighted as a good model.
5. A well-established robotic service with strong external commendation.
6. High PIFU rates, 6.5% demonstrating effective patient management.
7. A data-driven improvement culture, with effective use of GIRFT guidance and benchmarking.
8. GIRFT team praised the high level of engagement from senior leaders and were particularly impressed by the way the entire multidisciplinary team contributed and engaged throughout the visit.

GIRFT Recommendations:

1. Centralise the Upper Tract service at Russells Hall Hospital to streamline care.
2. Reduce time to ureteroscopy and TURBT to improve treatment timeliness.
3. Continue to support the established Robotic Fellowship.
4. Increase use of ESWL (Extracorporeal Shock Wave Lithotripsy) where clinically appropriate.
5. Expand the use of laser surgery for TURBT to enhance outcomes and reduce reoperation rates.

The Urology team should be commended for their ongoing commitment to service improvement and the delivery of high-quality, patient-centred care.

A full GIRFT report, including key metrics and a proposed action plan, will be received and actions agreed.

Following the successful review, the Urology team have been invited to deliver a presentation on Hospital to Home pathway at the upcoming GIRFT Urology Specialty Forum in October 2025. The is wonderful recognition for the team.

Physician Associates – The Leng Review

The Leng Review, an independent review commissioned by the Secretary of State for Health and Social Care to address concerns about the scope and safety of Physician Associates and Anaesthesia Associates in the NHS, was published on 16 July 2025. NHS England has provided a response to the recommendations with 5 immediate actions for the Trust including updated terminology, Primary Care entry requirements, changes to deployment, continued employment, and support for impacted staff. However, a judicial review of the Leng report and its recommendations is currently underway though timescales for completion are not available.

The Trust has and continues to develop a Policy and overarching Trust Wide Scope of Practice for Physician Associates and Anaesthesia Associates to provide a framework for appraisal, GMC registration, educational and clinical supervision, governance, research, and clinical practice. The Physician Associates and Anaesthesia Associates are currently working in line with the supervisory arrangements recommended in the Leng report.

The Trust has previously taken proactive steps to strengthen governance, supervision and support for Physician Associate, and the Board can take assurance that supervisory processes are in place to ensure that the Physician Associates/Anaesthesia Associates work within the supervisory framework recommended in the Leng report.

Black Country Provider Collaborative

The following are the key messages from the 4 August 2025 Black Country Provider Collaborative Executive meeting.

A. General

- **Updates from the Black Country Integrated Care Board –** Black Country Integrated Care Board is focused on transition arrangements to the new Integrated Care Board Clusters, with programmes of work identified for progression shortly. Announcements on Chair and Chief Executive Officer appointments are due in late August / early September with subsequent leadership roles to follow.
- **Updates from NHS West Midlands –** publication timeline for "shared leadership governance" together with that for "Wholly Owned Subsidiaries" (WOS) are still not known. Foundation Trust Assurance Framework is being re-invigorated, and it is anticipated that existing Foundation Trusts will also need to go through any new processes. Guidance on the "Model Region" is to be published soon, with the 26/27 National Oversight Framework (NOF) being guidance in development.
- **Black Country Provider Collaborative Managing Directors Quarterly Progress Report** - Robust report presented which highlighted:
  - The three programmes continue to make positive progress in delivering against priorities
  - Overall performance is RAG rated as Amber, reflecting minor areas where performance is marginally behind trajectory
  - Black Country Provider Collaborative budget is in a positive position, currently underspending against profile trajectory
  - Governance has been strengthened with clear objectives for each system lead and a more frequent operational meeting of the programme Senior Responsible Officer's
  - Key messages from the Joint Provider Committee were shared
  - Black Country Provider Collaborative were alerted to a range of forthcoming Collaborative activities.

B. Improvement

- The Collaborative Executive were provided a brief update on the following key items:
  - **Clinical Improvement programme** – The Black Country Provider Collaborative Managing Director presented a summary report highlighting the key progress reported at the recent monthly Clinical Network meetings. Positive strides continue to be made with a more detailed timeline of actions to be presented in the Black Country Provider Collaborative Managing Directors quarterly highlight report next month.
  - **Clinical Service Transformation** – The Black Country Provider Collaborative received relevant progress updates on priorities which included:
    - **BC Elective Hub** – Black Country Provider Collaborative Executive received confirmation that the formal business case had been submitted on the 31st July 2025 and now await formal feedback on approval. Informal meeting with NHSE colleagues held to assure of intent and progress. Phase 1 transition well underway, with plans for Phase 2 being mobilised soon.
    - **Breast DIEP Reconstruction** – Final draft of the Business Case received and approved by the Black Country Provider Collaborative Executive. Positive feedback received and good engagement with key forums and stakeholders (e.g. Integrated Care Board, Elective Care Board, Cancer Care Board)
    - **Vascular services** – Work underway by Task and Finish group, with baseline data being sourced for review and further dialogue on preferred model, with a Service Plan due in the Autumn for consideration and approval.
    - **System Transformation** – Breast Unit engagement workshop scheduled for October with consistent baseline positions of each partner Trust being sourced and presented as part of the socialisation and engagement activities.

      The Pharmacy Aseptic feasibility study continues to be drafted with the output report due in early autumn outlining possible options for next steps.

Formal output reports from a Colorectal / Robotically Assisted Surgery workshop and a separate Gynae-Oncology workshop were received by the Collaborative Executive, highlighting positive engagement and focused priorities to be progressed.

C. Transformation

- **Corporate Service Transformation (CST) –** The Black Country Provider Collaborative Senior Responsible Officer and Programme Lead provided an update on progress highlighting an urgent review of focus to be undertaken imminently and a realigned programme to be agreed.

  It was confirmed that partner Trusts are continuing to focus on the "corporate cost reduction target" established by NHSE as part of integrated Cost Improvement Plans, monitoring progress against trajectory through internal governance arrangements.

  The programme team continue to drive forward work to establish a solution on consolidating both "Collaborative Bank" and the recruitment functions, with expressions of interest being sought from the market.

D. Strategic & Enabling Priorities

- **Medical Bank Rate Harmonisation –** The task group led by the Black Country Provider Collaborative Chief Medical Officer presented their output report following extensive engagement, and baseline reviews from across the country. The proposed position was well received, with some further minor work required to avoid any perverse incentives especially in relation to "Waiting list Initiatives".
- **Communications - Public Involvement Exercise** – The public involvement exercise commissioned from STAND is nearing completion. Early indications are that the engagement has been positive, with responses now being analysed and an output report highlighting key issues to be addressed due for presentation in early September. This report will be utilised within any Business cases relating to Clinical Service Transformation areas being progressed.

Update on University Hospital Status and Proposed Name Changes

The Trust has recently been granted University Hospital status in recognition of our commitment to education, training, research, and clinical excellence. Aston University supports the university hospital status, and this partnership aims to drive innovation in clinical education, research, and patient care by combining academic expertise and clinical practice and sharing knowledge.

To mark this new status, we have been exploring a name change for our organisation.

The naming of NHS organisations, services and partnerships is a crucial part of the NHS Identity. It is important that names are clear, logical and understandable so that patients and the public can identify and locate the different organisations, services and partnerships which make up the NHS. There are NHS identity guidelines which must be followed and a process which includes stakeholder engagement in the new name. The full guidance can be found here

NHS Identity Guidelines | Naming principles

The following legislation relates to the naming of NHS Foundation Trusts:
Schedule 7 of the National Health Service Act 2006 says 'if the corporation is an NHS Foundation Trust, its name must include the words 'NHS Foundation Trust'. View Schedule 7 legislation.

In summary the name must adhere to the following principles:

- be clear, logical and descriptive
- be written out in full, without the use of acronyms, abbreviations or symbols such as '&' – except St for 'Saint' and NHS for 'National Health Service'
- include the letters 'NHS' within the written version of the name
- contain a geographic reference, unless it is a national NHS organisation, service or partnership (e.g. NHS Blood and Transplant)

- if it is an NHS partnership, the name should end with, or contain a term that shows that this is a partnership and not an organisation (e.g. Partnership, Alliance, Collaborative)
- if it is an NHS service, start with a geographic reference, then a descriptor for the service (e.g. Mental Health) and typically end with the word 'Service', unless it is a national service (e.g. NHS 111)
- the position of the word 'University' in an NHS organisation's name should be carefully considered. 'University' should be placed at the start of the name or within it. When it is placed at the end of the name, the prominence of the word could give the impression of the title of a university rather than an NHS Foundation Trust or NHS Trust.

Following feedback from the Trust's governors and staff members, and in line with NHS naming principles, we are proposing to update both our organisational name and one of our site names to the following:

1. **Organisational name:**
   From: *The Dudley Group NHS Foundation Trust*
   To: ***Dudley Group University NHS Foundation Trust***

2. **Site name:**
   From: *Russells Hall Hospital*
   To: ***Russells Hall University Hospital***

Our aim is to ensure the new names clearly convey our new university hospital status, while remaining easily recognisable to patients, staff, and partners.

During June – August 2025 we have undertaken the following stakeholder engagement to ensure people feel involved in this important decision and have the opportunity to share any options or views.

- **Staff engagement:** We started with asking staff for opinions on four possible name versions via In the Know and the Hub with a dedicated Microsoft Form poll. In addition, one-to-one discussions have been held to capture further ideas and feedback. Staff came back with the idea to include the university status in the Russells Hall site name as well as the Trust name.

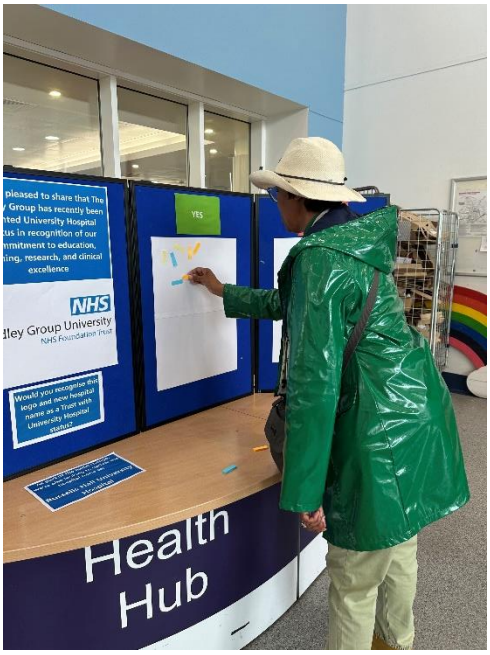
- **Collaboration:** Worked closely with Dr Gail Parsons, Julian Hobbs, and Aston University to announce the achievement of University Hospital Status. The press release we issued highlighted the strengthened partnership with Aston University and the positive impact this will have for patients through enhanced research, education, and innovation in healthcare.

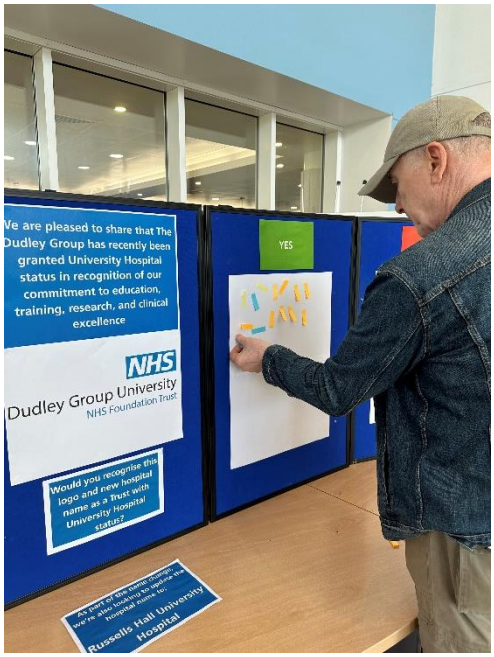
- **Executive input:** Worked with executive colleagues to agree on the proposed names – *Dudley Group University NHS Foundation Trust* and *Russells Hall University Hospital*.

- **Regulatory assurance:** Liaised with the Midlands NHS England team to confirm there are no conflicts with other Trusts or services.

- **Stakeholder consultation:** Wrote to local stakeholders to ensure the proposed names will not conflict with, or be confused with, existing or planned services in neighbouring NHS organisations.

- **Public and staff feedback on branding:** A mocked-up version of the new logo was displayed in the main reception at Russells Hall Hospital. Members of the public were encouraged to share their views, of those who expressed a view there was significant support for the new name with University Hospital Status. Staff were also invited to provide feedback.





- **Implementation planning:** Initial costings are being gathered for updating signage across the hospital, outpatient centres, and community settings and if approved it would be phased into the Trust literature and signage to minimise cost.
- **Next steps:**
    - Secure approval for the name change from the Board of Directors at the meeting on 11th September, Council of Governors at the meeting 18th September 2025 and then onwards to the Annual Members Meeting for constitutional change approval on the 16th October 2025.
    - Broaden public engagement via social media, sharing photos and outcomes from recent consultation activities and explaining the rationale for the name change.
    - Notify stakeholders and commence external communications, including media engagement and staff education on the use of the new names.
    - Begin phased replacement of signage and updates to internal documents.

Charity Update

NHS Big Tea

In July, wards and departments came together to host their own NHS Big Tea to celebrate the NHS's 77th birthday and raise funds for their own areas or the Dudley Group NHS Charity.

Every tea party looked amazing with colourful decorations and delicious treats. Patients and staff had a wonderful time celebrating the NHS, whilst enjoying an amazing array of cakes and treats.

So far over £2,200 has been raised and still counting, we are thankful for everyone's enthusiasm and generosity, the department who has raised the most funds will receive a big tea hamper so watch this space! There is still time to host your tea party, if you like to find out more, please visit - http://thehub/charity/SitePages/NHS%20Big%20Tea%202025.aspx.

Find out what staff at DGFT choose for their favourite hot drinks and biscuits! Click here to watch the video and comment on your favourites:
www.facebook.com/DudleyGroupNHSCharity

Charity Barn Dance

What a fantastic night we had at our Charity Barn Dance, raising funds for our Breast Imaging Department!

From the moment the music started, the barn was alive with laughter, energy and incredible community spirit. With hay bales, checked shirts and line dancing galore, the evening brought people together for a good old-fashioned knees-up – all for a great cause. Thank you to lively entertainment from Duo Banjacs and Billy the Busker.

Most importantly, we raised vital funds to support and enhance the work of our Breast Imaging Department, raising over an amazing £1,000.

A huge thank you to everyone who came along, donated, danced and made the evening such a success

Brave family purchases cold cots for the baby bereavement unit
A brave family, who lost their unborn son at 32 weeks, fundraised an incredible £5,000 for our baby bereavement appeal.

When parents, Tegan Turner and Kieran Maritza, attended a hospital appointment for a check-up, they were sadly informed their baby had no heartbeat and had passed away.

The family decided to organise raffles, charity car washes, a sponsored walk and a charity evening, plus a sponsored inflatable fun run. They were overwhelmed with the support from the public and managed to raise enough funds to purchase two cold cots, which allows
families to spend precious time, take photo to cherish, hold and cuddle him and make those lasting memories Whilst the family were absolutely devastated and utterly broken by their own loss, they decided to support others. The family organised raffles, charity car washes, a sponsored walk and a charity evening, plus a sponsored inflatable fun run. They were overwhelmed with the support from the public and managed to raise enough funds to purchase two cold cots, which allows families to spend precious time, take photo to cherish, hold and cuddle their baby and make those lasting memories together.

The cots have a plaque on them honouring Albie-Jo's memory. Albie-Jo will now live on in a beautiful way, knowing that his cold cots will help other families in the same way as they did for Tegan and Kieran.

Glitter Ball
The Dudley Group NHS Charity's flagship Glitter Ball event is back for its fifth year.

The business gala dinner brings together local businesses for an evening of networking and fundraising. This year's Glitter Ball will be taking place on 25th September at the Copthorne Hotel in Brierley Hill, Dudley.

Halesowen College is the platinum sponsor for the event, Dudley College of Technology is the gold sponsor alongside Summit Healthcare and How to Find a Care Home as silver sponsors and Trustmarque as the drinks sponsor.

Other local businesses attending the evening with table packages include Jackwolf Group, Lawrence Cleaning and Waldrons.

This year's event will be raising vital funds for the charity's cancer appeal to support patients and their loved ones affected by cancer, all funds raised will support alternative therapies such as massage, acupuncture and reflexology. We will be having a live JustGiving page shown throughout the evening.

If anyone would like to support the charity's appeal please scan the QR code or click on the link www.justgiving.com/campaign/glitterballcancerappeal.

Aati's Birthday Appeal
This year, our beloved mascot Aati turns ONE on the 30th of September! Over the past year, he has brought smiles, energy, and joy to countless events while helping raise awareness and support for the Dudley Group NHS Charity.

Instead of presents or cake, we're asking you to help us celebrate in the best way possible, by giving the gift of support to the charity. Every donation made in honour of Aati's birthday will go directly towards funding our vital work.

The charity team will also be fundraising on the charity hub in the main reception and Aati will be visiting our paediatric areas across the Trust.

Every donation, big or small, helps us do more. Let's make Aati's first birthday one to remember — together we can turn small birthday gifts into a big impact!

Donate scanning the QR code or clicking on this link:
https://www.justgiving.com/campaign/aatisappeal?utm_medium=CA&utm_source=CL

Healthcare Heroes

Frankii Hart
Frankii was nominated for all the time, effort and dedication she poured into organising this year's staff Committed to Excellence awards. She managed over 800 award nominations and 350 of our amazing staff being celebrated on the night.
The awards were highly successful and Frankii was absolutely pivotal in making it happen

Lydia Price
Lydia was nominated by a colleague for the invaluable support she provides to dementia patients but also their family, friends and loved ones as an Admiral Nurse; recognising dementia impacts everyone involved and not just the individual with the disease. She was described as kind, gentle, caring to everyone she interacts with and a friendly face to talk to at any time if people need a chat or have questions about dementia.

Community Response Team

They were nominated by a colleague for being a key source of support and advice all while covering a large area of the Dudley borough, saying 'we are very lucky to have such a valuable service, and I do not know how we would manage without it.' They were also commended for being professional, honest and thorough in their approach to a review for a palliative care patient that had deteriorated.

Patient Feedback

Pulmonary Rehabilitation Team - The environment was excellent and the exercises during the course I believe improved my fitness.

The Sunday Clinic - Staff very helpful, cheerful, professional and explained everything about my wound.

Minor Procedures Room - Everyone was very kind and respectful. The surgery was painless, and I am very pleased with the results.

Dudley Rehabilitation Service - Helped me to improve my balance, mobility and strength. Staff were friendly, helpful and supportive.

Endoscopy Unit - Whole experience from start to finish was well explained and I felt very comfortable and safe. Nurse looking after me kept me informed.

C8 - My dad was looked after very well. Staff very professional and treated everyone with kindness

B5 – The staff taking care of me have all treated me with me so much dignity. I was made aware of all steps, in a clean room and everyone has been so kind and friendly. A big thank you to everyone involved in my care.

A&E - It was very good how well I was looked after; there wasn't anything that could have made it better. I was treated excellent for the whole time I was there; I was so very Grateful for all they did for me. Can you tell them that I said Thank you so much for looking after me. I am so grateful.

Gynaecology - The staff were kind and considerate, they made me feel very comfortable during an uncomfortable procedure. They were professional and thorough. Honestly, they were perfection.

Awards

HSJ Awards Success

Congratulations to two of our fantastic teams who have been shortlisted for the prestigious national Health Service Journal Awards 2025.

Firstly, our head and neck cancer team One Stop Throat / Virtual Neck Lump Clinic for the suspected head and neck cancer has been nominated. The clinic improves the referral and diagnostic pathway for the suspected head and neck cancer by: utilising risk assessment via telephone questionnaire; direct-to-test ultrasound scheme for neck lumps; parallel diagnostic investigations taking place simultaneously; tissue sampling(biopsy) of the throat under local anaesthesia in the outpatient clinic using flexible endoscopy. The time between referral and definitive decision for cancer treatment has been reduced by 35% to 34 days.

In addition, our one stop respiratory clinic, led by Nazir Hussain, specialist respiratory pharmacist, has also been nominated for two HSJ safety awards. The one stop respiratory clinic helps to improve diagnosis and treatment for patients with lung conditions such as asthma or chronic obstructive pulmonary disease (COPD) within the community.

Placing patients at the centre of the care, the clinic focuses on prevention by proactively identifying those at higher risk of needing hospital treatment in the future. This is achieved by analysing how often patients have required care and what treatments they've received. This not only allows for personalised care but also helps tackle health inequalities in underserved communities. This initiative has been shortlisted for Primary Care Initiative of the year 2025 and Early – Stage Patient Safety Innovation of the Year 2025. The winners will be announced at Manchester Central on September 15th, 2025. This initiative has also been shortlisted for a HSJ awards in London.

We wish both teams the best of luck with their nominations.

TIDE Award

The Trust has maintained its gold TIDE award this year. The award recognises the Trust's commitment to inclusion.

Visits and Events

1 July	Executive Directors Sandwell & West Birmingham NHST Development Day
2 July	Black Country Regional Performance Tier Call
2 July	NHS Chief Executive 10 Year Health Plan webinar
4 July	Birmingham & Solihull Chief Executive's Development Session
4 July	Sandwell & West Birmingham NHST Long Service Staff Awards
9 July	Sandwell and West Birmingham Public and Private Board of Directors
10 July	Dudley Group NHSFT Public and Private Board of Directors
11 July	Birmingham & Solihull Chief Executive Officers
11 July	Dudley Group NHSFT Committed to Excellence Staff Awards
14 July	Black Country Provider Collaborative Senior Responsible Officers
15 July	Executive Directors Dudley Group NHSFT Development Day
16 July	Sandwell & West Birmingham NHST Long Service Staff Awards
16 July	Black Country Regional Performance Tier Call
17 July	Joint Dudley Group/Sandwell & West Birmingham Board Workshop
21 July	Black Country Integrated Care System Cancer Board
23 July	NHSE Midlands Regional Director Monthly Update Briefing
23 July	Black Country ICB Oversight & Assurance Sandwell & West Birmingham NHST
23 July	Further Faster 20 Senior Responsible Officers Group
24 July	Black Country ICB Oversight & Assurance Dudley Group NHSFT
24 July	Freedom to Speak Up Steering Group Dudley Group NHSFT
25 July	Joint Provider Committee
28 July	Black Country Provider Collaborative Senior Responsible Officers
28 July	Freedom to Speak Up Steering Group Sandwell & West Birmingham NHST
28 July	Midlands Endoscopy Board
30 July	Sandwell Together Partnership
30 July	Black Country Elective and Diagnostic Strategic Board
31 July	Finance and Productivity Committee
31 July	Finance and Productivity Committee Dudley Group NHSFT
31 July	Black Country Integrated Care Public and Private Board
1 August	Finance and Performance Committee Sandwell and West Birmingham NHST
4 August	Black Country Provider Collaborative Executive
4 August	Black Country ICS Chief Executive and Chief Finance Officers
7 August	Staff Meet & Greet Midland Met University Hospital
8 August	Birmingham & Solihull Chief Executive Officers
8 August	Sonia Kumar MP catch up meeting
11 August	Black Country Provider Collaborative Senior Responsible Officers
11 August	Staff Meet & Greet Sandwell General Hospital
12 August	Dudley Group & Sandwell & West Birmingham Joint Executive Development
13 August	Birmingham Cabinet Visit & Tour Midlands Met University Hospital
13 August	Black Country ICB Regional Performance Tie Call
14 August	Staff Meet and Greet Russells Hall Hospital
15 August	Birmingham & Solihull Financial Recovery
18 August	Black Country Integrated Care System Cancer Board
18 August	Further Faster 20 Senior Responsible Officers Group
27 August	Quality Committee Sandwell & West Birmingham NHST
27 August	Black Country Regional Performance Tier Call
28 August	Finance and Productivity Committee Dudley Group NHSFT
28 August	Finance and Productivity Committee Sandwell & West Birmingham NHST

Paper for submission to the Board of Directors 11th September 2025

Report title:	Public questions
Sponsoring executive / Presenter:	Sir David Nicholson, Chairman
Report author:	Helen Board, Board Secretary

1. Summary of key issues

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

In the current year, the Board of Directors (public session) has moved to holding its meetings in a face-to-face format. The agenda and meeting papers were circulated to the members of the Council of Governors. Additionally, a link to the Trust website and information providing the location of the meeting; agenda and papers has been provided to our local MPs and foundation trust members.

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

Questions received:

Nandi Shalembe, Foundation Trust Member
Q. At the last meeting held, we spoke about lung cancer, and how to publicise it so people can start to get themselves checked. Yes we spoke of “hubs”. Just to ask if we you have considered billboards especially in places were we know is rush hour time, where people are on they home from work stuck in traffic and board so they start gazing, E.G places like merry hill etc, bus stops or stations

A. **Billboards and Other Out-of-Home Advertising**
Thank you for your question. Placing high-impact ads in locations such as Merry Hill, bus stops, and commuter routes can certainly *boost awareness* and benefit from strong recall - especially in high-footfall areas. For example, highway billboards often achieve recall rates of up to 60%. However, when it comes to *actual engagement or conversion of awareness into action*, the numbers tell a different story. Across the industry, the typical engagement rate for outdoor advertising sits between 3% and 6%. So, in summary these channels are important but might not reach a specific audience and can have a high cost per interaction as a result.

Q. At the last board meeting the chief nurse had mentioned that having an input from members of the public due to they experiences in maternity would be beneficial. I’d like to make her aware of a lady named Joanne Bussey. She is Parent and Family engagement lead for West Midlands perinatal network (neonatal critical care clinical network who is very happy to assist in any manner. If you think this is a good idea I’ll pass over her details, as I have had a word with her and she’s more than happy to interact.

A. Thank you for your suggestion to put us in touch with Joanne Bussey. Providing Joanne is a Parent and Family Engagement Lead for the West Midlands Perinatal Network, it is likely she is already engaging with our teams, but Claire MacDiarmid (Director of Midwifery) or Katie Philpott (Head of Midwifery) would be happy to be contacted to discuss the offer further and engage with Joanne.

Q. Hawnes Lane Surgery doesn't seem to be operating at the moment, and everyone is using Feldon Lane Practice. Appointment booking to see a GP is between the hours of 8am-11am via phone books, as a Halesowen resident the phone is busy at 8am by the time you get threw, may that be 9;15 there no slots left and you told to ring again the following morning. Yes you can book online, but there is a 4weeks waiting period as there is a back log. What can you do to improve this? Also repeat prescription method has changed now you can't call over the phone, bearing in mind there's vuneral people the old and those that might be on opioids How do we tackle this seeing HAWNES LANE doesn't seem to be active.

A. Dr Mandiratta, GP partner at Feldon Lane Practice that also operates Hawnes Lane has confirmed that the Hawnes Lane is fully operational and with Nandi's agreement has asked the practice manager to liaise with her directly to resolve the queries raised.

2. Alignment to our Vision	
Patients: Deliver right care, in the right place, at the right time	**X**
People: Be a brilliant place to work and thrive	**X**
Place: Build innovative partnerships to improve the health of our communities	**X**

3. Report journey
Board of Directors September 2025

4. Recommendations
The Finance & Productivity Committee is asked to:
a) **Note** the questions received and response provided

5. Impact reflected in our Board Assurance Framework (BAF)		
BAF Risk 1.0	x	Failure to deliver the right care, in the right place every time
BAF Risk 2.0	X	Failure to ensure Dudley is a brilliant place to work and thrive
BAF Risk 3.0	X	Failure to build innovative partnerships to improve the health of our communities
BAF Risk 4.0	X	Failure to remain financially sustainable in 2025/26 and beyond
BAF Risk 5.0	X	Failure to achieve operational performance requirements & deliver strategic objectives
BAF Risk 6.0	X	Failure to take sustained action on infrastructures that enables strategic objectives
Is Quality Impact Assessment required if so, add date: n/a		
Is Equality Impact Assessment required if so, add date: n/a		

Paper for submission to the Board of Directors 11th September 2025

Report title:	Integrated Committee Upward Assurance Report
Sponsoring executive / Presenter:	Gary Crowe, Deputy Chair
Report author:	Gary Crowe, Deputy Chair Helen Board, Board Secretary

1. Summary of key issues

This paper outlines the key points of assurance, escalation, work commissioned following the Board Committee meetings held in July & August 2025. The committee chairs quadrant upward reports from Finance & Productivity, Quality, People, Integration and Joint Infrastructure Committees, are contained within the further reading pack. The revised agenda mapping and support for BAF development was approved for the new Infrastructure Committee with further update to come to committees when finalised.

Assure

All committee meetings held during the reporting period were quorate and demonstrated robust oversight across their respective domains. The following positive assurances are provided for Board consideration:

Finance & Productivity Committee

- Continued strong operational performance, particularly in elective pathways and cancer targets.
- Good progress on the Emergency Department redesign project.
- Improved Emergency Preparedness, Resilience, and Response (EPRR) compliance, moving from partial to full assurance.
- Procurement performance exceeded savings targets and benchmarked in the top national quartile.

Quality Committee

The Committee received wide-ranging assurance across patient safety, clinical effectiveness, and workforce standards:

- Patient Experience & Safety:
  - Reduction in complaints backlog following implementation of the responsiveness improvement plan. Decrease in Trust-acquired pressure ulcers, indicating improved preventative care. Significant improvements in diabetes care and insulin safety, with reduced incident rates.
- Training & Workforce Compliance:
  - Safeguarding Level 3 mandatory training compliance increased to 84% (from 70%).
  - Developing Workforce Safeguards compliance: 9 of 12 DGFT safe care standards fully met; 3 partially met.
  - Positive findings from the Clinical Nurse Specialist review, confirming appropriate capacity and skill mix.
- Infection Control:
  - Reduction in hospital-onset CDI and BSI cases in Q1 2025/26, below national thresholds.
- Emergency & Paediatric Care:
  - Weekly assurance reports confirm consistent performance in care of acutely unwell children in ED.
- Quality Oversight in Financial Planning:
  - Quality Impact Assessments (QIAs) are being effectively applied within the Cost Improvement Programme.
- Maternity Services:
  - UNICEF Baby Friendly Initiative reassessment yielded very positive feedback; Trust accreditation maintained.

- Safer Staffing:
    - Assurance received from the latest nursing staffing review, with approved uplifts for wards C3 and C1a/b, subject to funding.

People Committee

- Workforce KPIs show positive trends: vacancy rate reduced from 10% to 9%, improved retention, and high compliance with mandatory training (93.6%) and appraisals (92%).
- Deep dive into the Surgery, Women's & Children's division highlighted progress on staff survey actions, sickness absence, and training.
- Band 2/3 back pay is on track for payment in September 2025.
- ESR alignment between DGFT and SWBH progressing well, supporting best practice standardisation.

Integration Committee

- Strong engagement and early positive impact from Community Frailty Intervention teams and Care Home pilots.
- Community Services update aligned with the 10-year plan; CNC improvements include extended phoneline hours (6am–10pm), electronic referrals, and dedicated WMAS line.
- Six-month Health Inequalities update showed progress through equity-focused service planning, strengthened governance, and enhanced education and training.

Advise

Finance & Productivity Committee

- Continued scrutiny of the Black Country Pathology Service, with noted minor improvement.
- Winter Plan and Length of Stay actions to remain standing items, focusing on bed base reduction and improved patient flow.
- A deep dive report on screening programmes has been requested.

Quality Committee

- Midwifery Workforce: 14.0 WTE vacancies filled by newly qualified midwives starting in Sept/Oct 2025; bank staff used to mitigate. 9.0 WTE Midwifery Support Worker vacancies also recruited.
- IPC Oversight: Monthly meetings and deep dives underway to review cleaning provision across the Trust.
- Discharge Improvement: Discharge Lounge reinstated; REACCT and Care Transfer Hub models launched. CCTD and HITWAFE workstreams improved compliance with Estimated Discharge Dates to 85%.
- Digital Bed Management: System now live and fully integrated, enhancing real-time bed visibility and operational flow.
- Chest Pain Pathway: Deferred paper now received via RAG Highlight Report with assurance and next steps outlined.
- Digital Collaboration: Ongoing work across ICB and providers to explore joint contracts for Patient Administration System and Electronic Staff Record.

People Committee

- Sickness Absence: Increased to 5.68% in July, driven by long-term sickness. Mitigation includes occupational health access, return-to-work interviews, and targeted departmental support. Winter pressures may impact sustainability.
- Medical Bank Pay Rates: Proposed changes may prompt collective action; all Trusts advised to conduct risk assessments and align system-wide approach.

Integration Committee

- Performance Reporting: End-of-year report on High Oak and Chapel Street to be received. Future communications to include areas for improvement and feedback.
- Primary Care Development: Escalation to ICB regarding decision not to offer Dudley Quality Outcomes Framework in 2026/27 and delay in risk stratification tool development.
- Meeting Cancellation: August 27th meeting stood down due to high number of apologies.

Joint Infrastructure Committee

- Infrastructure Project Authority (IPA) Gateway 5 Review: Graded 'green' with commendation from the Review Team.

- Joint Workshop: Held 18 July; early progress on 2025/26 priorities, long-term ambitions, and shared best practice.
- Digital & Estates Planning: 3-year Digital Plan well progressed; to be merged with Estates Plan into a unified Infrastructure Plan.

Alert

Three key themes to alert the Board to: -

1. Operational performance concerns on ED triage and ambulance handovers contributing to delays in flow, use of Temporary Escalation Areas and poor patient experience.
2. Financial pressures on delivering the workforce plan, cost improvement plan and financial risk in the Winter Plan.
3. Quality concerns focus on compliance to Quality and Safety standards and practice.

Finance & Productivity Committee

- The Winter Plan presented a financial risk to achieving this year's budget.
- The lack of a fracture liaison service in the Dudley Borough (funding).
- The Trust faces a shortfall of £17.3m of Cost Improvement Programmes, noting the ongoing work to mitigate this.

Quality Committee

- Fragility of the Mental Health Act Administration Service contracted from Walsall Healthcare NHST.
- Current inability to fully meet the MIS Year 7 - Maternity and Neonatal Voices Partnership (MNVP) safety action due to a lack of national funding. Mitigations in place will support compliance but requires a longer-term solution.
- Increase in incidents to open Temporary Escalation Areas (TES) areas due to continued flow and challenge for ambulance offload requirements.
- Work ongoing to improve current low compliance with (i) second assessment for VTE to link with discharge planning, (ii) downward trend for sepsis compliance in ED and (iii) Vital Signs Q1 compliance at 60% (although improved).
- Stillbirth rate increased to 3.48 per 1,000 births in July. A Deep Dive is underway, with interim solutions in place to monitor impact and outcomes.
- Increase in complaints, with no themes or trends. Divisional review ongoing to explore how early intervention can prevent complaints and early resolution.

People Committee

- workforce plan is negative variance of 60 WTE, with bank usage over plan by 84 WTE (industrial action has contributed to a medical bank increase).

2. Alignment to our Vision

Patients: Deliver right care, in the right place, at the right time	**X**
People: Be a brilliant place to work and thrive	**X**
Place: Build innovative partnerships to improve the health of our communities	**X**

3. Report journey

Board of Directors September 2025 and committees held July & August 2025

4. Recommendations

The Public Trust Board is asked to:

a) **Note** the assurances provided, the matters for escalation and the decisions made

5. Impact reflected in our Board Assurance Framework (BAF)

BAF Risk 1.0	x	Failure to deliver the right care, in the right place every time
BAF Risk 2.0	X	Failure to ensure Dudley is a brilliant place to work and thrive
BAF Risk 3.0	X	Failure to build innovative partnerships to improve the health of our communities
BAF Risk 4.0	X	Failure to remain financially sustainable in 2025/26 and beyond
BAF Risk 5.0	X	Failure to achieve operational performance requirements & deliver strategic objectives
BAF Risk 6.0	X	Failure to take sustained action on infrastructures that enables strategic objectives
Is Quality Impact Assessment required if so, add date: n/a		
Is Equality Impact Assessment required if so, add date: n/a		

Paper for submission to the Board of Directors on 11th September 2025

Report title:	Month 4 Financial Position
Sponsoring executive / Presenter:	Chris Walker – Director of Finance
Report author:	Chris Walker – Director of Finance

1. Summary of key issues

Assure

1. The Board is asked to note the Month 4 (July 2025) Trust financial position. After technical changes the **July cumulative position is a £5.622m deficit.** This position is £0.160m better than the financial plan submitted to NHS England in March.

2. The Trust is forecasting that we will achieve our 2025/26 financial year planned break even position after technical adjustments but there is associated risk to deliver that the Trust is actively mitigating.

3. The Trust is forecasting a healthy cash balance for the 2025/26 financial year.

4. The Board is asked to note the Black Country Integrated Care System July 2025 financial position and year end plan of breakeven. The July position is £0.045m better than the financial plan submitted to NHS England in March. The System has received the first two quarters deficit funding from NHS England.

Advise

1. The Trust's financial forecast for the 2025/26 financial year remains in line with the plan at a breakeven position. The Trust continues to review the financial risk to achieve the plan which stands at £30.476m. The Trust needs to have a fully mitigated plan for the risk by the end of September.

2. Pay expenditure to the end of July was overspent against plan for the first time this financial year with an overspend of £0.028m. Additional costs were incurred in July relating to medical cover for the resident doctor's industrial action. The Trust needs to ensure it reduces both bank and agency expenditure for the remainder of the financial year.

Alert

1. Agency expenditure usage continues to see an increase against plan and is above the target by 13 whole time equivalents resulting in a cumulative overspend of £0.434m at the end of July. 99% of agency expenditure relates to consultants and career grade doctors.

2. Non-pay expenditure was above plan at the end of July by £2.209m. This is related to cost improvement savings shortfall and increased drug and devices expenditure.

3. Currently there is £14.316m of the cost improvement programme still classed as opportunities with no plans in place to deliver this amount. The Trust needs to have mitigation plans in place by the end of September to deliver the full cost improvement plan.

2. Alignment to our Vision	
Patients: Deliver right care, in the right place, at the right time	**X**
People: Be a brilliant place to work and thrive	**X**
Place: Build innovative partnerships to improve the health of our communities	**X**

3. Report journey
Month 4 (July 2025) detailed finance report presented to the Finance and Productivity Committee on the 28th August 2025. Summary Month 4 financial report presented to Executive Directors on 12th August 2025.

4. Recommendation(s)
The Public Trust Board is asked to:
a) Note the financial performance for the month of July 2025.
b) Note the reported Trust and System 2025/26 financial year end position and associated risks.

5. Impact reflected in our Board Assurance Framework (BAF)		
BAF Risk 1.0	X	Failure to deliver the right care, in the right place every time
BAF Risk 2.0	X	Failure to ensure Dudley is a brilliant place to work and thrive
BAF Risk 3.0	X	Failure to build innovative partnerships to improve the health of our communities
BAF Risk 4.0	X	Failure to remain financially sustainable in 2025/26 and beyond
BAF Risk 5.0	X	Failure to achieve operational performance requirements & deliver strategic objectives
BAF Risk 6.0	X	Failure to take sustained action on infrastructures that enables strategic objectives
Is Quality Impact Assessment required if so, add date:		
Is Equality Impact Assessment required if so, add date:		

REPORTS FOR ASSURANCE AND DECISION

FINANCE REPORT

REPORT TO PUBLIC BOARD OF DIRECTORS ON 11 SEPTEMBER 2025

1. EXECUTIVE SUMMARY

1.1 After technical changes the **July cumulative position is a £5.622m deficit.** This position is £0.160m better than the financial plan submitted to NHS England in March.

1.2 The cumulative actual position in July compared to plan shows the Trust being marginally better than plan. Positive variances in income offset expenditure variances linked to non-delivery of the cost improvement programme and activity related costs for drug and devices. Pay costs have now started to overspend for the first time this year with non-recurrent pay savings helping the position in the first four months but offset by agency being above plan.

1.3 Income is £2.191m better than plan. This relates to increases in pass-through drug/devices income with NHS England and Elective Recovery Fund overperformance with Black Country ICB. The Trust has also benefited in month 4 from the cumulative impact of the higher contract values with non-Black Country ICB's that have now been agreed. In summary, taking aside pass through income the Trust has benefitted in month 4 by the year to date catch up with the now agreed healthcare contracts and other income agreements.

1.4 Pay expenditure to the end of July was overspent against plan for the first time this financial year with an overspend of £0.028m. Substantive whole time equivalents increased by 5 whole time equivalents from the previous month but the main reason for the overspend relates to higher bank and agency costs with the main increase relating to medical staff. The medical staff increase relates to the industrial action cover during the resident doctor's strike, but the Trust remains behind plan for both bank and agency in terms of whole-time equivalents.

1.5 Non-pay expenditure was above plan at the end of July by £2.209m. This is related to cost improvement savings shortfall and increased drug and devices expenditure.

1.6 The phased Cost Improvement Programme plan to July equated to £5.991m. Achievement to July totals £6.171m, which is higher than plan by £0.180m. Of the total Cost Improvement Programme target of £38.976m plans in progress, fully developed, or implemented total £24.660m as at the end of July. This leaves £14.316m still classed as opportunities with no clear plans currently in place to deliver this amount. The Trust needs to have mitigation plans in place by the end of September to deliver the full cost improvement plan.

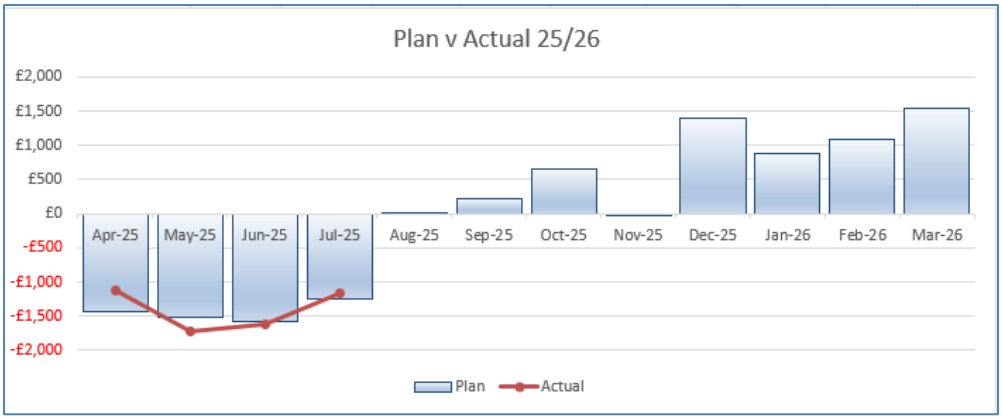
1.7 The Trust's financial forecast for the 2025/26 financial year remains in line with the plan at a breakeven position. The Trust continues to review the financial risk to achieve the plan which stands at £30.476m. The Trust needs to have a fully mitigated plan for the risk by the end of September.

1.8 The Integrated Care System reported an actual aggregate deficit of £31.184m for July. This is £0.045m better than the financial plan submitted to NHS England in March.

2. INCOME AND EXPENDITURE

2.1 After technical changes the **July cumulative position is a £5.622m deficit.** This position is £0.160m better than the financial plan submitted to NHS England in March.

2.2 The cumulative actual position in July compared to plan shows the Trust being marginally better than plan. Positive variances in income offset expenditure variances linked to non-delivery of the cost improvement programme and activity related costs for drug and devices. Pay costs have now started to overspend for the first time this year with non-recurrent pay savings helping the position in the first four months but offset by agency being above plan. The Trusts plan sees significant run rate reductions from August onwards and therefore if the Trust is to continue to achieve its financial plan reductions in pay costs and delivery of the cost improvement programme will need to improve in the coming months. The graph below highlights the run rate requirements for the remainder of the financial year.



2.3 Income is £2.191m better than plan. This relates to increases in pass through drug/devices income with NHS England (this is offset by increased non-pay costs associated with the drugs/devices) and Elective Recovery Fund overperformance with Black Country ICB (£0.343m). The Trust needs to manage within the elective recovery funding income associated with the agreed activity plan as Black Country ICB have no additional funding for over activity. The Trust has also benefited in month 4 from the cumulative impact of the higher contract values with non-Black Country ICB's that have now been agreed, and education income was also better than originally planned. In summary, taking aside pass through income the Trust has benefitted in month 4 by the year to date catch up with the now agreed healthcare contracts and other income agreements.

2.4 Substantive staff are 36 Whole Time Equivalents (WTE) below the target in July (May 49 WTE below the target). Substantive pay costs were £0.260m below plan at the end of July. The Trust continues to benefit from the brought forward Cost Improvement Programme savings linked to pay in the first four months of the year relating to the impact of the recruitment freeze at the back end of 2024 and enhanced vacancy controls now in place as well as the continuation of electronic patient record system development and the capitalisation of development staff. A vacancy freeze for all posts except clinically critical posts has been in place for the majority of this financial year.

2.5 Bank continues to underspend against the cumulative plan to July despite being over target for whole time equivalents. Bank is over the target by 84 Whole Time Equivalents (WTE) (May 7 WTE over the target). There is a cumulative underspend of £0.125m against plan at the end of July but this is reducing each month. The main reason for the financial saving will be attributable to the reduction of the bank rates that commenced in April. There has been an increase in bank

usage during July compared to the previous months, this is largely linked to medical staff driven by the impact of industrial action by resident doctors. Of the £0.446m increase in expenditure from June to July £0.398m (89%) related to medical staff providing cover during industrial action.

2.6 Agency usage continues to see an increase against plan and is above the target by 13 whole time equivalents resulting in a cumulative overspend of £0.434m. 99% of agency expenditure relates to consultants and career grade doctors with the spend comprising 0.8% of the total pay expenditure. The expenditure is spread across four specialties with high expenditure (greater than £0.100m) in Elderly Care, Paediatrics, ED, and Obstetrics. Work continues to support these areas to agree exit strategies as the Trust needs to eliminate these costs.

2.7 Non pay expenditure exceeded plan by £2.209m to July. Part of the overspent related to the non-delivery of Cost Improvement Programme savings classed as non-pay in the financial plan linked to productivity schemes. Other notable overspends included clinical supplies and drugs/devices. Some of this is offset by the pass-through income the Trust receives for these costs from NHS England.

2.8 The Trust's financial forecast for the 2025/26 financial year remains in line with the plan at a breakeven position.

2.9 The Trust conducted a review of the financial risk within the plan in May which stood at £34.360m. The Trust has continued to review the risk since May and at the end of July the risk was £30.476m. This is summarised in the table below:

Risk		**£000's**
Cost Improvement Programme		14,316
Risk Pool		3,460
Deficit Funding		10,600
Elective Recovery Fund Income		600
Reconfiguration Costs		1,500
Total Risk		**30,476**

The Trust needs to fully mitigate the Cost Improvement Programme short fall of £14.316m by the end of September as this is the biggest element of risk that the Trust has in its own control. Reconfiguration costs will become more understood once change processes are complete over the coming months and may need to be delayed until 2026/27 if they are not affordable. The remaining risk remains a System risk with deficit funding and the risk pool risk all dependent on the System's ability to achieve the overall financial plan.

3. CAPITAL AND CASH The cash position at the end of July was £1.362m higher than the previous month's forecast. Non-patient income receipts were £0.959m above forecast. This related to additional education income received than forecast and non-clinical contract payments made earlier than forecast. Supplier payments were £0.834m lower than forecast. This related to NHS payments that continue to be disputed and will be paid once credit notes are received. Capital payments were £0.454m higher than forecast and related to the timing of the receipt of invoices for payment.

3.2 Cash compared to plan was reduced by £0.650m compared to the previous month's forecast. The reduction relates to increased capital payments because of additional capital allocations provided to the Trust. The Trust has forecast that all deficit funding and risk pool funding will be paid within the contract value. Any different phasing of these payments or non-payment will change the in-month cash forecasts. The downside cash modelling currently shows a reduced

cash balance of £11.2m at the end of the financial year. This considers the current financial risk position for 2025/26.

3.3 Compliance with the Better Practice Payment Code was 93.7% in terms of number of invoices paid to non-NHS suppliers and 94.9% for NHS suppliers as at 31st July 2025. This was a further improvement from the June performance and is expected to continue in August to the point of achieving the 95% compliance.

3.4 In month 4 there was year to date capital expenditure of £6.699m against the original planned spend of £8.138m. The Emergency Department development is £1.006m behind the plan. This relates to a revised expenditure profile provided by the contractor. The scheme is not delayed, and the actual will catch up with the plan by the end of September. Community Health Partnerships lease remeasurement is the inflation increase in the lease which is lower than the estimated value by £0.206m. The Electronic Patient Record development is a new scheme funded by the medical equipment spare capital (£0.323m). A non-cash technical accounting transaction relating to PFI lifecycle is lower than plan by £0.181m.

3.5 Capital expenditure of £19.186m is planned for the 2025/26 financial year, an increase of £0.676m from last month's forecast. The Trust received £1m additional allocation relating to Urgent & Emergency Care incentive scheme which was offset by a reduction in funding of £0.350m relating to the Trusts' contribution to Black Country Pathology Service capital. There was also a donated asset increase of £0.026m

4. COST IMPROVEMENT PROGRAMME

4.1 The phased Cost Improvement Programme plan to July equated to £5.991m. Achievement to July totals £6.171m, which is higher than plan by £0.180m.

4.2 Of the total Cost Improvement Programme target of £38.976m plans in progress, fully developed, or implemented total £24.660m as at the end of July. This leaves £14.316m still classed as opportunities with no clear plans currently in place to deliver this amount. The Trust needs to have mitigation plans in place by the end of September to deliver the full cost improvement plan.

4.3 Of the total programme in the original plan 77% was planned to be recurrent (£29.978m) with 23% non-recurrent (£8.998m). The Trust will need to mitigate the plan with further non-recurrent schemes and ensure recurrent schemes are developed and delivering as we exit the 2025/26 financial year.

4.4 The Trust has held workshops with key operational managers to identify mitigating cost improvement solutions to deliver the £14.316m gap. Work continues to review and implement these ideas through the governance process with unpalatable options also being reviewed if the Trust is not able to fully mitigate the gap.

4.5 Work has continued with a third-party advisor to review the opportunities and solutions associated with the non-elective productivity schemes. The Trust expects to be in a position to take a proposal through the governance process with NHS England in October with some contribution expected to the cost improvement programme in 2025/26 but the majority in future years.

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

5.1 The Integrated Care System reported an actual aggregate deficit of £31.184m for July. This is £0.045m better than the financial plan submitted to NHS England in March. Three providers did not achieve their financial plan cumulatively to month four with the System achieving the plan following over achievement of plans in one provider and at the Integrated Care Board

5.2 The System has submitted a breakeven plan subject to the receipt of deficit funding from NHS England of £95m. Failure to deliver the plan will place the receipt of deficit funding at risk. The first quarter of deficit funding is assessed on the robustness of financial plans and NHS England have released this funding to the System. The second quarter related to System performance at the end of May and NHS England have released this funding to the System. The third quarter relates to System performance at the end of August.

6. RECOMMENDATIONS

6.1 The Trust Board is asked to note the financial performance for the period up to July 2025.

Chris Walker
Director of Finance
25th August 2025

Our Patients
Our People
Our Place

Enclosure 6

The Dudley Group NHS Foundation Trust

Paper for submission to the Public Board Thursday 11th September 2025

Report title:	Dudley's Approach to Neighbourhood Health
Sponsoring executive / Presenter:	Kat Rose, Group Chief of Integration
Report author:	Sally Cornfield, Programme Director

1. Summary of key issues

This report follows an update at the July Board where the Dudley Health and Care Partnership (DHCP) plans 2025/2026 were shared. It included an update on Neighbourhood Health Services which are a strategic pillar of integrated care, designed to deliver proactive, personalised support within communities as part of the 10 Year Health Plan.

Assure

In July Dudley partners undertook a National requirement to completed and submit a "Neighbourhood Health Maturity Self-Assessment" which evaluated system-wide progress across the six core components of neighbourhood health. This assessment clearly defines the standards, expectations, and developmental priorities required to advance integrated neighbourhood working in Dudley.

In July the Dudley Health and Care Partnership hosted a workshop to have a conversation about what neighbourhood health and hubs look like or mean to the people of Dudley and to provide an overview of what is already happening locally (in Dudley we have strong foundations with existing Family Hubs and integrated Community Partnership Teams well established). An infographic summarising the workshop is included as Appendix 1.

Also in July, Dudley completed an application to the National Neighbourhood Health Implementation Programme (NNHIP). All partners, including Primary Care Network Clinical Directors were instrumental in completing the application, and we have committed to do more to hear the voice of our primary care clinicians. A further workshop on Neighbourhood Health for Primary Care will be led by the Place Development Team in September/October. In addition to plans for Neighbourhood Health, to include the development of Children's Integrated Neighbourhood Teams (CPTs in Dudley), there will be further discussion amongst GPs regarding the announcements of new Neighbourhood contract's which is a subject of discussion and debate.

Advise

Successful applicants for the NNHIP will be notified on Friday 5th September.

Notwithstanding of the outcome of the NNHIP application we will need to develop a Neighbourhood Health Plans as stipulated in the Planning Framework for the NHS in England. At the point of writing, we still await further guidance on what is required within the plans but a lot of the work we have been undertaking and outline in this report and the report we provided to Board in July will form the foundation of the plan.

Neighbourhood Health Plans	These will be drawn up by local government, the NHS and its partners at single or upper tier authority level under the leadership of the Health and Wellbeing Board, incorporating public health, social care, and the Better Care Fund. The plan should set out how the NHS, local authority and other organisations, including social care providers and VCSE, will work together to design and deliver neighbourhood health services. DHSC will publish separate guidance to support their development (awaiting publication).

An update on Neighbourhood health and outputs from the Neighbourhood workshop was discussed at August Trust Management Group. Following the discussion, it was agreed that a further deep dive into what delivering Neighbourhood health means for the services the Trust provide is needed.

Alert

- There are ongoing conversations with Primary Care regarding the announcement of a new contract which is a subject of discussion and debate.
- Neighbourhood Health Services will be discussed at the September Health and Wellbeing Board.
- Ongoing changes in both the ICB and the Local Authority may impact the pace of change in Dudley.
- The outcome of the NNHIP application is likely to influence the level of autonomy in which we can respond to the public feedback.

2. Alignment to our Vision	
Patients: Deliver right care, in the right place, at the right time	**X**
People: Be a brilliant place to work and thrive	**X**
Place: Build innovative partnerships to improve the health of our communities	**X**

3. Report journey
N/A

4. Recommendations
The Public Trust Board is asked to:
a) **Consider** what are the key opportunities for DGFT in developing Neighbourhood Health?
b) **Commit** to providing strategic leadership to the development of Neighbourhood Health Services
c) **Contribute** to the development of Dudley's Neighbourhood Health Plan and ensure the Trusts Five-year Integrated Delivery Plan supports the delivery of Dudley's Neighbourhood plan.

5. Impact reflected in our Board Assurance Framework (BAF)		
BAF Risk 1.0		Failure to deliver the right care, in the right place every time
BAF Risk 2.0		Failure to ensure Dudley is a brilliant place to work and thrive
BAF Risk 3.0	X	Failure to build innovative partnerships to improve the health of our communities
BAF Risk 4.0		Failure to remain financially sustainable in 2025/26 and beyond
BAF Risk 5.0		Failure to achieve operational performance requirements & deliver strategic objectives
BAF Risk 6.0		Failure to take sustained action on infrastructures that enables strategic objectives
Is Quality Impact Assessment required if so, add date:		
Is Equality Impact Assessment required if so, add date:		

Dudley's Approach to Neighbourhood Health

Report to Public Board on 11th September 2025

1. Purpose

This purpose of this report is to share the following:

- The outcome of a Neighbourhood Health Maturity Self-Assessment which evaluated system-wide progress across the six core components of neighbourhood health. Dudley's submission can be found in the further reading pack.
- The feedback from stakeholders following a workshop in July on Neighbourhood Health (Appendix 1)
- The outcome of Dudley's application to the National Neighbourhood Health Implementation Programme. Dudley's submission can be found in the further reading pack. (This will be verbal during the Board meeting as the announcement follows the sharing of paper).

2. Neighbourhood Health

The NHS Neighbourhood Health Plan is a strategic initiative designed to improve population health and reduce health inequalities by delivering more integrated, localised care. It focuses on neighbourhoods of around 30,000–50,000 people, enabling Primary Care Networks (PCNs) and partners to work collaboratively with communities to address their specific health and wellbeing needs.

Key Objectives:

- Shift from reactive care to proactive, preventative, and personalised care
    - this supports financial sustainability by reducing demand on acute services.
- Strengthen multi-disciplinary, community-based teams led by primary care
    - this empowers local leadership and communities in co-designing services.
- Tackle wider determinants of health, including housing, employment, and education
    - this builds partnerships across NHS, local authorities, education, local businesses, the voluntary sector, and communities.
- Support health equity by targeting underserved populations
    - this enables better use of local data and insights to target interventions.

In order to develop Neighbourhood Health Services in Dudley, the organisations of the Dudley Health and Care Partnerships must oversee resource allocation, risk management, and impact evaluation in addition to:

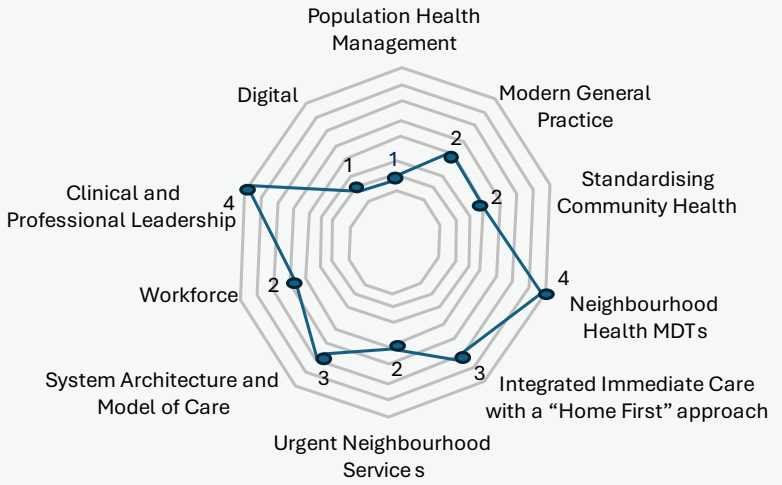
- Using data to guide investment in prevention and early intervention, particularly in underserved communities.
- Supporting integrated workforce models across organisations (e.g., community health, social care, voluntary sector).
- Allowing for cross-organisational use of assets and staff, tailored to community priorities.
- Working with ICSs, PCNs, local authorities, NHS and VCSE partners look to enable pooled or aligned budgets at neighbourhood level.

To support local areas NHSE developed a Neighbourhood Health Maturity Self-Assessment which evaluated system-wide progress across the six core components of neighbourhood health. This assessment clearly defines the standards, expectations, and developmental priorities required to advance integrated neighbourhood working in Dudley. The spiders web below demonstrated the areas of strength in Dudley and the areas that require improvement.

Neighbourhood Health Maturity Self -assessment

Each neighbourhood can assess themselves against each component and score themselves on a scale of:
1: “Starting”
2: “Progressing”
3: “Achieving”
4: “Excelling”
The outcome can be demonstrated as a spider diagram to demonstrate the areas of strength and required improvement.

Capability	Maturity level
Population health management	1
Modern general practice	2
Standardising community health services	2
Neighbourhood multidisciplinary teams (MDTs)	4
Integrated intermediate care with a ‘Home First’ approach	3
Urgent neighbourhood services	2
System architecture and model of care	3
Workforce	2
Clinical and professional Leadership	4
Digital	1



The diagram provides an overview of the component level at a glance.

On September 5th the Dudley Health and Care Partnership Executive Team will review the outcome of the assessment and develop an action plan to address the areas that require improvement and continue to excel in the areas of strength.

Prior to the completion of the self-assessment the Dudley Health and Care Partnership hosted a workshop to have a conversation about what neighbourhood health and hubs look like or mean to the people of Dudley and to provide an overview of what is already happening locally (in Dudley we have strong foundations with existing Family Hubs and integrated Community Partnership Teams well established). Using "we" statements we have summarised via an infographic the feedback from stakeholders (Appendix 1). This approach reinforces our culture of inclusion, accountability, and continuous improvement, and aligns with the Trust values of care, respect, responsibility.

During the workshop 3 foundations were clear:

1. We want community-led solutions driven by local people
2. We want to see our neighbourhoods as living systems with many parts
3. We want tailored support—because one size doesn't fit all

Main outcomes:

- **Public Communication & Engagement** - Everyone can easily access clear information about local services, benefit from better digital inclusion, engage regularly with visible impact, and experience inclusive communication that meets diverse needs.
- **Community-Based, Accessible Services** - People receive support in trusted, local spaces through culturally appropriate services delivered by community connectors and voluntary sector partners
- **Collaboration, Integration & Accountability** - All sectors work in partnership with aligned strategies, shared resources, coordinated efforts, and a genuine commitment to involving residents and partners equally in decision-making.
- **Investment, Funding & Resources** - There is long-term, needs-led investment in community care, ensuring services are affordable, effective, and built on existing local strengths and successes.
- **Prevention, Education & Empowerment** - Communities have timely access to mental health support, health education, and tools to manage wellbeing - within a system that prioritises cultural change, not just process reform.
- **Localised, Neighbourhood Based Vision** - Services are designed around neighbourhoods, supported by community-focused estate planning, local pride, environmental sustainability, and leadership rooted in lived experience.

The above was shared with Trust Management Group in August with the following discussion points:

- Despite being a "NHS" led event the conversation was largely around the wider determinants of health i.e. not in the gift of the Trust
- Participants want to use and improve existing spaces, not always build new.
- This is just the start – how can the Trust be part of the conversation
- The role of the Trust in taking this forward - how Divisions/Teams can contribute to Neighbourhood Health Services in Dudley and/or what services need to move into the community.
- The imperative for genuine coproduction has been clearly and consistently articulated. This Trust must now move beyond acknowledgement to action by embedding coproduction as a fundamental principle across all aspects of service redesign, strategic planning, and operational delivery. The voices of people with lived experience must not only be heard but actively shape the way services are conceived, developed, and implemented.

Following the discussion, it was agreed that a further deep dive into what delivering Neighbourhood health means for the services the Trust provide is needed and a plan to take this forward is being developed.

Also in July, Dudley completed an application to the National Neighbourhood Health Implementation Programme (NNIP). All partners, including Primary Care Network Clinical Directors were instrumental in completing the application, and we have committed to do more to hear the voice of our primary care clinicians. A further workshop ON Neighbourhood health for Primary Care will be led by the Place Development Team in September/October. In addition to plans for Neighbourhood Health, to include the development of Children's Integrated Neighbourhood Teams (CPTs in Dudley), there will be further discussion amongst GPs regarding the announcements of new Neighbourhood contract's which is a subject of discussion and debate.

2.1 Immediate Plans for Dudley's Approach to Neighbourhood Health

Notwithstanding the announcement of successful areas for the National Neighbourhood Health Implementation Programme, we will need to proceed with developing a plan for Dudley's Neighbourhood Health Service. We anticipate that one of the four Black Country areas will be successful, and we have an existing Action Learning Set across the 4 Places to share learning and develop our models.

The current NHS Planning Guidance specified the development of Neighbourhood Health Plans which will be drawn up by local government, the NHS and its partners at single or upper tier authority level under the leadership of the Health and Wellbeing Board, incorporating public health, social care, and the Better Care Fund. The plan should set out how the NHS, local authority and other organisations, including social care providers and VCSE, will work together to design and deliver neighbourhood health services. DHSC will publish separate guidance to support their development (awaiting publication). At the point of writing, we still await further guidance on what is required within the plans but a lot of the work we have been undertaking and outlined in this report and the report we provided to Board in July will form the foundation of the plan. Plans for Neighbourhood Health will be discussed at the Dudley Health and Wellbeing Board, September 25th.

During the week of October 13th – 17th the Dudley Improvement Practice will facilitate an improvement event focusing on Care Coordination within Dudley Community Partnership Teams (referred to as Integrated Neighbourhood Teams in NHS 10 Year Plan). Care Coordination is essential to the delivery of personalised, integrated car, particularly within the context of neighbourhood-based health models. They play a critical role in bridging gaps between services, improving patient outcomes, and supporting more proactive care, thereby reducing unplanned care and system inefficiencies.

2.1 Long Term Plans for Dudley's Approach to Neighbourhood Health

Developing a neighbourhood health service will require a long-term, system-wide approach that prioritises local needs, partnership working, and sustainable transformation. In addition to the immediate and medium-term actions identified via the Maturity Self-Assessment we need to agree how to approach the following:

- Sophisticated and robust data sharing – to use real-time data and analytics to understand population needs and target resources.
- Provide leadership development and governance support for local neighbourhood teams.
- Encourage flexible commissioning models that allow neighbourhood-level budgeting to rebalance investment towards preventative services, public health, and community support.
- Investment in Social Infrastructure
- Develop shared accountability frameworks with local partners and communities.

3. Conclusion and Recommendations

Neighbourhood health services are a critical enabler of the NHS's strategic shift toward integrated, preventative, and person-centred care. They support the long-term aims of reducing health inequalities, improving population outcomes, and delivering more care closer to home. Through Primary Care Networks and integrated neighbourhood teams, this model offers the opportunity to reshape care delivery around the real needs of communities.

The development and oversight of neighbourhood health services represent a key area of strategic importance. The Trust has a pivotal role in:

- Providing strategic leadership and alignment with ICS priorities;
- Ensuring robust governance, risk management, and resource allocation across organisational boundaries;
- Monitoring the impact of neighbourhood models on outcomes, access, and health equity;
- And ensuring accountability for delivering population health improvements at a local level.

This transformation will require sustained commitment, investment, and partnership working.

The Trust Board is asked to:

- Consider what are the key opportunities for DGFT in developing Neighbourhood Health?
- Commit to providing strategic leadership to the development of Neighbourhood Health Services
- Contribute to the development of Dudley’s Neighbourhood Health Plan and ensure the Trusts Five-year Integrated Delivery Plan supports the delivery of Dudley’s Neighbourhood plan.

Dudley Health and Care Partnership
Connecting communities and coordinating care to help citizens live longer, safer and healthier lives.

NEIGHBOURHOOD HUB WORKSHOP

Purpose

- To have a conversation about what neighbourhood health and hubs look like or mean to the people of Dudley
- To provide a brief overview and context of the NHS 10 year plan and what this means
- To provide an overview of what is already happening locally with neighbourhood teams as defined in the 10 years plan,
- To provide information on Dudley Health and Care Partnership and its role in Dudley

Venue

Brierley Hill Civic Hall, Bank St,Brierley Hill, DY5 3DH

Date and Time

Wednesday 23rd July
1:30pm until 4:30pm

Attendees

Over 100 attendees from a variety of backgrounds took part in what was a vibrant and collaborative session

Feedback on workshop

Top 3 words for event

Engaging
Informative
Thought-provoking

Common themes

Positive experience
Collaborative learning
Intellectual stimulation

WHAT DOES NEIGHBOURHOOD MEAN TO YOU?

Place & Environment

- We want neighbourhoods that are walkable, accessible, and well-connected
- We want clearly defined local areas that feel familiar
- We want green parks, clean air, and blue spaces (ponds, lakes, streams) to enjoy
- We want good infrastructure —transport, toilets, Wi-Fi, and community hubs
- We want to walk to places we use

People & Connection

- We want to feel connected, supported, and part of something
- We want friendly, neighbourly places where people know and help each other
- We want to include everyone and reduce isolation

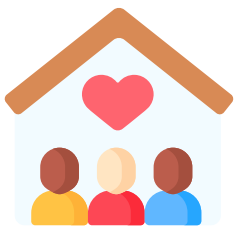
Services & Support

- We want local services we can trust—GPs, schools, libraries, youth clubs, pharmacies
- We want support to be joined-up, easy to navigate, and holistic
- We want services that are free or affordable and accessible to all
- We want access to faith groups

Health & Wellbeing

- We want support to stay healthy through community groups and activities
- We want mental health support, especially for young people
- We want help for families and carers in inclusive spaces

Identity & Belonging



- We want to feel at home and proud of where we live
- We want spaces that reflect our heritage, stories, and culture
- We want inclusive, welcoming places for all backgrounds

Ideas & Innovation

- We want flexible definitions of neighbourhood that reflect real life
- We want everyone to have access to digital tools and skills
- We want creative ways to connect—like therapy groups or WhatsApp hubs

Foundations

- We want community-led solutions driven by local people
- We want to see our neighbourhoods as living systems with many parts
- We want tailored support—because one size doesn't fit all

WHAT WOULD YOU EXPECT TO SEE IN A NEIGHBOURHOOD HUB AND WHERE WOULD YOU EXPECT TO FIND IT?

Strategic Vision

- We want flexible neighbourhoods shaped by how we live, not by maps
- We want planning rooted in land, jobs, housing, health, and education

Services & Facilities

- We want one-stop hubs for health, advice, and community support
- We want access to mental health care, screenings, and pharmacy-first services
- We want help with housing, debt, and crisis support
- We want everyday skills—cooking, tech, games, hobbies
- We want tailored support for different needs and life stages

Structure & Sustainability

- We want to use and improve existing spaces, not always build new
- We want hubs that are funded, staffed, and built to last
- We want hubs that are part of a wider local network
- We want community ownership and local decision-making

Community & Connection

- We want hubs to feel like home—safe, warm, and welcoming
- We want space to socialise—tea mornings, walking groups, shared gardens
- We want trusted local leaders to guide and connect us
- We want to meet the needs of those who need it most

Information, Engagement & Education

- We want clear info through local campaigns, leaflets, and events
- We want skills support—from jobs to confidence building
- We want everyone included in the digital world

Location & Accessibility

- We want hubs in places we already go—schools, shops, town centres
- We want walkable, accessible locations with good transport and parking
- We want welcoming spaces—libraries, churches, pharmacy—not clinical settings

WHAT GETS IN THE WAY OR WHAT ARE THE GAPS? BARRIERS AND CHALLENGES:

Access Barriers

- We need to get better at providing local, reliable transport
- We need to get better at removing physical barriers to buildings and spaces
- We need to get better at supporting digital access and offering face-to-face options
- We need to get better at making services easier to access and navigate

Financial Barriers

- We need to get better at reducing the cost of taking part
- We need to get better at supporting families through the cost of living crisis
- We need to get better at funding community services long-term

Social & Cultural Barriers

- We need to get better at tackling isolation and building confidence
- We need to get better at making spaces inclusive and welcoming to all
- We need to get better at connecting communities and strengthening local identity

Awareness & Information Gaps

- We need to get better at communicating what's available locally
- We need to get better at signposting and joining up services

Infrastructure Gaps

- We need to get better at creating and maintaining safe, family-friendly spaces
- We need to get better at using underused buildings and planning for growth
- We need to get better at defining and supporting neighbourhood identity

Systemic Barriers

- We need to get better at designing flexible, locally-led systems
- We need to get better at ensuring communities are part of decision-making
- We need to get better at resourcing services and preventing burnout

Cultural & Psychological Barriers

- We need to get better at addressing fear, judgement, and stigma
- We need to get better at rebuilding trust in systems and public plans

CHANGES AND OPPORTUNITIES

Integration & Joined-Up Services

- We want one place to access all the help and advice we need
- We want services working together in welcoming hubs
- We want joined-up, person-centred care, especially for complex needs
- We want local, remote health options that reduce hospital visits

Education, Empowerment & Self-Management

- We want to understand our health and how to manage it
- We want to feel confident using services, tech, and social media
- We want carers to be recognised, supported, and included

Neighbourhood Hubs & Community Services

- We want to build on what's already working in our communities
- We want flexible, inclusive, drop-in spaces close to home
- We want services brought into everyday places like shops and estates

Communication & Information Sharing

- We want clear, inclusive information from trusted sources
- We want to co-design services and be involved from the start
- We want to celebrate success and share real stories

Collaboration & System Leadership

- We want sectors to work together, not in silos
- We want shared goals that reflect local priorities
- We want budgets and decisions made at neighbourhood level

Digital Inclusion & Innovation

- We want support to get online and use digital tools
- We want new tech that helps with connection and care
- We want digital options to sit alongside face-to-face support

Community Building & Resilience

- We want to start with what's strong in our communities
- We want local connectors who bring people together
- We want spaces designed for everyone, especially those often excluded

Funding & Sustainability

- We want long-term investment in local and preventative services
- We want funding to shift from crisis response to community care
- We want free or low-cost services that people can afford

Tailored & Person-Centred Approaches

- We want flexible services that reflect different needs
- We want lived experience to shape what's offered
- We want support that builds confidence and independence

MAIN OUTCOMES

Public Communication & Engagement

Everyone can easily access clear information about local services, benefit from better digital inclusion, engage regularly with visible impact, and experience inclusive communication that meets diverse needs.

Community-Based, Accessible Services

People receive support in trusted, local spaces through culturally appropriate services delivered by community connectors and voluntary sector partners.

Collaboration, Integration & Accountability

All sectors work in partnership with aligned strategies, shared resources, coordinated efforts, and a genuine commitment to involving residents and partners equally in decision-making.

Investment, Funding & Resources

There is long-term, needs-led investment in community care, ensuring services are affordable, effective, and built on existing local strengths and successes.

Prevention, Education & Empowerment

Communities have timely access to mental health support, health education, and tools to manage wellbeing—within a system that prioritises cultural change, not just process reform.

Localised, Neighbourhood-Based Vision

Services are designed around neighbourhoods, supported by community-focused estate planning, local pride, environmental sustainability, and leadership rooted in lived experience.

Paper for submission to Board of Directors on 11 September 2025

Report Title:	Chief Nurse & Chief Medical Officer Report - Review of Dr Penny Dash's report on safety across the health and care landscape
Sponsoring Executive / Presenter:	Martina Morris, Chief Nurse and Director of IPC Dr Jonathan Odum, Interim Chief Medical Officer
Report Author:	CMO and CNO Office team

1. Summary of key issues

This paper focuses on the recently published Dr Penny Dash's review of safety across the health and care landscape. The review was commissioned by the Secretary of State for Health and Social Care, following Dr Penny Dash's earlier review of the Care Quality Commission (CQC) and responding to concerns about a fragmented and overlapping care quality system. This paper reviews Dr Penny Dash's findings against the position of The Dudley Group NHS Foundation Trust and outlines recommendations pertinent for the Trust and the wider system. The recommendations made within this report are aligned with the Trust's strategic objectives.

Assure
Whilst nationally there is apparent bureaucratic overlap and fragmentation as detailed in the report, as a provider Trust, it is important that we influence change whilst working through mitigations that promote a culture of quality and safety for our patients and staff. Mitigations are in place to manage the associated risks, and these will continue to be proactively reviewed as the NHS landscape and associated governance changes progress.

Advise
As well as the recommendations made with regards to regulation and associated governance, Dr Penny Dash makes important recommendations with regards to patient voice, complaints management, critical importance of moving care into community, ongoing focus on growing the digital agenda and a significant opportunity to positively influence the health inequalities agenda across the NHS and wider. In addition, it makes an important point of absent national quality strategy for social care.

Alert
Nil to note.

2. Alignment to our Vision

Patients: Deliver right care, in the right place, at the right time	x
People: Be a brilliant place to work and thrive	
Place: Build innovative partnerships to improve the health of our communities	x

3. Report journey

Trust Management Group and Quality Committee, August 2025 Public Trust Board, September 2025

4. Recommendations
The Public Trust Board is asked to:
a) **Note** the contents of Dr Penny Dash's Report and Trust analysis.
b) **Support** the recommendations for potential areas of opportunity identified by the paper.

5. Impact reflected in our Board Assurance Framework (BAF)		
BAF Risk 1.0	x	Failure to deliver the right care, in the right place every time
BAF Risk 2.0		Failure to ensure Dudley is a brilliant place to work and thrive
BAF Risk 3.0	x	Failure to build innovative partnerships to improve the health of our communities
BAF Risk 4.0		Failure to remain financially sustainable in 2025/26 and beyond
BAF Risk 5.0		Failure to achieve operational performance requirements & deliver strategic objectives
BAF Risk 6.0		Failure to take sustained action on infrastructures that enables strategic objectives
Is Quality Impact Assessment required if so, add date: N/A		
Is Equality Impact Assessment required if so, add date: N/A		

The Dudley Group
NHS Foundation Trust

Review of Dr Penny Dash's report on safety across the health and care landscape.

1 EXECUTIVE SUMMARY

1.1 A review was commissioned by the Secretary of State for Health and Social Care, following Dr Penny Dash's earlier review of the Care Quality Commission (CQC) and responding to concerns about a fragmented and overlapping care quality system. This report examines our position as a Trust, with the main aim being to identify what we do well and what gaps exist, to support continuous improvement and strengthening of our governance processes.

1.2 Whilst nationally there is apparent bureaucratic overlap and fragmentation, it is critical that as a provider Trust we influence change whilst working through mitigations that promote a culture of quality and safety for our patients and staff. As a provider, we have implemented mitigations to overcome these gaps and are building relationships to help inform and be part of any changes at a national level. The recommendations made within this report are aligned with the Trust's strategic objectives.

2 BACKGROUND INFORMATION

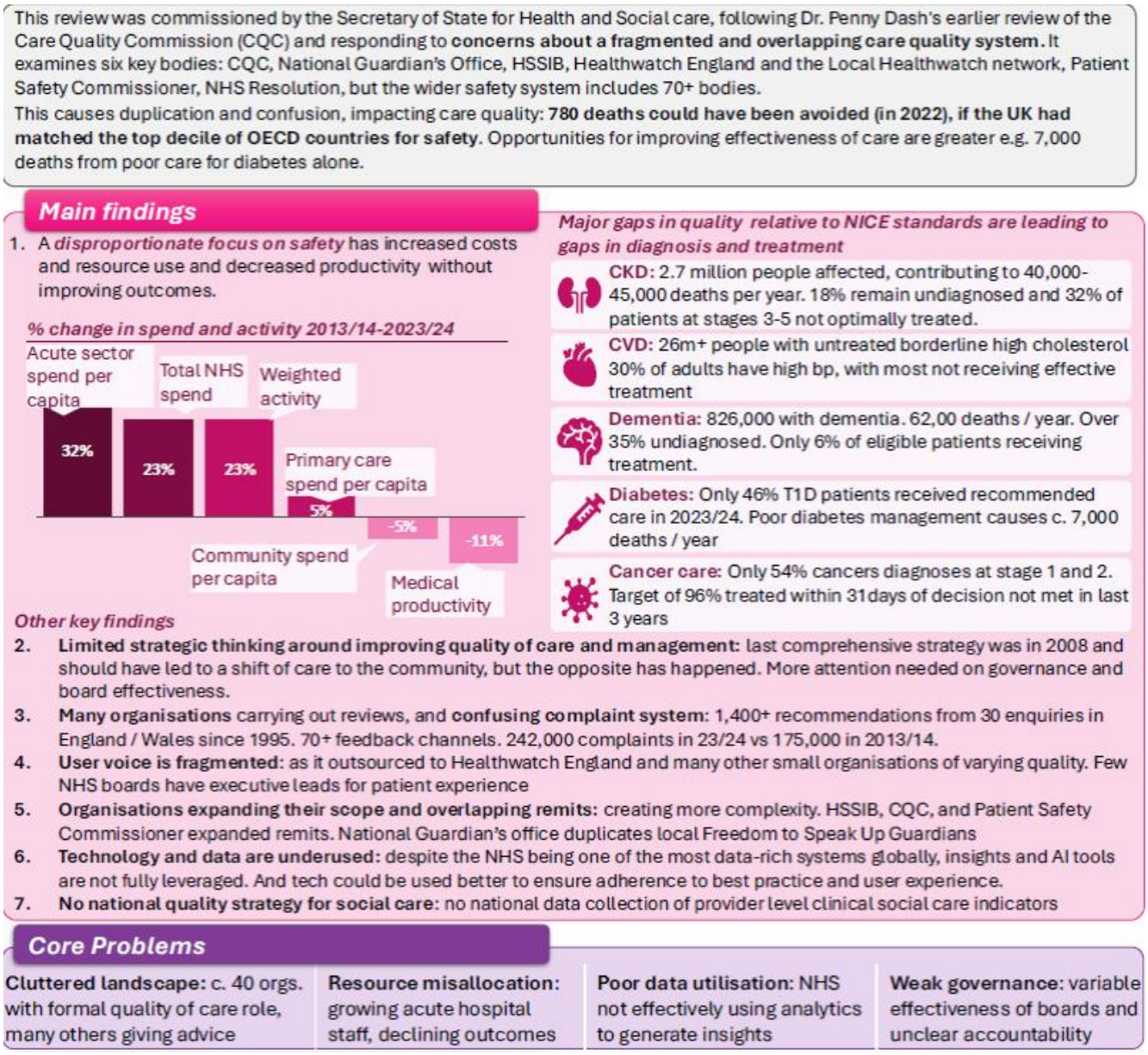
2.1 This review was commissioned by the Secretary of State for Health and Social Care, following Dr Penny Dash's earlier review of the Care Quality Commission (CQC) and responding to concerns about a fragmented and overlapping care quality system. It examines six key bodies: CQC, National Guardian's Office, Health Service Safety Investigation Branch, Healthwatch England and the Local Healthwatch network, Patient Safety Commissioner, NHS Resolution, but the wider safety system includes 70+ bodies. This causes duplication and confusion, impacting care quality: 780 deaths could have been avoided (in 2022), if the UK had matched the top decile of OECD countries for safety. Opportunities for improving effectiveness of care are greater, e.g. 7,000 deaths from poor care for diabetes alone. Fundamental quality issues persist despite massive investment in safety infrastructure. Yet, it is entirely feasible to see a step change improvement in care outcomes if the recommendations for a coordinated strategy are implemented.

The review is an important study that examines how well NHS services are working. It tests if patients are receiving the care they need and if the system is running smoothly. The review outlines what is working well and what needs to change.

This report examines the Trust's position, identifying what works well and outlying any gaps we need to strengthen whilst national recommendations are being developed and implemented.

2.2 Key Findings of the review

The main findings of the review are detailed in the graphic:



The Dudley Group's position on these findings is summarised in the table below.

2.3 DGFT Position of key findings

A disproportionate focus on safety has increased costs and resource use, and decreased productivity without improving outcomes.	The evidence suggests that the Trust has a focus on quality and safety whilst being efficient. Costs are reducing as part of cost improvement programmes. Standard Hospital Mortality is static with our hospital mortality a positive outlier. With seven-day services providing elective surgery reducing referral to treatment times in many specialities. Productivity metrics are regularly tracked in the Trust to see how our position is changing over time and in comparison to peers. These metrics contribute to the NHS Oversight Framework which has recently been published, and the Trust will ensure that the metrics that contribute to our scoring for segmentation will be front and centre of reporting to Committees and Board. A plethora of Safe Staffing (nursing, midwifery and AHP) reviews have been caried out in line with the recommendations outlined by the National Quality Board ensuring staffing resources are sufficient to meet patient acuity. Medical workforce has been reviewed via a separate process. There is a weekly learning and decision-making group that focuses on those incidents that may have caused harm. The Trust has a Quality and Safety Delivery Plan which focuses on quality improvement and aligning with the Trust Quality Priorities and the Trust's overarching Strategy. Quality and safety oversight is provided locally within the Divisions through the governance structures within the Trust feeding into Quality and Safety and Risk and Assurance groups, reporting to Quality Committee through to the Trust Board. There is a Chief Nurse Quality Dashboard, ward Clinical Accreditation programme and a CQC quality review programme. All these processes contribute to the body of evidence in maintaining Trust's oversight of providing a quality safe services to our patients. In line with national requirements, the Trust implemented the Patient Safety Incident Response Framework (PSIRF) in November 2023. One of the key aims of this framework is proportionality in terms of the resource invested in the investigation into safety concerns to ensure resource is redirected into the implementation of effective more holistic quality improvement. Although it is recognised that the approach taken at The Dudley Group could have been braver in terms of reducing the investigative element further, there has been significant progress made; with the number of full investigations significantly falling compared to working under the Serious Incident Framework. This more balanced approach has not impacted on the safety profile, with Never Event occurrence and national priority incidents for response remaining very low.

Financial Year - Number of Never Events:
2019/2020 - 4
2020/2021 - 3
2021/2022 - 0
2022/2023 - 2
2023/2024 - 1
2024/2025 - 0
2025/2026 - 2

National Priority Incidents Reported since transition to PSIRF	**Number of Responses**						
	Q3 23/24	**Q4 23/24**	**Q1 24/25**	**Q2 24/25**	**Q3 24/25**	**Q4 24/25**	**Q1 25/26**
National Never Events (PSII)		1					1
Deaths thought more likely than not due to problems in care (PSII)*						1	
Incident meeting Each Baby Counts criteria (MNSI)	1						1
Serious Hazards of Transfusion (SHOT) reportable incidents resulting in significant harm (PSII)				1			

The Trust recognises that, similar to other NHS organisations, there are increasing numbers of recommendations from safety reviews (incident investigations, peer reviews etc), however the organisation has taken steps to streamline the response, making use of single improvement plans, gatekeeping actions that are not SMART, and shifting our reporting approaches to outcome focus rather than counting action completion.

The work required to achieve effective and sustainable change remains a focus for the organisation; a plan is in place to work with the Dudley Improvement Practice to equip leadership teams with the skills and approaches.

	The health life expectancy of our Dudley population has decreased in recent years rather than increased. As a Trust we recognise that we still have more work to do to become more productive and have a great focus on prevention. We have highlighted where we need to put our focus over the next three years and the outcomes we need to address in our Trust Strategy 2025- 2028 (Strategy_2025-2028_final.pdf). These outcomes would suggest the Trust has a balanced approach to safety whilst maintaining a financial balance.
Limited strategic thinking around improving quality of care and management: last comprehensive strategy was in 2008 and should have led to a shift of care to the community, but the opposite has happened. More attention needed on governance and board effectiveness.	As a Trust we have recognised that we have more work to do to shift more care into the community, and in our Trust Strategy we have made a multiyear commitment to shift care from hospital to community. As a Trust we have updated our governance structure over the last few years to strengthen how the Trust approaches shifting care into the community and work with our partners and communities. We have introduced an Integration Committee which is responsible for overseeing the work the Trust is doing to transform the community services we offer and the work we are doing with our partners through the Dudley Health and Care Partnership. To support this each year, Dudley Improvement Practice selects two strategic programmes to focus significant resource on supporting Trust teams progress key strategic objectives from the Trust Strategic Planning Framework. In 2025/26, one of those 'Value Stream' programmes is Hospital to Community, also known as 'Community First'. Community Frailty Intervention Team (C-FIT) and Care Home pilots are launching in Q3 2025. Strong engagement across system partners, including health, care, voluntary sectors, and individuals with lived experience. Early indicators of positive impact where community intervention is reducing number of attendances and admissions at hospital from patients within the initial trial cohort. Process refinement and testing will then be spread to other GP practices and care homes. There is more work we need to do with our teams and partners on how to transform our services and how we plan to deliver service in the future to align with a neighbourhood approach to healthcare delivery. There are further opportunities that need to be explored to share the Community First models that have been put in at Sandwell and West Birmingham NHS Trust to support the opening of Midland Metrolpolitan University Hopsital (MMUH).
Many organisations carrying out reviews, and confusing complaint system: 1,400+ recommendations	The Trust has a robust complaints process in place that works well. However, there are gaps within the complaints process nationally as follows: • Complaints are handled internally and not necessarily independently. • There can be long delays in responding to complaints due to varying reasons. • Many patients and families find the process confusing.

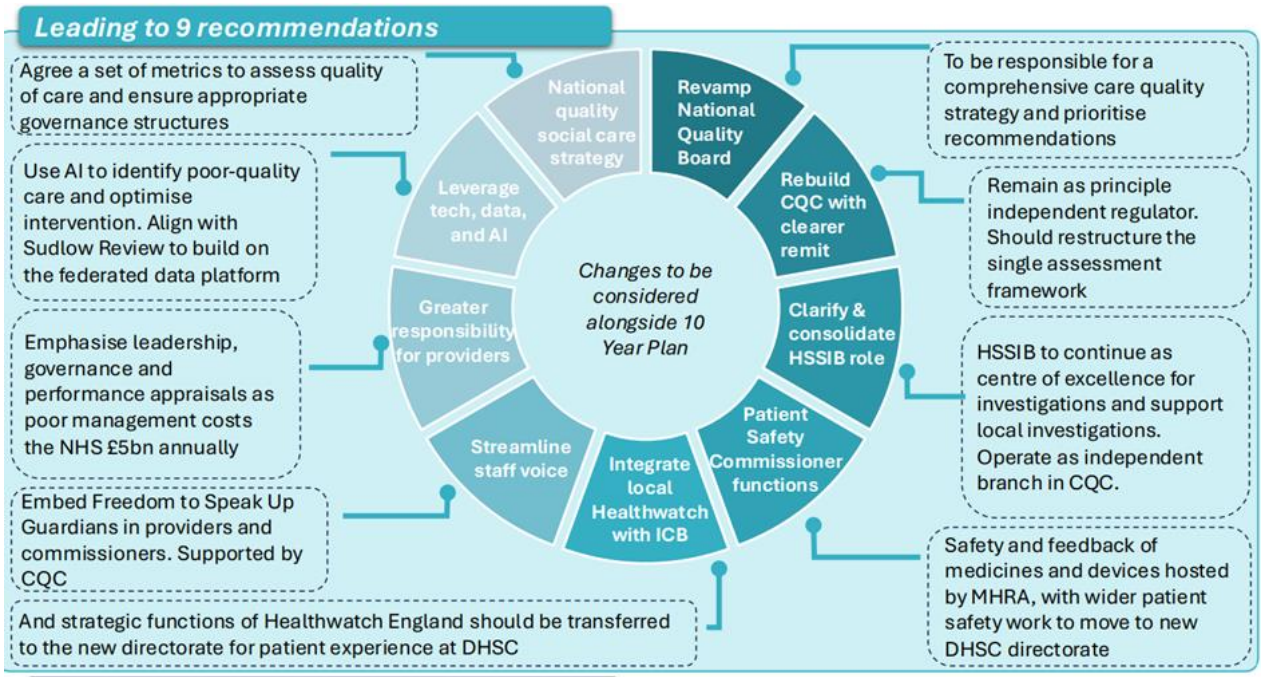
from 30 enquiries in England / Wales since 1995. 70+ feedback channels. 242,000 complaints in 23/24 vs 175,000 in 2013/14.	• Not all staff are aware of how the process works or how to respond to a complaint but do not attend the training available. • Responses can, at times, feel cold and dismissive. • Patients fear there will be retaliation if they make a complaint which will affect their care. • Patients are not involved enough in the process, policy and evaluating services nationally. **Mitigations within Trust** • Complaints are investigated by line managers, senior teams to ensure a thorough response. Ideally, complaints should be investigated by an independent party, however staff do not have the capacity to undertake this. This is partly mitigated by the support from PALS and Complaints team. • There is a thorough complaints process in place with three stages of escalation. However, it must be recognised that complaints can breach due to capacity, information not available, waiting for clinical notes, annual leave etc. • We provide both complaints and PALS in easy read format and different languages. • Training is available in many different formats, i.e. monthly training session, online training and bespoke training is available. • The Trust does ensure that our responses are holistic and with empathy. Each response goes through a thorough quality assurance process before signing off by the Chief Executive. • On speaking with complainants, we make it very clear that the complaint is not added to their clinical records. This means that only staff involved in the complaint will know about it.
User voice is fragmented: as it outsourced to Healthwatch England and many other small organisations of varying quality. Few NHS boards have executive leads for patient experience.	The Trust has an Executive Lead for Patient Experience, indicating clear Executive-level ownership. Senior roles include the Associate Director of Patient Experience and Patient Experience and Engagement Lead (x2 members of staff sharing the role across both DGFT and SWBH), which highlight corporate support to the Executive-level leadership and sponsorship. As a Trust there are opportunities to involve our patients as further described below, however this is not consistently applied across the Trust. • We have Patient Voice volunteers and Patient Safety Partners within the Trust that have been involved with our policies. The patient partners are involved in many things across the Trust from recruitment to service redesign. • As a Foundation Trust we have a Council of Governors that are often service users reflecting the local population. • Our workforce is built predominately from the local population who experience the Trust services first hand. • The Trust uses an array of feedback mechanisms, including Friends and Family Test (FFT), real-time face-to-face surveys, local and national surveys, PREMs (Patient Reported Experience Measures), online platforms like NHS Choices and Patient Opinion, listening events, patient panels, focus groups, and “Talk to Us” trolleys.

	• Over 77,476 feedback opportunities were recorded in 2024/2025, with 56,518 FFT responses and 12,175 PREMS responses, showing significant engagement with patient voice. • Clinical divisions are required to present how they have embedded the Patient Experience Strategy into their core business, with regular reporting to the Patient Experience Group. • DGFT hosts campaigns to elevate patient voice, e.g. the “What Matters to You” campaign and social media efforts aim to raise the profile of patient experience across the organisation. • Future plans include broader partnerships, including a patient forum, strengthening the Maternity and Neonatal Voices Partnership opportunities, etc. The 2024-2027 Improvement Plan includes increased collaboration with stakeholders, local Healthwatch, and voluntary/community groups, which is supportive of a structured approach to external engagement. There are a number of ways in which the voice of those we serve is used to shape priorities and ensure our services reflect the needs of the communities we serve. These mechanisms are embedded throughout our services and at each level in our organisation including the following at Board: • As part of the Trust Board, the Director of Communications brings strategic leadership to the Trust’s efforts to ensure patient and public involvement in the decisions we make. • Our Board of Governors represent the communities we serve and play a key role in our decision making. • At each meeting we start by sharing patient stories to inform and inspire service improvement. The above shows that the Trust has pockets of really good practice, but we recognise we do not consistently engage with our local communities to co-produce how our services should be accessed and delivered, and we need to take a more consistent approach to this across the Trust.
Organisations expanding their scope and overlapping remits: creating more complexity. HSSIB, CQC, and Patient Safety Commissioner expanded remits. National Guardian’s Office duplicates local	The Chief Nurse holds regular meetings with regulators such as the NMC and CQC. This promotes partnership working and a greater understanding of the changing landscape whilst working collaboratively. An example of this would be that the NMC are contacted in the first instance to discuss potential referrals prior to a referral being made. This helps reduce the workload of the NMC whilst reducing unwarranted lengthy delays for registrants. Similarly, the Medical Director has regular liaison meetings with the GMC. The National Guardian’s Office will be disbanded in this financial year. It is unclear what provisions will be in place at this time. However, the Group Chief Executive and Executive Directors are very supportive offering opportunities for staff to raise concerns and will continue with the Freedom To Speak Up (FTSU) role across the Trust.

Freedom to Speak Up Guardians.	At the current time, it is unclear what the exact future state landscape will look like. It is planned for Health Services Safety Investigations Body (HSSIB) to move into the CQC as a discrete unit, continuing to focus on proactive and independent safety investigations. As patient safety related organisations have expanded their scope and have overlapping remits, there is the potential that at a local Trust level this has had an impact on the functions and potential overlap of different departments overseeing, progressing and reporting different requirements for external organisations. As the future landscape gains clarity, the Trust should consider undertaking a mapping exercise to ensure that the most efficient model of operation locally.
Technology and data are underused: despite the NHS being one of the most data-rich systems globally, insights and AI tools are not fully leveraged, and tech could be used better to ensure adherence to best practice and user experience.	The Trust operates with a variety of systems to manage patient records and service delivery. Where possible, all Electronic Patient Records (EPRs) are integrated to streamline information sharing and support joined-up care. In instances where full integration is not feasible, such as within ITU, outputs from systems like GPICS are captured at the point of discharge and entered into platforms like Sunrise, ensuring critical information is accessible where needed. However, some services, such as Ophthalmology, remain as silos with limited interoperability, reflecting ongoing challenges in achieving comprehensive integration. Efforts continue to address these gaps, either by expanding integration across systems or by moving towards a 'data lake' model, which would allow all relevant data to be accessible across the Trust, regardless of the originating system. This ongoing work is central to the Trust's aim of optimising digital infrastructures and realising the full potential of its data-rich environment. The vision to embrace opportunities to digitalise is one of the Trust strategic aims within the Trust strategy. The Trust has developed an innovative senior role combining the statutory duties of the Clinical Safety Officer and Chief Nursing Information Officer to support this work alongside the Chief Clinical Information Officer.
No national quality strategy for social care: no national data collection of provider level clinical social care indicators.	This is an area more work needs to be done with our Local Authority collegues so that we have meaningful access to real time data that helps our teams make joint decisions and understand what our joint problems and opportunities are to work on this. To address this gap locally, the Trust has an established governance arrangement. Weekly discussions on care quality, discharge delays, and provider issues are held through the Care Transfer Hub meeting, supporting integrated decision-making and shared accountability across health and social care. In addition, the Dudley Risk-Based Quality Meeting provides a forum for reviewing market capacity, provider risk, and emerging concerns within the independent care sector. While these forums offer valuable oversight, their impact remains constrained by the absence of a national framework or consistent data reporting mechanisms. The Trust has recently appointed an Associate Director role with a focus on discharge, strengthening links with colleagues from social care.

2.4 Recommendations of the review

The Penny Dash review highlighted 9 key recommendations as detailed in the graphic below:



Whilst these are not all directly relatable to an individual Trust, there are some areas identified for the Trust to consider:

a. Agree a set of metrics to assess quality of care and ensure appropriate governance structures.
b. Use AI as appropriate to identify poor quality care and optimise intervention.
c. Emphasise leadership, governance and performance appraisals.
d. Further embed Freedom to Speak Up Guardians.

3. RECOMMENDATIONS

3.1 The review highlights a series of risks and observations in relation to the safety landscape nationally, however there is assurance that mitigations are in place locally. In order to further mitigate any risks and continue to evolve our approaches, the following opportunities and recommendtaions have been identified:

- Greater involvement in our patient population in shaping services, with thier voice being evidenced and heard at all levels of the Trust.
- Promote opportunities to involve our patients listening to their voice through their own lived experiences.
- Strengthened focus on reducing health inequalities.
- Continue to promote and progress the Trust vision of community first model of care.
- Continue to work with regulators and partners building relationships and helping shape the future of the NHS and specifically gaps within social care.
- Develop and streamline digital solutions at pace that enable sharing of information, reduce risks and enable efficiencies.

- Embrace artificial intelligence (AI) in our work locally, building on the work undertaken by the stroke service.
- Capitalise on our collaborative working with Sandwell West Birmingham NHS Trust (SWBH) to assess quality of care, learn from each other, align our approaches and future developments. In addition, the partnership offers the opportunity for robust peer review and support.
- As the future external organisational landscape becomes clearer, the Trust should consider undertaking a mapping exercise looking at reporting, monitoring and responding to requirements to ensure that any opportunities for efficiency gains are fully realised at Trust level.

Chief Nurse and Chief Medical Officer's Office
August 2025

Paper for submission to the Public Board of Directors on 11th September 2025.

Report title:	Integrated Quality and Operational Performance Report.
Sponsoring executive / Presenter:	Martina Morris, Chief Nurse and Director of Infection Prevention and Control Jonathan Odum, Chief Medical Officer Karen Kelly, Chief Operating Officer
Report author:	Leigh Dillon, Associate Deputy Chief Nurse - Quality

1. Summary of key issues

This report summarises the Trust's Quality and Performance data for the month of July 2025 (May/ June 2025 for Cancer and VTE).

The following reports are enclosed in the Board reading room for assurance, which have been discussed in detail by the Quality Committee:

IPC BAF: The Infection Prevention & Control (IPC) Board Assurance Framework (BAF) is a tool from NHS England used to help Trusts assess the effectiveness of the arrangements and systems in place for keeping patients safe with respect to good and effective infection prevention & control. The BAF is set in the context of the 10 criteria of The Health and Social Care Act 2008: Code of Practice on the Prevention and Control of Infections and Related Guidance - The Hygiene Code (Updated 2022). The BAF helps Trusts identify gaps in assurance of good IPC practice which may require further action. The NHSE Board Assurance Framework is available at: NHS England » National infection prevention and control The Hygiene Code is available at: Health and Social Care Act 2008: code of practice on the prevention and control of infections - GOV.UK

The August 2025 assessment notes generally good assurance with the primary exception of execution and maintenance of cleaning standards. There is some ongoing concern around supervision of domestic staff and the execution of training in cleaning techniques. The Trust Facilities Contract Manager is leading a deep dive exercise into cleaning methodology, techniques and training, with a view to working with the Trust soft services contractor to help bring about sustained improvements. In addition, an external Environmental Health audit in June 2025 resulted in a 3-star rating out of 5 at the Trust. This is concerning for a hospital facility and action is being followed up by the Estates Team with a view to improving hygiene standards. The detailed report is in the reading room.

Workforce: The safer staffing report outlines the approach taken by the Trust to undertake the safer staffing review, in line with national guidance, and provides the outcome and recommendations for individual clinical areas from an establishment and skill mix perspective. Overall, the safer staffing establishments are in a positive position to provide and deliver safe, effective, high-quality care. No significant quality and safety concerns were identified by Divisional Chief Nurses based on their current establishments, although patient acuity has increasingly been challenging in some areas requiring additional temporary staff to maintain patient safety. A decision with regards to recruiting into the 15% of the 22% headroom/uplift has been made, which requires approval from the Executive team. Currently the 22% headroom/uplift is not applied to all clinical teams and is used inconsistently, which makes it challenging when aiming to drive the bank usage down. It is evident from the quantitative data that there is a disconnect between the tools recommended staffing establishments and the current funded staffing establishments, due to quantitative data collection issues. Professional Judgement has been a key guiding influence with this and the knowledge of seasonal variation

within the patient cohorts, the impact of flow and capacity challenges during the data collection month and the additional measures undertaken to support patient flow, and experience.

Recommended workforce establishment increase, supported by the Chief Nurse and approved by the Executive team subject to funding identified:

- **C3** – an uplift in Band 2 Clinical Support Worker (CSW), 24 hours per day.
- **C1a and C1b** - an uplift of 1 WTE Band 2 CSW on long day shifts.

The full report is in the reading room.

CNS Review: A Clinical Nurse Specialist (CNS) review was undertaken within the Trust using a validated tool (Cassandra Tool) which captured 70-100 hours of time for everyone. Details of work time spent on clinical interventions, administration, psychological aspects of care were recorded. A register of 112 CNSs has been generated, with a response rate of 54% of CNSs completing the data collection process. Recommendations have been formulated with 'next steps' prioritised. The data collection process will be mandated for all CNS roles in the future'.

The full report is in the reading room.

Assure

Quality:

ED Acutely Unwell Child: Performance in the care of acutely unwell children has improved through a dedicated meeting chaired by the Head of Children's Services, with input from senior MDT members. Progress is monitored via weekly assurance reports and SPC charts. Key improvements include Paediatric ED triage compliance increased from 65% to 89%**,** with no missed triages since mid-June**.** Specialty review compliance improved from 22% to 56–76% following targeted education. Sepsis response and e-observations compliance have improved across all paediatric areas. A robust paediatric clinical review of incident and deterioration (PaediCRID) monitoring and learning process is in place. The group will continue until improvements are embedded and sustained.

Infection Prevention and Control (IPC): In July, the Trust reported:

	2025/2026 Threshold	HOHA July	COHA July	Cumulative Total 25/26
CDI Toxin	72	1	4	23
E. coli	68	4	9	30
Klebsiella	19	0	1	7
Pseudomonas	12	2	1	7
MSSA	N/A	5	2	20
MRSA	0	0	0	0

In line with the Patient Safety Incident Response Framework (PSIRF), the IPC team conducts post infection reviews for all Hospital Onset Healthcare Associated (HOHA) cases to identify recurring themes and support shared learning.

Due to the Trust exceeding BSI thresholds in 2024/25, and with further threshold reductions for 2025/26, the IPC team is developing a targeted improvement plan to run alongside the existing CDI improvement plan.

Encouragingly, there has been a reduction in HOHA cases for both CDI and BSI in Q1 2025/26, with 22 cases reported compared to 44 in Q1 2024/25. A refresh of the IPC BAF has been completed and is in the reading room.

Gold Standards Framework (GSF): GSF accreditation has been successfully achieved for AMU 1 and 2, C1b, and B2 Hip**,** with re-accreditation for C7**.**

Performance:

Discharge Ready Date (DRD): In July, performance against the Discharge Ready Date (DRD) metric improved significantly, with the average days from DRD to discharge reducing to 3.63 from the 5–6-day trend seen earlier in the year. This demonstrates the impact of strengthened discharge planning and closer coordination with community partners.

Emergency Performance: In July ED 4-hour performance was at 78.40% vs the national target of 78%.

Cancer Performance: 28 Day FDS: Achieved 78% against national target of 77% (March 2026 national target is 80%). Increased focus on individual tumour site pathways to achieve monthly plans submitted to NHSE and for performance to be sustained.

DM01 Performance: DM01 for July continues to improve with performance of 88.4% compared to 87.1% in June. Backlog and number of 13+ week waits has reduced from 263 last month to 192.

Elective Restoration & Recovery: Performance against the 18-week RTT standard has shown continued improvement, with 62.9% of patients treated within 18 weeks. This position is 1.4% ahead of trajectory.

Advise

Quality:

Safer staffing: Staffing compliance and Care Hours Per Patient Day (CHPPD) were slightly lower in July compared to June. There was a minor increase in care support worker bank usage, while registered nurse bank usage remained consistent. Bank usage continues to be utilised in areas with high vacancy rates, particularly in the Emergency Department (ED) and medical emergency wards, including coverage for the Temporary Escalation Space (TES) areas and additional beds in the Acute Medical Unit (AMU). The Corporate Nursing Team has continued to provide support in line with the established rota.

As of July, 130 student nurses on placement within the Trust are due to qualify between February and September 2025. Of these, 22 have been offered positions within the Trust, while 108 students are still seeking employment. The NHS England Chief Nursing Officer (NHSE CNO) has announced a *Graduation Guarantee* for all newly qualified nurses and midwives. The Trust awaits further guidance from the Integrated Care Board (ICB) regarding a system wide implementation approach.

Pressure Ulcers (PUs): In July, there was an increase in Trust acquired pressure ulcers, with 157 incidents reported compared to 135 in June. Of these, 83 occurred in inpatient ward areas and 74 in community settings. Of the 157 incidents, 32 triggered a Serious Incident Triage (SIT) investigation. Outcomes of the investigations found 22 cases resulted in no harm and 10 in low harm. No cases were classified as moderate harm. Key themes identified include inaccurate risk assessments and delays in equipment provision. These concerns have been escalated to the supplier. A new equipment tender process is currently live, with evaluations of the top three suppliers scheduled for 19th and 20th August. The Trust continues to work collaboratively with system partners to identify and implement strategies to reduce pressure ulcer incidence.

Falls: The total number of in-patient falls decreased slightly to 88 in July compared to June. Two After Action Reviews (AAR) were conducted, with one incident resulting in moderate harm and the other in low harm. The rate of recurrent falls has remained stable.

A trolley risk assessment has been developed for implementation across Emergency Department (ED), theatres, maternity, and day case areas and is in final consultation stage.

Performance:

ED Triage: July's Overall Triage position is 81.8% vs 95% national target. Arrivals via ambulances and front triages were high, limiting the front triage performance, along with high acuity of patients.

Cancer (Data to June) 28-day FDS: Performance to be sustained. Forecast shows achievement of monthly plan from July 2025.

31 day combined & 62 day combined: Gynae and skin capacity most challenged. Extra slots have been provided for both tumour sites and shows an improved position from July onwards.

DM01: Sleep Studies equipment and additional workforce providing extra capacity. Staffing challenges in June and July have impacted recovery plan and revised trajectory will clear 6+ week backlog by October 2025.

Elective Restoration & Recovery: For 52-week waits, a revised trajectory was agreed through the annual planning process, extending delivery to the end of Q2. Corrective actions are in place to recover this position and achieve zero 52-week breaches by the end of September. There were no 65-week breaches reported in July.

Alert

Quality:

ED Sepsis: The trust has noted a downward trend in sepsis compliance within the Emergency Department (ED). The department have identified several contributing factors impacting on their ability to deliver consistent, high quality sepsis care. The ED Sepsis Lead (Deputy Matron) has worked all but one shift in the last month as nurse in charge due to ongoing staffing challenges. This has significantly reduced their ability to undertake an oversight role, managing departmental operations, monitoring sepsis triggers, and providing ad hoc teaching and support at the point of patient triage. The additional areas open within the department are often staffed by other areas who may not be familiar with sepsis management. This inconsistency impacts the timely recognition and management of sepsis. The department has been increasingly dependent on bank staff, with poor fill rates leading to staffing shortfalls. There has been a noticeable rise in the number of patients triggering for sepsis, alongside a general increase in patient acuity, placing further pressure on available staff.

Despite the current challenges, the department remain fully committed to improving sepsis compliance to ensure the best outcomes for patients and maintain high clinical standards within the department. The department aim to meet to formulate a targeted action plan, drawing from the weekly Paediatrics Assurance Report submitted to the Divisional TRI. This will provide regular oversight and accountability. Utilisation of the AQUA data, provided by the Deteriorating Patient Lead, to inform actions based on specific areas of low compliance, this will enable data driven, focused improvements. The ED Sepsis Lead will attend the DPG meeting monthly, accompanied by a member of the nursing team. This will enhance shared learning, increase understanding of sepsis related harm, and build team wide ownership of compliance targets.

Temporary Escalation Space (TES) Incidents: The number of incidents related to Temporary Escalation Space (TES) areas being opened increased in July to 26, up from 21 in June. This continues the upward trend in TES use reporting observed since January 2025. In July, 53.8% of incidents were associated with site wide TES spaces and 46.2% occurred in the Emergency Department (ED). The increased usage of TES and ED corridor spaces is primarily due to

reduced patient discharges at the divisional level, leading to limited patient flow from ED and challenges in meeting West Midlands Ambulance Service (WMAS) offload targets. The discharge lounge was closed as an inpatient area on 8th August and now resumes as originally intended. Further extensive work remains on eliminating the use of TES areas. Notably, there has been improved compliance in the completion and updating of TES risk assessments on Datix. Additionally, AMaT audits for TES areas designed to monitor quality and safety went live on 1st July.

VTE: Initial VTE screening compliance remains compliant; however, there is low compliance with second assessments. A meeting is being scheduled to review recent VTE incidents and to ensure that meaningful and impactful actions are implemented to improve second assessment adherence.

Performance:

Discharge Ready Date: An organisational decision is required regarding the longer-term future of the Pathway 1 bridging model. While the initiative has delivered clear benefits in supporting timely discharge and maintaining flow, the associated costs present a material financial risk if continued without wider system support.

2. Alignment to our Vision	
Patients: Deliver right care, in the right place, at the right time	**X**
People: Be a brilliant place to work and thrive	**X**
Place: Build innovative partnerships to improve the health of our communities	**X**

3. Report journey
Quality Committee – 26th August 2025 Public Board – 11th September 2025

4. Recommendation(s)
The Public Trust Board is asked to
a) Note and discuss contents of this report and gain assurance on oversight of quality, safety and operational performance.

5. Impact reflected in our Board Assurance Framework (BAF)		
BAF Risk 1.0	x	Failure to deliver the right care, in the right place every time
BAF Risk 2.0	x	Failure to ensure Dudley is a brilliant place to work and thrive
BAF Risk 3.0	x	Failure to build innovative partnerships to improve the health of our communities
BAF Risk 4.0	x	Failure to remain financially sustainable in 2025/26 and beyond
BAF Risk 5.0	x	Failure to achieve operational performance requirements & deliver strategic objectives
BAF Risk 6.0	x	Failure to take sustained action on infrastructures that enables strategic objectives
Is Quality Impact Assessment required if so, add date: N/A		
Is Equality Impact Assessment required if so, add date: N/A		

Paper for submission to Board of Directors 11th September 2025

Report title:	Perinatal Quality Surveillance Report - Maternity Report
Sponsoring executive / Presenter:	Martina Morris - Chief Nurse, Board Level Maternity and Neonatal Safety Champion
Report author:	Claire Macdiarmid - Director of Midwifery

1. Summary of key issues

Assure

On July 17th the UNICEF Baby Friendly (BFI) initiative team visited the Maternity Unit to reassess the service under the BFI Standards. We received very positive feedback from the assessment team on the day and passed just over 50% of the elements. This means the Trust accreditation for BFI status remains. There will be a period of time where the BFI team will work with the Trust to ensure the other 50% of elements are in an improving state and will be achieved. There was very positive feedback about the positive culture and kindness of staff.

The report contains current compliance with MIS year 7. There are no safety actions (SAs) in a red position. Green actions highlight those that are complete but have not been heard or discussed at all required meetings or committees**. All 10 Safety actions are on a trajectory to be fully compliant by the end of the reporting period (30th November 2025).**

Appendix 2 outlines current position across Maternity and Neonatal services at The Dudley Group NHSFT in relation to the letter received from NHSE in June 2025, outlining the intention for a national rapid independent review into Maternity and Neonatal services. A further update will be provided once instruction/information has been received from the national teams with next steps.

Advise

The Dudley Group NHSFT is scoring 26 and has returned to a GREEN rating for August 2025 on the Maternity Regional heatmap. An outline of the red scores is highlighted within the report. Scores will begin to further decrease when new recruits commence in Midwifery Support Worker and Registered Midwifery posts. Results are expected to be published from the latest CQC Maternity survey during November 2025 which indicate a further improvement.

There was one new case referred to and accepted by the Maternity and Newborn Investigations (MNSI) during June and July 2025 by the Trust.

There have been no new internal incident responses commenced during June and July 2025.

There have been two Patient Safety Incident Investigations concluded during June and July 2025.

Initial touchpoint meeting for Saving Babies Lives V 3.2 scored the Trust as 96% compliant. Actions are ongoing to gain full compliance in the final required elements.

Alert

Stillbirth rates at DGFT increased to 3.48 per 1,000 births in July. This follows an upward trend observed over the past quarter, with rates of 3.0 in June, 2.99 in May, and 2.73 in April. The national rate stands at 3.22 (MBRRACE, 2025 State of Nation report, 2023 data). The recent rise relates to four stillbirths occurring in June and July, with no reduction in numbers over the previous rolling 12 months. An outline of the cases was discussed at Quality Committee and Mortality surveillance Group. All cases are being reviewed through governance processes and PMRT, and families' views sought as part of the process.

The requirements of MIS Year 7, SA7 outlines that Terms of Reference of attendance at a number of specific meetings, must show that the Maternity and Neonatal Voices Partnership (MNVP) lead

is a quorate member. The Trust has identified that whilst the MNVP have been invited to these meetings and feature in the terms of reference, they do not currently have capacity to attend all meetings. The technical detail of the SA does specify that as long as this escalation occurs to the Trust Board, and the Integrated Care Board, they remain compliant with the scheme. This escalation has been discussed at length at the Quality Committee and Local Maternity and Neonatal System (LMNS).

The appendices to accompany the full report are located in the reading room.

2. Alignment to our Vision	
Patients: Deliver right care, in the right place, at the right time	x
People: Be a brilliant place to work and thrive	x
Place: Build innovative partnerships to improve the health of our communities	x

3. Report journey
Quality Committee – August 2025.

4. Recommendation(s)
The Public Board is asked to:
a) **Accept** this paper as assurance against the requirements of SBL V 3.2 and MIS year 7.

5. Impact reflected in our Board Assurance Framework (BAF)		
BAF Risk 1.0	x	Failure to deliver the right care, in the right place every time
BAF Risk 2.0		Failure to ensure Dudley is a brilliant place to work and thrive
BAF Risk 3.0		Failure to build innovative partnerships to improve the health of our communities
BAF Risk 4.0		Failure to remain financially sustainable in 2025/26 and beyond
BAF Risk 5.0		Failure to achieve operational performance requirements & deliver strategic objectives
BAF Risk 6.0		Failure to take sustained action on infrastructures that enables strategic objectives
Is Quality Impact Assessment required if so, add date: n/a		
Is Equality Impact Assessment required if so, add date: n/a		

REPORT FOR ASSURANCE

Perinatal Quality Surveillance Model

Paper for submission to the Public Board of Directors 11th September 2025

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 July 2025**.** Please note that the PQSM is due to be revised during 2025 to the Perinatal Quality Oversight Model (PQOM). Further guidance is awaited from NHSE/NHSR on this change.

2. BACKGROUND INFORMATION

2.1 Perinatal Surveillance Dashboard

The dashboard is presented on the next page.

Perinatal Surveillence Dashboard

The data should be viewed in conjunction with the Maternity Dashboard and the Director 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	2024	2024	2024	2024	2024	2025	2025	2025	2025	2025	2025	2025
		Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	March	April	May	June	July
	MNSI open action plans													
PSIRF	The number of incidents logged as moderate or above:	0	1	1	1	0	0	0	1	1	1	0	0	s
	PSII Reported	0	1	0	1	0	0	0	1	1	0	1	0	0
	PSII Completed	0	0	0	0	1	3	1	0	0	0	0	1	1
	PSII Ongoing	4	5	5	6	5	2	1	2	3	3	4	3	2
	Oustanding Investigation Actions - overdue													
	Oustanding Investigation Actions - open													
	Maternity Incidents Improvement Plan - overdue actions	10	13	18	19	13	17	13	12	15	14	13	9	8
	Maternity Incidents Improvement Plan - open actions	18	28	24	23	17	31	24	21	18	17	14	10	15
Clinical Outcome measures	Stillbirth rate (National crude rate 3.22 per 1000 births) (National rates amended to reflect the 11th MBRRACE-UK Perinatal Mortality Surveillance Report)	2.63	2.39	1.92	1.92	2.68	2.92	3.17	3.19	2.46	2.73	2.99	3	3.48
	Neonatal Death Rate 1.63 (> 22+0 - up to 28 days post delivery)	1.68	1.2	1.2	0.72	0.73	0.73	0.49	0.49	0.49	0.24	0.25	0.25	0.25
	Neonatal death rate only including babies born over 24/40	0.96	0.72	0.72	0.24	0.24	0.24	0.24	0.24	0.24	0.24	0.25	0.25	0.25
	Total Perinatal Mortality Rate (MBRRACE figure 4.84 per 1000 births)	4.3	3.52	3.13	2.64	3.68	3.65	3.65	3.69	2.95	2.98	3.24	3.24	3.73
	Avoidable term admission to NNU (reported quarterly)		3			5			2					
Appraisals	All Maternity staff (90%) (Apraisal window April-July)	94.30%	94.30%									90% 2/6/25	92%	96.40%
Midwifery Training	Fetal Monitoring Training (90%)*	98%	98%	99%	99%%	100%	98%	99.00%	97%	98%	99%	98%	98%	97%
	Obstetric Emergency Simulation Training (PROMPT) (90%)*	99%	97%	99%	100%%	100%	98%	98.00%	99%	99%	99%	100%	100%	99%
	Safeguarding (level 3) Adult (90%) (Database not accurate)	85%	90%	90%	91%	87%	91%	92.00%	84%	91%	86%	84%	95%	92%
	Safeguarding (level 3) Children (90%)	90%	94%	95%	88%	86%	89%	80.00%	78%	83%	80%	66%	85%	89%
	Neonatal Resusitation (90-95%)*	88%	90%	90%	90%	92%	94%	96.00%	94%	95%	92%	82%	88%	90%
	Adult Resusitation (90 - 95%)*	90%	91%	92%	91%	92%	93%	92.00%	92%	92%	89%	88%	92%	92%
Obstetrics Training	Fetal Monitoring Training (90%)*	98%	97%	97%	97%	100%	100%	100.00%	98%	100%	100%	97%	100%	97%
	Obstetric Emergency Simulation Training (PROMPT) (90%)*	98%	97%	97%	98%	98%	100%	98.00%	97%	98%	100%	98%	100%	98%
	Safeguarding (level 3) Adult (90%)	93%	94%	100%	100%	80%	100%	100.00%	100%	100%	100%	94%	100%	100%
	Safeguarding (level 3) Children (90%)	80%	86%	66%	73%	82%	89%	85.00%	66%	70%	79%	58%	71%	69%
	Neonatal Resusitation (90-95%)*	90%	92%	90%	97%	90%	96%	90.00%	90%	97%	92%	76%	93%	84%
	Adult Resusitation (90 - 95%)*	90%	91%	90%	97%	95%	95%	90.00%	90%	92%	89%	87%	86%	84%
Safe staffing	Obstetric consultant cover on delivery suite	91	91	91	91	91	91	91	91	91	91	91	91	91
	Vacancies midwifery (WTE)	0	0	0	0	0	4	9	9	12	13	14	14	14
	Obstetric Consultant vacancies (WTE)	0	0	0	0	0	0.4	0.4	0.4	0.4	0.4	0.4	0.8	0.8
	Total Red flag data: Total number of red flags (As per acuity tool)	8	2	6	4	3	3	7	2	7	7	14	7	1
	Shift Leader supernumuary at start of shift : % of time	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
	1:1 care in labour achieved	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
	Birth Before Arrival (BBA)	4 (1unbooked	1	2	1	3	2	2	0	1	3	2	0	2

Service user feedback	MVP (Quarterly)	.	.	16.09.24	.	.	17.12.24	.	.	18.03.25	.	.		31.07.25
	MNVP Extraordinary meetings* Bereavement / Neonatal / EDI	Nil	Nil	Nil	Nil	Nil	Nil	Nil	Nil	Nil	Nil	20/05/25 15 steps	Nil	Nil
Engagement	Response Rate (%)	19%	12%	26%	11%	9%	12%	14%	13%	15%	21%	17%	20%	13%
	Recommendation Response Rate (Good/ Very Good %)	88%	84%	83%	76%	76%	84%	85%	90%	75%	88%	79%	89%	88%
	PALS	5	7	8	1	6	1	5	9	6	7	4	4	8
	Complaints	4	1	7	5	5	7	4	5	4	4	7	6	6
	Compliments	59	65	65	62	72	80	58	77	64	70	76	68	65
Safety Champion	Maternity Safety champions walk- about	24.7.24		25.9.24		04.11.2024		21.01.25	06.02.25	26.03.25		28/5/25		30/07/25
	Maternity and Neonatal Safety Champion Meeting		28.8.24		30.10.24		18.12.24			31.03.25			5/6/2025	16/07/25
	Perinatal Assurance meeting (previously Maternity Quad / MIS)	01.07.24	28.08.24			04.11.24		06.01.25			25/04/25	5/5/2025 Rearranged		21/07/25
External	MNSI/NHSR/CQC or other organisation with a concern or request for action made directly with the trust	0	0	0	0	0	0	0	0	0	0	0	0	0
Legal	New Legal cases (Maternity only- Including Coroners cases and ENS claims)	0	0	1	1	0	0	2	0	1	1	0	1	1
	Ongoing Claims Cases							17	17	17	18	18	18	
	Ongoing Early Notification Scheme Cases							4	4	4	5	5	5	

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

*Safeguarding children level 3, Neonatal resuscitation and Adult resuscitation are currently below the required 90% compliance in the obstetric training report. The team are working with staff to ensure this is completed urgently.

Safeguarding children level 3 for Midwives is now in an improved position at 89%.

2.2 Midlands Perinatal Heatmap

Appendix 1 demonstrates current position on the Midlands regional heatmap for July 2025. DGFT is in a green position with a score of 26. Points rated as red are collated as follows:

	Score	RAG rating
CQC Maternity survey	4	
MSW Vacancy	4	
Neonatal death rate	5	MBRRACE 2023 data
Perinatal death rate	5	MBRRACE 2023 data

Updated (2025) CQC survey results will be published during November 2025.

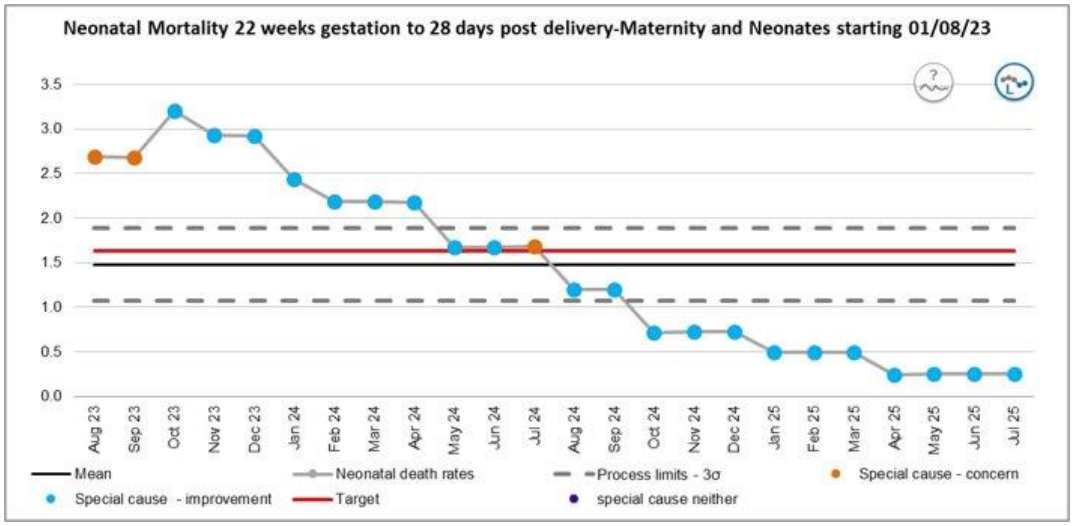
Midwifery support worker vacancy is now fully recruited to, and the start dates are awaited for all successful candidates.

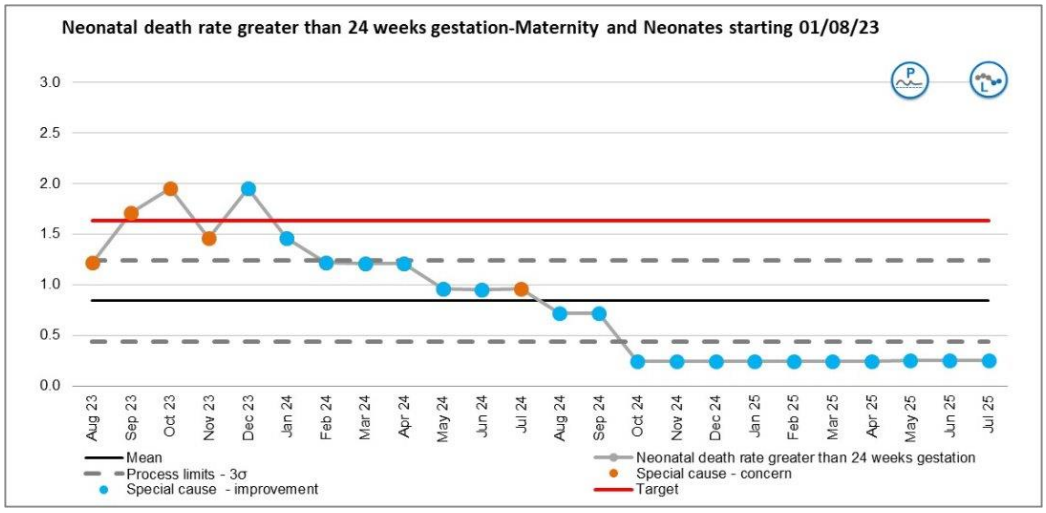
The Head of Midwifery post is now operational therefore points have now been removed.

Published Mortality data is only refreshed once per year, therefore these scores will remain until early 2026.

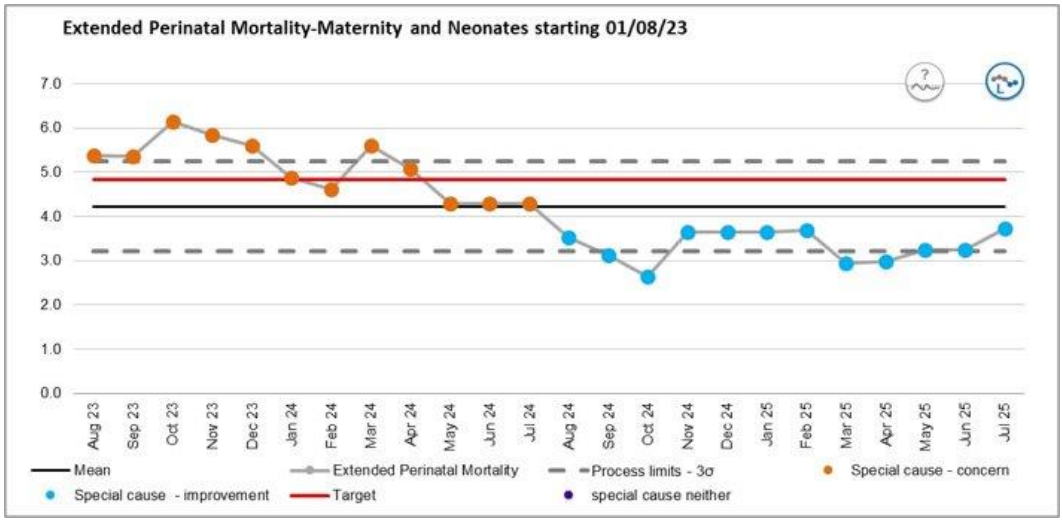
2.3 Perinatal Mortality data

Neonatal mortality rates

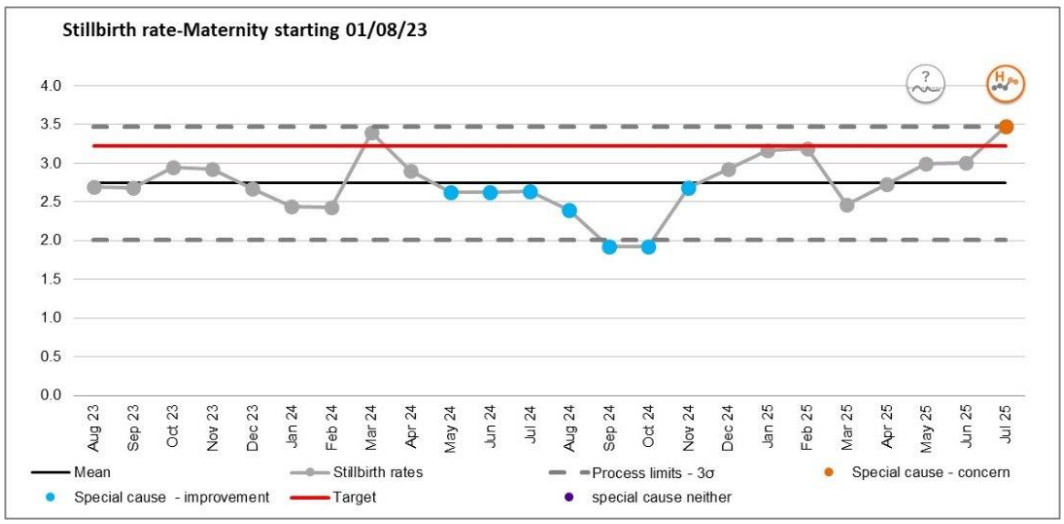




Extended Perinatal Mortality rates



Stillbirth rates



Stillbirth rates at DGFT increased to 3.48 per 1,000 births in July. This follows an upward trend observed over the past quarter, with rates of 3.0 in June, 2.99 in May, and 2.73 in

April. The national rate stands at 3.22 (MBRRACE, 2025 State of Nation report, 2023 data). The recent rise relates to four stillbirths occurring in June and July, with no reduction in numbers over the previous rolling 12 months.

The Trust continues to closely monitor these figures through routine investigation processes, including 72-hour MDT reviews and the national perinatal mortality review tool (PMRT). Initial further analysis to understand themes shows no clear patterns amongst the cases, except for the gestation of pregnancy at which the women received their first USS. 3 out of the 4 cases were classed as 'late bookers' but in each case the reason for this was because the women had miscalculated pregnancy dates, at the initial appointment with the midwife based on her last menstrual period (LMP).

2.4 Patient Safety Incident Investigations and Maternity and Newborn Safety Investigations

There was **1** new case referred to and accepted by the Maternity and Newborn Investigations (MNSI) during June and July 2025 by the Trust.

There have been **0** new internal incident responses commenced during June and July 2025.

There have been **2** Patient Safety Incident Investigations concluded during June and July 2025.

INC158471 – Following an induction of labour and during intrapartum care a patient's CTG monitoring showed signs of fetal distress requiring emergency caesarean section. At this point it was recognised that the patient's platelets were low (throughout pregnancy) meaning she was not suitable for spinal anaesthesia and general anaesthetic was required. Following the delivery of the baby, the patient experienced complications with extubating which led to an admission to ITU.

Areas for improvement were identified as follows:

- Ensure timely follow up of results from tests/ investigations
- Change in practice regarding review of pregnancy booking bloods
- Clear referral pathways for low platelets at varying levels

INC166136 - A patient, at high risk of preterm birth, was planned to be monitored through cervical length scans. The first cervical length scan was performed at 20 weeks (rather than 16 weeks) and shortening and funnelling of the cervix were identified. Initially, a cervical cerclage was planned. Following counselling the patient opted for progesterone pessaries and was discharged, however in the following week opted for cerclage. This was delayed due to emergencies on the Maternity Unit, and she continued with progesterone in the meantime. The cervical cerclage was performed at 23 weeks and she was found to be 1cm dilated. She subsequently presented to Maternity Triage; first with mucous loss and bleeding and no active labour and later presented in preterm labour. She was transferred to a level 3 unit and her baby was born extremely premature and sadly passed away.

Areas for improvement were identified as follows:

- To ensure that there is consistent and appropriate senior oversight of the preterm prevention pathway/ clinic.
- To ensure that patients with cervical shortening are provided with appropriate information to make an informed decision about their care and treatment.
- To ensure that there is a clear pathway for patients requiring or opting for cervical cerclage to avoid delays and further distress.
- To review local guidance regarding cervical cerclage and progesterone and current evidence available, including progesterone as prevention (from 16 weeks).

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 June or July 2025.

2.6 Baby friendly Initiative reaccreditation

The UNICEF UK Baby Friendly initiative (BFI) is a structured programme to implement evidence-based standards to support families in building close and loving relationships with their babies, to encourage and support families to feed their babies in ways that support optimal health and development, and to improve the quality of care given by healthcare providers. Guidelines are in place to underpin care. Dudley Group has been accredited with BFI for Maternity for a number of years and are the only Black Country Trust to achieve this.

There are 5 maternity standards that we aim to achieve:

- Pregnant women are prepared
- Closeness, skin-to-skin and feeding straight after birth
- Breastfeeding off to a good start
- Informed decisions about other food for babies
- Close and loving relationships

On July 17th the BFI team visited the Maternity Unit to reassess the service under the BFI Standards. We received very positive feedback from the assessment team on the day and passed just over 50% of the elements. This means the Trust accreditation for BFI status remains. There will be a period of time where the BFI team will work with the Trust to ensure the other 50% of elements are in an improving state and will be achieved. There was very positive feedback about the positive culture and kindness of staff.

The findings from the visit will now be heard at the BFI Designation Committee and a final report will then be sent to the Trust, and a time frame set to achieve the required actions. Huge well done to the Infant feeding team, for their hard work in maintaining the accreditation. The teams will be supported to implement the required changes to ensure full compliance is met within the timescales specified.

2.7 Maternity Incentive scheme (MIS) Year 7

Progress Update

Safety Action	Red	Amber	Green	Blue	Total Requirements
1	0	7	0	0	7
2	0	2	0	0	2
3	0	4	2	0	6
4	0	19	0	0	19
5	0	1	0	11	12
6	0	8	1	0	9
7	0	3	1	0	4
8	0	21	0	0	21
9	0	9	0	0	9
10	0	9	0	0	9
Total	0	83	4	11	98

Key:

Red	Not compliant
Amber	Partial compliance - work underway
Green	Full compliance - evidence not yet reviewed
Blue	Full compliance - final evidence reviewed

The table above highlights current progress with MIS year 7. There are no safety actions (SAs) in a red position. Green actions highlight actions that are complete but not been heard or discussed at all required meetings or committees.

All Safety actions are on trajectory to be fully compliant by the end of the reporting period (30th November 2025).

Safety action 7

The requirements of MIS Year 7, SA7 outlines that Terms of reference of attendance at a number of specific meetings, must show that the Maternity and Neonatal Voices Partnership (MNVP) lead is a quorate member. The trust has identified that whilst the MNVP have been invited to these meetings and feature in the terms of reference, they do not currently have capacity to attend all meetings. The technical detail of the SA does specify that as long as this escalation occurs to the Trust Board, and the ICB, they can remain compliant with the scheme. This escalation has been discussed at length at the Quality committee and LMNS.

2.8 Neonatal staffing against BAPM requirements

As per Safety action 4 of the Maternity Incentive Scheme year 7, there is a requirement that Neonatal Units meet the BAPM neonatal nursing standards. If standards cannot be met, there must be an action plan in place which is shared with Trust Boards, LMNS and Neonatal ODN. The latest Neonatal staffing stock take and associated action plan with rectification plans, for the trust show one action outstanding relating to number of Qualified in speciality (QIS) nurse numbers. This action is due to be completed by July 2026. This action plan has been shared and discussed with the Quality Committee.

Neonatal Medical Workforce have confirmed they are fully compliant as per The British Association of Perinatal Medicine (BAPM) Service provision of Neonatal Care in the UK-2022. The Board is to note this confirmation.

2.9 CQC Maternity Survey Feedback

Safety Action 7 - CQC Maternity Survey feedback was discussed with service users and members of the Maternity and Neonatal voices partnership on the 31/7/25 – There were 5 service users inputting into the conversation on that day. The action plan has been developed, is currently with the MNVP and families for final sign off and will be presented to a future committee for information. Results are expected to be published from the latest CQC Maternity survey during November 2025 which indicate a further improvement.

2.10 Saving Babies Lives Version 3.2 update

The Saving Babies Lives Care Bundle Version 3.2 was released in April 2025.

The implementation of this care bundle is the responsibility of the NHS Trust. Improvement trajectories, alongside overseeing, supporting and challenging local delivery is the joint responsibility of the Integrated Care Boards (ICBs) / Local Maternity and Neonatal System (LMNS).

The first touchpoint within the compliance period occurred 5th August 2025 with the LMNS, there was a delay from the previously arranged date in July 25 due to the publication of SBLCBv3.2 and subsequent Audit tool.

We declared 97% compliance. Email verified compliance of 96% following touchpoint.

Touchpoint 2 has been arranged for 21st October 2025 with an evidence submission date of 1st October 2025.

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)
Element 1	Smoking in pregnancy	Fully implemented	100%		0%
Element 2	Fetal growth restriction	Partially implemented	95%		0%
Element 3	Reduced fetal movements	Fully implemented	100%		0%
Element 4	Fetal monitoring in labour	Fully implemented	100%		0%
Element 5	Preterm birth	Fully implemented	100%		0%
Element 6	Diabetes	Partially implemented	83%		0%
All Elements	TOTAL	Partially implemented	97%		0%

Elements required for board confirmation and inclusion in Board minutes include:

- Board confirmation of fetal monitoring Lead Midwife 0.4WTE Beth McQueen-Pullen and Fetal Monitoring Lead Obstetrician 0.1WTE Miss Syeda have been appointed and are in post.
- Board confirmation Appointed leads of Preterm Obstetrics – Consultant Obstetrician Imran, Consultant Midwife Aqeela Hamilton, Neonatal Nursing ANNP Lisa Gough and Neonatal Medic Lead Dr Nicola Ruth are all substantively in post.

- Board confirmation of protocol Type 1Diabetes Mellitus pregnant Hybrid Closed Loop (HCL).
- Each maternity service specifies a named lead for implementation HCL to T1D in pregnancy, for The Dudley Group NHS Foundation Trust is Dr A Solomon.
- At least one named HCL Diabetes Consultant (Dr A Solomon) and one named HCL DM specialist RN (Jodie Hill) within ANC in each maternity service. The above are competent for onboarding and management of women using a pregnancy specific HCL. The last company representative training session in trust was 2/7/25 Plans are in place to ensure that relevant members of the DM ANC MDT are competent for onboarding and management of women using a pregnancy specific HCL.

The above is documented within the Diabetes in Pregnancy updated guideline that is due to be ratified in August due to a cancelled Maternity Governance meeting in August.

2.11 Maternity Safety Champions (MSC)

Feedback following a very positive walkaround 30/7/2025 from Chief Nurse Martina Morris (MM), Non-executive Director for maternity, Professor Liz Hughes (LH) and Interim Medical Director, Dr Jonathan Odum (JO).

- LH and MM spoke to two ladies who were happy with the care and gave positive comments about the food.
- One lady raised a concern re communication between Doctors and Midwives in terms of her care plan, she shared that she had waited several hours to be moved to an induction bed. MM discussed this with the Midwife who was caring for her, who promptly went to re-explain the plan of care to reduce anxiety.
- All areas visibly clean, reminder to book resuscitaires in for annual PAT test, due August (reference to learning from last year).
- Obstetric theatres posters need to be laminated and ICPC compliant.
- CCTV and Emergency Call Bells now in place within triage waiting room, with monitors visible in Triage and Delivery suite staff areas. Action complete following LMNS/Regional visit in April 2025.
- LH and MM had conversation with Holly Haden regarding the service she provides, continuing to be a real inspiration to us all.

Thanks were received from JO for the time spent showing him the Maternity and Neonatal unit. Praise for the commitment of the team to ensuring high quality service provisions and reassuring quality metrics. Plans for a follow up visit are to be arranged.

A **MSC Speak up session** was held on the 1st September 2025, face to face and via teams. Attended by Chief Nurse, Martina Morris, Interim Medical Director Jonathon Odum and Non-executive Director Liz Hughes. There were no escalations made from staff during this visit.

Perinatal Assurance Group
Perinatal assurance group met on the 21st July 2025, including the perinatal quad, the Board level safety champions, and non-executive director for maternity services. Minutes and action log are awaited, there were no escalations or concerns from the QUAD team to the Safety champions.

2.12 Maternity Triage update

The Quality Committee was presented with the data from Q1 audit report of maternity Triage, women being triaged within 15 minutes of arrival. National targets for this audit are 80%, however we have set a local ambition of 90%. Whilst targets are met robustly for initial triage times, there is a concern that there are increasing numbers of incorrect colour categorisations. Whilst this is often an over scoring of the complaint, the errors do require further scrutiny. The team have been asked to pull and report on this this data on a monthly basis for the next 3 months to allow closer analysis and to ensure the training and raised awareness of triage processes, are working. Data will be monitored through Maternity Governance Group and Maternity Safety Champions.

2.13 Response to the rapid Maternity and Neonatal review announcement by the Secretary of State for Health and Social Care and ask of Trust boards.

On the 23rd of June 2025, Sir Jim Mackey, Chief Executive of NHS England and Duncan Burton, Chief Nursing Officer for England, wrote to all Trust Chief Executives and informed them that there would be a rapid independent review into Maternity and Neonatal services nationally. They outlined that this would be undertaken between June and December 2025, and 10 NHS trusts would be selected for this investigation. These trusts are yet to be announced. In addition, alongside this, an independent Taskforce would be set up, led by the SoS H&SC to oversee actions required.

Appendix 2 outlines current position across Maternity and Neonatal services at The Dudley Group NHS Foundation Trust (DGFT). A further update will be provided once instruction/information has been received from the national teams with next steps.

Evidence to support initial assessment outlined in this paper is available in the monthly Perinatal Quality Report and a plethora of other resources such as MIS scheme evidence, 3-year delivery plan evidence.

2.14 Service user feedback

2.14.1 Friends and Family feedback

As I was in theatre for an emergency c section, all the staff were absolutely amazing. They all cared for me and went above and beyond. I cannot thank the surgeon. Alex enough! She truly made me feel relaxed and comfortable throughout the whole procedure.
The postnatal ward is just the same! they constantly checked in on me and answered any/all my questions I had. I breastfed for the first time and they were very supportive helping me! yet again, above and beyond.

Spent 4 days in HDU and all of the staff were amazing, despite being so poorly I would not have gotten through it without thew support of the midwives.

Lovely sonographer Sarah who was kind and talked me through everything. Staff on reception helpful and friendly.

I had to go away and think about the vaccine due to all the information given at 28 weeks however at 32 weeks I have decided to have this vaccine and again the staff went through everything so well at my visit.

Wait times, every time we have come to see a consultant the wait has been 1.5 hour and very poor treatment.

Heat as there was no air con at first but then it was sorted.

3. RECOMMENDATIONS

3.1 The Board is invited to accept the paper as assurance against the national requirements of Ockenden 2022, Maternity incentive scheme year 7 and Saving babies Lives version 3.2.

Name of Author: Claire Macdiarmid
Title of Author: Interim Group Director of Midwifery

Date: 1st September 2025

Paper for submission to the Board of Directors on 11th September 2025

Report title:	Learning from Deaths (Mortality Report)
Sponsoring executive / Presenter:	Dr Jonathan Odum, Interim Medical Director
Report author:	Dr P Brammer and Nuala Hadley

1. Summary of key issues

The Board of Directors is advised that the Learning from Deaths Report has been considered at the Quality Committee with appropriate scrutiny and challenge.

Assure

- Sustained improvement of perinatal/paediatric mortality
- Summarised Hospital Level Mortality Indicator and Hospital Standardised Mortality Ratio (SHMI/HSMR) remain stable and within expected range
- Structured Judgement Reviews providing assurance of good care for the trust

Advise

- CUSUM (Cumulative Sum control chart) alerts are early warning triggers, 4 alerts – 1 SHMI and 3 HSMR
- The Trust may observe some instability in the SHMI when Emergency Care Data Set (ECDS) coding is implemented.

Alert

- Fast track discharge on Risk Register

2. Alignment to our Vision

Patients: Deliver right care, in the right place, at the right time	**x**
People: Be a brilliant place to work and thrive	**x**
Place: Build innovative partnerships to improve the health of our communities	**x**

3. Report journey

Mortality Surveillance Group
Quality Committee

4. Recommendation

The Public Trust Board is asked to:

a) Be **assured** that mortality continues to improve and is within the expected levels

5. Impact reflected in our Board Assurance Framework (BAF)

BAF Risk 1.0		Failure to deliver the right care, in the right place every time
BAF Risk 2.0		Failure to ensure Dudley is a brilliant place to work and thrive
BAF Risk 3.0		Failure to build innovative partnerships to improve the health of our communities
BAF Risk 4.0		Failure to remain financially sustainable in 2025/26 and beyond
BAF Risk 5.0		Failure to achieve operational performance requirements & deliver strategic objectives
BAF Risk 6.0		Failure to take sustained action on infrastructures that enables strategic objectives
Is Quality Impact Assessment required if so, add date: No		
Is Equality Impact Assessment required if so, add date: No		

1. EXECUTIVE SUMMARY

The Board of Directors is advised that the Learning from Deaths Report has been considered at the Quality Committee with appropriate scrutiny and challenge.

SHMI is currently 98.29 and HSMR is currently 88.15. Both are now within the expected range, with HSMR as a positive outlier.

The work within the surgical division related to fractured neck of femur is ongoing and we continue to pursue sustained improvements through quality improvement work. Both Stroke and Fractured Neck of Femur are showing a decrease in SHMI with Stroke now at 98.97 and #NoF at 98.

Continued stability in perinatal mortality demonstrates that the work completed following the thematic review is fully embedded within the trust.

The Medical Examiner Service continues to be the largest source of referrals for Structured Judgement Review (SJR). Completed SJRs show a good quality of care and low level of avoidability. The Dudley Medical Examiner service is fully operational and all deaths within the Dudley Borough are undergoing a proportionate review each month.

The full report is located in the reading room associated with this meeting.

The Executive is asked to note the decreasing trend in SHMI and HSMR. It is likely that the improvement in HSMR / SHMI reflect an improvement in the denominator as well as quality of care and provides assurance in relation to previous alerts. Positive assurance related to quality of care includes SJRs output and falling HSMR with no weekend effect.

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

Nuala Hadley and Dr P Brammer on behalf of Dr J Odum
27/08/2025

Our Patients
Our People
Our Place

Enclosure 11

The Dudley Group NHS Foundation Trust

Paper for submission to the Board on 11th September 2025

Report title:	Winter Plan Board Assurance Document
Sponsoring executive / Presenter:	Karen Kelly, Chief Operating Officer and Deputy Chief Executive
Report author:	Jack Richards, Deputy Chief Operating Officer

1. Summary of key issues

Assure

In line with the NHS England Urgent and Emergency Care Plan 2025-6 the Trust has prepared the winter plan according to the key deliverables highlighted. The full winter plan is included within the reading room and included here is the document to be completed confirming board assurance for return to NHS England.

The plan has followed the internal Trust governance processes and has been previously presented at Public Board in July 2025 and to Finance and Productivity Committee in both June and July 2025. The full winter plan document is included in the reading room.

The document demonstrates that all of the assurance requirements have been met within the plan, although the Black Country system stress testing is due to take place on the 10th September with the NHSE regionally led stress testing to take place on September 17th. For this reason there may be alterations to the plan based on the findings of these events that occurs post presentation to the Board.

Advise

The Winter Plan is to remain a 'live' document with modifications made in response to any unexpected variation to the activity that has been planned for.

Alert

There are likely to be outputs from both the stress testing that is due to take place later in September and also from the findings of the work with the delivery partner, Newton. Any developments will be added to the plan and updates provided to both Quality Committee and Finance and Productivity Committee.

2. Alignment to our Vision

Patients: Deliver right care, in the right place, at the right time	**X**
People: Be a brilliant place to work and thrive	**X**
Place: Build innovative partnerships to improve the health of our communities	**X**

3. Report journey

The Board Assurance Document is being presented on 11th September for the first time.
The Winter Plan has been presented at Public Board on 10th July 2025. Finance and Productivity Committee on 26th June 2025 and 31st July 2025. All comments from these meetings have been incorporated into the plan. The plan has also been presented at ICB level with positive assurance recorded.

4. Recommendations
The Board of Directors is asked to
a) **Approve** the assurance statement for submission to NHSE
b) **Acknowledge** the work undertaken to date on the winter plan for this year

5. Impact reflected in our Board Assurance Framework (BAF)		
BAF Risk 1.0	X	Failure to deliver the right care, in the right place every time
BAF Risk 2.0	X	Failure to ensure Dudley is a brilliant place to work and thrive
BAF Risk 3.0	X	Failure to build innovative partnerships to improve the health of our communities
BAF Risk 4.0	X	Failure to remain financially sustainable in 2025/26 and beyond
BAF Risk 5.0	X	Failure to achieve operational performance requirements & deliver strategic objectives
BAF Risk 6.0		Failure to take sustained action on infrastructures that enables strategic objectives
Is Quality Impact Assessment required if so, add date:		
Is Equality Impact Assessment required if so, add date:		

Winter Planning 25/26

Board Assurance Statement (BAS)

NHS Trust

Introduction

1. Purpose

The purpose of the Board Assurance Statement is to ensure the Trust's Board has oversight that all key considerations have been met. It should be signed off by both the CEO and Chair.

2. Guidance on completing the Board Assurance Statement (BAS)

Section A: Board Assurance Statement

Please double-click on the template header and add the Trust's name.

This section gives Trusts the opportunity to describe the approach to creating the winter plan, and demonstrate how links with other aspects of planning have been considered.

Section B: 25/26 Winter Plan checklist

This section provides a checklist on what Boards should assure themselves is covered by 25/26 Winter Plans.

3. Submission process and contacts

Completed Board Assurance Statements should be submitted to the national UEC team via england.eecpmo@nhs.net by **30 September 2025.**

Section A: Board Assurance Statement

Assurance statement	Confirmed (Yes / No)	Additional comments or qualifications (optional)
Governance		
The Board has assured the Trust Winter Plan for 2025/26.	Yes	The plan was presented at Public Board on 10th July 2025. Finance and Productivity Committee on 26th June 2025 and 31st July 2025. All comments from these meetings have been incorporated into the plan. The plan has also been presented at ICB level with positive assurance recorded.
A robust quality and equality impact assessment (QEIA) informed development of the Trust's plan and has been reviewed by the Board.	Yes	Included within appendices of plan. For review and update through Quality Committee monthly.
The Trust's plan was developed with appropriate input from and engagement with all system partners.	Yes	The plan has been developed with involvement from West Midlands Ambulance Service, ICB, Dudley Local Authority, Voluntary Sector, Primary Care and all Acute Trust Services. The plans have also been shared across the Black Country Providers.
The Board has tested the plan during a regionally led winter exercise, reviewed the outcome, and incorporated lessons learned.	No	This is scheduled for 10th September, the lessons learned will be built into the plan but will not be completed by the time of the 11th September Board Meeting.
The Board has identified an Executive accountable for the winter period, and ensured mechanisms are in place to keep the Board informed on the response to pressures.	Yes	Karen Kelly, Chief Operating Officer and Deputy Chief Executive is the responsible Executive.
Plan content and delivery		
The Board is assured that the Trust's plan addresses the key actions outlined in Section B.	Yes	
The Board has considered key risks to quality and is assured that appropriate mitigations are in place for base, moderate, and extreme escalations of winter pressures.	Yes	
The Board has reviewed its 4 and 12 hour, and RTT, trajectories, and is assured the Winter Plan will mitigate any risks to ensure delivery against	Yes	This is included in Section 3.1 of the plan for UEC performance and the

the trajectories already signed off and returned to NHS England in April 2025.		RTT performance is included within the divisional plans in section 6.

Provider CEO name	Date	Provider Chair name	Date
Diane Wake		Sir David Nicholson	

Section B: 25/26 Winter Plan checklist

Checklist	Confirmed (Yes / No)	Additional comments or qualifications (optional)
Prevention		
1. There is a plan in place to achieve at least a 5 percentage point improvement on last year's flu vaccination rate for frontline staff by the start of flu season.	Yes	Section 11 within the plan outlines the strategy for achieving this.
Capacity		
The profile of likely winter-related patient demand is modelled and understood, and plans are in place to respond to base, moderate, and extreme surges in demand.	Yes	Section 2 within the plan outlines both the internal modelling and the modelling undertaken by the ICB. The deficit highlighted has been increased to 100 beds and this has been the number to which the plan has been focused on mitigating.
Rotas have been reviewed to ensure there is maximum decision-making capacity at times of peak pressure, including weekends.	Yes	A review of 7 day working practices has been undertaken and job plan reviews in some areas are underway.
Seven-day discharge profiles have been reviewed, and, where relevant, standards set and agreed with local authorities for the number of P0, P1, P2 and P3 discharges.	Yes	This work has been undertaken by the Associate Director for Discharge Improvement with a summary included in Section 12.
Elective and cancer delivery plans create sufficient headroom in Quarters 2 and 3 to mitigate the impacts of likely winter demand – including on diagnostic services.	Yes	This is being led within the Divisions and is included as part of their plans in Section 6.
Infection Prevention and Control (IPC)		
IPC colleagues have been engaged in the development of the plan and are confident in the planned actions.	Yes	The Director of Infection Prevention and Control and the Matron for IPC has been involved in the development of the plan.
Fit testing has taken place for all relevant staff groups with the outcome recorded on ESR, and all relevant PPE stock and flow is in place for periods of high demand.	Yes	Fit testing is undertaken through clinical skills. High usage areas have maintained competence and there is plan to roll out additional training if required.
A patient cohorting plan including risk-based escalation is in place and understood by site	Yes	This plan has been developed and is held by the IPC team. The IPC team maintain a 7 day

management teams, ready to be activated as needed.		per week on call service and would be available if it was needed to be activated.
Leadership		
On-call arrangements are in place, including medical and nurse leaders, and have been tested.	Yes	There is a robust silver and gold on call rota. In addition to this there is Matron cover across the 7 days of the week and cover until 9pm Monday to Friday. Speciality on call arrangements are in place for medical teams.
Plans are in place to monitor and report real-time pressures utilising the OPEL framework.	Yes	This is reported through the site team. The site position is reported through email six times per day and more frequently if required. Updates are also provided via the Shrewd application and is available via this in real time.
Specific actions for Mental Health Trusts		
A plan is in place to ensure operational resilience of all-age urgent mental health helplines accessible via 111, local crisis alternatives, crisis and home treatment teams, and liaison psychiatry services, including senior decision-makers.	NA	
Any patients who frequently access urgent care services and all high-risk patients have a tailored crisis and relapse plan in place ahead of winter.	NA	

Paper for submission to the Board on Thursday 11th September 2025

Report title:	Workforce Key Performance indicators (KPI) Report (July Data)
Sponsoring executive / Presenter:	James Fleet – Group Chief People Officer
Report author:	Karen Brogan – Director of People & OD

1. Summary of key issues

The full Key Performance Indicator report is located in the reading room

Assure

- Turnover and Retention: Trust-wide turnover has decreased to 6.66% (target ≤8%) and normalised turnover to 2.82% (target ≤5%). Retention remains strong at 92.9% (target ≥80%).
- Mandatory Training and Appraisals: Compliance remains above target with mandatory training at 93.56% and appraisals at 92%.
- Bank Fill Rates: Improved to 83% in July, with no non-medical agency shifts filled via the centralised team.
- Recruitment and Workforce Planning: Contracted WTE increased slightly, and the Trust is actively managing recruitment and retention through targeted initiatives.

Advise

- Sickness Absence: In-month sickness absence rose to 5.68% (target ≤5%), with rolling 12-month absence at 5.36%. Mitigations are in place, including targeted interventions and enhanced support.
- Vacancy Rate: Decreased to 9% from 10% in July but remains above the ≤7% target. Continued monitoring and recruitment efforts are underway.
- Employee Relations: Grievance KPI compliance improved to 67%, but MHPS and bullying/harassment cases still exceed the 12-week resolution target. Policy updates and training are ongoing.

Alert

- Long-Term Absence: 138 long-term absence cases remain open, with 18% of episodes accounting for 55% of FTE days lost (18 cases over 6 months in length)
- Medical & Dental Turnover: High turnover at 20.85%, with normalised turnover at 3.79%. Deanery rotations contribute significantly.
- Rostering Unavailability: Unavailability at 29% exceeds the 22% budgeted level, posing risks to staffing and budget control – this is actively being managed via Roster Confirm and Challenge meetings.
- Apprenticeship Activity: Recruitment freeze has impacted apprenticeship sign-ups and levy utilisation. Risk of under-delivery in funded programmes.

2. Alignment to our Vision

Patients: Deliver right care, in the right place, at the right time	**X**
People: Be a brilliant place to work and thrive	**X**
Place: Build innovative partnerships to improve the health of our communities	

3. Report journey
People Committee and Public Board

4. Recommendation(s)
The Board of Directors is asked to:
a) **Receive** the report for noting

5. Impact reflected in our Board Assurance Framework (BAF)		
BAF Risk 1.0	X	Failure to deliver the right care, in the right place every time
BAF Risk 2.0	X	Failure to ensure Dudley is a brilliant place to work and thrive
BAF Risk 3.0		Failure to build innovative partnerships to improve the health of our communities
BAF Risk 4.0	X	Failure to remain financially sustainable in 2025/26 and beyond
BAF Risk 5.0	X	Failure to achieve operational performance requirements & deliver strategic objectives
BAF Risk 6.0		Failure to take sustained action on infrastructures that enables strategic objectives

Paper for submission to the Board on Thursday 11th September 2025

Report title:	Performance Against Workforce Forecast (M4)
Sponsoring executive / Presenter:	James Fleet – Group Chief People Officer
Report author:	Karen Brogan – Director of People & OD

1. Summary of key issues

The full data report is located in the reading room.

Assure

- Substantive Workforce: Positive variance of +37 WTE against plan, reflecting effective vacancy control and recruitment freeze impact.
- Corporate Services & CCCS Divisions: Both divisions show positive performance against plan, with CCCS maintaining low agency usage and Corporate Services benefiting from substantive staffing reductions.
- Right Shift, Right Band Initiative: Flagged pay grade mismatches reduced by 37% since July, with weekly reporting and system alerts now embedded.
- Sickness Absence Management: ESR training, new EAP service, and targeted Occupational Health interventions have led to improved return-to-work compliance and reduced length of long-term sickness cases.

Advise

- Bank Workforce Usage: Increased to 585 WTE, 84 WTE above plan, driven by industrial action and capacity demands. Controls and reporting improvements are in place, but further reductions are needed.
- Agency Workforce Usage: Increased to 19 WTE (13 WTE above plan), with spend concentrated in high-cost specialties. Steering groups and exit strategies are being developed.
- Divisional Performance: Medicine and SWC divisions continue to report over-plan performance, requiring sustained reductions to meet year-end targets.

Alert

- SWC Division: Consistent underperformance across Months 1–4 poses a significant risk to achieving year-end workforce targets.
- Primary Care Complexity: Hosting arrangements for funded posts in Dudley Place continue to impact performance and delivery.
- Financial Risk: Agency overspend of £275k to June and continued above-plan bank usage threaten financial sustainability and delivery against the workforce plan.

2. Alignment to our Vision

Patients: Deliver right care, in the right place, at the right time	**X**
People: Be a brilliant place to work and thrive	**X**
Place: Build innovative partnerships to improve the health of our communities	

3. Report journey

People Committee, Quality Committee and Finance & Productivity committee and Public Board.

4. Recommendation
The Board are asked to
a) **Receive** the report for assurance

5. Impact reflected in our Board Assurance Framework (BAF)		
BAF Risk 1.0	X	Failure to deliver the right care, in the right place every time
BAF Risk 2.0	X	Failure to ensure Dudley is a brilliant place to work and thrive
BAF Risk 3.0		Failure to build innovative partnerships to improve the health of our communities
BAF Risk 4.0	X	Failure to remain financially sustainable in 2025/26 and beyond
BAF Risk 5.0	X	Failure to achieve operational performance requirements & deliver strategic objectives
BAF Risk 6.0		Failure to take sustained action on infrastructures that enables strategic objectives

Our Patients
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Enclosure 14

The Dudley Group NHS Foundation Trust

Paper for submission to the Trust Board on 4th September 2025

Report title:	Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard Annual Report 2025
Sponsoring executive / Presenter:	James Fleet, Group Chief People Officer
Report author:	Paul Singh, Head of Equality, Diversity, Inclusion & Workforce Wellbeing

1. Summary of key issues

NHS Boards play a key role in championing an organisational culture of equality, diversity and inclusion, as highlighted in NHS England's equality, diversity and inclusion (EDI) improvement plan, published on 8th June 2023.

Assure
The Workforce Race Equality Standard (WRES) and the Workforce Disability Equality Standard (WDES) provide key indicators and benchmarks for evaluating the impact and effectiveness of interventions for improving the experiences of staff across the organisation.

The Dudley Group NHS Foundation Trust has implemented a range of actions and interventions to embed an inclusive and compassionate culture which promotes equality and challenges all forms of discrimination.

Advise
This report presents The Dudley Group NHS Foundation Trust's performance against the Workforce Race Equality Standard (WRES) and the Workforce Disability Equality Standard (WDES) metrics for 2025. The report highlights key trends, as well as areas of progress and ongoing challenges. The report also sets outs the Trust's strategic actions to advance equity across the organisation.

Alert
Whilst improvements have been made for both WRES and WDES metrics there still remain some disparities and challenges for ethnically diverse staff and disabled staff. The Board are invited to consider the updated WRES and WDES metrics, as well as the plans for driving further improvements and to take assurance that this work has the support of the Trust's wider leadership.

2. Alignment to our Vision

Patients: Deliver right care, in the right place, at the right time	**X**
People: Be a brilliant place to work and thrive	**X**
Place: Build innovative partnerships to improve the health of our communities	

3. Report journey

Executive Directors – 19.08.2025
People Committee – 26.08.2025

4. Recommendations

The Board are asked to:

a) **Review** and consider the latest Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES) results, particularly the areas of improvement and those areas requiring further focus intervention, ahead of public publication and approve sign off.

b) Take **assurance** that the Trust is fully engaged and focused on tackling and reducing inequality and discrimination for staff from Black and Minority Ethnic backgrounds and disabled staff.
c) **Support** the major initiatives that are underway to drive further improvement for the staff of DGFT.
d) Require regular updates on progress.

5. Impact reflected in our Board Assurance Framework (BAF)		
BAF Risk 1.0		Failure to deliver the right care, in the right place every time
BAF Risk 2.0	x	Failure to ensure Dudley is a brilliant place to work and thrive
BAF Risk 3.0		Failure to build innovative partnerships to improve the health of our communities
BAF Risk 4.0		Failure to remain financially sustainable in 2025/26 and beyond
BAF Risk 5.0		Failure to achieve operational performance requirements & deliver strategic objectives
BAF Risk 6.0		Failure to take sustained action on infrastructures that enables strategic objectives
Is Quality Impact Assessment required if so, add date:		
Is Equality Impact Assessment required if so, add date:		

Report to the Trust Board on 4th September 2025
Workforce Race and Disability Equality Standard (WRES & WDES) Reports

1. Introduction

1.1. Equality, Diversity and Inclusion (EDI) is a strategic and legal duty for NHS Trusts, underpinned by national legislation, regulatory standards, and growing expectations from patients, the public, and the workforce. The Equality Act 2010 and the Public Sector Equality Duty place clear statutory responsibilities on the Trust to eliminate discrimination, advance equality, and foster inclusion across the nine protected characteristics. These obligations are reinforced by the NHS Constitution, the Workforce Race Equality Standard (WRES), the Workforce Disability Equality Standard (WDES), and the Health and Care Act 2022, all of which embed fairness, inclusion, and the reduction of health inequalities at the core of NHS values and service delivery.

1.2. The NHS England EDI Improvement Plan (2023–2025) sets clear expectations for inclusive leadership, equitable recruitment, and the elimination of disparities in patient outcomes, requiring Boards to actively oversee delivery and monitor progress. The Care Quality Commission's Single Assessment Framework also identifies EDI as a core element of the Well-Led domain, placing a regulatory requirement on Boards to demonstrate robust governance, accountability, and impact in advancing equality and inclusion. Alongside this, the NHS People Promise and the Long-Term Workforce Plan highlight that inclusive and supportive cultures are essential for workforce wellbeing, retention, and performance, factors that directly influence the quality and safety of patient care. Furthermore, achieving the ambitious goals within the 10-Year Plan will require NHS organisations to improve staff experience, strengthen retention, and attract talent from the widest possible pool, ensuring the workforce reflects and serves the diverse communities it supports.

1.3. The Board has a fundamental responsibility to ensure that EDI commitments are embedded within strategic priorities, operational practice, and cultural leadership. This report provides

assurance on current progress, identifies areas for improvement, and outlines how the Trust will continue to deliver measurable outcomes for its people.

2. DGFT Equality Diversity and Inclusion (EDI) Priorities

2.1. The Trust's Equality, Diversity and Inclusion (EDI) Journey 2023-2025 sets out the following priorities and programmes of work:

- Embedding inclusive recruitment & retention
- Being an inclusive employer
- Inclusive leadership & development
- Addressing workforce inequalities through equitable, inclusive practices and a just culture.

3. Workforce Race Equality Standard (WRES) & Workforce Disability Equality Standard (WDES)

3.1. In line with the national EDI 2024 plan, the Workforce Race Equality Standard and the Workforce Disability Equality Standard provide critical indicators for the Board to discharge its responsibility in overseeing, scrutinising, and driving the effectiveness of interventions that improve staff experience and advance equality across the organisation.

4. Workforce Race Equality Standard (WRES)

4.1. As Board members will be aware, the WRES, implemented in 2016, is a nationally mandated standard aimed at improving workplace experiences and career progression for NHS staff from Black and Minority Ethnic backgrounds (BME). It consists of nine specific metrics that allow organisations to compare the experiences of employees from BME backgrounds with those of white staff, enabling the identification of disparities and supporting targeted improvement efforts.

4.2. The 2025 WRES data highlights both progress and persistent inequalities for staff from ethnically diverse backgrounds within the Trust. Whilst improvements have been made in representation and internal experiences of bullying and discrimination, significant disparities remain in recruitment, disciplinary actions, training access, and career progression.

4.3. Metrics 5 to 8 are based on responses to the NHS Staff Survey, which in 2025 achieved a 49% response rate, which includes 24.8% from staff who identify as Black, Asian and Minority Ethnic.

4.4. The Trust is currently in the process of undertaking the Well-Led self-assessment, which includes a key EDI domain. The output of this self-assessment will further inform the improvement work that is being undertaken and will be reported to the People Committee, as well as the Board.

4.5. At its meeting in August 2025, the People Committee received, considered and discussed a detailed report and related improvement plan for both WRES and WDES, which focuses on addressing key areas for improvement, whilst also building on the areas where improvement has been achieved and sustained.

5. The key Highlights from the 2025 WRES report:

5.1. The 2025 WRES report shows signs of progress in workforce diversity but also highlights persistent inequalities affecting staff from ethnically diverse backgrounds.

5.2. Improved measures in 2025

- **Workforce Representation**: Staff from ethnically diverse backgrounds now comprise 29% of our workforce, with undeclared ethnicity reducing from 9% to 7%.
- **Disciplinary**: Staff from ethnically diverse backgrounds are 1.51 times more likely to enter formal disciplinary processes than white colleagues - a slight narrowing of the gap from the previous year.
- **Internal Bullying**: Reports declined for both groups, with a 2.7% drop among staff from ethnically diverse backgrounds.
- **Discrimination**: Reports of discrimination from managers or colleagues slightly declined but remain significantly higher for staff from ethnically diverse background (18.3% vs. 5.7%).

5.3. Declined and unchanged measures in 2025

- **Recruitment**: Applicants who are white remain 1.55 times more likely to be appointed from shortlisting than applicants from ethnically diverse backgrounds (19% vs.12%).
- **Development Access**: Staff from a white background are 1.28 times more likely to access non-mandatory training and CPD.
- **Harassment from the Public**: Reports increased among staff from ethnically diverse backgrounds (27%) and decreased among staff from a white background (21.67%).
- **Career Progression**: Perceptions of equal opportunity remain unchanged at 51.8% for staff from ethnically diverse backgrounds, with a 10.3% gap compared to staff from a white background.
- **Board Representation**: Ethnic diversity at Board level fell to 9.5%, below the 29% workforce benchmark.

5.4. Workforce Race Equality Standard Overview

The table below presents a summary of our performance and highlights trends across all nine metrics from 2020 to 2025.

Table 1.0

	WRES Indicator		Reporting Year 2020	2021	2022	2023	2024	2025	Trend
1	Workforce Representation. Percentage of staff from all other ethnic groups combined	Overall	18.1%	19.5%	20.4%	24.7%	27.5%	29.0%	
2	Relative likelihood of white applicants being appointed from shortlisting across all posts compared to applications from all other ethnic groups		2.58	1.95	1.49	1.54	1.41	1.55	
3	Relative likelihood of staff from other ethnic groups entering the formal disciplinary process compared to white staff		0.9	1.1	1.1	0.79	1.59	1.51	
4	Relative likelihood of white staff accessing non mandatory training and continuous		1.52	1.17	1.95	1.02	1.24	1.28	
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%	24.7%	27.0%	
		White	31.6%	25.6%	25.5%	24.8%	24.4%	21.7%	
6	Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months*	BME	33.0%	32.8%	26.8%	28.8%	29.9%	27.2%	
		White	28.4%	25.7%	19.7%	20.3%	20.6%	20.4%	
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%	51.8%	
		White	56.5%	61.8%	61.2%	63.2%	63.1%	62.2%	
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%	18.3%	
		White	6.3%	6.0%	5.1%	5.3%	6.3%	5.7%	
9	Board membership representation of staff from other ethnic groups **	Overall		5.6%	16.7%	16.7%	15.0%	9.5%	

** Staff survey from previous year*

***Total board members*

Note: Staff survey metrics are 1 year behind the submission year; the 2025 data shown in this table are 2024 staff survey metrics.

5.5. The data relating to performance against the WRES metrics over the past 5 years highlights some key areas of consistent and/or overall improvement, these are:

- **Workforce representation** - 18.1% in 2020 to 29% in 2025
- **Bullying & Harassment** – Ethnically diverse staff experiencing harassment, bullying or abuse from patients has reduced (31.2 % in 2020 to 27% in 2025), albeit this remains notably above the level reported by white staff.

Ethnically diverse staff experiencing harassment, bullying or abuse from staff has reduced (33% in 2020 to 27.2% in 2025), albeit this remains notably above the level reported by white staff.

- **Career Progression** – The number of ethnically diverse staff believing that the Trust provides equal opportunities for career progression has increased (42.9% in 2020 to 51.8% in 2025).

5.6. The data relating to performance against the WRES metrics over the past 5 years highlights some key areas of consistent and/or overall decline, these are:

- **Discrimination** – The number of ethnically diverse staff who have experienced discrimination at work has increased (17.4% in 2020 to 18.3% in 2025).
- **Board Representation** - Ethnic diversity at Board level fell to 9.5%, below the 29% workforce benchmark.

In summary for DGFT, representation of staff from ethnically diverse backgrounds has increased, bullying by staff has declined for staff from ethnically diverse backgrounds and reports of discrimination from managers or colleagues has slightly declined. This reflects our ongoing commitment to building a more inclusive organisation. However, whilst there have been some positive improvements, the data continues to demonstrate that there are areas requiring renewed focus and attention, as well as targeted and corporate level action. Disparities remain in recruitment, disciplinary processes, access to development, and senior leadership representation.

5.7. The 2024 national WRES report (published 25.06.25) highlights progress with equality, diversity, and inclusion in the NHS, with an 85% increase in very senior BME managers since 2018. However, the national data also confirms that 80% of Trust's white applicants were significantly more likely to be appointed from shortlisting higher than 76% last year and only 42.3% of Black staff feel they have equal career opportunities. White Gypsy or Irish Traveller staff report the highest workplace abuse, while BME staff face more harassment than white colleagues.

5.8. More locally, since 2020, the Black Country system has seen steady improvements in workforce diversity and inclusion, with BME workforce representation rising from 24.3% to 31.4%, career progression for BME staff improving from 34% to 48%, and board diversity increasing.

5.9. In response to the most recent WRES data, as well as drawing on the feedback from the EmbRACE staff Network, trade unions and other sources of staff, including FTSU the Trust is committed to taking action to further advance racial equity, reduce racism and embed an inclusive culture.

- **National Overview - WRES**
  The 2024 national WRES report highlights progress with equality, diversity, and inclusion in the NHS, with an 85% increase in very senior BME managers since 2018. However, challenges remain white applicants are still favoured in 80% of trusts, and only 42.3% of Black and Minority Ethnic staff feel they have equal career opportunities. White Gypsy or Irish Traveller staff report the highest workplace abuse, while BME staff face more harassment than white colleagues.

- **The Black Country System WRES overview**
  Since 2020, the Black Country system has had steady improvements in workforce diversity and inclusion, with BME workforce representation rising from 24.3% to 31.4%, career progression for BME staff has improved from 34% to 48%, and board diversity has increased. However, despite positive improvements in some of the WRES indicators, both nationally and at the system level, the data highlights several areas that still require focused attention and strategic action at both the individual, team and organisational levels.

Persistent disparities remain in recruitment, cultural indicators, disciplinary procedures, access to development opportunities and representation in senior leadership.

5.10. Driving Staff Improvements: Action Plan:

The Trust will take the following action:

- **Inclusive Recruitment & Career Development** – Enhancing recruitment practices with inclusive training, diverse panels, and better development opportunities to close progression gaps for ethnically diverse staff.
- **Fair Disciplinary Processes** – Promoting early intervention and bias-awareness training to ensure fairness.
- **Anti-Bullying & Anti-Discrimination Measures** – Strengthening protections, launching an Anti-Bullying & Anti-Discrimination policy, improving reporting mechanisms, and reinforcing the Trust's anti-racism and Anti-discrimination stance.
- **Leadership & Board Diversity** – Increasing ethnic diversity in senior roles through targeted development programmes to enable progression to Board level.

5.11. These WRES actions are part of the wider Equality, Diversity, and Inclusion (EDI) Workforce Journey, with the aim of fostering a culture where all staff feel valued and have equal opportunities to thrive.

6. Workforce Disability Equality Standard (WDES)

6.1. The WDES consists of ten specific measures (metrics) that enable Trusts to compare the experiences of disabled and non-disabled staff. These comparisons inform action plans and allow organisations to track progress in advancing disability equality.
6.2. The 2025 WDES results reflect progress and areas requiring continued focus. While we have seen improvements in disability declaration rates, board-level representation, and access to reasonable adjustments, disparities persist in staff experience, particularly around harassment, career progression, and feeling valued.
6.3. Metrics 5 to 9a are based on the NHS staff survey. The 2024 staff survey had 49% participation, 27% of the respondents who completed the survey declared that they have a disability or long-term condition (1%, an increase from 2023).

7. The key Highlights from the 2024 WDES report:

7.1. The 2025 WDES results show encouraging progress in disability declaration, leadership representation, presenteeism levels and sustained delivery of reasonable adjustments. However, significant challenges persist, particularly in staff experience related to harassment, feeling valued, and capability disparities.
7.2. Improved measures in 2025

- **Leadership Representation**: Board-level disability declaration increased from 5% to 9.5%, reflecting improved transparency and diversity at senior levels.
- **Career Opportunity Perception**: A small but positive shift in the perception of equal progression among disabled staff.
- **Managerial Behaviours & Reporting**: Improvements in managerial conduct and higher reporting rates suggest a maturing culture of accountability and support.
- **Presenteeism Decline**: Staff with long-term conditions are less likely to work while unwell, 28.5% in 2025 compared to 32% last year indicating growing awareness of health-first practices.
- **Reasonable Adjustments:** The percentage of staff receiving necessary adjustments remains consistent at 72.4%.

7.3. Declined Measures in 2025

- **Harassment and Abuse**: Nearly 30% of disabled staff experience abuse or harassment from the public a disproportionately high figure compared non-disabled staff.
- **Feeling Valued**: Only one-third of disabled staff feel valued by their organisation. Engagement scores are significantly lower than those of non-disabled peers.
- **Capability Disparities**: While numerically very small, disabled staff are 12 times more likely to enter capability procedures than their non-disabled colleagues.

8. Workforce Disability Equality Standard Overview:

8.1. The table below summarises our performance and provides a trend analysis from 2020 to 2025 on all ten metrics.

Table 2.0

WDES Summary

WDES Indicator			Reporting Year 2020	2021	2022	2023	2024	2025	Trend
1 Workforce Representation. Percentage of Disabled staff*		Overall		3.6%	4.0%	5.4%	6.1%	6.4%	
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	1.14	
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	0	10.63	
4a 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%	15.9%	14.1%	
		Staff without a long lasting condition or illness	15.8%	13.0%	8.7%	8.8%	8.6%	8.2%	
	From Other Colleagu	Staff with a long lasting health condition or illness	28.0%	29.4%	23.3%	25.3%	25.0%	26.0%	
		Staff without a long lasting condition or illness	19.4%	18.4%	14.3%	15.0%	15.1%	15.0%	
	From Patients / Public	Staff with a long lasting health condition or illness	37.9%	32.3%	29.7%	33.0%	29.4%	29.9%	
		Staff without a long lasting condition or illness	30.3%	24.4%	24.7%	22.6%	22.8%	20.3%	
4b Percentage of disabled staff compared to non-disabled staff saying that the last time they experienced harassment, bullying or abuse at work, they or a colleague reported it ***		Staff with a long lasting health condition or illness		52.9%	50.0%	44.7%	45.0%	50.5%	
		Staff without a long lasting condition or illness		49.6%	48.8%	45.9%	49.3%	53.3%	
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%	56.1%	
		Staff without a long lasting condition or illness	56.1%	59.6%	60.3%	61.1%	61.6%	60.5%	
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%	28.5%	
		Staff without a long lasting condition or illness	24.7%	28.7%	26.0%	20.4%	19.4%	20.0%	
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%	33.2%	
		Staff without a long lasting condition or illness	39.6%	44.2%	39.1%	42.6%	45.5%	43.2%	
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%	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	6.3	
		Staff without a long lasting condition or illness	6.8	6.9	6.8	6.9	7.0	6.9	
9b Percentage of trusts that facilitate the voices of Disabled staff to be heard within the organisation.				Yes	Yes	Yes	Yes	Yes	
10 Percentage of Disabled staff on Boards ****		Overall			6%	11%	5%	9.5%	

** non-executive directors excluded from 2023 data*
*** 23/24 and 24/25 data*
**** Staff survey from previous year*
***** Total board members, as of 31st March 2025*

Note: staff survey metrics are 1 year behind submission year; 2025 data shown in this table is 2024 staff survey metrics.

8.2. The data relating to performance against the WDES metrics over the past 5 years highlights some key areas of consistent and/or overall improvement, these are:

- **Representation:** Improved disability workforce representation (3.6% in 2020 to 6.4% in 2025).
- **Recruitment:** The relative likelihood of appointment for applicants with a disability improved, (1.14 in 2025 from 2.15 in 2020).
- **Bullying & Harassment**: Staff with a disability or long-term conditions report fewer incidents of bullying or harassment from managers, (14.1% in 2025 compared to 21.7% in 2020).
- **Career Progression**: in 2025 56.1% of staff with a long-term condition believe they have equal opportunities compared to 46.1% in 2020.
- **Presenteeism:** Fewer staff with a long-term condition reported feeling pressured to work while unwell (28.5% in 2025, down from 35.8% in 2020), suggesting progress in wellbeing support.
- **Board Representation**: Board-level disability declaration increased (6% in 2022 to 9.5% in 2025).

8.3. The data relating to performance against the WRES metrics over the past 5 years highlights some key areas of consistent and/or overall decline, these are:

- **Capability Disparities**: While numerically small, disabled staff are 12 times more likely to enter capability procedures than their non-disabled colleagues.
- **Bullying & Harassment**: Staff with long-term conditions continue to report higher rates of bullying and abuse, particularly from patients and colleagues, compared to those without.
- **Feeling Valued:** Only 33.2% of staff with a long-term condition feel valued by the organisation, compared to 43.2% of non-disabled staff, a gap that remains a key concern.

8.4. In Summary for DGFT, progress has been made in key areas such as disability declaration rates, board-level representation, presenteeism and access to reasonable adjustments. However, staff with long-term conditions continue to report disproportionately high levels of bullying, harassment, and abuse, highlighting ongoing cultural challenges and the need to strengthen trust and psychological safety. While perceptions of career progression have improved and presenteeism has declined, only a third of disabled staff feel valued, and engagement remains lower than peers, underlining the need for more profound cultural change. The rise in board-level disability representation and initiatives like This is Who I Am and ICAN show the impact of targeted, inclusive action.

8.5. According to the National WDES 2024 report (published 25.06.25) nearly one in four NHS staff have disabilities or long-term conditions, with increased representation on boards and better access to reasonable adjustments (74.5% in 2023). However, disabled staff remain more than twice as likely to be performance managed and experience higher levels of harassment, bullying or abuse from managers and colleagues.

8.6. More locally, since 2020, the Black Country system has seen, disabled staff representation nearly double from 3.1% to 6.1%, recruitment indicators improved, and board representation grew from 6.6% to 8.1%, reflecting ongoing commitment to equity and career development in the Black Country.

- **National WDES overview**
  The 2024 report highlights several positive trends, i.e. disabled people are more likely than average, to be represented on NHS boards than in the wider workforce, disabled candidates are also more likely to be appointed from an interview, and more employers are also making reasonable adjustments that enable disabled staff to carry out their work, disabled staff remain more than twice as likely to be performance managed compared to their non-disabled colleagues, and experienced higher levels of harassment, bullying and abuse from managers and other colleagues. The report also confirms that nearly one in four NHS staff have disabilities or long-term conditions.

- **Black Country System WDES overview**
  Since 2020, there have been notable improvements in the WDES metrics at a system level. Disabled staff representation nearly doubled from 3.1% to 6.1%, and recruitment indicators improved, and board representation grew from 6.6% to 8.1%, reflecting an ongoing commitment to equity and career development in the Black Country. However, it is acknowledged that there are ongoing challenges with staff experience related to harassment, bullying and abuse from patients and discrimination from other staff, and plans are in place to tackle these issues through individual Provider EDI plans and the NHSE Six High Impact Actions.

9. Driving Further Improvements – Action Plan:

9.1. While progress has been made in reporting and reducing experience gaps, staff with disabilities and long-term conditions continue to face higher levels of harassment, lower engagement, and reduced feelings of being valued. A comprehensive action plan aligned with the WDES framework will focus on:

- **Harassment & Abuse** – Zero tolerance messaging, enhanced manager training, real-time reporting, and stronger visibility of support roles.
- **Engagement & Value** – Sharing lived experiences, co-designed engagement forums, and embedding recognition into daily culture.
- **Career Progression** – Inclusive leadership programmes, mentoring, and equitable promotion processes.
- **Reasonable Adjustments & Health** – Training managers, normalising flexible working, and centralising adjustments.
- **Representation** – Inclusive recruitment, disclosure encouragement, senior-level targets, and pipeline reviews.
- **Capability Process** – Early coaching support over formal procedures.

9.2. These actions form part of the wider EDI Workforce Journey, supporting the Trust's vision of being a brilliant place to work and thrive. Progress will continue to be monitored and reported to the Board to ensure accountability and transparency.

10. Wider EDI Reporting

10.1. The Trust continues to report on the wider EDI domains and is increasingly developing reporting on an intersectionality basis. This supports recognising that people have complex and multiple identities, and that multiple forms of inequality or disadvantage sometimes combine to create obstacles that cannot be addressed through the lens of a single characteristic in isolation. This reporting covers; age, ethnicity, religion and belief, disability and gender.

11. Recommendations

11.1. The Board is asked to:

- **Review** and consider the latest Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES) results, particularly the areas of improvement and those areas requiring further focus intervention, ahead of public publication and approve sign off.

- **Take Assurance** that the Trust is fully engaged and focused on tackling and reducing inequality and discrimination for staff from Black and Minority Ethnic backgrounds and disabled staff.

- **Support** the major initiatives that are underway to drive further improvement for the staff of DGFT.

- **Require** regular updates on progress

James Fleet, Group Chief People Officer

Paul Singh, Head of Equality, Diversity, Inclusion & Workforce Wellbeing

Our Patients
Our People
Our Place

Enclosure 15

The Dudley Group NHS Foundation Trust

Paper for submission to the Board on 11th September 2025

Report title:	Freedom To Speak Up (FTSU) Quarter 1 2025 Data Report
Sponsoring executive / Presenter:	Diane Wake, chief executive
Report author:	April Burrows Freedom to Speak Up Guardian

1. Summary of key issues

The Board of Directors is advised that the Freedom to Speak Up report has been considered at the People Committee with appropriate scrutiny and challenge.

Assure
The FTSU delivery plan for 2025 – 2028 will be launched the end of September in line with FTSU Week 13th – 17th of October. The second Black Country Collaborative conference will be held on the 15th of October. More detail to follow

Advise
The FTSU team has had a total of 55 concerns raised during the reporting period of April 2025 - June 2025 quarter 1 of the 2025/2026 financial year. The total number of concerns raised in 2024/2025 have increased overall by 50% compared to 2023/2024.

Alert
The National Guardian's Office will be closed as part of the government's10 Year Health Plan. The role of Freedom to Speak Up Guardian will remain across the health service.

2. Alignment to our Vision

Patients: Deliver right care, in the right place, at the right time	
People: Be a brilliant place to work and thrive	**X**
Place: Build innovative partnerships to improve the health of our communities	

3. Report journey

FTSU Steering group, People Committee, Trust Board.

4. Recommendations

The Trust Board is asked to

a) Note the report for assurance and review the FTSU Delivery Plan located in the reading room

5. Impact reflected in our Board Assurance Framework (BAF)

BAF Risk 1.0		Failure to deliver the right care, in the right place every time
BAF Risk 2.0	X	Failure to ensure Dudley is a brilliant place to work and thrive
BAF Risk 3.0		Failure to build innovative partnerships to improve the health of our communities
BAF Risk 4.0		Failure to remain financially sustainable in 2025/26 and beyond
BAF Risk 5.0		Failure to achieve operational performance requirements & deliver strategic objectives
BAF Risk 6.0		Failure to take sustained action on infrastructures that enables strategic objectives
Is Quality Impact Assessment required if so, add date:		
Is Equality Impact Assessment required if so, add date:		

1. Executive Summary

Following on from Sir Francis review of the speaking culture within the NHS, which was published in 2015, Freedom to Speak Up remains a business-critical component to support the provision of safe effective care for our patients. Freedom to Speak Up remains on a transformational journey at the Dudley Group NHS Foundation Trust, to ensure all concerns are heard and appropriate and meaningful actions are taken as appropriate.

The report will provide an overview of the national picture of speaking up and collate this with the local speaking up culture.

The report will provide the steering group with a thematical overview of the concerns raised with a breakdown of the National Guardian Office (NGO) four themes, followed by the top three sub-category. The steering group will be advised of the action being taken to address these top three concern areas and the collaborative work being undertaken for wider organisational learning.

The Dudley Group FTSU Arrangements

32,167 cases raised nationally through FTSU services, and 97 cases raised at the Dudley Group of hospitals from 1st April 2023 to 31st March 2024. The Dudley Group of hospitals FTSU team consist of three guardians. One full-time lead FTSU Guardian and 2 Guardians who fulfils the role in addition to their substantive post. 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.

36 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 team has had a total of 55 concerns raised during the reporting period of April 2025 - June 2025 quarter 1 of the 2025/2026 financial year. 9 concerns have been raised through the network of Champions and 17% have been raised concerns anonymously. The main reason continuing to be fear of detriment. The total number of concerns raised has increased compared to Q1 2024/2025 and concerns raised in 2024/2025 overall have increased by 50% from 2023/2024.

2. Updates from the National Guardian's Office (NGO).

National Speak Up Cases: Q4 2024/2025 Snapshot

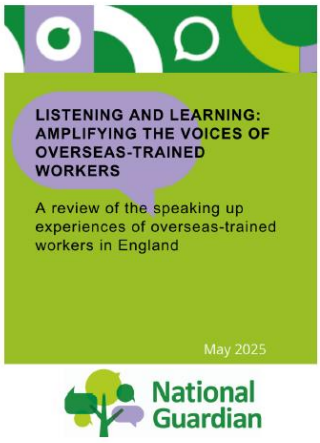
- Total Cases: 9,894 cases reported to Guardians.

- Trends:
    - Slight 1% drop from last quarter.
    - 14% increase compared to the same time last year.
- Breakdown of cases reported:
    - Worker Safety or Wellbeing: 44%
    - Inappropriate Behaviour (excluding bullying and harassment): 39%
    - Patient Safety: 18%
    - Bullying and Harassment: 17%
- Workers indicated they had suffered detriment after speaking up in 2% of cases.

Special Bulletin Issued 4 July 2025

- The National Guardian's Office will be closed as part of the government's10 Year Health Plan.
- The role of Freedom to Speak Up Guardian will remain across the health service. It is the functions of National Guardian's Office that will be changing i.e. to align the functions of the National Guardian's Office with the other staff voice functions in NHS England.
- A statement is available on the NGO website
- The Review of patient safety across the health and care landscape was published on 07 July 2025. More information from the NGO to follow.

Recent Publications



Introducing Speak UpWeek2025

- The NGO will be hosting a Speak Up week this year from **13 -17 October 2025** and the week's theme is "**Follow Up in action**".

- Building on last year's theme of "Listen Up", this year's focus highlights how leaders and chief executives are responding to concerns raised and driving meaningful change.

- **"Save the date"**
  15th of October with be the Second Black Country Collaborative online FTSU conference

3. FTSU Quarter 1 Data

The FTSU team has had a total of 55 concerns raised during the reporting period of April 2025 - June 2025 quarter 1 of the 2025/2026 financial year. 9 concerns have been raised through the network of Champions and 17% have been raised concerns anonymously. The main reason continuing to be fear of detriment. The total number of concerns raised has increased compared to quarter 1 2024/2025 and concerns raised in 2024/2025 have overall increased by 50% from 2023/2024 as shown in table 1. The increased number of concerns could be attributed to the increased visibility of the full-time guardian across the acute setting and Mwamba focusing on community services. Additionally, the Champions have double over the last 18 months. Also, the hub page is updated monthly to provide a timetable of guardian events and drop-in sessions.

Table 1

Freedom to Speak Up (FTSU)

	Unit	23/24 Value	24/25 Value	Definition	Comments
How many FTSU guardians does your organisation employ?	Num	2	3	The number of FTSU guardians supporting the workforce within your organisation (exclude FTSU guardians that support other organisations). [The cost associated with these should be included in 'Other non pay' in 'Costs' section for the 'Corporate Governance' sub-function].	
How many FTSU ambassadors/champions does your organisation have?	Num	20	34	The number of FTSU ambassadors or champions supporting the workforce within your organisation (exclude those FTSU staff that support other organisations). [The cost associated with these should be included in 'Other non pay' in 'Costs' section for the 'Corporate Governance' sub-function].	
How many FTSU cases were reported under each of the following categories?					
Bullying and harassment	Num	8	16	The number of FTSU reported cases relating to bullying and harassment.	
Patient safety and quality	Num	19	21	The number of FTSU reported cases relating to patient safety.	
Detriment as a result of speaking up	Num	3	0	The number of FTSU reported cases relating to detriment as a result of speaking up.	
Worker safety	Num	22	74	The number of FTSU reported cases relating to worker safety.	
Inappropriate attitudes and behaviours	Num	36	36	The number of FTSU reported cases relating to inappropriate attitudes and behaviour.	
Anonymous	Num	10	15	The number of FTSU anonymous reported cases.	
Total number of FTSU cases reported	Num	98	147	The total number of FTSU reported cases.	

Themes of Concerns raised

The NGO have four themes for concerns to be broken down into as shown in Table 2. 42% of the concerns in Quarter 1 relate to inappropriate attitudes or behaviours. Followed by worker safety or wellbeing with 36%.

The data has been broken down in Table 3 into sub-category for deeper understanding and to enable a nuanced action plan to improve culture within the organisation.

The top 3 themes reported were inappropriate attitudes or behaviours 22%, followed by Bullying or harassment directed at me 18% and Staff wellbeing - emotional or mental health with 16%

Table 2

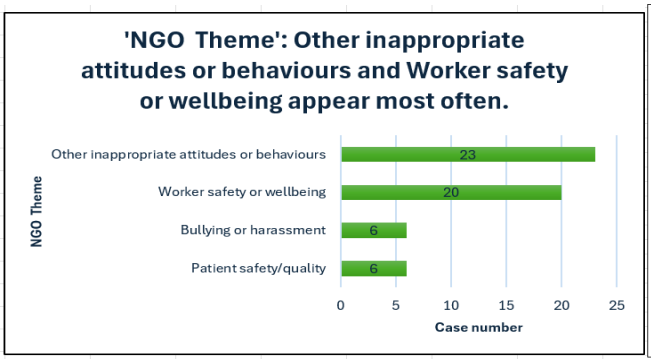
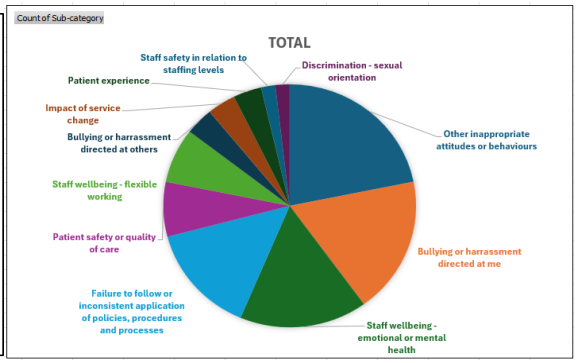


Table 3



The increase in concerns with themes of Other Inappropriate Attitudes or Behaviours can be attributed to a range of issues. The following points are to give background information relating to some of concerns. Whilst continuing to maintain individuals' confidentiality.

- Poor communication
- Misses use of power
- Inappropriate behaviour from Lead
- Verbal abuse from public
- Aggressive behaviour

Table 4 "Consent has been obtained to share the below information.

Concern	Action	Outcome
Perceived inappropriate feedback	A facilitated conversation between individuals	Improved working relationship.
Public verbally abusing volunteers and reception workers due to new car park payment system	Escalated to states manager and Mitie	Incorrect car park sign removed, and new instruction system implemented at main reception

The FTSU Guardians continuing to work with Human resources and Operation development to improve culture by imbedding the new trust strategy and Anti-Bullying, Anti-Discrimination Policy.

Divisional data

The highest number of concerns raised continue to be from CCCS with 40% and Medicine with 22%. On a positive note, CCCS concerns have reduced by 13% from last quarter as shown in Table 5

Table 6 shows an indication of NGO themes and broken down into division. Mwamba Bennett Continues to focus her time within the community services. Mwamba Bennett is based at Brierley Hill health and social care centre and is ideally situated to give maximum

support to the teams. Additional champions have been recruited within radiology and therapy department to improve culture and raise awareness.

Table 5

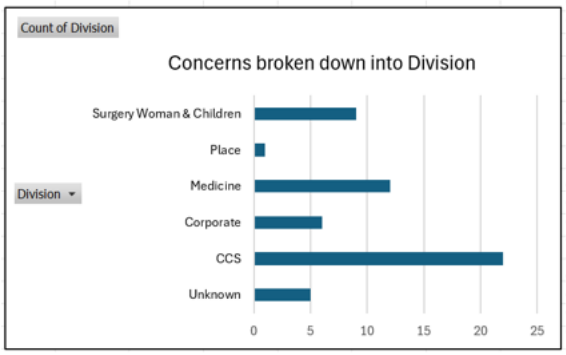
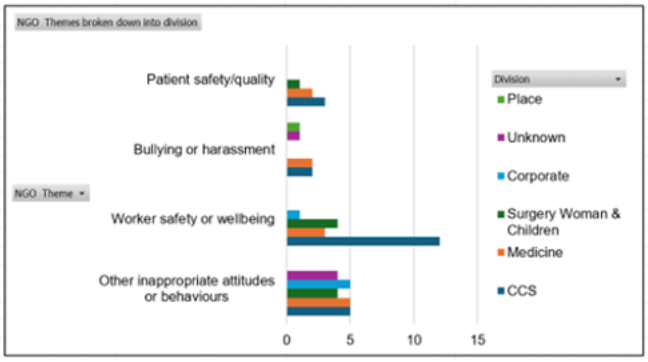
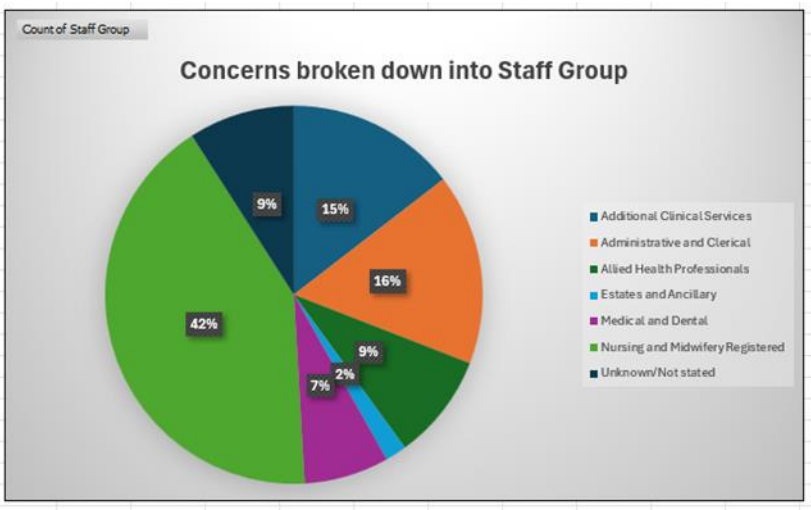


Table 6



The workforce Data

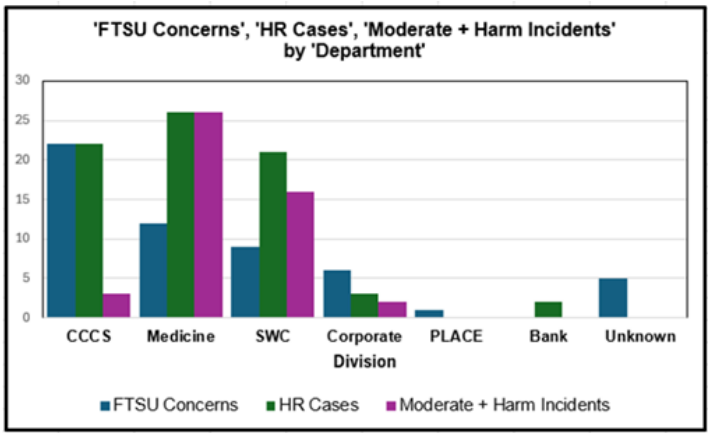
The nursing workforce continues to raise the most concerns over the 1st quarter. The new dashboard has been aligned to the national guardian's office staff groups. The additional clinical services include all members of staff who support registered professionals for example clinical support workers, imaging aides and phlebotomists. Additionally, 9% of concerns have been raised anonymously through the new Microsoft forms QR code on the hub page.



Over 2025 the FTSU team continue to raise awareness. Focusing heavily on the front door services, such as ED, AMU and SDEC. Over the last 10 years the Freedom to speak up service has established good links within the nursing teams. Moving forward the medical workforce are the next priority to ensure these hard-to-reach employees are aware of the service and feel comfortable to raise their concerns. A guardian will attend every welcome to Dudley session. With the aim to every new member of staff to the organisation will be welcomed by a member of the freedom to speak of service giving a brief overview for the service and contact information

Triangulated data

The data below is a sample of the collaboration between FTSU, HR and Moderate + Harm Incidents.



HR overview

This graph shows the number of cases open and closed between 1st April 2025 and 30th June 2025 spilt by Division.

SWC had the highest number of Disciplinary cases at 9 cases. Medicine had 8 hearing cases, 5 of which were Stage 3 sickness hearings, 3 of which resulted in dismissal.

CCCS had 4 appeals logged, 3 of which were for flexible working.

Number of Incidents overview

Of the 47 incidents reporting moderate, severe or fatal harm (*subject to validation*), the most common incident type was clinical care (assessment/monitoring) accounting for 20 (43%). Diagnosis and tests incidents 8 (17%) and appointments, discharge and transfer incidents 7 (15%) were the next most common incident types.

Moving forward It would be useful to consider the addition of the Learn from Patient Safety Events field capturing the staff concern over the incident and its implications. This could be added to future data if the FTSU Steering Group would like to proceed with exploring this

4. FREEDOM TO SPEAK UP Delivery Plan 2025-2028.

The full delivery plan document is located in the reading room.

Paper for submission to the Board of Directors on 11th September 2025

Report title:	Guardian of Safe Working
Sponsoring executive / Presenter:	Dr Jonathan Odum, Interim Medical Director
Report author:	Fouad Chaudhry, Guardian of Safe Working

1. Summary of key issues

This is the 8th report from the Guardian of safe working (GOSW) and covers the period between 16 February 2025 and 31 August 2025.

Assure

- 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).
- No fines have been issued in this reporting period. The outcome of the Exception Reports in this period combination of TOIL and payment.

Advise

- There have been 22 exception reports raised in the period. 2 carried forward from the previous report.
- Eight have been fully closed. 12 ERs are pending. There are currently 10 vacancies in the junior workforce.

Alert

- Reforms to the Guardian of Safe working process will commence 12th September 2025 including a new reporting pathway to HR and the Guardian of Safe Working Hours (GOSWH) instead of clinical supervisors, increased timeframe for submitting reports, revised fining guidance and a mandate for employers to provide a choice of payment or time off in lieu (TOIL) for worked additional hours.

2. Alignment to our Vision

Patients: Deliver right care, in the right place, at the right time	**X**
People: Be a brilliant place to work and thrive	**X**
Place: Build innovative partnerships to improve the health of our communities	

3. Report journey

People Committee, Board of Directors

4. Recommendation(s)

The Public Trust Board is asked to:

a) Note the current Exception Reporting data

b) Note the reforms to the Guardian of Safe working process from September 2025

5. Impact reflected in our Board Assurance Framework (BAF)

BAF Risk 1.0	X	Failure to deliver the right care, in the right place every time
BAF Risk 2.0	X	Failure to ensure Dudley is a brilliant place to work and thrive
BAF Risk 3.0		Failure to build innovative partnerships to improve the health of our communities
BAF Risk 4.0		Failure to remain financially sustainable in 2025/26 and beyond
BAF Risk 5.0		Failure to achieve operational performance requirements & deliver strategic objectives
BAF Risk 6.0		Failure to take sustained action on infrastructures that enables strategic objectives

Is Quality Impact Assessment required if so, add date:

Is Equality Impact Assessment required if so, add date:

REPORTS FOR ASSURANCE

Guardian of Safe working Report

Report to Trust Board September 2025

1 EXECUTIVE SUMMARY

This is the 8th report from the Guardian of safe working (GOSW) and covers the period between 16 February 2025 and 31 August 2025.

There have been **22** exception reports raised in the period. **2** was carried forward from the previous report. **8** have been fully closed. Outcome of ER is combination of TOIL and payment. **12** ERs are pending. No fines have been issued in this reporting period. There are currently **10** 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 26th GSW report and covers the period from 16 February 2025 to 31 August 2025. This is the eighth 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– 16/02/2025 – 31/08/2025

Exception Reports (ER) over past quarter	
Reference period of report	16/02/25 - 31/08/25
Total number of exception reports received	22
Number relating to immediate patient safety issues	1
Number relating to hours of working	21
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	ST5	0	1	1	0
Total			**0**	**1**	**1**	**0**
No. relating to hours/pattern	Accident and emergency	CT1	0	3	0	3
	Acute Medicine	Foundation house officer 1	0	1	1	0
	General medicine	Foundation house officer 1	1	8	2	4
	General medicine	FY1	0	1	0	1
	General medicine	ST4	1	0	1	0
	General medicine	ST5	0	1	1	0
	General surgery	Foundation house officer 1	0	1	1	0
	Psychiatry	Foundation house officer 1	0	1	0	1
	Trauma & Orthopaedic Surgery	Foundation house officer 1	0	5	1	3
	Urology	Foundation house officer 1	0	1	1	0
Total			**2**	**22**	**8**	**12**
No. relating to educational opportunities						
Total			**0**	**0**	**0**	**0**
No. relating to service support available						
Total			**0**	**0**	**0**	**0**

ER by Month

Month	Number of Doctors	Number of reports
February 2025	1	1
March 2025	1	2
April 2025	2	3
May 2025	2	3
June 2025	0	0
July 2025	0	0
August 2025	6	13

Historic Data

Year	Total Exception Reports
2018	55
2019	103
2020	60
2021	44
2022	72
2023	69
2024	81

Exception Reports and Fines.

- No fines submitted.

Medical Vacancy:

- Doctors in training vacancy: **10**
- Total number of doctors in training: **304**

Department	Foundation Year 1	Foundation Year 2	GPST/Lower Training	Higher Training	Grand Total
Acute internal medicine					
Anaesthetics			3	1	4
Cardiology				1	1
Chemical Pathology					
Child and adolescent psych					
Clinical Radiology					
Dental Core Training					
Emergency Medicine					
Endo and Diabetes Mellitus					
Gastroenterology					
General Psychiatry					
General Surgery				2	2
Geriatric Medicine					
Intensive Care Medicine				1	1
Obstetrics and gynaecology					
Oral and maxillofacial surgery					
Otolaryngology					
Paediatrics					
Palliative Medicine					

Rehabilitation Medicine					
Renal Medicine					
Respiratory Medicine				1	1
Stroke Medicine					
Tr & Orth Surgery					
Urology					
Vascular Surgery				1	1
					10

Mitigations:

Exception reporting reforms

Changes to exception reporting, primarily for resident doctors on the 2016 contract in England, include:

- A new reporting pathway to HR and the Guardian of Safe Working Hours (GOSWH) instead of clinical supervisors.
- Increased time for submitting reports (28 days).
- New employer fines for failing to provide access or breaching confidentiality.
- A mandate for employers to provide a choice of payment or time off in lieu (TOIL) for worked additional hours.
- Overall reforms taking effect from September 12, 2025.

Key Changes

Reporting Pathway:
Reports now go directly to HR and the Guardian of Safe Working Hours (GOSWH), rather than clinical supervisors, for greater confidentiality and to reduce conflicts of interest.

Employer Fines:
Fines will be introduced for employers who fail to onboard residents onto the exception reporting system within 14 days or who breach the new confidentiality processes for exception reporting data.

Payment for Additional Hours:
Residents are guaranteed a choice between payment or time off in lieu (TOIL) for all additional hours worked above their contracted hours, except in cases where a safe working hours breach mandates the award of TOIL.

Increased Reporting Window:
The timeframe to submit an exception report is increased from the previous 28 days.

Educational Reports:
All educational exception reports now go directly to the Director of Medical Education (DME) for approval.

Implementation

- Start Date: The reforms are set to be implemented from **September 12, 2025**.
- Partnership: NHS Employers and the British Medical Association (BMA) are working together to update the 2016 TCS contract and provide new guidance for employers to apply

these reforms.

Impact

- These changes aim to simplify processes, improve resident wellbeing, and ensure better compliance with contractual obligations regarding working hours.
- The reforms also seek to ensure doctors are not prevented from reporting issues and that employer actions, such as the unnecessary sharing of exception reporting information, do not adversely affect residents.

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 22. Guardian has engaged with the junior doctors through the above-mentioned engagement strategy. The trainees were also encouraged to do ER if they are denied of attending training opportunities.
- 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
August 2025

Paper for submission to the Board on Thursday 11th September 2025

Report title:	Green Plan
Sponsoring executive / Presenter:	Rachel Barlow – Group Chief Development Officer
Report author:	Ninette Harris – Head of Sustainability

1. Summary of key issues

Assure

The Trust's Green Plan sets out how the organisation will reduce its environmental impact and contribute to improved health and life chances for the local population. The Board is asked to discuss the Green Plan and act as advocates for this agenda.

The Trust's purpose is to improve the life chances and health outcomes of the local population. A key part of this is working collaboratively with partners to build healthier, fairer and more sustainable communities.

The Green Plan is central to this ambition and provides a framework for how the Trust will reduce its environmental footprint while supporting sustainable models of care.
The Green Plan outlines actions across the following domains for discussion:

- Travel and logistics
- Asset management
- Climate adaptation
- Capital projects
- Sustainable models of care
- Procurement
- Use of natural resources

The Joint Infrastructure Committee, with a remit covering digital, data, estates, facilities and sustainability, is aligned with the Government's 10-year plan. The Committee will ensure that infrastructure development supports clinical excellence, improved outcomes, and a sustainable future for the communities we serve.

The Infrastructure Committee will oversee the final submission of the Green Plan to NHS England by the end of October 2026.

Advise

The Green plan document is located in the reading room associated with this meeting.

Alert

None

2. Alignment to our Vision

Patients: Deliver right care, in the right place, at the right time	**X**
People: Be a brilliant place to work and thrive	**X**
Place: Build innovative partnerships to improve the health of our communities	**X**

3. Report journey
Trust Management Committee Executive Group Vitrually to the Infrastructure Committee – who will receive final version subject to Trust Board amendments in September 2025.

4. Recommendations
The Public Board of Directors is asked to:
a) **Discuss** the Green Plan and its alignment with the Trust's purpose.
b) **Endorse** the importance of sustainability as a driver of improved health and life chances.
c) **Act** as advocates for the Green Plan within the Trust and with external partners.

5. Impact reflected in our Board Assurance Framework (BAF)		
BAF Risk 1.0		Failure to deliver the right care, in the right place every time
BAF Risk 2.0		Failure to ensure Dudley is a brilliant place to work and thrive
BAF Risk 3.0	x	Failure to build innovative partnerships to improve the health of our communities
BAF Risk 4.0		Failure to remain financially sustainable in 2025/26 and beyond
BAF Risk 5.0		Failure to achieve operational performance requirements & deliver strategic objectives
BAF Risk 6.0	x	Failure to take sustained action on infrastructures that enables strategic objectives
Is Quality Impact Assessment required if so, add date:		
Is Equality Impact Assessment required if so, add date:		

Our Patients
Our People
Our Place

Enclosure 18

The Dudley Group NHS Foundation Trust

Paper for submission to the Board of Directors 11th September 2025

Report title:	Board of Directors and Committee Effectiveness report 2024/25
Sponsoring executive	Diane Wake, Group Chief Executive Officer
Report author / Presenter:	Helen Board, Board Secretary

1. Summary of key issues

Assure

Reflective of best practice, the Trust has undertaken an effectiveness review of the operation of its board and those of sub committees using an established process for the period 2024/25.

The effectiveness review of the Audit Committee followed the guidance set out in the NHS Audit Committee Handbook and completed an online survey and completed a detailed process checklist.

Following publication of The Insightful Provider Board guidance by NHS England in November 2024, the Trust commissioned the Good Governance Institute to facilitate a self-assessment evaluation followed by a workshop with the Board, based on NHS England's guide. A summary of the output is appended to this report

Alongside the review activity, the People Committee piloted an NHS Providers committee meeting effectiveness matrix tool (NHS Providers) that was undertaken by the deputy director of governance that enabled a ratings approach to the key elements that contribute to effective meetings; meeting management, Papers, Challenge, Outcomes, Relationships and behaviours. Each committee received it feedback report during Q1 2025/26.

Advise

The were no areas flagged as being of significant concern or representing any associated risk. The Board is asked to note that the report is for the period 2024/25 and that the Terms of Reference and workplans for all committees are being kept under review as part of the journey towards group working with Sandwell and the establishment of the Joint Committees.

Alert

none

2. Alignment to our Vision

Patients: Deliver right care, in the right place, at the right time	**X**
People: Be a brilliant place to work and thrive	**X**
Place: Build innovative partnerships to improve the health of our communities	**X**

3. Report journey

Board of Directors September 2025

4. Recommendations
The Public Trust Board is asked to:
a) **Note** that the Trust has followed best practice to undertake an annual review of the operation of the board and its Sub-committee

5. Impact reflected in our Board Assurance Framework (BAF)		
BAF Risk 1.0	x	Failure to deliver the right care, in the right place every time
BAF Risk 2.0	X	Failure to ensure Dudley is a brilliant place to work and thrive
BAF Risk 3.0	X	Failure to build innovative partnerships to improve the health of our communities
BAF Risk 4.0	X	Failure to remain financially sustainable in 2025/26 and beyond
BAF Risk 5.0	X	Failure to achieve operational performance requirements & deliver strategic objectives
BAF Risk 6.0	X	Failure to take sustained action on infrastructures that enables strategic objectives
Is Quality Impact Assessment required if so, add date: n/a		
Is Equality Impact Assessment required if so, add date: n/a		

Annual Review of effectiveness of the Board of Directors and its sub-committees 2024/25
Report to Trust Board on 11th September 2025

1 EXECUTIVE SUMMARY

1.1 It is best practice to undertake an annual review, by way of self-assessment, of the Board and it sub Committee's effectiveness. The Board and its Committees undertook a review in quarter 4 and the outcomes of that, including any recommended changes to terms of reference have been considered by each committee respectively. Any substantive changes to any committees Terms of Reference are summarised in this report.

Following publication of The Insightful Provider Board guidance by NHS England in November 2024, the Trust commissioned the Good Governance Institute to facilitate a self-assessment evaluation followed by a workshop with the Board, based on NHS England's guide. A summary of the output is appended to this report.

The Board is asked to note that the report is for the period 2024/25 and that the Terms of Reference for all committees are being kept under review as part of the journey towards group working with Sandwell and the establishment of the Joint Committees.

2 BACKGROUND INFORMATION

2.1 Committee effectiveness reviews

Each year the Trust undertakes committee effectiveness review work during quarter four. The format this year included individual meetings with the Deputy Chair during March 2025 providing an opportunity for each of the non-executive committee chairs to discuss and review committee performance, workplans and terms of reference.

To support the discussions and provide some continuity to the themes: support and infrastructure, leadership, effectiveness, stakeholder engagement and behaviours were considered. In preparation, executive leads and committee chairs met to discuss a review of the year as a look back as to what went well, review the Terms of Reference and Workplan and explore areas where changes might be introduced if needed. Feedback was also sought from committee members and attendees with a report of the findings, proposed changes to Terms of Reference and workplan presented at a subsequent meeting for approval.

In addition to the above process the Audit Committee followed the guidance set out in the NHS Audit Committee Handbook and completed an online survey and completed a detailed process checklist.

Alongside the review activity, the People Committee piloted an NHS Providers committee meeting effectiveness matrix tool (NHS Providers) that was undertaken by the deputy director of governance that enabled a ratings approach to the key elements that contribute to effective meetings; meeting management, Papers, Challenge, Outcomes, Relationships and behaviours. Each committee received it feedback report during Q1 2025/26.

2.2 Summary of committee reviews and changes to committees Terms of Reference

In year saw the introduction of enhanced upward assurance reporting to the Board of Directors utilising a refreshed cover sheet that adopts the 'Advise, Assure and Alert' approach and upward a quadrant report with assurance ratings assigned to key matters.

Audit Committee
The Committee is chaired by non-executive director, Joanne Hanley from June 2024. Reflecting best governance practice, the committee has undertaken an annual effectiveness review. The framework of this review for the Audit Committee was drawn from the Healthcare Financial

Management Associate (HFMA) NHS Audit Committee handbook. A committee effectiveness survey was distributed to all members and regular attendees. Results from the eight respondents was reviewed was considered by the Committee to determine whether there were any improvements or further steps necessary in relation to the responses with particular scrutiny on those that scored less than 100% agreement. Actions agreed included to undertake a review of the committee workplan, a review of the committee membership and consider any upskilling requirements.

There were no changes proposed to the Committee's Terms of Reference that would require a recommendation to the Board of Directors.

The table below captures the attendance of both members and required attendees for the period 1st April 2024 to 31st March 2025. To note that five meetings were held in 2024/2025.

Audit Committee Membership		Out of 5
Joanne Hanley	Non-executive director (chair from June 2024)	4/4
Peter Featherstone	Non-executive director	4/4
Ita O'Donovan	Associate non-executive director	4/4
Anne-Maria Newham	Non-executive director	3/4
Gary Crowe	Non-executive director (chair until May 2024)	2/2
Gurjit Bhogal	Associate non-executive director	1/1
In attendance		
Liz Abbiss	Director of communications	2/5
Julian Hobbs	Medical director	3/5
Diane Wake	Chief executive officer	2/5
Helen Board	Board secretary	5/5
Chris Walker	Deputy director of finance (interim CFO from 1/1/24)	5/5
Adam Thomas	Executive chief strategy & digital officer, deputy chief executive	5/5
Martina Morris	Chief Nurse	2/5
Andrew Proctor	Director of governance	3/5

The overall conclusion was the committee worked well and that there were no specific risks arising.

Nomination and Remuneration Committee

The Nomination and Remuneration Committee is a sub-committee of the board and holds at least one meeting per year. During 2024/25, it held four meetings and attendance at meetings were as below. Executive directors also attend the Nomination and Remuneration Committee on occasion. The terms and conditions for the executive directors and senior managers of the Trust are included in their individual contracts of employment which includes notice periods and any termination arrangements. The committee undertakes a review of its Terms of Reference each year as a minimum.

The Trust has an Equal Opportunity and Diversity Policy in place which was reviewed and approved in December 2022 and covers all aspects of the Trust's business.

Nomination and Remuneration Committee membership		**Attendance (/4)**
Gary Crowe	Deputy Trust chair	2
Catherine Holland	Non-executive director	3
Sir David Nicholson	Trust chair from 01/09/22	4
Vij Randeniya	Non-executive director, chair of committee	4
Lowell Williams	Non-executive director	2

Finance & Productivity Committee
The committee is chaired by Lowell Williams and met monthly throughout the year and was quorate on all occasions.

Positive aspects flagged included good organisation and quality of written papers that were clearly written. The Chair was recognised as being very well informed on the agenda and chaired the committee well ensuring that summations and actions to be taken post meeting were captured.

Development areas include the request from some non-executive colleagues to receive briefing from relevant directors. The Committee would strengthen its focus on productivity, system-wide financial sustainability, and the strategic deployment of resources to deliver long-term value. Provide greater clarity of requests for deep dive when commissioning such reports. Improvement and consistency of Non-executive director attendance and in particular advance notice on non-attendance.

The workplan for 2056/26 have been subject to review with minor changes proposed in relation to job titles. Subsequent to the conclusion of the annual review activity, the Terms of Reference have been kept under review as part of the journey towards group working with Sandwell and the establishment of the Joint Infrastructure Committee. Items relating to the PFI contract performance, estates matters and the Green Plan have been mapped to the Terms of Reference of the Joint Infrastructure and present to board for approval in July 2025.

Quality Committee
The committee is chaired by non-executive director Dr Liz Hughes and met monthly throughout the year and was quorate on all occasions with the exception of the March 2025 meeting. The committee also meets each quarter in private session and in 2024/25 held an extra meeting in June 2024 to consider annual reports.

Quality has remained a key focus in the Trust and in the committee including notable oversight of the completion of quality impact assessments linked to cost improvement programmes and financial recovery planning activity, perinatal quality report and compliance against the year 6 maternity incentive scheme, embedding of the Patient Safety Incident Response Framework (PSIRF), plans for improved complaints response times, and in year have developed a combined chief nurse and medical director report and continue to refine the integrated quality report; all reported as regular standing items along with oversight of patient experience measures including national and local survey data.

Areas identified for improvement related to the poor timeliness of the submission of papers and consistency of reports with a direct request to authors. Suggestion received to undertake more deep dive activity subject to available agenda time. There was good engagement with a range of key stakeholders. Patient Safety partners, governors and clinical leaders were engaged and involved at an appropriate level.

Future areas of additional focus; development and monitoring of the Quality and Safety Delivery Plan, research and innovation and ensuring that the sub-committees continue to work effectively.

The Terms of Reference were reviewed with one update where in ‘Section 8 Duties and responsibilities’ a new bullet point has been added as follows:

- In relation to National Patient Safety Alerts, the Clinical Effectiveness Group maintains oversight with upward reporting to the Risk and Assurance Group. Where there are concerns with alert deadlines, the Clinical Effectiveness Group will report this to the Risk and Assurance Group, which will in turn upward report to the Quality Committee. The upward report must provide assurance on the mitigations and actions being taken to resolve the concern.

The Terms of Reference continue to be kept under review as part of the working more closely with Sandwell & West Birmingham Hospitals NHS Trust and the wider work of the four Trusts that are part of the Black Country Provider Collaborative.

People Committee
The committee met monthly throughout the year and was quorate on all occasions and is chaired by non-executive director Catherine Holland. Alongside the review activity, the deputy director of governance also piloted a committee meeting effectiveness matrix tool (NHS Providers). It enables a ratings approach to the key elements that contribute to effective meetings:

The tool facilitated an observational assessment of a meeting. It should ideally be undertaken by someone independent of that meeting/work portfolio (non-member or attendee). Each element of an effective meeting was given a numerical rating; the higher the number, the more effective the meeting was considered. Only one meeting was reviewed (28th January 2025). The meeting was quorate but it was important to note that due to operational pressures at the time of the meeting, attendance was negatively impacted and two items were deferred to allow for the presenters to support clinical activity.

The meeting was assessed as rating 4-5 across all elements of 'the effective meeting'. Relationships and behaviours achieved the highest number of five rated elements. This was clearly evident when observing the meeting. The 'meeting reflection' section was particularly strong, with the committee acknowledging in a supportive way the key concerns reported in this assessment themselves.

Positive aspects flagged included noting that committee papers were mostly circulated on time and minutes were of a high standard and rarely need amending. Feedback received support the notion that the meeting was well chaired. Senior leaders engaged in the discussions, providing challenge as well as recognition for work well done where appropriate. Strategic issues were well covered and risks regularly reviewed. Where appropriate additional individuals are invited to present reports.

Matters for improvement relate to the considerable time spent chasing reports to meet the deadline. Report writers need to take responsibility for meeting the deadlines set and papers need to be more concise, with clear recommendations for the Committee to consider.

Terms of reference were subject to update with the committee membership reviewed alongside the required attendees. Other attendees should be as required by the agenda, and by specific invitation.

Integration Committee
The committee is chaired by Vij Randeniya and met monthly throughout the year and was quorate on all occasions.

Positive aspects noted that all the meetings were well attended, and all the papers arrive on time enabling them to be read ahead. The committee chair holds structured meetings prior to the main meeting with the responsible Director to ensure a smooth running.

Feedback received supports that the committee delivers well and is part of a key move towards the community first approach. The committee is working well and had strengthened its approach and understating since it was first initiated. The committee provides an assurance in a smaller forum that helps to scrutinise items in depth. The Directors provide clearly written papers on the key topics. It has grown in strength with many local successes. Everyone is respectful of each other with no negative behaviours noted - the dialogue and behaviour of the committee is very conductive to constructive open behaviour and considered, fruitful discussion. Follow up of

agreed actions are always checked. The committee is always asked to reflect on each meeting. Good mixture of in depth single issues and our Board Assurance Framework.

Areas for improvement have been identified and include developing next steps and to get more involved with partners and plan to take meetings out into community settings.

Terms of reference were subject to update with the committee membership reviewed alongside the required attendees. The statement regarding the purpose of the committee was strengthened emphasising improving the health of our community, multiyear commitments to shift care form hospital to community and develop thriving partnerships.

2.3 Board of Directors Effectiveness review

In response to The Insightful Provider Board guidance issued November 2024, the Board of Directors completed a self-assessment survey aligned to the key domains of the guidance. An externally facilitated board workshop was held in December 2024 where the findings were shared and next steps agreed. See appendix 1.

The Board met in April, May and June and bi-monthly thereafter and attendance of Directors is very high with absence being exceptional. The majority of meetings are held face to face and have been in several community venues including Brierley Hill Health and Social Care Centre, Stourbridge Health and Social Care Centre and the Black Country Institute of Technology. See table 1.

Table 1
Board of Directors' attendance 24/25 meetings

Position	Name	Commencing	End	Attendance out of 8*
Chief executive	Diane Wake	03/04/17		7
Chief finance officer (interim)	Chris Walker	01/01/24		8
Chief operating officer	Karen Kelly	02/01/18		7
Medical director	Dr Julian Hobbs	02/10/17		7
Chief nurse	Martina Morris	03/03/24		7
Interim chief people officer	Karen Brogan	01/05/24		6
Chief people officer (Interim 20/6/22 – 1/7/23)	Alan Duffell	20/06/22	31/04/24	1
Chief integration officer (formerly director of strategy & integration)	Kat Rose**	18/4/22		8
Chief strategy & digital officer (formerly chief information officer)	Adam Thomas	01/09/19		8
Director of governance	Andy Proctor **	01/06/22	31/03/25	5/6
Director of communications	Liz Abbiss**	01/05/23		7
Chair	Sir David Nicholson	01/09/22	31/03/27	8
Non-executive director	Prof Liz Hughes	15/11/19	15/11/25	8
Non-executive director	Julian Atkins	04/01/16	31/05/24	2
Non-executive director	Catherine Holland	01/09/18	31/08/26	7
Non-executive director	Lowell Williams	01/12/19	31/03/26	8
Non-executive director	Prof Gary Crowe	01/07/19	01//07/25	4
Non-executive director	Vij Randeniya	20/11/20	31/11/26	4
Non-executive director	Gurjit Bhogal	13/05/21	31/05/24	1/2
Non-executive director	Joanne Hanley	01/06/23	31/05/26	7
Non-executive director	Anne-Maria Newham	01/06/24	31/05/27	5/6
Non-executive director	Peter Featherstone	01/06/24	31/05/27	4/6

Non-executive director	Mohit Mandiratta	01/06/24	31/05/27	5/6
Associate non-executive director	Anthony Hilton**	01/07/23	31/07/25	7
Associate non-executive director	Ita O'Donovan***	01/06/24	31/05/25	4/6
Associate non-executive director	Thuvarahan Amuthalingham**	13/05/21	31/05/24	1/2

2.3 Board Development

The Board development programme maintained momentum during the year. In addition to a series of executive away days, the Trust board participated in a series of development sessions held either a single trust (DG) or sessions held as the Black Country Provider Collaborative (BCPC) with board members from all four acutes in attendance:

2024
April - BCPC joint event. Improvement leadership development
May – DG. Building understanding of Dudley Integrated Health and Care NHS Trust (DIHC), pharmacy services
June – DG. Strategy refresh and development. BAF and Risk Appetite review
July – DG. Building understanding of Dudley Integrated Health and Care NHS Trust, commissioning team
August – BCPC. Cyber Security: what Boards need to know. Improvement leadership development
September – Strategy development
October – DG. MHAA level 4, Strategic scoping
November – DG. NHS Resolution training for board – maternity incentive scheme
December – DG. PFI deep dive, Annual planning, Improvement leadership development

2025
January – DG. Primary Care CHC – adult and children, Intermediate care
February – DG. Black Country Plan, strategy & finance
March – BCPC. Forward Plan

3 RISKS AND MITIGATIONS

3.1 These are no significant risks identified.

4. RECOMMENDATIONS

- That the Board considers any actions that it wishes to implement having regard to the survey findings, and the further matters highlighted in the background information.

Helen Board
Board Secretary
July 2025

APPENDICES:
Appendix 1 – Insightful board next steps

Appendix 1

Insightful Board

Next steps: post December 2024 workshop

This document sets out developments by the trust since the workshop which have been shared by the board secretary, and suggested next steps, including possibilities for further support that GGI could provide to the trust or to the other trusts within the Black Country provider collaborative.

Theme	Steps to consider	Additional notes
Problem sensing and comfort seeking	Taking regular time as a board to reflect on whether the board is being problem sensing rather than comfort seeking. Holding a board development session to focus further on this area	Suggested topic added to board development plan list for 25/26
Thematic Reviews	Review the March thematic review and develop a plan for thematic reviews throughout 2025/26.	To complete as part of the joint board working SWB/DG
Using Data and Information	Having narrative in reports which sets out causes and actions in relation to the data, so that the reader is not left thinking 'so what?' • providing comparisons, such as external benchmarking, data over time	Committee chairs are meeting to discuss themes in their individual committees. Deep dives are being carried out into particular areas. Care is being taken in relation to aggregating information. The report writing guide has been revised and reissued to support improved report writing. Requesting regular feedback from board members on the quality of papers, in particular in relation to data and information. Consideration given for a training session for executive directors on their role in relation to reports developed and written by those in their team, where they are the sponsor not pursued.
The Role of Committees in active governance	Committees are key in carrying out detailed scrutiny which is then reported to the board.	Since the workshop changes have been made to committee reporting, including: - strengthening committee reporting to the board - improving report writing (as outlined above) - removing the reference to 3As from the cover sheet, which had been leading to management sharing assurance from their work rather than producing reports for committees and board to provide them with assurance
Areas for further exploration as a Board	In addition to the areas outlined above, there are other areas that the trust might wish to consider for board development which emerged during the course of the workshop. These included being a T shaped director, as part of being a member of a unitary board.	Next steps: consider the following topics as part of board development sessions (added to list for 25/26 development planning: - being a unitary board: what does that mean both to the board as a whole and to individual directors - assurance and reassurance, including the use of data and information and the role of committees Agreement made for GGI to support Sandwell & West Brimingham to undertake a similar exercise

Our Patients
Our People
Our Place

Enclosure 19

The Dudley Group NHS Foundation Trust

Paper for submission to the public Board on 11th September 2025

Report title:	Quarterly Trust strategy and annual plan progress report April – June 2025
Sponsoring executive / Presenter:	Adam Thomas Group Chief Strategy & Digital Officer
Report author:	Ian Chadwell Deputy Director of Strategy

1. Summary of key issues

The full report located in the reading room shows progress against each of the six in-year objectives identified in the Annual Plan 2025/26 using a revised and simplified format.

Progress against each of the ten assurance metrics that are being used to track progress against the new strategy which was formally approved at Board of Directors in July 2025 is also shown.

Assure

Recruitment to positions to enable the Care Navigation Centre to start operation, along with the development of pathways to support alternatives to hospital attendance and admission, mean that the new service is set to go live from 1st September.

Anti-bullying and anti-discrimination policy and toolkit have been launched and promoted across the organisation, including via the Make It Happen tours in May and June.

Plans to reduce back-office costs have been submitted to NHSE with plans for a £800k reduction included within the cost improvement programme this year.

Advise

Care Transfer Hub launched by bringing together different agencies into same physical space and electronic bed management system has been developed and is due to be deployed in the second quarter providing better information about the bed state and improving flow through the hospital.

A business case for an elective hub in the south of the Black Country has been developed with the aim of using space at Sandwell Health Campus.

Acute therapy appointments are now being offered in community locations with plans for use of four additional outpatient rooms at Merry Hill Centre being developed with some outpatient services set to re-locate next quarter.

Alert

Cost savings associated with the transformation of non-elective pathways have not yet been materialized and support has been sought from an external consultancy.

Changes to the NHS Payment system this year threaten the financial viability of the elective hub business case so that the emphasis is now on the relocation of services rather than provision of additional capacity.

2. Alignment to our Vision	
Patients: Deliver right care, in the right place, at the right time	**x**
People: Be a brilliant place to work and thrive	**x**
Place: Build innovative partnerships to improve the health of our communities	**x**

3. Report journey
Quality Committee – 29th July 2025 People Committee – 29th July 2025 Integration Committee – 30th July 2025 Finance & Productivity Committee – 31st July 2025

4. Recommendation(s)
The Public Board of Directors is asked
a) Note the progress report for quarter 1

5. Impact reflected in our Board Assurance Framework (BAF)		
BAF Risk 1.0	x	Failure to deliver the right care, in the right place every time
BAF Risk 2.0	x	Failure to ensure Dudley is a brilliant place to work and thrive
BAF Risk 3.0	x	Failure to build innovative partnerships to improve the health of our communities
BAF Risk 4.0	x	Failure to remain financially sustainable in 2025/26 and beyond
BAF Risk 5.0	x	Failure to achieve operational performance requirements & deliver strategic objectives
BAF Risk 6.0	x	Failure to take sustained action on infrastructures that enables strategic objectives
Is Quality Impact Assessment required if so, add date:		
Is Equality Impact Assessment required if so, add date:		

Paper for submission to Board of Directors 11th September 2025

Report title:	Board Assurance Framework
Sponsoring executive:	Diane Wake, Chief Executive
Report author:	Helen Board - Board Secretary

1. Summary of key issues

Background

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.

The Board of Directors is asked to receive a summary of each of the six BAF risks and the Trust's Board Assurance Framework current position given as appendix 1.

Summary of changes since the last report: July 2025

BAF Risk 1 Quality: Safe, High-Quality Care There is a risk that the Trust fails to deliver the right care, in the right place at the right every time resulting in poor clinical outcomes and patient experience.

The assigned risk appetite is 'Cautious' and is scored as 9 indicating that the BAF is currently being managed within the Risk Appetite and Tolerance limit score.

The proposed target score the 2025/26 is 9 (3x3). There is no change in the score reflecting no significant change in the position to indicate a change in the current residual risk score for Q1 25/26 which is given as 9.

Every attempt will be made to further reduce it, however given complexities associated with quality and safety, this may be too ambitious to achieve. The assigned risk appetite is 'Cautious' and is scored as 9 indicating that the BAF is currently being managed within the assigned Risk Appetite and Tolerance limit score.

At its last meeting, the Committee assigned a 'Positive' assurance rating and noted that BAF1 would be submitted to each meeting with any updates applied highlighted as needed.

BAF Risk 2 Inability to attract, retain, and develop a skilled and engaged workforce may compromise the delivery of safe, high-quality care, reduce staff morale, and risk non-compliance with regulatory standards.

The proposed target score is 6 (2x3). The Trust should be making appropriate plans to ensure that this is 'unlikely', and the impact would be 'moderate'.

The current risk score is 12 and reflects ongoing challenges in workforce retention, system optimisation, and cultural transformation.

The proposed risk appetite risk is Seek and is being managed within in Risk Appetite tolerance score. There are presently no red operational risks linked to this BAF.

Owing to the staffing situation and increased staff sickness absence, the Committee assigned an inconclusive assurance rating at its last meeting.

BAF Risk 3 - If the Trust fails to build innovative partnerships, there is a risk that the Trust will be unable to transform the way services are delivered which will impact on the Trust's ability to improve the health of our communities

The current risk score 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.

The inherent risk is 12 (3x4). The proposed target score is 8 (2x4). The Trust should be making appropriate plans to ensure that this is 'unlikely', whilst the impact would remain 'major'.

The proposed risk appetite Risk is Significant and is being managed within in Risk Appetite tolerance score. There are presently no operational risks linked to this BAF. The Committee assigned a positive assurance rating at its last meeting.

BAF Risk 4 – Failure of the Trust to achieve its financial plan in 2025/26 may result in NHS England taking regulatory action

The current risk score is 20 (5x4) based on an almost certain and major impact assessment. The Trust had set a breakeven plan which includes £26.95m of deficit funding and a distribution of the Integrated Care Board surplus. To achieve this plan the Trust is required to deliver a Cost Improvement Programme of £38.976m. While the £8.9m of the Cost Improvement Programme that was unidentified at plan submission has been found there is now a £14.3m risk to the delivery of the programme. If the Trust does not achieve its financial plan, then it will not receive risk pool funding and part of the deficit funding.

The target risk score is 12 (4x3). This is based on a reduction in likelihood (from 4 to 3) and a reduction in consequence (from 5 to 4). This will be reviewed throughout the year and will reflect the Trust having a robust forecast to deliver the 2025/26 financial plan, a fully identified Cost Improvement Programme for 2025/26 that is delivering and recurrent cost savings maintaining the Trusts underlying financial position against the financial recovery plan.

The Committee assigned an inconclusive assurance rating at its last meeting.

BAF Risk 5 – Failure to achieve operational performance requirements and deliver strategic goals

The current risk score is 16 (4x4). This is on the basis that the current likelihood is "likely". The impact of this risk, should it be realised for the Trust's services, is 'major'. The target risk score is 12 (3 x 4). The impact of this risk should it be realised would remain as major, but the likelihood for the Trust should be reduced to possible.

The Committee assigned a positive rating at its last meeting.

BAF 6 - Failure to take sustained action on infrastructures that enables strategic objectives

The Joint Infrastructure Committee BAF is intended to articulate Group risk appetite and ambition across compliance, financial investment, innovation, and sustainability in terms of digital, estates, and facilities infrastructure. This BAF was presented in a state of readiness for the committee to report to Board, however, it was caveated with the need for more detailed baselining and planning work throughout the year to revise the residual risk score and committee assurance rating – as this is underway, developing and is a major revision in itself, an assurance rating of 'inconclusive' rather than 'negative' was proposed for the committee to consider. At the last meeting held August 2025, the Committee agreed that further work was required before an assurance rating could be assigned.

2. Alignment to our Vision	
Patients: Deliver right care, in the right place, at the right time	**x**
People: Be a brilliant place to work and thrive	**x**
Place: Build innovative partnerships to improve the health of our communities	**X**

3. Report journey
Board committees July, August 2025. Board of Directors, Audit Committee September 2025

4. Recommendation(s)
The Public Trust Board is asked to:
a) **Approve** the BAF summary report noting the ongoing development related to BAF 6 overseen by the Infrastructure Committee

5. Impact reflected in our Board Assurance Framework (BAF)		
BAF Risk 1.0	X	Failure to deliver the right care, in the right place every time
BAF Risk 2.0	X	Failure to ensure Dudley is a brilliant place to work and thrive
BAF Risk 3.0	X	Failure to build innovative partnerships to improve the health of our communities
BAF Risk 4.0	X	Failure to remain financially sustainable in 2025/26 and beyond
BAF Risk 5.0	X	Failure to achieve operational performance requirements & deliver strategic objectives
BAF Risk 6.0	X	Failure to take sustained action on infrastructures that enables strategic objectives

Is Quality Impact Assessment required if so, add date: n/a
Is Equality Impact Assessment required if so, add date: n/a

Summary Draft Board Assurance Framework (BAF): September 2025 update

- The following table captures the progress related to development of BAF risks with proposed scores

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	Quality	Failure to deliver the right care, in the right place at the right every time resulting in poor clinical outcomes and patient experience.	Medical Director Chief Operating Officer Chief Nurse	Quality	**20** (4x5)	**9** (3x3)	**9** (3x3)	**Cautious 9**	**Positive** *Aug 25*
2	Workforce	Failure to recruit, retain, train, develop, engage, and support an effective workforce will compromise the ability to deliver safe and effective care, maintain staff morale and regulatory compliance.	Chief People Officer	People	**20** (4x5)	**12** (4x3)	**6** (3x2)	**Seek 16**	**Inconclusive** *Aug 25*
3	Partnerships	Failure to build innovative partnerships, there is a risk that the Trust will be unable to transform the way services are delivered which will impact on the Trust's ability to improve the health of our communities	Chief Integration Officer	Integration	**12** (3x4)	**12** (3x4)	**8** (2x4)	**Significant 20**	**Positive** *Aug 25*
4	Finance	Failure of the Trust to achieve its financial plan in 2025/26 may result in NHS England taking regulatory action	Director of Finance	Finance and Productivity	**20** (5x4)	**20** (5x4)	**12** (4x3)	**Open 12**	**Inconclusive** *Aug 25*
5	Operational Performance	Failure to achieve operational performance requirements and deliver strategic goals	Chief Operating Officer	Finance and Productivity	**20** (5x4)	**20** (5x4)	**12** (4x3)	**Open 12**	**Positive** *Aug 25*
6	IT and Digital Infrastructure	Failure to take sustained, ambitious action to optimise estates, facilities, digital, data, and technology functions risks undermining strategic transformation goals leading to financial strain, reduced quality and safety, weaker cyber-resilience, impaired collaboration, and loss of public trust.	Group Chief Strategy & Digital Officer Group Chief Development Officer	Infrastructure	**20** (4x5)	**20** (4x5)	**16** (4x4)	**Seek 16**	**Inconclusive** *Aug 25*

Risk Scoring Levels					
Consequence score	**1**	**2**	**3**	**4**	**5**
	Negligible	Minor	Moderate	Major	Catastrophic
5 Almost certain	5	10	15	20	25
4 Likely	4	8	12	16	20
3 Possible	3	6	9	12	15
2 Unlikely	2	4	6	8	10
1 Rare	1	2	3	4	5
Likelihood score	**1**	**2**	**3**	**4**	**5**
Descriptor	Rare	Unlikely	Possible	Likely	Almost certain
Frequency How often might it/does it happen	This will probably never happen/recur	Do not expect it to happen/ recur but it is possible it may do so	Might happen or recur occasionally	Will probably happen/recur but it is not a persisting issue	Will undoubtedly happen/recur, possibly frequently

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

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

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 Definitions and assigned tolerance range and upper limits

Appetite Definition	Risk score tolerance range	Tolerance Limit
None	**0**	**0**
Minimal	**1-5**	**5**
Cautious	**4-9**	**9**
Open	**8-12**	**12**
Seek	**12-16**	**16**
Significant	**16-25**	**20**