CONTENTS

Section A: Purpose, Introduction, Summary and Context

1. Purpose of Document

The purpose of this Winter Plan document is to:

• Inform all relevant organisations and individuals of the way in which the System intends to manage winter demand over 2023/24, including MMUH demand.

• Provide a collective overview of actions that will support operational resilience at The Dudley Group NHS Foundation Trust (DGFT) over the winter period (1st October 2023 to 31st March 2024).

• Hold information on the approach taken to building the winter plan.

• Collate historical data, learning from past winter periods and knowledge of the current position that has been used in the development of these arrangements, within the appendices.

• Provide 'organisational memory' of what was agreed, how and why.

• Provide a platform to monitor demand and performance variance to understand variance in subsequent performance and operational pressures.

• Outline the financial implications of the winter plan.

The Winter Plan should be read and implemented by:

• Members of Dudley Urgent and Emergency Strategic Care Board and the Urgent & Emergency Care Operational Group

• Trust Board members

• Divisional Teams

• Matrons

• Clinical Directors in all non-elective specialties

• Senior operational managers in the Trust

• All colleagues who are on an on-call rota.

• Senior operational managers in all system partner organisations

• Infection Control Leads

• Informatics Leads

• Black Country Urgent & Emergency Care Board

This document should be read in conjunction with the following documents, plans and arrangements:

• The appendix to this document

• Dudley A&E Delivery Board Improvement Plan

• Surge and Escalation policy

• Major Incident Policy

• Business Continuity Policy

• Service Level Business continuity plans

2. Summary of Winter Bed Position

The below table shows a summary of variance to ICB assurance and peak modelled targets (see figure 1 for both).

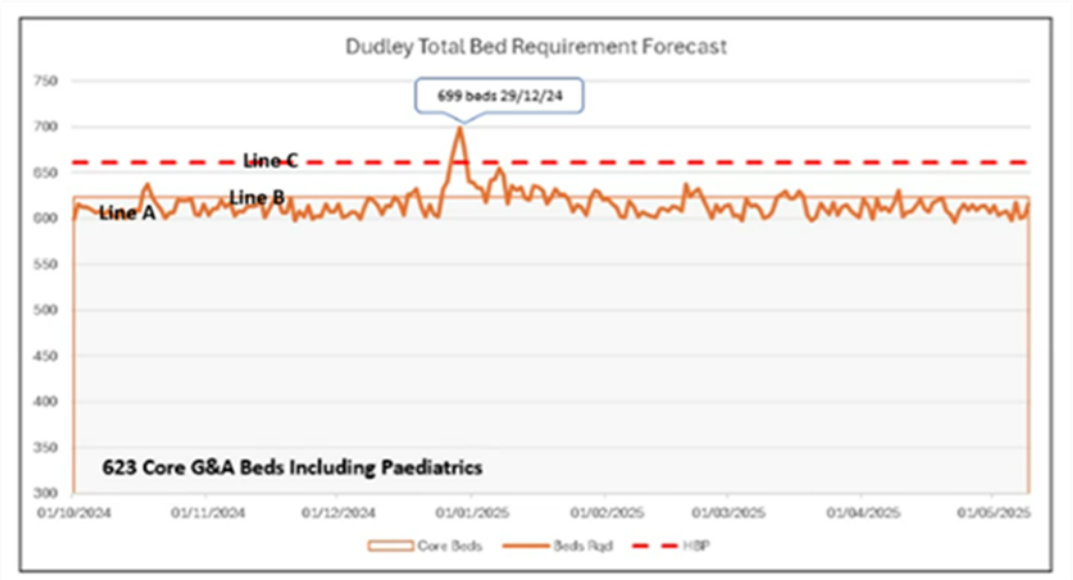
Figure 1 (Repeated): Variance to ICB Modelling

Element of winter plan	Variance to peak	Variance to ICB winter assurance level
MMUH	-15	
Winter	-27	
ICB Multiplier	-5	
Total	-47	-15

Figure 5: Dudley total and peak bed requirement and ICB assurance: ICB forecast

The below figure shows the agreed expected bed requirement for winter 24/25.

- Line A is predicted demand
- Line B is current capacity
- Line C represents the bed capacity to which the ICB must be assured.



NB: It is important to note that, due to factors explained within this paper, the Trust is currently not operating to the ICB modelling. This is due to both factors related to MMUH activity and MOFD explained within this paper.

3. Introduction and Key Risks

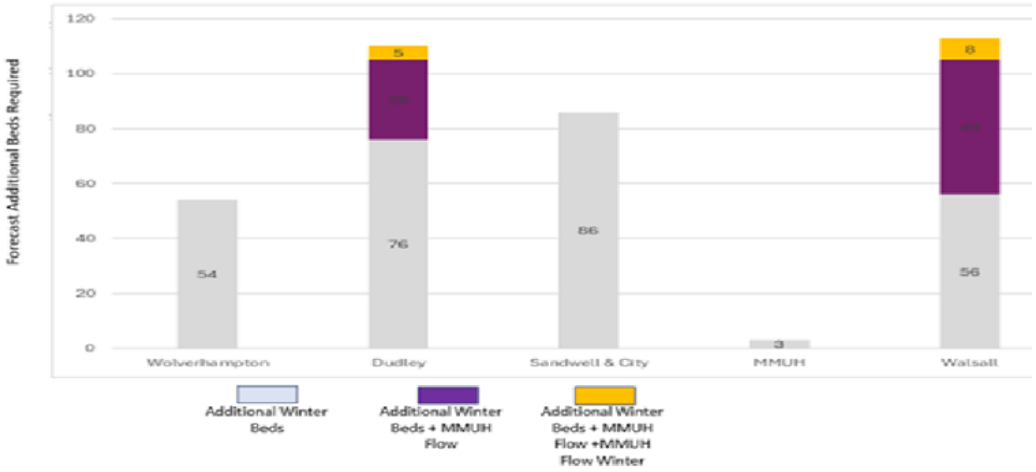
The Board is asked to discuss and note the content of this year's winter plan.

The DGFT Winter Plan is aligned to the Walsall Healthcare NHS Trust Winter Plan and Royal Wolverhampton Trust (RWT) plans through ICB-lead impact modelling detailed within this paper and recognises the potential risk to Dudley and wider Black Country as a result of the opening of the Midland

Metropolitan University Hospital (MMUH) on 6 October 24. The below graphic shows the ICB-led integration of plans and predicted bed gaps for MMUH across winter.

The plan acknowledges the poor starting position of the Trust; that there are 50 more complex MOFD in our bed base than the England average for a hospital of our size – and that this is being addressed through a project by the Dudley Improvement Practice team. The paper provides a deep dive into the reasons for this high prevalence of MOFD – these reasons are addressed as part of the winter plan.

Figure 6: ICB Winter and MMUH bed gaps projection



However, this plan does detail the actions the Trust is taking to mitigate the bed gap during winter and the impact MMUH. By November a number of schemes will be implemented which will mitigate 62 beds and then further actions will be taken in the remainder of winter 2024/5 which will then see all our planned mitigation in place. There is a financial consequences and detailed breakdown of the financial risk incurred by the plan is detailed in section 13. The table below show high level risks considered and RAG rated by the trust relevant to MMUH.

Risk	Mitigation	RAG + Score Increase/Decrease
Increased activity due to the opening of the new Midland Metropolitan Hospital (Walk ins and Ambulances +ICs) pressurises medical bed base; ambulance handover and admission delays	Weekly bed impact analysis and escalation to executives Continuous monitoring and escalation and ongoing engagement with system colleagues UEC group discusses weekly	**Walk Ins Risk** Red Walk-ins already much higher than envisaged, and account for 85% or admissions from new cohort from Sandwell postcodes **Ambulances Risk** Amber Ambulances remain within tolerance from original ICB modelling
Delay to recruitment a) CCCS community hub and b) medicine VW	Medicine frailty VW impacted through high levels of nurse sickness – substantive option to progress rapidly through VAR	Amber Delayed kick in of medicine Frailty VW
Pressure on ED: Long waits in waiting rooms and cubicles due to bed pressures and enhanced from door volumes	Opening SDEC to 12 Hours New front Door model (detailed within paper) Business Case to Open SDEC to 24h ICB and trust escalation levels	Amber Front door mitigations will bring significant elasticity to ED

Shortage of staff due to Staff Sickness + Continued Industrial Action	Trust processes in place • Annual winter vaccination programme to be launched - both Covid booster and flu • Divisional and Trust staff allocation meetings • Focus on building morale in ED • Divisional Raffle initiatives BMA has recommended Government's new pay deal for Junior Doctors to its members. Awaiting outcome • Strike planning will continue • Monitoring impact of Primary Care IA / Working to Rule	Very small uplift in sickness v this year; Junior Dr strikes resolved but primary care strike
Covid, Flu, Norovirus, etc. impacting on inpatient flow and nursing home closures	IP processes and guidelines in place • Joint work with Capacity • IP input to Nursing Homes • Community infection and vaccination rates are routinely monitored by the system and within the Trust	Mitigations effective
Closure of Resuscitation and re-provisioning in order to facilitate new rebuild	Acute Virtual Ward opened and to 5 beds as of 5/11	Mitigations effective
Delay to Rowley Stroke beds	Still no anticipated move-in date	Dialogue continuing, anticipated move-in date January

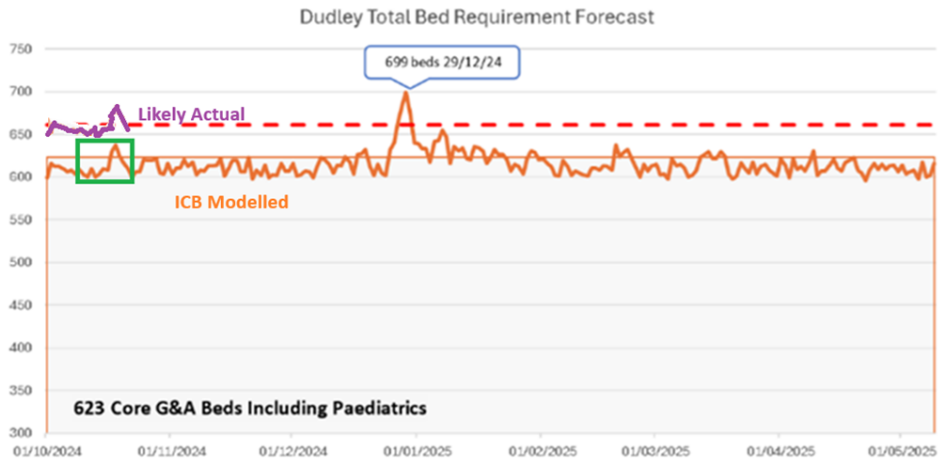
Further Risks to delivery of the Winter Plan, along with their mitigations are detailed in the table at appendix 3. This includes current risk scoring from the Trust's risk register RE: MMUH.

4. Current Position of the Trust: 'Why we are where we are'

<u>The below section sets out a full diagnostic so that the mitigations can be understood within the operational context the trust currently operates within.</u>

The current position of the Trust is compromised, and high numbers of ambulance delays are currently manifesting at the front door. The below graph shows a clear upward trend related to ambulance handovers at the Trust since Jan 2023. This is responsible for day-to-day flow pressure and long ambulance waits.

Figure 7: Predicted versus actual activity, MMUH



Activity related to the MMUH/Winter combination is, on early evidence, higher than that which the ICB have modelled.

As of 24/10/24, the Trust is experiencing 27 extra walk-ins day; this means 5.4 admissions per day (based on a previous/subsequent 16-day period, at an agreed 0.2 Conversion Ratio)

The Trust is experiencing an average of two extra ambulances per day – this equals 1

admission per day (based on a previous/subsequent 16-day period, (at a 0.5 conversion Ratio)

This, at a 7.9 LOS (the LOS agreed with the ICB at modelling stage) means 44.8 Admissions per week – **creating a 50.4 bed gap within the Trust.**

As per figure 6 above, the peak bed requirement for MMUH as modelled by the ICB is 29; and the Trust is nowhere near peak demand, which is anticipated around early January.

This is manifesting in increased ambulance handover delays since the opening of MMUH.

It is also manifesting in around 50 extra surge beds open at the trust. Surge beds are opened by the medicine division within SDEC and the discharge lounge when there is a deficiency of bedded space. This can hamper the operations of both SDEC – less patients can be seen in a smaller space – and the discharge lounge, which is no longer used as an enabler to discharge, as effectively.

Figure 8: Average number of MOFD patients within the RHH bed base, May to October 2024

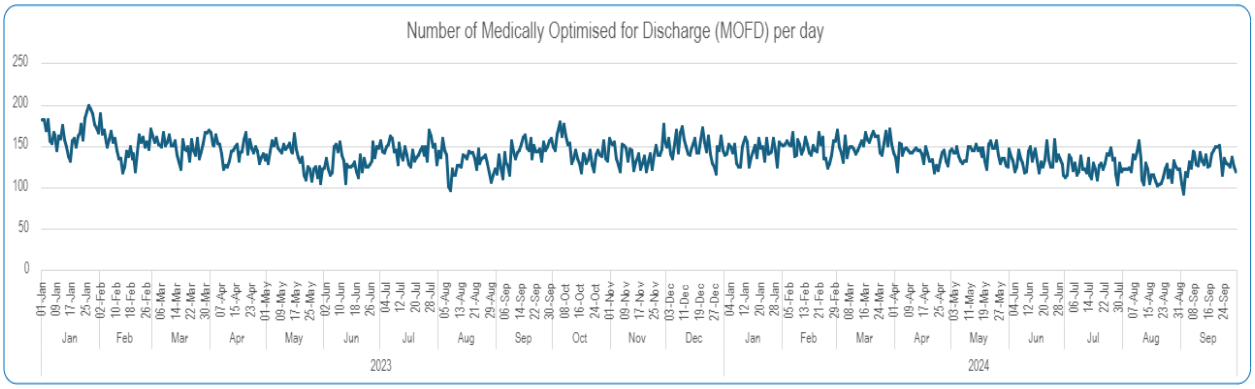
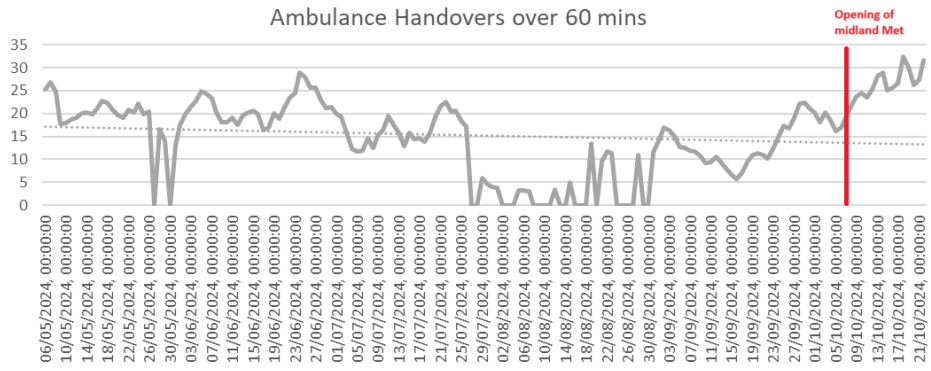
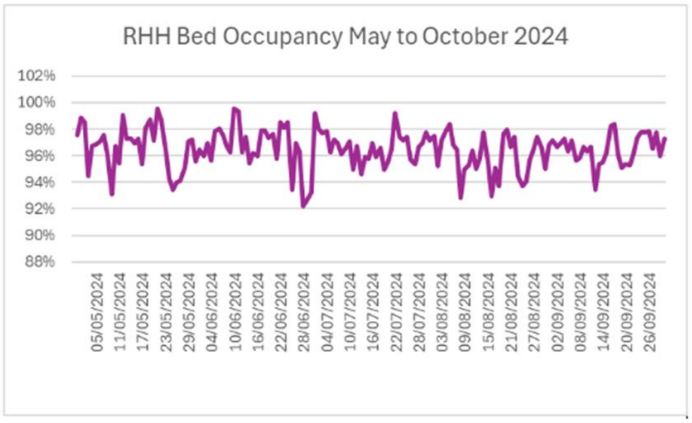


Figure 9: Number of 60 min Ambulance Handovers since May and vs MMUH opening



A causative factor is bed base occupancy, which leaves the Trust with a low bed balance from which to operate, and a small buffer before no beds exist in the Trust. This is contributed to both by MMUH impact, and a high level of MOFD within the Trust.

Figure 10: RHH Bed Occupancy May to October 2024



5. Focus on Discharges

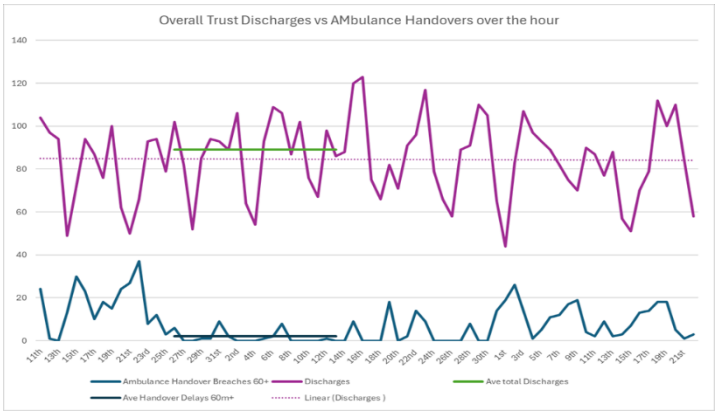
An audit of discharges at the Trust conducted but the medicine division was carried out in August and September 2024. Examination of the data from the last 3 months shows that the crucial number of discharges in a non-winter scenario is 89 per day; We as a Trust average 84, but this number is highly variable

With an expected additional volume of 110 admissions expected during the peak of winter (76+29+5), and an additional volume of 50 to ICB assurance, the trust should aim to attain 14% more daily discharges – so 96 during most of winter, 103 at peak (Dec-Jan).

A daily total of 65 or below is likely to have a negative impact on ambulance handover within 24 hours, ceteris paribus.

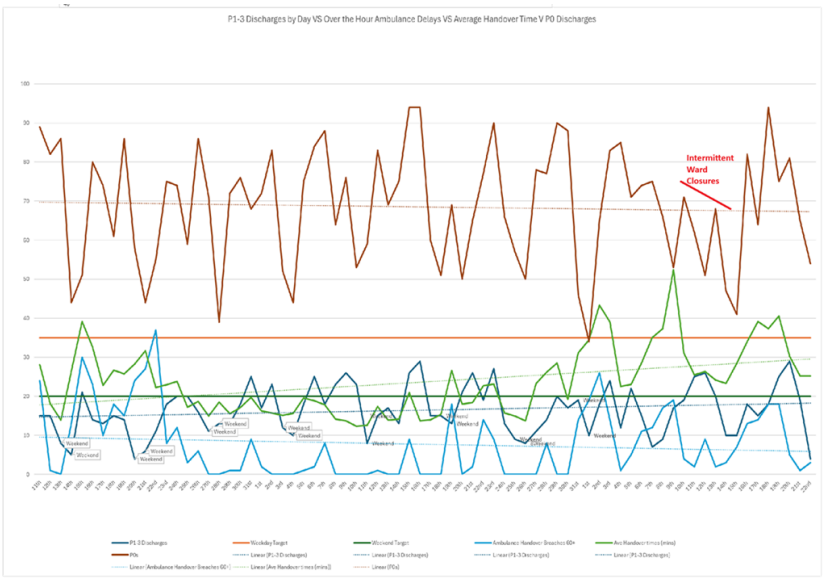
As the diagram below shows, where we dip below that number of discharges, ambulance over-the hour breaches tend to increase in prevalence, whereas over 89 discharges per day on average brings a very low number of ambulances over the hour breaches.

Figure 11: Overall Trust Discharges versus Ambulances over the hour Jul-Sept 2024



Taking a deeper look at this, it is possible to drill down into causative factors. The table below shows ward-led discharges versus complex discharges, overlayed with ambulance delays over the hour and average time to handover during August and September at the Trust.

Figure 12: Ward-Led vs Complex Discharges



As it is clearly possible to see, ward led discharges outstrip complex discharges; by a ratio of 4:1 (Wards are responsible for an average of 81% of Discharges from the Trust, whereas Complex are responsible for 19%). The correct ratio is 50/50:

Figure 13: Expected complex to simple discharge ratios, Institute of Social Care Excellence

Pathway 0	50 per cent of people: simple discharge, no input from health/social care.
Pathway 1	45 per cent of people: support to recover at home; able to return home with support from health and/or social care.
Pathway 2	4 per cent of people: rehabilitation or short-term care in a bed-based setting.
Pathway 3	1 per cent of people require ongoing 24-hour nursing care, often in a bedded setting; long-term care is likely to be required.

Source: https://www.scie.org.uk/providing-care/commissioning/hospital-discharge-admissions/

It is important to note that this is heavily dependent on local system, demography and population and services with skills and capacity been available to support this. Dudley has a number of challenges, according to the council's most recent Joint Strategic Needs Assessment, which do not afflict other areas:

- Patient-level data shows patient acuity 6% higher than pre-covid; not accounted for in clinical workforce or efficiency modelling. Male and female life expectancy has dropped; both OP and admission.
- Driven by multimorbidity; there are 1.5% more adults binge drinking in Dudley; 3% more adults are obese versus pre-covid.
- 2.1% more of the population have mental health diagnoses than pre-covid.

The Trust has a large number of medically fit patients within the bed base, often accounting for 25% of all available beds. The national average is one in six or 16.6% (BMJ, 10 March 2023), making the Trust a significant national outlier, and means that compared to the average sized trust with a similar bed base, **RHH has 50 more beds full of MOFD patients, the vast majority of which sit in Medicine.**

Discharge Review Workstream

The Trust is also reviewing discharge processes. The recently published NHS England Urgent and Emergency Care (UEC) acute patient flow clinical and operational improvement guide provides a range of change ideas for how UEC services can improve both patient care and productivity; it describes two principal aims:

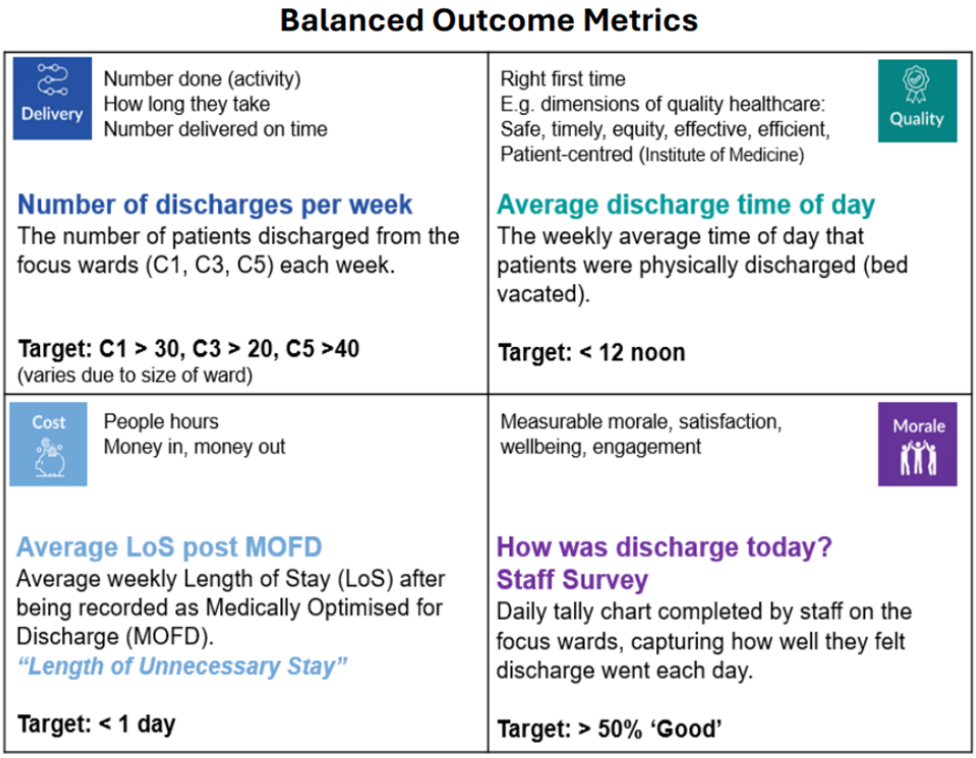
- Making care safer and patient experience better by increasing the adoption of evidenced best practice
- Maximising the value of patients' and clinicians' time and the productivity of services by tackling waste and addressing inefficient processes

Work has been commissioned via the Dudley Improvement Practice and in keeping with the universal flow principles described in the NHSE improvement guides, the following steps will take place over the four weeks commencing the 4th of October.

- Write up the current state process maps to focus attention on the most problematic parts of the discharge processes.
- Review all current ways of recording discharge data.
- Work with Organisational Development to plan relationship-building for wards and the site/capacity team.
- Meet with ward-level triumvirates to review the thematic review of problems
- Seek commitment and motivation to support a small number of change ideas which will have the greatest benefit to our discharge performance.
- Identify MDTs who are committed and motivated to owning the selected change ideas.
- Introduce an improvement approach to testing the change ideas – with reference to the national improvement guides.
- Set up an BCPC Learning and Improvement Network (LIN) in readiness to share our learning with the regional NHSE team
- Report against the proposed Balance Outcome Metrics and learning from tests of change on the focus wards.
- Promotion and comms, sharing success and learning to then identify other areas to engage and support.

It is expected that this work will begin to influence the following Balanced Outcome Metrics

Figure 14: Balanced Outcome metrics



Source: https://www.england.nhs.uk/improvement-hub/wp-content/uploads/sites/44/2017/11/How-to-Guide-for-Measurement-for-Improvement.pdf

Quality Oversight Workstream

In order to improve flow at the trust, the trust is undertaking extensive quality work, including:

- Ongoing oversight is maintained throughout each day via the Divisional leadership teams and Site and capacity team.
- The Chief Nurse, Medical Director and Chief Operating Officer maintain consistent and visible executive leadership within the UEC areas and across the Trust. Examples include regular presence in the areas, back to the floor which includes senior nursing, midwifery and AHP leaders, out of hours visits and additional support during times of extremis.
- Colleagues from the wider Executive team maintain consistent and visible leadership and support operational teams on a daily basis.
- Board to ward visits (include NEDs) and quality visits are in place across the whole organisation, with associated governance in place.
- Real time information about the current status in the Emergency Department is available to all Executives and is monitored on an ongoing basis each day.
- Hourly sitrep is received which included operational, workforce and quality related information.
- Escalation protocols are in place to decompress ED and maintain flow across the organisation, which includes risk assessments. The risk assessment process and process for placing additional patients onto wards are being strengthened.
- Utilisation of best practice, for example, recently shared temporary Escalation Places Principles (NHSE, 2024).
- Corridor nursing within ED continues to be avoided.
- Updates on 7-day services are submitted to the Board of Directors at least once a year with last received in May 2024, reporting compliance against all standards (4 priority) with evidence to suggest compliance amongst all standards. A number of standards have not been formally tested and have been included in the 2024/25 audit plan.
- Further work on a set of safety actions, clinical hub and admission avoidance.
- Trust wide vaccination programme (staff and patients) is ready, and the aim is to maximise it as much as possible.

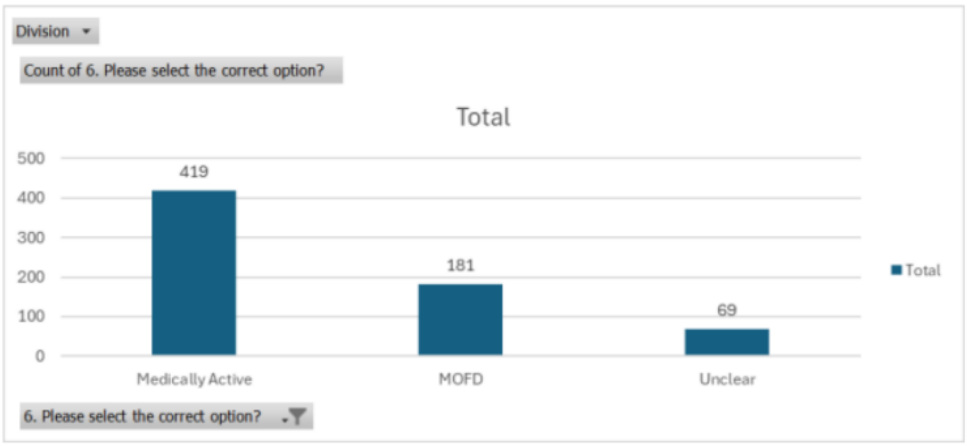
Remedial Work: Rebalancing MOFD at the trust

Work is underway aims to reduce the prevalence of medically fit patients within the bed base from 23% to 16%, which is the national average. This reduction is necessary so that the Trust's starting position is commensurate with ICB modelling.

As shown above, the key remedial piece of work which needs to be completed is the rebalancing of MOFD at the trust from circa 25% to 16.6%.

This releases roughly 50 beds; a recent census led by the Trust Medical Director, Julian Hobbs, confirmed this finding 63% (419) patients in the trust were medically active, while **27%** (181) were MOFD. 10% (69) was unclear whether they were ready for discharge or still medically active; <u>therefore, the opportunity may be greater than first thought.</u>

Figure 15: Trust Census Data, MOFD patients

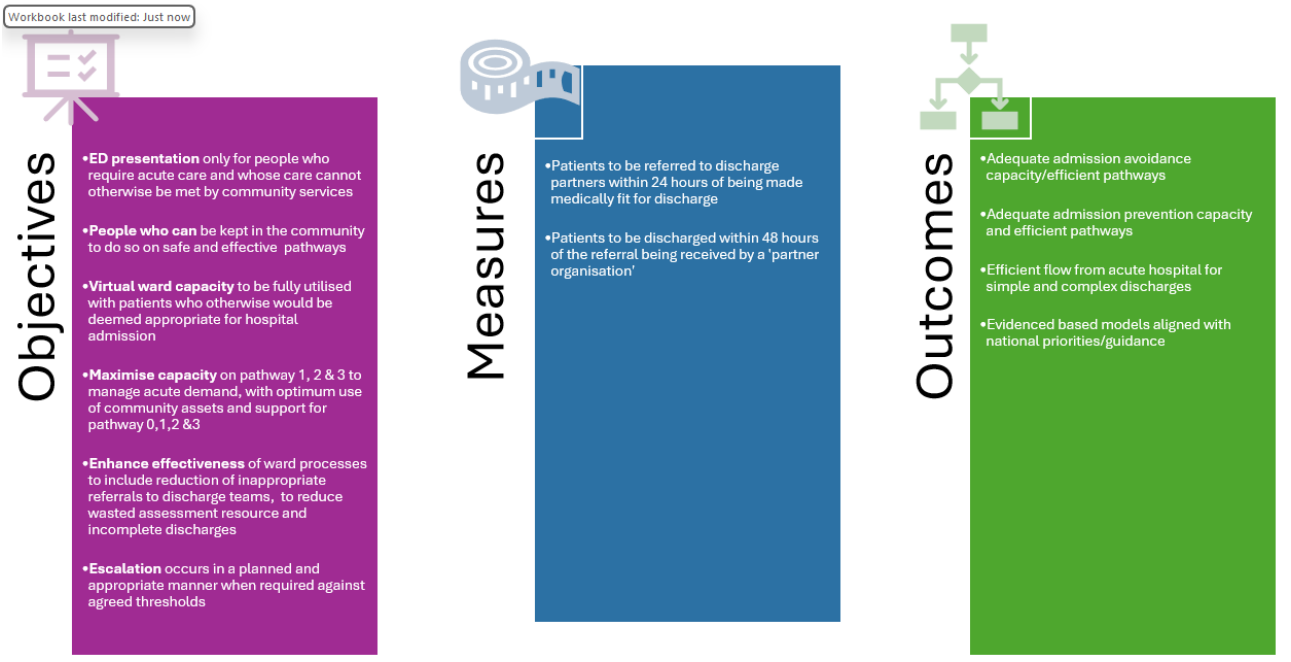


Source: Page 11 Trust Census October 2024

6. Dudley System Plan – Winter and beyond.

The Intermediate Care Framework for Rehabilitation, Reablement and Recovery following hospital discharge was published in October 2023. Dudley System Partners have been working collaboratively to benchmark against this guidance and are collectively working to achieve the following.

Figure 16: Dudley System Plan



Within this work is the agreement of clear and visible escalation processes to support Winter and beyond with a plan for new Level 4 Action Cards following the creation of the Place Division will be available in November.

Furthermore, there are initiatives that are being proposed to take forward admission and attendance avoidance of patients attending secondary care and encompassing a Community First Approach.

These include:

<u>Single Point of Access (SPoA).</u>

- Clear pathways to be in place for the provision of remote clinical assessment and advice through a SPoA prior to a decision to convey or attend ED.
- Ambulance services enabled to identify patients prior to dispatch for alternative pathways, as well as adopting 'call before you convey.'
- Direct referral pathways from SPoAs into community services such as Urgent Community Response (UCR) and Virtual Wards (VWs).
- Priority access to clinical advice for paramedics/ambulances staff and extending this in time to other health and care professionals, are homes, primary care (in-hours and out-hours GP services), community and other services.

Figure 17: Single Point of Access Guidance and Best Practice

Source: SPOA Guidance and outputs of workshop, Dudley Health and Care Partnership, Sept 2024

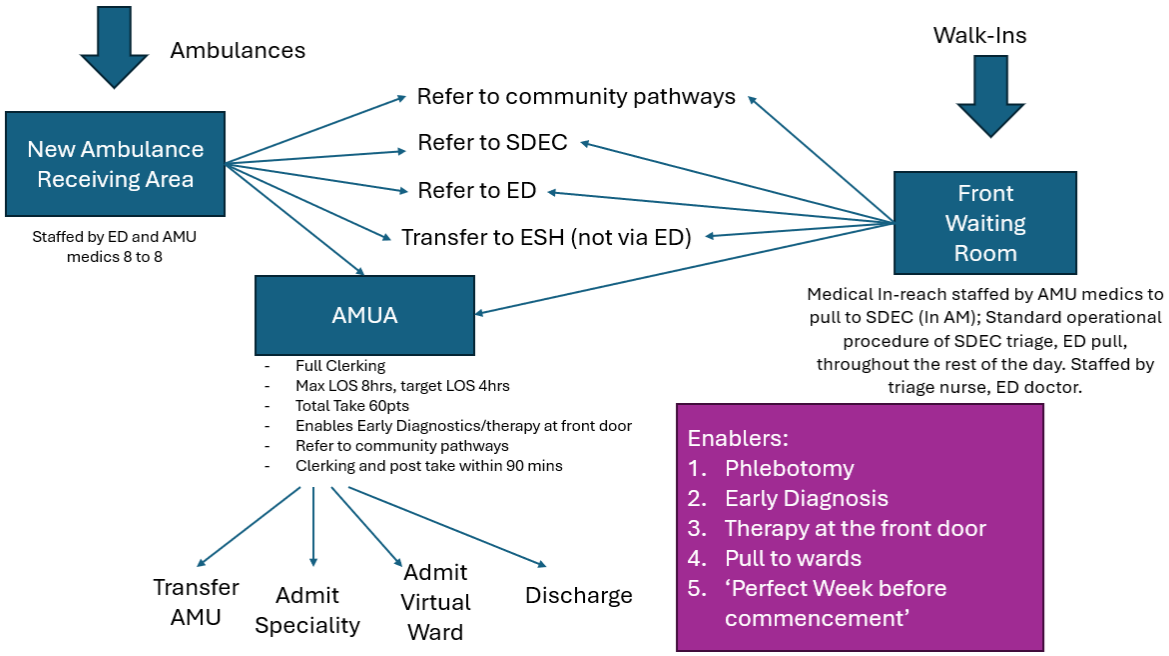
7. The Trust Plan for reduction of MOFD within the bed base

Preventing Admissions at the front door

The Medicine division have designed and are piloting a front door initiative designed to augment the skill mix at the front door in order to maximise redirection away from the trust bed base, where appropriate.

This will be supported by early interventions and diagnostics, and the running of a 'perfect week' before commencement in November 2024.

Figure 18: DGFT Front Door Winter Redesign



According to local Better Care Fund data, if this model facilitates a push to DGFT's best performance in terms of avoiding unnecessary ambulatory admissions, it is worth 13 beds worth of avoidance. If DGFT can replicate Sandwell's current performance (bet in the ICB), it is worth 15.5 beds; and if the model completely addresses unnecessary ambulatory admissions, it is worth 98 beds worth of avoidance.

In addition to this, the trust will incrementally open Same ay Emergency Care (AEC only) to a preliminary 12 hour, and then to a full 24h model to support the new front door.

Front-loading admission avoidance resources will improve:

- **Immediate Assessment and Triage, Including the Rapid Assessment and Triage (RAT) model:** By having skilled clinicians, such as nurse practitioners or physician assistants, at the front door, the hospital can quickly assess patients' conditions and determine the appropriate level of care needed. This can help to identify patients who can be treated on an outpatient basis or redirected to other healthcare facilities, such as urgent care or primary care.

  This includes the use of the RAT model, which typically involves the early assessment of 'majors' patients in ED, by a team led by a senior doctor, with the initiation of investigations and/or treatment. The approach consciously removes 'triage' and initial junior medical assessment from the pathway.

- **Access to Alternative Pathways:** Admission avoidance resources often include access to alternative pathways, such as outpatient therapy, telemedicine consultations, or specialized clinics accessed through the Dudley Clinical Hub. Providing these options at the point of entry can address patients' needs without resorting to hospitalization.

- **Care Coordination:** Front-door resources can facilitate connections to community services and follow-up care, ensuring that patients have access to necessary support without being admitted. This can include social work services, mental health resources, or post-acute care options.

- **Education and Self-Management Support:** Front-door teams can educate patients about self-management strategies for managing their conditions, which can reduce the likelihood of

exacerbations that would otherwise lead to hospital admissions. Providing patients with the tools and knowledge to manage their health proactively can help prevent crises.

- **Navigation Assistance:** Admission avoidance resources often include care navigators who can help patients understand their options and navigate the healthcare system. This can include scheduling follow-up appointments, arranging for home health services, or connecting with specialists.

- **Preventing Ambulatory Care Sensitive Conditions:** Many admissions are due to conditions that can typically be managed in outpatient settings with appropriate interventions (Such as HOT clinics at DGFT SDEC.. By addressing these issues proactively at the front door, hospitals can decrease the number of patients requiring hospitalization.

- **Data Collection and Analytics:** Front-door resources can gather data on patient presentations and outcomes, helping hospitals identify trends and adjust their services to better meet community needs. This responsiveness can lead to more effective prevention strategies over time.

8. **MMUH Impact and Mitigations: Unmitigated Impact of -15**

MMUH has a substantial impact on winter and needs to be understood in the context of the winter plan. DGFT has undertaken a detailed modelling exercise related to the full impact of MMUH, below. The Initial ICB modelling of MMUH was 26 beds, which was later adjusted to 29 –importantly, there are serious (acknowledged by the ICB) deficiencies in the ICB modelling for MMUH. Though the ICB have modelled for G&A beds, they did not model the impact on surgery, delayed transfers of care, ED cubicle space, or triage space. This then fell to the Trust to model, which we have done below, in order to provide a more realistic picture of what will happen. The actual gap, with the above factored, is likely to be 65 beds.

Figure 19: Full DGFT Bed Impact Analysis, Midland Metropolitan University Hospital

Bed Level	Category	Attribution	Scenario A: DGH Worst Case Scenario	Scenario B: BC ICB W/O Mitigation	Scenario C: BC ICB With Mitigation	Scenario C2, Hybrid
	Cubicles - excluded from this point for calculative purposes		15	13	10	9
	Triage					
	Walk-In		9537	9537	6268	6268
	Ambulance		3722	3722	2855	665
	Conversion Rate Amb		0.5	0.5	0.5	0.5
	Conversio rate WI		0.2	0.2	0.2	0.2
	Conv Amb		1861	1861	1428	333
	Conv WI		1907	1907	1254	1254
	Ave LoS		5.9	5.9	5.9	5.9
	Total Stay		22234	22234	15818	9358
	Total Beds		61	61	43	26
	Basic bed level		61	61	43	26
	Of Which AMU (40%)		24	24	17	10
	Of Which Specialty		37	37	26	15
	Comprised of:					
	General Medicine	32%	12	11.7	8.3	4.9
L1	Cardiology	11%	4	4.0	2.9	1.7
	Respiratory	17%	6	6.2	4.4	2.6
	Gastroenterology	8%	3	2.9	2.1	1.2
	Geriatric	23%	8	8.4	6.0	3.5
L1	Stroke	9%	3	3.3	2.3	1.4
	Virtual AMU?*Flex		20	20.0	20.0	20.0
	Delay Discharge impact		6	8	8	6
	Additional SURGICAL Beds required @30% basic bed level		18	18	13	11
	TOTAL Bed Requirement excluding cubicles, ic. VW		105	107	84	63
	Include Impact ED cubicles/Triage		22	22	22	22
	Total Physical beds		109	109	86	65

The actual bed gap is thus more likely to be 65, not 29. The Trust was then asked to model its mitigations to MMUH, and was careful to do so in respect of the 65, not the 29, within an at-risk financial envelope of 50% of the original submission.

The choice made by the Trust was to use the most cost-effective mitigations to create the largest possible bed mitigation

The following sections outline the initiatives the Trust are implementing to mitigate 50% of the MMUH project impact non recurrently. The cost of each of these mitigations are shown in the Costs section of this paper, and total £2,638,000

- **Estate at Rowley Regis OR alternate location (Ridge Hill): 15 Stroke beds – Start date TBC**

15 Early Supported Discharge stroke beds are available, which would contain DGFT Stroke Rehab patients, at Rowley Regis. This option is contingent on a zero cost for estates and facilities, with only staff costs being incurred. This is currently being worked through by the trusts – the costs are included in the cost section of this paper, with staffing expected to be completed in December.

Early Supported Discharge (ESD) services enable a percentage (generally 40%) of Stroke survivors to leave hospital earlier and receive intensive rehabilitation.

The Trust would be able to use these to step down stroke patients, many of whom occupy the bed base as MOFD, because they are waiting for rehab beds in the community which do not exist.

- **Frailty Virtual Ward: 20 beds – Start Date 21 October**

Virtual wards (VW) allow patients to get the care that they need at home safely and conveniently, rather than being in hospital. Virtual wards combine face-to-face clinical provision through remote monitoring technology, to enable high-quality treatment, diagnosis and monitoring to be delivered to patients' at the place they call home, including care homes. Hence, reducing the number of admissions overall as VW supports admission avoidance by providing an alternative to the traditional admission patient pathway into the acute bed-base, as well as facilitating earlier supported discharge of patients who require ongoing clinical supervision, but could be safely managed in the community thus reducing length of stay.

Dudley currently has a population of 320,320 (JSNA, 2019). Dudley only has 56 funded virtual ward beds, leaving Dudley a minimum of 72 virtual ward beds short. This initiative is a partial remedy or that shortfall.

An early pilot of the Frailty Virtual Ward was conducted earlier this year at RHH. The wind-down of this facility was commenced on 22nd April. As part of the rationalisation exercise with which the division attempted to fund this long term, three facts were ascertained which made the flex of resource between virtual wards impossible.

20 beds would be required on the Frailty Virtual Ward, which an evaluation of current demand within the Trust suggests could be filled with relative ease. The pilot of the acute medicine virtual ward in spring 2024 revealed an average 2.5 day LOS. This means that 20 beds in the acute virtual ward could prevent 56 admissions to physical beds per week.

The pilot of the Acute Medicine Virtual Ward was strongly correlated with lower trust EMS levels.

- **Expansion of services in Community in line with the 'Community first, Hospital when necessary' ethos. (15 Beds) – Community Hub (HUB) will be extending operational hours to 00.00 from w/c 4th November.**

The Clinical HUB over the last 12/18 months has collaborated with partners including the Acute Trust, Primary care, Local Authority and the Out of Hospital (OOH) group to develop pathways that support attendance/admission avoidance into ED. This is comprised of.

- Urgent Community Response (UCR) Falls pathway – in addition to collaborating closely with the Local authority to deliver the joint Falls pathway, the Clinical HUB went live with the UCR Falls pathway from April 2023.
- Care Home engagement event to increase volume and utilisation of Community Hub for Sandwell patients.
- Virtual Ward – The IV therapy/OPAT service sits as part of the Heart Failure VW pathway and has been supporting patients in community/clinic at Brierley Hill. Recently, the service was also involved in the provision of the AMU VW to facilitate continuation of IV treatment at home and thus reduce the length of stay on AMU, whilst supporting the patients to recover in their own homes.
- Introducing Paramedic presence within the HUB to embed call before you convey with WMAS between 16.00-000 each day, including weekends.

All these pathways have established positive relationships with external partners and supported the integration agenda. This is evidenced through the increased utilisation of the HUB by Primary care and Care homes. Work continues to support further engagement from WMAS but collaborating with Community teams has ensured an increase utilisation of the HUB by community teams for deteriorating patients further supporting the community first model and reducing the footfall in ED
The impact of the 50% reduction in the at-risk envelope this entails a 15 bed gap. As is sensible, the Trust have applied this -15 position to the ICB modelling, meaning that we have assured the ICB that we can mitigate for 14 beds of the MMUH impact, of the 29 they believe will need to be provisioned.

Figure 20: MMUH Mitigations post cost-effectiveness revisions

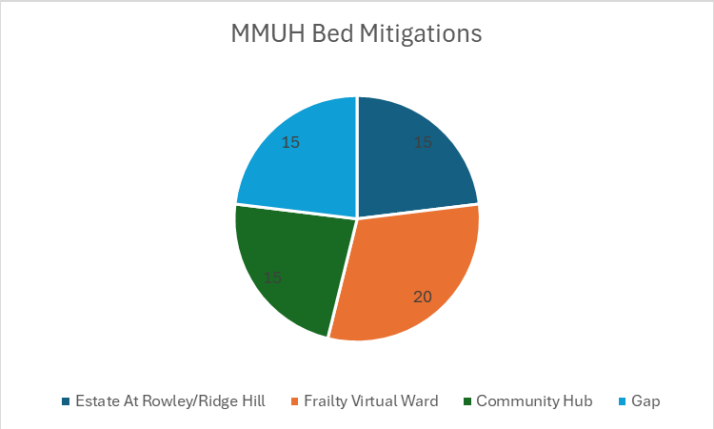
Mitigation	Number of beds	Cost	Cost per bed saved	Most cost effective use of 50%	
Rowley Stroke Beds	15	£635,000.00	£42,333.33	£635,000.00	15
Community Hub	24.6	£4,316,000.00	£175,447.15	£2,680,996.00	15
Acute Virtual Ward	20	£1,000,004.00	£50,000.20	£1,000,004.00	20
Packages of Care	5.4	£1,460,000.00	£270,370.37	£0	0
Total	65	£7,411,004.00		TOTAL BEDS PROPOSAL	50.28093
	50% of which	£3,705,502.00			

The impact of the 50% reduction in the at-risk envelope this entails a 15 bed gap. As is sensible, the trust have applied this -15 position to the ICB modelling, meaning that we have assured the ICB that we can mitigate for 14 beds of the MMUH impact, of the 29 they believe will need to be provisioned.

Subsequently, the trust realised that the cost supplied by CCCS for the prevention of an admission through the community hub was very high - £175k versus £50k for a virtual ward bed. The cost of this was benchmarked against studies of similar teams in Bristol and Enfield, and a rationalisation of cost leading to an additional 24 beds was found – this will be discussed in the context of winter, below. These teams focus specifically on care homes, and see a prevention of admission rate of 80-89% per call.

As such an important facet of the mitigative strategies, outcomes and admission avoidance will need to be monitored on a case-by-case basis by CCCS in order to ensure outcomes are being met.

Figure 21: Summary of MMUH bed mitigations and Gap



9. **Winter Impact and Mitigations:** Unmitigated Impact of -27

As detailed at figure 1 above, the winter bed gap is 76. The trust has planned a number of schemes which we will use to mitigate this risk

- 10-bed virtual acute ward, already approved by executives;
- 24 extra beds released through rationalisation of the community hub funding (above); i.e. the extra beds released due to lowering of the unit cost within the same cost envelope
- 15 beds released through adherence to the 35/20 Complex Discharge KPI; that is to say that the trust will achieve 35 discharges on a weekday, and 20 on a weekend day.

The latter two objectives will be achieved via:

- Working collaboratively with System Partners and ward teams to ensure minimum complex discharge delays.
- Robust RAG calls with respective local authorities, to achieve discharge from the acute bed base within 24 hours once known to system partners for patients identified on pathways
- Should patients be waiting 72 hours or more, this will trigger executive to executive escalation.
- Full utilisation of How to Find a Care Home capacity, 40 per month.
- Ensure 100% of Transfer of Care (TOC) completed within 24 hours of referral.
- Reduce the number of incomplete (failed) discharges to less than 5% per day.

This will be enabled by enhancing capacity within the Complex Discharge Team over winter to aim for 1 Discharge Facilitator per ward and increasing workforce at the weekend. System Partners, namely Sandwell, are seeking to co-locate social workers to be based alongside the discharge team at Russells Hall Hospital. The team continue working closely with Dudley Partners to embed principles of an Integrated Transfer Hub as outlined in the Dudley One Plan.

Crucially, the aim is to work with ward based teams, therapy and utilisation of community pathways to bring forward planning for discharges from admission.

- **Community with Core Clinical (CCCS) Division – In Hospital Schemes. To commence mid-November.**

To support flow and reduction in length of stay within the Trust the CCCS Division will be stepping up the following schemes from mid-November.

- Bringing forward ten inpatients for CT scan per evening (17.00-20.00) to support the following days ward and board round decisions

- Increasing the number of discharge facilitators in the Complex Discharge Team to aim for one Discharge Facilitator per ward each weekday and increasing workforce at the weekend, to further strengthen ward based MDT working and aiding planning admission on discharge.

- **Expansion of services in Community in line with the 'Community first, Hospital when necessary' ethos. (15 Beds) – Community Hub (HUB) will be extending operational hours to 00.00 from w/c 4th November. This scheme supports both MMUH mitigations as well as Winter.**

- Optimising Collaboration with Care Homes. The Health and Care Partnership Team with Place Division have undertaken a Deep Dive into Non-Elective Over 65 Admissions. Given the breadth of this topic, the review focused on Care Home Admissions. The engagement work with care homes, along with the expansion of the HUB hours, is seeking to avoid approximately 2000 care home attendances to ED per year.

- Primarily the initiation of a weekly Care Home Community Partnership Team (CPT), will co-ordinate all services providing a response to Care Homes and review all conveyances to understand is this a training, skill deficit, access issue and will look to take appropriate remedial action to minimise future avoidable conveyances. This CPT will commence in November.

- Virtual Ward – The IV therapy/OPAT service sits as part of the Heart Failure VW pathway and has been supporting patients in community/clinic at Brierley Hill. Recently, the service was also involved in the provision of the AMU VW to facilitate continuation of IV treatment at home and thus reduce the length of stay on AMU, whilst supporting the patients to recover in their own homes.

- Introducing Paramedic presence within the HUB to embed call before you convey with WMAS between 16.00-000 each day, including weekends.

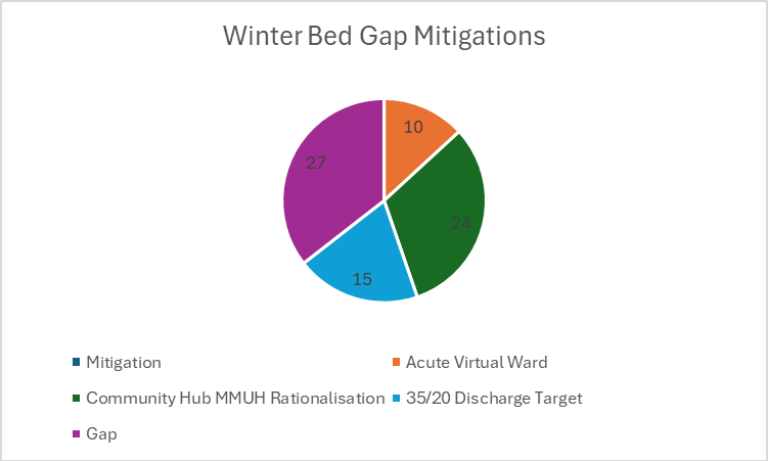
- **Optimisation of Voluntary Sector**

Dudley Health and Care Partnership Board, with Place Division, are working on the delivery of an NHS and Care Volunteers service to support patients in Dudley to commence in November. This service will deliver;

- Driver Support (Pick up and Deliver): Delivery of medication and equipment between NHS sites and to and from patients' homes including the return of devices of medical aids.
- Telephone Support: Calls to people in need of a friendly voice and a listening ear.
- Community Response: Assistance with essential shopping and prescription delivery.
- Community Response – Connect: Supporting individuals in enjoying social activities within the community.

The service works via an APP that will be centralised with the hospital site office; in the same way transport is co-ordinated.

Figure 22: Winter-Specific Mitigations and Gap

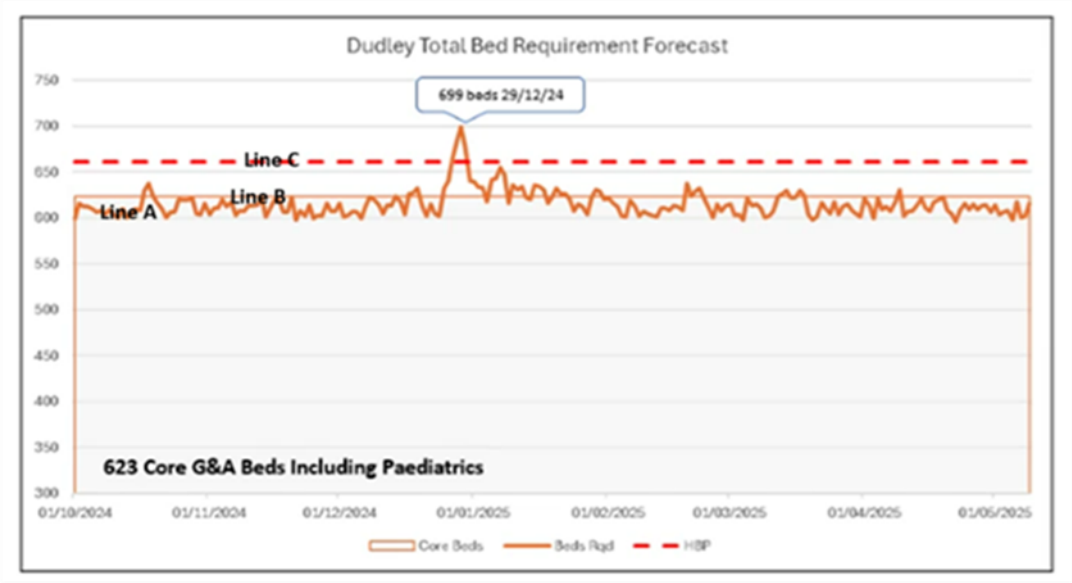


A gap of 27 beds exists as part of the winter plan (Non-MMUH-related)

The Trust has worked hard to mitigate the vast majority of beds required for winter. This has been made particularly difficult because the medicine division cannot provide any more physical or virtual space in the trust – surge is currently open, and virtual ward based mitigations planned maximise current opportunity.

8. Cumulative position versus Winter and MMUH

Figure 23: Activity Forecast DGFT Winter 2024/5



The Trust is thus short 15 beds in regards of MMUH, and 27 beds short in respect of winter – with both figures relative to peak occupancy. As per figure 1, there is a 5 bed multiplier effect, meaning the total gap to peak at full mitigation rollout is (15+27+5) 47 beds.

The gap to ICB assurance (32 beds lower) is thus 15 beds.

12. Cost and Workforce

Cost for Winter and MMUH Mitigations

The combined cost for both will be £2,637k, with a notional split of £1,581k for MMUH and £1,057k for winter.

The trust will primarily use bank where possible – where this is not possible, the trust will recruit on fixed term contracts. In the latter case, there are clear risks to delivery.

Beneath the costs, there is a second table which captures what benefits would accrue to the trust the MOFD exercise, that has commenced managed to reduce the number of patients by 50 (actually chosen 52 to enable the trust to close surge, change Discharge Lounge back to original purpose, reduce Acute Medicine Bed base back to 60 beds from current 82 to fit back into Rainbow Unit. It is likely that this would impact in January-Mar 25.

Figure 24: Summary of costs

Scheme	current beds	extra beds	annual per bed	start	Oct	Nov	Dec	Jan	Feb	Mar	Total
			£000		£000	£000	£000	£000	£000	£000	£000
A:Already doing:-											
Discharge Lounge	16		£75								
Surge / Supersurge	14		£97								
B:Proposed to do											
Acute Medicine Virtual Ward		20	£65	15/10/2014	£36	£130	£92	£81	£88	£109	£536
Stroke Rehab Ward		11	£352	01/12/2024				£322	£322	£322	£967
Frailty Virtual Ward		18	£55	15/11/2024		£41	£83	£83	£83	£83	£373
CCCS schemes											
Out of Hospital				01/11/2024		£40	£110	£110	£110	£110	£482
In Hospital				01/11/2024		£52	£55	£61	£55	£55	£280
Total		**49**			**£36**	**£264**	**£341**	**£658**	**£659**	**£680**	£2,637
IF MOFD initiative works then more patients would be discharged and additional capacity would be closed potential savings could be											
Surge / Supersurge		-14	£75					-£118	-£118	-£118	-£354
Discharge Lounge		-16	£97						-£61	-£61	-£122
Acute Medicine Ward		-22								-£258	-£258
Sub total					**£0**	**£0**	**£0**	**-£118**	**-£179**	**-£437**	**-£734**
Total cost after savings		**-52**			**£36**	**£264**	**£341**	**£540**	**£480**	**£243**	**£1,903**

Workforce

Summary of WTEs (In Post at point in time)

Proposed to do		**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**
Medicine Schemes							
Acute Medicine Virtual Ward		**3.03**	**11.15**	**11.79**	**11.79**	**11.79**	**15.7**
Stroke Rehab Ward		**0**	**0**	**0**	**35.87**	**35.87**	**35.87**
Frailty Virtual Ward		**0**	**8.74**	**17.48**	**17.48**	**17.48**	**17.48**
CCCS schemes		**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**
Out of Hospital		**0**	**5.81**	**24.3**	**24.27**	**24.27**	**24.27**
In Hospital		**0**	**4.68**	**11.1**	**11.06**	**11.06**	**11.06**

Risks to Launch

The Acute Medicine Virtual ward has no risks to recruitment, and is currently up and running, and will soon stretch to 20 beds.

The Frailty Virtual Ward has significant impediments to launch – 3 band 7s have recently become unavailable through a mixture of sickness, maternity and bereavement. This leaves the speciality unable to cover the virtual ward with bank, as planned. As a result, the directorate conducted an exercise whereby local fixed term capacity was scoped; none was forthcoming. The directorate did, however, generate a significant amount of interest in substantive posts, and will be submitting to exec VAR shortly.

The stroke rehabilitation ward is currently under negotiation, with a start date anticipated in January.

CCCS in and out of hospital schemes have suffered no significant risks to delivery, and are on schedule.

10. Conclusion

The above document sets out the winter plan for DGFT, and includes the mitigation to support the impact of MMUH Crucial to the correct and optimal implementation of this plan is

a) The acknowledgement and action upon the insufficient modelled volumes regarding the midland MET, to deliver circa 50 beds worth of avoidance;

b) The remedial work around discharge pathways within the Trust, to deliver circa 50 beds worth of complex MOFD avoidance.

c) The front door work to reduce admissions into the bed base

The combined cost for both will be £2,960k, with a notional split of £1,581k for MMUH and £1,057k for winter.

The impact of the mitigation is at **Figur**e 1 (repeated below)

Element of winter plan	Variance to peak	Variance to ICB winter assurance level
MMUH	-15	
Winter	-27	
ICB Multiplier	-5	
Total	-47	-15

Without the delivery of these, the planned MMUH and winter mitigations will not be as effective, and existing services such as SDEC will also provide the trust with no relief, as they are continually bedded to provide relief to the front door.

The Trust has been running critical incidents in order to clear these MOFD, and more structural, focussed work as described in the paper, is being conducted by, DIP, Site Team, and others, supported by the hard work of the medicine, surgery and CCCS divisions.

The Trust is in a challenged position to the lack of ability to expand physically into extra available space (as there is none), and so all solutions have had to be creative, whilst being most cost effective. Patients have far superior outcomes in the community and their own homes, and so to provide capacity expansion in the

form of virtual wards and community hub calls is the right thing to do not just for the trust, but for our patients. DGFT can be proud that we now have the biggest virtual ward in the Black Country; and our excellent occupancy (we recently, week commencing 13/10, hit 100% occupancy for the first time) rivals that of Sandwell and Wolverhampton, whom are a national exemplar in their use of virtual wards.

Once the Trust have successfully cleared residual MOFD we have a set of flexible mitigations which will keep our patients where they are safe and can experience optimal outcomes, in their own homes.

The board is asked to approve this plan.

Section C: Appendices

Appendix 1: Local Context and Performance

The winter of 2024/25 brings with it some very real potential challenges for the system, with the opening of the Midland Metropolitan University Hospital and the associated plans for moving two acute sites into a single new building. Whilst extensive planning has taken place, and the potential shift of patient numbers into Walsall and Dudley has been mitigated as far as reasonably practical, the System will need to work collaboratively to ensure trends are identified early to maintain flow across the System.

Secondly, the much-needed upgrade to the resuscitation facilities at Russells Hall Hospital will see extensive building works occur with the loss of six ED cubicles during the 12-18 months of work.

The opening of the Midland Metropolitan University Hospital and the movement of patients across from City and Sandwell begins with the transfer of Sandwell commencing on Sunday 6th October 2024, with City following on the 10th November 2024. Much analysis has been undertaken utilising both data and local engagement with patients in City and Sandwell EDs. This information has been used to inform planning and align our operational mitigations to immediate risks, ensuring patient flows are sustainably managed both through winter and beyond. The uncertainty and potential impact of industrial and collective action going forward is also not yet known at the time of writing and this plan will need to be flexible and adaptive as the situation develops. IMTs are already standing weekly for known action that is ongoing.

Historic UEC Performance

The winter of 2023/24 was an exceedingly difficult period for all our patients using NHS services and for those colleagues delivering care, the pressures experienced were very real and sustained. Our Emergency Departments apart from City Hospital all saw an increase in attendances compared to 2023/24 with 183,965 people arriving between December and March compared to 181,439 in 2023/24. The magnitude of increased attendances at Walsall Manor Hospital was particularly striking, and is part of a sustained pattern of increased attendances.

Figure 25: Total ED Attendances 22/3 and 23/4 Black Country ICB

ED Attends	Dec 22 - Mar 23	Dec 23 - March 24	% Variance
CITY HOSPITAL	37948	30395	-20%
SANDWELL GENERAL HOSPITAL	26194	27790	6%
MANOR HOSPITAL	31100	35630	15%
NEW CROSS HOSPITAL	50289	52475	4%
RUSSELLS HALL HOSPITAL	35908	37564	5%
ICS	181439	183854	1%

Figure 26: Ambulance Conveyances 22/3 and 23/4 Black Country ICB

Ambulance Conveys	Dec 22 - Mar 23	Dec 23 - March 24	% Variance
CITY HOSPITAL	7835	7530	-4%
SANDWELL GENERAL HOSPITAL	8211	7777	-5%
MANOR HOSPITAL	10689	12295	15%
NEW CROSS HOSPITAL	12528	13967	11%
RUSSELLS HALL HOSPITAL	11947	11921	0%
ICS	51210	53490	4%

Figure 27: ED attendances, split into Ambulance & Non-ambulance 2018-24

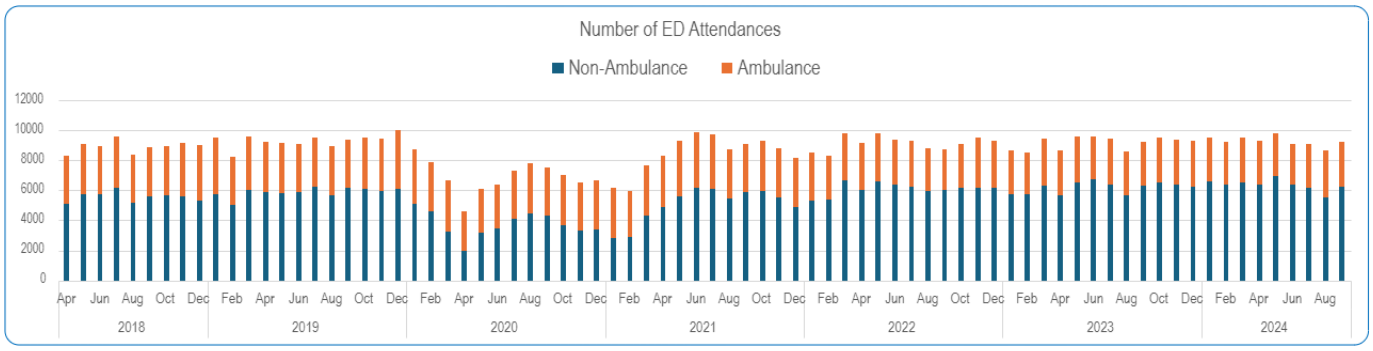
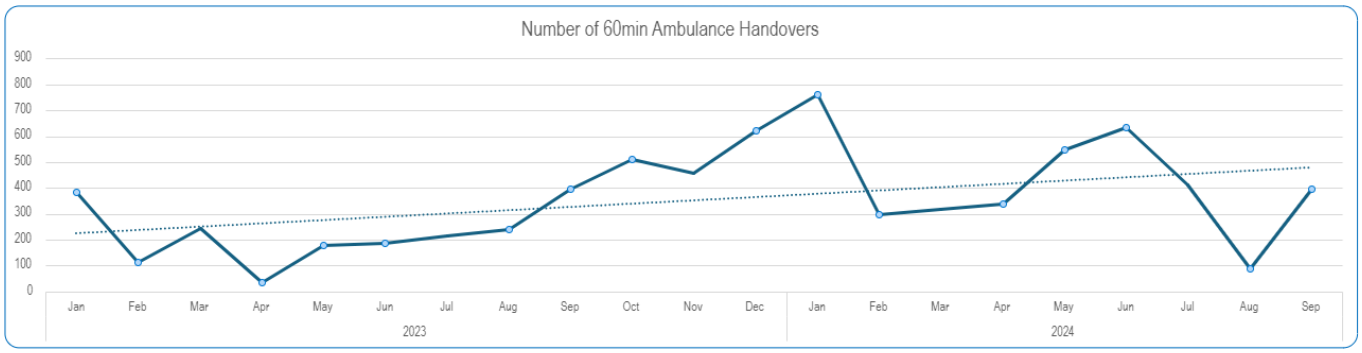
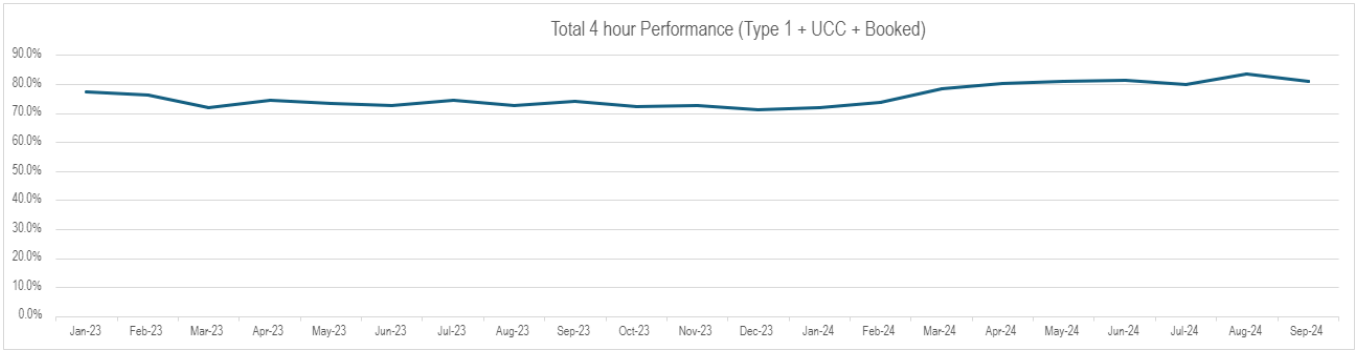


Figure 28: Number of ambulances over 60 mins 2023-4



Against a backdrop of this rise in activity, it is heartening to note that DGFT has significantly improved its 4-hour performance.

Figure 29: DGFT 4-hour performance - ED



The Trust is now ranked 11th in England, with the top 8 all being specialist trusts; further, the Trust is the top-ranked non-specialist trust in the West Midlands as of September 2024.

Figure 30: West Midlands 4-hour ED Performance Rankings

Name	Value	National Rank
Birmingham Women's And Children's NHS Foundation Trust	84.20%	5
The Dudley Group NHS Foundation Trust	81.18%	11
The Royal Wolverhampton NHS Trust	79.93%	12
Walsall Healthcare NHS Trust	76.21%	28
South Warwickshire NHS Foundation Trust	75.32%	33
George Eliot Hospital NHS Trust	74.63%	39
Sandwell And West Birmingham Hospitals NHS Trust	69.71%	72
University Hospitals Of North Midlands NHS Trust	69.24%	73
Worcestershire Acute Hospitals NHS Trust	68.45%	82
University Hospitals Coventry And Warwickshire NHS Trust	66.49%	89
Wye Valley NHS Trust	65.76%	94
University Hospitals Birmingham NHS Foundation Trust	62.85%	109
The Shrewsbury And Telford Hospital NHS Trust	52.16%	122

Appendix 2: **NHSE National Priorities and Trust Response**

NHS England have defined the below ten interventions as crucial. The below details some of the interventions which the Trust has planned which are relate to these.

Priority 1: Same Day Emergency Care: Reducing variation in SDEC provision by providing guidance about operating a variety of SDEC services for at least 12 hours per day, 7 days per week (NB – plans currently being costed to support 24/7 SDEC opening)

In line with the winter and MMUH plans, the trust will also ensure SDEC compliance by opening 12 hours a day, 7 days a week, and a front door Acute Frailty service 10 hours a day, again 7 days a week.

Priority 2 (Frailty): Reducing variation in acute frailty service provision. Improving recognition of cases that could benefit from specific frailty services and ensuring referrals to avoid admission.

An acute frailty hub is a specialized healthcare service or unit designed to provide comprehensive assessment, management, and support for older adults who are experiencing frailty.

The primary goals of an acute frailty hub include:

- Early Identification: Recognizing frailty in older patients upon admission to the hospital to ensure timely intervention.
- Multidisciplinary Approach: Involving a team of healthcare professionals, including geriatricians, nurses, physiotherapists, occupational therapists, and social workers, to address the complex needs of frail patients.
- Comprehensive Assessment: Conducting thorough evaluations of the patient's physical, cognitive, and social health to develop individualized care plans.
- Optimized Care Pathways: Streamlining processes to ensure that frail patients receive appropriate treatments and interventions, minimizing unnecessary tests and procedures.
- Discharge Planning: Facilitating safe and effective transitions from hospital to home or other care settings, including arranging for follow-up care and support services.
- Education and Training: Providing education for healthcare staff on the specific needs of frail older adults to improve overall care quality.

By focusing on these areas, acute frailty hubs aim to improve outcomes for older patients, reduce hospital stays, prevent readmissions, and enhance the overall quality of care for this vulnerable population. The Trust are introducing a front door Acute Frailty service 10 hours a day, 7 days a week.

Priority 3: Inpatient flow and length of stay (acute): Reducing variation in inpatient care and length of stay for key iUEC pathways/conditions/cohorts by implementing in-hospital efficiencies and bringing forward discharge processes for pathway 0 patients.

DGFT will continue work on standardizing care protocols and pathways for specific conditions ensures that all patients receive consistent treatment, minimizing unnecessary variations. The trust will major on enhanced communication among multidisciplinary teams leads to more coordinated care, promoting faster decision-making and timely interventions.

Additionally, the trust will explore employing data analytics and a trust bed management system helps identify bottlenecks in patient flow and supports real-time monitoring of patient progress, facilitating proactive adjustments to care plans.

Further, the trust will continue, utilize evidence-based guidelines and clinical pathways ensures that treatments are aligned with best practices, ultimately enhancing patient outcomes. Regular training and education for staff can further ensure adherence to these standards.

Priority 4: RHH bed base bed productivity and flow: Reducing variation in inpatient care and length of stay by implementing in-hospital efficiencies and bringing forward discharge processes.

The Trust are embarking upon a strategy with the aim of clearing a maximum of 50 beds of MOFD patients from the trust within a 6 week period. Crucial interventions related to this include

- Pathway Mapping of P1, P2, P3 patients
- Redesignation and redesign of MDT discharge lounge
- Operationalising the excellent peer review which our colleagues at Walsall did on our discharge processes
- Robust Winter demand and capacity modelling

The trust also have MDT huddles throughout the day to ensure the maximisation of flow, capacity, discharges

Priority 5: Care Transfer Hubs: Implementing a standard operating procedure and minimum standards for care transfer hubs to reduce variation and maximise access to community rehabilitation and prevent re-admission to a hospital bed.

A care transfer hub, also known as a discharge or transition hub, is a specialized service or unit within a healthcare system that focuses on facilitating smooth and effective transitions of care for patients between different healthcare settings or providers.

The Trust has rewritten its discharge policy, and authored a system development plan, which is overseen by our local urgent care operation group. The aim of this is to ensure seamless handoffs of patient care between hospitals, rehabilitation facilities, long-term care homes, and community-based services.

Priority 6: Intermediate care demand and capacity: Supporting the operationalisation of ongoing demand and capacity planning, including through improved use of data to improve access to and quality of intermediate care including community rehab.

Demand and capacity planning is a critical process used in various industries, particularly in manufacturing, healthcare, and service sectors, to ensure that an organization can meet customer demand efficiently while optimizing resource utilization

As per above, a Trust priority is working with our ICB partners to robustly map demand and capacity. The integration of DIHC gives an opportunity to use P1-3 budgets better through the implementation of Personal Health Budgets in health and social care; Personal Health Budgets will be a key facet of our new MDT discharge lounge.

Priority 7: Virtual wards: Standardising and improving care across all virtual ward services to improve the level of care to prevent admission to hospital and improve discharge.

The Trust is implementing 40 new Virtual Ward Beds for winter, by expanding capacity in the frailty virtual ward for winter and MMUH: 20 in acute medicine and 20 in frailty. This almost doubles the existing bed base, from 56 to 90. DGFT have some of the best bed occupancy in virtual wards in the Midlands, hitting a recent average of 96%.

Priority 8: Urgent Community Response: Increasing volume and consistency of referrals to improve patient care and ease pressure on ambulance services and avoid unnecessary admission.

The pivotal mitigation in respect of both Winter and MMUH is a markedly increased number of calls into the community hub. Not only are the Trust working with West Midlands Ambulance Service (WMAS) in order to maximise 'Call before you convey', the hub is maximising calls from care homes, which national studies, including one from Enfield, show can prevent admission from 80-90% of calls.

Having experienced a sub-optimal period of effectiveness as regards this initiative, the trust are now working differently with WMAS, using collaborative data sharing to help both parties understand trends and optimize resource allocation, ultimately improving patient outcomes and reducing unnecessary hospital admissions. Regular feedback loops will refine the process over time.

Priority 9: Single point of access: Driving standardisation of urgent integrated care coordination which will facilitate whole system management of patients into the right care setting, with the right clinician or team, at the right time.

The community hub, as above, is the DGFT single point of access, and the expansion of this service in line with MMUH and winter plans should see an increase in capacity and functionality to bring the Trust level with Sandwell, whom are the gold-standard exemplar within the region.

Priority 10: Acute Respiratory Infection Hubs: Support consistent roll out of services, prioritising acute respiratory infection, to provide same day urgent assessment with the benefit of releasing capacity in ED and general practice to support system pressures.

Respiratory hubs offer patients who have an acute respiratory infection / chronic condition (such as Asthma or COPD) an appointment with a GP or ACP to assess their condition and treat as required. These are in development by DGFT and will be in place for winter.

Quality KPIs
October 2024 Report (September 2024 Data)

Martina Morris Chief Nurse
Dr Julian Hobbs Medical Director

NHS
The Dudley Group
NHS Foundation Trust

CARE
RESPECT
RESPONSIBILITY

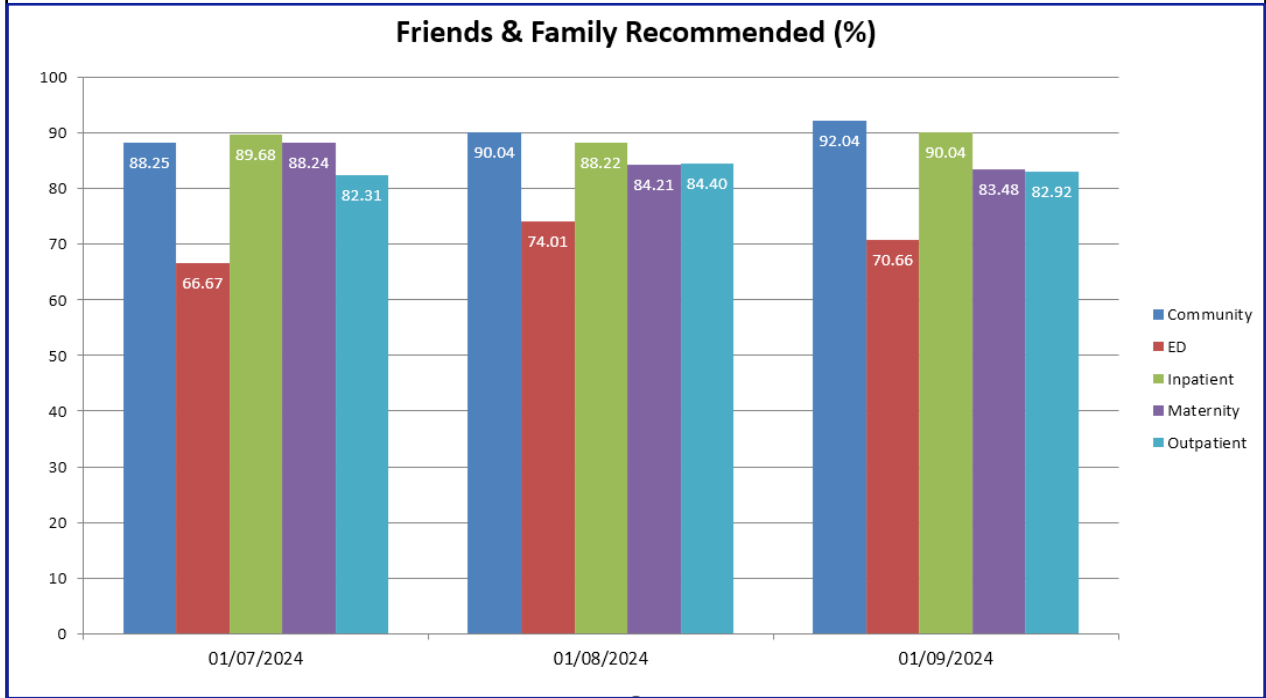
Contents / Icon Key

Contents

Friends and Family - Recommended

Background	FFT is an important feedback tool that provides patients and relatives an opportunity to share their experience of the care and treatment received. Listening to the views of patients helps identify what is working well, what can be improved and how.

Performance	
Date	September 2024
Trust Performance	See Graph
Performance Target / KPI	Above national average/% positive scores are increasing



What are the charts showing us

A total of 4963 responses were received in September 2024 in comparison to 4605 in August 2024. Overall, 84% of respondents have rated their experience of Trust services as 'very good/good' in September 2024, no change since August 2024. A total of 5% of patients rated their experience of Trust services as 'very poor/poor' in September 2024, no change from the previous month.

The A&E Department received the highest percentage negative score with 12% of patients rating their overall experience as very poor/poor in September 2024, no change since August 2024. Community received the highest positive score at 92%, an improvement of 2% since August 2024. Percentage very good/good scores have seen an improvement for the Inpatient Department from 88% in August 2024 to 90% in September 2024.

Areas Impacting on Compliance

FFT percentage very good/good scores remain below the national average for all divisions.

Mitigations / Timescales / Blockers

FFT percentage very good/good scores are monitored through the divisional updates at the Patient Experience Group for assurance and to highlight action taken to improve scores at ward/department level.

Risk Register

No

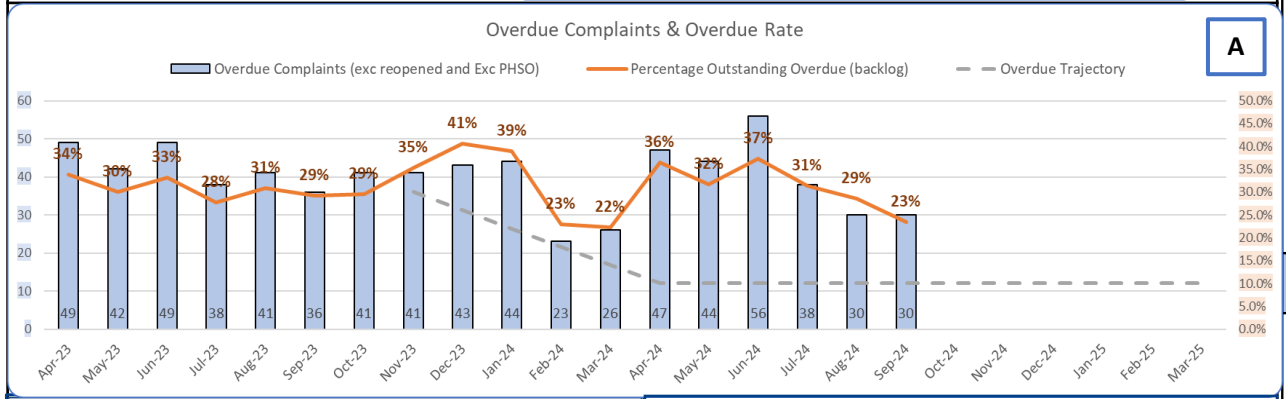
Key Points to Note

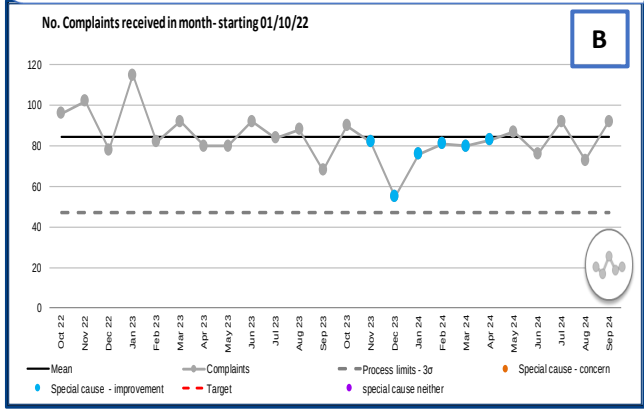
Increase in positive % very good/good scores for the Inpatient Department.

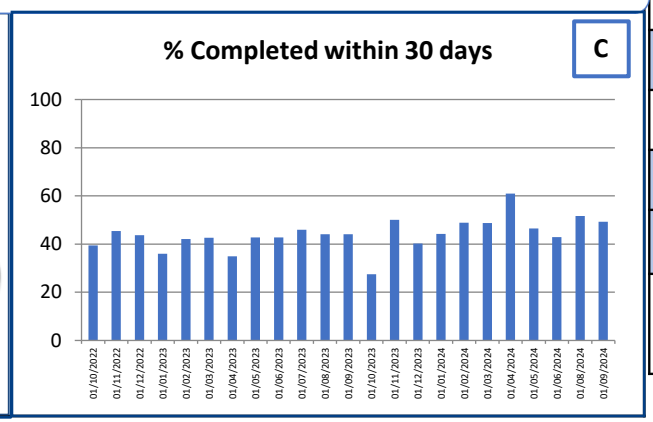
Complaints

Background	*Monitoring compliance against complaint responses*

Performance	
Date	September 2024
Trust Performance	A) 30 & 23% B) 92 C) 49.3%
Performance Target / KPI	49.3% against KPI of 90% response rate







What are the charts showing us

The Trust received 92 new formal complaints in September compared to 73 in August 2024. Of the 92 complaints received, all were acknowledged within 3 working days. The main theme for complaints for September 2024 was patient care. The Trust continues not to reach the KPI target of 90% being responded to within 30 days.

In September 2024, the Trust closed 75 complaints compared to 104 in August 2024. Of those 75 closed, 37 (49.3%) were closed within 30 working days. Not including re-opened complaints and Ombudsman cases, there were 67 complaints closed (first response) and of those 67 complaints, 33 were within 30 working days (49.3%), which is a decrease of 2.3% on last month's response rate of 51.6% (first response complaints). If reopened, Ombudsman cases and those requiring local resolution meetings (LRMs) (including those LRMs as first response), the Trust closed 62 complaints, 32 complaints were within 30 working days with a response rate of 51.6%.

The backlog of complaints (excluding reopened complaints and excluding Ombudsman cases) was 23.4% for September 2024 compared to 28.6% for August 2024 showing an improvement on the month before.
As of 30 September 2024, there were 157 complaints open (in total including reopened complaints and Ombudsman cases). There are 128 complaints open (excluding reopened complaints and excluding Ombudsman cases) with 30 of those in backlog. Of those 128 complaints; 12 are local resolution meetings, 29 are with complaints (including those in the final stages of review), 87 are with divisions (including those for response, queries and approval) and one is with an external organisation (joint response complaint).

Areas Impacting on Compliance

The response rate of 90% remains a challenge, along with the backlog. The complaints team continue to monitor and escalate to senior management when complaints have been open longer than 20 working days without a response from division(s).

Mitigations / Timescales / Blockers

The team have an escalation process in place bringing overdue complaints to the attention of the associated director.

Risk Register- no longer on the risk register

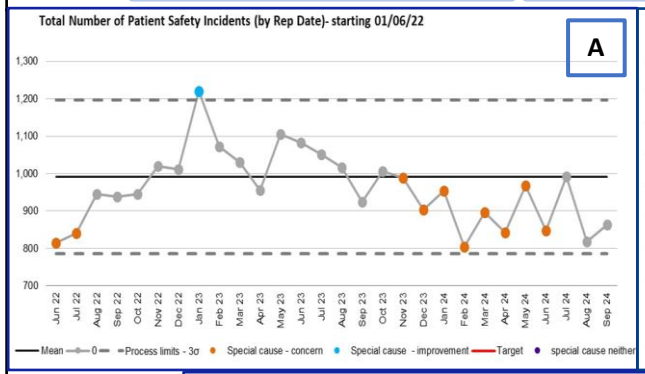
Key Points to Note

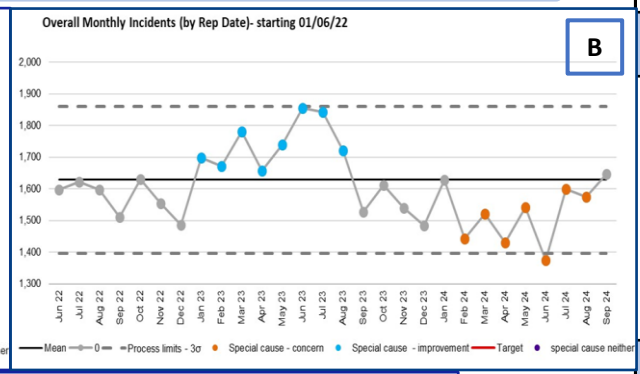
Early resolution is working well with 34 out of 60 responded to within 30 working days and 22 complaints within time and still under investigation. The backlog figure has reduced.

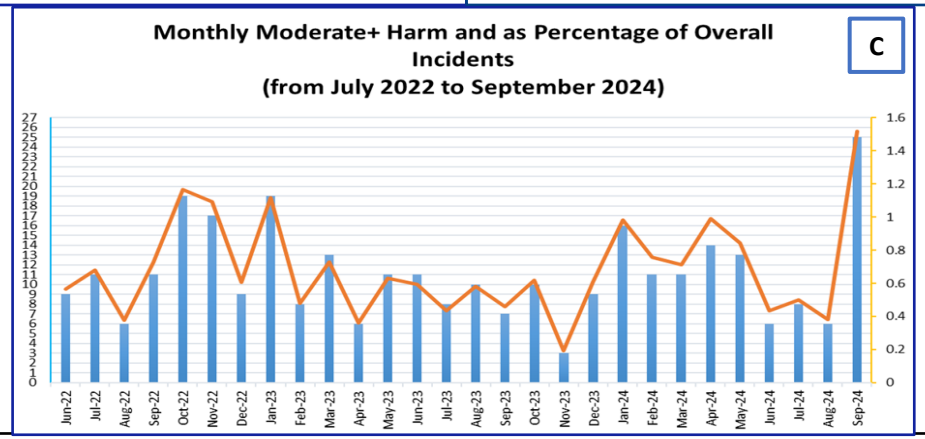
Incidents

Background	Incident reporting and patient harm monitoring is an essential approach for monitoring safety and the learning culture of an organisation

Performance	
Date	September 2024
Trust Performance	A) 863 B) 1665 C)
Performance Target / KPI	N/A







What are the charts showing us

The overall number of incidents reported in September has increased; continuing the upward trend. The number of patient safety incidents reported in September has also increased slightly; it is acknowledged that this may be monthly natural variation, but a plateauing of the previously noted downward trend may be emerging.
The number of incidents reported to result in significant harm (moderate/severe/death) has remained low and consistent with previous reporting periods (natural variation applicable across the period). NB harm levels in the reporting month are still under review and are likely to reduce following incident review and investigation. Historical monthly data sets will be refreshed upon collation of each report.
There were no new Never Events reported in September.

Areas Impacting on Compliance

The overall upward trend in reporting is a positive occurrence following a period of declining numbers after the implementation of LfPSE. The number of patient safety incidents remains lower than pre LfPSE transition. The downward trend in reporting is likely to be multi-factorial with the main negative factor being the transition to LfPSE mandating additional information fields mandated on incident form which hinders ease of reporting, The Patient Safety Team are working hard to promote reporting through communication plans and training schedules; this increase in reporting is likely to represent the early impact of this work. It is important to note that this downward trend is apparent across the system and wider NHS and is not unique to Dudley Group.
The proportion of incidents resulting in significant harm remains low and the overall number of incidents resulting in significant harm has remained consistent across the period (with natural variation)

Mitigations / Timescales / Blockers

The Patient Safety Team in conjunction with the Patient Safety Specialist are working through a plan to promote reporting and understand the barriers to reporting. Training packages on incident reporting including the new elements required for LfPSE continue to be rolled out to help drive reporting.
Incidents resulting in significant harm are subject to a prompt and robust initial MDT review to determine immediate learning and the level of response required.

Risk Register

N/A

Key Points to Note

N/A

Incidents

Background	Incident reporting and patient harm monitoring is an essential approach for monitoring safety and the learning culture of an organisation

Performance	
Date	September 2024
Trust Performance	A) 0 B) 0
Performance Target / KPI	N/A

A

B

What are the charts showing us

Chart A illustrates the monthly number of full investigations (PSII) commissioned under the Patient Safety Incident Response Framework (PSIRF). There were 0 full investigations launched in September. The overall numbers of PSII across the period remain within the planned resource. All duty of candour requirements have been met in terms of notification and engagement.
Chart B illustrates the monthly number of Swarm responses launched; Swarm responses are designed to be initiated as soon as possible after an incident and involves an MDT discussion to gather information about what happened and why it happened and what needs to be done to reduce the risk of reoccurrence. There were no new Swarm reviews in September.

It is important to note that 3 of the 4 Incident Decision and Learning Group meetings were stood down in September, due to either a lack of cases ready for review or capacity pressures impacting on staff availability. It is during this meeting that the responses are commissioned.

Areas Impacting on Compliance

Please above, which has contributed to the reduced numbers
There are no significant themes with respect the incidents under review; close monitoring continues.
SHOT incidents resulting in moderate/severe harm or death will be subject to a full PSII – process confirmed by ICB.

Mitigations / Timescales / Blockers

Decisions regarding the requirement for PSII, swarm or other reviews under the PSIRF are made collectively as part of the Incident Decision and Learning Group. Scheduled reviews of the meeting's activity and culture are underway to enable insights into the effectiveness of working in this new framework.

Risk Register

nil

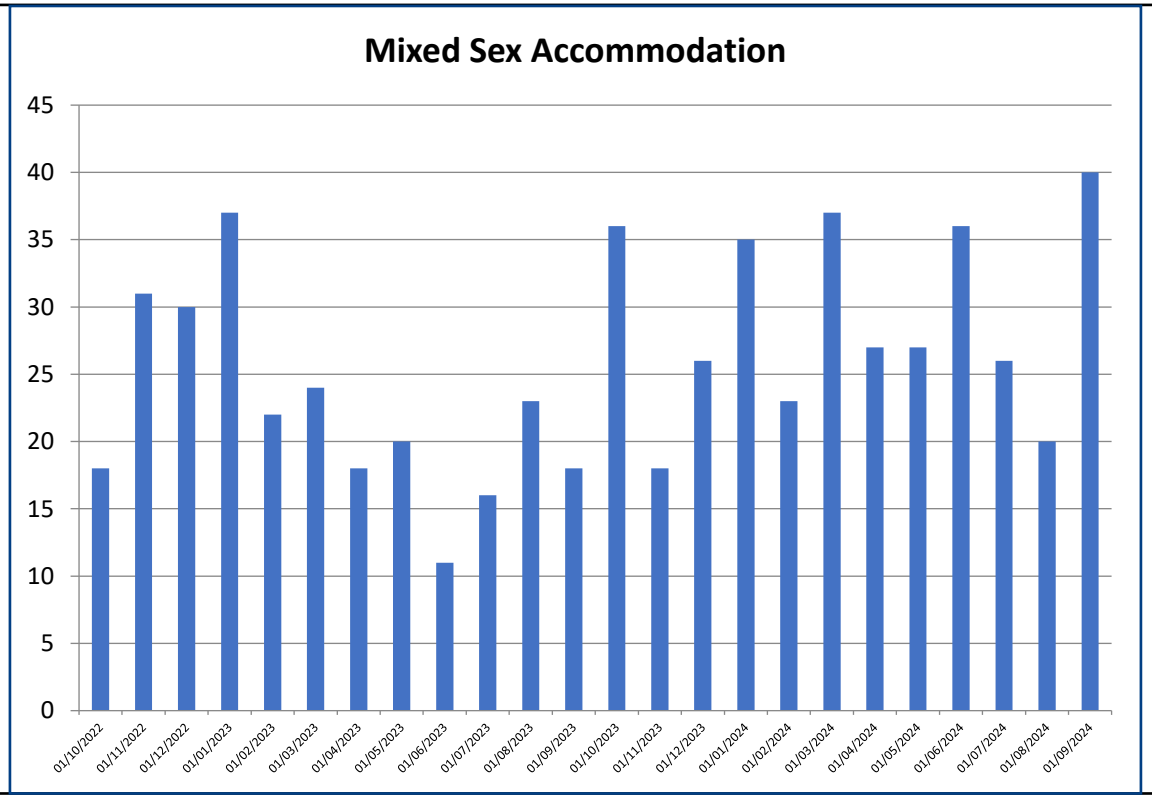
Key Points to Note

nil

Mixed Sex Accommodation

Background	KPI monitors all unjustified occurrences of patients receiving care that are in breach of the sleeping accommodation guidelines to enable enhanced patient choice and to drive improvement.

Performance	
Date	September 2024
Trust Performance	40
Performance Target / KPI	0



What are the charts showing us

There were 40 mixed sex accommodation breaches in September 2024, which continues to be a significant amount and the highest to date.

Areas Impacting on Compliance

Step downs from level 2/3 areas can be challenging against our ability to manage demand through our ED. This month continues to see a high demand at the front door requiring a balanced approach.

Mitigations / Timescales / Blockers

The Trust and site team are sighted on that require stepping down from critical care areas and the impact this may have on our patients staying in this environment for longer periods.

Risk Register

Delayed discharges from critical care which could impact upon timely admission to critical care is on the corporate risk register. Currently under review to consider psychological impact for patients.

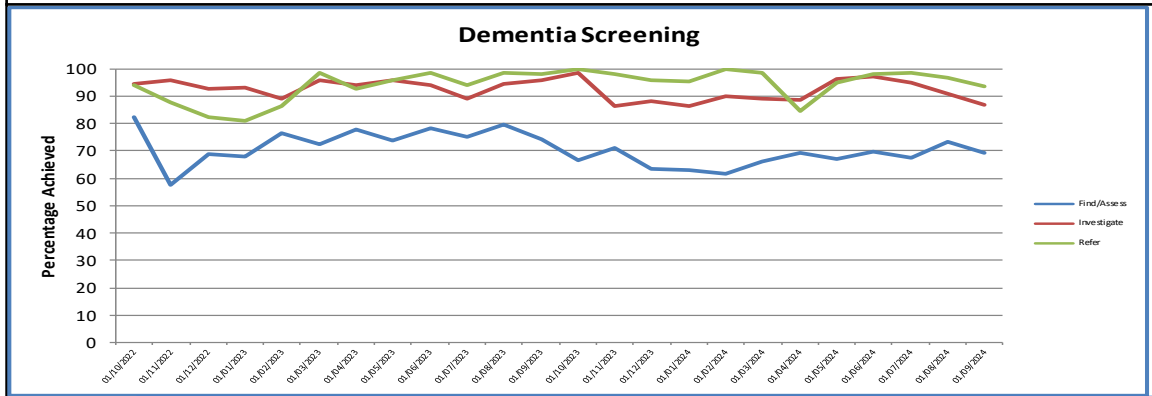
Key Points to Note

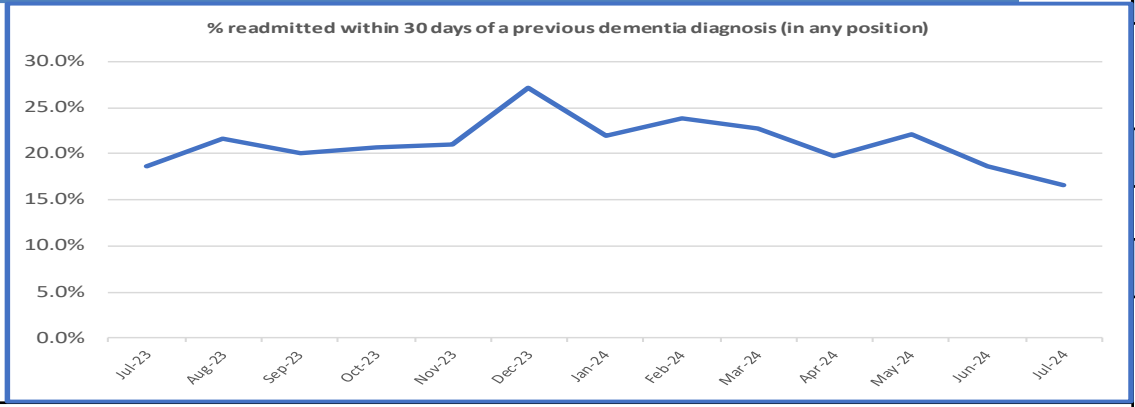
Highest number of delays reported in September 2024.
This is impacted by the high number of wardable patients on the unit making even cohorting in bays challenging.

Dementia

Background	*Patients aged 75 and over who have been identified as potentially having dementia and are appropriately assessed and referred on to specialist services. The number of patients readmitted within 30 Days with a diagnosis of Dementia.*

Performance	
Date	September 2024
Trust Performance	Find) 69.22% / Investigate) 86.96% / Refer) 93.75%
Performance Target / KPI	90%





What are the charts showing us

The first chart provides data regarding the number of patients who have been screened for dementia by the ward staff using the AMT 4 and the subsequent investigation and referral by the dementia and delirium team using the FAIR process. The number of completed screenings is at 69.22% which is below the target of 90%. It is a small decrease from the previous month with a general upwards trend from February 2024. The Investigate and Refer element completed by the dementia and delirium team are both above the 90% target. The second chart shows the number of patients with dementia who were readmitted within 30 days of discharge. The latest available data is for July 2024 where there is a decrease in readmissions from the previous month.

Areas Impacting on Compliance

A review of the FAIR data has commenced. Despite the review and assurance that data is now recorded correctly, the Trust is still below the compliance rate. Despite the Dementia and Delirium Team working at reduced capacity, they are responding to over 90% of referrals. Increased focus needs to take place on each ward to improve compliance.
The most recent data for readmissions of patients with a diagnosis of dementia is showing a decrease with a generalised downward trend from December 2023. A review of the reasons for readmission has been investigated. From this, there are common themes for readmission and are following national trends, including a reduction over the summer months and an increase over the winter period.

Mitigations / Timescales / Blockers

An Admiral Nurse post has been recruited and started with the Team 2.9.24.
A Band 4 post at 33 hours has been readvertised for the Dementia and Delirium Team with interviewed planned for 21.10.24.

Risk Register

Key Points to Note

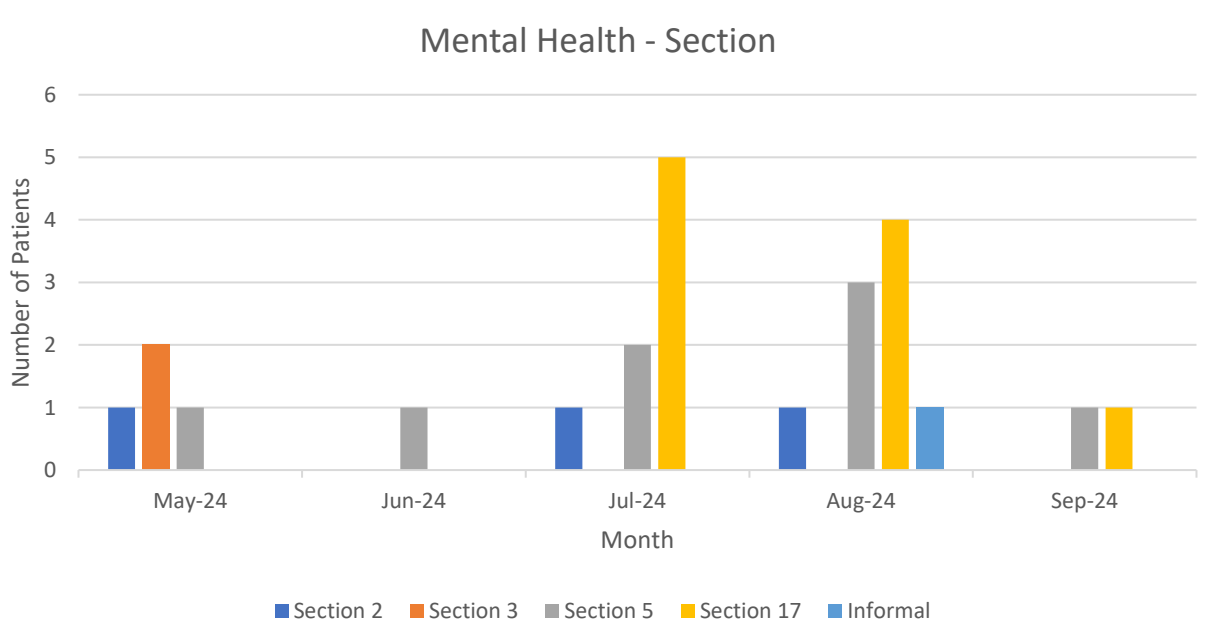
Despite a data cleanse, screening of patients remains low. The AMT4 is pending replacement with the 6CIT which is a more accurate screen. A request has been made to the Sunrise team for this change to be implemented.

Mental Health

Background

Performance	
Date	September 2024
Trust Performance	
Performance Target / KPI	CQC and MHA compliance.

Date of Admission	Section (Locate details C/O Rio if not on Sunrise and upload docs to Sunrise)
Sep-24	Section 5(2)
Sep-24	17 from external Trust



What are the charts showing us

There was 1 patient detained under section 5(2) to DGFT.
1 patient was admitted to DGFT on section 17 leave from a mental health unit.
No patients have been detained to DGFT under section 2 or 3.

Areas Impacting on Compliance

There has been a reduction in mental health activity during September when compared to August 2024. This may be due to reduced activity. Another factor may be patients being admitted to DGFT who are on section 17 leave, but DGFT is not aware in order to report this. Under reporting may be a factor.

Mitigations / Timescales / Blockers

A Mental Health Administrator service has been introduced to DGFT as of 8.7.24 to provide scrutiny of all detentions and section 17 leave from MH units. A Responsible Clinician contract has been implemented to DGFT to ensure legal detentions. The SOP and policy are still to be ratified for this process, but this is pending queries from BCHFT to be resolved. The process has had an outside legal review to ensure adherence to the MHA Code of Practice. One remaining point to address relates to the provision of medical scrutiny of medical recommendations as part of the detention process.

Risk Register

A variety of risks are on the Risk Register pertaining to MH.

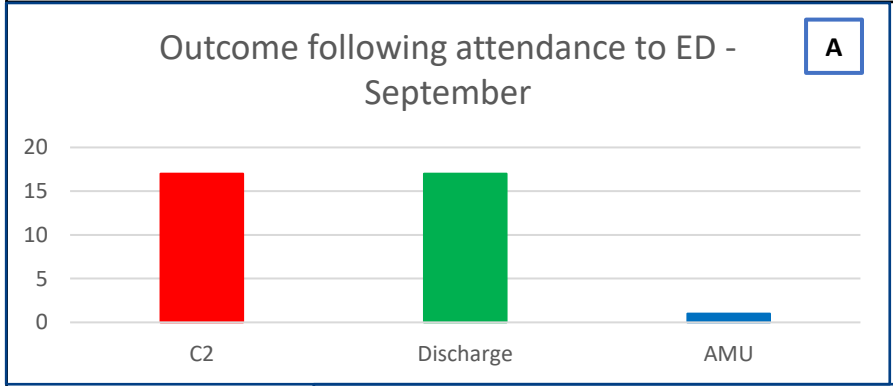
Key Points to Note

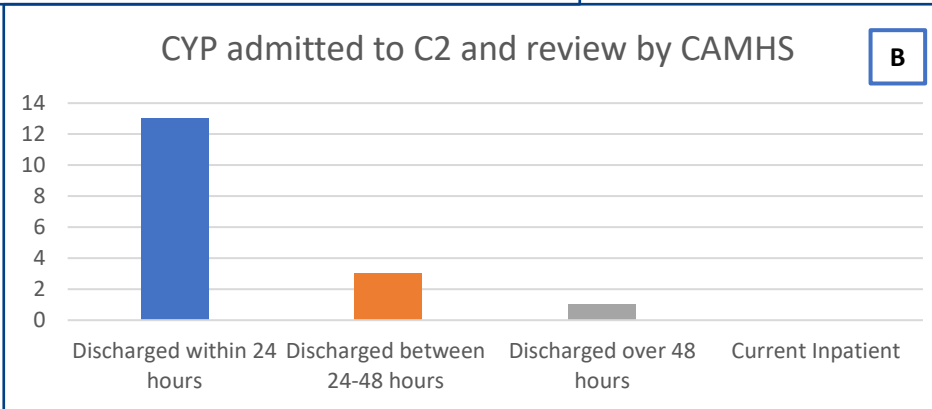
The contract for Responsible Clinician and Mental Health Administrator is now in place. Until a resolution is in place for medical scrutiny of MHA paperwork, the RC contract remains under threat. A meeting with BCHFT on 23.10.24 may lead to a resolution of this issue.

Mental Health - CYP

Background

Performance	
Date	September 2024
Trust Performance	A) C2,17 D/C,17 AMU,1 B)<24,13 24-48, 3 >48, 1
Performance Target / KPI	CQC compliant





What are the charts showing us

September had 35 CYP with mental health concerns attended the Trust. Of which, 17 CYP were reviewed in ED. ED were able to discharge 16 of these patients. Of these, 5 children were detained under a section 136. 1 of the section 136 CYP was transferred to Penn Hospital, the other 4 CYP were assessed and discharged home.

17 CYP were admitted to C2, with 2 of the CYP detained under a section 136. Both CYPs detained under a section 136 were discharged home.

1 CYP was admitted to AMU. They were discharged once medically fit.

13 CYP were admitted to C2 who were reviewed by CAMHS and discharged within 24 hours. 4 children remained admitted on the ward over 24 hours, of these 3 were admitted for 24-48 hours, and 1 admitted for over 48 hours. 0 patients remain admitted following admissions in September.

Areas Impacting on Compliance

September had a theme of an increased CYP contacts with mental health concerns attending the Trust.

Mitigations / Timescales / Blockers

The admission for 48 hours plus was due to a medical cause, not solely mental health need.

Risk Register

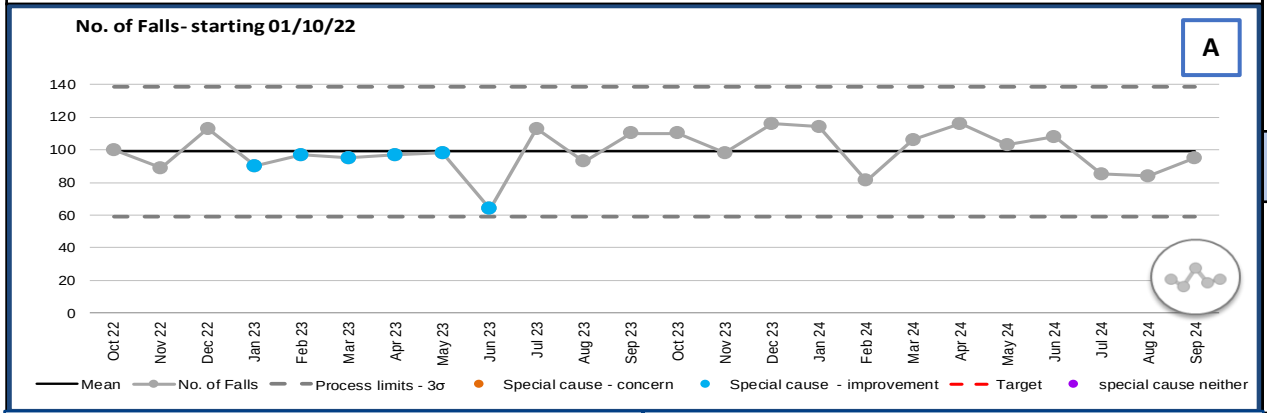
Key Points to Note

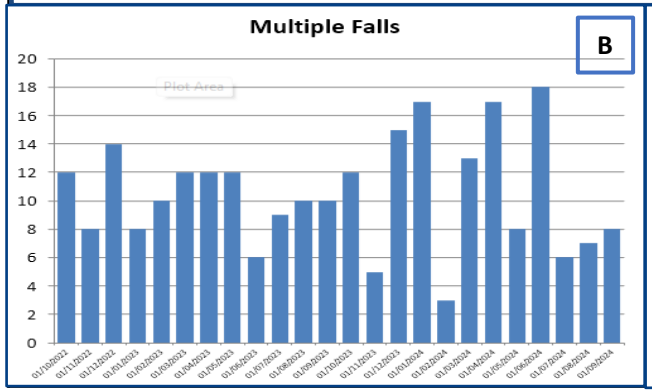
There were a number of section 136 detentions to the Trust and no CYP requiring a tier 4 bed.
136 data is to be captured within a separate chart for the next report.

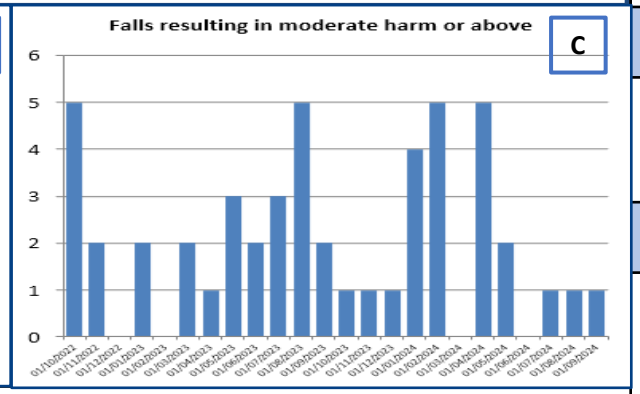
Falls

Background	*Monitoring the number of falls resulting in moderate harm and above allows for progress to be reviewed and learning from incident to be identified. This helps to ensure the most appropriate mitigations are in place to reduce risk of falls and associated injury.*

Performance	
Date	September 2024
Trust Performance	A) 95 B) 8 C) 1
Performance Target / KPI	







What are the charts showing us

The number of falls in September in comparison to August have remained stagnant. Similarly, the number of falls resulting in moderate harm and above remained low. In September, there was 1 moderate harm incidents reported. In addition, the number of recurrent falls in September remain stagnant.

Areas Impacting on Compliance

- Ward areas with the highest rate of falls for September C5 and C8. The rate of falls may be linked to increased admission of patients that are higher risk of falls linked to comorbidities.

Mitigations / Timescales / Blockers

- Focus support continues for the ward areas with the high rate of falls.
- Bed/trolley rails competency rolled out by Core skills team to help with compliance. Each ward area will have a dedicated trainer to continue to support any gaps in training.
- Community falls partners have successfully delivered workshops for the Nursing and AHP workforce in both Divisions.

Risk Register

Nil. However, a separate risk is in place for the NPSA alert pertaining to bed rails, trolleys, bed grab handles and lateral turning devices.

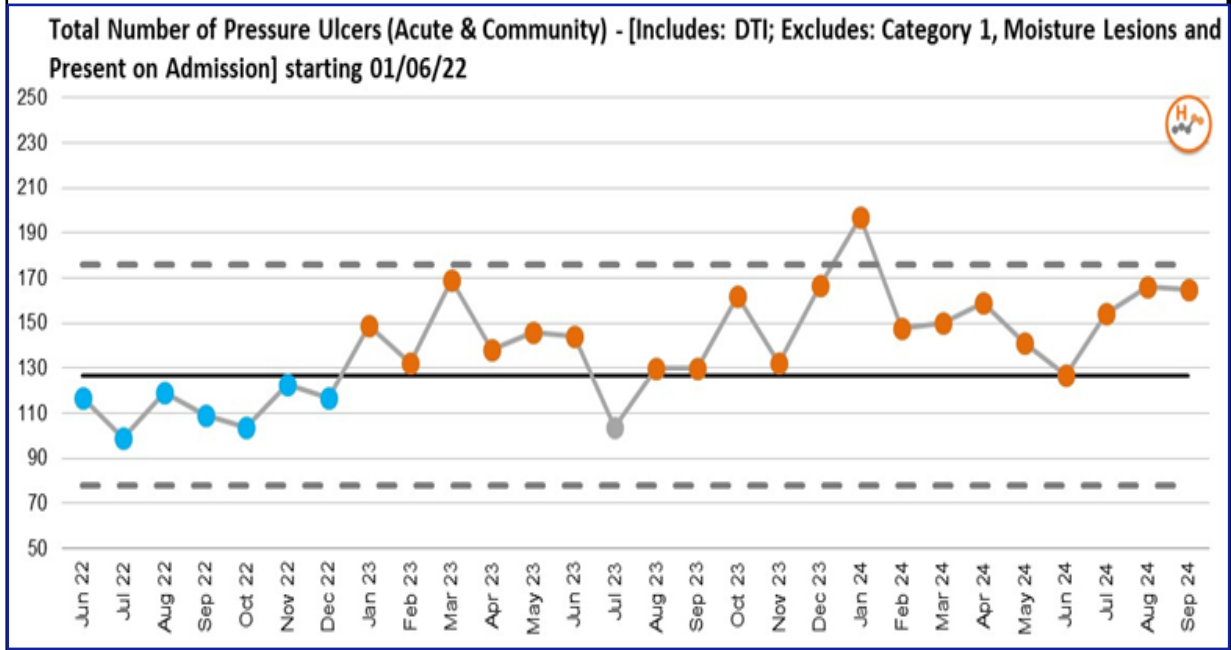
Key Points to Note

- Falls prevention and awareness month was a success, workshops were booked to full capacity.
- Falls Prevention competition created ‘a buzz’ that increased staff morale and engagement.

Pressure Ulcers

Background	Trend against pressure ulcer prevention performance

Performance	
Date	September 2024
Trust Performance	See chart
Performance Target / KPI	



What are the charts showing us

There were 165 pressure ulcers reported during the period (excludes POA, category 1 and moisture lesions). 57 of the reported incidents required a shortened investigation and presentation at the weekly pressure ulcer group. Of the 33 SITs reviewed in September, it was determined by the group that 5 incidents reviewed resulted in harm, two in low, one in moderate and two in severe. The two severe related to development of category 4 pressure ulcers.

In September the acute pressure ulcer rate per 1000 OBDs was 4.46 and community rate per 10,000 population was 2.60.

Areas Impacting on Compliance

Workforce challenges to reset model of care to a preventative model rather than a reactive model of care.

Mitigations / Timescales / Blockers

Each reported category 3,4 and unstageable pressure ulcer is reviewed by pressure ulcer group to determine level of harm.
Moving from Waterlow score to purpose T – anticipated in Nov/Dec 2024.

Risk Register

Challenges with workforce to deliver the contract.

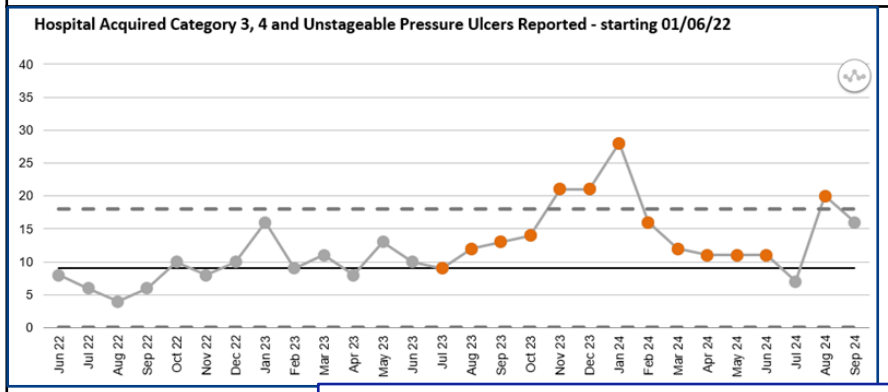
Key Points to Note

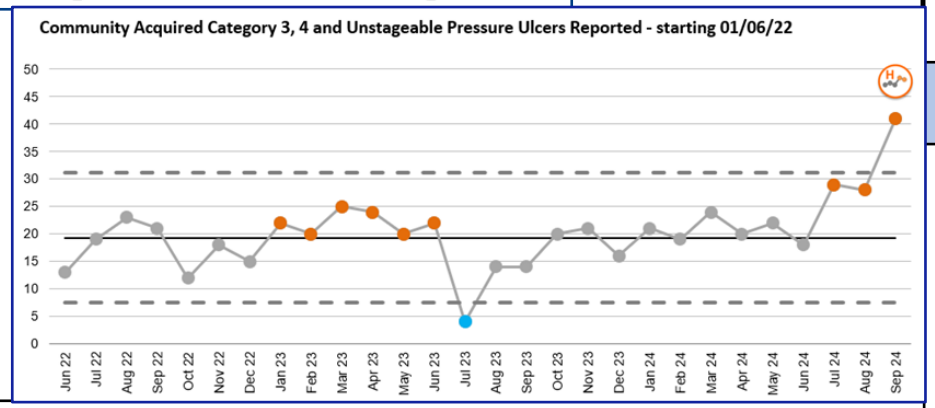
Reported on next slide.

Pressure Ulcers

Background	Trend against pressure ulcer prevention performance

Performance	
Date	September 2024
Trust Performance	See chart
Performance Target / KPI	





What are the charts showing us

There is an average of 10.3 days between reporting and review of all category 3,4 and unstageable pressure ulcers.

Areas Impacting on Compliance

Very small TVN team with long term sickness. This is resulting in a reactive model of care rather than one which focuses on prevention.

Mitigations / Timescales / Blockers

The team prioritise their efforts to urgent referrals. Early data indicates that the 'blue pillow scheme' is having a positive impact on improving patient comfort and reducing reported pressure ulcers. This has been rolled out at pace across acute and community this will help with expenditure spend on equipment.

Risk Register

Challenges with workforce to deliver the contract.

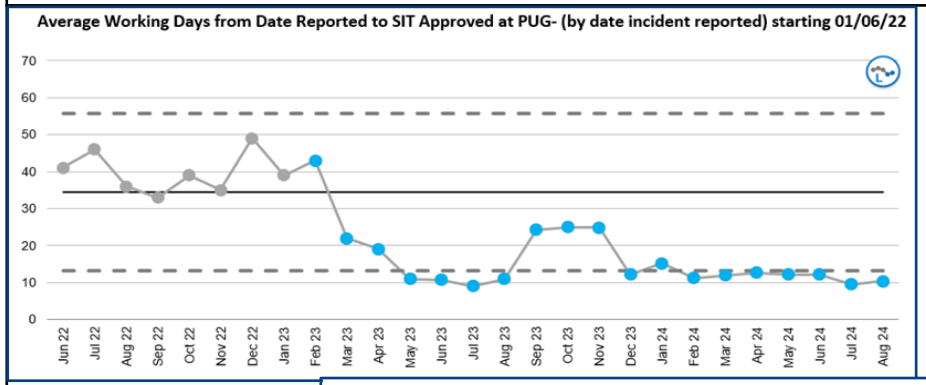
Key Points to Note

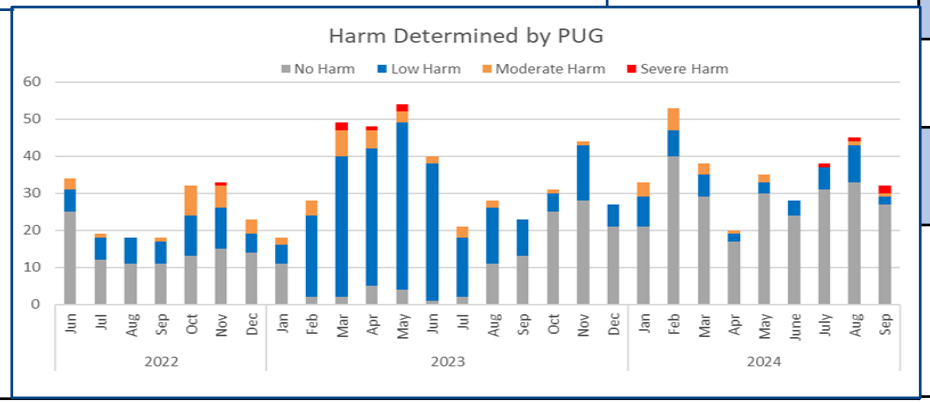
Workforce model continues to be a challenge recorded on the risk register as a 20.
Blue pillow scheme does not show any quantified benefits at this stage. However, our patients report they feel more comfortable. This approach has been rolled out across acute and community settings.
Actions in place to manage equipment spend across the Trust. Aiming to create a managed service by March 2025. This should create some efficiencies whilst allowing our small team of experts to focus on care provision.

Pressure Ulcers

Background	Trend against pressure ulcer prevention performance

Performance	
Date	September 2024
Trust Performance	See chart
Performance Target / KPI	





What are the charts showing us

Detailed overleaf

Areas Impacting on Compliance

Workforce challenges.

Mitigations / Timescales / Blockers

Prioritisation of workload. Model reactive rather than proactive.

Risk Register

Risk identified on risk register remains an overall score 20.

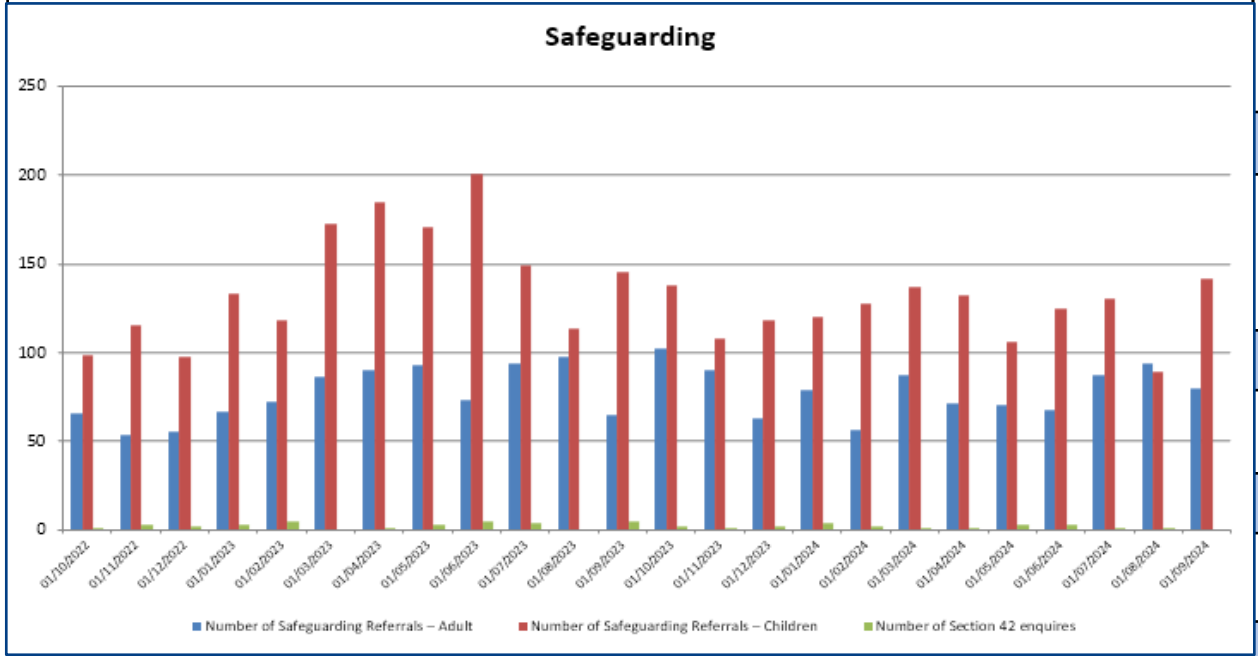
Key Points to Note

The Trust has received notification from the National PUG, stating that it does not support in moving over to the new PU categorisation. However, they fully support to transition between Waterlow and purpose T.

Safeguarding

Background	*The Trust has a statutory duty under the Children Act 1989 and Care Act 2014 to refer any cases of abuse to adults and children to the Local Authority. The Trust also has a statutory duty to undertake section 42 investigations into allegations of abuse within the Trust*

Performance	
Date	September 2024
Trust Performance	Adult) 80 / Children) 142 / Section 42) 0
Performance Target / KPI	



What are the charts showing us

The charts provide information regarding the number of safeguarding referrals for adults and children and the number of safeguarding enquiries against the Trust regarding standards of our care.
The number of children's safeguarding referrals had been entered incorrectly. This has now been amended from November 2023 onwards.
There has been an increase in safeguarding referrals for CYP. The number of referrals for mental health has doubled between August and September, this is likely to be due to return of children to school and school related anxiety.
There is a potential anomaly in the safeguarding adult incidents data due to different reports on Datix being used by the safeguarding team. This error is being rectified and does not impact on the data around safeguarding referrals. Neglect and Self-Neglect remain the 2 highest reasons for safeguarding referrals.
There have been 0 section 42 enquiries against the Trust in September. The number of S42 enquiries against the Trust has dropped significantly from 7 in Q1 to 2 in Q2

Areas Impacting on Compliance

The Trust is more than 85% compliant against the majority of safeguarding training requirements except for adult safeguarding level 3 training compliance which is currently at 77%. However, the compliance continues to improve.

Mitigations / Timescales / Blockers

Risk Register

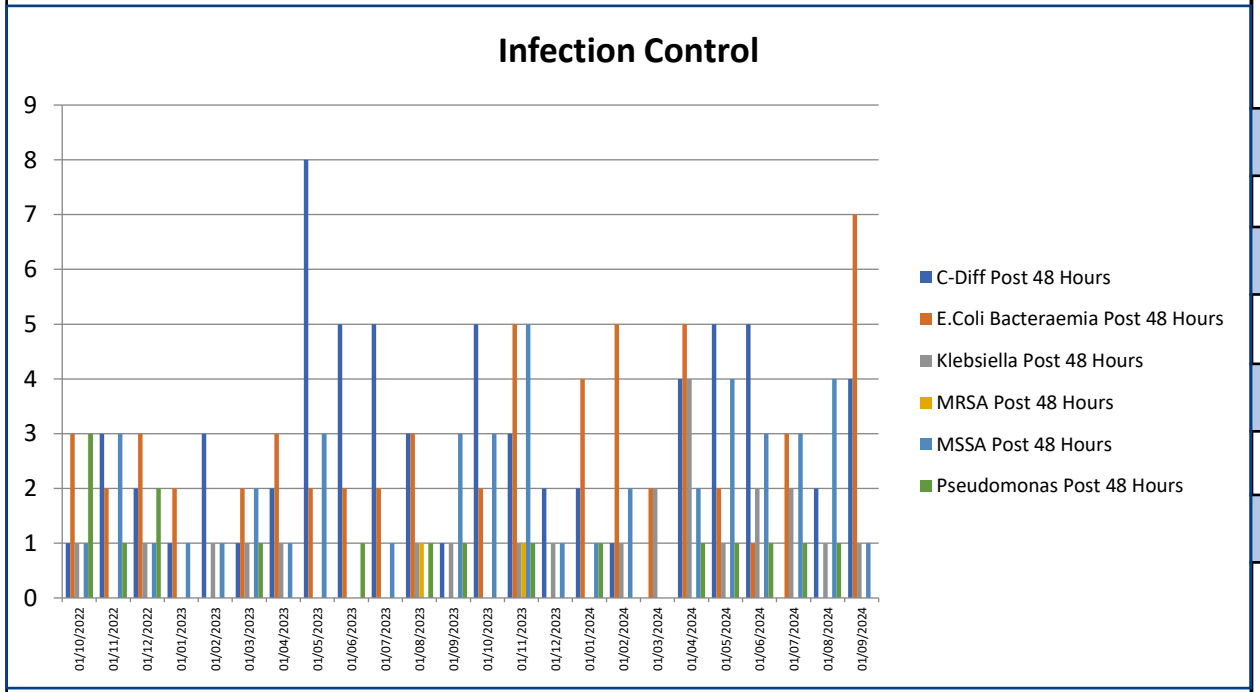
Risk re level 3 safeguarding children training remains on Divisional risk registers. Divisions are asked to submit compliance, actions and trajectories via the Trust Internal Safeguarding Board.

Key Points to Note

Infection Control

Background	IPC Healthcare Associated Data

Performance	
Date	September 2024
Trust Performance	Threshold reached for Kelbsiella and Pseudomonas for HCAI infections
Performance Target / KPI	HCAI reportable infections



What are the charts showing us

The Trust has received thresholds from NHSE for 2024 which have been amended below. The Trust has seen an increase in the threshold for CDI but reduction for Klebsiella, E coli and Pseudomonas MRSA bacteraemia remains unchanged and there continues to be no threshold for MSSA.
The trust has reported one COHA MRSA bacteraemia for June 2024. A meeting was held, and learning is being disseminated.
The trust has reported 2 HOHA cases of CDI and 2 COHA. August shows year to date as a total of 37 against a threshold of 73. Threshold increased from 42. The trust attends the ICB task and finish CDI group. CDI continues to increase nationally.
0 HOHA and 7 COHA cases of E coli BSI and 1 COHA. August shows year to date as a total of 28 against a threshold 75
1 HOHA and 0 COHA cases of Pseudomonas aeruginosa BSI. 5 of the COHA cases relate to one patient. August shows year to date as a total of 12 against a threshold of 12. Threshold reduced from 16.
1 HOHA and 2 COHA cases of Klebsiella spp. BSI. August shows year to date as a total of 19 against a threshold of 19. Threshold reduced from 24.
4 HOHA and 1 COHA MSSA bacteraemia cases but there is no threshold set. August shows year to date total of 27.

Areas Impacting on Compliance

The Trust has initiated meetings with PFI partners to review cleanliness standards within the Trust.

Mitigations / Timescales / Blockers

The Trust has adopted the PSIRF response to HCAI looking for themes and trends and is reviewing the deep dive reviewing all CDI cases for 2023/24.

Risk Register

The trust has a CPE policy in place.

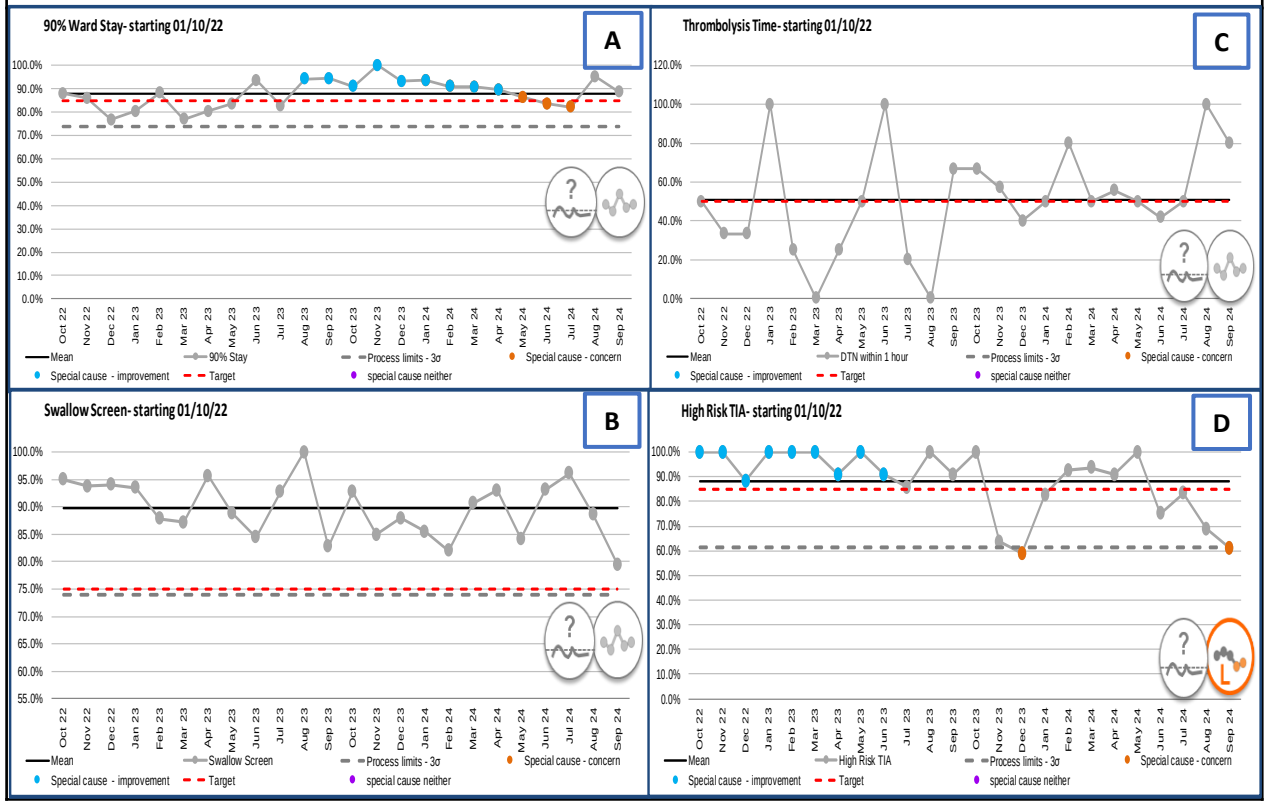
Key Points to Note

Outbreaks of infection in August 2024. The Trust reported 2 COVID-19 outbreaks.
Pathways and policies are in place for measles and pertussis following an increase nationally.
Mpox guidance and pathway is in place for both clade 1 and clade 2 cases.

Stroke (latest month is only provisional)

Background	Progress against National Stroke targets

Performance	
Date	August 2024 / September 2024
Trust Performance	A) 88.6% / B) 79.5% / C) 80.0% / D) 61%
Performance Target / KPI	85% / 70% / 50% / 85%



What are the charts showing us

Chart A, shows that 90% ward stay achieved 95% in August and 92% in September which is compliant with the 90% performance target. Chart B shows that swallow screen achieved the performance target in both August and September 24 and achieved SSNAP level A.
Chart C shows that thrombolysis was compliant in August (100%) and achieved a SSNAP level A. Thrombolysis performance achieved 60% in September 24 which is also compliant.
Chart D shows that HR TIA achieved 93% in August 24 and is compliant with the 85% performance. Chart D shows that the HR TIA is not compliant in September and is currently achieving 69%. However, the September position is currently unvalidated.
***Data for August and September currently unvalidated.**

Areas Impacting on Compliance

All areas are currently compliant with performance. Under performance in HR TIA in September is due to the data not yet being validated.

Mitigations / Timescales / Blockers

- Stroke DM and Matron attending QIP workshops and will be recognised as QSIR practitioners by January 25.
- Ongoing work with the site team to ring fence an additional stroke bed to ensure patients can be admitted to the stroke ward in a timely manner and to further improve the following KPI's: stroke unit within 4 hours, 90% ward stay, Thrombolysis within 1 hour and % of patients given thrombolysis.

Risk Register

Currently on Risk register: 1925 Inability to achieve A rating in SSNAP; aim to achieve SSNAP level A by Q4.

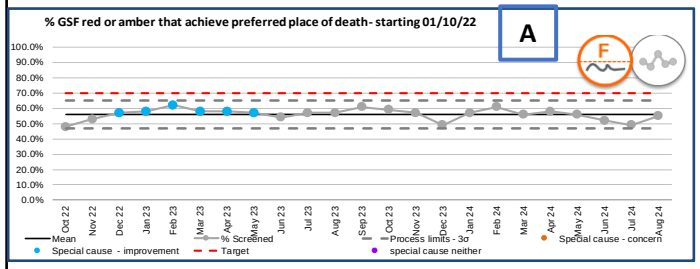
Key Points to Note

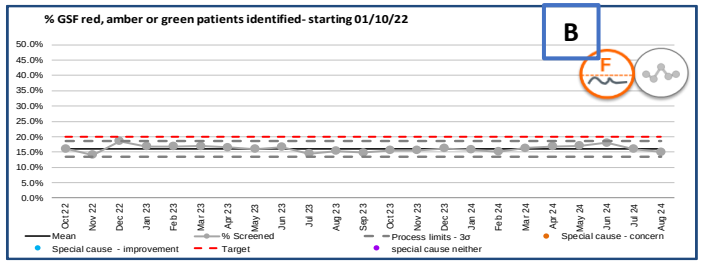
Russell hall hospital achieved a SSNAP level B in Q1 and was 1st out of 9 trusts in comparison to our peers.

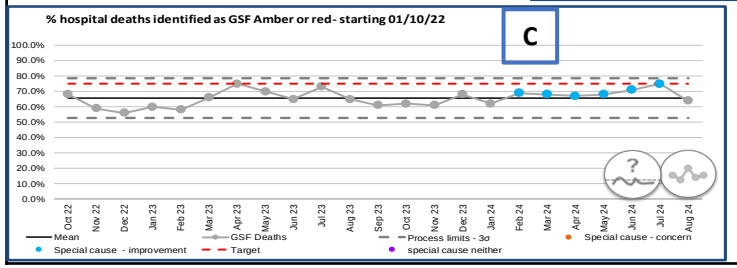
Gold Standards Framework (One Month in Arrears)

Background	KPI based on Nacel and Nice Guidance

Performance	
Date	August 2024
Trust Performance	A) 55.0%/ B) 15%/ C) 64%
Performance Target / KPI	70%/20%/75%







What are the charts showing us

55% of patients on red or amber GSF achieved their preferred place of death. Reduction in identification of GSF patients (15% in September). 64% of all deaths were identified as red or amber which is a measure of the quality of end-of-life care in the Trust.

Areas Impacting on Compliance

GSF document requires review and initial meeting to discuss bundle for GSF and next steps in progress to ensure clinically and reporting metrics improved. Recognising recording the preferred place of care data may not be accurate as it is reliant on staff to input. The GSF bundle may address this.

Mitigations / Timescales / Blockers

Continue to embed GSF across the hospital. Wards C5 and C6 have recently achieved the Gold Standard Framework (GSF) accreditation and wards C1A, B6 and C4 have achieved re-accreditation. In addition, ward B6 won the Ward of the Year award for GSF accreditation across England, Wales and Scotland.

Risk Register

Rapid Discharge added to the risk register as no assurance regarding standards fast track or rapid discharge. Paper regarding metrics produced to add to learning from deaths paper including advance care planning. This is also being picked up as part of the discharge group.

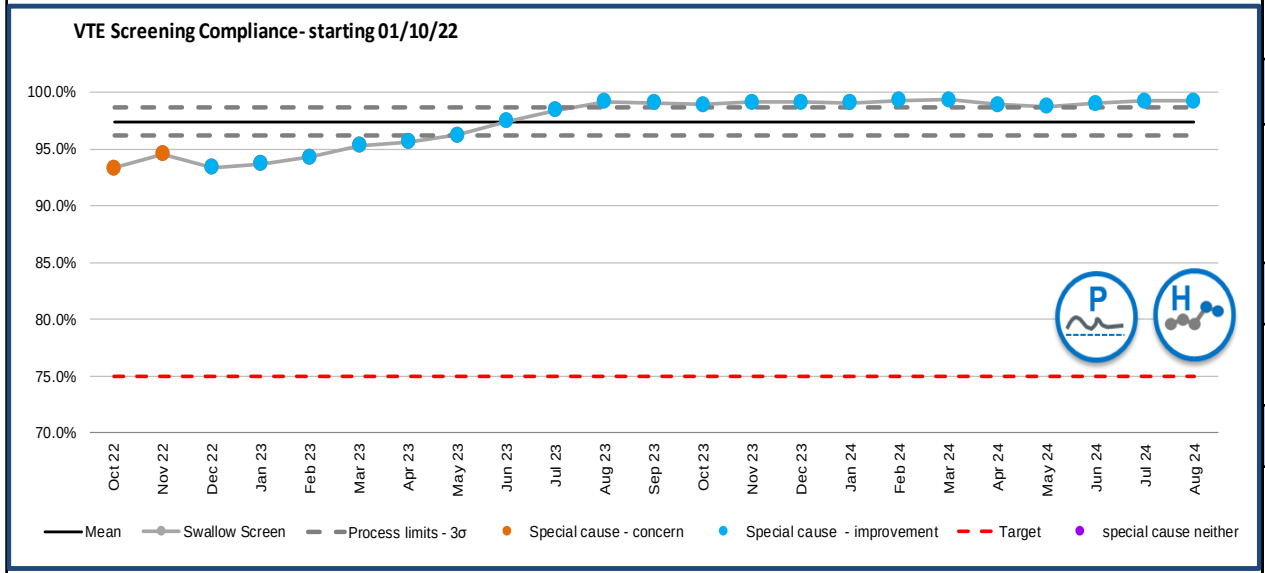
Key Points to Note

Ward B6 has won the Ward of the Year award for GSF accreditation across England, Wales and Scotland.
Fast track discharge on risk register as no assurance standards fast track or rapid discharge.

VTE (One Month in Arrears)

Background	*Achieving required VTE RA target of 95% (first assessment)*

Performance	
Date	August 2024
Trust Performance	99.0%
Performance Target / KPI	95%



What are the charts showing us

Cohorting now reviewed and correct.
Forcing function within Sunrise now in place.

Hospital associated thrombosis (HAT)

Positive scans are identified & cross referenced with admission system to identify if associated with hospital admission.
Cases of Hospital associated VTE (HAT) identified from radiology data
April 2024- 31/08/2024 - 82 cases of Hospital associated thrombosis 14 cases potentially preventable
Main themes identified

- Missed/not signed for doses (inappropriate omissions)
- Delays in/failure to prescribe prophylaxis following risk assessment
- Inappropriate risk assessment (e.g. identified incorrectly as not significant risk) and no review undertaken of risk assessment

Thematic review being undertaken biannually to identify common issues and action plan to address

Mitigations / Timescales / Blockers

- All radiological data for VTE reviewed for potential HAT. Investigation undertaken same week where possible
- Where issues identified reported back to responsible team to investigate further and implement actions. If no response team recontacted re outcome
- Where significant issue/harm identified Patient safety team contacted to review whether requires discussion at Weekly Meeting of Harm.

Risk Register

Potential risk - risk must be owned by each clinical division to ensure that where cases of potentially preventable HAT are identified that they implement mitigations locally to reduce risk of recurrence.

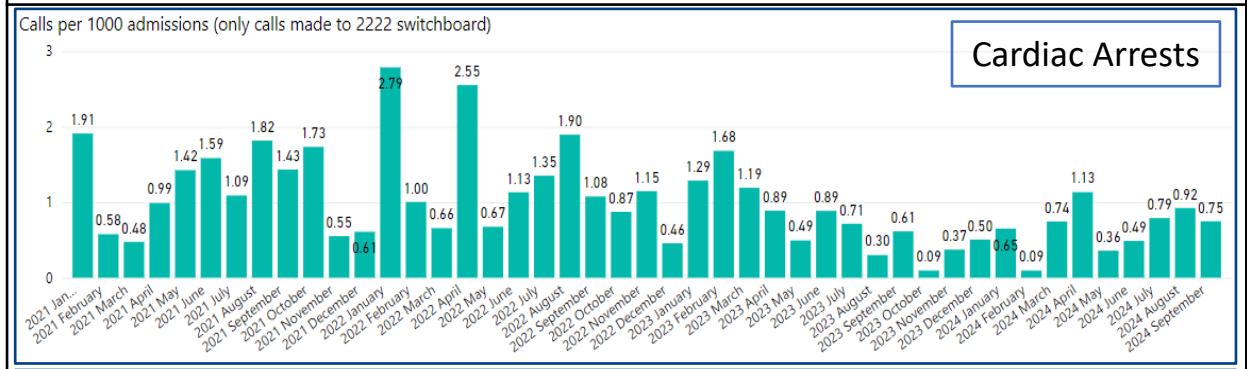
Key Points to Note

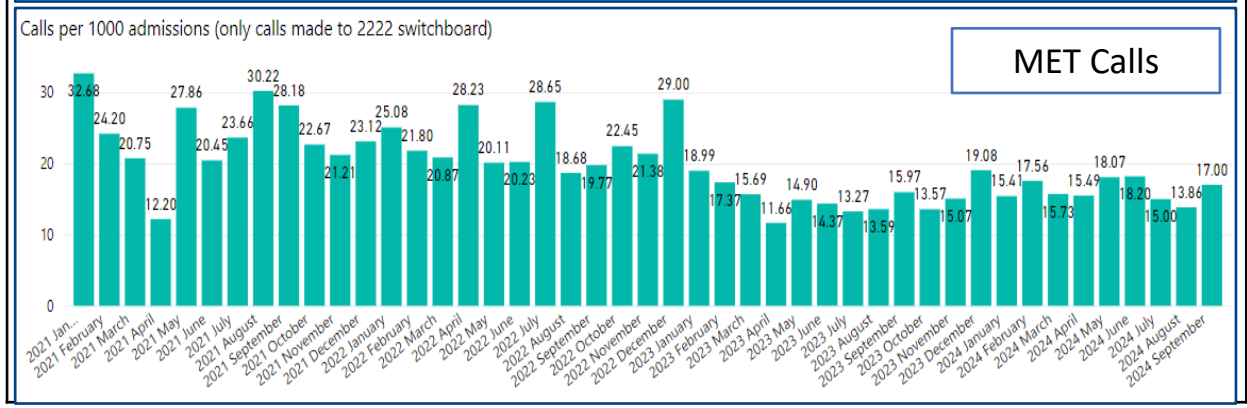
- All incidents of Hospital associated thrombosis reported on Datix
- Where issues identified reported back to responsible team to investigate further and action
- Patient safety team contacted and asked to review whether requires discussion at WMOH
- Concerns raised at Thrombosis Group meeting at how incidents in Datix are graded
- Thematic review being undertaken biannually to identify common issues and develop actions to address
- Work being undertaken to develop metrics to monitor progress with HAT
- The previous cases of possible harm following a delay in assessment previously reported, a report will be submitted to risk and assurance in November 2024.

Cardiac Arrests / MET Calls

Background	Medical emergency calls and cardiac arrests per 1000 admissions **(data is pre-validation by National Cardiac Arrest Audit)**

Performance	
Date	September 2024
Trust Performance	Cardiac arrests 0.75 /MET calls 17.00
Performance Target / KPI	N/A





What are the charts showing us

September saw less cardiac arrests than August which may possibly be attributable to an increase in treatment and escalations plans and an increase in MET calls (early recognition pre-arrest). One cardiac arrest was a member of the public visiting the site, others were all inpatients.

Areas Impacting on Compliance

An increase from 38% to 42.54% of 1307 inpatients had a documented treatment, escalation & resuscitation plan (TERP) in September, of which 79% of the documents contained DNACPR decisions (33% of all inpatients) and 22% were for full active treatment (9% of all inpatients).

Mitigations / Timescales / Blockers

- 52% of patients triggering on the deteriorating patient pathway (DPP) received a senior clinical review within 60 mins of trigger in August (increasing from 49% in August) and a further 24% after 60 minutes. MET calls receive an immediate review by the medical registrar on calls within 5 minutes of the 2222 call being placed on the RHH site.
- 22% of patients triggering on the DPP received a TERP as a result of the review at the point of deterioration.

Risk Register

- UC2350 Due to a lack of nursing presence to undertake visual observations in the front waiting room (Emergency Department) this could lead to a failure to recognise a deteriorating patient and potentially result in patient harm
- ASM2413 A potential patient safety risk associated with a lack of assurance that observations are completed on time and with the correct process for compliance with the deteriorating patient policy.

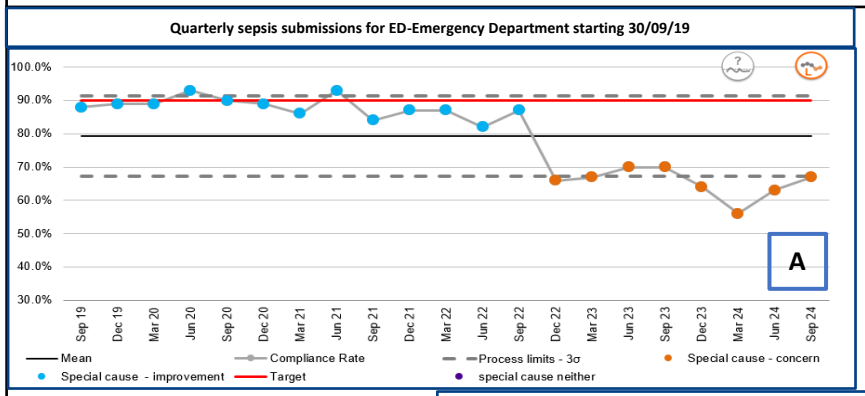
Key Points to Note

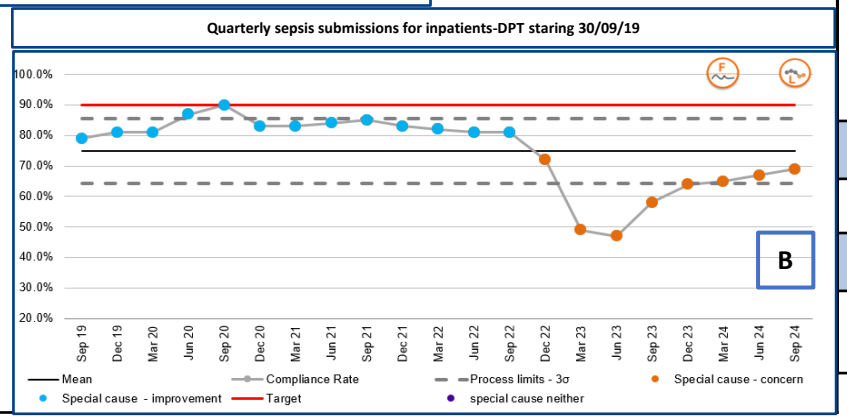
- More robust plans (with instructions of who to escalate to & when) are required in some patients to reduce 2222 calls.

Sepsis

Background	Quarterly submissions for compliance with intravenous antibiotic administration within 60 mins of deterioration in patients with suspected sepsis

Performance	
Date	September 2024 (Q2 2024/2025)
Trust Performance	A) 67% B) 69%
Performance Target / KPI	>90%





What are the charts showing us

Quarterly submissions for:
A) users presenting to the emergency department who undergo sepsis screening and who, where screening positive, receive IV antibiotic treatment <=1hour of time zero (67%).
B) inpatients who undergo sepsis screening and who, where screening positive, receive IV antibiotic treatment <=1hour of time zero (69%).

Areas Impacting on Compliance

- Timeliness of documentation of vital signs at the point of care can impact on available time to complete the sepsis six.
- Delays in prescribing or in the administration of antibiotics post prescription.
- Availability of ED cubicles to offload patients from ambulance or out of the waiting room, compliance is adversely affected by patients being treated in these two areas in comparison with those in majors & resus.

Mitigations / Timescales / Blockers

- Bulit in reminders into EPR that recognises the trigger of a deteriorating patient from the early warning scores and activates the deteriorating patient pathway (DPP).
- Countdown timers and icons to remind of time zero and outstanding DPP actions.
- Clinical areas report sepsis improvement action plans to divisional governance meetings.

Risk Register

COR1015, COR1420, COR1894, COM2386, COM2164, UC2259, ASM2264, ACC2265, ASM2268.

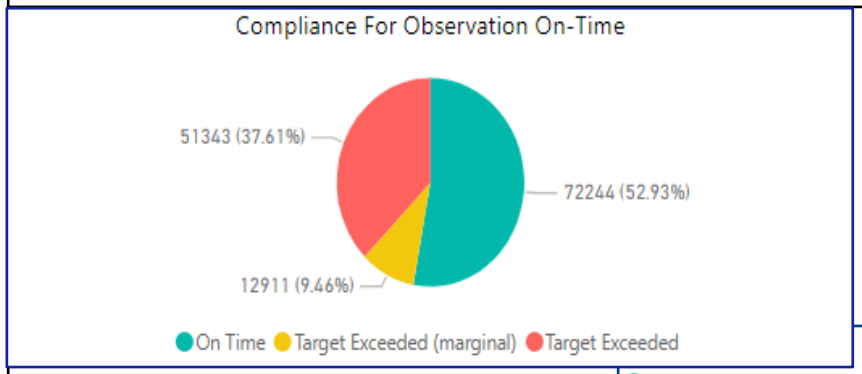
Key Points to Note

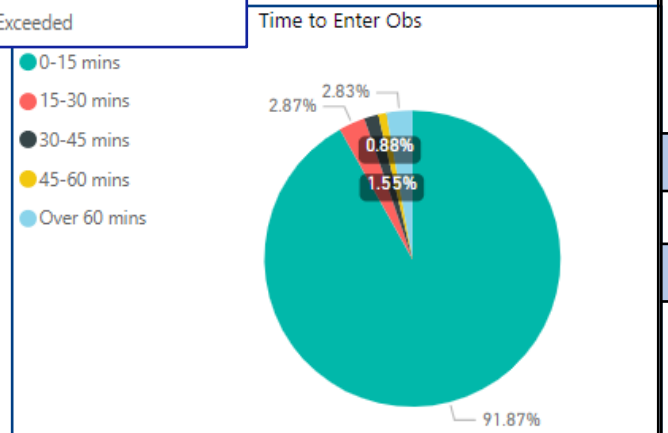
Sepsis data for both ED & inpatients have displayed an improvement between Q1 & Q2.

Vital Signs Compliance

Background	Vital signs should be documented at the point of care (within 6 mins of recording) and frequency according to risk level from early warning score (EWS)

Performance	
Date	September 2024
Trust Performance	52.93% on time/91.87% in 0-15mins
Performance Target / KPI	Vital signs recorded on time(via EWS risk level)





What are the charts showing us

Frequency of vital signs recordings are mandated by the clinical risk determined by the appropriate early warning score (NEWS2 = adults, NPEWS = paediatrics, MEOWS = maternal patients, [NNEWS = neonatal – not on EPR]).
The compliance for observations (vital signs) on time demonstrates an improvement with 52.93% of all vital signs recorded in the past 4 weeks, and a further 9.46% of the 4 hourly vital signs being recorded within 15 minutes of the target time.

Areas Impacting on Compliance

- Culture of using white boards to determine frequency means staff do not use the live tracking boards with countdown timer visible.
- Culture of writing vital signs onto paper rather than directly onto the EPR causes delays in documentation, escalation and treatment of time critical illnesses.

Mitigations / Timescales / Blockers

- Countdown timer on tracking board to when next vital signs are due & timer flashes amber when vital signs are due in next 15 minutes.
- Nurse in charge & lead nurses checking compliance in each area.
- Safety mechanisms of pop-up warnings for the deteriorating patient pathway are built into the EPR.

Risk Register

ASM2413, UC2350.

Key Points to Note

- Safety reminder on timeliness of vital signs published within “In the know”.
- Vital signs screensaver on all pc’s in October.
- Teams channel for vital signs assistance set up by DPT for leads & matrons.
- Education provided by DPT to clinical area leads on understanding the issues with their vital signs.

Quality KPI Dashboard

Background

Performance	
Date	October 2024 (September data)
Trust Performance	RAG: **Red <85%; Amber 85.1 - 94%**; **Green 94.1% +**
Performance Target / KPI	N/A

Audit	Apr	May	Jun	Jul	Aug	Sep	Improvement
Tissue Viability SKIN audit (CQUIN 12)	97.6%	96.7%	98.0%	97.4%	96.6%	96.7%	↔
Hand Hygiene '5 moments' audit	98.7%	98.2%	97.6%	97.8%	98.7%	98.4%	↔
Hand Hygiene Environment Audit	98.7%	99.2%	98.0%	98.5%	98.8%	99.1%	↔
Matron In Patient Audit	85.5%	88.1%	89.5%	91.9%	91.0%	84.0%	↔
Matron Audit - Out Patient Areas	N/A	N/A	N/A	90.4%	93.3%	94.2%	↑
Standard of Documentation Audit	96.4%	96.4%	97.0%	97.4%	97.5%	97.7%	↑
Lead Nurse In Patient Audit	92.8%	93.8%	94.1%	95.0%	92.7%	92.5%	↔

What are the charts showing us

- Sustained green RAG rating in most priority 1 audits.
- Matron Inpatient and outpatient audits progressing steadily towards required standard.
- Lead Nurse inpatient audit now amber RAG.

Areas Impacting on Compliance

- Completion of electronic nursing documents by staff in a consistent way.
- Compliance with mandatory training.
- Lead Nurse inpatient audit: Review of individual questions show compliance with discharge planning and referrals to other teams has fallen.

Mitigations / Timescales / Blockers

- Matrons and lead nurses have action plans in place to address shortfalls.
- The Matron inpatient audit has been reviewed by the Matrons and Divisional Chief Nurses. A new question proforma will be in place from September 2024 that may see compliance scores change.

Risk Register

- N/A

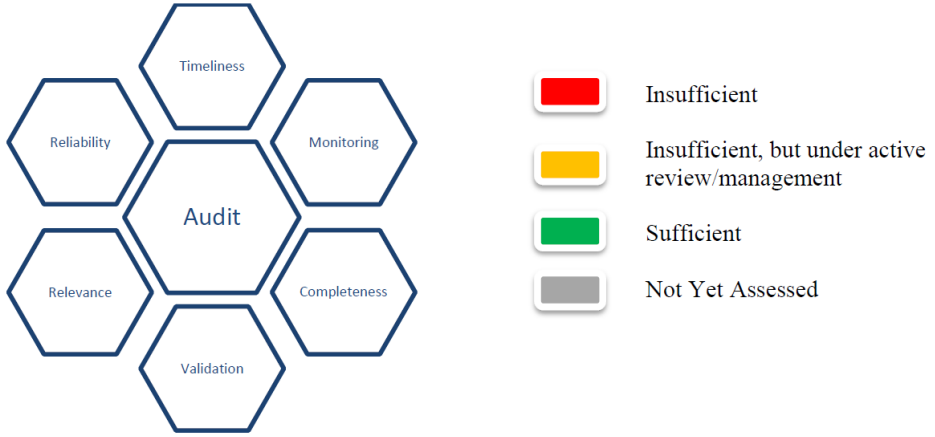
Key Points to Note

- Nursing dashboard, to include all relevant nursing quality metrics, is expected to be ready for use within the next 8 weeks once the format has been validated.
- Matrons requested a review of the inpatient audit to include additional areas of practice they wish to monitor. This was approved by the Quality Working Group in August and will go live from 1st September 2024. Questions consistently achieving a green RAG rating have been removed and replaced with new questions addressing safe care, staff competence, nutrition, sepsis management, safeguarding, complaints, incidents. There is greater focus on Matrons involving patients' opinion in this revised audit.

Kitemark Explanation

Element	Definition
Timeliness	The time taken between the end of the data period and when the information can be produced and reviewed. The acceptable data lag will be different for different performance indicators. Data should be captured as quickly as possible after the event or activity and must be available for the intended use within a reasonable time period. Data must be available quickly and frequently enough to support information needs and to influence the appropriate level of service or management decisions.
Monitoring	The degree to which the trust can drill down into data in order to review and understand operational performance. The level to which the trust needs to drill down into the data will vary for different performance indicators. Some information should always be available at patient level for performance monitoring purposes. Whereas some information may be sufficient if it is available at speciality level for all specialties or even trust level for performance monitoring purposes
Completeness	The extent to which all of the expected attributes of the data are populated but also the extent to which all of the records for the relevant population are provided.
Validation	The extent to which the data has been validated to ensure it is accurate and in compliance with relevant requirements. For example, correct application of rules and definitions. The level of validation required will vary from indicator-to-indicator and will depend on the level of data quality risk. Final validation is classified as sufficient where validation has been completed and where the indicator has received final approval from responsible individuals.
Audit	The extent to which the integrity of data (completeness, accuracy, validity, reliability, relevance, and timeliness) has been audited by someone independent of the KPI owner (for example, Internal Audit, External Audit, Clinical Audit or Peer Review) and the extent to which the assurance provided from the audit is positive.

Element	Definition
Reliability	The extent to which the data is generated by a computerised system, with automated IT controls, or a manual process. It also relates to the degree of documentation outlining the data flow, i.e. documented process with controls and data flows mapped. Data should reflect stable and consistent data collection processes across collection points and over time, whether using manual or computer-based systems or a combination. Managers and stakeholders should be confident that progress toward performance targets reflects real changes rather than variations in data collection approaches or methods.
Relevance	The extent to which the data is captured for the purposes for which it is used. This entails periodic review of the selection of key performance indicators to reflect changing needs, such as new strategic objectives. For example, is this indicator the right indicator by which to measure performance against a strategic objective. Strategic objectives will be defined within the scoping document for proposed new measures.



Click HERE for full kitemark explanation & policy

Performance KPIs

October Report (September 2024 Data for National Performance & August 2024 Data for Cancer & VTE)

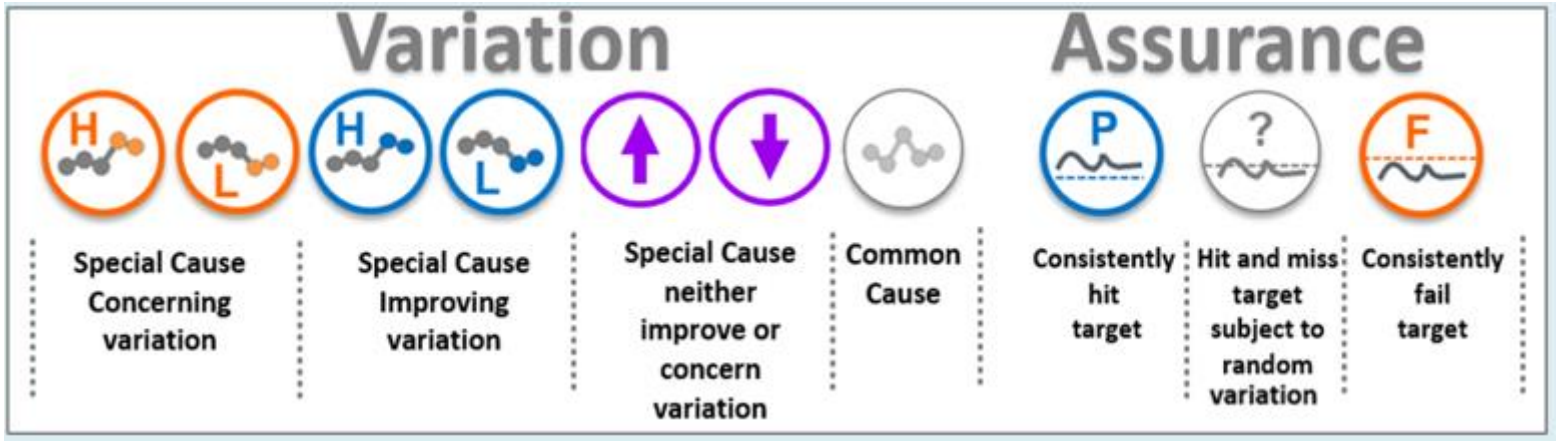
The Dudley Group NHS Foundation Trust

Karen Kelly, Chief Operating Officer

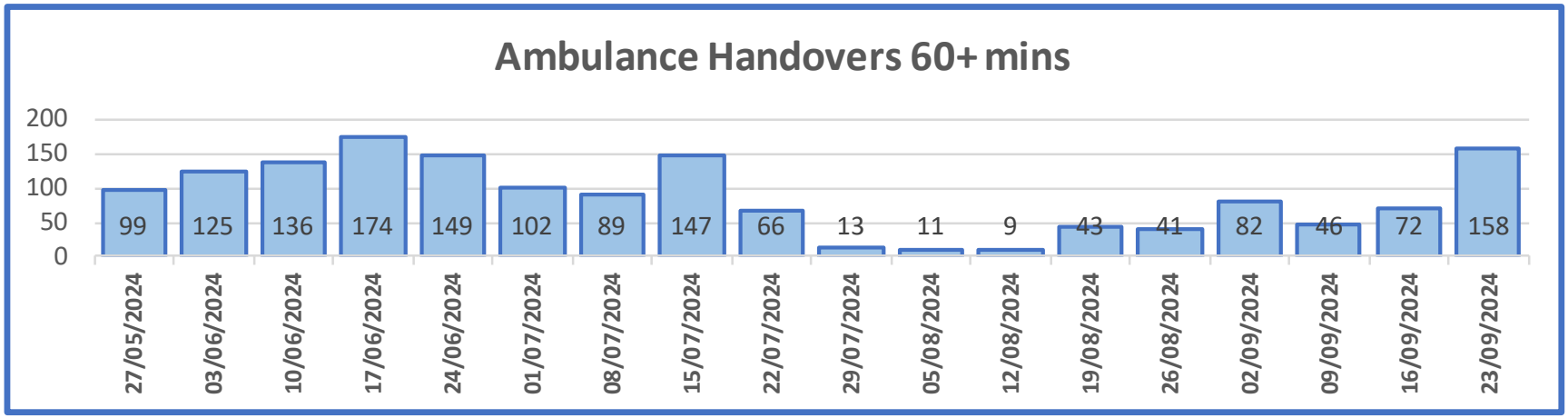
CARE RESPECT RESPONSIBILITY

Constitutional Performance

Constitutional Standard and KPI		Target	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24		
Emergency Access Standard (EAS)	Combined 4hr Performance	78.0%	72.8%	74.1%	72.5%	72.9%	71.5%	71.9%	73.8%	78.7%	80.3%	81.2%	81.6%	79.9%	83.6%	81.2%		
Triage	Triage - All	95.0%	80.2%	73.3%	71.0%	74.0%	78.0%	84.3%	73.3%	71.0%	74.0%	78.1%	84.3%	80.6%	80.6%	75.3%		
Referral to Treatment (RTT)	RTT Incomplete	92%	55.6%	55.6%	55.5%	55.0%	55.2%	55.8%	56.2%	56.5%	57.8%	58.2%	58.6%	58.6%	57.2%	57.5%		
Diagnostics	DM01 - Diagnostics achieved within 6 weeks	85%	64.4%	66.6%	68.9%	70.3%	71.5%	79.7%	90.6%	91.3%	89.6%	88.4%	86.9%	88.3%	86.3%	86.2%		
VTE	% Assessed on Admission	95%	99.1%	99.0%	98.9%	98.9%	99.1%	99.1%	99.3%	99.3%	98.9%	98.7%	99.0%	99.1%	99.2%	n/a		



Ambulance Handovers 60+ Mins



Performance

This month's activity saw 9,195 attendances. This has decreased when compared to the previous month of August with 8,663. 19 out of the 30 days saw >300 patients.

2934 patients arrived by ambulance; this shows a decrease from the 3187 ambulances that attended last month.

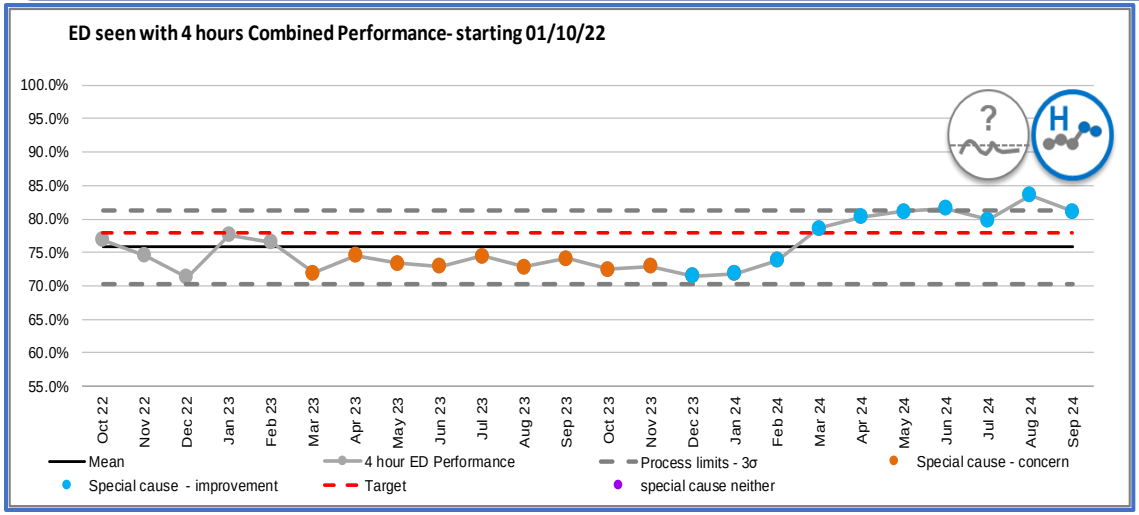
257 of these offloads took <1h (9%). This shows an improvement when compared with last month's performance of 3%.

Over the month, the average length of stay (LOS) in ED was 211 mins for non-admitted patients and 426 mins for those waiting for a bed following a decision to admit. This is a 13% (57 minute) increase in waiting time for patients to be admitted compared to last month at 369 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	2nd
81.2%	70	For Sept 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

RHH ED Performance remains the best in the black country despite high ambulance and walk-in attendance when compared to our regional neighbours.

We continue to validate performance and record reasons for each breach which is then explored by the ops team and the department tri

Last month's 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.
- Altering the registration process for patients arriving by the front door.

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

September 2024

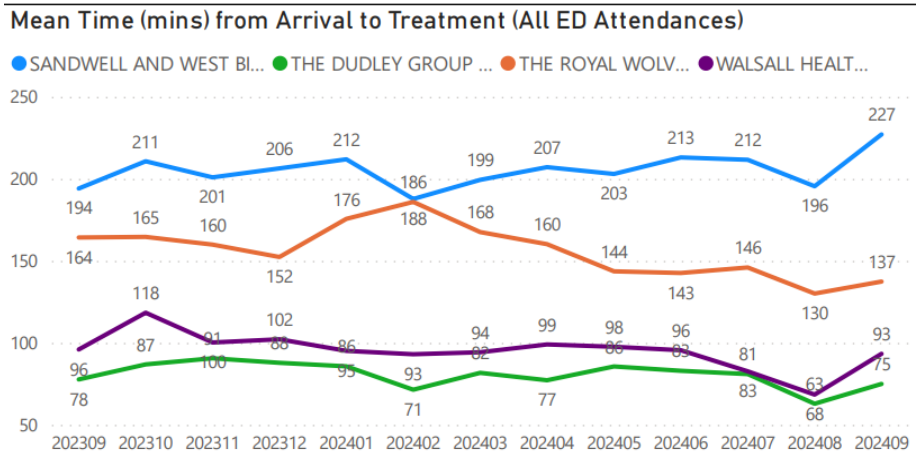
Latest Refresh
15/10/2024 11:15:34

Name	Value	National Rank
Birmingham Women's And Children's NHS Foundation Trust	84.20%	5
The Dudley Group NHS Foundation Trust	81.18%	11
The Royal Wolverhampton NHS Trust	79.93%	12
Walsall Healthcare NHS Trust	76.21%	28
South Warwickshire NHS Foundation Trust	75.32%	33
George Eliot Hospital NHS Trust	74.63%	39
Sandwell And West Birmingham Hospitals NHS Trust	69.71%	72
University Hospitals Of North Midlands NHS Trust	69.24%	73
Worcestershire Acute Hospitals NHS Trust	68.45%	82
University Hospitals Coventry And Warwickshire NHS Trust	66.49%	89
Wye Valley NHS Trust	65.76%	94
University Hospitals Birmingham NHS Foundation Trust	62.85%	109
The Shrewsbury And Telford Hospital NHS Trust	52.16%	122

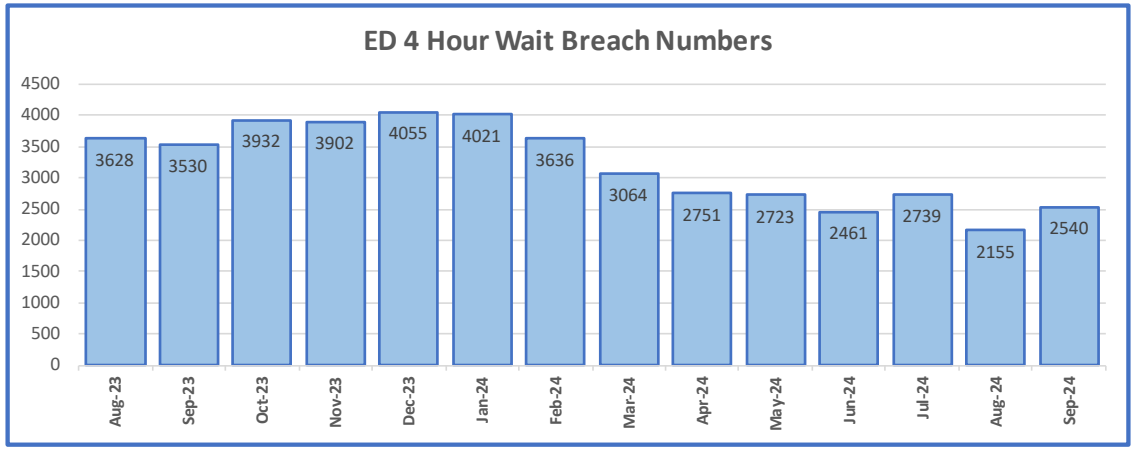
DGH

Ranking out of 122 Trusts

Source: Daily EAS - Power BI



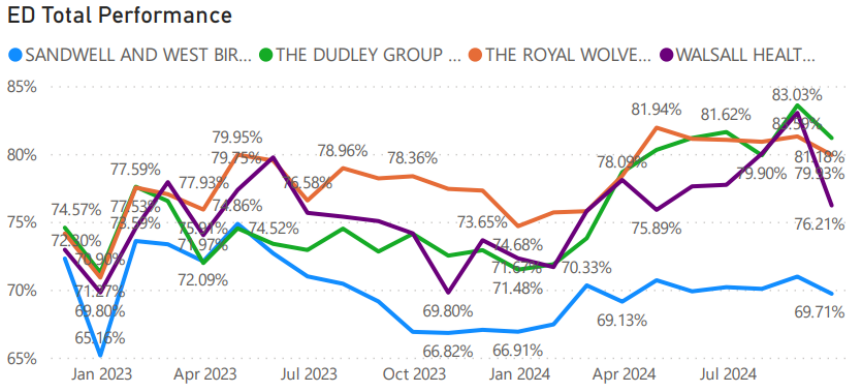
ED 4 Hour Wait Number of Breaches



Date	No Breaches
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
Aug-24	2155
Sep-24	2540

Performance

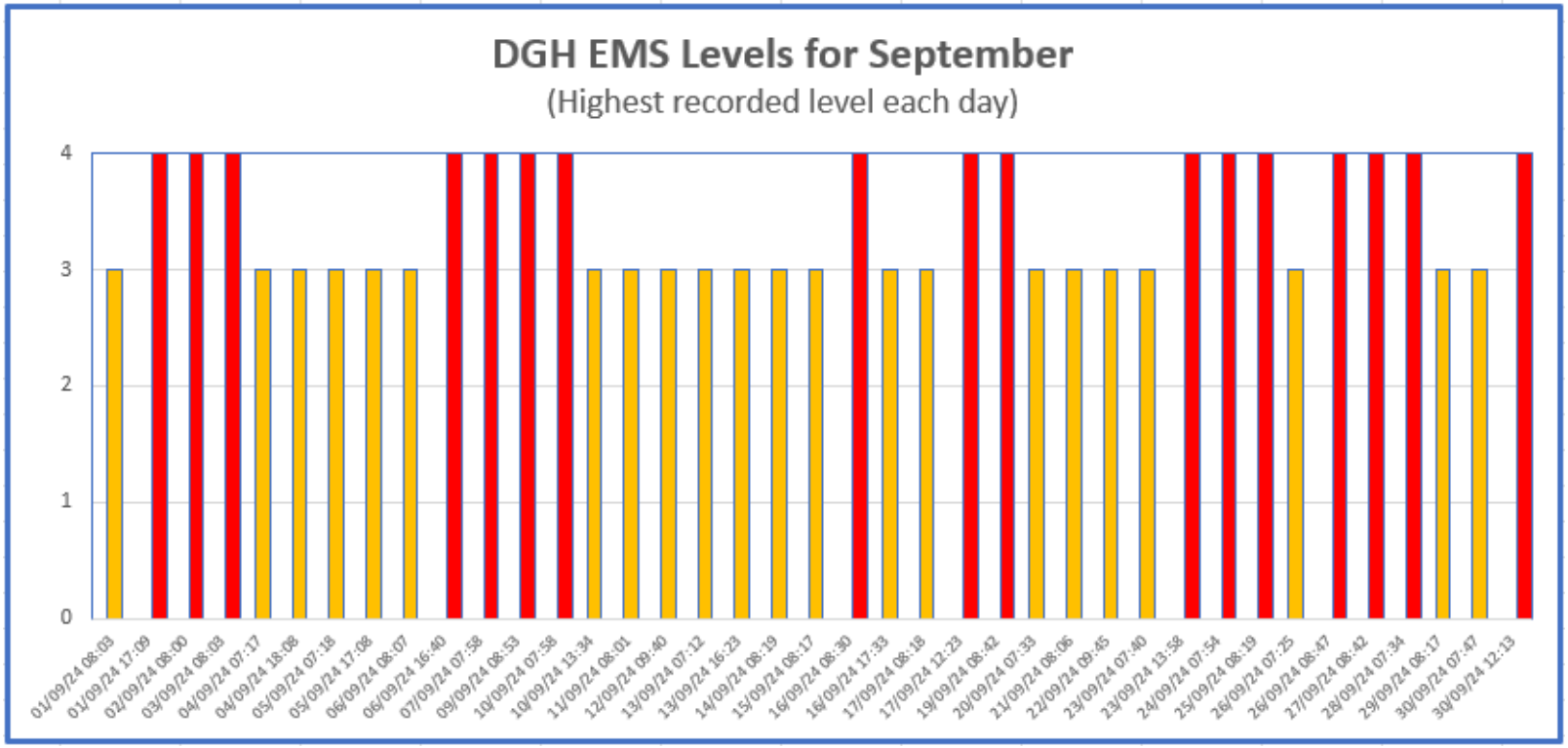
ED remains the best performing department in the black country and in the Top 11 nationally.



Action

- The ED performance for September remains above the national target of 78% at 81.2%
- Last month's 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 4 during September.

2934 patients arrived by ambulance; this shows a decrease from the 3187 ambulances that attended last month.

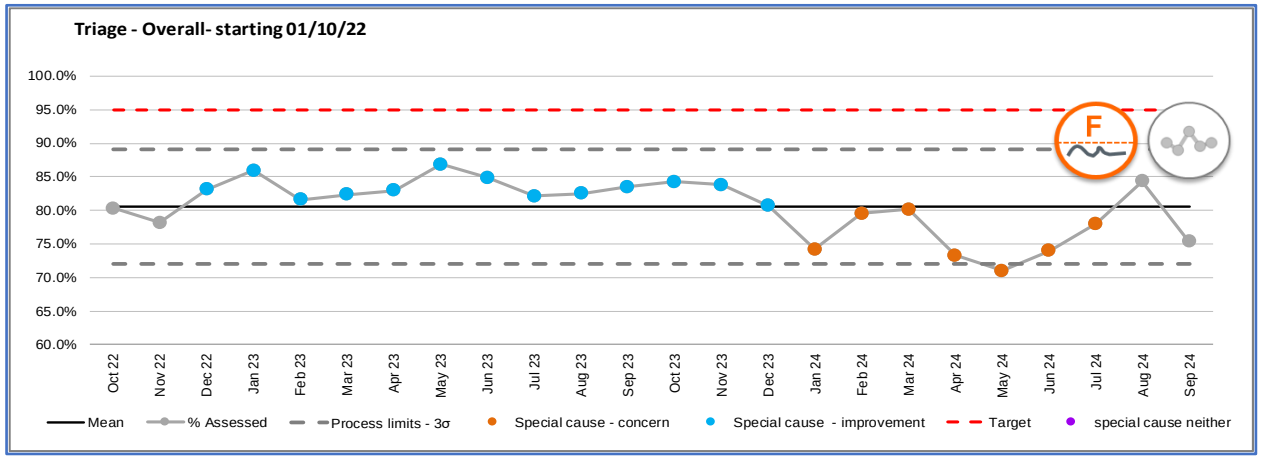
257 of these offloads took <1h (9%). This shows an improvement when compared with last month's performance of 3%.

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

75.33%

Triage – target 95%

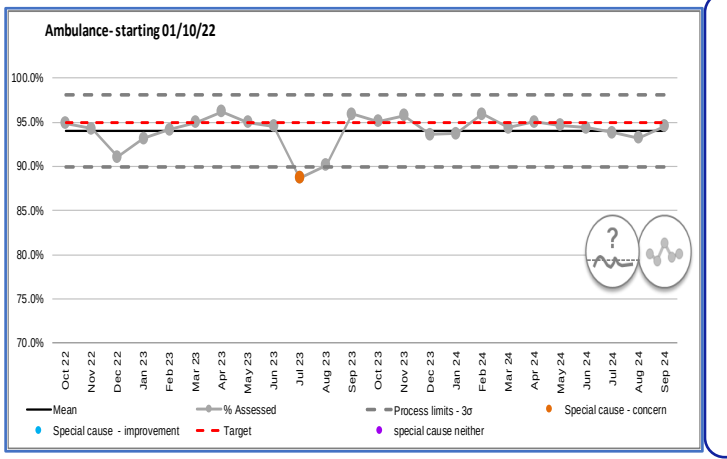
Performance

ED have reconfigured the treatment areas following the floor works and ahead of the planned building works and now have a dedicated triage space and we are monitoring performance daily.

Action

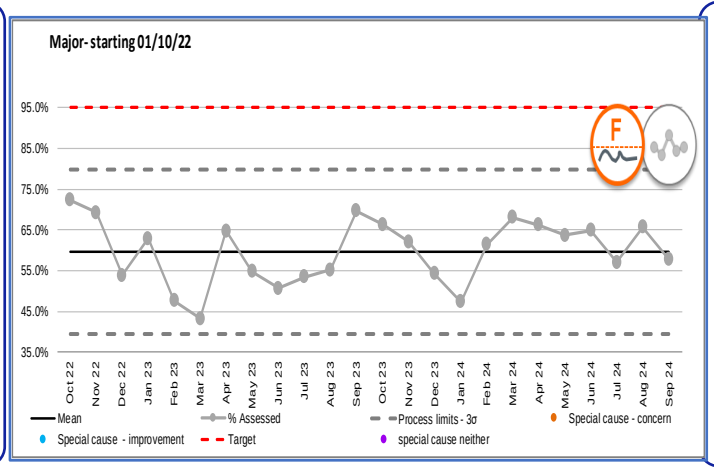
- Deputy Matron now leading on Triage improvement from October.
- Triage project has completed, and assurance report was submitted and presented to the execs with positive feedback.
- ED assurance report now submitted monthly to Execs.
- Daily triage continues to be monitored by the Deputy Matron.
- 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

94.6%



Latest Month

57.8%

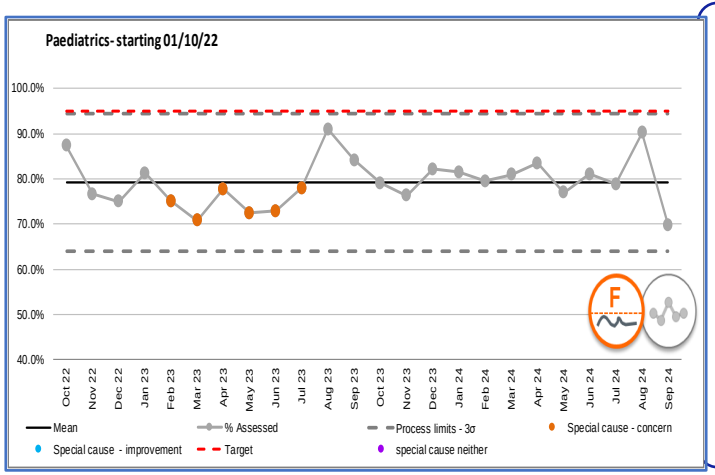
Performance

ED have reconfigured the treatment areas following the floor works and ahead of the planned building works and now have a dedicated triage space and we are monitoring performance daily

Action

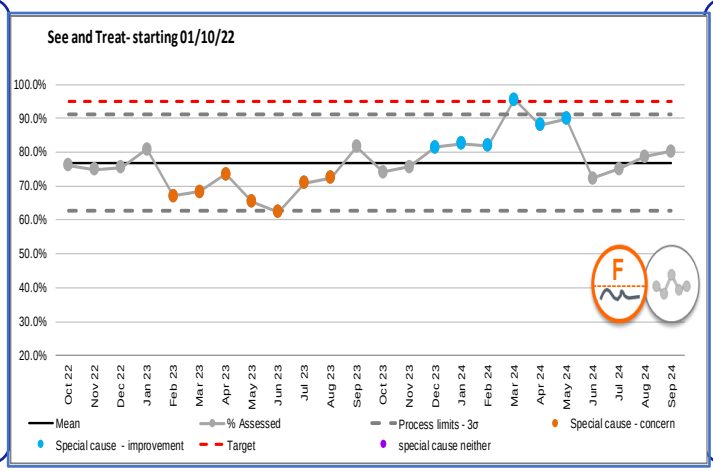
- Time spent in triage continues to be monitored
- Increased focus in direct to speciality patients being sent from UCC rather than being triaged in ED

ED Triage



Latest Month

69.6%



Latest Month

80.2%

Performance

ED have reconfigured the treatment areas following the floor works and ahead of the planned building works and now have a dedicated triage space and we are monitoring performance daily

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

	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24
28 Day Combined (75%)	76.9%	81.9%	87.2%	82.4%	82.5%	87.6%	81.2%	78.3%	83.9%	83.2%	82.2%	83.8%
31 Day Combined (96%)	85.0%	86.9%	81.4%	87.6%	81.1%	89.8%	86.7%	91.6%	92.2%	90.3%	94.5%	89.7%
62 Day Combined (85%)	67.1%	67.1%	68.1%	68.0%	58.3%	67.7%	71.5%	71.9%	66.8%	70.3%	74.9%	71.5%

Latest Month	Latest Month	Latest Month
83.8%	89.7%	71.5%
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 August 2024:

<u>28-day Faster Diagnosis Standard (FDS)</u>

• Performing well at 83.8% and remains above the constitutional target standard of 77%. Increased focus on cancer pathway detail going forward.

<u>31 day combined</u>

• Performance of 89.7% against constitutional target of 96%. Cancer Services Team and Directorate Managers work collaboratively to maximise surgical capacity. To address challenged pathways to improve.

<u>62 day combined</u>

• Achieved 71.5% and above NHSE target of 70% by end of March 2025. (This target does not supersede the 85% constitutional standard but set to support tiering measures for cancer performance).

Radioisotope shortage from 21st October for approx. 4 weeks impacting services. Guidance received for scan prioritisation (Red, Amber, Green).

Action

<u>28-day FDS</u>

- Performance to be sustained. Forecast shows continued achievement of target next month.

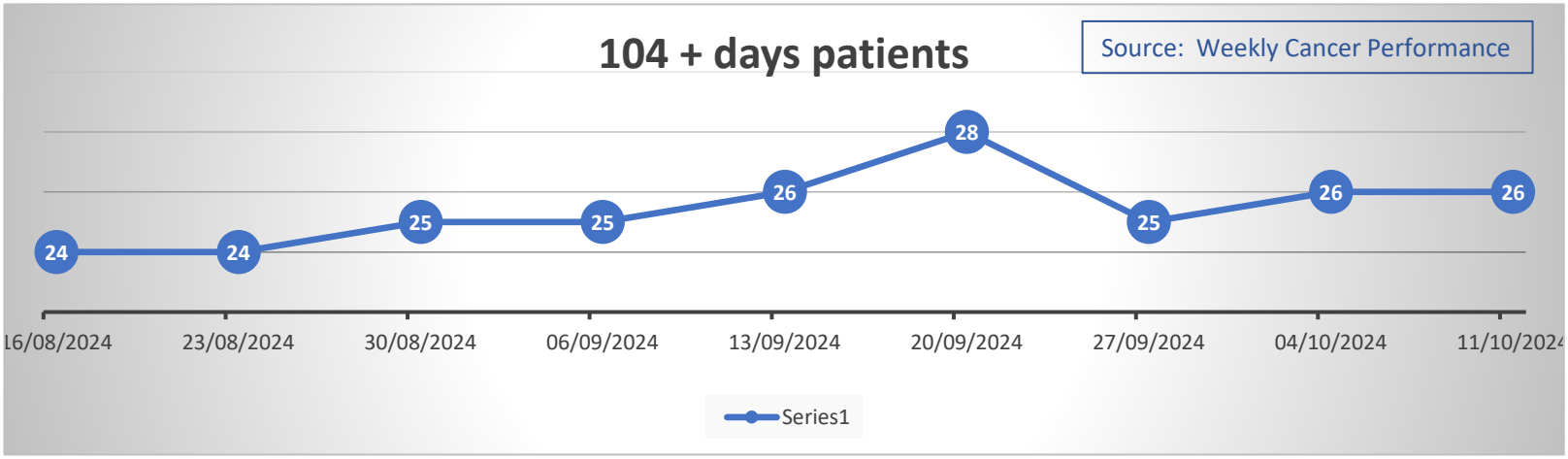
<u>31 day combined & 62 combined</u>

- Prostate: CNS is leading straight to test pathway for suitable patients and co-ordinated by care navigator. Trial has now started. LATP training in progress with plans for an extra nurse to commence training.
- Head and Neck: demand and capacity review commenced with RWT.
- Gynae: unable to recruit to hysteroscopy nurse. Extra capacity has reduced first appointment waiting times
- CDC Dermoscopy service continues for suspected cancer patients. Patients receive imaging in the community setting to support robust triage of referrals to ensure that we rapid access capacity utilised appropriately.

<u>BCPS</u>

- Clinical agreement to no longer send BCC skin as urgents. This should have biggest impact on reducing number of urgents sent. E-requesting went live during August.

Cancer Performance – 104 Day – Harm Review



Latest Week

(11/10/24)

26

All 104 week waits, target 10 Patients

Performance

Of the 26 over 104 days patients, urology remains the most challenged pathway with 15 patients waiting over 104 days as surgical capacity is limited.

8 of the 26 breaches have treatment plans / treatment dates. Those without treatment plans were awaiting surgery dates, best interest meetings or further investigations. Theatre capacity was impacted over the summer.

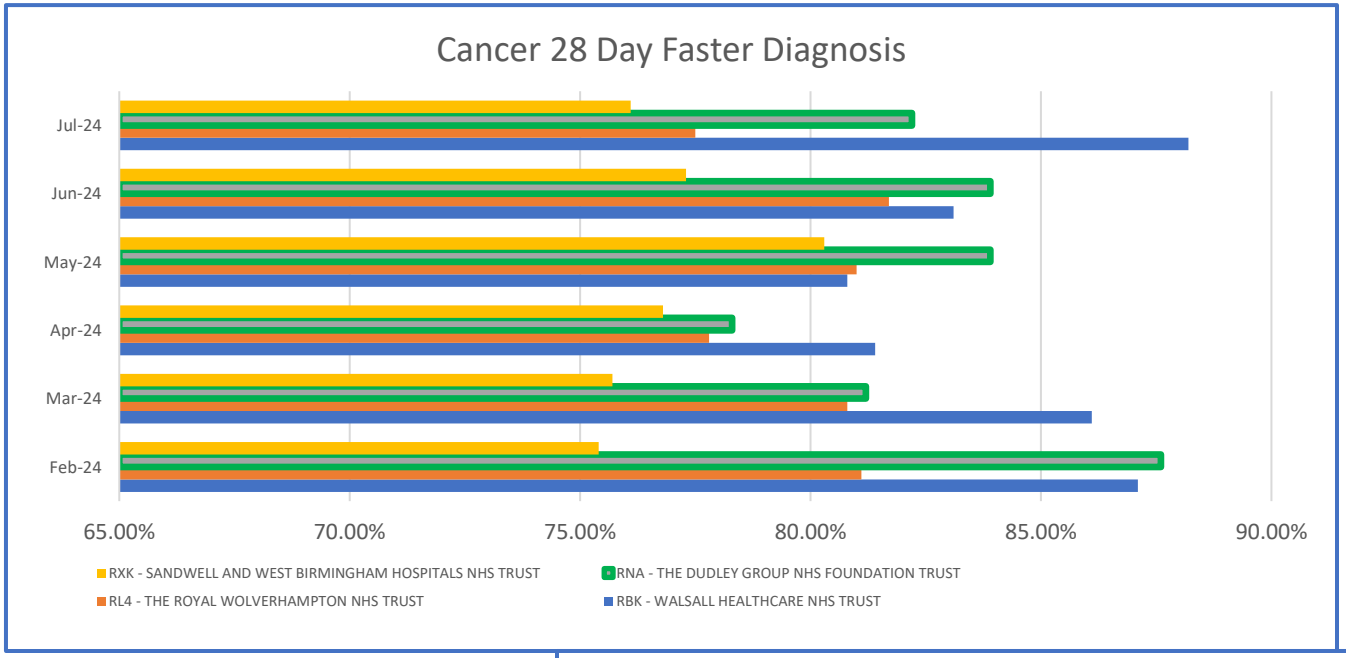
Following harm review, there were 0 patients for July (reported 2 months in arrears).

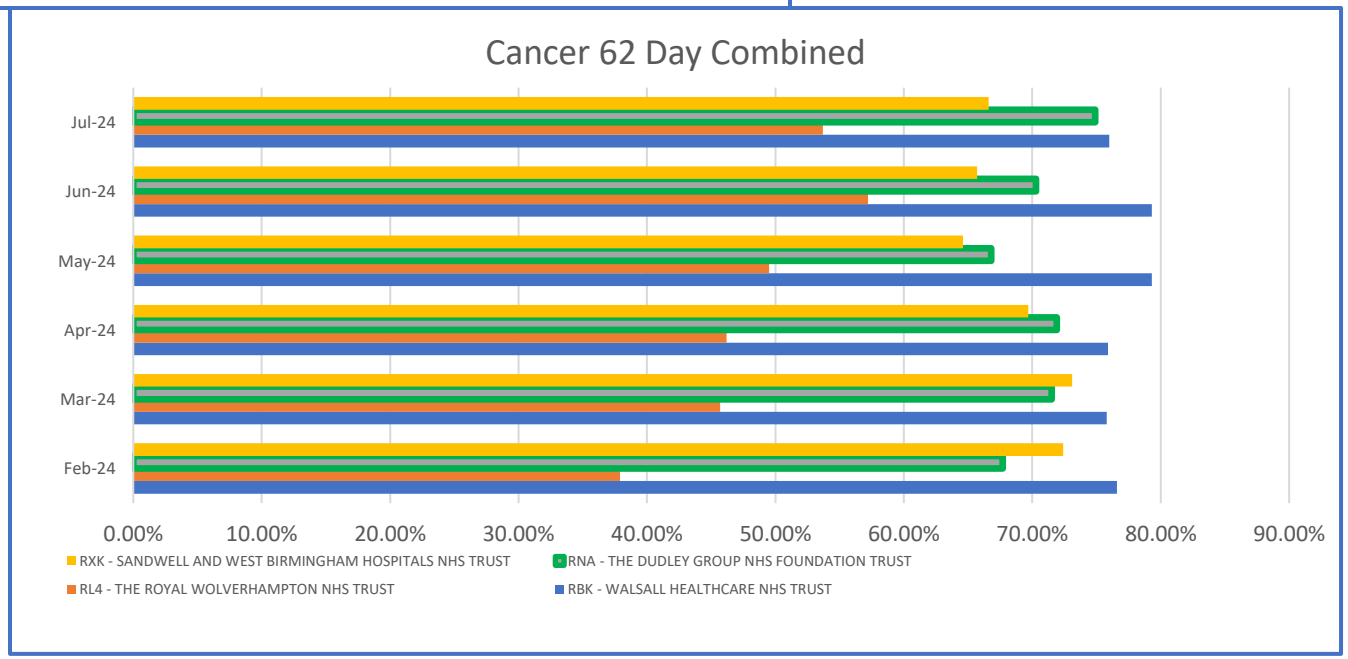
July we treated 21 patients waiting over 104 days at DGFT and tertiary centres

Action

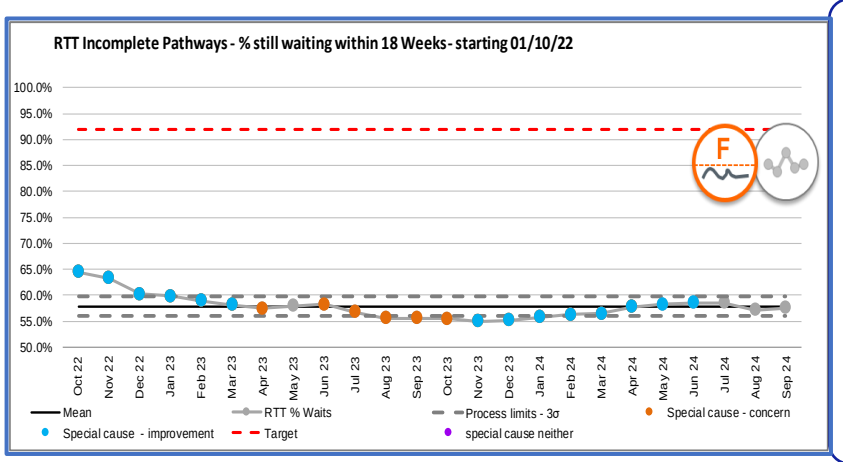
- Monthly harm review undertaken for patients waiting over 104 days on the cancer pathway.
- Focus on reducing the backlog of 104 day waits to release treatment capacity for 31 day and 62-day targets continues. Improve patient engagement earlier in the pathway.
- Renal work progressing with RWT.
- It is anticipated that actions taken to improve combined 62-day performance will support the reduction of patients waiting over 104 days.

Cancer Benchmarking





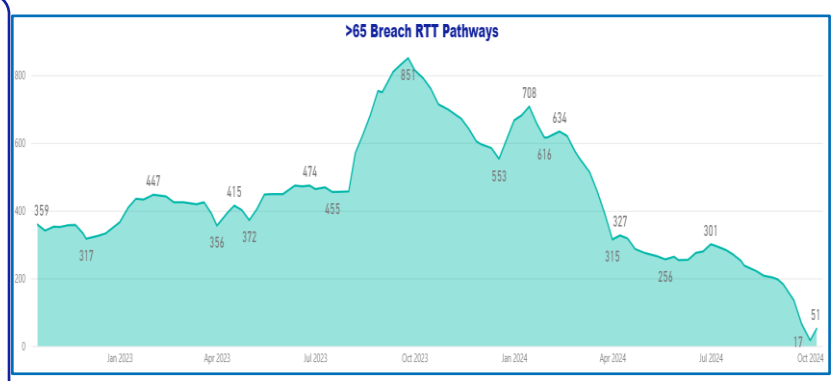
RTT Performance



Latest Month

57.5%

RTT Incomplete pathways target 92%



Taken from: RTT Incompletes - Post Validation Analysis - Power BI Report Server

Performance

September is the first month since November 2023 where the RTT performance has fallen slightly. The focus is on clearance of 65-week patients and also 52-week first outpatient appointments. As this clearance continues the RTT performance will again start to climb.

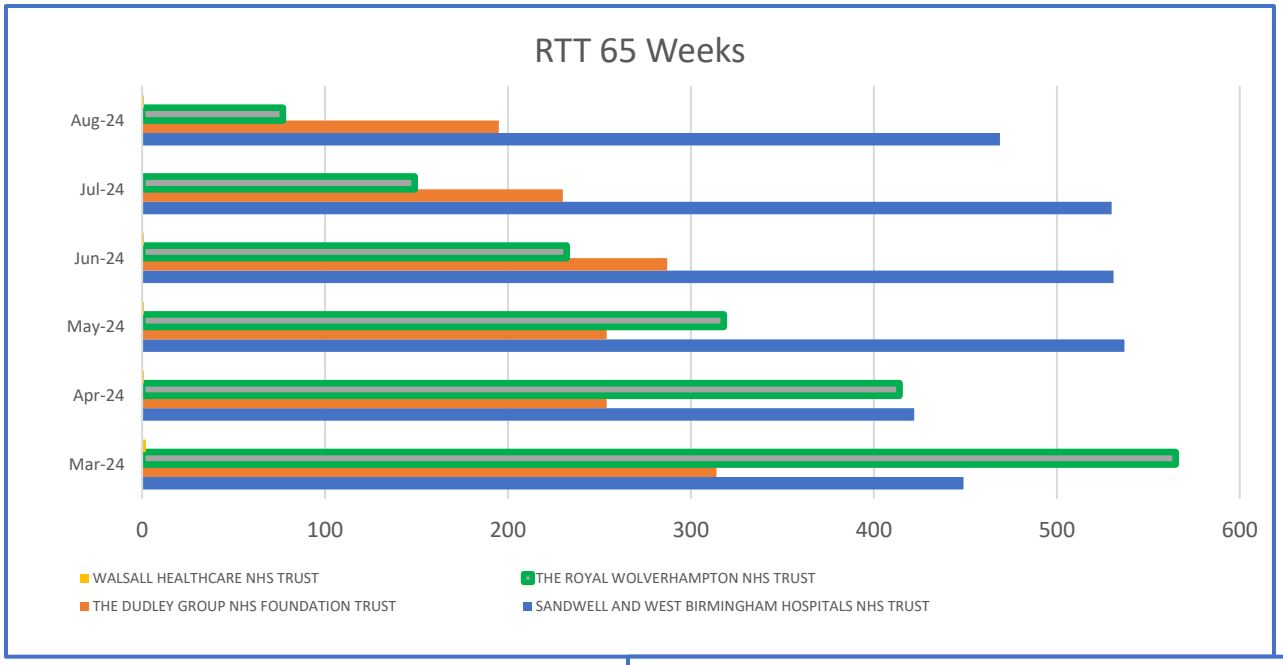
The trust continues to perform well against both the 78- and 65-week targets for both elective and outpatient procedures, acknowledging challenges particularly in General Surgery, Pain and Chemical Pathology. We are currently on track to deliver 65-week clearance at the end of October.

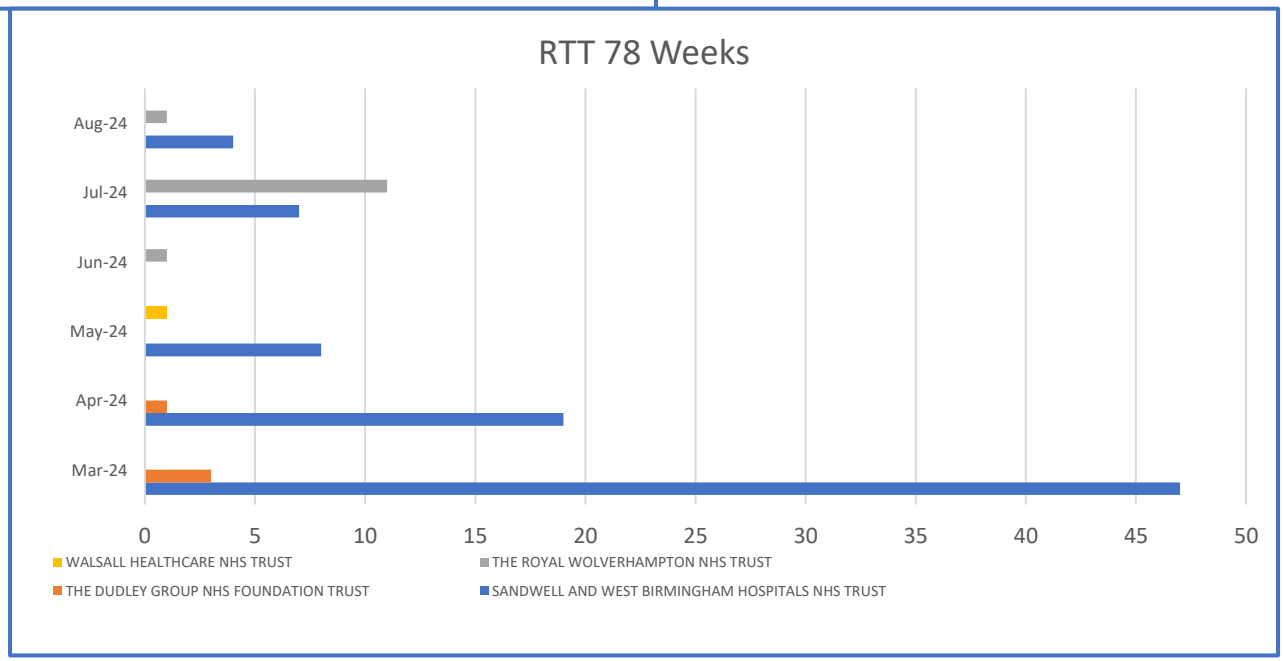
September RTT position 57.5% vs 92% national target, a continued improvement month on month

Action

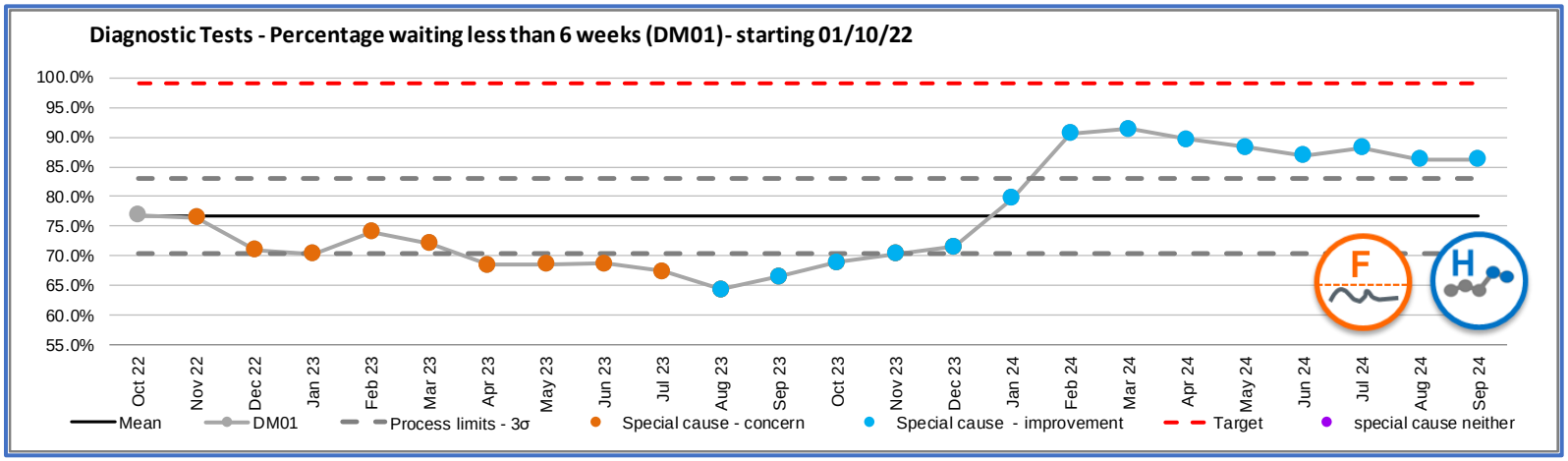
- Outsourcing to support Neurology and Dermatology. This has been extended in an attempt to increase the clearance towards 52 weeks..
- Continue to engage with the Further Faster Programme, a particular focus on Ophthalmology at present.
- With the 52-week target fast approaching in March 25 we are now looking to book all 52-week first outpatient appointments that would breach in March 25 by the end of November 24.

RTT Benchmarking





DM01 Performance



Latest Month

86.2%

DM01 combining 15 modalities - target 85%

Performance

September DM01 performance achieved 86.2% and is below trajectory.

CT, Dexa, Echo and Endoscopy are all performing above 90%.

Sleep Studies, Audiology and NOUS are most challenged areas. MRI has recently seen an increase in waits over 6 weeks.

Sleep studies performance is 53.5% in September. Due to change in NICCE guidance, demand now considerably outweighs capacity.

Audiology has improved from 65.96% to 75.39% in September.

NOUS in September is 86.2% and is impacted by ENT specialist scans. System mutual aid is provided to SWBH (600 slots a month).

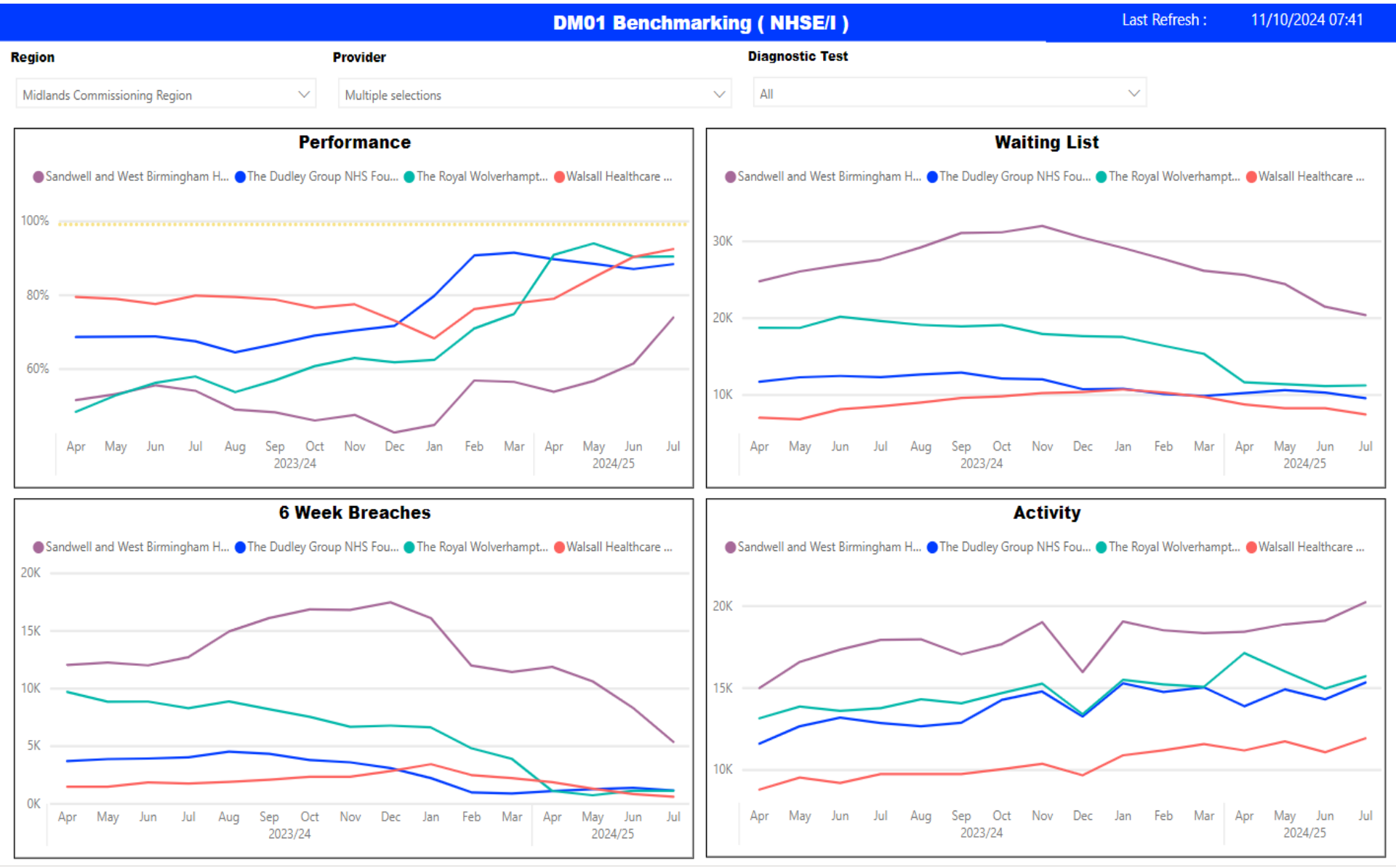
MRI is 88.06% in September. Long waits primarily for cardiac patients.

13-week diagnostic breaches monitored weekly by NHSE. DMO1 for September shows 132 patients waiting over 13 weeks. This is a reduction compared to 151 in August. Of the 132 patients, longest waits are MRI (56 breaches) and NOUS (64 breaches)

Action

- Recovery plan to improve sleep studies using bank shifts has been impacted by low staff uptake. Respiratory CDC from January 2025 is in development and recruitment is underway.
- 2 Audiology vacancies (1.68 wte) filled in August and staff now in post. Both staff are new/recent graduates and require training (approx. 3 months) before they can see patients autonomously. Plan to recover in December.
- NOUS performance impacted primarily by head and neck and gynae. Additional provision being sourced for head and neck and increased staffing in gynae will provide extra capacity. Plan revised to achieve 90% from November.
- All Trusts in the Black Country ICS have Cardiac MRI pressures. System mutual aid first requested in July 2024 and not yet successful. Recent offer from RWT is in progress with planned start date in November (to be confirmed).

DM01 Benchmarking



Source: [Imaging Cardiology CRIS Dashboard - Power BI]

Kitemark Explanation

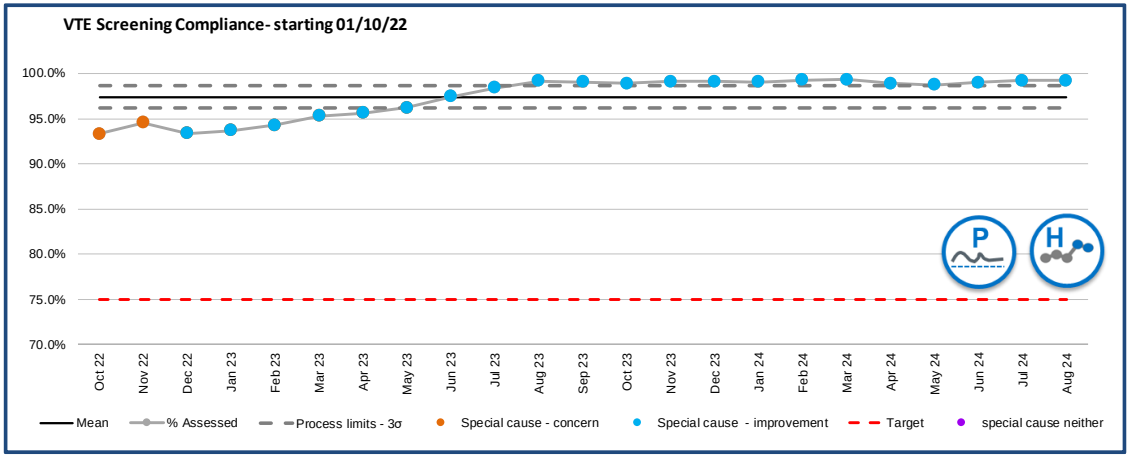
Element	Definition
Timeliness	The time taken between the end of the data period and when the information can be produced and reviewed. The acceptable data lag will be different for different performance indicators. Data should be captured as quickly as possible after the event or activity and must be 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

VTE Performance Please note: VTE figures now run 1 month in arrears



Latest Month	Latest Month	Latest Month
99.1%	99.3%	99.1%
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	

The Dudley Group NHS Foundation Trust

Paper for submission to Trust Board – 14th November 2024.

Report title:	National CQC Adult Inpatient Survey 2023.
Sponsoring executive:	Martina Morris, Chief Nurse and Director of IPC
Report author:	Jill Faulkner, Head of Patient Experience Tracy Cross, Patient Experience and Engagement Lead

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

Assure

- The results demonstrate an improved picture in comparison to the 2022 survey, both historically and when benchmarked against other Trusts nationally.
- There are no questions that have performed significantly worse in 2023, which is an improvement since the 2022 where six question were performing worse in comparison to the previous year's survey (2021).
- There are two questions that are performing 'significantly better' in 2023; for patients feeling that there were enough nurses on duty and knowing who to contact about any worries about their care and treatment after leaving hospital.
- There has been an improvement in the expected range scores with all section scores performing 'about the same' as trusts nationally, in comparison to five sections that were performing 'worse' and two sections that were 'somewhat worse' than the average of Trusts surveyed in 2022.
- There are fewer sections that sit in the bottom 5 trusts within the region in comparison to the 2022 survey.
- Scores for eight out of 11 sections have seen an increase since the previous survey. Scores for 'feedback on your quality of care' demonstrates the most improved score.
- Patients feeling that they were treated with respect and dignity was the highest scoring section overall at 9.1 (in comparison to 8.8 in 2022), a recurring theme from the previous year. The scores for overall experience have seen an improvement from the previous year from 7.8 in 2022 to 8.1 in 2023.
- There has been an improvement in the number of questions that are performing 'about the same' as other trusts nationally with 44 out of 49 questions that are performing 'about the same' in comparison to 21 out of 45 in 2022.

Advise

- There are three out of 11 sections (admission to hospital, nurses, and care and treatment) that are scoring in the bottom five in comparison to Trusts in the region who provide care to similar size populations.

- Two sections have decreased (the hospital and ward, and operations and procedures). Scores for operations and procedures show the biggest decline in 2023.

Alert

- A small number of questions within each section are performing below the range expected of the average of Trusts surveyed. Patients being given enough notice of discharge and being provided with information on what they should or should not do after leaving hospital are recurring themes from the 2022 survey. Patients being able to take their own medication, has been a continuing negative theme since 2020.

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	
Drive sustainability (financial and environmental)	
Build innovative partnerships in Dudley and beyond	
Improve health and wellbeing	

3. Report journey
Patient Experience Group – November 2024. Executive Team – November 2024.

4. Recommendation(s)
The Public Trust Board are asked to:
To receive the management report results for the National CQC Adult Inpatient Survey 2023 and note the performance when benchmarked against other Trusts surveyed. The Patient Experience Group will receive an action plan and monitor progress.

5. Impact		
Board Assurance Framework Risk 1.1	X	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
Is Quality Impact Assessment required if so, add date: N/A		
Is Equality Impact Assessment required if so, add date: N/A		

REPORT FOR ASSURANCE

National CQC Adult Inpatient Survey 2023.

1 EXECUTIVE SUMMARY

This report provides a summary of the findings from the National CQC Adult Inpatient Survey 2023 which was published 21 August 2024. Trusts sampled patients who met the eligibility criteria and were discharged from hospital during November 2023. Trusts counted back from the last day of November 2023, sampling every consecutively discharged patient until they had selected 1,250 patients. Fieldwork took place between January and April 2024.

The report benchmarks our performance against trusts nationally based on the 'expected range' to determine if the Trust is performing about the same, better, or worse compared with most other trusts.

Responses were received from 455 patients at The Dudley Group NHS Foundation Trust (41%). This is an improvement from the 2022 survey 38%. This compares with an average response rate of 42%.

Respondent Demographics

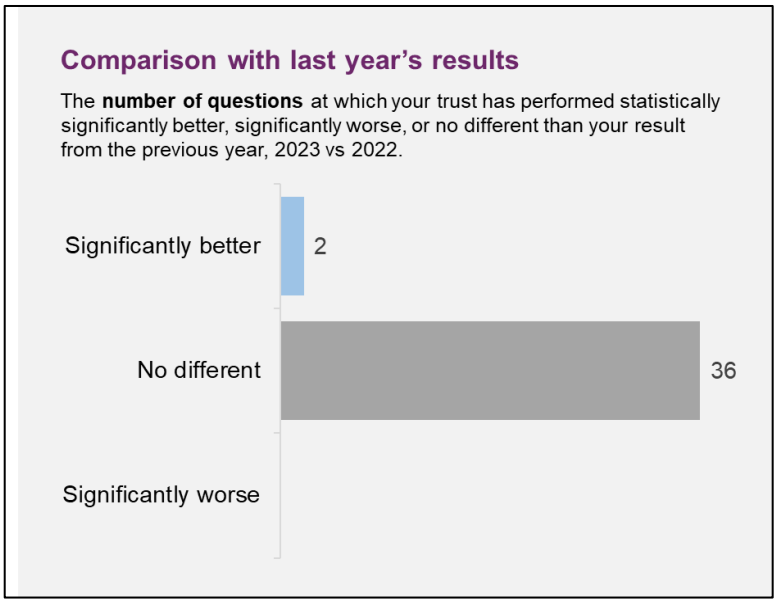
The highest number of respondents by age was over 66 at 67%. The lowest number of respondents were from the 16-35 (4%) and the 36-50 (8%) age groups. 91% of respondents were white, 47% were male/53% female and 87% of respondents said they had a long-term condition.

2 BACKGROUND INFORMATION

Headline results and benchmarking

Historical Comparison

As shown on the table below, there are no questions that have performed significantly worse in 2023 (in comparison to six questions in 2022).



There are two questions that are performing 'significantly better' in 2023:

1. Q23. In your opinion, were there enough nurses on duty to care for you in hospital? (7.0 in 2023 compared to 6.5 in 2022).
2. Q43. Did hospital staff tell you who to contact if you were worried about your condition or treatment after you left hospital? (7.3 in 2023 in comparison to 6.6 in 2022).

Comparison with other trusts

The table below demonstrates an improved picture in comparison to the 2022 survey. All section scores are performing 'about the same' as the average of Trusts surveyed (in comparison to five sections that were performing 'worse' than the average of Trusts surveyed and two sections that were 'somewhat worse' in the 2022 survey). There are three out of 11 sections that are scoring in the bottom five in comparison to Trusts in the region (compared to 9 out of 10 questions in 2022), demonstrating an improvement.

Scores for eight out of 11 sections have seen an increase since the previous survey. Two sections have decreased (the hospital and ward, and operations and procedures). Scores for operations and procedures show the biggest decline from 8.0 2022 to 6.8 in 2023, however this score was previously performing 'somewhat worse than expected' and the Trust was in the bottom five regionally. Scores for 'feedback on your quality of care' demonstrates the most improved score.

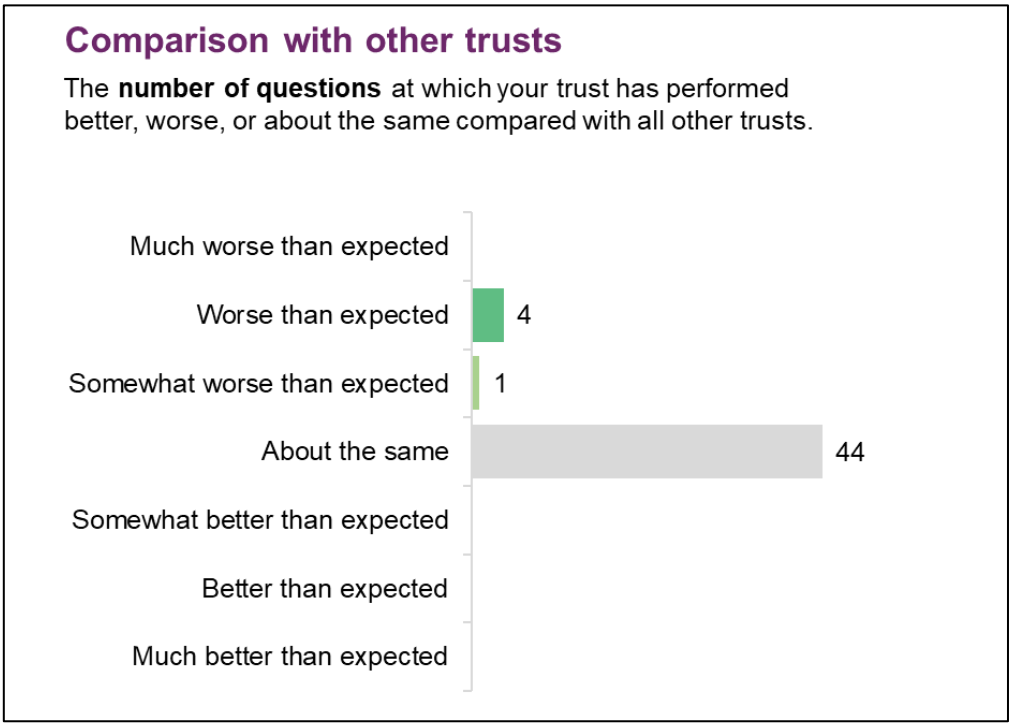
Patients feeling that they were treated with respect and dignity was the highest scoring section overall at 9.1 (in comparison to 8.8 in 2022), a recurring theme from the previous year. The scores for overall experience have seen an improvement from the previous year from 7.8 in 2022 to 8.1 in 2023.

Section number	Section Title	Score 2023	Expected Range 2023	Score 2022	Expected Range 2022	Score 2021	Expected Range 2021
1	**Admission to hospital**	**6.6**	**About the same** (*Bottom 5 regionally)*	**6.4**	**About the same** *(Bottom 5 regionally)*	**6.5**	**About the same**
2	**The hospital and ward**	**7.3**	**About the same**	**7.4**	**About the same** (*Bottom 5 regionally)*	**7.4**	**About the same**
3	**Doctors**	**8.5**	**About the same**	**8.3**	**Worse than expected** (*Bottom 5 regionally)*	**8.4**	**Somewhat worse than expected**
4	**Nurses**	**8.1**	**About the same** (*Bottom 5 regionally)*	**7.9**	**Worse than expected** (*Bottom 5 regionally)*	**8.1**	**About the same**

5	**Care and treatment**	**7.9**	**About the same** (*Bottom 5 regionally*)	**7.7**	**Worse than expected** (*Bottom 5 regionally*)	**7.7**	**About the same**
6	**Operations and procedures**	**6.8**	**About the same**	**8.0**	**Somewhat worse than expected.** (*Bottom 5 regionally*)	**7.8**	**About the same**
7	**Leaving Hospital**	**6.6**	**About the same**	**6.5**	**Worse than expected** (*Bottom 5 regionally*)	**7.0**	**About the same**
8	**Feedback on the quality of your care**	**2.7**	**About the same**	**1.5**	**About the same**	**1.4**	**About the same**
9	**Kindness and Compassion**	**8.8**	**About the same**	**N/A**	**N/A**	**N/A**	**N/A**
10	**Respect and dignity**	**9.1**	**About the same**	**8.8**	**Somewhat worse than expected** (*Bottom 5 regionally*)	**8.8**	**About the same**
11	**Overall experience**	**8.1**	**About the same**	**7.8**	**About the same** (*Bottom 5 regionally*)	**8.0**	**About the same**

As shown in the table below there are four questions that are performing ‘worse than expected’ in 2023 (in comparison to 14 in 2022), an improvement from the previous survey. One question is performing ‘somewhat worse than expected’ in 2023 (in comparison to nine in 2022).

There are no questions that are ‘much worse than expected’ in comparison to one in 2023 for pain management which was a recurring negative theme since 2021. This is score has seen an improvement from 8.2 in 2022 to 8.6 in 2023 and is now performing ‘about the same’ as the average of Trusts nationally. There has been an improvement in the number of questions that performing ‘about the same’ as other trusts nationally with 44 out of 49 questions that are performing ‘about the same’ as in comparison to 21 out of 45 in 2022).



A small number of questions within each section are performing 'somewhat worse than expected/worse than expected' in comparison to the average of Trusts surveyed. There are three out of four questions that are themes from previous surveys:

Much worse than expected	Worse than expected
• No questions fall within this banding.	1. Q11. If you brought medication with you to hospital, were you able to take it when you needed to? (*Recurring theme from 2022/ 2021/2020 surveys)* 2. Q31. Did the hospital staff take into account your existing individual needs? 3. Q38. Were you given enough notice about when you were going to leave hospital? *(recurring theme since 2022).* 4. Q39. Before you left hospital, were you given any information about what you should or should not do after leaving hospital? *(recurring theme since 2022).*
Somewhat worse than expected	**Somewhat better than expected**
1. Q41. Thinking about any medicine you were to take at home, were you given any of the following?	• No questions fall within this banding.
Better than expected	**Much better than expected**

• No questions fall within this banding.	• No questions fall within this banding.

Best and worst performance relative to the trust average

The top results for the Trust that are highest compared with the average of all Trusts are as follows:

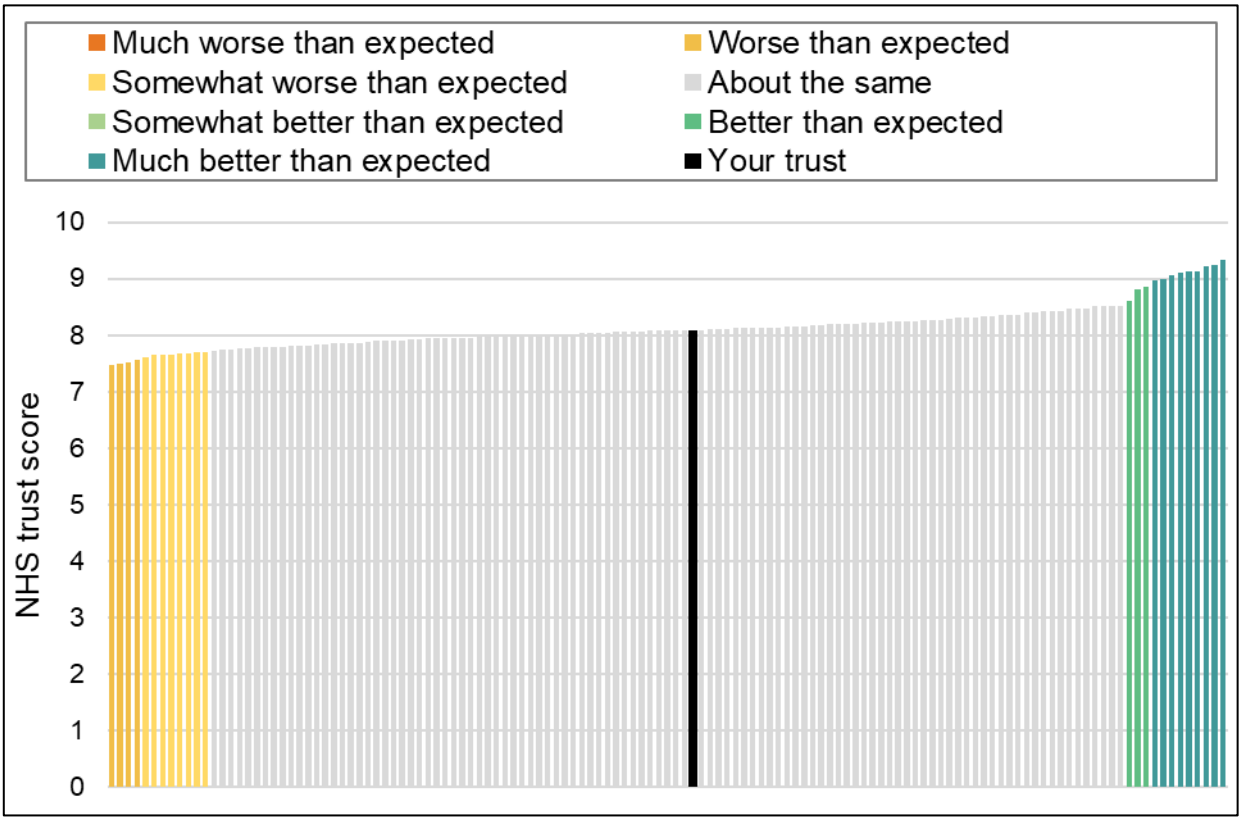
1. Q46. After leaving hospital, did you get enough support from health or social care services to help you recover or manage your condition?
2. Q6_4. Were you ever prevented from sleeping at night by any of the following? Hospital lighting.
3. Q9. How clean was the hospital room or ward that you were in?
4. Q44. Did hospital staff discuss with you whether you may need any further health or social care services after leaving hospital?
5. Q28. Were you given enough privacy when being examined or treated?

The bottom five scores for the trust that are lowest when compared with the average of all trusts where patient experience could be improved:

1. Q11. If you brought medication with you to hospital, were you able to take it when you needed to?
2. Q15. Were you able to get hospital food outside of set mealtimes?
3. Q50. During your hospital stay, were you ever given the opportunity to give our views on the quality of your care?
4. Q39. Before you left hospital, were you given any information about what you should or should not do after leaving hospital?
5. Q38. Were you given enough notice about when you were going to leave hospital?

Overall Patient experience Score (OPES)

The Overall Patient Experience Score (OPES) ranged from the lowest score in England of 7.4 to the highest trust score in England of 9.2. The Trust score for 2023 is 8.1, an improvement since 2022 (7.8) and is performing ‘about the same’ when compared to all other trusts.



National Picture

Results show that people's experiences of inpatient care have deteriorated since 2020. The results for the 2023 survey remain generally consistent with 2022 and 2021 following significant declines for almost all questions in the 2021 survey compared with 2020.

Most respondents reported a positive experience in their interactions with doctors and nurses, such as being treated with respect, dignity, kindness and compassion and being included in conversations, generally remaining consistent with the previous year, although those receiving clear answers to questions and having confidence and trust has decreased slightly. These findings are in line with the Trust results.

Discharge from hospital remains a challenging part of people's experiences of care. Fewer respondents felt involved in decisions about their discharge from hospital, with less than half feeling they were given enough notice before being discharged. These findings are in line with the Trust results.

3. RISKS AND MITIGATIONS

There are three out of 11 sections (admission to hospital, nurses, and care and treatment) that are scoring in the bottom five in comparison to Trusts in the region who provide care to similar size populations.

Two sections have decreased (the hospital and ward, and operations and procedures). Scores for operations and procedures show the biggest decline in 2023. However, this score was previously performing 'somewhat worse than expected' and the Trust was in the bottom five regionally in the 2022 survey.

There are four questions that are performing ‘worse than expected’ in 2023 (in comparison to 14 in 2022). One question is performing ‘somewhat worse than expected’ in 2023 (in comparison to nine in 2022).

A small number of questions within each section are performing below the range expected of the average of trusts surveyed. Patients being given enough notice of discharge and being provided with information on what they should or should not do after leaving hospital are recurring themes from the 2022 survey. Patients being able to take their own medication, has been a continuing negative theme since 2020.

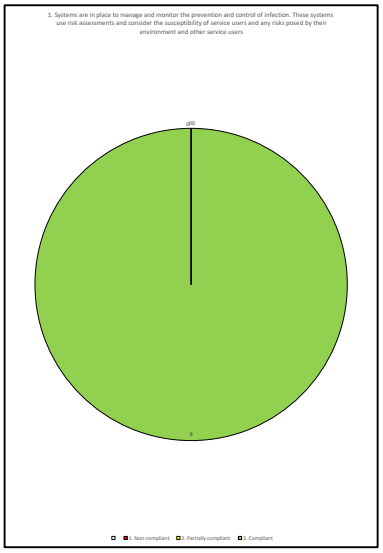
Results will be shared with the directors/operational and divisional leads and an action plan of areas for improvement to be agreed and finalised. The Patient Experience Group will monitor the improvement plan and progress of assigned actions.

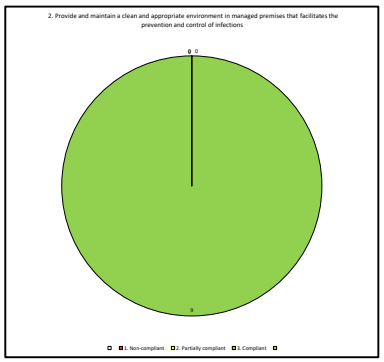
4. RECOMMENDATION(S)

To receive the NHS Adult Inpatient Survey 2023 Benchmark Report and note the performance when benchmarked against other trusts surveyed. The Patient Experience Group will receive an action plan and monitor improvements. The Patient Experience Team are in the process of contacting the best performing trusts to understand what we could learn from them to continue improving.

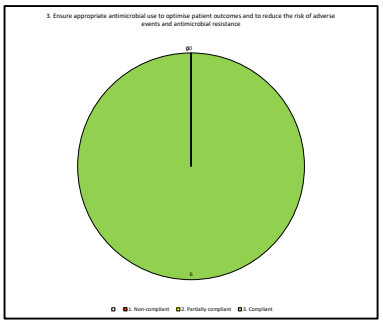
Infection Prevention and Control board assurance framework 2024/2025 v1.3

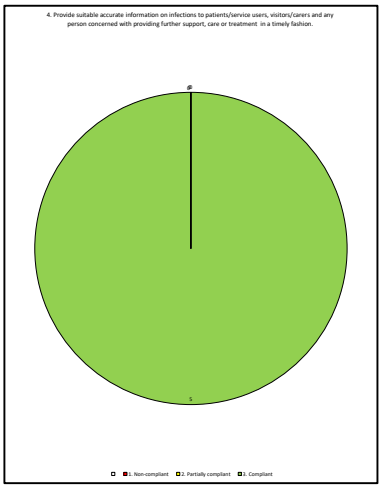
	Key Lines of Enquiry	Evidence	Gaps in Assurance	Mitigating Actions	Comments	Compliance rating
1. Systems to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of service users and any risks their environment and other users may pose to them						
Organisational or board systems and process should be in place to ensure that:						
1.1	There is a governance structure, which as a minimum should include an IPC committee or equivalent, including a Director of Infection Prevention and Control (DIPC) and an IPC lead, ensuring roles and responsibilities are clearly defined with clear lines of accountability to the IPC team.	The Trust has both a DIPC and Deputy DIPC in post. There is an IPC and Decontamination Lead in post. There is a clearly defined structure with clear accountability IPCG meeting meetings monthly with TOR agreed annually.				3. Compliant
1.2	There is monitoring and reporting of infections with appropriate governance structures to mitigate the risk of infection transmission.	HCAI data is reported to IPCG, Quality Committee, CQRM, IPR and in the Chief Nurse and Medical Director report. Divisions report into IPCG All outbreaks are reported internally and externally to UK HSA, ICB, and NSHE. There is an IPC Governance structure in place from IPCG Meeting to Public Board via Quality Committee. HCAI data is presented to external partners e.g. UK HSA, ICB, Dudley and Walsall Place and Dudley Metropolitan Council.				3. Compliant
1.3	That there is a culture that promotes incident reporting, including near misses, while focusing on improving systemic failures and encouraging safe working practises, that is, that any workplace risk(s) are mitigated maximally for everyone.	DATIX reporting is encouraged. There is a Freedom to Speak up Guardian in place. There are separate DATIX streams for IPC and Decontamination incidents to be reported and actioned. Health and Safety and Staff Health and Wellbeing attend IPCG. Decontamination incidents are raised at the Sterile Services and Decontamination Meetings. Meeting minutes available. Incidents are included in IPCG reporting.				3. Compliant
1.4	They implement, monitor, and report adherence to the NIPCM.	An IPC programme of audit is detailed in the IPC Annual Programme. Audits are recorded on Amat and monitored via the IPCG meeting and Chief Nurse and Medical Director reports to Board. IPC Audit tools are fluid documents and are reviewed annually and updated as required. IPCG minutes detail audit scores. Meeting minutes are available				3. Compliant
1.5	They undertake surveillance (mandatory infectious agents as a minimum) to ensure identification, monitoring, and reporting of incidents/outbreaks with an associated action plan agreed at or with oversight at board level.	HCAI data is reported to IPCG, CQRM, Q committee and IPR. Divisions report into IPCG All outbreaks are reported internally and externally to UK HSA, ICB and NSHE. There is an IPC Governance structure in place from IPCG Meeting to Public Board via Quality Committee SSI data is recorded and uploaded to UK HSA database				3. Compliant
1.6	Systems and resources are available to implement and monitor compliance with infection prevention and control as outlined in the responsibilities section of the NIPCM.	An IPC programme of audit is detailed in the IPC Annual Programme. A audits are recorded on Amat. Audit scores are monitored via the IPCG meeting reports.				3. Compliant
1.7	All staff receive the required training commensurate with their duties to minimise the risks of infection transmission.	IPC Training for both clinical and non-clinical staff is available via e-learning following the Health Education England programme. IPC induction training is delivered face to face. Bespoke training is delivered where required. IPC mandatory training data is reported via IPCG meetings and divisional reports.				3. Compliant
1.8	There is support in clinical areas to undertake a local dynamic risk assessment based on the hierarchy of controls to prevent/reduce or control infection transmission and provide mitigations. [primary care, community care and outpatient settings, acute inpatient areas, and primary and community care dental settings]	Risk assessments are available for use. Policies and procedures are developed to facilitate autonomy. IPC Doctor is on call out of ours for advice and support. IPC team attends daily site meetings A weekend plan with IPC is developed on a Friday and available to site and capacity A winter plan has been developed Policies, procedures, SOP, pathways and guidance is available via the Hub				3. Compliant
2. Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections						
System and process are in place to ensure that:						
2.1	There is evidence of compliance with National cleanliness standards including monitoring and mitigations (**excludes some settings e.g. ambulance, primary care/dental unless part of the NHS standard contract** these setting will have locally agreed processes in place).	Decontamination of the Environment Policy incorporating the National standards of Cleanliness adopted April 2022 Cleanliness audits completed and presented at IPCG Stars on the doors are displayed on the entrances to area There is a Minuted Cleaning meeting with PFI partners Cleaning is increased during an outbreak of infection			September 2024. A project is underway to review our cleaning FR ratings and cleaning contract against the national specification with an external agency. The cleaning and decontamination of the environment policy is also being review to reflect any changes to ratings.	3. Compliant
2.2	There is an annual programme of Patient-Led Assessments of the Care Environment (PLACE) visits and completion of action plans monitored by the board.	IPC audits and Quality walk rounds are recorded on AMAT. PLACE visits completed November 2023				3. Compliant
2.3	There are clear guidelines to identify roles and responsibilities for maintaining a clean environment (including patient care equipment) in line with the national cleanliness standards.	Cleaning is outsourced to PFI partners. Cleanliness audits and scores on the doors are produced Mitie follow the Trust's Decontamination of the Environment policy			September 2024. A project is underway to review our cleaning FR ratings and cleaning contract against the national specification with an external agency. The cleaning and decontamination of the environment policy is also being review to reflect any changes to ratings.	3. Compliant
2.4	There is monitoring and reporting of water and ventilation safety, this must include a water and ventilation safety group and plan. **2.4.1** Ventilation systems are appropriate and evidence of regular ventilation assessments in compliance with the regulations set out in HTM:03-01. **2.4.2** Water safety plans are in place for addressing all actions highlighted from water safety risk assessments in compliance with the regulations set out in HTM:04-01.	Ventilation The Trust has a ventilation group with PFI partners Mitie has an appointed authorising engineer for Ventilation Mitie undertake PPM and ventilation audits which are reported to the Ventilation Group Water The Trust has a Water Safety Plan and policies and procedures The Trust has a water safety group with PFI partners Mitie has an appointed authorising engineer for water Flushing, sampling regimes and results are reported to the Water Safety group The trust has trained competent appointed responsible persons for water. The above meetings report to IPCG				3. Compliant
2.5	There is evidence of a programme of planned preventative maintenance for buildings and care environments and IPC involvement in the development new builds or refurbishments to ensure the estate is fit for purpose in compliance with the recommendations set out in HBN:00-09.	Maintenance Controls 1.1 year and 5 year Maintenance Programme issued annually 2.Asset condition survey 3.Trust Helpdesk for reporting issues 4.Monthly Report to demonstrate compliance 5.Trust Monitoring Team for compliance Maintenance Improvements 1.Mitie/Summit to revisit asset lists 2.New CAFM system being implemented 3.Improved self-reporting for non-performance of PPMs IPC Capital Schemes Controls 1.Trust interface for small works and capital projects 2.Trust Policy for IPC in capital schemes 3.Schemes shared with IPC for comment (larger schemes) IPC Capital Schemes improvements 1.Full implementation of IPC policy for capital schemes 2.Trust to gain IPC sign off for designs 3.Trust to develop a Capital Works Policy 4.RE Water and Ventilation to sign off design and commissioning				3. Compliant
2.6	The storage, supply and provision of linen and laundry are appropriate for the level and type of care delivered and compliant with the recommendations set out in HTM:01-04 and the NIPCM.	Linen and laundry are supplied by Mitie via a PFI contract. Laundry is supplied and processed via a contract with Elis and duty of Care assurance visits are undertaken with the Trust and Mitie. Items are also laundered on site in a laundry operated by Mitie with is regularly audited but the Trust. Microbiological sampling on the laundry is also undertaken. These are reported to IPCG for assurance.				3. Compliant
2.7	The classification, segregation, storage etc of healthcare waste is consistent with HTM:07-01 which contains the regulatory waste management guidance for all health and care settings (NHS and non-NHS) in England and Wales including waste classification, segregation, storage, packaging, transport, treatment, and disposal.	Healthcare waste at the segregation of waste is provided by our PFI partner Mitie. A PFI partner waste group meets monthly. Waste segregation is included on the IPC induction and IPC training programmes. Waste is included on the estates report to IPCG Duty of Care visits are undertaken with the Trust and PFI partners to outside contractors including Tradebe, Elis, Biffa and Sharpsmart.				3. Compliant

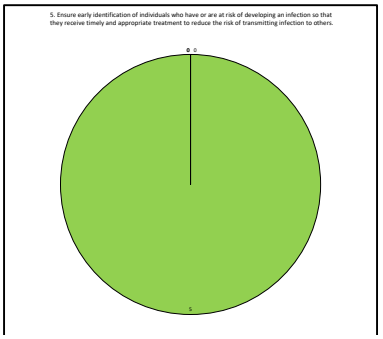




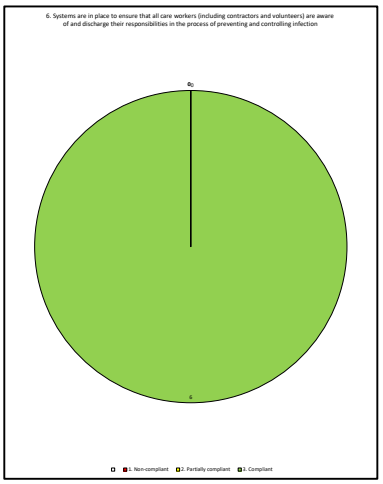
2.8	There is evidence of compliance and monitoring of decontamination processes for reusable devices/surgical instruments as set out in HTM 01-01, HTM 01-05, and HTM 01-06.	Standard infection precautions policy available on the Hub I am clean stickers are in use throughout the Trust Decontamination policy updated September 2022 available on the Hub Reusable non-invasive medical devices are decontaminated using universal wipes or Chlorine releasing agent in line with Trust policy and/or manufactures instructions. Sterile Services follow the HTM 01-01 guidelines. Sterile Services policies and procedures are audited internally and then followed through with our External Approved Body SGS annually. Decontamination programme of audit in place PAQ enquiries are completed with Procurement, EBME and the IPC teams prior to the purchasing of equipment to ensure it can be decontaminated New products are approved via the Trusts Clinical Product Evaluation Group.				3. Compliant
2.9	Food hygiene training is commensurate with the duties of staff **as per food hygiene regulations**. If food is brought into the care setting by a patient/service user, family/carer or staff this must be stored in line with food hygiene regulations.	Food hygiene training is undertaken by staff and recorded in ESR. Trust Staff have access to Food Hygiene Basics for Nursing and core staff. Food hygiene regulations. Food hygiene slide incorporated in IPC mandatory training				3. Compliant
3. Ensure appropriate antimicrobial stewardship to optimise service user outcomes and to reduce the risk of adverse events and antimicrobial resistance						
Systems and process are in place to ensure that:						
3.1	If antimicrobial prescribing is indicated, arrangements for antimicrobial stewardship (AMS) are maintained and where appropriate a formal lead for AMS is nominated.	AMS Group in place with AMS lead for the Trust and antimicrobial stewardship principles are implemented throughout the Trust. AMS is reported via the AMS lead attending IPCG				3. Compliant
3.2	The board receives a formal report on antimicrobial stewardship activities annually which includes the organisation's progress with achieving the UK AMR National Action Plan goals.	A formal report goes to board via medicines management group which covers AMS activities, achievements and risks. It is also included in annual IPC report to the board.				3. Compliant
3.3	There is an executive on the board with responsibility for antimicrobial stewardship (AMS), as set out in the UK AMR National Action Plan.	Chief Nurse is the executive on the board with responsibility for AMS. Chief Nurse is also the Director of infection prevention and Control.				3. Compliant
3.4	NICE Guideline NG15 'Antimicrobial Stewardship: systems and processes for effective antimicrobial medicine use' or Treat Antibiotics Responsibly, Guidance, Education, Tools (TARGET) are implemented and adherence to the use of antimicrobials is managed and monitored: •to optimise patient outcomes. •to minimise inappropriate prescribing. •to ensure the principles of Start Smart, Then Focus are followed.	The principles of Antimicrobial stewardship are embedded and tools, processes and support is available for effective antimicrobial use. NICE NG15 baseline assessment completed. AMS ward rounds across identified areas for support. AMS teaching sessions to Pharmacists, Drs and Nurses. AMS quality improvement projects. And effective monitoring system around antimicrobial consumption as a whole.				3. Compliant
3.5	Contractual reporting requirements are adhered to, progress with incentive and performance improvement schemes relating to AMR are reported to the board where relevant, and boards continue to maintain oversight of key performance indicators for prescribing, including: •Total antimicrobial prescribing. •Broad-spectrum prescribing. •Intravenous route prescribing. •Treatment course length.	All contractual reporting requirements are met and reports sent to Drugs and therapeutics Group, Medicines management Group and IPC Group which are then sent to Quality Committee and highlights presented to board.				3. Compliant
3.6	Resources are in place to support and measure adherence to good practice and quality improvement in AMS. This must include all care areas and staff (permanent, flexible, agency, and external contractors)	AMS team. Electronic prescribing aids (72 hours review) Micro guide (Trusts antibiotic guidelines) and induction sessions on antimicrobial stewardship. The Trust has adopted and promotes the IV to oral Switch.				3. Compliant
4. Provide suitable accurate information on infections to patients/service users, visitors/carers and any person concerned with providing further support, care or treatment nursing/medical in a timely fashion						
Systems and processes are in place to ensure that:						
4.1	Information is developed with local service user representative organisations, which should recognise and reflect local population demographics, diversity, inclusion, and health and care needs.	Patient facing information available on the Trust web site Patient leaflets available on the Trust website, different languages are available Interpreter service available DDIPC attends Dudley Health Board meetings DDIPC attends system IPC meetings chaired by the ICB DDIPC attended system health protection and promotion meetings with Walsall Place Updates and alerts received from NHSE, UK HSA are disseminated Meetings attended with NHSE weekly updates				3. Compliant
4.2	Information is appropriate to the target audience, remains accurate and up to date, is provided in a timely manner and is easily accessible in a range of formats (e.g. digital and paper) and platforms, taking account of the communication needs of the patient/service user/care giver/visitor/advocate.	Leaflets are reviewed annually and when guidance changes Paper and digital information is available Interpreter service is available PALS service available DDIPC attends Dudley Health Board meetings DDIPC attends system IPC meetings chaired by the ICB DDIPC attended system health protection and promotion meetings with Walsall Place Updates and alerts received from NHSE, UK HSA are disseminated				3. Compliant
4.3	The provision of information includes and supports general principles on the prevention and control of infection and antimicrobial resistance, setting out expectations and key aspects of the registered provider's policies on IPC and AMR.	Information is available on IPC and AMR. Information days are held at the Health Hub to promote AMR, Hand Hygiene and IPC weeks. Prescribing information available Micro guide is available to all staff IPC Policies and procedures available on the Hub CDI ward round held weekly with IPC and Pharmacy External partner CDI meetings attended Antimicrobial pharmacist attends IPCG AMR Systems meetings attended by IPC				3. Compliant
4.4	Roles and responsibilities of specific individuals, carers, visitors, and advocates when attending with or visiting patients/service users in care settings, are clearly outlined to support good standards of IPC and AMR and include: •Hand hygiene, respiratory hygiene, PPE (mask use if applicable) •Supporting patients/service users' awareness and involvement in the safe provision of care in relation to IPC (e.g. cleanliness) •Explanations of infections such as incident/outbreak management and action taken to prevent recurrence. •Provide published materials from national/local public health campaigns (e.g. AMR awareness/vaccination programmes/seasonal and respiratory infections) should be utilised to inform and improve the knowledge of patients/service users, care givers, visitors and advocates to minimise the risk of transmission of infections.	Supporting information available for visitors, patients and relatives, Patient leaflets and information available in paper or digital form. Interpreter available PALS service available Information available on hand hygiene, specific micro-organisms Hand hygiene provision at the entrance at the hospital and ward entrances, Information banners on entry to the building Information days are held at the Health Hub to promote AMR, Hand Hygiene and IPC weeks. Information available on fluid resistant and FFP3 surgical masks Clinical information given to patients documented in the patients notes or Sunrise				3. Compliant
4.5	Relevant information, including infectious status, invasive device passports/care plans, is provided across organisation boundaries to support safe and appropriate management of patients/service users.	Discharge documentation is completed Patients information is given on a need to know basis in line with IG procedures and governance				3. Compliant
5.Ensure early identification of individuals who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to others.						
Systems and processes are in place to ensure that patient placement decisions are in line with the NPCM:						
5.1	All patients/individuals are promptly assessed for infection and/or colonisation risk on arrival/transfer at the care area. Those who have, or are at risk of developing, an infection receive timely and appropriate treatment to reduce the risk of infection transmission.	As per policy patients are screened on admission or pre-admission and placed accordingly. Nursing documentation is completed on Sunrise Alerts are added to sunrise as prompts for infection and previous infection notification	Trust does not always have side rooms available Datix is completed if isolation cannot be accommodated Patient is isolated in the bay until suitable placement can be arranged.	Datix is completed if a patient cannot be isolated with 2 hours. Side room requests are escalated to site.		3. Compliant
5.2	Patients' infectious status should be continuously reviewed throughout their **stay/period of care**. This assessment should influence placement decisions in accordance with clinical/care need(s). If required, the patient is placed /isolated or cohorted accordingly whilst awaiting test results and documented in the patient's notes.	Patient is nursed in most appropriate place. If cannot be nursed in isolation then this is risk assessed and documented on Sunrise Isolation signs are available for protected and Source isolation Nursing notes are documented on Sunrise. Breaches in isolation times are reported via DATIX				3. Compliant
5.3	The infection status of the patient is communicated prior to transfer to the receiving organisation, department, or transferring services ensuring correct management/placement.	Discharge documentation is completed Patients information is given on a need to know basis in line with IG procedures and governance				3. Compliant
5.4	Signage is displayed prior to and on entry to all health and care settings instructing patients with respiratory symptoms to inform receiving reception staff, immediately on their arrival.	Notice and floor length banners are available at entrances to educate and remind patients and visitors. Social media is also used to advise visitors to the Trust				3. Compliant

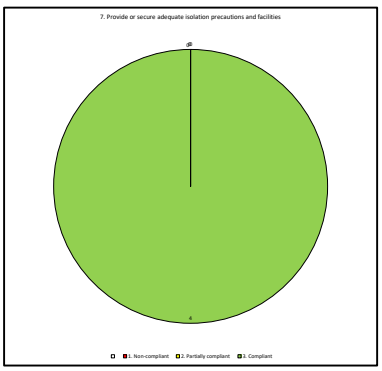


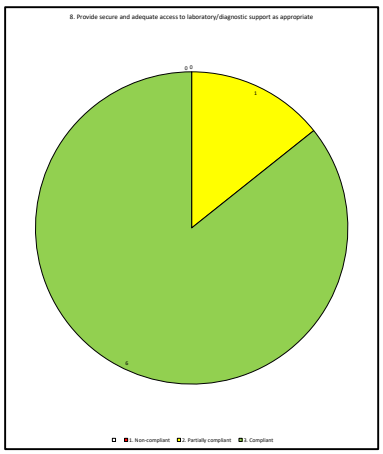


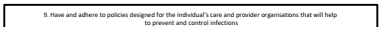


5.5	Two or more infection cases (or a single case of serious infection) linked by time, place, and person triggers an incident/outbreak investigation and this must be reported via governance reporting structures.	Outbreak policy available on the Hub Outbreak criteria reviewed and all potential outbreaks reviewed All outbreaks reported externally. Outbreaks reported to external partners including, NHSE,UK HSA and ICB Outbreak meetings held if required External partners invited to outbreak meetings			September 2024. Outbreak policy is currently under review. To be presented at the IPC Group on 2.10.24 for ratification and adoption.	3. Compliant
6. Systems are in place to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection						
Systems and processes are in place to ensure:						
6.1	Induction and mandatory training on IPC includes the key criteria (SICPs/TBPs) for preventing and controlling infection within the context of the care setting.	IPC induction training is face to face and includes information on HCAI, SIPC, PPE donning and doffing, single use and is community and acute focused. IPC training is developed to the Skills for Care Level 2 standard and includes waste, sharps and decontamination.				3. Compliant
6.2	The workforce is competent in IPC commensurate with roles and responsibilities.	Policies and procedures are available on the Hub IPC is included in staff job descriptions IPC training is mandatory Nursing staff complete annual hand hygiene assessments as part of the appraisal process.				3. Compliant
6.3	Monitoring compliance and update IPC training programs as required.	Notice and floor length banners are available at entrances to educate and remind patients and visitors.				3. Compliant
6.4	All identified staff are trained in the selection and use of personal protective equipment / respiratory protective equipment (PPE/RPE) appropriate for their place of work including how to safely put on and remove (donning and doffing) PPE and RPE.	PPE and Donning and doffing is included in mandatory face to face induction training. Information is available on the hub including NHSE/ UK HSA Donning and doffing video IPC information is provided to contractors attending site to undertake work. The trust has train the trainer session for FFP3 fit testing and regular sessions for fit testing are held throughout the Trust. Videos detailing donning and doffing are available on the Hub page				3. Compliant
6.5	That all identified staff are fit-tested as per Health and Safety Executive requirements and that a record is kept.	All staff who are required to wear FFP3 masks are fit tested every 2 years or when required if sooner. The Trust holds train the trainer sessions for fit testing throughout the Trust Records are held by the Health and Safety				3. Compliant
6.6	If clinical staff undertake procedures that require additional clinical skills, for example, medical device insertion, there is evidence staff are trained to an agreed standard and the staff member has completed a competency assessment which is recorded in their records before being allowed to undertake the procedures independently.	Competencies and additional training is provided for specific clinical procedures e.g. venepuncture, catheterisation.				3. Compliant
7. Provide or secure adequate isolation precautions and facilities						
Systems and processes are in place in line with the NIPCM to ensure that:						
7.1	Patients that are known or suspected to be infectious as per criterion 5 are individually clinically risk assessed for infectious status when entering a care facility. The result of individual clinical assessments should determine patient placement decisions and the required IPC precautions. Clinical care should not be delayed based on infectious status.	As per policy patients are screened on admission or pre-admission and placed accordingly.	Side rooms are not always available immediately	Datix is completed Patient is isolated in the bay until suitable placement can be arranged. Site team are notified if side room is required.		3. Compliant
7.2	Isolation facilities are prioritised, depending on the known or suspected infectious agent and all decisions made are clearly documented in the patient's notes. Patients can be cohorted together if: •Single rooms are in short supply and if there are two or more patients with the same confirmed infection. •There are situations of service pressure, for example, winter, and patients may have different or multiple infections. In these situations, a preparedness plan must be in place ensuring that organisation/board level assurance on IPC systems and processes are in place to mitigate risk.	Isolation facilities' in side rooms are provided Isolation matrix available to aid clinical placement Patients are cohorted, if appropriate Flu pandemic plan available IPC Business continuity plan available IPC Team attends capacity daily and more frequently when required Weekend plan produced Winter plan produced				3. Compliant
7.3	Transmission based precautions (TBPs) in conjunction with SICPs are applied and monitored and there is clear signage where isolation is in progress, outlining the precautions required.	SICP policy available on the Hub PPE readily available Isolation signage available for use source or protective signage available)				3. Compliant
7.4	Infectious patients should only be transferred if clinically necessary. The receiving area (ward, hospital, care home etc.) must be made aware of the required precautions.	All infectious patients are reviewed by the IPC team prior to relocation or transfer. Patients are transferred when clinically appropriate.				3. Compliant
8. Provide secure and adequate access to laboratory/diagnostic support as appropriate						
Systems and processes to ensure that pathogen-specific guidance and testing in line with UKHSA are in place:						
8.1	Patient/service user testing for infectious agents is undertaken by competent and trained individuals and meet the standards required within a nationally recognised accreditation system.	All swabs are sent to BCPS accredited lab at Royal Wolverhampton Hospital. POC testing in ED is undertaken by trained competent staff				3. Compliant
8.2	Early identification and reporting of the infectious agent using the relevant test is required with reporting structures in place to escalate the result if necessary.	Trust has access to IC NET laboratory reporting system All results are pulled through onto the Trusts Sunrise system	Screening for CPE following the latest Department of Health guidance. Awaiting outcome of review from ICB and BCPS for funding to meet the new guidance	Trust has an in date CPE policy based on the Department for Health guidance All in patients who meet the criteria and are high risk are screened for CPE on admission Rectal and faecal screening for CPE can be provided A new CPE policy following the new guidance has been drafted and approved. This is recorded as a risk on the IPC risk register.	CPE screening not following the latest Department of Health guidance has been raised with the ICB and has been recorded as a risk on their risk register. The IPC risk register is reviewed monthly at the IPC Grup meeting.	2. Partially compliant
8.3	Protocols/service contracts for testing and reporting laboratory/pathology results, including turnaround times, should be in place. These should be agreed and monitored with relevant service users as part of contract monitoring and laboratory accreditation systems.	Policies and procedures in place. Agreed with Black County Pathology Services. Concerns raised via DATIX or via direct contact with the Laboratory.				3. Compliant
8.4	Patient/service user testing on admission, transfer, and discharge should be in line with national guidance, local protocols and results should be communicated to the relevant organisation.	Policies, procedures and SOPs in place for testing for infections pre admission, admission and discharge. COVID_19 staff and screening policy in place Staff have access to LFD for patients, these are available from Capacity COVID-19 rapid swabs available on request POC Testing available in ED				3. Compliant
8.5	Patients/service users who develops symptom of infection are tested / retested at the point symptoms arise and in line with national guidance and local protocols.	PCR testing is available for symptomatic in patients for COVID-19 Patients for all other infections are tested at the point symptoms arise. POCT is available in ED Testing and retesting are available for all patients who require testing. Policies and SOPs available on the Hub				3. Compliant
8.6	There should be protocols agreed between laboratory services and the service user organisations for laboratory support during outbreak investigation and management of known/ emerging/novel and high-risk pathogens.	Policies and procedures are in place with BCPS for outbreak investigation and high risk pathogens				3. Compliant
8.7	There should be protocols agreed between laboratory services and service user organisations for the transportation of specimens including routine/ novel/ emerging/high risk pathogens. This protocol should be regularly tested to ensure compliance.	Policies and procedures are in place for the transportations of specimens to the laboratory in RWT.				3. Compliant
9. Have and adhere to policies designed for the individual's care and provider organisations that will help to prevent and control infections						

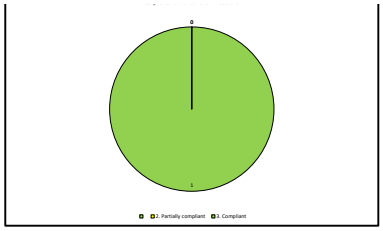


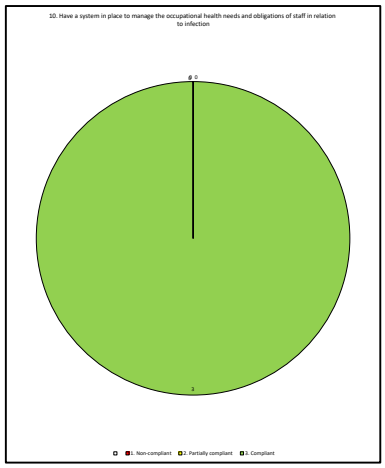






9.1	Systems and processes are in place to ensure that guidance for the management of specific infectious agents is followed (as per UKHSA 0, to 2 pathogen resourse, and the NIPCM). Policies and procedures are in place for the identification of and management of outbreaks/incidence of infection. This includes monitoring, recording, escalation and reporting of an outbreak/incident by the registered provider.	Policies, procedures and SOPS are in place for specific micro-organisms Outbreak and isolation policies are available All policies, procedures and SOPS are in date and available on the Trusts Hub. The Trust has access to IC NET All outbreaks are reported to external partners HCAI data is recorded and reported externally both and nationally. Outbreak meetings are held when required Specimens are sent for Ribotyping when required The trust has adopted the PSIRF approach to incident investigation.				3. Compliant
10. Have a system in place to manage the occupational health needs and obligations of staff in relation to infection						
Systems and processes are in place to ensure that any workplace risk(s) are mitigated maximally for everyone. This includes access to an occupational health or an equivalent service to ensure:						
10.1	Staff who may be at high risk of complications from infection (including pregnancy) have an individual risk assessment.	risk assessments are completed for staff who are at risk of complications from infection. Risk assessments are kept in staffs' personal file Staff have access to the Staff Health and Wellbeing Service (SHAW)				3. Compliant
10.2	Staff who have had an occupational exposure are referred promptly to the relevant agency, for example, GP, occupational health, or accident and emergency, and understand immediate actions, for example, first aid, following an occupational exposure including process for reporting.	The Trust has a Sharps Injury Policy and have access to a 24 hour Emergency Department on Site. A HIV PEP service is available A Datix system is available to all staff and there is a joined up service between Health and Safety and SHAW for the monitoring and reporting of SHarps Injuries All injuries are reported via the IPCG meeting A sharps flow chart is available for staff to follow in the event of an injury Sharps handing and injuries are covered in IPC mandatory face to face training. The Trust has a sharps safety task and finish group Safer sharps are promoted Vaccinations are given as required. Seasonal flu and COVID vaccination service provided in house. staff are encouraged to report all injuries via the DATIX system				3. Compliant
10.3	Staff have had the required health checks, immunisations and clearance undertaken by a competent advisor (including those undertaking exposure prone procedures (EPPs).	Pre employment checks for all staff are completed via the Staff Health and Wellbeing Service. Pree employment screening is undertaken on those staff undertaking EPP.				3. Compliant





REPORTS FOR ASSURANCE

Learning from Deaths

Report to Public Trust Board

1. EXECUTIVE SUMMARY

A further reduction in the 12-month rolling Summary Hospital-level Mortality Indicator (SHMI) and Hospital Standardised Mortality Ratio (HSMR) is reported. SHMI is currently 100.3 and HSMR is currently 85.76. Both are now within the expected range, with HSMR as a positive outlier.

Significant quality improvement work has also taken place in pneumonia, deteriorating liver disease and AKI. The work within the surgical division related to Fractured Neck of Femur is ongoing and we continue to pursue sustained improvements through quality improvement work. Both Stroke and Fractured Neck of Femur (#NoF) are showing a decrease in SHMI with Stroke now at 103 and #NoF at 123.

Maternal and neonatal services have pursued a wide-ranging review of their processes and services with improving mortality parameters.

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

2. BACKGROUND INFORMATION

This report has been structured to review outcomes throughout the chronological life cycle from conception to end of life care.

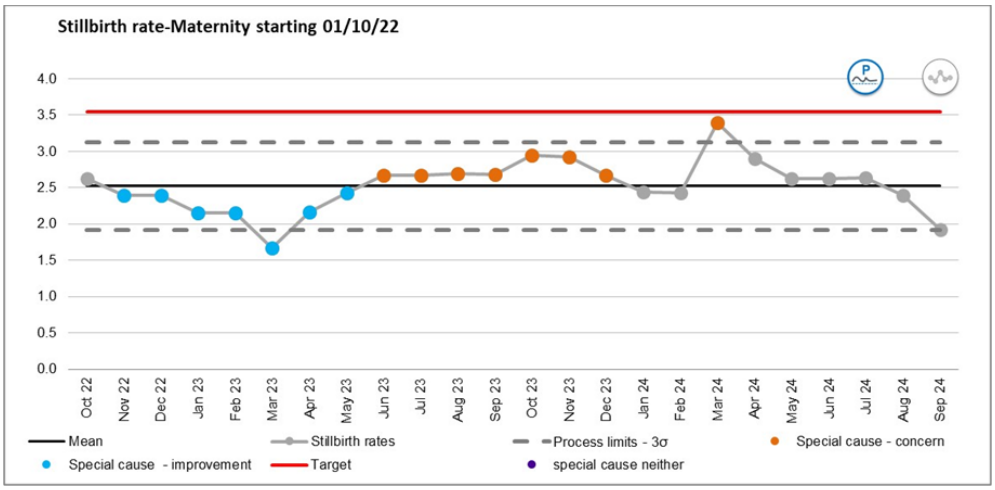
2.1 Conception to Birth

Stillbirths

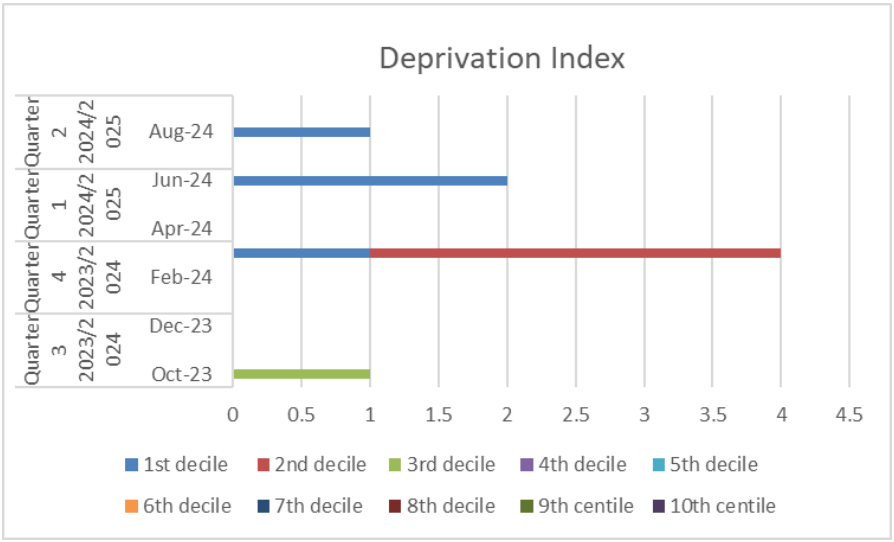
The National stillbirth rate is 3.54 (MBRRACE 2023) and it can be seen the Trust crude stillbirth rate for Quarter 2 2024/2025 is decreasing.

		Crude Rate	National crude rate	Number of stillbirths
Quarter 3 2023/2024	Oct-23	2.95	3.54	1
	Nov-23	2.92	3.54	0
	Dec-23	2.67	3.54	0
Quarter 4 2023/2024	Jan-24	2.44	3.54	0
	Feb-24	2.43	3.54	0
	Mar-24	3.4	3.54	4
	Apr-24	2.9	3.54	0

Quarter 1 2024/2025	May-24	2.62	3.54	0
	Jun-24	2.62	3.54	2
Quarter 2 2024/2025	Jul-24	2.63	3.54	0
	Aug-24	2.39	3.54	1
	Sep-24	1.92	3.54	0



The above chart provides a comparison of the stillbirth crude rate and national rate. Rates in Quarter 2 2024/2025 have continued to fall with values of July (2.63), August (2.39) and in September (1.92). It is noted that there were increased still births in March 2024.



The 8 women who had a stillbirth reside in areas with the most deprived deciles 1-3, with 7 (88%) of these being with the 2 most deprived deciles. Deprivation has been outlined by several national publications as an inequality in maternity care. Locally, there is a higher than national average of people living within the most deprived deciles and so it is possible that there will be an over representation of people experiencing stillbirths from the most deprived deciles compared to the national averages. This over representation of people living in the top 2 most deprived deciles who experience stillbirth shows an increase compared to data collated last year, which evidenced that 45% of pregnancies booked were to people living in that decile grouping. It should be noted that deprivation data is collated using postcode only and thus this does not take individual circumstances into consideration.

Saving Babies Lives Initiative

Whilst there is recognition of variations in outcome based on deprivation, the clinical teams have provided strong leadership in implementing the 6 elements of the Saving Babies Lives Initiative as evidenced below.

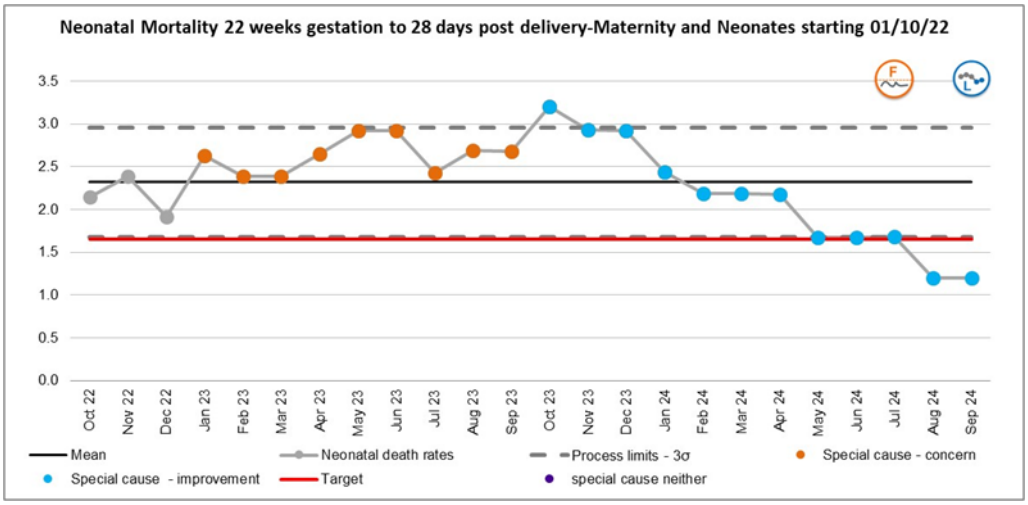
Intervention Elements	Description	Element Progress Status (Self assessment)	% of Interventions Fully Implemented (Self assessment)
Element 1	Smoking in pregnancy	Fully implemented	100%
Element 2	Fetal growth restriction	Fully implemented	100%
Element 3	Reduced fetal movements	Fully implemented	100%
Element 4	Fetal monitoring in labour	Fully implemented	100%
Element 5	Preterm birth	Partially implemented	85%
Element 6	Diabetes	Fully implemented	100%
All Elements	TOTAL	Partially implemented	94%

2.2 Neonatal

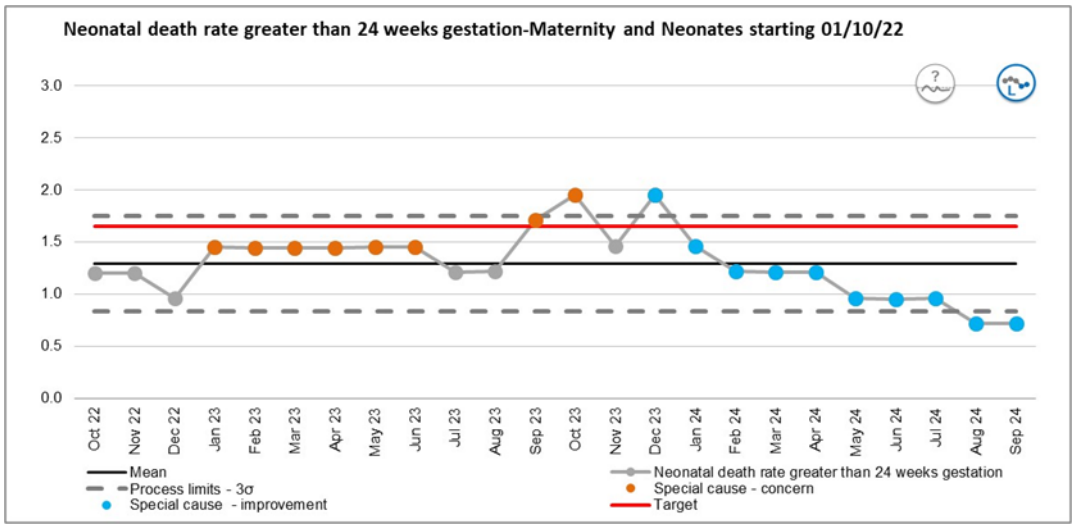
The National Neonatal Death (NND) rate is 1.65 (MBRRACE 2023). There has been a statistically significant decline in the neonatal death rate over the last 4 Quarters.

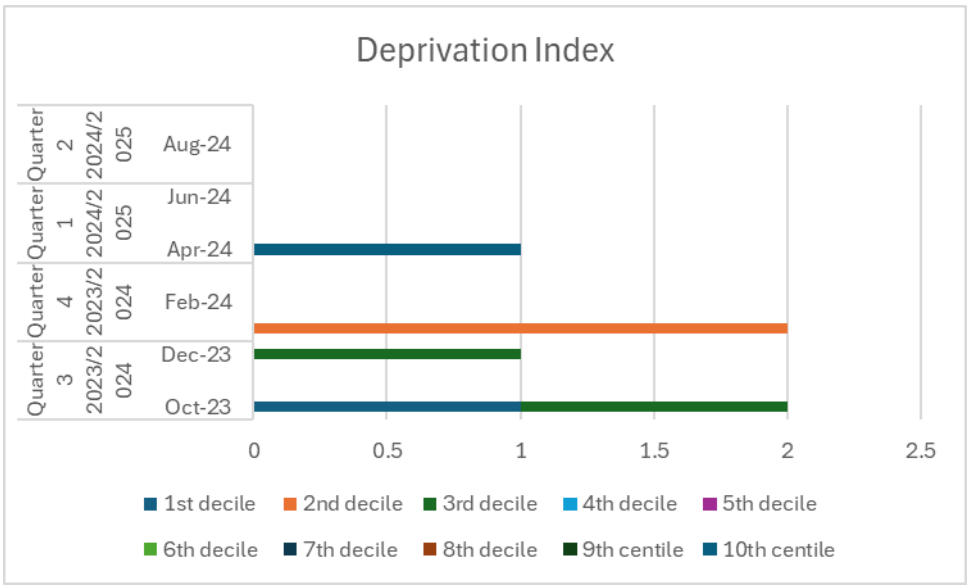
		Crude Rate	National Crude Rate	DGFT > 24 weeks gestation	Number of NND
Quarter 3 2023/2024	Oct-23	3.2	1.65		2
	Nov-23	2.93	1.65		0
	Dec-23	2.92	1.65		1
Quarter 4 2023/2024	Jan-24	2.44	1.65		1
	Feb-24	2.19	1.65		0
	Mar-24	2.19	1.65	1.21	0
Quarter 1 2024/2025	Apr-24	2.18	1.65	1.21	1
	May-24	1.67	1.65	0.96	0
	Jun-24	1.67	1.65	0.95	0
Quarter 2 2024/2025	Jul-24	1.68	1.65	0.96	0
	Aug-24	1.20	1.65	0.72	0
	Sep-24	1.20	1.65	0.72	0

In Quarter 2 2024/2025 in July (1.68), August (1.20) and September (1.20) the crude rate is marginally higher than the national rate 1.65 (MBRRACE 2023).



However, 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 rates are July (0.96), August (0.72) and September (0.72) which is significantly lower than the national rate.

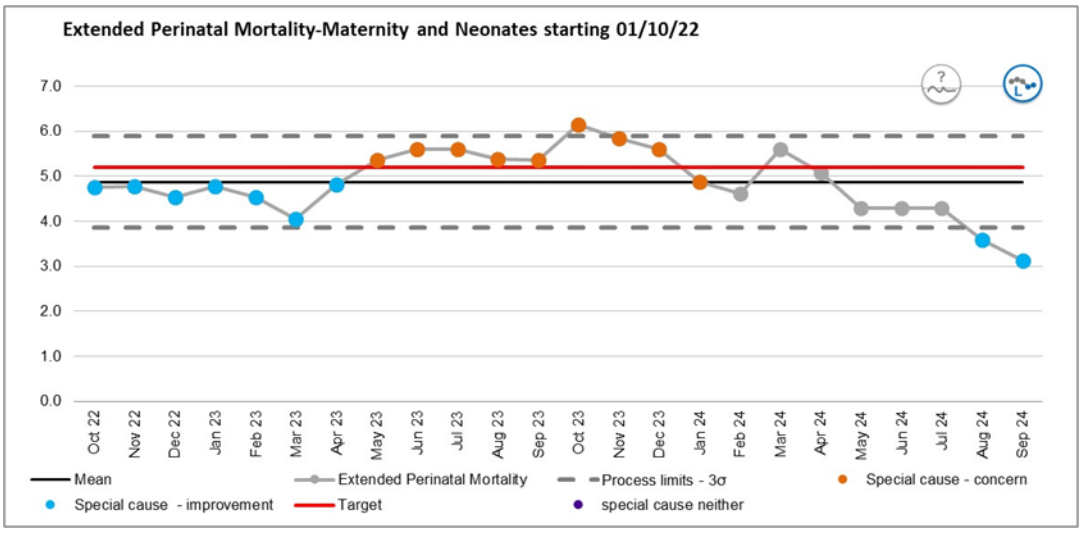




Of the women that experienced a NND 4 (80%) were identified as living within the 20% most deprived deciles. Again, this local statistic demonstrates that there is a significant over representation of people living in the 20% most deprived deciles who experience NND when

comparing with previous data. It should be noted that deprivation data is collated using postcode only therefore this does not take individuals circumstances into consideration.

The national extended perinatal mortality rate (all stillbirths and neonatal deaths) is 5.19 (MBRRACE 2023). Our data shows an extended decline.



Ethnicity Data

Chart for Still births and Ethnicity

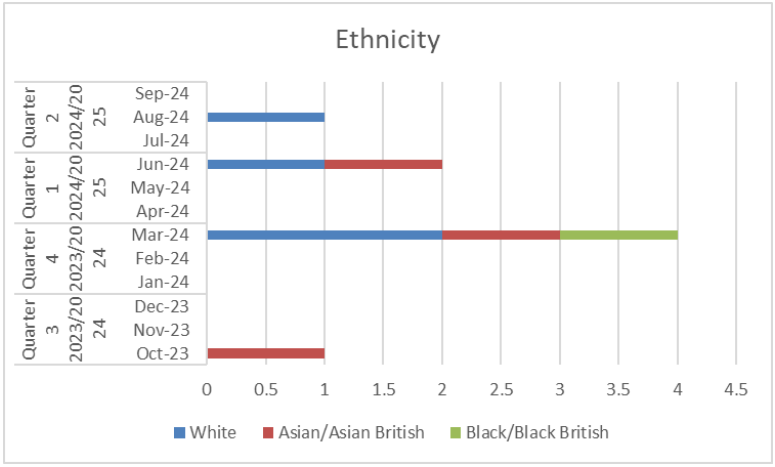
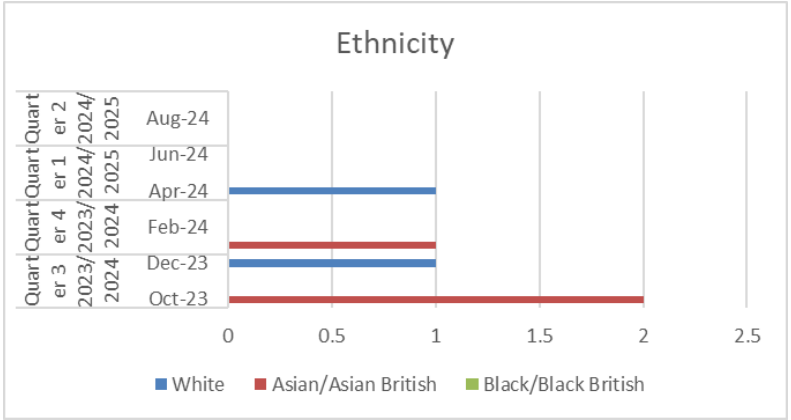


Chart for Neonatal Deaths and Ethnicity

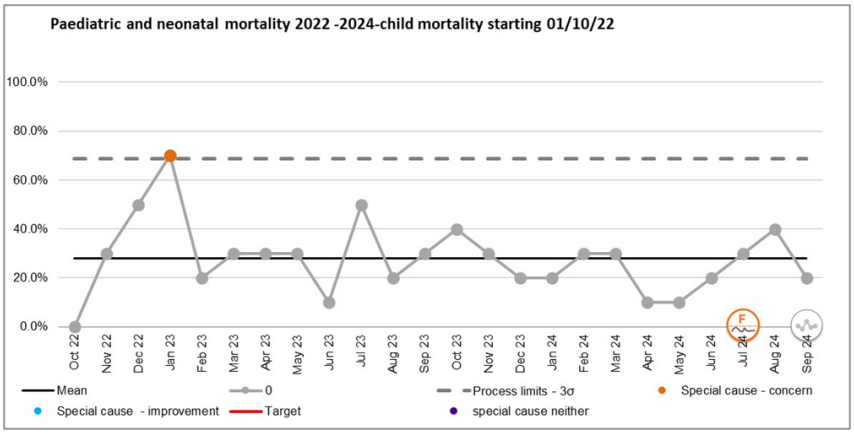


Stillbirths and neonatal deaths within BAME groups were small in number. It has been identified that the number of people who experienced a stillbirth who were from an Asian/Asian British background was proportionately higher than would be expected for our Trust average of people who booked a pregnancy from an Asian/Asian British background. Similar patterns are observed for neonatal deaths. This has been identified by publications such as MBRRACE-UK as a national inequality in maternity care where there are significant workstreams on going to reduce inequalities faced by those from global majority backgrounds.

2.3 Paediatric

Child Deaths

- There have been 8 deaths in Q2 of Dudley children. This is double the number from Q1.
- There have been 4 Sudden Unexpected Death in Infant/Child (SUDI/C).
- There has been 1 death of a child at Russells Hall Hospital who resided outside of the Dudley borough (SUDC).
- 6 of the deaths occurred external to Russells Hall Hospital including 1 death abroad.
- There have been no cases where there have been any lapses of care related to Dudley.



Dudley paediatric deaths over a 24-month period.

2.4 Adult Mortality

Overall Standardised Mortality indices: SHMI & HSMR

The Trust monitors standardised mortality indices and a summary of these can be found at https://www.chks.co.uk/userfiles/files/CHKS_Mortality%20measures%20compared_Dec2018.pdf

Indicator	Current	Trend
SHMI (Summary Hospital-level Mortality Indicator)	100.3 (Source HED May 23 To Apr 24)	The Trust SHMI is 100.3 for the last reporting period This is a decrease in previous periods and is within the 'Expected Range'
HSMR (Hospital Standardised Mortality Ratio) Aug 2022 to Jul 2023	85.76 (HES inpatient Aug 23 to Jul 24 data)	HSMR (in hospital deaths) continues to show a downward trend over the last 12 months down from 90. The Trust compares favourably to peers in the West Midlands.

Crude Mortality Crude Mortality is the number of deaths per year, per 1000 population.	Crude Mortality rates have consistently fallen year on year from 4.38% in 2019/20 to 3.06% in 2022/23 with a continuing trend in the 2024 calendar year to 2.22%.

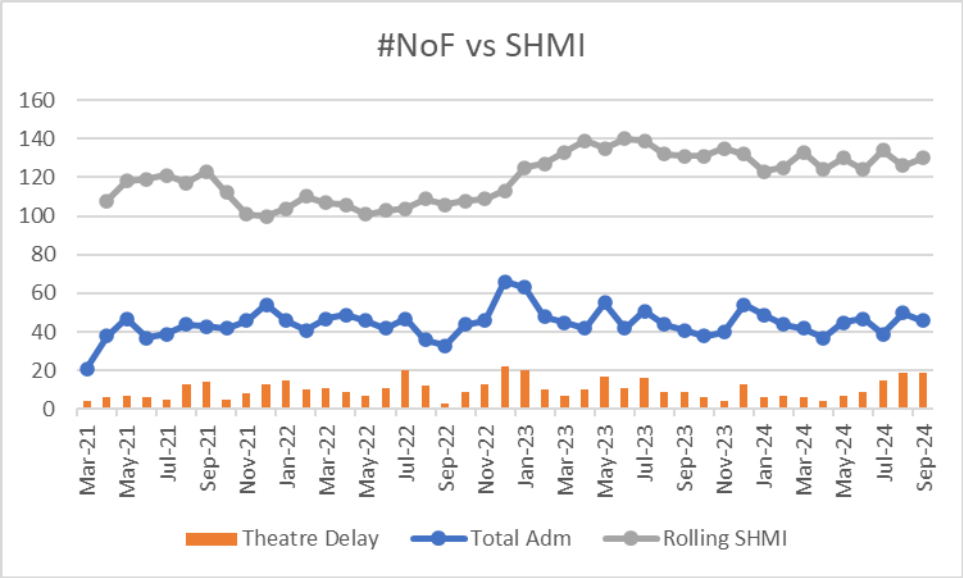
It should be noted that NHS digital and HED report slightly different SHMI values, but HED data is sometimes readjusted after data is further cleansed which may lead to variations in some reports. It is also worth reiterating that the Trust SHMI data was rebased from September 2022 to include all SDEC activity that had been removed in September 2016 leading to an increased SHMI. The subsequent re-inclusion of this data has led to sustained decline in SHMI back towards the pre-2016 baseline. There is ongoing work to reduce this further by both data analysis and accurate recording of co-morbidities especially within SDEC areas as well as quality improvement initiatives.

Improvement work (Fractured Neck of Femur)

In November 2023 an improvement group was formed to identify why the trust had an SHMI for fractured neck of femur patients. The working group is meeting on a twice monthly basis and bases the work around the KPIs set out by the National Hip Fracture Database.

KPI	Action	Progress	Due date
Prompt Surgery	Eligible patients to have undergone surgery within 36 hours of attendance	Current data shows that the average time to surgery is 34.5 hours	Mar 2025
Admitted to orthopaedic ward within 4 hours of attendance	All Hip # patients are transferred to B2 within 4 hours	There is a bed ringfenced for #NoF patients during working hours, but this is not always available out of hours. Current data shows 36% of patients are admitted to B2 within 4 hours	Mar 2025
Mobilised out of bed by day after surgery	All patients that have had surgery are mobilised out of bed within 24 hours of surgery.	Currently 72% of patients are being mobilised within 24 hours of surgery. Therapy is attending ward in the morning and if the patient is unable to mobilise at this point, they will revisit on the PM of the day. It is more difficult when the patient is on an outlying ward due to staffing and time constraints.	Mar 2025
Length of stay	To reduce the average length of stay to below 18.8 days	Currently the average length of stay is 19.8, by improving times of admission to appropriate ward, surgery and mobilisation there should be an improved length of stay.	Mar 2025

The SHMI remains elevated but with the production of a power BI based on the KPIs set out by the National Hip Fracture Database, it is hoped that this will enable the monitoring of each area and that the trust will be able to respond promptly as needed.



Recently DGH have been approached for by 3 Trusts who are experiencing higher than expected mortality rates for assistance in improving their data and establishing quality improvement initiatives related to mortality. This provides some evidence that the work and improvements that are been made within the trust are being recognised nationally and that DGH has been recognised as an improving trust. It has also enabled a process of collaboration and continued learning.

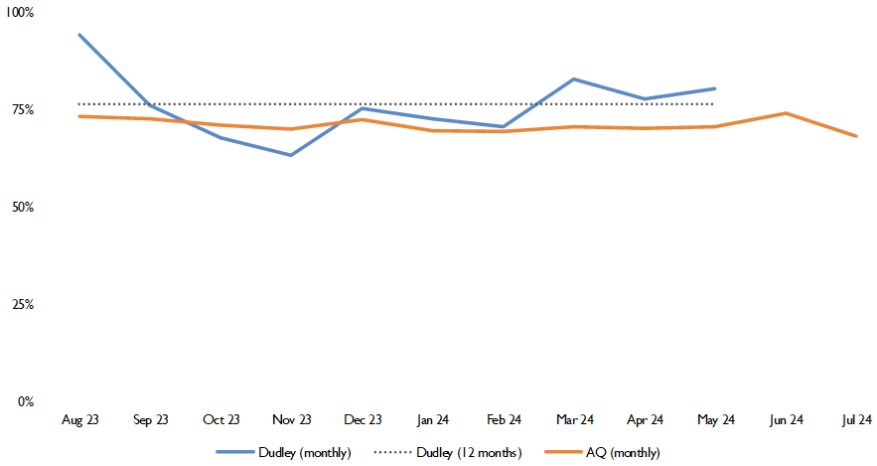
AQUA

Quality improvement work carried out in conjunction with AQUA has enabled the trust to improve the composite care score for three of the four focus areas. AKI has not seen the improvement that the other areas have but it is hoped that with the addition of new consultants and an improved renal action plan that the CPS will see an improvement.

AQ focus area	Total loaded	Total input	Data completeness	Excluded (n)	Excluded (%)	Total after exclusions	ACS *	CPS **
Acute Kidney Injury (AKI)	237	237	100.0%	119	50.2%	118	16.1%	46.6%
Decompensated Liver Disease (DLD)	181	181	100.0%	67	37.0%	114	48.2%	76.3%
Hospital Acquired Pneumonia (HAP)	-	-	-	-	-	-	-	-
Hip & Knee Replacement	-	-	-	-	-	-	-	-
Pneumonia (community-acquired)	263	263	100.0%	104	39.5%	159	34.0%	75.5%
SepsisNEWS	301	272	90.4%	130	47.8%	142	57.7%	76.4%

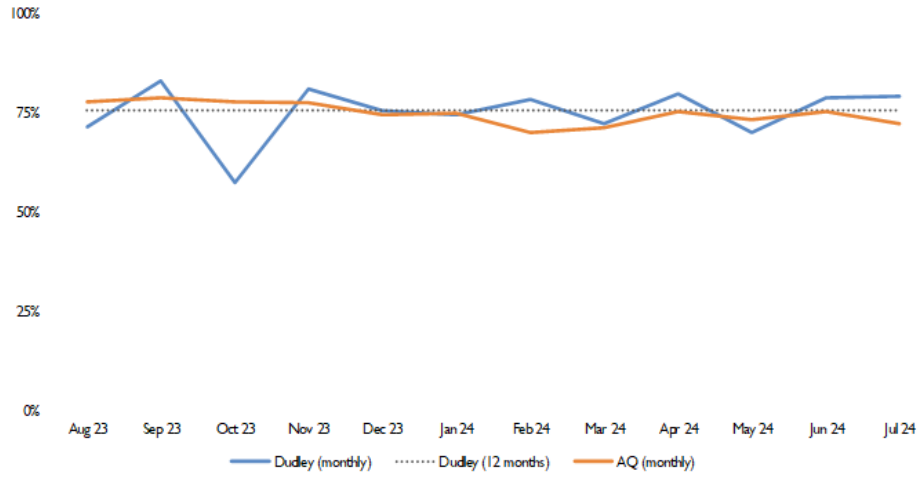
Sepsis – Composite Score

Aug 23	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24	Apr 24	May 24	Jun 24	Jul 24	
35	67	31	49	73	51	58	29	27	92		52	Eligible
33	51	21	31	55	37	41	24	21	74		43	Passed (n)
94.3%	76.1%	67.7%	63.3%	75.3%	72.5%	70.7%	82.8%	77.8%	80.4%		82.7%	Passed (%)



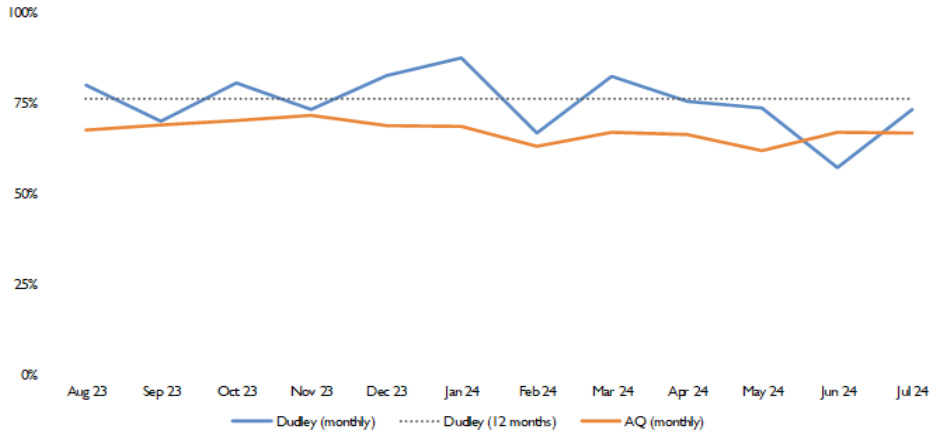
Pneumonia – Composite Score

Aug 23	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24	Apr 24	May 24	Jun 24	Jul 24	
21	41	47	42	57	47	51	83	89	40	33	86	Eligible
15	34	27	34	43	35	40	60	71	28	26	68	Passed (n)
71.4%	82.9%	57.4%	81.0%	75.4%	74.5%	78.4%	72.3%	79.8%	70.0%	78.8%	79.1%	Passed (%)



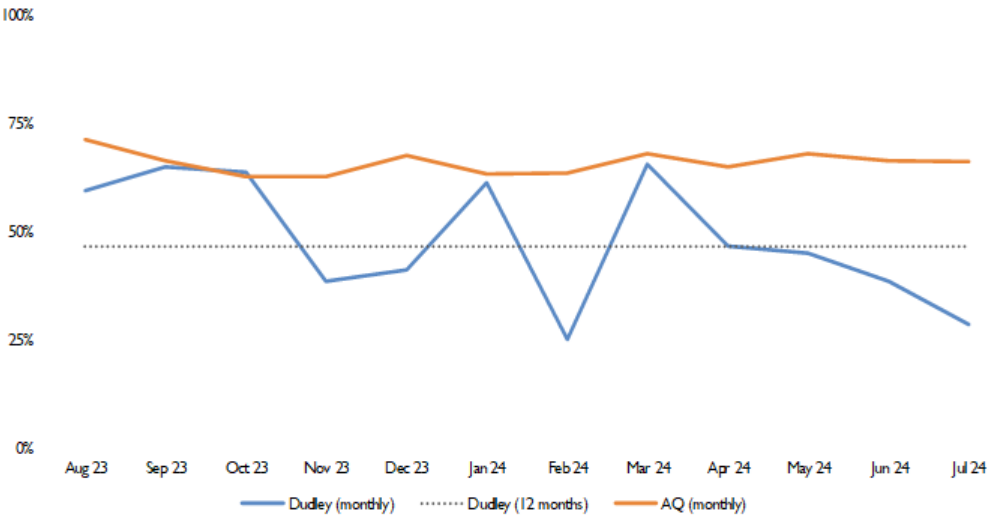
DLD – composite Score

Aug 23	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24	Apr 24	May 24	Jun 24	Jul 24	
20	20	41	30	46	16	27	40	49	38	14	30	Eligible
16	14	33	22	38	14	18	33	37	28	8	22	Passed (n)
80.0%	70.0%	80.5%	73.3%	82.6%	87.5%	66.7%	82.5%	75.5%	73.7%	57.1%	73.3%	Passed (%)



AKI – Composite Scores

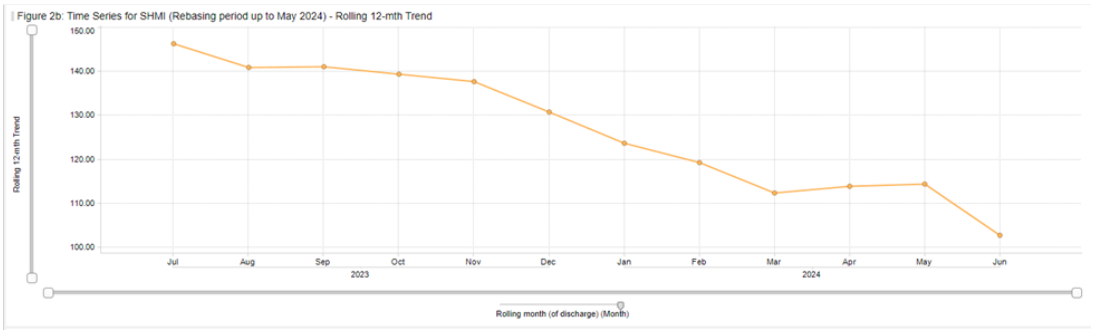
Aug 23	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24	Apr 24	May 24	Jun 24	Jul 24	
42	20	33	26	34	31	28	29	30	40	52	56	Eligible
25	13	21	10	14	19	7	19	14	18	20	16	Passed (n)
59.5%	65.0%	63.6%	38.5%	41.2%	61.3%	25.0%	65.5%	46.7%	45.0%	38.5%	28.6%	Passed (%)



Acute Cerebrovascular Disease

Continued validation of patient notes to confirm that documentation and coding are correct. SSNAP score is now B but with continued reviews of the national audit will help to identify where areas may be improved. The 12-month rolling SHMI for acute cerebrovascular disease – demonstrates that current improvement work is assisting in the reduction in mortality for this condition.

SHMI - 103



2.5 End of Life

GSF (Gold Standards Framework)

It is known that 30% of hospital inpatients are in the last year of life (Clarke et al 2014) and that approximately 75% of deaths are predictable (Blackmore et al 2011). Furthermore, it is established that 78% of all patients in England in the last year of life have at least one admission to hospital (Luta et al. 2020). Identifying and communicating that a patient may be in the last year of life remains the first step to providing support around advance care planning and timely specialist palliative care input and this is emphasised both in the NHS Long Term Plan (2019) and current Ambitions for Palliative and End of Life Care 2021. The Gold Standards Framework (GSF)

supports clinicians in identifying patients in their last year of life to aid the development of proactive, personalised, coordinated care.

The Gold Standards Framework (GSF) implementation commenced in 2019 at The Dudley Group NHS Foundation Trust (DGFT) to support identification of patients in the last year of life and development of an individual plan of care to support patients.

In autumn 2024 wards C5 and C6 have achieved GSF accreditation and C1A, B6 and C4 achieved re-accreditation.

Below is a summary of the outcomes that are reported from power BI that is based on the information recorded on sunrise. It shows the data for the previous 3 months. As stated above 30% of adult inpatients at any one time are in the last year of life.

The data shows that whilst the trust is not achieving the targets on identifying green and amber patients with an advanced care plan, it is continually achieving the targets for the amber and red patients with a DNA CPR. There are concerns over the poor compliance with the target of preferred place of care and priorities for care. This has been identified as a failure of documentation within the GSF document itself rather than failure of the process as nursing staff completes this information separately in nursing notes. It has been determined that a GSF nursing bundle should be developed to address this issue with an expectation of improved documented compliance with the target. It should be noted that hospital clinicians are well placed to ensure the full document is complete for those patients who are GSF red and many who are amber but are less so for those who are GSF green. These are invariably processes that should occur within primary care or within a collaborative setting.

Metric	Target	% Achieved May 24	% Achieved June 24	%Achieved July 24
% GSF identified	20%	17%	18%	16%
% GSF amber and green with ACP offered	75%	34%	50%	42%
% Hospital deaths with GSF Amber or red	60%	68%	71%	75%
% GSF red and amber with DNACPR	80%	98%	97%	98%
% GSF red with priorities for care	70%	45%	53%	42%
% GSF red, amber and green with preferred place of care documented	70%	67%	74%	72%
% GSF red or amber achieve preferred place of care on discharge/death	60%	56%	52%	49%

2.6 Assurance

Structured Judgement Review

All deaths are being reviewed by the Medical Examiner and any issues are escalated to the mortality co-ordinator on a weekly basis for consideration of SJR.

There have been 133 cases referred for 2024. 70% have been reviewed and 93% 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.

Referral Type	2024
A: Deaths where the bereaved or staff raise significant concerns about the care	37
B: Deaths of those with learning disabilities or severe mental illnesses	21
C: Deaths in a speciality, diagnosis or treatment group where an 'alarm' has been raised (for example, an elevated mortality rate, concerns from audit, CQC concerns)	1
D: Deaths where the patient was not expected to die – for example, in elective procedures	3
E: Deaths where learning will inform the provider's quality improvement work	6
F: Maternal or neonatal deaths	These are all reviewed via PMRT
Primary Review	8 also 4 referred by ME
Governance	28 – 8 also referred via ME
ED	39

Medical Examiner Service

The Medical Examiners service has consistently reviewed 100% of deaths in the previous 12 months.

Community Deaths

The statutory date was postponed in April 2024 but on 09 September 2024 the process became statutory and there was very little in the way of pushback and the system appears to be working well.

Coroners Inquests

The Trust has noted reducing numbers of Coroner's inquests. There have been no Regulation 28 notices issued by the HM Coroner since 2018

Health Inequality data

Nationally, there is evidence of variation in outcome for patients dependent on their place of residence or ethnicity. Some preliminary discussions have taken place with primary care colleagues to review and understand local data and further meetings are planned with Public Health. We have identified particular challenges for managing patients with drug and alcohol related disease which impact both primary and secondary care which warrant further investigation.

Future Work Planning

Continued focus on specific clinical conditions with high SHMI particularly #NOF and stroke

Continued work on EMLAP pathways to review and improve processes. This is based on incident reporting data rather than specific SHMI alerts. We are planning a systematic review of other condition specific SHMI areas where we feel there is scope for improvement.

We will be seeking assurance of mortality processes related to the implementation of ECDS (Emergency Care Data Set) coding.

Working with other trusts

Advice on to make improvements in the mortality data and review system has been sought from the Mortality Co-ordinator by three trusts over the last 12 months following the notable improvements that have been made at DGH. It is hoped that there will be an ongoing collaboration with these trusts which will prove to be mutually beneficial.

3. RECOMMENDATION(S)

The Trust Board is asked to note the decreasing trend in SHMI and HSMR. It is likely that the improvement in HSMR / SHMI reflect an improvement in the denominator as well as quality of care and provides assurance in relation to previous alerts. Positive assurance related to quality of care includes SJRs output, falling HSMR with no weekend effect and no Regulation 28 notices in 5 years.

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

Rebecca Edwards, Nuala Hadley, Dr P Brammer on behalf of Dr Julian Hobbs
22/10/2024

Workforce KPI Report – Full Report

September 2024

The Dudley Group
NHS Foundation Trust

CARE
RESPECT
RESPONSIBILITY

Summary

The Dudley Group NHS Foundation Trust

Metric	Rate	Target	Trend	
Absence – In Month	5.18	<=5%	↑	**Sickness Absence** In-month sickness absence for September 2024 is 5.18% an increase from 5.08% in August 2024.
Absence - 12m Rolling	5.10%	<=5%	=	The rolling 12-month absence has remained static at 5.10% in September 2024.
Turnover	7.57%	<=8%	↓	**Turnover** Turnover (all terminations) has decreased from 7.82% in August 2024 to 7.57% in September 2024.
Normalised Turnover	3.06%	<=5%	↓	Normalised Turnover has decreased from 3.23% in August 2024 to 3.06% in September 2024. Turnover (all terminations) is all terminations from the organisation. Normalised Turnover focuses on voluntary resignations and excludes dismissals, fixed-term contracts, redundancy, retirement and rotations.
Retention (12 month)	91.6%	>=80%	↑	**Retention** The 12-month retention rate increased slightly from 91.5% in August 2024 to 91.6% in September 2024.
Vacancy Rate	5%	<=7%	↓	**Vacancy Rate** The vacancy rate has reduced from 6% in August 2024 to 5% in September 2024.
Mandatory Training	92.22%	>=90%	↓	**Mandatory Training** Statutory Training decreased slightly from 92.6% in August 2024 to 92.22% in September 2024. Overall, it has remained above 90% target for a sustained period.

CARE RESPECT RESPONSIBILITY

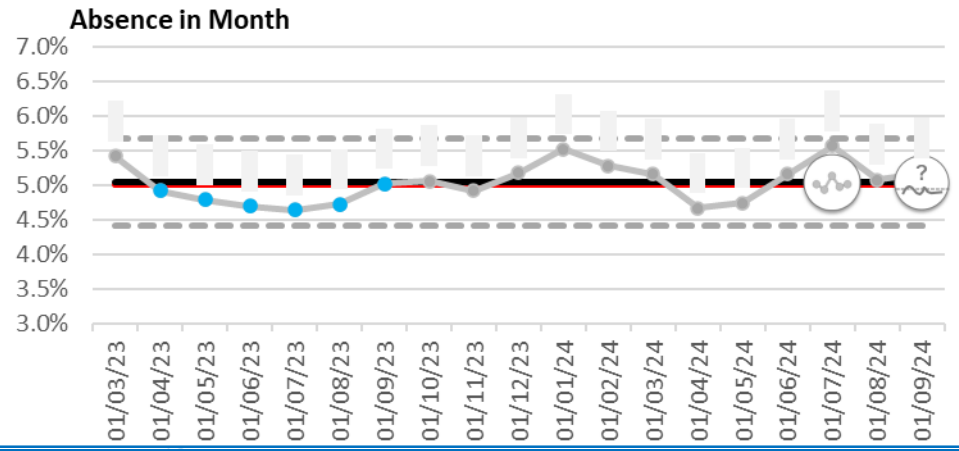
Exceptions/Improvement/Actions

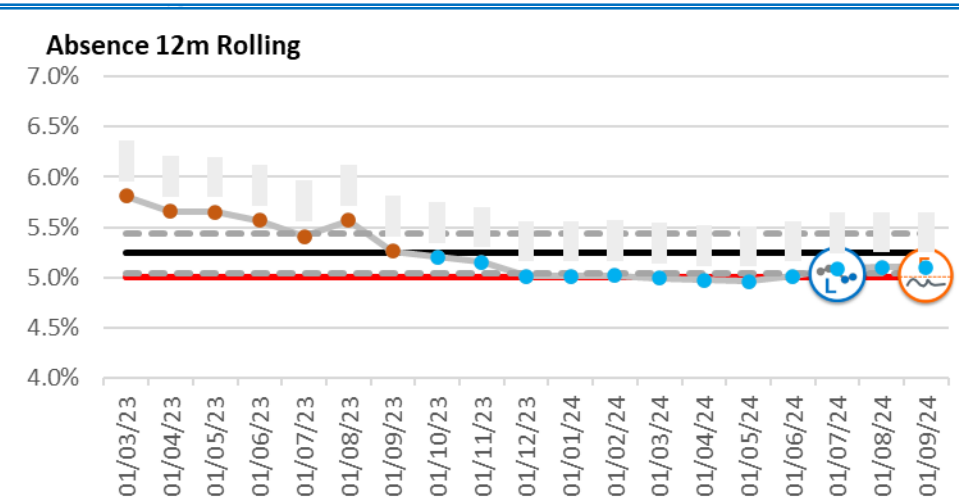
The Dudley Group
NHS Foundation Trust

METRIC	SUMMARY
Sickness	Sickness continues to remain RAG rated as amber, with the in-month figure for September 2024 increasing compared to August 2024. There are no long-term sickness cases over 12 months, but the number of cases between 6 and 12 months have increased. HR teams have produced robust plans with divisions for managing cases between 6 and 12 months in duration. Work is underway with the sub-group to look at how ESR can be utilised to record the stages individuals are on across the Trust to monitor compliance with implementation of the sickness policy. The Trust's Occupational Health function is currently under review alongside staff support and counselling services and staff Physio services to address higher levels of stress/anxiety/depression and MSK related absences.
Bank	The number of requests for bank shifts has reduced in September 2024 across all staff groups (excluding medical), except Healthcare scientists. However, fill rates have also declined slightly from 87% in August 2024 5o 86% in September 2024. Agency remains low. Bank usage continues to be above expected levels when compared with the workforce reduction plans. In November 2024, further controls are being explored such as blocking bank if an individual has a net hours owed positive balance and reinforcing unpaid breaks during a shift.
Statutory and Mandatory training	Performance overall is stable and above target. Safeguarding Adults Level 3 has now recovered to pre-review levels in the summer and work continues to reach target on this subject. There have been some declines in Resus training but there is significant activity planned during October (Restart a Heart campaign) which will improve this position.
Work Experience and Apprenticeships	There has been an increase in apprenticeship sign-ups to reach 56 at Q2. This leaves significant work required in Q3 and Q4 but these are generally higher sign-up months. We have planned activity on CSWs and Maternity Support Workers that mean Q3 activity will be significantly higher. Details are awaited on the national review of Apprentice Levy – to be the Growth and Skills Levy which will enable better utilisation of that funding. No Levy funds have expired in the last 3 months. ICan continues to be an area of success with Paid Work Experience and CSW placements starting in September.

Sickness Absence

The Dudley Group NHS Foundation Trust





In-Month Sickness Absence

In-month sickness absence for September 2024 is 5.18%, an increase from 5.08% in August 2024.

Rolling 12 M Sickness Absence

The rolling 12-month absence for September 2024 is 5.10%, which has remained static from August 2024.

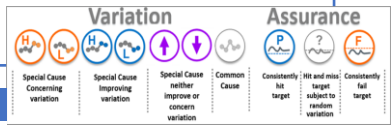
Assurance

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 roll out 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 looking at short-term absence management and prevention, as well as reduction of FTE days lost for Stress/Anxiety/Depression and MSK absences.

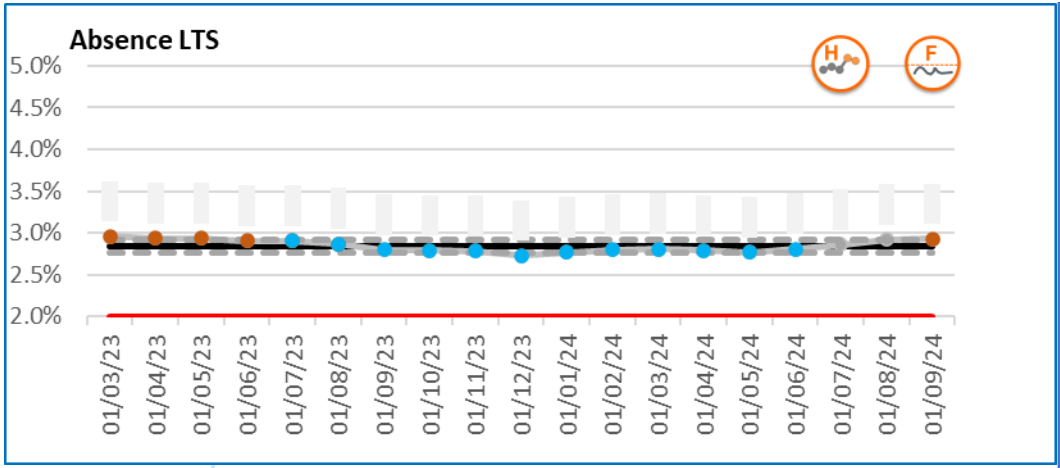


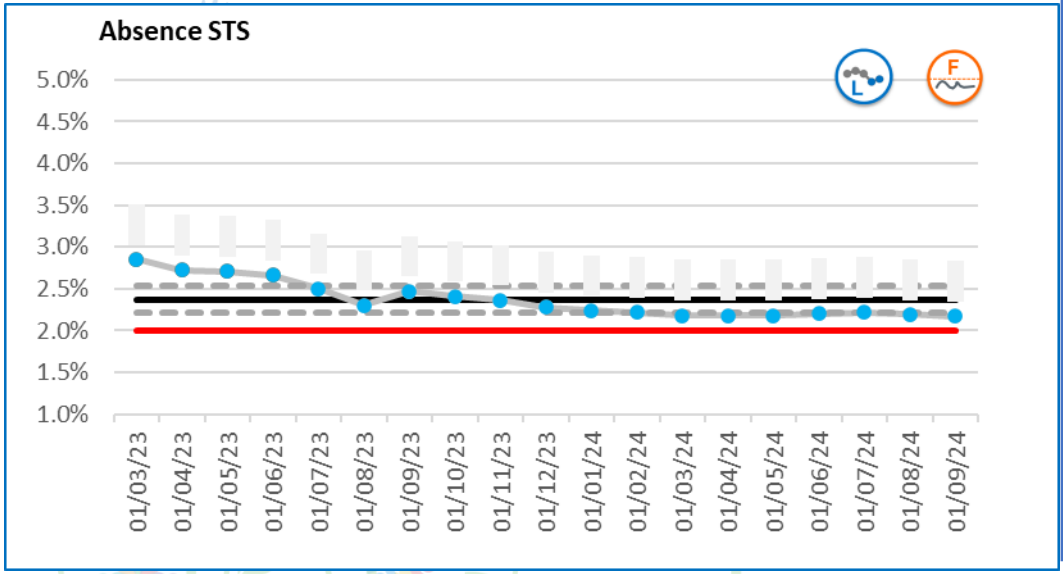
	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24
Absence in Month	5.06%	4.92%	5.18%	5.52%	5.28%	5.16%	4.67%	4.74%	5.16%	5.57%	5.08%	5.18%
Absence 12m Rolling	5.20%	5.15%	5.01%	5.01%	5.02%	4.99%	4.97%	4.96%	5.01%	5.09%	5.10%	5.10%

CARE RESPECT RESPONSIBILITY

Long-Term and Short-Term Absence

The Dudley Group NHS Foundation Trust





In September 2024 long-term absence has decreased from 2.19% in August 2024 to 2.17% in September 2024. Short-term sickness has increased slightly to 2.93% from 2.92%.

In September 2024 short-term absence accounted for 84% of all sickness absence episodes, with long-term absence (28 days +) accounting for 16% of absence episodes. Long-term absence accounted for 50% of all FTE days lost.

As of 30 September 2024, there were 130 long-term absences open across the Trust.

- 102 cases are between 28 days and 6 months
- 28 cases between 6 months and 12 months
- 0 cases over 12 months in length

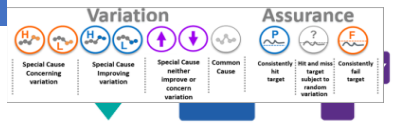
Assurance

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

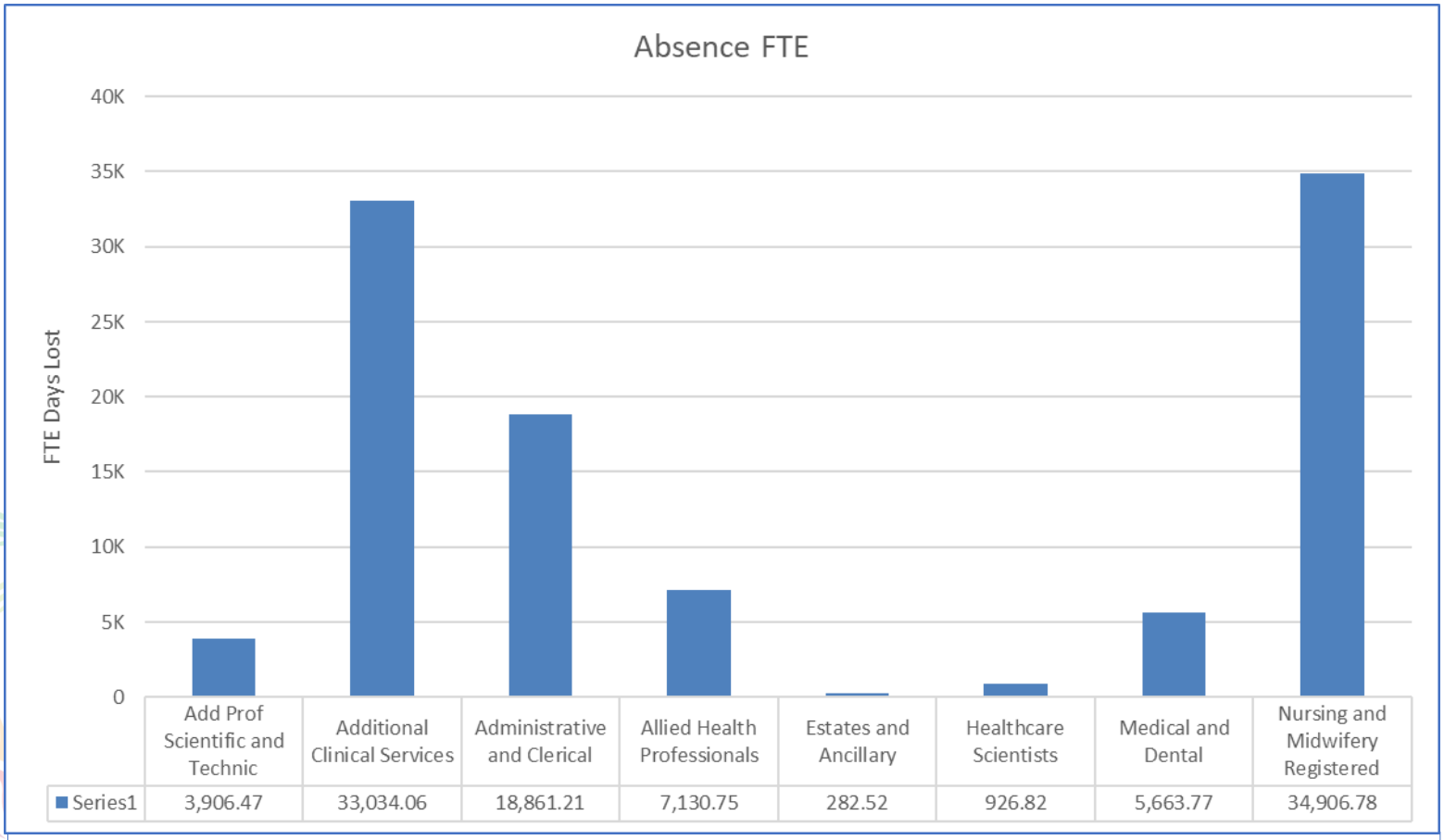
- A task force is looking at how to manage short-term absence more robustly using ESR.
- Review of OHP provision is needed to speed up management of LTS cases.

	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24
Absence LTS	2.79%	2.78%	2.73%	2.77%	2.80%	2.81%	2.79%	2.77%	2.81%	2.86%	2.92%	2.93%
Absence STS	2.41%	2.36%	2.28%	2.24%	2.22%	2.18%	2.18%	2.18%	2.20%	2.22%	2.19%	2.17%



Sickness Absence- Staff Groups

The Dudley Group
NHS Foundation Trust

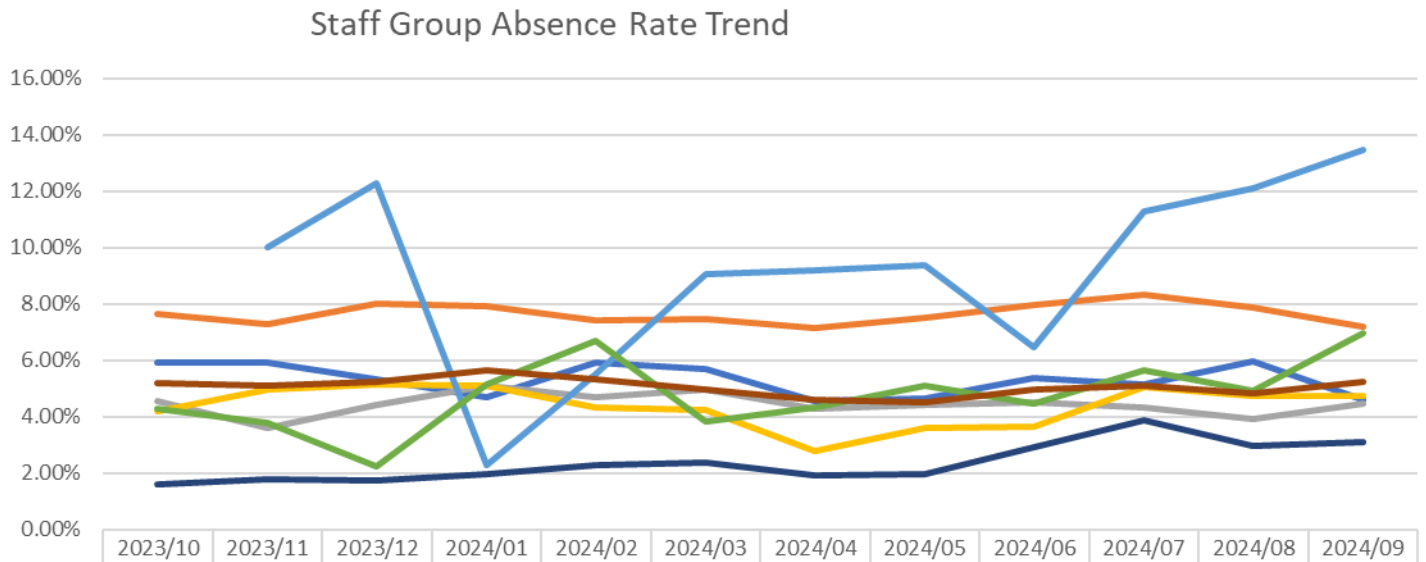


Year-to-date Nursing and Midwifery and Additional Clinical Services have lost the most FTE days as a result of sickness absence.

CARE RESPECT RESPONSIBILITY

Sickness Absence- Staff Groups

The Dudley Group NHS Foundation Trust



	2023/10	2023/11	2023/12	2024/01	2024/02	2024/03	2024/04	2024/05	2024/06	2024/07	2024/08	2024/09
Add Prof Scientific and Technic	5.91%	5.95%	5.33%	4.70%	5.92%	5.71%	4.58%	4.64%	5.37%	5.14%	5.97%	4.61%
Additional Clinical Services	7.65%	7.29%	8.01%	7.94%	7.41%	7.45%	7.14%	7.50%	7.98%	8.35%	7.86%	7.22%
Administrative and Clerical	4.55%	3.61%	4.41%	5.12%	4.71%	4.98%	4.29%	4.43%	4.53%	4.34%	3.93%	4.47%
Allied Health Professionals	4.19%	4.95%	5.17%	5.09%	4.31%	4.26%	2.81%	3.59%	3.63%	5.05%	4.76%	4.73%
Estates and Ancillary		10.00%	12.28%	2.28%	5.52%	9.06%	9.19%	9.38%	6.46%	11.28%	12.10%	13.45%
Healthcare Scientists	4.27%	3.78%	2.24%	5.14%	6.68%	3.82%	4.34%	5.09%	4.47%	5.67%	4.93%	6.98%
Medical and Dental	1.62%	1.80%	1.74%	1.98%	2.28%	2.38%	1.90%	1.95%	2.92%	3.89%	2.96%	3.09%
Nursing and Midwifery Registered	5.18%	5.09%	5.26%	5.67%	5.35%	4.98%	4.61%	4.52%	4.99%	5.12%	4.82%	5.24%

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

Admin and Clerical, Estates/Ancillary, Healthcare Scientists, Medical and Dental and Nursing/Midwifery have all had increased sickness absence rates in September 2024.

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	748	989	22,769.91	21.8
S13 Cold, Cough, Flu - Influenza	2349	3,157	11,046.96	10.6
S25 Gastrointestinal problems	2019	2,773	10,535.94	10.1
S12 Other musculoskeletal problems	542	672	10,343.42	9.9
S30 Pregnancy related disorders	280	801	5,752.63	5.5
S99 Unknown causes / Not specified	604	724	5,200.91	5.0
S28 Injury, fracture	213	230	5,116.42	4.9
S26 Genitourinary & gynaecological disorders	346	443	4,921.64	4.7
S98 Other known causes - not elsewhere classified	291	401	4,236.22	4.0
S11 Back Problems	304	355	3,730.18	3.6

Top 10 Absence Reasons by Absence Days

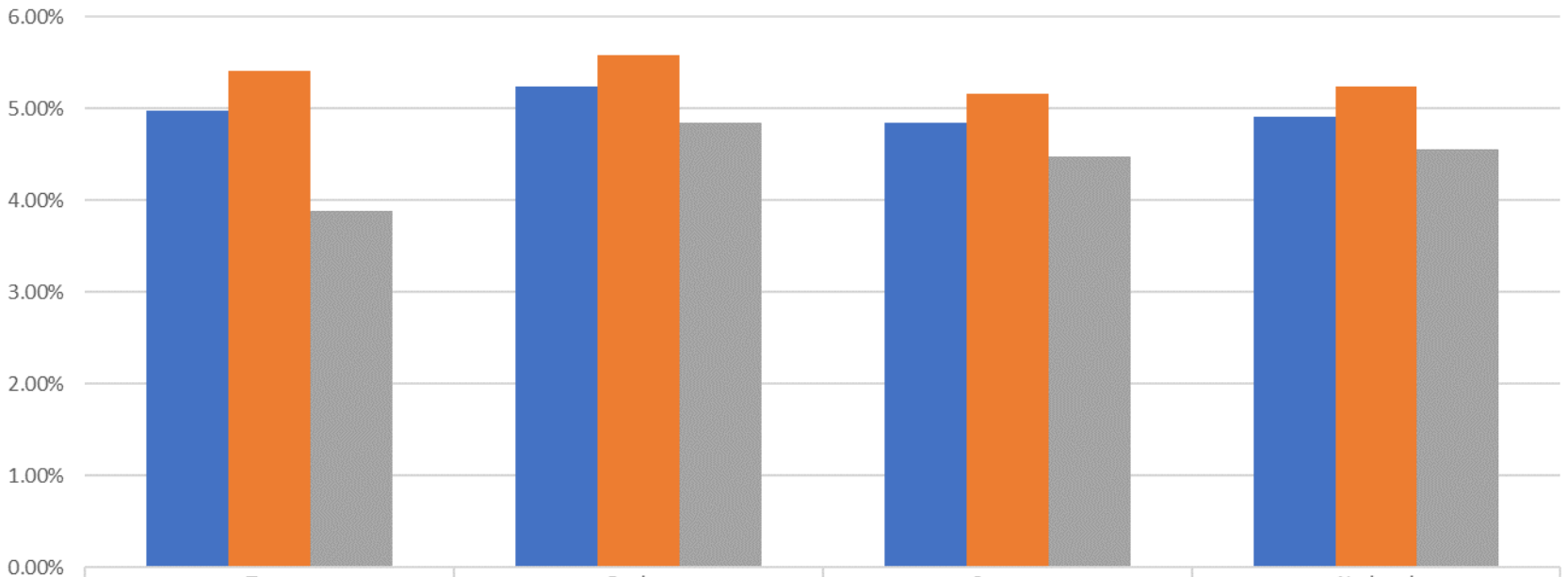
Absence Reason	Headcount	Abs Occurrences	Abs Days	%
S10 Anxiety/stress/depression/other psychiatric illnesses	748	989	26,899	22.1
S13 Cold, Cough, Flu - Influenza	2349	3,157	12,582	10.3
S12 Other musculoskeletal problems	542	672	12,349	10.1
S25 Gastrointestinal problems	2019	2,773	11,889	9.8
S30 Pregnancy related disorders	280	801	6,427	5.3
S99 Unknown causes / Not specified	604	724	6,181	5.1
S28 Injury, fracture	213	230	6,086	5.0
S26 Genitourinary & gynaecological disorders	346	443	5,849	4.8
S11 Back Problems	304	355	4,615	3.8
S98 Other known causes - not elsewhere classified	291	401	4,499	3.7

- 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
- 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

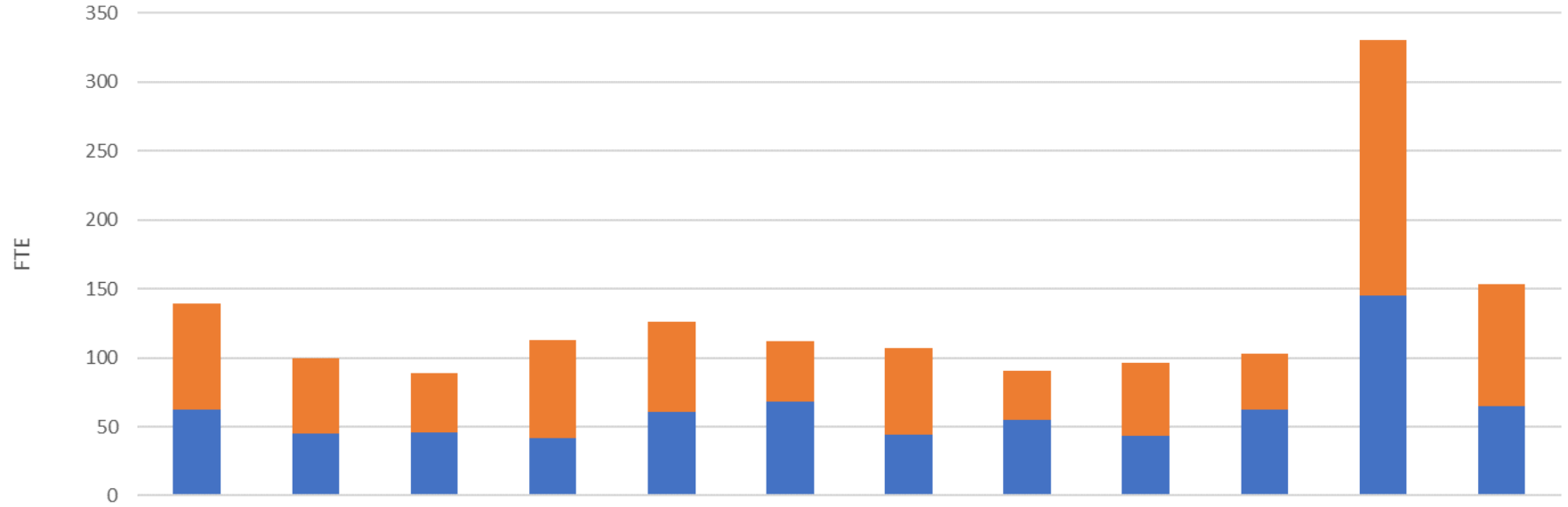


	Trust	Region	Country	National
MO3	4.98%	5.25%	4.85%	4.92%
MO4	5.42%	5.58%	5.17%	5.24%
MO5	3.89%	4.84%	4.48%	4.56%

- National and Regional benchmarking data is only available until end of August 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 August 2024 (M05), the Trust's sickness absence rate was lower than the Region, Country and Nationally.

CARE RESPECT RESPONSIBILITY

Starters and Leavers



	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24
Starters FTE	76.71	54.58	43.14	70.67	65.39	43.48	62.83	35.54	52.59	40.54	184.76	88.73
Leavers FTE	62.53	44.71	46.14	42.08	60.87	68.38	44.5	55.34	43.66	62.61	145.51	65.12

Starters vs Leavers

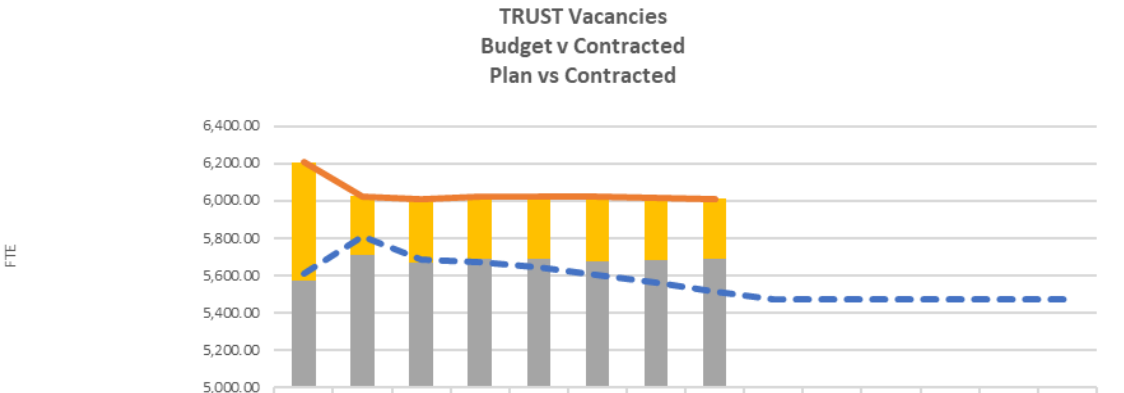
- This month we have seen more leavers than starters in September 2024.

Assurance

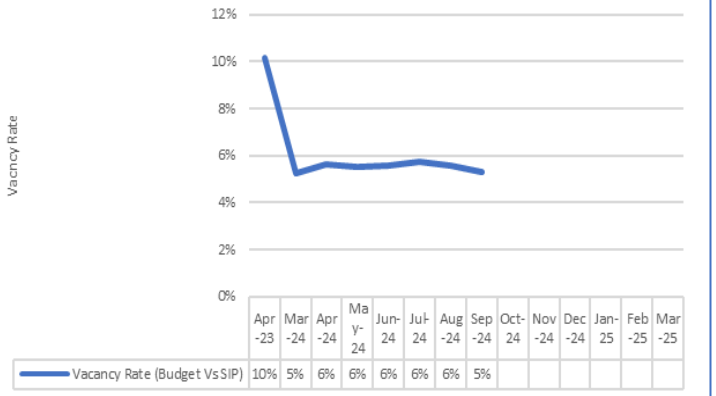
- Trust's recruitment and retention journey is now ratified and will be socialised through a new sub-group of People Committee. However, recruitment to roles continues to be subject to grip and control / Vacancy Control measures, which means a greater emphasis on retention over the coming months.

Recruitment/Vacancies/Turnover - TRUST

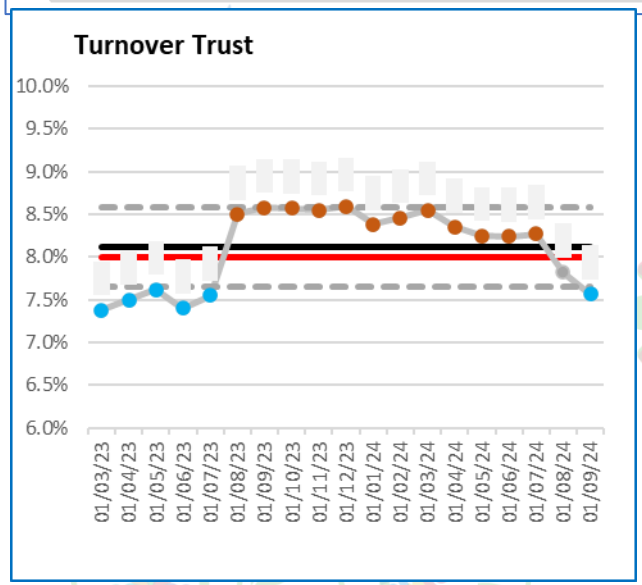
The Dudley Group
NHS Foundation Trust

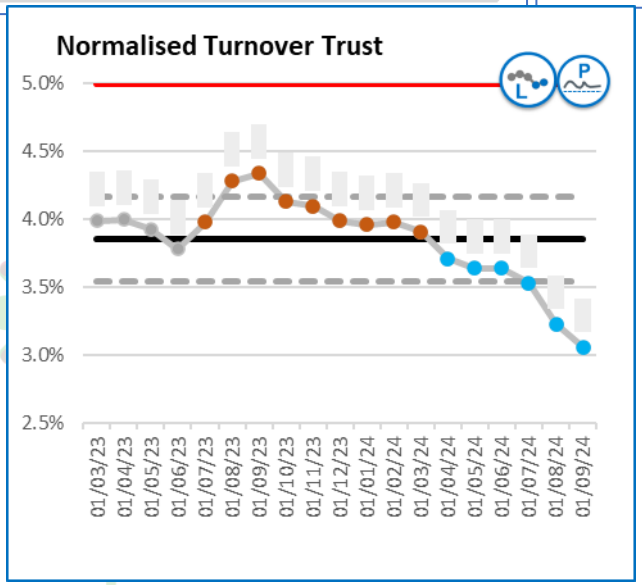


	Apr-23	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25
Funded establishment gap	630.36	315.71	336.72	331.20	335.77	344.84	335.45	319.58						
SIP	5574.67	5707.49	5670.63	5689.54	5686.4	5676.23	5680.82	5691.88						
Plan	5608.00	5811.74	5687.09	5672.09	5642.09	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	6016.27	6011.46						



	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%	6%	5%						





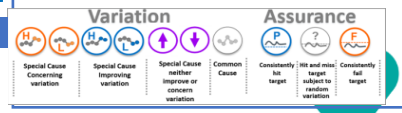
Contracted WTE staff has increased from 5680.82 in August 24 to 5691.88 in September 24.

For substantive staff this is 174.79 WTE above the workforce plan (more staff than we said we would have).

Total vacancies stand at 319.58 WTE in September 2024. This equates to a vacancy rate of 5%.

Overall staff turnover (rolling twelve months average) is at 7.57% with normalised turnover at 3.06% in September 2024.

	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24
Trust Turnover	8.57%	8.55%	8.59%	8.38%	8.46%	8.55%	8.35%	8.25%	8.24%	8.27%	7.82%	7.57%
Trust Normalised Turnover	4.13%	4.10%	3.99%	3.96%	3.98%	3.91%	3.71%	3.64%	3.64%	3.53%	3.23%	3.06%



RESPECT

RESPONSIBILITY

Top 5 Departments - High Vacancies

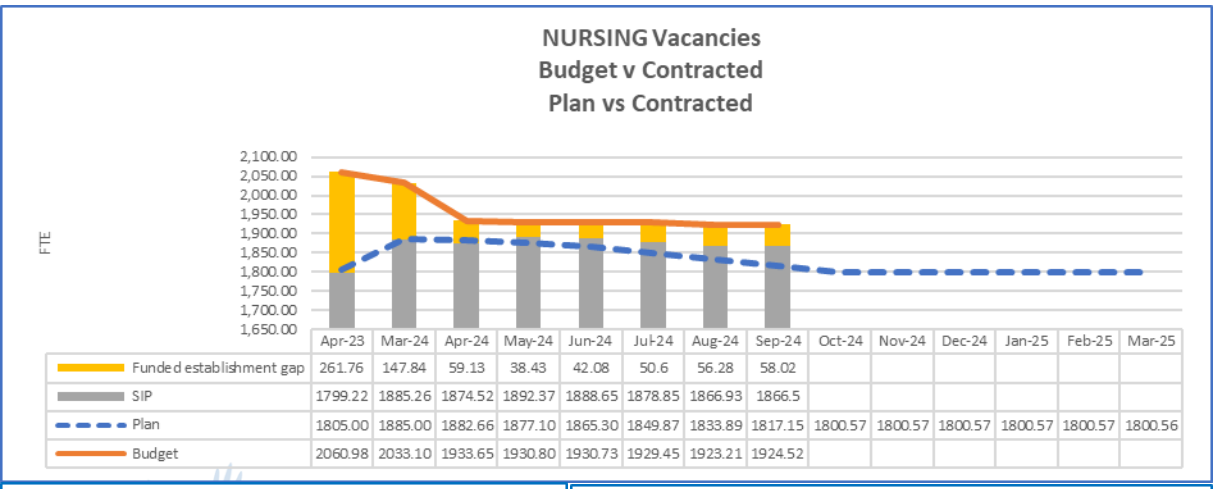
The Dudley Group
NHS Foundation Trust

Cost Centre Description	Budget WTE	Contracted WTE	Vacancy WTE	Vacancy %
Emergency Department Nursing	139.31	117.84	21.47	15%
Pharmacy Department	183.43	165.51	17.92	10%
Therapy Department	141.89	127.44	14.45	10%
Phlebotomists	68.76	55.08	13.68	20%
Medical Staff Paediatrics	61.9	48.72	13.18	21%

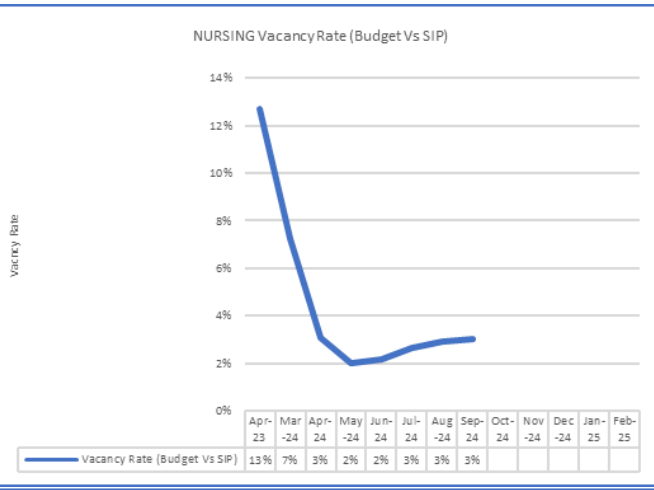
- ED nursing have been reviewing their skill mix and converting some vacant posts into different roles to try to attract Nursing to ED as well as implementing succession planning.
- Pharmacy have undertaken significant work to address known factors that create higher turnover and lower retention rates, such as addressing flexible working challenges. The vacancy gap is slowly closing but continues to be an ongoing progress.
- There has been a recent deep dive into AHP and Healthcare Scientist roles with an associated hot spots and action plan that the Being and Brilliant Place to Work group is supporting. There is also bespoke OD interventions to support improving the culture within the Therapy department.
- Further exploration of vacancies and turnover within Phlebotomy will be undertaken to understand the drivers behind higher vacancy rates and the plans for recruitment.
- Medical staff Paediatrics are actively recruiting with 5 WTE waiting to start.

Recruitment/Vacancies/Turnover - Registered Nursing & Midwifery

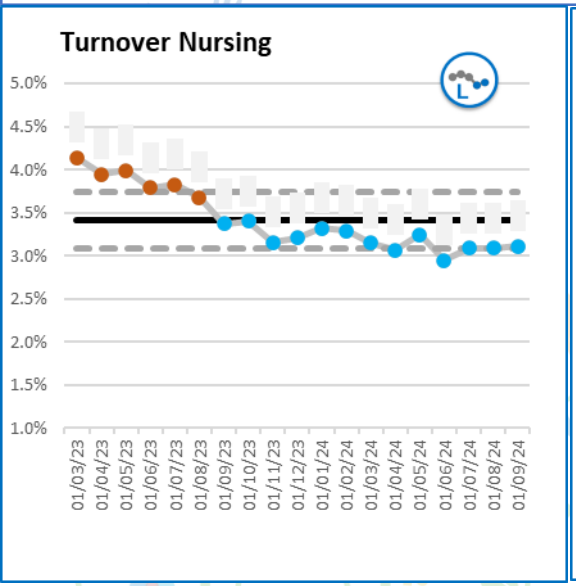
The Dudley Group NHS Foundation Trust

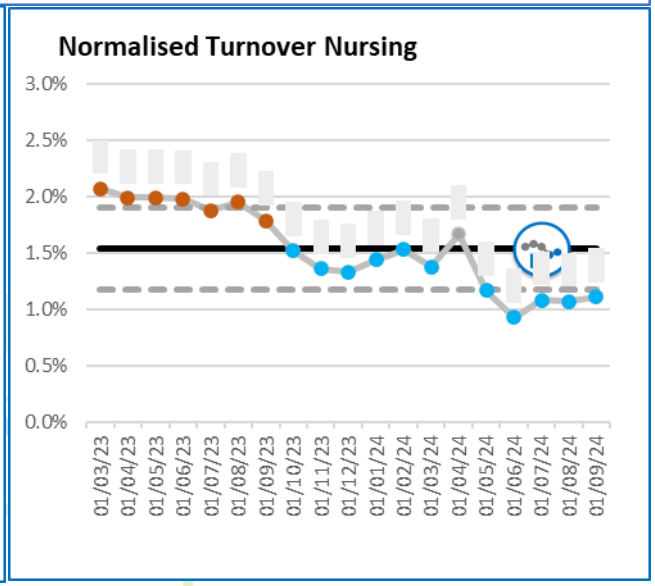


	Apr-23	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25
Funded establishment gap	261.76	147.84	59.13	38.43	42.08	50.6	56.28	58.02						
SIP	1799.22	1885.26	1874.52	1892.37	1888.65	1878.85	1866.93	1866.5						
Plan	1805.00	1885.00	1882.66	1877.10	1865.30	1849.87	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	1923.21	1924.52						



	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%	3%	3%					





Contracted WTE for nursing and midwifery staff in September 24 is 1866.5 WTE, compared with 1866.93 WTE in August 24.

This is 49.35 WTE above the workforce plan (more staff than we said we would have).

The total nursing and midwifery vacancies reported stands at 58.02 WTE, which equates to a vacancy rate of 3%.

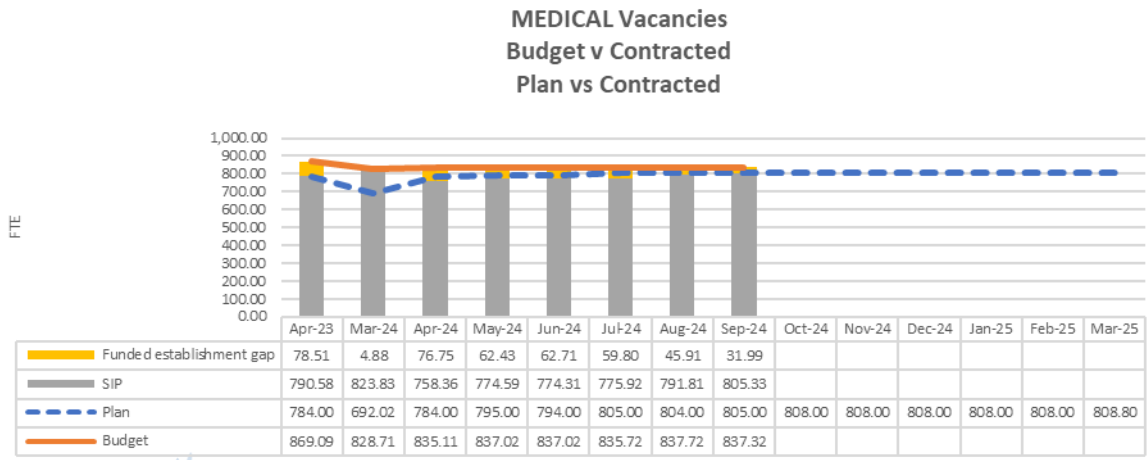
Staff turnover for nursing (rolling 12 months average) is at 3.11%, with normalised turnover at 1.11% in September 2024.

	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24
Nursing Turnover	3.40%	3.16%	3.21%	3.32%	3.29%	3.15%	3.07%	3.25%	2.95%	3.09%	3.09%	3.11%
Nursing Normalised Turnover	1.52%	1.36%	1.33%	1.44%	1.53%	1.38%	1.67%	1.17%	0.93%	1.08%	1.07%	1.11%

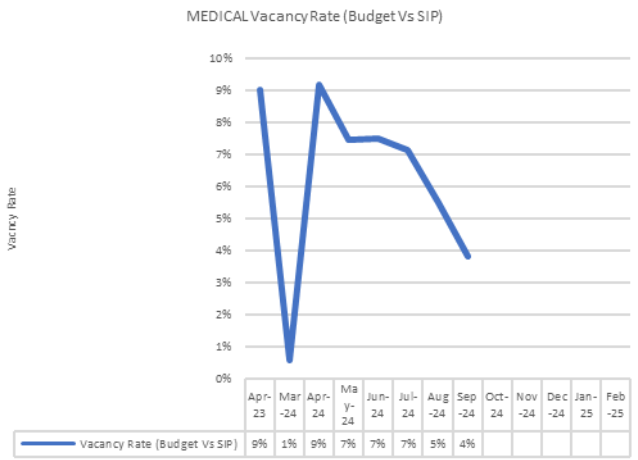
CARE RESPECT RESPONSIBILITY

Recruitment/Vacancies/Turnover - Medical & Dental

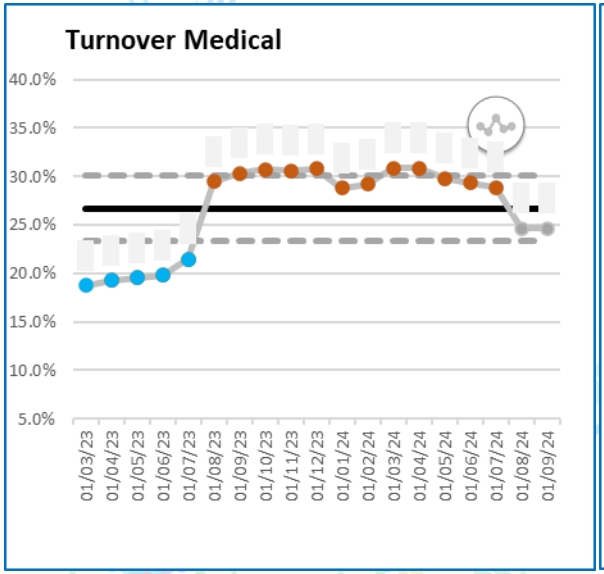
The Dudley Group NHS Foundation Trust

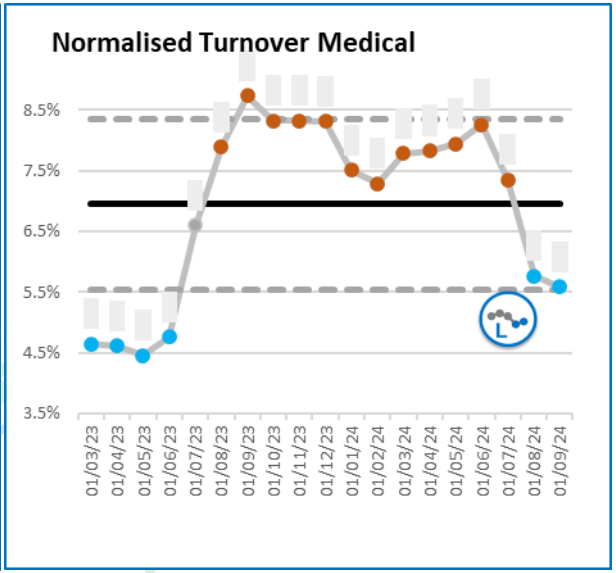


	Apr-23	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25
Funded establishment gap	78.51	4.88	76.75	62.43	62.71	59.80	45.91	31.99						
SIP	790.58	823.83	758.36	774.59	774.31	775.92	791.81	805.33						
Plan	784.00	692.02	784.00	795.00	794.00	805.00	804.00	805.00	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	837.72	837.32						



	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%	5%	4%					





Contracted WTE for medical and dental staff has increased to 805.33 WTE in Sept 24 from 791.81 WTE in Aug 24. This is 0.33 WTE above plan (more staff than we said we would have).

The total medical and dental vacancies stands at 31.99 WTE. The vacancy rate is 4%.

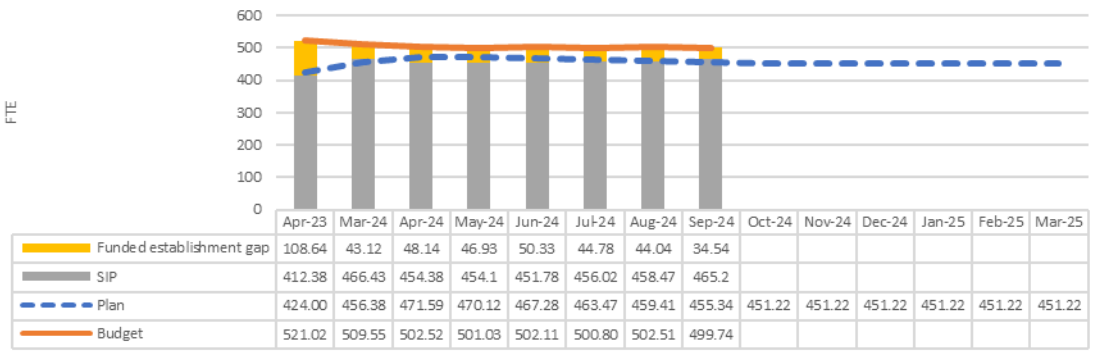
Staff turnover for medical and dental (rolling 12 months average) is 24.66% with normalised turnover at 5.59%. It should be noted that Deanery rotations are included in overall turnover.

	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24
M&D Turnover	30.71%	30.63%	30.82%	28.79%	29.19%	30.86%	30.86%	29.83%	29.34%	28.86%	24.64%	24.66%
M&D Normalised Turnover	8.32%	8.32%	8.31%	7.51%	7.29%	7.78%	7.83%	7.94%	8.26%	7.35%	5.77%	5.59%

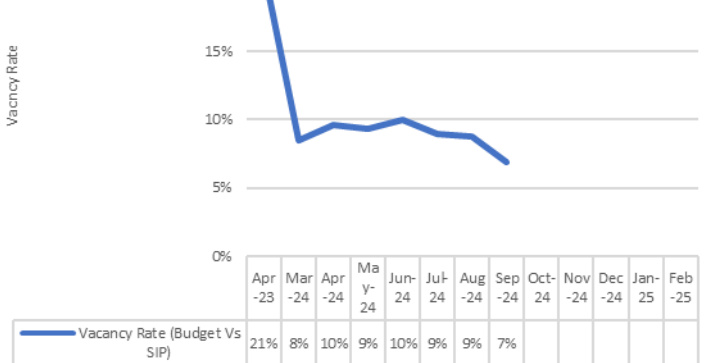
CARE RESPECT RESPONSIBILITY

Recruitment/Vacancies/Turnover - Allied Health Professional

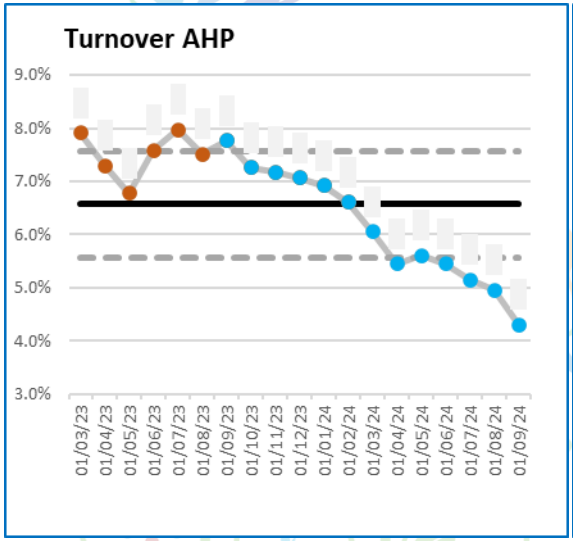
The Dudley Group NHS Foundation Trust

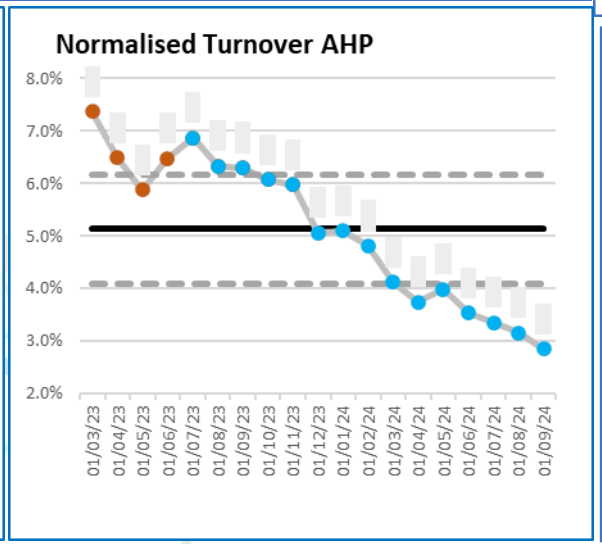


	Apr-23	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25
Funded establishment gap	108.64	43.12	48.14	46.93	50.33	44.78	44.04	34.54						
SIP	412.38	466.43	454.38	454.1	451.78	456.02	458.47	465.2						
Plan	424.00	456.38	471.59	470.12	467.28	463.47	459.41	455.34	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	502.51	499.74						



	Apr -23	Mar -24	Apr -24	May- 24	Jun- 24	Jul- 24	Aug -24	Sep -24	Oct- 24	Nov -24	Dec -24	Jan- 25	Feb -25
Vacancy Rate (Budget Vs SIP)	21%	8%	10%	9%	10%	9%	9%	7%					





Contracted WTE for AHP's has increased to 465.2 WTE in Sept 24 from 459.47 WTE in Aug 24.

This is 9.86 WTE above the workforce plan (more staff than we said we would have).

The total AHP vacancies in June 2024 are 34.54 WTE this is a vacancy rate of 7%.

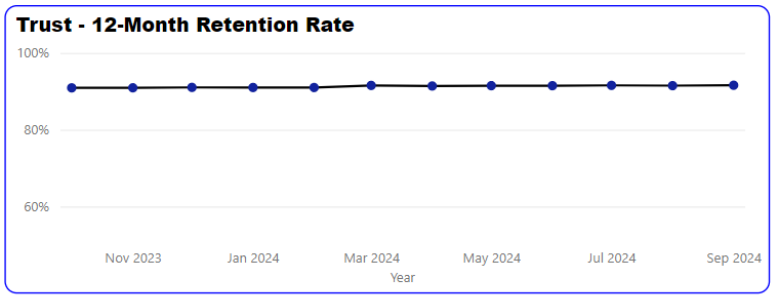
Staff turnover for AHP's (rolling 12 months average) is 4.30%, the normalised turnover is 2.85%.

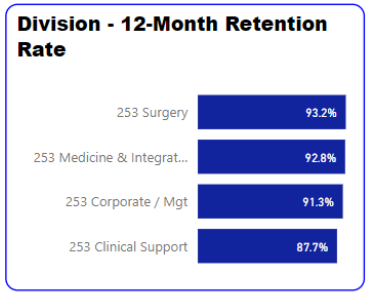
	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24
AHP Turnover	7.26%	7.17%	7.06%	6.92%	6.61%	6.05%	5.45%	5.61%	5.45%	5.15%	4.95%	4.30%
AHP Normalised Turnover	6.07%	5.98%	5.06%	5.10%	4.81%	4.12%	3.74%	3.98%	3.53%	3.35%	3.16%	2.85%

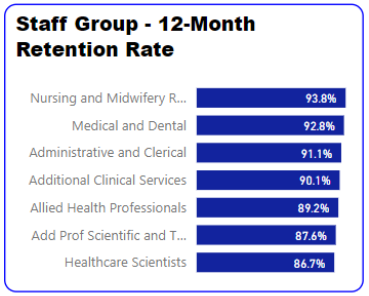
CARE RESPECT RESPONSIBILITY

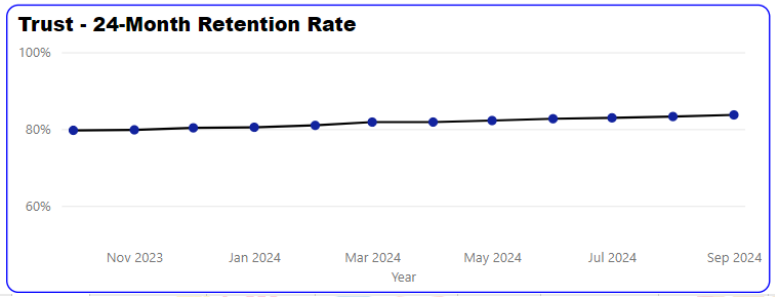
Retention

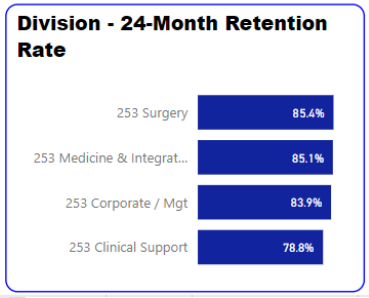
The Dudley Group NHS Foundation Trust

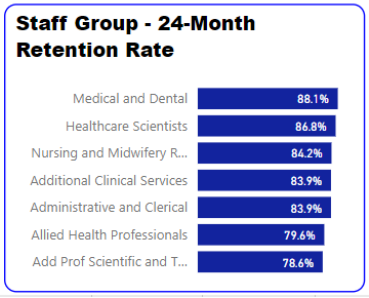










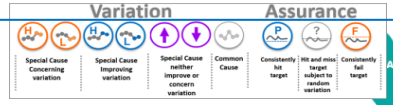


September 2024

12-Month	Trust 91.6%
24-Month	Trust 83.7%

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

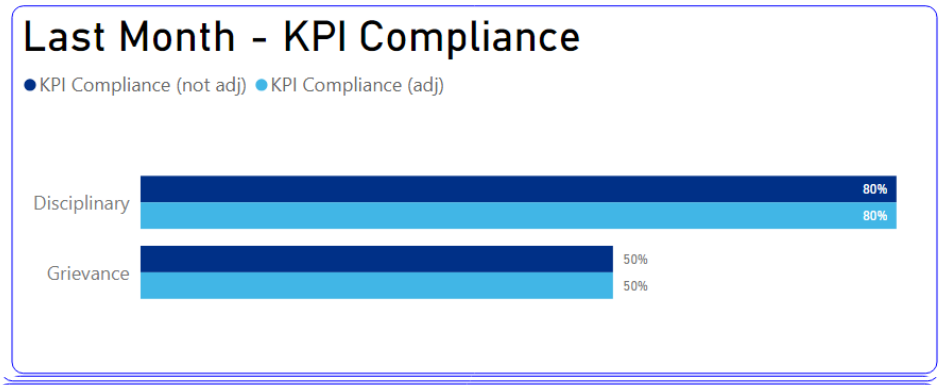
The division with the lowest 24-month retention rate is CCCS at 78.8% and both Additional Professional, Scientific and Technical staff and Allied Health Professionals are two staff groups that lower retention rates.

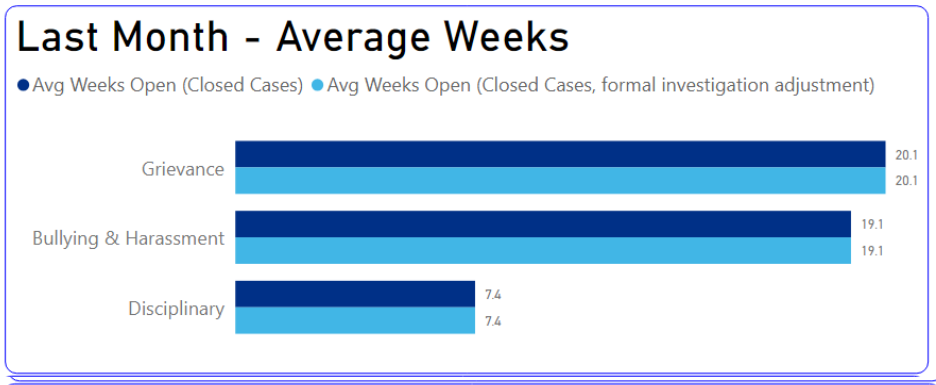


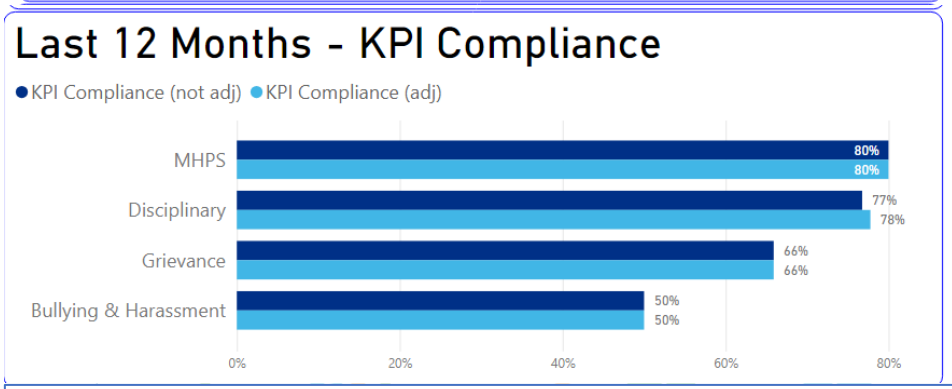
CARE RESPECT RESPONSIBILITY

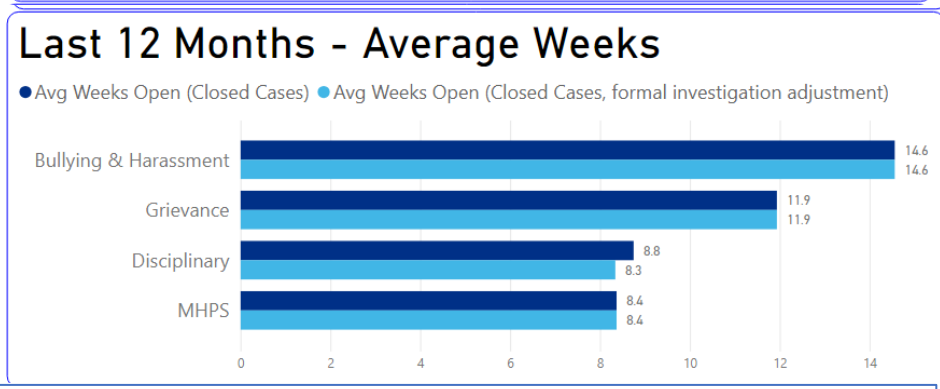
Employee Relations Casework KPI

The Dudley Group NHS Foundation Trust









Disciplinary – Average time taken to complete a disciplinary investigation is 7.4 weeks in September 2024 and 8.4 weeks over a rolling 12 month period. The percentage of closed cases meeting the KPI of 12 weeks in September was 80% and 78% over a rolling 12 month period.

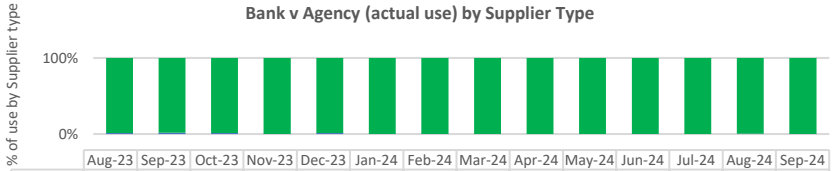
Grievances – Average time taken to complete the formal stage of the grievance process in September was 19.1 weeks, and 11.9 weeks over a rolling 12 month period. In September only 2 grievance cases closed, 1 of which was within the KPI of 12 weeks and one over 12 weeks, making the compliance with the KPI 50% in September. Over a rolling 12 month period the percentage compliance is 66%

B&H – 1 case in September closed, which was over the 12 week KPI at 20.1 weeks. Over a rolling 12 month period, on average, B&H cases take 14.6 weeks to close and only 50% compliance with the 12 week KPI.

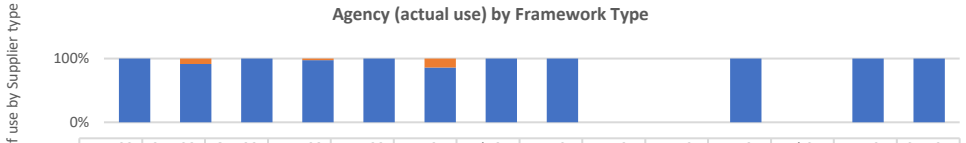
MHPS – no cases closed in September. Over 12 months, on average, cases closed within 8.4 weeks and there is an 80% compliance rate with

Bank and Agency Usage

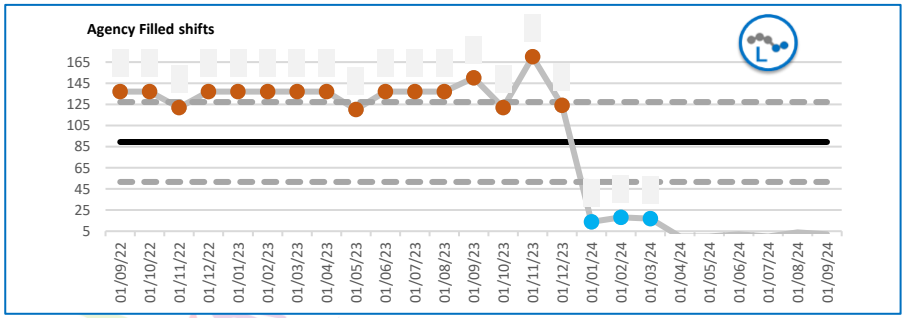
The Dudley Group NHS Foundation Trust

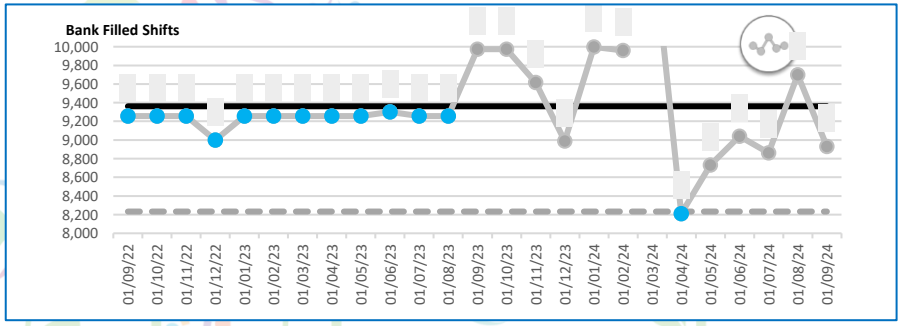


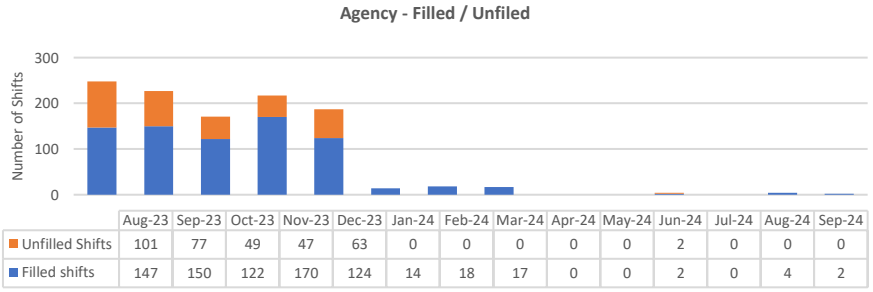
	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24
Bank	98.53%	98.43%	98.78%	98.26	98.64%	99.87%	99.82%	99.87%	100.00%	100.00%	99.98%	100.00%	99.50%	99.98%
Agency	1.47%	1.57%	1.22%	1.74%	1.36%	0.13%	0.18%	0.13%	0.00%	0.00%	0.02%	0.00%	0.50%	0.20%



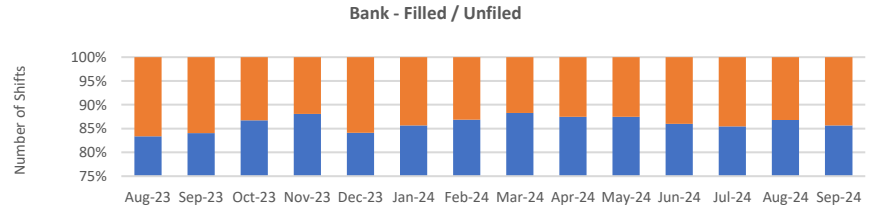
	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24
NFW		13		4	0	2	0	0	0	0	0	0	0	0
FW	147	137	122	170	122	12	18	17	0	0	2	0	4	2







	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24
Unfilled Shifts	101	77	49	47	63	0	0	0	0	0	2	0	0	0
Filled shifts	147	150	122	170	124	14	18	17	0	0	2	0	4	2



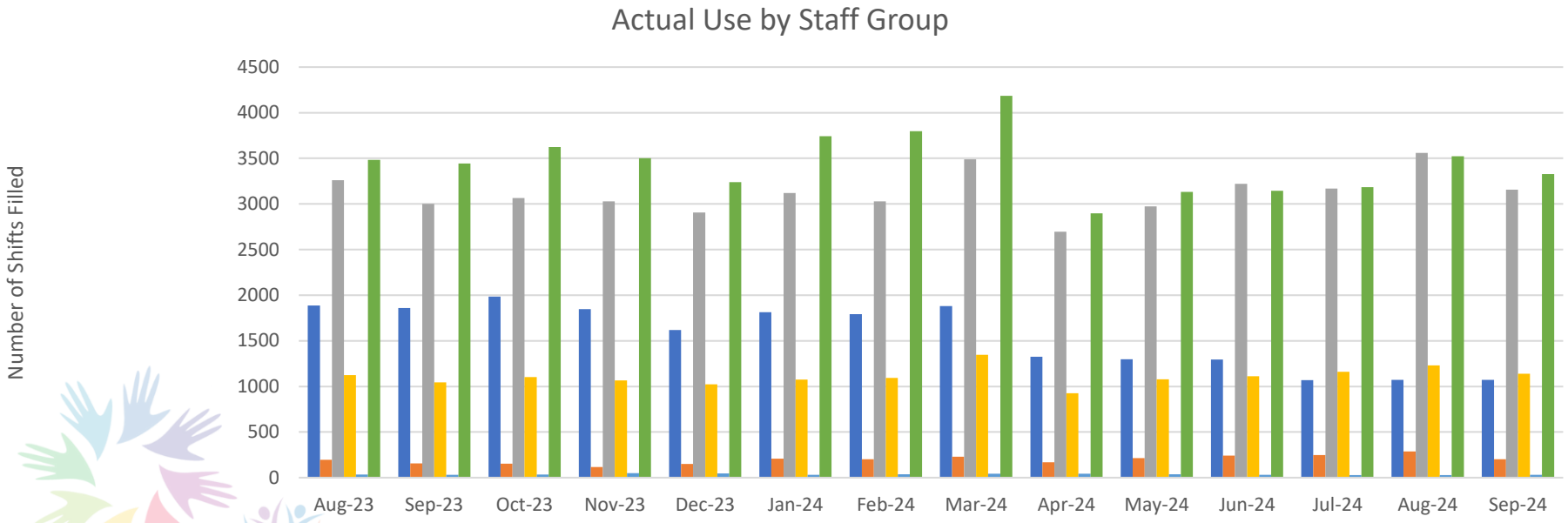
	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24
Unfilled Shifts	17%	16%	13%	12%	16%	14%	13%	12%	13%	12%	14%	15%	13%	14%
Filled Shifts	83%	84%	87%	88%	84%	86%	87%	88%	87%	88%	86%	85%	87%	86%

Bank Fill rates for September have reduced slightly from 87% in August 2024 to 86% in September 2024. Agency shifts (non-medic) reduced from 4 in August 2024 to 2 in September 2024.

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	Aug-24	Sep-24
A&C	1888	1860	1985	1848	1619	1812	1793	1881	1324	1299	1296	1069	1073	1073
Add Prof Scientific and Technic	195	155	152	115	150	208	201	230	168	215	242	249	288	202
Additional Clinical Services	3259	3001	3065	3028	2907	3120	3028	3490	2696	2972	3221	3168	3558	3156
AHP	1125	1044	1103	1065	1024	1076	1094	1348	926	1078	1111	1161	1229	1138
Healthcare Scientists	35	30	35	48	47	32	38	44	43	36	30	28	28	31
Nursing & Midwifery Registered	3484	3442	3623	3500	3239	3743	3799	4186	2898	3131	3144	3184	3522	3326

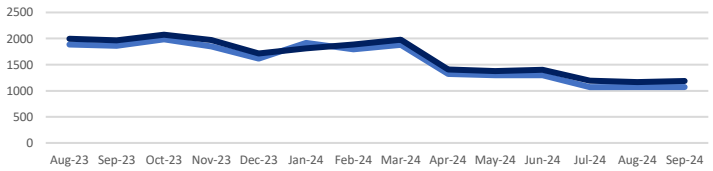
- Admin and Clerical bank usage has been steadily decreasing, since the introduction of the admin and clerical bank additional controls
- Admin and Clerical and Healthcare Scientists are the only staff group with a marked reduction in Bank since April 2024
- Additional Clinical and Nursing and Midwifery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

CARE RESPECT RESPONSIBILITY

Bank Fill Rates

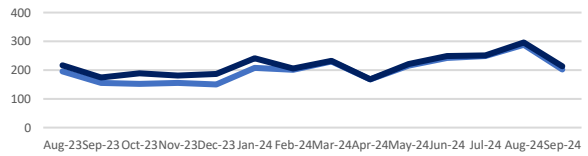
The Dudley Group
NHS Foundation Trust

Bank A&C Filled / Requested



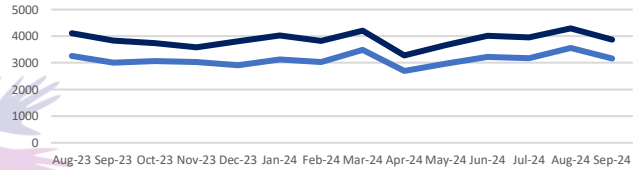
	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24
A&C Filled	1888	1860	1985	1852	1619	1919	1793	1881	1324	1299	1296	1069	1073	1072
Total Request	1994	1965	2074	1971	1717	1812	1885	1977	1406	1377	1401	1194	1166	1184

Bank Add Prof Scientific and Technic Filled / Requested



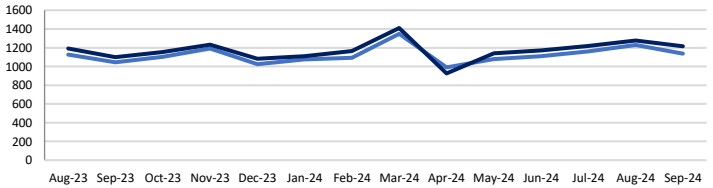
	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24
Add Prof Scientific and Technic Filled	195	155	152	155	150	208	201	230	168	215	242	249	288	202
Total Request	217	174	189	181	187	241	205	232	168	221	249	251	296	213

Additional Clinical Services Filled / Requested



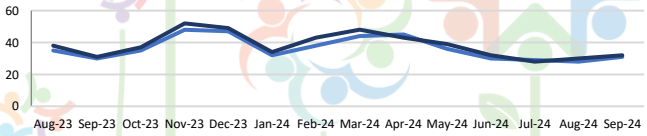
	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24
Additional Clinical Services Filled	3259	3001	3065	3028	2907	3120	3028	3490	2696	2972	3221	3168	3558	3156
Total Request	4116	3831	3733	3581	3812	4027	3819	4211	3278	3667	4019	3959	4293	3870

AHP - Filled / Requested



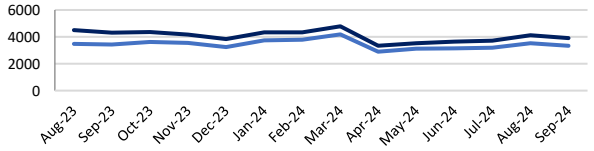
	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24
AHP Filled	1125	1044	1103	1193	1024	1076	1094	1348	990	1078	1111	1161	1229	1138
Total Request	1193	1100	1155	1231	1083	1109	1165	1410	926	1140	1170	1218	1278	1214

Health care Scientists 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	Aug-24	Sep-24
Healthcare Scientists Filled	35	30	35	48	47	32	38	44	45	36	30	29	28	31
Total Request	38	31	37	52	49	34	43	48	43	39	32	28	30	32

Registered RN Filled / Requested



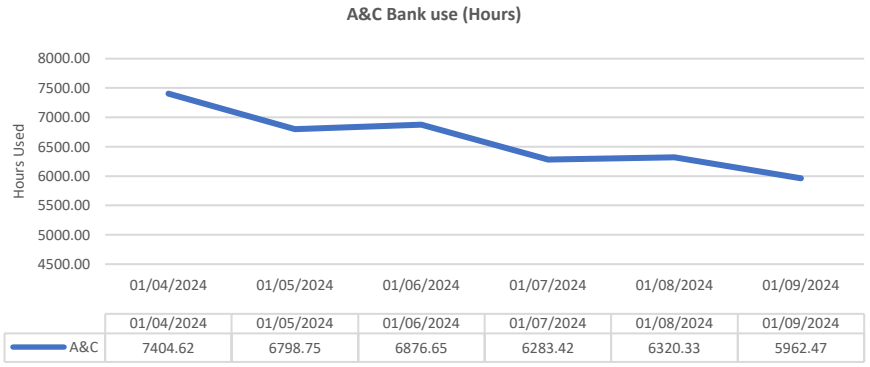
	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24
Nursing & Midwifery Registered Filled	3484	3442	3623	3550	3239	3743	3799	4186	2898	3131	3144	3184	3522	3326
Total Request	4493	4311	4349	4163	3832	4330	4342	4787	3339	3534	3649	3712	4112	3907

CARE RESPECT RESPONSIBILITY

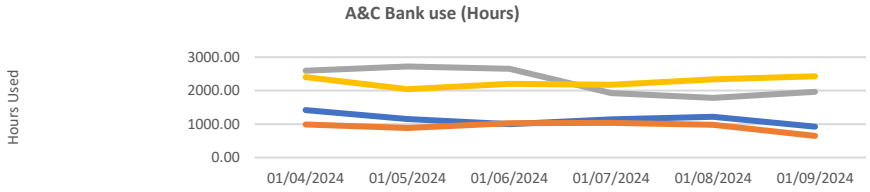
A&C Bank Use

Hours Used

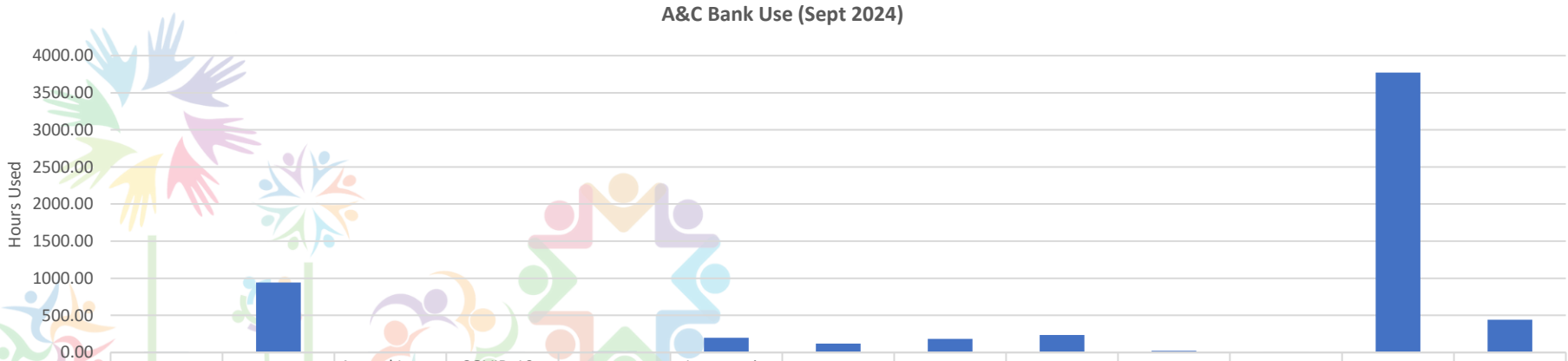
The Dudley Group
NHS Foundation Trust



	01/04/2024	01/05/2024	01/06/2024	01/07/2024	01/08/2024	01/09/2024
A&C	7404.62	6798.75	6876.65	6283.42	6320.33	5962.47



	01/04/2024	01/05/2024	01/06/2024	01/07/2024	01/08/2024	01/09/2024
Clinical Support	1417.92	1153.58	994.50	1143.58	1219.00	923.00
Corporate / Mgt	987.75	879.50	1022.75	1036.58	981.33	647.50
Medicine & Integrated Care	2592.62	2721.92	2656.15	1924.41	1782.66	1963.92
Surgery	2406.33	2043.75	2203.25	2178.83	2336.58	2428.05

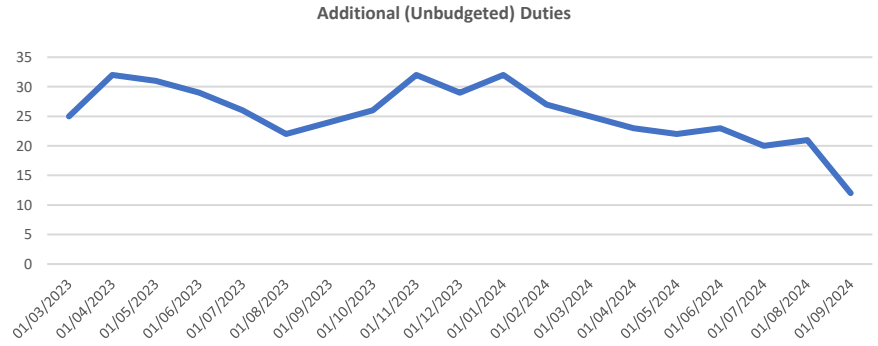


	1:1	Additional Activity	Annual Leave (Overbooked /Emergency)	COVID-19 - Vaccination Programme	Extra Clinic	Increase in capacity - beds/patients	Maternity	Sickness Long Term	Sickness Short Term	Special Leave	Study Leave	Vacant Post	Waiting List Initiative
Total	12.00	943.58	9.50	7.50	16.00	197.25	120.75	181.67	236.42	21.00	4.00	3772.05	440.75

CARE RESPECT RESPONSIBILITY

Rostering KPI

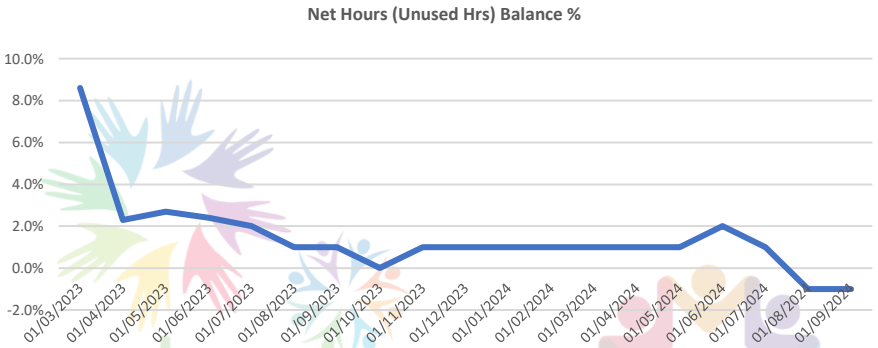
The Dudley Group
NHS Foundation Trust



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

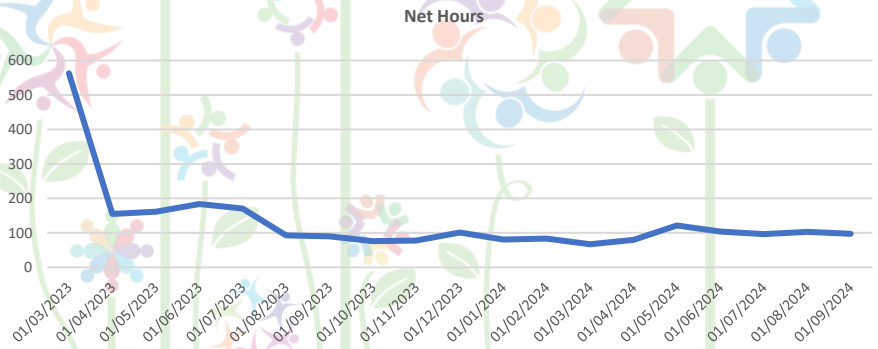
Registered 42%, Unregistered 58%

Top departments are Discharge Lounge, Ward C3, Ward C6 & Ward B5.
Top reasons are Increase in Capacity & 1:1



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

Target – Below 2% - currently compliant

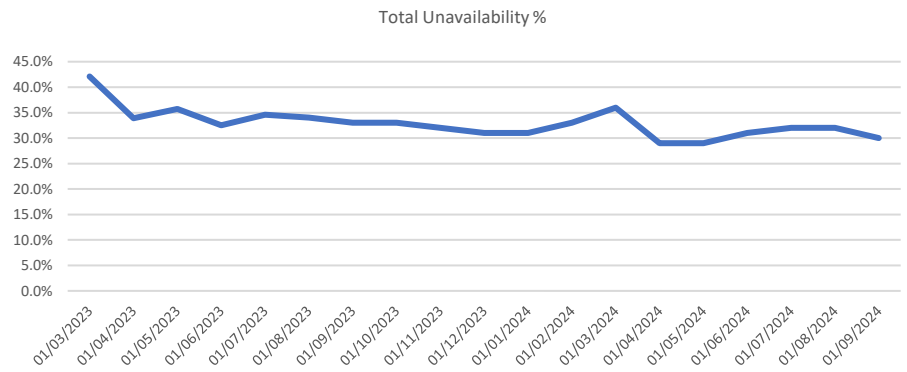


Average number of Divisional unused hours at the end of the roster period.

CARE RESPECT RESPONSIBILITY

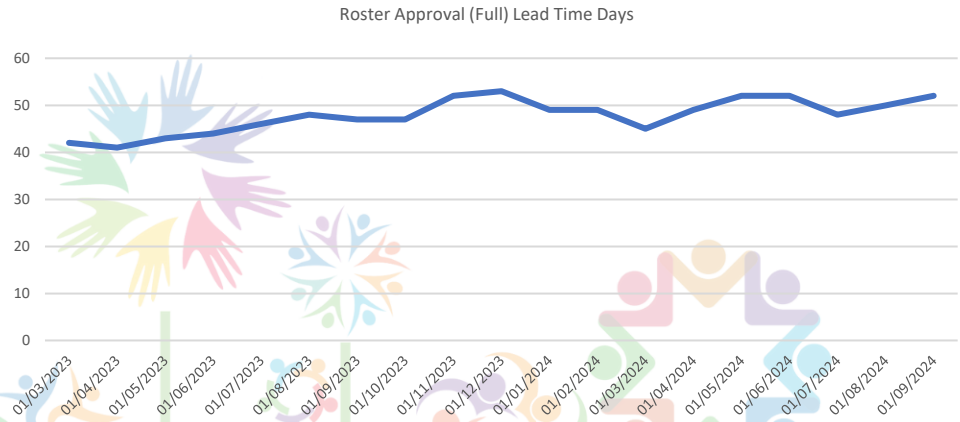
Rostering KPI

The Dudley Group
NHS Foundation Trust



The percentage of staff hours marked as unavailable. Made up of Annual Leave 12%, Sickness 7%, Parenting 5% , Other Leave 1%, Study Day 2% & 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.

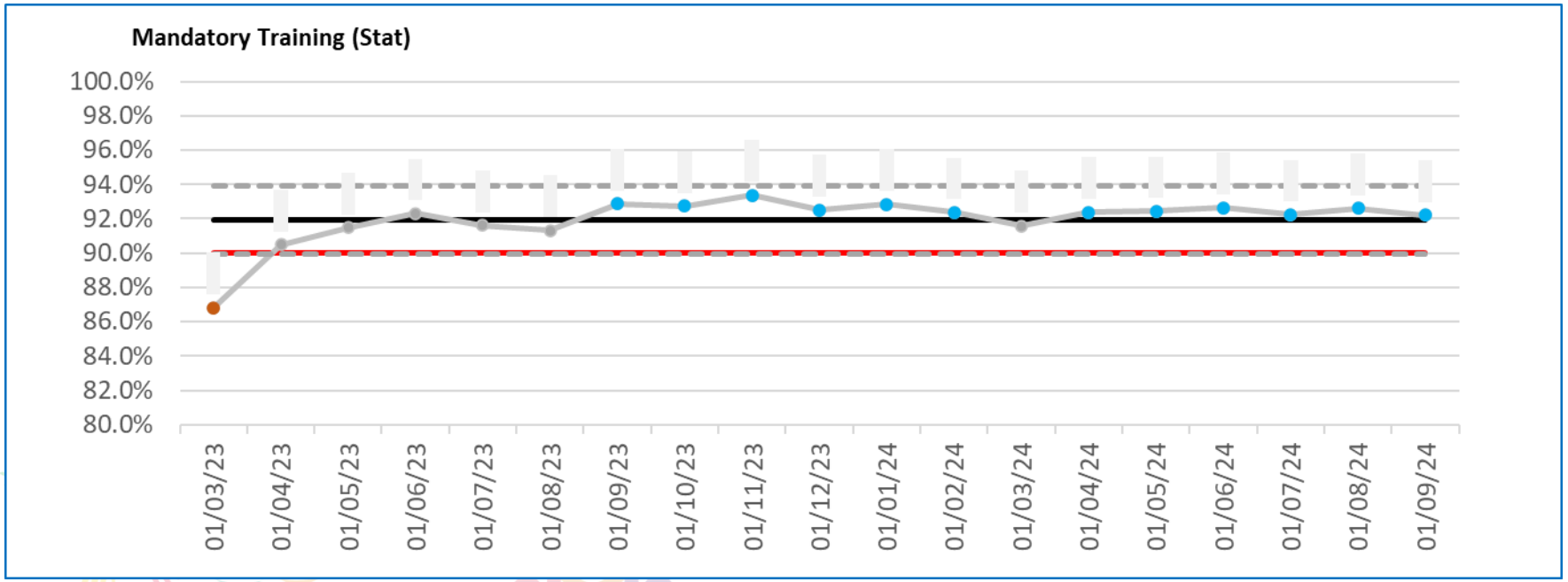
Trust target is 55 days. NHSE minimum is 42 days.

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

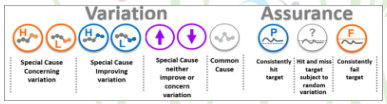
Mandatory Training

The Dudley Group
NHS Foundation Trust



The overall rate for September has maintained above trust target performance. This is sustained above target compliance for over 12 months. The issue around training needs for some staff in safeguarding subjects impacted on subject compliance during August and September but has now achieved amber status.

	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24
Mandatory Training (Stat)	92.74%	93.38%	92.52%	92.85%	92.37%	91.59%	92.39%	92.44%	92.65%	92.24%	92.60%	92.22%



CARE RESPECT RESPONSIBILITY

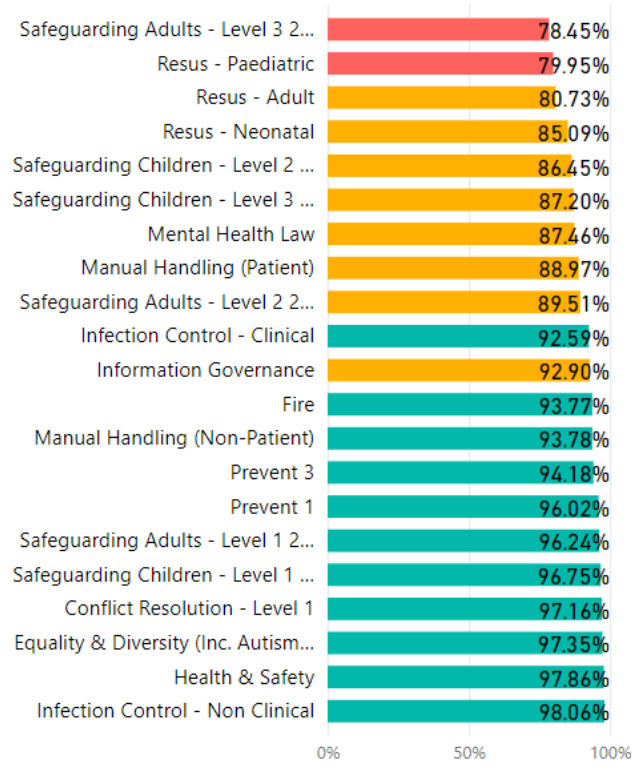
Mandatory Training – Priority 1

The Dudley Group NHS Foundation Trust

Month: September 2024	Trust	CS	Corporate	MIC	Surgery
	92.22%	94.42%	93.71%	91.60%	91.05%

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 MOC Medical Staff Serv	281	107	65.19%
253 Medical Staff - Acute Medicine Serv	753	76	81.75%
253 Ward C8 Serv	771	57	83.80%
253 General Surgery Medical Staff Serv	349	49	78.95%
253 iCan Serv	60	43	52.63%
253 Medical Staff (Older People) Serv	196	42	74.24%
253 Medical Staff Cardiology Serv	142	42	69.60%
253 Theatres Recovery & Anaesth Serv	511	40	83.49%
253 Urology Medical Staff Serv	111	40	66.46%
253 Maxillofacial Surgery Medical Staff Serv	37	39	44.04%
253 Main Theatre Other Specialities Serv	363	35	82.12%
253 Medical Staff Renal Serv	75	33	62.50%
253 Medical Staff Endocrin/Diab Serv	120	32	71.42%
253 Psychiatry Medics Rechg PCT Serv	35	30	48.61%
253 Theatres Emergency & Other Serv	458	27	85.13%
253 Ward B4 Serv	778	27	87.02%
253 Medical Staff - General Medicine Serv	194	23	80.49%
253 Medical Staff - Respiratory Serv	203	23	80.87%
253 Plastic Surgery Medical Staff Serv	66	21	68.75%
253 Anaesthetics Medical Staff Serv	916	19	88.24%
Total	**61,411**	**-1480**	**92.22%**

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 two red rated subjects and work continues on access to learning in order address this.

CARE RESPECT RESPONSIBILITY

Work Experience and Widening Participation

The Dudley Group NHS Foundation Trust

Employability Programmes

ICAN is a collaborative approach to pre-employment, widening participation and support into employment for people in Dudley. It is a developing programme of work delivered in partnership between Dudley MBC, Dudley Group and Dudley College. There are three key workstreams currently:

'I CAN Get Started' is a paid work experience programme for people facing significant barriers to employment.

10 new starters in September (3 clinical/ 7 Non clinical)

23 ICAN 's currently in post (14 clinical/9 non clinical)

2 currently on work trials for permanent roles

8 completed (6 employed into substantive roles here, 1 bank and 1 did not complete)

4 Care Certs gained

'Into Employment' Programme – 9 attending Info employment programme with more intake expected in October.

Careers Education Information Advice and Guidance (CEIAG)

Departments engagement: NHS Careers and opportunities, Pharmacy, Healthcare Science, AHP'S
Total Staff time given : 26 hours
Reached: 48 individuals.

Ambassadors

81 Careers Ambassadors are currently registered.

Work Experience

3 Clinical dept led placements all to gain access to higher education .

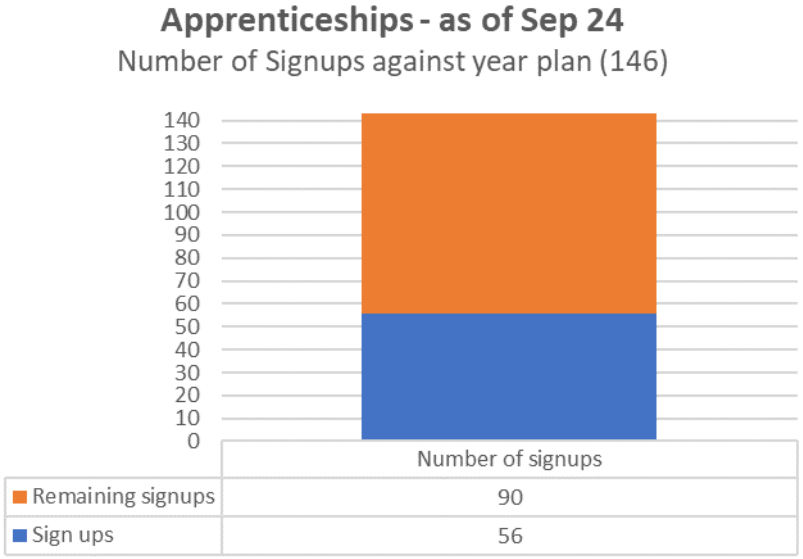
2 further placements cleared to start November.

65 applications received form central clinical WEX programme due to start November.

CARE RESPECT RESPONSIBILITY

Apprenticeships

The Dudley Group
NHS Foundation Trust



Total Active Apprenticeships **264**	
Apprenticeship Levy	£
Expired Levy April 24	£25,738
Expired Levy May 24	£15,833
Expired Levy June 24	£0
Expired Levy July 24	£0
Expired Levy August 24	£0
Expired Levy September 24	£0

More sign ups were expected for September, but the MSW support worker programme with Halesowen college is now confirmed at October start date.

Target for 2023/24 was not achieved – this was due to a range of factors including:

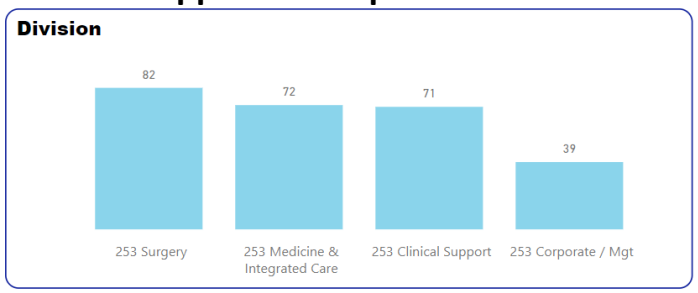
Expected recruitment activity was not able to go ahead as planned for the novice apprenticeship programme in January and nursing associate programme in March due to lack of available posts.
Cohorts planned in Q4 for the 4th CMI level 5 cohort and Senior Health Care Support Worker Level 3 have been moved to April due to capacity and availability of resources at the College.

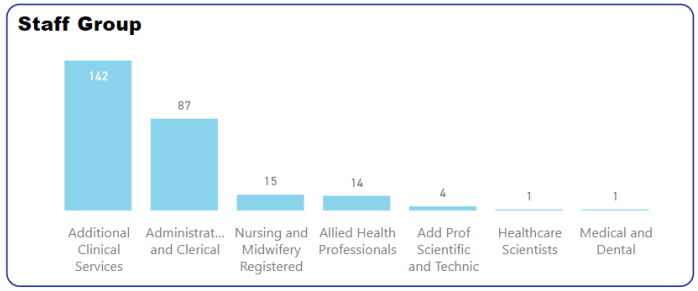
Sign-up activity has included:

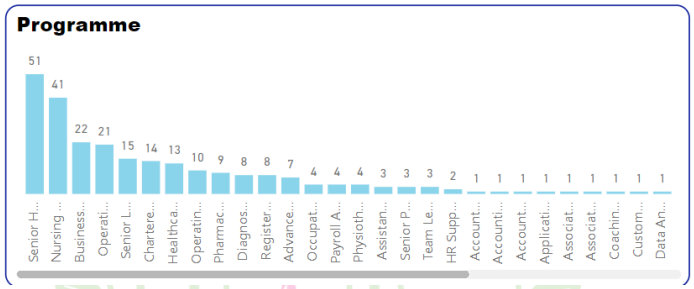
31 degree / master level apprenticeships including Chartered Manager, Senior Leader, Operating Department Practitioner, Occupational Therapy, Physiotherapy and Registered Nurse.
Continuation of Business Administration, Medical Administration, Pharmacy programmes and the 3rd CMI level 5 in July.
Introduction of IT programmes at level 4 and 6.
Introduction of Dietetic Masters level 7.

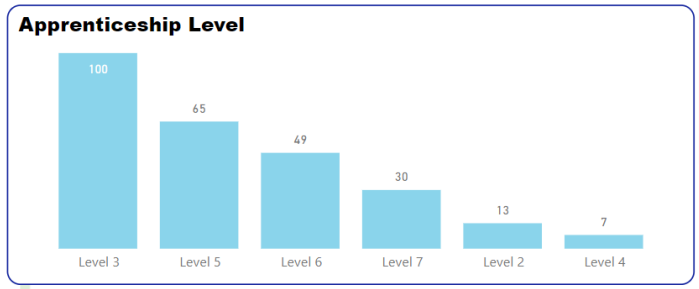
Work continues to promote internal apprenticeship opportunities in order to compensate for the lack of new apprentice opportunities.

Active Apprenticeships breakdown





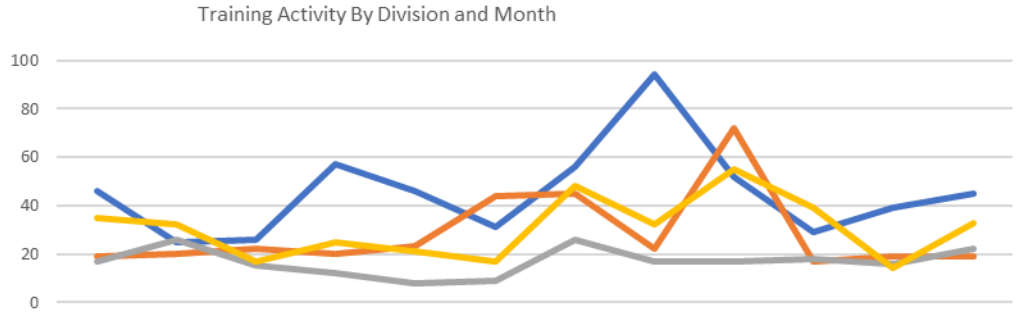




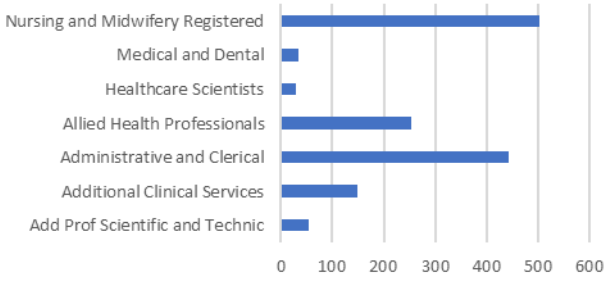
CARE RESPECT RESPONSIBILITY

Organisational Development

The Dudley Group
NHS Foundation Trust



	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24
253 Clinical Support	46	25	26	57	46	31	56	94	52	29	39	45
253 Corporate / Mgt	19	20	22	20	23	44	45	22	72	17	19	19
253 Medicine & Integrated Care	17	26	15	12	8	9	26	17	17	18	16	22
253 Surgery	35	32	17	25	21	17	48	32	55	39	14	33



Course	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Grand Total
253 Admin Essentials			8				14			13			35
253 Annual Review Training						12	45	43	18				118
253 Bespoke Training								21	23	6		10	60
253 Coaching	2					5			8		6		21
253 Communications 1	13	18	24		4	10	6		13	10	3	11	112
253 Communications 2				9	12		3		21		13		58
253 Developing Leaders					8								14
253 Flexible Working							8	16		9			33
253 Leading People at Dudley				4		6	12	8	3	4	9	4	50
253 Leading with Confidence Introduction												8	8
253 Living The Values	36	13		31	20	11	32	12	34	11		2	202
253 Local Induction Training		2		6		2		11		6	16		43
253 Managers Essentials	31	34	20	25	22	23	28	26	36	10	12	41	308
253 Welcome 2 Dudley Induction	18	10	8	19	14	14	8	15	8	5	13	21	153
253 Wellbeing 1		15	14	11	11	6	13	8	13	12	12	6	121
253 Wellbeing 2	11	11	6	9	7	6	3	5	9	11	4	10	92
253 Wellbeing Adhoc									10				10
253 Wellbeing Champions	6					6	3			6			21
253 Workforce Planning												6	6
Grand Total	**117**	**103**	**80**	**114**	**98**	**101**	**175**	**165**	**196**	**103**	**88**	**119**	**1465**

Training activity has increased in September in line with new programmes and following a pause during July and August. 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.

The Dudley Group NHS Foundation Trust

Paper for submission to Trust Board on Thursday 14th November 2024

Report title:	Workforce Plan
Sponsoring executive:	Karen Brogan – Interim Chief People Officer Chris Walker – Interim Director of Finance Martina Morris – Chief Nurse
Report author:	Karen Brogan – Interim Chief People Officer Richard Price – Deputy Director of Finance Martina Morris – Chief Nurse

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

Advise

The Trust plan assumed 4% efficiency (228 WTE posts by end October) for Substantive staff, 25% reduction in bank (153 WTE by end September) and a 25% reduction in agency (3 WTE by end September).

The report is present to People Committee, Finance and Productivity Committee and Quality committee and was rates as follows:

People Committee	Reasonable Assurance
Quality Committee	Partial Assurance
Finance and Productivity Committee	Partial Assurance

Alert

Overall, in comparison to August's (M5) position there has been a reduction of 59.04 WTE.

However, performance against plan at M6 is 311.71 adrift form plan. The cumulative finance position for Substantive, Bank and Agency now shows an adverse variance of £2.358m.

Adjusting for fully funded income backed posts (not in the plan), additional Deanery posts, the impact of open surge beds and the total impact of ERF (using WLI information as a proxy) reduces the adverse WTE variance to 195.7 WTE, a small reduction on August's position which was 211.58 WTE (Adjusted).

The substantive WTE has increased in September (12 WTE). There remains an underspend of £190k (RN/CSW). Average cost £71/person/month lower than plan, the underspend is reducing month on month.

Bank shows a significant reduction in September but remains more than plan (131.82 WTE), after adjustments this remains 55.81 WTE over plan. Finances are now £2.482m overspent.

Agency increased again in September and now 4.10 WTE over plan resulting in cumulative overspend of £66k. It should be noted that total agency usage is 13.77 WTE. Overall, agency remains very low with Trust spend of 0.7% of pay bill versus the target of 3.2%. The main driver for the increase over August and September relates to Aneasthetics.
medical staff.

				ADJUSTMENTS				
	TARGET	ACTUAL	DIFF	INCOME	DEANERY	SURGE	ERF	NET
Substantive	5,517.09	5,692.88	-175.79	15.89	24.05			-135.85
Bank	459.72	591.54	-131.82			24.09	51.92	-55.81
Agency	9.67	13.77	-4.10					-4.10
Total	5,986.48	6,298.19	-311.71	15.89	24.05	24.09	51.92	-195.76

Assure

Analysis of the data confirms that it is unlikely that the plan will be achieved, and a revised plan has been forecast. The initial plan was an overall 6.1% reduction, our revised forecast is a 2.7% reduction.

This is a 167.9 WTE reduction overall compared to March 24 position (made up of 129.09 WTE substantive staff, 33.9 WTE bank staff and 4.91 WTE agency staff.

	Baseline	Mar-25	% Reduction Forecast	% Plan Reduction
Subs	5,702.09	5,573.00	2.3%	4.0%
Bank	612.90	579.00	5.5%	25.0%
Agy	12.91	8.00	38.0%	25.1%
Total	**6,327.90**	**6,160.00**	**2.7%**	**6.1%**

Work is underway with the divisions to review the trajectories based on the amended forecasts and to develop alternative plans for costs out to ensure we meet out 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
Executive Directors, People Committee, Quality Committee, Finance & Productivity Committee Trust Board

4. Recommendation(s)
The Finance and Productivity Committee is asked to:
a) **ASSURANCE:** Receive the report for assurance.

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

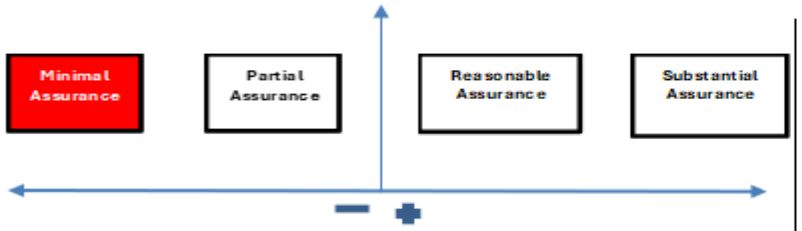
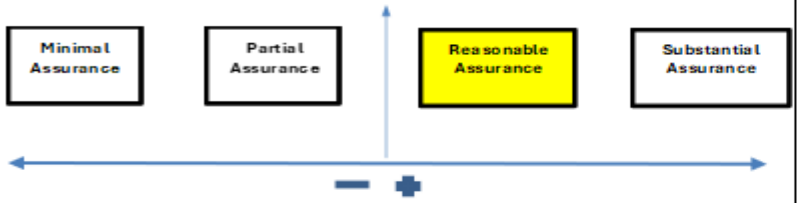
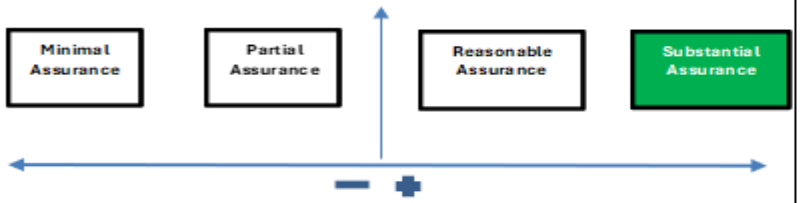
Performance Against Workforce Plan – M6

The Dudley Group
NHS Foundation Trust

M6 - Summary

	Assurance at previous Committee	In month update
Finance Will the workforce plan support the delivery of the financial plan	Reasonable Assurance	The Trust plan assumes 4% efficiency (228 WTE posts by end October) for Substantive staff, 25% reduction in bank (153 WTE by end September) and a 25% reduction in agency (3 WTE by end September). The performance until the end of September is significantly off target (see summary below): 135.85 The initial data shows staffing WTE to be 311.71 adrift from plan. Adjusting for fully funded income backed posts (not in the plan), additional Deanery posts, the impact of open surge beds and the total impact of ERF reduces the adverse WTE variance to 195.76. Substantive WTE has increased in September. There remains an underspend of £190k (RN/CSW). Average cost £71/person/month lower than plan. Bank shows a significant reduction in September but remains more than plan (RN/CSW). Finances now £2.482m overspent. Agency increased again in September and now 4.10 WTE over plan resulting in cumulative overspend of £66k. The cumulative finance position for Substantive, Bank and Agency now shows an adverse variance of £2.358m.
Staff Experience Is there any adverse impact associated with the financial and transformational plan	Partial Assurance	Across workforce metrics, whilst turnover remains above target it is stable. Sickness absence has increased in month. There are no material changes or evidence of adverse impact associated with the current measures to achieve the financial and transformational improvements, however given that turnover has reduced, and retention is high this will impact on the efficiencies available to be released.
Quality/Safety **Patient Experience** Is there any adverse impact associated with the financial and transformational plan	Partial Assurance	The monitored quality indicators, have seen no material changes or evidence of adverse impact associated with the current measures to achieve the financial and transformational improvements when compared with previous months. A suite of quality data and a summary of CIP related QIAs is provided in the pack for information. A joint Chief Nurse and Medical Director report continues to be produced and includes more details as well as the Quality Integrated report, both of which are reported via the agreed governance process. The nursing & midwifery quality dashboard is near its completion, which will provide a triangulated overview of key metrics, to showcase best practice and identify areas for improvement. As identified during the safer staffing review, the key metrics requiring improvements include patient observations being recorded on time and missed medication doses. In addition, ongoing work is required to improve practice as highlighted in the matrons' audits, night visits and pressure ulcer incidence.

				ADJUSTMENTS				
	TARGET	ACTUAL	DIFF	INCOME	DEANERY	SURGE	ERF	NET
Substantive	5,517.09	5,692.88	-175.79	15.89	24.05			-135.85
Bank	459.72	591.54	-131.82			24.09	51.92	-55.81
Agency	9.67	13.77	-4.10					-4.10
Total	5,986.48	6,298.19	-311.71	15.89	24.05	24.09	51.92	-195.76

	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)

M6 - Risks/Mitigations to Delivery

The Dudley Group
NHS Foundation Trust

Risks:

- Hosted/Income backed posts – impact on substantive posts (15.89 WTE in M6)
- Increased Deanery doctors due to national shortfall of places (24.05 WTE in M6)
- Increased Activity (ERF) – impact on bank usage estimated at 51.92 WTE in M6
- Demand and capacity – Surge beds – impact on bank usage (24.09 WTE bank in M6)
- Industrial action by Junior Doctors - impact on bank usage (14.11 WTE in M3 and 4.81 WTE in M4)
- Reduced turnover and increased retention

Mitigations:

- Development of forecast for hosted/income backed roles
- Divisional, Executive and ICB vacancy control process
- Divisional trajectories developed – monitored and challenged through Executive led confirm and challenge meetings and Finance Improvement group
- Additional oversight and controls regarding bank and agency usage, including a system wide plan

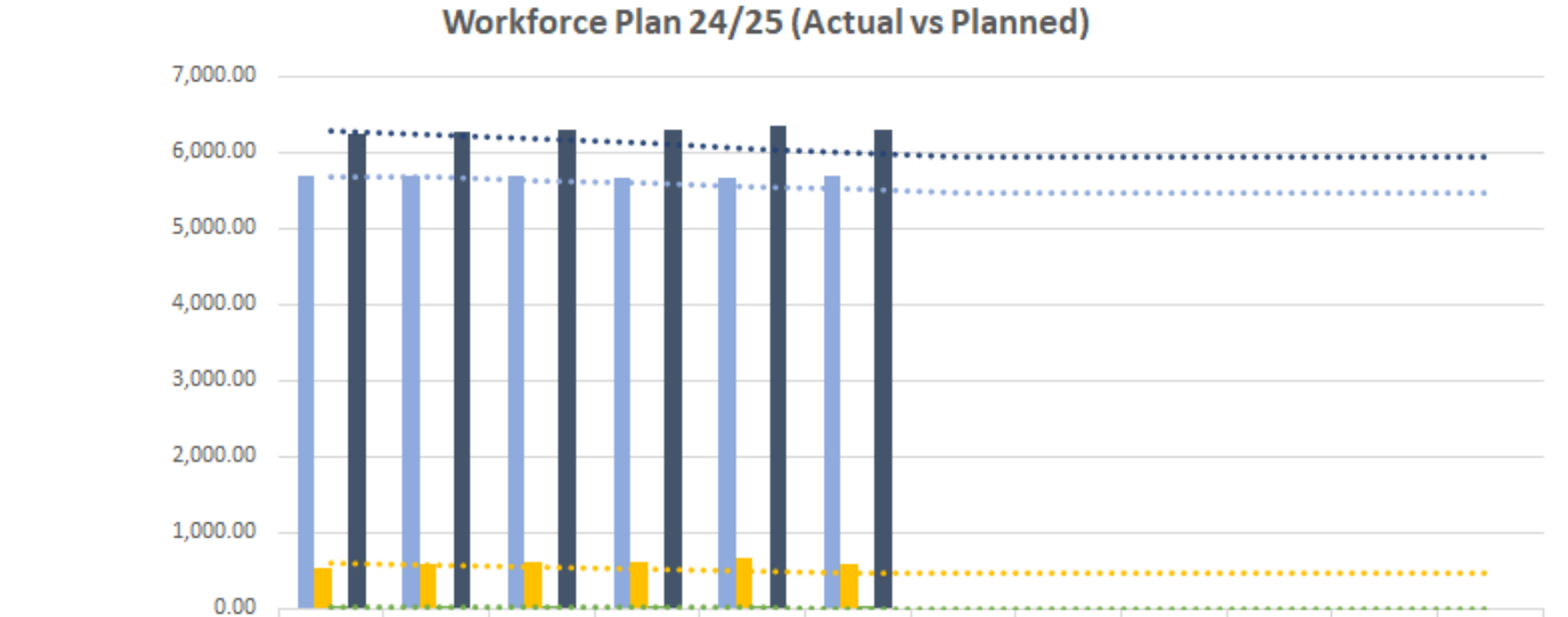
CARE RESPECT RESPONSIBILITY

Data Pack

NHS
The Dudley Group
NHS Foundation Trust

M6 Performance - Overview

The Dudley Group
NHS Foundation Trust



	WTE M1	WTE M2	WTE M3	WTE M4	WTE M5	WTE M6	WTE M7	WTE M8	WTE M9	WTE M10	WTE M11	
Substantive Actual	5,682.34	5,689.54	5,686.40	5,676.23	5,680.82	5,692.88						
Bank Actual	542.57	589.42	616.29	619.16	664.71	591.54						
Agency Actual	10.47	7.71	6.44	8.23	11.70	13.77						
Total Actual	6,235.38	6,286.67	6,309.13	6,303.62	6,357.23	6,298.19						
Substantive Plan	5,687.09	5,672.09	5,642.09	5,602.08	5,560.09	5,517.09	5,474.01	5,474.01	5,474.01	5,474.01	5,474.01	5,474.01
Bank Plan	587.40	561.90	536.35	510.78	485.28	459.72	459.72	459.72	459.72	459.72	459.72	459.72
Agency Plan	12.36	11.81	11.28	10.75	10.21	9.67	9.67	9.67	9.67	9.67	9.67	9.67
Total Plan	6,286.85	6,245.80	6,189.72	6,123.61	6,055.58	5,986.48	5,943.40	5,943.40	5,943.40	5,943.40	5,943.40	5,943.40

The Trust performance in month 6 shows the Trust has not achieved the forecasted WTE plan.

The variance against the total workforce forecasted M6 position is 311.71 WTE (above plan).

The substantive workforce has not seen the level of reductions forecasted and is 175.79 WTE over plan.

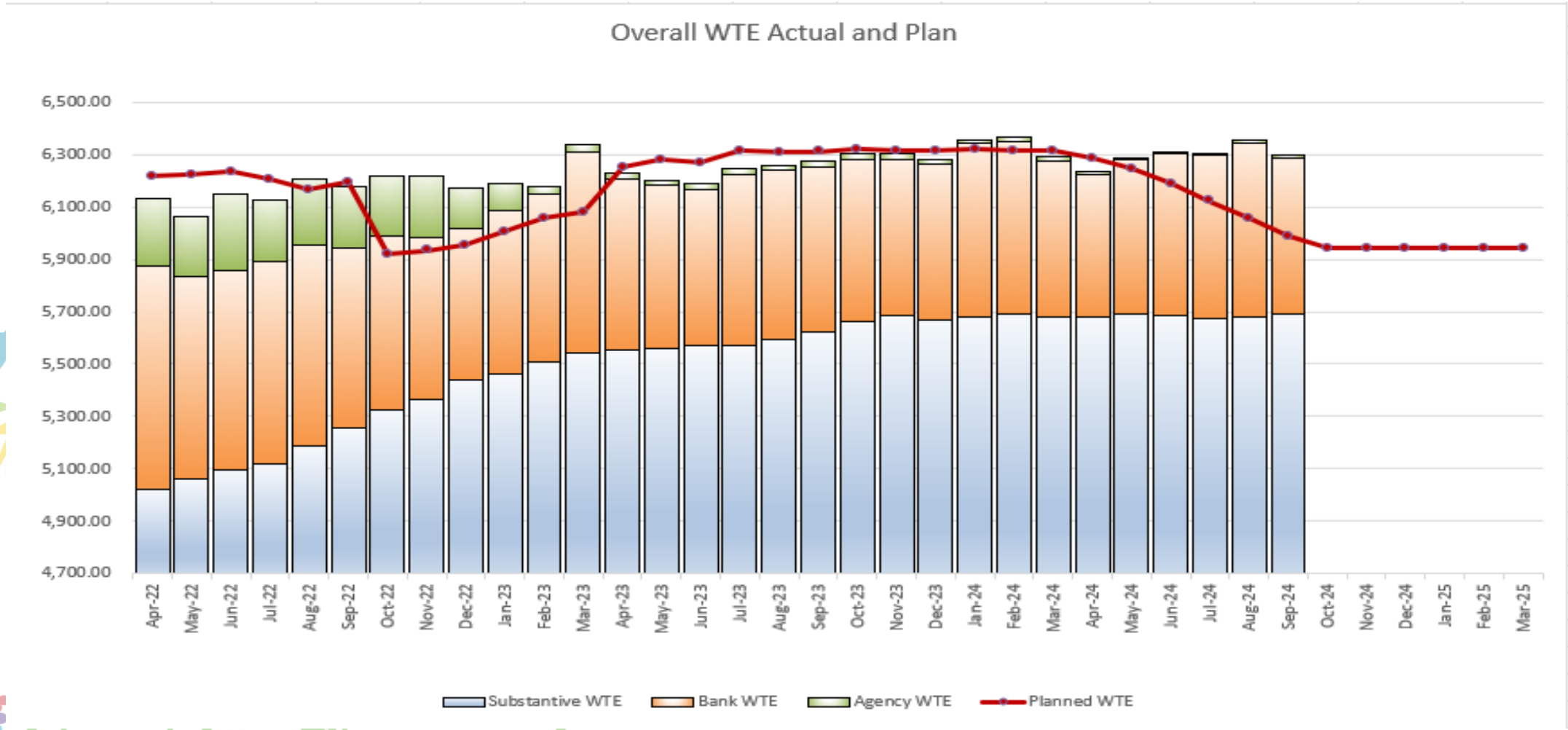
Bank workforce has also not reduced as planned and is 131.82 WTE over plan.

Agency is 4.1 WTE above plan

CARE RESPECT RESPONSIBILITY

WTE Plan/Actuals from April 2022

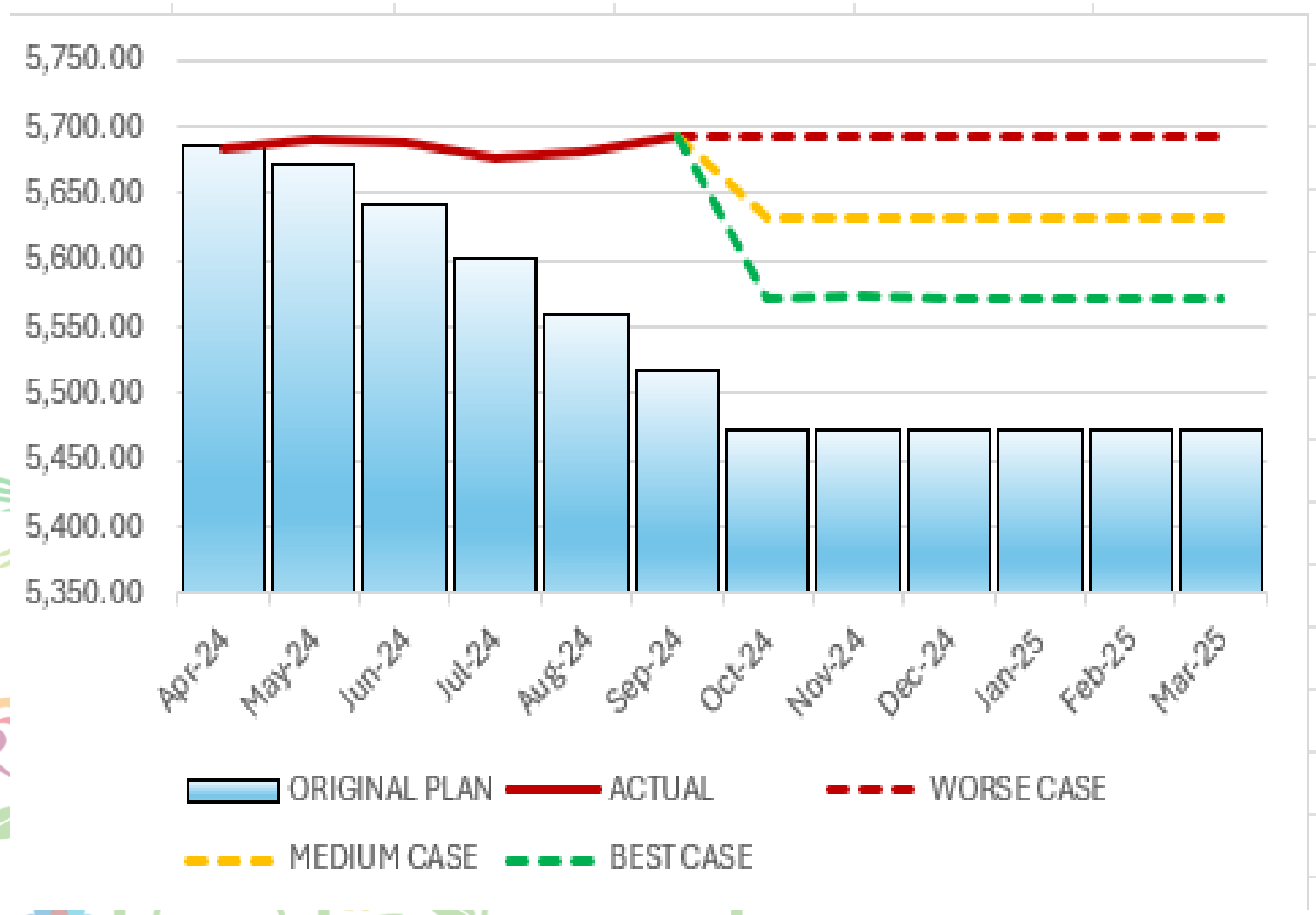
The Dudley Group
NHS Foundation Trust



CARE RESPECT RESPONSIBILITY

M6 Performance - Substantive

The Dudley Group
NHS Foundation Trust

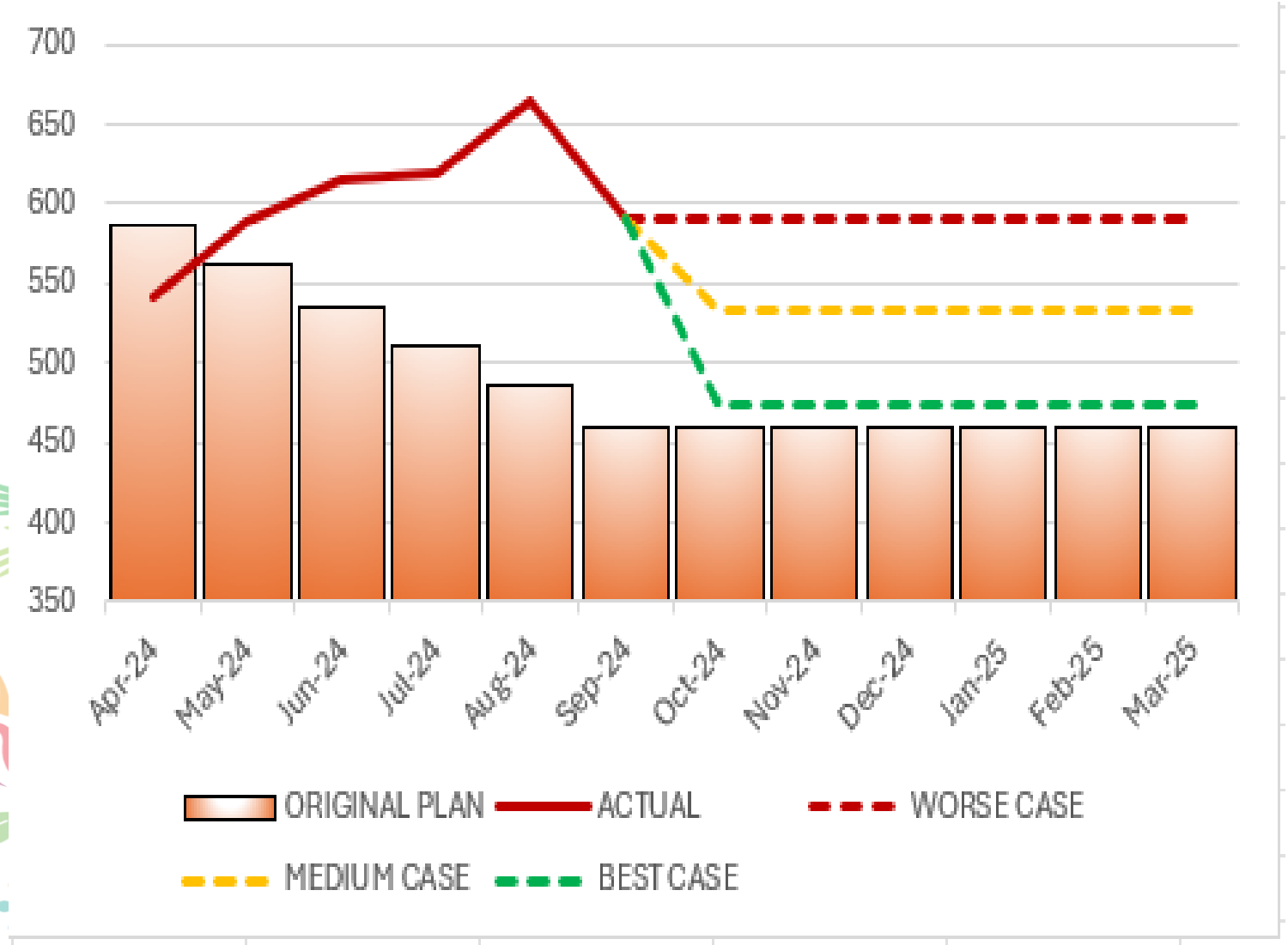


- Original plan shows 4% workforce reduction;
- Actual cost/WTE lower than figures assumed in plan;
- Reasons include case mix, pay award and higher averages used in plan;
- Based on current average cost/WTE, staff numbers would need to reduce by 122 between September and October for best case;
- Continuation of the Sep WTE would result in a c£3.2m adverse variance from Oct-Mar.

CARE RESPECT RESPONSIBILITY

M6 Performance - Bank

The Dudley Group
NHS Foundation Trust



£4.7m PRESSURE

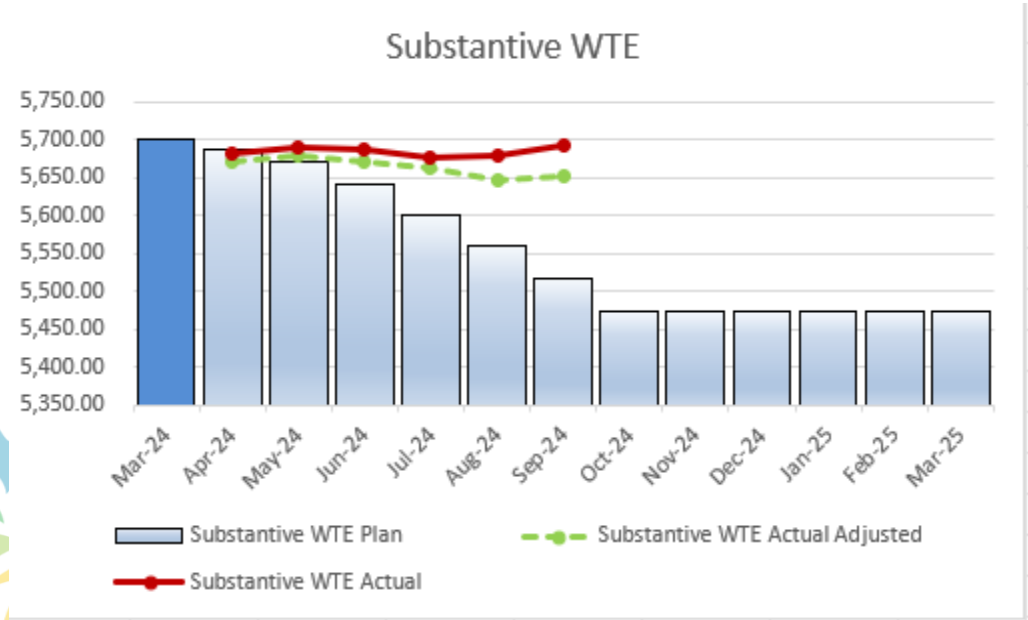
BREAKEVEN

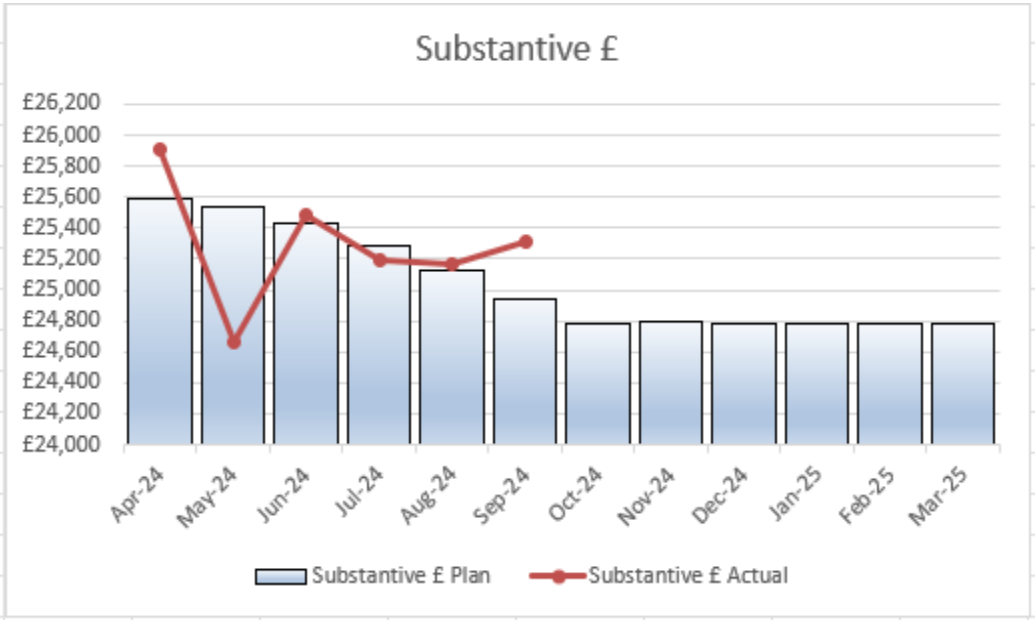
- Original plan shows 25% reduction;
- Average cost/WTE slightly lower than figures used in plan;
- Will be distortions due to bank holidays etc.;
- Based on current average cost/WTE, staff numbers would need to reduce by 117 between September and October for best case;
- Continuation of the Sep WTE would result in a c£4.7m adverse variance From Oct-Mar.

CARE RESPECT RESPONSIBILITY

M6 Performance - Substantive

The Dudley Group
NHS Foundation Trust





	LATEST
Med	-53.76
C&CCS	-51.10
Surg	-42.34
Corp	-28.60
TOTAL	**-175.79**

	LATEST
Admin	-66.23
Medic	-35.62
RN	-50.36
CSW	18.80
Other	-2.19
Sci/AHP	-40.19
TOTAL	**-175.79**

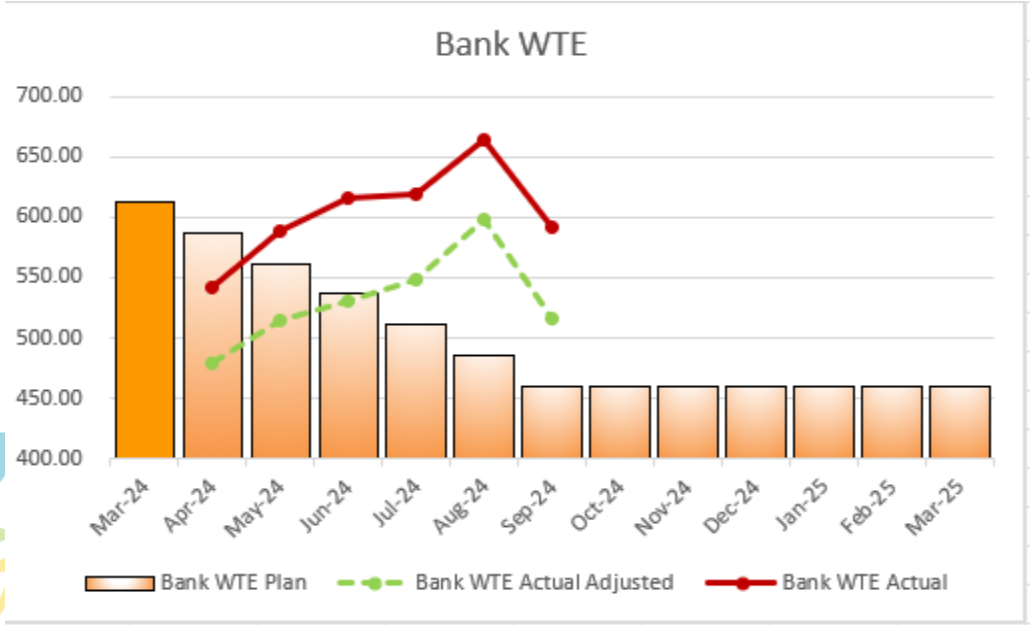
	YTD
Med	£440
C&CCS	£179
Surg	-£106
Corp	-£321
TOTAL	**£192**

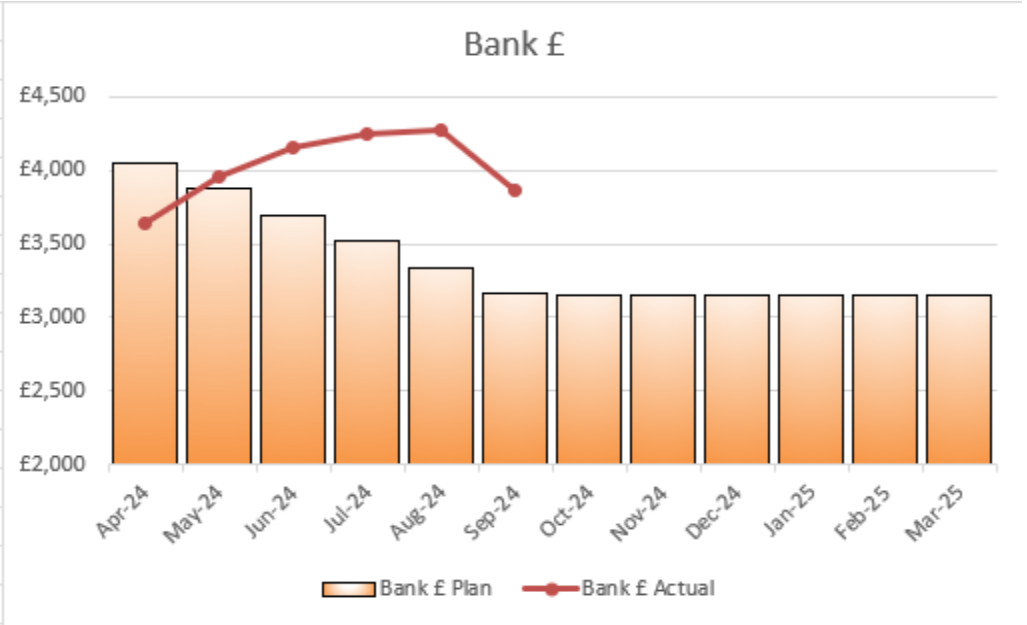
	YTD
Admin	-£281
Medic	-£346
RN	£362
CSW	£812
Other	-£89
Sci/AHP	-£268
TOTAL	**£190**

CARE RESPECT RESPONSIBILITY

M6 Performance - Bank

The Dudley Group
NHS Foundation Trust





	LATEST
Med	-59.25
C&CCS	-15.93
Surg	-56.56
Corp	-0.07
TOTAL	**-131.82**

	LATEST
Admin	4.06
Medic	-4.74
RN	-48.25
CSW	-57.08
Other	-0.23
Sci/AHP	-25.57
TOTAL	**-131.82**

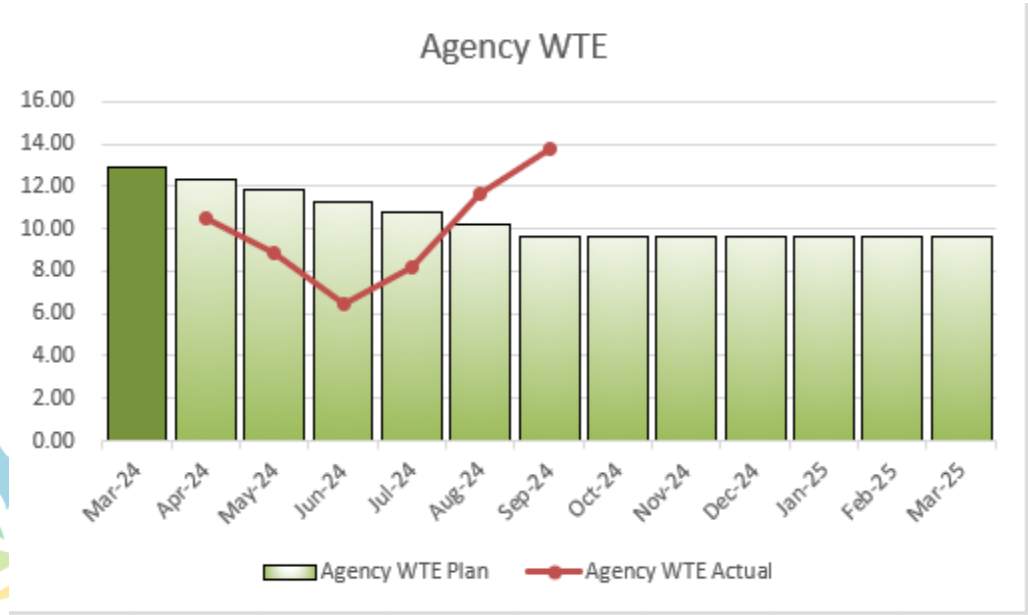
	YTD
Med	-£487
C&CCS	-£260
Surg	-£1,798
Corp	£64
TOTAL	**-£2,482**

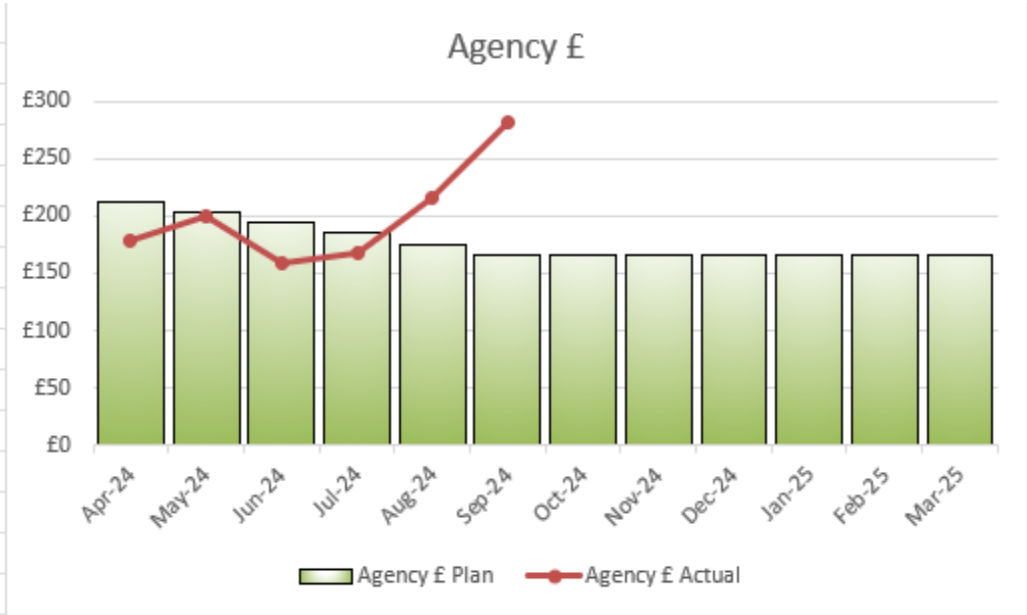
	YTD
Admin	£110
Medic	-£579
RN	-£636
CSW	-£881
Other	-£4
Sci/AHP	-£492
TOTAL	**-£2,482**

CARE RESPECT RESPONSIBILITY

M6 – Performance Agency

The Dudley Group
NHS Foundation Trust





	LATEST
Med	-0.29
C&CCS	-0.32
Surg	-3.49
Corp	0.00
TOTAL	**-4.10**

	LATEST
Admin	0.00
Medic	-6.00
RN	1.62
CSW	0.00
Other	0.00
Sci/AHP	0.29
TOTAL	**-4.10**

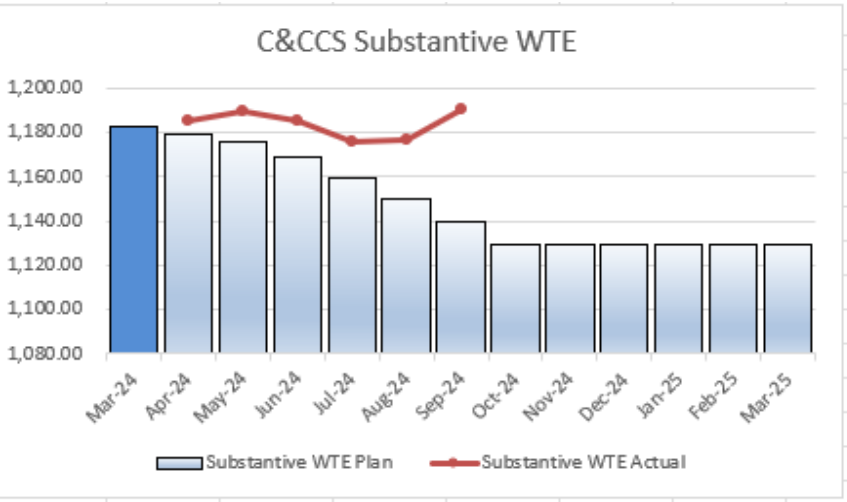
	YTD
Med	-£96
C&CCS	-£37
Surg	£67
Corp	£0
TOTAL	**-£66**

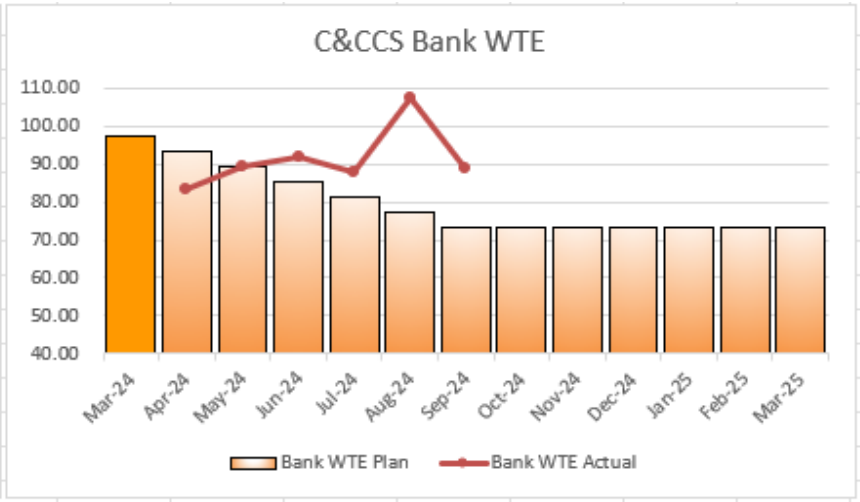
	YTD
Admin	£0
Medic	-£166
RN	£90
CSW	£0
Other	£0
Sci/AHP	£11
TOTAL	**-£66**

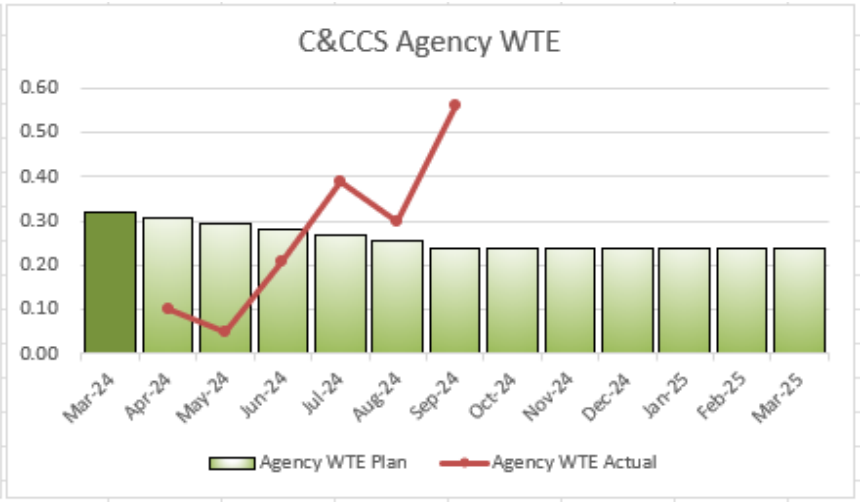
CARE RESPECT RESPONSIBILITY

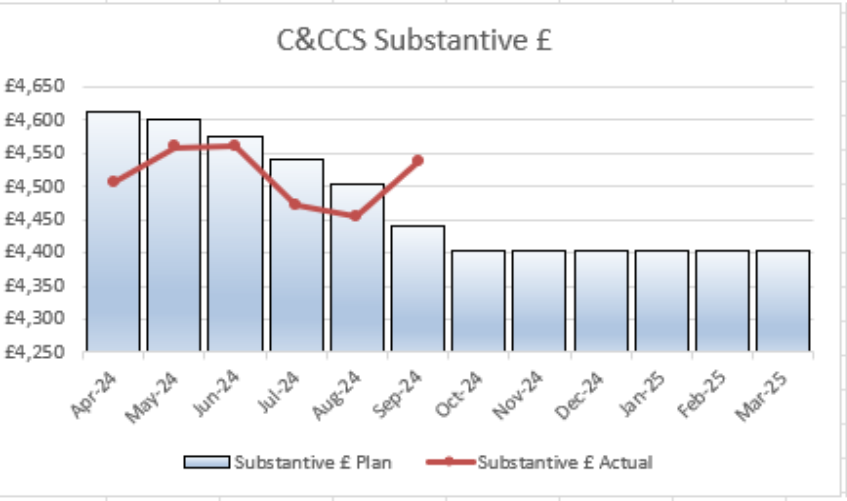
M6 – C&CCS

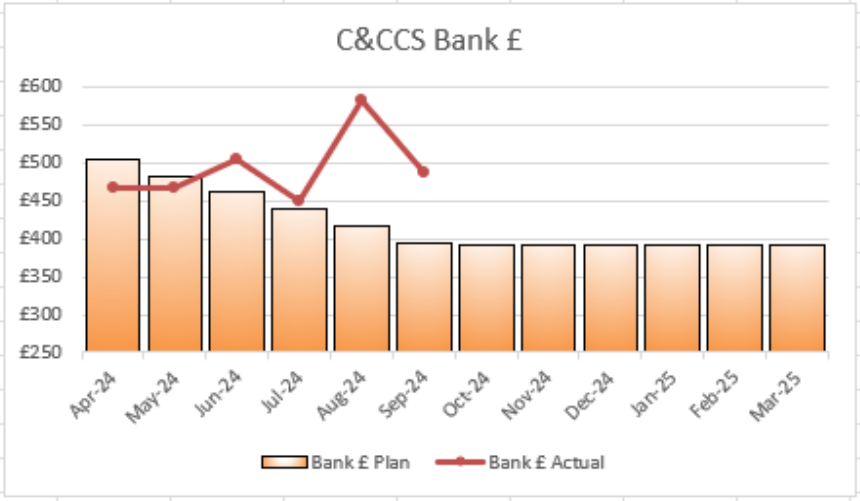
The Dudley Group
NHS Foundation Trust

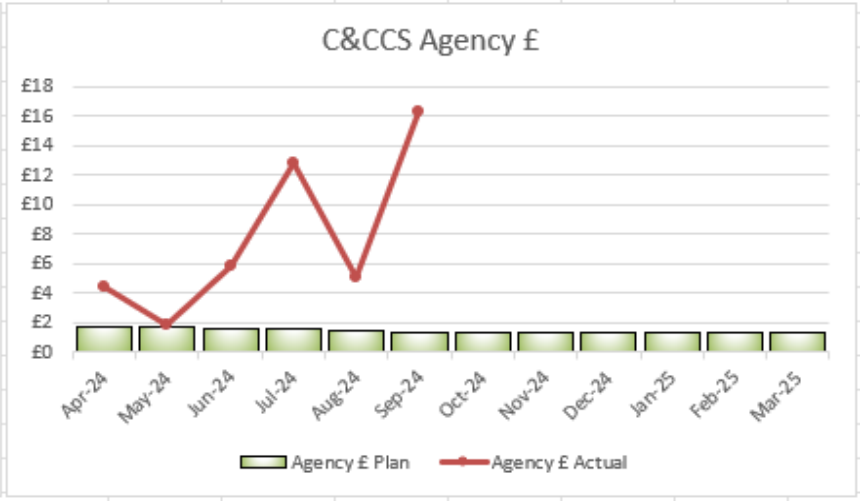








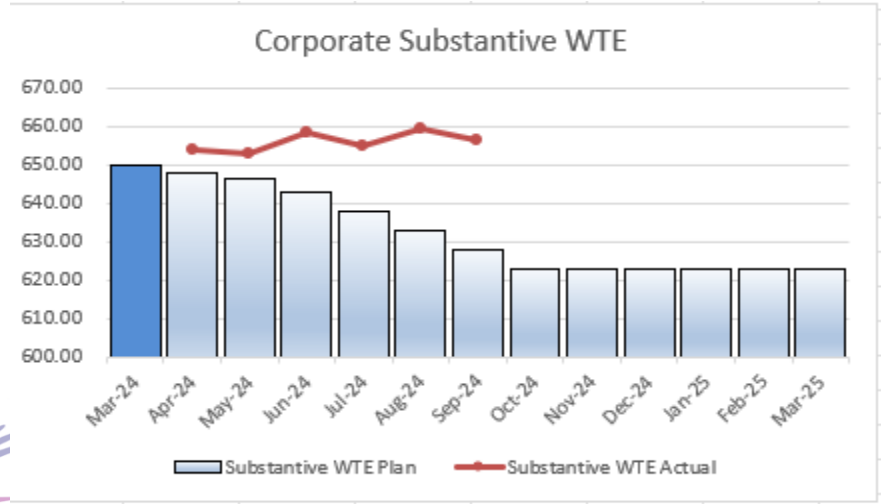


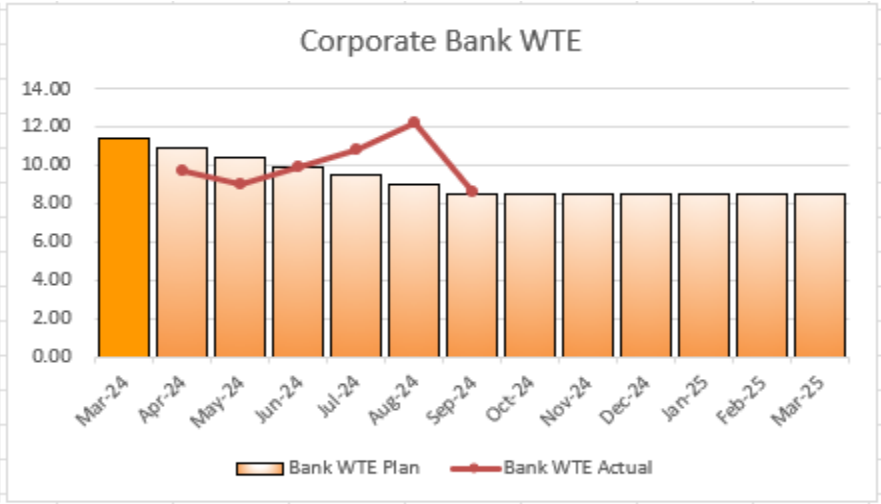


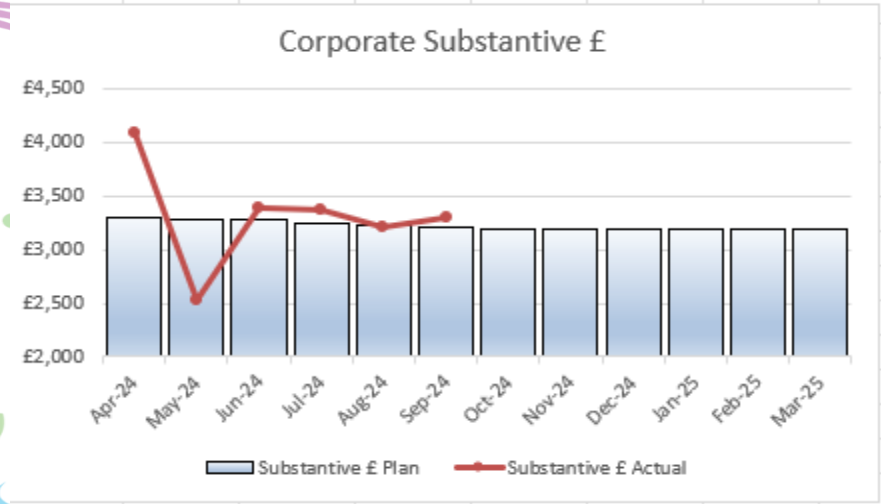
CARE RESPECT RESPONSIBILITY

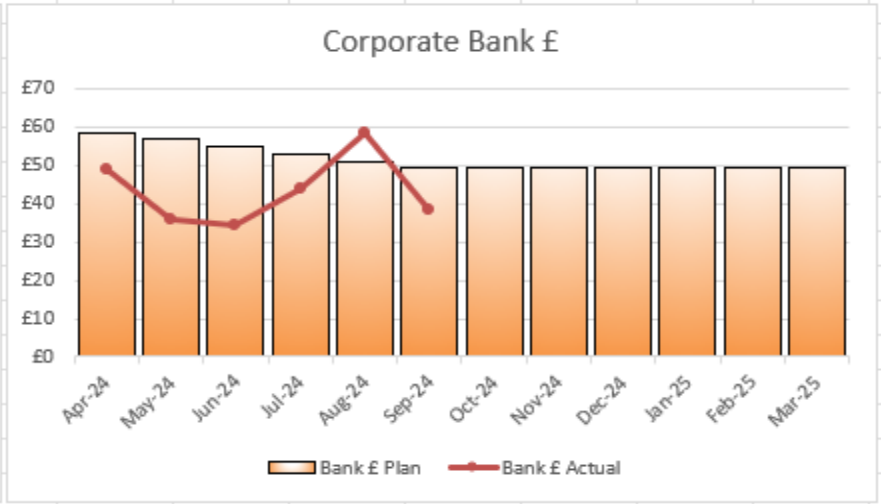
M6 – Corporate

The Dudley Group
NHS Foundation Trust





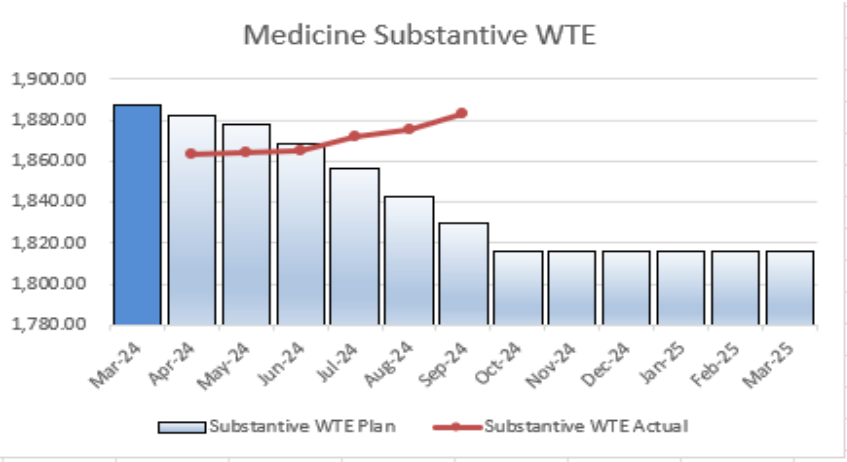


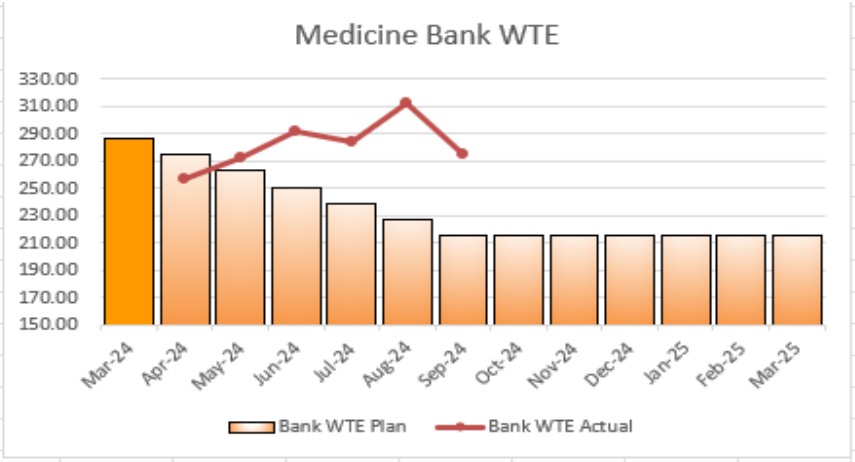


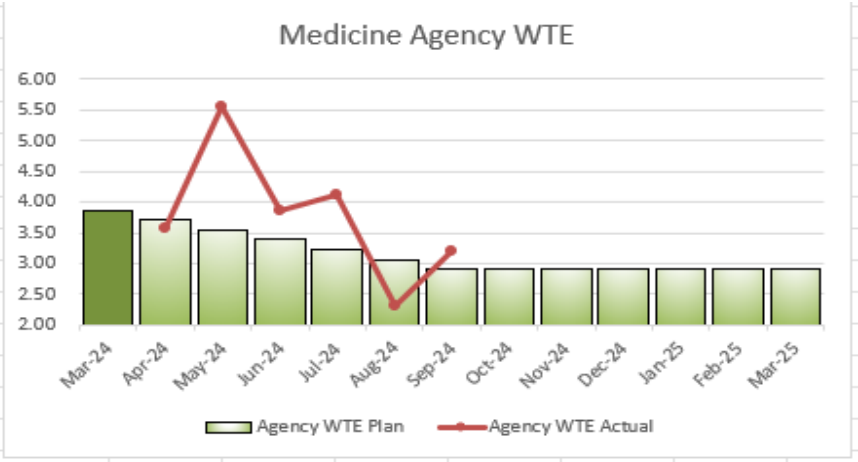
CARE RESPECT RESPONSIBILITY

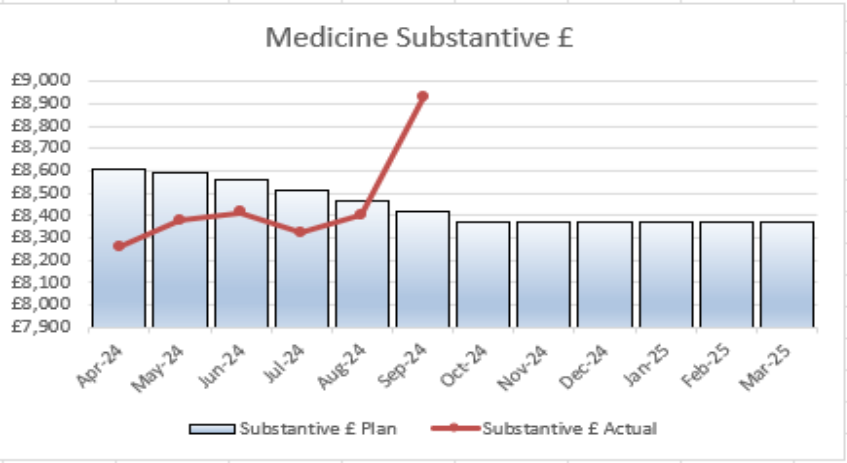
M6 – Medicine

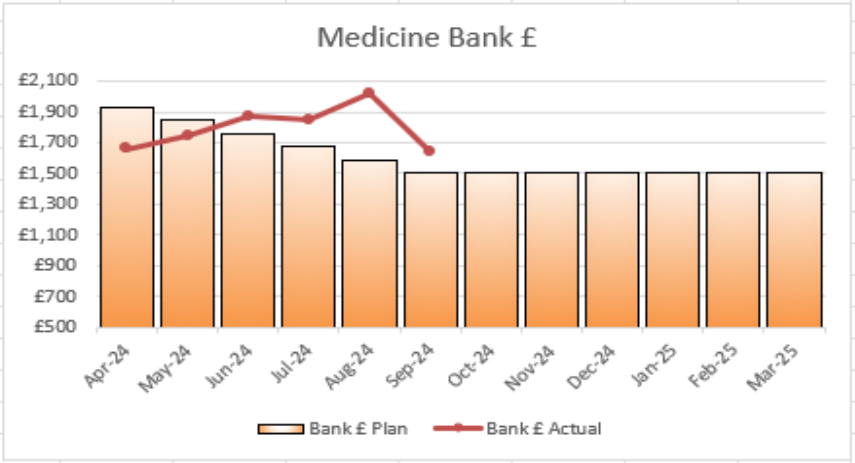
The Dudley Group
NHS Foundation Trust

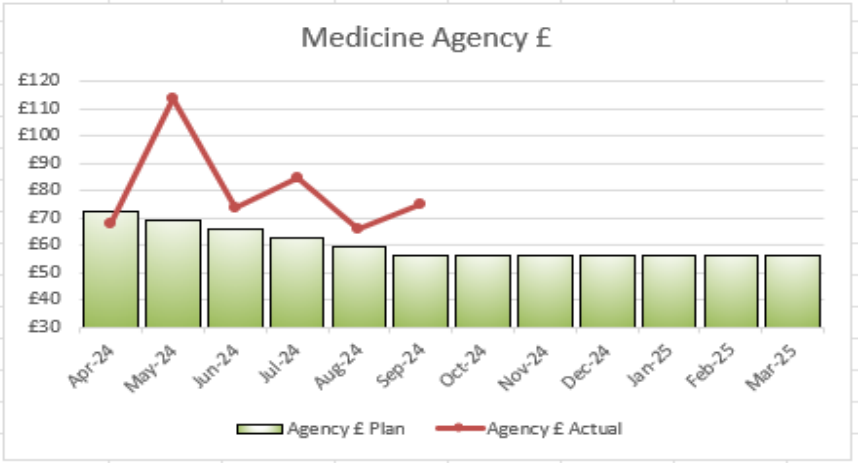








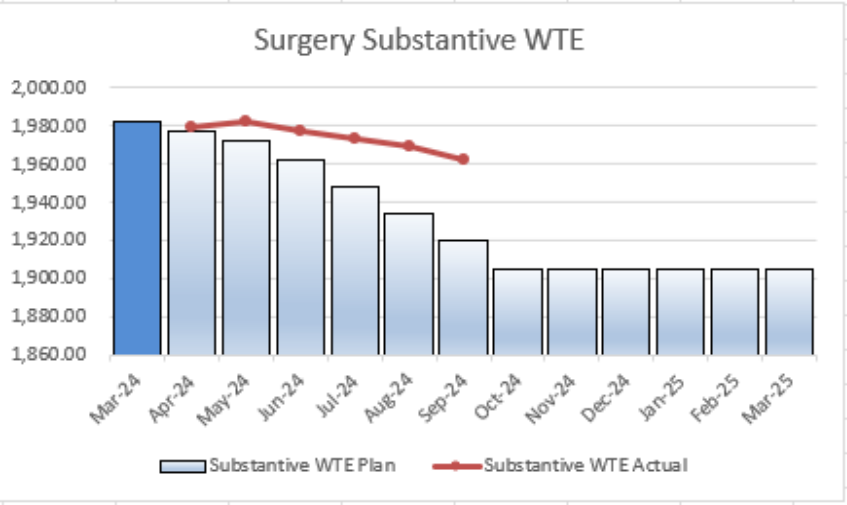


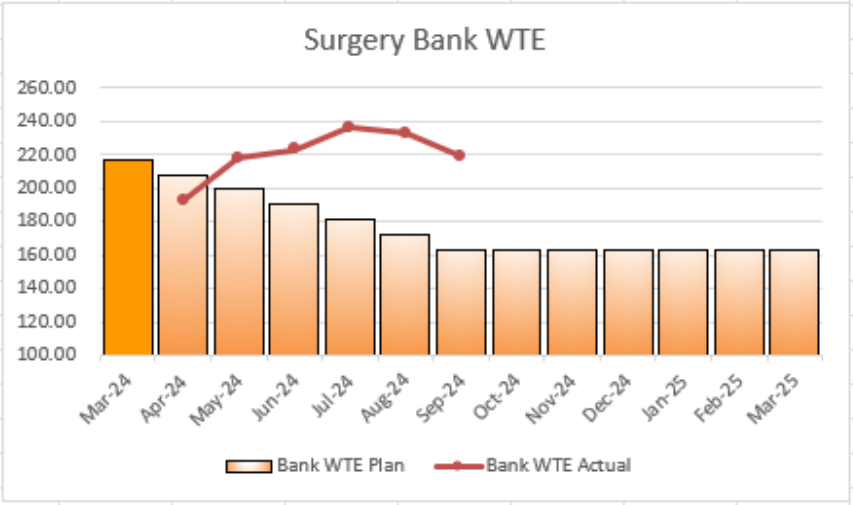


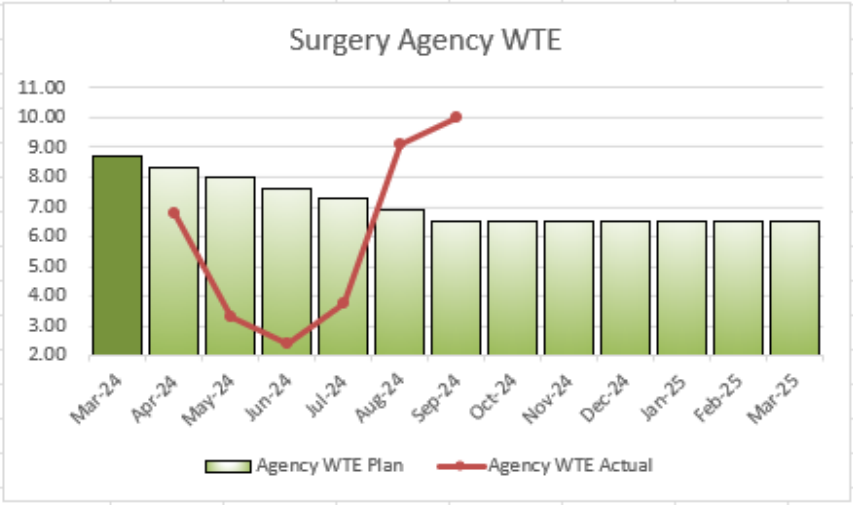
CARE RESPECT RESPONSIBILITY

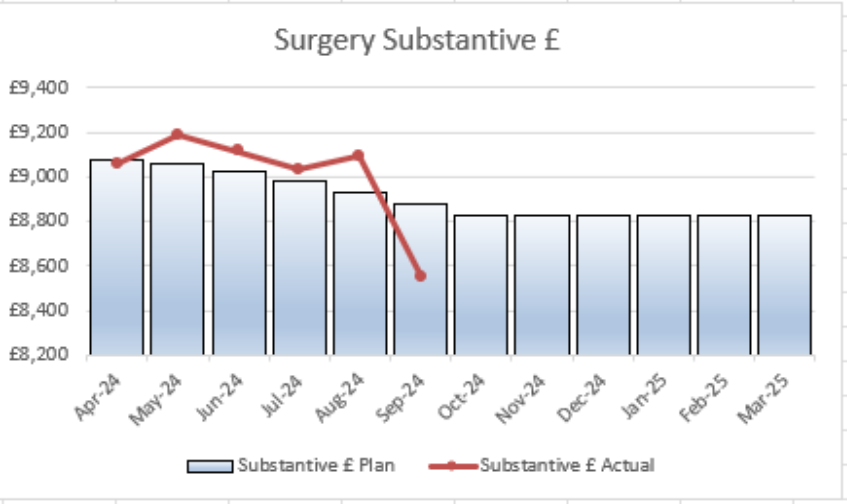
M6 – Surgery

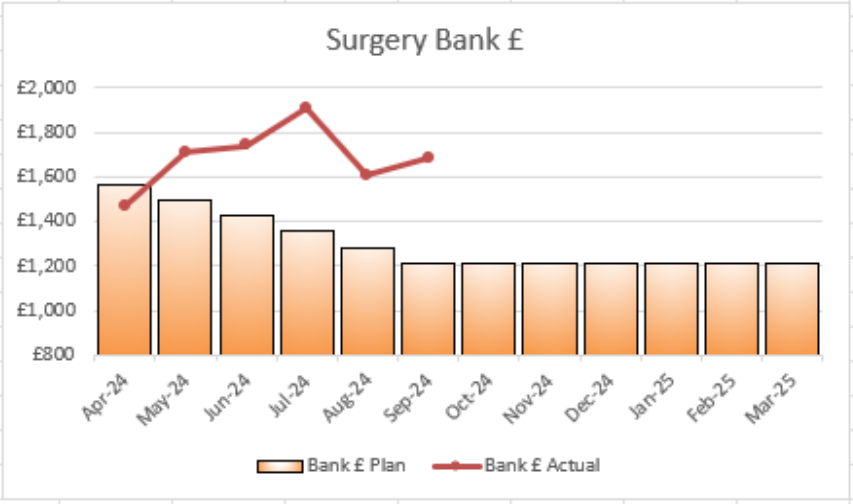
The Dudley Group
NHS Foundation Trust

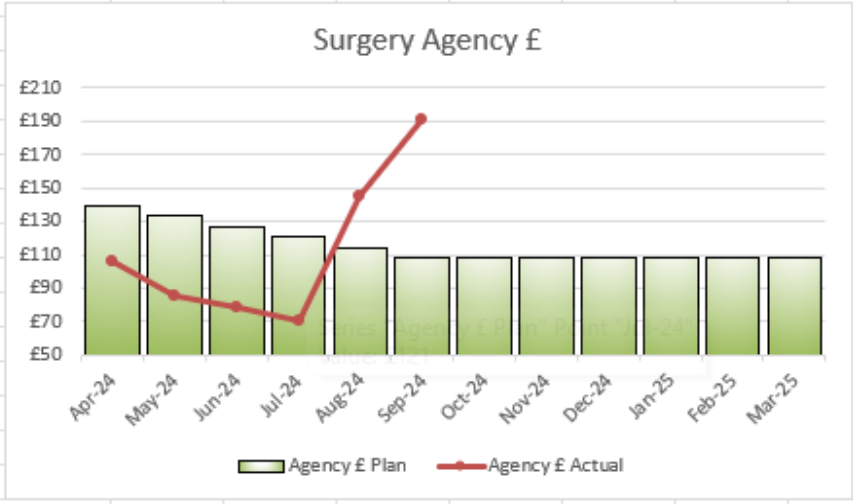












CARE RESPECT RESPONSIBILITY

M6 – Workforce Metrics

The Dudley Group
NHS Foundation Trust

Metric	Rate	Target	Trend	
Absence – In Month	5.18	<=5%	↑	**Sickness Absence** In-month sickness absence for September 2024 is 5.18% an increase from 5.08% in August 2024.
Absence - 12m Rolling	5.10%	<=5%	=	The rolling 12-month absence has remained static at 5.10% in September 2024.
Turnover	7.57%	<=8%	↓	**Turnover** Turnover (all terminations) has decreased from 7.82% in August 2024 to 7.57% in September 2024
Normalised Turnover	3.06%	<=5%	↓	Normalised Turnover has decreased from 3.23% in August 2024 to 3.06% in September 2024 Turnover (all terminations) is all terminations from the organisation. Normalised Turnover focuses on voluntary resignations and excludes dismissals, fixed-term contracts, redundancy, retirement and rotations.
Retention (12 month)	91.6%	>=80%	↑	**Retention** The 12-month retention rate increased slightly from 91.5% in August 2024 to 91.6% in September 2024
Vacancy Rate	5%	<=7%	↓	**Vacancy Rate** The vacancy rate has reduced from 6% in August 2024 to 5% in September 2024
Mandatory Training	92.22%	>=90%	↓	**Mandatory Training** Statutory Training decreased slightly from 92.6% in August 2024 to 92.22% in September 2024. Overall, it has remained above 90% target for a sustained period.

M6 – Vacancy Control Panel

The Dudley Group
NHS Foundation Trust

	Divisional Vacancy Control Panel					Executive Vacancy Control Panel				
Date	Post Presented	Posts Rejected	Posts Rejected %	Posts Approved	Posts Approved %	Post Presented	Posts Rejected	Posts Rejected	Posts Approved	Posts Approved %
03/09/2024	94	11	11.70%	83	88.30%	83	24	28.92%	59	71.08%
10/09/2024	50	16	32.00%	34	68.00%	34	11	32.35%	23	67.65%
24/09/2024	68	12	17.65%	56	82.35%	56	7	12.50%	49	87.50%
01/10/2024	60	11	18.33%	49	81.67%	49	1	2.04%	48	97.96%
Total	**272**	**50**	**18.38%**	**222**	**81.62%**	**222**	**43**	**19.37%**	**179**	**80.63%**

Please Note – The VAR process was amended W/c 10/09/2024 and the VAR on the 03/09/2024 contained 2 weeks posts

CARE RESPECT RESPONSIBILITY

Quality Impact Assessments
Cost Improvement bi-monthly report (Sept 2024 latest available data)

Scheme No	Scheme Name	Divisional Project Lead	Overall QIA Risk Score	Reassessment Return Date
CS-2425-005	Tendering of Consumables across BCPS	Raghvinder Ram	1	10/10/2024
CS-2425-010	CCCS Procurement Savings	Amandeep Tung-Nahal	4	02/10/2024
MIC-2425-001	MIC Procurement Savings	Rory McMahon	3	30/10/2024
MIC-2425-002	MIC Division Wide Vacancy Factor	Rory McMahon	4	30/10/2024
MIC-2425-003	MIC Budget Review	Rory McMahon	1	30/10/2024
MIC-2425-007	Medicines Optimisation Rebate Medicine 24/25	Ruckie Kahlon	5	30/07/2024
MIC-2425-009	Medicines Optimisation Tocilizumab Biosimilar - Medicine Share	Ruckie Kahlon	5	30/07/2024
MIC-2425-011	Overperformance of Elective Recovery Plan	Ruckie Kahlon	1	01/11/2024
MIC-2425-017	Recruitment of 2 Gastroenterology Consultants	Lucy Ford	1	04/01/2025
MIC-2425-020	Hepatology Workforce	Lucy Ford	1	30/10/2024
MIC-2425-021	Alcohol Care Team	Lucy Ford	1	30/10/2024
MIC-2425-032	Pharmacy Procurement Apixaban Saving	Sarah Kinnersley	6	04/10/2024
MIC-2425-036	5th Endoscopy Room	Lucy Ford	1	30/10/2024
MIC-2425-040	MIC- Review posts vacant for 3 months	Rory McMahon	3	15/02/2025
MIC-2425-042	Counting and Coding ERF Activity	Rory McMahon	1	04/01/2025
MIC-2425-044	Overperformance of Elective Recovery Plan	Rory McMahon	1	04/01/2025
SWC-2425-001	SWC Procurement Savings	Jack Richards	4	02/10/2024
SWC-2425-004	TCAPP - Additional income over ERF plan	Jack Richards	3	02/10/2024
SWC-2425-006	SWC RAS Referral Review	Jack Richards	3	29/01/2025
SWC-2425-007	Gynaecology Medicines Optimisation	Annie Willets	3	04/01/2025
SWC-2425-010	Ranibizumab Biosimilar Switch - SWC Share	Steve Randle	6	15/10/2024
SWC-2425-011	Children's Services Medicine Optimisation - SWC Share	Jack Henderson	2	15/10/2024
SWC-2425-015	3D Printing in Oral Surgery	Steve Randle	1	09/03/2025
SWC-2425-020	Reduce use of printed patient leaflets	Rita Khan	1	03/03/2025
SWC-2425-023	Obs & Gynae - Additional Income above ERF plan	Jo Molpass	3	02/10/2024
SWC-2425-024	Children's Services - Additional Income above ERF plan	Alis Rasul	3	02/10/2024
SWC-2425-025	Specialist Surgery - Additional Income above ERF plan	Steve Randle	3	02/10/2024
SWC-2425-026	SUV - Additional Income above ERF plan	Charlie Heaton	3	11/10/2024
SWC-2425-027	T&O (inc Plastics) - Additional Income above ERF plan	Jenny Workman	3	09/10/2024
SWC-2425-029	T&O - Pharmacy Procurement 24/25 - Apixaban Saving	Jenny Workman	6	15/10/2024
SWC-2425-030	SUV - Pharmacy Procurement 24/25 - Apixaban Saving	Charlie Heaton	6	15/10/2024
SWC-2425-031	Obstetrics Medicines Optimisation	Annie Willets	3	04/01/2025
SWC-2425-035	Coding	Jack Richards	3	04/01/2025
SWC-2425-037	ECT Contract	Matt Fisher	1	04/01/2025
SWC-2425-040	Review posts vacant for 3 months	Jack Richards	3	03/03/2025
SWC-2425-041	CNST Year 5 Delivery	Jack Richards	1	04/01/2025
SWC-2425-042	Negotiation of BWC T&O Consultant Contract	Matt Fisher	1	02/03/2025
CORP-2425-001	Corporate Procurement Savings	Paul Mellor	4	04/01/2025
CORP-2425-002	EBME 3rd Party Maintenance Rationalisation	Nigel Ford	1	06/01/2025
CORP-2425-003	PFI Commercial Agreement	Nigel Ford	2	06/01/2025
CORP-2425-009	Delay in Cloud Upgrade	Chris Benfield	1	19/12/2024
CORP-2425-010	IT 3rd Party Contracts	Sarah Ellis	1	10/10/2024
CORP-2425-011	Review Posts Vacant for 3 Months - Medical Director	Becky Edwards	2	22/01/2025
CORP-2425-015	Review posts vacant for 3 months - Finance	Richard Price	1	04/01/2025
CORP-2425-016	Governance Legal Fees	Andy Proctor	1	04/01/2025
CORP-2425-017	Review posts vacant for 3 months - Governance	Andy Proctor	1	04/01/2025
CORP-2425-018	Review posts vacant for 3 months - IT	Sarah Ellis	3	04/01/2025
CORP-2425-020	Review Posts Vacant for 3 Months - Nursing Director	Martina Morris	2	03/11/2024

Scheme No	Scheme Name	Divisional Project Lead	Overall QIA Risk Score	Reassessment Return Date
CORP-2425-021	Review posts vacant for 3 months - Strategy & Transformation	Adam Thomas	1	04/01/2025
CORP-2425-022	Finance Estates Trust Energy Costs	Nigel Ford	1	06/01/2025
CORP-2425-023	Finance Estates Rent and Service Charge Income	Nigel Ford	1	06/01/2025
CORP-2425-024	Review Posts vacant for 3 months - HR	Karen Brogan	1	20/11/2024
CORP-2425-025	Medical Director Training	Becky Edwards	2	17/11/2024
CORP-2425-026	HR Non-Recurrent Income	Karen Brogan	1	20/11/2024
CORP-2425-029	PFI Energy ETA	Nigel Ford	1	04/01/2025
CORP-2425-030	Finance PFI Commercial Agreement REC	Chris Walker	4	27/01/2025
CORP-2425-031	Additional income- Urgent & Emerg Care Growth Funding from ICB contract	Richard Price	1	17/01/2025
CORP-2425-032	HR Staffing Establishment VAC Reviews	Karen Brogan	1	17/01/2025
CORP-2425-034	Review posts vacant for 3 months - Operational Management	Karen Kelly	1	17/01/2025

Level 3 – Financial and/or Clinical QIA Approved. Awaiting final sign off at divisional level before going Live

Scheme No	Scheme Name	Divisional Project Lead	Overall QIA Risk Score
CCS-2425-002	Medicines Optimisation Rebate 24/25 - Pharmacy Share	Onajite Okoro	5
CCS-2425-003	Medicines Optimisation Tocilizumab Biosimilar - Pharmacy Share	Onajite Okoro	5
CCS-2425-004	Pharmacy Procurement - 24/25	Sarah Kinnersley	6
CCS-2425-004a	Pharmacy Procurement 24/25 - Apixaban Saving	Sarah Kinnersley	6
CCS-2425-006	Introduction of decontamination units	Bill Norton	1
CCS-2425-009	Children's Services Medicines Optimisation - Pharmacy Share	Jack Henderson	2
CCS-2425-011	Ranibizumab Biosimilar Switch - Pharmacy Share	Onajite Okoro	6
CCS-2425-039	CCCS ERF Over Performance	Amandeep Tung-Nahal	3
SWC_2425-039	4% Reduction in actually employed WTE in post | SWC	Jack Richards	15
CORP-2425-019	Nursing Director Income	Martina Morris	6

Level 2 – Financial and/or Clinical QIA Approved. Awaiting sign off at Divisional Manager level before going Live

Scheme No	Scheme Name	Divisional Project Lead	Overall QIA Risk Score
MIC-2425-014	CDC Dermoscopy Increased activity	Kate Keeling	1
MIC-2425-015	Neurology Review of services	Kate Keeling	1

There are currently no immediate risks from the cost improvement schemes listed in terms of their Quality Impact Assessment Scoring or review call back schedule. From a non-CIP related QIAs, the QIAs related to ED redesign carry the highest risks (medium and red rated) and these will continue to be reviewed by the ED Redesign Programme Board and associated working groups, as well as the Chief Nurse, Medical Director and Chief Operating Officer. QIAs related to the 4% workforce reduction are rated as high risk due to the high likelihood of non-delivery.

M6 - Summary of Nursing KPI Audits (September 2024)

The Dudley Group NHS Foundation Trust

Audit	Mar	Apr	May	Jun	Jul	Aug	Sep
Tissue Viability SKIN audit (CQUIN 12)	96.2%	97.6%	96.7%	98%	97.4%	96.6%	97%
Hand Hygiene '5 moments' audit (v2)	98.6%	98.7%	98.2%	97.6%	97.8%	98.7%	98.1%
Hand Hygiene Environment Audit	98.90	98.7%	99.2%	98%	98.5%	98.8%	99%
Matron In Patient Audit	87.9%	85.5%	88.1%	89.5%	91.9%	91%	83.7%
Matron Audit - Out Patient Areas	N/A	N/A	N/A	N/A	90.4%	93.3%	94.2%
Standard of Documentation Audit 2024	95.8%	96.4%	96.4%	97%	97.4%	97.5%	97.6%
Lead Nurse In Patient Audit January 2024	93.7%	92.8%	93.8%	94.1%	95%	92.7%	94.9%

CARE RESPECT RESPONSIBILITY

M6 - Safer Staffing Data (September 2024)

The Dudley Group
NHS Foundation Trust

Safer Staffing Summary Sept 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
B1	114	105	59	65	63	63	38	38	92%	110%	100%	100%	412	4.63	2.84	7.47
B2(H)	120	107	188	171	90	90	180	173	89%	91%	100%	96%	714	3.31	5.67	8.98
B2(T)	119	105	132	120	90	85	105	98	88%	91%	94%	94%	711	3.21	3.69	6.89
B3	190	178	196	158	182	176	166	151	94%	81%	97%	91%	1,110	3.75	3.34	7.09
B4	220	175	243	207	181	167	194	183	79%	85%	92%	94%	1,262	3.18	3.71	6.89
B5	241	192	168	159	232	218	106	97	80%	95%	94%	92%	1,024	4.90	2.92	7.83
B6	94	72	64	57	60	60	65	57	77%	89%	100%	88%	480	3.24	2.85	6.08
C1 A	123	121	132	113	90	89	105	99	99%	86%	99%	94%	714	3.45	3.56	7.01
C1 B	125	121	143	127	90	89	107	103	97%	89%	99%	96%	715	3.45	3.76	7.21
C2	273	228	65	69	243	220	63	69	83%	106%	90%	109%	580	9.06	2.79	11.84
C3	210	210	385	361	180	165	371	360	100%	94%	92%	97%	1,539	2.93	5.51	8.44
C4	200	172	66	58	120	104	60	72	86%	87%	86%	120%	649	4.97	2.31	7.28
C5 A	117	92	133	118	90	89	99	97	79%	88%	99%	98%	714	3.07	3.61	6.68
C5 B	155	143	120	118	150	150	91	85	92%	99%	100%	93%	708	4.87	3.44	8.31
C6	94	85	116	96	90	84	92	83	90%	83%	93%	90%	556	3.56	3.85	7.41
C7	210	176	182	159	150	146	181	176	84%	88%	97%	97%	1,074	3.51	3.75	7.26
C8	250	231	218	183	210	197	185	176	92%	84%	94%	95%	1,285	3.90	3.35	7.25
CCU_PCCU	244	223	59	52	213	209	32	30	91%	88%	98%	94%	718	7.07	1.37	8.44
Critical Care	509	412	114	90	510	418			81%	79%	82%		488	20.41	2.21	22.62
AMU	470	456	391	344	390	429	393	373	97%	88%	110%	95%	2,106	4.93	4.09	9.02
Maternity	829	760	257	210	510	482	150	138	92%	82%	94%	92%	1,266	9.37	3.21	12.58
MECU	90	90	33	29	90	90			100%	88%	100%		222	9.72	1.43	11.15
NNU	376	250			259	212			67%		82%		346	15.98	0.00	15.98
TOTAL	**5,373**	**4,704**	**3,463**	**3,064**	**4,284**	**4,030**	**2,782**	**2,658**	**88%**	**88%**	**94%**	**96%**	**19,393**	**5.19**	**3.50**	**8.69**

CARE RESPECT RESPONSIBILITY

Annex A

Illustrative Designated Body Annual Board Report and Statement of Compliance

This template sets out the information and metrics that a designated body is expected to report upwards, to assure their compliance with the regulations and commitment to continual quality improvement in the delivery of professional standards.

The content of this template is updated periodically so it is important to review the current version online at NHS England » Quality assurance before completing.

Section 1 – Qualitative/narrative
Section 2 – Metrics
Section 3 - Summary and conclusion
Section 4 - Statement of compliance

Section 1 Qualitative/narrative

While some of the statements in this section lend themselves to yes/no answers, the intent is to prompt a reflection of the state of the item in question, any actions by the organisation to improve it, and any further plans to move it forward. You are encouraged therefore to use concise narrative responses in preference to replying yes/no.

1A – General
The board/executive management team of
can confirm that:

1A(i) An appropriately trained licensed medical practitioner is nominated or appointed as a responsible officer.

Action from last year:	No changes in this area.
Comments:	Dr Julian Hobbs is both the Executive Medical Director for The Dudley Group NHS Foundation Trust as well as the Responsible Officer for this designated body. He has held this role throughout the review period of this report.
Action for next year:	No changes anticipated.

1A(ii) Our organisation provides sufficient funds, capacity and other resources for the responsible officer to carry out the responsibilities of the role.

Yes / No:	Yes
Action from last year:	Contract with IT software renewed alongside an associated 360 feedback tool.
Comments:	The process of supporting medical appraisal and revalidation is managed by a Revalidation Manager and medical appraisals are undertaken within

	a dedicated IT software solution that is linked to the 360-feedback tool to streamline the experience for individual doctors and strengthen monitoring.
Action for next year:	Preparatory work to review the remuneration for appraisers, ultimately to support an increase in their number as well as to improve the ability to maintain high quality outcomes, is underway.

1A(iii)An accurate record of all licensed medical practitioners with a prescribed connection to our responsible officer is always maintained.

Action from last year:	A review of the record of prescribed connections has been undertaken and cross-checked with colleagues in Medical Workforce to ensure accuracy.
Comments:	The Revalidation Manager maintains an accurate record of licensed medical practitioners connected to the organisation in close liaison with colleagues in Medical Workforce, Staff Bank, and the Postgraduate Centre (re: Medical Training Initiative Doctors). Medical and dental staff leaving the organisation are disconnected appropriately. This record is maintained on the Premier IT system which is now linked to GMC Connect.
Action for next year:	Plans to develop dashboards of actively employed staff, including new starters, leavers, and changes in assignment (roles) will improve the responsiveness of this process further. Further focus on GMC connections for doctors on our locum staff bank is planned as well as a review of the registration processes onto the bank to ensure appropriate connections.

1A(iv) All policies in place to support medical revalidation are actively monitored and regularly reviewed.

Action from last year:	The Medical Staff Appraisal Policy was re-ratified on 3rd May 2024 and remains valid until 31/3/2027 unless updated.
Comments:	There is a procedural document compliance team that ensure that procedural documents are maintained and updated.

Action for next year:	No document changes are planned.

1A(v) A peer review has been undertaken (where possible) of our organisation's appraisal and revalidation processes.

Action from last year:	Quality Assurance, using the ASPAT audit process of appraisal output forms, has been increased from an annual review of 20 examples, to a quarterly review of the same number. As such, 80 output forms have been assessed in the review period and feedback offered to the whole appraiser group. Those appraisers providing the highest scores, against the template, have received personal feedback and the whole group now receives quarterly 'newsletters' with the ASPAT results as well as 'bitesize' development content to improve appraisal performance. A new monthly Appraisal Group has been established which highlights any concerns around appraisal engagement and revalidation progress with appropriate escalation to a RO Advisory Group.
Comments:	Feedback from appraisees is made available to medical appraisers to enable further development of practice.
Action for next year:	No external peer review into appraisal and revalidation processes is planned.

1A(vi) A process is in place to ensure locum or short-term placement doctors working in our organisation, including those with a prescribed connection to another organisation, are supported in their induction, continuing professional development, appraisal, revalidation, and governance.

Action from last year:	No changes from previous year in this area.
Comments:	All GMC connected doctors and dentists have an account on our appraisal IT system and collate their supporting information for medical appraisal, and ultimately revalidation, within this system. SPA time is provided to support clinical governance activities, and all medical and dental staff are advised of the means of obtaining information relating to clinical governance, supporting their practice, include in their appraisals, from the relevant departments in the Trust.

	We are actively engaged in the MPIT process to share relevant information with other Trusts when locum doctors are connected to another organisation. Fixed term doctors are supported with trained medical appraisers in the same way as substantive staff.
Action for next year	No changes anticipated.

1B – Appraisal

1B(i) Doctors in our organisation have an annual appraisal that covers a doctor's whole practice for which they require a GMC licence to practise, which takes account of all relevant information relating to the doctor's fitness to practice (for their work carried out in the organisation and for work carried out for any other body in the appraisal period), including information about complaints, significant events and outlying clinical outcomes.

Action from last year:	Liaison with a local, independent sector, healthcare facility has improved the provision of 'exception reports' for work undertaken on that site to include in colleagues' appraisals and will be expanded to other institutions.
Comments:	Supported by the Revalidation Manager and the IT software, all doctors and dentists undertake annual, whole practice, medical appraisal unless unable. The proforma within the relevant software directs the appraiser to ensure that the whole scope of practice is reviewed, and this is supported through training. Alongside substantive consultant and SAS grade staff, locally appointed doctors and other fixed term staff are also managed within this system and are subject to whole practice appraisal. Within the organisation, governance departments, with a responsibility for significant events, complaints, etc., can collate reports of involvement for individuals to include in their appraisals.
Action for next year:	Work to develop patient outcome data into medical appraisals requires further work, limited by technical constraints, but remains a goal for further development. Discussions are underway to further develop our clinical governance system to increase the efficacy of this process reducing errors/missed episodes.

1B(ii) Where in Question 1B(i) this does not occur, there is full understanding of the reasons why and suitable action is taken.

Action from last year:	
Comments:	Individual medical and dental staff are encouraged to report circumstances that may provide a barrier to the completion of their medical appraisal. At this point, support is offered from the Revalidation Manager and senior medical staff. In the rare event of a failure to engage, escalation processes are in place.
Action for next year:	

1B(iii) There is a medical appraisal policy in place that is compliant with national policy and has received the Board's approval (or by an equivalent governance or executive group).

Action from last year:	The Medical Staff Appraisal Policy was re-ratified on 3rd May 2024 and remains valid until 31/3/2027 unless updated.
Comments:	There is a procedural document compliance team that ensure that procedural documents are maintained and updated.
Action for next year:	No action planned in this area.

1B(iv) Our organisation has the necessary number of trained appraisers[1] to carry out timely annual medical appraisals for all its licensed medical practitioners.

Action from last year:	We have recruited 5 new medical appraisers in the last twelve months.

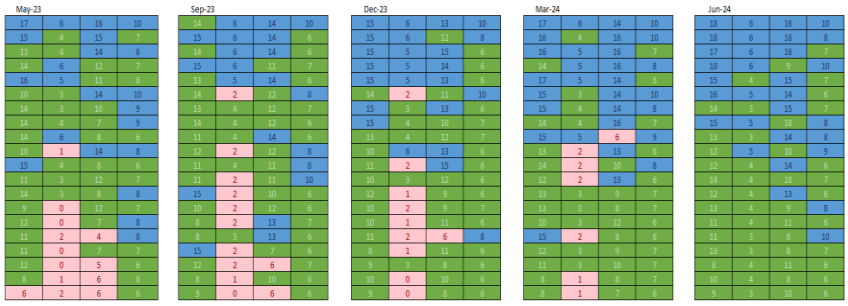
[1] While there is no regulatory stipulation on appraiser/doctor ratios, a useful working benchmark is that an appraiser will undertake between 5 and 20 appraisals per year. This strikes a sensible balance between doing sufficient to maintain proficiency and not doing so many as to unbalance the appraiser's scope of work.

Comments:	There are 78 medical appraisers within the Trust who support the process of medical appraisal. These colleagues are a mixture of substantive consultant and senior SAS doctors.
Action for next year:	There is a need to expand the numbers of medical appraisers to meet the current demand and provide a high-quality medical appraisal for all doctors and dentists. A programme to recruit and train new appraisers will be a priority for the next twelve months.

1B(v) Medical appraisers participate in ongoing performance review and training/ development activities, to include attendance at appraisal network/development events, peer review and calibration of professional judgements (Quality Assurance of Medical Appraisers or equivalent).

Action from last year:	Fifty licences were provided to current appraisers for online appraiser refresher training this year with the view of maintaining knowledge and skills in this area.
Comments:	The training record of medical appraisers is held and maintained by the Revalidation Manager. The ASPAT audit has been increased from annual to quarterly and forms the basis for a quarterly 'newsletter' with educational content and guidance on best practice for medical appraisal. Personalised positive feedback is provided for those with the highest quality appraisal outputs and overall reflections are shared with all medical appraisers
Action for next year:	Further recruitment to the medical appraiser role will enable further focus on the quality of appraisal outputs and allow further development of the quality assurance and training offering.

1B(vi) The appraisal system in place for the doctors in our organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group.

Action from last year:	The quality assurance process for medical appraisal has been reinforced in the last twelve months with an increase in the frequency of the ASPAT audit of appraisal outputs from annual to quarterly.  Each row above represents a random individual appraisal output, sorted with the highest scoring on top. Each block is a discrete exercise per quarter. The columns represent each of the four domains being assessed. Over the last 5 exercises, it is demonstrated that there has been improvement in the overall scores (mean increased by 9.2% to 74%) but also that the presence of red scores (<40%) has been removed and the blue scores (>80%) have increased. It is noted that this represents only 100 output forms reviewed and that the ASPAT exercise forms only one method of assessment.
Comments:	The AOA report is presented to the Trust Board for assurance.
Action for next year:	Further broadened QA will be developed, subject to resource.

1C – Recommendations to the GMC

1C(i) Recommendations are made to the GMC about the fitness to practise of all doctors with a prescribed connection to our responsible officer, in accordance with the GMC requirements and responsible officer protocol, within the expected timescales, or where this does not occur, the reasons are recorded and understood.

Action from last year:	No specific actions to report.
Comments:	The Responsible Officer maintains close relations with the GMC on matters of fitness to practice and revalidation recommendations are

	made in accordance with the GMC requirements and responsible officer protocol and in a timely manner.
Action for next year:	No changes anticipated.

1C(ii) Revalidation recommendations made to the GMC are confirmed promptly to the doctor and the reasons for the recommendations, particularly if the recommendation is one of deferral or non-engagement, are discussed with the doctor before the recommendation is submitted, or where this does not happen, the reasons are recorded and understood.

Action from last year:	No changes in practice to report.
Comments:	Doctors receive communication from the GMC to confirm that revalidation has been processed following positive recommendation. Any revalidation recommendations that need to be deferred are discussed with the doctor and plans are agreed to address any shortfalls. This process would extend to decisions around non-engagement but there have not been any from this designated body within this reporting period.
Action for next year:	No changes anticipated.

1D – Medical governance

1D(i) Our organisation creates an environment which delivers effective clinical governance for doctors.

Action from last year:	Introduction of PSIRF framework to support management of clinical incidents.
Comments:	Clinical governance arrangements exist across the organisation to support safe provision of clinical care. Learning from both adverse incidents and from excellence in healthcare is promoted and shared in local governance meetings. Shared learning is promoted through both local, divisional and Trust processes. Complaints are responded to promptly and with a view to continual learning and complements are collected and tracked. Medical staff

	undertake both colleague and patient feedback in each revalidation cycle as mandated. Attendance at clinical governance meetings is encouraged as well as reflection on these within annual appraisals.
Action for next year:	Improved transfer of clinical governance data to individuals to support reflection and practice improvement planned.

1D(ii) Effective systems are in place for monitoring the conduct and performance of all doctors working in our organisation.

Action from last year:	The organisation has worked with a local independent healthcare provider to improve the flow of information from that institution into our Trust appraisal system and will continue to develop this.
Comments:	The organisation has engaged with the NCIP project team to integrate these data, for clinicians and clinical teams. Information from national registries is also included in medical appraisals albeit led by the appraisee.
Action for next year:	Information to support medical appraisal is provided from the relevant discrete departments to support ongoing development and reflection. Attempts to coordinate this into a consolidated report are underway but challenged by IT considerations. Discussions around upgrades to the clinical governance software will aim to improve this process but are currently unavailable.

1D(iii) All relevant information is provided for doctors in a convenient format to include at their appraisal.

Action from last year:	Nil to report.

Comments:	Information to support doctors' appraisals is currently made available to individuals but is provided 'piecemeal' and requires the appraisee to seek the information themselves and upload into their portfolio.
Action for next year:	An action to improve the quality and completeness of information for doctors' appraisals is being explored. An update to our organisation's clinical governance management system, Datix, may facilitate this but such changes subject to other constraints.

1D(iv) There is a process established for responding to concerns about a medical practitioner's fitness to practise, which is supported by an approved responding to concerns policy that includes arrangements for investigation and intervention for capability, conduct, health and fitness to practise concerns.

Action from last year:	Plans in draft to update Medical Concerns process to ensure robust record keeping, single point of access via structured referral form and training and development for medical leaders. Training from NHS Resolution delivered to >20 medical leaders and draft proposal for process changes agreed.
Comments:	A process for managing professional concerns raised regarding medical staff, based on MHPS, is detailed in a ratified policy, active within the organisation. This policy is due for renewal and discussions are underway to strengthen the initial response to concerns with a focus on development of medical leaders, robust record keeping, and the monitoring of outcomes and timescales for investigations, including with regard to the impact of fairness across all protected characteristics. Close liaison with the GMC is in place with regular meetings and engagement with HLRO network events. NHS Resolution are consulted on case work where indicated.
Action for next year:	Complete and embed process changes above to ensure ongoing attention to fairness in escalation of medical concerns alongside cultural awareness training for decision makers.

1D(v) The system for responding to concerns about a doctor in our organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group. Analysis includes numbers, type and outcome of concerns, as well as aspects such as consideration of protected characteristics of the doctors and country of primary medical qualification.

Action from last year:	Additional data presented relating to current case mix and ethnicity association to characteristics of medical workforce. Classification of concern 'type' also presented to demonstrate incidence across different clinical areas.
Comments:	The presentation of the outcome of MHPS casework is presented to Board committees, and ultimately to the Trust Board on a bimonthly basis. The information shared includes casework numbers, analysis of categorisation of concerns, duration and progress of cases and spread across staff groups, including ethnicity.
Action for next year:	Plans to improve overall process of managing these concerns will, in turn, also improve ability to create dashboard-style reporting across several demographic metrics to increase transparency and ensure ongoing fairness for individuals.

1D(vi) There is a process for transferring information and concerns quickly and effectively between the responsible officer in our organisation and other responsible officers (or persons with appropriate governance responsibility) about a) doctors connected to our organisation and who also work in other places, and b) doctors connected elsewhere but who also work in our organisation.

Action from last year:	No significant changes to report.
Comments:	The Medical Revalidation team continue to use the official GMC MPIT (Medical Transfer of Information) forms between relevant Responsible Officers forms to ensure the appropriate information is transferred. Other Trusts may send a word document named TIO (Transfer of Information) request for a new starter on leaving our Trust, Our Trust ensures an official copy of a completed official GMC accredited MPIT form is returned to ensure this process is correctly applied and appropriate.
Action for next year:	No changes anticipated.

1D(vii) Safeguards are in place to ensure clinical governance arrangements for doctors including processes for responding to concerns about a doctor's practice, are fair and free from bias and discrimination (Ref GMC governance handbook).

Action from last year:	
Comments:	Concerns raised about medical and dental staff are considered by a diverse senior clinical and non-clinical group advising the Responsible Officer. Decisions to proceed to formal investigations under MHPS are considered in line with a just culture approach and with due consideration to the potential for unconscious bias.
Action for next year:	The organisation is currently revising these processes to ensure ongoing high-quality practice in this area with consideration of increased localised decision making, referral forms for consistent information transfer and fair access into process for all, and the introduction of structural process changes to ensure minimisation of bias or discrimination.

1D(viii) Systems are in place to capture development requirements and opportunities in relation to governance from the wider system, e.g. from national reviews, reports and enquiries, and integrate these into the organisation's policies, procedures and culture. (Give example(s) where possible.)

Action from last year:	Nil
Comments:	The Trust has an integrated governance team and a clinical effectiveness team who monitor and distribute key items for consideration. All NICE guidance, HSIB reports and national reviews requiring action for example are monitored via our clinical audit tool 'AMAT'. The Clinical Effectiveness Group meets monthly and reports to the Risk and Assurance Group. In addition, each division holds a monthly governance meeting. The Trust Library and Knowledge service support the governance team in ensuring all new and updated policies are accurate and the evidence is the most up to date.
Action for next year:	Continue to monitor the implementation of guidance and recommendations via the reporting structure outlined above

1D(ix) Systems are in place to review professional standards arrangements for all healthcare professionals with actions to make these as consistent as possible (Ref Messenger review).

Action from last year:	Nil
Comments:	The Trust has a Medical Concerns meeting for doctors and a parallel group for non-medical staff. Consistent HR support is provided across all professional groups and is allocated at divisional level. All concerns and referrals to professional bodies are considered by the Quality Committee with upward reporting to Trust board. This is a joint report between the Medical Director and Chief Nurse Offices.
Action for next year:	Review frequency of professional standards reporting to both Quality and Trust Board.

1E – Employment Checks

1E(i) A system is in place to ensure the appropriate pre-employment background checks are undertaken to confirm all doctors, including locum and short-term doctors, have qualifications and are suitably skilled and knowledgeable to undertake their professional duties.

Action from last year:	No significant development to report.
Comments:	Recruitment of new medical and dental staff – including fixed term workers – is coordinated through a bespoke IT software solution, TRAC. Pre-employment checks robustly completed including references and occupational health checks.
Action for next year:	Review of these processes for staff bank registrants is planned to ensure the same high level of scrutiny exists in that process.

1F – Organisational Culture

1F(i) A system is in place to ensure that professional standards activities support an appropriate organisational culture, generating an environment in which excellence in clinical care will flourish, and be continually enhanced.

Action from last year:	Nil

Comments:	The Trust has appointed an Associate Medical Director for Professional Concerns with a focus on fairness. The Just Culture framework for decision making has been adopted.
Action for next year:	No changes anticipated.

1F(ii) A system is in place to ensure compassion, fairness, respect, diversity and inclusivity are proactively promoted within the organisation at all levels.

Action from last year:	Nil
Comments:	There is an overarching behaviour framework in Dudley. The Trust has an EDI team who are leading a range of workstreams to promote equality and diversity in the Trust. A 'Women in Medicine' week was recently held as an example. Several networks are active in the Trust included Disability, Womens' and Embrace (ethnicity-focussed). The Just Culture framework for decision making has been adopted.
Action for next year:	Ongoing workplan in place from networks

1F(iii) A system is in place to ensure that the values and behaviours around openness, transparency, freedom to speak up (including safeguarding of whistleblowers) and a learning culture exist and are continually enhanced within the organisation at all levels.

Action from last year:	Nil
Comments:	The Trust has a Freedom to Speak Up Guardian who works across all professional groups and reports to Trust board. In terms of being a learning organisation, the Trust has a robust meeting structure to enable this including Mortality Surveillance Group, Deteriorating Patient Group and Clinical Effectiveness. A Framework for high reliability is in development.

	The Trust Board receive a joint CMO/CNO report monthly. A Weekly meeting of harm group exists to address incidents in a timely manner, learning is monitored by Risk and Assurance Group, a sub-committee of the Board. Patient Safety Bulletins are generated from incidents and circulated to all staff to ensure learning and key topics are shared.
Action for next year:	No changes anticipated.

1F(iv) Mechanisms exist that support feedback about the organisation' professional standards process by its connected doctors (including the existence of a formal complaints procedure).

Action from last year:	Nil
Comments:	The Trust has an active MHPS policy for management of concerns relating to medical staff. In addition, there is a capability and conduct policy in place. Should any member of staff have concerns about the handling of concerns there is a ratified Grievance policy in place.
Action for next year:	The timeliness of the handling of MHPS concerns will continue to be reported via Quality Committee and Trust Board

1F(v) Our organisation assesses the level of parity between doctors involved in concerns and disciplinary processes in terms of country of primary medical qualification and protected characteristics as defined by the Equality Act.

Action from last year:	Implementation of EDI data
Comments:	The Trust includes a range of EDI data in its reporting to Quality committee and Trust board.
Action for next year:	Review and refine current data included. Update data capture processes to ensure accuracy across the Trust

1G – Calibration and networking

1G(i) The designated body takes steps to ensure its professional standards processes are consistent with other organisations through means such as, but not restricted to, attending network meetings, engaging with higher-level responsible officer quality review processes, engaging with peer review programmes.

Action from last year:	The Responsible Officer and other members of the senior medical team have attended HLRO network meetings, where possible, and have made use of contacts from these meetings to inform responses to individual case studies. Communications between the RO (and team) and the GMC and NHS Resolution (PPAS) have also been used to ensure a process for professional standards that is consistent with the broader national approach from peers.
Comments:	The designated body has not been involved with peer review programmes relating to professional standards but maintains good relationships with other Responsible Officers through individual case work and national and regional bodies through regular meetings.
Action for next year:	No changes anticipated.

Section 2 – metrics

Year covered by this report and statement: 1st April 2023 – 31st March 2024 .

All data points are in reference to this period unless stated otherwise.

2A General

The number of doctors with a prescribed connection to the designated body on the last day of the year under review. This figure provides the denominator for the subsequent data points in this report.

Total number of doctors with a prescribed connection on 31 March	539

2B – Appraisal

The numbers of appraisals undertaken, not undertaken and the total number of agreed exceptions is as recorded in the table below.

Total number of appraisals completed	443
Total number of appraisals approved missed	88

Total number of unapproved missed	8

2C – Recommendations

Number of recommendations and deferrals in the reporting period.

Total number of recommendations made	83
Total number of late recommendations	0
Total number of positive recommendations	83
Total number of deferrals made	3
Total number of non-engagement referrals	0
Total number of doctors who did not revalidate	0

2D – Governance

Total number of trained case investigators	Approx. 6-8*
Total number of trained case managers	1
Total number of new concerns registered	12
Total number of concerns processes completed	16
Longest duration of concerns process of those open on 31 March	49 weeks
Median duration of concerns processes closed	Unable to provide
Total number of doctors excluded/suspended	0
Total number of doctors referred to GMC	0

2E – Employment checks

Number of new doctors employed by the organisation and the number whose employment checks are completed before commencement of employment.

Total number of new doctors joining the organisation	306
Number of new employment checks completed before commencement of employment	275

2F Organisational culture

Total number claims made to employment tribunals by doctors	5
Number of these claims upheld	0
Total number of appeals against the designated body's professional standards processes made by doctors	0
Number of these appeals upheld	0

Section 3 – Summary and overall commentary

This comments box can be used to provide detail on the headings listed and/or any other detail not included elsewhere in this report.

General review of actions since last Board report

- Introduce additional bespoke 360-patient feedback exercises for Anaesthesia, Radiology and Medical Examiners.
- Work closely with Medical Workforce, Locum Staff Bank and Informatics to manage leavers lists.
- Maintain and update Medical Appraisal Policy
- Continue to undertake annual ASPAT audit.
- Continue support for appraisees including 1:1 meetings.
- To recruit additional appraisers to accommodate the increase in the number of doctors in non-training posts.

Actions still outstanding

- Recruitment of additional appraisers
- Improve visibility of 'leavers list' of staff ceasing employment from perspective of GMC connection.

Current issues

- As stated in the responses above.

Actions for next year (replicate list of 'Actions for next year' identified in Section 1):

- Review of remuneration for medical appraisers with an aim to increase numbers and, in turn, improve quality of appraisal interaction.
- Introduce workforce dashboard for use in Revalidation Team to track staff changes and GMC connections for leavers, starters etc.
- Review process for recruitment of doctors to Staff Bank with specific focus on GMC connections and ensuring high quality of medical provision within the organisation.
- Continue to engage with patient safety team with specific regard to the upgrade of the Trust's clinical governance system and with a view to improving ability to create bespoke reporting for individuals on clinical governance matters.
- Broaden QA process for Medical Appraisal in the context of increased appraiser numbers with consideration of 'senior appraiser' roles.
- Introduce updated process for initial handling of medical concerns as well as to overall MHPS processes to improve responsiveness and fairness.
- Continue to work with informatic colleagues to develop improvements for individuals to access performance data for medical appraisal.
- *Create and maintain register of individuals trained as Case Managers/Case Investigators.

Overall concluding comments (consider setting these out in the context of the organisation's achievements, challenges and aspirations for the coming year):

Significant work has been undertaken to improve the quality assurance processes regarding medical appraisal and the data received has been used as a driver for demonstrable quality improvement. Robust monitoring processes are in place for medical appraisal completion with a substantive staff (Cons and Specialty/Specialist Doctors and similar) appraisal rate of 95.7%. A significant proportion of fixed term staff declare no previous appraisal and have therefore not been appraised within the review period due to their commencement in post. We will review this process with an intention to adopt an 'educational' approach with initial meeting, PDP setting, and subsequent whole practice appraisal to improve this.
Concerns around medical staff are handled with a Just Culture approach and monitoring of timescales and fairness with regards protected characteristics. This data is presented to the Trust Board regularly. The RO maintains a close relationship with the GMC and NHS Resolution on these matters.

Section 4 – Statement of Compliance

The Board/executive management team have reviewed the content of this report and can confirm the organisation is compliant with The Medical Profession (Responsible Officers) Regulations 2010 (as amended in 2013).

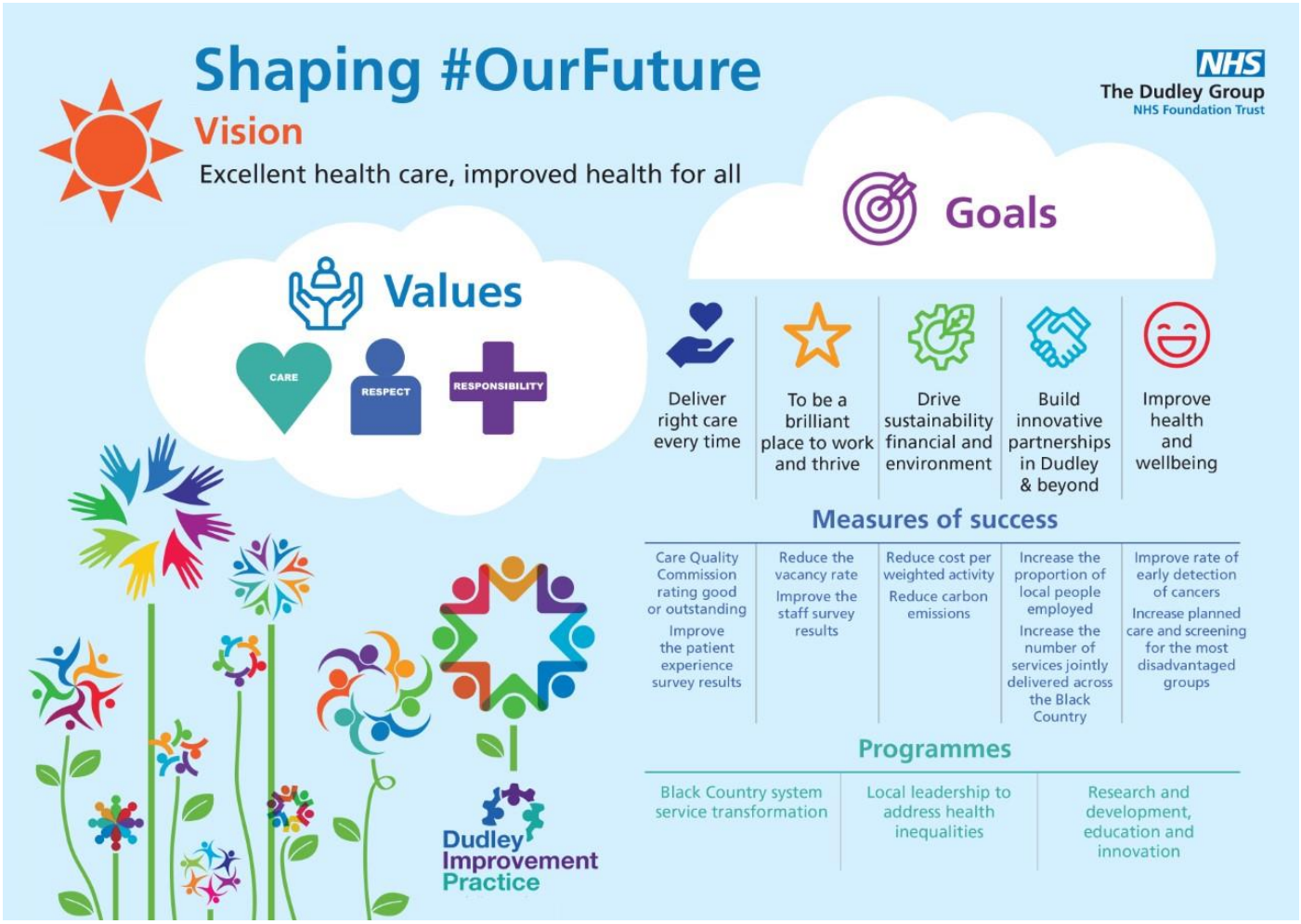
Signed on behalf of the designated body

Official name of the designated body:	The Dudley Group NHS Foundation Trust

Name:	Diane Wake
Role:	Chief Executive
Signed:	
Date:	

Progress report on implementing our strategy and annual plan 2024/25

Quarter 2: July – September 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	Trust CQC rating unchanged.		The CQC undertook an announced Mental health Act monitoring visit on 8th July 2024. The CQC raised initial concerns regarding the detention of patients without the Responsible Clinician (RC). The Trust provided a formal response to the CQC, sharing assurances regarding the provision of the RC and MHA administration with strengthened supportive procedures. Moreover, the Trust shared the findings of an independent retrospective review of potentially detained patients. The review has confirmed that none of the patients are deemed to have been detained outside of the legal remit. CQC self-assessments across the 10 core services have been undertaken during this quarter; work continues to finalise and share the findings of these reviews. CQC engagement meetings have continued with a focus on registering transferring DIHC services ahead of 1st October.	Quality and Safety Reviews to recommence during Q3. Ward to Board visits to continue. CQC self-assessment work finalisation and sharing with Trust Board and the Black Country Provider Collaborative.

Improve our patient experience results to top quartile performance (England) by 2025	*Inpatient Survey 2023* The results demonstrate a much-improved picture since the 2022 survey where a number of sections and questions were performing 'worse' or 'somewhat worse' than other Trusts nationally, and question scores have improved in comparison to the 2022 survey. In 2022, the Trust was performing 'worse' than average for 14 questions in comparison to 4 in 2023. Questions for patients feeling there were enough nurses on duty and having someone to contact if they were worried about their condition or treatment have significantly improved since 2023. The question regarding staff doing everything they could to control the patient's pain has seen an improvement in 2023 at 8.6 in comparison to 8.2 in 2022 where the		• All survey results have been presented to the Patient Experience Group (PEG) in October 2024. This generated detailed discussions regarding the results and ongoing themes, including actions required. • Actions are to be agreed and an update to be presented at the November 2024 PEG meeting.	Regular updates of improvements made will be reported to the Patient Experience Group which is held bi-monthly. The Patient Experience Team will meet with divisional chief nurses and matrons on a monthly basis to monitor progress and update actions.

	score was performing 'much worse' than other trusts nationally and scored 'worse' in 2021. All questions in the 'doctors', and 'nurses' sections have seen an improvement in 2023. The overall patient experience score for the Trust has improved from 7.8 in 2022 to 8.1 in 2023, and from 8.8 in 2022 to 9.1 in 2023 for patients feeling that they were treated with dignity and respect. There are three out of four questions that are performing 'worse' than expected and are recurring themes from the previous year (medication, notice of discharge, and information after discharge). *Cancer Patient Experience Survey* The survey demonstrates an improved picture in			

	comparison to the previous survey. 37 out of 61 questions have seen an improvement since the 2022 survey. Questions in the 'Hospital Care' and 'Your Treatment' section have seen the biggest improvement since the 2022 survey around communication and controlling pain. There has been a decrease in the number of scores that fall below the expected range from 25 in 2022 to 12 in 2023. There are four out of 61 questions that are above the national average (in comparison to five out of 61 in 2022). Waiting times for diagnostic tests and length of waiting time at clinic and day unit for cancer treatment, are recurring negative themes from the 2022 survey. Although the score for waiting time at clinic has seen an improvement from the previous year, this is still			

	below the expected range. The average rating of care scored from very poor to very good is 8.6 in 2023, an improvement since the 2022 survey (8.5). This score is in the lower expected range and below the national average score of 8.9. *Urgent and Emergency Care Survey 2024 (First Cut Picker Results)* There has been an improvement in the overall positive score ranking at 78% in 2024 in comparison to 75.0% in 2022. Scores for Trusts surveyed by Picker ranged from the highest at 85.0% and the lowest 74.0%. There is positive assurance highlighted in the survey for providing care and support from health or social care services after leaving A&E when needed. Scores have seen an improvement around			

	patients being informed of waiting times and being able to get help from staff with symptoms when needed. Scores have improved for patients understanding why tests are needed. The Trust scored 'significantly worse' for one question in the 2024 survey compared to nine questions in 2022, an improvement from the previous survey. The scores for overall A&E experience have seen a decline over the last two surveys. The rating for overall experience in A&E for the Trust is 68% in comparison to 74% in 2022 (and 86% in 2020). This compares to the Picker average of 69%. These scores are highlighted in the report as the most declined scores in 2024. Waiting & Doctors and Nurses, and Medications & Information and Overall were the worst			

	performing sections in the 2024 surveys. *<u>Maternity Survey 2024 (First Cut Picker Results)</u>* There has been a 50% improvement in the number of questions relating to 'significantly worse' in comparison to 2023. Scores for being discharged without delay have remained a positive theme since the 2023 survey. Women being given appropriate support and feeling that their concerns were taken seriously during labour and birth scored positively in 2024 where these were identified as negative themes in 2023. Scores have seen an improvement for women stating that as their partner was able to stay with them as much as they wanted.			

	The ‘Your Labour and the Birth of Your Baby’ section was the most positive scoring section with 13 out of 14 questions demonstrating improvement in the 2024 survey. Women were positive about being given appropriate support and feeling that their concerns were taken seriously during labour and birth. The overall positive score for the Trust has seen an improvement in 2024. Areas such as women being given information about where to have their baby, being asked about their mental health, having confidence in staff, their partner being able to stay with them as long as they wanted, and being involved in decisions are continuous recurring negative themes. Scores have seen a decline for midwives			

	being aware of medical history (postnatal), women being able to access support outside of hours, midwives taking personal circumstances into account, being offered a choice of where to have their baby (recurring negative theme since 2021) and being given information about mental health after having their baby (recurring negative theme since 2022). The lowest performing sections in comparison to the average of Trusts surveyed by Picker were 'care while you pregnant (antenatal)' and 'care after birth' with the highest number of questions in these sections that are scoring 'significantly worse' than the Picker average.			
Achieve NHS Constitution targets (Referral to treatment, diagnostics, cancer,	ED performance in July and August above 78% target		• Additional trolley capacity in place to ensure offloads happen promptly • Escalation of instances where no plan to offload ambulances at 30 minutes based on Kings College model	• Mental health team to have presence in the department overnight • Orientation for new audiology staff so can see patients autonomously • scope offer of mutual aid for cardiac MRI from RWT

emergency access)	Diagnostic waits in July and August above 85% target Cancer faster diagnosis standard (28 days) consistently being met		• Continued scrutiny that GP letters are directly streamed to appropriate area • Use of bank shifts in sleep studies • Recruitment to vacancies in audiology by new/recent graduates • E-requesting to Black Country Pathology Service went live • Clinical agreement to no longer send basal cell carcinoma as urgent to pathology service	
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 Q2, 2024/25 there were 257 new complaints received. In comparison to Q2, 2023/24, there were 240 new complaints received; this is an increase of 7.08% for the quarter. From April 2023 to September 2023 (Q1 & Q2), 492 complaints were received, compared to 503 in Q1 & Q2 2024. This is an increase of 2.2% increase.	The complaints team continue to offer an informal approach (PALS route) to address concerns where applicable to reduce the number of formal complaints received.
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 days		For Q2, 2024/25 the response rate for all complaints closed was 47.4% and 48.4% average for closed first response complaints (this excludes reopened complaints and Ombudsman cases). Average of 50.4% for first responses excluding local resolution meetings.	Continue with escalation process in place which is showing an improvement in responsiveness from divisions.
Increase responses to FFT patient experience survey by 20%	There are no targets set for response rates under the new FFT guidance (April 2020).		A total of 4605 responses were received in August 2024 in comparison to 5190 in July 2024. Overall, 84% of respondents have rated their experience of Trust services as ‘very good/good’ in August 2024, an improvement of 2% since July	The patient experience team will 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.

	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.		2024. A total of 5% of patients rated their experience of Trust services as 'very poor/poor' in August 2024, an improvement of 1% from the previous month. The A&E Department received the highest percentage negative score with 12% of patients rating their overall experience as very poor/poor in August 2024, an improvement of 4% since July 2024. The percentage very good/good scores have seen an improvement for the A&E Department from 67% in July 2024 to 74% in August 2023. Community received the highest positive score at 90%.	Each department is to provide an update on the 'You Said We Have' actions and monitor scores to address any areas of concerns and identify good practice.
Reduction in incidents resulting in significant harm (moderate, severe, death)	The percentage of incidents resulting in significant harm remained low in Q2 – below 1% of all incidents reported. There is not significant change in this percentage compared to previous periods. There were no new never events		PSIRF policy and plan reviewed and revised during Q2 – awaiting Trust Board approval. This documents the strengthening of incident review processes. Single improvement plans continue to be developed with focus on developing outcome metric reporting. Trust PSIRF processes were reviewed by the ICB via a onsite quality assurance visit in September. Positive feedback was verbally received; the ICB plan on sharing trust good practice across the system.	Continue work on outcome metric development A programme of action effectiveness checks to be undertaken to ensure actions have been embedded/sustained in practice and are having the desire impact

Standardised Hospital Mortality Index (SHMI) (quarterly) better than England average	SHMI (99.59) and HSMR (85.76) Both better than average.		There have been 130 cases referred for SJR in 2024. 66% have been reviewed and 88% showed average to excellent care. With the exception of one case the avoidability of death was slight to none. The case where harm and avoidability was identified was referred by governance.	Medical Examiners Service statutory from September 9th. Ongoing work re #NOF mortality overseen by Mortality Surveillance Group
Re-admission within 28 days better than England average	The Trust reported a 28 day re-admission rate of 8.13% which is below peer average (8.5%) and in line with national average (8.13%)		There has been a reduction in the 28 day emergency readmission rate in the latest reporting period (8.13% v 8.74%). The latest reporting month (May 2024) was the lowest rate for 12 months at 7.99%	Speciality level monitoring of readmission rates continues via Divisional governance structures.
Eliminate 65 week waits by Sept 24 and reduce 52 week waits	The original plan was to have all 65 week waiters cleared by the end of September. A handful of patients (4) were waiting over 65 weeks at the end of September booked for October		• Industrial action in July impacted ability to achieve elective targets • Continue to engage with the Further Faster Programme, a particular focus on Ophthalmology	Focus on 52 week waiters with the aim of booking all first outpatient appointments for this cohort by end of November
Improve productivity (reduce DNA rate to better than England average, increase PIFU to 5%, theatre utilisation at 85%)	Trust DNA rate – working towards 5% - July 24 Model Hospital performance 6.5% Trust reports PIFU in September 24 – 3.2%		Trust DNA July 24 Model Hospital Performance 6.5% (CSS 9% / MIC 5% / SWC 7%). Trust PIFU September 24 – 3.2% (CSS 13.6% / MIC 2.1% / SWC 2.8%). **THEATRES** Theatre utilisation has increased and is now above national and peer averages putting the Trust comfortably into the highest quartile. Theatre managers are maintaining the prioritisation of on-time starts and the accuracy and timeliness of data input.	**DNA actions – on going:-** Clinic Outcome Forms outstanding / completed. Text Reminder Service switched on for all relevant microsessions – for both Adults & Paediatric Setup a Trust wide CYP DNA working group. Clinics. Look to set Text Reminder Service as a default position unless opt out. Rollout Day 4 text reminder service across all Specialty areas. OPD 642 dashboard – Review of 2 week Backward Look DNA & Consecutive DNAs reports – to understand themes / mitigation plans. Clinical teams to Call Same Day DNAs – converted to Virtual Consultation – Oasis Updated.

			Utilisation during high turnover lists has been improved with work and advice from DIP and is already showing dividends. Patient throughput is still good and will increase with these improvements. Many specialties remain on target often exceeding 90%. Further improvements are expected in Ophthalmology, Pain Management and Plastics. The Trust has submitted its Hub Optimisation Plan to GIRFT following our recent deferral for Elective Surgical Hub accreditation. We received advice from other trusts who had been in a similar situation and have offered reassurance and further evidence to GIRFT. The Trust is awaiting feedback and a date for our next step in the accreditation process.	DNA Predictor Tool – Informatics are currently working on this, meanwhile, we will use the OPD 642 dashboard / OPD clinic efficiency model to allow DNA deep dives. Inactive Clinics / End Dates – are these closed on Oasis. OPD Mapping Event – Referral to Appointment. Exploring a 5% trajectory as a guide for all Specialty areas. **PIFU Actions – on going:-** Specialty areas continue to work towards the National 85th Percentile opportunities / trajectories set. Trust continues to work towards 5% target March 2025. **Theatre Actions – on going:-** Unbooked lists are now being closed with theatre and anaesthetic staff redirected to more urgent lists. Directorates are now more focussed on booking lists timelier. Were appropriate, occasional lists have been reinstated to accommodate urgent and emergency patients. Theatres are now focussed on prompt starts and the accurate recording of time stamps within the database. The importance of accuracy and completion are being ingrained. More surgeons have started doing HIT lists at weekends, usually one per day each Saturday and Sunday. Aside from the additional income they are generating, they are proving successful in reducing existing waiting lists. Paeds Super Saturdays have been booked for 16th November and 14th December, with the four theatres running simultaneously each day. General Surgery, ENT, MaxFax, and Ophthalmic will be running lists. All the above areas reviewed via Divisional Productivity Meetings / Monthly Productivity Task Force Meetings / OPD Transformation Meetings / Specialty GIRFT Meetings / Monthly SRO Further Faster Meetings.

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	2024 Staff Survey commenced 1st October.		Annual measure. Interim measure during quarter: People Pulse increased response rate from 8%-10%. Promotion of annual survey commenced. Divisions upward report through to Board in October on action plans and activity. Targeted work has been delivered in specific services/teams and across promises.	Delivery of staff survey 1st October – 29th November. Delivery of Divisional action plans continues with focus on managers essentials, flexible working, wellbeing and team-based support. Review and re-launch of bullying and harassment policy alongside support to embed.
Reduce vacancy rates to 7% or below	Vacancy rates continue to be reported at below 7%		In the last quarter a new subgroup has been established called 'Being a Brilliant Place to Work and Thrive' with key workstreams including 1.) Branding and Marketing 2.) Flexible Working 3.) Exit and Stay processes 4.) Bullying and Harassment 5.) Place and Anchor	• Define terms of reference for sub-groups and agreed outputs • Spotlight on bullying, harassment and anti discrimination
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	Contracted WTE for nursing and midwifery staff has decreased from 1878.85 in July 2024 to 1866.93 WTE in August 2024. The total nursing and midwifery vacancies reported stands at 56.28		In the last quarter a new sub group has been established called 'Being a Brilliant Place to Work and Thrive' with key workstreams including 1.) Branding and Marketing 2.) Flexible Working 3.) Exit and Stay processes 4.) Bullying and Harassment 5.) Place and Anchor	• Define terms of reference for sub groups and agreed outputs • Spotlight on bullying, harassment and anti discrimination • Feedback from Head of Midwifery on commissioned review

	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 1.07% in August 2024. Contracted WTE for AHP's has increased from 456.02 WTE in July 2024 to 458.47 WTE in August 2024. The total AHP vacancies in August 2024 are 44.04 WTE this is a vacancy rate of 9%. Staff turnover for AHP's (rolling 12 months average) is 4.95%, the normalised turnover is 3.16%		Key updates at the meetings are brought from AHP leads, ACP leads, Nursing and Midwifery leads with regards to professional specific targeted workstreams	
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	Results are annual through staff survey. Update expected Jan 2025		• New policy drafted	• Obtain feedback and consult on new proposed policy • Identify hot spot areas for targeted soft launch of the new policy and training • Design and delivery of training • Potential for Board development session
Raising concerns - I feel safe to speak up staff survey results better than England average	Results are annual through staff survey. Update expected Jan 2025		Activity to promote uptake of Speak Up and Listen Up training to staff and line managers. Additional work underway to promote FTSU month. Action plan presented to FTSU steering group and actions underway.	Programme of activity for FTSU month in October. Additional recruitment and training of FTSU Champions.
Recommend trust as a place to work staff survey results better than England average	Results are annual through staff survey. Update expected Jan 2025.		Divisional action plans on targeted work. Existing programmes of work continue including: Wellbeing activity to support	Staff survey delivery in progress 1st October – 29th November. Existing programmes of work continue including:

			access to health and wellbeing support, recruitment of champions and promotional campaigns; EDI activity increasing champions, activity on anti-racist organisation, events to support cultural awareness, inclusive recruitment, inclusive development programmes; Managers Essentials increased uptake; targeted work in teams/services identified as challenged.	Wellbeing activity to support access to health and wellbeing support, recruitment of champions and promotional campaigns; EDI activity increasing champions, activity on anti-racist organisation, events to support cultural awareness, inclusive recruitment, inclusive development programmes; Managers Essentials increased uptake; targeted work in teams/services identified as challenged.

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 a few 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	Engage in the new GIRFT programme Further Faster 20 focused on those trusts where there is greatest potential for waiting list reductions to improve health of working population Monthly focus on productivity and efficiency at Financial Improvement Group
Reduce Carbon Emissions (year-on-year decrease achieving net zero by 2040)	In the previous quarter many awareness events were held which has helped increase engagement leading to higher levels of feedback in this quarter surveys. This quarter we have had: - Parking Solution in July		Engagement is building throughout the year following the multiple awareness weeks and months in the previous quarter and the survey's launched this quarter. Travel survey launched in August with over 12% response rate, Make It Happen and People Pulse included three feature questions to support with the Green Plan refresh.	• Upcoming changes with the current bus travel offers. Working with TfWM to increase the current offer of one-month free travel, to one month free plus two months with 25% off. • This new offer will also be available for all patients via the

	- Green Plan focus for Make it Happen and People Pulse in July - Travel Survey in August Overall, we received 12% response rates. Carbon Footprint data to be collated in the next quarter to monitor progress against targets in 23/24.		Key feedback from the travel and parking solution surveys; staff prefer flexible working and remote work opportunities to reduce car use and parking pressure. Feedback on the Green Plan showed 1/3 of staff are well engaged and many ideas were related to recycling and reducing wastage.	general office. Plans are in development to support communication and uptake of this offer. • Awaiting guidance from NHSE for the Green Plan refresh, expected to be released in the coming quarter, with the potential expectation to have plans refreshed in April 2025. • Further work to engage staff with the Green Plan refresh • Plans to work with Dudley Council to engage schools and young people to help shape future • Data to be collated to start calculating the carbon footprint for 23/24
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 6 trust had a deficit which was £3.322m better than the submitted plan following receipt of NHSE deficit funding and additional ICB surplus		• Income via the elective recovery fund was higher than planned driven by higher than planned activity levels • Agency use remains very low • Divisional check and challenge with executive directors	• Continue to monitor elective performance and work to improve coding
Deliver recurrent cost improvement programme of £31.896m	• Trust has identified schemes that could deliver just over £33.779m against the plan target of £31.89m. • Additional savings have been contributed from Corporate and SWC divisions.		• At Month 5 we have delivered £10.68m against a £9.6m plan year to date. • £28.16m of the identified programme plan is recurrent in nature (88%) • Workforce Reduction savings are expected to deliver	• Ensure positive delivery against plan continues during Quarter 3. • Workforce to be reviewed monthly to ensure no adverse impact on productivity plans, e.g. ERF delivery and WLI expectations.

	• Year-end forecast has identified a potential programme underperformance of £3.78m due to particular schemes already being in exception.		£15.57m of the programme value. • There is high risk associated with the 4% Workforce Reduction schemes Trust Wide as the original divisional plans are no longer fully viable and alternative measures now need to be put in place.	• Additional new schemes must be identified to offset the forecast underperformance at year end. • Continued work to increase theatre activity and to move more outpatient follow up appointments onto PIFU pathways where appropriate. • Outcome forms and coding remains a clear focus to ensure all income is captured.
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		There was an adverse variance in August between planned bank use and actual was 179 wte driven in part by the use of surge beds and increased elective activity. Adjusting for this reduces the variance to 134 wte.	• Executive led confirm and challenge meetings • Additional bank controls • Performance monitoring through Finance Improvement group and Finance and Productivity Committee

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	Reported figure in (October 2024) – 68% of staff live within the local footprint		ICan programme has delivered Cohort 1 of paid work experience (all from local area) and 4/5 have secured employment post-programme. 1 is currently on a work-trial for employment. Cohort 2 (9 candidates) have commenced paid work experience with pathways through to employment identified for 3/9 already. ICan CSW programme Cohort 1 complete and Cohort 2 commenced. Reviewing reasonable adjustments offered to all candidates following learning from paid work experience. Reviewing live vacancies and promoting through local organisations and ICan into employment programme.	Continuation of Cohort 2 paid work experience – due to complete end Feb 2025. Delivery of Cohort 2 CSW programme. Recruitment to Cohort 3 CSW programme (due to commence Dec 2024) Evaluation and impact of programme underway with external support. Exploring funding opportunities for April 2025 onwards. Developing test programme into business as usual – adapting recruitment pathways into careers using pre-employment programmes and support.
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		• Refinement of work plan for provider collaborative following clinical improvement 'reset' meeting held on 20th September • Agreed KPIs and a plan on a page • Deep dive into emergency hospital admissions for over 65s with a focus on care home and agreed four recommendations to action • The transaction of staff and services from DIHC was approved by the secretary of state in September and	• Clinical summit being planned for the coming quarter (29th November) • Reporting on the actions and impact following deep dive • Deep dive into Dudley Clinical Hub with scope to be agreed • Reporting by exception against outcomes framework with a view to add value from partners • Run engagement event with voluntary sector about WorkWell to

	Dudley Health & Care Partnership with the transaction of staff and services from Dudley Integrated Health & Care Trust taking place on 1st October 2024 following secretary of state approval		the transaction formally took place on 1st October as planned • Reporting against agreed outcomes framework • WorkWell being mobilised and referrals have started to be received	identify gaps and areas that will have biggest impact
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)	13 people undertaken paid work experience. 4 into jobs. CSW programme – 3 into jobs; Cohort 2 still pending. On track to deliver by end March 2025		ICan programme has delivered Cohort 1 of paid work experience (all from local area) and 4/5 have secured employment post-programme. 1 is currently on a work-trial for employment. Cohort 2 (9 candidates) have commenced paid work experience with pathways through to employment identified for 3/9 already. ICan CSW programme Cohort 1 complete and Cohort 2 commenced.	Continuation of Cohort 2 paid work experience – due to complete end Feb 2025. Delivery of Cohort 2 CSW programme. Recruitment to Cohort 3 CSW programme (due to commence Dec 2024) Evaluation and impact of programme underway with external support. Exploring funding opportunities for April 2025 onwards. Developing test programme into business as usual – adapting recruitment pathways into careers using pre-employment programmes and support.
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	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 discharges are identified per day - 29 of the 33 are successfully facilitated. To mitigate		• 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 • transfer of care (TOC) process and paperwork reviewed to ensure discharge planning on admission	Working alongside community teams to establish processes for the delivery of equipment till 18.00 Reviewing access to overnight stay beds to avoid prolong periods in ED (funded via ICB)

are home for lunch for each RHH ward	impact of MMUH and winter the KPI for the average number of discharges required has been revised to be 35 per day Mon-Fri and 20 per day Sat-Sun from August 2024. • Per day we have an average of 5 incomplete (failed) discharges. This has improved from the previous quarter. 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		with a 100% success rate of TOCs being completed within 24 hours.	

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 and submitted to National Disease Registration Services (NDRS) for Q1 24/25 shows a staging completeness of 86.57% against 603 patients diagnosed and discussed at an MDT. Stage group data for the same quarter shows 62.1% were diagnosed at stage 1 or 2, which is an increase on the previous quarter (61.8%) The first participants of the Targeted Lung Health Check programme in Dudley were scanned on 13th August		Data completeness has improved, 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. • Implementation plans finalised • Scanning took place at Morrisons car park in Kingswinford for a week in August and a week in September • Pathways to manage patients identified with cancer or incidental findings have been finalised	Continue to monitor missing data • Monthly round of scanning to continue • Finalise next location of mobile scanner • Appoint additional nursing support to the programme team
Increase planned care and screening from disadvantaged groups (Breast screening uptake 70% or greater)	Proportion of OP appointments and elective procedures in lowest IMD and BAME continues to increase but remains below population demographics.		Colposcopy screening have presented Health Equity audit to NHSE. Where known adjustments were required additional time has been allocated to appointments. The addition of a flag to Oasis will support adjustments as currently the data received from laboratories does not include sufficient	Awaiting data drill down to speciality- being led in Health Inequalities Core Group Application for funding made to support paediatric asthma pathway. Work being undertaken with housing groups to improve outcomes in respiratory diseases.

			information to support first appointments. Text to be added to letters. Cervical Screening offer within the Trust to be extended to staff.	Health Inequality heatmaps to be utilised by screening services to identify projects.
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 Q4 71.03% Uptake Q1 68.24% which is currently unvalidated, and awaiting further data which will see a slight increase Uptake Q2 57.76%. This is too soon to be credible data. The data does show that the trajectory is on the increase year on year, which shows an increase above the national England average of 66.4%		Q2 Results following the relocation of the mobile to Stafford St in conjunction with PHE's Pharmacy and GP campaign. St James Round 10 pre-Covid19 65% Round 11 Covid 19 56% Round 12 Current 61% Keelinge House Round 10 Pre-Covid19 64% Round 11 Covid19 60% Round 12 Current 60% Central Clinic Round 10 Pre-Covid19 59% Round 11 Covid19 48% Round 12 Current 51% The overall increase has not seen Pre-Covid-19 uptake, with a portion of those rebooking back into their original site. The Mobile will return Nov 2024 to pick up the remaining Practices, enabling the overall PCN to be audited.	• Wolverhampton PNL audited with mixed results, which appear to be in line with those areas more affluent than others. Examples being Penn Surgery with 125 invites, 24 attended, overall, 22% uptake. Poplars Surgery 83 invited, 13 attended, 58% uptake. Conversely Stafford Street, 38 women received a PNL, only one attended. • Re-focusing on face-to –face Practice Manager engagement across the service, with Wolverhampton being a primary focus due to their performance having the lowest uptake across the service. • Cancer Champion Training over 180 Primary Care staff to date, with future dates being at risk due to the ICB not renewing staff contracts. • Pilot study with a Dudley PCN to add breast screening as a Pop-Up on Emiss, • To establish and implement a Staff Charter, so both the Trust values, and staff values are in alignment. The design and development of the Charter will help reinforce joint objectives and build positivity among

			Acknowledging data showing Black African/Caribbean are least likely to attend screening, and presenting late stage with GP's, 26% in comparison to 13% white women, projects were undertaken to produce three videos, with Black Breasts Matter women to encourage breast awareness and the process of a mammogram. These have been completed and can be accessed through the ICB Health Hub Video to film with the LGBTQ+ RHH staff to show the importance of screening	both new members and old. It will reinforce visions goals and responsibilities.

DUDLEY GROUP NHS FOUNDATION TRUST

STANDING FINANCIAL INSTRUCTIONS ANNUAL REVIEW – SEPTEMBER 2024

Introduction

The Standing Financial Instructions (SFI's) and Scheme of Delegation (SoD) detail the financial responsibilities, policies and procedures to be adopted by the Trust. They are designed to ensure that its financial transactions are carried out in accordance with the law and Government Policy in order to achieve probity, accuracy, economy, efficiency and effectiveness. It is recommended good practice that the SFI's and SoD are reviewed annually to take account of the changing control environment and additional financial governance arrangements.

September 2024 Review

The changes made to the SFI's are summarised in the table below.

Change	Reason	Section Numbers
General	To include the ability to submit a deficit plan if agreed by NSHE.	1.3.1
Fraud and Corruption	To update name of NHS fraud regulatory body.	3.2
Business planning, budgets, budgetary control and monitoring	To include statement that the Chief Executive can suspend delegation for employee recruitment at any time (e.g. this supports the VAR process in place)	4.3.2
Bank Accounts	Clarified statement around operation of bank accounts and those authorised to approve transactions.	6.3.1
External Borrowing and Investments	Now includes correct terminology around when the Trust can borrow.	11.1.3
Job titles and amended organisations	Updates to job titles and reference to NHSE and Black Country ICB	Throughout document
Schedule of authorised limits	Removed reference to Operational Director of Finance and replaced with Director of Finance. Update procurement national limits for contract finder and competitive tendering.	Appendix

	Updated the paragraphs where the scheme of delegation can be suspended during financial recovery or periods of financial 'grip and control' measures to include current position.	

The Trust and the Integrated Care Board (ICB) for the Black Country have put in place additional local and system governance arrangements which impact on the delegated authority of the Trust and the operation of the Trust's SFI's. These measures operate during times of financial recovery and enhanced financial 'grip and control' and therefore can be relaxed at a future date. The Trust is currently operating under enhanced local and system governance arrangements which include:

Internal

1. Removal of all delegated authority to recruit employees. Only the Directors can approve recruitment to posts through the Vacancy Approval process.
2. Removal of all delegated authority below Director level for the approval of goods or services that are non-stock items (e.g. not related to the day-to-day clinical operations within wards/clinical departments)
3. For a defined list of discretionary non-pay categories only the Chief Executive or Director of Finance can approve the expenditure.

Integrated Care Board

1. Approval from the ICB of new non-pay revenue expenditure where the expected level of expenditure equals or exceeds £10,000.
2. Approval from the ICB of the use of any non-clinical agency.
3. Approval from the ICB of Consultancy over £50k for onward submission to NHSE.

Recommendation

The Trust Board is asked to approve the proposed changes to the SFI's and Scheme of Delegation.

Attached: Full SFI's and SoD with revisions included highlighted in yellow.

CONTENTS

1. INTRODUCTION

1.1 GENERAL

1.1.1 These Standing Financial Instructions (SFIs) are issued in accordance with Chapter 5 and Schedule 7 of the National Health Service Act 2006 for the regulation of the conduct of the Trust in relation to all financial matters. They shall have effect as if incorporated in the Standing Orders (SOs) of the Trust.

1.1.2 These SFIs detail the financial responsibilities, policies and procedures to be adopted by the Trust. They are designed to ensure that its financial transactions are carried out in accordance with the law and Government policy in order to achieve probity, accuracy, economy, efficiency and effectiveness. They should be used in conjunction with the Scheme of Delegation adopted by the Trust.

1.1.3 These SFIs identify the financial responsibilities which apply to everyone working for the Trust. They do not provide detailed procedural advice. These statements should therefore be read in conjunction with the detailed departmental and financial procedure notes. All financial procedures must be approved by the Director of Finance.

1.1.4 Should any difficulties arise regarding the interpretation or application of any of the SFIs then the advice of the Director of Finance must be sought before acting. The user of these SFIs should also be familiar with and comply with the provisions of the Trust's SOs (included in Trust Constitution).

1.1.5 **FAILURE TO COMPLY WITH SFIs AND SOs IS A DISCIPLINARY MATTER WHICH COULD RESULT IN DISMISSAL.**

1.1.6 If SFIs are breached then this may result in criminal or disciplinary proceedings being instigated and could result in dismissal.

1.2 TERMINOLOGY

1.2.1 Any expression to which a meaning is given in Health Service Acts, or in the Financial Directions made under the Acts, shall have the same meaning in these instructions; and

a) "Trust" means The Dudley Group NHS Foundation Trust;

b) "Board" means the Board of the Directors of the Foundation Trust;

c) “Council of Governors” means the Council of Governors as constituted in accordance with the constitution of the Trust;

d) "Budget" means a resource, expressed in financial terms, proposed by the Board for the purpose of carrying out, for a specific period, any or all of the functions of the Trust;

e) "Budget Holder" means the director or employee with delegated authority to manage finances (Income and Expenditure) for a specific area of the organisation;

f) "Chief Executive" means the chief officer of the Foundation Trust;

g) "Director of Finance " means the chief financial officer of the Foundation Trust;

h) “Funds held on trust” shall mean those funds which the Foundation Trust holds at date of incorporation, receives on distribution by statutory instrument or chooses subsequently to accept under powers derived under section 51 of the National Health Service Act 2006. Such funds may or may not be charitable;

i) "Legal Adviser" means the properly qualified person appointed by the Trust to provide legal advice;

j) "NHS England (NHSE)" refers to the Independent Regulator of NHS Foundation Trusts;

k) “The Chairman” is the Chairman of the Board of Directors and the Council of Governors.

1.2.2 Wherever the title Chief Executive, Director of Finance, or other nominated officer is used in these instructions, it shall be deemed to include such other director or employees who have been duly authorised to represent them.

1.2.3 Wherever the term "employee" is used and where the context permits it shall be deemed to include employees of third parties contracted to the Trust when acting on behalf of the Trust.

1.3 RESPONSIBILITIES AND DELEGATION

1.3.1 The Board exercises financial supervision and control by:

(a) formulating the financial strategy;

(b) requiring the submission and approval of budgets within overall income or an agreed financial plan total with NHSE;

(c) defining and approving essential features in respect of important procedures and financial systems (including the need to obtain value for money); and

(d) defining specific responsibilities placed on directors and employees as indicated in the Scheme of Delegation.

1.3.2 The Board has resolved that certain powers and decisions may only be exercised by the Board in formal session. These are set out in the Scheme of Delegation.

1.3.3 The Board will delegate responsibility for the performance of its functions in accordance with the Scheme of Delegation document adopted by the Trust.

1.3.4 Within the SFIs, it is acknowledged that the Chief Executive is ultimately accountable to the Board, and as accountable officer to the Secretary of State, for ensuring that the Board meets its obligation to perform its functions within the

available financial resources. The Chief Executive has overall executive responsibility for the Trust's activities, is responsible to the Board for ensuring that its financial obligations and targets are met and has overall responsibility for the Trust's system of internal control.

1.3.5 The Chief Executive and Director of Finance, as far as possible, delegate their detailed responsibilities but they remain accountable for financial control.

1.3.6 It is a duty of the Chief Executive to ensure that existing directors and employees and all new appointees are notified of and understand their responsibilities within these Instructions.

1.3.7 The Director of Finance is responsible for:

(a) implementing the Trust's financial policies and for co-ordinating any corrective action necessary to further these policies;

(b) maintaining an effective system of internal financial control including ensuring that detailed financial procedures and systems incorporating the principles of separation of duties and internal checks are prepared, documented and maintained to supplement these instructions;

(c) ensuring that sufficient records are maintained to show and explain the Trust's transactions, in order to disclose, with reasonable accuracy, the financial position of the Trust at any time;

and, without prejudice to any other functions of directors and employees to the Trust, the duties of the Director of Finance include:

(d) the provision of financial advice to the Trust and its directors and employees;

(e) the design, implementation and supervision of systems of internal financial control; and

(f) the preparation and maintenance of such accounts, certificates, estimates, records and reports as the Trust may require for the purpose of carrying out its statutory duties.

1.3.8 All directors and employees, severally and collectively, are responsible for:

(a) the security of the property of the Trust;

(b) avoiding loss;

(c) exercising economy and efficiency in the use of resources; and

(d) conforming with the requirements of NHSE, the terms of authorisation, Standing Orders, Standing Financial Instructions, Financial Procedures and the Scheme of Delegation.

1.3.9 Any contractor or employee of a contractor who is empowered by the Trust to commit the Trust to expenditure or who is authorised to obtain income shall be covered by these instructions. It is the responsibility of the Chief Executive to

ensure that such persons are made aware of this.

1.3.10 For any and all directors and employees who carry out a financial function, the form in which financial records are kept and the manner in which directors and employees discharge their duties must be to the satisfaction of the Director of Finance.

2 AUDIT

2.1 AUDIT COMMITTEE

2.1.1 In accordance with Standing Orders the Board shall formally establish an Audit Committee, with clearly defined terms of reference, The Committee will provide an independent and objective view of internal financial control and clinical governance arrangements by:

(a) overseeing Internal and External Audit services;

(b) reviewing systems;

(c) monitoring compliance with Standing Orders and Standing Financial Instructions;

(d) reviewing schedules of losses and special payments and making recommendations to the Board.

2.1.2 Where the Audit Committee feel there is evidence of ultra vires transactions, evidence of improper acts, or if there are other important matters that the committee wish to raise, the chairman of the Audit Committee should raise the matter at a full meeting of the board. Exceptionally, the matter may need to be referred to the Council of Governors/NHSE.

2.1.3 It is the responsibility of the Director of Finance to ensure an adequate internal audit service is provided and the Audit Committee shall be involved in the selection process when an internal audit service provider is changed.

2.2 DIRECTOR OF FINANCE

2.2.1 The Director of Finance is responsible for:

(a) ensuring there are arrangements to review, evaluate and report on the effectiveness of internal financial control including the establishment of an effective internal audit function;

(b) ensuring that the internal audit is adequate and meets the NHS mandatory audit standards;

(c) deciding at what stage to involve the police in cases of misappropriation, and other irregularities;

(d) ensuring that an annual internal audit report is prepared for the consideration of the Audit Committee. The report must cover:

(i) a clear statement on the effectiveness of internal control,
(ii) major internal control weaknesses discovered,
(iii) progress on the implementation of internal audit recommendations,
(iv) progress against plan over the previous year,
(v) strategic audit plan covering the coming three years,
(vi) a detailed plan for the coming year.

2.2.2 The Director of Finance or designated auditors are entitled without necessarily giving prior notice to require and receive:

(a) access to all records, documents and correspondence relating to any financial or other relevant transactions, including documents of a confidential nature;

(b) access at all reasonable times to any land, premises or employee of the Trust;

(c) the production of any cash, stores or other property of the Trust under an employee's control; and

(d) explanations concerning any matter under investigation.

2.3 ROLE OF INTERNAL AUDIT

2.3.1 Internal Audit is an independent appraisal function of the Trust, designed to assist the Board and all levels of management to fulfil the corporate governance responsibilities.

2.3.2 The Internal Audit service will be subject to market testing at least every five years. Applications will be considered from private firms and from NHS audit agencies.

2.3.3 The terms of reference, the respective responsibilities of each party, the agreed services and total fee payable, together with the agreed qualitative and quantitive levels of performance shall be specified in a formal contract.

2.3.4 Whenever any matter arises which involves, or is thought to involve, irregularities concerning cash, stores, or other property or any suspected irregularity in the exercise of any function of a pecuniary nature, the Finance Director must be notified immediately.

2.3.5 The contract will be managed by the Director of Finance.

2.3.6 The services provided under the contract will be planned, carried out and managed in accordance with the Public Sector Internal Audit Standards.

2.3.7 The Internal Audit Provider will retain the right to plan, perform and report audit work independently.

2.3.8 The Internal Audit Provider will liaise with the Trust's Chief Executive, Director of Finance and the Audit Committee when drawing up a detailed audit plan for the forthcoming year. The plan will be based on a demonstrable assessment of risk and will show what areas are to be addressed, why they should be addressed and the benefits to the organisation of each risk and area audited.

2.3.9 Internal Audit will review, appraise and report upon

(a) the extent of compliance with, and the financial effect of, relevant established policies, plans and procedures;

(b) the adequacy and application of financial and other related management

controls;

(c) the suitability of financial and other related management data;

(d) the extent to which the Trust's assets and interests are accounted for and safeguarded from loss of any kind, arising from:

(i) fraud and other offences,
(ii) waste, extravagance, inefficient administration,
(iii) poor value for money or other causes.

2.3.10 The Internal Audit provider will normally attend Audit Committee meetings and has a right of access to all Audit Committee members, the Chairman and Chief Executive of the Trust.

2.3.11 The Internal Audit provider will liaise with the appointed external auditor and other organisations as necessary. Internal and external audit plans should be coordinated and maximise added value to the Trust.

2.4 EXTERNAL AUDIT

2.4.1 The external auditor is appointed by the Council of Governors. The Audit Committee must help ensure that the auditor provides a cost-efficient service. Should there appear to be a problem, this should be resolved in accordance with the Audit Code for NHS Foundation Trusts.

2.4.2 The External Auditor will present their annual opinion(s) to the Council of Governors annually.

3 FRAUD AND CORRUPTION

1.1. The Trust Chief Executive and Director of Finance shall monitor and ensure compliance with the standard NHS contract.

1.2. The Trust shall nominate a suitable person to carry out the duties of the Local Counter Fraud Specialist as specified by the NHS fraud and corruption manual and guidance. The Local Counter Fraud Specialist shall report to the Director of Finance and shall work with staff in the NHS Counter Fraud Authority in accordance with the NHS Executive Fraud and Corruption Manual.

1.3. The Local Counter Fraud Specialist will be responsible for preventing, detecting and investigating all acts of fraud and corruption. The Bribery Act 2010 places a responsibility on all Trust staff in relation to gifts and hospitality. If there is any concern relating to acts of fraud and corruption, then this is to be reported to the Local Counter Fraud Specialist to investigate.

Bribery - Giving (or offering) or receiving (or requesting) a financial or other advantage in connection with the improper performance of a position of trust, or a function that is expected to be performed impartially or in good faith.' (Bribery Act 2010)

Fraud - any person who dishonestly makes a false representation to make a gain for himself or another or dishonestly fails to disclose to another person, information which he is under a legal duty to disclose, or commits fraud by abuse of position, including any offence as defined in the Fraud Act 2006.

Local Counter Fraud Specialist – Bradley Vaughan	07436 268331 (mobile) 01782 216000 (office)

The contact number for the Anonymous Reporting Hotline is:

0800 028 40 60

4 BUSINESS PLANNING, BUDGETS, BUDGETARY CONTROL, AND MONITORING

4.1 PREPARATION AND APPROVAL OF BUSINESS PLANS AND BUDGETS

4.1.1 The Chief Executive will compile and submit to the Board an annual business plan which takes into account financial targets and forecast limits of available resources. The annual business plan will contain:

(a) a statement of the significant assumptions on which the plan is based;

(b) details of major changes in workload, delivery of services or resources required to achieve the plan;

(c) a summary Financial Plan; and

(d) such other requirements as may be determined by NHSE.

4.1.2 Prior to the start of the financial year the Director of Finance will, on behalf of the Chief Executive, prepare and submit budgets for approval by the Board. Such budgets will:

(a) be in accordance with the aims and objectives set out in the annual business plan;

(b) accord with workload and manpower plans;

(c) be produced following discussion with appropriate budget holders;

(d) be prepared within the limits of available funds as agreed with the Integrated Care System; and

(e) identify potential risks.

4.1.3 The Director of Finance shall monitor financial performance against budget and business plan, periodically review them, and report to the Board.

4.1.4 All budget holders must provide information as required by the Director of Finance to enable budgets to be compiled.

4.1.5 Service charges and developments must be financially appraised and include the FULL recovery of overheads, unless agreed with the Director of Finance.

4.1.6 The Director of Finance has a responsibility to ensure that adequate training is delivered on an on-going basis to budget holders to help them manage successfully.

4.2 BUDGETARY DELEGATION

4.2.1 The Chief Executive may delegate the management of a budget to permit the performance of a defined range of activities. This delegation must be in writing and be accompanied by a clear definition of:

(a) the amount of the budget;

(b) the purpose(s) of each budget heading;
(c) individual and group responsibilities;
(d) authority to exercise virement;
(e) achievement of planned levels of service; and
(f) the provision of regular reports.

4.2.2 The Chief Executive and delegated budget holders must not exceed the budgetary total or virement limits set by the Board.

4.2.3 Authority for virements between budgets held by any one employee shall be limited to:

- over £250,000 Board of Directors
- £75,000 - £250,000 Chief Executive and Director of Finance
- £50,000 - £75,000 Executive Directors
- £10,000 - £50,000 Relevant Director
- Below £10,000 Budget Holder
- (or lower limit for individual budget holders as set by the Chief Executive)

4.2.4 Expenditure for which no provision has been made in an approved budget and which is not subject to funding under delegated powers of virement shall only be incurred after proper authorisation – i.e. by the Chief Executive, or the Chairman and Chief Executive jointly, or the Board of Directors as appropriate within the delegated limits. NHSE or the ICB have the power to put in place financial controls that limit the delegated power of the Trust to approve non-budgeted expenditure.

4.2.5 Unless approved by the Chief Executive individually or jointly with the Chairman, after taking the advice of the Director of Finance, budgets shall only be used for the purpose for which they were provided. Any budgeted funds not required for their designated purpose(s) revert to the immediate control of the Chief Executive, subject to any authorised use of virement.

4.2.4 Non-recurring budgets should not be used to finance recurring expenditure without the authority in writing of the Chief Executive.

4.3 BUDGETARY CONTROL AND REPORTING

4.3.1 The Director of Finance will devise and maintain systems of budgetary control. These will include:

(a) monthly financial reports to the Board in a form approved by the Board

(i) income and expenditure to date showing trends and forecast year-end position;
(ii) movements in working capital; detailed balance sheet analysis including debtors and creditors movements;
(iii) cash flow forecasts;
(iv) capital project spend and projected outturn against plan;
(v) explanations of any material variances from plan;
(vi) details of any corrective action where necessary and the Chief Executive's and/or Director of Finance view of whether such actions are sufficient to correct the situation;

(b) the issue of timely, accurate and comprehensible advice and financial reports to each budget holder, covering the areas for which they are responsible;

(c) investigation and reporting of variances from financial, workload and manpower budgets;

(d) monitoring of management action to correct variances; and

(e) arrangements for the authorisation of budget transfers;

(f) adequate on-going training to budget holders to help them manage successfully.

4.3.2 Each Budget Holder is responsible for ensuring that:

(a) any likely overspending or reduction of income which cannot be met by virement is not incurred without the prior consent of the Board;

(b) the amount provided in the approved budget is not used in whole or in part for any purpose other than that specifically authorised subject to the rules of virement; and

(c) no permanent employees are appointed without the approval of the Chief Executive other than those provided for in the budgeted establishment as approved by the board. The Chief Executive has the authority to remove all delegation for the appointment of employees at any time.

4.3.3 The Chief Executive is responsible for identifying and implementing cost improvements and income generation initiatives in accordance with the requirements of the Annual Business Plan.

4.4 CAPITAL EXPENDITURE

4.4.1 Expenditure on fixed assets for the Trust must follow the correct delegation and reporting lines specifically designed for approval of capital expenditure detailed in the delegation of powers. Accounting for fixed assets must comply with the Trust's Accounting Policies.

4.4.2 Fixed assets should not be purchased from revenue funds.

4.5 MONITORING RETURNS

4.5.1 The Chief Executive is responsible for ensuring that the appropriate monitoring returns are submitted to the requisite monitoring organisations. This will include monthly and annual financial data submissions to NHS England (NHSE) and the Black Country Integrated Care System (ICS).

5 ANNUAL ACCOUNTS AND REPORTS

5.1 ANNUAL ACCOUNTS

5.1.1 The Trust (through its Chief Executive and accounting officer) shall prepare in respect of each Financial Year annual accounts in such form as NHSE may, with the approval of the Treasury, direct.

5.1.2 In preparing its annual accounts, the Trust shall comply with any directions given by NHSE with the approval of the Treasury as to:

(a) The methods and principles according to which the accounts are to be prepared; and

(b) The information to be given in the accounts.

5.1.3 The Trust shall:-

(a) Lay a copy of the annual accounts, and any report of the auditor on them, before Parliament; and

(b) Once it has done so, send copies of those documents to NHSE in accordance with the timetable prescribed by NHSE.

5.2 ANNUAL REPORT AND FORWARD PLANS

The Trust shall prepare annual reports and send them to NHSE. The reports are to give:-

5.2.1 Information on any steps taken by the Trust to secure that (taken as a whole) the actual membership of any public constituency is representative of those eligible for such membership; and

5.2.2 Any other information that NHSE requires.

5.2.3 The Trust shall comply with any decision NHSE makes as to:-

- the form of the reports.
- when the reports are to be sent to him.
- the periods to which the reports are to relate.

5.3 The Trust shall give information as to its forward planning in respect of each financial year to NHSE. This information shall be prepared by the Board of Directors, who must have regard to the views of the Council of Governors.

5.4 The annual report shall also be held at the Trust Headquarters for public inspection and shall be made available via the Trusts website.

5.5 The Trust's annual accounts, any report of the auditor on them and annual report must be presented to the Council of Governors at a public meeting together with, where applicable, summary financial statements.

6 BANK ACCOUNTS

6.1 GENERAL

6.1.1 The Director of Finance is responsible for managing the Trust's banking arrangements and for advising the Trust on the provision of banking services and operation of accounts. This advice will take into account guidance/ directions issued from time to time by NHSE.

6.1.2 **All funds of the Trust shall be held in accounts in the name of the Trust. No employee other than the Director of Finance shall open any bank account in the name of the Trust.**

6.1.3 The Board of Directors shall approve the banking arrangements.

6.2 BANK ACCOUNTS

6.2.1 The Director of Finance is responsible for:

(a) bank accounts;

(b) establishing separate bank accounts for the Trust's non-exchequer funds;

(c) approving the use of a Working Capital Facility or any loan arrangements with NHSE.

(d) reporting to the Board all arrangements made with the Trust's bankers for accounts to be overdrawn.

6.3 BANKING PROCEDURES

6.3.1 The Director of Finance will prepare detailed instructions on the operation of bank accounts which must include:

(a) the conditions under which each bank account is to be operated;

(b) the limit to be applied to any overdraft or other lending facility; and

(c) those authorised to approve transactions on the Trust's accounts.

6.3.2 The Director of Finance must advise the Trust's bankers in writing of the conditions under which each account will be operated.

6.3.3 The Director of Finance may enter into a formal agreement with other bodies for payment to be made on behalf of the Trust by electronic funds transfer (e.g. BACS). Where such an agreement is entered into, the Director of Finance shall ensure satisfactory security arrangements are made.

6.4 TENDERING AND REVIEW

6.4.1 The Director of Finance will review the banking arrangements of the Trust at regular intervals to ensure they reflect best practice and represent best value for money.

6.4.2 Unless specific NHS banking facilities are mandated by NHSE, competitive tenders should be sought at least every five years. The result of the tendering exercise should be reported to the Board of Directors.

6.4.3 Banking arrangements may be extended up to a maximum of two years if the Trust obtains a valuable benefit from the extension.

7 INCOME, FEES AND CHARGES AND SECURITY OF CASH, CHEQUES AND OTHER NEGOTIABLE INSTRUMENTS

7.1 INCOME SYSTEMS

7.1.1 The Director of Finance is responsible for designing, maintaining and ensuring compliance with systems for the proper recording, invoicing, collection and coding of all monies due.

7.1.2 The Director of Finance is also responsible for the prompt banking of all monies received.

7.2 FEES AND CHARGES

7.2.1 The Trust shall follow NHSE guidance in national financial frameworks in compiling annual costing data and in establishing values for Contracts with commissioners.

7.2.2 The Director of Finance is responsible for approving and regularly reviewing the level of all fees and charges other than those determined by NHSE or by Statute. Independent professional advice on matters of valuation shall be taken as necessary.

7.2.3 All employees must inform the Director of Finance promptly of money due arising from transactions which they initiate/deal with, including all contracts, leases, tenancy agreements, private patient undertakings and other transactions. The Director of Finance shall approve all contracts for income.

7.2.4 Only designated staff, identified by the Director of Finance, may raise invoices on behalf of the Trust.

7.3 DEBT RECOVERY

7.3.1 The Director of Finance is responsible for the appropriate recovery action on all outstanding debts.

7.3.2 Income not received should be dealt with in accordance with losses procedures.

7.3.3 Should an overpayment be detected recovery will be initiated.

7.4 SECURITY OF CASH, CHEQUES AND OTHER NEGOTIABLE INSTRUMENTS

7.4.1 The Director of Finance shall prescribe systems and procedures for any employee handling cash, pre-signed cheques and negotiable securities on behalf of the Trust, including:-

(a) approving the form of all receipt books, agreement forms, or other means of officially acknowledging or recording monies received or receivable;

(b) ordering and securely controlling any such stationery;

(c) the provision of adequate facilities and systems for employees whose duties include collecting and holding cash, including the provision of safes or

lockable cash boxes, the procedures for keys, and for coin operated machines; and

(d) arrangements for safe-keeping of duplicate keys and for the replacement of lost keys

(e) procedures for receiving and banking of cash, cheques and other forms of payment

(f) circumstances in which unofficial funds may be deposited in safes (see also 7.4.9 below).

7.4.2 Employees shall be informed in writing on appointment, of their responsibilities and duties for the collection, handling, distribution of cash, cheques etc. Any employee whose duty it is to collect or hold cash shall be provided with a safe or with a lockable cash-box which will normally be deposited in a safe. The employee concerned shall hold only one key.

7.4.3 During the absence (e.g. on holiday) of the holder of a safe or cash-box key, the employee who acts in their place shall be subject to the same controls as the normal holder of the key. There shall be written discharge for the safe and/or cash-box contents on the transfer of responsibilities and the discharge document must be retained for inspection.

7.4.4 All cash, cheques and other forms of payment received by any other employee shall be passed immediately to the holder of a safe or cash-box key or to the cashier, from whom a signed receipt shall be obtained.

7.4.5 All cheques, postal orders, cash etc., shall be banked intact. Disbursements shall not be made from cash received, except under arrangements approved by the Director of Finance.

7.4.6 Official money may never be used for the encashment of private cheques.

7.4.7 The opening of coin operated machines (including telephones) and the counting and recording of the takings shall be undertaken by two employees together, unless authorised in writing by the Director of Finance. The coin-box keys shall be held only by the nominated employee.

7.4.8 Any loss or shortfall of cash, cheques or other cash equivalents, however occasioned, shall be reported immediately in accordance with the agreed procedure for reporting losses (see also Section 14 Disposals, Losses and Special Payments)

7.4.9 The holders of safe keys shall not accept unofficial funds for depositing in their safes unless such deposits are in special sealed envelopes or locked containers. It shall be made clear to the depositors that the Trust is not to be held liable for any loss, and written indemnities must be obtained from the organisation or individuals absolving the Trust from responsibility for any loss.

8 CONTRACTING FOR PROVISION OF SERVICES

8.1 The Chief Executive is responsible for negotiating contracts for the provision of services to patients in accordance with the Business Plan, and for establishing the arrangements for providing extra-contractual services. In carrying out these functions, the Chief Executive should take into account the advice of the Director of Finance regarding:

(a) costing and pricing of services;

(b) payment terms and conditions; and

(c) amendments to contracts

8.2 Contracts should be so devised as to minimise risk whilst maximising the Trust's opportunity to generate income.

8.3 The Director of Finance shall produce regular reports detailing actual and forecast contract income with a detailed assessment of the impact of the variable elements of income.

8.4 **Any pricing of contracts at marginal cost must be undertaken by the Director of Finance and reported to the Board.**

8.5 Services provided to non-NHS organisations with a value greater than £500,000 over a three-year period or the period of the contract if longer, must be performed under a legal contract and be approved by the Board.

8.6 The risks and revenue streams associated with non-NHS activities should be approximately insured with commercial (i.e. non-NHS Resolution) underwriters.

8.7 No contract for the provision of services should be entered into by any officer of the Trust without prior agreement of the Director of Finance.

9 TERMS OF SERVICE AND PAYMENT OF DIRECTORS AND EMPLOYEES

9.1 REMUNERATION AND TERMS OF SERVICE

9.1.1 In accordance with Standing Orders the Board shall establish a Remuneration and Nomination Committee, with clearly defined terms of reference, specifying which posts fall within its area of responsibility, its composition, and the arrangements for reporting.

9.1.2 The Committee will:

(a) advise the Board about appropriate remuneration and terms of service for the Chief Executive and other executive directors including:

(i) all aspects of salary

(ii) provisions for other benefits, including pensions and cars;

(iii) arrangements for termination of employment and other contractual terms;

(b) make such recommendations to the Board on the remuneration and terms of service of executive directors to ensure they are fairly rewarded for their individual contribution to the Trust – having proper regard to the Trust circumstances and performance and to the provisions of any national arrangements for such staff where appropriate;

(c) monitor and evaluate the performance of individual executive directors through the Chief Executives monitoring framework; and

(d) advise on and oversee appropriate contractual arrangements for such staff including the proper calculation and scrutiny of termination payments taking account of such national guidance as is appropriate.

(e) ensure that all termination payments however arising, must be approved by the Director of Finance and the Chief Executive (and having taken the appropriate advice from the Board Secretary and Chief Internal Auditor) to confirm that, respectively, funding is available, no alternative employment opportunities exist and that current regulatory guidance is followed.

9.1.3 In accordance with Standing Orders, the Council of Governors shall establish a Appointments and Remuneration Committee, with clearly defined terms of reference, specifying which posts fall into its area of responsibility, its composition and the arrangements for reporting.

9.1.4 The Council of Governors Appointments and Remuneration Committee will advise the Council about appropriate remuneration and allowances and other terms and conditions of office of the Chairman and Non-Executive Directors'.

9.2 ESTABLISHMENT

9.2.1 The manpower plans incorporated within the annual budget, will form the establishment.

9.2.2 The funded establishment of any department may not be increased without a business case being approved in line with the business case process.

9.3 STAFF APPOINTMENTS

9.3.1 No director or employee may engage, re-engage, or re-grade employees, either on a permanent or temporary nature, or hire agency staff, or agree to changes in any aspect of remuneration:

(a) unless authorised to do so by the Chief Executive; and

(b) within the limit of his approved budget and funded establishment.

9.3.2 The Chief Executive will approve procedures for the determination of commencing pay rates, conditions of service, etc, for employees.

9.3.3 It is the duty of any director or authorised employee who engages staff to ensure that references are obtained and qualifications claimed are authenticated prior to commencement. These checks must be certified as performed and documentary evidence retained on the applicants personal file.

9.4 PROCESSING OF PAYROLL

9.4.1 The Director of Finance is responsible for:

(a) specifying timetables for submission of properly authorised time records and other notifications;

(b) the final determination of pay (with the advice of the Trusts Chief People Officer);

(c) making payment on agreed dates; and

(d) agreeing method of payment.

9.4.2 The Director of Finance will issue instructions regarding:

(a) verification and documentation of data;

(b) the timetable for receipt and preparation of payroll data and the payment of employees;

(c) maintenance of subsidiary records for superannuation, income tax, social security and other authorised deductions from pay;

(d) security and confidentiality of payroll information;

(e) checks to be applied to completed payroll before and after payment;

(f) authority to release payroll data under the provisions of the Data Protection Act;

(g) methods of, and procedures for, payment;

(h) procedures for the recall of cheques and bank credits;

(i) maintenance of regular and independent reconciliation of pay control accounts;

(j) separation of duties of preparing records and handling cash; and

(k) a system to ensure the recovery from leavers of sums of money and property due by them to the Trust.

9.4.3 Appropriately nominated managers have delegated responsibility for:

(a) submitting time records, and other notifications in accordance with agreed timetables;

(b) the certification of staff expense claim forms. The certification by or on behalf of the Budget Holder or Budget Manager shall be taken to mean that the authorising officer is satisfied that the journeys made were authorised, that expenses claimed were properly and necessarily incurred and that allowances are properly payable by the Trust. Eligible employees authorised claims for reimbursement of expenses shall be in an electronic format approved by the Director of Finance. Completed and authorised claims, supported by receipts as appropriate, shall be submitted to the Director of Finance on a regular basis in accordance with an agreed timetable, and as soon as practicable after the expense has been incurred.

(c) expense claims, Waiting List Initiative claims, bank and locum timesheets over three months old have to be authorised by the Director of Finance, in addition to the authorising officer.

(d) claims over three months old will not be paid except at the discretion of the Director of Finance.

(e) completing time records and other notifications in accordance with the Director of Finance's instructions and in the form prescribed by the Director of Finance; and

(f) submitting termination forms in the prescribed form immediately upon knowing the effective date of an employee's resignation, termination or retirement. Where an employee fails to report for duty in circumstances that suggest they have left without notice, the Director of Finance must be informed immediately.

9.4.4 Regardless of the arrangements for providing the payroll service, the Director of Finance shall ensure that the chosen method is supported by appropriate terms and conditions, adequate internal controls and audit review procedures and that suitable arrangements are made for the collection of payroll deductions and payment of these to appropriate bodies.

9.4.5 Payment to an individual shall not be made in advance of the normal pay day, unless there are extenuating circumstances, supported in writing by the appropriate Budget

Holder or Budget Manager, authorised by the Director of Finance, and will not exceed the net pay due at the time of payment. In no circumstances will an advance be made for less than £100.

9.4.6 All new employees shall be paid monthly by bank credit transfer (BACS), unless otherwise agreed by the Director of Finance. No employee will be able to transfer from payment by bank credit transfer to payment in cash or cheque.

9.5 CONTRACTS OF EMPLOYMENT

9.5.1 The Board shall delegate responsibility to each Executive Director for:

(a) ensuring that all employees are issued with a Contract of Employment in a form approved by the Board and which complies with employment legislation; and

(b) dealing with variations to, or termination of, contracts of employment.

9.5.2 The Board shall delegate responsibility to the Chief Executive for the authorisation of variations from Agenda for Change – Terms and Conditions of Service Handbook and Consultant Contracts.

10 NON-PAY EXPENDITURE

10.1 Delegation of Authority

10.1.1 The Board will approve the level of non-pay expenditure on an annual basis and the Chief Executive will determine the level of delegation to budget managers.

10.1.2 The Chief Executive will set out:

(a) the list of managers who are authorised to place requisitions for the supply of goods and services; and

(b) the maximum level of each requisition and the system for authorisation above that level.

10.1.3 The Chief Executive shall set out procedures on the seeking of professional advice regarding the supply of goods and services.

10.2 CHOICE, REQUISITIONING, ORDERING, RECEIPT AND PAYMENT FOR GOODS AND SERVICES

10.2.1 The requisitioner, in choosing the item to be supplied (or the service to be performed) shall always obtain the best value for money for the Trust. In so doing, the advice of the Trust's Procurement Department shall be sought. Where this advice is not acceptable to the requisitioner, the Director of Finance shall be consulted.

10.2.2 The Director of Finance shall be responsible for the prompt payment of accounts and claims. Payment of contract invoices shall be in accordance with contract terms, or otherwise, in accordance with national guidance.

10.2.3 The Director of Finance will:

(a) advise the Board regarding the setting of thresholds above which quotations (competitive or otherwise) or formal tenders must be obtained; and, once approved, the thresholds should be incorporated in standing orders and regularly reviewed;

(b) prepare procedural instructions on the obtaining of goods, works and services incorporating the thresholds;

(c) be responsible for designing and maintaining a system of verification, recording and payment of all amounts payable. The system shall provide for:

(i) A list of directors/employees (including specimens of their signatures) authorised to certify invoices.

(ii) Certification of invoices/goods received notes.

(iii) A timetable and system for submission to the Director of Finance of accounts for payment; provision shall be made for the early submission of accounts subject to cash discounts or otherwise

requiring early payment.

(iv) Instructions to employees regarding the handling and payment of accounts within the Finance Department.

(d) be responsible for ensuring that payment for goods and services is only made once the goods and services are received, except as below.

10.2.4 Prepayments are only permitted where exceptional circumstances apply and when agreed by the Director of Finance. The budget holder is responsible for ensuring that all items due under a prepayment contract are received and he/she must immediately inform the Director of Finance if problems are encountered.

10.2.5 Official Orders must:

(a) be consecutively numbered;

(b) be in a form approved by the Director of Finance;

(c) state the Trust's terms and conditions of trade; and

(d) only be issued to, and used by, those duly authorised by the Chief Executive.

10.2.6 Managers must ensure that they comply fully with the guidance and limits specified by the Director of Finance and that:

(a) all contracts (other than for a simple purchase permitted within the Authorised Limits or delegated budget), leases, tenancy agreements and other commitments which may result in a liability are notified to the Director of Finance in advance of any commitment being made;

(b) contracts above specified thresholds are advertised and awarded in accordance with Government rules on public procurement;

(c) where consultancy advice is being obtained, the procurement of such advice must be approved by Directors and be in accordance with guidance issued by NHSE;

(d) no order shall be issued for any item or items to any firm which has made an offer of gifts, reward or benefit to directors or employees, other than:

(i) isolated gifts of a trivial character or inexpensive seasonal gifts, such as calendars;

(ii) conventional hospitality, such as lunches in the course of working visits;

Employees receiving such offers shall notify the appropriate director; details of hospitality received shall be entered in a register maintained by the Board Secretary; and visits at a suppliers expense to inspect equipment etc. should not be undertaken without the prior approval of the Chief Executive.

(e) no requisition/order is placed for any item or items for which there is no budget provision unless authorised by the Director of Finance on behalf of the Chief Executive;

(f) all goods, services, or works are ordered on an official order except purchases from petty cash;

(g) verbal orders must only be issued very exceptionally - by employees designated by the Chief Executive and only in cases of emergency or urgent necessity. These must be confirmed by an official order, clearly marked "Confirmation Order";

(h) orders are not split or otherwise placed in a manner devised so as to avoid the financial thresholds;

(i) goods are not taken on trial or loan in circumstances that could commit the Trust to a future uncompetitive purchase;

(j) changes to the list of directors/employees authorised to certify invoices are notified to the Director of Finance;

(k) purchases from petty cash are restricted in value and by type of purchase in accordance with instructions issued by the Director of Finance; and

(l) petty cash records are maintained in a form as determined by the Director of Finance.

(m) certification of satisfactory delivery of the goods or services to the Finance Department is completed through the part-delivery advice (PDA) or “goods received note” process within 48 hours of receipt.

10.2.7 The Director of Finance shall ensure that the arrangements for financial control and financial audit of building and engineering contracts and property transactions comply with the guidance issued by NHSE. The technical audit of these contracts shall be the responsibility of the Finance Director.

11 EXTERNAL BORROWING AND INVESTMENTS

11.1 EXTERNAL BORROWING

11.1.1 The Trust must comply with the code, determined by NHSE and laid before Parliament, for the total amount of borrowing.

11.1.2 The Trust may borrow money for the purpose of or in connection with its functions.

11.1.3 The total amount of the Trust's borrowing is subject to the limit imposed by its authorisation, NHSE's minimum cash balance or any other limit in line with NHSE's cash funding regime.

11.1.4 The limit is reviewed annually by NHSE in line with annual financial plans and monthly financial monitoring.

11.1.5 Any application for a loan or overdraft or the use of any Working Capital Facility will only be made by the Director of Finance or by an employee so delegated by him/her.

11.1.6 The Director of Finance must prepare detailed procedural instructions concerning applications for loans and overdrafts.

11.1.7 All short term borrowings should be kept to the minimum period of time possible, consistent with the overall cash flow position. Any short term borrowing requirement must be authorised by the Director of Finance.

11.1.8 All Long Term borrowing must be consistent with the plans outlined in the current Business Plan approved by the Board of Directors.

11.2 PUBLIC DIVIDEND CAPITAL

The amount that was the public dividend capital immediately prior to becoming a Foundation Trust continues as the public dividend capital of the Trust.

11.2.1 The dividend paid by the Trust is to be the same as that payable by NHS Trusts in England in pursuance of the National Health Service Act 2006 (dividend on public dividend capital) and must be authorised by the Chief Executive;

11.2.2 Any amount paid to the Secretary of State by the Trust by way of repayment of public dividend capital is to be paid into the Consolidated Fund.

11.3 INVESTMENTS OF SURPLUS CASH

11.3.1 The Trust may invest money (other than money held by it as trustee) for the purposes of or in connection with its functions.

11.3.2 The investment may include investment by:

a) Forming or participating in forming, bodies corporate;

b) Otherwise acquiring membership of bodies corporate.

11.3.3 The Trust may not undertake any investment which contains financial risk to the Trust. All investments must be authorised by the Director of Finance or by a delegated officer.

11.3.4 A Treasury Management policy will be formulated by the Director of Finance in conjunction with Audit and Finance and Productivity Committees and approved by the Board of Directors.

12 CAPITAL INVESTMENT, PRIVATE FINANCING, FIXED ASSET REGISTERS AND SECURITY OF ASSETS

12.1 CAPITAL INVESTMENT

12.1.1 The Chief Executive:

(a) shall ensure that there is an adequate appraisal and approval process in place for determining capital expenditure priorities and the effect of each proposal upon business plans;

(b) is responsible for the management of all stages of capital schemes and for ensuring that schemes are delivered on time and to cost;

(c) shall ensure the Trusts annual capital plan does not exceed the capital resource provided by the Integrated Care System; and

(d) that the capital investment is not undertaken without the availability of resources to finance all revenue consequences, including capital charges.

12.1.2 For every capital expenditure proposal the Chief Executive shall ensure:

(a) that a business case, prepared to a standard format as determined by the Board of Directors is produced setting out:

(i) an option appraisal of potential benefits compared with known costs to determine the option with the highest ratio of benefits to costs; and

(ii) appropriate project management and control arrangements; and

(b) that the Director of Finance has certified professionally to the costs and revenue consequences detailed in the business case, and that the extent of external funding is identified.

12.1.3 For capital schemes where the contracts stipulate stage payments, the Chief Executive will issue procedures for their management, incorporating the recommendations of NHSE.

The Director of Finance shall issue procedures for the regular reporting of expenditure and commitment against authorised expenditure.

12.1.4 The approval of a capital programme shall not constitute approval for expenditure on any scheme. The Chief Executive shall issue to the manager responsible for any scheme:

(a) specific authority to commit expenditure;

(b) authority to proceed to tender;

(c) approval to accept a successful tender.

The Chief Executive will issue a scheme of delegation for capital investment management in accordance with the Trust's Standing Orders.

12.1.5 The Director of Finance shall issue procedures governing the financial management, including variations to contract, of capital investment projects and valuation for accounting purposes. This includes projects procured through the Private Finance Contract.

12.2 PRIVATE FINANCE

12.2.1 When the Trust proposes to use finance which is to be provided other than through its own resources or direct borrowing within its Prudential Borrowing Limit.

(a) The Director of Finance shall demonstrate in the business case that the use of private finance represents value for money and genuinely transfers risk to the private sector.

(b) Where the sum involved exceeds delegated limits, the business case must be referred to NHSE.

(c) The proposal must be specifically agreed by the Board.

12.3 ASSET REGISTERS

12.3.1 The Chief Executive is responsible for the maintenance of registers of assets, taking account of the advice of the Director of Finance concerning the form of any register and the method of updating, and arranging for physical checks of assets against the asset register to be conducted annually.

12.3.2 Each Trust shall maintain an asset register recording fixed assets. The minimum data set to be held within these registers shall be as specified in the Capital Accounting Manual as issued by the NHSE.

12.3.3 Additions to the fixed asset register must be clearly identified to an appropriate budget holder and be validated by reference to:

(a) properly authorised and approved agreements, architects' certificates, suppliers' invoices and other documentary evidence in respect of purchases from third parties;

(b) stores requisitions for own materials, appropriate overheads; and

(c) lease agreements in respect of assets held under a lease and capitalised.

(d) the appropriate guidance on assets arising as a consequence of PFI contracts.

12.3.4 Where capital assets are sold, scrapped, lost or otherwise disposed of, their value must be removed from the accounting records and each disposal must be validated by reference to authorisation documents and invoices (where appropriate).

12.3.5 The Director of Finance shall approve procedures for reconciling balances on fixed assets accounts in ledgers against balances on fixed asset registers.

12.3.6 The value of each asset shall be revalued and depreciated in line with the Trust's revaluation and depreciation accounting policy as agreed by the Board.

12.3.7 Buildings should be designated protected or non-protected.

12.4 SECURITY OF ASSETS

12.4.1 The overall control and security of fixed assets is the responsibility of the Chief Executive.

12.4.2 Asset control procedures (including fixed assets, cash, cheques and negotiable instruments, and also including donated assets) must be approved by the Director of Finance. This procedure shall make provision for:

(a) recording managerial responsibility for each asset;

(b) identification of additions and disposals;

(c) identification of all repairs and maintenance expenses;

(d) physical security of assets;

(e) annual verification of the existence of, condition of, and title to, assets recorded;

(f) identification and reporting of all costs associated with the retention of an asset; and

(g) reporting, recording and safekeeping of cash, cheques, and negotiable instruments.

12.4.3 All discrepancies revealed by verification of physical assets to fixed asset register shall be notified to the Director of Finance and the Local Security Management Specialist where theft is suspected.

12.4.4 Whilst each employee has a responsibility for the security of property of the Trust, it is the responsibility of directors and managers in all disciplines to apply such appropriate routine security practices in relation to NHS property as may be determined by the Board. Any breach of agreed security practices must be reported in accordance with instructions.

12.4.5 Any damage to the Trust's premises, equipment, or any loss of equipment, stores or supplies must be reported by directors and employees in accordance with the procedure for reporting losses.

12.4.6 Where practical, assets should be marked as Trust property.

13 STORES AND RECEIPT OF GOODS

13.1 Stores, defined in terms of controlled stores and departmental stores (for immediate use) should be:

(a) kept to a minimum;

(b) subjected to annual stocktake;

(c) valued at the lower of cost and net realisable value.

13.2 Subject to the responsibility of the Director of Finance for the systems of control, overall responsibility for the control of stores shall be delegated by the Chief Executive. The day-to-day responsibility may be delegated by them to departmental employees and stores managers/keepers, subject to such delegation being entered in a record available to the Director of Finance. The control of Pharmaceutical stocks shall be the responsibility of a designated Pharmaceutical Officer; the control of fuel oil and coal of a designated estates manager.

13.3 The responsibility for security arrangements and the custody of keys for all stores and locations shall be clearly defined in writing by the designated manager. Wherever practicable, stocks should be marked as health service property.

13.4 The Director of Finance shall set out procedures and systems to regulate the stores including records for receipt of goods, issues, and returns to stores, and losses.

13.5 Stocktaking arrangements shall be agreed with the Director of Finance.

13.6 The designated manager shall be responsible for a system approved by the Director of Finance for a review of slow moving and obsolete items and for condemnation, disposal, and replacement of all unserviceable articles. The designated officer shall report to the Director of Finance any evidence of significant overstocking and of any negligence or malpractice (see also 14, Disposals and Condemnations, Losses and Special Payments). Procedures for the disposal of obsolete stock shall follow the procedures set out (see 14) for disposal of all surplus and obsolete goods.

14 DISPOSALS AND CONDEMNATIONS, LOSSES AND SPECIAL PAYMENTS

14.1 DISPOSALS AND CONDEMNATIONS

14.1.1 The Director of Finance must prepare detailed procedures for the disposal of surplus/obsolete assets including condemnations and ensure that these are notified to managers.

14.1.2 When it is decided to dispose of a Trust asset, the head of department or authorised deputy will determine and advise the Director of Finance of the estimated market value of the item, taking account of professional advice (e.g. procurement) where appropriate. For those items likely to have a value, the means of disposal will be agreed by the Director of Finance. NHSE and the relevant ICB's must be notified through the Annual Plan and agree any disposal of protected assets.

14.1.3 All unserviceable articles shall be:

(a) condemned or otherwise disposed of by an employee authorised for that purpose by the Director of Finance;

(b) recorded by the Condemning Officer in a form approved by the Director of Finance which will indicate whether the articles are to be converted, destroyed or otherwise disposed of. All entries shall be confirmed by the countersignature of a second employee authorised for the purpose by the Director of Finance.

14.1.4 The Condemning Officer shall satisfy himself as to whether or not there is evidence of negligence in use and shall report any such evidence to the Director of Finance who will take the appropriate action.

14.2 LOSSES AND SPECIAL PAYMENTS

14.2.1 The Director of Finance must prepare procedural instructions on the recording of and accounting for condemnations, losses, and special payments. The Director of Finance must also prepare a 'fraud response plan' that sets out the action to be taken both by persons detecting a suspected fraud and those persons responsible for investigating it. Due regard to offences created under the Bribery Act 2010 need also be considered in relation to the giving (or offering) or receiving (or requesting) a financial or other advantage in connection with the improper performance of a position of trust, or a function that is expected to be performed impartially or in good faith.

14.2.2 Any employee discovering or suspecting a loss of any kind must immediately inform their head of department, who must inform their director or directorate manager. This officer will then appropriately inform the Director of Finance and/or Chief Executive. Where a criminal offence (theft or arson) is suspected, both the Police and the Local Security Management Specialist should be informed immediately. In cases of suspected fraud and corruption, the employee shall report suspicions to an officer independent from line management. In such circumstances, options include:-

- Director of Finance
- Local Counter Fraud Specialist

In such cases, the particular circumstances will determine at what stage the Police should be notified - this decision will be made by the Director of Finance, subject to procedural guidance laid down in the NHS Fraud and Corruption Manual.

14.2.3 For significant losses apparently caused by theft, arson, neglect of duty or gross carelessness, the Director of Finance must immediately notify:

(a) the Board, and

(b) the External Auditor.

14.2.4 Within limits delegated to it by NHSE, the Board shall approve the writing-off of losses.

14.2.5 The Director of Finance shall be authorised to take any necessary steps to safeguard the Trust's interests in bankruptcies and company liquidations.

14.2.6 For any loss, the Director of Finance should consider whether any insurance claim can be made.

14.2.7 The Director of Finance shall maintain a Losses and Special Payments Register in which write-off action is recorded.

15 INFORMATION TECHNOLOGY AND FINANCE SYSTEMS

15.1 The Director of Finance, who is responsible for the accuracy and security of the computerised financial data of the Trust, shall:

(a) devise and implement any necessary procedures to ensure adequate protection of the Trust's data, for which they are responsible from accidental or intentional disclosure to unauthorised persons, deletion or modification, having due regard for the Data Protection Act 2018;

(b) ensure that adequate controls exist over data entry, processing, storage, transmission and output to ensure security, privacy, accuracy, completeness, and timeliness of the data, as well as the efficient and effective operation of the system;

(c) ensure that adequate controls exist such that the computer operation is separated from development, maintenance and amendment;

(d) ensure that an adequate management (audit) trail exists through the computerised system and that such computer audit reviews as he/she may consider necessary are being carried out.

15.2 The Director of Finance shall satisfy themselves that new financial systems and amendments to current financial systems are developed in a controlled manner and thoroughly tested prior to implementation. Where this is undertaken by another organisation, assurances of adequacy will be obtained from them prior to implementation.

15.3 The Director of Finance shall ensure that contracts for computer services for financial applications with any other agency shall clearly define the responsibility of all parties for the security, privacy, accuracy, completeness, and timeliness of data during processing, transmission and storage. The contract should also ensure rights of access for audit purposes.

15.4 Where another agency provides a computer service for financial applications, the Director of Finance shall periodically seek assurances that adequate controls are in operation.

15.5 Where computer systems have an impact on corporate financial systems the Director of Finance shall satisfy themselves that:

(a) systems acquisition, development and maintenance are in line with corporate policies.

(b) data produced for use with financial systems is adequate, accurate, complete and timely, and that a management (audit) trail exists;

(c) Director of Finance staff have access to such data; and

(d) such computer audit reviews as are considered necessary are being carried out.

16 PATIENTS' PROPERTY

16.1 The Trust has a responsibility to provide safe custody for money and other personal property (hereafter referred to as "property") handed in by patients, in the possession of unconscious or confused patients, or found in the possession of patients dying in hospital or dead on arrival.

16.2 The Chief Executive is responsible for ensuring that patients or their guardians, as appropriate, are informed before or at admission that the Trust will not accept responsibility or liability for patients' property brought into Health Service premises, unless it is handed in for safe custody and a copy of an official patients' property record is obtained as a receipt.

16.3 The Director of Finance must provide detailed written instructions on the collection, custody, recording, safekeeping, and disposal of patients' property (including instructions on the disposal of the property of deceased patients and of patients transferred to other premises) for all staff whose duty is to administer, in any way, the property of patients.

16.4 Staff should be informed, on appointment, by the appropriate departmental or senior manager of their responsibilities and duties for the administration of the property of patients.

17 CHARITABLE FUNDS

17.1 INTRODUCTION

17.1.1 Standing Orders (SOs) identify the Trust's responsibilities as a corporate trustee for the management of funds it holds on trust and define how those responsibilities are to be discharged. They explain that although the management processes may overlap with those of the organisation of the Trust, the trustee responsibilities must be discharged separately.

17.1.2 As management processes overlap most of the sections of these SFIs will apply to the management of funds held on trust. This section covers those instructions which are specific to the management of funds held on trust.

17.1.3 The over-riding principle is that the integrity of each trust must be maintained and statutory and trust obligations met. Materiality must be assessed separately from Exchequer activities and funds.

17.2 CHARITABLE FUNDS

17.2.1 Within this section "charitable funds" are those gifts, donations and endowments made under the relevant charities legislation and held on trust for purposes relating to the National Health Service, the objects of which are for the benefit of the National Health Service in England. They are administered by the Board acting as trustees.

17.2.2 The Director of Finance shall maintain such accounts and records as may be necessary to record and protect all transactions and funds of the Trust as trustees of charitable funds including an Investments Register.

17.2.3 The Director of Finance shall prepare detailed procedural instructions concerning the receiving, recording, investment and accounting for charitable funds.

17.2.4 All gifts accepted shall be received and held in the name of the Trust and administered in accordance with the Trust's policy, subject to the terms of specific donations. For the protection of the Trust and its officers, all monies donated to the Trust, or any department thereof, shall be credited only to authorised bank accounts held by the Trust. As the Trust can accept gifts only for all or any purposes relating to the Health Service, officers shall, in cases of doubt, consult the Director of Finance before accepting any gifts. Advice to the Board on the financial implications of fund-raising activities by outside bodies or organisations shall be given only by the Director of Finance.

17.2.5 The Director of Finance shall be required to advise the Board on the financial implications of any proposal for fund raising activities which the Trust may initiate, sponsor or approve.

17.2.6 The Director of Finance shall be kept informed of all enquiries regarding legacies and shall keep an appropriate record. After the death of a testator all correspondence concerning a legacy shall be dealt with on behalf of the Trust by the Director of Finance who alone shall be empowered to give and execute a good discharge.

17.2.7 Charitable funds shall be invested by agreement of the Trust's Charitable Funds Committee in accordance with the Trust's policy and subject to statutory requirements.

17.2.8 Expenditure of any charitable funds shall be conditional upon the item being within the terms of the appropriate donation and the procedures approved by the Board. Approval limits are set out in the Appended Schedule of Authorised Limits.

17.2.9 Where it becomes necessary for the Trust to obtain Grant of Probate, or to make application for grant of letters of administration, in order to obtain a legacy due to the Trust under the terms of a Will, the Director of Finance shall be the Trust's nominee for the purpose.

18 STANDARDS OF BUSINESS CONDUCT

18.1 POLICY

18.1.1 Staff must comply with the national guidance contained in Standards of Business Conduct Policy issued by NHSE for NHS staff, the Trust's Conduct Policy on Standards of Business Conduct and the Fit and Proper Persons Requirements Policy. Key issues addressed in the policies are stated below.

18.2 PRINCIPLES OF CONDUCT IN THE NHS

18.2.1 To provide high quality health care, employees must;

(a) be impartial and honest in the conduct of their role and staff should ensure their actions remain above and beyond suspicion

(b) ensure that the interest of patients remains paramount at all times

(c) effectively utilise the funds entrusted to them to the best advantage of the service

(d) declare to their manager, should they secure private work through or as a result of their employment within the Trust

(e) declare any external work undertaken

18.3 THE LEGAL POSITION

18.3.1 Under the Trust's Disciplinary Policy and the terms and conditions of an employee's contract, it is an offence for staff to accept any inducement or reward for:

(a) doing, or refraining from doing anything in their official capacity

(b) showing favour or disfavour to any person in their official capacity

18.3.2 The Bribery Act reforms the criminal law of bribery, making it easier to tackle this offence proactively in the public and private sectors. The Bribery Act sets out four specific offences of:

1. Offering, promising or giving a bribe to another person to perform a relevant function or activity improperly, or to reward a person for the improper performance of such a function or activity.
2. Requesting, agreeing to receive or accepting a bribe to perform a function or activity improperly, irrespective of whether the recipient of the bribe requests or receives it directly or through a third party, and irrespective of whether it is for the recipients benefit.
3. Failure of a commercial organisation to prevent bribery (the corporate offence). This is a strict liability offence and an organisation can be found guilty of 'attempted' or 'actual' bribery on the organisation's behalf.
4. Bribing a foreign public official (not thought to be particularly applicable to NHS organisations/staff).

The penalties for person/s found guilty of committing any of the above offences can impose a maximum imprisonment of 10 years and a fine not exceeding the statutory maximum.

18.4 CONFIDENTIALITY

18.4.1 Employees in the course of their duties may gain access to business information in relation to the running of the Trust. Employees may also gain access to information that relates to staff, patients and/or other clients. Such information is regarded by the Trust as **CONFIDENTIAL.** Therefore all members of staff **must not** disclose such information either in the course of their duties whilst in employment or at any time after the termination of their contract, to any person who does not have the right to this information.

18.4.2 Employees are also not permitted to release in any form the whole or part of any document belonging to the Trust, except where **express consent** by a Director has been given, in relation to the proper performance of an employee's duties.

18.5 CASUAL GIFTS

18.5.1 Casual gifts offered by contractors or others, may not be in any way connected with an employee's performance of duties so as to constitute an offence under the terms and conditions of their employment contract. Articles of up to £50.00 need not necessarily be refused and need not be declared. Staff should consult their line manager if in doubt. Offences created under the Bribery Act 2010 need also be considered in relation to casual gifts. All gifts above £50.00 must be declared to the Board Secretary see section 18.18 below.

18.6 HOSPITALITY

18.6.1 **Appropriate** and modest hospitality may be acceptable and should be declared in the hospitality register held by the Board Secretary. Any hospitality from pharmaceutical companies must comply with the Association of British Pharmaceutical Industries (ABPA) guidelines. Offences created under the Bribery Act 2010 need also be considered in relation to hospitality.

18.6.2 Trust staff should decline all other offers of gifts, hospitality or entertainment which are over and above this level. Staff should consult their line manager if in doubt.

18.7 INTEREST OF OFFICERS IN CONTRACTS

18.7.1 If it comes to the knowledge of a director or an officer of the Trust that a contract in which he has any pecuniary interest whilst not being a contract to which they themselves are a party, has been, or is proposed to be, entered into by the Trust they shall, at once, give notice in writing to the Chief Executive of the fact that they are interested therein. In the case of married persons (or persons) living together as partners, the interest of one partner shall, if known to the other, be deemed to be also in the interest of that partner. The interest must be reported to the Board Secretary see section 18.18 below.

18.8 PRIVATE TRANSACTIONS

18.8.1 Trust staff must not seek or accept preferential rates or benefits in kind for private transactions carried out with companies with which they have had, or may have official dealings on behalf of the Trust. If individuals do receive benefits in kind or preferential rates as a result of their business this may be deemed as a contravention of the Bribery Act 2010 and may lead to criminal or disciplinary action being taken.

18.8.2 An officer must also declare to the Chief Executive any other employment or business or other relationship of his, or of a cohabiting **partner**, that conflicts, or might reasonably be predicted could conflict with the interests of the Trust.

18.8.3 All board members are required, upon appointment, to subscribe to the NHS Code of Conduct and Code of Accountability.

18.9 CANVASSING OF AND RECOMMENDATIONS BY DIRECTORS IN RELATION TO APPOINTMENTS

18.9.1 Canvassing of directors of the Trust or members of any committee of the Trust directly or indirectly for any appointment under the Trust shall disqualify the candidate from such an appointment. The contents of this paragraph of the Standing Order shall be included in employment contracts or otherwise brought to the attention of candidates.

18.10 RELATIVES OF DIRECTORS OR OFFICERS

18.10.1 Candidates for any staff appointment shall when making application disclose in writing whether they are related to any director or the holder of any office under the Trust or that of its collaboration partners. Failure to disclose such a relationship may disqualify a candidate and, if appointed, render them liable to instant dismissal.

18.10.2 The directors and every officer of the Trust with recruitment responsibility shall disclose to the Chief Executive any relationship with a candidate of whose candidature that director or officer is aware. It shall be the duty of the Chief Executive to put appropriate safeguards in place to ensure the decision making process is operated fairly.

18.10.3 On appointment, directors (and prior to acceptance of an appointment in the case of executive directors) should disclose to the Trust whether they are related to any other director or holder of any office under the Trust or that of its collaboration partners.

18.10.4 Where the relationship of an officer or another director to a director as outlined above, is disclosed, the Standing Order headed ‘Disability of directors in proceedings on account of pecuniary interest’ shall apply.

18.10.5 Staff must ensure that no special favour is shown to current or former employees or their close relatives or associates in awarding contracts to private or other businesses run by them or employing them in a senior or relevant management capacity. Contracts may be awarded to such businesses, but scrupulous care must be taken to ensure that the tendering and selection processes are conducted impartially, and that staff who are known to have a relevant interest take no part in

the selection process.

18.11 EMPLOYMENT

18.11.1 Staff are advised not to engage in outside employment which may conflict with the Trust's business or be detrimental to it or its reputation. Under exceptional circumstances employees may request formal agreement from their line-manager to engage in outside employment.

18.11.2 Staff are also reminded of their responsibility to ensure that work undertaken in addition to their substantive contractual duties with the Trust is not detrimental to their employment and does not impair their ability to perform their duties for the Trust. This must be declared in line with the Trusts Conduct Policy relating to outside employment/private practice, in addition to the declaration requirements under the Working Time Regulations.

18.12 PRICIPLES OF PRIVATE WORK

18.12.1 For medical staff:-

(a) Consultants and Associate Specialists employed under the Terms and Conditions of Service for Hospital Medical and Dental staff are permitted to carry out private practice in NHS Hospitals subject to the conditions outline in the handbook, "A Guide to the Management of Private Practice in the NHS". Consultants who have signed new contracts with the Trust will be subject to the terms applying to private practice in those contracts.

(b) All medical staff are entitled to fees for other work outside the NHS contractual duties under "Category 2" (Paragraph 37 of the Terms and Conditions for Medical and Dental staff) e.g. examinations and reports for life insurance purposes.

(c) Doctors in training should not undertake locum work outside their contracts where such work would be in breach of the New Deal provisions and/or breach of the Working Time Regulations.

(d) All private work must be declared in line with the Trusts Conduct Policy relating to outside employment/private practice.

18.12.2 All other types of NHS staff employed by the Trust are encouraged to refrain from carrying out private work. Under exceptional circumstances employees may request formal agreement from their line-manager to engage in private work. If an employee does engage in private work the following criteria must be complied with:

(a) They do not use their NHS titles or the Trust's name in advertising their private work,

(b) They do not use any NHS resource including Trust buildings or facilities, stationary, secretarial support, equipment or postage,

(c) It does not adversely affect their capacity to perform their NHS duties,

(d) Private work is only undertaken at times when staff are off duty or on annual leave,

(e) They do not leave business cards or place posters in Trust premises or use any of the Trust's social media platforms,

(f) Appropriate adherence is paid to Working Time Regulations and issues of Health and Safety in relation to working hours

If agreed, it is an Audit Committee requirement that the line manager must formally notify the arrangement to the Foundation Trust Board Secretary as a Declaration of Interest.

Furthermore, it should be noted that any remuneration received from external organisations or individuals through lecturing, teaching activities or for services provided during Trust time, is income that belongs to the NHS and should therefore be paid into the relevant directorate budget. This does not include SPA activities.

If staff carry out private work in NHS time, then this may be construed as fraud and passed to the Local Counter Fraud Specialist to investigate.

18.13 REWARDS FOR INITIATIVE

18.13.1 The Trust will ensure that it is in position to identify potential intellectual property rights (IPR), so that it may ensure that its staff receive any rewards or benefits e.g. royalties in respect of any work carried out by Trust employees. Appropriate specifications and provisions will be incorporated into contractual agreements.

18.13.2 Rewards may be given voluntarily to Trust staff who within the course of their duties have produced innovative work of outstanding benefit to the NHS. Similar rewards may also be applied to other activities such as publishing articles and giving lectures.

18.13.3 In the case of collaborative research work with manufacturers, the Trust will ensure that it obtains a fair reward for the input provided. The Trust will also ensure that involvement with a particular manufacturer does not influence the purchase of other supplies from that manufacturer.

18.14 COMMERCIAL SPONSORSHIP

17.14.1 Acceptance by Trust staff of commercial sponsorship for attendance at relevant conferences/course is acceptable on provision of the staff seeking permission in advance and the manager is satisfied that acceptance will not compromise any purchasing decisions. This must be declared in line with the requirements set out in 18.18 below.

17.14.2 Pharmaceutical companies may offer to sponsor a post for the Trust. The sponsorship must not affect the purchasing decisions made by the Trust and this will be monitored. Pharmaceutical companies may request collaboration in drug trials on their product. These will in all cases, be regulated by the local ethical committee. Any financial arrangements must comply with the Association of British Pharmaceutical Industries (ABPI) regulations and must be declared.

17.14.3 Under no circumstances will the Trust agree to “linked deals”, whereby sponsorship is linked to the purchase of particular products or services.

17.14.4 In circumstances where a firm offers free equipment, the free loan of equipment, or to provide equipment at what is, prima facie, less than cost:-

(a) the individual who has been approached must seek authority from their line manager, in order to ensure that this offer can in no way be construed as an inducement for future purchase.
(b) great caution must be exercised. In such cases, managers will be expected to ensure that the transaction will bear external scrutiny.

17.15 COMMERCIAL IN CONFIDENCE

17.15.1 Trust staff must avoid using or making public, internal information of “Commercial Significance”, particular if its disclosure would prejudice the principle of a fair purchasing system.

17.15.2 This information does not relate to service delivery and activity levels, which should be publicly available as outlined in the NHS guidelines on openness.

17.16 PROFESSIONAL CODES OF CONDUCT

17.16.1 Professional staff are reminded that they are also bound by their own codes of conduct within their profession. Professional staff should be aware of their codes of conduct. Managers will ensure that current Codes of Conduct are available for access by their staff.

17.17 WHISTLE BLOWING/FREEDOM TO SPEAK UP

17.17.1 Managers should create a climate for staff to report any inappropriate behaviour in the workplace. Trust staff must feel that their legitimate views will be welcomed and, where appropriate, acted on positively. The Trust will seek to offer practical support to staff. Refer to the Trust’s ‘Raising Concerns Speak up Safely (Whistleblowing) Policy’ for further guidance.

(a) All Trust staff have a clear duty to inform their managers of any instances of malpractice towards service users.

(b) The Trust expects openness to be fostered so that staff should be encouraged freely to contribute their views on all aspects of Trust activities, especially the delivery of care to service users.

(c) All Trust staff have a clear duty to inform their managers of financial irregularities.

(d) All Trust staff have a clear duty to inform their managers of any instances of unprofessional conduct.

(e) Managers should ensure Freedom to Speak up Guardians are there to offer an impartial and confidential service accessible to all staff.

17.18 DECLARATION OF GIFTS, HOSPITALITY AND INTERESTS

17.18.1 The Trust shall maintain a hospitality and gifts register, detailing both hospitality accepted and that which has been offered but declined. The register will also record gifts received and be held by the Board Secretary.

17.18.2 The Trust shall maintain a declaration of interests register. The register will be held by the Board Secretary.

17.18.3 Failure to declare interest, hospitality or the receipt of gifts within the dedicated registers may lead to criminal or disciplinary action being taken. See the Trust's Conduct Policy for more information on this area.

19 RETENTION OF DOCUMENTS

19.1 The Chief Executive shall be responsible for maintaining archives for all documents required to be retained under the direction contained in "Records Management: NHS Code of Practice", and to enable requests under the Freedom of Information Act (2000), to be met.

19.2 The documents held in archives shall be capable of retrieval by authorised persons.

19.3 Documents held under "Records Management: NHS Code of Practice", shall only be destroyed at the express instigation of the Chief Executive, records shall be maintained of documents so destroyed.

20 RISK MANAGEMENT AND INSURANCE

20.1 The Chief Executive shall ensure that the Trust has a programme of risk management which will be approved and monitored by the Board.

20.2 The programme of risk management shall include:

a) a process for identifying and quantifying risks and potential liabilities;

b) engendering among all levels of staff a positive attitude towards the control of risk;

c) management processes to ensure all significant risks and potential liabilities are addressed including effective systems of internal control, cost effective insurance cover, and decisions on the acceptable level of retained risk;

d) contingency plans to offset the impact of adverse events;

e) audit arrangements including; internal audit, clinical audit, health and safety review;

f) arrangements to review the risk management programme.

20.3 The Director of Finance shall ensure that insurance arrangements exist in accordance with the risk management programme.

APPENDIX

SCHEDULE OF AUTHORISED LIMITS

1. SIGNATORIES ON FINANCIAL INSTRUMENTS

			£
Limit on single signatory payments	-	To third parties (inc. Charitable Funds)	10,000
	-	To obtain cash	1,500

2. PETTY CASH

Petty cash limit	-	Reimbursement of patients monies (inc. payments to relatives of deceased patients)	100
	-	All other payments	50
	-	Reimbursement of petty cash above £50 and patients' monies above £100 by prior approval of the Director of Finance	

3. QUOTATIONS AND TENDERS (all to be sought by the Procurement Department unless stated)

2 minimum verbal quotations for goods & services (end users to obtain and provide assurance to Procurement)	5,000
3 written quotations for goods & services	5,001 – 30,000
Advertisement in Government Contract Finder	30,001–139,687*
Competitive Tendering (*Find a Tender service for goods and most services)	139,687 +
Single Tender and quotation dispensation (Waivers)	
Head of Operational Procurement	5,000 – 20,000
Director / Deputy Director of Procurement	20,001 – 50,000
Chief Executive and Finance Director	50,001 - 250,000
Trust Board	Over 250,000
Level above which a Non-Executive Director should be present at tender opening	150,000
Level above which tender evaluation should include:	
(i) Executive Director	150,000
(ii) Non-Executive Director	400,000
Level above which contract award must be approved by Board	500,000

4. WRITE OFFS

Limit of authority to approve write-offs:			
(i)	Financial Services Manager		500
(ii)	Director of Finance		25,000
(iii)	Trust Board	above	25,000

5. REVENUE BUDGET REQUISITIONS(1)

Authority to approve requisition for goods and service within budget levels approved by the Board of Directors

Authorising Officers	Lead Nurses/ Midwives Department Heads Directorate Managers	up to	3,000
Budget Managers	Theatre Specialty Managers Head of Technical Services – Cardiology Matrons Clinical Service Heads Service Heads – Clinical and Specialist Support Services Laboratory Managers Radiology Manager Divisional Managers Deputy/Principal Pharmacists	up to	10,000
Budget Holders	Clinical Directors Chief Pharmacist Deputy Directors – Corporate Departments	up to	50,000
Directors	Nursing Director Medical Director Director of Strategy & Performance Chief People Officer Chief Information Officer Directors of Operations	up to	75,000
	Chief Operating Officer	up to	125,000
	Chief Executive and Director of Finance	up to	250,000
	Finance & Performance Committee	up to	500,000
	Trust Board	Over	500,000
Drugs Only	Chief Pharmacist Deputy Pharmacist Principal Pharmacist Pharmacist	up to up to up to up to	100,000 50,000 20,000 10,000

NOTE: Immediate Line Manager required to sign in post holders absence

6. VARIATIONS TO PROJECT AGREEMENT WITH PRIVATE FINANCE PARTNER

Director of Finance	up to	125,000
Chief Executive and Director of Finance	up to	250,000
Finance & Performance Committee	up to	500,000
Trust Board	Over	500,000

7. CAPITAL BUDGET APPROVALS AND REQUISITIONS

Director of Finance	up to	125,000
Chief Executive and Director of Finance	up to	250,000
Finance & Performance Committee	up to	500,000
Trust Board	Over	500,000

8. BUSINESS CASE APPROVAL(2)

Chief Executive and Director of Finance	up to	250,000
Finance & Performance Committee	up to	500,000
Trust Board	Over	500,000

NOTE: In respect of capital schemes these will need to have been included in the Capital Programme approved by the Board and the revenue consequence having been agreed by the Directorate

9. CONSULTANCY – APPROVALS AND REQUISITIONS

All consultancy approvals are via the Executive Directors meeting and in line with NHSE guidance and approval. Approval limits then follow business case limits above.

10. CHARITABLE FUNDS – APPROVALS AND REQUISITIONS

All Funds

Clinical Service Head/Clinical Director Matrons		up to	1,000
All Directors		up to	5,000
Chief Executive and Director of Finance	countersigned by Treasury Manager	up to	50,000
Charitable Funds Committee with onward reporting to Trust Board		over	50,000

Note: **Countersignature of Treasury Manager is required to confirm availability of funding. (Financial Services Manager to sign in post holder absence)**

(1) The Authority to approve requisition for goods and service within budget levels can be suspended at any time by the Trust Board and delegated authority reduced. This is likely at times of Financial Turnaround and enhanced Financial 'Grip and Control'.
In the 2024/25 financial year and for the immediate future delegated authority has suspended and all delegated limits below Director's level has been removed. In addition further controls around discretionary non-pay are also in place where on the Chief Executive and Director of Finance can authorise the defined categories.

(2) The delegated authority for the Trust to approve business cases can be suspended at any time by NHSE and the ICB. This is likely at times of Financial Turnaround and enhanced Financial 'Grip and Control'. In the 2024/25 financial year the delegated limit for Trust for business cases that have an adverse impact on the Trusts financial position is £10k.