# DUDLEY INTEGRATED HEALTH AND CARE NHS TRUST BOARD

**TUESDAY 6th September 2022**

**09:30– 13:00**

**Dudley Canal & River Tunnel Trust, 501 Birmingham New Road, Dudley, West Midlands DY1 4SB**

# PUBLIC AGENDA

Please note, as part of DIHC's commitment to openness and accountability, members of the public are able to attend, but will need to notify in advance to do so. Should you wish to join the meeting please email Elaine Doyle, Trust Secretary on elaine.doyle6@nhs.net who will provide details and guidance on observing the meeting. Should you wish to ask a question about the issues on the Board Agenda please send your question prior to the meeting. The papers, minutes and any questions and answers to the items on the Board Agenda will be published on the DIHC website.

| Item No | Agenda Item | | | Presented by | Time |
|---|---|---|---|---|---|
| **Formalities:** to declare the meeting open, quorate and in accordance with the standing orders: | | | | | |
| **1.** | **Chair's Welcome**<br>1.1 Apologies<br>1.2 Declarations of Interest<br>1.3 Board of Directors' Register of Interests<br>1.4 Public Board Minutes – meeting held on 5th July 2022<br>1.5 Action Register and Matters Arising | <br>To Receive<br>To Receive<br>To Receive<br>For Approval<br>For Approval | Verbal<br>Verbal<br>Verbal<br>Enc 1.3<br>Enc 1.4<br>Enc 1.5 | Mr. H Turner<br>Mr. H Turner<br>Mr. H Turner<br>Mr. H Turner<br>Mr. H Turner<br>Mr. H Turner | 09:30 |
| **2.** | **Service Story**<br>2.1 School Nursing | For Information | Presentation | Ms. Laura Bickley | 09.40 |
| **3.** | **Standing Items**<br>3.1 Chair's Update<br>3.2 Chief Executive's Report<br>3.3 Agenda for Part Two – Private Board | <br>For Information<br>For Information<br>For Information | <br>Verbal<br>Enc 3.2<br>Enc 3.3 | <br>Mr. H Turner<br>Ms. P Harris<br>Mr. H Turner | 10:00 |
| **Delivering and Driving DIHC Strategy** | | | | | |
| **4.** | **4.1 Equality, Diversity and Inclusion Strategy**<br>**4.2 Equality, Diversity and** | For Approval | Enc 4.1 | Ms. S Cartwright | 10:10 |

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|---|---|---|---|---|---|
| | **Inclusion Annual Report** | For Approval | Enc 4.2 | Ms. S Cartwright | 10:25 |
| **Our Services** | | | | | |
| **5.** | **Board Assurance Framework and Corporate Risk Register** | To Review | Verbal | Ms. E Doyle | 10:40 |
| **Delivering safe and quality services, supported by integrated governance that drives quality clinical improvements** | | | | | |
| **6.** | **Quality and Safety Performance Report** | For Information | Enc 6 | Ms. S Nicholls | 10:50 |
| **7.** | **Quality and Safety Committee Assurance Report** | For Assurance | Enc 7 | Ms. V Little | 11:05 |
| **The best place to work, supported by a new leadership and workforce culture, organically co-developed, together** | | | | | |
| **8.** | **Workforce Performance Report** | For Assurance | Enc 8 | Ms. S Cartwright | 11:10 |
| **9.** | **People Committee Assurance Report** | For Assurance | Enc 9 | Mr. M Evans | 11:20 |
| **Doing the best with what we have, to be affordable today and sustainable tomorrow** | | | | | |
| **10.** | **Strategic Commissioning and Transformation Team Assurance Report** | For Assurance | Enc 10 | Ms. S Cartwright | 11:25 |
| **11.** | **Finance Report** | For Assurance | Enc 11 | Mr. M Gamage | 11:40 |
| **12.** | **Performance Report** | For Assurance | Enc 12 | Mr. P King | 11:55 |
| **13.** | **Finance, Performance and Digital Committee Assurance Report** | For Assurance | Enc 13 | Mr. I Buckley | 12:10 |
| **Help and Empower the People of Dudley to live longer and healthier lives through fully integrated community-based healthcare** | | | | | |
| **14.** | **Report from the Primary Care Integration Committee** | For Assurance | Enc 14 | Dr G Solomon | 12:15 |
| **15.** | **Dudley Place Arrangements** | For Assurance | Enc 15 | Ms. S Cartwright | 12:20 |
| **Fair, Accountable, Responsible and Transparent** | | | | | |
| **16.** | **Provider Declarations** | For Approval | Enc 16 | Ms. E Doyle | 12:35 |
| **17.** | **Use of Trust Seal** | For Assurance | Enc 17 | Ms. E Doyle | 12:40 |
| **End of Meeting Formalities:** to bring the meeting to an end and include reflections on the meeting before inviting an opportunity for questions from the public. Normally pre-submitted in advance of the meeting and answered during the allotted time or in writing following the meeting. | | | | | |
| **18.** | **Any Other Business** | To Receive | Verbal | Mr. H Turner | 12:45 |
| **19.** | **Questions from the public** pre-submitted | To Receive | Verbal | Members of Public | 12:50 |
| **20.** | **Risk Review** | To Receive | Verbal | Mr. H Turner | 12:55 |
| | **Date of next meeting:** 4th October 2022<br>Time: 9:30 am – 1:00 pm<br>Venue: Dudley College of Technology, The Broadway, Dudley, DY1 4AS. | | | | 13:00 |

**Dudley Integrated Health and Care NHS Trust**
**Declaration of Interest Register**

| Title | Name | Job Title/Relationship with Dudley Integrated Health and Care NHS Trust | Declared Interest | Financial Interest | Non-Financial Professional Interest | Non-Financial Personal Interest | Indirect Interest | From | To |
|---|---|---|---|---|---|---|---|---|---|
| Ms | Billie Lam | Associate Non-Executive Director | Volunteering for Staffordshire Healthwatch | | | ✓ | | Apr 2019 | |
| | | | Registered as a bank staff at Kettering General Hospital NHS Foundation Trust | ✓ | | | | Mar 2020 | |
| | | | Member of Seacole Group | | ✓ | | | Jun 2021 | |
| Mr | David Gilburt | Non-Executive Director & Audit and Risk Committee Chair | Cheshire Police Audit Committee Member | ✓ | | | | Apr 2017 | Mar 2024 |
| | | | Muir Group Housing Association Audit Committee Member | ✓ | | | | Apr 2021 | |
| | | | Associate Non-Executive at Robert Jones Orthopaedic Hospital NHS FT | ✓ | | | | Feb 2022 | |
| Dr | George Solomon | Non-Executive Director & Primary Care Integration Committee Chair | Partner is a Non-Executive Director at Coventry and Warwickshire ICB | | | | ✓ | Apr 2022 | |
| Dr | Gillian Love | Associate Non-Executive Director | GP Partner Halesowen Medical Practice | | ✓ | ✓ | | 1996 | |
| | | | Clinical Director of Halesowen PCN | ✓ | | | | 2019 | |
| | | | Director of Future Proof Health | ✓ | | | | Jan 2020 | |
| | | | Share Holder of Future Proof Health | ✓ | | | | Aug 2014 | |
| | | | Director of Mary Martin Enterprise Ltd | | | | | 2014 | |

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|---|---|---|---|---|---|---|---|---|---|
| Mr | Harry Turner | Chair | Chair – The Hospice Charity Partnership | | ✓ | | | Aug 2021 | |
| | | | Chair – The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Trust | | ✓ | | | Dec 2021 | |
| | | | Presiding Magistrate Worcestershire | | | | ✓ | 2005 | |
| | | | Son working as a scrub nurse in Acute Trusts across Black Country | | | | ✓ | Jul 2022 | |
| Mr | Ian Buckley | Non-Executive Director & Finance, Performance and Digital Committee Chair | N/A | | | | | | |
| Dr | Lucy Martin | Acting Joint Medical Director | Partner Eve Hill Medical Practice | ✓ | | | | 2001 | |
| | | | Shareholder Futureproof Health | | ✓ | | | Aug 2014 | |
| Mr | Martin Evans | Non-Executive Director & People Committee Chair | Director of MJE Associates Ltd | ✓ | | | | Apr 2020 | |
| Mr | Matthew Gamage | Interim Director of Finance, Performance and Digital | CIMA Member | | ✓ | | | 2012 | |
| | | | Currently seconded to Interim Director of Finance role from Dudley CCG | | ✓ | | | Apr 2020 | Sep 2022 |

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|---|---|---|---|---|---|---|---|---|---|
| Mrs | Penelope Ann Harris | Interim Chief Executive Officer | Director of Kerr Darnley Ltd | ✓ | | | | Sept 2013 | |
| | | | Specialist Consultant for PwC | ✓ | | | | Dec 2021 | |
| Mr | Philip King | Chief Operating Officer | Visiting lawyer and lecturer, Birkbeck School of Law, University of London | ✓ | | | | Sept 2002 | |
| | | | Member of Liberty Lawyers Group | | ✓ | | | Sept 2002 | |
| | | | Member of The Inner Temple | | ✓ | | | Sept 2000 | |
| | | | Registrant Member of the Bar of England and Wales | | ✓ | | | Sept 2002 | |
| | | | Member of the Royal College of Nursing | | ✓ | | | Jan 1987 | |
| | | | Director of Audenmark Ltd | ✓ | | | | Jan 1993 | |
| | | | Non Clinical Partner Chapel Street | | ✓ | | | 2022 | |

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|---|---|---|---|---|---|---|---|---|---|
| Dr | Richard Bramble | Acting Joint Medical Director | GP Partner, Links Medical Practice | ✓ | | | | 2013 | |
| | | | Shareholder, Futureproof Health | ✓ | | | | 2015 | |
| | | | Revival Fires Church | | | ✓ | | 2008 | |
| | | | GMS Contract Holder- GP Partner Chapel Street | | ✓ | | | May 2022 | |
| Mrs | Stephanie Cartwright | Director of Strategy, People and Partnerships | None | | | | | | |
| Dr | Stephen Cartwright | Associate GP Non-Executive Director | Partner GP - Keelinge House Surgery | ✓ | ✓ | | | 1991 | June 2022 |
| | | | Part owner of Keelinge House Building | ✓ | | | | 1998 | |
| | | | Shareholder of Future Proof Health | ✓ | | | | Aug 2014 | |
| Ms | Susan Nicholls | Director of Nursing, Quality and AHPs | Sessional Lecturer, Birmingham City University | ✓ | | | | Sep 2018 | |
| | | | Governor Arrow Vale School Redditch | | | ✓ | | Jun 2021 | |
| | | | Clinical practice – Hampton in Arden Surgery. Solihull | | ✓ | | | 2013 | |
| Ms | Valerie Ann Little | Non-Executive Director & Quality and Safety Committee Chair | Member of the Corporation of Dudley College of Technology | | ✓ | | | Jan 2016 | |

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|---|---|---|---|---|---|---|---|---|---|
| Mr | Adam Race | Interim Associated Director of People | Substantively employed as Deputy Chief People Officer at the Royal Wolverhampton NHS Trust | | ✓ | | | Oct 2018 | |
| | | | Chartered Member of the CIPD | | ✓ | | | 2012 | |
| | | | Employer Chair - West Midlands Social Partnership Forum | | ✓ | | | Feb 2021 | |
| | | | West Midlands Deputy HRD Network Chair | | ✓ | | | April 2020 | |
| | | | Wife works as Head of Medical Workforce and Temporary Staffing at University Hospitals Birmingham | | | | ✓ | Dec 2015 | |
| | | | | | | | | | |

Dudley Integrated Health and Care NHS Trust

# DUDLEY INTEGRATED HEALTH AND CARE NHS TRUST BOARD

**TUESDAY 5th July 2022**
**09:30– 13:00**

**The Drawing Room, Himley Hall, Himley Rd, Himley, Dudley DY3 4DF**

**Present:**

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| Mr H Turner (HT)(Chair) | Chair, DIHC |
| Ms P Harris (PH) | Interim CEO, DIHC |
| Mr I Buckley (IB) | Non-Executive Director, DIHC |
| Ms S Cartwright (SC) | Director of Strategy, People and Partnerships, DIHC |
| Mr M Evans (ME) | Non-Executive Director, DIHC |
| Mr M Gamage (MG) | Interim Director of Finance, Performance and Digital, DIHC |
| Mr D Gilburt (DG) | Non-Executive Director DIHC |
| Mr P King (PK) | Chief Operating Officer, DIHC |
| Ms B Lam (BL) | Associate Non-Executive Director, DIHC |
| Ms V Little (VL) | Non-Executive Director DIHC |
| Ms G Love (GL) | Associate Non-Executive Director, DIHC |
| Ms S Nicholls (SN) | Director of Nursing and AHPs, DIHC |
| Dr G Solomon (GS) | Non-Executive Director DIHC |

**In Attendance:**

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| Mrs L Elliott (LE) | Executive Assistant and Governance Officer (minutes) |
| Mr J Young (JY) | Associate Director of Governance |
| Mr A Gandy (AG) | Operational Manager, DIHC |
| Ms C Bugg (CB) | Chaplain, Listening and Guidance Service |
| Ms K Toofany (KT) | Lead Dietician |
| Mr D Jenkins (DJ) | Associate Director Pharmacy and Population Health Management |
| Mr L Dunn (LD) | Communications and Engagement Specialist |

| Item No | Agenda Item |
|---|---|
| 1. | **Chair's Welcome**<br><br>The Chair welcomed all attendees to the July Board meeting of Dudley Integrated Health and Care NHS Trust at Himley Hall.<br><br>The Chair provided an additional welcome to Alec Gandy, Clare Bugg and Kayenaat Toofany who were present to deliver the service story to Board, Alison Braham the recently appointed DIHC Chief of Office for the Medical Directorate, James Young to present Health and Safety Annual Report and finally Luke Dunn attending on behalf of Helen Codd for the Communications and Engagement Report.<br><br>1.1 Apologies<br><br>Apologies were received from Dr Richard Bramble, Dr Stephen Cartwright and Elaine Doyle. Apologies also received from Mayada Abuaffan of Dudley Council. |

1.2 Declarations of Interest

The chair asked the board to note the schedule of Declarations of Interest contained in the papers.

1.3 Board of Directors' Register of Interests

The Chair asked LE to note a declaration in the interests of transparency that their son is a scrub nurse working across the Black Country at various hospitals for Acute Trusts, not for DIHC.

1.4 Public Board Minutes – meeting held on 7th June 2022

ME referred to page 13 in the People update in relation to Ockenden report and advised the Chair that from a People Committee perspective they can provide assurance to the Trust that they have noted the recommendations.

SC advised that on Page 16 the acronym SAS highlighted refers to Special Allocation Scheme.

DG noted that on Page 19 in the Board performance report the paragraph reporting on High Oak vaccinations and would like clarity on narrative which refers to "but was still reporting a decreasing L", it seems this is a typo and requested for this to be corrected.

Noting the above amendments will be checked and file copies corrected the Board accepted the minutes of 5th June 2022 were a true and accurate record of the meeting.

PH asked the Chair to note that LE is covering the minutes for July which is now the governance managers responsibility and both HT and PH thanked LE for the support.

1.5 Action Register and Matters Arising

**PUB/MAY22/02** – The action item was discussed thoroughly. LM will discuss this further with AR and PK to investigate governance processes in place around employing salaried GP's with the medical director LM to provide assurance for the Board around this. ME also advised the People Committee will pick this up and the Board were content to close this action.

**PUB/MAY22/03** - MG provided the Board with an update and advised that they had discussed with Faye Duncan about providing an additional set of metrics in the performance report which takes into account complaints that are not resolved within time period to provide a more rounded view and it will also be taken through Quality and Safety Committee. Board agreed to close this action.

**2.**

**Service Story**

2.1 Listening & Guidance Social Prescribers & Lead Dietitian

Alec Gandy (AG) introduced the team in attendance which included Clare Bugg (CB) who is a listening and guidance prescriber and Kayennat Toofany (KT) a Dietician

CB provided an introduction to the Listening and Guidance Team (L&G) based at Kingswinford and Wordesley Primary Care Network. They advised the service provides prompt access for people in distress comprising of a 45 minute long consultation, the service employs chaplains as trained listeners. The service is available for anyone who has experienced any type of loss and explained the various

aspects of what loss comprises of, bereavement, loss of health, broken relationships and the service looks at emotional, social, and even spiritual needs.

CB explained the history of a referral sent to them due to a bereavement. The patient had cared for their parents for five years and their mother also had dementia. The patient provided support for their parents whilst their own spouse was suffering from cancer and going through active treatment. The patient was feeling very low and didn't want to burden their spouse with their problems. The patients father passed away and they commented that they were so consumed looking after everyone they didn't know how to grieve for their father. They had called their GP surgery, and this was why they were referred to the service.

CB explained what interventions they took which included a safe space to talk due to the patient's losses (Spouses health, mothers' dementia and fathers death). For the first 45 mins the patient could hardly talk and just cried and when consoled advised that they just wanted to talk and for someone to listen free of any judgment. Reflecting back what the patient says helps the listener to make sense of how the patient is feeling and coping. CB gave reflections on grief and how this affects a person, the process of grief of navigating towards a new normal. CB asked the patient about what they enjoyed in their life and the patient, consumed with grief couldn't remember. The listener gave the patient a better understanding of the grief process and understanding that they were not mentally ill which is what the patient had thought.

CB detailed the Impact Specifics which included

- Patient was able to express his sense of loss outside the family.
- Patient had a better understanding of the grief process.
- Patient received regular support in navigating his time to support his mental health.
- Patient learned how to build in self-care without guilt.

CB was able to reflect back to the patients what he had actually done for his family as he had not reflected on this, this was a revelation to him.

He had eight sessions with CB and not the usual six which shows the service is bespoke.

CB thanked the Board for listening and opened the floor for any questions.

LM thanked CB and stated as a practicing GP there is a lack of support for people who are recently bereaved. Also stated that there are issues with the referral criteria and noted that L&G is a really helpful service to have in their PCN.

GL commented their practice has two L&G, one with a more practical background and the other L&G adviser is a Chaplain. GL gave an insight into what one of the L&G team does as part of the service which included taking people to local parks so this service is morphing beyond practice based and more is needed.

PH commented that it is important we offer this service and commented the L&G team are not employed as chaplains and to be clear the service is open to all faiths and not specifically a faith-based service which needs to be accessible to all. CB commented the service is indeed open to all and the only time CB refers to matters of faith in a consultation is if the patient mentions their faith.

ME thanked CB or sharing and bringing a calming atmosphere to start of Board meeting and advised they are keen to understand how the Board capture the difference this makes as the service clearly made such a significant difference to this patients life.

AG commented that they were contacted by Sandwell regarding the L&G service and wanted someone to come across to speak to them as they would like to set one up.

CB added that people in distress need to see someone quickly and has a waiting list of six weeks at their PCN however they have a new person starting so this should help this.

SC commented that it was great to hear the difference the service and the listener made to this patient and was struck by the patient not wanting to engage in therapy but just wanted to talk. SC asked about training opportunities and what support CB gets from colleagues, does CB have support. CB commented they receive clinical supervision once per month and is happy to access further support and commented that as part of training it would be for people to understand the grief process adding people do not recover from grief but rather learn how to renavigate. So people do need a level of training to function effectively in this role.

PK thanked CB for attending commenting service originated via a chaplaincy route but they are open to a broader range of people also commented they agree there is a lack of these services and grief is a normal process until it does not become a normal process and perhaps a mental health service may be required and supporting people before it becomes a mental health issue.

SN commented on CB reference to support for grievance training adding that a training needs analysis was recently circulated and this has been highlighted so will pick up with CB outside meeting to discuss the offer.

The Chair thanked CB for the time taken to present the service story.

**Dietician Service**

AG introduced Kayeannet Toofany who is a Lead Dietician.

KT advised the board they work in Dudley from the Brierley Hill and Ambelcote PCN.

KT commented that historically there has not been a high referral rate as due to the criteria, many people did not meet requirement for referrals. KT added one of their first jobs was to talk to all surgery's and amended the referral criteria needed. KT commented that they see all ages from babies up to end of life and anyone can refer, patients can request a self refer, non clinical staff, and nursing services, KT has reduced much of the barriers and red tape and services is working quite seamlessly at the moment.

Providing some figures KT advised that in the last 18 months the service has seen 350 patients at least once.

KT provided an overview of the common conditions dieticians can support with which includes CMPA, Fussy eating, Malnutrition, Weight management, Pre-diabetes, Diverticulosis, Constipation, IBS, Food allergies, Frailty and End of life. KT advised that it is not just about weight loss as they have a high amount of weight gain patients.

Using interactive powerpoint slides, a patient case study was provided by KT covering an elderly patient who has COPD and was referred to KT by a social prescriber. The patient had various diet issues, they were house bound, experiencing a loss of appetite due to nausea and vomiting which resulted in marked weight loss. The patient has altered bowel habits and became very fearful of food. The result of all of this was she had gone from a healthy BMI and was malnourished. KT advised the board of the healthy calorie range of a healthy adult and compared this with someone with COPD which is quite different, a patient with COPD needs more calories. The patient had suspected cancer however following numerous tests it was diagnosed the patient had diverticulitis.

The patient's diet was changed to a high fibre diet, her nausea and vomiting subsided, now managing three meals per day and has now gained weight, although not at previous BMI this is being well managed. The patient is no longer house bound which is a great result.

The Chair thanked KT for the presentation and commented it was a great way to present using the interactive slides.

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| | BL thanked KT for the lively presentation and asked how do they measure success, KT answered that they look at base line weight at the start and BMI and monitor, assess and evaluate at the end of interventions, often lifestyle improvements provide a clear improvement trend, however there are multiple items monitored to evaluate successes. BL commented moving away from the medical model, how do they see PCN roles evolving, KT responded that in their opinion society has medicalized poverty and they are seeing patients placed on depression medication however with intervention and some lifestyle changes these can be improved. AG advised the board that KT had put in a business case concerning children with feeding difficulties and fussy eating to tackle feeding issues. BL also asked whether the service is available to DIHC staff, KT advised currently it is not, although a drop in clinic had been considered but there will be more to do in this area before this can be offered.<br><br>GL responded that there were Six community kitchens based in Dudley at one point and questioned whether these were still in operation. VL commented public health used to get funding for get cooking type centres based in local parks. VL commented it is in the social prescribing area and recommended talking to public health and KT added they do tap into and support "Lets get healthy Dudley" eating classes. GL added would like to offer support to KT with community dietetics and any challenges they experience with that and added KT was welcome to contact them to discuss.<br><br>MG commented on training received for staff delivering the service, this is beneficial and shows the purpose of integrated care. MG also asked whether KT has received training back from other members of the team. KT reported yes they had and within PCN they meet every week and share ideas stating that it is collaborative working. MG also asked about prescribing impact KT advised this has not been looked at as yet due to time pressures and increasingly large workloads.<br><br>JY asked about access for supporting children and can they link in with DIHC school nursing team. KT commented access isn't a concern it is skills and the time to access this as there are only two at the moment. SN commented that KT can link in with school nurses to do an awareness session. VL added weight management needs three components to have an effective weight management services.<br><br>The chair thanked both CB and KT for their presentation adding the Board is very grateful for what both services offer and for what they do and also thanked AG for coming to support them both. |
| **3.** | **Standing Items**<br><br>3.1 **Chair's Update**<br><br>The Chair was delighted to report following recommendation from the Appointments and Remuneration Committee to support the extension of PH contract for a further six months with a potential for a further three months to end of March 2023.<br><br>BL term also came to an end and BL has agreed they are happy to extend for a further 12 months.<br><br>The Chair advised they are delighted for both extensions of PH and BL and thanked them for their continued service to DIHC.<br><br>HT reported a number of DIHC team spent time at Liverpool Confed Expo in June and commented that there was a lot of discussions on various matter however highlighted the overwhelming focus was on primary care which helps focus on DIHC role within primary care.<br><br>3.2 **Chief Executive's Report**<br><br>PH took the report as read and thanked the Chair for the welcome on their extension to remain as CEO with the Trust over the next six months.<br><br>Highlights of the CEO included Confed Expo that the Chair had referred to and commented on the invite to the private meeting with Amanda Pritchard and since this also had a regional briefing yesterday where some interesting and strong messages where vocalized including Covid infection increases which potentially should peak at the end of July and this has caused difficulty in running some services across Trusts and nationally NHS are encouraging people to go back for their Covid |

boosters. PH commented on the national agenda and referenced the Four R's Recovery, Reform, Resilience and Respect. Recovery around elective agenda means that nearly all patients who have waited for two years who still want their operation and it is appropriate to proceed will have been operated on by end of July, numbers left will be small, this is a huge delivery across the NHS. This is a significant turnaround from where we have been.

Reform is around the new agenda and transformation and about changing the way we do things, there is a lot of discussion around commitments the system would like us to adhere to and parts which will be prioritized as part of a refreshed long term plan, no date for this yet but would like for the board to be aware. There was plenty of discussion on the new ICB's which came into being on 1st July and the real focus on collaboration, The Fuller report had a very positive reception across the conference and PH reiterated that it must be a priority for DIHC also.

Resilience focused on the plans and preparation for the upcoming winter months and ambulance and patient safety will be key. Six of the trusts have 35% of the handover problems and we have a significant problem in Dudley. We must think about sharing the risks and working collaboratively together.

Respect covered respect for patients, our staff and our tax payer and spending monies wisely. Again this is a clear message about working together.

Highlighting the discharge process, PH noted the board should be aware DIHC have put in an expression of interest to be a discharge integrated front runner, PH has also been asked to take on the role of SRO to lead this piece of work, has accepted and is very pleased about this as it is a very important piece of work and will feed back further to the Board on this at the next Board meeting.

PH added it was pleasing to see in the Medical Director report a focus on primary care and noted they have asked Dan King for update on primary care performance and will share this with Board in due course.

PH offered a thank you to the team delivery on the Quality accounts and Annual report noting the Value for Money audit is still to be done.

Linked to ICB, there is a new draft code of governance, key messages on collaborations as working as a system and system solutions and encouraged the board to read this document and has asked EFD to give the Board further details on in due course.

Finally, PH added a congratulations to PK for joining the Chapel Street practice.

LM provided an explanation of the charts within the Medical Director update in the CEO report for clarity. Commenting it is clear that High Oak is improving and mirrors sone of the high performing surgeries. Is keen to see the 2022/23 data and hopes the data is clearer but hopes to have better figures for September Board. Focus last month was shifted into taking more care on the primary care with PK and there is much improved actions in this regard under the new arrangements and LM role in particular.

SN pointed out the national and regional discussions on stepping up covid precautions and this is still underway. There is further focus on mask wearing in clinical areas and discussion on non-clinical areas. There was a Director of Nursing call recently and there are concerns over cost of living and the impact on the DIHC teams, especially community teams. The chief nursing officer for England is having regular conversations, encouraging Trusts to have open conversations with their teams. SN made references to people being off sick at end of month and potentially this might be due to lack of funds before pay day and Trust needs to keep an eye on this.

VL asked about comparator diagrams and comparisons with other like places as we move forward and where our practices sit alongside practices in other areas commenting will be interesting to see this.

On Primary Care performance SC reported DIHC are doing comparisons across the Back Country however note we are struggling with access to data. Was struck by todays presentations in the service story and this is exactly the data we need to record, the evidential

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| | difference that service is making to people and it's important to record the difference we make here, the impact. PH agreed we need to be much better at this and links to neighbour teams and linking to Dudley council which is something for executives to discuss. SC also commented on the added cost of living which is starting to effect DIHC staff, enquiries about working from home more sighting fuel costs as an issue and people team are sighted on this and will be managed through people and executive committee. PH added DIHC is paying a satisfactory rate for mileage in comparison to national rates.<br><br>DG commented that when they looked at page 25 and the table provided, over the three years it does highlight the impact of covid and impact of practices but it gives us a measure on restoration and hopefully the Trust will see improvements across 2022/23. It would be good to see these figures regularly. PH added they have already stated they would like a regular primary care report to come through Board. LM reported in relation to in relation to QOFF a lot of the work is done in final quarter so they are looking to establish monthly figures to aid with this, DG added quarterly figures would be helpful if not monthly.<br><br>ME commented on PH's report and feedback on the National Four "R's" and being respectful to our tax payers and asked about the risk we are bringing services in that are duplicating services that are already commissioned and was looking for assurance how the Trust get into a position we are not duplicating services and we are value for money. PH commented it is a challenge for the commissioning team and we do need to look at how services link together and ensure we are not duplicating, there is a lot of challenges our commissioning team need to bring a report back. SC reported one of the DIHC new commissioning manager is having a bird's eye view on these services.<br><br>AR commented on financials for staff across the Black country level discussion on mileage rates and there is a wider review of staff support from HR across the country in the NHS and will bring back discussions to executive committee in due course.<br><br>HT thanked the CEO for their thorough report and all for the input and comments across the CEO report.<br><br>The board were content with the Chief Executives report.<br><br>3.3 **Agenda for Part Two – Private Board**<br><br>HT referenced the private board agenda for information. |
| **4.** | **4.1 High Oak Consultation Update**<br><br>The High Oak Consultation report was taken as read.<br><br>PK reported this paper is an update from the last report at board and commented that a single scrutiny exercise of council commented on 15th June to which they attended with Helen Codd and Dr Richard Bramble and Sarbjit Basi and Stephen Terry from the CCG. Useful meeting, the Councillors passed a motion they wanted to see all of the services at Pensnett returned. PK was respectful of their position, but they and the CCG made it very clear there is a consultation process that CCG has now taken control of and engagement.<br><br>Stephen Terry who works with Sarbjit Basi at the CCG has a meeting on Friday of a Task & finish group, Helen Codd from DIHC communications team will support that process.<br><br>DG asked for clarification on CCG consultation. PK reported that the statute responsibility lies with commissioner and the CCG moving into the ICB will continue that function and it sits with Sarbjit Basi. DIHC's role is to ensure services are safe and effective as the operator and meet the requirements of our own objectives. DG asked about timescales, PK reported that is the first order of discussion on Friday. |

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| | SC added it politically very sensitive for DIHC, so we are very clear with the CCG where the role separation is.<br><br>PK added it is normal for a 12-week consultation which is normal. PH added unless an agreement otherwise is made with the local authority.<br><br>The board were content with the High Oak Consultation update and the discussions. |
| | **4.2 Clinical Audit Strategy**<br><br>The clinical audit strategy was taken as read and LM provided highlight notes.<br><br>LM commented that this is a must do for the trust, a full clinical audit programme is something we have not yet established mainly due to the pause as a result of the pandemic.<br><br>Strategy and documents have been written, templates have been published and are ready to use, we are making good progress on this.<br><br>PH thanked LM for the work on this commenting is a great paper and is aware of the work that has gone into this.<br><br>ME thanked LM commenting that the document, while articulating organizational culture, does not specifically reference 'just learning' and asked to ensure we use this same terminology and language throughout. On clinical audits and the cross-over of learning with other organisations and links to other organisations ME asked how we manage this. LM added this is not yet entirely clear but there will be some specific learning we can offer to practices once the quality and improvement group is established and gets working over the next month.<br><br>HT mentioned just culture and the session DIHC had six months ago and there was a question on this and where are we with this. ME reported it was picked up in the recent People Committee development session, it was agreed it does need refreshing and ME assured will scrutinize and will discuss and HT asked for a future report to Board.<br><br>VL referred to audit for quality improvement which is part of just learning culture. Asking about future cross-organisational care pathway audits, which may be challenging as outcomes may land in a different organisation, this should be a year two or three ambition. LM agreed and has spoken about this in principal with colleagues in Trust.<br><br>HT summarized and thanks LM for the report.<br><br>The board were content with the clinical audit strategy. |
| **5.** | **Board Assurance Framework and Corporate Risk Register**<br><br>The board assurance and corporate risk register was taken as read.<br><br>PH advised the board that EFD had been present this morning however she been called away for a family emergency and PH offered to provide a brief summary for the Board.<br><br>PH reported there were no changes in BAF. It was already noted previously that risks have been updated via various committees, a time out session planned next week when the board will discuss new BAF and added there is nothing more to add at this moment.<br><br>HT commented item we need to be sighted on for well led and a piece of work in development day next week to land on these.<br><br>PH reported that a fortnightly sub group is being set up to look at CQC and well led.<br><br>The board were content with the Board Assurance Report. |

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| **6.** | **Health and Safety Annual Report**<br><br>The report was taken as read.<br><br>JY reported that there had been no external requirements for visits from HSE or RIDDOR reported incidents.<br><br>There were seven incidents across the whole year, it is difficult to pull out any trends due to low numbers of incidents, but any actions have been taken where deemed appropriate.<br><br>Focused work has been carried out with the School nursing team to improve working areas, including relocating some of the teams to an alternative environment. JY added it is the first year reporting incidents onto Datix and the Chief Operating Officer and Health and Safety Executive Lead now chairs the H&S Committee meeting. Policy review work completed and building on supporting teams on local risk assessments. Recognise that DIHC staff work out of a number of other locations and we will work with practice managers and others regarding assurance visits; recently carried out a visit to Cross Street.<br><br>In summary JY commented that the Trust is acting on items needed to do to keep people safe and building on the established foundation.<br><br>PK thanked JY, and pointed out on table 3 page 76 regarding developing an in-house H&S function, noting the direction of travel on place and system we are exploring possibility of shared service but a little early to provide comment.<br><br>PH commented on the forward programme which will be important and advised an update would come via the executive committee in due course.<br><br>The board agreed they were content with the assurance provided in the Health and Safety report and the discussions. |
| **7.** | **Quality and Safety Performance Report**<br><br>SN reported that there are no specific escalations to advise board of. All reported incidents are reviewed and a weekly meeting takes place with clinical and non-clinical input for further oversight.<br><br>Three incidents in May related to the access of the RIO system, this was escalated and resolved with Black Country Health Trust<br><br>Three complaints in May, with no themes or trends noted. KPI data will be reported in regular monthly board report. No referrals to ombudsman to date.<br><br>SN provided the Board with an update in changes in IPC on mask wearing guidance as a result of rising cases. It was reflected that whilst patients were being encouraged to wear masks it was not enforceable.<br><br>In relation to safeguarding in CHC service DIHC have had detailed conversations with ICB and agreed three homes that DIHC will have responsibility for entire quality assurance monitoring in accordance with the delegated responsibilities from the ICB<br><br>There was a large scale enquiry for one specific home and there was a lot of wrap around support provided via DIHC and the ICB.<br><br>Covid Vaccination data in report for the Boards information. 1 in 6 over 75's category nationally |

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| | have not stepped forward for spring booster. Fourth autumn booster upcoming and there is a meeting coming up on management of this for Dudley borough.<br><br>The board were content on assurance received in the Quality and Safety Performance Report and the discussions. |
| **8.** | **Quality and Safety Committee Assurance Report**<br><br>The quality and safety committee assurance report was taken as read.<br><br>VL reported nothing to escalated in terms of risk.<br><br>The IAPT deep dive was very valuable to committee to understand fully where any issues lie and what we can do about these. Committee thanked the team involved in doing this.<br><br>Work force modelling was included showing value of analytics and issue of Information Technology infrastructure and analytical infrastructure was discussed although not in the report. FP&D are doing a deep dive into this.<br><br>VL added three points to support our delivery of a quality service which were discussed for assurance which included hardware architecture and infrastructure, software and whom has access to what area and lastly analytical capability with internal, external or a collaboration.<br><br>SC commented on the deep dive and added that The IAPT service lead responded to the request well and asked whether DIHC should offer our operational leads support on deep dives. SC will also do a report back to People Committee.<br><br>DG added reports were useful and asked about benchmarking, especially for safeguarding as this would give assurance we are in an acceptable range. SN advised she will take this away and speak to the team on this. VL offered a comment on DG request for benchmarking and challenged we would need to find an organisation with the same services and this can be tricky but we should indeed keep on top of any trends. PH added we can only benchmark safeguard by service so would be challenging and need to be careful with benchmarking as we want to encourage people to raise issues. With regards trends and themes, PH looks at all of the complaints and whilst there are many on CHC at the moment its more about the decision and not the process.<br><br>PK added a thanks to the IAPT team who found it a supportive process. Just finishing service reviews and there will be metrics out of this which will bring to Trust Management Board and Executive committee and onto Board. There is some work to do round metrics and to ensure we are measuring the right things.<br><br>MG commented on business intelligence and noted that we get good Value for Money for what we have invested at the moment, we need to ensure we have resilience in our business intelligence function to support our business services. Another piece of work we have started supported by The Head of Primary Care is on metrics and information sharing. It was reflected how we need to collaborate with the ICB on this. . Within the digital programme there is a primary care blue print project in place, recognizing separate IT arrangements for all of the GP practices which is a challenge at the moment. A meeting has been set up with the Primary care at the ICB to discuss any complex issues.<br><br>BL referred to Page 83 of the pack and actions on sharing lessons via Friday round up communication and asked whether SN looked at the impact and effectiveness of this. SN responded it is not our only method of communicating lessons learned there are also staff briefings which the CEO chairs and also service review meetings, lastly SN referred to new screensaver messaging so they are building up communications to reinforce messaging. Luke Dunn provided some statistics each week stating 950 opens per week of the Friday Round Up which shows people clicking on links more than once.<br><br>BL also made a general point around several references made on “deep dives” being carried out and agreed with SC point for some objectivity needed on these. PH commented that |

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| | deep dive means different things to different people so need to be clear on what deep dive actually means.<br><br>PH commented the quality account noting it was not just approved by the Chair of the committee but it was also approved by the CEO and a third member of the Board namely SN in line with the delegated authority.<br><br>The board were content on assurance received in quality and safety report and discussions.<br><br>**ACTION: PUB/JULY22/01** - SN to speak to Safeguarding team on looking at benchmarking metrics. |
| **9.** | **Workforce Performance Report**<br><br>The report was taken as read.<br><br>AR reported on KPI's showing a slight increase on turnover this is less than 5 people leaving organisation and commented that recruitment is out pacing those leaving.<br><br>Sickness remains within target, no other comments on this.<br><br>Key issues are appraisal rates are below target but a reduction in month and looking at 70% by the end of June and 78% by the end of July. People committee will escalate where targets are not met.<br><br>Mandatory training has reduced in compliance due to new mandatory training being introduced which has put pressure on staff to complete. PH asked about the mandatory training targets of 90%. AR added trusts set their own targets for mandatory training and confirmed that he would ask the People committee to reflect on the target currently being used. AR added we were meeting the target until the introduction of the new mandatory training was put in place.<br><br>SC commented we can reflect on the target ask and commented they are in touch with all executive leads where there are short falls.<br><br>PK added on the performance report the recruitment vacancy rate in the primary care mental health team and there were three points that came out of that which were that they had some very useful assistance from the People team. PK commented on the conversation rate on number of people applying and number being appointed, helpfully SN was able to give expertise and suggested we relate to of "agencies" and not "agents" in respect of specialist mental health nurses and thirdly suggestion that HR colleagues will speak to Black Country healthcare colleagues about joint recruitment to those as roles are they are hard to fill.<br><br>The board were content on assurance received in Workforce Performance Report and discussions. |
| **10.** | **People Committee Assurance Report**<br><br>HT noted in agreement with ME that the last meeting of the People Committee was a development session and not formal committee meeting. ME will pick up CEO's comments on mandatory training In relation to appraisals ME has asked for exception reports, he is disappointed targets were not met at end of June and this will be picked up in next meeting.<br><br>ME reported on the recent development sessions picking up points within the business plan. Looking at what we have done well and an honest look at delivery areas i.e. Just Learning Culture etc during the first two years as an organisation.<br><br>IB asked about agency costs on how many agency staff we have as these were not in report and would like to ensure there are no gaps. PK responded on the longevity point on locums and this metric would be useful.<br><br>The Board were content with assurance report. |

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| 11. | **Finance Report**<br><br>MG reported the financial position for months one and two (April and May 2022) which reflect the income envelopes agreed with the ICB. MG reported that the year to date position for the first two months is break even and this is also the expected forecast position for the end of the financial year. Key points are the number of mental health vacancies and this was addressed earlier by PK. There is an overspend on corporate items and this is largely due to non recurrent project expenditure. An in depth review of the financial position will be undertaken at the end of quarter 1.<br><br>From a cash perspective DIHC have £2.7 million in bank at the moment with £1.1 million remaining on the loan received from Black Country Healthcare NHS Foundation Trust.<br><br>The Trust will closely monitor its efficiency programme and CIP delivery during 2022/23.<br><br>The Trust is required to embed tighter control of agency expenditure, using HFMA good finance governance principles.<br><br>PH added there will be a couple of temporary interim posts to note against the budget. Also to note that MG is doing a lot of work currently due to Deputy Director of Finance post being vacant. |
| 12. | **Performance Report**<br><br>The performance report was taken as read.<br><br>PK reported that in terms of CHC figures would like the Board to understand their role is broad, currently there are involved in an assessment on behalf of Dudley group in relation to the discharge process and also supporting the care homes which is a significant piece of work.<br><br>In the last quarter there has been a spend of just over £4 million on CHC placements, there does need to be further process around our intermediate health care to ensure we have full oversight of that and to ensure it fits into commissioning role. Need to also ensure the CHC team are fully engaged with the ICB.<br><br>Extended access continues to work well and the contract has been extended for three months, this has been very successful.<br><br>Continuing issues around nursing input into High Oak, these are small numbers however and there is a number of processes in place to address this.<br><br>Chapel Street metrics are now in the report and there will be post transfer scrutiny on the processes with support from LM and the medical directorate |
| 13 | **Finance, Performance and DigitalCommittee Assurance Report**<br><br>The finance performance and digital report was taken as read.<br><br>IB confirmed the work in progress as far as cost improvement programme (CIP) are concerned and confirmed there will be a deep dive on IT and that the Board will be updated in due course<br><br>HT asked whether too much data is being received by the board in relation to the primary care services. MG added it has been reviewed and reduced but would work to ensure that only the key areas are reported through to the Board to ensure that the reporting does not become impractical. |

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| 14. | **Extraordinary Audit and Risk Committee**<br><br>The report was taken as read<br><br>DG responded that a positive review of our year end by the auditors took place and will be coming back in September in for Value for Money. HT commented for the benefit of the board that the relevant committee with the relevant people based on the delegation approved the accounts.<br><br>There were no questions and the Board were content with the report. |
| 15. | **Population Health Management**<br><br>The report was taken as read.<br><br>Duncan Jenkins thanked the Board for the opportunity to come and talk about the population health management approach and commented he has provided a high level view on the health of the Dudley population and compelling arguments for the need to embrace a population health management approach in Dudley.<br><br>DJ advised the board that this is a proposal and will need to go out for further consultation and ensure our stakeholders have ownership to embed in Dudley Place.<br><br>A top line development plan for the rest of the year has been provided and DJ commented that population health management is a fairly new term, however this type of work has been ongoing for many years. We should welcome new focus that the pandemic has shone a light upon, inequalities in particular for the health service and embed principles into what we are doing. There are initiatives we can deliver ourselves, ones we can lead on (community and consultant team in local system), we can support others to plan and develop their interventions and we can influence others to take account of population health in their own plans.<br><br>We need to accept health services do have a limited impact on population health but we have the ability to influence other partners outside of health, for instance housing, education, air quality, those items that have an impact on the population.<br><br>Population health management is not a few projects, it should pervade the whole organisation if we are to improve the health of the Dudley population and should be a prime focus. In terms of life expectancy there is a small gap between Dudley population and the whole of England, when you drill down further at inequalities there is an 8-10 year gap in life expectancy within the Dudley population. People in deprived areas are both dying younger and are spending more years of life in poor health, we need to address these inequalities.<br><br>The paper puts forward a number of priority areas and briefly noted the big four which are the big causes of the gaps seen in life expectancy between affluent and deprived communities (Cancer, Circulatory disorders, Respiratory and now Covid).<br><br>DJ quoted children immunisations and the first 1001 days and this is the best place to invest funds but note will not get return on investment for arguably 20 years plus so there is a political consideration. Also other areas are end of life, frail elderly and mental health are all potential priorities.<br><br>Dr Lloyd baron working in DJ team on a health inequalities plan as part of the EDI strategy. A number of areas identified here and includes health status of females in borough is declining which is a concern.<br><br>In terms of the next steps show an outline plan in table one. DJ advised working with Partnership board on this and is working with David Pitches from Public Health at Dudley Metropolitan Borough Council.<br><br>PH thanked DJ for his paper and commented that they agree population health management is critical, commenting if you look at national information it is about pooling the information we have got |

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| | to target specific areas in the right way and developing services based off this information and we need to have a set of targeted pieces of work, noting that small steps make big differences if they are targeted in the right way, this paper is really helpful and gives a good framework for us to start and getting the correct governance together to take this on.<br><br>HT commented the delivery of population health management is not limited to those on the Partnership Board and we need to engage with others in this. DJ added it needs to include all of the above and to empower our clinician communities and with our council or housing colleagues to look at environmental factors. PH commented the piece of work Balvinder Heron is leading at Dudley Council is doing and we need to start the conversation.<br><br>IB added they would welcome the base line by primary care network, stop talking just about Dudley but direct our budgets to the best areas and get our activities to those areas to put forward our own plans and track ourselves, adding it's a great piece of work and is very supportive of it.DJ added a challenge is getting all the data together and there is a risk with the new structure of losing local data.<br><br>SC added it is wider than the partnership board and commented for DJ to link in with Piotr in the strategy team as Piotr is doing a piece of work on community asset approach from a mental health perspective. DJ added he agreed but there hasn't been much appetite in the past, PH added this is where the Fuller Report comes in to pull this all together.<br><br>VL added three points, firstly on the framework which PH outlined and they support this, secondly once we have identified a programme or area you have to do the segmentation of the population and the tools needed for this. Thirdly in terms of data sets and local authorities don't talk about conditions, they are interested in functional capability so it can be complicated. A final point which is what PH raised which is learning by example and learning from all the work done around the country. We need to establish what public health is doing and plug into that.<br><br>DG asked about ethnicity data feeding into this due to the impacts of different ethnicities so we understand it and target the work we do in the right areas. DJ agreed and pointed out everyone acknowledges this however noted the challenge is we do not have insight due to coding issues there are 70 different ethnicity codes.<br><br>AR asked if there is a role for us as a local employers and regional purchaser in the community.<br><br>GS investment in 20 years time will we have enough proxy measures to keep the momentum going. DJ said it is a challenge but hopes we do have the momentum and quoted 1001 days.<br><br>BL thanked DJ for the paper which she found an enjoyable read and also the discussion today and is particularly enthused about targeted programmes.<br><br>HT summarised overall comments and it was clear the Board is supportive on the direction of travel and looks forward to further feedback via executive committee and looks forward to an update on future progress. |
| **16.** | **Report from the Primary Care Integration Committee**<br><br>The report was taken as read.<br><br>SC described how the recent meeting was a development session and dedicated to Primary Care strategy and engagement with PCN Clinical Directors including reflection on the Fuller Review and Dan King provided a presentation on the different elements of the strategy that were being developed. It was a successful session, and the Board reflected that there was a lot of support for the work DIHC is doing from the PCN Clinical Directors.<br><br>SC added DIHC will be running two events over the summer period (12th July and 10th August) which will be the same event running twice. SC added they are grateful to the PCN's for agreeing to engage on providing these primary care events with DIHC. SC added all board members are welcome and encouraged to attend. SC closed adding the Primary Care Strategy will be presented to Board in September. |

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| | IB agreed it was a useful session where people were very engaged, vision, aims and objectives were agreed, it was very positive.<br><br>HT added this is a very important workstream and is pleased to hear the feedback. |
| **17.** | **Report from the Strategy and Transformation Board**<br><br>SC advised that this committee ran a development session to thoroughly discuss and debate the role and function of the committee moving forward. There was a unanimous agreement to continue with the meetings but not as an assurance committee of the Board.<br><br>The proposal for the Board today is for this to change to a Strategy and Transformation Forum attended by executives, non-executive directors and members of the senior management team and chaired by HT or IB in HT's absence. It will continue to look at development of DIHC, the development journey and progress of business plan implementation. Terms of Reference are included with papers which was robustly discussed at the committee meetings.<br><br>With Boards approval this will be the final report of this type and feedback will be made to Board through the Chief Executives Board report.<br><br>HT summarised noting the board needs to be agile throughout coming months which may mean committees do need to change and not be rigid and noted the transformation element of this remains very important.<br><br>PH added the strategy will be set in this room with this group and decisions are at Executive Committee or at Board.<br><br>The Board approved the report from the strategy and transformation committee and approved the amendment for the Strategy and Transformation Committee to transition into the Strategy and Transformation Forum. |
| **18.** | **Communications and Engagement**<br><br>The report was taken as read and Luke Dunn reported on a few highlights from the report.<br><br>The summary included facilitating an online café dying matters supported by Dr Poonam Tank, had some positive feedback this will help to develop services and literature moving forward. Linked to that there was a press release in local news showing how we linked with local stakeholders.<br><br>During mental health awareness week there was a live radio interview with Black Country Blokes and Dudley Talking Therapies attended and focused on mental health and reducing stigma around this especially around men's mental health.<br><br>The Dudley Group NHS Foundation Trust and DIHC School Nursing team visiting Chilly Kiddy's for world asthma day, again great feedback from 31 families who attended, this was shared with the Integrated Care System and there was a marketing campaign as a result.<br><br>As a team they have got involved with a number of projects including the green plan, quality accounts formatting, EDI strategy, creating screensavers, and nurses day which was shared with NHSEI.<br><br>HT commented the statistics are impressive if we looked back over a year. SC added going forward will need to look at the impact of engagements we do and the difference it is making to the population. SC reported the Trust do save money with the skills of the communications team and the team are working very well in the local community.<br><br>ME added the importance of the communications to let us know about what is going on, without this channel many of the board wouldn't know, recognition that there is some great things happening. |

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| | PH added the communication should also go the other way and to consider press releases after the Board meetings to get key messages out into the community. Understanding DIHC reach is very critical and to proactively use our media team to do this. Also recommendation that the EA team to also include where possible local community buildings to host some of the future board meetings to ensure DIHC are present out in the community to enable the public to attend meetings within the borough.<br><br>HT added that Jayne Ilic used to tweet live from Board, PH added it needs to be more targeted and offered a suggestion to consider hosting board meetings in community centres for so the community can visit us.<br><br>A robust discussion took place about using social media for messaging. Luke Dunn will reflect on all views with communications and engagement team.<br><br>**ACTIONS:**<br>**PUB/JULY22/02** - Communications and Engagement team to reflect on discussions around messaging in community and consider press releases post board meetings. |
| **19.** | **Any Other Business**<br><br>PK commented one staff movement with Zoe Dixon who will become AHP lead. She will still be working with us due to structure but more of a professional leadership rather than operational.GL asked on plans to replace her vacant role, PK confirmed this is in progress. |
| **20.** | **Questions from the public**<br>No questions were pre-submitted |
| **21.** | **Risk Review**<br><br>HT commented this is a work in progress and there is no requirement to discuss this any further.<br><br>HT requested as there is no Board meeting in August a one pager on any issues would be useful. |
| | **Date of next meeting:**<br>6th September 2022 |

# DIHC Public Board Action Register

NHS Dudley Integrated Health and Care NHS Trust

| Ref | Date Raised | Details | Action Lead | Due Date | Update | Status | |
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| PUB/JULY22/01 | 5-Jul | Board Member David Gilbert found Q & S Committee reports very useful and asked about benchmarking metrics, especially for safeguarding as this would give assurance Trust are in an acceptable range. Sue Nicholls advised they will take this away and speak to the safeguarding team on this | SN | 06/10/2022 | | | |
| PUB/JULY22/02 | 5-Jul | Comms and Engagement team to consider press release after board meetings to endure the community have an awareness of what the trust is actively doing and to increase general pubilicity for DIHC. | HC | 06/10/2022 | Comms and Engagement team will continue to promote positive stories via a number of communication channels around the good work that DIHC continues to deliver on. | | |

Dudley Integrated Health and Care NHS Trust

# DUDLEY INTEGRATED HEALTH & CARE NHS TRUST BOARD

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| **TITLE OF REPORT:** | Chief Executives Report |
| **PURPOSE OF REPORT:** | To provide the Board with an update on CEO Activities and current issues |
| **AUTHOR OF REPORT:** | Penny Harris, Interim Chief Executive Officer |
| **DATE OF MEETING:** | 6th September 2022 |
| **KEY POINTS:** | 1. Summary of CEO Activities July and August 2022<br>2. Chief Operating Officer Update<br>3. Medical Directors Update<br>4. Autumn Covid-19 Booster and Flu Vaccination Programme<br>5. Introduction of the Patient Safety Incident Response Framework (PSIRF)<br>6. Care Quality Commission (CQC)<br>7. Safeguarding Accountability and Assurance Framework (SAAF) |
| **RECOMMENDATION:** | • The Board is asked to note contents of the report |
| **ANY CONFLICTS OF INTEREST IDENTIFIED IN ADVANCE:** | None identified |
| **ACTION REQUIRED:** | Approve ☐ |
| | Assurance ☐ |
| | Information ☒ |

**Report Title:** **Chief Executives Monthly Update Report**

**To:** **Board of Directors, Dudley Integrated Health and Care NHS Trust**

**From:** **Penny Harris, Interim Chief Executive Officer**

**Date:** **6th September 2022**

## 1.0 Summary of CEO Activities – July and August 2022

The following provides an overview of activities throughout July and August. I trust many of the Board have enjoyed some well-deserved annual leave and time with family. There were no service visits planned due to many service leads being on annual leave and these will resume again in the Autumn. The report provides some further detail of business activities of the executive team and I have been involved in as Chief Executive and useful information from wider NHS sources for your information.

### 1.1 Delivery and Continuous Improvement Review Roundtable

I received a personal invitation from Sir Julian Hartley (CEO of Leeds Teaching Hospitals) to attend a roundtable discussion, which was convened to provide thinking on how approaches to improvement can make the best use of performance, improvement, transformation, data, digitisation, systems transformation, workforce and leadership development. The review aims to develop a universal improvement approach across the NHS drilling into what works well and what could be improved in approach – and how we might go about making things better. It was well attended by a number of very senior NHS leaders and Julian will be submitting the output to NHSE to support the change in oversight arrangements currently being implemented with ICBs.

### 1.2 Joint Oversight Arrangements

I recently met with Rebecca Farmer and Alistair McIntyre who was standing in for Mark Axcell. The meeting was to ensure NHSEI/ICS have appropriate oversight for trusts and have an opportunity to discuss any key areas of concern, options for oversight and monitoring arrangements and to also identify any support requirements. A formal letter of feedback is expected and will be shared with Board members in due course.

### 1.3 Primary Care

Along with the Chair, some of our Executive Directors and our Primary Care team I attended our first of two face to face Primary Care events at Dudley Golf Club on 20th July. The aim of the event was to bring together Dudley GP's and Practice Managers and invite them to review and contribute to the development of the DIHC Primary Care Strategy. Both events were very well attended and colleagues commented on how beneficial it was to be able to gather face to face and discuss development and support areas. There was a wide ranging conversation with significant interest in the difference made by DIHC in primary care, and also numerous ideas shared about how the DIHC role can be expanded to support primary care. I look forward to many more events of this nature as we have agreed with our primary care colleagues to continue our events now face to face.

1.4 Out of Hospital Services – Senior Responsible Officer (SRO)

As SRO for out of hospital I have been involved in reviewing the governance and in detail with oversight of the progress with 100 day discharge programme. The below diagram sets out the portfolio of work and key workstreams, delivery of course is via each of the place based partnerships and Philip King will provide an update on some of local progress in his update in 2.0 below.


1.4.1 100 Day Discharge

Building on the work of the taskforce and the learning from the 14 NHS pilot sites and 12 social care sites that the taskforce has supported to date, 10 best practice initiatives have been identified that demonstrably improve flow and should be implemented in every trust and system to improve discharge which include

- Identify patients needing complex discharge support early
- Ensure multi-disciplinary engagement in early discharge plan
- Set expected date of discharge
- Ensure consistency of process, personnel and documentation in ward rounds
- Apply 7 day working to enable discharge of patients during the weekend
- Treat delayed discharge as a potential harm event
- Streamline operation of transfer of care hubs
- Develop demand and capacity modelling for local and community systems
- Establish flexible surge workforce capacity
- Revise intermediate care strategies to optimise recovery and rehabilitation

Further details on each of these initiatives can be viewed here

## 2.0 Operational Update

### 2.1 High Oak Consultation

Dudley Integrated Health and Care NHS Trust in the persons of the Chief Operating Officer, Joint Medical Director/Acting Clinical Director Primary Care and Head of Communications, Engagement & Partnerships, attended a further meeting chaired by the ICB in relation to the consultation process for the future location of the High Oak surgery. Our role in this was as the provider of services. Other partners that attended included Healthwatch Dudley and local councillors and the MP for South Dudley. At this meeting a variety of options were tabled for consideration and the ICB will continue its process of consultation, with a formal report coming back to DIHC's Board to coincide with this process

### 2.2 Winter Planning and Place Based support:

Following the publication of the Winter Planning Guidance, and in keeping with the need to support place on 100 days discharge, DIHC are working with partners on place based solutions Regional and Place based proposals will be considered on 31 August and 2 September. The proposals focus on facilitating discharge and admission avoidance.

At the request of the Council we have been working with them on a set of solutions and proposals, which will be featured as our place based contributions:

i. For DIHC to provide a high level reablement team, contracted to social care and health to utilise hybrid workers in order to speed effective pathway 1 discharge from hospital
ii. Planning with PCNs to transfer patients in care homes in Dudley to Chapel Street and to utilise our expertise within Primary Care and our CHC and IHC to monitor the enhanced needs of the care home population and thus avoid admissions.
iii. Potential to pool expertise and leadership with Council colleagues
iv. Exploring further and different uses of the Saltwells care home in partnership with the current provider and partner organisations.
v. Potential for extension of Extended Hours and closer links with Urgent Care.

A further and fuller report will be put forward to the next DIHC Board meeting.

## 3.0 Medical Directors Update

The medical directors update aims to provide the Board with an overview of current work-stream achievements under the remit of the Medical Directorate. The activities taking place within these workstreams directly align with the strategic priorities of DIHC, primarily "improving the health of our population and reducing inequalities" and "supporting and ensuring the sustainability of Primary Care".

**Primary Care Services**

- **Medical Leadership** - Dr Lucy Martin (Joint Medical Director) continues to provide direct medical leadership support and development to each of DIHC's primary care provision services.

- **Primary Care Improvement Group -** This recently established group (chaired by Dr Lucy Martin) has oversight for how each of DIHC's primary care provision services are run. The group will also oversee the development of a primary care operating model that will set out how DIHC will support GP practices sub-contracted into the Trust.

- **GP Engagement Events -** GPs and practice staff were invited to attend one of two engagement events hosted by DIHC in July 2022. Those who attended the session gave feedback on how DIHC can improve the support provided to practices. A number of great ideas were shared around the themes of 'Workforce, Estates and Patient Education'.

- **Friends of High Oak Engagement Event via Pensnett Councillors –** We held a 'Friends of High Oak' engagement event and invited our registered patients and local community members. We asked for their help to develop a Patient Participation Group (PPG) for the practice as we would like the local community to help co-design how this could look and work practically. PPGs can be really valuable in helping to hear the patient voice, make improvements and build relationships with communities and strengthen connections. We were joined by around 20 patients and the three local ward councillors (which also included the Mayor of Dudley). It was great to see local people chatting with each other, sharing stories and catching up over tea and coffee. We also offered health checks which were appreciated.

- **Chapel Street Engagement with Community via Lye Councillor Hanif -** An initial scoping meeting with Councillor Hanif took place and an engagement event with community leaders is planned for 30 August 2022. This will provide the opportunity to discuss changes in practice management arrangements and how DIHC can best work together to support the community. We discussed how we could work collaboratively to improve the uptake of breast screening, and detection of atrial fibrillation and hypertension.

- **Heatwave & Commonwealth Response –** In response to an urgent request from the Integrated Care Board (ICB), with just one working days' notice, DIHC provided additional appointments at the extended access hub. These appointment slots were put in place for patients with respiratory disease in anticipation of the July 2022 heatwave. Similarly, in response to the EPRR request, dedicated appointments were offered to specific practices along the Commonwealth Games Cycling Route on 4 August 2022.

- **DQOFH** – Following implementation of a new Long-Term Condition (LTC) management process across both practices, we are now able to plan and track progress throughout the year towards meeting improved QOF performance by 31 March 2023.

- **National GP Patient Survey 2022 –** This is an England-wide annual survey of patients aged 16 and over and provides GP practice-level data about patients' experiences of general practice. The survey is based on feedback shared by patients during the previous year with results published in July each year.

  Findings from the survey reflect an overall deterioration in the positive experiences of patients nationally. However, locally we have seen improvements in patient satisfaction scores with some areas in line with national scores or higher across the following areas:

  - Patients felt their needs were met at their last GP appointment
    - National score: 91%
    - High Oak: 93%
    - Chapel St: 93%

- Patients had a good experience overall of their GP practice
  - National score: 72%
  - High Oak: 75%
  - *Chapel St: 66%

- Patients had confidence and trust in the healthcare professional they last saw or spoke to
  - National score: 93%
  - High Oak: 92%
  - *Chapel St: 90%

* Chapel Street surgery patient survey results cover the period prior to the practice being managed by DIHC. We aim to improve patient satisfaction scores in the next annual survey.

## Policies

The policies outlined below have been produced and implemented via the Medical Directorate:

| Policy | Author | Renewal date |
|---|---|---|
| Clinical Record Keeping and Coding Policy | Dr Lucy Martin | 30/06/2023 |
| Chaperone Policy | Dr Lucy Martin | 30/06/2024 |
| Clinical Audit Policy | Dr Lucy Martin | 31/07/2024 |
| Exception Reporting (DQOF) Procedure | Dr Lucy Martin | 31/05/2024 |
| Clinical Audit Proposal Form | Dr Lucy Martin | 31/07/2024 |
| Clinical Audit Report Template | Dr Lucy Martin | 31/07/2024 |
| Home Visit Decision (Primary Care) SOP | Dr Lucy Martin | 31/05/2025 |

## Quality Improvement Group

The recently established Quality Improvement Group will have oversight of the clinical audit programme (including mandatory national audits and local audits), mortality reviews, research and innovation reports, internal and external visits, service reviews and other agreed quality improvement activities. The Group will support and embed a culture of Quality Improvement and provide assurance through the Quality and Safety Committee.

## Integrated Model of Care

We continue to work with system partners on Dudley's Integrated Model of Care. Our GP Clinical Leads and ICT Leads are involved in this through four priority Transformation Groups focussing on Mental Health, Children & Young People, Integrated Care Teams and Dudley's Clinical Hub. These Transformation Groups are finding many areas of consensus and will be sharing their recommendations over the coming few months.

Our Clinical Leads continue to work with system partners on multiple clinical pathways including Population Health Management strategy, Health Inequalities, Diabetes, and End of Life Care. An example of community engagement was our attendance at a Syrian celebration event where we were able to hear views of this population and to perform around 30 NHS Health Checks.

## 4.0 Autumn Covid-19 Booster and Flu Vaccination Programme

Trusts have now received a formal letter from NHS England to set out the actions needed and to provide details of operational details systems should consider. These include

- Campaign activities
- Campaign completion date
- Prioritising vaccination of care homes and housebound people
- Vaccination of frontline health and social care workers
- Vaccination of Eligible 5 to 17 year olds
- Supply and Delivery
- Assurance and Workforce

Full details of the communication can be viewed here

Following feedback from staff on the Trusts 21/22 flu campaign, the Trust is providing a peer flu vaccination programme this year. A task and finish group led by the Trusts Infection Prevention and Control Specialist commenced in June 22 with broad representation from the Trust. Vaccinations have been ordered and we are in the process of ensuring staff vaccinators are confident and competent in accordance in line with the requirements. The Director of Nursing, AHPs and Quality and the Medical Director are joint sponsors of the programme. Covid boosters will be offered to eligible staff via the vaccination centre. Oversight is undertaken via the Quality and Safety Steering Group with assurance provided to the Quality and Safety Committee. A staff communication campaign will commence during September which will include utilising the voice of the Trusts Infection Prevention and Control Champions.

## 5.0 Introduction of the Patient Safety Incident Response Framework (PSIRF)

On 16th August NHS England through the National Director of Patient Safety in England published the Patient Safety Incident Response Framework which looks at how the NHS responds to patient safety incidents and this is a major component of the NHS Patient Safety Strategy that sits alongside the wider NHS Long Term Plan and replaces the Serious Incident Framework (SIF).

The introduction of PSIRF is quoted to be a major step towards improving the safety management process across the healthcare system in England.

The transition to PSIRF from SIF will be a gradual process expected to take 12 months to complete and NHS England has asked that Trusts commence the process from September 2023 with an aim to completion transition by Autumn 2023.

This implementation of PSIRF is aligned to one of the Trusts Quality priorities and a key aspect of the Trusts clinical governance development plan. With the formal guidance now published, the Quality and Safety team are working on a detailed implementation programme which will include a review of the expectations aligned to the Patient Safety Specialist role.

## 6.0 Care Quality Commission (CQC)

The CQC are changing their approach to regulation. The new approach will utilise a single assessment framework which can be viewed at the following link - Single assessment framework - Care Quality Commission (cqc.org.uk)

The single assessment framework applies to providers, local authorities and integrated care systems. The ratings and five key questions will remain central to the approach. Under each key question (safe, effective, caring, responsive and well-led) there are a set of topics and a set of quality standards.

The CQC will:-

- use a range of information to assess providers flexibly and frequently. Assessment is not tied to set dates or driven by a previous rating
- collect evidence on an ongoing basis and can update ratings at any time. This helps us respond more flexibly to changes in risk
- tailor our assessment to different types of providers and services
- score evidence to make our judgements more structured and consistent
- use inspections (site visits) as a vital tool to gather evidence to assess quality
- use data and insight to decide which services to visit. When on site, we will observe care and talk to staff and people who use services
- produce shorter and simpler reports, showing the most up-to-date assessment

Until this new assessment framework is introduced (anticipated in 2023) the CQC will continue to use their current methods to monitor, assess and rate providers. We have regular relationship meetings with the CQC and will continue to update the Board on any key changes / timelines.

## 7.0 Safeguarding Accountability and Assurance Framework (SAAF)

A revised Safeguarding Accountability and Assurance Framework was published by the Chief Nursing Officer, England in July 2022. The document strengthens the NHS commitment to promoting the safety, protection and welfare of children, young people and adults. The document clearly sets out the safeguarding roles and responsibilities of all individuals working in providers of NHS funded care settings and NHS commissioning organisations. The Trusts new Head of Safeguarding across the Life Course commences in September and will be asked to undertake a review against the requirements of the revised SAAF applicable to DIHC. Assurance reports are provided to the Quality and Safety Committee and the outcome of the review will be presented there.

The Dudley Safeguarding People Partnership Board has agreed a number of priority audits over 22/23. This will support all NHS providers working in Dudley to benchmark against a core audit set. DIHC will be participating in these audits. In addition, the DSPBB is in the process of agreeing a benchmarking dataset through the Quality Assurance and Performance Adults subgroup. We are members of the subgroup and will contribute to this dataset. Any variances will be reported to the Quality and Safety Committee and subsequently the Trust Board.

# DUDLEY INTEGRATED HEALTH AND CARE NHS TRUST BOARD

**TUESDAY 6th September 2022**
**13:30hrs to 15:00hrs**

**Dudley Canal & River Tunnel Trust, 501 Birmingham New Road, Dudley, West Midlands DY1 4SB**

# PRIVATE AGENDA

| Item No | Agenda Item | | | Presented By | Time |
|---|---|---|---|---|---|
| **Formalities: to declare the meeting open, quorate and in accordance with the standing orders:** | | | | | |
| **1** | **Chair's Welcome**<br>1.1 Apologies<br>1.2 Declarations of Interest<br>1.3 Private Board Minutes – meeting held on 5th July 2022<br>1.4 Action Register and Matters Arising<br>1.5 Items Carried Forward from Part One | To Receive<br>To Receive<br>For Approval<br>For Approval<br>For Discussion | Verbal<br>Verbal<br>Enc 1.3<br>Enc 1.4<br>Verbal | Mr. H Turner | 13.30 |
| **2** | DIHC Development | For Information | Verbal | Ms. P Harris | 13:35 |
| **3.** | Annual Report and Accounts 2021/22<br>*Delegated approval requested* | For approval | Enc 3 | Ms. E Doyle | 13:50 |
| **4.** | **Committee Minutes (to be taken as read)**<br>4.1 Finance, Performance and Digital Committee – meeting held on 23rd June 2022<br>4.2 Quality and Safety Committee – meeting held on 21st June 2022<br>4.3 People Committee – meeting held on 19th July 2022 | For Information<br>For Information<br>For Information | Enc 4.1<br>Enc 4.2<br>Enc 4.3 | | 14:20 |

| | | | | | |
|---|---|---|---|---|---|
| | | | | | |
| **5.** | **Board Meeting Reflections** | To Receive | Verbal | Mr. H Turner | 14:35 |
| | | | | | |
| **6.** | **Any Other Business** | To Receive | Verbal | Mr. H Turner | 14:40 |
| | | | | | |
| | **Date of next meeting:** 4th October 2022<br><br>Venue: Dudley College of Technology, The Broadway, Dudley, DY1 4AS. | | | | 15:00 |

Dudley Integrated Health and Care NHS Trust

# DUDLEY INTEGRATED HEALTH AND CARE NHS TRUST BOARD

| | |
|---|---|
| **TITLE OF REPORT:** | Equality, Diversity and Inclusion Strategy 2022-2025 |
| **PURPOSE OF REPORT:** | To share with Board the DIHC Equality and Diversity Strategy 2022-2025 |
| **AUTHOR OF REPORT:** | Stephanie Cartwright, Director of Strategy, People and Partnerships |
| **DATE OF MEETING:** | 6th September 2022 |
| **KEY POINTS:** | • The Trust's Equality, Diversity and Inclusion Committee commissioned the development of an EDI strategy and objectives<br>• The EDI Strategy has been in development over the last few months, and has gone through various iterations which have been shared with members of the Committee<br>• The Strategy is inclusive of both patient and workforce Equality, Diversity and Inclusion objectives<br>• The strategy has been developed with lead experts throughout the Trust and stakeholders, including the Trust's Inclusion Network<br>• The Equality, Diversity and Inclusion Committee endorsed the Strategy at its Committee meeting on 12th August 2022<br>• The People Committee endorsed the Strategy at its Committee meeting on 23rd August 2022<br>• The Equality, Diversity and Inclusion Committee will receive a quarterly update on progress against the detailed delivery plan and provide update reports to People Committee thereafter |
| **RECOMMENDATION:** | The Board are asked to approve the Equality, Diversity and Inclusion Strategy 2022-2025 |
| **ANY CONFLICTS OF INTEREST IDENTIFIED IN ADVANCE:** | None |
| **ACTION REQUIRED:** | Decision ☐ |
| | Approval ☒ |
| | Assurance ☐ |

NHS
Dudley Integrated Health and Care
NHS Trust

# Equality, Diversity and Inclusion (EDI) Strategy

# 2022 - 2025

# Foreward

**Stephanie Cartwright - Director of Strategy, People and Partnerships**

**Billie Lam - Associate Non-Executive Director**

Welcome to Dudley Integrated Health and Care Trusts' Equality, Diversity and Inclusion Strategy (EDI).

This strategy focuses on three important areas:

- Health inequalities and digital inclusion
- Patient voice and engagement
- Workforce equality

All three components are critical to ensuring that our Trust is a place where patients and service users get the highest quality service, where our population are engaged in shaping what we do, and how we do it, so that it is meeting their needs, and is a great place to work.

Our belief is that equality, diversity and inclusion should be an intrinsic part of our organisational culture.

We expect our staff to be educated around what it means to be inclusive, and to demonstrate our commitments and values in their everyday activities with our patients, population and each other. We will, of course, provide the development and support needed to enable this.

For our patients and service users, we are determined to understand where health inequalities occur and to utilise this knowledge for narrowing the equality gap. We will design immediate actions, as well as developing an ambitious long-term strategy to address health inequalities. We will adopt a collaborative approach by working with our partners in this endeavour.

For our staff, our aim is to be an organisation that has an embedded restorative just and learning culture. In simple terms, this means that we will support our staff when things go wrong, will look at 'what' went wrong and not who was to blame, explore how we learn from errors, and support staff to reflect and change. This does not mean we will ignore or accept any behaviour that falls short of our expectations, nor will we tolerate overt or deliberate discrimination or prejudice.

Moreover, we will seek out and listen to patient stories and experience and use that information to help co-design services with local people.

We will be an organisation that is empathetic, understanding and listens to understand, before it acts.

We hope you will read this strategy and get a sense of how important this agenda is to our Trust. Equality, Diversity and Inclusion is a part of who we are, and our ambition is for each and every one of our staff to feel their value in DIHC

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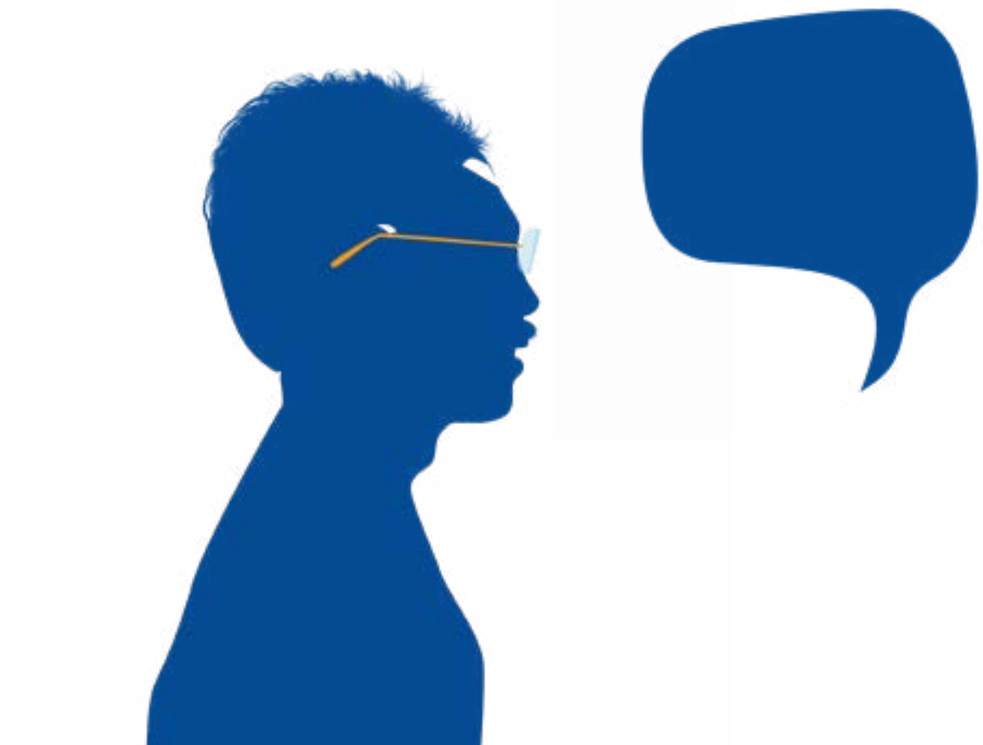


# Introduction

To understand health inequalities within Dudley our industrial heritage needs to be appreciated. As one of the birthplaces of the industrial revolution, heavy industry influenced the development of the borough, patterns of migration and the health of the populace. The subsequent decline of this industry corresponds with some aspects of deprivation faced in Dudley, and the associated intergenerational inequality patterns we see today. Dudley has a strong sense of identity, firmly linked to this history, however, present-day Dudley consists of diverse communities and people. This diversity is cause for celebration, but it is also vital that we recognise and tackle the disproportionate impacts of inequality within our communities.

NHS organisations are changing with a renewed effort to prioritise the reduction of health inequalities, both nationally and at system level. The Coronavirus pandemic has highlighted how entrenched health inequalities are within our society and has led to their exacerbation.

The creation of Integrated Care Boards (ICBs) and support for Integrated Care Systems (ICSs) provide a platform to effectively tackle health inequalities. As an integrated care provider, we are uniquely placed to incorporate the consideration of health-related inequalities to all of the services we provide and commission. Additionally, we can assess where inequities occur in the design of new services to prevent and drive down health inequalities across Dudley.

At the very heart of our organisation are the key aims to provide the best possible integrated health and care services to the people of Dudley, that is aligned to cultural need, and improves healthy life expectancy. We are committed to a people first approach and want every individual in Dudley to benefit regardless of their background or circumstances. We recognise that health inequalities exist within Dudley, disproportionately affecting some individuals and communities. We passionately believe that avoidable health inequalities must be tackled, reduced, and eliminated where possible, to truly improve the health and wellbeing for all of Dudley.

Health inequalities encompass a range of domains and constitute a broad spectrum of the health and social care system, alongside wider determinants of health that are largely managed outside the NHS. This creates a challenge that goes beyond the lifetime of this strategy, we will seek to build support for our health inequalities agenda and raise awareness of the need to consider health inequalities with regard to all we do. We will continue to collaborate with our partners across the ICS, forging strong and long-lasting partnerships that promote and deliver our collective health inequalities plan.

This is a bold and ambitious strategy, demonstrating both how our organisation is committed to tackling health related inequalities and enshrining this into our long term aims. In some cases the timescales provided exceed the life of this strategy, this is in line with system wide targets.

We shall focus upon place-based initiatives that are designed specifically for our local population whilst collaborating with our neighbouring areas that form part of the Black Country Integrated Care Board (Black Country ICB). We shall ensure our organisation is represented at the Health Inequalities Prevention Board (HIPB)[1] and collaborate with system wide initiatives. This will ensure the Dudley population can benefit from the shared resources and expertise provided by the ICB whilst being tailored to suit our local needs. Utilising the data held by registered patient lists enables a robust and systematic approach that is required to effectively tackle health inequalities.

Our Trust holds an integration agreement with 40 of the 43 Dudley practices, directly runs one practice and subcontracts one other. This integration and direct service provision allows our organisation a unique and powerful opportunity to drive down health inequalities utilising this data at a large scale.

This strategy therefore aims to ensure we focus on reducing these inequalities for population and our staff, ensuring that our services are, wherever possible, culturally sensitive, and provide a positive experience for patients and staff.

*[1] HIPB consists of representation from across the Black Country ICS and reports to the Black Country ICB*

# Message From Our Inclusion, Anti-Racism And Allyship Network

We want everyone to feel able to bring their whole selves to their employment with us. We want to enable our people to be open about their individual characteristics and feel safe to do so.

We want people to believe that diversity is one of our greatest strengths. Diversity gives us a unique perspective on the challenges facing the world and enables us to build bridges across cultures and communities.

As a Trust we understand that EDI is the cornerstone of the culture that we want to ensure exists for our future workforce. We want our people to be able to fully participate and achieve their potential and for our Trust to be a place where difference is celebrated and supported.

The aims of the Staff Network are:

- Provide a forum for staff to network and at which they can discuss issues of specific interest that influence us
- Act as a voice for staff offering a source of consultation and a means of communicating with senior leadership about staff issues in relation policies and practices
- Assist with policy development on staff issues by providing advice and feedback to the Equality, Diversity and Inclusion Committee, Human Resources and other relevant DIHC committees
- Provide mutual support and representation for all staff
- Facilitate staff experience challenges due to their protected characteristics, to access confidential advice and support.
- Increase wider understanding of staff issues by organising information sharing events and advising on staff training.
- Strengthen the EDI agenda by supporting initiatives to improve the recruitment and retention of staff.

# Freedom To Speak Up

Often those who experience exclusion and inequality are not heard, and outdated systems do not provide a meaningful way for people to speak up. One of the ways we are tackling this is through our Freedom to Speak Up Guardian, who supports staff to speak up to raise concerns or report mistreatment when they feel they are unable to do so by other routes. The Freedom to Speak Up Guardian also ensures that barriers to speaking up are addressed, a positive culture of speaking continues to be encouraged and matters raised are used as opportunities for learning and improvement.

# Our Anti-Racist Statement

As a Trust we know that the care of our patients is strengthened through diversity of thought, approach, and culture, delivered by staff from rich and different backgrounds. A lack of diversity will stifle true innovation and transformation. Without diversity, our organisation will not thrive.

We are deeply aware of the extent to which black, Asian, or other ethnically diverse people are underrepresented across our staff teams, the senior management team and on our Board. Ensuring that this situation changes, not only through a genuinely held commitment but also through robust and proactive action, is a priority for us. We wish to go beyond the legal requirements for equality, so we are a truly inclusive and fair organisation.

We know we might make mistakes along the way, and we commit to acknowledge them and strive to do better.

We are aware that systemic racism is deeply ingrained in our society and whilst attempts have been made to address this reality, actual change is long overdue. Public institutions such as ours have a crucial role to play in promoting anti-racism, and in tackling inequalities in health, through building a more tolerant, inclusive, equal, and empathetic culture.

The board have committed to tackle racism in our workplace, and to see growth in diversity across the organisation. We believe we have to be proactively anti-racist, and this means every one of us standing up against racism or any discriminatory behaviour. As an organisation, we will not tolerate racist or discriminatory behaviours or beliefs.

**'We Stand' Against Racism**

# How We Have Developed Our Strategy

We have developed our strategy in partnership with our EDI Steering Group and Inclusion network, and through the utilisation of a range of data to ensure we are addressing the key issues we face; including population health data, patient feedback, staff survey feedback, Workforce Race Equality and Disability Equality Standards.

We have also utilised learning from our partners across the system and nationally, focusing on what is working well in other areas and adapting to suit our organisational form.

# The Population We Serve - 2022

## Population

322,363

## Smoking

Higher smoking rates in the region (**17.1%**) compared to the national average (**12.4%**)

- Sedgley, Cosely and Gornal
- Dudley and Netherton
- Kingswinford and Wordsley
- Brierley Hill
- Stourbridge, Wollescote and Lye
- Halesowen

## Life Expectancy

♂ Men - 78.8

♀ Women - 82.2

Life expectancy for men in the most deprived areas of Dudley is **9.2 years lower** than in the least deprived areas, **8.6 years lower** for women.

## Welfare and Benefits

| | |
|---|---|
| 26,049 | Receiving Housing Benefits or a Council Tax Reduction. |
| 33,961 | Universal Credit claimants within the Dudley Borough. |
| £669k | Awarded in Discretionary Housing Payments. |

## Deprivation

| | |
|---|---|
| 104th | Most deprived of 317 local authorities in England. |
| 28.6% | Of the Dudley population live in areas amongst the 20% most deprived in England. |
| 16.9% | Of the Dudley population live in areas amongst the 20% least deprived in England. |



# Our Challenges

The population of Dudley is diverse and face a range of health inequalities. We want our population to be served by a workforce that is representative so that we can truly understand and meet their needs.

As an NHS organisation, and a public body, we have a duty to ensure we are doing all we can to eliminate discrimination, remove barriers, and reduce inequalities of all kinds whether that be for our staff, our patients, or our population in line with the Public Sector Equality Duty.

Health inequalities should have no place in our system, and we have a critical role to play in supporting systemic change. We have outlined the history of Dudley and health inequalities in the opening of this strategy document.

We have outlined some of the known challenges that this strategy aims to address:

- We need to improve the demographic data we have for our population, and to undertake deeper analysis of health data to understand diversity and access, including challenges around digital accessibility and exclusion.
- We know racism exists and that we have a moral duty to be allies, to challenge and to work to eliminate racism.
- There are barriers to people with disabilities gaining employment and being able to easily access and use our services.
- Our population sees significant levels of deprivation and health inequalities.
- Digital healthcare is increasing and enabling digital access to our population is critical.
- Our workforce is overall more representative of the communities we serve overall from a black, Asian, and ethnic minority perspective, but we see less of that representation at more senior levels in the organisation.
- Staff from black, Asian or other ethnic backgrounds have a significantly different view to white staff about the fairness and equity of career progression and opportunities.
- Whilst the Trusts survey results around bullying, harassment and discrimination are better than many peers, we must work towards zero.

# Why EDI Matters To Us

We believe that in the 21st century there is no place for inequity and we must take a proactive role in working to eliminate inequity, inequality, and discrimination of any kind within our organisation, and across the borough of Dudley, so our population feels the benefit.

Our strategy is about promoting a fair and just society; where individuals have the opportunity to achieve; where individual differences are embraced, and the benefits of difference are seen; where everyone matters; where barriers are removed; where the population feels the benefits.

# We Have A Role As An Anchor Institution

Anchor Institutions are organisations that are rooted in local communities, and through their size and scale can contribute to the local area in ways beyond the provision of healthcare. Through this contribution the NHS can have a greater impact on wider socio-economic factors which can positively influence the health and wellbeing of our communities. DIHC, as an anchor institution in the Dudley Borough, has a responsibility to advance the welfare of the population we serve and to eliminate health inequalities. We have assets and influence that can be used to support local community, through procurement and spending power, workforce, and training, and influencing how health and social care is delivered. By working and engaging with our community, we should develop strategies to increase opportunities and narrow the inequality gaps that exist. This has never been so important, given the health inequalities that the COVID-19 pandemic has further exposed.

# Link To National And Local Strategies

We have ensured we have considered and aligned our strategy to the objectives nationally and locally. We are a key partner within the Black Country system, and know that our strategy and objectives will play a part in enabling the wider system to tackle inequalities and achieve national objectives and targets.

The strategy therefore aligns to:

The NHS People Plan: is a national people strategy with a wide range of objectives. It focuses on the NHS needing more people, working differently in a compassionate, inclusive and restorative culture.

Black Country ICS EDI Strategy: DIHC works in partnership across our system and is proactively engaged in the development of the ICS EDI strategy, as well as the wider ICB strategy and aims.

As an organisation that works within the Dudley Health and Care System, we also embrace the values that have been developed by our Dudley Health and Care Partnership. These are shown below, and are fully supported by all health and care partners in the Dudley system.




# Embedding EDI And The Importance Of A Restorative, Just And Learning Culture

Our mission is to make EDI part of how we do things in our Trust. It should an instinctive part of how we operate, how we think, how we behave, how we design and deliver services.

We will be an organisation that is empathetic, courageous and that learns when things go wrong.

We are passionate about embedding a restorative just and learning culture that ensures our staff feel safe to speak up when they make a mistake in the knowledge that the organisational approach is, first and foremost, to support them. We know that this will make our services safer for our patients and population, and ensure our staff work in an environment that make them feel valued. This is particularly important for staff from under-represented groups who may feel their voice is less heard.

The restorative just and learning culture approach will be threaded throughout our objectives.

# Four Overarching EDI Priorities

| Our Patient Priorities | | Our People Priorities | |
|---|---|---|---|
| **Priority 1** | **Tackling Health Inequalities** | **Priority 3** | **Inclusive recruitment and career progression** |
| **Priority 2** | **Hearing the Patient Voice** | **Priority 4** | **Inclusive Culture and Experience** |
| **Our Patients** | | **Our People** | |
| • We will work towards balancing health outcomes offering support proportionate to the levels of disadvantage faced<br>• We will have our 'bigger picture' approach to tackling health inequality, alongside focus on those from special groups who may face additional disadvantages<br>• We will actively seek the views and thoughts of our patients and population in our organisational direction, particularly those from under-represented groups<br>• We will grow our approach to co-design to ensure our services are meeting the needs of our population | | • We will close the gap between people with or without protected characteristics being recruited or progressing<br>• We will have an equitable and representative workforce demographic at all levels<br>• We will close the gap in how people with or without protected characteristics view the organisational culture<br>• We will close the gap in how people with or without protected characteristics are treated<br>• We will embed a restorative just and learning culture | |



# Our Patient / Population Priorities

The introduction to the strategy outlines the very real health inequalities challenges across Dudley and we have developed our priorities to tackle those inequalities.

Utilising the Core20PLUS5 [2] approach we will target our resource to drive down health inequalities utilising local data. We will focus on health inequalities that are already recognised and evidenced by these data.

We are aware there are many unknown health inequalities and will seek to understand where these occur and adapt our approach accordingly. We recognise the need for immediate action and provide a plan based upon six broad domains (below).

Please refer to Appendix 1 for background detail for each domain


[2] NHS England » Core20PLUS5 – An approach to reducing health inequalities

# Priority 1: Tackling Health Inequalities

## A. Reduction of the Life Expectancy Gap in Dudley

Within this domain we aim to reduce the morbidity and mortality contributing to the life expectancy gap in Dudley, with a reduction envisaged by 2037.

**A1.Hypertension and Lipid Optimisation**

We will: improve the rate of Hypertension detection and Lipid optimisation across Dudley, with specific emphasis on areas of deprivation with higher premature mortality rates due to circulatory disorders.

- Restore hypertension case finding and treatment to pre-covid levels (2019/20 data)
- Aim to achieve 80:80 hypertension case finding and management across all Dudley practices by 2029 [3]
- Focus increased uptake in areas with higher deprivation indices and higher cardiovascular mortality rates
- Expand the existing BP at home programme
- Encourage and empower patients to monitor their own blood pressure utilising validated simple guidelines and via provision of BP monitors
- Support practices to use of validated scoring for cardiovascular risk and offer of Statins and lifestyle advice to eligible patients

Key resources and enablers

- DIHC Clinical Divisional Director, Pharmacy and Population Health Management
- DIHC Strategic Commissioning and Transformation Team
- DIHC Clinical lead for Health Inequalities
- PCN Clinical Directors (PCN CDs)
- Pharmaceutical adviser
- Practice based pharmacy teams
- Project Support to Pharmaceutical Public Health Team
- Community pharmacists
- Dudley MBC Public Health Team
- Funding via prevention and health inequalities funding stream

**A2. Smoking**

We will: improve Rates of Smoking Cessation Offers across Dudley, with specific emphasis on areas of deprivation which are associated with higher smoking prevalence.

- Aim for 90% of patients who smoke being offered smoking cessation by 2024/25
- Utilise new digital technologies embedded within primary care such as AccuRx [4] to target large groups of patients to promote self-referral. For example sending a message to all patients coding as currently smoking offering an intervention.
- Provide simple guidance to all clinical staff working in primary care to identify and signpost those currently smoking
- Collaborate with the local public health team to provide promotional material to charitable and third sector organisations, places of worship, youth services and other community services
- Consider how we improve data collection regards vaping incidence and illicit tobacco use

Key resources and enablers

- Dudley MBC Public Health
- Dudley MBC Health and Wellbeing Team
- DIHC Clinical Divisional Director, Pharmacy and Population Health Management
- DIHC Strategic Commissioning and Transformation Team
- DIHC Clinical lead for health inequalities
- PCN CDs
- DIHC Health coaching team
- Funding via prevention and health inequalities funding stream

**A3. Cancer**

We will: seek to improve cancer screening rates in our most deprived communities alongside ensuring cancer screening rates improve across the whole population of Dudley

- Work with the current DIHC clinical lead for cancer to ascertain where inequalities exist regards cancer screening in Dudley
- Support targeted interventions for our most deprived communities to boost uptake
- Utilise National QoF targets as an objective measure to benchmark success
- Explore the use of an existing online training package for clinical staff training to raise awareness of where reduced cancer screening in our communities occurs and how to address this in the clinical setting

Key resources and enablers

- DIHC Clinical lead for Cancer
- DIHC Clinical Divisional Director, Pharmacy and Population Health Management
- DIHC Strategic Commissioning and Transformation Team
- DIHC Clinical lead for Health Inequalities
- PCN CDs
- Dudley MBC Health and Wellbeing Team

**A4. Diabetes and Mental Health**

We will: identify key health inequalities in Dudley in conjunction with the nominated clinical leads and proposed Health Inequalities Steering Group.

- Support projects with a focus on Black and Asian minority ethnic groups
- Provide a regular update from the health inequalities steering group to the diabetes and mental health clinical leads
- Provide support and advice where required in relation to new service design to ensure ongoing consideration of health inequalities with a plan to reduce them where possible.

Key resources and enablers

- DIHC Divisional director of Mental Health
- DIHC Clinical lead for Diabetes
- DIHC Clinical Divisional Director, Pharmacy and Population Health Management
- DIHC Strategic Commissioning and Transformation Team
- Dudley Group Foundation Trust (DGFT) Lead for Health Inequalities
- DIHC Clinical lead for Health Inequalities
- PCNs CDs
- Dudley MBC Health and Wellbeing Team

## B. Organisational and Patient Engagement

### B1. Tackling Neighbourhood Health Inequalities

The PCN DES sets out a contractual obligation to tackle health inequalities at a PCN level. In Dudley planning remains at an early stage however the PCNs have agreed to pool funding to develop a Dudley wide plan tailored to each PCN. Early drafts of this plan encompass some of the work around hypertension and support will be provided to ensure this work complements and builds upon this wider strategy.

### B2. Health Inequalities Steering Board

We will: set up a new Health Inequalities Steering Board creating a forum for feedback from our ICS partners and our patients

- Aim to formally launch in September 2022
- Bi-monthly meeting and chaired by the Clinical Lead for Health Inequalities
- Invite representatives from across the ICS to attend regularly
- Invite patients and their representatives to feedback on their needs and experiences
- Provide succinct updates to the PCN Clinical Directors following these meetings to support PCN DES health inequalities related projects
- Utilise this data to inform and shape existing projects and proposed service design.

Key resources and enablers

- DIHC Clinical Divisional Director, Pharmacy and Population Health Management
- DIHC Clinical Lead for Health Inequalities
- DIHC People Team
- DIHC Communications Team
- DIHC School Nursing Team
- DIHC Administration support
- Local authority and ICS partners

### B3. Data Management

We will: improve the data in primary care records to help ensure our focus is right and improve reporting

- Utilise existing work that has been undertaken at High Oak and Chapel Street surgery and how this can be adapted to support all practices
- Focus on recording of data relating to Ethnicity to allow analysis of health inequalities affecting our Black and Asian minority ethnic groups
- Over the next 2-3 years, we will work across our primary care networks to support data quality improvement
- Develop and grow reporting on health inequalities and population health to support the ongoing development of our strategic objectives

Key resources and enablers

- DIHC Digital Team
- DIHC Clinical Divisional Director, Pharmacy and Population Health Management
- DIHC Clinical Lead for Health Inequalities

### B4. First 1001 days

Following HM Government report The Best Start for Life 2021 [5] there needs to be a focus on joined up, equitable care for babies and their families from conception to age 2.

We will: focus on the first 1001 days by supporting the Dudley Public Health Team who will lead on this initiative

- Assess the data of our 14+ health checks to ensure that follow up plans are put in place – this will be utilised for evidence of improvement
- Train our clinical teams in 'making every contact count' with pregnant women to encourage breast feeding
- Training clinical teams in recognition of potential post-natal depression within new mothers
- Seek to improve training of teenagers in sexual health to break cycles
- Undertake research on prescribing of post-natal depression medication with a view to reducing and using alternative approaches

Key resources and enablers

- Dudley MBC Public Health
- Dudley MBC Health and Wellbeing Team
- DIHC Clinical Divisional Director, Pharmacy and Population Health Management
- DIHC Clinical Lead for Children and Young People
- DIHC Clinical Lead for Health Inequalities
- DIHC Strategic Commissioning and Transformation Team
- DGFT Lead for Health Inequalities
- DGFT Maternity Team

### B5. Maternity

We will: engage with DGFT to support their initiatives in this domain

- Liaise with DGFT clinical leads to ascertain the work being conducted within this area
- Provide guidance as to delivery of their goals in relation to primary care and how GP practices can support their agenda to increase success.
- Canvass school nurse opinion regards educational opportunities and sexual education

Key resources and enablers

- DGFT Lead for Health Inequalities
- DGFT Maternity Team
- DIHC Clinical Lead for Health Inequalities
- PCN CDs
- DIHC School nursing team

### B6. Audit

We will: embed equality into audit

- Utilise the Health Equity Assessment Toolkit (HEAT) in relation to new service design
- Consider applying HEAT retrospectively to current services to assess if health inequalities are being addressed
- Assess the quality of data that can assist with EDI improvement and seek to improve collection of said data
- Develop guidance on how to include consideration of health inequalities in audit data
- Initial areas of focus will be
  - Health promotion
  - Smoking cessation pre-pregnancy/during pregnancy
  - Breast feeding education and promotion
  - Parenting skills
  - Diabetes education programmes
  - Educating clinicians how to embed EDI into audit

Key resources and enablers

- DIHC Clinical Divisional Director, Pharmacy and Population Health Management
- DIHC Digital Team
- DIHC Clinical Lead for Health Inequalities
- DIHC Quality Improvement Group

**B7. Digital Inclusion**

We will: locally adopt and implement the system wide approach being developed by the Black Country ICB:

- Support the dissemination of promotional material proved by Black Country ICB
- Become an active member of the ICS Digital Inequalities Sub-Group
- Promote and be an active participant in Black Country Connected – a four-pillar programme encompassing
  - Access to Kit
  - Access to Connectivity
  - Access to Skills (incorporating 1:1 and hands-on support)
  - Access to Information
- Work with key Health and Care professionals on the design of our clinical systems to ensure they meet the Accessible Information Standard, and they capture all relevant data to assist with Population Health Management analyses
- Promote the Digital Inclusion agenda across primary care utilising existing communications streams and canvas opinion from the PCNs how this can work in practice.

Key resources and enablers

- DIHC Lead for Digital Inclusion
- DIHC Digital Team Systems Managers
- DIHC Clinical Divisional Director, Pharmacy and Population Health Management
- DIHC Strategic Commissioning and Transformation Team
- DIHC Clinical Lead for Health Inequalities
- PCN CDs

**B8. Palliative and End of Life Care**

We will: develop an understanding of palliative and end of life related health inequalities in Dudley in collaboration with the Mary Stevens Hospice.

- Analyse data for evidence of health inequalities relating to access to hospice and palliative care services
- Collaborate with Mary Stevens Hospice on selected community engagement projects to help us better understand patient's needs
- Seek to ensure the importance of equitable access to palliative and end of life care embedded across our primary care clinical teams

Key resources and enablers

- The Mary Stevens Hospice Inclusion Team
- DIHC Clinical Lead for Health Inequalities
- DIHC Strategic Commissioning and Transformation Team
- PCN CDs



## C. Special Populations

**C1. Learning Disabilities**

We will: develop a clinical operational model which supports and assures the annual Learning Disability Health Check.

- Expand and promote the existing Learning Disability steering group to ensure collaboration with the learning disability services alongside community and voluntary sector groups
- Provide a quality assurance and support service to ensure health checks are high quality, tailored and encompass wellbeing, patient experience and the wider health needs of individuals and their carers/ family
- Develop and provide an educational aspect in conjunction with Black Country Healthcare to raise awareness with a focus on access and reasonable adjustments
- Work closely with Dudley Voices for Choice to gain ongoing patient and care provider feedback and opinion to ensure services adapt and flex to the patient group's needs.

Key resources and enablers

- DIHC Clinical Lead for Health Inequalities
- DIHC Strategic Commissioning and Transformation Team
- Ridge Hill Learning Disability Service
- Dudley Voices for Choice
- Black Country Healthcare

**C2. Homeless Health**

We will: explore the options for a specialised service to support those classed as homeless gain access to timely healthcare and reduce the reliance upon urgent care services

- Collaborate with a wide range of partners across the health and social care system to understand this complex cohorts needs
- Develop a business case for funding to launch a Homeless Health Service to ensure we improve access to routine health care services as well as integrating this approach with housing, drugs services and voluntary sector to deliver interventions to improve health
- Collaborate with Mary Stevens Hospice to provide an educational programme considering advance care planning and end of life care

Key resources and enablers

- DIHC Clinical Lead for Health Inequalities
- DIHC Strategic Commissioning and Transformation Team
- Independent substance misuse provider
- The Mary Stevens Hospice Inclusion Team

- C3. Substance Misuse

We will: Work with the local authority and commissioned drug service provider to improve collaboration with primary care

- Consider trialling a substance misuse specific Integrated Care Team (ICT)
- Allow ICT leads to seek representation from the drug services at ICTs and GP MDTs
- Advise Dudley Public Health team regards the supplementary substance misuse grant to improve community drug services and support GP practices with complex cases

Key resources and enablers

- DIHC Divisional Director of Mental Health
- DIHC Clinical Lead for Health Inequalities
- DIHC Strategic Commissioning and Transformation Team
- Independent substance misuse provider
- Dudley MBC Adults and Older people public health team

## D. Research Active Organisation

We will: Develop DIHC as a research active organisation and join up all our practices to provide their data for research purposes and support practices to be research active.

- Develop a research engagement agreement for all Dudley GP practices to provide their data for research purposes
- Work with the National Institute for Health Research (NIHR) to implement the engagement agreement and provide support to both our clinical and non-clinical staff
- Build in guidance supporting equity of access to research with a focus on our most deprived communities
- Organise a yearly research conference for Dudley to showcase research and develop collaboration across our partner organisations
- Forge a formal partnership with a local higher education institution to develop original research and understand local health related issues.

Key resources and enablers

- DIHC Clinical Lead for Health Inequalities
- Strategic Commissioning and Transformation Team
- NIHR Research Operations Manager
- PCN CDs

## E. Prevention and Education

We will: Seek to build a partnership with the local authority to consider how we support the delivery of health-related education within primary and secondary schools as well as further education institutions. Work here will be led by the Local Authority and DIHC providing an advisory and support role.

- Identify schools in areas where deprivation is high and co-design educational sessions with GPs, Nurses, ARRS staff and other services such as substance misuse, gambling, LGBTQ+ to support personal and social education
- Utilise these links to offer work experience based placement within anchor institutions such as the NHS and its partners to young people from background with a recognised disadvantage or protected characteristic.

Key resources and enablers

- DIHC Clinical Lead for Health Inequalities
- Strategic Commissioning and Transformation Programme Team
- Dudley Health and Wellbeing Team
- Independent substance misuse provider
- DIHC Clinical Lead for Health Inequalities



## F. Longer Term View

In the longer term we will seek to identify health inequality related issues in relation to our special populations and consider how we will engage, develop aims, and deliver these aims these include

- LGBTQ+ community
- Refugees and Traveller Communities
- Chronic Addiction
- Gender inequality

**Priority 2: Hearing the Patient Voice**

We know that our patients and communities are the experts in their own health and will have their own aspirations of what they need to create and sustain healthier lifestyles. We want to help build resilient communities who talk positively about the care and support they receive. Our vision is to actively seek out and listen to patient stories and experience and use that information to help co design services which are responsive to the needs of local people, recognising the need to deliver culturally sensitive services across the diverse population of Dudley. We are an organisation that wants to be rooted within the local community.

Ensure our information is accessible to all and that we are meeting the Accessible Information Standard

- Ensure that our staff can access training for the Accessible Information Standard
- Develop and improve our website and intranet information and messaging for patients with different needs
- Provide improved and accessible interpreter and translation services

Develop and grow our approach to co-design and understanding experience

- Work with patients with learning disabilities and a range of partners to involve them in developing key material including our quality account
- Continue to build relationships with different groups (hearing impaired, learning disability, language barriers, visual impairment, mental health, Roma, dementia) to focus on where we can improve our services and make them more accessible
- Co-design a mechanism for gathering patient stories to both celebrate positive experiences and learn from negative experiences
- Develop a pro-active and structured approach to co-design working with key stakeholders, partners and groups
- Seek to develop Community Champions based around Primary Care
- Engage our younger population in support the design of the school nursing services for 16–19-year-olds

*[3] The ambition for hypertension is that 80% of the expected number of people with high BP are detected by 2029, and that 80% of the population diagnosed with hypertension are treated to target (ref).*

*[4] Accurx platform access at Accurx | Home*

*[5] The best start for life a vision for the 1 001 critical days.pdf (publishing.service.gov.uk)*

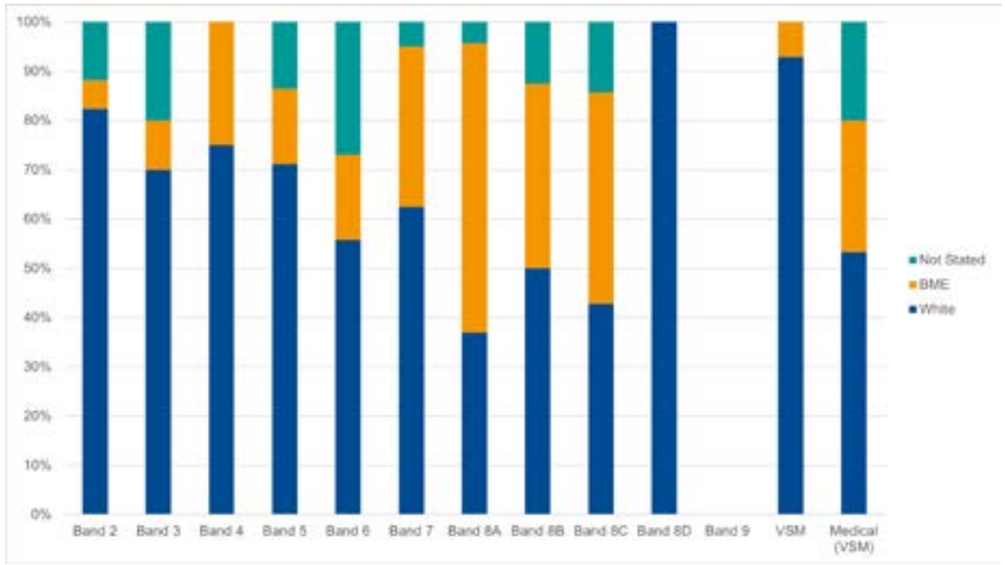
# Our People Priorities

We employ almost 400 staff in a range of roles, both clinical and non-clinical.

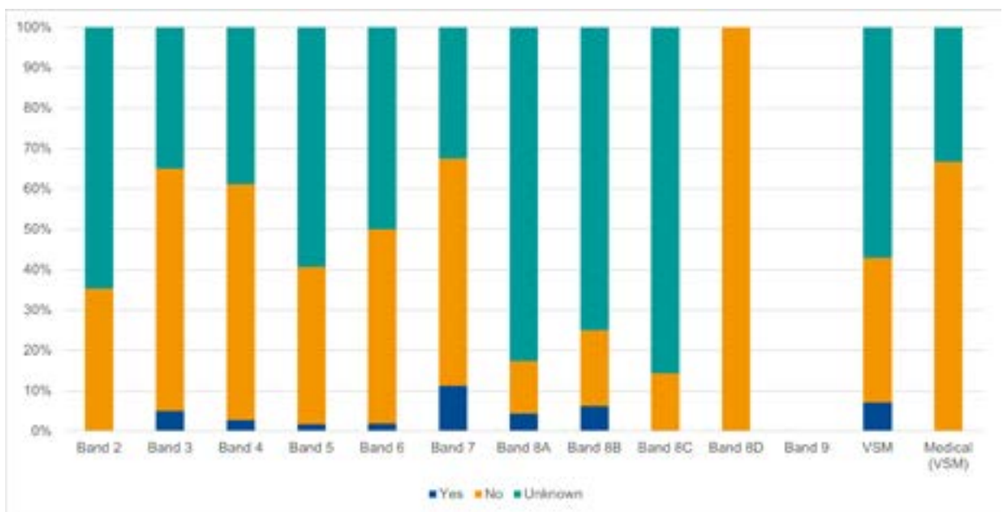
We look at the demographics of our people to assess if we are employing people that represent the communities we serve. We particularly look at the ethnicity of our people, and how many people that work for us that have disabilities. The graphs that follow show the proportions of staff, in each of our pay bands.

Part of our EDI strategy is to see the proportions change positively so that we have greater ethnicity representation across the pay bands and have greater proportions of disabled staff employed.

### Workforce Profile by Ethnicity - All Staff (As of 31st March 2022)




### Workforce Profile by Disability - All Staff (As of 31st March 2022)






In our National Staff Survey results (2021), we saw the following outcomes that this strategy needs to address:

65.9% of our staff agree that the Trust acts fairly in relation to career progression.

When looked at from a diversity perspective however:

- 73.3% of staff from a white background agreed with this, as opposed to just 45.5% of staff from black, Asian, or other minority ethnic groups
- 66.4% of staff without a disability or long-term health condition agreed, as opposed to 65.9% of staff with a disability or long-term health condition.

Staff experiencing bullying and harassment data shows that:

- 19.3% of white staff experience bullying or harassment from patients as opposed to 18.2% of staff from black, Asian or other minority ethnic groups.
- This changes when looking at experience of harassment and bullying from colleagues.
- 13.2% of white staff state they have experienced bullying or harassment from colleagues, whereas this is much higher for black, Asian or other minority ethnic staff at 18.2%.
- For staff with disabilities or long-term health conditions, we saw 22% experience bullying and harassment from patients or service users, whereas this lessens for staff without a disability, to 16.8%.
- Experience of bullying/harassment from managers sees 7.3% of staff with disabilities having this experience, and slightly less staff without, at just 6.6%
- Reports of bullying and harassment from colleagues see 6.6% of staff without a disability report this experience, but this almost doubles for staff with a disability, at 12.8%.

The aims of our EDI strategy are to see these statistics improve over time.

There are 2 key priorities for our staff outlined within this strategy and within each of these there are 3 high level actions.

We have set out an ambitious and detailed delivery plan, which aims to deliver a range of initiatives and programmes of work within the lifetime of this strategy. We know, however, that there will be elements of these that will extend beyond the lifetime of this strategy.

We will work across our system to ensure we are aligned to the strategic objectives, working in partnership to focus not only within our organisation but to the whole workforce across our system. We will be represented at ICB People Board and associated sub-groups, to collaborate and benefit from the wider resources and initiatives.

**Priority 3: Inclusive recruitment and career progression**

We want our workforce to be truly diverse and representative not just of the population we serve, but of the wider region. We believe the promotion of inclusivity is not just the right thing to do, but a critical path to our Trust being able to truly deliver its aims and goals. Diversity shines a different light on situations, and drives innovation.

Our patients and population need to know that we understand their needs, and we can only achieve that through true diversity within the our workforce.

We will be consistently reviewing our processes and approaches to how we recruit, select and support our staff.

We recognise that currently we see disparity in our recruitment and demographic data,, particularly between white and black, Asian and minority ethnic staff, and staff with or without disability or long-term health conditions.

We will commit to take positive action to close these gaps.

There are 3 high level actions within the Inclusive Recruitment and Career Progression priority:

3A We will open the doors to a wider demographic and encourage a wider pool of diverse applicants
3B We will train and coach managers to be inclusive in their recruitment practice
3C We will support bespoke career progression for under-represented groups

We will expect to see the impact of the actions through the following outcome measures:

- Diversity and representation, particularly at senior levels is showing year on year improvement, and aligned to the Midlands Workforce Race Equality strategic aims
- The percentage of our black, Asian, and other minority ethnic staff who feel that career progression is fair, improves incrementally over the next 3 years
- Number of staff from under-represented backgrounds achieving promotion within DIHC is equitable
- Equality in likelihood of recruitment is improving
- Increase in numbers of applications to DIHC from people from under-represented groups and the local population
- Number of workshops/support offered to populations in harder to reach areas
- Number of work experience opportunities created

**Priority 4: Inclusive Culture (A Great Place to Work)**

Our aim is that our Trust is seen as great place to work, that people hear about us and want to work for us. We want our staff to be our greatest advocates and to 'sell' DIHC as a great employer. We want our staff, regardless of their backgrounds or lived experiences, to say they feel valued, treated well, cared for, developed, and supported. We do not want this experience to be different for anyone. We want our staff to be proud to work for us, and to speak proudly of how our organisation exemplifies equality, diversity, and inclusion.

This must be about how everyone behaves and treats each other, with every individual taking responsibility for their own behaviour and actions. This is where the importance of a restorative just and learning culture comes in. Leadership will be key in setting those standards and expectations in line with the Trust commitments.

There are 3 high level actions within the Inclusive Culture priority:

4A We will develop our leaders and staff to be instinctively inclusive in their day-to-day interactions and activities
4B We will develop supportive policies, practices and systems that ensure equity for all
4C We will engage and hear from our diverse workforce, act on their feedback, and celebrate difference

We will expect to see the impact of the actions through the following outcome measures:

- The number of leaders engaging in training, mentoring and reverse mentoring is increasing incrementally
- Engagement and survey scores for diverse groups is showing year on year improvement
- The percentage of black, Asian and other minority ethnic staff, and staff with disabilities who state they have been bullied and harassed by colleagues shows year on year decrease
- Achievement of accreditations over the next 3 years (Disability Confident, Stonewall, RACE Code and Fawcett)
- Improved ESR and demographic data (numbers of not stated decreases)
- Uptake of bespoke offers for under-represented groups is positive and shows year on year improvement
- Numbers of staff engaged in the restorative just and learning culture sessions
- Growth of network(s)

**Monitoring our Progress on our People Priorities**

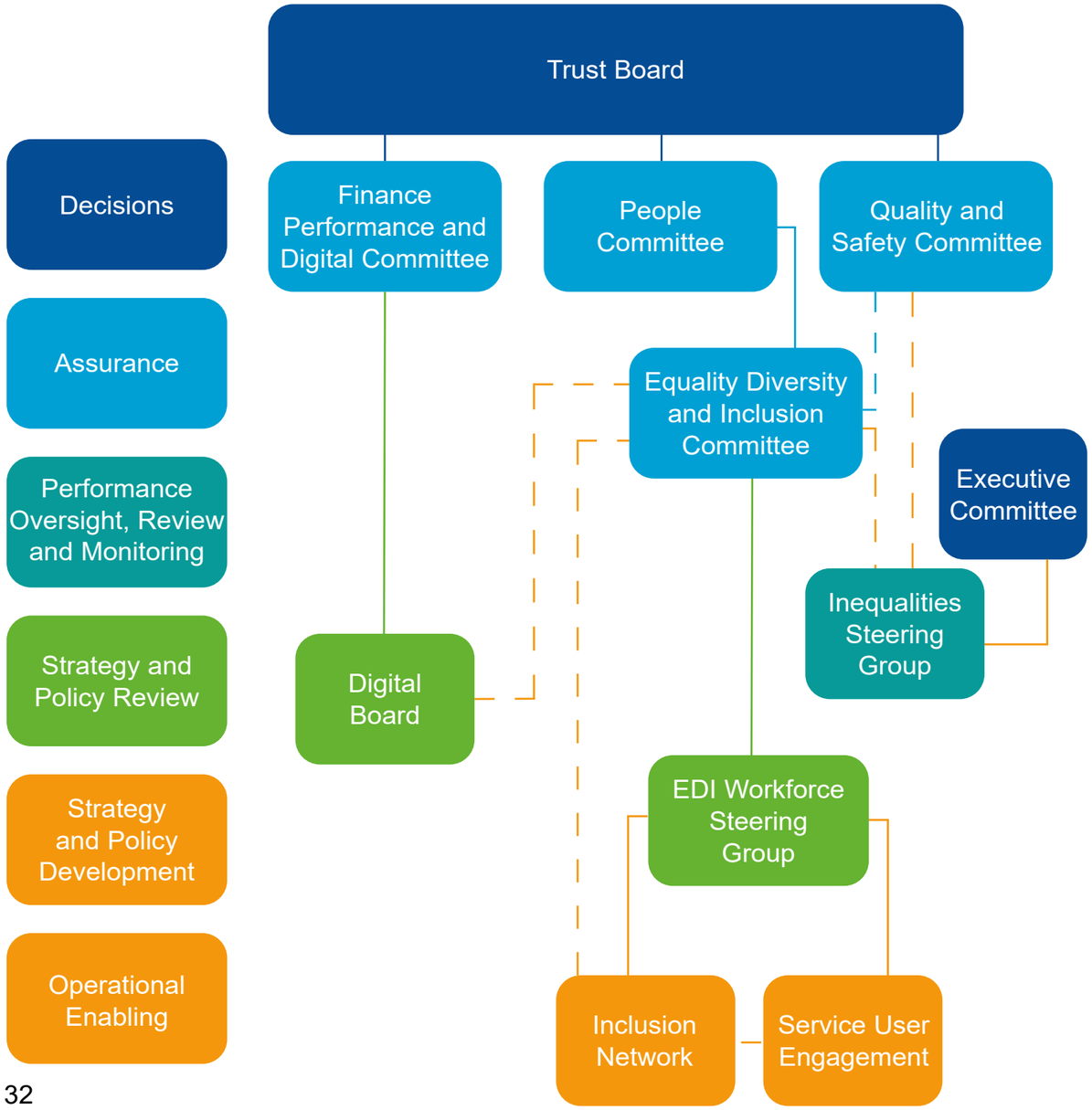
We have developed a detailed delivery plan and will be overseen by our EDI Steering Group and reports will be provided quarterly to our EDI Committee.

# Governance Structure Of EDI

It is critical that we have a robust governance approach to ensure the monitoring of the delivery of this strategy.

This includes the establishment of two key steering groups, one focused on the patient/population priorities, one on the workforce priorities. These groups will have a range of stakeholders that will support the implementation of the delivery plans.

There will be a senior level champion for EDI identified within the Digital Board to ensure the specific priority around Digital Inclusion is supported.






# In Conclusion

We are proud of what we have achieved since our inception in April 2020.

As a new organisation, we have an opportunity to create a culture that embeds equality, diversity, and inclusion. We have developed our policies, processes, training, and cultural expectations from scratch. Whilst this has offered fantastic opportunity to think differently and really focus on the culture we want to see; it has also presented challenges.

We are now in a positive place to truly embed the culture, values, and behaviours we want to see within our organisation, and to significantly influence change across Dudley and our wider system, so that our patients, service users, staff and wider population, feel the benefits of our Trust, and experience greater levels of equality.

We have set ourselves some stretching objectives within this strategy because we believe without ambition and a belief that we can make a difference we settle for complacency.

**“Diversity is being invited to the party; inclusion is being asked to dance.”**

(Vernā Myers)

# Appendix 1. Background For Health Inequalities Priorities

**Our Strategy**

Core20PLUS5 is a national NHS England and NHS Improvement approach to support the reduction of health inequalities and a framework by which we can tackle health inequalities. This approach can be coupled with the Black Country ICB 'Attain reducing health inequalities plan' to ensure compliance with overarching regional and national aims. Furthermore, this data can be utilised to deploy resources where needed in order we can focus on short term measures that can improve patient outcomes.

**A. Reduction of the Life Expectancy Gap in Dudley**

Dudley performs worse compared to the national average for all causes of mortality and this is not distributed evenly across the borough (see Fig 1)

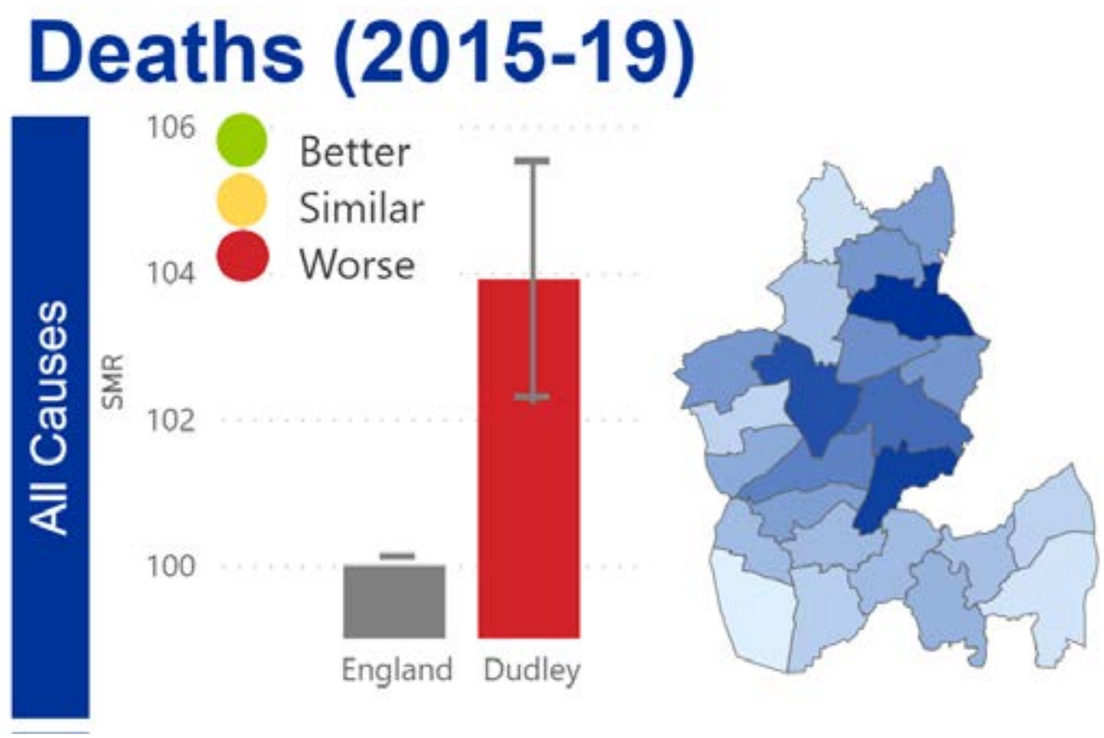



*Figure 1 Deaths in Dudley for all Causes 2015-2019 Compared to England Average (ONS, 2020) [6]*

[6] Accessed at; Understanding Dudley Health and Wellbeing - All About Dudley Borough



These data utilise Standardised Mortality Ratios (SMR) which are the number of observed deaths in the sample group compared to expected deaths in the general population, where these are equal the value is 100, a value above 100 suggests more deaths than expected. In Dudley all cause SMR is 104 with circulatory disease at 105 and coronary heart disease at 110. Fig 1 demonstrates an uneven distribution where the SMR for all causes was highest at 152 in Castle and Priory with 149 for Circulatory disease and 161 for coronary artery disease. The Castle and Priory ward whilst not universally deprived has a large proportion of the population in the most deprived decile. This suggests a link between deprivation and increased mortality in this population.

The Dudley top three causes are;

- Circulatory
- Cancer
- Respiratory

These account for over 50% contribution in the life expectancy gap for both males and females.

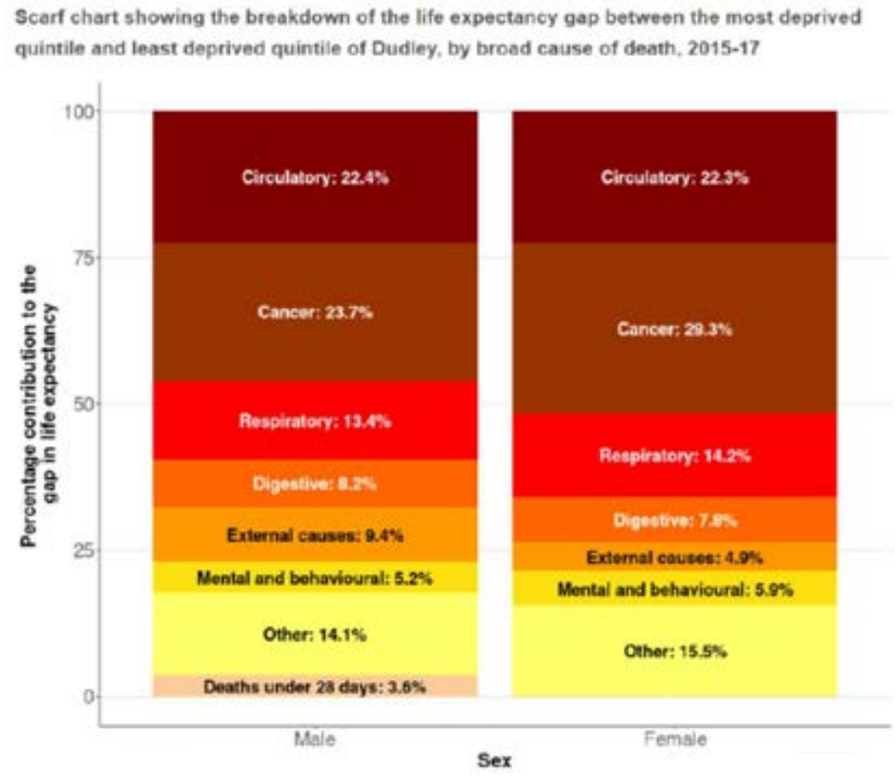



*Figure 2 Breakdown of the Life Expectancy Gap within Dudley (ONS, 2022)*

Our immediate strategy will focus upon these 3 areas with the short term aim of reducing morbidity and mortality as well as providing the foundations for the longer term aims of reducing the life expectancy gap attributed to these health inequalities in Dudley. This will also help form longer term aims around prevention due to greater understanding of interventions which increase engagement, strong collaborative links with local partners as well as community and patient relationship building.

**Hypertension and Lipid Optimisation**

This work is already in progress within the Division of Pharmacy and Population Health Management. Local data have been analysed and pilot projects commenced within Dudley and Netherton Primary Care Network (PCN). This project will be resourced utilising the DIHC pharmacy workforce and expanding to community pharmacies. PCN initiatives will contribute within the PCN Direct Enhanced Service (PCN DES) for health inequalities. Financial resource will be drawn upon from the Health Inequalities budget allocated from Black Country ICB.

**Smoking**

Smoking rates in Dudley are higher than the national average with prevalence rates at 17.1% compared to a national average 12.1% of adults in England smoking. There is a clear link with deprivation with prevalence rates increasing within the more deprived wards of Dudley [7]. Smoking cessation is clearly linked with a reduction in mortality and morbidity associated with Circulatory, cancer and respiratory related causes therefore this is a priority area. Dudley falls behind the national average for offers of smoking cessation support and it is estimated an additional 3017 patients should be offered smoking cessation support to meet the 90% England average (attain for BCWB CCG, 2021).

**Cancer**

Cancer accounts for the second largest proportion of the life expectancy gap in Dudley. Smoking is likely a major factor here owing to Lung cancer contributing to the largest life expectancy disparity relating to cancer. As such smoking interventions will play a key role. There are also other disparities namely increased excess deaths in Females due to Colorectal cancer and excess deaths for men due to prostate cancer compared to the England average. [8] In areas of higher deprivation cancer screening uptake is lower than the national and regional average (Public Health England, 2020) highlighting an important health inequality.

**Diabetes and Mental Health**

These remain a key focus in terms of health inequalities, and both have established clinical leadership teams. We will support their agenda and provide advice and guidance to embed the need to tackle health inequalities within these domains.

**Maternity**

Whilst this forms part of the Core20PLUS5 services are commission by Dudley Group of Hospitals. This offers and opportunity for collaboration. Our primary care services also provide support for pregnant women from pre-conception to the post-natal period as well as for their children. This is both direct via the GP and associated healthcare staff as well as hosting maternity clinics within the community.

**B. Organisational and Patient Engagement**

The broad and complex nature of health inequalities requires us to utilise all of our resources effectively as well as engage with our partners across the ICS and importantly our patients with an emphasis on those patients affected by health-related inequalities. We need the assistance and skills of our GP leaders across the PCNs and wider clinical and clerical workforce. This section outlines how we will support other clinical divisions to integrate health related inequalities into their work and service design.

**Palliative and End of Life Care**

National data demonstrates that health inequalities also occur at the end of life with those in more deprived communities, who are less likely to access specialist hospice care, as well as more likely to be admitted to hospital for end-of-life care compared to those from least deprived backgrounds (London School of Economics, 2015) [9]. Disparities also exist within Black, Asian and minority ethnic groups, those from LGBTQ+ communities, traveller communities and those experiencing homelessness (Tobin et al, 2022) [10]. Furthermore, these inequities exist prior to end of life with poor access to advance care planning opportunities for the aforementioned groups.

The Mary Stevens Hospice, located in Stourbridge, provides palliative and end of life care to the population of

the Dudley Borough and surrounding areas. They have an established inclusion and community partnerships programme. Significant engagement with communities affected by health and socio-economic inequalities related to palliative and end of life care is one of their core strategic objectives. Their programme is ambitious and broad and seeks to improve access to palliative and end of life care for all the population they serve.

**C. Special Populations**

Alongside these 'big picture' actions, we will have more bespoke support to special groups who may not only face deprivation but may also have additional disadvantage. These groups may be:

- Learning Disabilities
- LGBTQ+ community
- Ethnic minority communities
- Homelessness or housing stress
- Refugees and Traveller Communities
- Chronic mental illness
- Chronic Addiction
- Gender inequality

These aspects form part of the medium-longer term plan for tackling health inequalities with significant progress already made with regards to Learning disability patients and Homelessness.

**Learning Disabilities**

Specialist services are provided by Black Country Healthcare and our initial focus will be to improve the uptake and quality of the Annual Health Check which is conducted within the primary care setting.

**D. Research Active Organisation**

Overarching our work will be the availability of good quality local data and the ability to interrogate this data to enable analyses of success, areas requiring improvement and importantly emerging and unforeseen trends. A long-term aim is to build research into our organisation and more importantly ensure health inequalities are a standard aspect of DIHC led research projects.

**E. Prevention and Education**

The long term aims of improved life expectancy and reduced health inequalities will require a long-term preventative strategy with a particular focus on the young people of Dudley. Our ability to influence and shape the next generation with regards to their wellbeing and health will improve their outcomes. Whilst this work is largely undertaken within the education system, we believe support and expertise from our staff can enhance this work as well as ensuring education doesn't entrench health inequalities but indeed tackles them within the education system.

[7] *Accessed at DPH-Report-2010.pdf (allaboutdudley.info)*

[8] *Public Health England Segment Tool accessed at Segment Tool (phe.gov.uk)*

[9] *Equity in the Provision of Palliative Care in the UK: Review of Evidence (mariecurie.org.uk)*

[10] *Hospice care access inequalities: a systematic review and narrative synthesis | BMJ Supportive & Palliative Care*

Contact
dihc.communications@nhs.net
to request this document in another language or a different format.

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# DUDLEY INTEGRATED HEALTH AND CARE NHS TRUST BOARD

| | |
|---|---|
| **TITLE OF REPORT:** | Equality, Diversity and Inclusion (EDI) Workforce Annual Report (2021/22) |
| **PURPOSE OF REPORT:** | To share with Board the EDI Workforce Annual Report (2021/22) |
| **AUTHOR OF REPORT:** | Stephanie Cartwright, Director of Strategy, People and Partnerships |
| **DATE OF MEETING:** | 6th September 2022 |
| **KEY POINTS:** | • Every NHS organisation is required to produce an EDI annual report as part of the Public Sector Equality Duty (PSED)<br>• The appended report is the DIHC Workforce EDI Annual report for the year 2021/22<br>• It picks up key metrics from 2021/22 in relation to Workforce Race Equality Standard, Workforce Disability Equality Standard, other statutory requirements, and workforce demographic data aligned to the Equality Act 2010 defined protected characteristics<br>• It reflects on the fact that DIHC data was limited during this period, particularly due to National Staff Survey data aligned to the equality reporting requirements<br>• It outlines the good work undertaken by the Trust on Workforce EDI during the period and reflects the work in developing the new EDI Strategy<br>• The board will be receiving the Trusts newly developed EDI strategy in September which outlines the strategic aims aligned to patient and population health and tackling health inequalities, as well as workforce equality objectives. |
| **RECOMMENDATION:** | The Board are asked to approve the Workforce Equality, Diversity and Inclusion Annual Report 2021/22 |
| **ANY CONFLICTS OF INTEREST IDENTIFIED IN ADVANCE:** | None |
| **ACTION REQUIRED:** | Decision ☐<br>Approval ☒<br>Assurance ☐ |

Dudley Integrated Health and Care NHS Trust

# Workforce Equality, Diversity and Inclusion

# Annual Report

# 2021/22

## Our Inclusivity Achievements

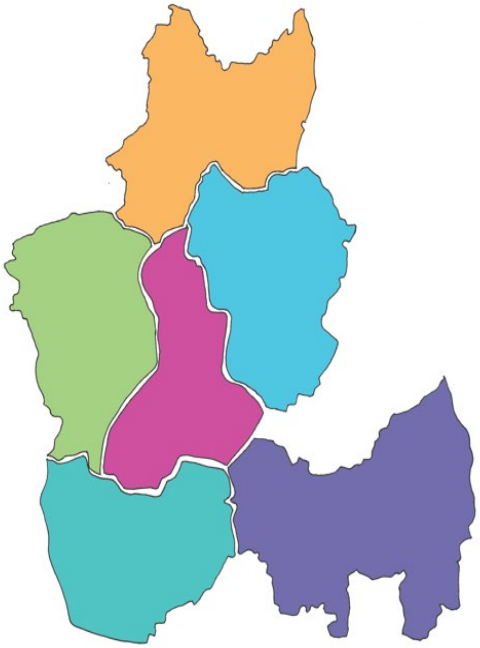
## An Introduction to Our Organisation – Dudley Integrated Health and Care NHS Trust

Dudley Integrated Health and Care NHS Trust was formed in 2020 to provide integrated, community-based healthcare services to the people of Dudley. We serve a population of just over 331,000 people, with the aim of supporting "Community where possible, hospital when necessary".

The Trust was created by the local system partnership in Dudley who are implementing a model of care that integrates primary care with community-based services to provide the optimum opportunity for caring for as many people as possible in their home.

We are a new type of NHS organisation that are also focussed on supporting the development and sustainability of primary care.

We work very closely with our Primary Care Networks (PCNs) and all of our practices to support them to deliver their services and develop out of hospital care. This support includes employing a number of PCN Additional Roles Reimbursement Scheme (ARRS) staff as well as directly providing day to day management support to Chapel Street Surgery.



At the heart of what we do is putting patients first with care and wellbeing services and support wrapped around them. Our communities are diverse with a rich culture and heritage and DIHC are proud to be rooted in these communities and committed to improving healthy life expectancy and reducing health inequalities. Our focus is improving the health of our local population.

## Our Local Population

The Office of National Statistics records show the Dudley total population standing at just over 331,000, of which 59.1% are aged 18 to 64 and 20.3% are 65 and above. Around 14% of the population are from BAME backgrounds.

The vision for the Dudley system is "**Community where possible; hospital when necessary….**" Our aims, purpose and commitments describe the essence of our organisation and what we are here to achieve.

## Our Commitment to Equality, Diversity and Inclusion

At DIHC we are committed to promoting equality of opportunity; celebrating and valuing diversity; eliminating unlawful discrimination, harassment and victimisation, including cyber or e-bullying and harassment; and promoting good relations.

This means we all play our part:

- To be a caring and progressive organisation that promotes equality, values and celebrates diversity and creates an inclusive and compassionate environment for receiving care and as a place to work.
- To ensure that our staff provide inclusive services that are equally good to all service users, which meet their needs and are delivered with kindness, dignity and respect.
- To ensure that all our team members are engaged, valued and treated equally with kindness, dignity and respect.

The Equality, Diversity and Inclusion (EDI) Annual Report summarises the actions we have taken over the past year towards our strategic aim of elimination of health inequalities, unlawful discrimination and advance equality of opportunity between persons who share relevant protected characteristic.

We have set out our EDI Strategy plan for improving Equality, Diversity and Inclusion. The strategy includes key workforce priorities focussing on:

- Inclusive recruitment and career progression and
- Inclusive culture and experience



## Our Legal Duty for Equality and Inclusion

The Equality Act (2010) places an Equality Duty on public bodies that ensure the Trust engages with communities it serves to make sure that policies and services are appropriate, responsive, and accessible to all.

The Public Sector Equality Duty Section 149 of the Equality Act (2010) requires us to demonstrate compliance with the Public Sector Equality Duty (PSED) that places a statutory duty on NHS Trusts to address:

The Equality Duty consists of a General Duty with three main aims. It requires the Trust to have due regard to the need to:

- Eliminate unlawful discrimination, harassment and victimisation and other conduct prohibited by the Equality Act (2010).
- Advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it.
- Foster good relations between persons who share a relevant protected characteristic and persons who do not share it.

Having 'due regard' means the Trust must take account of these three aims as part of our decision making processes; in how we act as an employer, how we develop, evaluate and review policy; how we design, deliver and evaluate services; and how we commission and purchase services from others.

The general duty is also underpinned by a number of specific duties which include the need for us to:

- Set specific, measurable equality objectives at least every 4 years.
- Analyse the effect of our policies and practices on equality and consider how they further the equality aims.
- Publish information to demonstrate we have complied with the general equality duty on an annual basis.

To provide services that are relevant and accessible to the needs of the local population, our workforce then must reflect the diversity of Dudley. There is also a need to build a clear picture of the people that use our services and those who might potentially need our services in the future.

At DIHC we are committed to promoting equality of opportunity; celebrating and valuing diversity; eliminating unlawful discrimination, harassment and victimisation, including cyber or e-bullying and harassment; and promoting good relations.

We have set out our four-year plan for improving equality, diversity and inclusion (these are currently being reviewed by our Equality, Diversity and Inclusion Committee)

Our Workforce Equality Objectives 2020-2024

- Making DIHC the best place to work
- Improving our culture
- Responding to new equality and human rights legislation and mandatory standards

## The Human Right Act 1998

The Human Rights Act 1998 sets out a range of rights that have implications for the way services are managed and delivered. In practice this means that we must:

- Act compatibly with the rights contained in the Human Rights Act in everything we do
- Recognise that anyone who is a 'victim' under the Human Rights Act can bring a claim against the Trust (in a UK court, tribunal, hearing or complaints procedure)
- Wherever possible existing laws that the Trust as a public body deals with, must be interpreted and applied in a way that fits with the rights in the Human Rights Act 1998

In practice this means treating individuals with fairness, respect, equality, dignity, and autonomy, this is known as the FREDA Principles.

## The NHS Constitution

The Constitution sets out rights for patients, public and staff. It outlines NHS commitments to patients and staff, and the responsibilities that the public, patients, and staff owe to one another to ensure that the NHS operates fairly and effectively.

## The Health and Social Care Act 2012

Duties as to Reducing Inequalities

NHS Trusts, must in the exercise of its functions, have due regard to the need to:

- Reduce inequalities between patients with respect to their ability to access health services.

- Reduce inequalities between patients with respect to the outcomes achieved for them by the provision of health services.
- Promote the involvement of patients and their carers in decisions about provision of health services to them.
- Enable patients to make choices with respect to aspects of their care.

## The Equality Delivery System (EDS)

Supports NHS Trusts:

- Improve the services they provide for their local communities
- Improve the experiences of people using health services
- Consider reducing health inequalities in their locality
- Provide better working environments, free of discrimination, for those who work in the NHS

## Accessible Information Standard

The aim of the Accessible Information Standard is to ensure that people who have a disability, impairment or sensory loss receive information that they can access and understand and any communication support that they need.

NHS services must have a regard to this standard, in so much as they must ensure that they enable and support compliance through their relationships with provider organisations. This standard is in all the NHS Standard Contracts and is monitored by our Quality and Performance Key Performance Indicators.

## Sexual Orientation Monitoring Information Standard

This Information Standard provides the mechanism for recording the sexual orientation of all patients/service users aged 16 years and over across the whole of health and social care in England. The standard may act as an enabler for the Equality Act 2010, supporting good practice and reducing the mitigation risk for organisations required to comply with the Act.

## Workforce Race Equality Standard

The NHS Workforce Race Equality Standard (WRES) is a useful tool to identify and reduce any disparities in experience and outcomes for NHS employees and job applicants of different ethnicities. The Standard is used by organisations to consider the extent of any disparity or gap between the diversity of the workforce, senior management, and leaders. And help eliminate discrimination in the treatment of BAME employees. In 2015 the WRES became a mandatory requirement. NHS Trusts are required to give due regard to the standard and demonstrate full compliance.

## The Workforce Disability Equality Standard

The Workforce Disability Equality Standard (WDES) Is a set of specific measures (metrics) that enables NHS organisations to compare the experiences of disabled and non-disabled staff all NHS Standard Contracts for 2018 set out that NHS Trust and NHS Foundation Trusts will have to implement the WDES in the first year. This information is then used by relevant organisations to develop a local action plan and enable to demonstrate progress against the indicators of disability equality.

## Modern Slavery Act 2015

All public authorities are required to co-operate with the police commissioner under the Modern Slavery Act 2015. This means that police and health care services, together with voluntary organisations, are legally required to work together to support people who have experienced slavery. The Trust has a zero tolerance for modern day slavery and breaches of human rights, and ensures this protection is built into the processes and business practices with partners and our providers.

## Gender Pay Gap

It is now mandatory for organisations with 250 or more employees to report annually on their gender pay gap. Government departments are covered by the Equality Act 2010 (Specific Duties and Public Authorities) Regulations 2017 that came into force on 31 March 2017. These regulations underpin the Public Sector Equality Duty and require relevant organisations to publish their gender pay gap by 30 March 2018 (and then annually) including: the mean and median gender gaps in hourly pay; the mean and median gender gaps in bonus pay; the proportion of men and women who received bonuses; and the proportions of male and female employees in each pay quartile.

# Our Aims, Purpose and Commitments

## Aim

Dudley first: community where possible, hospital where necessary.

We are truly different. We are a new type of NHS organisation created to serve our Dudley population in a genuinely integrated way.

## Purpose

To connect with the people of Dudley, embrace our diversity and support them to live longer healthier lives.

We will do this by ensuring everyone involved in the provision of care works together, keeping the person at the heart of everything they do.

## Commitments

**Put people first.** We will:

- Care and advocate for all
- Provide the highest quality care
- Speak up for those who cannot or ask us to.
- Empower our service users to be joint decision makers in their care

**Enable and support our staff**. We will:

- Ensure our staff have the skills to deliver our purpose to the best of their ability
- Put their safety at the forefront of operational delivery
- Proactively support their health and wellbeing

**Simplify what can be complex.** We will:

- Enable our staff to create and innovate.
- Empower them with the skills and resources so they can improve and transform the services they provide.
- Make this a priority freeing up their time to participate.
- Make our services easy to navigate for both patients, staff, and citizens
- Work with our citizens to be the co-designers of future services

**Be accountable for our actions.**

Our job is to serve the people of Dudley and ultimately; they will judge our actions:

- Each of us has a personal responsibility for our decisions and actions; to be leaders. Only through our actions will we build trust and respect for the work we do.
- Be accessible and responsive - listen to our staff, service users and local population; actively seeking those whose voice is quieter than others or those that are ‘hard to reach’; and then respond with the means available to us.
- We will behave inclusively, building on our diversity
- We will encourage our population to be part of our future workforce and service suppliers.

## Equality, Diversity and Inclusion Committee

We know that we need to continue to be proactive to ensure our organisation is and remains truly representative. We want to become more inclusive, equal and diverse. We have continued to review how our EDI Committee works over this past year, and to challenge ourselves as to whether the trust is focusing on the right things.

Last year, we agreed a number of workstreams and plans to put improvements in place, aligned to our objectives. These have continued to be monitored via a quarterly report to the committee.

We recruited an Associate Non-Executive Director specifically for EDI who is an active participant and lead in our EDI Committee and board.

Our EDI Committee have been pleased with progress against the objectives but recognised that we needed to develop a full EDI Strategy. This is in development involving all key stakeholders and will be finalised during 2022. This will include a refresh and update of our objectives.

## Inclusion, Anti-Racism and Allyship Network

Our Inclusion, Anti-Racism and Allyship Action Group encourages people with varied lived experiences or protected characteristics, as well as those who want to be allies, to come together, share experiences and to support positive change. This group was established in 2021 and has grown significantly. We have recently undertaken a vote for members of the group to become the formal chair, and vice chair. To ensure ongoing connection to the board, the network chair is a key member of the EDI Committee.

The network have been fully engaged in developing our objectives, workplans, strategy, and also in helping design our approach to promoting important cultural or topical events.

## Community Inclusion and Tackling Health Inequalities

We have and will continue to develop strong links with our patients and our communities through a range of mechanisms ensuring there are different ways that people can be involved and have a voice.

We have worked to develop an understanding of our different communities and define what is seldom heard whether through a protected characteristic, socio economic status, or digitally excluded.

We have appointed a number of Social Prescribers across our Primary Care Networks to support our community in having better life experiences, and have undertaken specific work with the migrant community, traveller community, homelessness, patients with learning disabilities, and a range of other groups.

We have strong links and relationships with the voluntary sector who have expertise and trusted relationships with these groups and have a seat at the Health and Wellbeing Board subgroup for marginalised communities.

We have actively involved our community and patient involvement groups in the recruitment of senior level posts to ensure their voices were heard in selecting individuals to the trust.

We have refreshed and reviewed our Equality Delivery System (EDS2) to reflect our work to date.

## Disability-confident Employer

We are a disability-confident employer; we are committed to supporting staff who have a disability or become disabled during their employment. As part of this commitment, we guarantee an interview to those who meet the minimum criteria of the role and make adjustments for applicants with disabilities. We have developed our policy and guidance on reasonable adjustments and developed an adjustment passport to ensure anyone with a disability or long-term health condition are supported throughout their career with DIHC.

We plan to move to the final stage of the disability confident standard in the next 12 months.

## Our Commitment to be an Anti-Racist Organisation

DIHC wants to ensure its culture is one of inclusivity and equality, and we know that part of supporting that culture is developing ourselves as individuals as well as our organisation. Our board have made a public statement against racism. We have commissioned the charity Show Racism the Red Card to work with us in developing the knowledge of our staff, and with a particular focus on developing our leaders to understand what it means to lead inclusively. We have developed a civility and respect toolkit to help embed the culture we want to see, and encourage individuals to form respectful relationships, and have confidence to constructively and compassionately challenge any behaviours that they find unacceptable.

## Our Anti-Racist Statement

As a Trust we know that the care of our patients is strengthened through diversity of thought, approach and culture, delivered by staff from rich and different backgrounds. A lack of diversity will stifle true innovation and transformation. Without diversity, our organisation will not thrive.

We are deeply aware of the extent to which black, Asian or other ethnically diverse people are underrepresented across our staff team, the senior management team and on our Board. Ensuring that this situation changes, not only through a genuinely held commitment but also through robust and proactive action, is a priority for us. We wish to go beyond the legal requirements for equality, so we are a truly inclusive and fair organisation.

We know we might make mistakes along the way, and we commit to acknowledge them and strive to do better.

We are aware that systemic racism is deeply ingrained in our society and whilst attempts have been made to address this reality, actual change is long overdue. Public institutions such as ours have a crucial role to play in promoting anti-racism, and in tackling inequalities in health, through building a more tolerant, inclusive, equal and empathetic culture.

The board have committed to tackle racism in our workplace, and to see growth in diversity across the organisation. We believe we have to be proactively anti-racist, and this means every one of us standing up against racism or any discriminatory behaviour. As an organisation, we will not tolerate racist or discriminatory behaviours or beliefs.

**‘We Stand’ against Racism**

**Our plans for change:**

- Taking positive action to diversify the Trust Board and wider organisation with targets for improvement

    - In 2021 we recruited to our Executive and Non-Executive Team and saw a small change in the diverse make up of our board.
    - We have monitored the percentage of the workforce from a BAME background at all levels and see significant improvement in some senior levels (band 7 and 8a particularly).

- Reviewing our recruitment practices to ensure they are fully inclusive, communicated as widely as possible and are welcoming to diverse and under-represented groups

    - We are moving our recruitment processes in house and have a full training roll out plan during the early part of 2022. This will include inclusive recruitment practice.
    - We have developed detailed guidance to aid applicants in understanding our processes, what to expect, how to make a good application, and encouraged applicants from diverse backgrounds to apply.

- Planning and delivering a comprehensive programme of anti-racism and inclusion training for all staff, managers and the board

    - We have seen around 50% of our current managers attend our programme during 2021 and plan to ensure the rest attend during 2022
    - Ongoing monitoring of our EDI mandatory training and widening the educational offer

- Reviewing and revising all relevant policies, processes and practices to ensure they are explicit about anti-racism and are inclusive

    - We have reviewed the majority of our policies during 2021 and we have ensured we thread expectations around inclusivity throughout
    - We have a robust process for equality impact assessments for all policies

- Embedding inclusion objectives into appraisals

    - We have embedded an expectation into appraisals that staff reflect on their commitment and input to supporting the Trust achieve its' EDI objectives
    - We will enhance this further for leaders in 2022 as part of the development of our leadership framework

- Participating in reciprocal mentoring schemes that support growth and change
    - We were scheduled to be involved in a national programme which was delayed
    - We are currently exploring how we embed a programme internally through our leadership programme

- Creating the environment for courageous conversations and for staff to raise concerns with confidence they will be listened to and action taken
    - We have developed our Equality, Diversity and Inclusion Policy and within this is a Restoration and Resolution Framework that provides clear guidance to staff about raising concerns and how to manage them

## COVID-19

DIHC EDI approach to COVID-19 was collaborative, systematic and responsive in saving lives. There are times when organisational response is tested in challenging situations and in 2020/2021 COVID-19 was a testing chapter in the life of DIHC and EDI delivered highlighting the need to protect the most vulnerable in our organisation and communities.

Ethnicity is a complex entity composed of genetic make-up, social constructs, cultural identity, and behavioural patterns. Ethnic classification systems have limitations but have been used to explore genetic and other population differences. Individuals from different ethnic backgrounds vary in behaviours, comorbidities, immune profiles, and risk of infection. BAME communities are at increased risk of acquisition, disease severity, and poor outcomes in COVID-19 for several reasons (figure 1). Specific ethnic groups, such as South Asians, have higher rates of some comorbidity, such as diabetes, hypertension, and cardiovascular diseases, which have been associated with severe disease and mortality in COVID-19. Ethnicity could interplay with virus spread through cultural, behavioural, and societal differences including lower socioeconomic status, health-seeking behaviour, and intergenerational cohabitation.

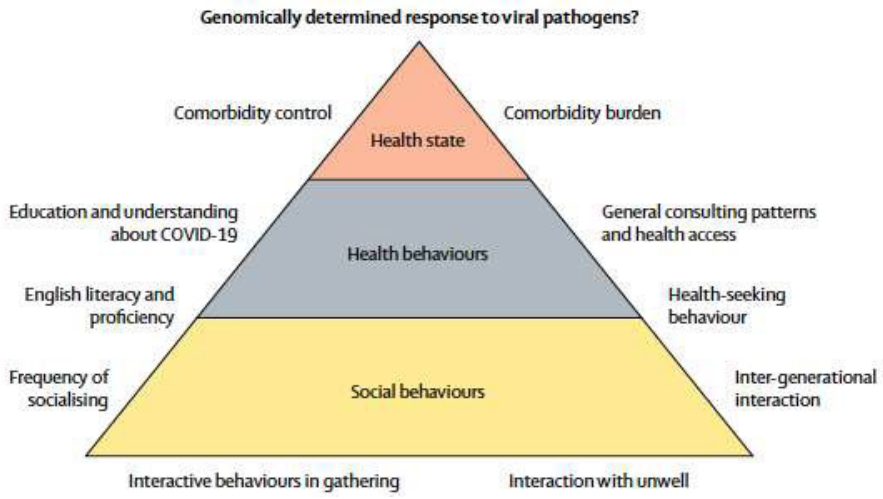


Figure 1 -The potential interaction of ethnicity related factors on COVID-19

BAME staff were disproportionality impacted by Covid. The moral case for EDI was clear and evidently reflected in the data. The disproportionate percentage of BAME staff recorded as COVID-19 positive called for immediate action at DIHC.

This action recognised the evidence and data of what was happening sat alongside a wave of fear and concern that was palpable among BAME staff. When things get difficult, diversity and inclusion can get forgotten resulting in negative impact for BAME staff and the organisation.

The Staff Network provides support and advice for BAME staff and was consulted to establish the challenges that BAME frontline staff were experiencing, during COVID-19.

We have actively supported the vaccination programme across Dudley and have seen 89% of our workforce take up their vaccination.

We took an empathetic, individualised approach to supporting any of our staff who were vaccine hesitant through 1:1 discussion, listening to their concerns, providing support through any appropriate means and routes, and ensuring we were non-judgemental, respecting individual choice.

We have ensured our staff have been enabled and supported throughout the pandemic through home working, flexible working and safe practice.

As we emerge from the pandemic, we have ensured we align to all national guidelines. We have developed our Agile and Flexible Working Policy to ensure we have a truly hybrid and flexible model of working going forward. Whilst we want to see more 'return to normal' we also recognise that this will be difficult for staff, and we should take this slowly.

## Covid 19 Risk Management

During the year DIHC implemented a proactive methodological approach in the development of the risk assessment planning and response to COVID-19.

The Risk assessment methodology organically and systematically evolved at DIHC with a future ready oriented approach, ensuring staff and patients were protected against COVID-19.

The challenges of foresight, analysis and risk assessment methodologies were discussed in the light of the need to complete the development of risk assessments in a limited amount of time. Focusing on risk assessment of critical infrastructure and response whilst managing opportunities and uncertainties in the onset of COVID-19.

The fundamental approach to risk assessment development was that the moment you come into contact with someone that has tested positive to COVID-19, you are exposing yourself to risk of infection. In order to set up an infrastructure at DIHC to protect against the infection

an operational and strategic approach was required. Not only did the senior executive management team understand the immediate requirements to safeguard staff and patients, but it was also to explore the risks associated with COVID-19 and how to best mitigate this risk with swift action. This approach required immediate senior executive buy in and CEO commitment. The EDI risk assessment response was aligned to clear directives on risk assessment planning and implementation. The intention was to quickly establish the risks, where they were and what mattered the most.

This methodology to risk assessment planning in 2021 was an intensive process. People that were involved had been informed of the threats and prevalence rates of the COVID-19 infection and potential vulnerabilities of specific staff groups. All aspects of information including physical and environmental, administrative and management, as well as technical measures had to be considered in the methodology and planning, delivery of DIHC risk assessments. Two types of risk assessment qualitative and quantitative were considered. Quantitative risk analysis, numeric values were independently assigned to the different risk assessment components as well as the level of potential risk. When all elements are quantified, the process is considered to be fully quantitative. Qualitative risk analysis did not assign numeric values to the risk assessment components. It was scenario-based and the assessors and participants went through different threat-vulnerability scenarios and tried to answer "what if" type of questions. Generally, qualitative risk assessment tended to be more subjective in nature.

The risk assessment approach at DIHC continued throughout the pandemic and "New Normal" to help identify trends, risks and controls needed to be put in place to tackle risks identified. DIHC focused on ensuring quality assurance; meeting the organisational internal assurance standard and criteria to save lives, protect staff and patients.

COVID-19 required health and social care, professionals to be flexible in what they did. It meant working in unfamiliar circumstances or surroundings or working in clinical areas outside of their usual practice for the benefit of patients, individuals and the population as a whole. Any redeployment had to be done within the basic principles of best practice and with a rational, pragmatic approach to varying practice to cover this challenging time.

Individuals risk assessments were proactively used in the redeployment process and the receiving manager ensured that if an impact had been identified that all efforts will be made to mitigate the impact thus ensuring that the staff member could work and add value in the new redeployment role.

## Freedom to Speak Up Guardian

Often those facing exclusion and inequality are not heard and outdated systems do not provide a meaningful way for people to speak up. One of the ways we are tackling this is through our Freedom to Speak Up Guardian, who support staff to speak up to raise concerns or report mistreatment when they feel they are unable to do so by other routes.

During this year, the Trust has worked hard to progress its Freedom to Speak Up and continues its journey towards creating a culture of speaking up within a safe environment and ensuring that speaking up is business as usual. This year has seen the appointment of Ms. Mwamba Bupe Bennett, our first FTSU Guardian who will be focussing efforts in 2022/23 to re-launch the FTSU service and using our results from the NHS Staff survey as part of planned staff and manager FTSU training sessions.

## Equality Delivery System (EDS2)

We are working to ensure we continually improve against the EDS2 framework so that our patients, communities and staff have positive, fair, equitable and accessible services. The EDS2 aligns to our Equality and Organisational Objectives, and our actions will continue to be monitored through our internal governance arrangements. EDS2 is all about making positive differences to healthy living and working lives. We have reviewed and refreshed our EDS2 involving all stakeholders.

## Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES)

Our first WRES and WDES were submitted in Autumn 2021. Our data was, however, minimal as much of the data is taken from the National Staff Survey which DIHC did not take part in during 2020. We have published our data and action plans on our website.

We are pleased that we have not seen any formal disciplinary processes for any staff given our commitment to a restorative just and learning culture.

We will be submitting our second WRES and WDES in 2022, and will have full survey data from our 2021 survey to include. The survey results do demonstrate some disparity, particularly in the views of staff about equity of progression opportunities. We will therefore have a specific focus on this in the coming year as part of our EDI objectives. We also recognise the need to ensure we are focusing on recruiting a more diverse board and posts at senior levels.

Our formal WRES and WDES data set and reports are published on our Trust website.

## Gender Pay Gap

DIHC will be required to publish its first gender pay gap report in 2022 as we now employ in excess of the 250 staff threshold to require reporting of the Gender Pay Gap. This will be developed and published in quarter 1 of 2022 and an action plan will also be developed to address any specific issues that arise from the data. This will be published on the Trust website.

## Our Staff

DIHC is an expanding and growing organisation and as such, so is its workforce. We have a diverse workforce but recognise that we have more to do to ensure we are truly representative of our communities.

As at 31st March 2022, DIHC directly employed 354 staff (excluding non-executive directors).

- 26.84% are from a Black, Asian, or other ethnic background (12.99% have not specified)
- 3.67% have declared a disability (53.67% have not specified)
- 0.56% have declared themselves as bi-sexual and 1.13% have declared themselves as gay or lesbian (58.19% have not specified)
- 82.77% are Female

**Staff composition by gender (excluding non-executive directors)**

| Title | Female | Male | Total |
|---|---|---|---|
| **Executive Directors** | **5** | **2** | **7** |
| **Senior Managers** | **13** | **11** | **24** |
| **Other Employees** | **275** | **48** | **323** |
| **TOTAL** | **292** | **61** | **354** |

**Staff composition by grade (excluding non-executive directors)**

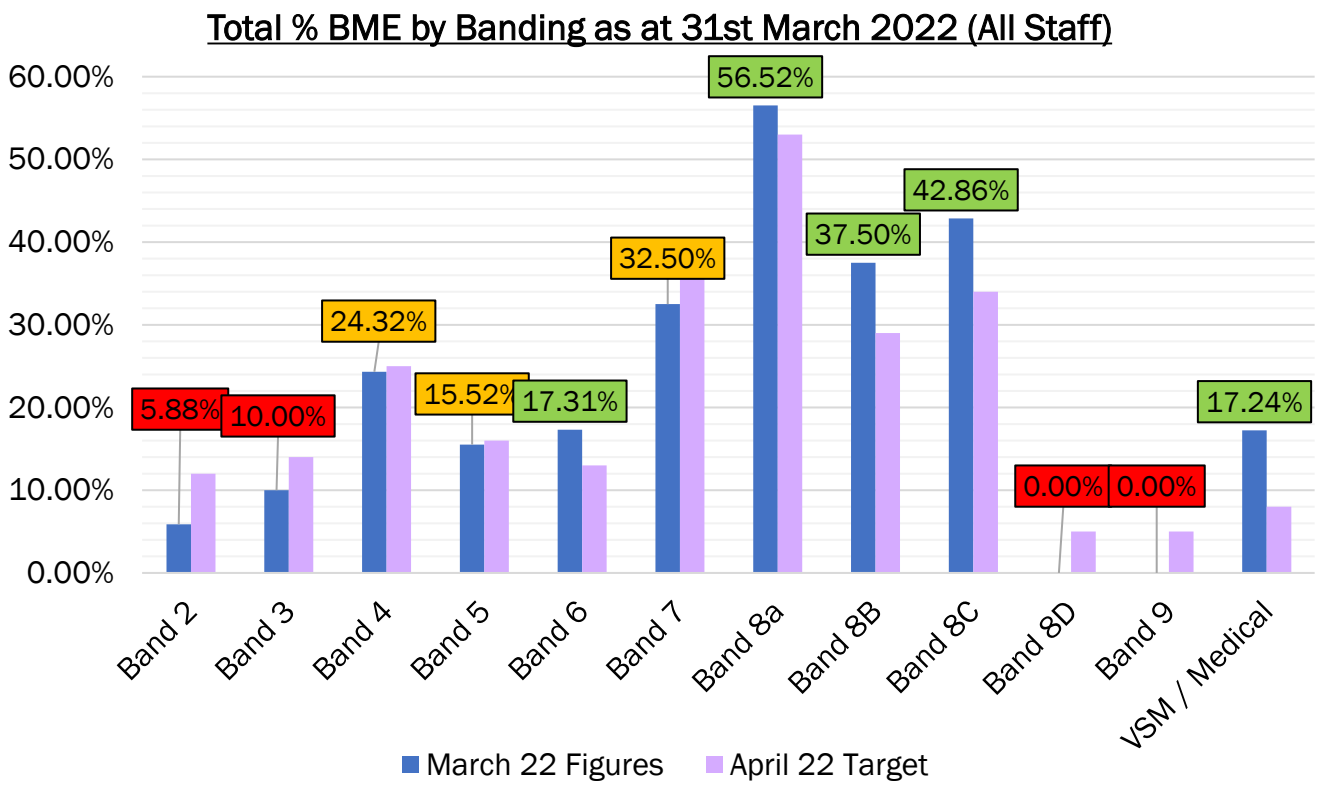
| Grade | Female Headcount No. | Male Headcount No. | Total Headcount No. |
|---|---|---|---|
| Director | 5 | 2 | **7** |
| Employee | 288 | 59 | **347** |
| **Total** | **293** | **61** | **354** |

We have some significant gaps in our workforce data that we continue to focus on improving.

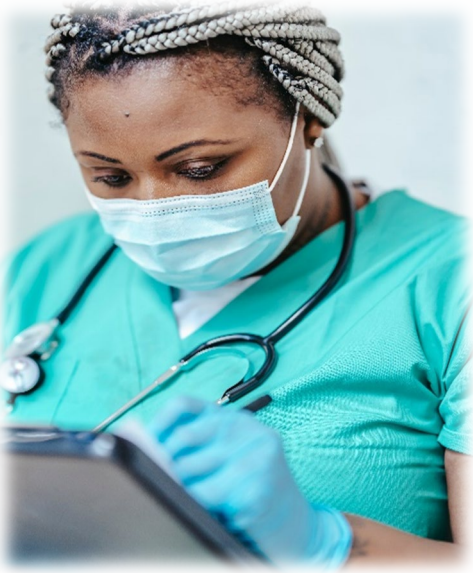
Since last year, our workforce has grown by around 140 staff, and we have seen the proportion of BAME staff increase from 20% overall to almost 27%, and our staff with declared disabilities from 2.6% to 3.3%.

From an ethnic demographic specific, DIHC has a workforce profile that is more diverse than the community of Dudley. We do know however, that representation at more senior levels is much lower than we would like, and this is a key part of our objectives, particularly in very senior and board level roles

Our current race disparity data shows:




We have set a target to achieve at least 19% BAME representation at every level over the next 3 years, aligned to the expectations of the National Race Equality strategy, and our EDI strategy focuses on inclusive recruitment and career progression to support this aim.



## Our EDI Actions to Date

We're proud of what we've achieved in the past 12 months, particularly as we continue to be an evolving organisation with some resource limitations.

Alongside all the usual NHS requirements around governance, committees and mandatory reporting, we've set about setting out our ambitions for creating DIHC as a great place to work through ensuring we are fair and inclusive.

We've achieved:

- Equality Delivery System (EDS2) and Equality Objectives – The Trust continues to progress with the EDS2 implementation action plan and has successfully achieved progress against the Trust's equality objectives.
- Accessible Information Standard (AIS) – Working towards ensuring our data and information is accessible.
- Equality Impact Analysis (Assessments) – Developed the framework for EqIA's for policies, procedures and service development areas.
- Revision and redevelopment of our EDI Committee
- Appointment of Ms. Billie Lam, Associate Non-Executive Director as a lead for EDI
- Seen growth of our Inclusion, Anti-racism and Allyship network
- Appointed a chair and vice chair of the network and supported their development
- Commissioned and delivered anti-racism training to a number of staff and managers
- Developed further guidance on inclusivity in recruitment and selection practices
- Begun roll out of recruitment training
- In collaboration with Mersey Care and Northumbria university, redesigned the Restorative and Just Learning training to roll out to all managers, commencing April 2022.
- Delivered development session to the board
- Reviewed and refreshed our objectives and made significant progress to the development of our strategy
- Held an all staff away day and listened to our staff
- Developed our leadership framework and development portfolio which includes a range of inclusion development
- Worked with our network to develop a bespoke leadership offer to staff from under-represented groups which will include mentoring and reciprocal mentoring
- Been an active member of the Integrated Care System People Board sub-group on EDI

## Our Objectives

Our objectives are published, and include more specific information on our activities, plans and measures.

Our objectives take us through to 2024 but are reviewed and refreshed regularly.

We are currently undertaking a full review of our objectives and developing our EDI strategy to take us through the next 3 years. This will be published during 2022.

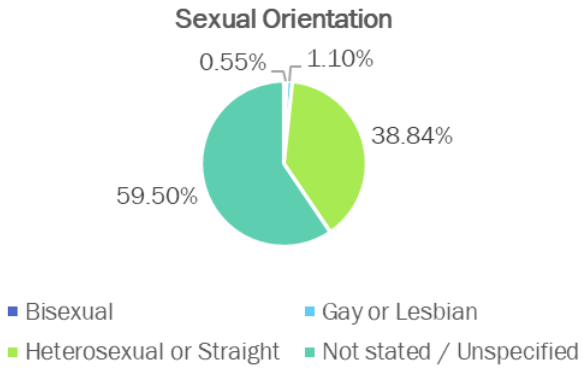
We have been working as part of our ICS People Board, ensuring we are supporting the system wide EDI objectives, and have been proactive in supporting the development of the ICS EDI strategy, as well as ensuring we are working to deliver against the Midlands Workforce Race Equality Strategy, including monitoring ourselves against the race disparity data, and setting targets for workforce diversity growth aligned to the NHS expectations.

## Our Achievements

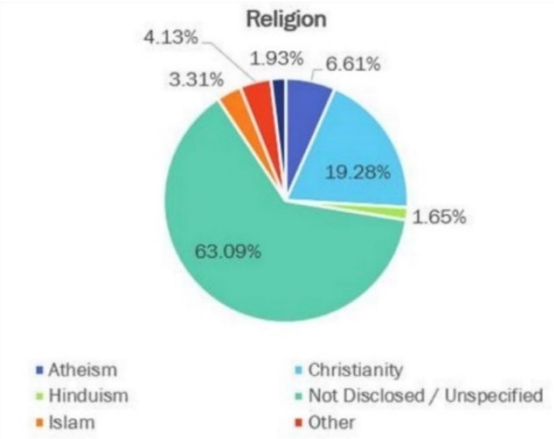
We successfully delivered our first staff away day 'Moving Forwards Together' on the 20th of October 2021. This was a highly successful event that received lots of positive feedback. The day involved several engagements and listening session events, and led to the generation of our Moving Forwards Together Action Plan with 17 key 'You Said, We Did' areas.

We also worked in lockstep with the people of Dudley this year, delivering several events and engagement sessions to the heart of our community. This included the Tough Enough to Care event promoting men's mental health, our Community Connect session promoting our services, Suicide prevention and awareness workshops, and other events enabled by our strong connections with our grassroots voluntary sector in Dudley.

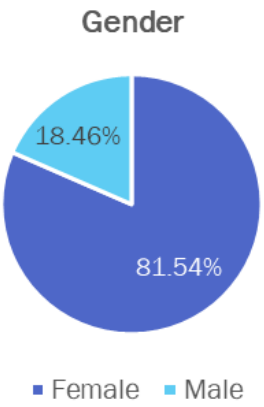
# Our Workforce Profile (All Staff)



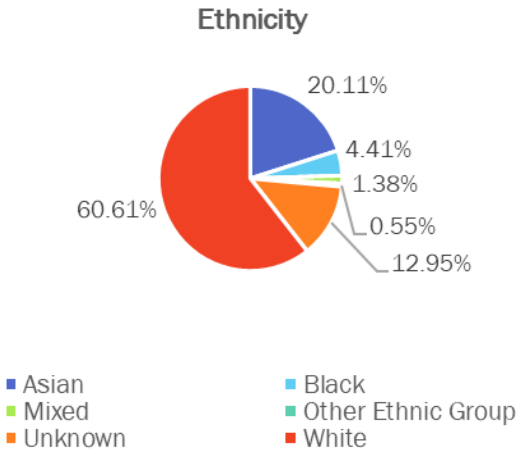

As with other data, our unspecified percentage is exceptionally high and an area we want to address. Those that have declared are mainly heterosexual or straight. 0.55% of our workforce are gay, lesbian or bisexual and this is largely unchanged since the previous year.



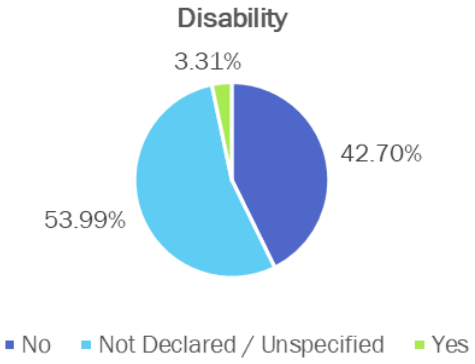

We have seen a slightly improvement in the undisclosed figure but this is still exceptionally high. Otherwise, our split remains largely unchanged.



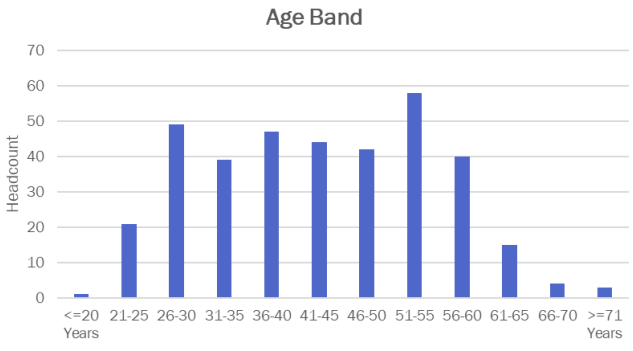

Our male to female split has changed very slightly since last year, seeing an increase of 1.5% in females. This split is fairly standard across the NHS. Currently ESR does not allow for recording of gender other than male / female and this is something that is being looked at nationally to enable those who identify differently to be able to state this.




Our percentage of unspecified remains exceptionally high and is largely unchanged since last year. We have seen the proportion of our Asian workforce increase by 7% since last year, and our proportion of black staff increase by just over 1%. Overall our proportion of BAME staff has increased.




Our level of unspecified has improved a little since last year (by around 10%), but still remains high. We have seen a small increase in the number of staff with disabilities since last year.




We have a fairly even spread across the age bands, however, see a larger number of staff in the 51-55 age range. We have undertaken significant work on our flexible working and flexible retirement policies, along with a retire and return policy to encourage our older workforce to remain in our employment and mitigate potential risk to losing this valuable resource and experience.

## Staff Networks

We want everyone to feel able to bring their whole selves to their employment with us. We want to enable our people to be open about their individual characteristics and feel safe to do so. We want people to believe that diversity is one of our greatest strengths. Diversity gives us a unique perspective on the challenges facing the world, and enables us to build bridges across cultures and communities.

As a Trust we understand that EDI is the cornerstone of the culture that we want to ensure exists for our future workforce. We want all our people to be able to fully participate and achieve their potential and for our Trust to be a place where difference is celebrated. The staff network at DIHC aims to give a voice to all those with protected characteristics.

The aims of the Staff Network are:

- Provide a forum for staff to network and at which they can discuss issues of specific interest that have an effect on us
- Act as a voice for staff offering a source of consultation and a means of communicating with senior leadership about staff issues in relation policies and practices
- Assist with policy development on staff issues by providing advice and feedback to the Equality, Diversity and Inclusion Committee, Human Resources and other relevant DIHC committees
- Provide mutual support and representation for all staff
- Facilitate staff experiencing difficulty due to their protected characteristics to access confidential advice and support.
- Increase wider understanding of staff issues by organising information-sharing events and advising on staff training.
- Strengthen the EDI agenda by supporting initiatives to improve the recruitment and retention of staff.

## Conclusion

We are working towards being a fairer, more just organisation, embedding this approach into our systems, structures and processes.

The rise in global consciousness of the Black Lives Matter movement has accelerated reflections on how centuries of White-privilege and colonialism in the UK continue to impact on communities racialized as 'non white'. The harm from COVID-19 on ethnic minority communities cannot be separated from wider racial injustices.

We remain focused on health inequalities across Dudley, ensuring our employment practices aim to support our communities, and our overall strategy focuses on key work to support the elimination of health inequalities.

It is not enough, to call for individual actions. Instead, we must seek to transform the way power operates in our organization. We must dissect the policies, practices, and working cultures that frame our services and commit to the hard work of transformation for our staff, patients and communities we serve.

Our Trust Board has taken time to reflect and focus on racism as an issue of direct relevance to delivering safe and high quality services. This will be an ongoing process and supported by considered actions to address and challenge structural racism and its entrenchment in our organization.

Our reviewed objectives will be published during 2022 once finalized and agreed with our network and EDI Committee. These will focus on:

- Reduction of health inequalities
- Hearing the patient voice
- Inclusive recruitment and career progression
- Creating an inclusive culture

Dudley Integrated Health and Care NHS Trust

# Quality and Safety Report

## Reporting Period: July 2022

**Reported to:** September 2022, Trust Board

**Reported by:** Sue Nicholls – Director of Nursing, AHPs and Quality

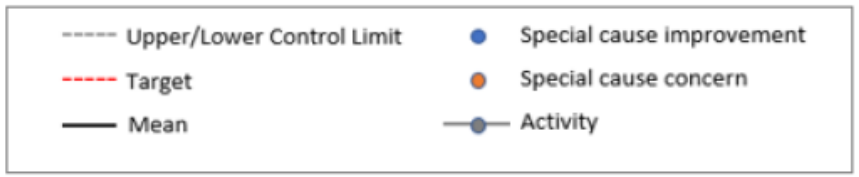
# Key:

## Variation and Assurance Icons

*SPC charts and Icons require a minimum of 15 data points to create a robust analysis, Due to the infancy of the organisation we are using 2+ data points in some cases e.g. CHC, Intermediate Care, High Oak Surgery. Winter Access, NCMP. Therefore, Please take this into consideration when reviewing the information.*

| Variation | | | | Assurance | | |
|---|---|---|---|---|---|---|
|  |  |  |  |  |  |  |
| **Common cause** – no significant change | **Special cause** of **concerning** nature or higher pressure due to (H)igher or (L)ower values | **Special cause** of **improving** nature or lower pressure due to (H)igher or (L)ower values | **Special cause variation** when up or down arrow is neither an improvement or concern | Variation indicates **inconsistently passing** and **falling** short of the target | Variation indicates consistently **(P)assing** the target | Variation indicates consistently **(F)alling** short of the target |

## Statistical Process Chart (SPC)



# Summary

**Data / Quality Indicators**

- No Serious Incidents reported this period
- Seven formal complaints reported this period; four relate to CHC which are managed on behalf of the ICB

**Other**

- Update provided from latest (July) H&S Committee
- The scorecard now includes indicators for acknowledgment and response timescales for complaints.

**Recommendations**

- Based on the quality indicator data currently available, together with the area-specific narrative relating to key areas of quality & safety there do not appear to be any concerns regarding the quality of services currently provided by the Trust.
- Based on the quality indicator data currently available there do not appear to be any concerns with regards to emerging trends; this assurance will be improved by the development of appropriate statistical analysis over time
- **There are no further issues or concerns requiring escalation to the Board**

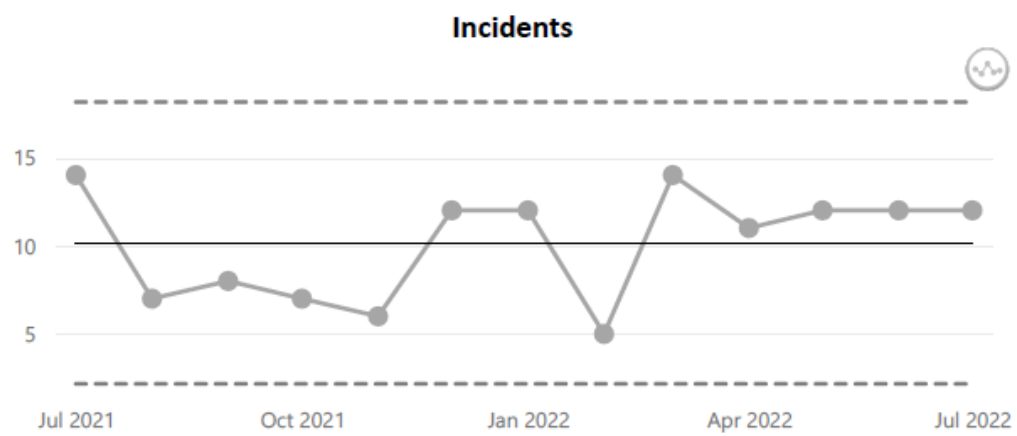
# DIHC Performance Scorecard 2022/23

| Domain | Sub domain | Metric | Metric Type | Latest Date | Value | YTD | Target | Variation | Assurance |
|---|---|---|---|---|---|---|---|---|---|
| Q&S | Feedback | Mental Health Friends and Family Test – % Positive | Local | Jul 2022 | 100% | 100% | - | | |
| | | Mental Health Friends and Family Test – % Positive (Qtr) | Local | Jun 2022 | 100% | 100% | - | | |
| | | Feedback - Informal Concern | Local | Jul 2022 | 5 | 15 | - | | |
| | | Feedback - Compliments | Local | Jul 2022 | 2 | 10 | - | | |
| | | Feedback - Complaints | Local | Jul 2022 | 7 | 17 | - | | |
| | | An acknowledgment of the complaints within 3 days (DIHC) | National | Jul 2022 | 100% | 100% | - | | |
| | | A formal response to the complaint sent within 45 days (DIHC) | Local | Jul 2022 | 100% | 100% | - | | |
| | Incidents | Duty of Candour | National | Jun 2022 | 100% | 100% | 100% | | |
| | | Occurrence Of Any Never Event | National | Jul 2022 | 0 | 0 | - | | |
| | | Incidents | Local | Jul 2022 | 12 | 47 | - | | |
| | | Serious Incidents | Local | Jul 2022 | 0 | 0 | - | | |
| | Patient Safety | Patient Safety Alerts Completed By Deadline | National | Jul 2022 | 100% | 100% | - | | |
| | Safeguarding | Number of Safeguarding Concerns - Adults | Local | Jul 2022 | 66 | 218 | - | | |
| | | Number of Safeguarding Concerns - Child | Local | Jul 2022 | 22 | 85 | - | | |
| | | Number of Safeguarding Concerns - Age unknown | Local | Jul 2022 | 2 | 4 | - | | |
| | | Number of SARs - Open | Local | Jul 2022 | 2 | 2 | - | | |
| | | Number of CSPRs - Open | Local | Jul 2022 | 4 | 4 | - | | |
| | | Number of S42s - Open | Local | Jul 2022 | 2 | 2 | - | | |
| | | Number of S42s - Overdue | Local | Jul 2022 | 2 | 2 | - | | |

**Footnotes**

There are were no incidents requiring Duty of Candour in July 2022

# Incidents



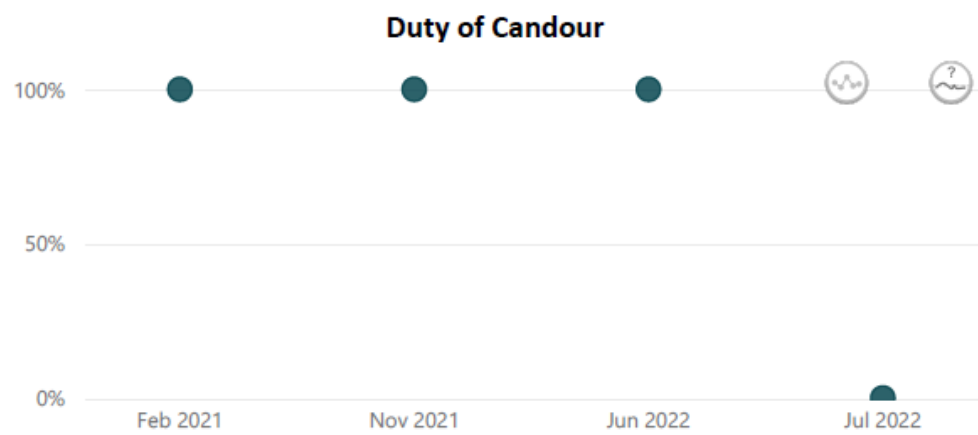

Jul 2022
Date

12
Value

-
Target

Common Cause
Variation

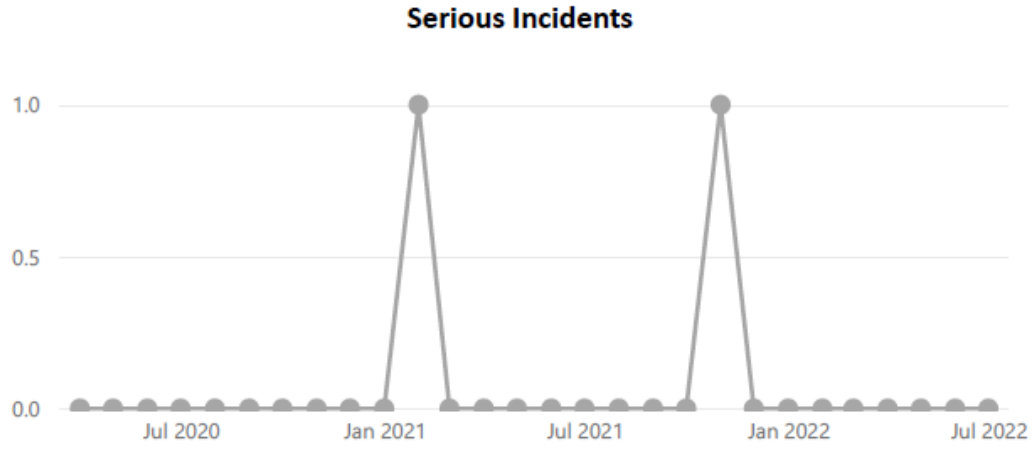
No Target
Assurance




Jul 2022
Date

0%
Value

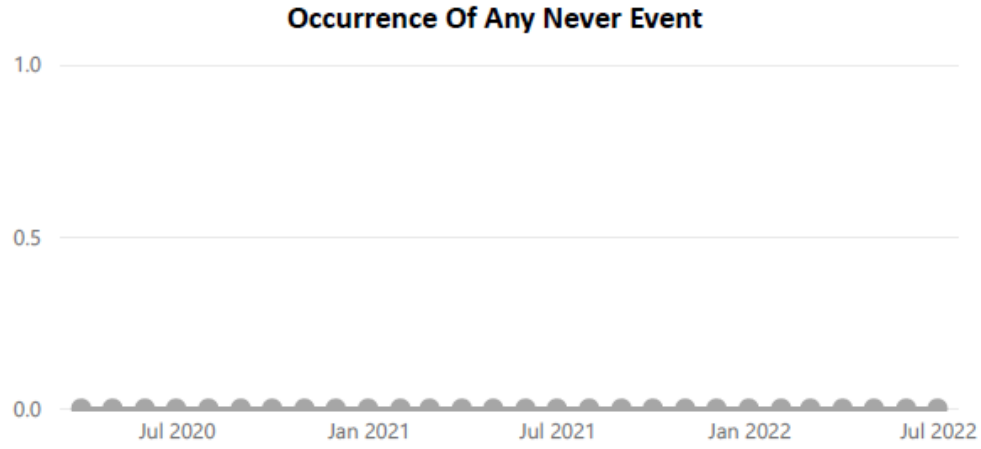
100%
Target




Jul 2022
Date

0
Value

-
Target




Jul 2022
Date

0
Value

-
Target

## Service comments

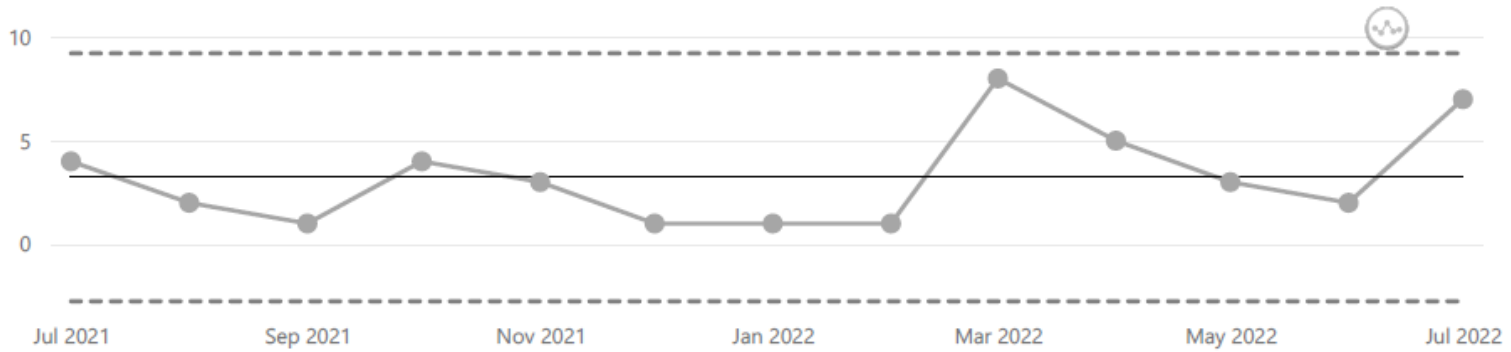
- No obvious trends or concerns identified;  six incidents relate to actual or potential self-harming behaviour, reported by our MH teams during routine appointments; all appropriate actions were taken to ensure patients are safe and any opportunities for learning will be identified from the investigations once complete

## Actions

- No specific actions currently required in relation to the incidents reported; the Trust has signed up to the zero tolerance alliance and have encouraged all staff (not just focussed on our MH services) to complete suicide awareness training

# Feedback

## Feedback - Complaints




Jul 2022
Date

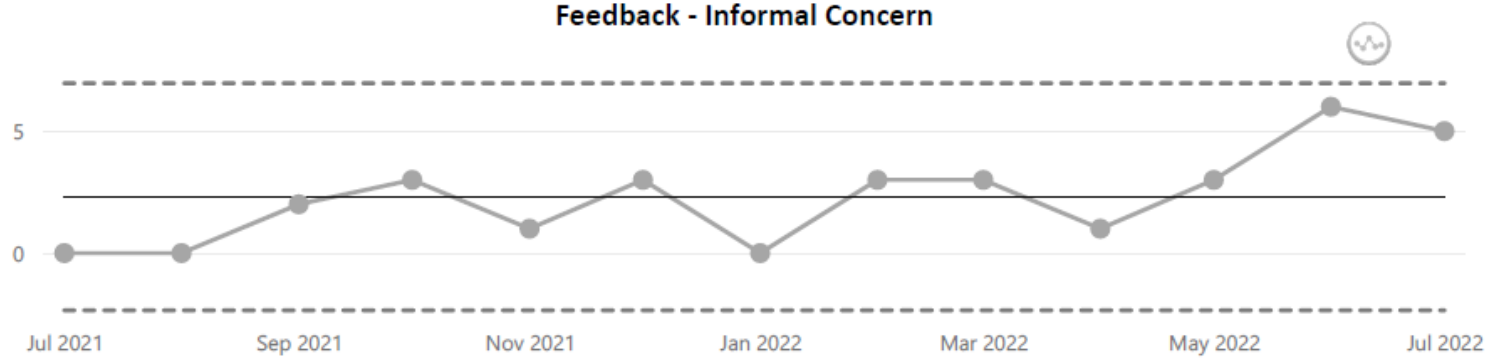
7
Value

-
Target

Common Cause
Variation

No Target
Assurance

## Feedback - Informal Concern




Jul 2022
Date

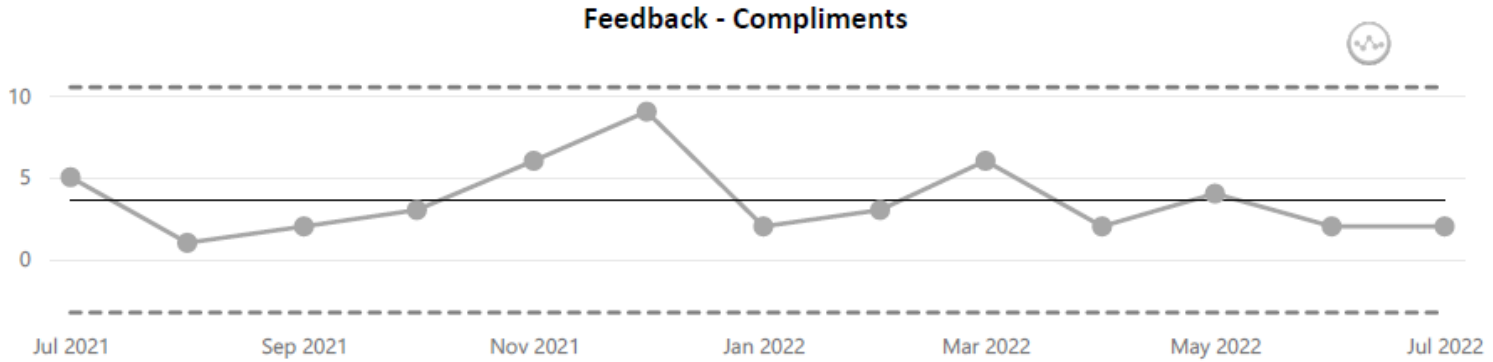
5
Value

-
Target

Common Cause
Variation

No Target
Assurance

## Feedback - Compliments




Jul 2022
Date

2
Value

-
Target

Common Cause
Variation

No Target
Assurance

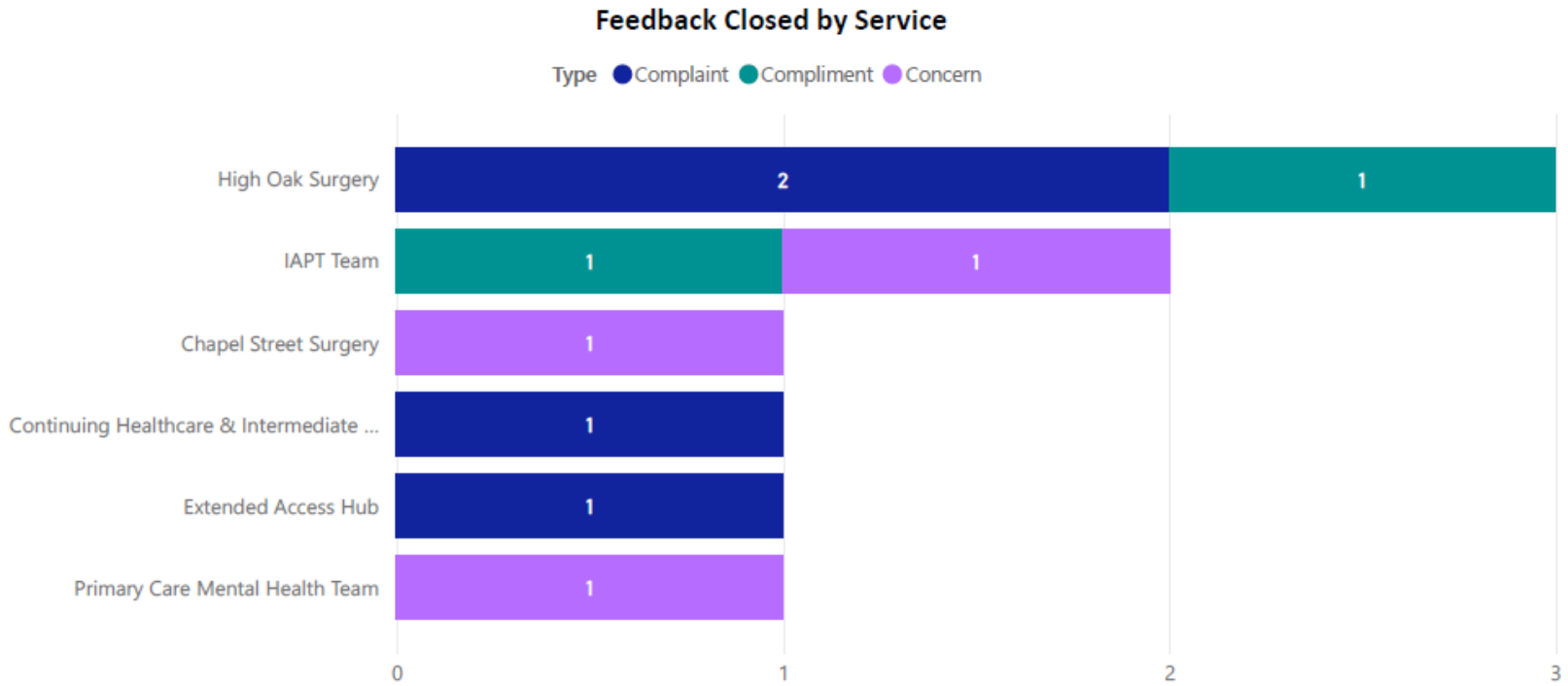
## Service comments

- No obvious trends or themes; four complaints relate to CHC
- All complaints were acknowledged and responded to within the agreed timescales (3 days and 45 days respectively)
- Four complaints closed in July 22, one was not upheld and one partially upheld

## Actions

- No specific actions currently required

# Incidents and Feedback Closed Within: July 2022

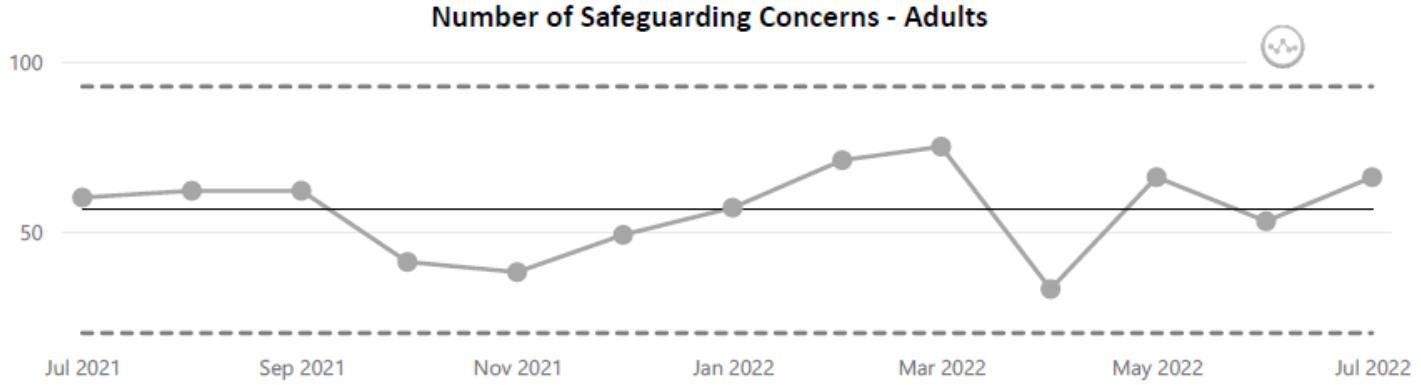

## Key Lessons Learnt

- Better use of shared mailboxes to enable appointment management when individual staff members are absent to mitigate the risk of single point of failure
- Focussed piece of work identified to look at improved task management activities within primary care

## Actions

- See above

# Safeguarding



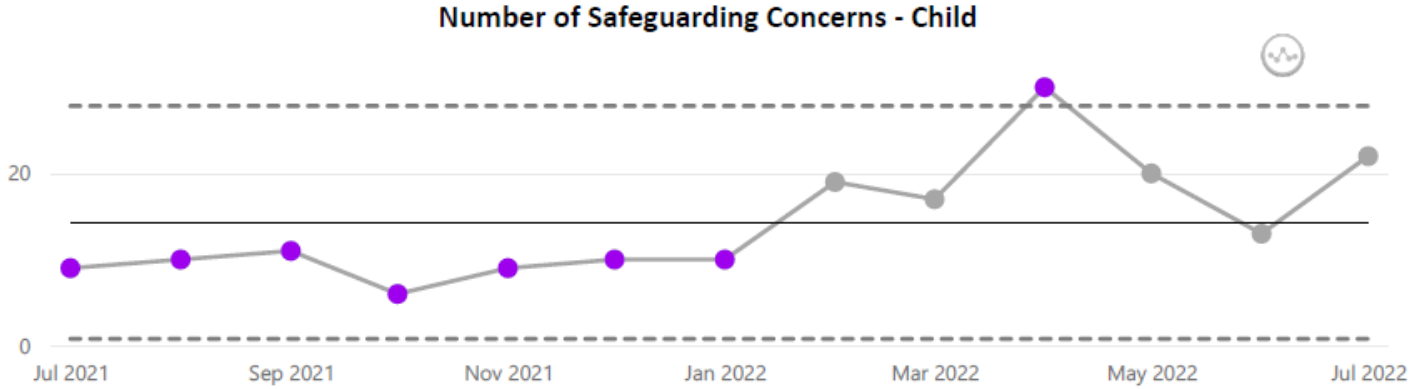

Jul 2022
Date

66
Value

-
Target

Common Cause
Variation

No Target
Assurance



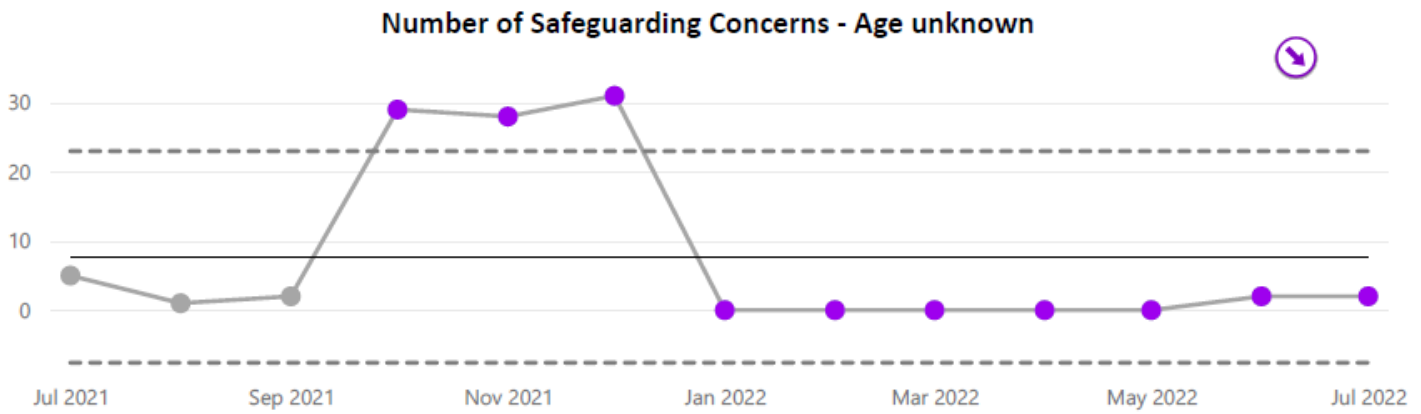

Jul 2022
Date

22
Value

-
Target

Common Cause
Variation

No Target
Assurance




Jul 2022
Date

2
Value

-
Target

Neither
Variation

No Target
Assurance

## Service comments

- Q1 detailed safeguarding report presented to Quality and Safety Committee in August 2022.
- Practitioners are 'Thinking Family' and considering the impact of parental issues on children following the introduction of safeguarding supervision to the adult workforce.
- Awareness sessions have been delivered to all services around what to include in a safeguarding referral which should increase the number of safeguarding alerts being recorded on Datix.
- Safeguarding MDTs have now commenced in High Oak and Chapel Street Primary Care services with safeguarding supervision being rolled out
- Safeguarding Supervision compliance remains over 90%
- Safeguarding training provided to the pharmacy team
- The 3 main themes highlighted continue to be
  - domestic abuse,
  - historical sexual abuse and
  - psychological/emotional abuse

## Actions

As part of the wider Trust commissioning responsibilities, the team have supported quality assurance reviews of two nursing homes;

The learning and recommendations from the recent national Child Safeguarding Practice Review into the deaths of Arthur Labinjo Hughes and Star Hobson has been presented to Nursing and AHP

# COVID VACCINATIONS – Patients (High Oak Surgery)

- Covid vaccination programme at High Oak continues; latest uptake data (as of 02/08/2022):

| Group | Population in Cohort | Vaccinated 1st Dose | Vaccinated 2nd Dose (%) | Total Vaccinated Booster Dose (%) | Total Declined / contraindicated | Not Vaccinated |
|---|---|---|---|---|---|---|
| 01. Residential Care Home Patients | 6 | 100% | 100% | 83% | 0 | 0 |
| 02. Age 80y+ and HSC Workers | 179 | 95% | 94% | 92% | 5 | 5 |
| 03. Age 75-79y (excl care home) | 119 | 95% | 93% | 90% | 3 | 3 |
| 04. Age 70-74y or Covid High Risk (excl care Home) | 245 | 92% | 91% | 82% | 5 | 12 |
| 05. Age 65-69y (excl Care home) | 143 | 96% | 95% | 87% | 2 | 4 |
| 06. Age 16-64y with UHC (excl care home) | 652 | 86% | 83% | 70% | 13 | 80 |
| 07. Age 60-64y or UHC (excl care home) | 91 | 100% | 90% | 79% | 2 | 7 |
| 08. Age 55-59y (excl care home) | 130 | 91% | 88% | 76% | 3 | 9 |
| 09. Age 50-54y (excl care home) | 138 | 84% | 83% | 63% | 2 | 20 |
| 10. Age 40-49y (excl care home) | 284 | 78% | 74% | 56% | 4 | 59 |
| 11. Age 30-39y (excl care home) | 536 | 72% | 66% | 43% | 19 | 132 |
| 12. Age 18-29y (excl care home) | 455 | 69% | 59% | 29% | 3 | 141 |
| 13. Age 16-18y, no UHCs | 71 | 34% | 30% | 6% | 0 | 39 |
| 14. Age 12-15y with specific UHC or household contact | 11 | 54% | 45% | 9% | 0 | 5 |
| 15. Age 12-15y no UHCs | 201 | 41% | 25% | 0% | 0 | 117 |
| 16. Age 5-11y with specific UHC or household contact | 22 | 0% | 0% | 0% | 0 | 22 |
| 17. Age 5-11y no UHCs | 462 | 6% | 2% | 0% | 0 | 433 |

Planning has commenced for the delivery of the Autumn Booster and the flu vaccination campaign.

Age groups exclude care homes unless otherwise stated
UHC – underlying health conditions
HSC – health and social care

# HEALTH & SAFETY – update from last H&S Committee

- Last H&S Committee held 25/07/22
- Key points:
  - All key H&S policies now been reviewed, revised and issued to staff
  - Good progress being made against 2022/23 work plan;
  - Update provided from latest Estates Safety & Compliance sub-group held in June – discussions included latest IPC guidance regarding mask wearing, identifying priority locations for DIHC compliance / assurance H&S site visits and progressing the revision of the fire evacuation plans for Trust HQ (see below)
  - Update provided on assurance visit schedule; Cross Street Health Centre latest visit to be undertaken with good engagement from both our services and the Cross Street Practice Manager
  - The Chief Operating Officer (chair) gave an update on ongoing discussions regarding future H&S support provision, including with system partners
- Since the meeting, the Trust HQ fire evacuation plan has been revised and re-issued to staff; as part of this, a new group of fire wardens have been identified and trained to support fire evacuations

Dudley Integrated Health and Care NHS Trust

# COMMITTEE ASSURANCE REPORT TO THE BOARD

**Committee**: **Quality & Safety Committee**

**Date of meeting:** 16 August 2022 (via Microsoft Teams)

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| **Significant risks/issues for escalation** | No significant risk/issues for escalation to the Board |
| **Key issues/matters discussed at the Committee** | The Committee was quorate.<br><br>**Quality and Safety Report**<br>• The quality report contained July 2022 data, with the exception of childhood immunisations where a national level system issue has interrupted data flows.<br>• Based on the quality indicator data available to Q&S Committee there were no significant concerns regarding the quality of services currently provided by the Trust for escalation to the Board.<br>• There were no reportable serious incidents in July 2022.<br>• Seven formal complaints were reported for this period, four of which relate to CHC and are managed on behalf of the ICB. All are being managed in accordance with the NHS complaints regulations.<br><br>**Infection Prevention and Control (IPC)**<br>Committee received the regular bimonthly report on IPC. This included a report on the ongoing hand hygiene audits and also the quarterly IPC audits that were completed in July 2022 for High Oak Surgery and Chapel Street Medical Practice, with their detailed action plans for improvement.<br><br>The Staff Flu Vaccination Campaign planning is in progress with peer vaccinator programmes being pursued.<br><br>Three more IPC Policies and Procedures have been approved in PPDG and are now available on the intranet. August priority policy review/rewrites include Seasonal Influenza and the IPC/EPRR joint Infectious Disease Plan policy.<br><br>Committee noted the need to give consideration to IPC capacity as the Trust develops and work programmes expand.<br><br>The Committee received the report for assurance. |

**Safeguarding**

Quarter 1 2022 Safeguarding update was received by Committee for assurance and information. Committee were assured that DIHC continue to fulfil its statutory duty in relation to safeguarding adults and children and reflected upon the strengths and expertise of the team, and the positive progress already achieved this year.

**Learning from Serious Incidents**

Learning was shared at the System Quality Oversight Committee and an update was provided to the Trusts Quality and Safety Committee following the recent coroner's inquest. The inquest concluded that sadly death was due to a rare but recognised complication of the Astra Zeneca COVID19 vaccination.

Committee reflected that although the actions arising from the Prevention of Future Deaths – regulation 28 report from the coroner related to acute hospitals processes and not those in primary care, it was essential to recognise where lessons can be learnt. The importance of timely and accurate information at the point of patient consent being a case in point.

Committee received the report for information.

**Quality Assurance Review in Care Homes**

Committee received a verbal update in relation to the quality assurance reviews undertaken on the care homes for which DIHC hold quality assurance responsibility. Committee were informed that following detailed contractual discussions it has been agreed that DIHC holds full quality assurance and oversight responsibility for 2 homes and 1 unit. This is due to the fact that DIHC Continuing HealthCare Team/Intermediate Care Team (CHC / ICT) are the sole commissioners. In order to ensure consistency of approach across the Black Country DIHC are utilising the Quality Assurance Framework (QAF) developed by the Black Country. These reviews were undertaken in collaboration with the ICB.

Report recommendations for action have been sent to the care home managers and are being monitored by the CHC team. Monthly updates are provided by the CHC team to the ICB. For all other homes we have proposed to the ICB that we will continue to monitor individual CHC placements in accordance with the national framework and work in collaboration with the ICB to ensure relevant information is shared appropriately in order to accurately appraise the quality of the service. We continue to discuss this proposal with the ICB quality team.

A detailed written report will be submitted to September Committee referencing report findings, remedial action plans and progress with implementing these.

**Clinical Governance Development**

Committee noted the workplan and the update provided. Committee were assured on the advances in policy development and review at PPDG and the ongoing workstreams that ensure clinically effective business as usual and adherence to CQC standards.

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| | Committee acknowledged the progress made against the workplan and were pleased to note that Clinical Audit processes have been implemented and that the Quality Improvement Group has been established and have now met.<br><br>Committee accepted an updated report following the 'Significant Assurance' received in April 2022 from internal auditors in relation to the Quality Framework and was assured by the progress made against the action plan.<br><br>**Board Assurance Framework & Risk Register**<br><br>Committee were advised of a proposal, and subsequently agreed to recommend the reduction in a corporate risk rating regarding the 'Revision and review of corporate policies' (C-207) due to the significant progress made in this area.<br><br>Committee were alerted to proposals for change in regards to a new BAF, expected in September 2022 and in the reporting processes for Committees and Board that is expected to start from 1 October 2022. Written reports will come to Committee outlining the changes and agreed arrangements in September 2022 and October 2022 respectively.<br><br>**Quality and Safety Steering Group**<br><br>Committee received a verbal update relating to the progress being made in High Oak Surgery and Chapel Street Medical Practice and the methodology being used to monitor infection prevention and control and safeguarding processes plus the Quality Impact Assessments policy and the formalised processes within. Committee regularly receives minutes from this group, once they are agreed.<br><br>Committee noted the verbal report. The next set of agreed minutes are due for the Committee's September meeting.<br><br>**Health and Safety Update**<br><br>The Chief Operating Officer provided verbal assurance to Committee regarding the ongoing work plans to improve the Health and Safety processes in the Trust. Work continues with Estates colleagues to ensure effective monitoring and compliance and paying particular attention to lessons learnt from across the Black Country regarding Legionella and the risk assessments thereof. |
| **Decisions made by the Committee** | No decisions to report and no items to refer to Board. |
| **Implications for the Corporate Risk Register or the Board Assurance Framework (BAF)** | Proposed new BAF expected and reduction in corporate risk (C-207) level recommended. |
| **Items/Issues for referral to other Committees** | No issues to refer. |

Dudley Integrated Health and Care NHS Trust

# DUDLEY INTEGRATED HEALTH AND CARE NHS TRUST BOARD

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| **TITLE OF REPORT:** | Workforce Performance Report |
| **PURPOSE OF REPORT:** | To update the Trust Board on workforce performance information for July 2022 |
| **AUTHOR OF REPORT:** | Faye Duncan – Business Intelligence Service Delivery Manager<br>Heather Rees – People Partner<br>Lashauna Vaughan – People Systems & Reporting Manager |
| **DATE OF MEETING:** | 6th September 2022 |
| **KEY POINTS:** | • In the report an * has been added to the commentary to suppress any figures which are 5 or less. This is to prevent any information being identifiable.<br><br>• Normalised turnover (turnover based upon voluntary reasons for leaving) has been introduced as a new metric to measure turnover; and should be viewed in the context of the unadjusted turnover figures.<br><br>• Turnover (12 months) for July 2022 decreased to 14.55% and Normalised Turnover (12 months) was 11.35%. Current and historic analysis shows the impact of the end of temporary contracts over the unadjusted turnover figure over the last 12 months.<br><br>• The Trust Vacancy Rate (actual staff in post compared to the establishment) continues to decrease reaching 13.13%.<br><br>• Sickness Absence during July was reported as 3.00%, whilst Sickness Absence over the last 12 months was reported as 3.54%. Both these metrics remain under the Trust targets.<br><br>• Both Appraisal and Mandatory Training compliance for July 2022 was above the 85% and 90% targets, respectively.<br>  ○ Appraisal compliance reached 97.85% after most appraisals in non-compliant areas were completed through July 2022.<br>  ○ Mandatory training compliance now stands at 91.56% and this figure demonstrates staff actively engaging with the new additional mandatory training modules<br>  ○ The People Team continue to support with compliance in these areas through on-going reporting, pre-liminary reporting and circulating non-compliant and due soon notifications to line managers |

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| **RECOMMENDATION:** | The Board are asked to note the report and its contents. |
| **ANY CONFLICTS OF INTEREST IDENTIFIED IN ADVANCE:** | None |
| **ACTION REQUIRED:** | Decision ☐ |
| | Approval ☐ |
| | Assurance ☒ |

NHS
Dudley Integrated Health and Care
NHS Trust

# Workforce Performance Report

**Reporting Period:** July 2022

**Reported to:** September 2022, Trust Board

**Reported by:** Adam Race, Interim Associate Director of People

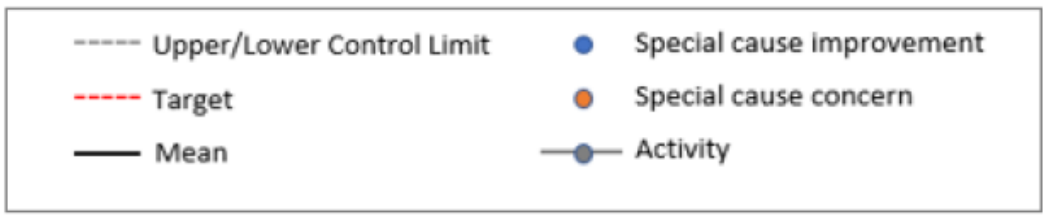
# High Level Key:

## Variation and Assurance Icons

*SPC charts and Icons require a minimum of 15 data points to create a robust analysis, Due to the infancy of the organisation we are using 2+ data points in some cases e.g. CHC, Intermediate Care, High Oak Surgery. Winter Access, NCMP. Therefore, Please take this into consideration when reviewing the information.*

| Variation | | | | Assurance | | |
|---|---|---|---|---|---|---|
|  |  |  |  |  |  |  |
| **Common cause** – no significant change | **Special cause** of **concerning** nature or higher pressure due to (H)igher or (L)ower values | **Special cause** of **improving** nature or lower pressure due to (H)igher or (L)ower values | **Special cause variation** when up or down arrow is neither an improvement or concern | Variation indicates **inconsistently passing** and **falling** short of the target | Variation indicates consistently **(P)assing** the target | Variation indicates consistently **(F)alling** short of the target |

## Statistical Process Chart (SPC)



# DIHC Performance Scorecard 2022/23

| Domain | Sub domain | Metric | Metric Type | Latest Date | Value | YTD | Target | Variation | Assurance |
|---|---|---|---|---|---|---|---|---|---|
| Workforce | Staff in Post | Vacancy % | Local | Jul 2022 | 13.13% | 15.27% | 10% | | |
| | | Turnover % (12 Months) | Local | Jul 2022 | 14.55% | | 13% | | |
| | | Normalised Turnover % (12 Months) | Local | Jul 2022 | 11.35% | 11.78% | - | | |
| | | Turnover % (In Month) | Local | Jul 2022 | 0.48% | | 1.1% | | |
| | | Normalised Turnover % (In Month) | Local | Jul 2022 | 0.31% | 0.63% | - | | |
| | Development | Appraisal % | Local | Jul 2022 | 97.85% | 97.85% | 85% | | |
| | | Training Compliance % | Local | Jul 2022 | 91.56% | 91.56% | 90% | | |
| | Absence | Sickness % (In Month) | Local | Jul 2022 | 3% | 3.28% | 3.8% | | |
| | | Sickness % (12 Months) | Local | Jul 2022 | 3.54% | | 3.8% | | |
| | | Short Term Sickness (In Month) | Local | Jul 2022 | 32.47% | 29.07% | - | | |
| | | Long Term Sickness (In Month) | Local | Jul 2022 | 67.53% | 70.93% | - | | |
| | | Maternity % (In Month) | Local | Jul 2022 | 0.96% | 1.12% | - | | |

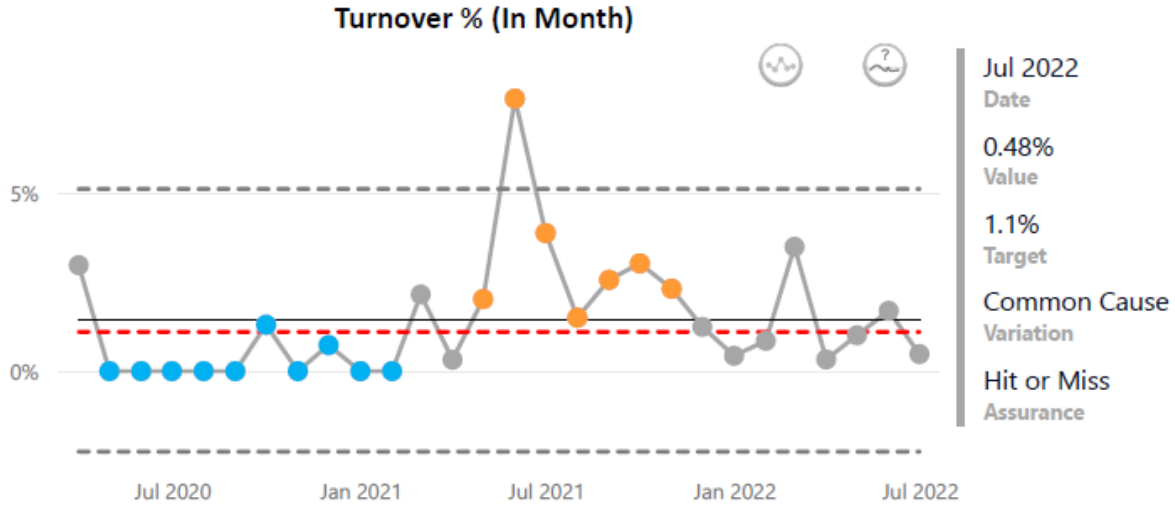
**Key**

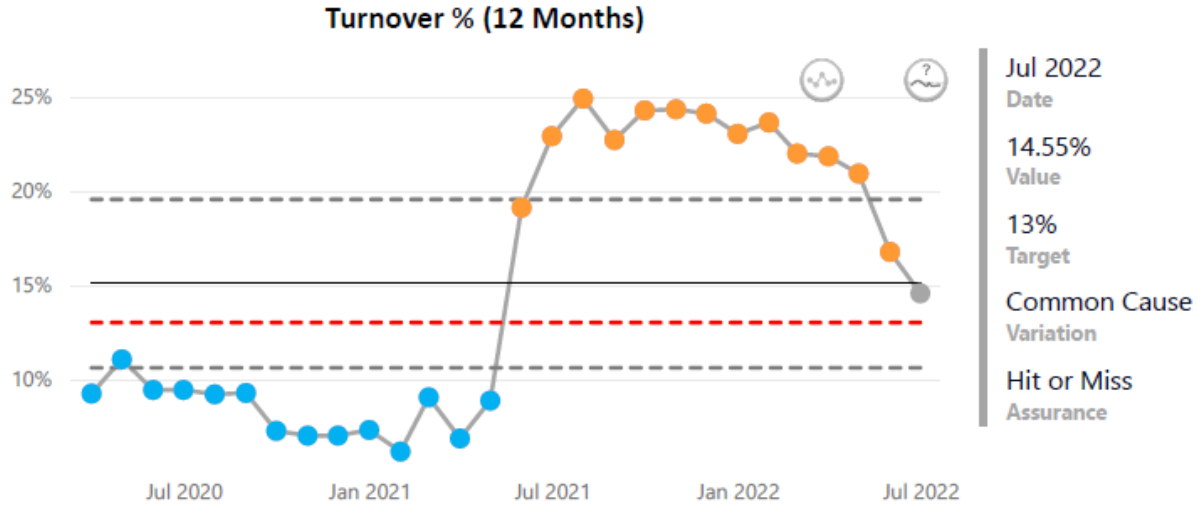
| Variation | | | Assurance | | |
|---|---|---|---|---|---|
| Common cause – no significant change | Special cause of concerning nature or higher pressure due to (H)igher or (L)ower values | Special cause of improving nature or lower pressure due to (H)igher or (L)ower values | Variation indicates inconsistently passing and falling short of the target | Variation indicates consistently (P)assing the target | Variation indicates consistently (F)alling short of the target |

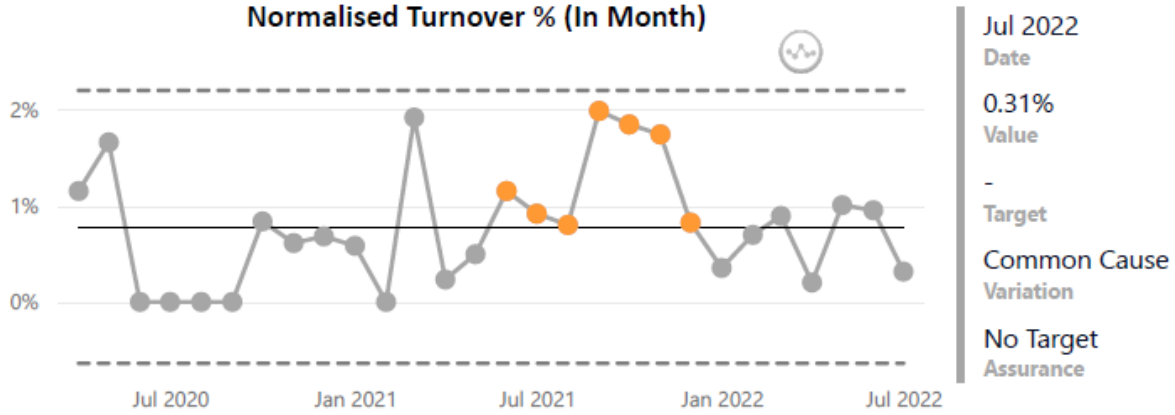
**Footnotes**

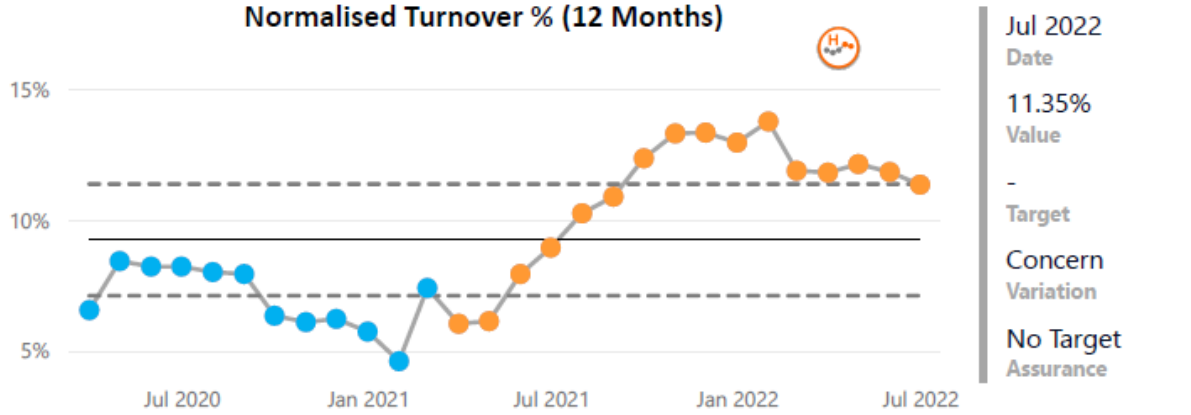
- A " - " has been used to represent that no target is available at the time of reporting

# Workforce - Staff in Post




## Service comments

**Staff in Post and Staff Movements**

- The funded establishment as at the end of July 2022 was 382.89 (WTE) and there were 398 staff in post (326.58 WTE). The vacancy rate (actual staff in post compared to the funded establishment) for July 2022 was 13.13%, and we expect this to continue to improve over the coming months.
- There were 7 new starters (3.10 FTE) who joined the Trust during July 2022 and the Trust saw * staff (1.58 FTE) leave the Trust.

***Please note: * represents suppressed data as 5 or less***

**Turnover**

- Normalised turnover has been introduced reflecting turnover based upon voluntary reasons for leaving.
- Both Turnover (12 Months) and Normalised Turnover (12 Months) have shown improvement over the last 3 months, and we anticipate this to reach the Trust target over the next few months.

## Actions

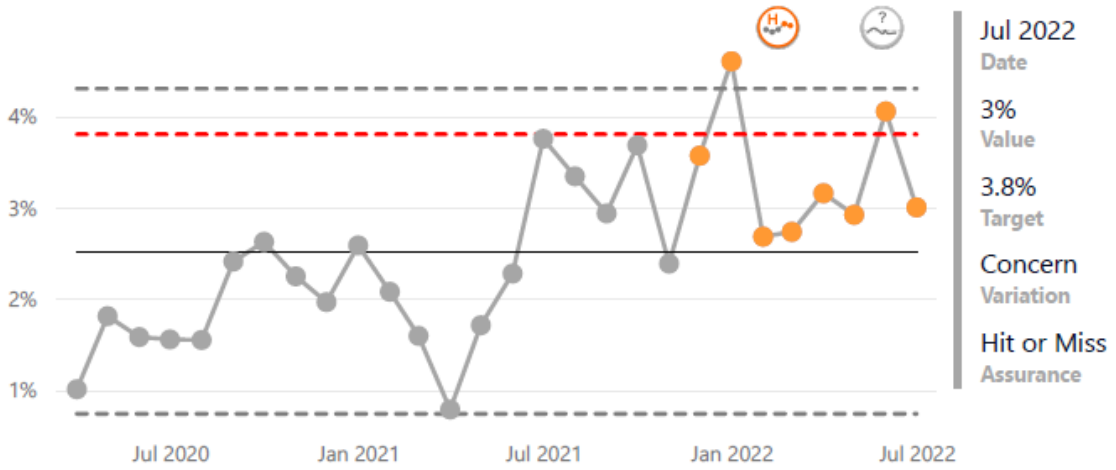
**Recruitment**

Throughout July 2022:

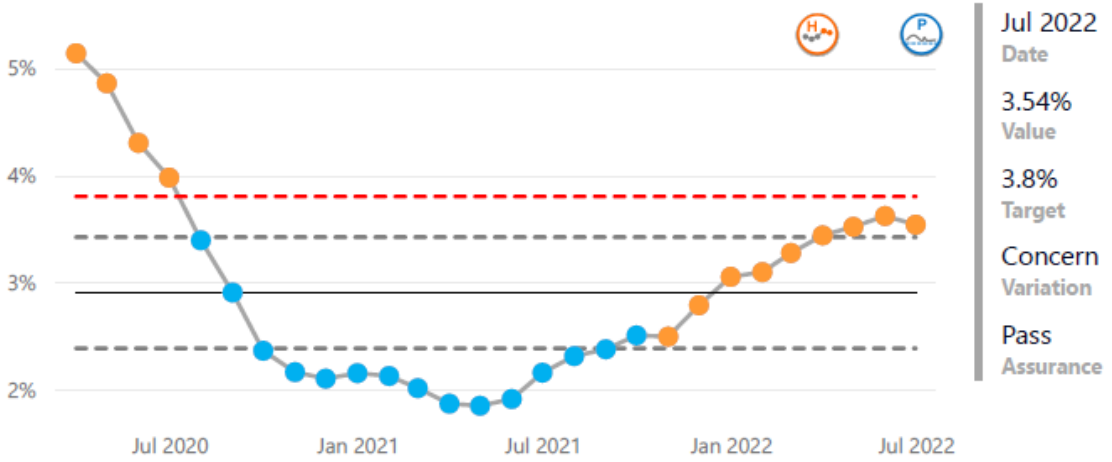
- 13 vacancies were advertised (including re-advertisements)
- 16 conditional job offers were made
- 14 unconditional job offers were issued with start dates over the next few months

# Workforce - Absence

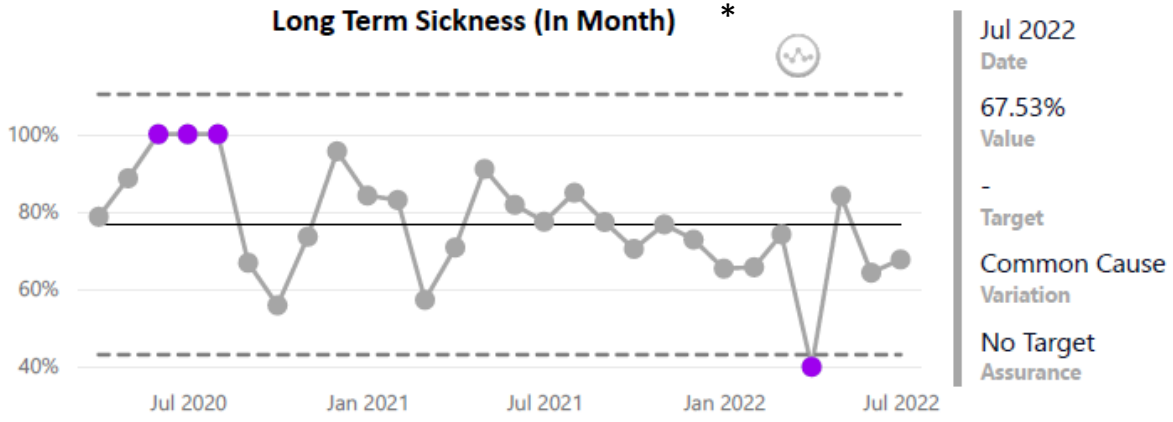
## Sickness % (In Month)



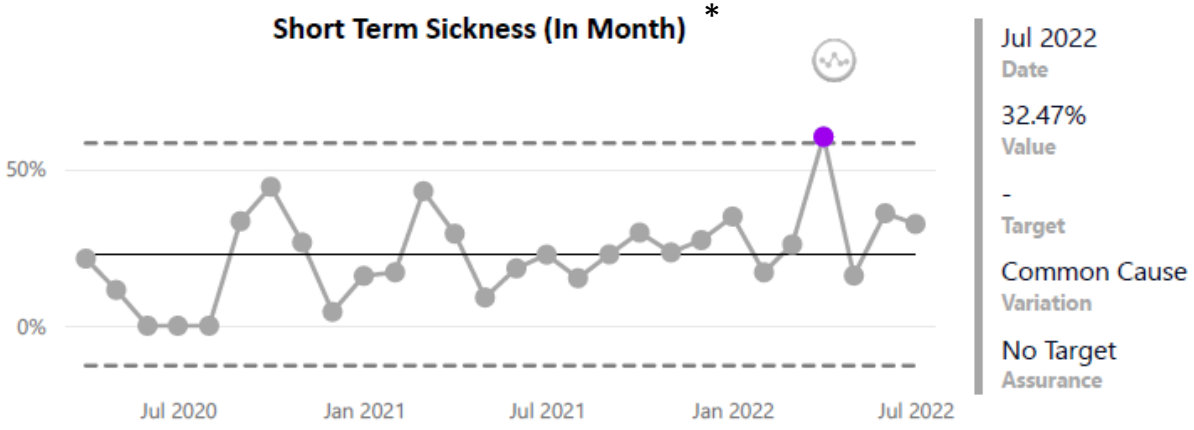

## Sickness % (12 Months)




## Long Term Sickness (In Month) *




## Short Term Sickness (In Month) *




* Long Term/Short Term Sickness is a proportion of the Sickness % e.g. 67.53% of the 3% were classed as long term absences

## Service comments

**Sickness Absence over the last 12 Months**

The most prevalent sickness absence reasons were:

- Cold, cough, flu related (71 episodes – 309 FTE Days Lost)
- Gastrointestinal problems (41 episodes – 216 FTE Days Lost)

***Please note: * represents suppressed data as 5 or less***

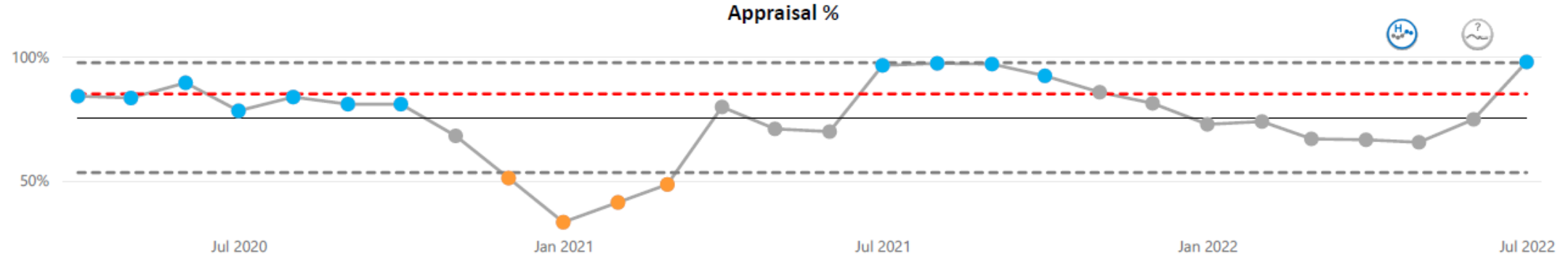
**Sickness Absence during July 2022**

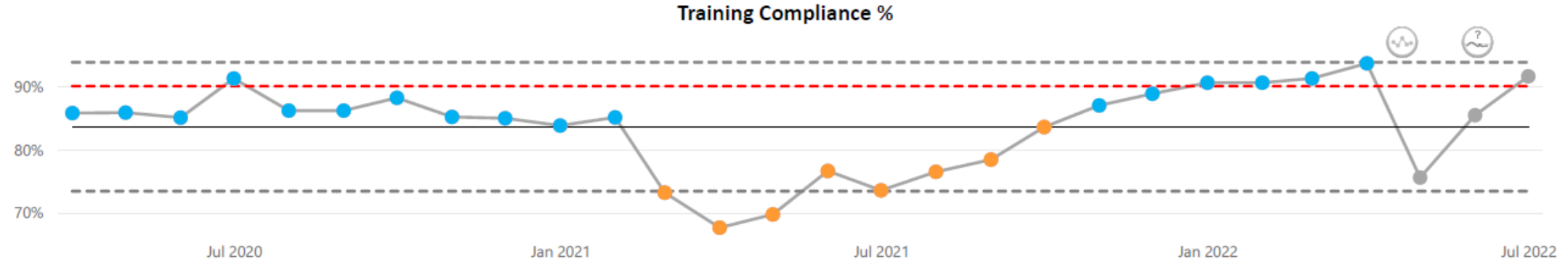
- At the end of July 2022, 8 staff were on long term sickness.
  - * staff returned from long term sickness through July 2022.
- There were 35 episodes of sickness absence, the most common reason being cold, cough, flu (11 episodes – 51 FTE Days Lost). 26 of these absences were experienced by patient facing staff
- Throughout July 2022, 14 staff were reported to the People Team as experiencing COVID

## Actions

- Sickness absence continues to be reported 3 times a week in order to track the levels of sickness absence due to the pandemic .
- The People Team continue to actively monitor and support managers with long term sickness within departments.

# Workforce - Training




## Service comments

**Mandatory Training Compliance**

Mandatory training compliance for July 2022 increased by 5.7% to 91.56% meaning that the Trust is now above the target for training compliance. This is positive progress as additional mandatory training modules were introduced in May 2022 which saw compliance drop slightly, but reflects staff being able to complete their training throughout July.

**Microsoft Bookings Launch**

The launch of Microsoft Bookings for training has significantly streamlined the process of administering and managing classroom based training. There has been positive feedback on this new system and the People Team continue to support and encourage other departments to utilise the system, starting with IPC and the coordination of Hand Hygiene training from August.

**Leadership, Learning and Development**

A range of developmental courses for staff continue to be advertised on the HR Bookings Calendar with staff been actively attending & booking on to.

The GREAT Leadership sessions that have been ran so far have been well attended and feedback for the sessions has been excellent.

Restorative Just Learning Culture Training for Managers and Culture Training sessions for all staff will be launched in September.

Additional BLS Training Sessions have been made available for staff to book onto, and those who require this training, are encouraged to sign up for a course. Training Needs Analysis carried out by the Nursing Directorate will confirm how many future courses are required.

## Actions

Discussions continue with Royal Wolverhampton NHS Trust training department to support the delivery of a number of training modules including BLS and Conflict Resolutions Training.

A training upload form has been created to support the People Team with upload of any external training modules / courses onto ESR (for example Domestic Abuse Awareness Training and Safeguarding Adults Level 3).

Training spotlights have been added to the ESR Dashboard to signpost recommended training for staff to complete, such as Cultural Competence Training and Suicide Awareness Training.

# Appraisals by Directorate

**Appraisal Rate Compliance by Directorate and Team**

| Directorate | Total Compliant | Due Soon | Overdue | Eligible Employee | % Compliance |
|---|---|---|---|---|---|
| **Directorate of Finance, Performance & Contracting** | **3** | | **2** | **5** | **60.00%** |
| Contract Management Team | 3 | | | 3 | 100.00% |
| Finance Team | | | 2 | 2 | 0.00% |
| **Directorate of Nursing, AHPs & Quality** | **2** | | **1** | **3** | **66.67%** |
| Nursing Directorate | 2 | | 1 | 3 | 66.67% |
| **Directorate of Operations** | **130** | **19** | **2** | **151** | **98.68%** |
| ARRS PCN | 59 | | | 59 | 100.00% |
| Continuing Healthcare and Intermediate Care Team | 13 | | | 13 | 100.00% |
| High Oak Practice | 4 | | 2 | 6 | 66.67% |
| IAPT Team | 39 | | | 39 | 100.00% |
| Operations Management Team | 2 | | | 2 | 100.00% |
| Primary Care Mental Health Team | 8 | 2 | | 10 | 100.00% |
| School Nursing Team | 5 | 17 | | 22 | 100.00% |
| **Directorate of Strategy, People & Partnerships** | **10** | | | **10** | **100.00%** |
| Communications Team | 1 | | | 1 | 100.00% |
| People Team | 3 | | | 3 | 100.00% |
| Strategy and Development Team | 2 | | | 2 | 100.00% |
| Strategy and Transformation Team | 4 | | | 4 | 100.00% |
| **Executives Directorate** | **13** | | | **13** | **100.00%** |
| Chair and Non-Executives Team | 9 | | | 9 | 100.00% |
| Executive Management Team | 4 | | | 4 | 100.00% |
| **Medical Directorate** | **51** | | | **51** | **100.00%** |
| GP Clinical Leads | 9 | | | 9 | 100.00% |
| Medical Directorate Management Team | 1 | | | 1 | 100.00% |
| Pharmaceutical Public Health Team | 31 | | | 31 | 100.00% |
| Prescribing Ordering Direct (POD) Team | 10 | | | 10 | 100.00% |
| **Total** | **209** | **19** | **5** | **233** | **97.85%** |

**Appraisals and Developmental Reviews**

Appraisal compliance showed a significant improvement to 98% during July 2022. This is a 23% increase in performance compared to the previous month, and is the first time that the Trust target for appraisals has been achieved.

The appraisal figure excludes all new staff and internal job movers who are within the first 12 months of their new role.

Throughout July, appraisals for areas of non-compliance under 85% was

- Continuing Healthcare Team – the deadline of 31st July 2022 for appraisal completion was achieved
- ARRS PCN services – all outstanding appraisals were successfully completed during July 2022. The revised structure put in place should support with appraisal compliance in the coming 12 months, enabling a more staggered approach to completion.
- Prescribing and Ordering Direct Service – all outstanding appraisals were successfully completed during July 2022

For areas with compliance less than 85%:

- Finance Department – appraisals have been scheduled in the coming months and due to change of management within the team, we expect compliance over the next few months.
- High Oak Practice – the remaining appraisals have been scheduled and support will continue to be offered to aid with the completion of these.
- Nursing Directorate – the outstanding appraisal has been scheduled for completion

The overdue and due soon compliance notifications continue to be circulated with teams, and appraisals continue to be discussed at monthly managers meetings, in which the People Team are in attendance to offer support and guidance.

# Training by Directorate

**Mandatory Training Compliance**

| Attribute | Total Compliant | Total Expiring Soon | Total Not Compliant | % Total Compliance |
|---|---|---|---|---|
| NHS\|CSTF\|Resuscitation - Level 2 - Adult Basic Life Support - 1 Year\| | 118 | 1 | | 100.00% |
| NHS\|CSTF\|Fire Safety - 2 Years\| | 375 | | 7 | 98.17% |
| NHS\|CSTF\|Moving and Handling - Level 1 - 3 Years\| | 374 | 6 | 8 | 97.91% |
| NHS\|CSTF\|Preventing Radicalisation - Basic Prevent Awareness - 3 Years\| | 374 | 2 | 8 | 97.91% |
| NHS\|CSTF\|Health, Safety and Welfare - 3 Years\| | 373 | 4 | 9 | 97.64% |
| NHS\|CSTF\|Safeguarding Adults (Version 2) - Level 1 - 3 Years\| | 373 | 1 | 9 | 97.64% |
| NHS\|CSTF\|Equality, Diversity and Human Rights - 3 Years\| | 370 | 4 | 12 | 96.86% |
| NHS\|CSTF\|Infection Prevention and Control - Level 1 - 3 Years\| | 196 | 5 | 8 | 96.08% |
| NHS\|CSTF\|Safeguarding Children (Version 3) - Level 1 - 3 Years\| | 367 | 5 | 15 | 96.07% |
| NHS\|CSTF\|Information Governance and Data Security - 1 Year\| | 364 | 66 | 18 | 95.29% |
| 445\|LOCAL\|DoLS (LPS) Awareness - Level 1\|Information and Knowledge | 215 | 1 | 19 | 91.88% |
| 445\|LOCAL\|Mental Capacity Act Awareness - Level 1\|Information and Knowledge | 214 | 1 | 20 | 91.45% |
| 445\|LOCAL\|Learning Disabilities Awareness - Level 1\|Information and Knowledge | 345 | | 37 | 90.31% |
| NHS\|CSTF\|Preventing Radicalisation - Prevent Awareness - 3 Years\| | 177 | 13 | 20 | 89.85% |
| NHS\|CSTF\|Infection Prevention and Control - Level 2 - 1 Year\| | 159 | 14 | 19 | 89.33% |
| NHS\|CSTF\|Dementia awareness - 3 Years\| | 331 | 4 | 51 | 86.65% |
| NHS\|CSTF\|Safeguarding Children (Version 3) - Level 2 - 3 Years\| | 64 | | 10 | 86.49% |
| NHS\|CSTF\|Safeguarding Adults (Version 2) - Level 2 - 3 Years\| | 64 | | 11 | 85.33% |
| 445\|LOCAL\|Domestic Abuse Awareness - Level 1\|Information and Knowledge | 285 | 1 | 97 | 74.61% |
| NHS\|CSTF\|Safeguarding Children (Version 3) - Level 3 - 3 Years\| | 139 | 2 | 58 | 70.56% |
| NHS\|CSTF\|Safeguarding Adults (Version 2) - Level 3 - 3 Years\| | 134 | 1 | 63 | 68.02% |
| **Total** | **5411** | **131** | **499** | **91.56%** |

*Safeguarding Adults & Children Level 3 compliance is based upon completion of e-Learning modules only. Work remains on-going to record Safeguarding Training Passports onto ESR which will reflect full completion of the requirements for these courses

The non-compliant and due soon compliance notifications continue to be circulated with teams to improve compliance and mandatory training continues to be discussed at monthly managers meeting to reinforce the need for compliance.

Dudley Integrated Health and Care NHS Trust

# COMMITTEE ASSURANCE REPORT TO THE BOARD

**Committee**: People Committee

**Date of meeting:** 19th July and 23rd August 2022 (via Microsoft Teams)

**Presented By:** Martin Evans, Non-Executive Director

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|---|---|
| **Significant risks/issues for escalation** | Nil |
| **Key issues/matters discussed at the Committee** | • The committee was quorate at both meetings.<br>• The risks allocated to the People Committee were reviewed at both meetings. In the August meeting the committee had a robust discussion around risk C-064 – 'Risk of substantive workforce shortage' where a proposal had been received to reduce the risk score from 12 (3x4) to 8 (likelihood 2, impact 4). Although considerable progress has been made in recruiting staff into the organisation, the committee highlighted some of the challenges that remain such as the need to replace agency staff and recruitment of GPs and agreed that this risk should remain at 12 at this time.<br>• The committee received up to date information on the pay award discussions for NHS staff which are ongoing. Assurance was sought and provided that the Executive team are giving due consideration to the potential for some level of industrial action at some point in the next few months. The committee recognised that any such action would impact on more than just the People committee and that there was a need for agreement on which assurance committee would oversee the Trust's preparation and response for such action.<br>• In considering the wellbeing of staff, in light of the cost-of-living pressures, the committee recognised the need to ensure that the organisation is providing the best possible offer of financial support to staff. Assurance was provided that this is being considered by the Executive team, in line with colleagues across the Black Country and the committee will receive an update on support to be offered at the September meeting.<br>• The committee received a progress update on HR policies at both meetings. Assurance was provided that all but one policy has now been approved, with an ongoing system for review and re-approval in place. It was agreed that HR policy management was now 'business as usual' and appropriate updates would be provided to committee on a quarterly basis.<br>• The July committee received an overview of the identified benefits since recruitment was taken 'in house' at the start of April 2022. Assurance was provided on the improvements that have already been made to the on boarding of new recruits and the speed of recruitment referred to as 'time to hire'. Since April |

the organisation has achieved below the recommended nine-week timescale for time to hire.

- The workforce performance report was reviewed at both meetings. The committee has given particular focus to the need to improve compliance levels for mandatory training and appraisals over a number of months and was provided with assurance at the August meeting that both mandatory training and appraisals levels are now above target. The committee had a robust discussion about the target set for mandatory training compliance which is currently higher than other NHS Trusts (current DIHC target of 90% against a more generally used target of 85% by neighbouring Trusts). Although currently exceeding both targets, the committee agreed that it made sense to be consistent with neighbouring Black Country Trusts and that the compliance target for mandatory training compliance should be changed to 85%.
- The committee was assured that the People team has introduced a system to improve and assess the quality of appraisals findings of which will be reported to the committee on a quarterly basis.
- The August committee received and considered the draft Equality, Diversity and Inclusion Strategy 2022 – 2025. The committee acknowledged the significant work that had gone into the strategy and were pleased to see that the strategy focused on the three key areas of workforce equality, heath inequalities & digital inclusion and patient voice & engagement. The committee went through the strategy with the chair of the EDI Committee and key contributors and, subject to a small number of additions, were happy to give the committees support for the strategy to be approved by the Board. The committee requested that proposed plans for the launch and appropriate communication of the strategy are prepared in readiness for the formal approval of the strategy.
- The August committee reviewed the outcomes of the Quarter 2 NHS People Pulse survey. It was agreed that feedback from the survey evidenced that further work was required around the following areas:-
    - Communication
    - Health & Wellbeing
    - Staff engagement – with a focus on involvement in making improvements

The committee will review the actions required above at the September meeting.

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| **Decisions made by the Committee** | • The committee support the submission of the Equality, Diversity and Inclusion Strategy 2022 – 2025 to the Board for approval.<br>• Agreed to recommend to change the Mandatory training compliance target to 85%. |
| **Implications for the Corporate Risk Register or the Board Assurance Framework (BAF)** | Nil |
| **Items/Issues for referral to other Committees** | Consideration and agreement of the most appropriate assurance committee to oversee Trust preparation for any potential industrial action. |

Dudley Integrated Health and Care NHS Trust

# DUDLEY INTEGRATED HEALTH AND CARE NHS TRUST BOARD

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| **TITLE OF REPORT:** | Strategic Commissioning and Transformation Team<br>Assurance Report to Board |
| **PURPOSE OF REPORT:** | To provide the Board with an update on the work of the Strategic Commissioning and Transformation Team |
| **AUTHOR OF REPORT:** | Stephanie Cartwright – Director of Strategy, People and Partnerships |
| **DATE OF MEETING:** | 6th September 2022 |
| **KEY POINTS:** | • The report provides a summary for the Board on the key Strategic Commissioning and Transformation activities in accordance with the following areas:<br>○ Children, Young People and Families<br>○ Mental Health<br>○ Primary Care<br>○ Adults and Long-term Conditions<br>○ Older Adults<br>• A total of 101 Contract review meetings have been completed over the full range of services |
| **RECOMMENDATION:** | Board is asked to accept the report for Assurance |
| **ANY CONFLICTS OF INTEREST IDENTIFIED IN ADVANCE:** | None |
| **ACTION REQUIRED:** | Decision ☐ |
| | Approval ☐ |
| | Assurance ☒ |

# Strategic Commissioning and Transformation Team Assurance Report

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| **Department:** | Strategic Commissioning and Transformation Team |
| **Date Period:** | Progress update Q1 (April – June 2022) |
| **Author/s:** | **Director of Strategy, People and Partnerships**<br>○ Stephanie Cartwright<br><br>**DIHC Strategy & Transformation Leads**<br>○ Joanne Taylor – Primary Care, Adults and Long-term Conditions<br>○ Linda Cropper – Children, Young People and Families<br>○ Piotr Gass – Mental Health<br>○ William Overfield – Older Adults |
| **Responsible Executive:** | Stephanie Cartwright – Director of Strategy, People and Partnerships |

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| **Executive Statement for Board Assurance** | The Strategic Commissioning and Transformation team commission services and manage contracts on behalf of the Integrated Care Board (for Dudley Place) whilst seeking out new opportunities to provide greater care options for the residents of the Dudley Borough.<br><br>This report provides a summary for the Board on the key activities from each quarter. The report has been prepared in accordance with the four lead areas described above. |
| **Children, Young People and Families** | **Paediatric Musculo-Skeletal Service (MSK)**<br>This has been commissioned from an independent provider for a 6-month interim solution (until the 30th September) until the Paediatric Physiotherapy Service at Black Country Healthcare Foundation Trust (BCHFT), commence service provision on 1st October 2022.<br><br>**Review of Speech and Language and Speech Communication Language Needs (SCLN) for children and young people up to the age of 25 in Dudley.**<br>An initial scoping exercise was undertaken in 2021 to gain a shared understanding of the phrases used within Education Health Care Plans (EHCP). Subsequently, a task and finish Group has been established to oversee the development, which will report to the Special Educational Needs and Disability (SEND) Health Pathways group and ultimately to the SEND Oversight Group.<br><br>**Children and Young People Mental Health and Emotional Wellbeing Local Transformation Plan 2021/22**.<br>A Black Country wide plan was submitted to NHSE in June 2021, for which progress is monitored monthly through the Dudley Emotional Health and Wellbeing Steering Group (EH&WBSG). |

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| | **Dudley Children's Occupational Therapy & Educational Psychology Sensory Provision**<br>A business case has been formulated and has been referred to the Joint Mental Health Learning Disabilities & Autism Commissioning Forum for consideration.<br><br>**Community Autism Assessment Service (CAAS)**<br>DIHC and Black Country Healthcare NHS Foundation Trust (BCHFT) have reviewed the existing specification against the service model and a new specification is jointly being developed to improve the patient journey.<br><br>**Community Medical Officer Contract**<br>DIHC are in discussion with The Dudley Group NHS Foundation Trust to develop the service specification for the Community Medical Officer Contract.<br><br>**Single Point of Access (SPoA) for Childhood Behavioural Issues for 0-6 year olds**.<br>The SPoA has been successfully running, as a pilot, in the Halesowen PCN since July 2022 and will be transferred to The Dudley Group NHS Foundation Trust by 1st April 2023. The SPoA has reduced the number of referrals to Paediatric Outpatient clinics as CYP are signposted to alternative appropriate services.<br><br>**Paediatric Triage**<br>The current service (originally commissioned in 2009 and provided by a provider outside of the Dudley system) is planned to transfer to The Dudley Group NHS Foundation Trust, on 1st April 2023, and will be part of the model developed through the CYP Workstream workshops.<br><br>**Acute Triage and Paediatric Virtual Ward**<br>The Dudley Group NHS Foundation Trust currently provide a Paediatric Hot Clinic (PHC) service for 0 – 16 years (up to 19 years if in designated special school for children) who need a senior paediatric opinion within 5 days but are unlikely to need admission.<br>The Paediatric Virtual Ward was successfully introduced as an early supported discharge pathway following assessment through Paediatric Assessment Unit (PAU) on 1st March 2022. Preliminary evaluation is very positive with evidence of reduction in length of stay and good patient experience.<br><br>**Child Clinical Assessment Hubs**<br>Work is underway to ensure there is a Child Clinical Assessment Hub in each of the 6 PCNs. A process that will bring together a variety of Children and Young People (CYP) community teams, greater collaboration and consistency and better co-ordination of these resources which will enhance our offer to CYP has commenced. Better aligned pathways and the removal of organisational barriers will lead to a speedier more efficient journey for the CYP, their family and the staff in every model of care. |

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| | A partner scoping exercise will be undertaken to determine which services, based on population needs are best delivered on a practice, locality or borough basis, and will be part of discussions at the CYP Transformation Group workshops.<br><br>**School Readiness**<br>The Black Country Early Outcomes website has been developed to support parents, practitioners and professionals around the school readiness agenda. This includes access to a wide range of training, supporting materials and includes a child friendly story about what to expect when a child starts Reception. |
| **Mental Health** | **Zero Suicide Alliance Membership**<br>DIHC has become a member of the Zero Suicide Alliance alongside several other NHS Trusts, and organisations from the public, private and voluntary sectors. DIHC's ambition is to create a zero-suicide borough in Dudley with high quality training delivered to all staff in across partner Trusts and all stakeholders.<br><br>**Real Time Suicide Surveillance System – Suicide Prevention**<br>As part of the wider Suicide Prevention Strategy, DIHC are leading the development of a collaborative Real Time Suicide Surveillance System in Dudley. The system enables partners to proactively review the data to prevent further suicide and ensure that all support mechanisms have been utilised to support anyone affected by any suicide related incident.<br><br>**Community Engagement**<br>Visits to various locations across Dudley have taken place to speak with the local residents, businesses, community and youth centres, charities and places of worship. This is to obtain their feedback on the current experience of Dudley's mental health services, and to get a clear understanding of how to best support Dudley's communities.<br><br>**Gambling Commission application**<br>DIHC have formed a partnership with Phase Trust and Dudley Council to apply for funds from the Gambling Commission, to introduce proactive and preventive measures to support vulnerable individuals suffering or at risk of being exposed to gambling harms. The initial application has been successful at Stage 1 of the process, and DIHC are currently submitting the Stage 2 final phase application with partners.<br><br>**Improving Access to Psychological Therapies (IAPT)**<br>DIHC are currently working with the regional and national NHS teams to review Dudley IAPTs access, outcomes and overall performance, to ensure that the team continues to evolve and provide high quality care and services to the population of Dudley. Mental Health Leads have also been collaborating with colleagues and teams across the system to address any gaps between primary and secondary care mental health services.<br><br>**First Contact Mental Health Practitioners (FCMHP)** |

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| | Following the successful introduction of the role in July 2020, this has now been expanded as a team and covers 4 of the 6 PCN areas with plans in place to recruit to staff in the two remaining PCNs. The team continue to receive very positive feedback from practices and excellent patient satisfaction. |
| **Primary Care** | **Dudley Quality Outcomes for Health (DQOFH) – Primary Care Framework**<br>This scheme which is a replacement for the National Quality Outcomes Framework (QOF) has been fully restored and is live in 41 of our 43 GP practices during 2022/23. The annual cycle for review of DQOFH will commence in September, led by a dedicated steering group who will make recommendations for any proposed changes for 2023/24.<br><br>**Access Hub**<br>Following the original extension (April – June) the access hub has been further commissioned by the ICB to provide services until end of September 2022. The hub continues to prioritise children but operates a flexible model to ensure the additional capacity (324 face to face GP appointments per week) is maximised. The hub continues to perform well with 84% of people being seen within 15 minutes of arrival at the Hub and receive feedback with 96% of the public utilising the service rating their experience as good or very good. The Hub has received regional recognition from NHSE as an example of good practice for improving access to Primary Care and supporting the Dudley system during Winter.<br><br>**Enhanced Access – Support for Primary Care Networks**<br>As part of the new specification requirements within the PCN DES, DIHC have been collaboratively working with PCNs to develop a support offer to deliver enhanced access from 1st October 2022. Proposals are currently being finalised and agreed with the PCNs.<br><br>**Local Improvement Schemes (LIS)**<br>The full range of LIS schemes have continued to be commissioned from Primary Care, for which the contracts are in the process of completion.<br><br>**Primary Care Diagnostics**<br>An exercise to define the scope of this programme has commenced and will be undertaken in context with the development of Community Diagnostic Hubs (as part of the Elective Care recovery programme) to avoid any duplication. |
| **Adults and Long-term Conditions** | **Learning Disabilities Health & Well-being Service**<br>A dedicated steering group has been developing this programme of which the aim is to:<br>• develop a gold standard education and training to upskill GP practices<br>• unsure all service users receive a quality health check annually by embedded a Quality Assurance process<br>• develop a health & well-being approach to ensure any issues are being addressed |

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| | The proposal was well received when presented to the Equality, Diversity and Inclusion (EDI) Committee and forms a key initiative within the EDI Strategy.<br><br>**Long Covid pathway**<br>Working with The Dudley Group NHS Foundation Trust, the pathway has been fully established and embedded to support people suffering from symptoms of Long Covid. DIHC are working with services to address waiting times and ensure people get timely access to services when they need support.<br><br>**Virtual Wards**<br>This programme will support people (to remain at home or in a care home) who would normally be in a hospital bed. Working with The Dudley Group NHS Foundation Trust a clear plan has been developed for the implementation and upscaling of technology enabled virtual wards for paediatrics, respiratory, acute respiratory infection and frailty over the next 12 – 18 months. The pathways will commence with an early support discharge model and then further develop the admission avoidance models. The paediatric pathway is already live, with acute respiratory infection to go live in September and all other virtual ward pathways planned to be live by December 2022.<br><br>**Homeless pathway**<br>A dedicated pathway, including an outreach service is currently being finalised. A business case to support implementation is currently being drafted and is part of the DIHC EDI Strategy.<br><br>**Cardiovascular disease prevention**<br>Working with PCNs and GP practices this forms part of the health inequalities programme and is one of the PCN DES specifications. The aim is to meet the national ambition of 80% of detected Hypertension prevalence compared to expected prevalence and that 80% of people with Hypertension are treated to target (140/90 mmHg).<br><br>**Diabetes Clinical Pathway**<br>A Dudley system wide Diabetes Steering group has been established, which will oversee the service review and development of future service model. This has included to date:<br>• survey to establish practice level delivery models and associated workforce requirements<br>• implementation of a risk stratification tool to support standardisation of patient selection during multi-disciplinary team (MDT) discussions<br>• alignment to the Integrated Care Team model to further support people who are poorly controlled<br>• planned patient engagement sessions to commence September to co-design the new pathway<br><br>**Community based Musculoskeletal / Chronic pain service**<br>Building on the work that has been trailed in Dudley & Netherton (D&N) PCN there is a plan in place to expand the model to provide |

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| | a borough wide service. The business case is currently in development, further service modelling is required to ensure the service provision is cost-effective and will meet the future needs of the population.<br><br>**Community Physiotherapy**<br>Harmonisation of previous specifications and contracts which were in place with Community Physiotherapy independent providers has been completed. New contracts have been agreed and are now in place with providers.<br><br>**Stroke pathway**<br>A review of the current stroke pathway is in progress. DIHC will be working with the North Midlands Integrated Stroke Delivery Network (ISDN) and Midlands Stroke Quality Improvement for Rehabilitation (SQuIRe) teams to undertake an independent review of services and implement any recommendations. |
| **Older Adults** | **Enhanced Health in Care Homes (Primary Care Network Direct Enhanced Service (DES))**<br>As part of the specification requirements within the PCN DES, DIHC are supporting PCN's and GP Practices to establish a long-term sustainable model of care for people residing in nursing and residential care homes. This includes working across multiple partners to ensure we are providing the best available service for these vulnerable residents.<br><br>**New Headache Clinic**<br>DIHC has just launched a new community Neurological Clinic based at Brierley Hill Health and Social Care Centre. The referral pathway is for people who suffer reoccurring migraines and headaches and will support those patients who could be better served within the community.<br><br>**Memory Assessment Service (MAS)**<br>Dudley MAS Service successfully transferred provider organisations from Midlands Partnerships NHS Trust to Black Country Healthcare NHS Foundation Trust on 1st July 2022, to align services across the Black Country. The current service will remain unchanged whilst a service review is undertaken by the new provider to align the service to the existing service provision across the Black Country.<br><br>**Palliative / End-of-Life Care (PEOLC)**<br>DIHC has launched a new service based on the ReSPECT progrmme, which includes three Palliative Care Nurses who work within GP practices and care homes to refresh and implement Advanced ReSPECT Care Plans. The service is aimed at providing a patient centred approach to difficult conversations to ensure peoples wishes are captured and clearly documented.<br><br>**Palliative and End of Life Care ICS Oversight Committee**<br>The group has been formed to oversee the implementation of Black Country Strategy. A six step audit has been undertaken in Dudley which will form part of this Strategy. |

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| **Post Capgemini – Clinical transformation work streams** | Following completion of the workshops with Capgemini in March and May 2022, a series of priority Transformation Groups have been established to further develop the integrated model of care for the Dudley population. These Transformation Groups are overseen by an Integrated Model of Care Implementation Group (IMOCIG) which has system wide clinical and strategic representation and will report to the Dudley Health and Care Partnership Board. The four priority transformation groups are as follows:<br>• **Mental Health** – To design the primary care model for Dudley. A draft model has been developed and was presented to Integrated Model of Care Implementation Group on 10th August 2022<br>• **Integrated Care Teams and Care Co-ordination –** to further develop the Integrated Care Team model in Dudley and define the role of care co-ordination, the group is meeting weekly with good progression. A staff feedback survey is currently being completed and a full day workshop is being planned for early September.<br>• **Childrens Model** – to define the model for children and young people services, an initial workshop has taken place in August with a second workshop planned in September and an anticipated agreed model being developed by October<br>• **Clinical Hub** – to further enhance and expand the provision in the Clinical Hub, a first meeting has taken place with another planned in September and a model planned to be completed by November.<br><br>All members of the Strategic Commissioning and Transformation team have active roles in the above groups, as pertinent to their individual areas. |
| **Contract review meetings completed** | All contract reviews that were due within the first quarter have been completed (30 out of a total of 101). |
| **Collaborative working within ICS established programmes** | Representation at the following ICS workstreams:<br>• Children and Young Peoples Board<br>• Long-Term Conditions Board<br>• Out of Hospital Board<br>• Mental Health Programme Board<br>• PEOLC Oversight Committee<br>• ICS Clinical Networks |

Dudley Integrated Health and Care NHS Trust

# DUDLEY INTEGRATED HEALTH AND CARE NHS TRUST BOARD

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| **TITLE OF REPORT:** | Finance Report for the period April to July 2022 |
| **PURPOSE OF REPORT:** | The report details the financial performance for period April to July 2022. |
| **AUTHOR OF REPORT:** | Matthew Gamage – Director of Finance, Performance and Digital |
| **DATE OF MEETING:** | 6th September 2022 |
| **KEY POINTS:** | • The Trust is reporting a break-even position for the period to April to July 2022.<br>• There are divisional financial performance exception items in respect of Mental Health & LD services, where vacancies result in a forecast underspend of £414k, and Corporate Services, linked to the additional infrastructure required to support the developing Digital and Business Intelligence requirements of the organisation resulting in a forecast overspend of £343k.<br>• In addition to the direct budgets held by DIHC, the Trust also manages a significant amount of commissioning budgets held by the ICB.<br>  ○ Draft budgets of £107m have been issued by the ICB<br>  ○ The final ICB budgets require approval by the Integrated Care Board<br>  ○ The management of these budgets is described within the service specification schedule of the Goods and Services contract between the ICB and DIHC. The G&S contract variation is currently going through the internal approval processes of the ICB and will be signed imminently.<br>• The Trust is reporting a cash balance of £2.9m as at the end of July 2022. |
| **RECOMMENDATION:** | The Board is asked to receive the report for assurance |
| **ANY CONFLICTS OF INTEREST IDENTIFIED IN ADVANCE:** | None identified |
| **ACTION REQUIRED:** | Decision ☐ |
| | Approval ☐ |
| | Assurance ☒ |

Dudley Integrated Health and Care

# Finance Report

## **Reporting period:** April – July 2022

**Reported to:** August 2022 Finance, Performance and Digital Committee

**Reported by:** Matthew Gamage, Director of Finance, Performance and Digital

# Contents

# Finance Dashboard – NHS Oversight Framework

The finance dashboard shows performance against finance elements of the national NHS Oversight Framework for Dudley Integrated Health and Care NHS Trust for the period to April to July 2022.

| Indicator | Definition | Scoring criteria | | | | Actual | Score |
|---|---|---|---|---|---|---|---|
| **NHS Oversight Framework** | | **1** | **2** | **3** | **4** | | |
| Capital Service Cover Rating | Degree to which the provider's generated income covers its financial obligations | >2.5x | 1.75-2.5x | 1.25-1.75x | <1.25x | 0.2 | 4 |
| Liquidity Rating | Days of operating costs held in cash or cash equivalent forms, including wholly committed lines of credit available for drawdown | >0 | (7)-0 | (14)-(7) | <(14) | 43 Days | 1 |
| I&E Margin Rating | I&E surplus or deficit/total revenue | >1% | 1-0% | 0-(1)% | <(1)% | 2.38% | 1 |
| Distance from Financial Plan | Year to date actual I&E surplus/deficit in comparison to Year-to-date plan I&E surplus/deficit | >0% | (1)-0% | (2)-(1)% | <(2)% | 0.00% | 2 |
| Agency Rating | Distance from providers cap | <0% | 0%-25% | 25-50% | >50% | Agency cap expecting to be reinstated from September | |
| Overall Score | | | | | | 2 | |

## Exception Report – Capital Service Cover

The **Capital Service Cover** rating measures the ability of the Trust to pay for any financial obligations, such as loan principal and interest repayments, from its surplus. The Trust is currently reporting actual capital service cover of 0.2x liabilities, which indicates that its reported surplus is only sufficient to cover 50% of these financial obligations, and as a result is reporting a score of 4 and red rating

As previously reported, the reason for this rating is that the £1.1m outstanding balance of the working capital loan received from BCH at the Trust's inception is greater than the surplus generated by the Trust. Due to the current NHS financial regime the Trust has set a breakeven expenditure plan for 2022/23, and it is for this reason that the rating is as reported.

The loan repayments are also the cause of a long-term reduction in the trust's **liquidity rating**, which although green rated has reduced from 139 days in March 2021 to 43 days in July 2022. However, the Trust's actual cash balance remains sufficient to repay the outstanding loan balance while still ensuring the Trust retains acceptable liquidity.

# Income and Expenditure Summary – DIHC Services

## Overall Surplus/(Deficit)

The Trust is reporting a breakeven position to NHSE/I as at month 4, and also to the end of the financial year. The Trust makes a technical surplus due to the IFRS16 impact of Peppercorn rents of occupied premises, but this is removed for reporting purposes when calculating the position reported to NHSEI

## Divisional Position

The table to the right shows the divisional position of the Trust and highlights key variances at a divisional level.

In a change to reporting in the 21/22 financial year, the table shows the income and expenditure position of each division. In the current month this itemises only specific service-level income, however future reports will also itemise main contract income to divisional level.

Exceptions are reported where a forecast variance to plan exceeds £250k or 25% of the annual plan value, resulting in exceptions in respect of:

- **Mental Health and LD Services – Forecast Underspend £414k (11%)**
  Mental Health services continue to see underspends due to a high level of vacancies within the team, with 18.81wte posts currently vacant, partially offset by the use of agency staff where these are available.

  The Trust has recently re-advertised a number of posts within these teams, however recruitment has proven difficult and the forecast assumes that vacancies will persist for some time.

- **Corporate Services – Forecast Overspend £343k (4%)**
  Corporate Services are forecast to overspend by £343k, with the main cause for this being a £300k overspend on IM&T linked to the additional infrastructure required to support the developing Business Intelligence requirements of the organisation.

| | WTE Budget | WTE Actual | WTE Variance | YTD Budget £000's | YTD Actual £000's | YTD Variance £000's | Annual Budget £000's | Forecast Actual £000's | Forecast Variance £000's |
|---|---|---|---|---|---|---|---|---|---|
| **MAIN CONTRACT INCOME** | | | | | | | | | |
| INCOME | 0 | 0 | 0 | (5,471) | (5,471) | - | (16,414) | (16,445) | 31 |
| **MAIN CONTRACT INCOME Total** | **0** | **0** | **0** | **(5,471)** | **(5,471)** | **-** | **(16,414)** | **(16,445)** | **31** |
| **CHILDREN & YOUNG PEOPLE** | | | | | | | | | |
| EXPENDITURE | 29.06 | 25.76 | 3.3 | 436 | 384 | 52 | 1,307 | 1,202 | 105 |
| **CHILDREN & YOUNG PEOPLE Total** | **29.06** | **25.76** | **3.3** | **436** | **384** | **52** | **1,307** | **1,202** | **105** |
| **MENTAL HEALTH & LEARNING DISABILITY** | | | | | | | | | |
| INCOME | 0 | 0 | 0 | (38) | (74) | 36 | (115) | (150) | 36 |
| EXPENDITURE | 83.83 | 65.02 | 18.81 | 1,297 | 1,113 | 184 | 3,892 | 3,514 | 378 |
| **MENTAL HEALTH & LEARNING DISABILITY Total** | **83.83** | **65.02** | **18.81** | **1,259** | **1,039** | **220** | **3,778** | **3,364** | **414** |
| **PCN SERVICES** | | | | | | | | | |
| INCOME | 0 | 0 | 0 | (1,844) | (1,703) | (141) | (5,532) | (5,197) | (335) |
| EXPENDITURE | 88.76 | 86.37 | 2.39 | 1,315 | 1,262 | 53 | 3,946 | 3,732 | 214 |
| **PCN SERVICES Total** | **88.76** | **86.37** | **2.39** | **(529)** | **(441)** | **(88)** | **(1,586)** | **(1,465)** | **(121)** |
| **PHARMACEUTICAL & PUBLIC HEALTH** | | | | | | | | | |
| INCOME | 0 | 0 | 0 | (13) | (0) | (13) | (38) | (38) | - |
| EXPENDITURE | 51.3 | 48.14 | 3.16 | 923 | 868 | 55 | 2,769 | 2,634 | 135 |
| **PHARMACEUTICAL & PUBLIC HEALTH Total** | **51.3** | **48.14** | **3.16** | **910** | **868** | **42** | **2,731** | **2,596** | **135** |
| **PHYSICAL HEALTH** | | | | | | | | | |
| INCOME | 0 | 0 | 0 | - | (41) | 41 | - | (103) | 103 |
| EXPENDITURE | 22.61 | 25.26 | -2.65 | 525 | 590 | (66) | 1,574 | 1,720 | (146) |
| **PHYSICAL HEALTH Total** | **22.61** | **25.26** | **-2.65** | **525** | **549** | **(24)** | **1,574** | **1,617** | **(43)** |
| **PRIMARY CARE** | | | | | | | | | |
| INCOME | 0 | 0 | 0 | (289) | (608) | 319 | (912) | (1,400) | 488 |
| EXPENDITURE | 14.61 | 11.62 | 2.99 | 275 | 581 | (305) | 870 | 1,342 | (471) |
| **PRIMARY CARE Total** | **14.61** | **11.62** | **2.99** | **(14)** | **(27)** | **14** | **(41)** | **(58)** | **17** |
| **CORPORATE SERVICES** | | | | | | | | | |
| INCOME | 0 | 0 | 0 | (216) | (302) | 86 | (259) | (357) | 98 |
| EXPENDITURE | 83.72 | 58.38 | 25.34 | 3,101 | 3,207 | (106) | 8,912 | 9,352 | (441) |
| **CORPORATE SERVICES Total** | **83.72** | **58.38** | **25.34** | **2,884** | **2,905** | **(21)** | **8,652** | **8,995** | **(343)** |
| **Grand Total** | **373.89** | **320.55** | **53.34** | **0** | **(195)** | **195** | **-** | **(195)** | **195** |
| **Adjustments as per NHSEI Reported Position** | | | | | **195** | **(195)** | | **195** | **(195)** |
| **Adjusted Financial Position Reported to NHSEI** | **373.89** | **320.55** | **53.34** | **0** | **(0)** | **0** | **0** | **(0)** | **0** |

# Income and Expenditure Run Rate

The chart on the right provides detail of the Trust's income and expenditure run rate for the 21/22 financial year and first four months of the 22/23 financial year.

There are a number of areas where, due to national guidance and mandated requirements, month 12 is difficult to interpret in terms of trend, and this period is therefore greyed out and should be set aside for comparison purposes.

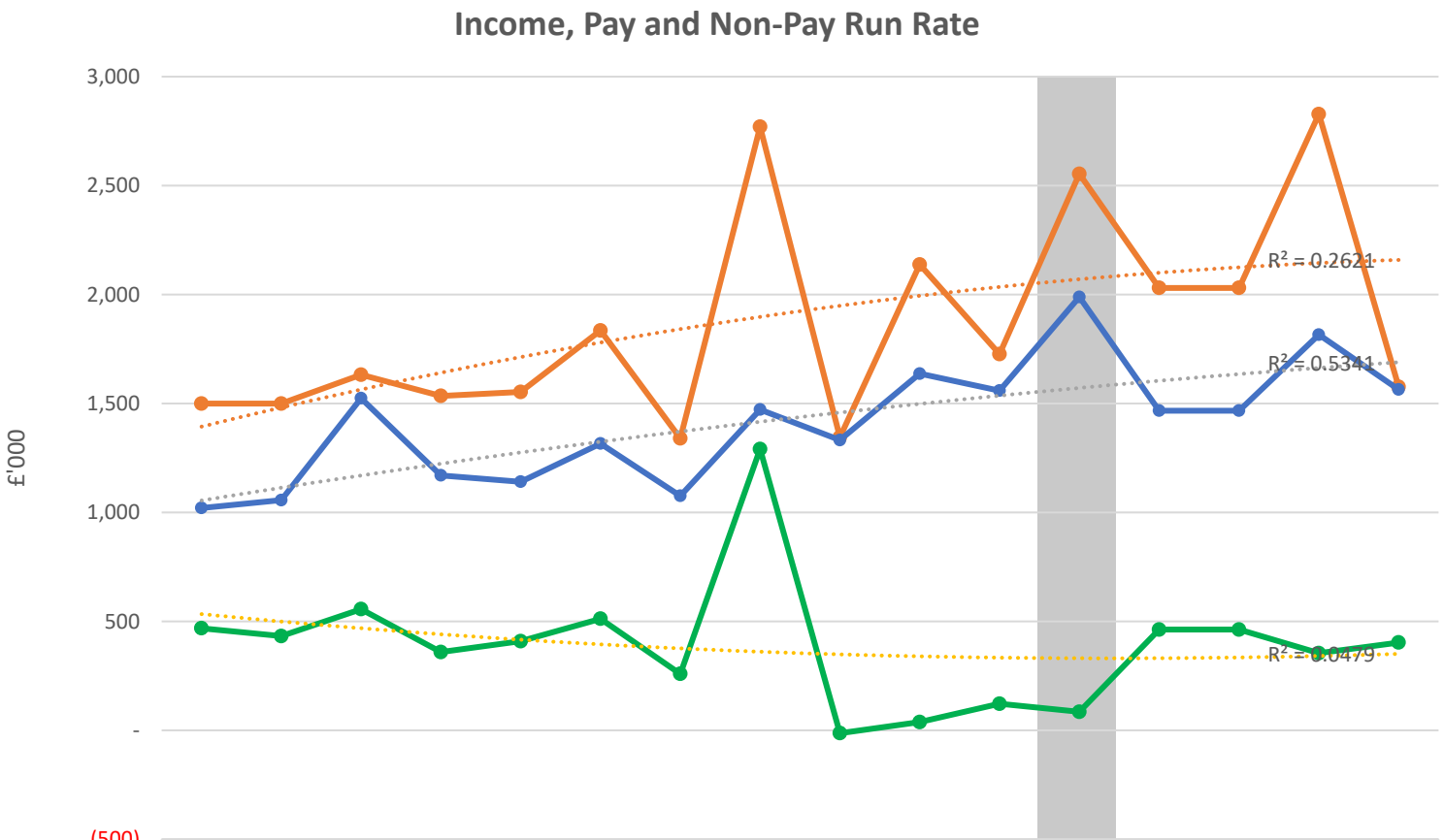
As financial information was not reported in month 1, costs reported at month 2 are split evenly across each month

Key messages from this adjusted data are as follows:

- **Income** has grown slightly from the average of months 7-11 in the previous financial year, at £2,116k per month compared to £1,864 in months 7-11

- **Pay costs** have plateaued after increasing in the second half of the 21/22 financial year. There continue to be a number of vacancies within operational and corporate teams, driving a high level of agency usage. There is a growing national focus on Agency usage and reviews of agency expenditure are being undertaken by Executive Leads for their individual areas with action plans being developed to reduced expenditure, particularly in relation to non clinical agency usage. This subject will also be discussed at the budget meetings the finance team hold with budget managers with corrective actions being monitored through the Trusts efficiency programme.

- **Non-pay costs** of £421k per month are above the average of £377k seen in the 21/22 financial year. This is largely due to expected increased Digital costs as noted in the I&E summary




| | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | 1 | 2 | 3 | 4 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Income | 1,500 | 1,500 | 1,632 | 1,535 | 1,553 | 1,835 | 1,340 | 2,770 | 1,345 | 2,138 | 1,727 | 2,554 | 2,031 | 2,031 | 2,828 | 1,576 |
| Pay | 1,021 | 1,057 | 1,524 | 1,170 | 1,141 | 1,316 | 1,076 | 1,472 | 1,332 | 1,637 | 1,559 | 1,989 | 1,467 | 1,467 | 1,816 | 1,564 |
| Non-Pay | 469 | 433 | 556 | 359 | 409 | 512 | 259 | 1,291 | (13) | 38 | 122 | 85 | 463 | 463 | 354 | 403 |

# Managed Service Reporting

In addition to the direct budgets held by DIHC, the Trust also manages a significant amount of commissioning budgets held by the ICB.

The table on the right shows the draft budget values for 2022/23 and the associated budget holder within DIHC. The total value equates to £107m.

The final budgets require approval by the Integrated Care Board. Following confirmation of the budgets, the ICB finance team will provide the Trust with monthly performance information which will be then be reported as part of this finance report.

| Service Area | Budget Holder | Draft 2022/23 Budget £ |
|---|---|---|
| Prescribing | Duncan Jenkins | 60,285,239 |
| NHS Continuing Healthcare | Jenny Cale | 24,540,259 |
| Intermediate Care | Jenny Cale | 7,599,192 |
| Childrens Services | Linda Cropper | 7,441,611 |
| Community Services | Joanne Taylor | 3,942,686 |
| Long Term Conditions | Joanne Taylor/ William Overfield | 1,060,263 |
| Hospices | William Overfield | 875,847 |
| Childrens Continuing Care | Kellie Lennon/ Linda Cropper | 847,705 |
| Palliative Care | William Overfield | 690,015 |
| **Total** | | **107,282,817** |

The management of these budgets is described within the service specification schedule of the Goods and Services contract between the ICB and DIHC. The G&S contract variation is currently going through the internal approval processes of the ICB and will be signed imminently.

# Capital Summary

## Summary

The Trust's agreed capital plan for the financial year 2022/23 totals £233,000, as part of the wider ICS control total of £84.8m. The plan is split across Network Infrastructure, Mobile Technology and EPR upgrades.

The year-to-date plan is zero, with expenditure planned into the second half of the financial year, and the Trust Digital Team continues to work on plans to utilise the allocation in full.

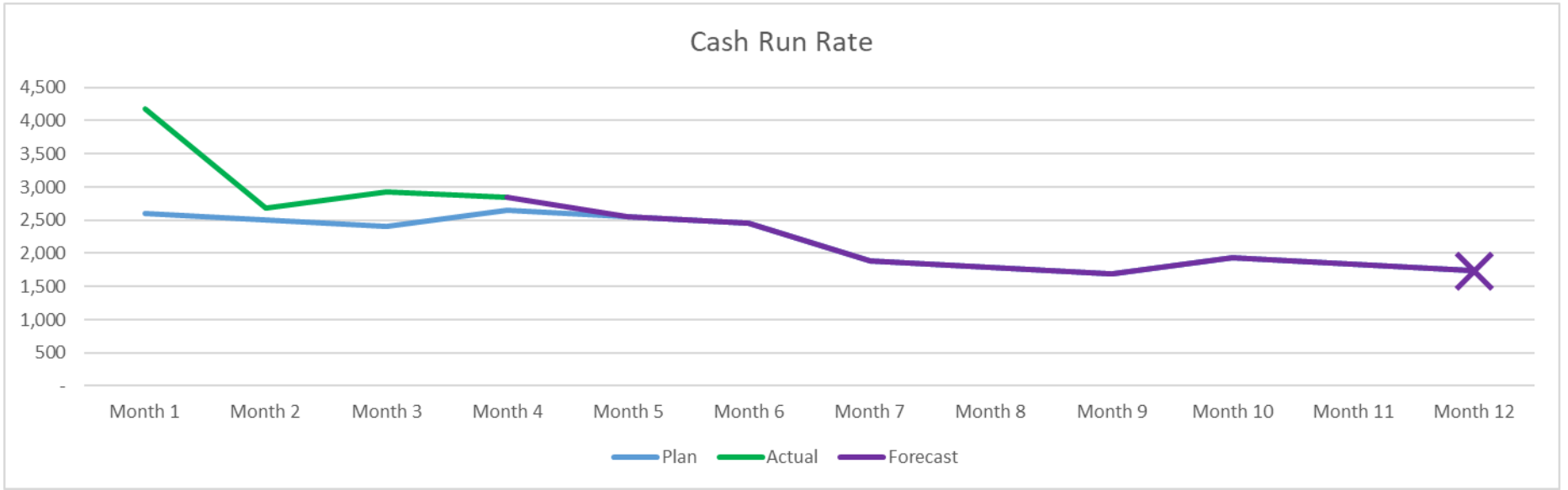
| Scheme | YTD Budget £000's | YTD Actual £000's | YTD Variance £000's | Annual Plan £000's | Forecast Actual £000's | Forecast Variance £000's |
|---|---|---|---|---|---|---|
| Network Infrstructure Refresh | - | - | - | 50 | 50 | - |
| Mobile technology | - | - | - | 40 | 40 | - |
| EPR Levelling Up | - | - | - | 143 | 143 | - |
| **Total** | **-** | **-** | **-** | **233** | **233** | **-** |

# Balance Sheet Summary

| | Actual Closing 2021/22 | Actual May-22 Closing | Actual Jun-22 Closing | Actual Jul-22 Closing | Month on Month Movement |
|---|---|---|---|---|---|
| | £'000 | £'000 | £'000 | £'000 | £'000 |
| **Non-current assets** | | | | | |
| Intangible assets | - | - | - | - | - |
| Property, plant and equipment | 503 | 688 | 677 | 633 | (44) |
| Other investments / financial assets | 14 | 14 | 14 | 14 | - |
| | **517** | **702** | **691** | **647** | **(44)** |
| **Current assets** | | | | | 0 |
| Inventories | - | - | - | - | - |
| NHS receivables | 1,056 | 18 | 785 | 918 | 133 |
| Non-NHS receivables | 460 | 2,691 | 1,840 | 1,941 | 101 |
| Other current assets | - | - | - | - | - |
| Cash and cash equivalents | 4,186 | 2,677 | 2,934 | 2,850 | (84) |
| | **5,702** | **5,386** | **5,559** | **5,709** | **150** |
| **Current liabilities** | | | | | 0 |
| Capital trade payables | (47) | - | - | (7) | (7) |
| Revenue trade payables | (3,335) | (3,343) | (3,843) | (4,019) | (176) |
| Borrowings | (1,133) | (1,147) | (1,147) | (1,147) | - |
| Deferred income | (180) | (82) | (82) | - | 82 |
| Other financial liabilities | - | (328) | - | (6) | (6) |
| Provisions | (53) | (53) | (53) | (53) | - |
| | **(4,748)** | **(4,953)** | **(5,125)** | **(5,232)** | **(107)** |
| **Net Current Assets** | **954** | **433** | **434** | **477** | **43** |
| **Non-current liabilities** | | | | | - |
| Capital payables | - | - | - | - | - |
| Revenue payables | - | - | - | - | - |
| Borrowings | (567) | (14) | (14) | (14) | - |
| Deferred Income | - | - | - | - | - |
| Other financial liabilities | - | - | - | - | - |
| Provisions | (41) | (41) | (41) | (41) | - |
| | **(608)** | **(55)** | **(55)** | **(55)** | **-** |
| **Total Net Assets Employed** | **863** | **1,080** | **1,070** | **1,069** | **(1)** |
| **Financed by** | | | | | - |
| Public dividend capital | 2,568 | 2,568 | 2,568 | 2,568 | - |
| Revaluation reserve | - | - | - | - | - |
| Other reserves | - | - | - | - | - |
| Income and expenditure reserve | (1,705) | (1,488) | (1,498) | (1,499) | (1) |
| **Total Taxpayers' Equity** | **863** | **1,080** | **1,070** | **1,069** | **(1)** |

- The overall net assets position has increased since the pre-audit 2021/22 closing position, as follows:
  - £11k relating to an adjustment made for the post audit 2021/22 closing position
  - £195k YTD surplus, which relates to the recognition of notional income to fund a right of use asset, capitalised under IFRS16. This is adjusted out in the adjusted financial performance of the Trust.
- The cash position continues to be healthy at £2.9m. A loan repayment of c£0.6m will be made on 1 October 2022. The forecast year end cash position is £1.1m.
- As a result of the implementation of IFRS 16, £223k of 'right of use' assets have been recognised, which are offset by borrowings where a lease exists and notional income where the arrangement is a peppercorn lease.
- Significant receivables are being recorded in relation to;
  - £0.7m invoiced income, the majority of which is PCN recharges
  - £2.1m prepayments and accrued income, which mainly relate to LA, ICB and CSU
- Significant payables are being recorded in relation to;
  - £0.1m invoiced payables with a purchase order
  - £0.2m invoiced payables without a purchase order
  - £2.5m accrued expenditure, of which £0.8m relates to NHS and other WGA bodies
  - £1.2m other, including payroll related balances

# Cashflow




- The overall cash position is in line with plan at 31 July 2022 and is expected to track in line with plan for the year.
- The forecast cash position provides the Trust with sufficient headroom to manage working capital requirements.

Dudley Integrated Health and Care NHS Trust

# DUDLEY INTEGRATED HEALTH AND CARE NHS TRUST BOARD

| | |
|---|---|
| **TITLE OF REPORT:** | Performance Report |
| **PURPOSE OF REPORT:** | The report details the performance information for July 2022. |
| **AUTHOR OF REPORT:** | Philip King - Chief Operating Officer<br>Faye Duncan – BI Service Delivery Manager |
| **DATE OF MEETING:** | 6th September 2022 |
| **KEY POINTS:** | • CHC received 38 referrals in July 2022. 74% of these referrals were eligible for a full assessment. 100% of the assessments were completed within 28 days and outside of an acute setting.<br>• A revised trajectory has been submitted to NHS England alongside a 3–5-year recovery plan. This is subject to change. However, the IAPT service have achieved 105% of the new expected access rate in July 2022.<br>• The Dudley IAPT service are consistently treating 98% of service users within 18 weeks.<br>• On average the Dudley IAPT service has 4% of patients waiting 90+ days between 1st and 2nd appointment.<br>• The recovery target continues to be missed, with 42% of people who have completed treatment moving to recovery against a target of 50%. The BI Team and IAPT service are developing an internal metric to monitor IAPT recovery which excludes early dropouts, and the service are looking to develop a service improvement plan.<br>• The overall IAPT Data Quality Metric has fallen to 84% in April 2022 due to an error during the submission process. This has been rectified from June's data onwards.<br>• The National Child Measurement Programme (NCMP) which is performed by the school nursing team have achieved 100% of the July target for both Year 6 and Reception children.<br>• In July 2022, the ARRS PCN service has seen just over 6500 patients with an attendance rate of 94%. *Please note, this data excludes activity* |

| | |
|---|---|
| | *from Chapel Street Surgery, and some practices in Brierley and Amblecote PCN as the data was not available at the time of reporting.*<br><br>• Extended Access has received 1,147 referrals with 92% attending an appointment. 97% of patients were discharged home.<br><br>• Extended Access Phlebotomy have received 331 referrals with an 87% patient attendance rate.<br><br>• The overall Dudley QOF performance for Chapel Street Surgery was 32% and High Oak Surgery achieved 41% compared to Dudley's overall performance of 38%.<br><br>• Please note, there is a delay in receiving the April & May child immunisation data due to a national issue with EMIS supplying data to Immform. This has impacted both High Oak surgery and Chapel Street surgery. |
| **RECOMMENDATION:** | The trust board is asked to receive the report for assurance |
| **ANY CONFLICTS OF INTEREST IDENTIFIED IN ADVANCE:** | None identified |
| **ACTION REQUIRED:** | Decision ☐ |
| | Approval ☐ |
| | Assurance ☒ |

NHS
Dudley Integrated Health and Care
NHS Trust

# Performance Report

## **Reporting period:** July 2022

**Reported to:** September 2022, Trust Board

**Reported by:** Philip King, Director of Operations

# Introduction

The Integrated Performance Scorecard is designed to provide the board with an overview of the trust performance within all key areas of the business on a monthly basis.

## Exception Reports

The full Integrated Performance Scorecard will presented to each committee to provide a balanced view of the Trusts performance. However, the exception reporting will be focussed on the areas of interest for the individual committee (as shown below)

- Finance Performance and Digital Committee – Finance and Operational Performance Exceptions
- People Committee – Workforce Exceptions
- Quality and Safety Committee – Quality Exceptions

## Additional Caveats

- SPC charts and Icons require a minimum of 15 data points to create a robust analysis, Due to the infancy of the organisation we are using 2+ data points in some cases e.g. CHC, Intermediate Care, High Oak Surgery. Winter Access, NCMP. Therefore, Please take this into consideration when reviewing the information.
- Targets are still being developed for some of the new measures. These targets will reviewed and agreed by individual services and the executive
- CQC Rating - 2 refers to Good
- NCMP - National Child Measurement Programme runs until the end of July. Therefore, the annual target has been set using the trajectory required by end of July 2022.
- Data Quality Maturity Index for IAPT is published via NHS Digital in arrears.
- The Flu campaign does not start until 1st October 2022.
- There were no incidents of Duty of Candour in July 2022
- ARRS PCN July figures excludes Chapel Street Surgery and some practices in the Brierley and Amblecote PCN as the data was not available at the time of reporting.
- Child Immunisations are reported a month in arrears. The April & May data is not available at the time of reporting due an issue with the data being supplied from EMIS to Immform.
- The ICB have sponsored a review of Primary Care Mental Health Services.

# Key:

## Variation and Assurance Icons

*SPC charts and Icons require a minimum of 15 data points to create a robust analysis, Due to the infancy of the organisation we are using 2+ data points in some cases e.g. CHC, Intermediate Care, High Oak Surgery. Winter Access, NCMP. Therefore, Please take this into consideration when reviewing the information.*

| Variation | | | | Assurance | | |
|---|---|---|---|---|---|---|
|  |  |  |  |  |  |  |
| **Common cause** – no significant change | **Special cause** of **concerning** nature or higher pressure due to (H)igher or (L)ower values | **Special cause** of **improving** nature or lower pressure due to (H)igher or (L)ower values | **Special cause variation** when up or down arrow is neither an improvement or concern | Variation indicates **inconsistently passing** and **falling** short of the target | Variation indicates consistently **(P)assing** the target | Variation indicates consistently **(F)alling** short of the target |

## Statistical Process Chart (SPC)

# DIHC Integrated Performance Scorecard 2022-23

| Domain | Sub domain | Metric | Metric Type | Latest Date | Value | Target | YTD | Annual Target | Variation | Assurance |
|---|---|---|---|---|---|---|---|---|---|---|
| Finance | Best Practice Payment | BPP - Number of Payments - NHS | Local | Jul 2022 | 91.67% | 95% | 97.87% | 95% | | |
| | | BPP - Number of Payments - Non NHS | Local | Jul 2022 | 98.88% | 95% | 99.38% | 95% | | |
| | | BPP - Value of Payments - NHS | Local | Jul 2022 | 95.72% | 95% | 98.91% | 95% | | |
| | | BPP - Value of Payments - Non NHS | Local | Jul 2022 | 99.21% | 95% | 99.46% | 95% | | |
| Q&S | Safeguarding | Number of Safeguarding Concerns - Adults | Local | Jul 2022 | 66 | - | 218 | - | | |
| | | Number of Safeguarding Concerns - Child | Local | Jul 2022 | 22 | - | 85 | - | | |
| | | Number of Safeguarding Concerns - Age unknown | Local | Jul 2022 | 2 | - | 4 | - | | |
| | | Number of SARs - Open | Local | Jul 2022 | 2 | - | 2 | - | | |
| | | Number of CSPRs - Open | Local | Jul 2022 | 4 | - | 4 | - | | |
| | | Number of S42s - Open | Local | Jul 2022 | 2 | - | 2 | - | | |
| | | Number of S42s - Overdue | Local | Jul 2022 | 2 | - | 2 | - | | |
| | Q&S | CQC Rating - Community MH Services | Local | Apr 2020 | 2 | - | 2 | - | | |
| | | CQC Rating - High Oak Surgery | Local | Apr 2020 | 2 | - | 2 | - | | |
| | | Staff Flu Vaccinations (2022/23) | CQUIN | Jul 2022 | 0% | 0% | 0% | 90% | | |
| | Patient Safety | Patient Safety Alerts Completed By Deadline | National | Jul 2022 | 100% | - | 100% | - | | |
| | Incidents | Duty of Candour | National | Jun 2022 | 100% | 100% | 100% | 100% | | |
| | | Occurrence Of Any Never Event | National | Jul 2022 | 0 | - | 0 | - | | |
| | | Incidents | Local | Jul 2022 | 12 | - | 47 | - | | |
| | | Serious Incidents | Local | Jul 2022 | 0 | - | 0 | - | | |
| | Feedback | Mental Health Friends and Family Test – % Positive | Local | Jul 2022 | 100% | - | 100% | - | | |
| | | Mental Health Friends and Family Test – % Positive (Qtr) | Local | Jun 2022 | 100% | - | 100% | - | | |
| | | Feedback - Informal Concern | Local | Jul 2022 | 5 | - | 15 | - | | |
| | | Feedback - Compliments | Local | Jul 2022 | 2 | - | 10 | - | | |
| | | Feedback - Complaints | Local | Jul 2022 | 7 | - | 17 | - | | |
| | | An acknowledgment of the complaints within 3 days | National | Jul 2022 | 100% | - | 100% | - | | |
| | | A formal response to the complaint sent within 45 days | Local | Jul 2022 | 100% | - | 100% | - | | |
| Workforce | Staff in Post | Vacancy % | Local | Jul 2022 | 13.13% | 10% | 15.27% | 10% | | |
| | | Turnover % (12 Months) | Local | Jul 2022 | 14.55% | 13% | | 13% | | |
| | | Normalised Turnover % (12 Months) | Local | Jul 2022 | 11.35% | - | 11.78% | - | | |
| | | Turnover % (In Month) | Local | Jul 2022 | 0.48% | 1.1% | | 1.1% | | |
| | | Normalised Turnover % (In Month) | Local | Jul 2022 | 0.31% | - | 0.63% | - | | |
| | Development | Appraisal % | Local | Jul 2022 | 97.85% | 85% | 97.85% | 85% | | |
| | | Training Compliance % | Local | Jul 2022 | 91.56% | 90% | 91.56% | 90% | | |
| | Absence | Sickness % (In Month) | Local | Jul 2022 | 3% | 3.8% | 3.28% | 3.8% | | |
| | | Short Term Sickness (In Month) | Local | Jul 2022 | 32.47% | - | 29.07% | - | | |
| | | Long Term Sickness (In Month) | Local | Jul 2022 | 67.53% | - | 70.93% | - | | |
| | | Maternity % (In Month) | Local | Jul 2022 | 0.96% | - | 1.12% | - | | |

# DIHC Integrated Performance Scorecard 2022/23

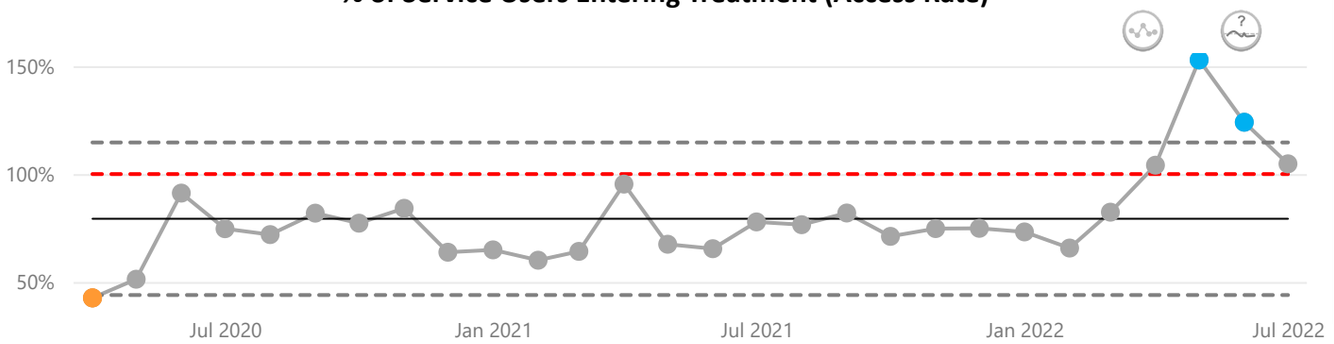
| Domain | Sub domain | Metric | Metric Type | Latest Date | Value | Target | YTD | Annual Target | Variation | Assurance |
|---|---|---|---|---|---|---|---|---|---|---|
| Operational Performance | CHC | Number of Referral for CHC | Local | Jul 2022 | 38 | - | 184 | - | | |
| | | % of Referrals Eligible for a Full CHC Assessment | Local | Jul 2022 | 73.68% | - | 60.87% | - | | |
| | | % of CHC Assessments Completed Within 28 Days | National | Jul 2022 | 100% | 80% | 98.9% | 80% | | |
| | | % of Assessments Completed in an Acute Setting | National | Jul 2022 | 0% | 15% | 0% | 15% | | |
| | CHC - End of life | Number of Fast Track Referrals | Local | Jul 2022 | 68 | - | 283 | - | | |
| | | % of Newly Eligible Fast Track Patients | Local | Jul 2022 | 54.41% | - | 64.31% | - | | |
| | CHC - Pathway 3 | Number of Patients in a Pathway 3 Bed | Local | Jul 2022 | 20 | - | 154 | - | | |
| | | Number of Patients Discharged from Pathway 3 | Local | Jul 2022 | 0 | - | 22 | - | | |
| | IAPT | Number of Service Users Referred for Psychological Therapies | Local | Jul 2022 | 659 | - | 2838 | - | | |
| | | % of Referrals for Older People 65+ | National | Jul 2022 | 10.17% | - | 9.76% | - | | |
| | | % of Service Users Entering Treatment (Access Rate) | Local | Jul 2022 | 104.75% | 100% | 121.28% | 100% | | |
| | | % of Service Users Who Complete Treatment Who Are Moving to Recovery | National | Jul 2022 | 42.46% | 50% | 41.71% | 50% | | |
| | | IAPT Recovery Rate for BME Groups | National | Jul 2022 | 50% | 50% | 44.03% | 50% | | |
| | | % of Service Users Who Are Treated Within 6 Weeks of Referral | National | Jul 2022 | 94.15% | 75% | 87.95% | 75% | | |
| | | % of Service Users Who Are Treated Within 18 Weeks of Referral | National | Jul 2022 | 97.55% | 85% | 98.71% | 85% | | |
| | | 90+ Day Wait Between 1st and 2nd Appt | Local | Jul 2022 | 5.65% | 10% | 4.29% | 10% | | |
| | | Data Quality Maturity Index for IAPT | Local | Apr 2022 | 84.2% | 95% | 84.2% | 95% | | |
| | | Use of Anxiety Disorder Specific Measures in IAPT | CQUIN | Jul 2022 | 88.68% | 65% | 79% | 65% | | |
| | Intermediate Care | Number of Patients in a Step Down Facility | Local | Jul 2022 | 144 | - | 561 | - | | |
| | | Number of New Patients Admitted to Step Down | Local | Jul 2022 | 44 | - | 186 | - | | |
| | | Average Length of Stay | National | Jul 2022 | 58 | 42 | 183 | 42 | | |
| | | Number of Patients Discharged | Local | Jul 2022 | 44 | - | 113 | - | | |
| | Primary Care Mental Health | Number of Referrals to Primary Care Mental Health | Local | Jul 2022 | 181 | - | 621 | - | | |
| | School Nursing | Number of Referrals to School Nursing Service | Local | Jul 2022 | 201 | - | 986 | - | | |
| | | NCMP - Year 6 Status | Local | Jul 2022 | 100% | 100% | | 100% | | |
| | | NCMP - Reception Status | Local | Jul 2022 | 100% | 100% | | 100% | | |
| | | Number of Child In Need on Caseload | Local | Jul 2022 | 194 | - | 194 | - | | |
| | | Number of Looked After Child on Caseload | Local | Jul 2022 | 311 | - | 311 | - | | |
| | | Number of Looked After Child Health Assessments Completed | Local | Jul 2022 | 15 | - | 15 | - | | |
| | | Number of Child Protection on Caseload | Local | Jul 2022 | 157 | - | 157 | - | | |
| | | Number of Young Carers Identified as Needing Support | Local | Jul 2022 | 1 | - | 1 | - | | |

# DIHC Integrated Performance Scorecard 2022/23

| Domain | Sub domain | Metric | Metric Type | Latest Date | Value | Target | YTD | Annual Target | Variation | Assurance |
|---|---|---|---|---|---|---|---|---|---|---|
| Operational Performance | ARRS PCN | % of Patient Attendance | Local | Jul 2022 | 93.51% | - | 94.85% | - | | |
| | | % DNA Rate | Local | Jul 2022 | 6.49% | - | 5.15% | - | | |
| | | % Utilisation Rate | Local | Jul 2022 | 68.89% | - | 69.6% | - | | |
| | Extended Access | Number of Referrals to Extended Access Hub | Local | Jul 2022 | 1147 | - | 4744 | - | | |
| | | % Utilisation Rate | Local | Jul 2022 | 81.81% | 75% | 81.43% | 75% | | |
| | | % of Patient Attendance | Local | Jul 2022 | 92.15% | - | 93.38% | - | | |
| | | % of Patients seen in under 5 minutes | Local | Jul 2022 | 51.84% | - | 61.08% | - | | |
| | | % of Patients seen in 5-15 minutes | Local | Jul 2022 | 40.4% | - | 34.83% | - | | |
| | | % DNA Rate | Local | Jul 2022 | 8.51% | - | 6.88% | - | | |
| | | Outcome - % Discharged Home | Local | Jul 2022 | 96.78% | - | 96.14% | - | | |
| | | Outcome - % Referred to GP | Local | Jul 2022 | 1.23% | - | 2.03% | - | | |
| | | Outcome - % Referred to Hospital | Local | Jul 2022 | 2.27% | - | 2.98% | - | | |
| | Extended Access – Phlebotomy | Number of Referrals | Local | Jul 2022 | 331 | - | 1194 | - | | |
| | | % Utilisation Rate | Local | Jul 2022 | 86.71% | - | 86.6% | - | | |
| | | % of Patient Attendance | Local | Jul 2022 | 86.71% | - | 91.32% | - | | |
| | | % DNA Rate | Local | Jul 2022 | 10.27% | - | 9.8% | - | | |
| | GP - Chapel Street Surgery | CERVS1 - Aged 25-49 adequate smear last 3 years and 6 months..... [ 45-80% ] | National | Jul 2022 | 56.27% | 80% | 56.27% | 80% | | |
| | | CERVS2 - Aged 50-64 adequate smear last 5 years and 6 months..... [ 45 - 80% ] | National | Jul 2022 | 70.83% | 80% | 70.83% | 80% | | |
| | | DM7 - HbA1c, BP & Cholesterol treated to target..... [ 32 - 44% ] | National | Jul 2022 | 16.67% | 14.67% | 16.67% | 44% | | |
| | | MH3 - Received comprehensive physical health assessment... [ 60 - 80% ] | National | Jul 2022 | 15% | 26.67% | 15% | 80% | | |
| | | LD1 - Learning Disabilty annual review completed..... [ 64 - 88% ] | National | Jul 2022 | 0% | 29.33% | 0% | 88% | | |
| | | CVDPP3.2 - Eligble for annual review (QRisk 10%)..... [ 28 - 56% ] | National | Jul 2022 | 60.54% | 56% | 60.54% | 56% | | |
| | | DQOF - Overall (Chapel Street Surgery) | Local | Jul 2022 | 31.58% | - | 31.58% | - | | |
| | GP - High Oak Surgery | CERVS1 - Aged 25-49 adequate smear last 3 years and 6 months..... [ 45-80% ] | National | Jul 2022 | 54.3% | 80% | 54.3% | 80% | | |
| | | CERVS2 - Aged 50-64 adequate smear last 5 years and 6 months..... [ 45 - 80% ] | National | Jul 2022 | 63.1% | 80% | 63.1% | 80% | | |
| | | DM7 - HbA1c, BP & Cholesterol treated to target..... [ 32 - 44% ] | National | Jul 2022 | 16.61% | 14.67% | 16.61% | 44% | | |
| | | MH3 - Received comprehensive physical health assessment... [ 60 - 80% ] | National | Jul 2022 | 13.16% | 26.67% | 13.16% | 80% | | |
| | | LD1 - Learning Disabilty annual review completed..... [ 64 - 88% ] | National | Jul 2022 | 10.71% | 29.33% | 10.71% | 88% | | |
| | | CVDPP3.2 - Eligble for annual review (QRisk 10%)..... [ 28 - 56% ] | National | Jul 2022 | 57.48% | 56% | 57.48% | 56% | | |
| | | DQOF - Overall (High Oak Surgery) | Local | Jul 2022 | 41.21% | - | 41.21% | - | | |
| | | % Vaccinated - MMR (5 yrs) - 2nd dose | National | Mar 2022 | 83.33% | 95% | 90.28% | 95% | | |

# Exception Report: IAPT Recovery

## % of Service Users Entering Treatment (Access Rate)




Jul 2022
Date

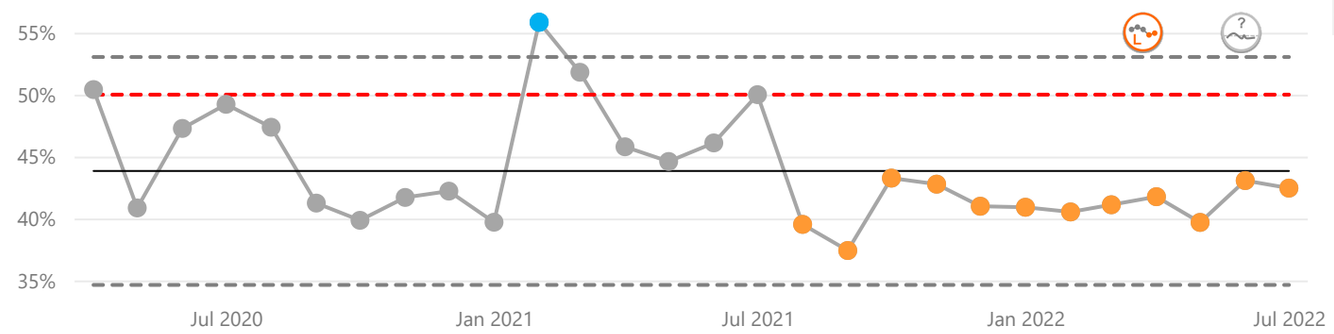
104.75%
Value

100%
Target

Common Cause
Variation

Hit or Miss
Assurance

## % of Service Users Who Complete Treatment Who Are Moving to Recovery




Jul 2022
Date

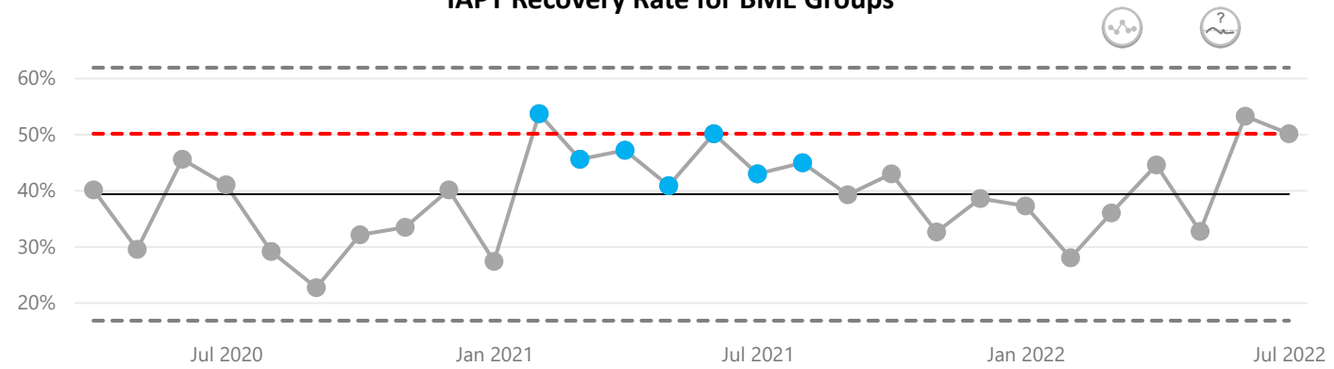
42.46%
Value

50%
Target

Concern
Variation

Hit or Miss
Assurance

## IAPT Recovery Rate for BME Groups




Jul 2022
Date

50%
Value

50%
Target

Common Cause
Variation

Hit or Miss
Assurance

## Service comments

- The impact of the introduction of a First Contact Practitioner for Mental Health in each PCN is currently being reviewed. The DIHC early implementer FCP role evaluation has shown that approximately 25% of patients seen are referred on to the IAPT service.
- The design of the delivery of mental health services within DIHC continues to be under review.
- The ICS Mental Health Programme Board have recognised the difficulties in achieving the IAPT performance targets across the Black Country and therefore a revised trajectory for access has been submitted to NHS England, alongside a 3-5 year recovery plan looking at increasing staffing to meet the national ambition.

  The Trajectory for 2022/23 (*subject to change*) is below:

  Q1 - 1459

  Q2 - 1516

  Q3 - 1773

  Q4 - 1836

  Total - 6584

- Recovery rates are improving as treatment engagement improves, however those stopping treatment in the early stages of therapy are impacting on our recovery rate.

## Actions

- June data has been refreshed as per the national submission timetable. July data is indicative.
- A recruitment and retention strategy for staff is underway. Agency staff are being sourced to support the work to reduce waiting lists and increase assessment numbers.
- Recruitment is currently underway for this year's low and high intensity trainees.
- Development of an internal recovery metric which will exclude early drop-outs.

# Exception Report

Metric

Data Quality Maturity Index for IAPT

Apr 2022
Latest Date

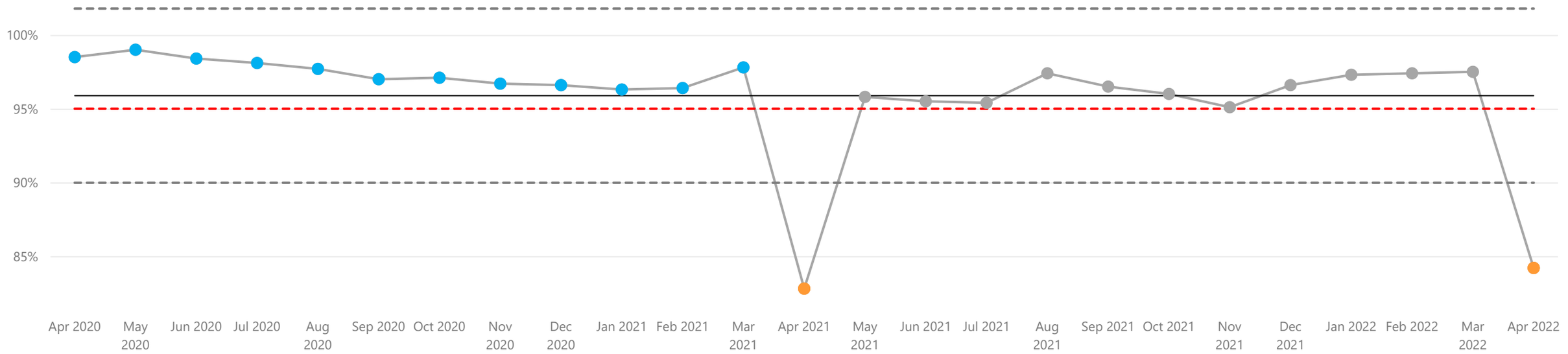
84.2%
Value

95%
Target

Variation

Assurance

## Operational Performance: Data Quality Maturity Index for IAPT




### Service comments

- The overall IAPT DQMI metric has fallen to 84.2% in April 2022 due to an error during the submission process which caused the source of referral to not be populated. This has been rectified from June 2022 onwards.

### Actions

- To add additional controls to the process to ensure all relevant information is captured.

Dudley Integrated Health and Care

# COMMITTEE ASSURANCE REPORT TO THE BOARD

**Committee**: **Finance, Performance and Digital Committee**

**Date of meeting:** 22nd August 2022

| | |
|---|---|
| **Significant risks/issues for escalation** | None identified |
| **Key issues/matters discussed at the Committee** | • The committee received a report in relation to the Board Assurance Framework and Corporate Risk Register for assurance.<br>• The committee received the month 4 finance report for assurance. The report confirmed that the Trust is achieving a breakeven position for the period April – July 2022 and forecasting to achieve breakeven by the end of the financial year.<br>• The committee received the June 2022 performance report for assurance<br>• The committee received an update report in relation to Digital and BI for assurance. The committee agreed to reschedule the digital 'deep dive' report to the September committee.<br>• The committee quarterly update Information Governance report for assurance. The report confirmed that the 95% mandatory training compliance had now been achieved.<br>• The committee received an update on Greener NHS for assurance. |
| **Decisions made by the Committee** | |
| **Implications for the Corporate Risk Register or the Board Assurance Framework (BAF)** | |
| **Items/Issues for referral to other Committees** | |

Dudley Integrated Health and Care NHS Trust

# COMMITTEE ASSURANCE REPORT TO THE BOARD

**Committee**: **Primary Care Integration Committee**

**Author of the Report: Dr George Solomon, Non-Executive Director**

**Date of meeting: 6th September 2022**

| | |
|---|---|
| **Significant risks/issues for escalation** | • None |
| **Key issues/matters discussed at the Committee** | ○ The Committee held a Development Session on 17th August 2022<br><br>○ The key topics covered are set out below:<br><br>**Feedback from two face to face GP Engagement Events**<br><br>○ There were two engagement events held on 20th July and 10th August 2022 with our GP and primary care community.<br>○ It was the first face to face events held since pre pandemic and everyone appreciated the difference that face to face interaction provides.<br>○ Primary Care continue to be very supportive of DIHC, and gave numerous ideas about how the support to primary care from DIHC can be expanded.<br>○ Recognition was given to the pressures that primary care are under and the impact of the wider system, with robust agreement that a solid foundation in primary care alleviates pressures across the whole health system.<br>○ There was significant interest in the improvement and successes at DIHC's practices (Chapel Street and High Oak) which will be shared in more detail at a future event.<br>○ The DIHC team will be sharing more information with practices about the support available, particularly for practices who are currently struggling.<br>○ There was significant in development support within Dudley and the wider ICS around retention |

| | |
|---|---|
| | of GPs following training. DIHC will be taking forward conversations in this area with ICB colleagues.<br>○ There was also significant interest in support around back office functions, ARRS onboarding, Estates planning and accessing capital funding.<br><br>**Primary Care Strategy Development Update**<br><br>An update was presented and discussed by the DIHC team on the development of the Primary Care Strategy, including reflection on successes so far and how the draft strategy aligns with the issues raised by the Primary Care Network Clinical Directors and from colleagues at the GP Engagement Events. The strategy will focus on how we support and help develop Primary Care at practice, PCN, place and system levels.<br><br>The Primary Care Strategy will be further developed and presented to the Primary Care Integration Committee meeting on 21st September 2022 prior to being approved by the Board at its meeting on 4th October 2022. |
| **Decisions made by the Committee** | • None as this was a development session of the Committee |
| **Implications for the Corporate Risk Register or the Board Assurance Framework (BAF)** | • None identified |
| **Items/Issues for referral to other Committees** | ○ None identified |

Dudley Integrated Health and Care NHS Trust

# DUDLEY INTEGRATED HEALTH AND CARE NHS TRUST BOARD

| | |
|---|---|
| **TITLE OF REPORT:** | Dudley Place Arrangements |
| **PURPOSE OF REPORT:** | To share with Trust Board a paper that has been agreed by the Dudley Health and Care Partnership Board in relation to the development of place based arrangements in Dudley. |
| **AUTHOR OF REPORT:** | Stephanie Cartwright, Director of Strategy, People and Partnerships |
| **DATE OF MEETING:** | 6th September 2022 |
| **KEY POINTS:** | • At its meeting on 13th July 2022 the Dudley Health and Care Partnership Board received the attached paper with a series of recommendations with regards to establishing a supporting structure to place based arrangements.<br>• The attached paper has been revised since the Board to reflect the recommendations agreed.<br>• It was agreed at the Dudley Health and Care Partnership Board for each partner Board to receive a copy of the attached report to give their support to the recommended arrangements.<br>• The report recommends a change of name from the Dudley Partnership Board to the Dudley Health and Care Partnership Board. The revised terms of reference have been approved and are included as an appendix in the report.<br>• The report recommends that the existing rotational chair arrangements continue and this was agreed.<br>• The report recommends the establishment of a Dudley Place Executive Team. This has been agreed and the terms of reference have been approved which are included as an appendix in the report. The Executive Team will begin meeting in September 2022.<br>• The report recommends that the Integrated Model of Care Implementation Group will report to the Dudley Health and Care Partnership Board. The terms of reference have been approved and are included as an appendix to the report.<br>• The Dudley Health and Care Partnership Board approved the recommendation of option 2 as the recommended governance arrangements for place.<br>• The place based arrangements will be reviewed alongside the establishment of governance arrangements between the ICB and place. These arrangements are currently being developed |
| **RECOMMENDATION:** | The Board are asked to note the contents of the attached report and the associated recommendations which were agreed at the meeting on 13th July 2022. |

| | | |
|---|---|---|
| | The Board is asked to formally note its support to the proposed arrangements. | |
| **ANY CONFLICTS OF INTEREST IDENTIFIED IN ADVANCE:** | None | |
| **ACTION REQUIRED:** | Decision | ☐ |
| | Approval | ☐ |
| | Assurance | ☒ |

# DUDLEY PARTNERSHIP

## A DISCUSSION PAPER

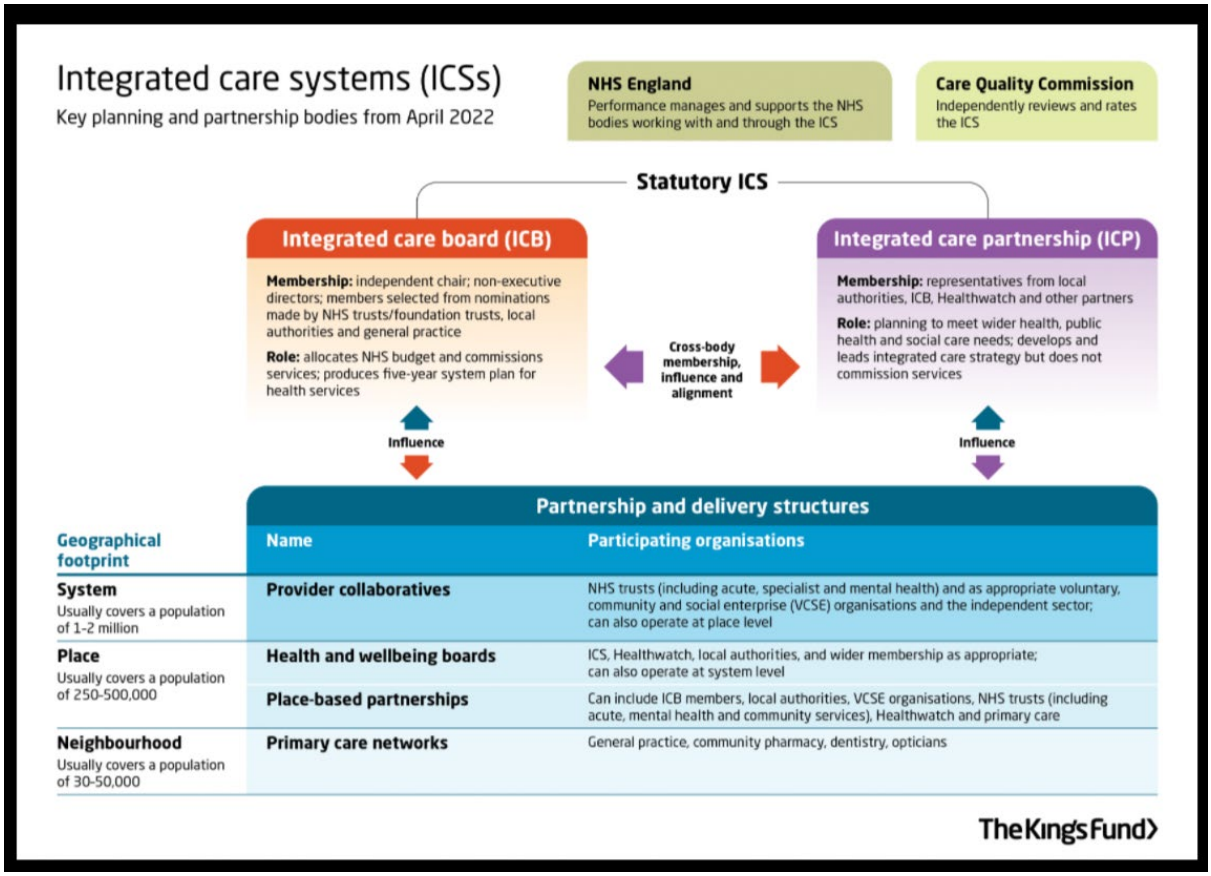
## PURPOSE

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

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

## BACKGROUND INFORMATION

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



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

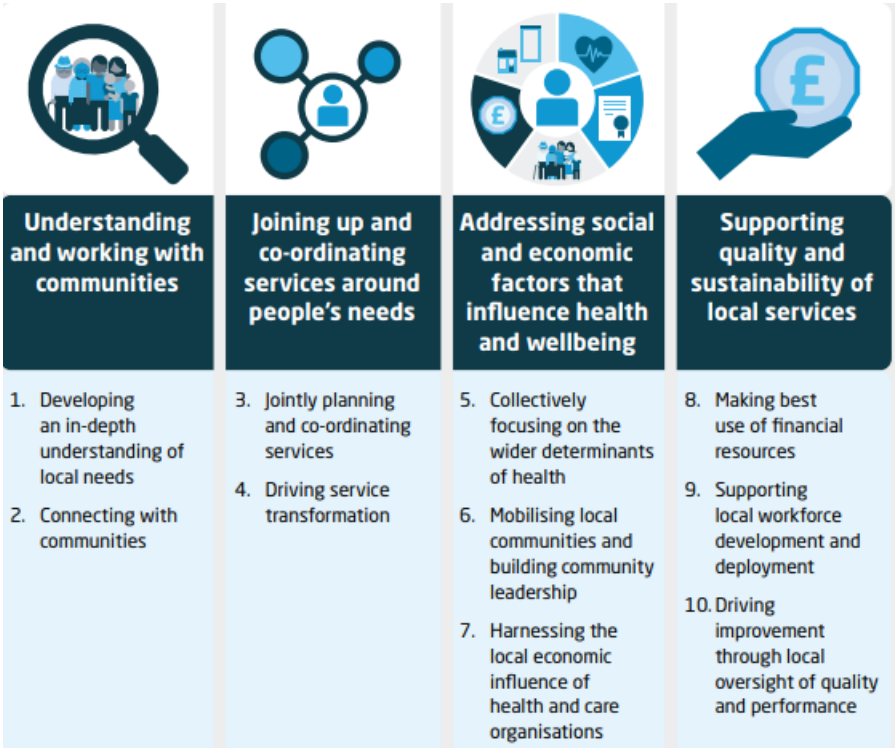
- Place-based Partnerships should start from understanding people and communities and agreeing shared purpose before defining structures.
- Effective partnerships are often built 'by doing' – acting together and building collaborative arrangements to support this action as it evolves.
- Governance arrangements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

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

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

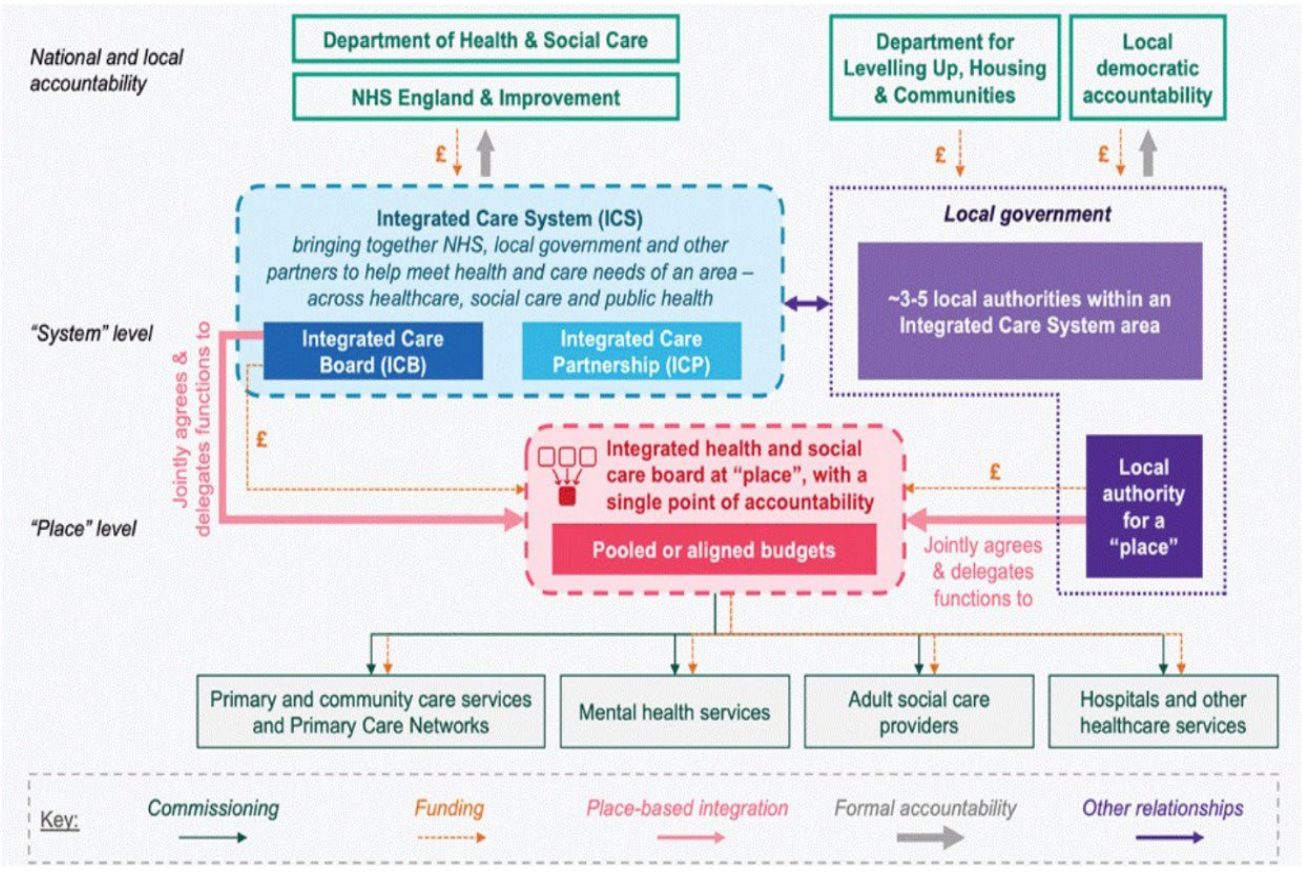
Previous discussions at Partnership Board have identified that a joint committee was the preferred way forward for Dudley at the appropriate point in time.

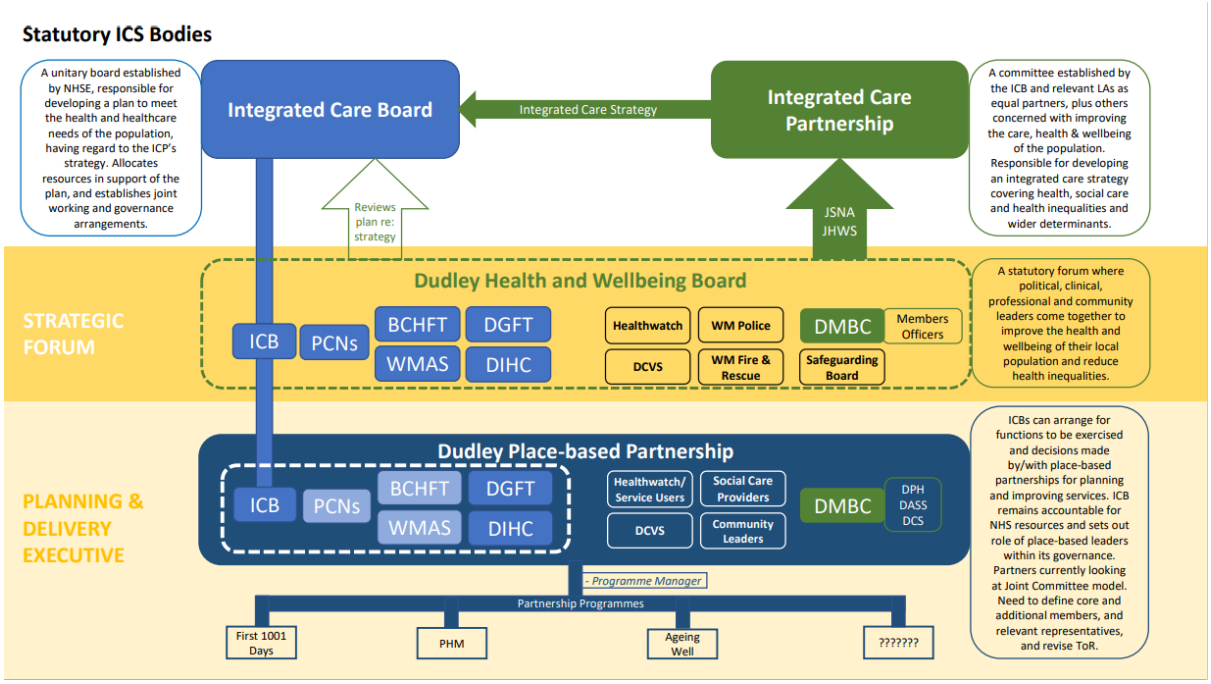
The Kings Fund have outlined 10 key functions that place based partnerships should perform:



| Understanding and working with communities | Joining up and co-ordinating services around people's needs | Addressing social and economic factors that influence health and wellbeing | Supporting quality and sustainability of local services |
|---|---|---|---|
| 1. Developing an in-depth understanding of local needs<br>2. Connecting with communities | 3. Jointly planning and co-ordinating services<br>4. Driving service transformation | 5. Collectively focusing on the wider determinants of health<br>6. Mobilising local communities and building community leadership<br>7. Harnessing the local economic influence of health and care organisations | 8. Making best use of financial resources<br>9. Supporting local workforce development and deployment<br>10. Driving improvement through local oversight of quality and performance |

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






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

## DUDLEY HEALTH & CARE DEVELOPMENT

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

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

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

At the Partnership Board in June 2022 an update on the progress that has been made by the place development programme was given. This programme is due to finish in

July 2022. As a result of the vision and leadership module a set of values for the Partnership Board have been agreed and are described below. There is unanimous support for these values to be adopted by the transformation groups that have been established to implement the integrated model of integrated care who have a developed the following vision statement '***Happy and Healthy Communities… Community where possible, Hospital when necessary.'*** The Dudley system, through the Vision and Leadership module of the Place Based Development Programme and the Accelerated Solutions Environment events that have taken place to develop the new integrated model of care, have agreed to adopt the vision statement above and the values below in all of their communications across the system.


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

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

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

The final iteration of the Model of Care has been developed with the Capgemini Team and the clinicians from the Integrated Model of Care Implementation Group. A system wide communication plan is currently being developed.

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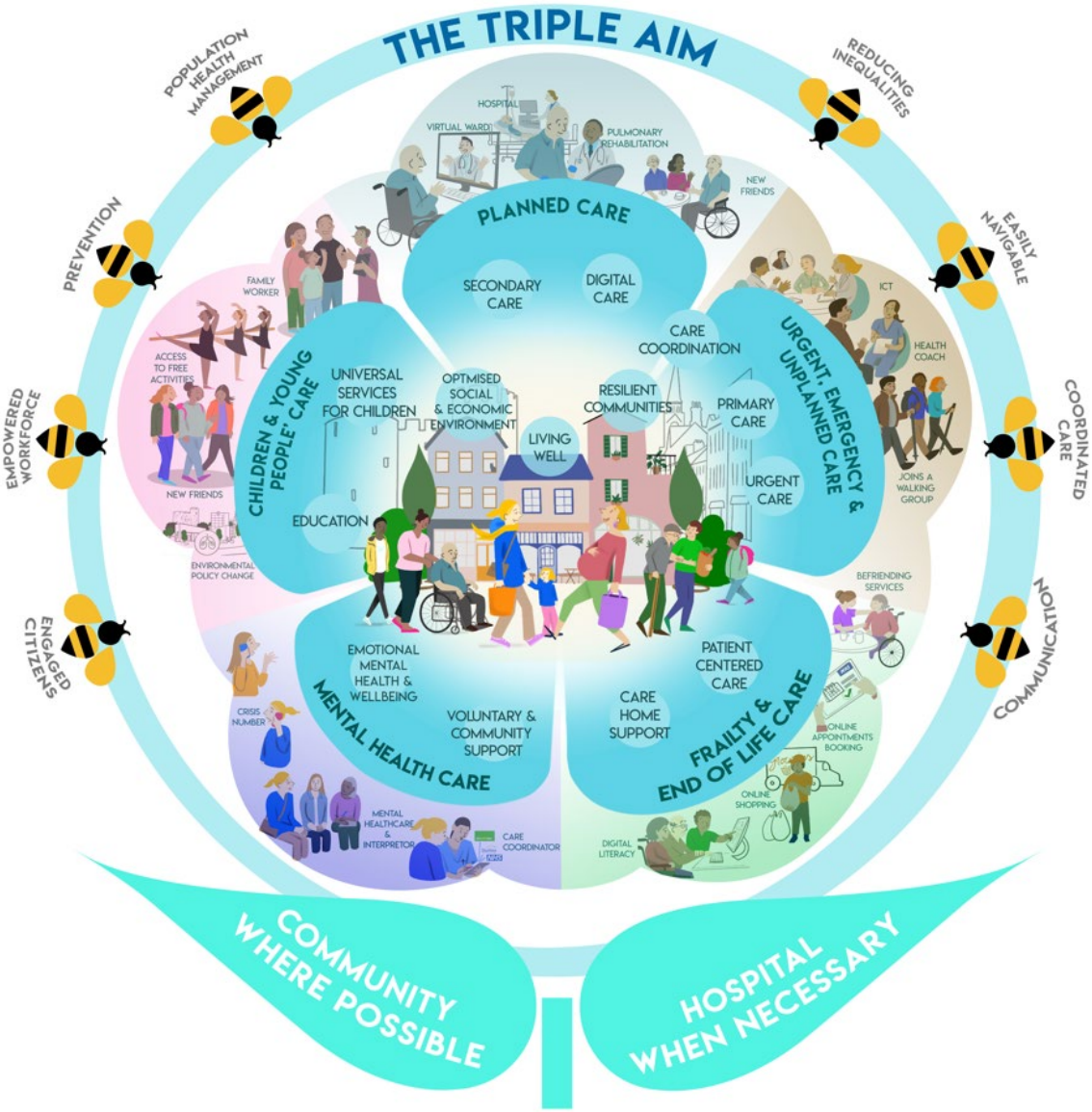
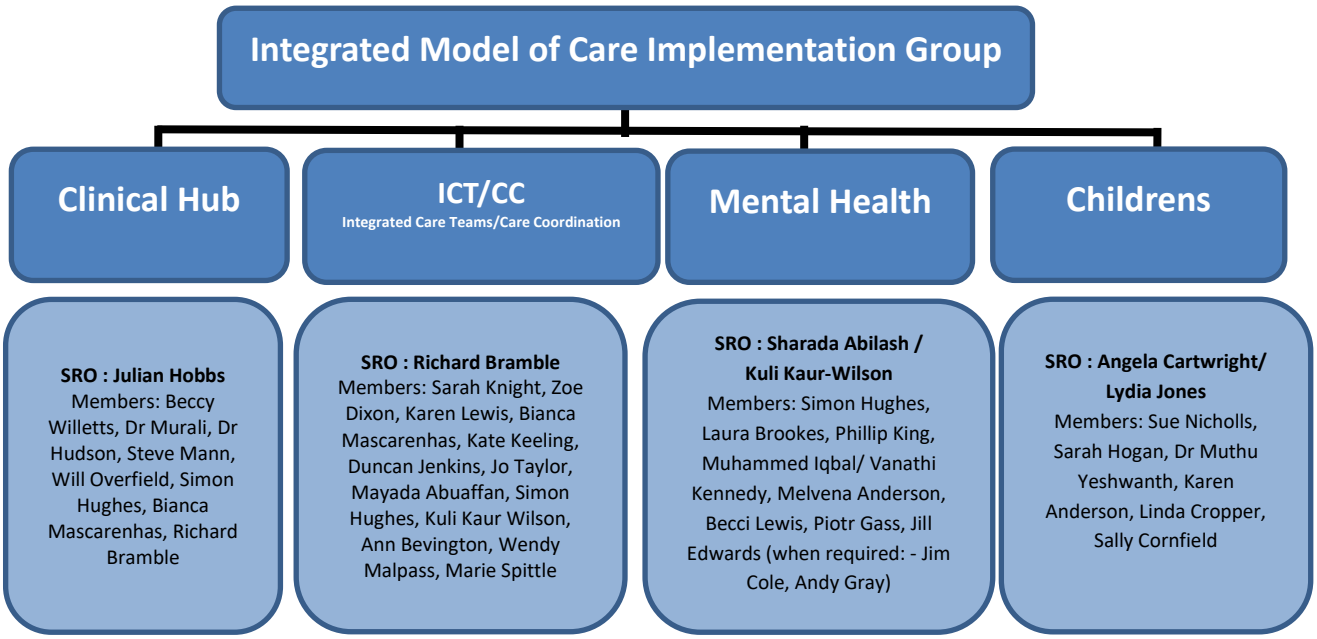



Following the ASE events an Integrated Model of Care Implementation Group has been established and initial priority Transformation Groups have been set up. It is proposed

that the Integrated Model of Care Implementation Group will report into the Dudley Health & Care Board. The terms of reference for this group are in Appendix A.

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




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

## OPTIONS FOR THE FUTURE

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

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

Currently the Partnership Board is being supported by a part time Programme Manager as it was recognised that to deliver the priorities at place some dedicated resources will be required. The Programme Manager has helped drive forward actions within one of the Partnership Boards priorities the first 1001 days. However as we mature and the

role of the System and Place becomes clearer there will be a need to have a full time dedicated resource to focus on providing direction to the 'engine room' team that needs to be established and supporting the Board to hold partners to account for implementing integration and collaboration within Dudley's health and social care services.

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

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

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

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

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

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

| System Role | Area | Dudley's Role |
|---|---|---|
| **Create system-wide strategies for**: (not an exhaustive list)<br>• System Finance Strategy<br>• System Digital Strategy<br>• Workforce Strategy<br>• ICP Integrated Care Strategy | **Set Strategy** | **Create Dudley strategies for:**<br>• Health and Well Being strategy<br>• Neighbourhood/PCN level strategies for population health management and reducing health inequalities.<br>• Workforce Development |
| Determine and set the priority areas of focus for System and Place. | **Determine Priorities** | Develop the delivery plan to address the agreed priorities<br>Develop plans for local "bottom-up" PHM initiatives. |

| | | |
|---|---|---|
| | | Publish the Joint Strategic Needs Assessment |
| Strategic allocation of resources between system and place and determine place-level allocations. | **Allocate Resources** | Tactical distribution of delegated resources to support the delivery of place priorities. |
| Strategic level commissioning where consistency of access and equality of outcome are paramount. | **Develop Commissioning / Access Policies** | Tactical level commissioning where variations in local infrastructure or organisation may prevent a single system solution and to support transformation |
| Programme leadership in national priority areas. | **Ensure Delivery** | Local delivery resources aligned to priority areas. |
| Set strategic outcomes for Place to aim for in their delivery plan and define the proxy performance measures to assess progress. | **Outcomes** | Report progress against the outcomes and proxy performance measures. |
| Oversee performance across System and Place priorities.<br>Manage reporting relationship with NHSE region and national.<br>Assure actions to address areas of concern. | **Performance** | Monitor detailed performance at local level.<br>Report to ICB on exceptions against agreed standards. |

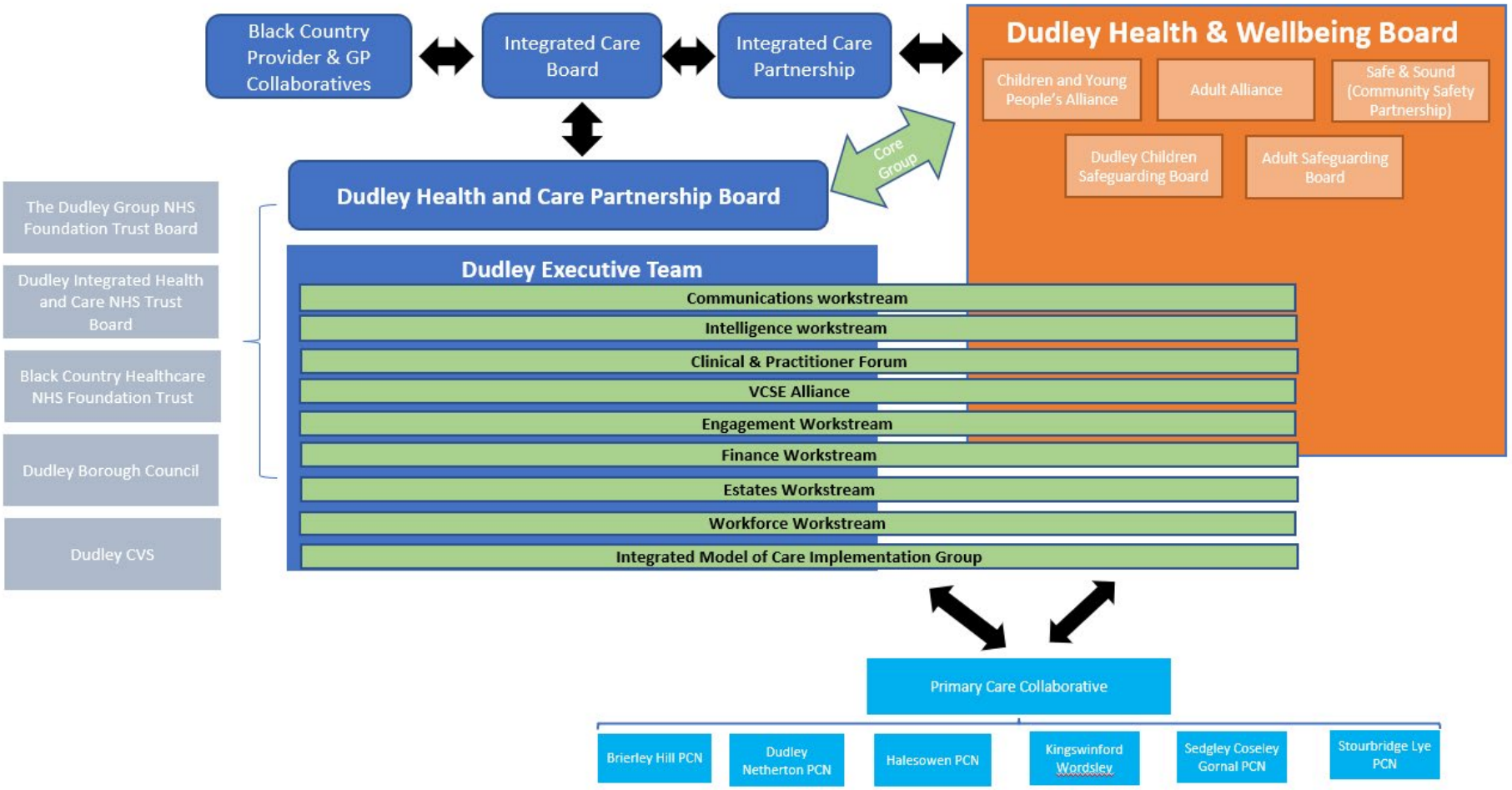
There are four places in the Black Country ICS aligned to the four local authorities. Different approaches to the development of Place-based Partnerships are in evidence. In preparation for the transition to becoming an ICS, the ICS as part of the Reset Governance Workstream has developed a discussion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

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

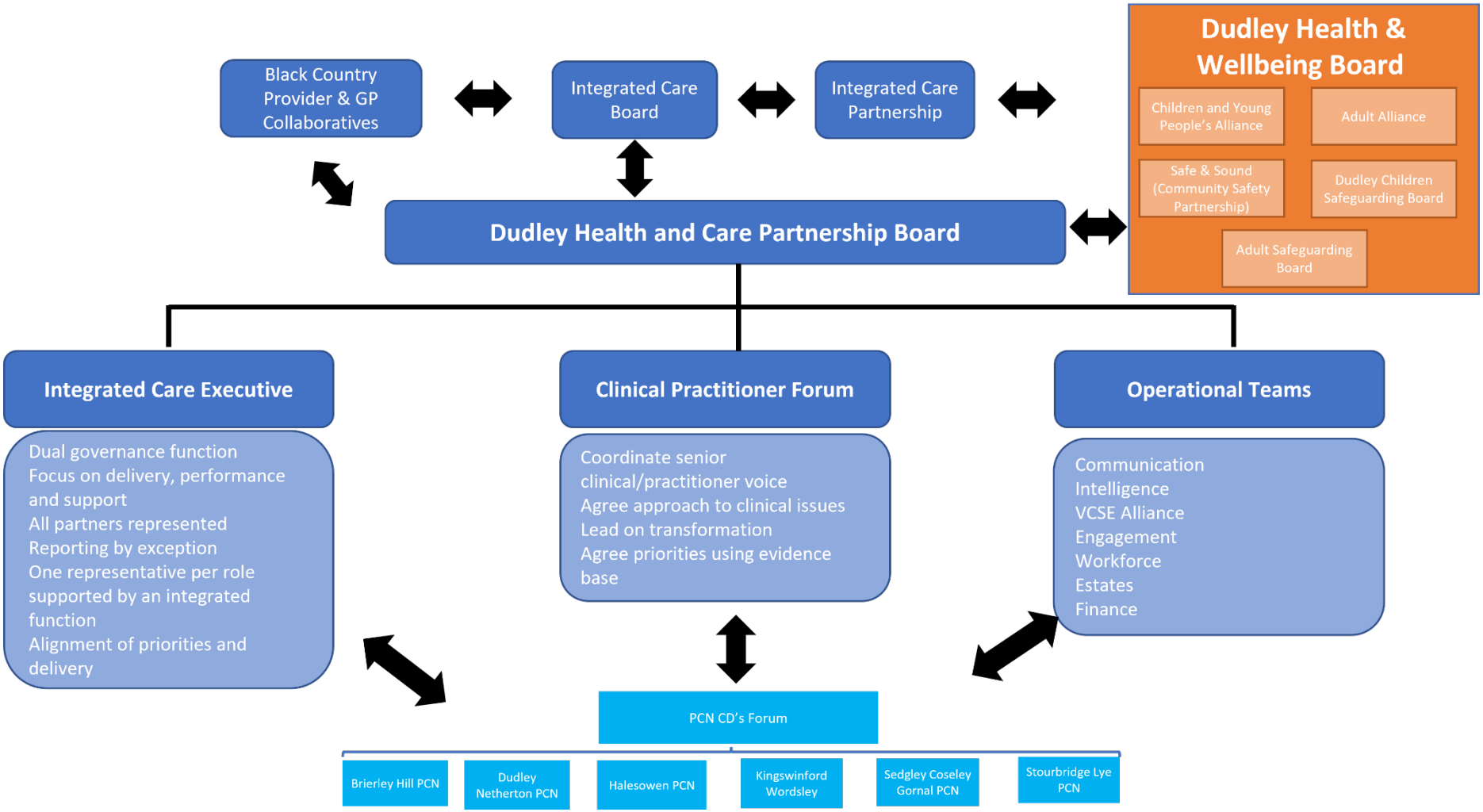
For each of the options partners should consider the ability to:

- make timely, effective, high-quality and enduring decisions;
- be accountable for the most effective use of very significant taxpayer funding;
- enable joined-up decision-making and delivery across the range of services meeting immediate care and support needs;
- support safe and effective delivery of ICB functions and responsibilities alongside wider functions of the partnership;
- take on executive responsibility for functions delegated by the ICS or local authority;
- enable non-statutory partners to play an appropriate role in decision-making
- support the exercise of primary care leadership, including through leadership and operational support.

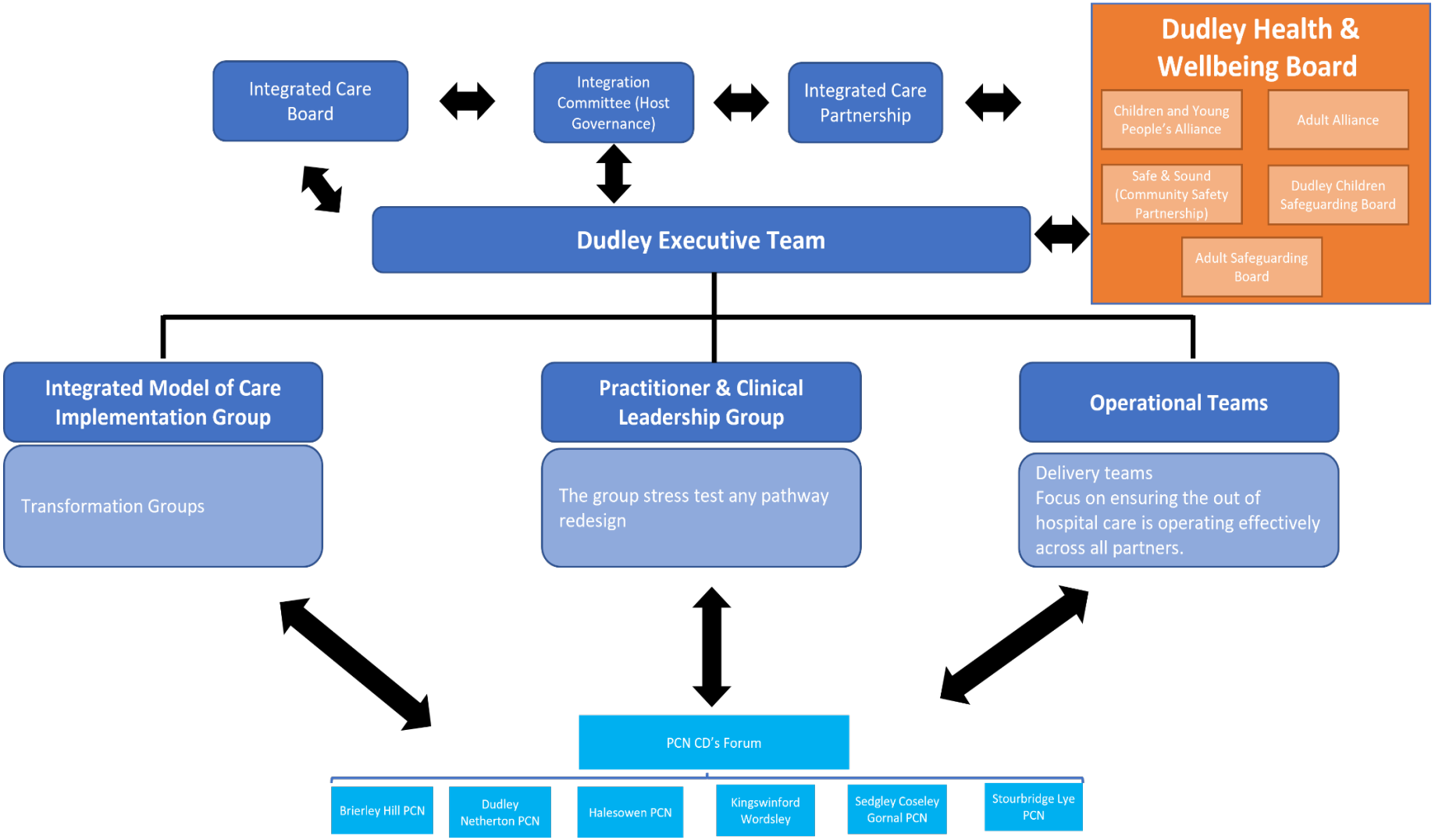
Option 1 – This option shows the establishment of the Dudley Health & Care Partnership Executive Team which would oversee the delivery of all of the various workstreams that would be established and would provide assurance to the Health & Care Partnership Board. The Health & Care Partnership Board could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



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



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



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

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

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

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

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

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

**Confirmations from the Partnership Board held on July 13th 2022**

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

## RECOMMENDATIONS

1. Partnership Board is renamed Dudley Health and Care Partnership Board and that the revised terms of reference in Appendix A have been approved.
2. Partnership Board moves towards operating as a Joint committee. Will be considered further in light of ICB delegation.
3. Option 1 is approved as the preferred governance structure for Dudley. During the transition period the Chief Executives and Chairs will continue to meet on a short term basis. It is envisaged that at the appropriate time this group will be stood down and replaced with a meeting of the Chief Executives of the Dudley system.
4. An Executive Team is established to support the Dudley Health and Care Partnership Board and the Terms of Reference in Appendix B are approved.
5. Partnership Board supports the establishment of the Integrated Model of Care Implementation Group and ratifies the Terms of Reference in Appendix C and approves it formally reporting into the Dudley Health and Care Partnership Board.
6. To appoint a short term Independent Chair for the Integrated Model of Care Implementation Group.
7. The Partnership Executive Team to consider the appointment of a new Programme Director who will be responsible for driving forward integration and collaboration in Health and Social Care within Dudley who would report to the Chair of the Partnership Board.
8. Further consideration to be given to commissioning arrangements following receipt of the paper developed through ICB Governance Workstream
9. This paper is shared with partner boards in September.

Appendix A

# Dudley Health & Care Partnership Board

## Terms of Reference: June 2022

## 1. PRIMARY PURPOSE/S

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

1.2 The DHCPB will be responsible for:

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

## 2. ACCOUNTABILITY

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

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

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

## 3. SCOPE

3.1 Will be delegated by the ICB

## 4. LEAD OFFICER

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

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

## 5. SERVICED BY

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

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

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

## 6. COMPOSITION & MEMBERSHIP

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

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

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

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

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

## 7. FREQUENCY OF MEETINGS

7.1 Meetings shall be held monthly.

## 8. QUORACY & DECISION MAKING

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

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

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

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

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

## 9. REPORTING ARRANGEMENTS

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

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

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

## 10. REVIEW DATE

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

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

## 11. DATE APPROVED

11.1 July 2022

Appendix B

# Dudley Health & Care Partnership Executive Team

## Terms of Reference – August 2022

## 1. PRIMARY PURPOSE/S

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

1.2

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

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

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

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

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

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

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

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

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

## 2. ACCOUNTABILITY

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

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

## 3. SCOPE & BOUNDARIES

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

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

## 4. LEAD OFFICER

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

## 5. SERVICED BY

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

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

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

## 6. COMPOSITION & MEMBERSHIP

6.1 The DPET will comprise of the following core members:

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

6.2 The DPET core membership will comprise these 9 members.

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

## 7. RESPONSIBILITIES

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

**Strategic Developments & Planning**

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

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

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

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

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

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

**Governance**

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

h. Overseeing an agreed place level integrated care risk register

**Performance**

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

**Resource management**

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

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

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

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

**Workforce, HR & OD**

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

**Communication & Engagement**

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

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

**Risk Management**

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

**Others**

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

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

## 8. RESOURCES

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

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

## 9. FREQUENCY OF MEETINGS

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

## 10. QUORACY

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

## 11. VOTING RIGHTS

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

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

## 12. REPORTING ARRANGEMENT & ESCALATION

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

## 13. MINUTES CIRCULATION

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

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

## 14. REVIEW DATE

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

## 15. DATE APPROVED

15.1 August 2022.

Appendix C

# INTEGRATED MODEL OF CARE IMPLEMENTATION GROUP
# Terms of Reference June 2022

## 1. PURPOSE & DUTIES

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

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

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

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

1.3. The functions of the Implementation Group are to:

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

## 2. MEMBERSHIP

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

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

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

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

## 3. ATTENDEES

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

## 4. ATTENDANCE

4.1. Members are expected to attend all meetings.

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

## 5. QUORUM

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

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

## 6. FREQUENCY OF MEETINGS

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

## 7. REVIEW AND REVISION

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

## 8. ADMINISTRATIVE ARRANGEMENTS

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

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

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

## 9. REPORTING ARRANGEMENTS

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

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

## 10. Date Approved

10.1 June 2022

Dudley Integrated Health and Care NHS Trust

# DUDLEY INTEGRATED HEALTH AND CARE NHS TRUST BOARD

| | |
|---|---|
| **TITLE OF REPORT:** | Provider Declarations |
| **PURPOSE OF REPORT:** | This paper informs the Board of the self-certification against the provider licence requirements which is mandatory for all NHS Trusts |
| **AUTHOR OF REPORT:** | Elaine Doyle, Trust Secretary |
| **DATE OF MEETING:** | 6th September 2022 |
| **KEY POINTS:** | Following an NHSEI review of provider licence compliance in July 2021 all NHS Trusts are required to make a declaration against two conditions within the provider licence.<br><br>The two conditions which NHS Trusts are required to comply with are:<br>• Condition 1 – G6 (3) Systems or compliance with licence conditions, in accordance with General condition 6 of the NHS provider licence.<br>• Condition 2 – FT4 (8) Compliance with statement of corporate governance.<br><br>The self-assessment indicates that the Trust meets the declaration requirements and no areas of significant risk have been identified.<br><br>Both declarations will be published on the Trust website and do not need to be submitted to NHSEI unless requested by them for the purposes of audit. NHSEI perform random audits and if we are selected, we will then be required to submit evidence of compliance, as necessary. |
| **RECOMMENDATION:** | • Approve the self-certification against the provider licence requirements for publication on the website |
| **ANY CONFLICTS OF INTEREST IDENTIFIED IN ADVANCE:** | None identified |
| **ACTION REQUIRED:** | Decision ☐<br>Approval ☒<br>Assurance ☐ |

This template may be used by Foundation trusts and NHS trusts to record the self-certifications that must be made under their NHS Provider Licence.
You do not need to return your completed template to NHS Improvement unless it is requested for audit purposes.

# Self-Certification Template - Conditions G6 and CoS7

**Dudley Integrated Health and Care NHS Trust** *Insert name of organisation*

Foundation Trusts and NHS trusts are required to make the following self-certifications to NHS Improvement:

*Systems or compliance with licence conditions - in accordance with General condition 6 of the NHS provider licence*
*Availability of resources and accompanying statement - in accordance with Continuity of Services condition 7 of the NHS provider licence (Foundation Trusts designated CRS providers only)*

These self-certifications are set out in this template.

**How to use this template**
1) Save this file to your Local Network or Computer.
2) Enter responses and information into the yellow data-entry cells as appropriate.
3) Once the data has been entered, add signatures to the document

**Worksheet "G6 & CoS7"**

Financial Year to which self-certification relates: 2021/22

## Declarations required by General condition 6 and Continuity of Service condition 7 of the NHS provider licence

*The board are required to respond "Confirmed" or "Not confirmed" to the following statements (please select 'not confirmed' if confirming another option). Explanatory information should be provided where required.*

**1 & 2 General condition 6 - Systems for compliance with licence conditions (FTs and NHS trusts)**

1 Following a review for the purpose of paragraph 2(b) of licence condition G6, the Directors of the Licensee are satisfied that, in the Financial Year most recently ended, the Licensee took all such precautions as were necessary in order to comply with the conditions of the licence, any requirements imposed on it under the NHS Acts and have had regard to the NHS Constitution. — Confirmed

**3 Continuity of services condition 7 - Availability of Resources (FTs designated CRS only)**

EITHER:

3a After making enquiries the Directors of the Licensee have a reasonable expectation that the Licensee will have the Required Resources available to it after taking account distributions which might reasonably be expected to be declared or paid for the period of 12 months referred to in this certificate. — Confirmed

OR

3b After making enquiries the Directors of the Licensee have a reasonable expectation, subject to what is explained below, that the Licensee will have the Required Resources available to it after taking into account in particular (but without limitation) any distribution which might reasonably be expected to be declared or paid for the period of 12 months referred to in this certificate. However, they would like to draw attention to the following factors (as described in the text box below) which may cast doubt on the ability of the Licensee to provide Commissioner Requested Services.

OR

3c In the opinion of the Directors of the Licensee, the Licensee will not have the Required Resources available to it for the period of 12 months referred to in this certificate.

**Statement of main factors taken into account in making the above declaration**

In making the above declaration, the main factors which have been taken into account by the Board of Directors are as follows:

No qualifications other then recognising the impact of the system financial plan for 2022/23

Signed on behalf of the board of directors, and, in the case of Foundation Trusts, having regard to the views of the governors

| | | |
|---|---|---|
| **Signature** | | **Signature** |
| **Name** | Harry Turner | **Name** | Penny Harris |
| **Capacity** | Chair | **Capacity** | Chief Executive Officer |
| **Date** | ########## | **Date** | 22 June 2022 |

Further explanatory information should be provided below where the Board has been unable to confirm declarations under G6.

This template may be used by Foundation trusts and NHS trusts to record the self-certifications that must be made under their NHS Provider Licence.
You do not need to return your completed template to NHS Improvement unless it is requested for audit purposes.

# Self-Certification Template - Condition FT4

**Dudley Integrated Health and Care NHS Trust** *Insert name of organisation*

Foundation Trusts and NHS trusts are required to make the following self-certifications to NHS Improvement:

*Corporate Governance Statement - in accordance with Foundation Trust condition 4 (Foundations Trusts and NHS trusts)*
*Certification on training of Governors - in accordance with s151(5) of the Health and Social Care Act (Foundation Trusts only)*

These self-certifications are set out in this template.

**How to use this template**

1) Save this file to your Local Network or Computer.
2) Enter responses and information into the yellow data-entry cells as appropriate.
3) Once the data has been entered, add signatures to the document.

**Worksheet "FT4 declaration"**

**Financial Year to which self-certification relates** | **2021/22**

## Corporate Governance Statement (FTs and NHS trusts)

*The Board are required to respond "Confirmed" or "Not confirmed" to the following statements, setting out any risks and mitigating actions planned for each one*

| | Corporate Governance Statement | Response | Risks and Mitigating actions |
|---|---|---|---|
| 1 | The Board is satisfied that the Licensee applies those principles, systems and standards of good corporate governance which reasonably would be regarded as appropriate for a supplier of health care services to the NHS. | Confirmed | There are no conditions imposed upon the Trust to prevent discharging of our statutory responsibilities and all services that are subject to CQC inspection are rated as Good. |
| 2 | The Board has regard to such guidance on good corporate governance as may be issued by NHS Improvement from time to time | Confirmed | Standing Orders and Standing Financial Instructions have been reviewed and updated with all appropriate guidance reviewed. Board and Committee Effectiveness Reviews have been completed and the Audit and Risk Committee has taken account of the HFMA Audit Committee handbook and taken appropriate action as necessary. |
| 3 | The Board is satisfied that the Licensee has established and implements:<br>(a) Effective board and committee structures;<br>(b) Clear responsibilities for its Board, for committees reporting to the Board and for staff reporting to the Board and those committees; and<br>(c) Clear reporting lines and accountabilities throughout its organisation. | Confirmed | The Board has undertaken a comprehenive Effectiveness Review including reviiew of the Consitution and Standing Orders. There are clear governance structure supported by Board agreed Terms of Reference for each of its principle commtitees. NED Chairs and membership have been considered and there are clear responsibiltiies in place includiing assurance Board, with robust papers presented to the Board and robust consideration of risk and assurance. |
| 4 | The Board is satisfied that the Licensee has established and effectively implements systems and/or processes:<br><br>(a) To ensure compliance with the Licensee's duty to operate efficiently, economically and effectively;<br>(b) For timely and effective scrutiny and oversight by the Board of the Licensee's operations;<br>(c) To ensure compliance with health care standards binding on the Licensee including but not restricted to standards specified by the Secretary of State, the Care Quality Commission, the NHS Commissioning Board and statutory regulators of health care professions;<br>(d) For effective financial decision-making, management and control (including but not restricted to appropriate systems and/or processes to ensure the Licensee's ability to continue as a going concern);<br>(e) To obtain and disseminate accurate, comprehensive, timely and up to date information for Board and Committee decision-making;<br>(f) To identify and manage (including but not restricted to manage through forward plans) material risks to compliance with the Conditions of its Licence;<br>(g) To generate and monitor delivery of business plans (including any changes to such plans) and to receive internal and where appropriate external assurance on such plans and their delivery; and<br>(h) To ensure compliance with all applicable legal requirements. | Confirmed | The Board is satisfied that:<br>(a) The Trust operates efficiently, economically and effectively and received an unqualified value for money opinion from its Audtors.<br>(b) Timely and effective finance and performance reports are recevied through the Trust governance structure from its Committees to Board.<br>(c) There are no restrictions applied by any of the regulators incuding SoS, CQC, or any other regulators.<br>(d) The Trust remains a going concern as confirmed by the Audtors opinion on the accounts.<br>(e) Comprehensive, timely and relevant information is considered by the Committees and Board monthly.<br>(f) There is in place a robust Board Assurance Framework and risk management system in place to identify and manage risk and compliance.<br>(g) There is a Businss Plan and Strategic Priorities supported by a detailed milestone plan with external assurance against delivery through the Annual Report.<br>(h) The Trust complies with all its legal requirements. |

| | | | |
|---|---|---|---|
| 5 | The Board is satisfied that the systems and/or processes referred to in paragraph 4 (above) should include but not be restricted to systems and/or processes to ensure:<br><br>(a) That there is sufficient capability at Board level to provide effective organisational leadership on the quality of care provided;<br>(b) That the Board's planning and decision-making processes take timely and appropriate account of quality of care considerations;<br>(c) The collection of accurate, comprehensive, timely and up to date information on quality of care;<br>(d) That the Board receives and takes into account accurate, comprehensive, timely and up to date information on quality of care;<br>(e) That the Licensee, including its Board, actively engages on quality of care with patients, staff and other relevant stakeholders and takes into account as appropriate views and information from these sources; and<br>(f) That there is clear accountability for quality of care throughout the Licensee including but not restricted to systems and/or processes for escalating and resolving quality issues including escalating them to the Board where appropriate. | **Confirmed** | The Board is satisfied that:<br>(a) The Trust has sufficient capacity at Board to provide effective leadership and quality of care through the Executive Directors and Chief Executive Officer. The Board has Joint Acting Medical Directors who are General Practitioners, Director of Nursing, AHPs and Quality and Chief Operating Officer with a professional nursing background and three additional GP Non-Executive Directors.<br>(b) The Strategic Priorities, Quality Accounts and Quality Priorities articulate the continued focus on quality of care and the Board and Committees receive stories from Service Users, Staff, Services from clincial and non-clinical backgrounds and reports from the Medical and Nursing and AHP Senior Leadership.<br>(d) Timely and effective reports on quality of care through Quality and Safety Performance including Infection, Prevention and Control are recevied through the Trust governance structure from its Committees to Board.<br>(e) The Trust actively engages with service users, staff and stakeholders and takes into account appropriate views.<br>(f) There is accountabiliity for quality of care embedded into the assurance and governance processes for Board. |
| 6 | The Board is satisfied that there are systems to ensure that the Licensee has in place personnel on the Board, reporting to the Board and within the rest of the organisation who are sufficient in number and appropriately qualified to ensure compliance with the conditions of its NHS provider licence. | **Confirmed** | The Board is satisfied that there are sufficient capacity and capability and appropriate numbers of Board members, Non-Eecutive and Executive Directors. All Board members have completed their Fit and Proper Persons declarations. |

Signed on behalf of the Board of directors, and, in the case of Foundation Trusts, having regard to the views of the governors

| | |
|---|---|
| **Signature** | **Signature** |
| **Name** Harry Turner | **Name** Penny Harris |

| | |
|---|---|
| | Further explanatory information should be provided below where the Board has been unable to confirm declarations under FT4. |
| A | |

Dudley Integrated Health and Care NHS Trust

# DUDLEY INTEGRATED HEALTH AND CARE NHS TRUST BOARD

| | |
|---|---|
| **TITLE OF REPORT:** | Use of Trust Seal |
| **PURPOSE OF REPORT:** | Report to update the Board on the use of the Trust Seal |
| **AUTHOR OF REPORT:** | Elaine Doyle, Trust Secretary |
| **DATE OF MEETING:** | 6th September 2022 |
| **KEY POINTS:** | The Standing Orders outline the process for the use of the common seal of the Trust. The Board are asked to note that following a resolution of the Board at the Extra-Ordinary meeting of the seal was used during June 2022, details are outlined below:<br>• Deed of Indemnity between Philip King and DIHC, was signed by the Chief Executive Officer and Trust Secretary on 29th June 2022, the common seal was applied. |
| **RECOMMENDATION:** | • Note the use of the Trust Seal |
| **ANY CONFLICTS OF INTEREST IDENTIFIED IN ADVANCE:** | None identified |
| **ACTION REQUIRED:** | Decision ☐ |
| | Approval ☐ |
| | Assurance ☒ |