Bundle Board Meeting 12 September 2024

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PUBLIC SESSION

The Dudley Group NHS Foundation Trust

Board of Directors
Thursday 12 September at 10:00am
Stourbridge Health & Social Care Centre, John Corbett Dr, Amblecote, Stourbridge DY8 4JB
AGENDA

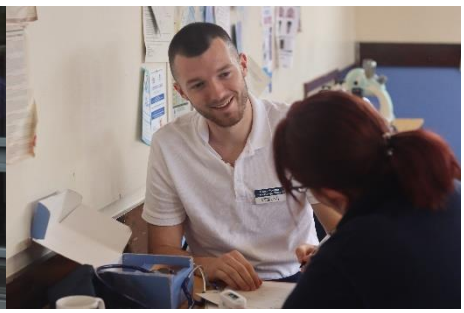
	ITEM	PAPER REF	LEAD	PURPOSE	TIME
1	**Chairman's welcome and note of apologies**	Verbal	Chair	For noting	10:00
2	**Staff & Patient Story – Ward B6 Frailty Services** Introduced by H Bromage, Deputy Chief Nurse				
3	**Declarations of Interest**	Enclosure 1	Chair	For noting	10:20
4	**Minutes of the previous meeting** Thursday 11 July May 2024 Action Sheet 11 July 2024	Enclosure 2 All complete	Chair	For approval	
5	**Chief Executive's Overview**	Enclosure 3	D Wake	For information & assurance	
6	**Chair's Update** - Public questions (as submitted)	Verbal / enclosure	Chair	For information	
6.1	Integrated Committee upward assurance report - Finance & Performance, Quality, People, Integration - Joint Provider Committee	Enclosure 4 Enclosure 5	G Crowe with Non-executive committee chairs	For approval	
7	**Drive sustainability financial and environment** Reduce the cost per weighted activity | Reduce carbon emissions				11:30
7.1	Finance & Productivity matters • Finance report Month 4 (July '24) inc. Cost Improvement update	Enclosure 6	C Walker	For approval	
	Comfort break (10 mins)				
8	**Build Innovative Partnerships in Dudley & beyond** Increase the proportion of local people employed | Increase the number of services jointly across the Black Country				11:50
8.1	Integrated Performance Dashboard *Full report in further reading pack*	Enclosure 7	K Kelly	For assurance	
9	**Deliver right care every time** CQC rating good or outstanding | Improve the patient experience survey results				12:10
9.1	Chief Nurse & Medical Director report *Safer Staffing report in further reading pack*	Enclosure 8	H Bromage/ P Brammer	For assurance	
9.2	Perinatal Clinical Quality Surveillance - Maternity Incentive Scheme year 6 update	Enclosure 9	C Macdiarmid / S Muammar	For assurance	
10	**To be a brilliant place to work and thrive** Reduce the vacancy rate | Improve the staff survey results				12:25

10.1	Workforce Key Performance indicators *Full report in further reading pack*	Enclosure 10	K Brogan	For approval	
11	**GOVERNANCE**				12:35
11.1	Strategy and Annual Plan progress report – Q1 2024/25	Enclosure 11	A Thomas	For approval	
11.2	Board & Committee Effectiveness review	Enclosure 12	H Board	For approval	
11.3	Board Assurance Framework	Enclosure 13	H Board	For approval	
12	**Any Other Business**		All	For noting	
13	**Date of next Board of Directors meeting** (public session) Thursday 14 November 2024				
14	**Meeting close**				13:00
Quorum: One Third of Total Board Members to include One Executive Director and One Non-executive Director					

Board of Directors Meeting Public Papers

Thursday 12th May 2024
10:00 – 13:30

Stourbridge Health & Social Care centre,
John Corbett Drive,
Stourbridge, DY8 4JB



BOARD MEETINGS
PUBLIC INFORMATION SHEET

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

1. Introduction

This sheet provides some information about how Board meetings work.

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

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

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

Helen Attwood
Directorate Manager to:
Sir David Nicholson, Chairman
The Dudley Group NHS Foundation Trust
And, Sandwell & West Birmingham Hospitals NHS Trust
DDI: 01384 321012 (Ext. 1012)
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Helen Board
Board Secretary
The Dudley Group NHS Foundation Trust
Tel: 01384 321124 ext 1124
email: helen.board@nhs.net

2. Board Members' interests

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

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

3. Opportunity for questions

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

4. Debate

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

5. Minutes

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

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

6. Key Contacts

Andy Proctor
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Tel: 01384 4561111
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Helen Attwood
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And, Sandwell & West Birmingham Hospitals NHS Trust
DDI: 01384 321012 (Ext. 1012)
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Enclosure 1

Register of interests 01/04/2024 - 31/03/2025

Accessed 30/08/2024

Name	Position	Date of interest	Description	Value	Was Accepted	Percentage Of Shareholding
Elizabeth Abbiss	Director of Communications	05/06/2023	Commenced work at Sandwell & West Birmingham NHS Hospitals Trust one day per week as Strategic Communications Advisor			
Karen Brogan	Chief People Officer	19/07/2024	Nil			
Gary Crowe	Deputy Chair	01/09/2019	Independent Member, The Human Tissue Authority			
Gary Crowe	Deputy Chair	01/09/2019	Non Executive Director, University Hospitals of North Midlands NHS Trust			
Gary Crowe	Deputy Chair	01/09/2019	Occasional lecturer, Keele University			
Peter Featherstone	Non-Executive Director	23/10/2023	Associate consultant, Commercially Public Ltd, management consultant to local authorities			
Peter Featherstone	Non-Executive Director	30/07/2024	Interim Programme Design Lead - Children's Model of Care, London Borough of Hounslow			
Peter	Non-Executive Director	01/02/2024	NED, Dudley Integrated Health and Care NHS Trust			
Peter	Non-Executive Director	01/11/2018	NED, Shropshire Community Health NHS Trust			
Peter	Non-Executive Director	10/07/2008	Featherstone Management Consultancy Ltd, Managing director and company owner			100
Joanne Hanley	Non-Executive Director	01/01/2004	Executive employment with Lloyds Banking Group			
Anthony Hilton	Associate Non-Executive Director	19/07/2024	Nil			
Anthony Hilton	Associate Non-Executive Director	01/03/2020	Aston University - Pro-vice Chancellor and Executive Dean			
Anthony Hilton	Associate Non-Executive Director	01/01/2010	Director, Microbiology Consulting Limited			
William Hobbs	Medical Director - Operations	19/07/2024	Nil			
Catherine Holland	Senior Independent Director	30/08/2024	Nil			
Elizabeth Hughes	Non-Executive Director	03/09/2021	Medical Director NHS England (formerly Health Education England)			
Elizabeth Hughes	Non-Executive Director	02/08/2021	Appointed Honorary Professor at Warwick Medical School			
Elizabeth Hughes	Non-Executive Director	01/04/1990	Consultant Chemical Pathologist Sandwell and West Birmingham Hospitals NHS trust			
Elizabeth Hughes	Non-Executive Director	20/06/2021	Development of educational material for Novartis			
Elizabeth Hughes	Non-Executive Director	01/04/2018	Director Dinwoodie Charitable Company			
Elizabeth Hughes	Non-Executive Director	26/11/2021	Educational Speaker for Amgen			
Elizabeth Hughes	Non-Executive Director	08/05/2021	Educational Speaker for Sobi educational material preparation			
Elizabeth Hughes	Non-Executive Director	06/10/2020	Educational Speakers Bureau Daiichyi Sankyo -occasional lecture			
Elizabeth Hughes	Non-Executive Director	01/09/2016	Honorary Professor University of Aston			
Elizabeth Hughes	Non-Executive Director	01/07/2008	Honorary Professor University of Birmingham			
Elizabeth Hughes	Non-Executive Director	01/03/2017	Honorary Professor University of Worcester			
Elizabeth Hughes	Non-Executive Director	01/06/2022	Non-executive Director - chair of Quality Committee for Birmingham and Solihull ICS			
Elizabeth Hughes	Non-Executive Director	01/01/2022	Professor of General Practice University of Bolton			
Elizabeth Hughes	Non-Executive Director	01/04/2022	Speakers Bureau Amarin occasional lecture			
Elizabeth Hughes	Non-Executive Director	01/07/2024	Speakers Bureau Novo Nordisk - 0ccasional lecture and preparation of educational material			
Elizabeth Hughes	Non-Executive Director	03/07/2007	Trustee HEARTUK charity			
Elizabeth Hughes	Non-Executive Director	08/03/2023	Honorary Professor (Vice Chancellor) University of Coventry			

Register of interests 01/04/2024 - 31/03/2025

Accessed 30/08/2024

Elizabeth Hughes	Non-Executive Director	01/12/2023	Sponsorship of community lipid clinics by Amarin			
Elizabeth Hughes	Non-Executive Director	01/12/2023	Sponsorship of nursing and admin staff for community lipid clinics within sandwell and west Birmingham for a maximum of 2 years			
Karen Kelly	Chief Operating Officer	30/08/2024	Nil			
Mohit Mandiratta	Non-Executive Director	01/01/2016	Chair Dudley Prescribing and Medicines Optimisation Sub-committee (DIHC)			
Mohit Mandiratta	Non-Executive Director	01/01/2021	GP on BBC Breakfast -			
Mohit Mandiratta	Non-Executive Director	01/01/2018	GP Partner at Feldon Practice, Halesowen			
Mohit Mandiratta	Non-Executive Director	01/06/2024	Futureproof Health Ltd- Practice based shareholding			0
Martina Morris	Chief Nurse	01/03/2024	Maintain membership of Royal College of Nursing 1342889			
Anne-Maria	Non-Executive Director	01/07/2023	Chair of small Ltd company called Nuture Care Ltd			
David Nicholson	Chairman	01/04/2023	Chair - Royal Wolverhampton NHS Trust and Walsall Healthcare NHS Trust			
David Nicholson	Chairman	01/09/2022	Chair - Sandwell and West Birmingham Hospitals NHS Trust			
David Nicholson	Chairman	01/09/2022	Visiting Professor - Global Health Innovation, Imperial College			
David Nicholson	Chairman	01/01/2023	Spouse appointed National Director of Urgent and Emergency Care and Deputy Chief Operating Officer of the NHS (full-time)			
Ita O'Donovan	Non-Executive Director	01/01/2010	Managing director - Beechgrove Associates LTD. Own company, consultancy in local government			100
Andrew Proctor	Director of Governance	10/05/2024	Trustee for The Countryside Charity (CPRE), Staffordshire. Voluntary/Unremunerated charity			
Vijith Randeniya	Non-Executive Director	06/02/2024	Commissioner for South Wales Fire and Rescue Service.			
Vijith Randeniya	Non-Executive Director	06/10/2014	Board member of Aston University			
Vijith Randeniya	Non-Executive Director	01/05/2023	Chair of Birmingham Women and Childrens facilities management company called Vital			
Vijith Randeniya	Non-Executive Director	05/10/2020	Chair, Trent Regional Flood and Coastal Committee, DEFRA			
Vijith Randeniya	Non-Executive Director	01/08/2022	Director of Dudley Clinical Services Limited which is 100% owned subsidiary of the Trust			0
Kathleen Rose	Director of Integration	29/07/2024	Nil			
Adam Thomas	Chief Strategy and Digital Officer	01/07/2019	Director of Dudley Clinical Services Limited which is 100% owned subsidiary of the Trust			0
Diane Wake	Chief Executive	27/04/2024 - 27/04/2024	Attended Aston Villa Game (Diane and spouse) in an executive box at an Aston Villa game -	500.00	Yes	
Diane Wake	Chief Executive	04/07/2022	Provider CEO member on the BC ICB Board			
Diane Wake	Chief Executive	01/03/2023	Spouse: Peter Williams, appointed non-executive director at University Hospitals Birmingham			
Chris Walker	Finance Director	09/10/2012	Director of Dudley Clinical Services Limited which is a 100% owned subsidiary company of the			
Lowell Williams	Non-Executive Director	01/08/2017	Chair, Dudley Academies Trust			
Lowell Williams	Non-Executive Director	01/04/2021	Director of Dudley Clinical Services Limited which is 100% owned subsidiary of the Trust			0
Lowell Williams	Non-Executive Director	01/12/2019	Lowell Williams Consulting Limited			100
Lowell Williams	Non-Executive Director	24/10/2023	Registered as Director at NCHSR Limited. National College for High Speed Rail			0
Lowell Williams	Non-Executive Director	01/04/2022	Director - Transformational Technologies Partnership Ltd (which oversees the Black Country & Marches Institute of Technology)			
Lowell Williams	Non-Executive Director	04/05/2023	Elected as a Councillor to Warwick District Council on behalf of the Green Party			

Enclosure 2

The Dudley Group
NHS Foundation Trust

UNCONFIRMED Minutes of the Public Board of Directors meeting (Public session) held on Thursday 11th July 2024 10:00hr
Rooms 7&8, Clinical Education Centre, Russells Hall Hospital, Dudley

Present:
Liz Abbiss, Director of Communications (LA)
Karen Brogan, Interim Chief People Officer (KB)
Peter Featherstone, Non-executive Director (PF)
Joanne Hanley, Non-executive Director (JHa)
Anthony Hilton, Associate Non-executive Director (AH)
Julian Hobbs, Medical Director (JHo)
Catherine Holland, Non-executive Director (CH)
Liz Hughes, Non-executive Director (LH)
Karen Kelly, Chief Operating Officer/Deputy Chief Executive (KK)
Mohit Mandiratta, Non-executive Director (MMa)
Martina Morris, Chief Nurse (MM)
Sir David Nicholson (SDN) **Chair**
Andy Proctor, Director of Governance (AP)
Kat Rose, Director of Integration (KR)
Adam Thomas, Executive Chief Strategy & Digital Officer (AT)
Diane Wake, Chief Executive (DW)
Chris Walker, Interim Director of Finance (CW)
Lowell Williams, Non-executive Director (LW)

In Attendance:
Helen Board, Board Secretary (HB)
Bobbie Bedford, Lead Nurse, Renal Unit and colleagues [for item 2]
April Burrows, Freedom to Speak Up Guardian (AB) [for item 10.4]
Alison Fisher, Executive Officer (Minutes) (AF)
Claire Macdiarmid, Head of Midwifery (CM) [for item 9.3]
Madhuri Mascarenhas, Governance Admin. Lead (MM)
Basem Muammar (BM) [for item 9.3]
Paul Singh, Head of Equality, Diversity and Inclusion (PS) [for item 10.2

Apologies
Fouad Chaudhry, Guardian of Safe Working
Gary Crowe, Deputy Chair
Liz Hughes, Non-executive Director
Anne-Maria Newham, Non-executive Director
Ita O'Donovan, Associate Non-executive Director
Vij Randeniya, Non-executive Director

Governors and Members of the Public and External attendees
Pat Bradley, FT member
Benn Russell, FT member
Nandi Shelembe, FT member

24/57 Note of Apologies and Welcome

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

The Chair welcomed newly appointed Non-executive Director Dr Mohit Mandiratta to his first Board meeting.

24/58 Staff and Patient Story – Renal Services

MM introduced the Patient Story. The meeting was joined by the Renal Unit Lead Nurse, Bobbie Bedford and two members of her team.

The story focussed on improving the home Haemodialysis patient pathway, a service provided for over 30 years with a decline in numbers in recent years for a number of reasons.

The Board heard Carol's story who had been a long time user of the service with both positive and negative experiences. Following several failed kidney transplants, Carol has continued to work closely with the team and lives a fulfilled life on home dialysis with lots of holidays abroad.

The Board thanked the team for their good presentation and for the fantastic work they do for the patients of Dudley.

It was **RESOLVED** to

- Note the patient story

24/59 Declarations of Interest

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

24/60 Minutes of the previous meeting held on 9th May 2024

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

It was **RESOLVED** to

- approve the minutes of the last meeting

Action Sheet of 9th May 2024

All actions were noted to be complete.

24/61 Chief Executive's Overview and Operational Update

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

Urgent care activity had remained high with good management of ambulance handovers to maintain performance. Six cubicles within the ED department were to be closed whilst a new floor was laid and noted mitigations were in place to maintain flow.

On elective recovery there were zero patients waiting for 104 or 78 weeks and the focus would be on clearing the backlog of 65 weeks by the end of September 2024. Profiling was taking place on a trajectory to achieve 18 weeks by September 2028.

The Trust's diagnostic performance remained above target and on trajectory to achieve 95% by March 2025.

The board were asked to note the strong cancer services performance with the Trust achieving 80% against a 70% standard.

The latest industrial action by junior doctors had taken place at the end of June and advised that effective planning and mitigations had only incurred a small impact on patient services.

The Black Country Provider Collaborative continued to work well, with key workstreams actively focussed on delivery of key objectives.

The Trust's charity had been rebranded, with excellent areas of fundraising taking place in recent weeks including the superhero fun run held at Himley Hall.

Chief Pharmacist Ruckie Kahlon had been designated as Fellow of the Royal Pharmaceutical Society for distinction in the profession of Pharmacy. The Board commended Ruckie for her excellent work.

Congratulations were given to all Committed to Excellence winners and in particular Professor Ishaq for his lifetime achievement award.

PF asked about the impact of the Black Country Provider Collaborative Allocate e-rostering proposal. KB commented that there was a national level of attainment for e-rostering. The trust currently had three rostering systems and was working to reduce this and noted the opportunities to work with the four providers to align e-rostering to deliver benefits. Contract end date alignment across providers had taken place to fully realise benefits.

MMa raised the workforce and estate issues within the Pharmacy aseptic unit and asked what mitigations were in place to ensure the service was maintained. DW confirmed that a plan to future proof the aseptic services across the Black Country was in development that included a feasibility study at Sandwell and Dudley. AT commented that workforce modelling within pharmacy would need to change nationally to retain our staff. KB confirmed that training and retention initiatives were in place within the Dudley Group pharmacy teams and succession planning was underway with workforce mitigations in place.

It was **RESOLVED**

- To note the report and assurances provided

23/62 Chair's Update

The Chair commented that the new Government had announced that an audit of the NHS would be undertaken to give a baseline picture. Integration of primary and secondary care services would be a key area of the audit and a 10 year plan for the NHS was expected thereafter. The anticipated spending review for this parliament would be limited and only likely to increase NHS spending in later years.

The Governments manifesto had pledged to undertake additional 40,000 electives procedures to reduce the waiting lists. The Black Country has maintained a positive trajectory moving to achieve 18 weeks. Winter planning would get underway to mitigate capacity pressures.

Investment in primary care services would be key to develop the community first model and move activity away from acute settings. Productivity was key and The Dudley Group would need to ensure all opportunities were realised. VR asked if there were clinical variances across services for efficiency. DW confirmed there were and improving productivity in all areas would deliver improved productivity. JH commented that the new style Medical Director and Chief Nurse report was focusing

on quality improvements and productivity and would draw this out. CH commented that digital technology investment was key to delivering productivity and all efforts to be made to secure funding. AT agreed and highlighted a concern with some organisations submitting a low digital maturity assessment which may secure them digital funding above others submitting a higher maturity assessment.

KK highlighted that the Trust used the GIRFT programme to help review productivity with clinicians. Using GIRFT helped raise awareness of different productivity levels and drive improvement noting that whilst the trust was doing well with GIRFT there were many areas to improve.

It was **RESOLVED**

- To note the report

24/63 Drive Sustainability Financial and Environmental

24/63.1 Finance and Productivity Matters

24/63.1.1 Committee Upward Assurance Report

LW summarised the reports from previous Committee meetings held on 30th May and 27th June 2024, given as enclosure four, and thanked all contributors to the meetings and for allowing clarity around the Trusts finance and performance.

The Committee had considered and robustly discussed all matters relating to financial challenges, focused on performance against related targets and reviewed the Workforce Plan and related productivity. Points to highlight from the Finance and Productivity Committee meetings include:

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

JHo commented that delivery of timely histopathology reporting was critical for our patients. Black Country Pathology Services achievement of their targets had been an issue for over 12 months but did need to take into account the increase in demand. Interventions were in place and additional staff appointed. The Royal Wolverhampton (RWT) Chief Executive had commissioned a review of the service against national benchmark data. The F&P Committee would receive an update. RWT were tier 1 for cancer and pathways were being reviewed as histopathology shows the lack of timeliness of reporting. External focus on this so improvement must be made. LW noted his concern at the slow uptake of review and if there could be other areas of concern that were not being raised between the different boards to ensure timely intervention.

It was **RESOLVED**

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

24/63.1.2 Finance Report Month 2 (May 2024)

CW presented the Month 2 (May 2024) Finance Report given as enclosure five.

The Board noted the Month 2 Trust financial position. After technical changes the May cumulative position was a £6.578m deficit: trust position was £0.294m better than the updated phased plan submitted to NHSE in June.

The plan had been updated for the final June submission to include the latest Cost Improvement Programme (CIP) phasing and the improved position of identified CIP. The Trust was forecasting that it would achieve its 2024/25 financial year planned deficit of £32.565m after technical adjustments.

It was noted that the improved position was due to excellent performance of elective recovery but would be a challenge to continue due to known issues arising.

Good CIP delivery that was above plan noting that achievement of financial targets would become more challenging as the year progressed.

Pay was slightly underspent due to phasing of budget. Controls in place for recruitment were seeing some benefits. Bank had seen excellent performance in April, but more spend incurred in May due to increased surge areas open. Non-pay budget was slightly overspent due to additional activity.

The cash forecast remained on plan. System would receive revenue funding which would remove the need to borrow cash.

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

LW reported that the F & P Chairs of each Black Country organisation were meeting to review the impact on quality on financial controls in place.

It was **RESOLVED** to

- Note the financial performance for Month 2 (May 24) and the reported Trust and System 2024/25 financial year end position

24/63.1.3 Cost Improvement Programme (CIP) Update

AT presented the CIP Update Report given as enclosure six.

The Board noted the status of the 2024/25 Cost Improvement Programme since the last report on 30th May 2024, and progression in closing the unidentified gap as follows:

- Reduced gap in unidentified CIP since last report – specific areas identified
- 84% of identified CIP is recurrent saving
- 57% of programme has now completed Quality Impact Assessment process – now at 65% today
- Note schemes with high risk to delivery (table 5 of the report)
- Agreed at Executive Team and Finance Committee that future CIP reporting will be streamlined and included in the financial report.

The focus remained on divisional oversight and then Executive monthly challenge.

JHa asked if there had been any quality impacts following QIA from rejected schemes. AT confirmed that no schemes had been rejected. JHo reported that national guidance had been

received on QIAs and he confirmed that good QIA's are undertaken. AT confirmed that robust assessment was in place and a look back at schemes was undertaken so any lessons learnt could be applied in future.

AH commented that the educational system could be used to help fulfil the WTE reductions.

It was noted that moving forward CIP reporting would be built into the finance report.

It was **RESOLVED** to

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

24/63.1.4 Black Country Finance Undertakings

CW presented the Black Country Finance Undertakings Report given as enclosure seven.

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

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

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

The Board was asked to discuss the final agreed undertakings and formally accept them by returning a counter-signed copy to NHS England by 12th July 2024.

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

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

It was **RESOLVED** to

- Accept the final agreed undertakings from NHS England and authorise the Chair or Chief Executive to sign the undertakings

24/64 Build Innovative Partnerships in Dudley and Beyond

24/64.1 Integrated Performance Dashboard

KK presented the Integrated Performance Report for May 2024 given as enclosure eight. The full IPR was included in the reading pack associated with the meeting. The Board noted the following key highlights:

Good performance across the majority of targets and standards.

Working with partners to expediate discharges to improve delays in the admitted patient pathway. Focus on community services and re-educating patients to seek primary care services before they arrive at ED. Malling Health, provider of the Urgent Treatment Centre, were working with the Trust to stream patients directly into services and not into ED.

The Trust continued to provide mutual aid for cancer services. Waiting list management was key across the Black Country and not just the Trust to ensure patients received timely treatment. AH asked about delays in ophthalmology procedures. KK commented that the Trust was working with national guidance to improve and reduce backlog using GIRFT. AH commented that Aston University had ophthalmology trainees who could potentially assist with triage patients.

DW confirmed that Governor Craig Nevin, although not present at the meeting, had raised a question in advance:

Urology currently makes up 40% of our "long Wait" numbers backlog for patients waiting over 62 days for cancer care mainly due to limited capacity of specialist robotic prostatectomy treatment within the Black Country (Source: Healthier Futures Black Country Integrated Care System Issue 13 July 2024).

1) Has a funding bid been submitted to enable BCICS to purchase a "Specialist Robotic Prostatectomy Robot"?

2) How can Governors jointly assist the BCICS in making a successful bid to purchase a "Specialist Robot"?

3) Can the robots in the system operate on any areas of the body or are they restricted to certain areas of the body? Do surgeons have control over the robots?

DW confirmed that there had been investment in Surgical robots within the Black Country in the last 18 months. At the Royal Wolverhampton (RWT) there were three Surgical robots, Walsall healthcare had one robot, Sandwell and West Birmingham had one robot and the Dudley Group have two robots.

There was dedicated robot capacity for undertaking the prostatectomy work at RWT and work was also underway to move Urology work from RWT to Dudley to free up more robot capacity to undertake more of the prostatectomy work.

Patients who are waiting over 62 days are offered an alternative provider to have their robotic surgery undertaken but often chose to wait locally to have their surgery (40%). The system is focused on improving the cancer waiting times for all patients awaiting cancer diagnostic or surgical interventions and improvement will continue over the coming months in terms of time waiting.

Questions were also received from Miss Nandi Shelembe:

(1) What they doing to improve the waiting time of patients in A&E regardless of came via ambulance – reductions stream work with WMAs to work with clinical hub. Senior clinicians at front door. Demand still outstrips capacity and delays are in patients requiring admitting. Review patients can be steamed

(2) And the follow up via consultants in regard to children who are past NICU patients and born extremely premature. Soon at they reach over the age of 8, it seems the main consultant does not review even once in two years it's like the children get lot in the system. appointment to reduce delay in patients being seen. Most seen in time but still more work to

do to improve service. Peri prem interventions good performance and has a positive impact on patients in later life to present conditions occurring later in life.

Q1 - KK answered that several interventions are in place to improve waiting times including, streaming work with WMAs to work with clinical hub and senior clinicians at the front door to review patients on arrival. Demand still outstripped capacity and delays occurred when patients require admitting.

Q2 - If a child has a developmental need they were will still be seen by the clinicians. If no developmental need they were referred back to GP. JHo commented that this related to a very small number of patients. Premature babies are covered by guidance up to four years old. If any neuro developmental needs, the child was referred to specialist.

It was **RESOLVED** to

- To receive the report for assurance of the Trust's performance

[short comfort break]

24/65 Deliver Right Care Every Time

24/65.1 Quality Committee Upward Assurance Report

LH had tendered apologies. The Board received the upward report from the Committee meetings held on 28th May and 25th June and 4th July 2024, given as enclosure nine for information.

The Board was asked to note that the Quality Committee met on 24th June 2024 where a series of Annual Reports were received: -

- The Neonatal Annual Report
- The Paediatric Annual Report
- The Infection, Prevention and Control Annual Report
- The Safeguarding Annual Report
- The Health and Safety Annual Report
- The Complex Vulnerabilities Annual Report
- The Learning from Deaths Annual Report
- The Incident Management Annual Report
- The Patient Experience Annual Report
- The Complaints Annual Report
- The Clinical Effectiveness Annual Report
- The End of Life Annual Report
- The Medicines Management Annual Report

It was **RESOLVED** to

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

24/65.2 Chief Nurse and Medical Director Report

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

This report provided an overview of key quality, safety and professional matters from a multiprofessional perspective, to demonstrate how multiprofessional teams worked collaboratively to

positively influence everyday practice and focus on improving quality outcomes and patient experience.

Assure

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

Advise

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

- 46.4% of complaints received were closed within 30 days, a slight decrease on April's performance.

Alert

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

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

MM commented that the number of Deprivation of Liberty Safeguards should be 35, not 335 as stated in report.

JHo commented on the change of focus in paper to escalation of deteriorating patient focus.

MMa enquired about the high number of pressure ulcers in the community. MM replied that this was multifactorial and reporting was good. Pressures ulcers were reported at an early stage so educational elements were required to help stop them developing. Some complex cases and piloting of a blue pillow scheme is taking place, including education which was key for staff and patients.

PF asked what the repeat fallers is telling us (8 cases). MM confirmed that focus was on repeat fallers and noted work undertaken to look at data and understand outcomes. She confirmed that they were nearly all complex patients with cognitive impairment, requiring 1:1 nursing in place when necessary but not easy to fully mitigate. Need to understand what support the patient required, including what the family need for support.

LW enquired about safeguarding as this was an area that had seen an increase in activity. MM agreed and highlighted that the number of complex safeguarding cases had exponentially increased. The Trust had a good team in place. Professional curiosity was key to managing safeguarding matters and harder with new staff to give them confidence with being inquisitive and raise concerns. Mentoring and clinical supervision were in place. The had been a National increase especially post-pandemic. MM was to review skill set of staff to establish whether an increase would be needed in certain areas. There were named doctors for safeguarding adults and children in place. JHo commented that safeguarding was becoming multi-professional and the Trust had a good service in place with escalations made when identified.

It was **RESOLVED** to

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

24/65.3 Perinatal Clinical Quality Surveillance (Maternity and Neonatal Dashboard) - Maternity Incentive Scheme year 6

CM and BM joined the meeting to present the Perinatal Clinical Quality Surveillance Dashboard and Maternity Incentive Scheme Year 6 Report given as enclosure 11, including the following key issues:

Perinatal mortality data has shown an improvement with the stillbirth rate, neonatal death

rate and total mortality death rates all reducing. Neonatal death rates were now at 1.67 with the national benchmark being 1.65. This was the lowest the rate for over 12 months.

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

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

PERIPrem data was included for information on progress since its launch in November 2023. Six elements were fully achieved and five require further action to ensure full consistent compliance.

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

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

The Chair noted the large number of reports and actions plans in place covering these services and asked how it might be possible to look at the whole service and where the board would get its assurance from that services were safe. CM commented that national enquiries and staff were aware of the improvements made and what still needed to be undertaken to continue improvement. Staff listening events were well received and positive. Three year overarching improvement plan in place. DW heatmap helps give assurance and highlights areas to the board. Quality of service improved year on year.

DW commented however that services user view did not correlate with the service users experience and asked how it was being tested. CM replied that gaining feedback from families was invaluable. The patient team reviewed service user survey data on a monthly basis and walk arounds took place to speak to patients. Improvements had been put in place and actions plans were followed.

MM commented that a Director of Midwifery was not in place and was a national requirement. The role currently undertaken by CM had been reviewed and would be resolved. CM reported that informatics issues had caused a data quality issue and this was being reviewed to rectify. Improvement should be seen next time board received the report.

VR asked if mortality demography is consistent with other areas. CM commented that a thematic review into deaths took place noting that the Trust did have different demographic of patient so was benchmarking with similar peers.

It was **RESOLVED** to

- Accept assurance of progress made with 3-year delivery plan and the current position with Maternity Incentive Scheme year 6.

24/65.4 Maternity and Obstetric Workforce Report

CM and BM presented the Maternity and Obstetric Workforce Report given as enclosure 12. Including the following key issues:

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

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

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

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

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

It was recognised that maternity specific training required 34 hours per year per midwife, in addition to Trust statutory mandatory training and was impacting on an increase in the unavailability within the department.

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

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

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

MM highlighted that the Quality Committee received reports and had supported recommendations within the report.

It was **RESOLVED** that the Board:

- Note the current position with Maternity staffing, including BR+ requirement and agree the recommendations and next steps outlined within the paper pertaining to staffing Midwifery staffing and current mitigations

24/65.5 Complaints Annual Report

MM presented the Complaints Annual Report given as enclosure 13 noting the following key highlights:

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

Complaints:

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

Achievements:

- There was a decrease in the number of new complaints received by 7.9% from 2022/23. This is the first decrease the Trust has seen in the number of complaints received for several years.
- The team closed 1059 complaints.
- All new complaints were acknowledged within three working days.
- 42.8% of complaints received a response within 30 working days. An improvement from
- 2022/23 which had a response rate of 35.9%.
- There were 98 complaints under the early resolution process with 86 of the 98 complaints
- (88%) responded to within 30 working days.
- There has been a decrease in the number of complaints upheld/partially upheld in 2023/24
- to 54% when compared to 2022/23 of 64%.
- The complaint activity versus the patient activity for the Trust has decreased from 0.08% to
- 0.07% for 2023/24.
- No complaints were formally investigated by the Local Government Ombudsman (LGO)
- during the year.

Challenges and opportunities:

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

Actions taken to overcome challenges and maximise opportunities:

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

The full report was included in the further reading pack associated with the meeting.

It was **RESOLVED** that the Board:

- Note the complaints and PALS activity in 2023/24 and how the learning from complaints and PALS feedback is being implemented, the challenges faced, and improvement actions taken

24/65.6 Safeguarding Annual Report

MM presented the Safeguarding Annual Report given as enclosure 14 and highlighted the following:

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

Achievements:

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

Challenges and opportunities:

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

Actions taken to overcome challenges and maximise opportunities:

- Review and develop the safeguarding service to re-focus activity towards promoting awareness and learning, with the aim of preventing abuse.
- Work with Black Country health providers to review and align safeguarding training and consider collaborative and consistent approach to training across the system.

- Use of role modelling, supervision, incident feedback and awareness raising events to
- supplement training opportunities.
- Continue to work in partnership with the Complex Vulnerabilities team and Divisions to support a workforce that can think critically, challenge assumptions and can have difficult conversations about abuse across the lifespan, to identify hidden harm and abuse.
- Maintain a highly visible and proactive safeguarding service which seeks to engage with
- Divisional leadership teams in methods to improve the sharing of learning and monitoring of how learning is embedded. This includes awareness raising via a variety of communications and increased presence at Divisional operational and governance meetings.

It was **RESOLVED** that the Board:

- Note the information provided regarding trends, themes, achievements, and challenges in safeguarding during 1st April 2023 to 31st March 2024. To gain assurance with respect to compliance with statutory responsibilities and contractual standards

24/65.7 Complex vulnerabilities Annual Report

MM presented the Complex Vulnerabilities Annual Report given as enclosure 15 and highlighted the following:

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

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

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

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

Achievements:

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

- Successful proposal to introduce an Admiral Nursing Service into the Trust to support improvements in care to patients living with Dementia.

Challenges and opportunities:

- Strengthen governance around use of chemical restraint and PRN (as required) sedation.
- Strengthen process of Mental Health Act detentions.
- Improve monitoring and oversight of LeDeR learning actions
- Embedding of the digital Learning Disability Reasonable Adjustment Flag process.
- Direction and focus on care of patients with Dementia.
- Ensure that the Mental Health Act Administrator and Responsible Clinician contracts are implemented, which are currently in the final stages of being available.

Actions taken to overcome challenges and maximise opportunities:

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

The full report was available in the further reading pack associated with the meeting.

It was **RESOLVED** that the Board:

- Note the information provided regarding trends, themes, achievements, and challenges in the work supporting patients with complex vulnerabilities during 1st April 2023 to 31st March 2024 and gain assurance with respect to compliance with statutory responsibilities and contractual standards.

24/66 To be a Brilliant Place to Work and Thrive

24/66.1 People Committee Upward Assurance Report

CH summarised the report given as enclosure 16 relating to the Committee meetings held on 28th May and 25th June 2024 and highlighted the following matters.

May 2024

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

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

Major actions commissioned/underway
An update on the progress made on the NHS Rainbow Badge Assessment was given, a further progress report would be given in July.

A deep dive into employee relations was presented, which demonstrated the benefits of the new database which had logged 248 cases since April 2023, as a full year's data was available for analysis.

The Medicine & Integrated Care division presented a deep dive into their division.

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

June 2024

Matters of concern/key risks to escalate
An update was given on the Sexual Safety Charter and the sexual safety survey results. Key that the Board members work and report any incidents. Performance against the workforce plan had slipped, but a longer-term trend was required to fully understand the position.

Positive assurances
The workforce KPI report presented positive assurance against all measures, particularly sickness absence which was demonstrating a longer-term positive trend. Mandatory training compliance had improved with sustained performance above target since Q2 2023/24.Good progress had been made on apprenticeships.

Positive reports were received from the Wellbeing and Equality, Diversity & Inclusion Steering Groups. Disability Confident Leader Status had been maintained. Surgery Women and Children's division presented a deep dive into their division, which gave good assurance to the Committee of a good grasp of the issues and demonstrated effective leadership and management.

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

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

It was **RESOLVED** to

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

24/66.2 Workforce KPIs

KB summarised the report given as enclosure 17and highlighted the following key areas for noting:

Analysis of the report workforce KPI's shows overall positive assurance with seven of the eight

reported metrics performing at or better than target.

The Board was asked to note the following positive assurance and areas of challenge:

Sickness Absence - The rolling 12-month absence has seen a reducing trend since March 2023 and was now sitting below target, supported by a reducing trend across both short and long-term sickness absence. In May there were 103 long-term absences open across the Trust 87 (85%) cases are between 28 days and six months in length.

Retention - The retention rate was relatively stable and had been since September 2023.

Agency Usage - Agency remained very low, with only Medical & Dental agency being utilised. There was no off-framework agency usage.

Mandatory Training - Performance against target remains above 90% for the month. This was an ongoing sustained performance at above target since Q2 23/24. The overall position was stable with variations in staff groups (medical staff) and subjects (Paediatric Resus). Whilst performing above target cumulatively, eight individual subjects remain under target – these included manual handling, safeguarding and resus. The corporate nursing and HR teams were supporting the divisions to address this.

Turnover - Turnover had been just above Trust target since August 2023 but was still below the industry average. This is an area of focus through the 'being a brilliant place to work and thrive' group.

Bank Usage - There had been a general increase in clinical bank use this month, specifically within the Additional Clinical Services staff group. This was paired with an increase in requests for registered nursing but a lower fill rate than the previous month. Admin & Clerical requests and actual use have reduced for the third consecutive month.

It was **RESOLVED** to

- note the report for assurance

24/66.3 Public Sector Equality Duty (PSED) Annual Report

PS presented the Public Sector Equality Duty (PSED) Annual Report given as enclosure 18 and highlighted the following key areas:

The Board noted that the purpose of the annual Public Sector Equality Duty (PSED) report was to provide an overview with progress towards creating an inclusive workplace where all employees were treated fairly and with respect. It outlined the strategies/approaches, initiatives, and actions taken and planned by the Trust over the last twelve months to promote equality, diversity, and inclusion.

The PSED report was the second one produced by The Dudley Group, the first being produced in 2023.

The Trust Board were required to provide final sign off of the PSED annual report for assurance. The report served as a tool for transparency and accountability, as it communicated the Trust's commitment to equality, diversity, and inclusion, and its progress in this area alongside internal and external stakeholders.

The full PSED report was enclosed within the further reading pack associated with the meeting for

information and had been reviewed by the Executive Directors Committee and the People Committee where both meetings had confirmed approval of this year's PSED compliance submission report.

The PSED annual report would be published on the Trust internal and external websites as required.

It was **RESOLVED** to

- The Board approved the annual progress on Public Sector Equality Duty (PSED).

24/66.4 Guardian of Safe Working Report

JHo presented the Guardian of Safe Working Report given as enclosure 19 and highlighted the following key areas:

The Board noted that the purpose of the report was to give assurance to the Trust Board that Junior Doctors in Training (JDT) were safely rostered, and their working hours were compliant with the Terms and Conditions of Service for NHS Doctors and Dentists in Training (England) 2016 (TCS).

This paper provided a summary of the following areas related to JDT and the 2016 TCS:

- Challenges
- Exception reports
- Vacancies (data provided by Medical Work Force Department)

It was **RESOLVED** to

- note the mitigations to support effective engagement with the Junior doctors.

24/66.5 Freedom to Speak Up Report

AB presented the Freedom to Speak Up (FTSU) report given as enclosure 20 and highlighted the following key areas:

The Board noted that the report provided an update on recent FTSU activity. There were presently 20 trained multi professional and diverse FTSU champions providing a network of support across our acute and community sites which provides greater accessibility to the service.

The service was supported by named executive and non-executive directors. Catherine Holland was the newly assigned non-executive director.

E-Learning for health completed training data showed 37 staff members had completed the Speak Up training module, with 20 members of staff completed the Listen up module and finally only six members of staff had completed the follow up module for senior leads.

In the past three months The Dudley Group Freedom to Speak Up service handled 25 concerns brought by 25 members of staff (some people prefer to raise concerns in small groups). One concern had been raised anonymously. Forty per cent of concerns were from the medicine division with staff wellbeing equating to 28% and was the highest reoccurring theme.

The Chair asked for further information referrals on staff wellbeing and staff safety. AB stated that some related to flexible working requests being turned down. KB commented that triangulation of data was required and noted that a new flexible working policy had been released adding that the Being a Brilliant Place to Work and Thrive Group were overseeing this. DW stated that consistency

of managers approach was an area that is raised by staff and noted there was more work to do in this area.

It was **RESOLVED** to

- note the Freedom to Speak up E-Learning for health completed training data and that the NGO would release the updated strategy during July 2024

24/67 Governance

24/66.1 Audit Committee Upward Assurance Report

JHa summarised the report given as enclosure 21 relating to the Committee meeting held on 24th June 2024. The Board noted the following key highlights:

A number of items were approved including:

The Audit Committee Terms of Reference (TOR) were reviewed and agreed as a recommendation to Board for endorsement – appendix 1.

Under delegated authority from the Chair, the Trust Annual Accounts for 2023/24 were approved.

The Committee approved the Trust Annual Report and Annual Governance Statement for 2023/24

The Committee approved the Grant Thornton letter of representation.

External Audit saw the positive conclusion of audits for financial accounts and Value for Money. External Auditors were complimentary on the excellent standard of the accounts.

Internal audit noted good progress on their audit plan. The Audit plans had provided good assurance to the committee. Cyber Security was noted to have partial assurance but with a path to green. The Internal Audit and Counter Fraud plans were approved. IFRS adjustment was noted and assurance provided that actions were in line with national guidance.

Items for the Board to note included that the BAF would continue to be embedded and evolve and the 2024/25 planning process would surface any new risks. There had been robust discussion about discharge management and partial assurance received noting it would be an area of focus with KK overseeing a number of actions in relation to this.

It was **RESOLVED** to

- note the report, the assurances provided by the Committee, the matters for escalation and the decisions made
- endorse the Audit Committee Terms of Reference

24/66.2 Integration Committee Upward Assurance Report

LW summarised the report given as enclosure 22 relating to the Committee meetings held on 29th May and 26th June 2024. The Board noted the following key highlights:

May
The committee received an update on Health and Care Partnerships, which the committee noted. An update was given on the DIHC transaction and approved the post transaction implementation plan, as the general election had been called for 4th July 2024, discussions were ongoing to

understand the impact on the 1st of July transfer date, as this was subject to sign-off by the Secretary of State. The first update was received on the University Hospital Trust Application.

Positive assurance was received within three deep dive presentations on Procurement, Abdominal Aortic Aneurysm (AAA) and Breast Screening Service (BSS). The committee received an update on the impact and mitigations on the Midland Met University Hospital (MMUH), which the committee noted.

It was agreed that the assurance level of the BAF Risk 6 risk would remain unchanged.

June
The Committee received an update on DIHC Transaction, where it was noted that no decisions on a revised date of transaction this will be agreed until after the general election. Positive assurance was given through the update on the Dudley Health and Care Partnership. The committee received its first update on Targeted Lung Health Check Programme, where positive assurance was received, noting the update is to be added onto the Committee workplan and update every quarter.

A Memorandum of Understanding (MoU) between the Trust and Dudley Academies Trust was supported by the Committee. The Committee also supported a proposal of neighbourhood working to improve relationships with Primary Care, a working group will be set up to look at implementing shadowing between primary and secondary care clinicians.

Positive assurance was received from the two-prevention programme deep dives that were presented within the Alcohol and Tobacco Care teams, both having actions to feedback at a future Committee.

MM commented that it was an excellent opportunity to reset relationships and cultures and work collaboratively with primary care colleagues.

It was **RESOLVED** to

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

24/66.3 Joint Provider Committee Upward Report

The Chair summarised the report given as enclosure 23 relating to the Joint Provider Committee (JPC) meeting held on 21st June 2024. Key discussion points included:

Focus was on moving the corporate services transformation forward. It was noted that there would be three main areas of focus at the August Joint JPC:

- addressing he financial challenges and taking stock on progress being made would be the main theme.
- MMUH collective discussion
- Progress on community services/primary care/hospital utilisation and sharing best practice
- QI – Improvement Leadership Development
- Cyber security – what our leaders need to know

It was **RESOLVED** to

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

24/66.4 Charitable Funds Committee Upward Report

The Board noted the Charitable Funds Committee Report from the meeting held in June 2024, given as enclosure 24.

The Committee was chaired for the first time by Gary Crowe. A range of matters were considered and should be noted:

- The Staff Wellbeing Working Group has been established to deploy the NHS charities grant £121k held to renovate rest areas. The Committee agreed to target at least 10 rooms/areas for improvement.

- Four general fund requests for funding were received and approved.

- Brewin Dolphin had been appointed as the new investment manager (£2.5m investable funds held, investment approach to be agreed).

- The Charity had completed a rebranding exercise and had launched internally. Three yearly Strategy refresh work has commenced.

It was **RESOLVED** to

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

24/66.5 Digital Committee Close Out Report

CH presented the Digital Committee Close Out Report from the meeting held on 22nd May given as enclosure 25.

The Board noted that the Digital Committee was disestablished on the 22nd May 2024 with the Digital Trust Steering Group (DTSG) reporting directly to the Trust Management Group, Executive Directors, Committees and Trust Board as required. The Board noted the following key highlights:

- BAF 8 had met its interim in year target risk score of 16 and assurance reporting would continue bimonthly via Finance and Procurement (F&P) starting July 2024
- The Digital Trust Steering Group (DTSG) revised Terms of Reference were approved
- The proposed governance reporting recommendations for digital post disestablishment of
- the Digital Committee were approved – see Appendix 1
- Positive assurance in terms of the risk associated with the ongoing infrastructure project
- Positive assurance on the ongoing CareCERT – Respond to a Cyber Alert management process
- The Trust's non-executive director Champion for Security (including Cyber) moving forward would be Lowell Williams.

It was **RESOLVED** to

- note the report, and confirm that the arrangements for the transfer of the Committees business are satisfactory

24/66.6 Board Assurance Framework

HB presented the Board Assurance Framework (BAF) given as enclosure 26. The Board noted the following key highlights:

The Board Assurance Framework (BAF) provided a structure and process to enable the Board to

focus on the key risks that might compromise the achievement of the Trust's strategic goals.

Of the nine risks listed, committee assurance ratings have changed from the previous summary report:

- Eight (was six) assigned a 'positive' rating
- One (was three) assigned an 'inconclusive' rating
- None assigned a 'negative' rating

The BAF and the risk appetite statement would be refreshed as part of the strategy refresh activity that would be considered at board development sessions during the year.

It was **RESOLVED** to

- Approve the update made since the last meeting and note the ongoing work to embed effective risk management with further Board development workshop activity being scheduled for 2024/2025,

24/67 Any other Business

There was none raised.

Pat Bradley thanked the board and all trust staff for all the excellent work they did for patients and staff.

24/68 Date of next Board of Directors Meeting

The next meeting would be held on Thursday 12th September 2024.

24/69 Meeting Close

The Chair declared the meeting closed at 12:52 hr.

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Sir David Nicholson

Chair Date:

Enclosure 3

The Dudley Group NHS Foundation Trust

Paper for submission to the Board of Directors on 12 September 2024

Report title:	Public Chief Executive Report
Sponsoring executive:	Diane Wake, Chief Executive
Report author:	Alison Fisher, Executive Officer

1. Summary of key issues using Assure, Advise and Alert

Assure

- Transfer of Care Hub Visit
- Elective Hub Visit

Advise

- Dudley Integrated Healthcare Agreement
- Operational Performance
- Best Practice Tariff Targets
- Pay Awards
- Green Plan Launch
- Black Country Integrated Care Board Chair
- Equality and Inclusion
- Charity Update
- Healthcare Heroes
- Patient Feedback
- Awards
- Visits and Events

Alert

- None

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

3. Report journey
Board of Directors

4. Recommendation(s)
The Public Trust Board is asked to:
a) Note and discuss the contents of the report

5. Impact		
Board Assurance Framework Risk 1.1	X	Deliver high quality, safe person centred care and treatment
Board Assurance Framework Risk 1.2	X	Achieve outstanding CQC rating.
Board Assurance Framework Risk 3.0	X	Ensure Dudley is a brilliant place to work

Board Assurance Framework Risk 4.0	X	Remain financially sustainable in 2023/24 and beyond
Board Assurance Framework Risk 6.0	X	Build innovative partnerships in Dudley and beyond
Board Assurance Framework Risk 7.0	X	Achieve operational performance requirements
Board Assurance Framework Risk 8.0	X	Establish, invest and sustain the infrastructures, applications and end-user devices for digital innovation

CHIEF EXECUTIVE'S REPORT – PUBLIC BOARD – 12 SEPTEMBER 2024

Dudley Integrated Healthcare Agreement

The Trust had been working with Dudley Integrated Health and Care (DIHC) NHS Trust on mobilisation and transition plans for service to transfer to DGFT on 1st July 2024. Unfortunately the general election resulted in an extension to the original timeframes and Dudley Integrated Health and Care are now working to a phased transfer of services. Phase 1 occurred on 1 August 2024, which saw the transfer of the following services to Black Country Healthcare FT and three Primary Care Networks:

Black Country Healthcare NHS Foundation Trust	IAPT/Dudey Talking Therapies for Anxiety and Depression
	Primary Care Mental Health
	First Contact Mental Health Practitioners
	Mental Health Commissioning Function
Stourbridge, Wollescote and Lye Primary Care Network	Additional Role Reimbursement Scheme (ARRS) staff via lead practice
Sedgley, Coseley and Gornal Primary Care Network	Additional Role Reimbursement Scheme (ARRS) staff via lead practice
Kingswinford and Wordsley Primary Care Network	Additional Role Reimbursement Scheme (ARRS) staff via lead practice

The final transfer of services is anticipated to occur on 1 October 2024 which will also coincide with the proposed dissolution of Dudley Integrated Health and Care. This consists of services transferring to Dudley Group Foundation Trust as host for Dudley Health and Care Partnership and Black Country Integrated Care Board. However, this is subject to Secretary of State approval.

Services anticipated to transfer on 1 October:

The Dudley Group NHS Foundation Trust (DGFT) – host of Place Partnership	ICB Commissioned primary care services
	High Oak and Chapel Street Surgeries
	Special Allocation Scheme
	Research
	Continuing Health Care/Intermediate Care
	Integrated Medicines Management
	GP Clinial Leadership
	Ex-CCG Corporate Functions
	Additional Role Reimbursement Scheme (ARRS) staff for Brierley Hill and Amblecote Primary Care Networks
	Additional Role Reimbursement Scheme (ARRS) staff for Halesowen Primary Care Networks
	Additional Role Reimbursement Scheme (ARRS) staff for Dudley and Netherton Primary Care Networks
	Adult Safeguarding
Black Country Integrated Care Board (BCICB)	Designated Clinical Officer Function
	Staf not covered by TUPE
	Legacy issues

Operational Performance

Elective Restoration & Recovery

We continue to perform well with Elective Restoration and Recovery. We are now focusing on patients at 65 weeks with a plan to have all cleared at the end of September. The next target for focus is the 52 week wait patients being treated by the end of March 25.

Cancer Outcomes & Service Dataset (COSD)

As a Trust we achieved above 80% stage completeness in the Cancer Outcomes and Services Dataset (COSD) submissions for the whole of 2023. Feedback received from the NHS National Disease Registration Service (NDRS) "As you are aware we have been monitoring this work and your provider has made a significant achievement and is directly attributable to the hard work of clinical and administrative staff in your cancer teams. We would like to express our sincere thanks for this work".

Best Practice Tariff Targets

The latest National Emergency Laparotomy Audit (EMLap) Best Practice Tariff report recently released, showed that the Trust had achieved our Best Practice Tariff targets for January - March 2024. This is a significant achievement, as only 20% of hospitals have managed to reach these targets nationally.

This success is particularly encouraging for our recently created EMLap Improvement Group. This accomplishment will strengthen our resolve to maintain these high standards.

Transfer of Care Hub Visit

A peer review took place on 30th July 2024, co-ordinated by the Urgent Emergency Care Midlands Regional Team. The review stems from the expectations laid out within the delivery plan for recovering urgent and emergency care (January 2023) that includes commitments such as, speeding up discharges from hospital, expanding new services in the community, accessing right care first time and reducing unwarranted variation.

The aim of the review was to assess patient pathways and identify potential areas for improvement whilst highlighting good practice. The review team consisted of health and social care providers from across the Region.

Dudley hosted an event that would enable the reviewers to access to all elements of the patient journey from community through health and social care and back to community. It included a welcome and overview from our Chief Operating Officer, Karen Kelly. The team were walked through the patient journey from Integrated Front Door Team, ward teams, therapy, Local Authority, Transfer of Care Hub and to Intermediate Care. The reviewers joined our daily integrated meetings, visited wards, spoke to staff, undertook observations, joined virtual meetings, received presentations and attended a site visit to Tiled House (one of our intermediate care facilities in the community). We further provided a recent case review example of a complex discharge to identify real barriers and issues that require national discussion on overseas visitors, homelessness, together with the real pressures faced within the system.

The peer review team identified areas of good practice and points of note, such as;

- Staff with high morale and an honest and open approach to managing quality improvement
- Acknowledgement of the disconnect/lack of visibility of how finances flow across Place

- Recognition that Dudley had invited a Black Country peer review team in earlier in the year and were able to demonstrate the learning from this within its programme of work, agreed as a partnership single plan.
- Awareness that the local implementation of the national pathways is not aligned to the national framework and the impact of this on demand and capacity modelling, national returns and cross border working.
- The team were undertaking a deep dive into understanding why people on P3 were going home i.e. had they been identified for the correct pathway first time.
- Data is being used to highlight focused work around delays and variance discharging within and out of area.
- Proactive, practical resolutions for managing delays including
    a. daily touch points with all neighbouring local authorities
    b. daily internal delays meeting
- An electronic transfer of care document (TOC) had been developed and 92% are completed within 24 hours of referral.
- Discharge presence at the front door (Integrated Front Door Team) with 51% of the referrals made to the Integrated Front Door Team discharged at the front door
- The hub operates 7 days a week.
- An intermediate care patient passport starts on the acute wards and follows the patient into out of hospital providers.
- Ability to flex community beds to meet P2 and P3 demand
- Pathway 1 community provision for rehabilitation (Own Bed Instead) and reablement is responsive and integrated and can support both step down and admission avoidance referrals. It is noted that demand is exceeding capacity currently.

A sample of the recommendations from the review team were;

1. Ensure that the Dudley Place partnership single plan enables a shared understanding and responsibility in using resources wisely, maintaining budgetary control, taking steps to minimise waste and shared visibility of all the performance data to ascertain what is affordable.

2. Use data to support a focus on Pathway 0, where the largest volume of discharges are managed across the Trust.

3. Support with demand and capacity modelling for pathways 1, 2, 3.

4. Reinforce the need for clear actions at ward level specifically around who needs to do what and when to facilitate a discharge today and if not today then, when?

5. Review the workforce in the Dudley Group hub and consider the opportunities to form a co-located integrated workforce with the aims to:
    a. Enhance shared knowledge and skills across teams creating an ongoing culture of relationship building resulting in shared accountability/ responsibility for patient flow. The benefits of co-location are achieved through regular Safety Huddles, informal multi-disciplinary working, team meetings, shared vision.
    b. Shared accountability and further trusted assessment will improve efficiency by reducing the number of forms, handovers and steps within referral pathways.
    c. A culture of shared problem solving, and accountability will result in operational staff utilising all available capacity across the partnership e.g. reduction in cancelled or delayed discharges creating waste within Local Authority packages of care, early supported discharge and readmission avoidance via Virtual Wards, and Admission Avoidance joining the Red Amber Green (RAG) call.

6. Continue to develop the database and business intelligence to provide live data around patient tracking and visibility across the patient journey along with dashboards to show performance and outcomes.

7. Cross partnership senior leadership support for people with the longest delays and most complex presentations as per the shared case study e.g. The senior responsible officer (SRO) for intermediate care to work with the Director level leads in Integrated Care Board and Local Authority to lead multi-disciplinary meetings, inviting expert reference groups, and present a unified front to operational staff who can deliver the plan in the interests of the citizen.

8. Implement an integrated approach for reviews of all readmissions and include leads for Urgent Community Response and Virtual Wards.

Elective Hub Visit

The Trust welcomed a team from Getting it Right First Time to come and assess our surgical services on the 10th July 2024 to ascertain if we were able to be accredited as a 'Surgical Hub'. In an acute site the aim is to be an integrated hub where there is an elective surgical unit within an existing hospital site with all facilities physically segregated from acute areas. At Dudley we have dedicated elective theatres and also a dedicated elective surgical ward for Adults; in Paediatrics we have a more hybrid model where our elective spaces are housed within the standalone Paediatric Ward on the second floor.

Initial feedback was received on the day, verbally on 5th August and the formal feedback was received on 12th August. The areas of good practice identified included:

- The accreditation team unanimously highlighted the very strong focus on teamwork and a multi-professional approach as observed on the day of the visit. Staff were highly engaged, dynamic and there were several examples of joined up working across departments
- There is a strong focus on enhanced recovery and enabling patients to recover at home as soon as possible
- The hub has a strong focus on training and development
- Quality improvement approached are embedded and the accreditation team observed many examples of teams engaged in continuous improvement projects; there is a general focus on improvement
- The trust has achieved Anaesthesia Clinical Service Accreditation
- Successful pilot of a 'super surgery day', this is an excellent initiative and more of these with dedication of day case facilities is anticipated

There were also some opportunities for improvement:

- There is a need to introduce a fully digital pre-operative assessment process to enable effective triage and virtual pre-operative assessment for all suitable patients, supported by a digital portal. We are in the procurement process to obtain this.
- Cases per list in some specialities are low, some improvement work is ongoing particularly in Ophthalmology.
- Need to physically separate the elective and emergency space within paediatrics

The feedback concluded that at present we are not in a position to be accredited as a surgical hub, but there are some steps that we can make to look to apply for a further visit in the coming months.

Pay Awards

On the 29th of July, the government has announced the 2024/25 pay award for staff under the remits of the NHS Pay Review Body (NHS PRB - AFC) and Doctors' and Dentists' Review Body (DDRB).

The details of the award are summarised below - All pay uplifts will be backdated to 1 April 2024.

NHS Pay Review Body (Agenda for Change)	With effect from 1 April 2024, a 5.5 per cent consolidated uplift for all Agenda for Change staff on NHS terms and conditions. To be paid in October 2024 with arrears back to April 2024.
Doctors and Dental Review Body (Medical and Dental	For doctors and dentists this will mean uplifting salaries by six per cent, applying to: • consultants • specialty and specialist (SAS) doctors • doctors and dentists in training who will also receive an uplift of £1,000 • salaried dentists, including those working in community dental services and public dental services. • contractor general medical practitioners • salaried general medical practitioners pay ranges. • pay element of dental contracts • no uplifts in Local Clinical Excellence Awards (these remain frozen)

Green Plan Launch

The Green Plan was approved by the Board of Directors in December 2020 setting targets to reduce our environmental impact and carbon emissions. The Trust are working on plans to refresh the Green Plan including consulting staff, the updated plan is due to be released in April 2025.

Progress so far:

- expanded the green team to over 100 members
- free bus passes for staff - over 400 monthly passes claimed, 8% of staff
- sustainability category in the committed to excellence awarded to the pharmacy team for medicine returns
- theatres are using remanufactured devices which reduces wastage whilst saving close to £18,000 and 125kg CO2e.
- amongst many more

There is more work to do to reduce our emissions, in 2022/23 we reduced emissions by 1% compared to the 2019/20 baseline. To meet NHSE targets we would need to reduce emissions by a further 46% by 2032 and net-zero by 2040.

Climate change threatens the foundations of good health, with direct and immediate consequences for our patients, the public and the NHS. Implementing the Green Plan not only reduces emissions but can improve patient care and health and wellbeing. We all have a role to play to reduce emissions and reduce admissions.

For more information visit:

Environmental Sustainability - The Dudley Group NHS Foundation Trust (dgft.nhs.uk)

or

the Hub at Greener NHS - Home

Black Country Integrated Care Board Chair

The Black Country Integrated Care Board have appointed Anu Singh as their new Chair. Anu took over from the current Chair Jonathan Fellows on 1 September 2024. We look forward to working with Anu.

Equality and Inclusion

The Trust has achieved a significant milestone in successful maintaining our Gold Status and moved to the sustain level for the Employers Network for Equality and Inclusion Talent Inclusion and Diversity Evaluation (TIDE report) . This is a fantastic achievement and demonstrates the passion and dedication to ensuring equality and inclusion within the Trust.

Charity Update

C2 Playroom Launch

Colleagues from across the Trust gathered on 29 July for the launch of the Children's Ward's newly refurbished playroom. The modernised playroom has been funded by the Dudley Group NHS Charity through a combination of charitable funds and community grants. The welcoming room has a bright and fun underwater theme and is equipped with activities and toys suitable for all young patients and there is now plenty of storage space for arts and crafts activities, a wet area, and a gallery where children's artwork can be proudly displayed. There is also a reading corner for those children who may need some quiet time.

The room was officially opened by Trust chief executive Diane Wake alongside Albie aged five, a young patient on the ward, Albie's mum Leah said: "It's such a beautiful room to help distract children from their hospital stay. It's both adaptable and inviting to allow children to continue learning through play".

The Dudley Group NHS Charity is still fundraising for soft furnishings and toys for the room. If anyone would like to donate and get involved, please head to charity page on the hub (Children's Ward Playroom Appeal - JustGiving).

Glitter Ball

The charity's annual flagship Glitter Ball is set to return for a fourth year!

The business gala dinner will be held at the Copthorne Hotel in Dudley on Thursday 14th November 2024 and will see local businesses come together to show support for their local Trust, and to the Dudley Group NHS charity.

This year the Glitter Ball is raising vital funds for the dementia appeal, which supports patients living with dementia at the Forget Me Not unit at Russells Hall Hospital.

The charity is appealing to local businesses that would be interested in attending what promises to be a wonderful evening. If you are able to share any connections, please email nithee.patel@nhs.net

Supporting Cancer Services

This year the charity has funded three scalp cooling machines for our cancer services. Many people undergoing chemotherapy in the UK are completely unaware that scalp coolers exist, let alone that they could help cancer patients undergoing chemotherapy to keep their hair. Losing your hair can be the final straw and can have a devastating impact not only on the patient, but also their families, particularly for children and young people.

By using these machines many people have reported that their hair loss was so minimal which enabled them to 'just feel normal' whilst undergoing treatment.

Christmas Chocolate Appeal

The Dudley Group NHS Charity is launching a Christmas chocolate appeal to provide chocolate selection boxes for all patients to enjoy over the Christmas period.

The Trust charity is appealing to local businesses, the public and staff for Christmas chocolate selection box donations to help spread joy to all our patients, who will be in hospital over the Christmas period.

Spending Christmas in hospital can be a very lonely and isolating experience. This may be a small token of appreciation, but we know our patients will appreciate the gesture throughout the Christmas period.

The deadline to receive chocolate boxes is 6th December 2024 and can be dropped off to the Charity Department, 2nd floor, South Block, Russells Hall Hospital.

If you would like to support the Christmas chocolate appeal, please contact the fundraising team on: dgft.fundraising@nhs.net.

Healthcare Heroes

Individual award

Picture – Samuel Johnston and Kat Rose

Samuel Johnston

An incredible physiotherapist in our therapy dept, Samuel is always there to help students and patients, who praise his supportiveness and outstanding holistic approach. Students boast about his welcoming and polite ways, making the working environment a delight to enter. Many patients claim Samuel augments confidence within them. Thank you so much Samuel for your amazing work!

Team award

Picture – Own Bead Instead Team and Chris Walker

Our Own Bed Instead team, who are based at Brierley Hill Health and Social Care centre, were the latest recipients of our team healthcare hero award.

The team were nominated for always being there to support patients when they really need it and for the valuable advice and insight they provide to other members of staff in the Trust.

Their vital work alongside the Therapy department based at Russells Hall Hospital was also recognised with the team saying that they are so grateful for the work Own Bed Instead do every day and that without their support the Therapy team would be lost.

Patient Feedback

Ward C5 - The lovely nurses who were very dedicated and caring. The consultant had a wonderful bedside manner.

Maternity (Antenatal) - Fantastic communication, very relaxed but efficient environment. Staff were excellent and thoughtful. Julie was amazing.

Day Case Unit, Corbett - Kind and friendly staff but also very professional and caring, wonderful people. Just a great service.

Post Coronary Care Unit/Coronary Care Unit - The whole of the staff from the consultant to the auxiliary staff were very professional, caring, and helpful.
General Community - We have had great experience of care been giving by yourself and hospital we can't fault anything. Everyone so friendly.

C2 (Children's) - All staff are amazing & very supportive. Can't asked for more. Everyone on the unit is compassionate & can't thank you all enough. Thank you one and all.

Surgical Pre-Assessment - Really caring staff, who were so kind and thoughtful to my needs when I was upset. Keep up the great work, you are all amazing.

Critical Care - Huge thank you to the amazing critical care team who supported me and my family during such a tragic time.

Clinical Research Unit - Caring professional staff, confidential practice and perfect clinical techniques. Listened to my thoughts and acted according. Very pleased with appointment.

Visits and Events

1 July	Black Country Provider Collaborative Executive
10 July	Black Country Quarterly System Review
11 July	Dudley Group Public and Private Board
16 July	Dudley Group Oversight and Assurance
16 July	Black Country System Chief Executive Officers
17 July	West Midlands Cancer Alliance Board
19 July	Black Country Joint Provider Committee
24 July	Midlands Chief Executive Update with NHS Midlands Regional Director
24 July	Black Country Financial System Oversight Group
25 July	Finance and Productivity Committee
25 July	Black Country Integrated Card Board Public and Private Board
29 July	Dudley Learning Event with Walsall Together
29 July	Get It Right First Time Senior Responsible Officer meeting
30 July	Regional Access Board
30 July	Black Country System Chief Executive Officers
1 August	Integrated Care Board Development Session
2 August	Black Country Elective and Diagnostic Strategic Board
19 August	Corporate Services Transformation Delivery Group
22 August	Black Country Financial Recovery System Oversight Group
23 August	Black Country Provider Collaborative Joint Board Workshop
27 August	Black Country System Chief Executive Officers
29 August	Dudley Group Finance and Productivity Committee

The Dudley Group NHS Foundation Trust

Paper for submission to the Board of Directors on 12th September 2024

Report title:	Public Questions
Sponsoring executive:	Sir David Nicholson, Chairman Daine Wake, Chief Executive Officer
Report author:	Helen Board, Board Secretary

1. Summary of key issues using Assure, Advise and Alert

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

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

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

Questions received:

CN, Public Trust Governor
Q1: What provisions have been put in place by the Trust, to address the main theme of complaints in 2023/2024 which was for "Poor Communication with patients and relatives"?

Q2: What Improvements have been made by the "Division of Surgery" who in 2023/2024 received 442 complaints, more than any other Division within the Trust?

A: Thank you for taking the time to write in. Please receive the response below prepared by our Associate Director of Patient Experience, Jill Faulkner:

1. **Senior Oversight**: The senior nursing teams and consultant teams within directorates continue to review complaints and identify patterns, themes or any systemic issues. The directorate teams are working to address these issues and prevent future complaints. if any themes are identified, these are reported into the surgical divisional governance meeting as well as the divisional quality confirm and challenge meetings. Shared learning is also discussed as part of the lead nurse and matron forums and forms part of the agenda at the directorate governance meetings. Matrons and lead nurses are allocated clinical shifts per week to work alongside the clinical teams, role modelling best practice and standards.
2. **Staffing and Resource Allocation**: Reviewing and adjusting staffing levels to ensure that there are enough staff members to provide high-quality care. Local risk assessments are carried out daily to ensure the best possible patient outcomes, with matron oversight.
3. **Patient Education**: Providing better education for patients about what to expect from their surgical procedures and recovery processes has been identified as a key indicator. This can help manage expectations and reduce misunderstandings. The matrons are using the CNS teams to help facilitate some of the patient education outcomes.
4. **Process Improvements**: The division are reviewing and working towards streamlining administrative processes to reduce delays and errors, such as those related to scheduling,

pre-operative assessments, and follow-up care. Theatre utilisation is high on the division's agenda and this is managed at director level.

5. **Patient Feedback:** The patient experience team have been supporting ward areas with collecting and acting upon patient data in real time. This has allowed patients to voice their concerns and has given the clinical teams a more robust mechanism for addressing complaints promptly.

In terms of communication, the division absolutely recognise that we need to enhance communication:

- **Communication:** we are working towards clearer communication protocols between patients and medical staff. Teams are encouraged to frequently update patients about treatment plans and progress, better handling of patient concerns, and improving bedside manner. There are robust processes in place in terms of an MDT approach to white board reviews, this allows for any patient concerns to be identified early in the day.
- **Training:** we are focusing on additional training for the surgical and nursing teams including support staff, particularly in areas such as patient interaction, empathy, and handling complaints effectively.
- **Thematic review:** we are undertaking thematic reviews of quality care across our inpatient areas, aiming to deliver a programme of continuous improvement. The thematic reviews will help identify any themes or trends, it provides a benchmark for performance and helps to identify and facilitate any learning or development. The reviews will help the clinical teams to have a greater understanding into any concerns or issues, enabling this to be addressed promptly.

By implementing these types of improvements, the Division of Surgery can work towards addressing the root causes of complaints and enhancing overall patient satisfaction

KMc, Foundation Trust Member

Q: Hello Helen Hope you are well and wondered if I could ask if the following question could be raised with the board we have recently started creating a broadcast with Black Country radio on disability while we were waiting for our interview to arrive today we were talking to our producer Brian Dakin, who is also known as the artist Billy Sake mom Told us that when raising funds for various units within Russellville hospital he has been told by a member of staff who believes to be a manager that he is not allowed along with his colleague to come inside the hospital building even in poor weather to do his fundraising which he does by singing with a banjo and washboard and he cannot enter the reception area. We feel this is very unfair as both of them are working to raise funds for the hospital and that it does not seem to make any sense to ask them to perform outside in poor weather, heat rain snow etcetera could you ask the board to reconsider this decision or if they are aware of it to look at changing it?

A: Thank you for taking the time to write in. Please receive the response below prepared by our Head of Fundraising, Nithee Patel:

Billy is a longstanding very well-respected fundraiser of the Dudley Group NHS Charity; over the last few years he has raised enormous amounts of donations through busking for multiple departments across the Trust. Billy has been invited to our external fundraising events such as our superhero fun run, cricket matches and community days. We were thrilled that he attended our Glitter Ball event last November as one of our keynote speakers to our corporate partners and senior leaders from across the Trust.

We absolutely welcome Billy and his supporters to busk at the Trust as we know he brings a lot of joy and happiness to staff, patients, and visitors.

As you can imagine the main reception at Russells Hall is a busy area and we have had feedback from staff members who are based in offices nearby that they struggle with increased noise levels. We are actively working with Billy to explore other locations where Billy could play across the Trust including our satellite sites at the Corbett or Guest Outpatient Centres.

We are also currently in the planning stage of which department Billy and his supporters will be fundraising for in 2025.

SH, Foundation Trust Member
Q: How is the trust preparing for the inevitable avalanche of issues in the form of threats and opportunities arising from the current and potential use of A.I. tools in healthcare generally and diagnosis specifically?

A: There are very specific rules governing the use of AI and how it is a tool to aid with healthcare and diagnosis but should be used alongside clinical practice, not instead of.

Aligning with the National Cyber Security Centre (NCSC) 'Secure by Design' principles, the Trust has a robust IT Vetting and Assurance process in place to support the procurement, secure design, secure development, secure deployment and secure operational support and continual improvement for all digital solutions including those which utilise AI.

In parallel with IT Vetting and cyber security, the Trust also has robust Information Governance processes including the provision of Data Protection Impact Assessments (DPIA) for all solutions and activities which include the processing of data.

All Trust staff complete annual statutory Data Security Awareness Training which includes cyber security awareness and the key message of Cyber Resilience = Patient Safety to promote vigilance throughout all staff groups. Awareness of AI and considerations in terms of data and cyber security is also included in this training.

2. Alignment to our Vision [indicate with an 'X' which Strategic Objective[s] this paper supports]	
Deliver right care every time	**X**
Be a brilliant place to work and thrive	**X**
Drive sustainability (financial and environmental)	**X**
Build innovative partnerships in Dudley and beyond	**X**
Improve health and wellbeing	**X**

3. Report journey
Board of Directors

4. Recommendation(s)
The Public Trust Board is asked to:
a) **Note** the questions received and response provided.

5. Impact		
Board Assurance Framework Risk 1.1	X	Deliver high quality, safe person centred care and treatment
Is Quality Impact Assessment required if so, add date:		
Is Equality Impact Assessment required if so, add date:		

The Dudley Group NHS Foundation Trust

Paper for submission to the Board of Directors on 12 September 2024

Report Title:	Integrated Committee Upward Assurance Report
Sponsoring Executive:	Gary Crowe, Deputy Chair
Report Author:	Gary Crowe, Deputy Chair Helen Board, Board Secretary

1. Summary of key issues using Assure, Advise and Alert

This paper outlines the key points of assurance and escalation from the Board Committee meetings Finance & Productivity:F&P, Quality:Q, People:P, Integration:I held in July and August 2024 as indicated. The report details work commissioned as a result of discussions held and any decisions made.

Assure

- Strong overall operational performance was seen against national standards and local recovery plans. F&P
- Year to date the Trust was £364k ahead of budget and £812k ahead of CIP targets, noting that pressing challenges lie ahead. F&P
- No issues to date had arisen from RAAC surveys. F&P
- Stillbirth and neonatal death rates have improved, the stillbirth rate is now less than national average and the neonatal death rate is at national average. Q
- Decreased Summary Hospital-level Mortality Indicator (SHMI) and Hospital Standardised Mortality Ratio (HSMR) over last 12 months continues. SHMI for stroke and fracture neck if femur has decreased Q
- All clinical facing Teams excelling utilising multiprofessional working, setting own standards and quality improvement measures recognised with National Awards, supporting bid to become a University Hospital. Q
- Good level of compliance with Priority 1 and 2 mandatory training. Q
- Positive progress with Gold Standards Framework Accreditation across the Trust with both new ward accreditations and reaccreditations. Making the Trust a national exemplar. Q
- Excellent patient and family involvement in Patient Safety Incident Response Framework (PSIRF) investigations significantly adding to learning from incidents. Q
- Positive assurance was received on the finalised Dudley Health and Care Partnerships annual report. I
- Positive assurance was received on the ongoing work to process the DIHC Transaction. I

Advise

- A review of Whole Time Equivalent (WTE) staffing was commissioned and revised productivity performance at the next F&P meeting in order to consider a new strategic approach. P
- Workforce Race Equality Standard & Workforce Disability Equality Standard data submissions reports were endorsing for publication noting that changes would be required ahead of publication to focus on what the Trust is actually doing to address areas for improvement. P
- AHP Workforce Review has been completed and presented to the Executive Team. P
- Good compliance with 3-year service delivery plan for Maternity and Neonates. Work is ongoing to improve culture, development of maternity EPR portal, deprivation and equality strategies, strengthening patient/family voice, local and national development programmes and midwifery workforce business case. Q

- Work is ongoing with Divisions and Black Country Collaborative with regards to workforce alignment and benchmarking. P
- Loss of CAHMS funding for admission avoidance, which has been escalated and is being mitigated, with service provision remining in place. Q
- Staffing challenges within the Tissue Viability Team, with some improvement anticipated during September 2024. Q
- iCan project update received – excellent partnership working providing paid apprenticeships with 10 new recruits starting in September. P
- Organisational development & Leadership journey with significant work underway providing a very structured approach and committee was very assured about developments in this area. P
- Integration committee agreed the health inequalities recommendations to develop a work programme for health inequalities for remainder of 2024/25 to be included in next health inequalities report to October 2024 with indication of longer term actions required as part of the refreshed strategy.

Alert

- Current risk of non-delivery against the workforce and bank reduction targets in line with the Financial Recovery Plan. Call for plan B with cohesive oversight from each of the committees – F&P, Quality with committee chairs to meet to discuss. All Committees
- The Responsible Clinician contract and Mental Health Administrator SLA are now in place. However, there are ongoing challenges from Black Country Healthcare NHS Foundation Trust regarding implementation of the Responsible Clinician contract. Q
- MIS Year 2 compliance and remedial action plan request from NHS Resolution. Q
- Decrease in L3 Safeguarding Adults training compliance as a result of approximately 350 staff not assigned to the correct level of training. Actions have been taken to address this timely. Q. P
- Following the presentation from the family hubs, concern was raised with regards to the funding for the family hubs ceasing on the 31st March 2025. I

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

3. Report journey
Board of Directors, 12/09/2024.

4. Recommendation(s)
The Public Trust Board is asked to:
a) Note the assurances provided by the Board Committees, the matters for escalation and the decisions made .

5. Impact		
Board Assurance Framework Risk 1.1		Deliver high quality, safe person centred care and treatment
Board Assurance Framework Risk 1.2		Achieve outstanding CQC rating.
Board Assurance Framework Risk 2.0		Effectively manage workforce demand and capacity
Board Assurance Framework Risk 3.0		Ensure Dudley is a brilliant place to work
Board Assurance Framework Risk 4.0		Remain financially sustainable in 2023/24 and beyond

Board Assurance Framework Risk 5.0		Achieve carbon reduction ambitions in line with NHS England Net Zero targets
Board Assurance Framework Risk 6.0		Build innovative partnerships in Dudley and beyond
Board Assurance Framework Risk 7.0		Achieve operational performance requirements
Board Assurance Framework Risk 8.0		Establish, invest and sustain the infrastructures, applications and end-user devices for digital innovation

Finance and Productivity Committee Chairs Report

Committee Chair: Lowell Williams

25th July 2024
New upward reporting format was not adopted for this meeting.

See quadrant immediately below

29th August 2024	
National Cost Collection	Substantial Assurance
Integrated Performance Report Month 4 2024/25	Substantial Assurance
Black Country Pathology Service	Partial Assurance
Finance Update Month 4 2024/25	Reasonable Assurance
Workforce Update Month 4 2024/25	Reasonable Assurance
PFI Performance	Substantial Assurance
Procurement Performance	Substantial Assurance
Contract Award for Merry Hill	Substantial Assurance

Meeting held 25th July 2024

MATTERS OF CONCERN OR KEY RISKS TO ESCALATE	MAJOR ACTIONS AGREED
• There was a concern related to the increase in ambulance handovers over 30 mins and 1 hour waits, exasperated by slower discharge. • Workforce numbers were above target for substantive and bank.	• The committee asked for further information on risk mitigation in respect to the Admit, Transfer and Discharge (ADT) process. • A paper was requested exploring how emergency team performance could be improved without oversight. • A review of Whole Time Equivalent (WTE) staffing was commissioned and revised productivity performance at the next meeting in order to consider a new strategic approach.
POSITIVE ASSURANCES TO PROVIDE	**DECISIONS MADE**
	• No formal approvals were made.

• The committee took positive assurance from the strong performance against cancer standards. • ERF performance continued to be strong. • The review of the Community Diagnostic Centre (CDC) business case was positive and supported cancer diagnostic performance.	

Meeting held 29th August 2024

MATTERS OF CONCERN OR KEY RISKS TO ESCALATE	MAJOR ACTIONS AGREED
• Whilst noting improvement, the committee was only partially assured by the performance of the Black Country Pathology Service (BCPS). • Workforce reduction is not being achieved; the Trust was 168 WTE above target driven by bank spend. It was noted that bank spend had reduced from the prior year and had been impacted by industrial action and additional elective work. • There was a concern around the potential adverse year end variance to budget of £12.4m. However, the committee noted that mitigations were in place to offset negative variances arising.	• Additional data on the financial performance and benchmarking targets was requested to be added to the Black Country Pathology (BCPS) report. • The committee requested additional data disaggregating bank spend within the workforce report.
POSITIVE ASSURANCES TO PROVIDE	**DECISIONS MADE**
• Strong overall operational performance was seen against national standards and local recovery plans. • Year to date the Trust was £364k ahead of budget and £812k ahead of CIP targets, noting that pressing challenges lie ahead. • Substantial levels of assurance were gained from the divisional deep dive into Surgery, Women and Childrens division. • There had been a sustained performance of the PFI contract into quarter one of this year. • No issues to date had arisen from RAAC surveys. • The Trusts strong operational performance provided the committee with positive assurance.	• The committee approved the retrospective submission of reference costs work. • The approval of the contract award to the DMR Group for the Merry Hill unit was recommended to Board.

Quality Committee Chair's Report

Committee Chair: Professor Liz Hughes

30 July 2024	
Quality Integrated Report	**Partial Assurance**
Medical Director & Chief Nurse Report	**Reasonable Assurance**
Quality Impact Assessment Update	**Reasonable Assurance**
Quality Priorities	**Reasonable Assurance**

27 August 2024	
3-year delivery plan for Maternity & Neonates	**Partial Assurance**
Perinatal Clinical Quality Surveillance	**Partial Assurance**
Black Country Thematic Review of Stillbirths	**Partial Assurance**
Quality Integrated Report	**Partial Assurance**
Patient Safety Specialist Report	**Substantial Assurance**
Medical Director & Chief Nurse Report, including Safer Nursing Staffing Review report (bi-annual)	**Reasonable Assurance**
Workforce Plan	**Minimal Assurance**

MATTERS OF CONCERN OR KEY RISKS TO ESCALATE

- Ongoing challenges from Black Country Healthcare Trust regarding implementation of Responsible Clinician contract.
- Loss of CAHMS funding for admission avoidance. However, the 24/7 crisis helpline continues to be manned by core CAMHS from 9am to 5pm, which is funded and remains in place. From 17:00 to 08.00, the telephone line is manned by the Crisis Team. Additional funding has been requested from the Provider Collaborative for a second supporting clinician, however the outcome of this bid is outstanding. Therefore, support continues to be provided by the BCHFT Crisis Team with a hope to further enhance it.
- MIS Year 2 compliance and remedial action plan request from NHSR.

MAJOR ACTIONS AGREED/WORK UNDERWAY

- Nursing Safer Staffing Review - strengthened processes in line with national requirements. Reviewed with Divisions considering the data, using professional judgement and reviewing quality indicators to determine safer staffing levels in each area. Overall, positive position to provide and deliver safe, effective and high-quality care. Presented to Executive Team to discuss establishment change requests considering financial restraints.
- AHP Workforce Review - presented to Executive Team, work to continue to ensure all areas of workforce covered and include quality elements in QPR. Integrated Report due to Board with Performance Report in November 2024.

• IPCG meetings changed to monthly to strengthen focus on IPCG agendas and oversight of issues around cleanliness. • Workforce challenges in the Tissue Viability Team. • Work ongoing to improve compliance with complaint responses. • Work ongoing to improve sewerage issues in the Imaging department to maintain safety and support staff morale. • Workforce Plan to ensure quality and safety of patients and staff. Work ongoing with Divisions and Black Country Collaborative on workforce alignment. DGFT WTE above target due to case mix, pay award and higher averages in plan, however cumulative saving of £594,000. Significant overspend for Bank use for clinical staff due to additional capacity areas remaining open and industrial action. Agency spend reduced. Work ongoing with Divisions and Executives review nursing and medical Bank usage. • Right Care, Right Person - Section 136 of Mental Health Act to be introduced 21 October 2024; handover of patients from Police to NHS within 1 hour. System wide actions in progress. Discussion ongoing at DGFT for impact on ED and Mitie resources. • Latest GMC National Trainee Survey highlighted, General Surgery and Paediatrics require improvement. An action plan in place to further address issues.	• Gloves Off Campaign - work ongoing to support staff, undertaking audits, posters displayed and IPC team working with PFI Partners. Working with sustainability partners to reduce waste and cost. Planned hand hygiene campaign during IPC Week. • Cultural change required with Senior Nurses and Midwives undertaking back to the floor days/night visits to role model improvements and raise standards. • 3-year service delivery plan for Maternity and Neonates - good compliance, currently 82% rated as Green. Work ongoing to strengthen including culture, development of maternity EPR portal, deprivation and equality strategies, strengthening patient/family voice, local and national development programmes and midwifery workforce business case. • Birth Trauma Inquiry - working group established to address actions required to be fully compliant with the recommendations. • LMNS still births report presented in detail and resultant action plan developed. One recommendation is to develop PGD for Midwives to dispense Aspirin, working with Pharmacy. • Medical Staffing Review to be undertaken at request of Executive Team.
POSITIVE ASSURANCES TO PROVIDE • Improvements with Level 3 Safeguarding compliance (reported in July). Since then, it has been discovered that not all staff have been aligned to the correct level of training. Remedial plan is in place. • DGFT only organisation with Critical Care Service Gold Standard Framework (GSF) accreditation. In addition, wards C5 and C6 achieved Gold Standard Framework (GSF) accreditation and wards C4, C1a and B6 achieved reaccreditation. • Responsible Clinician contract and Mental Health Administrator SLA now in place. • Stroke SSNAP performance has shown improvement. • NED walkaround of Maternity and Neonates impressive with staff working hard to make improvements.	**DECISIONS MADE** • The assurance level for BAF Risk 1.1 remains as inconclusive. However, the Committee has noted a positive progress across a variety of areas and actions articulated within the BAF. The key threats to fully mitigating the risk include; the current very challenging financial position; potential impact of MMUH opening and consistent application of best practice and standards. The Trust's QIA process has been further strengthened to ensure that quality impact is understood and fully mitigated as required. • The assurance level for BAF Risk 1.2 remains as positive. • The Committee reviewed, discussed, and approved the following report:

• Teams excelling utilising multiprofessional working, setting own standards and quality improvement measures recognised with National Awards, supporting bid to become a University Hospital. • Good progress with Quality Priorities in Q1; new Admiral Nurse will commence in post in September to provide improvements in patient journey, and quality improvement work and review of processes underway for fractured neck of femur and stroke pathway. • Good assurance around Quality Strategy update, PSIRF and PIFU. • DGFT stillbirth and neonatal death rate has shown improvement - stillbirths now less than national average (DGFT 2.63, against national average of 3.54) and neonatal death rate at national average. Saving Babies Lives currently 94% compliant. • Recent bimonthly Maternity Safety Champion walkaround concluded current provision acceptable in both Maternity and Neonatal Units, handover improving. • VTE performance consistently remained above 95% since June 2023. • Trust's Patient Safety Strategy to be combined with the Trust's Quality Strategy. Implementing PSIRF framework involving patient safety partners working with Dudley Improvement Practice at DGFT. Piloting family/patient engagement in relation to falls and pressure ulcers identified additional learning. • Decreased Summary Hospital-level Mortality Indicator (SHMI) and Hospital Standardised Mortality Ratio (HSMR) over last 12 months; improvement in denominator and quality of care including Senior Judgement Reviews, falling HSMR with no weekend effect and no Regulation 28 notices in 5 years. • Good progress against CQC action plans including maternity, paediatrics and neonates and ED. • Good level of assurance from all divisions with Priority 1 and 2 mandatory training. • 4 Research, Education and Innovation grant applications made, developing ACP governance. Recent Library Quality visit concluded positive feedback.	- Children's Services Strategy • The Committee reviewed, discussed, and approved the following documents: - Terms of Reference: Research, Education and Innovation Working Group - Terms of Reference: End of Life Working Group • The following Terms of Reference were not approved: - Infection Prevention and Control Working Group • No Health Clearances issued until staff completed vaccination course(s) for required role, minimum MMR vaccination course, Varicella vaccination course and EPP blood testing, noting no impact on recruitment timescales during trial period. Associated recommendations and report approved. • Nursing Safer Staffing review report received, and the Executive Team decision noted.

People Committee Chairs Report

Committee Chair: Catherine Holland

30 July 2024	
• Workforce Key performance Indicators continue to provide a good picture overall with some concerns about short term sickness absence but comfortable that actions to address are in place.	**Reasonable Assurance**
• Workforce Plan not achieving what it set out to achieve and called for plan B with cohesive oversight from each of the committees – F&P, Quality and suggest committee chairs to meet to discuss	**Minimal Assurance**
• Workforce Race Equality Standard & Workforce Disability Equality Standard data submissions reports were endorsing the board approval for publication noting that changes would be required ahead of publication to focus on what the Trust is actually doing to address areas for improvement	**Reasonable Assurance**
• Organisational development & Leadership journey with significant work underway providing a very structured approach and committee was very assured about developments in this area.	**Substantial Assurance**

MATTERS OF CONCERN OR KEY RISKS TO ESCALATE	Major works commissioned/ actions agreed
• Workforce Plan not achieving what it set out to achieve and called for plan B with cohesive oversight from each of the committees – F&P, Quality and suggest committee chairs to meet to discuss	• Freedom to Speak up report to be reviewed – committee needs to be able to better understand the issues and remedies applied • People Promise update – nationally funded post recruited to support our organisational development; committee will be receiving an evaluation later. Work will focus on delivering the high impact interventions set out in the People Promise to achieve improved outcomes and optimum staff satisfaction and retention
POSITIVE ASSURANCES TO PROVIDE	**DECISIONS MADE**
• Black Country Provider Collaborative Workforce workstream verbal update received – system wide Memorandum of Understanding to support movement of staff, hard to fill vacancies, workforce	• Workforce Race Equality Standard & Workforce Disability Equality Standard data submissions reports were endorsing the board approval for publication noting that changes would be required ahead

productivity tool, aligning rates AfC and medical and dental rates, B2 to B3 change in profile. • Workforce KPI continue to provide a good picture overall with some concerns about short term sickness absence but comfortable that actions to address are in place. • iCan project update received – excellent partnership working providing paid apprenticeships with 10 new recruits starting in September • Organisational development & Leadership journey with significant work underway providing a very structured approach and committee was very assured about developments in this area. • Committee noted new working group established 'Being a Brilliant Place to Work and Thrive – progress reports will follow	of publication to focus on what the Trust is actually doing to address areas for improvement • Agreed to retain BAF committee assurance levels as 'Positive' for BAF 2 & 3 • People Committee Terms of Reference approved subject to benchmarking with other trusts in respect of delegation of decision making related to national data submissions

Integration Committee Chairs Report

Committee Chair: Vij Randeniya

31 July 2024	
Dudley Health and Care Partnerships Annual Report	**Reasonable Assurance**
DIHC Transaction Update	**Substantial Assurance**
Intermediate Care Framework	**Reasonable Assurance**
Health Inequalities update	**Reasonable Assurance**

28 August 2024	
Board Assurance Framework – Risk 6	**Reasonable Assurance**
DIHC Transaction Update – Self Certification	**Substantial Assurance**
Dudley Health and Care Partnerships	**Substantial Assurance**
Health Inequalities Deep Dive - Maternity and Childrens services	**Substantial Assurance**
Health Inequalities Deep Dive - Carers Hub/ Dudley CVS	**Substantial Assurance**

MATTERS OF CONCERN OR KEY RISKS TO ESCALATE

31st July 2024

- Following the presentation from the family hubs, concern was raised with regards to the funding for the family hubs ceasing on the 31st of March 2025.

28th August 2024

- No key matters of concern were raised at the Integration Committee meeting on the 28th August.

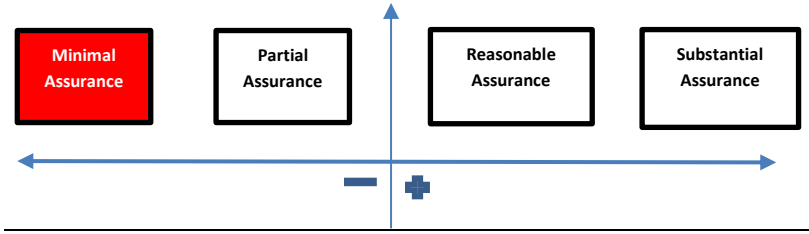
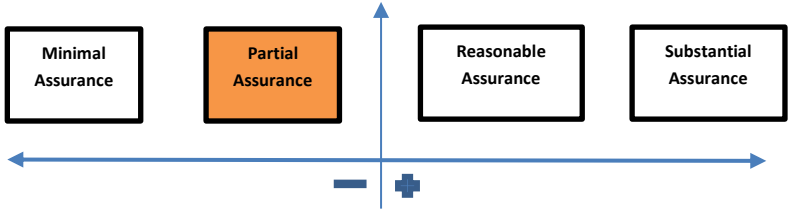
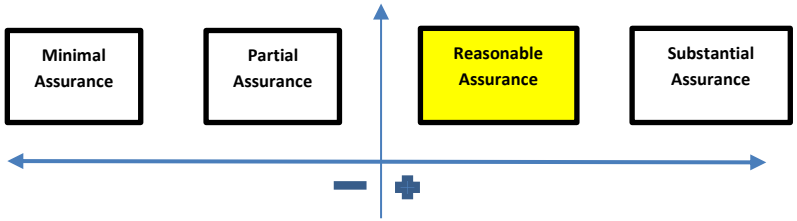
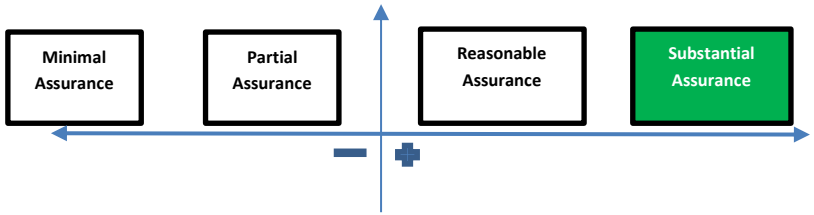
Major works commissioned/ actions agreed

31st July 2024

- DIHC self-certification process to be presented to the next Integration Committee in August, prior to presenting to Trust Board in September.
- The committee agreed the health inequalities recommendations to develop a work programme for health inequalities for remainder of 2024/25 to be included in next health inequalities report to October 2024 with indication of longer term actions required as part of the refreshed strategy.
- The committee asked that work was undertaking to scope how Dudley Health System can shift capacity to focus on preventative services and what the demand for this would be and build this into the Trusts clinical service plan and To look at how other health systems have shifted the focus to delivering preventative intervention delivered by integrated services.

28th August 2024

	• The committee agreed to share any feedback to Kat Rose to collate on behalf of the Trust, on the Future Black Country Primary Care Outlined Strategy. • Following the deep dives on health inequalities, the chair (Vij Randeniya) asked the committee if we could receive a health inequalities deep dive on Adults & Elderly care.
POSITIVE ASSURANCES TO PROVIDE **31st July 2024** • Positive assurance was received on the finalised Dudley Health and Care Partnerships annual report. • An update on the work been undertaken in relation to the Intermediate Care Framework provided positive assurance. • The health inequalities update received positive assurance on the work ongoing, and work commencing within the partnership. • The family hubs practice manager joined the committee to share an insight into the services that they provide. The committee received positive assurance noting great partnership and integrated working. **28th August 2024** • Positive assurance was received on the ongoing work to process the DIHC Transaction. • Positive assurance was provided following the update on Dudley Health and Care Partnerships, with the ongoing collaborative and integrated work within the partnership. • The health inequalities deep dive within maternity services received positive assurance. • Positive assurance was received following the deep dive on the Carers Hub, which is called the 'Information Hub (patients/ carers/ staff) which is opening within September.	**DECISIONS MADE** **31st July 2024** • The committee approved the updated Terms of Reference, minor amendments were proposed in terms of the membership. • The committee agreed that BAF risk 6 assurance level remains the same. **28th August 2024** • DIHC self – certification process was received, where the committee confirmed it was satisfied with the requirements of appendix 7 of the NHSE Transaction guidance is met. • The committee agreed that BAF risk 6 assurance level remains the same.

	Management cannot clearly articulate the matter or issue; something has arisen at Committee for which there is little or no awareness and no action being taken to address the matter; there are a significant number of risks associated where it is not clear what is being done to control, manage or mitigate them; and the level of risk is increasing.
	There is partial clarity on the matter to be addressed; some progress has been made but there remain a number of outstanding actions or progress against any plans so will not be delivered within agreed timescales; independent or external assurance shows areas of concern; there are increasing risks that are only partially controlled, mitigated or managed.
	There is evidence of a good understanding of the matter or issue to be addressed; there are plans in place and these are being delivered against agreed timescales; those that are not yet delivered are well understood and it is clear what actions are being taken to control, manage or mitigate any risks; where required there is evidence of independent or external assurance.
	There is evidence of a clear understanding of the matter or issue to be addressed; there is evidence of independent or external assurance; there are plans in place and these are being actively delivered and there is triangulation from other sources (e.g. patient or staff feedback)

Joint Provider Committee – Report to Trust Boards

Date: 19th July 2024

Agenda item:

TITLE OF REPORT:	Report to Trust Boards from the 19th of July 2024 JPC meeting.
PURPOSE OF REPORT:	To provide all partner Trust Boards with a summary of key messages from the 19th of July 2024 Joint Provider Committee.
AUTHOR(S) OF REPORT:	Sohaib Khalid, *BCPC Managing Director*
MANAGEMENT LEAD/SIGNED OFF BY:	Sir David Nicholson - *Chair of BC JPC & Group Chair of DGFT, SWBH, RWT, & WHT* Diane Wake - *CEO Lead of the BCPC*
KEY POINTS:	The Joint Provider Committee (JPC) was held, and was quorate with attendance by the Chair, two Deputy Chairs, and all three CEO's. Key discussion points included: a. A progress update from the BCPC CEO Lead with a particular focus on key agreements at its recent meeting. b. An update on the progress being made to deliver the CIP schemes across the four BCPC partners. c. An update on plans to address the increased UEC activity within the Black country, and the underlying financial gap. d. An update on the establishment and progression of the Corporate Services Transformation work. e. An update on the development of the programme for the forthcoming Joint Board Development Workshop on the 23rd August 2024.
RECOMMENDATION(S):	The partner Trust Boards are asked to: a) **RECEIVE** this report as a summary update of key discussions at the 19th of July 2024 JPC meeting. b) **NOTE** the key messages, agreements, and actions in section 2 of the above report.
CONFLICTS OF INTEREST:	There were no declarations of interest.
DELIVERY OF WHICH BCPC WORK PLAN PRIORITY:	The Joint Provider Committee oversees and assures progress against the agreed BCPC annual Work Plan, as outlined in schedule 3 of the Collaboration Agreement, and any other delegations.
ACTION REQUIRED:	☒ Assurance ☐ Endorsement / Support ☒ Approval ☐ For Information

Possible implications identified in the paper:	
Financial	The following agenda items have a potential risk implication: ▪ Urgent & Emergency Care has a c£8m risk to the system and potentially to the four partners of the BCPC. ▪ The non delivery of the BCPC CIP schemes as part of the system FRP ('Clinical & Operational Productivity') ▪ The non-delivery of cash efficiency savings from the Corporate Services Transformation work
Risk Assurance Framework	The following agenda items have a potential risk implication: ▪ Corporate Services Transformation – require a clear plan of planned efficiency savings, productivity improvement, and resilience.
Policy and Legal Obligations	▪ N/A
Health Inequalities	▪ N/A
Workforce Inequalities	The following agenda items have a workforce inequalities implication: ▪ The BCPC CIP schemes as part of the system FRP ('Clinical & Operational Productivity'), and in particular the configuration of the agreed 4% workforce reduction. ▪ Corporate Services Transformation work – if not specified correctly could have workforce inequalities implications
Governance	▪ N/A
Other Implications (e.g. HR, Estates, IT, Quality)	The following agenda item has a potential implications: ▪ BCPC CIP schemes – may have positive/ negative implications for quality depending on the focus of the CIP scheme. ▪ Corporate Services Transformation work – if not specified correctly could have workforce inequalities implications

1. PURPOSE

1.1 To provide all partner Trust Boards with a summary of key messages from the 19th of July 2024 Joint Provider Committee.

2. SUMMARY

2.1 The Joint Provider Committee was held on the 19th of July 2024. The meeting was quorate with attendance by the Chair, three CEO's and two of the four Deputy Chairs.

2.2 The minutes of the previous meeting were accepted as an accurate record. The Action Log was reviewed with progress discussed and accepted.

2.3 The following is a summary of discussions with agreements noted:

a) **Items for Approval / Noting**

- **CEO Leads update report** – The JPC received an update report from the Chair of the Collaborative Executive, which focused on a smaller range of important topics, highlighting the following:
  - The positive progress being reported (based on month 2 data) in delivering to plan across the four BCPC partners on the programme of CIPs. It was noted that there remain some challenges ahead, but positive progress is being made to close the unidentified year 1 'gap' from £45m to c.£39m.
  - A focused discussion on the corporate transformation programme which updated on the formation of governance and leadership arrangements, in addition to some key principles and communication messages to come.
  - The confirmation of a consolidated clinical contracting function to be established on behalf of the four partners, and to be hosted by RWT, following due processes.
  - A review of the proposed changes to the Collaboration Agreement, with all partners supporting and approving the updates and revisions. A Board paper will follow shortly to confirm changes and seek delegations which will require adjustments to all partner Trusts 'Scheme of Reservation or Delegations' (S.O.R.D).

b) **Items for Discussion**

- **Clinical & Operational Productivity** – The JPC received a detailed and up to date position (based on out-turn month 3 data). It was noted that efficiency delivery remains on track, but non-recurrent delivery is ahead of plan compensating for under-delivery on recurrent schemes.

  Workforce plans are off-track, which may be due to the recent Industrial Action, but will require a focused effort moving forward.

  There remains a significant challenge ahead, due to the profiling of efficiency savings incrementally growing monthly from Q3 onwards, in addition to the need to convert non-recurrent efficiency savings to recurrent savings.

  Given its tier 4 status, the Black Country ICS has been informed by NHSE that it will be undergoing some focused 'Investigation & Intervention' work, with the system selecting PA Consulting as its partner for this work. Phase 1 will

commence immediately, lasting for about 4-6 weeks, and resulting in an assurance assessment of the governance arrangements in place for planned delivery, alongside the identification of 4-6 further interventions which may support delivery of efficiencies.

- **Plan for Urgent & Emergency Care Flows** – The JPC received an updated system paper outlining the range of issues driving a financial gap for Urgent & Emergency Care (UEC) activity. It was noted that the Black Country system is a net importer of UEC activity from surrounding systems which is a significant cause of operational and financial pressures across most of the Black Country Acute sites.

  Currently there is a projected c£8m revenue gap for which options were presented and discussed. The JPC provided firm guidance on managing this risk, which will be conveyed by the UEC Chair (and SWBT CEO) to the BC ICB imminently.

- **Corporate Services Transformation** – The JPC received an update from the SRO confirming agreements at the 1st of July 24 Collaborative Executive. Governance and leadership arrangements are being established, and the first meeting of the Corporate Services Transformation programme – Delivery Group (CSTP-DG) will take place shortly.

  Our external partners, BC Integrated Care Board and Black Country Healthcare NHS trust have confirmed their participation in the Corporate Services Transformation work.

  A communications and engagement plan is being developed and will be shared as soon as possible, together with a 'detailed benefits schedule' and other key supporting processes.

- **Joint Board Development Workshop** – The JPC reviewed the draft programme for the forthcoming Joint Board Development Workshop. It was noted that acceptance to attend was high, and all logistics were in hand. A slight adjustment to the programme was requested to include a short slot on the progress for opening the MMUH.

c) Any Other Business

- There was no A.O.B.

3. REQUIRED ACTIONS

3.1 The partner Trust Boards are asked to:

a. **RECEIVE** this report as a summary update of key discussions at the 19th of July 2024 JPC meeting.

b. **NOTE** the key messages, agreements, and actions in section 2 of the above report.

Enclosure 6

The Dudley Group NHS Foundation Trust

Paper for submission to the Board of Directors on 12th September 2024

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

1. Summary of key issues using Assure, Advise and Alert

Assure

1. The Board is asked to note the Month 4 (July 2024) Trust financial position. After technical changes the July cumulative position is a £14.088m deficit. This position is £0.364m better than the updated phased plan submitted to NHSE in June.

2. Performance against the Elective Recovery Fund continued to be positive in July.

3. The Trust has overachieved on the Cost Improvement Programme plan as at the end of July by £0.812m.

4. The Trust is forecasting that we will achieve our 2024/25 financial year planned deficit of £32.565m after technical adjustments.

Advise

1. The Board is asked to note the Black Country Integrated Care System July 2024 financial position and year end deficit plan of £119.2m. The System has been subject to an 'Investigation and Improvement' review from NHSE which has consisted of a third-party review of plans and year to date performance and controls and will report back to NHSE on confidence in delivery of the financial plan

Alert

1. Pay expenditure to the end of July showed an overspend of £0.167m against plan. Substantive and bank whole time equivalent reductions were not achieved compared to the July plan.

2. Currently there is a forecast shortfall on delivery of the Cost Improvement Programme of £6.118m. Divisions are developing mitigations along with the 'Investigation and Improvement' solutions to ensure delivery of the financial plan.

2. Alignment to our Vision [indicate with an 'X' which Strategic Objective[s] this paper supports]	
Deliver right care every time	**X**
Be a brilliant place to work and thrive	**X**
Drive sustainability (financial and environmental)	**X**
Build innovative partnerships in Dudley and beyond	**X**
Improve health and wellbeing	**X**

3. Report journey

Month 4 (July 2024) detailed finance report presented to the Finance and Productivity Committee on the 29th August 2024.

Summary Month 4 financial report presented to Executive Directors on 13th August 2024.

4. Recommendation(s)
The Public Trust Board is asked to:
a) Note the financial performance for the month of July 2024.
b) Note the reported Trust and System 2024/25 financial year end position.
c)

5. Impact		
Board Assurance Framework Risk 1.1	X	Deliver high quality, safe person centred care and treatment
Board Assurance Framework Risk 1.2	X	Achieve outstanding CQC rating.
Board Assurance Framework Risk 2.0	X	Effectively manage workforce demand and capacity
Board Assurance Framework Risk 3.0	X	Ensure Dudley is a brilliant place to work
Board Assurance Framework Risk 4.0	X	Remain financially sustainable in 2024/25 and beyond
Board Assurance Framework Risk 5.0	X	Achieve carbon reduction ambitions in line with NHS England Net Zero targets
Board Assurance Framework Risk 6.0	X	Deliver on its ambition to building innovative partnerships in Dudley and beyond
Board Assurance Framework Risk 7.0	X	Achieve operational performance requirements
Board Assurance Framework Risk 8.0	X	Establish, invest and sustain the infrastructures, applications and end-user devices for digital innovation
Is Quality Impact Assessment required if so, add date: No		
Is Equality Impact Assessment required if so, add date: No		

REPORTS FOR ASSURANCE AND DECISION

FINANCE REPORT

REPORT TO PUBLIC BOARD OF DIRECTORS ON 12 SEPTEMBER 2024

1. EXECUTIVE SUMMARY

1.1 After technical changes the **July cumulative position is a £14.088m deficit.** This position is £0.364m better than the phased plan submitted to NHSE as part of the June plan resubmission.

1.2 The actual position in July is slightly better than the revised plan. Over achievement on income predominantly Elective Recovery Fund overperformance and Cost Improvement Programme (CIP) performance being ahead of plan is offset by non-pay overspends relating to drug overspends, surge bed expenditure, industrial action costs and the maternity improvement scheme year two repayment.

1.3 Performance against the Elective Recovery Fund continued to be positive in July. Estimates for July activity show a predicted over performance of £4.063m against the assumed Elective Recovery Fund NHSE target. This is also £0.537m higher than the Trust internal plan which includes Elective Recovery Fund CIP schemes.

1.4 Pay expenditure to the end of July showed an overspend of £0.167m against plan. Although substantive whole time equivalent reductions were not achieved compared to plan as at the end of July substantive pay costs are £0.594m below plan. This relates to a high-cost mix of staff costs being used in the plan relating to the workforce reduction scheme. Bank expenditure has continued to exceed plan in July with bank now being overspent by £0.852m. Agency usage remains very low and is £0.091m under spent against plan with only medical staff being used in July.

1.5 Non pay spend continued to exceed the budget in July. This was partly attributable to ICB passthrough drugs within the block contract, general drugs, Black Country Pathology Service contract and the maternity improvement scheme year two repayment.

1.6 The phased Cost Improvement Programme plan to July equated to £7.439m. Achievement to July totals £8.251m which is better than plan by £0.812m. Of the total Cost Improvement Programme target of £31.896m, 98% had been identified by the end of July equating to £31.359m. The risk is now the delivery of the programme, especially the workforce related elements.

1.7 The Trust financial forecast for the 2024/25 financial year remains in line with plan at a £32.565m deficit. A risk analysis has been undertaken showing a worst-case scenario of a £12.368m deficit against that plan. Actions are being put in place at a Trust and System level to mitigate this risk.

1.8 The Integrated Care System reported an actual aggregate deficit of £80.479m for July. This is £15.214m worse than the plan submitted to NHSE in June.

1.9 The System submitted a £119.2m deficit plan to NHSE in June. The System has been subject to an 'Investigation and Improvement' review from NHSE which has consisted of a third-party review of plans and year to date performance and controls and will report back to NHSE on confidence in delivery of the financial plan.

2. INCOME AND EXPENDITURE (APPENDIX 1)

2.1 After technical changes the **July cumulative position is a £14.088m deficit.** This position is £0.364m better than the phased plan submitted to NHSE.

2.2 The actual position in July is slightly better than the revised plan. Over achievement on income predominantly Elective Recovery Fund overperformance and Cost Improvement Programme (CIP) performance being ahead of plan is offset by non-pay overspends relating to drug overspends, surge bed expenditure, industrial action costs and the maternity improvement scheme year two repayment.

2.3 Performance against the Elective Recovery Fund continued to be positive in July. Estimates for July activity show a predicted over performance of £4.063m against the assumed Elective Recovery Fund NHSE target. This is also £0.537m higher than the Trust internal plan which includes Elective Recovery Fund CIP schemes. This is despite industrial action in June/July which it is estimated lost the Trust £0.400m in Elective Recovery Fund income.

2.4 Substantive staff are 74.15 Whole Time Equivalents (WTE) behind target in July (June 44.31 WTE behind the target). Allowing for increased Deanery and externally funded posts reduces the shortfall to 62.71 WTE. Despite the adverse position, the finance position is £0.594m better than plan. This is largely due to pay awards funded in the plan and the high-cost mix of staff being used to establish the plan compared to the actual costs of WTE's.

2.5 Bank has continued to overspend against plan in July and is over target by 108.37 Whole Time Equivalents (WTE) (June 79.94 WTE behind the target). The Trust continues to operate with large amounts of surge bed areas open due to the pressures of emergency activity as well as the impact of industrial action in June and July. There is a cumulative overspend of £0.852m against plan at the end of July.

2.6 Agency usage remains very low with only medical staff being used in July. This equated to an improvement against the target of 2.52 WTE in July, resulting in a cumulative saving of £0.091m.

2.7 Non pay spend continued to exceed the budget in July. This was partly attributable to ICB passthrough drugs within the block contract, general drugs, Black Country Pathology Service contract and the maternity improvement scheme year two repayment.

3. CAPITAL AND CASH

The cash position at the end of July was £0.837m lower than the previous month's forecast. Non-patient income receipts were £0.255m above forecast. This related to additional non-NHS contract payments being received over and above the forecast position which were mainly a timing difference. Payments were £1.517m higher than the forecast in July. Payments to suppliers made up most of this movement. There were several annual invoices that were paid in July that had been forecast to be paid monthly as well as a catch up on pharmacy invoices from June. While some of this is a timing difference some is over and above the forecast position.

3.2 The Cash forecast for the financial year has increased compared to plan after Month 4 by £1.101m. The forecast now assumes £9m of revenue cash support from NHSE. This has reduced from £14m because of the capital forecast reduction. This will commence in October and be required until March. The System will receive deficit revenue funding as in 2023/24 and this will remove the need to borrow cash. However, the timing of this is yet to be confirmed by NHSE.

Downside currently shows the Trust running below minimum cash balance in November, but this would mean additional revenue cash support from NHSE.

3.3 Compliance with the Better Practice Payment Code was 95.9% in terms of number of invoices paid to non-NHS suppliers and 95.3% for NHS suppliers as at 31st July 2024.

3.4 In month 4 there was capital expenditure of £3.657m against a planned spend of £4.892m. Non-cash items including PFI lifecycle were underspent against plan as well as the ED scheme which has now been reprofiled. The System has now agreed the revised capital allocations for 2024/25 following the reduction in System capital funding from NHSE. The Trust has finalised the ED scheme forecast and agreed with NHSE that all the funding can be drawn down in 2024/25 even though £6m of the scheme will not be expended until 2025/26. The System have agreed to top slice £6m from the 2025/26 System allocation as a first call to the ED scheme. This all now means the Trusts capital forecast is £26.460m for 2024/25 a reduction of £6.170m from plan.

4. COST IMPROVEMENT PROGRAMME

4.1 The phased Cost Improvement Programme plan to July equated to £7.439m. Achievement to July totals £8.251m which is better than plan by £0.812m.

4.2 Of the total Cost Improvement Programme target of £31.896m, 98% had been identified by the end of July equating to £31.359m. Of this amount 83% is recurrent. The Medicine division have fully identified their plan and Corporate have exceeded plan by £1.527m There is a net overall unidentified amount of £0.537m with shortfalls on C&CCS of £1.254m and Surgery of £0.810m.

4.3 70 schemes have passed through the QIA process (70% of the programme).

4.4 Currently there is a forecast shortfall on delivery of the Cost Improvement Programme of £6.118m. This relates to the unidentified elements of the programme and the current estimated shortfall on delivery of the workforce reduction scheme.

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

5.1 The Integrated Care System reported an actual aggregate £80.479m deficit for July. This is £15.214m worse than the plan submitted to NHSE in June.

5.2 The System submitted a £119.2m deficit plan to NHSE in June. The System has been subject to an 'Investigation and Improvement' review from NHSE which has consisted of a third-party review of plans and year to date performance and controls and will report back to NHSE on confidence in delivery of the financial plan.

5. RECOMMENDATIONS

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

Chris Walker
Interim Director of Finance
27th August 2024

Enclosure 7

The Dudley Group NHS Foundation Trust

Paper for submission to the Board of Directors September 2024

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

1. Summary of key issues using Assure, Advise and Alert

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

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

Assure

Emergency Performance

In July ED 4 hour performance was at 79.9% vs the national target of 78%.

ED has gone through three weeks of floor works, which has significantly and adversely affected the ED footprint to see and treat patients affecting triage performance this month. Despite these works, we saw only a 2% drop compared to an anticipated 4% in relation to the ED 4 hour performance.

On going focus on:

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

Cancer Performance

The 28 day Faster Diagnostic Standard (FDS) achieved 83.9% (June 24 validated) against the constitutional standard of 77%.

31-day combined decision to treat performance achieved 90.3% in June against the national target of 96%. This is mainly driven by surgical capacity.

Performance against the 62 Day combined target achieved 70.2% in June which is above the national target of 70%.

DM01 Performance

July's DM01 performance achieved 88.3%. Diagnostic wait trajectories for each modality have been submitted to ICB to deliver 95% NHSE target by end of March 2025.

Clinical Hub Performance

June Urgent Community Response (UCR) performance reported was 86% against a target of 70%.

Black Country Pathology Service (BCPS)
E-requesting went live on the 07/08/2024. Based on initial response, compliance is forecasted to achieve 35% by end of August.

Cancer Outcomes & Service Dataset (COSD)
As a Trust we achieved above 80% stage completeness in the Cancer Outcomes and Services Dataset (COSD) submissions for the whole of 2023. Feedback received from the NHS National Disease Registration Service (NDRS) "As you are aware we have been monitoring this work and your provider has made a significant achievement and is directly attributable to the hard work of clinical and administrative staff in your cancer teams. We would like to express our sincere thanks for this work".

Elective Restoration & Recovery
We continue to perform well with Elective Restoration and Recovery. We are now focusing on patients at 65 weeks with a plan to have all cleared at the end of September.

The next target for focus is the 52 week wait patients being treated by the end of March 25. We are now looking to book all 52 week first outpatient appointments that would breach in March 25 by the end of November 24. This is a challenging ask, but the teams are currently working on plans to achieve.

As in previous reports industrial action has impacted us significantly with respect to these targets, the strike at the end of June into July was particularly impactful to elective care with a number of cases rescheduled. It is hoped that the offer made in relation to this by the government will mean that future action is avoided reducing the impact moving forwards.

July RTT position 58.6% vs 92% national target, a continued improvement month on month.

Advise

ED Triage
July's Overall Triage position 80.6% vs 95% national target.

ED has gone through three weeks of floor works, which has significantly and adversely affected the ED footprint to see and treat patients affecting triage performance this month.

Following the replacement of the Front-Triage floor and in preparation for the loss of cubicle during the Resus Build, there has been the opportunity to review existing flow within the department. A reconfiguration of front triage with the colocation of minors went live 01/08/2024. The reconfiguration will support further improvements with collaborative working, increasing visibility of patients and ensuring quicker senior decision making.

Ambulance Handover
This month's activity saw 9,085 attendances. This has increased when compared to the previous month of June with 8,988 - 15 out of the 31 days saw >300 patients.

2930 patients arrived by ambulance; this shows an increase from the 2763 ambulances that attended last month. 287 of these offloads took >1hr (10%). This shows an improvement when compared with last month's performance of 18%.

Over the month, the average length of stay (LOS) in ED was 212 mins for non-admitted patients and 428 mins for those waiting for a bed following a decision to admit. This is a 30% (132 minutes) decrease in waiting time for patients to be admitted compared to last month at 560 minutes.

Cancer (Data to June)

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

31-day combined decision to treat performance achieved 90.3% in June against the national target of 96%. This is mainly driven by surgical capacity.

31 day combined & 62 combined actions

- Increased focus on the 31-day target when escalating for treatments going forward and ensuring data validation is undertaken monthly.
- Weekly PTL meetings to incorporate 31-day decision to treat date in addition to 62-day decision to treat date.
- Unvalidated 31-day performance shows improvement at 93%
- CDC Dermoscopy in place with plans to expand. The service supports dermatology referrals for suspected cancers. Patients receive imaging in the community setting to support robust triage of referrals to ensure that we rapid access capacity utilised appropriately. Only 50% of patients currently get a rapid access appointment.
- Unvalidated 62-day performance shows improvement at 72%

There is robust monitoring of patients over 104 days, reported externally for any potential harm reviews. The total number of patients over 104 days is at 24 of these 12 have treatment plans. Several of the patients waiting over 104 days are late tertiary referrals or patient comorbidities.

DM01

July's DM01 performance has improved from the previous month and achieved 88.3%.

Both Cardiology and Endoscopy are performing well and achieved 95.43% and 98.31%, respectively. MRI saw an improvement from 89.66 last month to 91.14% in July. CT and Dexa continue to perform well having achieved 96.27% and 100% respectively.

NOUS has improved from 86.9% to 89.7% in July and has seen a reduction in 6 week breaches from 553 last month to 374 in July. Reduced staffing has impacted performance, and recruitment to address staffing challenges is almost complete. ENT has the largest backlog and additional specialist capacity is required to support. A third room for NOUS opened on 18/07/2024 to provide additional capacity. System mutual aid continues to be offered to SWBH (600 slots) and will be regularly reviewed.

Cardiac MRI waiting times is challenged. System mutual aid has been requested.

Sleep studies is an area of focus with performance of 56.15%. Audiology is challenged due to reduced staffing with July performance of 78.23%. Sleep studies experiencing equipment issues and a short-term recovery plan is in place to utilise bank shifts to reduce waiting times. Audiology recruitment plan in progress with new starter commenced in July.

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

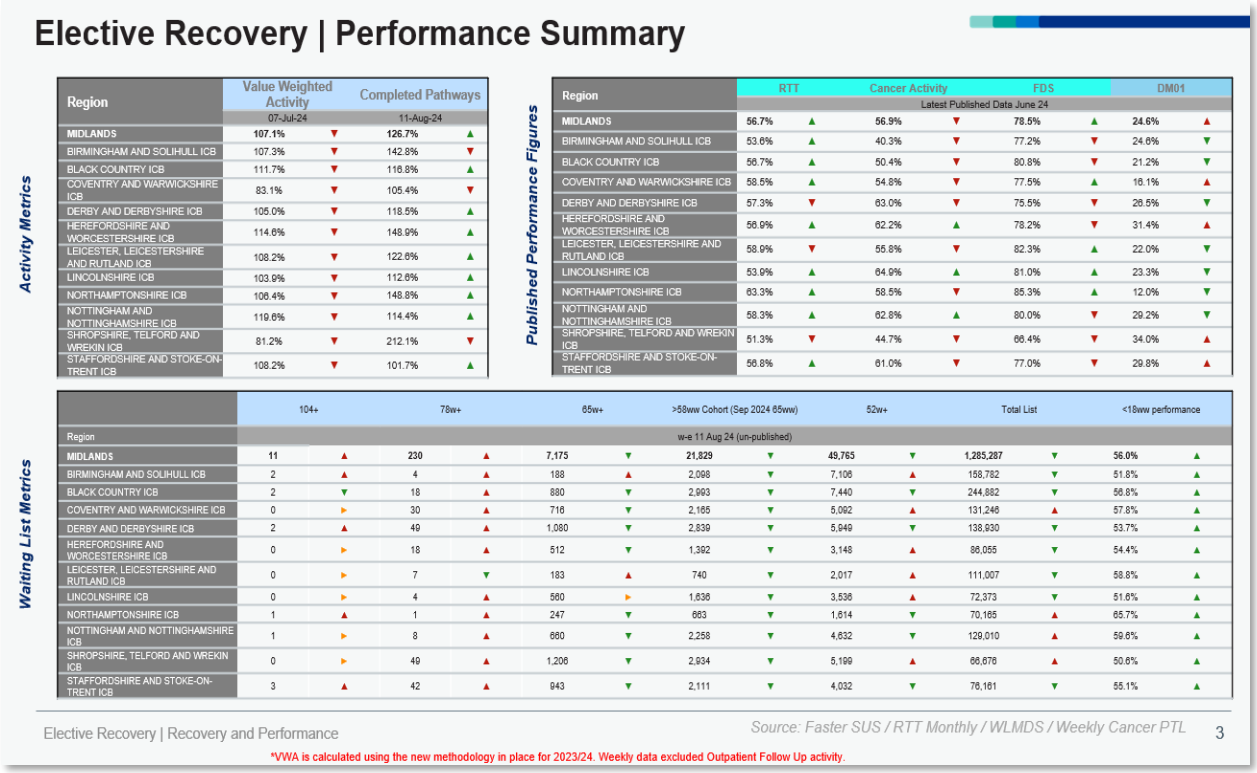
Elective Restoration & Recovery

The next target for focus is the 52 week wait patients being treated by the end of March 25. We are now looking to book all 52 week first outpatient appointments that would breach in March 25 by the end of November 24. This is a challenging ask, but the teams are currently working on plans to achieve.

As in previous reports industrial action has impacted us significantly with respect to these targets, the strike at the end of June into July was particularly impactful to elective care with a number of cases rescheduled. It is hoped that the offer made in relation to this by the government will mean that future action is avoided reducing the impact moving forwards.

Elective Recovery Programme – NHSE Midlands 16.08.24

Black Country ICB Performance Summary – Completed Pathways to 11.08.04



Elective Recovery | Performance Summary

Activity Metrics

Region	Value Weighted Activity 07-Jul-24		Completed Pathways 11-Aug-24	
MIDLANDS	107.1%	▼	126.7%	▲
BIRMINGHAM AND SOLIHULL ICB	107.3%	▼	142.8%	▼
BLACK COUNTRY ICB	111.7%	▼	116.8%	▲
COVENTRY AND WARWICKSHIRE ICB	83.1%	▼	105.4%	▼
DERBY AND DERBYSHIRE ICB	105.0%	▼	118.5%	▲
HEREFORDSHIRE AND WORCESTERSHIRE ICB	114.6%	▼	148.9%	▲
LEICESTER, LEICESTERSHIRE AND RUTLAND ICB	108.2%	▼	122.6%	▲
LINCOLNSHIRE ICB	103.9%	▼	112.6%	▲
NORTHAMPTONSHIRE ICB	106.4%	▼	148.8%	▲
NOTTINGHAM AND NOTTINGHAMSHIRE ICB	119.6%	▼	114.4%	▲
SHROPSHIRE, TELFORD AND WREKIN ICB	81.2%	▼	212.1%	▼
STAFFORDSHIRE AND STOKE-ON-TRENT ICB	108.2%	▼	101.7%	▲

Published Performance Figures

Region	RTT		Cancer Activity		FDS		DM01	
	Latest Published Data June 24							
MIDLANDS	56.7%	▲	56.9%	▼	78.5%	▲	24.6%	▲
BIRMINGHAM AND SOLIHULL ICB	53.6%	▲	40.3%	▼	77.2%	▼	24.6%	▼
BLACK COUNTRY ICB	56.7%	▲	50.4%	▼	80.8%	▼	21.2%	▼
COVENTRY AND WARWICKSHIRE ICB	58.5%	▲	54.8%	▼	77.5%	▲	16.1%	▲
DERBY AND DERBYSHIRE ICB	57.3%	▼	63.0%	▼	75.5%	▼	26.5%	▼
HEREFORDSHIRE AND WORCESTERSHIRE ICB	56.9%	▲	62.2%	▲	78.2%	▼	31.4%	▲
LEICESTER, LEICESTERSHIRE AND RUTLAND ICB	58.9%	▼	55.8%	▼	82.3%	▲	22.0%	▼
LINCOLNSHIRE ICB	53.9%	▲	64.9%	▲	81.0%	▲	23.3%	▼
NORTHAMPTONSHIRE ICB	63.3%	▲	58.5%	▼	85.3%	▲	12.0%	▼
NOTTINGHAM AND NOTTINGHAMSHIRE ICB	58.3%	▲	62.8%	▲	80.0%	▼	29.2%	▼
SHROPSHIRE, TELFORD AND WREKIN ICB	51.3%	▼	44.7%	▼	66.4%	▼	34.0%	▲
STAFFORDSHIRE AND STOKE-ON-TRENT ICB	56.8%	▲	61.0%	▼	77.0%	▼	29.8%	▲

Waiting List Metrics

	104+		78w+		65w+		>58ww Cohort (Sep 2024 65ww)		52w+		Total List		<18ww performance	
Region	w-e 11 Aug 24 (un-published)													
MIDLANDS	11	▲	230	▲	7,175	▼	21,829	▼	49,765	▼	1,285,287	▼	56.0%	▲
BIRMINGHAM AND SOLIHULL ICB	2	▲	4	▲	188	▲	2,098	▼	7,106	▲	158,782	▼	51.8%	▲
BLACK COUNTRY ICB	2	▼	18	▲	880	▼	2,993	▼	7,440	▼	244,882	▼	56.8%	▲
COVENTRY AND WARWICKSHIRE ICB	0	▸	30	▲	716	▼	2,165	▼	5,092	▲	131,246	▲	57.8%	▲
DERBY AND DERBYSHIRE ICB	2	▲	49	▲	1,080	▼	2,839	▼	5,949	▼	138,930	▼	53.7%	▲
HEREFORDSHIRE AND WORCESTERSHIRE ICB	0	▸	18	▲	512	▼	1,392	▼	3,148	▲	86,055	▼	54.4%	▲
LEICESTER, LEICESTERSHIRE AND RUTLAND ICB	0	▸	7	▼	183	▲	740	▼	2,017	▲	111,007	▼	58.8%	▲
LINCOLNSHIRE ICB	0	▸	4	▲	560	▸	1,636	▼	3,536	▲	72,373	▼	51.6%	▲
NORTHAMPTONSHIRE ICB	1	▲	1	▲	247	▼	663	▼	1,614	▼	70,165	▲	65.7%	▲
NOTTINGHAM AND NOTTINGHAMSHIRE ICB	1	▸	8	▲	660	▼	2,258	▼	4,632	▼	129,010	▲	59.6%	▲
SHROPSHIRE, TELFORD AND WREKIN ICB	0	▸	49	▲	1,206	▼	2,934	▼	5,199	▲	66,676	▲	50.6%	▲
STAFFORDSHIRE AND STOKE-ON-TRENT ICB	3	▲	42	▲	943	▼	2,111	▼	4,032	▼	76,161	▼	55.1%	▲

Elective Recovery | Recovery and Performance

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

3

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

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

Alert

None.

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

3. Report journey
The Integrated Performance Report was submitted to the Finance and Productivity Committee on Thursday 29 August 2024 and Board of Directors in September 2024.

4. Recommendation(s)
The Public Trust Board is asked to:
a) Receive the report as assurance of Trust performance

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

Paper ref:	PublicTB September 2024

The Dudley Group NHS Foundation Trust

Report title:	Chief Nurse and Medical Director's Joint Report.
Sponsoring executive:	Martina Morris – Chief Nurse Dr Julian Hobbs – Medical Director
Report author:	Jo Wakeman and Helen Bromage – Deputy Chief Nurses and Specialty Leads.
Meeting title:	Public Trust Board
Date:	12th September 2024

1. Summary of key issues using Assure, Advise and Alert *two or three issues you consider by the* TMC

This report provides an overview of key quality, safety and professional matters from a multiprofessional perspective, to demonstrate how multiprofessional teams work collaboratively to positively influence everyday practice and focus on improving quality outcomes and patient experience. The data presented relates to July 2024.

Assure

- Reduction in SHMI (99.53) and HSMR (85.76) continues to be sustained.
- 92% of our consultant job plans have been signed off in this round. AHP job planning continues.
- Initial VTE performance has consistently remained above 95% since June 2023.
- Senior clinical reviews as part of the Deteriorating Patient Pathway have increased by 11% along with patients being screened for sepsis following a trigger activation by 6%.
- No cases of Hospital Onset Healthcare Associated CDI (*Clostridiodes difficile*) were reported.
- Patient Safety Incident Response Framework work regarding the improvements made to the prevention and management of pressure ulcers in the Community, resulting in the positive outcomes to our patients was presented as part of internal governance.
- Signed contract for the provision of Responsible Clinician and a signed Service Level Agreement for the provision of the Mental Health Administrator service are in place, making the Trust compliant with the Mental Health Act requirements. However, there are ongoing conversations with the ICB and Black Country Healthcare NHSFT regarding the embedding of the new process, which has been challenging at times. The patient detention data is reported via the integrated Quality report and is also enclosed in the main body of this report.
- The IPC team have had a poster accepted on their QI improvement initiative leading to a reduction in caesarean section surgical site infection for presentation the IPS conference in September 2024.

Advise

- Nursing safer staffing review across acute inpatient wards (adult and paediatrics), assessment units and Emergency Department has been completed and the resultant report is enclosed as Appendix 1 of this report. Changes across 9 clinical areas to staffing (reduction, increase or re-balancing of the skill mix) have been proposed with 3 requiring additional funding within the Division of Medicine and Integrated Care. Following careful consideration of the proposed changes by the Executive Team, the changes which require an increase in headcount and financial investment will not be approved at the present time (AMU2: 2.6 WTE RN; B6: 2.6 CSW and C3: 2.6 WTE CSW). However, it is not anticipated that this will have an adverse impact on quality and safety as the additional

staffing resources were recommended not because the current staffing establishments are unsafe, but to further enhance them. Quality Impact Assessments will be completed for any changes and where the proposed changes cannot be authorised to ensure there is no adverse impact as a result. During September-October 2024, a safer staffing review data collection will be conducted in Theatres, Critical Care, Neonates and the Clinical Nurse Specialist group.

- Development of the Nursing Quality Dashboard continues, and it should be functional within the next 8 –12 weeks.
- There was 1 Section 42 enquiry against the Trust during July 2024, relating to a case of neglect and act of omission.
- Despite the decrease of complaint closure in June 2024, July has seen an increase. Improvement and escalation focus continues to drive improvements.
- Reduction was noted in the completion of Deprivation of Liberty Safeguards, which can be attributed to staff availability of the specialist teams.
- The Trust continues to report on average 160 pressures ulcers monthly as having occurred within our care. In part, this can be attributed a positive reporting culture with the majority reported relate to category 2. Improvement focus continues to drive their reduction. The Tissue Viability Team's fragility is improving, with staff returning from long term sickness/maternity leave during July to September. The Team is working on introducing the National Pressure Ulcer Strategy as a focus to address the key themes identified as part of the thematic review.
- 62% of patients triggering for sepsis received antibiotics within 60 minutes.
- NMC independent culture review was published in July 2024, with a discussion conducted to reflect on its finding at the Senior Nursing, Midwifery and AHP leaders Group. A regional Task and Finish Group (NHSE led) has been set up to take forward a variety of actions to strengthen the current approach and oversight of NMC referral case management.

Alert

- Increase of reopened complaints by a third. Key themes continue to be monitored by the Patient Experience Group to ensure learning and the Trust is holding a staff engagement event at the end of August to take forward a more engaging approach and ownership to driving improvements in patient experience.
- An issue was discovered in early August 2024 whereby over 350 staff have not been assigned to the correct level of safeguarding training for adult. Rectification actions have been taken to ensure that all staff receive the top up training required. A review of the safeguarding children training is underway to ensure the same issue does not apply.
- The Trust maintains a RAG rated green score for patients receiving a VTE and bleeding risk assessment within 12 hours of admission. However, there is reduced compliance for the repeat second VTE assessment for patients within 24 hours of admission. This is being reviewed by the Thrombosis Group.

2. Alignment to our Vision [indicate with an 'X' which Strategic Objective[s] this paper supports]	
Deliver right care every time	**X**
Be a brilliant place to work and thrive	**X**
Drive sustainability (Financial and environmental)	**X**
Build innovative partnerships in Dudley and beyond	**X**
Improve health and wellbeing	**X**

3. Previous consideration *[at which meeting[s] has this paper/matter been previously discussed?]*
Trust Management Group – August 2024. Quality Committee – August 2024. Public Trust Board – September 2024.

4. Recommendation(s)
The Public Trust Board is asked to:
a) Acknowledge the work undertaken by the Chief Nurse and Medical Director's office, to drive continuous improvements in the provision of high quality of care and patient experience and contribute to the successful achievement of the Trust Strategy's objectives.
b) Note the biannual review of safer staffing (nursing) report and associated decisions with regards to proposed staffing/skill-mix changes.

5. Impact *[indicate with an **'X'** which governance initiatives this matter relates to and, where shown, elaborate in the paper]*		
Board Assurance Framework Risk 1.1	x	Deliver high quality, safe person-centred care and treatment
Board Assurance Framework Risk 02	x	Address critical shortage of workforce capacity
Board Assurance Framework Risk 03	x	Improve and sustain staff satisfaction and morale
Board Assurance Framework Risk 04	x	Remain financially sustainable in 2023/24 and beyond
Board Assurance Framework Risk 05	x	Deliver on its ambition to building innovative partnerships in Dudley and beyond
Corporate Risk Register [Safeguard Risk Nos]	x	**COR2183 (ASM2183)** The IT configuration of the Telemetry devices is not compatible with the Trust WiFi network resulting in telemetry monitoring being unreliable consequently data drop out pauses are occurring which could mean potentially life threatening arrythmia's will go unnoticed **COR2353** Insufficient staffing and inadequate competency in cleaning and infection prevention & control by the PFI Partner domestic workforce could lead to poor standards of cleanliness and potentially infection control issues **COR1185** Lack of systemic process to ensure clinicians review all results for all radiological investigations performed could result in an abnormal result not being actioned causing significant patient harm **COR1422** Lack of systemic process to ensure clinicians review all results for all pathology investigations performed could result in an abnormal result not being actioned causing significant patient harm **COR2135** As detaining Authority the Trust has no agreement in place to provide Responsible Clinician (consultant psychiatrist) and Mental Health Act Administrator responsibilities to patients who are detained under the Mental Health Act, leading to the possibility of unlawful detention of patients under the Mental Health Act, and potential litigation and reputational damage.
Is Quality Impact Assessment required if so, add date: Yes, as part of safer staffing reviews.		
Is Equality Impact Assessment required if so, add date: No		

Trust Strategy - Deliver the right care every time

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

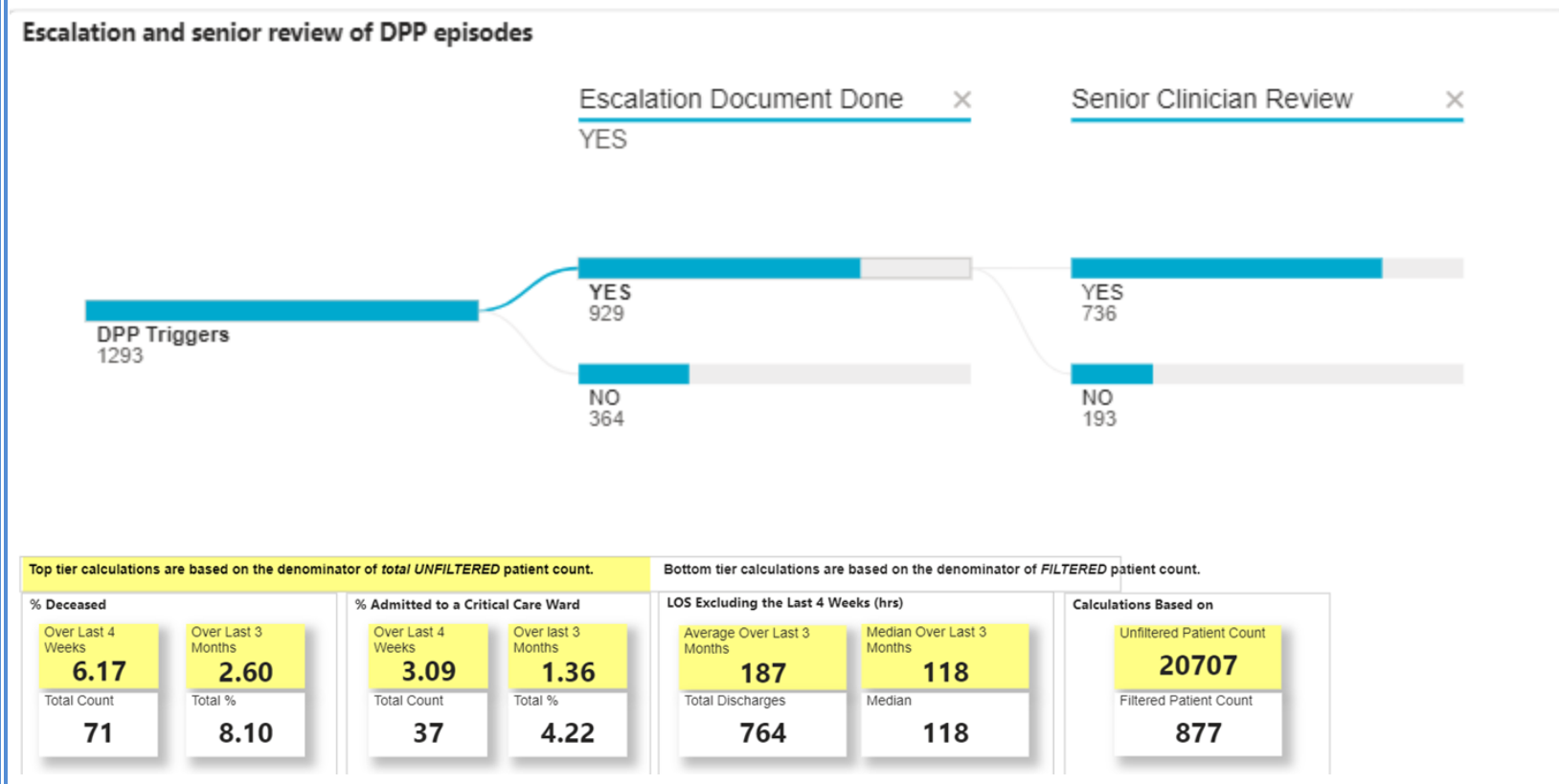
Deteriorating patient pathway (DPP)

The deteriorating patient pathway consists of 3 elements: an escalation document, a senior clinical review document and the sepsis screen, there are always more patients triggering the DPP versus those that require a sepsis screen. The DPP may retrigger if the patient has deteriorated significantly as indicated by their early warning score. In July, 240 less patients triggered the DPP (1293) than in May (1533) with an increase in escalation documents being completed by 58.2% to 71.8%. There is variation across all areas with ongoing review, education and training from DPT/DPG to further support.

The number of senior clinical reviews completed on the DPP within 60 mins of deterioration also increased from 45.9% to 56.9%. Patients being screened for sepsis following a trigger increased from 84.1% to 90%. Of those patients who were screened 15.8% were deemed as requiring treatment for sepsis and 62% received the IV antibiotics within 60 minutes of their trigger which is a reduction from May's documented 70%.

The other patients who triggered the DPP were treated for other non-sepsis related reasons, outcome data suggests even less patients who have triggered compared to May have been admitted to critical care or deceased in the last 4 weeks compared to the 3-month averages.

A senior clinician review is deemed done if a Senior clinician/Ward round/Critical care review document was completed.



Mortality

The Summary Hospital-level Mortality Indicator (SHMI) remains at 99.53 and the Hospital Standardised Mortality Ratio (HSMR) is 85.76. Crude mortality rate for the calendar year 2024 is 2.31% year to date. There have been 107 cases referred for 2024 for a Structured Judgement Review. 72% have been reviewed and 98% showed average to excellent care. The cases with poor to very poor care have been reviewed by the Governance team. There are no cases reviewed for 2024 with avoidability more likely than not.

Safeguarding

There was 1 Section 42 enquiry against the Trust during July 2024, relating to a case of neglect and act of omission concerning pressure area care. This has been completed and returned by the Lead Nurse.

All Midwives and Paediatric Nurses are required to be in receipt of regular safeguarding supervision. The latest compliance with supervision is as follows: Maternity - 95%, Community MW - 91%, NNU - 98%, Paediatrics - 80%. Supervision to community midwives is a challenge due to capacity issues within the service.

Safeguarding Training

Safeguarding Adults L1	96%
Safeguarding Adults L2	89%
Safeguarding Adults L3	88%
Safeguarding CYP L1	97%
Safeguarding CYP L2	87%
Safeguarding CYP L3	88%
Prevent	96%
WRAP	92%

Level 3 safeguarding training remains on the risk register for Surgery, Women's and Childrens Division. In addition, an issue was discovered in early August whereby over 350 staff have not been assigned to the correct level of safeguarding training for adult. Rectification actions have been taken to ensure that all staff receive the top up training required. A review of the safeguarding children training is underway to ensure the same issue does not apply.

Deprivation of Liberty Safeguards (DoLS)

In July 2024, there were 44 DoLS applications, this represents a decrease on the previous month. It should be noted that there is 1 x RMN within the Dementia and Delirium Team which may account towards this reduction as a 0.6 band 6 nurse left the team June 24. An Admiral Nurse has been recruited and will commence in post on 2.9.24. A Band 4 Associate Nurse post is currently under Band Matching and if agreed, this will support another addition to the team at 33 hours which will support this portfolio further.

Mental Health Act (MHA)

A Service Level Agreement has been finalised with Walsall and Wolverhampton NHS Trusts to provide a Mental Health Act Administrator service. This service has been operational as of Monday 8th July 2024. This will provide an increased level of assurance that the Trust is compliant with the Mental Health Act and provide additional support and monitoring to ensure patients' rights are upheld. The Contract for the provision of Responsible Clinician (RC) by the Black Country Healthcare NHS Trust has also been signed. As of 5.8.23, daily MH update SITREPs are being shared

with key staff to ensure that all required parties are aware of the current detentions and updates within the Trust. The detention data is reported via the Quality Integrated Report. As part of this service, MHA awareness training is being rolled out to all key staff, including the Trust Board. This will support review and challenge of pending MHA assessments concerning whether the Trust will accept a detention. Section 5(2) training dates have also been identified for medical staff with 2 x dates per month planned from 4.9.24. There is an agreement that this will form part of the doctor's induction programme, with dates to be confirmed. A Standard Operating Procedure and MHA policy have been updated/developed to support the new service and are currently out for review, with feedback requested by 7.8.24.

A Mental Health monitoring visit was conducted by Care Quality Commission (CQC) on Monday 8th July 2024, resulting in positive feedback with regards to Trust policies and processes and acknowledging that the Trust was aware of its challenges and had mitigations in place. However, due to the previous gap with RC provision, a request has been made by the CQC for the Trust to look back to April 2020 to check that there have been no illegal detentions. This is currently under review with the Trust's legal team undertaking a review in relation to potential illegal detentions. There is an ongoing dialogue with the Trust and legal team to review this situation.

During July, there have been the following MHA detentions:

- 2 x section 5(2) to DGFT– neither resulted to further detentions.
- 1 x section 2 directly to DGFT where the section lapsed with intent and the patient became informal.
- 5 x section 17 leave, of which 1 patient came into the hospital on 2 separate occasions and so this has been classed as 2 separate incidents.

VTE

At the time of report writing, July's data was not available. The Trust maintains a RAG rated green score for patients receiving a VTE and bleeding risk assessment within 12 hours of admission. However, there is reduced compliance for the repeat second VTE assessment for patients within 24 hours of admission. This is being reviewed by the Thrombosis Group.

First Assessment +/- 12 hours from Admissions

MonthYear	Total	IRA	CRA	Total RA	% Compliance
01/06/2024	13058	2700	10229	12929	99.01
01/05/2024	14203	3005	11021	14026	98.75
01/04/2024	13339	2887	10305	13192	98.89
01/03/2024	13399	3059	10252	13311	99.34
01/02/2024	13165	2842	10228	13070	99.27

Second Assessment <24 hours from Admission (only spells over 24 hours in denominator)

MonthYear	Total	IRA	CRA	Total RA	% Compliance
01/06/2024	1022	155	0	155	15.16
01/05/2024	1072	109	0	109	10.16
01/04/2024	1044	143	1	144	13.79
01/03/2024	1063	85	1	86	8.09
01/02/2024	1029	91	1	92	8.94

Length of Stay (LOS)

Daily trend for LOS from 02.02.24 – 22.07.24

LOS broken down into Divisions/Elective/Non-elective categories (data as of w/c 22.07.24)

Average LOS Medicine – Non-elective	3.60
Average LOS Surgical – Non-elective	3.12
Average LOS Surgical – Elective	2.23

Trust staff work daily with capacity and discharge teams to ensure patients LOS is in line with their clinical needs. However, some patients exceed the average LOS due to their clinical condition or the need for provision of ongoing care support, e.g., care packages, residential/nursing homes. As of LOS data for w/c 22.07.24, the extended LOS position is:

Extended LOS patients 7-14 days	168
Extended LOS patients 15 –21 days	65
Extended LOS patients >21 days	92

Readmissions

July data validated to w/c 22.07.24

Number of readmissions within 7 days of discharge	5
Number or readmissions within 30 days of discharge	14

Readmissions are benchmarked and reviewed at specialty and consultant level within divisions. A readmissions audit is included in the audit forward plan for Q3.

Nursing Quality Report

Work continues with the informatics team to interface the differing audit/reporting systems, producing data on one page that will enable finance, workforce and quality metrics to be viewed in one place. Informatics estimate this work will be finalised for use within the next 8 -12 weeks.

Current quality data from AMaT:

	Feb	Mar	Apr	May	Jun	Jul
Tissue Viability SKIN audit (CQUIN 12)	96.0%	96.2%	97.6%	96.7%	98.0%	97.4%
Hand Hygiene '5 moments' audit (v2)	97.8%	98.6%	98.7%	98.2%	97.6%	97.8%
Hand Hygiene Environment Audit	99.0%	98.9%	98.7%	99.2%	98.0%	98.5%
Matron In Patient Audit	86.0%	87.9%	85.5%	88.1%	89.5%	91.9%
Matron Audit - Out Patient Areas						90.4%
Standard of Documentation Audit 2024	95.7%	95.8%	96.4%	96.4%	97.0%	97.4%
Lead Nurse In Patient Audit January 2024	84.2%	93.7%	92.8%	93.8%	94.1%	95.0%

The Matron audit for outpatients is a new addition from July. Divisional Nursing, Midwifery and AHP leads receive a monthly update on quality metric findings that are discussed within Division Governance and the Senior Nursing/Midwifery/AHP meetings. Action plans are implemented and monitored monthly. Improvements in audits are noted within amber RAG areas.

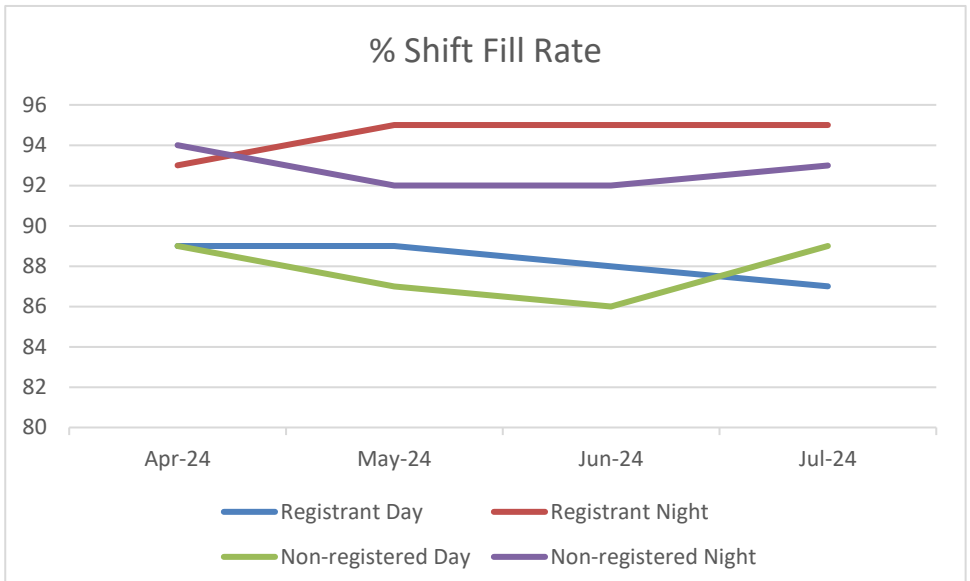
Senior Nursing, Midwifery and AHP presence within clinical areas

Quarter 2 'Back to the Floor' and 'nighttime visits' by the senior nursing/midwifery/AHP team has commenced. Feedback will be collated at the end of the quarter. The Divisional Chief Nurses/AHP have been requested to provide their update on improvement actions taken. Due to some concerns, a thematic review has been conducted for C7, to identify whether any improvement actions are required. The existing improvement plan is being updated to include additional actions as identified as art of the review. Ward B3 continue to embed their improvement actions and a thematic review is due to be conducted on wards B2 hip and C6.

Safer Nursing and Midwifery staffing July 2024

Safer Staffing Summary Jul — Days in Month 31

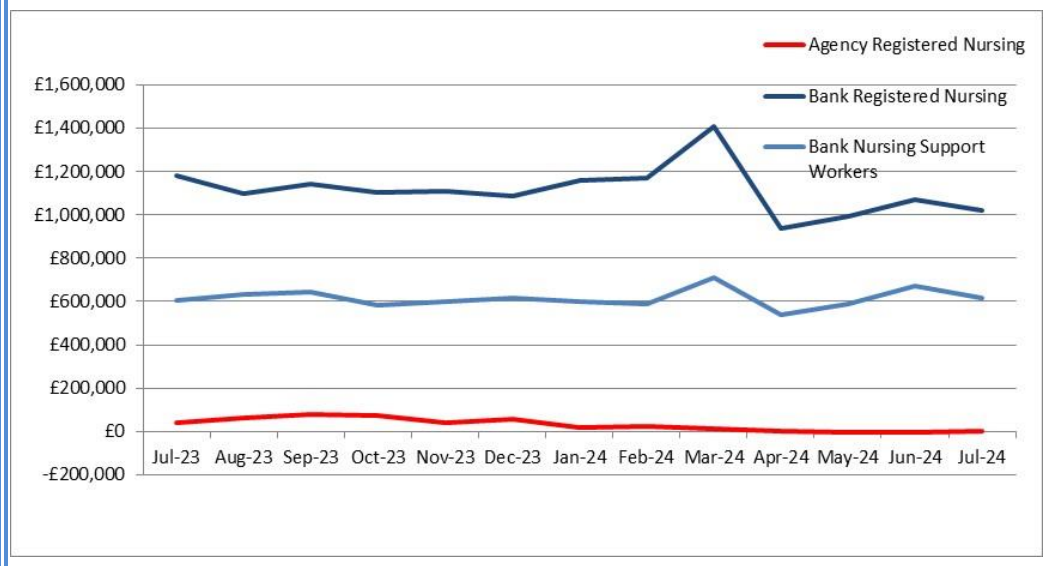
Ward	Day RN Plan	Day RN Actual	Day CSW Plan	Day CSW Actual	Night RN Plan	Night RN Actual	Night CSW Plan	Night CSW Actual	RN Day %	CSW Day %	RN N %	CSW N %	Sum 24:00 Occ	Actual CHPPD Registered	Actual CHPPD Care staff	Actual CHPPD Total
B1	121	108	60	70	64	64	50	51	89%	116%	100%	102%	424	4.61	3.26	7.87
B2(H)	124	100	195	187	93	89	184	177	80%	96%	96%	96%	733	3.09	5.83	8.92
B2(T)	124	100	151	134	93	89	125	116	81%	89%	96%	93%	713	3.18	4.21	7.39
B3	194	178	206	169	187	184	183	172	92%	82%	99%	94%	1,191	3.57	3.43	7.01
B4	226	191	262	222	186	180	223	194	85%	85%	97%	87%	1,308	3.33	3.82	7.15
B5	250	196	158	158	239	223	93	83	78%	101%	93%	89%	957	5.37	2.94	8.31
B6	98	82	73	55	63	62	80	65	83%	76%	98%	81%	485	3.47	2.97	6.44
C1 A	128	125	134	119	93	89	129	116	98%	89%	96%	90%	734	3.42	3.84	7.26
C1 B	129	114	140	122	93	92	98	88	88%	87%	99%	90%	737	3.28	3.34	6.62
C2	285	242	71	69	249	228	67	67	85%	98%	91%	100%	490	11.26	3.27	14.53
C3	217	215	380	365	186	171	364	357	99%	96%	92%	98%	1,604	2.89	5.28	8.17
C4	210	178	68	66	124	103	63	72	85%	97%	83%	114%	659	4.97	2.41	7.38
C5 A	121	93	134	122	93	91	105	94	77%	91%	98%	90%	730	3.06	3.55	6.61
C5 B	162	149	128	117	156	153	97	95	92%	91%	98%	98%	734	4.84	3.46	8.30
C6	97	93	103	96	93	85	76	73	96%	93%	91%	96%	574	3.65	3.53	7.18
C7	222	167	209	172	159	150	213	190	75%	82%	94%	89%	1,106	3.36	3.93	7.29
C8	259	233	221	198	217	213	182	167	90%	90%	98%	92%	1,326	3.95	3.30	7.25
CCU_PCCU	244	231	66	56	217	218	35	29	94%	85%	100%	83%	726	7.26	1.41	8.66
Critical Care	529	438	126	95	528	455			83%	76%	86%		479	22.39	2.39	24.78
AMU	486	489	406	368	405	445	406	389	101%	91%	110%	96%	2,139	5.12	4.25	9.37
Maternity	858	790	267	218	527	505	155	140	92%	82%	96%	90%	1,369	9.04	3.06	12.10
MECU	94	92	35	32	94	94			98%	91%	100%		207	10.76	1.68	12.44
NNU	388	265			269	215			68%		80%		439	13.05	0.00	13.05
TOTAL	**5,565**	**4,867**	**3,591**	**3,210**	**4,428**	**4,198**	**2,928**	**2,735**	**87%**	**89%**	**95%**	**93%**	**19,864**	**5.25**	**3.55**	**8.81**



% fill rate	Apr-24	May-24	Jun-24	Jul-24
Registrant Day	89	89	88	87
Registrant Night	93	95	95	95
Non-registered Day	89	87	86	89
Non-registered Night	94	92	92	93

Staffing fill rates have remained similar to the previous month. Whilst a minimal value of decrease with the Registrants in the day, with the significant numbers of additional capacity beds the Trust have had opened, this decrease has made a significant difference to the availability of staff to be deployed into the additional areas. To continue to maintain patient safety, it has been necessary for the Lead Nurses to increase their dedicated clinical time and redeploy additional staff from within wider corporate teams. The redeployment of additional staff [whilst necessary] has had an impact on the availability of mandatory training capacity, student support and supervision, preceptorship support and supervision and the wider attainment of educational KPI targets.

Bank and Agency usage



Area	Nursing Vacancy %	Agency Registered Nursing	Bank Registered Nursing	Bank Nursing Support Workers	Grand Total
Emergency Department Nursin	**15%**	£0	£98,598	£46,535	£145,133
Ward B3	**12%**	£0	£37,592	£39,857	£77,449
Discharge Lounge	**7%**	£0	£53,896	£23,427	£77,322
Ward B4	**9%**	£0	£38,236	£34,826	£73,062
Ward C7	**7%**	£0	£34,883	£33,459	£68,342
Theatres Weekend Lists		£0	£48,344	£19,410	£67,753
I.T.U.	**-10%**	£0	£56,636	£5,401	£62,037
Ward C8	**9%**	£0	£27,145	£31,020	£58,165
Ward B5	**-1%**	-£561	£35,865	£22,062	£57,366
Ward AMU Assessment	**19%**	£0	£32,153	£22,435	£54,588

Agency use continues to be extremely low. Bank usage has however slightly decreased.

Safer staffing (nursing) review – June 2024

Throughout June and July 2024, the Safer Staffing review for nursing was completed. Adult inpatients, Adult Assessment Units, Children's inpatients and assessment units and the Emergency Department were all reviewed. The resultant report in enclosed as Appendix 1 of this report. Key points include:

- Overall, the safer staffing establishments are in a positive position to provide and deliver safe, effective, high-quality care.
- It is evident from the quantitative data that there is a disconnect between the tools recommended staffing establishments and the current funded staffing establishments, due to quantitative data collection issues. Professional Judgement has been a key guiding influence with this and the knowledge of seasonal variation within the patient cohorts, the impact of flow and capacity challenges during the data collection month and the additional measures undertaken to support patient flow, and experience.
- The following table provides a summary of the that areas that have requested changes and if these were supported, subject to the Divisions identifying their required workforce reduction elsewhere; identifying funding to enact the change and completion of a QIA:

Jun-24	Requests suggested by ward leadership.	Changes supported by Division	Jun-24	Requests suggested by ward leadership.	Changes supported by Division	Jun-24	Requests suggested by ward leadership.	Changes supported by Division
AMU1	No	No	**B6**	Yes	Yes	**C7**	Yes	Yes
AMU2	Yes	Yes	**C1A**	No	No	**C8**	No	Yes
AMU3 (A4)	No	No	**C1B**	No	No	**CCU**	Yes	Yes
AMUA	No	No	**C2**	No	No	**DL**	No	No
B1	Yes	Yes	**C3**	Yes	Yes	**ESH**	No	No
B2H	No	No	**C4**	No	No	**MECU**	No	No
B2T	No	No	**C5A**	Yes	Yes	**FMU**	No	No
B3	No	No	**C5B**	No	Yes	**ED Adults**	No	No
B4	No	No	**C6**	No	No	**ED Paeds**	No	No

Establishment change requests following reviews	
AMU 2	Increase in RN overnight (2.6 WTE).
B1	Reduce RN establishment by 1.8 WTE.
B6	Increase night time CSW by 1 (2.6 WTE) - would reduce the overall temporary staffing use.
C3	Increase night time CSW by 1 (2.6 WTE) - would reduce the overall temporary staffing use.
C5A	Increase RN (B6) presence overnight (cost neutral).
C5B	Support C5A with request (cost neutral).
C7	Increase staffing provision throughout the traditional twilight period. Possible within the current establishment and cost neutral.
C8	Parity of workload division between Band 7 Lead Nurses. To be reviewed and managed within the current establishment.
CCU	Increase RN x 1 on day shift on a weekend Saturday and Sunday as there had previously been a reduction. Possible within the current establishment and it will be filled by including the clinical band 7 in the numbers of rostered staff.
DL	Work to reinstate as a Discharge Lounge.

- The review has also highlighted there is wider work which is ongoing looking at the location of current specialities, in particular B4, B6 and C6 and the options for relocation. As this would be cross divisional, a collaborative piece is being created to progress this work further.

The Safer staffing (nursing) review report was received and discussed by Executive Team (08/24) and Senior Nursing Midwifery and AHP leaders Group (08/24). Following careful consideration of the proposed changes by the Executive Team, the changes which require an increase in headcount and financial investment will not be approved at the present time (AMU2: 2.6 WTE RN; B6: 2.6 CSW and C3: 2.6 WTE CSW). However, it is not anticipated that this will have an adverse impact on quality and safety as the additional staffing resources were recommended not because the current staffing establishments are unsafe, but to further enhance them. The proposed reduction of RN establishment by 1.8 WTE on B1 has been approved as well as the other proposed cost neutral changes described in the above table. Quality Impact Assessments will be completed for any changes and where the proposed changes cannot be authorised to ensure there is no adverse impact as a result. The Quality Committee received the report in late August, and it is planned to be received for information by People Committee in September 2024.

Allied Health Professionals (AHP) workforce deep dive

July 2024 saw the completion of the Trust's first AHP and Healthcare Scientist (HCS) workforce deep dive undertaken by AHP professional Lead Jenny Glynn. This is building on the work already taken place that has seen the AHP vacancy rate fall from 21% to 8% and 10% to 7% respectively. The report provides targeted insight into the Trust's position in relation to EDI, gender, age, disability and sickness trends and provides detailed recommendations to address the most fragile professions of Speech and Language Therapy, Podiatry and Occupational Therapy. The Dudley Group is in line with national trends related to AHP workforce challenges and is taking a service, organisational and system approach to training, recruitment and retention.

Graduate Nurse Recruitment

The recruitment of graduate nurses who have been placed with the Dudley Group during their training has continued to be a challenge in the first half of 2024 due to reduced band 5 vacancies across all areas of the organisation. Since November 2023, 28 band 5 staff nurse vacancies have been identified as suitable for graduate nurses who have had 3rd year placements during their training with The Dudley Group and priority has been given to them to apply. This process is currently ongoing as we continue to support our graduate nurses to have the best opportunity to gain employment with The Dudley Group.

GRADUATE NURSE RECRUITMENT POSITION – AUGUST 2024.

Total number of students placed with the Dudley Group graduating in 2024	Total number offered a job with The Dudley Group	Total NOT yet secured job offer with The Dudley Group
88	24	64

In summary:

- We have already secured the employment of 27.2% of the 88 graduate nurses due to qualify in 2024.
- 28.5% are currently engaged with us and continuing to seek employment with us.
- The remaining 44.3% are not actively seeking employment with The Dudley Group or have secured employment elsewhere.

The above data is based on a recent survey of all 88 graduate nurses placed with the Dudley Group who have graduated or are due to graduate in 2024.

Fundamentals of care (Care certificate)

The Trusts Professional Development Team in conjunction with the lead AHP Support worker have extended and contextualised the Care certificate training to AHP support workers in Acute Therapies, Imaging and Orthoptics. The next phase will ensure clinical support workers band 2 & 3 across all professional groups will be supported to complete the care certificate ensure training on the fundamentals of care is available to all our pivotal patient facing support workforce.

Complaints

New Complaints

The Trust received 92 new formal complaints in July 2024 compared to 76 in June 2024 (there were 84 complaints for July 2023). Of the 92 complaints received, all were acknowledged within 3 working days. The main theme for complaints for July 2024 was patient care.

Closed complaints

In July 2024, the Trust closed 116 complaints compared to 74 in June 2024. Of those 116 closed, 52 (44.8%) were closed within 30 working days. Not including re-opened complaints and Ombudsman cases, there were 106 complaints closed (first response) and of those 106 complaints, 47 were within 30 working days (44.3%), which is an increase of 0.4% on last month's response rate of 42.9% (first response complaints).

Reopened Complaints

There has been an increase of reopened complaints (11) for July 2024 compared to 9 for June 2024. There are currently 32 reopened complaints in total under investigation.

Outstanding complaints

Position as of 31 July 2024 was as follows:

- Outstanding for all complaints (including new, reopened and ombudsman cases) = 159
- Outstanding complaints (excluding reopened and excluding Ombudsman cases) = 121

Concerted efforts and strengthened escalation processes remain in place to drive improvements in complaint responsiveness. There is currently a vacancy within the complaints team which is impacting response time, and this is to be filled by 12 August 2024.

Patient Experience

(Please note patient experience data is for June 2024 as July data is not yet available)

FFT

A total of **4941** responses were received in June 2024 in comparison to **5097** in May 2024.

Overall, 82% of respondents have rated their experience of Trust services as 'very good/good' in June 2024, no change since the previous month. A total of 6% of patients rated their experience of Trust services as 'very poor/poor' in June 2024, no change from the previous month. The A&E Department received the highest percentage negative score with 15% of patients rating their overall experience as very poor/poor in June 2024, no change from the previous month. Community received the highest percentage positive score at 91%, a recurring theme from the previous month. The Inpatient Department score for patients rating their overall experience as 'very poor/poor' show an improvement of 2%.
Maternity Antenatal response rate scores have seen the biggest improvement in June 2024 from 2% in May 2024 to 15% in 2024. The overall score for patients rating their experience as 'very good/good' has increased from 77% in May 2024 to 89% in June 2024 for the Maternity Department.

Compliments
The number of compliments received has decreased in June 2024. The Trust received 315 compliments in June 2024 compared to 381 compliments in May 2024. Ward C4 received the highest number of compliments (50) in May 2024.

Departmental surveys
Patient feedback highlights positive assurance around the attitude of staff involved in patient care and communication, including patients feeling listened to and supported.

Real-time surveys
The real-time patient survey feedback shows that patients were complimentary about the care and treatment received and for the caring nature of staff. Areas for improvement focused on communication around discharge.

Trust Strategy - To be a brilliant place to work

Links to compassionate and strong leadership, Developing the Nursing, Midwifery and AHP workforce and sustainability and growth in the Nursing, Midwifery and Allied Health Professionals strategy

Due to the time of year July has been full of support work encouraging school leavers, and those embarking on work experience placements to consider a career in healthcare. The team have facilitated numerous placements and experiences for our local schools and colleges as well as supporting our HEI's with the recruitment of September's next generation nurses and midwives. The practice placement teams are working with the Universities to ensure clinical placements are allocated and available for the next academic year.

Job Planning (Medical)
Medical job plans were open for editing between January-March 2024. As of 07/08/2024, 92% of consultants are signed off or in the sign off process. The outcome of an internal RSM led audit is due in August and will be reported via People Committee in October.

Library and Knowledge Services Quality Visit
The Trust participated in a quality visit from HEE in July to review Library and Knowledge services. The visiting team highlighted good practice in terms of the libraries involvement in policy development, collaboration with Research projects, a well-arranged physical space and a positive contribution to the University Hospital Status application. A full report is expected in September, however initial feedback highlight recommendations around the promotion of the service, increasing the qualified librarian capacity in line with HEE staff ratio policy, embedding clinical decision-making tools at the point of care and the ongoing monitoring and evaluation of the service. The formal recommendations will be reviewed at the Research, Education and Innovation Group when received.

Trust Strategy - Drive sustainability and financial environment

Links to sustainability and growth.

Complex Nutrition

- A second round of interviews for administration assistant are taking place week commencing 5th August 2024 and once filled, this will make the team fully established.

Clinical

- Changing the Parenteral Nutrition (PN) bags to comply with National standards and new evidence around protein requirements in Critical Care patients continues.
- Collaboration with pharmacy to change PN prescriptions to electronic has been successful. We are modelling a process from Sandwell Hospital and will be requesting authorisation from Electronic Prescribing Medication Administration (EPMA) Steering committee to proceed with this by December 2024.
- There is a steady increase of patients with complex disordered gut brain interaction (DGBI) disorders which require enteral and parenteral nutrition support and extensive multiprofessional working.

Virtual ward

- A bid to create a new Gastroenterology virtual ward will be completed next month. An audit has been completed to look at length of stay and value added to patients care in the last 3 days of admissions for GI bleeding. The results of this audit will be presented next month and will provide great possibilities of reducing length of stay for this cohort of patients.

Research

- A primary research project poster completed by Izzie Gibson (ACP) has been accepted for presentation at the European Society of Parenteral and Enteral Nutrition (ESPEN) to increase international the profile of the complex Nutrition Team and organisation across Europe. The team have secured partial funding to present this poster.

Celebrations:

- Winners of Dr Falks nurse innovation award.
- Winners of Trust's Committed to Excellence Awards.
- Research accepted at ESPEN.
- Nomination for parliamentary award.
- Application to HSJ virtual award.
- Collaboration with research design service and future grant applications as hosts.
- A Nursing associate undertaking her top degree in Adult Nursing at the University of Wolverhampton has won an apprenticeship award for her resilience shown, through her apprenticeship journey.

The team success is due to outstanding support from manager Jo Wakeman, Directorate Manager Lucy Ford and Dr Paul Hudson.

Trust Strategy - Build innovative partnerships in Dudley & beyond

Links to Developing the Nursing, Midwifery and AHP workforce, Patient safety and improved quality and care outcomes and sustainability and growth in the Nursing, Midwifery and Allied Health Professionals strategy.

University Hospital Status

The working group continues to meet with support from our partners at Aston University as a core component of the UHS application process. A scoping exercise in relation to the facilities required to onboard St Mary's students has commenced with a workshop held in July to look at expanding teaching facilities and resources.

Trust Strategy - Improve health and wellbeing

Links to listening and learning for improvement in the Nursing, Midwifery and Allied Health Professionals strategy.

Infection Prevention and Control

- During July 2024, the Trust saw a reduction in outbreaks with 2 Covid-19 and 1 diarrhoea and vomiting (norovirus) outbreak. Appropriate outbreak and incident management meetings have taken place, with actions agreed to address any learning. Additional cleaning was provided by Mitie during outbreak periods and staff have been reminded of best practice including uniform adherence and everyone's roles and responsibilities.
- The Trust reported a Community Onset Healthcare Associated (COHA) MRSA bacteraemia in June and the learning from this is being disseminated throughout the Trust. The patient has had contact with various day case and community areas prior to admission.
- *Clostridiodes difficile* continues to increase regionally and nationally, and the IPC team have joined regional NHSE calls to review current practices and interventions. The Trust reported zero HOHA CDI infections for July 2024. The ICB has also set up a CDI task and finish group which the Trust attends.
- The Trust continues to promote awareness of measles and pertussis vaccines for patients and staff.
- Mpox information has been shared with ED for information following an alert of an increase in prevalence.
- The IPC team have had a poster accepted on their QI improvement initiative leading to a reduction in caesarean section surgical site infection for presentation the IPS conference in September.

Surgical Site Infection Prevention

This is a new metric requested to be added to this report. 4a ensures the patient is prepared correctly before surgery and 4b ensures the patient has correct processes applied in theatre, both of which reduce the risk of infection for patients undergoing surgery.

	Feb	Mar	Apr	May	Jun	Jul
Saving Lives HII No 4a - Surgical site infection prevention - Preoperative	100%	100%	100%	92.9%	100%	100%
Saving Lives HII No 4b - Surgical site infection prevention - Intraoperative	100%	100%	100%	100%	100%	100%

Pressure Ulcers (PUs)

In July 2024, there was a total of 370 pressure ulcers reported (this includes DTIs and excludes category 1 and moisture acquired skin damage), of these 160 were reported as having occurred whilst in our care of these 49 % related to acute care and 51 % related to community care. 38 of the overall numbers related to category 3,4 and unstageable. There were 30 in the community relating to category 3,4 and unstageable and 8 within acute care. There were 36 deep tissue injuries reported within acute and 30 reported within the community. It is recognised the high numbers reported overall which in part demonstrates a positive reporting culture. However, the TVN team plan to implement the recommendations of the National Pressure Ulcer Strategy which should demonstrate positive outcome with a reduction of pressure ulcers occurring within our care.

- The Single Improvement plan continues to be progressed.
- The 2nd thematic review has been completed and will be presented at the Quality & Safety Group meeting in August 2024.

Falls July 2024

July- 2024 falls data	
Inpatient falls	85
Outpatient/Community falls	3
Repeat fallers	6
Harm level	No harm 45: Low harm 39: Moderate harm 1
AAR	B2 Trauma – Neck of Femur fracture

The number of inpatient falls has declined by 26% from June. Similarly, the number of falls resulting in moderate harm has remained low in July. In July there was 1 moderate harm incident reported. The national average for the number of falls with moderate harm or above per 1000 occupied bed days was 0.19. The Dudley Group remains below the national average at 0.006 due to 1 moderate harm incident reported in July.

Falls Study received an award for Outstanding Community Engagement. The study "Impact of the Patient Safety Incident Response Framework" has been recognized for its outstanding community engagement, earning an award in the "We Research" competition. At the Regional Falls Prevention event hosted by the ICB, the Trust was acknowledged for its significant contributions to fall prevention in the last 12 months. Discussions about ongoing quality improvement projects and the current research study captured the interest of neighbouring trusts, opening the door to potential collaborations and future funding for a multi-site research initiative. Improvement actions include:

- The Single Improvement plan has had a positive impact on preventing and decreasing inpatient falls.
- The 2nd thematic review has been completed and will be presented at the Quality & Safety Group meeting in August 2024.
- The local partners successfully conducted the first Community Falls integration workshop at the Clinical Education Centre for staff in July, which received positive feedback from attendees and more workshops will be held throughout August and September.

Nutrition and Hydration Improvement Group

The Trust has established a new Nutrition and Hydration Improvement Group (NHIG) to monitor and improve the experience of patients, visitors and staff in relation to food and drink provision. This is in response to patient feedback, findings of mealtime audits and the requirement for Trusts to benchmark against national Standards for Healthcare food and drink. To date the group:

- has developed training material for ward areas in relation to menu options and accessibility, and support provided for people requiring special diets.
- is exploring the purchase of specialist equipment to support patients to eat and drink independently.
- is working with the Trust's Wellbeing Business Partner and Embrace network chair to understand the experiences of staff in relation to food availability across all sites over the 24-hour period with a specific focus on nutritious options, cultural preferences and special dietary requirements.
- Exploring options in maternity vending machines to ensure partners of birthing women have access to a range of nutritious and sustaining food and drink to ensure that they do not need to leave their partners to access the restaurant.

Enclosure 9

The Dudley Group NHS Foundation Trust

Paper for submission to Board of Directors on 12th September 2024

Report title:	**Perinatal Clinical Quality Surveillance**
Sponsoring executive:	Martina Morris- Chief Nurse
Report author:	Claire Macdiarmid- Head of Midwifery Basem Muammar- Clinical Director for Obstetrics and Gynaecology

1. Summary of key issues using Assure, Advise and Alert

Assure

Perinatal mortality rates remain in an improved position. The Trust stillbirth rate is now 2.63 per 1000 births (National rate 3.54 per 1000 births). The Trust neonatal death rate is 1.68 per 1000 births when including all gestations of babies born, and 0.96 per 1000 births when only including all babies born over 24 weeks (National rate is 1.65) These rates are greatly improved over the last 6 months.

Maternity incentive scheme (MIS) year 6 remains on track for full compliance. 6/10 safety actions are marked as green and 4 as amber. Work remains ongoing with all safety actions.

Midlands Maternity heatmap published for August 2024 shows a score of 23 for the Dudley Group. This is the joint second lowest score within the Midlands. There are further areas to enable a further reduction in the score

A paper was submitted to the August Quality committee updating current position on the Three year service delivery plan for Maternity and Neonatal services, with headline discussion around areas requiring further attention.

Advise

Maternity safety champions work remains ongoing with bimonthly meetings and alternate bimonthly walkarounds.

There have been 0 Maternity and Newborn safety investigations (MNSI) cases reports and 3 new Patient safety incident investigations (PSII) commenced. These relate to two stillbirths and one SHOT (Serious hazards of Transfusion) reportable incident.
Claims scorecard is included for information in relation to current incident and complaint themes.

The trust is currently 94% compliant with Saving Babies Lives version 3 (SBLV3). This is currently awaiting sign off from the LMNS.

Alert

The Perinatal culture and leadership program (PCLP) remains ongoing with the Perinatal quad. An action plan is in development and will be brought to a future committee for awareness and sign off. Actions to tackle issues raised with culture, commence in October 24 being led by the division.

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

3. Report
Quality Committee

4. Recommendation(s)
The Public Trust Board is asked to:
a) **Accept** assurance provided regarding improved mortality figures.
b) **Note** Progress with the 3 year delivery plan, SBLV3, MIS year 6

5. Impact		
Board Assurance Framework Risk 1.1	x	Deliver high quality, safe person centred care and treatment
Board Assurance Framework Risk 1.2	x	Achieve outstanding CQC rating.
Board Assurance Framework Risk 2.0	x	Effectively manage workforce demand and capacity
Board Assurance Framework Risk 3.0	x	Ensure Dudley is a brilliant place to work
Is Quality Impact Assessment required if so, add date:		
Is Equality Impact Assessment required if so, add date:		

REPORT FOR ASSURANCE

Perinatal Clinical Quality Surveillance
Report to Public Board of Directors 12th September 2024

1 EXECUTIVE SUMMARY

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

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

2. BACKGROUND INFORMATION

2.1 Perinatal Mortality Overview

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

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

Perinatal mortality rate: Stillbirth and neonatal deathrates combined.

Table 1: Perinatal Safety data including mortality and serious incidents

2024

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

	CQC Maternity Inspection April 2023 (safe and Well Led) (Previous rating from 2019)	Safe	Effective	Caring	Well-Led	Responsive			
		Good	Good	Good	Good	Good			
		2024 Jan	2024 Feb	2024 March	2024 Apr	2024 May	2024 Jun	2024 Jul	2024 Aug
PMRT	Perinatal Mortality Review Tool cases opened in month	1	0	4	1	1	2	0	
	PMRT reviewed in month	2	1	2	2	2	2	2	
HSIB/ MNSI	Number of cases referred to and accepted by MNSI (with 72 hr revi	0	0	0	0	0	0	0	
	Reports received from MNSI	0	0	0	1	2	0	1(SWBH)	
	MNSI investigations ongoing	4	4	4	3	1	1	1(RWT)	
	MNSI open action plans	0	0	0	1	1			
PSIRF	The number of incidents logged as moderate or above:	1	0	1	0	0	2	0	
	PSII Reported	0	1	0	0	0	4	0	
	PSII Completed	0	0	0	2	0	1	0	
	PSII Ongoing	2	3	3	1	1	4	4	
	Oustanding Investigation Actions - overdue	7	3	3	5				
	Oustanding Investigation Actions - open			6	7				
	Maternity Incidents Improvement Plan - overdue actions					12	12	10	
	Maternity Incidents Improvement Plan - open actions					13	15	8	
Outcome measures	Stillbirth rate (National crude rate 3.54 per 1000 births)	2.44	2.43	3.4	2.9	2.62	2.62	2.63	
	Neonatal Death Rate 1.65 (> 22+0 - up to 28 days post delivery)	2.44	2.19	2.19	2.18	1.67	1.67	1.68	
	Neonatal death rate only including babies born over 24/40			1.21	1.21	0.96	0.95	0.96	
	Total Perinatal Mortality Rate (MBRRACE figure 5.19 per 1000 births)	4.88	4.62	5.59	5.08	4.29	4.29	4.3	
	Avoidable term admission to NNU (reported quarterly)		3			4			
Appraisals	All Maternity staff (90%) (Apraisal window April-July)						93% (16.7.24	94.30%	
Midwifery Trai	Fetal Monitoring Training (90%)*	99%	97%	98%	96%	96%	99%	98.00%	
	Obstetric Emergency Simulation Training (PROMPT) (90%)*	99%	97%	96%	96%	98%	99%	99.00%	
	Safeguarding (level 3) Adult (90%) (Database not accurate)	84%	83%	77%	70%	83%	78%	85.00%	
	Safeguarding (level 3) Children (90%)	78%	79%	82%	79%	83%	80%	90.00%	
	Neonatal Resusitation (90-95%)*	93%	92%	90%	86%	90%	87%	88.00%	
	Adult Resusitation (90 - 95%)*	94%	93%	91%	86%	84%	88%	90.00%	
Obstetrics Tra	Fetal Monitoring Training (90%)*	97%	100%	100%	95%	95%	98%	98.00%	
	Obstetric Emergency Simulation Training (PROMPT) (90%)*	92%	97%	97%	95%	100%	100%	98.00%	
	Safeguarding (level 3) Adult (90%)	81%	73%	73%	80%	80%	93%	93.00%	
	Safeguarding (level 3) Children (90%)	68%	68%	71%	72%	80%	80%	80.00%	
	Neonatal Resusitation (90-95%)*	86%	85%	80%	90%	92%	87%	90.00%	
	Adult Resusitation (90 - 95%)*	86%	85%	91%	88%	90%	91%	90.00%	
							*Element 4 and 5 of CCFv2 as included in other training days		
Safe staffing	Obstetric consultant cover on delivery suite	91	91	91	91	91	91	91	
	Vacancies midwifery (WTE)	0	0	0	0	0	0	0	
	Obstetric Consultant vacancies (WTE)	0	0	0	0	0	0	0	
	Total Red flag data: Total number of red flags (As per acuity tool)	5	1	0	14	14	12	8	
	Shift Leader supernumuary at start of shift : % of time	100%	100%	100%	100%	100%	100%	100%	
	1:1 care in labour achieved	100%	100%	100%	100%	100%	100%	100%	
	Birth Before Arrival (BBA)	2	1	1	3	2	2	(1unbooke	
Service user feedback	MVP (Quarterly)	.	.	6.3.24	.	.	~~6.6.24~~	.	.
	MNVP Extraordinary meetings* Bereavement / Neonatal / EDI	.	.	21.3.24	25.4.24	-			
Engagement	Response Rate (%)	7.00%	11.00%	25.00%	33.00%	17.00%	20.00%	19.00%	
	Recommendation Response Rate (Good/ Very Good %)	17.00%	86.00%	81.00%	82.00%	77%	89.00%	88.00%	
	PALS	3	9	5	3	4	9	5	
	Complaints	5	5	3	6	4	6	4	
	Compliments	71	65	70	72	67	67	59	
Safety Champ	Maternity Safety champions walk- about	None	Cancelled	None	none	13.5.24		24.7.24	
	Maternity and Neonatal Safety Champion Meeting	None	28/2/24	None	24.4.24		26.6.24		28.8.24
	Maternity Incentive Scheme meeting (previously Maternity Quad)	None	None	None	25.4.24	Kornferry	None	1.7.24	28.08.24
External	MNSI/NHSR/CQC or other organisation with a concern or request for action made directly with the trust	0	0	0	0	0	0	0	
Legal	Legal cases (Maternity only- Including Coroners cases and ENS claims)	1 closed	0	0	3	0	2	0	
Annual Respo	Proportion of Midwives responding with 'Agree' or 'Strongly Agree' on whether they would recommend their trust as a place to work or receive treatment	60.60%							
	Proportion of all doctors responding with 'excellent or good' on how they would rate the quality of clincial supervision out of hours	57.10%							
	Speciality OBS/Gynae with 'Good' or 'Excellent' for support	Awaiting							

*Please note the improved position in training rates, all are within the amber rate, and none are rated as red.

2.2 Perinatal Mortality overview (table 1)

The Women and Children's service continues to report perinatal mortality rates through Divisional Governance each month and into the Trusts Mortality Surveillance Group

All stillbirths and neonatal deaths are reviewed using the National Perinatal Mortality Review Tool (NPMRT) which includes parent's perspectives and questions as part of the review. The system allows for a report to be produced covering all aspects required as part of Maternity incentive scheme (MIS) Safety Action 1.

The neonatal death rate has decreased significantly as per table 1 below. There has been a month-on-month reduction over the last 7 months. The Trust rate is now at 1.68 (July 2024), the national rate is 1.65 per 1000 births.

Table 1:

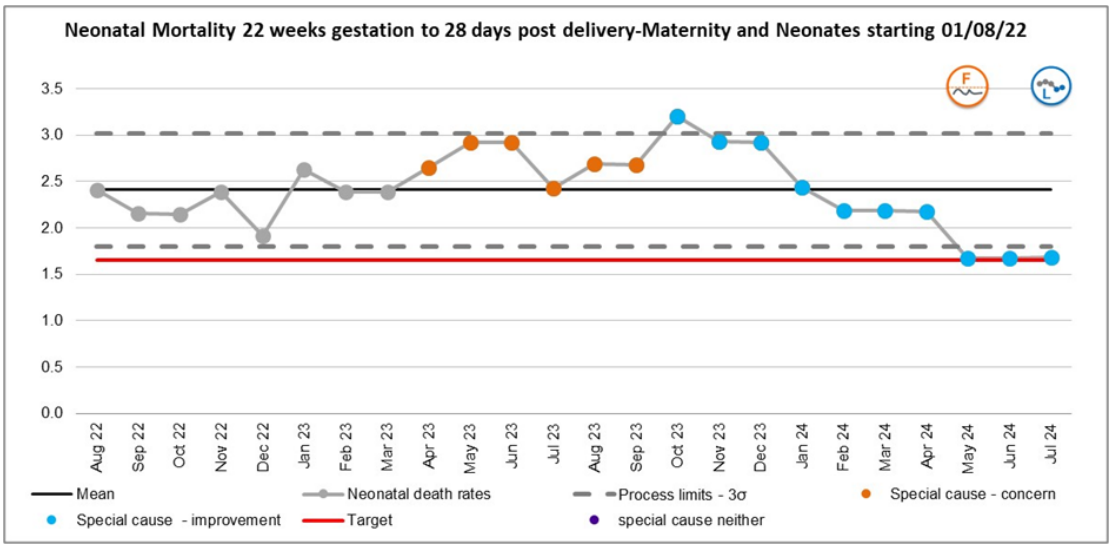
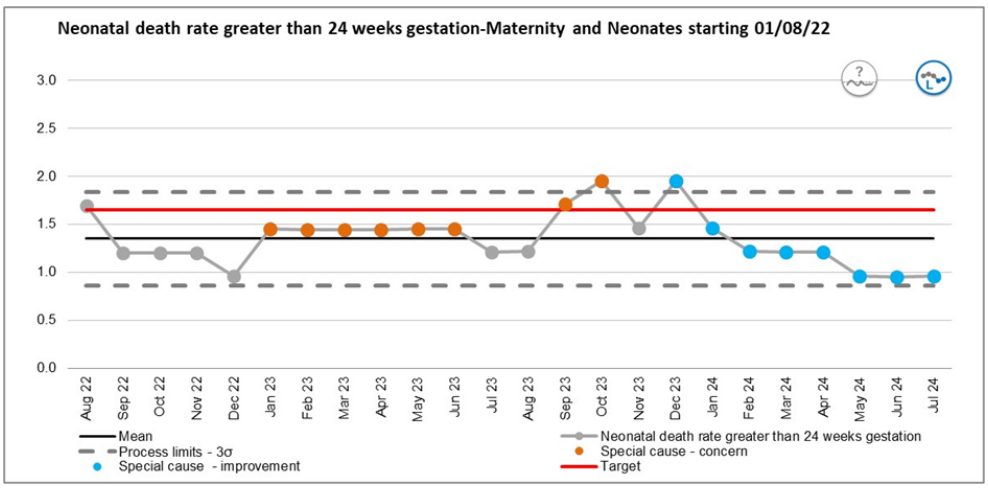


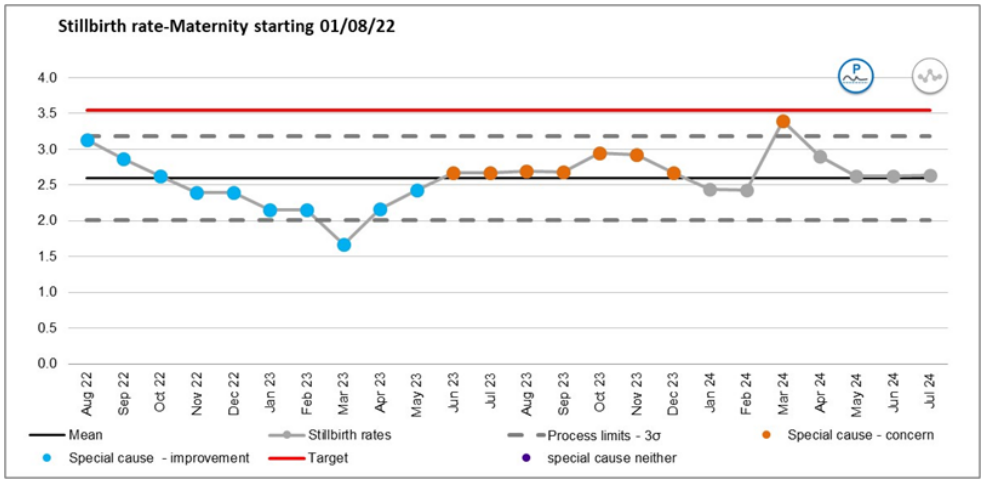
Table 2 demonstrates neonatal deaths >24 weeks gestation and the national crude rate. MBRRACE (2023) neonatal death crude rate (1.65) only includes NND from 24 weeks gestation and when DGFT rate is recalculated including NND >24 weeks gestation the rate is 0.96 per thousand births.

Table 2:



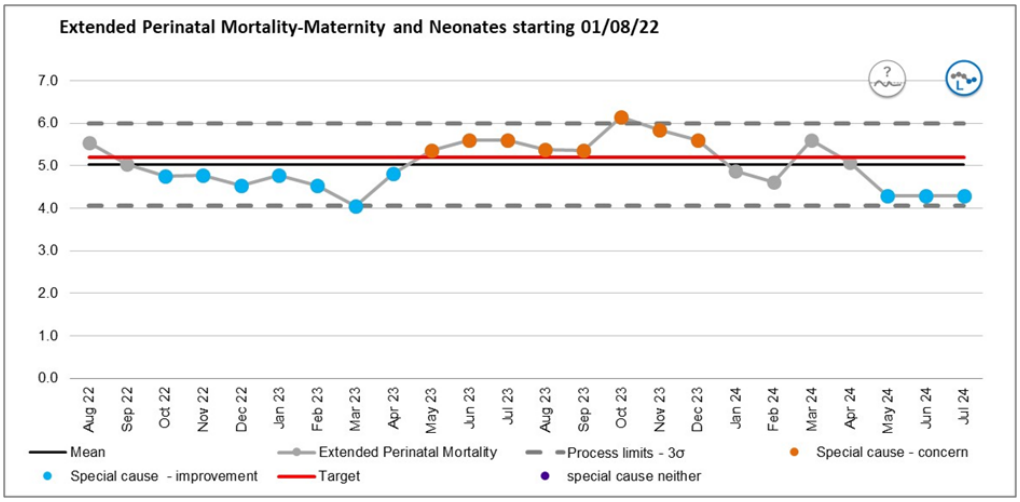
The Trust stillbirth rate increased during March 2024 to 3.4 per 1000 births, however, has now returned to a rate significantly below the national average of 2.63 per 1000 births, demonstrated in table 3.

Table 3:



Extended Trust perinatal mortality rate is now at 4.30, below the national rate of 5.19 per 1000 births.

Table 4:



There have been 2 stillbirths during June and July 2024. Both deaths will be investigated via the perinatal mortality review tool (PMRT) and will seek the views of the family to form the themes of the investigation.

There have been 0 neonatal deaths during June and July 2024.

*Future quarterly reports will include further analysis into the demographics relating to these deaths, to allow us to identify themes and trends and shape future work accordingly.

2.3 Serious incidents and Maternity and Newborn Safety Investigations

There have been no cases referred to the Maternity and Newborn Safety Investigations (MNSI) during June and July 2024, by the Trust, however, there has been a request for information by MNSI in relation to a case referred by RWT, as the woman also received care at DGFT.

There have been 3 new Patient Safety Incident Investigations (PSII) commenced during June and July 2024; a wrong blood in tube near miss, which has been reported to Serious Hazards of Transfusion (SHOT); and 2 stillbirths.

There has been 1 PSII and 1 MNSI case concluded during June and July 2024. A summary is detailed below.

- INC144642 – PSII – Neonatal death
- INC147607 – MNSI – Hypoxic Ischemic Encephalopathy (HIE)

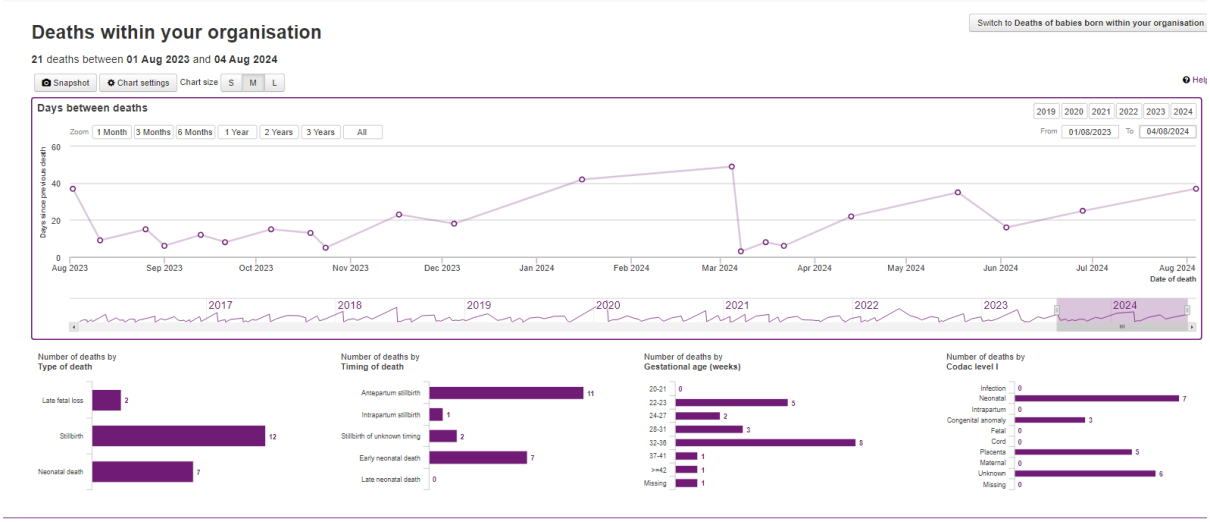
2.4 Perinatal Mortality Review tool (PMRT)

*PMRT Quarter 1 2024/225 paper has been discussed at the Quality committee (27/8/24), Mortality surveillance group and will be discussed at Private board October 2024.

2.4.1 PMRT real time data monitoring tool

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

Table 5:



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

2.5 Coroner Regulation 28 made directly to the Trust

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

2.6 Claims Scorecard: Updated scorecard due September 2024, to be presented at November Board. **(Table 6)**

Claims Scorecard Incident date 01/04/2013 to 31/03/2023

Top injuries by volume:	**Top injuries by value:**
Brain damage (6) Unnecessary pain (6) Stillborn (6) Not specified (5) Loss of baby (3)	Brain damage (6) Cerebral palsy (2) Hypoxia (2) Not specified (5) Stillborn (6)
Top causes by volume:	**Top causes by value:**
Fail/ delay in treatment (17) Inappropriate treatment (3) Foreign body left in situ (3) Fail to recognise complication (3) Failure/ delay in diagnosis (2)	Fail to monitor 2nd stage labour (2) Fail/ delay treatment (17) Other (1) Fail antenatal screening (1)

Complaints Quarter 1 2024-25

13 complaints in total
7 Clinical care/ treatment
2 Values and Behaviours
2 Appointments
1 Waiting times
1 Communication

Incidents Quarter 1 2024-25

4 PSII incidents (2 x Stillbirths, 2 x SHOT reportable)
4 PMRT cases (1 x pregnancy loss, 1 x extreme prem NND, 2 stillbirths (PSIIs))
28 unexpected term admissions to NNU
14 maternal readmissions
7 massive obstetric haemorrhage >1500mls
6 third degree tears
2 fourth degree tears
12 delay/ failure in treatment
3 delayed/ incorrect diagnosis
10 workload/ staffing

Maternity Incentive Scheme – SA9

Quarterly review of Trust's claim scorecard alongside incident and complaint data and discussed by the maternity, neonatal and Trust Board level Safety Champions at Trust level (Board or directorate) quality meeting.

Themes Quarter 1 2024-25

Maternal readmissions with wound infection
Timely stepdown from NNU to TC
Management of diabetes
Intermittent auscultation
Hypertension in ANC
Care outside of guidance

Learning/ Actions Quarter 1 2024-25

Patient awareness of wound care (development of patient information leaflet)
Raising awareness within medical team via teaching sessions, regarding timely stepdown to TC.
Teaching session by Endocrinologist regarding appropriate management of diabetic patients in pregnancy.
Review of diabetes related guidelines to ensure clarity and consistency
Strengthening of intermittent auscultation training within fetal monitoring study day
Reconfiguration of ANC to allow vital signs to be taken in presence of reviewing clinician.
Referral pathway/ clinics/ care plans with Consultant Midwife for women opting for care outside of guidance

2.7 Maternity Safety Champions

Maternity safety champions met on the 26th June 2024. Issues discussed were:

- Verbal update for Maternity and Neonatal Safety and Quality Dashboard
- MIS year 2
- Saving Babies Lives following LMNS update
- Action plan update from Maternity survey 2023 (update 2024)
- Training needs analysis
- Heatmap update and issues requiring attention
- Single delivery plan.
- Quarterly perinatal mortality report update
- Neonatal Safety Champion update
- Maternity safety champions listening session date

Next meeting to be held 28th August 2024.

Feedback from Maternity Safety Champion walkaround

A Maternity and Neonatal safety walkaround occurred on the 24th July 2024, attended by the Chief Nurse, Martina Morris, Medical director Julian Hobbs and non-executive director for maternity, Dr Liz Hughes.

Questions were raised on both maternity and neonatal around storage of milk and the query as to whether the milk fridges required locks. Both milk kitchens are swipe access only and are not accessible to families. On review of practice at local maternity and neonatal units and following published guidance as per Paediatric group of the British Dietetic Association (BDA) the below is stated:

“Hospital milk storage fridges and freezers should be lockable or housed in a locked room if they are not constantly supervised. To help prevent milk errors and to promote best practice for the handling and storage of breast milk, only staff should have access to fridges and freezers containing breast milk from more than one mother.”

In conclusion, current provision is acceptable in both Maternity and Neonatal units.

Handover was observed by Dr Hobbs, and this was reported to have been improved from previous observations. Work remains ongoing in improving the format and content of medical handover.

Martina Morris and non- executive director for Maternity and Neonatal services- Liz Hughes spoke to several patients during the walkaround. There was a lot of praise for the teams caring for them that day. One lady felt she got conflicting information from the medical teams at times, and this was discussed and resolved during the time of the visit.

No other issues were identified from observations or from staff present on the day. Safety champion walkarounds remain bimonthly, with Safety champion meetings occurring in the alternate months.

A further speak up session was held in July 2024 open to all maternity and neonatal staff. It was hosted by Board level safety champions Martina Morris and Julian Hobbs. Multiple staff from b=various groups attended. Issues raised were mainly from Midwifery support workers

around band 2 to 3 progression. The matron team will be regularly updating the MSW group around progress with this work at trust level.

They also highlighted queries around working patterns which have been discussed amongst the team and clarity has been provided. Sessions are to be held quarterly to allow any concerns to be raised.

2.8 Saving Babies Lives

As part of the Three year delivery plan for maternity and neonatal services, NHS trusts are responsible for implementing SBLCBv3 and integrated care boards (ICBs) / Local Maternity and Neonatal Systems (LMNS) are responsible for agreeing a local improvement trajectory with providers, along with overseeing, supporting, and challenging local delivery.

Compliance as of LMNS review on 06/12/23 was 80% overall and MIS requirements have been met with at least 50% compliance for each element – exceeding the minimum requirement set out by SBLCBv3.

Following additional evidence being submitted in March 2024, our self-assessed compliance sits at 93%, This is still pending verification by the LMNS. A resubmission was requested for August where our self-assessed compliance increased to 94%.

Table 7

Implementation Progress

Intervention Elements	Description	Element Progress Status (Self assessment)	% of Interventions Fully Implemented (Self assessment)	Element Progress Status (LMNS Validated)	% of Interventions Fully Implemented (LMNS Validated)
Element 1	Smoking in pregnancy	Fully implemented	100%	Not implemented	0%
Element 2	Fetal growth restriction	Fully implemented	100%	Not implemented	0%
Element 3	Reduced fetal movements	Fully implemented	100%	Not implemented	0%
Element 4	Fetal monitoring in labour	Fully implemented	100%	Not implemented	0%
Element 5	Preterm birth	Partially implemented	85%	Not implemented	0%
Element 6	Diabetes	Fully implemented	100%	Not implemented	0%
All Elements	TOTAL	Partially implemented	94%	Not implemented	0%

SBL is due for discussion at Maternity Governance group in September for the quarterly review.

2.9 Maternity and Perinatal incentive scheme (MIS) year 6

MIS Year 6 launched the 2nd April 2024, with a compliance period until 30th November 2024. Full compliance for all safety actions is expected, with a deadline for submission of the self-certification declaration from the Trust Board to NHS Resolution (NHSR) by 3rd March 2025. An updated audit tool was issued July 2024 to include the amendments made to Year 6 guidance following concerns raised across the system to Safety Action 8.

The submission of papers and evidence continue to relevant committees and Board to provide assurance. The current compliance is as below, Table 8), as well as an update on successes and challenges to date.

Current success

Safety Action 2 - MSDS – July data now complete, waiting for publication in October 2024

Safety Action 3 – Neonatal Quality improvement project now registered with improvement team, as well as registered on AMAT. This was presentation at maternity safety champions August 2024.

Safety Action 4 – Midwifery Workforce report presented to July board. Business case to follow to ensure actions are taken to become compliant with birthrate plus recommendations.

Safety Action 9 – Board Assurance, improved claims scorecard presented to Quality committee/ Board.

Challenges

Safety Action 6 – Saving Babies Lives – Element 2 Fetal Growth risk assessment, surveillance and management. Fetal Medicine Unit at SWBH, short term capacity reduction due to staffing challenges therefore adjustments to accepted referrals implemented, risk register updated with new risk. Divergence meeting cancelled July by NHSE, rearranged date September 2024.

Safety Action 7 – Listening to women, parents and families using maternity and neonatal services and coproduce services with users. Risk registers to be updated, as per LMNS recommendations, due to capacity with Gateways service for MIS requirements.

Trust Current position MIS year 6- Table 8

Safety Action	Safety Action Title Theme	RAG rating as of August 2024.
1	Perinatal Mortality review tool	
2	Maternity Services Dataset (MSDS) (awaiting publication of results October)	
3	Transitional Care and and Quality improvement	
4	Clinical Workforce	
5	Midwifery Workforce	
6	Saving Babies Lives	
7	Listen to women, parents and families using maternity and neonatal services and coproduce services with users.	
8	Training	
9	Board Assurance	
10	Maternity and Neonatal Safety Investigations and Early Notification Scheme	

***RAG rating reflects actions completed to date. Please note further actions are required within each of the 10 actions to become fully compliant.**

2.10 Three year service delivery plan for Maternity and Neonates

The three-year service delivery plan for maternity and Neonates was published in March 2023. The trust has been working towards full compliance with all recommendations since July 2023.

A new online compliance tool has been launched by NHSE to aid trusts in tracking progress. This is the first time this format has been presented.

Current progress is greatly improved:

- 18% of actions remain amber
- 82% are rated as green. This is a position.
- No red actions

Summary of current work being undertaken is:

- Culture work within the staff teams and SCORE survey results
- Development of a Maternity EPR portal to enhance information available to families
- Enhanced work around deprivation and equity strategies
- Development of the labour ward leaders, through attendance in local and national development programs.
- Workforce business case development (Midwifery)
- Strengthened mechanisms for hearing the patient/family voice

Table 9: Update on progress with 3 year service delivery plan

Theme	Objective	Compliance			Full Compliance
1	Listening to and working with women and families with compassion				
	1		3	1	
	2			2	Full Compliance
	3			1	
2	Growing, retaining, and supporting our workforce				
	4		0	3	Full Compliance
	5		2	4	
	6			3	Full Compliance
3	Developing and sustaining a culture of safety, learning and suppor				
	7		0	5	Full Compliance
	8		1	5	
	9		1	4	
4	Standards and structures that underpin safer, more personalised, and more equitable care				
	10		1	3	
	11			2	Full Compliance
	12			3	Full Compliance
	Total	0	8	36	
	Current July 2024	0.00%	18.00%	82.00%	
	Previous July 2023	2.3%	45.5%	52.2%	

2.11 Perinatal Culture Leadership Programme (PCLP) update

The Perinatal quad commenced the PCLP in July 2023. The aim of the course is to bring Perinatal leadership teams together to assess their service and to be able to make a positive impact on the culture and therefore safety of their unit. A SCORE culture survey was undertaken late 2023 and results were presented to the quad during the spring. An action plan is currently in development, being supported by NHSE and their designated support company (Kornferry). The first action to be taken is listening sessions with an external culture coach in October, across Obstetrics and gynaecology, Nursing Midwifery and medical teams. The action plan will be bought to this committee for their awareness and sign off.

2.12 Maternity Regional Heatmap (Appendix 1)

Appendix 1 demonstrates trusts current position with the regional Maternity Heat map for August 2024. The lower the score, the less the number of concerns have been raised about the Trust. Dudley is achieving a green score of 23 and is currently the second lowest scoring trust in the Midlands region.

Areas to highlight are:

- An increase in score of 1 for stakeholder concerns on Julys heatmap. This related to a lack of obstetric workforce data being submitted by the trust. We have received assurance that this issue has now been rectified and await the updated position reflected in next month's scoring.
- The CQC maternity survey scores 4 due to being a negative outlier and work remains ongoing in improving this. This score cannot improve until publication of this year's results (Due September 2024- embargoed until December 2024)
- Senior leadership remains a score of 5 however this score should reduce when the change in title from Head of Midwifery to Director of Midwifery has reflected in the scoring to the regional team. To note this leadership score also relates to the requirement for a consultant midwife to be in post and a deputy Head/director of Midwifery. Our consultant midwife is currently on a fixed term contract and departmental funding has been reallocated to ensure employment can continue for this vital post.
- To note our neonatal death rate has reduced to a score of 1 due to its persistent decline towards the national rate.

2.13 Service user feedback- Maternity and Neonatal voices partnership (MNVP)

The scheduled quarterly MNVP meeting due to be held in July 2024 was postponed due to the general election. This is now taking place in September. This has caused some delays to the schedule of meeting content.

A meeting has been arranged for September 16th at Mary Stevens Park to allow members to discuss the Maternity CQC action plan progress and to add their views and ideas to the plan. This was taken to the March meeting however due to lack of time within the meeting, the MNVP members were unable to contribute fully to the plan, hence revisiting in September.

The MNVP send representation to Maternity governance meetings, Maternity safety champions PMRT, as well as LMNS workstreams and regular 1:1s with the Head of Midwifery. They have vocalised that they do not have capacity to fully support all requirements of the Maternity incentive scheme requirements for patient input, therefore a risk is being considered to potentially be added to the risk register.

2.13.1 Service user feedback- Friends and Family results June and July 2024

'Support when labour was difficult was outstanding. All staff went above and beyond to help and support myself and husbands questions. Thank you all'

'I felt listened to, I really feel that the Midwife in charge introduced themselves to me in each department and they knew what was going on with me and the plan. I had the same medical team with me, great for continuity. I feel supported by the Midwifes in the scariest moments. Midwifes, nurses and the team. Security team were very welcoming.'

'All the staff were lovely and helpful. Thank you to Ruth + Aimee for delivering Renny and Heather for helping with breast feeding'

'The other patients on the ward spoke across the room to each other until 4am so I could not sleep at all.'

3. RECOMMENDATION

3.1 The Board of Directors is invited to accept the assurance provided in this report as current position with perinatal mortality, serious incidents (PSII) and learning, Regional Maternity heatmap scoring, Perinatal culture and leadership program, 3 year service delivery plan and progress with the Maternity incentive scheme year 6.

Name of Authors: Claire Macdiarmid and Basem Muammar
Title of Author Head of Midwifery and Clinical Director for Obstetrics and Gynaecology

Date 1st September 2024

Appendix 1: Regional maternity Heatmap August 2024

Regional Maternity Heatmap

Data refreshed: 27/08/2024 16:11:54

Heatmap

Version: 2
Deployed Oct 2023

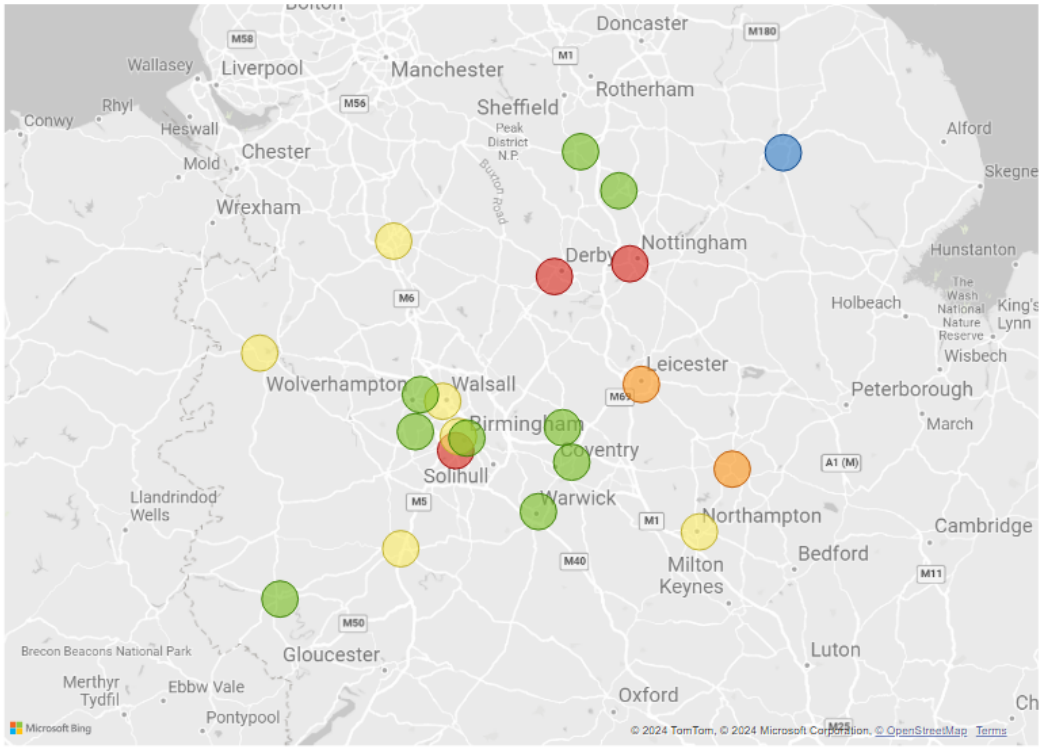
Region: Midlands

NHS England

Overall heatmap scoring key: >40 | 36-40 | 30-35 | 20-29 | <20

Region average score: **32.9**

Heatmap month: August 2024



Provider	Overall score
UNIVERSITY HOSPITALS OF DERBY AND BURTON NHS FOUNDATION TRUST	73.0
NOTTINGHAM UNIVERSITY HOSPITALS NHS TRUST	52.0
UNIVERSITY HOSPITALS BIRMINGHAM NHS FOUNDATION TRUST	43.0
KETTERING GENERAL HOSPITAL NHS FOUNDATION TRUST	39.0
UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST	38.3
NORTHAMPTON GENERAL HOSPITAL NHS TRUST	35.0
THE SHREWSBURY AND TELFORD HOSPITAL NHS TRUST	35.0
UNIVERSITY HOSPITALS OF NORTH MIDLANDS NHS TRUST	32.0
WALSALL HEALTHCARE NHS TRUST	31.0
WORCESTERSHIRE ACUTE HOSPITALS NHS TRUST	31.0
SANDWELL AND WEST BIRMINGHAM HOSPITALS NHS TRUST	30.0
BIRMINGHAM WOMEN'S AND CHILDREN'S NHS FOUNDATION TRUST	29.0
SHERWOOD FOREST HOSPITALS NHS FOUNDATION TRUST	29.0
UNIVERSITY HOSPITALS COVENTRY AND WARWICKSHIRE NHS TRUST	28.0
THE ROYAL WOLVERHAMPTON NHS TRUST	27.0
SOUTH WARWICKSHIRE UNIVERSITY NHS FOUNDATION TRUST	26.0
GEORGE ELIOT HOSPITAL NHS TRUST	25.0
CHESTERFIELD ROYAL HOSPITAL NHS FOUNDATION TRUST	23.0
THE DUDLEY GROUP NHS FOUNDATION TRUST	23.0
WYE VALLEY NHS TRUST	23.0
UNITED LINCOLNSHIRE HOSPITALS NHS TRUST	18.0

Regional Maternity Heatmap

Data refreshed: 27/08/2024 16:11:54

Scoring

Region: Midlands

NHS England

Heatmap month: August 2024

Provider	Overall score	CQC Mat overall rating	Stake holder concerns	CQC S29a	CQC s31	Ext. ind. review	Coroner reg 28	Mat Oversight	MIS	CNST repay ment	Eth. DQ	CQC Mat Survey	SBL	Midw ives vac.	MSW vac.	Obs vac.	Unfilled roles	Snr L'ship not in post	Safety champs	Birthrate + (last 3 yrs)	Neonatal death rate	Perinatal death rate	Stillbirth rate
BIRMINGHAM WOMEN'S AND CHILDREN'S NHS FOUNDATION TRUST	29.0	1.0	1	0	0	0	0	0	0	0	0	3	3	2	2	3	1	0	0	0	5	5	3
CHESTERFIELD ROYAL HOSPITAL NHS FOUNDATION TRUST	23.0	3.0	2	0	0	0	0	0	3	0	0	0	3	2	1	3	1	0	0	0	1	1	3
GEORGE ELIOT HOSPITAL NHS TRUST	25.0	1.0	0	0	0	0	0	0	0	0	0	3	3	2	2	5	1	0	0	1	1	3	3
KETTERING GENERAL HOSPITAL NHS FOUNDATION TRUST	39.0	3.0	3	0	0	0	0	5	2	0	0	3	3	3	2	1	1	0	0	0	5	5	3
NORTHAMPTON GENERAL HOSPITAL NHS TRUST	35.0	3.0	1	0	0	0	0	0	2	0	0	3	5	2	5	5	0	0	0	0	3	3	3
NOTTINGHAM UNIVERSITY HOSPITALS NHS TRUST	52.0	3.0	6	0	0	5	0	5	4	0	3	2	3	3	4	5	0	0	0	0	3	3	3
SANDWELL AND WEST BIRMINGHAM HOSPITALS NHS TRUST	30.0	1.0	5	0	0	0	0	3	0	0	0	3	3	3	3	0	0	0	0	0	3	3	3
SHERWOOD FOREST HOSPITALS NHS FOUNDATION TRUST	29.0	1.0	1	0	0	0	5	0	0	0	0	2	3	1	2	5	0	0	0	0	3	3	3
SOUTH WARWICKSHIRE UNIVERSITY NHS FOUNDATION TRUST	26.0	1.0	0	0	0	0	0	0	0	0	3	3	3	0	5	1	0	0	0	1	3	3	3
THE DUDLEY GROUP NHS FOUNDATION TRUST	23.0	1.0	3	0	0	0	0	0	0	0	0	4	3	0	0		0	5	0	0	1	3	3
THE ROYAL WOLVERHAMPTON NHS TRUST	27.0	1.0	0	0	0	0	0	2	0	0	0	3	3	0	0	4	1	0	0	0	5	5	3
THE SHREWSBURY AND TELFORD HOSPITAL NHS TRUST	35.0	3.0	1	0	0	5	0	5	0	0	0	2	3	0	1	2	0	0	0	0	5	5	3
UNITED LINCOLNSHIRE HOSPITALS NHS TRUST	18.0	1.0	1	0	0	0	0	0	0	0	0	2	3	1	4	0	0	0	0	0	0	3	3
UNIVERSITY HOSPITALS BIRMINGHAM NHS FOUNDATION TRUST	43.0	4.0	6	5	0	0	0	5	3	0	0	5	3	1	0	0	0	0	0	0	5	3	3
UNIVERSITY HOSPITALS COVENTRY AND WARWICKSHIRE NHS TRUST	28.0	1.0	0	0	0	0	0	0	0	0	0	4	3	2	3	5	0	0	0	1	3	3	3
UNIVERSITY HOSPITALS OF DERBY AND BURTON NHS FOUNDATION TRUST	73.0	5.0	7	10	5	5	4	5	5	0	0	3	5	1	0	0	0	5	0	0	5	5	3
UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST	38.3	2.3	4	0	0	0	0	3	0	0	0	4	3	2	2	5	0	0	0	0	5	5	3
UNIVERSITY HOSPITALS OF NORTH MIDLANDS NHS TRUST	32.0	3.0	0	5	0	0	0	2	0	0	0	3	3	2	1	0	0	0	0	0	5	5	3
WALSALL HEALTHCARE NHS TRUST	31.0	3.0	2	0	0	0	0	0	0	0	0	3	3	2	5	2	0	0	0	0	5	3	3
WORCESTERSHIRE ACUTE HOSPITALS NHS TRUST	31.0	1.0	2	0	0	0	0	2	2	0	3	3	3	2	4	0	0	0	0	0	3	3	3
WYE VALLEY NHS TRUST	23.0	1.0	0	0	0	0	0	0	0	0	0	3	3	0	1	0	1	5	0	0	3	3	3

Enclosure 10

The Dudley Group NHS Foundation Trust

Paper for submission to the Board of Directors on 12th September 2024

Report title:	Workforce KPI Report
Sponsoring executive:	Karen Brogan - Interim Chief People Officer
Report author:	Hannah White - Head of People

1. Summary of key issues using Assure, Advise and Alert

Assure

- Normalised turnover (voluntary resignations) remains low, mirrored by a high retention rate. There is a renewed focus on retention for 2024/25 as part of the Trust's Recruitment and Retention Journey within the People Plan, with focus on key retention strategies such as flexible working, stay interviews and exit data and culture and bullying and harassment.

- The appraisal window closed, above target at 91.8%

- ICan Paid Work experience – 2/5 candidates have secured employment post-work experience. Work is underway to support the remaining candidates into work. A further 10 candidates will commence paid work experience in September. This scheme is providing key insight into inclusive recruitment practices and supporting changes to ensure our recruitment is fair, equitable and supports local people into work.

Advise

- Both the rolling 12-month average and the in-month sickness % for July have increased, for the second month in a row. Sickness absence rates are RAG rated as amber being slightly above the tolerance level of 5%. The identified area of concern is short-term sickness absence. A taskforce has been established address this.

Alert

- Bank usage has been increasing month on month since April 2024, largely due to increased pressures through Acuity, staffing unavailability being above tolerance levels and the opening of surge areas which are unbudgeted and not part of the establishment. Through grip and control measures implemented the Admin & Clerical bank usage has started to decline. Further work is in progress to improve grip and control across all staff groups.

- For statutory and mandatory, however there has been an issue identified with the training needs for some staff in safeguarding subjects which will see a change to the requirements and increase the number of staff who require Level 3 training. Compliance for Safeguarding Adults Level 3 and Safeguarding Children Level 3 has dropped in month (August). This has had a small impact on the overall compliance rate, but this remains above target. Targeted training is in place to support early completion of training for those staff impacted.

2. Alignment to our Vision [indicate with an 'X' which Strategic Objective[s] this paper supports]	
Deliver right care every time	**X**
Be a brilliant place to work and thrive	**X**
Drive sustainability (financial and environmental)	**X**
Build innovative partnerships in Dudley and beyond	**X**
Improve health and wellbeing	**X**

3. Report journey
People Committee

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

5. Impact		
Board Assurance Framework Risk 1.1	X	Deliver high quality, safe person-centred care and treatment
Board Assurance Framework Risk 1.2	X	Achieve outstanding CQC rating.
Board Assurance Framework Risk 2.0	X	Effectively manage workforce demand and capacity
Board Assurance Framework Risk 3.0	X	Ensure Dudley is a brilliant place to work
Board Assurance Framework Risk 4.0	X	Remain financially sustainable in 2023/24 and beyond
Board Assurance Framework Risk 5.0	X	Achieve carbon reduction ambitions in line with NHS England Net Zero targets
Board Assurance Framework Risk 6.0	X	Build innovative partnerships in Dudley and beyond
Board Assurance Framework Risk 7.0	X	Achieve operational performance requirements
Is Quality Impact Assessment required if so, add date:		
Is Equality Impact Assessment required if so, add date:		

Workforce KPI Report

July 2024

The Dudley Group
NHS Foundation Trust

Summary

The Dudley Group NHS Foundation Trust

Metric	Rate	Target	Trend	
Absence – In Month	5.57	<=5%	↑	**Sickness Absence** In-month sickness absence for July 2024 is 5.57% an increase from 5.16% in June 2024. The rolling 12-month absence has increased to 5.09% from 5.01% in June 2024.
Absence - 12m Rolling	5.09%	<=5%	↑	
Turnover	8.27%	<=8%	↑	**Turnover** Turnover (all terminations) has increased from 8.24% in June 2024 to 8.27% in July 2024 Normalised Turnover has slightly decreased from 3.64% in June 2024 to 3.53% in July 2024 Turnover (all terminations) is all terminations from the organisation. Normalised Turnover focuses on voluntary resignations and excludes dismissals, fixed-term contracts, redundancy, retirement and rotations.
Normalised Turnover	3.53%	<=5%	↓	
Retention (12 month)	91.6%	>=80%	↑	**Retention** The 12-month retention rate increased slightly from 91.5% in June 2024 to 91.6% in July 2024.
Vacancy Rate	6%	<=7%	=	**Vacancy Rate** The vacancy rate has remained static at 6%
Mandatory Training	92.24%	>=90%	↑	**Mandatory Training** Statutory Training decreased slightly from 92.65% in June 2024 to 92.24% in July 2024. Overall, it has remained above 90% target for a sustained period.
Appraisal Rate	91.8%	>=90%	↑	**Appraisal** The appraisal window ran from 1st April to 14th July 2024 – the rate at closure of the window was 91.8% - with all divisions above 90%

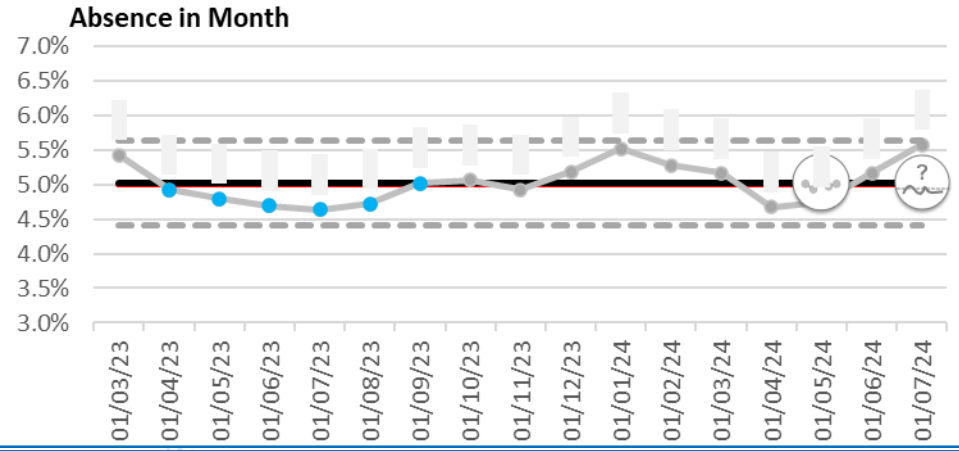
Exceptions/Improvement/Actions

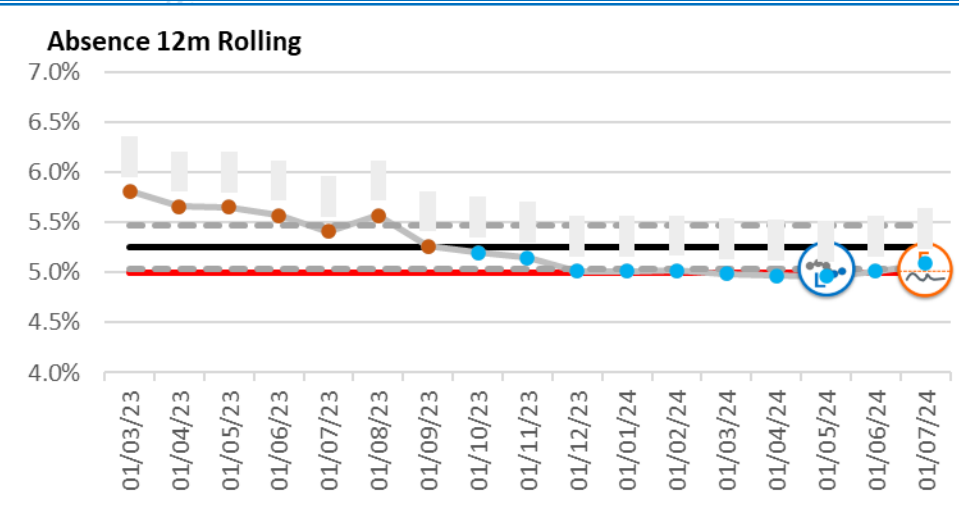
The Dudley Group
NHS Foundation Trust

METRIC	SUMMARY
Sickness	Both the rolling 12-month average and the in-month sickness % for July have increased, this is for the second month in a row. Sickness absence rates are RAG rated as amber being slightly above the tolerance level of 5%. The data shows robust management of long-term absence. The area of focus for 2024/25 has been on reducing FTE days lost due to Stress/Anxiety/Depression and MSK related absences as well as reducing the number of absences recorded as unknown. However, given concerns around short-term sickness absence a renewed taskforce will be established to tackle short-term sickness absence as well as embedding the Wellbeing Journey for a preventative approach. There is also a need to review OHP provision as there are some delays with processing Ill Health retirement applications, which extends the length of time someone is absent, contributing towards the rates.
Turnover	Although Turnover is slightly above the Trust's tolerance level of 8%, normalised turnover (voluntary resignations) remains low. In fact, turnover at 8.27% is still considered a relatively low turnover rate. There is a renewed focus on retention for 2024/25 as part of the Trust's Recruitment and Retention Journey within the People Plan and a Retention Business Partner is due to commence in August 2024 with a focus on key retention strategies such as flexible working, stay interviews and exit data and culture and bullying and harassment.
Bank	Bank usage has been increasing month on month since April 2024, largely due to increased pressures through Acuity, staffing unavailability being above tolerance levels and the opening of surge areas, which are unbudgeted and not part of the establishment. Through grip and control measures implemented the A&C bank usage has started to decline. Further exploration is being undertaken to establish tighter controls across other staff groups where there are unbudgeted requests.
Statutory and Mandatory training	The overall rate for July has maintained above Trust target performance. There has been an issue identified with the training needs for some staff in safeguarding subjects which will see a change to the requirements and increase the number of staff who require Level 3 training. Compliance for Safeguarding Adults Level 3 and Safeguarding Children Level 3 has dropped in month (August). This has had a small impact on the overall compliance rate, but this remains above target. Targeted training is in place to support early completion of training for those staff impacted.
Work Experience and Apprenticeships	ICan Paid Work experience – 2/5 candidates have secured employment post-work experience. Work is underway to support the remaining candidates into work. A further 10 candidates will commence paid work experience in September. This scheme is providing key insight into inclusive recruitment practices and supporting changes to ensure our recruitment is fair, equitable and supports local people into work.

Sickness Absence

The Dudley Group
NHS Foundation Trust





In-Month Sickness Absence

In-month sickness absence for July 2024 is 5.57%, an increase from 5.16% June 2024.

Rolling 12 M Sickness Absence

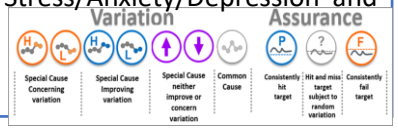
The rolling 12-month absence has increased to 5.09% in July 2024 from 5.01% in June 2024.

Assurance

A lot of work has been undertaken to date including the implementation of the Wellbeing Journey, a complete re-write of the Supporting Attendance Policy and rollout of associated training.
There is good grip and control over long-term sickness absence management, although some cases have been delayed from concluding due to OHP provision.

What next?

Task and finish group to have a renewed focus to look at short-term absence management and prevention, as well as reduction of FTE days lost for Stress/Anxiety/Depression and MSK absences.

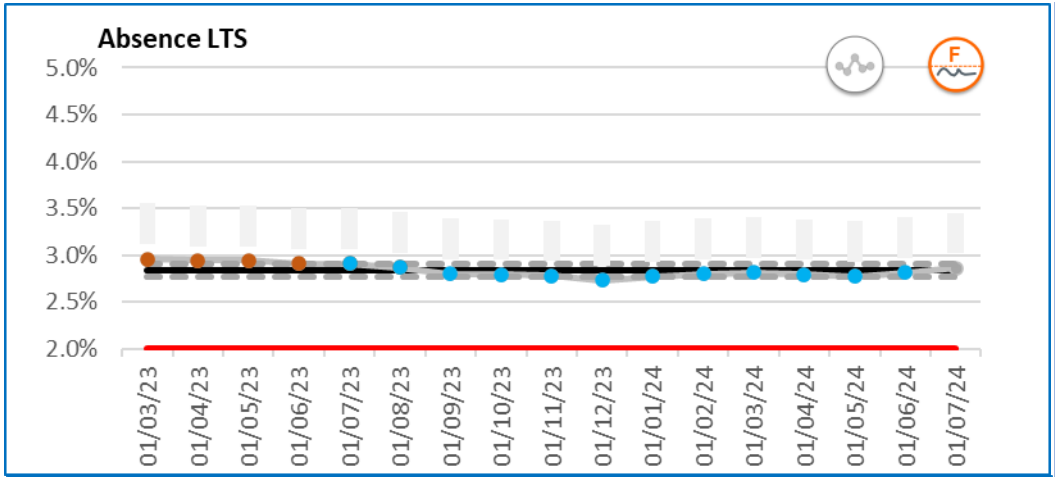


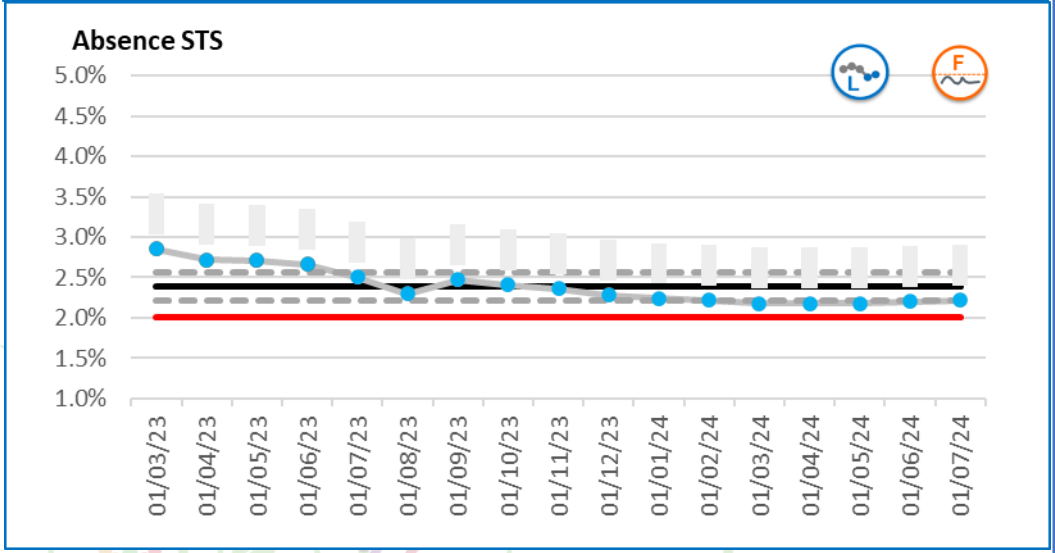
	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24
Absence in Month	4.72%	5.02%	5.06%	4.92%	5.18%	5.52%	5.28%	5.16%	4.67%	4.74%	5.16%	5.57%
Absence 12m Rolling	5.57%	5.26%	5.20%	5.15%	5.01%	5.01%	5.02%	4.99%	4.97%	4.96%	5.01%	5.09%

CARE RESPECT RESPONSIBILITY

Long-Term and Short-Term Absence

The Dudley Group NHS Foundation Trust





In July 2024 long-term absence has marginally increased to 2.86% from 2.81% in June 2024. Short-term sickness has also increased slightly to 2.22% from 2.20%.

In July 2024 short-term absence accounted for 83% of all sickness absence episodes, with long-term absence (28 days +) accounting for 17% of absence episodes. Long-term absence accounted for 54% of all FTE days lost, compared to 46% for short-term absence.

As of 31st July 2024 there were 119 long-term absences open across the Trust.

- 103 cases are between 28 days and 6 months
- 14 cases between 6 months and 12 months
- 2 cases over 12 months in length

Assurance

Long-term sickness is robustly managed through regular reporting and tracking cases centrally through Divisional HR teams, reduction in cases over 12 months over the last year.

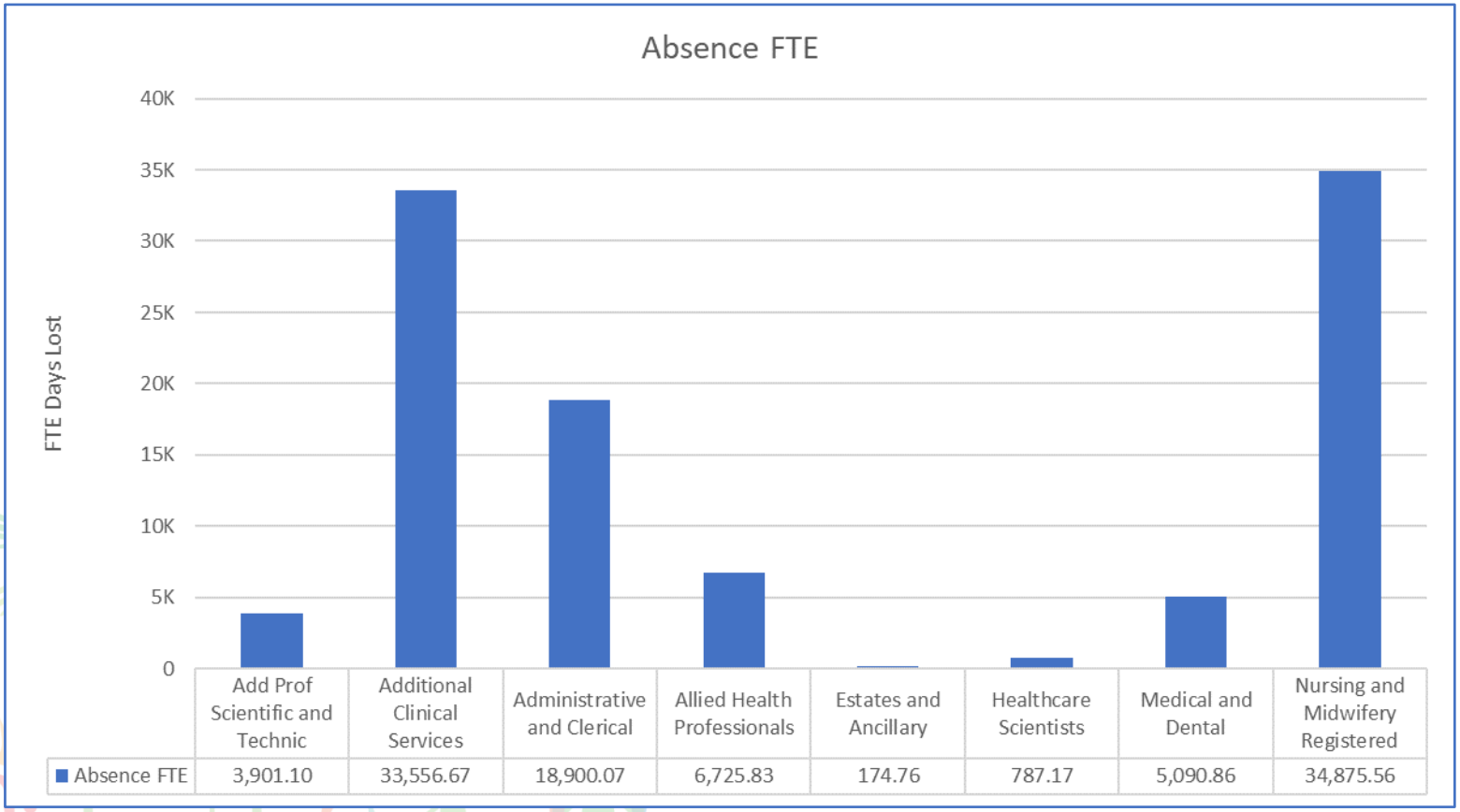
What next

- A task force to be set up to look at how to manage short-term absence more robustly.
- Review of OHP provision is needed to speed up management of LTS cases.

	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24
Absence LTS	2.87%	2.80%	2.79%	2.78%	2.73%	2.77%	2.80%	2.81%	2.79%	2.77%	2.81%	2.86%
Absence STS	2.36%	2.41%	2.41%	2.36%	2.28%	2.24%	2.22%	2.18%	2.18%	2.18%	2.20%	2.22%

Sickness Absence- Staff Groups

The Dudley Group
NHS Foundation Trust



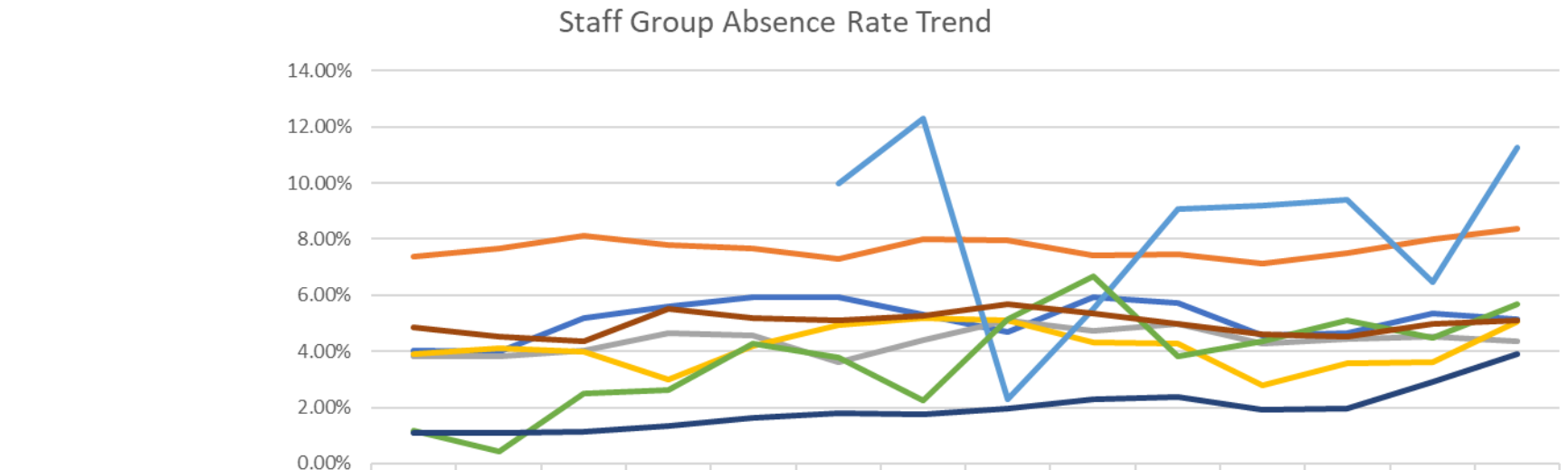
	Add Prof Scientific and Technic	Additional Clinical Services	Administrative and Clerical	Allied Health Professionals	Estates and Ancillary	Healthcare Scientists	Medical and Dental	Nursing and Midwifery Registered
Absence FTE	3,901.10	33,556.67	18,900.07	6,725.83	174.76	787.17	5,090.86	34,875.56

Year to date Nursing and Midwifery and Additional Clinical Services have lost the most FTE days as a result of sickness absence. This is proportionate to the headcount employed within these staff groups.

CARE RESPECT RESPONSIBILITY

Sickness Absence- Staff Groups

The Dudley Group NHS Foundation Trust



	2023/06	2023/07	2023/08	2023/09	2023/10	2023/11	2023/12	2024/01	2024/02	2024/03	2024/04	2024/05	2024/06	2024/07
Add Prof Scientific and Technic	4.03%	3.99%	5.19%	5.59%	5.91%	5.95%	5.33%	4.70%	5.92%	5.71%	4.58%	4.64%	5.37%	5.14%
Additional Clinical Services	7.38%	7.66%	8.13%	7.78%	7.65%	7.29%	8.01%	7.94%	7.41%	7.45%	7.14%	7.50%	7.98%	8.35%
Administrative and Clerical	3.81%	3.82%	4.03%	4.64%	4.55%	3.61%	4.41%	5.12%	4.71%	4.98%	4.29%	4.43%	4.53%	4.34%
Allied Health Professionals	3.90%	4.11%	3.97%	3.00%	4.19%	4.95%	5.17%	5.09%	4.31%	4.26%	2.81%	3.59%	3.63%	5.05%
Estates and Ancillary						10.00%	12.28%	2.28%	5.52%	9.06%	9.19%	9.38%	6.46%	11.28%
Healthcare Scientists	1.17%	0.42%	2.51%	2.62%	4.27%	3.78%	2.24%	5.14%	6.68%	3.82%	4.34%	5.09%	4.47%	5.67%
Medical and Dental	1.09%	1.07%	1.13%	1.35%	1.62%	1.80%	1.74%	1.98%	2.28%	2.38%	1.90%	1.95%	2.92%	3.89%
Nursing and Midwifery Registered	4.85%	4.54%	4.37%	5.50%	5.18%	5.09%	5.26%	5.67%	5.35%	4.98%	4.61%	4.52%	4.99%	5.12%

In July 2024, Estates and Ancillary and Additional Clinical staff groups have the highest percentage of absence and show in increasing trajectory.

Absence for all staff groups has increased, except for Admin and Clerical and Additional Professional Scientific and Technical. Healthcare Scientist, AHP and Medical and Dental appear to have had a sharp rise in month.

CARE RESPECT RESPONSIBILITY

Reasons for Absence

The Dudley Group NHS Foundation Trust

Top 10 Absence Reasons by FTE Days Lost

Absence Reason	Headcount	Abs Occurrences	FTE Days Lost	%
S10 Anxiety/stress/depression/other psychiatric illnesses	726	977	22,503.08	21.6
S13 Cold, Cough, Flu - Influenza	2345	3,141	10,947.43	10.5
S12 Other musculoskeletal problems	562	677	10,250.35	9.9
S25 Gastrointestinal problems	2004	2,758	10,078.52	9.7
S30 Pregnancy related disorders	272	810	5,665.73	5.4
S99 Unknown causes / Not specified	603	724	5,223.97	5.0
S28 Injury, fracture	210	228	5,138.94	4.9
S26 Genitourinary & gynaecological disorders	346	442	4,717.63	4.5
S98 Other known causes - not elsewhere classified	289	424	4,148.80	4.0
S11 Back Problems	297	350	3,522.56	3.4

Top 10 Absence Reasons by Number Of Occurences

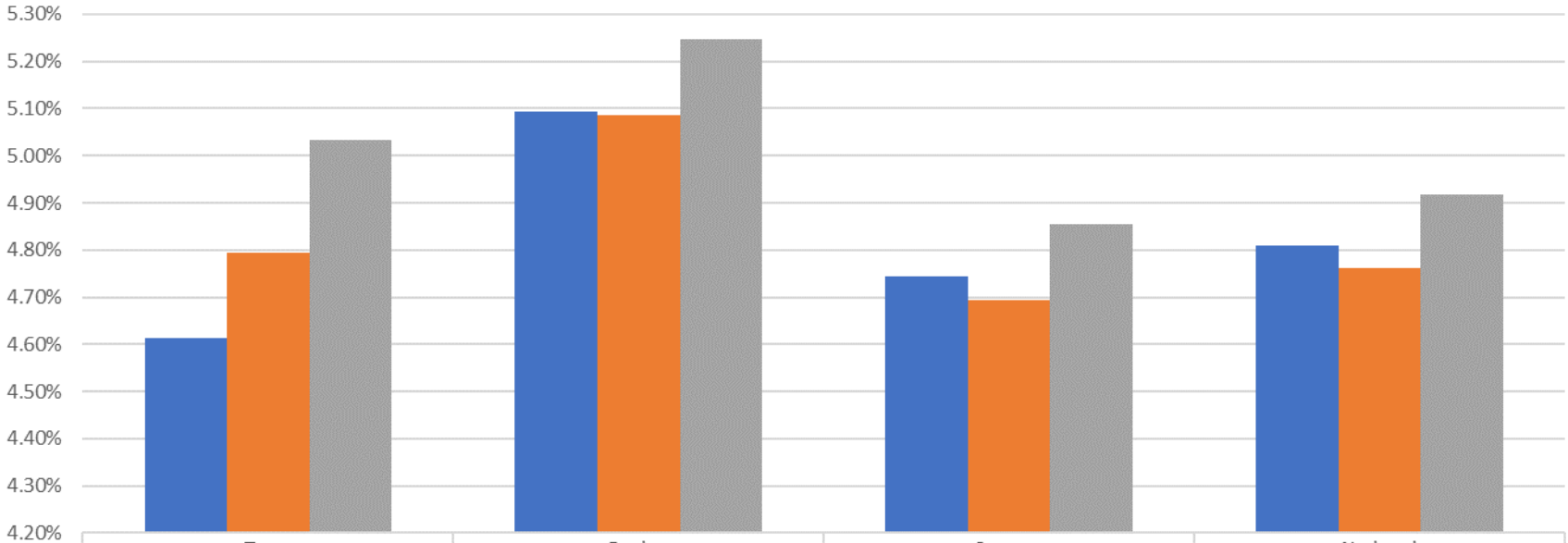
Absence Reason	Headcount	Abs Occurrences	FTE Days Lost	%
S13 Cold, Cough, Flu - Influenza	2345	3,141	10,947.43	10.5
S25 Gastrointestinal problems	2004	2,758	10,078.52	9.7
S16 Headache / migraine	780	1,106	2,885.11	2.8
S10 Anxiety/stress/depression/other psychiatric illnesses	726	977	22,503.08	21.6
S30 Pregnancy related disorders	272	810	5,665.73	5.4
S99 Unknown causes / Not specified	603	724	5,223.97	5.0
S12 Other musculoskeletal problems	562	677	10,250.35	9.9
S27 Infectious diseases	624	651	3,338.53	3.2
S21 Ear, nose, throat (ENT)	404	477	2,453.73	2.4
S26 Genitourinary & gynaecological disorders	346	442	4,717.63	4.5

- Anxiety/Stress/Depression/Other Psychiatric illness continues to be the top reason for absence that causes the most number of FTE days lost and Cough Cold Flu is the second highest reason.
- Cough, Cold, Flu is the top reason for absence that has the highest number of occurrences followed by gastrointestinal problems and Headache and Migraine.
- The focus for 24/25 will be reducing the number of FTE days lost due to Stress and MSK related absences and reduction (with a view to eradicate) unknown causes being recorded.

CARE RESPECT RESPONSIBILITY

Absence Benchmarking

The Dudley Group NHS Foundation Trust



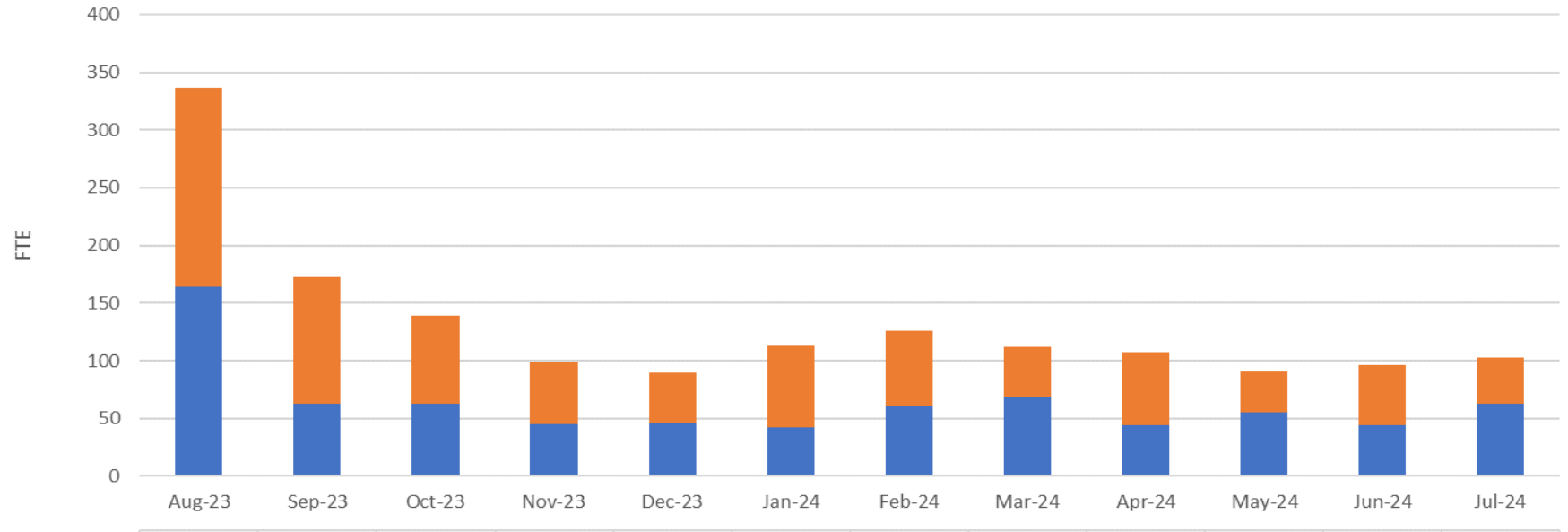
	Trust	Region	Country	National
MO1	4.61%	5.09%	4.74%	4.81%
MO2	4.79%	5.09%	4.69%	4.76%
MO3	5.03%	5.25%	4.85%	4.92%

- National and Regional benchmarking data is only available until end of June 2024.
- Due to local differences in timeframes and methods used for recording sickness absences, national and regional comparative data is subject to change. DGFT absence includes COVID related absences and is refreshed each month twelve months in arrears.
- In June 2024 (M03), the Trust's sickness absence rate was lower than the Region but higher than the Country (England) and National reported figures. The charts also show that month 3 sickness absence regionally and nationally has increased.

CARE RESPECT RESPONSIBILITY

Starters and Leavers

The Dudley Group NHS Foundation Trust



	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24
Starters FTE	172.18	109.84	76.71	54.58	43.14	70.67	65.39	43.48	62.83	35.54	52.59	40.54
Leavers FTE	164.49	62.96	62.53	44.71	46.14	42.08	60.87	68.38	44.5	55.34	43.66	62.61

Starters vs Leavers

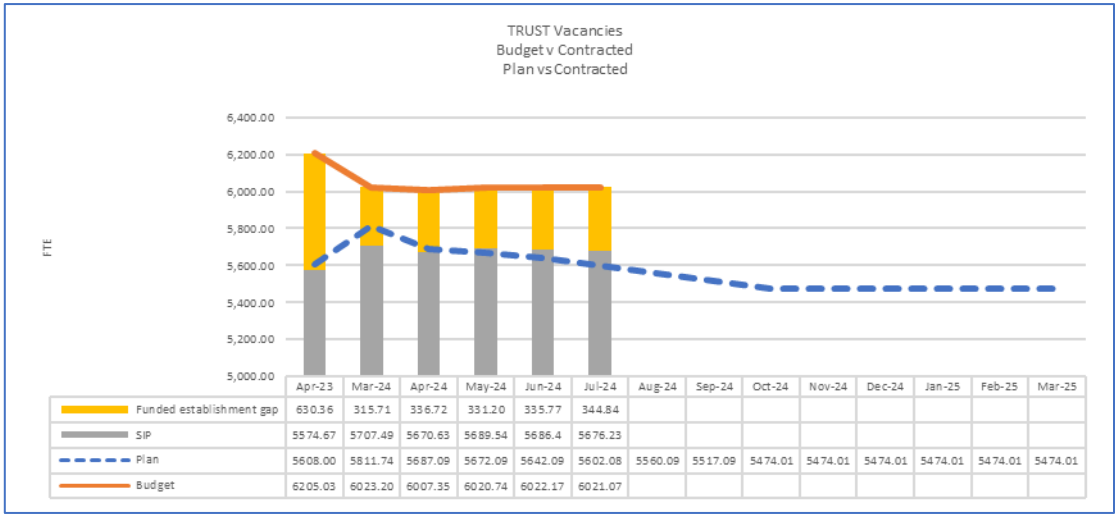
- This month we have seen more leavers than starters in July 2024.

Assurance

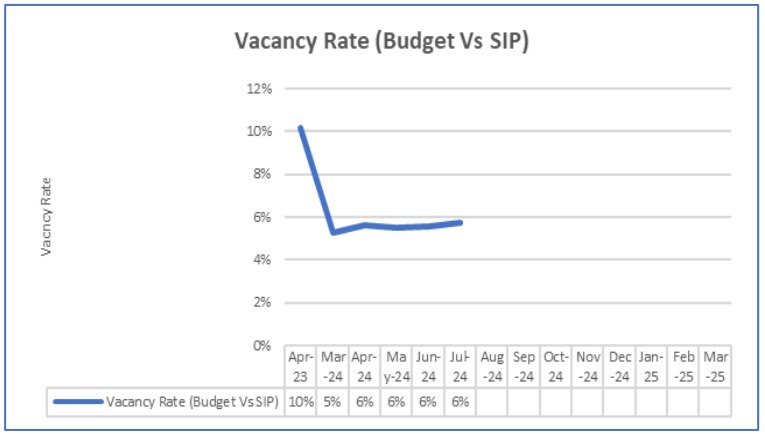
- Trust's recruitment and retention journey is now ratified and will be socialised through a new sub-group of People Committee. However, recruitment to roles continues to be subject to grip and control / Vacancy Control measures, which means a greater emphasis on retention over the coming months.

Recruitment/Vacancies/Turnover - TRUST

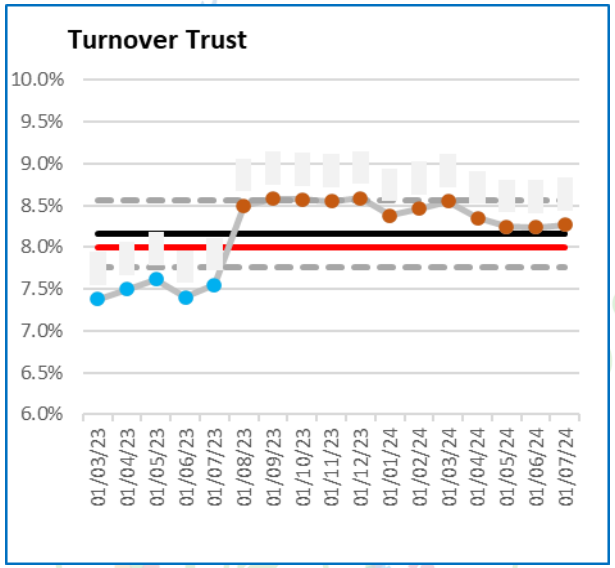
The Dudley Group NHS Foundation Trust

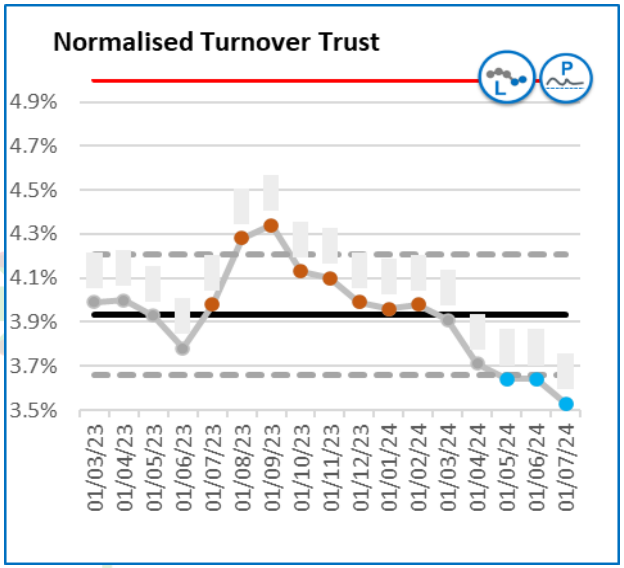


	Apr-23	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25
Funded establishment gap	630.36	315.71	336.72	331.20	335.77	344.84								
SIP	5574.67	5707.49	5670.63	5689.54	5686.4	5676.23								
Plan	5608.00	5811.74	5687.09	5672.09	5642.09	5602.08	5560.09	5517.09	5474.01	5474.01	5474.01	5474.01	5474.01	5474.01
Budget	6205.03	6023.20	6007.35	6020.74	6022.17	6021.07								



	Apr-23	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25
Vacancy Rate (Budget Vs SIP)	10%	5%	6%	6%	6%	6%								





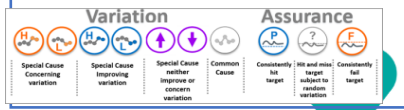
Contracted WTE staff has decreased from 5686.4 in June 2024 to 5676.25 in July 2024.

For substantive staff this is 74.15 WTE above the workforce plan (more staff than we said we would have).

Total vacancies stand at 344.84 WTE in July 2024. This equates to a vacancy rate of 6%.

Overall staff turnover (rolling twelve months average) is at 8.27% with normalised turnover at 3.53% in July 2024.

	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24
Trust Turnover	8.50%	8.58%	8.57%	8.55%	8.59%	8.38%	8.46%	8.55%	8.35%	8.25%	8.24%	8.27%
Trust Normalised Turnover	4.28%	4.34%	4.13%	4.10%	3.99%	3.96%	3.98%	3.91%	3.71%	3.64%	3.64%	3.53%



RESPECT RESPONSIBILITY

Top 5 Departments - High Vacancies

The Dudley Group
NHS Foundation Trust

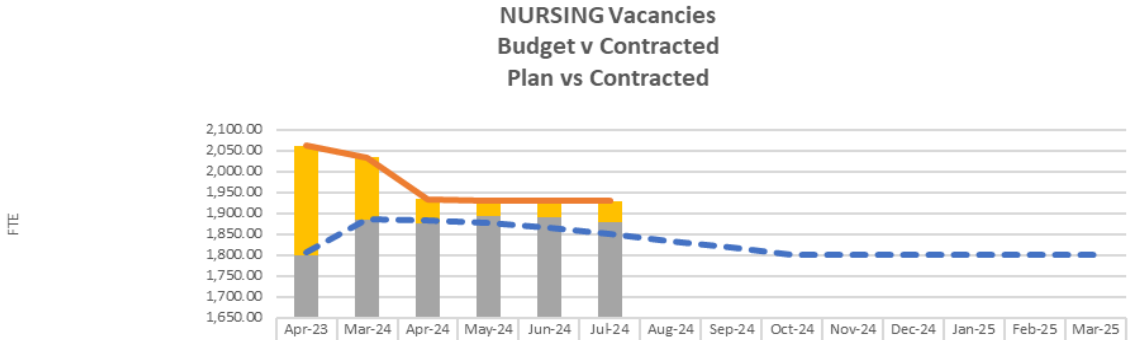
Cost Centre Description	Budget WTE	Contracted WTE	Vacancy WTE	Vacancy %
Pharmacy Department	187.44	159.33	28.11	15%
Emergency Department Nu	139.31	119.04	20.27	15%
Phlebotomists	70.55	54.48	16.07	23%
Therapy Department	144.98	129.29	15.69	11%
Breast Screening Mobile	50.8	37.11	13.69	27%

Pharmacy has the highest WTE vacancies in July 2024 with 28.11 WTE which equates to a 15% vacancy rate.

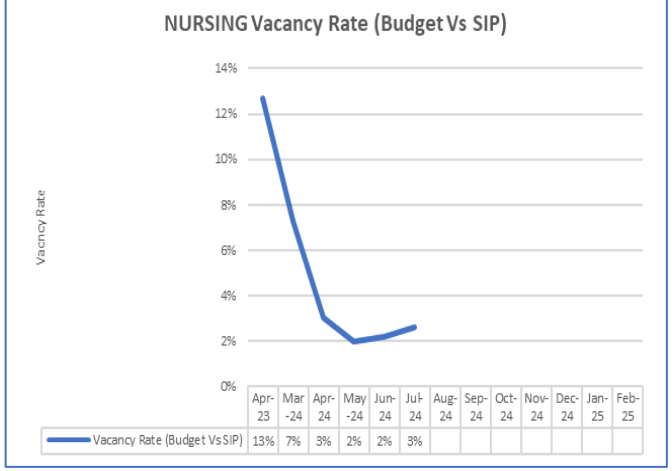
CARE RESPECT RESPONSIBILITY

Recruitment/Vacancies/Turnover - Registered Nursing & Midwifery

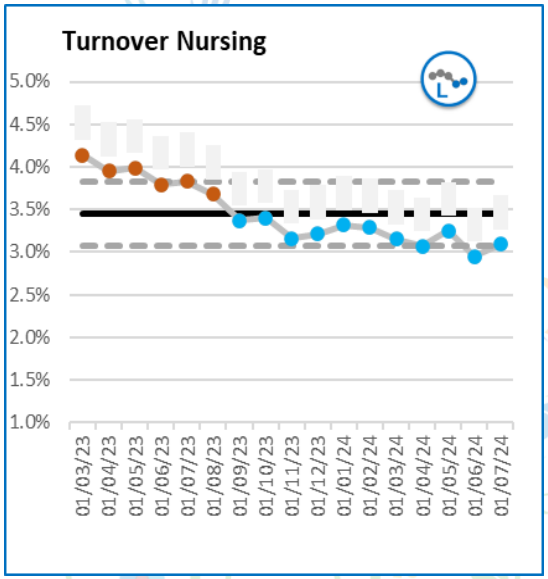
The Dudley Group NHS Foundation Trust

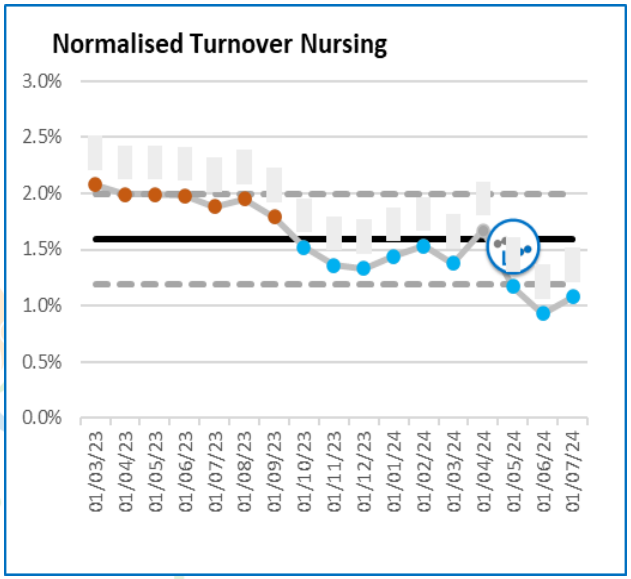


	Apr-23	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25
Funded establishment gap	261.76	147.84	59.13	38.43	42.08	50.6								
SIP	1799.22	1885.26	1874.52	1892.37	1888.65	1878.85								
Plan	1805.00	1885.00	1882.66	1877.10	1865.30	1849.87	1833.89	1817.15	1800.57	1800.57	1800.57	1800.57	1800.57	1800.56
Budget	2060.98	2033.10	1933.65	1930.80	1930.73	1929.45								



	Apr-23	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25
Vacancy Rate (Budget Vs SIP)	13%	7%	3%	2%	2%	3%							





Contracted WTE for nursing and midwifery staff has decreased from 1888.65 in June 2024 to 1878.85 WTE in July 2024.

This is 28.98 WTE above the workforce plan (more staff than we said we would have).

The total nursing and midwifery vacancies reported stands at 50.6 WTE, which equates to a vacancy rate of 3%.

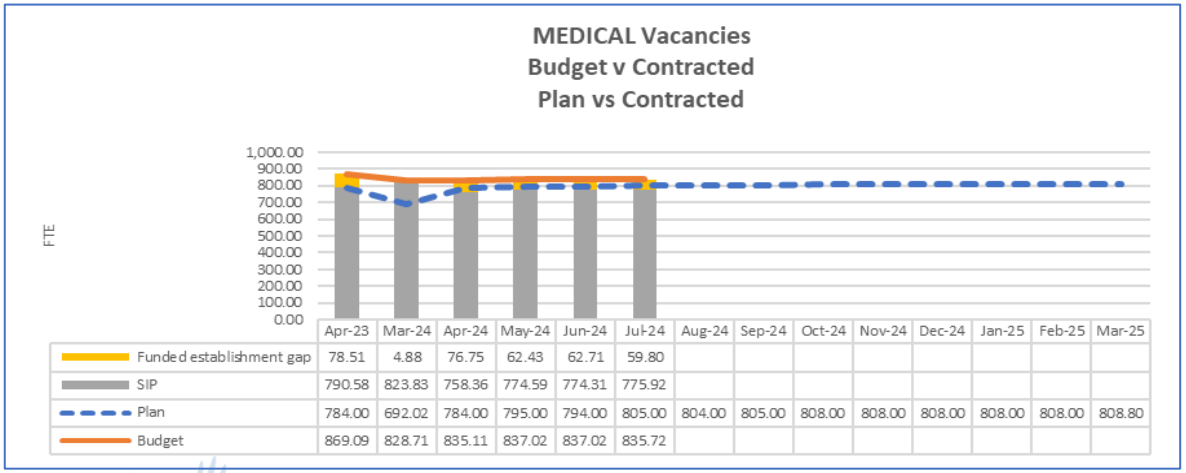
Staff turnover for nursing (rolling 12 months average) is at 3.09%, with normalised turnover at 1.08% in July 2024.

	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24
Nursing Turnover	3.68%	3.37%	3.40%	3.16%	3.21%	3.32%	3.29%	3.15%	3.07%	3.25%	2.95%	3.09%
Nursing Normalised Turnover	1.95%	1.79%	1.52%	1.36%	1.33%	1.44%	1.53%	1.38%	1.67%	1.17%	0.93%	1.08%

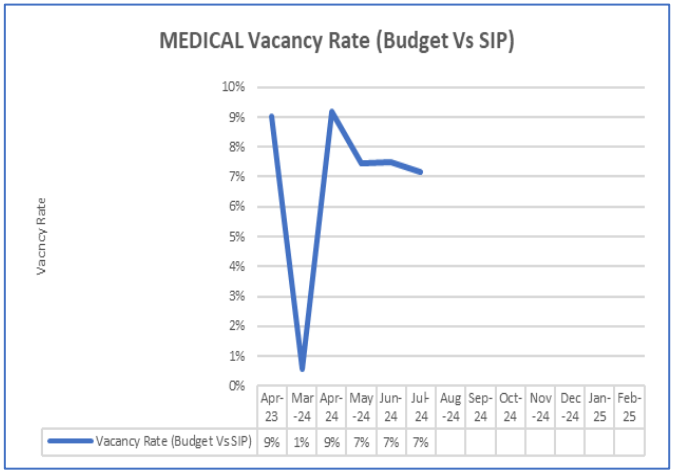
CARE RESPECT RESPONSIBILITY

Recruitment/Vacancies/Turnover - Medical & Dental

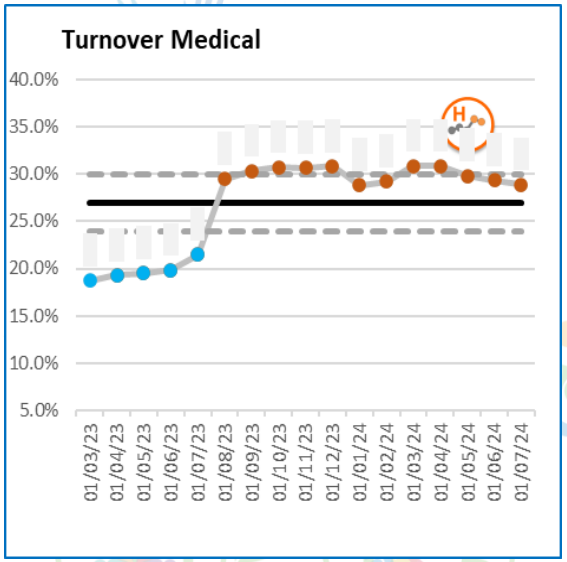
The Dudley Group NHS Foundation Trust

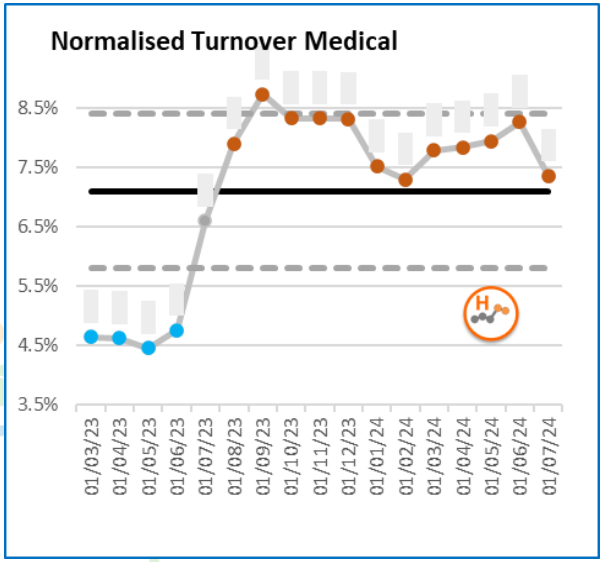


	Apr-23	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25
Funded establishment gap	78.51	4.88	76.75	62.43	62.71	59.80								
SIP	790.58	823.83	758.36	774.59	774.31	775.92								
Plan	784.00	692.02	784.00	795.00	794.00	805.00	804.00	805.00	808.00	808.00	808.00	808.00	808.00	808.80
Budget	869.09	828.71	835.11	837.02	837.02	835.72								



	Apr-23	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25
Vacancy Rate (Budget Vs SIP)	9%	1%	9%	7%	7%	7%							



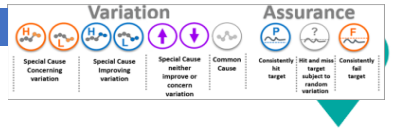


Contracted WTE for medical and dental staff has increased from 774.31 in June 2024 to 775.92 WTE in July 2024. This is 29.08 WTE below plan (less staff than we said we would have).

The total medical and dental vacancies stands at 62.71 WTE. The vacancy rate is 7%.

Staff turnover for medical and dental (rolling 12 months average) is 28.86% with normalised turnover at 7.35%. It should be noted that Deanery rotations are included in overall turnover.

	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24
M&D Turnover	29.45%	30.84%	30.72%	30.63%	30.82%	28.79%	29.19%	30.86%	30.86%	29.83%	29.34%	28.86%
M&D Normalised Turnover	7.89%	8.73%	8.32%	8.32%	8.31%	7.51%	7.29%	7.78%	7.83%	7.94%	8.26%	7.35%

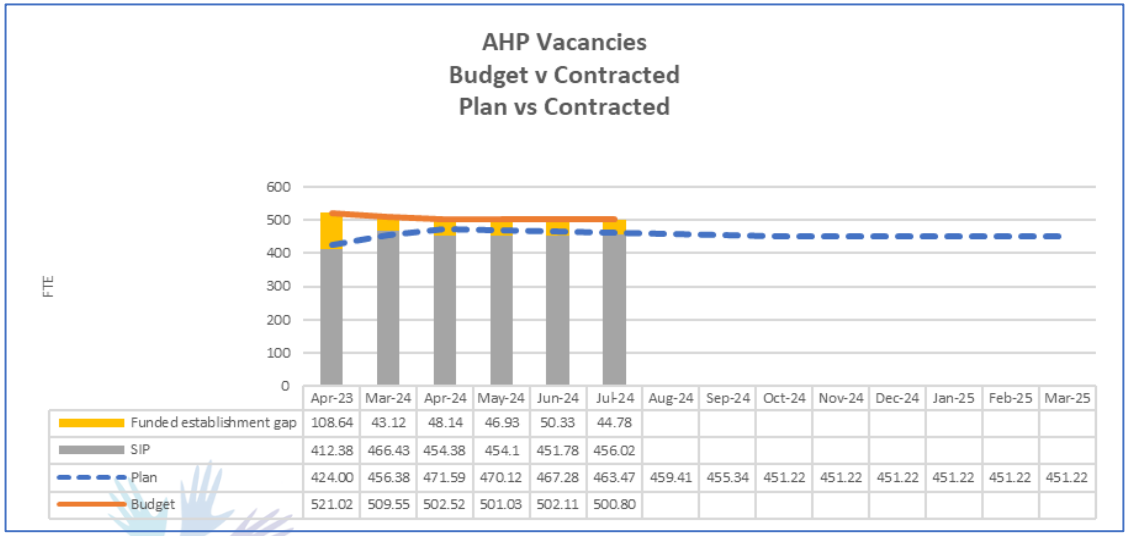


RESPECT

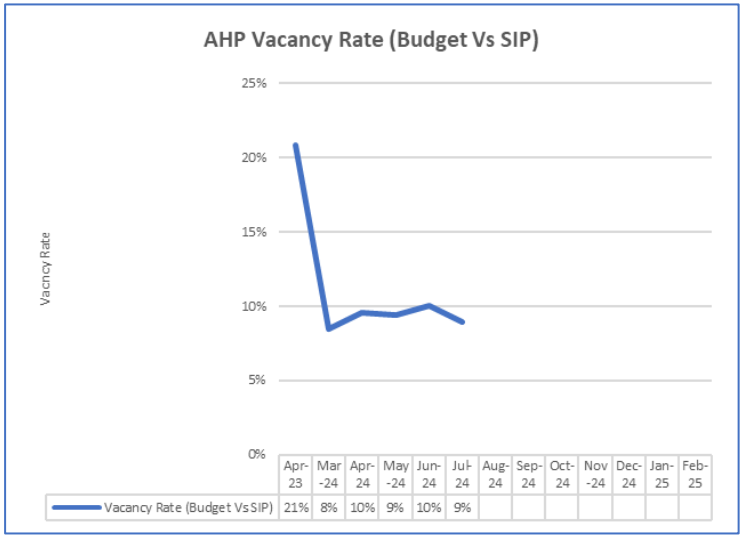
RESPONSIBILITY

Recruitment/Vacancies/Turnover - Allied Health Professional

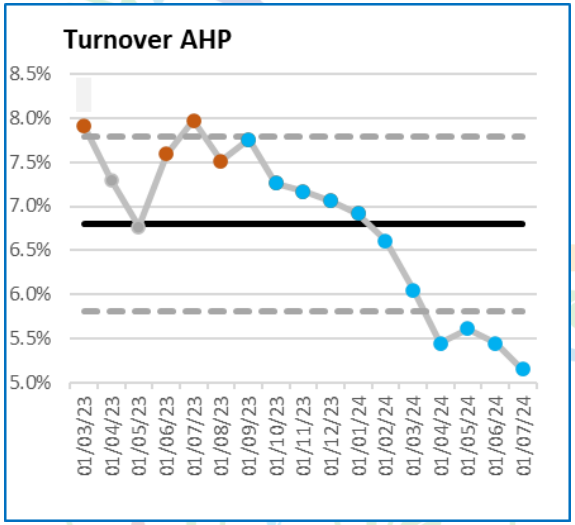
The Dudley Group NHS Foundation Trust

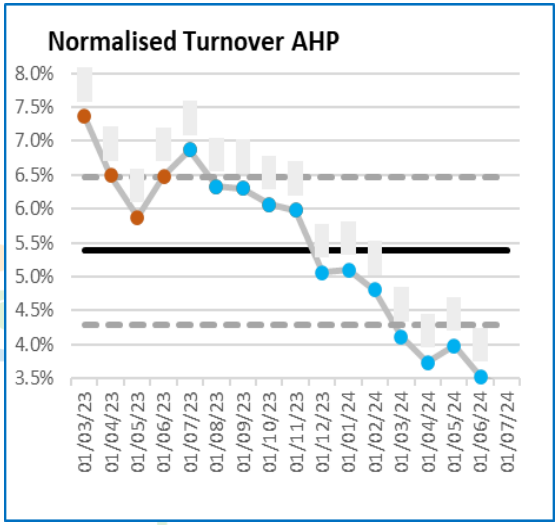


	Apr-23	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25
Funded establishment gap	108.64	43.12	48.14	46.93	50.33	44.78								
SIP	412.38	466.43	454.38	454.1	451.78	456.02								
Plan	424.00	456.38	471.59	470.12	467.28	463.47	459.41	455.34	451.22	451.22	451.22	451.22	451.22	451.22
Budget	521.02	509.55	502.52	501.03	502.11	500.80								



	Apr-23	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25
Vacancy Rate (Budget Vs SIP)	21%	8%	10%	9%	10%	9%							





Contracted WTE for AHP's has increased from 451.78 WTE in June 2024 to 456.02 WTE in July 2024.

This is 7.45 WTE below the workforce plan (less staff than we said we would have).

The total AHP vacancies in June 2024 are 44.78 WTE this is a vacancy rate of 9%.

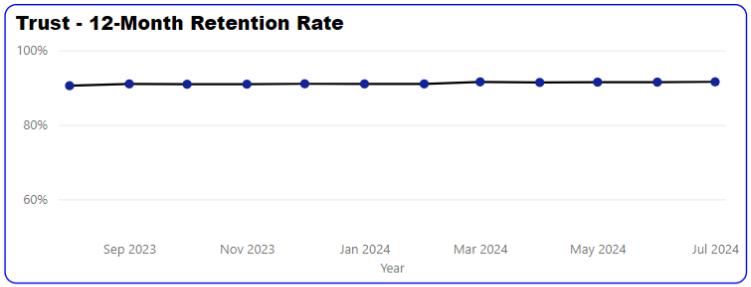
Staff turnover for AHP's (rolling 12 months average) is 5.15%, the normalised turnover is 3.35%.

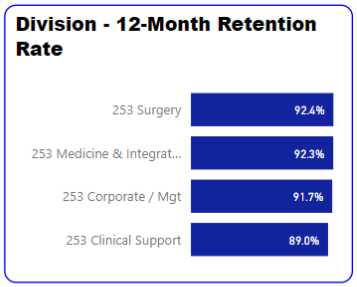
	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24
AHP Turnover	7.51%	7.76%	7.36%	7.17%	7.06%	6.92%	6.61%	6.05%	5.45%	5.61%	5.45%	5.15%
AHP Normalised Turnover	6.23%	6.30%	6.07%	5.98%	5.06%	5.10%	4.81%	4.12%	3.74%	3.98%	3.53%	3.35%

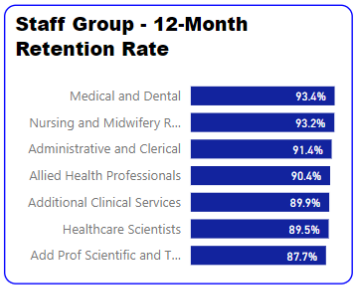
CARE RESPECT RESPONSIBILITY

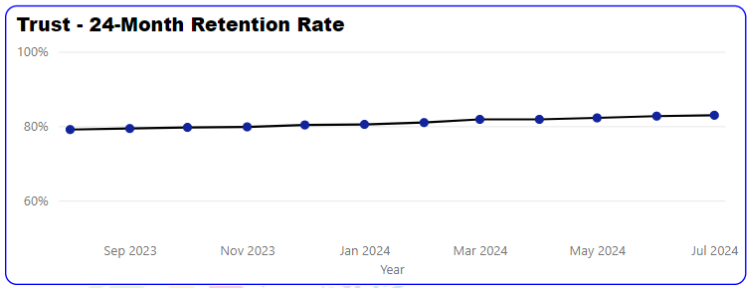
Retention

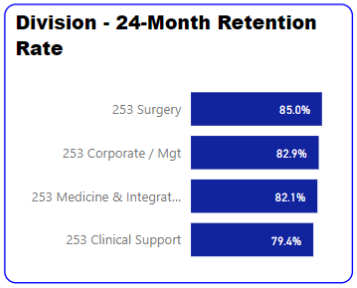
The Dudley Group
NHS Foundation Trust

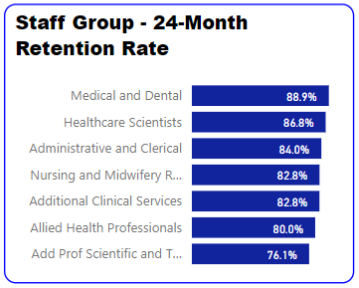












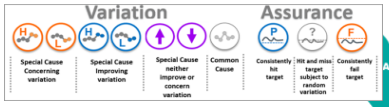
July 2024

12-Month Trust 91.6%

24-Month Trust 82.9%

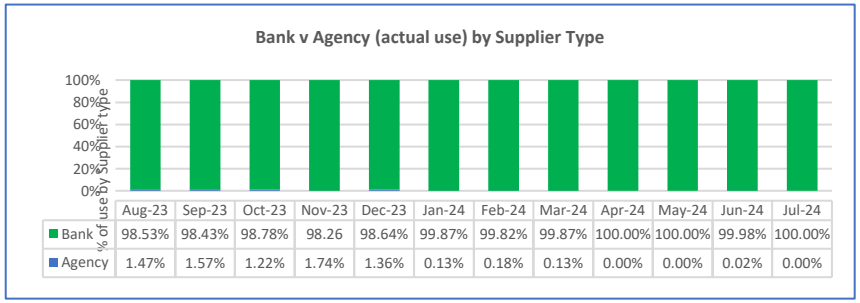
The retention rate is relatively stable and has been since September 2023. The retention rate increased slightly to 91.6% in July 2024 from 91.5% in June 2024.

The division with the lowest 24-month retention rate is CCCS at 79.4% and both Additional Professional, Scientific and Technical staff and Allied Health Professionals are two staff groups that lower retention rates.

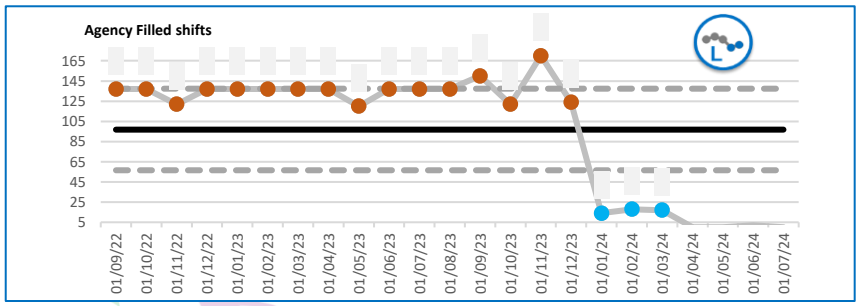


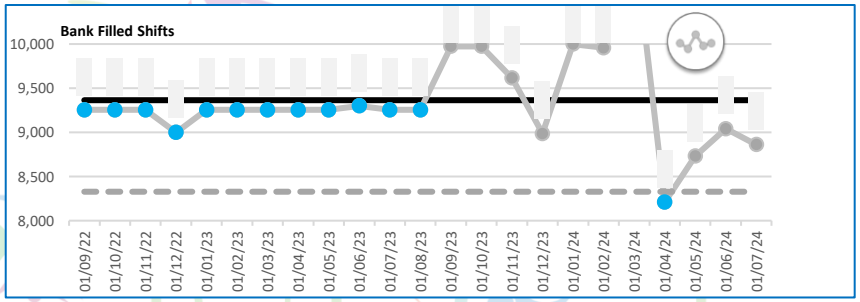
Bank and Agency Usage

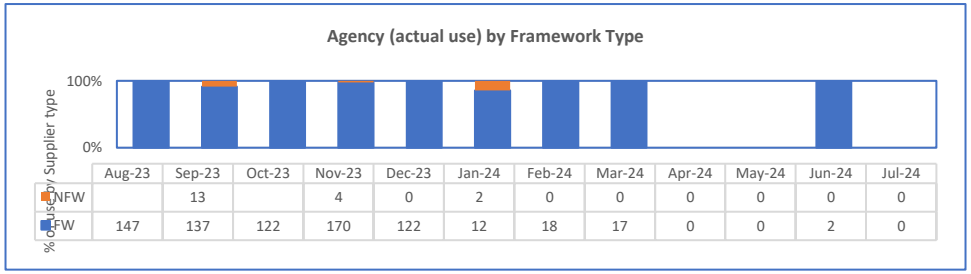
The Dudley Group NHS Foundation Trust



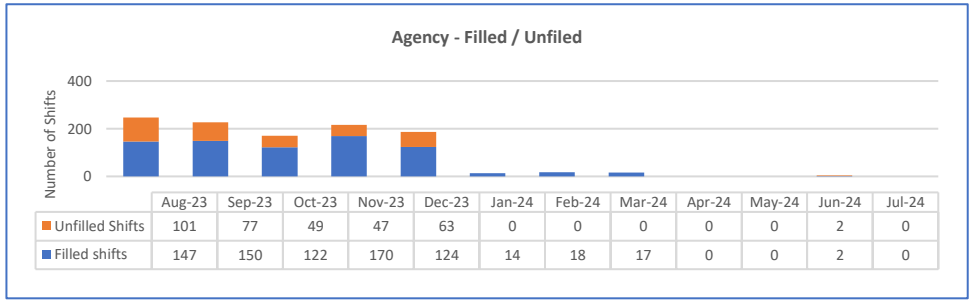
	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24
Bank	98.53%	98.43%	98.78%	98.26	98.64%	99.87%	99.82%	99.87%	100.00%	100.00%	99.98%	100.00%
Agency	1.47%	1.57%	1.22%	1.74%	1.36%	0.13%	0.18%	0.13%	0.00%	0.00%	0.02%	0.00%



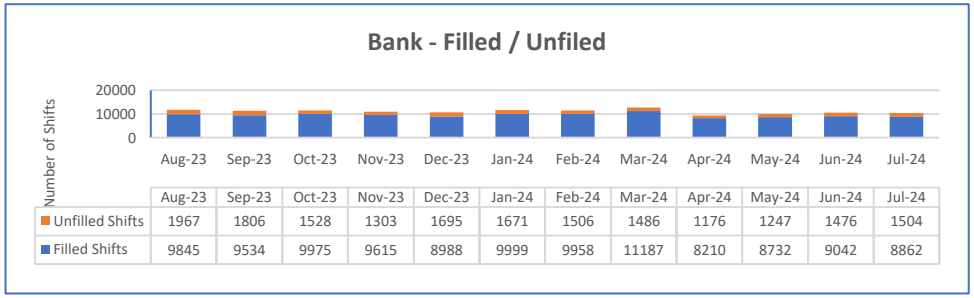




	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24
NFW		13		4	0	2	0	0	0	0	0	0
FW	147	137	122	170	122	12	18	17	0	0	2	0



	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24
Unfilled Shifts	101	77	49	47	63	0	0	0	0	0	2	0
Filled shifts	147	150	122	170	124	14	18	17	0	0	2	0



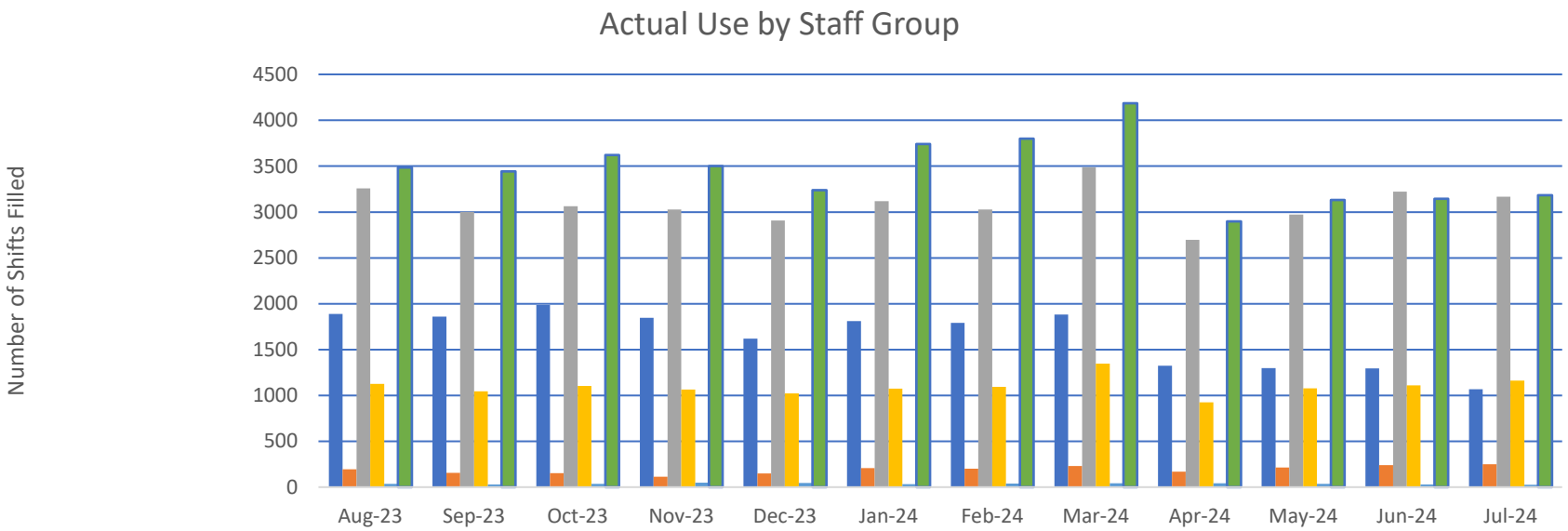
	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24
Unfilled Shifts	1967	1806	1528	1303	1695	1671	1506	1486	1176	1247	1476	1504
Filled Shifts	9845	9534	9975	9615	8988	9999	9958	11187	8210	8732	9042	8862

Bank fill rates for July are 85.4%. A slight reduction from June 2024 where the fill rate was 85.9%
The number of shifts requested had been increasing from April to June. In July there was a slight reduction from 10518 shifts requested in June 2024 to 10366 shifts in July 2024
Higher than expected bank requests have been as a result of opening of ad-hoc discharge units where no substantive staff are based along with an increase in unavailability.

CARE RESPECT RESPONSIBILITY

Bank Usage by Staff Group

The Dudley Group
NHS Foundation Trust



	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24
A&C	1888	1860	1985	1848	1619	1812	1793	1881	1324	1299	1296	1069
Add Prof Scientific and Technic	195	155	152	115	150	208	201	230	168	215	242	249
Additional Clinical Services	3259	3001	3065	3028	2907	3120	3028	3490	2696	2972	3221	3168
AHP	1125	1044	1103	1065	1024	1076	1094	1348	926	1078	1111	1161
Healthcare Scientists	35	30	35	48	47	32	38	44	43	36	30	28
Nursing & Midwifery Registered	3484	3442	3623	3500	3239	3743	3799	4186	2898	3131	3144	3184

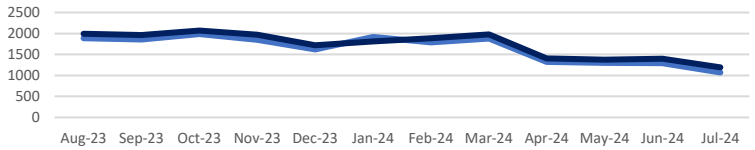
- Admin and Clerical bank usage has been steadily decreasing, since the introduction of the admin and clerical bank additional controls
- Admin and Clerical and Healthcare Scientists are the only staff group with a marked reduction in Bank since April 2024
- Additional Clinical and Nursing and Midwifery have had the largest increases in bank usage since April 2024.

CARE RESPECT RESPONSIBILITY

Bank Fill Rates

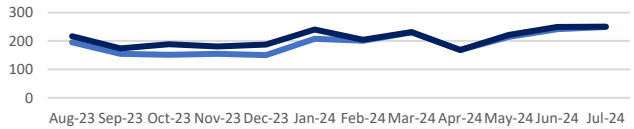
The Dudley Group
NHS Foundation Trust

Bank A&C Filled / Requested



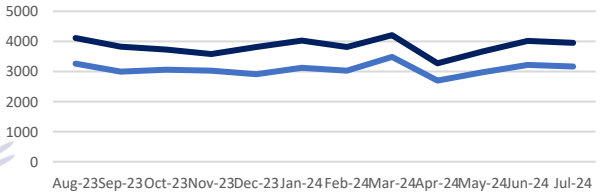
	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24
A&C Filled	1888	1860	1985	1852	1619	1919	1793	1881	1324	1299	1296	1069
Total Request	1994	1965	2074	1971	1717	1812	1885	1977	1406	1377	1401	1194

Bank Add Prof Scientific and Technic Filled / Requested



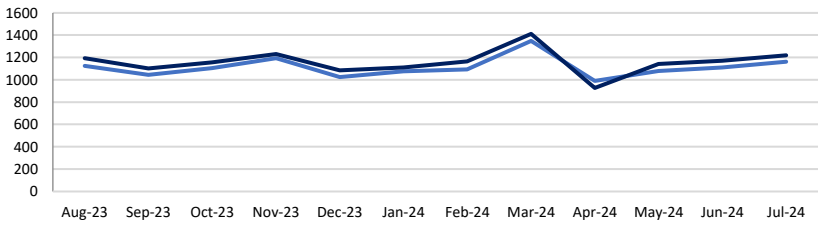
	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24
Add Prof Scientific and Technic Filled	195	155	152	155	150	208	201	230	168	215	242	249
Total Request	217	174	189	181	187	241	205	232	168	221	249	251

Additional Clinical Services Filled / Requested



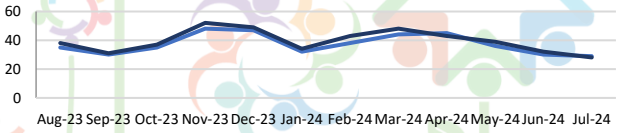
	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24
Additional Clinical Services Filled	3259	3001	3065	3028	2907	3120	3028	3490	2696	2972	3221	3168
Total Request	4116	3831	3733	3581	3812	4027	3819	4211	3278	3667	4019	3959

AHP - Filled / Requested



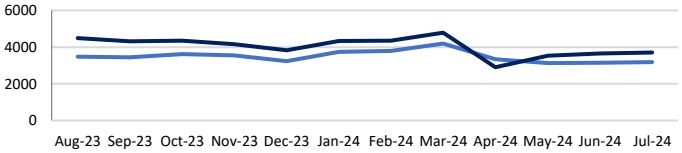
	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24
AHP Filled	1125	1044	1103	1193	1024	1076	1094	1348	990	1078	1111	1161
Total Request	1193	1100	1155	1231	1083	1109	1165	1410	926	1140	1170	1218

Registered Filled / Requested



	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24
Healthcare Scientists Filled	35	30	35	48	47	32	38	44	45	36	30	29
Total Request	38	31	37	52	49	34	43	48	43	39	32	28

Registered Filled / Requested



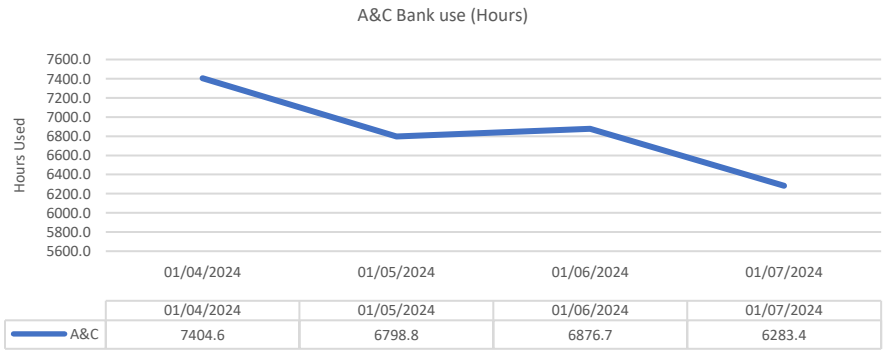
	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24
Nursing & Midwifery Registered Filled	3484	3442	3623	3550	3239	3743	3799	4186	3339	3131	3144	3184
Total Request	4493	4311	4349	4163	3832	4330	4342	4787	2898	3534	3649	3712

CARE RESPECT RESPONSIBILITY

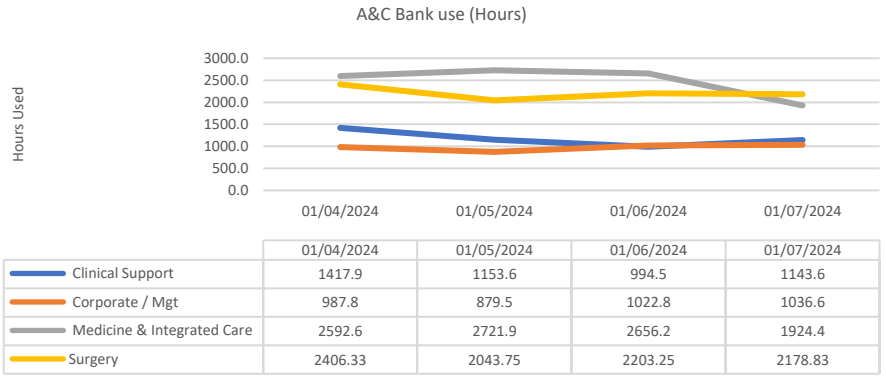
A&C Bank Use

Hours Used

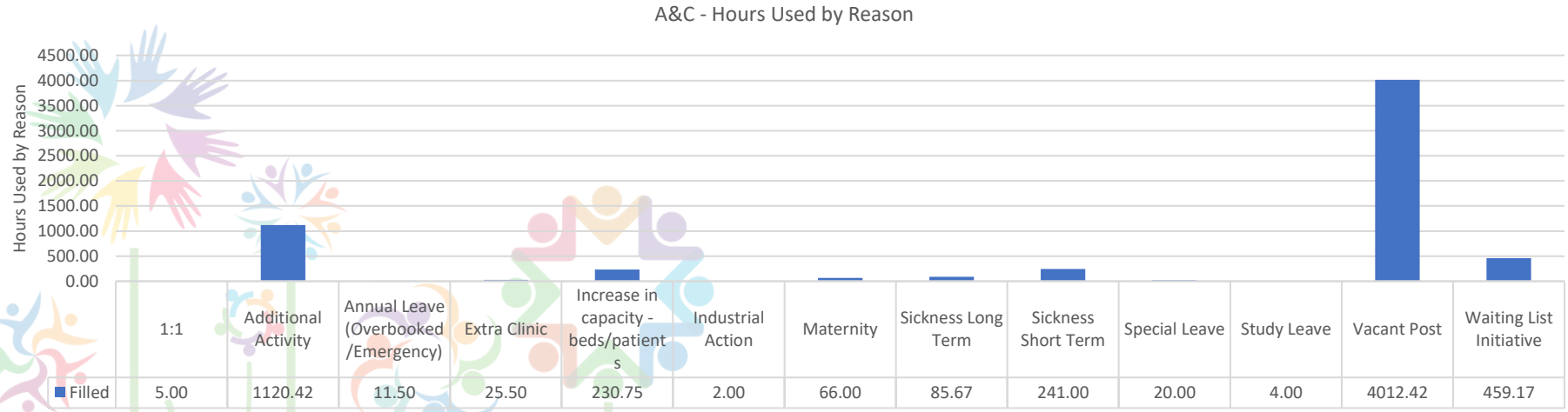
The Dudley Group
NHS Foundation Trust



	01/04/2024	01/05/2024	01/06/2024	01/07/2024
A&C	7404.6	6798.8	6876.7	6283.4



	01/04/2024	01/05/2024	01/06/2024	01/07/2024
Clinical Support	1417.9	1153.6	994.5	1143.6
Corporate / Mgt	987.8	879.5	1022.8	1036.6
Medicine & Integrated Care	2592.6	2721.9	2656.2	1924.4
Surgery	2406.33	2043.75	2203.25	2178.83

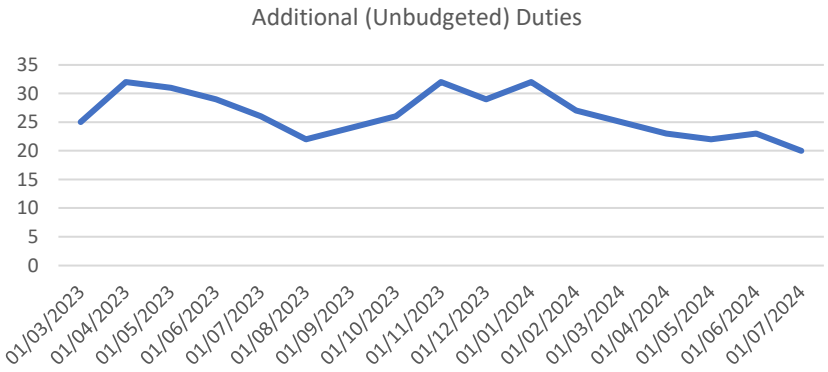


	1:1	Additional Activity	Annual Leave (Overbooked /Emergency)	Extra Clinic	Increase in capacity - beds/patients	Industrial Action	Maternity	Sickness Long Term	Sickness Short Term	Special Leave	Study Leave	Vacant Post	Waiting List Initiative
Filled	5.00	1120.42	11.50	25.50	230.75	2.00	66.00	85.67	241.00	20.00	4.00	4012.42	459.17

CARE RESPECT RESPONSIBILITY

Rostering KPI

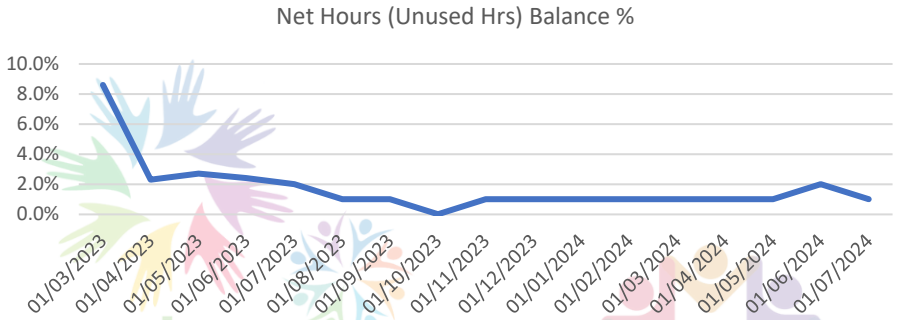
The Dudley Group
NHS Foundation Trust



Average number of additional assigned unbudgeted shifts per department. These are in addition to the agreed budgeted establishment.

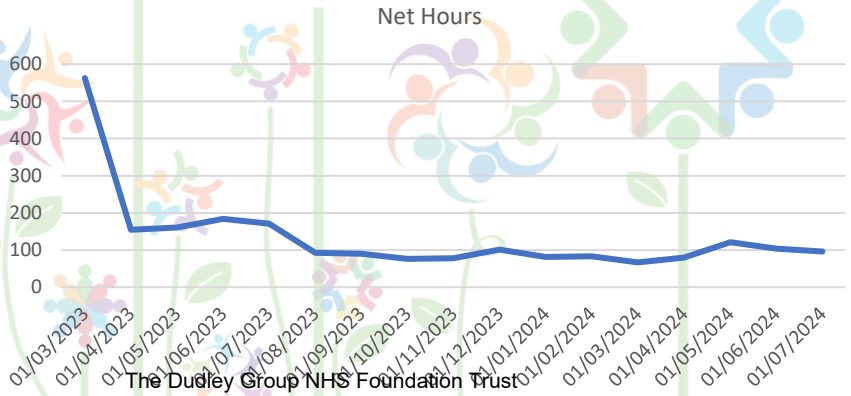
Registered 48%, Unregistered 52%

Top departments are Discharge Lounge, Neonatal & B2 Trauma & C3.
Top reasons are Increase in Capacity & 1:1



Percentage of unused hours at the end of the roster period.

Target – Below 2% - currently compliant

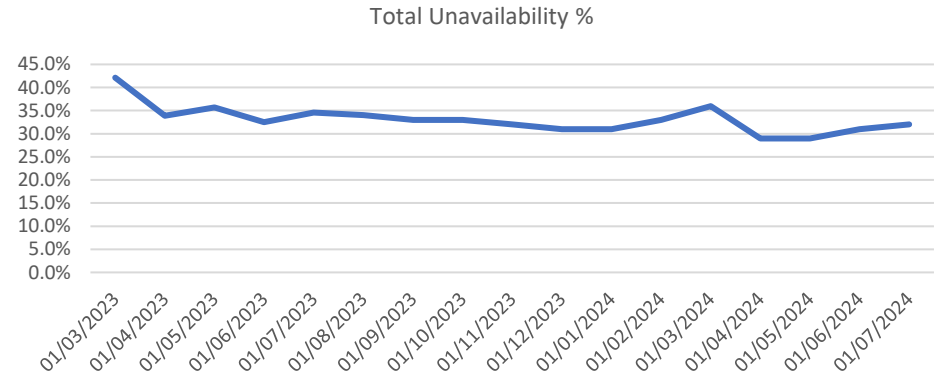


Average number of Divisional unused hours at the end of the roster period.

CARE RESPECT RESPONSIBILITY

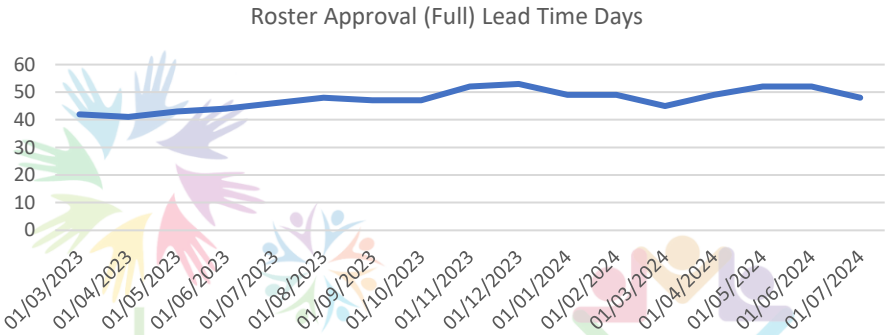
Rostering KPI

The Dudley Group
NHS Foundation Trust



The percentage of staff hours marked as unavailable. Made up of Annual Leave 16%, Sickness 7%, Parenting 5% , Other Leave 1%, Study Day 1% & Working Day 2%.

Headroom percentage built into budgets is 22%.



The average amount of days the 4-week roster has been visible for staff to view before the first day of the roster period.

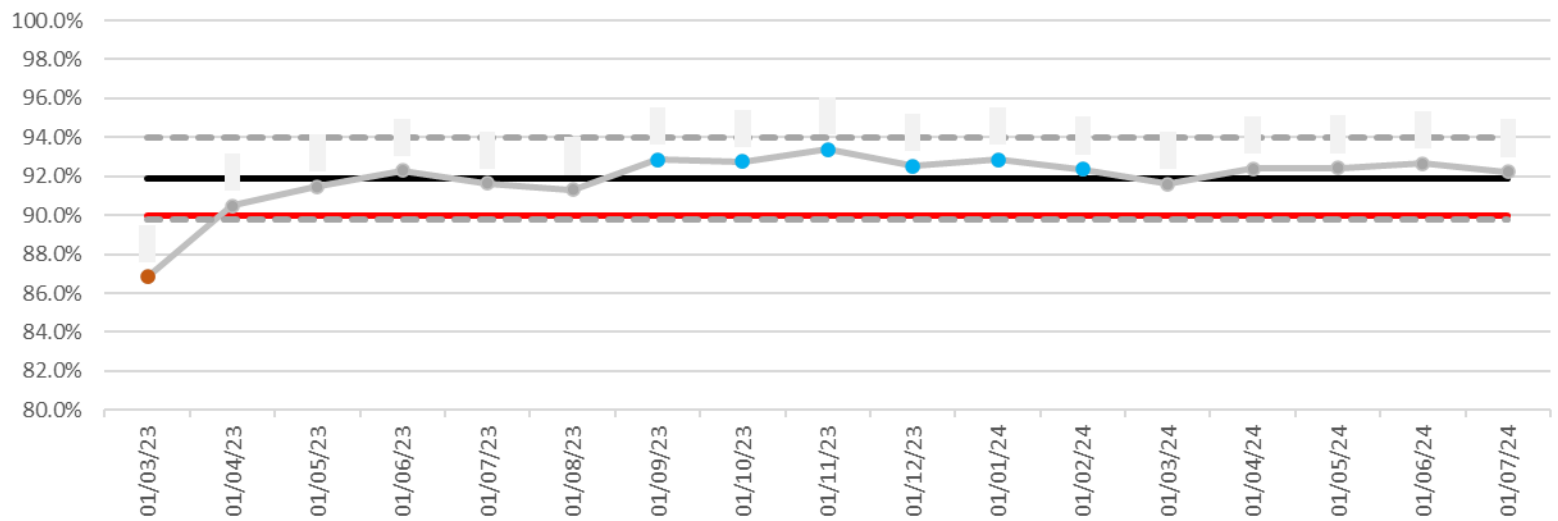
Trust target is 55 days. NHSE minimum is 42 days.

This is trending in the right direction. Confirm & Challenge meetings along with frequent e-mail notifications now being used to improve compliance.

CARE RESPECT RESPONSIBILITY

Mandatory Training

The Dudley Group
NHS Foundation Trust



The overall rate for July has maintained above trust target performance. There has been an issue identified with the training needs for some staff in safeguarding subjects which will see a change to the requirements and increase the number of staff who require Level 3 training. Compliance for Safeguarding Adults Level 3 and Safeguarding Children Level 3 has dropped in month (August). This has had a small impact on the overall compliance rate, but this remains above target. Targeted training is in place to support early completion of training for those staff impacted.

	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24
Mandatory Training (Stat)	91.32%	92.86%	92.74%	93.38%	92.52%	92.85%	92.37%	91.59%	92.39%	92.44%	92.65%	92.24%

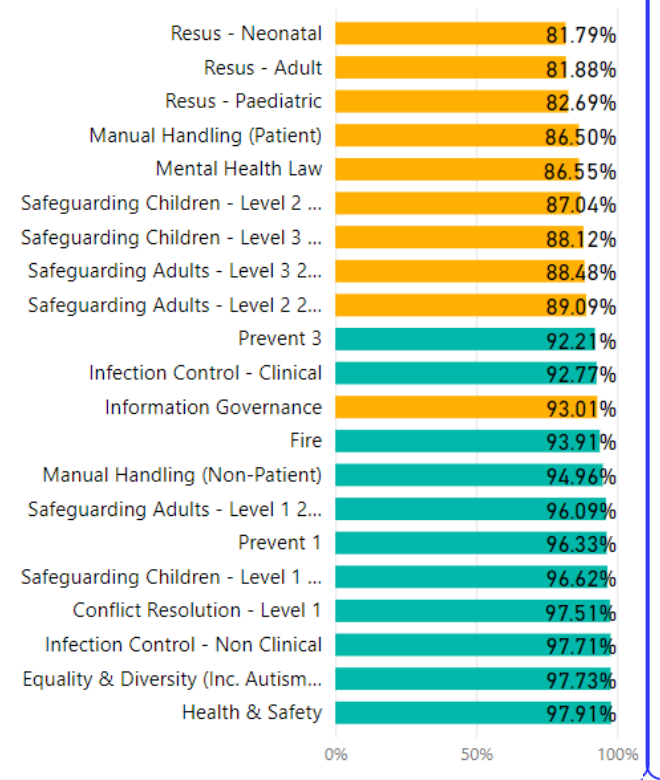
Mandatory Training – Priority 1

The Dudley Group
NHS Foundation Trust

Month: July 2024	Trust	CS	Corporate	MIC	Surgery
	92.24%	94.32%	94.59%	91.51%	91.04%

Course Compliance

Course Compliance (based on selections)



Depts by no. required to achieve 90%

Ward/Service (based selections)

Group5Description	Actual	No. to Target	%' tage
253 Ward C8 Serv	770	66	82.97%
253 Medical Staff - Acute Medicine Serv	843	64	83.71%
253 Medical Staff (Older People) Serv	232	60	71.60%
253 MOC Medical Staff Serv	360	57	77.75%
253 Theatres Recovery & Anaesth Serv	535	50	82.43%
253 General Surgery Medical Staff Serv	438	47	81.41%
253 Medical Staff - GI Serv	185	41	73.70%
253 Urology Medical Staff Serv	136	36	71.20%
253 Anaesthetics Medical Staff Serv	995	32	87.20%
253 Maxillofacial Surgery Medical Staff Serv	56	31	58.33%
253 Main Theatre Other Specialities Serv	368	30	83.25%
253 Medical Staff Cardiology Serv	210	28	79.54%
253 Pathology - Phlebotomy Serv	596	25	86.50%
253 Medical Staff GP Medicine Serv	64	23	66.66%
253 Theatres Emergency & Other Serv	452	22	85.93%
253 Ambulatory-Medics Dermatology Serv	98	21	74.24%
253 Medical Staff - Respiratory Serv	238	21	82.92%
253 Cardiology Clinical Measurement Serv	443	16	87.03%
253 RHH Day Case Theat&Recov Serv	412	16	86.73%
Total	**62,287**	**-1518**	**92.24%**

Statutory Training remains above target across all divisions and this has been sustained over the last 12 months.

There still need to be improvements to reach target across Safeguarding and Resuscitation subjects but these remain above the 2023/24 position.

There are currently no red rated subjects in July.

CARE RESPECT RESPONSIBILITY

Work Experience and Widening Participation

The Dudley Group NHS Foundation Trust

Work Experience

20 face-to-face department-led placements took place in July (17 of which were clinical, 3 being non-clinical, and 11 with a purpose of gaining access to higher education or professional training including medical school, and the other 8 as part of organised work experience through college, and 1 for its own sake).

The Trust's annual medical work experience programme commenced in June – students apply earlier on in the year and are able to apply to complete one-week centralised programme that is aimed specifically at students looking to apply to medical school. The programme runs for 2 weeks with week 2 being a repeat of week 1 but with different students. The very popular programme is run by the team in the Undergraduate Centre. This year Week 1 was reported in June KPIs, and week two recorded here in July KPIs. There were 102 applicants with 21 being offered for week 1 and 21 offered for wk2. 20 places were undertaken in week 2 with one drop out.

Work Related Learning

Behind the Scenes Event took place on 4th July with 48 students from all four of the Dudley Academies Trust Schools attending. Feedback was positive – please see below for link to feedback summary.

https://forms.office.com/Pages/AnalysisPage.aspx?AnalyzerToken=7LlBzf3TQaFKHLc4qusQiviKJO1CV5A2&id=slTDN7CF9UeyIge0jXdO47lZf2hZLhFMsqJk3SJpnelUQzNXRTI5RFNSUFlRWUVLVE5HWUU1UDY5Si4u

Careers Education Information Advice and Guidance (CEIAG)

221 contacts were recorded during June (this comprised of employer talks at 2 local secondary schools, and a 1:1 online careers advice and guidance conversation).

Ambassadors

80 ambassadors currently registered. One new and one change of role since the last report.

Employability Programmes

Paid work experience (6-month placement)

-5 in progress and receiving employability support due to complete early August

(1 has joined the below CSW training programme)

-Further 10 recruited and in pre-employment checks – due to start September

(7 nonclinical, 3 Clinical)

'I CAN Get Started' We currently have 18 active ICAN placements within trust.

'Into Employment' Programme – No sessions ran during July.

Healthcare Support Worker Novice Programme:

-5 in progress

-Further 9 started end of July

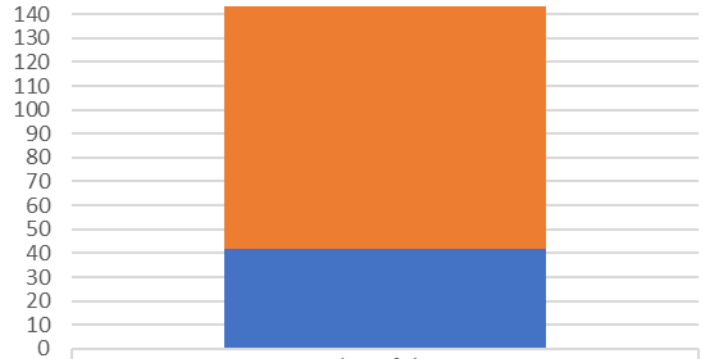
CARE RESPECT RESPONSIBILITY

Apprenticeships

The Dudley Group NHS Foundation Trust

Apprenticeships - as of July 24

Number of Signups against year plan (146)



	Number of signups
Remaining signups	104
Sign ups	42

Total Active Apprenticeships **300**	
Apprenticeship Levy	£
Expired Levy April 24	£25,738
Expired Levy May 24	£15,833
Expired Levy June 24	£0
Expired Levy July 24	£0

Activity for the quarter is expected to increase, with at least 24 sign ups in September.

Target for 2023/24 was not achieved – this was due to a range of factors including:

Expected recruitment activity was not able to go ahead as planned for the novice apprenticeship programme in January and nursing associate programme in March due to lack of available posts.
Cohorts planned in Q4 for the 4th CMI level 5 cohort and Senior Health Care Support Worker Level 3 have been moved to April due to capacity and availability of resources at the College.

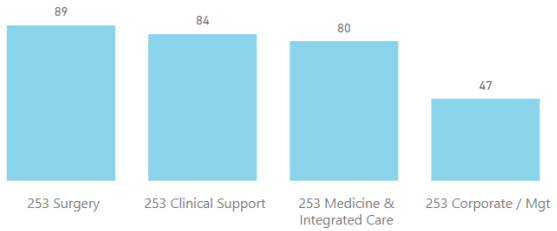
Sign-up activity has included:

31 degree / master level apprenticeships including Chartered Manager, Senior Leader, Operating Department Practitioner, Occupational Therapy, Physiotherapy and Registered Nurse.
Continuation of Business Administration, Medical Administration, Pharmacy programmes and the 3rd CMI level 5 in July.
Introduction of IT programmes at level 4 and 6.
Introduction of Dietetic Masters level 7.

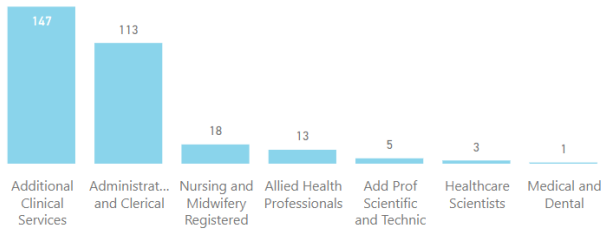
Work continues to promote internal apprenticeship opportunities in order to compensate for the lack of new apprentice opportunities.

Active Apprenticeships breakdown

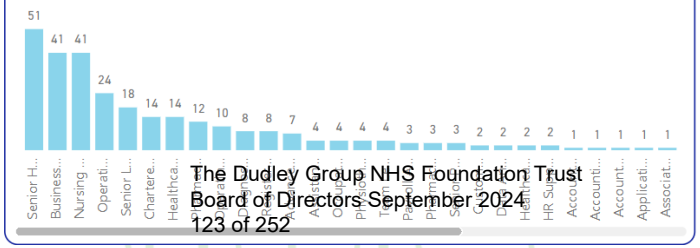
Division



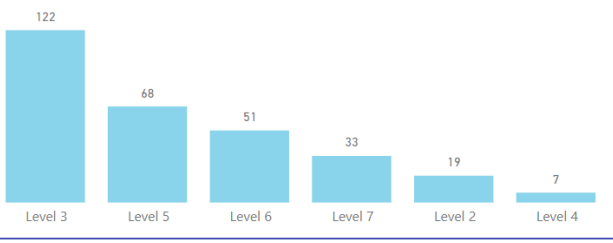
Staff Group



Programme

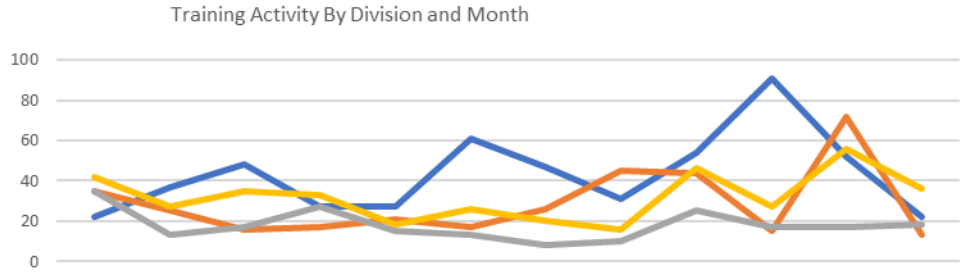


Apprenticeship Level



CARE RESPECT RESPONSIBILITY

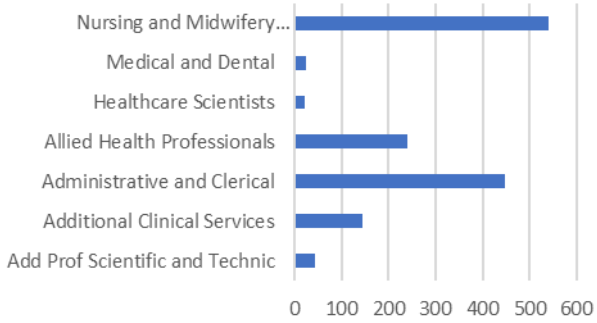
Organisational Development



	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24
253 Clinical Support	22	37	48	27	27	61	47	31	54	91	52	22
253 Corporate / Mgt	35	25	16	17	21	17	26	45	44	15	72	13
253 Medicine & Integrated Care	35	13	17	27	15	13	8	10	25	17	17	18
253 Surgery	42	27	35	33	18	26	20	16	46	27	56	36

The Dudley Group NHS Foundation Trust

Training By Staff Group
(Aug 23-Jul 24)



Course	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Grand Total
253 Admin Essentials					8				14			8	30
253 Annual Review Training								12	45	44	19		120
253 Bespoke Training										21	23	6	50
253 Coaching			2					5			8		15
253 Communications 1	12	8	13	18	24		5	10	6		13	10	119
253 Communications 2						10	12		3		21		46
253 Developing Leaders		6					8						14
253 Leading People at Dudley						4		7	13	8	3	4	39
253 Living The Values	5	10	37	13		31	21	11	32	12	34	11	217
253 Local Induction Training	7	7		2		6		2		11		6	41
253 Managers Essentials	18	25	29	34	20	26	23	23	28	26	36	10	298
253 Welcome 2 Dudley Induction	12	11	18	10	9	19	14	14	9	15	8	5	144
253 Wellbeing 1	24	18		16	14	12	11	6	13	8	13	12	147
253 Wellbeing 2	8	6	11	11	6	9	7	6	3	5	9	11	92
253 Wellbeing Adhoc	48										10		58
253 Wellbeing Champions		11	6					6	3			6	32
Grand Total	**134**	**102**	**116**	**104**	**81**	**117**	**101**	**102**	**169**	**150**	**197**	**89**	**1462**

Training activity has increased in April due to the launch of annual review training and uptake of communication training. Demand for Living the Values training continues to increase alongside increased participation in Manager's Essentials. Promotion continues across the organisation to ensure effective utilisation of training.

Enclosure 11

The Dudley Group NHS Foundation Trust

Paper for submission to the Board of Directors on 12th September 2024

Report title:	Strategy & Annual Plan progress report – Q1 2024/25
Sponsoring executive:	Adam Thomas Executive Chief Strategy and Digital Officer/Deputy CEO
Report author:	Ian Chadwell, Deputy Director of Strategy

1. Summary of key issues using Assure, Advise and Alert

A new format has been created to report progress against the five strategic goals and the 18 in-year objectives identified in the annual plan which was approved by Board of Directors at the extraordinary meeting on 2nd May.

Assure

- Good progress against the constitutional targets (elective, diagnostic, cancer and emergency access) although not meeting the trajectory for reduction of 65+ week waiters;
- Continued strong performance on mortality;
- Delivering the financial plan with a deficit position slightly better than plan;
- High proportion of the required cost improvement programme identified with the focus now on delivery, especially the planned reduction in workforce;
- Paid work experience placements started as part of the 'ICan' programme;

Advise

- Small reduction in complaints but not meeting in-year objective;
- Productivity metrics show a mixed picture with overall improving trend and continued participation in GIRFT Further Faster programme;
- Not yet meeting the agreed system-wide targets for discharge although indicators showing improvement;
- Working with third party provider and other stakeholders to commence targeted lung health checks in the upcoming quarter.

Alert

- None

This summary report is supported by additional information available in the reading pack associated with this meeting.

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

3. Report journey
Executive Directors – 16th July 2024 Relevant sections to all four committees – 24th, 25th, 30th April 2024 Public Trust Board – 12th Sept 2024

4. Recommendation(s)
The Public Trust Board is asked to:
a) To note the strategy progress report for Q1 2024/25

5. Impact		
Board Assurance Framework Risk 1.1	X	Deliver high quality, safe person centred care and treatment
Board Assurance Framework Risk 1.2	X	Achieve outstanding CQC rating.
Board Assurance Framework Risk 2.0	X	Effectively manage workforce demand and capacity
Board Assurance Framework Risk 3.0	X	Ensure Dudley is a brilliant place to work
Board Assurance Framework Risk 4.0	X	Remain financially sustainable in 2023/24 and beyond
Board Assurance Framework Risk 5.0	X	Achieve carbon reduction ambitions in line with NHS England Net Zero targets
Board Assurance Framework Risk 6.0	X	Deliver on its ambition to building innovative partnerships in Dudley and beyond
Board Assurance Framework Risk 7.0	X	Achieve operational performance requirements
Board Assurance Framework Risk 8.0	X	Establish, invest and sustain the infrastructures, applications and end-user devices for digital innovation
Is Quality Impact Assessment required if so, add date:		
Is Equality Impact Assessment required if so, add date:		

STRATEGY PROGRESS REPORT – Q1 2024/25

Report to Board of Directors on 12th September 2024

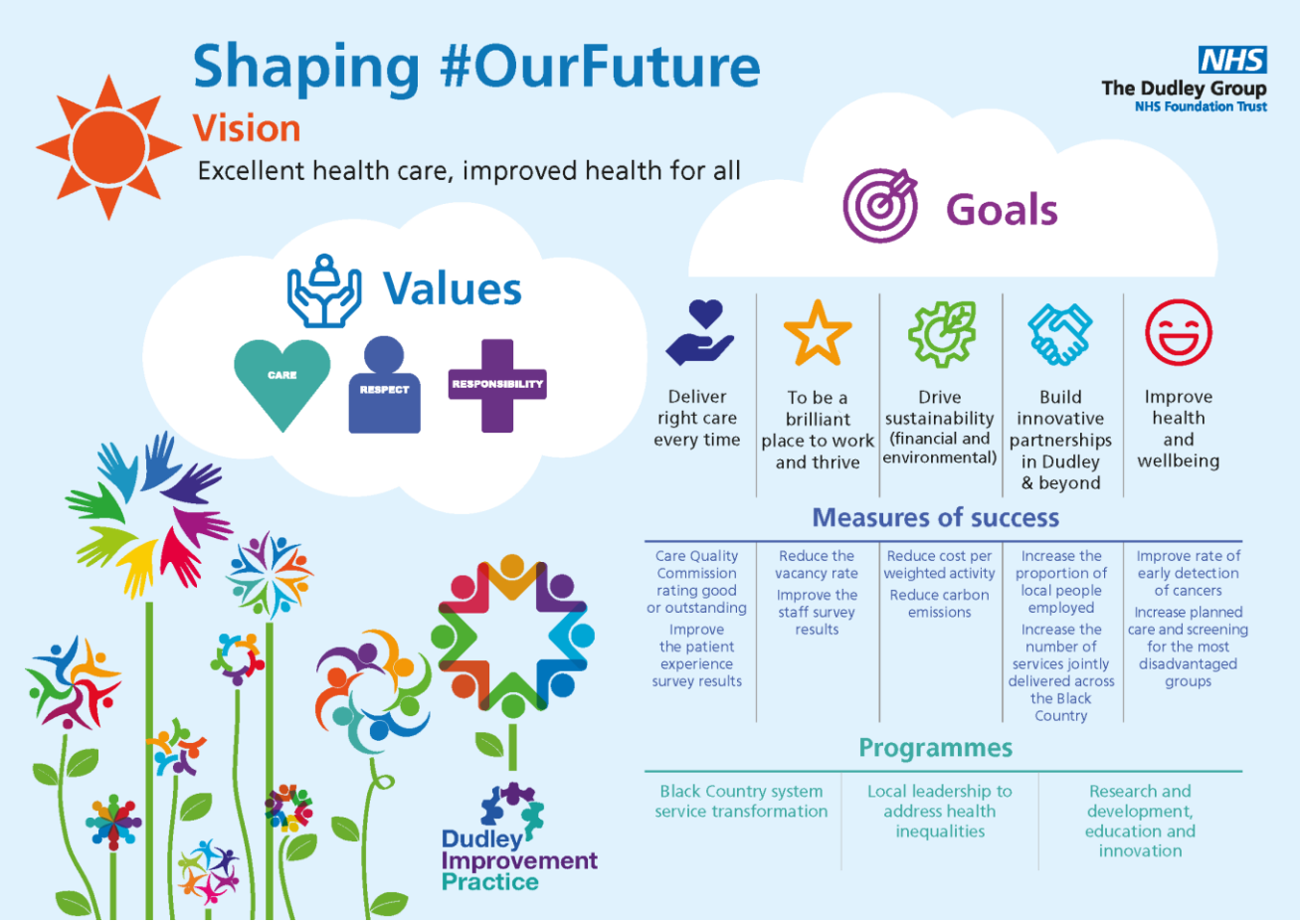
EXECUTIVE SUMMARY

This report summarises progress against the goals and measures of success in the Trust's strategic plan 'Shaping #OurFuture' and the annual plan 2024/25. Detailed progress updates were made to Executive Directors and the relevant Board sub-committees during July.

The committees received the reports as being a comprehensive reflection.

BACKGROUND INFORMATION

The Strategic Plan 'Shaping #OurFuture' was approved by Board of Directors in September 2021. Quarterly reporting on progress against the five goals and the three transformation programmes in the strategic plan has been in place since the last quarter of 2021/22.



Current status, progress in the past quarter and actions planned for the next quarter for each workstream contributing to the delivery of the goals has been compiled. This has been presented to Executive Directors and then at the respective board committees according to the following schedule of delegation for assurance.

Goal	Committee
Deliver right care every time	Quality
Be a brilliant place to work and thrive	People
Drive sustainability	Finance & Productivity
Build innovative partnerships in Dudley and beyond	Integration Committee
Improve health & wellbeing	Integration Committee

The committees have received the detailed reports in July as being a comprehensive reflection with no changes requested. Appendix 1 contains the summary of status against each measure of success.

Progress to highlight from quarter 1 2024/25

- Good progress against the constitutional targets (elective, diagnostic, cancer and emergency access) although not meeting the trajectory for reduction of 65+ week waiters;
- Continued strong performance on mortality;
- Delivering the financial plan with a deficit position slightly better than plan;
- High proportion of the required cost improvement programme identified with the focus now on delivery, especially the planned reduction in workforce;
- Paid work experience placements started as part of the 'ICan' programme;

- Small reduction in complaints but not meeting in-year objective;
- Productivity metrics show a mixed picture with overall improving trend and continued participation in GIRFT Further Faster programme;
- Not yet meeting the agreed system-wide targets for discharge although indicators showing improvement;
- Working with third party provider and other stakeholders to commence targeted lung health checks in the upcoming quarter.

A copy of the full quarterly report that went to the Committees is included in the reading pack if further information is required.

RISKS AND MITIGATIONS
Risks and mitigations associated with delivery of the strategic plan are recorded within the Board Assurance Framework which is reported to public Board.

RECOMMENDATIONS

To note the strategy progress report for Q1 2024/25.

Ian Chadwell
Deputy Director of Strategy
5th August 2024

APPENDICES:

Appendix 1 – Summary progress against strategy and objectives in the annual plan 2024/25

Appendix 2 – Strategic Planning Framework 2024/25 as agreed by Board of Directors

Appendix 1

Summary progress against strategy and objectives in the annual plan 2024/25

Goal, success measure and objective from annual plan	RAG rating	
	This quarter	Last quarter
Deliver right care every time		
Measures of success		
CQC good or outstanding		
Improve the patient experience results		
Achieve NHS constitution targets		
Objectives from the annual plan		
Reduce complaints by 15% compared to 23/24		
90% of complaints to be responded to in 30 days		
Increase responses to patient experience survey by 20%		
Reduction in incidents resulting in significant harm		
Standardised hospital mortality index (SHMI) better than England average		
Re-admission within 28 days better than England average		
Eliminate 65 week waits by September 2024 and reduce 52 week waits		
Improve productivity (reduce DNA rate to better than England average, increase PIFU to 5%, theatre utilisation 85%)		
Be a brilliant place to work and thrive		
Measures of success		
Improve the staff survey results to better than England average		
Reduce the vacancy rate to 7% or below		
Objectives from the annual plan		
Improve retention rates for nursing, midwifery and AHP groups		
Bullying and harassment – staff survey results better than England average		
Raising concerns – staff survey results better than England average		
Recommend trust as a place to work – staff survey results better than England average		
Drive sustainability		
Measures of success		
Reduce cost per weighted activity to better than England average		
Reduce carbon emissions (year-on-year decrease to achieve net zero by 2040)		
Objectives from the annual plan		
Deliver financial plan (deficit of £32.565m)		
Deliver recurrent cost improvement programme of £31.896m		
Reduction in use of bank by 25%		
Build innovative partnerships in Dudley and beyond		
Measures of success		
Increase proportion of local people employed to 70 by Mar-25		
Increase the number of services delivered jointly across the Black Country		
Objectives from the annual plan		
A total of 35 people into work via ICan (through jobs and skills hubs or paid work experience		
Improve discharge processes		
Improve health and wellbeing		
Measures of success		
Improve rate of early detection of cancers (75% of cancers diagnosed at stages I,II by 2028)		
Increase planned care and screening from disadvantaged groups		
Objectives from the annual plan		
Achieve acceptable coverage for breast screening (70%) and work towards achievable level (80%)		

Appendix 2

Strategic Planning Framework 2024/25

	DRIVE SUSTAINABILITY	RIGHT CARE EVERY TIME		INNOVATIVE PARTNERSHIPS	HEALTH & WELLBEING	BRILLIANT PLACE TO WORK
	Finance	**Experience**	**Quality**	**Access**	**Inequalities**	**Workforce**
Success Measures	Achieve financial sustainability	Improve our patient experience results	CQC rated good or outstanding	Achieve NHS Constitution targets (Referral to treatment, diagnostics, cancer, emergency access)	Improve rate of early detection of cancers	Staff survey results above England average
	Reduce cost per weighted activity to better than average			Increase the number of services delivered jointly across the Black Country	Increase planned care and screening from disadvantaged groups	Reduce vacancy rates
	Reduce Carbon Emissions				Increase proportion of local people employed	
In year objectives	Deliver financial plan (deficit of £32.565m)	Reduce complaints by 15% compared to 2023/24	Reduction in incidents resulting in significant harm (moderate, severe, death)	Eliminate 65 week waits by Sept 24 and reduce 52 week waits	Achieve acceptable coverage for breast screening (70%) and work towards achievable coverage (80%)	Improve retention rates for Nursing, Midwifery and AHP groups in particular retain 80% of our internationally recruited workforce
	Deliver recurrent cost improvement programme of £31.896m	90% of complaints to be responded to in 30 days	Standardised Hospital Mortality Index (SHMI) (quarterly) better than England average	Improve productivity (reduce DNA rate to better than England average, increase PIFU to 5%, theatre utilisation at 85%)	A total of 35 people into work via ICan (through jobs and skills hubs or paid work experience)	Bullying and harassment - experience of bullying from managers - staff survey results better than England average experience of bullying from colleagues: staff survey results better than England average
	Reduction in use of bank by 25%	Increase responses to patient experience survey by 20%	Re-admission within 28 days better than England average	Improve discharge processes (30 discharges per day from MOFD list, 90% of patients to be discharged within 24 hours once known to system partners, reduce number of incomplete discharges on the complex list – no more than 5% failed per day, 30% of In-patient's discharges are home for lunch for each RHH ward		Raising concerns - I feel safe to speak up staff survey results better than England average
						Recommend trust as a place to work staff survey results better than England average
Multi-year commitments	Delivery of Digital 3 year Plan					
	Work collaboratively to increase elective capacity Delivery of Financial Recovery Plan Productivity (outpatient transformation, theatre utilisation, discharge)					
	Delivery of People Plan and associated journeys (Recruitment and Retention, EDI, Wellbeing, OD and leadership)					
	Delivery and Implementation of Community Diagnostic Centre					
	Implement Delivery plan for maternity and neonatal services					
	Transformation and integration of community services					
	Implement Targeted Lung Health Check Programme					
	Working towards university hospital status (DGFT, SWBH and Aston University)					
Task and finish	Consolidate payroll function across provider collaborative	Redevelopment of resuscitation area in ED	Embedding of Patient Safety Incident Response Framework (PSIRF)	Transfer services from DIHC into DGFT	ICan (pre-employment programme)	Establishment and embedding of the Brilliant Place to Work group to deliver actions associated with the Culture and Learning journey
	Corporate improvement programme	Discharge, Nutrition, hydration and pain quality improvement programmes established	Provision of more services in the Family Hubs to provide better services to families	Establish structures to support DGFT becoming Lead Provider for Dudley Health and Care Partnership by March 2026	Develop policies and procedures around patient equality	An improvement project to be included in each staff appraisal as part of embedding the Dudley Improvement Practice
		Development and implementation of dementia and delirium and autism and learning disability strategies			Contribute to design of Health Innovation Dudley and the range of courses offered	Establishment and embedding of the recruitment and retention group to deliver actions associated with the journey
		Shared across Joint Provider Committee (Black Country)		Shared across Dudley Health & Care Partnership		

The Dudley Group NHS Foundation Trust

Paper for submission to the Board of Directors 12th September 2024

Report title:	Board & Committee Effectiveness review
Sponsoring executive:	Diane Wake, Chief Executive
Report author:	Helen Board, Board Secretary

1. Summary of key issues using Assure, Advise and Alert

Assure

It is best practice to undertake an annual review, by way of self-assessment, of the Board and its sub Committee's effectiveness. Each Committee undertook a review during quarter four 2023/24 and the outcomes of that, including any recommended changes to terms of reference have considered by the respective committee and been reported up to the Board.

Board members were also asked to complete a questionnaire in relation to the scope and operation of the Board, and a summary of that is appended to this report. The survey explored themes: support & infrastructure, structure, leadership, effectiveness, stakeholder engagement, and behaviours.

Board member attendance at board meetings has been very high with any absence being exceptional.

Advise

During quarter 4, 2023/24, the survey was circulated to all 20 board members in post and was completed by nine out of 20 (45%).

Thirty five of the 37 questions received a green rating based on responses selecting 'average, above average of fully satisfactory. There were zero responses where the 'hardly ever/poor' was selected.

Throughout the year the Board met each month plus one extraordinary board meeting and met face to face where possible and during 24/25 will also be holding a number of board meetings in community settings.

A varied Board development programme has been maintained during the year supporting the themes of working together as a Board, culture and strategy development, regulatory and risk compliance matters and a strong focus on emerging system working.

Appendices within the document include:
Appendix 1 - Questionnaire Self-assessment Responses
Appendix 2 – Board attendance 2023/24
Appendix 3 – Board & Committee Structure
Appendix 4 – Board Agenda Summary 2023/24

Alert

There were two questions where one responder selected 'below average' as follows and the Board is asked to note that where items have been identified, mitigation has either been completed or are making good progress:

- succession planning
- periodic review of organisational culture and plan to maintain a positive culture

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

3. Report journey
Public Trust Board – 12th Sept 2024

4. Recommendations
The Public Trust Board is asked to:
a) **Review** the responses and determine whether there are further steps necessary in relation to the responses.
b) Note that it is best practice to undertake an annual review, by way of self-assessment, of the Board and it sub Committee's effectiveness

5. Impact		
Board Assurance Framework Risk 1.1	X	Deliver high quality, safe person centred care and treatment
Board Assurance Framework Risk 1.2	X	Achieve outstanding CQC rating.
Board Assurance Framework Risk 2.0	X	Effectively manage workforce demand and capacity
Board Assurance Framework Risk 3.0	X	Ensure Dudley is a brilliant place to work
Board Assurance Framework Risk 4.0	X	Remain financially sustainable in 2023/24 and beyond
Board Assurance Framework Risk 5.0	X	Achieve carbon reduction ambitions in line with NHS England Net Zero targets
Board Assurance Framework Risk 6.0	X	Deliver on its ambition to building innovative partnerships in Dudley and beyond
Board Assurance Framework Risk 7.0	X	Achieve operational performance requirements
Board Assurance Framework Risk 8.0	X	Establish, invest and sustain the infrastructures, applications and end-user devices for digital innovation
Is Quality Impact Assessment required if so, add date:		
Is Equality Impact Assessment required if so, add date:		

The Dudley Group
NHS Foundation Trust

Annual Review of effectiveness of the Board of Directors 2023/24
Report to Trust Board on 12th September 2024

1 EXECUTIVE SUMMARY

1.1 It is best practice to undertake an annual review, by way of self-assessment, of the Board and it sub Committee's effectiveness. Each Committee undertook a review during quarter four 2023/24 and the outcomes of that, including any recommended changes to terms of reference have considered by the respective committee and been reported up to the Board.

Board members were also asked to complete a questionnaire in relation to the scope and operation of the Board, and a summary of that is appended to this report. The survey explored themes: support & infrastructure, structure, leadership, effectiveness, stakeholder engagement, and behaviours.

2 BACKGROUND INFORMATION

2.1 Questionnaire Self-assessment Responses – see appendix 1

During quarter 4, 2023/24, the survey was circulated to all 20 board members in post and was completed by nine out of 20 (45%).

Thirty five of the 37 questions received a green rating based on responses selecting 'average, above average of fully satisfactory. There were zero responses where the 'hardly ever/poor' was selected.

There were two questions where responders selected 'below average' as follows and the Board is asked to note that where items have been identified, actions have either been completed or are making good progress:

Structure
Succession planning – one respondent selected 'below average'.

The refined succession planning framework was reviewed in 2023 and on conclusion of the 2024 round of appraisals is currently under review. It is submitted on a regular basis to the Remuneration and Nominations Committee and kept under review to reflect any guidance released by NHS England.

Leadership
Periodic review of organisational culture and plan to maintain a positive culture - one respondent selected 'below average'.

The Trust regularly reviews progress and delivery against its People Plan (Dudley People Plan) which is aligned to the NHS People Plan 2020/2021 and the Trust's strategic objective for the Trust to be 'a brilliant place to work and thrive', including key workforce development, transformation and wellbeing initiatives.

The board approved the revised Dudley People Plan 2023-2026 which is an overarching framework to enable us to deliver the Trust's Shaping #OurFuture strategy. The plan outlines our overall direction for our services which support our people and our ambition for Dudley to be a brilliant place to work and thrive. Our Leadership Way sets out the compassionate and inclusive behaviours we want all our leaders at every level to show towards us as individuals and colleagues.

The implementation of the plan is overseen by the People Committee, supported by an Equality, Diversity and Inclusion Steering Group, and also a Health and Wellbeing Steering Group.

The Trust collates and reviews data every month for a range of workforce metrics, quality and outcomes indicators and productivity measures. This enables the Trust to undertake safe workforce planning and delivery against its ambitious People Plan priorities, including improvements in staff satisfaction and inclusivity.

One comment was received using the free text option:

"Opportunity to more effectively use the Board Paper templates in the way intended/designed to support the right conversation/focus. Data to underpin/support assurances - relevant not all data got."

Effective use of the Board Paper templates in the way intended/designed to support the right conversation/focus: Report cover sheet template updated to standardise for use at each trust within the Black Country Provider Collaborative and launched August 2024 to support focus of discussion using Assure, Advise and Alert. The report writing guide also updated and launched at same time.

Data reporting has seen the introduction of SPC charts and work is ongoing to refine the integrated reporting to Board including the work of the chief nurse and medical director to develop a combined report that was launched at the May board meeting and has been well received.

2.2 Frequency of Meetings and attendance

During the year, the Board (private session) met monthly with 13 (including one extraordinary board meeting July 2023) meetings held during the year.

Public sessions of the Board of Directors meetings were held bi-monthly with six held during 2023/24 /23. There were 55 tier one committee meetings held during 2023/24 (including three extraordinary meetings) compared to 55 in 2022/23 and 58 in 2021/22.

Attendance of Directors is very high with absence being exceptional. See table given in appendix 2.

2.3 On Site Meetings

During 2023/2024, the Board transitioned to face-to-face meetings with 5 out of 13 being held face to face in the Clinical Education Centre at Russells Hall Hospital. During 2024/2025, the majority of board meetings will be held face to face with a number being held at community locations.

2.4 Board Development

From 1st April 2023 system working and maturing provider collaboration supported a move towards shared chair over four trusts.

Opportunities exist for all four boards to come together to consider strategic items that are relevant to all. A varied Board development programme has been maintained during the year supporting the themes of working together as a Board, strategy development, regulatory and risk compliance matters and a strong focus on emerging system working. All four boards have come together for Joint Board Development sessions in September and December

2023, February and June 2024 to consider strategic items that are relevant to all parties and other emerging topics.

Dudley Board development activities 2023/2024

2023	Topic
April	Culture development session led by Alan Duffell
June	'All things Risk' workshop delivered by the Good Governance Institute
July	Joint Governor development session with Black Country Healthcare NHSFT
September	Safeguarding training for senior leaders – national requirement Black Country Provider Collaborative - Joint Board Development Session
October	BAF and Risk Appetite review with RSM audit findings
December	All things Culture with Roger Kline
2024	
January	'NHS Boards under attack' the legal challenges faced by Boards delivered by Weightmans Annual planning 24/25 - workshop
February	Cyber resilience delivered by Adam Thomas Culture/behaviour framework delivered by Rachel Andrew

2.5 Board & Committee structure
The tier 1 board and committee structure diagram was reviewed as part of the board and committee effectiveness review process. It is made available on the Trust intranet with the latest version updated in August 2024. See appendix 3.

2.6 Board agenda summary 2023/2024
A summary of the board agenda plan is prepared for the year ahead and is circulated to all board members. See appendix 4.

3. RISKS AND MITIGATIONS

3.1 These are identified in the body of this report.

4. RECOMMENDATIONS

- That the Board considers any further actions that it wishes to implement having regard to the survey findings, and the further matters highlighted in the background information.

- That the Board continue to support the programme of bi-monthly public board meetings to develop the capacity for Board development and strategy review activity.

Helen Board
Board Secretary
August 2024

Appendix 1

Board of Directors Annual Review 2023/24

Legend	100% agreement	Where responders selected 'occasionally/below average' or 'hardly ever/poor'

Support and Infrastructure

Does the Board receive timely information		
All of the time / Fully satisfactory	11%	1
Most of the time / Above average	89%	8
Some of the time / Average	0%	0
Occasionally / Below average	0%	0
Hardly ever / Poor	0%	0
Is the information of the right quality		
All of the time / Fully satisfactory	33%	2
Most of the time / Above average	67%	3
Some of the time / Average	0%	0
Occasionally / Below average	0%	0
Hardly ever / Poor	0%	1
Is the information sufficiently concise		
All of the time / Fully satisfactory	0%	0
Most of the time / Above average	33%	3
Some of the time / Average	67%	6
Occasionally / Below average	0%	0
Hardly ever / Poor	0%	0
Is information in the right form to enable the Board to make sound decisions		
All of the time / Fully satisfactory	11%	1
Most of the time / Above average	78%	7
Some of the time / Average	11%	1
Occasionally / Below average	0%	0
Hardly ever / Poor	0%	0
The number and length of meetings and access to resources is sufficient to allow the Board to fully discharge its duties		
All of the time / Fully satisfactory	33%	3
Most of the time / Above average	67%	6
Some of the time / Average	0%	0
Occasionally / Below average	0%	0
Hardly ever / Poor	0%	0
Is the agenda sufficient to allow the Board to carry out its functions		
All of the time / Fully satisfactory	44%	4
Most of the time / Above average	56%	5
Some of the time / Average	0%	0
Occasionally / Below average	0%	0
Hardly ever / Poor	0%	0
Does the agenda prioritise the right issues		
All of the time / Fully satisfactory	22%	2
Most of the time / Above average	78%	7
Some of the time / Average	0%	0
Occasionally / Below average	0%	0
Hardly ever / Poor	0%	0
Sufficient time is spent on each agenda item		

All of the time / Fully satisfactory	44%	4
Most of the time / Above average	33%	3
Some of the time / Average	22%	2
Occasionally / Below average	0%	0
Hardly ever / Poor	0%	0
The Board receives an appropriate amount of presentations from Clinicians, Managers and others to remain informed		
All of the time / Fully satisfactory	44%	4
Most of the time / Above average	44%	4
Some of the time / Average	11%	1
Occasionally / Below average	0%	0
Hardly ever / Poor	0%	0
Board Committee meetings are held sufficiently far in advance of Board meetings to allow for the resolution of issues		
All of the time / Fully satisfactory	33%	3
Most of the time / Above average	56%	5
Some of the time / Average	11%	1
Occasionally / Below average	0%	0
Hardly ever / Poor	0%	0
Theme - Structure		
The Board have the right balance of skills, knowledge and experience to deal with current and anticipated challenges		
All of the time / Fully satisfactory	78%	7
Most of the time / Above average	22%	2
Some of the time / Average	0%	0
Occasionally / Below average	0%	0
Hardly ever / Poor	0%	0
Board Members are clear on the role of the Board as a whole		
All of the time / Fully satisfactory	67%	6
Most of the time / Above average	33%	3
Some of the time / Average	0%	0
Occasionally / Below average	0%	0
Hardly ever / Poor	0%	0
The Board is clear as to its role in relation to Governance across the Trust		
All of the time / Fully satisfactory	67%	6
Most of the time / Above average	33%	3
Some of the time / Average	0%	0
Occasionally / Below average	0%	0
Hardly ever / Poor	0%	0
The Board is the right size to ensure effective decision making		
All of the time / Fully satisfactory	67%	6
Most of the time / Above average	33%	3
Some of the time / Average	0%	0
Occasionally / Below average	0%	0
Hardly ever / Poor	0%	0
Is a succession plan in place		
All of the time / Fully satisfactory	11%	1
Most of the time / Above average	44%	4
Some of the time / Average	33%	3
Occasionally / Below average	11%	1
Hardly ever / Poor	0%	0

Leadership		
Does the Board periodically review organisational culture and plan to maintain a positive culture		
All of the time / Fully satisfactory	11%	1
Most of the time / Above average	78%	7
Some of the time / Average	0%	0
Occasionally / Below average	11%	1
Hardly ever / Poor	0%	0
Does the Board collectively and individually model behaviours consistent with organisational values and culture		
All of the time / Fully satisfactory	56%	5
Most of the time / Above average	33%	3
Some of the time / Average	11%	1
Occasionally / Below average	0%	0
Hardly ever / Poor	0%	0
Does the time spent on strategy result in defined proposals to be incorporated into the business plan		
All of the time / Fully satisfactory	44%	4
Most of the time / Above average	33%	3
Some of the time / Average	22%	2
Occasionally / Below average	0%	0
Hardly ever / Poor	0%	0

Is the Board satisfied that it has identified the strategic risks facing the organisation, and that it has the controls to manage them		
All of the time / Fully satisfactory	33%	3
Most of the time / Above average	56%	5
Some of the time / Average	11%	1
Occasionally / Below average	0%	0
Hardly ever / Poor	0%	0
The governing body challenges and understands the reporting from this committee		
All of the time / Fully satisfactory	67%	6
Most of the time / Above average	33%	3
Some of the time / Average	0%	0
Occasionally / Below average	0%	0
Hardly ever / Poor	0%	0
Does the Board keep abreast of changes in the external environment and considers their impact on the strategic direction of the Trust		
All of the time / Fully satisfactory	22%	2
Most of the time / Above average	67%	6
Some of the time / Average	11%	1
Occasionally / Below average	0%	0
Hardly ever / Poor	0%	0

Effectiveness

Does the Board spend sufficient time discussing the organisations strategic direction		
All of the time / Fully satisfactory	22%	2
Most of the time / Above average	56%	5
Some of the time / Average	22%	2
Occasionally / Below average	0%	0
Hardly ever / Poor	0%	0

The Board assures itself that patient safety and quality issues are being addressed		
All of the time / Fully satisfactory	67%	6
Most of the time / Above average	33%	3
Some of the time / Average	0%	0
Occasionally / Below average	0%	0
Hardly ever / Poor	0%	0
The committee receives clear and timely reports from other governing body committees which set out the assurances they have received and their impact (either positive or not) on the organisation's assurance framework		
Strongly Agree	0%	0
Agree	100%	6
Disagree	0%	0
Strongly Disagree	0%	0
Unable to Answer	0%	0
Is the Board Assurance Framework effective		
All of the time / Fully satisfactory	44%	4
Most of the time / Above average	33%	3
Some of the time / Average	22%	2
Occasionally / Below average	0%	0
Hardly ever / Poor	0%	0

Communication between the Board and its Committees is adequate and effective		
All of the time / Fully satisfactory	56%	5
Most of the time / Above average	44%	4
Some of the time / Average	0%	0
Occasionally / Below average	0%	0
Hardly ever / Poor	0%	0

Stakeholder engagement		
Does the Board inform and involve key stakeholders in its work and check their views		
All of the time / Fully satisfactory	0%	0
Most of the time / Above average	44%	4
Some of the time / Average	56%	5
Occasionally / Below average	0%	0
Hardly ever / Poor	0%	0
The Board has clearly identified open channels of communication with Staff and external Stakeholders in order to improve patient care		
All of the time / Fully satisfactory	11%	1
Most of the time / Above average	44%	4
Some of the time / Average	44%	4
Occasionally / Below average	0%	0
Hardly ever / Poor	0%	0
Does the Chair ensure that there is sufficient challenge on each issue on the Boards agenda		
All of the time / Fully satisfactory	33%	3
Most of the time / Above average	67%	6
Some of the time / Average	0%	0
Occasionally / Below average	0%	0
Hardly ever / Poor	0%	0

Behaviours

The Chair demonstrates good listening skills		
All of the time / Fully satisfactory	67%	3

Most of the time / Above average	33%	6
Some of the time / Average	0%	0
Occasionally / Below average	0%	0
Hardly ever / Poor	0%	0
Board meetings encourage a high quality of debate with robust and probing discussions		
All of the time / Fully satisfactory	33%	3
Most of the time / Above average	67%	6
Some of the time / Average	0%	0
Occasionally / Below average	0%	0
Hardly ever / Poor	0%	0
The Board responds positively and constructively to bad news in order to encourage future transparency		
All of the time / Fully satisfactory	33%	5
Most of the time / Above average	67%	4
Some of the time / Average	0%	0
Occasionally / Below average	0%	0
Hardly ever / Poor	0%	2
The Chair operates satisfactorily in terms of promoting effective and efficient meetings, with an appropriate level of involvement outside of the formal meetings		
All of the time / Fully satisfactory	33%	3
Most of the time / Above average	56%	5
Some of the time / Average	11%	1
Occasionally / Below average	0%	0
Hardly ever / Poor	0%	0
Executive and Non-Executive Board members have a frank and open relationship with each other and each Director understands his/her own personal Board level responsibilities		
All of the time / Fully satisfactory	56%	5
Most of the time / Above average	33%	3
Some of the time / Average	11%	1
Occasionally / Below average	0%	0
Hardly ever / Poor	0%	0
The Board has a good understanding of key people issues, particularly those regarding Transformation		
All of the time / Fully satisfactory	11%	1
Most of the time / Above average	78%	7
Some of the time / Average	11%	1
Occasionally / Below average	0%	0
Hardly ever / Poor	0%	0
All Board members attend and actively contribute at meetings		
All of the time / Fully satisfactory	56%	5
Most of the time / Above average	44%	4
Some of the time / Average	0%	0
Occasionally / Below average	0%	0
Hardly ever / Poor	0%	0
All Board members have sufficient time and commitment to fulfil their responsibilities		
All of the time / Fully satisfactory	22%	2
Most of the time / Above average	67%	6
Some of the time / Average	11%	1
Occasionally / Below average	0%	0
Hardly ever / Poor	0%	0
Board members undertake ongoing personal development		
All of the time / Fully satisfactory	0%	0
Most of the time / Above average	100%	9
Some of the time / Average	0%	0

Occasionally / Below average	0%	0
Hardly ever / Poor	0%	0

Appendix 2 – Board attendance

Board attendance 2023/24

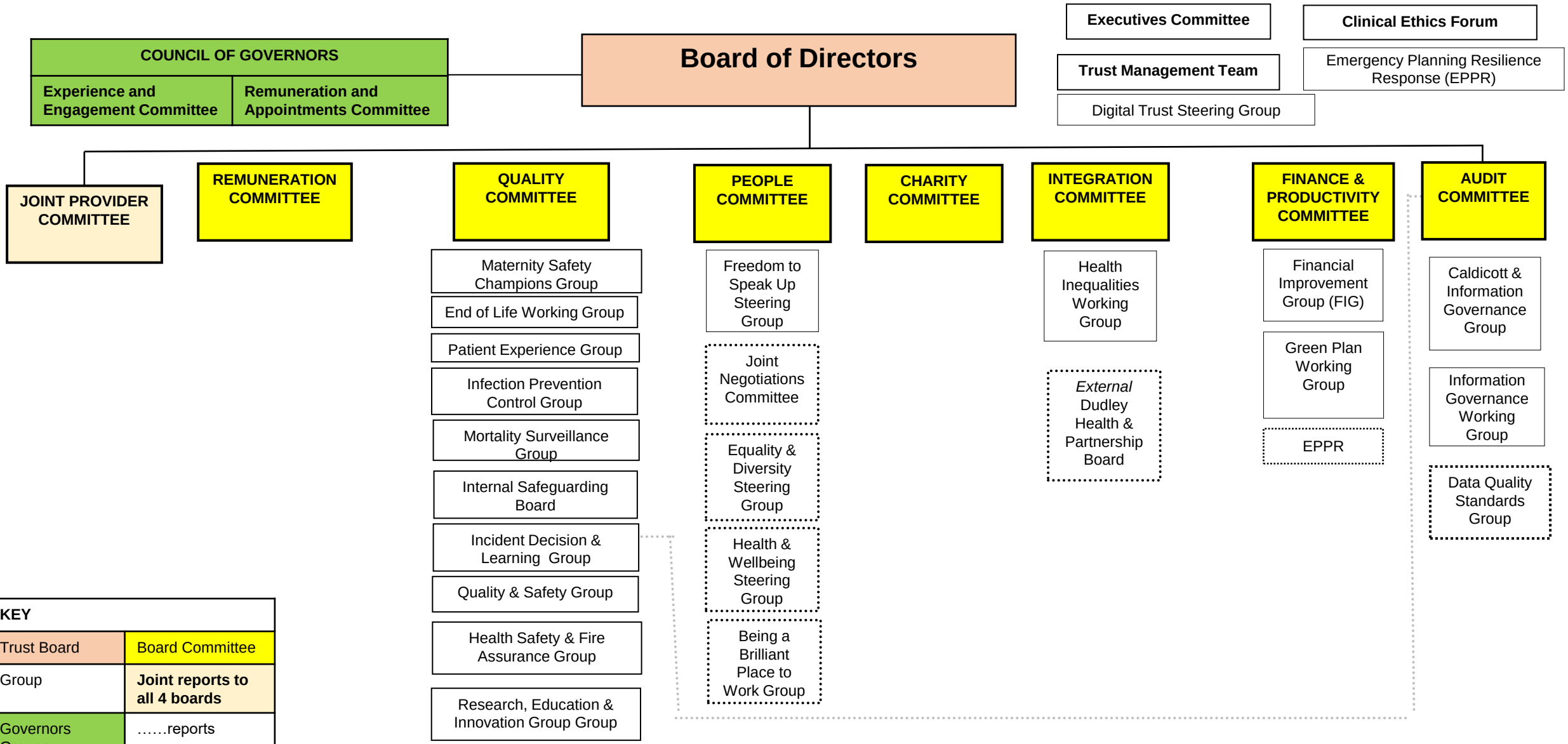
Table 1

Position	Name	Commencing	End	Attendance out of 13*
Chief executive	Diane Wake	03/04/17		13/13
Chief finance officer (interim)	Chris Walker	01/01/24		3/3
Chief finance officer (Interim 1/6/22 – 1/7/23)	Kevin Stringer	01/06/22	31/12/23	9/10
Chief operating officer	Karen Kelly	02/01/18		12/13
Medical director	Dr Julian Hobbs	02/10/17		12/13
Interim chief nurse	Helen Blanchard	23/10/23	21/03/24	5/5
Chief nurse	Mary Sexton	29/11/19	31/10/23	6/8
Chief nurse	Martina Morris	03/03/2024		1/1
Chief people officer (Interim 20/6/22 – 1/7/23)	Alan Duffell	20/06/22		12/13
Director of strategy & integration	Kat Rose**	18/4/22		12/13
Executive chief strategy and digital officer and deputy chief executive	Adam Thomas	01/09/19		11/13
Director of governance	Andy Proctor **	01/06/22		11/13
Director of communications	Liz Abbiss**	01/05/23		13/13
Chair	Sir David Nicholson	01/09/22		11/13
Non-executive director	Prof Liz Hughes	15/11/19	15/11/25	10/13
Non-executive director	Julian Atkins	04/01/16	31/05/23	12/13
Non-executive director	Catherine Holland	01/09/18	31/08/26	12/13
Non-executive director	Lowell Williams	01/12/19	31/03/26	12/13
Non-executive director	Prof Gary Crowe	01/07/19	01//07/25	12/13
Non-executive director	Vij Randeniya	20/11/20	31/11/26	13/13
Associate non-executive director	Thuvarahan Amuthalingham****	13/05/21	12/05/23	13/13
Non-executive director	Gurjit Bhogal	13/05/21	12/05/26	11/13
Associate non-executive director	Anthony Hilton****	01/07/23	31/07/24	4/9
Non-executive director	Joanne Hanley	01/06/23	31/0/5/26	9/10

**There was one extraordinary meeting held in May 2023.*
***non voting*
*****associate non-executive directors are non voting*

Appendix 3

BOARD COMMITTEE STRUCTURE 2024



Board of Directors - annual planner 2023/2024 Public session

Appendix 4

Strategic Goal	Executive lead	May 11	July 13	September 14	November 8	January 11	March 14	Notes
Chairs update	Chair							
Chief Executives Update	Chief Executive							CQC action plan /matters reported
Deliver right care every time								
Chief Nurse Report	Chief Nurse							
Patient story	Chief Nurse/Medical Director	Own bed instead	Community nursing	Family Hubs				
Quality Committee Assurance report	NED committee chair							
7 Day Service Board Assurance report	Chief Operating Officer							at least annually
Quality Account	Chief Nurse							Considered at June Private Board and received at June Full Council of Governors
NHS Resolution Maternity Incentive Scheme	Chief Nurse			update	update	board sign off		
Quality Strategy	Chief Nurse							tbc
Clinical Strategy	Chief Nurse/Medical Director							
Maternity & Neonatal dashboard	Chief Nurse/ Head of Midwifery							
Infection Prevention Control BAF	Chief Nurse							
Nurse staffing	Chief Nurse							
PLACE inspection findngs and action plan	Director of Estates & Facilities							timing tbc owing to relaunch of national audit activity
Learning from Deaths	Medical Director							
Patient Safety Incident Framework (PSIRF)	Director of Governance							PSIRF Policy and Plan documents reviewed/ approved at Private Board in October
Be a brilliant place to work and thrive								
Staff Voice	Chief People Officer	AHP	Heart failure team	Inc in patient story				September staff voice to be taken at Full Council meeting 5/10
People Committee assurance report	NED committee chair							
Dudley People Plan	Chief People Officer			For approval				
Workforce KPIs	Chief People Officer							
Freedom to Speak Up report	FTSU Guardian							
Guardian of Safe Working report	Guardian							
Gender pay gap report	Chief People Officer							
Annual Medical Revalidation Report	Medical Director							to meet submission requirements signed off at Private board October
Staff survey Report	Chief People Officer							
Annual EDI Public Sector Equality Duty report								to meet submission requirements signed off at June Private board
Workforce Race Equality Standards Report	Chief People Officer							to meet submission requirements signed off at Private board August
Workforce Disability Equality Report	Chief People Officer							to meet submission requirements signed off at Private board August
Drive sustainability (financial and environmental)								
Finance & Productivity Committee assurance report	NED committee chair							matters raised in respect of assurance, concern, decisions made and projects commissioned
Finance report	Director of Finance	Month 12	Month 2	Month 4	Month 6	Month 8	Month 10	
Annual Plan & Business plan	Director of Strategy							workforce, activity, finance - narrative
Board approval of Financial Plan	Director of Finance							
EPRR assurance statement and annual report	Chief Operating Officer							Emergency Preparedness Resilience and Responsiveness
Revenue business cases / capital investment								as set out in Schedule of Authorised Limits
Capital Programme	Director of Finance							taken to Finance & Productivity Committee
Estates Strategy 2022 - 2027								Updates to Finance & Productivity
Going Concern, auditor annual report								
Build innovative partnerships in Dudley and beyond								
Integration Committee assurance report	NED committee chair							Established July 2023
Joint Provider Committee assurance report	Deputy Chair							established August 2023
Research & Development Report	Medical Director							
Digital Committee assurance report	NED committee chair							
Community Operational Plan 2023-2025	Chief Operating Officer							considered at meeting of June private board

Board of Directors - annual planner 2023/2024 Public session								
Strategic Goal	**Executive lead**	**May 11**	**July 13**	**September 14**	**November 8**	**January 11**	**March 14**	**Notes**
	Improve health and wellbeing							
Integrated Performance Report/ board metrics	Chief Operating Officer							
Winter Plan	Chief Operating Officer	Debrief		Draft plan				
Governance								
Annual Board/ Committee effectiveness report								
Audit Committee assurance report								
Audit Committee Annual Report	NED committee chair							
NHS Provider Licence self certification	Board Secretary							endorsed at June meeting of Full Council of Governors
Board Assurance Framework								

The Dudley Group NHS Foundation Trust

Paper for submission to the Board of Directors 12th September 2024

Report title:	Board Assurance Framework
Sponsoring executive:	Diane Wake, Chief Executive
Report author:	Helen Board, Board Secretary

1. Summary of key issues using Assure, Advise and Alert

Assure

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

The Board Assurance Framework Report provides the Board of Directors with a summary view on the status of progress towards the achievement of its agreed strategic goals and the Trust objectives supporting each of them. This includes the risks, controls and gaps in controls, assurances, and mitigations associated with each.

Each committee receives their individual BAF risks scheduled throughout the year tabled by the Executive lead for that risk; the date of most recent meeting is indicated. The Board of Directors receive a one page summary of the BAF at its public meetings, given in appendix 1.

All BAF risks reflect audit recommendations issued in quarter 4 and have been subject to a review and reset for 2024/25. Further BAF refresh work will proceed as part of the strategy refresh activity later in the year.

Advise

Summary of changes since the last report – June 2024

Each of the Committees articulate their assurance levels for each BAF risk for which they have oversight. This approach informs the agenda and regular management information received by the lead committee.

Of the nine risks listed, committee assurance ratings have not changed from the previous summary report:

- Eight (was eight) assigned a 'positive' rating
- One (was one) assigned an 'inconclusive' rating
- None (was none) assigned a 'negative' rating

Responding to the request for increased cross committee oversight of risks, each BAF risk is summarised in this document for the reporting period as follows:

BAF Risk 1.1: Quality: Safe, High-Quality Care There is a risk that the Trust fails to deliver high quality, safe, person centred care and treatment resulting in incidents of avoidable harm and poor clinical outcomes

Overseen by Quality Committee, last reviewed 27/08/24 and assigned an 'inconclusive' committee assurance level and noted the need to clearly articulate the exit criteria to support movement of overall score.

The current risk score Q4, 23/24 is 12 (3x4) as there is a variation in ownership and embedding of key actions and learning. The Q4 2024/25 target score is 9 (3x3). The target is to reduce the

likelihood score to 'possible' whilst the impact remains major. Note: Quality and Safety links to patient flow articulated in BAF 7.

Items to note

- Stroke and #NOF Summary Hospital Mortality Indicator (SHMI) improved
- Implementation of Martha's rule in 2024/25 (Trust is part of the national pilot and has implemented the initiative very proactively)
- Deteriorating patient - 6% increase in senior review rates within target time
- MHA administrator – gone live on 08/07/24 with mental health metrics being developed for inclusion in Quality Integrated report. Walsall Healthcare Trust has now been secured as DGFT's new supplier of the MHA administrator service from Monday 08/07/24. The specification has been accepted and will apply on an implied basis whilst the appropriate full contract is drawn up, but DGFT can use them from Monday. The MOU for staff movement as an overarching, and then the specification and emails can be provided as evidence. In addition, the final draft of the Responsible Clinician contract has been received and formally signed. (actions completed).
- Quality impact assessments The revised policy is in its final stages and will be subject to the required sign off process. A communication to the Divisions will then take place. However, the Chief Nurse has already made the requirements clear to all senior nursing, midwifery and AHP leaders.
- Patient experience and complaints framework - Internal audit recommendations received and there is a good grip with progressing the recommended actions, with many already completed. Work remains on progressing opportunities for early resolution of concerns and preventing them from escalating to formal complaints.
- Quality account and agreed quality priorities - Quality Committee received an update on progress in July, demonstrating an overall positive position. During quarter 1, significant improvements can be demonstrated across the Clinical Effectiveness priorities. In terms of the Patient Safety and Experience priorities, positive progress has been made to achieve the required outcomes.

The links to risks that are held on Trust risk registers have been updated to reflect the current situation as of May 2024. The risk appetite is defined as Cautious.

BAF Risk 1.2: Compliance and Regulatory Failure to achieve Outstanding CQC rating and comply with external quality reviews, reports, and inspections could result in regulatory action.

Overseen by Quality Committee, last reviewed 27/08/24 and agreed to retain a 'positive' committee assurance level.

The current risk score is 12 (3x4). Updated August 24 (was 9)
Current Trust overall rating of Requires Improvement with recent CQC inspections:

- Announced Inspection of Maternity (Apr23) increased to Good overall. This increased Trust Safe Domain to Requires Improvement
- Unannounced inspection of ED (May 23); report published Nov 23. Improvement in 2 domains to Good; however, the overall rating remained as Requires Improvement
- Unannounced inspection of Children and Young People (Jun23) Report published Nov 23, overall rating increased to Good.
- However recent increase in the consequence score as a result of:
  - Announced CQC Mental Health Act monitoring visit in July 24. Regulatory compliance concern identified.
  - Delays and some non-engagement in CQC self-assessment process
  - Slow progress made with improvement actions following internal/external reviews

- Limited activity for Q&S reviews due to capacity refocused to CQC self-assessment process

Increase in number of risks aligned to BAF1.2

The target score is 6 (2x3) as there is potential for possible breaches of standards and performance challenges, but these would not be considered to pose significant challenges to resolve/recover.

The risk appetite is defined as Open.

Items to note

- The CQC self-assessment activity due date extended to October 2024
- Challenges experienced for mitigations actions include standardisation in approach to undertake self-assessment process, quality and safety reviews paused, completion of actions arising from reviews achieving minimal progress, specific workplans and escalation in place with minimal progress
- Corporate and red divisional risks updated 13.08.24

BAF Risk 2 – Failure to increase workforce capacity If the Trust fails to effectively plan for, recruit and retain people with the right skills, this may adversely impact on the Trust's ability to deliver the Trust's strategy and to deliver safe and effective care.

Overseen by People Committee, last reviewed 30/07/24 and agreed to retain a 'positive' committee assurance level.

Whilst there are existing staffing challenges, normalised vacancy levels are low, retention remains high. There has been a decrease in turnover. There is however a continuation of medical industrial action and a national shortage in some professions such as Allied Health Professionals (Radiographers).

There remain challenges around data quality, impacting on workforce planning for current and future workforce requirements (including number of staff, skill-mix, and training) which may lead to impaired ability to deliver the quantity of healthcare services to the required standards of quality; and inability to achieve the business plan and strategic objectives.

Target score 9 (3x3) (Moderate x Possible). The target risk will remain under consideration given the detailed workforce plan and potential risk. Assigned Risk appetite 'seek'.

Items to note

Proposed completion dates extended or exceeded for the following actions:

- Implement establishment control in ESR (Electronic Staff Record), to enable the analysis of vacancy, turnover and retention data: July 2024 - This work is an ongoing piece of work. The background work around position codes is in progress.
- Review of rostering solutions for Medics – benefits assessment of Allocate versus Medirota.
- Continuous promotion of the Trust's 'Stay' process: Further review in place in line with People Promise Manager in August. Review impact and outcomes Sept 24.
- Review of Occi Health SLA (service level agreements) with Wolverhampton to ensure the service maintains some stability. July 24 On track awaiting approval from RWT finance.

Items completed include:

- Integrate HR Business Partners (HRBP's) into rostering confirm and challenge meetings
- Confirm and Challenge to be in place for individuals with a high number of episodes of absences

- Ensure age profile of the workforce is known at departmental level and upskilling managers to have proactive conversations regarding retirement intentions and options
- Pre-Employment Health Questionnaire (PEHQ) processes are in place, paying particular attention to staff requiring vaccinations and areas where exposure-prone procedure (EPP) – being presented to Quality Committee in August.
- Ensure Occupational Health input into Supporting Attendance Training to improve the quality of referrals and avoiding re-signposting.
- Establish formal governance arrangements to establish a recruitment and retention group and reporting lines to People Committee.

BAF Risk 3: If issues affecting staff experience are not addressed, this will adversely impact on staff motivation, engagement and satisfaction and consequently could impact turnover, retention, and absence.

Overseen by People Committee, last reviewed 30/07/24 and retained a 'positive' committee assurance level.

The current risk score is 12 (3x4). Given the improvements in key indicators of staff satisfaction the likelihood is deemed to be 'Possible' The impact of this risk, should it be realised, would be 'Major.' There are a range of mitigating actions in place, which will reduce the risk score (Post Mitigation Risk Score) to 6 (Minor/Possible) during 2024/25.

Whilst there has been improved staff retention and reduced vacancy levels and stable sickness absence, the Trust has remained stable in terms of staff survey results, with scores performing around benchmark position for all people promises and staff engagement and morale themes.

For 2023, the Trust remains at benchmark average performance across all themes and promises. There are slight differences with four promises the same as benchmark, four slightly lower than benchmark (by 0.1) and one slightly above. Between 2022 and 2023, performance across the nine promises and themes has remained the same for three out of the nine indicators. We have improved in six out of the nine. In terms of scores, these are small changes (0.1-0.2).

Failure to maintain a coherent and co-ordinated structure and approach to succession planning, organisational development and leadership development may jeopardise: the development of robust clinical and non-clinical leadership to support service delivery and change; the Trust becoming a clinically led organisation; staff being supported in their career development and to maintain competencies and training attendance; staff retention; and the Trust being a "well-led" organisation under the CQC (Care Quality Commission) domain.

A failure to develop and maintain our culture in line with the Trust values and the NHS (National Health Service) People Promise (which includes being compassionate and inclusive, recognition and reward, having a voice that counts, health, safety, and wellbeing of staff, working flexibly, supporting learning and development, promoting equality, diversity and inclusivity and fostering a team culture) could result in; harm to staff; an inability to recruit and retain staff; a workforce which does not reflect Trust and NHS values; and poorer service delivery.

To support the Trust's financial plan, the workforce plan assumes a 4% reduction of substantive workforce and a 25% bank and agency reduction. The delivery of the above presents risks around the ability to recruit to persistent vacancies or to retain staff which could lead to the quality and quantity of healthcare being impaired, pressure on existing staff and decreased resilience, health & wellbeing, and staff morale and loss of the Trust's reputation as an employer of choice. Mitigating actions are in place, i.e. delivery of the People Plan and associated actions.

Increased financial scrutiny and additional restrictions to support delivery of the financial recovery plan are likely to negatively impact staff engagement and morale. The transfer in of DHIC staff is an unknown impact on engagement and this will need to be closely monitored to support proactive action.

The target score is 6 (2x3), The aim is to move the likelihood to 'Possible,' whilst the impact of the risk will be Minor.

Items to note

Proposed completion dates extended or exceeded for the following actions:

- Pilot flexible working profiles within job adverts. July update: flexible working group to be established from the recruitment/retention group. To be reviewed via this group. People Promise manager to review once in post in August 2024
- Continuous promotion of the Trust's 'Stay' process: Review planned by People Promise manager in Sept 24 to revisit outcomes and uptake.
- Establish Task and Finish Group on Bullying and Harassment: Formal group delayed but actions on policy, mediation and training commenced. Group to be established in Sept 2024.
- Deliver Executive and Divisional Leadership development programme: Commence profiles during Q3 and readiness to launch programme in Q4/Q1 2025/26.
- Annual promotion of Prospectus prior to Annual Review window: Awaiting redesign. Due 31/7/24

Items completed include:

- Ensure age profile of the workforce is known at departmental level and upskilling managers to have initiative-taking conversations regarding retirement intentions and options.
- Relaunch of Behaviour Framework through programme of engagement across the organisation
- All improvement training accredited with CPD (Continuing Professional Development) standard office to provide formal recognition of achievement in applying improvement skills.
- Establish formal governance arrangements to establish a recruitment and retention group reporting to People Committee

BAF Risk 4 – Financial Sustainability Failure to remain financially sustainable.

Overseen by Finance & Productivity Committee, last reviewed 29/08/24 and received a 'positive' committee assurance level.

The current risk score is 20 (5x4) based on an almost certain and major impact assessment. The Trust has set a deficit plan of £32.6m which is extremely challenging. To achieve this plan the Trust is required to deliver £31.9m CIP. The Trust will need revenue cash support of £14m from NHSE in 2024/25. The medium-term financial plan requires further work at a system level to substantiate future years efficiency plans.

The target risk score is 12 (4x3). This is based on a reduction in likelihood (from 4 to 3) but unchanged impact. This reflects the Trust having a fully identified CIP plan for 2024/25 and a clear medium-term plan showing financial sustainability.

Items to note

- The Trust is £364k ahead of its plan at the end of Month 4 with a positive variance on CIP and ERF offset by overspends relating to surge beds, pathology, drugs, CNST and industrial action.

- At month 4 reporting there is £0.537m unidentified CIP with £31.359m identified. Of the identified £26.028m is recurrent.
- Delivery of the identified CIP plan is currently forecast to be a shortfall of £6.124m.
- At the end of Month 4 the Trust is above its workforce plan by 180 WTE's. While there are some mitigations for this increase the delivery of this CIP is now a high risk with divisions forecasting circa £6m shortfall. The Trust will need to identify further CIP schemes to mitigate this shortfall on delivery.
- As at the end of July ERF is performing well with the Trust overperforming against the internal plan by £0.537m and against the NHSE plan by £4.063m.

BAF Risk 5 – Carbon Emissions Reduction
Failure to successfully adapt and reduce carbon emissions due to competing organisational and PFI pressures and availability of resources, resulting in a failure to meet targets set by NHSE and outlined within the Health and Social Care Act (2022). The resulting impact will cause risk in the following areas: regulatory, financial, workforce, patient safety, and increased health inequalities.

Overseen by Finance & Productivity Committee, last reviewed 25/04/24 and received a 'positive' committee assurance level.

The current risk score is 12 (3x4). This is because we still developing our understanding of what actions will have the biggest change on carbon emissions. A baseline has been published but actions particularly around decarbonisation of the estate will only demonstrate impact over a longer time frame. The impacts of climate change are here now, and the Trust needs to adapt to ensure risk and impact are mitigated. The target score is 8 (4x2). The Trust needs to develop appropriate plans to ensure that this is unlikely, whilst the impact would remain major.

The Committee agreed to receive an update every six months with the next report due October 2024.

BAF Risk 6 – Build Partnerships Failure to successfully build innovative partnerships due to competing organisation pressures, priorities and historic actions results in the Trust being unable to transform clinical services, improve the outcomes of our local population and develop our future workforce. The resulting impact will cause a risk to the following areas: regulatory, financial, workforce, patient outcomes, operational performance, and Trust reputation.

Overseen by Integration Committee, last reviewed 28/08/24 and retained a 'positive' committee assurance level.

To note residual score for BAF 6 is 12 (3x4). This is based on a possible and major impact assessment. The impact is assessed as major as the health outcomes of our population will not improve without us working in partnership to deliver transformation. There will also be an impact on our reputation.

The target score is 8 (2x4). The Trust should be making appropriate plans to ensure that this is 'unlikely', whilst the impact would remain 'major'. Risk appetite is Open.

Items to note
The following updates have been applied.
- The following items are complete:
    - Develop work plan of opportunities to work with Dudley College and Dudley Academy Schools (Deputy Director of Strategy)

    - Memorandum of Understanding agreed and approved by Integration Committee in June between the Trust and Dudley Academy Schools
- The following actions planned completion date has been amended:
    - Dudley Stakeholder map and management plan to be updated and refreshed regularly

BAF Risk 7 – Achieve Operational Performance/Strategic goals Failure to achieve operational performance requirements and deliver strategic goals and potential to be subject to regulatory action.

Overseen by Finance & Productivity Committee, last reviewed 29/08/24 and received a 'positive' committee assurance level.

The current risk score remains 20 (5x4). This is on the basis that the current likelihood is "almost certain". The impact of this risk, should it be realised, for the Trust's services, is 'major'. The target score is 12 (3x4). The aim is to reduce the likelihood to "possible", whilst the impact would remain 'major'.

Items to note

- Risk profile changed due to the risk regarding Theatres & the impact on elective targets. There may also be a financial risk in loss of income during this period, however the Surgical Division is working at pulling back activity & income once we have full cover
- ED Redesign has now commenced which has seen the loss of 6 cubicles within the ED footprint and a further 2 cubicles within AMU assessment
- Opening of MMUH is scheduled for October, we are awaiting confirmation
- Mitigations regarding the opening of MMUH have now been in an ICB and Board approved paper which has general support for implementation as they mainly include community based proposals.

BAF Risk 8 – IT & Digital infrastructure If DGFT does not establish, invest and sustain, the resources, infrastructures, applications and end-user devices for digital innovation THEN the Trust's operational performance and strategic objectives will not be delivered or risk major disruption in the event of a cyber-attack.

Previously overseen by Digital Committee, last reviewed by the F&P Committee 25/07/24 and retained a 'positive' committee assurance level. Following the dissolution of the Digital Committee in May 2024, it was agreed that BAF 8 would now be reviewed and monitored bi-monthly by the Finance & Productivity Committee; the document will be submitted to the September meeting.

Next Steps

To note that the Trust's Risk Management Framework has been subject to review and will be submitted to the Audit Committee in late September ahead of circulation.
There will be further Board development workshop activity in December to finalise the BAF risks and appetite aligned to the work underway to refresh the Trust strategy.

Alert

None

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

3. Report journey
Public Trust Board – 12th Sept 2024

4. Recommendation(s)
The Public Trust Board is asked to:
a) **Approve** the updates made since the last meeting
b) **Note** ongoing work embed effective risk management with further Board development workshop activity being scheduled for 2024/2025

5. Impact		
Board Assurance Framework Risk 1.1	X	Deliver high quality, safe person centred care and treatment
Board Assurance Framework Risk 1.2	X	Achieve outstanding CQC rating.
Board Assurance Framework Risk 2.0	X	Effectively manage workforce demand and capacity
Board Assurance Framework Risk 3.0	X	Ensure Dudley is a brilliant place to work
Board Assurance Framework Risk 4.0	X	Remain financially sustainable in 2023/24 and beyond
Board Assurance Framework Risk 5.0	X	Achieve carbon reduction ambitions in line with NHS England Net Zero targets
Board Assurance Framework Risk 6.0	X	Deliver on its ambition to building innovative partnerships in Dudley and beyond
Board Assurance Framework Risk 7.0	X	Achieve operational performance requirements
Board Assurance Framework Risk 8.0	X	Establish, invest and sustain the infrastructures, applications and end-user devices for digital innovation
Is Quality Impact Assessment required if so, add date:		
Is Equality Impact Assessment required if so, add date:		

Summary Board Assurance Framework (BAF): August 2024 update

The key elements of the BAF are:

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

Tables relating to scoring and ratings are given on page 2. *'No move indicates no change from last report'*

					Ratings as reported at June 2024				
ID	**Area**	**Risk Description**	**Lead Exec**	**Lead Committee**	**Inherent Risk score**	**Current Residual Risk score**	**Target Risk Score**	**Risk Appetite**	**Committee Assurance Rating/** last reviewed
1.1	Quality: Safe, High-Quality Care	Failure to deliver high quality, safe, person centred care and treatment resulting in incidents of avoidable harm and poor clinical outcomes.	Medical Director Chief Operating Officer Chief Nurse	Quality	**20** (4x5)	→ **12** (3x4)	**9** (3x3)	**Cautious**	**Inconclusive** *27/08/24*
1.2	Compliance and Regulation	Failure to achieve Outstanding CQC rating and comply with external quality reviews, reports, and inspections could result in regulatory action	Director of Governance	Quality	**20** (4x5)	↑ **12** (3x)	**9** (3x3)	**Open**	**Positive** *27/08/24*
2	Workforce	Failure to effectively manage workforce demand and capacity to deliver Trust Strategic Objectives	Chief People Officer	People	**20** (4x5)	→ **9** (3x3)	**9** (3x3)	**Seek**	**Positive** *27/08/24*
3	Staff satisfaction	Failure to ensure Dudley is a brilliant place to work and thrive will impact turnover, retention, and absence.	Chief People Officer	People	**15** (3x5)	→ **12** (3x4)	**6** (2x3)	**Open**	**Positive** *27/08/24*
4	Finance	Failure to remain financially sustainable in 2024/25 and beyond	Director of Finance	Finance and Productivity	**20** (4x5)	→ **20** (5x4)	**12** (4x3)	**Open**	**Positive** *29/08/24*
5	Environmental	Failure to achieve carbon reduction emissions in line with NHS England Net Zero targets	Director of Finance	Finance and Productivity	**16** (4x4)	→ **12** (3x4)	**8** (4x2)	**Open**	**Positive** *25/04/24*
6	Partnerships	Failure to deliver on its ambition to build innovative partnerships in Dudley and beyond	Director of Integration	Integration Committee	**16** (4x4)	→ **12** (3x4)	**8** (2x4)	**Open**	**Positive** *28/08/24*
7	Operational Performance	Failure to achieve operational performance requirements and deliver strategic goals	Chief Operating Officer	Finance and Productivity	↑ **25** (5x5)	→ **16** (4x4)	**12** (3x4)	**Open**	**Positive** *27/08/24*
8	IT and Digital Infrastructure	Failure to establish, invest and sustain, the resources, infrastructures, applications and end-user devices for digital innovation	Executive Chief Strategy & Digital Officer	Finance and Productivity	**25** (5x5)	→ **16** (4x4)	**16** (4x4)	**Open**	**Positive** *27/06/24*

Risk Scoring Levels

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

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

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

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

Risk Scoring =Consequence x Likelihood (C x L)

Committee Assurance Level *descriptors updated March '23*

Positive	The committee is satisfied that the current approach to managing this strategic risk is appropriate and effective. Prompt and proportionate action is being taken to close any gaps in control or assurance, providing confidence that we can reduce the risk to its target score within twelve months.
Inconclusive	Progress is being made to close gaps in controls and assurance but not all actions have been completed on time or have yet had the desired impact. It is uncertain whether the current approach to managing this strategic risk will be sufficient to reduce the level of the risk to the target score within twelve months.
Negative	There has been a lack of progress with the actions necessary to manage this risk. The level of risk may also have increased significantly since the risk was originally assessed, due to factors outside of the trust's direct control. The current approach to managing this strategic risk is unlikely to be effective and requires major revision

This approach informs the agenda and regular management information received by the relevant lead committees, to enable them to make informed judgements as to the level of assurance that they can take, and which can then be provided to the Board in relation to each Principal Risk and also to identify any further action required to improve the management of those risks.

Risk Appetite	Descriptor
None	Avoidance of Risk is a key organisational objective
Minimal	Preference for very safe delivery options that have a low degree of inherent risk and only a limited reward potential
Cautious	Preference for safe delivery options that have a low degree of residual risk and only a limited reward potential
Open	Willing to consider all potential delivery options and choose whilst also providing an acceptable level of reward
Seek	Eager to be innovative and to choose options offering higher business rewards (despite greater inherent risk)
Significant	Confident in setting high levels of risk appetite because controls, forward scanning and responsive systems are robust

Performance KPIs

August Report (July 2024 Data for National Performance & June 2024 Data for Cancer & VTE)

Karen Kelly, Chief Operating Officer

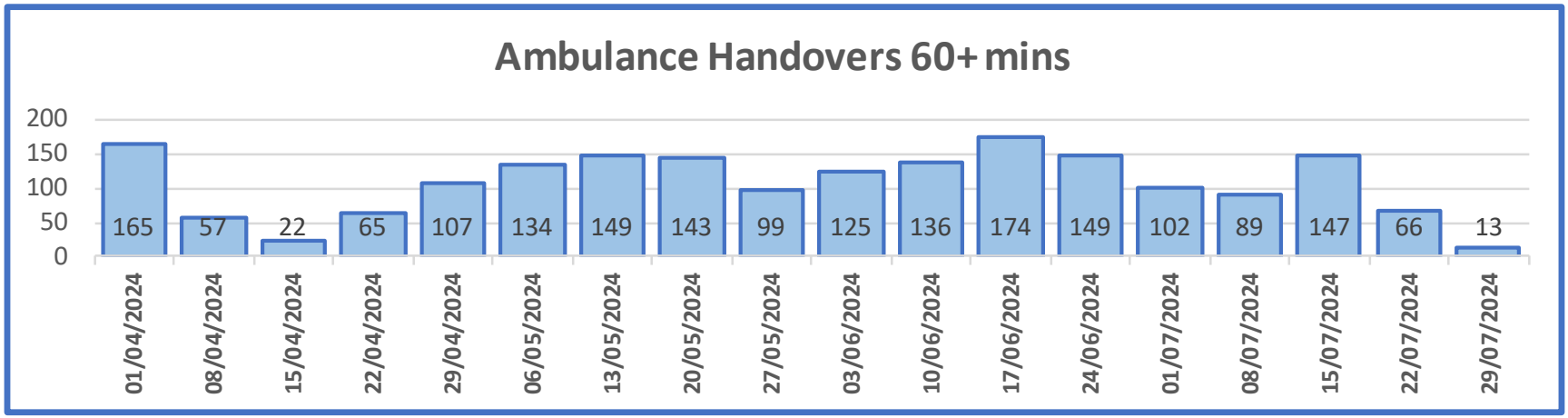
The Dudley Group NHS Foundation Trust

Constitutional Targets Summary	Page 2
ED Performance	Pages 3-10
Cancer Performance	Pages 11-13
RTT Performance	Pages 14-15
DM01 Performance	Pages 16-17
VTE	Page 18
Screening Programmes	Page 19
Kitemark Explanation	Page 20

Constitutional Performance

Constitutional Standard and KPI		Target	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24		
Emergency Access Standard (EAS)	Combined 4hr Performance	78.0%	74.5%	72.8%	74.1%	72.5%	72.9%	71.5%	71.9%	73.8%	78.7%	80.3%	81.2%	81.6%	79.9%		
Triage	Triage - All	95.0%	79.5%	80.2%	73.3%	71.0%	74.0%	78.0%	84.3%	73.3%	71.0%	74.0%	78.1%	84.3%	80.6%		
Referral to Treatment (RTT)	RTT Incomplete	92%	56.7%	55.6%	55.6%	55.5%	55.0%	55.2%	55.8%	56.2%	56.5%	57.8%	58.2%	58.6%	58.6%		
Diagnostics	DM01 - Diagnostics achieved within 6 weeks	85%	67.4%	64.4%	66.6%	68.9%	70.3%	71.5%	79.7%	90.6%	91.3%	89.6%	88.4%	86.9%	88.3%		
VTE	% Assessed on Admission	95%	98.3%	99.1%	99.0%	98.9%	98.9%	99.1%	99.1%	99.3%	99.3%	98.9%	98.7%	99.0%	N/a		

Ambulance Handovers 60+ Mins



Performance

This month's activity saw 9,085 attendances. This has increased when compared to the previous month of June with 8,988 - 15 out of the 31 days saw >300 patients.

2930 patients arrived by ambulance; this shows an increase from the 2763 ambulances that attended last month.

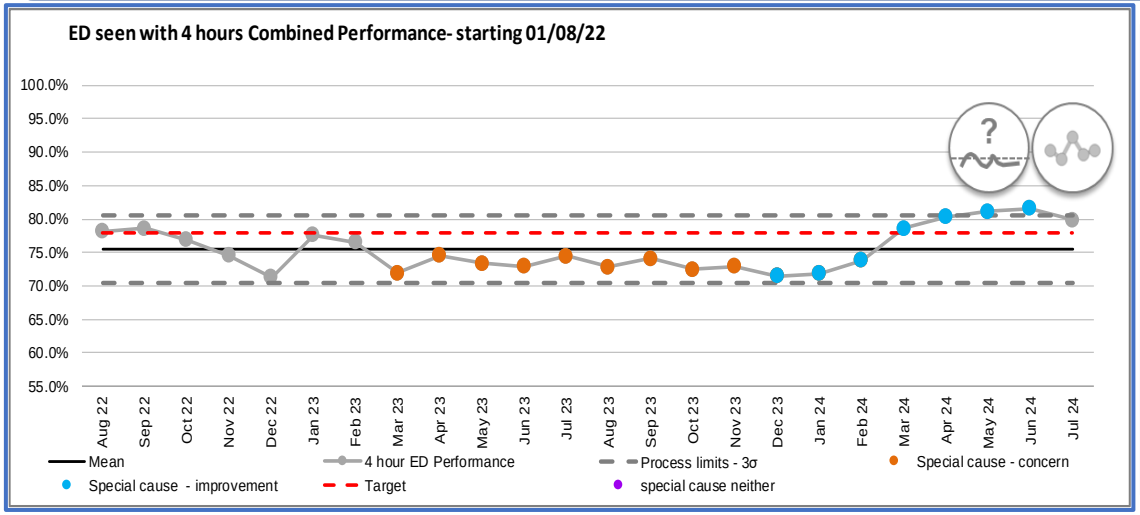
287 of these offloads took >1hr (10%). This shows an improvement when compared with last month's performance of 18%.

Over the month, the average length of stay (LOS) in ED was 212 mins for non-admitted patients and 428 mins for those waiting for a bed following a decision to admit. This is a 30% (132 minutes) decrease in waiting time for patients to be admitted compared to last month at 560 minutes.

Action

- Continue to use RAT for all ambulance patients to ensure assessment, treatment and medication are given quickly.
- Mental health team to be present within the department overnight to provide support and guidance for patients attending and requiring mental health assessments. Mental health referrals are to be explored with a telephone referral rather than a bleep. This is to decrease the long wait it can take for a bleep referral to be acknowledged.
- Escalation of ambulances without a plan to offload at 30mins to Site Team with additional role cards to link AMU & Site teams based on the Kings College Model.
- Additional trolley capacity now in place to ensure offloads can happen promptly at the ambulance entrance.
- Streamers and triage nurses continue to utilise pathways as early as possible and sit out suitable patients to free up ambulance.
- Designated ED Tracker monitoring ambulance offloads/pinning. Regular escalation to both halo, site, ops management and NIC
- ED operational escalation bleep initiated through office hours and point of contact for urgent escalations

ED Performance



Latest Month	Latest Month	4th
79.9%	89	For July 2024
EAS 4 hour target 78% for Type 1 & 3 attendances	DTA 12 hour breaches - target zero	DGFT ranking out of 13 West Midlands area Trusts

Performance

ED has gone through three weeks of floor works which has significantly and adversely affected our footprint to see and treat patients affecting our triage performance this month. Despite these works though we saw only a 2% drop compared to an anticipated 4% - July 4 hour combined performance at 79.9% vs 78% national target.

Last months data have allowed for identification of themes and increased focus on these have been:

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

Action

- Deputy Matrons are further highlighting 4h performance whilst on clinical floor to teams.
- Continued scrutiny that GP letters are being directly streamed to appropriate area to avoid being booked into ED.
- Focus now on NHSE's 5 priority ED improvement initiatives
  - Streaming & Redirection
  - Rapid Assessment & Treatment
  - Maximising UTC use
  - Improving Ambulance Handover process
  - Reducing the time in department

ED 4 Hour Waits Benchmarking

National 4 hour EAS Target Comparison

This is based on trust activity for the following:
Inclusion of Type 1-4
Inclusion of 111 booked activity for all types

July 2024

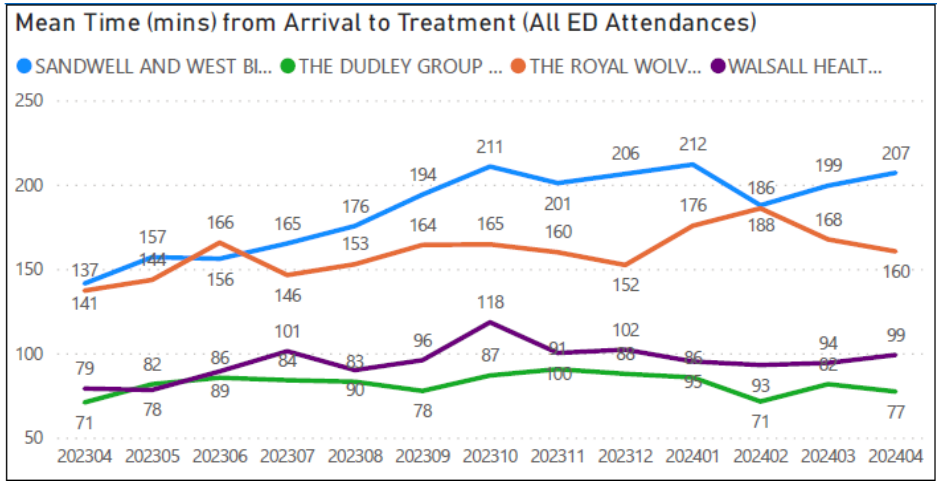
Latest Refresh
19/08/2024 13:22:50

Name	Value	National Rank
Birmingham Women's And Children's NHS Foundation Trust	87.05%	5
The Royal Wolverhampton NHS Trust	80.90%	14
Walsall Healthcare NHS Trust	80.03%	17
The Dudley Group NHS Foundation Trust	79.90%	18
George Eliot Hospital NHS Trust	74.60%	43
South Warwickshire NHS Foundation Trust	74.50%	44
University Hospitals Of North Midlands NHS Trust	71.17%	75
Sandwell And West Birmingham Hospitals NHS Trust	70.07%	80
Wye Valley NHS Trust	68.32%	91
Worcestershire Acute Hospitals NHS Trust	66.68%	94
University Hospitals Coventry And Warwickshire NHS Trust	66.06%	100
University Hospitals Birmingham NHS Foundation Trust	62.41%	114
The Shrewsbury And Telford Hospital NHS Trust	54.67%	121

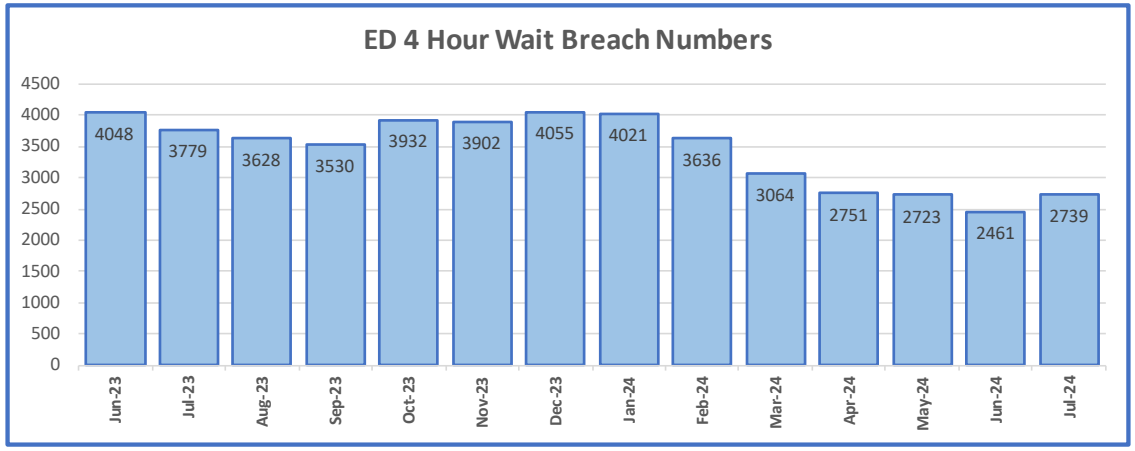
DGH

Ranking out of 122 Trusts

Source: Daily EAS - Power BI



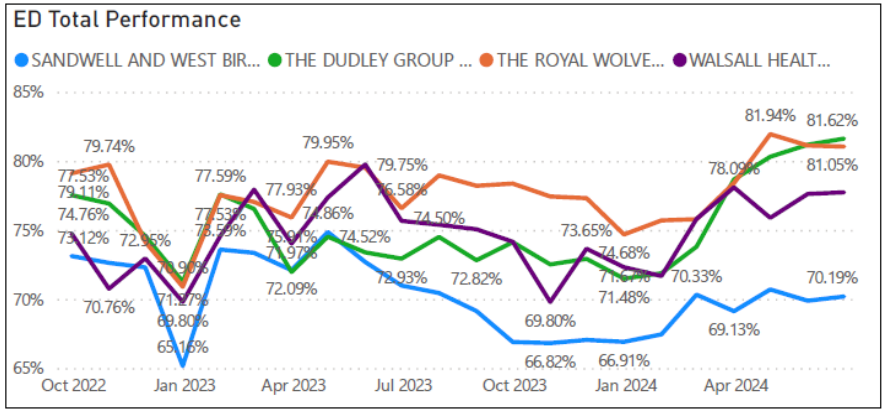
ED 4 Hour Wait Number of Breaches



Date	No Breaches
Jun-23	4048
Jul-23	3779
Aug-23	3628
Sep-23	3530
Oct-23	3932
Nov-23	3902
Dec-23	4055
Jan-24	4021
Feb-24	3636
Mar-24	3064
Apr-24	2751
May-24	2723
Jun-24	2461
Jul-24	2739

Performance

ED has gone through three weeks of floor works which have significantly and adversely affected our footprint to see at treat patients affecting our triage performance this month. Despite these works though we saw only a 2% drop compared to an anticipated 4%.

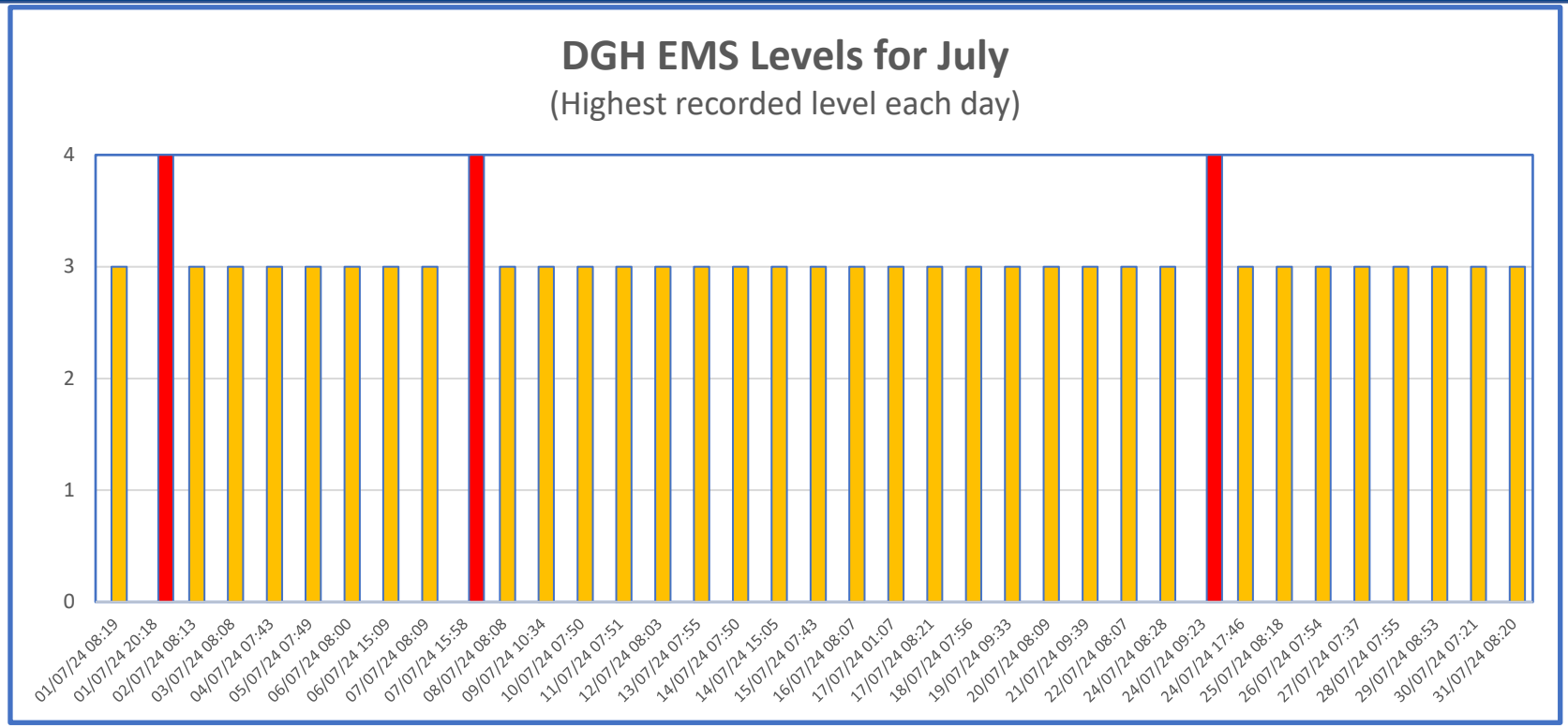


Action

- The ED performance for July remains above the national target of 78% at 79.90%
- Last months data have allowed for identification of themes and increased focus on these have been:

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

EMS Level for last month



Performance

EMS Levels 3/4 during July.

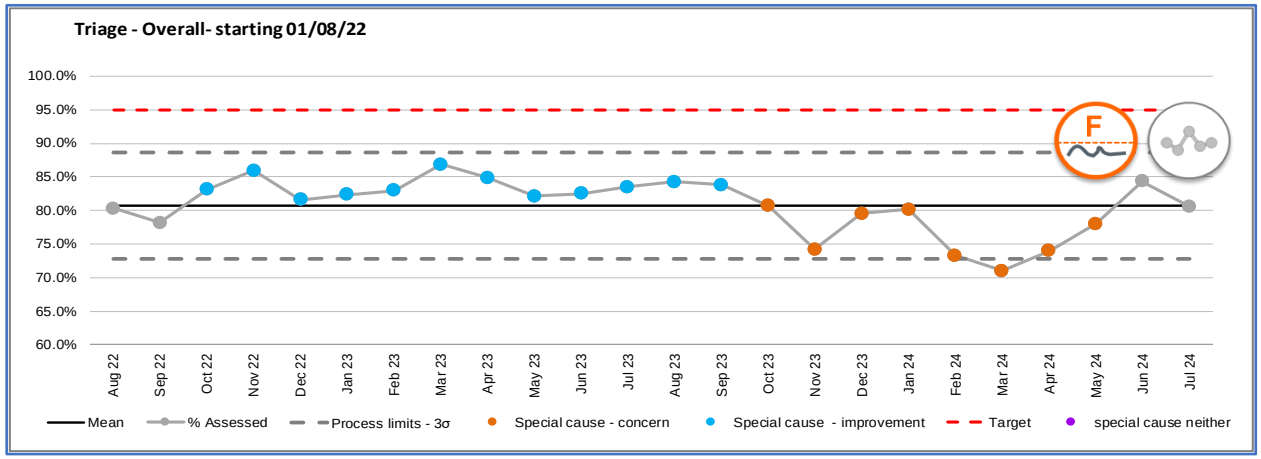
There has been an increase in performance in ambulance handover for both >30 mins and handovers >60mins.

14 out of the 31 days we have seen >300 patients attend ED. Attendance figures for July did not go below 254. In terms of capacity the trust continues to be impacted by medically optimised for discharge patients, which is further exacerbating flow issues and leading to pressure at both the front and back door.

Action

- To continue to utilise non-admitted pathways wherever possible.
- Maintain step downs from acute areas to ensure provision available for the highest acuity patients.
- Focus now on NHSE's 5 priority ED improvement initiatives
  - Streaming & Redirection
  - Rapid Assessment & Treatment
  - Maximising UTC use
  - Improving Ambulance Handover process
  - Reducing the time in department

ED Triage



Latest Month

80.57%

Triage – target 95%

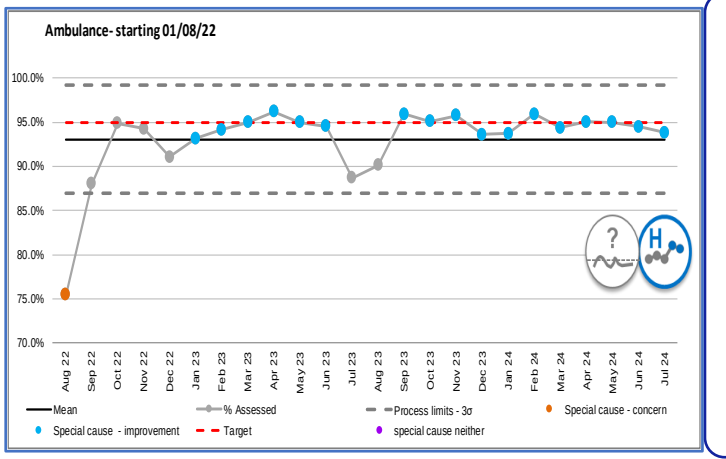
Performance

ED has gone through three weeks of floor works which have significantly and adversely affected our footprint to see at treat patients affecting our triage performance this month. Despite these works though we saw only a 2% drop compared to an anticipated 4%.

Action

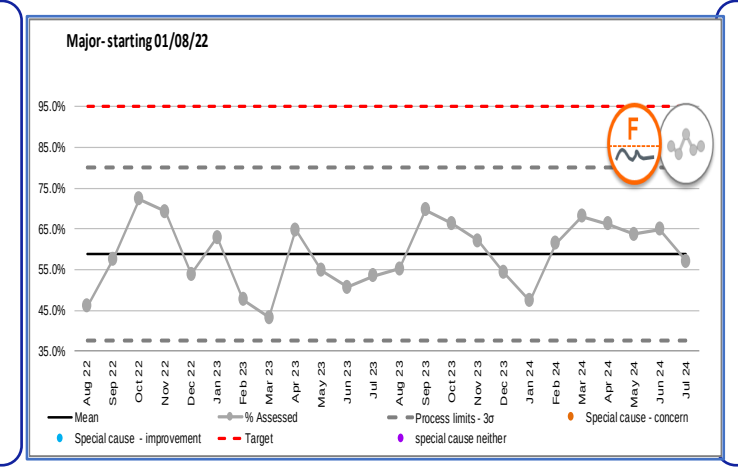
- Deputy Matron now leading on Triage improvement from October.
- Triage project has completed, and assurance report was submitted and presented to the execs with positive feedback.
- ED assurance report now submitted monthly to Execs.
- Daily triage continues to be monitored by the Deputy Matron.
- Front door triage demand continues to be higher than the available capacity of area and staff.
- New lead nurse for both majors and paediatrics have commenced in post from Monday 18th March.
- More nurses have received their ESI training with additional codes which have been purchased.

ED Triage



Latest Month

93.9%



Latest Month

57.1%

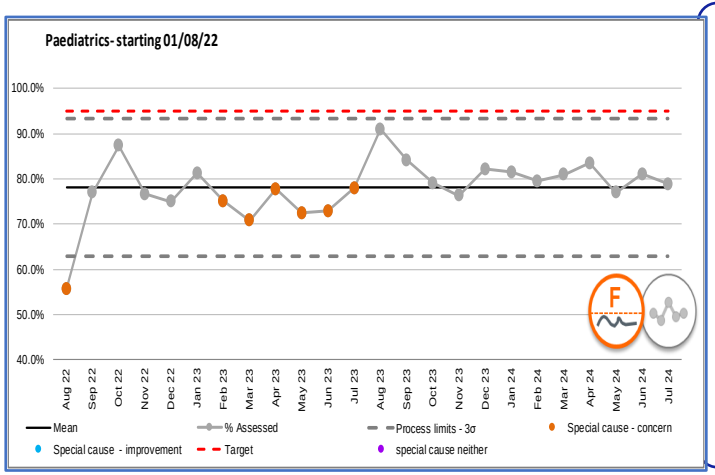
Performance

ED has gone through three weeks of floor works which have significantly and adversely affected our footprint to see at treat patients affecting our triage performance this month. Despite these works though we saw only a 2% drop compared to an anticipated 4%.

Action

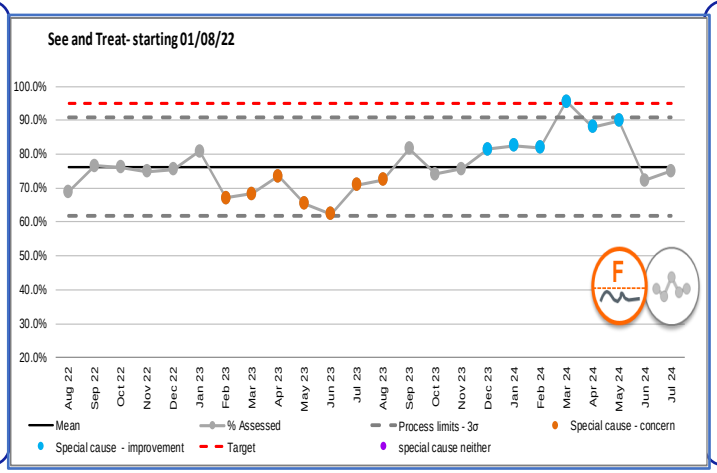
- Time spent in triage continues to be monitored
- Increased focus in direct to speciality patients being sent from UCC rather than being triaged in ED

ED Triage



Latest Month

78.9%



Latest Month

75.0%

Performance

ED has gone through three weeks of floor works which have significantly and adversely affected our footprint to see at treat patients affecting our triage performance this month. Despite these works though we saw only a 2% drop compared to an anticipated 4%.

Action

- Paeds daily huddles have restarted to good effect and triage performance and escalations are discussed.
- Paediatric Lead nurse commenced in post from 18th March.
- Develop process for quickly monitoring and altering when minor's patients need to begin having early "eyes on" assessments rather than just seeing and treating patients all in one go – this is being developed and supported by Nurse/ENP/Medical teams.
- New minors Nursing role (band 6) focused on triage and treatments have commenced in post and actively working on increasing performance.
- ACP trial to commence from Monday 25th March increasing the scope of injuries which can be treated in minors.

Cancer

	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24
28 Day Combined (75%)	83.6%	80.1%	76.9%	81.9%	87.2%	82.4%	82.5%	87.6%	81.2%	78.3%	83.9%	83.2%
31 Day Combined (96%)	84.6%	86.9%	85.0%	86.9%	81.4%	87.6%	81.1%	89.8%	86.7%	91.6%	92.2%	90.3%
62 Day Combined (85%)	69.5%	70.5%	67.1%	67.1%	68.1%	68.0%	58.3%	67.7%	71.5%	71.9%	66.8%	70.2%

Latest Month	Latest Month	Latest Month
83.2%	90.3%	70.2%
All cancer 28 Day FDS waits – target 77%	31 day Combined Target 96%	62 Day Combined Target 70%

Performance

*All cancer data reports two months behind. Data included is up to and including June 2024:

<u>28-day Faster Diagnosis Standard (FDS)</u>

- Performance achieved 83.2% which is above the constitutional target standard of 77%.

<u>31 day combined</u>

- Performance achieved 90.3% against the constitutional target of 96%. One of the main challenges is surgical capacity.

<u>62 day combined</u>

- Performance achieved 70.2% which is above the national target of 70%. NHSE target is to achieve 70% by the end of March 2025. (This target does not supersede the 85% constitutional standard but set to support tiering measures for cancer performance)

Action

<u>28-day FDS</u>

- To sustain performance

<u>31 day combined & 62 combined</u>

- Increased focus on the 31-day target when escalating for treatments going forward and ensuring data validation is undertaken monthly.
- Weekly PTL meetings to incorporate 31-day decision to treat date in addition to 62-day decision to treat date.
- Unvalidated 31-day performance shows improvement at 93%
- CDC Dermoscopy in place with plans to expand. The service supports dermatology referrals for suspected cancers. Patients receive imaging in the community setting to support robust triage of referrals to ensure that we rapid access capacity utilised appropriately. Only 50% of patients currently get a rapid access appointment.
- Unvalidated 62-day performance shows improvement at 72%

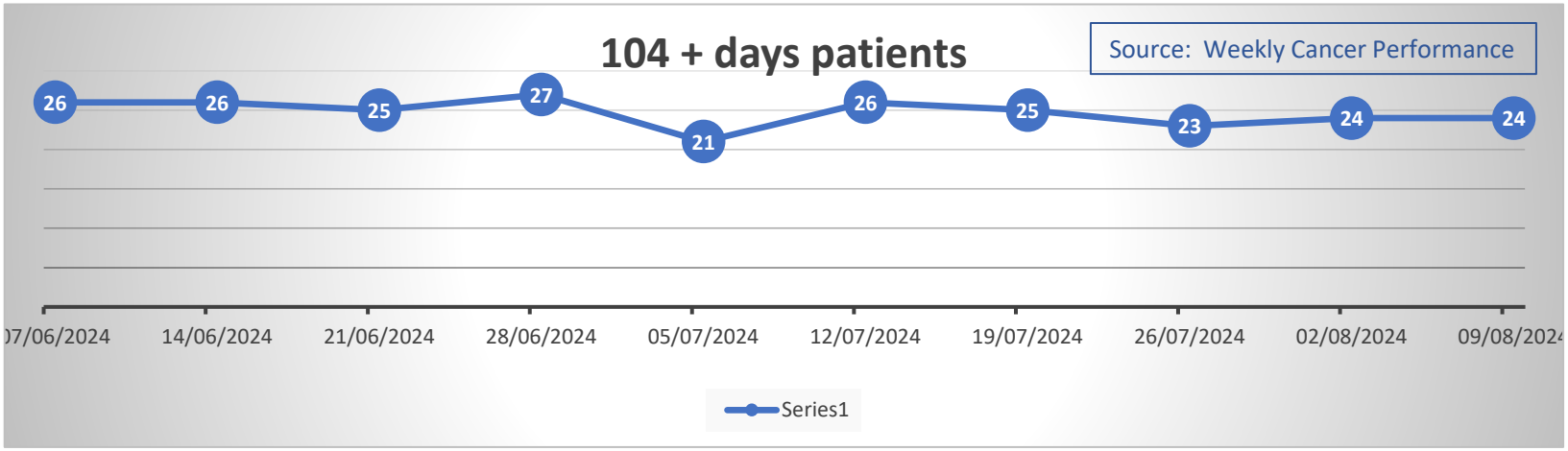
<u>BCPS</u>

- e-requesting went live on the 07/08/2024. Based on initial response compliance is forecasted to achieve 35% by end of August.

<u>COSD</u>

- As a Trust we achieved above 80% stage completeness in the Cancer Outcomes and Services Dataset (COSD) submissions for the whole of 2023.

Cancer Performance – 104 Day – Harm Review



Latest Week

(09/08/24)

24

All 104 week waits, target 10 Patients

Performance

Of the 24 over 104 days patients, urology remains the most challenged pathway with 14 patients waiting over 104 days.

2 of the 24 104+ day patients are tertiary referrals from other Trusts for Urology (Robotic Renal work).

12 of the 24 breaches have treatment plans / treatment dates. Those without treatment plans were awaiting surgery dates, best interest meetings or further investigations.

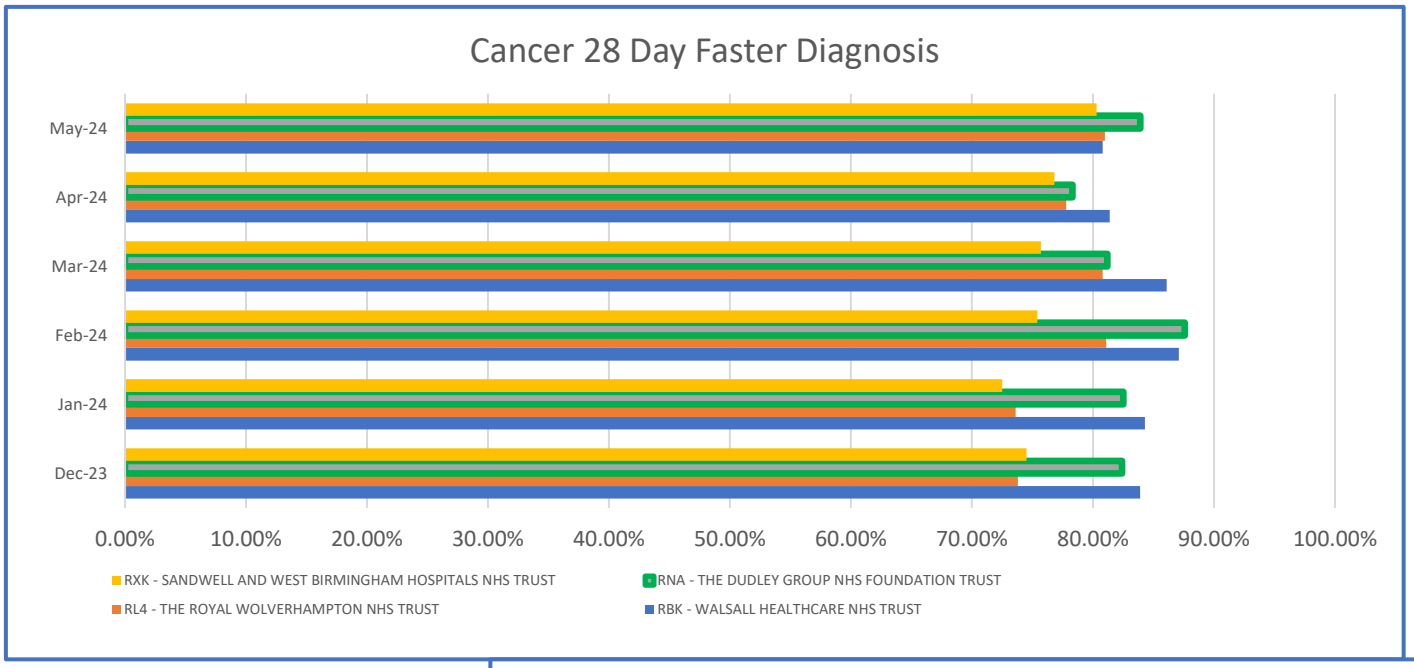
Following harm review, there were 0 patients for June (reported 2 months in arrears).

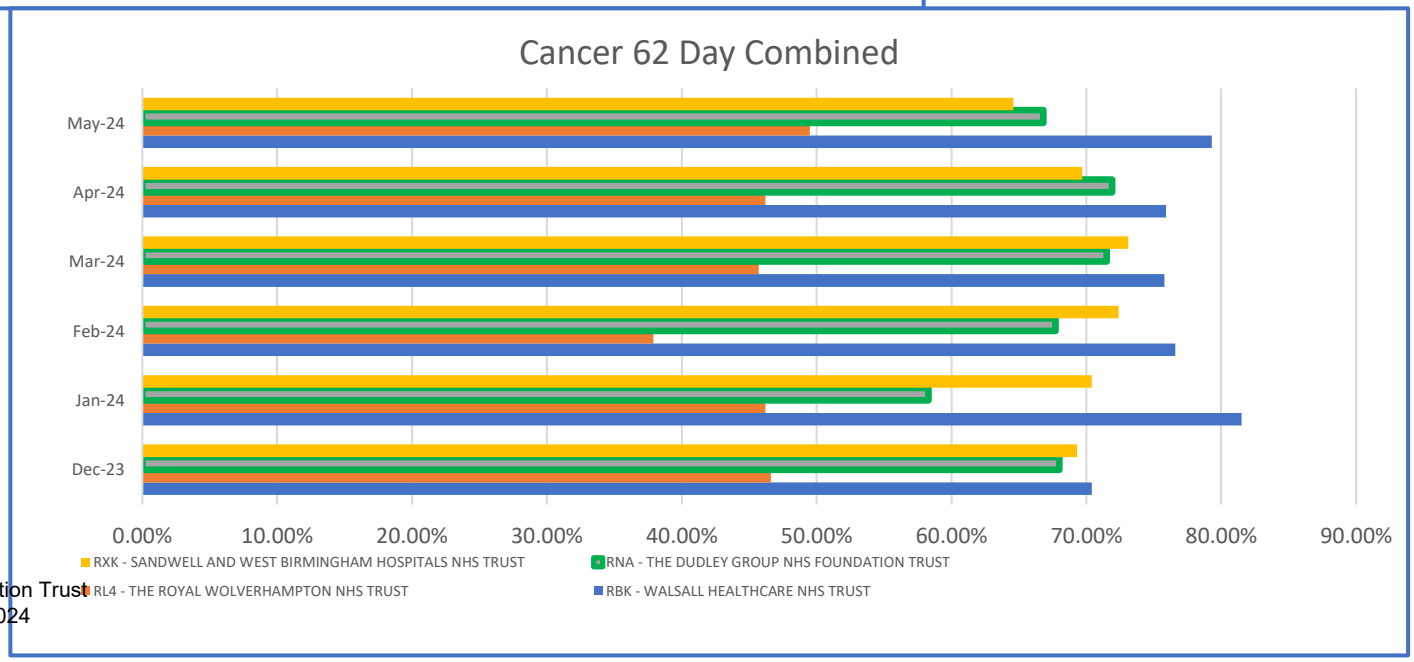
June reported 24 patients waiting over 104 days.

Action

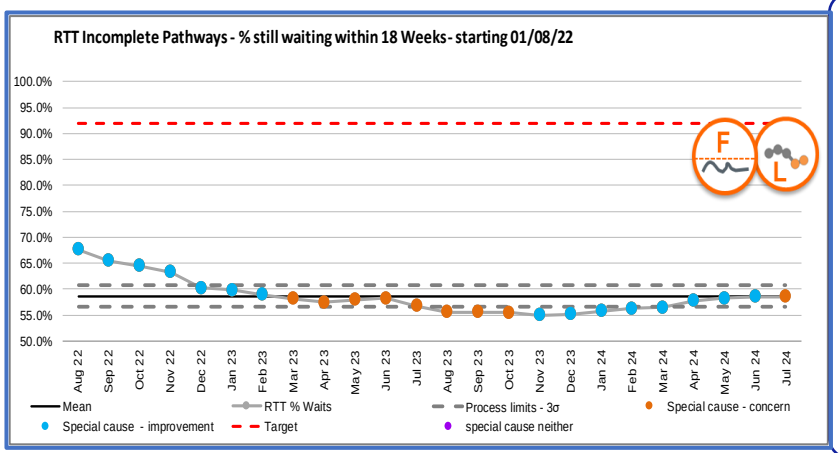
- Monthly harm review undertaken for patients waiting over 104 days on the cancer pathway. No harms identified for March.
- Focus on reducing the backlog of 104 day waits to release treatment capacity for 31 day and 62-day targets continues. Improve patient engagement earlier in the pathway.
- It is anticipated that actions taken to improve combined 62-day performance will support the reduction of patients waiting over 104 days.

Cancer Benchmarking





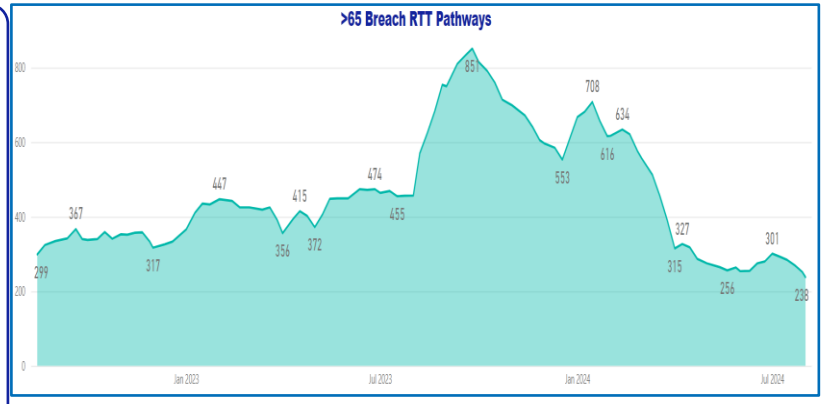
RTT Performance



Latest Month

58.6%

RTT Incomplete pathways target 92%



Taken from: RTT Incompletes - Post Validation Analysis - Power BI Report Server

Performance

July is the first month since November 2023 where the RTT performance has remained the same. This is an impact of the last round of industrial action, and it is anticipated that this will again improve in August. This continues to not be monitored with the key focus being on ensuring that we are clearing the longest waiting patients from our waiting list.

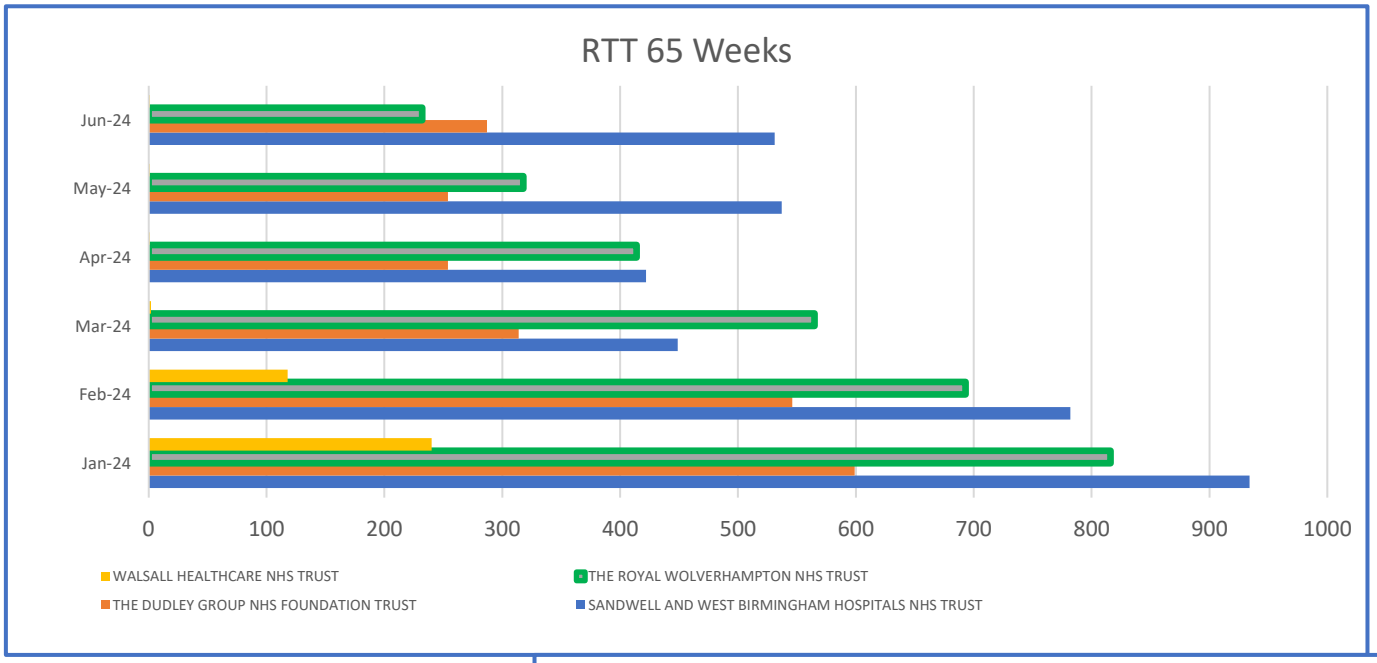
The trust continues to perform well against both the 78- and 65-week targets for both elective and outpatient procedures, acknowledging challenges particularly in General Surgery, Pain and Chemical Pathology. We are currently on track to deliver 65-week clearance at the end of September.

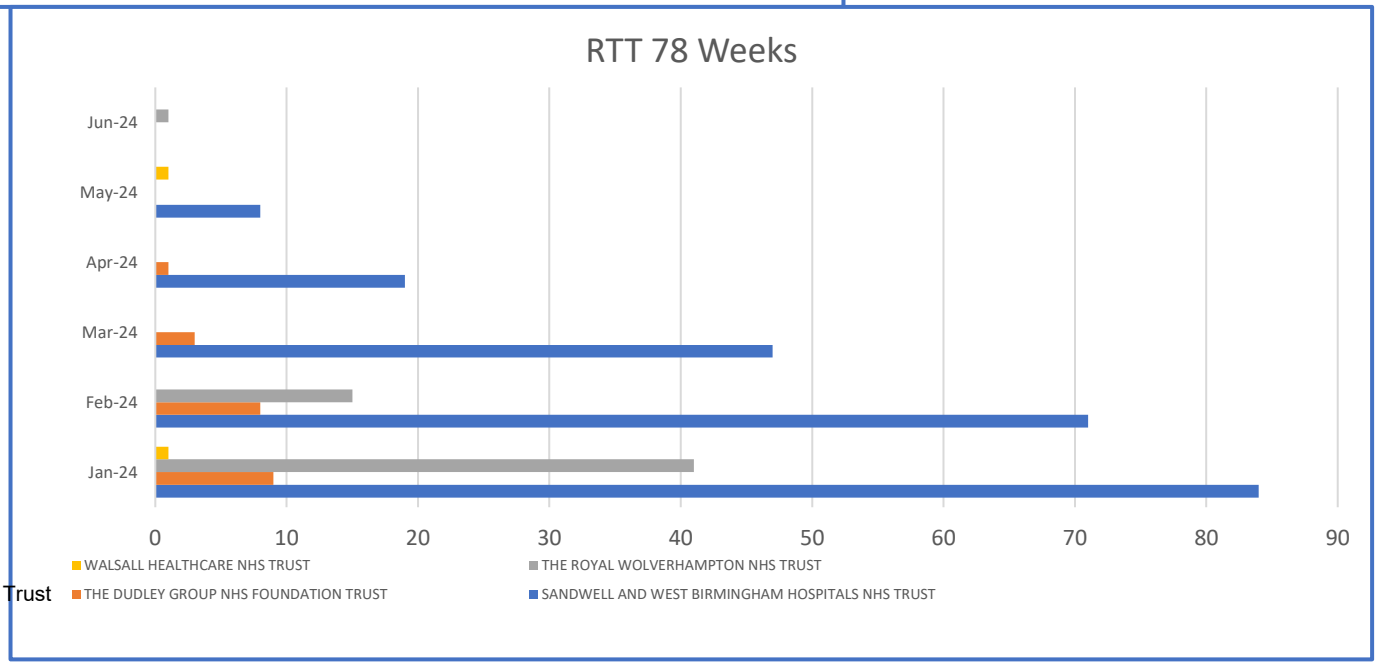
July RTT position 58.6% vs 92% national target, a continued improvement month on month

Action

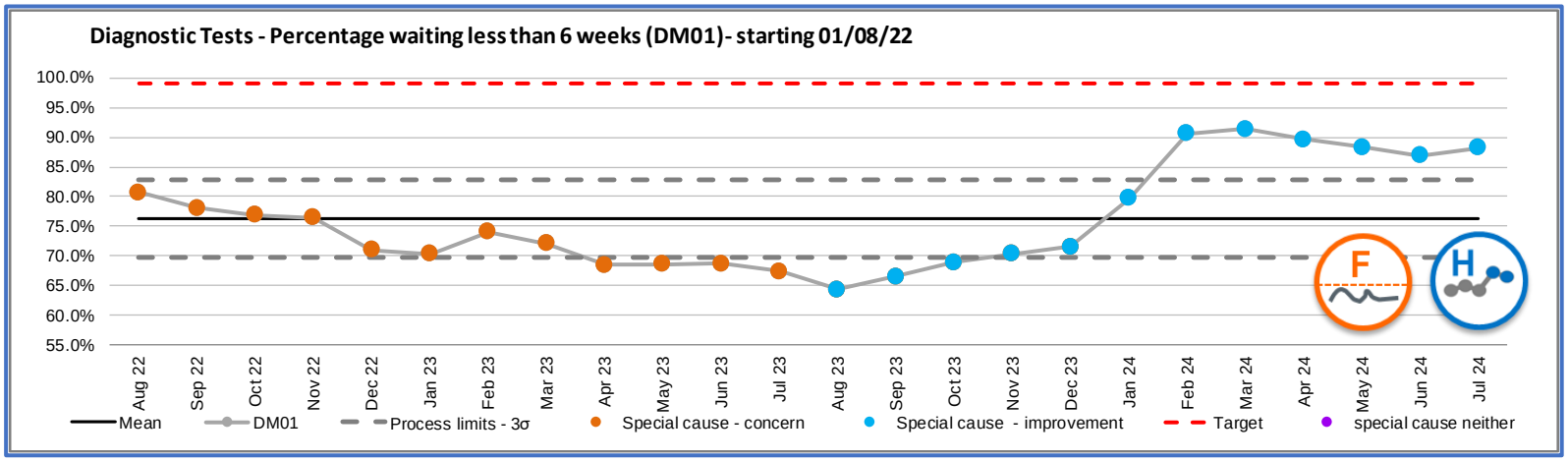
- Outsourcing to support Neurology, Dermatology & Gynaecology long waiters which is proving effective. We are now looking to exit from outsourcing in Gynaecology as our in-house position is now more robust.
- Continue to engage with the Further Faster Programme, a particular focus on Ophthalmology at present.
- With the 52-week target fast approaching in March 25 we are now looking to book all 52-week first outpatient appointments that would breach in March 25 by the end of November 24. This is a challenging ask, but the teams are currently working on plans to achieve.

RTT Benchmarking





DM01 Performance



Latest Month

88.3%

DM01 combining 15 modalities - target 85%

Performance

July DM01 performance achieved 88.3% and is an improved position compared to 86.9% in June

All modalities are achieving above 90% with exception of NOUS, Audiology and Sleep Studies

NOUS has improved from 86.9% to 89.7% in July. Number of 6 week breaches have reduced from 553 to 374

Audiology has slightly improved from 77.8% to 78.2% in July

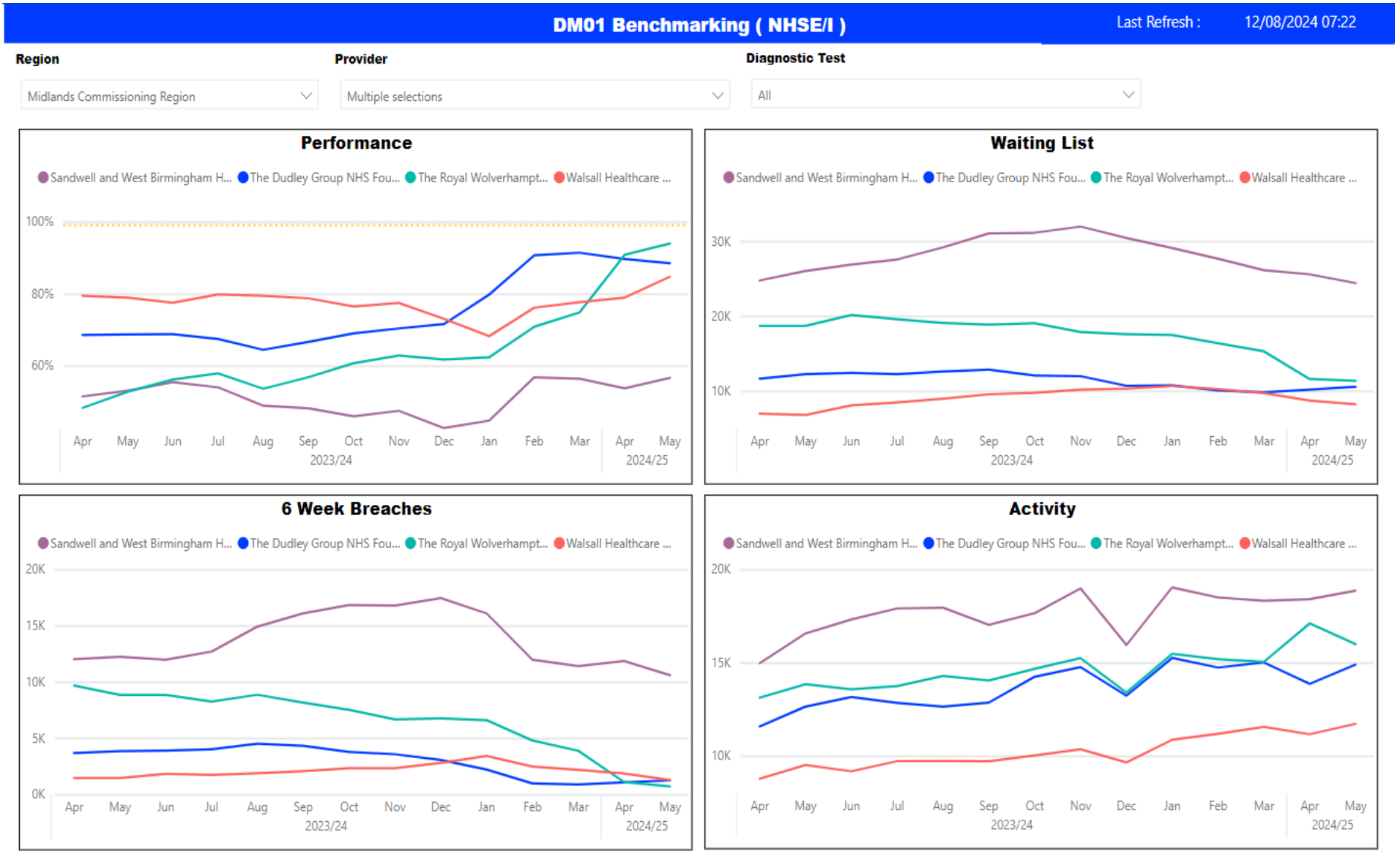
Sleep studies remains significantly low at 56.2% compared to 55.9% in June

13-week diagnostic breaches and route to zero are monitored weekly by NHSE. Areas of focus for further reduction are MRI and NOUS with plan to clear 13 week waits by September and November respectively. There has been a significant reduction in NOUS 13 week breaches from 72 in June to 5 in July

Action

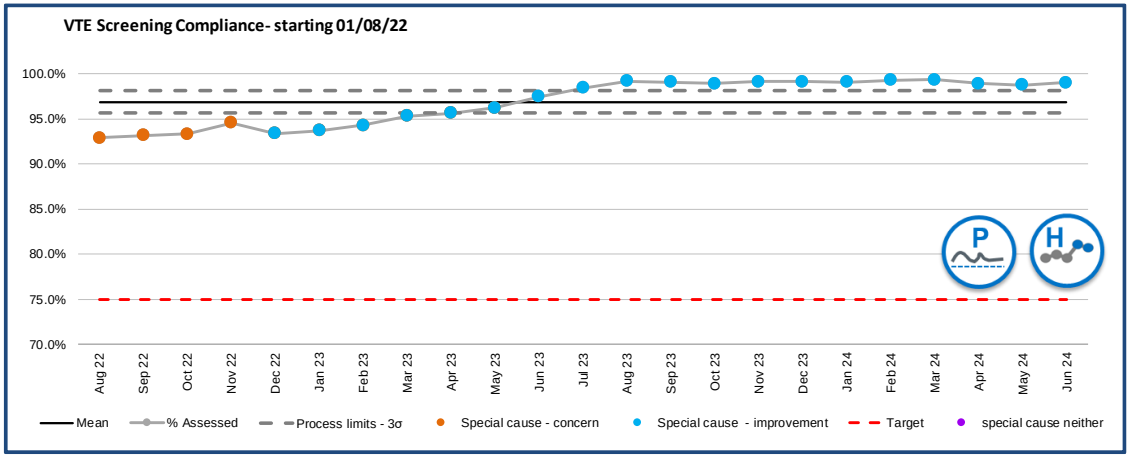
- Recruitment to address NOUS staffing challenges almost complete. Additional specialist capacity to support ENT backlog. Additional CDC capacity commenced end of July. System mutual aid is provided to SWBH (600 slots a month) and remains under review
- Audiology recruitment in progress. New starter commenced in July
- Sleep studies experiencing equipment issues, working through options. Short term recovery is to utilise bank shifts to reduce waiting times
- Request for system mutual aid for Cardiac MRI to reduce 13 week breaches
- Diagnostic performance is reviewed fortnightly at system tiering calls with NHSE

DM01 Benchmarking



Source: Imaging Cardiology CRIS Dashboard - Power BI

VTE Performance Please note: VTE figures now run 1 month in arrears



Latest Month	Latest Month	Latest Month
99.0%	99.1%	98.8%
Trust overall Position	**Medicine & IC**	**Surgery, W & C**

Performance

VTE performance sustained above the standard of compliance in consecutive months since March 2023.

Action

Ward level reporting is available, and this is being monitored as part of the ward performance reviews.

Screening Programmes

Screening Programme Performance for IPR (F&P)

Description	Comments	Reference	Target	Q1	Q2
NHS Abdominal Aortic Aneurysm Screening Programme (AAA) 2023/24 (@ ICB level)	Percentage of abnormal screens reviewed ≤ 21 days of the initial screen date within the reporting period.	AAA-S12	Acceptable: ≥60.0% Achievable : ≥95.0%	16.67%	29.41%
NHS Breast Screening Programme 2023/24 (@ ICB level)	The proportion of eligible women who have a technically adequate screen less than or equal to 6 months from date of first offered appointment	BSP-S03a	Acceptable: ≥70.0% Achievable : ≥80.0%	69.00%	77.00%
NHS Colposcopy Intervention/treatment 6 week appointment 2023/24	Proportion of women who are offered a colposcopy within 6 weeks of referral due to a positive HR-HPV test and negative cytology OR borderline changes or low-grade dyskaryosis.	CSP-S11	>=99% Green <99% Red	87.00%	100.00%
NHS FASP Trisomy screening 2023/24	Indequate samples for Downs/Edwards/Patau screening a) Combined samples	FA4	To be Set	0.70%	1.20%
NHS FASP Trisomy screening 2023/25	Indequate samples for Downs/Edwards/Patau screening a) Quadruple samples	FA4	To be Set	0.70%	2.00%
NHS Infectious Diseases in Pregnancy Screening 2023/24	The proportion of pregnant women eligible for human immunodeficiency virus (HIV) screening for whom a confirmed screening result is available at the day of report	ID1(IDPS-S01)	>=99% Green 95%-99% Amber <95% Red	99.80%	99.90%
NHS Infectious Diseases in Pregnancy Screening 2023/24	The proportion of pregnant women eligible for hepatitis B screening for whom a confirmed screening result is available at the day of report	ID3(IDPS-S02)	>=99% Green 95%-99% Amber <95% Red	99.80%	99.90%
NHS Infectious Diseases in Pregnancy Screening 2023/24	The proportion of pregnant women eligible for syphilis screening for whom a confirmed screening result is available at the day of report	ID4(IDPS-S03)	>=99% Green 95%-99% Amber <95% Red	99.80%	99.90%
NHS FASP Fetal Anomaly scan 2023/24	The proportion of pregnant women eligible for NIPT screening for whom a conclusive screening result is available at the day of report.	FASP NIPT-S01	Thresholds are not set for this metric	81.00%	80.00%
NHS Sickle Cell and Thalassaemia screening 2023/24	The proportion of pregnant women having antenatal sickle cell and thalassaemia screening for whom a screening result is available ≤10 weeks + 0 days gestation	ST2	>=75% Green 50%-75% Amber <50% Red	43.20%	50.10%
NHS Newborn Blood Spot screening 2023/24	The proportion of first blood spot samples that require repeating due to an avoidable failure in the sampling process	NB2 (NBS-S06)	<=1% 1%-2% Amber >=2% Red	0.80%	1.00%
NHS Newborn Hearing Screening 2023/24	Coverage	NHSP-S01 & KPI NH1	>=99.5% Green 98%-99.5% Amber <98% Red	98.50%	Not Yet Available
NHS Newborn and Infant Physical Examination screening 2023/24	Coverage	ANNB NIPE NP1	>=97.5% Green 95%-97.5% Amber <95% Red	96.60%	95.90%
NHS Newborn and Infant Physical Examination screening 2023/24	Timeliness	ANNB NIPE NP3	>=95% Green 90%-95% Amber <90% Red	85.20%	91.40%
Child Vision screening commenced in September				Not Yet Avaialble	

Kitemark Explanation

Element	Definition
Timeliness	The time taken between the end of the data period and when the information can be produced and reviewed. The acceptable data lag will be different for different performance indicators. Data should be captured as quickly as possible after the event or activity and must be available for the intended use within a reasonable time period. Data must be available quickly and frequently enough to support information needs and to influence the appropriate level of service or management decisions.
Monitoring	The degree to which the trust can drill down into data in order to review and understand operational performance. The level to which the trust needs to drill down into the data will vary for different performance indicators. Some information should always be available at patient level for performance monitoring purposes. Whereas some information may be sufficient if it is available at speciality level for all specialties or even trust level for performance monitoring purposes
Completeness	The extent to which all of the expected attributes of the data are populated but also the extent to which all of the records for the relevant population are provided.
Validation	The extent to which the data has been validated to ensure it is accurate and in compliance with relevant requirements. For example, correct application of rules and definitions. The level of validation required will vary from indicator-to-indicator and will depend on the level of data quality risk. Final validation is classified as sufficient where validation has been completed and where the indicator has received final approval from responsible individuals.
Audit	The extent to which the integrity of data (completeness, accuracy, validity, reliability, relevance, and timeliness) has been audited by someone independent of the KPI owner (for example, Internal Audit, External Audit, Clinical Audit or Peer Review) and the extent to which the assurance provided from the audit is positive.

Element	Definition
Reliability	The extent to which the data is generated by a computerised system, with automated IT controls, or a manual process. It also relates to the degree of documentation outlining the data flow, i.e. documented process with controls and data flows mapped. Data should reflect stable and consistent data collection processes across collection points and over time, whether using manual or computer-based systems or a combination. Managers and stakeholders should be confident that progress toward performance targets reflects real changes rather than variations in data collection approaches or methods.
Relevance	The extent to which the data is captured for the purposes for which it is used. This entails periodic review of the selection of key performance indicators to reflect changing needs, such as new strategic objectives. For example, is this indicator the right indicator by which to measure performance against a strategic objective. Strategic objectives will be defined within the scoping document for proposed new measures.

Insufficient

Insufficient, but under active review/management

Sufficient

Not Yet Assessed

Click HERE for full kitemark explanation & policy

Paper ref:	PublicTB September 2024

Report title:	Safer staffing review (nursing).
Sponsoring executive:	Martina Morris – Chief Nurse
Report author:	Helen Bromage – Deputy Chief Nurse Sharon Phillips – Programme/ NMP Lead
Meeting title:	Public Trust Board
Date:	12th September 2024

1. Summary of key issues using Assure, Advise and Alert *two or three issues you consider by the* PublicTB

This report outlines the approach taken by the Trust to undertake the safer staffing review, in line with national guidance, and provides the outcome and recommendations for individual clinical areas from an establishment and skill mix perspective.

PROCESS

- There are national recommendations to report safer staffing to Trust Boards using a triangulated approach of evidence-based tools, professional judgement, and patient outcomes to provide assurance of safer, sustainable, and effective staffing (NHSI 2018, NQB 2018, Lord Carter of Coles Review 2016).
- The recommendation of establishment setting must be undertaken bi-annually (NHSI 2018).
- Reviews look at patient acuity/dependency, activity levels, professional judgement, seasonal variation, service developments/changes/commissioning, staff supply and experience, temporary staffing above establishment and patient/staff outcome measures. This information is then compared with the Authorised Funding Establishment for each ward/clinical area.
- The review includes nursing staff (registered and non-registered) who provide direct care. It does not include housekeepers or ward clerks. It also includes the uplift on establishment of 22%, an allowance for periods of leave staff are not available e.g. annual leave, sickness, mandatory training.
- Evidence base assessment tools must be utilised for these reviews. The safer staffing review completed in June-July 2024 at The Dudley Group NHS Foundation Trust was undertaken using the latest validated Safer Nursing Care Tool (SNCT).

SAFER NURSING CARE TOOL (SNCT)

- Is an evidence-based tool developed to measure patient acuity and/or dependency (considers patient flow, enhanced therapeutic observations and nurse sensitive indicators).
- It measures acuity and dependency twice yearly for each area.
- It has in build algorithms to work out the average of the combined data sets which is used to support nurse establishment setting/resetting.
- It includes a suite of tools for different settings. The Trust used the tools for adult inpatient wards in acute hospitals, adult acute assessment units, emergency departments and children and young people's ward in acute hospitals.
- It requires data collection each day (30 days for wards and 14 days for ED) by trained individuals. For wards, this is once a day at a set time and for ED twice a day covering each hour of the day.
- It requires external validation of acuity and dependency measurement weekly referred to as quality assurance.
- It also assesses the supervisory status for staff in leadership roles.

OUR APPROACH

- All staff involved in the staffing reviews, either with the initial data capture or quality assurance, were invited to attend training. This involved delivery of the theory to underpin the practice and an assessment to confirm competence. This included face to face training, prior and during the review period, cascade training by the Divisional Chief Nurses and Matrons, weekly face to face sessions and informal drop-in

sessions during the data collection period. In addition, the development of a Workforce department HUB page with all key document, training and guidance.

- Data was collected at 15:00 each day within the inpatient and assessment unit areas for the whole month of June 2024.
- Within the Emergency Department, the data was collected over a 2-week period in June 2024 (twice a day with time staggered to capture each hour of the 24-hour period).
- To reduce the risk of transcription errors, bespoke Microsoft forms were created for each ward and a quality assurance/validation form.
- Input data was centrally collated and reviewed with any anomalies raised for action with the Divisional Nursing Leadership team.
- Quality assurance/validation was undertaken by trained senior clinical staff weekly for each area.
- Shared folders were developed for each clinical area for the Divisional Chief Nurses in which their collated and sanitised data was place in addition to extracts of all data sources to support scrutiny, triangulation and critical analysis.
- The Divisional Chief Nurses undertook their confirm and challenge conversations with their Lead Nurses, Matrons, HR and Finance Business Partners. As part of this the professional judgement framework was used as a template for the conversations and guidance.
- The Divisional Chief Nurses presented the outcomes of their staffing reviews and confirm and challenge meetings with the Chief Nurse and Deputy Chief Nurses.

TRUST DATA USED TO SUPPORT SCRUTINY, TRIANGULATION AND CRITICAL ANALYSIS

For a staffing review to be robust and valid for workforce planning (NHSI 2018) it is recommended that during the process, a series of data sets are considered and triangulated with the outcome of the acuity and dependency review. The Trust has used the nationally recommended data sets (detailed below). For the purpose of the review, the data was broken down for each ward and used as part of the triangulation and professional judgement. The following is an overview of these data sets:

Skill mix (section 3)

- The RCN recommend 65/35 Registered Nurses (RN) to care support workers (CSW). The Trust had agreed an aspiration skill mix of 70/30 but this is often not achieved with an average ratio of 60/40. Within the areas where there is clear derogation from the RCN skill mix recommendation, assurances have been provided by the ward leadership teams that dynamic risk assessments were in place at the point of derogation. It was felt that having knowledgeable Nursing Associates and CSWs, was safer for the patients than having RNs who were not familiar with the ward/clinical area.
- In some areas, the ratio of RNs to CSWs can be lower in less acute areas where care needs are greater than nursing skill needs or if other staff are involved in care delivery e.g. Allied Health Professionals or Assistant Practitioners.

Fill rates (section 4)

- Fill rates are calculated by comparing planned (rostered) hours against actual hours worked for both RN and HCA. It should be noted a low rate does not always mean that the staffing levels were unsafe.

% Fill Rate	April 2024	May 2024	June 2024
Registrant Day	89	89	88
Registrant Night	93	95	95
Non Registered Day	89	87	86
Non Registered Night	94	92	92

- Where temporary staff are used to support the workforce requirements, the Trust makes every effort to not have more than 50% of the clinical team as temporary staff, swapping and reallocating staffing across the clinical areas and divisions where necessary.

Red flags (NICE 2021) and Nurse Sensitive Indicators (section 5)

- Two key red flags were examined through this review – Patient vital signs not assessed or recorded and unplanned omissions of medication. These are nationally regarded as two key indicators which are affected by the availability of nursing staff.

Patient Vital Signs	Sets to be completed	Number over the required time	% Observations on time
30 min observations	1533	1212	21
Hourly observations	3905	2643	33.2
4 hourly observations	123,811	60,127	52.5

There were over 96 thousand late or missed medicines throughout the data collection period. 32154 were late (30 minutes or more after the directed time on the prescription) and 63148 which were not performed. Due to the significant number of administered medications, it is currently too challenging to create a stable report to give data on those which were given on time.

Nurse sensitive indicators

- Nurse sensitive indicators are included are quality outcomes that can be linked to nurse staffing issues including leadership, establishment levels, skill-mix and training and development of staff. For the purpose of the review, these were medication errors, slips, trips & falls and pressure ulcers.
- Throughout June 2024, there were 103 falls across the clinical areas and 102 Pressure Ulcers reported through the DATIX system (to note the data extract at the end of June 2024 and used by the Divisions would have been unvalidated data and all incidents would not have gone through the Trust internal validation frameworks e.g. Pressure ulcer scrutiny Group or Falls Group).
- There were 5 medication administration incidents throughout June 2024. 4 related to a delay in administration (3 incurring minimal harm and 1 no harm) and 1 related to an omitted medication (no harm).
- There were 21 infection prevention and control escalations in June 2024. These were 4 Covid-19, 3 Norovirus, 12 CDI, 1 E coli Bacteraemia and 3 MSSA

Safeguarding

- Safeguarding is a key marker due to the length of time to complete the referrals due to their nature and complexity. Anecdotally, each referral takes 45-60 minutes with additional work following for case conferences, preparation of reports and ensuring the additional safety requirements of the patients are met. Throughout the review period there were 135 safeguarding referrals.

Professional Judgement (section 7)

- Professional judgement is an essential element of staffing decisions. For staffing reviews this looks at ward layout/facilities, escort duties, shift patterns, multiprofessional working.

Staff related incidents (section 8)

There were 65 Incidents relating to staffing. This is a 55% reduction based on last year's review.

June 2022 107 incidents	June 2023 143 incidents	June 2024 65 incidents

The Trust, since the previous review, now has clear guidance (policy) for the escalation of staffing aligned to their Black Country Provider collaborative partners. This is in conjunction with a much better staffing position and a significantly reduced nursing and CSW vacancy rate, which has positively impacted on the number of staffing related incidents.

Outcome of the Review (section 10)

- Overall, the safer staffing establishments are in a positive position to provide and deliver safe, effective, high-quality care.
- It is evident from the quantitative data that there is a disconnect between the tools recommended staffing establishments and the current funded staffing establishments, due to quantitative data collection issues. Professional Judgement has been a key guiding influence with this and the knowledge of seasonal variation within the patient cohorts, the impact of flow and capacity challenges during the data collection month and the additional measures undertaken to support patient flow, and experience.
- The following table provides a summary of the that areas that have requested changes and if these were supported, subject to the Divisions identifying their required workforce reduction elsewhere; identifying funding to enact the change and completion of a QIA:

Jun-24	Requests suggested by ward leadership.	Changes supported by Division	Jun-24	Requests suggested by ward leadership.	Changes supported by Division	Jun-24	Requests suggested by ward leadership.	Changes supported by Division
AMU1	No	No	B6	Yes	Yes	C7	Yes	Yes
AMU2	Yes	Yes	C1A	No	No	C8	No	Yes
AMU3 (A4)	No	No	C1B	No	No	CCU	Yes	Yes
AMUA	No	No	C2	No	No	DL	No	No
B1	Yes	Yes	C3	Yes	Yes	ESH	No	No
B2H	No	No	C4	No	No	MECU	No	No
B2T	No	No	C5A	Yes	Yes	FMU	No	No
B3	No	No	C5B	No	Yes	ED Adults	No	No
B4	No	No	C6	No	No	ED Paeds	No	No

Establishment change requests following reviews	
AMU 2	Increase in RN overnight (2.6 WTE).
B1	Reduce RN establishment by 1.8 WTE.
B6	Increase night time CSW by 1 (2.6 WTE) - would reduce the overall temporary staffing use.
C3	Increase night time CSW by 1 (2.6 WTE) - would reduce the overall temporary staffing use.
C5A	Increase RN (B6) presence overnight (cost neutral).
C5B	Support C5A with request (cost neutral).
C7	Increase staffing provision throughout the traditional twilight period. Possible within the current establishment and cost neutral.
C8	Parity of workload division between Band 7 Lead Nurses. To be reviewed and managed within the current establishment.
CCU	Increase RN x 1 on day shift on a weekend Saturday and Sunday as there had previously been a reduction. Possible within the current establishment and it will be filled by including the clinical band 7 in the numbers of rostered staff.
DL	Work to reinstate as a Discharge Lounge.

- The review has also highlighted there is wider work which is ongoing looking at the location of current specialities, in particular B4, B6 and C6 and the options for relocation. As this would be cross divisional, a collaborative piece is being created to progress this work further.

Limitations / Risks (section 11)

- Although frequent training sessions and drop-in session were offered centrally during the review, attendance to many of these was poor. This was in contrast to the sessions and support delivered face to face in the workplace.
- 8 out of 27 areas collected acuity data every day. This can negatively impact on the overall averages used within the tool and the overall recommendations of staffing form the tool.

- The quality assurance process was followed with most areas being reviewed over 50% of the required ask. These did not flag any anomalies, but this was in contrast to the interrogation of the entire data set which identified concerns around application of the acuity scores and the process followed.
- The wider triangulation of information and the conversations with finance business partners also highlighted that there are differences in understanding of budgets and what is and is not included in the establishments.
- Due to how the data is available and the need for collation, there has been a significant amount of transcription of information undertaken. This increases the risk of transcription and human error.
- It must also be noted that the data was pulled from the systems on 1st July, so any internal validation which is usually performed was not undertaken so data sets could be different to subsequent extracts.

Next Steps (section 12)

- The RCN recommendations do not currently include Nursing Associates (RNA) in their Registered Nurse category. As a Trust, we have supported numerous RNAs into our workforce. Currently the Trust has 59 RNAs with a further 9 undertaking the conversion programme to Level 1 Registered Nurse.
- Further data collection and review of Adult Inpatient areas, adult assessment Units, Children and Young People and Emergency Department areas to be undertaken as planned in January 2025.
- Continue with the CNO Provider collaborative aligned plan to implement additional reviews and the rolling programme.
- Continue with refining the training programme and facilitating further sessions. In addition to the Trust training, two colleagues have attended the NHSE 2-day safer staffing training to further build the necessary knowledge and skills with regards to safer staffing in the organisation. Furthermore, one senior nurse has applied to complete the NHSE the Safer Stafing Fellow programme (response from NHSE is awaited).
- Work with IT and data analysts to support easier access to the data required.
- Finance colleagues reviewing the financial envelope for support with the recommended changes.

2. Alignment to our Vision [indicate with an 'X' which Strategic Objective[s] this paper supports]	
Deliver right care every time	**X**
Be a brilliant place to work and thrive	**X**
Drive sustainability (Financial and environmental)	**X**
Build innovative partnerships in Dudley and beyond	
Improve health and wellbeing	

3. Previous consideration *[at which meeting[s] has this paper/matter been previously discussed?]*
Executive Team on 6th August 2024. Quality Committee on 27th August 2024. Trust Board on 12th September 2024.

4. Recommendation(s)
The Public Trust Board is asked to:
a) Note the biannual review of safer staffing (nursing) report and associated decisions with regards to proposed staffing/skill-mix changes.

5. Impact		
Board Assurance Framework Risk 1.1	x	Deliver high quality, safe person-centred care and treatment
Board Assurance Framework Risk 02	x	Address critical shortage of workforce capacity

Board Assurance Framework Risk 03	x	Improve and sustain staff satisfaction and morale
Board Assurance Framework Risk 04	x	Remain financially sustainable in 2023/24 and beyond
Board Assurance Framework Risk 05		Deliver on its ambition to building innovative partnerships in Dudley and beyond
Corporate Risk Register [Safeguard Risk Nos]		N/A
Is Quality Impact Assessment required if so, add date: Yes, as part of any approved staffing changes.		
Is Equality Impact Assessment required if so, add date: No		

The Dudley Group
NHS Foundation Trust

Safer Staffing Review – June and July 2024.

1. EXECUTIVE SUMMARY

The purpose of this report is to inform the Quality Committee and the Executive Group of the outcomes of the June 2024 assessment of Nursing Safer Staffing using the Safer Nursing Care Tool (SNCT), Shelford Group 2023) and professional judgement. The Developing Workforce Safeguards, published by NHS improvement in 2018 builds on various publications by the National Quality Board (2018) and Lord Carter of Coles review (February 2016) providing guidance and recommendations in relation to the reporting of safe staffing to Trust Boards.

The Developing Workforce Safeguards (NHSI 2018) reinforces the requirement for Trusts to adopt a triangulated approach for the use of evidence-based tools, professional judgement, and patient outcomes to provide assurance of safer, sustainable, and effective staffing. Compliance with the principles outlined in the document is to be assessed annually.

In relation to workforce planning, the guidance recommends that establishment setting must be undertaken bi-annually and this process should consider the following:

- Patient acuity and dependency using the latest validated Shelford Safer Nursing Care Tool
- Activity levels
- Professional Judgement
- Seasonal variation in demand
- Service developments/changes and commissioning.
- Staff supply and experience including e-rostering data.
- The use of temporary staffing above the set establishment
- Patient and staff outcome measures

Additionally, comprehensive quality impact assessments must be completed when new roles are introduced, there is workforce redesign or a change in skill mix is considered.

This review will make comparisons between this information and the Authorised Funded Establishment (AFE) for each ward which is adjusted to reflect the number of nursing staff (registered and non-registered) who provide direct care to patients. Housekeepers, cleanliness support and ward clerks are not included in the calculation as they do not provide direct nursing care to patients. In addition, when planning the staffing, there is a need for an allowance to be made for periods of leave to ensure that there are sufficient nurses available to provide the planned level of nurse staffing.

The review has also considered the correlation between what the wards think is their AFE, vacancy, and actual staff in post establishment. This has been challenging to correlate with discrepancies between the data set provided, the dashboard data accessed, and the information given by the subject matter experts/Business partners.

This report fulfils expectations 1 and 2 of the Nursing Quality Board's requirements for Trusts in relation to safer nurse staffing and fulfils a number of the requirements outlined in the NHS Improvement Developing Workforce Safeguards guidance which sets out how to support providers to deliver hight quality care through safe and effective staffing. This review also meets standards outlined in the RCN Nursing Workforce Standards (May 2021). Organisations are expected to be compliant with the recommendations in these reports and are subject to review on this as part of the CQC inspection programme under both 'safe' and 'well led' domains.

At The Dudley Group NHS Foundation Trust, the level of cover (relief) built into ward establishments is 22% (429 hours) per Whole Time Equivalent (WTE) staff member. This includes:

- 17.5% Annual leave and Bank Holiday
- 3.5% Short term sickness
- 1% Mandatory Training time

It is recognised that the allocated 1% (15 hours) time for mandatory training is not sufficient. The undertaking of Priority 1 training, appraisal support and preparation, professional registration reflections, Practice Supervisor and Assessor requirements and any additional champion/link roles requires on average 143 hours for a nurse, midwife or Allied Health Professionals (AHP).

Authorised funded establishments should also afford staff in leadership roles the time to assume supervisory status which is evidenced to improve staff engagement and improve patient outcomes. The SNCT includes an allowance for ward leaders to undertake their leadership roles in a supervisory capacity for 40% of their time. As a Trust we have committed to supporting our Lead Nurses to have 80% of their time in a supervisory capacity. This is less than our partners within the Black Country Provider Collaborative. The Tool provides clear guidance of expectations to follow called Red Rules. Our compliance with these rules is detailed in appendix 1.

2. PROCESSES

The safer staffing review has been undertaken using the latest validated Safer Nursing Care Tool (SNCT). This is a NICE-endorsed evidence-based tool currently used in the NHS. The overall data collection output when using the tool can be viewed at Appendix 2

The SNCT includes a suite of tools for different settings:

Used by the Trust:

- Adult inpatient wards in acute hospitals (updated 2023 – all previous versions of the tool are no longer valid).
- Adult acute assessment units (updated 2023 – all previous versions of the tool are no longer valid).
- Children and young people's inpatient wards in acute hospitals.
- Emergency Departments.

Not applicable to the Trust:

- Mental health inpatient wards.

The SNCT has been developed to help NHS Hospitals measure patient acuity and/or dependency to inform evidence-based decision making on staffing and workforce. Each tool has their own decision matrix (Appendix 3/4) to support the measurements. The tool, when allied to Nurse Sensitive Indicators (NSIs), offers nurse leaders a reliable method against which to deliver evidence-based workforce plans to support existing service or the development of new services.

Acuity and dependency measurements should take place twice yearly at a minimum with data collection timeframes locally agreed. Trusts should collect data across the wards on the same months/timeframe to enable benchmarking. An average of the combined data sets is used to support nurse establishment setting/resetting (Appendix 5). Ultimately this evidence base should support workforce plans for nursing that should accurately predict and enable resources to be identified to support nursing establishments that meet patient and service needs.

During data collection periods it is strongly recommended that external validation of acuity and dependency measurements is undertaken weekly in partnership with the designated ward nurse. This validation must be undertaken by a senior professional who has been appropriately trained. The Trust identified key senior professionals who were allocated areas to quality assure and validate data collection (Appendix 6).

Quality control is seen as fundamental to ensure a robust approach to the data collection. This process ensures accuracy and consistency of scoring whilst providing greater assurance to the Trust board in relation to the tool's recommendations.

Patient Flow The tool considers patient flow, such as admissions, discharges transfers/escorts. There for the addition of resources for these elements may result in double counting and lead to inaccurate recommendations.

Enhanced therapeutic observations (present in previous versions of the tool) of the additional staffing requirement to support patient needs for safety reasons and/or reducing risk of harm, was not included and needed to be collected separately. The new version of the tool, used in the review has new levels of acuity to meet this progressing need.

Nurse Sensitive Indicators are quality outcomes linked to nursing care. They inform nurses of good and poor patient outcomes enabling sharing of good practice and review of potential reasons for poor quality. Nurse sensitive indicators when aligned to acuity and dependency data and supported with professional judgement will enable agreement of nursing establishment appropriate to meet the needs of each ward/department. These indicators or outcomes can vary between speciality and therefore should be locally agreed for each clinical area.

The main NSIs reviewed as part of this review are unplanned omissions in providing patient medication and patient observation's (Early Warning Scores EWS) not assessed or recorded as outlined in the plan of care. It is recommended that a delay of 30 minutes in providing pain relief is also reviewed, however this data is challenging to obtain due to the lack of preset family groupings of the medications on the system.

It is widely accepted that these NSIs can be linked to nurse staffing challenges, including leadership, establishment levels, skill-mix and training and development of staff.

3. SKILL MIX

The minimum skill mix recommended by the Royal College of Nursing (RCN) is a ratio of 65/35 Registered Nurses/clinical support workers. The Trust agreed aspirational skill mix is 70/30 ratio, however this is often not achieved with an average ratio of 60/40.

Jun-24	RN/CSW%		Jun-24	RN/CSW%		Jun-24	RN/CSW%
AMU1	60/40		B6	55/45		C7	50/50
AMU2	55/45		C1A	50/50		C8	55/45
AMU3 (A4)	50/50		C1B	50/50		CCU	80/20
AMUA	55/45		C2	80/20		DL	60/40
B1	60/40		C3	55/45		ESH	70/30
B2H	40/60		C4	70/30		MECU	75/25
B2T	50/50		C5A	60/40		FMU	30/70

B3	55/45		C5B	55/45		ED Adults	60/40
B4	50/50		C6	50/50		ED Paeds	50/50

The RCN recommendations do not currently include Nursing Associates (RNA) in their Registered Nurse category. As a Trust we have understood the benefits of and therefore supported numerous RNAs into our workforce. Currently the Trust has 59 RNAs with a further 9 undertaking the conversion programmed to Level 1 Registered Nurse.

Within the areas where there is clear derogation from the RCN skill mix recommendation, assurances have been provided by the ward leadership teams that dynamic risk assessments were in place at the point of derogation, and it was often felt that having knowledgeable Nursing Associates and Care Support Workers, was safer for the patients than having Registered Nurses who were not familiar with the ward/clinical area.

Skill-mix continues to evolve due to the development and introduction of new roles within the Nursing and Midwifery workforce. In many areas where the acuity and intensity of patients has increased, and treatment and medication regimes are complex, further reduction in the overall skill-mix of registered to unregistered staff is not appropriate to maintain safe staffing levels and ensure adequate supervision. Focus is required to continue reviewing the overall registered to unregistered ratios to ensure any derogation is linked to planned model of care changes.

The ratio of Registered Nurses to clinical support workers may be lower in some less acute areas such as areas where care needs are greater than nursing skill needs, or where other staff are involved in delivering care, for example, Assistant Practitioners and Allied Health Professionals (registered professionals) contribute significantly towards meeting patient needs.

Whilst the Safer Nursing Care Tool focuses on the clinical acuity and dependency of the patient, when triangulating the national standards, it is necessary to have a mixed economy in terminology. The RCN standard of 1 nurse to 8 patients during the day equates to each patient receiving nursing focus for 7.5 minutes of every hour.

Nurse: Patient Ratio	Nurse time per hour (In minutes)	Nurse time per 12-hour shift
1:4	15	180 minutes or 3 hours
1:6	10	120 minutes or 2 hours
1:8	7.5	90 minutes or 11/2 hours
1:10	6	72 minutes
1:12	5	60 minutes or 1 hour

It should be noted that on average, a routine set of observations/vital signs should take 5 minutes to complete with the average patient medicine round taking over 20 minutes to complete, providing no intravenous (IV) medication is required. If a patient is on IV fluids, a nurse must review the cannula site (VIP Score) hourly and record

how much fluid has been infused. If undertaken efficiently this action takes just under 6 minutes to complete. If a patient is not mobile or has an increase in risk of pressure area damage, review, and regular skin assessments to support intervention will take between 10 – 25 minutes dependant on the mobility and care needs of the patient. It must also be noted that when safeguarding thresholds are met and additional needs are required, a referral often takes over 60 minutes to complete with additional unaccounted for time from the ward-based teams when supporting the ongoing process once referrals have been made. To note there were 135 safeguarding referrals.

Jun-24	No safeguarding					Jun-24	No safeguarding
AMU1	2		B6			C7	1
AMU2			C1A			C8	3
AMU3 (A4)			C1B			CCU	1
AMUA			C2	2		DL	
B1			C3			ESH	
B2H	1		C4			MECU	4
B2T			C5A	1		FMU	
B3	1		C5B			ED Adults	57
B4	3		C6			ED Paeds	59

4. FILL RATES

Acute trusts are required to collate and report staffing fill rates for external data submission to NHSE/I monthly. Fill rates are calculated by comparing planned (rostered) hours against actual hours worked for both RN and HCA.

The summary position for quarter 1 of 2024 is shown in table below. A more detailed position is in appendix 7.

% Fill Rate	April 2024	May 2024	June 2024
Registrant Day	89	89	88
Registrant Night	93	95	95
Non-Registered Day	89	87	86
Non-Registered Night	94	92	92

It should be noted that there were still some wards where shifts were below expected levels and that the fill rates are based on current expected levels and may not reflect the required numbers from SNCT and professional judgement results. It should also be noted that a low fill rate does not always mean that staffing levels were

unsafe as bed occupancy may have been lower and the anticipated acuity of the patients may have been different. Throughout June 2024, the demand on services would not have allowed for a lower bed occupancy.

Fill rates also do not consider the skill-mix within an area including what percentage of this fill was temporary staff; all of which are contributing factors to quality and safety within the clinical environment. Following the RCN standards advice, the Trust makes every effort to not have more than 50% of the clinical team as temporary staff.

5. NICE RED FLAGS & NURSE SENSITIVE INDICATORS (Appendix 8 for full data set)

Nursing Red Flags are specified in Safer Staffing for Nursing in Adult Inpatient Wards in Acute Hospitals overview (NICE 2021). 2 key red flags have been examined through this review, patient vital signs not assessed or recorded as outlined in the care plan, and unplanned omissions is providing patient medications

Patient vital signs not assessed or recorded as outlined in care plan

Patient Vital Signs	Sets to be completed	Number over the required time	% Observations on time
30 min observations	1533	1212	21
Hourly observations	3905	2643	33.2
4 hourly observations	123,811	60,127	52.5

The observation interval '30 minutes' has an additional requirement of a Medical Emergency call being placed and an emergency team response being activated. Throughout the month of June there were 208 emergency calls placed. 171 of these were Medical Emergency Team calls and 4 were Cardiac Arrest calls. The remainder of the calls were obstetric or neonatal calls.

Area	Number of MET calls	Area	Number of MET calls	Area	Number of MET calls
AMU1	21	**B4**	11	**C5A**	5
AMU2	6	**B5**	6	**C5B**	3
AMU3	3	**B6**	5	**C6**	9
AMUA	6	**C1A**	3	**C7**	10

Area	Number of MET calls	Area	Number of MET calls	Area	Number of MET calls
B1	4	**C1B**	2	**C8**	5
B2	3	**C3**	8	**CCU**	6
B3	14	**C4**	9	**MECU**	3

Unplanned omission in providing patient medications

There were over 96 thousand late or missed medications throughout the month of June. 32154 were late (30 minutes or more after the directed time on the prescription) and 63148 which were not performed. Due to the significant number of given medications, it is currently too challenging to create a stable report to give data on those which were given on time.

Other medication incidents

There were 5 medication administration incidents reported in DAIX throughout June 2024. Of these, 4 related to a delay in administration (3 incurring minimal harm and 1 no harm) and 1 related to an omitted medication (no harm).

Nurse Sensitive Indicators

Nurse sensitive indicators (NSI) refer to quality outcomes that can be linked to nurse staffing issues, including leadership, establishment levels, skill-mix and training and development of staff. This information can be further used to support ward staffing requirements identified through acuity and dependency measurement. Medication errors, slips, trips & falls and pressure ulcers are all NSIs which have been identified as key indicators of quality of care with specific sensitivity to nursing intervention and lack of.

These are regularly scrutinised across the divisions and within the clinical areas, with a significant amount of work being undertaken to support their reduction.

Pressure Ulcer Damage and Falls

Throughout June 2024 there were 103 falls across the areas and 102 Pressure Ulcers reported through the DATIX system (to note the data extract at the end of June 2024 and used by the Divisions would have been unvalidated data and all incidents would not have gone through the Trust internal validation frameworks e.g. Pressure ulcer scrutiny Group or Falls Group).

PRESSURE ULCER DAMAGE							
Jun-24	No PU		Jun-24	No PU		Jun-24	No PU
AMU1	7		B6	5		C7	4
AMU2	8		C1A	7		C8	3
AMU3 (A4)	1		C1B	1		CCU	6
AMUA	1		C2			DL	8
B1			C3	4		ESH	2
B2H	4		C4	2		MECU	
B2T	8		C5A	6		FMU	3
B3	4		C5B	5		ED Adults	3
B4	9		C6	1		ED Paeds	

FALLS							
Jun-24	No Falls		Jun-24	No Falls		Jun-24	No Falls
AMU1	7		B6	6		C7	7
AMU2	7		C1A	3		C8	4
AMU3 (A4)	6		C1B	1		CCU	6
AMUA	9		C2	1		DL	4
B1	1		C3	4		ESH	2
B2H	4		C4	1		MECU	
B2T	4		C5A	3		FMU	3
B3	4		C5B	3		ED Adults	5
B4	5		C6	3		ED Paeds	

INFECTION PREVENTION CONTROL ESCALATIONS									
Jun-24			**Jun-24**			**Jun-24**			
AMU1	1 - Norovirus		**B6**	1 - COVID-19		**C7**	2 - CDI		
AMU2	1 - Norovirus		**C1A**	1 - COVID-19 1 - Norovirus		**C8**			
AMU3 (A4)	1 - COVID-19 1 - Norovirus		**C1B**			**CCU**	2 - CDI		
AMUA	2 – CDI 1 - Norovirus		**C2**	1 - MSSA		**DL**			
B1			**C3**			**ESH**	2 - CDI		
B2H			**C4**	1 - COVID-19 1 – CDI 1 – E coli		**MECU**			
B2T			**C5A**			**FMU**	1 - CDI		
B3	1 - MSSA		**C5B**			**ED Adults**	1 - CDI		
B4B	1 - MSSA		**C6**			**ED Paeds**			

N.B. Please note the outbreak of norovirus on AMU1, AMU2 and AMU3 was one outbreak and not three separate.

In addition to the above indicators, as a Trust we believe that the number of complaints which are received is also a strong indicator of nursing care and levels of staffing. Throughout June there were 40 complaints. As previously mentioned, safeguarding is another key marker which is felt to be noteworthy. The nature and complexity of the referrals is not to be underestimated and the workload this creates is substantial for both the teams undertaking the initial referrals and subsequently the teams who support with the inpatient care of these patients. Throughout the review period there were 135 safeguarding referrals.

A breakdown of the nurse sensitive indicators per clinical area can be reviewed in Appendix 8.

6. CHPPD

Care Hours per Patient Day (CHPPD) is a useful means of benchmarking against other NHS Trusts via the Model Hospital website. CHPPD is calculated by dividing the total numbers of nursing hours on a ward or unit by the number of patients in beds at the midnight census. This calculation provides the average number of care hours available for each patient on the ward or unit. A detailed individual ward position is available in appendix 7.

CHPD	April 2024	May 2024	June 2024
Registered	5.24	5.2	5.15
Care Staff	3.57	3.45	3.45
Total	8.81	8.65	8.6

7. PROFESSIONAL JUDGEMENT

Professional judgement can be described as the use of accumulated knowledge and experience, as well as critical reasoning to make an informed professional decision – often to help solve a problem, or in relation to a patient; or policies and procedure affecting patients. Staffing decisions based solely on professional judgement are considered subjective and may not be transparent.

However, professional judgement remains an essential element of safer staffing decisions. For this reason, the Trust uses a triangulated approach, with safer staffing data, clinical quality indicators and professional judgement. Details of the data sources, in addition to the below can be found in Appendix 9.

As part of the safer staffing reviews professional judgement must include consideration of the following:

- **Ward layout/facilities:** The configuration of wards and facilities affect the nursing time available to deliver care to patients, and this can be reflected in staffing establishments through professional judgement. For example, ward layouts, might make adequate surveillance of vulnerable patients more difficult. Some ward layouts are associated with significantly more walking between patients than others. Some wards have essential functions (dirty utility) out of the main ward environment.

- **Escort duties:** This is not captured by the Safer Nursing Care tool. Consideration needs to be given if this role is likely to affect the numbers of staff required, a local data collection and analysis exercise must be undertaken to determine a percentage to be added to the establishment to ensure staffing remains responsive to daily patient care need. This data has been captured using the Safecare (Allocate) system and the data has been made available for review.

- **Shift pattern:** The type of shifts (long day versus short day) in use may affect the overall establishment required to ensure shift-to-shift staffing levels. These should be monitored to understand the impact and effect on staff and patients.

- **Multi-professional working:** Consider the make-up of the care team for the ward. Would specific AHPs or support roles meet the needs of patient groups at particular periods of the day more appropriately? Conversely the absence of administrative support staff such as ward clerks may increase nurses' workload at particular times.

The following questions have been considered throughout this review:

- What is the care/treatment to be provided?
- What competencies are required to deliver that care/treatment?
- Which staff member (taking into consideration the wider multidisciplinary team) is competent and best placed to deliver that care/treatment?
- Can aspects of the care/treatment be safely delegated with appropriate education and training (if so, to whom)?
- What are all members of the team responsible for?

Another key item which has been factored into the review is the time commitments required when undertaking our safeguarding processes. Anecdotally each referral takes 45-60 minutes with additional work following for case conferences, preparation of reports and ensuring the additional safety requirements of the patients are met.

It is clear from the quantitative data that there is a disconnect between the tools recommended staffing establishments and the current funded staffing establishments. Throughout the reviews gaps have been scrutinised as best as possible and all the available data has been triangulated. However, it is recognised that some data has not been collected in the desired way. Professional Judgement has been a key guiding influence with this and the knowledge of seasonal variation within the patient cohorts, the impact of flow and capacity challenges during the data collection month and the additional measures undertaken to support patient flow, and experience.

8. STAFFING RELATED INCIDENTS RAISED

Throughout the review period there were 65 Incidents relating to staffing. This is a 55% reduction based on last year's review.

June 2022 107 incidents	June 2023 143 incidents	June 2024 65 incidents

The majority of incidents raised were by the site coordinators. Since the previous review, the Trust has finalised and aligned the Trusts staffing policy with our Black Country Provider collaborative partners. This policy provides clear guidance for the escalation of staffing issues and concerns and has an escalation process for the raising of these. This, in conjunction with an improved staffing position and a significantly reduced nursing and CSW vacancy rate, has positively impacted on the number of staffing related incidents.

9. TRAINING

If data integrity was to be assured, it was essential all individuals involved in the data collection and data assurance were knowledgeable and competent to assess acuity and use the Safer Nursing Care Staffing Tool. To achieve this, a multipronged approach to training and competency assessment was adopted. This included face to face training, prior and during the review period. This comprised of the tool's origins, theoretical components and how this was used in practice. The sessions were widely advertised and attended from across the organisation and via cascade training by the Divisional Chief Nurses and Matrons. In addition, during the data collection period, weekly additional face to face sessions and informal drop-in sessions were facilitated to cohort additional staff or support and revisit the requirements if staff needed additional support. To enable reflection and easy access to information the presentation, tools and guidance were all available to staff to access on the Workforce Department HUB page.

Following completion of training, individuals who were undertaking the reviews or quality assuring the reviews completed an assessment to verify competence. The assessment was completed either electronically via a link on the Workforce Department HUB page (marked by the central workforce review team) or via hard copy in the Divisions (marked by the Divisional Chief Nurses or Matrons). Individuals who undertook assurance reviews assessments were marked by the central workforce team.

It is worth noting although frequent sessions and drop-in session were offered centrally during the review, attendance to many of these was poor. This was in contrast to the sessions and support delivered face to face in the workplace.

10. WHAT DOES THE DATA TELL US

Overall, the safer staffing establishments are in a positive position to provide and deliver safe, effective, high-quality care. However, a significant number of anomalies with the data collection and the process was identified during the review. This has resulted in a significant reliance on other systems being reviewed for accuracy and the wider knowledge and professional judgement of the leadership team.

The data was collected at 15:00 each day within the inpatient and assessment unit areas for the entire month of June. Within the Emergency Department, the data was collected over a period of 2 weeks, twice a day with the times staggered to capture every hour in the day and night (Appendix 10). To reduce the risk of transcription errors a bespoke Microsoft form was created for each ward area along with a bespoke quality assurance/validation document. The input data was centrally collated and independently reviewed by key members of the Corporate Nursing Team including the Deputy Chief Nurse leading this work to ensure consistency of application approach. Any overt anomalies identified were raised with the Divisional Leadership team for rectification where possible. This approach did not allow for independent oversight of data collection from the Matron and divisional leadership team which will be recommended for change with the next

review. Quality assurance/validation was undertaken with a variety of senior clinical staff being asked to undertake. Following the period of data collection the data was collated and sanitised and made available for the Divisional Chief Nurses to undertake their confirm and challenge conversations. A list of what this included is available in Appendices 8/9.

Divisional Chief Nurses undertook their confirm and challenge conversations with their Lead Nurses, Matrons, HR and Finance Business partners. All the available data was scrutinised and triangulated to understand what the ward and service need. As part of this, the professional judgement framework was used as a template for the conversations and guidance to ensure all items were given due consideration. Appendix 12 provides an overview of each area of their professional judgement and key data sources.

At these conversations, some ward areas approached their divisional review with requests for changes to their establishments. These requests have been scrutinised by the Divisional Chief Nurses and the viability and other options have been reviewed.

Below is the collated establishment changes which detail ward level asks, Divisional Chief Nurse level ask and if supported by the Trusts Chief Nurse.

Area	Ward/Department Request/Amendments	Divisional Chief Nurse (DCN) Outcome of Divisional Confirm and Challenge.	Chief Nurse Outcome of Confirm and Challenge
AMU2	Current staffing establishment does not support the national SAM guidance for the night shift staffing. Request an uplift of 1 RN overnight. The SNCST tool recommends additional uplift of 6.21 WTE which would account for the 2.6 WTE required to meet the guidance.	The Lead nurse is also the lead for another ward area (Not congruent of Trust policy or RCN guidance). Additional patients are regularly taken within the ward footprint both day and night increasing the RN need. DCN supportive of the request. Would require financial investment.	Supportive of the clinical need subject to the Division: • Identifying their required workforce reduction elsewhere. • Identifying funding to enact the change. • Completing a QIA.
B1		There has been a change in shift pattern and the service needs and demands in the clinical area. Recommend a reduction in 1.8 WTE RN.	Supportive of the reduction subject to the Division completing a QIA.
B6	Request for an additional 1 WTE CSW. This would increase the CSWs on shift by 1. This is supported with multiple additional staffing requests and red flags raised on safecare for staffing concerns. These staffing concerns have been validated by	Area is a high bank use area which would be reduced by this increase. Staffing numbers reduce at night with less RNs on shift. 3:2 day 2:2 night Would require financial investment. Supportive of the request.	Supportive of the clinical need subject to the Division: • Identifying their required workforce reduction elsewhere.

Area	Ward/Department Request/Amendments	Divisional Chief Nurse (DCN) Outcome of Divisional Confirm and Challenge.	Chief Nurse Outcome of Confirm and Challenge
	the matron and 80% of them remained unchanged. The SNCST tool also reflects the need for an uplift in staffing. Request an increase in 2.6 CSW WTE. This would be at the band 2 level.		• Identifying funding to enact the change. • Completing a QIA.
C3	Recognised significant spend on bank for additional CSW staff. On average 3 additional requests for CSW's made each day. 50% of the additional shifts filled. 18 red flags raised due to staffing on the safecare system. The tool data suggests the ward is at a deficit of 16WTE. This area had 100% data collection.	Area is a high bank use area which would be reduced by this increase. Significantly high number of patients' requiring enhanced therapeutic observations and care. Staffing numbers reduce at night with less RNs on shift. Would require financial investment. Supportive of the request.	Supportive of the clinical need subject to the Division: • Identifying their required workforce reduction elsewhere. • Identifying funding to enact the change. • Completing a QIA.
C5a	Uplift of a B5 to a band 6 for night shift (Cost neutral). NIC carries the NIV bleep day and night. This is a B6 duty during the day but not at night.	Recognise that not having a B6 on duty 24 hours day is not reflective of the care needs for the patients and the support of the pathway for NIV initiation and remediation in other ward areas. Would not require financial investment. Team feels this is within their gift to support with a direct swap between C5A and C5B. It is felt there would be no negative impact to C5B with this move. Supportive of the request.	Supportive of the clinical need subject to the Division completing a QIA.
C5b		A review of the rosters has demonstrated 6 hours of B5 time not being used. This equates to a 1.36 WTE and 1.9 WTE B2 money. This is suggested to be reallocated to support some of the recommendations which would require financial investment. This review has also identified that the need for a B6 on C5a overnight can be accommodated by working collectively with C5b resulting in a cost and WTE neutral change.	Supportive of the clinical need, subject to the redistribution of funds and completion of QIA.
C7	Identified night times are busy and would like additional staff to support with the patient care. Ward area feels this is manageable within their current staff and look to change a RN shift from day to twilight.	Supportive of request. No financial investment required.	Supportive of the clinical need subject to the Division completing a QIA.

Area	Ward/Department Request/Amendments	Divisional Chief Nurse (DCN) Outcome of Divisional Confirm and Challenge.	Chief Nurse Outcome of Confirm and Challenge
C8		This review has identified inconsistencies in the band 7 workload. A review has been requested by the division to ensure parity of workload distribution.	
CCU	Identified that the previous reduction of 1 RN in the day at weekends, is not supportive of quality patient care and would like to have that shift reinstated.	Following exploration with the leadership team, it was identified that a band 7 practitioner was not entirely within the numbers. Utilising the shifts not rostered, this would free up the additional shifts required to the increase. No financial investment required. Supportive of the request.	Supportive of the clinical need subject to the Division completing a QIA.
DL		The nature of the capacity challenges has led to this area being open 24 hours 7days a week, which it is not staffed for.	The aim needs to be to reinstate this area as a Discharge Lounge.

It is recognised that the suggested changes in establishments will both release finances and create financial challenges.

Within the Division of Medicine, the C5a and C5b changes would be cost neutral, the suggested changes for CCU would also be cost neutral alongside the C7 suggested changes. The other suggestions would incur a financial increase, which the finance business partners are collaboratively working with the Division to identify appropriate financial streams to support further discussions.

The review has highlighted there is wider work which is ongoing looking at the location of current specialities, in particular B4, B6 and C6 and the options for relocation. As this would be cross divisional, a collaborative approach is being taken to progress this work further.

11. RISKS

Some risks have been identified with this review and the outputs and suggested establishment changes.

Data integrity

The tool asks for data to be collected for 30 days at the prescribed time and by a maximum of 3 collectors each day. Throughout our review there has been some days of data collection which was missed (further details can be seen in Appendix 10).

Jun-24	Data days collected (?/30)	Weekly QA numbers (?/4)	Jun-24	Data days collected (?/30)	Weekly QA numbers (?/4)	Jun-24	Data days collected (?/30)	Weekly QA numbers (?/4)
AMU1	29	3	B6	23	4	C7	27	3
AMU2	28	4	C1A	30	4	C8	29	4
AMU3 (A4)	26	4	C1B	30	4	CCU	22	4
AMUA	27	3	C2	23	3	DL	25	3
B1	29	4	C3	30	4	ESH	30	3
B2H	26	4	C4	28	3	MECU	29	2
B2T	30	4	C5A	27	4	FMU	23	4
B3	30	4	C5B	23	3	ED Adults	24/24	1/2
B4	27	4	C6	25	3	ED Paeds	24/24	1/2

The quality assurance process was followed with most areas being reviewed over 50% of the required ask. The quality assurance reviews did not flag any anomalies, however interrogation of the entire data set identified concerns around the application of the acuity scores and the process. It also raised question about the due diligence of the data collectors.

The lack of days of data collection will have an impact on the overall averages used within the tool and the overall recommendations of staffing form the tool.

The wider triangulation of information and the conversations with finance business partners also highlighted that there are differences in understanding of budgets and what is and is not included in the establishments. This made it challenging to see the clear financial envelope and skill mic of staff in place.

Jun-24	Beds	Recommended WTE (Reg)	Recommended WTE NR	Recommended Overall Total	Funded Budget	Diff FB is to Rec Over	Ward Profile Document WTE
AMU1	22	48.57	20.82	69.39	79.98	10.59	-18.92
AMU2	30	46.92	20.11	67.03	59.16	-7.87	-0.83
AMU3 (A4)	12	16.99	7.28	24.27	24.03	-0.24	0.54
AMUA	22	30.22	12.95	43.18	63.23	20.05	-2.17
B1	26	19.79	8.48	28.27	31.86	3.59	-1.57
B2H	24	30.15	12.92	40.08	48.69	8.61	-3.82
B2T	24	26.89	11.53	38.42	42.06	3.64	0.75
B3	36	42.19	18.08	60.27	65.82	5.55	-3.05
B4	48	47.67	20.43	68.1	84.84	16.74	-5.97
B6	16	19.21	8.23	27.45	25.52	-1.93	-0.95

C1A	**24**	31.71	13.59	45.3	42.24	-3.06	-3.34
C1B	**24**	27.85	11.94	39.79	42.24	2.45	-3.34
C2	**47**	37.6	16.1	53.7	53.51	-0.19	-0.46
C3	**36**	53.85	23.08	76.93	60.76	-16.17	-0.47
C4	**24**	19.91	8.53	28.44	42.19	13.75	-1.71
C5A	**24**	30.27	12.97	43.24	41.15	-2.09	-0.32
C5B	**24**	28.1	12.04	40.14	51.94	11.8	-0.75
C6	**19**	18.86	8.08	26.94	33.01	6.07	-3.31
C7	**36**	48.55	20.81	69.36	66.93	-2.43	0.71
C8	**44**	50.89	21.81	72.7	91.8	19.1	-5.76
CCU	**24**	29.58	12.68	42.26	52.1	9.84	1.57
DL	**16**	20.37	8.73	29.1	25.3	-3.8	-15.16
ESH	**26**	38.31	16.42	54.72	69.58	14.86	-5.25
MECU	**8**	11.91	5.11	17.02	23.18	6.16	-0.66
FMU	**16**	17.98	41.95	59.93	49.34	-10.59	-2.25
ED Adults	-------	72.1	30.9	103	164.19	61.19	3.04
ED Paeds	-------	19.3	8.3	27.6	35.43	7.83	0.01

The use of professional judgements remains subjective, however has been extremely important with the understanding as to the differences in recommendations between the tools and the actual of the current establishments. The interpretation of the data available is also subjective however it is felt that the scrutiny and wider understanding of the information by the Deputy Chief Nurse and Chief Nurse has been able to support the Divisional Chief Nurses interpretation.

Due to how the data is made available and the need for collation, there has been a significant amount of transcription of information undertaken. This ranges from the need and necessity of the tool requirements to the manual collation of the information from the data collection. This has all had to be manually collated and inputted which increases the risk of transcription and human error. Where possible all data transcription has been double checked and any formulas used within software packages has also been reviewed. Divisional Chief Nurses have also been asked to ensure the data reflects their knowledge and wider narrative. It must also be noted that the data was downloaded from the systems on 1st July 2024, so any internal validation which is usually performed was not undertaken.

The SNCT has been revised with new descriptors being used. This is the first time the newer acuity tool has been used within the adult inpatient areas and the first time the bespoke children and young people tool and the Emergency Department tool were used. Variety of training sessions has been undertaken prior to this implementation and review and has continued throughout the process. An assessment in practice test has been introduced which has been a compulsory ask for all who were undertaking the data collection.

12. NEXT STEPS

The proposed next steps are detailed following this review

- Further data collection and review of Adult Inpatient areas, adult assessment Units, Children and Young People and Emergency Department areas to be undertaken as planned in January 2025.
- Finance colleagues to continue with wider consolidation of opportunities to support the suggested establishment changed.
- Further training sessions to be made available in November and December 2024 before the next data collection is undertaken.
- Two colleagues have attended the NHSE 2-day safer staffing training to further build the necessary knowledge and skills with regards to safer staffing in the organisation. In addition, one senior nurse has applied to complete the NHSE the Safer Stafing Fellow programme (response from NHSE is awaited).
- Take forward the implementation of staffing reviews over the coming months in alignment with the Black Country Provider Collaborative work.
- Work with IT colleagues to support easier access to the data required to support the reviews.
- Work with Divisions to review ideas relating to clinical area moves and correct environments for services to be delivered.
- Work with safeguarding colleagues to fully understand the average time commitment for safeguarding referral completion and subsequent work.

APPENDICES:

Trust Compliance with Safer Nursing Care Tool Red Rules - Appendix 1

	SNCT Red Rule	June 2024 Compliance	RAG		SNCT Red Rule	June 2024 Compliance	RAG
AIP AAU CYP ED	Nominate a senior registered nursing lead to quality control the data collection, process and outputs. This will include data collection timeframes, training records, external validation rotas, data analysis and dissemination of results. This should be a senior member of the corporate nursing team.	Helen Bromage Deputy Chief Nurse		AIP AAU CYP ED	Ensure a training and education process is in place, on how to implement the SNCT in practice encompassing and inter-rater reliability assessment and ongoing refresher training. Up to date and accessible training records must be maintained and held at trust level.	Numerous training sessions facilitated throughout the month leading up to the data collection month and throughout the data collection month. Further dates have been planned and in place for the next review. Training records are stored on a central Teams folder which is accessible the Division Chief nurses, their deputies and the corporate team.	
AIP AAU CYP	Identify no more than 3 leads per ward to complete the scoring daily for the duration of the data collection period.	Clear instructions were given to the ward teams. The collated data sets support a maximum of 3 people in ward collected data each day		AIP AAU CYP ED	The data collection should take place a minimum of twice per year to allow incorporation of variation within the year. The average combined data sets are used to support establishment setting/resetting.	Agreed across the Black Country Provider Collaborative that data collection will take place every June and January	
ED	Identify a sufficient cohort if leads/shift leaders in the department to complete the scoring twice daily for the						

	duration of the data collection period						
AIP AAU CYP ED	The three leads must include the Ward manager. If no Ward Manager is available a nominated member of staff should be agreed with the senior nurse for the Directorate/Division	Clear instructions were given to the ward teams, that the Lead Nurse and if not available the NIC should be one of the 3 people.		AIP AAU	During data collection periods, every patient needs to have a level of care recorded daily for a minimum of 30 days using the decision matrix measuring the patient care required/received retrospectively for the previous 24 hours.	Data collected as directed at 15:00 each day. ED data collected at the prescribed hours.	
				CYP	During data collection periods, every patient needs to have a level of care recorded daily for a minimum of 20 days using the decision matrix measuring the patient care required/received retrospectively for the previous 24 hours.		
				ED	Acuity and dependency data should be collected for each patient in the department at the set twice daily intervals.		
AIP AAU	Data collection should be undertaken over 30 consecutive days and be undertaken by appropriately trained and assessed staff.	AIP, AAU and CYP areas collected data for the entire month of June. ED collected data for 14 days.		AIP AAU CYP ED	Acuity and dependency data should be collected for each patient in each bed at the same agreed time, as part of a bed ward round.	As above for all areas/	
CYP	Data should be collected for a minimum of 20 days						
ED	Data should be recorded on every patient present in the						

	department for a total of 12 days minimum.						
AIP AAU CYP ED	External validation is conduced weekly with the designated ward nurse as part of the daily ward round by a senior nurse outside of the ward's budgetary responsibility	Rota plan created and disseminated for the QA areas.		AIP AAU CYP ED	Nurse sensitive indicators/quality outcomes data for the same timeframe are to be collected retrospectively by a senior nurse or directly pulled from the electronic incident reporting system	Data collated from the central systems where possible. Datix, Allocate safecare and Sunrise being the main ones. These were collated by the Corporate team and reviewed by the leading Deputy Chief Nurse.	
AIP AAU CYP ED	Ensure the senior nurses undertaking the external validation has been appropriately trained and assessed.	All asked to undertake the training and the AIP assessment. Cross referencing this		AIP AAU CYP ED	Results should be provided to Ward Managers, Matrons, Heads of Departments Directors of nursing as soon as possible	All results were available to the Lead Nurse, Matron, Deputy Divisional Chief Nurse, Divisional Chief Nurse, HR Business Partner, Finance Business Partner, Trust Deputy Chief Nurses and Trust Chief Nurse by 17:00 2nd July 2024	
				AIP AAU CYP ED	These results should be reviewed within your biannual establishment setting process in line with the National Quality Board and Developing Workforce Safeguards guidance.	Challenge conversations within the divisions was undertaken 3rd, 4th and 5th July 2024	

AIP – Adult Inpatient
AAU – Adult Assessment Unit
CYP – Children & Young People
ED – Emergency Department

Data Collection Output At a Glance - Appendix 2a

Jun-24	Beds	Acuity 0	Acuity 1a	Acuity1b	Acuity1c	Acuity1d	Acuity2	Acuity3	Acuity BE	Data days collected (?/30)	Weekly QA numbers (?/4)	No safeguarding	No Falls	No PU	Covid 19	Norovirus	CDI	E Coli	MSSA	Observations post target			Medicines Late/Unplanned ommission		
																				L	M	H	Late	Unplanned Ommission	
AMU1	22	0.93	8.48	13.07	1.79	0.21	4.97	0.07	1.07	29	3	2	7	7	0	1	0	0	0	2424	297	168	1642	2280	AMU1
AMU2	30	1.39	9.71	15.21	3.21	0.04	0.32	0.04	0.07	28	4	0	7	8	0	1	0	0	0	2493	81	37	1254	2212	AMU2
AMU3 (A4)	12	2.08	2.50	5.96	0.58	0.00	0.04	0.00	0.85	26	4	0	6	1	1	1	0	0	0	1126	9	1	801	724	AMU3 (A4)
AMUA	22	3.22	8.74	8.67	0.67	0.04	0.30	0.00	0.37	27	3	0	9	1	0	1	2	0	0	1883	43	20	758	1869	AMUA
B1	26	17.52	1.00	0.55	0.52	0.00	0.00	0.03	6.38	29	4	0	1	0	0	0	0	0	0	1245	6	1	642	1123	B1
B2H	24	4.30	0.15	18.63	0.67	0.04	0.00	0.00	0.22	26	4	1	4	4	0	0	0	0	0	2092	32	18	541	2261	B2H
B2T	24	8.48	0.10	15.03	0.34	0.00	0.00	0.00	0.03	30	4	0	4	8	0	0	0	0	0	2202	13	9	741	2598	B2T
B3	36	12.67	2.77	16.03	1.00	0.47	2.00	0.00	0.73	30	4	1	4	4	0	0	0	0	1	3145	13	12	1583	3326	B3
B4	48	21.48	5.76	16.24	1.17	0.00	1.07	0.00	1.28	27	4	3	5	9	0	0	0	0	11	3414	60	27	1383	3904	B4
B6	16	6.30	0.96	6.83	1.09	0.22	0.04	0.00	0.57	23	4	0	6	5	1	0	0	0	0	1371	20	5	658	849	B6
C1A	24	2.17	1.70	18.73	1.30	0.00	0.00	0.00	0.10	30	4	0	3	7	1	1	0	0	0	492	29	3	818	1258	C1A
C1B	24	3.47	3.77	16.53	0.03	0.00	0.00	0.00	0.20	30	4	0	1	1	0	0	0	0	0	2152	85	20	937	1361	C1B
C2	47	23.22	0.35	3.57	-------	-------	0.13	0.00	15.74	23	3	2	1	0	0	0	0	0	1	1263	322	47	------	------	C2
C3	36	3.00	1.27	26.40	5.33	0.00	0.00	0.00	0.00	30	4	0	4	4	0	0	0	0	0	2970	30	17	771	1996	C3
C4	24	2.55	15.62	2.90	0.07	0.00	0.03	0.00	0.41	28	3	0	1	2	1	0	1	1	0	1602	26	31	1530	1398	C4
C5A	24	2.15	6.67	12.52	1.81	0.00	0.56	0.00	0.00	27	4	1	3	6	0	0	0	0	0	2097	45	18	749	1404	C5A
C5B	24	1.67	7.63	12.50	0.04	0.00	2.00	0.00	0.00	23	3	0	3	5	0	0	0	0	0	2148	68	21	699	1425	C5B
C6	19	9.41	0.59	8.89	0.07	0.00	0.00	0.00	0.04	25	3	0	3	1	0	0	0	0	0	1585	94	68	570	2116	C6
C7	36	1.56	3.70	27.89	2.26	0.00	0.11	0.00	0.59	27	3	1	7	4	0	0	2	0	0	3563	82	55	1184	2723	C7
C8	44	8.68	7.00	25.86	0.71	0.00	1.18	0.00	0.39	29	4	3	4	3	0	0	0	0	0	3887	62	68	1390	1560	C8
CCU	24	2.59	8.64	10.27	0.41	0.14	1.68	0.00	2.27	22	4	1	6	6	0	0	2	0	0	626	39	9	790	1438	CCU
DL	16	1.44	0.84	12.96	0.32	0.04	0.00	0.00	0.36	25	3	0	4	8	0	0	0	0	0	5	1	0	5	05-Jan	DL
ESH	26	21.94	5.06	7.01	0.17	0.00	0.13	0.00	2.24	30	3	0	2	2	0	0	2	0	0	3190	18	19	1630	2844	ESH
MECU	8	1.45	1.62	1.76	0.41	0.28	1.76	0.00	1.72	29	2	4	0	0	0	0	0	0	0	244	6	0	581	708	MECU
FMU	16	0.22	0.04	2.81	12.85	0.04	0.00	0.00	0.04	23	4	0	3	3	0	0	1	0	0	1237	2	2	401	1415	FMU
ED Adults	-------	118.00	42.00	54.00	16.00	-------	5.00	1.00	-------	24/24	1/2	57	5	3	0	0	1	0	0	1408	507	424	------	------	ED Adults
ED Paeds	-------	46.00	16.00	7.00	1.00	-------	0.00	0.00	-------	24/24	1/2	59	0	0	0	0	0	0	0	105	45	10	------	------	ED Paeds

Data Collection Output At a Glance - Appendix 2b

Jun-24	Beds	RN/CSW%	Recommended WTE (Reg)	Recommended WTE NR	Recommended Overall Total	Funded Budget	Diff FB is to Recc Over	Ward Profile Document WTE	Requests suggested by ward leadership.	Changes supported by Division	Change requested WTE	QIA requirement	
AMU1	22	60/40	48.57	20.82	69.39	79.98	10.59	-18.92	No	No			AMU1
AMU2	30	55/45	46.92	20.11	67.03	59.16	-7.87	-0.83	Yes	Yes	↑ RN WTE	✓	AMU2
AMU3 (A4)	12	50/50	16.99	7.28	24.27	24.03	-0.24	0.54	No	No			AMU3 (A4)
AMUA	22	55/45	30.22	12.95	43.18	63.23	20.05	-2.17	No	No			AMUA
B1	26	60/40	19.79	8.48	28.27	31.86	3.59	-1.57	Yes	Yes	↓RN WTE	✓	B1
B2H	24	40/60	30.15	12.92	40.08	48.69	8.61	-3.82	No	No			B2H
B2T	24	50/50	26.89	11.53	38.42	42.06	3.64	0.75	No	No			B2T
B3	36	55/45	42.19	18.08	60.27	65.82	5.55	-3.05	No	No			B3
B4	48	50/50	47.67	20.43	68.1	84.84	16.74	-5.97	No	No			B4
B6	16	55/45	19.21	8.23	27.45	25.52	-1.93	-0.95	Yes	Yes	↑ CSW WTE	✓	B6
C1A	24	50/50	31.71	13.59	45.3	42.24	-3.06	-3.34	No	No			C1A
C1B	24	50/50	27.85	11.94	39.79	42.24	2.45	-3.34	No	No			C1B
C2	47	80/20	37.6	16.1	53.7	53.51	-0.19	-0.46	No	No			C2
C3	36	55/45	53.85	23.08	76.93	60.76	-16.17	-0.47	Yes	Yes	↑ CSW WTE	✓	C3
C4	24	70/30	19.91	8.53	28.44	42.19	13.75	-1.71	No	No			C4
C5A	24	60/40	30.27	12.97	43.24	41.15	-2.09	-0.32	Yes	Yes	Work together for B6 cover on	✓	C5A
C5B	24	55/45	28.1	12.04	40.14	51.94	11.8	-0.75	No	Yes	night & surplus £ identified	✓	C5B
C6	19	50/50	18.86	8.08	26.94	33.01	6.07	-3.31	No	No			C6
C7	36	50/50	48.55	20.81	69.36	66.93	-2.43	0.71	Yes	Yes	Redistribute of B7 work	✓	C7
C8	44	55/45	50.89	21.81	72.7	91.8	19.1	-5.76	No	Yes	Redistribute of B7 work	✓	C8
CCU	24	80/20	29.58	12.68	42.26	52.1	9.84	1.57	Yes	Yes	↑ RN WTE	✓	CCU
DL	16	60/40	20.37	8.73	29.1	25.3	-3.8	-15.16	No	Yes	Return to a Discharge Lounge		DL
ESH	26	70/30	38.31	16.42	54.72	69.58	14.86	-5.25	No	No			ESH
MECU	8	75/25	11.91	5.11	17.02	23.18	6.16	-0.66	No	No			MECU
FMU	16	30/70	17.98	41.95	59.93	49.34	-10.59	-2.25	No	No			FMU
ED Adults	-------	60/40	72.1	30.9	103	164.19	61.19	3.04	No	No			ED Adults
ED Paeds	-------	50/50	19.3	8.3	27.6	35.43	7.83	0.01	No	No			ED Paeds

Safer Nursing Care Tool Decision Matrix Adult Inpatient and Adult Acute Assessment Units- Appendix 3

the SHELFORD GROUP

Safer Nursing Care Tool (SNCT)

Safer Nursing Care Tool

Care level	Descriptor *Care requirements may include the following:*
Level 0 Hospital Inpatient Needs met by provision of normal ward cares.	• Underlying medical condition requiring on-going treatment. • Post-operative / post-procedure care - observations recorded as per local policy. • National Early Warning Score (NEWS) is within normal threshold. • Patients requiring oxygen therapy. • Patients not requiring enhanced therapeutic observations (according to local policy). • Patients requiring assistance of one with some activities of daily living.
Level 1a Acutely ill patients requiring intervention or those who are UNSTABLE with a GREATER POTENTIAL to deteriorate.	• Step down from Level 2 care. • Requiring continual observation / invasive monitoring/physiological assessment. • NEWS local trigger point reached and requiring intervention/action/review. • Pre-operative optimisation/post-operative care for complex surgery. • Requiring additional monitoring/clinical interventions/clinical input including: – Patients at risk of a compromised airway – Oxygen therapy greater than 35%, + / - chest physiotherapy 2–6 hourly or intermittent arterial blood gas analysis – Post 24 hours following insertion of tracheostomy, central lines, epidural or multiple chest drains – Severe infection or sepsis – New spinal injury/cord compression
Level 1b Patients who are in a STABLE condition but are dependent on nursing care to meet most or all of their care needs.	• Complex wound management requiring more than one nurse or takes more than one hour to complete. • Patients with stable Spinal/Spinal Cord Injury. • Patients who consistently require the assistance of two or more people with mobility or repositioning. • Requires assistance with most or all care needs. • Complex Intravenous Drug Regimes – (including those requiring prolonged preparatory/administration/post-administration care). • Patient and/or carer's requiring enhanced psychological support owing to poor disease prognosis or clinical outcome. • Patients requiring intermittent or within eyesight observations according to local policy. • Facilitating a complex discharge where this is the responsibility of the ward-based nurse.
Level 1c Patients who are in a STABLE condition but are requiring additional intervention to mitigate risk and maintain safety	• Patients requiring arm's length or continuous observation as per local policy.

Care level	Descriptor *Care requirements may include the following:*
Level 1d Patients who are in a STABLE condition but are requiring additional intervention to mitigate risk and maintain safety	• Patients requiring arm's length or continuous observation by 2 or more members of staff (provided from within ward budget) as per local policy.
Level 2 Patients who may be managed within clearly identified, designated beds with the resources, expertise and staffing levels required OR may require transfer to or be cared for in a dedicated Level 2 facility/unit.	• Deteriorating / compromised single organ system. • Step down from Level 3 care or step up from Level 1a. • Post-operative optimisation/ extended post-op care. • Cardiovascular, renal or respiratory optimization requiring invasive monitoring. • Patients requiring non-invasive ventilation/respiratory support; CPAP/BiPAP in acute respiratory failure. • First 24-hours following tracheostomy insertion or patients post 24-hours requiring 2-hourly suction. • CNS depression of airway and protective reflexes. • Patients with burns where more than 30% body surface area is affected or requiring conscious sedation for dressing changes. • Requires a range of therapeutic interventions which may include: – Greater than 50% oxygen continuously – Requiring close observation due to acute deterioration and needing advanced organ support – Drug Infusions requiring more intensive monitoring e.g. vasoactive drugs (amiodarone, inotropes, gtn) or potassium, magnesium – CNS depression of airway and protective reflexes – Invasive neurological monitoring including ICP, external ventricular drains and lumbar drains
Level 3 Patients needing advanced respiratory support and/ or therapeutic support of multiple organs.	• Monitoring and supportive therapy for compromised/collapse of two or more organ/ systems. • Respiratory or CNS depression/compromise requires mechanical/invasive ventilation. • Invasive monitoring, vasoactive drugs, treatment of hypovolaemia/haemorrhage/ sepsis or neuro protection.

Published October 2023

Safer Nursing Care Tool Decision Matrix Children and Young People - Appendix 4

The Children's & Young People's Safer Nursing Care Tool - Decision Matrix

The Children's & Young People's Safer Nursing Care tool (C&YP SNCT) is based upon, but not aligned to, the Paediatric Intensive Care Society classifications (Paediatric Intensive care Society 2010). These classifications have been adapted to support measurement across a range of C&YP wards/specialties.

Children's & Young Peoples Safer Nursing Care Tool - Decision Matrix

Levels of Care	Descriptor
Level 0 Child/young person requires hospitalisation - needs met through normal inpatient care	**Care requirements may include the following** • Oxygen therapy less than 40% and patient stable • May have underlying medical condition requiring on-going treatment • Patients awaiting discharge • Post-operative/post-procedure care – observations recorded half hourly initially then 4-hourly. • Regular observations 2 – 4 hourly • Basic fluid Management • Intravenous Medication Regimes – (NOT requiring prolonged preparation/ administration/post-administration care) • **Early Warning Score** is within normal threshold.
Level 1a Child /young person is acutely ill requiring close supervision and monitoring, or is **unstable** with a **greater potential** to deteriorate usually available through normal inpatient care	**Care requirements may include the following** • Oxygen therapy greater than 40% +/- Chest Physiotherapy six hourly • Respiratory care requiring two hourly nebulised medicine • Stable nasopharyngeal airway • Post op care following complex trauma/surgery in acute phase • Patient within 24 hour of returning from PICU/ICU • Instability requiring increased level of observation and therapeutic intervention or continual observation • Patient on PCA/NCA/Epidural • Emergency Admissions requiring immediate therapeutic intervention. • **Early Warning Score** - trigger point reached and requiring escalation.

Levels of Care	Descriptor
Level 1b Child/young person is **stable** but dependent on nursing care interventions/ intensive therapy to meet most or all their care.	**Care requirements may include the following** • Unaccompanied children • Established High Humidity, High Flow Nasal Cannula (HHHFNC) • Recurrent apnoea-self resolving • Stable patient requiring two hourly blood sampling • Post op care following complex trauma/surgery in rehab phase • Complex wound management requiring more than 1 nurse or takes more than 1 hour to complete. • Spinal Instability/Spinal Cord injury – rehab phase • Mobility or repositioning difficulties requiring two staff • Complex Intravenous Drug Regimes – (including those requiring prolonged preparation/administration/post-administration care) • Patient and/or carers requiring enhanced psychological support due to poor disease prognosis or clinical outcome or high level of emotional support • End of life care • Confused children/young people who are at risk or requiring constant supervision • Potential for self-harm and requires constant observation • Facilitating a complex discharge where this is the responsibility of the ward-based nurse • High level Safeguarding input • Tracheostomy – post seven-days.
Level 2 Child/young person who may require closer observation & monitoring than is usually available through normal inpatient care.	**Care requirements may include the following** • CPAP/ BiPAP • Unstable nasopharyngeal airway • Tracheotomy- initial seven days • Instability requiring a range of therapeutic interventions and invasive monitoring • Respiratory care requiring IV therapy • Unstable diabetic ketoacidosis • Single organ monitoring and support • Exchange transfusions • Chest drains • Hypovolaemic/neurogenic shock • Complex fluid +/or electrolyte management • Glasgow coma scale 8-12 • Prolonged seizures requiring intervention • Recurrent apnoea requiring intervention • Patients requiring NIV/respiratory support as a step down from level three care or acute illness phase
Level 3 Child/young person is unstable and requires advanced respiratory and therapeutic support for multiple organ problems.	**Care requirements may include the following** • Monitoring and Supportive Therapy for Compromised/Collapse of two or more Organ/Systems • Respiratory or CNS depression/compromise requires Invasive ventilation • Children requiring advanced respiratory support whilst awaiting transfer i.e. PICU admission. • CPAP/BiPAP Tracheotomy- initial seven days in a single room facility • Active resuscitation • Invasive monitoring, vasoactive drugs, treatment of hypovolaemia/ haemorrhage/sepsis or neuro-protection • Child/Young person receiving 1:1 nurse 'specialing'

Safer Nursing Care Tool Acuity Data- Appendix 5

Jun-24	Beds	Acuity 0	Acuity 1a	Acuity 1b	Acuity 1c	Acuity 1d	Acuity 2	Acuity 3	Acuity BE
AMU1	**22**	0.93	8.48	13.07	1.79	0.21	4.97	0.07	1.07
AMU2	**30**	1.39	9.71	15.21	3.21	0.04	0.32	0.04	0.07
AMU3 (A4)	**12**	2.08	2.50	5.96	0.58	0.00	0.04	0.00	0.85
AMUA	**22**	3.22	8.74	8.67	0.67	0.04	0.30	0.00	0.37
B1	**26**	17.52	1.00	0.55	0.52	0.00	0.00	0.03	6.38
B2H	**24**	4.30	0.15	18.63	0.67	0.04	0.00	0.00	0.22
B2T	**24**	8.48	0.10	15.03	0.34	0.00	0.00	0.00	0.03
B3	**36**	12.67	2.77	16.03	1.00	0.47	2.00	0.00	0.73
B4	**48**	21.48	5.76	16.24	1.17	0.00	1.07	0.00	1.28
B6	**16**	6.30	0.96	6.83	1.09	0.22	0.04	0.00	0.57
C1A	**24**	2.17	1.70	18.73	1.30	0.00	0.00	0.00	0.10
C1B	**24**	3.47	3.77	16.53	0.03	0.00	0.00	0.00	0.20
C2	**47**	23.22	0.35	3.57	-------	-------	0.13	0.00	15.74
C3	**36**	3.00	1.27	26.40	5.33	0.00	0.00	0.00	0.00
C4	**24**	2.55	15.62	2.90	0.07	0.00	0.03	0.00	0.41
C5A	**24**	2.15	6.67	12.52	1.81	0.00	0.56	0.00	0.00
C5B	**24**	1.67	7.63	12.50	0.04	0.00	2.00	0.00	0.00
C6	**19**	9.41	0.59	8.89	0.07	0.00	0.00	0.00	0.04
C7	**36**	1.56	3.70	27.89	2.26	0.00	0.11	0.00	0.59
C8	**44**	8.68	7.00	25.86	0.71	0.00	1.18	0.00	0.39
CCU	**24**	2.59	8.64	10.27	0.41	0.14	1.68	0.00	2.27
DL	**16**	1.44	0.84	12.96	0.32	0.04	0.00	0.00	0.36
ESH	**26**	21.94	5.06	7.01	0.17	0.00	0.13	0.00	2.24
MECU	**8**	1.45	1.62	1.76	0.41	0.28	1.76	0.00	1.72
FMU	**16**	0.22	0.04	2.81	12.85	0.04	0.00	0.00	0.04
ED Adults	---------	118.00	42.00	54.00	16.00	-------	5.00	1.00	-------
ED Paeds	---------	46.00	16.00	7.00	1.00	-------	0.00	0.00	-------

QUALITY ASSURANCE PLAN JUNE 2024 V1

	Week Commencing 3rd June	Week Commencing 10th June	Week Commencing 17th June	Week Commencing 24th June
Helen Bromage	C2	B5	C2	B5
Alison Perry	B1	B2	B1	B2
Cat Wharton	C1A	C3	C1A	C3
Claire Weatherstone	B5	B1	B5	B1
Cleo Mckenzie	C1B	C1B	C1B	C1B
Debra Vasey	B2	C4	B2	C4
Gemma Powell	B3	C2	B3	C2
Hollie Murphy	C7	C8	C7	C8
Jayne Tranter	B4	POCU	B4	POCU
Jenny Bree	B5	B3	B5	B3
Jo Wakeman	MECU	Super Surge	MECU	ED
Karen Lewis	A4	C7	A4	C7
Leanne Beedles	B6	Discharge Lounge	B6	Discharge Lounge
Lesley Leddington	C8	C1A	C8	C1A
Liz Watkins	AMU1	AMU2	AMU1	AMU2
Lucy Rozga	C5B	B4	C5B	B4
Maria Dance	VASCU	C8	VASCU	C8
Marie Banner	POCU	Cardiology	POCU	Cardiology
Michelle Jinks	Super Surge	B3	Super Surge	B3
Michelle Pinto	Cardiology	C5B	Cardiology	C5B
Nat Hill	ED	C3	ED	C3
Nicola Thompson	C3	FMU	C3	FMU
Nusratt Bibi	FMU	AMU1	FMU	AMU1
Rachel Collins	AMU2	VASCU	AMU2	VASCU
Rachel Ormston	B5	C1B	ED	C1B
Sara Davis	Discharge Lounge	B6	Discharge Lounge	B6
Simon Gregory	C4	C5A	C4	C5A
Tracy Simner	C5A	AMU2	C5A	AMU2
Vicky Cheedle	C6	A4	C6	A4

If you are Matron on for the weekend in your allocation week, please can you undertake your QA at the weekend.
Please remember to use the dedicated link to record your QA. Available on the Hub.
If you have been allocated an area which falls into your portfolio, please swap with someone and let me know of the changes

QUALITY ASSURE A MINIMUM OF ONE THIRD OF THE PATIENTS ON THE AREA YOU HAVE BEEN ALLOC

Safer Staffing Summary **Jun** Days in Month 30

Ward	Day RN Plan	Day RN Actual	Day CSW Plan	Day CSW Actual	Night RN Plan	Night RN Actual	Night CSW Plan	Night CSW Actual	RN Day %	CSW Day %	RN N %	CSW N %	Sum 24:00 Occ	Actual CHPPD Registered	Care staff	Total
A2 /A4	94	75	60	49	60	59	60	58	80%	82%	98%	97%	336	4.67	3.83	8.51
B1	126	106	59	63	61	59	57	51	84%	107%	97%	89%	436	4.31	3.00	7.31
B2(H)	121	98	189	172	90	85	177	170	81%	91%	94%	96%	715	3.07	5.61	8.68
B2(T)	120	104	139	124	91	86	116	108	86%	89%	94%	93%	712	3.19	3.91	7.10
B3	166	183	217	167	158	177	203	179	110%	77%	112%	88%	1,130	3.74	3.67	7.41
B4	219	189	240	207	181	173	190	175	86%	86%	96%	92%	1,246	3.42	3.68	7.09
B5	225	183	140	139	213	200	74	66	81%	99%	94%	89%	975	4.82	2.45	7.27
C1	245	226	246	231	180	176	195	184	92%	94%	98%	94%	1,420	3.32	3.51	6.83
C2	272	234	63	67	241	218	62	64	86%	107%	90%	104%	553	9.59	2.79	12.38
C3	210	214	395	344	180	160	382	355	102%	87%	89%	93%	1,553	2.89	5.29	8.18
C4	198	165	65	71	120	100	60	75	84%	108%	83%	125%	647	4.80	2.59	7.39
C5	261	223	248	226	240	238	188	179	86%	91%	99%	95%	1,419	3.94	3.43	7.37
C6	94	91	93	84	90	86	67	63	97%	90%	96%	94%	552	3.76	3.19	6.95
C7	211	154	199	181	152	147	197	170	73%	91%	97%	86%	1,068	3.32	3.94	7.25
C8	250	228	210	182	210	197	178	166	91%	87%	94%	93%	1,279	3.90	3.27	7.16
CCU_PCCU	236	221	60	64	212	209	30	30	94%	107%	99%	100%	707	7.14	1.60	8.74
Critical Care	510	410	120	87	510	427			80%	73%	84%		505	19.88	2.08	21.95
EAU AMU	470	460	412	344	399	433	415	383	98%	84%	109%	92%	2,202	4.76	3.96	8.72
Maternity	835	771	329	211	509	485	194	133	92%	64%	95%	69%	1,325	9.05	3.03	12.08
MECU	93	89	37	32	96	92			96%	85%	96%		214	10.15	1.63	11.78
NNU	377	257			267	227			68%		85%		494	11.71	0.00	11.71
TOTAL	**5,333**	**4,680**	**3,520**	**3,043**	**4,259**	**4,034**	**2,845**	**2,609**	**88%**	**86%**	**95%**	**92%**	**19,488**	**5.15**	**3.45**	**8.60**

Nursing Sensitive Indicators – 30th June 2024 - Appendix 8

Commented [MM1]: Please include IPC data too - MRSA, c-diff and the number of outbreaks.

Jun-24	No Safeguarding	No Falls	No PU	Infection Prevention Control Escalations					Observations post Target			Medicines Late/Unplanned Omission	
				Covid 19	Norovirus	CDI	E Coli	MSSA	L	M	H	Late	Unplanned Omissions
AMU1	2	7	7		1				2424	297	168	1642	2280
AMU2		7	8		1				2493	81	37	1254	2212
AMU3 (A4)		6	1	1	1				1126	9	1	801	724
AMUA		9	1		1	2			1883	43	20	758	1869
B1		1							1245	6	1	642	1123
B2H	1	4	4						2092	32	18	541	2261
B2T		4	8						2202	13	9	741	2598
B3	1	4	4					1	3145	13	12	1583	3326
B4	3	5	9					11	3414	60	27	1383	3904
B6		6	5	1					1371	20	5	658	849
C1A		3	7	1	1				492	29	3	818	1258
C1B		1	1						2152	85	20	937	1361
C2	2	1						1	1263	322	47	------	------
C3		4	4						2970	30	17	771	1996
C4		1	2	1		1	1		1602	26	31	1530	1398
C5A	1	3	6						2097	45	18	749	1404
C5B		3	5						2148	68	21	699	1425
C6		3	1						1585	94	68	570	2116
C7	1	7	4			2			3563	82	55	1184	2723
C8	3	4	3						3887	62	68	1390	1560
CCU	1	6	6			2			626	39	9	790	1438
DL		4	8						5	1		5	05-Jan
ESH		2	2			2			3190	18	19	1630	2844
MECU	4								244	6		581	708
FMU		3	3			1			1237	2	2	401	1415
ED Adults	57	5	3			1			1408	507	424	------	------
ED Paeds	59								105	45	10	------	------

Data Sources Supporting the Professional Judgement (June 2024) - APPENDIX 9

TOPIC	CONTENT
Complaints	All complaints received and summary of content
Falls	Number of falls per team extracted from incident management system
Medications	All late, missed or unexpected omitted medications
Safeguarding	Number of safeguarding referrals made per team
Pressure Ulcers	Number of pressure ulcers per team extracted from incident management system
Observations	Total number of observations and which were recorded early, on time or late
Red Flags	Number and reason for red flags raised in Safecare (erostering) per team
Professional Judgement	The records of all professional judgements recorded in Safecare per team
Ward attenders	The number of ward attenders per team
Patient Transfers / escorts	Number of patient transfers and escorts per team

Patient Acuity /Dependency Summary Sheet Schedule Emergency Department – Appendix 10

Jun-24																														
Day	Day 1		Day 2		Day 3		Day 4		Day 5		Day 6		Day 7		Day 8		Day 9		Day 10		Day 11		Day 12		Day 13		Day 14	
Time	00:00	12:00	01:00	13:00	02:00	14:00	03:00	15:00	04:00	16:00	05:00	17:00	06:00	18:00	07:00	19:00	08:00	20:00	09:00	21:00	10:00	22:00	11:00	23:00	00:00	12:00	01:00	13:00

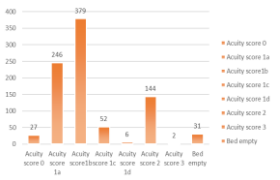
Data Collection and Quality Assurance Compliance – Appendix 11

Jun-24	1st	2nd	3rd	4th	5th	6th	7th	QA	8th	9th	10th	11th	12th	13th	14th	QA	15th	16th	17th	18th	19th	20th	21st	QA	22nd	23rd	24th	25th	26th	27th	28th	QA	29th	30th
AMU1																13								25								28		
AMU2								5th								11								19								29		
AMU3 (A4)								6th								14								20								27		
AMUA								7th								13								20										
B1								7th								14								20								28		
B2H								7th								14								24								28		
B2T								7th								14								24								28		
B3								6th								13								20/22								27/28		
B4								6th								15/16								21								25/28		
B6								6th								14								22								25		
C1A								7th								12								21								28		
C1B								5th								14								21								28		
C2								8th								14								17										
C3								5th								14/15								17								25		
C4								6th								13								19										
C5A								7th								14								17								25		
C5B																13								20								27		
C6								7th								14								20										
C7								7th																20								26		
C8								7th								14								20								27		
CCU								5th								11								21								28		
DL								7th								13																28		
ESH								5th								14								20										
MECU								7th																								25		
SS	N/O													N/O																	?? Open			
FMU								6th								12								21								28		
ED AM																																		
ED PM																																		

Ward at a Glance Professional Judgement and Data Sets – Appendix 12

Bed Numbers- 22 — **Safer Staffing Review June 2024 – Ward AMU1** — NHS The Dudley Group NHS Foundation Trust — **M**

Acuity Data



Professional Judgement

- 22 beds and ligature free rooms (2 reduced visibility
- High volume of admissions (159) (15 transferred to level 2/3 areas)
- Data integrity- recorded empty beds instead of recording acuity of previous patient
- Unable to observe patient in bays unless in the bay-high numbers of escorts internal and external. Ward rounds are continuous
- 8 monitored beds (level1) Included in this where staffing ratio is 1:4 with a supernumerary band 6 in charge of the unit.
- Band 7 clinical nurse is not allocated a group of patients. Area consistently has additional patients which are not able to be accounted for in the SNCT figures.

Current Total Establishment (Inc relief)	79.98
Registrants WTE	47.2
Non-registrant WTE	32.8
Skill mix ratio (RN : CSW)	8:6
Tool Recommended Establishment	**69.39**
Registrants WTE	48.97
Non-registrant WTE	20.82

Nurse Sensitive Indicators

Observations	Number	On target	Post target
EWS Low	5215	2791	2424
EWS Medium	387	90	297
EWS High	201	33	168

Medicines	Total -
Late	1642
Unplanned Omission	2280

Falls	Pressure Ulcers	Complaints
7	7	0

What the data tells us

- Turnover 0
- Sickness 4%
- KPIs and rostering within target
- RN and CSW split 55/45- higher in monitored areas

No Change Recommended

Next steps & impact

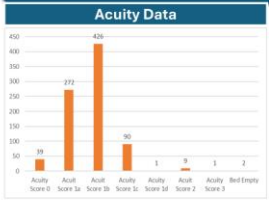
- Recommend no change

Risks

- Lead nurse also responsible for AMU assessment (Breach of RCN guidance (equates 52 patients inc 8 level 1 and 14 staff)

BED NUMBERS - 30 — **Safer Staffing Review June 2024 – Ward AMU2** — NHS The Dudley Group NHS Foundation Trust — **M**

Acuity Data



Professional Judgement

- Lead Nurse budgeted to this ward but also covers ward AMU3 (Breach of RCN guidelines)
- Ligature free rooms (1 reduced visibility(complex mental health pts)
- Data integrity - recorded empty bed and not the previous patients acuity, didn't capture additional patients when moved bed base, missed having additional patients. 2 days data collection missed
- High volume of admissions (392), discharges (206) and transfers out (206)
- Direct admissions from ED
- 28 patients NEWS between 5/6 and 14 NEWS7
- Retention good and downward trajectory for sickness

Current Total Establishment (Inc relief)	59.16
Registrants WTE	31.9
Non-registrant WTE	27.3
Skill mix ratio (RN/CSW)	D 6:5 N 5:5
Tool Recommended Establishment	**67.03**
Registrants WTE	46.92
Non-registrant WTE	20.11

Nurse Sensitive Indicators

Observations	Number	On target	Post target
EWS Low	4869	2376	2493
EWS Medium	104	23	81
EWS High	44	7	37

Medicines	Total -
Late	1254
Unplanned Omission	2212

Falls	Pressure Ulcers	Complaints
7	8	3

What the data tells us

- Current staffing establishment does not support the national SAM guidance with their night shift staffing. Request uplift of 1 RN overnight. The tool recommends additional uplift of 6.21WTE which would account for the 2.6 WTE required to meet the guidance.

Changes recommended

Next steps & impact

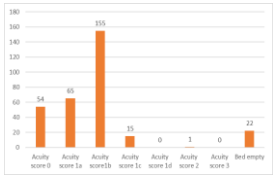
- Recommendation – increase of 2.6 WTE RN to allow for 6 RN on a night shift and bring inline with the SAM guidelines.

Risks

- Current staffing establishment does not support the national SAM guidance with their night shift staffing.

Bed Numbers - 12 — Safer Staffing Review June 2024 – Ward AMU3 — M

Acuity Data



Professional Judgement

- Data integrity– missed 4 days data collection. Beds closed for norovirus outbreak
- 40 admissions and 20 discharges and 20 transfers
- Had had 8 falls reported for 1 complex patient
- No budgeted lead nurse for this area shared lead nurse with AMU2 – clinical time shared between both
- Lead nurse also responsible for AMU2 (Breach RCN guidance)

Current Total Establishment (Inc relief)	**24.03**
Registrants WTE	13.1
Non-registrant WTE	10.09
Skill mix ratio (RN/CSW)	WD 3:2 WED 2:2 N 2:2
Tool Recommended Establishment	**24.27**
Registrants WTE	16.99
Non-registrant WTE	7.28

Nurse Sensitive Indicators

Observations

Observations	Number	On target	Post target
EWS Low	1547	421	1126
EWS Medium	12	3	9
EWS High	1	0	1

Medicines

Medicines	Total -
Late	801
Unplanned Omission	724

Falls	Pressure Ulcers	Complaints
6	1	0

What the data tells us

- Current total establishment is comparable to the SNCT recommendation. Professional judgement supports Authorised establishment with no reduction

No Change Recommended

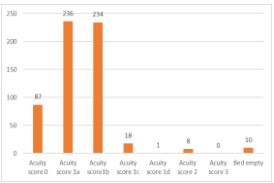
Next steps & impact

- Potential to change specialty of area- currently in discussion with consultants
- Recommend no changes

Risks

Bed Numbers- 4 Cubicles - 18 — Safer Staffing Review June 2024 – Ward AMUA — M

Acuity Data



Professional Judgement

- Lead nurse from AMU1 covers this area- 72 patient spaces– 8 level 1 – 140 staff (Breach RCN guidance)
- 18 single cubicles and 1 4 bedded bay not visible from main dept
- Ward round continuous from 8am to 9pm
- 735 admissions, 114 discharges and 621 transferred to bed bases
- Data integrity– missed 3 days data collection, entered empty beds instead of previous patients' acuity
- Cubicles are consistently full
- Direct admissions from ED
- No phlebotomy service band 3 CSW support
- Band 7 is not allocated patients but oversees AMU assessment and A4.

Current Total Establishment (Inc relief)	**63.23**
Registrants WTE	35.9
Non-registrant WTE	27.3
Skill mix ratio (RN/CSW)	6:5
Tool Recommended Establishment	**43.18**
Registrants WTE	30.22
Non-registrant WTE	12.95

Nurse Sensitive Indicators

Observations

Observations	Number	On target	Post target
EWS Low	4163	2280	1883
EWS Medium	57	14	43
EWS High	24	4	20

Medicines

Medicines	Total -
Late	758
Unplanned Omission	1869

Falls	Pressure Ulcers	Complaints
9	1	0

What the data tells us

- SNCST recommendation of 43.18 in contrast to the Trust authorised funded budget of 63.23 (reduction of 20.05). Agreed the higher Established funding is more representative to maintain quality and safety following professional judgement discussion.

No Change Recommended

Next steps & impact

- Recommend no changes due to volume and acuity.

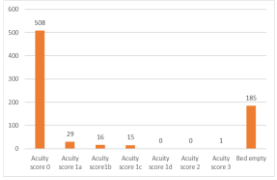
Risks

- Lead nurse also responsible for AMU1 (Breach of RCN guidance

Bed Numbers - 26 — Safer Staffing Review June 2024 – Ward B1

S

Acuity Data



Professional Judgement

- Planned changes to night shift planned; 3 trained, 3 CSWs. Station 2 ring fenced, empty.
- Committed to losing budget, keep two 12 hours on night shifts to flex for flaps requiring 1:1.
- £100k saving, roughly 1.8 WTE reduction.
- SD happy safe and with quality indicators. Matron in full support.

Current Total Establishment (Inc relief)	31.86
Registrants WTE	20.13
Non-registrant WTE	11.73
Skill mix ratio (RN/CSW)	D 4:2 N 3:2
Tool Recommended Establishment	**28.27**
Registrants WTE	19.79
Non-registrant WTE	8.48

Nurse Sensitive Indicators

Observations

Observations	Number	On target	Post target
EWS Low	3509	2264	1245
EWS Medium	7	1	6
EWS High	1	0	1

Medicines

Medicines	Total -
Late	642
Unplanned Omission	1123

Falls	Pressure Ulcers	Complaints
1	0	1

What the data tells us

- Potential changes being explored which will release funding of 1.8 WTE. This needs to be explored to ensure maintained quality and safety. Changes to be made at January 2025 review to be done safely.

Changes recommended

Next steps & impact

- Reduction of 1.8 WTE RN

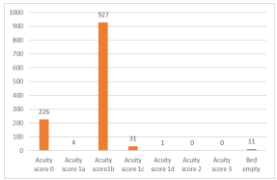
Risks

- Division have not identified ayrisks surrounding this reduction

Bed Numbers - 24 — Safer Staffing Review June 2024 – Ward B2H

S

Acuity Data



Professional Judgement

- High acuity of 1:1s and complexities of hip, log rolls, confused post-op, LOS long. When medically fit should go to medicine, but model not there yet.
- Day shift - 4 RNs, 2 to each station, and 6 CSWs, 2 to each station. Extra 2 CSWs for 1:1s within budget recognising 1:1s high. No extra 1:1s via Bank in day.
- Night shift - 3 RNs, 5 CSWs.
- Bank usage minimal at night, dependent on acuity of 1:1s.
- SD happy with rationale. Noted extra CSW at night would help to remove need for occasional Bank.

Current Total Establishment (Inc relief)	48.69
Registrants WTE	20.13
Non-registrant WTE	28.56
Skill mix ratio (RN/CSW)	D 4:6 N 3:5
Tool Recommended Establishment	**43.08**
Registrants WTE	30.15
Non-registrant WTE	12.92

Nurse Sensitive Indicators

Observations

Observations	Number	On target	Post target
EWS Low	2923	831	2092
EWS Medium	40	8	32
EWS High	21	3	18

Medicines

Medicines	Total -
Late	451
Unplanned Omission	2261

Falls	Pressure Ulcers	Complaints
4	4	0

What the data tells us

- SNCST recommendation of 43.08 in contrast to the Trust authorised funded budget of 48.69 (reduction of 8.61). Agreed the higher Established funding is more representative due to the high acuity and complexities of the patient group to maintain safety and quality.
- Suggest an extra CSW at night toeduce minimal bank usage.

No Change Recommended

Next steps & impact

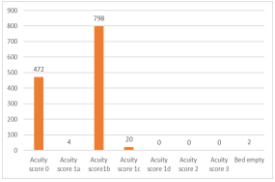
- To review internal movement across the Division to fund additional CSW on nights.

Risks

Bed Numbers - 24 — Safer Staffing Review June 2024 – Ward B2T

S

Acuity Data



Professional Judgement

- High acuity specialist logroll patients, complex IV patients, high turnover trauma elective, flex up and down to help B2 Hip.
- Day shift - 4 RNs, 4 CSWs. Night shift 3 RNs and 3 CSWs.
- Concerns about timeliness of obs, many being done later than expected, average 300 minutes. Area currently being managed advised Lead Nurse now returned following 6 months off.

Current Total Establishment (Inc relief)	42.06
Registrants WTE	22.12
Non-registrant WTE	19.94
Skill mix ratio (RN/CSW)	D 4:4 N 3:3
Tool Recommended Establishment	**38.42**
Registrants WTE	26.89
Non-registrant WTE	11.53

Nurse Sensitive Indicators

Observations	Number	On target	Post target
EWS Low	2941	739	2202
EWS Medium	15	2	13
EWS High	10	1	9

Medicines	Total -
Late	741
Unplanned Omission	2598

Falls	Pressure Ulcers	Complaints
4	8	0

What the data tells us

- SNCST recommendation of 38.42 in contrast to the Trust authorised funded budget of 42.06 (reduction of 3.64). Agreed the higher Established funding is more representative to maintain safety and quality.

No Change Recommended

Next steps & impact

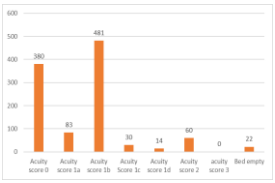
- No changes– Authorised budget to remain at 42.06

Risks

Bed Numbers- 36 — Safer Staffing Review June 2024 – Ward B3

S

Acuity Data



Professional Judgement

- Ward B3 is a 36 bedded ward Including a 4 bedded VASC which is an enhanced care unit. B3 is the Vascular Hub for the Black Country and accepts referrals from Wolverhampton, Stafford and Walsall, the services are looking to also extend to Sandwell.
- Patients often need complex, life changing surgeries.
- Often the patients are required to be recovered in VASCU for the more complex surgeries.
- Nursing staffhave tohave additional competencies
- Nurse to patient ratio is 1:4 unless the patient's require organ support e.g. metaraminol, in this case staff nurse 1:2.
- Data collection identified multiple errors

Current Total Establishment (Inc relief)	65.82
Registrants WTE	34.79
Non-registrant WTE	31.03
Skill mix ratio (RN/CSW)	D 6:6 N 6:5
Tool Recommended Establishment	**60.27**
Registrants WTE	42.19
Non-registrant WTE	18.08

Nurse Sensitive Indicators

Observations	Number	On target	Post target
EWS Low	6326	3181	3145
EWS Medium	34	21	13
EWS High	23	11	12

Medicines	Total -
Late	1583
Unplanned Omission	3326

Falls	Pressure Ulcers	Complaints
0	4	0

What the data tells us

- SNCST recommendation of 60.27 in contrast to the Trust authorised funded budget of 65.82 (reduction of 8.61). Agreed the higher Established funding is more representative due to the high acuity, complexities, VASCU and changing nurse/patient ratios to maintain safety and quality.

No Change Recommended

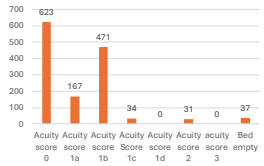
Next steps & impact

- No changes– Authorised budget to remain at 65.82

Risks

Bed Numbers - 48 — Safer Staffing Review June 2024 – Ward B4 — S

Acuity Data



Professional Judgement

- Emergency surgery and colorectal ward. 4 beds are based on the post operative Care unit (POCU) (require level 1 + care and Increased monitoring). Patients have had complex surgeries & nutritional requirements (high numbers on Total parental nutrition) need multiple nursing interventions, often with the assistance of 2 members of staff. Followed by intense physiotherapy
- There is a high volume of patients who require enhanced observations and require additional monitoring.
- Data integrity questioned due to post submission reflections
- The footprint within current beds, commissioned beds is to be being looked at.
- Complex discharges.

Current Total Establishment (Inc relief)	84.84
Registrants WTE	43.1
Non-registrant WTE	41.71
Skill mix ratio (RN/CSW)	D8:8 WDN 7:6 WEN 7:7
Tool Recommended Establishment	**68.10**
Registrants WTE	47.67
Non-registrant WTE	20.43

Nurse Sensitive Indicators

Observations	Number	On target	Post target
EWS Low	5704	2290	3414
EWS Medium	85	25	60
EWS High	38	11	27

Medicines	Total -
Late	1383
Unplanned Omission	3904

Falls	Pressure Ulcers	Complaints
5	9	0

What the data tells us

- The footprint within the current beds and commissioned beds needs to be reviewed to explore improved ways of working to improve quality and safety of patient care. Potentially to lose POCU with those patients coming under ITU

No Change Recommended

Next steps & impact

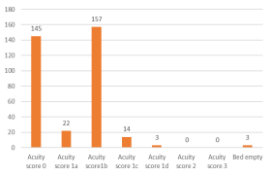
- Service review is underway challenging themselves as to if POCU care is being delivered in the best way currently.

Risks

- To continue to collect POCU data for an addition couple of weeks to map data for assurance of patient safety.

Bed Numbers- 16 — Safer Staffing Review June 2024 – Ward B6 — M

Acuity Data



Professional Judgement

- 34 red flags raised (26 agreed red / 8 amber)
- The ward has 16 beds which are housed within 4 bays. The bays are not visible from the nursing station and the sluice is not on the main ward. This impacts on the oversight of patients and requirements to the staffing ratio to maintain safety.
- Data integrity– Blocked beds due to outbreak
- Accuracy of data collected identified as not reflective of acuity of patients due to individuals' interpretation of the tool. One week of data missing
- Day shift 3 RNs and 2 CSWs bank currently being used (26 additional shifts requested in June with only 8 filled).
- Area has high bank usage

Current Total Establishment (Inc relief)	26.52
Registrants WTE	15.6
Non-registrant WTE	10.9
Skill mix ratio (RN/CSW)	D- 3:2 N 2:2
Tool Recommended Establishment	**27.45**
Registrants WTE	19.21
Non-registrant WTE	8.23

Nurse Sensitive Indicators

Observations	Number	On target	Post target
EWS Low	1795	242	1371
EWS Medium	27	7	20
EWS High	9	4	5

Medicines	Total -
Late	658
Unplanned Omission	849

Falls	Pressure Ulcers	Complaints
6	5	0

What the data tells us

Additional CSW support increasing the CSW's on shift by 1. This is supported with the multiple additional staffing requests and the red flags raised on safecare for staffing concerns. These staffing concerns have been validated by the matron and 80% of them remained unchanged. The tool data also reflects the need for an uplift in staffing. This would mean and increase in 2.6 CSW WTE. This would be at the band 2 level

Changes recommended

Next steps & impact

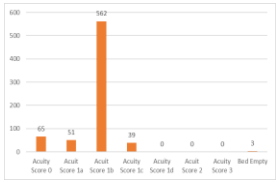
- Request of Increase of CSW at night 2.6WTE
- To explore movement of staff with potential reduction of RN on nights and additional CSW.
- Although recommended SNCST establishment suggests a 1.88 Increase this is not felt this is required

Risks

- Finance to support he establishment recommendations.

Bed Numbers - 24 — Safer Staffing Review June 2024 – Ward C1A — M

Acuity Data



Professional Judgement

- 24 endocrinology beds across 2 stations
- Was an outbreak area during June
- Complex patients with diabetes, sliding scales, complex drug regimes, step downs form MECU and DKA patients
- Increased number patients with learning difficulties also accepts patient who don't fit in 'normal' specialties
- 6 red flags raised for additional support, 16 additional requests made to support with 1:1 and escorts

Current Total Establishment (Inc relief)	42.24
Registrants WTE	23.1
Non-registrant WTE	19.1
Skill mix ratio (RN/CSW)	D 4:4 N 3:3
Tool Recommended Establishment	**45.30**
Registrants WTE	31.71
Non-registrant WTE	13.59

Nurse Sensitive Indicators

Observations

Observations	Number	On target	Post target
EWS Low	2714	2222	492
EWS Medium	32	3	29
EWS High	5	2	3

Medicines

Medicines	Total -
Late	818
Unplanned Omission	1258

Falls	Pressure Ulcers	Complaints
3	7	1

What the data tells us

- Good complement of trained staff during the day working 1:12 team had previously tried 1:6 but quality metrics not effective. Have 4CSW for day shift and 3 CSW for night shift which is proving to be effective

No Change Recommended

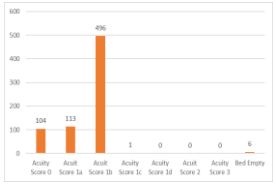
Next steps & impact

- Team want an extra trained and CSW on the night lack of band 6 on nights
- Review task allocation nursing
- Divisional Chief Nurse not supportive of the additional staff Overall recommendation of no change.

Risks

Bed Numbers - 24 — Safer Staffing Review June 2024 – Ward C1B — M

Acuity Data



Professional Judgement

- Data integrity– two days collection missed, consideration if dialysis patients recorded as level 2 and not level 1a
- High numbers of dialysis patient on the ward, care of lines, access ports
- Patients require high levels of counselling and psychological support
- Provide dialysis on the unit (improve experience). This needs to be reflected in the staffing going forward
- Elective theatre list 1 x weekly, direct admissions from critical care and step down
- Complex discharges, time critical medications and reverse barrier concerns for transplant patients
- Had 12 red flags but no additional shift requests made

Current Total Establishment (Inc relief)	42.24
Registrants WTE	23.1
Non-registrant WTE	19.1
Skill mix ratio (RN/CSW)	D 4:4 N 3:3
Tool Recommended Establishment	**39.79**
Registrants WTE	27.85
Non-registrant WTE	11.94

Nurse Sensitive Indicators

Observations

Observations	Number	On target	Post target
EWS Low	2642	490	2152
EWS Medium	87	2	85
EWS High	21	1	20

Medicines

Medicines	Total -
Late	937
Unplanned Omission	1361

Falls	Pressure Ulcers	Complaints
1	1	0

What the data tells us

- SNCST recommendation of 39.79 in contrast to the Trust authorised funded budget of 42.24 (reduction of 2.25). Agreed the higher Established funding is more representative due to the high number dialysis patients counselling and psychological support. In additions pending growing service provision.

No Change Recommended

Next steps & impact

- To discuss task allocation following discussion with Matron
- No changes– Authorised budget to remain at 42.24

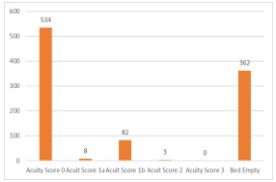
Risks

- Patients starting to be dialysed on the unit and growing service provision in the community, need a PDSA model to be costed and reviewed for this expansion of service provision

Bed Numbers- 47 — Safer Staffing Review June 2024 – Ward C2

S

Acuity Data



Professional Judgement

- PAU adds to complexities and security issues. following GIRFT review this is looking to be moved.
- PAU staffing 1 RN, 1 CSW, 2 floats to flex for HDU and PAU on demand and day case. Sister in charge and another float. Commissioned for 3 HDU, 67 in winter takes float.
- Remains some work to do with sepsis and deteriorating patient, just moved over to Sunrise.
- CAHMS room for complex cases. Demand for safeguarding was on an upward trajectory

Current Total Establishment (Inc relief)	53.51
Registrants WTE	45.03
Non-registrant WTE	8.48
Skill mix ratio (RN/CSW)	WD 9:2 WED 8:2 N 8:2
Tool Recommended Establishment	**53.7**
Registrants WTE	37.6
Non-registrant WTE	16.1

Nurse Sensitive Indicators

Observations

Observations	Number	On target	Post target
EWS Low	3767	2504	1263
EWS Medium	658	336	322
EWS High	61	14	47

Medicines

Medicines	Total -
Late	Electronic prescribing not embedded to pull data
Unplanned Omission	Electronic prescribing not embedded to pull data

Falls	Pressure Ulcers	Complaints
0	0	0

What the data tells us

- Current total establishment is comparable to the SNCST recommendation. Professional judgement supports Authorised establishment with no reduction

No Change Recommended

Next steps & impact

- No changes– Authorised budget to remain at 53.51

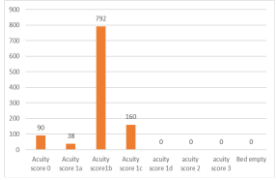
Risks

- Security issues (GIRFT review) Looking movement of PAU. HB suggested tagging if neonates transferring to C2, PAU and paeds ED to move to improve patient journey.

Bed Numbers - 36 — Safer Staffing Review June 2024 – Ward C3

M

Acuity Data



Professional Judgement

- 36 beds and 3 stations, difficult visibility across the stations
- 101 additional requests made for staffing gaps,47 filled, 18 red flags raised
- High numbers of 1:1,cohorted patients and Parkinson time critical medications
- Sickness levels low 2.8% and good staff retention 0% turnover. No concerns quality metrics
- High numbers skin and falls bundles
- High numbers of bankusagedue to acuity of patients.
- Complex patients with difficult social needs and discharge
- 3 CSW between 3 stations at night
- Staffing numbers reduce at night with less RNs on shift
- 100% data collection.

Current Total Establishment (Inc relief)	60.76
Registrants WTE	33.5
Non-registrant WTE	27.3
Skill mix ratio (RN/CSW)	D 6:5 N 5:5
Tool Recommended Establishment	**76.93**
Registrants WTE	53.85
Non-registrant WTE	23.08

Nurse Sensitive Indicators

Observations

Observations	Number	On target	Post target
EWS Low	3437	467	2970
EWS Medium	35	5	30
EWS High	18	1	17

Medicines

Medicines	Total -
Late	771
Unplanned Omission	1996

Falls	Pressure Ulcers	Complaints
4	4	0

What the data tells us

Recognised significant spend on bank for additional CSW staff. On average 3 additional requests for CSW's made each day. 50% of the additional shifts filled. 18 red flags raised due to staffing on the safecare system. The tool data suggests the ward is at a deficit of 16WTE.

Changes recommended

Next steps & impact

- Team want uplift of CSW number in the day to try and reduce bank spend
- Action – As RN reduced on the nightwould the additional CSW be more beneficial as a twilight– Team reviewing this suggestion.

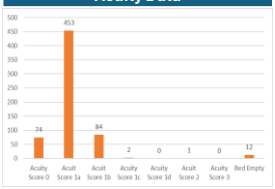
Risks

Bed Numbers - Beds 16 Isolation Cubicles 6

Safer Staffing Review June 2024 – Ward C4

M

Acuity Data



Professional Judgement

- Beds and isolation cubicles are geographically not colocated
- Data integrity– missed 1 day data collection. There were empty beds due to breakout
- High demand for escorts to New Cross and QE
- High number of red flags for sickness and maternity leave
- Establishment covers SDEC Haem/Onc unit as follows: band 3: 1 WTE, band 6: 1.92 WTE, band 7: 1WTE
- Lead chemotherapy nurse (does not do a rostered clinical shift on ward C4). Part of her role is advisory and teaching SACT predominantly on C4 day case unit and the ward. She also administers chemotherapy for outlier patients around the hospital.
- Intense psychological support for patient/family cohort
- High numbers iv treatments
- Triage moves to the ward out hurs

Current Total Establishment (Inc relief)	42.19
Registrants WTE	31.3
Non-registrant WTE	10.9
Skill mix ratio (RN/CSW)	D 5:2 N 4:2

Tool Recommended Establishment	28.44
Registrants WTE	19.91
Non-registrant WTE	8.53

Nurse Sensitive Indicators

Observations

Observations	Number	On target	Post target
EWS Low	3598	1996	1602
EWS Medium	130	104	26
EWS High	40	9	31

Medicines

Medicines	Total -
Late	1530
Unplanned Omission	1398

Falls	Pressure Ulcers	Complaints
1	1	2

What the data tells us

- SNCST recommendation of 28.44 in contrast to the Trust authorised funded budget of 42.19 (reduction of 13.75). Agreed the higher Established funding is accurate as SDEC staff included and chemotherapy nurse whose acuity was not reviewed.

No Change Recommended

Next steps & impact

- Recommend no change to current establishment of 42.19

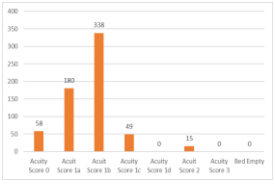
Risks

Bed Numbers - 24

Safer Staffing Review June 2024 – Ward C5A

M

Acuity Data



Professional Judgement

- 24 beds which includes 8 side rooms, no bay or side room visible from nursing station. 1 ligature room light room
- Take additional patients every day to support flow
- Band 6 caries NIV outreach bleep
- Data integrity– 3 days data collections missed
- Average 4-6 discharges per day (most complex) have direct admissions from ED, step up and down to level 2 facility and complex barrier patients.
- When capacity on C5b is unable to take the sicker patients these come to C5a and require TB/NIV.CPAP high flow oxygen
- 4-6 complex discharges per day

Current Total Establishment (Inc relief)	41.15
Registrants WTE	22
Non-registrant WTE	19.1
Skill mix ratio (RN/CSW)	D 4:4 N 3:3

Tool Recommended Establishment	43.24
Registrants WTE	30.27
Non-registrant WTE	12.97

Nurse Sensitive Indicators

Observations

Observations	Number	On target	Post target
EWS Low	2812	715	2097
EWS Medium	59	14	45
EWS High	22	4	18

Medicines

Medicines	Total -
Late	749
Unplanned Omission	1404

Falls	Pressure Ulcers	Complaints
3	6	2

What the data tells us

- SNCST recommendation of 43.24 in contrast to the Trust authorised funded budget of 41.15 (increase of 2.09). Agreed the suggested SNCST increased establishment is not required.
- Skill mix on nights needs a band 6

Changes recommended

Next steps & impact

- Team want uplift band 5 line to band 6 at night
- Matron agreed that she can mitigate the request to uplift band 5 at night to band 6 by movement of skill mix between C5a and C5B

Risks

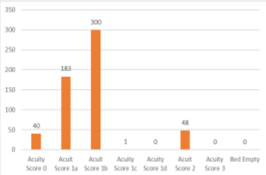
Bed Numbers - 24

Safer Staffing Review June 2024 – Ward C5B

The Dudley Group NHS Foundation Trust

M

Acuity Data



Professional Judgement

- 24 beds (8 are side rooms)– none visible from the nursing station. Unit most days flexes up to 25 beds (high acuity).
- Data integrity – 6 days of missing data
- Budget pays for Band 7 PDN for medicine not included in numbers.
- The unit supports the NIV bleep service (staff off the ward for long periods)
- Accommodates the Respiratory Support Unit (higher nurse to patient ratio due to the acuity of patients, complexity of treatments and pts with altered airway and mini tracheostomy/suction. One of the highest areas for complex discharges
- NCEpod guidance suggests 1:2 ratio for acute NIC however dept. recognises mixture of acute and chronic there for 1:4 ration agreed
- CCOT level one competencies required for staff on the respiratory enhanced unit
- Season variation

Current Total Establishment (Inc relief)	**51.94**
Registrants WTE	32.8
Non-registrant WTE	19.1
Skill mix ratio (RN/CSW)	D 6:4 N 5:3
Tool Recommended Establishment	**40.14**
Registrants WTE	28.10
Non-registrant WTE	12.04

Nurse Sensitive Indicators

24	Observations	Number	On target	Post target
	EWS Low	2920	772	2148
	EWS Medium	79	11	68
	EWS High	24	3	21

Medicines	Medicines	Total -
	Late	699
	Unplanned Omission	1425

Falls	Pressure Ulcers	Complaints
3	5	0

What the data tells us

- SNCST recommendation of 40.14 in contrast to the Trust authorised funded budget of 51.94 (reduction of 11.8). Agreed there is potential for reduction of establishment and movement of skill mix to support C5a. Currently looking at new service via internal PDSA to improve patient experience

Changes recommended

Next steps & impact

- Recommend – movement of skill mix to support C5a uplift of band 5 to band 6 at night
- Action remove 1.36 WTE of unused band 5 monies to mitigate upliftfrom 5 to 6.
- Action 1.9 WTE band 2 monies can be release to help with mitigation in other areas

Risks

- JB advised instigated new service via internal PDSSA to save bed days , improve patient experience as not waiting to go tohave treatment at Stoke Hospital.

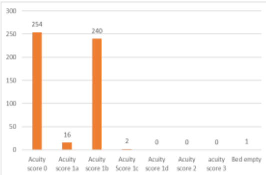
Bed Numbers - 19

Safer Staffing Review June 2024 – Ward C6

The Dudley Group NHS Foundation Trust

S

Acuity Data



Professional Judgement

- Urology/general surgical ward. Is open plan/nightingale ward so the door between the 2 areas remains closed to avoid single sex breaches and maintaining the privacy and dignity of the patients.
- Impacts on ward staffing (2 RNS rostered to work in the 12 bedded area (male) and 1 RN the caseload of female patients). Has two clinic rooms (prostate biopsy clinic and urology hot clinic) on week days, service supported by the fourth trained rostered on the LD.
- The prostate biopsy clinic is to increase over time due to new Local Anaesthetic Transperineal Prostate biopsy service, this will increase patient capacity on the ward. Every six weeks a Lithotripsy clinic is undertaken on the ward by an external provider/Radiographer this

  Service is also supported by the fourth RN allocated to clinic activity.

Current Total Establishment (Inc relief)	**33.01**
Registrants WTE	20.4
Non-registrant WTE	12.61
Skill mix ratio (RN/CSW)	WD 4:3 WED 3:3 WN 3:2 WEN 3:3
Tool Recommended Establishment	**26.94**
Registrants WTE	18.86
Non-registrant WTE	8.08

Nurse Sensitive Indicators

Observations	Observations	Number	On target	Post target
	EWS Low	3178	1593	1585
	EWS Medium	114	20	94
	EWS High	82	14	68

Medicines	Medicines	Total -
	Late	570
	Unplanned Omission	2116

Falls	Pressure Ulcers	Complaints
3	1	0

What the data tells us

- SNCST recommendation of 26.94 in contrast to the Trust authorised funded budget of 33.01 (reduction of 6.07).

No Change Recommended

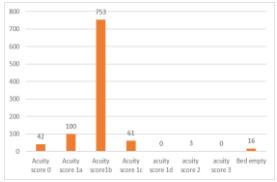
Next steps & impact

Work cross divisional to understand if the ward and the service delivery is accurately reflecting the need of the patients and the wider aims.

Risks

Bed Numbers - 36 — Safer Staffing Review June 2024 – Ward C7 — M

Acuity Data



Professional Judgement

- Data integrity – 6 days of data missing
- Staff moved to support surge/discharge lounge
- 20 additional CSW shifts requested to support enhanced care.
- Seeing a reduction in detoxing patients but an increase in complex nutritional compromised patients requiring a psychological aspect to their care
- 14 red flags, 6 related to RN shortage (1RN and 1CSW redeployed undergoing investigation)
- 0.68 WTE Band 6 PDN works supernumary with junior staff.
- High number of IVs including central line access for acutely unwell
- Additional training given to staff for escalation and breakaway due to patient group and high number of 1:1s.
- Staff also responsible for patients in C7 AIR room. Bedded overnight on 6 occasion. 26 patients over the month, 6 overnight stays. average stay per patient in month = 5.2 hours. longest time in AIR room 21

Current Total Establishment (Inc relief)	66.93
Registrants WTE	34.2
Non-registrant WTE	32.8
Skill mix ratio (RN/CSW)	WD 7:6 WED 6:6 N 5:6
Tool Recommended Establishment	**69.36**
Registrants WTE	48.55
Non-registrant WTE	20.81

Nurse Sensitive Indicators

Observations

Observations	Number	On target	Post target
EWS Low	4455	892	3563
EWS Medium	100	18	82
EWS High	60	5	55

Medicines

Medicines	Total -
Late	1184
Unplanned Omission	2723

Falls	Pressure Ulcers	Complaints
7	4	1

What the data tells us

- SNCST recommendation of 69.36 in contrast to the Trust authorised funded budget of 66.93 (reduction of 2.43). Agreed the higher Established funding is required to maintain quality and safety.
- Identified as nights are busy an additional staff members would be beneficial.

Changes recommended

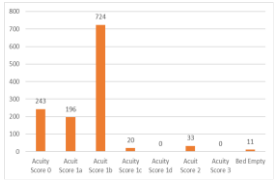
Next steps & impact

Ward area the current staffing establishment is adequate and are looking to change a RN shift from day tonight for additional support.

Risks

Bed Numbers - 44 — Safer Staffing Review June 2024 – Ward C8 — M

Acuity Data



Professional Judgement

- Band 5/6 are bleep holders- these are not based on the ward but in the budget
- High complex neurological issues
- Daily complex MDT and weekly MDT
- 11 WTE not giving direct care
- Requirement to achieve SSNAP requirements- daily meetings
- Staff support discharge lounge
- Run clinics equating to 10 hours per week

Current Total Establishment (Inc relief)	91.80
Registrants WTE	56.3
Non-registrant WTE	35.5
Skill mix ratio (RN/CSW)	D 8:7 N 7:6
Tool Recommended Establishment	**72.70**
Registrants WTE	50.89
Non-registrant WTE	21.81

Nurse Sensitive Indicators

Observations

Observations	Number	On target	Post target
EWS Low	5045	1158	3887
EWS Medium	69	7	62
EWS High	68	0	68

Medicines

Medicines	Total -
Late	1390
Unplanned Omission	1560

Falls	Pressure Ulcers	Complaints
4	3	1

What the data tells us

- SNCST recommendation of 72.70 in contrast to the Trust authorised funded budget of 91.80 (reduction of 19.1). Agreed the higher Established funding is appropriate to maintain quality and safety. Bleep holders who form part of the budget were no included in the review or based on the ward and staff support discharge lounge and run clinics

No Change Recommended

Next steps & impact

- Recommendation no change to current establishment of 91.80

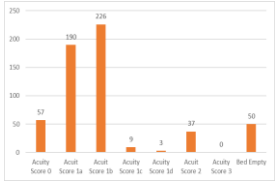
Risks

Bed Numbers – CCU 8 PCCU 16

Safer Staffing Review June 2024 – Ward CCU

M

Acuity Data



Professional Judgement

- BACCN staffing recommendation for CCU is 1:2 PCCU 1:6 with NIC
- No bays in PCCU are visible from staff work base
- Day case and Cath lab included in the overall budget
- There is a proposed plan to increase interventional procedures in the Cath Lab with (additional CCU consultant is commencing in post in September 2024 who is an interventional cardiologist) .
- Staff can be called intocath lab out of hours
- Data integrity– 8 days of data collection missed. 15 days beds flexed to 10 but only 9 recorded. Input error level 1ds should have been recorded as 1cs
- Complex caseloads, drugregimes and multiple comorbidities
- CCU 43 discharges, PCCU 72 discharges. Direct admissions from ED step up and stepdown level 2/3
- High turnover of staff . Staff have multiple additional requirements

Current Total Establishment (Inc relief)	52.10
Registrants WTE	43.9
Non-registrant WTE	8.2
Skill mix ratio (RN/CSW)	SD 1:0 WD 8:2 WED 7:2 N 7:1
Tool Recommended Establishment	**42.26**
Registrants WTE	29.58
Non-registrant WTE	12.68

Nurse Sensitive Indicators

Observations

Observations	Number	On target	Post target
EWS Low	1236	610	626
EWS Medium	44	5	39
EWS High	11	2	9

Medicines

Medicines	Total -
Late	790
Unplanned Omission	1438

Falls	Pressure Ulcers	Complaints
6	6	0

What the data tells us

SNCST recommendation of 42.24 in contrast to the Trust authorised funded budget of 52.10 (reduction of 9.84). Agreed the higher Established funding is more representative to maintain quality and safety due to layout and proposed plans to increase interventional procedures. Identified that the previous reduction of 1 RN in the day at weekends, is not supportive of quality patient care and would like to have that shift reinstated.

Changes recommended

Next steps & impact

- Clinical band 7 will increase clinical shifts from 1 – 3 this will mitigate the request to increase 7RNs to 8RNs on weekend shift

Risks

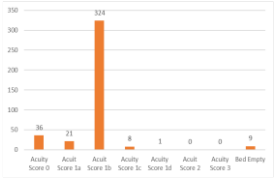
- Increased work loadin cath lab – requires demand and capacity modelling forcath lab and day case which will form part of the Biosense proposal

Bed Numbers - 16

Safer Staffing Review June 2024 – Discharge Lounge

M

Acuity Data



Professional Judgement

- 16 beds (4 bays of 4). Bays are secluded and not visible from nursing station
- Currently funded as a discharge lounge (5 days) but has been an inpatient ward for over 12 months (7 days)
- 2 staff on redeployment due to HR issue
- Data integrity 5 days data collection missed. One input error of a 1d recorded instead of a 1c
- Ward isolated overnight with no surrounding services
- Band 7 cover provided by the lead Nurse form C8 approx. 0.3WTE
- Provide support for the Surge area which can be open for up to 14 patients regularly
- Due to site pressures accepts patients who are not in the acceptance criteria for the lounge
- No Full MDT as operating outside the discharge lounge SOP

Current Total Establishment (Inc relief)	25.30
Registrants WTE	14.4
Non-registrant WTE	10.9
Skill mix ratio (RN/CSW)	D 3:2 N 2:2
Tool Recommended Establishment	**29.10**
Registrants WTE	20.37
Non-registrant WTE	8.73

Nurse Sensitive Indicators

Observations

Observations	Number	On target	Post target
EWS Low	7	2	5
EWS Medium	1	0	1
EWS High	0	0	0

Medicines

Medicines	Total -
Late	5
Unplanned Omission	5

Falls	Pressure Ulcers	Complaints
4	8	1

What the data tells us

- SNCST recommendation of 29.10 in contrast to the Trust authorised funded budget of 25.30 (increase of 3.8). Felt although the recommendation is to have a higher establishment the current establishment is adequate

Changes recommended

Next steps & impact

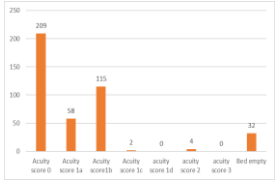
- Work to bring this area back to a discharge lounge

Risks

- Lead nurse over is the also the Lead Nurse from C8 only provides 0.3WTE cover (Breach of RCN guidance

Bed Numbers- | Safer Staffing Review June 2024 – Ward ESH | M

Acuity Data



Professional Judgement

- Triage nurses in addition to patients admitted into funded bed base (unclear of acuity levels at point of triage). Patients receive care and treatment whilst located within waiting room as necessary.
- Data cut in 2 different ways; ESH S1 and S2 using assessment unit tool, ESH S3, S4 and S5 using data collection tool for inpatients.
- Data integrity questioned as post checks identified some anomalies
- S1 SDEC - 4 beds, 10 recliners, 3 triage trollies, 24 chaired waiting room - all surgical admissions. HOT clinics.
- S2 GAU waiting room- 4 patients, examination room and 10 beds. All females. SD highlighted future plan for protected room.
- S3 - 12 beds, short stay. Quick turnover.

Current Total Establishment (Inc relief)	69.58
Registrants WTE	49.91
Non-registrant WTE	19.67
Skill mix ratio (RN/CSW)	D 8:5 N 8:3
Tool Recommended Establishment	**47.50**
Registrants WTE	33.25
Non-registrant WTE	14.25

Nurse Sensitive Indicators

Observations	Number	On target	Post target
EWS Low	6660	3470	3190
EWS Medium	30	12	18
EWS High	29	10	19

Medicines	Total -
Late	1630
Unplanned Omission	2844

Falls	Pressure Ulcers	Complaints
?	?	1

What the data tells us

- SNCST recommendation of 47.50 in contrast to the Trust authorised funded budget of 69.58 (decrease of 14.86). Existing funding to remain. For full review following ward /specialty reconfiguration

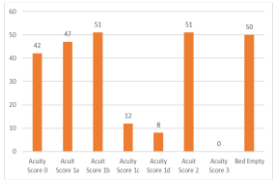
No Change Recommended

Next steps & impact: Further work being undertaken regarding the service provision and needs of the patients.

Risks

Bed Numbers – 8 | Safer Staffing Review June 2024 – Ward MECU | M

Acuity Data



Professional Judgement

- 8 Bed (2 side rooms), increases to 9 when required to commence treatment pathways prior to transfer to CS- poor visibility of side rooms
- Majority of patients acuity 1a- patients likely to deteriorate and require continuous monitoring
- Difficult geographical layout- storage, sluice, patient toilets away from main area. If preparing drugs have to wedge open doors to listen for audible alarms
- Variable workload dependent on acuity

Current Total Establishment (Inc relief)	23.18
Registrants WTE	17.7
Non-registrant WTE	5.5
Skill mix ratio (RN/CSW)	3:1
Tool Recommended Establishment	**17.02**
Registrants WTE	11.91
Non-registrant WTE	5.11

Nurse Sensitive Indicators

Observations	Number	On target	Post target
EWS Low	409	165	244
EWS Medium	6	0	6
EWS High	0	0	0

Medicines	Total -
Late	581
Unplanned Omission	708

Falls	Pressure Ulcers	Complaints
0	3	0

What the data tells us

- SNCST recommendation of 17.02 in contrast to the Trust authorised funded budget of 23.18 (decrease of 6.16). Existing authorised funding is required to maintain patient quality and safety following review of professional judgement.

No Change Recommended

Next steps & impact:

- Recommendation– no change to existing authorised budget of 23.18

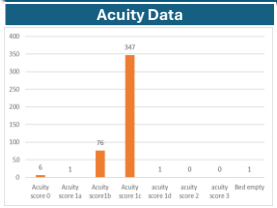
Risks

Bed Numbers - 16

Safer Staffing Review June 2024 – Ward FMU

M

Acuity Data



Professional Judgement

- Data integrity- Missed three days acuity of data collection
- 16 beds of 4 side rooms and 3 bays with reduced disability and 1 ligature light room
- Pathway 3 complex discharge patients
- Demential UK recommends there should be stimulation activities which current staffing levels can provide
- The ward does have additional patients
- Most patients on pathway 3 with very complex discharge plans
- Staff support patient discharge and accompany them with Driving Miss Daisy to their residence
- RN to CSW ration 30/70

Current Total Establishment (Inc relief)	49.34
Registrants WTE	16.6
Non-registrant WTE	32.8
Skill mix ratio (RN/CSW)	D 3:6 N 2:6
Tool Recommended Establishment	**59.93**
Registrants WTE	17.98
Non-registrant WTE	41.95

Nurse Sensitive Indicators

Observations

Observations	Number	On target	Post target
EWS Low	1422	185	1237
EWS Medium	2	0	2
EWS High	2	0	2

Medicines

Medicines	Total -
Late	401
Unplanned Omission	1415

Falls	Pressure Ulcers	Complaints
3	3	0

What the data tells us

- SNCST recommendation of 59.73 in contrast to the Trust authorised funded budget of 49.34 (decrease of 10.59).
- With recent uplift of CSW at night both Matron and lead Nurse feel the current staffing establishment meets the needs of the patients– supports by quality indicators and sickness

No Change Recommended

Next steps & impact

- Recommend no change

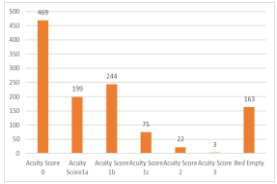
Risks

Trolley Numbers-

Safer Staffing Review June 2024 – ED Adults

M

Acuity Data



Professional Judgement

- Teams 1 band 6 PDN, 1 band 7 Governance lead, 4 deputy matrons, redeployed staff on roster (band 6 and band 2)
- Multiple clinical areas
- 8,988 patients. 18 out 30 days excess 300 patients per day. 1,165 patients above 12h LOS
- Band 3 : 20 hrs per week supports ED clinic and is not part of rse to patientstaffing ratio.
- High numbers of complex safeguarding cases
- Data integrity staff recorded acuity at the time in resus and high dependency not what it had been, recorded empty bed and not the acuity of patient who had been in the bed
- Waiting room patients needed treatment not included or patients on ambulance

Current Total Establishment (Inc relief)	Majors & Minors 164.19
Registrants WTE	104.1
Non-registrant WTE	60.1
Skill mix ratio (RN/CSW)	D 17/11 N16/11
Tool Recommended Establishment	**103**
Registrants WTE	72.1
Non-registrant WTE	30.9

Nurse Sensitive Indicators

Observations

Observations	Number	On target	Post target
EWS Low	15698	14290	1408
EWS Medium	928	331	597
EWS High	557	133	424

Falls	Pressure Ulcers	Complaints
5	3	12

What the data tells us

- SNCST recommendation of 103 in contrast to the Trust authorised funded budget of 164.19 (decrease of 61.19).
- Existing funding to remain to maintain quality and safety and pending resuscitation rebuild and predicted 15% increase with the opening of the Midland Met. In addition, not all posts in the budget were included in the review.

No Change Recommended

Next steps & impact

- Recommend no change

Risks

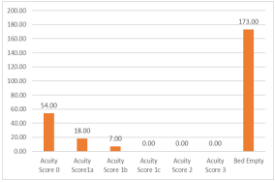
- Consider the impact of the Midland Met predicted activity and ED resus redesign
- Predicted 15% increase in activity with opening of Midland Met and resus design

Trolley Numbers-

Safer Staffing Review June 2024 – Ward ED Paeds

M

Acuity Data



Professional Judgement

- Areas sperate for the main ED- intubation room separate to the area so paed nurse must leave when patient in there
- Plastering equipment and seminar room within xray dept so staff need to lead paed ED to get equipment
- None of the cubicles visible from staff base
- Limited access to isolation cubicles
- Need consider seasonal adjustments
- Has 40% vacancy rate (recently appointmed x2 band 5 and x1 RCN.
- Area is not co located to majors ED Band 4 is a band 3 in training. Band 3 play facilitator is not included in nurse patient ratio. this post was recognised as a requirement by CQC and PEER review.
- Need for additional training requirements
- High numbers of complex safeguarding referrals, children waiting CAMHS

Current Total Establishment (Inc relief)	33.75
Registrants WTE	21.6
Non-registrant WTE	12.1
Skill mix ratio (RN/CSW)	D 3:2 WD 3:3 WN 3:1
Tool Recommended Establishment	**27.6**
Registrants WTE	19.3
Non-registrant WTE	8.3

Nurse Sensitive Indicators

Observations	Number	On target	Post target
EWS Low	1490	1385	105
EWS Medium	117	72	45
EWS High	31	21	10

Falls	Pressure Ulcers	Complaints
0	0	2

What the data tells us

- SNCST recommendation of 27.6 in contrast to the Trust authorised funded budget of 33.75 (decrease of 7.83). Existing funding to remain to mitigate geographical layout of clinical area, additional training requirements and complex safeguarding.

No Change Recommended

Next steps & impact

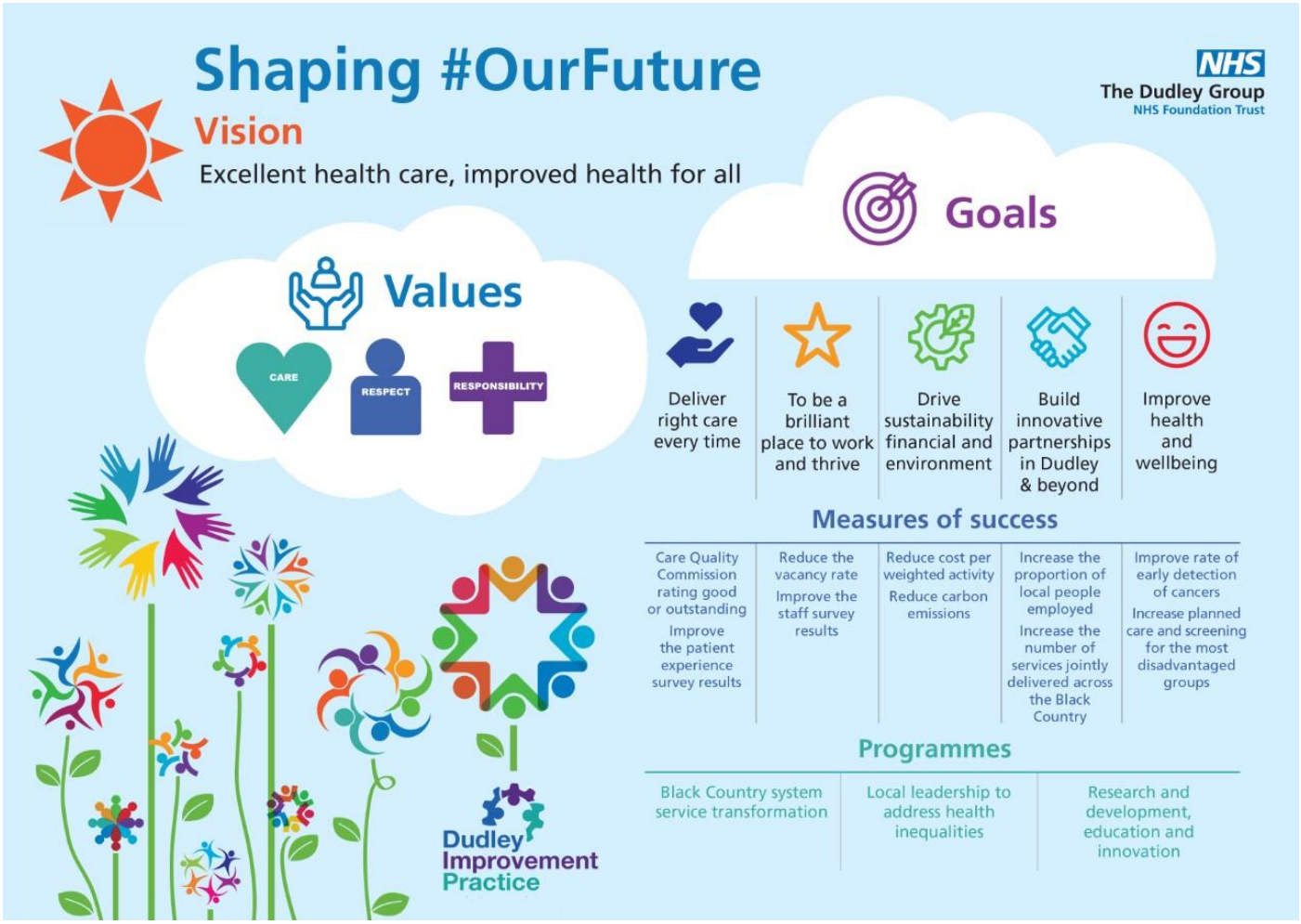
- Recommend no change

Risks

- National shortage paed children nurses – unable to meet the workforce standards to enable mitigation of risk to patients
- Bank usage June 32%

Progress report on implementing our strategy and annual plan 2024/25

Quarter 1: April - June 2024



This report provides an update on the implementation of the strategic plan 2021 – 2024 and the annual plan 2024/25.

Progress has been RAG rated where:

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

Summary progress against strategy and objectives in the annual plan 2024/25

Goal, success measure and objective from annual plan	RAG rating	
	This quarter	Last quarter
Deliver right care every time		
Measures of success		
CQC good or outstanding		
Improve the patient experience results		
Achieve NHS constitution targets		
Objectives from the annual plan		
Reduce complaints by 15% compared to 23/24		
90% of complaints to be responded to in 30 days		
Increase responses to patient experience survey by 20%		
Reduction in incidents resulting in significant harm		
Standardised hospital mortality index (SHMI) better than England average		
Re-admission within 28 days better than England average		
Eliminate 65 week waits by September 2024 and reduce 52 week waits		
Improve productivity (reduce DNA rate to better than England average, increase PIFU to 5%, theatre utilisation 85%)		
Be a brilliant place to work and thrive		
Measures of success		
Improve the staff survey results to better than England average		
Reduce the vacancy rate to 7% or below		
Objectives from the annual plan		
Improve retention rates for nursing, midwifery and AHP groups		
Bullying and harassment – staff survey results better than England average		
Raising concerns – staff survey results better than England average		
Recommend trust as a place to work – staff survey results better than England average		
Drive sustainability		
Measures of success		
Reduce cost per weighted activity to better than England average		
Reduce carbon emissions (year-on-year decrease to achieve net zero by 2040)		
Objectives from the annual plan		
Deliver financial plan (deficit of £32.565m)		
Deliver recurrent cost improvement programme of £31.896m		
Reduction in use of bank by 25%		
Build innovative partnerships in Dudley and beyond		
Measures of success		
Increase proportion of local people employed to 70 by Mar-25		
Increase the number of services delivered jointly across the Black Country		
Objectives from the annual plan		
A total of 35 people into work via ICan (through jobs and skills hubs or paid work experience		
Improve discharge processes		
Improve health and wellbeing		
Measures of success		
Improve rate of early detection of cancers (75% of cancers diagnosed at stages I,II by 2028)		
Increase planned care and screening from disadvantaged groups		
Objectives from the annual plan		
Achieve acceptable coverage for breast screening (70%) and work towards achievable level (80%)		

Goal: Right care every time

Executive lead: Medical Director / Chief Nurse/ Director of Governance				
Strategic measures of success				
Measure of success and target	**Current status**	**RAG**	**Summary of progress this quarter**	**Actions planned for next quarter**
CQC good or outstanding	No change in ratings during Q1. No new inspections during this period		The CQC undertook an unannounced full inspection of ED in May 2023. The overall rating of the service remained the same (Requires Improvement) but improvement in the well-led and effective domain were seen (Good). The post inspection action plan is near completion with 21/22 completed. One action is a longer-term action (due date 31/5/2026). The CQC undertook an unannounced full inspection of Children and Young People Services in June 2023. The overall rating for the service has improved to Good, with all domains rated as Good with the exception of Safe which remains as requires improvement. The post inspection action plan is ongoing; 17/24 actions are documented as complete, with 7 actions breached. Formal engagement meetings with the CQC have been reinstated. The Trust have maintained timely responses to CQC enquiries without significant concern/exceptions.	Post inspection action plan monitoring and effectiveness testing continues. Quality and Safety Reviews along with responsive /unplanned walks arounds continue to help prepare the Trust for further inspection. IPC focused reviews planned to support improvements and preparation for external visit. Ward to Board visits to continue. CQC self-assessment work due to conclude during this period for reporting to Trust Board in Autumn. Ratification of a CQC Guideline document to support staff during the inspection process. CQC have planned an inspection of the Mental health Act application on 8th July 2024, the feedback following this will be appropriately acted upon

Improve our patient experience results to top quartile performance (England) by 2025	The first cut results were published by Picker in May 2024. The Trust score has seen an improvement in the number of questions that are performing 'significantly worse' in 2023 in comparison to the Picker average (10 out of 45 questions compared to 23 out of 43 questions in 2022): 1. Admission to hospital and the hospital and ward (3 out of 13) 2. Doctors and nurses (1 out of 7) 3. Your care & treatment (2 out of 8) 4. Leaving hospital (3 out of 13) 5. Overall and about you (1 out 4) In the 'admission to hospital and the hospital and ward' section the question about patients being able to take their own medication when needed is performing 'significantly worse' than the Picker average at 78% in comparison to 87%. This question has		• The Chief Nurse has discussed the results with the Divisional Chief Nurses/Allied Health Professional and Head of Midwifery. • A presentation of the results was provided by the head of Patient Experience to the Divisional Chief Nurses/Allied Health Professional, Head of Midwifery, matrons and lead nurses on Tuesday 4th June 2024. This generated detailed discussions regarding the results and ongoing themes, including actions required. • Actions agreed have been collated and included as part of the overarching action plan. • The Chief Nurse has discussed the matter with the Medical Director and suggested that a medical representative joins the Patient Experience Group. • The Chief Nurse has raised the need for an MDT engagement at June's Risk and Assurance Group and asked the Chiefs of each Division to ensure engagement. Discussions about the actions required have also taken place at May's Patient Experience Group. • The Deputy Chief Nurse (quality), Head of Patient Experience, communications team and Dudley Improvement Practice team met in June 2024 to agree how we could approach these improvements differently. • Broader engagement sessions will be facilitated during July and August with multidisciplinary teams (MDT), to share the results, ongoing themes and encourage broader engagement. • Three key workstreams have been established, to drive improvements which include The Discharge Improvement Group, Nutrition and Hydration Group and Pain Group.	Regular updates of improvements made will be reported to the Patient Experience Group which is held bi-monthly. The three workstreams will continue to meet regularly to ensure improvements are achieved across the Trust. The Patient Experience Team will meet with divisional chief nurses and matrons on a monthly basis to monitor progress and update actions.

	been performing worse than the average of Trusts surveyed by Picker every year since the 2019 survey. Scores for patients getting enough to drink have seen an improvement since the 2022 survey from 90.5% where this score was performing 'significantly worse' to 92.3% in 2023. Questions about getting meals outside of mealtimes and support for dietary requirements have remained recurring themes since the 2021 survey. The overall rating of the food as being very or fairly good has seen a decline since the 2022 survey and is below the average of Trusts surveyed by Picker. Patients being asked to give views on quality of care has scored 'significantly worse' for the last four years in comparison to the Picker average, although this score is performing significantly better when compared to the previous		• The Head of Patient Experience attends the above Groups and is a member of the Chief Nurse's Senior Leaders Professional Group, with patient experience being a standard agenda item. • The Back to the Floor approach continues, which includes periodic night visits undertaken by senior nurses/midwives/ AHPs, with positive feedback received from those participating and clinical staff. • Oversight of progress will be maintained via the Patient Experience Group, Quality Committee and Senior Nursing, Midwifery and AHP Leaders group.	

	year's results for the Trust. The Trust is ranked 50 out of 64 Trusts that participated in the survey based on the overall positive score for every other organisation that ran the NHS Inpatient survey with Picker (in comparison to 63 out 70 Trusts in 2022).			
Achieve NHS Constitution targets (Referral to treatment, diagnostics, cancer, emergency access)	ED performance in April and May above 78% target Diagnostic waits at 88.4% in May Cancer faster diagnosis standard (28 days) consistently being met		• Streamlining of emergency pathways so that patients do not need to attend ED • Joint working with surgery to ensure patients proactively taken from ED • Provision of mutual aid to system for ultrasound • Performance of sleep studies affected by equipment issues	• Continued scrutiny that GP letters are directly streamed to appropriate area • Recruitment for ultrasound service to address staffing challenges • Address equipment issues in sleep studies
Objectives from the annual plan				
Objective	**Current status**	**RAG**	**Summary of progress this quarter**	**Actions planned for next quarter**
Reduce complaints by 15% compared to 2023/24	At the end of 2023/24, the Trust had received 956 new complaints. To reduce this figure by 15% for 2024/25, an anticipated number of new complaints received would be 812 for 2024/25		During Q1, there were 246 new complaints received. In comparison to Q1 2023/24, there were 252 new complaints received and this is a decrease in the number of complaints received by 2.4%.	The complaints team will offer an informal approach (PALS route) to address concerns where applicable.
90% of complaints to be responded to in 30 days	The average response rate for 2023/24 was 42.8% for all complaints closed within 30 working		For Q1, the response rate for all complaints closed was 43.3% and 50.1% average for closed first response complaints (this excludes reopened complaints and Ombudsman cases). This is an	New escalation process in place to improve responsiveness from divisions.

	days. For Q1, this currently stands at 43.3% for all complaints closed and 50.1% average for closed first response complaints (this excludes reopened complaints and Ombudsman cases).		increase from the Trust average of 2023/24. It does not meet the KPI of 90% response rate.	Focus on reducing the backlog of complaints (those over 30 working days) by ensuring escalation plan strictly followed. Online complaints training available and accessible via the Complaints Department hub page so all staff who require training on how to investigate complaints and write responses can access this at all times rather than wait for training delivered by a member of the complaints team.
Increase responses to FFT patient experience survey by 20%	There are no targets set for response rates under the new FFT guidance (April 2020). NHS England guidance states that reporting should focus on what feedback has been collected and what has been done with it, rather than response rates and scores. The Trust will continue to monitor how many surveys are completed for each service/department to ensure that all people who access services are asked for their views.		A total of 5,097 responses across all areas have been received during May 2024, an increase since April 2024 (5,085). The inpatient department have seen an improvement in response rates in May 2024. Response rates for all other departments have declined in May 2024. The patient experience team support wards and departments in implementing systems for collecting the FFT in line with national NHS England guidance. Ensure the FFT test is available to all patients and people who use services, including carers, parents, and family members. We have established a group of Patient Champions to drive patient experience within their area and encourage patients to respond to the FFT survey within their ward/department. We have created business cards and posters with a QR code/online link to the survey for patients to	The Patient Experience Team will continue to support team with the necessary resources to be provided to patients to enable them to complete the FFT within each ward/department. Ensure the FFT test is available to all patients and people who use services, including carers, parents, and family members. Ensure that monthly summary reports of the FFT are circulated within the Trust to include a breakdown of responses to the FFT by ward/clinic/department.

			respond to the FFT after they have left hospital, and these methods are promoted throughout the Trust.	
Reduction in incidents resulting in significant harm (moderate, severe, death)	The percentage of incidents resulting in significant harm remained low in Q1. There is no significant change compared to Q4. There were no new Never Events reported in Q1		PSIRF response tools continue to be utilised and developed to review system-based factors contributing to incident occurrence. External training in PSIRF principles and methodologies took place during this quarter which will equip staff to undertaken system-based investigations with more effective outcomes to help reduce harm from incidents. Single improvement plans are in place for a number of the speciality areas. Newly designed incident reporting and management training packages implemented.	Work continues to widen the use of Single Improvement Plans. Monitoring forums are in place. Work to commence to utilise Dudley Improvement Practice (DIP) expertise to strengthen improvement plans as part of PSIRF responses A programme of action effectiveness checks to be undertaken to ensure actions have been embedded/sustained in practice and are having the desire impact. Work continues to promote reporting through newly up-dated training programmes.
Standardised Hospital Mortality Index (SHMI) (quarterly) better than England average	SHMI (99.77) and Hospital Standardised Mortality Ratio (HSMR) (84.95). Both better than average and HSMR 10th best in England.		102 cases referred for SJR in 2024 with 75% reviewed to date. 98% of cases reviewed highlight average to excellent care. Martha's Law initiative 'Call for Concern' has been launched. Working groups for fractured neck of femur, sepsis and chest pain continue to meet and report to Mortality Surveillance Group	Pathway compliance work to continue with AQuA. Ongoing reporting via Quality Committee and Trust Board.
Re-admission within 28 days better than England average	There has been an increasing number of readmission spells over the preceding 12 months		• Review of Healthcare Evaluation Database (HED) and GIRFT data commenced • Surgical dashboard in operation	• Trust wide re-admissions audit to be completed with support of Clinical Effectiveness Team

	(Source HED) The Trust is slightly above England average but remains below peer average. Trust : 8.74% Peer: 10.23% England Average: 8.42%			• Previous dashboard to be reviewed and updated
Eliminate 65 week waits by Sept 24 and reduce 52 week waits	The trust continues to perform well against the 65-week target for both elective and outpatient procedures, acknowledging challenges particularly in general surgery, pain and chemical pathology June target = 250 June actual = 302		• Outsourcing to support neurology, dermatology and gynaecology long waiters • 65 week 1st outpatient attendance target continues to be challenging. Pain is on track to clear by the end of the July and trajectories for dermatology and chemical pathology are prepared	• Continue to engage with the Further, Faster programme • Further improvements to PIFU rates
Improve productivity (reduce DNA rate to better than England average, increase PIFU to 5%, theatre utilisation at 85%)	DNA rate in Mar-24 (6.4%) was slightly better than national average (6.5%) PIFU utilisation rate continues to improve. In Apr-24 it was 2.5% against a national average of 3.1% but continues to increase Theatre utilisation has consistently been above national and peer averages in recent weeks		Continue to work on the National GIRFT Further Faster Programme related to delivering on Outpatients and improving pathways – progress to date: - PRE-APPOINTMENT (A&G / RAS / CINAPSIS) – On going **A&G 50/50% / RAS 80/20%** – May 24 – delivered 9k referrals via A&G / RAS – a combination of 56 Specialty areas. **Teledermatology (Cinapsis)** From January 23 to May 24- 4487k Referrals received – 36% Accepted, 46% A&G, 18% Additional information required. **CDC Dermoscopy Hub Pilot Rapid Access Referrals** commenced January 24 – May 24 - to support images / referrals – 1006 referrals received	Continue to drive the GIRFT Further Faster Programme to improve efficiency and productivity.

			to date: - 50% Accepted to RA, 11% Urgent, 12% Routine, 27% A&G. **Cinapsis Eye eRS System** – commenced December 23 – May 24: - electronic eye referrals from Community Optometrists – 352 referrals received – 76% Accepted / 12% A&G, 1% Rejected, 11% Additional information required. **CNS teams** - Gynae, Vascular, Breast, Colorectal, Neurology, Hepatology supporting with ASI / RA triaging. **Gastroenterology Endoscopy Nurse Practitioners** undergoing training to vet Endoscopy Referrals – new development. **Therapy Services> MSK Referrals>** Routine Referrals via Orthopaedic Assessment Group Triaging Model MISSED APPOINTMENTS (DNAs) Trust DNA Performance April 2024 - 6.2% Model Hospital November 23 to April 24 - 2% reduction  REMOTE APPOINTMENTS Virtual 20% vs F2F 80% 12-week rolling period (11 March – 27 May 24) – Virtual Sessions by Areas: - Ambulatory 25% – CORRE 20% - GEMS 39% - GHOPE 58% - Pathology 45% - SUV 28% - T&O	

			21% - Urgent Care 29% - Childrens Services 32%. **Further exploring Video Consultation Acute & Community Areas for Remote Appointment Sessions.** PIFU – MAY 2.7% Trust PIFU (CSS 11.3%, SWC 2.4%, MIC 2%) – Community PIFU data excluded from EROC submissions Continue to work towards the National 85th percentile opportunities. Work closer with Medical Directors Office / Chiefs of Service – part of Specialty teams job planning objectives. **Community PIFU Areas to May 24: -** CMAPS (MSK) 16.2%, Podiatry 23.3% & Dietetics 9.3%. **PIFU Dashboard** – developed to track PIFU pathways / no Specialty PIFU Risks identified to date. Number of Patients Moved/Transferred to PIFU (and % when compared to the number of Clinic Attendances) CalendarMonthDate / Division: April 2024 Activity / % PIFU; May 2024 Activity / % PIFU; June 2024 Activity / % PIFU Clinical Support Division: 347 / 10.0%; 359 / 11.3%; 329 / 11.0% Medicine & Integrated Care Division: 429 / 1.9%; 461 / 2.0%; 410 / 2.3% Surgery Division: 683 / 2.1%; 771 / 2.4%; 582 / 2.0% **Total: 1459 / 2.5%; 1591 / 2.7%; 1321 / 2.6%** June PIFU unvalidated currently. **GIRFT FURTHER FASTER SPECIALTY MEETINGS** – Continue across the Surgical & Medicine Specialty Areas. **GIRFT FURTHER FASTER CHECK LISTS** Continue to embed / Standardise across Specialty areas to drive efficiencies & productivity. THEATRES - updated position Theatre utilisation remains stable; uncapped utilisation has improved over the last month to just below target. Validation and data cleansing of theatre start and finish times is now carried our daily to identify errors and omissions and to rectify immediately. Likewise, specialties are being pushed	

			to maximise their use of individual theatre sessions through the Strategic List Planning meeting. Many specialties remain on target for utilisation, with a number exceeding 90%. Extra work is still needed in some specialties; the nature of their work being high turnover is affecting how their utilisation is recorded. Work continues in relation to the Trust's Elective Surgical Hub submission for June 2024, and preparations for the GIRFT site visit on the 10th of July. COMMUNITY DIAGNOSTICS CENTRE (CDC) Corbett CDC Hub and Spoke model. Positive impact on DM01 performance and reduced waits for cancer patients. Echocardiography longstanding waiting list reduced. Endoscopy and Spirometry commencing during 2024. Mutual aid continues to be provided to SWBH for ultrasound since Nov 2023.	

Goal: Be a brilliant place to work and thrive

Executive lead: Director of Operational HR				
Strategic measures of success				
Measure of success and target	**Current status**	**RAG**	**Summary of progress this quarter**	**Actions planned for next quarter**
Improve the staff survey results to better than England average by 2024/25	Staff Survey results for 2023 were at benchmark average across all People Promises and Themes. There is some variation within Divisions and departments. Next results due March 2025.		Divisional action plans in place and progressing including targeted action in areas with challenged performance across each division; and on core actions around Managers Essentials, Living the Values, Health and Wellbeing. Annual review performance is at 75% with 7 days until the end of the window.	Divisional action plans continue to deliver actions outlined in challenge areas and to embed divisional focus on annual reviews, managers essentials, health and wellbeing and engagement. Delivery of actions outlined in Culture, Leadership and Learning and Recruitment and Retention Journeys. #makeithappen and People Pulse planned for delivery
Reduce vacancy rates to 7% or below	Vacancy rates are currently at 6% and have remained at 7% or under since October 2023		Vacancies and turnover continue to be monitored at Divisional and Trust level. Recruitment and Retention Journey has been ratified and is in the final stages of publication. There is a new sub-committee of People Committee that will embed the People Plan and associated recruitment and retention journey.	Publication of the recruitment and retention journey. Monitoring of vacancy rates, turnover and retention through the Trust KPI report Delivery of the People Plan and journeys through the 'Being a Brilliant Place to Work and Thrive' Committee.
Objectives from the annual plan				
Objective	**Current status**	**RAG**	**Summary of progress this quarter**	**Actions planned for next quarter**
Improve retention rates for Nursing, Midwifery and AHP groups in particular retain 80% of our internationally recruited workforce	Staff turnover for nursing (rolling 12 months average) is at 3.25%, with normalised turnover at 1.17% in May 2024. Turnover has increased in May 2024 but normalised turnover has decreased.		Although there are fluctuations in the retention and turnover figures, turnover remains low. Retention is a key focus of the People plan and this quarter a new sub committee of People Committee has been established to drive forwards the deliverables under the Recruitment and Retention Journey.	Establishing task and finish groups with a focus on: - Flexible Working - Exit interviews and data collection on reasons for leaving - Employer branding and promotion - Tackling Bullying and Harassment

	Staff turnover for AHP's (rolling 12 months average) is 5.61%, the normalised turnover is 3.98%. Both of which have increased from the previous month			
Bullying and harassment - experience of bullying from managers - staff survey results better than England average experience of bullying from colleagues: staff survey results better than England average	Staff Survey results for 2023 were at benchmark average across all People Promises and Themes. There is some variation within Divisions and departments. Next results due March 2025.		Development of action plan underway. Launch of anti-racist statement. Re-launch of behaviour framework. Commenced review of policies to support reporting and action.	Launch of Bullying and Harassment task and finish group. Review and relaunch of policies. Training for corporate services on supporting staff to report bullying and harassment.
Raising concerns - I feel safe to speak up staff survey results better than England average	Staff Survey results for 2023 were at benchmark average across all People Promises and Themes. There is some variation within Divisions and departments. Next results due March 2025.		Development of action plan underway. Increased promotion of FTSU training through Induction, Managers Induction and Managers Essentials. Ongoing programme of awareness raising through drop-ins and surgeries.	Delivery of actions within plan, including: Promotion of training for senior leaders, line managers and all staff. Review of data collection and reporting arrangements.
Recommend trust as a place to work staff survey results better than England average	Staff Survey results for 2023 were at benchmark average across all People Promises and Themes. There is some variation within Divisions and departments. Next results due March 2025.		Annual review performance is at 75% with 7 days until the end of the window. People Pulse (April) has lower response rate and cannot be directly compared to Staff Survey. However, % recommending to work is at benchmark position. Roll out of flexible working training and support.	#makeithappen and People Pulse to be delivered in July. Delivery of actions outlined in Culture, Leadership and Learning, Health and Wellbeing and Recruitment and Retention Journeys.

			Increased attendance at Managers Essentials (35 for May; expected 35 for June). Promotion of Dudley People Plan.	

Goal: Drive sustainability

Executive lead: Director of Finance				
Strategic measures of success				
Measure of success and target	**Current status**	**RAG**	**Summary of progress this quarter**	**Actions planned for next quarter**
Reduce cost per weighted activity to better than England average by 2024/25	Productivity metrics from Model Hospital for 2021/22 show the trust in the highest quartile for overall cost per weighted activity unit (WAU), medical and nurse staffing costs per WAU Implied productivity growth which is a new metric shows that trust is one of only 13 to be showing a positive variance compared to 19/20 A basket of productivity metrics from Model Hospital (Appendix 2) shows a varied picture highlighting instances where the trust is already meeting benchmarks and where there is further work to do		• Trust engaging well with GIRFT Further Faster programme and showing improvement across the key metrics • Productivity metrics based on more recent performance such as theatre utilisation, day case rates and length of stay continue to show improvement • Productivity and efficiency discussed monthly at Financial Improvement Group	Continue to drive the GIRFT Further Faster Programme to improve efficiency and productivity. Monthly focus on productivity and efficiency at Financial Improvement Group.
Reduce Carbon Emissions (year-on-year decrease achieving net zero by 2040)	Overall footprint reduced by 1%, not on track with target. Green Team membership is growing, looking to increase the uptake of training to lead to more projects in clinical areas to help further reduce emissions.		Previous reports indicated the Trust reduced the overall footprint by 1% from the baseline year of 2019/20. Looking at the emissions within the Black Country, Russells Hall Hospital is the largest contributor to the carbon emissions from energy use, with DGFT having the highest	Make It Happen in July is focused on the Green Plan, staff will be asked three questions to gauge the current level of understanding and ask what they think is the most important action to improve sustainability. This feedback along with the

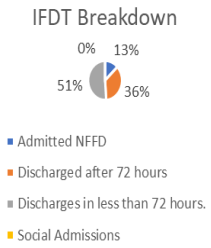
			energy use (kWh) per m2, and 6th highest in the Midlands region. First Sustainability Award at the Committed to Excellence Awards, the winning group was the sustainable medicines project within Pharmacy. This project has returned and redistributed 582 drugs, saving £19,225.38 and 15.8 tCO2e. They have also recently swapped plastic bags for reusable ones for delivering medicines to Wards. Greener NHS training has been embedded within the Preceptorship Programme and Developing Leaders.	outcomes from workshops will help us update the Green Plan which is due in April 2025. Travel survey to be launched in August. Looking to further embed greener NHS training with development pathways within the Trust. The upcoming Chief Nurse Fellowship has a focus on sustainability improvement projects.
Objectives from the annual plan				
Objective	**Current status**	**RAG**	**Summary of progress this quarter**	**Actions planned for next quarter**
Deliver financial plan (deficit of £32.565m)	At month 3 trust had a deficit which was £281k better than the submitted plan		• Income via the elective recovery fund was higher than planned driven by higher than planned activity levels • Agency use remains very low • Income Working Group revised work programme to maximise income from different sources	Continue to monitor elective recovery fund and work to improve coding so that activity is correctly captured and income received Monthly reporting to Financial Improvement Group
Deliver recurrent cost improvement programme of £31.896m	£27.9m of savings identified to date or 87% of the Programme. Of this, £23.5m is recurrent. Gap of £3.9m to find.		Continue with outstanding project documentation and quality impact assessments. Revisit all Corporate Department budgets for additional savings. Revisit divisional plans and realign activity schedules for additional income. Add in mental health recharges. 4% workforce plans to be reviewed and updated to provided assurance these are viable.	Confirm reduced gap due to previous quarter actions being undertaken. Identify system wide transformation schemes Get divisions lined up to review savings for 2025/26 as annual planning process is due to start later in 2024

			Identify what the provider collaborative is owning and delivering from a system wide financial perspective.	
Reduction in use of bank by 25%	The Trust plan assumes 25% reduction in bank (156 WTE by end September 2024). The divisions have developed reduction trajectories		The plan for May assumed efficiencies of 25.5 WTE on the April position. April showed a significant reduction, but the May position increased due to extra surge beds being opened and increased elective activity. The actual performance was 27.52 over the May target – with the division furthest from target being Surgery, Women's and Children's and the increase driven by increase in qualified nursing and medical staff. There remains a cumulative saving of £332k although this has reduced from the April reported position.	• Executive led confirm and challenge meetings • Additional bank controls • Performance monitoring through Finance Improvement group and Finance and Productivity Group

Goal: Build innovative partnerships in Dudley and beyond

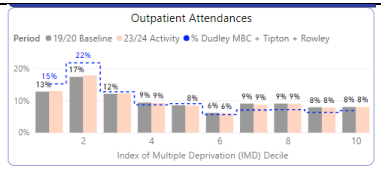
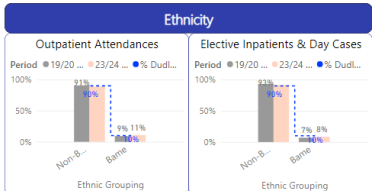
Executive lead: Chief Strategy & Digital Officer				
Strategic measures of success				
Measure of success and target	**Current status**	**RAG**	**Summary of progress this quarter**	**Actions planned for next quarter**
Increase proportion of local people employed to 70% by Mar-25	Proportion of local people employed has remained stable at 68% at end of Q1		Ongoing delivery of ICan programmes focussed on local employment opportunities. Promotion of jobs and support to access opportunities delivered to the 4th cohort undertaking Into Employment programme during June. The first cohort of 5 Novice CSWs, recruited from the Into Employment programme have also commenced in June. An MoU with Dudley Academies Trust has been signed signalling an intention to work more closely with these schools that support some of the most disadvantaged communities in Dudley borough.	Ongoing delivery of ICan programmes focussed on local employment opportunities. Into Employment cohort 5 will commence during Q2. I Can Started paid work experience cohort 1 will complete placements during Q2 and are being supported to secure employment post-placement. Recruitment to a second cohort of 10 placements is currently ongoing, these will start in September. 'Behind the scenes event' for local secondary school students scheduled for 4th July.
Increase the number of services delivered jointly across the Black Country	Matrix of collaboration (appendix 3) shows the level to which services are integrated at system and place from the perspective of DGFT Trust plays active role in provider collaborative Trust plays active role in Dudley Health & Care		• agreement of work plan of provider collaborative and resources to support implementation • DHCP has produced an Annual Report for 2023/24. • Interim performance indicators have been agreed and a plan on a page produced to align the 17 KPIs to outcomes and the 5 strategic goals of the partnership.	• Recruitment to posts within provider collaborative

	Partnership with plans for transaction of services from DIHC postponed due to general election		• An outcomes framework has been established with reporting to Board commencing in quarter 2. • The transition of DIHC services to DGFT has been delayed due to the calling of a general election. Despite this integration and collaboration is ongoing with strengthened partnerships and working practice evident. • The Black Country is one ICS chosen to pilot WorkWell, which will provide early intervention to people who are experiencing barriers to gain or retain employment due to health conditions or disabilities. •	• Work continues to plan for the sustainability of the Family Hubs with work underway to link to the Women's Hubs agenda.
Objectives from the annual plan				
Objective	**Current status**	**RAG**	**Summary of progress this quarter**	**Actions planned for next quarter**
A total of 35 people into work via ICan (through jobs and skills hubs or paid work experience)	5 paid work experience placements under way. 5 novice CSWs recruited. (total 10)		Recruitment undertaken for second cohort of novice clinical support worker (CSW) programme. Recruitment commenced for 10 paid work experience placements. Ongoing employability support in place for existing work experience candidates. Ongoing support for Into Employment programme and guaranteed interviews for attendees.	Second cohort of novice CSWs will commence (9 in pipeline) during quarter 2. Second cohort of paid work experience to commence late quarter 2 (10 candidates).
Improve discharge processes (30 discharges per day from MOFD list, 90% of patients to be discharged within 24 hours once known to system partners, reduce number of incomplete discharges on the complex list –	Current KPIs set within the team are not being met although we have seen an improvement in the data over the last 6 months. • On average 33 complex		Integrated Front Door team: Dedicated team of discharge facilitators and discharge specialists attend board rounds at front of house each day to ensure patients are identified to turn them around.	Working alongside community teams to establish processes for the delivery of equipment till 18.00 Capacity Demand Modelling – joint ICB/ ECIST – meeting TBC to set timeframe

no more than 5% failed per day, 30% of In-patient's discharges are home for lunch for each RHH ward	discharges are identified per day - 23 of the 33 are successfully facilitated (current KPI set at 30 actual discharged) • Per day we have an average of 10 incomplete (failed) discharges. Incomplete workstream and internal escalation calls on-going to reduce the number of Incomplete discharges. • 2 most common reasons were patients becoming medically unwell or TTO's not being requested/requiring • amendments. 63% of failings were due to internal issues, 28% external and 9% family refusal • transfer of care (TOC) process and paperwork reviewed to ensure discharge planning on admission with a 97% success rate of TOCs being completed within 24 hours		Working closely with the Care Coordinators we have made 87 referrals into community services such as High intensity user groups, Long Term Conditions Nurses etc.  Dudley Partners have an agreement that if patients are referred before15:00 they will obtain start package of care for the same day, after 15:00 will be the next day. Out of hours agreement - referrals to be sent to 'How To Find A Care Home'	Reviewing access to overnight stay beds to avoid prolong periods in ED (funded via ICB)

Goal: Improve health and wellbeing

Executive lead: Chief Operating Officer				
Strategic measures of success				
Measure of success and target	**Current status**	**RAG**	**Summary of progress this quarter**	**Actions planned for next quarter**
Improve rate of early detection of cancers (75% of cancers diagnosed at stages I, II by 2028)	Data held by Cancer Services for Q4 23/24 shows a staging completeness of 92.2% against 78 patients diagnosed Of those patients 35% were diagnosed at stage 1 or 2 which is a reduction on the previous quarter (44%) Implementation plans with Inhealth drawn up with the aim of starting scanning in August for the Targeted Lung Health Programme		Data completeness has improved and now sits above 90%, there are still patients who have not been staged at multi-disciplinary team (MDT) but this may be down to factors such as patient has passed away before full diagnosis or referred straight for best supportive care etc. Staging has increased for lung and there has been a decrease of missing staging. Data for 2019/20 was updated retrospectively and submitted to ensure that there is baseline data for the Targeted Lung Health Check programme. We continue to monitor patients where data in incomplete using missing data reports. Appointment of clinical director and responsible clinician for Targeted Lung Health programme and recruitment processes for other roles progressed. Engagement with primary care to facilitate data sharing agreements so that invites can be sent out.	Continue to monitor missing data Appointment to remaining posts for the Targeted Lung Health Programme Finalisation of implementation actions to enable scanning to start in August

Increase planned care and screening from disadvantaged groups (Breast screening uptake 70% or greater)	 OP attendances for those in the lower IMD has increased from 19/20 baseline  OP and elective attendances have increased in the BAME population and is representative group in the overall population DNAs have increased in BAME and lower decile IMD groups but have also increased across all groups. Awaiting Q1 data for AAA screening		Super Saturday for Childrens theatres (ENT and general surgery). Pilot in Lye family hub for paediatric neuro disability clinic Transport vouchers introduced in paediatrics and rolled out across planned care AAA screening-Strategic approach targeting GPs in lowest decile IMD areas. Visited GPs, pop up shops, 'men in shed', British Legion etc to increase uptake of screening. Visited care homes. Reasonable adjustments e.g. easy read information and desensitisation using old probes and gel. DNA clinics for non attendees in higher profile areas, reduced timeslots for efficiency, Increased return rate by 1.5%. Evening and weekend clinics.	Data focus drill down by speciality to highlight areas for targeted speciality approach-each directorate to take forward one health inequalities project. Internal working group to oversee progress and actions. Secure funding for a support worker via charity for pathway for children with asthma. Target core 20+5 groups in paediatrics for provision in family hubs Introduce meal vouchers for children attending outpatients Little steps project-primary school children reviewing areas Engagement in Public Health led health inequalities workshops. Creation of health inequality service development improvement plans in conjunction with commissioners of AAA screening programme.

Objectives from the annual plan

Objective	Current status	RAG	Summary of progress this quarter	Actions planned for next quarter
Achieve acceptable coverage for breast screening (70%) and work towards achievable coverage (80%)	Uptake for Q3 stands at 69% a slight decrease and just under the acceptable level of 70%. Historically low uptake at some of our Wolverhampton practices would have affected this time period in the round plan.		Q1 – relocation of the Dudley mobile unit to a central location March 24, initial indicators are that there is no significant increase in uptake for the 3 practices used as part of this project. There are still women yet to attend and this will be evaluated at the end of Q2. Pharmacy initiative with the advertising on the bags was well received.	The service will continue to liaise with the relevant stakeholders across the patch including public health leads amongst others to look at initiatives to continue to increase uptake. Due to the long-term absence of the Health Equity Lead more local involvement in initiatives are on hold due to other commitments of the Programme

	Q4 (unvalidated) is currently at 71% Q1 currently at 64% however is too soon following quarter end.		J Essex and Lesley Thorpe (Macmillan) attended the NHS Confed Expo in Manchester to present initiatives being undertaken and collaboration with the ICB, PHE, charities and others for Dudley. Programme manager also presented this at a national meeting for all 77 services to engage in health promotion activity.	Managers availability and that the rest of the team are primarily clinical. This will gain further momentum on her return. Building on/new initiatives • Build on the engagement work carried out with beauty salons and hairdressers, voluntary sector organisations and faith settings. To work with them to discuss how a tailored approach can be used to reach those that are less likely to attend. • More engagement work required with Pharmacies, to identify if they can integrate awareness message through the services they deliver and put up a promotion display in their health zone area. • Trial an initiative where women are sent a pre invitation letter on GP header letter. This has been tested in Wolverhampton and has been effective. Dudley is keen to pilot this approach